NHS
The Leeds Teaching Hospitals NHS Trust

Trust Board
Ockenden Assurance
31 March 2022

Presented for:	Information and Assurance
Presented by:	Sue Gibson, Director of Midwifery
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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 - we will deliver safe and effective patient care through having adequate systems and processes in place to ensure the Trust has 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 to patients and manage risks that could limit the ability to achieve safe and effective care for our patients	Cautious	↔ (same)
Financial Risk			Choose an item	↔ (same)
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	
Provide assurance following analysis of the LTHT Ockenden evidence submission by the regional maternity team there were no immediate safety concerns raised with any of the seven Immediate and Essential Actions.	Information and Assurance
Provide assurance he maternity services are working collaboratively with the Local Maternity Systems across the Yorkshire and Humber network to establish and implement the maternal medicine centres	Information and Assurance
Provide assurance strategies are being developed to support engagement with harder to reach communities and increasing the available evidence to support assurance of service user choice, involvement and engagement in care	Information and Assurance
Provide assurance the Birthrate+ review has been completed which identified some gaps in clinical and non-clinical/specialist areas. Recurrent funding will be provided from NHSEI via the Local Maternity System on a fair share basis which will facilitate closure of these gaps	Information and Assurance
Provide assurance the senior midwifery leadership structure has been reviewed and aligned with RCM leadership manifesto to incorporate Director, Head and Deputy Head of Midwifery posts.	Information and Assurance

1.0 Summary

This paper provides information and assurance to the Trust Board with regard to the Immediate and Essential Actions identified in the Interim Ockenden report published in December 2020. The service continues to monitor compliance with the safety actions through internal governance frameworks.

2.0 Background

The first draft of the Ockenden Report was published in December 2020, with detailed failings in the maternity and neonatal care provided by Shrewsbury and Telford NHS Trust over a number of years. Seven 'Immediate and Essential Actions' (IEA's) were identified, for all Maternity care providers in England, with twelve clinical priorities requiring immediate implementation.

A need for critical oversight of maternity services was also recognised with increased need for system and partnership working. In view of this, increased accountability and authority was given to Local Maternity Systems to ensure safety and quality in the Maternity Services they represent. The PMO from the West Yorkshire and Harrogate LMS now attends the regional perinatal Quality Assurance Group chaired by the regional Chief Midwifery Officer to provide assurance and identify opportunities for shared learning. Internally the maternity services provide assurance of the quality and safety of services through scheduled attendance and presentations at the Quality Assurance Committee and the Trust Board.

All maternity services received a letter on the 25th of January 2022 from NHSEI (see Appendix 1) asking that they re-evaluate their position in relation to the seven IEA's to monitor progress and prepare for further publication of reports into the maternity services in the coming months. The letter asks that a discussion of progress with implementation of the seven IEAs and maternity services workforce plans is undertaken at Trust Public Board by the end of March 2022. It further stipulates that ensuring local system oversight of maternity services is a key element in the Ockenden review and therefore Trusts should ensure

progress is shared and discussed with their LMS and ICS and progress reported to the regional maternity team by 15 April 2022.

3.0 Assessment of Evidence

LTHT maternity services benchmarked against the seven IEA's in January 2021. The service self-assessed as compliant with the recommendations from the Ockenden report bar the advocacy role. The advocate element now sits at a national level with the job description under review by the national team and will be implemented locally at the earliest opportunity. An assurance self-assessment tool was completed and presented to LTHT Quality Assurance Committee on 4/2/21, and submitted to NHSE North East & Yorkshire Regional Chief Midwifery Officer on 15/2/21. The initial feedback from the regional team was provided via a RAG rated report. This highlighted some areas as amber and red as the service had provided a summary as requested rather than a detailed narrative including supporting evidence.

In June 2021 all maternity units were asked to provide supportive evidence of their self-assessments via a national portal to facilitate external review. A process was developed nationally for the regional maternity teams to analyse the data and assess providers' ability to provide evidence of compliance with the seven IEA's. The minimum evidence was quality assured by the regional maternity team following submission. LTHT received the analysis of the evidence submission in October 2021 (see Appendix 2) and subsequently the leadership team met with the regional midwifery team to review the findings of the Ockenden evidence submission. This meeting was also attended by the Chief Nurse, Director of Quality and Safety, the link Patient Quality Safety Manager for the Women's CSU and the PMO for the West Yorkshire and Harrogate LMS. There were some areas highlighted where the service needs to strengthen the available evidence to support assurance, but overall there were no immediate safety concerns raised. It is anticipated that the delivery of the action plan (as detailed in appendix 3) will provide evidence to support full compliance with all seven IEA's. This will result in green ratings across the full spectrum of the evidence submission by April 2022. The remaining areas identified for further development to facilitate full assurance are implementation of the maternal medicine centre and informed choice and involvement in decision making processes.

As the chosen provider host for implementing the Maternal Medicine service, the maternity team are meeting regularly with colleagues in the South Yorkshire LMS and Humber, Coast and Vale LMS to progress plans. The NHSE Specialised Commissioning service specification has been published. Benchmarking against the service specification has been undertaken and plans are in place to address the identified gaps in provision. The responsibility and accountability for maternal medicine is shared between the PMO's for each of the Local Maternity Systems (LMS) within Yorkshire and the Humber. The implementation group is led by Karen Poole the PMO for West Yorkshire and Harrogate LMS. There are three defined work-streams focusing on workforce, pathway development and implementation of the maternal medicine centres. Recruitment into the posts aligned with the maternal medicine centre is anticipated in the next one to two months. At this stage the maternal medicine centres will be in a position to move to the implementation phase.

The leadership team are working closely with the Leeds Maternity Voices Partnership to develop strategies to engage and collaborate with the harder to reach communities to ensure representation of the local population in co-producing and co-designing maternity services. Strategies are also being developed to explore further methods of evidencing women's choice and involvement in their care. Personalised care and support plans have recently been launched throughout the service which enables service users to document their wishes/preferences and use as a working document to facilitate conversations with health care providers. The uptake of these is monitored on the maternity clinical dashboard.

5.0 Embedding and Monitoring the Immediate and Essential Actions

It is imperative that continued compliance with the IEA's is regularly monitored and responsive actions initiated as appropriate. An assurance paper detailing key performance indicators associated with the IEA's is developed quarterly and reviewed at the Women's CSU overarching governance assurance group. In addition to CSU oversight, the quality and safety of the maternity services including compliance with the Ockenden recommendations is a standing agenda item on corporate governance meetings. Maternity services present an assurance paper monthly to the Quality Safety and Assurance Group which details:

- Progress against national agendas
- Oversight of compliance/progress with the seven Ockenden IEA's
- Compliance with Maternity Incentive Scheme and any areas at risk
- Compliance with Key Performance Indicators
- A breakdown of all reported incidents within the service
- Oversight of on-going investigations
- Summary of external referrals to HSIB and Early Notification Scheme (ENS)
- Summary of Perinatal Mortality Review Tool (PMRT) findings and feedback

Additionally the maternity services report directly to the Quality Safety and Assurance Group, and Quality Assurance Committee, a committee of the Trust Board. The Clinical Director and the Director of Midwifery presented the LTHT Ockenden position and areas for further development at Board workshop in November 2021. All fetal, neonatal and maternal mortality, serious incidents and moderate or above harm incidents are presented bi- monthly to the Trust Board via the IQPR pack.

The LTHT Executive and Womens CSU leadership teams met virtually with the National Maternity Leaders on the 8th March 2022 as part of a programme of engagement events with all maternity providers in England. Jacqueline Dunkley-Bent (CMO) delivered a presentation on safer sustainable maternity care. The presentation highlighted the historic issues around the safety of maternity services and the ambition to reduce variation in services and embed sustainable change. Key questions were posed for consideration from the Trust board regarding assurance of safe quality services. A revised safety self-assessment tool was discussed and a link provided. The tool has been designed to enable maternity providers to self-assess whether their operational service delivery meets national standards, guidance and regulatory requirements. The tool can be used by organisations to inform the Trust's maternity quality improvement and safety plan and support communication and triangulation with the Trust Board and all other relevant stakeholders. There was an opportunity for questions and feedback from the Trust. There were no concerns raised regarding the quality and safety of LTHT maternity services.

6.0 Maternity Workforce Update

As part of the safer staffing requirements for maternity services an establishment review was commissioned by Birthrate+ (BR+). The use of BR+ has been recommended in all recent Department of Health Maternity Policy; is endorsed by the Royal College of Midwives and is incorporated within CNST standards issued by the NHS Litigation Authority. It is the only

validated maternity workforce tool and has a 24 year history of application in 100+ trusts in the UK and Ireland.

BR+ provides the intelligence and insights required to support leaders of maternity services and Trust Boards to model midwifery numbers, skill mix and deployment required to support safe and sustainable maternity services. The use of BR+ enables Trusts to calculate their specific workforce needs based on activity, case mix, demographics and skill mix. It also takes account of the contribution to the quality of services by non-clinical staff such as managers, governance teams and other non-clinical specialist roles.

The BR+ review identified gaps in the staffing establishment from a clinical and non-clinical/specialist perspective. Recurrent funding to support compliance with the IEA's including the workforce element is being provided by NHSEI. This funding will be allocated to the West Yorkshire and Harrogate LMS and distributed on a fair share basis. The available funding will enable the gaps identified in the BR+ report to be closed.

The importance of strong sustained leadership within maternity services is echoed throughout all of the national reports evaluating the safety of maternity services. Elements of ineffective leadership and lack of oversight of key processes to maintain a safe quality service is highlighted in these reports. The structure of the LTHT leadership team has been evaluated and support provided to implement a structure comprising of a Director, Head and Deputy Head of Midwifery. Recruitment processes have been undertaken and substantive appointments made for all of these roles.

7.0 Recommendation

The Trust Board is asked to:
i) To receive this paper
ii) To note progress with the Ockenden Immediate and Essential Actions
iii) To note areas for continued improvement
iv) To note the recurrent funding stream to support full compliance with all 7 IEA's
v) To note the workforce plans

Supporting Information
Appendix 1 CNO Letter
Appendix 2 National Analysis of LTHT Ockenden Evidence
Appendix 3 LTHT Ockenden Action Plan

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