

NHS England and NHS Improvement Board meetings held in common

Paper Title: National Response to the First Ockenden Report

Agenda item: 9.1 (Public session)

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Paper type: For discussion

Organisation Objective:

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| NHS Mandate from Government | <input type="checkbox"/> | Statutory item | <input type="checkbox"/> |
| NHS Long Term Plan | <input type="checkbox"/> | Governance | <input checked="" type="checkbox"/> |
| NHS People Plan | <input type="checkbox"/> | | |

Executive summary:

The NHS is committed to providing safe, compassionate, maternity services. While there has been clear progress over last 5 years of the Maternity Transformation Programme (MTP), Donna Ockenden's first report (the Ockendon report) has highlighted variation and women and their families are not always receiving the care that they should.

The 7 "immediate and essential actions" (IEAs) outlined in the Ockendon report include local, system and regional actions. We have introduced a quality assurance (QA) process to evaluate compliance against the 7 IEAs, and to then support those organisations requiring improvement plans to reach full compliance.

As a first step, we are also investing £95m in the three overarching themes that have been identified; workforce numbers, training and development programmes to support culture and leadership, and strengthening board assurance and surveillance to identify issues earlier, thereby enabling rapid intervention.

Action required:

The Boards are asked to note the progress to date.

Risk:

This paper links to the care quality events risk.

Background

1. The Maternity Transformation Programme was launched in 2016, following the publication of [Better Births](#) to oversee implementation of the recommendations to deliver safer more personalised care across England, This included delivering the ambition to halve the rate of stillbirths, neonatal deaths, maternal

deaths and serious intrapartum brain injuries by 2025, and a 20% reduction by 2020 from a 2010 baseline.

2. Encouraging progress has been made. Between 2010 and 2019, there was a 25% reduction in stillbirths, and a reduction of 29% for neonatal deaths after 24 weeks; both ahead of the trajectory. There has been a smaller reduction in maternal mortality from 10.6 per 100,000 to 9.7 (2017/19), and slower progress on the reduction in the serious brain injury rate; 7.5% between 2018 and 2019, from 4.6 to 4.2 per 1000 births.
3. The programme has delivered inclusion in the GP contract of a postnatal maternal health check, increased access to perinatal mental health care, and the 2019 [CQC survey](#) showing improvement in the experiences of women using maternity services. The perinatal quality surveillance model has been launched, and 98% of providers have implemented improvement activities over the 5 elements of the Saving Babies Lives Care Bundle. Personalised care planning will be rolled out in 2021 and work continues to deliver Maternal Medicine Networks across England.
4. Investment in leaders of the profession included the creation of the first Chief Midwifery Officer in 2019, along with two deputy chief midwives and seven regional chief midwives.
5. The Maternity Safety Support Programme (MSSP) was fully established in 2018 and revised in 2020. This is a programme of intensive support to trusts with an overall rating 'requires improvement' and in the safe, well-led or one other domain for their maternity services to improve.
6. [Donna Ockenden's first report](#), published on 11 December 2020, sets out local actions required for Shrewsbury and Telford Hospital Trust, (progress is described at annex A), and 7 "Immediate and Essential Actions" (IEAs) to improve care and safety in all maternity services.
7. In our consideration of how to implement the actions in the Ockenden report, we reviewed implementation and delivery of the MTP. We have also looked at three recurring overarching themes:
 - Board assurance – clear line of sight and accountability at trust, local, regional and national levels is required. The introduction of the board assurance tool for completion at a trust level, is one of the tools to ensure provider organisations are delivering safe maternity care. Our national governance structure has been strengthened to include surveillance, early rapid intervention and improvement support.
 - Leadership and culture - by training together, Ockenden suggests multidisciplinary teams will work better together and therefore we will invest in workforce training capacity. To support this, we have commissioned a safety culture development programme for leaders across maternity services.

- Workforce numbers –We undertook a workforce survey to consider both midwifery vacancy rates and the establishment requirement, and this is currently being analysed in conjunction with HEE. The obstetric workforce needed also to deliver on the consultant-led ward rounds and fetal monitoring requirements of the IEAs.
8. In this paper we set out the work to date, the immediate priorities to support organisations to embed the IEAs consistently and the national initiatives to ensure that key themes within the report are addressed.

Considerations

9. In order to respond to the Ockenden report fully, the 7IEAs need to be implemented consistently across England, whilst addressing the three overarching themes: board assurance, leadership and culture and workforce numbers.
10. Board Assurance
- a. The Ockenden Board assurance tool has been completed by all trusts delivering maternity services and we asked that the tool should be used to support the discussion at trust public board meetings. A full report of compliance against the IEAs at local, regional and national levels is expected at the end of March.
 - b. All trust boards will know from the board assurance tool where they need to take action to implement the IEAs. Evidence submitted by trusts to their regional chief midwife to demonstrate their compliance will be quality assured (QA) and inform the schedule of QA visits to trusts by the maternity improvement advisors. These QA visits are to support trusts with their improvement plans; to embed the IEAs and to achieve sustainable improvement. Themes identified will be escalated through the Ockenden Implementation Group.
 - c. The assurance process for the implementation of the Ockenden actions will be used for any future reports, including the final Ockenden report expected in autumn 2021, and the East Kent review in 2022 (Annex B).
 - d. The Maternity National Safety Champions have a pivotal role as chairs of the Maternity Quality and Safety Assurance Committee in the strengthened governance structure. (annex C). There are clear reporting lines to executive and oversight groups. The perinatal safety surveillance model is reported through Local Maternity Systems (LMS) to regions and into the National Maternity Safety and Surveillance Concerns Group.
 - e. The National Maternity Safety and Surveillance Concerns Group, the membership of which includes Royal Colleges, CQC, professional regulators as well as DHSC and HSIB, was established in 2020. Its remit is to share information and intelligence, and to work collaboratively across the multi-disciplinary professions to identify issues early and support challenged maternity services with rapid intervention. Coupled with the MSSP, which routinely reports to this group as well as the Joint Strategic Oversight Group and DHSC, and the Ockenden QA visits, an improved early warning system will be established.
 - f. The report was clear that LMS need to have greater accountability and

responsibility and LMSs are currently reviewing their terms of reference to ensure there are clear routes of accountability. Independent scrutiny and challenge through peer review and peer support are fundamental to LMS operations and, as highlighted in the report, this cannot be done when there is only one organisation within a LMS. Therefore, aligning LMS with ICS is a work-in-progress and will also contribute to the action that the LMS chair must be on the board of the ICS (CCG in the interim).

- g. A review of the MTP was planned for 2021, the 5-year point; to build on progress to date and to simplify what is a complex programme to deliver change. To align with the patient safety strategy, the future of the programme will focus on three areas: improvement, infrastructure and insight. The Ockenden actions map to much of the work being delivered by the MTP and, therefore, as part of this review we have ensured there is collaboration with other programmes and inclusion within the strengthened governance structure described here.

11. Leadership and Culture

- a. The safety culture development programme has been co-designed with a range of stakeholders, including the RCOG and RCM. The board level and NED programme will be launched in March with the delivery of the programme for frontline leaders later in the year.
- b. Capacity to release clinicians for training is challenging. Investing in workforce capacity to allow teams to train together will improve the way the multidisciplinary teams work together.
- c. A culture of listening to women and their families is a central theme of the MTP. National Maternity Voices is the national network of local Maternity Voices Partnership (MVP) of whom 1/3 of members are women and their families who have had experience of their local service. The Maternity and Neonatal Service User Voice Summit 2021 was held in March, showcasing the strength of the partnerships and coproduction in maternity and neonatal services with women, people and families, at local, regional and national level. .
- i. There is user representation in every workstream of the programme as well as on the national stakeholder council. The IEAs seek to strengthen this by the introduction of an independent advocate, which we are investing in at a national level to ensure consistency and reduce variation, with links to both trust boards and the LMS and a non-executive director to have oversight of maternity services, ensuring women and their families voices are heard at board level.

12. Workforce

- a. All maternity services have responded to a survey assessing their midwifery staffing levels against those recommended using a workforce planning tool: BirthRate plus (BR+). Fuller analysis is being undertaken of both vacancy rates, and the gap between current establishment and that required to meet the BR+ recommendations, at a local, system and regional level. Targeted local increases in midwifery workforce will help reduce variation and improve the quality of care
- b. The RCoG has secured funding from DHSC to produce a similar workforce planning tool to assess the obstetric staffing levels.

13. Digital transformation was one of the key ambitions of the MTP; the development of the iDecide tool which supports women and their families to record their wishes and consent, and the digital care record. The NHSX paper describes the delivery of these and the other digital elements that will support delivery of the Ockenden IEAs.
14. The MTP has a Stakeholder Council, chaired by Baroness Cumberlege. This group, together with the National Maternity Safety and Surveillance Concerns Group and the MVPs are just three of the ways we engage with our stakeholders. A Stakeholder Council Ockenden event was held in February to map where work on the IEAs already aligns, and engagement across all stakeholders will continue.

Risks and implications

15. Workforce numbers some services may need to increase their establishment and a phased approach has been agreed. The NHS and HEE will work together to define the most appropriate workforce strategy for understanding undergraduate entry alongside more immediate service level interventions such as international recruitment and retention.
16. Success is dependent on delivery at all levels in the system, including engagement of clinicians to adapt to improved ways of working and culture. The mechanism for boards to understand their maternity services and have oversight are in place, as is support for organisations for their improvement plans from regional and national teams. Engagement is currently high with 100% returns for the Board assurance tool. Driving momentum and sustaining this level of engagement will be key to success.
17. The board assurance tool and, the QA process, including visits and peer review and support, are designed to keep a focus on improvement of maternity services, and the implementation of the IEAs. The surveillance framework in place will allow concerns to be identified and early intervention. This is supported by a robust communications strategy to deliver a consistent and coherent message as well as ensuring we continue to hear from stakeholders.
18. There is a changing landscape as we move to system-working, and a variation in maturity of Integrated Care Systems (ICSs), and variation in operational capabilities of LMSs. There is now a formal expectation of regular ICS board consideration of maternity, and more accountability of ICSs for delivering maternity objectives through mainstream ICS assurance. The MTP will continue to support LMS through these changes.

Next Steps

19. In 21/22 we are investing £95m nationally, with follow-on funding subject to decisions in future years.

20. Support at a regional level will be increased by the introduction of a regional obstetrician role for improved oversight, a deputy chief midwife role and project management support.
21. Maternity Improvement Advisors support organisations on their improvement plans and the delivery of the IEAs.
22. The introduction of the Independent Senior Advocate role will ensure there is consistency across England. This will link to the development of patient safety champions to ensure there is collaboration and not duplication.
23. The governance structure described in this paper will be used to oversee the implementation of the actions from Ockenden's final report, expected autumn 2021, and the report by Dr Bill Kirkup on East Kent Hospital Trust maternity services expected in 2022, and any reports and other intelligence that highlight safety concerns in maternity services.
24. Detailed review of board assurance reports. Using evidence submitted by trusts to support their reports, this quality assurance will be completed and a schedule visits drawn up for trusts requiring support to improve. The outputs of both the compliance and the visits will be reviewed at the Quality and Innovation Committee in June.
25. Maternity services will remain the focus of operational meetings, with reporting and discussion at the COO-led Regional Focus Groups and Provider Oversight Group.
26. A Maternity Summit with stakeholders is being planned for May. This will build on the engagement to date, inform the implementation plan, identify risks to delivery and how they can be mitigated.