NHS
Wirral University Teaching Hospital
NHS Foundation Trust

Maternity & Neonatal Trust Board Safety Report

Board of Directors / Quality Committee Monthly Report

Presented by Jo Lavery, Divisional Director of Nursing and Midwifery, Women's and Children's Division

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Executive summary

Wirral University Teaching Hospital
NHS Foundation Trust

The maternity and neonatal service continues to demonstrate strong, sustained improvement across all key domains of quality, safety, and workforce. Progress remains aligned to national priorities including Ockenden, East Kent, MOSS, and the Three-Year Delivery Plan. Governance structures are now more robust, safety culture is strengthening, and workforce stability is improving, with the majority of deliverables rated Blue or Green.

The service reports no MOSS safety signals, high compliance with fetal monitoring training, and timely review of all moderate-and-above incidents. Staff feedback indicates improved psychological safety and confidence in escalation, reflecting the impact of strengthened leadership and multidisciplinary learning.

Personalised care continues to be embedded, with five enhanced Continuity of Carer teams sustained in areas of vulnerability. Maternity achieved full UNICEF BFI accreditation in October 2025, and neonatal services are progressing on a two-year accreditation plan. Service-user involvement remains strong, supported by an active MNVP and evidence submitted through MIS Safety Action 7.

Workforce indicators show a positive trajectory. The BR+ report (March 2025) has been received, the Trust remains funded to establishment, and recruitment to midwifery, MSW, and obstetric consultant posts is stable, with consultant vacancies. Turnover, sickness, and leaver rates are improving and within expected ranges. A small number of data-quality issues have been identified in PWR reporting, and a regional meeting is scheduled to resolve these.

One area requiring strengthened assurance is compliance with the Accessible Information Standard, where recent Board papers indicate limited assurance. The Trust has submitted updated policy evidence, and further monitoring is underway.

Overall, the service is performing well, with clear evidence of maturing governance, improved safety culture, and sustained progress against national standards. Remaining risks are known, monitored, and supported by active improvement plans

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Data measures – perinatal quality oversight tool

Slide No.	Metric	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Notes
7	1. Findings of review of all perinatal deaths using the real time data monitoring tool													
10	2. Findings of review of all cases eligible for referral to MNSI													
11	2a. The number of patient safety incidents logged and what actions are being taken													
19	2b. Training compliance for all staff groups in maternity, related to the core competency framework and wider job essential training													
20	2c. Minimum safe staffing in maternity services to include obstetric cover on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover versus actual prospectively													
22/30	3. Service user voice feedback - themes													
21	4. Staff feedback from frontline champion and walk-abouts - themes													
10	5. MNSI/NHSR/CQC or other organisation with a concern or request for action made directly with Trust													
12	6. Coroner Reg 28 made directly to Trust													
11	7. Progress in achievement of CNST MIS Year 8 6 safety actions (Multiple slides for discussion with risks identified relating to workforce)													
	8. Proportion of midwives responding with ‘Agree’ or ‘Strongly Agree’ on whether they would recommend their trust as a place to work or receive treatment	Reported annually: Completed as part of staff survey												
	9. Proportion of speciality trainees in Obstetrics & Gynaecology responding with ‘Excellent’ or ‘Good’ on how they would rate the quality of clinical supervision out of hours	Reported annually; Due 2026												

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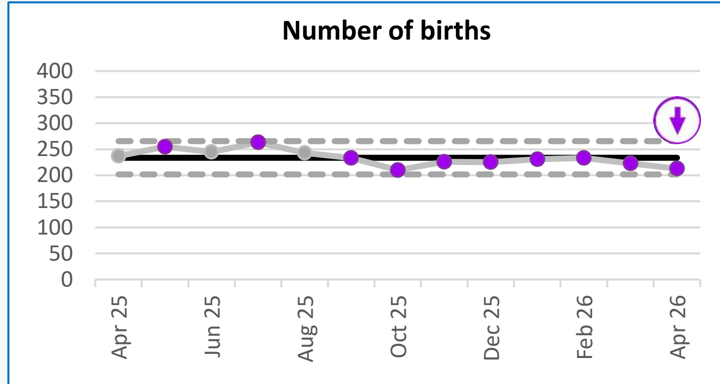
Maternity Overview

Wirral University Teaching Hospital NHS Foundation Trust

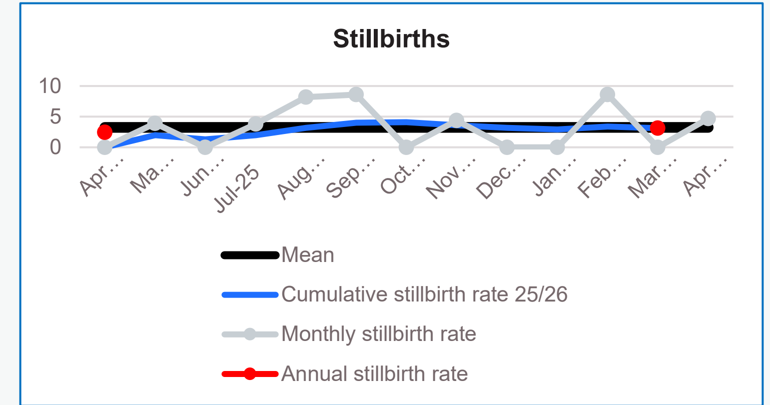
Latest month April 2026
Number of births **213**

Significant reduction



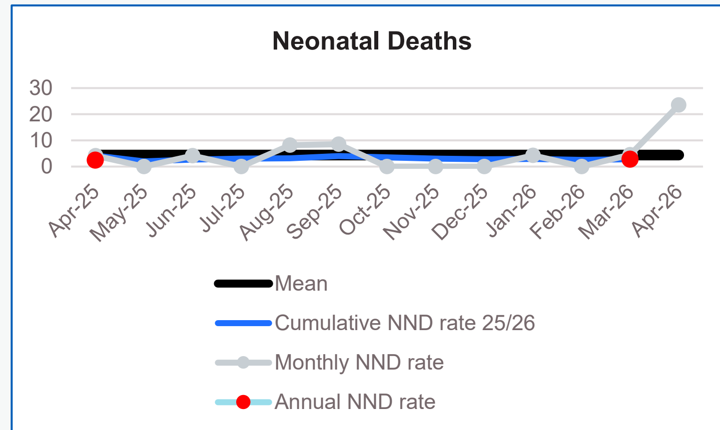
Latest month April 2026
Still birth rate/1000 **4.7**

No significant change



Latest month April 2026
Neonatal Death rate/1000 **23.5**

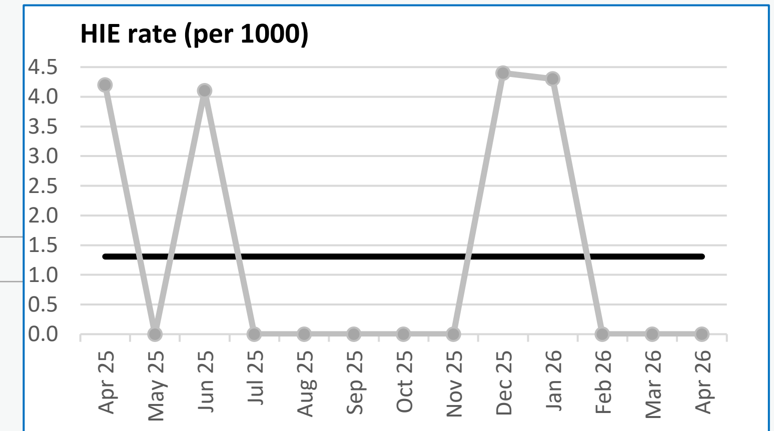
No significant change



Latest month April 2026

HIE rate/1000 **0.0**

No significant change

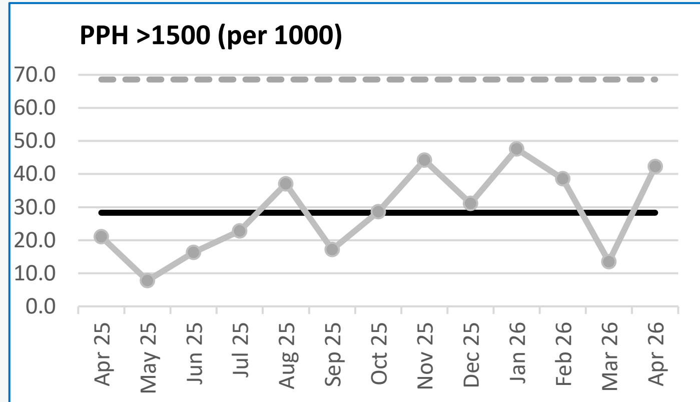


Maternity Overview

Wirral University Teaching Hospital
NHS Foundation Trust

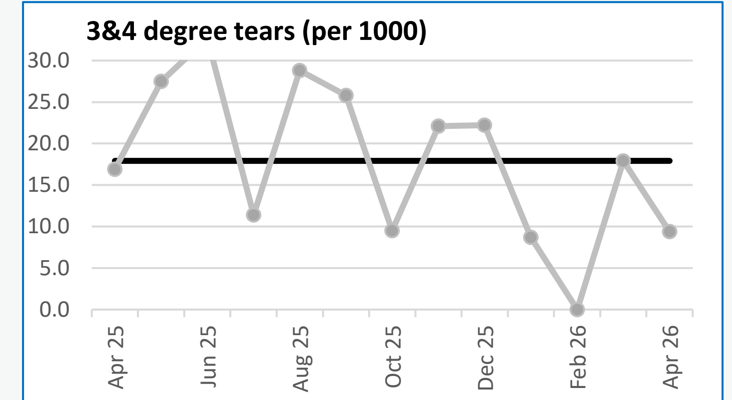
Latest month April 2026
PPH > 1500/1000 **213**

Significant reduction



Latest month April 2026
3&4 degree tars/1000 **9.4**

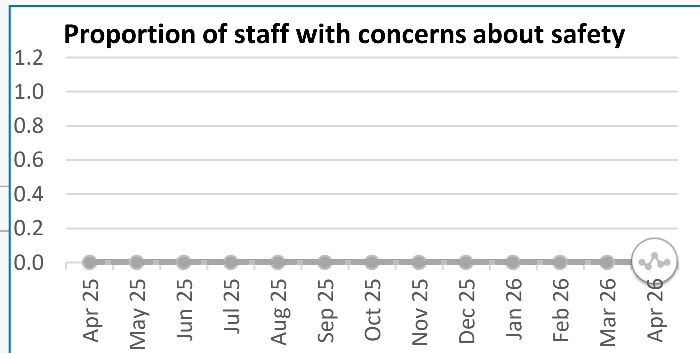
No significant change



Latest month April 2026

Proportion of staff raising concerns about safety **0%**

No significant change



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1. Perinatal Mortality rate

The graphs above demonstrate how the Trust is performing against the national safety ambition.

All stillbirths, neonatal deaths are subject to both internal and external investigations

Ref. No.	Incident Category	Outcome/Learning/Actions	Responsible (role)	By when
1	PPH's >1500mls	All reviewed and CIF and no themes/trends noted	JKL / Obstetric Labour Ward Lead	Ongoing

Theme	Issue	Actions	Responsible (role)	By when
1	3/4th Degree Tears	Outlier of the national average; QI project underway including training; since commenced reduction seen in April 2026	JKL/ Pelvic Health Lead	31/08/2026

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Perinatal Loss data

Wirral University Teaching Hospital NHS Foundation Trust

There were no stillbirths in March and 1 neonatal death – a planned withdrawal of care. Initial reviews showed no immediate care or safety concerns and the case will be discussed at PMRT MDT panel in June.

	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sept 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	TOTAL 2025/26
Total births	237	255	245	263	243	233	210	226	225	231	233	223	2824
No. of stillbirths >24/40	**0**	**1**	**0**	**1**	**2**	**2**	**1**	**0**	**0**	**0**	**2**	**0**	**9**
Late fetal loss 22-24/40	0	0	0	0	0	0	0	0	1	1	1	0	3
Stillbirth rate / 1000 births	**0**	**2.0**	**1.3**	**2.0**	**3.2**	**4.0**	**4.1**	**3.6**	**3.2**	**2.9**	**3.4**	**3.1**	**3.1**
No. of NND (born from 20+0)	1	0	1	1	1	2	0	0	0	1	0	1	8
NND rate / 1000 births	**4.2**	**2.0**	**2.7**	**3.0**	**3.2**	**4.0**	**3.5**	**3.1**	**2.8**	**2.9**	**2.6**	**2.8**	**2.8**

The table shows numbers and rates for stillbirths and neonatal deaths for 2025/26. Regional / national comparison data is awaited. Annual PMRT report is in progress to give assurance of learning and improvement from perinatal deaths.

Learning from PMRT reviews

1 perinatal loss cases was discussed at PMRT MDT panel (including external Midwifery, Neonatal & Obstetric representation) in March:

Case type	Grading	Learning Themes	Actions
Neonatal death 5 days old	B, B	Missed neonatal abstinence observations (mother had used codeine in pregnancy)	Learning shared. This case is also subject to police / coroner investigation and SUDIC process, outcomes awaited. Wider discussions regarding communication between various agencies regarding safeguarding processes.

Grading criteria

A	No care issues identified
B	Care issues identified which the panel considered would have made no difference to the outcome
C	Care issues identified which the panel considered MAY have made a difference to the outcome
D	Care issues identified which the panel considered were LIKELY to have made a difference to the outcome

MBRRACE-UK
Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK

Update regarding Perinatal mortality report: 2024 births

Report findings:

2024 stillbirth rate: 3.48 per 1,000 births (**in line with average** for similar Trusts)
Excluding congenital anomalies – **3.16 per 1,000 births** (**in line with average** for similar Trusts)

Neonatal mortality rate: 2.39 per 1,000 live births (more than 5% higher than the average for similar Trusts)
Excluding congenital anomalies - **1.62 per 1,000 live births** (more than 5% higher than the average for similar Trusts)

Overall perinatal mortality rate: 5.96 per 1,000 total births (more than 5% higher than the average for similar Trusts)
Excluding congenital anomalies - **4.83 per 1,000 total births** (**in line with average** for similar Trusts)

* The report includes only babies who were born at WUTH – it does not include babies who were born elsewhere and transferred to WUTH for Level 3 care.

A thematic review of the 11 neonatal mortality cases included in the report showed the following:

- 10 babies were born at extreme preterm gestations (29 weeks or less). There were no issues with preterm optimisation for these babies.
- 6 mothers were booked elsewhere and were intra-uterine transfers to WUTH as a Level 3 unit due to suspected / threatened preterm labour.
- 6 babies were born at WUTH and died in another Trust.
- 3 babies had congenital cardiac anomalies which were identified as the cause of death.
- 1 case where care provided by WUTH may have contributed to outcome for baby – this relates to a bowel perforation that was not picked up on review of a chest xray to assess breathing tube position. A process was implemented whereby any concerns regarding x-rays are escalated to the Neonatal Consultant, with reiteration of the use of x-ray stickers to aid review.

Mortality (NNU admissions)

Mortality is reported in the quarter baby would have been 44 weeks corrected gestation

Further Analysis

25/26 Q3

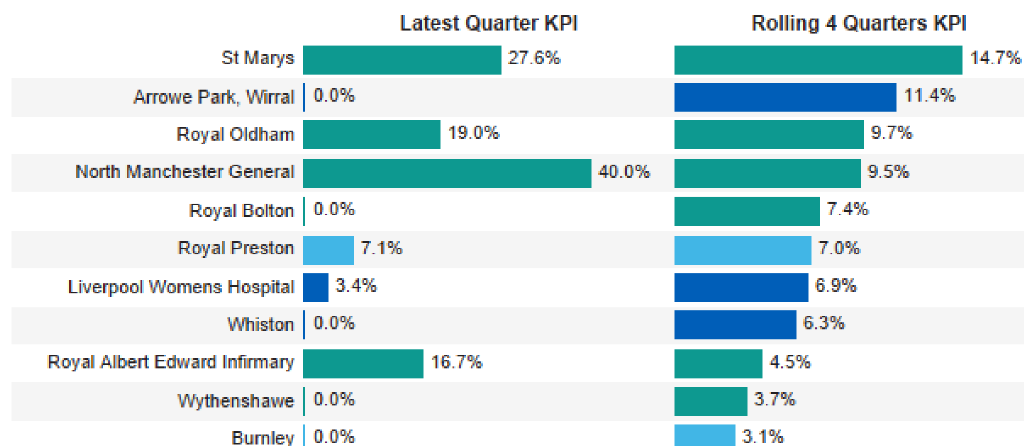
25/26 Q3		NWNODN Totals	24/25 Q4	25/26 Q1	25/26 Q2	25/26 Q3	Rolling year
			7.1%	6.2%	5.2%	8.3%	6.7%
Mortality gestation 24-31 weeks ▲	8.3% (Change 3.1%)	CM	10.2%	3.7%	6.7%	1.5%	5.5%
		GM	6.8%	8.1%	5.4%	14.9%	9.0%
		LSC	2.8%	5.0%	3.5%	2.6%	3.5%
Mortality gestation 22-23 weeks ▲	61.5% (Change 1.5%)	CM	50.0%	0.0%	100.0%	100.0%	58.3%
		GM	60.0%	50.0%	63.6%	37.5%	53.1%
		LSC	50.0%	66.7%	33.3%	100.0%	58.3%
Mortality gestation 24-27 weeks ▲	18.9% (Change 3.5%)	CM	22.7%	5.9%	21.1%	0.0%	14.7%
		GM	13.6%	15.6%	17.6%	32.3%	20.6%
		LSC	8.3%	8.3%	6.3%	0.0%	5.8%
Mortality gestation 28-31 weeks ▲	4.6% (Change 2.7%)	CM	2.7%	2.7%	0.0%	1.8%	1.8%
		GM	3.8%	4.5%	2.7%	7.1%	4.5%
		LSC	0.0%	3.6%	2.4%	3.7%	2.5%
Mortality gestation 32+ weeks ▼	0.2% (Change -0.1%)	CM	0.2%	0.5%	0.0%	0.0%	0.2%
		GM	0.2%	0.6%	0.6%	0.3%	0.4%
		LSC	0.3%	0.2%	0.5%	0.3%	0.3%
Mortality gestation all weeks ▲	1.3% (Change 0.1%)	CM	1.3%	0.7%	0.7%	0.7%	0.8%
		GM	1.0%	1.9%	1.8%	2.2%	1.7%
		LSC	0.6%	1.1%	0.9%	0.6%	0.8%

CM | GM | LSC

Mortality gestation 24-31 weeks - Rolling 4 Quarters

	24/25 Q4	25/26 Q1	25/26 Q2	25/26 Q3	Mean
Arrowe Park, Wirral	29.4%	0.0%	0.0%	0.0%	7.4%
Countess of Chester				0.0%	0.0%
Leighton	0.0%	0.0%	0.0%	0.0%	0.0%
Liverpool Womens Hospital	4.8%	4.0%	14.8%	3.4%	6.8%
Macclesfield District General	0.0%			0.0%	0.0%
Ormskirk	0.0%	0.0%	0.0%	0.0%	0.0%
Warrington	0.0%	0.0%	0.0%	0.0%	0.0%
Whiston	0.0%	33.3%	0.0%	0.0%	8.3%

Unit level - Mortality gestation 24-31 weeks



2.0 Maternity and Newborn Safety Investigation Programme (MNSI)

2.1 .Investigation progress update

No new referrals made in April 2026.
One case is ongoing – awaiting the draft report

MNSI Ref	Reason for referral	Date of confirmed investigation	Family Informed	Duty of candour complete Y/N	Early notification, external notifications and other investigations
MI-050329	Cooled Baby	December 2025	DOC Completed	Yes	REC Completed

2.2 .Learning from MNSI Investigations

No final MNSI reports were received in April 2026, Nil new identified

Theme	Issue	Actions	Responsible (role)	By when

2.3 Maternity and Neonatal Patient Safety Incidents (PSI)

Patient Safety Incident Investigations (PSII's) continue to be reported monthly on the regional dashboard by all maternity providers including C&M and Lancashire and South Cumbria (Northwest Coast). PSSI's are also reported to the LMNS and the newly formed QSSG (Quality & Safety Steering Group) will have further oversight of all Maternity PSII's across the region.

There were no Patient Safety Investigation Incidents (PSII's) declared in April 2026 for maternity services. All cases have been appropriately referred to Maternity and Newborn Safety Investigations (MNSI) and to date there is one active case.

There were no Patient Safety Investigation Incidents (PSII's) declared in April 2026 for neonatal services.

Ref No.	Incident Category	Outcome/Learning/Actions	Responsible (role)	By when

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2.4 Coroners' reports

Outstanding report due

There are no outstanding reports due for WUTH maternity service

Identifier	Date listed	Summary

Regulation 28 report issued

There are no regulation 29 reports issued for WUTH maternity service

Identifier	Action required	Progress	Responsible (role)	By when

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2.5 Review of NHS Resolution Scorecard

A quarterly review of Trust's claims scorecard alongside incident and complaint data should be discussed by the maternity, neonatal and Trust Board level safety champions at a Trust level (Board or directorate) quality meeting

Themes identified from Claims Scorecard (10 years)	Themes identified from Complaints (current/most recent)
15 claims, incident date range 2017-2023, estimated value £59.7m Themes recurring: Intrapartum incidents Brain injury (neonate), Psychiatric/Psychological damage (Mother) Stillbirth/neonatal death	4 claims, incident date range 2015-2016, Recurring themes: • Immobility relating to epidural continuous monitoring • Wet Inco pads • Scarring • Sacrum Following tissue viability QI projects, no claims seen since 2016
Themes identified from Maternity Patient Safety Incidents	**Themes identified from other sources (e.g. staff feedback, family feedback, FSU etc)**
No triangulated themes between claims and safety metrics Separate Maternity PSIRF Plan required Mandatory PROMPT training to be in line with MIS Year 6	Quicker response rate to hot debriefs

Themes identified	Actions	Responsible	By when
Maternity PSIRF Plan required	To be drafted and approved at BoD	JKL	6/6/2026
Impacted Fetal Head and brain injury nationally a cause of claims	Emergency completed in 2025 supported by ABC initiative; to ensure any new doctors are training in 2026	JKL	30/11/2026

3.0 Maternity Outcomes Safety Signals System (MOSS)

There are no safety signals to report for WUTH during this reporting period. Routine monitoring continues, and all indicators remain within expected parameters.

The maternity service maintains compliance with national MOSS surveillance requirements, with no triggers necessitating a Critical Safety Check

4.0 Safety Improvement Plan

Overall position:

The maternity service continues to progress against its Safety Improvement Plan, with actions aligned to national priorities including Maternity Safety, Ockenden, East Kent, and MOSS requirements.

Clinical Governance Strengthening — Governance structures have been refreshed, with clearer escalation routes and strengthened oversight through the Maternity Governance Group. Monthly thematic reviews continue to inform learning and improvement.

Workforce and Culture — Recruitment to key posts remains stable. Safety huddles and multidisciplinary training compliance remain above target. Staff feedback indicates improved psychological safety and confidence in escalation.

Intrapartum Safety — CTG training compliance remains high, and the service continues to embed the national Fetal Monitoring Programme. No MOSS signals were generated this period, and all intrapartum indicators remain within expected limits.

Learning from Incidents — All incidents graded as moderate or above have undergone timely review. Themes continue to focus on communication, documentation, and situational awareness. Resulting actions have been embedded into the safety huddle framework.

Service User Experience — Feedback from MVP engagement shows outstanding confidence in antenatal communication and continuity of carer where available. Work continues to strengthen personalised care planning

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5.0 Three Year delivery plan

Progress:-

The WUTH maternity service continues to demonstrate strong, sustained progress across all domains of the Three-Year Delivery Plan, with the majority of deliverables rated Blue and Green. Governance, workforce stability, and safety processes are now embedded, and the service is aligned with national priorities including Ockenden, East Kent, MOSS, and the national Maternity Safety Programme.

Two statements from the evidence base capture the overall directions:-

- The maternity service continues to progress against its Safety Improvement Plan, with actions aligned to national priorities
- Staff feedback indicates improved psychological safety and confidence in escalation."

Overall Position:-

The service is largely compliant, with clear evidence of maturing governance, strengthened safety culture, and improved workforce stability.

Most actions are complete or on track, with LMNS and the maternity service continues to demonstrate strong, sustained progress across all domains of the Three-Year Delivery Plan, with the majority of deliverables rated Blue and Green. Governance, workforce stability, and safety processes are now embedded, and the service is aligned with national priorities including Ockenden, East Kent, MOSS, and the national Maternity Safety Programme.

Key Achievements:-

- Safety & Governance
  - Governance structures refreshed with clearer escalation routes.
  - Monthly thematic reviews embedded, informing continuous learning.
  - All moderate-and-above incidents reviewed within expected timeframes.

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5.0 Three Year delivery plan

Workforce:-

- BR+ report (March 2025) received; Trust funded to establishment by 31/3/2026
- Recruitment stable across midwifery, MSW, and obstetric consultant roles, with 1wte *consultant vacancy*
- Turnover, sickness, and leaver rates improving and within expected ranges.
- Workforce plan for 2025 reviewed and assured.

Intrapartum Safety:-

- CTG and fetal monitoring training compliance remains high.
- No MOSS signals generated this period.
- National Fetal Monitoring Programme continues to be embedded.

Personalised & Equitable Care:-

- PCSP training included in TNA; personalised care audits in place.

5 enhanced MCoC teams

- Sustained in areas of vulnerability; exceptional nationally achieved and meets Better Births
- Maternity achieved full UNICEF BFI accreditation (Oct 2024); NNU progressing on a 2-year plan.
- Interpreter policy uploaded, though assurance remains limited.
- 6th team being launched

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6.0 Performance Metrics

6.1 Service Suspensions

	Monthly Commencing Jan 2026							
Obstetric unit Closures/Diverts	0	0	0	0				
Neonatal unit (internal)	0	0	0	0				
Neonatal unit (external)	0	0	0	0				

6.2 Women experiencing delays to induction >24hrs

	Monthly commencing January 2026									
	Jan 2026	Feb 2 026	March 2026	April 2026	May 2026	June 2026	July 2026	Aug 202	Sept 2026	Oct 2026
Delays to induction >24hr	2	0	5	0						

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6. Training compliance – April 2026

Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training

	Midwives	Obstetricians (split by consultant/ other Dr)	MSWs	Anaesthetists	Neonatal medics (split by consultant/ other Dr)	Neonatal nurses (Nrs/ ANNP)
Saving Babies Lives Care Bundle (Annually covered in PROMPT)	97%	100%				
Fetal monitoring and surveillance	98%	100%				
Multi professional Maternity Emergencies training	97%	80% Booked for May 2026	86% (New starters)	97%		
Equality/ equity and personalised care (3-yr Programme)	97%	80% Booked for May 2026	86% (New starters)	97%		
Care during labour and immediate post-natal period (3-yr programme)	97%	80% Booked for May 2026	86% (New starters)	97%		
Neonatal resus training	97%	80% Booked for May 2026	86% (New starters)	97%		
% QIS						

7.2 Staffing Vacancy rates

Staff group	Vacancy rate
Midwifery	3.45wte leavers within next 4-6 weeks; advert out Vacancy rate <2%
Midwife Support workers	0.5wte hours to be advertised Vacancy rate <1%
Obstetric consultants **Resident doctors**	Establishment: 14,5, 1wte vacancy = 6.5% Establishment 7.6wte resident doctor x 2 wte trust doctors with, 1wte vacancy and x 1 on adjusted duties = 10% (Obs and Gynae)
Neonatal Nurses	0% vacancy rate
ANNP	0% vacancy rate
Neonatology consultants **Resident doctors**	Fully established to BAPM and no current vacancies 0%
Obstetric anaesthetists **Resident doctors**	Data requested

7.3 Midwifery Red flags, actions and mitigations

Red Flag	Delivery Suite	Maternity Ward
Delayed or cancelled time critical activity	6	1
Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	0	2
Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	0	1
Delay in providing pain relief	0	10
Delay between presentation and triage	0	0
Full clinical examination not carried out when presenting in labour	0	0
Delay between admission for induction and beginning of process	4	2
Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	0	0
Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	0	0
Delivery Suite Coordinator unable to maintain supernumerary status	0	N/A
Coordinator unable to maintain supernumerary status & providing 1:1 care	0	0
Total	**10**	**14**

8. Safety Champions meeting

8.1 Meeting Log

Date	Role	Attendance
27/3/26	Board Safety Champion – NED	✓
27/3/26	Board Safety champion – Chief Nurse	
27/3/26	Perinatal Obstetric Lead	
27/3/26	Perinatal Midwifery lead	✓
27/3/26	Perinatal neonatal lead	
27/3/26	Perinatal management lead	
27/3/26	MNVP lead	✓

8.2 Safety Champions feedback

Feedback raised by staff	Action and progress
Patient experience delay in pain relief – Ward Manager to be supported to complete Prescribers course and progress with self medication	Actioned and approved for Ward Manager to complete course Self medication at pilot stage as QI Prject
All areas feedback increased in staffing levels have reduced escalation and supporting acuity	Continue to monitor the feedback
Feedback raised by service users	**Action and progress**
Delays continue in doctor reviews within triage; discussed option of additional AMP's to support as an alternative; medical staffing levels suboptimal	Continue to report via incident reporting; consider AMP's; introduce telephone triage and statement of case require for additional medic to support core hours
Thermoregulation an issue on Neonatal unit	Resolved immediately with Estates team
Additional safety champions intelligence	**Action and progress**
Testing how staff receive learning communication	Post all communications with options and continue to seek feedback

8.3 Themes and progress with Cultural surveys or equivalent *(as applicable)*

Theme	Progress	Support requirements
Staff Survey – Three Priority Themes include:- - Compassion and inclusivity - Health and well-being safety at work - Sharing learning from incidents	Staff Feedback session held in April 2026 to:- Identify team Champions for each of the 3 priority areas to lead the deliverables through a teamwork and ownership approach. Champions and senior leadership team to share staff survey action plan widely and arrange staff check in to sense check actions are reflective of staff survey results workshop. Action plan developed and will be monitored via monthly Divisional In Touch	Trust approach to the consistent message re: Racism and zero tolerance

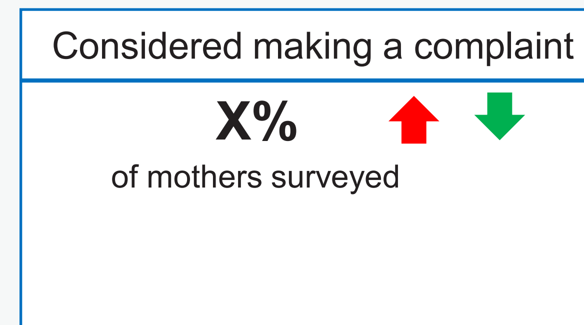
9. Insights from service users and Maternity & Neonatal Voices Partnership Co-production (Appendix 1)

Item	Description	RAG Rating
Trisomy 21 Pathway	Filming has begun, last filming day 1/05/26 ready for training packages. Presentation for NHS England Regional Day 11/05/26	Green
Underspend	Items have been delivered to trust via the MNVP – 10 x LED mood lamps, 10x Radios and 1x Lamp 2x Acrylic Wall Art have been delivered, ready to be dropped off at trust.	Green
New Surveys	Experiences of contact maternity services during early labour FICare survey – CQC Survey Action Plan	Green
Information on physical recovery after birth	Need to liaise with team to review existing postnatal recovery information - CQC Survey Action Plan	Amber

9.1 CQC national maternity survey action plan 2026

Theme	Progress	Support requirements/Timescales
Parents reported gaps in relevant feeding information during pregnancy and insufficient help and advice about feeding in the first 4 weeks after birth	MNVP gathered targeted parent feedback on infant feeding information and support across antenatal and early postnatal pathways, and produce a themed insight report with co-produced recommendations	Engagement completed and report shared by May **2026**
Some parents did not feel they received appropriate advice or support when contacting a midwife or the hospital at the start of labour	MNVP collection of qualitative feedback on experiences of contacting maternity services in early labour, focusing on communication, reassurance and responsiveness, and present findings to the Trust	Findings shared with Maternity staff in **February 2026**
Parents reported not always receiving adequate information about physical recovery after birth once at home	MNVP reviewing existing postnatal recovery information with parents and co-produce a summary of "what parents say they needed to know" to inform service improvements	Recommendations submitted by **April 2026**
Some parents felt midwives or doctors were not always aware of their medical history during antenatal care	MNVP gathering parent examples where lack of continuity or repeated history-taking impacted experience, and share themed feedback with relevant Trust leads	Feedback shared by **May 2026**
Parents need to see how feedback leads to change	MNVP to gather parent examples where lack of continuity or repeated history-taking impacted experience, and share themed feedback with relevant Trust leads	Quarterly review throughout **2025–26**

CQC survey: Percentage of mothers that considered making a complaint during their maternity care journey



9.2 Additional Service User feedback

Debriefs / Birth Afterthoughts	Action and progress
Birth outside of guidance in the community setting.	SoP and monthly MDT introduced in March 2026 to support both women and staff when requested to birth outside of guidance
Friends and Family test	**Action and progress**
Continue to increase maternity response rates in the maternity Friends and Family Test (FFT) response rate	A targeted approach has seen a steady increase seen within maternity FFT response rates with ongoing monitoring demonstrating improvement; reflective and overall increase in Reponses Very Good and Good; Introduction of Posters. Ward folders and kiosk have demonstrated impact
Areas of focus include: • Waiting times in Antenatal Clinic, • Not enough seating and chairs and unconformable when experiencing log waits • Cold rooms on the maternity ward	Antenatal clinic workflow requires review and real time flow monitoring to support escalation and busy times A full audit of seating capacity and confirm has been undertaken in the waiting areas; funding being explored to support an order to replace and increase number of chairs Temperature has been reviewed and heaters have been ordered
Complaints and Compliments	**Action and progress**
Themes relating to delays in pain relief being received both on labour ward for epidurals and routine medications on the maternity ward.	In response the maternity team have escalated inconsistencies to the anaesthetic team, and an audit is underway to establish the reasons for delay. On the postnatal ward, self medication has been designed for implementation, supported by the Ward Manager undertaking the prescriber's course to support Doctor delays/ward rounds; In addition, ward staffing has been increased on the day shift to 4 midwives from 22 to support acuity and complexity

10. Saving Babies Lives v3.2

	Compliance / progress / action	Responsible (role)	By when
EI 1: Smoking in pregnancy	100% Compliant – no current action plan		
EI 2: Fetal growth	100% Compliant – no current action plan		
EI 3: Reduced fetal movement	100% Compliant – no current action plan		
EI 4: Fetal monitoring	100% Compliant – no current action plan		
EI 5: Pre-term births	100% Compliant -– no current action plan		
EI 6: diabetes in pregnancy	100% Compliant – no current action plan		

11. Progress in achievement of Maternity Incentive Scheme 6 safety actions

	Current Position
SAA: Workforce and capacity	In progress and working towards compliance with Board of Directors oversight: *"The key changes for the Board of Directors in MIS Year 8 centre on stronger governance expectations, regular structured oversight, and a shift from process-checking to assuring real safety outcomes"*
SAB: Training	In progress and working towards compliance with Board of Directors oversight: *"A key amendment to the MIS Year 8 safety action relates to staff training. The action now requires all identified staff groups to complete enhanced safety training, with clear expectations for content, frequency, and compliance monitoring".*
SAC: Learning from Reviews and Investigations	In progress and working towards compliance with Board of Directors oversight: *"Key change: strengthened requirements for timely, structured reviews and investigations, with clearer standards, timeframes, and oversight"*
SAD: Service User Voice and Equity	In progress and working towards compliance with Board of Directors oversight: *"Safety Action D in MIS Year 8 introduces two major changes: (1) a stronger, measurable emphasis on service-user voice and acting on feedback, and (2) a new, explicit requirement to demonstrate equity of access and communication, with both elements streamlined into just two broad sub-actions".*
SAE: Care Bundles	In progress and working towards compliance with Board of Directors oversight: *"Safety Action E in MIS Year 8 shifts from evidence submission to board-level assurance, simplifies requirements, and strengthens expectations around equity, audit quality, and sustained implementation of the mandated care bundles".*
SAF: Board Oversight, Governance, Culture and leadership	In progress and working towards compliance with Board of Directors oversight: *"Safety Action F has been strengthened in Year 8 to emphasise active Board leadership, culture improvement, and clearer accountability, while reducing unnecessary evidence submission. The focus is now on assurance, behaviours, and visibility, not paperwork".*

Risk Register Overview

Wirral University Teaching Hospital NHS Foundation Trust

Maternity currently holds 34 risks (including divisional risks; some of these will overlap with Neonatal services).

Current Top risks - Maternity

Risk	Score	Area	Details
2050	16	Triage	There is currently a risk of poor clinical outcome and missed recognition of clinical deterioration of maternity triage patients due to the waiting area being situated away from triage staff.
2322	16	Delivery Suite	Ageing and decommissioned epidural infusion pumps on Labour Ward risk insufficient availability, potentially delaying or preventing epidural analgesia and compromising patient safety – capital bid submitted for replacement. 6 have been delivered and are with EBME.
2330	15		Approx 20 aged CTG machines – risk of reliability degrading / failure during antenatal or intrapartum monitoring

1 new risk was added for Maternity in March:

- **2376 –** FMU Consultant vacancy (score 12)

2 risks were closed:

- **2039** – Delay in treatment of jaundice – new Bilibeds acquired and training implemented.
- **2296** – Overhead lights in Delivery suite – now replaced, plan in place for maintenance.

2 risks had scores changed:

- **1109** – Thermoregulation of rooms on Delivery Suite (score **downgraded** from 12 to **2**)
- **1129** – Risk of poor imaging resulting in missed diagnosis of fetal abnormalities (score **downgraded** from **16** to 12)

0 new risks were added for Neonatal services in April 2026

0 Neonatal risks closed in April 2026.

Neonatal services currently hold 13 risks (plus 14 divisional risks; some of these will overlap with Maternity services).

Risk	Score	Details
2248	20	**There is a risk to the safe transfer of Neonates due to the age of the transport ventilator. There were 2 Baby Pac ventilators for use with the 2 Giraffe shuttle transporters, 1 of the ventilators has now been condemned and removed and the remaining ventilator is at risk as parts are now obsolete. This ventilator has exceeded recommended replacement time.**
2223	15	**Allied Health professional input into the Neonatal unit does not currently meet the required BAPM standards for a NICU**
2341	15	**Risk of non-compliance with BAPM neonatal standards and MIS Safety Action 4:-** **This is due to Chronic illness resulting in foreseeable difficulties to achieve the consultant rota BAPM standard and potential impact on future maternity incentive schemes resulting in the possibility the service may fail to meet BAPM consultant neonatal standards and the Maternity Incentive Scheme due to:-** **- Insufficient cover to provide 12-hour on-site weekend coverage at all times**

0 new risks were added for Neonatal services in April 2026

0 Neonatal risks closed in April 2026.

The Board of Directors/Quality Committee is asked to receive and discuss the content of the report. They are also asked to record in the Trust Board minutes as requested to provide evidence for the maternity incentive scheme.

MNVP Catch update
April 2026
APPENDIX 1

Maternity Surveys – Postnatal ward

Average score of overall experience: 8

One clear theme emerged this month:

Communication:

- Conflicting information given around visiting times
- TC care - Conflicting clinical messages and poor team communication resulted in uncertainty and heightened anxiety for parents
- Discharge - Lengthy discharge and lack of hands-on training reduced confidence at home

Maternity Surveys – IOL

Average score of overall experience: 5 (out of 5)

100% of respondents felt well informed and waited less than 12 hours for the next stage of induction.

"The induction process was actually less scary than I thought it would be, it was explained clearly and I discussed with a dr before coming in all the pros and cons and she answered my millions of questions, I felt understood and well informed"

Maternity Surveys – Infant Feeding

100% of respondents felt supported by hospital staff during their feeding journey. However, a lack of ongoing support was identified, with families reporting uncertainty around who to contact and inconsistent follow-up from staff.

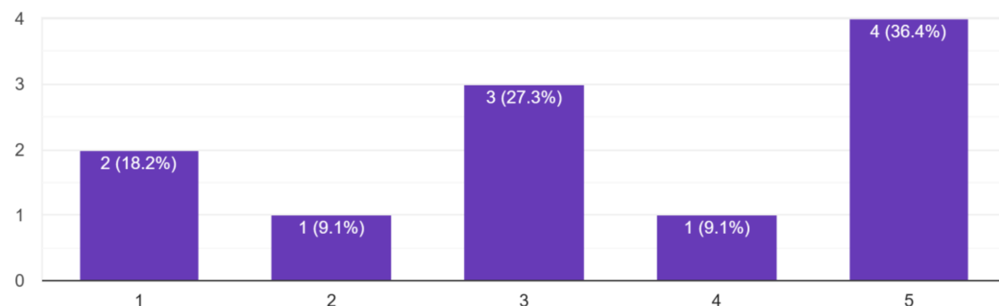
"On the maternity ward we were promised someone would return to support with infant feeding but often they never returned. When formula feeding they supported when baby was sleepy to bottle feed. The hire of the two week breast pump made the biggest difference to carry on breastfeeding!"

Maternity Surveys – Early Labour Contact

- Average score of overall experience: 3.4 (out of 5)

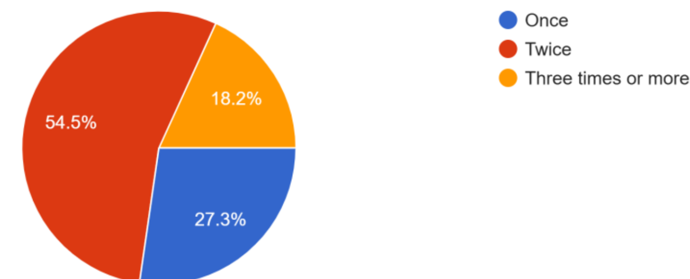
How would you describe your overall experience when contacting services in early labour?

11 responses



Roughly how many times did you make contact before being advised to come in or being seen?

11 responses



Experiences of triage communication were **highly inconsistent**. While some parents described feeling supported, listened to, and in control of their decisions, others reported feeling dismissed, unheard, and not taken seriously.

For those with positive experiences, communication was described as calm, clear, and reassuring, enabling them to feel confident in managing early labour at home. However, a significant number of respondents described negative interactions, including feeling like a burden, having their concerns minimised, or not being believed.

These experiences often led to increased anxiety, reduced confidence in services, and, in some cases, delayed escalation of care during a critical period.

Neonatal Surveys – Neonatal Ward

Average score of overall experience: 5 (out of 5)

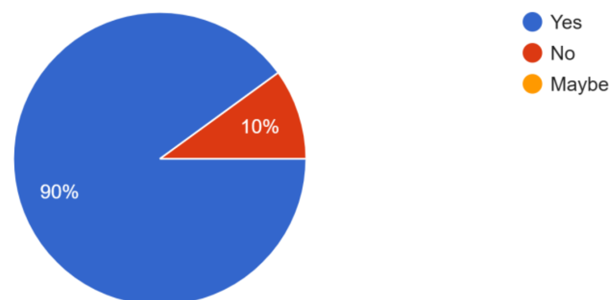
Parents reported a clean, caring environment and compassionate staff

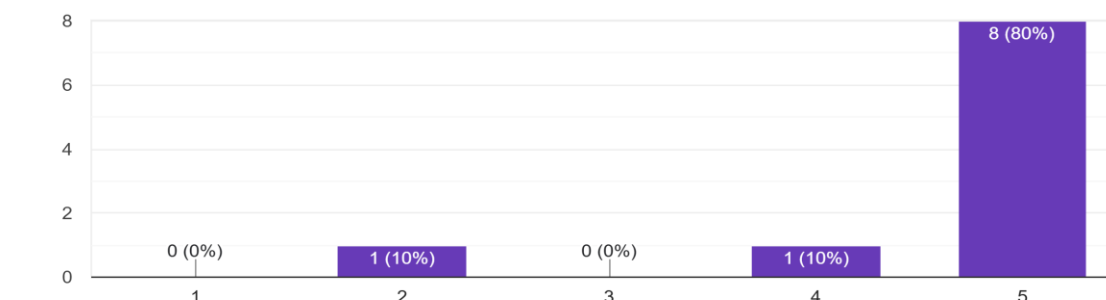
Parents consistently described the neonatal environment as clean, calm, and supportive, with staff recognised as compassionate, caring, and attentive. Families felt well informed about their baby's care, which helped to build trust and reassurance during a highly emotional time.

However, a gap was identified in awareness of neonatal leave entitlements, with parents reporting that this information was not clearly visible or routinely communicated. Increasing the visibility of resources, such as posters or signposting, could help ensure families are better informed about the support available to them.

Neonatal Surveys – FICare

- Average score of overall experience: **4.5 / 5**





Staff create a supportive, inclusive environment that empowers parents:

parent, not a visitor*(4.3 / 5)*

Families welcomed as part of the care team (4.1 / 5)

Strong support to learn how to care for their baby (4.6 / 5)

Positive communication is not consistently experienced by all families: Emotional support rated 4.2 / 5

Feeling listened to rated 3.9 / 5 (lowest area

What families said:

Felt reassured, calm, and supported But some felt unheard, dismissed, or not taken seriously

Families experience highly compassionate, family-centred care, with strong support and involvement. However, inconsistencies in communication, listening, and discharge processes impact confidence and overall experience.

NHS Resolution

Maternity (Perinatal) Incentive Scheme Year 8 v1.0

Conditions of the scheme
Six core perinatal safety actions

Published March 2026

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Introduction

A refreshed and streamlined scheme for Year 8

Year 8 marks an important transition for the Maternity (Perinatal) Incentive Scheme (MIS). As national priorities for maternity and neonatal care continue to evolve, the scheme has been refreshed directly in response to the findings of our MIS evaluation, national inquiries, system feedback, and feedback directly from Trusts, staff and families. It recognises the significant pressures on services and the need to focus effort where it makes the greatest difference locally. The focus this year is on strengthening the core elements of safe, effective care and making the scheme simpler through a model which is more principles based, outcomes focused and aligned with the needs of women, families and the workforce.

*Throughout this document, the term ‘women’ is used when discussing pregnancy and birth. We recognise that some people with different identities may also experience pregnancy and birth, and the information provided is intended to be inclusive of everyone to whom it may apply.

Purpose and role of the MIS safety actions

The standards within the MIS are not created solely for the purposes of the scheme. They reflect the essential components of safe and effective maternity and neonatal services - the foundations that every Trust should already have in place. MIS is intended to be a practical tool that supports leaders to drive improvement, secure investment and strengthen governance supporting local accountability, rather than a reporting requirement in isolation. We have heard through the evaluation of MIS that for many Trusts, the scheme provides the evidence base and structure needed to underpin business cases, influence prioritisation and accelerate change.

Year 8 introduces a streamlined set of **six core safety actions** enabling Trusts to focus on the areas that have the greatest impact on outcomes for their population. This shift reflects learning from previous years and responds to feedback from providers about the need to reduce duplication and process heavy activity. The intention is to support Trusts to concentrate on what matters most: securing the right workforce, learning from adverse events, improving clinical standards, strengthening culture, delivering better experiences for women, families and carers and supporting Trust flexibility while emphasising Board accountability and oversight.

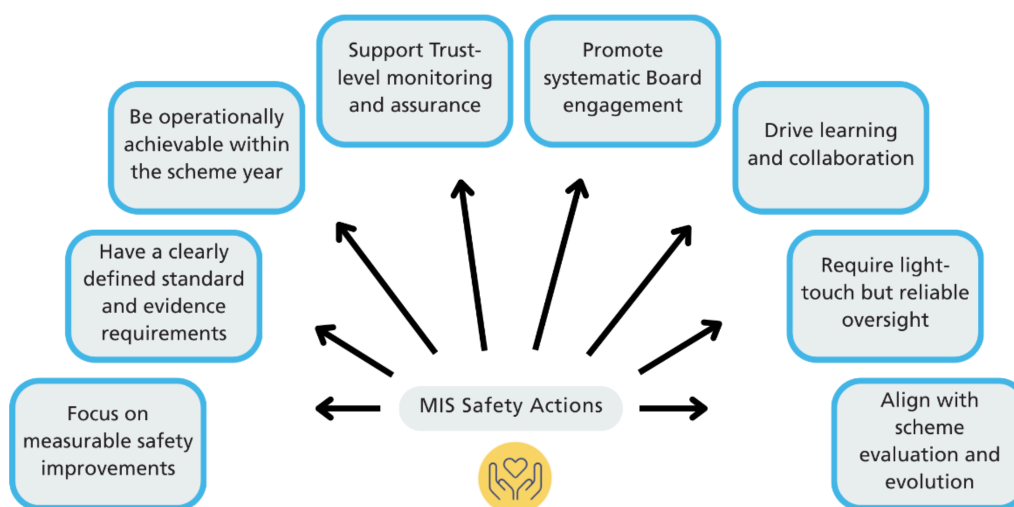
Figure 1: MIS Safety Actions

As part of this refresh, the MIS document has been streamlined to provide greater clarity on the rationale and intended outcome for each standard. This core document is now complemented by separate supporting guidance, which outlines considerations and shared multidisciplinary responsibilities needed to meet the standards. The supplementary document also offers additional guidance and examples to support Trusts in understanding what good implementation and robust evidence might look like in a high-performing Trust.

A move toward a more outcomes-based model

Year 8 provides a bridge between the established MIS model and an approach that is more flexible, proportionate, focused on outcomes and developed around an agreed set of principles. It affords organisations more flexibility and accountability for focusing on the priorities that are specific to their organisation, and which matter most to women and families. This refreshed MIS is underpinned by a set of agreed priorities, agreed among the system partners and service user voice representatives on our Collaborative Advisory Group (CAG).

Figure 2: Principles underpinning MIS six core safety actions



Developing the Year 8 standards

The revised standards for Year 8 have been developed and agreed collaboratively with our Collaborative Advisory Group (CAG) which includes NHS Resolution, NHS England, Royal College of Obstetricians and Gynaecologists (RCOG), Royal College of Midwives (RCM), Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE-UK), Royal College of Anaesthetists (RCoA), College of Operating Department Practitioners (CODP), the Neonatal Clinical Reference Group (CRG), The British Association of Perinatal Medicine (BAPM), the Neonatal Nursing Association (NNA), the Care Quality Commission (CQC), the Maternity and Newborn Safety Investigation Programme (MNSI), the Nursing and Midwifery Council (NMC) and a group of service user representatives.

The Year 8 documents have also been shaped through external review with input from a wide range of provider Trusts including midwifery and neonatal leaders, obstetricians, neonatologists, governance and assurance leads, and service-user representatives, alongside extensive feedback from regional maternity teams. We are sincerely grateful for the time and insight colleagues have contributed. Their input has helped refine the structure, clarify areas of ambiguity, and ensure the scheme reflects the realities of maternity and neonatal services.

This partnership approach will continue throughout the year, with a shared commitment to supporting Trusts to deliver the highest standards of perinatal care. Each Safety Action workstream will be collectively owned by system leads.

Strengthened governance, leadership and culture

Effective Board oversight and accountability remain central to the scheme. Boards are expected to demonstrate curiosity and visible leadership, to act promptly when risks or gaps in mitigation are identified, and to ensure that the resources, investment and organisational support required to run safe services are made available. MIS provides a structured mechanism through which Boards can understand risk, monitor progress and take decisive action to support their maternity and neonatal teams.

Importantly, the scheme reinforces the importance of listening to and acting on the voices of women, families and carers. Their experiences and insights are essential to shaping safe, equitable and compassionate care, and they remain a core part of the scheme's design and expectations.

The Trust Board is wholly accountable and ultimately responsible for ensuring the safety and quality of all care provided in the organisation, which is why it must maintain robust assurance of progress and compliance with MIS requirements, and formally provide its agreement and consent for the Chief Executive Officer (CEO) to undertake the organisation's final MIS sign-off.

Throughout this document, the following definitions apply:

- **Trust Board** refers to the full Trust Board or a formally delegated committee (such as a Quality Governance Committee) acting on its behalf.

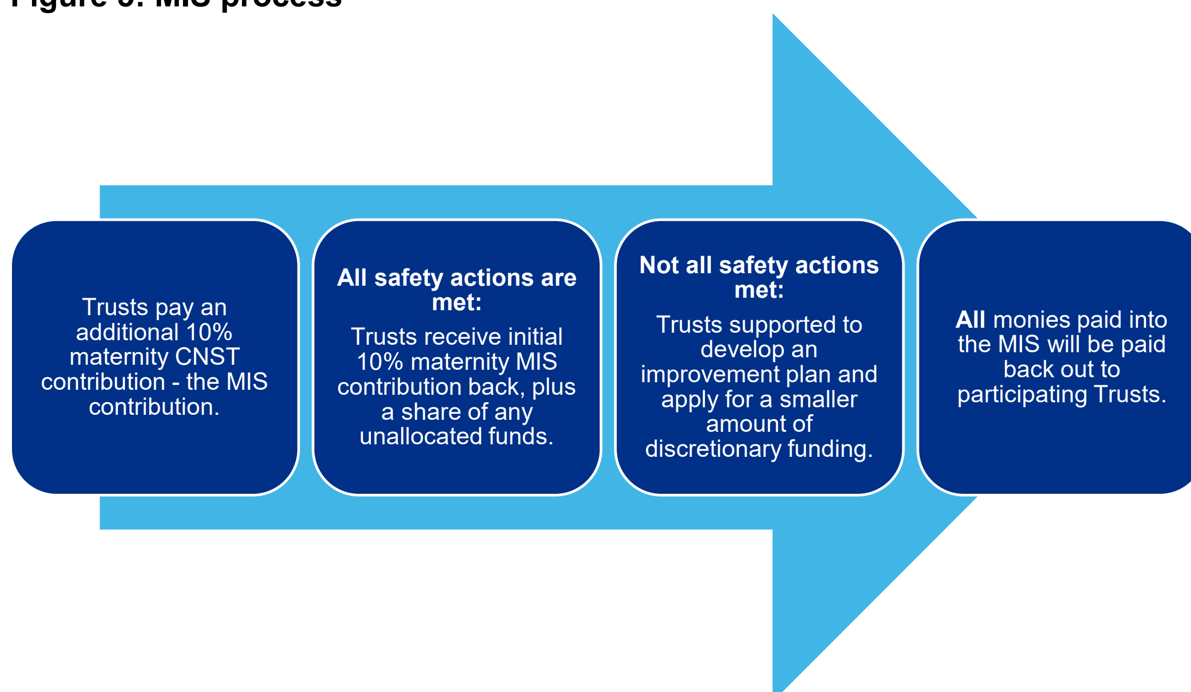
- **Executive Board** refers to a private or executive only meeting of Board members where sensitive, small number or confidential material (e.g. mortality themes) is more appropriately discussed.

Detailed thematic reports may be reviewed by the Executive Board or Quality Governance Committee, but a summary including escalations and exceptions must be presented to the Trust Board to ensure full oversight.

MIS Year 8: conditions

The MIS applies to all acute Trusts that deliver maternity services and are members of the Clinical Negligence Scheme for Trusts (CNST). As in previous years, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST MIS fund:

Figure 3: MIS process



- To be eligible for payment under the scheme, Trusts must submit their completed Board declaration form to NHS Resolution via nhsr.mis@nhs.net by **12:00** on **2 March 2027** and must comply with the following conditions:
- Trusts must achieve all six perinatal safety actions.
- The declaration form is submitted to the Trust Board with an accompanying joint presentation detailing position and progress with perinatal safety actions by the Perinatal Leadership Team, including the Maternity and Neonatal Voices Partnership (MNVP) Lead where MNVP arrangements exist.

NHS Resolution

The Trust's CEO must sign to confirm that:

- ☑ The Trust Board are satisfied that the evidence provided to them demonstrates achievement of the six core perinatal safety actions and meets the required safety actions' sub-requirements as set out in this document.
- ☑ There are no reports covering either year 2025/26 or 2026/27 that relate to the provision of maternity and / or neonatal services that may subsequently provide conflicting information to your declaration from the same time-period (e.g. CQC inspection report, Health Services Safety Investigations Body (HSSIB) or MNSI investigation reports etc.). All such reports should be brought to the MIS team's attention before 2 March 2027.
- ☑ Any reports covering an earlier time-period may prompt a review of a previous MIS submission.
- ☑ If, following a review of a previous MIS submission, it is found that the Trust was non-compliant then the Trust will immediately return to NHS Resolution that year's MIS funds that were awarded, irrespective of it being a prior financial year.

The Trust Board must then give their permission to the CEO to sign the Board declaration form prior to submission to NHS Resolution. The Trust Board declaration form must be signed by the Trust's CEO. If the form is signed by another Trust member this will not be considered.

The Regional Chief Midwives will continue to provide support and oversight to Trusts when receiving Trusts' updates from regional meetings, focusing on themes highlighted. They will be notified when Trusts have incorrectly declared MIS compliance for previous years of MIS.

NHS Resolution will continue to investigate any concerns raised about a Trust's compliance either during or after the confirmation of the MIS results. See 'Reverification'.

NHS Resolution will publish MIS compliance annually, Trust by Trust, for each year of the scheme (updated on the NHS Resolution website).

Evidence for submission

- The Board declaration form must not include any narrative, commentary, or supporting documents. This evidence should be provided internally in the Trust only, to support the Trust Board decision and declaration. This will not be reviewed by NHS Resolution unless requested. See 'Reverification' and 'Additional Assurance'. Boards remain accountable for ensuring they are fully assured before signing.

- On the Board Declaration form Trusts must declare YES/NO or N/A (not applicable), where appropriate, against each of the elements within each safety action sub-requirements.
- Trusts will only be able to declare N/A against specific sub requirements where this is applicable.

Safety action No. 2

Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

From 30 May 2023 until 7 December 2023

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Was your Trust compliant with at least 10 out of 11 Clinical Quality Improvement Metrics (CQIMs) by passing the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023? Final data for July 2023 will be published during October 2023.	Yes
2	Did July's 2023 data contain a valid ethnic category (Mother) for at least 90% of women booked in the month? Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001)	Yes
Has the Trust Board confirmed to NHS Resolution that they have passed the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023 for the following metrics:		
3	i. Over 5% of women who have an Antenatal Care Plan recorded by 29 weeks also have the Continuity of Carer (CoC) pathway indicator completed.	Yes
	If maternity services have suspended all Continuity of Carer (CoC) pathways, criteria ii is not applicable:	
4	ii. Over 5% of women recorded as being placed on a Continuity of Carer (CoC) pathway where both Care Professional ID and Team ID have also been provided.	N/A
5	Did the Trust make an MSDS submission before the Provisional Processing Deadline for July 2023 data by the end of August 2023?	Yes
6	Has the Trust at least two people registered to submit MSDS data to SDCS Cloud who must still be working in the Trust?	

- The Trust must also declare on the Board declaration form whether there are any external reports which may contradict their MIS submission.
- In the event that an MIS submission is found to be knowingly false or misleading, NHS Resolution will escalate the matter to the appropriate regulatory and investigative authorities.
- Trusts will need to report compliance with MIS by **12:00 on 2 March 2027** using the Board declaration form, which will be published on the NHS Resolution website in the forthcoming months.
- The Board declaration form will be made available on the MIS webpage during the MIS reporting period.

'What Good Looks Like'

Trusts are reminded to retain all evidence used to support their local assessment of compliance. In the event that NHS Resolution are required to review supporting evidence at a later date (as described below) it must be made available as it was presented to support Board assurance at the time of the original submission.

Additional assurance

Trust submissions will continue to be sense-checked alongside Care Quality Commission (CQC) information. Where CQC visits fall within the reporting period, the CQC will cross-reference their findings to the MIS through the relevant Key Lines of Enquiry.

For Year 8, NHS Resolution will introduce a mid-year MIS 'spot check' at the halfway point of the reporting period (July/August). In this first year, the spot check will be advisory only and is intended to help organisations ensure they remain on track to meet compliance requirements. One Trust per region may be randomly selected to

provide NHS Resolution with a progress update against a randomly selected safety action (further details to follow). The collated and anonymised themes from the findings of these spot checks may be shared to support wider system learning.

The purpose of this additional step is to help reduce any concerns associated with moving away from the previous mandated evidence model, and to provide additional mitigation and support as Integrated Care Boards (ICB) step back from their assurance role this year.

NHS Resolution will pilot additional alternative assurance approaches in 2026 with a small number of self-selected pilot trusts, including service-user and peer review models. Trusts involved in piloting these alternative models will be exempt from the mid-year spot check process, to avoid any potential duplication and additional reporting requests.

Timescales and appeals

- Any queries relating to the safety actions must be sent in writing by e-mail to NHS Resolution via nhsr.mis@nhs.net prior to 2 March 2027.
- The Board declaration form must be sent to NHS Resolution via nhsr.mis@nhs.net between 16 February 2027 and 2 March 2027 at 12:00. An electronic acknowledgement of Trust submissions will be provided within 48 hours from 2 March 2027.
- Submissions and any comments/corrections received after 12:00 on 2 March 2027 will not be considered.
- The Appeals Advisory Committee (AAC) will consider any valid appeal received from participating Trusts within the designated appeals window timeframe.
- There are two possible grounds for appeal:
  - Alleged failure by NHS Resolution to comply with the published ‘conditions of scheme’ and/or guidance documentation.
  - Technical errors outside the Trust’s control and/or caused by NHS Resolution’s systems which a Trust alleges has adversely affected its CNST rebate.
- The NHS Resolution MIS clinical team will review all appeals to determine if these fall into either of the two specified grounds for appeal. If the appeal does not relate to the specified grounds, it will be rejected, and NHS Resolution will correspond with the Trust directly with no recourse to the AAC.
- Any appeals relating to a financial decision made, for example a discretionary payment made against a submitted improvement plan, will not be considered.
- Appeals must be made in writing to NHS Resolution on the agreed template within two weeks of the final notification of results. Information on how to do this will also be communicated to all Trusts when the confirmed MIS results are sent out.

Trusts who have not met all six core safety actions

Trusts that have not achieved all six core safety actions may be eligible for a smaller amount of discretionary funding to support progress towards achieving these standards in future years. To apply for funding, such Trusts must submit a completed improvement plan together with their completed Board declaration form by 12:00 on 2 March 2027 to NHS Resolution nhsr.mis@nhs.net.

Improvement plans submitted must be:

- On the improvement plan template included in the Board declaration form.
- Signed and dated by the Trust CEO.
- Specific to the action(s) not achieved by the Trust.
- SMART (specific, measurable, achievable, realistic and timely) and must enable the financial calculation of the funding requested.
- Detailed regarding banding and Whole Time Equivalent (WTE) for any new roles to be introduced as part of an action plan.
- Sustainable - funding is for one year only, so Trusts must demonstrate how future funding (if needed) will be secured, particularly regarding new roles/recruitment.

The NHS England Chief Nursing Officer (CNO) wrote to all NHS Trusts on 8 April 2021 confirming that it is the role of commissioners to ensure that any funding awarded to implement the agreed action plan for improvement is ringfenced for the maternity service to support the delivery of the action plan.

Reverification

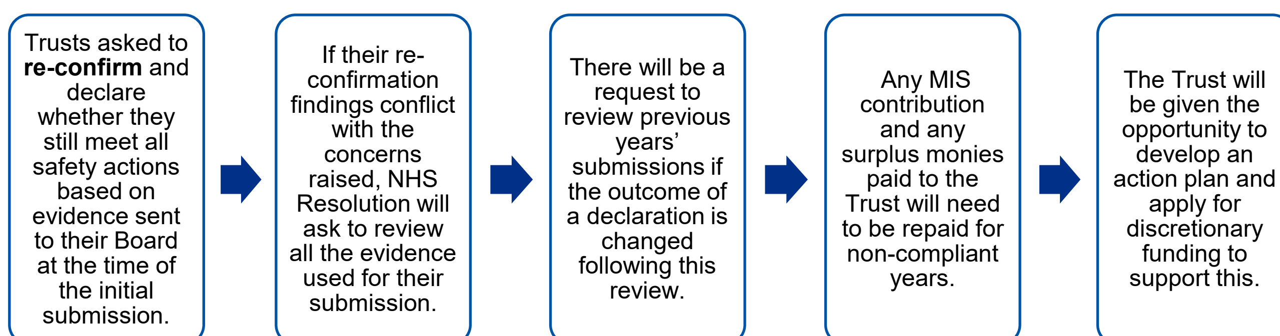
Reverification is initiated if a concern is raised that a Trust Board may have incorrectly declared compliance with one or more of the safety actions' sub-requirements within the MIS. This may be identified through a number of channels including whistleblowing, another review such as an MNSI or Early Notification (EN) investigation, or following a CQC report that may call into question the original declaration. This concern may relate to any completed year of the MIS.

In the first instance, Trusts are asked to complete their own internal review of the evidence that was used to support their compliance for the relevant year at the time of submission. This must be the same evidence that was used to inform the Trust Board at the point of declaration. Trusts will be given the opportunity to downgrade their position at this point.

If following their own internal review, the Trust remains confident that their compliance declaration was correct, the Trust will be asked to provide all of their supporting evidence to NHS Resolution. A full independent review of the relevant evidence will then be undertaken by two members of the MIS clinical team.

Following this review, any Trusts found to have mis-declared compliance will be notified and will be required to repay the funds originally awarded to them for that MIS year. They will be asked to develop an action plan to introduce safety improvements and work towards full compliance, and they will be advised to bid for discretionary funding to support this action plan. Any discretionary funds agreed must be spent on the improvements in the agreed plan. Any amount of discretionary funding agreed will be deducted from the total MIS rebate amount repayable to NHS Resolution.

Figure 4: MIS reverification process



If a mis-declaration has been identified (as above), reverification of the previous MIS year will automatically be initiated. When a further mis-declaration is identified, this process will then be repeated for the previous year. Automatic reverification will be limited to the MIS year in question, and the two preceding historical MIS years only. For each year where a mis-declaration is identified, the Trust must return to NHS Resolution the full MIS funds originally rewarded for those years, irrespective that they are previous financial years.

Any funds retrieved from non-compliant Trusts will be redistributed to all Trusts that achieved compliance for the applicable MIS year. This redistribution must take place within the same financial year that NHS Resolution receives the funds.

Need help?

If you have any queries or concerns regarding any aspect of the MIS, please contact the MIS clinical team on nhsr.mis@nhs.net. There is a FutureNHS MIS workspace which is a key source of up-to-date information about the scheme, including the opportunity to raise queries and share additional resources.

To ensure you receive all correspondence relating to the MIS, please add your name to the MIS contacts list.

MIS Document overview

Year 8 introduces a more structured format for the MIS document. While the layout has been strengthened, the intention is not to prescribe how individual Trusts must deliver each requirement. Instead, the document highlights the core outcomes that matter and the minimum elements required for compliance, while giving organisations flexibility in how they implement and evidence these locally. Trusts must determine the specific improvements they will make and how they will demonstrate sufficient assurance to their Board. The separate supplementary guidance accompanying this core document provides more detailed examples of how these could be achieved in practice and what robust evidence could look like. Much of this reflects approaches already embedded within effective services. By bringing this material together, the aim is to support teams to focus on achieving meaningful improvement rather than following a single mandated method.

Understanding the structure of each safety action

Each safety action section follows a consistent structure. This supports clarity, strengthens alignment across standards, and helps Trusts understand both the purpose and the practicalities of each requirement.

Outcome
This refers to the change(s) that result from the implementation required in the mandatory elements of the standard.

Why
This section explains the purpose behind the requirement.
In a busy, complex environment, tasks can sometimes feel procedural rather than purposeful. The Why section reconnects each standard with the broader safety, quality or cultural improvements it is intended to influence. It helps ensure the focus remains on the impact, including changes that should follow when themes, delays or risks are identified. It supports the continued shift toward outcome-focused improvement.

What
A high-level outline of the mandatory elements required for MIS compliance. This section is intentionally concise and acts as a map setting out the core elements required. It offers an overview on what needs to be in place, without going into operational detail, or prescribing a single approach to take.
How Trusts achieve the minimum requirement will differ depending on local circumstances, and it will be for them to determine (and to provide Board assurance) on to the approach meeting the minimum requirements.
Examples of how this might be achieved can be found in the supplementary guidance.

The enhanced structure of the standards and the supplementary guidance directly reflects what Trusts have asked for:

- stronger articulation of purpose and outcomes
- flexibility for local implementation
- less emphasis on processes
- clearer focus on areas of key impact, aligning with other national priorities and requirements
- explicit evidence examples
- improved guidance relating to governance and assurance

Much of this aligns with business-as-usual governance in effective Trusts. By setting it out clearly, the **Year 8 supplementary guidance document** aims to provide advice to strengthen consistency, reduce avoidable ambiguity, and support teams to focus on delivering meaningful and sustained improvement.

The supplementary guidance also includes additional clarity regarding roles and responsibilities, and further technical guidance on standards where appropriate.

MIS Year 8: reporting period

The MIS reporting periods are structured to align approximately with Q1–Q3 of the financial year, however trusts should view the associated requirements as a continuous, year-round responsibility rather than activity undertaken solely for MIS purposes. The requirements set out in MIS reflect core operational practices that should already form part of effective routine perinatal service delivery, rather than activities undertaken solely for the purposes of the scheme

While any assurance exercise or reverification for Year 8 will focus on activity and supporting evidence from Q1–Q3 of 2026/27 (April-December), we expect Trusts to maintain the same standards and operational processes throughout Q4 to ensure a consistent and embedded approach to patient safety and learning.

2026/27 local improvement work in line with MIS and other annual guidance

Summary of key changes (Year 7 to Year 8)

Overall changes

- **Year 7:** Ten separate safety actions with varying levels of technical detail and duplication across themes.
- **Year 8:** Six core safety actions reorganised by theme and intention.
- Safety actions two (MSDS data reporting) and three (Transitional care) have been removed following review and collective agreement of this at CAG. These processes were felt to be embedded or well underway across most organisations and are supported through other national programmes. Removing these actions enables MIS Year 8 to focus on areas that are newer, still developing, or where national incentivisation continues to add focus and value.
- The removal or absence of certain elements from MIS does not imply that they are no longer valuable. Many practices that sit outside the scope of MIS remain important components of high-quality perinatal care and should continue where they add value. MIS concentrates on a focused set of actions with the strongest evidence for reducing the risk of avoidable catastrophic harm and improving perinatal outcomes, rather than attempting to capture every activity that contributes to safe care.
- Safety actions with a common purpose/outcome have been integrated where practical to do so (four and five, one and 10), fostering a more joined-up approach.
- The requirements for Year 8 are based on outcomes, rather than capturing all elements of a process, giving Trusts flexibility to determine local priorities and the most appropriate approach to achieve these.
- The standards are supported by examples of good practice contained in a supplementary guidance document, which is designed to support perinatal leads in implementation. This approach keeps the emphasis on improvements that have a real impact for women, babies and families; and recognises the significance of local variation in priorities, pressures and workforce, and the central role of Board accountability.
- Locally held evidence which has been used by Boards as the basis of assuring compliance must still be documented and available to NHS Resolution if assurance or reverification is required. A revised version of the audit tool will be available to support this process locally if required.

Summary of changes by safety action

This section summarises changes within each safety action. These are outlined more fully in the standards section (A-F) which follows.

A. Workforce and capacity (summary)

- Year 8 combines all maternity and neonatal workforce requirements into one multi-professional action.
- Sets clearer expectations for consultant presence, anaesthetic cover, neonatal staffing and locum use.
- Removes supernumerary coordinator and 1:1 labour care from MIS, but services should still monitor via red-flags.
- Adds operational capacity monitoring, including elective Caesarean activity via SitRep.
- Continues funded midwifery establishment (BirthRate+) and introduces funded neonatal establishment requirements.
- Confirms need for trained anaesthetic assistants and progress towards peri-operative team models.

B. Training (summary)

- Year 8 strengthens training and assurance with two compliance checkpoints (30 Nov plus one local).
- Training continues to cover fetal monitoring, maternity emergencies and neonatal resuscitation.
- In-situ simulation now required in both hospital and community settings.
- Anaesthetic training requirement reduced to a half-day to support attendance.
- Impacted Fetal Head (IFH) scenarios must be included by year end to align with Avoiding Brain Injury in Childbirth (ABC) preparation.

C. Learning from reviews and investigations (summary)

- Year 8 strengthens triangulation of reviews with wider safety intelligence, ensuring early identification of themes and meaningful family involvement.
- The Perinatal Mortality Review Tool (PMRT), MNSI and Early Notification (EN) learning now aligned, with Submit a Perinatal Event Notification (SPEN) as the single national notification route.
- PMRT external review threshold increased to 60%.
- Quarterly Board-level thematic reports required.
- Greater focus on learning → action → impact.
- Statutory Duty of Candour reporting removed from MIS (already a legal requirement).

D. Service-user voice and equity (summary)

- Strengthened focus on communication equity, ensuring women and families can understand their care and participate fully with appropriate language support and reasonable adjustments.
- Service-user-led improvement, using lived experience to identify priorities and barriers to safe, respectful care.
- Emphasis on equity, using local data to identify groups with poorer access or outcomes and addressing identified gaps.
- Maternal and Neonatal Voices Partnership (MNVP) guidance issued by NHS England still applies. However, recognising capacity is sometimes limited, it is no longer a requirement for MIS. Where capacity is limited, trusts must ensure diverse and representative service user voices inform priorities, improvement work and governance.

E. Care bundles (summary)

- Year 8 introduces a more targeted local approach to Saving Babies' Lives Care Bundle (SBLCB) alongside preparation for the new Maternity Care Bundle (MCB).
- Quarterly SBLCBv3.2 reports required at Trust Board, reflecting local progress, implementation, incidents and safety intelligence.
- ICB assurance step removed as ICBs no longer hold a formal oversight role.
- Trusts must develop an MCB implementation plan with quarterly Board oversight.

F. Board oversight, governance, culture and leadership (summary)

- Clearer expectations for Board-level assurance and use of safety intelligence.
- Routine use of the Maternity Outcomes Signal System (MOSS) and associated SOPs.
- Bimonthly Board Safety Champion meetings with MNVP involvement.
- Live Perinatal Culture Improvement Plan required, with quarterly Board review.

Year 8 places a much stronger emphasis on achieving outcomes, supported by a clearer structure of MIS safety actions with reduced prescription on the underlying process. The mandatory components of each action (Outcome, Why, and What) set out the expectations. The more detailed How, When and Who sit in the Supplementary Guidance document as examples of what good can look like, giving Trusts flexibility to determine the local priorities, evidence and assurance required by their Board. This enables Trusts to demonstrate assurance against outcomes rather than processes, with flexibility to determine how improvements are delivered and evidenced locally. It reinforces operational readiness, equity, service user involvement and culture as central pillars of safe maternity and neonatal care.

Safety Action A – Workforce and capacity

Outcome

Board oversight of effective multidisciplinary (MDT) workforce and capacity planning. Ensuring the maternity and neonatal service have funded establishments for obstetric, midwifery, neonatal, anaesthetic, and perioperative teams meeting nationally recognised workforce standards.

Why

- National and local reviews (including Ockenden, Kirkup, MBRRACE, NHS Resolution claims) repeatedly highlight that workforce shortfalls (including rota gaps, lack of trained multi-professional team and insufficient senior presence) and capacity constraints resulting in delays to planned caesarean births are key contributors to avoidable harm, and poor experiences for women, babies, and staff.
- Workforce pressures affect staff morale, retention, and the ability to deliver high quality care.
- Understanding and measuring workforce and capacity issues is the first step to improvement (H. James Harrington, *Area Activity Analysis: Aligning Work Activities and Measurements to Enhance Business Performance*, McGraw-Hill, 1999).

What are the minimum requirements that must be completed to achieve this outcome?

Staffing

1. **Consultant attendance (obstetric workforce)**
   Compliance with RCOG "Roles and Responsibilities of the Consultant providing acute care" standard: ≥80% consultant presence in defined acute care situations.

2. **Short-term locum certification (obstetric workforce)**
   Trusts must ensure locum certification and maintain a local (Trust-specific), continuously updated database of all short-term locums (≤2 weeks) working on tier 2/3 obstetric rotas. Eligibility must be verified before first engagement and reviewed annually for all locums on the register.

3. **Neonatal workforce establishment (nursing & medical)**
   Trusts must have a clear plan for a fully funded neonatal nursing and medical establishment that aligns with the relevant BAPM standards for their unit designation (Neonatal Intensive Care Unit (NICU), Local Neonatal Unit (LNU), Special Care Unit (SCU)) and the neonatal nursing workforce calculator output (2020).

   MIS acknowledges the updated medical staffing standards for LNU and SCU (Recommended Medical Workforce Standards for Local and Special Care

Neonatal Units in the UK | British Association of Perinatal Medicine). As this is new and includes significant changes, for year 8 the previous staffing standards (BAPM_Service_Quality_Standards_FINAL.pdf) or the updated version will be accepted as meeting the requirements.

4. **Midwifery workforce establishment**
   Trusts must have a fully funded midwifery establishment that aligns with a Birthrate Plus (BR+) review completed within the last three years as a minimum baseline. In addition, further adjustments based on professional judgement of the Director and Head of Midwifery should be added where appropriate. Regional Chief Midwives are able to support this process if required.

5. **Anaesthetic workforce**
   Trusts must ensure that obstetric services have a duty anaesthetist available 24/7 in line with ACSA standards 1.7.2.1 and a trained anaesthetic assistant available 24/7 in line with ACSA standards 1.3.1.2.

Capacity to deliver planned and emergency care

Trusts must demonstrate that capacity is sufficient to deliver timely elective and emergency maternity/neonatal care. **Trusts do not need to prove that delays never occur. They must demonstrate that delays are detected, analysed, reported and that persistent issues are escalated.**

6. **Planned Caesarean birth capacity mapping**
   Trusts must undertake annual demand–capacity mapping for planned Caesarean birth lists, covering the full pathway (preoperative assessment → theatre → recovery → postnatal ward). Trusts should use existing NHS England regional maternity SitRep data wherever possible to avoid duplication.

Governance, escalation, and improvement

7. **Board and governance oversight** (as detailed in Safety Action F)
   Trusts must have a governance system that ensures workforce and capacity risks are monitored, scrutinised and escalated appropriately. This should include a six-monthly integrated workforce report covering maternity and neonatal staffing levels and rota gaps across medical, midwifery, neonatal, anaesthetic and perioperative teams.

Safety Action B – Training

Outcome

Effective Board oversight of maternity and neonatal MDT training and competency. Ensuring all maternity, neonatal and anaesthetic staff are trained, assessed and supported to maintain the knowledge, skills and behaviours required for safe, high quality multidisciplinary care.

Why

National reviews have repeatedly identified inadequate, inconsistent or poorly embedded training as a recurrent contributory factor in avoidable harm.

High quality multidisciplinary training, particularly scenario-based learning that integrates clinical skills, escalation, human factors and communication, improves:

- Team performance
- Situational awareness
- Safety culture
- Escalation behaviours
- Clinical outcomes

Sustained competence requires:

- Structured, role-specific training programmes
- Protected time for staff to attend
- Regular assessment of competence
- Clear escalation pathways
- Visible governance oversight

What are the minimum requirements that must be completed to achieve this outcome?

Trusts should aim to ensure all staff have attended the required annual training listed below. A minimum of ≥90% compliance must be achieved for every required staff group at two points during the MIS year (April to November 2026): 30 November (mandatory MIS checkpoint), and one other Trust selected checkpoint, declared in advance through Quality Governance Committee. Please see the technical guidance (in the supplementary guidance document) for further details of training, and identification of staff that may be excluded from this calculation, including new and rotational staff in their first 3 months, and staff on maternity and long-term sick-leave.

1. **Obstetric emergency training**
   Trusts must ensure that maternity staff attend annual multidisciplinary

obstetric emergency training that incorporates local learning, human factors, communication, teamwork, escalation pathways and situational awareness.

Anaesthetists working in maternity are required to attend at least half of the MDT training day as a minimum, during which obstetric emergencies requiring anaesthetic input (e.g. Postpartum haemorrhage (PPH)), escalation pathways, call chains, teamwork, communication and human factors are rehearsed.

Trusts must ensure that an impacted fetal head (IFH) scenario is incorporated into obstetric emergency training by the end of MIS Year 8 (November 2026) as a preparatory step for Avoiding Brain Injury in Childbirth (ABC) implementation, aligning to the proposed ABC methodology. There is not an expectation that all staff will have received training.

2. **Neonatal resuscitation**
   As a minimum, trusts must ensure that all staff who may act as an unsupervised first attender or primary resuscitator at any birth (including all midwives) complete annual neonatal resuscitation training and are assessed as meeting at least basic capability, as defined in the BAPM Neonatal Airway Safety Standard. Where further enhanced training is in place for additional staff groups, this should continue (e.g. NLS (Newborn Life Support) Course or equivalent).

3. **Fetal monitoring training**
   Trusts must ensure that all staff who provide care in antenatal or intrapartum settings, whether substantively or when responding in escalation, complete annual fetal surveillance training.

4. **In situ multi-professional perinatal emergencies simulations**
   Trusts must deliver at least two in-situ multiprofessional perinatal emergencies simulations during the MIS reporting period. One that begins in a hospital area (e.g. labour ward, obstetric theatre, triage, ED, NICU) and another that begins in a community area. Where possible there should be involvement with relevant partners such as paramedics, ED and theatre teams. These should be based on local and/or national learning and include real time practice of escalation pathways.

5. **Training compliance oversight** (as detailed in Safety Action F)
   Trust Boards must have oversight of training compliance for all maternity and neonatal staff groups. Compliance must be reported quarterly through established governance routes, presented in a clear trend-based format (ideally using Statistical Process Control (SPC) charts), monitored against a trajectory towards 100 percent and working towards maintaining ≥90 percent compliance throughout the following year.

Safety Action C – Learning from reviews and investigations

Outcome

Effective Board oversight of thematic learning and progress with actions arising from local and national reviews of adverse incidents.

Why

The focus of this Safety Action is to ensure that every perinatal and maternal death, and every baby with potential for severe brain injury, is consistently identified, investigated, and learned from using the appropriate national processes.

This includes, but is not limited to, the Perinatal Mortality Review Tool (PMRT) via MBRRACE-UK, the Maternity and Newborn Safety Investigations (MNSI), the NHS Resolution Early Notification Scheme (NHSR EN), and a Maternity Outcomes Signal System (MOSS) critical safety check. This Safety Action aims to embed a culture in which findings are not only reported but critically analysed for their meaning and impact, focusing on the essential 'so what'. The intention is that learning translates into measurable improvements in safety, equity, and outcomes across maternity and neonatal care. This should include learning from examples of excellence when good care is identified.

Recent national inquiries such as Ockenden (2020 and 2022), Kirkup East Kent and MBRRACE-UK, and coronial Prevention of Future Deaths (PFD) notices have consistently shown that failures to robustly investigate and learn from perinatal deaths, maternal deaths and patient safety incidents perpetuate avoidable harm. These findings highlight the need for Trusts to move beyond process compliance, demanding that learning from PMRT, MBRRACE-UK, MNSI, NHSR EN, MOSS and other national reports is actively used to drive change. National priorities now require that review and investigation findings should result in clear actions with a demonstrable impact on outcomes and equity, and that these are tracked and reported to ensure transparency and continuous improvement. The focus is on closing the loop. Not just identifying what happened, but understanding why, making changes where needed, and ensuring care is improved for mothers, babies, and families.

What are the minimum requirements that must be completed to achieve this outcome?

Reporting & Review

1. **Notify all qualifying events**
   All eligible events must be notified through the NHSE Submit a Perinatal Event Notification (SPEN) portal to MBRRACE-UK, NHSR EN and MNSI as soon as possible after the death/diagnosis.

2. **Seek parents' views of care**
   For the deaths of all babies in your trust eligible for PMRT review ensure parents are given multiple opportunities to meaningfully provide their

experience of all elements of care and the impact of that care and raise any questions and comments they may have prior to the PMRT review starting.

3. **External multi-disciplinary reviewers**
   For a minimum of 60% of the deaths reviewed, external members of relevant specialties must be present at the multi-disciplinary review and this should be documented within the PMRT.

Sharing information with families

4. **Provide relevant information**
   Provide relevant information regarding the role of MNSI, NHSR EN scheme and PMRT reviews to families in a format that is relevant and accessible to them. Information about duty of candour must be provided for all parents where the event is eligible for duty of candour.

5. **Offer parents a meeting with relevant specialists**
   Offer parents a meeting with relevant specialists to share the findings with them from reviews and investigations, and relevant incident reports.

Learning and governance

6. **Thematic reports of learning and actions**
   The Trust must produce thematic reports that summarise learning and progress on actions arising from MNSI and NHSR EN reports, local PMRT and PSIRF reviews, MOSS critical safety checks, NHSR claims scorecards and relevant national reports. Trusts must also use demographic data to identify and understand any disparities in outcomes.

   These thematic reports must be reviewed with the Trust Perinatal and Board level Safety Champions and submitted to the Trust Executive Board at least quarterly. Reports should clearly demonstrate the measures implemented to address recurrent themes, and progress with these, including how learning has been shared and, where appropriate, incorporated into existing multidisciplinary training.

Safety Action D – Service-user voice and equity

Outcome

The voices and experiences of all women accessing maternity and neonatal services are used to drive local improvements, using local population demographics to understand and target efforts to support a reduction in inequities in experience and outcomes.

Why

National inquiries and reviews have repeatedly shown that failures to listen to (and act on) women and families experiences contribute directly to avoidable harm, poor experience, and widening inequalities. Ockenden (2020 and 2022), Kirkup, MBRRACE, CQC reports, Prevention of Future Death (PFD) reports, and NHS England equity guidance all highlight the same themes: communication gaps, missed concerns, inequitable experiences, and limited involvement of families in shaping care.

This safety action incentivises maternity and neonatal services to place service user voice at the centre of improvement. Its purpose is to ensure that insights from women and families across all demographic groups directly influence local decision-making, drive meaningful and measurable change, and support the delivery of safe, equitable, and high-quality care for every woman, baby, and family.

What are the minimum requirements that must be completed to achieve this outcome?

1. **Communication equity, language support and accessible information**
   Trusts should demonstrate continued progress towards ensuring that women and families, including those who may require translation, interpreting support, or reasonable adjustments, are supported to understand their care, options, and decisions at key points in the perinatal journey. Trusts should recognise that where information is not understood, consent may not be informed, valid or lawful. Reliance on family members, friends or informal interpretation must be treated as a patient safety, safeguarding and human rights risk.

2. **Service-user voice driving safety and quality improvement**
   Trusts must demonstrate that insights from women, families and carers using maternity and neonatal services are captured and used to inform service improvement plans. Trusts must use demographic data to understand their local population and demonstrate that the voices of women and families from different demographic groups, are actively captured and used to shape priorities within the service.

   Progress with this work should be monitored through established governance routes quarterly to ensure that actions lead to measurable improvements in safety, quality, or experience.

Safety Action E – Care bundles

Outcome

Board oversight of progress with implementation of Saving Babies' Lives Care Bundle (SBLCBv3.2), a plan to implement the Maternal Care Bundle by March 2027, and assurance that a guideline for neonatal pulse oximetry testing has been developed in line with national guidance.

Why

MBRRACE UK reports continue to highlight avoidable variation and persistent inequalities contributing to maternal and neonatal deaths. Consistent implementation of the Saving Babies' Lives Care Bundle and the Maternal Care Bundle is essential to reduce preventable harm, standardise best practice, and ensure equitable, safe care for all families.

The Saving Babies' Lives Care Bundle has been part of the Maternity Incentive Scheme since its' inception, achieving high levels of compliance and driving meaningful improvements. As services move towards embedding this as business as usual, incentivisation of progress will help demonstrate impact.

Equivalent incentivisation is now required for the introduction of the recently announced Maternal Care Bundle to ensure uniform adoption across Trusts, reduce unwarranted variation, and support targeted interventions where improvement is most needed. This iterative approach will ensure measurable assurance that avoidable harm is being actively mitigated against, and that both bundles are delivering the impact they were designed to achieve.

In addition to this, CAG identified the need to promote and support neonatal pulse oximetry testing, which supports earlier detection of conditions associated with hypoxaemia that may not be apparent on clinical examination, helping ensure timely and equitable care for newborns.

What are the minimum requirements that must be completed to achieve this outcome?

1. **Saving Babies' Lives Care Bundle (SBLCBv3.2) - Quarterly reporting to the Trust Board**
   The provider must report quarterly to the Trust Board on progress against full SBLCBv3.2 implementation. Quarterly reports should demonstrate how the Trust has prioritised the requirements of the SBLCB based on local progress, implementation status, and any relevant safety intelligence, including themes and learning from local adverse incidents.

   In light of the recent NHSE and RCOG fetal growth chart safety communication, Trusts should include a brief review within their local SBL priorities to confirm safe and appropriate fetal growth surveillance, confirming that fetal growth charts and surveillance pathways meet most recent national safety advice and identifying any local risks or improvement actions relating to

fetal growth restriction (FGR) detection as highlighted.

2. **Maternal Care Bundle – Implementation Plan**
   In collaboration with all relevant services, the provider agrees a plan with the Trust Board to implement the Maternal Care Bundle by March 2027. Progress with implementation is reviewed quarterly through established governance routes.

3. **Neonatal pulse oximetry testing**
   Trusts must develop a standardised, equitable, and governance approved guideline for neonatal pulse oximetry testing, aligned to the BAPM framework. The guideline must describe the required clinical processes, data entry standards, and pathways for all birth settings (including homebirths) to ensure that every baby receives pulse oximetry screening between 2 and 24 hours of age, with clear escalation processes for babies in the amber and red pathways.

Safety Action F – Board oversight, governance, culture and leadership

Outcome

The Trust Board has effective oversight of the quality and safety of their maternity and neonatal services.

Why

Independent investigations into maternity and neonatal services have repeatedly shown that safety issues are often not identified, escalated or addressed until significant harm has already occurred. Governance structures and the cultures that underpin them remain highly variable across Trusts.

Trusts with consistent oversight, reliable escalation processes and compassionate, connected and visible leadership are better able to identify risks early and act decisively. A positive safety culture supports staff wellbeing, strengthens multidisciplinary working and reduces the likelihood of avoidable harm. Strong Board engagement and challenge ensure that risks are not only recognised but resourced, prioritised and mitigated, contributing to safer care and a more supportive working environment.

What are the minimum requirements that must be completed to achieve this outcome?

1. **Board Oversight of Maternity and Neonatal Quality and Safety**
   Trusts must demonstrate that, through established governance routes, the Board routinely receives, reviews and responds to a comprehensive assessment of maternity and neonatal quality and safety. This assessment should cover training, workforce, staff and service user experience, and progress against the care bundles at the frequencies **outlined in Safety Actions A–E**.

   Trusts must also ensure that findings arising from detailed scrutiny at the Quality Governance Committee (or equivalent) are formally escalated to the Executive Board, providing full oversight in line with good governance practice and the expectations of the [Perinatal Quality Oversight Model] (PQOM). Where Trust level mitigation to concerns is insufficient, escalation to Regional Midwifery Officer teams should be documented, alongside PQOM aligned actions.

2. **Maternity Outcomes Signal System**
   Trusts must evidence that the critical safety check (Annex 1 of the MOSS [standard operating procedures]) was completed in the event of signals, or that a test drill (Annex 9) was carried out if no signals occurred. An accountable trust board executive (i.e. Chief Nurse, Chief Medical Officer or Executive Trust Board Safety Champion) must approve completed checks, including drills. This will be externally validated through regional assurance - services

must send a completed copy of critical safety check(s) or test drill to regions, for forwarding to the national team at england.moss@nhs.net

3. **Maternity and Neonatal Board Safety Champions**
   Trusts must demonstrate that Maternity and Neonatal Board Safety Champions are actively supporting the perinatal leadership team (including the MNVP Lead where they are in commissioned in line with MNVP guidance), in creating and embedding a positive local safety culture, with regular two-way communication and clear escalation to the Trust Board where any concerns are identified.

4. **Perinatal Culture Improvement Plan**
   Trusts must demonstrate that they have an agile perinatal culture improvement plan in place which triangulates data and engagement from multiple sources, uses recognised improvement methodology to evidence progress and impact, and is reviewed by the Trust Board at least six monthly.

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Maternity (Perinatal) Incentive Scheme Year 8 v1.0

Supplementary guidance

Roles and Responsibilities: 'What good might look like'
Technical guidance, Abbreviations, References

Published March 2026

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Supplementary Guidance - What Good Might Look Like

The following sections provide supplementary guidance to the core Maternity (Perinatal) Incentive Scheme (MIS) document. They offer examples of 'what good might look like' and illustrate how a high-functioning Trust might deliver and assure each requirement. These explicit steps are not mandated; this is intended to support local application and strengthen consistency.

This is structured around the following sections:

Who – Roles and Responsibilities

The roles and teams that should be involved in delivering, monitoring and assuring the standards.

This section reinforces the multidisciplinary nature of MIS: responsibility does not sit with one individual, but with the whole perinatal leadership team, including midwifery, obstetrics, neonatology (nursing and medical), anaesthetics, service user representation, governance, data, and executive leadership.

It also reflects established good governance practices, including effective use of quality governance committees (or equivalent delegated committees) and timely and appropriate escalation to the Executive Board.

How

Evidence examples for each Safety Action. Processes that may be in place in a Trust that meets the requirements. This will vary depending on local context.

Many elements will align with routine governance activity already embedded within safe, effective services. This content responds directly to Trusts' requests for clearer interpretation, practical examples of *what good looks like*, improved guidance on evidence and Board assurance. It also supports the broader shift toward demonstrating change and improvement, rather than meeting processes in isolation.

References

Key evidence sources, national reports and frameworks underpinning the Safety Action.

The enhanced structure directly reflects what Trusts have asked for:

- Support for flexibility to allow for local prioritisation and processes.
- Support interpreting standards.
- More explicit evidence examples.
- Stronger articulation of purpose and outcomes.
- Support to provide greater consistency in governance and assurance.

Much of this aligns with business-as-usual governance in effective Trusts. By setting it out clearly, the Year 8 supplementary document aims to support trusts to strengthen consistency, reduce avoidable ambiguity, but also enable teams local flexibility to focus on delivering meaningful and sustained improvement.

Who - Roles and responsibilities

Delivering the MIS safety actions requires a coordinated, multidisciplinary approach. Responsibility does not sit with any single individual or staff group. Instead, it relies on shared leadership across midwifery, obstetrics, neonatology, anaesthetics, governance, data, service user voice and executive oversight. High performing Trusts demonstrate collective ownership, clear role boundaries, and regular cross-professional communication to ensure timely action, triangulated assurance and sustained improvement. Some key roles (recognising there may be local variation in naming conventions) involved in delivering the scheme include:

Head / Director of Midwifery

Provides strategic and operational leadership for maternity services, overseeing governance, workforce, training, safety actions and improvement plans. Ensures accurate reporting, effective escalation and Board level assurance.

Clinical Director for Obstetrics

Provides senior medical leadership for obstetric services, ensuring clinical oversight of investigations, care bundles, training, workforce compliance and escalation of risk through governance structures.

Clinical Director / Lead for Neonatology

Leads neonatal medical governance, ensuring compliance with national standards, oversight of neonatal elements of investigations and care bundles, and contribution to joint maternity–neonatal safety and improvement work.

Lead Nurse for Neonatal Services

Oversees the neonatal nursing workforce, training, compliance with British Association of Perinatal Medicine (BAPM) standards and supports pathway development, data quality and neonatal input into investigations and quality improvement.

Lead Anaesthetist for Obstetrics

Ensures obstetric anaesthetic staffing, rota oversight, compliance with standards and anaesthetic contribution to emergency training, escalation pathways and governance.

Governance and Risk Lead (Maternity & Neonatal)

Coordinates all maternity and neonatal governance processes, maintains trackers and logs, triangulates data and produces reports for governance committees and the Board. Ensures risks and learning are escalated and monitored.

Education & Training Leads / Practice Development Teams

Coordinate delivery, monitoring and recording of all mandatory and multidisciplinary team training (MDT) training. Support competency assessment, programme development and reporting of training compliance to governance forums.

Digital Leads

Support accurate data capture, data entry processes, digital workflows and assurance on data quality for required reporting, including neonatal screening and pulse oximetry.

Departmental Managers / HR Leads

Oversee rota management, workforce records, locum verification, induction, and workforce related compliance logs. Support escalation where staffing pressures impact safety or capacity.

Board Maternity and Neonatal Safety Champions (Executive & Non-Executive)

Provide visible leadership, challenge and advocacy for maternity and neonatal safety. Ensure risks, themes and learning are escalated and that actions are delivered, monitored and resourced appropriately. Provides a link from the 'Board to Ward' and back up again.

Maternity and Neonatal Voices Partnership (MNVP) Lead and Service User Representatives

Provide independent insight into family experience, equity, communication and service design. Contribute to co-production of information and challenge governance discussions, ensuring service-user voice informs improvement.

Maternity and Neonatal Governance Forum

The operational forum for monthly triangulation of incidents, investigations, service user insight, workforce, training and improvement data. Prepares verified summaries for Quality Governance Committee (QGC) and flags risks requiring escalation.

Quality Governance Committee

Formally delegated committee of the Trust Board. Scrutinises quarterly maternity and neonatal quality and safety information, including training, workforce, incidents, investigations, care bundles and service user themes. Escalates risks and unmet actions to the Trust Board / Executive Board.

Executive Board

Holds ultimate accountability for maternity and neonatal safety. Receives escalations and quarterly summaries, approves plans, allocates resources and assures delivery of improvement through the perinatal quality oversight model (PQOM) aligned oversight. Formally provides agreement and consent for the Chief Executive Officer (CEO) to undertake the organisation's final MIS sign-off.

Perinatal Leadership Team

Cross specialty leadership group responsible for coordinating delivery across all Safety Actions, overseeing culture improvement, triangulating insight and maintaining a coherent improvement plan. It typically includes (but is not restricted to) the Director of Midwifery, Clinical Directors for Obstetrics and Neonatology, the Lead Nurse for Neonatal Services, the Lead Anaesthetist for Obstetrics, and the MNVP Lead, who represents the wider service user voice.

How - Evidence examples

Safety Action A – Workforce and capacity

Safe staffing levels - Trusts must demonstrate that funded establishments for obstetric, midwifery, neonatal, anaesthetic, and perioperative teams meet nationally recognised workforce standards.

1. Consultant attendance (obstetric workforce)

Compliance with the Royal College of Obstetricians and Gynaecologists (RCOG) "Roles and Responsibilities of the Consultant providing acute care" standard: ≥80% consultant presence in defined acute care situations.

What good might look like:

- A local summary or guideline that clearly sets out the RCOG consultant attendance and "inform" criteria.
- Consultant rotas and job plans that show how labour ward responsibilities are covered.
- Up to date documentation confirming competence sign off for senior trainees or specialty, associate specialist and specialist (SAS) doctors, where this affects attendance requirements.
- Clinical records that note when the consultant was informed or attended, with reasons documented where they did not.
- Short audit reports showing consultant attendance against RCOG scenarios, with any exceptions explained.
- Examples of case reviews or debriefs that highlight consultant involvement and learning.
- Relevant risk register entries or workforce updates where recurring gaps or challenges have been recognised and managed.
- Evidence of Board oversight of compliance with this sub-action (linking to sub-action A7 and Safety Action F governance and reporting).

2. Short-term locum certification (obstetric workforce)

Trusts must ensure locum certification and maintain a local (Trust-specific), continuously updated database of all short-term locums (≤2 weeks) working on tier 2/3 obstetric rotas. Eligibility must be verified before first engagement and reviewed annually for all locums on the register.

What good might look like:

- A current, Trust specific locum register showing all short-term locums and the dates their eligibility was verified and last reviewed.
- Confirmation that each locum has a valid NHS Certificate of Eligibility for Locums (CEL) or, where applicable, documented checks of specialist registration and recent NHS experience.
- Records showing that key pre-employment checks (such as GMC status, references, training) were verified before the locum undertook any clinical work.
- A brief induction record for each locum, including access to local systems, guidelines, escalation routes, and identification of their named consultant support.
- Periodic checks or audits showing all locums on the register remain compliant and that ineligible locums are not being booked.
- Notes from governance or workforce meetings showing oversight of locum use and any issues identified with agency supplied locums.
- Evidence of Board oversight of compliance with this sub-action (linking to sub-action A7 and Safety Action F governance and reporting).

3. Neonatal workforce establishment (nursing & medical)

Trusts must have a clear plan for a fully funded neonatal nursing and medical establishment that aligns with the relevant BAPM standards for their unit designation (NICU, LNU, SCU) and the neonatal nursing workforce calculator output (2020).

What good might look like:

- A recent neonatal workforce review that clearly shows how the funded posts compare with what BAPM standards, and the neonatal nursing calculator say is needed.
- Identification of any gaps, along with a realistic (SMART) plan for how the Trust intends to move toward full compliance.
- Routine monitoring of workforce pressures (for example, cot closures, staffing related transfers, red flags, or mismatch between dependency levels and available staff) with evidence of escalation and mitigations.
- A neonatal workforce dashboard or report that is regularly discussed in neonatal and maternity governance meetings.
- Clear evidence that neonatal staffing is considered alongside maternity staffing pressures, rather than in isolation.
- Evidence of Board oversight of compliance with this sub-action (linking to sub-action A7 and Safety Action F governance and reporting).

4. Midwifery workforce establishment

Trusts must have a fully funded midwifery establishment that aligns with a Birthrate Plus (BR+) review completed within the last three years as a minimum baseline. In addition, further adjustments based on professional judgement of the Director / Head of Midwifery should be added where appropriate. Regional Chief Midwives are able to support this process if required.

What good might look like:

- A recent BR+ report (within three years) demonstrating how the funded midwifery establishment compares with the BR+ recommendations.
- Evidence of explanation where professional judgement has been used to adjust BR+ numbers (for example, reflecting local case mix, service configuration, acuity trends, development roles and headroom uplifts).
- A clear explanation for any differences between funded and required numbers, and an agreed plan for how the Trust intends to address these gaps over time (n.b. aligned midwifery establishment must be funded for MIS compliance).
- Routine monitoring of key safety indicators such as one-to-one care in labour, red flags, missed breaks, or high acuity periods, with actions taken in response.
- A monthly or quarterly update to governance groups showing workforce trends, pressures, and progress against recruitment or retention plans.
- Examples of joint conversations across maternity and neonatal teams to ensure midwifery staffing is seen as part of wider perinatal workforce planning.
- Evidence of Board oversight of compliance with this sub-action (linking to sub-action A7 and Safety Action F governance and reporting).

5. Anaesthetic workforce

Trusts must ensure that obstetric services have a duty anaesthetist available 24/7 in line with ACSA standards 1.7.2.1 and a trained Anaesthetic Assistant available 24/7 in line with ACSA standards 1.3.1.2.

What good might look like:

- Rotas that clearly show 24/7 obstetric anaesthetic cover, with arrangements for planned and unplanned leave to maintain safe staffing.
- Evidence that a trained Anaesthetic Assistant is always available, including escalation plans when cover is at risk.
- A regular review of obstetric theatre delays or incidents where anaesthetic staffing was a factor, with actions recorded where needed (linking to sub-action A6).

- Evidence of job plans showing named anaesthetic lead for obstetrics, with protected time to support service delivery, governance, and workforce planning.
- Meeting notes or workforce reports showing that anaesthetic staffing pressures are monitored and discussed alongside maternity and neonatal activity.
- Examples of collaborative working between anaesthetic, midwifery, obstetric, and theatre teams to ensure the service runs safely during busy or complex periods (also linking to sub-action A6).
- Evidence of Board oversight of compliance with this sub-action (linking to sub-action A7 and Safety Action F governance and reporting).

Capacity to deliver planned and emergency care

Trusts must demonstrate that capacity is sufficient to deliver timely elective and emergency maternity/neonatal care. **Trusts do not need to prove that delays never occur. They must demonstrate that delays are detected, analysed, reported and that persistent issues are escalated.**

6. Planned Caesarean birth capacity mapping

Trusts must undertake annual demand–capacity mapping for planned Caesarean birth lists, covering the full pathway (pre-operative assessment → theatre → recovery → post-natal ward). Trusts should use existing data reported through NHS England regional maternity SitRep requirements wherever possible to avoid duplication.

What good might look like:

- An annual demand–capacity review showing how planned Caesarean activity compares with available theatre time, staffing, recovery and post-natal ward capacity.
- Use of regional maternity SitRep data to understand pressure trends and seasonal variation, reducing the need for local data duplication.
- A summary of recurring delays, including cases where planned procedures were carried out on emergency lists, outlining the reasons, the impact on services and service users, and any mitigations.
- Evidence that outputs from capacity mapping inform service planning, such as increased protected elective lists, improved scheduling, or increased anaesthetic or theatre support.
- Evidence of routine monitoring of same day delays, with clear escalation when capacity issues begin to affect emergency or urgent workload.

- Regular discussion of Caesarean birth capacity at maternity and theatre governance meetings, ensuring the whole pathway is understood and managed jointly.

Governance, escalation, and forward planning

Trusts must have robust governance processes to monitor workforce risks, escalate issues, and plan for future workforce needs.

7. Board and governance oversight (as detailed in Safety Action F)

Trusts must have a governance system that ensures workforce and capacity risks are monitored, scrutinised and escalated appropriately. This should include a six-monthly integrated workforce report covering maternity and neonatal staffing levels and rota gaps across medical, midwifery, neonatal, anaesthetic and perioperative teams.

What good might look like:

- A regular, integrated workforce report to the Board (at least six-monthly) presenting a clear picture of staffing levels, vacancies, sickness, rota gaps, and reliance on temporary staffing across all maternity and neonatal professions.
- A Statistical Process Control (SPC) based workforce dashboard showing key trends and early warning signs such as red flags, one-to-one care in labour, neonatal dependency levels, and indicators of capacity pressure.
- Clear routes for escalating persistent workforce or capacity issues through governance structures, with evidence that these issues are discussed and actions tracked.
- Governance meeting minutes showing routine triangulation of workforce data with incidents, complaints, outcomes, and staff and service user feedback.
- A Trust risk register entry (or equivalent) reflecting any significant workforce risks, with up-to-date mitigation plans and progress updates.
- Examples of Board and senior leadership discussions demonstrating understanding of the current workforce position, challenges, and improvement plans across obstetric, midwifery, neonatal, anaesthetic and perioperative teams.

Safety Action B – Training

Trusts should aim to ensure all staff have attended the required annual training listed below. A minimum of ≥90% compliance must be achieved for every required staff group at two points during the MIS year (April 26-November 26): 30 November (mandatory MIS checkpoint), and one other Trust selected checkpoint, declared in advance through Quality Governance Committee (QGC). Please see the technical guidance for further details of training, and identification of staff that may be excluded from this calculation, including new and rotational staff in their first three months, and staff on maternity and long-term sick leave.

1. Obstetric emergency training

Trusts must ensure that maternity staff attend annual multidisciplinary obstetric emergency training that incorporates local learning, human factors, communication, teamwork, escalation pathways and situational awareness.

Anaesthetists working in maternity are required to attend at least half of the MDT training day as a minimum, during which obstetric emergencies requiring anaesthetic input (e.g. post-partum haemorrhage (PPH)), escalation pathways, call chains, teamwork, communication and human factors are rehearsed.

Trusts must ensure that an impacted fetal head (IFH) scenario is incorporated into obstetric emergency training by the end of MIS Year 8 (November 2026) as a preparatory step for Avoiding Brain Injury in Childbirth (ABC) implementation, aligning to the proposed ABC methodology. There is not an expectation that all staff will have received training.

What good might look like:

- An annual MDT training plan that covers the required emergencies and integrates local learning, communication and teamwork principles, escalation routes and human factors.
- A local training needs analysis used to identify priorities, ensure training content reflects local risks, and tailor the programme to emerging themes.
- A training trajectory or forward plan outlining how the service will maintain high attendance and meet future training needs, including scheduling, workforce release planning and projected compliance.
- Attendance records showing participation from maternity, neonatal, anaesthetic and theatre staff, with anaesthetists attending the required portion of the programme.
- Scenario outlines demonstrating that key obstetric emergencies including PPH, maternal collapse, shoulder dystocia and cord prolapse are regularly practised, and from this year incorporating IFH.
- Evidence that learning from incidents, claims, complaints and governance reviews is fed into training design.

- Evidence of service user input. For example, involving MNVP representatives in shaping scenario design, highlighting communication challenges, or identifying areas where service users felt emergencies were poorly understood or explained.
- Feedback summaries or debrief notes indicating that training is relevant, realistic and supports effective MDT working.
- Examples of collaborative delivery involving obstetrics, anaesthetics, midwifery, neonatology and theatre teams.

2. Neonatal resuscitation

As a minimum, Trusts must ensure that all staff who may act as an unsupervised first attender or primary resuscitator at any birth (including all midwives) complete annual neonatal resuscitation training and are assessed as meeting at least basic capability, as defined in the BAPM Neonatal Airway Safety Standard. Where further enhanced training is in place for additional staff groups, this should continue (e.g. NLS or equivalent).

What good might look like:

- A local training register showing annual neonatal resuscitation training and capability sign-off for all relevant staff, supported by completed assessment records.
- Assessments clearly mapped to the BAPM standard, demonstrating that staff meet basic capability before undertaking unsupervised primary resuscitator roles.
- Scenario-based training plans reflecting local environments and escalation pathways, with updates informed by recent incidents or debriefs and service user feedback about communication during neonatal emergencies. Scenarios include community births.
- A training needs analysis used to shape the annual programme and identifying any areas requiring additional support.
- Evidence of neonatal resuscitation compliance and capability included in routine maternity/neonatal training reports to the Board, ensuring ongoing oversight of any gaps or risks.

3. Fetal monitoring training

Trusts must ensure that all staff who provide care in antenatal or intrapartum settings, whether substantively or when responding in escalation, complete annual fetal surveillance training.

What good might look like:

- A local training register showing annual fetal monitoring training and assessment for all relevant staff, including those who may ever cover shifts in escalation.
- Evidence that training content aligns with national guidance and local learning, with session plans, eLearning records or competency sign-offs available.
- Scenario or case-based training reflecting local risks and recent incidents, with updates documented through governance routes.
- Service user feedback, for example via MNVP input into communication elements of CTG interpretation or escalation scenarios, helping ensure the training reflects how monitoring and decision making are experienced by women and families.
- A simple training needs analysis informing the annual programme and identifying staff groups requiring targeted support.
- Fetal monitoring training compliance included within routine reporting to maternity/neonatal governance groups and the Board, ensuring oversight of any gaps.

4. In situ muti-professional maternity emergencies simulations

Trusts must deliver at least two in-situ multiprofessional maternity emergencies simulations during the MIS reporting period. One that begins in a hospital area (e.g., labour ward, obstetric theatre, triage, Emergency Department (ED), NICU) and another that begins in a community area. Where possible there should be involvement with relevant partners such as paramedics, ED and theatre teams. These should be based on local and/or national learning and include real time practice of escalation pathways.

What good might look like:

- A plan outlining at least one hospital based and one community based in-situ simulation each year, with scenarios informed by local incidents, national learning and Prevent Future Deaths (PFD) themes etc.
- Shared planning with relevant partners such as paramedics, ED, theatres or allied care teams to ensure realistic pathways and smooth MDT coordination.
- Evidence that human factors, teamwork and communication are explicitly practised, including challenging scenarios such as language barriers or unclear escalation chains.
- Participation records showing involvement from relevant professions and agencies, reflecting how teams work together in real emergencies.
- Debrief notes capturing key learning, system issues, and MDT reflections, with updates to scenarios or guidance documented through governance routes. Sharing of learning.
- Service user input, for example via MNVP, helping shape communication elements of scenarios or identifying where families experienced confusion during previous emergencies.

- Confirmation that learning from simulations is reviewed in maternity/neonatal governance and forms part of regular assurance reporting to senior leaders and the Board.

5. Training compliance oversight (as detailed in Safety Action F)

Trust Boards must have oversight of training compliance for all maternity and neonatal staff groups. Compliance must be reported quarterly through established governance routes, presented in a clear trend-based format (ideally using SPC charts), monitored against a trajectory towards 100 percent and working towards maintaining ≥90 percent compliance throughout future years.

What good might look like:

- A quarterly training report presenting clear trend-based data (e.g. SPC charts) for all maternity and neonatal staff groups, underpinned by verified local training registers.
- A locally maintained dashboard that distinguishes active staff requiring training from those who are temporarily exempt, such as staff on long-term sickness, maternity leave, or those still within their documented induction period.
- Monitoring arrangements for new and rotational staff, ensuring they either complete relevant training within three months of joining or can evidence that they were trained within the current year at their prior organisation.
- Clear governance oversight, with compliance themes, risks and improvement actions discussed at maternity/neonatal governance and reported onwards to the Board.
- Evidence of practical action where compliance falls, such as adjusting release time, increasing training availability, or targeted reminders for teams or staff groups.
- A maintained trajectory toward 100% compliance, with transparent explanations where temporary dips occur (e.g. high turnover, large intake of new starters).

Safety Action C – Learning from reviews and investigations

Reporting & Review

1. Notify all qualifying events

All eligible events must be notified through the NHSE Submit a Perinatal Event Notification (SPEN) portal to MBRRACE-UK, NHSR Early Notification Scheme (EN) and Maternity and Newborn Safety Investigations (MNSI) as soon as possible after the death/diagnosis.

What good might look like:

- A local process that ensures all qualifying events are identified quickly and submitted via SPEN without delay, supported by clear guidance and accessible instructions for staff.
- Notification responsibilities that are shared across the team rather than resting with a single individual, so that reporting continues reliably during leave, sickness or out-of-hours periods.
- System checks (e.g. cross-referencing SPEN submissions with incident reports, neonatal dashboards or bereavement notifications) to ensure every eligible case is captured.
- Routine governance review highlighting any missed or late notifications, with actions agreed and monitored to strengthen reliability.
- Inclusion of notification timeliness and completeness within maternity/neonatal governance reporting and Board-level assurance, demonstrating consistent oversight.

2. Seek parents' views of care

For the deaths of all babies in your trust eligible for PMRT review ensure parents are given multiple opportunities to meaningfully provide their experience of all elements of care and the impact of that care and raise any questions and comments they may have prior to the PMRT review starting.

What good might look like:

- A clear, sensitive process for approaching parents at appropriate times, ensuring they are offered more than one opportunity to share their views in the way that feels right for them (written, verbal, virtual or in person).
- Use of supportive materials such as leaflets and discussion prompts (linking to sub-actions C4 and D1) that explain the PMRT process and encourage parents to reflect on all aspects of their care experience.
- Evidence that staff record when and how opportunities were offered, ensuring the process does not rely on a single individual and remains consistent during leave, shift changes or busy periods.

- Feedback from parents captured in a structured, compassionate way (e.g. using PMRT parent forms, free-text reflections or facilitated conversations) and included in the evidence provided to reviewers.
- Governance oversight confirming that parent feedback is consistently sought, received and used to inform PMRT reviews, with trends or themes shared through maternity/neonatal governance and included in Board-level assurance.
- Where service users (e.g. MNVP representatives) have helped shape the parent-facing materials or approach, this is reflected in meeting notes or guidance updates.

3. External multi-disciplinary reviewers

For a minimum of 60% of the deaths reviewed external members of relevant specialties must be present at the multi-disciplinary review and this should be documented within the PMRT.

What good might look like:

- Clear arrangements for involving external reviewers from appropriate specialties (e.g. neonatology, obstetrics, midwifery, anaesthetics) to ensure the required 60% threshold is met.
- A reciprocal arrangement with neighbouring Trusts or network partners so that each organisation both provides and receives external reviewers, helping maintain availability and avoid reliance on a single individual.
- PMRT entries that clearly document who attended, their specialty, and whether they were external to the Trust, providing straightforward evidence of compliance.
- A small, reliable pool of external clinicians identified through local networks or LMNS arrangements, with contingency options to maintain reviewer availability during leave or periods of high activity.
- Governance oversight confirming external reviewer involvement, with any gaps explained and actions taken to strengthen arrangements.
- Summary outputs from reviews demonstrating how external perspectives have contributed to learning, challenge, and quality improvement, and included in routine maternity/neonatal governance reporting.

Sharing information with families

4. Provide relevant information

Provide relevant information regarding the role of MNSI, NHSR Early Notification (EN) scheme and PMRT reviews to families in a format that is relevant and accessible to them. Information about duty of candour must be provided for all parents where the event is eligible for duty of candour.

What good might look like:

- Clear, accessible written and verbal information available for parents explaining MNSI, the EN scheme and the PMRT process, offered in a sensitive and timely way.
- Materials provided in different formats (including, but not limited to: 'Easy-read', translated versions, or interpreter-supported conversations, aligning with sub-action D1) to ensure families with language or communication needs can understand what is happening.
- Evidence that information is offered more than once (aligning with sub action C2) so families have multiple opportunities to ask questions or share their views before the PMRT review begins.
- Duty of Candour conversations and letters documented clearly, with families given time, support and contact details for follow-up.
- Feedback from families (where appropriate, via MNVP or bereavement services) informing improvements to the language, tone or accessibility of parent-facing materials.
- Confirmation through governance or assurance reports that families routinely receive the right information at the right time and that Boards have oversight of any gaps or improvements needed.

5. Offer parents a meeting with relevant specialists

Offer parents a meeting with relevant specialists to share the findings with them from reviews and investigations, and relevant incident reports.

What good might look like:

- Parents are proactively offered a meeting with the appropriate specialists (e.g. neonatology, obstetrics, midwifery, bereavement leads) once review findings are available, with the offer made in a sensitive and timely way.
- Evidence that offers are documented and made more than once where needed, ensuring families have opportunities to meet when they feel ready.
- Meetings arranged in a setting that supports open, compassionate discussion, with clear explanations of findings and space for parents to ask questions or share reflections.
- Documentation confirming who attended, what was discussed and any follow-up actions, ensuring continuity and avoiding reliance on a single team member to coordinate.
- Input from service users (e.g. MNVP or bereavement services) informing how meetings are structured, how information is shared and how any communication barriers (including language needs) are addressed.

- Governance oversight confirming that meetings are routinely offered, uptake is monitored and any gaps or learning about the process are acted on and reflected in reports to senior leaders.

Learning and governance

6. Thematic reports of learning and actions

The Trust must produce thematic reports that triangulate information and summarise learning and progress on actions arising from MNSI and NHSR EN reports, local PMRT and Patient Safety Incident Response Framework (PSIRF) reviews, Maternity Outcomes Signal System (MOSS) critical safety checks, NHSR claims scorecards and relevant national reports. Trusts must also use demographic data to identify and understand any disparities in outcomes.

These thematic reports must be reviewed with the Trust Perinatal and Board level Safety Champions and submitted to the Trust Executive Board at least quarterly. Reports should clearly demonstrate the measures implemented to address recurrent themes, and progress with these, including how learning has been shared and, where appropriate, incorporated into existing multidisciplinary training.

What good might look like:

- A quarterly thematic report that brings together learning and actions across all relevant sources, with clear summaries and simple evidence of progress (e.g. action trackers, completed changes, updates from risk owners).
- Use of demographic data within the report to identify disparities in outcomes or experience, supported by analysis and follow-up actions where inequities are identified.
- Use of recognised improvement methodology (e.g. Plan-Do-Study-Act (PDSA), driver diagrams, measurable aims) to show structured actions and demonstrable progress.
- Evidence of routine discussion with the Trust's Perinatal and Board-level Safety Champions, captured through meeting notes and agreed actions.
- Reports that highlight recurrent themes and show how these have been addressed, including changes to pathways, escalation processes, documentation, or workforce plans.
- Clear examples of how learning has been shared across teams (e.g. safety huddles, newsletters, teaching sessions) and, where appropriate, incorporated into multidisciplinary training.
- Governance records demonstrating that these thematic reports are received and reviewed at Executive Board level each quarter, with any further actions or scrutiny clearly documented.

Safety Action D – Service-user voice and equity

1. Communication equity, language support and accessible information

Trusts should demonstrate continued progress towards ensuring that women and families, including those who may require translation, interpreting support, or reasonable adjustments, are supported to understand their care, options, and decisions at key points in the perinatal journey. Trusts should recognise that where information is not understood, consent may not be informed, valid or lawful. Reliance on family members, friends or informal interpretation must be treated as a patient safety, safeguarding and human rights risk.

What good might look like:

- Clear local processes ensuring timely access to professional interpreters (face-to-face, telephone or video), with usage evidenced in clinical records rather than reliance on relatives or friends.
- Accessible information provided in formats suited to individual needs. For example (and not limited to) translated materials, Easy read versions, visual prompts or communication aids, with records showing how these were offered.
- Staff routinely checking understanding, documenting how consent discussions were supported (e.g. interpreter present, communication aids used) and escalating concerns if communication barriers remain.
- Evidence of reasonable adjustments being made, such as adapted appointment formats, longer consultation times or additional follow-up for those with language or communication needs.
- Service user insight, for example via MNVP or community engagement, informing improvements to communication materials and identifying where families experienced barriers or misunderstandings.
- Governance oversight showing that any communication risks, interpreter usage and themes around informed consent are routinely monitored and included in reports to senior leaders and the Board.
- Use of recognised improvement methodology (e.g. PDSA, driver diagrams, measurable aims) to show structured actions and demonstrable progress.
- Evidence for Board assurance, including audit, spot checks, incident/complaint themes and service user feedback, demonstrates that communication equity processes are consistently applied.

2. Service-user voice driving safety and quality improvement

Trusts must demonstrate that insights from women, families and carers using maternity and neonatal services are captured and used to inform service

improvement plan. Trusts must use demographic data to understand their local population and demonstrate that the voices of women and families from different demographic groups, are actively captured and used to shape priorities within the service.

Progress with this plan should be monitored through established governance routes quarterly to ensure that actions lead to measurable improvements in safety, quality, or experience.

What good might look like:

- Multiple, accessible routes for women, families and carers to share their experiences. For example, through MNVP engagement, listening events, surveys (including Picker), 15 steps type exercises, friends and family tests, community outreach or digital platforms, with evidence that feedback is recorded and reviewed.
- Insights collected from a diverse range of demographic groups, using translation, interpreting support, targeted outreach or community partnerships to ensure under-represented voices are heard.
- A service improvement plan that clearly incorporates service-user feedback, showing how views and suggestions have shaped priorities, actions or pathway changes.
- Routine use of demographic data (e.g. ethnicity, deprivation, protected characteristics, language needs) to identify disparities in experience or outcomes, with associated actions documented and tracked.
- Governance minutes and regular reports demonstrating that progress is monitored, with improvements or gaps escalated as needed.
- Examples of how service-user themes have influenced practice, such as changes to communication materials, adjustments to antenatal or postnatal pathways, or updates to training scenarios.
- Use of recognised improvement methodology (e.g. PDSA, driver diagrams, measurable aims) to show structured actions and demonstrable progress.
- Board-level assurance reports highlighting key service-user themes, equity issues and actions taken, demonstrating that their voices inform decision making at every level (linking with Safety Action F).

Safety Action E – Care Bundles

1. Saving Babies' Lives Care Bundle (SBLCBv3.2) - Quarterly reporting to the Trust Board

The provider must report quarterly to the Trust Board on progress against SBLCBv3.2 implementation. Quarterly reports should demonstrate how the Trust has prioritised the requirements of the Care Bundle based on local progress, implementation status, and any relevant safety intelligence, including learning from local adverse incidents.

In light of the recent NHSE and RCOG fetal growth chart safety communication, Trusts should include a brief review within their local SBL priorities to confirm safe and appropriate fetal growth surveillance, confirming that fetal growth charts and surveillance pathways meet most recent national safety advice and identifying any local risks or improvement actions relating to fetal growth restriction (FGR) detection as highlighted.

What good might look like:

- A clear quarterly report to the Board summarising progress against each SBLCB v3.2 element, using indicators or dashboards (e.g. the national implementation tool where in use) to show implementation status, gaps and recent improvements.
- Evidence that local safety intelligence (e.g. incident themes, PSIRF findings, audit results or learning from MNSI/MBRRACE) is used to prioritise which Care Bundle elements need the most immediate focus locally.
- A short update confirming that fetal growth charts and surveillance pathways comply with current SBLCB v3.2 guidance, with any risks or actions around FGR detection clearly described.
- Documentation showing how actions arising from SBLCB audits or reviews are tracked, escalated and monitored through maternity governance.
- Board-level minutes demonstrating active discussion of SBLCB progress, areas of concern, and decisions about resourcing or improvement priorities.
- Examples of how SBLCB learning has been incorporated into training, communication materials or local pathways, particularly where FGR detection or monitoring processes have been strengthened.

2. Maternal Care Bundle – Implementation Plan

In collaboration with all relevant services, the provider agrees a plan with the Trust Board to implement the Maternal Care Bundle by March 2027. Progress with implementation is reviewed quarterly through established governance routes.

What good might look like:

- A Board-approved implementation plan setting out clear milestones, responsibilities and timescales for achieving full Maternal Care Bundle delivery by March 2027.
- Evidence of collaborative planning with all relevant services (e.g. maternity, anaesthetics, emergency medicine, critical care, community services) reflected in meeting notes or agreed action logs.
- A simple quarterly update that shows progress against each element of the bundle, highlights risks or delays, and outlines the actions being taken to address them.
- Governance oversight demonstrating that progress is monitored through existing maternity/neonatal safety groups, with escalation routes clearly documented.
- Board papers or minutes showing regular discussion of implementation status, resource needs and any required changes to support timely delivery.
- Examples of how learning from incidents, reviews or national guidance has shaped the local implementation approach.

3. Neonatal pulse oximetry testing

Trusts must develop a standardised, equitable, and governance-approved guideline for neonatal pulse oximetry testing, aligned to the BAPM framework. The guideline must describe the required clinical processes, data entry standards, and pathways for all birth settings (including homebirths) to ensure that every baby receives pulse oximetry screening between two and 24 hours of age, with clear escalation processes for babies in the amber and red pathways.

What good might look like:

- A single Trust-wide guideline, or an adopted regional guideline adapted locally if needed, describing consistent screening and escalation processes across all birth settings.
- Clear inclusion of when testing should occur (2–24 hours of age), how results should be documented and how amber/red pathways should be escalated.
- Evidence that the guideline has been approved through maternity/neonatal governance, with a plan in place for implementation and staff awareness.
- Routine review through governance to ensure the guideline remains aligned with BAPM expectations and that progress towards implementation continues.

Safety Action F – Board Oversight, Governance, Culture and Leadership

1. Board Oversight of Maternity and Neonatal Quality and Safety

Trusts must demonstrate that, through established governance routes, the Board routinely receives, reviews and responds to a comprehensive assessment of maternity and neonatal quality and safety. This assessment should cover training, workforce, staff and service user experience, and progress against the care bundles as **outlined in Safety Actions A–E**. Trusts must also ensure that findings arising from detailed scrutiny at the Quality Governance Committee are formally escalated to the Executive Board, providing full oversight in line with good governance practice and the expectations of the Perinatal Quality Oversight Model (PQOM). Where Trust-level mitigation is insufficient, escalation to Regional Midwifery Officer teams should be documented, alongside PQOM-aligned actions.

What good might look like:

- Regular Board-level maternity and neonatal quality and safety reports bringing together key themes from training, workforce, incidents, complaints, service-user feedback, clinical outcomes and care bundle progress.
- Evidence that the Quality Governance Committee (or equivalent with delegated authority) undertakes detailed scrutiny of these reports, with key metrics, themes, risks and required actions formally escalated to the Executive Board through established governance routes.
- Executive Board minutes showing active discussion, curiosity, challenge and follow-up, including requests for further assurance where needed, and decisions relating to resourcing, risk mitigation, targeted improvement work and alignment with wider strategic priorities and future planning.
- A consistent governance cycle ensuring all required information (e.g. from Safety Actions A–E) is reported at the correct frequency, supported by dashboards or trend analyses (ideally SPC-based) to demonstrate performance over time.
- Clear documentation of how deep-dive findings or emerging risks identified at the Quality Governance Committee level are escalated, recorded and tracked for impact at Executive Board level.
- Examples of improvements or policy changes made in response to Board scrutiny, demonstrating that oversight leads to measurable changes in safety, quality and experience.

2. Maternity Outcomes Signal System

Trusts must evidence that the critical safety check (Annex one of the MOSS standard operating procedures) was completed in the event of signals, or that a test drill was carried out. An accountable trust Board Executive (i.e. Chief Nurse, Chief Medical Officer or Executive Trust Board Safety Champion) must approve completed checks, including drills. This will be externally validated through regional assurance -

services must send a completed copy of critical safety check(s) or test drill to regions, for forwarding to the national team at england.moss@nhs.net.

What good might look like:

- A clear local process ensuring that whenever a MOSS signal is triggered, the critical safety check is promptly completed using the Annex 1 template, or a structured test drill (Annex 9) is undertaken as part of routine annual practice as per the standard operating procedures.
- Completion of Annex 1 showing timely completion of checks or drills, with the responsible executive reviewing and approving each one, and their approval clearly recorded.
- Checks and drills are not reliant on a single individual - perinatal leadership teams complete through co-production with staff working on the labour ward.
- Routine submission of each completed critical safety check or drill to the regional chief nurse, midwife, obstetrician and medical director (as per the standard operating procedures), and the regional assurance team.
- Perinatal leadership teams can arrange a meeting with the national MOSS project team at NHS England to discuss any aspect of MOSS. Half-hour slots are available on Mondays between 1.30pm-3pm. Please contact england.moss@nhs.net to arrange.
- Local governance oversight confirming that safety issues identified through MOSS checks are escalated for discussion to the next public trust board meeting for acting on.
- Continued trust board oversight and active engagement to ensure changes or improvements are made at the required speed, with examples of these highlighted at trust board meetings.

3. Maternity and Neonatal Board Safety Champions

Trusts must demonstrate that Maternity and Neonatal Board Safety Champions are actively supporting the perinatal leadership team (including the MNVP Lead where they are in commissioned in line with MNVP guidance), embedding a positive local safety culture, with regular two-way communication and clear escalation to the Trust Board.

What good might look like:

- Regular contact between Board Safety Champions and the perinatal leadership team (including MNVP representatives), with clear evidence of two-way communication about safety themes, service-user concerns and improvement priorities.
- Attendance or involvement of Safety Champions at key maternity and neonatal meetings, walk-arounds, listening events or MNVP sessions,

demonstrating visible leadership and active engagement with staff and families.

- A clear process for escalating risks, concerns or emerging themes from frontline teams and service users to the Executive Board, supported by brief notes or agreed actions.
- Documentation showing Safety Champions influencing priorities. For example, by supporting resource requests, endorsing improvement work, or ensuring alignment with wider Trust strategy.
- Inclusion of Safety Champion updates within regular governance and Board reports, demonstrating their ongoing role in oversight, assurance and the promotion of a positive safety culture.
- Examples of improvements or changes made as a result of Safety Champion involvement, showing impact rather than representation alone.

4. Perinatal Culture Improvement Plan

Trusts must demonstrate that they have a perinatal culture improvement plan in place which triangulates data and engagement from multiple sources, uses recognised improvement methodology to evidence progress and impact, and is reviewed by the Trust Board at least six-monthly.

What good might look like:

- A clear perinatal culture improvement plan that draws together insights from staff surveys, focus groups, staff walkarounds, service-user feedback (including MNVP), incident and audit findings, workforce data, and safety intelligence, user feedback (including MNVP), incident and audit findings, workforce data, and safety intelligence.
- Use of recognised improvement methodology (e.g. PDSA, driver diagrams, measurable aims) to show structured actions and demonstrable progress.
- Evidence that staff and service users are engaged in shaping priorities, with themes reflected in the plan and tracked over time.
- Regular updates through maternity/neonatal governance showing what has improved, what remains challenging, and what actions are underway.
- Inclusion in quarterly Board reports (aligning with sub-action F1) demonstrating scrutiny, discussion and follow-up actions, including requests for further assurance where needed.
- Examples of changes made in response to the plan, such as improvements to teamwork, communication, psychological safety, or escalation behaviours, showing real cultural impact.

Appendix 1 - Technical Guidance

Safety Action B – Training

<table>
<tr><td>How will the 90% attendance compliance be calculated?</td><td>The training requires 90% attendance at two pre-determined points during the MIS Year (April to November 2026): 30 November (mandatory MIS checkpoint), and one other Trust selected checkpoint, at the following training where applicable dependant on staff group:

1. Fetal monitoring training
2. Multi-professional maternity emergencies training
3. Neonatal resuscitation training</td></tr>
<tr><td>Which maternity staff should be included for Fetal monitoring and surveillance (in the antenatal and intrapartum period)?</td><td>Staff who have any antenatal or intrapartum obstetric responsibility must attend the fetal surveillance training, either through their substantive role, or in the event of escalation.

Maternity staff attendees must be 90% compliant for each of the following groups to meet the minimum standards:

• Obstetric Consultants and SAS Doctors.
• All other Obstetric Doctors contributing to the obstetric rota (without the continuous presence of an additional resident-tier Obstetric Doctor).
• Midwives (including Midwifery Managers and Matrons, Community Midwives; Birth Centre Midwives (working in co-located and standalone birth centres and bank/agency midwives). Maternity Theatre Midwives who also work outside of theatres.

Staff who do not need to attend include:

• Anaesthetic staff
• Neonatal staff
• Maternity Critical Care staff (including Operating Department Practitioners, Anaesthetic Nurse Practitioners, Recovery and High Dependency Unit Nurses providing care on the maternity unit)
• MSWs
• GP and Foundation Level Trainees</td></tr>
<tr><td>Which maternity staff should be included for Maternity emergencies and multi-professional training?</td><td>Maternity staff attendees must include 90% of each of the following groups to meet the minimum standards:

• Obstetric Consultants and SAS Doctors.
• All other Obstetric Doctors including Obstetric Trainees (ST1-7), Sub-Speciality Trainees, Locally Employed Doctors (LED), Foundation Year Doctors and GP Trainees contributing to the obstetric rota.
• Midwives (including Midwifery Managers and Matrons), Community Midwives; Birth Centre Midwives (working in</td></tr>
</table>

	co-located and standalone birth centres) and bank/agency Midwives. • Maternity Support Workers and Health Care Assistants (to be included in the maternity skill drills as a minimum). • Maternity theatre staff are a vital part of the multidisciplinary team and are encouraged to attend the maternity emergencies and multiprofessional training, however they will not be required to attend to meet MIS Year 8 compliance assessment. • Neonatal staff are a vital part of the multidisciplinary team and are encouraged to attend the maternity emergencies and multiprofessional training, however there will be no formal threshold for attendance required to meet MIS Year 8 compliance.
What maternity emergencies and multi-professional training do anaesthetists need to attend?	The following anaesthetic team members are required to attend a minimum of half of the wider MDT maternity emergencies training day. The schedule of the day should ensure the anaesthetists are able to join those locally agreed scenarios most relevant to anaesthetic involvement (e.g. PPH) • Obstetric Anaesthetic Consultants and autonomously practising Obstetric Anaesthetic Doctors. • All other obstetric anaesthetic doctors (staff grades and anaesthetic trainees) who contribute to the obstetric rota. This updated requirement is supported by the RCoA and OAA. Sharing of learning with the wider anaesthetic team (that do not have regular responsibilities in maternity, but may be called upon in escalation) after the training with a focus on local learning is best practice.
Training attendance for agency staff	It is the responsibility of the employing agency to provide training for their staff, so these staff will not be included in your MIS declaration. However, it is the responsibility of the Trust to ensure that all agency staff have met minimum training requirements before working in the Trust.
Long-term sickness and maternity leave	Any staff absent from work due to long-term sickness (>28 days) or on maternity / parental leave (28 days) will be unable to work clinically or attend training while absent, so these staff will not be included in your MIS declaration while they are absent from work, and for one month after their return. These staff should be prioritised to attend any outstanding training as soon as possible on their return.
Training attendance for	It is the gold standard that all staff attend training in the unit that they are currently working in, so that they can benefit from local learning and training alongside their multi-disciplinary

rotational medical staff	colleagues, however it is appreciated that this may be especially challenging for rotational staff. In the following circumstances, evidence from rotating resident doctors having completed their training in another maternity unit will be accepted: • Staff must be on rotation. • The training must have taken place in any previous Trust on their rotation during the MIS training reporting 12-month period. This evidence may be a training certificate or correspondence from the previous maternity unit.
Rotational staff, and staff new to the organisation	Staff still working in their formal induction period will not be included in your MIS declaration until their induction period is completed. For all staff, training should be completed as soon as is practicable, and no later than three months after starting with the organisation. Training attendance as part of a formal trust induction is best practice.
Where do the multidisciplinary obstetric emergency drills need to take place? **Do we need to include paramedics in the community scenario?**	At least two emergency scenario/drills should be conducted during the whole MIS reporting period. One in a hospital based clinical area, and another starting in a community / home location The hospital clinical area can be any area where clinical activity takes place e.g. Delivery Suite, any clinic, ED, theatre, a ward. This should not be a simulation suite. Attendance from the relevant wider professional team is strongly encouraged, including (where applicable) theatre staff, paramedics, porters, haematology services and neonatal staff. This will require shared planning and cross-agency support. Learning from recent PFD reports highlights the importance of this multi-agency approach.
Which staff should be included for neonatal resuscitation training?	The staff listed below are required to attend neonatal resuscitation training within MIS Year 8: • Neonatal Consultants/SAS Doctors or Paediatric Consultants/SAS Doctors covering neonatal units. • Neonatal resident Doctors (who attend any births) • Neonatal Nurses (Band 5 and above) • Advanced Neonatal Nurse Practitioner (ANNP) • Midwives (including Midwifery Managers and Matrons), Community Midwives, Birth Centre Midwives (working in

	co-located and standalone birth centres) and bank/agency Midwives. The staff groups below are not required to attend in-house neonatal resuscitation training within this MIS year: • Staff who have already attended an external neonatal resuscitation training course consistent with BAPM basic capability Neonatal Airway Capability or above (including external courses such as NLS) during MIS Year 8 • NLS instructors that have taught on a course during MIS Year 8 • All Obstetric and Anaesthetic Doctors (Consultants, SAS, LE Doctors and Anaesthetic Trainees) contributing to the obstetric rota. • Maternity Critical Care staff (including Operating Department Practitioners, Anaesthetic Nurse Practitioners, Recovery and High Dependency Unit Nurses providing care on the maternity unit). • Local policy should determine whether Maternity Support Workers are included in basic neonatal resuscitation dependent on their role within the service. • If Nursery Nurses work within the service, this should also be recognised in your local training needs analysis.
Which members of the team can teach basic neonatal resuscitation?	Registered RC-trained NLS instructors should deliver the in-house neonatal resuscitation training annual updates and assessments in line with BAPM Neonatal Airway Basic Capability standards.
Neonatal resuscitation training	All staff that require training should be trained and assessed in line with The British Association of Perinatal Medicine Neonatal Airway Safety Standard Framework for Practice (April 2024). All neonatal [and maternity] staff undertaking responsibilities as an ***unsupervised*** first attender / primary resuscitator attending any birth must have reached a minimum of 'basic capability' as described in the BAPM Neonatal Airway Capability Framework. No specific training course is mandated. However, the Resuscitation Council UK Neonatal Life Support (NLS) provider certification includes all skills required for Basic capability and most skills required for Standard capability.

	Staff that attend births **with supervision at all times** will not need to complete this assessment process for the purpose of MIS compliance.
Enhanced neonatal resuscitation training	Where additional or enhanced neonatal resuscitation training is already in place for specific staff groups, this should continue (e.g. NLS or equivalent). Local decisions may determine which staff receive enhanced training, but priority should be given to staff who may act as the primary resuscitator at any birth, whether in hospital or in community settings. Organisations should consider neonatal resuscitation training for Tier 2 and Tier 3 neonatal staff, ensuring formal training on the skills and scenarios required to meet intermediate airway capability as described in the BAPM Neonatal Airway Safety Standard, with annual training for staff on Tier 2 and Tier 3 neonatal rotas.

Safety Action C – Learning from Reviews and Investigations

1. Reporting and review: Notify all qualifying events and deaths	
1a. Qualifying events and deaths are defined as:	• Details of which perinatal deaths must be notified to **MBRRACE-UK** are available at: www.npeu.ox.ac.uk/mbrrace-uk/perinatal-programme • Notification and surveillance information must be provided for babies who die after a home birth where the care was provided by your Trust and those babies who die at home having been discharged from your Trust. • All maternal deaths during pregnancy and up to one year following the end of the pregnancy (regardless of how the pregnancy ended) must be notified to **MBRRACE-UK.** • Details of which maternal deaths, perinatal deaths and babies with brain injury must be notified to Maternity and Newborn Safety Investigations (**MNSI**) programme are available at: https://www.mnsi.org.uk/for-nhs/investigation-overview-for-nhs/#what-we-investigate • Details of which babies with brain injury must be notified to **NHS Resolution (NHSR) EN** scheme are available at, we strongly recommend that reporting occurs within 14 days, this is to support NHS Resolution commence engagement with families: https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/early-notification-scheme/support-for-nhs-trusts-or-member-organisations/
1b. The process and timeline for event/death notification and use of the data:	• Notifications of all the events and deaths listed above are made through the NHS England Submit a Perinatal Event Notification (SPEN) portal, which automatically directs information about the appropriate deaths/events to MBRRACE-UK, MNSI and the NHSR EN scheme. • For the purposes of the maternity incentive scheme (MIS), all eligible perinatal deaths and events for MBRRACE-UK and MSNI must be notified via SPEN within seven working days of the death/event. • Neonatal deaths notified via SPEN to MBRRACE-UK continue to be automatically and

	immediately transferred to the appropriate local Child Death Overview Panel (CDOP) via the Cascade system. See 1(c) below for the timings for notifying neonatal deaths. • Once eligible perinatal deaths have been notified to MBRRACE-UK via SPEN, MBRRACE-UK users should log on to the MBRRACE-UK/PMRT system to complete the surveillance information; and PMRT users should log on to start the PMRT review for eligible deaths. • When referring through SPEN an event that meets MNSI and NHSR EN criteria the portal will provide guidance to complete the submission as an MNSI reference number will be requested to support referral to NHSR EN. • The MOSS system also automatically receives a Trust-specific data feed from the relevant events notified via SPEN.
1c. The statutory obligation to notify neonatal deaths to local CDOPs:	• The Child Death Review Statutory and Operational Guidance (England) sets out the obligations of notification of neonatal deaths to local Child Death Overview Panels. • Neonatal deaths must be notified to Child Death Overview Panels (CDOPs) within two working days of the death (where working days are regarded as Monday to Friday). • This guidance is available at: https://www.gov.uk/government/publications/child-death-review-statutory-and-operational-guidance-england
1d. Checking notifications:	• MBRRACE-UK system users can log on to the MBRRACE-UK/ PMRT system to check the deaths they have notified are complete and correct. • MBRRACE-UK system users must log on to MBRRACE-UK to complete the surveillance information and to start a PMRT review.
2. Reporting and review: Seek parents' views of care	
2a. For the deaths of all babies in your trust eligible for PMRT review ensure parents are given multiple opportunities to meaningfully provide their experience of all	• Parents must be informed following the death of their baby, and preferably in person before leaving hospital, that a local review of all elements of their care and that of their baby will take place. • In the case of a neonatal death, parents should also be told that a local CDOP review will also be undertaken.

elements of care and the impact of that care, and raise any questions and comments they may have prior to the PMRT review starting.	• Verbal information should be supplemented with written information using plain language and translated formats where necessary. • Parents' experience of all elements of their care must be treated as essential information required to complete the clinical picture for a meaningful review. The review process is primarily for parents, and only by incorporating parents' experiences, perspectives and questions can the Trust understand how care was offered, given and received by parents. This information must be entered into the PMRT to enable it to form part of the review; the parent questions appear first in the PMRT to reflect their central importance. • Without being intrusive parents should be given multiple opportunities to meaningfully provide information about their experience of care, and the impact of that care, and to raise any questions and comments they may have. • The process of gathering parents' experiences must start at least two weeks before the review begins. A trauma-informed approach should be considered. https://www.gov.uk/government/publications/working-definition-of-trauma-informed-practice Trauma-informed care in the UK: where are we? A qualitative study of health policies and professional perspectives | BMC Health Services Research • It is important to recognise that gathering parent experiences across antenatal, intrapartum, postnatal, bereavement, and neonatal care may require more than one conversation or meeting, including in-person discussions where appropriate. Templates for gathering this as written information can also be used where appropriate and examples are provided on the PMRT website: https://www.npeu.ox.ac.uk/pmrt/parent-engagement-materials. Other materials to support the parent engagement process are also provided on that page. • If information about parent experiences is held in another data system it needs to be brought to the review meeting, entered into the PMRT and considered as part of the review discussion. • In communications with parents' staff should ensure they approach this with the principles of equity in mind to ensure that socially

	disadvantaged, disabled and ethnic minority parents are positively included. It also is important that the process of parent engagement is guided by the parents. A single key professional contact can help parents navigate this difficult process. • Parents should be given the opportunity to review, amend or add to their reflections before the review begins if they wish.
2b. Ensure parents' feedback informs the review, the findings and actions, and that unmet requirements are addressed.	• Trusts should conduct quarterly audits of whether family feedback has been reflected upon in PMRT reviews and whether their feedback influenced review findings and actions, including clear "you said, we did" examples. • Where requirements are not met for all eligible deaths, this should be escalated to the Board through the quarterly report, setting out the reasons and the resulting SMART actions. • SMART actions must be co-developed with MNVPs and service user representatives and integrated into the wider service-level improvement plan, aligned with other quality, safety and equity priorities. Progress should be monitored and reported through existing governance and assurance structures.
2c. Ensure all parents are given the opportunity to be involved in the review process, including where they choose not to engage or do not respond.	• Trusts must ensure that all parents are informed that a review will take place and should ensure that participation options are accessible to all parents, including through plain language and translated or interpreted materials where required (see point 2b). • Parents' decisions not to engage must be respected. However, some parents may change their mind; without being intrusive, Trusts must provide more than one opportunity for them to contribute. • Where parents do not respond, Trusts should consider the steps set out in the PMRT parent engagement guidance, including use of the flow chart and where appropriate the translated parent-facing materials available on the PMRT website.
3. Reporting and Review: Include external reviews in the PMRT review panel	
3a. For a minimum of 60% of the deaths reviewed external	• External panel member(s) must be relevant senior clinician(s) who are currently practicing clinically and work in a hospital external to the

<table>
<tr><td>members of relevant specialties must be present at the multi-disciplinary review and this should be documented within the PMRT.</td><td>trust undertaking the review and external to any trust involved in the care at any stage. Ideally, the external reviewer(s) should be the specialist(s) relevant to the care provided, for instance an obstetrician for all deaths, and a neonatologist for neonatal deaths.
• A gold standard review of a neonatal deaths would involve an external obstetrician and an external neonatologist.
• In addition to currently practicing clinically an external reviewer could be, for example, a member of another Trust/Health Board governance team. However, they must possess relevant clinical expertise, be up-to-date with training and continuing professional development (CPD), and either currently undertake clinical shifts or be in a position to do so if required. This is crucial because externality demands clinical credibility, requiring the experience and current knowledge necessary to reflect on care provision and offer authoritative, robust, objective challenge when required.
• If more than one Trust is involved in the review because more than one Trust was involved in the care, none of these staff members are ‘external’ panel members because they cannot provide an independent view of the care. They should not be listed as ‘external’ members in the PMRT participant list.
• Although an MNVP member is not employed directly by the Trust they should not be regarded, nor documented as, an ‘external’ member. They are present to represent the wider parent voice.
• Parents value highly the independence of review that comes with the involvement of externals as otherwise Trusts are regarded as ‘marking their own homework’.

Note that this is a minimum requirement for Year 8 of 60% of reviews having an external member present for the MDT meeting.</td></tr>
<tr><td colspan="2">4. Sharing information with families: Provide relevant information to parents about the role of investigations and reviews</td></tr>
<tr><td>4a. Provide relevant information regarding the role of MNSI, NHSR EN scheme and PMRT reviews to families in a</td><td>• Information provided to parents and families should clearly explain, in plain language what reviews and/or investigations are relevant to their circumstances. For example, all perinatal deaths (but not babies with brain injury) will have a</td></tr>
</table>

format that is relevant and accessible to them. Information about duty of candour must be provided for all parents where the event is eligible for duty of candour.	PMRT review. Whereas, for example, early neonatal deaths at term will have a PMRT review, be eligible for an MNSI investigation, a statutory CDOP review will take place, and the death may be referred to the coroner. • Information could include a link to 'Learn Together', to support parents' and families' understanding of learning and improvement following adverse outcomes and reinforcing principles of openness, shared learning, and partnership with parents. • Where relevant, information must include a link to the Duty of Candour (Regulation 20) guidance, explaining families' rights to openness and honesty following incidents. • Using branded MNSI materials where available will help to ensure consistency and clarity. If there are any queries in relation to MNSI these can be directed through the trust MNSI link team member or Enquiries@mnsi.org.uk • PMRT parent-facing materials are available to be used to explain the local review process, the role of parent experience within the review, and how parents' questions and perspectives are included. These materials are available to be modified in line with Trust-specific processes. • During the development of local written and digital materials, an accessibility assessment should be completed for all written and digital materials, considering language, literacy, disability, sensory needs, digital access, and cultural appropriateness. Materials should be provided in translated or alternative formats where required. Translated materials are provided by PMRT and NHSR EN scheme. • When interacting with parents an assessment of comprehension should be undertaken, to ensure parents understand the information provided. This should include opportunities for parents to ask questions, check understanding, and request further explanation or support, rather than relying solely on written information. • Information should be provided in a trauma-informed way https://www.gov.uk/government/publications/working-definition-of-trauma-informed-practice, recognising that families may need time and more than one opportunity to engage with and

	understand complex processes. The following is a list of links and advice to consider when providing information for parents and families: • PMRT parent engagement materials (including materials translated into some other languages): Parent Engagement Materials | PMRT | NPEU • MNSI information for families: https://www.mnsi.org.uk/for-families/ • NHS Resolution family pages: Support for families or carers - NHS Resolution • NHS Resolution Early Notification Scheme information animation: Early Notification Scheme animation on Vimeo • NHS Resolution translated resources: Translated resources - NHS Resolution • Consideration of information accessibility: https://www.england.nhs.uk/accessible-information-standard/ • Duty of candour: https://www.cqc.org.uk/guidance-regulation/providers/regulations-service-providers-and-managers/health-social-care-act/regulation-20/incidents • Learn Together: https://learn-together.org.uk/
5. Sharing information with families: Offer parents a meeting to share report findings	
5a. Offer parents a meeting with relevant specialists to share the findings with them from reviews and investigations, and relevant incident reports.	• Trusts must ensure that parents are offered a meeting to share the findings with them from PMRT reviews, MNSI investigations, and other relevant reviews or incident reports. These meetings should be centred on the needs of parents. https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-2.-Engaging-and-involving...-v1-FINAL.pdf • Where this meeting is to discuss care of a baby who received neonatal care ensure that that this is a joint meeting with both maternity and neonatal staff. • The purpose of this meeting is to discuss with parents what has been reviewed, what has been found, and what learning or actions have been identified, using plain language and avoiding technical or defensive terminology. This should also include discussion of any implications for their future care.

	• The discussion should be at a pace and in a format that is guided by the parents. This may require more than one meeting and must allow families time to process information and ask questions. • Families should be supported to understand how their experiences, perspectives, and questions were considered within the PMRT and other review processes, and how these influenced findings and actions. • Where review findings are shared in writing, these must be accompanied by a verbal explanation and opportunities for clarification. Written materials must use plain language and be provided in translated or alternative formats where required. The letter should describe what was discussed in the meeting and provide a summary of the PMRT report in understandable non-technical language. • Trusts should avoid one-off or transactional communication. Follow-up contact must be offered so families can raise further questions after receiving or reflecting on the information they have received so far. • Where families do not wish to engage directly, or find direct engagement too distressing, they should be offered the option to receive information. For example, the offer of an on-line appointment for parents who do not wish to attend the hospital where their baby died. Providing a letter which summarises the review findings which in two envelopes so if they do not wish to read the review information they can decide not two open the second envelope – a covering letter should explain this. Offering a follow-up appointment for a later date when they feel ready to receive the information. Offering an open appointment which they can take up in the future if and when they feel ready to receive the information. • Trusts should ensure that learning and actions shared with families are consistent with what is reported through governance structures, including Boards and PQOM, to avoid conflicting messages or loss of trust. • MNSI has a tripartite meeting process in place, this is where they support the trust to meet with the family when a safety investigation has been completed. This enables a discussion to go through the findings and recommendations and

	for the Trust to share how these will be taken forwards.
6. Learning and Governance: Implement system and process actions	
6a. Implement system and process actions in response to learning from investigations (including MNSI, NHSR EN scheme), local reviews (including PMRT reviews) and national reports which will improve the provision of safe care in your trust.	• Learning from MNSI investigations, PMRT reviews, NHSR EN reports, other local reviews/investigations and national reports must be translated into SMART system and process actions which are clearly owned. • Actions must not sit in isolation. They must be incorporated into an existing service-wide action plan and/or improvement tracker, aligned with wider priorities for quality, safety, equity, and subject to formal Board oversight. • Where appropriate actions should be co-developed with MNVPs and/or service user representatives, ensuring that proposed changes reflect family experience. • For multi-site Trusts, learning should be assessed at site level, with evidence of site-specific actions and implementation. Trusts should develop more than one action where learning applies differently across sites. • When deciding which system-level actions to implement, Trusts should explicitly consider and align actions with themes reported to the Board, prioritising actions most likely to deliver meaningful and sustained change. This approach supports effective Board scrutiny and facilitates access to resources where required. • Progress against actions should be monitored through existing governance arrangements, with clear reporting on delivery, impact, and any barriers to implementation.
7. Learning and Governance: Thematic reports of learning, actions and outcomes	
7a. Thematic reports of learning and actions that triangulate information and summarise learning and progress on actions arising from MNSI and NHSR EN reports, local PMRT and PSIRF reviews, MOSS critical safety checks, NHSR claims scorecards and	• See below for the guidance on the contents of the thematic reports. • Submit and discuss these reports with the Trust Perinatal and Board Level Safety Champion prior to submission to the Trust Executive Board with a minimum frequency of quarterly. • Larger Trusts with larger number of deaths/events may report more frequently than quarterly. • Authorised PMRT users can generate reports for their trust which summarise the results from completed PMRT reviews over a period of time

relevant national reports. Trusts must also use demographic data to identify and understand any disparities in outcomes. These must be discussed with the Trust Perinatal and Board Level Safety Champions and submitted to the Trust Executive Board at least quarterly. Reports should clearly demonstrate the measures implemented to address recurrent themes, including how learning has been shared and, where appropriate, incorporated into existing multidisciplinary training.	defined by the user. These are available under the 'Your Data' tab in the section entitled 'Perinatal Mortality Reviews Summary Report and Data extracts'. These reports can be used to support the writing of the quarterly reports. Note that these reports will only show summaries, issues and action plans for reviews that have been completed and published, therefore the time period selected may need to relate to an earlier period than the current quarter and may lag behind the current quarter by up to six months. • These reports should be a synthesis of learning and emerging findings. For learning based on events and deaths in the trust the learning should be cumulative and emergent, rather than just relating to the specific quarter. This way recurrent issues and themes across longer periods of time can be highlighted rather than treating the findings, based on a relatively small number of events/deaths, in each quarter in isolation. • These reports provide the important evidential basis for escalating key risks, recurrent themes, and resource requirements to the Executive Board
Suggested report headings	
(i) Where the learning has come from	• Describe where the learning reported this quarter has come from. This may be from MNSI investigations of events in your trust, local PMRT reviews, a MOSS critical safety check(s), recent PSIRF findings, a recent national report issued by MNSI, a recent national report issued by MBRRACE-UK, a recent national report from a hospital specific enquiry e.g., the East Kent Inquiry, your Trust CQC report, Coronial Prevention of Future Deaths notices, and the NHS Resolution EN scheme. • Trusts with larger numbers of deaths are encouraged to submit reports more frequently than quarterly. • For smaller trusts there may not have been any specific deaths/events in the particular quarter to report. In this situation include the analysis of recent national reports and how their relevance has been considered in the trust and what actions, if any, have followed

	• Important evidence of learning also comes from service user feedback, and this should be triangulated with other relevant learning.
(ii) What learning and actions have been prioritised	• Describe what learning and actions you have identified and how have these been prioritised to support safe care in your perinatal services. Describe how, in this process, the learning and actions have been triangulated with information about parents' experience, quarterly insight reports from MNVPs, complaints, CQC survey findings etc.
(iii) What actions have been implemented	• Describe the actions you have implemented to provide safer care in response to your learning priorities.
(iv) What impact have earlier actions had	• Describe the safer care impacts and outcomes that have been seen following the implementation of earlier actions. This is to demonstrate sustained actions and impact.
(v) What you need help with from the Executive Board	• Highlight areas of challenge, key risks and recurrent themes, and whether these have been included on your risk register and what mitigation has been put in place. Describe what additional help/resources are required to meet these challenges.

MIS FAQ

What do you mean by Trust Board?	Unless explicitly stated, Trust Board can be interpreted as 'the Trust Board or appropriate sub-committee with delegated authority' as long as these sub-committees provide Trust Board with output following their review and discussion.
Why aren't we reporting everything directly to Trust Boards?	Trust Boards have a broad scope of responsibility, covering all aspects of the Trust's governance, strategy, and finances. They provide strategic direction and oversight, while sub-committees such as the Quality Governance Committee takes a more hands-on role in monitoring quality and safety performance reviewing and scrutinising operational detail. It is vital that the most pertinent information that is conveyed to Trust Boards is clearly recognised and not lost in the operational detail of reporting. A sub-committee's in-depth examination of data, reports, and practices provides the Board with a clear understanding of the Trust's performance on quality and safety, including any immediate priorities or exceptions.
How can I evidence an appropriate sub-committee?	A Board Assurance Framework should highlight the decision-making processes within a Trust and detail those committees with delegated authority from the Board. Individual Terms of Reference from sub-committees should also contain this information. Minutes of sub-committee meetings should demonstrate that the required discussion around MIS safety actions have taken place, including any output which will be conveyed to the Trust Board. This must be recognised within Trust Board minutes.
What is a Quality Governance Committee (or equivalent), and how does it differ from a Trust Board?	A QGC (or equivalent) is a committee of the Trust Board responsible for overseeing the Trust's quality and safety governance arrangements. It provides assurance to the Trust Board that the Trust has robust systems in place to identify, assess, and mitigate risks to patient safety. The QGC also reviews the Trust's quality improvement initiatives and provides recommendations to the Trust Board. The information presented to a QGC will be more detailed and specific than the information presented to the Trust Board. They should receive regular updates on the Trust's performance in key quality and safety areas, as well as specific data on individual incidents and concerns. The QGC should also have the opportunity to discuss the

	Trust's quality improvement plans and provide feedback and recommendations. A QGC is appropriate to review evidence around safety actions, provide additional scrutiny **and then report to the Trust Board, delivering a summary and highlighting any exceptions or particular areas of concern.** **It is important to ensure that this process facilitates Trust Board oversight, rather than replaces it.**
Where can I find more information about Board Reporting via Quality Governance Committees?	Effective Board Assurance Committees Quality Governance in the NHS
Does 'Board' refer to the Trust Board or would another committee suffice for the Board notification form?	Trust Boards must self-certify the Trust's final MIS declaration following consideration of the evidence provided. It is recommended that all executive members e.g. finance directors are included in these discussions. If subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of governance which we will escalate to the appropriate arm's length body/NHS system leader. We escalate these concerns to the CQC for their consideration if any further action is required, and to the NHS England regional director, the Deputy Chief Midwifery Officer, Regional Chief Midwife and Department of Health and Social Care (DHSC) for information. In addition, we now publish information on the NHS Resolution website regarding the verification process, the name of the Trusts involved in the MIS re-verification process as well as information on the outcome of the verification (including the number of safety actions not passed).
What documents do we need to send to you?	The Board declaration form will need to be sent to NHS Resolution. Ensure the Board declaration form has been approved by the Trust Board, signed by the Trust CEO and AO (ICB). Where relevant, an action plan is completed for each action the Trust has not met. **Please send only the Board notification form to NHS Resolution. Do not send your evidence or any narrative related to your submission to NHS Resolution unless requested to do so for the purpose of reverification.**

	Any other documents you are collating should be used to inform your discussions with the Trust Board. These documents and any other evidence used to assure the Board of your position must be retained. In the event that NHS Resolution are required to review supporting evidence at a later date it must be made available as it was presented to support Board assurance at the time of submission.
Where can I find the Trust reporting template which needs to be signed off by the Board?	The Board declaration Excel form will be published on the NHS Resolution website in 2026 and all Trusts will be notified. It is mandatory that Trusts use the Board declaration Excel form when declaring compliance to NHS Resolution. If the Board declaration form is not returned to NHS Resolution by 12:00 on 2 March 2027, NHS Resolution will treat that as a nil response.
Will you accept late submissions?	We will not accept late submissions. The Board declaration form and any action plan will need to be submitted to us no later than **12:00 on 2 March 2027**. If not returned to NHS Resolution by this time, NHS Resolution will treat that as a nil response.
Our Trust has queries, who should we contact?	Any queries prior to the 2 March 2027 must be sent in writing by e-mail to NHS Resolution via nhsr.mis@nhs.net
Please can you confirm who outcome letters will be sent to?	The MIS outcome letters will be sent to Trust's nominated MIS leads.
What if Trust contact details have changed?	It's the responsibility of the Trusts to inform NHS Resolution of the most updated MIS link contacts via the link on the NHS Resolution website.
What if my Trust has multiple sites providing maternity services?	Multi-site providers will need to demonstrate the evidential requirements for each individual site. The Board declaration should reflect overall actions met for the whole Trust.
Will there be a process for appeals this year?	Yes, there will be an appeals process. Trusts will be allowed 14 days to appeal the decision following the communication of results. The Appeals Advisory Committee (AAC) will consider any valid appeal received from participating Trusts within the designated appeals window timeframe. There are two possible grounds for appeal:

	• Alleged failure by NHS Resolution to comply with the published 'conditions of scheme' and/or guidance documentation. • Technical errors outside the Trusts' control and/or caused by NHS Resolution's systems which a Trust alleges has adversely affected its CNST rebate. NHS Resolution clinical advisors will review all appeals to ensure validity, to determine if these fall into either of the two specified Grounds for Appeal. If the appeal does not relate to the specified grounds, it will be rejected, and NHS Resolution will correspond with the Trust directly with no recourse to the AAC. Any appeals relating to a financial decision made, for example a discretionary payment made against a submitted action plan, will not be considered. Further detail on the appeals window dates will be communicated when final results are confirmed and sent to Trusts.
How does the financial element of the scheme work?	NHS Resolution introduced the MIS to support the delivery of safer maternity care through the introduction of an incentive element to contributions to the CNST. NHS Trusts that provide maternity services are charged an amount in addition to their CNST maternity contribution for the MIS. Where a trust has successfully demonstrated achievement against the ten safety actions, it will recover its element of MIS contribution that went into the maternity incentive fund, plus a share of any unallocated funds. **This rebate will be returned to the original funding source**. Trusts unable to demonstrate achievement of the ten actions may be able to apply for a lesser sum from the fund to help them achieve any unmet actions. Where a reverification of a prior year takes place, if the trust is found to have mis-declared compliance it must immediately repay to NHS Resolution the funds originally awarded for that MIS year. This is irrespective of the reverification being conducted in a different financial year. Any funds retrieved from non-compliant trusts will be redistributed to all trusts that achieved compliance for the applicable MIS year. This redistribution will take place within in the same financial year that NHS Resolution receives the returned funds. As NHS Resolution is not deemed a supplier in this arrangement and the arrangement does not meet the definition of a contract, the monies received from the scheme are considered out of scope of IFRS 15. Instead,

	they are treated as per IAS 1, in that the receipts of funds are offset against the cost of the scheme.
If we haven't spent our MIS funds, can we carry them over to the next financial year.	You will need to adhere to the relevant statutory accounting standards for NHS bodies that this may fall under. NHS Resolution has no influence over this, and if you need any further guidance on the accounting treatment then we recommend speaking to your regional finance contact at NHS England.
Merging Trusts	Trusts that will be merging during the Year 8 reporting period (March 2026 – March 2027) must inform NHS Resolution of this via nhsr.mis@nhs.net so that arrangements can be discussed. In addition, Trust's Directors of Finance or a member of the finance team must make contact with the NHS Resolution finance team by email at nhsr.contributions@nhs.net as soon as possible to discuss the implications of the changes in the way maternity services are to be provided. This could have an impact on the contributions payable for your Trust in 2026/27 and the reporting of claims and management of claims going forward.

Appendix 2 - Abbreviations

A

- **ABC** – *Avoiding Brain Injury in Childbirth* (RCOG programme)
- **ACSA** – *Anaesthesia Clinical Services Accreditation*
- **AAC** – *Appeals Advisory Committee*
- **ARCP** – *Annual Review of Competency Progression*

B

- **BAPM** – *British Association of Perinatal Medicine*
- **BR+ / BR Plus** – *Birthrate Plus® midwifery workforce planning tool*

C

- **CAG** – *Clinical Advisory Group*
- **CCFv2** – *Core Competency Framework Version 2*
- **CDOP** – *Child Death Overview Panel*
- **CEO** – *Chief Executive Officer*
- **CNST** – *Clinical Negligence Scheme for Trusts*
- **CODP** – College of Operating Department Practitioners
- **CPD** – *Continuing Professional Development*
- **CQC** – *Care Quality Commission*
- **CRG** – *Clinical Reference Group*
- **CTG** – *Cardiotocography*

D

- **DoC** – *Duty of Candour*

E

- **EN** – *Early Notification scheme* (NHS Resolution)
- **ESR** – *Electronic Staff Record*

F

- **FGR** – *Fetal Growth Restriction*
- **FTSU** – *Freedom to Speak Up*

G

- **GPAS** – *Guidelines for the Provision of Anaesthesia Services*

H

- **HSIB** – *Healthcare Safety Investigation Branch* (previous structure)
- **HSSIB** – *Health Services Safety Investigations Body* (current)

I

- **IOL** – *Induction of Labour*
- **IFH** – *Impacted Fetal Head*

L

- **LNU** – *Local Neonatal Unit*
- **LMNS** – *Local Maternity and Neonatal System*

M

- **MBRRACE-UK** – *Mothers and Babies: Reducing Risk Through Audits and Confidential Enquiries*
- **MCB** – *Maternal Care Bundle*
- **MNSI** – *Maternity and Newborn Safety Investigations*
- **MNVP** – *Maternity and Neonatal Voices Partnership*
- **MIS** – *Maternity (Perinatal) Incentive Scheme*
- **MOH** – *Massive Obstetric Haemorrhage*
- **MOSS** – *Maternity Outcomes Signal System*
- **MVP** – *Maternity Voices Partnership (previous terminology)*

N

- **NHSR** – *NHS Resolution*
- **NICU** – *Neonatal Intensive Care Unit*
- **NICE** – *National Institute for Health and Care Excellence*
- **NMC** – *Nursing and Midwifery Council*
- **NND / ND** – *Neonatal Death* (used within PMRT definitions)

O

- **ODN** – *Operational Delivery Network*
- **OKTA** – *Identity authentication system for NHS England applications*

P

- **PALS** – *Patient Advice and Liaison Service*
- **PFD** – *Prevention of Future Deaths Notices*
- **PMA** – *Professional Midwifery Advocate*
- **PM** – *Post-Mortem*
- **PMRT** – *Perinatal Mortality Review Tool*
- **PQOM** – *Perinatal Quality Oversight Model*
- **PSIRF** – *Patient Safety Incident Response Framework*

Q

- **QGC** – *Quality Governance Committee*

R

- **RCoA** – *Royal College of Anaesthetists*
- **RCOG** – Royal College of *Obstetricians and Gynaecologists*
- **RCM** – *Royal College of Midwives*
- **RTDM** – *Real Time Data Monitoring* (MBRRACE-UK)

S

- **S4N / SMaRT4NIPE** – *Newborn and Infant Physical Examination data system*
- **SAS** – *Specialist and Associate Specialist Doctors*
- **SBLCBv3.2** – *Saving Babies' Lives Care Bundle Version 3.2*
- **SCU** – *Special Care Unit*
- **SitRep** – *Situation Report* (NHS England operational data)
- **SOP** – *Standard Operating Procedure*
- **SPEN** – *Submit a Perinatal Event Notification system*

T

- **TN / Tier 2 / Tier 3** – *Neonatal medical staffing tiers*
- **TNA** – *Training Needs Analysis* (not explicit but related; excluded unless you want included)

W

- **WTE** – *Whole Time Equivalent*

Appendix 3 - References

Safety Action A

- NHS England – *Neonatal Critical Care Service Specification (March 2024)*
- British Association of Perinatal Medicine (BAPM) – *Service and Quality Standards for Provision of Neonatal Care in the UK*
- BAPM – *Recommended Medical Workforce Standards for Local and Special Care Neonatal Units in the UK*
- Neonatal ODN – *Guidance for the Neonatal Nursing Workforce Tool*
- Royal College of Obstetricians and Gynaecologists (RCOG) – Certificate of Eligibility for short-term locums (CEL)
- Royal College of Obstetricians and Gynaecologists (RCOG) – Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology
- Royal College of Obstetricians and Gynaecologists (RCOG) – *Workforce Census 2025*
- Royal College of Anaesthetists (RCoA) – *Guidelines for the Provision of Anaesthesia Services (GPAS), Chapter 9: Obstetric Anaesthesia*
- Royal College of Anaesthetists (RCoA) – *Anaesthesia Clinical Services Accreditation (ACSA)*
- Birthrate Plus® – *Midwifery Workforce Planning Tool*
- Ockenden Report (Final and Interim) – *Independent Review of Maternity Services*
- MBRRACE-UK – *Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries*
- Embrace – *Perinatal Mortality and Morbidity Reports*
- NHS Resolution – *Early Notification Scheme and Maternity Claims Reports*

Safety Action B

- NHS England » Core competency framework version two
- NHS England – Maternity and Neonatal Safety Improvement Programme (MatNeoSIP)
- NHS England – Patient Safety Incident Response Framework (PSIRF)
- Making Data Count on NHS Learning Hub
- BAPM Neonatal Airway Safety Standard | British Association of Perinatal Medicine
- BAPM Neonatal Airway Safety Standard (NHS Learning Hub)
- Avoiding Brain Injury in Childbirth (ABC) Programme – Royal College of Obstetricians and Gynaecologists (RCOG)
- UK Government announcement on national rollout of the ABC Programme
- Health Innovation Oxford & Thames Valley – ABC Programme Overview
- HSSIB National Learning Report – Assessment of Risk During the Maternity Pathway
- HSIB/HSSIB National Learning Reports – Emphasis on MDT response and communication
- Maternity and Newborn Safety Investigations (MNSI) – Publications and National Learning

- NICE Guideline NG121 – Intrapartum Care for Healthy Women and Babies (Teamworking & Escalation)
- NICE Guideline NG229 – Fetal Monitoring in Labour
- e-Learning for Healthcare (e-LfH) – Neonatal Airway Programme
- RCOG – Multi-disciplinary Team Working
- PROMPT Maternity Foundation – PROMPT Obstetric Emergencies Training
- Royal College of Anaesthetists (RCoA) – Anaesthesia and MDT Maternity Care Standards
- NHS Resolution – Early Notification Scheme Reports (MDT learning themes)

Safety Action C

See technical guidance

Safety Action D

- Ockenden Review – Final Report
- MBRRACE-UK – Maternal and Perinatal Mortality Reports
- CQC – National Review of Maternity Services in England (2022–2024)
- NHS England – Improvement Framework: Community Language, Translation and Interpreting Services
- NHS England – Accessible Information Standard
- NHS England – Equity and Equality Guidance for Local Maternity Systems
- NHS England – Core20PLUS5
- NHS England – Working in Partnership with People and Communities
- NHS England – Patient Safety Incident Response Framework (PSIRF)
- Maternity and Neonatal Safety Improvement Programme
- Preventing Future Deaths (PFD) – Judiciary Reports
- Nottingham / Amos Maternity Review (official site)

Safety Action E

- NHS England » Saving babies' lives: version 3

Safety Action F

- Maternity Outcomes Signal System (MOSS) – NHS England Applications Portal
- OKTA Registration for NHS England Applications
- MBRRACE-UK Real-Time Data Monitoring (RTDM)
- Perinatal Quality Oversight Model (PQOM)
- Maternity and Neonatal Voices Partnerships (MNVP) Guidance
- Freedom to Speak Up (FTSU) Guardian Guidance
- Professional Midwifery Advocate (PMA) Guidance
- NHS England Culture and Leadership Improvement Resources
- NHS Staff Survey
- Model Region Blueprint (for regional oversight transfer)

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Overview of progress on MIS year 8 safety action requirements

Safety Action	Not started	Compliance risk	In progress & on track	Meets compliance	Fully embedded	Total sub-actions
A	0	1	5	1	0	7
B	0	0	5	0	0	5
C	0	0	6	0	0	6
D	0	0	1	1	0	2
E	0	0	1	2	0	3
F	0	0	3	0	1	4
Local work	0	0	0	0	0	0
National	0	0	0	0	0	0
Total	**0**	**1**	**21**	**4**	**1**	

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.

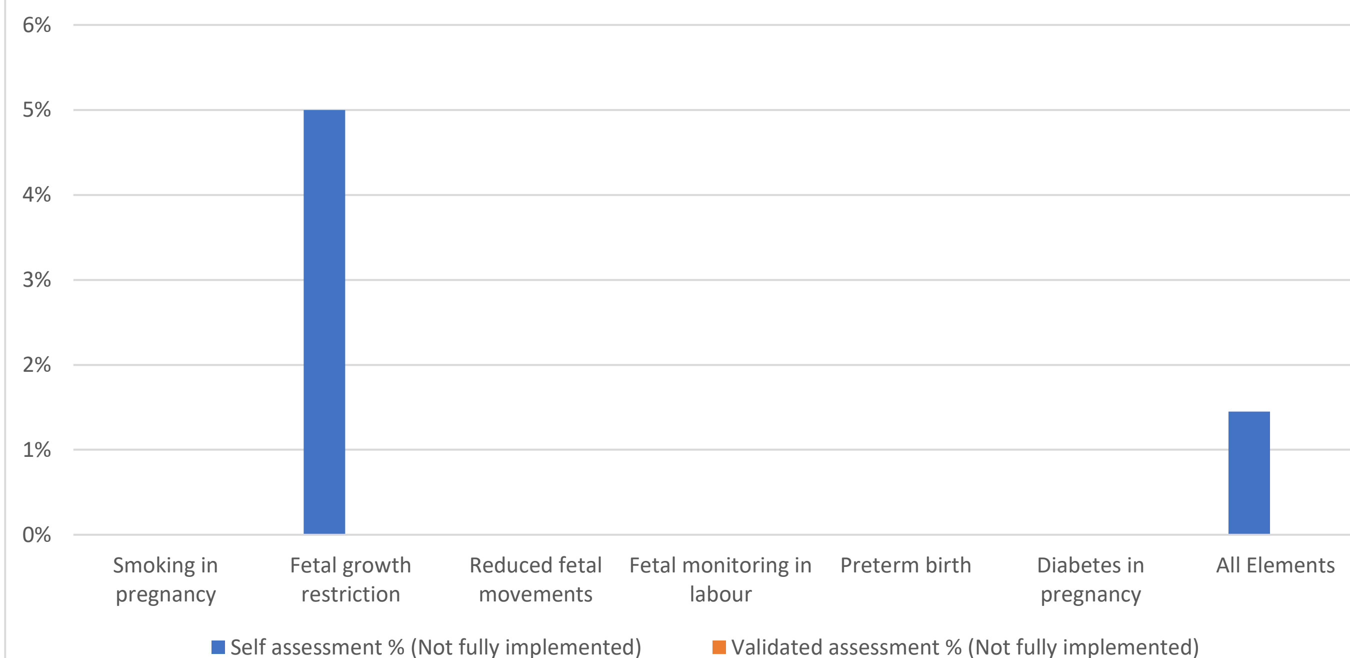
ONS and MBRRACE-UK data demonstrate the urgent need to continue reducing preventable mortality. Developed 4 years after SBLCBv2, Version 3 of the Care Bundle (SBLCBv3) has been developed through a collaboration of frontline clinical experts, service users and key stakeholder organisations. All existing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

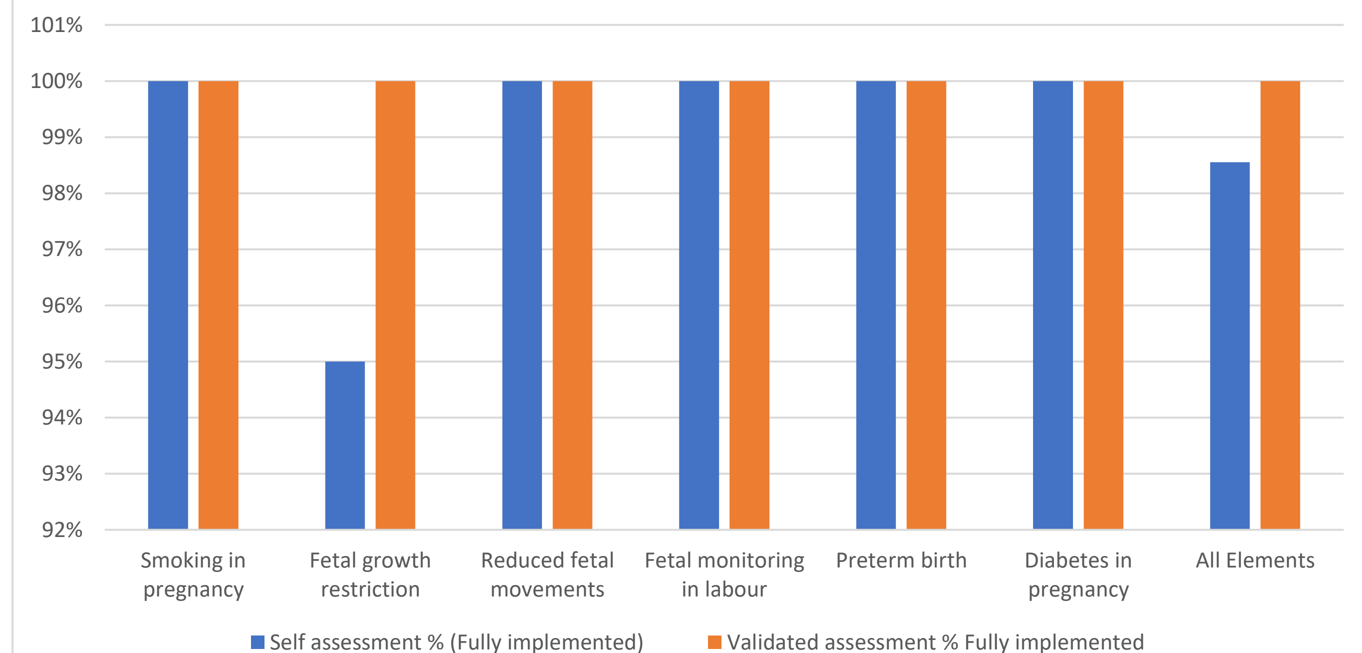
As part of the Three Year Delivery Plan for Maternity and Neonatal Services, all NHS maternity providers have been responsible for fully implementing SBLCBv3 by March 2024.

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	Partially implemented	95%	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%	Fully implemented	100%
Element 6	Diabetes	Fully implemented	100%	Fully implemented	100%
All Elements	TOTAL	Partially implemented	99%	Fully implemented	100%



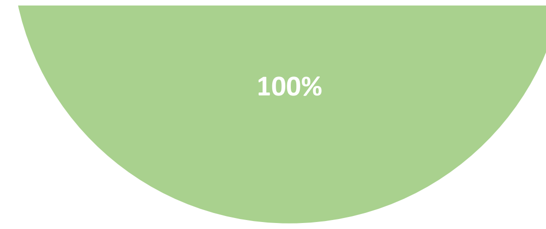


Action Plan

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.	MSDS data for Nov 2025. Regional guideline noted Review Feb 2027 Audit NOv 100% Dec 100% CO at booking
1.2	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
1.3	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Smoking ststus recorded at booking - NOV and Dec 2025 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. Women referred for smoking cessation Nov 100% Dec 200% 2025
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 Oct 30% 25% (threshold 20 - 60%) 9 women , Nov 24%, Dec
1.7	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Nov 2025 Audit 100% Dec 2025 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 July 25 data, overall 90% Midwives 89% and
1.9	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	VBA covered in 2 presentations for training on Prompt. November 025 additonal evidence submitted see above - now compliant
1.10	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	JH certifcate Nov 2025 noted - need to be reviewed annually

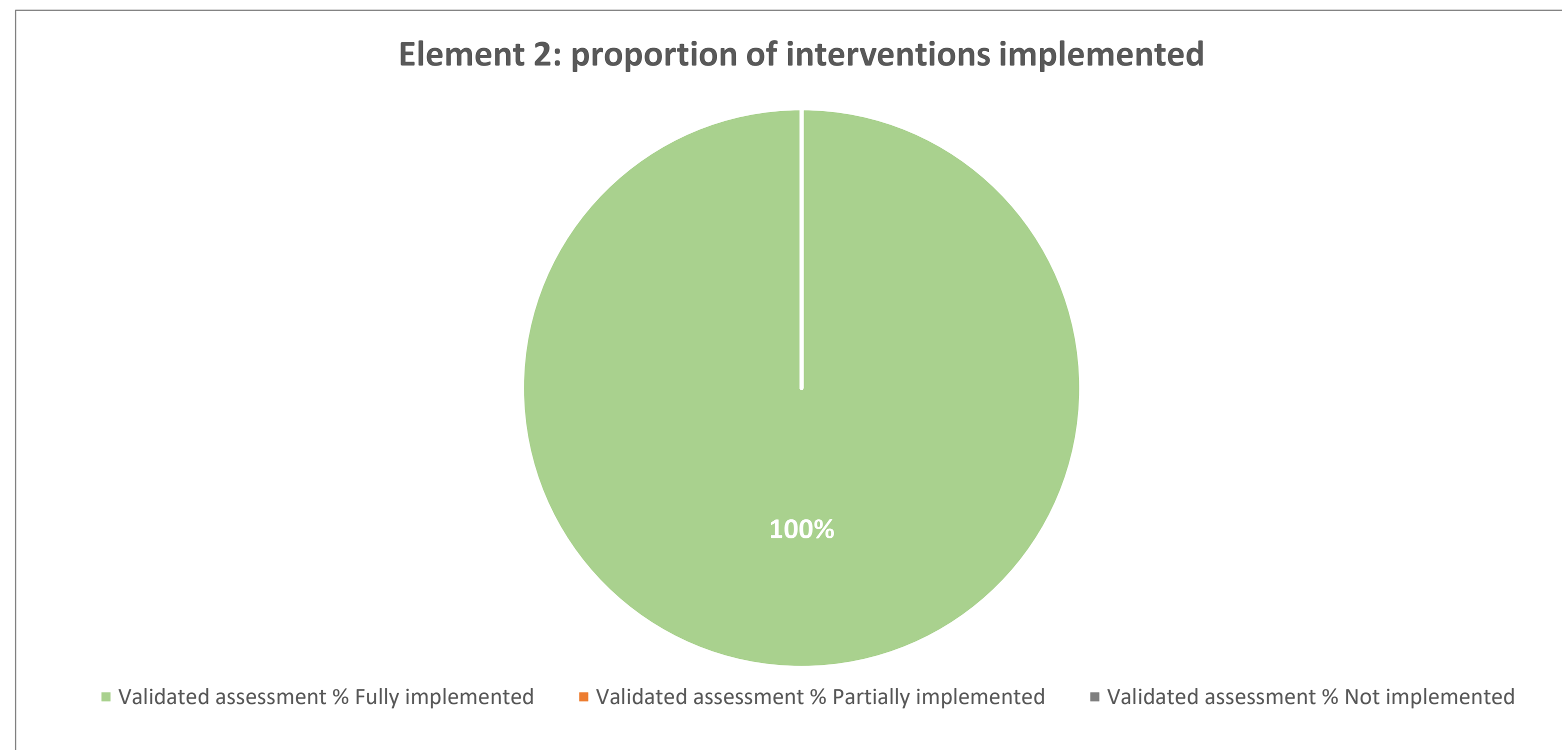
Element 1: proportion of interventions implemented



Element 2

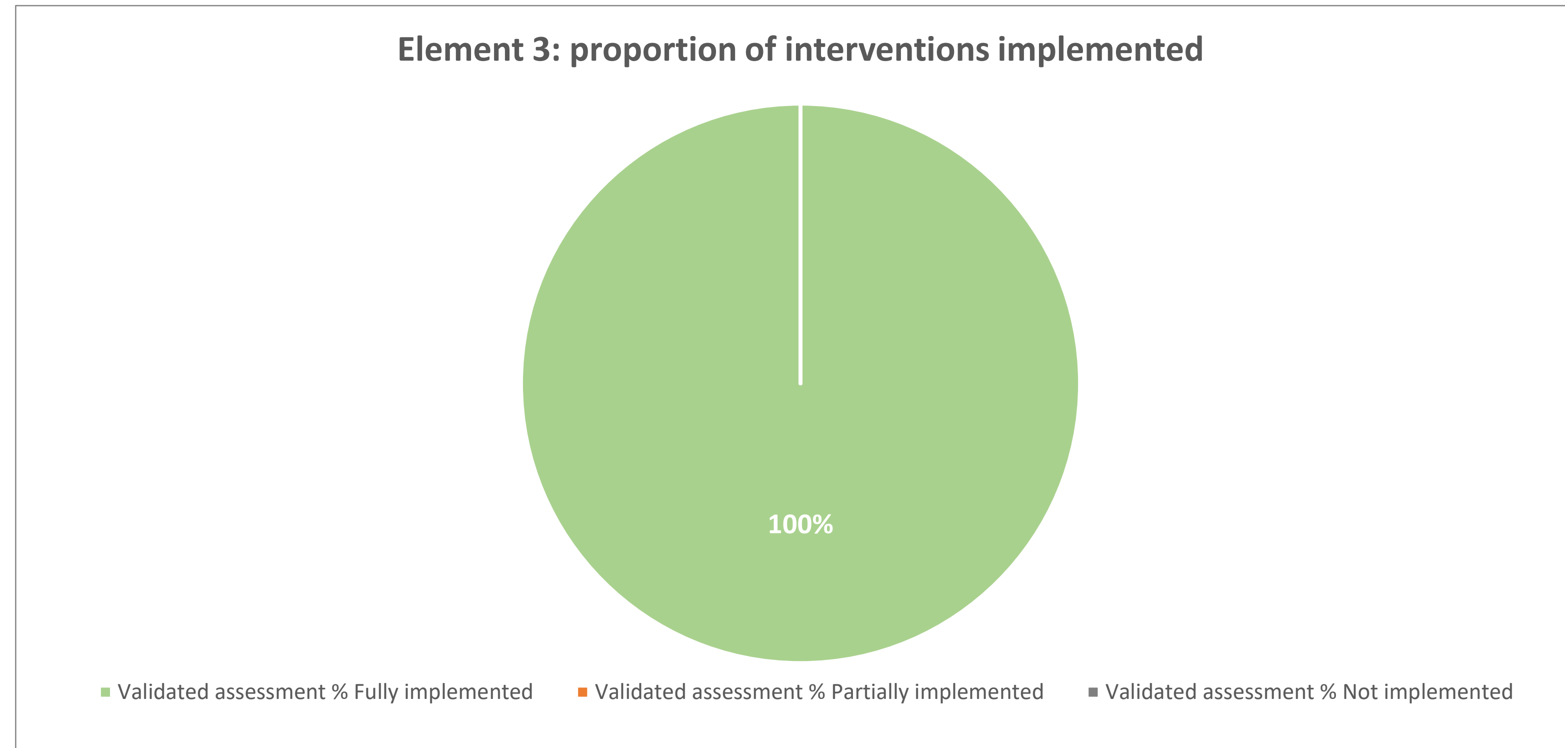
INTERVENTIONS				
2.1	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Wuth Confirmed Regional Guideline April 2025 in use last quarter and uploaded in that evidence file covers all guideline requirements. Audit Jan 2026 100%
2.2	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Jan 2026 95%
2.3	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
2.4	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Wuth Confirmed Regional Guideline April 2025 in use. Audit Risk assessment for IUGR 100% Jan 2026
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	Partially implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	WUTH team have confirmed Regional Guideline April 2025 in use. No high risk women in audit Dec 1 person identified 100% Jan 2026 100% no high risk women in sample. .
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. Audit Jan 2026 20 Women 100%.
2.11	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	WUTH Confirmed Regional Guideline April 2025 in use. Jan 2026 Prompt over 90% - please confirm SFH training is in PROMPT
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.	WMPI data shows compliance
2.19	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	WMPI data shows compliance
2.20	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Wuth Confirmed Regional Guideline April 2025 in use



INTERVENTIONS

Element 3					
	[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)
	[4.2]	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Audit Dec 2025 100%
	[4.3]	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	SBL Data Q3 2025/26 No cases where fetal monitoring an issue.
	[4.4]	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Audit not required.
	[4.5]	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Fetal Surveillence Leads still in post

Element 4: proportion of interventions implemented

100%

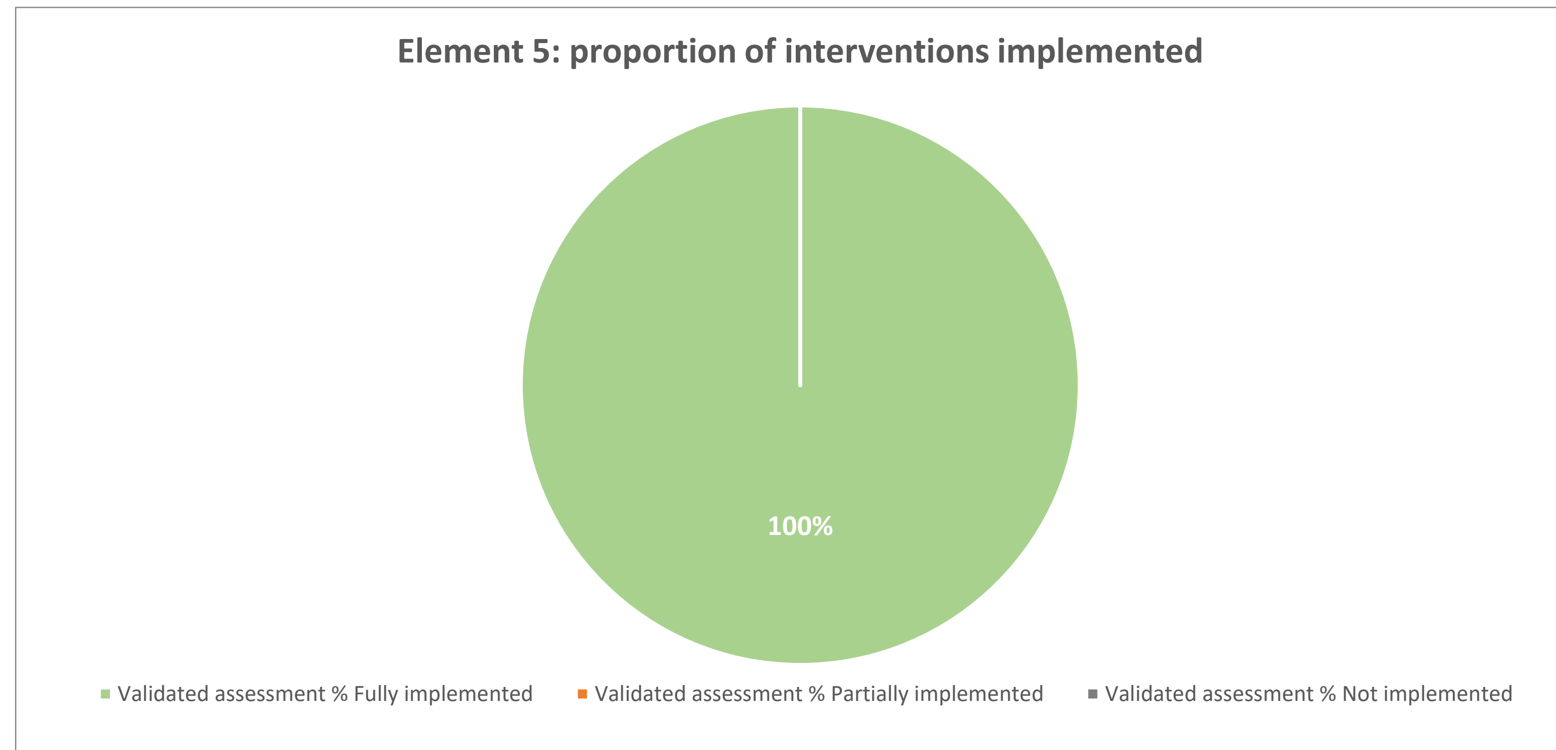
Validated assessment % Fully implemented
Validated assessment % Partially implemented
Validated assessment % Not implemented

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	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Regional Preterm birth Guideline not found please upload and confirm you are using it.
5.3	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Review date of guideline April 2026
5.4	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Cervical length and transvaginal 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 this
5.6	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Guideline now references April 2024 twins and triplets NICE Guidance. Updated Oct 2025 but still states for review at Sept 2026.
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.	Booking appointment guideline noted - Review April 2026
5.9	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0

Element 5

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. Email uploaded by LMNS into
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 . Bookings guideline is in Q2 25-26 archive
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	Fully meets standard - continue with regular monitoring of implementation.	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.	AN steroids Jan 2026 50%; Dec 2025 67% - Dec compliant
5.20	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	MGSO4 Jan 2025 Audit 100%
5.21	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	June anitbiotics audit 75% , July audit 0% 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 Jan 88% compliant
5.23	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	July Data (under early breastmilk) shows normothermic was 88% Jan 20026
5.24	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Jan 2026 Breastmilk 88%
5.25	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0

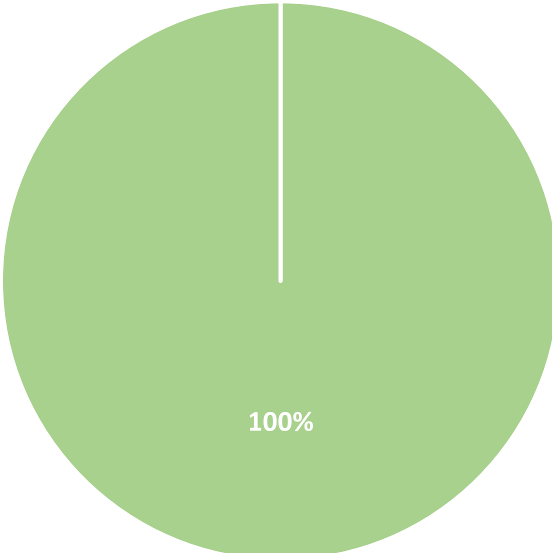
5.26	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0



Element 6

INTERVENTIONS				
6.1	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Job plans received clarification on roles. WUTH team confirmed roles still in place
6.2	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Audit data Oct - Dec 2025 Jul, Aug HCL system offered 100%
6.3	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Guideline noted. Audit Q3 2025 100%
6.4	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Guideline noted. Audit Q3 2025 100%
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.	DKA guideline in place and review date may 2028

Element 6: proportion of interventions implemented


100%
Validated assessment % Fully implemented
Validated assessment % Partially implemented
Validated assessment % Not implemented

Ockenden Essential Actions - May 2026

V19 updated May 2026

			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 same 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 compliance
		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.		Birth rate 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 compliant
		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, business case supported and achieved compliance
			Essential Action : Training		
			Work to update orientation packages for |Band 7 staff with process to allocate a mentor. Decision re NQM with NHSE as more of 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 place 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 Human Factors training however National Programme awaited. Completion of any national programme to be agreed. Gap analysis and booklet review; ongoing training initiatives
		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 professional 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. May 2026 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 ongoing
		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 escalation 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 - withhold complete roll out but continue with partial roll out pending national guidance and regional input. No further teams will be rolled out and meet national requirements
		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 e.g. 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 in line with MIS Year 8
			3: ESCALATION AND ACCOUNTABILITY		
			Processes in place - same to be audited 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 for when a consultant obstetrician should attend.	**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		Completed
		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 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 in view 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
		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/audited.		
4 : CLINICAL	Trust boards must have oversight of the quality and performance of their maternity services.	**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. Maternity 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 actions 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

GOVERNANCE-LEADERSHIP	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.	**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; reviewing 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. Ongoing review
		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-disciplinary leads in place. Consultant Midwife co leads with audit/research.
		7	All maternity services must ensure they have midwifery and obstetric co-leads for audits		Audit plan in place and embedded
			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 incorporate 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 - expanded 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.		Included on al annual updates with all staff including PROMPT
		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-pregnancy 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 with 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		
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)	**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.
		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
		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.		Annual checks in place
		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 audited		

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, post dural 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 however 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 included 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, develop the workforce and enhance the experience of families. This work must now progress at pace.	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
		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 provision Maternity 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 Liaison team..
		3	Psychological support for the most complex levels of need should be delivered by psychological practitioners who have specialist expertise and experience in the area of maternity care		Psychiatric liaison team and dedicated psychologist to support. WUTH also involved in regional project to further enhance PMH support.

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

Three Year Single Delivery Plan for Maternity and Neonatal Services - May 2026

Objective	Description	No.	Action	RAG Rating	Lead	Review Date	Comments / Lead Progress
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 understand; languages
		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	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 template
		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 enagagement April 2024, staff survey 2025 and ongoing divisional engagement and progression with evolving action plan; Ask a question to the senior team set up Jan 2026; Staff survey results shared in April 2026 and workshop held
Objective 6:	Staff feel valued when they are supported to develop. We are investing in our staff by ensuring they have ongoing training and	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

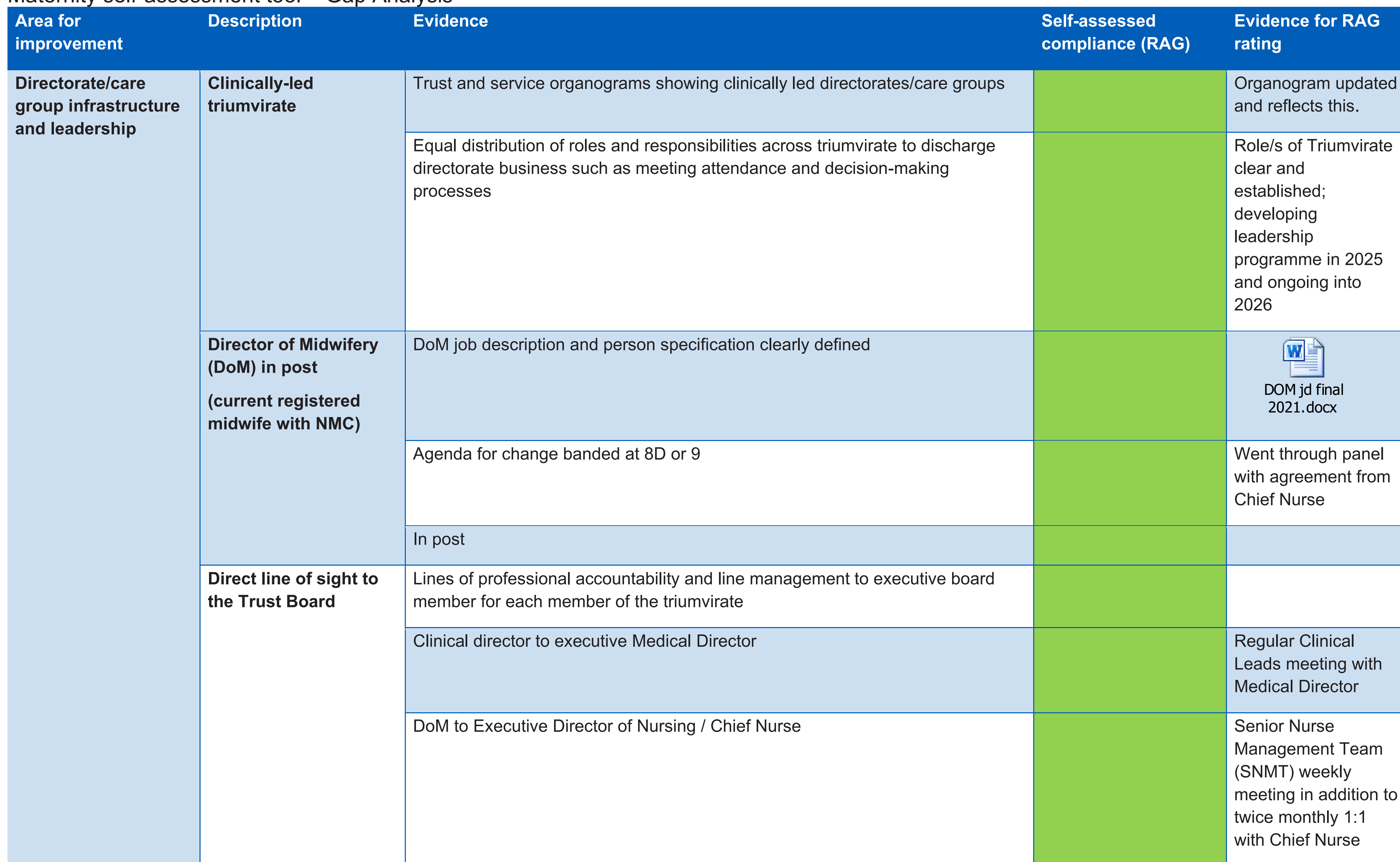
Objective	Description	No.	Standard	RAG Rating	Lead	Review Date	Comments / Lead Progress
Invest in skills	career development opportunities. Effective training of frontline clinicians in technical and non-technical skills has been shown to	23	All staff have regular training to maintain and develop their 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 97%; review of MCoC to address women with inequalities; MIS Year 7 submission with compliance of all 10 safety actions; MIS Year 8 lauched and guidance available - working towards compliance
		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 Feedback	Q1 25/26 LMNS Questions to Provider / Request for Additional Information	Q2 25/26 Provider Self Assessment BRAG	Q2 25/26 Provider Update / Rationale for BRAG	Q2 25/26 LMNS is Assured?	Q2 25/26 LMNS Rationale for BRAG / LMNS Feedback	Q2 25/26 LMNS Questions to Provider / Request for Additional Information	Q3 25/26 Provider BRAG Rating	Q3 25/26 Provider Update / Rationale for BRAG	Q3 25/26 LMNS Assured?	Q3 25/26 LMNS BRAG Rating	Q3 25/26 LMNS Rationale for BRAG	Q4 25/26 Provider BRAG Rating	Q4 25/26 Provider Update / Rationale for BRAG	Q4 25/26 LMNS Assured?	Q4 25/26 LMNS BRAG Rating	Q4 25/26 LMNS Rationale for BRAG
Objective 1: Care that is personalised	Is PCSP training included in the TNA?	1) LMNS to review each TNA and confirm the inclusion of PSCP training for each provider. 2) If the provider declares non compliance, LMNS to agree a completion date with the provider. If the provider is not compliant by the agreed date a recovery plan will need to be agreed between the LMNS and the provider 3) All none compliance actions and agreed recovery plans will be reviewed at each MPOP meeting each quarter.	Update required for Q3 Partial Assurancein Q1 - Need further detail re ccf	Further evidence/detail included as evidence to include TNA 2025		Y	Blue	TNA evidence reviewed and note inclusion of PCSP training	Provider - Blue	No change in Q4	Y	Blue	LMNS assured	Blue	No change	Yes	Blue	LMNS assured - TNA evidence reviewed and note inclusion of PCSP training	Blue	No change	Y	Blue	LMNS assured	Blue	No change	Y	Blue	LMNS assured - TNA remains in place	Blue	LMNS assured - TNA remains in place			
	Are Personalised care audits being undertaken regularly?	1) Provider to submit a copy of the audit schedule to the LMNS for review. 2) LMNS to provide reassurance at MPOP that the audit schedule has been submitted and includes PCSP audits.	Update required for Q3 - Trust to upload additonal 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	Y	Blue	LMNS assured	Blue	No change	Y	Blue	LMNS assured - evidence of PCSP audits and PCSP Audit Schedule	Blue	LMNS assured - evidence of PCSP audits and PCSP Audit Schedule			
	Is the trust in a position to roll out MCoC?	1) Where the provider states they are in a position to roll out MCoC in line with the principles of safe staffing https://www.england.nhs.uk/wp-content/uploads/2022/09/B2011-Midwifery-Continuity-of-Carer-letter-210922.pdf The minimum evidence requirement is an up to date MCoC Plan confirming the 13 building blocks are in place. 2) Provider to share Plan with the LMNS and reassurance provided to the regional team at the MPOP meeting, that it has been reviewed.	Update required for Q3			Y	Green	5x CoC Teams currently in place - no further teams planned at present	Provider - Green	No change in Q4	Y	Blue	LMNS assured	Blue	No change	Yes	Blue	LMNS assured - LMNS note 5x CoC Teams currently in place, with no further teams planned at present	Blue	No change	Y	Blue	LMNS assured	Blue	No change	Y	Blue	LMNS assured - Teams sustained	Blue	LMNS assured - Teams sustained			
	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.	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/ECoC LMNS Workstream/Community of Practice Meeting	Blue	Self assessment BAG rate altered to action	Y	Blue	LMNS assured - Teams sustained	Blue	No change	Y	Blue	LMNS assured - Teams sustained	Blue	LMNS assured - Teams sustained			
	Number of EMCoC teams planned to be rolled out in line with national guidance?	1) LMNS to confirm assurance arrangements in place for future number of teams to be rolled out in line with national guidance. 2) LMNS to review evidence of MCoC meetings where EMCoC teams are discussed or alternatively submit tracker which demonstrates EMCoC teams are in place.	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 BAG rate altered to action	Y	Blue	as above	Blue	No change	Y	Blue	LMNS assured - Teams sustained	Blue	LMNS assured - Teams sustained			
	Has the trust achieved UNICEF BFI accreditation?	1) Each provider to provide a copy of the BFI accreditation status for Maternity and Neonates to the LMNS. 2) If provider does not have full accreditation, the LMNS should review and monitor evidence of the provider's schedule and plan for full achievement by 2027 3) If a provider has a certificate of accreditation action and dates for stage 1 this should be shared with the LMNS. 4) If provider is at stage 1, evidence and dates are required for planned stage 2 accreditation and so on until the provider can demonstrate full accreditation. 5) Once a provider has achieved full accreditation, evidence of their sustainability plans with annual audit schedule is required and should be submitted to the LMNS.	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 tack 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	Y	Blue	LMNS assured - Action plan for maternity on target and NNU training underway	Blue	No change	Y	Blue	LMNS assured - WUTH achieved full accreditation October 2024 for maternity and hence are not yet due for reaccreditation	Blue	LMNS assured - WUTH achieved full accreditation October 2024 for maternity and hence are not yet due for reaccreditation			
Objective 2: Improve equity for mothers and babies	Does the trust provide access to interpreter services, which adheres to the Accessible Information Standard?	1) A copy of the provider guideline/algorithm/SOP/operational plan for the use of interpreters that is clearly mapped against the Accessible Information Standard, should be shared with the LMNS. 2) LMNS to provide reassurance to the MPOP that they are assured each provider is compliant with the Accessible Information Standard. 3) Where a provider is identified as non-compliant the LMNS will set target dates for compliance with the provider and monitor accordingly.	Update required for Q3 No assurance in Q1: no interpreter policy received.	Interpretation policy uploaded as evidence		Y	Green	Draft Trust wide policy submitted as evidence. Provider to confirm if it meets accesible information standards for Q4.	Provider - Green	Confirmation sent post Q3 WUTH meetings accessible standards and uploaded	Y	Amber	Latest Board paper evidence received from the Trust outlines areas of concern and limited assurance to the Trust Board regarding adherence to accessible information standard. Hence, amber status	Blue	Policy uploaded	Yes	Blue	LMNS assured - Trust have provided detailed email from Trust lead Tony Probbing confirming compliance with national guidance	Blue	No change	Y	Blue	LMNS assured - Trust have provided detailed email from Trust lead Tony Probbing confirming compliance with national guidance	Blue	No change	Y	Blue	LMNS assured - Trust have provided detailed email from Trust lead Tony Probbing confirming compliance with national guidance	Blue	LMNS assured - Trust have provided detailed email from Trust lead Tony Probbing confirming compliance with national guidance			
	Is data collected and disaggregated based on population groups?	1) LMNS to confirm the provider's EPR system has the capability to collect and disaggregate data based on population groups. (both ethnicity & deprivation) 2) Where a provider demonstrates non-compliance, LMNS to agree a recovery plan for compliance and monitor accordingly. 3) LMNS to provide progress updates to MPOP.	Update required for Q3 Partial Assurance in Q1 - more evidence required.	Data collected includes age, ethnic minority, marital status, postcode, language/s spoken and other data as per MSDS requirements. Analysis examples uploaded as evidence		Y	Green	LMNS assured on track, but further evidence required in Q4 (as per Q1 request)	Provider - Green	Examples uploaded as evidence	Y	Blue	LMNS assured - further evidence provided as requested in Q3			Yes	Blue	LMNS assured - Presentation uploaded with evidence of bookings data by location and ethnicity	Blue	No change	Y	Blue	LMNS assured	Blue	No change	Y	Blue	LMNS assured - evidence of data collection received and reviewed	Blue	LMNS assured - evidence of data collection received and reviewed			
Objective 3: Work with service users to improve care	Are service users involved in quality, governance, and co-production when planning the design and delivery of maternity and neonatal services?	1) LMNS to review the provider's MNVP annual workplan and gain assurance that the NMVP are involved in quality, governance, and co-production when planning the design and delivery of maternity and neonatal service. 2) Where a provider demonstrates non compliance, LMNS to agree target dates for compliance and monitor accordingly. 3) LMNS to provide reassurance to MPOP that this measure is embedded in the organisation.	Q1 - LMNS in receipt of MNVP Workplan; MNVP lead in post for 16 hours per week	Evidence submitted as Safety Action 7 and compliance signed off for MIS Year 6		Y	Blue	LMNS Assured	Provider - Blue	No change in Q4	Y	Blue	LMNS assured	Blue	No change	Yes	Blue	LMNS assured - evidence submitted as part of MIS Year 7	Blue	No change	Y	Blue	LMNS assured	Blue	No change	Y	Blue	LMNS assured - evidence received and reviewed	Blue	LMNS assured - evidence received and reviewed			
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 MPOP	LMNS Assured in Q1	Assured: June 2021 New BR+ scheduled for January 2025. BR plus commenced in June 2023; final report expected Feb 2025		Y	Green	LMNS Assured, but require Trust to submit BR plus recent report in Q 4	Provider - Blue	BR Plus report (March 2025) uploaded as evidence	Y	Blue	LMNS assured - BR+ report noted	Blue	Staffing paper for workforce uploaded as evidence and SOC being prepared for additional staffing	Yes	Blue	LMNS assured - BR+ Report March 25 received	Blue	No change	Y	Blue	LMNS assured	Blue	No change	Y	Blue	LMNS assured - BR+ report March 2025 noted	Blue	LMNS assured - BR+ report March 2025 noted			
	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 can 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; 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	Y	Blue	LMNS assured - Statement of case; accompanying documents that went to BOD for approval which was supported has been submitted as evidence	Blue	No change	Y	Blue	LMNS assured - Statement of case; accompanying documents that went to BOD for approval which was supported has been submitted as evidence	Blue	LMNS assured - Statement of case; accompanying documents that went to BOD for approval which was supported has been submitted as evidence			
	Planned date of next BR+	1) Planned date of next BR+ report to be agreed with the LMNS. 2) BR+ compliance to be discussed with MPOP	Update required for Q3	Underway - awaiting report; data collection for accuracy has taken longer than expected and due by end Feb 2025		Y	Green	LMNS assured that this is underway. Trust has confirmed awaiting report; data collection for accuracy has taken longer than expected	Provider - Green	Uploaded as evidence	Y	Blue	LMNS assured - BR+ report received 2025 - not due for 3 years	Blue	No change	Yes	Blue	LMNS assured - BR+ report March 25 received - BR+ assessment not due for 3 years	Blue	No change	Y	Blue	LMNS assured	Blue	No change	Y	Blue	LMNS assured - Most recent BR+ was March 2025	Blue	LMNS assured - Most recent BR+ was March 2025			
	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.	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	Y	Blue	LMNS assured - Midwifery Workplan 2025 reviewed	Blue	No change	Y	Blue	LMNS assured - Midwifery Workplan 2025 reviewed	Blue	LMNS assured - Midwifery Workplan 2025 reviewed			
	Does the annual workforce plan include support for newly qualified staff and midwives who wish to return to practice?	1) LMNS to review the annual workforce plan and confirm if it includes support for newly qualified staff and midwives who wish to return to practice. 2) LMNS to provide updates to MPOP where compliance not achieved.	Update required for Q3	Evidence uploaded to support RTP; in 2025 annual workforce plan will include support for newly qualified staff and RTP midwives		Y	Green	Trust to submit updated Maternity Workplan in Q4, to include additional information from BR+ Report	Provider - Green	Workforce plan uploaded	Y	Blue	LMNS assured - new evidence provided	Blue		Yes	Blue	LMNS assured - Midwifery Workplan 2025 received and reviewed	Blue	No change	Y	Blue	LMNS assured - Midwifery Workplan 2025 reviewed	Blue	No change	Y	Blue	LMNS assured - Midwifery Workplan 2025 reviewed	Blue	LMNS assured - Midwifery Workplan 2025 reviewed			
	MW Vacancy Rate (please provide additional narrative to support data)	1) LMNS to undertake quarterly review of Maternity Workforce PWR data. 2) LMNS to discuss plan to improve vacancy rates with provider 3) LMNS to provide reassurance to MPOP that plan is in place to reduce vacancy rate.	Trust to input PWR date from Q3 and beyond	PWR data uploaded as received; LMNS will discuss distribution with NWMO		Y	Green	Business Case received, which supports PWR narrative	Provider - Green	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	LMNS assured - Trust has confirmed statement of case approved	Green	PWR data uploaded and business case approved and recruitment in progress for all posts	Y	Green	PWR data uploaded and business case approved and recuitment in progress for all posts. WUTH are providing evidence of an improved position through existing LMNS reviews, including Gold Command. Subject to	Blue	PWR data uploaded and business case approved and rall posts recuited into			
	MW Leaver Rate (please provide additional narrative to support data)	1) LMNS to undertake quarterly review of Maternity Workforce PWR data. 2) LMNS to discuss plan to improve leaver rates with provider. 3) LMNS to provide reassurance to MPOP that plan is in place to reduce leaver rate.	Trust to input PWR date from Q3 and beyond	PWR data uploaded as received; LMNS will discuss distribution with NWMO		Y	Green	Business Case received, which supports PWR narrative	Provider - Green	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	as above	Green	PWR data uploaded and business case approved and recruitment in progress for all posts	Y	Blue	LMNS assured - Nov 25 PWR leaver rate = 2.1%	Blue	LMNS assured - Nov 25 PWR leaver rate = 2.1%			
	MW Turnover Rate (please provide additional narrative to support data)	1) LMNS to undertake quarterly review of Maternity Workforce PWR data. 2) LMNS to discuss plan to improve turnover rate with provider. 3) LMNS to provide reassurance to MPOP that plan is in place to reduce turnover	Trust to input PWR date from Q3 and beyond	PWR data uploaded as received; LMNS will discuss distribution with NWMO		Y	Green	Business Case received, which supports PWR narrative	Provider - Green	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	as above	Green	[illegible]	Y	Green	Nov 25 PWR turnover rate = 6% and is in line with national average	Green	Nov 25 PWR turnover rate = 6% and is in line with national average			
	MW Sickness Rate (please provide additional narrative to support data)	1) LMNS to undertake quarterly review of Maternity Workforce PWR data. 2) LMNS to discuss plan to improve turnover rate with provider. 3) LMNS to provide reassurance to MPOP that plan is in place to reduce turnover	Trust to input PWR date from Q3 and beyond	PWR data uploaded as received; LMNS will discuss distribution with NWMO		Y	Green	Business Case received, which supports PWR narrative	Provider - Green	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]			
	Obstetric Consultant Vacancy Rate (please provide additional narrative to support data)	1) LMNS to undertake quarterly review of Maternity Workforce PWR data. 2) LMNS to discuss each plan to improve obstetric consultant vacancy rate with provider. 3) LMNS to provide reassurance to MPOP that plans are in place to reduce obstetric consultant vacancy rate.	Trust to input PWR date from Q3 and beyond	PWR data uploaded as received; LMNS will discuss distribution with NWMO		Y	Green	DoM confirmed that the 1 WTE consultant gap (as of 01.11.24) has now been recruited to, with a planned start date of 01.04.25	Provider - Blue	Fully recruited to establishment	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]			
	MSW Vacancy Rate (please provide additional narrative to support data)	1) LMNS to undertake quarterly review of Maternity Workforce PWR data. 2) LMNS to discuss plan to improve MSW vacancy rate with provider. 3) LMNS to provide reassurance to MPOP that plans are in place to reduce MSW vacancy rate.	Trust to input PWR date from Q3 and beyond	PWR data uploaded as received; LMNS will discuss distribution with NWMO		Y	Green	Business Case has been completed by Trust and uploaded, which supports PWR narrative	Provider - Blue	Fully recruited to establishment	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]			
	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.	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 interest due to long term absence …	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]			
Objective 5: Value and retain our workforce	Does the trust have a retention improvement action plan?	1) LMNS to review provider Retention Improvement Action Plan for assurance. 2) LMNS to agree monitoring to ensure the improvement plan remains on track. 3) LMNS to provide reassurance to MPOP	Update required for Q3 Partial Assurance in Q1 - No improvement plan attached but evidence in document that compliance achieved; vacancy rate <2% no further actions identified; rolling recruitment campaigns continue	Vacancy rate continues at <2%; rolling recruitment campaign and Trust agreed business case to increase establishment		Y	Green	Business Case received, which supports the narrative for this deliverable	Provider - Green	No change in Q4	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]			
	Is there a plan in place to reduce workforce inequalities?	1) If yes LMNS to review the workforce inequalities plan for assurance 2) If no LMNS/ICB to work with the provider and agree a time frame for the development of a workforce equalities plan 3) LMNS to provide reassurance to MPOP As a minimum each provider needs to provide evidence of a baseline of staff in …	Evidence received inequalities plan	Evidence uploaded		Y	Blue	LMNS Assured - Trust wide policy received	Provider - Blue	No change in Q4	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]			
	Is the trust signed up to the North West Black, Asian, and Minority Ethnic Assembly Anti-racist Framework?	1) LMNS to review the provider's self assessment status against the framework for assurance. 2) LMNS to seek evidence of annual action plan to attain accreditation including evidence that it has been reported at board to ensure delivery and commitment. 3) LMNS to provide reassurance to MPOP https://www.england.nhs.uk/north-west/wp-content/uploads/sites/48/2023/07/The-North-West-BAME-Assembly-Anti-racist-Framework-FINAL.pdf	Evidenced received - LMNS assured but would like to see self-assessment	Self assessment uploaded as evidence		Y	Green	LMNS Assured - Certificate of Recognition, EDI Bi-annual Report and Workforce Race Equality Standard Report received Trust to submit self-assessment in Q4	Provider - Blue	Evidence submitted	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]			
	Do the trust have a mechanism to identify and address issues highlighted in student and trainee feedback surveys?	1) LMNS to confirm with provider what mechanisms are in place to identify and address issues highlighted in student and trainee feedback surveys? - (This could be NTS NETS or PARE placement feedback)? 2) LMNS to provide reassurance to MPOP	Update required for Q3 Partial Assurance in Q1 - WUTH need to explain what is being done with the feedback	Workforce plan submitted; no further action		Y	Green	LMNS note that the Trust is one of the top performers in the North West. Trust to submit Board Report in Q4, to evidence that survey results have been communicated to Board	Provider - Blue	Report to BoD and minutes uploaded …	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]			
	Does the trust offer a preceptorship programme to every newly registered midwife, with supernumerary time during orientation and protected development time?	1) LMNS to review provider's preceptorship programme and confirm it includes: a) length of preceptorship period b) length of supernumerary period c) the supernumerary period being applied to each clinical rotation during the preceptorship programme d) minimum expectation of all clinical areas during the preceptorship period 2) LMNS to confirm an target date for compliance is in place where all of the above are not included in the preceptorship policy 3) LMNS to provide reassurance to MPOP	Update required for Q3 Partial Assurance in Q1 - Require Preceptorship pack as evidence	Further evidence uploaded		Y	Blue	LMNS Assured - Preceptorship Programme in place	Provider - Blue	No change in Q4	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]			
	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	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	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]			
	Does the trust have a leadership succession plan which reflects the ethnic background of the wider workforce? .	1) LMNS to review provider leadership succession plan, and gain assurance that it reflects the ethnic background of the wider workforce. 2) LMNS to discuss and agree completion date for plan with provider where this is not yet in place. 3) LMNS to provide progress update to MPOP	Update required for Q3 Partial Assurance in Q1 - elements relating to ethnicity require strengthening			Y	Green	LMNS note Bronze award. However, minimal evidence received - provider to upload Black, Asian and Minority Ethnic Self Assessment Tool in Q4, which will support evidence of this deliverable	Provider - Green	Evidence uploaded	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]			
	Does the trust's TNA align with the core competency framework?	1) Provider to submit TNA including CCF alignment details - LMNS to review and confirm compliance - LMNS to agree target date for compliance and monitor where necessary 2) LMNS to provide re-assurance to MPOP. https://www.england.nhs.uk/long-read/core-competency-framework-v2-minimum-standards-and-stretch-targets/	Update required for Q3 Partial Assurance - Need further detail re ccf	TNA 2025 uploaded		Y	Green	Trust to submit final ratified TNA in Q4	Provider - Blue	Final TNA uploaded as evidence	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]			

Objective	Question	Minimum evidence / actions	Q1/Q3 status	Q3 update	Q4 RAG	Q4 commentary	Provider RAG	Provider Q4 update	Y	RAG	LMNS comment	RAG	Change	Yes	RAG	LMNS comment	RAG	Change	Y	RAG	LMNS comment	RAG	Change	Y	RAG	LMNS comment	RAG	LMNS comment
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	Update required for Q3 Partial Assurance in Q1 - Require more evidence.	Evidence uploaded	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 6: additional consultant now on rota	Blue	No change	Yes	Blue	LMNS assured - evidence reviewed as part of MIS	Blue	No change	Y	Blue	LMNS assured	Blue	No change	Y	Blue	LMNS assured - evidence received and reviewed	Blue	LMNS assured - evidence received and reviewed
	Do temporary medical staff covering middle grade rota possess an RCOG certificate of eligibility for short-term locums?	It is a statutory requirement that all middle grade temporary medical staff working within maternity services should provide an RCOG certificate of eligibility to the provider 1) LMNS to seek assurance from provider that the CD holds RCOG certificates for all short term locum doctors 2) LMNS to reassurance to MPOP	Update required for Q3	Locums not utilised at WUTH	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		Y	Blue	LMNS assured - Trust does not use locums	Blue	No change	Y	Blue	LMNS assured - Confirmation received from the Trust that they do not use locums	Blue	LMNS assured - Confirmation received from the Trust that they do not use locums
Objective 7: Develop a positive safety culture	Do maternity and neonatal leads have time within their job plan to access training and development, Including time to engage stakeholders, and MNVP leads?	1) If provider reports YES - LMNS to gain assurance by reviewing evidence how much time allocated in job plan and of achievement and confirm reassurance. 2) If provider reports NO - LMNS to provide support to the provider to become compliant.	LMNS Assured in Q1	No further action at Q3	Blue	LMNS Assured in Q1 - Job Plans received	Provider - Green	No change in Q4	Y	Blue	LMNS assured - job plans reviewed	Blue		Yes	Blue	LMNS assured - Job plans reviewed	Blue		Y	Blue	LMNS assured	Blue		Y	Blue	LMNS assured - Trust has uploaded job plans as evidence	Blue	LMNS assured - Trust has uploaded job plans as evidence
	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	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	Y	Blue	LMNS assured - Tust have confirmed that senior leaders continue to attend sessions and internal OD leadership development being implemented	Blue	OD leadership programme ongoing into 2026	Y	Blue	LMNS assured - Tust have confirmed that senior leaders continue to attend sessions and internal OD leadership programme ongoing into 2026	Blue	LMNS assured - Tust have confirmed that senior leaders continue to attend sessions and internal OD leadership programme ongoing into 2026
	Does the trust board support the implementation of a focused plan to improve and sustain maternity and neonatal culture and regularly review progress?	1) Provider to submit evidence of board agendas/minutes where QIP is discussed to LMNS for review. 2) LMNS to provide reassurance at MPOP meetings.	LMNS Assured in Q1	No further action at Q3	Green	LMNS assured on track, but further update required in Q4	Provider - Green		Y	Blue	LMNS asssured - evidence submitted and reviewed as part of MIS SA9	Blue	Additional papers uploaded to demonstrate sustainability	Yes	Blue	LMNS asssured - Evidence submitted and reviewed as part of MIS SA9	Blue	No change	Y	Blue	LMNS assured	Blue		Y	Blue	LMNS assured - Maternity and Neonatal Culture Annual Report uploaded as evidence	Blue	LMNS assured - Maternity and Neonatal Culture Annual Report uploaded as evidence
	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.	LMNS Assured Q1	No further action at Q3	Green	LMNS note that the Trust uses AID as a toolkit and that the Trust was a pilot site for the introduction nationally of the escalation tool. This has been rolled out.	Provider - Green	No change in Q4	Y	Blue	LMNS assured	Blue		Yes	Blue	LMNS assured - LMNS note that the Trust uses AID as a toolkit and that the Trust was a pilot site for the introduction nationally of the escalation tool. This has been rolled out.	Blue	No change	Y	Blue	LMNS assured	Blue		Y	Blue	LMNS assured - evidence received and reviewed	Blue	LMNS assured - evidence received and reviewed
	Is there a Freedom to Speak Up Guardian?	1) If YES - FTSU JD to be reviewed by the LMNS. 2) If NO - action plan detailing when the FTSU guardian will be in place required. 3) Action plan to be monitored by the LMNS with regional oversight at MPOP	LMNS Assured	No further action at Q3	Blue	Name of FTSU Guardian received and JD for post	Provider - Blue	No change in Q4	Y	Blue	LMNS assured	Blue		Yes	Blue	LMNS assured - Name of FTSU Guardian received and JD for post	Blue	No change	Y	Blue	LMNS assured	Blue		Y	Blue	LMNS assured	Blue	LMNS assured
	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.	Update required for Q3 Partial Assurance in Q1 - Need to see evidence of the content of the training	Evidence uploaded	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		Y	Blue	LMNS assured	Blue		Y	Blue	LMNS assured	Blue	LMNS assured
	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.	PSIRF implemented but no maternity chapter. …	No further action; all evidence uploaded as …	Green	PSIF Policy in place. However, Maternity Chapter currently paused by NHS Regional …	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		Y	Blue	LMNS assured	Blue		Y	Blue	LMNS assured - PSIRF policy in place	Blue	LMNS assured - PSIRF policy in place
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	… incident policy … Management Strategy	Provider - Green	No change in Q4	Y	Blue	LMNS assured	Blue		Yes	Blue	LMNS assured - LMNS note included in Trust incident policy and Maternity Risk Management Strategy	Blue		Y	Blue	LMNS assured	Blue		Y	Blue	LMNS assured - PSIRF policy in place	Blue	LMNS assured - PSIRF policy in place
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	… FLO role, the role is …	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 goverance team for FLO within PSIRF and incident management	Blue	No change	Y	Blue	LMNS assured	Blue		Y	Blue	LMNS assured - PSIRF policy in place	Blue	LMNS assured - PSIRF policy in place
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	… Lead in place	Provider - Blue		Y	Blue	LMNS assured	Blue		Yes	Blue	LMNS assured - as above	Blue		Y	Blue	LMNS assured	Blue		Y	Blue	LMNS assured - PSIRF policy in place	Blue	LMNS assured - PSIRF policy in place
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	… required - Trust has …	Provider - Green		Y	Green	No change from Q3	Green		Yes	Green	LMNS awaiting ICB confirmation of updated policy - Trust to confirm for Q2 submission	Green		Y	Blue	LMNS assured	Blue		Y	Blue	LMNS assured - PSIRF policy in place	Blue	LMNS assured - PSIRF policy in place
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	… further update	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		Y	Blue	LMNS assurance	Blue		Y	Blue	LMNS assured	Blue	LMNS assured
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	… is in place to … SQB and lessons … committee, shared … examples and flow … 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	Y	Blue	LMNS assured	Blue		Y	Blue	LMNS assured	Blue	LMNS assured
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	… Quality … Board monthly as …	Provider - Green	No change in Q4	Y	Blue	LMNS assured - embedded process for SA9 to Board for oversight and assurance	Blue	No change, embedded	Yes	Blue	LMNS assured - embedded process for SA9 to Board for oversight and assurance	Blue	No change	Y	Blue	LMNS assured	Blue		Y	Blue	LMNS assured	Blue	LMNS assured
Objective 8: Support and oversight	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	… Chief Nurse JD in Q4	Provider - Green	Evidence (JD) uploaded	Y	Blue	LMNS Assured - NED JD reviewed	Blue		Yes	Blue	LMNS Assured - NED JD reviewed	Blue		Y	Blue	LMNS assured	Blue		Y	Blue	LMNS assured	Blue	LMNS assured
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	… received	Provider - Green		Y	Blue	LMNS assured	Blue		Yes	Blue	LMNS assured - quadrumvirate continues to be in place	Blue	No change	Y	Blue	LMNS assured	Blue		Y	Blue	LMNS assured	Blue	LMNS assured
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	… confirmed MNVPs …	Provider - Blue	Further evidence uploaded	Y	Blue	LMNS assured	Blue		Yes	Blue	LMNS Assured - DoM confirmed MNVPs understand complaint themes	Blue	No change	Y	Blue	LMNS assured	Blue		Y	Blue	LMNS assured	Blue	LMNS assured
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	… DoM, HoM, CN, … included in safety … minutes uploaded as …	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	Y	Blue	LMNS assured	Blue		Y	Blue	LMNS assured	Blue	LMNS assured
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	… further evidence …	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	Y	Blue	LMNS assured	Blue		Y	Blue	LMNS assured	Blue	LMNS assured
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		Provider - Blue	No change in Q4	Y	Blue	LMNS assured	Blue		Yes	Blue	LMNS assured	Blue			Blue	LMNS assured	Blue		Y	Blue	LMNS assured - Trust achieved an overall compliance rate of 97% for Q3	Blue	LMNS assured - Trust achieved an overall compliance rate of 97% for Q3
Objective 10: Standards to ensure best practice	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	… from Cerner … electronic … requested update	Provider - Amber	No progress; on risk register	Y	Amber	Issues remain with digital Cerner programme - Trust has added to Risk Register NW Regional Team: request confirmation of the trusts mitigation(s)?			Yes	Green	Trust confirmed on track with this deliverable. Plan is to release MEWS 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		Green	Trust on track - plan is to release MEWS by end of September or early October and NEWTT 2 by end of October/ early November 2025. Trust to provide update as part of Q3 submisssion. Following LMNS review and assurance, this deliverable can turn Blue	Green	Update provided in evidence folder	Y	Green	Trust is on track to implement by Q4	Green	Advised latest position that IT build will be completed end of 2026
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	… with Quality … Quarterly PMRT Report	Provider - Green	Further evidence uploaded	Y	Blue	LMNS assured - LMNS note WUTH submitted best SA9 evidence across all Trusts	Blue		Yes	Blue	LMNS assured - LMNS note WUTH submitted best SA9 evidence across all Trusts	Blue	No change	Y	Blue	LMNS assured	Blue		Y	Blue	LMNS assured	Blue	LMNS assured
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	… BOD papers … update required in …	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	Y	Blue	LMNS assured	Blue		Y	Blue	LMNS assured	Blue	LMNS assured
Objective 11: Data to inform learning	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	… run reports on … backgrounds - … Q4	Provider - Green	Examples included as evidence …	Y	Green	No change from Q3	Green		Yes	Blue	LMNS assured - Trust has provided detailed evidence regarding ability to disagregate data	Blue	No change	Y	Blue	LMNS assured - Trust has provided detailed evidence regarding ability to disagregate data	Blue	No change	Y	Blue	LMNS assured - Trust has provided detailed evidence regarding ability to disagregate data	Blue	LMNS assured - Trust has provided detailed evidence regarding ability to disagregate data
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	… reflects system … criteria have been …	Provider - Blue	No change in Q4	Y	Blue	LMNS assured	Blue		Yes	Blue	LMNS assured - LMNS note MSDS scorecard reflects system is operational; and all 11 criteria have been met	Blue	No change	Y	Blue	LMNS assured	Blue		Y	Blue	LMNS assured	Blue	LMNS assured
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		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		Y	Blue	LMNS assured - evidence of SOPs submitted	Blue	No change	Y	Blue	LMNS assured - evidence of SOPs submitted	Blue	LMNS assured - evidence of SOPs submitted
	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	… received. However, … 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	Y	Blue	LMNS assured - Digital Strategy and Roadmap received by the LMNS	Blue	No change	Y	Blue	LMNS assured - Digital Strategy and Roadmap received by the LMNS	Blue	LMNS assured - Digital Strategy and Roadmap received by the LMNS
Objective 12: Make better use of digital technology in maternity and neonatal services	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	… received. However, … 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			Blue	LMNS assured	Blue		Y	Blue	LMNS assured	Blue	LMNS assured

	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 complaint 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		Blue	LMNS assured - evidence of compliance received	Blue	See evidence folder	Y	Blue	LMNS assured - evidence of compliance received	Blue	LMNS assured - evidence of compliance received			

Maternity self-assessment tool – Gap Analysis



Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
Directorate/care group infrastructure and leadership	**Clinically-led triumvirate**	Trust and service organograms showing clinically led directorates/care groups		Organogram updated and reflects this.
		Equal distribution of roles and responsibilities across triumvirate to discharge directorate business such as meeting attendance and decision-making processes		Role/s of Triumvirate clear and established; developing leadership programme in 2025 and ongoing into 2026
	Director of Midwifery (DoM) in post **(current registered midwife with NMC)**	DoM job description and person specification clearly defined		DOM jd final 2021.docx
		Agenda for change banded at 8D or 9		Went through panel with agreement from Chief Nurse
		In post		
	Direct line of sight to the Trust Board	Lines of professional accountability and line management to executive board member for each member of the triumvirate		
		Clinical director to executive Medical Director		Regular Clinical Leads meeting with Medical Director
		DoM to Executive Director of Nursing / Chief Nurse		Senior Nurse Management Team (SNMT) weekly meeting in addition to twice monthly 1:1 with Chief Nurse

Maternity self-assessment tool – Gap Analysis

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		General Manager to Executive Managing Director		Divisional Director has line of sight to EMD
		Maternity services standing item on Trust Board agenda as a minimum three-monthly Key items to report should always include: • SI Key themes report, Staffing for maternity services for all relevant professional groups • Clinical outcomes such as SB, NND HIE, Attain, SBLCB and CNST progress/Compliance. • Job essential training compliance • Ockendon learning actions		Board papers can be accessed via the website as public. Quarterly update to Board by DoM. NED Safety Champion feeds back to Board monthly by exception.
		Monthly review of maternity and neonatal safety and quality is undertaken by the Trust Board via the Perinatal Quality Oversight Model (PQOM)		Perinatal Quality Oversight Model report goes to Board monthly.
		There should be a minimum of three PAs allocated to clinical director to execute their role		3 PA's allocated
	Collaborative leadership at all levels in the directorate/ care group	Directorate structure and roles support triumvirate working from frontline clinical staff through to senior clinical leadership team		Clear structure in place
		Adequate dedicated Senior Human Resource Partner is in place to support clinical triumvirate and wider directorate Monthly meetings with ward level leads and above to monitor recruitment, retention, sickness, vacancy and maternity leave		Effective relationship with HR Business Partner and Senior HR advisors – part of senior leadership structure and attendance at meetings / DPR

Maternity self-assessment tool – Gap Analysis

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Adequate Senior Financial Manager is in place to support clinical triumvirate and wider directorate		In place, support at regular meetings include divisional surgeries, monthly workforce, transformation and DPR
		Monthly meetings with all ward level leaders and above to monitor budgets, ensure updated and part of annual budget setting for each area		In place from an establishment perspective . Finance attend Divisional Surgeries.
		Adequate senior operational support to the delivery of maternity services in terms of infrastructure and systems that support high quality service delivery aligned with national pathways		Directorate Manager in post supported by Triumvirate.
		From governance and senior management meetings that all clinical decisions are made collaboratively by multiprofessional groups		Agreed actions from CG meetings, LWSG etc. Evidence of stakeholder engagement throughout
		Forums and regular meetings scheduled with each professional group are chaired by the relevant member of the triumvirate, e.g. senior midwifery leadership assembly		Senior Midwifery meeting; Consultant meeting; DM meetings in place and chaired appropriately. 7 Features of Safety supported and demonstrated within the Division. Training – MDT reinforces a leadership culture.
		Leadership culture reflects the principles of the '7 Features of Safety'.		

Maternity self-assessment tool – Gap Analysis

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Leadership development opportunities	Trust-wide leadership and development team in place		L&D Team, top leaders programme, effective managers etc. Leadership Masterclasses supported by the Trust.
		Inhouse or externally supported clinical leadership development programme in place		Top Leaders programme, plus externally supported programmes for Midwifery Leaders. Revised programme for senior leaders in 2026/26; divisional leadership programme
		Leadership and development programme for potential future talent (talent pipeline programme)		Aspiring HOM's programmes completed regionally and nationally.
		Credible organisations provide bespoke leadership development for clinicians/ frontline staff and other recognised programmes, including coaching and mentorship		Directory of Learning & Development opportunities further supports professional development.
	Accountability framework	Organisational organogram clearly defines lines of accountability, not hierarchy		Organisational structure defines clear lines of accountability from ward to Board.

Maternity self-assessment tool – Gap Analysis

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Organisational vision and values in place and known by all staff		Trust Values in place, known and respected by the teams. Staff held to account to deliver against the values.
		Organisation's behavioural standards framework in place: Ensure involvement of HR for advice and processes in circumstances where poor individual behaviours are leading to team dysfunction. [Perinatal Surveillance model]		As above.
	Maternity strategy, vision and values	Maternity strategy in place for a minimum of 3–5 years		In place and can be evidenced. Regional Strategy and Blue print exercise underway
		Strategy aligned to national Maternity Transformation Programme, local maternity systems, maternity safety strategy, neonatal critical care review, National Ambition for 2025 and the maternity and children's chapter of the NHS Long Term Plan		In place and can be evidenced.
		Maternity strategy, vision and values that have been co-produced and developed by and in collaboration with MNVP, service users and all staff groups.		MDT approach to strategy production supported. Can be evidenced on request. MNVP Partnership active and meets all requirements of Safety Action in Maternity Incentive Scheme 9Year 7_. Year 8 includes specific re: service user involvement
		Demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services [Ockenden Assurance]		

Maternity self-assessment tool – Gap Analysis

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Maternity strategy aligned with Trust Board LMNS and MNVP's strategies		Maternity Strategy aligned to that of the National Five Year Forward View and other national objectives.
		Strategy shared with wider community, LMNS and all key stakeholders		Completed but not shared widely as separate regional strategy. Trust strategy available on request by external stakeholders including LMNS..
	Non-executive maternity safety champion	Non-executive director appointed as one of the board level maternity safety champions and is working in line with national role descriptor		In place – Mr Steve Ryan.
		Maternity and neonatal safety champions to meet the NED and exec safety champion to attend and contribute to key directorate meetings in line with the national role descriptor		Bi-monthly meetings take place. Job description in place and Safety Champion work log updated with key actions.
		All Safety champions lead quality reviews, e.g. 15 steps quarterly as a minimum involving MNVPs, service users, commissioners and trust governors (if in place)		Regular walkabouts from safety champions, 15 steps repeated annually for maternity and neonates
		Trust Board meeting minutes reflect check and challenge on maternity and neonatal services from non-executive safety champion for maternity services		Can be evidenced as part of public board papers.

Maternity self-assessment tool – Gap Analysis

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		A pathway has been developed that describes how frontline midwifery, neonatal, obstetric and Board safety champions share safety intelligence from floor to Board and through the local maternity system (LMNS) and MatNeoSIP Patient Safety Networks. [MIS]		Pathway in place and included as evidence for Ockenden.
Multi-professional team dynamics	**Multi-professional engagement workshops**	Planned schedule of joint multi-professional engagement sessions with chair shared between triumvirate, i.e. quarterly audit days, strategy development, quality improvement plans		Monthly audit days, multi-professional encouragement to attend.
		Record of attendance by professional group and individual		Record of attendee's held by clinical governance teams.
		Recorded in every staff member's electronic learning and development record		Initially not recorded on ESR however project undertaken with Trust L&D Team to pilot reporting onto ESR in Maternity Services which is now in place.
	Multiprofessional training programme	Annual schedule of job essential maternity-specific training and education days, that meet the NHS England and NHS Improvement Core Competency framework as a minimum published and accessible for all relevant staff to see		Within ESR and on PROMPT, Block C. TNA in place and shared with LMNS with reporting template.
		A clear Training Needs analysis in place that identifies the minimum hours of training required for each professional group and by grade/ seniority		Recently updated as required for Ockenden
		All staff given time to undertake mandatory and job essential training as part of working hours		As Prompt/Block C plus additional 4 hours to undertake K2

Maternity self-assessment tool – Gap Analysis

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Full record of staff attendance for last three years		Can be produced on request
		Record of planned staff attendance in current year		Can be produced on request
		Clear policy for training needs analysis in place and in date for all staff groups		As above, updated annually
		Compliance monitored against training needs policy and recorded on roster system or equivalent		Discussed and monitored monthly at DMB
		Education and training compliance a standing agenda item of divisional governance and management meetings		As above, in addition also monitored at PSQB, DPR etc.
		Through working and training together, people are aware of each other's roles, skills, and competencies (who does what, how, why and when) and can work effectively together, thus demonstrating "collective competence". [7 Steps]		Can evidence if required – PROMPT supports this requirement.
		Individual staff Training Needs Analysis (TNA) aligned to professional revalidation requirements and appraisal		TNA in place outlining requirements of Competency Framework. Quarterly reporting to the LMNS. Reviewed and updated annually.
	Clearly defined appraisal and professional revalidation plan for staff	All job descriptions identify individual lines of accountability and responsibility to ensure annual appraisal and professional revalidation		Structure/ line of accountability included in the template of each job description.

Maternity self-assessment tool – Gap Analysis

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Compliance with annual appraisal for every individual		Sustained >90% consistently. Same monitored through DPR.
		Professional validation of all relevant staff supported by internal system and email alerts		In place within ESR
		Staff supported through appraisal and clearly defined set objectives to ensure they fulfil their roles and responsibilities		Robust appraisal system which includes objectives
		Schedule of clinical forums published annually, e.g. labour ward forum, safety summit, perinatal mortality meetings, risk and governance meetings, audit meetings		In place within monthly clinical governance gems newsletter
	Multi-professional clinical forums	HR policies describe multi-professional inclusion in all processes where applicable and appropriate, such as multi-professional involvement in recruitment panels and focus groups		Stakeholder panels take place in all
	Multi-professional inclusion for recruitment and HR processes	Organisational values-based recruitment in place		Vales based questions asked at interview
		Multi-professional inclusion in clinical and HR investigations, complaint and compliment procedures		In place
		Standard operating procedure provides guidance for multi-professional debriefing sessions following clinical incidents or complaints		HOT debrief or After Action Reviews based on NHSE template in place
		Debriefing sessions available for all staff groups involved following a clinical incident and unusual cases in line with trust guideline and policy		As above.
		Schedule of attendance from multi-professional group members available		Record of attendance kept for all debrief sessions

Maternity self-assessment tool – Gap Analysis

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Multi-professional membership/ representation at Maternity Voices Partnership forums	Record of attendance available to demonstrate regular clinical and multi-professional attendance.		Bi-weekly sessions
		Maternity Voice Partnership involvement in service development, Quality Improvement, recruitment and business planning through co-production and co-design		Abundance of evidence available on request
		Quality improvement plan (QIP) that uses the SMART principle developed and visible to all staff as well as Maternity Voice Partnership/service users		Improvement plan in and SMART principles applied
	Collaborative multi-professional input to service development and improvement	Roles and responsibilities in delivering the QIP clearly defined, i.e. senior responsible officer and delegated responsibility		QI lead in post. Evidence of QIP – MatNeo collaboration.
		Clearly defined and agreed measurable outcomes including impact for women and families as well as staff identified in the QIP		Evidenced in MatNeo work.
		Identification of the source of evidence to enable provision of assurance to all key stakeholders		Evidenced according to QIP – both locally and regionally.
		The organisation has robust repository for collation of all evidence, clearly catalogued and archived that's has appropriate shared access		Divisional Governance team use/store all evidence on shared drive. Same accessible to key staff.
		Clear communication and engagement strategy for sharing with key staff groups		Trust strategy recently updated and staff engagement plan updated within the Division.

Maternity self-assessment tool – Gap Analysis

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		QIP aligned to national agendas, standards and national maternity dataset and national maternity quality surveillance model requirements		Maternity Transformation agenda outlines specific requirements – further supported by NHSE/I regional team and the LMNS.
		Weekly/monthly scheduled multi-professional safety incident review meetings		Weekly for all specialities within W&C
	Multi-professional approach to positive safety culture	Schedule in place for six-monthly organisation-wide safety summit that includes maternity and the LMNS		Held quarterly and a key recommendation of the revised Blueprint recommendation
		Positive and constructive feedback communication in varying forms		SCORE survey previously undertaken. Repeated as part of leadership programme. Staff engagement survey undertaken annually and gaps actioned accordingly. PULSE survey also quarterly. Action plan for staff survey 2026; response rate 47% increase by 10%

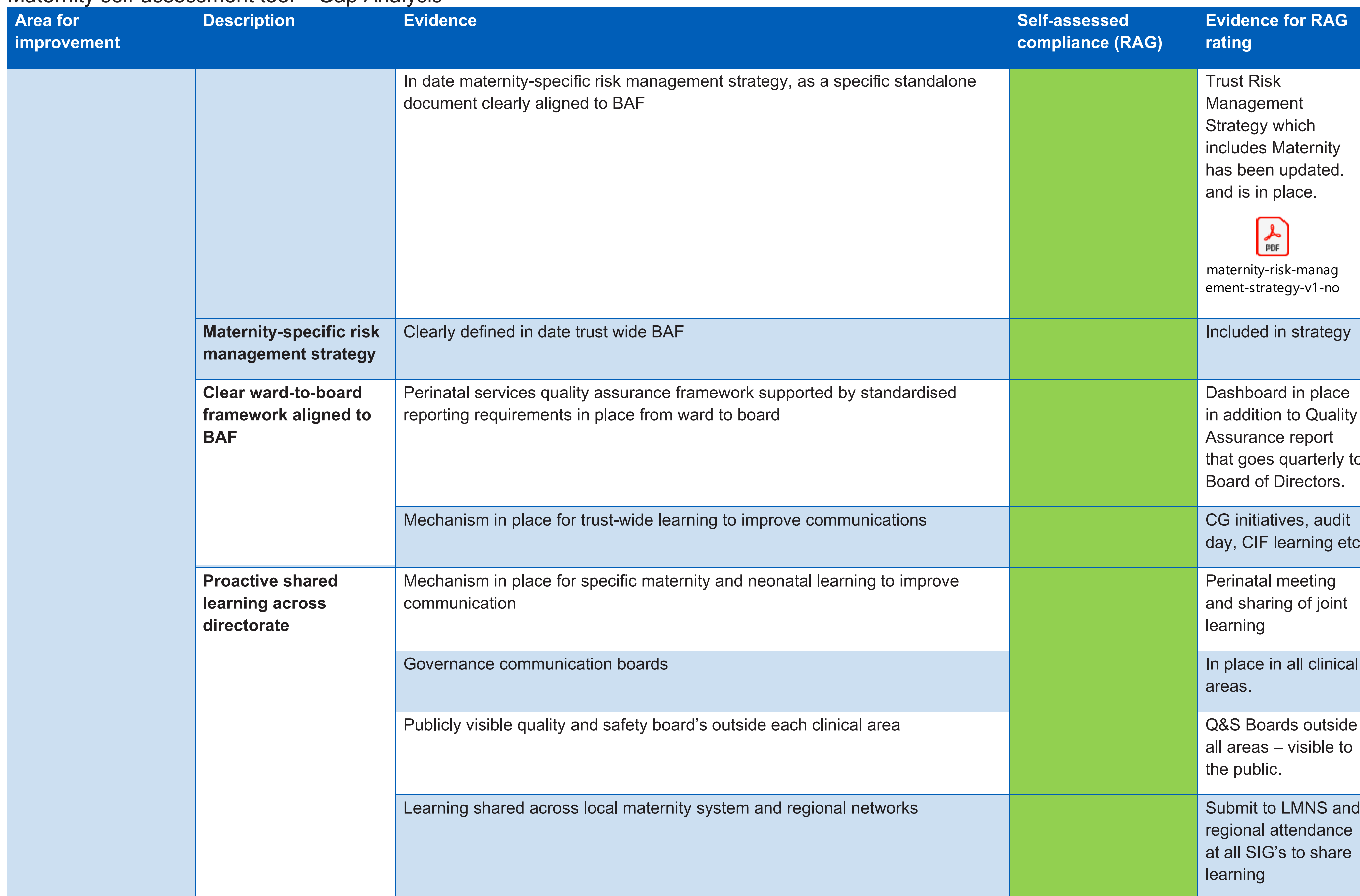
Maternity self-assessment tool – Gap Analysis

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Debrief sessions for cases of unusual or good outcomes adopting safety 2 approach		Audit day and CIF learning. Clinical QA reports, CG Boards
		Senior members of staff make sure that more junior staff have opportunities to debrief and ask questions after experiencing complex clinical situations, and that they learn from theirs and others' experience. [7 steps to safety]		In place – same led by Governance team, CI's and ADN/HoM.
		Schedule of focus for behavioural standards framework across the organisation		Trust Vision / Values structure supports standards framework.
	Clearly defined behavioural standards	Application of behavioural standards framework in trust-wide and directorate meetings, with specific elements the focus each month		In place as described above
		Unsafe or inappropriate behaviours are noticed and with HR support corrected in real time, so they don't become normalised. [7 steps]		In place as described above
		All policies and procedures align with the trust's board assurance framework (BAF)		
Governance infrastructure and ward-to-board accountability	**System and process clearly defined and aligned with national standards**	Governance framework in place that supports and promotes proactive risk management and good governance		In place within the Division with clear structure / oversight of maternity services.
		Staff across services can articulate the key principles (golden thread) of learning and safety		Participated in the EBC learn and support work – also discussed on PROMPT and Block C.

Maternity self-assessment tool – Gap Analysis

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Staff describe a positive, supportive, safe learning culture		Evidenced through staff engagement survey / feedback.
		Robust maternity governance team structure, with accountability and line management to the DoM and CD with key roles identified and clearly defined links for wider support and learning to corporate governance teams		In place as described above.
	Maternity governance structure within the directorate	Maternity governance team to include as a minimum: Maternity governance lead (Current RM with the NMC) Consultant Obstetrician governance lead (Min 2PA's) Maternity risk midiwfe (Current RM with the NMC or relevant transferable skills) Maternity clinical incident leads Audit midwife Practice development midwife Clinical preceptorship midwife Clinical educators to include leading preceptorship programme Appropriate Governance facilitator and admin support		Maternity Governance structure reviewed and Q&S matron and Risk Midwife in post; additional post Audit and Guideline midwife in 2025
		Roles and responsibilities for delivery of the maternity governance agenda are clearly defined for each team member		Job descriptions clearly articulate roles and responsibilities.
		Team capacity able to meet demand, e.g. risk register, and clinical investigations completed in expected timescales		Difficult at times however clear Trust oversight process through weekly SI panel.

Maternity self-assessment tool – Gap Analysis



Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		In date maternity-specific risk management strategy, as a specific standalone document clearly aligned to BAF		Trust Risk Management Strategy which includes Maternity has been updated. and is in place. PDF maternity-risk-management-strategy-v1-no
	Maternity-specific risk management strategy	Clearly defined in date trust wide BAF		Included in strategy
	Clear ward-to-board framework aligned to BAF	Perinatal services quality assurance framework supported by standardised reporting requirements in place from ward to board		Dashboard in place in addition to Quality Assurance report that goes quarterly to Board of Directors.
		Mechanism in place for trust-wide learning to improve communications		CG initiatives, audit day, CIF learning etc,
	Proactive shared learning across directorate	Mechanism in place for specific maternity and neonatal learning to improve communication		Perinatal meeting and sharing of joint learning
		Governance communication boards		In place in all clinical areas.
		Publicly visible quality and safety board's outside each clinical area		Q&S Boards outside all areas – visible to the public.
		Learning shared across local maternity system and regional networks		Submit to LMNS and regional attendance at all SIG's to share learning

Maternity self-assessment tool – Gap Analysis

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Engagement of external stakeholders in learning to improve, e.g. CCG, Strategic Clinical Network, regional Director/Heads of Midwifery groups		Trust has number of staff who Chair these regional meetings/groups
		Well-developed and defined trust wide communication strategy to include maternity services in place and in date. Reviewed annually as a minimum.		Communication Strategy in place and maternity included
		Multi-agency input evident in the development of the maternity specification	N/A due to ICB introduction / PLACE	ICB/LMNS oversight of maternity services
Application of national standards and guidance	**Maternity specification in place for commissioned services**	Approved through relevant governance process		Process in place
		In date and reflective of local maternity system plan		Specification in place and links in with LMNS plan/Deliverables.
		Full compliance with all current 10 standards submitted		Externally audited by MIAA for assurance
	Application of CNST 10 safety actions	A SMART action plan in place if not fully compliant that is appropriately financially resourced.		Ongoing action plan in place to meet requirements of all ten safety actions. Trust Board updated re progress of same.
		Clear process defined and followed for progress reporting to LMNS, Commissioners, regional teams and the Trust Board that ensures oversights and assurance before formal sign off of compliance		LMNS have oversight of compliance with MIS safety actions and were provided with Board declaration forms

Maternity self-assessment tool – Gap Analysis

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Clear process for multi-professional, development, review and ratification of all clinical guidelines		Process in place within the Division.
	Clinical guidance in date and aligned to the national standards	Scheduled clinical guidance and standards multi-professional meetings for a rolling 12 months programme.		The process if for MDT discussion at weekly Risk meeting – same are circulated for input from all stakeholders and ratified as per Trust policy.
		All guidance NICE complaint where appropriate for commissioned services		NICE Guidance monitored and gap analysis undertaken with any newly published guidance.
		All clinical guidance and quality standards reviewed and updated in compliance with NICE		Process in place and evidenced.
		All five elements implemented in line with most updated version		
	Saving Babies Lives care bundle implemented	SMART action plan in place identifying gaps and actions to achieve full implementation to national standards.		Fully implemented and monitored through LMNS.
		Trajectory for improvement to meet national ambition identified as part of maternity safety plan		On target and monitored as safety action in MIS.
		All four key actions in place and consistently embedded		Evidence to support same.
	Application of the four key action points to reduce inequality for	Application of equity strategy recommendations and identified within local equity strategy		Gap analysis undertaken and action plan in place and completed.

Maternity self-assessment tool – Gap Analysis

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	BAME women and families	All actions implemented, embedded and sustainable		LMNS – ongoing work regarding LMNS requirements. Any amendments to be added to existing plan. Consultant Midwife leading on same.
	Implementation of 7 essential learning actions from the Ockendon first report	Fetal Surveillance midwife appointed as a minimum 0.4 WTE		In post
		Fetal surveillance consultant obstetrician lead appointed with a minimum of 2-3 PAs		In post with required number of PA's
		Plan in place for implementation and roll out of A-EQUIP		A-Equip model – Professional Midwifery Advocates in place.
	A-EQUIP implemented	Clear plan for model of delivery for A-EQUIP and working in collaboration with the maternity governance team		Plan in place which has had further update.
		Training plan for transition courses and succession plan for new professional midwifery advocate (PMA) A-EQUIP model in place and being delivered		PMA team developed – additional training sourced when required.
		Service provision and guidance aligned to national bereavement pathway and standards		WUTH piloted national pathway and have led / implemented regionally agreed pathway.

Maternity self-assessment tool – Gap Analysis

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Maternity bereavement services and support available	Band 7 Lead Bereavement midwife Band 6 Bereavement midwife Band 3 MSW support		Fully established team
		Information and support available 24/7		Training extended to EMC team and additional Band 6 post advertised to support service
		Environment available to women consistent with recommendations and guidance from bereavement support groups and charities		Butterfly and ApplePip Rooms available 24/7. Early environment area improvements underway
		Quality improvement leads in place		Minimal hours currently – same being reviewed in conjunction with MatNeo work.
	Quality improvement structure applied	Maternity Quality Improvement Plan that defines all key areas for improvement as well as proactive innovation		QIP in place linked to Maternity Transformation Programme.
		Recognised and approved quality improvement tools and frameworks widely used to support services		Evidenced through MatNeo work
		Established quality improvement hub, virtual or otherwise		In place as part of MatNeo but same to be further developed.

Maternity self-assessment tool – Gap Analysis

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Listening into action or similar concept implemented across the trust		LIA type processes in place – use of MatNeo plans/hub.
		Continue to build on the work of the MatNeo Sip culture survey outputs/findings.		Regular meetings with Lead progressing work.
	MatNeo Sip embedded in service delivery	MTP and the maternity safety strategy well defined in the local maternity system and quality improvement plan		Evidence of same – regional Lead progressing further work with providers.
	Maternity transformation programme (MTP) in place	Dynamic maternity safety plan in place and in date (in line with spotlight on maternity and national maternity safety strategy)		Plan in place and evidenced. Ockenden evidence further supports this requirement.
Positive safety culture across the directorate and trust	**Maternity safety improvement plan in place**	Standing agenda item on key directorate meetings and trust committees		Maternity agenda on cycle/s of business. Not on all agendas but is included on relevant meetings including BoD agenda. Decision taken to implement Mat Neo Assurance Board
		FTSU guardian in post, with time dedicated to the role		In place and evidenced.
	Freedom to Speak Up (FTSU) guardians in post	Human factors training lead in post		Lead within Division and L&D leading on work throughout the Trust to further support.

Maternity self-assessment tool – Gap Analysis

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Human factors training available	Human factors training part of trust essential training requirements		Included in PROMPT training.
		Human factors training a key component of clinical skills drills		In PROMPT and is evidenced.
		Human factors a key area of focus in clinical investigations and formal complaint responses		Key point included on template used.
		Multiprofessional handover in place as a minimum to include. Board handover with representation from every professional group: • Consultant obstetrician • ST7 or equivalent • ST2/3 or equivalent • Senior clinical lead midwife • Anaesthetist And consider appropriate attendance of the following: • Senior clinical neonatal nurse • Paediatrician/neonatologist? • Relevant leads form other clinical areas e.g., antenatal/postnatal ward/triage.		Handover processes updated and in place further supported by twice daily ward rounds on Delivery Suite.
	Robust and embedded clinical handovers in all key clinical areas at every change of staff shift	Clinical face to face review with relevant lead clinicians for all high-risk women and those of concern		Evidence of twice daily ward rounds in place. Further evidence supports Ockenden requirements.
		A minimum of two safety huddles daily in all acute clinical areas to include all members of the MDT working across and in maternity services as well as the opportunity to convene an urgent huddle as part of escalation process's		In place.

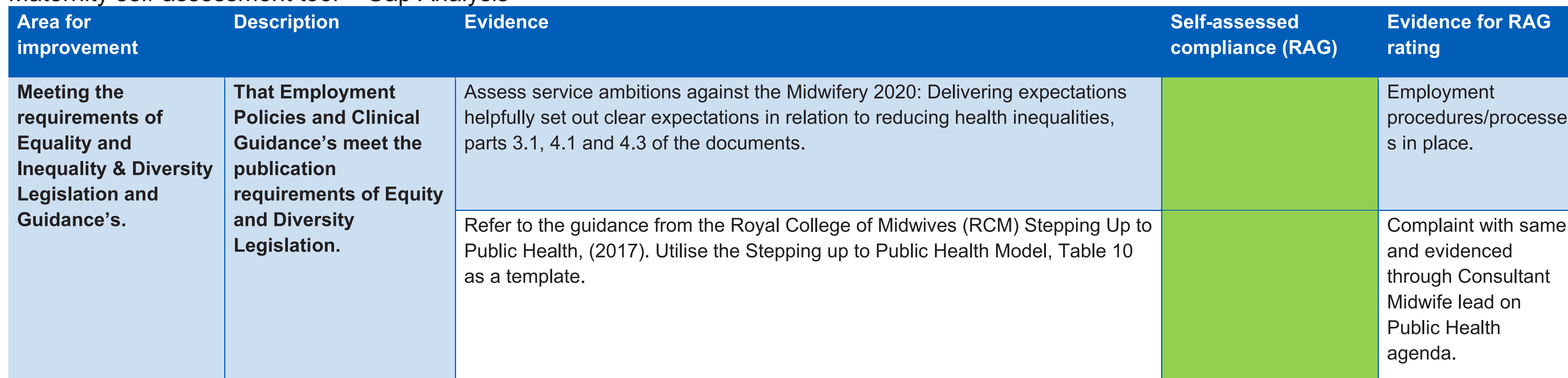
Maternity self-assessment tool – Gap Analysis

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Safety huddles	Guideline or standard operating procedure describing process and frequency in place and in date		SOP developed and huddles taking place
		Audit of compliance against above		All safety huddles recorded and documented. Daily signing sheet completed and checked
		Annual schedule for Swartz rounds in place		Pre Covid this was in place.
	Trust wide Swartz rounds	Multi-professional attendance recorded and supported as part of working time		Process in place Trust wide.
		Broad range of specialties leading sessions		Inclusive of all Divisions.
		Trust-wide weekly patient safety summit led by medical director or executive chief nurse		Pre Covid this was in place.
	Trust-wide safety and learning events	Robust process for reporting back to divisions from safety summit		Process in place – oversight from Governance team.
		Annual or biannual trust-wide learning to improve events or patient safety conference forum		World Patient Safety Day evidenced learning Trust wide.
		Trust Board each month opened with patient story, with commitment to action and change completed in agreed timeframes		In place and story shared.
		In date business plan in place		Cycle of business in place for each meeting.
		Meets annual planning guidance		In place Trust wide.

Maternity self-assessment tool – Gap Analysis

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
Comprehension of business/ contingency plans impact on quality. **(i.e. Maternity Transformation plan, Neonatal Review, Maternity Safety plan and Local Maternity System plan)**	**Business plan in place for 12 months prospectively**	Business plan supports and drives quality improvement and safety as key priority		Trust wide processes in place
		Business plan highlights workforce needs and commits to meeting safe staffing levels across all staff groups in line with BR+ or other relevant workforce guidance for staff groups		Compliance with BR+ given current model of care
		Consultant job plans in place and meet service needs in relation to capacity and demand		In place following review
		All lead obstetric roles such as: labour ward lead, audit lead, clinical governance lead and early pregnancy lead are in place and have allocated PAs in job plans		There was disparity in the allocation of PA's – same reviewed as part of the job planning work.
		Business plans ensures all developments and improvements meet national standards and guidance		Operational plan and Strategy supports the MTP and National agenda.
		Business plan is aligned to NHS 10-year plan, specific national initiatives and agendas.		Strategy updated and reflects same.
		Business plans include dedicated time for clinicians leading on innovation, QI and Research		Dedicated research and audit lead. Oversight and Lead for QI.
		That service plans and operational delivery meets the maternity objectives of the Long Term Plan in reducing health inequalities and unwarranted variation in care. Note the Maternity and Neonatal Plans on Pages 12 & 13.		Plans in place to reduce inequalities – further work ongoing to improve same.

Maternity self-assessment tool – Gap Analysis



Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
Meeting the requirements of Equality and Inequality & Diversity Legislation and Guidance's.	**That Employment Policies and Clinical Guidance's meet the publication requirements of Equity and Diversity Legislation.**	Assess service ambitions against the Midwifery 2020: Delivering expectations helpfully set out clear expectations in relation to reducing health inequalities, parts 3.1, 4.1 and 4.3 of the documents.		Employment procedures/processe s in place.
		Refer to the guidance from the Royal College of Midwives (RCM) Stepping Up to Public Health, (2017). Utilise the Stepping up to Public Health Model, Table 10 as a template.		Complaint with same and evidenced through Consultant Midwife lead on Public Health agenda.

WUTH Board of Directors

03 June 2026

Title	Midwifery Staffing update
Area Lead	Chris Douglas, Chief Nurse
Author	Jo Lavery, Divisional Director of Nursing and Midwifery

Purpose of the Report and Recommendation

Report For	Information

As part of the Maternity Incentive Scheme (MIS) there is a requirement to evidence a midwifery staffing review therefore the Birth Rate Plus review of current midwifery staffing within the maternity service will contribute to the compliance with the requirements of the MIS (Year 8).

As part of the Maternity Incentive Scheme (MIS) published in April 2026 there is a requirement to provide the Trust Board evidence the midwifery establishment is reflective of the evidence-based process (BR+). This was included in the September 2025 Board papers and will be included in the Quarterly Maternity Report to Board of Directors in June 2026 and September 2026.

It is recommended that the Board: -

- Note the report.

Key Points to Note

The maternity establishment is now fully compliant with the Birth Rate Plus recommendations. The associated action plan, previously approved by the Board of Directors, has been completed in full, and all posts have been advertised and successfully recruited to.

This provides assurance that the service is appropriately staffed to meet clinical demand, support safe care, and maintain compliance with national workforce standards.

Key Risks

This report relates to these key risks:

BAF references 1,2,4 and 6
Positives:

- The Trust has several processes that review and record patient quality indicators, incidents and patient experience metrics monthly against staffing data to identify emerging risk/s. This includes a monthly midwife to birth ratio recorded on the maternity dashboard.
- The Trust fulfils its duty to undertake 6 monthly establishment reviews including an update on midwifery staffing. The Trust has also supported a Birth Rate Plus Workforce review at least every 5 years as a minimum, however suggested recommendation is every 3 years.

- The recommendations from the Birth Rate Plus Workforce review received in March 2025 have all been completed.
- The Division uses the Birth Rate Plus acuity tool to undertake acuity and dependency reviews on Delivery Suite every 4 hours. This has been extended for use on the maternity ward and a LMNS regional platform informing staffing, acuity, and dependency.
- The Division has safe staffing governance with a clear process of escalation both locally and across Cheshire and Merseyside.

Negatives:

- The Trust currently operates two models of care for the provision of Maternity Continuity of Carer (MCoC). While this dual-model approach is not fully equitable, the existing arrangements are working effectively and are ensuring that women in vulnerable groups continue to receive appropriate, prioritised continuity of care. Targeted allocation of MCoC resources has enabled the service to focus on those with the greatest clinical and social need, mitigating risk and supporting improved outcomes. Work is ongoing to develop a sustainable, single-model approach that delivers equity, consistency, and compliance with national expectations.

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

Contribution to strategic objectives:	
Delivering Excellence – We will create the conditions for outstanding care and performance	Yes
Our People – We will nurture an inclusive, compassionate culture where people thrive	Yes
Improve & Innovate – We will make improvement and innovation part of how we work	Yes
Healthier Communities – We will drive health equity and support healthier lives	Yes
Collaboration and Partnerships – We will work as one system and one organisation	Yes
Advance Digitally – We will develop a secure, connected digital ecosystem fit for the future	No

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
June 2026	Maternity and Neonatal Assurance Meeting	Midwifery Staffing update	Information
June 2026	Divisional Quality Board	Midwifery Staffing update	Information
June 2026	Patient Safety and Quality Board	Midwifery Staffing update	Information

1	Narrative
1.1	Birthrate Plus® (BR+) is a framework for workforce planning and strategic decision-making and has been in variable use in UK maternity units since 1988, with periodic revisions as national maternity policies and guidance are published. It is based upon an understanding of the total midwifery time required to care for women and on a minimum standard of providing one-to-one midwifery care throughout established labour. The principles underpinning the BR+ methodology is consistent with the recommendations in the NICE safe staffing guideline for midwives in maternity settings and have been endorsed by the RCM and RCOG. Current processes within the maternity service ensure that on a 24/7 basis staff are deployed effectively within the service, including the flexing of staff across both the acute and community care settings including the maternity continuity of carer teams. Staff working on Delivery Suite use an acuity tool that formally assesses acuity on Delivery Suite every 4 hours as a minimum. At times of high acuity, the tool is used more frequently to assess acuity, and reports into a regional platform that was launched in September 2022. Weekly staffing reports are generated from the acuity data, and whilst this does predominantly focus on staffing within Delivery Suite the acuity tool is being expanded to include staffing across all inpatient areas. Monthly staffing reports are generated and shared by the Local Maternity and Neonatal System (LMNS) on this data regionally. It is proposed that these reports will further inform and provide assurance regarding safe maternity staffing and will provide assurance to all Maternity Safety Champions including the Executive and Non-Executive Safety Champions who are required to have oversight, assurance and visibility of safe staffing within the maternity service. Currently the quarterly maternity update to the Board of Directors includes reference to maternity staffing and a Divisional nurse / midwifery staffing update is also included in the 6 monthly midwifery staffing paper that is presented at the Board of Directors meeting.
1.2	The RCM strongly recommends using Birthrate Plus® (BR+) to undertake a systematic assessment of workforce requirements, since BR+ is the only recognised national tool for calculating midwifery staffing levels. Whilst birth outcomes are not influenced by staff numbers alone, applying a recognised and well-used tool is crucial for determining the number of midwives and support staff required to ensure each woman receives one-to-one care in labour. Birthrate Plus® has been used in maternity units ranging from stand-alone community/midwifery led units through to regional tertiary centres, with birth rates ranging from only 10 births annually through to those that have in excess of 9000 births. In addition, it caters for the various models of care in existence, including a traditional model, community-based teams and continuity of carer/caseload teams. Birthrate Plus® is the most widely used tool for workforce assessment classifying women and babies according to their needs and using clinical outcome data to calculate the

	numbers of midwives required to provide inpatient/outpatient antenatal care, intrapartum and postnatal care in either WUTH, community or neighbouring maternity unit. The method used works out the clinical establishment based on agreed standards of care and specialist needs and then includes the midwifery management and specialist roles required to manage maternity services. The recommendation is to provide total care to women and their babies throughout the 24 hours 7 days a week inclusive of the local % for annual, sick & study leave allowance and for travel in community. The most recent Birthrate Plus® workforce review was undertaken in 2024, with the full report published in spring 2025. This analysis confirmed that, although the overall birth rate has remained static since the previous review in 2021, the complexity of women and birthing people's needs has increased, driven by rising caesarean section and induction of labour rates. The review also incorporated the CQC recommendation to always ensure two midwives in maternity triage and a designated telephone-triage midwife during weekday core hours. Following approval of the associated business case, the maternity service is now fully established in line with Birthrate Plus® requirements, providing assurance that staffing levels are safe, sustainable, and aligned with national standards
1.3	There is still a requirement for Trusts to provide a model of care providing continuity of carer to women during the whole maternity episode. This model of care was initially detailed in Better Births in 2016 and included in the National Maternity Transformation Programme given its evidence based providing improved outcomes for mums and babies. The target date to deliver 100% continuity of carer had been removed, instead providers were requested to develop local plans that work for them ensuring staffing requirements are met along with an upskilled workforce. WUTH had previously submitted a plan with an ambition to achieve by MCoC as the default model by June 2024. Adaptations have been made to the plan in line with the current workforce, safe staffing levels and achieving 60% of women offered this model of care and those in the vulnerable groups are majority included. The benefits of a woman being cared for by the same team of midwives throughout her pregnancy including the delivery and following cannot be underestimated. Clinical outcomes are improved with this model of care, with women reporting positive birth experiences and with the woman less likely to experience postnatal illness. A woman who receives care from a known midwife is more likely to: • Have a vaginal birth • Have fewer interventions during birth • Have a more positive experience of labour and birth • Successfully breastfeed her baby • Cost the health system less • Less likely to experience pre-term birth • Less likely to lose their baby before 24 weeks gestation

	Considering pre-term birth alone, it is well evidenced that the high rates of morbidity and mortality arising from preterm birth impose a considerable burden on finite health care resources. Preterm infants are at increased risk of a range of adverse neonatal outcomes including chronic lung disease, severe brain injury, retinopathy of prematurity, necrotizing enterocolitis and neonatal sepsis. In later life, preterm infants are at increased risk of motor and sensory impairment, learning difficulties and behavioural problems. The economic consequences include the costs of neonatal care as well as the costs associated with living with disabilities. There is a substantial literature on the short and (to a lesser extent) long term clinical consequences of prematurity. The total cost of preterm birth to the public sector has been estimated to be £2.946 billion. The average cost of a pre-term birth and the provision of care is £100,000k which considers 4 weeks ITU care, 4 weeks HDU care and 2 weeks SCBU prior to discharge. This does not include the financial burden of complex investigations, tests and the long term. The incremental cost per preterm child surviving to 18 years compared with a term survivor was estimated at £22885. The corresponding estimates for a very and extremely preterm child were substantially higher at £61781 and £94740, respectively. The Trust has six embedded teams, five of which deliver antenatal, intrapartum and postnatal care and the other which focuses on antenatal and postnatal care. At present no further teams are anticipated, however in line with national guidance this will be closely monitored. WUTH has undertaken its own data collection based on models of care and outcomes concluding there were benefits as described in Better Births (2016), however they were not as significant as the RCT's reported in Better Births. Improved outcomes are also mitigated by other initiatives such as Saving Babies Lives. There are currently no plans to roll out any further teams and internal review is underway to the current team's sustainability in line with staffing levels and a continued focus on those women that most benefit. Any proposed changes will take into consideration a balanced perspective with workforce, safety and system capacity.
1.4	The maternity service is currently fully established in line with BirthRate Plus® requirements, following completion of the 2024 workforce review, publication of the full report in spring 2025, and approval of the associated business case. All posts have been recruited to, and there are no further actions required at this time in relation to maternity staffing. The service will continue to monitor national guidance and await the publication of the 2026 reports, including the AMoS review, which are expected to inform any future direction or adjustments to the maternity workforce model. Until these updates are released, the current establishment is considered appropriate, sustainable, and compliant with national standards.

2	**Implications**
2.1	**Patients** • The maternity service is currently fully established in line with Birthrate Plus® requirements, ensuring that safe staffing levels are in place to support high-quality, one-to-one care in labour and timely triage assessment. This

<table>
<tr><td></td><td>provides strong assurance regarding patient safety, particularly for women with complex needs and those in vulnerable groups who continue to receive prioritised continuity of carer.
The service’s focus on evidence-based models of care, including targeted MCoC provision, supports positive patient experience, improved outcomes, and equitable access to personalised care. No further changes to staffing are required at present, and the service will adapt once national 2026 reports (including AMoS) provide updated direction.</td></tr>
<tr><td>2.2</td><td>People
The current establishment ensures that staffing levels are safe, sustainable, and aligned with national standards, supporting staff wellbeing, manageable workloads, and consistent deployment across acute and community settings.
There is no additional workforce actions required at this time. Internal review of MCoC team sustainability continues to ensure the model remains deliverable and equitable. The approach supports inclusion by ensuring that staff across all teams have fair access to training, development, and safe working conditions. Stakeholders including maternity, neonatal, community teams, and Maternity Safety Champions benefit from strengthened visibility of staffing and acuity.</td></tr>
<tr><td>2.3</td><td>Finance
There are no further financial implications arising from the maternity staffing position. The business case approved following the 2024/25 Birthrate Plus® review has been fully implemented, and all posts have been recruited to.
The current establishment represents a stable and cost-effective position, aligned with national standards and regulatory expectations.
Future financial considerations will be informed by the publication of national 2026 reports, including AMoS, which may shape future workforce requirements. Until then, no additional investment is required.</td></tr>
<tr><td>2.4</td><td>Compliance
The current staffing model ensures compliance with:
Birthrate Plus® national workforce standards
CQC recommendations for triage staffing
NICE safe staffing guidance
NHS Resolution and LMNS reporting requirements
National policy expectations relating to continuity of carer for vulnerable groups
The Trust is compliant with all current requirements, and no further actions are needed until updated national guidance is released in 2026.</td></tr>
</table>

WUTH Board of Directors

03 June 2026

Title	Neonatal Staffing Update – A review of the Neonatal Nursing and Medical Workforce
Area Lead	Chris Douglas, Chief Nurse
Author	Jo Lavery, Divisional Director of Nursing and Midwifery

Purpose of the Report and Recommendation

Report For	Information

The purpose of this paper is to provide an 6 monthly update as to neonatal nursing and medical staffing requirements. The paper also includes an update on the requirements in line British Association of Perinatal Medicine (BAPM).

The report further identifies the staffing requirements to meet all the BAPM standards and the actions being taken to meet Safety Action A of the Maternity Incentive Scheme (MIS) Year 8 compliance.

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

It is recommended that the Board of Directors:

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

Key Points to Note

It summarises the neonatal workforce position including identified deficits for both medical and nursing staff groups and outlines the quality improvement actions underway.

Key Risks

This report relates to these key risks:

BAF references 1,2,4 and 6

Positives: -

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

Negatives: -

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

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

Contribution to strategic objectives:	
Delivering Excellence – We will create the conditions for outstanding care and performance	Yes
Our People – We will nurture an inclusive, compassionate culture where people thrive	Yes
Improve & Innovate – We will make improvement and innovation part of how we work	Yes
Healthier Communities – We will drive health equity and support healthier lives	Yes
Collaboration and Partnerships – We will work as one system and one organisation	Yes
Advance Digitally – We will develop a secure, connected digital ecosystem fit for the future	No

Governance journey

Date	Forum	Report Title	Purpose/Decision
June 2026	Maternity and Neonatal Assurance Meeting	Neonatal Staffing Update – A review of the Neonatal Nursing and Medical Workforce	Information
June 2026	Divisional Quality Board	Neonatal Staffing Update – A review of the Neonatal Nursing and Medical Workforce	Information
June 2026	Patient Safety and Quality Board	Neonatal Staffing Update – A review of the Neonatal Nursing and Medical Workforce	Information

1	Narrative
1.1	**Level 3 Neonatal Unit Wirral University Teaching Hospital** Neonatology is a vibrant, progressive specialty and services will continue to change, both in terms of organisation and workforce. Outcomes for babies and families in our care improve year on year and although in many neonatal units' facilities for parents are less than optimal, the role of parents as partners in their baby's care is rightly gaining widespread acceptance in UK neonatal practice.

	Neonatal care in the UK should continue to be provided under a network model, with centralisation of care for the smallest and sickest babies. It is essential that core activity levels are maintained in both neonatal intensive care units (NICUs). NICUs (formerly Level 3 units) should admit at least 100 very low birth weight (VLBW) babies per year and undertake at least 2000 intensive care (IC) days per annum. **Neonatal categories/levels of care** • Intensive care: care provided for babies who are the most unwell or unstable and have the greatest needs in relation to staff skills and staff to patient ratios. E.g. any form of mechanical respiratory support via a tracheal tube; *both* non-invasive ventilation and parenteral nutrition; British Association of Perinatal Medicine (BAPM 2011) Categories of care. • High dependency care: care provided for babies who require highly skilled staff but where the ratio of nurse to patient is less than intensive care. BAPM 2011. • Special care: care provided for babies who requires oxygen by nasal cannula; feeding by nasogastric tube, jejunal tube or gastrostomy; has an intravenous cannula; or has any of a number of interventions as described in BAPM 2011. • Transitional care: neonatal transitional care (NTC) care provided by the mother or an alternative resident carer and a health care professional trained in delivering elements of neonatal special care but not necessarily with a specialist neonatal qualification Based on: British Association of Perinatal Medicine (2011) Categories of care and British Association of Perinatal Medicine (2017) A Framework for Neonatal Transitional Care
1.2	**Part 1 - Neonatal Nursing Workforce** **Background** **Neonatal Nurse Staffing Toolkits/ Standards** The Toolkit for High Quality Neonatal Services, the NCCR, Getting it Right First Time (GIRFT) reports and other documents produced describe the anticipated pattern of medical, nursing and allied health professional staff cover in different types of NNU. These recommendations have been further developed within the BAPM Frameworks for Practice for NICUs, LNUs and SCUs. The chance of survival of the smallest and most preterm babies relates not only to nurse staffing ratios but also to the specialist levels of education and experience of nurses delivering care. The nursing role has, through enhanced skills and both advanced and consultant practice status, become increasingly integrated with the work of doctors. Networks should ensure that demand for training and development of specialist, enhanced and advanced neonatal nurse practitioners is met and workforce planning secure. Specialised neonatal nursing requires specific knowledge and skills. All new nurses and midwives should undertake an induction programme which relates specifically to the care

of the neonate and their family within a neonatal service. All nurses attending deliveries and/or involved in direct clinical care of the neonate should have undertaken a Newborn Life Support course appropriate to their role as recommended by the Resuscitation Council UK (22) and receive regular training updates.

Neonatal Nurse Staffing Levels for Direct Patient Care

The following recommendations are based on professional consensus. They outline the numbers of nursing staff that should be available on each shift. Variations in the time available to each baby may occur, *e.g.*, during nursing staff breaks or over the initial period of admission of a baby. Because of the acute nature of neonatal practice and the difficulty of predicting patient activity, there will be times when recommended nurse staffing levels are not able to be met, and conversely time when the nursing staff provision is more generous. It is essential that the *average* nurse: patient ratio meets recommended standards. During periods of high activity, it will be necessary to consider multiple factors in deciding if the available nursing staff complement is safe, or if the NNU needs to close.

Recommendation staffing levels

- Intensive care 1:1
- HDU 1:2
- Special Care 1:4
- TC 1:4

WUTH Nursing Staffing Metrics based on BAPM standards (all data is shared monthly with the Cheshire and Mersey Neonatal Nurse Operational Development Network (NNODN)

The neonatal nursing workforce requirements are included in ***Appendix 1: -***

Neonatal Workforce - Arrowe

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

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

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

Description: QIS above 70% compliance and sustained roll out of training annually, approximately four places in two cohorts,

Status – Complaint

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

Description: Enhanced practice roles exist where QIS nurses have undergone additional training and education. Addition to QIS and currently awaiting network guidance/recommendations and potential funding.

Status – Non compliant

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

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

Fully established ANNP team embedded with two individuals in consolidation.

Status - Compliant

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

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

Status – Non compliant

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

Description: This would include but is not exclusive to nursery nurses, maternity care assistants and neonatal support workers.   We have 10.6 wte neonatal support workers for the service this includes support of the Transitional Care Unit.

The revised guidance requires Band 4 for TC support workers and a Band 7 Lead which is not the Ward Manager.

Status – Non-Compliant

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

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

Status – Non Complaint

The Board is requested to note a statement of case is being prepared and a gap analysis which will require submission to Board of Directors for oversight as required in line with the Maternity Incentive Scheme (Year 8) and will be presented at the next quarterly paper.

Current position

As stated above, WUTH NNU has been compliant in 2 of the 6 BAPM standards for nurse staffing for a number of years, with improvements in metrics noted year on year. WUTH is currently non-complaint with the enhanced roles of ENNP, Nurse consultant and specialist roles i.e. bereavement nurse, data analysis.

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

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

There are a number of specialist posts outstanding to meet BAPM compliance and neonatal service specification.

Maternity Incentive Scheme (MIS) Year 8 Safety Action A - Workforce

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

Previous Actions to address Gaps in Compliance

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

Actions:-

Other considerations:

- The support of nurses to undertake the QIS should continue from 2 to 3 staff per year. Additional Funding received from NWODN received.
- With the planned completion of the Thirlwall enquiry the development of the role of an expert bereavement neonatal nurse would support families and align with FiCare.

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- Development and interest to be explored re the role of EDI lead/champion this is a conversation that has started in the NWODN,
- Increased student placements to support and raise awareness of education and training available for student the NNU should be promoted.
- Appointment of an information analysist/ quality improvement nurse should be priorities to support data quality/production for internal and external stakeholders.
- NWODN have provided positive feedback regarding the engagement of the NNU teams with the NWODN to support patient quality outcomes.

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<u>Part 2 – Neonatal Medical Workforce</u>

Medical staffing

BAPM standards for Neonatal Intensive care Units (NICU) medical staffing are as follows: -

***Standard 1* - All tiers separate rota compliance**

Description - Staff at each level should only have responsibility for the NICU and Trusts with more than one neonatal unit should have separate cover at each level of staff at all times.

Status – Compliant

***Standard 2* - Tier 1 separate rota compliance 24/7**

Description - Tier 1 staff (ANNP or junior doctor ST1-3) should be available 24/7 and have no responsibilities outside of neonatal care. This was previously compliant at 1:7, however compliance has been updated in 2025 to a 1:8 rota.

Status – Non-Compliant

***Standard 3* - Tier 2 separate rota compliance 24/7**

Description - Tier 2 staff (ANNP or junior doctor ST4 and above) should be available 24/7 and have no responsibilities outside of neonatal care (including neonatal transport). This was previously compliant at 1:7, however compliance has been updated in 2025 to a 1:8 rota.

Status – Non Compliant

***Standard 4* - Tier 3 separate rota compliance 24/7**

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	Description - Tier 3 (consultant) staff available 24/7 with principal duties, including out of hours cover, are to the neonatal unit. ***Status – Partially Compliant*** ***Standard 5 - Tier 3 presence on the unit*** Description - Tier 3 (consultant) presence on the unit for at least 12 hours per day (generally expected to include two ward rounds/handovers). In January 2025 an additional consultant was recruited to support the workforce to be able to meet the standard and whilst the establishment is available there are adjusted duties in place therefore compliance is at 95%. The Board of Directors is required to note the position and an action plan for approval will be presented in the next neonatal workforce paper.
1.4	**Current Position** As stated above, WUTH is compliant with 2/5 BAPM standards for medical staffing and will present an action plan at the next update. **Maternity Incentive Scheme (MIS) Year 8 - Safety Action A Workforce** As part of the Maternity Incentive Scheme (MIS) there is a requirement to demonstrate that as a trust we are fully compliant with all BAPM medical staffing standards. Failure to meet these standards will result in the unit being unable to provide gold standard care as per best practice recommendations of BAPM. **Actions to Address Gaps in Compliance** • Action plan to address consultant presence at the weekend for 12 hours to meet compliance. • Statement of cases to be prepared to meet the identified deficit in Medical Workforce, Allied Health Professional and Speciality Nursing Roles. **Other Considerations** While we maintain full compliance with BAPM requirements for Tier 1 and Tier 2 rota staffing, this is often achieved using locum shifts or by redeploying consultants into junior-tier duties. This approach is costly and detrimental to consultant well-being, particularly when short-notice shifts are required. Up until the change in guidance issued by BAPM in May 2025 which revised the rota`s standard from 1-in-7 to 1-in-8 we were fully compliant with the previous standard. This change is now recorded on the Trust's risk register, with a plan to develop a business case to expand both the Tier 1 and Tier 2 workforce. Current mitigations include maximising the contribution of our Advanced Neonatal Nurse Practitioner (ANNP) workforce, supported by a successful in-house ANNP training programme.

	BAPM stipulates that for NICU services, Tier 1 and Tier 2 rotas must each comprise a minimum of 8 designated staff, dedicated solely to neonatal care, with no cross-cover from general paediatrics. At present, we fall short of this number, partly due to inconsistent trainee allocations from the Merseyside and North Wales deaneries, leading to variable fill rates especially for Tier 1. As a result, rota gaps are frequently covered using locum doctors, MTI placements, or training LAT roles. BAPM recognises ANNPs as an integral part of both Tier 1 and Tier 2 teams, provided they hold the required competencies. Given the scarcity of fully trained ANNP applicants, we must continue to invest in internal training by offering staff the opportunity to undertake accredited advanced practice programmes at Higher Education Institutions (HEIs). Further workforce modelling will be required to assess the long-term expansion needed to meet the 1-in-8 BAPM standard consistently.
1.5	**Recommendation:** In summary: - • Note the progress and the appointment of an additional consultant in line with the 24/25 action plan strengthening the workforce with the intention of Standard 5 compliant, however full compliance has not been met due to adjustments in the workforce. • Note the recommendations from the Northwest Neonatal Operational Delivery Network (NWODN) and the requirement to address and deliver the identified workforce gaps.

2	**Implications**
2.1	**Patients** • There is a risk of neonatal care and safety if the nursing and medical workforce standards cannot be met in line with BAPM recommendations.
2.2	**People** • Continuation of supporting the nursing roles in NNU to have enhanced and advanced skills to provide gold standard care to neonates. • It would not be possible to meet BAPM standards without the investment to the neonatal nursing and medical workforce.
2.3	**Finance** • The financial impact of delivering the standards in the workforce has been identified and the additional consultant is in post. • Additional financial funding will be required to meet the recommended workforce gaps identified by NWODN.

2.4	**Compliance** • Compliance with BAPM is essential to maintain Level 3 status and evidence for Safety Action A of the Maternity Incentive Scheme.

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Jo Lavery, Director of Midwifery
Wirral University Teaching Hospital
NHS Foundation Trust

8th April 2026

Dear Jo,

Thank you so much for hosting the Regional Maternity team and LMNS at our annual visit on the 5th March. It was a fantastic opportunity for us to hear directly from the team about your journey over the last 12 months, celebrate improvements in your services, and discuss your plans for the coming year.

Unfortunately, Alex Heazell, Regional Lead Obstetrician, was unable to join the visit, and so we will share back with him the learning around the PMRT cases, the potential for review of the induction of labour guideline, and the information shared by staff around middle grade rotas.

Firstly, congratulations again on your re-accreditation of BFI!

We enjoyed hearing about your various initiatives to support patients, such as the maternity passport for women with learning disabilities, digitalisation of information leaflets, and the event that you held for refugees. Thank you for sharing the priority for the next 12 months for your MNVP relating to improvements for parents experiencing bereavement. We want to acknowledge all the hard work of your passionate MNVP, Steph.

The work you presented on Edward's and Down syndrome, and how you have been auditing the work was very interesting, and we would like you to present the item at our upcoming learning event on 11th May 2026. We were also very impressed with your training approach with "Pregna"; it is a truly innovative way of MDT learning.

Following discussion about the ongoing challenges with your maternity EPR system Cerner, we recommend your digital midwife links back into Cerner to discuss developments in other systems you are aware of. They can work with you to make sure that WUTH doesn't get digitally left behind despite being locked into their bespoke maternity EPR package. Please do also consider the current other solutions for the hybrid approach to electronic and paper notes and documentation. For example, you are currently printing and storing all CTGs, which are better suited to digital archive.

I would like to speak to you further about your telephone triage, and your home birth service. As discussed, please share the legal advice you received which will be a helpful reference point for our conversation. Katie will be in touch with you to set up a meeting.

There were concerns raised with the management of your caesarean section list. We do not feel it is realistic for the labour ward manager to maintain oversight and schedule all the elective sections, and the theatre scheduling team within the trust may be able to provide support. When we meet about telephone triage, I would like you to update me with what actions have been taken to resolve this matter.

It was raised that maternity is currently not referenced in the PSIRF policy. We understand the policy is due to reviewed and we recommend you include a maternity chapter within the updated version and we are happy to share some examples from our providers, if this would be useful. Again, I look forward to hearing when this matter has been resolved. Please can you share a copy of the new policy once this is complete.

Shared learning appears to be midwifery-heavy, and we would prefer this to be shared across the MDT. You could benefit from testing whether learning from incidents is embedded in clinical services and making a difference. This could be facilitated by your safety champion during their regular department walk-rounds.

We also discussed issues around hot debriefs not being timely, and this limiting the learning you might gain following incidents. It was also noted the duplication in safeguarding processes (such as police alerts being sent to all staff rather than key colleagues). We highlighted that your safeguarding lead midwife only has 15 hours per week. We do not feel this is enough to ensure true coordination and facilitation of safeguarding activities, and we ask that this is reviewed. Please update us accordingly.

We discussed the ongoing concerns around using community midwives in times of escalation and peak activity, we advised you to consider an internal escalation rota to cover the maternity unit during times of escalation, rather than relying on community midwives. We also talked about working with the local authority to overcome obstacles in accessing estate to ensure care in the community can be provided more effectively.

It was fantastic to hear about your unique initiatives being led by the MSW, and that some of them have gone on to become midwifery students. We would encourage you to think about how you can enhance the MSW role for colleagues who do not wish to become midwives.

Overall, your commitment to service improvement, staff wellbeing, and family-centred care is evident throughout your work. We encourage you to continue building on these strengths, addressing the highlighted challenges, and pursuing collaborative solutions with the LMNS and networks.

Please do not hesitate to contact myself or colleagues at the Regional Team and LMNS if there is anything we can do to support you.

With best wishes,

Claire Mathews
North West Regional Chief Midwife
NHS England
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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

Wirral University Teaching Hospital NHSFT

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

1/10/2025 to 31/12/2025

Summary of perinatal deaths*

Total perinatal* deaths reported to the MBRRACE-UK perinatal mortality surveillance in this period: *2*

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	4	0	2	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**
0	0	0	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 = 2)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	**22-23**	**24-27**	**28-31**	**32-36**	**37+**	**Total**
Late Fetal Losses (<24 weeks)	**0**	**1**	**--**	**--**	**--**	**--**	**1**
Stillbirths total (24+ weeks)	**0**	**0**	**1**	**0**	**0**	**0**	**1**
Antepartum stillbirths	*0*	*1*	*1*	*0*	*0*	*0*	*2*
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**	**1**	**1**	**0**	**0**	**0**	**2**
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**	**1**	**1**	**0**	**0**	**0**	**2**
Mother gave birth in a setting appropriate to her and/or her baby's clinical needs:							
Yes	**0**	**0**	**1**	**0**	**0**	**0**	**1**
No	**0**	**1**	**0**	**0**	**0**	**0**	**1**
Missing	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Parental perspective of care sought and considered in the review process:							
Yes	**0**	**1**	**1**	**0**	**0**	**0**	**2**
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**	**1**	**0**	**0**	**0**	**0**	**1**
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 = 2)

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	1	1	0	0	0	2
No	0	0	0	0	0	0	0
Hospital post-mortem offered	0	1	1	0	0	0	2
Hospital post-mortem declined	0	0	0	0	0	0	0
Hospital post-mortem carried out:							
Full post-mortem	0	1	1	0	0	0	2
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	1	1	0	0	0	2
No	0	0	0	0	0	0	0
Placental histology carried out by paediatric/perinatal pathologist*:							
Yes	0	1	1	0	0	0	2
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 = 2)

Role	Total Review sessions	Reviews with at least one
Chair	2	100% (2)
Vice Chair	0	0%
Admin/Clerical	0	0%
Ambulance Team	0	0%
Bereavement Team	3	100% (2)
Community Midwife	0	0%
External	1	50% (1)
Management Team	1	50% (1)
Midwife	23	100% (2)
MNVP Lead	2	100% (2)
Neonatal Nurse	0	0%
Neonatologist	0	0%
Obstetrician	5	100% (2)
Other	4	100% (2)
Risk Manager or Governance Team	10	100% (2)
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 = 2)

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	1	0	0	0	0	1
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	0	1	0	0	0	1
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 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	1	0	0	0	1
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother	0	1	0	0	0	0	1
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 = 2)

Timing of death	Cause of death
Late fetal losses	**1 causes of death out of 1 reviews**
	Necrotising acute chorioamnionitis with maternal inflammatory response.
Stillbirths	**1 causes of death out of 1 reviews**
	Fetal vascular malperfusion, an overcoiled umbilical cord, severe acute chorioamnionitis and necrotising funisitis.
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

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

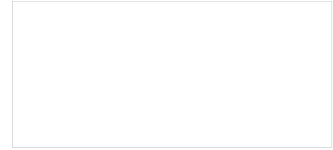
Table 8: Issues raised by the reviews which are of concern but not directly relevant to the deaths reviewed, by the number of deaths in which this issue was identified* and the actions planned

Issues raised which were identified as not relevant to the deaths	Number of deaths	Actions planned
The baby had to be transferred elsewhere for the post-mortem	2	No action entered
		No action entered
Documented evidence that pt was told what to do in event of concerns but healthcare leaflet missing.	1	QR code updated to link to Trust website - QR stickers to be added to all hand held notes to enhance info discussed at AN appointments
This baby was small for gestational age at birth, but appropriate growth surveillance had not been carried out	1	SGA guidance due update - once in circulation training to be provided
This mother did not give birth in a setting appropriate to her and/or her baby's clinical needs	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



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

Wirral University Teaching Hospital NHSFT

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

1/1/2026 to 31/3/2026

There are no published reviews for Wirral University Teaching Hospital NHSFT in the period from 1/1/2026 to 31/3/2026

WUTH Board of Directors

03 June 2026

Title	MBRRACE-UK Perinatal Mortality Report (2024 Births), Arrowe Park Hospital
Area Lead	Sarah Thompson, Neonatal Consultant and Clinical Service Lead
Author	Jo Lavery, Divisional Director of Nursing and Midwifery

Purpose of the Report and Recommendation

Report For	Information

This report provides an overview of the 11 neonatal deaths included in the MBRRACE-UK Perinatal Mortality Report for 2024 births at Arrowe Park Hospital.

It is recommended that the Board/Committee (delete as appropriate):

- Note the report.

Key Points to Note

It summarises the circumstances of each case, identifies themes for learning, and outlines the quality improvement actions underway. All cases have undergone robust governance review, including Medical Examiner scrutiny and full PMRT assessment with external representation.

Key Risks

This report relates to these key Risks:

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

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

Contribution to strategic objectives:	
Delivering Excellence – We will create the conditions for outstanding care and performance	Yes
Our People – We will nurture an inclusive, compassionate culture where people thrive	Yes
Improve & Innovate – We will make improvement and innovation part of how we work	Yes
Healthier Communities – We will drive health equity and support healthier lives	Yes

Collaboration and Partnerships – We will work as one system and one organisation	Yes
Advance Digitally – We will develop a secure, connected digital ecosystem fit for the future	No

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
22nd May 2026	Maternity and Neonatal Assurance Meeting	MBRRACE-UK Perinatal Mortality Report (2024 Births), Arrowe Park Hospital	Information

1	Narrative
1.1	**1. Overview of Neonatal Deaths** A total of 11 neonatal deaths were reported for 2024: • 7 infants were admitted to the Neonatal Unit (NNU) • 4 infants died in the delivery suite without NNU admission • This distribution reflects the complexity of cases at the threshold of viability, congenital anomalies, extreme prematurity, and severe neonatal illness. **2. Neonatal Deaths Without NNU Admission** Four infants died in the delivery suite. Key themes: • All cases occurred at extremely preterm gestations or involved non-viable presentations. • Antenatal counselling was provided appropriately from 21+5 weeks, in line with local and national guidance. • Parental wishes were central to decision-making, with clear documentation of plans for active care, airway-only intervention, or palliative care. • One case involved a concealed pregnancy with the infant brought in deceased. Good practice identified: Appropriate, timely, and compassionate antenatal counselling at the threshold of viability. **3. Neonatal Deaths Following NNU Admission** Seven infants were admitted to the NNU and subsequently died. These cases fell into three categories: a) Congenital / Birth Defects • Three infants had severe congenital anomalies, including: • Hypoplastic left heart syndrome • Cystic hygroma with multi-organ involvement • Spinal cord compression due to a calcified mass • Care was redirected following multidisciplinary review and parental discussion. PMRT grades: A, B, B. b) Early Neonatal Sepsis

- One infant (25+5 weeks) died following overwhelming E. coli sepsis associated with maternal infection. PMRT grade: B.

c) Complications of Extreme Prematurity

Three infants (23+5 to 24+1 weeks) died following severe complications including:

- Spontaneous intestinal perforation
- Severe respiratory failure
- Haemodynamic instability
- Multiple resuscitation attempts
- PMRT grades: A, B, B.

4. Governance and Review

All neonatal deaths underwent:

- Medical Examiner review
- Internal mortality review
- PMRT review with external neonatology, obstetric, and midwifery representation
- This provides strong assurance of independent scrutiny, learning capture, and transparent reporting.

5. Quality Improvement and Actions

Thermoregulation Quality Improvement Bundle: -

A Trust-wide thermoregulation bundle was introduced in late 2024, aligned with BAPM guidance. Compliance has steadily improved:

Year	Normothermia Compliance
2025	62.7%
2025	63.6%
2026 to 17 April	73.9%

Challenges remain in achieving temperature measurement within 1 hour of birth due to:

- Increased delivery room interventions (e.g., CPAP)
- Early skin-to-skin contact (“birthday cuddle”)
- These practices support bonding and stabilisation but impact compliance with the 1-hour standard.

Additional Improvement Actions: -

- Videolaryngoscopy introduction in the delivery room to support safer intubation
- Consultant presence for all deliveries ≤27 weeks
- Adherence to NWODN difficult airway guidelines
- Ongoing audit of prophylactic hydrocortisone and risk of spontaneous intestinal perforation (no significant correlation identified to date; further data collection planned)

6. Summary for Board Assurance

The 2024 neonatal deaths reflect:

- The high-risk nature of extreme prematurity
- The impact of severe congenital anomalies

	• The complexity of neonatal sepsis and multi-organ failure Key strengths include: • High-quality antenatal counselling • Strong multidisciplinary decision-making • Compassionate end-of-life care • Robust governance and external scrutiny **Key areas for continued improvement**: • Thermoregulation compliance • Delivery room intubation safety • Equipment reliability and transfer processes • The Board can be assured that learning is being actively embedded and that quality improvement actions are progressing with measurable impact.

2	Implications
2.1	**Patients** • The findings from the MBRRACE-UK report have important implications for patient safety, particularly in relation to thermoregulation, delivery room stabilisation, and the management of extremely preterm infants. The ongoing quality-improvement programme including the thermoregulation bundle, video laryngoscopy rollout, and strengthened consultant presence provides clear mitigations to reduce future risk. • Patient experience is positively influenced by the Trust's strong emphasis on compassionate antenatal counselling, shared decision-making, and sensitive end of life care. Continued focus on communication, documentation, and multidisciplinary involvement will further enhance experience. • From an EDI perspective, the review supports equitable access to high-quality neonatal care. The approach to counselling at the threshold of viability ensures that all families receive consistent, evidence-based information. Monitoring outcomes by deprivation, ethnicity, and language will help identify and address any disparities, maximising opportunities for inclusion
2.2	**People** • The report highlights workforce implications, including the need for enhanced delivery-room skills, reliable equipment, and timely temperature measurement. These requirements may increase short-term pressure on staff capacity, particularly during high-acuity periods. • Mitigations include the introduction of video laryngoscopy, strengthened guidelines, and targeted training, all of which support staff wellbeing, confidence, and professional development. • EDI considerations include ensuring that training, support, and development opportunities are accessible to all staff groups, and that learning from mortality reviews is shared inclusively across multidisciplinary teams.

	• Stakeholders affected include internal teams (Neonatal, Maternity, Obstetrics, Governance, Medical Examiners) and external partners (NWODN, regional neonatal networks, MBRRACE-UK). The findings reinforce the importance of collaborative working across organisational boundaries.
2.3	**Finance** • There are no significant immediate financial pressures arising from the report; however, some quality-improvement actions such as equipment upgrades, video laryngoscopy rollout, and enhanced training may require modest investment. • These actions represent invest to save opportunities by reducing avoidable harm, improving compliance with national standards, and supporting safer care pathways. • Strengthened governance and improved outcomes also support the Trust's position within wider programmes such as the Maternity Incentive Scheme, with potential financial benefits linked to compliance.

2.4	**Compliance**
	• The actions outlined directly support statutory and regulatory compliance, including:
	  ○ NHS Resolution expectations for learning from harm
	  ○ MBRRACE UK national reporting standards
	  ○ PMRT requirements for structured, multidisciplinary mortality review
	  ○ CQC domains relating to safety, effectiveness, and leadership
	• Strengthened governance processes, external scrutiny, and documented quality improvement activity provide assurance that the Trust is meeting its obligations for transparent reporting, learning, and continuous improvement