NHS
The Leeds Teaching Hospitals
NHS Trust

Ockenden Assurance Report

26 May 2022

Presented for:	Information & Assurance
Presented by:	Susan Gibson, Director of Midwifery & Maternity Safety Champion Dr Kelly Cohen, Clinical Director & Maternity Safety Champion
Author:	Rebecca Musgrave, Head of Midwifery
Previous Committees:	NONE.

Trust Goals	
The best for patient safety, quality and experience	✓
The best place to work	✓
A centre for excellence for research, education and innovation	
Seamless integrated care across organisational boundaries	
Financial sustainability	

Trust Risks (Type & Category)				
Level 1 Risk	(✓)	**Level 2 Risks**	**(Risk Appetite Scale)**	**Risk**
Workforce Risk		Workforce Supply Risk - We will deliver safe and effective care through having adequate systems and processes in place to ensure LTHT Maternity Services are aligned with National Maternity Transformation Plans and have access to appropriate levels of workforce supply.	Cautious	↔ (same)
Operational Risk			Choose an item	Choose an item.
Clinical Risk		We will provide high quality services and manage risks that could limit the ability to achieve safe and effective care for our women and families.	Minimal	↔ (same)
Financial Risk			Choose an item	Choose an item.
External Risk		Regulatory Risk - We will comply with or exceed all regulations, retain its CQC registration and always operate within the law	Averse	↔ (same)

Key points	
1. The maternity leadership team are continuing to identify and manage risks associated with the future delivery of the Continuity of Carer model and its alignment with National Maternity Transformation Plans.	For Information
2. Following review of the final Ockenden report published on the 30th March 2022, the leadership team have undertaken a gap analysis against the 15 new Immediate and Essential Actions and the Local Actions for Learning.	For Information

1. Summary

This paper provides information and assurance to the Trust Board following the publication of the final Ockenden report, an independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust published on 30th March 2022.

2. Background

The Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust commenced in the summer of 2017. The final report was published on the 30th March 2022. Ockenden Maternity Review | Independent review of maternity care at Shrewsbury and Telford Hospitals NHS Trust. An independent and multi-professional team of midwives and doctors reviewed the maternity care of 1,486 families, the majority of which were patients at the Trust between the years 2000 and 2019. Some families had multiple clinical incidents therefore a total of 1,592 clinical incidents involving mothers and babies have been reviewed with the earliest case from 1973 and the latest from 2020. The report has highlighted avoidable errors and a failure to learn, and has described recurrent incidents of avoidable harm to mothers and babies. The report details local actions for learning and a further 15 recommendations for all maternity services in England.

3. Proposal

After reviewing the report, Trusts have been asked to take action to mitigate any risks identified and develop robust plans against areas where the service 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

4. Financial Implications

Significant investment in the maternity services has been announced by NHSE. In 2022/23 each Local Maternity System is receiving additional recurrent funding to support implementation of the Ockenden Immediate and Essential Actions which include delivering a staffing model that matches Birth Rate+ recommendations. Based on a fair share basis associated with 2021/22 bookings the funding for Leeds Maternity

service is circa £1.4 million. The women's CSU plan to use this funding to pay for the recommended staffing levels indicated in the birth rate plus report and to support obstetric staffing gaps.

5. Risk

5.1 Safe Staffing and Continuity of Carer

In a letter received by NHSEI on the 1st April 2022 (see Appendix 1) all Trusts were asked to immediately assess their staffing position against the implementation of Continuity of Carer 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 on-going 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 MCoC 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.

The review of staffing and supporting the continuation of the Continuity of Carer model at LTHT is impacted by two contributory factors; the number of vacancies and the ability to deploy newly qualified midwives into the continuity of carer teams. One of the recommendations in the final Ockenden report states that newly qualified midwives should only work in the hospital setting for the first 12 months post registration. If all Band 5 midwives are deployed in the acute hospital service, Band 6 midwives would need to be deployed to the community services to fill the gaps and this would negatively impact the skill mix in the hospital setting. LTHT maternity services provide high risk tertiary care in addition to low risk maternity care. It is pivotal to the quality and safety of the whole service that the skill mix across the service is balanced.

The maternity leadership team are continuing to identify and manage risks associated with the future delivery of the Continuity of Carer model and its alignment with National Maternity Transformation Plans. The leadership team are meeting with the regional and national continuity leads on the 18th of May 2022. The team will be supported to populate the nationally recognised Continuity of Carer workforce deployment tool. This will provide the intelligence required to support a decision about the current position and subsequent roll out of the Continuity of Carer model. LTHT will not be suspending the Continuity of Carer model, but due to increased attrition of midwives during the last 2 months and the final Ockenden report recommendation of not deploying newly qualified midwives into the teams it is anticipated that there may need to be a temporary reduction in the number of teams providing Continuity of Carer across the entire maternity pathway. The senior leaders are committed to supporting the evidence base and are also exploring innovative ways of optimising antenatal Continuity of Carer. It is acknowledged that the intrapartum benefits will not be realised with this

approach, however it is anticipated that it would have a significant positive impact on the national safety agenda. Antenatal continuity has the potential to reduce premature births, brain injuries, stillbirths and neonatal deaths.

The leadership team continue to review the initial 7 Immediate and Essential Actions identified in the interim Ockenden report published in December 2020 through the CSU governance group. Of the 7 Immediate and Essential Action 5 are fully compliant and progress continues to be made regarding Immediate Action 4 - the implementation of a maternal medicine centre, and Immediate and Essential Action 7 relating to informed choice and involvement in decision making from service users.

The team have undertaken a gap analysis of the 15 Immediate and Essential Actions and the Local Actions for Learning highlighted in the Final Ockenden report published on 30th March 2022. The leadership team are assured that whilst there are some areas for improvement identified in the Immediate and Essential actions and the Local Actions for Learning, these are achievable within a reasonable timeframe. Further national direction in terms of the recommendations from the Ockenden report is anticipated following the publication of the East Kent report which is expected June 2022.

During a recent webinar Jackie Dunkley Bent, Chief Midwife for England stated that an independent advisory group was being established to review the Ockenden recommendations and provide clarity on some of the areas that are slightly ambiguous. There is no definitive timescale for the completion of this review. The key areas discussed for further discussion are:

- Newly Qualified Midwives to work only in the hospital setting during the first 12 months post registration
- The provision of care by midwives trained in high dependency care
- The supernumerary status of clinical educators.

5.2 A well-trained workforce

Multidisciplinary training is a key area within the Maternity Incentive Scheme: compliance with mandatory training is monitored on a weekly basis by the clinical education leads. Actions are in place to ensure compliance with all training needs by the end of May 2022. The maternity services have achieved full compliance for all elements of multidisciplinary training in years 1, 2 and 3 of the Maternity Incentive Scheme. In addition to the PROMPT RCOG accredited mandatory training the service has implemented regular real time simulations of a variety of obstetric emergencies with multidisciplinary attendance.

5.3 Learning from incidents

LTHT Maternity services are committed to learning from incidents and offer a variety of multimedia platforms to support individual learning and training needs.

A crucial part of improving the quality and safety of healthcare is creating ‘an organisation with a memory’. High-risk industries outside of healthcare such as aviation and nuclear energy have achieved high levels of safety by viewing errors and incidents as rich sources of learning, revealing weaknesses in systems and processes where improvement efforts can be focused. Based on these principles an ‘organisation

with a memory' learning resource has been developed. This constructs memorable incident narratives using generic themes drawn from incident reviews and translates these narratives into memorable stories for all staff. This approach is used alongside detailed explanations of the contributory human factors using electronic lectures made accessible to the entire department during live-streamed teaching sessions and via a learning website www.switchlab.co.uk.

5.4 Listening to families

Input from women and families are inextricably linked with the investigatory processes within the Maternity Services. The majority of incident investigations in the maternity services are undertaken by the Healthcare Safety Investigation Branch who ensure that the families are engaged and their voices are heard at all stages of the investigation. This approach is reflected in local investigations and the nominated 'being open lead' or bereavement midwife in the case of perinatal mortality review cases liaises with the family.

Virtual 'Walk the Patch' events have continued throughout the pandemic as they are recognised as an excellent way of obtaining real-time patient feedback that is directly reported to the senior team. Working closely with Leeds Maternity Voices this process has been reviewed to provide a deeper dive into themes highlighted from complaints, PALS and FFT. The new approach is scheduled to commence early May 2022. The MVP has been successful in appointing an engagement lead who will prioritise engaging with families from diverse communities. Work has progressed with city partners to ensure the experiences of women from all backgrounds are heard. This includes linking in with a culturally diverse women's hub that are holding a maternity event where maternity experience is shared**.**

6. Communication and Involvement

The leadership team are acutely aware of the potential impact of the Ockenden report on the maternity teams and service users. It is recognised that the current climate is a very challenging time for maternity staff, and this report is a very difficult read for everyone committed to improving outcomes for mums and babies. Staff have been signposted to additional Health and Wellbeing support. The service is facilitating a series of dedicated listening events for staff and service users to address any concerns that people may have about the service and offer reassurance that the service will be working hard over the next few weeks and months to listen and learn from the recommendations of the Ockenden report.

7. Equality Analysis

A Quality Impact Assessment is in progress to support the decisions about Continuity of Carer at LTHT. Priority will be given to continuing Continuity of Carer models for women at greatest risk of health inequalities in accordance with the National Maternity Transformation Plans.

8.Publication Under Freedom of Information Act

This paper is exempt from publication under Section 22 of the Freedom of Information Act 2000, as it contains information which is in draft format and may not reflect the organisation's final decision.

9.Recommendation
Members of the Trust Board are requested to note this Ockenden progress report.

Rebecca Musgrave
Head of Midwifery
2nd May 2022