Ockenden Essential Actions - April 2022

			1: WORKFORCE PLANNING AND SUSTAINABILITY	RAG Rating	Lead
			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 NO		
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.		JL
		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.		JL
		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.		JL
		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.		
Essential Action : Training					
			Work to update orientation packages for |Band 7 staff with process to allocate a mentor. Decision re NQM with NHSE as moreof a risk. Additional work re support for senior leaders.		
	We state that the Health and Social Care Select Committee view that a proportion of maternity budgets must be ring-fenced for training in every maternity unit should be implemented	**5**	All trusts must implement a robust preceptorship programme for newly qualified midwives (NQM), which supports supernumerary status during their orientation period and protected learning time for professional development as per the RCM (2017) position statement for this.		SW/JL
		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.		TBC
		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.		TBC
		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.		JL/SW
		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.		JL
		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		JL
		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.		JL/MS/LMNS
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		
		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.		JL
		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.		JL,MS & LS

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.	**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.		
		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.		JL/DF
		5	The reinstatement of MCoC should be withheld until robust evidence is available to support its reintroduction	N/A	JL
		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.		JL/NP/JL
		7	All trusts must ensure there are visible, supernumerary clinical skills facilitators to support midwives in clinical practice across all settings.		
		8	Newly appointed Band 7/8 midwives must be allocated a named and experienced mentor to support their transition into leadership and management roles.		JL/DF
		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.		
		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.		JL/MS/LS
3: ESCALATION AND ACCOUNTABILITY					
			Processes in place - same to be auditted with clear SOPs.		
3: ESCALATION AND ACCOUNTABILITY	Staff must be able to escalate concerns if necessary There must be clear processes for ensuring that obstetric units are staffed by appropriately trained staff at all times. If not resident there must be clear guidelines 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		JL/LS/MS
		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		JL/LS/MS
		3	Trusts should aim to increase resident consultant obstetrician presence where this is achievable		JL/MS/LS
		4	There must be clear local guidelines for when consultant obstetricians' attendance is mandatory within the unit		
		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.		JL/MS/LS/NP
4. Clinical governance and leadership					
			Review of additional resource as detailed above to support. Training in place but to be formalised/auditted.		
4 : CLINICAL GOVERNANCE-LEADERSHIP	Trust boards must have oversight of the quality and performance of their maternity services. In all maternity services the Director of Midwifery and Clinical Director for obstetrics must be jointly operationally responsible and accountable for the maternity governance systems.	**1**	Trust boards must work together with maternity departments to develop regular progress and exception reports, assurance reviews and regularly review the progress of any maternity improvement and transformation plans		
		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		
		3	Every trust must ensure they have a patient safety specialist, specifically dedicated to maternity services		
		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		MS/LS
		5	All trusts must ensure that those individuals leading maternity governance teams are trained in human factors, causal analysis and family engagement.		JL
		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.		
		7	All maternity services must ensure they have midwifery and obstetric co-leads for audits		MS/LS/JL
5: CLINICAL GOVERNANCE - INCIDENT INVESTIGATING AND COMPLAINTS					
			Robust governance processes in place - same to be reviewed with MVP Chair		
		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.		

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.	**2**	Lessons from clinical incidents must inform delivery of the local multidisciplinary training plan.		
		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.		CC/JL
		4	Change in practice arising from an SI investigation must be seen within 6 months after the incident occurred.		JL/CC
		5	All trusts must ensure that complaints which meet SI threshold must be investigated as such		
		6	All maternity services must involve service users (ideally via their MVP) in developing complaints response processes that are caring and transparent		
		7	Complaints themes and trends must be monitored by the maternity governance team.		
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.		TBC
		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.		TBC
		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.		TBC
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.		JL/CC/MS/LS
		2	Multidisciplinary training must integrate the local handover tools (such as SBAR) into the teaching programme at all trusts.		
		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.		
		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.		JL/SW
		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.		
		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.		
		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		
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.		JL
		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		JL
		3	NICE Diabetes and Pregnancy Guidance 2020 should be followed when managing all pregnant women with pre-existing diabetes and gestational diabetes.		
		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.		
		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).		
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.		
		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.		
		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.		
		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.		
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		
		2	Midwifery-led units must complete yearly operational risk assessments.		JL/DF
		3	Midwifery-led units must undertake regular multidisciplinary team skill drills to correspond with the training needs analysis plan		JL/DF
		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		DE/JL
		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.		
		6	Centralised CTG monitoring systems must be made mandatory in obstetric units across England to ensure regular multi-professional review of CTGs		DE
11: OBSTETRIC ANAESTHESIA					
			Close links with Anaesthetic leads with compliance to standards - same to be auditted		
11: OBSTETRIC ANAESTHESIA	In addition to routine inpatient obstetric anaesthesia follow-up, a pathway for outpatient postnatal anaesthetic follow-up must be available in every trust to address incidences of physical and psychological harm.Documentation of patient assessments and interactions by obstetric anaesthetists must improve. The determination of core datasets that must be recorded during every obstetric anaesthetic intervention would result in record-keeping that more accurately reflects events.Staffing shortages in obstetric anaesthesia must be highlighted and updated guidance for the planning and provision of safe obstetric anaesthesia services throughout England must be developed.	**1**	Conditions that merit further follow-up include, but are not limited to, postdural puncture headache, accidental awareness during general anaesthesia, intraoperative pain and the need for conversion to general anaesthesia during obstetric interventions, neurological injury relating to anaesthetic interventions, and significant failure of labour analgesia		JL/NP/JL
		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.		JL/NP/JL
		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		NP/JL/JL
		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.		
	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.		NP/JL/JL
		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.		JL/JL/NP

		7	• The competency required for consultant staff who cover obstetric services out-of hours, but who have no regular obstetric commitments.		JL/JL/NP
		8	• Participation by anaesthetists in the maternity multidisciplinary ward rounds as recommended in the first report		JL/JL/NP
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		JL
		2	Unwell postnatal women must have timely consultant involvement in their care and be seen daily as a minimum		JL
		3	Postnatal readmissions must be seen within 14 hours of readmission or urgently if necessary		JL
		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.		
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.		
		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.		
		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		
		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		
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.		
		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.		
		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.		
		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.		
		5	Each network must report to commissioners annually what measures are in place to prevent units from working in isolation.		
		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		JL
		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.		JL
		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.		AB/ AK
15: SUPPORTING FAMILIES					
			Ensure support covers maternity and neonatal care/services		
15: SUPPORTING FAMILIES	Care and consideration of the mental health and wellbeing of mothers, their partners and the family as a whole must be integral to all aspects of maternity service provisionMaternity care providers must actively engage with the local community and those with lived experience, to deliver services that are informed by what women and their families say they need from their care	1	There must be robust mechanisms for the identification of psychological distress, and clear pathways for women and their families to access emotional support and specialist psychological support as appropriate.		AK
		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.		AK
		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		AK

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.

Review Date	Comments / Lead Progress
	DN secured. Midwifery staffing reviewed with BR+ however as per ask re increased uplift for additional training PER HEAD COUNT not wte sme to be reviewed as a priority.
31/3/23	Neonatal service Staffing Review undertaken and bid for national monies successful.: Adam Brown with Angela MacDonald. Anaesthetic staffing review to be undertaken :Medical & Anaesthetic staffing review to be undertaken: Alice Arch. Libby Shaw and Mustafa Sadiq. Midwifery Staffing review undertaken but same to be reviewed and updated pending CoC model: Debbie Edwards and Jo Lavery. Deadline - July 2022. Staffing review given reduction in substantive NHSE funding indicates that with further implementation of Continuity of Carer there will be a small deficit circa 5wte midwives/MSWs).
31/3/23	Dependant on midwifery model which will dictate the staffing required. From the last BR+ review staffing was identified as appropriate with the additional funding from NHSE to support complaince with BR+ findings. Workforce paper being produced to outline the deficit in staffing should continuity of carer be delivered at 100%. This will also go to Board of Directoprs to update.
31/3/23	Local uplift to be calculated and compared to BR+ staffing requirements. The uplift of 24% is in keeping with national guidance/local LMNS calculation.
	Recommendation reviewed - WUTH to await Regional / National review which is currently ongoing.
31/3/23	National programme being developed however robust preceptorship in place currently. For review once national work completed and recommendation made. Current robust programme in palce and embedded.
31/3/23	Recommendation reviewed - WUTH ready however awaiting Regional / National review
31/3/23	Shift Coordinators have attended development Programmes including Hiuman Factors training however National Programme awaited. Completion of any national prohramme to be agreed. D
31/3/23	Orientation pack currently in use but same to be reviewed nationally and to include study time for profrssional development. To continue with current process in the interim.
30/8/22	EMC Team based on DS and all midwives have undergone recognised specific HDU training.
31/3/23	Workforce strategy in place however this will be reviewed and include reference to leadership roles. Compl;eltion date - September 2022; leadership programmes and initiiatves in place
31/3/23	Recommendation reviewed - WUTH ready however awaiting Regional / National review
31/3/23	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.
30/4/23	Escalation in-house at present therefore formal process - SOP to be developed and agreed at Board to formalise process.Leads: Mustafa Sadiq and Libby Shaw. Completion date - TBA following further national guidance.

	Specific job description in place with personal specification. JD has been through matching process.
31/3/23	Debbie Edwards and Jo Lavery have reviewed staffing establishments as detailed above - staffing previously has supported CoC - withold complete roll out but continue with partial roll out pending staffing review. Further team to go out in January 2023. Review of national guidance in Febryary 2023 re next steps.
31/3/23	Final position statement on this to be formalised nationally - completion date awaited. Locally MCofC is not withheld - meeting compliance as per staffing numbers.
31/3/23	Job plans review in progress Natalie Park, Jon Lund, Mustafa Sadiq and Libby Shaw.to finalise. Review 31/3/23.
	Facilitators in post to support - guidance awaited re what should be included. Date TBCSarah Weston, Ali Campion, Jo Allen and Karen Cullen
31/3/23	Process to be reviewed and agreed with L&D Team within the Trust. Also include specific requirements for appraisals and support for leadership training eg Top Leaders; 4 C's
	CoC - Engagement, listening events, one-to-one meetings, Block C update, Senior midwife meeting joint with all leads.
31/3/23	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 Gapa analysis required with assurance mechanisms. Review following any additional NHSE recomendations.
31/12/22	Guidance in place but standalone policy with flowcharts required. Libby Shaw developing SOP as per EBC Guidance. Completion date July 2022.
31/3/23	Mustafa Sadiq and Libby Shaw to lead on embedding the Locum package being embedded and evidence of assurance
31/3/23	Ward round take place at weekend, twice daily however resident consultant presence not in place 24/7; Added to Risk Register inview of non-compliance but review completed by WUTH therefore no further action required at present.
	Guidance in place / in policy
31/3/23	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.
31/3/23	Mat Neo agenda is in place and other QI work is reported in Governance meetings but there is limited Board oversight - same to be reviewed. Maternty safety champions and regular board meetings. Processes embedded - review in March 2023.
31/3/23	Self-assessment tool completed with actons in place and presented to Board. However same to be reviewed following Ockenden and an updated self assessment to go to Board in January 2023
	In place. Structure organogram required
31/3/23	In self-assessment tool to include neonates and anaesthetists. Only obstetric time currently supported. Completion date - July 2022; reviwing additional PA's and funding to achieve
31/3/23	Staff currently trained however review of staff group required and additional training to be identified. For further review in March 2023.
	Multi-discipinary leads in place. Consultant Midwife coleads with audit/research.
31/3/23	Audit plan in place - same to be strengthened for Maternity and Neonates.Obstetric leads in place but midwifery leads for the audit plan to be agreed with Mustafa Sadiq Completion date - June 2022.
	In place and evidenced. Robust process for reviewing documents before they are sent to families.

	In place in various forums both internal and external to the Trust
31/12/22	Implementation of actions recorded and monitored however audit of same to be reviewed.Link with audit plan
31/12/22	Learning put in place immediately. - evidenced on individual reports.
	Clear MDT process in place - SI Panel. Process embedded.
	Complaint response processes in place however MVP to review and to identify improvements to further strengthen the process
	Processes currently in place to incorportae all patient feedback - LEAP to include Feedback Friday - positive and negative feedback and trends to be communicated to all staff.
31/3/23	Recommendation reviewed - WUTH ready however awaiting Regional / National review
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31/3/23	Midwifery and middle grades involved in audit - need to expand to neonatal evidence of same and allocated time to be evidenced.
	SBAR in all training including neonates. Audit of same to be further improved.
	For all staff attend human factors training however guidance re content awaited from LMNS
31/3/23	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.
	Jo Allen support for NQM. PMAs. NWAS has toolkit for staff Contact Steph Heyes. Discussed psychological support that was available in ITUs during Covid pandemic - that there was psychological support present at work.This helped staff to attend work becuase they knew the support would be there.
	Karen Cullen in post for CTG / Fetal Physiology in addition to Ali Campion and Libby Shaw.
	PROMPT, K2, fetal physiology, CIF meetings, Pass mark for CTG assessment is mandated and reviewed monthly.
31/3/23	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
31/3/23	Twins Trust coming in multi-pregnacy clinic - Mustafa Sadiq is lead.
31/3/23	Guidance in place - to link wth Rachel Tildesley and Lauren Evertts. Need to look at audit to support compliance. For FAAP 2023
31/3/23	In place but could be subject to audit to demonstrate compliance. For FAAP 2023
31/3/23	Guidance in place to support this practice - specific clinic to be reviewed. Audit compliance in March 2023. For FAAP 2023

	Policy in place with clear guidance.
	Guidance discussed at time dependant on individual situation. Guidance in place re type of monitoring as per gestation of pregnancy.
	Regional policy - link in with Angela MacDonald and Sanjeev Rath re any further update
	Current review of Level 3 neonatal services however as WUTH Level 3 currently this is not applicable.
	Practice in place - Demonstrated in care metrics
31/3/23	In place however annual check for 2023 to be undertaken for Deacombe and Eden Suite.
31/3/23	All staff included in PROMPT training however schedule of drills to be recorded and ad-hoc taken forward
31/3/23	Transfer policy in place regionally and adopted locally - same reviewed and updated with NWAS.
	Pathways in place - same being reviewed regionally.
31/3/23	Purchase of system currently being undertaken. Procurement In progress once approved at CMG meeting. IT support required and request for same requested. Review March 2023.
31/3/23	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
31/3/23	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
31/3/23	Documentation is recorded in maternity record hwoever need to review audit process. Completion date - July 2022; part of assurance process 11.1; part of assurance process 11.1
TBC	Recommendation reviewed - WUTH ready however awaiting Regional / National review
31/3/23	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
31/3/23	Staffing of same to be reviewed. Completion date - July 2022; assurance process to be developed

31/3/23	As point 5; assurance process to be developed
31/3/23	All anaesthetists attend PROMPT MDT training; assurance process to be developed
31/3/23	Process in place - document to be developed to support process
31/3/23	Process in place - document to be developed to support process
31/3/23	Process in place - document to be developed to support process
	Acuity tool used and effective
	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
	EMC staff and coordinators - can be inlcuded in development package for coordinators
	In place - dual with obstetrics and neonates
	Pathway in place and in use.
	Guidance in place
31/3/23	Recommendation reviewed - WUTH ready however awaiting Regional / National review
	This is a unit with onsite Level 3 NICU
31/3/23	Recommendation reviewed - WUTH ready however awaiting Regional Neonatal ODN Guidance
31/3/23	Recommendation reviewed - WUTH ready however awaiting Regional Neonatal ODN Guidance
31/3/23	Evidence of this happening in practice to be confirmed and to be followed up with Angela McDonald, Adam Brown and Sanjeev Rath
31/3/23	NLS Guidance followed - action to be followed up with neonatal team
31/3/23	Staffing review undertaken as above -Adam Brown and Anand to feedback to DMB.
31/3/23	Perinatal mental health team in post. GIRFT identified need for neonatal support. This is in place regionally
31/3/23	Perinatal mental health team in post with further support from Psychiatric Liason team..
31/3/23	Psychiatric liaison team and dedicated psychologist to support. WUTH also involved in regional project to further enhance PMH support.

NHS England

Three year delivery plan for maternity and neonatal services

March 2023

Contents

Summary

With this plan we aim to make care safer, more personalised, and more equitable, by:

Listening to women and families with compassion which promotes safer care.

- All women will be offered personalised care and support plans. By 2024, every area in England will have specialist care including pelvic health services and bereavement care when needed; and, by 2025, improved neonatal cot capacity.
- During 2023/24, Integrated care systems (ICSs) will publish equity and equality plans and take action to reduce inequalities in experience and outcomes.
- From 2023/24, Integrated care boards (ICBs) will be funded to involve service users. National policy will be co-produced, keeping service users at the heart of our work.

Supporting our workforce to develop their skills and capacity to provide high-quality care.

- Trusts will meet establishment set by midwifery staffing tools and achieve fill rates by 2027/28, with new tools to guide safe staffing for other professions from 2023/24.
- During 2023/24, trusts will implement local evidence-based retention action plans to positively impact job satisfaction and retention.
- From 2023, NHS England, ICBs, and trusts will ensure all staff have the training, supervision, and support they need to perform to the best of their ability.

Developing and sustaining a culture of safety to benefit everyone.

- Throughout 2023, effectively implement the NHS-wide “PSIRF” approach to support learning and a compassionate response to families following any incidents.
- By 2024, NHS England will offer a development programme to all maternity and neonatal leadership teams to promote positive culture and leadership.
- NHS England, ICBs, and trusts will strengthen their support and oversight of services to ensure concerns are identified early and addressed.

Meeting and improving standards and structures that underpin our national ambition.

- Trusts will implement best practice consistently, including the updated Saving Babies Lives Care Bundle by 2024 and new “MEWS” and “NEWTT-2” tools by 2025.
- In 2023, NHS England’s new taskforce will report on how to better detect and act sooner on safety issues, arising from relevant data, in local services.
- By 2024, NHS England will publish digital maternity standards; services will progress work to enable women to access their records and interact with their digital plans.

Introduction

1. This plan sets out how the NHS will make maternity and neonatal care safer, more personalised, and more equitable for women, babies, and families. We are grateful to the many people and organisations that have shared what needs to be done including NHS staff, Donna Ockenden, Dr Bill Kirkup, and organisations representing families. Most importantly, we would like to thank those using maternity and neonatal services for informing this plan. While the birth of a baby represents the happiest moment of many people's lives, some families have experienced unacceptable care, trauma, and loss, and with incredible bravery have rightly challenged the NHS to improve.

2. The summary above sets out the benefits we expect to deliver for families through this plan. This will continue to require the dedication of everyone working in NHS maternity and neonatal services in England, who work tirelessly to support families and improve care. Most women have a positive experience of NHS maternity and neonatal services, and outcomes have improved with over 900 more families welcoming a healthy baby each year compared to 2010.

3. But we must acknowledge that there are times when the care we provide is not as good as we want it to be. Recent independent reports by Donna Ockenden on maternity services in Shrewsbury and Telford and by Dr Bill Kirkup on maternity and neonatal services in East Kent, and previously Morecambe Bay, set out many examples of poor care over years. We know that families from some groups, especially ethnic minorities, have had particularly poor experiences. We must work together to change this, and this plan sets out how we will do this.

4. In preparing this plan we have listened to what you have to say. We know all staff want women and babies to be at the centre of care, and with so many improvement initiatives it can be difficult to know what to prioritise. We know gaps in staffing mean those who provide care do not always have time to learn and improve, and on occasion, struggle to provide care to the highest standards. We have heard that some people feel disempowered by negative team cultures and a lack of strong leadership.

5. For the next three years, we are asking services to concentrate on **four high level themes**. Please take some time to consider these themes, what they mean to you and to the women and babies you care for. Working together, we can make a real difference.

Responsibilities

6. This plan sets out what we need to have in place, and responsibilities for each part of the NHS:

   - Trusts are the main operational unit of maternity services in the NHS and the employer of most staff. Trust boards have a statutory duty to ensure the safety of care, including ensuring staff have the resources they need.
   - Integrated care boards (ICBs) commission most maternity services. Each ICB will be a partner in an integrated care system (ICS). ICSs are a partnership of organisations that plan and deliver joined up health and care services. The local maternity and neonatal system (LMNS) is the maternity and neonatal arm of the ICS. ICBs commission maternity and neonatal voices partnerships (MNVPs) which are designed to facilitate participation by women and families in local decision-making.
   - NHS England provides national leadership for the NHS in England. NHS England operates through regional teams which are responsible for relationships with individual ICBs. NHS England has statutory responsibility for commissioning neonatal services, through regional specialised commissioning teams and operational delivery networks (ODNs).

7. It is everyone's responsibility to provide or support high quality care. That includes a responsibility at each level of the NHS to understand the quality of care and identify, address, and escalate concerns. We have sought to improve our approach to quality surveillance at trust, ICS, regional, and national level. This involves bringing together all relevant partners at each level to facilitate robust understanding and action, informed by shared and accurate information. Some trusts need additional support to improve – this is provided through the Maternity Safety Support Programme (MSSP), which aligns with the overall NHS Oversight Framework and tiered support, so that support for maternity and neonatal care forms part of a wider response where needed.

What you told us

8. We could not develop this delivery plan without talking to people who use, work in, lead, or have an interest in these services. We want to thank everyone who shared their views to inform this plan. We held 50 meetings reaching over 1,000 attendees, including 191 service users, 419 workforce members, 329 leaders of services, systems, and regions, and 106 stakeholders. We additionally received 2,128 responses to our survey from 782 service users, 1,133 workforce members, 105 leaders, and 108 stakeholders.

9. While most people using maternity and perinatal services are women, the CQC Maternity Survey (2022) found that 0.65% of respondents stated that their gender was not the same as their sex registered at birth. Intersex, transgender, and non-binary people experiencing pregnancy and birth can experience particular health inequalities including poorer access and a lack of information and support in relation to their specific clinical and care needs within maternity services. The information in this plan also applies to these individuals; particularly the principles described in Theme 1.

10. While each of the groups who helped inform this plan had different areas they gave greatest importance to, there was clear agreement on what the plan's focus should be. This consensus has shaped the four themes, and the objectives within each of these.

11. The most consistent priority among those using and providing services was safe care. Delivering safe care remains central to this delivery plan.

    "Safe, compassionate care, which allows you the confidence to speak up and be listened to if something is not right." (Service user)

    "We need to take action and make a pledge to improve the safety of every maternity service in England." (Leader)

12. You told us how important improving equity and equality is. We have a dedicated objective on improving equity.

    "Those that are most vulnerable should be enabled to have a strong voice within maternity care provision." (Stakeholder)

13. You told us that we need to be clear about who is responsible for doing what, and to bring the asks of services and systems into one place. This delivery plan sets out clear responsibilities and measures of success across services and systems.

"One clear plan that looks to encompasses the recommendations from various reports such as Better Births, Ockenden, Kirkup." (Workforce member)

Listening to and working with women and families with compassion

14. You told us that personalised care supports safety, makes women feel valued, and avoids families needing to re-tell their story – who they are or what they need. You told us it is important to join up care across maternity and neonatal pathways.

"To be treated as an individual human being." (Service user)

"Consistency! I saw so many different people I had to tell them my 'story' every time." (Service user)

"Being fully informed without judgement on pros and cons of all care offered." (Service user)

"Listening to the families using the care and embedding their voices along all pathway." (Leader)

"Supporting parents to be actively involved in the care of their baby on the neonatal unit (family integrated care)." (Service users)

Growing, retaining, and supporting our workforce

15. You told us that there needs to be enough staff in services, with the time and training to support their effectiveness as well as to protect their wellbeing.

"Safe staffing that will then provide safe and personalised care." (Leader)

"Enough staffing to feel supported, safe and provide care when it is needed." (Service user)

"Adequate staff with the appropriate training working in the right environment. Having the time and resources to listen to women and their families." (Workforce member)

Developing and sustaining a culture of safety, learning, and support

16. You told us that there needs to be a positive culture and leadership in services. Staff need to be free to speak up, in an environment that learns from experiences and incidents and does so with compassion.

"Listening, learning and facing up to failings." (Stakeholder)

"Confidence in the care provider, trust, integrity and honesty if mistakes occur." (Leader)

"Leadership training to enable managers to better manage teams and support them." (Workforce member)

"Psychological safety at work and teams that work together with a shared vision and a foundation of kindness." (Stakeholder)

Standards and structures that underpin safer, more personalised, and more equitable care

17. You told us that we need to improve our data collection to help oversight and improvement, among other important standards and infrastructure. Our fourth theme focuses on these crucial elements that support the other themes.

"Notes to be available to all staff when required rather than just to one person." (Service user)

"Delivering high quality, evidence-based care in a local environment for service users." (Workforce member)

"Improved data collection and IT systems - joined up maternity and neonatal electronic patient record systems which are user friendly and accessible." (Workforce member)

"Organisational transparency and providing in depth data to provide meaningful data that can be used to prevent as well as respond to trends and themes." (Leader)

Theme 1: Listening to and working with women and families with compassion

1.1 Listening and responding to all women and families is an essential part of safe and high-quality care. It improves the safety and experience of those using maternity and neonatal services and helps address health inequalities. Better Births identified that "women wanted to be listened to about what they want for themselves and their baby, and to be taken seriously when they raise concerns". The Ockenden report into maternity services at Shrewsbury and Telford described how families who raised concerns "were brushed aside, ignored and not listened to". This section sets out actions for personalised care, improving equity, and working with service users.

1.2 Key commitments for women and families include:

Empowering staff to ensure that all women are offered personalised care and support plans as part of their care.

Ensuring pregnant women and new mothers have access to pelvic health services in every area of England by 2024 to identify, prevent, and treat common pelvic floor problems.

Rolling out perinatal mental health services to improve the availability of this specialist care.

Investing to ensure the availability of bereavement services 7 days a week by the end of 2023/24 for women and families who sadly experience loss.

Funding to increase and better align neonatal cot capacity throughout 2023/24 and 2024/25.

Implementing local plans to reduce inequalities in experience and outcomes for women and babies, including neonatal and maternal mortality.

Ensuring local maternity and neonatal voice partnerships (MNVPs) have the infrastructure they need to be successful and put service user voices at the heart of service improvement. This includes funding MNVP workplans and providing appropriate training, and administrative and IT support.

Objective 1: Care that is personalised

1.3 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. This information can be included in each personalised care and support plan to help ensure that service users do not have to repeat their story. While many women and babies experience excellent personalised care (CQC, 2023), it is clear from independent reports that not all do.

1.4 Our ambition is:

- 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.
- 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.
- 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 Re:Birth report, and is co-produced.
- All women have equitable access to specialist care, including perinatal mental health services, perinatal pelvic health services, maternal and fetal medicine networks, and neonatal care, when needed.
- 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.

- 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.
- Compassionate and high-quality care for bereaved families including appropriate accommodation, which is easily accessible but separate from maternity and neonatal units.

How we will make this happen

1.5 It is the responsibility of trusts to:

- Empower maternity and neonatal staff to deliver personalised care by providing the time, training, tools, and information, to deliver the ambitions above.
- Monitor the delivery of personalised care by undertaking regular audits, seeking feedback from women and parents, and acting on the findings.
- Consider the roll out of midwifery continuity of carer in line with the principles around safe staffing that NHS England set out in September 2022.
- Achieve the standard of the UNICEF UK Baby Friendly Initiative (BFI) for infant feeding, or an equivalent initiative, by March 2027.

1.6 It is the responsibility of integrated care boards (ICBs) to:

- Commission for and monitor implementation of personalised care for every woman.
- Commission and implement perinatal pelvic health services by the end of March 2024, in line with national service specifications, to identify, prevent, and treat common pelvic floor problems in pregnant women and new mothers.
- Commission and implement community perinatal mental health services including maternal mental health services, in line with national service specifications, to improve the availability of mental health care.

1.7 NHS England will:

- Work with service users and other partners to produce standardised information to aid decision-making, focusing on priorities identified by service users: intrapartum interventions, mode of birth, induction of labour, and pain relief.

- Extend the national support offer to the 38 maternity services yet to achieve UNICEF BFI accreditation or an equivalent initiative.
- Publish national postnatal care guidance by the end of 2023, setting out the fundamental components of high-quality postnatal care, to support ICSs with their local improvement initiatives. Information for GPs on the 6-8 week postnatal check will be published in spring 2023.
- In Spring 2023, publish a national service specification for perinatal pelvic health services alongside associated implementation guidance.
- Create a patient reported experience measure (PREM) by 2025 to help trusts and ICBs monitor and improve personalised care.
- By March 2024, act on findings from the evaluation of independent senior advocate pilots as set out in the interim Ockenden report.
- Invest to ensure availability of bereavement services 7 days a week by the end of 2023/24. This will help trusts to provide high quality bereavement care including appropriate post-mortem consent and follow-up.

Objective 2: Improve equity for mothers and babies

1.8 Significant health inequalities exist in maternity and neonatal care in England. For example, outcomes for women and babies from minority ethnic groups are worse than for white women, and outcomes for those living in the most deprived areas are worse than for those in the least deprived (MBRRACE-UK, 2022). Though we know NHS staff want to provide the best care to every woman and baby, a National Institute for Health and Care Research funded study found that "multiple structural and other biases exist in UK maternity care". (Knight, M et al, 2021).

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 areas.

1.9 Our ambition is:

- To reduce inequalities for all in access, experience, and outcomes.
- Targeted support where health inequalities exist in line with the principles of proportionate universalism.
- Services listen to and work with women from all backgrounds to improve access, plan, and deliver personalised care. Maternity and neonatal voice partnerships

ensure all groups are heard, including those most at risk of experiencing health inequalities.

- The NHS collaborates with local authority services, other public sector organisations, and a wide range of private and voluntary sector organisations (NHS Constitution Principle 5, 2021) to address the social determinants of health, which are a significant driver of health inequalities (WHO, 2022).

How we will make this happen:

1.10 It is the responsibility of trusts to:

- Provide services that meet the needs of their local populations, paying particular attention to health inequalities. This includes facilitating informed decision-making, for example choice of pain relief in labour where we know there are inequalities, ensuring access to interpreter services, and adhering to the Accessible Information Standard in maternity and neonatal settings.
- Collect and disaggregate local data and feedback by population groups to monitor differences in outcomes and experiences for women and babies from different backgrounds. This data should be used to make changes to services and pathways to address any inequity or inequalities identified, to improve care.

1.11 It is the responsibility of ICBs to:

- During 2023/24, continue to publish and lead implementation of their LMNS equity and equality action plan alongside neonatal ODNs, working across organisational boundaries.
- Commission MNVPs to reflect the ethnic diversity of the local population and reach out to seldom heard groups.

1.12 NHS England will:

- Provide regional and national support for the implementation of LMNS equity and equality action plans.
- Pilot and evaluate new service models designed to reduce inequalities, including enhanced midwifery continuity of carer, and from 2023, culturally sensitive genetics services for couples practising close relative marriage in high need areas.
- Continue to work with the Maternity Disparities Taskforce to explore disparities in maternity care and identify how to improve outcomes.

- In spring 2023, publish the National Review of Health and Social Care in Women's Prisons. This review covers maternity and perinatal services.

Objective 3: Work with service users to improve care

1.18 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 organisations representing service users.

1.19 Our ambition is:

- MNVPs listen to and reflect the views of local communities. All groups are heard, including bereaved families.
- MNVPs have strategic influence and are embedded in decision-making.
- MNVPs have the infrastructure they need to be successful. Workplans are funded. MNVP leads, formerly MVP chairs, are appropriately employed or remunerated and receive appropriate training, administrative and IT support.

1.20 In addition, neonatal parental advisory groups represent service user experience as part of operational delivery networks.

How we will make this happen:

1.21 It is the responsibility of trusts to:

- Involve service users in quality, governance, and co-production when designing and planning delivery of maternity and neonatal services.

1.22 It is the responsibility of ICBs to:

- Commission and fund MNVPs, to cover each trust within their footprint, reflecting the diversity of the local population in line with the ambition above.
- Remunerate and support MNVP leads, and ensure that an annual, fully funded workplan is agreed and signed off by the MNVP and the ICB. All MNVP members should have reasonable expenses reimbursed.
- Ensure service user representatives are members of the local maternity and neonatal system board.

1.23 NHS England will:

- Co-produce national policy and quality improvement initiatives with national and regional service user representatives and MNVP leads.
- Through operational delivery networks, support parent representation in the governance of neonatal services.
- Provide funding for clinical leadership and programme management of ICBs, which includes funding to support service user involvement.

Determining success for Theme 1

1.24 We will determine overall success by listening to women and their families:

- Our outcome measure for this theme will be indicators of women's experience of care from the Care Quality Commission (CQC) maternity survey. They will be aggregated at trust, ICB, and national levels and at national level analysed by ethnicity and deprivation.
- We will use these progress measures:
  - Perinatal pelvic health services and perinatal mental health services are in place.
  - The number of women accessing specialist perinatal mental health services as indicated by the NHS Mental Health Dashboard.
  - The proportion of maternity and neonatal services with UNICEF BFI accreditation.
- Evidence which ICBs can use includes:
  - Feedback on personalised care gathered via MNVPs from a wide range of service users.
  - Local evidence of working with women and families to improve services, including co-production.
- Relevant regulation and incentivisation includes:
  - The CQC will continue to consider compassionate and personalised care as key lines of enquiry during inspections.
  - The NHS Resolution CNST Maternity incentive scheme which encourages the use of MNVPs.

Case Study: Seeking Sanctuary Clinic - to enhance the maternity care of anyone seeking sanctuary

The Seeking Sanctuary Clinic, hosted in Berkshire West, is a specialist maternity clinic developed in 2021 from co-production between Royal Berkshire NHS Foundation Trust maternity team, and Berkshire West public health team, to enhance the maternity care of anyone seeking sanctuary such as refugees, asylum seekers, those fleeing conflict, undocumented migrants and people who have been trafficked.

This is a 'one stop shop' style clinic held in a children's centre, delivered in two-hour sessions held every two months, aimed specifically for these families, in addition to their usual antenatal and postnatal care. The barriers to access and inequalities that these families may be experiencing are removed where possible. For example, women are able to bring their partners and children with them, there are interpreters booked for every language in attendance, refreshments are provided and transport is available to support people to get to the clinic.

There are many health care professionals and voluntary organisations that come together at the clinic including midwifery and obstetrics. There is also accessible antenatal education with New Directions, sexual health, health visiting, a tuberculosis service, health in pregnancy advisors, Compass Recovery College (mental health and wellbeing support), Reading Refugee Support and Reading Voluntary Action.

The clinic is ever evolving, and additional professionals and organisations are invited to sessions to meet the bespoke needs of the group. Local charity The Cowshed donated to the clinic enabling each family that attends to be provided a ready-made birth bag to assist them on their journey.

The local Maternity Voices Partnership also attends to offer feedback sessions for these groups. While the project is in an initial evaluation phase, feedback so far has been very positive from service users, with more than fifty families supported so far, predominantly from Afghanistan, Syria, and Ukraine.

Theme 2: Growing, retaining, and supporting our workforce

2.1 The ambition of safer, more personalised, and more equitable maternity and neonatal services in this plan can only be delivered by skilled teams with sufficient capacity and capability. However, despite significant investment leading to increases in the midwifery, obstetric, and neonatal establishment, NHS maternity and neonatal services do not currently have the number of midwives, neonatal nurses, doctors, and other healthcare professionals they need. This means existing staff are often under significant pressure to provide the standard of care that they want to. We need to change that. The plan is informed by the best available evidence, including the QMNC framework which underpins the NMC midwifery standards. This theme sets out three areas of action for maternity and neonatal staffing: continuing to grow our workforce; valuing and retaining our workforce; and investing in skills.

2.2 Key commitments for women and families include:

NHS services will ensure the right numbers of the right staff are available to provide the best care for women and babies through regular local workforce planning, including trusts meeting staffing establishment levels and achieving fill rates by 2027/28 for midwifery.

Implementing staff retention improvement action plans to identify and address local retention issues. During 2023/24, retention midwives will be funded in every maternity unit.

Supporting the retention and recruitment of staff caring for babies in neonatal units by continuing to invest in education and workforce leads.

Providing a core competency framework that will inform local mandatory training programmes to ensure that the skills relevant to staff's roles are kept up to date.

Objective 4: Grow our workforce

2.3 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.

2.4 Established midwifery posts have increased by over 2,000 WTE since March 2021, with obstetric consultant posts and maternity support worker posts each increasing by around 400 WTE since April 2021. For neonatal services, we have invested to establish over 550 new neonatal nurses, care-coordinators, and workforce and education leads, and have committed to funding 130 WTE new allied health professional and over 40 WTE new psychologist posts.

2.5 Our ambition is for:

- Workforce capacity to grow as quickly as possible to meet local needs.
- 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, absence, and leave.
- Aligned local and national strategies supporting recruitment to those vacant posts identified through workforce planning.

How we will make this happen

2.6 It is the responsibility of trusts to:

- Undertake regular local workforce planning, following the principles outlined in NHS England's workforce planning guidance. Where trusts do not yet meet the staffing establishment levels set by Birthrate Plus or equivalent tools endorsed by NICE or NQB, to do so and achieve fill rates by 2027/28.
- Develop and implement a local plan to fill vacancies, which should include support for newly qualified staff and clinicians who wish to return to practice.
- Provide administrative support to free up pressured clinical time.

2.7 It is the responsibility of ICBs to:

- Commission and fund safe staffing across their system.
- Agree staffing levels with trusts, following NHS England workforce planning principles, for those healthcare staff where an evidence-based planning tool does not yet exist. National guidance should be considered when determining staffing levels (for example, guidelines for the provision of anaesthesia services for an obstetric population and implementing the recommendations of the neonatal critical care transformation review).

- Align commissioning of services to meet the ambitions outlined in this delivery plan with the available workforce capacity. It is expected that from 2024/25 ICBs will assume delegated responsibility for the commissioning of neonatal services.
- Work with trusts and higher education institutions to maximise student placement capacity, ensuring the breadth and quality of clinical placements.

2.8 NHS England will:

- Assist trusts and regions with their workforce growth plans by providing direct support, including through operational delivery networks for neonatal staffing.
- Boost midwifery workforce supply across undergraduate training, apprenticeships, postgraduate conversion, return to midwifery programmes, and international recruitment.
- Increase medical training places across obstetrics and gynaecology and anaesthetics, to expand the consultant workforce in maternity services.
- Collaborate with the Royal College of Obstetricians and Gynaecologists (RCOG) to support their work developing an obstetric workforce planning tool, to be published in 2023/24. This initiative will help establish the staffing levels required to appropriately resource clinical leadership and intrapartum care.

Objective 5: Value and retain our workforce

2.9 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. A growing number of staff who leave are aged under 55 and do so for reasons other than retirement. Some staff groups, including ethnic minority staff, are more likely to report negative experiences of working in NHS maternity and neonatal services. We need to do more to improve the experience of all our staff, to retain them within the NHS.

2.10 Our ambition is:

- 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.
- All staff are included and have equality of opportunity.

- A safe environment and inclusive culture in which staff feel empowered and supported to take action to identify and address all forms of discrimination.

How we will make this happen

2.11 The NHS Long Term Plan and NHS People Plan set out how improving the experience of our NHS people will encourage them to stay with us for longer.

2.12 It is the responsibility of trusts to:

- Identify and address local retention issues affecting the maternity and neonatal workforce in a retention improvement action plan.
- Implement equity and equality plan actions to reduce workforce inequalities.
- Create an anti-racist workplace, including for example, acting on the principles set out in the combatting racial discrimination against minority ethnic nurses, midwives and nursing associates resource.
- Identify and address issues highlighted in student and trainee feedback surveys, such as the National Education and Training Survey.
- Offer a preceptorship programme to every newly registered midwife, with supernumerary time during orientation and protected development time. Newly appointed Band 7 and 8 midwives should be supported by a mentor.
- Develop future leaders via succession planning, ensuring this pipeline reflects the ethnic background of the wider workforce.

2.13 It is the responsibility of ICBs to:

- Share best practice for retention and staff support.
- Highlight common or high-impact retention challenges to the national team to enable consideration of a national approach.

2.14 NHS England will:

- Support retention with funding to continue a retention midwife in every maternity unit during 2023/24, with ICBs maintaining the focus on retention thereafter.
- Continue to invest in neonatal operational delivery network (ODN) education and workforce leads to support the recruitment and retention of neonatal staff.
- In 2023/24, provide funding to establish neonatal nurse quality and governance roles within trusts, to support cot-side clinical training and clinical governance.

- In 2023/24, strengthen neonatal clinical leadership with a national clinical director for neonatal and national neonatal nurse lead.
- Continue to address workforce inequalities through the Workforce Race Equality Standard.
- Provide national guidance for implementation of the A-Equip model and for the professional midwifery advocate role to provide restorative clinical supervision in local services.
- By July 2023, develop a safe clinical learning environment charter for trusts; by April 2024, develop models for coaching; and, by October 2024, embed a framework to support the standards of supervision and assessment for midwifery students. These initiatives will help to ensure high quality clinical placements for those training to be midwives.

Objective 6: Invest in skills

2.15 Staff feel valued when they are supported to develop. We are investing in our staff by ensuring they have ongoing training and career development opportunities. Effective training of frontline clinicians in technical and non-technical skills has been shown to improve outcomes, yet unwarranted variation in training and competency assessment currently exists, especially for temporary staff (for example, Stulberg et al, 2020, McCulloch et al, 2008).

2.16 Our ambition is:

- 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.
- 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.

How we will make this happen

2.17 It is the responsibility of trusts to:

- Undertake an annual training needs analysis and make training available to all staff in line with the core competency framework.

- Ensure junior, speciality and associate specialist obstetricians, and neonatal medical staff have appropriate clinical support and supervision in line with RCOG guidance and BAPM guidance, respectively.
- Ensure temporary medical staff covering middle grade rotas in obstetric units for two weeks or less possess an RCOG certificate of eligibility for short-term locums.

2.18 NHS England will:

- Refresh the curriculum for maternity support workers (MSWs) by June 2023.
- Provide tools to support implementation of the MSW competency, education, and career development framework by September 2023.
- Work with RCOG to develop leadership role descriptors for obstetricians by summer 2023 to support job planning, leadership, and development.
- Establish a sustainable national route for the training of obstetric physicians, to support the development of maternal medicine networks.
- Work with royal colleges and professional organisations to understand and address the challenges involved in recruiting and training the future neonatal medical workforce.
- Through action set out above to grow the workforce, help to address pressures on backfill for training.

Determining success for Theme 2

2.19 We will determine overall success by listening to staff:

- Our outcome measures for this theme will be the NHS Staff Survey, the National Education and Training Survey, and the GMC national training survey.
- Our progress measures will be:
  - Establishment, in-post and vacancy rates for obstetricians, midwives, maternity support workers, neonatologists, and neonatal nurses, captured routinely from provider workforce return data.
  - In line with the 2023/24 workforce planning guidance, there will be an annual census of maternity and neonatal staffing groups. This will facilitate the collection of baseline data for obstetric anaesthetists, sonographers, allied health professionals, and psychologists.

  - To assess retention, we will continue to monitor staff turnover and staff sickness absence rates alongside NHS Staff Survey questions on staff experience and morale.
- Evidence that ICBs can use includes:
  - Progress against workforce, retention, succession, and training plans.
  - Local staff feedback mechanisms.
  - Progress against the nursing and midwifery high impact retention interventions.
- Relevant regulation and incentivisation includes:
  - The CQC inspection criteria includes key lines of enquiry around staff skills, knowledge, experience, and opportunities for development.
  - The NHS Resolution CNST maternity incentive scheme incentivises trusts to evidence that training in accordance with the core competency framework is in place.

Case study: One stop obstetric ambulatory service

The Chelsea and Westminster Hospital NHS Foundation Trust cares for approximately 5,500 maternity patients per year. The maternity team identified common themes in complaints about their service, including delays in receiving care and long waits for obstetric or scan reviews. The team felt they could improve triage management, patient experience and care, through a truly multidisciplinary approach so set up a 'one stop' service since January 2021.

The team recognised a key cause of delay within the department was delays in obstetric reviews. They were able to increase consultant presence and recruit a clinical fellow with obstetric ultrasound training to work solely in the triage department for five mornings a week, to deliver a 'see and treat' set up, comparable to the way emergency departments are run.

The triage team also includes midwives and maternity support workers, who greet attendees, perform initial observations and a dedicated receptionist who enables clinicians to focus on care rather than administrative tasks. Some midwives have developed professionally to perform tasks that are usually undertaken by obstetricians, such as prescribing and performing presentation scans.

From October 2022 to February 2023 the service has had on average 850 visits per month, with around 100 ultrasound scans performed. The department answers approximately 2,500 phone calls per month, with one midwife allocated to answer phone calls each day to triage and support women.

Improvements in the new obstetric ambulatory service triage system mean the department works more efficiently and safely with staff feeling better supported. Waiting times have been reduced, with 80-95% of women seen within 15 minutes of arrival which exceeds the national KPI (within 30 minutes) for maternity triage services. Feedback from women has also been increasingly positive. The team are exploring future opportunities to expand the service hours and increase the scope of midwifery and maternity support workers, supporting the team's development and dynamic skillset.

Theme 3: Developing and sustaining a culture of safety, learning, and support

3.1 An organisation's culture is shaped by the behaviour of everyone in it. In maternity and neonatal services, a safety culture improves the experience of care and outcomes for women and babies and supports staff to thrive. We want everyone to experience the positive culture that exists in many services – poor cultures need to be challenged and addressed. The failures in care identified in the Kirkup report stemmed from weaknesses in culture throughout the organisation, including a lack of teamworking, professionalism, compassion, listening, and learning. This theme sets out actions in three areas: developing and sustaining a positive safety culture for everyone; learning and improving; and support and oversight.

3.2 Key commitments for women and families include:

> Supporting staff to work with professionalism, kindness, compassion, and respect. Leaders will empower their teams to do this, with practical guidance and training through the perinatal culture and leadership programme by 2024.
>
> Implementing an NHS-wide approach in 2023 for all incidents to support families with a compassionate response, and to ensure learning.
>
> Listening and acting upon issues raised by staff or service users through Freedom to Speak Up (FTSU) Guardians, the complaints process, or maternity and neonatal voices partnerships (MNVPs).

Objective 7: Develop a positive safety culture

3.3 Culture is everyone's responsibility and key to enabling cultural change is compassionate, diverse, and inclusive leadership in maternity and neonatal services and beyond.

3.4 Our ambition is:

- 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.
- Teams value and develop people from all backgrounds and make the best use of their diverse skills, views, and experiences.
- 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'.
- Instances of behaviour that is not in line with professional codes of conduct, are fairly addressed before they become embedded or uncontrollable.
- 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.
- Staff investigating incidents are provided with appropriate training, while those staff affected by an incident are offered timely opportunity to debrief.

How we will make this happen

3.5 It is the responsibility of trusts to:

- Make sure maternity and neonatal leads have the time, access to training and development, and lines of accountability to deliver the ambition above. This includes time to engage stakeholders, including MNVP leads.
- Support all their senior leaders, including board maternity and neonatal safety champions, to engage in national leadership programmes (see below) by April 2024, identifying and sharing examples of best practice.
- At board level, regularly review progress and support implementation of a focused plan to improve and sustain culture, including alignment with their FTSU strategy.
- Ensure staff are supported by clear and structured routes for the escalation of clinical concerns, based on frameworks such as the Each Baby Counts: Learn and Support escalation toolkit.
- Ensure all staff have access to FTSU training modules and a Guardian who can support them to speak up when they feel they are unable to in other ways.

3.6 It is the responsibility of ICBs to:

- Monitor the impact of work to improve culture and provide additional support when needed.
- Provide opportunities for leaders to come together across organisational boundaries to learn from and support each other.

3.7 NHS England will:

- By April 2024, offer the perinatal culture and leadership programme to all maternity and neonatal leadership quadrumvirates including the neonatal, obstetric, midwifery and operational leads. This includes a diagnosis of local culture and practical support to nurture culture and leadership.

Objective 8: Learning and improving

3.8 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 improvement approach, from teams to ICBs.

3.9 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.

3.10 The Healthcare Safety Investigation Branch undertake investigations of incidents which meet their criteria. The responsibilities for trusts and ICBs set out below, also apply to these, or any other external investigations.

How we will make this happen

3.11 It is the responsibility of trusts to:

- Establish and maintain effective, kind, and compassionate processes to respond to families who experience harm or raise concerns about their care. These should include the principles of duty of candour and a single point of contact for ongoing dialogue with the trust.
- Understand 'what good looks like' to meet the needs of their local populations and learn from when things go well and when they do not.
- Respond effectively and openly to patient safety incidents using PSIRF.

- Act, alongside maternity and neonatal leaders, on outcomes data, staff and MNVP feedback, audits, incident investigations, and complaints, as well as learning from where things have gone well.
- Ensure there is adequate time and formal structures to review and share learning, and ensure actions are implemented within an agreed timescale.
- Consider culture, ethnicity and language when responding to incidents (NHS England, 2021).

3.12 It is the responsibility of ICBs to:

- Share learning and good practice across all trusts in the ICS.
- Oversee implementation of the PSIRF safety improvement plan during 2023/24, monitoring the effectiveness of incident response systems in place.

3.13 NHS England will:

- Throughout 2023, support the transition to PSIRF through national learning events.
- Through regional teams, share insights between organisations to improve patient safety incident response systems and improvement activity.

Objective 9: Support and oversight

3.14 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.

3.15 Our ambition is:

- Robust oversight through the perinatal quality surveillance model (PQSM) that ensures concerns are identified early, addressed, and escalated where appropriate.
- Well led services, with additional resources channelled to where they are most needed.
- Leadership for change, with a focus on ensuring new service models have the right building blocks for high quality care, especially the workforce.

How we will make this happen

3.16 It is the responsibility of trusts to:

- Maintain an ethos of open and honest reporting and sharing of information on the safety, quality, and experience of their services.
- Regularly review the quality of maternity and neonatal services, supported by clinically relevant data including – at a minimum – the measures set out in the PQSM and informed by the national maternity dashboard.
- Appoint an executive and non-executive maternity and neonatal board safety champion to retain oversight and drive improvement. This includes inviting maternity and neonatal leads to participate directly in board discussions.
- Involve the MNVP in developing the trust's complaints process, and in the quality safety and surveillance group that monitors and acts on trends.
- At board level, listen to and act on feedback from staff, including Freedom to Speak Up data, concerns raised, and suggested innovations in line with the FTSU guide and improvement tool.

3.17 It is the responsibility of ICBs to:

- Commission services that enable safe, equitable, and personalised maternity care for the local population.
- Oversee quality in line with the PQSM and NQB guidance, with maternity and neonatal services included in ICB quality objectives.
- Lead local collaborative working, including the production of a local quality dashboard that brings together intelligence from trusts.

3.18 NHS England will:

- Through our regional teams, listen to the local NHS and through our national governance listen to frontline staff voices and continue to work RCOG, RCM, BAPM, and others.
- Continue to work closely with national bodies, ICBs, and trusts to address issues escalated to national level.
- Provide nationally consistent support for trusts that need it through the Maternity Safety Support Programme (MSSP).
- Work to align the MSSP with the NHS oversight framework, improve alignment with the recovery support programme, and evaluate the programme by March 2024.
- During 2023/24, test the extent to which the PQSM has been effectively implemented.

- By March 2024, provide targeted delivery of the maternity and neonatal board safety champions continuation programme to support trust board assurance, oversight of maternity and neonatal services, and a positive safety culture.

Determining success for Theme 3

3.19 Achieving meaningful changes in culture will take time and progress measures are difficult to identify and can have unintended consequences. We will primarily determine overall success by listening to the people who use and work in frontline services.

3.20 Our outcome measures for this theme are midwives' and obstetrics and gynaecology specialists' experience using the results of the NHS Staff Survey; the National Education and Training Survey and the GMC National Training Survey. We will explore how to better understand the experiences of other staff groups.

- The evidence ICBs can use across maternity and neonatal services includes:
  - Assurance from trust boards that they are using an appreciative enquiry approach to support progress with plans to improve culture.
  - Whether trust boards regularly share and act on learning.
  - Staff feedback on how incidents and issues of concern are managed.
- Relevant regulation includes:
  - The CQC will continue to consider whether a trust has a learning and responsive culture, strong leadership, and robust governance.

Case study: NFaST - Neonatal Families and Staff Together, supporting neonatal units to become more emotionally supportive environments

In 2021, the North West Neonatal Operational Delivery Network commissioned Spoons, a Greater Manchester-based charity specialising in neonatal family support, to research how their neonatal units could become more emotionally supportive environments for service users and staff.

The project worked with 13 neonatal units and a 28-family focus group, collecting data from more than 260 parents and 250 staff members, exploring their emotional needs. The project identified that the experience of neonatal care has a profound long-term impact on parents and their infants. In turn, the experience of working on a neonatal unit is emotionally challenging and can have significant impact on a staff member's individual wellbeing.

Volunteer peer supporters, who had personal experience of neonatal care, were trained for the units. Psychological training was provided to 100 staff across four neonatal units, including doctors, nurses, and support staff. Reflective practice group sessions were led by a clinical psychologist, to help the teams collaborate and understand each other and the needs of their babies and families better.

The pool of volunteer peer supporters continues to grow, and additional peer support training has been commissioned, with a model of ongoing supervision in development. This project demonstrates the power of true collaboration between the NHS, service users and third sector partners.

Theme 4: Standards and structures that underpin safer, more personalised, and more equitable care

4.1 To deliver the ambition set out in this plan, maternity and neonatal teams need to be supported by clear standards and structures. This includes being enabled to implement best clinical practice for all families, having high quality data to inform the decisions of clinicians and leaders, and having digital tools that enable information to flow. In many areas this is already in place; this plan does not seek to introduce new standards, extra reporting, or change structures, but to ensure that these enablers are consistently implemented to support care.

4.2 Key commitments for women and families include:

Making care safer by consistently implementing best practice, including:

- By 2024, an updated version of the updated Saving Babies Lives Care Bundle – a package of interventions to reduce stillbirth, neonatal brain injury, neonatal death, and preterm birth.
- By 2025, the national maternity early warning score and updated newborn early warning trigger and track tools to improve the care of unwell mothers and babies, enabling timely escalation where needed.

In 2023, NHS England's new taskforce will report on how data can be used as an early warning system to detect safety issues within maternity and neonatal services, enabling action to address any issues sooner.

By 2024, the NHS will publish refreshed data and recording standards that allow us to collect more meaningful standardised data that can then be used to improve care.

Supporting the roll out electronic patient records to enable women to access their records and interacting with their digital plans and information to support informed decision-making.

Objective 10: Standards to ensure best practice

4.3 Advances in clinical practice have been crucial in the improvement in maternity and neonatal outcomes over the last decade. However, the Ockenden report found that many women cared for at the trust were not offered care in line with best clinical practice. 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. Additionally, the Kirkup report highlighted the detrimental effect that sub-optimal estates have on the provision and experience of care.

4.4 Nationally defined best practice already exists, including:

- The Saving Babies Lives Care Bundle, a package of interventions to reduce stillbirth, neonatal brain injury, neonatal death, and preterm birth.
- The national maternity early warning score (MEWS)and updated newborn early warning trigger and track (NEWTT-2) tools to improve the detection and care of unwell mothers and babies, enabling timely escalation of care.
- NICE guidance, which sets out the evidence based best practice in maternity and neonatal care.

4.5 Our ambition is:

- Consistent implementation of nationally defined best practice with due regard to the needs of local populations to reduce variation and inequalities.
- 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 care.
- 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.
- 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.
- 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.

How we will make this happen

4.6 It is the responsibility of trusts to:

- Implement version 3 of the Saving Babies' Lives Care Bundle by March 2024 and adopt the national MEWS and NEWTT-2 tools by March 2025.
- Regularly review and act on local outcomes including stillbirth, neonatal mortality and brain injury, and maternal morbidity and mortality to improve services.
- Ensure staff are enabled to deliver care in line with evidence-based guidelines, with due regard to NICE guidance.
- Complete the national maternity self-assessment tool if not already done, and use the findings to inform maternity and neonatal safety improvement plans.

4.7 It is the responsibility of ICBs to:

- Prioritise areas for standardisation and co-produce ICS-wide clinical policies such as for implementation of the Saving Babies' Lives Care Bundle.
- Oversee and be assured of trusts' declarations to NHS Resolution for the maternity incentive scheme.
- Monitor and support trusts to implement national standards.
- Commission care with due regard to NICE guidelines.

4.8 NHS England will:

- Keep best practice up to date through version 3 of the Saving Babies Lives Care Bundle and the MEWS and NEWTT-2 tools, as well as developing tools to improve the detection and response to suspected intrapartum fetal deterioration.
- Support the integration of MEWS, NEWTT-2, and other clinical tools into existing digital maternity information systems by autumn 2024.
- Provide support to capital projects to increase and better align neonatal cot capacity throughout 2023/24 and 2024/25.
- Over the next 3 years, undertake a national maternity and neonatal unit infrastructure compliance survey and report, to determine the level of investment needed for an environmentally sustainable development of the maternity and neonatal estate across England.
- Continue to learn from research and evaluation as set out in the National Maternity Research Plan available on the FutureNHS platform.

Objective 11: Data to inform learning

4.9 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.

4.10 Our ambition is:

- 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.
- 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.
- 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.

How we will make this happen

4.11 It is the responsibility of trusts to:

- Review available data to draw out themes and trends and identify and promptly address areas of concern including consideration of the impact of inequalities.
- Ensure high-quality submissions to the maternity services data set and report information on incidents to NHS Resolution, the Healthcare Safety Investigation Branch and national perinatal epidemiology unit.

4.12 It is the responsibility of ICBs to:

- Use data to compare their outcomes to similar systems and understand any variation and where improvements need to be made.

4.13 NHS England will:

- At a regional level, understand any variation in outcomes and support local providers to address identified issues.
- Convene a taskforce to progress the recommendation from the Kirkup report for an early warning system to detect safety issues within maternity and neonatal services, reporting by autumn 2023.

- Create a single notification portal by summer 2024 to make it easier to notify national organisations of specific incidents.

Objective 12: Make better use of digital technology in maternity and neonatal services

4.14 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). Most neonatal units use the same electronic product, which is designed for neonatal data capture, though some trusts and neonatal units are considering how to improve neonatal alignment with maternity and paediatrics as part of their EPR roll out.

4.15 Our ambition is:

- 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.
- All clinicians are supported to make best use of digital technology with sufficient computer hardware, reliable Wi-Fi, secure networks, and training.
- Organisations enable access to key information held elsewhere internally or by partner organisations, such as other trusts and GP practices.

How we will make this happen

4.16 It is the responsibility of trusts to:

- Have and be implementing a digital maternity strategy and digital roadmap in line with the NHS England what good looks like framework.
- Procure an EPR system – where that is not already being managed by the ICB – that complies with national specifications and standards, including the digital maternity record standard and the maternity services data set and can be updated to meet maternity and neonatal module specifications as they develop.

- Aim to ensure that any neonatal module specifications include standardised collection and extraction of neonatal national audit programme data and the neonatal critical care minimum data set.

4.17 It is the responsibility of ICBs to:

- Have a digital strategy and, where possible, procure on a system-wide basis to improve standardisation and interoperability.
- Support women to set out their personalised care and support plan through digital means, monitoring uptake and feedback from users.
- Support regional digital maternity leadership networks.

4.18 NHS England will:

- Set out the specification for a compliant EPR, including setting out the requirements for maternity by March 2024.
- Publish a refreshed digital maternity record standard and maternity services data set standard by March 2024.
- Grow the digital leaders' national community, providing resources, training, and development opportunities to support local digital leadership.
- Incorporate pregnancy-related data and features into the NHS App to enhance the facility for women to view their patient records via the NHS app.
- Develop facets of a digital personal child health record with service user-facing tools to support neonatal and early years health by March 2025.

Determining success for Theme 4

4.19 We will determine overall success by focusing on clinical outcomes:

- Outcome measures for this theme are those of our existing safety ambition: maternal mortality, stillbirths, neonatal mortality, brain injury during or soon after birth, and preterm births. We will monitor these measures nationally by ethnicity and deprivation.
- The progress measures we will use are:
  - Local implementation of version 3 of the Saving Babies' Lives Care Bundle using a national tool.
  - Of women who give birth at less than 27 weeks, the proportion who give birth in a trust with on-site neonatal intensive care.

  - The proportion of full-term babies admitted to a neonatal unit, measured through the avoiding term admissions into neonatal units (ATAIN) programme.
  - A periodic digital maturity assessment of trusts, enabling maternity services to have an overview of progress in this area.
- The evidence that ICBs can use includes:
  - Clinical audits of implementation of shared standards. A standardised tool will be provided for assuring version 3 of the Saving Babies' Lives Care Bundle.
  - An ICB-wide dashboard to support benchmarking and improvement. The national maternity dashboard contains LMNS benchmarking on metrics where possible.
  - Progress against locally planned improvements.
- Relevant regulation and incentivisation includes:
  - The NHS Resolution CNST maternity incentive scheme supports trusts to provide safer maternity services through incentivising compliance with 10 safety actions.
  - The CQC key lines of enquiry for inspections will consider whether care is in accordance with best available evidence, such as NICE guidance.

Case Study: Ask A Midwife - using social media to communicate with service users

Ask A Midwife (AAM) is a social media messaging service managed by midwives, which empowers service users to make timely and informed decisions about their maternity care. AAM is coordinated centrally to ensure consistency of delivery and messaging by the Humber and North Yorkshire local maternity and neonatal system (LMNS), and four acute trusts are now working collaboratively to offer the service via Facebook, Instagram, and email.

The service is staffed by trust midwives who have a dual role in supporting the AAM service on a part-time basis alongside their clinical work. Questions from women and families range from pregnancy, birthing options, appointments, and the care of a new-born baby.

More than 94% of queries can be answered immediately and midwives can refer women to other health professionals and support organisations where required. The service routinely averages 800 queries per month, with more than 8,500 queries answered overall in 2022 and 508 onward referrals to health professionals, maternity units, NHS 111, and pharmacies. Patient confidentiality is conducted in the same way as telephone queries would be in a hospital, but the usual ways of contacting the hospital maternity team, such as by phone, are also available.

The service also allows the LMNS to cascade timely public health updates for pregnant women, including communications around vaccinations, perinatal mental health, postnatal care, and infant feeding. For example, when the AAM team saw an increase in messages around winter viruses they responded by posting self-help information.

AAM is promoted through Maternity Voices Partnership groups, with printed postcards and posters distributed in maternity settings, Children's Centres, through direct referral by midwives, and attendance at community outreach events, such as one in Spring 2023 specifically for people from the Romanian and Polish community.

Support available to staff, trusts, and systems

The maternity hub on the FutureNHS platform has relevant material for each theme.

Theme 1: Listening to and working with women and families with compassion

- Personalised care and support planning guidance and the Personalised Care Institute
- Equity and Equality guidance for Local Maternity and Neonatal Systems
- NHS statutory guidance for working in partnership with people & communities
- National maternity voices partnership toolkit
- Service specification for care of pregnant and post-natal women in detained settings
- Delivering Midwifery Continuity of Carer at full scale
- Maternal medicine network national service specification

Theme 2: Growing, retaining, and supporting our workforce

- Nursing and midwifery retention self-assessment tool
- National preceptorship framework
- Advanced Clinical Practice: capability framework for midwifery
- RCOG advice and guidance on workforce planning and flexibility
- A 'how to' guide and templates to reflect the Core Competency Framework

Theme 3: Developing and sustaining a culture of safety, learning, and support

- Maternity and Neonatal Safety Champions toolkit
- NHS national freedom to speak up policy and guidance

Theme 4: Standards and structures that underpin safer, more personalised, and more equitable care

- Support for quality improvement through patient safety collaboratives
- The Maternity self-assessment tool
- The recommendations register
- NICE guidance
- Saving Babies Lives Care Bundle
- An MSDS guidance hub
- For digital health there is Digital Maternity Leaders training course and the Shuri Network brings together women from minority ethnic groups

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- The Independent Working Group, chaired by the Royal College of Midwives and Royal College of Obstetricians and Gynaecologists. Members include:
  - British Association of Perinatal Medicine
  - Royal College of Paediatrics and Child Health
  - Royal College of Anaesthetists
  - Obstetric Anaesthetists Association
  - Society of Radiographers
  - Care Quality Commission
  - The Department of Health and Social Care
  - Health Education England
  - Service user voice representatives.

- Hearing from around 3,000 people via events and a survey. This included:
  - People who use maternity and neonatal services
  - National and regional service user voice representatives
  - Frontline professionals, including midwives, obstetricians, and neonatal colleagues
  - Integrated care boards
  - NHS England regional teams
  - Voluntary, community, and social enterprise organisations
  - National Guardian's Office
  - National stakeholders.

We remain committed to working closely with partners as we deliver this plan. Thank you to all the individuals and organisations who have shared their time, expertise, and experience so far.

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This publication can be made available in a number of alternative formats on request.

Theme	Area requiring further enquiry or shared intelligence	Outlier	Evidence
Clinical Care	Outlier for rates of stillbirth as a proportion of births	no	No escalation from SCN / LMNS on outlier report
	Outlier for rates of neonatal deaths as a proportion of birth	no	No escalation from SCN / LMNS on outlier report
	Rates of HIE where improvements in care may have made a difference to the outcome	no	Very low rates of HIE, sitting way below the lower control limit for the region. No current cases
	Number of SI's	no	x 1 SI declared in Feb 2023; in progress
	Progress on SBL care bundle V2	no	SBLCBV2 has been fully implemented at WUTH with progress monitored using audits which are registered on the FAAP. Awaiting confirmation and launch of SBL3
	Outlier for rates of term admissions to the NNU	no	The rate of avoidable term admissions remains low. Regular multi-disciplinary reviews of care take place
Service user and staff	MVP or Service User concerns/complaints not resolved at trust level	no	Not an outlier regarding the number of complaints. Since 20/08/2022, there was no breached complaint responses outstanding and active complaints with the division investigated and responded to well within timescales; There was one breached complaint in February 2023 - now resolved
	Trainee survey	no	No update this month
	Staff survey	no	Trust Staff Survey in progress
	CQC National survey	no	Nil to report this month
	Feedback via Deanery, GMC, NMC	no	Nil to report this month
	Poor staffing levels	no	There are 0.8 wte vacancies in the maternity Band 5/6 staff group: > 1%; workforce paper submitted to exec tam and the continued roll of MCoC model outlining the safe staffing requirements; Band 5 advert for newly qualified Midwives in progress
	Delivery Suite Coordinator not super nummary	no	Super nummary status is maintained for all shifts
Leadership and relationships	New leadership within or across maternity and/or neonatal services	no	Quality & Safety Lead (8a Clinical Governance) post - commences 17th April 2023
	Concerns around the relationships between the Triumvirate and across perinatal services	no	Good working relationship between the teams /Directorates
	False declaration of CNST MIS	no	Externally audited by MIAA. MIS Year 4 submission and declaration submitted by 12 noon on 2nd February 2023
	Concerns raised about other services in the Trust e.g. A&E	no	Nil of note
	In multi-site units - concerns raised about a specific unit i.e. Highfield/CoC teams	no	Nil to report this month
Safety and learning culture	Lack of engagement in HSIB or ENS investigation	no	Good engagement processes in place with north west team leader. Monthly reports received of ongoing cases and recent discussions regarding the process of arbitration with regional lead. Quarterly regional meetings arranged with excellent MDT attendance. Quarterly meeting held in Feb 2023; nil to escalate
	Lack of transparency	no	Being open conversations are regularly had and 100% compliance with duty of candour evident.
	Learning from SI's, local investigations and reviews not implemented or audited for efficacy and impact	no	Robust processes following lessons learned from all SI's, local reviews, rapid reviews, complaints and compliments. Engagement with staff to assess and improve how learning is shared. Patient experience strategy in progress. Trust wide lessons learnt forum has commenced reviewing themes from SI's, complaints and audits.
	Learning from Trust level MBRRACE reports not actioned	no	All reports receive a gap analysis to benchmark against the recommendations.
	Recommendations from national reports not implemented	no	All reports receive a gap analysis to benchmark against the recommendations. No exceptions to report. Three year single delivery plan for maternity and neonatal services published 30th March 2023 - gap analysis in progress and will monitored via WUTH CG structure and BoD
Incident reporting	Low patient safety or serious incident reporting rates	no	Consistent rates of reporting across the speciality groups. Regular training takes places on the importance of incident reporting, underpinning the Trust stance of safe reporting and non-punitive culture.
	Delays in reporting a SI where criteria have been met	no	Robust SI process and SI framework followed with timely reporting of all cases that meet the SI framework.
	Never Events which are not reported	no	No maternity or neonatal never events in January 2023
	Recurring Never Events indicating that learning is not taking place	no	N/a
	Poor notification, reporting and follow up to MBRRACE-UK, NHSR ENS and HSIB	no	Excellent reporting within the required timescales.
Governance processes	Unclear governance processes		Clear governance processes in place that follow the SI framework - Within division there is maternity and neonatal review of governance processes: 3 separate meetings. Staff are informed of top risks and incident themes. Governance notice boards updated and newsletters disseminated.
	Business continuity plans not in place	no	Business continuity plans in place.
	Ability to respond to unforeseen events e.g. pandemic, local emergency	no	Nil to report this month.
CQC inspection and DHSC or NHSE/I request for support	DHSC or NHS England Improvement request for a Review of Services or Inquiry	no	Nil to report this month
	An overall CQC rating of Requires Improvement with an Inadequate rating for either Safe and Well-Led or a third domain	no	N/a
	An overall CQC rating of Inadequate	no	N/a
	Been issued with a CQC warning notice	no	N/a
	CQC rating dropped from a previously Outstanding or Good rating to Requires improvement in the safety or Well-Led domains	no	N/a
	Been identified to the CQC with concerns by HSIB	no	N/a

North West Coast Clinical Network Maternity Dashboard Statistical & Graphical Report, Full Version

Wirral University Teaching Hospital NHS FT

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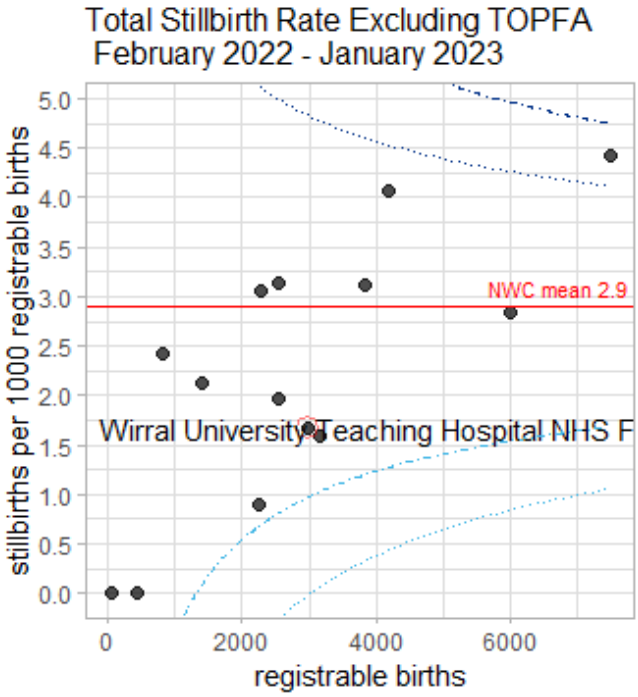
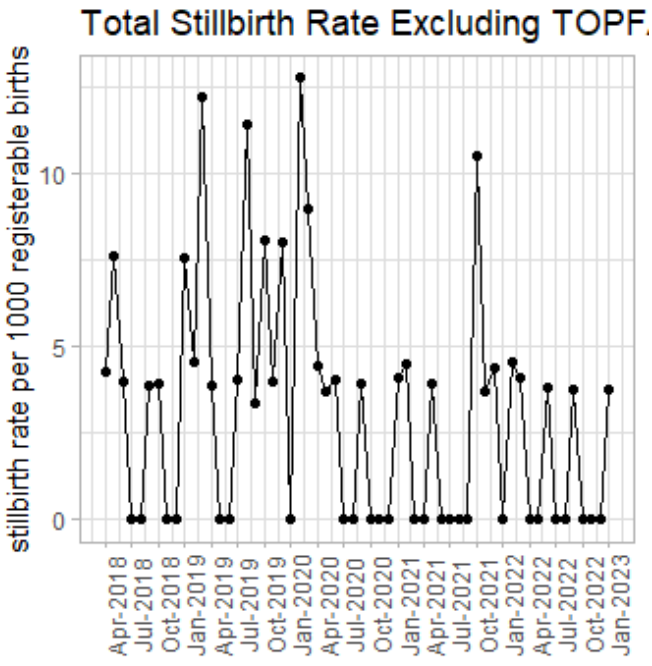
Stillbirths

Total Stillbirth Rate Excluding TOPFA



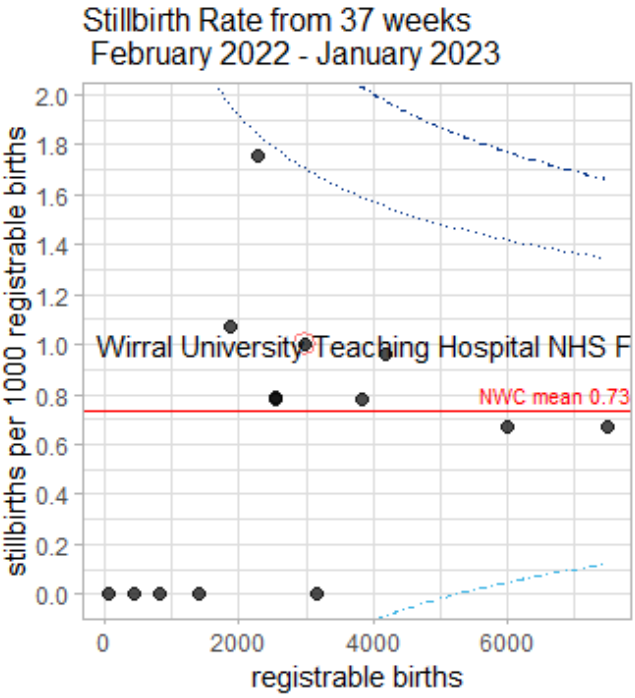
Data Source: NWC CN Maternity Dashboard

Run Chart for Total Stillbirth Rates Excluding TOPFA



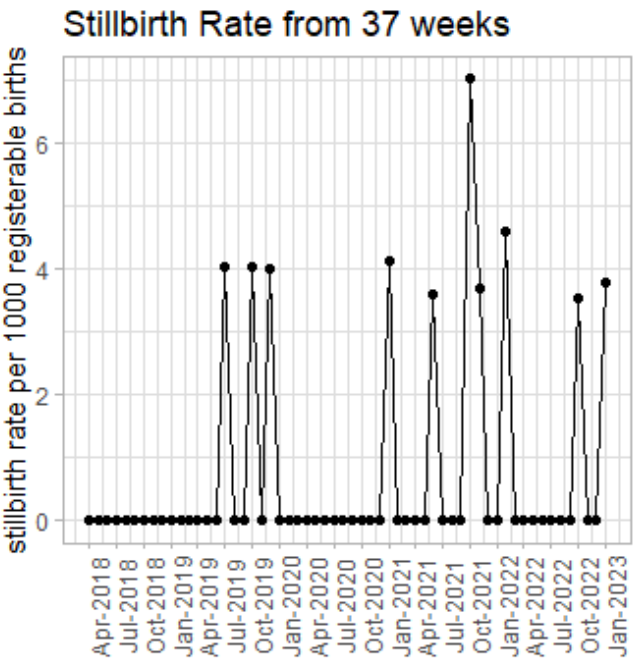
Data Source: NWC CN Maternity Dashboard

Stillbirth Rate from 37 weeks



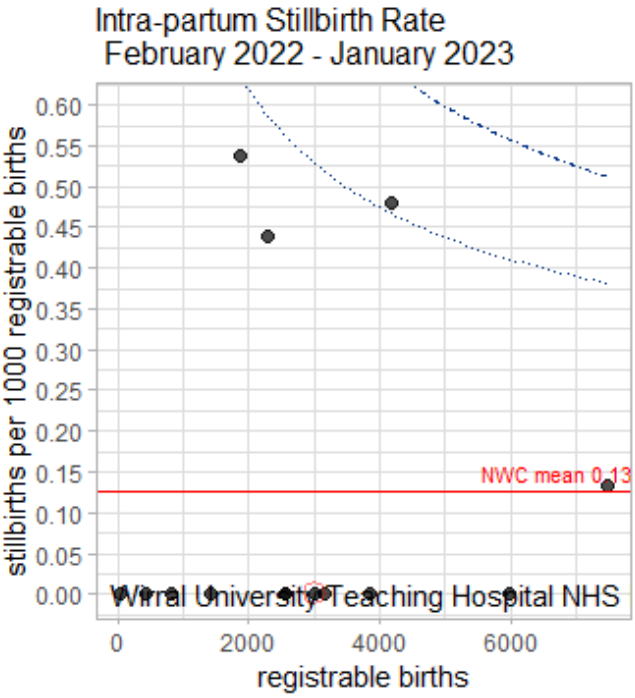
Data Source: NWC CN Maternity Dashboard

Run Chart for Stillbirth Rates from 37 weeks



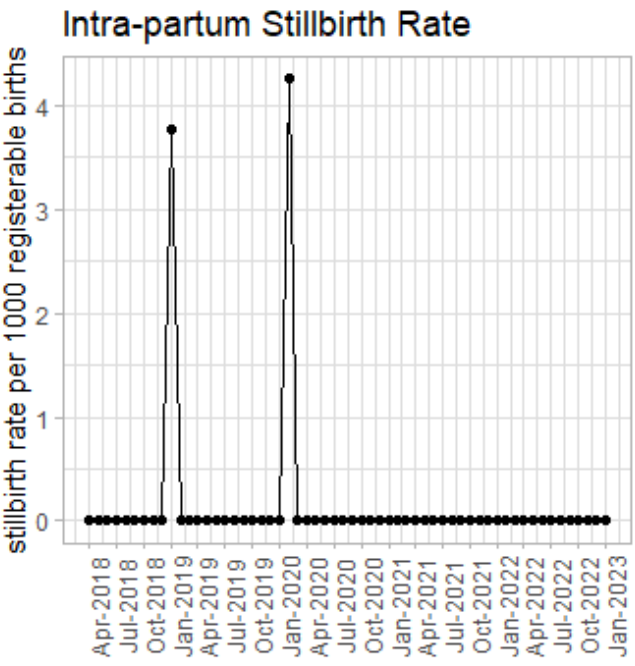
Data Source: NWC CN Maternity Dashboard

Intra-partum Stillbirth Rate



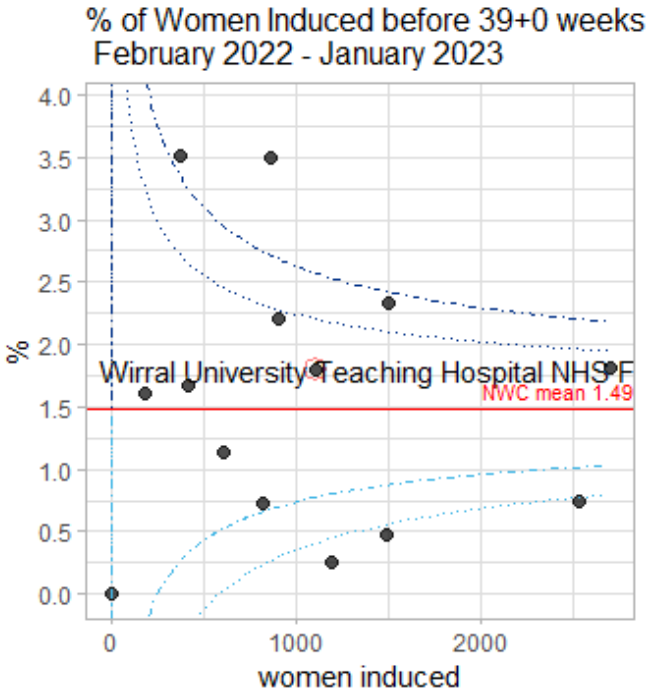
Data Source: NWC CN Maternity Dashboard

Run Chart for Intra-partum Stillbirth Rate



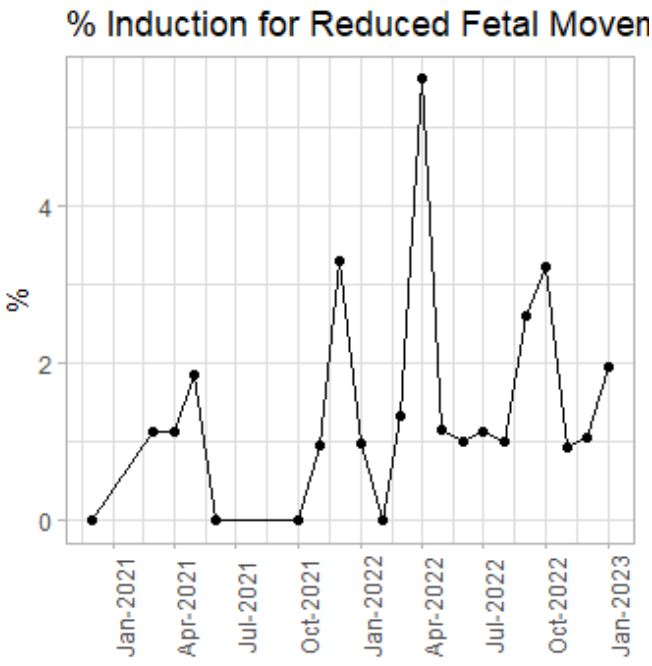
Data Source: NWC CN Maternity Dashboard

Induction for Reduced Fetal Movement Only



Data Source: NWC CN Maternity Dashboard

Run Chart for Induction for Reduced Fetal Movement Only



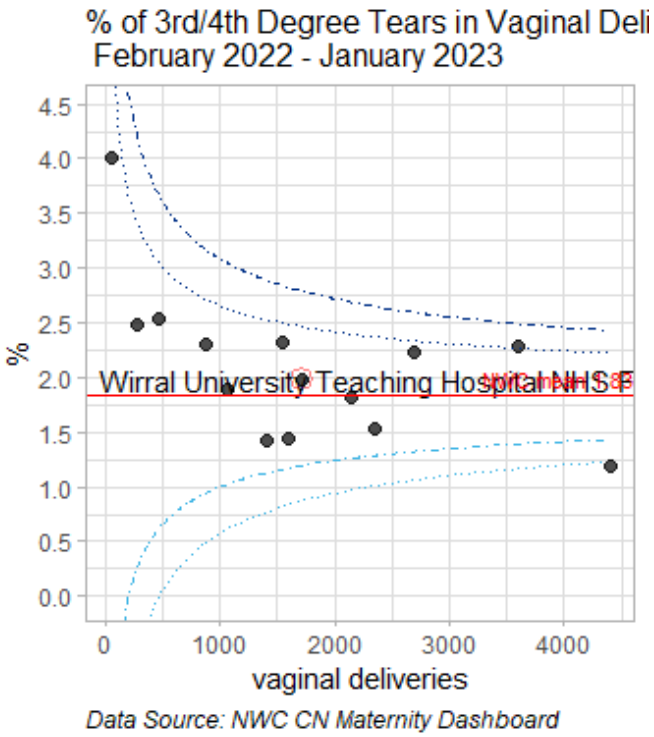
Data Source: NWC CN Maternity Dashboard

Low Birth Weight

Safety

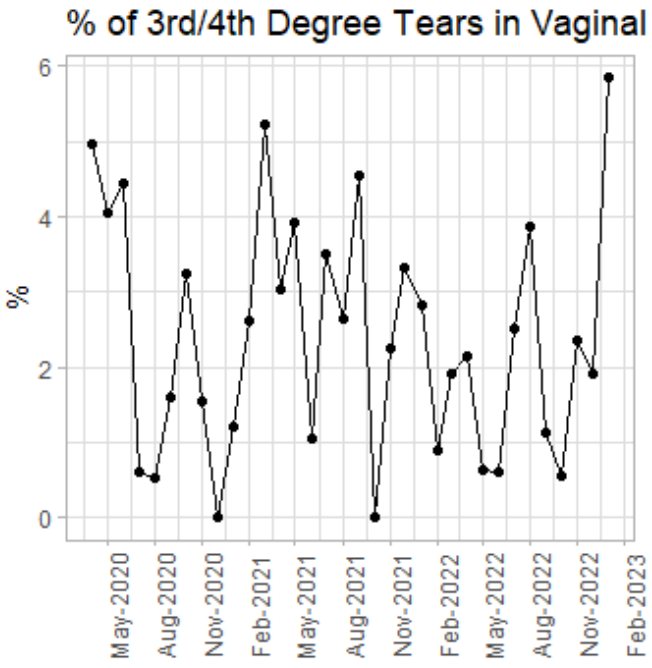
3rd/4th Degree Tears

3rd/4th Degree Tears in Vaginal Deliveries



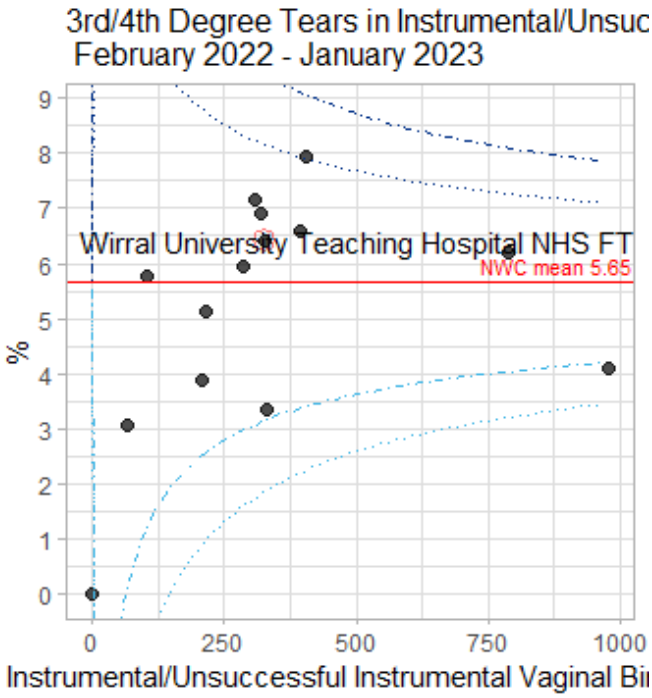
Data Source: NWC CN Maternity Dashboard

Run Chart for % of 3rd/4th Degree Tears in Vaginal Deliveries



Data Source: NWC CN Maternity Dashboard

3rd/4th Degree Tears in Instrumental/Unsuccessful Instrumental Vaginal Births



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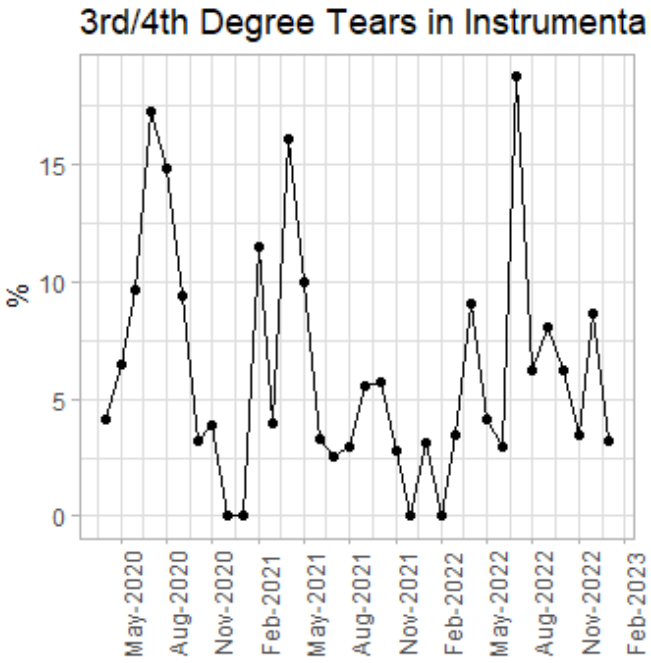
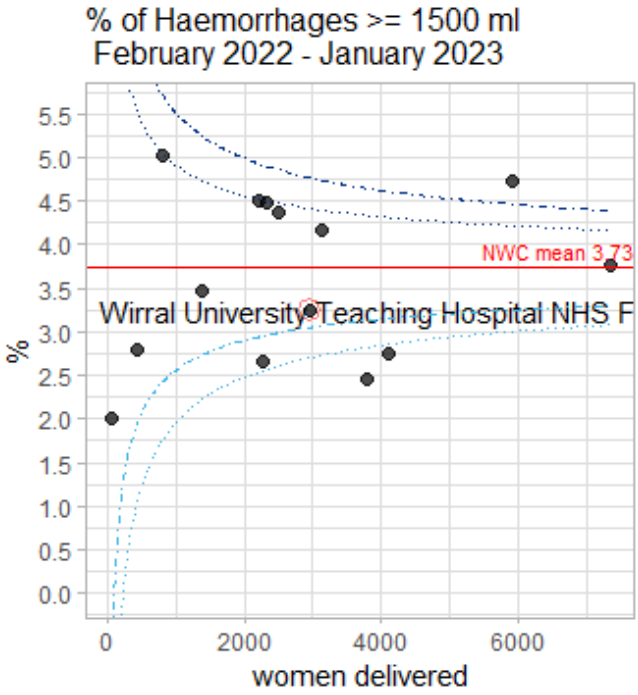


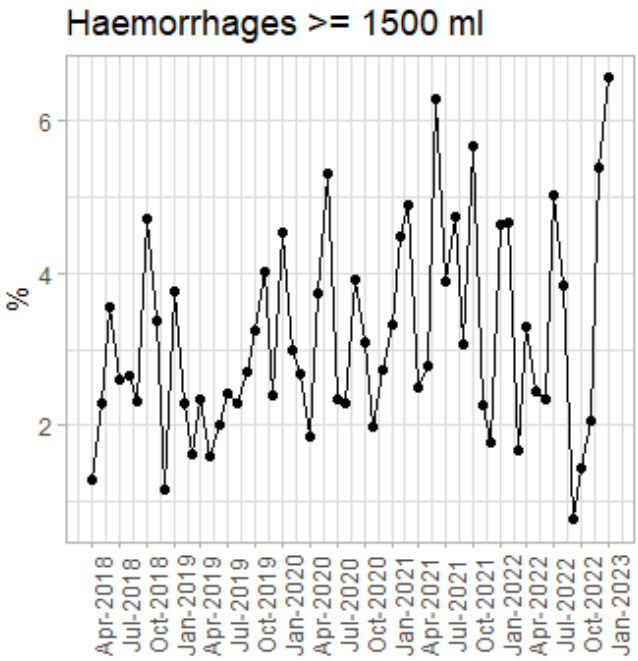
Data Source: NWC CN Maternity Dashboard

% of Haemorrhages ≥1500 ml



Data Source: NWC CN Maternity Dashboard

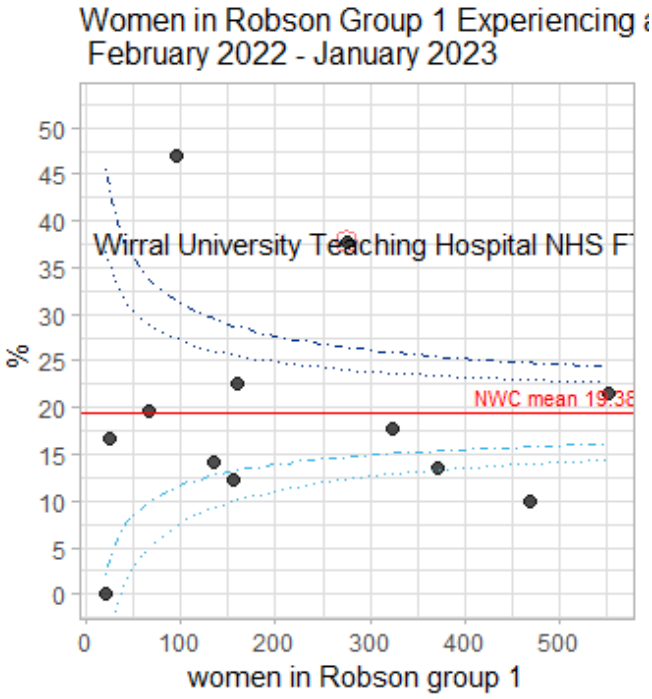
Run Chart for % of Haemorrhages ≥1500 ml



Data Source: NWC CN Maternity Dashboard

Caesarean Sections

Women Experiencing a C-Section and in Robson Group 1



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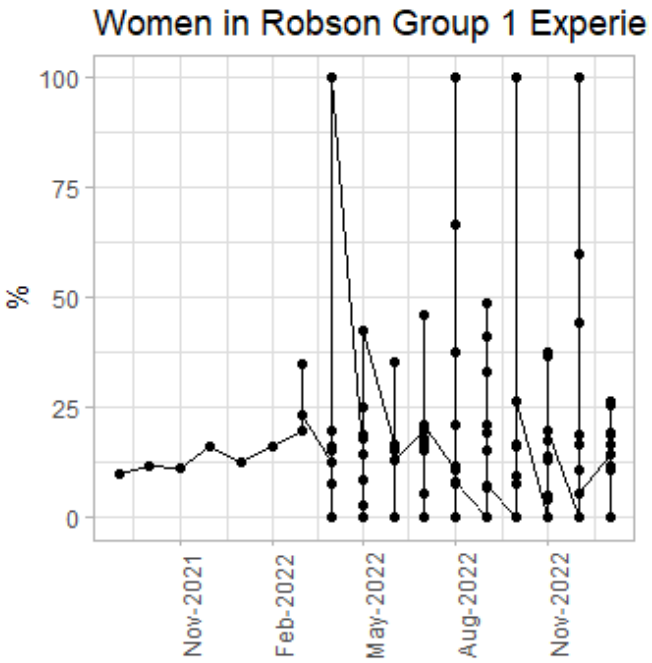
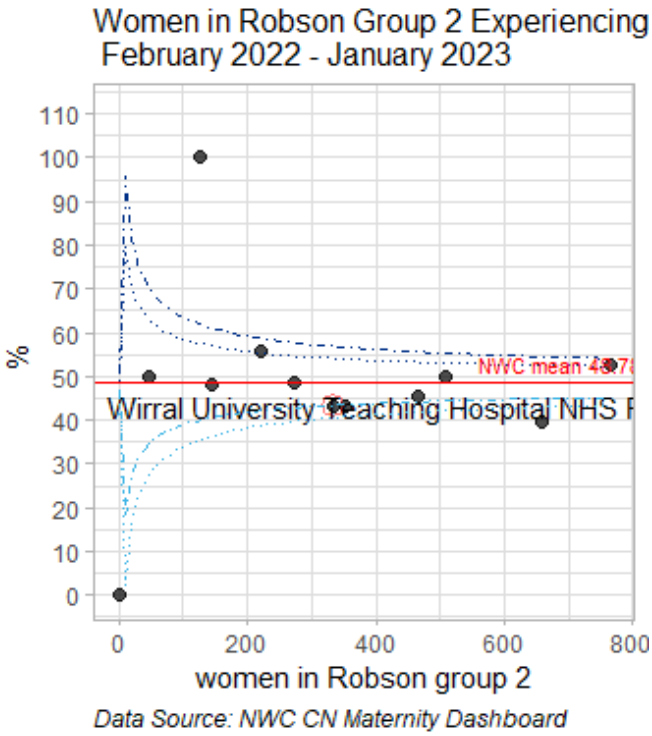


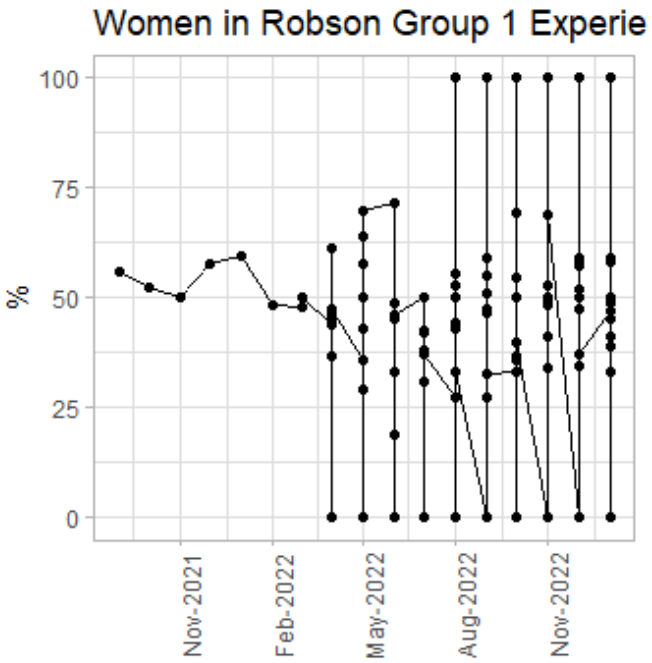
Data Source: NWC CN Maternity Dashboard

Women Experiencing a C-Section and in Robson Group 2



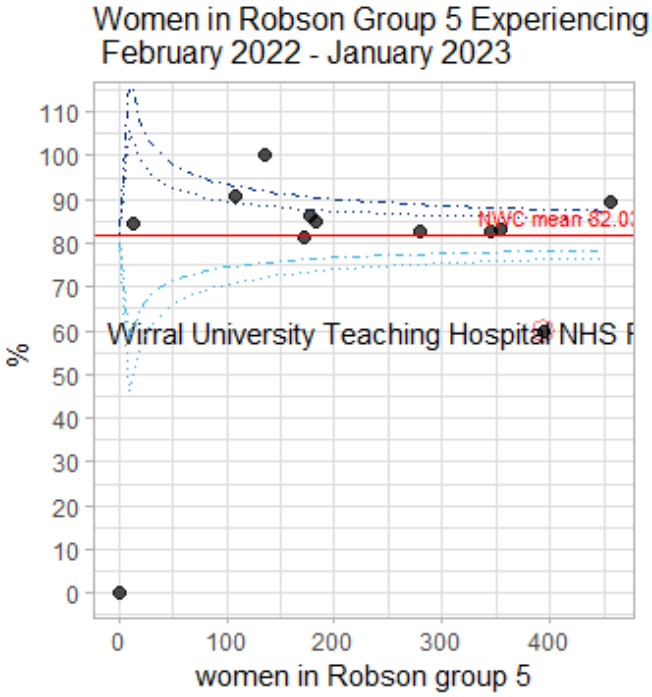
Data Source: NWC CN Maternity Dashboard

Run Chart for Women Experiencing a C-Section and in Robson Group 2



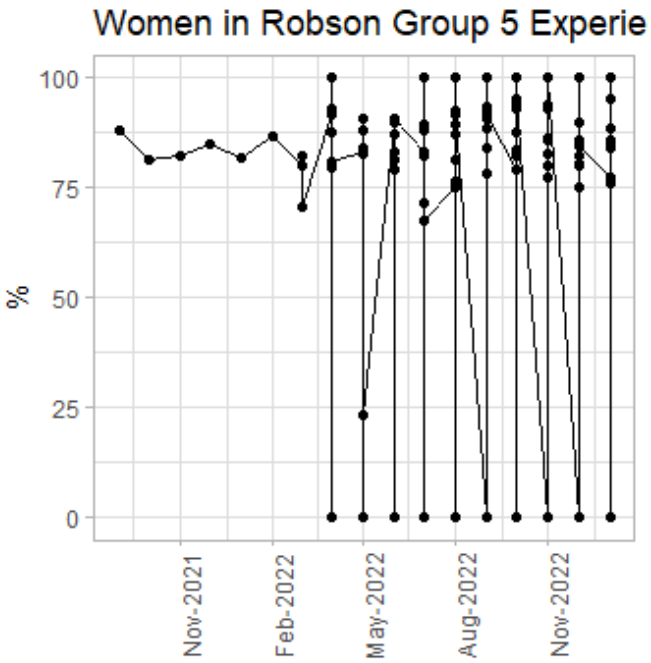
Data Source: NWC CN Maternity Dashboard

Women Experiencing a C-Section and in Robson Group 5



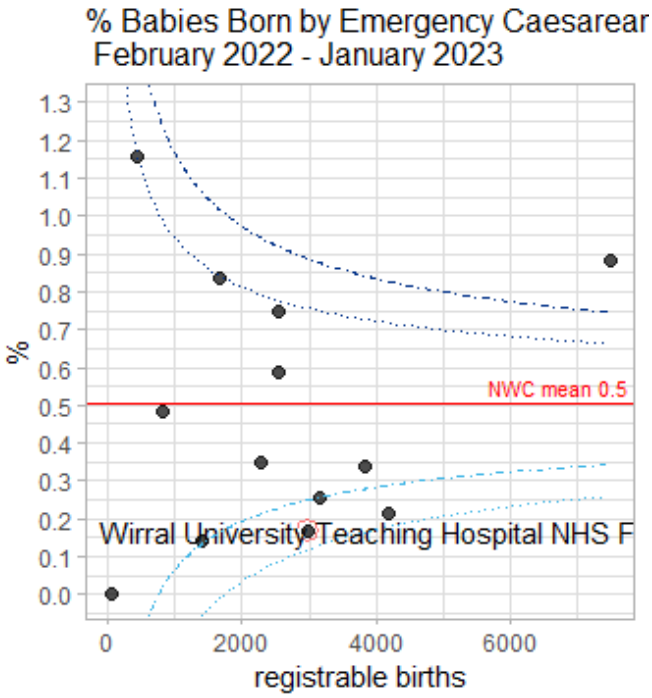
Data Source: NWC CN Maternity Dashboard

Run Chart for Women Experiencing a C-Section and in Robson Group 5



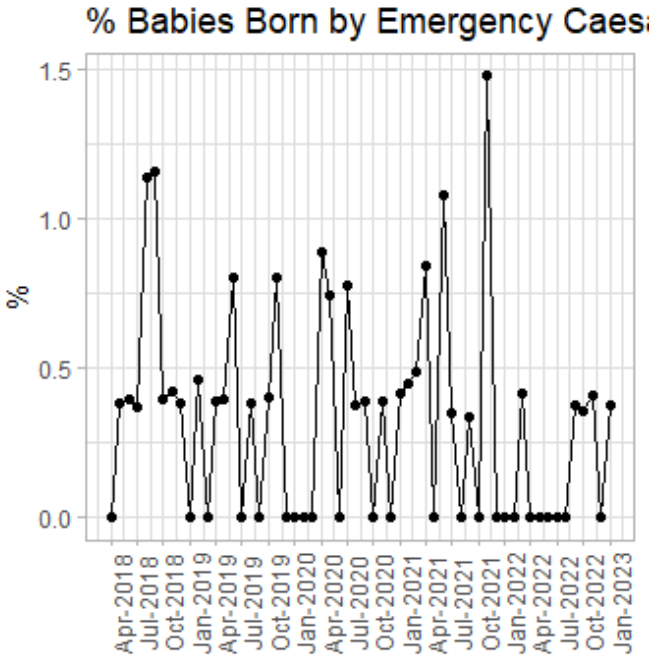
Data Source: NWC CN Maternity Dashboard

Babies Born by Emergency Caesarean Section, Post Failed Instrumental Delivery



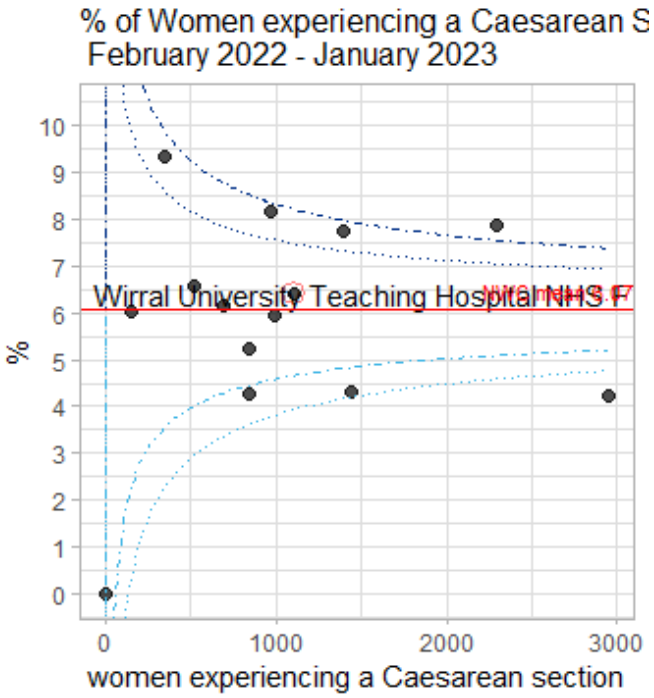
Data Source: NWC CN Maternity Dashboard

Run Chart for Emergency Caesarean Section, Post Failed Instrumental Delivery



Data Source: NWC CN Maternity Dashboard

Women experiencing a Caesarean Section with General Anaesthesia



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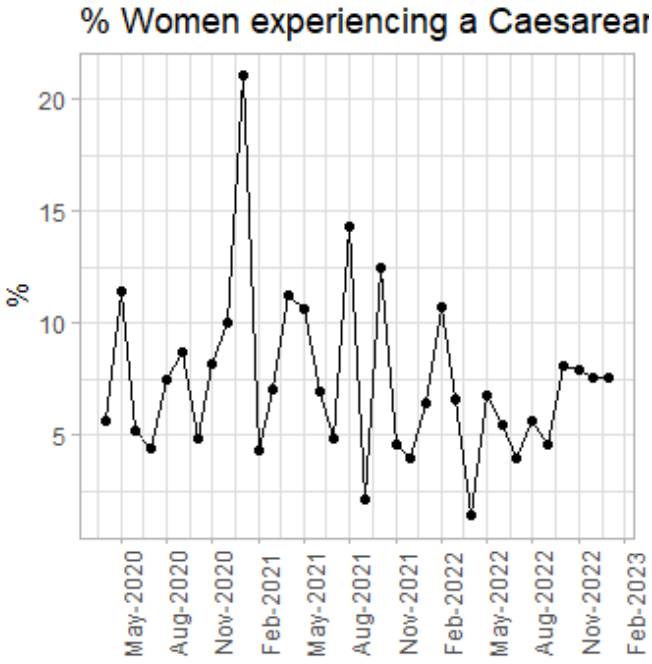
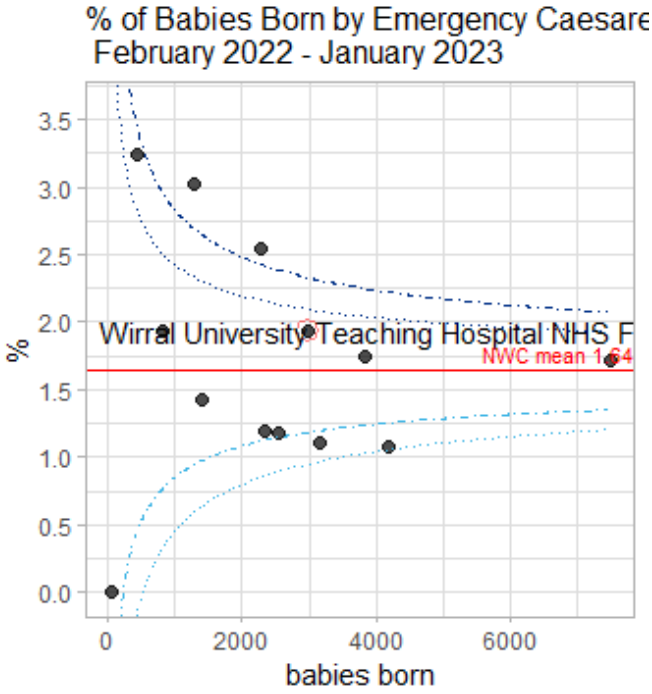
Run Chart for Women experiencing a Caesarean Section with General Anaesthesia



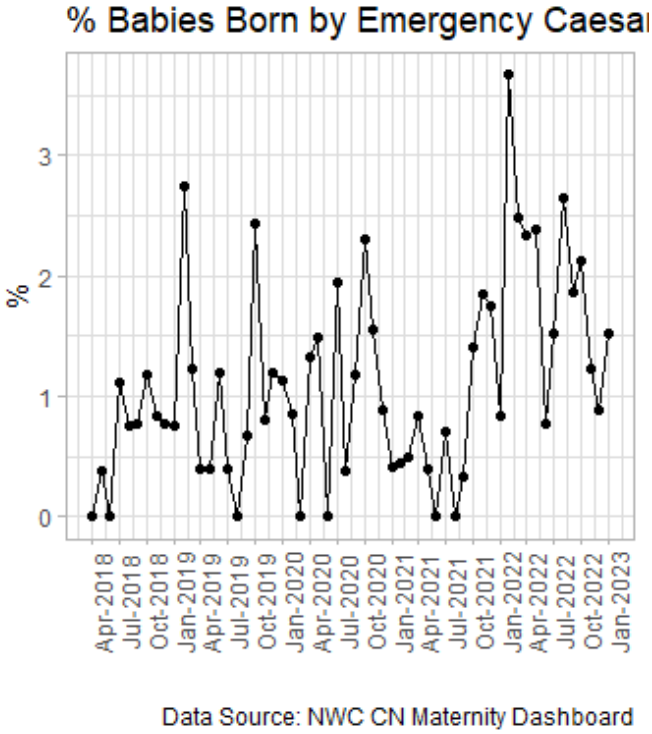
Data Source: NWC CN Maternity Dashboard

Babies Born by Emergency Caesarean Section at Full Dilation



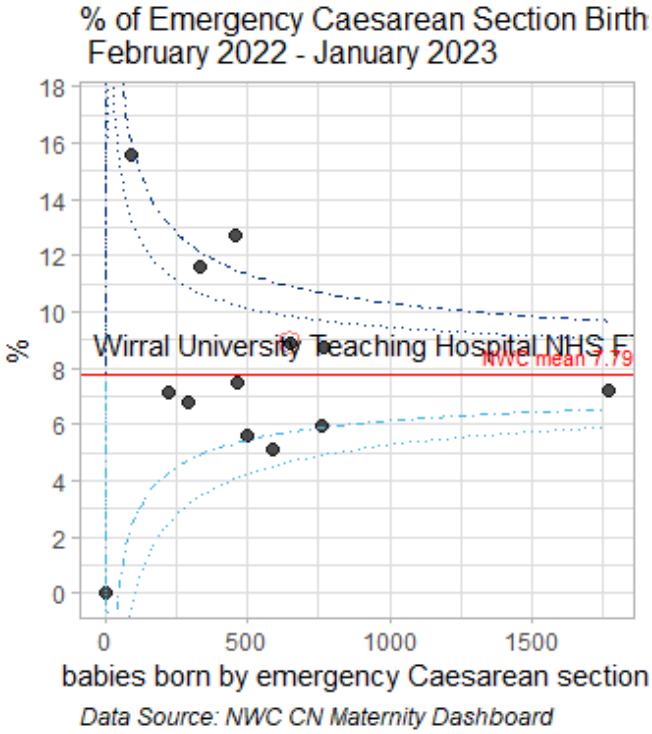
Data Source: NWC CN Maternity Dashboard

Run Chart for Babies Born by Emergency Caesarean Section at Full Dilation



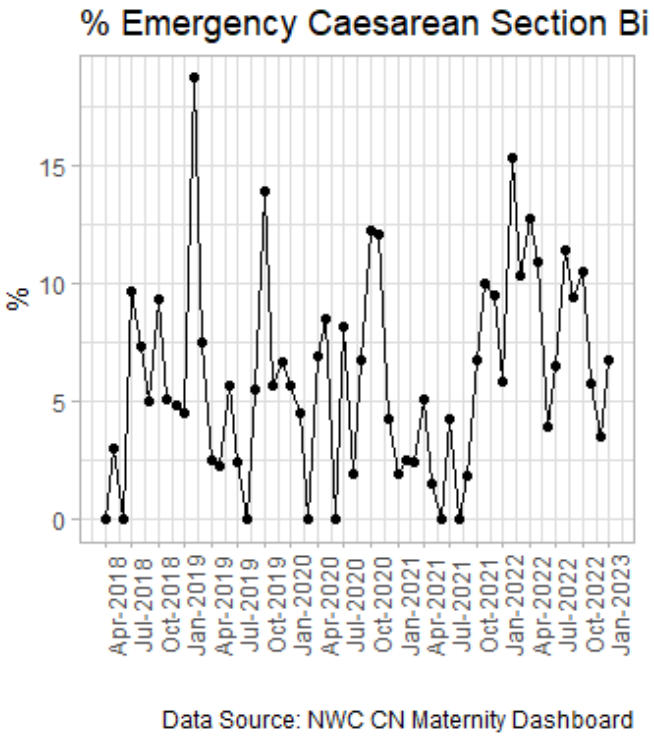
Data Source: NWC CN Maternity Dashboard

Emergency Caesarean Section Births undertaken at Full Dilation



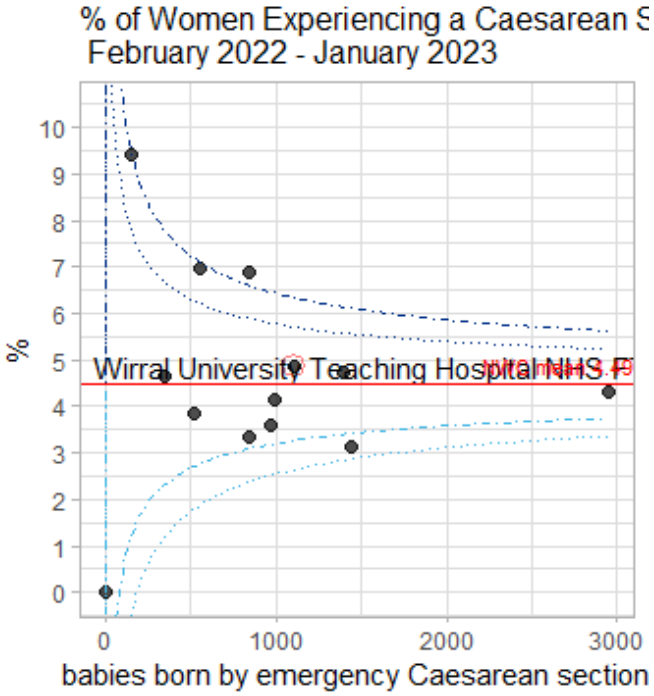
Data Source: NWC CN Maternity Dashboard

Run Chart for Emergency Caesarean Section Births undertaken at Full Dilation



Data Source: NWC CN Maternity Dashboard

Women Experiencing a Caesarean Section at Full Dilation



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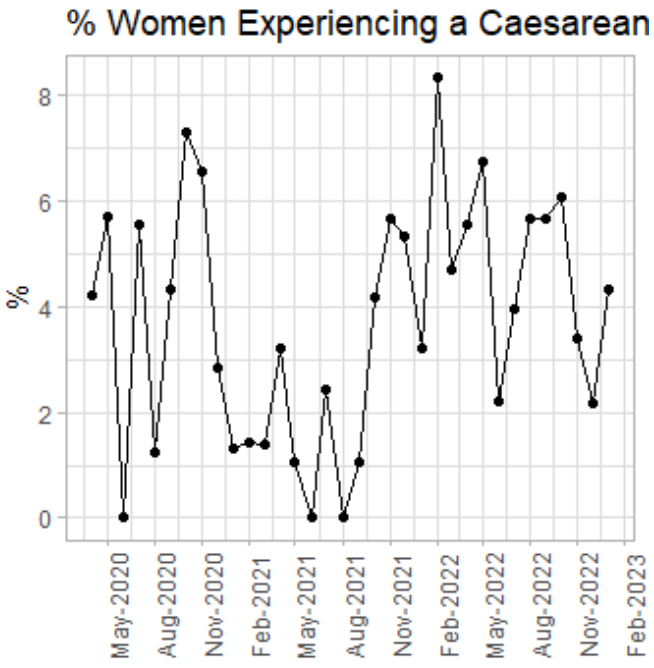
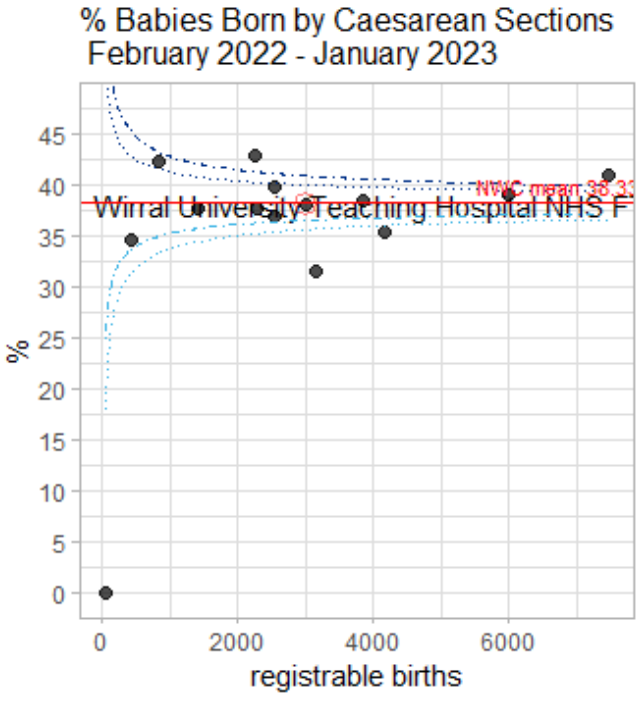
Run Chart for Women Experiencing a Caesarean Section at Full Dilation



Data Source: NWC CN Maternity Dashboard

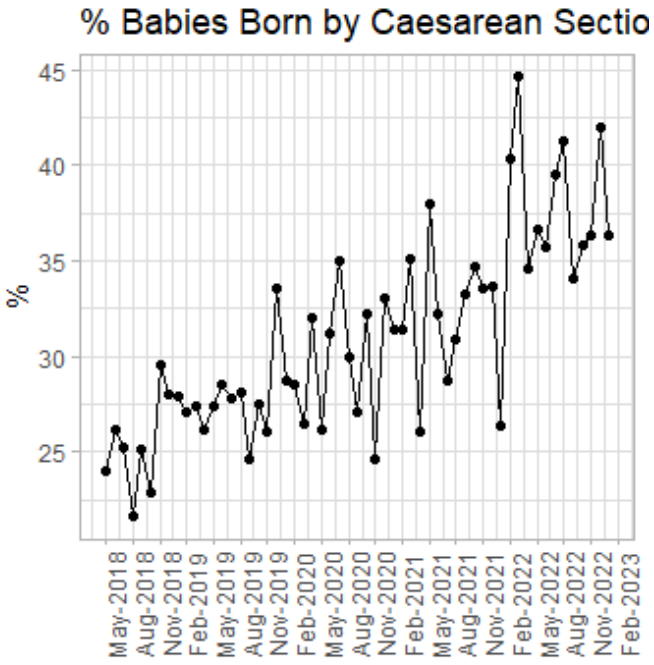
Caesarean Section Metrics Only for Context

Total Caesarean Sections



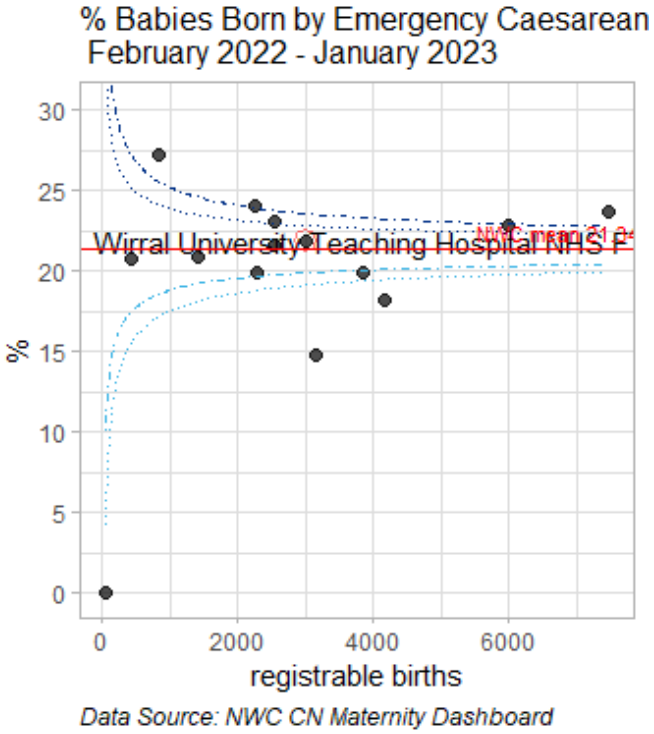
Data Source: NWC CN Maternity Dashboard

Run Chart for Caesarean Section



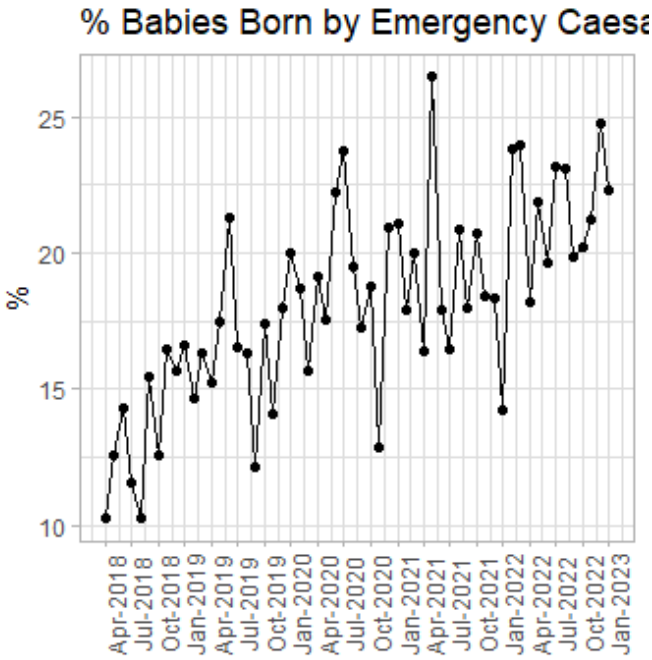
Data Source: NWC CN Maternity Dashboard

Emergency CS Rate



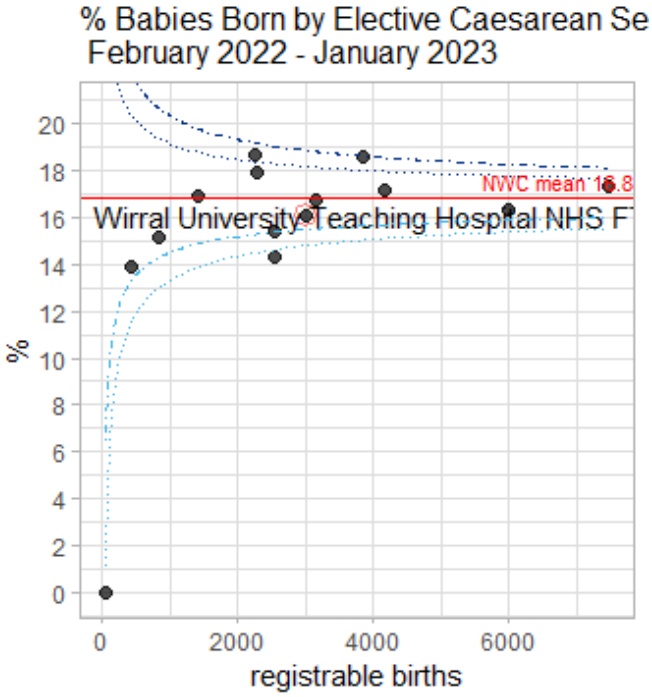
Data Source: NWC CN Maternity Dashboard

Run Chart for Emergency Caesarean Section



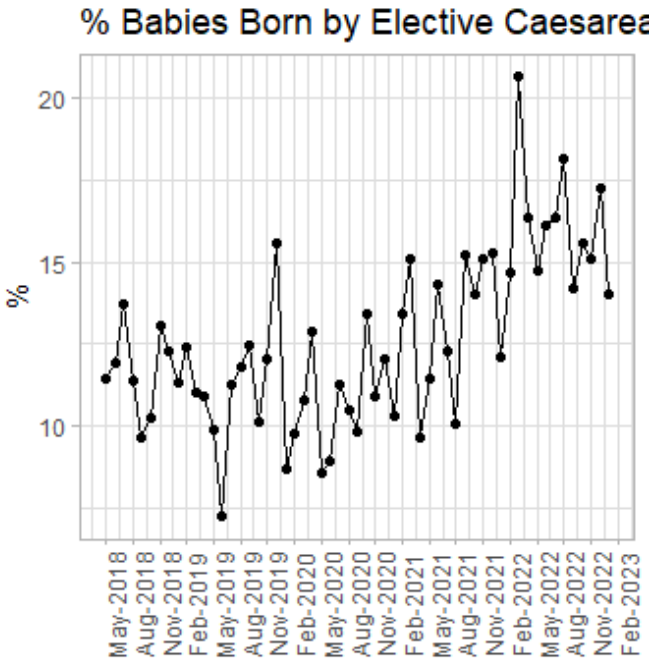
Data Source: NWC CN Maternity Dashboard

Elective (Cat 4) Caesarean Section



Data Source: NWC CN Maternity Dashboard

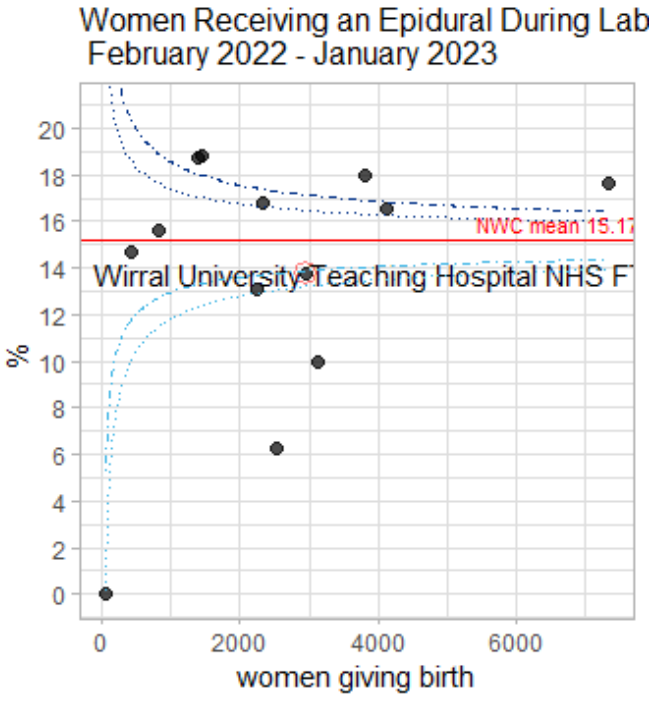
Run Chart for Elective Caesarean Section



Data Source: NWC CN Maternity Dashboard

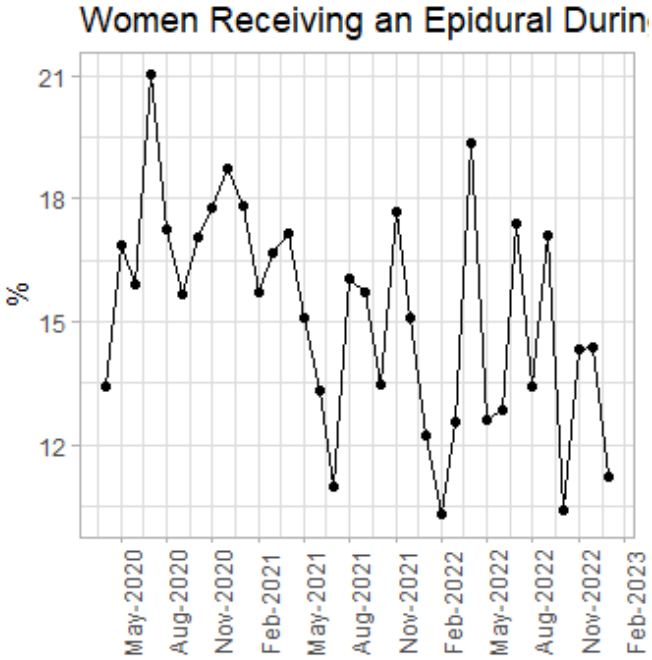
Epidural

Women Recieving an Epidural During Labour



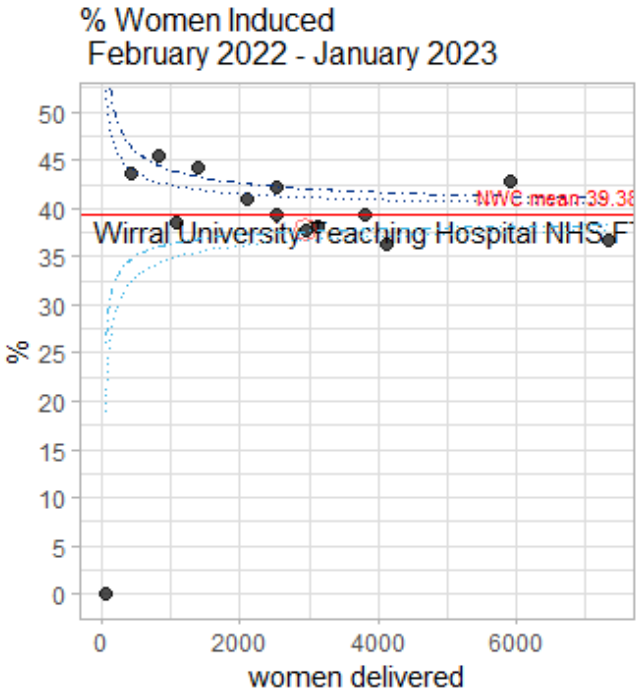
Data Source: NWC CN Maternity Dashboard

Run Chart for Women Receiving an Epidural During Labour



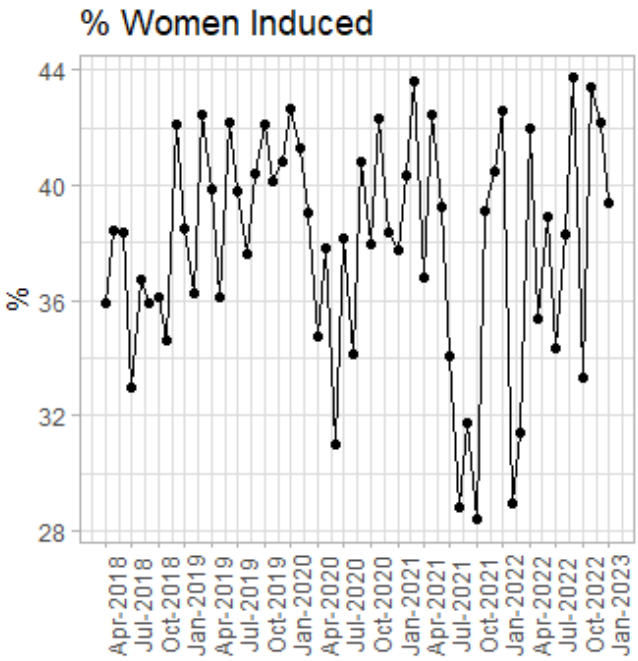
Data Source: NWC CN Maternity Dashboard

Induction of Labour



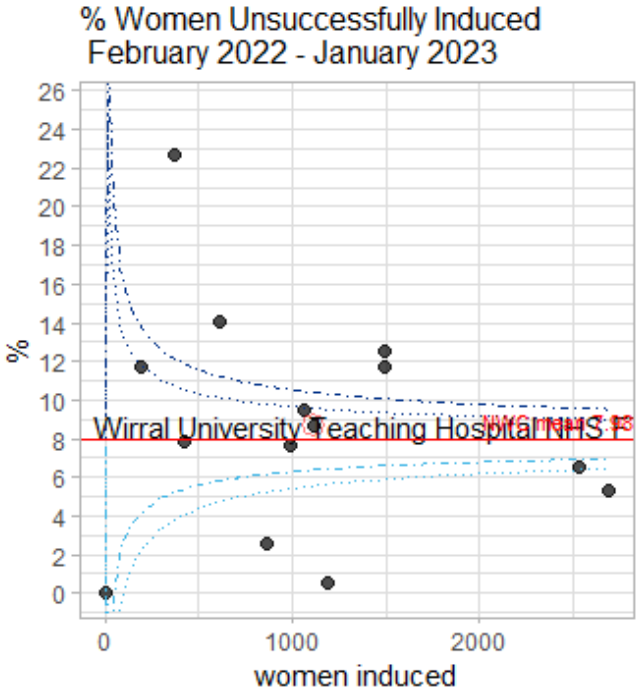
Data Source: NWC CN Maternity Dashboard

Run Chart for Induction of Labour



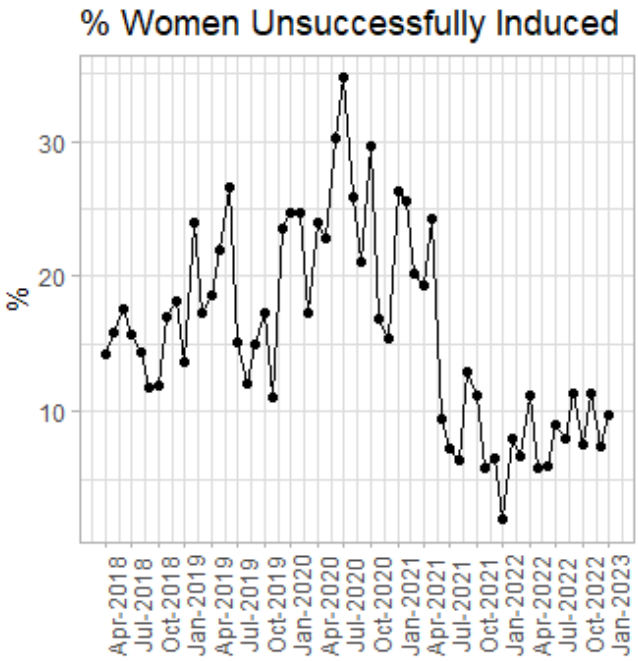
Data Source: NWC CN Maternity Dashboard

Unsuccessful Induction of Labour



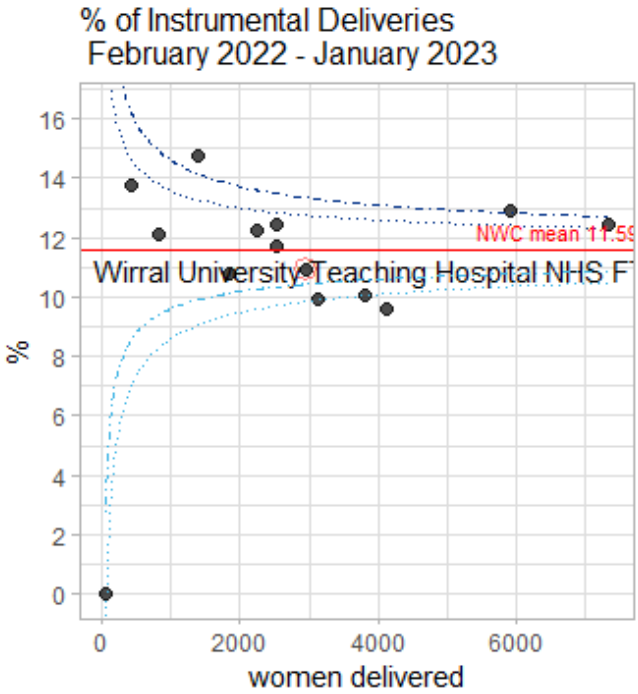
Data Source: NWC CN Maternity Dashboard

Run Chart for Unsuccessful Induction of Labour



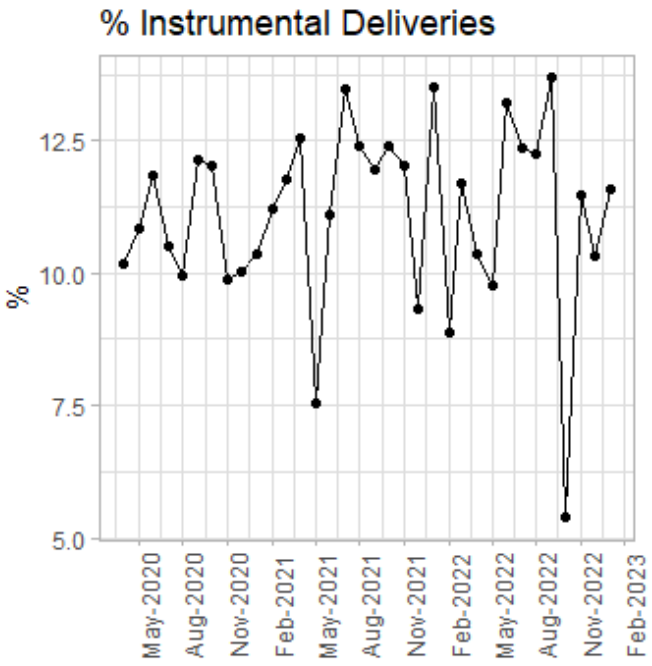
Data Source: NWC CN Maternity Dashboard

Instrumental Deliveries



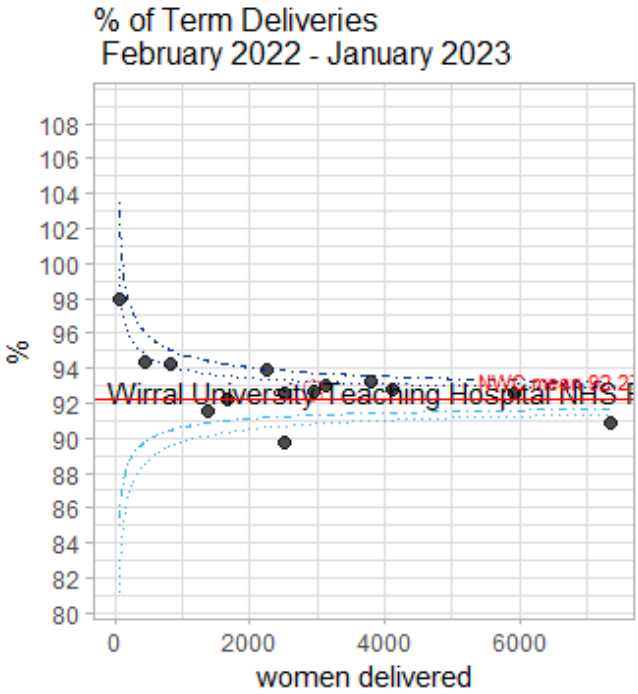
Data Source: NWC CN Maternity Dashboard

Run Chart for Instrumental Deliveries



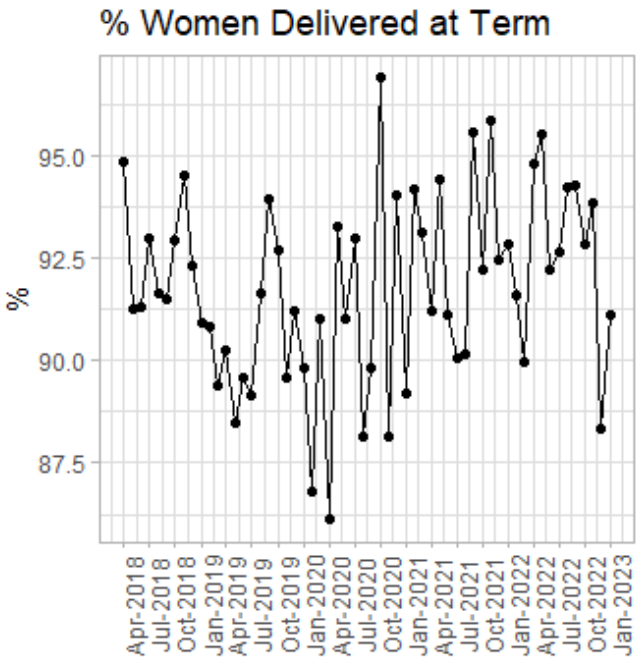
Data Source: NWC CN Maternity Dashboard

Term Deliveries



Data Source: NWC CN Maternity Dashboard

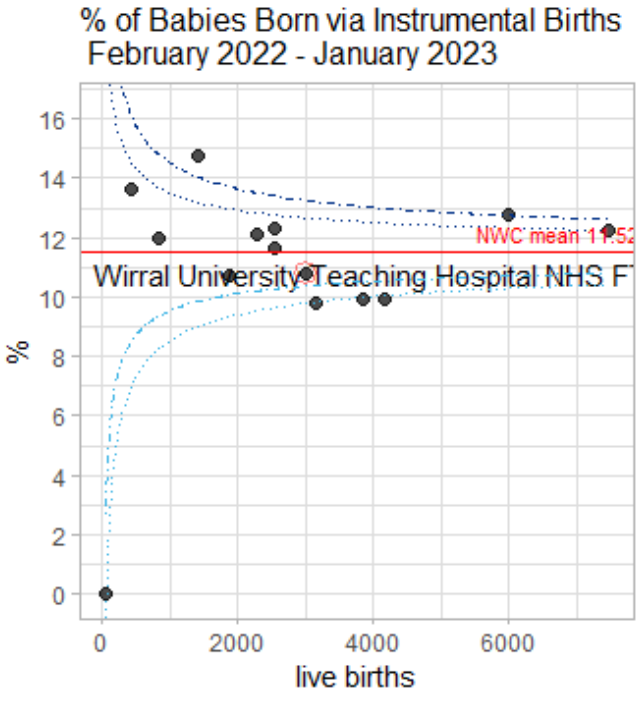
Run Chart for Term Deliveries



Data Source: NWC CN Maternity Dashboard

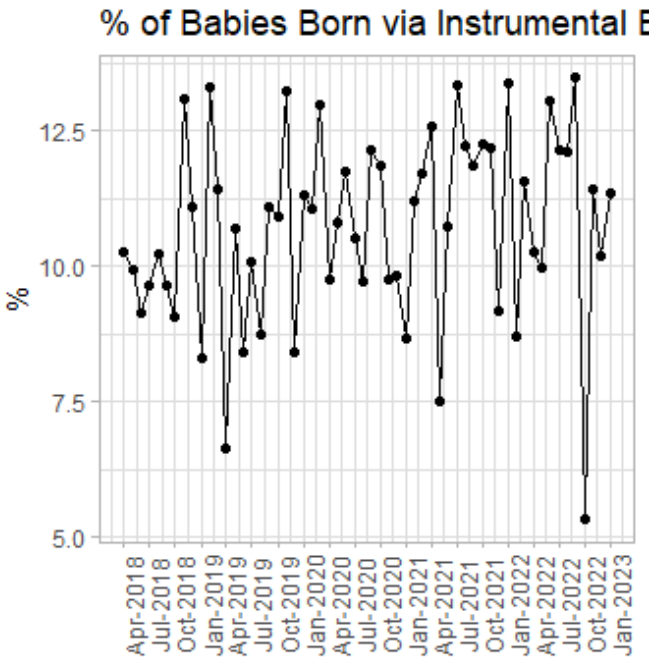
Assisted Vaginal Births

Babies Born via Instrumental Births



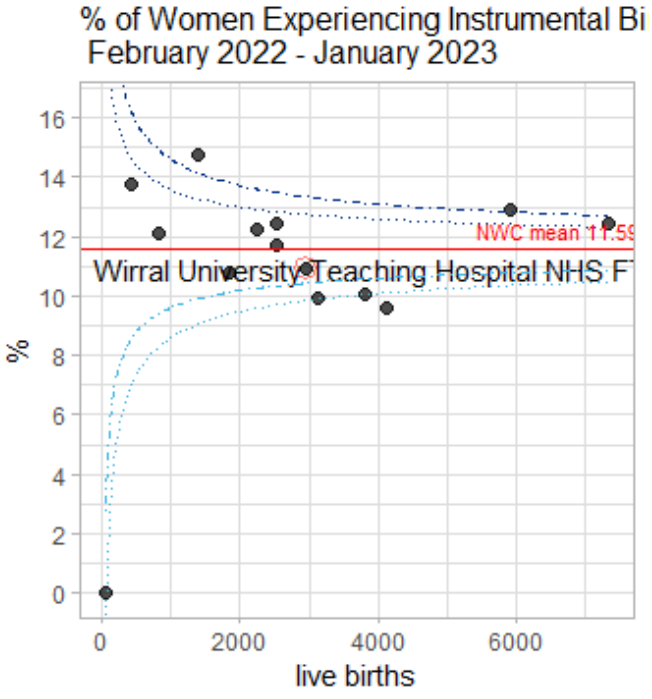
Data Source: NWC CN Maternity Dashboard

Run Chart for % of Babies Born via Instrumental Births



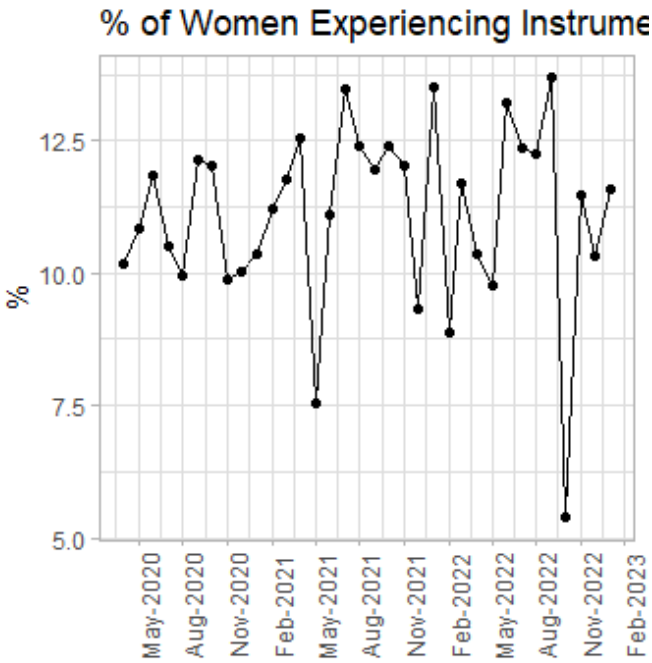
Data Source: NWC CN Maternity Dashboard

Women Experiencing Instrumental Births



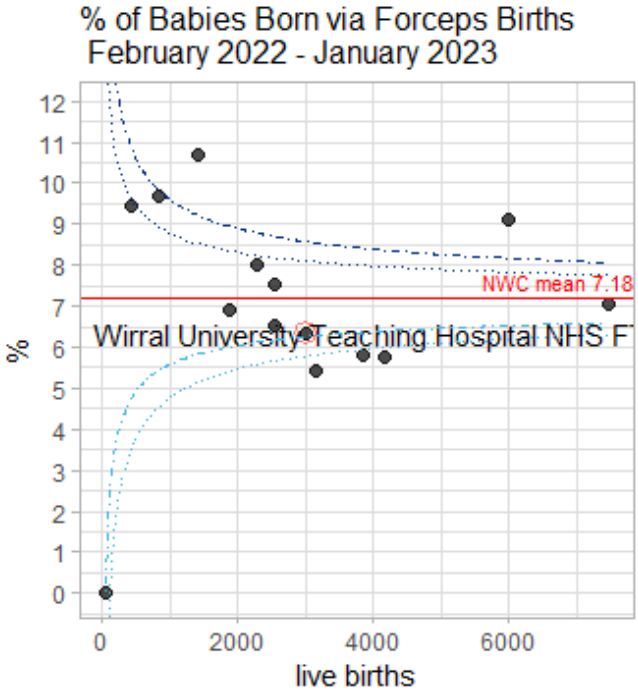
Data Source: NWC CN Maternity Dashboard

Run Chart for % of Women Experiencing Instrumental Births



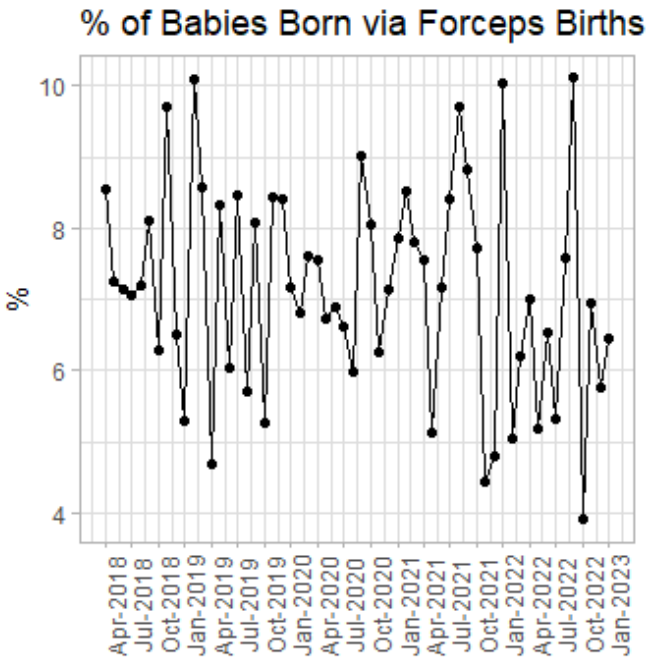
Data Source: NWC CN Maternity Dashboard

Babies Born via Forceps Births



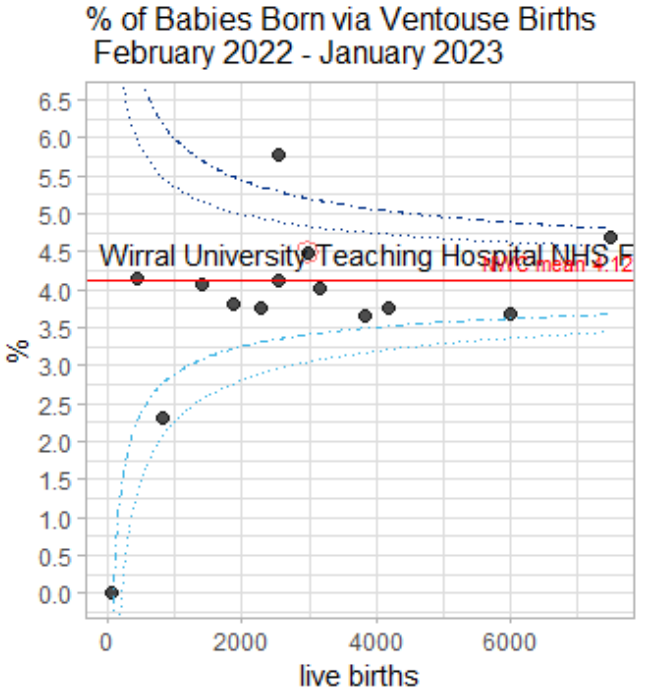
Data Source: NWC CN Maternity Dashboard

Run Chart for % of Babies Born via Forceps Births



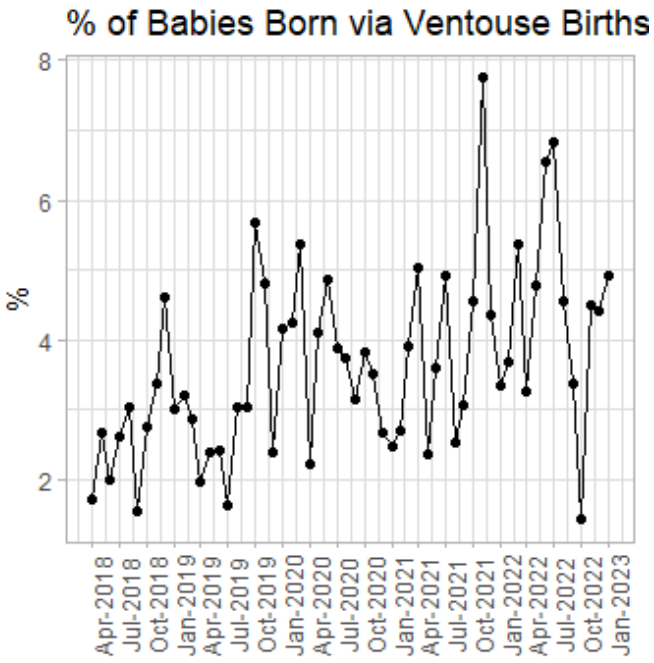
Data Source: NWC CN Maternity Dashboard

Babies Born via Ventouse Births



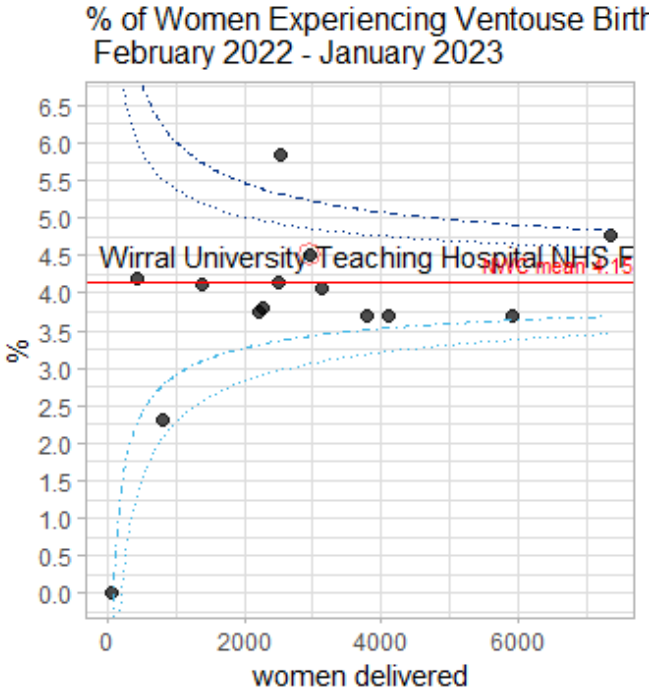
Data Source: NWC CN Maternity Dashboard

Run Chart for % of Babies Born via Ventouse Births



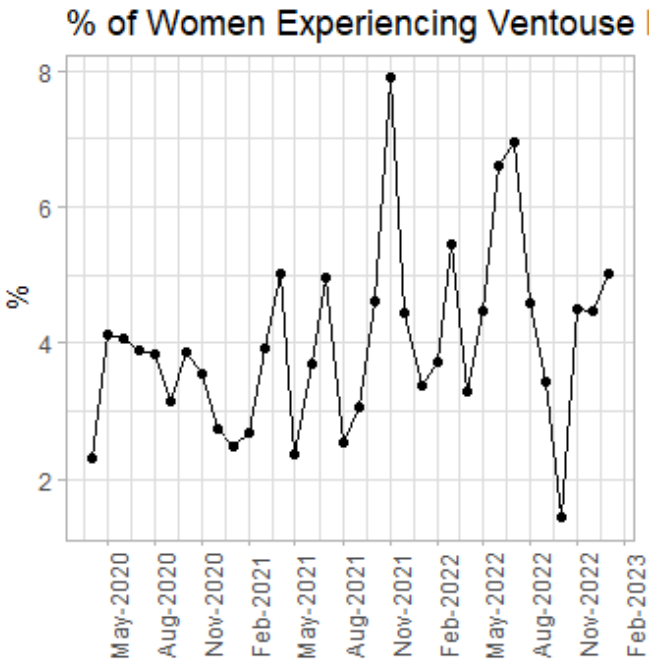
Data Source: NWC CN Maternity Dashboard

Women Experiencing Ventouse Births



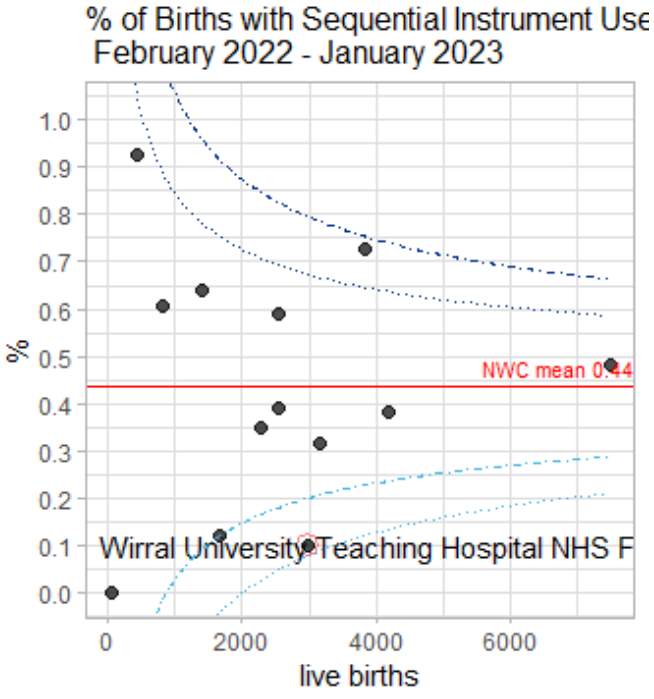
Data Source: NWC CN Maternity Dashboard

Run Chart for % of Women Experiencing Ventouse Births



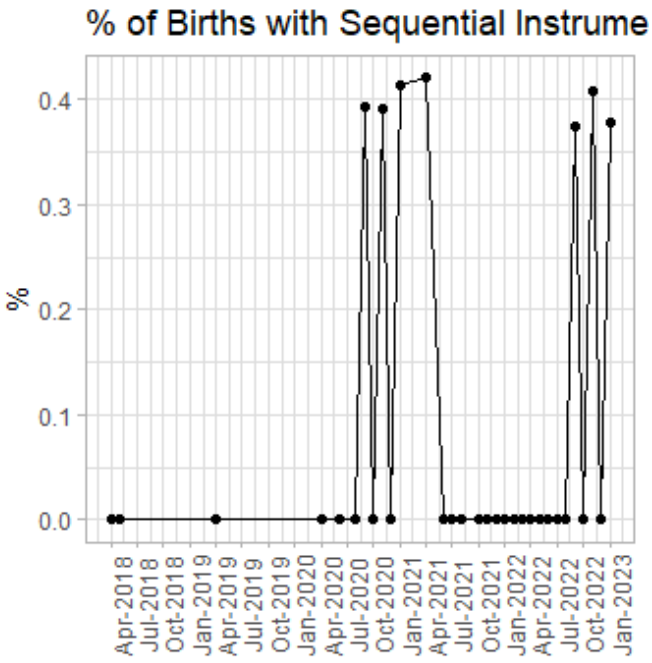
Data Source: NWC CN Maternity Dashboard

Births with Sequential Instrument Use



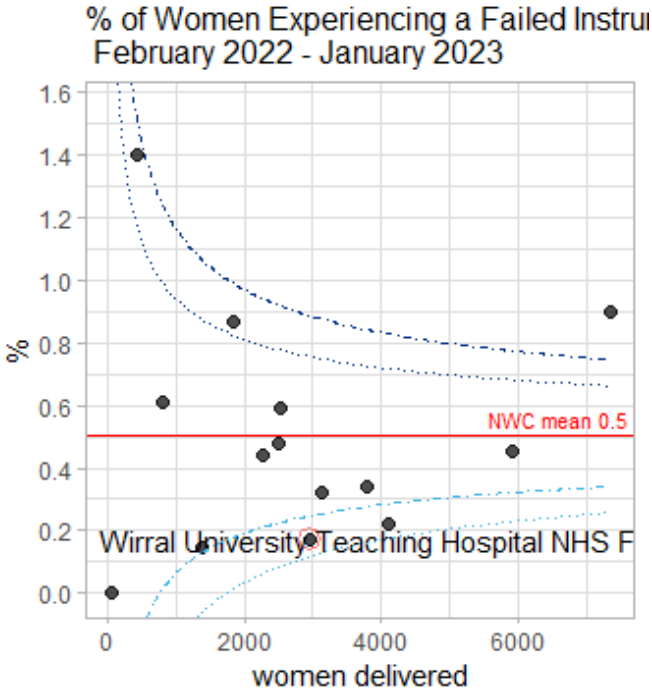
Data Source: NWC CN Maternity Dashboard

Run Chart for % of Births with Sequential Instrument Use



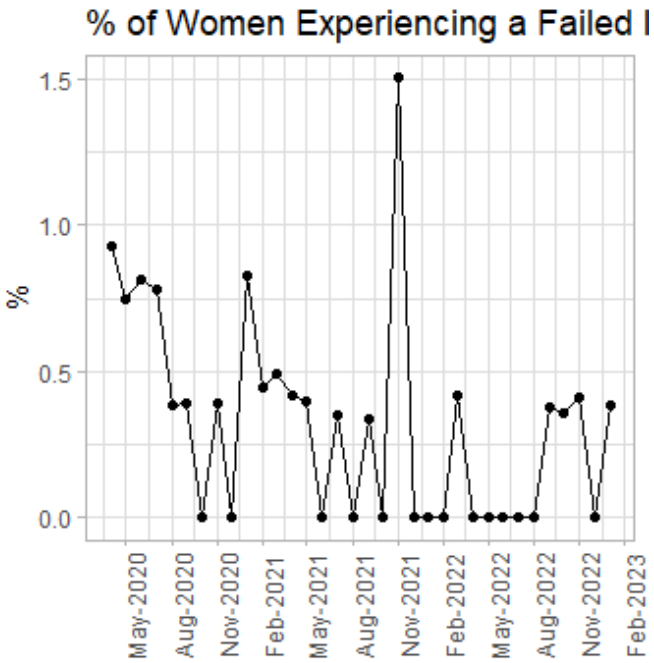
Data Source: NWC CN Maternity Dashboard

Women Experiencing a Failed Instrumental Births



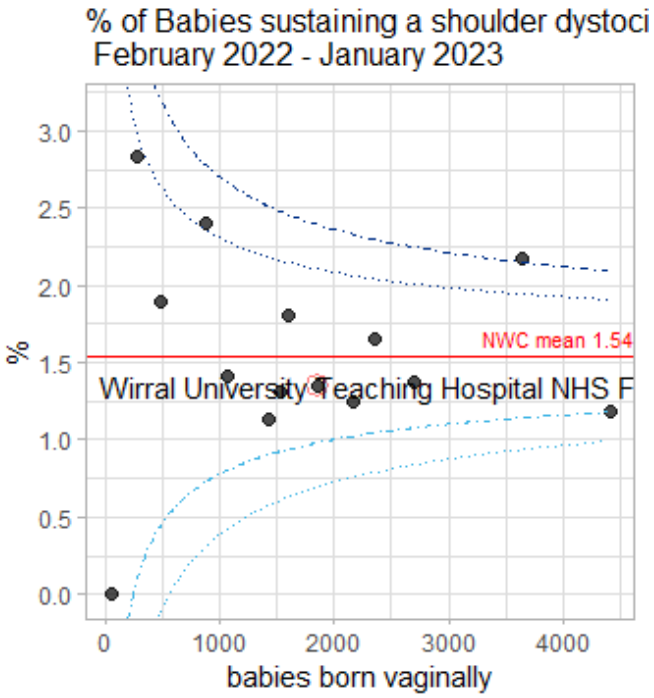
Data Source: NWC CN Maternity Dashboard

Run Chart for % of Women Experiencing a Failed Instrumental Births



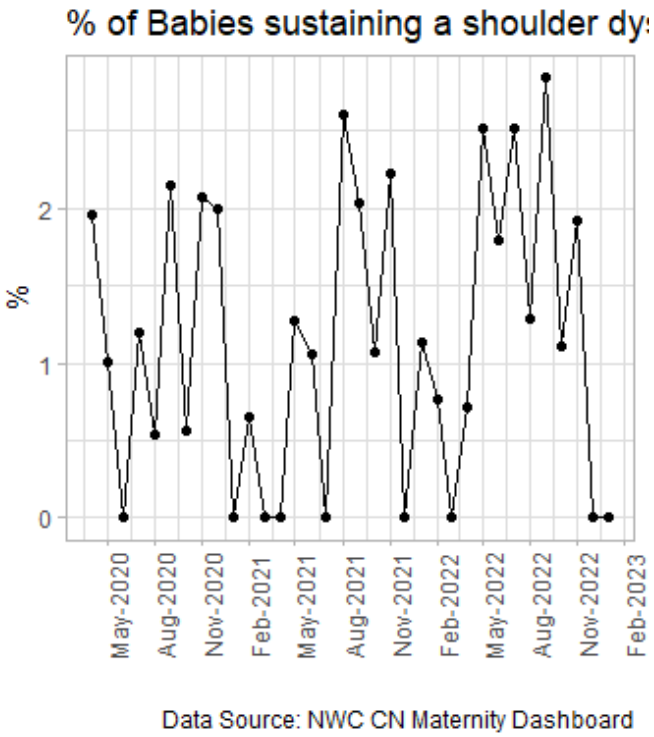
Data Source: NWC CN Maternity Dashboard

Babies sustaining a shoulder dystocia event during labour / birth



Data Source: NWC CN Maternity Dashboard

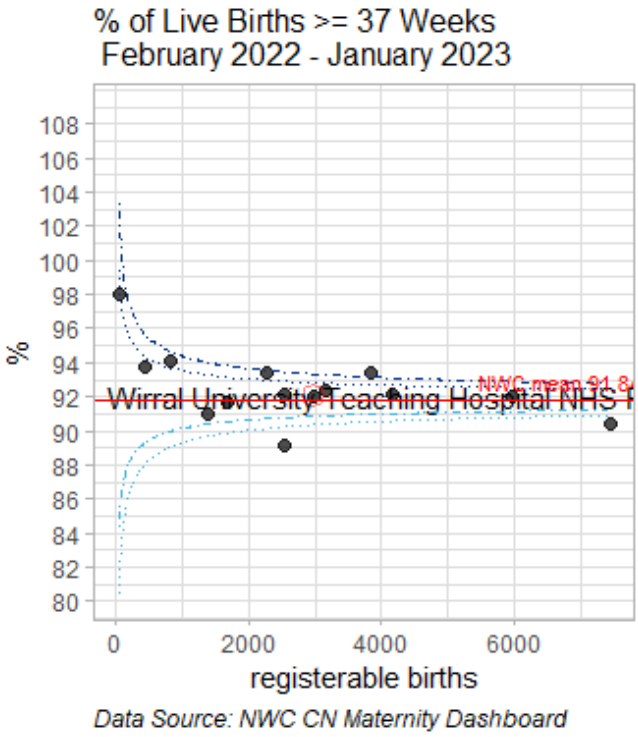
Run Chart for Shoulder Dystocia



Data Source: NWC CN Maternity Dashboard

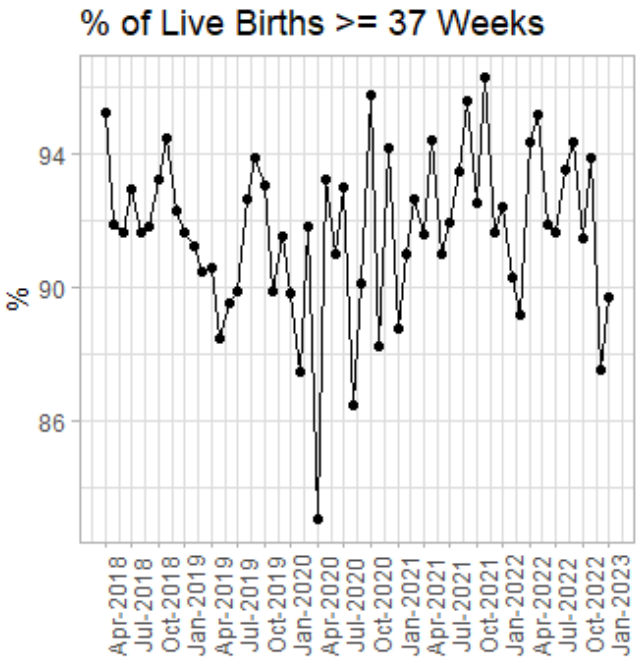
Pre Term

Live Births >= 37 Weeks



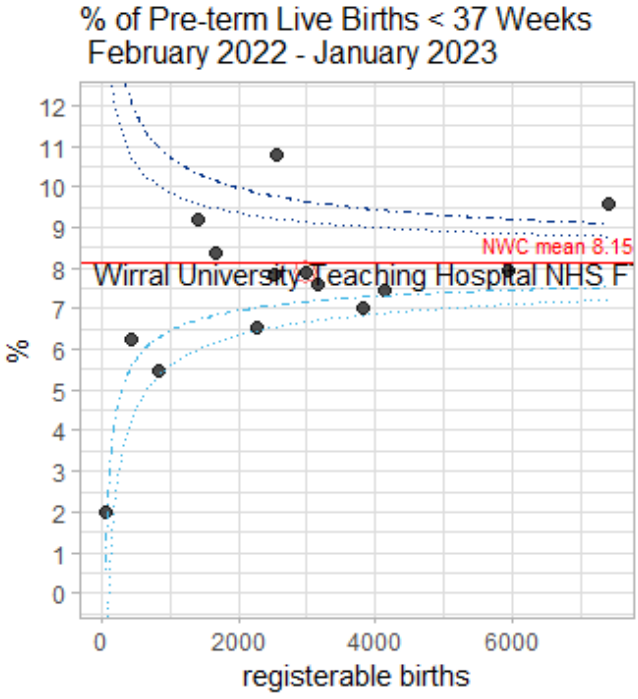
Data Source: NWC CN Maternity Dashboard

Run Chart for % of Live Births >= 37 Weeks



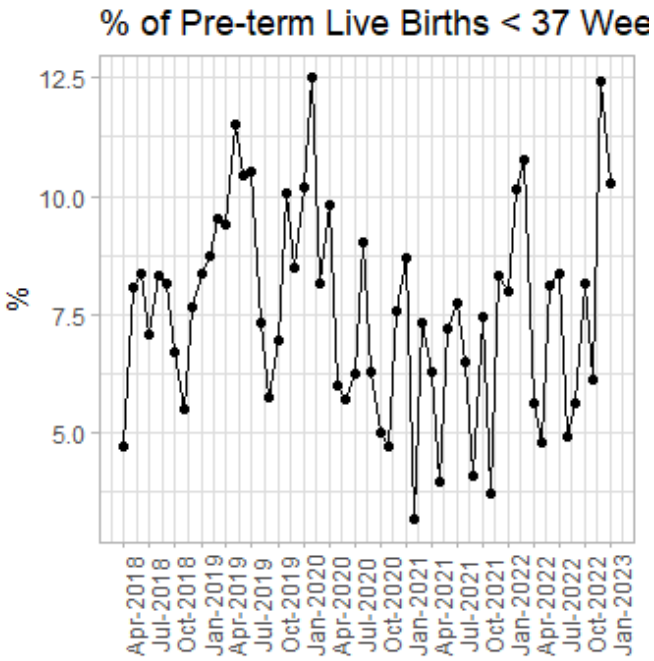
Data Source: NWC CN Maternity Dashboard

Pre-term Live Births < 37 Weeks



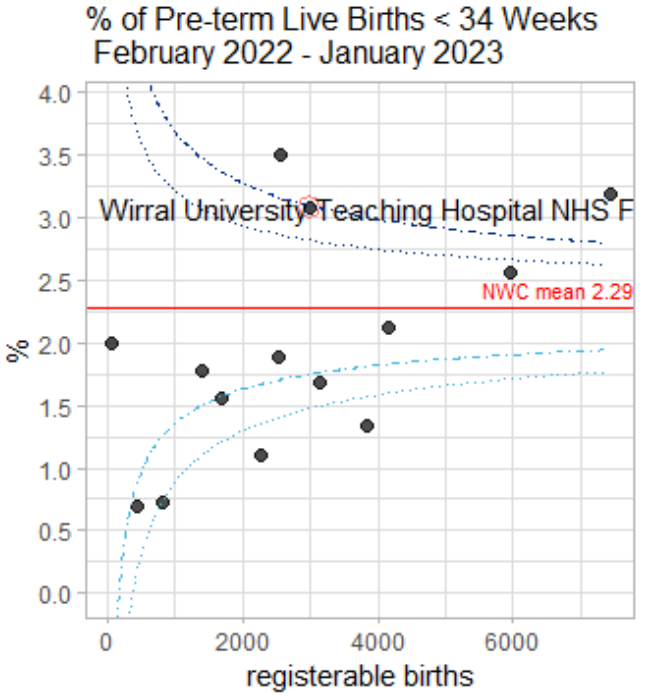
Data Source: NWC CN Maternity Dashboard

Run Chart for % of Pre-term Live Births < 37 Weeks



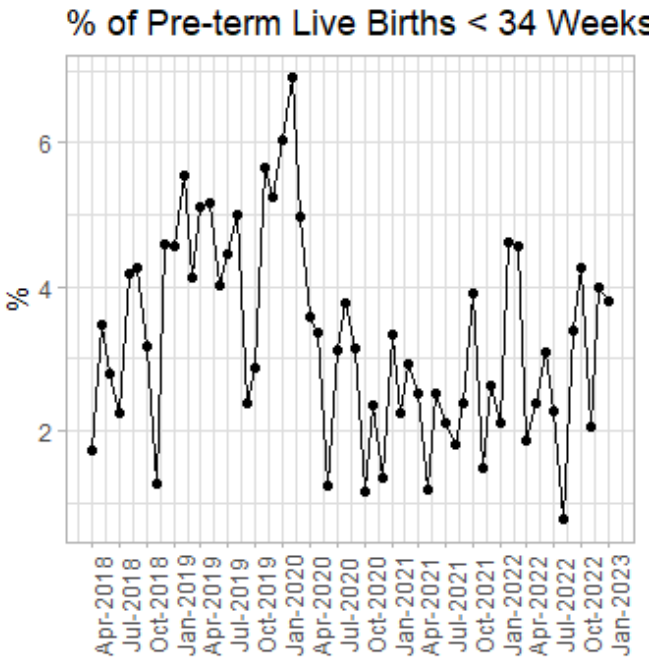
Data Source: NWC CN Maternity Dashboard

Pre-term Live Births < 34 Weeks



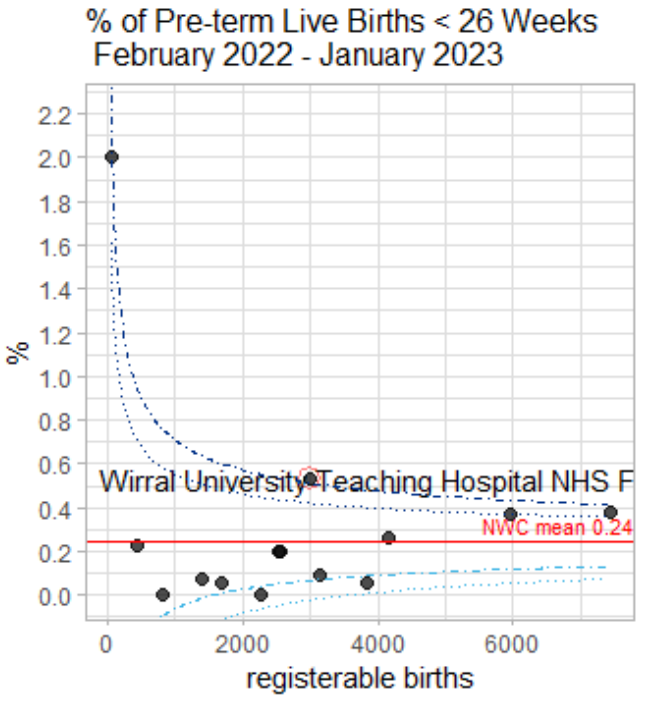
Data Source: NWC CN Maternity Dashboard

Run Chart for % of Pre-term Live Births < 34 Weeks



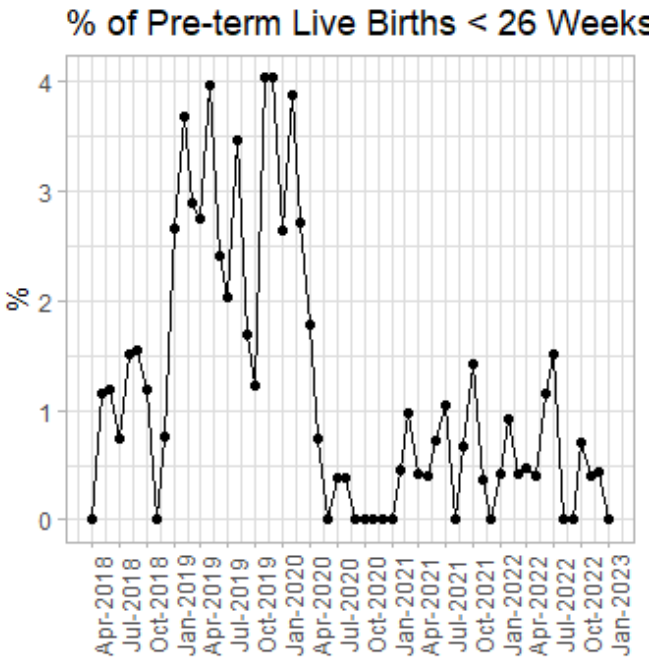
Data Source: NWC CN Maternity Dashboard

Pre-term Live Births < 26 Weeks



Data Source: NWC CN Maternity Dashboard

Run Chart for % of Live Births < 26 Weeks

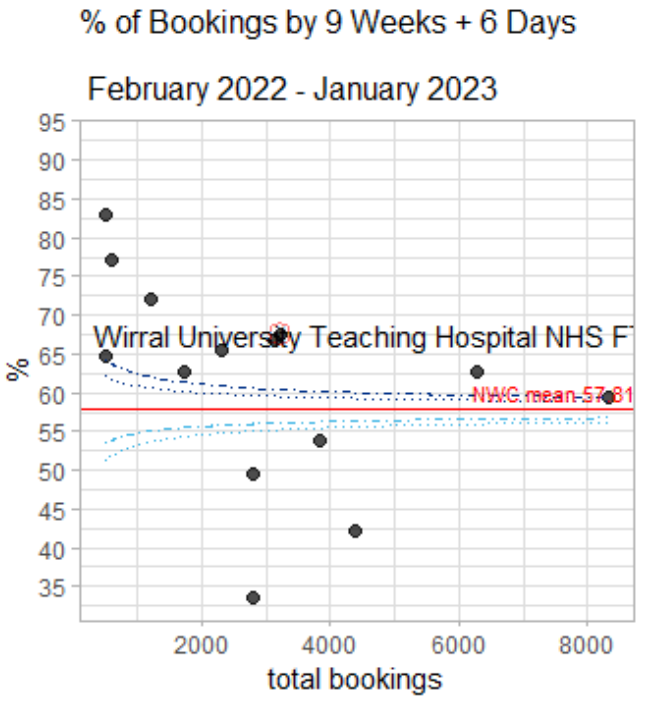


Data Source: NWC CN Maternity Dashboard

Additional Metrics

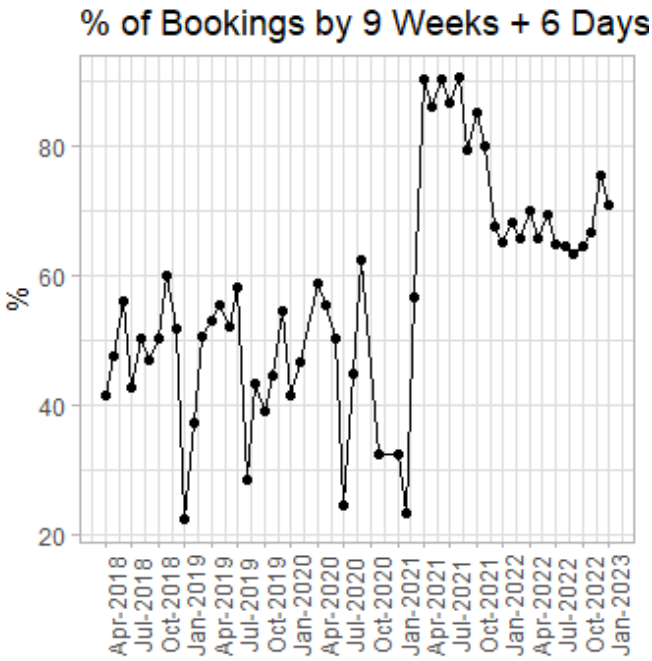
Bookings

Bookings by 9 Weeks + 6 Days



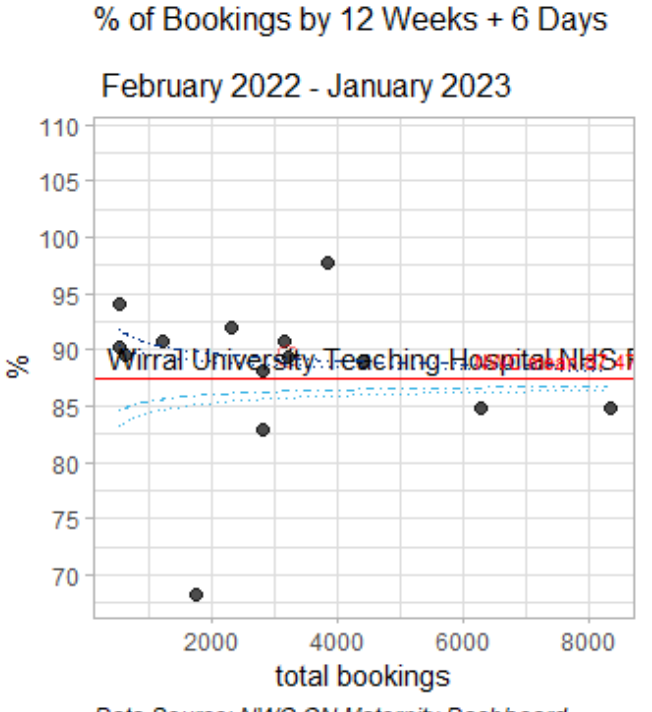
Data Source: NWC CN Maternity Dashboard

Run Chart for % of Bookings by 9 Weeks + 6 Days



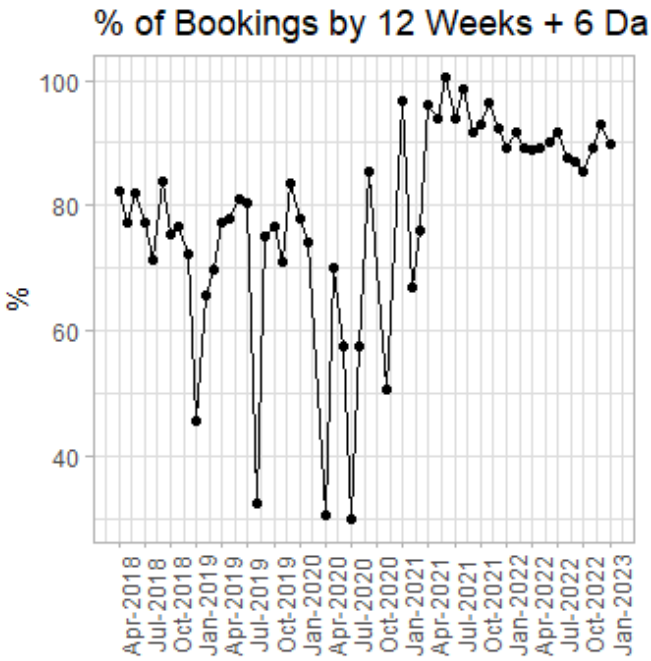
Data Source: NWC CN Maternity Dashboard

Bookings by 12 Weeks + 6 Days



Data Source: NWC CN Maternity Dashboard

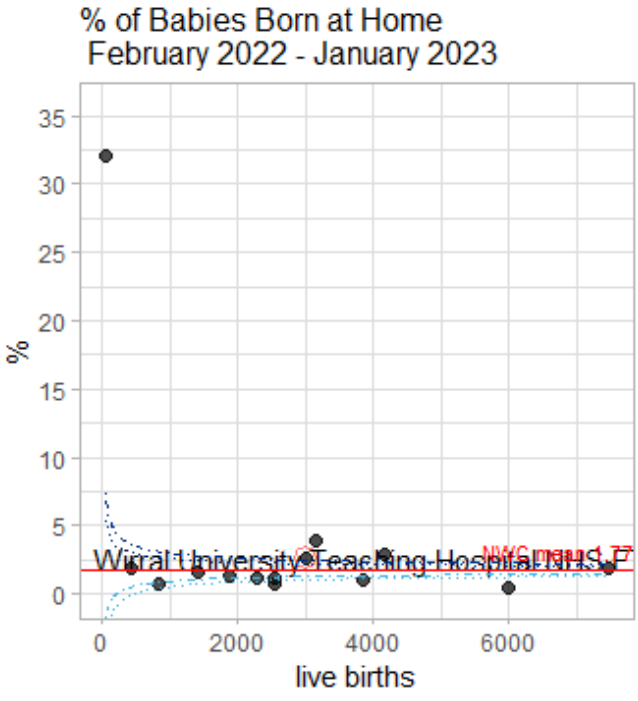
Run Chart for % of Bookings by 12 Weeks + 6 Days



Data Source: NWC CN Maternity Dashboard

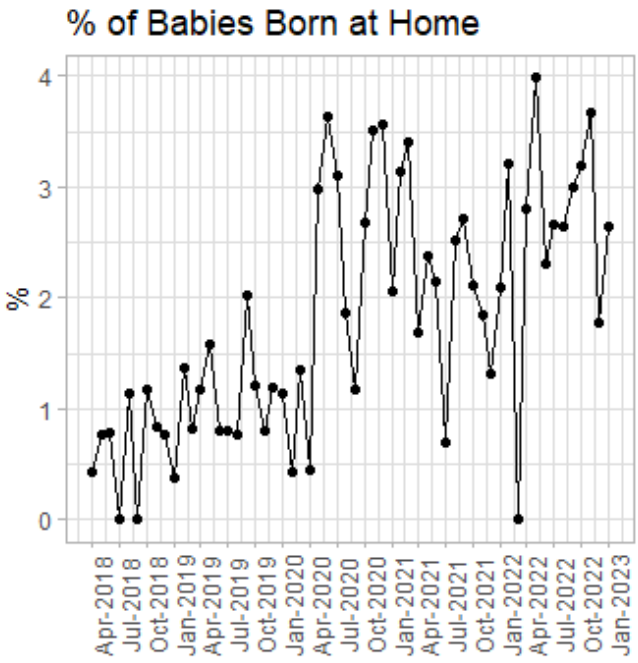
Birth Location

Babies Born at Home



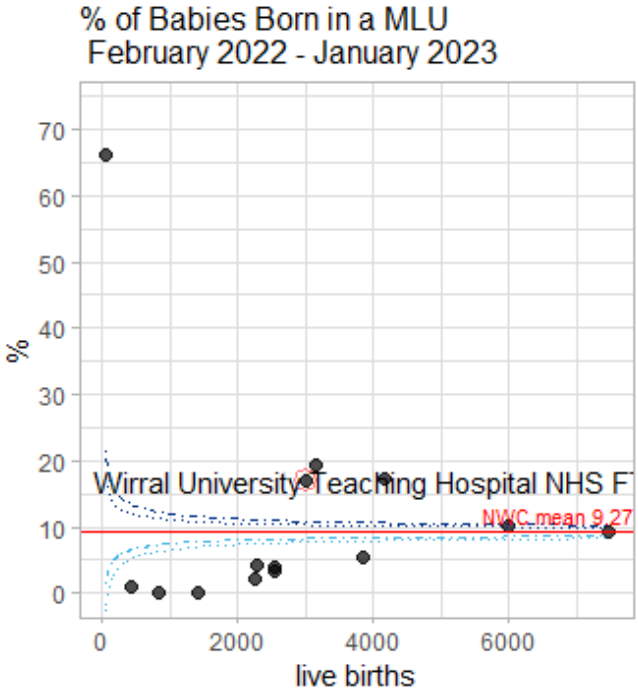
Data Source: NWC CN Maternity Dashboard

Run Chart for % of Babies Born at Home



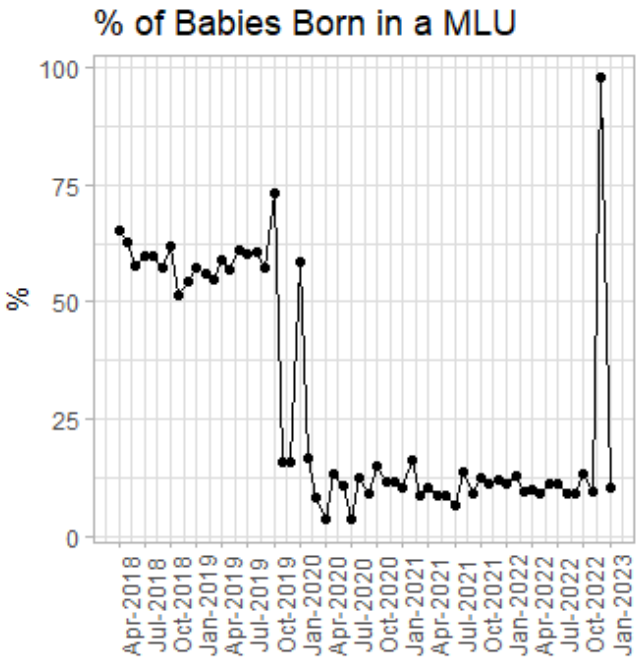
Data Source: NWC CN Maternity Dashboard

Babies Born in a MLU



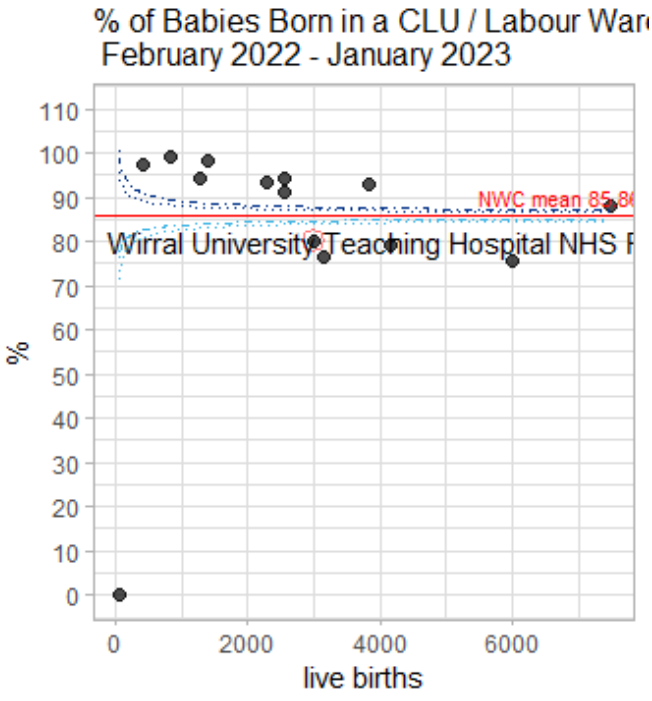
Data Source: NWC CN Maternity Dashboard

Run Chart for % of Babies Born in a MLU



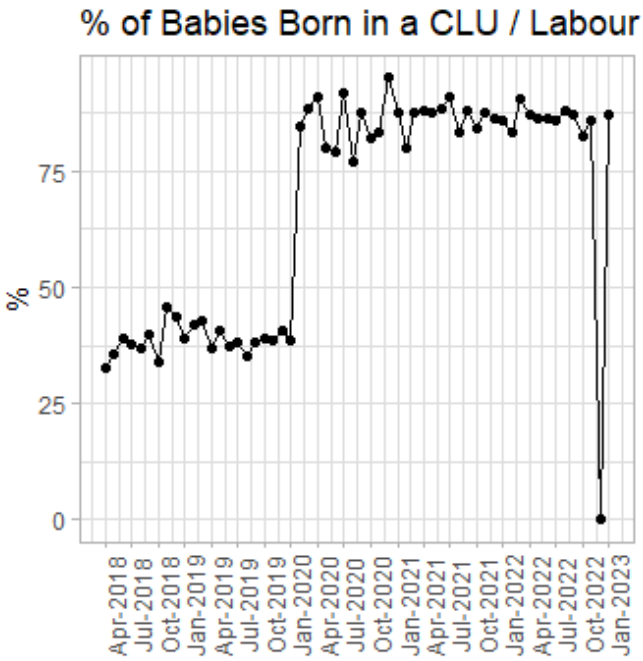
Data Source: NWC CN Maternity Dashboard

Babies Born in a CLU / Labour Ward



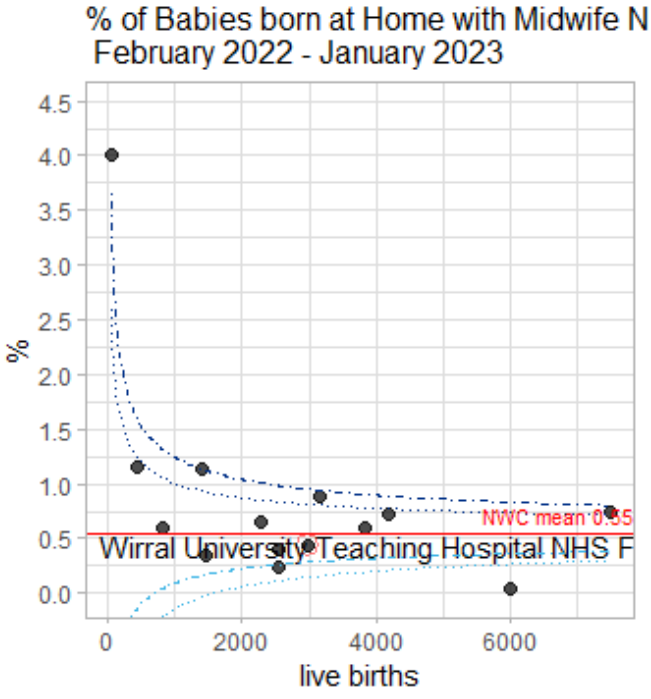
Data Source: NWC CN Maternity Dashboard

Run Chart for % of Babies Born in a CLU / Labour Ward



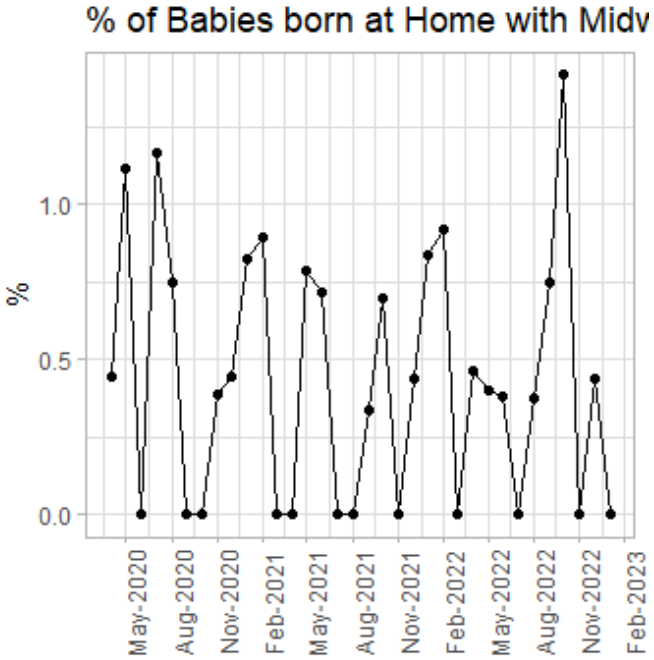
Data Source: NWC CN Maternity Dashboard

Babies born at Home with Midwife NOT present



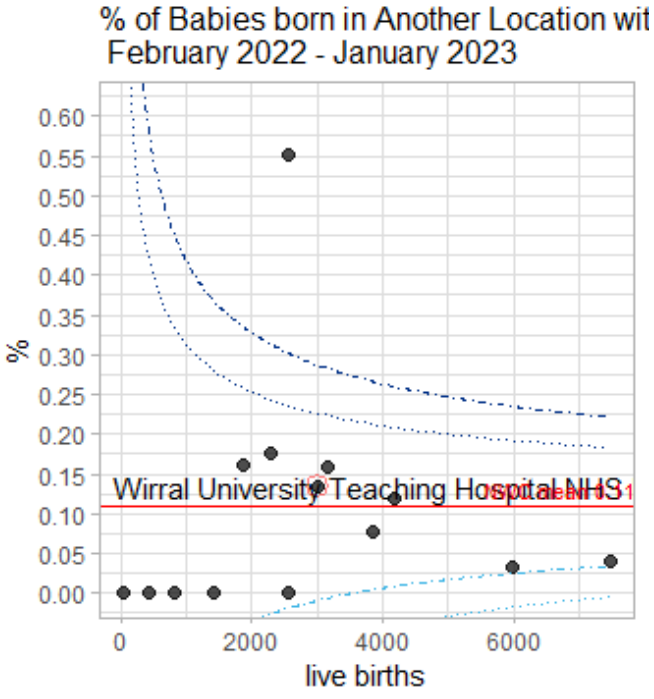
Data Source: NWC CN Maternity Dashboard

Run Chart for % of Babies born at Home with Midwife NOT present



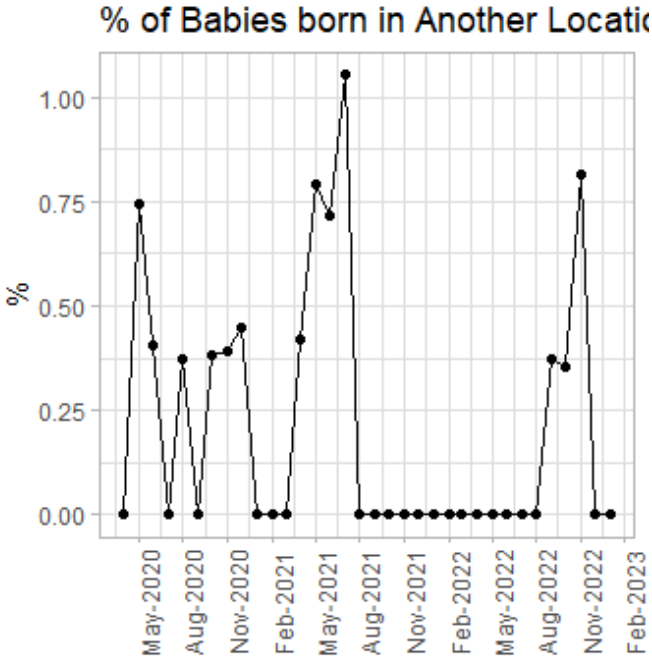
Data Source: NWC CN Maternity Dashboard

Babies born in Another Location with Midwife NOT present



Data Source: NWC CN Maternity Dashboard

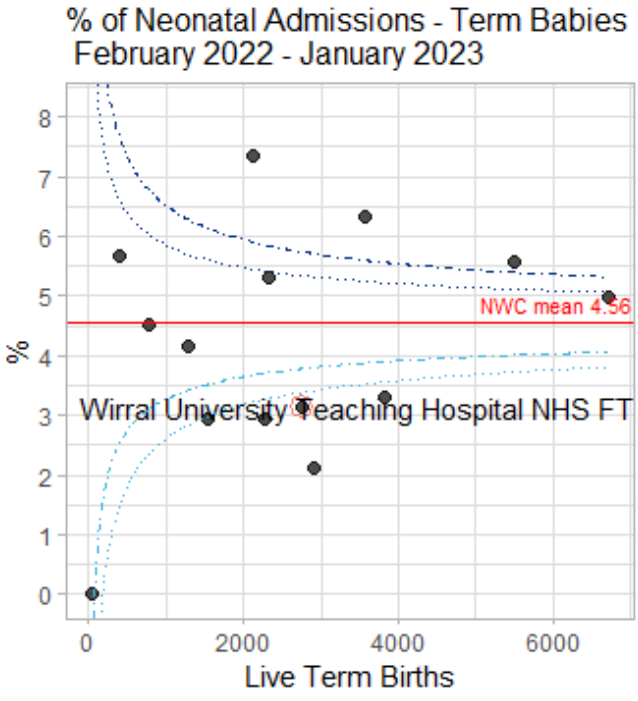
Run Chart for % of Babies born in Another Location with Midwife NOT present



Data Source: NWC CN Maternity Dashboard

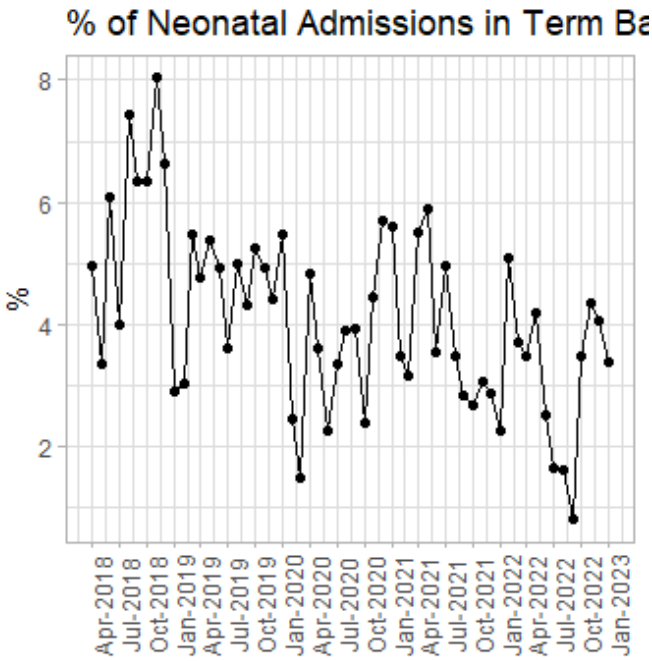
Neonatal Care

Neonatal Admissions in Term Babies



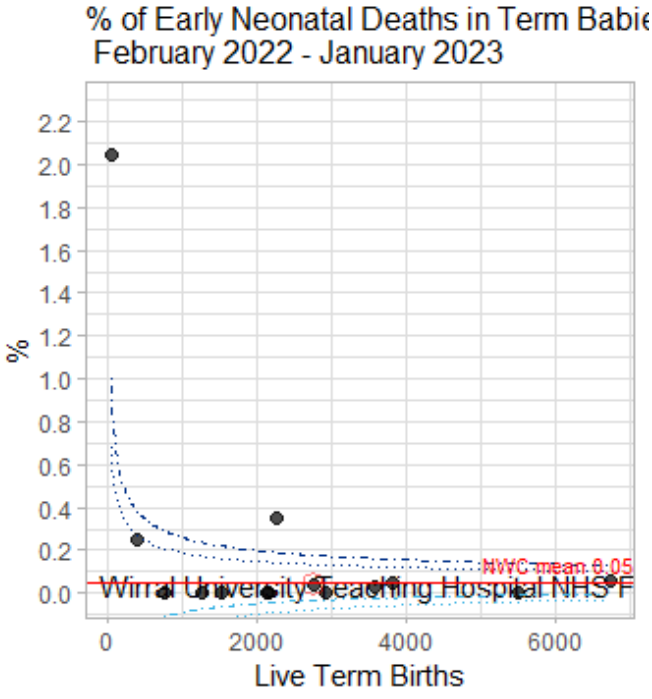
Data Source: NWC CN Maternity Dashboard

Run Chart for % of Neonatal Admissions in Term Babies



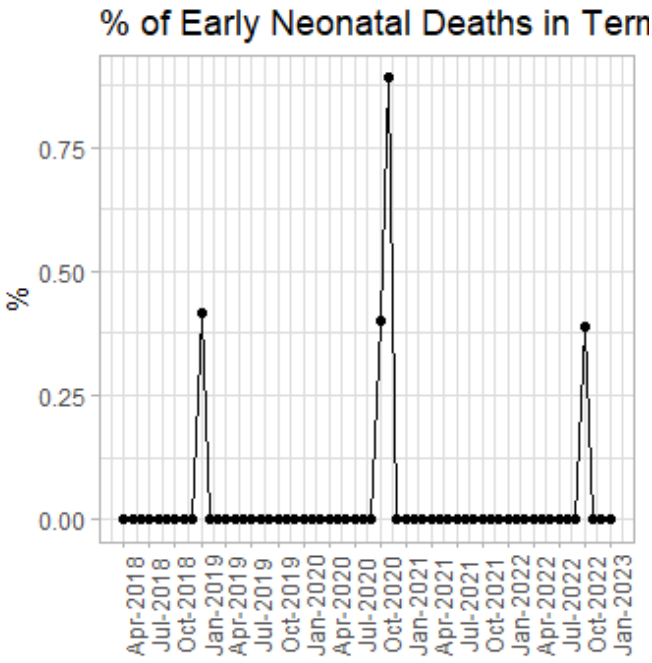
Data Source: NWC CN Maternity Dashboard

Early Neonatal Deaths in Term Babies



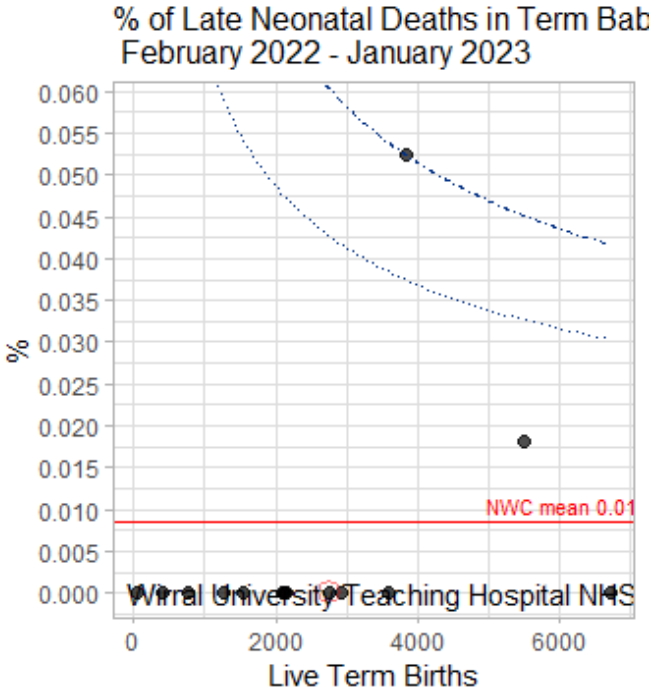
Data Source: NWC CN Maternity Dashboard

Run Chart for % of Early Neonatal Deaths in Term Babies



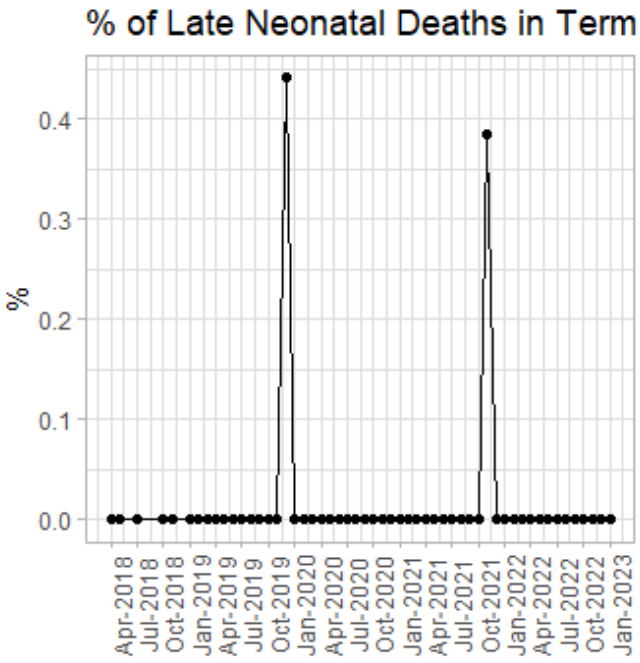
Data Source: NWC CN Maternity Dashboard

Late Neonatal Deaths in Term Babies



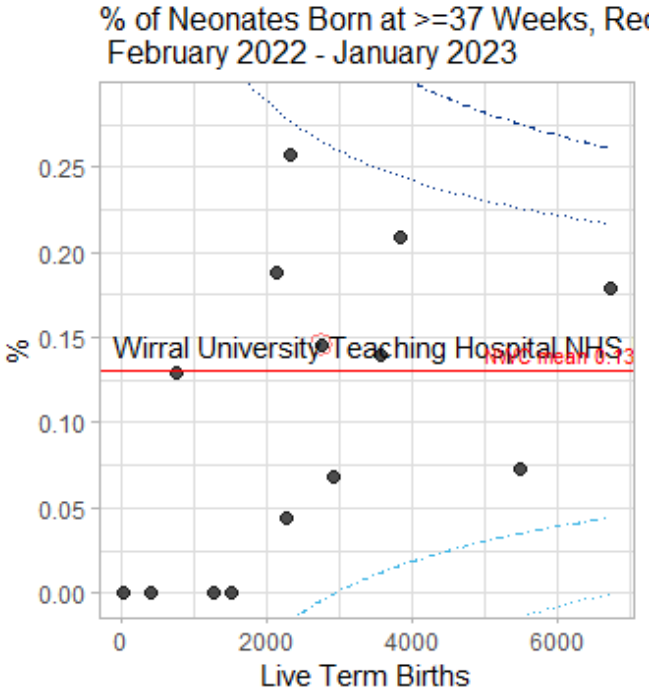
Data Source: NWC CN Maternity Dashboard

Run Chart for % of Late Neonatal Deaths in Term Babies



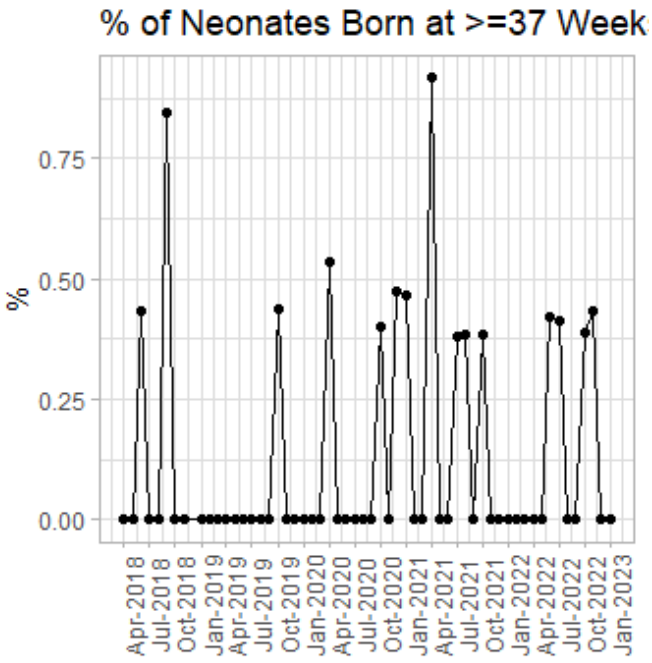
Data Source: NWC CN Maternity Dashboard

Neonates Born at >=37 Weeks, Requiring Therapeutic Cooling



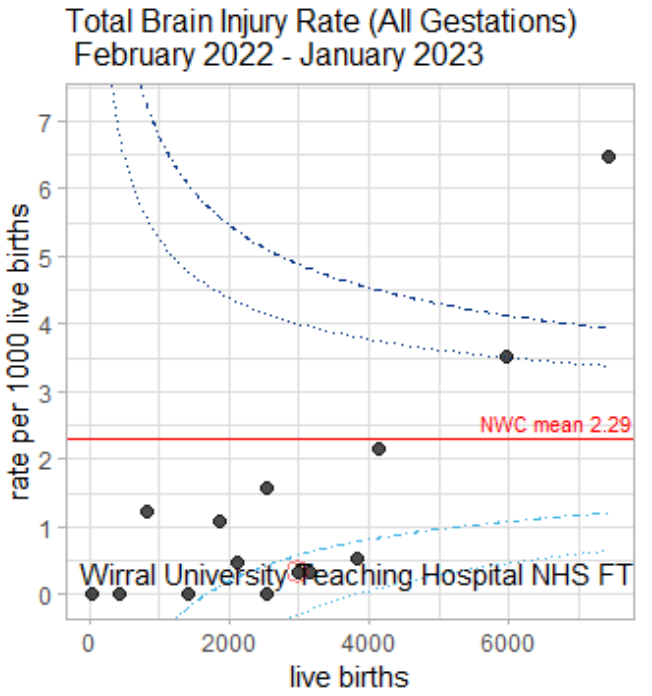
Data Source: NWC CN Maternity Dashboard

Run Chart for % of Neonates Born at >=37 Weeks, Requiring Therapeutic Cooling



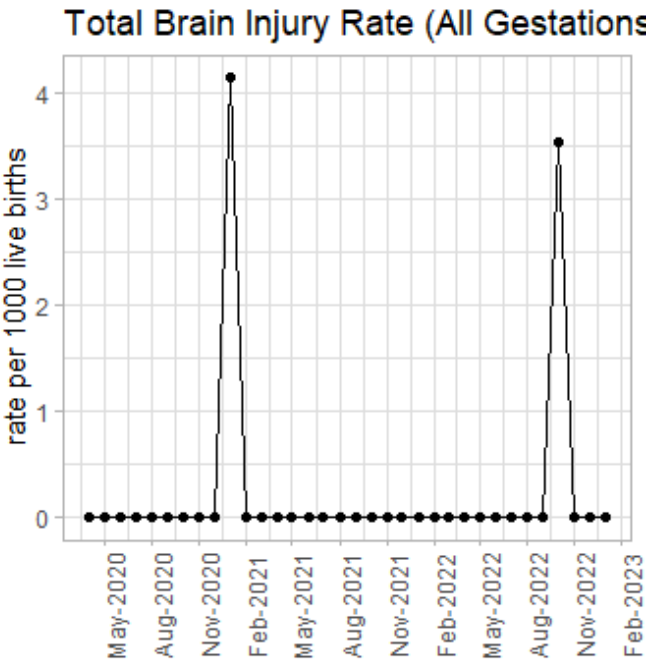
Data Source: NWC CN Maternity Dashboard

Total Brain Injury Rate (All Gestations)



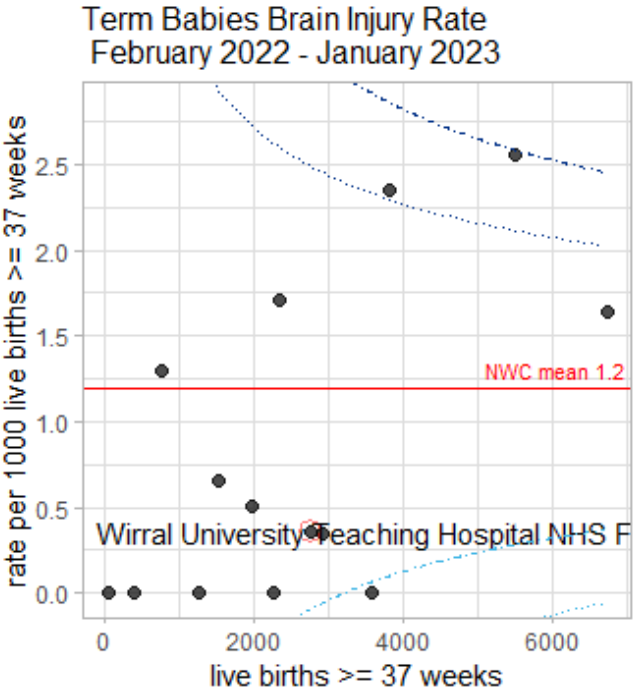
Data Source: NWC CN Maternity Dashboard

Run Chart for Total Brain Injury Rate (All Gestations)



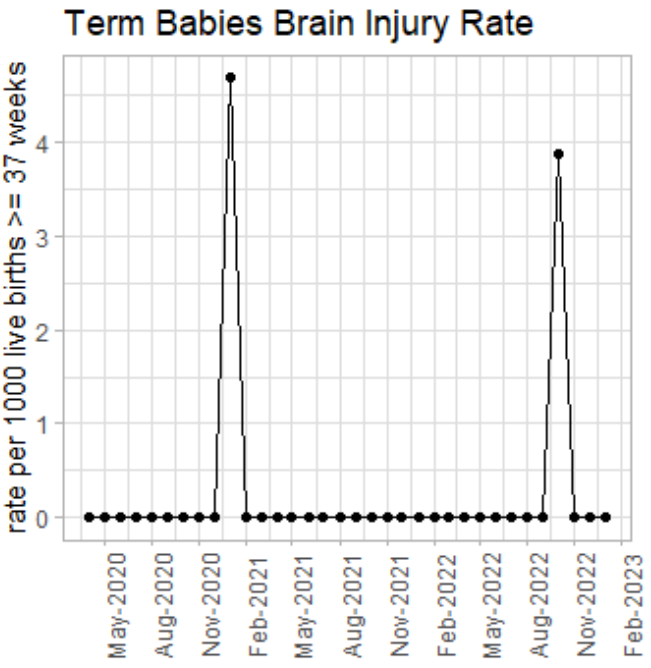
Data Source: NWC CN Maternity Dashboard

Term Babies Brain Injury Rate



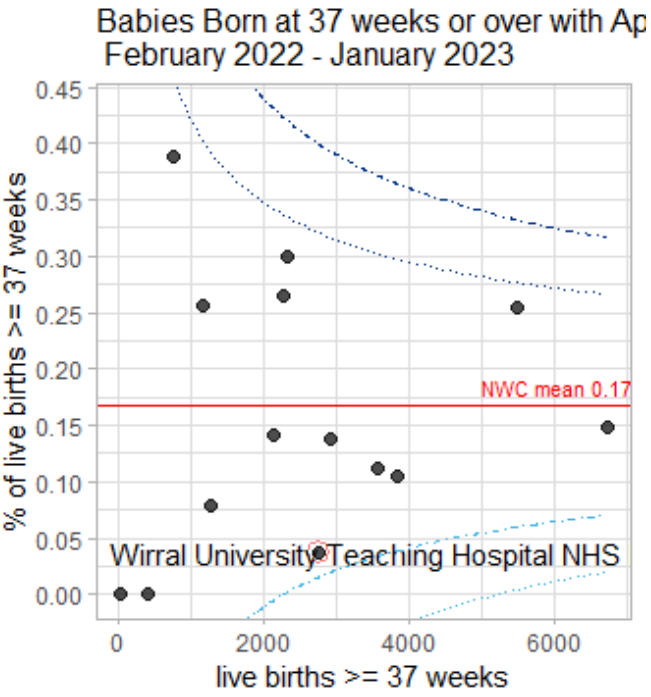
Data Source: NWC CN Maternity Dashboard

Run Chart for Term Babies Brain Injury Rate



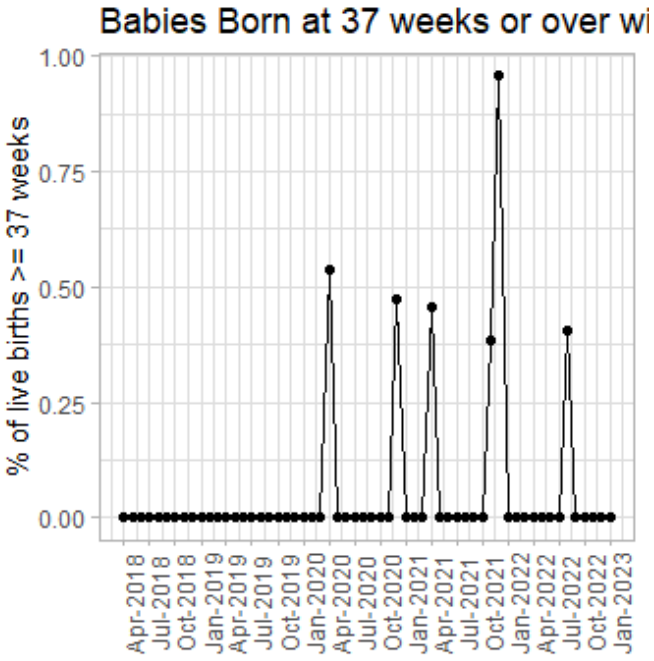
Data Source: NWC CN Maternity Dashboard

Babies Born at 37 weeks or over with Apgar Score below 4 at 5 minutes



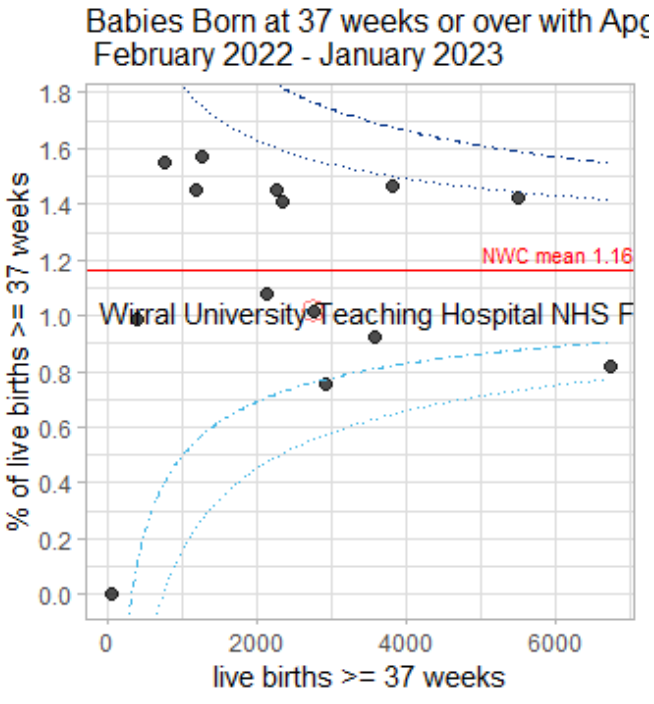
Data Source: NWC CN Maternity Dashboard

Run Chart for Babies Born at 37 weeks or over with Apgar Score below 4 at 5 minutes



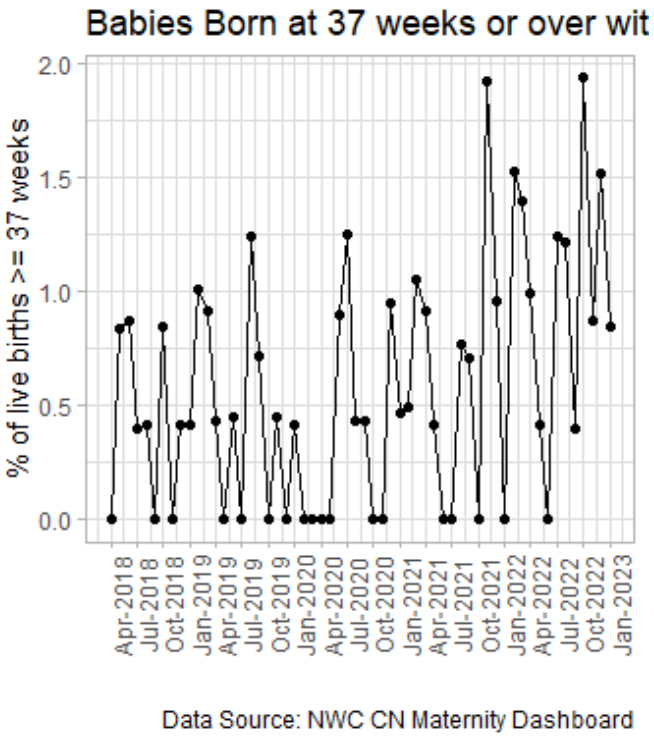
Data Source: NWC CN Maternity Dashboard

Babies Born at 37 weeks or over with Apgar Score below 7 at 5 minutes



Data Source: NWC CN Maternity Dashboard

Run Chart for Babies Born at 37 weeks or over with Apgar Score below 7 at 5 minutes

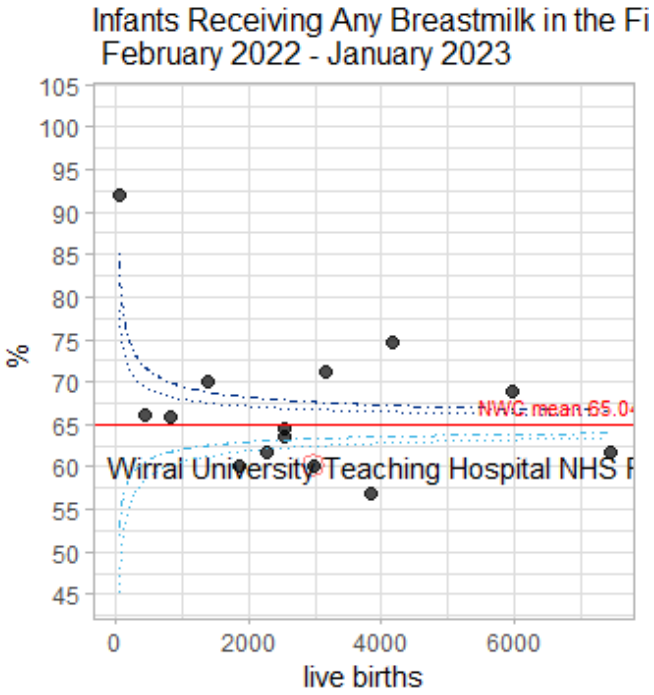


Data Source: NWC CN Maternity Dashboard

Health Promotion

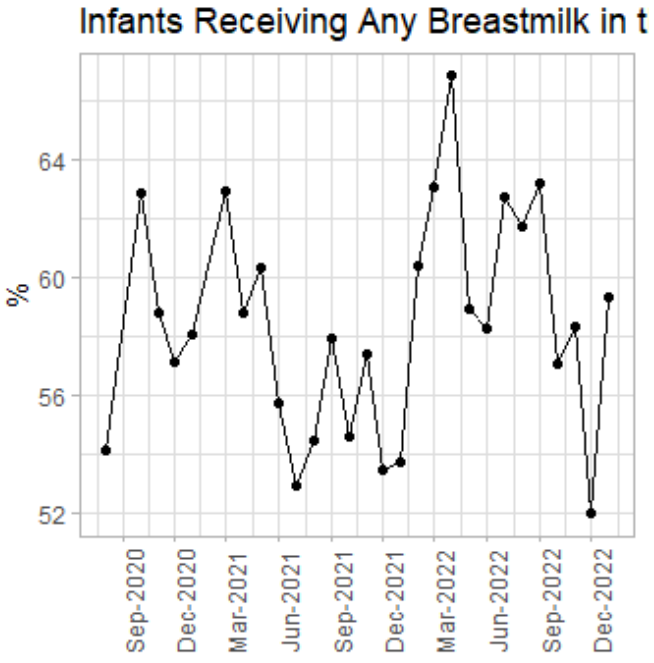
Breast Feeding

Infants Receiving Any Breastmilk in the First 48 Hours



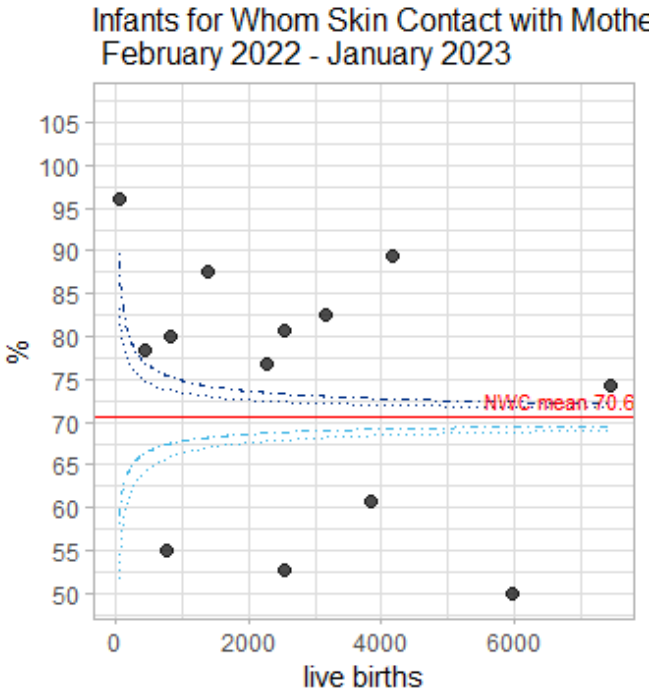
Data Source: NWC CN Maternity Dashboard

Run Chart for Infants Receiving Any Breastmilk in the First 48 Hours



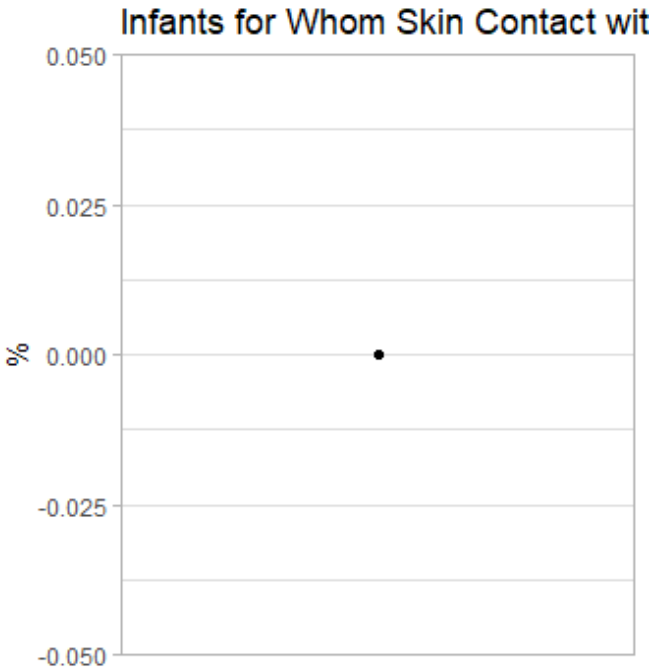
Data Source: NWC CN Maternity Dashboard

Infants for Whom Skin Contact with Mother was Initiated After Birth



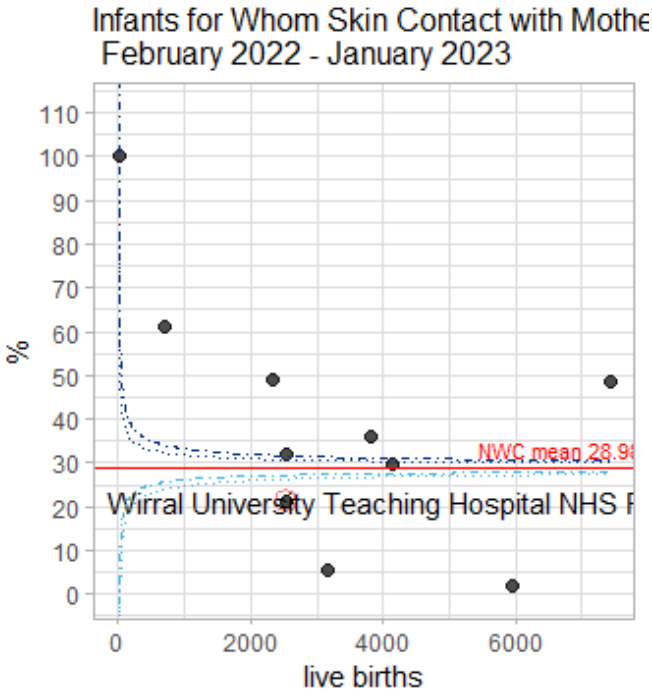
Data Source: NWC CN Maternity Dashboard

Run Chart for Infants for Whom Skin Contact with Mother was Initiated After Birth



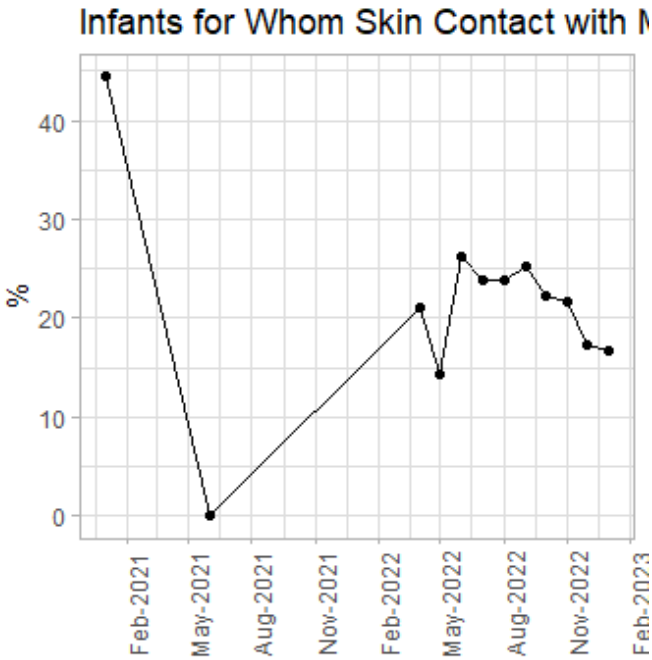
Data Source: NWC CN Maternity Dashboard

Infants for Whom Skin Contact with Mother Lasted 60 Minutes or More



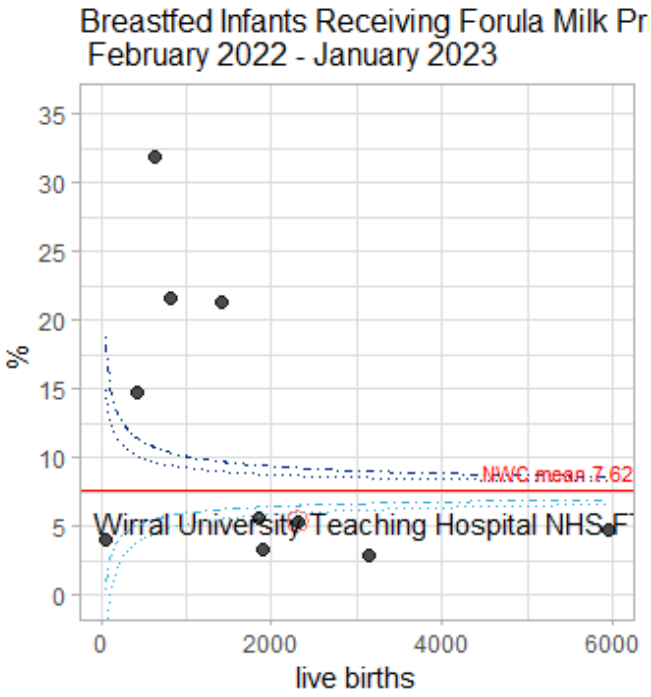
Data Source: NWC CN Maternity Dashboard

Run Chart for Infants for Whom Skin Contact with Mother Lasted 60 Minutes or More



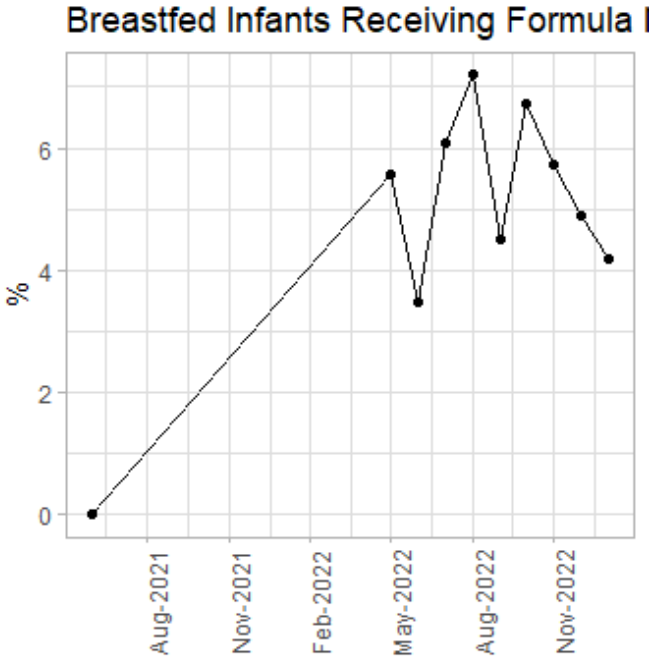
Data Source: NWC CN Maternity Dashboard

Breastfed Infants Receiving Formula Milk Prior to Discharge



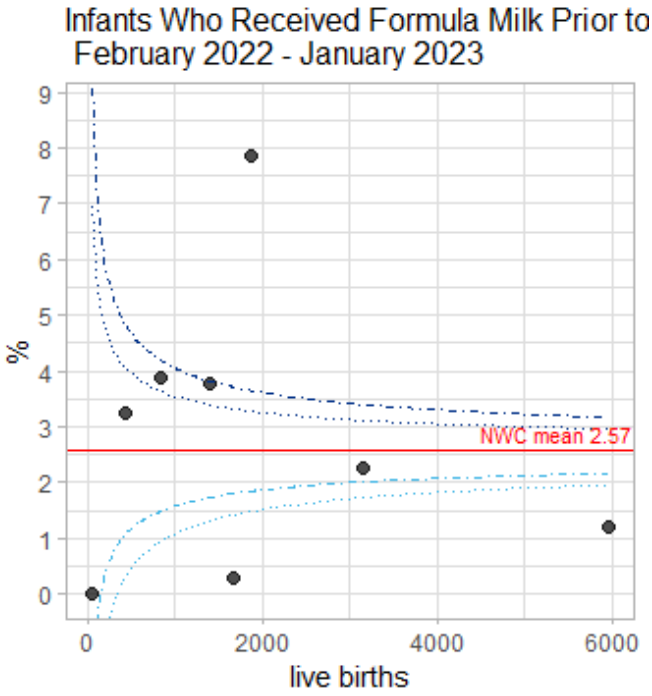
Data Source: NWC CN Maternity Dashboard

Run Chart for Breastfed Infants Receiving Formula Milk Prior to Discharge



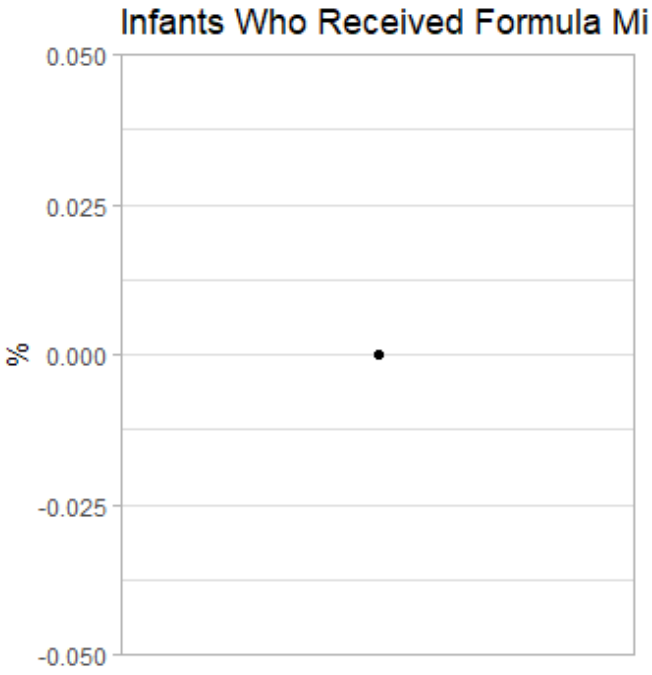
Data Source: NWC CN Maternity Dashboard

Infants Who Received Formula Milk Prior to Discharge for Medical Reasons and are Discharged Breastfeeding



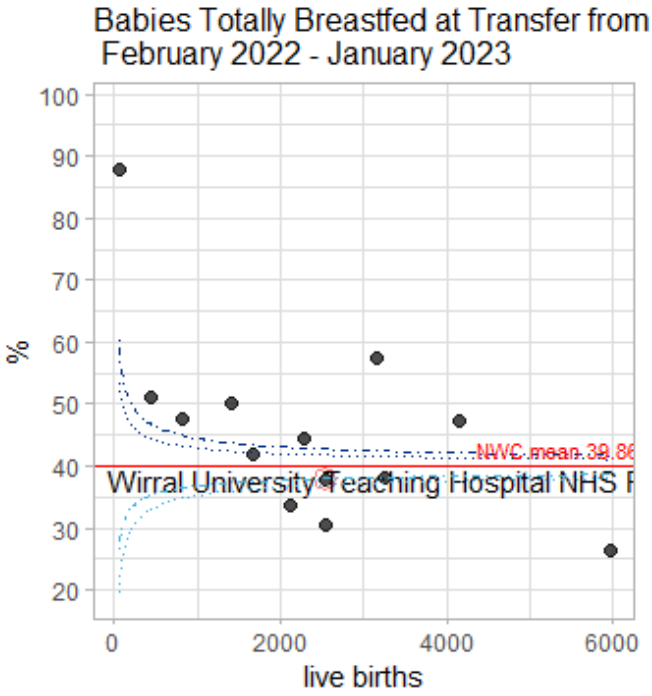
Data Source: NWC CN Maternity Dashboard

Run Chart for Infants Who Received Formula Milk Prior to Discharge for Medical Reasons and are Discharged Breastfeeding



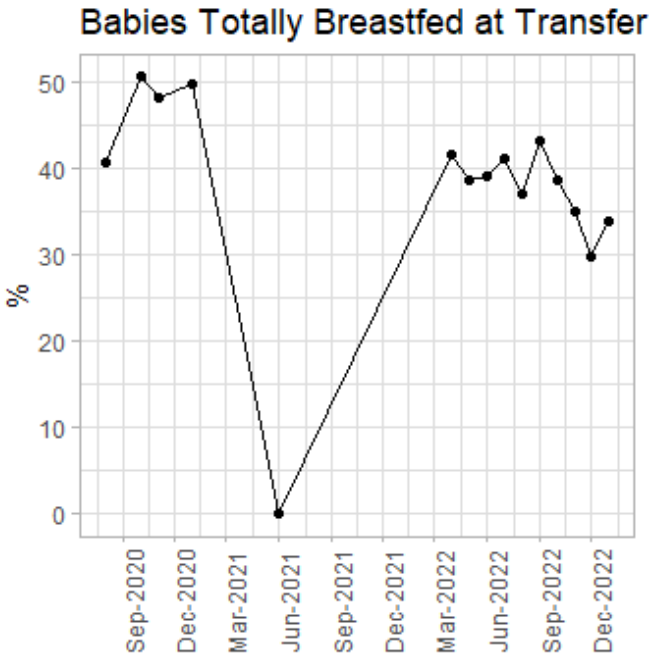
Data Source: NWC CN Maternity Dashboard

Babies Totally Breastfed at Transfer from Hospital Care to Home Care



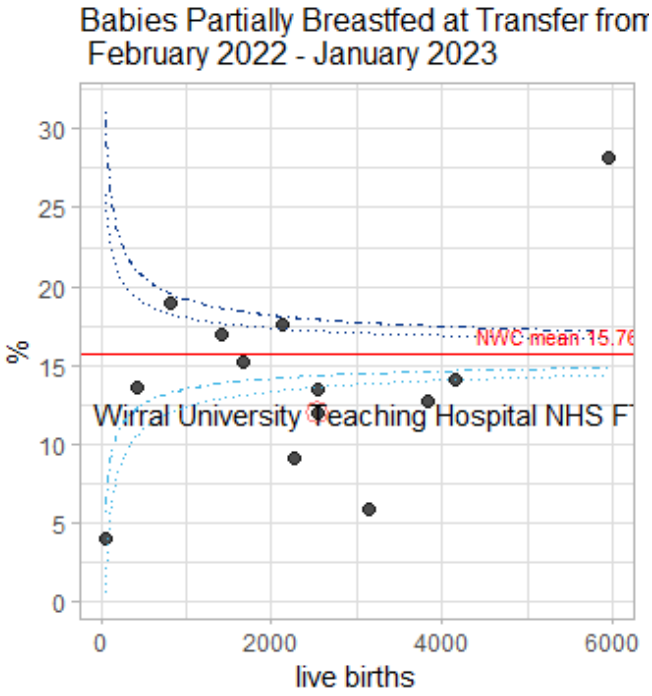
Data Source: NWC CN Maternity Dashboard

Run Chart for Babies Totally Breastfed at Transfer from Hospital Care to Home Care



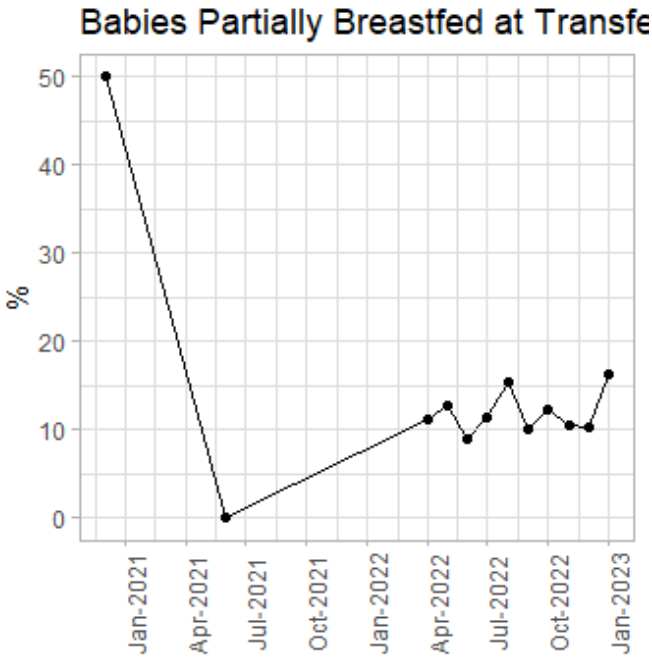
Data Source: NWC CN Maternity Dashboard

Babies Partially Breastfed at Transfer from Hospital Care to Home Care



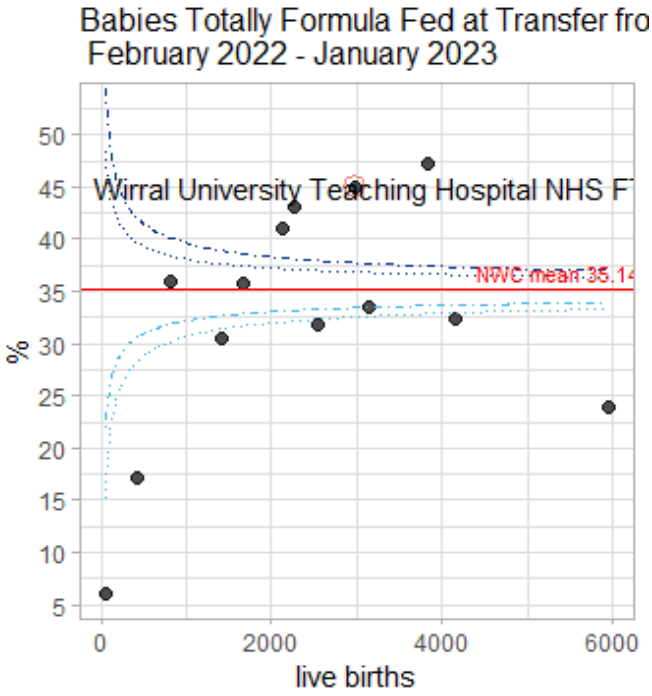
Data Source: NWC CN Maternity Dashboard

Run Chart for Babies Partially Breastfed at Transfer from Hospital Care to Home Care



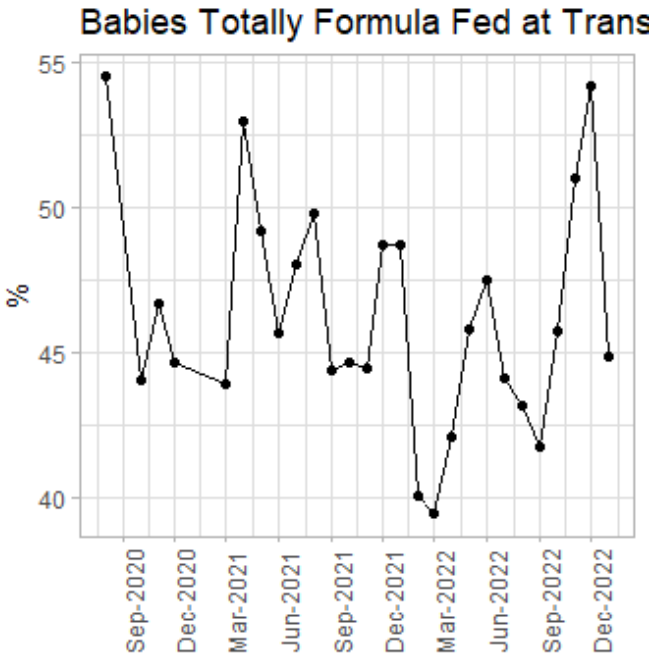
Data Source: NWC CN Maternity Dashboard

Babies Totally Formula Fed at Transfer from Hospital Care to Home Care



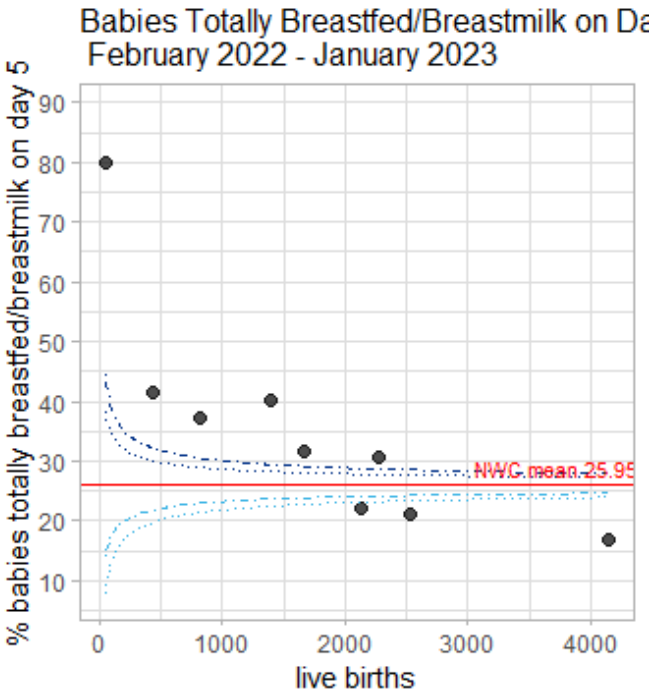
Data Source: NWC CN Maternity Dashboard

Run Chart for Babies Totally Formula Fed at Transfer from Hospital Care to Home Care



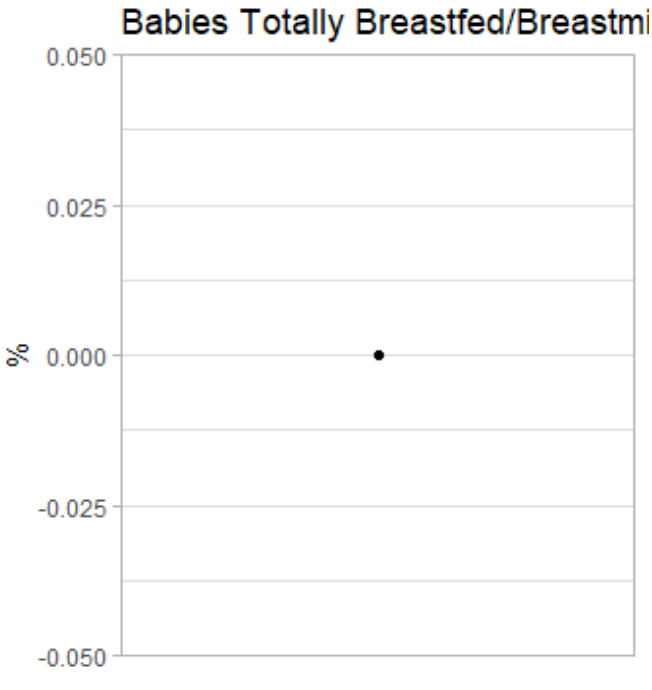
Data Source: NWC CN Maternity Dashboard

Babies Totally Breastfed/Breastmilk on Day 5



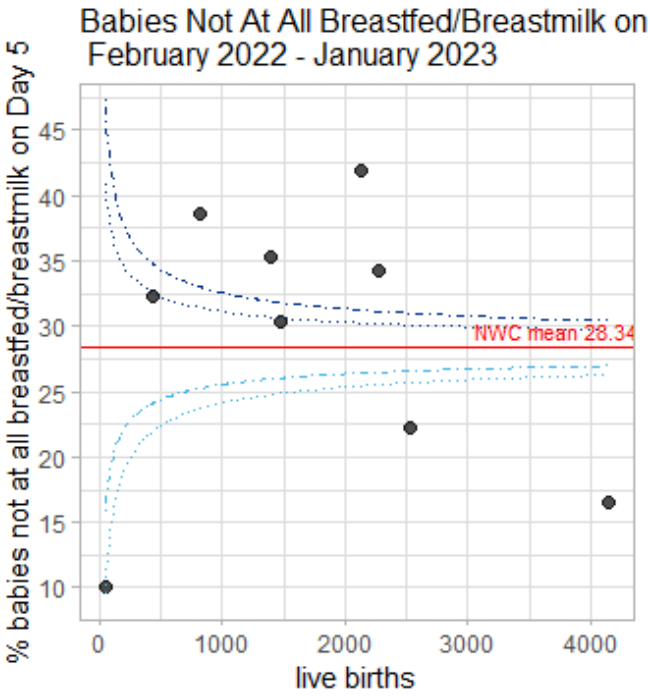
Data Source: NWC CN Maternity Dashboard

Run Chart for Babies Totally Breastfed/Breastmilk on Day 5



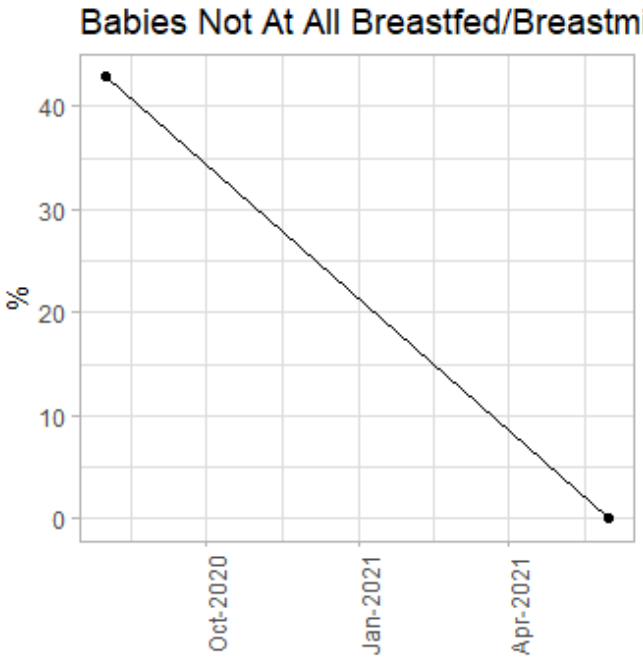
Data Source: NWC CN Maternity Dashboard

Babies Not At All Breastfed/Breastmilk on Day 5



Data Source: NWC CN Maternity Dashboard

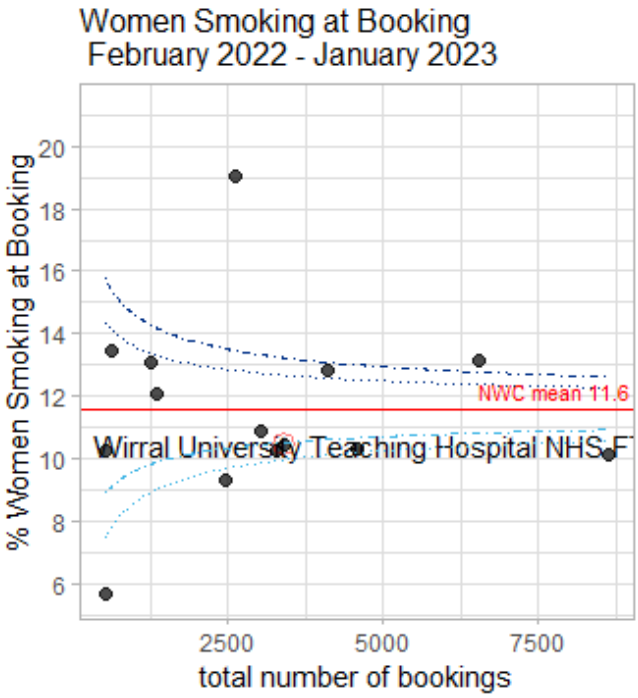
Run Chart for Babies Not At All Breastfed/Breastmilk on Day 5



Data Source: NWC CN Maternity Dashboard

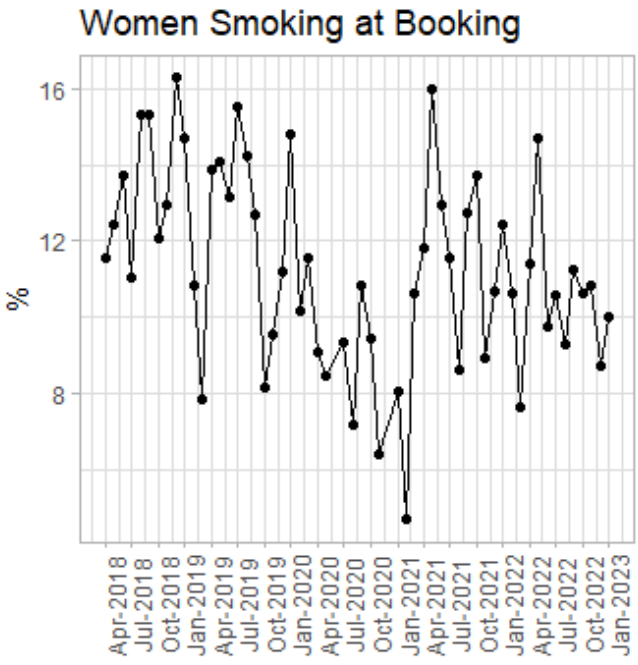
Smoking in Pregnancy

Women Smoking at Booking



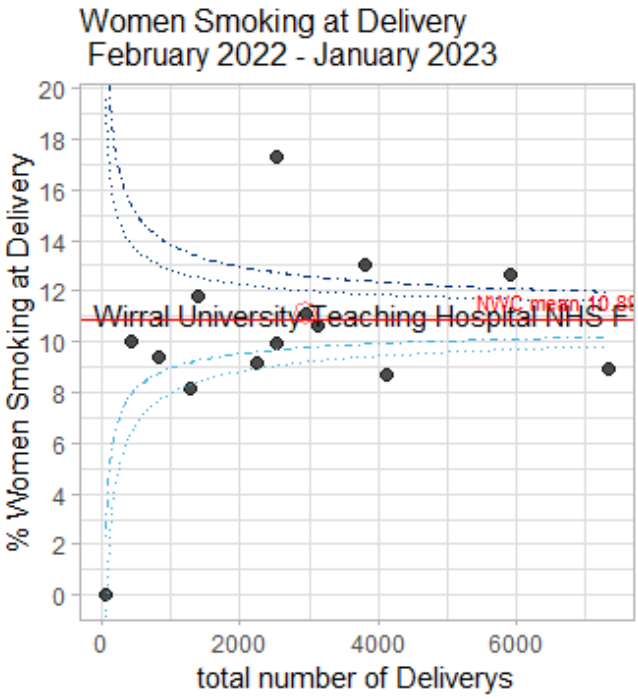
Data Source: NWC CN Maternity Dashboard

Run Chart for Women Smoking at Booking



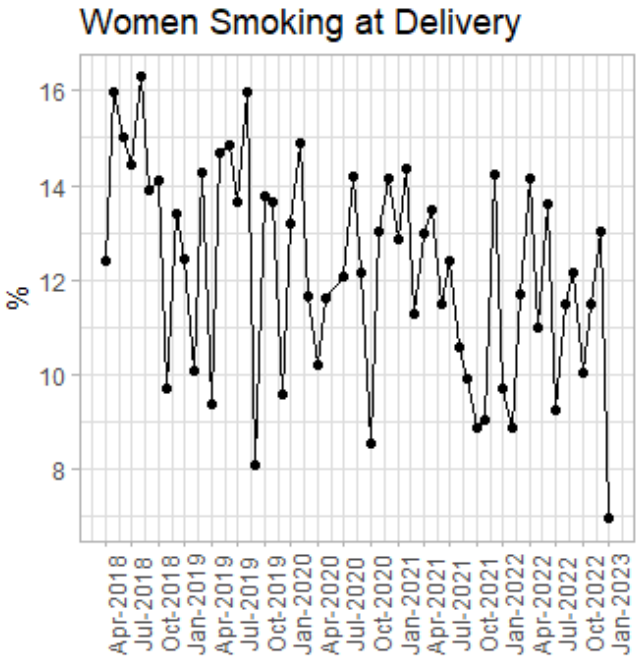
Data Source: NWC CN Maternity Dashboard

Women Smoking at Delivery



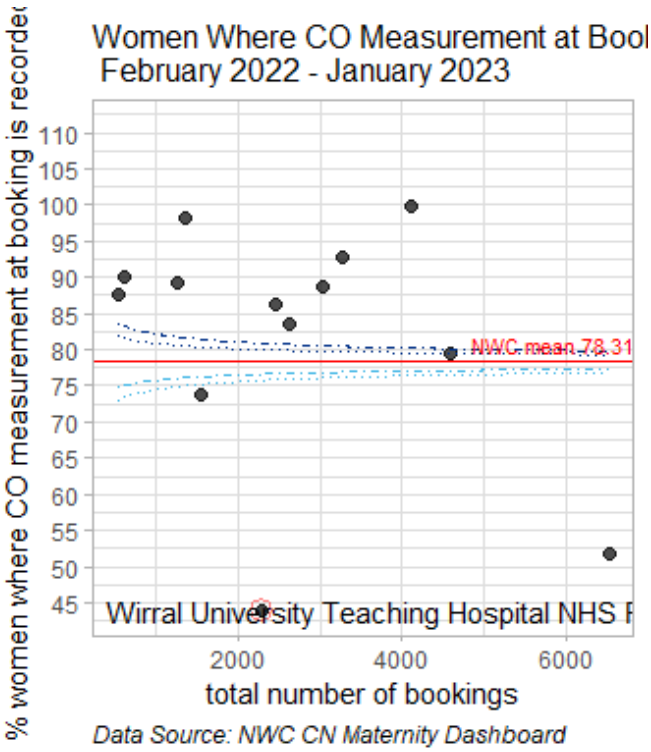
Data Source: NWC CN Maternity Dashboard

Run Chart for Women Smoking at Delivery



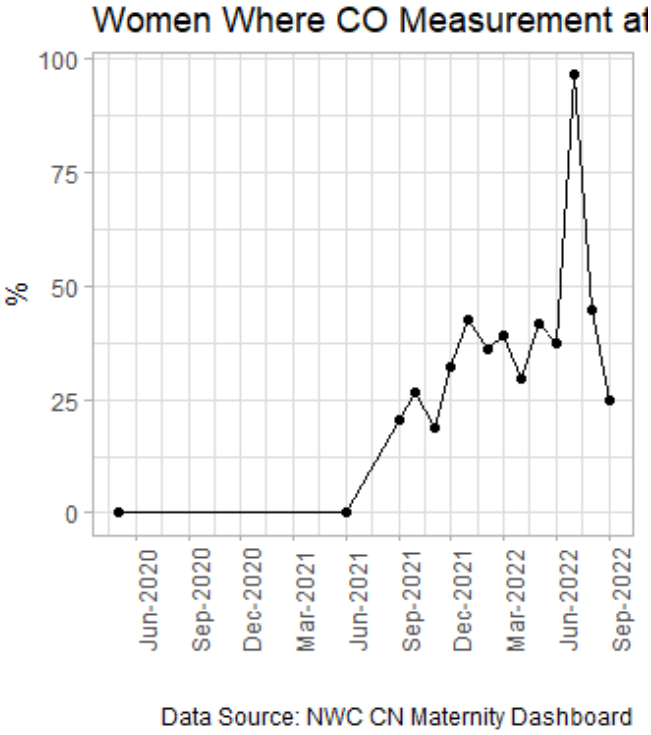
Data Source: NWC CN Maternity Dashboard

Women Where CO Measurement at Booking is Recorded



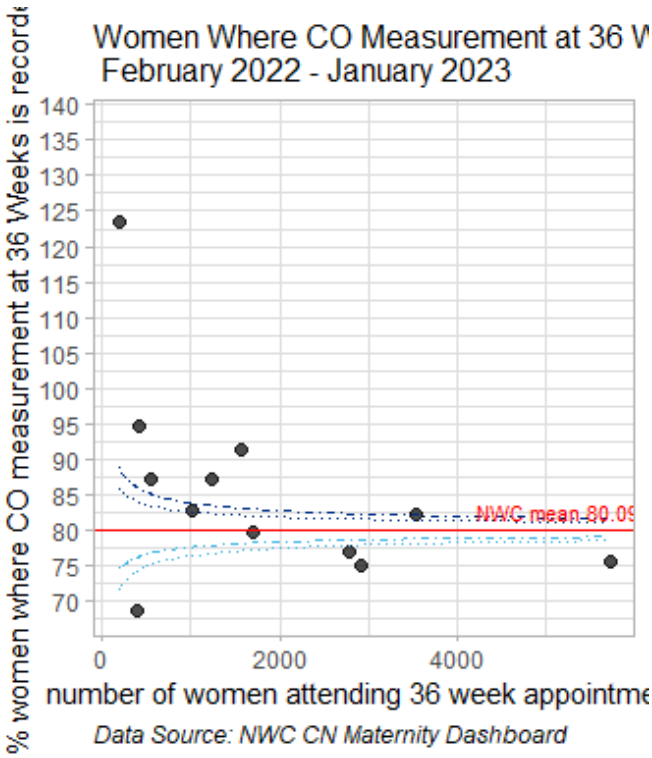
Data Source: NWC CN Maternity Dashboard

Run Chart for Women Where CO Measurement at Booking is Recorded

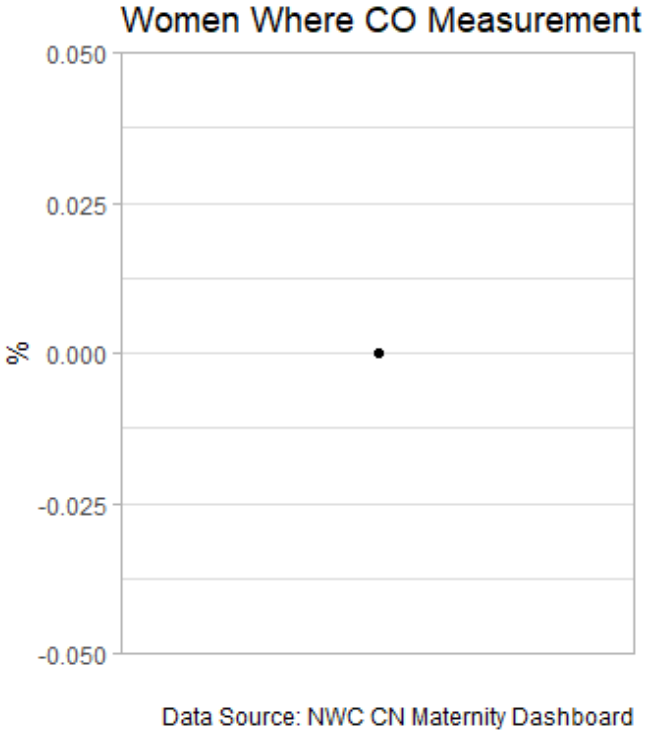


Data Source: NWC CN Maternity Dashboard

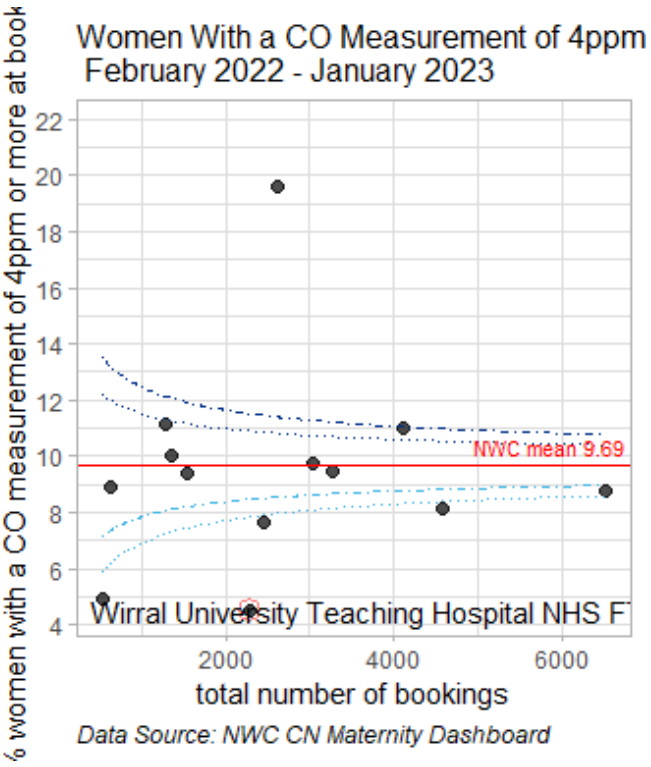
Women Where CO Measurement at 36 Weeks is Recorded



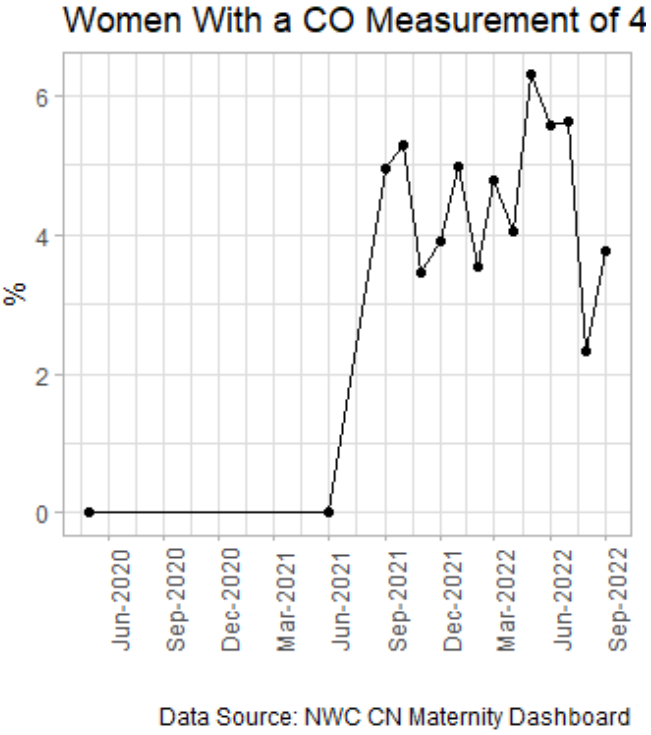
Run Chart for Women Where CO Measurement at 36 Weeks is Recorded



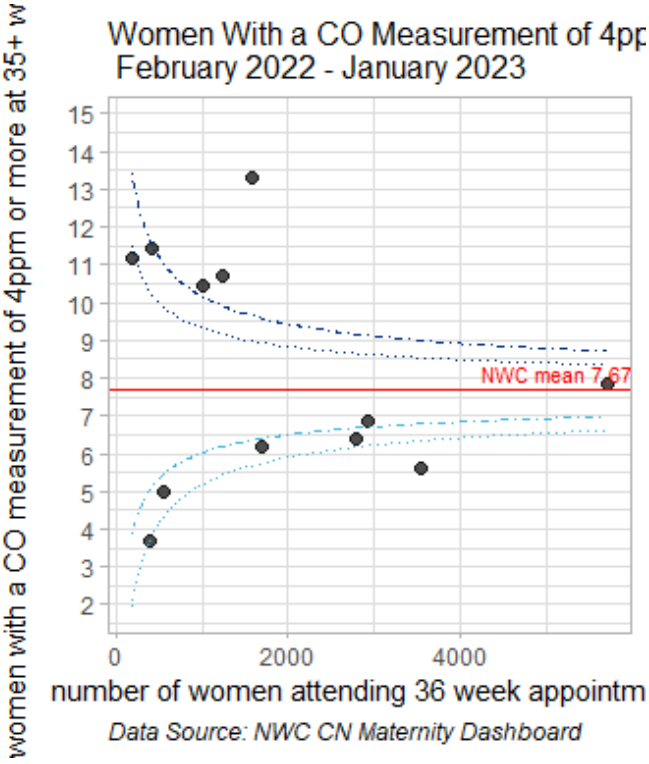
Women With a CO Measurement of 4ppm or More at Booking



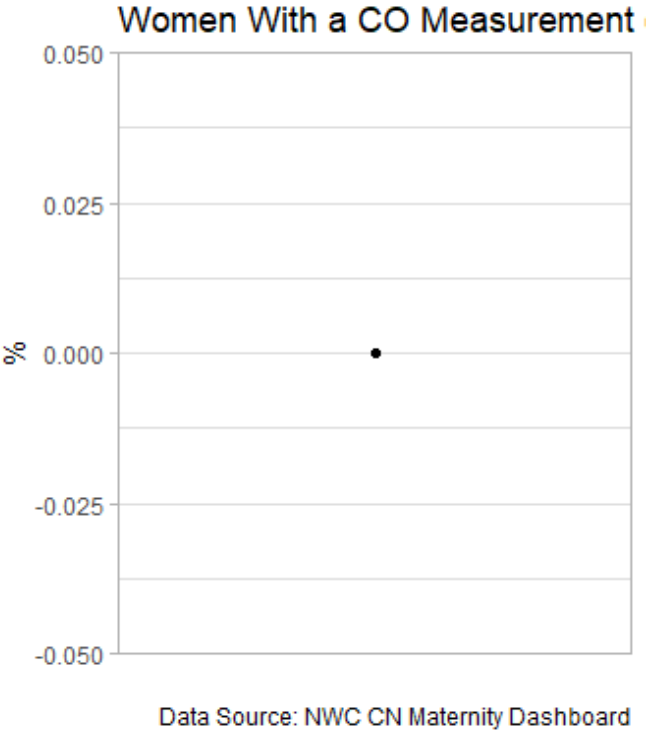
Run Chart for Women With a CO Measurement of 4ppm or More at Booking



Women With a CO Measurement of 4ppm or More at 35+ Weeks

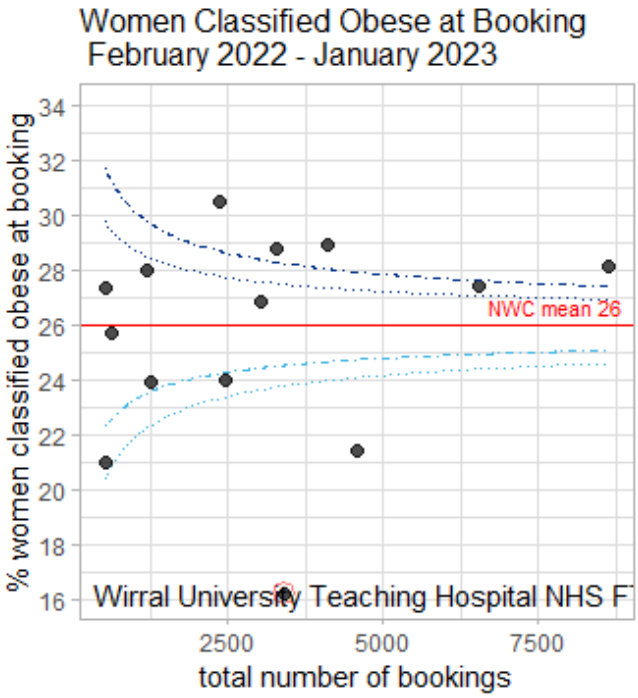


Run Chart for Women With a CO Measurement of 4ppm or More at 35+ Weeks



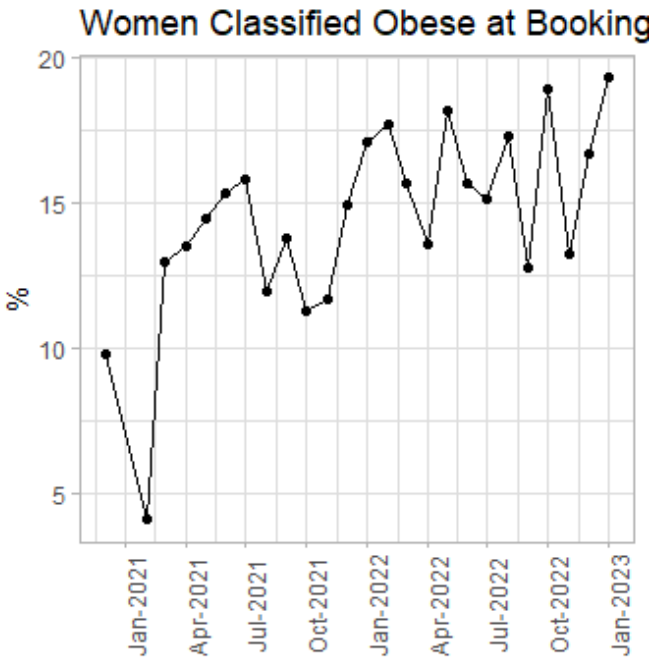
Obesity

Women Classified Obese at Booking



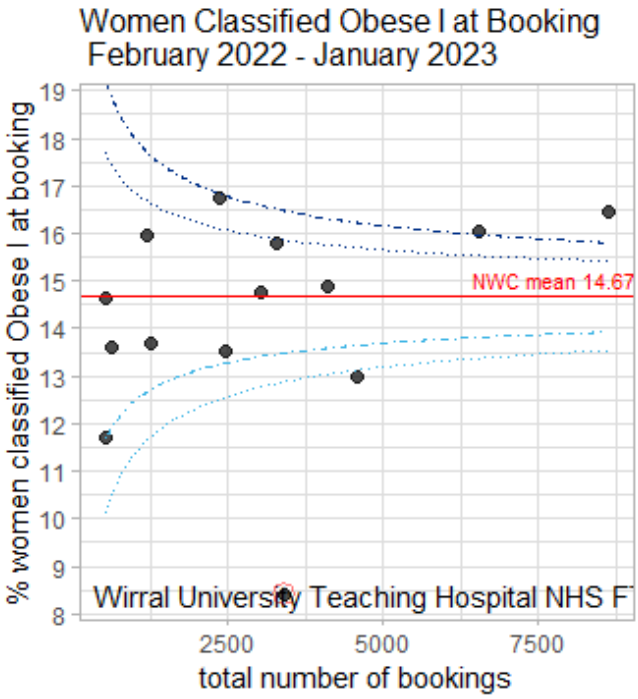
Data Source: NWC CN Maternity Dashboard

Run Chart for Women Classified Obese at Booking



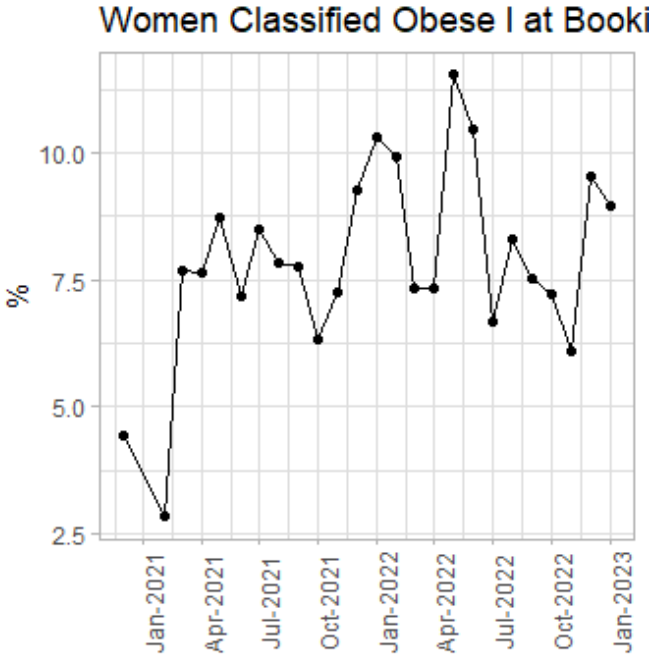
Data Source: NWC CN Maternity Dashboard

Women Classified Obese I at Booking



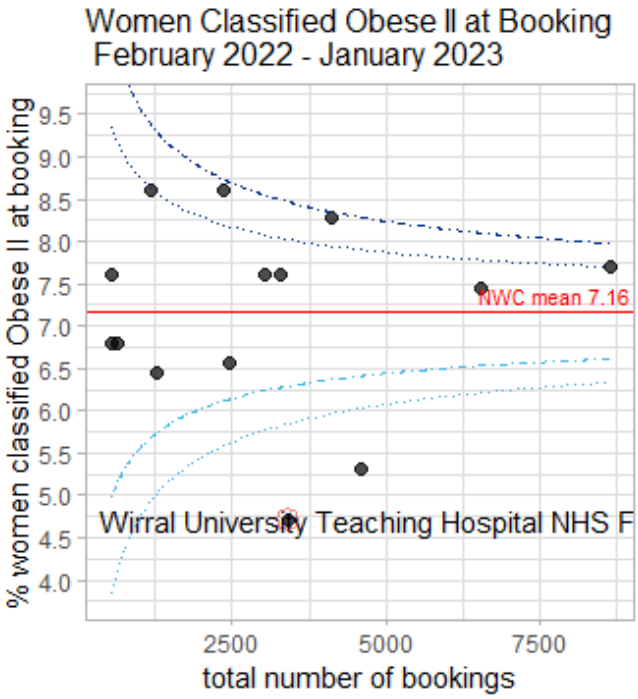
Data Source: NWC CN Maternity Dashboard

Run Chart for Women Classified Obese I at Booking



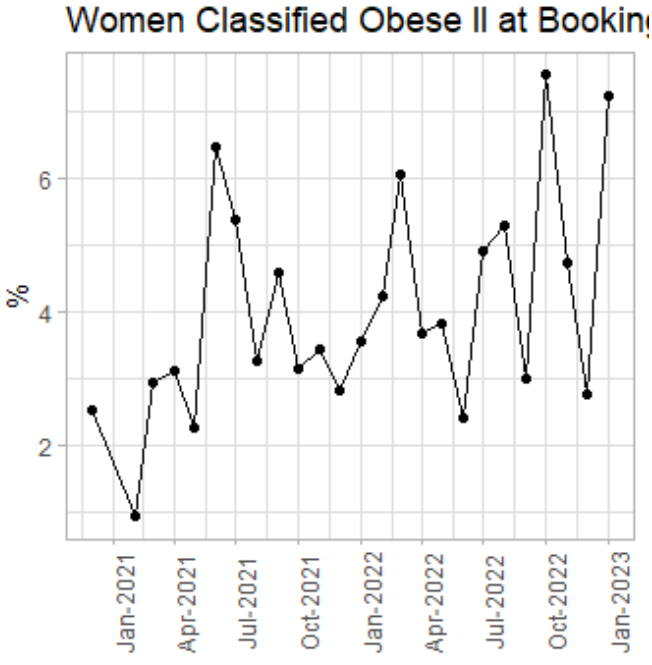
Data Source: NWC CN Maternity Dashboard

Women Classified Obese II at Booking



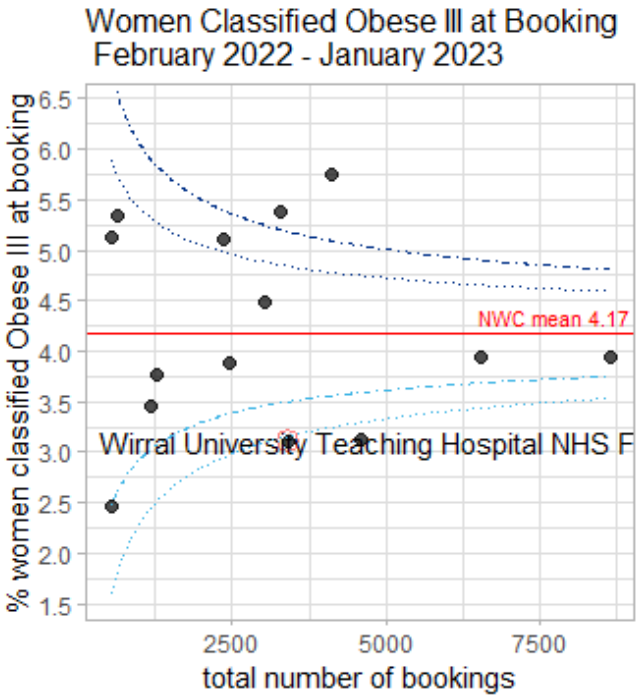
Data Source: NWC CN Maternity Dashboard

Run Chart for Women Classified Obese II at Booking



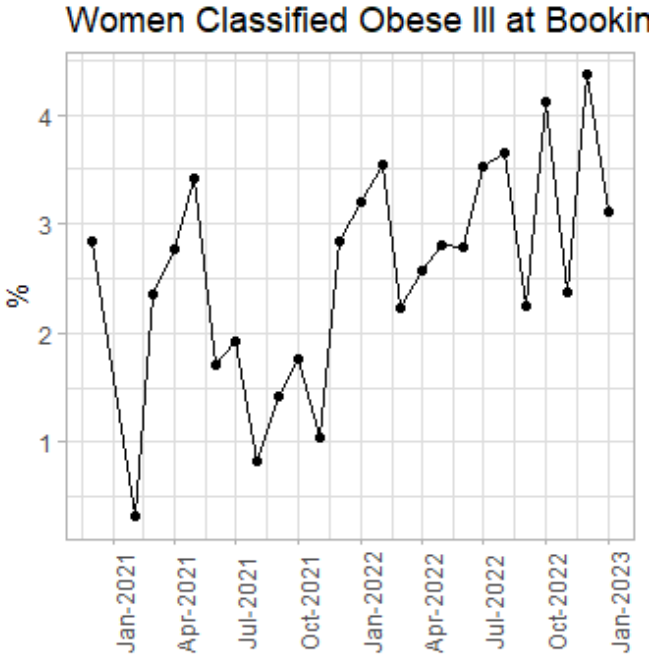
Data Source: NWC CN Maternity Dashboard

Women Classified Obese III at Booking



Data Source: NWC CN Maternity Dashboard

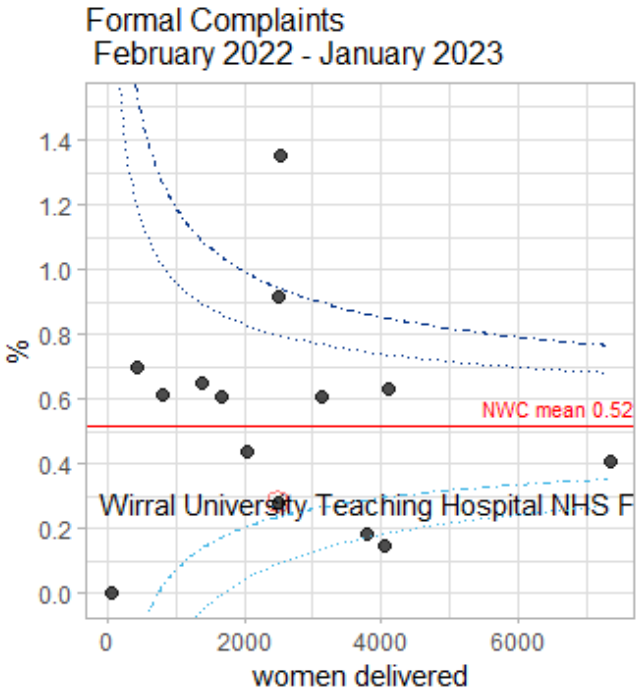
Run Chart for Women Classified Obese III at Booking



Data Source: NWC CN Maternity Dashboard

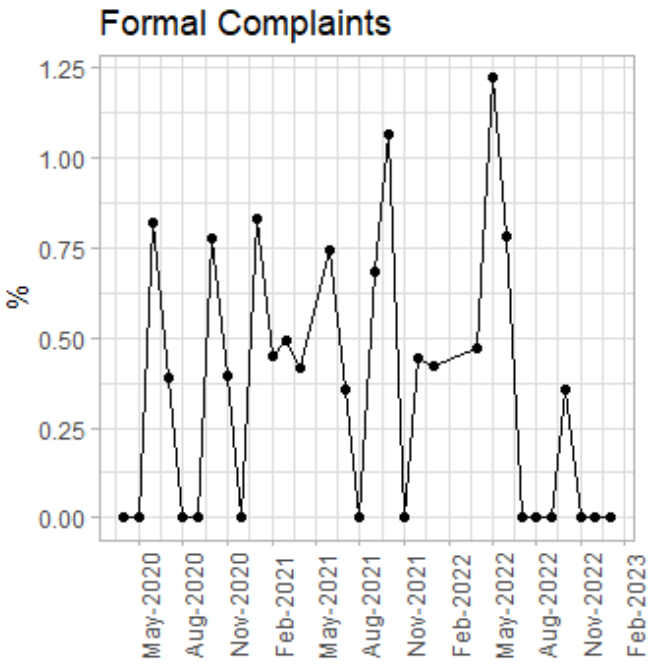
Complaints & Incidents

Formal Complaints



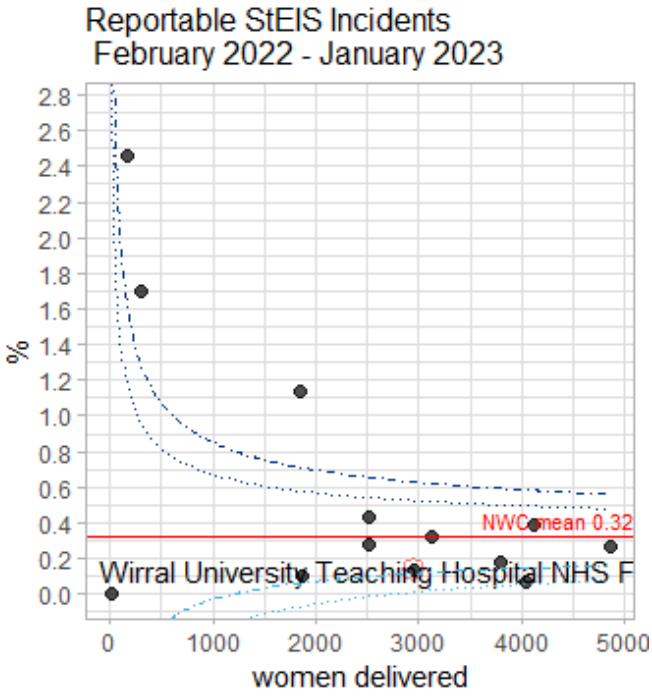
Data Source: NWC CN Maternity Dashboard

Run Chart for Formal Complaints



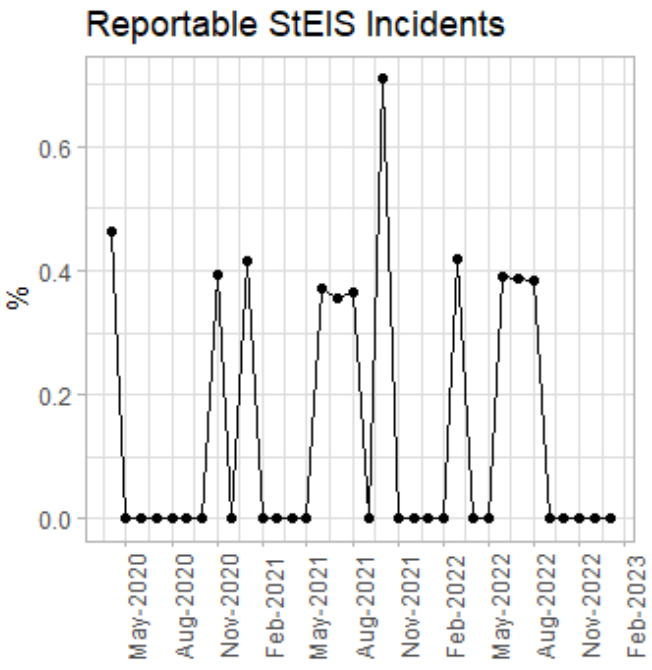
Data Source: NWC CN Maternity Dashboard

Reportable StEIS Incidents



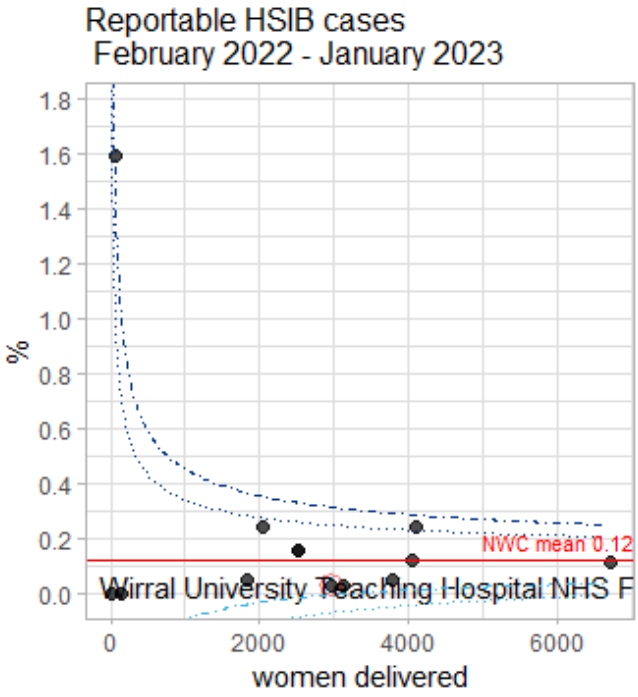
Data Source: NWC CN Maternity Dashboard

Run Chart for Reportable StEIS Incidents



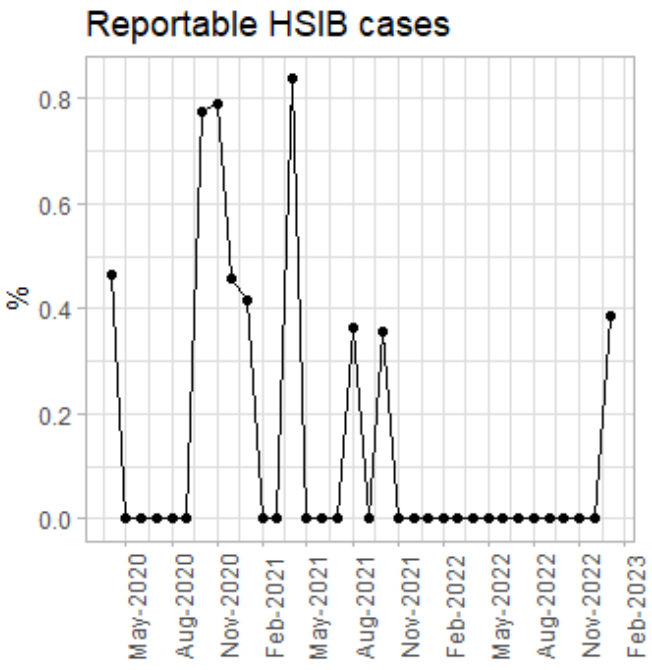
Data Source: NWC CN Maternity Dashboard

Reportable HSIB Cases



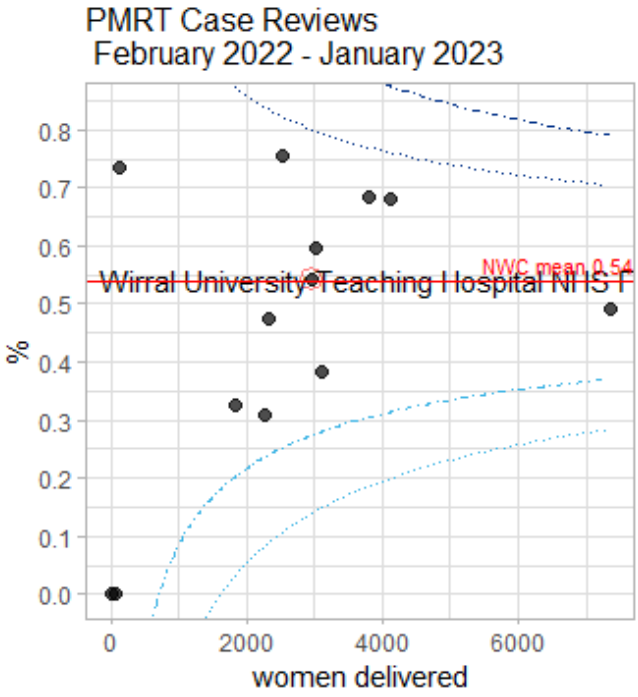
Data Source: NWC CN Maternity Dashboard

Run Chart for Reportable HSIB Cases



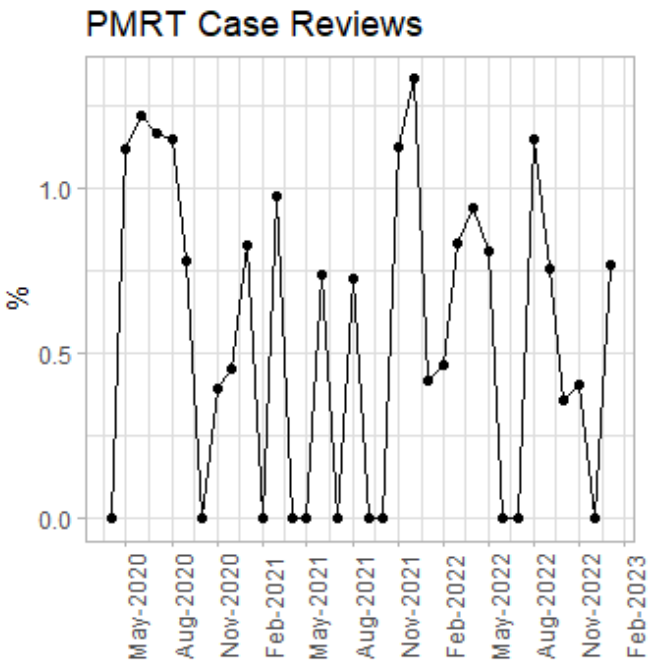
Data Source: NWC CN Maternity Dashboard

PMRT Case Reviews



Data Source: NWC CN Maternity Dashboard

Run Chart for PMRT Case Reviews



Data Source: NWC CN Maternity Dashboard

Wirral University Teaching Hospital NHS Foundation Trust

Gap Analysis for Nitrous Oxide/Entonox Exposure

Compliance with Control of Substances Hazardous to Health COSHH Regulations 2002

Date disseminated: March 2023

Review Lead:	David Farmer		
Summary of Current Compliance (Please highlight)	Partially Compliant	Non-Compliant	Fully Compliant
Completion Date:	27th March 2023		

No.	Recommendation	Action Needed to Comply	Resource needed to comply	Action Lead	Date to be achieved by?	Monitoring & Feedback
1 Undertaking H&S inspections/COSHH risk assessments.						
1.1	Regular monitoring of staff exposure to Nitrous Oxide (Entonox) and environment levels of Nitrous Oxide to ensure safe levels in all rooms on Delivery Suite		External company identified and plan in place to undertake 6 monthly	Emma Rohlmann (ER) Dave Farmer (DF)	End Feb 2023 and 6 monthly thereafter	Monitoring timeframe to be reduced from an annual check to 6 monthly
	1.12 Analysis report to be shared with estates managers	Last report received 17.03.2023 and shared		Emma Rohlmann (ER)	30th April 2023	
	1.13 Estates team to visit unit to discuss failings within report	One room non-compliant; estates to review remedial woks	Review of room ventilation by Estates	Dewi Jones (DJ)	30th April 2023	Retest to be arranged one remedial works identified and corrected Room not in use as a labour room
1.2	Health and safety inspections to be completed every quarter by Delivery Suite Manager			Emma Rohlmann (ER)		Inspections ongoing

No.	Recommendation	Action Needed to Comply	Resource needed to comply	Action Lead	Date to be achieved by?	Monitoring & Feedback
1.3	Annual Health & Safety inspections to be performed			H&S Team	Due Sept 2023	On target to achieve
1.4	All staff to be aware of location of COSHH file on Delivery Suite,			Emma Rohlmann (ER) /	30th April 2023	Responsibility of all staff working on delivery Suite to familiarize themselves with COSHH file location and contents; communication via daily huddle in month of April and L&D page
2. Reduction of exposure (by engineering means and/or by provision of suitable personal protective equipment (PPE) as far as reasonably practicable.						
2.1	Full maintenance and annual validation of the ventilation/scavenger systems completed			Dewi Jones (DJ)	31st Dec 2022	Completed
2.2	Additional window extractor fans to be filled to Delivery Suite windows			Dewi Jones (DJ)	31st Jan 2023	Completed
2.3	Lowering of scavenger system vents to floor level	To be discussed with estates dept	Agreement with estates	Dave Farmer (DF)	31st May 2023	Timeframes to be agreed with Estates; partially complaint as no concerns in all rooms except 1
2.4	Ensure minimum number of air changes is achieved	Any rooms with insufficient air changes to be recorded in the COSHH file	To confirm with estates dept	Dave Farmer (DF)	30th April 2023	
	2.41 – staff to be made aware of any additional risk assessments if appropriate	Awaiting 2.4 to be achieved			30th April 2023	
2.5	Provision of PPE for all staff		Face masks available for all staff.	All staff groups	31st March 2023	Completed

No.	Recommendation	Action Needed to Comply	Resource needed to comply	Action Lead	Date to be achieved by?	Monitoring & Feedback
2.6	Provide clear instruction for women on the correct use of the equipment being used (face mask/mouthpiece) including instruction to exhale into the re=breather mask or out through the mouthpiece.	To be included on safety Huddle		Emma Rohlmann (ER) / with shift leader staff groups	Ongoing	Included on daily huddles for month of April 2023
2.7	Pregnant staff in their first trimester to be allocated to work on ward area	Staff compliance in informing manager of pregnancy			Ongoing	Risk assessments with all pregnant staff undertaken
3 - Provision of information, instruction and training.						
3.1	Training package in the safe use of Entonox to be adopted once made available through NHSE/H&S Executive		Training package will be adopted on launch	Sarah Weston (SW)	30th September 2023	NHSE and the H&S Executive are currently working on a training package with Mid and South Essex NHS Trust (Basildon Hospital)
3.2	Orientation of all staff working within Delivery Suite to include the safe use and operation of the Scavenger System			Emma Rohlmann (ER)	Ongoing	To be included on orientation to Delivery Suite.
4 Appropriate mitigation including elimination or substitution.						
4.1	Rooms that have readings in excess of safe exposure level to be removed from use for labouring women	To be included on safety Huddle	Complete	Emma Rohlmann (ER)	31st May 2023	Room 4 on Delivery suite removed from use for laboring women
4.2	Staff to ensure all gasses are switched off when not in use	To be included on safety Huddle		Emma Rohlmann (ER)	31st May 2023	Included on daily huddles for month of April and May 2023
4.3	Unplugging Entonox regulators when not in use	To be included on safety Huddle		Emma Rohlmann (ER)	31st May 2023	Included on daily huddles for month of April and May 2023

No.	Recommendation	Action Needed to Comply	Resource needed to comply	Action Lead	Date to be achieved by?	Monitoring & Feedback
4.4	Regular monitoring of the equipment for leaks.	To be included on safety Huddle		Emma Rohlmann (ER)	30th May 2023	Included on daily huddles for month of April and May 2023

Maternity Clinical Service Strategy

2021-2026

Updated April 2023

NHS
Wirral University Teaching Hospital
NHS Foundation Trust

together we will

Maternity Clinical Service Strategy Update

April 2023

Following a national focus on Maternity and Neonatal services, and learning shared from the Ockenden Review and findings from East Kent 'Reading the Signals' report, we must ensure that we have a Maternity strategy that is fully aligned to updated national priorities such as those that have been put forward by the NHS England 'Three-year delivery plan for maternity and neonatal services'.

At WUTH, we have engaged with staff within the Women & Children's Division, and at Trust Board Level to review the current Maternity Clinical Service Strategy, with support from the Strategy & Business Planning Team to refresh the Strategy. Details on this process can be observed in Appendix 1.

We have introduced a Maternity Vision and a set of Core Commitments that will underpin our Trust Vision. To measure the implementation of this new strategic focus, we have also introduced new priorities against our Trust strategic objectives, in order to continue to deliver our five-year Maternity Clinical Service Strategy, in line with our updated priorities.

Maternity

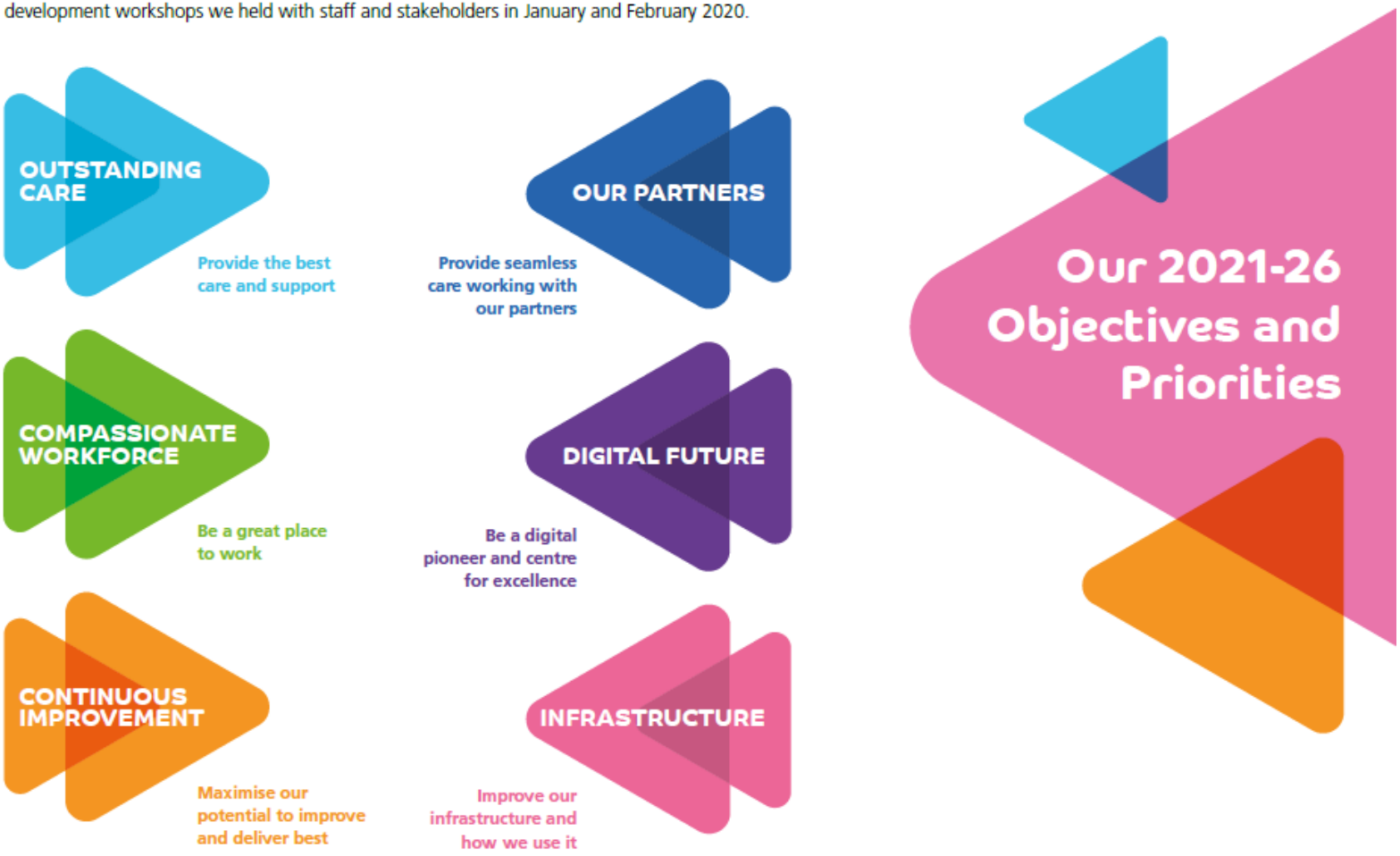
Our Maternity service is based in the Women and Children's hospital on the Arrowe Park Hospital campus. The service is managed by the Women and Children's division. The service has a workforce of over 160 staff made up of nursing and midwifery, medical and administrative and clerical.

Each year the service delivers:

- 3,500 Outpatient New Obstetric appointments
- >46,000 Outpatient Follow Up Obstetric appointments
- Around 3,100 babies delivered

95% of activity comes from Wirral Residents with the remainder of activity received from local health providers.

Our Strategic Objectives and Priorities have been derived from a process of reviewing national, regional and local context, detailed strategic analysis as well as feedback from the series of strategy development workshops we held with staff and stakeholders in January and February 2020.



Maternity Vision and Core Commitments

NHS Wirral University Teaching Hospital NHS Foundation Trust

Our Trust Vision

together we will

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

Maternity Vision

To work together with women, birthing people, partners and their families to provide a maternity service that delivers a personalised, high quality, safe birth experience.

We strive to be the best maternity provider and achieve an excellent patient experience through working collaboratively, efficiently and effectively with our kind and committed staff and the local Maternity & Neonatal Voice Partnership.

Maternity Core Commitments

We will provide unbiased, timely information to enable women and birthing people to participate fully in personalised care planning. They will be encouraged to explore and question all available options.

We will adopt an approach that optimises physical and mental health, providing public health interventions that positively impact on outcomes for women and children.

We will enhance safety through making sure the Multidisciplinary team learn together.
Staff will have the skills and confidence to deliver consistent and effective evidence-based care.

We will always look for ways to improve our maternity service.
We encourage involvement, value contributions, listen to, and positively act on, feedback.

SWOT – Maternity (July 2020 - Revisited March 2023)

STRENGTHS

- Forward thinking and innovative service
- B/F Initiation and rates: GOLD
- People travel to use the service due to reputation
- Workforce are attracted to work here due to reputation
- Lead regionally and within the Network
- Excellent CQC Outcomes
- Antenatal Screening
- Training and Leadership

WEAKNESSES

- Resistance to change
- If lose Level 3 it may become less attractive to the workforce
- Continuity of Care Teams, move from hospital, community midwives less interest
- No standardised approach
- Estates

OPPORTUNITIES

- Build on brand
- Scenario modelling e.g. failure of providers, high risk neo nates
- Birthing Centre between Countess and WUTH
- Community Hubs
- Community Team – Enhanced team
- Further development in triage and with workforce

THREATS

- Focus on C&M perspective
- Regional Plan
- Succession Planning
- Political
- Blended Payments model

Maternity Clinical Service Priorities 2021-2026

Updated April 2023

1. Outstanding Care - Provide the best care and support

- Develop the use of the Patient Portal and review the use of Maternity Apps to support care delivery
- Explore best practice in social media to inform and develop the current offering and to increase awareness of service provision
- Broaden maternity experience from early pregnancy through postnatal care
- Promote personalised and enhanced care promoting perinatal mental health and well-being

2023 Update:

- Adhere to local and national drivers including: CNST Maternity Incentive Scheme, Saving Babies Lives, Continuity of Carer, HSIB/PMRT, National Bereavement Pathway, and ATAIN
- Work towards actions committed to in 'Better Births' and reports of the independent investigations at Shrewsbury & Telford NHS Hospital & East Kent Hospital

2. Compassionate Workforce - Be a great place to work

- Concentrate and Focus on the development of workforce to support the delivery of high-quality care
- Continued focus on culture embedding Trust Values and Beliefs
- Support the development of local and regional dashboards to inform maternity specific metrics
- Raise profile and understanding of Maternity Services within WUTH so service and people are valued and recognised

3. Continuous Improvement -Maximise our potential to improve and deliver best value

- Explore regional benchmarking to inform different initiatives and quality improvement
- Utilise business Intelligence in collaboration with Maternity Specific data to produce and improve performance metrics
- Ensure time and staff engagement to enable a focus on Quality Improvement, ensuring services are innovative and sustainable

2023 Update:

- Including Maternal and Neonatal Safety Improvement Programme's (MatNeoSIP) collaboration work and The Birmingham Symptom Specific Obstetric Triage System (BSOTS)

Maternity Clinical Service Priorities 2021-2026

Updated April 2023

4. Our Partners - Provide seamless care working with our partners

- Explore collaborative working with partners to further develop Fetal and Maternal medicine services
- Build partnership with Community Trust through joint ventures, to further enhance maternity care and experiences
- Explore the potential of working collaboratively with neighbouring Trusts including CoC and LWH
- Look at potential of expanding the service to increase the number of women choosing to birth at WUTH
- Explore opportunities to support increase in student numbers and to expand opportunities to across C&M Higher Education Institutions
- Engage with Service users and MVP to work collaboratively to improve care

5. Digital Future - Be a digital pioneer and centre for digital excellence

- Develop and support production of local, regional and national dashboards to monitor performance
- Develop and support an IT focused service to improve social media outputs
- Explore the digitalisation of Maternity care to improve the continuity of care of women and their families

6. Infrastructure - Improve our infrastructure and how we use it

- Develop a plan for current space recognising other specialty needs e.g expansion into Gynae footprint
- Maximize efficiency of antenatal care through exploring using a telephone service/virtual clinics
- Create capacity through moving nonclinical rooms e.g note storage room
- Explore basement capacity for potential development

Appendix 1

Strategy Refresh Approach

Maternity Clinical Service Vision

2021-2026

Updated April 2023

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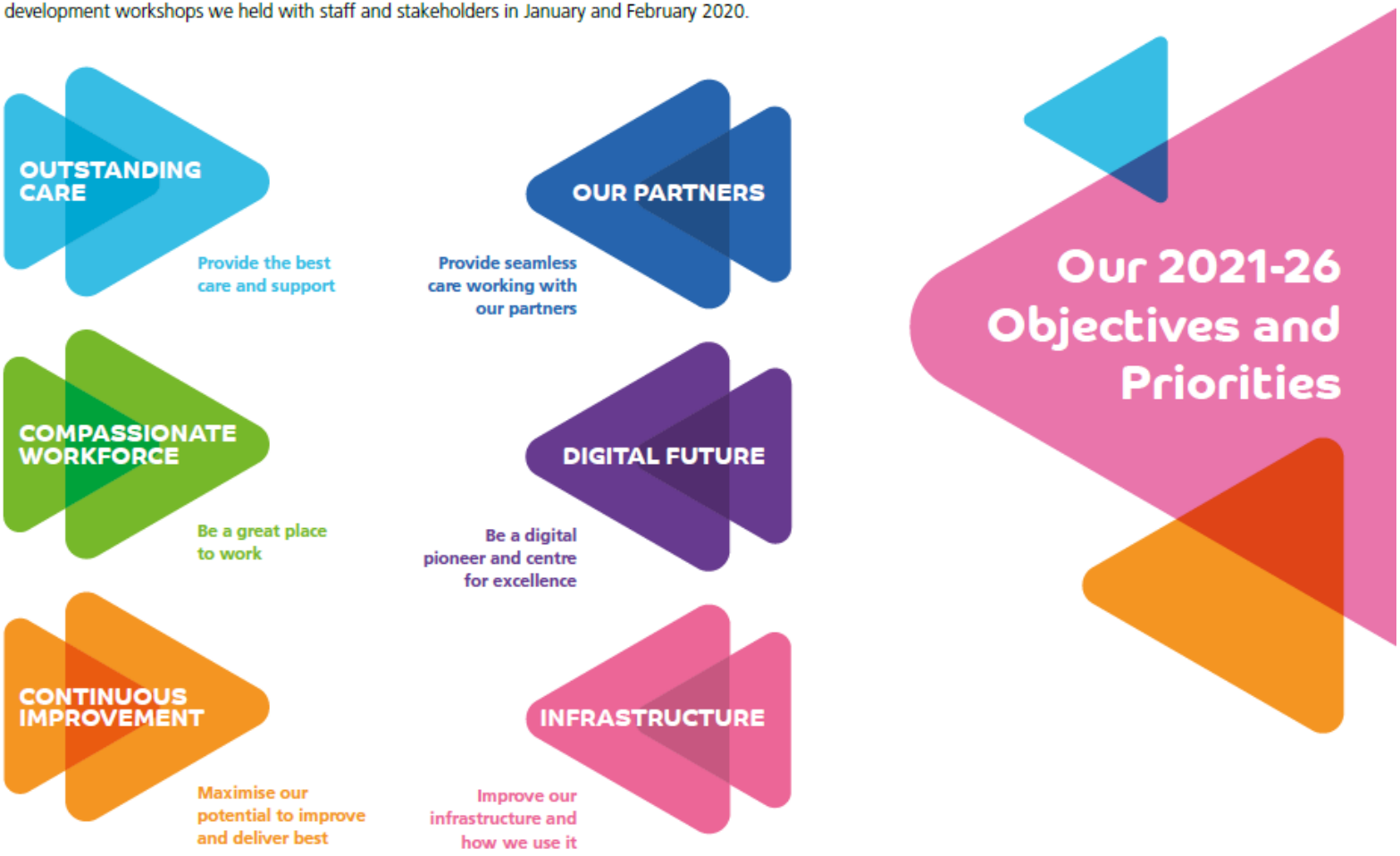

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