Cambridgeshire and Peterborough
Integrated Care System

System Partnership Board Report

Meeting	System Partnership Board Meeting in Public
Date of Meeting	Wednesday 28 July 2021
Agenda item:	05
Title:	**Quality and Safety Updates in Maternity and Neonatal**
Lead:	Carol Anderson, Chief Nurse, CPCCG
Author:	**Rachael Clarke – Quality Midwife, Cambridge and Peterborough CCG**

Report purpose *(Please mark one in bold)*

APPROVAL	DECISION	**ASSURE**	**INFORM**

Committees/groups where this has been presented to before

CPCCG Governing Body

Purpose of the paper

This paper sets out the key findings of the independent review of maternity services at Shrewsbury and Telford NHS Trust (SaTH) and the Immediate and Essential Actions (IEAs) that have been identified for implementation within all maternity units across England. Sets out the progress to date with implementing for Cambridgeshire & Peterborough Local Maternity and Neonatal System (LMNS) and Integrated Care System (ICS.)

Recommendation

The Cambridgeshire and Peterborough System Partnership Board is asked to note:

- the work and support this priority programme of activity'
- the revised Terms of Reference which were approved at the LMNS Board in May 2021 as part of the requirements of Ockenden actions'
- current risks in the Cambridgeshire & Peterborough system and mitigations in place to address them

The Cambridgeshire and Peterborough System Partnership Board is also asked to note that we will continue with developing the integration of the LMNS Board within the ICS governance and structure in line with the Ockenden requirements, alongside monitoring safety through dashboards at the LMNS board and Regional Perinatal Quality Safety Committee.

1 ISSUE

1.1 On the 10 December 2020 the Ockenden Report was published (Appendix 1). The report is an independent maternity review which focuses on all reported cases of maternal and neonatal harm between the years 2000 and 2019 at Shrewsbury and Telford NHS Trust (SaTH) Early recommendations identified 7 Immediate and Essential Actions (IEAs) for implementation as soon as practically possible within all maternity units across England. There is the requirement that evidence be uploaded to support the initial Trust compliance self-assessment against the 7 IEA's criteria. This will be assessed outside of the Local Maternity System (LMNS)

1.2 Each broader action links to a maternity safety action and then a specific urgent clinical priority. An overview if the IEAs can be seen in (Appendix 2).

1.3 Action 1 of the IEA's states that there is a plan to implement the Perinatal Clinical Quality Surveillance Model. This is a national programme of quality improvement and assurance (Appendix 3)

1.4 The NHS Operational Planning and Contracting Guidance 2021/22 highlights further deliverables for maternity and neonatal services this year (including the IEA's). Appendix 4 is the NHS Operational Planning and Contracting Guidance 2021/22 and has been rag rated for our LMNS showing the progress and risks within our system.

2 KEY POINTS

2.1 One of the fundamental findings from Ockenden was the level of Trust Board oversight and external maternity reviews. The Perinatal Clinical Surveillance Model when fully implemented should provide the appropriate framework for systems to be assured of their safety or alerted to any emergent risks. This is because a focus of the Perinatal Clinical Quality Surveillance Model is upon LMNS's taking a more formal role in perinatal quality oversight alongside existent transformation and improvement activity. It is essential therefore that the LMNS Board is part of ICS governance arrangements for 2021/22, and to ensure that future arrangements maintain direct line of sight from the statutory ICS Board to the LMNS Board, (although there may be a period of transition during 2021/22)

2.2 The Cambridgeshire and Peterborough (C&P) LMNS has been working since the release of the report to assess services against the IEA's, developed plans for action where improvement is needed and submitted the assessments and plans in line with the national reporting schedule.

2.3 Completion of confirmation of compliance with immediate actions was signed off by each Trusts Chief Executive Officer, the local LMNS Chair and Regional Chief Midwife (21 December 2020)

2.4 Trusts completed the assurance self-assessment tool and shared this with the LMNS and the Trusts Boards and submitted to the region by 15th January 2021**.** The tool includes:

- All 7 IEAs of the Ockenden report (completed)
- NICE guidance relating to maternity (ongoing)

- Clinical Negligence Scheme for Trusts (CNST) compliance (compliance has subsequently been demonstrated by both Trusts prior to evidence submission 30th July 2021)
- A workforce gap analysis (also complete)

2.5 Trust Boards confirmed that they have a plan in place for Birth-rate Plus (BR+) standard by 31 January 2021 confirming timescales for implementation.

2.6 Trusts' individual responses formed part of the presentation and discussion at the NHSEI Public Board in January 2021

2.7 Trusts have reviewed the report at their Public Board and have reflected on whether the assurance mechanisms within their Trusts are effective and in collaboration with the LMNS are assured that wherever possible poor care and avoidable deaths, with no visibility or learning, is mitigated in their organisations.

2.8 Critical to sustaining quality and safety within maternity services is the implementation of a revised Perinatal Quality Surveillance Model. This is based on 5 principles:

1 Strengthening trust-level oversight for quality.
2 Strengthening LMNS and ICS role in quality oversight.
3 Regional oversight for perinatal clinical quality.
4 National governance aligned to reflect the revised perinatal clinical quality model.
5 Agreed principles to support local, regional, and national decision making.

2.9 The C&P LMNS has been working through the 5 principles including strengthened oversight of data and outcomes with a greater focus on safety as a core element of the transformation programme. The revised terms of reference for The LMNS Board reflect these new requirements (Appendix 6)

2.10 The NHS Operational Planning Guidance also states the implementation of Ockenden's requirements as a 21-22 deliverable, alongside Pandemic Recovery, Transformation Priorities and Transformation Priorities: Continuity of Carer (Appendix 5). This represents a substantial amount of work within our system some of which is already there just requires restabilising. Whereas some areas of work require more focus due to current resourcing. However, this has been partially addressed via the workforce bid and represents a significant financial support for maternity services.

3 RECOMMENDATIONS

3.1 Cambridgeshire and Peterborough System Partnership Board is asked to:

- Note the work and support this priority programme of activity.
- Note the revised ToR which were approved at the LMNS Board in May '21 required for local evidence of the Perinatal Quality Surveillance Model- "evidence clear lines of reporting and escalation" (Principle 2)
- Note current risks in the C&P system and mitigations in place to address them.

4 REASON FOR RECOMMENDATION

4.1 To ensure that local maternity and neonatal services meet the national requirement of addressing quality and safety in maternity and neonatal units.

4.2 To ensure that as a system we can provide and evidence assurance of the above.

5 BACKGROUND

5.1 The publication of a national report detailing catastrophic maternity and neonatal services failings at Shrewsbury and Telford hospitals NHS Foundation Trust December 2020, (known as the Ockenden Report after its author) (Appendix 1) was in response to a high-profile Maternity scandal at Shrewsbury and Telford Hospital where sub-standard care led to numerous avoidable baby deaths, far exceeding national averages. This independent maternity review focused on all reported cases of maternal and neonatal harm between the years 2000 and 2019. These include cases of stillbirth, neonatal death, maternal death, hypoxic ischaemic encephalopathy (HIE grades 2 and 3) and other severe complications in mothers and new-born babies. The number of families involved in the enquiry has grown over time.

5.2 The report submitted on the 10 December 2020 is not the final report but was published so that immediate actions could be considered. The final report is due for publication some time in 2021. Emerging findings and themes have formed Local Actions for Learning and early recommendations have been identified as Immediate and Essential Actions (IEA's). The 12 IEAs grouped under 7 key headings are to be implemented 'as soon as is practically possible' within all maternity units across England. (Appendix 2)

5.3 Included within this report is Appendix 8 which details the LMNS position around 4 of the 7 IEA's.

5.4 Full QA briefing attached at Appendix 8

6 CONCLUSION

6.1 We have highlighted that maternity and neonatal services have significant challenges to deliver all components of the 21-22 Operational and Planning Guidance and ensure that services are safe. However, a significant amount of work has already been undertaken to establish effective governance processes and oversight within the LMNS and up to the ICS Board.

6.2 There is assurance that the Trusts have implemented the 7 IEA's and we are working as an LMNS on our deliverables. What we don't know yet is if the measures will result in a reduction in harm and improvement of services as this will need to be tracked and monitored through the Trusts and the regions quality and safety dashboard, safety meetings and mandated submissions.

Appendices

Appendix 1-The Ockenden Report 2020

Appendix 2-Ockenden 7 High Immediate and Essential Actions (IEAs)

Appendix 3-Implementing a Revised Perinatal Quality Surveillance Model

Appendix 4-NHS Operational Planning and Contracting Guidance 2021/22

Appendix 5-Continuity of Carer Matrix

Appendix 6- LMNS Board Draft ToR

Appendix 7-April 2021 LMNS Highlight Report

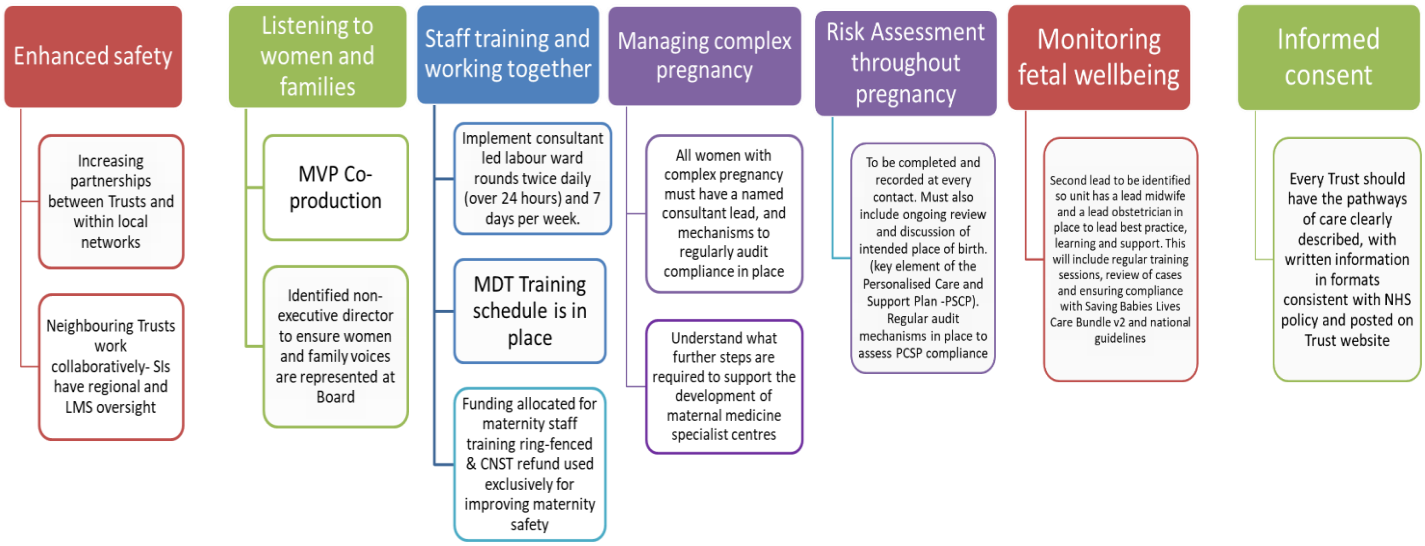
Appendix 8- QA Ockenden Report

Appendix 1

Ockenden Report 2020

https://www.gov.uk/government/publications/ockenden-review-of-maternity-services-at-shrewsbury-and-telford-hospital-nhs-trust

Appendix 2 Ockenden 7 High Immediate and Essential Actions (IEAs)



Appendix 3

Implementing a Revised Perinatal Quality Surveillance Model December 2020

https://www.england.nhs.uk/wp-content/uploads/2020/12/implementing-a-revised-perinatal-quality-surveillance-model.pdf

Appendix 4

NHS Operational Planning and Contracting Guidance 2021/22 – RAG rated for Cambridgeshire & Peterborough LMNS

LMNS Deliverables

2021/22 Priorities	Delivery Date
Pandemic Recovery	
Reopen any services that have been suspended as a result of COVID-19	Ongoing
Take active steps to help maternity staff recover from the pressures of the pandemic	Ongoing
Remove restrictions on women's access to support, on the basis of a risk assessment and in line with Supporting pregnant women using maternity services during the coronavirus pandemic: Actions for NHS providers	Ongoing
Whilst COVID-19 remains a risk to pregnant women and their babies, the NHS in England must continue to implement the four actions to minimise the additional risk of COVID-19 for Black, Asian and minority ethnic women and their babies	30-Apr-21
Ockenden	
Those LMNSs that have not already done so should now also take on full and ongoing oversight of quality, ensuring that an understanding of the quality of maternity and neonatal services informs transformation. All LMNSs should review their terms of reference and work programme by 3 June 2021 and to ensure that the LMNS purpose specifically includes all of the following: •To oversee quality in line with Implementing a revised perinatal quality surveillance model •To share information and learning in a structured and systematic way, working with partners to turn learning into service improvement •To oversee local trust actions to implement the seven immediate and essential actions from the Ockenden report •To ensure action is taken to improve the culture of maternity and neonatal services as a building block for safe, personal and more equitable care •To co-design and implement a vision for local maternity and neonatal services with local women through Maternity Voices Partnerships	03-Jun-21

•To implement shared solutions wherever possible through shared clinical and operational governance	
We are therefore asking existing ICSs to take on formal, structured and systematic oversight of how their LMNS delivers its functions	
•ICSs should set out a plan by 3 June 2021 outlining how this will be delivered	03-Jun-21
•Implementation should be no later than 1 April 2022	01-Apr-22
LMNSs, in consultation with regional teams, to identify a buddy LMNS and implement processes for peer review and support	03-Jun-21
ICSs to ensure the LMNS Board is part of governance arrangements for 2021/22, and ensure that future arrangements maintain direct line of sight from the statutory ICS Board to the LMNS Board, (although there may be a period of transition during 2021/22)	Ongoing

Transformation Priorities	
Ensure every woman is offered a **Personalised Care and Support Plan**, underpinned by a risk assessment and in line with national guidance	31-Mar-22
Implement the five elements of the **Saving Babies' Lives** care bundle, and in particular ensure that:	
•Every provider has a pre-term birth clinic	Ongoing
•At least 85% of women who are expected to give birth at less than 27 weeks' gestation are able to do so in a hospital with appropriate on site neonatal care	
Make new **NHS smoke free pregnancy pathways** available for up to 40% of maternal smokers	31-Mar-22
Embed **maternal medicine networks** so that women with acute and chronic medical problems have timely access to specialist advice and care at all stages of pregnancy from the start of the 2021/22 planning year	30-Sep-21
Embed the offer to all women with type 1 diabetes of **continuous glucose monitoring** fully during 2021/22	31-Mar-22
Following the publication of a national **Perinatal Equity Strategy,** LMNSs will be asked to submit:	
•An equity analysis (covering health outcomes, community assets and staff experience) and a coproduction plan	30-Sep-21
•LMNSs will then co-produce Equity Action Plans	31-Dec-21
Work with neonatal Operational Delivery Networks to implement local **neonatal improvement plans**	Ongoing
Implement the Core Competency Framework and ensure all maternity staff receive **multi-disciplinary training** – in line with the Ockenden report this must be validated by the LMNS three times over the course of the year	Ongoing
Ensure that all trusts, working with ICS digital leads:	
•Have an **information system** which records maternity information and which is compliant with relevant Information Standards Notices by March 2022	TBC

•Delivers this work through use of the **commercial digital framework** once available	

Transformation priorities: Continuity of Carer	
Put in place the building blocks by March 2022 so that continuity of carer is the default model of care offered to all women by March 2023	31-Mar-22
Undertake a Birth-rate Plus assessment to understand the current midwifery workforce required and follow this through with recruitment	31-Jul-21
Co-design a plan by July 2021 with local midwives, obstetricians and service users for implementation of continuity of carer teams in compliance with national principles and standards, and phased alongside the fulfilment of required staffing levels. This plan should also take into account the need for maternity staff to be supported to recover from the challenges of the pandemic	31-Jul-21
Prioritise those most likely to experience poorer outcomes first, including ensuring most women from Black, Asian and mixed ethnicity backgrounds and also from the most deprived areas are placed by on a continuity of carer pathway by March 2022	31-Mar-22
Develop the ability to measure progress electronically and report it to the Maternity Services Dataset	31-Mar-22
Develop an enhanced model of continuity of carer which provides for extra midwifery time for women from the most deprived areas for implementation from April 2022	31-Mar-22

Appendix 5

Continutiy of Carer Matrix

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Appendix 6

LMNS Draft Board ToR

Draft CP Board Terms of Reference v5.docx

East of England Regional Perinatal Quality Oversight Group
Highlight Report

LMNS: Cambridgeshire and Peterborough | **Reporting period : April 2021**

Overall System RAG (Please refer to key next slide)

CQC DOMAINS

Maternity unit	CUH (date of last inspection)						Peterborough City Hospital (October 2019)					Hinchingbrooke (2018)				
C-caring R-responsive E-effective W-well-led S-safe	C	R	E	W	S	Action Plan Status: To commence Progressing Completed	C	R	E	W	S	C	R	E	W	S

KPI (see slide 4)	Measurement / Target		Trust Rate (current reporting period)								Combined Trust	
Please see exemplar v5 for full detail			CUHFT		PCH		HH		NWAFT	
Caesarean Section rate	Elective	13%	13.3%		13.58%		15.1%		14.34%	
	Emergency	17%	20.25%		14.16%		13.3%		13.73%	
Preterm birth rate	≤26+6 weeks	≤6% annual rolling rate	0.21%		0	0%	0	0%	0	0
	≤36+6 weeks		6.75%		6.6%		5.8%		6.2%	
Massive Obstetric Haemorrhage	≥1.5l	<2.9%	4.79%		2.88%		4.3%		3.32%	
Term admissions to NNU (all levels)		<6%	6.31%		2.39%		7.3%		4.85%	
3rd & 4th degree tear	SVD (unassisted)	<3.5 overall rate (Unassisted 2.8%) (Assisted 6.8%)	1.55%		2.8 8%		0%		1.44 %	
	Instrumental (assisted)		0.66%	2.2 1%	1.4 4%	4.3 2%	0%	1.1%	0.72 %	2.16 %
Right place of birth		95%			100%		99%		99.5%	
Smoking at time of delivery		≤6%	5.09%		11.05%		4.1%		7.58%	
Percentage of women placed on CoC pathway		≥35% (March 21)			0%		0%		0%	
Percentage of women on CoC pathway : BAME / areas of deprivation)	BAME	≥75%								
	Area of deprivation									0%

KEY : CQC DOMAINS
Outstanding
Good
Requires Improvement
Inadequate

MW to birth ratio			Vacancy rate (MW)	LW co-ordinator supernumerary (%)
	BR+ recommendation	Actual		
CUH	1.24	1:24:6	8.8%	100
PCH	1:23	1:33.9	18.94	74.4%
HH	1:23	1:23.8	0	94%

Incident Reporting											LMNS confirmation of SI oversight (evidenced through governance & safety meetings) Yes ☐ No ☐			
	Datix		Maternity Serious Incidents	Maternity Never Events	HSIB cases	Still Births			HIE cases (grade 2 or 3)	Neonatal deaths		Maternal Mortality	
	Unactioned	Open > 30 days				All	Term	Intrapartum		Early	Late	Direct	Indirect
CUH						2	0	2		0	0	0	0
PCH	0	33	0		0			0	0	0	0		
HH	0	20	0	0	0			0	0	0	0		

Areas of focus

- Massive Obstetric Haemorrhage – HH NB small numbers so % are distorted
- Term admissions HH - NB small numbers so % are distorted
- Smoking at time of delivery – PCH (higher level of deprivation and minority ethnicity)
- Continuity of Carer – NWAFT (staffing and previous leadership issues)

CNST, SBLCBv2 and Ockenden assessment April 2021 for LMNS providers

Assessed compliance with10 Steps -to-Safety				
	Please identify unit	CUHFT	PCH	HH
1	Perinatal review tool			
2	MSDS			
3	ATAIN			
4	Medical Workforce			
5	Midwifery Workforce			
6	SBLCB V2			
7	Patient Feedback			
8	Multi-professional training			
9	Safety Champions			
10	Early notification scheme (HSIB)			

Key	
Complete	The Trust has completed the activity with the specified timeframe – No support is required
On Track	The Trust is currently on track to deliver within specified timeframe – No support is required
At Risk	The Trust is currently at risk of not being deliver within specified timeframe – Some support is required
Will not be met	The Trust will currently not deliver within specified timeframe – Support is required

Evidence of SBLCB V2 Compliance				
	Please identify unit	CUHFT	PCH	HH
1	Reducing smoking			
2	Fetal Growth Restriction			
3	Reduced Fetal Movements			
4	Fetal monitoring during labour			
5	Reducing preterm birth			

Assessment against Ockenden Immediate and Essential Action (IEA)			
Please identify unit	CUHFT	PCH	HH
Audit of **consultant led labour ward rounds** twice daily			
Audit of **Named Consultant** lead for complex pregnancies			
Audit of **risk assessment** at each antenatal visit			
Lead **CTG Midwife and Obstetrician** in post			
Non Exec and Exec Director identified for Perinatal Safety			
Multidisciplinary training – PrOMPT, CTG, Obstetric Emergencies (90% of Staff)			
Plan in place to meet **birth rate plus** standard (please include target date for compliance)			
Flowing accurate data to **MSDS**			
Maternity SIs shared with trust Board			

a) Both trusts reporting they are compliant for Clinical Negligence Scheme for Trusts – 10 steps to safety
b) Saving Babies Lives Care Bundle v2 reducing smoking at CUHFT is an issue although previous slide indicates NWAFT should also be amber
c) Ockenden – Audit of consultant rounds on amber for CUHFT now reporting verbally Green in May. Multidisciplinary training provision at NWAFT due to staffing issues and changes in leadership needing to prioritise other areas initially with work in progress to address

Appendix 8

QA Ockenden for Board- Final .docx