The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting: 14 March 2024

Agenda item		048/24		
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 Integrated Maternity Report presents the latest position in relation to: the delivery of actions from the Independent Maternity Review, the Maternity Transformation Programme, The Clinical Negligence Scheme for Trusts, Saving Babies Lives, The Three Year Delivery Plan, Maternity and Neonatal Quality Data, and the Care Quality Commission's Maternity Survey 2023		
Recommendations for the Board:		The Board of Directors is requested to: • Receive this report for information and assurance • Confirm in the minutes of this meeting that it has reviewed all nine of the Appendices contained in the supplementary information pack, and as listed at the foot of this report. • Decide if any further information, action and/or assurance is required		
Appendices:		All appendices are in the Board Supplementary Information Pack		

1.0 Purpose of this report

1.1 The Board of Directors is familiar with the requirements for it to receive regular updates relating to the Trust's maternity services. This is in order to continue to monitor progress relating to the delivery and sustainability of the actions arising from the Independent Maternity Review, chaired by Donna Ockenden, comply with some of the actions therein and, also, receive other key 'set pieces' of information. The specific requirements were set out in previous iterations of this report.

1.2 This report provides information on the following:

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

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

1.5 The Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS)

1.6 Saving Babies Lives Care Bundle Version Three

1.7 Three Year Delivery Plan for Maternity and Neonatal Services

1.8 Maternity and Neonatal Quality Data

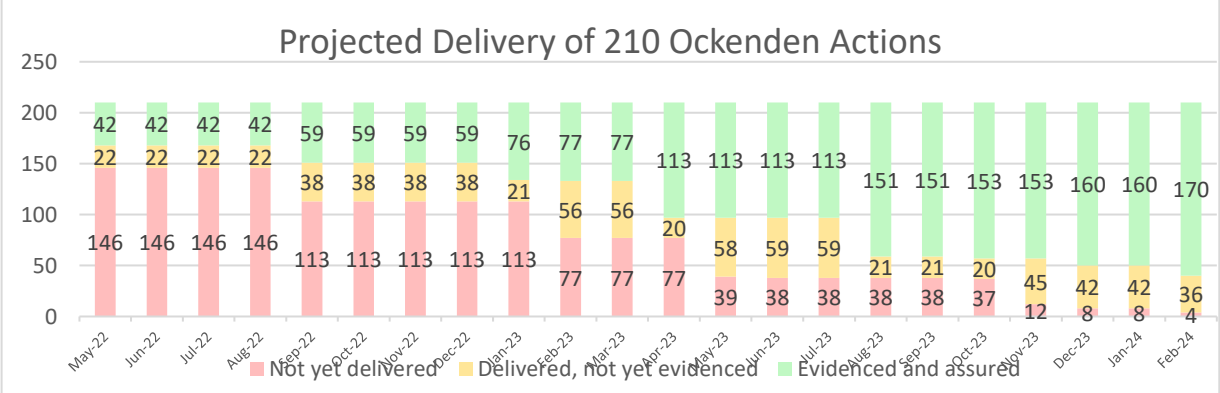
1.9 The Care Quality Commission's Maternity Survey 2023

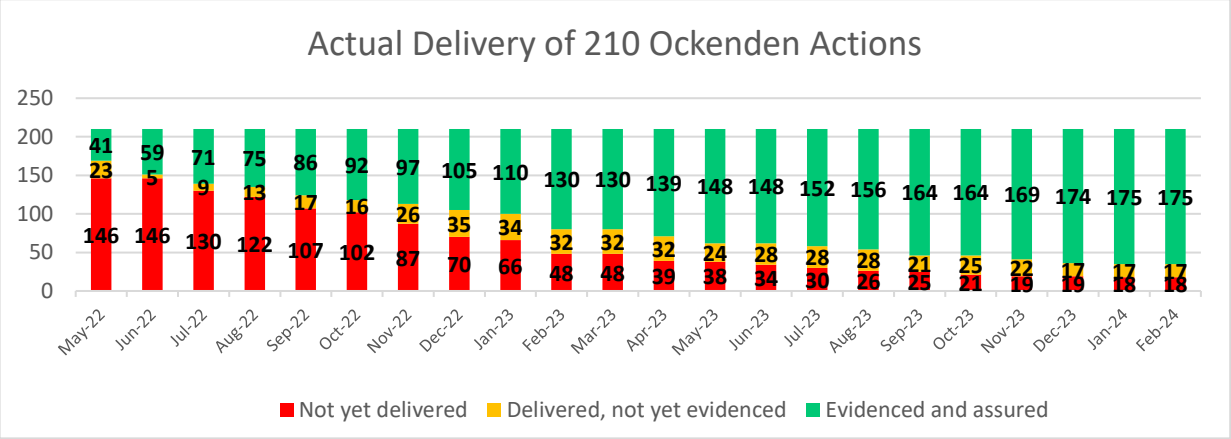
1.10 To support this paper, more detailed information is provided in the Board supplementary information pack, which contains all appendices to this report (as listed at the end of the report). Further information on any of the topics covered is available on request, also.

2.0 The Ockenden Report Progress Report

2.1 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 February 2024. The 210 actions from the Independent Maternity Review, chaired by Donna Ockenden, are incorporated into relevant workstreams within the Trust's Maternity Transformation Programme (MTP). However, as this Trust was the subject to the IMR, this section presents this information separately.

2.2 The following graphs show the projected versus actual trajectories for the delivery of the 210 actions from both reports.





The Trust remains ahead of schedule with its delivery plan, overall. 175/210 actions are now 'Evidenced and Assured' (Green/Green), which is five greater than plan at this time. However, this pace of delivery is slowing down. Of the 35 actions that have yet to be delivered fully (Evidenced and Assured - Green/Green), the summary breakdown is detailed in the next section.

2.3 Actions yet to be delivered – summary

2.3.1 The fuller position with all actions from both reports is contained in the action plan at **Appendix One** in the supplementary information pack provided for today's meeting. However, in summary, 35/210 actions from both reports have yet to be fully delivered, evidenced, and assured, with the full break down, as follows:

Progress Status	Number (Progress Rating)
Completed fully (Evidenced and Assured)	175
On track	10
Off track	4
At Risk	12
De-scoped	9
Total	210

2.3.2 The following section describes in summary detail the actions that are yet to be delivered.

2.4 'Off Track' Actions

2.4.1 Four actions remain effectively 'Not Yet Delivered' and 'Off Track', and are summarised as follows:

Action ref.	Description	Delivery Status	Current Progress Status	Risk to service score
IEA 1.4 (First Report)	*"An LMS cannot function as one maternity service only."* Local Maternity and Neonatal System (LMNS) stakeholders continue to work on the best way to deliver this action, but it remains 'Red/Red' with no discernible date for full delivery yet. An exception report requesting 'descope status' is to be brought to the Mar-24 MTAC.	**Not Yet Delivered**	**Off Track**	NA

IEA 2.1 (First Report)	*"Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards"* Action 'Off Track' as the appointed advocate has resigned from role. The Feb-24 MTAC accepted the suggested revised timescales for delivery advised by LMNS colleagues of Aug-24 for delivery deadline and Dec-24 for assurance deadline. The delivery status will revert to 'Not Yet Delivered' at the Mar-24 MTAC	**Delivered Not Yet Evidenced**	**Off Track**	9
IEA 2.2 (First Report)	*"The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome."* As per IEA 2.1	**Not Yet Delivered**	**Off Track**	9
IEA 14.4 (Final Report)	*"Neonatal Operational Delivery Networks must ensure that staff within provider units have the opportunity to share best practice and education to ensure units do not operate in isolation from their local clinical support network. For example senior medical, ANNP and nursing staff must have the opportunity for secondment to attend other appropriate network units on an occasional basis to maintain clinical expertise and avoid working in isolation."* Action 'off track' as the Advanced Neonatal Nurse Practitioners have not visited other NICU's for educational purposes as of yet, due to operational pressures. An exception report will be brought to the Mar-24 MTAC with new deadline date proposals. Also, at the Feb-24 MTAC meeting, a request was made for this action to be 'descoped' as it was suggested that lead responsibility for this action lies outside the Trust's scope of work. However, this discussion has not taken place with the ODN. This request was rejected. The committee requested for this to be brought back to the Mar-24 MTAC once there is clarification in terms of who owns this action as the lead – the Trust or the ODN? Unless this is agreed affirmatively, it will remain the Trust's action to lead on.	**Not Yet Delivered**	**Off Track**	9

2.5 'At Risk' Actions

2.5.1 Actions 'At Risk' that require additional funding

2.5.2 Eleven actions are 'at risk' awaiting additional, recurrent, investment to be able to deliver and sustain them, which are still within the business planning processes. These are summarised in the following table, with descriptions of any mitigating actions in place currently.

Action ref.	Description	Delivery Status	Current Progress Status	Risk to service score
IEA 4.3 (Final Report)	*"Every trust must ensure they have a patient safety specialist, specifically dedicated to maternity services."*	**Not Yet Delivered**	**At Risk**	12
Mitigation: This action is not yet delivered as it is linked to the business case and requires investment funds which should be recurrent. In the meantime, the division has a governance support team in place.				
IEA 8.1 (Final Report)	*"Women with pre-existing medical disorders, including cardiac disease, epilepsy, diabetes, and chronic hypertension, must have access to preconception care with a specialist familiar in managing that disorder and who understands the impact that pregnancy may have."*	**Not Yet Delivered**	**At Risk**	20
Mitigation: This action is not yet delivered as it is linked to the business case and requires investment funds which should be recurrent. It is not possible to put any mitigation in place for this action, without having the additional resource in place.				
IEA 11.1 (Final Report)	*"Conditions that merit further follow-up include, but are not limited to, postdural puncture headache, accidental awareness during general anaesthesia, intraoperative pain, and the need for conversion to general anaesthesia during obstetric interventions, neurological injury relating to anaesthetic interventions, and significant failure of labour analgesia."*	**Delivered Not Yet Evidenced**	**At Risk**	9
Mitigation: The pathway for a post-anaesthetic follow up clinic has been ratified at Trust governance, and the clinics are running on an ad hoc basis, currently. Two anaesthetic consultants undertake clinic reviews at RSH, and patient feedback is monitored. However, funds are required to be able to job plan this clinic in order to sustain it in future.				
LAFL 14.32 (Final Report)	*"The Trust must develop a robust pregnancy diabetes service that can accommodate timely reviews for women with pre-existing and gestational diabetes in pregnancy. This service must run on a weekly basis and have internal cover to permit staff holidays and study leave."*	**Delivered Not Yet Evidenced**	**At Risk**	16
Mitigation: This action has been delivered but requires investment to sustain delivery as this is currently being provided from within the clinical establishment which is not sustainable.				
LAFL 14.52 (Final Report)	*"The Trust's executive team must urgently address the impact of the shortfall of consultant anaesthetists on the out-of-hours provision at the Princess Royal Hospital. Currently, one consultant anaesthetist provides out-of-hours support for all the Trust's services. Staff appointments must be made to establish a separate consultant on-call rota for the intensive care unit as this will improve availability of consultant anaesthetist input to the maternity service."*	**Not Yet Delivered**	**At Risk**	12

Mitigation: The Trust has agreed to support the splitting of the Intensive Therapy Unit and Anaesthetic on call rotas, and the department is working the split rotas on a locum basis. New job adverts are being published with the new on call commitments added to the job descriptions, which is anticipated to support recruitment. Due to recent retirements and resignations within anaesthetics at PRH, this will mean there is a greater locum presence compared to permanent staff. Without the additional funds, the service will have to revert back to a 'non-split' rota and the department simply cannot recruit with this arrangement in place.				
LAFL 14.57 (Final Report)	*"As the Trust has benefitted from the presence of Advanced Neonatal Nurse Practitioners (ANNPs), the Trust must have a strategy for continuing recruitment, retention, and training of ANNPs."*	**Delivered, Not Yet Evidenced**	**At Risk**	20
Mitigation: A strategy for the continued recruitment, retention, and training for ANNP's is in place. Non-recurrent funding has been used to commence delivery of this programme for 2023 - 2025. Further to this, additional funding would be required for the programme to be implemented sustainably.				
LAFL 14.59 (Final Report)	*"The number of neonatal nurses at the Trust who are "qualified-in-specialty" must be increased to the recommended level, by ensuring funding and access to appropriate training courses. Progress must be subject to annual review."*	**Delivered Not Yet Evidenced**	**At Risk**	9
Mitigation: A workforce plan to ensure the number of neonatal nurses who are 'qualified in specialty' has been produced and non-recurrent funding has been used to commence delivery of this programme. The plan is subject to an annual review. To mitigate the short term risk while staff are being trained, the Divisional Director of Nursing has established a process to review the department's staffing plan aligned with acuity on a twice daily basis. If necessary, agency staff will be booked to ensure minimum QIS standards are met.				
IEA 14.8 (Final Report)	*"Neonatal providers must ensure sufficient numbers of appropriately trained consultants, tier 2 staff (middle grade doctors or ANNPs) and nurses are available in every type of neonatal unit (NICU, LNU and SCBU) to deliver safe care 24/7 in line with national service specifications."*	**Not Yet Delivered**	**At Risk**	16
Mitigation: The key area where funding is required to fully deliver IEA 14.8 is in association with delivery of neonatal nurse staffing in line with the British Association of Medicine Services (BAPM) standards. BAPM stipulates that neonatal services should have a number of dedicated quality roles in place in addition to core clinical provision. In an effort to mitigate the risk of not having these posts in place, some elements of service provision have been implemented such as dedicated hours allocated for discharge planning and education and practice development. However, this risk cannot be fully mitigated without the required funding allocation.				
IEA 1.2 (Final Report)	*"Minimum staffing levels should be those agreed nationally, or where there are no agreed national levels, staffing levels should be locally agreed with the LMNS. This must encompass the increased acuity and complexity of women, vulnerable families, and additional mandatory training to ensure trusts are able to safely meet organisational CNST and CQC requirements."*	**Delivered, Not Yet Evidenced**	**At Risk**	5
Mitigation: This action has been delivered, but to get to a position of evidenced and assured requires additional funding to be made available which should be recurrent. This specifically relates to job plans for consultants within obstetrics whose mandatory training requirements are much greater than those of a				

medical or surgical consultant, and this needs to be reflected within job plans once sustained funding has been sourced.				
IEA 12.2 (Final Report)	*"Unwell postnatal women must have timely consultant involvement in their care and be seen daily as a minimum."*	**Delivered, Not Yet Evidenced**	**At Risk**	12
Mitigation: This action has been delivered but to get to a position of evidenced and assured requires additional funding to be made available which should be recurrent, in line with requirements to deliver IEA 3.3 which increases overall Consultant capacity. To note, the medical workforce for obstetrics is managed as a hybrid service with gynaecology. To mitigate the short term risk for delivery of IEA 12.2, a process has been established within the division whereby inpatient activity is prioritised over outpatient/ planned care activity. While this addresses the risk for delivery of this IEA, there is a consequent risk for delivery of gynaecology services, which cannot be fully mitigated**.**				
IEA 12.3 (Final Report)	*"Postnatal readmissions must be seen within 14 hours of readmission or urgently if necessary."*	**Delivered, Not Yet Evidenced**	**At Risk**	12
Mitigation: This action has been delivered but to get to a position of evidenced and assured requires additional funding to be made available which should be recurrent, in line with requirements to deliver IEA 3.3 which increases overall Consultant capacity. To note, the medical workforce for obstetrics is managed as a hybrid service with gynaecology. To mitigate the short term risk for delivery of IEA 12.3, a process has been established within the division whereby inpatient activity is prioritised over outpatient/ planned care activity. While this addresses the risk for delivery of this IEA, there is a consequent risk for delivery of gynaecology services as a consequence that cannot be fully mitigated.				

2.5.3 Actions 'At Risk' for logistical reasons

2.5.4 One action remains at risk for logistical reasons, as follows:

IEA 1.7 (Final Report	*"All trusts must ensure all midwives responsible for coordinating labour ward attend a fully funded and nationally recognised labour ward coordinator education module, which supports advanced decision-making, learning through training in human factors, situational awareness and psychological safety, to tackle behaviours in the workforce."* Action 'rescoped' at the Jan-24 MTAC; as the programme has been approved Nationally. However, it is unlikely that all staff will complete it by the Mar-24 deadline. Hence, the action flagged as 'at risk.'	**Delivered, Not Yet Evidenced**	**At Risk**	5
Mitigation: The coordinators have completed an internal coordinator development programme, which is what the national programme is based upon; however, new elements have been added which cannot be completed prior to the March 2024 deadline.				

2.3.6 'De-scoped' Actions

Nine actions remain 'de-scoped,' currently. 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. Eight remain 'Not Yet Delivered,' and one is 'Delivered Not Yet Evidenced.' These actions remain under review by the Trust at MTAC quarterly, to check on any progress.

2.3.7 The Board can be assured that all appropriate preparatory work to support full delivery of these actions is underway as far as is reasonably practicable.

3.0 Ockenden Report Assurance Committee (ORAC)

3.1 ORAC last met on 28 November 2023. The next scheduled ORAC meeting is 27 February 2024, and the final Ockenden meeting is scheduled for 30 April 2024. Following this, the progress against and the sustainability of IMR actions will continue to be reported to the Quality and Safety Assurance Committee, and via this paper to the Board of Directors.

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

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

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) Three 'at risk' Ockenden actions linked to business case
2. People and Culture	Ockenden Actions	**On Track**	Ongoing delivery of Ockenden Ongoing delivery of engagement events (e.g., second maternity services open day and Improvewell app promotion)	Six 'at risk' Ockenden actions linked to business case, all workforce-related
3. Governance and Risk	Ockenden Actions	**On Track**	Delivery of Ockenden actions now complete. Ongoing development of the Maternity Transformation Assurance Tool	None identified
4. Learning, Partnership and Research	Ockenden Actions	**On Track**	Ongoing delivery of Ockenden	Capacity of the clinical teams to fulfil new Training Needs

	Data Extraction for Epidemiological Research (DExtER) Project*		Ongoing delivery of DEXTER Scoping underway to include improvement projects – two proposals presented at MTAC in Jan-24	Analysis (TNA) to meet new CNST SA 8 One 'at risk' Ockenden action – Staff unlikely to have completed training by Mar-24, as delivery suite coordinator module has only just recently been nationally approved
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**	Only 2 reports remain open with outstanding actions preventing closure. These reports are substantive in terms of size and are being progressed. The remaining closure reports (17) are in the process of being written and will make their way through divisional business.	Some delays due to capacity against competing priorities
7. Anaesthetics	Ockenden Actions	**On Track**	Ongoing delivery of Ockenden	Two 'at risk' Ockenden actions linked to business case

4.3 As described in section three, there is a potential risk to the ongoing delivery of some elements 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, which was accepted by the Trust. This requirement continues to be reviewed as part of the annual business planning round.

5.0 Clinical Negligence Scheme for Trusts (CNST) – Maternity Incentive Scheme (MIS)

5.1 As the Board is aware, Year 5 of the CNST MIS has closed with the Trust declaring compliance against all 10 safety standards. In line with the ongoing reporting requirements of CNST, the Board is required to oversee the following reports once they have been through divisional governance processes:

5.1.1 Avoiding term admissions in neonates (ATAIN) Q3 2023/24 (**Appendix Two**)
5.1.2 Transitional care Q3 2023/24 **(Appendix Three)**
5.1.3 Perinatal mortality review tool Q3 2023/24 **(Appendix Four)**
5.1.4 ATAIN annual action plan 2024 **(Appendix Five)**

5.2 In addition to being presented at the maternity governance meeting, these reports have also been discussed at the Trust's Safety Champions meeting and the Quality and Safety Assurance Committee (QSAC) before being shared outside of the organisation to the Local Maternity and Neonatal System (LMNS) in-line with the requirements of the scheme.

5.3 As part of the cycle of business, reports will continue to be brought periodically as part of this integrated maternity report.

5.4 The technical guidance and standards for year six of the CNST MIS have yet to be published.

6.0 Saving Babies Lives Care Bundle Version 3 (SBLCBv3)

6.1 As the Board of Directors is aware, the SBLCBv3 minimum standards were met as part of Year 5 of the CNST MIS, and work continues towards the stretch targets that the Trust must achieve to be fully compliant by 31 March 2024.

6.2 A Saving Babies Lives progress report is included at **Appendix Six**. This provides a detailed update for all six elements of the bundle, and highlights areas were there are risks to delivery. The risks centre on element six: 'management of pre-existing diabetes in pregnancy.' There is a risk that the service does not have a dedicated diabetic dietician to support the diabetes pregnancy clinic and, despite funding being identified for this resource, it is unlikely to be resolved before the scheme ends on 31 March 2024. Discussions are ongoing with Clinical Support Services who have verbally agreed that, in the interim, they will provide this resource from within their current establishment which mitigates the risk to patient safety.

6.3 The supplementary information pack contains two additional reports that the Board is required to see. These are:

6.3.1 The Review of Small for Gestational Age (SGA) and fetal growth restriction (FGR) Report Quarter 3 - 2023-2024 **(Appendix Seven)**, and;
6.3.2 Quarter 3 - 2023/4 Review of Pre-term births **(Appendix Eight)**

6.4 The Board of Directors will continue to receive regular progress reports in line with the recommendations of the bundle as part of this integrated maternity report.

7.0 Three-Year Delivery Plan for Maternity and Neonatal Services

7.1 The Board is already aware of the Three-Year Delivery Plan which was presented to the Board in December 2023. The Trusts position was benchmarked against the

themes, objectives and actions that comprise the report and a GAP analysis co-produced with the Integrated Care Board/Local Maternity and Neonatal System to ensure an overarching position was obtained for the system.

7.2 Since the Board was last updated on progress, work has begun to combine the 'Three-Year Delivery Plan' and the 'Equality and Equity' action plan into one overarching 'Single Delivery Plan for maternity and neonatal services.' The rationale for the amalgamation was to reduce the risk of any duplication, and combine the resources required to deliver against the plans within the appropriate workstreams.

7.3 The plan will be delivered through several workstreams, some of which are new, while others are already well established within the system. These workstreams are:

- Workforce (new)
- MNVP
- Quality and Safety (new)
- Digital & Data (new)
- Perinatal Mental Health
- Personalised Care & Support Plans (new)
- Neonatal
- Healthy Pregnancy & Healthy Families

7.4 The LMNS is leading this piece of work, and is currently reviewing the workstreams assigned to support delivery of the plan against the technical guidance for outcomes framework. The Trust has reviewed the terms of reference and core membership requirements for those attending the workstreams to ensure there is appropriate representation and that outputs are aligned.

7.5 The Board will continue to receive updates as part of this integrated maternity report.

8.0 Maternity and Neonatal Quality Data

8.1 The Trust Board must review a minimum data set pertaining to maternity and neonatal quality at every meeting, in keeping with the requirements of the Perinatal Clinical Quality Surveillance Model (PQSM).

8.2 Trust Safety Champions (including Executive and Non-Executive Directors) already see these datasets monthly, which enables any early action to be taken and support to be provided, should the data identify an area of concern or need.

8.3 The Safety Champions' Locally Agreed Dashboard for Quarter 3 – 2023/4 can be found at **Appendix Nine**. The Board is asked to review this dashboard each month, ensuring this is noted within the minutes of every meeting moving forward.

9.0 Care Quality Commission (CQC) Maternity Survey 2023

9.1 The Care Quality Commission has published its National Maternity Survey 2023 results

9.2 The 2023 CQC Maternity Survey involved 121 NHS Trusts in England and received more than 25,000 responses. It is designed to build an understanding of the risk and quality of maternity services and care. The survey highlights women's views on all aspects of their maternity care from the first time they see a clinician or midwife, through to the care provided at home in the weeks following the arrival of their baby. The survey comprised

54 questions and was administered entirely independently of the Trust. For this Trust, 300 women were contacted, with a response/participation rate of 153 (51%). This compares to the national response rate of 41%.

9.3 The results for this Trust were:

9.4 Better, somewhat better, or much better than most other trusts in three questions.

9.5 When broken down by section, in the category ‘your labour and birth,’ this Trust scored ‘much better’ than most other trusts; and,

9.6 This Trust was the highest scoring in its region. There were no sections in which the Trust scored worse than most others.

9.7 The questions where the Trust received a ‘better,’ ‘somewhat better’ or ‘much better’ score, were:

9.7.1 Thinking about your antenatal care, were you treated with respect and dignity? (somewhat better)

9.7.2 Before you were induced, were you given appropriate information and advice on the benefits associated with an induced labour? (better)

9.7.3 Before you were induced, were you given appropriate information and advice on the risks associated with an induced labour? (much better)

9.8 The Trust received a score higher than 9/10 in 14 questions from the survey, including:

9.8.1 During your antenatal check-ups, did your midwives listen to you?

9.8.2 Thinking about your antenatal care, were you involved in decisions about your care?

9.8.3 During labour and birth, were you able to get a member of staff to help you when you needed it?

9.8.4 Thinking about your care during labour and birth, were you treated with kindness and compassion?

9.8.5 Did a midwife or health visitor ask you about your mental health?

9.9 The Trust also saw a decrease in some scores around Infant Feeding and Mental Health from previous years, though those scores remained within the upper range of ‘As Expected.’

9.10 One question was rated ‘Worse than expected’: “Were you told who to contact if you needed advice about any changes you might experience to your mental health after the birth?.”

9.11 As in previous years, the Trust and the Maternity and Neonatal Voices Partnership (MNVP) will co-produce an action plan to address any required improvements, which will be monitored via the Trust’s internal governance and assurance systems and processes and, also, via the Local Maternity and Neonatal System.

9.12 The Women’s and Children’s Division will take these survey results through its governance and assurance processes, and will keep the Board of Directors apprised of progress against any actions via this report.

10.0 Summary

10.1 Good progress continues to be made with the actions arising from the Independent Maternity Review chaired by Donna Ockenden. Some potential risks remain to some outstanding actions, but these will continue to be reviewed and any risks mitigated where possible.

10.2 The Maternity Transformation Programme continues to progress well, notwithstanding the acknowledgement of some actions being at risk currently.

10.3 The Trust has declared compliance against all ten safety actions that make up CNST MIS Year 5, and the outcome of this is awaited from NHS Resolution and is expected in the new financial year. Year 6 guidance is awaited.

10.4 Now that the minimum targets of the Saving Babies Lives Care Bundle v3 have been met as part of CNST MIS Year 5, the Trust needs to progress the remaining elements of the bundle to meet the LMNS agreed stretch targets, to fully deliver the bundle. This work continues.

10.5 The CQC Maternity Survey 2023 results are overall positive for the Trust and its service users, but with some areas of improvement still required.

11.0 Action Required of the Board of Directors

11.0 The Board of Directors is requested to:

11.2 Receive this report for information and assurance.

11.3 Confirm in the minutes of this meeting that it has reviewed all nine of the Appendices contained in the supplementary information pack, and as listed at the foot of this report.

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

Hayley Flavell
Executive Director of Nursing
March 2024

All appendices are in the Board Supplementary Information Pack and are listed, as follows:

Appendix One:	Ockenden Report Progress Report Action Plan, as at 12 February 2024
Appendix Two:	ATAIN Q3 2023 (Oct-Dec) Report
Appendix Three:	Transitional Care Audit Report Q3 - 2023/24
Appendix Four:	Perinatal Mortality Review Tool Q3 & PMRT Board Report
Appendix Five:	ATAIN Annual Action Plan 2024
Appendix Six:	Saving Babies Lives Report February 2024
Appendix Seven:	Review of Small for Gestational Age and Fetal Growth Restriction Report Q3 - 2023_4
Appendix Eight:	Quarter 3 2023-2024 Review of Preterm Births
Appendix Nine:	Locally agreed Maternity/Neonatal Dashboard - Safety Champions Q3 2023