Meeting title:	Trust Board **Public Trust Board paper F**					
Date of the meeting:	9 March 2023					
Title:	Maternity Assurance & Compliance Update (including Ockenden)					
Report presented by:	Julie Hogg, Chief Nurse & Danni Burnett, Director of Midwifery					
Report written by:	Danni Burnett, Director of Midwifery and Liz James, Senior Project Manager					
Action – this paper is for:	Decision/Approval		Assurance	x	Update	X

To your knowledge, does the report provide assurance or mitigate any significant risks? If yes, please detail which
This report provides a consolidated overview of maternity services position in respect to national maternity standards. Areas of non-compliance are outlined within the report.

Acronyms used:
HSIB: Healthcare Safety Investigation Branch
ICB: Integrated Care Board
MDT: Multidisciplinary team
Full wording is included in the text with all other acronyms

PURPOSE OF THE REPORT

This report provides a consolidated overview of maternity assurance and compliance in respect of the following:

- Ockenden Recommendations
- Reading the Signals: Review of Maternity & Neonatal Services in East Kent
- Saving Babies Lives Care Bundle (version 2)
- Maternity Incentive Scheme, NHS Resolution 10 Safety Actions

The report provides an update on the actions to ensure UHL truly learns from the national reviews and continues to strive to reduce perinatal mortality, improve experience, and provides care which is inclusive and personalised.

The report outlines the intentions to strengthen internal and external oversight and assurance to robustly monitor and scrutinise the quality of our maternity service.

EXECUTIVE SUMMARY

Progress is being made against the recommendations outlined within the Ockenden Report, however challenges remain in terms of pace of change and improvement with particular focus on workforce planning and sustainability.

The East Kent Report generated further insight into the themes around teamwork, professionalism, compassion, responding to investigations, and failures to listen. A maternity services improvement programme is being established and will incorporate these themes. An extensive programme of work has already commenced to improve the culture of the service.

Continued work is in place to improve compliance of implementing the Saving Babies Lives Care Bundle with targeted actions for 2 out of the 5 standards. This includes improving timely antenatal steroids for preterm birth and reducing smoking in pregnancy.

Since January 2023 progress has been made in evidencing compliance with the NHS Resolution Maternity Incentive Scheme (MIS) with 4 out of the 10 Safety Action Standards now met.

RECOMMENDATION

Trust Board are asked to be assured by the progress to date and note the plans in place to achieve full compliance.

Trust Board are asked to note the establishment of the LLR Ockenden Assurance Meeting and endorse the implementation of an Executive-Led UHL Maternity Assurance Committee

Trust Board are asked to note the intention to establish a Maternity Improvement Programme and divisional-led operational oversight model to ensure sufficient scrutiny and support of assurance and compliance, reporting into the newly established Maternity Assurance Committee.

MATERNITY ASSURANCE REPORT – FEBRUARY 2023 UPDATE

1. Ockenden Recommendations

Following the initial Ockenden Report (December 2020) evidence of compliance has been collated and shared with commissioners and regulators against each of the 7 Ockenden Immediate and Essential Actions (IEA's). Evidence was reviewed and feedback received from NHS England (NHSE) indicating compliance with one exception: external clinical specialist opinion for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death.

February 2023 Update on External Clinical Specialist Opinion: Indicator remains partially compliant. Actions taken includes a HSIB cluster review (October 2022), a peer review with Leeds Teaching Hospital, an independent desktop review of the maternity services' governance systems, themes and trends (commissioned by LLR ICB formally CCG), ongoing work through the UHL Mortality and Learning from Deaths programme working with medical examiners, and work with our buddy maternity Trusts (Northampton General Hospital and Birmingham Women's Hospital) to establish a formal process for external review and input of Serious Incidents and HSIB cases.

NHSE Regional Perinatal Team and LLR Local Maternity & Neonatal System conducted an Ockenden Insight Visit to UHL during July 2022 which generated several actions for attention, this included strengthening communication across the service on plans and actions, plus recognition of the impact on compliance due to the lack of a Maternity Voices Partnership (MVP) across the LLR system. Below are the actions which remain outstanding following the feedback from the Insight Visit:

Overview	RAG	Outstanding Actions	Update (February 2023)
IEA 1: Listening to women and families			
Includes the roles of safety champions and maternity voices partnership (MVP)		Strengthen MVP role and the relationship between safety champions and service users	UHL have engaged in the redesign of the MVP being led by the LLR ICB. Procurement panel conducted February 2023 with successful bidder to be awarded, timeframe for implementation awaits.

			In addition, there is continuous evidence of engagement with service users in Quality Improvement projects continues to be captured such as: Leicester Mammas engagement and collaboration through the development of the Equity and Equality plans, support with Unicef Baby Friendly Accreditation (BFI) and Breastfeeding Peer Support, development of Red Flags and Symptom Checkers. Plus, further work to improve our communication with women and their families such as development of an App for South Asian Women (JANAM App)
IEA 3: Staff training and working together			
Focus on staff training together and working together.		Consultant led MDT ward rounds twice each day	Insight visit highlighted need for midwife co-ordinator, anaesthetist and consultant to be present as a minimum for compliance. Targeted action based on monthly audits to increase anaesthetic representation and reduce gaps in documenting attendance.
IEA 7: Informed consent			
Focus on information available to women		Information available on the maternity website	A task and finish group has been established to review the maternity website. MVP involvement to be progressed once in place. Multiple innovative solutions to support effective communication with women in progress i.e. CardMedic pilot and the JANAM App

During the Autumn 2023 work was undertaken at UHL to understand the progress against the original 7IEAs but also the final Ockenden Report which was released in March 2022.

Further work has been undertaken to understand how the recommendations from Ockenden are monitored but also truly embedded. A review of the evidence indicates the need to strengthen assurance and embed through a whole service quality improvement programme. This programme will include a comprehensive plan for people and culture.

February 2023 Update on Oversight of Assurance & Quality Improvement: During Quarter 4 a stocktake review of all evidence submitted against each of the 15 Ockenden recommendations is to occur. UHL are a partner of the LLR Local Maternity & Neonatal System (LMNS) and the LMNS will support and play an active role in oversight of progress. UHL are working with the LMNS PMO and LLR ICB to establish formal reporting (LLR Ockenden Assurance Meetings scheduled for 20 April 2023 with a preliminary meeting in March 2023 to agree approach and terms of reference). UHL will establish an Executive-Led Maternity and Assurance Committee (MAC) which will take the lead on assurance in relation to the delivery, evidence, sustainability, and impact of the implementation of the actions arising from Ockenden and East Kent. In addition, MAC will have oversight of NHSR submissions and key actions from the wider Maternity Improvement Programme once established.

Whilst establishing MAC below provides a snapshot of the ongoing work to respond to the recommendations:

Immediate and Essential Actions (IEA)	Examples of Ongoing Actions
IEA1: Workforce Planning and Sustainability	• Funded midwifery staffing in line with Birth Rate Plus • Matron for Midwifery Safe Staffing and Recruitment, Retention, and Pastoral Midwives now in post
IEA2: Safe Staffing	• Safe Staffing for nursing & midwifery policy updated (February 2023) • Refreshed Maternity & Neonatal Escalation Policy aligned to the NHSE Regional Escalation Policy • BirthRate Plus® Acuity summaries included within formal reporting
IEA3: Escalation and Accountability	• Increase in Consultant PA time, focus on weekend and job plans
IEA4: Clinical Governance (Leadership)	• Trust Board oversight in place with standing item of perinatal scorecard and annual work plan • MAC to be established
IEA5: Clinical Governance (Incident Investigation and Complaints)	• Additional resource to support the governance team • UHL involvement in the MVP procurement exercise
IEA6: Learning from Maternal Deaths	• Active Perinatal Mortality Review Group • Rapid Review process in place • Close working with Medical Examiners and Learning from Deaths programme
IEA7: Multi-Disciplinary Training (MDT)	• MDT training meets 90% compliance as per NHSR since November 2022 • Face to face training recommenced from January 2023
IEA8: Complex Antenatal Care	• Plans to develop specialist multifetal clinic
IEA9: Preterm Birth	• Focus on improving compliance of Saving Babies Lives Care Bundle (SBLCBv2) – reducing smoking in pregnancy and addressing the variation of antenatal steroids
IEA10: Labour and Birth	• Consultant Midwife leadership on women who choose birth outside of guidelines
IEA11: Obstetric Anaesthesia	• Head of Service national involvement with work on anaesthetic documentation, local audits in place • Business case to build capacity • Improving participation on ward rounds
IEA12: Postnatal Care	• Implementation and embedding BirthRate Plus® acuity tool in the postnatal ward areas
IEA13: Bereavement Care	• Substantive bereavement team increased to 7day service • Training embedded into mandatory training with close monitoring of staff trained in post-mortem consent
IEA14: Neonatal Care	• Business case in development for allied health professionals (AHPs) • Increasing capacity for critical care beds • Refresh of local Transitional Care plans
IEA15: Supporting Families	• Ongoing work to improve access to families requiring specialist support

February 2023 Update on Embedding Assurance & Quality Improvement: In addition to MAC and the LLR Ockenden Assurance Meeting the Women's & Children CMG will re-establish internal monitoring of progress and scrunty of evidence through a confirm and challenge approach. This will allow for an in-depth and multi-disciplinary review of actions to ensure sustainability. The CMG will also review the infrastructure and support needs to enable an improved approach to triangulation

and gathering of evidence. An update on the new approach will be presented at the inaugural MAC meeting for approval.

2. Reading the Signals (Bill Kirkup Report 2022) Update

UHL have considered the themes outlined in the report. The findings align to a quality improvement programme of work which had already been initiated by the Trust. Below provides an update on this work:

- **Monitoring Safety Performance:** A perinatal surveillance scorecard has been implemented with monthly presentation at Trust Board. A system-wide Maternity Inequalities Dashboard is in development across LLR focusing on: maternity care; neonatal outcomes and perinatal mental health. The dashboard will provide intelligence to inform actions to improve outcomes related to ethnicity and social deprivation. An external review of the maternity performance dashboard is to be commissioned to ensure we can continue to improve on our assurances and early identification of risks and themes

- **Standards of clinical behaviour**: A comprehensive listening exercise (known as the Empowering Voices programme) has been commissioned across the service. Action plans have been developed by the teams. A bespoke Band 7 development programme has been commissioned and a senior leadership programme has commenced facilitated by Enono (Vitality Programme). Other work includes review of the preceptorship programme, focus on recruitment, retention and pastoral support, Active Bystander sessions, engagement in the NMC pilot for Professional Behaviours Patient Safety, and increasing attendance at a variety of leadership programmes such as Leading an Empowered Organisation (LEO)™

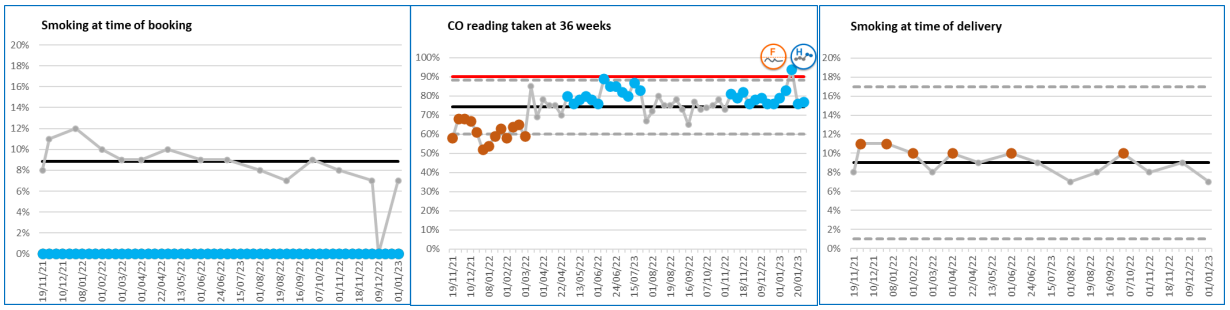
- **Flawed team working:** In addition to the work described within this paper, work has commenced on a UHL trust-wide approach to co-create a strategic framework with a plan to refresh Trust Values. The LMNS are also leading the development of the maternity strategy which will ensure the teams visions are aligned (awaiting the national operational plan and priorities for maternity). Further work is planned to improve operational tactical oversight, planning and support across maternity teams.

- **Organisational behaviour - looking good whilst doing badly:** Maternity and Neonatal Safety Champions are in place, actively engaging with the workforce with a you said we did approach to test out whether actions are embedding alongside understanding safety cultures across the service. A refresh of organisational governance and oversight is embedding to ensure there is a culture of assurance rather than reassurance, with a renewed focus on making data count and equipping teams and directors with timely and accurate information and intelligence.

3. Saving Babies Lives Care Bundle v2 (SBLCBv2) Update

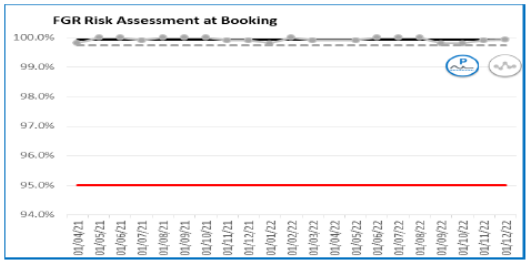
SBLCBv2 (2019) consists of 5 elements designed to reduce perinatal mortality. Compliance with each care standards forms part of the Ockenden IEAs and the NHSR Maternity Incentive Safety Scheme (MIS) Safety Actions. An update of the SBLCB is expected in March 2023 and it is anticipated that a new standard is to be included in relation to women with diabetes. UHL report compliance against 3 of the 5 safety standards. Below provides an update and outlines the actions agreed to address the 2 standards which require improvement:

- **Element 1: Reduced smoking in pregnancy (non-Compliant)**



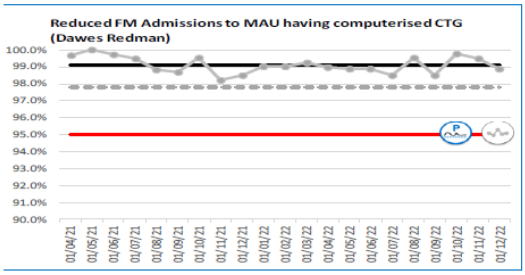
Progress continues in carbon monoxide (CO) monitoring with consistent compliance achieved at booking. CO monitoring is now around 85-90% at booking (previously 80-87%) and 70-80% at 36 weeks (previously 50-60%). Improved communication with community and hospital midwives and a new Maternity Cure inpatient and community pathway is in place to support. In addition, Nicotine Replacement Advisors will be in post during March 2023 and additional CO monitoring equipment has been ordered for antenatal clinics to support the inpatient pathway.

- **Element 2: Reducing preterm birth (Compliant)**



This element is complaint however is under enhanced surveillance. There is consistent compliance with risk assessment at booking which has been further strengthened through the implementation of an electronic scan referral process. However there has been notable variation in compliance for the course of antenatal steroids in the 7 days before birth. This is due to challenges in predicting pre-term birth. Issues identified include securing equipment for near patient testing which has now been resolved. A training and awareness programme is planned with increased compliance expected in Quarter 1 2023/2024.

- **Element 3: Raising awareness of reduced fetal movements (RFM) (Compliant)**



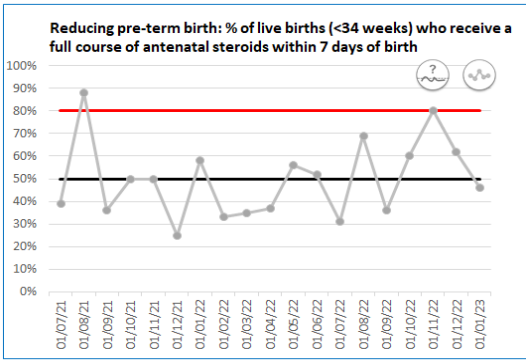
Element 3 consistently meets required targets. Actions are in place to improve women's understanding of reduced fetal movements which includes increasing access to information in multiple languages and drawing upon learning from serious incidents and rapid reviews.

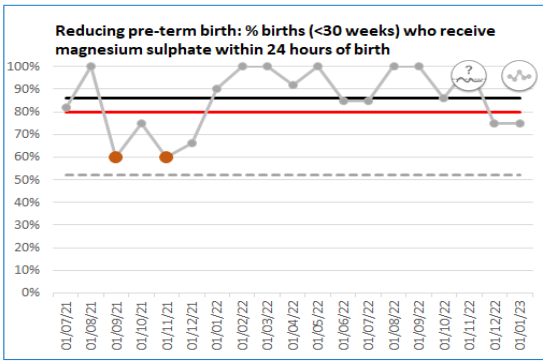
- **Element 4: Effective fetal monitoring in labour (Compliant)**

% staff attending FM training & assessment	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec	YTD
	94%	82%	82%	87%	80%	96%	95%	95%	97%	92%	92%

NHSR MIS requires compliance above 90% in all staff groups, this has been achieved since November 2022. Face-to-Face training for obstetricians, anaesthetists and midwives recommenced January 2023 which will support maintaining position.

- **Element 5: Reducing preterm birth (non-Compliant)**





There is significant variation in complaints for receiving the full course of antenatal steroids, during December 2022 62% was achieved against a target of 95%. A periprem quality improvement project (10 interventions) is now in place. Issues regarding access to equipment for near patient testing have now been resolved. Compliance for those receiving magnesium sulphate is also under close surveillance with further work required to understand the decrease in performance for December 2022 and January 2023.

4. Maternity Incentive Scheme (MIS) Update

Trust Board members and the public were informed in January 2023 that there would be a declaration of non-compliance to NHS Resolution with only 2 of the 10 safety actions met. Progress has been made compliance in a further 2 safety actions. Actions for all standards with partial compliance are in progress.

Safety Action	**Compliance (no. of elements evidenced as complete)**
Perinatal mortality	10/10
Maternity Data Set	12/12
Avoiding term admissions to neonatal services and transitional care	6/19
Clinical workforce planning	2/8
Midwifery workforce planning	2/3
Saving Babies Lives Care Bundle V2	25/28
MDT training	18/18
Patient Feedback	3/7
Safety Champions & Ward to board reporting	16/25

Reporting to HSIB and NHSR	8/8

RECOMMENDATION

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