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 completed and referred x 1 referred to MNSI as the other case not eligible
	Number of neonatal deaths (before 28days) at WUTH	0		x 1 Extreme prematurity, all governance process initiated; x 1 5 Day P/N community death
	Number of maternal deaths (up to 28 days following delivery)	0		
	Post partum haemorrhage >1500mls	6		x 6 reported; all have had full reviews via the CIF process and have been managed in line with policy
	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; recruitment underway
	Midwifery staff absence rate in month (sickness)	3.78%		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	5.00%		All posts out for recruitment
	Midwife : Birth ratio	01:27		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	8		Theme: delay in providing pain relief; improvement noted from previous months
Service user /	Staff survey	37%		Divisional compliance for 2024 staff survey 37%, midwifery staff groups below national average, requires improvement; action plan produced with key priorities; focus on 2025 survey and objective to increase response rate
	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	No		All posts etsablished and recruited to
	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 7 to be submitted March 2026, sign off by BoD to be requested in Jan 2026
	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	No		Nil of note
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	2		Reporting for September 2025
	Number of Maternity or Neonatal PSII's	0		No new PSII's for maternity; x 1signed off 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
Governance 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 critical incident decelared at WUTH in relation to sterile services
	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	42		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 MNSI with concerns	No		N/A

Trust Board sign-off requirements for MIS year 7

n.b. 'Completed' set to 'No' as default
Change to 'Yes' and add date when complete.

	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 full	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 (BSC)	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:

1/7/2025 to 30/9/2025

Summary of perinatal deaths*

Total perinatal* deaths reported to the MBRRACE-UK perinatal mortality surveillance in this period: *9*

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
6	1	4	1	0

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
4	0	4	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	0	1	0	1
Antepartum stillbirths	*0*	*0*	*0*	*0*	*1*	*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	0	1	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	0	0	0	0
Not Applicable	0	0	0	0	1	0	1
Mother gave birth in a setting appropriate to her and/or her baby's clinical needs:							
Yes	0	0	0	0	1	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	0	1	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	0	1	0	1
No	0	0	0	0	0	0	0
Hospital post-mortem offered	0	0	0	0	1	0	1
Hospital post-mortem declined	0	0	0	0	0	0	0
Hospital post-mortem carried out:							
Full post-mortem	0	0	0	0	1	0	1
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	1	0	1
No	0	0	0	0	0	0	0
Placental histology carried out by paediatric/perinatal pathologist*:							
Yes	0	0	0	0	1	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	0	0%
Vice Chair	0	0%
Admin/Clerical	0	0%
Ambulance Team	0	0%
Bereavement Team	2	100% (1)
Community Midwife	0	0%
External	2	100% (1)
Management Team	2	100% (1)
Midwife	8	100% (1)
MNVP Lead	0	0%
Neonatal Nurse	0	0%
Neonatologist	0	0%
Obstetrician	3	100% (1)
Other	0	0%
Risk Manager or Governance Team	0	0%
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	1	0	1
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 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	0	1	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**
	Placental Abruption
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
In view of this mother's risk factors there was not appropriately senior involvement in the management plans for her delivery prior to the establishment of labour or elective delivery	1	Escalated to clinical director to address with individual and Consultant body
This mother booked late. Did this affect her care?	1	No action entered
This mother's risk status during labour was assessed and it had changed but she was not managed appropriately	1	Learning shared with wider team relating to adhering to the Northwest Stillbirth Pathway and risks around DIC.

*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
NICE guidance recommends carbon monoxide testing for all mothers at booking; this mother was not screened	1	No action entered
This mother booked late. Are there any organisations to consider in relation to her booking late?	1	No action entered

*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
Patient Factors - Mental/Psychological Factors - Motivation issue	1	This mother booked late. Did this affect her care?
Staff Factors - Cognitive Factors - Preoccupation / narrowed focus (Situational awareness problems)	1	In view of this mother's risk factors there was not appropriately senior involvement in the management plans for her delivery prior to the establishment of labour or elective delivery
Work Environment - Work load and hours of work	1	This mother's risk status during labour was assessed and it had changed but she was not managed appropriately

Board Report and Action Plan on Implementation of the Saving Babies Lives Care Bundle (Version 3.2)

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 3.2 of the Saving Babies' Lives Care Bundle (SBLCBv3.2) published on 24 April 2025, 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.

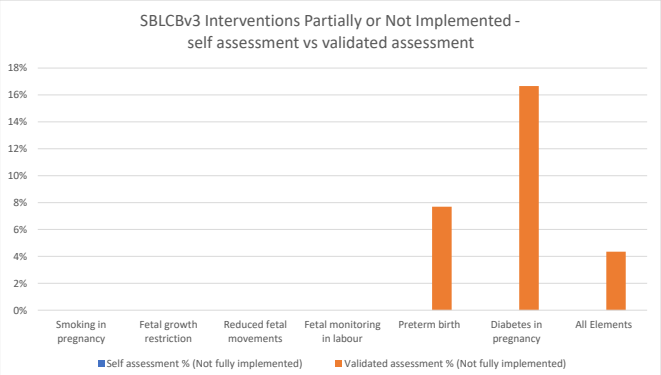
ONS and MBRRACE-UK data demonstrate the urgent need to continue reducing preventable mortality. Developed 4 years after SBLCBv2, Version 3 of the Care Bundle (SBLCBv3) has been developed through a collaboration of frontline clinical experts, service users and key stakeholder organisations. All existing 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. SBLCBv3.2 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.

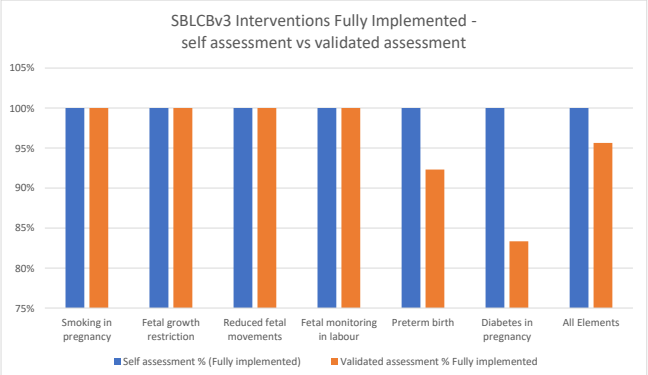
As part of the Three Year Delivery Plan for Maternity and Neonatal Services, all NHS maternity providers have been responsible for fully implementing SBLCBv3 by March 2024.

Implementation Grading

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)
Element 1	Smoking in pregnancy	Fully implemented	100%	Fully implemented	100%
Element 2	Fetal growth restriction	Fully implemented	100%	Fully implemented	100%
Element 3	Reduced fetal movements	Fully implemented	100%	Fully implemented	100%
Element 4	Fetal monitoring in labour	Fully implemented	100%	Fully implemented	100%
Element 5	Preterm birth	Fully implemented	100%	Partially implemented	92%
Element 6	Diabetes	Fully implemented	100%	Partially implemented	83%
All Elements	TOTAL	Fully implemented	100%	Partially implemented	96%

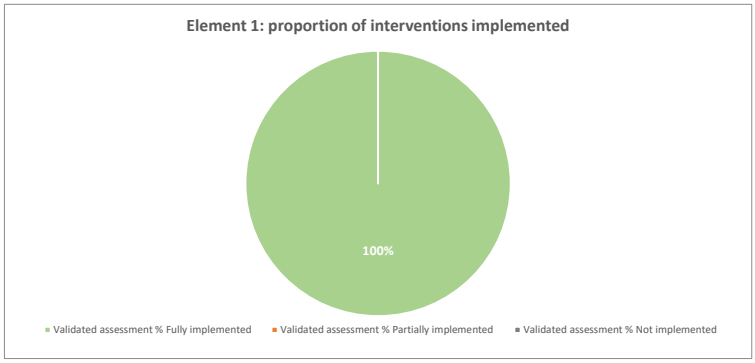




Action Plan

Element 1

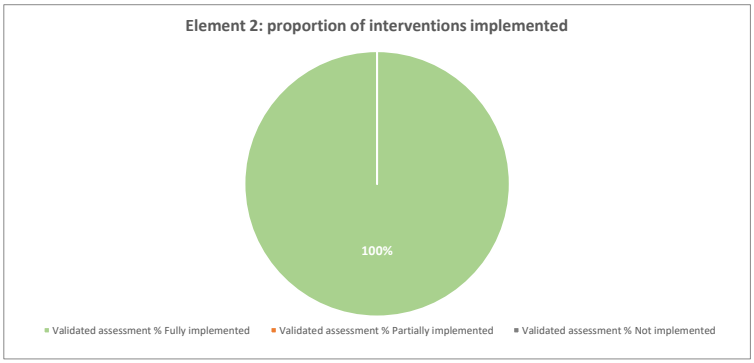
Intervention Ref	Self-Assessment Status	LMNS Validated Assessment Status	LMNS Recommendation of Actions Required	LMNS Suggested Improvement Activity
INTERVENTIONS				
1.1	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Please upload MSDS quality imporvement metric photo not in folder. Smioke free pregnancy regional guideline noted Review Feb 2027
1.2	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	June audit twenty women 98% (161/164)
1.3	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Smoking ststus recorded at booking - June audit 20/20 women 100% Action Plan noted
1.4	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Booking Appointments Guideline is up for review in April 2026. June 2025 Audit 10/10 women referred for smoking cessation 100%
1.5	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Guideline noted
1.6	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	WUTH Nicotine replacement therapy NRT v5 noted Review Nov 2026. Quit dates set January 25 is 40.6% Feb is 20% and March 29% April 17.5%
1.7	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	May Audit 100% of notification of non engagement from ABL
1.8	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	May 25 Data Midwives 91% and MSW 96% Midwifery practice update June 25 data, Midwives 90% and MSW 91%
1.9	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	VBA covered in 2 presentations for training on Prompt. Please upload agenda for study day and TNA noted (review date 2026) for all six core competencies.
1.10	Fully implemented	Fully implemented	Focus required on improvement of compliance levels to meet implementation ambitions and LMNS trajectories.	Certificates uploaded need renewal Nov 2025 - Midwife confirmed in email will update when due. Please upload new certificates next Quarter.



Element 2

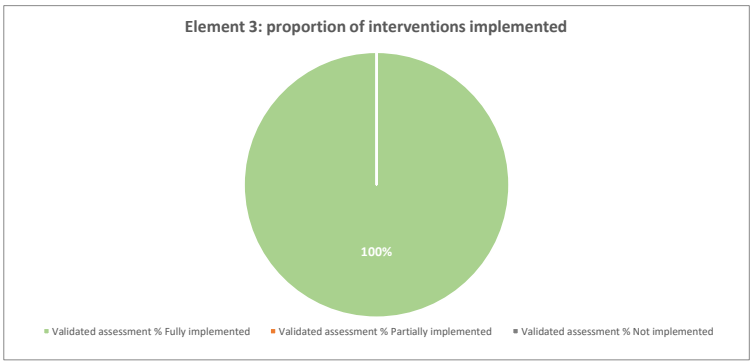
INTERVENTIONS				
2.1	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Wuth Confirmed Regional Guideline April 2025 in use
2.2	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Wuth Confirmed Regional Guideline April 2025 in use
2.3	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Element 1 compliant
2.4	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Wuth Confirmed Regional Guideline April 2025 in use
2.5	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Wuth Confirmed Regional Guideline April 2025 in use
2.6	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Hypertension in pregnancy gudiline Policy review Sept 2026 noted states use of automated BP machines. Confirmed in use at Sept 2025 meeting.
2.7	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Wuth Confirmed Regional Guideline April 2025 in use
2.8	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Wuth Confirmed Regional Guideline April 2025 in use
2.9	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Wuth Confirmed Regional Guideline April 2025 in use
2.10	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Wuth Confirmed Regional Guideline April 2025 in use
2.11	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Wuth Confirmed Regional Guideline April 2025 in use
2.12	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Wuth Confirmed Regional Guideline April 2025 in use
2.13	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Wuth Confirmed Regional Guideline April 2025 in use
2.14	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Wuth Confirmed Regional Guideline April 2025 in use

2.15	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Wuth Confirmed Regional Guideline April 2025 in use
2.16	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Wuth Confirmed Regional Guideline April 2025 in use
2.17	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Wuth Confirmed Regional Guideline April 2025 in use
2.18	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Wuth Confirmed Regional Guideline April 2025 in use
2.19	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Wuth Confirmed Regional Guideline April 2025 in use
2.20	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Wuth Confirmed Regional Guideline April 2025 in use



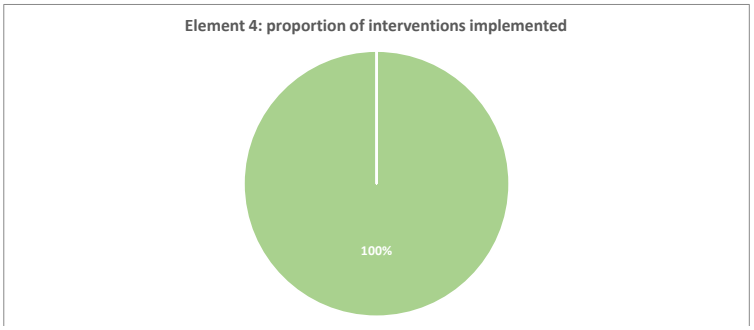
Element 3

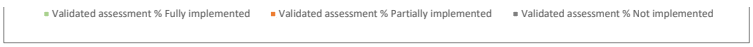
INTERVENTIONS				
3.1	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Regional Guideline - Review date March 26
3.2	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Regional Guideline noted CTG Audit Data:



Element 4

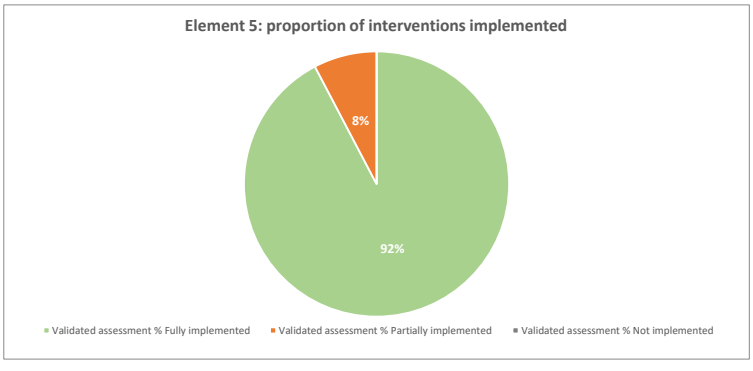
INTERVENTIONS				
4.1	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	TNA meets the criteria and is in date (2026-27) Is Personalised care only supported in PROMPT covering training and
4.2	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Sept 2025 100% staff compliance in fetal monitoring study day and fetal monitoring assessment.
4.3	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	SBL Data April, May and June 25, references 3.2 and 5.2 also shows fetal monitoring. 1 out of 4 cases requires fetal monitoring no issues highlighted. LMNS have uploaded this presentation to element 4 folder. WUTH team to
4.4	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	June 25 Audit score is 95% out of 20 cases. Audit not required.
4.5	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Fetal surveillience JD and roster noted. Roster up until 31st July 2025. Clinical Lead JD noted please clarify which part of the JD covered fetal





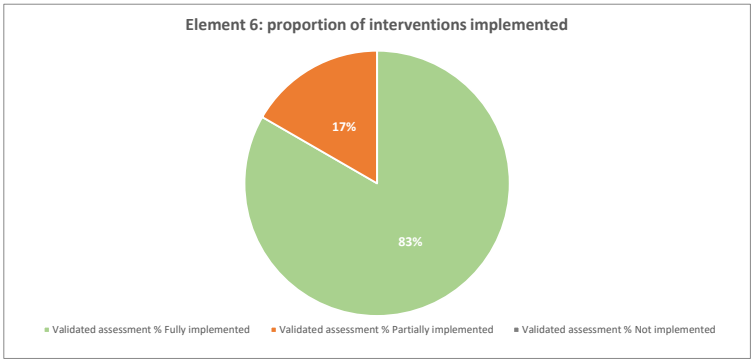
Element 5

INTERVENTIONS				
5.1	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	JD and Job plan received for Sarah Thompson (neonatologist) Job plan received for Lauren Evetts Preterm High risk midwife lead.
5.2	Fully implemented	Partially implemented	Evidence not in place - improvement required.	Regional Guideline noted No audit data received, please upload relevant audit data.
5.3	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Following Regional Guidance. Booking appointment guidance is compliant with NICE 2021.
5.4	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Cervical length and transviginal scanning included in Guideline.
5.5	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Regional Pre-term birth guideline notes
5.6	Fully implemented	Partially implemented	Focus required on improvement of compliance levels to meet implementation ambitions and LMNS trajectories.	Guideline only references the 2019 version of twins and triplets NICE Guidance.
5.7	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
5.8	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
5.9	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
5.10	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	NW Preterm birth guideline located in email - three of the uploaded guidelines are only front copies - with WUTH logo and author as Mustafa Sidiqui. Please correct this for next quarter.
5.11	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Booking guideline talks about MSU however does not talk about follow up. Please provide evidence thrugh pMRT regarding missed MSUs
5.12	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
5.13	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Referral Guideline Feb 2025 for review 2027
5.14	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Review Date is July 2026 Patient information leaflet noted in PTB Guideline.
5.15	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
5.16	Fully implemented	Fully implemented	Evidence not in place - improvement required.	Please confirm you have the information leaflet in different languages for your local population. WUTH give RCOG leaflet paper - this is now available digitally with translation to different languages. Screen shot of languages
5.17	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
5.18	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	No audit data uploaded but noted they are level 3 neonatal unit and so babies will be born in the right place.
5.19	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Mat / Neo Collaborative Agenda 3rd Sept 2025 noted.
5.20	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Audit data is 100% for June 25 Mat / Neo Collaborative Agenda 3rd Sept 2025 noted.
5.21	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	June anitbiotics audit 75% MInutes Wed 3rd Sept Mat / Neo collaborative uploaded.
5.22	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Optimal cord clamping 100% in July
5.23	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	July Data (under early breastmilk) shows normothermic was 83%
5.24	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	June Data Breast Milk 83%
5.25	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	May - No admissions June - one eligible = 100%
5.26	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	June Caffeine Audit 100%



Element 6

INTERVENTIONS				
6.1	Fully implemented	Fully implemented	Evidence not in place - improvement required.	Job plans received clarification on roles. Need confirmation of a dietician.
6.2	Fully implemented	Partially implemented	Evidence not in place - improvement required.	No audit data available. Hybrid pumps just being introduced 2 women started on pumps. WUTH will review data;
6.3	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Guideline noted
6.4	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Q1 Audit 2/25 received and achieved 100% complinace. Audit broken down by ethnicity.
6.5	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Email confirms it is based on the MMN Guideline.
6.6	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Guideline noted



Ockenden Essential Actions - May 2024

V15 update November 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 - November 2025							
	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/AK	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; WUTH plans updated against original t
			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	Ongoing annually	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	Ongoing annually	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	31/3/26	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; QI projects continue with the EPR system to support; to date all available implemented
			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

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 Q...	Q1 25/26 LMNS Questions to Provider / Request for Additional Information	Q2 25/26 Provider Self-Assesment BRAG	Q2 25/26 Provider Update / Rationale for BRAG	Q2 25/26 LMNS is Assured?	Q2 25/26 LMNS Rationale for BRAG / LMNS Q...	Q2 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 MPDP 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	Yes	Blue	LMNS assured - TNA evidence reviewed and note inclusion of PCSP training	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 MPDP 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	Yes	Blue	LMNS assured - Maternity Personalised Care and Support Plan Audit Schedule 2025/2026 received and reviewed	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 MPDP 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	Yes	Blue	LMNS assured - LMNS note 5x CoC Teams currently in place, with no further teams planned at present	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 to LMNS at MPDP	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	Yes	Green	LMNS note all teams sustained, with ongoing review via MCoC/EMCoC LMNS Workstream/Community of Practice Meeting	Blue	Self assessment RAG rate altered to action complete as meet national driver			
	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 MPDP.	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	Yes	Green	As above	Blue	Self assessment RAG rate altered to action complete as meet national driver			
	Has the trust achieved UNICEF BFI accreditation?	1) Each provider is 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 MPDP.	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 track 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	Yes	Blue	LMNS assured - LMNS note Action Plan for maternity on target and NNU training underway	Blue	No change			
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 MPDP 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 MPDP.	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 accesible information standard. Hence, amber status	Blue	Policy Iploaded	Yes	Blue	LMNS assured - Trust have provided detailed email from Trust lead Tony Priddding confirming compliance with national guidance	Blue	No change			
	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 MPDP.	Update required for Q3 Partial Assurance in Q1 - more evidence required.	Data collected includes age, ethnic minority, marital status, postcode, language/is 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	Exemples uploaded as evidence	Y	Blue	LMNS assured - Further evidence provided as requested in Q3			Yes	Blue	LMNS assured - Presentation uploaded with evidence of bookings data by location and ethnicity	Blue	No change			
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 MPDP 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	Yes	Blue	LMNS assured - evidence submitted as part of MIS Year 7	Blue	No change			
Objective 4: Grow our workforce	Date of last BR+	1) Provider to submit copy of the latest BR+ report to LMNS. 2) BR+ compliance to be discussed with MPDP	LMNS Assured in Q1	Assured: June 2021 New BR+ scheduled for January 2025 - BR plus commenced in June 2025; BR plus 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 evidence and SOC being prepared for additional staffing	Yes	Blue	LMNS assured - BR+ Report March 25 received	Blue	No change			
	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	Yes	Blue	LMNS assured - Business case uploaded and reviewed	Blue	Statement of case; accompanying documents that went to BOD for approval which was supported			
	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 MPDP	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	Yes	Blue	LMNS assured - BR+ report March 25 received - BR+ assessment 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		Yes	Blue	LMNS assured - Midwifery Workplan 2025 received and reviewed	Blue	No change			
	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 MPDP 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 initiatives		Y	Green	Trust to submit updated Maternity Workplan in Q4, to include additional information from BR+ Raport	Provider - Green	Workforce plan uploaded	Y	Blue	LMNS assured - new evidence provided			Yes	Blue	LMNS assured - Midwifery Workplan 2025 received and reviewed	Blue	No change			
	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 MPDP 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	Yes	Green	**Trust to upload PWR data for Q2 submission**	Green	Statement of case approved			
	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 MPDP 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	Yes	Green	**Trust to upload PWR data for Q2 submission**	Green	Statement of case approved			
	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 MPDP 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	Yes	Green	**Trust to upload PWR data for Q2 submission**	Green	Statement of case approved			
	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 MPDP 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	Yes	Green	**Trust to upload PWR data for Q2 submission**	Green	Statement of case approved			
	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 MPDP 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 01.12.24) 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 ISPAs for a period of 12 months to cover adjusted duties of one individual	Yes	Green	**Trust to upload PWR data for Q2 submission**	Green	Maternity cover due to commence Jan 2026 on qualification			
	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 MPDP 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 tasset to recruit	Yes	Blue	**Trust to upload PWR data for Q2 submission**	Blue	No change			

	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 MPDP	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	Yes	Green	LMNS note post out to advert as internal opportunity / secondment for 6 months to cover career break - **Trust to provide update for Q2 submission**	Blue	Individual in post to cover career break				
	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 MPDP	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	Yes	Green	**Trust to confirm whether an Action Plan is only required if turnover rate is above Trust target and if so, what is the Trust target**	Green					
	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 MPDP 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 change	Yes	Blue	LMNS assured - Trust wide policy received and reviewed	Blue	No change				
	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 MPDP https://www.england.nhs.uk/north-west/wp-content/uploads/sites/49/2023/07/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	Yes	Blue	LMNS assured - LMNS note Bronze status	Blue	No change				
Objective 5: Value and retain our workforce	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 MPDP	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	Yes	Blue	LMNS assured - BoD paper received and reviewed, which demonstrates area of great practice	Blue	No change				
	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 MPDP	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	Yes	Blue	LMNS Assured - LMNS note Preceptorship Programme in place	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 prosress update to MPDP 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	Yes	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	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 MPDP	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 targeting Amber can we discuss	Yes	Green	Detailed corporate board paper received and reviewed. However, plan requires strengthening in relation to the wider workforce (i.e. no reference to workforce from ethnic backgrounds) - **Trust to liaise with HR Team to support with an update for Q2 submission**					
	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 MPDP. 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	Yes	Blue	LMNS assured - TNA received and reviewed	Blue	No change				
Objective 6: Invest in skills	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 MPDP	Update required for Q3 Partial Assurance in Q1 - Require more evidence	Evidence uploaded			Y	Green	Trust to submit Neonatal Workforce Paper, which includes MIS SA5	Provider - Blue	Safety Action 5 compliance signed off; additional NNU consultant in post	Y	Blue	LMNS assured - evidence reviewed as part of MIS Year 4: additional consultant now on rota	Blue	No change	Yes	Blue	LMNS assured - evidence reviewed as part of MIS	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 MPDP	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	Yes	Blue	LMNS assured - Trust does not use locums	Blue	No change				
	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 MPDP 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	Yes	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	Yes	Blue	LMNS assured - Quad has attended national leadership programme	Blue	Continue to attend sessions and internal OD leadership development being implemented				
Objective 7: Develop a positive safety culture	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 MPDP meetings.	LMNS Assured in Q1	No further action at Q3			Y	Green	LMNS assured on track, but further update required in Q4	Provider - Green	No change in Q4	Y	Blue	LMNS assured - evidence submitted and reviewed as part of MIS SA9	Blue	Additional papers uploaded to demonstrate sustainability	Yes	Blue	LMNS assured - Evidence submitted and reviewed as part of MIS SA9	Blue	No change				
	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 policy/it does not meet compliance standard - LMNS to support provider to develop policy which the LMNS will maintain oversight. 4) LMNS to provide reassurance to MPDP	LMNS Assured Q1	No further action at Q3			Y	Green	LMNS note that the Trust uses AD 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	Yes	Blue	LMNS assured - LMNS note that the Trust uses AD as a toolkit and that the Trust was a pilot site for the introduction nationally of the escalation tool. This has been rolled out.	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 MPDP	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	Yes	Blue	LMNS assured - Name of FTSU Guardian received and JD for post	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 MPDP	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	Yes	Blue	LMNS assured - evidence reviewed ELFH	Blue	No change				
	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 MPDP	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	Yes	Green	**LMNS awaiting ICB confirmation of updated policy - Trust to confirm for Q2 submission**	Green					
	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 3YO plan measure 3) LMNS to provide quarterly update at MPDP 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	Yes	Blue	LMNS assured - LMNS note included in Trust incident policy and Maternity Risk Management Strategy	Blue	No change				

Objective 8: Learn and Improve	Has the organisation 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	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	Yes	Blue	LMNS assured - Trust has no designated FLO but uses the exisiting governance team for FLO within PSIRF and incident management	Blue	No change						
	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	Yes	Blue	LMNS assured - as above	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	Yes	Green	**LMNS awaiting ICB confirmation of updated policy - Trust to confirm for Q2 submission**	Green						
	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 sustainability	Y	Green	Parental feedback uploaded as evidence	Green	No change	Yes	Green	**LMNS awaiting ICB confirmation of updated policy - Trust to confirm for Q2 submission**	Green						
Objective 9: Support and oversight	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	Yes	Blue	LMNS assured - LMNS note embedded processes within Trust	Blue	No change						
	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	LMNC 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 SAI to Board for oversight and assurance	Blue	No change, embedded	Yes	Blue	LMNS assured - embedded process for SAI to Board for oversight and assurance	Blue	No change						
	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	Yes	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	Yes	Blue	LMNS assured - quadrumvirate continues to be in place	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	Yes	Blue	LMNS Assured - DoM confirmed MNVPs understand complaint themes	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	Yes	Blue	LMNS assured - LMNS note that the MNVP, DoM, HoM, CN, NED and Neonatologist are included in safety champion walk abouts. Minutes uploaded as evidence	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	Yes	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 97-97%, quarterly submission and reviews as evidence			Y	Blue	LMNS Assured	Provider - Blue	No change in Q4	Y	Blue	LMNS assured	Blue		Yes	Blue	LMNS assured	Blue	No change						
	Is the organisation on track to adopt the national MSWS and NEWTT-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 MSWS and NEWTT- 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 obligation(s)?**			Yes	Green	Trust confirmed on track with this deliverable. Plan is to release MSWS by end of September or early October and NEWTT 2 by end of October/ early November 2025 - **Trust to provide update as part of Q2 submission**	Green	Further update requested from Cerner						
	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 update 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 SAI evidence across all Trusts	Blue		Yes	Blue	LMNS assured - LMNS note WUTH submitted best SAI evidence across all Trusts	Blue	No change						
	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		Yes	Blue	LMNS assured - LMNS note updated Maternity Self Assessment Tool	Blue	No change						
	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 if 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 sy	Y	Green	No change from Q3	Green		Yes	Blue	LMNS assured - Trust has provided detailed evidence regarding ability to disaggregate data	Blue	No change						
Objective 11: Data to inform learning	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; 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	Yes	Blue	LMNS assured - LMNS note MSDS scorecard reflects system is operational; and all 11 criteria have been met	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	Yes	Blue	LMNS assured - evidence of SOPs submitted	Blue	No change						

Objective 12 - Make better use of digital technology in maternity and neonatal services	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	Yes	Blue	LMNS assured - Digital Strategy and Roadmap received by the LMNS	Blue	No change			
	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 Portfolio 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	Yes	Blue	LMNS assured - as above	Blue	No change			
	Does the organisation have an EPR system that complies with national specifications 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			P	Amber	Update from trust received 29/07/25 - one area of non compliance (sex and gender) is currently under review with CERNER. Trust aim to be compliant with this outstanding national requirement by 03/11/25 - this will ensure they complete all requirements by the 31/12/25 . **Trust to provide update as part of Q2 submission**	Amber	Requested update and not yet received from Trust wide			