The Shrewsbury and Telford Hospital NHS Trust

# Board of Directors' Meeting: 12 October 2023

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|---|---|---|---|---|---|
| **Agenda item** | | 129/23 | | | |
| **Report Title** | | Integrated Maternity Report | | | |
| **Executive Lead** | | Hayley Flavell, Executive Director of Nursing | | | |
| **Report Authors** | | Annemarie Lawrence, Director of Midwifery<br>Carol McInnes, Divisional Director of Operations – W&C<br>Mike Wright, Programme Director – Maternity Assurance | | | |
| | | | | | |
| **CQC Domain:** | | **Link to Strategic Goal:** | | **Link to BAF / risk:** | |
| Safe | √ | Our patients and community | √ | BAF1, BAF4, BAF 3 | |
| Effective | √ | Our people | √ | | |
| Caring | √ | Our service delivery | √ | **Trust Risk Register id:** | |
| Responsive | √ | Our governance | √ | CRR 16, 18, 19, 23, 27, 7, 31 | |
| Well Led | √ | Our partners | √ | | |
| **Consultation Communication** | | Directly to the Board of Directors | | | |
| | | | | | |
| **Executive summary:** | | This is the first version of the new Integrated Maternity Report to the Board of Directors, to meet the requirements of the Independent Maternity Review, and also CNST reporting requirements. | | | |
| **Recommendations for the Board:** | | The Board of Directors is requested to:<br>• Provide any feedback on this new report format, which has been compiled to meet the requirements of the Independent Maternity Review.<br>• Confirm that they have received the information in section 5, and the accompanying CNST information pack, and record this in the minutes.<br>• Approve the need for an extraordinary Board meeting to sign off the final CNST submission, as set out in section 5.10.<br>• Receive this report for information and assurance<br>• Decide if any further information, action and/or assurance is required | | | |
| **Appendices:** | | Appendix One: Board Reporting Schedule (see below)<br>Appendix Two: Ockenden Progress Report Action Plan, as at 12 September 2023 (contained within Board Supplementary information pack)<br>Appendix Three: RCOG Closure Report<br>Appendix Four: CNST Information Pack (separate pack)<br>Appendix Five: The Black Maternal Health gap analysis | | | |

## 1.0 Purpose of this report

1.1 This report provides information on the following:

1.2 The current progress with the delivery of actions arising from the Independent Maternity Review (IMR), chaired by Donna Ockenden

1.3 A summary of progress with the Maternity Transformation Programme (MTP)

1.4 The Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) Year 5 - latest information that must be approved by the Board of Directors

1.5 A gap-analysis against the recently published 'Black Maternal Health' report for assurance

## 2.0 Context

2.1 The provision of maternity services is complex in any organisation. By definition, maternity services can be a high-risk clinical speciality, which has its own separate CNST insurance premium in place. To meet the exacting requirements of the scheme and receive a reduction in financial premiums for the scheme, Trust Boards are required to receive and approve 'set pieces' of information at pre-determined times to confirm certain safety standards are being met. These are non-negotiable if a Trust is to meet all required standards and obtain the reduction in the insurance premium.

2.2 There are further national initiatives in maternity to help improve the safety of, and health outcomes for, women and babies. These include:

- Better Births: Improving outcomes of maternity services in England – A Five Year Forward View for maternity care (2016)
- Saving Babies Lives – A care bundle for reducing stillbirths (2016)
- The NHS Patient Safety Strategy (2019)
- The Maternity Transformation Programme (2019)
- The Three-Year Delivery Plan for Maternity and Neonatal care (2023)
- Black Maternal Health report (2023)

2.3 Most providers of NHS maternity care have in place Maternity Improvement Plans (MIP) and/or Maternity Transformation Plans (MTP's) or similar, to coordinate and manage most or all their safety and improvement initiatives. This Trust has both in place.

2.4 In addition to what happens in all providers of NHS maternity care in England, and since January 2021, this Board of Directors has received a report at each of its meetings in public detailing the progress being made against all actions from the Independent Maternity Review into maternity care at the Trust, chaired by Donna Ockenden.

2.5 In her final report, which was published in March 2022, Donna Ockenden set out two specific actions; one for this Trust and one for all providers of maternity services in England to address, which relate to reporting to the Board of Directors. These are:

2.5.1 Local Action for Learning 14.24 (specifically for this Trust) - "*The Trust Board must review the progress of the maternity improvement and transformation plan every month."*

2.5.2 Immediate and Essential Action 4.1 (for all NHS providers of maternity services) – "*Trust Boards must work together with maternity departments to develop regular progress and exception reports, assurance reviews and regularly review the progress of any maternity improvement and transformation plans."*

2.6 This is a new report format that will provide an integrated report to cover all these matters.

2.7 Not every topic needs to be covered every month; however, a timetable/work plan is attached at **Appendix One**, at the end of this report, to advise the Board what it can expect to receive at each Board meeting in public, going forward.

2.8 To support this paper, more detailed information is provided in a separate information pack. Further information is available on request.

2.9 This first report, in its new format, will present the following:

2.9.1 The Ockenden Report Progress Report

2.9.2 Maternity Transformation Programme (MTP) – High Level Progress Report

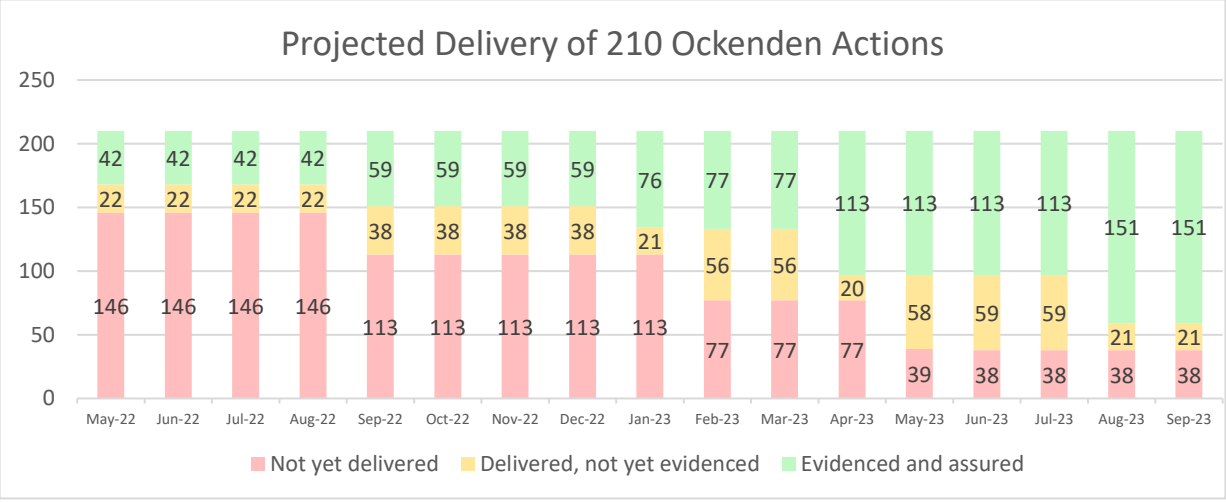
2.9.3 CNST MIS Year 5 Progress Report

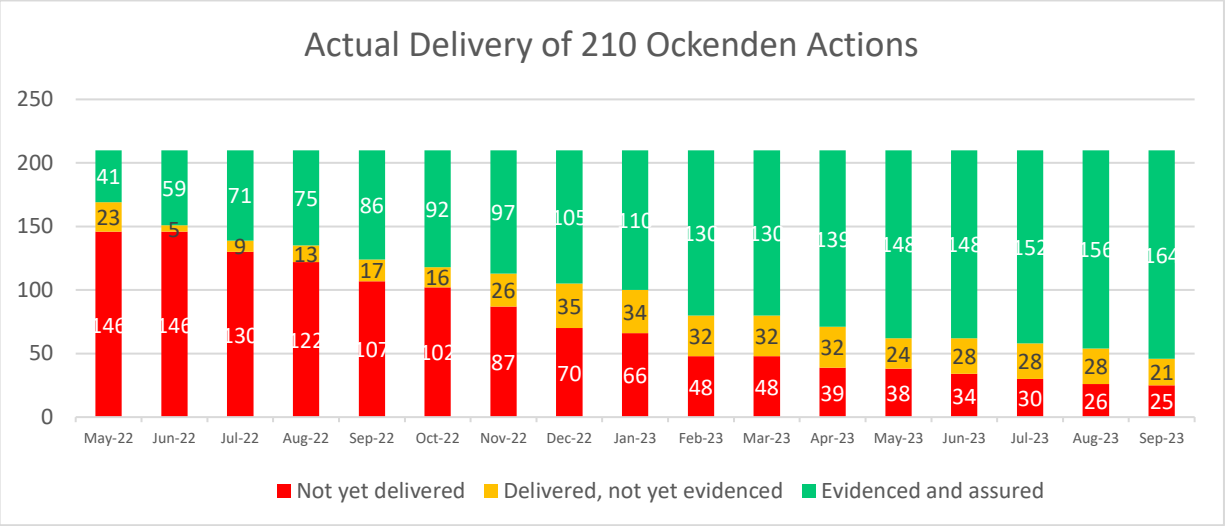
2.9.4 A Gap Analysis against the 'Black Maternal Health' Report

## 3.0 The Ockenden Report Progress Report

3.1 This section provides the position against all actions from the two Ockenden reports as validated by the Maternity Transformation Assurance Committee (MTAC) at its meeting on 12 September 2023. The 210 actions from the Independent Maternity Review are incorporated into relevant workstreams within the MTP. However, as this Trust was the subject of the IMR, this section presents this information separately.

3.2 The following graphs show the projected versus actual trajectories for the delivery of the 210 actions from both reports. As can be seen, the Trust is ahead of schedule with its delivery plan.






## 3.3 Off track actions

3.3.1 As at 12 September 2023, only one action remains both 'Not Yet Delivered' and 'Off-track' (Red/Red). This is Local Action For Learning (LAFL) 1.4 from the first report (2020): *"An LMS cannot function as one maternity service only."* The action is being led by the NHS Shropshire, Telford, and Wrekin Integrated Care Board (ICB) and, whilst a memorandum of understanding has been agreed and signed with other Local Maternity and Neonatal Systems (LNMS), there is still no clarity on the expected delivery date for this to become operational and/or the expected benefits realisation from this arrangement. This continues to be pursued at each MTAC meeting.

3.3.2 From the first report (2020), there are two Immediate and Essential Actions (IEA's 2.1 and 2.2), which centre on the creation and implementation of independent senior advocate roles that are accessible to women and families and that report directly to Trust and ICB boards. NHS Shropshire, Telford, and Wrekin ICB lead on these two actions. This system was successful in becoming an early implementer pilot site and funding was obtained for six months in the first instance. The role was created and recruited to successfully; however, MTAC was advised at its last meeting that ICB's have been advised by NHS England to pause any further implementation of the roles until further notice. As such, this is suspended and the reasons for this are yet unclear. IEA 2.2 will now go 'off track' and an exception report will be presented to MTAC for this in October 2023.

## 3.4 De-scoped Actions

3.4.1 Ten actions remain 'de-scoped'. These relate to nationally led external actions (led by NHS England, CQC, etc), and are not within the direct control of the Trust to deliver. These actions remain under review by the Trust at MTAC quarterly, to check on any progress. As such, all these actions are not yet delivered.

## 3.5 Ockenden Report Assurance Committee (ORAC)

3.5.1 ORAC met on 25 July 2023 and 26 September 2023. This Chair's report from the July meeting is scheduled on today's agenda.

3.5.2 The following table sets the draft/proposed agenda items for future ORAC meetings:

| Date | Agenda Structure | Thematic Topic |
|---|---|---|
| 26/09/23 | 1. High-level Ockenden plan update (first report)<br><br>2. High-level Ockenden plan update (final report)<br><br>3. Sustainability & Remaining Actions<br><br>4. Thematic engagement piece/measurable benefits | • Community Midwifery Services (+/- Specialist Midwives)<br>• Role of Mat/Neo Safety Champions |
| 28/11/23 | | • Learning from investigations, and how we investigate complaints, service user feedback and implement learning |
| Feb 24 (tbc) | | • How do we know our maternity services are safe (outcome measures)<br>• Latest CQC Survey/Inspection (if available) |
| April 24 (tbc) | | • Round up of the overall learning from Ockenden<br>• Celebration of successes<br>• Rolling programme of audit - sustainability<br>• Work still to do – transfer to BAU<br>• Latest CQC Survey/Inspection |

3.5.3 As can be seen from the table, the April 2024 ORAC will be its last meeting. Scrutiny and evidence of action delivery will transition into business as usual arrangements via MTAC, the Quality & Safety Assurance Committee and the Board of Directors' meetings.

## 4.0 Maternity Transformation Programme (MTP) – High Level Progress Report

4.1 The Trust's Maternity Transformation Programme comprises seven workstreams, each of which is led by a senior clinician or director. The workstreams comprise:

4.1.1 Clinical Quality and Choice – led by Mr Guy Calcott, Consultant Obstetrician and Dr Mei-See Hon, Consultant Obstetrician and Clinical Director for Obstetrics
4.1.2 People and Culture – led by Mrs Rhia Boyode, Director of People and OD
4.1.3 Governance and Risk – led by Ms Kimberly Williams, Head of Midwifery
4.1.4 Partnership, learning and research – led by Mr Will Parry-Smith, Consultant Obstetrician & Gynaecologist
4.1.5 Communications and engagement – led by Ms Dudu Nyathi, Consultant Midwife
4.1.6 Maternity Improvement Programme – led by Mrs Annemarie Lawrence, Director of Midwifery
4.1.7 Obstetric Anaesthesia – led by Dr Gauri Dashputre, Consultant Anaesthetist

4.2 The following table provides a high-level summary of each workstream, its progress and any risks to delivery. Further details are available on request.

| MATERNITY TRANSFORMATION PROGRAMME WORKSTREAMS | | | | |
|---|---|---|---|---|
| **Workstream** | **Scope of Work** | **Status** | **Commentary** | **Associated Risks** |
| **1. Clinical Quality and Choice** | Ockenden Actions | On Track | Ongoing delivery of Ockenden | Ockenden actions linked to external partners (e.g., IEA 1.4) |
| **2. People and Culture** | Ockenden Actions | On Track | Ongoing delivery of Ockenden | None identified |
| **3. Governance and Risk** | Ockenden Actions | On Track | Ongoing delivery of Ockenden | None identified |
| **4. Learning, Partnership and Research** | • Ockenden Actions<br>• Data Extraction for Epidemiological Research (DExtER) Project* | On Track | • Ongoing delivery of Ockenden<br>• Ongoing delivery of DEXTER | Capacity of the clinical teams to fulfil new Training Needs Analysis (TNA) to meet new CNST SA 8 |
| **5. Communication and Engagement** | • Ockenden Actions<br>• Comms and Engagement plan (including new website development and social media | On Track | • Ongoing delivery of Ockenden<br>• Ongoing delivery of new website<br>• Maintenance of Comms plan | Capacity of communication team to deliver work |
| **6. Maternity Improvement Plan (MIP)** | Implementation of the 30 identified 'historical reviews' of maternity services | On Track | • 8 action plans 'evidenced and assured', - now closed<br>• 19 'delivered not yet evidenced', - closure reports being drafted<br>• 2 'not yet delivered'<br>• 1 de-scoped (external) | None identified |
| **7. Anaesthetics** | Ockenden Actions | On Track | Ongoing delivery of Ockenden | None identified |

4.3 The report of the 'Review of Maternity Services at Shrewsbury and Telford Hospital NHS Trust – The Royal College of Midwives (RCM) and The Royal College of Obstetricians and Gynaecologists (RCOG) 2017/18' forms part of Workstream 6. However, to update the Board of Directors specifically, progress with the delivery of the required actions is, as follows:

- The review from 2017/18 contained 37 recommendations. Each of these has been implemented, except for two, which were descoped, as they were no longer relevant with the current infrastructures in place.
- The RCOG review was fully evaluated as part of workstream 6: Maternity

Improvement Plan.

- A closure report was ratified at the Women and Children's Divisional Committee in March 2023, at the Maternity Transformation Assurance Committee (MTAC) on 12 September 2023, and the Quality and Safety Assurance Committee (QSAC) on 27 September 2023. This closure report is attached at **Appendix Three.**

4.4 There is a potential risk to the ongoing delivery of the Maternity Transformation Programme and, as the Board is aware, the Mersey Internal Audit Assurance (MIAA) review of the governance and assurance of Ockenden action delivery in November 2022, highlighted the need for the Trust to continue the funding of the maternity transformation support resource. This requirement continues to be reviewed as part of the annual business planning round.

## 5.0 CNST Maternity Incentive Scheme (MIS) Year 5 – Progress Report

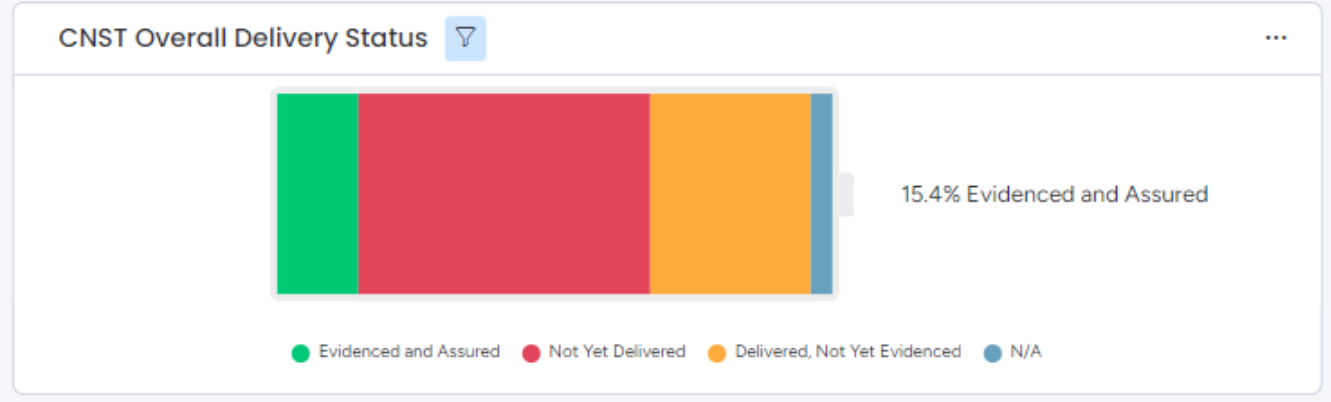
5.1 SaTH is a member of the CNST MIS, which is regulated by NHS Resolution (NHSR) and is designed to support the delivery of safer maternity care.

5.2 The scheme incentivises ten maternity safety actions. Trusts that can demonstrate they have achieved all ten safety actions in full will recover the element of their contribution relating to the CNST maternity incentive fund, and will also receive a share of any unallocated funds.

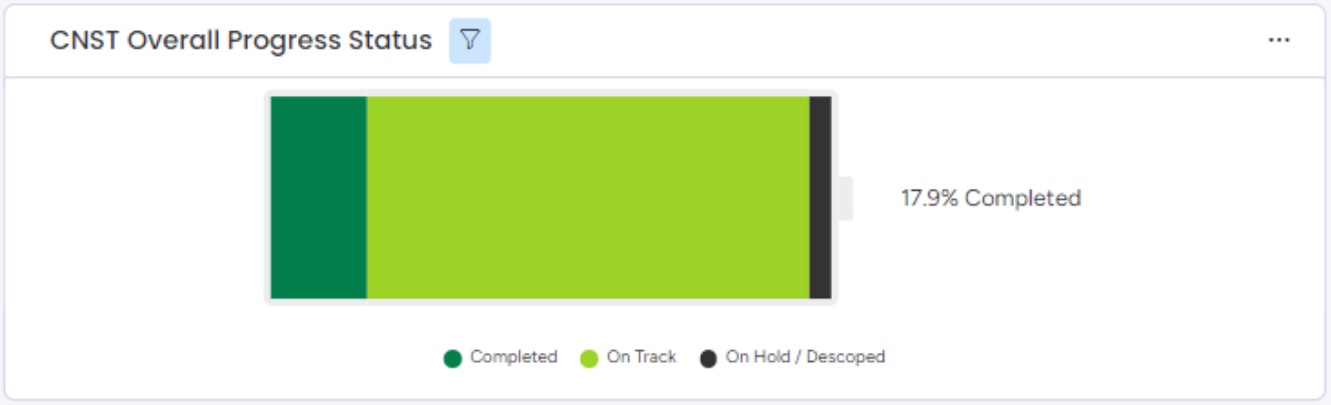
5.3 Year 5 guidance was published on 31 May 2023, and references a relevant time period of 30 May 2023 until 7 December 2023 for delivery of the scheme.

5.4 Since this iteration, revised guidance was issued on 30 June 2023, and a further full update published on 19 July 2023.

5.5 The following chart shows the CNST completion rate, as at 10 September 2023, of 15.4% 'Evidenced and Assured', 28.2% 'Delivered Not Yet Evidenced', and 51.3% 'Not Yet Delivered'.




5.6 The overall delivery status battery should be viewed in conjunction with the following progress battery. This provides evidence of the overall status of progress, which is on track. One element remains 'on hold', and this relates to Midwifery Continuity of Carer (MCOC), which is currently paused in line with the national letter that was published in September 2022.




5.7 The following table provides a high-level summary of the risks to delivery of CNST MIS – Year 5.

| There is a risk that… | The risk is caused by… | The potential impact of the risk is… | The mitigation in place is… |
|---|---|---|---|
| The Trust may not achieve version 3 of the Saving Babies Lives Care Bundle (SBLCB) | New additions to the updated guidance pertaining to elements 6 which relate to the endocrinology service, diabetes glucose monitors and dietician services. | Failure of safety action 6 | The Trust has submitted a divergence request for the timing of HBA1C monitoring which is supported by our system partners. The outcome of the request will be notified to the Trust within 28 days |
| The Trust may miss the 90% target for training for midwives, Drs, and support staff | The 12 months consecutive date range begins from the date used to inform compliance for the year 4 scheme therefore compliance must be achieved by October 2023. | Failure of safety action 8 | This is a common risk across many trusts.<br>There are several sessions planned to try and capture as many staff as possible however this is intrinsically linked with a high unavailability rate/planned industrial action therefore it is likely that our position will not be known until the qualifying period ends. |

5.8 SaTH is mostly on track to achieve CNST MIS Year 5, although there remains a very significant risk to delivery for Safety Actions 6 and 8 for the reasons specified above. The team is working hard to mitigate these risks wherever possible and reduce the risk of non-compliance; however, this will not be confirmed until after the scheme reporting period ends on 7 December 2023.

5.9 The technical guidance for CNST MIS Year 5 stipulates that it is a requirement that the Board oversees the quality of their perinatal services at every meeting. This comprises a substantial number of reports and appendices. These are included in a separate CNST folder as part of the Board's Supplementary Information pack. This pack is extensive and comprises the reports and associated appendices that have been presented to the Quality and Safety Assurance Committee (QSAC) already. The following table

# Board of Directors' Meeting
# 12 October 2023

| | | | | |
|---|---|---|---|---|
| **Agenda item** | 129/23a APPENDIX 3 | | | |
| **Report Title** | Maternity Improvement Plan–RRD DOCROOHJHDU Obstetrics & GQDHFROGis Closure Report | | | |
| **Executive Lead** | Hayley Flavell, Executive Director of Nursing | | | |
| **Report Author** | Annemarie Lawrence, Director of Midwifery | | | |
| | **Link to strategic goal:** | | **Link to CQC domain:** | |
| | Our patients and community | √ | Safe | √ |
| | Our people | √ | Effective | √ |
| | Our service delivery | √ | Caring | √ |
| | Our governance | √ | Responsive | √ |
| | Our partners | | Well Led | √ |
| | **Report recommendations:** | | **Link to BAF / risk:** | |
| | For assurance | √ | BAF1, BAF2 & BAF 3 | |
| | For decision / approval | √ | **Link to risk register:** | |
| | For review / discussion | | CRR 7, 16, 18, 19, 23, 27, 31 | |
| | For noting | | | |
| | For information | | | |
| | For consent | | | |
| ***Presented to:*** | *Divisional Committee July 2023, Maternity Transformation Assurance Committee Sept 2023, Quality & Safety Assurance Committee Sept 2023* | | | |
| **Executive summary:** | The Royal College of Obstetrics and Gynaecologists (RCOG) undertook a review of maternity services at the Trust during July 2017 which was published in 2018. The review was commissioned by the Trust Board to evaluate the culture, and to assess the safety and effectiveness of both maternity and neonatal services at SaTH, and comprised of 37 recommendations in total. In addition, there was also a review into the handling of the RCOG Report, which was published in 2020. Within that report there were actions identified that were specifically for the Trust Board rather than the Division. The Quality & Safety Assurance Committee has received the report and is satisfied that the actions arising from the RCOG report are complete, or have been superseded, and have had the intended outcome. | | | |
| **Recommendations for the Board:** | • The Board is asked to receive this report for information and assurance. | | | |
| **Appendices** | | | | |

## 1. Introduction

1.1 Maternity Services at SaTH are engaged in delivery of a number of change initiatives; some recent, and some that have been open for a number of years. For reasons of good governance, the service is working to close out these reports and their subsequent action plans, ensuring that they are fully embedded and all relevant learning has taken place.

1.2 One such report is the RCOG Review of Maternity Services at SaTH which has now been completed. The purpose of this report is to provide assurance of this.

1.3 The report was undertaken in July 2017 and highlights 37 recommendations for the Trust to implement to improve outcomes for women.

1.4 Despite being published in 2018, there was no evidence that this report or its actions had been received through the Trusts internal governance processes and therefore this was added to the Maternity Improvement Plan and addressed within Workstream 6.

## 2. Recommendations.

The paragraphs are the verbatim recommendations from the RCOG Review of Maternity Services at SaTH and the sub-paragraphs show the actions taken by the Trust to deliver these.

2.1 The transfer of postnatal women from the labour ward/postnatal ward on the Consultant Led Unit (CLU) to the Wrekin Midwifery Led Unit (MLU) should be monitored to ensure the MLU is not being used as an overflow for the hospital-based maternity service.

*2.1.1 There are no postnatal beds on the MLU aside from the intrapartum facilities which are available to those suitable to receive low risk care.*

2.2 Following the suspension of postnatal inpatient facilities at the Ludlow, Oswestry and Bridgnorth MLU, postnatal capacity and length of stay in the other units should be reviewed. SaTH should consider alternative ways of providing postnatal care nearer to home for women living in or near Ludlow, Oswestry and Bridgnorth.

*2.2.1 This action was descoped in line with the then Clinical Commissioning Groups (CCGs) pre-consultation business case and will be addressed within a full consultation as part of the future plan of the Integrated Care Systems (ICSs).*

2.3 The Trust should address the 10% higher than group average neonatal and extended perinatal mortality rates reported in the last two MBRRACE-UK Perinatal Mortality Surveillance Reports for the periods January–December 2015

and January–December 2014. The deaths should be reviewed and resulting action plans need to be achieved within a defined timescale with evidence of shared learning and practice change.

*2.3.1 Deaths from 2014/15 and any associated action plans were reviewed to ensure completion. Additionally, the introduction of the Perinatal Mortality Review Tool (PMRT) has standardised the review process for all stillbirths and neonatal deaths, enabling a detailed and robust governance process to be implemented. This is also evidenced by the delivery of Year 4 of Clinical Negligence Scheme for Trusts Maternity Incentive Scheme (CNST MIS), and the achievement of safety action 1.*

2.4 The Trust should audit its practice in the clinical indicators ranked as outliers in the 2016 RCOG Patterns of Maternity Care in English NHS Hospitals 2013/14 and the National Perinatal and Mortality Audit.

*2.4.1 The division benefits from a forward audit assurance plan (FAAP) which is well embedded. All reports received into the Trust are mapped through the divisional governance process which includes both maternity governance and divisional committee meetings. The National Perinatal and Mortality Audit is now known as the National Maternity and Perinatal Audit (NMPA) and the process of receiving the reports includes a review of any outlier position, ensuring this is linked to the FAAP.*

2.5 The maternity dashboard should indicate the actual mother to midwife ratio. Currently indicated is the establishment of midwives which fails to record maternity and sick leave and usage of bank/agency staff.

*2.5.1 The maternity dashboard now includes the midwife:birth ratio which is in line with the recommendations from the latest Birthrate Plus assessment. Additionally, the service has committed to an over establishment to address the unavailability of staff through either long-term sickness or maternity leave. This additional information is shared via the monthly staffing paper that goes to maternity governance.*

2.6 The maternity clinical dashboards should include transfer rates and reasons for transfer from each MLU to the CLU, with each MLU having its own birth, maternal and fetal outcomes.

*2.6.1 The maternity dashboard includes the number of transfers from the MLU to the consultant unit however the dashboard is not formed for qualitative data therefore does not include reason for transfer. This information is provided within the maternity infographics which are published monthly and shared both internally via the IT screens/maternity newsletter, and wider with our system partners/Maternity Voices Partnership (MVP).*

2.7 The antenatal triage service should be provided on a 24/7 basis to ensure non-labouring women are not admitted to the labour ward in the hospital setting.

*2.7.1 Maternity triage is available 24/7 and has its own budget/staffing model to evidence this. Triage opening times are indicated on all patient information and shared widely via the maternity Facebook page and MVP pages.*

2.8 The neonatal guidelines should follow the regional network guidelines whenever possible. Deviation should have a clear local rationale and must be reviewed on an annual basis

*2.8.1 Guideline adoption is reported to the ODN with rational explained where deviation occurs.*

2.9 Involve service users via the MEG and other platforms on developing the Baseline Assessment Tool for each new NICE obstetric guideline.

*2.9.1 Maternity Voices Group developed – the ToR for this group include consultation and coproduction where possible.*

2.10 Care Group should formulate a comprehensive workforce plan, supported by the latest Birthrate Plus® data, for presentation to the Trust Board. This plan should include the skill mix required on all sites. Skill mix requirements will depend on the services offered at each MLU and at the CLU.

*2.10.1 There is a comprehensive workforce plan in place which is based upon the recommendations from the latest Birthrate Plus® assessment. This is reviewed monthly via divisional finance surgeries and presented bi-annually to the Trust Board in line with the recommendations of the CNST MIS.*

2.11 The Band 7 labour ward coordinator should be supernumerary. A shortfall in this standard should constitute a ‘red flag’ staffing alert and trigger a review through the Care Group governance structure.

*2.11.1 Supernumerary status of the Band 7 labour ward coordinator is embedded as standard and any deviation from this would be reported as a red flag within the BirthRate Plus (BR+) acuity tool in addition to being reported via the Trusts incident reporting system ‘Datix’. All red flags are captured within the monthly staffing report which is presented to maternity governance and the bi-annual staffing paper that goes to Trust Board.*

2.12 Professional Midwifery Advocates (PMAs) should receive PMA training, have a PMA job profile and be allocated time in their job plan as recommended in the

2017 NHS England A-EQUIP a model of clinical midwifery supervision document (A- EQUIP: an acronym for Advocating for Education and Quality Improvement).

*2.12.1 SaTH have adopted a hybrid model of both lead PMAs and sessional PMA's. All PMA's are required to complete formal training in line with AEQUIP, with both lead and sessional PMAs allocated time in their job plan to deliver the model.*

2.13 The Trust should invest in the Care Group Patient Safety Team. The risk management midwife post removed in 2015 should be reinstated at the same banding. This midwife should be accountable to the Head of Midwifery. The Safety Team would benefit from having among its members a risk management consultant obstetrician.

*2.13.1 The Divisional Governance team has been strengthened to include additional roles to deliver the governance agenda. There is a Band 8a lead midwife who reports to the Director of Midwifery in addition to a Consultant Obstetrician who has 2PA's allocated to deliver the role 'obstetric risk lead'.*

2.14 Neonatal staffing issues highlighted and already on the Trust's risk register need to be addressed.

*2.14.1 BAPM standards have been achieved and can be evidenced by the delivery of safety action 4 of the CNST MIS. Additionally, there is an ongoing action plan to achieve the required number of Qualified in Speciality (QIS) nurses which continues to be highlighted and monitored regularly via the divisional risk register.*

2.15 New senior management team in the Care Group, namely the Care Group Director and the Head of Midwifery, need to clarify their roles in order to work effectively together to develop a vision for the service centred on safety and learning. Once developed, the vision needs to be embedded within the service so that all staff are aware of the direction of travel.

*2.15.1 The maternity services vision is 'to provide excellence in maternity care for the communities we serve' and is linked with a new maternity strategy for 2022/23. The Director of Midwifery and Divisional Director of Operations have a close working arrangement which is evidenced by their effective working relationship.*

2.16 Head of Midwifery would benefit from a mentor to provide guidance and support during her first years in post.

*2.16.1 The Director of Midwifery has engaged with the NHSE coaching programme, with the addition from a personal mentor from outside of region.*

2.17 Consultant anaesthetic cover of the labour ward should be in accordance with the 2013 OAA/AAGBI guidelines for obstetric anaesthesia.

*2.17.1 Achieved as part of CNST SA4, audited as part of the Ockenden report implementation.*

2.18 Increase staff awareness of examples of good practice identified through patient experience surveys/reports. This would improve staff morale and consistency of care through maternity services

*2.18.1 Embedded safety huddles in all areas, with content identified for digital screens installed in all units. Additionally, the introduction of 'learning from complaints/compliments' folders to areas enables the sharing of good practice whilst evidencing consistency in complaint responses.*

2.19 There should be a review of the manager on call rota arrangements in relation to the escalation policy. Clear guidance on accountability should be reflected in the plan to ensure a safe, effective care provision.

*2.19.1 The escalation policy has been reviewed and updated to mirror the regional framework, in addition to the local on-call training package. Expectations are outlined with clear guidance to support the delivery of safe maternity care.*

2.20 Monitoring of the escalation processes should be evident at the monthly Care Group clinical governance meetings.

*2.20.1 Monthly staffing paper produced and presented to maternity governance which details number of red flags alongside safer staffing processes.*

2.21 Staff feedback on the benefits of the twice-weekly CTG meetings held on the labour ward should be sought.

*2.21.1 Feedback obtained, meeting moved to virtual at least weekly, attendance as needed.*

2.22 Trends in incidents involving electronic fetal monitoring (EFM) misinterpretation should be analysed once the centralised monitoring system is in use.

*2.22.1 This forms part of the monthly CTG audits undertaken by the fetal monitoring lead midwives. Cases for learning are presented at the CTG teaching sessions or the fetal monitoring study day.*

2.23 Frequency of risk management meetings should be increased from monthly to weekly.

*2.23.1 This refers to the incident review meetings which take place weekly each Tuesday and the schedule is outlined within the terms of reference for the meeting.*

2.24 Review team advise that over reliance on one individual, such as the Patient Safety Lead, to oversee the timeline and process should be avoided. A wider pool of RCA-trained investigators should be used to carry out this task.

*2.24.1 More RCA trained investigators trained across the Trust, weekly rapid review meetings in place led by execs. Additionally, the divisional governance team has been expanded to ensure there are the appropriate number of team members to deliver the governance agenda.*

2.25 SI reporting should follow the NHS Improvement Serious Incident Framework

*2.25.1 SI Framework implemented and followed as standard.*

2.26 There should be promotion of independent external review and the request for invited review with all SIs and high-risk case reviews (HRCRs). Doing this portrays a culture of openness and willingness to learn from tragic events.

*2.26.1 NHSE/I SI Framework followed and reflected in Trust framework – no longer undertake HRCRs. For maternity incidents, if meets criteria they are investigated by Healthcare Safety Investigation Branch (HSIB) and any SI's investigated outside of the division. Additionally, there is external attendance at RALIG.*

2.27 For an RCA investigation to be of benefit, a trained multidisciplinary team needs to address root causes, to challenge existing practice, to write a report with clear action plans, specific directives and timescales. Timeframes should be adhered to with an escalation process if there is slippage.

*2.27.1 All lead investigators are trained and supported by the wider governance team to ensure the full RCA ask is met. Although national timescales were removed during covid, the Trust aims to adhere as closely to these as possible. Any deviations are agreed by the ICS SIRG/RALIG currently however the introduction of PSIRF will bring a new process and the SI policy will be updated accordingly.*

2.28 The Patient Safety Team should ensure that final reports are circulated to all staff. Evidence obtained from interviews suggests that shared learning from action plans was mainly obtained by staff attending the clinical governance feedback meetings.

*2.28.1 All completed SI reports are shared with staff via a number of routes which include as direct links in the clinical governance gems newsletter, via the 3-minute brief, via daily safety brief huddles, via the RALIG agenda and the IRM slides.*

2.29 All medical staff should be reminded of their legal responsibility to legibly date and sign each entry, along with a printed signature and their GMC registration number.

*2.29.1 All clinicians are provided with a stamp with their name and GMC number. The use of stamp usage was previously audited annually however this is now superseded by the BadgerNet health records system which automatically logs usage with each entry into the patient record.*

2.30 The Trust should inform the parents of any local review taking place and invite them to contribute in accordance with their wishes.

*2.30.1 Multiple processes are in place to ensure parents are offered to be involved, or are involved in any review such as a serious incident review or PMRT review etc. These processes are audited as part of the FAAP.*

2.31 Review team suggest that a logbook of all requests for consultant attendance, with reason for attendance, time of request and time of arrival onto the unit.

*2.31.1 This has been descoped as superseded by 24/7 consultant presence as part of Tier 3 rota.*

2.32 During the current closures of Ludlow, Oswestry and Bridgnorth MLU, it is essential to keep service users informed, with answer machines providing contact names and numbers, on where and how services are provided. Regular updates should also be performed.

*2.32.1 Clear communication provided about the closures which occurred several years ago. All pregnancy information documentation has been updated, including the birth options leaflet updated and the SaTH intranet/maternity Facebook page updated.*

2.33 Trust management should review and enhance MEG awareness through raising its profile. The Trust should consider rebranding as Maternity Voices in accordance with Better Births. https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf

*2.33.1 MEG rebranded as MVP which is very well established and resourced, with collaboration and coproduction well embedded. The MVP chair is an attendee on the monthly maternity governance meeting and maternity seniors meeting, in addition to being a representative on all senior leadership team recruitments.*

2.34 Trust management should consider engaging service users via social media, drawing upon the professional expertise of communication and social media advisors. This would access the untapped source of the vast majority of women

who are unable to attend the MEG meetings in person, many of whom are on Facebook and other social media platforms.

*2.34.1 Social media platform expanded through MVP (MVP Facebook) and Trust (Maternity Services Facebook/Twitter) platforms.*

2.35 The Trust management should consider paying travel and childcare expenses to all MEG service user representatives.

*2.35.1 Travel expenses are covered as part of the MVP agreement. Although an agreement to cover childcare is not currently in place, this is because it is not currently required by the MVP Chair, however, would be considered on a case-by-case basis.*

2.36 Trust management should review the effectiveness of online antenatal education provision, especially for first-time parents.

*2.36.1 There is currently an antenatal education working group in place involving staff, service users and MVP representatives which is looking at the current offer to ensure it is fit for purpose.*

2.37 The Trust management should review the consistency and quality of breastfeeding support and the availability of trained staff for this across all SaTH sites.

*2.37.1 SaTH are currently working towards gaining accreditation with the Baby Friendly Initiative (BFI). We are compliant with our infant feeding training which forms part of maternity annual mandatory training requirement and have an embedded frenulotomy service in place which is delivered by 2 additional lactation consultants.*

## 3. Assessment

3.1 All of the recommendations within the RCOG Review of Maternity Services at SaTH have been thoroughly implemented through the application of robust processes, or descoped as they have been superseded by updated guidance or recommendations that mean they are no longer applicable.

3.2 Given the length of time since this report was produced, it is accepted that some recommendations will have been descoped due to being superseded by updated evidence.

3.3 The Board can also take assurance that the existing recommendations from previous reports were either already in place or have also been implemented, with evidence pertaining to this being loaded into Monday.com where required.

## 4. Review of the Handling of the RCOG Report (2020).

4.1 In addition to the RCOG review of Maternity Services at SaTH, there was also a review into the handling of the RCOG Report which was published in 2020.

4.2 Within that report, there were actions identified that were specifically for the Trust Board rather than the Division. The actions from the report are as follows:

*4.2.1 The Board should satisfy itself that the governance issues identified in this review have been addressed. This should include the flow of information from local to corporate governance forums, and the ongoing oversight of action plans.*

*4.2.2 The Board should satisfy itself that the actions arising from the RCOG report are complete or have been superseded and have had the intended outcome.*

*4.2.3 The Trust should ensure that, particularly where a number of action plans exist from different reviews, management takes a step back from the detail and considers the overall themes. The Trust should ensure that plans also include recommendations from national guidance so that quality can be sustained as well as improved reactively following external reviews. The success of actions should be measured by looking at outcomes, not just the completion of process.*

4.3 To confirm, points 4.2.1 and 4.2.2 above are covered within this closure report for completion.

4.4 Additionally, point 4.2.3 was covered under the maternity action plan update report that went to the Quality & Safety Assurance Committee (QSAC) in July 2023.

## 5. Recommendations for the Board of Directors

The Board of Directors is asked to:

*5.1.1* Take **assurance** from this paper that the RCOG Review of Maternity Services (2018) at SaTH findings have been reviewed and all recommendations have been fully implemented and **note** its completion.

*5.1.2* Note that the actions arising from the RCOG report 2020 are complete or have been superseded, and have had the intended outcome.

The Shrewsbury and Telford Hospital NHS Trust

# Board of Directors' Meeting

## 12 October 2023

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| **Agenda item** | 129/23b APPENDIX 5 | | | |
| **Report** | **GAP Analysis: Black Maternal Health – Third Report of Session 2022-23** | | | |
| **Executive Lead** | **Hayley Flavell, Executive Director of Nursing** | | | |
| | **Link to strategic pillar:** | | **Link to CQC domain:** | |
| | Our patients and community | √ | Safe | √ |
| | Our people | √ | Effective | √ |
| | Our service delivery | √ | Caring | √ |
| | Our partners | √ | Responsive | √ |
| | Our governance | √ | Well Led | √ |
| | **Report recommendations:** | | **Link to BAF / risk:** | |
| | For assurance | | | |
| | For decision / approval | | **Link to risk register:** | |
| | For review / discussion | | | |
| | For noting | √ | | |
| | For information | | | |
| | For consent | | | |
| **Presented to:** | Maternity Governance September 2023 | | | |
| **Executive summary:** | The UK has the lowest maternal mortality ratios in the World. There are however persistent disparities in outcome for women depending on their ethnicity.<br>MBRRACE-UK's most recent report was published in November 2022 (using data from 2018-2020) and found that:<br>• Black women were 3.7 times more likely to die than White woman.<br>• 1 in 9 of the women who died during or up to a year after pregnancy in the UK were at severe and multiple disadvantages.<br>• Women living in the most deprived areas continue to have the highest mortality rates.<br>• Cardiac disease remains the largest single cause of indirect deaths. Thrombosis and thromboembolism (DVT) remain the leading cause of direct maternal deaths during or up to six weeks after the end of pregnancy.<br>• Improvements in care may have made a difference to the outcome of 38% of women who died.<br><br>The recommendations from the report have been reviewed and a GAP analysis produced to support service improvements. | | | |
| **Recommendations for the Board** | The Board of Directors is requested to note the report. | | | |
| **Appendices** | None | | | |

## Introduction

The Women and Equalities Select Committee Report on Black Maternal Health was published on the 18th of April 2023.

The work was undertaken to scrutinise progress to date. To review what was already known about the causes for maternal health disparities and critically assess the various solutions which have been proposed. Ethnicity data has regularly appeared in the confidential enquires reports from at least 2000 onwards. All reports have shown a greater risk for mothers from ethnic minority backgrounds, compared to White mothers.

Although the report is titled 'Black maternal Health', to acknowledge and address the particular stark disparity between Black and White women. The recommendations were intended to address the ethnic disparities more broadly, as well as the overlapping disparity for women suffering socio-economic deprivation.

The aim of this paper is to review the recommendations from the report and the current provision of maternity care to the Black, Asian and multiethnic communities as well as women suffering socio-economic deprivation.

## The Key conclusion and recommendation of the Report:

1. The maternity workforce must be properly equipped to understand and recognise the significant disparities that exist, and to use that knowledge to deliver personalised, effective and respectful care*. Health Education England must lead a co-ordinated review involving the National Midwifery Council, General Medical Council, Royal College of Midwives and the Royal College of Obstetricians and Gynaecologists, to ensure that both the training curricula and continuing professional development requirements for all maternity staff include evidence-based learning on maternal health disparities, its possible causes, and how to deliver culturally competent, personalised, and evidence-led care.*

2. A fully staffed, properly funded maternity service workforce is fundamental to delivering safe, personalised care to pregnant women and new mothers, and a prerequisite to rolling out any measures to combat inequalities (Midwifery Continuity of Carer) *The Government should commit to increasing the annual budget for maternity services to £200–350 million from the next financial year.*

3. *The Government should publish measures for gauging the success of the Maternity Disparities Taskforce. It should commit to publishing the dates of meetings in advance, and the minutes of the meetings soon after. The Taskforce should update this Committee on a six-monthly basis on the progress the Taskforce has made to tackling maternal health disparities.*

Box 1: **Maternity Disparities Taskforce: summarised terms of reference**

- The Taskforce will particularly focus on improving pre-conception care and access to maternity care for women from ethnic minorities and those living in most deprived areas and "will look to explore and consider evidence-based interventions for the following areas":
- reduce rates of smoking, drinking and drug use in pregnancy
- improve education and awareness of pre-conception health with a focus on planning for pregnancy such as taking folic acid supplement before pregnancy and maintaining a healthy weight.
- improve personalised care and support plans and focus on addressing wider social determinants of health.
- improve access to maternity care for all women and develop interventions for women from the most vulnerable groups.
- improve access and support for informed decision-making during childbirth for all women

4. *NHS England should set out their approach for assessing and monitoring the strategies of local maternity services. The Government should also provide clear timescales for the roll-out of the maternal morbidity indicator.*

5. *The Office for National Statistics, NHS England, hospital trusts and all relevant stakeholders should work with the National Perinatal Epidemiology Unit (NPEU) to minimise delays in the delivery of data. The NPEU should provide us with a progress update on this work within 12 months of the date of publication of this report.*

6. *NHS England and NHS Improvement (NHSEI) and NHS Digital must prioritise the accurate and complete capture of ethnicity data and ensure their new system for ethnicity data captures granular level data on ethnicity. NHSEI should provide us with a progress update on the implementation of this system within 12 months of the date of publication of this report.*

7. *The Maternity Disparities Taskforce must ensure a minimum number of seats or spaces at each meeting is reserved for representatives of organisations run by and for Black women. Part of the Taskforce's focus over the next 12 months should be on working with stakeholders to ensure Black women can be better represented in maternal health research; both as participants and researchers*.

| Themes | Recommendation | Current status | Desired Status | GAP | Confidence RAG | Action Owner | Target Completion Date |
|---|---|---|---|---|---|---|---|
| 1.Causes of Maternal Health Disparities | 1.The maternity workforce must be properly equipped to understand and recognise the significant disparities that exist, and to use that knowledge to deliver personalised, effective, and respectful care. | All maternity staff undertake mandatory Equality and Diversity training. | All staff to have undertaken Cultural competence training as recommended by the NHS Equity& Equality Guidance. | Not currently being undertaken | | EDI Midwife – TBC<br><br>Consultant Midwife<br><br>Trust EDI Midwife<br><br>Educational Lead Midwife | September 2024 |
| | | | Employment of an EDI Midwife (Recruitment in progress) | EDI Midwife not currently in Post | | Consultant Midwife | September 2023 |
| | | Staff receive Personalised care training on Mandatory training days. | | GAP not identified | | EDI Midwife – TBC<br><br>Consultant Midwife | August 2023 |
| | | A number of Staff have undertaken external | All Staff to have receive Personalised care training. | Gap not identified as now incorporated | | Consultant Midwife | August 2023 |

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| | | Personalised Care On-line training. | | on Mandatory Training | | Educational Lead Midwife | |
| | | Personalised care plans within Digital system (Badgernet) | | GAP not identified | | Digital Midwife | Completed |
| | | Mandatory Training Day to include Equity and Equality training (due to commence August 2023). | PROMT training to include an awareness of the differing clinical signs in Black or Brown skinned women and babies (E.g., Wound Infection, jaundice) | | | Consultant Midwife<br><br>Trust EDI Midwife<br><br>Educational Lead Midwife | Completed August 2023 |
| | | | Guidelines to include recognition of differing signs and symptoms with Black and mixed ethnicity. | Not all guidelines include signs and symptoms pertaining to Black and Brown skinned women. | | Guideline Midwife.<br><br>EDI Midwife – TBC | September 2023 |
| | | Trust has an Equality, | | EDI Midwife not in post | | Consultant Midwife | September 2023 |

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| | | Diversity, and Inclusion Team. | | Recruitment in progress | | | |
| | | | Engagement work to commence when EDI midwife is in role (currently out to recruitment)<br>Ensure culture is considered when designing resources. | EDI Midwife not currently in Post | | Consultant Midwife<br><br>Trust EDI Midwife | September 2023 |
| | | Employment of International Midwives to increase diversity within the Maternity workforce. | Employment of 10 International Midwives. | 5 International Midwives currently undergoing OSCE Preparation | | EDI Midwife – TBC<br><br>Consultant Midwife | September 2023 |
| | | National Reports Shared widely with safe via safety huddles, staff Facebook page. | | GAP not identified – Regular updates are shared with MDT | | Consultant Midwife<br><br>Trust EDI Midwife<br><br>DOM | September 2023 |

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| | 2. Due to broader taboos and stigma around discussing mental health and/or pregnancy, patients may not have talked about their experiences or received support around previous birth trauma or trauma from baby loss. | Current provision of PNMH service including Lighthouse Service and Improving women's Health Midwife (IWH) | PNMH training to include training on service users from Black and Asian communities. | Not currently in place | | EDI Lead Midwife<br><br>Improving Women's Health Midwife<br><br>Lighthouse Specialist midwife | September 2024 |
| | | | Ensure resources pertaining to mental Health are provided via Badgernet and maternity Internet pages are available in multiple languages such as (https://perinatalpositivity.org/) | No current resources in multiple languages available | | EDI Lead Midwife<br><br>Improving Women's Health Midwife<br><br>Lighthouse Specialist midwife<br><br>Digital Lead Midwife<br><br>Communications Team | September 2024 |
| | | Lighthouse service has Psychologist who is champion for | Engagement work to commence and<br>Ensure culture is considered when designing resources. | No current specific service targeted at Black, Asian | | Improving Women's Health Midwife | September 2024 |

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| | | service users from High areas of deprivation and attends community engagement | | communities, women within areas of high deprivation. | | Lighthouse Specialist midwife<br><br>Consultant Midwife<br><br>Trust EDI Midwife | |
| | | Bereavement Midwives currently in post who work closely with the Chaplin service in relation to specific cultural practices. | Ensure resources produced by Trust are available in multi languages | No specific service for Black and Asian service users. | | Bereavement Midwives<br><br>Trust EDI Midwife | September 2024 |
| | | Sensitive bereavement care provided by the Bereavement Midwives and the National bereavement Care pathway for Pregnancy and Baby Loss. | | | | | |

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| | | Bereavement Midwives provide Ibrahims Gift to our Muslim families.<br>QR codes are provided to which direct the family to the SANDS Support Booklet in a different language e.g. Urdu. | | | | | |
| | 3.The Government should publish measures for gauging the success of the Maternity Disparities Taskforce. | The Government Task force is currently focusing on pre-pregnancy care and is working in collaboration with the membership to produce pre-pregnancy guidance targeted for ethnic minority women and those living in most deprived areas. | Guidance under development- no update received to LMNS/Trusts | Not within SATH scope currently | | | |

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| 2. Tackling the Disparities | 1.A fully staffed, properly funded maternity service workforce is fundamental to delivering safe, personalised care to pregnant women and new mothers, and a prerequisite to rolling out any measures to combat inequalities (Midwifery Continuity of Carer). | MCoC Teams suspended, and new roll out suspended in line with Ockendon recommendations of safe staffing and national letter received to all trust in September 2022.<br><br>National target date to deliver MCoC have been removed (21/09/2022) | Roll out of enhanced MCoC teams in areas of high deprivation once staffing levels allow. | Work is ongoing on building blocks.<br><br>Risk of Staff not wanting to work within MCoC Teams.<br><br>MCoC model not yet decided. | | Continuity of Carer Specialist Midwife<br><br>EDI Midwife<br><br>Consultant Midwife | September 2024 |
| | | Working on building blocks for MCoC focusing on enhanced MCoC. | Continue staff engagement regarding MCoC. | Risk of Staff not wanting to work within MCoC Teams. | | Continuity of Carer Specialist Midwife<br><br>Consultant Midwife | September 2024 |

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| | | MCoC staff survey has recently been completed (9/8/23). | Continue staff engagement regarding MCoC.<br><br>Work with MNVP to conduct Service users specific MCoC survey | No recent Service users Survey specifically for continuity of carer needs.<br><br>Risk of Staff not wanting to work within MCoC Teams. | | Continuity of Carer Specialist Midwife<br><br>MNVP | September 2024 |
| | | An updated BR+ was undertaken in November 2022.<br>Maternity workforce plan has been developed and ratified. | | Gap not identified | | HOM | September 2023 |
| | | WF Plan includes 24 % uplift and an additional 10wte to mitigate for unavailability | Ongoing monthly workforce reviews.<br><br>Ensure sustained staffing levels prior to roll out of MCoC. | Gap not identified | | HOM<br><br>CoC specialist Midwife | September 2023 |

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| | | and attrition within the current workforce. Currently Staffing is up to template but with unavailability. | | | | | |
| | | | Undertake CoC workforce planning Tool | Not yet undertaken | | CoC specialist Midwife<br><br>Consultant Midwife | September 2023 |
| | | Ongoing monthly workforce reviews | Continue with Monthly workforce reviews. | Gap not identified | | HOM<br><br>Matrons | Ongoing |
| | | MCoC Midwife has undertaken review of ethnicity breakdown of bookings, areas of deprivation within the LMNS area and LSOA areas of Deprivation. | Engagement with local communities | No current engagement with local communities | | Continuity of Carer Specialist Midwife<br><br>EDI Midwife<br><br>Consultant Midwife<br><br>MNVP | September 2024 |
| | | MNVP have recruited Engagement Champion. | For MNVP and Trust to work collaboratively to ensure representation from Black and Asian service users | No current MNVP representation from black or | | EDI Midwife | September 2024 |

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| | | | | Asian service users | | Consultant Midwife<br><br>MNVP | |
| | | CoC Midwife commenced undertaken engagement with staff (focus group). | Continue staff engagement in regard to MCOC. | Risk of Staff not wanting to work within MCoC Teams. | | Continuity of Carer Specialist Midwife<br><br>Consultant Midwife | September 2024 |
| | | Retention Midwife involved in stay conversation. | Continue with offering stay conversations.<br><br>Ward managers inform retention Midwife of potential Leavers. | Gap not identified | | Retention Midwife<br><br>PMAs | September 2024 |
| | | PMA's involved in stay conversation. | | Gap not identified | | | |
| | | Preceptor package with 100% retention of preceptors in last two years. | Continue to offer robust preceptor package in line with national agenda. | Gap not identified | | PEFs<br><br>Retention Midwives | September 202. |
| | | Recruitment of 10 WTE international | On going support for International recruited Midwives | Risk of International | | EDI Midwife | September 2024 |

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| | | Midwives and ensure support and pastoral care to ensure retention. | | Midwives not being retained. | | Retention Midwife. | |
| | 2.NHS England should set out their approach for assessing and monitoring the strategies of local maternity services.<br><br>All LMNS will publish their Equity and Equality action plan by 31st March 2024 | Trust has work collaboratively with LMNS to develop an Equity and Equality action plan (currently in draft form) The interventions within the plan are designed to reduce health inequalities and ensure equity is part of how care is provided (e.g., perinatal mental health). Maternity Strategy includes Shared Decision making. | Recently published, Trust will work with LMNS to support the E&E strategy. | | | EDI Midwife<br><br>Consultant Midwife<br><br>CoC specialist Midwife<br><br>LMNS | September 2024 |
| | | | Increase/launch services within areas of higher deprivation communities (e.g sonography services) | Minimal hubs with local communities | | EDI Midwife<br><br>Consultant Midwife<br><br>Community Matron | September 2024 |
| | | | Engagement with local communities and build Trust with community members through direct engagement. | No current Engagement with Local Community | | EDI Midwife<br><br>Consultant Midwife<br><br>Community Matron<br><br>MNVP | September 2024 |
| | | | Engagement with community leaders to increase knowledge and traditions | No current Engagement | | EDI Midwife | September 2024 |

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| | | | which can complement and enhance knowledge of healthcare professionals. | with Local Community | | Consultant Midwife<br><br>Community Matron<br><br>MNVP | |
| | | | Work with MNVP to ensure those seldom heard voices are represented.<br>Increase demographic reach through MVP. | No current representation from Black and Asian service users within MNVP.<br><br>No specific surveys targeted at Asian and Black services users in relation to their experiences. | | EDI Midwife<br><br>Consultant Midwife<br><br>MNVP | September 2024 |
| | | | Ensure Information Leaflets and information is provided in multiple languages. | Service users' information videos (e.g. IOL) currently not available in other languages.<br><br>Badgernet not currently able to have | | EDI Midwife<br><br>Consultant Midwife<br><br>MNVP<br><br>Digital Midwife<br><br>Coms Team | September 2024 |

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| | | | | multiple languages available. | | | |
| | | | Ensure Interpreting services are used for all contacts where women do not speak English. | No current Video interpreting service – additional to current service | | | September 2024 |
| | 4.NHS England Have developed 14 Maternal medicine Networks | SATH work in collaboration with Birmingham Women's which is the nearest Maternal Medicine Network.<br><br>All women with chronic and acute medical problems around pregnancy, have access to specialist management.<br><br>SATH have Diabetes specialist Midwife/ clinics | Continue to work closely with Maternal Medicine Network.<br><br>Ensure Information provided is culturally sensitive and available in multiple languages. | Risk of Service users from areas of high deprivation unable to travel to other units due to financial concerns (cost of living).<br><br>Large geographical areas within LMNS and poor transport links. | | MDT | September 2024 |

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| 3.Research and Data | 1.The Office for National Statistics, NHS England, hospital trusts and all relevant stakeholders should work with the National Perinatal Epidemiology Unit (NPEU) to minimise delays in the delivery of data. | SATH met all 10 safety actions MIS year 4. Safety action 2 pertains to Ethnic coding data – SATH stands currently at over 90%.<br><br>SATH are meeting the final submission deadlines and have passed CNST metrics for April 2023.<br><br>Working towards MIS year 5 | Continue to work towards meeting all safety actions MIS year 5. | | AMBER | | September 2024 |
| | 2.NHS England and NHS Improvement (NHSEI) and NHS Digital must prioritise the accurate and complete capture of ethnicity data and ensure their new system for ethnicity data captures granular | SATH Maternity Ethnicity Data currently above 90% complying with MIS Safety Action 2. | New PAS system- Careflow will strengthen process and accuracy through mandatory fields. Careflow will also align with Ethnic categories set by NHS England.<br>Ensure Ethnicity is recorded at Booking and compliance monitored by Digital Team. | Currently Historical DATA has discrepancies.<br><br>Digital Team currently having to ensure Data is entered. | AMBER | Digital Lead Midwife<br><br>Data Analyst | September 2024 |

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| | level data on ethnicity | All service users are asked their ethnicity at point of referral via Badgernet- single point of access.<br><br>Booking coordinators add ethnic category to PAS<br><br>Ethnicity data is being monitored on a weekly basis by Digital Midwife Team<br><br>SATH Met all of 10 CNST | | No further Gaps identified | | | |
| | 3.The Maternity Disparities Taskforce must ensure a minimum number of seats or spaces at each meeting is reserved for representatives of organisations run by and for Black women. | Research team is working with OBS-UK on Equality and diversity. | Research team to consider using the Race equality framework Self-assessment tool to improve racial equity in health and care research | Currently no research being undertaken specifically Targeted Black African, Asian and Caribbean-heritage communities. | | Research Midwife<br><br>EDI Lead Midwife<br><br>Consultant Midwife | September 2024 |

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| | | | | Research team aware of Race equality Framework but no formal work around this currently | | | |
| | | Launch of REACH study which is looking at using 'Pregnancy circles. This is being trailed with One community team within an area of highest Deprivation in Telford and Wrekin. Will also capture Black and Brown women within the study. | | | | Research Midwife<br><br>EDI Lead Midwife<br><br>Consultant Midwife<br><br>Community Matron | September 2024 |
| | Part of the Taskforce's focus over the next 12 months should be on working with stakeholders to ensure Black women can be | DOM regularly shares Clinical Research and leadership opportunities for those healthcare professionals | Ensure Staff from Ethnic Minorities continue to be made are aware Leadership opportunities. | | | DOM<br><br>HOM<br><br>SLT | September 2024 |

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| | better represented in maternal health research; both as participants and researchers. | from Ethnic Minorities to all Maternity staff | | | | | |

**References**


Black Maternal Health Third Report April 2023 https://committees.parliament.uk/publications/38989/documents/191706/default/

Black Maternal Health: Government Response to the Committee's Third Report - Women and Equalities Committee (parliament.uk)