Item Number:	11	**Enclosure Number:**	I
Meeting:	ICS Partnership Board		
Date of meeting:	5 May 2022		
Report Title:	Ockenden Review Final Report 2022: Summary of Findings & the Nottingham and Nottinghamshire Position		
Sponsor:	Rosa Waddingham, Chief Nurse, Nottingham and Nottinghamshire Integrated Care System and CCG		
Place Lead:			
Clinical Sponsor:			
Report Author:	Danni Burnett, Deputy Chief Nurse, Nottingham and Nottinghamshire CCG		
Enclosure / Appendices:	None		

Summary:

The findings of the final Ockenden report on 30 March reflect a comprehensive and wide-ranging review, focusing on the experience of families in receipt of care, setting out a clear mandate for all maternity services.

This briefing details how we are working across Nottingham and Nottinghamshire to meet the Ockenden requirements and improve safety in our maternity services. The Local Maternity and Neonatal System (LMNS) are working as partners supported by our Maternity Voices Partnership (MVP). The briefing details the partnership and oversight arrangements in place and the progress made against the Ockenden immediate and essential actions (IEAs).

Actions requested of the ICS Partnership Board

the LMNS Programme Management Office team are working with maternity providers Sherwood Forest Hospitals NHS Foundation Trust and Nottingham University Hospitals NHS Trust to formulate and agree a plan for delivery of the entire set of Ockenden recommendations. Oversight of this plan will be led by the LMNS Executive Partnership reporting into the ICB Board.

At present no actions are requested of the ICS Board. There is a plan for the LMNS to update the ICB Board of the progress during Quarter 2 (2022/2024).

Recommendations:

1.	**NOTE** the significance and relevance of the final Ockenden report in relation to maternity services safety and scrutiny across Nottingham and Nottinghamshire.

Presented to:

Board	Transition and Risk Committee	Clinical Executive Group	System Executive Group	Finance Directors Group
☒	☐	☐	☐	☐

Quality Group	Bassetlaw Place	Mid Nottingham-shire Place	Nottingham City Place	South Nottingham-shire Place
☒	☒	☐	☐	☐

Contribution to delivering System Level Outcomes Framework ambitions

Our people and families are resilient and have good health and wellbeing	☐	Our people will have equitable access to the right care at the right time in the right place	☒	Our teams work in a positive, supportive environment and have the skills, confidence and resources to deliver high quality care and support to our population	☒

Conflicts of Interest

☒ No conflict identified
☐ Conflict noted, conflicted party can participate in discussion and decision
☐ Conflict noted, conflicted party can participate in discussion, but not decision
☐ Conflict noted, conflicted party can remain, but not participate in discussion or decision
☐ Conflict noted, conflicted party to be excluded from meeting

Risks identified in the paper

Risk Ref	Risk Category	Risk Description	Residual Risk				Risk owner
			Likelihood	Consequence	Score	Classification	
Ref	e.g. quality, financial, performance	Cause, event and effect There is a risk that…	L1-5	L1-5	L x I	Grading	*Person responsible for managing the risk*

Is the paper confidential?

☐ Yes
☒ No
☐ Document is in draft form

Note: Upon request for the release of a paper deemed confidential, under Section 36 of the Freedom of Information Act 2000, parts or all of the paper will be considered for release.

Ockenden Review Final Report 2022: Summary of Findings and the Nottingham and Nottinghamshire position

Background

1. An interim Donna Ockenden Report was published in December 2020 following an independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust (SaTH). The interim report contains seven immediate and essential actions (IEAs) which align with existing maternity safety improvement and assurance measures. All Trusts providing maternity services in England were asked to assess their current position against seven IEAs:

   - Enhanced Safety
   - Listening to Women & Families
   - Staff Training & Working Together
   - Managing Complex Pregnancy
   - Risk Assessment Throughout Pregnancy
   - Monitoring Fetal Wellbeing
   - Informed Consent

2. Since the publication of the first report, the government has introduced a range of measures and invested in supporting maternity services across the country. This focus and funding elevate maternity services and creates much needed visibility of the quality of care being provided. The Ockenden report asked for workforce planning actions to be assessed and implemented and it is expected that a large proportion of the national investment is for workforce expansion[1].

Introduction

3. This briefing paper follows the publication of the final Ockenden report on 30 March 2022.

'This final report…is about an NHS maternity service that failed. It failed to investigate, failed to learn and failed to improve and therefore often failed to safeguard mothers and their babies at one of the most important times in their lives.'
Ockenden 2022 (pi)

4. The report findings reflect a comprehensive and wide-ranging review, focusing on the experience of families in receipt of care, setting out a clear mandate for all maternity services.

5. The final report builds upon the seven IEAs and includes fifteen recommendations for changes to all maternity services in England. These include funding a safe maternity workforce, ensuring time for training for staff, and having a clear escalation and mitigation policy when staffing levels are not met. A summary is contained in Appendix A.

[1] NHS Providers has estimated the cost of full expansion of the maternity services workforce to be £200 to £250 million.

6. The Local Maternity and Neonatal System (LMNS) are working as partners supported by the Maternity Voices Partnership (MVP). This briefing details how the system are working to meet the Ockenden requirements and improve safety in maternity services as well as the partnership and oversight arrangements in place.

Current Oversight Arrangements: Implementing the Ockenden Recommendations

7. Maternity safety, improvement and transformation is co-ordinated through the LMNS with both Nottingham University Hospitals (NUH) and Sherwood Forest Hospitals (SFH) holding key membership. The LMNS Executive Partnership Board currently reports through the Quality Assurance and Improvement Group (QAIG) chaired by Chief Nurse for the Nottingham and Nottinghamshire, Clinical Commissioning Group (CCG) / Integrated Care System (ICS). The governance is outlined in Appendix B.

8. The LMNS Executive Partnership and LMNS Programme Management Office (PMO) Team have maintained oversight from the previous Ockenden submission, working with providers to assess actions plans to embed work.

9. The LMNS Executive Partnership have formalised oversight of the actions and recommendations through an agreed standard operating procedure (SOP). This aligns with the LMNS transformation programme plus maternity service Trust governance. The SOP proposes the following principles:

    - Quarterly reviews in advance of formal NHSEI submissions, to support discussion around areas where compliance ratings have changed, and to provide opportunities for shared learning.
    - Monthly review meetings with representatives from the LMNS PMO, CCG/ICB and Provider Representatives to monitor and provide ongoing assurance of progress against the IEAs.
    - Engagement and involvement from women, their families, and staff to inform triangulation of evidence and intelligence.
    - A Quality Insights programme for maternity service is established. This allows partners the opportunity to seek operational assurance of the quality of services being provided. IEA compliance will provide key lines of enquiry for the visit plans and focus.

10. The LMNS PMO are currently working with the NHSEI Regional Maternity Team to schedule follow-up Ockenden visits to each provider as part of the April 2022 submission of evidence. Visits are currently scheduled for 6 and 7 September 2022.

Progress against the Ockenden Immediate and Essential Actions (IEAs)

11. The seven IEAs from the interim Ockenden Report (2020) and workforce planning actions have been mapped locally and assessed through a combination of self-assessment and independent external validation and feedback facilitated by NHSEI.

12. An Ockenden Review Panel was held on 23 March 2022. This panel received progress reports and evidence presented by NUH and SFH representatives ahead of the Ockenden progress submission to Trust Boards and NHSEI. The panel provided a supportive confirm and challenge to review submissions on compliance and share learning.

13. Actions have continued to be monitored and a refresh of the progress against the seven IEAs is outlined in Appendix C. Progress has continued across all IEA domains, and apart from the "Informed Consent" action SFH are declaring compliance. Progress against this action has been impacted by the chair vacancy within the MVP and the wider system review of MVP.

14. For NUH, work and focus continues to ensure plans are in place to reach compliance. "Enhanced Safety" was assessed as the domain where there has been significant progress with evidence provided on the development of the Maternity Dashboard in addition to engaging with the LMNS on aligning internal quality, risk, and governance with the LMNS perinatal surveillance work, such as seeking independent clinical input into all serious incident investigations.

15. The LMNS are mapping current engagement with the public and staff to identify gaps to inform the LMNS review of the MVP in addition to the development of the Equity Strategy.

16. The final Ockenden report builds upon the foundations of the initial seven IEAs and concludes with a revised list of fifteen IEAs:

IEA1 Workforce planning & sustainability	IEA9 Preterm Birth
IEA2 Safe Staffing	IEA10 Labour and Birth
IEA3 Escalation & Accountability	IEA11 Obstetric anaesthesia
IEA4 Clinical Governance (Leadership)	IEA12 Postnatal care
IEA5 Clinical Governance (Investigations & Complaints)	IEA13 Bereavement care
IEA6 Learning from maternal deaths	IEA14 Neonatal care
IEA7 Multidisciplinary training	IEA15 Supporting families
IEA8 Complex antenatal care	

17. A benchmarking exercise to align actions, reassess progress and propose recommendations is being undertaken by the LMNS PMO. By end of May 2022, transformation workstreams will be refreshed to ensure alignment and improve the use of data by workstream leads to measure impact.

Next Steps

18. There are real challenges to delivering the Ockenden requirements, especially for NUH in the context of delivering a complex improvement programme whilst managing operational services in challenging circumstances. At SFH the safety culture is more embedded, however, operational challenges are not diminished, and the potential impact of increased demand poses a substantial risk. The final Ockenden report is a critically significant publication which requires immediate attention and action.

19. The CCG (and from 1 July 2022, the ICB) with the support of the whole system will be in a strong position to provide consistent and proportionate support, challenge and scrutiny than was the case pre-2019. As Donna Ockenden states *"if the 'whole system' underpinning maternity services commits to implementation of all the IEAs within this report, with the necessary funding provided, then this review could be said to have led to far-reaching improvements for all families and NHS staff working within maternity services".*

20. The LMNS Executive Partnership will take the lead on this system response. System partners are fully committed to safeguarding mothers, their babies, and their families.

21. A proactive approach will be taken rather than awaiting the findings of the Independent Thematic Review. This includes implementing the recommendations outlined in Donna Ockenden's review of care at SaTH and Dr Bill Kirkup's review of care at East Kent Hospitals University NHS Foundation Trust.

22. Good progress has been made across the system in response to the initial seven IEAs, despite the operational demands and issues around workforce. The work done to date provides a valuable foundation for future action, and the heightened system awareness has resulted in widespread support as well as surveillance.

Recommendations

23. Whilst the LMNS PMO, SFH, and NUH formulate and agree a plan for delivery of the entire set of Ockenden recommendations the Board are asked to **NOTE** the significance and relevance of the final Ockenden report in relation to maternity services safety and scrutiny across Nottingham and Nottinghamshire.

'This final report…is about an NHS maternity service that failed. It failed to investigate, failed to learn and failed to improve and therefore often failed to safeguard mothers and their babies at one of the most important times in their lives.'

Ockenden 2022 (pi)

Appendix A

Immediate and Essential Action

Better Births
Nottingham and Nottinghamshire
NHS

In December 2020, a review into maternity services was published by Senior Midwife Donna Ockenden and a team of leading health care professionals. The report had seven immediate and essential actions that NHS Trusts needed to follow. Here are some of the ways we are working together to provide the best maternity care possible for women and their families across Nottingham and Nottinghamshire.

1 Enhanced Safety

What we need to do:

Neighbouring Trusts must work together to make sure that investigations into serious maternity incidents (SIs) are looked into by local and regional maternity teams.

Our plan:

- We have set up a system working group to review and learn from serious incidents.
- Our Local Maternity and Neonatal System (LMNS) Board will have oversight of safety and learning from serious incidents will be shared across our local NHS organisations to make services safer.

2 Listening to Women and Families

What we need to do:

Maternity services must make sure that women and their families are listened to with their voices heard.

Our plan:

- We are working closely with our Maternity Voices Partnership (MVP) to involve women and families in planning and decisions about their care.
- We are working with local partners to make sure services involve fathers and partners in discussions about appointments and care.

3 Staff Training and Working Together

What we need to do:

Staff who work together must train together

Our plan:

- We will make sure staff have the right skills needed to safely care for women and thier families.

4 Managing Complex Pregnancy

What we need to do:

Make sure there are processes in place to help manage and support women with complex pregnancies

Our plan:

- Trusts have developed ways to help support women with complex pregnancies and will continue to review this.
- We are working with neonatal services to make sure women are able to give birth in the setting that is safest for them and their babies.

5 Risk Assessment Throughout Pregnancy

What we need to do:

Staff must make sure women have a risk assessment at each contact throughout their pregnancy.

Our plan:

- Midwives will continue to support women to make the right choice for them about where they want to have their baby.
- We are working together with women and their families to plan their care based on their needs.

6 Monitoring Fetal Wellbeing

What we need to do:

All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with expertise to focus and show best practice in fetal monitoring.

Our plan:

- Trusts will have Midwife and Consultant Fetal Monitoring leads to improve practice, share learning and support staff with fetal wellbeing monitoring.

7 Informed Consent

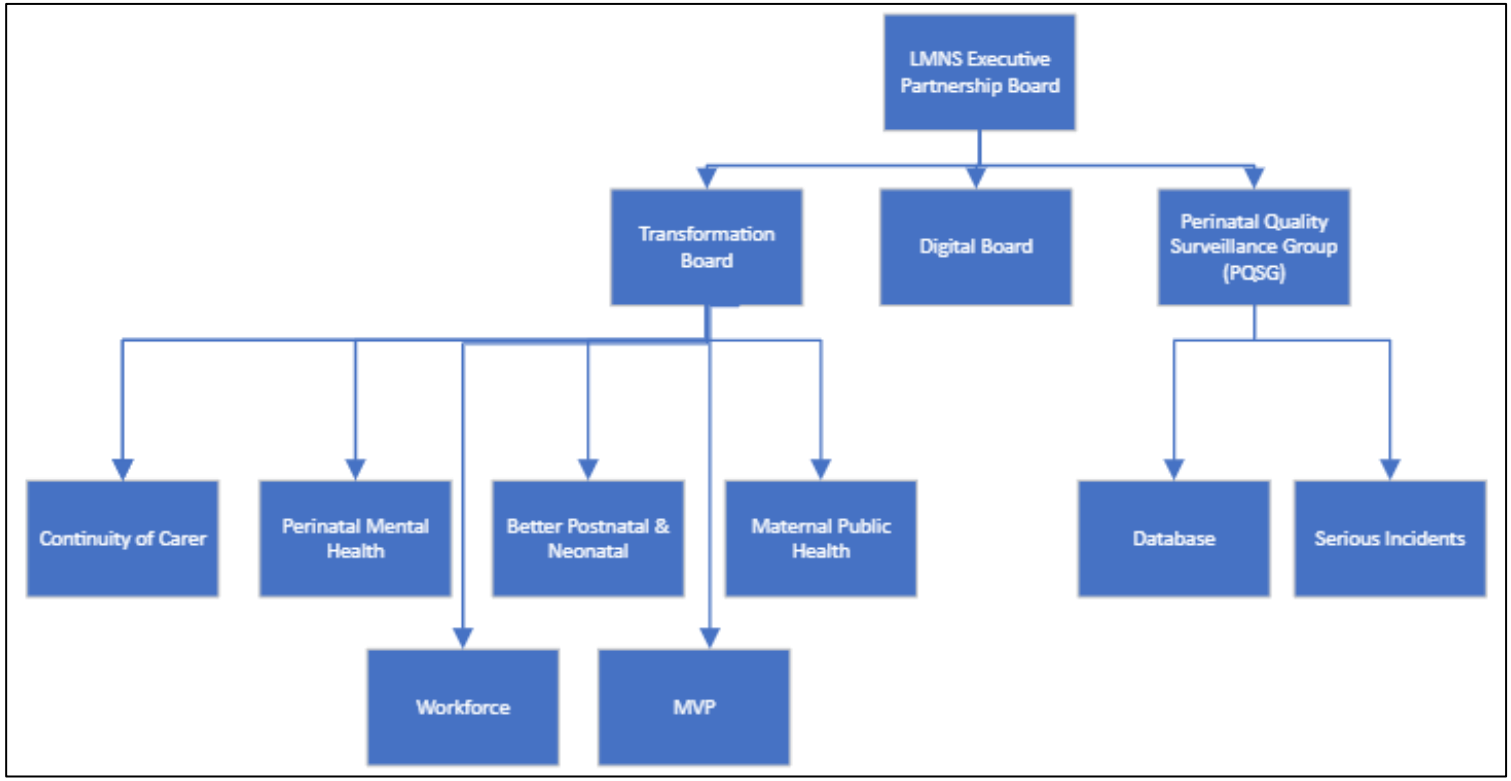
What we need to do:

All Trusts must make sure women have access to accurate information so they can make choices about where they want to give birth and the mode of birth, including maternal choice for caesareans.

Our plan:

- Trusts will continue to update their websites to provide women and families with information about places of birth and how they will receive care, with printed and translated information also available.
- Trusts will work with the MVP and other partners make sure information is easy to find and suitable.

Appendix B


LMNS Executive Partnership Board
Transformation Board
Digital Board
Perinatal Quality Surveillance Group (PQSG)
Continuity of Carer
Perinatal Mental Health
Better Postnatal & Neonatal
Maternal Public Health
Database
Serious Incidents
Workforce
MVP

Appendix C

Table 1

NOTTINGHAM AND NOTTINGHAMSHIRE LMNS	NUH		SFH	
Ockenden Reference (Action/Theme)	**Jan 22**	**April 22**	**Jan 22**	**April 22**
IEA1 Enhanced Safety	56%	100%	100%	100%
IEA2 Listening to women and families	88%	99%	88%	100%
IEA3 Staff training and working together	56%	63%	100%	100%
IEA4 Managing complex pregnancy	79%	89%	100%	100%
IEA5 Risk assessment throughout pregnancy	67%	70%	100%	100%
IEA6 Monitoring fetal well being	67%	94%	100%	100%
IEA7 Informed consent	50%	57%	71%	71%
Workforce	70%	80%	100%	100%

Table 2

IEA3	- Consultant cover increased to support full implementation twice daily ward rounds. Active recruitment expedited. - Utilisation of additional funds to support training - PROMPT training provision for Multi-Disciplinary Training - LMNS oversight and validation of training data
IEA4	- Review and development of antenatal care pathways to ensure NICE compliance and emerging Maternal Medicine Centre - Continued work towards full SBLCBv2 compliance overseen by the LMNS and Regional Perinatal Team
IEA5	- Personal care and support plans developed and embedded supporting formal risk assessment at each contact, this will be supported by the implementation of a new systemwide Maternity Information System