East Suffolk and North Essex NHS Foundation Trust

Meeting of the Trust Board in Public

5th May 2022

Report Title:	**Update on Ockenden Immediate and Essential Actions – One Year On**
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Previously considered by:	N/A

☐ **Approval** ☑ **Discussion** ☑ **Information** ☑ **Assurance**

Purpose of the Report

On 30th March 2022, the final report from Donna Ockenden's independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust was published.

This report provides:

1. A summary of all remaining outstanding actions from the interim report issued in December 2020, on which the Board received a full progress report ("Ockenden – One year on") in March 2022.
2. An overview of the final report issued on 30th March 2022.
3. An overview of the impact of the Ockenden report on Midwifery Continuity of Carer plans, together with quarterly update on progress.

Action Required of the Committee

- The Board is requested to receive this report for information and assurance purposes that the Trust is enacting and reviewing all recommendations regarding the Ockenden Final report.
- The Board is asked to approve receipt of the Trust's Midwifery Continuity of Carer plan at the June Board, in line with national requirements, following further work being concluded in light of the Ockenden recommendations.

Link to Strategic Objectives (SO)		**Please tick**
SO1	Keep people in control of their health	☑
SO2	Lead the integration of care	☐
SO3	Develop our centres of excellence	☑
SO4	Support and develop our staff	☑
SO4	Drive technology enabled care	☐

Risk Implications for the Trust *(including any clinical and financial consequences)*	A failure to ensure that the Trust is compliant with all the Urgent and Immediate Actions as outlined in the Ockenden report, caused by inadequate planning and activity, may lead to

	pregnant people and their families coming to harm, leading to concerns about maternity services being raised to Trust regulators. This may lead to sanctions being placed against the Trust's license.
Trust Risk Appetite	The Board has a cautious risk appetite when it comes to compliance and regulatory issues. Where the laws, regulations and standards are about the delivery of safe, high quality care, it will make every effort to meet regulator expectations and comply with them and will only challenge them if there is strong evidence or argument to do so.
Legal and regulatory implications *(including links to CQC outcomes, Monitor, inspections, audits, etc.)*	A failure to ensure that systems and processes are in place to support the safe delivery of maternity services may lead to a breach of the Trust's registration in line with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In particular, this may specifically call into question Regulation 12 Safe Care and Treatment; Regulation 13 Safeguarding service users from abuse and improper treatment, and Regulation 18 Staffing
Financial Implications	Consideration of the Trust being an organisation that can expand and deliver increased services, through bids for capital and increased revenue, may be affected if the Trust cannot evidence the delivery of safe and effective care across all its services.
Equality and Diversity	Due to the nature of maternity services it is recognised that any gaps in service provision will negatively affect pregnant people and their families, and any detriments to their healthcare must be addressed as an urgent priority.

1. Summary of outstanding actions from the interim Ockenden report issued December 2020.

Immediate and Essential Action	Question	Action	Outstanding element/s	Expected closure date
1 - Enhanced safety	Q2	External clinical specialist opinion for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death	Relevant inter-LMNS arrangement in place with fully ratified SOP. Audit of the process has been added to the ACAP but first audit yet to take place following process implementation on 1st April 2022.	31/10/2022
	Q3	All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months	Process in place since December 2021, with relevant item included monthly on the Maternity Assurance section of the Board Performance Report. The reporting process is covered by the Maternity Guideline - Managing and Sharing of Dashboards and Safety Reports. To further evidence the process is in place, currently establishing whether there is a SOP or TOR for the reporting process in which this item can be specifically set out.	31/05/2022
	Q3	Confirmation that SI GO TO Trust Board & LMNS	Whilst this process is in place for PSIIs, since ESNEFT does not utilise the SI classification or terminology, a query has been raised with NSHE/I regionally as to whether any additional reporting is required (cases which would formerly have been SIs but don't meet the PSII criteria).	31/05/2022
	Q4	Using the National Perinatal Mortality Review Tool to review perinatal deaths	Whilst the process is in place, the related SOP has yet to be ratified - due end April 2022.	31/05/2022
2 - Listening to women and families		No outstanding actions		
3 - Staff working and training togethe	Q18	Twice daily consultant-led and present multidisciplinary ward rounds on the labour ward.	Twice daily consulant-led ward rounds have been permanently resourced and implemented. Delivery Suite Ward Rounds guideline to be updated to reflect changes made in March 2022 (minor amendment to the document).	30/06/2022
	Q19	External funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only	Whilst we have confirmation of this from the Finance Director, evidence is pending of recent cases where implemented.	31/05/2022

5 - Risk assessment throughout pregr	Q31	Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.	Outstanding element is the implementation of a guideline at Colchester which replicates one already in place at Ipswich, "Birth outside guidance" guideline - due for completion circa 31/07/2022.	31/07/2022
6 - Monitoring fetal wellbeing	Q34	Appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring	All posts in place, and to complete this action we will require evidence of the Leads' involvement in incident investigations and reviews as part of the role - evidence not yet available.	30/09/2022
7 - Informed consent	Q41	Women must be enabled to participate equally in all decision-making processes	Outstanding element is an audit of 1% of notes, demonstrating compliance. The audit is underway and will in fact cover 5% of notes, as the parameters cover two different required audits. Due for completion in June 2022.	30/06/2022
	Q42	Women's choices following a shared and informed decision-making process must be respected	The audit is underway and will in fact cover 5% of notes, as the parameters cover two different required audits. Due for completion in June 2022.	30/06/2022
	Q44	Pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website.	Gap analysis against "best practice" example website completed by MVP as per requirements, and the service is assessing whether to adopt each of the recommendations, once the current freeze on ESNEFT website content is lifted.	30/06/2022

2. Overview of final Ockenden report issued on 30th March 2022

2a. <u>The Ockenden Final Report: Shrewsbury and Telford</u>

- The final report from Donna Ockenden's independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust was published on 30 March 2022.
- The report provides an immediate call to action for all commissioners and providers of maternity and neonatal services to ensure lessons are rapidly learned and service improvements for women, babies, and their families are driven forward as quickly as possible.
- NHSE and NHSI are working with the Department of Health and Social Care to implement the 15 Immediate & Essential Actions (IEAs). Every Trust, Integrated Care System (ICS) and Local Maternity & Neonatal System (LMNS) Board must consider and then act on the report's findings.
- The £127m investment announced before the publication of the report will build on the £92m distributed to Maternity services to fund workforce expansion, leadership development, capital to increase neonatal cot capacity, additional support to LMS/LMNS and retention support.
- All Boards will take the Ockenden report to their next public Board meeting to be shared with all relevant stakeholders.

2b. The Ockenden Report: Four key pillars

All organisations should take action to mitigate any risks identified and develop robust plans against areas where your services need to make changes, paying particular attention to the report's four key pillars:

1. Safe staffing levels
2. A well-trained workforce
3. Learning from incidents
4. Listening to families

The report highlights the importance of listening to women and their families.

We need to ensure women have the necessary information and support to make informed, personalised, and safe decisions about their care.

2c. Ockenden Report: Fifteen work streams

The Immediate and Essential Actions set out in the final report fall within 15 work streams, for each of which a high level summary follows. There is greater detail in the report and we are currently benchmarking ESNEFT maternity services against the requirements.

1. Workforce planning and sustainability

a. Financing a safe maternity workforce

The recommendations from the Health and Social Care Committee Report: '*The safety of maternity services in England'* must be implemented.

b. Training

The Health and Social Care Select Committee view that a proportion of maternity budgets must be ring-fenced for training in every maternity unit should be implemented.

2. Safe staffing

All Trusts must maintain a clear escalation and mitigation policy where maternity staffing falls below the minimum staffing levels for all health professionals.

3. Escalation and accountability

Staff must be able to escalate concerns if necessary.

There must be clear processes for ensuring that obstetric units are staffed by appropriately trained staff at all times. If not resident, there must be clear guidelines for when a consultant obstetrician should attend.

4. Clinical governance – leadership

Trust boards must have oversight of the quality and performance of their maternity services. In all maternity services the Director of Midwifery and Clinical Director for obstetrics must be jointly operationally responsible and accountable for the maternity governance systems.

5. Clinical governance – Incident investigation and complaints

Incident investigations must be meaningful for families and staff and lessons must be learned and implemented in practice in a timely manner.

6. Learning from maternal deaths

Nationally all maternal post-mortem examinations must be conducted by a pathologist who is an expert in maternal physiology and pregnancy related pathologies. In the case of a maternal death a joint review panel/investigation of all services involved in the care must include representation from all applicable hospitals/clinical settings

7. Multidisciplinary training

Staff who work together must train together. Staff should attend regular mandatory training and rotas. Job planning needs to ensure all staff can attend. Clinicians must not work on labour ward without appropriate regular CTG training and emergency skills training.

8. Complex antenatal care

Local Maternity Systems, Maternal Medicine Networks and trusts must ensure that women have access to pre-conception care. Trusts must provide services for women with multiple pregnancy in line with national guidance Trusts must follow national guidance for managing women with diabetes and hypertension in pregnancy

9. Pre-term birth

The LMNS, commissioners and trusts must work collaboratively to ensure systems are in place for the management of women at high risk of preterm birth. Trusts must implement NHS Saving Babies Lives Version 2 (2019).

10. Labour and birth

Women who choose birth outside a hospital setting must receive accurate advice with regards to transfer times to an obstetric unit should this be necessary. Centralised CTG monitoring systems should be mandatory in obstetric unit

11. Obstetric anaesthesia

In addition to routine inpatient obstetric anaesthesia follow-up, a pathway for outpatient postnatal anaesthetic follow-up must be available in every trust to address incidences of physical and psychological harm. Documentation of patient assessments and interactions by obstetric anaesthetists must improve. The determination of core datasets that must be recorded during every obstetric anaesthetic intervention would result in record-keeping that more accurately reflects events. Staffing shortages in obstetric anaesthesia must be highlighted and updated guidance for the planning and provision of safe obstetric anaesthesia services throughout England must be developed.

12. Postnatal care

Trusts must ensure that women readmitted to a postnatal ward and all unwell postnatal women have timely consultant review. Postnatal wards must be adequately staffed at all times

13. Bereavement care

Trusts must ensure that women who have suffered pregnancy loss have appropriate bereavement care services

14. Neonatal care

There must be clear pathways of care for provision of neonatal care. This review endorses the recommendations from the Neonatal Critical Care Review (December 2019) to expand neonatal critical care, increase neonatal cot numbers, develop the workforce and enhance the experience of families. This work must now progress at pace.

15. Supporting families

Care and consideration of the mental health and wellbeing of mothers, their partners and the family as a whole must be integral to all aspects of maternity service provision Maternity care providers must actively engage with the local community and those with lived experience, to deliver services that are informed by what women and their families say they need from their care

2d. Next steps

- ✓ Trusts are asked to set out at a Public Board our progress against the seven IEAs in the interim Ockenden report – occurring today
- ➢ Update and discuss progress with the LMNS and ICS and report to regional teams.
- ➢ Provide a breakdown of progress reports and compliance with the first Ockenden IEAs at NHSE/I public Board in May (end May).
- ➢ Reliable data submitted as part of the provider workforce return, with executive level oversight (from April 2022)

- Benchmark the Trust against all criteria within each immediate and essential action – work commenced in the Trust from April 2022

3. Impact of the Ockenden report on Midwifery Continuity of Carer (MCoC) plans, together with quarterly update on progress.

3a. Reporting

Following presentation to the Trust Board in December 2021 ESNEFT's MCoC plans were approved by the Suffolk and North Essex Local Maternity Neonatal System (LMNS) Board in January 2022 for submission to NHS England and Improvement.

The following report is the first of the required quarterly updates for the Board of Directors and the LMNSB, detailing progress against the building blocks required in the publication from NHSE/I "Delivering Midwifery Continuity of Carer at full scale" dated October 2021.

3b. Safe Staffing

The Better Births Lead has worked with the regional team to look at projections for staffing required to maintain safe staffing levels during the implementation of MCoC as a default model of care. Regular meetings are ongoing with the senior management teams to monitor current staffing levels and to review the recruitment plan and staffing projections. Recruitment continues both nationally and internationally to address the current vacancy rates.

3c. Planning Spreadsheet

This has been completed for both sites in line with Birth Rate+ recommendations from 2019 with guidance from the regional leads. This has been used to ensure safety from a staffing perspective at each level of implementation.

3d. Communication and Engagement

The Communications plan has now been finalised to ensure all relevant parties are informed of progress and intentions. Monthly open Q&A sessions are taking place, which will increase to fortnightly from May 2022. These sessions have allowed staff to express any concerns and enabled them to have access to local Trust staff members already implementing this care pathway. The common themes from these meetings have been collated and ongoing feedback is being given to staff as a presentation at the beginning of each new session.

A web-based padlet (digital communiation medium) is under construction to provide staff with easy access to all MCoC information and materials to date. This had been implemented effectively in a neighbouring Trust and proved an efficient way to share guidance and documentation with maternity staff on the ground.

3e. Skill Mix

Ongoing work with the recruitment and practice development teams is underway to ensure a training needs analysis (TNA) is worked through for all staff and that they are supported to refresh/gain the skills required to work in all aspects of maternity care.

Ongoing work to monitor midwifery skill mix both in community and inpatient settings continues to ensure support for preceptees and those new to the Trust.

3f. Linked Obstetrician

Initial conversations have progressed between the Consultant teams and the Better Births Lead Midwife. The Consultants felt they would like to be able to network and discuss this model of care with Consultants already working in this way. The regional team are organising an event in May 2022 for Consultants to attend to be able to have this opportunity.

3g. Standard Operating Procedure

This is available as per original plans and will have amended appendices for each team to address any specific requirements for the team members and local demographic, including any additions to the usual

care pathway, plans for how pregnant people will be able to meet the whole team, and off duty examples for the midwives.

3h. Pay

Ongoing work is underway to implement the 4.5% uplift in pay for midwives who work in continuity teams, in line with the national recommendation.

3i. Estate and Equipment

Funding was secured in February 2022 from the LMNS to purchase extra equipment to support implementation of MCoC. Ongoing work by community matrons is underway to secure more clinical space in the community as hubs for the MCoC teams as they roll out. The first phase of the plan has these in place and further hubs for the subsequent teams are being sourced. For the North East Essex teams, the Clacton Hospital site will be utilised and is already set up as a stand-alone hub in the current working pattern. For the Ipswich and East Suffolk teams, the Cardinal Medical Practice will be used as the main hub for the first 2 teams in IP1, using the surrounding hubs of the Wellington Children's Centre and The Willows Children Centre to absorb those that are not within the first two teams from that geographical area.

3j. Ockenden Final Report IEAs

The recent report into maternity services by Donna Ockenden contained certain recommendations impacting on MCoC plans.

One of the latest immediate and essential actions states:

"All Newly Qualified Midwives (NQMs) must remain within the hospital setting for a minimum period of one-year post qualification."

Regional advice is to not pull from existing teams any preceptees who are already working in this way. Extra support for this group of staff will be explored and a plan to implement a supportive preceptorship programme will be implemented.

The other immediate and essential action directly impacting on the implementation of MCoC states:

"All trusts must review and suspend if necessary the existing provision and further roll out of Midwifery Continuity of Carer (MCoC) unless they can demonstrate staffing meets safe minimum requirements on all shifts "

Trusts have been asked to assess their staffing position and make one of the following decisions for their maternity service:

1. Trusts that can demonstrate staffing meets safe minimum requirements can continue existing MCoC provision and continue to roll out, subject to ongoing minimum staffing requirements being met for any expansion of MCoC provision.

2. Trusts that cannot meet safe minimum staffing requirements for further roll out of MCoC but can meet the safe minimum staffing requirements for existing MCoC provision, should cease further roll out and continue to support at the current level of provision or only provide services to existing women on MCoC pathways and suspend new women being booked into MCoC provision.

3. Trusts that cannot meet safe minimum staffing requirements for further roll out of CoC and for existing MCoC provision, should immediately suspend existing MCoC provision and ensure women are safely transferred to alternative maternity pathways of care, taking into consideration their individual needs; and any midwives in MCoC teams should be safely supported into other areas of maternity provision.

In response to this, regional guidance supported by NHS England is that where staffing levels are safe, MCoC provision should be continued. At ESNEFT the ongoing work is to ensure that the staffing levels are both at the correct levels and with an appropriate skill mix to implement our first teams. The Better Births Lead midwife is working closely with the senior management team and practice development team to be able to evidence that both are adequate before roll out of the initial phase.

4. Summary

The Board is requested to receive this report for information and assurance purposes that the Trust is enacting and reviewing all recommendations regarding the Ockenden Final report.

The Board is asked to approve receipt of the Trust's Midwifery Continuity of Carer plan at the June Board, in line with national requirements, following further work being concluded in light of the Ockenden recommendations.