Manchester City Council
Report for Information

Report to: Health Scrutiny Committee – 22 June 2022

Subject: The Ockenden Report - Manchester Foundation Trust's Response

Report of: St Marys Hospital, Manchester University NHS Foundation Trust

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Summary

Dame Donna Ockenden was appointed to conduct an independent review of maternity services at Shrewsbury and Telford NHS Trust. A report highlighting the initial findings was published in December 2020[1]. Manchester Foundation Trust produced and completed an action plan in relation to its recommendations.

The second and final report into Dame Donna Ockenden's review of maternity services at Shrewsbury and Telford NHS Trust was published on 30 March 2022[2]. It describes 15 Immediate and Essential Actions, which must be taken forward by all local maternity service providers. Manchester Foundation Trust describe their response to the final Ockenden Report.

Recommendations

The Committee is recommended to consider, question and comment upon the information in the report.

Wards Affected: All

Environmental Impact Assessment - the impact of the issues addressed in this report on achieving the zero-carbon target for the city
None

Equality, Diversity and Inclusion - the impact of the issues addressed in this report in meeting our Public Sector Equality Duty and broader equality commitments
It is recognized within the Ockenden report that women from black and ethnic minority backgrounds, and women living in areas with higher rates of social deprivation, are at increased risk of maternal and neonatal morbidity and mortality. Implementation of the recommendations of the Ockenden report, as described in this paper, will improve access to services for these women and reduce variations in care and improve outcomes for women.

[1] https://www.donnaockenden.com/downloads/news/2020/12/ockenden-report.pdf
[2] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1064302/Final-Ockenden-Report-web-accessible.pdf

Manchester Strategy outcomes	Summary of how this report aligns to the OMS/Contribution to the Strategy
A thriving and sustainable city: supporting a diverse and distinctive economy that creates jobs and opportunities	N/A
A highly skilled city: world class and home grown talent sustaining the city's economic success	N/A
A progressive and equitable city: making a positive contribution by unlocking the potential of our communities	N/A
A liveable and low carbon city: a destination of choice to live, visit, work	N/A
A connected city: world class infrastructure and connectivity to drive growth	N/A

Full details are in the body of the report, along with any implications for:

- Equal Opportunities Policy
- Risk Management
- Legal Considerations

Financial Consequences – Revenue
N/A

Financial Consequences – Capital
N/A

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Background documents (available for public inspection):

The following documents disclose important facts on which the report is based and have been relied upon in preparing the report. Copies of the background documents are available up to 4 years after the date of the meeting. If you would like a copy please contact one of the contact officers above.

1 Emerging Findings and Recommendations from the Independent Review of MATERNITY SERVICES at the Shrewsbury and Telford Hospital NHS Trust. December 2020

2 Independent Maternity Review. (2022). Ockenden report – Final: Findings, conclusions, and essential actions from the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust (HC 1219). Crown. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1064302/Final-Ockenden-Report-web-accessible.pdf

1.0 Introduction

1.1 In the summer of 2017, following a letter from bereaved families, raising concerns where babies and mothers died or potentially suffered significant harm whilst receiving maternity care at The Shrewsbury and Telford Hospital NHS Trust, the former Secretary of State for Health and Social Care, Jeremy Hunt, instructed NHS Improvement to commission a review assessing the quality of investigations relating to newborn, infant and maternal harm at The Shrewsbury and Telford Hospital NHS Trust. Donna Ockenden, senior midwifery advisor, was asked to lead this independent review**.**

1.2 The 'Ockenden report' is based on the themes identified within the Independent Review of Maternity Services at the Shrewsbury and Telford Hospitals NHS Trust.

1.3 Donna Ockenden's first report: Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospitals NHS Trust was published on 11th December 2020. This report identified 7 immediate and essential actions (IEAs) which maternity providers across England were mandated to take forward.

1.4 The second and final report was published on 30 March 2022 and identified a further 15 IEA's.

1.5 Saint Mary's Managed Clinical Service (SM MCS), as part of Manchester University NHS Foundation Trust (MFT), manages the maternity services on the North Manchester General Hospital, Wythenshawe and Oxford Road Campus sites). In this paper, SM MCS provides an update on compliance with the first report and describes their response to the final Ockenden Report. This is to inform the Committee of areas where maternity care is already compliant with the recommendations; highlight areas where actions are being taken and outline the process by which the action plan will be monitored.

2.0 Manchester Foundation Trust response to emerging findings from the first Ockenden report

2.1 Following the publication of Donna Ockenden's first report NHS England and Improvement (NHSE & I) wrote to all Chief Executives of all Trusts providing maternity services, setting out the immediate response required.

2.2 It was mandated that each Trust should proceed to implement the full set of Ockenden IEAs, and to confirm that the 12 urgent clinical priorities from the IEAs had been implemented by 5pm on 21st December 2020.

2.3 Confirmation of compliance with these immediate actions was signed off by the MFT Chief Executive along with the Regional Chief Midwife by 21st December 2020.

2.4 Saint Mary's Managed Clinical Service (SM MCS), who provide maternity and neonatal services within MFT, reported no major non - compliance on the 21st

December 2020 with any of the IEA's and informed the MFT BoD in January that in responding to the immediate and essential actions maternity services did not identify any high-level patient safety concerns.

2.5 SM MCS, as requested, completed the National Assurance Assessment Tool which was reported through the Greater Manchester and East Cheshire Local Maternity Service (GMEC LMS) to the NW Regional Office on the 15th February 2021. This provided a greater level of detail as to the level of compliance with all 7 IEAs of the first Ockenden Report.

2.6 SM MCS developed a comprehensive action plan to deliver full compliance against each of the workstreams. Whilst there was full compliance with several Immediate and Essential Actions, aspects of the service which could be strengthened were identified and included in the Action Plan.

2.7 SM MCS First Ockenden response plan included 83 actions against the 7 Immediate and Essential Actions (IEAS) and full compliance was confirmed for all by 31st December 2021.

2.8 In June 2021, an extensive submission of evidence related to areas of compliance was submitted via the Future NHS Collaborative Platform for review by the Clinical Support Unit (CSU), Regional Maternity Transformation Programme. GMEC LMS) subsequently received evidence of SM MCS compliance against all IEA's.

2.9 In addition, all Trusts were asked to submit funding bids to NHS England for monies to support compliance with specific actions relating to workforce gaps which had been identified following the completion of Birth Rate Plus in March 2021.

2.10 Birth Rate Plus is a nationally recognised midwifery staffing toolkit, which was funded by GMEC LNMS, and had identified that SM MCS required 17 WTE midwives to ensure safe staffing levels.

2.11 SM MCS was successful in receiving funding from NHS England which supported an increase in midwifery establishment to Birth Rate Plus recommended safe staffing levels.

2.12 By September 2021, SM MCS had made recruitment offers to fill the new 17 WTE vacancies arising from the increase in establishment.

2.13 The first Ockenden action plan was monitored monthly via SM MCS Maternity Division Quality and Safety committee, reported quarterly to Trust Board of Directors throughout 2021.

2.14 By 31st December 2021, SM MCS had completed all actions with the action plan and completed all provider level Ockenden actions required from the initial report published in December 2020. There remain 3 outstanding actions which sit with GMEC LMNS relating to a process on how the system is to

receive maternity training data. It is expected that this will be completed by the end of June 2022.

2.15 A summary of the action plan is shared in Appendix 1.

2.16 Formal Assurance Visits by the NHS England Regional Midwifery Team to review progress against the first Ockenden IEAs are scheduled to take place across SM MCS on the 24th 25th and 26th of August 2022, with evidence of compliance against specific metrics within the 7 IEAs provided to the regional team 1 week prior.

3.0 Manchester Foundation Trust response to emerging findings from the final Ockenden report

3.1 In March 2022, SM MCS reported to Trust Board of Directors the expected publication of the final Ockenden report.

3.2 On 30th March 2022, the final Ockenden Report[3] was released, which identified a further 15 Immediate and Essential Actions.

3.3 Key Findings of the report specifically relating to maternity services related to:

- Poor governance across a range of areas, especially board oversight and learning from incidents
- Lack of compassion and kindness by staff
- Poor assessment of risk and management of complex women
- Failure to escalate
- Poor fetal monitoring practice and management of labour
- Suggestion of reluctance to perform LSCS - women's choices not respected
- Poor bereavement care
- Obstetric anaesthetic provision
- Neonatal care documentation and care in the right place.

3.4 The Ockenden report focuses on maternity services however the 4 overarching themes identified provide wider learning for the wider healthcare system. These are:

- Safe staffing levels
- A well-trained workforce
- Learning from incidents
- Listening to families

3.5 In April 2022, SM MCS completed an initial review of the 15 IEA's against current service provision which was submitted to Trust Board of Directors in May 2022 (Appendix 2).

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3 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1064302/Final-Ockenden-Report-web-accessible.pdf

3.6 The 15 IEA's (split into 27 sections) include 97 separate elements which Trusts must achieve to be compliant. This expectation was communicated to the MFT Board of Directors in March 2022.

3.7 By May 2022 SM MCS were able to report to Trust Board of Directors that they were already compliant with 57 of the 97 elements. Work is required by SM MCS to achieve compliance with 26 elements and an action plan has been generated (Appendix 3). The other 14 elements require work to be undertaken by external bodies such as NHSE, or Royal Colleges, or for SM MCS to work in conjunction with these bodies.

3.8 SM MCS are already fully compliant with the IEAs relating to Clinical Governance Leadership, Complex Antenatal Care and Bereavement Care.

3.9 For ease SM MCS have developed the following table (Table 1) for clarity of reporting against all the 15 IEAs (incorporating 27 sections) and SM MCS compliance in May 2022.

Table 1 Current compliance of Saint Mary's MCS with the 15 IEAs

IEAs	Section	Comment
Immediate and Essential Action 1 -Workforce planning and sustainability	Financing a safe maternity workforce	Work ongoing
	Training	Work ongoing
Immediate and Essential Action 2 - Safe staffing	All trusts must maintain a clear escalation and mitigation policy where maternity staffing falls below the minimum staffing levels for all health professionals	Work ongoing
Immediate and Essential Action 3 - Escalation and Accountability	Staff must be able to escalate concerns if necessary	Work ongoing
	There must be clear processes for ensuring that obstetric units are staffed by appropriately trained staff at all times. If not resident there must be clear guidelines for when a consultant obstetrician should attend	Work ongoing
Immediate and Essential Action 4 - Clinical Governance Leadership	Trust boards must have oversight of the quality and performance of their maternity services.	Compliant
	In all maternity services the Director of Midwifery and Clinical Director for	Compliant

IEAs	Section	Comment
	obstetrics must be jointly operationally responsible and accountable for the maternity governance systems.	
Immediate and Essential Action 5 - Clinical Governance Incident Investigation and complaints	Incident investigations must be meaningful for families and staff and lessons must be learned and implemented in practice in a timely manner	Work ongoing
Immediate and Essential Action 6 - Learning from Maternal Deaths	Nationally all maternal post-mortem examinations must be conducted by a pathologist who is an expert in maternal physiology and pregnancy related pathologies.	Work required by external bodies (RCOG)
	In the case of a maternal death a joint review panel/investigation of all services involved in the care must include representation from all applicable hospitals/clinical settings	Work required by external (RCOG)
Immediate and Essential Action 7 - MDT Training	Staff who work together must train together	Compliant
	Staff should attend regular mandatory training and rotas. Job planning needs to ensure all staff can attend.	Work ongoing
	Clinicians must not work on labour ward without appropriate regular CTG training and emergency skills training	Work ongoing
Immediate and Essential Action 8 - Complex Antenatal Care	Local Maternity Systems, Maternal Medicine Networks and trusts must ensure that women have access to pre-conception care.	Compliant
	Trusts must provide services for women with multiple pregnancy in line with national guidance	Compliant
	Trusts must follow national guidance for managing women with diabetes and hypertension in pregnancy	Compliant
Immediate and Essential Action	The LMNS, commissioners and trusts must work collaboratively to ensure systems are in place for the	Work ongoing

IEAs	Section	Comment
9 - Preterm Birth	management of women at high risk of preterm birth.	
Immediate and Essential Action 10 Labour and Birth	Women who choose birth outside a hospital setting must receive accurate advice with regards to transfer times to an obstetric unit should this be necessary.	Work ongoing
	Centralised CTG monitoring systems should be mandatory in obstetric units	Compliant
Immediate and Essential Action 11 Obstetric anaesthesia	In addition to routine inpatient obstetric anaesthesia follow-up, a pathway for outpatient postnatal anaesthetic follow-up must be available in every trust to address incidences of physical and psychological harm.	Work ongoing
	Documentation of patient assessments and interactions by obstetric anaesthetists must improve. The determination of core datasets that must be recorded during every obstetric anaesthetic intervention would result in record-keeping that more accurately reflects events.	Work required by external bodies
	Staffing shortages in obstetric anaesthesia must be highlighted and updated guidance for the planning and provision of safe obstetric anaesthesia services throughout England must be developed.	Work ongoing
Immediate and Essential Action 12 Postnatal Care	Trusts must ensure that women readmitted to a postnatal ward and all unwell postnatal women have timely consultant review.	Work ongoing
	Postnatal wards must be adequately staffed at all times	Compliant
Immediate and Essential Action 13 Bereavement Care	Trusts must ensure that women who have suffered pregnancy loss have appropriate bereavement care services	Compliant
Immediate and Essential Action 14 Neonatal Care	There must be clear pathways of care for provision of neonatal care.	Work ongoing

IEAs	Section	Comment
Immediate and Essential Action 15 Supporting Families	Care and consideration of the mental health and wellbeing of mothers, their partners and the family as a whole must be integral to all aspects of maternity service provision.	Work ongoing

Progress against the action plan is monitored through the extended governance framework which has been developed. Progress is reported at Divisional level within the maternity unit; to the Saint Mary's Quality and Safety Committee; to the MFT Group Quality and Safety Committee and to the Board of Directors. The Board Safety Champions (including a Non-Executive Director) meet regularly with the Medical Director and Director of Midwifery and Nursing, as does the CCG Deputy Director of Quality and Patient Safety Specialist. Assurance is also provided to the Local Maternity System, to the Regional Maternity Team and returns are submitted nationally.

4.0 Recommendations

4.1 The Committee is recommended to consider, question and comment upon the information in this report.