Report to Scrutiny Board

Name of Scrutiny Board	Adults Health & Social Care
Meeting Date	1st June 2022
Subject	Ockenden Review Update, Calderdale and Huddersfield NHS Foundation Trust (CHFT)
Wards Affected	All
Report of	Executive Director of Nursing/Deputy Chief Executive (CHFT)

Why is it coming here?
To inform the committee of CHFT's response to the Ockenden Report.

What are the key points?
• Key findings of the Ockenden Report • Immediate Essential Actions (IEA) • CHFT response to IEAs (December and March reports) • Response to recommendation in relation to Midwifery Continuity of Carer • Next steps to assure the Local Midwifery System / NHSE and key milestones • CHFT Maternity Improvement Plan.

Possible courses of action (Recommendations)
Note Trusts actions to date.

Contact Officer
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Should this report be exempt?
No

Calderdale Council

Report to Scrutiny Board

1. Background

On the 30th March 2022, the Secretary of State for Health and Social Care published Dame Donna Ockenden's final report from the independent review of maternity services at Shrewsbury and Telford Hospital NHS Trust. This second report builds upon the first report published in December 2021.

The investigation team heard evidence from 1486 families throughout their review of services. Families who wanted to understand what had happened during their care but also wanted the system to learn from what had happened at Shrewsbury and Telford. The investigation team interviewed 60 current and former members of staff to gain their opinion on the services they worked within and 84 staff completed a questionnaire for the review. The team considered all aspects of clinical care in maternity services including antenatal (pre-birth), intrapartum (care during labour and birth) and postnatal (care following birth), obstetric anaesthesia and neonatal care.

Throughout the review of 1486 families' care the investigation team identified thematic patterns in the quality of care and investigation procedures carried out by the Trust, and identified where opportunities for learning and improving the quality of care have been missed.

In the 9 months preceding the avoidable death of Kate Stanton- Davies (whose parents instigated the independent review) the review team identified two further babies who had died in similar circumstances. The review found evidence of poor investigation of these cases and a lack of transparency with families which resulted in missed opportunities for learning and lost opportunities to prevent further baby deaths.

12 maternal deaths were considered by the review team. They concluded that none of the mothers received care in line with best practice at the time. Only 1 maternal death was investigated by external clinicians and the internal investigations were rated as poor. The investigations did not recognise system and service wide failings to follow appropriate procedures and guidance.

498 cases of stillborn babies were reviewed and graded. One in four cases were found to have significant or major concerns which if managed appropriately might or would have resulted in a different outcome.

The review team found failures in governance and leadership, failure to follow national guidelines, failure to escalate and work collaboratively across disciplines. The report describes a culture of "them and us" between midwives and obstetricians leading to a fear amongst midwives to escalate concerns to obstetricians, which led to a lack of psychological safety in the workplace and an inability to make positive change.

In terms of clinical governance investigatory processes were not followed, and were not to a standard that would have been expected at the time. Reviews were not multidisciplinary and maternity governance teams downgraded serious incidents to local investigations to avoid external scrutiny.

The review found that the Trust board did not have oversight or a full understanding of the issues and concerns within the maternity service, and there was a lack of oversight by the Trust board when investigations took place.

This first report made explicit recommendations around 7 Immediate Essential Actions (IEAs) with an expectation that all providers provide assurance against, these were:

- Enhanced Safety
- Listening to Women and Families
- Staff training and working together
- Managing complex pregnancies
- Risk assessments during pregnancy
- Monitoring foetal well-being
- Informed consent

The Final report includes a further 15 IEA recommendations, again with an expectation that all Trusts will ensure compliance, these actions are:

- Workforce Planning and Sustainability
- Safe Staffing
- Escalation and Accountability
- Clinical Governance and Leadership
- Clinical Governance and Leadership – Incident Investigation and Complaints
- Learning from Maternal Deaths
- Multi-Disciplinary Training
- Complex Antenatal Care
- Pre-term Birth
- Labour and Birth
- Obstetric Anaesthesia
- Postnatal Care
- Bereavement Care
- Neonatal Care
- Supporting Families

A significant recommendation of the review has been the expectation that all Trusts will review their plans for Midwifery Continuity of Carer (COC). COC is a system of midwifery care delivery where a midwife follows a woman through ante natal, intra-partum and post-natal care pathways. Trusts have been monitored against the milestone targets ste by NHSE. This has proved to be a challenge nationally in terms of staffing levels to support.

NHSE have asked all Trusts to undertake an additional review of internal governance arrangements.

There are 2 further reports into maternity services expected to report in the near future into East Kent and Nottingham University Hospital.

2. Main Issues for Scrutiny

Maternity Services have undertaken a self-assessment against all the immediate and essential actions. The service has taken the learning from the submission requirements for the 7 IEAs of the first Ockenden report and ensured that the self-assessment against the 15 IEA's within the final report. The Trust is fully compliant with the 7 IEAs and are either fully or partially compliant with each element of the 15 IEAs. The governance self-assessment has also been undertaken and actions in place to address any gaps. The evidence to support the self-assessment will be tested out through the Regional Midwifery team assessment visit on the 28th June 2022.

The action plan in relation to the IEAs is being progressed and reports through to Trust Board.
There remains some RAG rated red actions in terms of the 15 IEAs, much of this is in relation to outstanding publication of national guidance and the need to undertake more detailed analysis of medical workforce models, plans are in place for the latter.

In terms of clinical outcomes the Trust performs well on all elements of the safer births key performance indicators. However, what Ockenden reminds us of is the importance of "softer" intelligence sources. As such the Trust has put in place enhanced systems to enable staff to speak out safely in the event of having any concerns around quality of services. In addition, the Trust has appointed 2 clinicians independent of the service to undertake a review of compliance against the action plan by way of an extra level of assurance to the Board and external regulators. All of the action plans have been assimilated into an overarching Maternity Improvement Plan to ensure a co-ordinated approach to sustainable change and improvement.

The Trust has worked very closely with the Maternity Voices Partnership and will continue to strengthen this partnership in line with Ockenden recommendations.

Further examples of developments:

- A debrief service is in place to support women who may have had a traumatic birth.
- Set up a Rainbow clinic for women following pregnancy loss, supporting them to have continuity of carer along with specialist input
- Discovery interviews with families form BAME communities to gain insight into their lived experiences.
- English for speakers of languages (ESOL) classes for pregnant women and partners
- Developed training module for cultural competency training.
- Developed an improved smoke-free pregnancy pathway
- We have recruited 2 clinical midwifery educators to support NQM.
- Recruited a Band 7 Professional Development Midwife.
- We have introduced the Birmingham Symptom-Specific Obstetric Triage System (BSOTS) tool in our Maternity Assessment Centre
- 1 of only 2 Trusts regionally who have delivered and continue to deliver the M-AIM course (Maternal- Acute Illness Management.
- Lead Midwife for Each baby Counts Project – one of only 16 Trusts nationally.
- We have a named lead midwife and obstetrician for fetal wellbeing.
- Improved processes for undertaking hot and cold briefs following serious incidents.
- Dedicated midwife to lead on electronic patient records.

Midwifery Continuity of Carer (MCoC)

On the 1st April 2022, Trusts received a letter from the NHS Chief Executive, Chief Nursing Officer and National Medical Director in response to the publication of Dame Donna Ockenden's review.

The letter made particular reference to the Trusts submissions of their MCoC plans; in line with the national maternity transformation programme; by the 15th June, which must take now take account of the requirement within immediate essential action (IEA) 2 Safe staffing:
"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."

The letter asks trusts to immediately assess their staffing position and make one of the following recommendations:

- Trusts that can demonstrate staffing meets safe minimum requirements can continue existing MCoC provision and continue to roll out
- Trusts that cannot meet safe minimum staffing requirements for further roll out of MCoC, but can meet 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
- 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 transfer them to alternative maternity pathways of care.

A paper was presented at Trust Board on the 5th May 2022 outlining our current position and recommendations, summarised below:

CHFT currently has 4 teams who book an average of 25% of women on to a MCoC pathway each month and an average 50% of all BAME women. However, due to vacancy levels and staff unavailability, it is becoming increasingly difficult to maintain this position and safe staffing levels in all areas. Traditional Community caseload teams have been reviewed and aligned into small teams of approx. 4 midwives to deliver antenatal and postnatal care.

The recommendations are that two mixed risk locality-based teams in areas of highest deprivation would suspend the delivery of care in labour and focus on increasing antenatal and postnatal continuity from a named midwife and buddy.

Current community midwife out of hours on call service would continue to support women wishing to birth at home.

The Trust has appointed a non-executive maternity champion to provide a level of independent scrutiny to all elements of the Maternity Improvement Plan, clinical outcomes and COC arrangements.

3. Further Action/Timescales

- Continue to progress the action plan in relation to both the 7 IEA and 15 IEA. Reporting into Trust Board.
- Prepare for the Regional Maternity Team Review on 28th June 2022 where compliance with the IEAs will be assessed.
- Confirm the Trust position in relation to COC to the Local Midwifery System (LMS) on 15th June 2022
- To progress the independent review of maternity services.
- Formally review the COC position in 6 months' time.
- Consider the recommendations from the East Kent and Nottingham reviews and respond to the findings and recommendations.

4. Options Appraisal

N/A

5. Climate Change

N/A

6. Conclusion

The Trust welcomes the Ockenden Report and are fully committed to progress actions to address the recommendations. We are in a good position in relation to assurance against the actions and where compliance is rated Amber or Red we have a plan to address these. In addition CHFT will progress the independent review and are committed to progress the maternity improvement plan. Trust Board will continue to receive assurance around the Maternity Improvement Plan.

The current risks to compliance are around awaiting the publication of national guidance, the national shortage of midwives and obstetricians and the need to undertake a more comprehensive review of neonatal care. Areas where the Trust performs well includes work with the Maternity Voices Partnership, oversight of incidents clinical education support to newly qualified midwives.

A key priority for the Trust is to build on the good work in place by ensuring our continued performance around clinical outcomes, strengthen the voices of families and become an exemplar in Freedom to Speak Up.

7. Background Documents

Not included, for signposting/further reading purpose only:

- Ockenden Review Report
- Better Births
- CHFT Public Board Papers