Oxford University Hospitals
NHS Foundation Trust

Public Trust Board Meeting: Wednesday 10 March 2021

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Title:	**Ockenden Review of Maternity Services: Assurance Assessment Tool**

Status:	**For Discussion**
History:	**New Report**

Board Lead:	**Chief Nursing Officer**
Author:	**Alison Cuthbertson, Director of Midwifery, Niamh Kelly, Clinical Governance Manager,**
Confidential:	**No**
Key Purpose:	**Assurance**

Executive Summary

1. This paper provides the Committee with an overview of the position of this Trust in relation to the recommendations from the immediate and essential actions from the Ockenden report published in December 2020.
2. The first requirement was for an initial declaration by the Chief Executive Officer against 12 specific urgent clinical priorities to be submitted to NHSI by December 2021, which was completed
3. The second requirement is for the Trust to implement the full set of seven Ockenden immediate and essential actions (IEAs) and for the Board to review an associated report at the next public Board meeting.
4. A gap analysis has been completed in relation to maternity services provided by Oxford University Hospitals NHS Foundation Trust. The analysis has been completed using the recommendations from the Ockenden report; the table forms the basis of this paper.
5. The Trust is compliant with the majority of the Ockenden seven immediate and essential actions with the exception of one. This exception is included in the report, the main points include:
    - Action Point 5: *Risk Assessment throughout pregnancy* – partially compliant
6. In order to support Board discussions there is a requirement for Trusts to complete and take to the Board an assurance assessment tool. As part of the Maternity Assessment and Assurance tool a review of compliance has been completed against the following as an overarching review of maternity service provision:
    - All seven IEAs of the Ockenden Report (Assurance tool)
    - A current workforce gap analysis
    - NICE guidance relating to maternity
    - The previous Care Quality Commission (CQC) report
    - Morecambe Bay report
    - Birthrate Plus (BR+)
7. The assurance assessment tool has been reviewed at the Integrated Assurance Committee on the 10th February 2021. It has also been reported through the Local Maternity System (LMS) and shared with regional teams by the **15th February 2021**, in order to complete a gap and thematic analysis which was reported to the regional and national Maternity Transformation Boards.

Conclusion

8. Maternity services have undertaken a review of the Ockenden report and key recommendations to ensure safety in maternity services. The Trust is compliant with the majority of the recommendations in the report and action plans have been developed where further work is required which will be reported to the Regional Midwife for NHSE and NHSI.

Recommendations

9. The Trust Board is asked to consider whether the assurance mechanisms within this Trust are effective and, with the local maternity system (LMS), they are assured that poor care and avoidable deaths with no visibility or learning cannot happen in this organisation.

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Ockenden Review of Maternity Services: Assurance Assessment Tool

1. Purpose

1.1. This paper provides the Committee with an overview of the position of the Trust in relation to the recommendations from the immediate and essential actions from the Ockenden report published on the 10 December 2020.

2. Background

2.1. The Ockenden report was written following a review at The Shrewsbury and Telford Hospital NHS Trust following a letter from bereaved families, raising concerns where babies and mothers died or potentially suffered significant harm whilst receiving maternity care at the hospital. The former Secretary of State for Health and Social Care, Jeremy Hunt instructed NHS Improvement to commission a review assessing the quality of investigations relating to new-born, infant and maternal harm at that Trust.

2.2. The first terms of reference for the review were written in 2017 for a review comprising of 23 families. Since the review commenced more families contacted the review team raising concerns about the maternity care and treatment they had received at the Trust. The terms of reference were amended in November 2019 to encompass over a thousand families.

2.3. Due to the size of the review the second and final independent report is due in 2021. Having performed the first 250 clinical reviews the review team identified emerging themes. Recommendations were issued for all acute Trusts offering maternity care and the wider maternity community across England to be addressed as soon as possible.

3. Ockenden Report

3.1. There are seven immediate and essential actions (IEAs) within the Ockenden report comprising 12 specific urgent clinical priorities. An initial gap analysis has been undertaken with the input of the Trust maternity safety champion, Local Maternity System and the executive leads.

3.2. In fulfilment of requirements a declaration against the immediate actions was submitted as required on the 21st December 2020 (appendix 1). Individual responses from trusts will form part of a presentation and discussion at the NHSEI Public Board in January 2021.

3.3. At the time of the initial declaration the Trust was compliant with the majority of the recommendations with the exception of two, however, receipt of this paper by the public Trust board meets the requirements for compliance with action point 1 (see below).

Action Point 1: *Enhanced Safety* - Compliant with the principles of the new model “Implementing a revised perinatal quality surveillance model” received by Trusts 18 December 2020 however to be compliant a formal update is required to the Public Trust board which is planned for the 15th January (see appendix 2).

Action Point 5: *Risk Assessment throughout pregnancy* – partially compliant. The current NICE schedule of antenatal care is in place as required. To enable full compliance with this new recommendation, the Trust needs to have the ability to demonstrate regular audit mechanisms to assess Personalised Care and Support Plan (PCSP) compliance. A plan is in place which will be enabled by a digital solution. This work is advanced, with user testing completed and local maternity systems (LMS) support. The outcome of a digital options appraisal went to the Public Trust Board on January 15th with a roll out plan.

3.4. The second requirement made by the Regional Chief Midwife, NHS England and NHS Improvement for the South East is for the Trust to implement the full set of seven Ockenden immediate and essential actions (IEAs) and for the Board to review an associated report at the next public Board meeting.

3.5. In order to facilitate reporting a further overarching assessment using a National Health Service England (NHSE) designated toolkit, for which is recommended has been undertaken.

3.6. This toolkit has been devised to support providers to assess their current position against the seven Immediate and Essential Actions (IEAs) in the Ockenden Report and provide assurance of effective implementation to their boards, Local Maternity System and NHS England and NHS Improvement regional teams (appendix 3).

3.7. As part of this review, and also as part of the reporting requirements associated with the maternity incentive scheme, maternity services are asked to review the workforce planning to demonstrate their compliance; with standards; this includes neonatal services.

3.8. Maternity services are compliant with the requirement to complete birth-rate plus (BR+) (appendix 4) which is a toolkit used to assess the maternity staffing requirements. Currently there is no workforce gap. However, there is a high risk of non-compliance with neonatal nursing workforce which is being reviewed and addressed by NOTSSCaN Division (see appendix 3 – Workforce and Leadership tab)

3.9. Maternity services have been asked to review their approach to assurance against NICE guidelines, ensuring these are assessed and implemented where appropriate. Assessment of current provision shows compliance with requirements and highlights the existence of a robust system in place to review NICE guidance and compliance (appendix 3- NICE Guidance tab).

3.10. As part of the recommendations associated with the Ockenden report maternity services have been asked to review their compliance against the actions from the previous Care Quality Commission (CQC) report that was published on the 07 June 2019. Assessment of compliance with the requirements shows that improvements have been made and there is still ongoing work required. (see appendix 3, CQC tab)

3.11. As part of this assurance process, maternity services have also been asked to review their service in relation to the Morecambe Bay investigation (2015) (see appendix 3, Morecambe Bay tab)

4. Conclusion

4.1. Maternity services have undertaken a review of the Ockenden report and key recommendations to ensure safety in maternity services. The Trust is compliant with the majority of the recommendations in the report and action plans have been developed where further work is required which will be reported to the Regional Midwife for NHSE and NHSI.

5. Recommendations

5.1. The Trust Board is asked to reflect and to consider on whether the assurance mechanisms within this Trust are effective and, with the local maternity system (LMS), they are assured that poor care and avoidable deaths with no visibility or learning cannot happen in this organisation.

6. **Appendix 1 Declaration against the 12 urgent clinical priorities identified within the seven immediate and essential actions from the Ockenden Report** (submitted to Amanda Pritchard, Chief Operating Officer, NHS England and NHS Improvement and Chief Executive, NHS Improvement)

		Immediate and Essential Actions	Position
1.	Enhanced safety	a) A plan to implement the Perinatal Clinical Quality Surveillance Model, further guidance will be published shortly	**Compliant with the principles of the new model – Model received by Trusts 18 December for formal update to Public Trust board 15th January 2021.**
		b) All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB	**Compliant**
2.	Listening to Women and their Families	a) Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services	**Compliant**
		b) In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard. Further guidance will be shared shortly.	**Compliant**

3.	Staff Training and working together	a) Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.	**Compliant**
		b) The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented, In the meantime we are seeking assurance that a MDT training schedule is in place.	**Compliant**
		c) Confirmation that funding allocated for maternity staff training is ring-fenced and any CNST Maternity Incentive Scheme (MIS) refund is used exclusively for improving maternity safety	**Compliant**
4.	Managing complex pregnancy	a) All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place	**Compliant**
		b) Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres	**Compliant**
5.	Risk Assessment throughout pregnancy	a) A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance.	**Partially compliant:** The current NICE compliant schedule of antenatal care is in place: this includes full antenatal assessment. Referral onto a suitably trained professional will be dependent on outcome of risk assessment. Each antenatal check social and psychological indicator are part of the wider risk assessment & where required (GAD/Whooly/CO screening & Routine Enquiry) Place of birth is first discussed at booking & revisited periodically throughout pregnancy and

			again at 36 weeks' gestation. Referrals to mode of birth clinic or consultant antenatal clinic are made if women are wishing to birth outside of guidance or any medical/obstetric concerns are raised during the pregnancy. **To enable full compliance – The Trust needs to have the ability to demonstrate regular audit mechanisms to assess PCSP compliance – The solution will be enabled via a digital solution. Planning for this is advanced, with user testing completed and LMS support – The outcome of an options appraisal is planned to come to Public Trust Board on January 15th with a roll out plan.**
6.	Monitoring Fetal Wellbeing	a) Implement the saving babies lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.	**Compliant**
7.	Informed Consent	a) Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. An example of good practice is available on the Chelsea and Westminster website.	**Compliant**

7. Appendix 2: Implementing a revised perinatal quality surveillance model taken from the tool kit NHSE and NHSI 2020

Principle	Requirements	OUH comment
Principle 1 – Strengthening trust-level oversight for quality	1. To appoint a Non-Executive Director to work alongside the board-level perinatal safety champion to provide objective, external challenge and enquiry. 2. That a monthly review of maternity and neonatal safety and quality is undertaken by the trust board. 3. That all maternity Serious Incidents (SIs) are shared with trust boards and the Local Maternity System (LMS), in addition to reporting as required to HSIB. 4. To use a locally agreed dashboard to include, as a minimum, the measures set out in Appendix 2, drawing on locally collected intelligence to monitor maternity and neonatal safety at board meetings. 5. Having reviewed the perinatal clinical quality surveillance model in full, in collaboration with the (LMS) Lead and Regional Chief Midwife, formalise how trust-level intelligence will be shared to ensure early action and support for areas of concern or need. 6. To review existing guidance, refreshed how to guides and a new safety champion toolkit to enable a full understanding of the role of the safety champion, including strong governance processes and key relationships in support of full implementation of the quality surveillance model.	1. Board maternity Safety Champion has confirmed that this post will be recruited to. 2. Monthly meeting with Maternity Safety Champion already in place. PMRT paper goes to board quarterly which incorporates the monthly review of perinatal deaths. This is a multi-professional structured meeting that reviews perinatal deaths. The maternity dashboard is reviewed by the board in the integrated performance report monthly. This highlights the red, amber and green areas. This dashboard is also included in the Divisional quality report that is discussed at the Trust corporate clinical governance committee each month. 3. The Trust has a robust process which reviews all incidents within these criteria. It includes the reporting to Health Safety Investigation Branch (HSIB). There is a quarterly meeting which collates learning from incidents to ensure learning is disseminated. The detailed minutes of the perinatal regional governance meeting and embedded slides are shared with the Berkshire, Oxfordshire and Buckingham (BOB) LMS project manager who in turn shares them with the LMS board. The level of detail reflects accurately the SIs that is presented by the trust governance lead, the shared learning and any actions agreed by this group. HSIB attend the regional governance meeting,

		4. We will commence the use of this tool from January 2021. 5. The service has reviewed the documentation. The assessment tool will be sent to the regional midwifery lead by the 15th February 2021. The regional maternity team will then complete a gap and thematic analysis which will be reported to the regional and national Maternity Transformation Programme Boards. 6. The Board Safety Champion meets monthly with the maternity and neonatal leads. This will be a formal agenda item at the January meeting. The board safety champion has a copy of the “Implementing a revised perinatal quality surveillance model”.
Principle 2 – Strengthening LMS and ICS role in quality oversight	The LMS should support the integrated care system (ICS) to oversee perinatal clinical quality by: 1. Ensuring an appropriately experienced and senior representative of the LMS (provider or commissioner with a clinical background) is a member of the ICS level local quality surveillance group (QSG). 2. Leading on the production of a local quality dashboard which brings together a range of sources of intelligence relevant to both maternity and neonatal services from provider trusts within the LMS. 3. Ensuring intelligence is shared and discussed regularly at meetings of the local surveillance group. Ensuring representation of perinatal quality issues at the ICS partnership board and the QSG as part of exception reporting. 5. Taking timely and proportionate action to address any concerns identified and building this into local transformation plans. The onus should be on trusts to	External to the Trust

	share responsibility for making improvements, making use of strengths in individual neighbouring trusts within the LMS to ensure that learning and data gathered through perinatal improvement work is shared across the ICS to inform wider delivery improvement. 6. Reporting concerns to the regional chief midwife and lead obstetrician and regional quality committees, where necessary with a request for additional support. 7. Ensuring, as appropriate, that perinatal services are included in the quality objectives set by ICS, which are then reviewed regularly and updated.	
Principle 3 – Regional oversight for perinatal clinical quality	Perinatal clinical quality is routinely reviewed at a regional level committee, ensuring that: 1. The region decides how this should be implemented, e.g. through a standalone perinatal committee or a dedicated standing agenda item on an existing committee, e.g. a regional quality committee. 2. The committee meet regularly, methodically consider perinatal clinical quality, marshal input from representatives with perinatal expertise and intelligence, ensuring that perinatal clinical quality is not considered in isolation, and escalate concerns to national level. 3. The regional chief midwife and regional lead obstetrician are standing members of regional quality oversight groups to avoid perinatal quality being siloed. 4. Oversight for perinatal clinical quality should involve the regional chief nurse, regional chief midwife and a lead obstetrician, who should work closely with regional neonatal leadership.	External to the Trust

	5. There is a formal process for gathering insights from multiple partners including the LMS, neonatal ODNs, maternity clinical networks, Maternity Voices Partnerships chairs, CQC, NHS Resolution, HSIB, RCM, RCOG and where relevant, feedback from HEE, deaneries and coroners, providing the regional model with a helicopter view of perinatal clinical quality 6. Regular thematic reviews of perinatal clinical quality are undertaken. 7. Additional insights are informed by a regional quality dashboard which brings together a range of sources of intelligence. 8. Timely and proportionate action is taken to address any concerns identified. The initial response is likely to involve support for local resolution and action, with escalation used to gain additional expertise, leverage and resources to resolve the concern. 9. Once agreed through the regional committee and in agreement with the regional chief nurse, concerns should be reported by the regional chief midwife to the executive quality group and by the regional chief midwife and lead obstetrician to the new national NHS England and NHS Improvement-led Maternity Safety Surveillance and Concerns Group, where necessary with a request for additional support.	
Principle 4 – National oversight for perinatal clinical quality	A new Maternity Safety Surveillance and Concerns Group (MSSCG) was set up at national level in November 2020. It enables: • the timely identification and escalation of any trust-level concerns by national partners with insights into maternity and neonatal services, including HSIB,	External to the Trust

	CQC, RCOG, RCM, RCPCH, DHSC, NMC, GMC, MBRRACE-UK, HEE and NHS England and NHS Improvement • the sharing and gathering of intelligence from respective member organisations • discussion around concerns in relation to trust compliance with the Maternity Incentive Scheme • agreement on thresholds and means by which risks/cases of concern will be identified • agreement on the most appropriate organisation to offer support, intervention and follow up on themes and/or concerns discussed • agreeing appropriate levels of action where there are indications of a concern. Actions might include appreciative enquiry, monitoring, peer-to-peer support or, if criteria are met, entry into the Maternity Safety Support Programme • agreeing timeframes for monitoring and follow-up • ensuring appropriate, fair and consistent follow-up on cases/trusts at subsequent meetings or sooner if warranted • Identifying themes which might require a national policy response and escalating this to the MTP.	
Principle 5: Identifying concerns, taking proportionate action and triggering escalation	**Provider Level** • Discussion between frontline champions, MVP, board and non-executive lead to appraise, understand the issue, agree action, timeframes and follow-up. • Ensure involvement of human resources (HR) for advice and processes in circumstances where poor individual behaviours are leading to team	**Provider level** Currently there are monthly staff safety meetings where all staff groups can raise concerns. These are captured on an action log and discussed at the safety champion meetings. The MVP is in weekly contact with the service. They also have open access to the Director of Midwifery and quarterly formal meetings with representatives from the Trust. The service has a Coach, Leadership & Organisational Development

	dysfunction. • Issue discussed at the trust board and an action plan is agreed as a priority. • Issue(s) discussed with LMS lead and regional Chief Midwife and action plan shared. • LMS/ICS to support implementation of the action plan, escalating to regional teams if needed. **LMS/ICS level** • Appreciative enquiry and supportive approach to Board Safety Champion and perinatal triumvirate by LMS lead and regional chief midwife to agree, implement and oversee progress with the action plan. • Advice and support from the regional chief midwife and lead obstetrician with provision of resources, e.g. best practice documents and guidance. • Support from MatNeoSIP if the issue lends itself to a quality improvement (QI) approach. • Peer-to-peer support from a provider trust within the LMS with a 'good' or 'outstanding' CQC rating. • Mentorship from the clinical network. • Access to specific training. • LMS to share relevant learning.	Consultant working with them on a variety of projects which are triggered either by staff or by users of the service. Maternity services have a dedicated HR consultant to ensure that there is advice and support available. They also assist with actions required as a result of the staff survey. The service has also undertaken a board seminar in November 2020 to provide the board with an oversight of the challenges and achievements within the service.

	• LMS to reflect relevant issues at ICS-chaired quality committee as agreed with trust and regional chief midwife and lead obstetrician. • Regional chief midwife and lead obstetrician escalate to the regional chief nurse as required. **Regional Level** • Relevant issues escalated to regional quality committee by the regional chief nurse, regional chief midwife and lead obstetrician. • Action plan and progress with meeting the plan is provided. • Advice and support from the regional chief midwife and lead obstetrician with provision of resources, eg best practice documents and guidance. • • Discussion on any additional action or support required is agreed by the regional quality committee. This might include regional quality Improvement team support, escalation to JSOG or an unannounced CQC inspection. **National** • Discussion on any additional action or support required and if criteria are met, entry into the Maternity Safety Support Programme.	

8. Appendix 3 Assessment and Assurance Tool

The evidence referred to in the report is available to the Board and has been reviewed at the Integrated Assurance Committee meeting on the 10th February 2021.

The list of evidence is as follows:

- All seven IEAs of the Ockenden Report (Assurance tool tab)
- Workforce and Leadership tab
- NICE Guidance tab
- Care Quality Commission (CQC) tab
- Morecambe Bay tab

9. Appendix 4 Birthrate Plus (BR+) assessment

The evidence referred to in the report is available to the Board and has been reviewed at the Integrated Assurance Committee meeting on the 10th February 2021.