Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

BNSSG CCG Governing Body Meeting

Date: Tuesday 4th May 2021
Time: 14:00pm
In light of Government advice regarding social distancing, the Governing Body will meet virtually until further notice. The meeting will be accessible to members of the public. Please see our website for more details.

Agenda Number :	7.1
Title:	**Current compliance against the 7 immediate and essential actions resulting from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust (The Ockenden Report)**
Purpose: Discussion	
Key Points for Discussion:	
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 new-born, infant and maternal harm at The Shrewsbury and Telford Hospital NHS Trust. The review is ongoing and will be published at the end of 2021, however a report outlining "Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust" was published on December 14th along with a letter from NHS England and Improvement requesting a submission by all providers of their assurance against the seven immediate and essential actions signed off by their Chief Executive Officer and the Chair of the Local Maternity System (LMS) NBT and UHBW undertook an initial self-assessment against the Immediate and Essential Actions and these were reviewed through the Local Maternity System (LMS). The aggregated returns were discussed at the NHS England and Improvement Public Board session at the end of January 2021 and this report provides an update of the agreed compliance against the 7 immediate and essential actions for both organisations.	
Recommendations:	To note the report and the progress against actions underway for the BNSSG system
Previously Considered By and feedback :	This report was considered at Quality Committee on 22 April 2021. It was agreed that going forward the Quality Committee will receive oversight of the Maternity dashboard as part of the Quality slides. Discussion regarding Continuity of Carer took place and the

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	committee asked for assurance related to this particular issue which will be sought from the LMS.
Management of Declared Interest:	None
Risk and Assurance:	NBT and UHBW undertook an initial self-assessment against the Immediate and Essential Actions. The assessments were reviewed through the Local Maternity System (LMS) and the aggregated returns were discussed at the NHS England and Improvement Public Board session at the end of January 2021. Going forward oversight and assurance for implementation of the actions will be undertaken through the BNSSG LMS reporting to the BNSSG Quality Surveillance Group, Trust Boards for the Providers and Quality Committee for the CCG
Financial / Resource Implications:	The delivery of Continuity of Carer may have resource implications in relation to the system having sufficient workforce to deliver
Legal, Policy and Regulatory Requirements:	Compliance with Serious Incident Framework with regard to the effective investigation of Maternity Serious Incidents and the embedding of learning
How does this reduce Health Inequalities:	The provision of safe and effective maternity services for all families will contribute to the improvement in outcomes including reducing the rate of stillbirths, neonatal and maternal deaths and brain injuries that are caused during or soon after birth as well as reducing smoking in pregnancy and increasing breast feeding rates.
How does this impact on Equality & diversity	As above
Patient and Public Involvement:	Recommendation 2 of the report is that “Maternity services must ensure that women and their families are listened to with their voices heard”. The LMS appointed a new chair for the Maternity Voices Partnership and this role is key to the success of meeting this recommendation and ensuring that the voices of all families are heard in a way that is representative of our community in BNSSG.
Communications and Engagement:	This report has previously and noted at the Quality Committee on 22 April 2021.
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Sponsoring Director / Clinical Lead / Lay Member:	Rosi Shepherd, Director of Nursing and Quality

Glossary of terms and abbreviations

BNSSG	Bristol, North Somerset & South Gloucestershire
NBT	North Bristol NHS Trust
UHB	University Hospitals Bristol NHS Foundation Trust
WAHT	Weston Area Health Trust
UHBW	University Hospitals Bristol and Weston NHS Foundation Trust

Agenda item: 7.1

Report title: Current compliance against the 7 immediate and essential actions resulting from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust (The Ockenden Report)

1. Background

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 new-born, infant and maternal harm at The Shrewsbury and Telford Hospital NHS Trust.

The review is ongoing and will be published during late 2021, but a report outlining "Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust" was published on December 14th 2020 along with a letter from NHS England and Improvement requesting submission from providers of their assurance against the seven immediate and essential actions signed off by their Chief Executive Officer and the Chair of the Local Maternity System (LMS).

Both NBT and UHBW undertook an initial self-assessment against the Immediate and Essential Actions and these were reviewed through the Local Maternity System (LMS). The aggregated returns were then discussed at the NHS England and Improvement Public Board session at the end of January 2021 and this report provides an update of the agreed compliance against the 7 immediate and essential actions for both organisations.

2. Immediate and essential actions to improve care and safety in maternity services.

These recommendations were made ahead of the full report being published towards the end of 2021 at the request of the Minister of State for Mental Health, Suicide Prevention and Patient Safety in order to take action to help improve safety in maternity services across England. Since the release of these actions, in March 2021, NHS England committed to investing £95 million to support improvements in the three identified themes from the report, workforce numbers, training and development programmes to support culture and leadership, and strengthening board assurance and surveillance, thereby improving maternity services.

Table 1 (one) on Page 4 demonstrates the current position of UHBW and NBT against the 7 immediate and essential actions laid out in the Ockenden report. The information contained within the table has been collated from the organisations' internal documents which have been through their internal governance processes. A BNSSG system Quality Surveillance Group undertook a thematic review into maternity services which focused on the current compliance against the requirements of the Ockenden report, plans for achieving compliance going forward and how the national Quality Surveillance Model will be built into planning guidance for 2021/22. The Regional Chief Midwife clarified how the model will impact at a system level and the requirements of the LMS and Trusts in achieving these requirements. The Quality Committee will receive a QSG update report from the QSG meeting in May 2021.

The RAG ratings within the table reflect the position of each action after review of the self-assessment by the regional team.

Table 1 – Current position against implementation of the 7 immediate and essential actions from the Ockenden report

Recommendation	Action	UHBW	Rag Rating	NBT current processes	Rag Rating
1. Enhanced Safety	a) Safety in Maternity units by strengthening partnerships between Trusts and within local networks. b) Serious incidents I. Share all maternity SI's with Trust Board at least monthly II. Share all maternity SI's with LMS monthly III. Report incidents as required to HSIB	• Joint discussions undertaken to self-assess against the 7 immediate and essential actions • Outcomes of self-assessment jointly presented to the LRM • Collaborating on future projects going forward • SI's shared with Trust Board and LMS receive oversight. 100% of qualifying cases shared with HSIB		• Joint discussions undertaken to self-assess against the 7 immediate and essential actions • Outcomes of self-assessment jointly presented to the LRM • Maternity Dashboard in place and shared at LMS from March 2021. • SI's shared with Trust Board and LMS receive oversight. 100% of qualifying cases shared with HSIB	
2. Listening to Women and their Families	a) Robust mechanism for gathering service user feedback b) Identification of a named Executive Director and named Non-Executive Director	• A monthly survey is undertaken and the information is used to improve services. • Named Executive Director and Non-Executive Director for maternity services in place		• Opportunities being identified going forward to listen to service users • Named Executive Director and Non-Executive Director for maternity services in place	Partial
3. Staff Training and working	a) Implement Consultant led labour rounds twice daily and 7 days a	• MDT Consultant ward rounds in place twice daily and 7 days a week.		• To achieve full compliance with Consultant led MDT ward rounds requires the	Partial

Recommendation	Action	UHBW	Rag Rating	NBT current processes	Rag Rating
together	week. b) Implement a MDT training schedule c) Ring fenced funding for maternity staff training and exclusive use of CNST MIS refunds used.	• MDT training schedule in place, which includes live drills • CNST funding exclusively used for maternity safety.		addition of an anaesthetist; staffing review required to achieve this. • Further work required to progress the MDT training. • Confirmed that training budget is ring fenced	
4. Managing Complex pregnancy	a) Women with a complex pregnancy to have a named Consultant. b) Mechanisms in place to audit the above requirement regularly c) Understand further steps required to develop maternal medicine specialist centres	a) Processes being reviewed to improve compliance in this area. b) Audits to be put in place to provide assurance. c) The Trust offers specialist tertiary MDT care throughout the SW of England	Partial	a). Compliant c) Added to Audit Programme d) Currently an EOI in place to become a maternal medicine specialist centre.	Partial
5) Risk Assessment throughout pregnancy	a) A risk assessment must be completed and recorded at every contact; to include ongoing review and discussion of intended place of birth (as part of the Personalised Care and Support Plan (PCSP). b) Regular audit mechanisms are in place to assess PCSP compliance.	a) Risk assessment undertaken at each antenatal review and during labour. b) Audit programme of above requirement currently being added to the annual documentation audit.	Partial	• Formal risk assessment at booking. Regular risk reviews throughout pregnancy. Further formal risk assessment at 36 weeks. • Audits undertaken to measure compliance and will be added to the Trust Audit programme • Further work required to improve documentation of planned place of birth	Partial
6) Monitoring Fetal Wellbeing?	a) Implement the saving babies lives bundle	• Compliant with all 5 elements of SBLV2.		• Currently not compliant with all 5 elements of	

Recommendation	Action	UHBW	Rag Rating	NBT current processes	Rag Rating
	b) Identify a 2nd lead to support leading on best practice, learning & Support.	• Dedicated Lead Midwife and Obstetrician in place. • Yearly fetal monitoring training for maternity staff in place and compliance against national guidance. • Three year online fetal monitoring MDT training programme in place; compliance of attendance monitored. • Programme of weekly MDT CTG and M&M meeting led by a consultant obstetrician.		SBLV2; robust action plan being developed with timeline for full compliance. This will be monitored via the Trust internal governance processes. • Dedicated Lead Midwife and Obstetrician in place	
7) Informed Consent	a) Clear visible pathways of care clearly described in written formats & posted on the Trust website.	• Patient information on maternity services available on Trust website. • Link to “My pregnancy” App available on the Trust website and women informed of this at booking appointment.	Partial	• Information is easily accessible to women on the Trust website and is available in different languages. • Further work required	Partial

3. Recommendations and Next Steps

Ongoing oversight in the BNSSG system with clear routes of accountability to the Integrated Care System will be through the Healthier Together LMS reporting to the BNSSG Quality Surveillance Group.

Next steps include:

- Providers and the LMS set out their plan to meet the Ockenden recommendations by 06th May 2021
- Review the Terms of Reference for the LMS to include responsibilities for oversight of implementation of the Ockenden recommendations – this will be undertaken at the end of April 2021
- Review and agree the LMS work programme and delivery framework by 03rd June 2021.

The Governing Body is asked to note the current position of UHBW and NBT actions proposed for ongoing governance and oversight and implementation of the recommendations 7 immediate and essential actions resulting from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust (The Ockenden Report).