The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting: 12 October 2023

Agenda item		/23			
Report Title		Integrated Maternity Report			
Executive Lead		Hayley Flavell, Executive Director of Nursing			
Report Authors		Annemarie Lawrence, Director of Midwifery Carol McInnes, Divisional Director of Operations – W&C 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 Matenrity Report to the Board of Directors in public. In order ot mee the requirements of the Indepdent Matnerity Review and, also CNST reporting requirements.			
Recommendations for the Board:		The Board of Directors is requested to: • Provide any feedback on this new report format, which has been compiled to meet the requirements of the Independent Maternity Review. • Record that they have received the information in section 5, and the supplementary CNST information pack, and record this in the minutes. • Approve the need for an extraordinary Board meeting to sign of the final CNST submission, as set out in section 5.10 • Receive this report for information and assurance • Decide if any further information, action and/or assurance is required			
Appendices:		Appendix One: Board Reporting Schedule (see below) Appendix Two: Ockenden Report Progress Report Action Plan, as at 12 September 2023 (contained within Board Supplementary information pack) Appendix Three: RCOG Closure Report Appendix Four: CNST Information Pack (contained within the Board Supplementary information Pack) 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 at in the Board supplementary 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

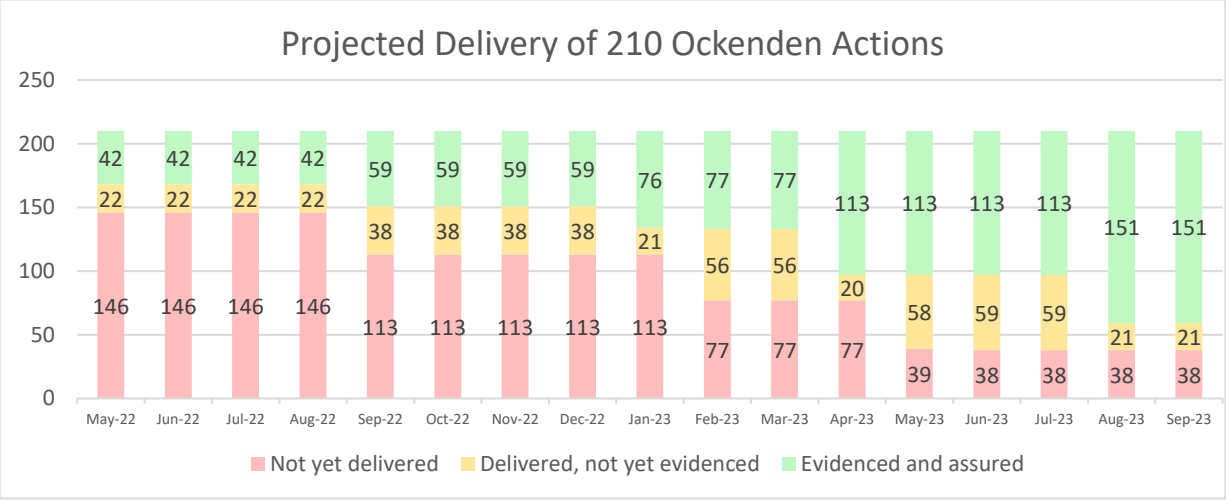
2.9.3 CNST MIS Year 5 Progress Report

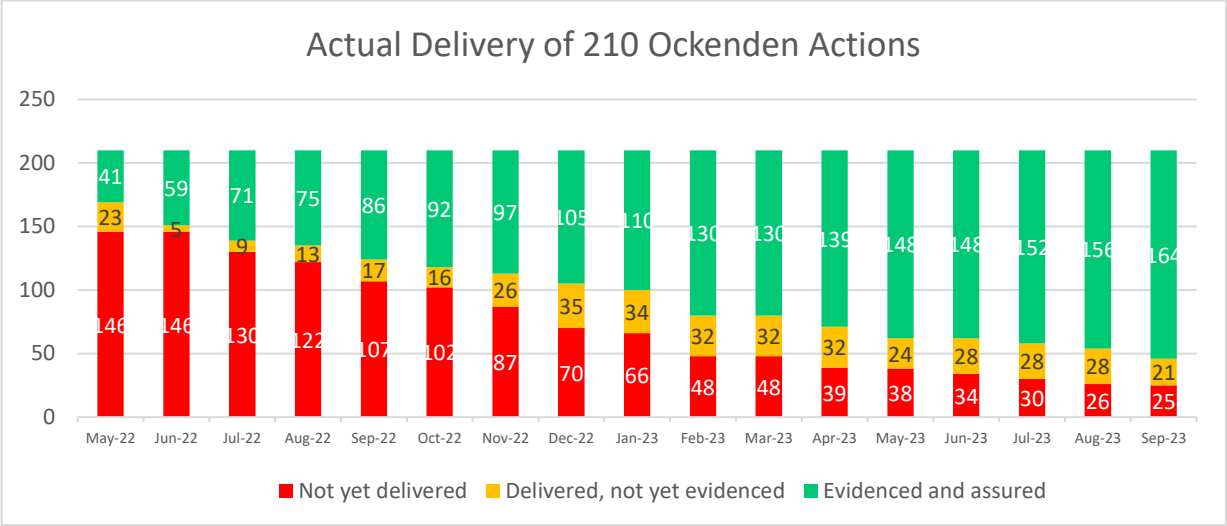
2.9.4 A Gap Analysis against the 'Black Maternal Health' Report

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 to 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 MATC 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) 2. High-level Ockenden plan update (final report) 3. Sustainability & Remaining Actions 4. Thematic engagement piece/measurable benefits	• Community Midwifery Services (+/- Specialist Midwives) • 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) • Latest CQC Survey/Inspection (if available)
April 24 (tbc)		• Round up of the overall learning from Ockenden • Celebration of successes • Rolling programme of audit - sustainability • Work still to do – transfer to BAU • 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 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 • Data Extraction for Epidemiological Research (DExtER) Project*	On Track	• Ongoing delivery of Ockenden • 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 • Comms and Engagement plan (including new website development and social media	On Track	• Ongoing delivery of Ockenden • Ongoing delivery of new website • 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 • 19 'delivered not yet evidenced', - closure reports being drafted • 2 'not yet delivered' • 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 (RCOG) and Gynaecologists 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 MIS Year 5 – Progress Report

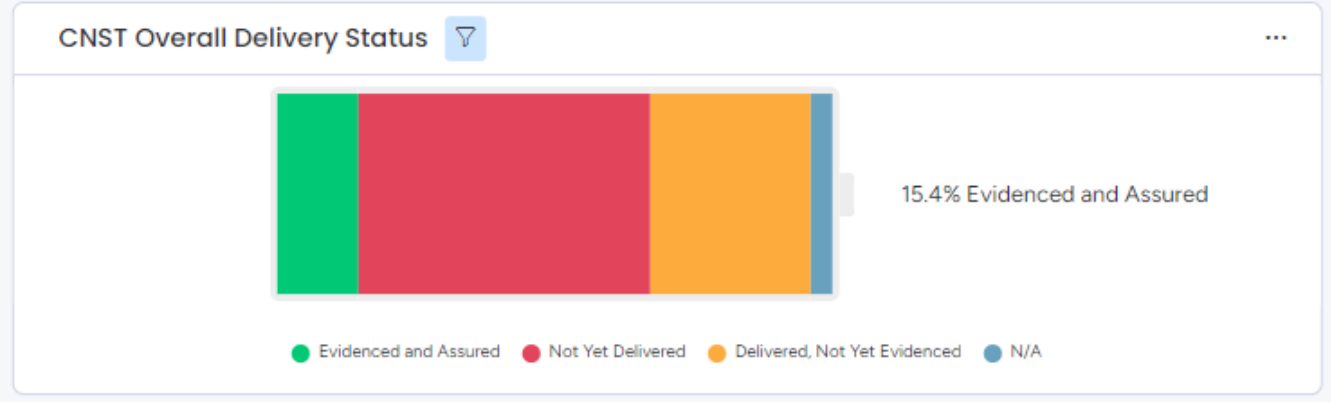
5.1 SaTH is a member of the CNST MIS, which is regulated by NHS Resolution (NHSR) and is designed to support the delivery of safer maternity care.

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.

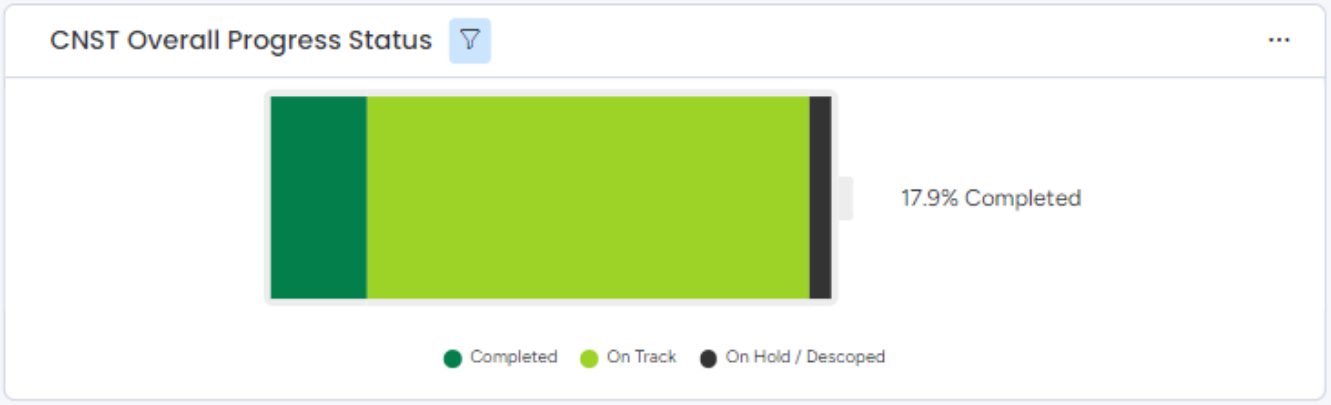
5.3 Year 5 guidance was published on 31 May 2023, and references a relevant time period of 30 May 2023 until 7 December 2023 for delivery of the scheme.

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. 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

summarises each piece of evidence that is in the folder to assist with the navigation of them.

No.	Name of Report	Appendices Included	Where previously received	Date received
1	CNST MIS Year 5 progress report – June 2023	Appendix 1: CNST MIS YEAR 5	Maternity Governance W&C Divisional Committee QSAC	27 June 23 27 June 23 28 June 23
2	CNST MIS Year 5 progress report – July 2023	Appendix 1 NHSR update email Appendix 2 PMRT quarterly report Q1 2023 Appendix 3 Transitional Care audit report Q1 2023 Appendix 4 ATAIN report Q1 2023 Appendix 5 Obstetric Workforce Paper	Maternity Governance W&C Divisional Committee QSAC LMNS	17 July 23 25 July 23 26 July 23 18 Sept. 23
3	CNST MIS Year 5 progress report – August 2023	Appendix 1 MIS Year 5 Update V1.1 July 2023 Appendix 2 Neonatal medical workforce paper Appendix 3 Saving Babies Lives report Appendix 4 Pre-term Birth Appendix 5 Small for gestational age	Maternity Governance W&C Divisional Committee QSAC LMNS	21 August 23 22 August 23 01 Sept. 23 TBC - Oct
4	CNST MIS Year 5 progress report – September 2023	Appendix 1 – SBL progress report Appendix 2 – SBL divergence paper Appendix 3 – Quad/Board safety champion minutes	Maternity Governance W&C Divisional Committee QSAC LMNS	15 Sept. 23 26 Sept. 23 27 Sept. 23 TBC - Nov
5	Safety Champions AAA September 2023	Appendix 1 – Safety champs June 23 Appendix 2 – Safety champs July 23 Appendix 3 – Safety champs August 23	W&C Divisional Committee MTAC QSAC	26 Sept. 23 12 Sept. 23 27 Sept. 23
6	Safety Champions Dashboard Q1		Maternity Governance Neonatal Governance	September 23 TBC

5.10 The submission for the maternity incentive scheme must be made to NHS Resolution no later than **12 noon on 1 February 2024**. Therefore, the Board of Directors is advised that a 'sign-off' meeting will need to be scheduled in advance of this date, to receive the

last pieces of information. This meeting will need to approve for the Chief Executive to make the submission on behalf of the Board of Directors. The submission window is open between 25 January and 1 February 2024. The last pieces of information will not be able to be produced until after the scheme ends on 7 December 2023. Regrettably, this is too late for this information to go through the required governance and assurance systems and processes before the December 2023 Board meeting.

6.0 Black Maternal Health

6.1 The UK has the lowest maternal mortality ratios in the World. There are however persistent disparities in outcome for women depending on their ethnicity. MBRRACE-UK's most recent report was published in November 2022 (using data from 2018-2020) and found that:

6.1.1 Black women were 3.7 times more likely to die than White women.

6.1.2 One person in nine of the women who died during or up to a year after pregnancy in the UK, were at severe and multiple disadvantages.

6.1.3 Women living in the most deprived areas continue to have the highest mortality rates.

6.1.4 Cardiac disease remains the largest single cause of indirect deaths in this population. Thrombosis and thromboembolism (DVT) remain the leading cause of direct maternal deaths during, or up to six weeks after, the end of pregnancy.

6.1.5 Improvements in care may have made a difference to the outcome of 38% of women who died.

6.2 The Trust's position has been benchmarked against the recommendations from the report and a GAP analysis, at **Appendix Five,** has been produced to support service improvements within maternity care to the Black, Asian and multi-ethnic communities, as well as women suffering socio-economic deprivation.

6.3 Within the comprehensive action plan that has been produced, there is an expected delivery date of September 2024, which is realistic and commensurate to the areas of focus; the team is linking in with the LMNS to map any crossover to its equality and equity action plan, which will reduce the risk of duplication for the Trust, system partners and the local Maternity and Neonatal Voices Partnership (MNVP).

6.4 The Trust is committed to working through the actions at pace with the support of the local MNVP, in line with the technical guidance of CNST MIS safety action 7.

7.0 Summary

7.1 This is the first version of the new-style Integrated Maternity Report. The Board of Directors is requested to provide any feedback on its structure and content.

7.2 As the Board of Directors meets every two months in public, it is regrettable that the CNST section needs to contain such large amounts of information; however, this is unavoidable due to the very specific requirements of the CNST scheme.

7.3 Good progress continues to be made with the actions arising from the Independent Maternity Review chaired by Donna Ockenden. Also, good progress continues to be

made with the overall Maternity Transformation Plan, the CNST MIS Year 5 scheme and the Black Maternal Health Plan.

7.4 The service continues to manage and mitigate any risks to these within its control.

8.0 Action required of the Board of Directors

8.1 The Board of Directors is requested to:

8.2 Provide any feedback on this new report format, which has been compiled to meet the requirements of the Independent Maternity Review.

8.3 Record that they have received the information in section 5, and the supplementary CNST information pack, and record this in the minutes.

8.4 Approve the need for an extraordinary Board meeting to sign of the final CNST submission, as set out in section 5.10

8.5 Receive this report for information and assurance.

8.6 Decide if any further information, action and/or assurance is required

Hayley Flavell
Executive Director of Nursing
September 2023

Appendix One: Board Reporting Schedule (see below)
Appendix Two: Ockenden Report Progress Report Action Plan, as at 12 September 2023 (contained within Board Supplementary information pack)
Appendix Three: RCOG Closure Report
Appendix Four: CNST Information Pack (contained within the Board Supplementary information Pack)
Appendix Five: The Black Maternal Health gap analysis

Appendix One – Integrated Maternity Report – Board Reporting Schedule

Board of Directors' meeting in public	Set Topics	Additional Topics
14 December 2023	1. Ockenden Report Progress Report 2. Maternity Transformation Programme (MTP)	CNST Three-Year Delivery Plan update
15 February 2024	1. Ockenden Report Progress Report 2. Maternity Transformation Programme (MTP)	TBC

**Financial Year 24/25 to follow in due course