Meeting of BNSSG ICB Board

Date: Thursday 4th September 2025
Time: 12:45 – 16:15
Location: Bristol Citadel Community Church and Family Centre, 6 Ashley Road, St Paul's, Bristol BS6 5NL

Agenda Number:	6.4	
Title:	BNSSG response to the Maternity National Review	
Confidential Papers	**Commercially Sensitive**	No
	Legally Sensitive	No
	Contains Patient Identifiable data	No
	Financially Sensitive	No
	Time Sensitive – not for public release at this time	No
	Other (Please state)	

Purpose: For Information/Discussion

Key Points of Discussion:

On the 23rd of June 2025, the Secretary of State for Health and Social Care announced a rapid independent investigation into maternity and neonatal services. He has also announced an independent taskforce, alongside immediate actions required to improve care.

Sir Jim Mackey, Chief Executive NHS England and Duncan Burton, Chief Nursing Officer for England have written to all Trust Chief Executives and Chairs, detailing the five immediate actions to improve care, and have asked every local NHS Board with responsibilities relating to maternity and neonatal care to:

1. Be rigorous in tackling poor behavior where it exists. Where there are examples of poor team cultures and behaviours these need addressing without delay.
2. Listen directly to families that have experienced harm at the point when concerns are raised or identified. It is important we all create conditions for staff to speak up, learn from mistakes, and at the same time staff who repeatedly demonstrate a lack of compassion or openness when things go wrong need to be robustly managed.
3. Ensure you are setting the right culture: supporting, listening and working, through coproduction, with your Maternity and Neonatal Voice Partnership, and local women, and families.

4. Review your approach to reviewing data on the quality of your maternity and neonatal services, closely monitoring outcomes and experience and delivering improvements to both.
5. Retain a laser focus on tackling inequalities, discrimination and racism within your services, including tracking and addressing variation and putting in place key interventions. A new anti-discrimination programme starting in August will support our leadership teams to improve culture and practice. This also means accelerating our collective plans to provide enhanced continuity of care in the most deprived neighborhoods, providing additional support for the women that most need it.

This paper is for committee to note the current progress and assurance processes which the system has in place and our alignment with delivering the five immediate actions to improve care.

Recommendations:	To note the reports including any risks, mitigating actions and responsibilities as appropriate.
Previously Considered By and feedback :	Taken by Steve Hams (Joint CNO) to joint Trust Board
Management of Declared Interest:	Considered and none declared
Risk and Assurance:	The report and appendices provide an update to the Outcomes, Quality & Performance Committee in relation to the Maternity National Enquiry and the current BNSSG system wide position.
Financial / Resource Implications:	Considered and none declared
Legal, Policy and Regulatory Requirements:	Considered and none declared
How does this reduce Health Inequalities:	Every aspect of maternity services work aims to reduce health inequalities and this whole report shows what is happening at a system level.
How does this impact on Equality & diversity	EQIA not required at this time
Patient and Public Involvement:	The report outlines the importance of service user voice and is considered and utilised via the MNVP in all areas of the Maternity work programme.
Communications and Engagement:	The reports are provided to the Outcomes, Quality, & Performance Committee for information and discussion. This report will then be taken to ICB Board in September 2025.

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Sponsoring Director / Clinical Lead / Lay Member:	Rosi Shepherd- Chief Nursing Officer BNSSG ICB

NHS Bristol NHS Group Bristol | Weston

NHS Bristol, North Somerset and South Gloucestershire Integrated Care Board

Report To:	North Bristol NHS Trust (NBT) and University Hospitals Bristol and Weston NHS Foundation Trust (UHBW) Board in Common		
Date of Meeting:	8th July 2025		
Report Title:	Secretary of State for Health and Social Care - Rapid independent investigation into maternity and neonatal services.		
Report Authors:	Sarah Windfeld, Director of Midwifery and Nursing, and the maternity team at UHBW. Julie Northrop, Director of Midwifery and Nursing, and the maternity team at NBT. Layla Green, Deputy Director Safety & Quality Maternity & Neonatology BNSSG ICB.		
Report Sponsor:	Prof. Steve Hams, Group Chief Nursing and Improvement Officer		
Purpose of the report:	**Approval**	**Discussion**	**Information**
		X	
	This paper is to assure the Board that the five immediate actions are in place within Maternity and Neonatal Services across the Bristol NHS Group, which were outlined in a letter from the Chief Executive of NHS England and Chief Nursing Officer for England.		

Key Points to Note *(Including any previous decisions taken)*

On the 23rd of June 2025, the Secretary of State for Health and Social Care announced a rapid independent investigation into maternity and neonatal services. He has also announced an independent taskforce, alongside immediate actions required to improve care.

Sir Jim Mackey, Chief Executive NHS England and Duncan Burton, Chief Nursing Officer for England have written to all Trust Chief Executives and Chairs, detailing the five immediate actions to improve care, and have asked every local NHS Board with responsibilities relating to maternity and neonatal care to:

1. Be rigorous in tackling poor behaviour where it exists. Where there are examples of poor team cultures and behaviours these need addressing without delay.
2. Listen directly to families that have experienced harm at the point when concerns are raised or identified. It is important we all create the conditions for staff to speak up, learn from mistakes, and at the same time staff who repeatedly demonstrate a lack of compassion or openness when things go wrong need to be robustly managed.
3. Ensure you are setting the right culture: supporting, listening and working, through coproduction, with your Maternity and Neonatal Voice Partnership, and local women, and families.
4. Review your approach to reviewing data on the quality of your maternity and neonatal services, closely monitoring outcomes and experience and delivering improvements to both.
5. Retain a laser focus on tackling inequalities, discrimination and racism within your services, including tracking and addressing variation and putting in place key interventions. A new anti-discrimination programme from August will support our leadership teams to improve culture and practice. This also means accelerating our

collective plans to provide enhanced continuity of care in the most deprived neighbourhoods, providing additional support for the women that most need it.

This paper is for committee to note the current progress and assurance processes which the system has in place and our alignment with delivering the five immediate actions to improve care.

Strategic and Group Model Alignment

This is in line with the strategic priority of patient safety and supports the Hospital Group model alignment, with Maternity and Neonatal services across Bristol.

Risks and Opportunities

There is a potential risk of low morale of the staff working in maternity services and an anticipated increase in patient complaints, following media coverage of this independent investigation. There is the opportunity for Bristol Group Maternity Services to raise our national profile and showcase our good practice in maternity and neonatal services, whilst always improving our services, listening to women and our colleagues, and learning from others.

Recommendation

This report is for **Discussion**

- The Board is asked to discuss our initial response to the five immediate actions to improve maternity and neonatal care (as outlined in the letter from Sir Jim Mackey and Duncan Burton), whilst considering areas of continued development, improvement, oversight and any additional assurance required.

History of the paper (details of where paper has <u>previously</u> been received)

N/A	N/A

Appendices:	**Appendix 1 – Letter from Sir Jim Mackey and Duncan Burton**  PRN02043 - Letter from Jim Mackey and

Secretary of State for Health and Social Care - Rapid independent investigation into maternity and neonatal services.

Bristol NHS Group

July 2025

1. Purpose

This paper is to provide an update to the Board following the announcement by the Secretary of State for Health and Social Care of a rapid independent investigation into maternity and neonatal services, and the subsequent letter written to all NHS Chief Executives and Board Chairs by Sir Jim Mackey and Duncan Burton, requesting that NHS providers of maternity and neonatal services ensure that five immediate actions to improve care are understood by Boards and delivered.

The paper details a current position statement relating to each of the five immediate actions, alongside an assessment of further improvement. The paper concludes with a set of next steps to further progress our ambitions for delivering high quality, safe and compassionate maternity services at University Hospitals Bristol and Weston NHS Foundation Trust (UHBW) and North Bristol NHS Trust (NBT), 'The Bristol NHS Group'.

Obstetric incidents can be catastrophic and life-changing for families, when harm occurs during pregnancy, birth, or the postnatal period, it not only affects the physical and emotional wellbeing of women and babies but can also have profound, long-term impacts on families, communities, and staff involved in their care. Ensuring maternity safety requires a relentless focus on learning, transparency, and compassionate leadership. By further embedding a culture of continuous improvement, and inclusive teamwork across our maternity services, we can increasingly anticipate risk, act swiftly when concerns arise, and provide care that is both safe and woman centred. For all working throughout maternity and neonatal services across Bristol and Weston, there is a collective determination to make every contact count and every birth as safe and supported as possible.

2. Background

The Bristol NHS Group provides a range of local and regional specialist perinatal maternity services, combined the Group is one of the largest providers of maternity and specialist neonatal services, delivering in excess of 10,000 babies per year. Services are provided from Southmead Hospital, St Michael's Hospital and community services provided at Weston General Hospital,

Cossham Hospital and through a network of community teams delivering antenatal and postnatal care.

Following a national comprehensive inspection of maternity services by the Care Quality Commission in 2023, maternity services provided by UHBW and NBT are both rated 'good' overall, with NBT improving it's 'safe' rating from 'requires improvement' to 'good', both organisations had minor improvements to make, which have been completed through organisational improvement plans.

Both UHBW and NBT have participated in the NHS Resolution Maternity Incentive Scheme (MIS), a programme now in its 7th year is designed to enhance maternity safety within the NHS, by successfully meeting all ten safety actions both organisations have committed to delivering safe services. Both organisation consistently report and engage with the MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK, and consistently use the Perinatal Mortality Review Tool (PMRT) to support objective, robust and standardised local reviews of care when babies die, The PMRT is designed to support the review of baby deaths, from 22 weeks' gestation onwards, including late miscarriages, stillbirths, and neonatal deaths.

In addition, both organisations have executive and non-executive maternity and neonatal safety champions, with responsibility for listening to the voice of women and colleagues and acting to improve maternity services. Maternity safety champions provide regular updates to the Quality and Outcomes Committee of each organisation are asked to comment and support improvements to maternity and neonatal safety. The maternity and neonatal safety champions, alongside members of the Board, and Divisional Leadership Teams are able to scrutinise and seek further clarification on the data published monthly via the Perinatal Quality Surveillance Model (PQSM), to support improvement and enable transparency (as shared in public Board). The PQSM has over 100 input measures, measuring every aspect of our maternity services, both organisations now use the same PQSM format mandated by NHS England, the Bristol, North Somerset and South Gloucestershire (BNSSG) Local Maternity and Neonatal System (LMNS) are currently establishing a 'system' dashboard so that measures can be easily accessed.

The Maternity and Newborn Safety Investigations (MNSI) is an external source of investigation, hosted by the Care Quality Commission, all NHS trusts are required to tell the MNSI about certain patient safety incidents that happen in maternity care. This is so that they can carry out an independent investigation and where relevant, make safety recommendations to improve services at local level and across the whole maternity healthcare system in England. Throughout investigations they work closely with the families, NHS trusts and staff involved. MNSI investigations are reviewed by each Maternity Leadership Team, and recommendations acted upon and shared.

The Three-year delivery plan for maternity and neonatal services published in April 2023 enshrined in its commitment to listen to local women the requirement that all Integrated Care Boards (ICBs) supported the establishment of a Maternity and Neonatal Voices Partnership (MNVP), in BNSSG this partnership has been slower to develop, however in the last six months has developed considerably with strong and effective leadership, mechanisms to listen to woman and families and integrated within aspects of maternity and neonatal governance, i.e. PMRT reviews. Their activities are co-ordinated through the BNSSG LMNS chaired by the BNSSG ICB Chief Nursing Officer, the LMNS was established in response to the 2016

publication of Better Births: Improving outcomes of maternity services in England – A Five Year Forward View for Maternity Care.

3. Actions which Boards are requested to take

3.1 Be rigorous in tackling poor behaviour where it exists. Where there are examples of poor team cultures and behaviours, these, especially need addressing without delay.

UHBW

- Maternity statutory and mandatory training "civility saves lives" is used as a theme, using examples and incidents to improve culture and learning.
- As part of the three-year delivery plan, NHS England offered a development programme to all maternity and leadership teams to promote positive culture and leadership. UHBW Maternity and Neonatal Quad (Director of Midwifery, Clinical lead for Obstetrics, Clinical Director for NICU and Deputy Divisional Director) took part in the programme in 2024, and the SCORE (Safety, Communication, Operational Reliability and Engagement) survey was sent to all staff working in maternity and neonatal services, including theatres, with results received in July 2024. This was followed by a series of cultural conversations, facilitated by an organisational consulting firm in August 2024.
- The SCORE survey results demonstrated that there was a culture of learning and speaking up is easy. The environment is safe for patients, safety is good, there is a culture of wanting to do better, and improve work life balance scores were positive. Where there are opportunities based on SCORE results, burnout is high across all groups but especially Consultants, teamwork could be stronger, related to breakdowns in communication and following up on difficult situations, leadership is visible, but staff wanted more feedback, support and performance management.
- From the results of the SCORE, an action plan was developed, part of which was to work with theatre staff (Division of Surgery) and Central Delivery Suite (CDS) midwives to improve relationships and culture. Theatre staff have since shadowed the midwife in charge on CDS and vice versa, to improve understanding of each other's roles, there have been joint away days and the introduction of a phone for the theatre and CDS co Ordinator, to improve communication.
- The Division has implemented "Nip it in the bud" as part of the Respecting Everyone Policy within Maternity Services and, following a recent listening event.

NBT

- As business as usual each year staff survey results are analysed and action plans to improve lowest scoring areas are implemented with changes fed back to staff.
- Divisional Management and Leadership teams across the Trust have attended the Perinatal Leadership Programme in 2024 and the SCORE survey has been undertaken with associated improvement plans. Other culture focused leadership courses include Healthcare Excellence in Leadership and Management (HELM), Black Maternity Matters and compassionate leadership courses.

- Mandatory Multi-Disciplinary Training (i.e. PROMPT) includes psychological safety, civility, escalation of clinical concerns.
- Feedback on culture from outside agencies such as CQC and our student midwives is supportive of the work we are doing to live our NBT values.
- Staff wellbeing is supported via multiple wellbeing offers and psychological support (for example PIITSOP debrief) when staff may have experienced challenging situations.

Areas for continued development

- UHBW - the Division is to commence work within the Neonatal Unit team to improve multi-professional working, using the civility saves lives framework.
- NBT – developing a theatres culture project and effective information sharing and communication when transferring into Central Delivery Suite and Percy Phillips (postnatal ward) to be area of focus for future culture work.
- NBT - Estates improvement work such a prayer room, further disabled facilities, hoists, and improving privacy and dignity in all ward areas.

3.2 Listen directly to families that have experienced harm at the point when concerns are raised or identified. It is important we all create the conditions for staff to speak up, learn from mistakes, and at the same time staff who repeatedly demonstrate a lack of compassion or openness when things go wrong need to be robustly managed.

UHBW

- Maternity Services ensure duty of candour is undertaken when something goes wrong with a patient's care. This duty is regularly audited to ensure no patient and/or their families is missed. Where applicable, or if requested, patients and/or their families are offered de-briefs following any such incident occurring.
- Patients and/or their families often meet with the Director of Midwifery as part of the complaint resolution process, which enables first-hand patient and family experience to be heard.
- In October 2025, trauma-informed care training is planned for Community Midwives.
- Over 75% (270) of eligible staff have completed the Trust compassionate and inclusive leadership programme at St Michael's Hospital.
- Monthly patient safety walkabouts are undertaken with the Maternity Safety Board Champion or deputy, Director of Midwifery, member of the Maternity and Neonatal Voices Partnership (MNVP) and the patient safety lead. This provides an opportunity for staff, patients and families to raise any issues or concerns which they may have, with this team. Issues and/or concerns which have been raised are fed back to the managers of the relevant area, with support provided to make any changes or improvements as required.
- There is a Trust Speaking-up Guardian and local speaking-up champions within each of the maternity and neonatal departments. There is also a monthly 'Meet the Managers' session, which enable staff to raise any concerns or discuss any challenges.
- Staff survey response rates at St Michael's Hospital are 44.7%; below the overall Trust response rate of 54.4%. and the feel safe to speak up about anything that concerns me in this organisation question; St Michael's Hospital is 68.4% which is higher than the Trust

average of 68.2%, with the organisation acts on concerns raised by patients/ services users' question at 81.4%, which is much higher than the Trust average of 74%.

NBT

- Maternity Services ensure duty of candour is undertaken when something goes wrong with a patient's care. This duty is regularly audited to ensure no patient and/or their families is missed. Where applicable, or if requested, patients and/or their families are offered de-briefs following any such incident occurring.
- Patients and/or their families often meet with the Director of Midwifery as part of the complaint resolution process, which enables first-hand patient and family experience to be heard.
- There are specialised teams in place across services to listen directly to families who raise concerns or who have experienced poor outcomes (such as our bereavement team, birth reflections service and patient experience team).
- Staff are actively encouraged and given the routes to raise concerns and escalate in a psychologically safe environment such as listening events (inc. MNVP), Freedom to Speak Up, Professional Midwifery Advocates and safety champions walk arounds.
- There is a 'Being Fair' approach across the Trust to manage staff behaviours in the appropriate and fair manner, supported by Unions.
- The service actively monitors and respond compassionately to complaints, compliments Patient Advice and Liaison Service (PALS) data and the Friends and Family Test, Local Resolution Meetings are offered to all women / families who make a complaint.
- The Continuous Improvement and Learning Team (CILT) embedded within the Division with the MNVP frequently supporting improvement work.
- Women and or families are given one point of contact for dedicated services to ensure continuity if they have raised concerns.
- For MNSI cases tripartite meetings are always offered and PMRT family feedback supports the weighting of PMRT grading of care.
- Staff survey response rates for Women's and Children's Division are 57.5%; below the overall Trust response rate of 62%. and the feel safe to speak up about anything that concerns me in this organisation question; Women's and Children's Division is 62.8% which is lower than the Trust average of 66.01%, with the organisation acts on concerns raised by patients/ services users' question at 79.6%, which is much higher than the Trust average of 53.06%.

Areas for continued development

- UHBW - continue to ensure the actions and opportunities described above for listening to and acting on feedback from both patient/ families and staff are in place.
- UHBW and NBT - seek to improve further staff engagement through increased response rate in the staff survey in 2025.
- UHBW and NBT – continue to develop the relationship with the BNSSG MNVP and further strengthen the voice of women.
- UHBW and NBT – continue to embed new language and interpretation services across both organisations to reduce language barriers.
- UHBW and NBT – review our approach to 'learning from' now that both organisations have fully implemented The Patient Safety Incident Response Framework (PSIRF).
- UHBW and NBT – we will further embed the Patient Safety Partners (PSPs) model into maternity services, these are individuals who partner with the NHS to improve patient safety by providing the patient and public perspective.

- UHBW and NBT – continue to listen to colleagues and find additional ways to create environments for optimum care delivery, recognising the challenges with an aged estate.
- NBT - continue with the strategy to bring care closer to home, explore areas for further roll out of community obstetric clinics and services at home such at blood pressure monitoring.
- NBT - understand the demographic and any disparity in representation to improve access to our services based on what women want.

3.3 Ensure you are setting the right culture: supporting, listening, and working, through co-production with your Maternity and Neonatal Voice Partnership, local women and families.

UHBW

- The Maternity and Neonatal Voices Partnership (MNVP) are valued contributors to the Maternity and Neonatal services, and attend the Maternity Safety Champions meetings, Women's Clinical Governance meetings and the Women's Patient Experience meeting. The MNVP also take part in the monthly safety walkabouts and feedback on the patient and family interactions which they experience as part of their role. The MNVP have recently undertaken the 15-Steps challenge in St. Michael's Maternity Service and Weston and have fed back findings which were hugely positive, especially feedback from the women about how kind staff had been. However issues with the old estate were raised, which the Division is aware of, such as the state of the patient toilets and bathrooms. Some of this estates work has been prioritised by the Director of Midwifery for PLACE (Patient led Assessments of the Care Environment) funding.
- Within the community setting, the role of the Enhanced Maternity Support Workers in the Juniper team located in Easton and Montpelier, is to engage with our global majority patients to listen and improve services for them. As a result of this work, UHBW have set up a bespoke ante natal class for these women.
- There has been recent co-production with the MNVP in improving both the bereavement areas and the waiting areas within St. Michael's Hospital.

NBT

- The service user voice and co-design is embedded throughout quality improvement, service redesign and transformation whether this be independently of or in collaboration with the MNVP.
- The MNVP team in BNSSG meets the national guidance across maternity and neonatal.
- The MNVP is a recently established team, and work is ongoing to improve the interface between Trusts, the MNVP and the service user voice they represent. There is also a patient partner group to enable service user collaboration and co-design.
- The outcome and results of Project SMILE (where women voice their wants and needs) was the catalyst for establishing the Patchway Clinic and Maternity Support Worker Community Champions training model).
- NBT run a Trust GRT engagement group which has received positive feedback for maternity services.
- The MNVP support with contacting vulnerable or groups likely to experience poorer outcomes to support QI initiatives. Prior to having an established MNVP team NBT established a Patient Partner Group to support patient engagement. MNVP funding from both Trusts has been increased recognising the value that formal engagement with woman and communities brings to developing services.

- Patient stories shared with Trust Board, and a recent example was an example of a woman receiving support for breastfeeding.

LMNS

- National MNVP guidance published December 2023 which clearly laid out a gold standard framework of staffing model including roles and responsibilities
- Key priority of 24/25 to develop this within BNSSG in collaboration with acute maternity trusts and Healthwatch via The Care Forum (host organisation)
- We now have a structure that replicates national guidance (strategic lead, trust liaison, community engagement and neonatal specialist lead)
- BNSSG is the only ICB/LMNS within the South West to achieve this
- Currently developing two-year strategic ambition framework to focus on improving equity and reducing inequalities.
- Our Community Engagement Lead regularly attends and gains insight & feedback from our whole population including underserved communities-
  -Mothers for Mothers- supporting mothers experiencing mental health challenges in the perinatal period.
  -Caafi Health- working with Somali and other ethnic minority communities to improve health access and outcomes.
  -Refugee women of Bristol- Supporting refugee and asylum seeking women through community connection, language and wellbeing services.
  -Black Mothers Matter- focuses on improving maternity care and wellbeing for Black mothers and families.
  -Project Mama- Provides support for displaced and migrant women throughout pregnancy and early motherhood.
  -Bristol Family Hubs- Offers support for families across different parts of Bristol focusing on early years and parenting services.
  -Bristol Women's Voice- Advocates for all women in Bristol, ensuring their voices are heard in local decision making.
  -African Voices Forum- Represents African and African-Caribbean communities and works towards equality and inclusion.
  -WomenKind- Offers mental health and emotional support specifically for women.
  -Health Innovation West Of England- A regional health body focused on improving health systems and promoting innovation in care.
  -Det Community- A grassroots organisation working with African and Caribbean communities to improve health, wellbeing and social inclusion.

Areas for continued development

- UHBW and NBT – continued assessment the maternity and neonatal estate as part of the Single managed service programme, using feedback from women and families.
- UHBW and NBT - review of patient information to better connect with our population.
- UHBW and NBT - The Real Birth Company have been commissioned to improve our antenatal education including availability of languages, this has changed based on feedback from local women, who have valued a consistent approach to antenatal support.
- UHBW and NBT - improve MNVP engagement at maternity and neonatal safety and governance meetings (now included on PMRT meetings, consider forums and Divisional Governance).

- UHBW and NBT - implement results of BadgerNet survey alongside the MNVP, improving access to digital maternity records for local women.
- UHBW and NBT – working with the MNVP better understand the drivers for 'birthing out of guidance', so as to better manage expectations and risks of the woman.

3.4 Review your approach to reviewing data on the quality of your maternity and neonatal services, closely monitoring outcomes and experience and delivering improvements to both.

UHBW and NBT

- At UHBW and NBT, the Board Quality and Outcomes Committee (QOC) receives a monthly report of the Maternity dashboard (PQSM) and a spotlight presentation, which enables scrutiny and discussion, this is presented by the Director of Midwifery and Nursing.
- Each Trust Board has the PQSM available as part of the wider Integrated Performance Report.
- The LMNS are working jointly with both Group Trusts in Bristol to develop an updated Maternity-specific dashboard. There will be a new national Perinatal Mortality Review Tool (PMRT) being introduced in due course, however in the meantime, the two acute Trusts are working on a joint PMRT. Both acute Trusts are part of the LMNS Quality and Safety meeting, which facilitates challenge and peer review.
- UHBW is a pilot site for the Maternity Outcomes Signal System (MOSS), which assists in identifying any potential safety issues or themes arising in maternity care. This tool remains in the testing phase at present.
- At UHBW the Women's Patient Experience Group reviews complaints, results from monthly in-patient survey and Friends and Family Test (FFT), using IQVIA (a patient feedback hub) to consider themes. From this data, a patient experience action plan has been developed. The MNVP are part of our Patient Experience Group and gather feedback from women and families, which is then included in the action plan.
- In the 2024 National Maternity Survey, scores indicated that UHBW performed in the top 30% of Trusts nationally.
- Since the implementation of the BadgerNet IT System, concern has been raised that there has been a reduction in the quality of completed documentation, through digital midwife fellows and support from the digital team areas of improvement are being developed.
- At NBT MNSI findings and recommendations are overseen and implemented by the continuous improvement and learning team. Local findings are embedded into training along with service user case studies (i.e. National safety standards for invasive procedures (NatSSIPS) into PRactical Obstetric Multi-Professional Training (PROMPT). Learning is shared in both organisations with staff on a regular basis through various routes i.e. hotspot training and newsletters.
- At NBT National Maternity and Perinatal Audit outlier response and proactive workplan ongoing to reduce 3rd and 4th degree tears.
- At UHBW and NBT there is proactive use of MBRRACE-UK tool to monitor and report neonatal and still birth rates.
- Implementation of Birmingham Symptom Specific Obstetric Triage System (BSOTS) to improve, standardise and monitor the triage of women contacting maternity services.

LMNS

- The LMNS has worked with both NBT and UHBW maternity and BI teams to develop an intelligent system wide dashboard with a focus on identifying where inequity in outcomes occurs
- This will be the first maternity dashboard in the South West where the data will pull directly from Badgernet in real time allowing all outcomes to be interrogated by ethnicity, IMDB, age, postcode etc which will allow us to understand where we need to focus Quality Improvement.

Areas for continued development

- At both UHBW and NBT, there is a continued focus on data quality and use of BadgerNet to support high quality evidence of care and decision making, this will further improve the data available for benchmarking and reviewing outcomes of care.
- A recognised need for data in real time and additional business intelligence and analyst resource to support with quality improvement and transformational, proactive change.
- A clinical area performance dashboard of the service daily to identify hot spot areas, similar to that used in the Emergency Department.
- Improve accessibility and capacity of digital and IT support.

- **Retain a laser focus on tackling inequalities, discrimination and racism within your services, including tracking and addressing variation and putting in place key interventions. A new anti-discrimination programme from August will support our leadership teams to improve culture and practice. This also means accelerating our collective plans to provide enhanced continuity of care in the most deprived neighbourhoods, providing additional support for the women that most need it.**

UHBW and NBT

- UHBW has a Diversity and Inclusion midwife in post, who works both clinically and in a practice development role. Race inequalities and anti-discrimination is included within the multi-professional maternity statutory and mandatory training for staff.
- UHBW and NBT were early adopters of the Black Maternity Matters training programme, which the senior midwifery and obstetric leaders across maternity and neonatal services have undertaken, including the Director of Midwifery, Lead Obstetrician and Divisional Director. The programme is now being rolled out to span staff of all grades and disciplines with Maternity and Neonatal Services. In addition, senior and Executive-level leaders within both organisations, including the Chief Executive have participated in the programme. AT UHBW, A quality improvement project linked to the knowledge gained from Black Maternity Matters is currently being developed, which will dovetail with the Trust's pro-equity programme.
- UHBW has midwifery continuity teams in areas of the city with high numbers of global majority patients, and there is a dedicated consultant clinic in those areas. This has helped to promote patient engagement and start to build the trust of our local communities. Enhanced maternity support workers in these areas have enabled the service to understand the barriers preventing some communities in engaging with maternity services early during their pregnancies.
- At NBT a continuity model is in place at the Eastwood Park Prison, the home birth team also offers a continuity model for women, the Patchway Clinic and complex care teams also support aspects of continuity for our more deprived and or vulnerable populations in South Gloucestershire.

- At NBT Instagram has been launched following a study to understand how global majority women engage with social media, with Instagram being the most used platform.
- The BNSSG LMNS is part of the Race and Health Observatory Learning Action Network: Maternal Health and focuses on improving outcomes for premature babies born to our global majority women, both organisations have been actively engaged in this work.
- At UHBW there are Equality Diversity and Inclusivity (EDI) advocates within maternity and neonatal departments and Equality and Diversity is a standing agenda item at the St. Michael's Hospital Leadership meeting, held monthly. The item is used to raise awareness, discuss and cascade key aspects of Equality and Diversity information and links closely to the Trust pro-equity agenda. The Director of Midwifery and Nursing is the Southwest Regional Representative at the National Senior Ethnic Minority Leaders in Maternity meeting, and cascades information and learning.
- A joint (NBT and UHBW) translation service has been launched, improving timely access to translator services, widening languages available and access to video call.

LMNS

- BNSSG LMNS actively continues to support the Black Maternity Matters anti-racism training for perinatal staff to support the goal of improving outcomes and experience of our global majority population within maternity and neonatal services.
- We have had more than 300 perinatal staff attend Black Maternity Matters training, including all of our system senior leaders.
- The Health Innovation West of England have just released their full evaluation report of the second training cohort. Key findings include:
    - Increased confidence among staff to recognise and address racism
    - High levels of participant motivation and a shift towards meaningful action, including team level change initiatives
    - Strong endorsement of the safe, reflective learning environment, with many describing the training as 'life-changing' and distinct from prior equality, diversity and inclusion courses.
- NHSE requirement for all LMNS's to publish their Equity & Equality Action Plan- this has been achieved and is on the ICB website.
- Highlight report developed to capture system equity and equality achievements to share with system and region showing our progress against all objectives.
- We will now work closely with the ICB communications team to make an accessible easy read version for the public which will be shared widely
- MNVP engaged re KPIs for improving public perception of maternity services related to improved outcomes.
- One of only 10 systems across England to be chosen to work with the Race and Health Observatory Learning and Action Network
- Aim to reduce health inequalities and improve outcomes for Black and Asian mothers and babies
- 15-month project within BNSSG focusing on pre-term births and the disparity with antenatal interventions between our white and global majority population
- During the project we have worked collaboratively with trauma informed anti-racist practitioners to gain the stories and experiences of black mothers within our system who have lived experience of pre-term birth to guide the focus of quality improvement with an anti-racist lens

Areas for continued development

- On going bespoke anti-discrimination, and racism training in addition to the maternity mandatory and statutory training for all maternity and neonatal staff which will dovetail with the UHBW and NBT pro-equity and antiracism programme.
- Widen the focus on quality improvement work to other protected characteristics such as disability.
- Improve reporting of data relating to protected characteristics, specifically in relation to patient safety, complaints, quality and outcome data.
- Continued involvement with the Black Maternity Matters programme, supported by Health Innovation West of England.
- We will implement the new anti-discrimination programme from NHS England once published.
- Build our strategic ambition and delivery plan to be the safest place for a black woman to have a baby in the United Kingdom.

4. Recommendations

The Board is asked to discuss our initial response to the five immediate actions to improve maternity and neonatal care (as outlined in the letter from Sir Jim Mackey and Duncan Burton), whilst considering areas of continued development, improvement, oversight and any additional assurance required.

To:
- Trust CEOs and chairs

cc.
- ICB CEOs
- Regional directors

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

23 June 2025

Dear colleague

Maternity and neonatal care

Today, the Secretary of State for Health and Social Care has announced a rapid independent investigation into maternity and neonatal services. He has also announced an independent taskforce, alongside immediate actions to improve care.

This announcement comes on the back of significant failings in maternity services in parts of the NHS and we need – with real urgency – to understand and address the systemic issues behind why so many women, babies and families are experiencing unacceptable care.

It is clear that we are too frequently failing to consistently listen to women and their families when they raise concerns and too many families are being let down by the NHS. There remain really stark inequalities faced by Black and Asian women and women in deprived areas. In addition, we continue to have significant issues around safety and culture within our maternity workforce.

These have been persistent issues over recent years, so we now need to act with urgency to address these. The vast majority of births in England are safe and we have teams providing good and outstanding maternity and neonatal care every day. However, the variation in quality and performance across the NHS underscores why we can't accept the status quo.

So, between now and December, the independent investigation will conduct urgent reviews of up to 10 trusts where there are specific issues. We'll meet with relevant leaders of several organisations over the next month and while there will be some challenging conversations, we are really keen to hear what more we can be doing to support you to go further and faster in improving maternity and neonatal care.

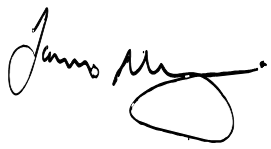
In the meantime, we ask every local NHS Board with responsibilities relating to maternity and neonatal care to:

- Be rigorous in tackling poor behaviour where it exists. Where there are examples of poor team cultures and behaviours these need addressing without delay.

- Listen directly to families that have experienced harm at the point when concerns are raised or identified. It is important we all create the conditions for staff to speak up, learn from mistakes, and at the same time staff who repeatedly demonstrate a lack of compassion or openness when things go wrong need to be robustly managed.
- Ensure you are setting the right culture: supporting, listening and working, through coproduction, with your Maternity and Neonatal Voice Partnership, and local women, and families.
- Review your approach to reviewing data on the quality of your maternity and neonatal services, closely monitoring outcomes and experience and delivering improvements to both.
- Retain a laser focus on tackling inequalities, discrimination and racism within your services, including tracking and addressing variation and putting in place key interventions. A new anti-discrimination programme from August will support our leadership teams to improve culture and practice. This also means accelerating our collective plans to provide enhanced continuity of care in the most deprived neighbourhoods, providing additional support for the women that most need it.

This is really challenging for all of us and the most important step we have to take to rebuild maternity and neonatal care is to recognise the scale of the problem we have and work together to fix it.

This will require us all to work together and this includes teams where care is outstanding where you will have a role to play in sharing best practice and supporting others to return their services to where their communities and staff want and need them to be. We hope you understand the importance of this and, as always, please get in touch if you want to discuss this ahead of the CEO call later in the week.



Sir Jim Mackey
Chief Executive

Duncan Burton
Chief Nursing Officer for England