

To: NHS Trust and Foundation Trust Chief Executives

CC: Trust Chairs, STP and ICS Leaders, CCGs

14 December 2020

Dear colleague,

OCKENDEN REVIEW OF MATERNITY SERVICES – URGENT ACTION

Following the publication of Donna Ockenden's first report: [Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospitals NHS Trust](#) on 11 December 2020, this letter sets out the immediate response required of all Trusts providing maternity services, and next steps to be taken nationally.

You will have read the report and recognise the deep and lasting impact on those families who have lost loved ones, and those who continue to live with the injury and trauma caused.

Despite considerable progress having been made in improving maternity safety, there continues to be too much variation in experience and outcomes for women and their families. We must use this report and its 7 Immediate and Essential Actions (IEA) to redouble efforts to bring forward lasting improvements in our maternity services.

Immediate Actions

You should proceed to implement the full set of the Ockenden IEAs. However, we have identified 12 urgent clinical priorities from the IEAs which we are asking you to confirm you have implemented by **5pm on 21 December 2020**. The priorities are:

1) Enhanced Safety

- a) A plan to implement the Perinatal Clinical Quality Surveillance Model, further guidance will be published shortly
- b) All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB

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
- 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.

3) Staff Training and working together

- a) Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.
- 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.
- c) Confirmation that funding allocated for maternity staff training is ringfenced and any CNST Maternity Incentive Scheme (MIS) refund is used exclusively for improving maternity safety

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
- b) Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres

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 (PCSP). Regular audit mechanisms are in place to assess PCSP compliance

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.

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.

Workforce - the report is clear that safe delivery of maternity services is dependent on a Multidisciplinary Team approach. The Maternity Transformation Programme has implemented a range of interventions to deliver increases in healthcare professionals and support workers including: the development of the maternity support worker role, the expansion of midwifery undergraduate numbers, additional maternity placements and active recruitment.

Alongside this, local maternity leaders should align assessments, safety, and workforce plans to the needs of local communities. We are therefore asking Trust Boards to confirm that they have a plan in place to the Birthrate Plus (BR+) standard by **31 January 2021** confirming timescales for implementation.

Please send confirmation of your compliance with these immediate actions signed off by you, as the CEO, along with confirmation of sign off from the Chair of your local LMS to your Regional Chief Midwife, **by 21 December**. They are available to support you with this request. Your individual responses will form part of the presentation and discussion at the NHSEI Public Board in January 2021 when the report, and immediate and longer-term actions will be considered.

We are also asking every trust providing maternity services to review the report at your next public board. The Board should reflect on whether the assurance mechanisms within your Trust are effective and, with your local maternity system (LMS), you are assured that poor care and avoidable deaths with no visibility or learning cannot happen in your own organisation. To support these discussions, we are asking Trusts to complete and take to your board the **assurance assessment tool**, which will be published shortly and draws together elements including:

- 1) All 7 IEAs of the Ockenden report,
- 2) NICE guidance relating to maternity,
- 3) compliance against the CNST safety actions, and
- 4) a current workforce gap analysis

Your assurance assessment tool should also be reported through your LMS and shared with regional teams by the **15 January 2021**, in order to complete a gap and thematic analysis which will be reported to the regional and national Maternity Transformation Boards.

We undertake to work with regions, systems and Royal Colleges to implement the Ockenden 7 IEAs including: those for LMS; the independent senior advocate role in Trusts; and ensuring that networked maternal medicine is implemented across all regions. We will also review the MTP, now entering its final year, to ensure future plans are in line with the Ockenden 7 IEAs.

We are planning a webinar this week with Amanda Pritchard (Chief Operating Officer, NHS England and NHS Improvement and Chief Executive, NHS Improvement), Sarah-Jane Marsh (Chair, Maternity Transformation Programme, Chief Executive, Birmingham Women's and Children's NHS Foundation Trust) and Ruth May (Chief Nursing Officer, NHS England and NHS Improvement) to discuss and answer any questions you may have about this letter and the requests contained herein.

As you will no doubt agree our women and families deserve the best of NHS care and we must therefore act without delay to make further improvements. Thank you in advance in your collective support in responding to this.

Yours sincerely

A handwritten signature in black ink that reads "A. Pritchard". The signature is written in a cursive style with a large initial 'A'.

Amanda Pritchard
Chief Operating Officer, NHS England and NHS Improvement
Chief Executive, NHS Improvement

A handwritten signature in black ink that reads "Ruth May". The signature is written in a cursive style with a large initial 'R'.

Ruth May
Chief Nursing Officer, England

A handwritten signature in black ink that reads "Steve Powis". The signature is written in a cursive style with a large initial 'S'.

Professor Steve Powis
National Medical Director
NHS England and NHS Improvement