NHS
South Tyneside and Sunderland
NHS Foundation Trust

Maternity Assurance update for Sunderland Overview and Scrutiny Committee

November 2022

Introduction

The last update received by the Overview and Scrutiny Committee on maternity services at South Tyneside and Sunderland NHS Foundation Trust (STSFT) was provided in November 2019 following the reconfiguration of Obstetric service across South Tyneside and Sunderland in August 2019. Since this report the Trust has experienced considerable external factors that were unforeseen at this time, namely the COVID-19 pandemic and three high profile national reviews into maternity services provided by two NHS Trusts (the Ockenden Review into Shrewsbury and Telford NHS Trust December 2020 & March 2022 and the report into East Kent maternity services October 2022).

This paper provides an update against the ten safety actions within the Central Negligence Scheme for Trusts Maternity Incentive Scheme (CNST MIS) via the Ockenden maternity assurance and assessment process, which have been included within the assurance framework. It is noted that Overview and Scrutiny Committee commented on the partial compliance declared for CNST MIS for Year 3 as reported in the Trust's Annual Quality Report 2021/22.

This paper provides an overview of the enhanced scrutiny on all maternity services across the country and also covers the progress of maternity provision for women and families in Sunderland against the national actions.

Maternity service provision – the last two years

1. COVID-19

The pandemic brought considerable challenges to ensuring provision of maternity care remained safe from increased risk through infection from COVID-19. By its very nature maternity couldn't be stood down and instead adaptation to the provision of care was essential. It is important to mention the exceptional care that our maternity team continued to provide to pregnant women and partners during this period of uncertainty and evolving infection control guidance. Women who received care in STSFT during 2021 took part in the annual Care Quality Commission survey of maternity care and STSFT scored higher than other Trusts for care in hospital (supportive, safe), during labour (comfortable, listened to) and postnatal support from healthcare practitioners.

2. National Maternity Reviews

1. Ockenden – Emerging Findings Report December 2020

The Ockenden Report published on 10 December 2020, presented the Emerging Findings and Recommendations from an Independent Review of a number of alleged avoidable neonatal and maternal deaths and harm at The Shrewsbury and Telford NHS Trust. The first of two reports, reviewing a selection of 250 cases, including the original 23 cases, covering the period from 2000 to 2019.

Key findings:

- 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
- Women's choices not respected
- Poor bereavement care
- Obstetric anaesthetic provision
- Neonatal care documentation and care in the right place

The report contained 27 recommendations for Shrewsbury and Telford NHS Trust and seven Immediate and Essential actions (IEAs) for all maternity services in the country covering:

1. Enhanced Safety;
2. Listening to women and families;
3. Staff working and training together;
4. Managing complex pregnancy;
5. Risk Assessment throughout pregnancy;
6. Monitoring fetal well-being; and
7. Informed consent

The second element of the report covered maternity workforce planning; effective workforce planning for obstetric and midwifery staff; adopting NICE guidance for safe midwifery staffing/principles of Royal College of Obstetricians and Gynaecologists workforce; and reporting through to Trust Board workforce gaps.

All maternity units across the country were tasked to provide evidence to demonstrate compliance with a newly developed Maternity Services Assessment and Assurance Tool to self-assess against the required actions. These were cross referenced to both recommendations made from the Morecambe Bay investigation in 2015 and the 10 Safety Actions contained within the Maternity Incentive Scheme (CNST). This resulted in a total of 49 standards to be addressed.

2. Ockenden – Final Report March 2022

Published on 31st March 2022, this report brought together a full review of the experiences of 1,486 families who received maternity care at the Shrewsbury and Telford Hospitals NHS Trust.

Over 60 local actions for learning are identified in the final Report for Shrewsbury and Telford Hospital NHS Trust. In addition 15 immediate and essential actions to improve care and safety in maternity services across England are proposed, relating to:

- Workforce planning and sustainability
- Safe staffing
- Escalation and accountability
- Clinical governance and leadership
- Incident investigation and complaints
- Learning from maternal deaths
- Multidisciplinary training
- Complex antenatal care
- Pre term birth
- Labour and birth
- Obstetric anaesthesia
- Postnatal care
- Bereavement care
- Neonatal care
- Supporting families

The Report also endorsed the Health and Social Care Committee Report (2021) in relation to the need

- for a further £200 – 350 million per annum is required to properly fund maternity services;
- to deliver adequate and sustainable medical training posts in obstetrics, obstetric anaesthesia and neonates;
- to ring fence maternity training budgets and back fill;
- to establish a single set of maternity training targets which should be enforced; by the NHSI/E Maternity Transformation Programme and CQC;
- to end the monitoring of caesarean section rates; and
- support the NHS Maternity Digital Programme.

3. East Kent – reading the signals – October 2022

In February 2020, the Department of Health and Social Care commissioned an independent review into maternity and neonatal services at East Kent Hospitals University NHS Foundation Trust, following concerns raised about the quality and outcomes of maternity and neonatal care. Dr Bill Kirkup CBE conducted the extensive review of 202 cases, publishing the report on 19 October 2022. The report titled ‘Reading the Signals’ was commissioned to ‘set out the truth’ of what happened to women and babies at the maternity units at East Kent between 2009 and 2020.

Since the report of the Morecambe Bay Investigation in 2015, maternity services have been subject to more significant policy initiatives than any other service. This report acknowledges that a change in approach is required based on the minimal impact from reviews undertaken since the Inquiry into Ely Hospital Cardiff 1967-69.

Unlike these reviews, the report's recommendations are not focussed on policy changes but are to address wider systemic issues.

The East Kent report identified four areas of action and subsequent recommendations:

1. Identifying poorly performing units "Monitoring safety performance – finding signals among the noise"

   The prompt establishment of a Task Force with appropriate membership to drive the introduction of valid maternity and neonatal outcome measures capable of differentiating signals among noise to display significant trends and outliers, for mandatory national use

2. Giving care with compassion and kindness "Standards of clinical behaviour – technical care is not enough"

   Those responsible for undergraduate, postgraduate and continuing clinical education be commissioned to report on how compassionate care can best be embedded into practice and sustained through lifelong learning.
   Relevant bodies, including Royal Colleges, professional regulators and employers, be commissioned to report on how the oversight and direction of clinicians can be improved, with nationally agreed standards of professional behaviour and appropriate sanctions for non-compliance

3. Team working with a common purpose "Flawed team work – pulling in different directions"

   Relevant bodies, including the Royal College of Obstetricians and Gynaecologists, the Royal College of Midwives and the Royal College of Paediatrics and Child Health, be charged with reporting on how team working in maternity and neonatal care can be improved, with particular reference to establishing common purpose, objectives and training from the outset.
   Relevant bodies, including Health Education England, Royal Colleges and employers, be commissioned to report on the employment and training of junior doctors to improve support, team working and development

4. Responding to challenge with honesty "Organisational behaviour – looking good while doing badly"

   The Government reconsider bringing forward a bill placing a duty on public bodies not to deny, deflect and conceal information from families and other bodies.
   Trusts be required to review their approach to reputation management and to ensuring there is proper representation of maternity care on their boards.
   NHSE reconsider its approach to poorly performing trusts, with particular reference to leadership

Reflecting on the recommendations put forward report it is important to note that this report:

- is more far-reaching in nature with the focus beyond the technical provision of care, bringing to the fore the wider harm to families who were involved in this review. That this harm is no less significant than clinical outcomes; and
- recognises that enablers for addressing sup optimal care are not solely the responsibility of Trusts, requiring action from the wider infrastructure. This report goes further than the Ockenden reports in seeking action from regulators but also professional bodies.
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Maternity services for the women and families of Sunderland

Following the publication of the initial Ockenden report (December 2020) national investment was announced to reduce variation in experience and outcomes for women and their families across England. NHS England/Improvement (NHSE/I) invested an additional £95.9m in 2021/22 to support the system to address all 7 Immediate and Essential Actions consistently, and to bring sustained improvements in maternity services. STSFT was awarded a sum of £380k (full year) against a bid of £932k.

This investment supported increasing the number of frontline midwifery staff by 4.71 whole time equivalents along with increased obstetric time for fetal well-being and multidisciplinary training.

In January 2022, the Trust's Executive Team approved recurrent investment of £680k into maternity services enabling appointments of specialist midwifery roles and increasing the number of maternity support workers. Requisite to enhancing safety and quality of maternity care.

Further national bid monies have been available this financial year and STSFT has been successful in securing investment towards recruitment and retention activities, enhancing access to bereavement care, dedicated psychological well-being support for our maternity team, increasing time for obstetric leadership, MDT training and enhancing patient experience through a dedicated lead Midwife.

Among the Ockenden essential actions for maternity services across England, the report stated that robust pathways must be in place for managing women with complex pregnancies, to include regional integration of maternal mental health services. In November 2019, STSFT was successful in an Integrated Care System-led bid to be a fast follower site for the Maternal Mental Health Service. This was launched on 28 March 2022. This service is focused on women with moderate to severe or complex perinatal psychological needs relating to, or arising from, their maternity experience. Previously these women were falling through the gaps in existing service provision. In South Tyneside and Sunderland this accounts for 3.85% of women giving birth (c.3700)

STSFT Maternity Assurance update

Since the publication of the initial Ockenden report all maternity services have been required to submit evidence of compliance against the Immediate and Essential Actions (triangulated against the CNST safety actions).

NHSEI and the Local Maternity Neonatal System (LMNS) also undertook assurance visits across the country, with a remit of a supportive critical challenge to indicate where further progress was required to achieve compliance for the 7 IEAs. One output from the initial Ockenden report was moving the role of LMNS from advisory to one of assurance.

STSFT received a visit on 11th May 2022 where the service still had further progress to make against 4 of the 7 IEA's. The Trust declared full compliance against all IEA's in September 2022. (See attached Appendix 1– IEA's position)

The final Ockenden report published in March introduced an additional 15 IEAs. The position of STSFT maternity services as at September 2022 is full compliance for 2 IEAs (supporting families and Pre-term Birth) and partial for 13 IEAs.

There are 82 sub actions in total sitting under the overarching 15 IEAs.

Noting compliance is achieved where the service can demonstrate evidence of embedded practice in line with the action requirement.

NHSE is set to issue a single delivery plan early in 2023 to cover the actions for maternity and neonatal from the Ockenden and East Kent reports.

In terms of the CNST Maternity Incentive scheme the Trust is now in year 4 with self-declaration sign off by the Trust's Board of Directors and submitted to NHS Resolution before 3 February 2023. The approach for Year 4 reflects learning from Year 3, utilising the investment received to support the action plans arising from Year 3 partial compliance. Good progress is being made against the Year 4 safety actions with regular updates via the Trust governance process.

Recommendations

The overview and scrutiny committee is asked to note the contents of the report, acknowledging the heightened national and subsequent regional assurance requests on maternity services across the country.

This level of scrutiny is expected to continue with a further review currently underway of maternity services at Nottingham University Hospitals NHS Foundation Trust.

Claire McManus

Divisional Director Family Care

South Tyneside and Sunderland NHS Foundation Trust

14.11.22

APPENDIX 1

7 Ockenden IEAs (including 12 Clinical Priorities): Trust _____ Exec Sign off _____	Compliant	Partially Compliant	Non-Compliant
1) Enhanced Safety			
A plan to implement the Perinatal Clinical Quality Surveillance Model			
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			
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			
Identification of an Executive Director with specific responsibility for maternity services and confirmation of a named non-executive director who will support the Board maternity safety champion			
3) Staff Training and working together			
Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week			
The report is clear that joint multi-disciplinary training is vital. We are seeking assurance that a MDT training schedule is in place.			
Confirmation that funding allocated for maternity staff training is ringfenced			
4) Managing complex pregnancy			
All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place			
Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres			
5) Risk Assessment throughout pregnancy			
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 (PSCP). Regular audit mechanisms are in place to assess PCSP compliance			
6) Monitoring Fetal Wellbeing			
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			
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.			