

Meeting of the ICB Board

Date: Wednesday 30th September 2026

Time: 11.15 – 13:00

Location: Ground Floor Committee Room, Shire Hall, Gloucester

Agenda Number:	7
Title:	National Maternity and Neonatal Reviews 2026: Implications and Assurance for the ICB
Confidential Papers	<i>Commercially Sensitive</i> No <i>Legally Sensitive</i> No <i>Contains Patient Identifiable Data</i> No <i>Financially Sensitive</i> No <i>Time Sensitive – not for public release at this time</i> No <i>Other</i> No
<i>Purpose: Discussion and For Information</i>	
Key Points for Discussion:	
National context. The 2026 Ockenden review into Nottingham Hospital and Baroness Amos's Independent National Maternity and Neonatal Investigation describe recurring system-wide concerns: women and families not being listened to; inequity and discrimination; workforce and capacity pressure; fragmented governance; inconsistent recognition and escalation of deterioration; weak learning after incidents; poor culture and psychological safety; and estates and digital constraints. • National response: NHS England's 10 Point Plan sets urgent actions while the National Maternity and Neonatal Taskforce develops a National Action Plan expected in December 2026. • Local position: BNSSG and Gloucestershire have established quality oversight, escalation and experience mechanisms, with further work required on explicit joint executive accountability, staff listening, equity, triage, estates, trauma-informed practice and consistent evidence of delivery. • Board role: maintain visible scrutiny of provider delivery, risks, outcomes, experience and inequalities, and support shared learning through the clustered Local Maternity and Neonatal System.	

Recommendations:	The Board is asked to: • note the findings and implications of the 2026 national maternity and neonatal reviews; • note the current BNSSG and Gloucestershire position against the NHS England 10 Point Plan; • endorse continued ICB and provider Board oversight through existing quality governance and the clustered Local Maternity and Neonatal System; • support development of a consolidated action and assurance plan, including clear executive ownership, milestones, risks and escalation; and • request a further progress report following publication of the National Action Plan in December 2026.
Previously Considered By and feedback:	Provider Trust Boards and existing maternity and neonatal quality governance arrangements. The NHS England post-death care Board Assurance Statement was submitted to both Trust Boards by 31 July 2026.
Management of Declared Interest:	No specific conflict of interest is identified from the source material.
Risk and Assurance:	There is a risk of avoidable harm, poorer experience and loss of public confidence if national learning is not translated into timely, evidenced local action. Principal controls include Perinatal Quality Oversight reporting, provider escalation arrangements, incident and complaints processes, workforce and acuity monitoring, maternity triage improvement, lived-experience input and regional assurance.
Patient and Public Involvement:	Women's and families' experience is central to the national findings and the local response. Both systems have Maternity and Neonatal Voices Partnerships aligned to national guidance. Experience data, Friends and Family Test feedback and complaints are included within quality oversight. No formal consultation is proposed because this paper provides assurance rather than seeking approval for a service change.
Financial / Resource Implications:	No specific financial commitment is requested through this paper.
Legal, Procurement, Policy and Regulatory Requirements:	No procurement decision is sought. The ICB and providers must continue to meet statutory and regulatory duties relating to quality, safety, equality, candour and

	public involvement. Any future commissioning, workforce, digital or estates proposals arising from the national action plan will require separate legal, procurement and governance assessment.
How does this impact on health inequalities, equality and diversity and population health?	The national reviews identify persistent inequalities and the impact of racism, discrimination and communication barriers. Local work includes Black Maternity Matters activity and development of an equity dashboard with the Intelligence Centre, pending national rollout of the Perinatal Equity and Anti-discrimination Programme. An Equality and Health Inequalities Impact Assessment should accompany any material service redesign.
Insights from population level data	The source presentation does not include a detailed local quantitative dataset. Current assurance draws on maternity experience measures, Friends and Family Test feedback, complaints, clinical audit, acuity information and escalation returns. The proposed equity dashboard should enable more consistent analysis of outcomes and experience by population group and geography. A future update should include trend, variation and benchmark data.
ICS Green Plan and the Carbon Net Zero target?	No direct carbon impact is identified from this assurance paper. Future estates, digital and service redesign proposals should assess carbon impacts and seek alignment with the ICS Green Plan, including efficient use of estate, travel and digital infrastructure.
Communications and Engagement:	Outputs from staff listening events and existing feedback routes should inform a shared action plan. Communications should explain the national reviews, local response, routes for women, families and staff to raise concerns, and how progress will be reported through public Board governance.
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Sponsoring Director:	Rosi Shepherd Chief Nursing Officer

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Report title: National Maternity and Neonatal Reviews 2026: Implications and Assurance for the ICB

a. 1. Executive summary and background

The publication of the 2026 Ockenden review into maternity services at Nottingham University Hospitals NHS Trust and Baroness Amos's Independent National Maternity and Neonatal Investigation represents a significant national patient-safety and quality milestone. Although the reports arise from national and provider-level investigations, their findings require every integrated care board and provider Board to test whether local governance, culture, workforce, clinical pathways and learning systems provide sufficient assurance.

The recurring themes are not confined to a single organisation: women and families were not consistently listened to; racism, discrimination and inequalities affected care; workforce and capacity pressures undermined safety; leadership, governance and teamworking were insufficiently reliable; deterioration was not always recognised or escalated; investigations and organisational learning were weak; and estates and digital systems did not consistently support safe care.

NHS England has responded with a 10 Point Plan of urgent actions, alongside a national assurance process. Trusts are expected to submit a Board-approved baseline assessment by 25 September 2026 and a progress update by 31 December 2026. The National Maternity and Neonatal Taskforce is developing a wider National Action Plan expected in December 2026.

The Thirwell Report (published last week) identified significant failures in culture, safeguarding, governance, leadership and escalation processes that contributed to missed opportunities to protect babies at Countess of Chester Hospital. NHS England has directed all NHS trust and ICB boards to review the findings and seek assurance that robust patient safety, safeguarding, speaking-up and governance arrangements are in place locally. Key themes include fostering a culture of openness and professional curiosity, strengthening safeguarding and escalation processes, improving oversight of patient safety intelligence, ensuring transparency with families, and reinforcing leadership accountability. The Inquiry's recommendations align closely with ongoing maternity and neonatal safety improvement programmes and should inform future board assurance and oversight.

b. 2. National findings and required response

The Ockenden review considered more than 2,500 family cases and set out 18 Immediate and Essential Actions. It described long-standing failures in listening, leadership, governance, staffing, clinical care, learning, workplace culture, bereavement support and

equitable care. The Amos investigation reviewed evidence across 12 NHS trusts and made eight recommendations aimed at long-term system and cultural transformation. Its central conclusion is that incremental improvement is insufficient and that maternity and neonatal services require a more coherent, accountable, equitable and person-centred model.

The government has announced the creation of a Maternity and Neonatal Commissioner and additional national investment in maternity and neonatal estates. These measures reinforce the expectation that local response should combine immediate delivery with preparation for longer-term reform.

NHS England has also published a response to the Thirwell Report with recommendations and actions that are currently being reviewed locally. However the central message is that the Inquiry is not solely about neonatal services. It highlights the need for every NHS organisation to ensure that concerns are listened to, safeguarding is prioritised, safety signals are acted upon promptly, and governance arrangements enable effective challenge and accountability.

2. 3. Local position against the NHS England 10 Point Plan

Urgent action	Current local position and next steps
Listening to women and families, including Martha's Rule	Gloucestershire was an early adopter and rolled Martha's Rule into maternity in April 2025, with support to BNSSG providers. Both systems use experience, complaints, Friends and Family Test and clinical audit information through the Perinatal Quality Oversight Model; both have a Maternity and Neonatal Voices Partnership.
Joint Board-level accountability	Current oversight is led by the Chief Nurse with active Medical Director support. Governance documentation should explicitly reflect shared accountability, with visible obstetric, midwifery, neonatal and operational leadership when risks and assurance are considered.
'Amos into action' staff listening	Listening events are taking place across BNSSG hospital sites and Gloucestershire is being supported to establish its approach. Named leads, attendance support, joint action plans and Board-level consideration are required, including action on estates themes.
Equity and anti-discrimination	Black Maternity Matters activity is continuing and an equity dashboard is being developed with the Intelligence Centre. The system awaits rollout of the national Perinatal Equity and Anti-discrimination Programme.

24/7 safety and responsiveness	Redeployment and acuity are monitored across sites. Daily huddles and OPEL situation reporting support escalation, with flow midwives used locally. Assurance should demonstrate the impact of these controls on outcomes and staff experience.
Homebirth services	Gloucestershire are working towards reinstating their homebirth services while progressing community transformation. BNSSG providers continue to offer homebirth and have completed urgent reviews; PROMPT scenarios are being developed to strengthen multidisciplinary learning.
Humanity, candour and trauma-informed response	Providers have approved Patient Safety Incident Response Framework policies and plans, with a maternity safety priority on maternal and neonatal deterioration. BNSSG uses a panel, including Maternity and Neonatal Voices Partnership input, where complainants remain dissatisfied. Further trauma-informed training is subject to funding.
Safe and effective maternity triage	Providers are benchmarking against the national specification and use the Birmingham Symptom-specific Obstetric Triage System. Gloucestershire has a triage improvement plan and dashboard; estates improvements are under way, including significant estates work at St Michael's Hospital.
Post-death care	The required Board Assurance Statement was completed and submitted to both Trust Boards by 31 July 2026. Regional oversight continues through the Regional Quality Group.

3. 10. Next steps and proposed assurance

- a.** Complete and maintain a single clustered Local Maternity and Neonatal System action and assurance plan mapped to the 10 Point Plan and subsequent National Action Plan.
- b.** Confirm named executive and operational owners, milestones, evidence requirements, dependencies and escalation routes for every action.
- c.** Ensure provider Board-approved baseline and progress submissions meet national deadlines and are reviewed through ICB quality governance.
- d.** Bring together provider performance, safety, experience, workforce and equity intelligence into a concise Board dashboard.
- e.** Report staff-listening findings and agreed actions, including workforce, culture and estates themes, with evidence that feedback has led to change.
- f.** Return to the Board following publication of the National Action Plan in December 2026 with a refreshed gap analysis and delivery plan (including local benchmarking against the Thirwell Inquiry).

Appendices

Glossary of terms and abbreviations

Key terms used in this paper are set out below.

Term	Meaning
BNSSG	Bristol, North Somerset and South Gloucestershire
BSOTS	Birmingham Symptom-specific Obstetric Triage System
EHIA	Equality and Health Inequalities Impact Assessment
ICB	Integrated Care Board
LMNS	Local Maternity and Neonatal System
MNVP	Maternity and Neonatal Voices Partnership
NHS England	National body responsible for leading the National Health Service in England
OPEL	Operational Pressures Escalation Levels
PROMPT	Practical Obstetric Multi-Professional Training
PSIRF	Patient Safety Incident Response Framework