Appendix 1

Theme	Detail of metrics used for WUTH Perinatal Quality and Safety Model (PQSM)	Number	RAG	Narrative / Actions taken
Clinical Care	Number of stillbirths	1		REC's completed and MNSI referral; abruption - c/section
	Number of neonatal deaths (before 28days) at WUTH	0		No NNU deaths
	Number of maternal deaths (up to 28 days following delivery)	0		No maternal deaths
	Post partum haemorrhage >1500mls	6		x 1 PHH recorded
	Rates of HIE where improvements in care may have made a difference to the outcome	0		No HIE
	Number of occasions where the Delivery Suite Coordinator is not supernumerary at start of shift	0		100% compliant
	Number of times when the Delivery Suite Coordinator is not supernumerary for a period of one hour or more during a shift	0		Maintain shift leader to be supernumery at start of shift and throughout as best practice
	% Compliance of 1:1 care in labour	100%		Data captured via 4 hourly BR Plus activity/acuity, achieved 100% of time, escalation processes followed to revert to supernumerary status within 1 hour
	%Consultant presence at delivery when indicated (as per RCOG Guidance)	100%		Monthly audit as per RCOG guidance and guidance updated to reflect RCOG; submitted as part of MIS Year 6
	Midwifery staffing is below BR+ Acuity	Yes		P/N Ward acuity consistently in the Red RAG rating for acuity/activity; BR Plus report received in March 2025 and staffing levels suboptimal; business case required to support an increase in establishment
	Midwifery staff absence rate in month (sickness)	6.60%		Trust processes implemented and additional support offered by HR for hot spot areas; above Trust recommended target; national rate 5.0% and reported as below
	Midwifery vacancy rate	10.00%		Low vacancy rate consistently reported; 7.96 wte vacancy permanent; 4.3 wte additional out to advert; 3wte temporary hours; will most likely carry until Sept 25
	Midwife : Birth ratio	01:26		Within parameters
	Number of times transfer in to the Neonatal unit for Level 3 care has been declined to internal transfer	0		Nil
	Number of times transfer in to the Neonatal unit for Level 3 care has been declined to external transfer	0		Nil
	BAPM compliance - Neonatal medical staff	Yes		Consultant recruited; org change underway for 24/7 cover at weekends to achieve BAPM compliance
	BAPM compliance - Neonatal nursing staff	Yes		Workforce report to BoD annually demonstrates compliance
	Number of times Maternity unit has been on divert/closed to admissions	0		Nil; mutual aid requested
	Total number of Red Flags reported	20		Theme: delay in providing pain relief
Service user e	Staff survey	37%		Divisional compliance for 2024 staff survey 37%, midwifery staff groups below national average, requires improvement; action plan produced with key priorities
	CQC National survey	Yes		Published and action plan in place; repeat due Feb 2025; report to BoD at next quarterly report
	SCORE Survey	Yes		Participated in 2024; facilitated workshops and ongoing action plan
	Feedback via Deanery, GMC, NMC	No		Nil of note
	%Consultant presence at delivery when indicated (as per RCOG Guidance)	100%		Monthly audit as per RCOG guidance and guidance updated to reflect RCOG; submitted as part of MIS Year 6
Leadership and relationships	New leadership within or across maternity and/or neonatal services	Yes		Q&S Lead Matron starting 26/9/25; Risk Midwife internal recruitment commencing 4/8/25
	Concerns around the culture / relationships between the Triumvirate and across perinatal services	Nil		Good working relationships between teams / directorates
	False declaration of CNST MIS	No		MIS Year 6 submitted by 3/3/25; appeal relaing to data transcription error with Safety Action 1 - appeal rejected; MIS Year 7 launched April 2025
	Concerns raised about other services in the Trust impacting on maternity /neonatal services e.g. A&E	No		Nil of note
	Concerns raised about a specific unit e.g. Highfield Birthing Unit	Yes		Maternity ward concerns re: staff attitude, poor food options and inadequate pain relief; action plan and close weekly monitoring; co-production with MNVP
Safety and learning culture	Lack of engagement in MNSI or ENS investigation	No		Positive feedback quarterly review meetings and transparency through number of rejected cases
	Lack of transparency	No		Robust governance processes
	Learning from PSII's, local investigations and reviews not implemented or audited for efficacy and impact	No		Learning shared internally and via MNSG (NW region)
	Learning from Trust level MBRRACE reports not actioned	No		Nil of note
	Maternity/Neonatal Safety Champion concern; negative feedback; escalation	Nil		Regular safety champion meetings and walkabouts; all feedback actioned and feedback given
	Recommendations from national reports not implemented	Yes		CQC inspection publication action plan in progress to address quality improvements in line with recommendations; report to BoD quarterly progress
Incident reporting	Number of PSIRF reported incidents graded moderate or above	14		Reporting for July 2025; high incidences relating to staffing issues and acuity levels
	Number of Maternity or Neonatal PSII's	0		No new PSII's for maternity; x 1 ongoing for NNU
	Number of cases referred to MNSI	1		x 1 New referral
	Delays in reporting a PSSI where criteria have been met	0		N/A
	Reported Never Events	0		Nil for maternity
	Never Events which are not reported	0		N/A
	MNSI/NHSR/CQC with a concern raised or a request for information	0		N/A
	Recurring Never Events indicating that learning is not taking place	0		N/A
	All safery action 1 report to MBBRACE within timeframe to include FQ's	Yes		Since data entry error all cases and FQ's reported as MIS timescales
	Poor notification, reporting and follow up to MBRRACE-UK, NHSR ENS and HSIB	0		N/A
Governanc e processes	Unclear governance processes / Business continuity plans not in place	Nil		Clear governance processes in place following PSIRF; awaiting revised publication for maternity services expected 2025; LMNS feedback required assurance of governance referrals to external organisations are made by maternity MDT team and not central governance
	Ability to respond to unforeseen events e.g. pandemic, local emergency	Yes		Maternity and Neonatal services responded to a major incident with
	Number of maternity/neonatal risks on the risk register overdue	0		Nil overdue
	Number of maternity/neonatal risks on the risk register with a score >12	33		NNU estates and IPC - plans to address; all reviewed up-to-date with mitigation and actions
CQC inspection and DHSC or NHSE/I request for support	DHSC or NHS England Improvement request for a Review of Services or Inquiry	No		Nil to report this month
	Coroner Regulation 28 made direct to Trust	No		CQC reports published in April 2023 'GOOD' for maternity services
	An overall CQC rating of Requires Improvement with an Inadequate rating for either Safe and Well-Led or a third domain	No		N/A
	CQC Rating overall	GOOD		N/A
	Been issued with a CQC warning notice	No		N/A
	CQC rating dropped from a previously Outstanding or Good rating to Requires improvement in the safety or Well-Led domains	No		N/A
	Been identified to the CQC by HSIB with concerns	No		N/A

Select protective marking

Perinatal Quality Oversight Model

Contents

Perinatal Quality Oversight Model 1

1. Introduction 3
2. Purpose, Responsibilities and Principles 4
3. Roles in Perinatal Oversight across the NHS 6
3.1. Trust 6
3.2. System 7
3.2.2 Service User Voice 8
3.3 Region 9
3.3.2 Service User Voice 10
3.4 National 10
4. Identifying risks, taking proportionate action and triggering escalation 11
4.1 Action and support 12
4.1. Who to involve at each stage 14

1. Introduction

The Perinatal Quality Surveillance Model (PQSM) was published in December 2020 and Trusts and systems were expected to implement the actions with immediate effect. Following revision to bring it up to date, this document is now being re-published as the Perinatal Quality Oversight model (PQOM). In recognition that neonatal services are interdependent with maternity services, we refer to maternity and neonatal in terms of 'perinatal' throughout this document.

The NHS is currently going through a period of transition to enable delivery of the new government mandate and the 10 Year Health Plan. Whilst we are keen to provide clarity for systems and Trusts on perinatal governance, it is also important to recognise that there may be further changes to ensure alignment with new ways of working and therefore this model will be reviewed again following publication of the 10-Year Health Plan and related documents.

The PQOM was established in response to the need to proactively identify trusts that require support before serious issues arise, seeking to provide for consistent and methodical oversight of NHS perinatal services. The model has also been developed to gather ongoing learning and insight, to inform improvements in the delivery of perinatal services.

The provider trust and its board ultimately remain responsible for the quality of the services provided and for ongoing improvement. The board is supported in this by the perinatal leadership team and the Board Safety Champion. The PQOM supports trusts and Integrated Care Boards (ICBs) to discharge their duties, while providing a mechanism for escalation of any emerging risks, trends or issues that cannot be resolved at local level or would benefit from wider sharing.

Since the implementation of the PQSM, ICBs have been established with the general statutory function of arranging health services for their population. This role is currently being reshaped to lay the foundations for delivery of the 10 Year Health Plan and will focus on strategic commissioning to improve population health, reduce inequalities and improve access to consistently high-quality care.

Good practice principles for quality management are set out in National Quality Board's (NQB) National Guidance on System Quality Groups and includes creating an open culture and learning system that enables improvement across a shared understanding of needs and issues. The NQB's Guidance on Risk Response and Escalation also sets out how quality risks and concerns should be mitigated and managed through the established governance, in alignment with the NHS Oversight and Assessment Framework and other frameworks.

This includes the use of Rapid Quality Reviews and Quality Improvement Groups where concerns are being identified and need to be managed.

Quality is defined in this document in accordance with the National Quality Board's Shared Commitment to Quality, as care that is safe, effective, equitable, provides a personalised experience, is well led and sustainable.

2. Purpose, Responsibilities and Principles

As detailed in the Three Year Delivery Plan for Maternity and Neonatal Services, the purpose of the PQOM is to have in place robust oversight of quality, identifying and escalating risks early, helping to ensure a positive experience and outcomes for women and their families.

The model provides a structure with clear lines of responsibility and accountability for addressing and escalating quality and safety risks at trust, ICB, region and national level.

- Trusts are the main operational unit of maternity and neonatal services in the NHS and the employer of most staff. Trust boards have accountability for perinatal oversight, with a statutory duty to ensure the safety of care, including ensuring staff have the resources they need and to consider health inequalities.
- Integrated care boards (ICBs) commission most maternity services have now had responsibility for neonatal care delegated to them. Each ICB will be a partner in an integrated care system (ICS). ICSs are a partnership of organisations that plan and deliver joined up health and care services. ICBs commission maternity and neonatal voices partnerships (MNVPs) which are designed to facilitate participation by women and families in local decision making. ICBs (and NHS England) have legal duties (under the Health and Care Act 2022) to take account of health inequalities issues in the exercise of their functions.
- Neonatal Operational Delivery Networks (also known as Neonatal Critical Care Clinical Networks or NCC clinical networks) were established to ensure high quality neonatal care, improving outcomes for all babies and families, providing safe expert care as close to their home as possible, and keeping mother and baby together while they need care. Neonatal Operational Delivery Networks (ODNs) help to manage patient flow across the network, balancing capacity and demand, ensuring services meet the needs of patients
- Until April 2025, NHS England had statutory accountability for commissioning neonatal services. By April 2025 this will be delegated to ICBs. NHS England has a

responsibility to share and spread good practice, learning and improvement and will work with regulators to ensure there is a coherent system of quality oversight and regulation in place.

It is everyone's responsibility to provide or support high quality care. That includes a responsibility at each level of the NHS to understand the quality of care and identify, address, and escalate risks. Quality care must be equitable, focused on reducing inequalities and addressing wider determinants of health.

We have sought to improve our approach to quality oversight at trust, ICB, regional, and national level in alignment with the NHS Oversight Framework. Quality oversight involves bringing together all relevant partners at each level to facilitate robust understanding and action, informed by shared and accurate information.

Safety oversight should take place as near to the patient level as possible. An ICB and its related provider trusts, led by their boards, should take responsibility for monitoring and improving quality. Within the ICB this will be embedded in the commissioning cycle. Only if an issue cannot be **resolved** at this level should it be formally escalated to the next level, unless there are significant failings representing a threat to service users/staff or opportunities for learning. **Resolution** means that there are active action/ improvement plans to meet the required standards which are being consistently delivered against in a timely and effective manner.

The role of regional and national oversight is usually to support the Trust and ICB to make the required improvements rather than leading those improvements – this will vary depending on identified need.

Shared working principles across all levels:

- Agree shared ways of working, based on trust, collaboration, sustainable improvement and equality.
- Develop shared views of the quality, operational, workforce and financial position in all circumstances.
- Share intelligence in an open, timely way.
- Proactively monitor and follow up on early warning signs, including feedback from staff and people using services.
- Agree responsibilities, accountabilities and governance routes.
- Monitor and mitigate future risks.

3. Roles in Perinatal Oversight across the NHS

3.1. Trust

3.1.1 The role of provider trusts includes:

- statutory responsibility for high-quality services which are safe, effective, efficient and take account of health inequalities
- effective system working and delivery of their contribution to ICS strategies and plans.

We expect trusts to carry out dynamic monitoring of the quality of maternity and neonatal services, supported by clinically relevant data which should be informed by the key data items and wider insights identified in Appendix 1.

Perinatal Board Safety Champions have been in place since 2017, their remit is to develop strong partnerships, promote the professional cultures needed to deliver better care, and play a central role in ensuring that mothers and babies receive the safest care possible by adopting best practice.

Each trust should have in place the following to ensure board oversight for perinatal quality and safety is robust:

1. A Board Safety Champion Non-Executive Director (NED) is visibly working alongside the board safety champion for perinatal (midwifery, obstetric and neonatal) to provide objective, external challenge and enquiry.
2. Each trust must also have an identified frontline midwifery, obstetric and neonatal safety champion who meet on a regular basis with the board safety champion(s)
3. The trust board (or an appropriate sub-committee with delegated responsibility) discusses perinatal safety intelligence at least quarterly, demonstrates professional curiosity and is responsible for shared learning across the organisation. Discussions must include ongoing monitoring of services and trends over a longer time frame; concerns raised by staff and service users; progress and actions relating to a local improvement plan utilising the Patient Safety Incident Response Framework (PSIRF). For neonatal incidents, the Trust should work with the relevant neonatal ODN to identify and manage risks alongside the ICB.
4. A locally agreed board report which should consider including the recommended measures set out in Appendix 1. This should be presented by a member of the perinatal leadership team to provide supporting context. Data should include

analyses by subgroups where possible, including as a minimum ethnic group and deprivation of the mother's postcode, to identify potential health inequalities for investigation and action.

3.1.1. Share safety and quality intelligence with ICB

Providers are expected to share safety and quality intelligence with their ICB through the commissioning cycle and must escalate any risks where mitigating actions are not bringing about the required change within agreed timeframes. Providers are also expected to identify opportunities for shared learning.

Where common issues/contributory factors to poor outcomes are identified these can be addressed as part of the Trusts Patient Safety Incident Response Plan.

3.1.2. Share safety and quality intelligence with Neonatal Operational Delivery Network (ODN)

As per the neonatal critical care service specification and Trust contracts, provider trusts must have a process for sharing patient safety concerns with their Neonatal ODN. This should include proactive engagement on quality and workforce issues

Trusts must engage with ODN governance processes and attend relevant governance meetings to raise concerns appropriately to the ICB/NHS England region specialised commissioning.

3.1.3. Service User Voice

The MNVP lead is a key partner to the trust frontline safety champions. They should be a member of relevant trust maternity and neonatal safety meetings such as Safety Champion meetings, governance meetings, perinatal quality meetings, and audit meetings to provide scrutiny through a service user voice lens and support transparency and oversight to the quality of the service. They should be able to contribute insight from surveys, walkabouts and other engagement activity carried out by the MNVP. MNVP leads should receive feedback to any risks raised including actions taken to address any safety issues.

3.2. System

3.2.1 Integrated Care Boards

As we transition to new ways of working, ICBs will focus on strategic commissioning to improve population health, reduce inequalities and ensure access to high quality care.

ICBs have the following responsibilities:

- responsible for achieving the 4 principal Integrated Care System (ICS) purposes: improving population health and healthcare; tackling inequalities in outcomes,

experience and access; enhancing productivity and value for money; and supporting social and economic development
- statutory responsibility for arranging local services through effective strategic commissioning
- hold their partners in the ICS to account using the system levers that bind them together, such as their joint system plans, partnership agreements, joint committees and collaboratives

ICBs should continue to manage clinical quality risks in line with the National Quality Board guidance on risk response and escalation

ICBs should retain expertise in strategic commissioning of maternity and neonatal care. This will include monitoring outcomes, identifying unwarranted variation and setting priorities for quality assurance. Quality management will primarily be via contractual routes. Commissioning includes a systematic approach to user involvement and co-design.

NHS England has commissioned a review of direct commissioning functions to determine where accountability and responsibility should sit in future and how these can most effectively be supported but in the interim, ICBs have delegated responsibility for commissioning Neonatal care services. With respect to Neonatal services, ICBs should:

- Collaborate with their Neonatal ODN in the development, maintenance and review of provider patient safety incident response policies and plans
- where an ICB has concerns with neonatal services, they should, in the first instance, agree an action plan together with the relevant Neonatal ODN

Additionally, ICBs should:

- ensure that where there is an incident arising from the mental health of a woman who is pregnant or up to one year post-partum, any implications for maternity services or for joint working between maternity and mental health services are acted on.
- similarly, where there is a risk relating to pregnant women outside of maternity services (e.g. emergency departments (ED), ambulance services, primary care), joint working with maternity safety champions should be undertaken

3.2.2 Service User Voice

There should be strategic service user voice leadership embedded within the ICB maternity and neonatal strategic commissioning function. As per MNVP guidance this should enable a clear and accessible pathway for intelligence and insights from provider level MNVPs to feed into quality meetings and allow meaningful service user voice involvement.

3.2.3 Neonatal Operational Delivery Network

It is the role of the Neonatal ODN to:

- be responsible jointly to ICBs and regional specialised commissioning for the management of local pathways and monitoring of locally agreed targets
- be accountable to the regional team of NHS England via the appropriate board within the region
- agree with regional specialised commissioning and all ICBs within the network's geography a single network plan and deliverables as per the ODN Specification; this should be agreed and signed off by the region

The ODN is integral to neonatal oversight and is the lead for quality improvement. The ICB should work with the ODN across the perinatal pathway.

Each Neonatal ODN should:

- share data with the ICBs within its geography
- share intelligence on neonatal critical care services with the ICB
- escalate any identified risks and opportunities for shared learning to the ICB and regional team

3.3 Region

3.3.1 It is the role of the NHS England regional team to:

- provide oversight of ICBs' delivery of plans and performance and, through them, gain assurance of place-based systems and individual organisations
- translate national strategy and policy to fit local circumstances, ensuring local health inequalities and priorities are addressed
- share good practice, learning and improvement to support peer learning, including thematic learning
- support systems to manage quality in perinatal services, including statutory intervention if required
- discuss and escalate risks and concerns with the specialised commissioning quality governance group, national perinatal surveillance group and/or Regional Quality Group as appropriate
- work jointly with other regulators to share intelligence and support improvement, e.g. the Care Quality Commission (CQC)
- identify cross-cutting themes which may require a regional or national response such as additional policy guidance.

Each region will have a perinatal quality forum to consider insight from a wide range of quantitative and qualitative sources, examples of which include but are not limited to the key data items and wider insight identified in Appendix 1. Membership of the forum should be extended to specialised commissioning for neonatal critical care services, and to perinatal mental health as an associate member. This forum should have representation from other statutory agencies able to provide insight into maternity services such as CQC and Maternity and Neonatal Safety Investigations Programme (MNSI).

In addition, the regional perinatal quality group will determine whether to escalate to the National Perinatal Surveillance Group in order to manage risk and share and spread good practice, learning and improvement within maternity and neonatal services and also wider health services.

Where issues are escalated, it should be clear whether this is for management, decision or information. Requests for management/decision should not be sent to more than one meeting.

Any risks which cannot be resolved following discussion at national level or where expected progress is not being made, will be referred to the regional support group in order to agree what support can be provided to ICBs to enable delivery.

3.3.2 Service User Voice

A service user voice representative should be a member of regional maternity and neonatal safety meetings and be able to contribute insight from system MNVP leads or regional engagement activity as well as providing the service user lens on safety issues discussed.

3.4 National

3.4.1 It is the role of NHS England's national team to:

- set national strategy, priorities and incentives to improve standards of care
- with regions, facilitate supportive interventions to improve performance and outcomes
- lead on support for organisations where performance falls below an acceptable standard or there are governance concerns about an ICB or a provider which have led to entry into the recovery support programme.

The NHS England Maternity and Neonatal Programme operates the National Perinatal Surveillance Group (NPSG). This is the national quality oversight meeting for maternity and neonatal services, and is the national escalation point of the PQOM.

The purpose of the NPSG is to support the timely identification and escalation of concerns from regional teams and draw on insights from service users, regulators and other national bodies to inform decisions and subsequent action(s).

NPSG will also identify best practice and opportunities for shared learning. NPSG will provide oversight of Trusts on MSSP alongside the Recovery Support Programme.

NPSG reports into the Quality Surveillance Group – a committee of the Maternity and Neonatal Programme board.

NPSG will have representation from two nationally appointed service user voice representatives to provide the voice of women and families. They will be able to provide additional insight from issues and themes raised with them by regional service user voice representatives.

NPSG will have representation from specialised commissioning to ensure that any national risks relating to neonatal critical care services can be considered by the group and that there is cross-reference to the Specialised Commissioning Quality and Governance group. There should be a clear decision on whether risks raised and subsequent action are owned by NPSG or Specialised Commissioning Quality and Governance group.

4. Identifying risks, taking proportionate action and triggering escalation

Wherever possible, oversight, action and response should take place at trust level with the support of the governance team, safety champions and trust board, and other trusts in the System or Neonatal ODN. Based on discussions and sharing of insights, identified issues should prompt collective decision-making drawing on the views of representatives on the board or committee as to responsibility, accountability and action.

Systems are encouraged to use an appreciative inquiry approach to learning and oversight. Appreciative inquiry is a strengths-based approach to creating change. Rather than identify a problem and look at how to solve it, appreciative inquiry involves exploring what is already working and how to build on that.

Providers and ICBs are encouraged to use the following tools (also referenced in Appendix 1) to support the identification of risks:

- The Maternity and Neonatal Three Year Delivery Plan Oversight Tool (available via NHS Futures) for Trust level outcome and progress measures against the priorities set out in the delivery plan.
- The Maternity Services Dashboard for Trust level Clinical Quality Improvement Metrics, which benchmarks performance against peers.
- Local/system/region quality improvement dashboards (where available). We would encourage that these utilise, for example, run charts or statistical process control (SPC) to identify changes in trends and to benchmark against best practice. NHS IMPACT provides a recommended approach and key resources to support continuous improvement.
- Neonatal dashboards: National Neonatal Audit Programme (NNAP)/Specialised Services Quality Dashboard/ Specialised Services Oversight Reporting Tool.
- The MBRRACE-UK Real Time Data Monitoring Tool (available via local MBRRACE-UK accounts) for regular monitoring of critical safety issues for maternity and neonatal services; a potential excess in stillbirth and neonatal deaths over a period of time.
- In future (launch date TBC), the Maternity Outcomes Signal System (MOSS) which also relies on near-real time data will become available and will allow regular monitoring of critical safety issues within intrapartum care.

4.1 Action and support

Action and support for both trusts and ICBs where there is an identified concern in relation to maternity or neonatal services is aligned to the NHS Performance Assessment Framework, and, where needed, the Recovery Support Programme (RSP).

- Enhanced: If the provider is in **segment 1 or 2** then it would not normally receive support from the Maternity Services Support Programme (MSSP). Instead, the appropriate support offer would be determined at a Rapid Quality Review Meeting or equivalent that includes Provider, CQC, ICB/Neonatal ODN and region. This review meeting would also consider wider intelligence from regulatory bodies and stakeholders.

- Enhanced/Intensive: If the provider is in **segment 3** the support offer will be customised on the basis of recommendations from a Rapid Quality Review Meeting

including the Provider, ICB/Neonatal ODN, region and MSSP. There are 3 possible decisions:

a) If all are in agreement that intensive support is required rapidly than the trust could be entered onto the MSSP as part of the regionally agreed recovery plan.
b) Alternatively, the MSSP could be asked to undertake a targeted diagnostic visit to provide a greater depth of understanding around the challenges faced. This would occur over a matter of days and be conducted by a team that would ideally include Maternity Improvement Advisers as well as representatives of the ICS and/or region. This would have the benefits of providing a learning experience for all as well as contributing to greater alignment between members as to the appropriate way forward and would include the options of the Trust entering the MSSP or remaining under regional/ICB supervision.
c) Finally, the review meeting might conclude that MSSP input was not required with the region and ICB providing support and oversight of the improvement journey.

- Intensive: If the provider is in **segment 4** and going onto the Recovery Support Programme (**segment 5**) then entry to the MSSP would be considered. The MSSP will work in very close collaboration with the RSP, regional and ICB teams to ensure the sustainability of the improvement journey and agreeing clear exit criteria. Maternity Improvement Advisors operating within the MSSP will liaise with the relevant Neonatal ODN in order to address any safety and quality concerns relating to these services or the interface between neonatal and critical care services.

ICBs will receive oversight in line with the NHS Performance and Assessment Framework. Where there are identified concerns, an improvement plan would be agreed between the system and the region following a discussion with Regional Quality and Performance teams. ICBs experiencing the most serious / complex problems would enter the recovery support programme.

For ICBs and trusts allocated to segment 4, the national Recovery Support Programme (RSP) can provide focused and integrated support, working in a coordinated way with the ICB, regional and national NHS England teams. Where necessary, regional teams will lead and co-ordinate support requirements identified for the ICB.

Where risks have been escalated to NPSG, resulting action taken may include:

- referral of a risk to the regional support group for a discussion with one or all regions, for management between region and system
- development of national policy or guidelines
- referral to Specialised Commissioning Quality and Governance Group
- referral to the Maternity and Neonatal Quality, Performance and Surveillance Committee
- referral to the Executive Quality Group where there is a risk or learning broader than maternity and neonatal services.

4.1. Who to involve at each stage

As a minimum, core membership at each level of the PQOM should include representation from the following:

- Neonatal, Midwifery, obstetric and perinatal manager representative
- Quality lead for maternity and neonatal care
- Service user representative

At regional and national level there should also be representation from:

- CQC
- Maternity and Newborn Safety Investigation Programme
- Nursing and Midwifery Council (NMC)
- General Mecical Council (GMC)
- NHS Resolution
- Specialised Commissioning for Neonatal / Neonatal ODN
- Perinatal Mental Health

This list is not exclusive.

Appendix 1 – Key data and insights to consider under the Perinatal Quality Oversight Model

Trusts and Integrated Care Systems should give due regard to the outcome and progress measures published in the Maternity and Neonatal Three Year Delivery Plan, which are collated in technical guidance and available to view at Trust level via the Maternity and Neonatal Three Year Delivery Plan Oversight Tool on NHS Futures. We recommend these should form the basis of a locally agreed report to be presented by a member of the perinatal leadership team at Trust Boards. Data should include analyses by subgroups where possible, including as a minimum ethnic group and deprivation of the mother's postcode, to identify potential health inequalities for investigation and action.

Trusts and Integrated Care Systems should consider additional key insights and data to include in locally agreed reports. We recommend the following items associated with key themes from the delivery plan.

Theme	Key data and insights to consider	Availability
Listening to women and families	Service user feedback via: -Friends and Family Test -Maternity and Neonatal Voices Partnerships -Complaints and compliments sent to the service -Independent Safety Advocates -FTSU -Safety Champions - Healthwatch	Locally
Workforce	Provider Trust workforce returns	Locally

	Training compliance	Locally
	Minimum staffing in maternity and neonatal units Local Staff surveys and feedback	Locally Locally
Culture of learning, safety and support	Thematic learning informed by: -Patient Safety Incident Response Plans (including from joint maternity and perinatal mental health cases) -Cultural surveys -SCORE staff survey - NHS Resolution claims Scorecard (Using your claims scorecard on Vimeo)	Locally
	Trust progress against relevant intervention, for example: -CQC inspection -Entry onto the Maternity Safety Support Programme -Maternity and Newborn Safety Investigation - NHS Resolution learning themes -Patient Safety Incident Response Plans -Deanery -Coroner's Regulation 28 report to prevent future deaths	Locally

Structures and Standards Underpinning Safer, more Personalised, Equitable care	Clinical Quality Improvement	National Neonatal Audit Programme measures including: -Birth <27wks gestation in a centre with NICU -Measures associated with perinatal optimisation	National Neonatal Audit Programme Online (https://nnap.rcpch.ac.uk/default.aspx).
		Clinical Quality Improvement Metrics	The Maternity Services Dashboard (https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/maternity-services-data-set/maternity-services-dashboard) or local/system alternative
	Regulatory	CQC inspections	CQC (https://www.cqc.org.uk/care-services)
		Maternity Incentive Scheme compliance	NHS Resolution (https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/maternity-incentive-scheme/)

	Critical Safety Signal Systems	MBRRACE-UK Real Time Monitoring Data	MBRRACE-UK local accounts (log-in required via https://www.mbrrace.ox.ac.uk/)
		Maternity Outcomes Signal System (MOSS)	To be released
	Operational	Maternity and Neonatal SitRep	Request from NHS England via maternityanalysis@nhs.net

As a minimum, Trust Boards should consider the following data measures at least quarterly

1.Findings of review of all perinatal deaths using the real time data monitoring tool with actions
2. Findings of review of all cases eligible for referral to MNSI with actions
Report on: 2a. Themes and actions from patient safety incidents
2b. Training compliance for all staff groups in maternity and neonatal critical care related to the core competency framework and wider job essential training (%)
2c. Minimum safe staffing in maternity and neonatal services to include obstetric cover on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover versus actual prospectively
3.Service User Voice Feedback - themes
4.Staff feedback from frontline champion and walk-abouts – themes
5.MNSI/NHSR/CQC or other organisation with a concern or request for action made directly with Trust
6.Coroner Reg 28 made directly to Trust where applicable
7.Progress in achievement of Maternity Incentive Scheme 10 Safety actions

8.Proportion of midwives responding with 'Agree' or 'Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment (reported annually)
9.Proportion of speciality trainees in Obstetrics and Gynaecology responding with 'excellent' or 'good' on how they would rate the quality of clinical supervision out of hours (reported annually)

Trust Board sign-off requirements for MIS year 7

n.b. 'Completed' set to 'No' as defa
Change to 'Yes' and add date whe

	Requirement		Completed	Date
SA1	A quarterly report should be received by the Trust Executive Board each quarter on an ongoing basis that includes details of the deaths reviewed **from 1 December 2024**, any themes identified and the consequent action plans. The report should evidence that the PMRT has been used to review eligible perinatal deaths and that the required standards have been met.	*Q1	No	
		Q2	No	
		Q3 (third report may fall outside MIS reporting period)		
SA3	If not already in place, an action plan should be signed off by Trust and LMNS Board for a move towards the transitional care pathway based on BAPM framework for babies from 34+0 with clear timescales for implementation and progress from MIS Year 6.	By 30/11/25	No	
SA4	Trusts/organisations should implement the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance with Trust Board, Trust Board level safety champions and at LMNS meetings.	By 30/11/25	No	
	Trusts must ensure compliance with Consultant attendance in person to the clinical situations listed in the RCOG workforce document: 'Roles and Responsibilities of the Consultant providing acute care in obstetrics and gynaecology' into their service. Trusts should demonstrate	By 30/11/25	No	
	The Trust is required to formally record in Trust Board minutes whether it meets the relevant BAPM recommendations of the neonatal medical workforce. If the requirements are not met, Trust Board should agree an action plan with updates on progress against any previously developed action plans. This should be monitored via a risk register.	By 30/11/25	No	
	The Trust is required to formally record to the Trust Board minutes compliance to BAPM Nurse staffing standards annually using the Neonatal Nursing Workforce Calculator (2020). If the requirements are not met, Trust Board should agree an action plan with updates on progress against any previously developed action plans. This should be monitored via a risk register.	By 30/11/25	No	
SA5	A midwifery staffing oversight report that covers staffing/safety issues should be received by the Trust Board every 6 months (in line with NICE midwifery staffing guidance), during the maternity incentive scheme year six reporting period.	Q1 & Q2	No	
		Q3 & Q4 (second report may fall outside MIS reporting period)		
	In line with midwifery staffing recommendations from Ockenden, Trust Boards must provide evidence (documented in Board minutes) of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations. Where Trusts are not compliant with a funded establishment based on BirthRate+ or equivalent calculations, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls.	By 30/11/25	No	

SA6	If the SBL Implementation tool is not in use, Trusts should be able to provide a signed declaration from the Executive Medical Director declaring that Saving Babies' Lives Care Bundle, Version 3 is fully / will be in place as agreed with the ICB.	By 30/11/25	No	
SA8	For rotational medical staff that commenced work on or after 1 July 2025 a lower training compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	By 30/11/25	No	
SA9	Evidence that a non-executive director (NED) has been appointed and is visibly working with the Board safety champion	By 30/11/25	No	
	Evidence that a quarterly review of maternity and neonatal quality and safety is undertaken by the Trust Board (or an appropriate Trust committee with delegated responsibility) using a minimum data setas outlined in the PQSM . This should be presented by a member of the perinatal leadership team to provide supporting context. This must include a review of thematic learning informed by PSIRF, themes and progress with plans following cultural surveys or equivalent, training compliance, minimum staffing in maternity and neonatal units, and service user voice feedback.	Q1	No	
		Q2	No	
		Q3 (third report may fall outside MIS reporting period)	No	
	Evidence that in addition to the monthly Trust Board/sub-committee review of maternity and neonatal quality as described above, the Trust's claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level Safety Champions at a Trust level (Board or directorate) meeting. Scorecard data is used to agree targeted interventions aimed at improving patient safety and reflected in the Trusts Patient Safety Incident Response Plan. These quarterly discussions must be held at least twice in the MIS reporting period at a Board or directorate level quality meeting.	Q1	No	
		Q2	No	
		Q3 (third report may fall outside MIS reporting period)	No	
	Evidence in the Trust Board minutes that Board Safety Champion(s) are meeting with the Perinatal leadership team at a minimum of bi-monthly (a minimum of three in the reporting period) and that any support required of the Trust Board has been identified and is being implemented.	Apr/May	No	
		Jun/Jul	No	
		Aug/Sep	No	
		Oct/Nov	No	
	Evidence in the Trust Board (or an appropriate Trust committee with delegated responsibility) minutes that progress with the maternity and neonatal culture improvement plan is being monitored and any identified support being considered and implemented.	By 30/11/25	No	
	Evidence in the Board minutes that the Board Safety Champion(s) are meeting with the perinatal 'Quad' leadership team as a minimum of bi-monthly and that any support required of the Board has been identified and is being implemented. There must have been a minimum of 3 meetings held in the MIS reporting period.	Apr/May	No	
		Jun/Jul	No	
		Aug/Sep	No	
		Oct/Nov	No	
SA10	Trust Board must have sight of Trust legal services and maternity clinical governance records of qualifying MNSI/ EN incidents and numbers reported to MNSI and NHS Resolution.	By 30/11/25	No	

	Trust Board must have sight of evidence that the families have received information on the role of MNSI and NHS Resolution's EN scheme.	By 30/11/25	No	
	Trust Board must have sight of evidence of compliance with the statutory duty of candour.	By 30/11/25	No	

PMRT - Perinatal Mortality Reviews Summary Report

This report has been generated following mortality reviews which were carried out using the national Perinatal Mortality Review Tool

Arrowe Park Hospital, Wirral University Teaching Hospital NHSFT

Report of perinatal mortality reviews completed for deaths which occurred in the period:

1/1/2025 to 31/3/2025

Summary of perinatal deaths*

Total perinatal* deaths reported to the MBRRACE-UK perinatal mortality surveillance in this period: *3*

Summary of reviews**

Stillbirths and late fetal losses

Number of stillbirths and late fetal losses reported	Not supported for Review	Reviews in progress	Reviews completed and published ***	Grading of care: number of stillbirths and late fetal losses with issues with care likely to have made a difference to the outcome for the baby
2	0	1	1	1

Neonatal and post-neonatal deaths

Number of neonatal and post-neonatal deaths reported	Not supported for Review	Reviews in progress	Reviews completed and published ***	Grading of care: number of neonatal and post-neonatal deaths with issues with care likely to have made a difference to the outcome for the baby
2	0	2	0	0

*Late fetal losses, stillbirths and neonatal deaths (does not include post-neonatal deaths which are not eligible for MBRRACE-UK surveillance) – these are the total deaths reported and may not be all deaths which occurred in the reporting period if notification to MBRRACE-UK is delayed. Termination of pregnancy are excluded. All other perinatal deaths reported to MBRRACE-UK are included here regardless of whether a review has been started or is published.

** Post-neonatal deaths can also be reviewed using the PMRT

*** If a review has been started, but has not been completed and published then the information from that review does not appear in the rest of this summary report

Table 1: Summary information for the babies who died in this period and for whom a review of care has been completed – number of babies (N = 1)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
Late Fetal Losses (<24 weeks)	0	0	--	--	--	--	0
Stillbirths total (24+ weeks)	0	0	0	1	0	0	1
Antepartum stillbirths	*0*	*0*	*0*	*1*	*0*	*0*	*1*
Intrapartum stillbirths	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Timing of stillbirth unknown	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Early neonatal deaths (1-7 days)*	0	0	0	0	0	0	0
Late neonatal deaths (8-28 days)*	0	0	0	0	0	0	0
Post-neonatal deaths (29 days +)*	0	0	0	0	0	0	0
Total deaths reviewed	0	0	0	1	0	0	1
Small for gestational age at birth:							
IUGR identified prenatally and management was appropriate	0	0	0	0	0	0	0
IUGR identified prenatally but not managed appropriately	0	0	0	0	0	0	0
IUGR not identified prenatally	0	0	0	1	0	0	1
Not Applicable	0	0	0	0	0	0	0
Mother gave birth in a setting appropriate to her and/or her baby's clinical needs:							
Yes	0	0	0	1	0	0	1
No	0	0	0	0	0	0	0
Missing	0	0	0	0	0	0	0
Parental perspective of care sought and considered in the review process:							
Yes	0	0	0	1	0	0	1
No	0	0	0	0	0	0	0
Missing	0	0	0	0	0	0	0
Booked for care in-house	0	0	0	0	0	0	0
Mother transferred before birth	0	0	0	0	0	0	0
Baby transferred after birth	0	0	0	0	0	0	0
Neonatal palliative care planned prenatally	0	0	0	0	0	0	0
Neonatal care re-orientated	0	0	0	0	0	0	0

*Neonatal deaths are defined as the death within the first 28 days of birth of a baby born alive at any gestational age; early neonatal deaths are those where death occurs when the baby is 1-7 days old and late neonatal death are those where the baby dies on days 8-28 after birth. Post-neonatal deaths are those deaths occurring from 28 days up to one year after birth

Table 2: Placental histology and post-mortems conducted for the babies who died in this period and for whom a review of care has been completed – number of babies (N = 1)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
Late fetal losses and stillbirths							
Placental histology carried out							
Yes	0	0	0	1	0	0	1
No	0	0	0	0	0	0	0
Hospital post-mortem offered	0	0	0	1	0	0	1
Hospital post-mortem declined	0	0	0	1	0	0	1
Hospital post-mortem carried out:							
Full post-mortem	0	0	0	0	0	0	0
Limited and targeted post-mortem	0	0	0	0	0	0	0
Minimally invasive post-mortem	0	0	0	0	0	0	0
External review	0	0	0	0	0	0	0
Virtual post-mortem using CT/MR	0	0	0	0	0	0	0
Neonatal and post-neonatal deaths:							
Placental histology carried out							
Yes	0	0	0	0	0	0	0
No	0	0	0	0	0	0	0
Death discussed with the coroner/procurator fiscal	0	0	0	0	0	0	0
Coroner/procurator fiscal PM performed	0	0	0	0	0	0	0
Hospital post-mortem offered	0	0	0	0	0	0	0
Hospital post-mortem declined	0	0	0	0	0	0	0
Hospital post-mortem carried out:							
Full post-mortem	0	0	0	0	0	0	0
Limited and targeted post-mortem	0	0	0	0	0	0	0
Minimally invasive PMpost-mortem	0	0	0	0	0	0	0
External review	0	0	0	0	0	0	0
Virtual post-mortem using CT/MR	0	0	0	0	0	0	0
All deaths:							
Post-mortem performed by paediatric/perinatal pathologist*							
Yes	0	0	0	0	0	0	0
No	0	0	0	0	0	0	0
Placental histology carried out by paediatric/perinatal pathologist*:							
Yes	0	0	0	1	0	0	1
No	0	0	0	0	0	0	0

*Includes coronial/procurator fiscal post-mortems

Table 3: Number of participants involved in the reviews of late fetal losses and stillbirths without resuscitation (N = 1)

Role	Total Review sessions	Reviews with at least one
Chair	1	100% (1)
Vice Chair	0	0%
Admin/Clerical	0	0%
Ambulance Team	0	0%
Bereavement Team	1	100% (1)
Community Midwife	0	0%
External	2	100% (1)
Management Team	0	0%
Midwife	10	100% (1)
MNVP Lead	0	0%
Neonatal Nurse	0	0%
Neonatologist	0	0%
Obstetrician	2	100% (1)
Other	0	0%
Risk Manager or Governance Team	3	100% (1)
Safety Champion	0	0%
Sonographer or Radiographer	0	0%

Table 4: Number of participants involved in the reviews of stillbirths with resuscitation and neonatal deaths (N = 0)

Role	Total Review sessions	Reviews with at least one
Chair	0	0%
Vice Chair	0	0%
Admin/Clerical	0	0%
Ambulance Team	0	0%
Bereavement Team	0	0%
Community Midwife	0	0%
External	0	0%
Management Team	0	0%
Midwife	0	0%
MNVP Lead	0	0%
Neonatal Nurse	0	0%
Neonatologist	0	0%
Obstetrician	0	0%
Other	0	0%
Risk Manager or Governance Team	0	0%
Safety Champion	0	0%
Sonographer or Radiographer	0	0%

Table 5: Grading of care relating to the babies who died in this period and for whom a review of care has been completed – number of babies (N = 1)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
STILLBIRTHS & LATE FETAL LOSSES							
Grading of care of the mother and baby up to the point that the baby was confirmed as having died:							
A - The review group concluded that there were no issues with care identified up the point that the baby was confirmed as having died	0	0	0	0	0	0	0
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	0	0	0	0	0	0
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	1	0	0	1
Not graded	0	0	0	0	0	0	0
Grading of care of the mother following confirmation of the death of her baby:							
A - The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby	0	0	0	1	0	0	1
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother	0	0	0	0	0	0	0
C - The review group identified care issues which they considered may have made a difference to the outcome for the mother	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
NEONATAL AND POST-NEONATAL DEATHS							
Grading of care of the mother and baby up to the point of birth of the baby:							
A - The review group concluded that there were no issues with care identified up the point that the baby was born	0	0	0	0	0	0	0
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	0	0	0	0	0	0
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
Grading of care of the baby from birth up to the death of the baby:							
A - The review group concluded that there were no issues with care identified from birth up the point that the baby died	0	0	0	0	0	0	0
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	0	0	0	0	0	0
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
Grading of care of the mother following the death of her baby:							
A - The review group concluded that there were no issues with care identified for the mother following the death of her baby	0	0	0	0	0	0	0
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother	0	0	0	0	0	0	0
C - The review group identified care issues which they considered may have made a difference to the outcome for the mother	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0

Table 6: Cause of death of the babies who died in this period and for whom a review of care has been completed – number of babies (N = 1)

Timing of death	Cause of death
Late fetal losses	**0 causes of death out of 0 reviews**
Stillbirths	**1 causes of death out of 1 reviews**
	Umbilical cord, morphology: Moderately over coiled and grooved umbilical cord High grade Fetal Vascular Malperfusion
Neonatal deaths	**0 causes of death out of 0 reviews**
Post-neonatal deaths	**0 causes of death out of 0 reviews**

Table 7: Issues raised by the reviews identified as relevant to the deaths reviewed, by the number of deaths affected by each issue* and the actions planned

Issues raised which were identified as relevant to the deaths	Number of deaths	Actions planned
The baby was small for gestational age at birth, scans were indicated but had not been performed	1	Immediate action was implemented as part of the rapid review to change how reduced fetal movement USS are requested regardless of upcoming routine growth scan appointments. The panel discussed further changes to the sonography appointments and if a patient is late or does not attend there should be review of the plan of care for the patient.
This mother had a risk factor(s) for having a growth restricted baby but serial scans were not performed at correct times/intervals	1	Immediate action was implemented as part of the rapid review to change how reduced fetal movement USS are requested regardless of upcoming routine growth scan appointments. The panel discussed further changes to the sonography appointments and if a patient is late or does not attend there should be review of the plan of care for the patient.
This mother presented with reduced fetal movements and scan was indicated but not carried out	1	Immediate action was implemented as part of the rapid review to change how reduced fetal movement USS are requested regardless of upcoming routine growth scan appointments. The panel discussed further changes to the sonography appointments and if a patient is late or does not attend there should be review of the plan of care for the patient.
This mother presented with reduced fetal movements, scans and and/or other investigations were indicated but were not caried out	1	Immediate action was implemented as part of the rapid review to change how reduced fetal movement USS are requested regardless of upcoming routine growth scan appointments. The panel discussed further changes to the sonography appointments and if a patient is late or does not attend there should be review of the plan of care for the patient.

*Note - depending upon the circumstances in individual cases the same issue can be raised as relevant to the deaths reviewed and also not relevant to the deaths reviewed.

Table 8: Issues raised by the reviews which are of concern but not directly relevant to the deaths reviewed, by the number of deaths in which this issue was identified* and the actions planned

Issues raised which were identified as not relevant to the deaths	Number of deaths	Actions planned
The risk allocation of this mother based on her history at booking was incorrect	1	To share learning regarding uterine fibroids and the indication for a high risk pathway at booking.
The type of care this mother was booked for was inappropriate for her risk allocation at booking	1	To share learning regarding uterine fibroids and the indication for a high risk pathway at booking.
This mother's progress in labour was not monitored on a partogram	1	The digital healthcare record partogram is not easily accessible when a pregnancy has closed so it is difficult to tell whether the partogram was used. The IT midwife will review this functionality and share learning of the importance of using the partogram to monitor progress in labour.

*Note - depending upon the circumstances in individual cases the same issue can be raised as relevant to the deaths reviewed and also not relevant to the deaths reviewed.

Table 9: Top 5 contributory factors related to issues identified as relevant to the deaths reviewed, by the frequency of the contributory factor and the issues to which the contributory factors related

Issue Factor	Number of deaths	Issues raised for which these were the contributory factors
Task Factors - Procedural or Task Design	1	The baby was small for gestational age at birth, scans were indicated but had not been performed
		This mother presented with reduced fetal movements and scan was indicated but not carried out
		This mother presented with reduced fetal movements, scans and and/or other investigations were indicated but were not caried out
		This mother had a risk factor(s) for having a growth restricted baby but serial scans were not performed at correct times/intervals

PMRT - Perinatal Mortality Reviews Summary Report

This report has been generated following mortality reviews which were carried out using the national Perinatal Mortality Review Tool

Arrowe Park Hospital, Wirral University Teaching Hospital NHSFT

Report of perinatal mortality reviews completed for deaths which occurred in the period:

1/4/2025 to 30/6/2025

There are no published reviews for Arrowe Park Hospital, Wirral University Teaching Hospital NHSFT in the period from 1/4/2025 to 30/6/2025

Report Generated by: Jo Lavery
Date report generated: 18/07/2025 10:19

Board Report and Action Plan on Implementation of the Saving Babies Lives Care Bundle (Version 3)

Implementation Report

Trust	**Wirral University Teaching Hospital NHS Foundation Trust**
Date of Report	
ICB Accountable Officer	
Trust Accountable Officer	
LMNS Peer Assessor Names	

Background

Version three of the Saving Babies' Lives Care Bundle (SBLCBv3) published on 31 May 2023, aims to provide detailed information for providers and commissioners of maternity care on how to reduce perinatal mortality across England. The third version of the care bundle brings together six elements of care that are widely recognised as evidence-based and/or best practice:

1. Reducing smoking in pregnancy
2. Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction (FGR)
3. Raising awareness of reduced fetal movement (RFM)
4. Effective fetal monitoring during labour
5. Reducing preterm birth
6. Management of diabetes in pregnancy

The Care Bundle is now a universal innovation in the delivery of maternity care in England and continues to drive quality improvement to reduce perinatal mortality. It has been included for a number of years in the NHS Long Term Plan, NHS Planning Guidance, the Standard Contract and the CNST Maternity Incentive Scheme, with every maternity provider expected to have fully implemented SBLCBv2 by March 2020.

ONS and MBRRACE-UK data demonstrate the urgent need to continue reducing preventable mortality. Developed 4 years after SBLCBv2, Version 3 of the Care Bundle (SBLCBv3) has been developed through a collaboration of frontline clinical experts, service users and key stakeholder organisations. All existing elements have been updated, incorporating learning from the Clinical Negligence Scheme for Trusts: Maternity Incentive Scheme (CNST MIS) and insights from NHS England's regional maternity teams. SBLCBv3 aligns with national guidance from NICE and the RCOG Green Top Guidelines where available but it aims to reduce unwarranted variation where the evidence is insufficient for NICE and RCOG to provide guidance. SBLCBv3 also includes a new element on optimising care for women with pregnancies complicated by diabetes.

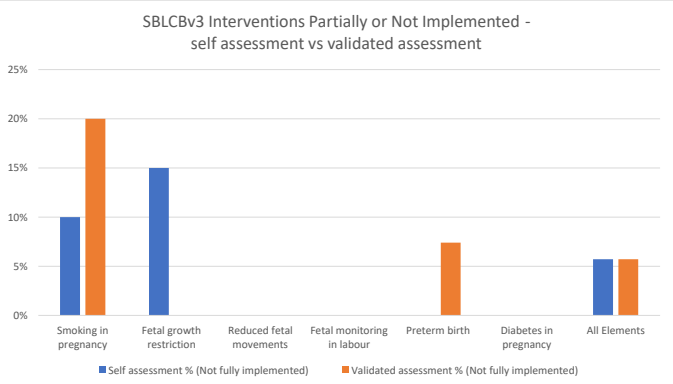
As part of the Three Year Delivery Plan for Maternity and Neonatal Services, all NHS maternity providers are responsible for fully implementing SBLCBv3 by March 2024.

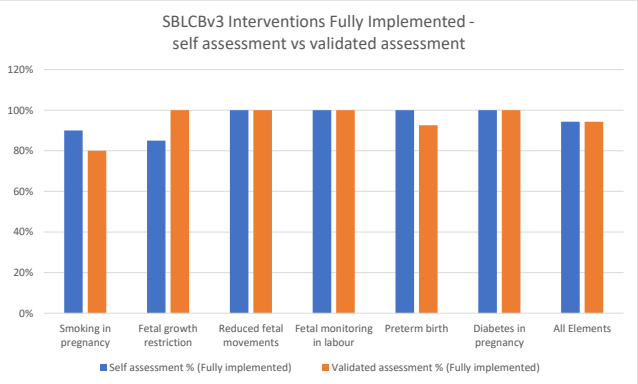
Implementation Grading

Significant Assurance - Except for specific weaknesses identified the activities and controls are suitably designed and operating with sufficient effectiveness to provide reasonable assurance that the control environment is effectively managed.

Implementation Progress

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)	NHS Resolution Maternity Incentive Scheme
Element 1	Smoking in pregnancy	Partially implemented	90%	Partially implemented	80%	CNST Met
Element 2	Fetal growth restriction	Partially implemented	85%	Fully implemented	100%	CNST Met
Element 3	Reduced fetal movements	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 4	Fetal monitoring in labour	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 5	Preterm birth	Fully implemented	100%	Partially implemented	93%	CNST Met
Element 6	Diabetes	Fully implemented	100%	Fully implemented	100%	CNST Met
All Elements	TOTAL	Partially implemented	94%	Partially implemented	94%	CNST Met





Action Plan

Element 1

Intervention Ref	Self-Assessment Status	LMNS Validated Assessment Status	LMNS Recommendation of Actions Required	LMNS Suggested Improvement Activity
INTERVENTIONS				
1.1	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Trust SOP meets requirements (due for review in Sept 26). MSDS DQ check passed in Feb 25.
1.2	Fully implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Dec 24-50% Feb 25- 35%
1.3	Fully implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Smoking status at Booking: Oct 24- 100%, Nov 24-100%, Dec 24 (mixed sample & only smokers)- 100%, Feb-May 25-100%
1.4	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Feb-May 25- 100%
1.5	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Direct supply NRT provided by in-reach service
1.6	Fully implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	Setting a quit date: WUTH dashboard states Oct 24-43.7%, Nov 24-40%, Dec 24-24.2% (ABL data suggests Dec 24- 19.3%). WUTH dashboard and ABL data state Jan 25- 40.6%, Feb 25- 20%, March 25-
1.7	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	WUTH dashboard states Oct 24-80%, Nov 24-100%, Dec 24-100%. Jan-April 25-100%.
1.8	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Midwifery Study Day presentation noted in previous submission (VBA & CO monitoring). Session also delivered to MDT on PROMPT. Training compliance posters state 93% compliance on Midwifery
1.9	Partially implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Midwifery Study Day presentation noted in previous submission (VBA & CO monitoring). Session also delivered to MDT on PROMPT. Training compliance posters state 93% compliance on Midwifery
1.10	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Certificates noted in previous submissions. Please note, Practitioners should complete NCSCT e-learning and assessments annually (Jen and Claire due to re-complete in Nov 25).

Element 2

Intervention Ref	Self-Assessment Status	LMNS Validated Assessment Status	LMNS Recommendation of Actions Required	LMNS Suggested Improvement Activity
INTERVENTIONS				
2.1	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	April 25- 100%
2.2	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	April 25- 100%
2.3	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	See element 1 evidence. CO and smoking status at 36/40 requires improvement.
2.4	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	April 25- 100%
2.5	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Evidenced in previous submission
2.6	Partially implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Guideline updated. Email noted regarding rollout of BP monitors in February 2024.
2.7	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Jan-May 25- 21 cases=100% compliant.
2.8	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	PMRT summary slides accessed in Element 3 folder. No cases appear related to FGR management in Q3 24/25.
2.9	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Evidenced in previous submission
2.10	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Audit noted as 100% compliant Jan-Oct 24. Oct 24 audit of low risk sample shows 100% compliance. Nov 24-
2.11	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	November 24- MWs 90% and Obs 100%. Overall= 90% (141 of 156) so compliant at present.
2.12	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Evidenced in previous submission
2.13	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Evidenced in previous submission
2.14	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Evidenced in previous submission
2.15	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Evidenced in previous submission
2.16	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Evidenced in previous submission
2.17	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	As per intervention 5.6: Twins trust Re-audit document noted from September 2023 in evidence archive.
2.18	Partially implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	GAP 1.5 report (line 2C)- Q4 of 2024 was 50% (1 of 2). GAP 2.0 report (line 2c)- Q4 of 2024 shows 41.7% (5 of 12). Merged rate of 43% (6 of 14) so deemed compliant.
2.19	Partially implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Antenatal detection of SGA- WUTH dashboard states 0% for all of 2024. GAP 1.5 report (line 4A)- Q3 of 2024 was 66.7% and Q4 of 2024 was
2.20	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Evidenced in previous submission

Element 3

INTERVENTIONS				
3.1	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Local guideline noted in previous submission and due for review in March 26. NW Regional guideline due for review in Oct 26.
3.2	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Computerised CTG snapshot audit of 20 cases in Sept 24- 100% and Oct 24- 100%. Nov 24- 100%, Dec 24- 100%. Dashboard states 100% compliance sustained between Jan-March 25.

Element 4

INTERVENTIONS				
4.1	Fully implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	4a (Fetal Surveillance Study Day)- As of April 25- Midwives 95%, Consultants 83%, Rotational Drs- 88%, overall 91% which meets required compliance.
4.2	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	LMNS direct Trust to the NW Fetal Monitoring guidelines: https://www.england.nhs.uk/north-west/north-west-services/north-west-maternity-services/north-west-guidelines/
4.3	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	PMRT update noted within Powerpoint presentation- April to June 24, 0% cases relating to fetal monitoring. Q3 PMRT summary powerpoint (located in element 3 folder) shows 1 case had incorrect
4.4	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Fresh eyes/ears audit noted with high compliance achieved in Q4 24/25.
4.5	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Confirmation that all staff remain in post noted.

Element 5

INTERVENTIONS				
5.1	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Email confirmation received in Q3 24/25. Discussion at quarterly meeting: staff remain in post.
5.2	Fully implemented	Partially implemented	Focus required on quality improvement intiatives to meet recommended standard.	Births 16+0-23+6: Oct 24- 0.37%, Nov 24-0%, Dec 24-0.42%. No Q4 evidence provided.
5.3	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	April 25-100%
5.4	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Evidenced in previous submission
5.5	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Evidenced in previous submission
5.6	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	As per intervention 2.17: Twins trust Re-audit document noted from September 2023 in evidence archive.
5.7	Fully implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	See evidence in element 1-Smoking status at 36/40 requires improvement.
5.8	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Evidenced in previous submission
5.9	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	WUTH using Actim Partus testing. Local audit shows 100% compliance in Jan-March 25.
5.10	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Evidenced in previous submission. See also 2.1.
5.11	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Local audit shows 100% compliance in April 25.
5.12	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Evidenced in previous submission
5.13	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Evidenced in previous submission
5.14	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Staffing paper and CoC powerpoint presentation noted from previous submission.
5.15	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Evidenced in previous submission
5.16	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	<34/40 births Jan 25- 67% (2 of 3), Feb 25- 100% (6 of 6), March 25- 100% (7 of 7),
5.17	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Nov 24- 61%, Dec 24- 59%, Jan 25- 50%, Feb 25- 17%, March 25-17%, April 25- 0%
5.18	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Evidenced in previous submission
5.19	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	NICU level site. WUTH SBL dashboard reports 100% compliance sustained
5.20	Fully implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	Aug 24- 86%, Sept 24- 83%, Oct 24- 58%, Nov 24-43%, Dec 24-33%. Jan 25- 100%, Feb 25- 100% which meets required compliance within the last 6 months, March 25- 33%, April 25- 31%.
5.21	Fully implemented	Partially implemented	Focus required on quality improvement intiatives to meet recommended standard.	Jan 25- 100%, Feb 25- 100%, March 25-100%, April 25-100% LMNS have accessed the NODN dashboard for Brain Injury and will
5.22	Fully implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	Jan 25- 67%, Feb 25- 50%, March 25-75%, April 25-25%
5.23	Fully implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	Jan 25- 100%, Feb 25- 83%, March 25-67%, April 25-77%
5.24	Fully implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	Jan 25- 100%, Feb 25- 33%, March 25-83% which meets threshold, April 25-31%

5.25	Fully implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	Jan 25- 50%, Feb 25- 67% which meets threshold, March 25-33%, April 25-38%
5.26	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	NWODN Action Plan noted in previous submission. Local audit states Jan 25-100%, Feb 25- 100%, March 25- 100%, April
5.27	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Jan 25- 100%, Feb 25- 100%, April 25-100%

Element 6

INTERVENTIONS				
6.1	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Evidenced in previous submission. Local Diabetes in pregnancy guideline due for review in Oct 26. Overall element specific action plan noted.
6.2	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	CGM Audit 100% complaint Oct-Dec 24 (n6). Q4 24/25- 100% compliant (n10). Ethnicity anaylsis noted. LMNS advise inclusion of deprivation decile
6.3	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Evidenced in previous submission.
6.4	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Jan-March 25 audit (n10) states 100% compliance with HbA1C as appropriate. Additional surveillance for result >48mmol stated as 100%.
6.5	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Evidenced in previous submission
6.6	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Evidenced in previous submission. Trust DKA policy due for review in May 25- awaiting D&T committee.

Ockenden Essential Actions - May 2024

V15 updated July 2025

			1: WORKFORCE PLANNING AND SUSTAINABILITY	RAG Rating	Comments / Lead Progress
			Full workforce review required in 2022 - Priority to Neonatal and Obstetric Workforce with focus on additional governance related work and training. Neonatal nursing workforce reviewed and additional funding via NODN secured. Midwifery staffing reviewed with BR+ however as per ask re increased uplift for additional training PER HEAD COUNT not wte sme to be reviewed as a priority.		
1: WORKFORCE PLANNING AND SUSTAINABILITY	The recommendations from the Health and Social Care Committee Report: The safety of maternity services in England must be implemented.	**1**	The investment announced following our first report was welcomed. However to fund maternity and neonatal services appropriately requires a multi-year settlement to ensure the workforce is enabled to deliver consistently safe maternity and neonatal care across England.		Workforce reviews continue 6 monthly to monitor RAG rating of complaince
		2	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.		Safety Action 4 and 5 met for CNST Year 6 with all evidence submitted and reviewed by the LMNS for sign off. Action plan in place to achieve Safety Action 4 in Year 7 requiring further to be BR plus compliant
		3	Minimum staffing levels must include a locally calculated uplift, representative of the three previous years' data, for all absences including sickness, mandatory training, annual leave and maternity leave.		Local uplift to be calculated and compared to BR+ staffing requirements. The uplift of 24% is in keeping with national guidance/local LMNS calculation. Update May 2024 - uplift remains 24%; Birth Rate plus full review to be repeated in Summer 2024 and report will be due Autumn 2024
		4	The feasibility and accuracy of the BirthRate Plus tool and associated methodology must be reviewed nationally by all bodies. These bodies must include as a minimum NHSE, RCOG, RCM, RCPCH.		Birthrate+ report received and deficit of midwifery staffing partially addressed with business case and further SOC required
			Essential Action : Training		
			Work to update orientation packages for |Band 7 staff with process to allocate a mentor. Decision re NQM with NHSE as moreof a risk. Additional work re support for senior leaders.		
	We state that the Health and Social Care Select Committee view that a proportion of maternity budgets must be ring-fenced for training in every maternity unit should be implemented	**5**	All trusts must implement a robust preceptorship programme for newly qualified midwives (NQM), which supports supernumerary status during their orientation period and protected learning time for professional development as per the RCM (2017) position statement for this.		National programme being developed however robust preceptorship in place currently. For review once national work completed and recommendation made. Current robust programme in palce and embedded.
		6	All NQMs must remain within the hospital setting for a minimum period of one year post qualification. This timeframe will ensure there is an opportunity to develop essential skills and competencies on which to advance their clinical practice, enhance professional confidence and resilience and provide a structured period of transition from student to accountable midwife.		Recommendation reviewed - WUTH ready however awaiting Regional / National review
		7	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.		Shift Coordinators have attended development Programmes including Hiuman Factors training however National Programme awaited. Completion of any national prohramme to be agreed. Gap analysis and booklet review
		8	All trusts to ensure newly appointed labour ward coordinators receive an orientation package which reflects their individual needs. This must encompass opportunities to be released from clinical practice to focus on their personal and professional development.		Orientation pack currently in use but same to be reviewed nationally and to include study time for profrssional development. To continue with current process in the interim.
		9	All trusts must develop a core team of senior midwives who are trained in the provision of high dependency maternity care. The core team should be large enough to ensure there is at least one HDU trained midwife on each shift, 24/7.		EMC Team based on DS and all midwives have undergone recognised specific HDU training. July 2025 update - continue to develop sustain team; EMC available on all shifts
		10	All trusts must develop a strategy to support a succession-planning programme for the maternity workforce to develop potential future leaders and senior managers. This must include a gap analysis of all leadership and management roles to include those held by specialist midwives and obstetric consultants. This must include supportive organisational processes and relevant practical work experience		Workforce strategy in place however this will be reviewed and include reference to leadership roles. Compl;eltion date - September 2022; leadership programmes and initiiatves in place
		11	The review team acknowledges the progress around the creation of Maternal Medicine Networks nationally, which will enhance the care and safety of complex pregnancies. To address the shortfall of maternal medicine physicians, a sustainable training programme across the country must be established, to ensure the appropriate workforce long term.		Recommendation reviewed - WUTH ready however awaiting Regional / National review
			2: SAFE STAFFING		
			Escalation policy to be further reviewed re risk assessment specifically for medical Process re assessing staffing in place but review will provide further assurance. This includes review of rotas for Obs and Gynae. RCOG tool to be used once introduced to assess medical staffing. Progress with the roll out of the		
2: SAFE STAFFING	All trusts must maintain a clear escalation and mitigation policy where maternity staffing falls below the minimum staffing levels for all health professionals.	**1**	When agreed staffing levels across maternity services are not achieved on a day-to-day basis this should be escalated to the services' senior management team, obstetric leads, the chief nurse, medical director, and patient safety champion and LMS.		Escalation processes in place and the number of diverts is included on the maternity dashboard. Staffing related incident forms reviewed and reported monthly. Staffing reviewed and reported monthly with Chief Nurse oversight.C&M escaltion and GOLD
		2	In trusts with no separate consultant rotas for obstetrics and gynaecology there must be a risk assessment and escalation protocol for periods of competing workload. This must be agreed at board level.		Completed
		3	All trusts must ensure the labour ward coordinator role is recognised as a specialist job role with an accompanying job description and person specification.		Specific job description in place with personal specification. JD has been through matching process.
		4	All trusts must review and suspend if necessary the existing provision and further roll out of Midwifery Continuity of Carer (MCoC) unless they can demonstrate staffing meets safe minimum requirements on all shifts. This will preserve the safety of all pregnant women and families, which is currently compromised by the unprecedented pressures that MCoC models place on maternity services already under significant strain.		Jo Lavery and Katherine Wilkinson have reviewed staffing establishments as detailed above - staffing previously has supported CoC - withold complete roll out but continue with partial roll out pending national guidance and regional input. No further teams will be rolled out and an options appraisal prepared to consider next steps.
		5	The reinstatement of MCoC should be withheld until robust evidence is available to support its reintroduction	N/A	Final position statement on this to be formalised nationally - completion date awaited. Locally MCofC is not withheld - meeting compliance as per staffing numbers.
		6	The required additional time for maternity training for consultants and locally employed doctors must be provided in job plans. The protected time required will be in addition to that required for generic trust mandatory training and reviewed as training requirements change.		Job planning embedded annually as a process
		7	All trusts must ensure there are visible, supernumerary clinical skills facilitators to support midwives in clinical practice across all settings.		Facilitators in post to support
		8	Newly appointed Band 7/8 midwives must be allocated a named and experienced mentor to support their transition into leadership and management roles.		Process to be reviewed and agreed with L&D Team within the Trust. Also include specific requirements for appraisals and support for leadership training eg Top Leaders; 4 C's
		9	All trusts must develop strategies to maintain bi-directional robust pathways between midwifery staff in the community setting and those based in the hospital setting, to ensure high quality care and communication.		CoC - Engagement, listening events, one-to-one meetings, Block C update, Senior midwife meeting joint with all leads.
		10	All trusts should follow the latest RCOG guidance on managements of locums. The RCOG encourages the use of internal locums and has developed practical guidance with NHS England on the management of locums. This includes support for locums and ensuring they comply with recommended processes such as pre-employment checks and appropriate induction.		Locum pack developed and shared across C&M- Libby Shaw and Mustafa Sadiq to check RCOG guidance for locum guidance to further support current process. Locum pack and Gap analysis required with assurance mechanisms. Review following any additional NHSE recomendations.
			3: ESCALATION AND ACCOUNTABILITY		
			Processes in place - same to be auditted with clear SOPs.		
3: ESCALATION AND ACCOUNTABILITY	Staff must be able to escalate concerns if necessary There must be clear processes for ensuring that obstetric units are staffed by appropriately trained staff at all times. If not resident there must be clear guidelines	**1**	All trusts must develop and maintain a conflict of clinical opinion policy to support staff members in being able to escalate their clinical concerns regarding a woman's care in case of disagreement between healthcare professionals		Guidance in place but standalone policy with flowcharts required. Libby Shaw developing SOP as per EBC Guidance. Completion date July 2022.
		2	When a middle grade or trainee obstetrician (non-consultant) is managing the maternity service without direct consultant presence trusts must have an assurance mechanism to ensure the middle grade or trainee is competent for this role		Mustafa Sadiq and Libby Shaw to lead on embedding the Locum package being embedded and evidence of assurance
		3	Trusts should aim to increase resident consultant obstetrician presence where this is achievable		Ward round take place at weekend, twice daily however resident consultant presence not in place 24/7; Added to Risk Register inview of non-compliance but review completed by WUTH therefore no further action required at present.
		4	There must be clear local guidelines for when consultant obstetricians' attendance is mandatory within the unit		Guidance in place / in policy

	for when a consultant obstetrician should attend.	5	There must be clear local guidelines detailing when the consultant obstetrician and the midwifery manager on-call should be informed of activity within the unit.		Partial guidance in place and currently no dedicated maternity on call rota in place as Trust on call provides OOH cover. Specific Maternity on call put on hold pending further advice and guidance from NHSE in February 2023.
4. Clinical governance and leadership					
			Review of additional resource as detailed above to support. Training in place but to be formalised/auditted.		
4 : CLINICAL GOVERNANCE-LEADERSHIP	Trust boards must have oversight of the quality and performance of their maternity services. In all maternity services the Director of Midwifery and Clinical Director for obstetrics must be jointly operationally responsible and accountable for the maternity governance systems.	1	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		Mat Neo agenda is in place and other QI work is reported in Governance meetings but there is limited Board oversight - same to be reviewed. Maternty safety champions and regular board meetings. Processes embedded
		2	All maternity service senior leadership teams must use appreciative inquiry to complete the National Maternity Self-Assessment Tool if not previously done. A comprehensive report of their self-assessment including governance structures and any remedial plans must be shared with their trust board		Self-assessment tool completed with actons in place and presented to Board. However same to be reviewed following Ockenden and an updated self assessment to go to Board quarterly
		3	Every trust must ensure they have a patient safety specialist, specifically dedicated to maternity services		In place. Structure organogram required
		4	All clinicians with responsibility for maternity governance must be given sufficient time in their job plans to be able to engage effectively with their management responsibilities		In self-assessment tool to include neonates and anaesthetists. Only obstetric time currently supported. Completion date - July 2022; reviwing additional PA's and funding to achieve
		5	All trusts must ensure that those individuals leading maternity governance teams are trained in human factors, causal analysis and family engagement.		Staff currently trained however review of staff group required and additional training to be identified. For further review in March 2023.
		6	All maternity services must ensure there are midwifery and obstetric co-leads for developing guidelines. The midwife co-lead must be of a senior level, such as a consultant midwife, who can drive the guideline agenda and have links with audit and research.		Multi-discipinary leads in place. Consultant Midwife coleads with audit/research.
		7	All maternity services must ensure they have midwifery and obstetric co-leads for audits		Audit plan in place - same to be strengthened for Maternity and Neonates.Obstetric leads in place but midwifery leads for the audit plan to be agreed with Mustafa Sadiq Completion date - June 2022.
5: CLINICAL GOVERNANCE - INCIDENT INVESTIGATING AND COMPLAINTS					
			Robust governance processes in place - same to be reviewed with MVP Chair		
5: CLINICAL GOVERNANCE – INCIDENT INVESTIGATION AND COMPLAINTS	Incident investigations must be meaningful for families and staff and lessons must be learned and implemented in practice in a timely manner.	1	All maternity governance teams must ensure the language used in investigation reports is easy to understand for families, for example ensuring any medical terms are explained in lay terms.		In place and evidenced. Robust process for reviewing documents before they are sent to families.
		2	Lessons from clinical incidents must inform delivery of the local multidisciplinary training plan.		In place in various forums both internal and external to the Trust
		3	Actions arising from a serious incident investigation which involve a change in practice must be audited to ensure a change in practice has occurred.		Implementation of actions recorded and monitored however audit of same to be reviewed.Link with audit plan
		4	Change in practice arising from an SI investigation must be seen within 6 months after the incident occurred.		Learning put in place immediately. - evidenced on individual reports.
		5	All trusts must ensure that complaints which meet SI threshold must be investigated as such		Clear MDT process in place - SI Panel. Process embedded.
		6	All maternity services must involve service users (ideally via their MVP) in developing complaints response processes that are caring and transparent		Complaint response processes in place however MVP to review and to identify improvements to further strengthen the process
		7	Complaints themes and trends must be monitored by the maternity governance team.		Processes currently in place to incorportae all patient feedback - LEAP to include Feedback Friday - positive and negative feedback and trends to be communicated to all staff.
6: LEARNING FROM MATERNAL DEATHS					
6: LEARNING FROM MATERNAL DEATHS	Nationally all maternal post-mortem examinations must be conducted by a pathologist who is an expert in maternal physiology and pregnancy related pathologies. In the case of a maternal death a joint review panel/investigation of all services involved in the care must include representation from all applicable hospitals/clinical settings.	1	NHS England and Improvement must work together with the Royal Colleges and the Chief Coroner for England and Wales to ensure that this is provided in any case of a maternal death.		Recommendation reviewed - WUTH ready however awaiting Regional / National review
		2	This joint review panel/investigation must have an independent chair, must be aligned with local and regional staff and seek external clinical expert opinion where required.		Recommendation reviewed - WUTH ready however awaiting Regional / National review
		3	Learning from this review must be introduced into clinical practice within 6 months of the completion of the panel. The learning must also be shared across the LMS.		Recommendation reviewed - WUTH ready however awaiting Regional / National review
7: MULTIDISCIPLANRY TRAINING					
			MDT in place - same to be extended and recorded (ad hoc drills)		
7: MULTIDISCIPLINARY TRAINING	Staff who work together must train together Staff should attend regular mandatory training and rotas. Job planning needs to ensure all staff can attend. Clinicians must not work on labour ward without appropriate regular CTG training and emergency skills training	1	All members of the multidisciplinary team working within maternity should attend regular joint training, governance and audit events. Staff should have allocated time in job plans to ensure attendance, which must be monitored.		Midwifery and middle grades involved in audit - need to expand to neonatal evidence of same and allocated time to be evidenced.
		2	Multidisciplinary training must integrate the local handover tools (such as SBAR) into the teaching programme at all trusts.		SBAR in all training including neonates. Audit of same to be further improved.
		3	All trusts must mandate annual human factor training for all staff working in a maternity setting; this should include the principles of psychological safety and upholding civility in the workplace, ensuring staff are enabled to escalate clinical concerns. The content of human factor training must be agreed with the LMS.		For all staff attend human factors training however guidance re content awaited from LMNS
		4	There must be regular multidisciplinary skills drills and on-site training for the management of common obstetric emergencies including haemorrhage, hypertension and cardiac arrest and the deteriorating patient.		PROMPT includes all of these topics however all staff groups including neonatal staff to be included in PROMPT - same to be reviewed after national recommendation/s.
		5	There must be mechanisms in place to support the emotional and psychological needs of staff, at both an individual and team level, recognising that well supported staff teams are better able to consistently deliver kind and compassionate care.		Jo Allen support for NQM. PMAs. NWAS has toolkit for staff Contact Steph Heyes. Discussed psychological support that was available in ITUs during Covid pandemic - that there was psychological support present at work.This helped staff to attend work becuase they knew the support would be there.
		6	Systems must be in place in all trusts to ensure that all staff are trained and up to date in CTG and emergency skills.		Karen Cullen in post for CTG / Fetal Physiology in addition to Ali Campion and Libby Shaw.
		7	Clinicians must not work on labour wards or provide intrapartum care in any location without appropriate regular CTG training and emergency skills training. This must be mandatory		PROMPT, K2, fetal physiology, CIF meetings, Pass mark for CTG assessment is mandated and reviewed monthly.
8: COMPLEX ANTENATAL CARE					
			Review of High Risk team and support to implement MMN links. Review of preconceptual care and further progress in secondary care.		
8: COMPLEX ANTENATAL CARE	Local Maternity Systems, Maternal Medicine Networks and trusts must ensure that women have access to pre-conception care.Trusts must provide services for women with multiple pregnancy in line with national guidance Trusts must follow national guidance for managing women with diabetes and hypertension in pregnancy	1	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.		Do not currently offer routine pre conception care. Will discuss regionally at what can be offered - will look at what high risk team could provide. Completion date - July 2022; Plan to be developed; Two consultants currently have pre-conception clinics and any referrals sent are accommodated from a specialist referral; Pre-conception counselling education with GP's
		2	Trusts must have in place specialist antenatal clinics dedicated to accommodate women with multifetal pregnancies. They must have a dedicated consultant and have dedicated specialist midwifery staffing. These recommendations are supported by the NICE Guideline Twin and Triplet Pregnancies 2019		Twins Trust coming in multi-pregnacy clinic - Mustafa Sadiq is lead.
		3	NICE Diabetes and Pregnancy Guidance 2020 should be followed when managing all pregnant women with pre-existing diabetes and gestational diabetes.		Guidance in place - to link wth Rachel Tildesley and Lauren Evertts. Need to look at audit to support compliance. For FAAP 2023
		4	When considering and planning delivery for women with diabetes, clinicians should present women with evidence-based advice as well as relevant national recommendations. Documentation of these joint discussions must be made in the woman's maternity records.		In place but could be subject to audit to demonstrate compliance. For FAAP 2023
		5	Trusts must develop antenatal services for the care of women with chronic hypertension. Women who are identified with chronic hypertension must be seen in a specialist consultant clinic to evaluate and discuss risks and benefits to treatment. Women must be commenced on Aspirin 75-150mg daily, from 12 weeks gestation in accordance with the NICE Hypertension and Pregnancy Guideline (2019).		Guidance in place to support this practice - specific clinic to be reviewed. Audit compliance in March 2023. For FAAP 2023
9: PRETERM BIRTH					
			Both 9 + 10 are in place - audit of processes needed		
		1	Senior clinicians must be involved in counselling women at high risk of very preterm birth, especially when pregnancies are at the thresholds of viability.		Policy in place with clear guidance.

9: PRETERM BIRTH	The LMNS, commissioners and trusts must work collaboratively to ensure systems are in place for the management of women at high risk of preterm birth. Trusts must implement NHS Saving Babies Lives Version 2 (2019)	**2**	Women and their partners must receive expert advice about the most appropriate fetal monitoring that should be undertaken dependent on the gestation of their pregnancies and what mode of delivery should be considered.		Guidance discussed at time dependant on individual situation. Guidance in place re type of monitoring as per gestation of pregnancy.
		3	Discussions must involve the local and tertiary neonatal teams so parents understand the chances of neonatal survival and are aware of the risks of possible associated disability.		Regional policy - link in with Angela MacDonald and Sanjeev Rath re any further update
		4	There must be a continuous audit process to review all in utero transfers and cases where a decision is made not to transfer to a Level 3 neonatal unit and when delivery subsequently occurs in the local unit.		Current review of Level 3 neonatal services however as WUTH Level 3 currently this is not applicable.
10: LABOUR AND BIRTH					
10: LABOUR AND BIRTH	Women who choose birth outside a hospital setting must receive accurate advice with regards to transfer times to an obstetric unit should this be necessary. Centralised CTG monitoring systems should be mandatory in obstetric units	**1**	All women must undergo a full clinical assessment when presenting in early or established labour. This must include a review of any risk factors and consideration of whether any complicating factors have arisen which might change recommendations about place of birth. These must be shared with women to enable an informed decision re place of birth to be made		Practice in place - Demonstrated in care metrics
		2	Midwifery-led units must complete yearly operational risk assessments.		In place however annual check for 2023 to be undertaken for Seacombe and Eden Suite.
		3	Midwifery-led units must undertake regular multidisciplinary team skill drills to correspond with the training needs analysis plan		All staff included in PROMPT training however schedule of drills to be recorded and ad-hoc taken forward
		4	It is mandatory that all women who choose birth outside a hospital setting are provided accurate and up to date written information about the transfer times to the consultant obstetric unit. Maternity services must prepare this information working together and in agreement with the local ambulance trust		Transfer policy in place regionally and adopted locally - same reviewed and updated with NWAS.
		5	Maternity units must have pathways for induction of labour, (IOL). Trusts need a mechanism to clearly describe safe pathways for IOL if delays occur due to high activity or short staffing.		Pathways in place - same being reviewed regionally.
		6	Centralised CTG monitoring systems must be made mandatory in obstetric units across England to ensure regular multi-professional review of CTGs		Completed and implemented
11: OBSTETRIC ANAESTHESIA					
			Close links with Anaesthetic leads with compliance to standards - same to be auditted		
11: OBSTETRIC ANAESTHESIA	In addition to routine inpatient obstetric anaesthesia follow-up, a pathway for outpatient postnatal anaesthetic follow-up must be available in every trust to address incidences of physical and psychological harm.Documentation of patient assessments and interactions by obstetric anaesthetists must improve. The determination of core datasets that must be recorded during every obstetric anaesthetic intervention would result in record-keeping that more accurately reflects events.Staffing shortages in obstetric anaesthesia must be highlighted and updated guidance for the planning and provision of safe obstetric anaesthesia services throughout England must be developed.	**1**	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		Alice Arch overview: If a post-operative debrief would be useful these can be arranged to be purely or involve a Consultant Anaesthetist and we do this for lots of patients already - we usually offer this at 6-8 weeks post event unless the patient requests it to be earlier or later - and these patients can be referred to the Obstetric Anaesthetic Assessment clinic if they present in subsequent pregnancies; Assurance process developing
		2	Anaesthetists must be proactive in recognising situations where an explanation of events and an opportunity for questions may improve a woman's overall experience and reduce the risk of long-term psychological consequences.		Currently being undertaken but need to review guidance to ensure all criteria included with audit of same. Completion date - July 2022; part of assurance process 11.1
		3	All anaesthetic departments must review the adequacy of their documentation in maternity patient records and take steps to improve this where necessary as recommended in Good Medical Practice by the GMC		Documentation is recorded in maternity record hwoever need to review audit process. Completion date - July 2022; part of assurance process 11.1; part of assurance process 11.1
		4	Resources must be made available for anaesthetic professional bodies to determine a consensus regarding contents of core datasets and what constitutes a satisfactory anaesthetic record in order to maximise national engagement and compliance.		Recommendation reviewed - WUTH ready however awaiting Regional / National review
	Obstetric anaesthesia staffing guidance to include:	**5**	The role of consultants, SAS doctors and doctors-in-training in service provision, as well as the need for prospective cover, to ensure maintenance of safe services whilst allowing for staff leave.		Staff who do not do regular Obstetric Anaesthesia sessions want to do a Consultant Accompanied CPD session in Obstetric Anaesthesia to keep skills up to date we are more than happy to facilitate this - and several people have already taken up this opportunity. Process to be reviewed. Completion date - July 2022; assurance process to be developed
		6	• The full range of obstetric anaesthesia workload including, elective caesarean lists, clinic work, labour ward cover, as well as teaching, attendance at multidisciplinary training, and governance activity.		Staffing of same to be reviewed. Completion date - July 2022; assurance process to be developed
		7	• The competency required for consultant staff who cover obstetric services out-of hours, but who have no regular obstetric commitments.		As point 5; assurance process to be developed
		8	• Participation by anaesthetists in the maternity multidisciplinary ward rounds as recommended in the first report		All anaesthetists attend PROMPT MDT training; assurance process to be developed
12: POSTNATAL CARE					
			Audit and review of processes / policies re postnatal care		
12: POSTNATAL CARE	Trusts must ensure that women readmitted to a postnatal ward and all unwell postnatal women have timely consultant review.Postnatal wards must be adequately staffed at all times	**1**	All trusts must develop a system to ensure consultant review of all postnatal readmissions, and unwell postnatal women, including those requiring care on a non maternity ward		Process in place - document to be developed to support process
		2	Unwell postnatal women must have timely consultant involvement in their care and be seen daily as a minimum		Process in place - document to be developed to support process
		3	Postnatal readmissions must be seen within 14 hours of readmission or urgently if necessary		Process in place - document to be developed to support process
		4	Staffing levels must be appropriate for both the activity and acuity of care required on the postnatal ward both day and night, for both mothers and babies.		Acuity tool used and effective
13: BEREAVEMENT CARE					
13. BEREAVEMENT CARE	Trusts must ensure that women who have suffered pregnancy loss have appropriate bereavement care services.	**1**	Trusts must provide bereavement care services for women and families who suffer pregnancy loss. This must be available daily, not just Monday to Friday.		Bereavement midwife in post but works Monday to Friday. EMC team upskilled and shift coordinators. With development of bereavement champions in teams. Cover available 24/7
		2	All trusts must ensure adequate numbers of staff are trained to take post-mortem consent, so that families can be counselled about post-mortem within 48 hours of birth. They should have been trained in dealing with bereavement and in the purpose and procedures of post-mortem examinations.		EMC staff and coordinators - can be inlcuded in development package for coordinators
		3	All trusts must develop a system to ensure that all families are offered follow-up appointments after perinatal loss or poor serious neonatal outcome		In place - dual with obstetrics and neonates
		4	Compassionate, individualised, high quality bereavement care must be delivered for all families who have experienced a perinatal loss, with reference to guidance such as the National Bereavement Care Pathway		Pathway in place and in use.
14: NEONATAL CARE					
			Close links with NODN to progress - this links in with the regional transformational work with Exec input to support		
14: NEONATAL CARE	There must be clear pathways of care for provision of neonatal care. This review endorses the recommendations from the Neonatal Critical Care Review (December 2019) to expand neonatal critical care, increase neonatal cot numbers,	**1**	Neonatal and maternity care providers, commissioners and networks must agree on pathways of care including the designation of each unit and on the level of neonatal care that is provided.		Guidance in place
		2	Care that is outside this agreed pathway must be monitored by exception reporting (at least quarterly) and reviewed by providers and the network. The activity and results of the reviews must be reported to commissioners and the Local Maternity Neonatal Systems (LMS/LMNS) quarterly.		Recommendation reviewed - WUTH ready however awaiting Regional / National review
		3	Maternity and neonatal services must continue to work towards a position of at least 85% of births at less than 27 weeks gestation taking place at a maternity unit with an onsite NICU.		This is a unit with onsite Level 3 NICU
		4	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.		Recommendation reviewed - WUTH ready however awaiting Regional Neonatal ODN Guidance
		5	Each network must report to commissioners annually what measures are in place to prevent units from working in isolation.		Recommendation reviewed - WUTH ready however awaiting Regional Neonatal ODN Guidance

	develop the workforce and enhance the experience of families. This work must now progress at pace.	**6**	Neonatal providers must ensure that processes are defined which enable telephone advice and instructions to be given, where appropriate, during the course of neonatal resuscitations. When it is anticipated that the consultant is not immediately available (for example out of hours), there must be a mechanism that allows a real-time dialogue to take place directly between the consultant and the resuscitating team if required		Evidence of this happening in practice to be confirmed and to be followed up with Angela McDonald, Adam Brown and Sanjeev Rath
		7	Neonatal practitioners must ensure that once an airway is established and other reversible causes have been excluded, appropriate early consideration is given to increasing inflation pressures to achieve adequate chest rise. Pressures above 30cmH2O in term babies, or above 25cmH2O in preterm babies may be required. The Resuscitation Council UK Newborn Life Support (NLS) Course must consider highlighting this treatment point more clearly in the NLS algorithm.		NLS Guidance followed - action to be followed up with neonatal team
		8	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.		Staffing review undertaken as above -Adam Brown and Anand to feedback to DMB.
15: SUPPORTING FAMILIES					
			Ensure support covers maternity and neonatal care/services		
15: SUPPORTING FAMILIES	Care and consideration of the mental health and wellbeing of mothers, their partners and the family as a whole must be integral to all aspects of maternity service provisionMaternity care providers must actively engage with the local community and those with lived experience, to deliver services that are informed by what women and their families say they need from their care	**1**	There must be robust mechanisms for the identification of psychological distress, and clear pathways for women and their families to access emotional support and specialist psychological support as appropriate.		Perinatal mental health team in post. GIRFT identified need for neonatal support. This is in place regionally
		2	Access to timely emotional and psychological support should be without the need for formal mental health diagnosis, as psychological distress can be a normal reaction to adverse experiences.		Perinatal mental health team in post with further support from Psychiatric Liason team..
		3	Psychological support for the most complex levels of need should be delivered by psychological practitioners who have specialist expertise and experience in the area of maternity care		Psychiatric liaison team and dedicated psychologist to support. WUTH also involved in regional project to further enhance PMH support.

Recommendation reviewed - WUTH ready however awaiting Regional / National Guidance
Fully Embedded
On target to achieve; no risks
Partially Compliant
Non Compliant/risk identified on risk register
NOTE: Completion dates are provisional pending detailed improvement plan.

	Three Year Single Delivery Plan for Maternity and Neonatal Services - May 2024							
	Theme1: Listening to and working with women and their families with compassion				RAG Rating	Lead	Review Date	Comments / Lead Progress
	Objective 1: Care that is personalised	Personalised care gives people choice and control over how their care is planned and delivered. It is based on evidence, what matters to them, and their individual risk factors and needs	**1**	Women experience care that is always kind and compassionate. They are listened and responded to. Open and honest ongoing dialogue between a woman, her midwife, and other clinicians, to understand the care she wants, any concerns she may have, and to discuss any outcomes that are not as expected. All women are offered personalised care and support plans which take account of their physical health, mental health, social complexities, and choices. Plans consider inequalities in the broadest sense, including protected characteristics and Core20PLUS5. The care plan includes a risk assessment updated at every contact, including when the woman is in early or established labour.		JL	No further action	CQC Patient survey Debrief clinics to go through pregnancy outcomes. Birth Options clinic to evidence discussion of women's preferences Examples of care plans; PMH plans; Risk assessment audits Look at further improving inequalities as per equity and equality plan – Consultant Midwife to support with MNVP involvement.
			2	Women receive care that has a life course approach and preventative perspective, to ensure holistic care for women and the best start in life for babies. This includes NHS-led smoke-free pregnancy pathways to provide practical support for pregnant women who are smokers, and evidence-based information about screening and vaccination		AK/ER	No further action	Evidence of smoking cessation midwife/work with ABL. Use of NRT. ANNB Screening Programme QA; ANNB Screening action plan to further review screening information
			3	Women have clear choices, supported by unbiased information and evidence- based guidelines. Information is provided in a range of formats and languages, uses terminology in line with the Rebirth report, and is co-produced.		AK/ER	Completed	Rebirth report review completed. Clear choices and information is in place including the updated/revamped website. Continue to work with MNVP re equity and equality to ensure all people receive information they understa
			4	All women have equitable access to specialist care, including perinatal mental health services, perinatal pelvic health services, maternal and foetal medicine networks, and neonatal care, when needed		JKL	No further action	All services with guidelines are in place except perinatal pelvic health services – same being introduced; Set up a perinatal pelvic health service and work closely with LMNS re guidance/requirements; funding secured and JD to be matched; initial discuss with PPHS lead and service to be set up at WUTH; in post setting up services
			5	Women experience personalised, joined-up, high-quality care right through to the postnatal period with handover to health visiting services and a GP check 6-8 weeks after birth. They are provided with practical support and information that reflects how they choose to feed their babies		KW	No further action	Processes in place although clarity needed regarding 6-8week GP check post pandemic; Check with HV team re GP follow up check
			6	Parents are partners in their baby's care in the neonatal unit through individualised care plans utilising a family integrated care approach, together with appropriate parental accommodation.		ST/AMC	No further action	FI Care review undertaken with action plan developed following feedback positive in May 2022; repeated in May 2023 and GREEN accreditation achieved
			7	Compassionate and high-quality care for bereaved families including appropriate accommodation, which is easily accessible but separate from maternity and neonatal units		AK/ER	No further action	Bereavement midwife in post. Bereavement Suite on site. Use of Ron McDonald House is also an option that is used
	Objective 2: Improve equity for mother and babies	The NHS approach to improving equity (Core20PLUS5) involves implementing midwifery continuity of carer, particularly for women from minority ethnic communities and from the most deprived area It is the responsibility of trusts to: Provide services that meet the needs of their local populations, paying particular attention to health inequalities. This includes facilitating informed decision-making, for example choice of pain relief in labour where we know there are inequalities, ensuring access to interpreter services, and adhering to the Accessible Information Standard in maternity and neonatal settings.	**8**	To reduce inequalities for all in access, experience and outcomes		JL/ER	31/8/25	Equity and Equality plan developed by LMNS following gap analysis which the Trust completed; Further work re equality to be undertaken; WUTH completed; awaiting LMNS update
			9	Targeted support where health inequalities exist in line with the principles of proportionate universalism		No further action	No further action	MCoC teams to be set up as a wraparound service but the support is already in place from these Leads; MCoC teams in place and embedded in the identified areas; review MCoC
			10	Services listen to and work with women from all backgrounds to improve access, plan and deliver personalized care. Maternity and Neonatal voice partnerships ensure all groups are heard, including those most at risk of experiencing health inequalities.		JL	No further action	
			11	The NHS collaborates with local authority services, other public sector organisations (NHS Constitution Principle 5, 2021) to address the social determinants of health, which are a significant driver of health inequalities (WHO, 2022)		JL/KW	No further action	Maternity services to work with PLACE; LMNS and ICB leads to progress; PH g=meeting, familuy hubs, ICB (ID) MNVP, Wirral Place collboration and report; LMNS regular meetings
			12	In spring 2023, publish the National Review of Health and Social Care in Women's Prisons. This review covers maternity and perinatal services		JL/MB	No further action	To achieve requirement to work with the LMNS to meet and no local prisons feed into WUTH; consider a SoP with safeguarding midwife involvement
	Objective 3: Work with service users to improve care	Acting on the insights of women and families improves services. Co-production is beneficial at all levels of the NHS and is particularly important for those most at risk of experiencing health inequalities (NICE, 2018). Involving service user representatives helps identify what needs to improve and how to do it. This is done through maternity and neonatal voices partnerships (MNVPs) and by working with other	**13**	MVNPs listen to and reflect the views of local communities. All groups are heard, including bereaved families.		JL	No further action	Equity and Equality plan developed by LMNS following gap analysis which the Trust completed; Further work re equality to be undertaken as detailed above
			14	MNVPs have strategic influence and are embedded in decision making		JL	No further action	MIS evidence supports work and undertaken and co-production
			15	MNVPs have the infrastructure they need to be successful. Workplans are funded. MNVP leads, formally MVP chairs, are appropriately employed or remunerated and receive appropriate training, administrative and IT support.		JL	No further action	MNVP embedded; full funding of post with agreed workplan from ICB awaited; local workplan in place
	Theme 2: Growing, retaining and supporting workforce				RAG Rating	Lead	Review Date	Comments / Lead Progress
	Objective 4: Grow our workforce	The maternity and neonatal workforce encompasses a wide range of professions, including midwives, maternity support workers, obstetricians, anaesthetists, neonatologists, neonatal nurses, sonographers, allied health professionals, and psychologists. Growing our workforce requires the tailoring of interventions to professional groups, career stage, and local requirements	**16**	Workforce capacity to grow as quickly as possible to meet local needs.		JL	No further action	Workforce plan in place with report to Board every 6 months
			17	Local and national workforce planning to utilise evidence-based tools, endorsed by NICE or the National Quality Board (NQB), that allow for medical and social complexity, training,		JL	No further action	Nursing and Medical workforce planning tools used. BR+ Report in date. Also work with regional Leads
			18	Aligned local and national strategies supporting recruitment to those vacant posts identified through workforce planning		JL	No further action	No specific work done with Rebirth report – review of same. Clear choices and information is in place including the updated/revamped website. Continue to work with MNVP re equity and equality to ensure all people receive information they understand.
	Objective 5: Value and retain our workforce	Our maternity and neonatal staff perform critical, life-changing work every day. We must ensure they are valued and have a fulfilling and sustainable career within the NHS. We need to do more to improve the experience of all our staff, to retain them within the NHS	**19**	Staff feel valued at all stages of their career. This includes support to get off to a good start, opportunities for progression and flexible working, and support when approaching retirement age to allow staff to continue to use their skills and experience.		JL	No further action	
			20	All staff are included and have equality of opportunity		JL	No further action	
			21	A safe environment and inclusive culture in which staff feel empowered and supported to take action to identify and address all forms of discrimination		JL/HW/MS/ET	Ongoing annually	Score survey undertaken for Maternity and Neonates; feedback sessions in November 2023; staff engagement April 2024
	Objective 6:	Staff feel valued when they are supported to develop. We are investing in our staff by ensuring they have ongoing training and career	**22**	All staff are deployed to roles where they can develop and are empowered to deliver high quality care. Specialist roles within each profession, for example the labour ward coordinator, have a job description, orientation package, appropriate training, and ongoing development		JL	No further action	Evidence collated for Ockenden improvement plan

	Invest in skills	development opportunities. Effective training of frontline clinicians in technical and non-technical skills has been shown to improve outcomes.	**23**	All staff have regular training to maintain and develop their skills in line with their roles, career aspirations, and national standards. Training is multi-disciplinary wherever practical to optimise teamworking		JL	No further action	TNA in place and reviewed annually
	Theme 3: Developing and sustaining a culture of safety, learning and support				RAG Rating	Lead	Review Date	Comments / Lead Progress
	Objective 7: Developing a positive safety culture		**24**	All staff working in and overseeing maternity and neonatal services: -Are supported to work with professionalism, kindness, compassion, and respect. Are psychologically safe to voice their thoughts and are open to constructive challenge. -Receive constructive appraisals and support with their development. -Work, learn and train together as a multi-disciplinary team across maternity and neonatal care.		JL	No further action	MDT training in place. TNA supports training requirements incl psychological safety. Appraisal process in place with good compliance monitored at Board level.
			25	Teams value and develop people from all backgrounds and make the best use of their diverse skills, views, and experiences.		JL	No further action	Training in place to support
			26	There is a shared commitment to safety and improvement at all levels, including the trust board, and attention is given to 'how' things are implemented not just 'what'		JL	No further action	Evidenced through safety champions meetings; Newly formed divisional MatNeo Assurance Board
			27	Instances of behaviour that is not in line with professional codes of conduct, are fairly addressed before they become embedded or uncontrollable.		JL	No further action	Trust training and policies support professional behaviour/s. Disciplinary processes support appropriate action when needed
			28	Systems and processes enable effective coordination, rapid mobilisation, and supportive communication based on agreed principles. The team can escalate concerns and, should there be a disagreement between healthcare professionals, they will be supported by a conflict of clinical opinion policy.		JL	No further action	Policy in place – provided for Ockenden evidence
			29	Staff investigating incidents are provided with appropriate training, while those staff affected by an incident are offered timely opportunity to debrief		JL/DC	No further action	Training in place for staff and this is reviewed and provided by the Trust Governance team
	Objective 8: Learning and Improving	Staff working in maternity and neonatal services have an appreciation and understanding of 'what good looks like.' To promote safer care for all, we must actively learn from when things go well and when they do not. To do this, we need a continuous learning and	**30**	Our ambition is framed by the patient safety incident response framework (PSIRF) which provides a consistent approach across clinical specialties, including for maternity and neonatal services		JL/DC	No further action	PSIRF launched in the Trust September 2023; nataional guidance awaited specific for maternity services; embedded
			31	The Healthcare Safety Investigation Branch undertake investigations of incidents which meet their criteria		JL/MD	No further action	MNSI quarterly meetings take place and Trust evidenced 100% reporting by the Trust
	Objective 9: Support and oversight	While some trusts and ICSs do effectively support their maternity and neonatal services to improve and change; others do not. Good oversight is about understanding the issues leaders face and helping to resolve them, and having clear systems in place that promote timely escalation and intervention before serious problems arise	**32**	Robust oversight through the perinatal quality surveillance model (PQSM) that ensures concerns are identified early, addressed, and escalated where appropriate		JL	No further action	Evidence Monthly PQSM report to Board with quarterly detailed maternity /neonatal reports presented
			33	Well led services, with additional resources channelled to where they are most needed		JL	No further action	CQC visit supported well led service at last inspection. Other evidence / outcomes also support
			34	Leadership for change, with a focus on ensuring new service models have the right building blocks for high quality care, especially the workforce.		JL	Ongoing annually	Leadership training in place and underway x various programmes for Senior Leaders, Quad perinatal leadership programme; W&C leadership development plan ongoing
	Theme 4: Standards and structures that underpin safer, more personalised and more equitable care				RAG Rating	Lead	Review Date	Comments / Lead Progress
	Objective 10: Standards to ensure best practice	Advances in clinical practice have been crucial in the improvement in maternity and neonatal outcomes over the last decade. Better Births also identified that variation in protocols, policies, and standards between services creates additional burden and hinders the ability to work together to provide effective care.	**35**	Consistent implementation of nationally defined best practice with due regard to the needs of local populations to reduce variation and inequalities		JL/MS	31/8/25	MIS year 6 submitted and confrimation of 9 safety actions; SBLv3 implemented 94%; review of MCoC to address women with inequalities; MIS Year 7 published and in progress;
			36	Healthcare professionals have access to shared standards and guidelines, including transfer, transport, and referral protocols, so that clinical teams across the ICS work to the same definitions of best practice		JL	30/9/25	Ongoing work with ICB; standardised policies within C&M available and development ongoing
			37	Where local policy varies from national standards, this is subject to careful local scrutiny through governance processes. The whole multidisciplinary team is involved when developing local guidance		JL	No further action	Processes in place to ensure MDT are involved with developing local policy
			38	Policies and guidelines recognise women as the decision-makers in their maternity care and are not used to prevent women from seeking care that is outside these guidelines		AK/ER	No further action	Policy in place and women are supported by the consultant midwife/Obstetric/Neonatal Leads
			39	Neonatal care is provided in units with clear designation of the level of care to be provided. Units work together across ODNs to optimise capacity and ensure care can be provided in the right place for very pre-term or very sick babies		Leads	No further action	Policy in place and women are supported by the consultant midwife/Obstetric/Neonatal Leads
	Objective 11: Data to inform learning	The Kirkup report highlighted the need for accurate, up to date data to highlight safety issues promptly. Such data enables providers to learn and act. Work is underway to review what data is needed for monitoring, and in the meantime, the NHS should continue to use the data it already collects	**40**	Standardised data is collected in a consistent way, primarily through the Maternity Services Data Set. Additional data collections are minimised, to focus on gathering the right data to drive insights, understanding and assurances.		JL	No further action	MSDS submitted in addition to completion of a local and regional dashboard
			41	Monitoring trends at both national and local level is enabled by analysing data from different sources alongside themes from MBRRACE-UK , and the national clinical audits patient outcome programme reports		DC	No further action	LMNS support in leading on monitoring trends regionally. Outlier reports are presented to Board quarterly; Improvement plans are developed to address any outlier reports
			42	The national maternity dashboard provides demographic data, clinical quality improvement metrics and national maternity indicators enabling trusts and LMNSs to benchmark their services and inform continuing quality improvement work		JL/DC	No further action	Data submitted to national dashboard; Given limited metrics the national dashboard is not currently reviewed – work to be identified to address an improvement moving forwards.
	Objective 12: Make better use of digital technology	Digital technology will make it easier for women to access the information they need and for services to offer safe and personalised care. There is currently significant variation in the use of digital technology. While some maternity services remain almost entirely paper-based, others support personalised care with apps and benefit from an integrated electronic patient record (EPR).	**43**	Women can access their records and interact with their digital plans and information to support informed decision-making. Parents can access neonatal and early years health information to support their child's health and development. Information meets accessibility standards, with non-digital alternatives available for those who require or prefer them		JL/KW	30/9/25	Processes in place for women to access their records electronically – work to progress to roll out patient portal; personalied care plans beig developed; access to app's; access to GROW
			44	All clinicians are supposed to make best use of digital technology with sufficient computer hardware, reliable Wi-Fi, securing networks and training			No further action	Full IT system in place and supported with equipment
			45	Organisation's enable access to key information held elsewhere internally or by partner organisations, such as other trusts and GP practices			No further action	Work across Wirral with the introduction of the single care record is supporting this

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.

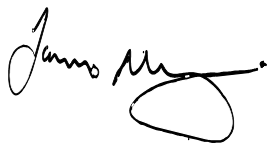
In the meantime, we ask every local NHS Board with responsibilities relating to maternity and neonatal care to:

- 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

Appendix 10

Board of Directors in Public

03 September 2025

Title	Gap Analysis: Trust Readiness for Maternity and Neonatal Services Inquiry (June 2025)
Area Lead	Sam Westwell, Chief Nurse
Author	Jo Lavery, Divisional Director of Nursing & Midwifery (Women's and Children's')
Report for	Information

Report Purpose and Recommendations

To provide the Board of Directors with a gap analysis of the Trusts readiness for the Maternity and Neonatal Services Inquiry announced in June 2025.

The Board of Directors is recommended: -

- To note the report content.
- Support the recommendations, assurance report and draft action plan.

Key Risks

This report relates to these key Risks:

- BAF Risk 1.4, Failure to ensure adequate quality of care resulting in adverse patient outcomes and an increase in patient complaints.

Contribution to Integrated Care System objectives (Triple Aim Duty):	
Better health and wellbeing for everyone	Yes
Better quality of health services for all individuals	Yes
Sustainable use of NHS resources	Yes
Which strategic objectives this report provides information about:	
Outstanding Care: provide the best care and support	Yes
Compassionate workforce: be a great place to work	Yes
Continuous Improvement: maximise our potential to improve and deliver best value	Yes
Our partners: provide seamless care working with our partners	Yes
Digital future: be a digital pioneer and centre for excellence	No
Infrastructure: improve our infrastructure and how we use it.	No

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
July 2025	Safety Champions Meeting	Gap Analysis: Trust Readiness for Maternity and Neonatal Services Inquiry (June 2025); Draft action plan and Gap Analysis to statements	For discussion and approval to Board of Directors and Board of Directors
August 2025	Board of Directors	Gap Analysis: Trust Readiness for Maternity and Neonatal Services Inquiry (June 2025)	For discussion and approval
August 2025	Patient Safety and Quality Board	Gap Analysis: Trust Readiness for Maternity and Neonatal Services Inquiry (June 2025)	For information
September 2025	Maternity & NNU Assurance Board	Quarterly Maternity and Neonatal Services Report	For information

1	Background
	On 17 June 2025, the Department of Health and Social Care formally launched the independent and Neonatal Services Inquiry, following persistent and widespread failings across several NHS Trusts. The investigation comes alongside a package of immediate actions to improve care, including greater intervention by the Secretary of State and NHS Chief Executive to hold failing trusts to account - a key step in delivering the government's mission to build an NHS fit for the future through the Plan for Change. This announcement came on the back of significant failings in maternity services in parts of the NHS and the urgent request to understand and address the systemic issues behind why so many women, babies and families are experiencing unacceptable care. There was reference to frequently failing to consistently listen to women and their families when they raise concerns and too many families being let down by the NHS. It was noted there remains stark inequalities faced by Black and Asian women and women in deprived areas. In addition, WUTH continue to have significant issues around safety and culture within our maternity workforce. Whilst most births in England are safe, it was acknowledged there are persistent issues over recent years and the need to act with urgency to address these with a vision to have teams providing good and outstanding maternity and neonatal care every day. From July to December 2025, an independent investigation will conduct urgent reviews of up to 10 trusts where there are specific issues. Currently 4 Trusts have named. A further 10 Trusts have been identified as having higher profile failings and CQC

	inadequate ratings are also being reviewed. WUTH has not been identified among one of these Trusts in the recent national inquiry. The relevant leaders of several organisations will be met over the period of a month and with a view to hearing what more can be done to support going further and faster in improving maternity and neonatal care. In the meantime, every local NHS Board with responsibilities relating to maternity and neonatal care have been asked to review 5 statements: - The inquiry will assess how services are governed, resourced, and experienced across the UK with an emphasis on: • Being rigorous in tackling poor behaviour where it exists and 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 and creating 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. • Setting the right culture: supporting, listening and working, through coproduction, with Maternity and Neonatal Voice Partnership, 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.

2	**Gap Analysis Table**
	NHS providers are expected to demonstrate transparency, learning and measurable action. Included at **Appendix 11** is WUTH's current position against each of the statements. Included at **Appendix 12** is a high-level analysis table identifying gaps against the key themes and actions to work towards prior to the publication of the inquiry expected in December 2025.

3	**Key Risks for Board of Directors' Attention**
	• Inadequate establishment to deliver safe care in line with Birthrate Plus including Trained Staff, Senior Leadership Structure and Maternity Support Workers. • Recommendations from the Northwest Neonatal Operational Delivery Network the identified gaps in the AHP workforce for Neonatal Unit.

	• Inadequate Obstetric medical staffing resulting in women/birthing people having delays in triage reviews. • PSIRF with oversight of its effectiveness and a standardised approach of learning from incidents would strengthen the current position further. • Gaps in joined up perinatal governance (maternity and neonatal).

4	Recommendations
	• Endorse the Maternity and Neonatal Assurance Board to be the readiness taskforce monitoring group of the inquiry and report quarterly to Board of Directors. • Support the funding and Trust approval processes to close midwifery and obstetric gaps as identified by the Birth-rate Plus workforce planning tool. • Note and support the requirement to explore the identified gaps in the Neonatal staff groups • Strengthen governance by including MNVP at relevant subcommittees. • Continue to actively monitor and address any shortfalls quarterly the learning and compliance from past reviews (Ockenden, Kirkup, East Kent) which are built into Trust wide assurance frameworks.

5	Conclusion
	The recently announced Maternity and Neonatal Inquiry (2025) underscores the national imperative to ensure the highest standards of safety, transparency and accountability in perinatal care. This paper has outlined the key issues, identified risks and recommendations associated with the recently announced inquiry and associated statements. The Board of Directors is asked to note the current position the paper and appendices has outlined focusing on the current position in relation to the inquiry themes, including leadership, culture, governance, workforce, family engagements and learning from incidents. The support the recommended next steps and provide strategic oversight as we continue to monitor the impact on service delivery, workforce sustainability along with maternity and neonatal performance. Ongoing evaluation and stakeholder engagement will be essential to ensure the risks are mitigated are requested to note the content within this exception report and progress being made to identify any potential gaps prior to the publication of the inquiry. As further inquiry details and timelines emerge, the Board of Directors will continue to be updated. The Maternity and Neonatal Assurance Board Meeting will continue to support the governance process.

6	Implications
6.1	**Patients**

	• The appendices outline the standards we adhere to in order to deliver a safe service, with excellent patient care.
6.2	**People** • The outstanding relationship with MNVP demonstrates co-production with service users and patient involvement, noting areas to build and improve further on. • The commitment to reviewing governance processes, workforce, family engagement support women and birthing people on the Wirral.
6.3	**Finance** • Birthrate Plus workforce planning has indicated investment is required to support safe staffing maternity levels and confirmed a deficit in midwifery staffing levels. • Increasing workforce will have financial implication on the Trust and funding options will be explored.
6.4	**Compliance** • This supports several reporting requirements, each highlighted within the report.

Author	Jo Lavery, Director of Midwifery & Nursing - Women and Children's Division
Contact Number	0151 678 5111, Ext 2792
Email	Jo.lavery@nhs.net

NHS
Wirral University Teaching Hospital
NHS Foundation Trust

Maternity and Neonatal Inquiry Announcement June 2025 Gap Analysis and Overarching Evidence Analysis (SBAR approach) whilst awaiting next steps

Prepared by Jo Lavery Divisional Director of Nursing and Midwifery (Women's and Children's)

July 2025

together we will
...deliver the best quality and safest care to the communities we serve

Maternity and Neonatal Inquiry Announcement

Wirral University Teaching Hospital NHS Foundation Trust

Situation and Background

In June 2025, the Secretary of State for Health and Social Care announced a rapid independent investigation into maternity and neonatal services. It was also announced an independent taskforce, alongside immediate actions to improve care.
This announcement came on the back of significant failings in maternity services in parts of the NHS and the urgent request to understand and address the systemic issues behind why so many women, babies and families are experiencing unacceptable care.
There was reference to frequently failing to consistently listen to women and their families when they raise concerns and too many families being let down by the NHS.
It was noted there remains 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.
Whilst the vast majority of births in England are safe, it was acknowledged there are persistent issues over recent years and the need to act with urgency to address these with a vision to have teams providing good and outstanding maternity and neonatal care every day.

Plan

From July to December 2025, an independent investigation will conduct urgent reviews of up to 10 trusts where there are specific issues. Currently 4 Trusts have been named.
The relevant leaders of several organisations will be met over the period of a month and with a view to hearing what more can be done to support going further and faster in improving maternity and neonatal care.
In the meantime, every local NHS Board with responsibilities relating to maternity and neonatal care have been asked to review 5 statements.

Maternity and Neonatal Inquiry Assessment

Wirral University Teaching Hospital NHS Foundation Trust

Statement 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.

Response

- Demonstrate and review at least quarterly reporting to BoD compliance with Ockenden including all leadership elements
- Demonstrate and review at least quarterly reporting to BoD on target to achieve Three Year Delivery Plan and the majority RAG rated as complete
- CQC Report (2023) reported a healthy safety culture and regulatory rating was GOOD with evidence of outstanding practice
- Evidence in line with NHS England Maternity Improvement Strategy
- No reported themes via staff survey reporting bullying, safety concerns, undermining or discrimination
- Maternity Voices feedback relating to any staff attitudes and behaviours addressed immediately and monitored via patient feedback mechanisms Patient concerns relating to any staff attitudes and behaviours addressed immediately and monitored via patient feedback mechanisms
- Organisational Development collaborative approach to culture programme of work designed to measure and enhance teamwork, staff development and patient experience, with outputs presented to Executives bimonthly via Divisional Performance Reviews and is being utilised by PCLP as a case study of good practice (Appendix 1)
- Not an identified outlier for avoidable deaths
- No identified public loss of trust, negative media or enforcement actions

Maternity and Neonatal Inquiry Assessment

Wirral University Teaching Hospital NHS Foundation Trust

Statement 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

Response

- Demonstrate and review at least quarterly reporting to BoD compliance with Ockenden including all leadership elements
- Demonstrate and review at least quarterly reporting to BoD on target to achieve Three Year Delivery Plan and the majority RAG rated as complete
- CQC Report (2023) reported a healthy safety culture and regulatory rating was GOOD with evidence of outstanding practice
- LMNS / NHSE Annual visit and feedback mechanism; considered safe and well managed – recognising areas for improvement, demonstrates measurable progress, good governance and excellent fami y partnership
- Active MNVP operating independently but well integrated into governance structures
- Commitment to listening, ensuring the voices of women and families are heard, valued acted upon and is continually embedded:
  - Maternity surveys for service users inviting feedback
  - Review of Friends and Family testing collated monthly and themed to any emerging concerns and positive trends
  - Aftercare and listening clinics; patient stories and feedback shared through a variety of communication channels
  - Weekly reviews of complaints and PAL data to identifying cases, themes emerging
- Introduction and 55% of women/birthing people on a continuity of carer model

Maternity and Neonatal Inquiry Assessment

Wirral University Teaching Hospital NHS Foundation Trust

Statement 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.

Response

- Maternity and Neonatal Voices Partnership fully established; full funding utilised to support 24 hours per week (above the recommendations)
- Included as part of Maternity Incentive Scheme (SA7). Fully achieved in Years 1-6 and evidence submitted for Year 7
- Evidence via quarterly reports, 15 steps process, member of key meetings both regionally and locally including PMRT, Safety Champions, PFEG, Maternity and Neonatal Assurance Meeting
- Events for service users planned each year, active Facebook and Instagram Pages with over 4k followers, evidence of live posts regularly co-produced and live streams
- CQC Report (2023) reported MNVP as having outstanding practices

Maternity and Neonatal Inquiry Assessment

Wirral University Teaching Hospital NHS Foundation Trust

Statement 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.

Response

- LMNS / NHSE Annual visit and feedback mechanism; considered safe and well managed – recognising areas for improvement, demonstrates measurable progress, good governance and excellent fami y partnership
- Monthly dashboards for Maternity and Neonatal; submitted to ICB and monitored via internal governance processes. Quality indicator examples include, mortality rates, PPH, IOL, B/F initiation, admission rates to NNU, BAPM compliance
- Maternity and neonatal QI focus group embedded
- Evidence via compliance of Saving Babies Lives and improved outcomes – currently at 94% compliance with QI Action plans for the elements requiring improvement
- LMNS data provided and able to benchmark against Cheshire & Mersey – no currently identified as an outlier
- Governance and oversight frameworks including Maternity and neonatal meeting, PSQB and BoD reporting including monthly PSQM
- Quarterly report to Trust Board and submission to the LMNS as part of Maternity Incentive Scheme; monthly report to BoD including maternity red flags via Trust wide staffing report
- Daily huddles of any safety issues / emerging themes

Maternity and Neonatal Inquiry Assessment

Wirral University Teaching Hospital NHS Foundation Trust

Statement 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.

Response

- Commitment to ensuring every woman/birthing person and family receives equitable, respectful and safe maternity care; included as part of maternity strategy and vision
- Achieving 50% Maternity Continuity of Carer models for women in areas of deprivation and BAME community; since 2019 have rolled out covering 75% of the WUTH community
- Stratify maternity outcomes by ethnicity, deprivation and language
- Examples of thematical analysis if required and reporting to BoD, regional sharing culture established
- Co-production with MNVP – ongoing work with hard to reach populations included; examples include socially deprived areas& the refuge
- Divisional EDI objective to drive inclusive career opportunities to drive a diverse workforce
- Members of C&M and NW network groups
- Demonstrate as a Trust part of overall strategy, vision, mandatory training
- Metrics reviewed at local governance groups
- QI project on supporting all literature in other languages

Recommendations

Wirral University Teaching Hospital NHS Foundation Trust

- Continue to provide all the assurances and evidences outlined against each statement
- Include the Maternity and National Inquiry updates within the appropriate reports and agenda's
- Continue with the maternity and neonatal governance structures embedded and comprehensive BoD reporting, LMNS assurance and NHS Future platform evidence
- Continue the co-production with MNVP and service users acting immediately on any escalations; monitoring patient feedback via all mechanisms embedded
- Continue to train and develop leaders in a just culture approach and support opportunities to speak up and share learning via appropriate forums
- Develop a performance data set for Board reporting and benchmarking
- Develop real life patient stories and case studies for sharing in staff reflection and governance sessions
- Quality Improvement project to support cultural backgrounds with information within a variety of key languages and access links via the WUTH internet site
- MNVP to develop a listening event with all maternity and neonatal staff to widen understanding and support embedding culture
- Develop leadership journey commenced in Spring 2025 (Appendix 1) – W&C OD Collaboration
- Focus on sharing enhanced learning from cases and clinical governance feedback as a quality improvement

APPENDIX 1:
W&C & OD Collaboration: 3 Areas of Focus
Linked to Patient Experience and Workforce

Wirral University Teaching Hospital NHS Foundation Trust

Triumvirate and Senior Divisional Leadership

- Triumvirate time out – development of Divisional objects and triumvirate working – February 2025
- Senior Divisional leader away day – Divisional vision and objectives and triumvirate working – May 2025
- Perinatal Culture Leadership Programme (PCLP) – 3 x coaching sessions for Maternity and Neonatal Quadrumvirate; DD, DDoN&M, Obstetrics CD and Neonates CD

Staff Engagement

- Staff engagement session/listening events
- Freedom to speak up champions
- Staff survey feedback events – March 2025
- Appraisal and check ins

Leadership Development

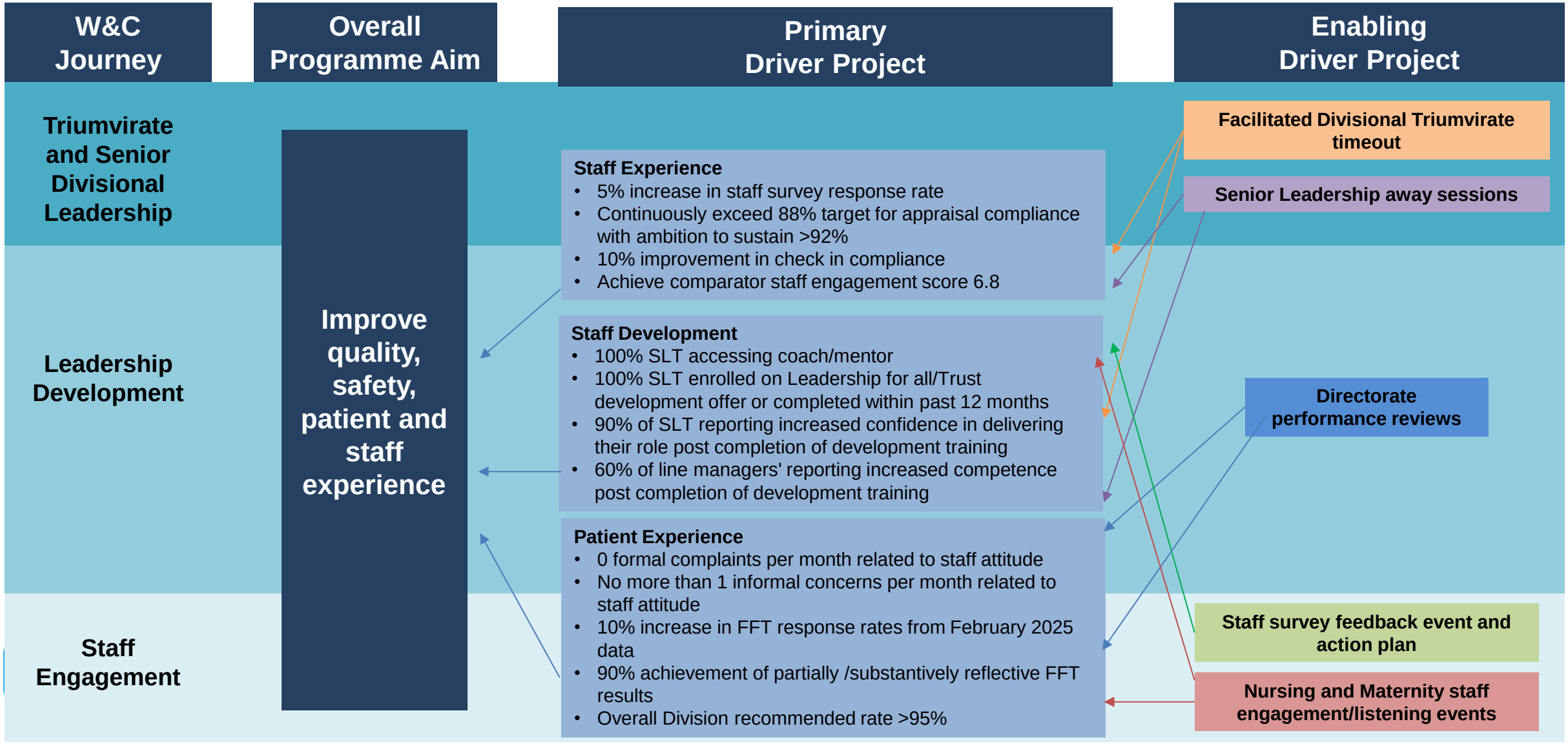
- Developing our Divisional leaders
- Quality improvement coaches
- Culture coach (PCLP)
- People champions – new opportunity
- Access to coaches and mentors
- Apprenticeships

Culture

Measuring Success

Driver projects have KPIs to measure and monitor progress
Enabling projects support delivery of driver project KPIs

Wirral University Teaching Hospital
NHS Foundation Trust



Appendix 12

Key Theme	Current position	Identified Gap	Recommended Action	Lead	Due Date
1. Leadership and Board Oversight	Maternity Data included in integrated performance reports	Board receives limited narrative on safety issues and brief updates on the family voice	Enhance reporting with soft intelligence and MNVP User Feedback	Director of Midwifery	Q3 2025
2. Incident reporting and learning	PMRT and MNSI compliance; incidents reviewed	Opportunities for learning mechanisms from cases to be broadened and shared widely	Standardise learning dissemination and review evidence of actions; ICB oversight of PSII's / noting of themes and dissemination of learning from other providers	Quality and Safety Lead	Q3 2025
3. Listening to families and MNVP	MNVP Meetings occur every other week and quarterly meetings; MNVP is a member of the Safety Champion and Maternity and Neonatal Assurance Board; MNVP do not currently attend PMRT meetings or all Clinical Governance forums including Labour Ward Steering Group	MNVP engagements are not all officially documented and are involved in all Quality Improvement activity, PMRT and CG Forums	Co-design key metrics and reviews process with MNVP and include in the workplan as evidence for Safety Action 7 including capturing all activity; invite to PMRT and monthly Clinical Governance meeting / Labour Ward Steering Group	Director of Midwifery / Maternity and Neonatal Voices Partnership Lead	Q3 2025
4. Workforce Planning and Safe Staffing	Birth Rate Plus review completed 2025; Neonatal visit has recommended gaps in workforce	Gaps in midwifery staffing establishment identified Gaps in AHP in NNU Obstetric medical staffing gap to support Maternity Triage and avoid delayed reviews	Statement of case to close gaps and recruit to funded posts	Director of Midwifery / Director of Operations	Q2 2025
5. Neonatal Collaboration	Maternity and Neonatal strategic governance structure in place; shared governance framework includes Clinical	Opportunities to strengthen Maternity and Neonatal Daily coordination with neonatal to strengthen safe, responsive care. Formalising the effective	Strengthen integrated perinatal governance structure – review structure and standardise approach to safety huddles, handovers, co-ordination between lead;	Clinical Directors	Q1 2026

	Governance and the Maternity and Neonatal Assurance Board	daily co-ordination ensures oversight of risks, safe staffing and escalation of concerns	encourage maternity and neonatal joint reviews		
6. Equity & Outcomes	Ethnicity recorded; continuity pathways for some groups	75% of women on continuity pathways;	Review of maternity continuity teams and model required to target all women/ birthing people Outcomes require metric and monitoring against LMNS equity plan	Consultant Midwife	Q1 2026
7. Safety Culture & Staff Voice	FTSU Guardians in place; local forums active	Staff survey response rates poor and feedback not reflective	Strengthen staff survey response rates and ensure actions from staff survey; cultural support to Managers in Antenatal and Postnatal to give them confidence to address any concerns in behaviours	Triumvirate / HR	Q4 2025
8. Oversight of Safety Actions	MIS (Maternity Incentive Scheme) compliance process in place via a robust clinical governance process	Safety Action 2-9 reviewed by the LMNS and assurance of compliance given. Assurance for SA1 and SA10 externally verified; uncertainty of LMNS assurance process in the future pending re-organisation of NHSE	Formalise tracking of MIS progress for Safety Action 1 and Safety Action 10 for Board oversight and assurance. Dependent on changes to the assurance process currently in place consider options for compliance assurance	Director of Midwifery	Q3 2025
9. Patient Engagement and Feedback	Overall patient feedback via various mechanisms is positive	There has been a recurrent theme on the maternity ward regarding poor staff attitude, and inadequate pain relief in a timely manner	Action plan required to address the specific issues and monitoring of improvement; plan to include progressing with self-medication at pace and supporting Managers with competence and confidence to uphold standards	Director of Midwifery	Q3 2025

Wirral University Teaching Hospital NHS Foundation Trust

Appendix 13

Board of Directors in Public

04 June 2025

Title	Midwifery Staffing Update
Area Lead	Sam Westwell, Chief Nurse
Author	Jo Lavery, Divisional Director of Nursing & Director of Midwifery (Women's and Children's)
Report for	Information

Executive Summary and Report Recommendations

Executive Summary

As part of the Maternity Incentive Scheme (MIS) there is a requirement to evidence a midwifery staffing review therefore the BR+ review of current midwifery staffing within the maternity service will contribute to the compliance with the requirements of the MIS (Year 7).

As part of the Maternity Incentive Scheme (MIS) published in April 2025 there is a requirement to provide the Trust Board evidence the midwifery establishment is reflective of the evidence-based process (BR+). This was included in the March 2025 Board papers and will be included in the Quarterly Maternity Report to Board of Directors in June 2025 and September 2025.

There is a requirement for providers to change the current model of care delivered within maternity services nationally, through the transformation Programme to that of a continuity of carer model. The final BR+ report identifies a need for additional midwifery staffing to enable progression of a continuity of carer model of care.

It is recommended that the Board of Directors:

- Note the report
- Support a statement of case as the agreed plan to the Business Development and Investment Sub Committee (BDISC) recommending the increase in midwifery establishment as outlined in the Birth Rate Plus Workforce review in line with Ockenden requirements and to ensure compliance with Safety Action 5 of the Maternity Incentive Scheme (Year 7).

Key Risks

This report relates to these key risks:

BAF references 1,2,4 and 6

Positives:

- The Trust has several processes that review and record patient quality indicators, incidents and patient experience metrics monthly against staffing data to identify emerging risk/s. This includes a monthly midwife to birth ratio recorded on the maternity dashboard.

- The Trust fulfils its duty to undertake 6 monthly establishment reviews including an update on midwifery staffing. The Trust has also supported a Birth Rate Plus Workforce review at least every 5 years as a minimum, however suggested recommendation is every 3 years.
- The recommendations from the Birth Rate Plus Workforce review received in March 2025.
- The Division uses the Birth Rate Plus acuity tool to undertake acuity and dependency reviews on Delivery Suite every 4 hours. This has been extended for use on the maternity ward and a LMNS regional platform informing staffing, acuity, and dependency.
- The Division has safe staffing governance with a clear process of escalation both locally and across Cheshire and Merseyside.

Negatives:

- The Trust having two models of care for the provision of MCoC which is inequitable, and which has additional implications and risks.

Contribution to Integrated Care System objectives (Triple Aim Duty):	
Better health and wellbeing for everyone	Yes
Better quality of health services for all individuals	Yes
Sustainable use of NHS resources	Yes

Contribution to WUTH strategic objectives:	
Outstanding Care: provide the best care and support	Yes
Compassionate workforce: be a great place to work	Yes
Continuous Improvement: maximise our potential to improve and deliver best value	Yes
Our partners: provide seamless care working with our partners	Yes
Digital future: be a digital pioneer and centre for excellence	No
Infrastructure: improve our infrastructure and how we use it.	No

1	Narrative
1.1	**Background** Birthrate Plus® (BR+) is a framework for workforce planning and strategic decision-making and has been in variable use in UK maternity units since 1988, with periodic revisions as national maternity policies and guidance are published. It is based upon an understanding of the total midwifery time required to care for women and on a minimum standard of providing one-to-one midwifery care throughout established labour. The principles underpinning the BR+ methodology is consistent with the recommendations in the NICE safe staffing guideline for midwives in maternity settings and have been endorsed by the RCM and RCOG. Current processes within the maternity service ensure that on a 24/7 basis staff are deployed effectively within the service, including the flexing of staff across both the acute and community care settings including the maternity continuity of carer teams.

	Staff working on Delivery Suite use an acuity tool that formally assesses acuity on Delivery Suite every 4 hours as a minimum. At times of high acuity, the tool is used more frequently to assess acuity, and reports into a regional platform that was launched in September 2022. Weekly staffing reports are generated from the acuity data, and whilst this does predominantly focus on staffing within Delivery Suite the acuity tool is being expanded to include staffing across all inpatient areas. Monthly staffing reports are generated and shared by the Local Maternity and Neonatal System (LMNS) on this data regionally. It is proposed that these reports will further inform and provide assurance regarding safe maternity staffing and will provide assurance to all Maternity Safety Champions including the Executive and Non-Executive Safety Champions who are required to have oversight, assurance and visibility of safe staffing within the maternity service. Currently the quarterly maternity update to the Board of Directors includes reference to maternity staffing and a Divisional nurse / midwifery staffing update is also included in the 6 monthly midwifery staffing paper that is presented at the Board of Directors meeting.
1.2	**Current position** The RCM strongly recommends using Birthrate Plus® (BR+) to undertake a systematic assessment of workforce requirements, since BR+ is the only recognised national tool for calculating midwifery staffing levels. Whilst birth outcomes are not influenced by staff numbers alone, applying a recognised and well-used tool is crucial for determining the number of midwives and support staff required to ensure each woman receives one-to-one care in labour. Birthrate Plus® has been used in maternity units ranging from stand-alone community/midwifery led units through to regional tertiary centres, with birth rates ranging from only 10 births annually through to those that have in excess of 9000 births. In addition, it caters for the various models of care in existence, including a traditional model, community-based teams and continuity of carer/caseload teams. Birthrate Plus® is the most widely used tool for workforce assessment classifying women and babies according to their needs and using clinical outcome data to calculate the numbers of midwives required to provide inpatient/outpatient antenatal care, intrapartum and postnatal care in either WUTH, community or neighbouring maternity unit. The method used works out the clinical establishment based on agreed standards of care and specialist needs and then includes the midwifery management and specialist roles required to manage maternity services. The recommendation is to provide total care to women and their babies throughout the 24 hours 7 days a week inclusive of the local % for annual, sick & study leave allowance and for travel in community**.** The last full Birthrate Plus full analysis and report was undertaken in 2024 and reviewed the date from a three-month period. It has been noted since the previous Birth Rate plus full analysis reported in 2021, whilst the birth rate has not increased and remained static, women/birthing people have more complex needs. This is in relation to the rising c/section and induction of labour rates. In addition, the most recent analysis has taken

	into account the CQC recommendation to ensure two midwives in maternity triage at all times and a designated telephone triage midwife in weekday core hours.
1.3	**Maternity Incentive Scheme (MIS) Safety Action 5 Required Standards:** 1. The allocated midwifery co-ordinator in charge has been supernumerary at the start of every shift. In the reporting period from July 2024 to December 2024 the midwifery co-ordinator has been supernumerary at the start of every shift. 2. The midwifery coordinator in charge of labour ward must have supernumerary status to ensure there is oversight of all birth activity within the service. There were 4 occasions over 6 months throughout the 24-hour reporting period from July 2024 to December 2024 (Q2 24/25 and Q3 24/25) the midwifery coordinator reported being unable to maintain supernumerary status. This is reported as short-term until the interim plan of the caseload being handed over with the initiation of the continuity midwife arriving or escalation processes followed to ensure further midwifery staff to rectify and ensure the midwifery co-ordinator resumes oversight of all the birth activity within the service. 3. Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall in staff. The maternity service has robust escalation processes to manage short falls in staffing level during periods of high acuity. 4. The midwife: birth ratio The midwife to birth ratio is reported monthly within the maternity dashboard and has been RAG rated green during the period from July – December 2024 in line with NICE guidance and safe maternity staffing levels. 5. The percentage of specialist midwives employed and mitigation to cover inconsistences. Birthrate plus incorporates a review of specialist midwives employed and the roles are in line with the recommended 10%. The trust has recruitment the additional Pelvic Specialist Midwife post (0.4WTE) in line with the recurrent funding received from NHSE as supported from the Three-Year delivery plan. 6. The provision of all women receiving one to one midwifery care in active labour is reported at care in labour. Maternity services from the period January to June 2024 reports via the Birthrate plus platform 100% of women receiving one to one care in active labour.
1.4	**Continuity of Carer:** There is still a requirement for Trusts to provide a model of care providing continuity of carer to women during the whole maternity episode. This model of care was initially detailed in Better Births in 2016 and included in the National Maternity Transformation Programme given its evidence based providing improved outcomes for mums and

	babies. The target date to deliver 100% continuity of carer had been removed, instead providers were requested to develop local plans that work for them ensuring staffing requirements are met along with an upskilled workforce. WUTH had previously submitted a plan with an ambition to achieve by MCoC as the default model by June 2024. Adaptations have been made to the plan in line with the current workforce, safe staffing levels and achieving 50% of women offered this model of care and those in the vulnerable groups are majority included. The benefits of a woman being cared for by the same team of midwives throughout her pregnancy including the delivery and following cannot be underestimated. Clinical outcomes are improved with this model of care, with women reporting positive birth experiences and with the woman less likely to experience postnatal illness. A woman who receives care from a known midwife is more likely to: • Have a vaginal birth • Have fewer interventions during birth • Have a more positive experience of labour and birth • Successfully breastfeed her baby • Cost the health system less • Less likely to experience pre-term birth • Less likely to lose their baby before 24 weeks gestation Considering pre-term birth alone, it is well evidenced that the high rates of morbidity and mortality arising from preterm birth impose a considerable burden on finite health care resources. Preterm infants are at increased risk of a range of adverse neonatal outcomes including chronic lung disease, severe brain injury, retinopathy of prematurity, necrotizing enterocolitis and neonatal sepsis. In later life, preterm infants are at increased risk of motor and sensory impairment, learning difficulties and behavioural problems. The economic consequences include the costs of neonatal care as well as the costs associated with living with disabilities. There is a substantial literature on the short and (to a lesser extent) long term clinical consequences of prematurity. The total cost of preterm birth to the public sector has been estimated to be £2.946 billion. The average cost of a pre-term birth and the provision of care is £100,000k which considers 4 weeks ITU care, 4 weeks HDU care and 2 weeks SCBU prior to discharge. This does not include the financial burden of complex investigations, tests and the long term. The incremental cost per preterm child surviving to 18 years compared with a term survivor was estimated at £22885. The corresponding estimates for a very and extremely preterm child were substantially higher at £61781 and £94740, respectively. The Trust has five embedded teams and at present no further teams are anticipated, however in line with national guidance this will be closely monitored. WUTH has undertaken its own data collection based on models of care and outcomes concluding there were benefits as described in Better Births (2016), however they were not as significant as the RCT's reported in Better Births. Improved outcomes are also mitigated by other initiatives such as Saving Babies Lives. There are currently no plans to roll out any further teams and internal review is underway to the current team's sustainability in line with staffing levels and a continued focus on those women that most benefit. Any proposed changes will take into consideration a balanced perspective with workforce, safety and system capacity.

	It is also important within the model to consider workforce sustainability and midwives report burnout linked to MCoC models and challenges with various ways of working to support work-life balance.
1.5	**NHSE Bid** The planning Guidance for 2021-22 specifically referenced additional funding for maternity services of £95million – Service Development Funding (SDF) extending to £137million in 2022-23. A detailed bid based on midwifery staffing requirements was submitted to NHSE for consideration given the requirements outlined in the Ockenden report. WUTH was successful in its bid to secure additional funding however, the process for distributing Ockenden funding changed between 2021/22 and 2022/23. In order to ensure recurrent funding, the monies were distributed regionally on a fair share basis and has been allocated to the ICB rather than directly to individual Trusts resulting in a mismatch to the funding allocated last year. Funding allocated to Cheshire & Merseyside ICB for 2022/23 is £3,731,000 which is slightly more than the total FYE allocated to all C&M Trusts last year, however, is the decision regarding the allocation of funding sits with the ICB and the LMNS in deciding which is the best and most sustainable way to split this funding between Trusts. The recurrent funding received in 2024/25 totalled £462k (in line with the revised allocation from the ICB). WUTH maternity services were also allocated £165k for Ockenden II workforce to include retention, bereavement services, maternity support work investment, preceptorship and obstetrics. Organisations offering full enhanced maternity care were also allocated funds equating to £240k. The LMNS/ICB have outlined quarterly financial reviews will be undertaken to ensure all LMNS finances have been committed and spent as specified. The funding allocation continued in 2024/25 and there are currently no anticipated changes to the funding allocation for 2025/26.
1.6	**Birth Rate Plus (BR++ Findings** Birthrate Plus. (BR+) is a framework for workforce planning and strategic decision-making and has been in variable use in UK maternity units since 1988, with periodic revisions as national maternity policies and guidance are published. It is based upon an understanding of the total midwifery time required to care for women and on a minimum standard of providing one-to-one midwifery care throughout established labour. The principles underpinning the BR+ methodology is consistent with the recommendations in the NICE safe staffing guideline for midwives in maternity settings and have been endorsed by the RCM and RCOG. Birthrate Plus® is the most widely used system for classifying women and babies according to their needs and using clinical outcome data to calculate the numbers of midwives required to provide intrapartum and postpartum care. The BR+ Report received in March 2025 as per Ockenden requirements to repeat every three years. It was based on a 24% uplift to reflect all the additional training requirements included in the Maternity Incentive Scheme, (which equated to an additional 40hours per annum per midwife).

The results of the report were based on delivering 55% continuity of carer (5 teams), no changes to the number of births, however its accounts for the additional midwifery hours required for the increasing number of women with complex needs, the increasing induction and caesarean section rates. The analysers were also requested to include the requirement for an additional c/section list and telephone triage core weekday hours as recommended in the CQC publication (2024).

Table 1 summarises the comparison between Birthrate Plus WTE recommendation and with current funded WTE in clinical staff

Current WTE	Birthrate Plus WTE	Variance
147.11	156.25	-9.14

The above outlines total recommended midwifery staff numbers (Band 3-7) for Wirral University Teaching Hospital is 156.24wte. Current establishment is 147.11wte, which equates to a shortfall of 9.14wte.

BDISC recently approved a business case to support the funded posts to be recruited into permanently and recurrent, which has supported the recruitment process for 4.3wte Band 5 Midwives and 2.96wte Maternity Support Workers

The shortfall to meet safe clinical staffing levels in 1.88wte.

Table 2 summarises the comparison between Birthrate Plus WTE recommendation and current funded WTE in additional specialist and senior management staffing

Current funded wte	Birthrate Plus wte	WTE Variance
13.72	18.75	-5.03

The above shows the current funded establishment has a small deficit of 5.03wte allocated for specialist roles. Again, the recent business case has supported and

	approved two additional specialist posts which have been recruited to and the overall shortfall is 3.03wte specialist roles. In addition to the shortfall recommendations were made in areas of focus to include a second Matron, Audit and Guideline Midwife, Clinical Governance relating to the workload with Saving Babies Lives and the Maternity Incentive Scheme regulation and requirements. The overall deficit to meet safe maternity staffing levels is 4.91wte (Band 5-8). The current staffing model does not meet the requirements based on the most recent workforce Birthrate Plus recommendations for safe staffing and midwifery staffing. Whilst is it suboptimal the recently approved business case to recruit into all funded posts recurrent and permanently the deficit has been closed significantly. There are no recommendations to make any immediate changes to the current models of maternity care, however, acknowledge a review is being undertaken.
1.7	**Recommendation** The Board is asked to:- • Support the preparation of a detailed Statement of Case for additional midwifery staffing. • Recognise this is as priority workforce investment, essential to delivering safe maternity care and to meet Safety Action 5 of the CNST Maternity Incentive Scheme (MIS), CQC recommendations and addressing work pressures.
1.8	**Conclusion** Maternity services are experiencing caring for an increased number of women with complex needs resulting in a requirement further midwifery care hours. National reviews and regulatory bodies emphasise the critical importance of safe staffing in maternity services to prevent avoidable harm and promote high-quality care. Current Birthrate + modelling identifies a minimal shortfall of 4.96wte midwifery staff to deliver care safely and meet the needs of women and families. Staffing gaps contribute to increased clinical risk, reduced staff wellbeing, and service pressures Options for maternity models of care have been considered and in line with national guidance maternity continuity of carer teams will continue for women/birthing people with enhanced needs. The allocated funding to maternity services will be spent as specified and for its intended purpose to maintain quality and safety.

2	**Implications**
2.1	**Patients**

	• There is some risk to patient care and safety in having two models of care as an equitable service is not being delivered, however positive outcomes are evident in women with enhanced needs being on an MCoC pathway. • Patient experience within both models of care is positive and there have been no relating complaints to either. • Ensuring stability and structure with minimal disruption to both models provide continuity antenatally and postnatally. • Staffing gaps can contribute to clinical risk, delays in care and sustainability of high-quality care. •
2.2	**People** • Below safe staffing levels impact on staff morale, burnout and employee well-being. • A two-model approach to midwifery care impacts on wellbeing and employee experience. Internal escalation process is utilised to mitigate, and revised working patterns/escalation processes have been embedded
2.3	**Finance** • The financial impact to meet safe staffing levels in maternity services will have financial implications.
2.4	**Compliance** • Better Births (2016) recommendations is to improve continuity of carer, teams have been set up across Wirral University Teaching Hospital (WUTH) meeting the current national drive. • The published Birthrate Plus report has ensured WUTH have had a 3 yearly workforce review in line with Ockenden. • The published Birthrate Plus report recommendation has a risk to Safety Action 5 of the CNST MIS in the vent staffing levels are not met or a clear action plan to achieve.

APPENDIX 14

SAFETY ACTION 5 – MIDWIEFRY WORKFORCE PLANNING ACTION PLAN

Purpose
To ensure midwifery workforce meets service needs in line with *Birthrate Plus* recommendations and variance are escalated, mitigated and monitored.

BRAG RATING KEY

RED – ACTION ACTIVE WITH MAJOR CONCERNS FOR COMPLETION.

AMBER – ACTION ACTIVE WITH MINOR CONCERNS FOR COMPLETION.

GREEN – ACTION ACTIVE AND ON TRACK FOR COMPLETION.

BLUE – ACTION COMPLETED

1. Action Plan

Objective	Action	Lead	Timescale	Evidence / Output	Date Action Completed	RAG Status
Annual workforce review completed using Birthrate Plus	Commission three yearly workforce review in line with Ockenden	DoM / HoM	Q1 24/25	Workforce review report completed and approved	March 2025	
Recruit into all funded midwifery posts to reduce the gaps identified in the workforce review	Recruitment campaigns for the identified permanent midwifery posts from the deferred income funds and 12 month contracts	DoM / HoM	*Q2 25/26*	Recruitment campaigns in progress		

	from the discretionary income posts.					
Staffing establishment meets Birthrate Plus recommendations	Compare funded establishment against Birthrate Plus output. Develop and present statement of case to address gaps (permanent recruitment) including recruitment plan and costings; seek confirmation of funding	DoM / DD	Q2 25/26	Business case, Board approval minutes		
Escalation process for staffing shortfalls	Maintain and circulate escalation SoP; ensure all shift leaders have appropriate training	HoM	Monthly refresh	SoP document; training levels		
Real time acuity monitoring	Sustain use of BR plus validated acuity tool on every shift; monitor monthly	DoM / HoM	Monthly	Weekly / Monthly reports		
Monitor workforce reporting	Review and monitor monthly workforce dashboards (vacancies, sickness, acuity variances, NHSP usage)	Senior Leadership Team	Monthly	Dashboard reports / Minutes of meetings		
Mitigate actions for persistent shortfalls	Deploy staff flexibly across the maternity unit and instigate escalation / requests for mutal aid as required	Matron	Daily	Escalation logs / incident reports		

Staff wellbeing initiatives	Maintain wellbeing champions and support; regular updates and communications	Matron	Daily	Staf survey results		
Governance oversight	Include workforce compliance in quality assurance papers, divisional performance reviews, safety champions and escalation to BoD / LMNS	DoM	Monthly	Agendas and papers		

2. Monitoring and Review

- Weekly: Matron level review of acuity logs
- Monthly: Governance Committee reviews
- Quarterly: LMNS and Board of Directors updates
- Annually: Workforce review completed

3. Key Performance Indicators

- % of shifts meeting Birthrate Plus staffing levels (Target >90%)
- % of shifts with complete acuity tool entry (Target 100%)
- Vacancy rate (Target <3%)
- Sickness absence rate (Target <5%)
- Time to recruit midwives (Target <8 weeks from advert to start

4. Risk Management

- Risks: inability to secure funding and inability to recruit to establishment; sustained sickness rates and rising complex patients' needs
- Controls: NHSP usage; redeployment; escalation process
- Assurance: Risk on register; regular workforce reports, LMNS oversight, Board of Directors oversight

Wirral University Teaching Hospital NHS Foundation Trust

Appendix 15

Board of Directors in Public

03 September 2025

Title	Neonatal Staffing Update – A review of the Neonatal Nursing and Medical Workforce
Area Lead	Sam Westwell, Chief Nurse
Author	Jo Lavery, Divisional Director of Nursing & Director of Midwifery (Women's and Children's)
Report for	Approval

Executive Summary and Report Recommendations

Executive Summary

The purpose of this paper is to provide an annual update as to neonatal nursing and medical staffing requirements. The paper also includes an update on the requirements in line British Association of Perinatal Medicine (BAPM).

The report further identifies the staffing requirements to meet all the BAPM standards and the actions being taken to meet safety action 4 of the Maternity Incentive Scheme (MIS) Year 6 compliance.

The paper describes how WUTH are currently performing against the standards, and outline plans to address gaps in the workforce.

It is recommended that the Board of Directors:

- Note the report
- Support the recommendations within the report to meet BAPM standards

Key Risks

This report relates to these key risks:

BAF references 1,2,4 and 6
Positives: -

- The Trust has several processes that review and record patient quality indicators, incidents, and patient experience metrics monthly against staffing data to identify emerging risk/s. These are reported monthly on the neonatal dashboard.
- The Trust fulfils its duty to undertake 6 monthly establishment reviews.
- The Division has safe staffing governance with a clear process of escalation both locally and across Neonatal network.

Negatives: -

- If the BAPM standards are not met there is a risk to the Trust's reputation and maintaining Level 3 status.
- Failure to meet these standards will result in the unit being unable to provide gold standard care as per best practice recommendations of BAPM.

Contribution to Integrated Care System objectives (Triple Aim Duty):	
Better health and wellbeing for everyone	Yes
Better quality of health services for all individuals	Yes
Sustainable use of NHS resources	Yes

Contribution to WUTH strategic objectives:	
Outstanding Care: provide the best care and support	Yes
Compassionate workforce: be a great place to work	Yes
Continuous Improvement: maximise our potential to improve and deliver best value	Yes
Our partners: provide seamless care working with our partners	Yes
Digital future: be a digital pioneer and centre for excellence	No
Infrastructure: improve our infrastructure and how we use it.	No

1	Narrative
1.1	**Level 3 Neonatal Unit Wirral University Teaching Hospital** Neonatology is a vibrant, progressive specialty and services will continue to change, both in terms of organisation and workforce. Outcomes for babies and families in our care improve year on year and although in many neonatal units' facilities for parents are less than optimal, the role of parents as partners in their baby's care is rightly gaining widespread acceptance in UK neonatal practice. Neonatal care in the UK should continue to be provided under a network model, with centralisation of care for the smallest and sickest babies. It is essential that core activity levels are maintained in both neonatal intensive care units (NICUs). NICUs (formerly Level 3 units) should admit at least 100 very low birth weight (VLBW) babies per year and undertake at least 2000 intensive care (IC) days per annum. **Neonatal categories/levels of care** • Intensive care: care provided for babies who are the most unwell or unstable and have the greatest needs in relation to staff skills and staff to patient ratios. E.g. any form of mechanical respiratory support via a tracheal tube; *both* non-invasive ventilation and parenteral nutrition; British Association of Perinatal Medicine (BAPM 2011) Categories of care. • High dependency care: care provided for babies who require highly skilled staff but where the ratio of nurse to patient is less than intensive care. BAPM 2011. • Special care: care provided for babies who requires oxygen by nasal cannula; feeding by nasogastric tube, jejunal tube or gastrostomy; has an intravenous cannula; or has any of a number of interventions as described in BAPM 2011. • Transitional care: neonatal transitional care (NTC) care provided by the mother or an alternative resident carer and a health care professional trained in delivering elements of neonatal special care but not necessarily with a specialist neonatal qualification. Based on: British Association of Perinatal Medicine (2011) Categories of care and British Association of Perinatal Medicine (2017) A Framework for Neonatal Transitional Care

1.2	**Part 1 - Neonatal Nursing Workforce** **Background** **Neonatal Nurse Staffing Toolkits/ Standards** The Toolkit for High Quality Neonatal Services, the NCCR, Getting it Right First Time (GIRFT) reports and other documents produced describe the anticipated pattern of medical, nursing and allied health professional staff cover in different types of NNU. These recommendations have been further developed within the BAPM Frameworks for Practice for NICUs, LNUs and SCUs. The chance of survival of the smallest and most preterm babies relates not only to nurse staffing ratios but also to the specialist levels of education and experience of nurses delivering care. The nursing role has, through enhanced skills and both advanced and consultant practice status, become increasingly integrated with the work of doctors. Networks should ensure that demand for training and development of specialist, enhanced and advanced neonatal nurse practitioners is met and workforce planning secure. Specialised neonatal nursing requires specific knowledge and skills. All new nurses and midwives should undertake an induction programme which relates specifically to the care of the neonate and their family within a neonatal service. All nurses attending deliveries and/or involved in direct clinical care of the neonate should have undertaken a Newborn Life Support course appropriate to their role as recommended by the Resuscitation Council UK (22) and receive regular training updates. **Neonatal Nurse Staffing Levels for Direct Patient Care** The following recommendations are based on professional consensus. They outline the numbers of nursing staff that should be available on each shift. Variations in the time available to each baby may occur, *e.g.*, during nursing staff breaks or over the initial period of admission of a baby. Because of the acute nature of neonatal practice and the difficulty of predicting patient activity, there will be times when recommended nurse staffing levels are not able to be met, and conversely time when the nursing staff provision is more generous. It is essential that the *average* nurse: patient ratio meets recommended standards. During periods of high activity, it will be necessary to consider multiple factors in deciding if the available nursing staff complement is safe, or if the NNU needs to close. Recommendation staffing levels • Intensive care 1:1 • HDU 1:2 • Special Care 1:4 • TC 1:4 *WUTH Nursing Staffing Metrics based on BAPM standards (all data is shared monthly with the Cheshire and Mersey Neonatal Nurse Operational Development Network (NNODN)*

Month	NNU Unit Level	% Shifts Staffed to BAPM Recommendations	% Shifts with Team Leader	Average Nurses on Shift	Average Nurses Required on Shift
October 2024	3	67.8	86.4	9	9
November 2024	3	72.73	87.27	9	9
December 2024	3	58.93	78.57	9	9
January 2025	3	94.74	92.98	8	7
February 2025	3	96	92	8	6
March 2025	3	100	91.67	8	7
April 2025	3	96.77	90.32	8	8
May 2025	3	96.77	96.7	8	6
June 2025	3	91.67	91.67	9	7

To note the figures for % shifts staffed to BAPM recommendations will not be accurate when a higher ration of nurses per patient are on a shift.

BAPM Service and Quality Standards for The Provision Of Neonatal Care In The Uk (2022)

This report will describe how we are currently performing against the standards, and outline plans to address gaps in the workforce.

Standard One: **BAPM Standard Neonatal Nursing Staff – Qualified in Specialty (QIS)**

Description: 61 Qualified Staff in total. Total QIS figure is 83.3% of all qualified staff. Band 7-6 100% compliant Band 5, 11 out of 27 staff have completed QIS. X2 are in training and x3 are enrolled for the Oct 2025 intake.

Planned Development

August 2025, 2 staff are currently awaiting QIS competency outcome results.
A total of 54 staff have completed the FiN programme with x3 in training and x1 enrolled for the October 2025 intake.

Status – Complaint

Standard Two**: Nurses QIS Working in Roles with Enhanced Practice Skills (ENNP)**

Description: Enhanced practice roles exist where QIS nurses have undergone additional training and education.

Status – noncompliant

***Standard Three*: Advanced Neonatal Nurse Practitioners (ANNPs)**

Description: ANNPs are now highly valued and indispensable members of most neonatal teams. The BAPM ANNP Capability Framework details development in seniority across four pillars of practice.

2024 5.61wte band 8a ANNP, 2025 7.53wte with 1NNAP .92 in foundation year, ending March 26. I trainee ANNP due to complete in September 2025.

Status - Compliant

***Standard Four*: Neonatal Consultant Role**

Description: The nurse consultant role is likely to include involvement in education, training and support of members of the neonatal team across a network as well as designing and delivering audit and clinical research projects with a specialist expertise in one area of practice. A job description has been produced in a draft format.

Status – Non compliant

***Standard Five:* Other Clinical Staff Undertaking Nursing Roles**

Description: This would include but is not exclusive to nursery nurses, maternity care assistants and neonatal support workers. We have 9.2wte neonatal support workers for the service this includes support of the TCU. 2025 0.45 WTE Infant feeding co-ordinator to work alongside the Neonatal Infant Feeding Co-ordinator.

Status – Compliant

***Standard Six*: Additional Nursing Roles**

Description: Identified nurses acting as champions for the quality of practice within each unit should have protected time and responsibility in the following areas:
• Infant feeding
• Family care.
• Developmental care.
• QI in perinatal optimisation.
• Safeguarding children.
• Bereavement support and palliative care.
• Discharge planning and outreach nursing

Status – Non-Complaint Gap analysis enclosed

Neonatal Nursing
BAPM Gap Analysis J

Current position

- As stated above, WUTH NNU has been compliant in 3 of the 6 BAPM standards for nurse staffing for a number of years, with improvements in metrics noted year on year. WUTH is currently non-complaint with the enhanced roles of ENNP, Nurse consultant and specialist roles i.e. bereavement nurse, data analysis. To be noted in 2023 1.61 wte educators had been supported in post, however currently WUTH have only 0.8wte is in post. The recommendations for the unit from the NWNODN would be 2WTE (band 7 and band 6).

The unit has benefited by the employment of highly skilled and experienced international nurses, whom have a wide variety of skills and competencies to support the neonate.

The employment from funds received from the NNODN of the 0.4 wte clinical psychologist to support the health and well-being of the family and staff members and 0.4wte occupational therapist to support the development requirements of the neonate. The cultural benefits of this professional staff group working within the department is key to Family integrated care and staff health and well-being.

Maternity Incentive Scheme (MIS) Safety Action 4

As part of the Maternity Incentive Scheme (MIS) there is a requirement to demonstrate that as a trust we are fully compliant with all BAPM Service and Quality Standards for The Provision of Neonatal Care In The UK (2022). Failure to meet these standards will result in the unit being unable to provide gold standard care as per best practice recommendations of BAPM.

Previous Actions to address Gaps in Compliance

- Funding was identified in 23/34 to provide a full-time Neonatal Matron. The vacancy has been recruited into and the postholder remains in post.
- Funding was identified in 23/24 to provide a full time BFI lead. The vacancy has been recruited into and the postholder remains in post.

Actions:-

Other considerations:

- The support of nurses to undertake the QIS should continue from 2 to 3 staff per year. Additional Funding received from NWODN received.
- With the planned completion of the Thirlwall enquiry the development of the role of an expert bereavement neonatal nurse would support families and align with FiCare.
- Development and interest to be explored re the role of EDI lead/champion this is a conversation that has started in the NWODN,
- Increased student placements to support and raise awareness of education and training available for student the NNU should be promoted.
- Appointment of an information analysist/ quality improvement nurse should be priorities to support data quality/production for internal and external stakeholders.
- NWODN have provided positive feedback regarding the engagement of the NNU teams with the NWODN to support patient quality outcomes.

1.3	**<u>Part 2 – Neonatal Medical Workforce</u>** **Medical staffing** BAPM standards for Neonatal Intensive care Units (NICU) medical staffing are as follows: - ***Standard 1* - All tiers separate rota compliance** Description - Staff at each level should only have responsibility for the NICU and Trusts with more than one neonatal unit should have separate cover at each level of staff at all times. ***Status – Compliant*** ***Standard 2* - Tier 1 separate rota compliance 24/7** Description - Tier 1 staff (ANNP or junior doctor ST1-3) should be available 24/7 and have no responsibilities outside of neonatal care. ***Status – Compliant*** ***Standard 3* - Tier 2 separate rota compliance 24/7** Description - Tier 2 staff (ANNP or junior doctor ST4 and above) should be available 24/7 and have no responsibilities outside of neonatal care (including neonatal transport). ***Status – Compliant*** ***Standard 4* - Tier 3 separate rota compliance 24/7** Description - Tier 3 (consultant) staff available 24/7 with principal duties, including out of hours cover, are to the neonatal unit. ***Status – Compliant*** ***Standard 5 - Tier 3 presence on the unit*** Description - Tier 3 (consultant) presence on the unit for at least 12 hours per day (generally expected to include two ward rounds/handovers). In January 2025 an additional consultant was recruited to support the workforce to be able to meet the standard and is fully implemented.

Status – Compliant

Current Position

As stated above, WUTH is compliant in all 5 BAPM standards for medical staffing.

Maternity Incentive Scheme (MIS) Safety Action 4

As part of the Maternity Incentive Scheme (MIS) there is a requirement to demonstrate that as a trust we are fully compliant with all BAPM medical staffing standards. Failure to meet these standards will result in the unit being unable to provide gold standard care as per best practice recommendations of BAPM.

Actions to Address Gaps in Compliance

No further actions identified.

Other Considerations

While we maintain full compliance with BAPM requirements for Tier 1 and Tier 2 rota staffing, this is often achieved through the use of locum shifts or by redeploying consultants into junior-tier duties. This approach is costly and detrimental to consultant well-being, particularly when short-notice shifts are required.

Up until the change in guidance issued by BAPM in **May 2025**—which revised the rota`s standard from **1-in-7** to **1-in-8**—we were fully compliant with the previous standard. This change is now recorded on the **Trust's risk register**, with a plan to develop a **business case to expand both the Tier 1 and Tier 2 workforce**. Current mitigations include maximising the contribution of our **Advanced Neonatal Nurse Practitioner (ANNP) workforce**, supported by a successful in-house ANNP training programme.

BAPM stipulates that for NICU services, **Tier 1 and Tier 2 rotas must each comprise a minimum of 8 designated staff**, dedicated solely to neonatal care, with no cross-cover from general paediatrics. At present, we fall short of this number, partly due to inconsistent trainee allocations from the Merseyside and North Wales deaneries, leading to variable fill rates—especially for Tier 1. As a result, rota gaps are frequently covered using locum doctors, MTI placements, or training LAT roles.

BAPM recognises ANNPs as an integral part of both Tier 1 and Tier 2 teams, provided they hold the required competencies. Given the scarcity of fully trained ANNP applicants, we must continue to **invest in internal training** by offering staff the opportunity to undertake accredited advanced practice programmes at Higher Education Institutions (HEIs).

Further workforce modelling will be required to assess the long-term expansion needed to meet the **1-in-8 BAPM standard** consistently.

1.4	**Recommendation:** In summary: - • Note the progress and the appointment of an additional consultant in line with the 24/25 action plan strengthening the workforce and Standard 5 compliant. • Note the recommendations from the Northwest Neonatal Operational Delivery Network (NWODN) and the requirement to address and deliver the identified workforce gaps. •

2	**Implications**
2.1	**Patients** • There is a risk to neonatal care and safety if the nursing and medical workforce standards can not be met in line with BAPM recommendations.
2.2	**People** • Continuation of supporting the nursing roles in NNU to have enhanced and advanced skills to provide gold standard care to neonates. • It would not be possible to meet BAPM standards without the investment to the neonatal nursing and medical workforce.
2.3	**Finance** • The financial impact to deliver the standards in the workforce have been identified and the additional consultant is in post. • Additional financial funding will be required to meet the recommended workforce gaps identified by the NWODN.
2.4	**Compliance** • Compliance with BAPM is essential to maintain Level 3 status and evidence for Safety Action 4 Maternity Incentive Scheme.

Objective	Deliverables	Minimum evidence requirements for LMNS to gain assurance	LMNS Q2 Feedback	Q3 Update	Q3 Provider BRAG Rating	Q3 LMNS is assured ?	Q3 LMNS BRAG Rating	LMNS Q3 Feedback	Q4 Provider Self Assessment BRAG	Q4 Provider Update	Q4 LMNS is Assured	Q4 LMNS BRAG Rating	Q4 LMNS Rationale for BRAG	Q1 25/26 Provider Self-Assessment BRAG	Q1 25/26 Provider Update / Rationale for BRAG	Q1 25/26 LMNS is Assured?	Q1 25/26 LMNS Rationale for BRAG / LMNS Feedback	Q1 25/26 LMNS Questions to Provider / Request for Additional Information
Objective 1: Care that is personalised	Is PCSP training included in the TNA?	1) LMNS to review each TNA and confirm the inclusion of PSCP training for each provider. 2) If the provider declares non compliance, LMNS to agree a completion date with the provider. If the provider is not compliant by the agreed date a recovery plan will need to be agreed between the LMNS and the provider 3) All none compliance actions and agreed recovery plans will be reviewed at each MPOP meeting each quarter.	Update required for Q3 Partial Assurancein Q1 - Need further detail re ccf	Further evidence/detail included as evidence to include TNA 2025		Y	Blue	TNA evidence reviewed and note inclusion of PCSP training	Provider - Blue	No change in Q4	Y	Blue	LMNS assured	Blue	No change			
	Are Personalised care audits being undertaken regularly?	1) Provider to submit a copy of the audit schedule to the LMNS for review. 2) LMNS to provide reassurance at MPOP that the audit schedule has been submitted and includes PCSP audits.	Update required for Q3 - Trust to upload additional evidence (e.g. forward audit schedule and recent audit data)			Y	Green	Evidence of PCSP audits obtained via LMNS PCSP Community of Practice Group - Further information/evidence requested for Q4	Provider - Green	Audit schedule uploaded	Y	Blue	LMNS assured	Blue	No change			
	Is the trust in a position to roll out MCoC?	1) Where the provider states they are in a position to roll out MCoC in line with the principles of safe staffing https://www.england.nhs.uk/wp-content/uploads/2022/09/B2011-Midwifery-Continuity-of-Carer-letter-210922.pdf The minimum evidence requirement is an up to date MCoC Plan confirming the 13 building blocks are in place. 2) Provider to share Plan with the LMNS and reassurance provided to the regional team at the MPOP meeting, that it has been reviewed.	Update required for Q3			Y	Green	5x CoC Teams currently in place - no further teams planned at present	Provider - Green	No change in Q4	Y	Blue	LMNS assured	Blue	No change			
	Number of EMCoC teams operating in line with national guidance?	1) Provider to confirm number of EMCoC teams in place operating in line with national guidance. 2) LMNS to review evidence of EMCoC meetings where EMCoC teams are discussed or alternatively submit tracker which demonstrates EMCoC teams are in place. 3) Provider EMCoC progress report to be provided by LMNS at MPOP.	Update required for Q3	5 MCoC teams embedded in the areas of vulnerability / social deprivation		Y	Green	The Trust have 5 enhanced MCoC teams providing in place, embedded in areas of vulnerability / social deprivation - no further teams planned at present	Provider - Green	No change in Q4	Y	Green	No change from Q3	Green	No change; all teams sustained			
	Number of EMCoC teams planned to be rolled out in line with national guidance?	1) LMNS to confirm assurance arrangements in place for future number of teams to be rolled out in line with national guidance. 2) LMNS to review evidence of MCoC meetings where EMCoC teams are discussed or alternatively submit tracker which demonstrates EMCoC teams are in place. 3) As above LMNS to provide progress update for each provider at MPOP.	Update required for Q3	5 MCoC teams embedded in the areas of vulnerability / social deprivation			Y	Green	The Trust have 5 enhanced MCoC teams providing in place, embedded in areas of vulnerability / social deprivation - no further teams planned at present	Provider - Green	No change in Q4	Y	Green	Presently no plans at Trust to increase the number of CoC teams due to staffing	Green	No change; all teams sustained			
	Has the trust achieved UNICEF BFI accreditation?	1) Each provider to provide a copy of the BFI accreditation status for Maternity and Neonates to the LMNS. 2) If provider does not have full accreditation, the LMNS should review and monitor evidence of the provider's schedule and plan for full achievement by 2027 3) If a provider has a certificate of accreditation action and dates for stage 1 this should be shared with the LMNS. 4) If provider is at stage 1, evidence and dates are required for planned stage 2 accreditation and so on until the provider can demonstrate full accreditation. 5) Once a provider has achieved full accreditation, evidence of their sustainability plans with annual audit schedule is required and should be submitted to the LMNS. 6) LMNS to provide progress update for each provider at MPOP.	Update required for Q3 Partial Assurance in Q1 Maternity is stage 3 Neonatal not accredited - raised PO	Maternity is stage 3 and application has been submitted for NNU - 2 year plan with training commenced and 1wte in post to lead; on back to deliver in timeframe		Y	Green	LMNS note that Maternity is at stage 3 and an application has been submitted for NNU Trust to confirm UNICEF assessment dates and to upload a copy of the UNICEF Action Plan in Q4	Provider - Blue	UNICEF Action plan uploaded as evidence	Y	Blue	LMNS assured - UNICEF action plan noted	Blue	Action plan for maternity on target and NNU training underway			
Objective 2: Improve equity for mothers and babies	Does the trust provide access to interpreter services, which adheres to the Accessible Information Standard?	1) A copy of the provider guideline/algorithm/SOP/operational plan for the use of interpreters that is clearly mapped against the Accessible Information Standard, should be shared with the LMNS. 2) LMNS to provide reassurance to the MPOP that they are assured each provider is compliant with the Accessible Information Standard. 3) Where a provider is identified as non-compliant the LMNS will set target dates for compliance with the provider and monitor accordingly. 4) LMNS to provide progress updates to MPOP.	Update required for Q3 No assurance in Q1: no interpreter policy received.	Interpretation policy uploaded as evidence		Y	Green	Draft Trust wide policy submitted as evidence. Provider to confirm if it meets accesible information standards for Q4.	Provider - Green	Confirmation sent post Q3 WUTH meetings accessible standards and uploaded	Y	Amber	Latest Board paper evidence received from the Trust outlines areas of concern and limited assurance to the Trust Board regarding adherence to accessible information standard. Hence, amber status	Blue	Policy iploaded			
	Is data collected and disaggregated based on population groups?	1) LMNS to confirm the provider's EPR system has the capability to collect and disaggregate data based on population groups. (both ethnicity & deprivation) 2) Where a provider demonstrates non-compliance, LMNS to agree a recovery plan for compliance and monitor accordingly. 3) LMNS to provide progress updates to MPOP.	Update required for Q3 Partial Assurance in Q1 - more evidence required.	Data collected includes age, ethnic minority, marital status, postcode, language/s spoken and other data as per MSDS requirements. Analysis examples uploaded as evidence		Y	Green	LMNS assured on track, but further evidence required in Q4 (as per Q1 request)	Provider - Green	Examples uploaded as evidence	Y	Blue	LMNS assured - further evidence provided as requested in Q3					
Objective 3: Work with service users to improve care	Are service users involved in quality, governance, and co-production when planning the design and delivery of maternity and neonatal services?	1) LMNS to review the provider's MNVP annual workplan and gain assurance that the NMVP are involved in quality, governance, and co-production when planning the design and delivery of maternity and neonatal service. 2) Where a provider demonstrates non compliance, LMNS to agree target dates for compliance and monitor accordingly. 3) LMNS to provide reassurance to MPOP that this measure is embedded in the organisation.	Q1 - LMNS in receipt of MNVP Workplan; MNVP lead in post for 16 hours per week	Evidence submitted as Safety Action 7 and compliance signed off for MIS Year 6		Y	Blue	LMNS Assured	Provider - Blue	No change in Q4	Y	Blue	LMNS assured	Blue	No change			
	Date of last BR+	1) Provider to submit copy of the latest BR+ report to LMNS. 2) BR+ compliance to be discussed with MPOP	LMNS Assured in Q1	Assured: June 2021 New BR+ scheduled for January 2025. BR plus commenced in June 2023; final report expected Feb 2025		Y	Green	LMNS Assured, but require Trust to submit BR plus recent report in Q 4	Provider - Blue	BR Plus report (March 2025) uploaded as evidence	Y	Blue	LMNS assured - BR+ report noted	Blue	Staffing paper for workforce uploaded as evidencce and SOC being prepared for additional staffing			
	Funded to BR+ establishment	Where a provider is not compliant with establishment recommendations in BR+ : 1) Gap analysis of variance between current budgeted establishment vs BR+ recommendations to be reviewed by the LMNS. 2) Business case to meet BR+ establishment to be reviewed by the LMNS. 3) Copy of the risk assessment where an executive board does not support the findings of the BR+ report to be reviewed by the LMNS.	LMNS Assured in Q1 - Funded to establishment	Remain funded to current BR plus workforce and all funded posts (non-recurrent) Trust has agreed to recruit to all posts permanently increasing current establishment. Minutes of meeting to be uploaded at Q4		Y	Green	Trust remain funded to current BR plus workforce and all funded posts (non-recurrent). Trust has agreed to recruit to all posts permanently increasing current establishment. Minutes of meeting to be uploaded at Q4	Provider - Blue	Approved business case uploaded; EARC minutes uploaded	Y	Blue	LMNS assured - business case reviewed	Blue	No change			
	Planned date of next BR+	1) Planned date of next BR+ report to be agreed with the LMNS. 2) BR+ compliance to be discussed with MPOP	Update required for Q3	Underway - awaiting report; data collection for accuracy has taken longer than expected and due by end Feb 2025		Y	Green	LMNS assured that this is underway. Trust has confirmed awaiting report; data collection for accuracy has taken longer than expected	Provider - Green	Uploaded as evidence	Y	Blue	LMNS assured - BR+ report received 2025 - not due for 3 years	Blue	No change			
	Bi-Annual workforce plan for maternity and neonates including obstetrics in place?	1) LMNS to confirm that the Bi-annual workforce plan includes maternity, neonates and obstetrics has been submitted to board. 2. LMNS to confirm date for next bi-annual plan submission to board.	LMNS Assured in Q1 - Workforce plan provided	Workforce plan submitted; no further action		Y	Blue	LMNS Assured in Q1 - Workforce plan submitted and reviewed	Provider - Blue		Y	Blue	LMNS assured	Blue				
	Does the annual workforce plan include support for newly qualified staff and midwives who wish to return to practice?	1) LMNS to review the annual workforce plan and confirm if it includes support for newly qualified staff and midwives who wish to return to practice. 2) LMNS to provide updates to MPOP where compliance not achieved.	Update required for Q3	Evidence uploaded to support RTP; in 2025 annual workforce plan will include support for newly qualified staff and RTP midwives		Y	Green	Trust to submit updated Maternity Workplan in Q4, to include additional information from BR+ Report	Provider - Green	Workforce plan uploaded	Y	Blue	LMNS assured - new evidence provided	Blue				

Objective 4: Grow our workforce	MW Vacancy Rate (please provide additional narrative to support data)	1) LMNS to undertake quarterly review of Maternity Workforce PWR data. 2) LMNS to discuss plan to improve vacancy rates with provider 3) LMNS to provide reassurance to MPOP that plan is in place to reduce vacancy rate.	Trust to input PWR date from Q3 and beyond	PWR data uploaded as received; LMNS will discuss distribution with NWMO		Y	Green	Business Case received, which supports PWR narrative	Provider - Green		Y	Green	Regional Team have noted errors in reporting which have effected the funded establishment within the PWR report - Regional Meeting to be held to discuss with the provider	Green	Note comment LMNS last and no meeting held to date; latest PWR attached			
	MW Leaver Rate (please provide additional narrative to support data)	1) LMNS to undertake quarterly review of Maternity Workforce PWR data. 2) LMNS to discuss plan to improve leaver rates with provider. 3) LMNS to provide reassurance to MPOP that plan is in place to reduce leaver rate.	Trust to input PWR date from Q3 and beyond	PWR data uploaded as received; LMNS will discuss distribution with NWMO		Y	Green	Business Case received, which supports PWR narrative	Provider - Green		Y	Green	PWR data reviewed	Green	Business case previously submitted and further statement of case in progress			
	MW Turnover Rate (please provide additional narrative to support data)	1) LMNS to undertake quarterly review of Maternity Workforce PWR data. 2) LMNS to discuss plan to improve turnover rate with provider. 3) LMNS to provide reassurance to MPOP that plan is in place to reduce turnover.	Trust to input PWR date from Q3 and beyond	PWR data uploaded as received; LMNS will discuss distribution with NWMO		Y	Green	Business Case received, which supports PWR narrative	Provider - Green		Y	Green	PWR data reviewed	Green	Business case previously submitted and further statement of case in progress			
	MW Sickness Rate (please provide additional narrative to support data)	1) LMNS to undertake quarterly review of Maternity Workforce PWR data. 2) LMNS to discuss plan to improve turnover rate with provider. 3) LMNS to provide reassurance to MPOP that plan is in place to reduce turnover.	Trust to input PWR date from Q3 and beyond	PWR data uploaded as received; LMNS will discuss distribution with NWMO		Y	Green	Business Case received, which supports PWR narrative	Provider - Green		Y	Green	PWR data reviewed	Green	Business case previously submitted and further statement of case in progress			
	Obstetric Consultant Vacancy Rate (please provide additional narrative to support data)	1) LMNS to undertake quarterly review of Maternity Workforce PWR data. 2) LMNS to discuss each plan to improve obstetric consultant vacancy rate with provider. 3) LMNS to provide reassurance to MPOP that plans are in place to reduce obstetric consultant vacancy rate.	Trust to input PWR date from Q3 and beyond	PWR data uploaded as received; LMNS will discuss distribution with NWMO		Y	Green	DoM confirmed that the 1 WTE consultant gap (as of 01.11.24) has now been recruited to, with a planned start date of 01.04.25	Provider - Blue	Fully recruited to establishment	Y	Blue	LMNS assured - 0 consultant vacancy	Green	Consultant maternity leave cover out to advert and x 1 application; additional funding recieved from MIS discretionary funding to support 6PA's for a period of 12 months to cover adjusted duties of one individual			
	MSW Vacancy Rate (please provide additional narrative to support data)	1) LMNS to undertake quarterly review of Maternity Workforce PWR data. 2) LMNS to discuss plan to improve MSW vacancy rate with provider. 3) LMNS to provide reassurance to MPOP that plans are in place to reduce MSW vacancy rate.	Trust to input PWR date from Q3 and beyond	PWR data uploaded as received; LMNS will discuss distribution with NWMO		Y	Green	Business Case has been completed by Trust and uploaded, which supports PWR narrative	Provider - Blue	Fully recruited to establishment	Y	Blue	LMNS assured - 0 MSW vacancy rate	Blue	MSW establishment being increased in line with business case and on target to recruit			
	Is there a retention midwife in post? (please provide additional narrative to support data)	1) Provider to provide confirmation of Retention Midwife in post (name, job title and WTE) 2) LMNS to review Job description 3) If the provider is non compliant LMNS to confirm if the national NHSE Retention funding was received by provider? If YES LMNS should confirm what has the funding been utilised for and evidence of this being approved by the Trust Board to be provided to the LMNS. 4) LMNS to provide reassurance to MPOP	Update required for Q3 Partial Assurance in Q1 - JD needs strengthening to include retention	JD updated and uploaded as evidence		Y	Green	LMNS Assured - Retention Midwife is in post. However, the LMNS also acknowledge operational issues experienced by the Trust due to bereavement leave (Retention Midwife). However, the LMNS is satisfied with mitigations in place, with support provided by the PDM.	Provider - Green	Post in establishment; post out for internal interest due to long term absence	Y	Green	Evidence reviewed and discussed with Trust in Q3 regarding existing post holder. Q4 update - internal advert out to recruitment	Green	Post out to advert as internal opportunity / secondment for 6 months to cover career break			
Objective 5: Value and retain our workforce	Does the trust have a retention improvement action plan?	1) LMNS to review provider Retention Improvement Action Plan for assurance. 2) LMNS to agree monitoring to ensure the improvement plan remains on track. 3) LMNS to provide reassurance to MPOP	Update required for Q3 Partial Assurance in Q1 - No improvement plan attached but evidence in document that compliance achieved; vacancy rate <2% no further actions identified; rolling recruitment campaigns continue	Vacancy rate continues at <2%; rolling recruitment campaign and Trust agreed business case to increase establishment		Y	Green	Business Case received, which supports the narrative for this deliverable	Provider - Green	No change in Q4	Y	Green	No change from Q3	Green	No change			
	Is there a plan in place to reduce workforce inequalities?	1) If yes LMNS to review the workforce inequalities plan for assurance 2) If no LMNS/ICB to work with the provider and agree a time frame for the development of a workforce equalities plan 3) LMNS to provide reassurance to MPOP As a minimum each provider needs to provide evidence of a baseline of staff in post by ethnic group in order to monitor any positive improvements	Evidence received inequalities plan	Evidence uploaded		Y	Blue	LMNS Assured - Trust wide policy received	Provider - Blue	No change in Q4	Y	Blue	LMNS assured	Blue	No			
	Is the trust signed up to the North West Black, Asian, and Minority Ethnic Assembly Anti-racist Framework?	1) LMNS to review the provider's self assessment status against the framework for assurance. 2) LMNS to seek evidence of annual action plan to attain accreditation including evidence that it has been reported at board to ensure delivery and commitment. 3) LMNS to provide reassurance to MPOP https://www.england.nhs.uk/north-west/wp-content/uploads/sites/48/2023/07/The-North-West-BAME-Assembly-Anti-racist-Framework-FINAL.pdf	Evidenced received - LMNS assured but would like to see self-assessment	Self assessment uploaded as evidence		Y	Green	LMNS Assured - Certificate of Recognition, EDI Bi-annual Report and Workforce Race Equality Standard Report received Trust to submit self-assessment in Q4	Provider - Blue	Evidence submitted	Y	Blue	LMNS assured - bronze status assessment reviewed (action plan)	Blue	No change			
	Do the trust have a mechanism to identify and address issues highlighted in student and trainee feedback surveys?	1) LMNS to confirm with provider what mechanisms are in place to identify and address issues highlighted in student and trainee feedback surveys? - (This could be NTS NETS or PARE placement feedback)? 2) LMNS to provide reassurance to MPOP	Update required for Q3 Partial Assurance in Q1 - WUTH need to explain what is being done with the feedback	Workforce plan submitted; no further action		Y	Green	LMNS note that the Trust is one of the top performers in the North West. Trust to submit Board Report in Q4, to evidence that survey results have been communicated to Board	Provider - Blue	Report to BoD and minutes uploaded as evidence of outstanding practice	Y	Blue	LMNS assured board paper reviewed, which demonstrates area of great practice	Blue	Paper presented at BOD			
	Does the trust offer a preceptorship programme to every newly registered midwife, with supernumerary time during orientation and protected development time?	1) LMNS to review provider's preceptorship programme and confirm it includes: a) length of preceptorship period b) length of supernumerary period c) the supernumerary period being applied to each clinical rotation during the preceptorship programme d) minimum expectation of all clinical areas during the preceptorship period 2) LMNS to confirm an target date for compliance is in place where all of the above are not included in the preceptorship policy 3) LMNS to provide reassurance to MPOP	Update required for Q3 Partial Assurance in Q1 - Require Preceptorship pack as evidence	Further evidence uploaded		Y	Blue	LMNS Assured - Preceptorship Programme in place	Provider - Blue	No change in Q4	Y	Blue	LMNS assured	Blue	No change			
	Do the trust offer newly appointed Band 7 and 8 midwives support with a mentor?	If the provider reports Yes: 1) LMNS should seek evidence in the form of a SOP or alternative. If the provider reports No: 1) LMNS to discuss challenges and barriers to provision with provider and agree plan for delivery 2) LMNS to provide progress update to MPOP for non compliance	SOP received	No further action		Y	Blue	LMNS Assured - LMNS note Trust SOP for Band 7 & 8 mentorship as an example of best practice to be shared across the system to support shared learning	Provider - Blue	No change in Q4	Y	Blue	LMNS assured	Blue	No change			
	Does the trust have a leadership succession plan which reflects the ethnic background of the wider workforce? .	1) LMNS to review provider leadership succession plan, and gain assurance that it reflects the ethnic background of the wider workforce. 2) LMNS to discuss and agree completion date for plan with provider where this is not yet in place. 3) LMNS to provide progress update to MPOP	Update required for Q3 Partial Assurance in Q1 - elements relating to ethnicity require strengthening			Y	Green	LMNS note Bronze award. However, minimal evidence received - provider to upload Black, Asian and Minority Ethnic Self Assessment Tool in Q4, which will support evidence of this deliverable	Provider - Green	Evidence uploaded	N	Amber	LMNS note Bronze award. - provider to upload Black, Asian and Minority Ethnic Self Assessment Tool, which will support evidence of this deliverable **NW Regional Team: request timeline for submission of evidence**	Green	Self assessment tool for LQF on-line available, uploaded as evidence of Trust current position? Was Green and now reporting Amber- can we discuss			
Objective 6: Invest in the	Does the trust's TNA align with the core competency framework?	1) Provider to submit TNA including CCF alignment details - LMNS to review and confirm compliance - LMNS to agree target date for compliance and monitor where necessary 2) LMNS to provide re-assurance to MPOP. https://www.england.nhs.uk/long-read/core-competency-framework-v2-minimum-standards-and-stretch-targets/	Update required for Q3 Partial Assurance - Need further detail re ccf	TNA 2025 uploaded		Y	Green	Trust to submit final ratified TNA in Q4	Provider - Blue	Final TNA uploaded as evidence	Y	Blue	LMNS assured	Blue	No change			
	Do junior and SAS obstetricians and neonatal medical staff meet RCOG and BAPM guidance for clinical and support supervision?	1) Provider to provide evidence to LMNS that junior and SAS obstetricians and junior neonatal medical staff meet RCOG and BAPM guidance for clinical and support supervision 2) LMNS to provide assurance to MPOP	Update required for Q3 Partial Assurance in Q1 - Require more evidence.	Evidence uploaded		Y	Green	Trust to submit Neonatal Workforce Paper, which includes MIS SAS	Provider - Blue	Safety Action 5 compliance signed off; additional NNU consultant in post	Y	Blue	LMNS assured - evidence reviewed as part of MIS Year 6: additional consultant now on rota	Blue	No change			

	Do temporary medical staff covering middle grade rota possess an RCOG certificate of eligibility for short-term locums?	It is a statutory requirement that all middle grade temporary medical staff working within maternity services should provide an RCOG certificate of eligibility to the provider 1) LMNS to seek assurance from provider that the CD holds RCOG certificates for all short term locum doctors 2) LMNS to reassurance to MPOP	Update required for Q3	Locums not utilised at WUTH		Y	Green	Confirmation received from the Trust that locums are not utilised. However, LMNS will require ongoing assurance that short term locums are not used	Provider - Green	Remains unchanged and no Locums required	Y	Blue	LMNS assured - Trust doesn't need one as doesn't use locums	Blue	No change and sustained the Trust has not required to use locums			
Objective 7: Develop a positive safety culture	Do maternity and neonatal leads have time within their job plan to access training and development, Including time to engage stakeholders, and MNVP leads?	1) If provider reports YES - LMNS to gain assurance by reviewing evidence how much time allocated in job plan and of achievement and confirm reassurance. 2) if provider reports NO - LMNS to provide support to the provider to become compliant. 3) LMNS to provide quarterly updates at MPOP re non-compliance.	LMNS Assured in Q1	No further action at Q3		Y	Blue	LMNS Assured in Q1 - Job Plans received	Provider - Green	No change in Q4	Y	Blue	LMNS assured - job plans reviewed	Blue	No change			
	Have senior leaders attended national leadership programmes this year, including board maternity and neonatal safety champions?	provider to share with LMNS names, job titles and dates of training attended, to include non exec board level safety champion & board level safety champion, e.g. chief nurse	Update required for Q3 LMNS Assured but Trust required to confirm dates	Commenced programme April 2023 into 2024; all members completed full programme; continues support from Amanda Andrews in 2025		Y	Green	LMNS note all members have completed the full programme, with support from Amanda Andrews to continue in 2025	Provider - Green	No change in Q4	Y	Blue	LMNS assured - Quad has attended national leadership programme	Blue	Ongoing contact with the leadership programme and internal journey commenced - evidence attached			
	Does the trust board support the implementation of a focused plan to improve and sustain maternity and neonatal culture and regularly review progress?	1) Provider to submit evidence of board agendas/minutes where QIP is discussed to LMNS for review. 2) LMNS to provide reassurance at MPOP meetings.	LMNS Assured in Q1	No further action at Q3		Y	Green	LMNS assured on track, but further update required in Q4	Provider - Green		Y	Blue	LMNS assured - evidence submitted and reviewed as part of MIS SA9	Blue	Additional papers uploaded to demonstrate sustainability			
	Is there a clear and structured route for the escalation of clinical concerns? (i.e. Each Baby Counts: Learn and Support escalation toolkit).	1) If escalation policy is in place - LMNS to review for assurance . 2) LMNS to ensure escalation policy includes EBC learning and support escalation toolkit 3) If no escalation policylit does not meet compliance standard - LMNS to support provider to develop policy which the LMNS will maintain oversight. 4) LMNS to provide reassurance to MPOP	LMNS Assured Q1	No further action at Q3		Y	Green	LMNS note that the Trust uses AID as a toolkit and that the Trust was a pilot site for the introduction nationally of the escalation tool. This has been rolled out.	Provider - Green	No change in Q4	Y	Blue	LMNS assured	Blue	No change			
	Is there a Freedom to Speak Up Guardian?	1) If YES - FTSU JD to be reviewed by the LMNS. 2) If NO - action plan detailing when the FTSU guardian will be in place required. 3) Action plan to be monitored by the LMNS with regional oversight at MPOP	LMNS Assured	No further action at Q3		Y	Blue	Name of FTSU Guardian received and JD for post	Provider - Blue	No change in Q4	Y	Blue	LMNS assured	Blue	No change			
	Is there a FTSU training module for staff?	Minimum evidence requirement - Induction training manual or equivalent 1) If YES - provider to provide evidence of FTSU training module or equivalent (no further monitoring) 2) If NO - provider to develop action plan with date for when the FTSU will be included in the induction training manual or equivalent. 3) Action plan to be monitored by the LMNS with regional oversight at MPOP	Update required for Q3 Partial Assurance in Q1 - Need to see evidence of the content of the training	Evidence uploaded		Y	Green	Ongoing review of evidence required. Provider to upload evidence link for Q4.	Provider - Green		Y	Blue	LMNS assured - evidence reviewed ELFH	Blue	No change			
Objective 8: Learn and improve	Has the trust implemented PSIRF?	1) If provider reports PSIRF implemented, LMNS to review the PSIRF plan. LMNS to confirm if the PSIRF plan includes a chapter for maternity. 2) If provider reports PSIRF not in place - LMNS to monitor and offer support to attain full implementation 3) Action plan to be monitored by the LMNS with regional oversight at MPOP	PSIRF implemented but no maternity chapter. Maternity chapter anticipated Q3 24/25, until this is released LMNS will deem this assured.	No further action; all evidence uploaded as current PSIRF		Y	Green	PSIF Policy in place. However, Maternity Chapter currently paused by NHS Regional Team.	Provider - Green	No change in Q4	Y	Green	Trust in discussions with ICB QS leads	Green	No change			
	Is there a formal structure to review and share learning? (with agreed timescales)	This should be included in the PSIRF plan. Minimum evidence requirement - LMNS to review provider PSIRF plan for assurance 1) If PSIRF plan include a formal structure to review and share learning which includes timeframes - no further monitoring required 2) If plan does not include structure to review LMNS to support providers to achieve 3YD plan measure 3) LMNS to provide quarterly update at MPOP where provider not compliant.	LMNS Assured in Q1 - Included in incident policy - Trust and Maternity Risk Management Strategy.	No further action at Q3		Y	Green	LMNS note included in Trust incident policy and Maternity Risk Management Strategy	Provider - Green	No change in Q4	Y	Blue	LMNS assured	Blue	No change			
	Has the organisation established effective, kind, and compassionate processes to respond to families who experience harm or raise concerns about their care?	Minimum evidence requirement - LMNS to review if the provider has an established effective, kind, and compassionate processes to respond to families who experience harm or raise concerns about their care. 1) PSIRF plan should include a FLO - YES/NO 2) LMNS to provide assurance update at MPOP on processes in place	LMNS Assured in Q1	No further action at Q3		Y	Green	Whilst there is no specific FLO role, the role is built into specialised JDs	Provider - Green	No change in Q4	Y	Green	Whilst there is no specific FLO role, the role is built into specialised JDs	Blue	Change to blue as there no actions to be completed			
	Has the organisation adopted a single point of contact process for families where ongoing dialogue is required with the trust?	Minimum evidence requirement - This measure should be included in the PSIRF plan. LMNS to review PSIRF plan to confirm that a single point of contact process for families has been embedded. 1) If YES - No further updates required at MPOP unless process changes. 2) If No - Date to be provided when process will be in place. LMNS to monitor progress. 3) LMNS to provide assurance updates at MPOP	LMNS Assured in Q1 - Dedicated Lead	No further action at Q3		Y	Blue	LMNS Assured - Dedicated Lead in place	Provider - Blue	No change in Q4	Y	Blue	LMNS assured	Blue	No change			
	Is the organisation sensitive to culture, ethnicity, and language when responding to incidents?	Minimum evidence requirement - this measure should be included in the PSIRF plan. LMNS to review PSIRF plan to confirm the plan includes a chapter on how to support a family whose first language is not English, when they are involved in a serious event. 1) The PSIRF plan should include a chapter around language barriers a) If YES - LMNS to provide reassurance at MPOP b) IF NO - LMNS to agree a date with provider when this will be achieved, provide ongoing monitoring 2) LMNS to provide quarterly progress updates at MPOP.	Update required for Q3	All Trust policies/evidence uploaded as evidence		Y	Green	Automative data report required - Trust has requested this from Cerner	Provider - Green		Y	Green	No change from Q3	Green	No change			
	Is there a process of triangulation of outcomes data, staff, and MNVP feedback, audits, incident investigations, and complaints, as well as learning from where things have gone well?	Minimum evidence requirement. If the trust has stated YES, the LMNS needs to understand what the process is discuss at MPOP. 1)NO - The LMNS to support the trust with the development of a process to triangulate outcome data, staff and MNVP feedback, audits, incident investigations and complaints as well as learning from when things have gone well. Target dates for completion need to be agreed with the provider. 2) YES - If the LMNS are assured that the process is embedded 3) LMNS to provide re-assurance at MPOP that they are satisfied that this measure has been implemented and is being sustained.	LMNS Assured in Q1 - Multiple minutes from assurance minutes reviewed	No further action at Q3		Y	Green	LMNS assured on track, but further update required in Q4	Provider - Green	Further evidence uploaded to demonstrate sustainablity	Y	Green	Parental feedback uploaded as evidence	Green	No change			
	Does the organisation share open and honest information on the safety, quality, and experience of their services?	1) Where provider self assesses YES - LMNS need to understand what this looks like and gain assurance that the process is embedded 2)Where provider self assesses NO - LMNS to monitor progress, set target dates to meet this requirement 3) LMNS to provide quarterly updates to MPOP.	LMNS Assured in Q1	No further action at Q3		Y	Green	LMNS note that the following is in place to support this deliverable - PSQB and lessons learnt forum, RMC and risk committee, shared learning via C&M MNSG. Examples and flow chart of embedded process received	Provider - Green	No change in Q4	Y	Blue	LMNS assured - embedded processes within Trust	Blue	No change			

Objective 9: Support and oversight	Does the organisation regularly review the quality of maternity and neonatal services?	Minimum evidence requirement - Maternity Dashboard - Other quality monitoring processes. If YES 1) LMNS to explore how this is achieved. Evidence of the use of Maternity Safety Dashboard 2) LMNS to confirm assurance at MPOP that provider is regularly reviewing the quality of their maternity and neonatal services. If NO 1) LMNS to support the organisation to establish and regularly review quality and safety of services 2) LMNS to provide quarterly updates to MPOP on progress	LMNS Assured in Q1 - Monthly Quality Surveillance tool goes to Board monthly as per Safety Action 9 - MIS Year 5.	Evidence continues to be uploaded as evidence		Y	Green	LMNS note that the Monthly Quality Surveillance tool goes to Board monthly as per Safety Action 9	Provider - Green	No change in Q4	Y	Blue	LMNS assured - embedded process for SA9 to Board for oversight and assurance	Blue	No change, embedded			
	Have maternity safety champions been appointed, including NED?	1) If YES - Provider to submit Names and titles of safety champions and JDs to LMNS for review 2) If NO - Provider to confirm dates when they will be in post, reason not in post. 3) LMNS to monitor progress and provide update at MPOP	Update required for Q3 Partial Assurance in Q1 - Safety Champions names received but LMNS require JD	JD's uploaded		P	Amber	Trust required to submit Chief Nurse JD in Q4 - agreed at MPOP meeting	Provider - Green	Evidence (JD) uploaded	Y	Blue	LMNS Assured - NED JD reviewed	Blue	No change			
	Has the quadrumvirate been appointed?	1) If YES - Provider to submit Names and titles of quadrumvirate for assurance 2) If NO - Provider to confirm dates when they will be in post, reason not in post. 3) LMNS to monitor progress and provide update at MPOP	LMNS Assured in Q1	No further action at Q3, no changes to quad		Y	Blue	LMNS Assured in Q1 - names received	Provider - Green		Y	Blue	LMNS assured	Blue	No change			
	Are MNVPs involved in the development of the organisations complaints process?	Minimum evidence requirement - minutes of provider meetings confirming involvement 1) If YES - LMNS to review notes from meetings where MNVP was present during this discussion. 2)If NO - LMNS to discuss when will this be achieved with provider. Dates to be added to action plan. 3) LMNS to monitor progress and provide update at MPOP	Update required for Q3 Partial Assurance in Q1	Evidence uploaded		Y	Blue	LMNS Assured - DoM confirmed MNVPs understand complaint themes	Provider - Blue	Further evidence uploaded	Y	Blue	LMNS assured	Blue	No change			
	Are MNVPs involved in the quality, safety and surveillance group that monitors and acts on trends.	Minimum evidence requirement - Terms of Reference and minutes for provider meetings 1) If YES - LMNS to review minuted attendance for the MNVP 2) If NO - LMNS to discuss when this will be achieved with provider with dates added to action plan 3) LMNS to provide reassurance at MPOP	Update required for Q3 Partial Assurance - Require meeting minutes	Evidence uploaded		Y	Green	LMNS note that the MNVP, DoM, HoM, CN, NED and Neonatologist are included in safety champion walk abouts. Minutes uploaded as evidence	Provider - Green	Further evidence uploaded	Y	Blue	LMNS assured - further evidence provided	Blue	No change			
	Is FTSU data reported to board and acted upon?	Minimum evidence requirement - minutes of Board meetings with evidence of how data is acted upon. If YES 1) Minutes from board meeting 2) Evidence of how data is acted upon? If NO 1) LMNS to agree with provider when will this be achieved and dates to be added to action plan LMNS to monitor progress 2) Provide quarterly update at MPOP	LMNS Assured in Q1- Trust Policy supports process	No further action at Q3.		Y	Green	BOD minutes received - further evidence required in Q4	Provider - Green	Further evidence uploaded	Y	Blue	LMNS assured - Board paper reviewed and assurance noted	Blue	No change			
Objective 10: Standards to ensure best practice	Has the organisation implemented version 3 of the Saving Babies' Lives Care Bundle?	Minimum evidence requirement - Provider's latest submission to the SBL implementation HUB Q4 23/24 If YES - LMNS to review latest submission If NO - 1) LMNS to agree with provider when this will be achieved and dates to be added to action plan 2) LMNS to monitor progress 3) Provide quarterly update at MPOP	LMNS Assured June 2024 96%	Achieved 87-97%; quarterly submission and reviews as evidence		Y	Blue	LMNS Assured	Provider - Blue	No change in Q4	Y	Blue	LMNS assured	Blue				
	Is the organisation on track to adopt the national MEWS and NEWT?-2 tools by March 2025?	Minimum evidence requirement - self assessment Where provider reports YES - LMNS to continue support and report to MPOP on exception basis. Where a provider reports NO - 1) LMNS to consider barriers to implementation of the national roll out of MEWS and NEWT?- 2) Provide progress updates quarterly at MPOP	Update required for Q3 Partial Assurance in Q1 - More evidence required.	Awaiting confirmation from Cerner Millenium how to build into IT system as electronic record; Risk on register to support position		P	Amber	Trust awaiting confirmation from Cerner following a request for an electronic observation chart – LMNS requested update in Q4	Provider - Amber	No progress; on risk register	Y	Amber	Issues remain with digital Cerner programme - Trust has added to Risk Register **NW Regional Team: request confirmation of the trusts mitigation(s)?**					
	Does the organisation regularly review and act on local outcomes including stillbirth, neonatal mortality and brain injury, and maternal morbidity and mortality to improve services?	Minimum evidence requirement: Narrative on what this looks like and SOP. Where provider reports YES - LMNS to review SOP and examples of reviews for assurance. Where provider reports NO - LMNS to provide assurance that they are supporting the provider to achieve this measure. LMNS to provide progress updates at MPOP	LMNS Assured in Q1	No further action		Y	Green	LMNS note monthly update with Quality Surveillance tool and quarterly PMRT Report as per MIS Year 5	Provider - Green	Further evidence uploaded	Y	Blue	LMNS assured - LMNS note WUTH submitted best SA9 evidence across all Trusts	Blue				
	Has the organisation completed the national maternity self-assessment tool? .	Minimum evidence requirement - LMNS to review provider's maternity self-assessment tool YES 1) submission of the maternity self-assessment tool 2) LMNS to review the quality and effectiveness of the self-assessment tool i.e. is it being utilised as an iterative process and updated regularly, who has oversight and what meeting is it discussed at NO 1) LMNS needs to agree target date for provider to complete the self-assessment tool and submit for review 2) LMNS to monitor progress against completion and provide update at MPOP	Update required for Q3	Evidence uploaded to include BOD papers who have oversight		Y	Green	Evidence received including BOD papers who have oversight - further update required in Q4	Provider - Green	Further evidence uploaded	Y	Blue	LMNS assured - further evidence provided	Blue				
Objective 11: Data to inform learning	Does the organisation have a process for reviewing available data which draws out themes and trends and identifies and addresses areas of concern including consideration of the impact of inequalities?	Minimum evidence requirement : Provider use of dashboard If YES 1) LMNS to review dashboard including where data is reviewed, frequency of review meetings and by whom 2) LMNS to confirm it includes measures for inequalities? If NO - LMNS to monitor progress against completion and agree improvement plan with provider and provide update at MPOP	Update required for Q3	Evidence to support current position uploaded		Y	Green	DoM confirmed Cerner can run reports on women with social deprivation backgrounds - - further update required in Q4	Provider - Green	Examples included as evidence, via an IT requ	Y	Green	No change from Q3	Green				
	Does the organisation have a system that ensures high-quality submissions to the Maternity Services Data Set?	Minimum evidence requirement - Provider to submit MSDS data via the Strategic Data Collection Service in the Cloud (SDCS Cloud) using a registered account. If YES 1) LMNS to confirm evidence of SDCS account 2) Provider to submit monthly scorecard as evidence	Update required for Q3	MSDS scorecard reflects system is operational; and all 11 criteria met		Y	Blue	LMNS note MSDS scorecard reflects system is operational; and all 11 criteria have been met	Provider - Blue	No change in Q4	Y	Blue	LMNS assured	Blue	No change			
	Does the organisation have robust processes in place to ensure referrals to NHSR, MNSI, and the National Perinatal Epidemiology Unit?	Minimum evidence requirement : Guideline which demonstrates process for reporting If YES - provider to submit guideline If NO- provider to agree when guideline will be in place and target dates to be added to action plan LMNS to monitor progress and provide updates at MPOP	Update required for Q3	Evidence uploaded		Y	Green	Further evidence requested	Provider - Green	Further evidence uploaded	Y	Green	No change from Q3	Blue	Change to blue as there no actions to be completed			
	Does the organisation have a digital maternity strategy and digital roadmap?	Minimum evidence requirement : Digital Maternity Strategy If YES - provider to submit copy of strategy to LMNS If NO - provider to agree when strategy will be in place with target dates to be added to action plan LMNS to monitor progress and provide updates at MPOP	LMNS Assured in Q1	No further action at Q3		Y	Green	Maternity Digital Strategy received. However, further evidence required in Q4	Provider - Green	Further evidence uploaded		Green	The LMNS note that the Trust has recently uploaded their Digital Strategy and Roadmap	Blue	Change to blue as there no actions to be completed			

Objective 12: Make better use of digital technology in maternity and neonatal services	Is the digital strategy and roadmap being implemented?	Minimum evidence requirement : Progress reports on digital roadmap delivery against strategy If YES - provider to submit updates of progress to LMNS for review If NO - provider to agree with LMNS when progress will be made with target dates added to action plan LMNS to monitor progress and provide updates at MPOP	LMNS Assured in Q1	No further action at Q3		Y	Green	Digital Project Porfolio received. However, further evidence required in Q4	Provider - Green	Further evidence uploaded	Y	Green	The LMNS note that the Trust has recently uploaded their Digital Strategy and Roadmap	Blue	Change to blue as there no actions to be completed			
	Does the organisation have an EPR system that complies with national specificaitons and standards, including the Digital Maternity Record Standard and the Maternity Services Data Set?	1)Provider to confirm with LMNS details of EPR system is in place. 2)LMNS to confirm whether EPR system complies with digital maternity record standard. LMNS to provide progress updates to MPOP where non compliance for provider.	LMNS Assured in Q1	No further action at Q3		Y	Green	Cerner Millenium in place. Further evidence required in Q4	Provider - Green	Further evidence uploaded		Amber	The LMNS note that the Trust has recently uploaded national standard practice v1.1 from Cerner (draft), but await confirmation from the Trust regarding compliance against national standards					

Appendix 17

Board of Directors in Public

03 September 2025

Title	Annual Board Assurance Statement – Sustaining Maternity and Neonatal Culture Initiatives
Area Lead	Sam Westwell, Chief Nurse
Author	Jo Lavery, Divisional Director of Nursing & Midwifery (Women's and Children's')
Report for	Information

Report Purpose and Recommendations
To provide the Board of Directors with assurance that maternity and neonatal assurance services at WUTH continue to prioritise and embed positive culture initiatives, aligned with national priorities and the Trust's Quality Strategy.

Key Risks
This report relates to these key Risks: • BAF Risk 1.4, Failure to ensure adequate quality of care resulting in adverse patient outcomes and an increase in patient complaints.

Contribution to Integrated Care System objectives (Triple Aim Duty):	
Better health and wellbeing for everyone	Yes
Better quality of health services for all individuals	Yes
Sustainable use of NHS resources	Yes
Which strategic objectives this report provides information about:	
Outstanding Care: provide the best care and support	Yes
Compassionate workforce: be a great place to work	Yes
Continuous Improvement: maximise our potential to improve and deliver best value	Yes
Our partners: provide seamless care working with our partners	Yes
Digital future: be a digital pioneer and centre for excellence	No
Infrastructure: improve our infrastructure and how we use it.	No

1	**Background**
	Creating and sustaining a positive safety culture in maternity and neonatal services is a key recommendation from national reviews including: • Ockenden Review • Kirkup East Kent Report

	• NHS Patient Safety Strategy • Three-Year Delivery Plan for Maternity and Neonatal Services (NHS England, 2023) Culture improvements is also central to the Maternity Incentive Scheme Safety Actions and Local Maternity and Neonatal System (LMNS) priorities.

2	Current Initiatives
	Leadership Visibility & Staff Engagement:- Executive and Non-Executive Maternity and Neonatal Safety Champions conduct monthly walkabouts in all areas of maternity including visits to the Seacombe Birth Centre and Neonatal Unit engaging directly with staff and families. • Regular update sessions held with staff to provide updates, raise concerns or suggestions. • Continued workshop and engagement with the perinatal and culture leadership programme as members of the quad have changed. • In Jan 2025 Women's and Children OD Triumvirate developed a programme with three areas of focus to include: - ○ Triumvirate and Senior Divisional Leadership ○ Staff Engagement ○ Leadership Development • Commencing from September engagement sessions at least bi-monthly with staff to provide updates, raise concerns or suggestions for the Women's and Children's Division. *Evidence: Walkabout logs and staff engagement slide packs* **Safety Culture Measurement** Annual **Safety Culture Survey** in maternity and neonatal teams, using validated tools SCORE (2023) and the annual NHS Staff Survey culture domains. • Results analysed by themes and fed into service-level improvement plans. *Evidence: Survey results; Improvement plan tracking actions and progress* **Learning and Just Culture** • Adoption of a **Just Culture framework** for incident reviews, ensuring fair, system focused analysis. • All Maternity and Newborn Safety Investigations (MNSI) and Patient Safety Incident Investigations (PSIIs) in maternity/neonatal services include human factors review.

	Evidence: PSII reports; just culture training records. **Multi-Disciplinary Training** Ongoing joint obstetric, midwifery, neonatal, anaesthetic, and theatre simulation training, with 95%+ compliance. Training includes human factors, escalation protocols, and teamwork under pressure. *Evidence: Training logs; simulation debrief summaries.* **Service User Involvement in Culture** • Maternity and Neonatal Voices Partnership (MNVP) co-leads improvement projects. • MNVP Lead sits on governance committees and service user representatives' involvement co-produced e.g. 15 steps, community events. • Collaboration with MNVP, Service Users and Staff on projects such as the neonatal expansion. *Evidence: MNVP, Safety Champion minutes; co-production project records.* **Governance Oversight** Monthly: Maternity & Neonatal Governance Committee monitors cultural improvement KPIs and training uptake. Quarterly: Reports and discussions at Maternity and Neonatal Assurance Board include safety culture metrics and thematic incident review findings. Annually: Board receives full assurance report on maternity/neonatal quality, safety, and culture. *Evidence: Minutes of Meetings*

3	Assurance Statement
	Assurance Statement to the Board of Directors The Board can be assured that: • Culture remains a live and sustained focus in maternity and neonatal services. • Leadership commitment is demonstrated through visibility, resourcing, and governance integration. • Staff feel empowered to raise concerns, share learning, and improve care. • Service users are partners in shaping the culture and service development.

	• Continuous measurement and monitoring ensure that cultural improvements are embedded and evidenced. • There is a focus to continually seek new initiatives and quality improvement projects line with all the reports there is a focus to strengthen the sharing of learning widely both locally and regionally.

4	Recommendations
	It is recommended the Board of Directors: - • Receive and note this assurance of continued focus on maternity and neonatal culture initiatives. • Support ongoing investment in leadership, training, and staff engagement to maintain positive culture momentum.

5	Conclusion
	The Board of Directors are requested to note the content within the annual report and progress made within maternity and neonatal services.

6	Implications
6.1	**Patients** • The appendices outline the standards we adhere to in order to deliver a safe service, with excellent patient care.
6.2	**People** • The outstanding relationship with MNVP demonstrates co-production with service users and patient involvement, noting areas to build and improve further on. • The commitment to reviewing governance processes, workforce, family engagement support women and birthing people on the Wirral. • The commitment to a safety culture, learning and continued staff engagement
6.3	**Finance** • Safety culture and learning reduces potential litigation claims.
6.4	**Compliance** • This supports several reporting requirements, each highlighted within the report.

Author	Jo Lavery, Director of Midwifery & Nursing - Women and Children's Division
Contact Number	0151 678 5111, Ext 2792
Email	Jo.lavery@nhs.net

Appendix 18

Board of Directors in Public

03 September 2025

Title	Compliance with Consultant Obstetric Attendance on Labour Ward in line with RCOG Guidance
Area Lead	Sam Westwell, Chief Nurse
Author	Jo Lavery, Divisional Director of Nursing & Midwifery (Women's and Children's')
Report for	Information

Report Purpose and Recommendations
To provide the Board of Directors with assurance that WUTH is compliant with Safety Action 4 of the NHS Resolution Maternity Incentive Scheme (MIS), ensuring consultant obstetricians attend the labour wards in specified clinical situations in line with RCOG standards. In Year 7 of the Maternity Incentive scheme there is a requirement for the evidence to be shared with the Board of Directors.

Key Risks
This report relates to these key Risks: • BAF Risk 1.4, Failure to ensure adequate quality of care resulting in adverse patient outcomes and an increase in patient complaints.

Contribution to Integrated Care System objectives (Triple Aim Duty):	
Better health and wellbeing for everyone	Yes
Better quality of health services for all individuals	Yes
Sustainable use of NHS resources	Yes
Which strategic objectives this report provides information about:	
Outstanding Care: provide the best care and support	Yes
Compassionate workforce: be a great place to work	Yes
Continuous Improvement: maximise our potential to improve and deliver best value	Yes
Our partners: provide seamless care working with our partners	Yes
Digital future: be a digital pioneer and centre for excellence	No
Infrastructure: improve our infrastructure and how we use it.	No

1	**Background**
	Part of Safety Action 4 requires: -

	Documented compliance with RCOG standards on consultant attendance for high-risk clinical scenarios (e.g. Major Obstetric Haemorrhage). Clear escalation protocols in place and applied by all staff Monitor and evidence attendance occurs as per policy. RCOG recommends: - • 24/7 consultant presence on labour ward in high volume units (>6000 births/annum). • For other units including WUTH clear on call availability with defined maximum response times. • Attendance for all situations outlined in Obstetric Early Warning and escalation criteria.

2	Current Position
	Policy and Escalation Criteria *The Trust has n obstetric escalation policy aligned with the RCOG guidance and approved by the Maternity Clinical Governance Group.* Criteria include: 1. Category 1 caesarean section. 2. Maternal collapse or severe compromise. 3. Massive obstetric haemorrhage (>1500ml). 4. Shoulder dystocia with fetal compromise. 5. Complex multiple births. 6. Any situation where midwifery/medical staff feel additional senior support is required **Workforce & Rota Compliance** • 24/7 consultant on-call rota with guaranteed <30 min response time (on-site within this period). • Consultants present on labour ward during peak activity periods and for all planned high-risk deliveries. **Training & Awareness** • Escalation policy embedded in **mandatory obstetric emergency training** for all grades. • New junior doctors receive specific induction on escalation triggers and consultant contact. **Evidence of Compliance** **Labour Ward Consultant Attendance Logs** – recorded in Cerner Millenium and validated monthly by Clinical Director. **Audit Results (March, April and May 2025):** • 100% consultant attendance for early warning score protocol or sepsis screening which suggests HDU/ITU care likely.

- 100% consultant attendance for all major placenta previa / abnormal invasive placenta.
- 100% consultant attendance for caesarean births for women with a BMI >50.
- 100% consultant attendance for caesarean births <28 weeks.
- 0% consultant attendance for premature twins (<30/40) weeks. There was one case during the audit period and clear documentation transcribed of the events. On arrival delivery was imminent and the patient was provided care by a Senior Registrar (Competent to deliver premature twins and an Advanced Midwife Practitioner with expert midwifery knowledge). The consultant was contacted and remained on the telephone throughout the event.
- There were no cases of fourth degree tears or unexpected intrapartum in the audit period.
- 100% consultant attendance for eclampsia.
- 100% consultant attendance for maternal collapse/severe compromise.
- 100% attendance for major obstetric haemorrhage.
- 99% of consultants attended for the obstetric procedure when the Senior Doctor was not signed off as competent. There was one case out of 86 where this was not achieved and this was due to theatre activity and other ongoing emergencies on labour ward. The midwife updates on the management progress as the consultant is on site.

Incident Review – No adverse events linked to delayed consultant attendance in reporting period.

Governance & Oversight

Monthly: Labour Ward Forum to review attendance data and feedback.

Quarterly: Maternity Governance Committee reviews compliance and escalation incidents.

Annually: Rota and escalation policy reviewed against updated RCOG standards.

Risks & Mitigation

Risk	**Mitigation**
Consultant delayed due to theatre commitments	Second on-call cover for high-risk periods
Delivery imminent in some cases	Assess situation and remain in communication to support if deemed arrival to unit not achievable.

	Junior staff reluctant to escalate	Mandatory training, escalation awareness campaign
	Rota gaps due to sickness/leave	Locum consultant cover (internal) sourced in advance

3	Conclusion
	The evidence confirms that WUTH meets the MIS Safety Action 4 requirement. Consultants are attending labour ward for all RCOG-defined scenarios, escalation processes are embedded, and compliance is monitored through audit and governance structures

4	Recommendations
	It is recommended the Board of Directors: - • Note this assurance of compliance with Safety Action 4. • Approve submission of compliance evidence to NHS Resolution for MIS Year 7. • Support ongoing monitoring through quarterly maternity safety reports.

5	Implications
5.1	**Patients** • The paper outlines the standards we adhere to in order to deliver a safe service, with excellent patient care.
5.2	**People** • The commitment to providing safe and high-quality care.
6.3	**Finance** • The increasing number of complex cases will impact on the current establishment and resources which will require further investment in the future to comply with workforce requirements.
6.4	**Compliance** • This supports several reporting requirements, each highlighted within the report.

Author	Jo Lavery, Director of Midwifery & Nursing - Women and Children's Division
Contact Number	0151 678 5111, Ext 2792
Email	Jo.lavery@nhs.net