Manchester City Council
Report for Information

Report to:	Health Scrutiny Committee – 19 July 2023
Subject:	1. The Ockenden Report - Manchester University NHS Foundation Trust's Response 2. Actions being taken to address inequalities for women from Black and Minority Ethnic (BAME) backgrounds 3. Actions taken in response to a CQC 29A Warning notice
Report of:	Saint Mary's Managed Clinical Service (MCS), 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], with the second and final report being published in March 2022[2]. A report detailing Saint Mary's MCS progress against delivering the immediate and essential actions to both reports was presented at the Health Scrutiny Committee on 22 June 22. This report provides a further update on our progress against the remaining actions.

In addition, as requested by the Health Scrutiny Committee in June 2022, Saint Mary's MCS have provided actions being taken to address inequalities for our most vulnerable women from Black and Minority Ethnic (BAME) backgrounds.

This report also provides a summary of actions taken by the Saint Mary's MCS in response to a 29A warning notice issued by the CQC, and outlines improvements made in key metrics.

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

[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

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 recognised 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, reduce variations in care and improve outcomes for women. See **Section 4** for Saint Mary's Managed Clinical Services (SM MCS) actions to date to support the maternal health of women and families from Black African, Asian, and other ethnic minority groups

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 – N/A
- Risk Management – N/A
- Legal Considerations – N/A

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. Introduction

1.1. As reported to Health Scrutiny committee in June 2022, the ‘Ockenden report’ is based on the themes identified within the Independent Review of Maternity Services at the Shrewsbury and Telford Hospitals NHS Trust.

1.2. There were 7 immediate and essential actions (IEAs) within the initial report (2020) and a further 15 IEAs in the final report (2022).

1.3. 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.

1.4. As previously reported to Health Scrutiny Committee, SM MCS remain fully compliant with the 7 IEAs from the initial Ockenden report. In this paper, SM MCS describe their response to the final Ockenden Report and actions underway to achieve full compliance.

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

2.1. A report from Saint Mary’s MCS to the Health and Security Committee on 23rd June 2022 confirmed full compliance with the initial Ockenden report. This has been maintained and is monitored bi-monthly at the MFT Group Quality and Performance Scrutiny Committee and is submitted quarterly to the Greater Manchester and Eastern Cheshire Local Maternity and Neonatal System (GMEC LMNS) informing them of maintained compliance with all 7 IEAs of the first Ockenden Report.

2.2. Since reporting to Health Scrutiny Committee, and as part of the national NHS England review to provide assurance with Ockenden IEA’s, Saint Mary’s MCS welcomed the Regional Midwifery Team to review progress against the first Ockenden IEAs in August 2022. This included an onsite visit to all 3 maternity sites and submission of evidence of compliance against specific metrics within the 7 IEAs (provided to the regional team 1 week prior).

2.3. Confirmation was received that the regional team were assured of continued compliance with initial Ockenden IEA’s and provided additional feedback for consideration, relating to areas of good practice. See Table 1 for clarity of recommendations and compliance.

Ockenden Insight Visit Recommendation / Point for consideration	RAG
The Trust should undertake r**eciprocal arrangements** with other specialist trusts to ensure **PMRT review**s are subject to external scrutiny.	Complete (Sept 2022)
The Trust should **promote the role of the Safety Champio**n to ensure staff at all levels were aware of who they are and their function.	Complete (Sept 2022)
The Trust should continue to **mirror the best practice** from **one site across all three t**o ensure a consistent and high-quality care is across the sites.	Complete (Sept 2022)
The Trust should adopt the **birth talk service** across the three sites.	Complete (Sept 2022)
The Trust should continue to **harmonise guidanc**e across the three sites as a priority.	Complete (Feb 2023)
The Trust must as a matter of urgency **return resuscitation equipment to theatres at NM** to prevent the separation of mother and baby at birth.	Complete (Aug 2023)
The t**ransitional care model offered at the Wythenshawe site should be replicated across the three sites without delay.**	In progress estimated completion by December 2023

Table 1 Current compliance of Saint Mary's MCS Ockenden Insight Visit recommendations

3. Manchester Foundation Trust response to findings from the final Ockenden report

3.1. As reported to Health Scrutiny Committee in June 2022, the 15 IEAs in the final Ockenden report were made up of 97 separate elements, of which SM MCS were fully compliant with 57 elements.

3.2. SM MCS has made good progress and at the end of June 2023 there are five outstanding provider led actions (three within Clinical Scientific Services (CSS), one within SM MCS and one at Group level) to achieve full compliance with the Final Ockenden report[3]. There remain 10 actions to be completed by external bodies and are detailed within the full action plan provided in Appendix 1.

[3] https://www.ockendenmaternityreview.org.uk/wp-content/uploads/2022/03/FINAL_INDEPENDENT_MATERNITY_REVIEW_OF_MATERNITY_SERVICES_REPORT.pdf

3.3. Of the five outstanding provider led actions:

- Two are related to build within Hive (the Electronic Patient Record introduced to MFT in Sep 2022) which have been delayed due to clinically significant Hive build taking priority. Neither action impact on patient safety and system builds remain ongoing (expected to complete by the end of July 2023).
- Two are related to additional obstetric anaesthetic staffing
- One action which relates to involvement of a maternity service user representative within the complaints process is being led at Group level and has been scheduled into the Corporate Patient Experience Team's 2023/24 workstreams/objectives.

3.4. Progress against the action plan is reported at divisional level and 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 ICB 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. Support for the maternal health of women and families from Black African, Asian and other ethnic minority groups

4.1. SM MCS cares for over 16,500 women each year across the three maternity units. Approximately 35% of women are from Black, Asian or minority ethnic backgrounds and almost 50% of births are to parents not born within the United Kingdom. Manchester has the second highest proportion of deprived neighbourhoods in England (Manchester City Council, 2023[4]).

4.2. Following publication of confidential perinatal (Draper, 2022[5]) and maternal (Knight, 2022[6]) enquiry reports, research publications and national surveys (such as that from the Five X More Campaign) it was important for the Saint Mary's MCS (SM MCS) to initiate and support actions to minimise the risk to

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[4] Manchester City Council, 2019. Indices of Deprivation (https://manchester.gov.uk)

[5] Draper ES, Gallimore ID, Smith LK, Matthews RJ, Fenton AC, Kurinczuk JJ, Smith PW, Manktelow BN, on behalf of the MBRRACE-UK Collaboration. MBRRACE-UK Perinatal Mortality Surveillance Report, UK Perinatal Deaths for Births from January to December 2020. Leicester: The Infant Mortality and Morbidity Studies, Department of Health Sciences, University of Leicester. 2022

[6] Knight M, Bunch K, Patel R, Shakespeare J, Kotnis R, Kenyon S, Kurinczuk JJ (Eds.) on behalf of MBRRACE-UK. Saving Lives, Improving Mothers' Care Core Report - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2018-20. Oxford: National Perinatal Epidemiology Unit, University of Oxford 2022.

women from more at-risk groups. Saint Mary's MCS has worked closely with the Local Maternity and Neonatal System (LMNS) and Maternity Voices Partnerships (MVPs) to prioritise and implement several workstreams.

Reaching out and reassuring women with tailored communications and advice.

4.3. SM MCS has worked closely with other maternity service providers in the Northwest to co-produce a suite of ten key messages, in several different languages to promote safe maternity care. These messages include information on reduced fetal movements, mental health, Vitamin D deficiency and pre-eclampsia.

4.4. SM MCS has worked with the Maternity Voices Partnerships (MVPs) and voluntary sector organisations to engage with and signpost women to these resources which are also available digitally from a QR code that each midwife carries on a fob (Northwest safety information). To ensure that digitally isolated women have equal access to these important key messages, a booklet is available in 11 translated languages, for women to take away when attending clinics and other midwifery appointments.

4.5. Since black women are more likely to be Vitamin D deficient, they are given tailored advice about this. Discussion of Vitamin D supplementation is included when women are first seen in pregnancy and timely prescribing of higher dose Vitamin D for those women at increased risk from deficiency has been embedded into our pathways. The SM MCS Public Health Matron has also worked very closely with midwifery staff and voluntary sector organisations in areas with high ethnic diversity to increase uptake of the Healthy Start Scheme, to reduce food insecurity and improve access to healthy nutrition.

4.6. During the Covid-19 pandemic SM MCS also ensured that women, particularly women such as black women, those who were known to be at greater risk of poorer outcomes, were given access to evidence-based information about the Covid-19 vaccine (in collaboration with voluntary sector organisations), and drop-in vaccine clinics were held on-site to increase vaccine uptake successfully. Drop-in vaccination clinics continue to be supported for Covid-19, Pertussis and Flu.

Raising the awareness of staff about the disparities in outcomes

4.7. Bespoke information about the increased risk of poorer outcomes for women from ethnic minority backgrounds has been developed for staff to ensure that all health care staff are aware of the differences for some groups. Clinicians have been encouraged to have a lower threshold to review and consider admission and multidisciplinary escalation in women from Black, Asian, and ethnic minority backgrounds who call or present to maternity triage.

4.8. We have also recently appointed two midwives to work across the MCS as Cultural Safety and ethnic minority engagement midwives. These midwives

will work closely with our MVPs, voluntary sector organisations and communities to ensure services listen to women and families from Black, Asian and ethnic minority groups.

Research and being responsive to data

4.9. Over the previous two years SM MCS clinical and academic staff have undertaken several pieces of work to ensure local data are captured and analysed to facilitate provision of care that is responsive to these findings. One of the consultant obstetricians has led on work analysing a large data set of birth outcomes and found differences in the rates of fetal growth restriction in certain geographical areas with high ethnic diversity. This work will ensure targeted clinical care is focused on trying to reduce these rates or to detect growth restricted fetuses and provide appropriate intervention.

4.10. A consultant midwife has led work on understanding the maternity experiences of women living in areas of high diversity and a multidisciplinary team undertook work investigating high level incidents in relation to ethnicity (Farrant et al, 2022[7]). Future work in all of these areas is planned as well as working with the Manchester Foundation Trust (MFT) health inequalities group.

4.11. MFT has recently introduced a Trust-wide electronic patient record system (Epic/ Hive) which will provide the opportunity to interrogate data at a more granular level. This work is evolving but will allow investigation of inequalities in processes rather than outcomes (for example are there differences in waiting times on triage for Black women). SM MCS also ensures that ethnicity is now recorded on any high-level incidents, complaints, and audit data so that any trends or disparities can be examined.

Working with the Local Maternity and Neonatal System (LMNS) and Maternity Voices Partnerships

4.12. There has been close working between the SM MCS and the Greater Manchester and Eastern Cheshire (GMEC) LMNS to support development of the Equity and Equality Action Plan which was published last year (GMEC E and E Action Plan) . This comprehensive and ambitious co-produced 5-year plan contains 36 interventions against 36 national or local priorities and there are 363 individual actions.

4.13. Several areas have been prioritised in anticipation that they will have a greater impact on improving equity and reduce inequality for women in Manchester. SM MCS will work closely with the LMNS to enact these high impact interventions which include preconception care, early access to antenatal

[7] Farrant K., Faluyi D., Watson K., Vause S., Birds H., Rowbotham S., Heazell AEP., 2022. Role of ethnicity in high-level obstetric incidents: a review of cases from a large UK NHS maternity unit. *BMJ OPEN Quality,* 11:e.

services, personalised care and support planning, addressing raised Body Mass Index and increasing the number of smokefree pregnancies.

4.14. A further intervention is ensuring that 12 Black and Asian maternity equity standards are fulfilled, and this will be a priority for SM MCS.

4.15. We have three vibrant and well-led MVPs that will support us with this vitally important and ongoing work. The absolute priority for SM MCS is to ensure we remain focused on providing safe, equitable and personalised care that is responsive, culturally sensitive and meets the needs of our diverse communities and continues to reduce inequalities.

5. Response to CQC 29A Warning Letter

5.1. A CQC inspection of Saint Mary's MCS Maternity Services took place between the 7th and 9th March 2023.

5.2. MFT were notified of a CQC Warning Notice issued under Section 29A of the Health and Social Care Act on the 24th of March 2023. The three main concerns were:

- The service did not operate effective and timely triage process to protect women, birthing people and newborns.
- The service did not facilitate timely access to appropriate treatment and birth settings for women, birthing people and newborns.
- The service did not always have enough sufficiently skilled and experienced midwifery and medical staff to appropriately assess and care for women and birthing people and mitigate risks in a timely manner.

5.3. MFT were given a 12-week warning notice period to demonstrate compliance and improvement. A compliance action plan was developed covering three areas: maternity triage; no delays (specifically in the induction pathway and caesarean section pathway) and, relation to 'safer staffing'.

5.4. Three working groups were set up, with an overarching Operational Delivery Group, reporting to a Midwifery Oversight Group chaired by the Group Chief Nurse and Deputy Chief Executive.

5.5. Submissions to the CQC in relation to the compliance plan have been submitted on:

- 27th April 2023
- 15th May 2023
- 26th May 2023 (Interim Report)
- 23rd June 2023 (Final Report)

5.6. The submission on the 23rd of June 2023, prepared by SM MCS comprised a comprehensive end-point report detailing progress and completion of the compliance action plan.

Progress on Success Measures

5.7. Triage

- Continuous and sustained improvement has been seen in:

  - Response to telephone calls to triage
  - Allocation to a category of urgency (denoted by a colour) using the Birmingham Symptom Specific Obstetric Triage System (BSOTS)

- Improvement has been seen in ‘time to initial midwifery triage’ and ‘time to medical review’, but work is ongoing to achieve further improvements. Actions which have been taken in response include :

  - Reviewed and increased midwifery staffing on all 3 maternity triage units
  - Increased senior medical presence within maternity triage on all sites
  - Escalation policy reinforced with midwifery and medical staff
  - Increased visibility of categorisation and waiting times on the Patient Status at a Glance (PSAG) board
  - Improved oversight of those awaiting review by senior midwives and consultant

- Invited external review visits to Maternity Triage by Local Maternity and Neonatal System have been completed across the 3 maternity sites. The team at the Oxford Road site invited an external ‘critical friend’ visit from colleagues at University Hospital Coventry.

- Improvements have been achieved in all categories of the action plan for triage including time to be seen within 15 minutes of arrival and time to be reviewed by a doctor. These metrics will continue to be monitored as part of our response to the national 3-year improvement plan for maternity services.

5.8. Patient pathways – Caesarean section and Induction of labour

- A rising Caesarean section rate has led to a review of the capacity required for elective Caesarean sections as some elective caesarean sections were needing to be performed by the labour ward team. The increased pressure on the labour ward capacity had resulted in delays to women being induced.

- Implementation of additional capacity for elective caesarean section activity since the 1st of May 2023 has supported improvement in the reduction of delays across the maternity elective pathways.

- The Trust has approved long term substantial investment and recruitment to increase the number of obstetric consultants, obstetric anaesthetic sessions, theatre team support, midwifery staffing and consumables.

- By increasing the Caesarean section capacity, more caesarean sections are done when scheduled (fewer postponements). Additionally, the pressure on labour ward capacity has been relieved resulting in significant reductions in delays for women who are being induced.

- All metrics for access to theatres are improving and will continue to be monitored as part of our response to the NHSE 3-year improvement plan.:

5.9 Staffing

5.9.1 *Midwifery staffing*

- Review of midwifery and support worker staffing levels – was in progress with the LMNS.
- Daily and weekly staffing oversight arrangements for midwifery staffing have been reviewed and improved processes established for reporting and escalation in line with agreed SOP

- Proactive recruitment
  - 137 midwives in the domestic pipeline:
  - 10 experienced band 6 midwives to join between June and September 2023
  - 127 newly qualified midwives to join between September 2023 and January 2024.
  - Proactive international recruitment
- A rolling advert to attract midwives has run over the last 12 months, for both general and specialty specific roles. A new recruitment campaign is being launched to attract both experienced and newly qualified midwives

- Retention midwives in post on each site

- There has been a reduction in leavers during May and June 2023.

5.9.2 *Medical staffing*

- Investment for consultants and junior doctors included within Caesarean Section business case
- Increased Tier 2 doctor shifts on triage
- Reassessment of Junior doctor establishment to ensure that both service needs and training needs are included
- Proactive and frequent recruitment to medical vacancies with positive advertising of learning and career opportunities to attract locally employed junior and senior doctors. Utilised the Manchester International Fellowship scheme and RCOG MTI scheme and supporting the partnership with RefuAid
- Development and implementation of Medical Staffing Escalation standard operating procedure

6. Recommendations

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

7. Appendices

Appendix 1 - Progress since June 22 to achieve compliance with Immediate and Essential Actions of the final Ockenden Report