Theme	Area requiring further enquiry or shared intelligence	Outlier	Evidence
Clinical Care	Outlier for rates of stillbirth as a proportion of births	na	No escalation from SCN / LMNS on outlier report; internal thematic review being undertaken; NW region outlier report no longer published and NW Regional dashboard now available however discusssed regionally as Data to May 2023 and decision awaited on key reporting metrics and also data collection methodology; all user
	Outlier for rates of neonatal deaths as a proportion of birth	na	No escalation from SCN / LMNS on outlier report; internal thematic review being undertaken; NW region outlier report no longer published and NW Regional dashboard now available however discusssed regionally as Data to May 2023 and decision awaited on key reporting metrics and also data collection methodology; all user
	Rates of HIE where improvements in care may have made a difference to the outcome	na	Very low rates of HIE, sitting way below the lower control limit for the region. No current cases
	Number of SI's	na	x 1 serious incidents reported in September 2023 included to inform Board of Directors
	Progress on SBL care bundle V3	no	SBLCBV2 has been fully implemented at WUTH with progress monitored using audits which are registered on the FAAP. SBLv3 launched and will continue to be a key safety action of MIS Year 5 with an additional element 6: mgt of pre-existing diabetes; nataional toolkit available and quarterley meetings with ICB to monitor to be set up; update will be provided via the national toolkit at the next quarterley meeting; on target to meet compliance
	Outlier for rates of term admissions to the NNU	na	The rate of avoidable term admissions; regular multi-disciplinary reviews of care take place; NW region outlier report no longer published and awaiting national guidance on monitoring processes
Service user and st	MNVP or Service User concerns/complaints not resolved at trust level	no	Not an outlier regarding the number of complaints; to date all complaints have been addressed for maternity in the target timeframesand there is nil to escalate
	Trainee survey	no	No update this month
	Staff survey	no	Trust Staff Survey completed and divisional response has included staff engagement and continuation with the Pulse surveys; Score survey inititaive underway for MatNeo
	CQC National survey	no	Will be included in report on publication
	Feedback via Deanery, GMC, NMC	no	Nil to report this month
	Poor staffing levels	no	All vacancies have been recruited into for Band 5 and Band 6 midwives; further retirements anticipated later and in the year. New starters have started in Sept/Oct 2023. <1% vacancy rate and posts advertised are to meet MCoC in line with Birth rate plus
	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	Nil of note; full establishment; governance structure review and revised structure proposed to meet requirements and maternity self assessment tool
	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; MIS Year 5 published 31/5/2023 and submission cycle will be Feb 2024
	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; funding options explored; 2 teams to be launched Feb/March 2024 and final 2 teams by Autumn 2024 subject to safe staffing and upskilling
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; site visit May 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 31th 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; PSIRF with effect from 1/9/2023
	Never Events which are not reported	no	No maternity or neonatal never events in August 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
Governanc e 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. Additional quality assurance framework agreed with effect from June 2023 to give the BoD addiitonal assurances in monitoring of MIS, Three year delivery plan etc. Awaiting further guidance re: PSIRF and maternity services
	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	CQC reports published for maternity sites Seacombe Birth Centre and APH site for the domains Safe and Well led; both sites were rated 'GOOD'
	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

Safety action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?			
	Year 5	**Compliance with Standards**	**Comments / Evidence**
Standard Required			
a)	a) All eligible perinatal deaths should be notified to MBRRACE-UK within seven working days. For deaths from 30 May 2023, MBRRACE-UK surveillance information should be completed within one calendar month of the death.		On review to date all deaths meeting the relevant criteria have been r eported to date.To ensure that the process is robust there is a need to introduce a failsafe/audit process to ensure compliance is consistently being met. Two cases require review (to confirm compliance) therefore need to look at cases 88579 and 88576 (DC to action)See evidence in emails re complaince to date (12/09)
b)	b) For 95% of all the deaths of babies in your Trust eligible for PMRT review, parents should have their perspectives of care and any questions they have sought from 30 May 2023 onwards.		To further evidence - DC to upload evidence of bereavement care presentation/evidence of parents involvement to MIS folder.
c)	c) For deaths of babies who were born and died in your Trust multi-disciplinary reviews using the PMRT should be carried out from 30 May 2023. 95% of reviews should be started within two months of the death, and a minimum of 60% of multi-disciplinary reviews should be completed to the draft report stage within four months of the death and published within six months.		Standard is currently being met but process to be further improved. To introduce failsafe/audit process to ensure compliance being met (can pull data direct from MBRRACE system) JS - Analyst to action. Same actioned - evidence on mat dashboard moving forwards.
d)	d) Quarterly reports should be submitted to the Trust Executive Board from 30 May 2023.		Robust process established. To upload evidence of quarterly reports to the folder. These are sent to trust mortality group.
Minimum evidential requirement for Trust Board			
	Notifications must be made, and surveillance forms completed using the MBRRACE-UK reporting website (see note below about the introduction of the NHS single notification portal). The PMRT must be used to review the care and reports should be generated via the PMRT. A report should be received by the Trust Executive Board each quarter from 30 May 2023 that includes details of the deaths reviewed, any themes identified and the consequent action plans. The report should evidence that the PMRT has been used to review eligible perinatal deaths and that the required standards a), b) and c) have been met. For standard b) for any parents who have not been informed about the review taking place, reasons for this should be documented within the PMRT review.		Actions are added to the regional lessons learned templates. These templates are shared at audit meetings, added to CG Gems Newsletters and bereavement bulletin. Going forward -
Validation process			
	Self-certification by the Trust Board and submitted to NHS Resolution using the Board declaration form. NHS Resolution will use data from MBRRACE-UK/PMRT, to cross-reference against Trust self-certifications.	No Change	Dates for Board paper/s and sign off reviewed. JL to update progress in BoD paper/s.
What is the relevant time period?			
	From 30 May 2023 until 7 December 2023	Note date	
What is the deadline for reporting to NHS Resolution?			
	12 noon on 1 February 2024	Note date	

Safety action 2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?			
	Year 5	**Compliance with Standards**	**Comments / Evidence**
Standard Required			
1)	Trust Boards to assure themselves that at least 10 out of 11 Clinical Quality Improvement Metrics (CQIMs) have passed the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023. Final data for July 2023 will be published during October 2023.		Meeting arranged with data analyst to review latest scorecard to confirm current compliance with data submission/s. Standard met for April and June - further work ongoing but no issues anticipated re meeting 10/11 standards for MIS submission.
2)	July 2023 data contained valid ethnic category (Mother) for at least 90% of women booked in the month. Not stated, missing, and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001)		Ethnicity confirmed as datafield evident in records.
3)	Trust Boards to confirm to NHS Resolution that they have passed the associated data quality criteria in the " Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023 for the following metrics:		Confirmation received WUTH passed all metrics
4)	Trusts to make an MSDS submission before the Provisional Processing Deadline for July 2023 data by the end of August 2023.		Meeting arranged to conifrm same. MSDS submission before end July - outcome awaited I nOctober.
5)	Trusts to have at least two people registered to submit MSDS data to SDCS Cloud who must still be working in the Trust.		Compliance evidenced
Continuity of carer (CoC)	Midwifery Continuity of carer (MCoC) Note: If maternity services have suspended all MCoC pathways, criteria ii is not applicable. i. Over 5% of women who have an Antenatal Care Plan recorded by 29 weeks and also have the CoC pathway indicator completed. ii. Over 5% of women recorded as being placed on a CoC pathway where both Care Professional ID and Team ID have also been provided.		Confirmation received WUTH passed all metrics
	These criteria are the data quality metrics used to determine whether women have been placed on a midwifery continuity of carer pathway by the 28 weeks antenatal appointment, as measured at 29 weeks gestation. Final data for July 2023 will be		Confirmation received WUTH passed all metrics
Personalised Care and Support Planning (PCSP)			
Minimum evidential requirement for Trust Board			
	The "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series can be used to evidence meeting all criteria.		
Validation process			
	All criteria to be self-certified by the Trust Board and submitted to NHS Resolution using the Board declaration form. NHS England will cross-reference self-certification of all criteria against data and provide this information to NHS Resolution.		
What is the relevant time period?			
	From 30 May 2023 until 7 December 2023		
What is the deadline for reporting to NHS Resolution?		Note dates	
	1 February 2024 at 12 noon	Note dates	

Safety action 3: Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?			
	Year 5	**Complaince with Standards**	**Comments / Evidence**
Standard Required			
a)	Pathways of care into transitional care (TC) have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care.		Revised pathway ratified.
b)	A robust process is in place which demonstrates a joint maternity and neonatal approach to auditing all admissions to the NNU of babies equal to or greater than 37 weeks. The focus of the review is to identify whether separation could have been avoided. An action plan to address findings is shared with the quadrumvirate (clinical directors for neonatology and obstetrics, Director, or Head of Midwifery (DoM/HoM) and operational lead) as well as the Trust Board, LMNS and ICB.		Atain meetings are multidisciplinary with input/leads from amternity and neonatal services. Action plan/s to be signed off by Director of Midwifery. Action plan from Atain meetings to go to Mat Neo Q&S Assurance Board for sign off in October; ATAIN action plan signed off and presented
c)	Drawing on the insights from the data recording undertaken in the Year 4 scheme, which included babies between 34+0 and 36+6, Trusts should have or be working towards implementing a transitional care pathway in alignment with the BAPM Transitional Care Framework for Practice for both late preterm and term babies. There should be a clear, agreed timescale for implementing this pathway.		Revised pathway ratified and is in use clinically.
Minimum evidential requirement for Trust Board			
standard a)	Evidence for standard a) to include: Local policy/pathway available which is based on principles of British Association of Perinatal Medicine (BAPM) transitional care where: • There is evidence of neonatal involvement in care planning • Admission criteria meets a minimum of at least one element of HRG XA04 • There is an explicit staffing model • The policy is signed by maternity/neonatal clinical leads and should have auditable standards. • The policy has been fully implemented and quarterly audits of compliance with the policy are conducted.		
Standard b)	Evidence for standard b) to include: • Evidence of joint maternity and neonatal reviews of all admissions to the NNU of babies equal to or greater than 37 weeks. • Evidence of an action plan agreed by both maternity and neonatal leads which addresses the findings of the reviews to minimise separation of mothers and babies born equal to or greater than 37 weeks. 21 • Evidence that the action plan has been signed off by the DoM/HoM, Clinical Directors for both obstetrics and neonatology and the operational lead and involving oversight of progress with the action plan. • Evidence that the action plan has been signed off by the Trust Board, LMNS and ICB with oversight of progress with the plan.		
Standard c)	Evidence for standard c) to include: Guideline for admission to TC to include babies 34+0 and above and data to evidence this is occurring OR An action plan signed off by the Trust Board for a move towards a transitional care pathway for babies from 34+0 with clear time scales for full implementation.		
Validation process			
	Self-certification by the Trust Board and submitted to NHS Resolution using the Board declaration form	No Change	
What is the relevant time period?			
	30 May 2023 to 7 December 2023		
What is the deadline for reporting to NHS Resolution?			

	01-Feb-24	Note date	

Safety action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?			
	Year 5	**Compliance with Standards**	**Comments / Evidence**
Standard Required			
	a) Obstetric medical workforce 1) NHS Trusts/organisations should ensure that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas: a. currently work in their unit on the tier 2 or 3 rota or b. have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP) or c. hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums.		Meeting arranged to further review compliance against the standard. No locum used in last 12 months who hasn't worked at WUTH. Rotas will provide further evidence of this.
	2) Trusts/organisations should implement the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings. rcog-guidance-on-the-engagement-of-long-term-locums-in-mate.pdf		Guidance in place but compliance against standard o be confirmed. Rota's to further evidence. Audit to be undertaken to further support.
	3) Trusts/organisations should implement RCOG guidance on compensatory rest where consultants and senior Speciality and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day. Services should provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings. rcog-guidance-on-compensatory-rest.pdf		Guidance in place but compliance against standard to be confirmed.
	4. Trusts/organisations should monitor their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document: 26 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/ when a consultant is required to attend in person. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance.		Policy detailing requirements reviewed, updated and ratified. Audit against standards to be undertaken September 2023; audit being undertaken in October 2023
	b) Anaesthetic medical workforce A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1)		Anaesthetic cover in place - audit against standard to confirm complaince awaited. Rotas further evidence meeting standard as Obstetrics is prioritised at a cost to other specialities - same to be added to Risk Register for surgery.

	c) Neonatal medical workforce The neonatal unit meets the relevant British Association of Perinatal Medicine (BAPM) national standards of medical staffing. If the requirements have not been met in year 3 and or 4 or 5 of MIS, Trust Board should evidence progress against the action plan developed previously and include new relevant actions to address deficiencies. If the requirements had been met previously but are not met in year 5, Trust Board should develop an action plan in year 5 of MIS to address deficiencies. Any action plans should be shared with the LMNS and Neonatal Operational Delivery Network (ODN).		partially compliant against standard - Neonatal ODN are aware and are working with service to support complaince. Action plan being developed to mitigate risk and to identify current shortfall in neonatal consultant cover. Action plan resulted in submission of statement of case/business being developed and was presented to BoD in October 2023; BDISC requested further details
	d) Neonatal nursing workforce The neonatal unit meets the BAPM neonatal nursing standards. If the requirements have not been met in year 3 and or year 4 and 5 of MIS, Trust Board should evidence progress against the action plan previously developed 27 and include new relevant actions to address deficiencies. If the requirements had been met previously without the need of developing an action plan to address deficiencies, however they are not met in year 5 Trust Board should develop an action plan in year 5 of MIS to address deficiencies. Any action plans should be shared with the LMNS and Neonatal Operational Delivery Network (ODN).		Neonatal nurse staffing reviewed with Neonatal ODN and additional funding has supported the recruitment of additional nursing staff. BAPM Guidance in November 2022 outlines severla roles required for the service. Gap analysis undertaken and paper identifying shortfall was presented to Board in October 2023.
Minimum evidential requirement for Trust Board			
a)	Obstetric medical workforce 1) Trusts/organisations should audit their compliance via Medical Human Resources and if there are occasions where these standards have not been met, report to Trust Board Trust Board level safety champions and LMNS meetings that they have put in place processes and actions to address any deviation. Compliance is demonstrated by completion of the audit and action plan to address any lapses. Information on the certificate of eligibility (CEL) for short term locums is available here: www.rcog.org.uk/cel This page contains all the information about the CEL including a link to the guidance document: Guidance on the engagement of short-term locums in maternity care (rcog.org.uk) A publicly available list of those doctors who hold a certificate of eligibility of available at https://cel.rcog.org.uk		
b)	2) Trusts/organisations should use the monitoring/effectiveness tool contained within the guidance (p8) to audit their compliance and have a plan to address any shortfalls in compliance. Their action plan to address any shortfalls should be signed off by the Trust Board, Trust Board level safety champions and LMNS.		
c)	3) Trusts/organisations should provide evidence of standard operating procedures and their implementation to assure Boards that consultants/senior SAS doctors working 28 as non-resident on-call out of hours are not undertaking clinical duties following busy night on-calls disrupting sleep, without adequate rest. This is to ensure patient safety as fatigue and tiredness following a busy night on-call can affect performance and decision-making. Evidence of compliance could also be demonstrated by obtaining feedback from consultants and SAS doctors about their ability to take appropriate compensatory rest in such situations. NB. All 3 of the documents referenced are all hosted on the RCOG Safe Staffing Hub Safe staffing | RCOG		
d)	4) Trusts' positions with the requirement should be shared with the Trust Board, the Board-level safety champions as well as LMNS.		
	Anaesthetic medical workforce The rota should be used to evidence compliance with ACSA standard 1.7.2.1. Neonatal medical workforce The Trust is required to formally record in Trust Board minutes whether it meets the relevant BAPM recommendations of the neonatal medical workforce. If the requirements are not met, Trust Board should agree an action plan and evidence progress against any action plan developed previously to address deficiencies. A copy of the action plan, outlining progress against each of the actions, should be submitted to the LMNS and Neonatal Operational Delivery Network (ODN). Neonatal nursing workforce The Trust is required to formally record to the Trust Board minutes compliance to BAPM Nurse staffing standards annually using the Neonatal Nursing Workforce Calculator (2020). For units that do not meet the standard, the Trust Board should agree an action plan and evidence progress against any action plan previously developed to address deficiencies. A copy of the action plan, outlining progress against each of the actions, should be submitted to the LMNS and Neonatal Operational Delivery Network (ODN).		

Validation process			
	Self-certification by the Trust Board and submitted to NHS Resolution using the Board declaration form.		
What is the relevant time period?			
	Obstetric medical workforce 1. After February 2023 – Audit of 6 months activity 2. After February 2023 – Audit of 6 months activity 3. 30 May 2023 - 7 December 2023 4. 30 May 2023 - 7 December 2023 Anaesthetic medical workforce Trusts to evidence position by 7 December 2023 at 12 noon Neonatal medical workforce A review has been undertaken of any 6 month period between 30 May 2023 – 7 December 2023 a) Neonatal nursing workforce Nursing workforce review has been undertaken at least once during year 5 reporting period 30 May 2023 – 7 December 2023		
What is the deadline for reporting to NHS Resolution?			
	01-Feb-24		

Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?			
	Year 5	**Compliance with Standards**	**Comments / Evidence**
Standard Required			
a)	A systematic, evidence-based process to calculate midwifery staffing establishment is completed.	No Change	Updated review of midwifery staffing completed in 2022 using Birthrate+.
b)	Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above.		Budget partially identifies budgetary requirements. Presentation of workforce paper presented Board in October 2023.
c)	The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service.		Compliance evidenced.
d)	All women in active labour receive one-to-one midwifery care.		1:1 midwifery care calculated monthly demonstrating compliance.
e)	Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year five reporting period.		Midwifery staffing paper presented to Board in October 2023. This will demonstrate shortfall in meeting staffing requirements for continuity of carer.
Minimum evidential requirement for Trust Board			
	A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated		
	In line with midwifery staffing recommendations from Ockenden, Trust Boards must provide evidence (documented in Board minutes) of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations.		
	Where Trusts are not compliant with a funded establishment based on BirthRate+ or equivalent calculations, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls.		
	The plan to address the findings from the full audit or table-top exercise of BirthRate+ or equivalent undertaken, where deficits in staffing levels have been identified must be shared with the local commissioners.		
	Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall in staffing. o The midwife to birth ratio o The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives.		
	Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator status and the provision of one-to-one care in active labour. Must include plan for mitigation/escalation to cover any shortfalls.		
Validation process			
	Self-certification to NHS Resolution using the Board declaration form		
What is the relevant time period?			
	30 May 2023 – 7 December 2023	Note dates	
What is the deadline for reporting to NHS Resolution?			
	1 February 2023 at 12 noon	Note dates	

Safety action 6: Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?			
	Year 5	**Compliance with Standards**	**Comments / Evidence**
Standard Required			
1	Provide assurance to the Trust Board and ICB that you are on track to fully implement all 6 elements of SBLv3 by March 2024.		Implementation plan agreed within the Division and work ongoing to implement all required standards. Partial complaince met. Detailed report to next Board meeting in November 2023; data and evidence deadline 30/10/2023
2	Hold quarterly quality improvement discussions with the ICB, using the new national implementation tool.		No formal arrangement regarding meeting structure with ICB in place. Meeting with LMNS and ICB to be arranged to confirm. Process for discussion c larified by LMNS - NO ICB meetings being introduced as agreed with LMNS who will act as the ICB sign off. Concerns re ICB oversight communicated at meeting on 04/09/23; meetings in place and set up by ICB/LMNS
Minimum evidential requirement for Trust Board			
1	1) The Three-Year Delivery Plan for Maternity and Neonatal Services sets out that providers should fully implement Version Three by March 2024. A new implementation tool is now available to help maternity services to track and evidence improvement and compliance with the requirements set out in version three. The tool is based on the interventions, key process and outcome measures identified within each element, and is available at https://future.nhs.uk/SavingBabiesLives Providers should use the new national implementation tool to track compliance with the care bundle and share this with the Trust Board and ICB. To evidence adequate progress against this deliverable by the submission deadline in February, providers are required to demonstrate implementation of 70% of interventions across all 6 elements overall, and implementation of at least 50% of interventions in each individual element. These percentages will be calculated within the national implementation tool.		Previous presentation at Board of 3 Year Single Delivery plan.
2	2) Confirmation from the ICB with dates, that two quarterly quality improvement discussions have been held between the ICB (as commissioner) and the Trust, using the implementation tool and includes the following: • Details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element. 42 • Progress against locally agreed improvement aims. • Evidence of sustained improvement where high levels of reliability have already been achieved. • Regular review of local themes and trends with regard to potential harms in each of the six elements. • Sharing of examples and evidence of continuous learning by individual Trusts with their local ICB and neighbouring Trusts.		Progress meetings in place and delegated to LMNS from ICB
Validation process			
1	Self-certification to NHS Resolution using the Board declaration form.	For information	
2			
3			
What is the relevant time period?			
		Note date	
What is the deadline for reporting to NHS Resolution?			

Safety action 7: Listen to women, parents and families using maternity and neonatal services and coproduce services with users			
	Year 5	**Complaince with Standards**	**Comments / Evidence**
Standard Required			
1	Ensure a funded, user-led Maternity and Neonatal Voices Partnership (MNVP) is in place which is in line with the Delivery Plan and MNVP Guidance (due for publication in 2023).Parents with neonatal experience may give feedback via the MNVP and Parent Advisory Group.		Fully complaint and work ongoing to further improve partnership
2	Ensuring an action plan is coproduced with the MNVP following annual CQC Maternity Survey data publication (due each January), including analysis of free text data, and progress monitored regularly by safety champions and LMNS Board.		Action plan in place and recent CQC result has hilighted the outstanding work that is ongoing with the MNVP.
3	Ensuring neonatal and maternity service user feedback is collated and acted upon within the neonatal and maternity service, with evidence of reviews of themes and subsequent actions monitored by local safety champions.		MNVP Chair is a safety champion and attends all meetings.
Minimum evidential requirement for Trust Board			
	Minutes of meetings demonstrating how feedback is obtained and evidence of service developments resulting from coproduction between service users and staff. • Evidence that 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. • The MNVP's work plan. Evidence that it is fully funded, minutes of the meetings which developed it and minutes of the LMNS Board that ratified it. • Evidence that service users receive out of pocket expenses, including childcare costs and receive timely payment for these expenses. • Evidence that the MNVP is prioritising hearing the voices of neonatal and bereaved families as well as women from Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation, given the findings in the MBRRACE-UK reports about maternal death and morbidity and perinatal mortality.		
Validation process			
	Self-certification to NHS Resolution using the Board declaration form		
What is the relevant time period?			
	Trusts should be evidencing the position as 7 December 2023		
What is the deadline for reporting to NHS Resolution?			
	1 February 2023 at 12 noon		

Safety action 8: Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?			
	Year 5	**Complaince with Standards**	**Comments / Evidence**
Standard Required and minimum evidential requirement			
1	1. A local training plan is in place for implementation of Version 2 of the Core Competency Framework.		Training Needs Analysis in place and follows national guidance set out on NHSE Future Platform. Training compliance trajectory on track to meet target. On track
2	The plan has been agreed with the quadrumvirate before sign-off by the Trust Board and the LMNS/ICB.		Sign off to be discussed and agreed at Maternity and Neonatal Assurance Board -
3	The plan is developed based on the "How to" Guide developed by NHS England.		See above narrative
Validation process			
	Self-certification to NHS Resolution using the Board declaration form.		
What is the relevant time period?			
	12 consecutive months should be considered from 1st December 2022 until 1st December 2023 to ensure the implementation of the CCFv2 is reported on and, an appropriate timeframe for trust boards to review. It is acknowledged that there will not be a full 90% compliance for new elements within the CCFv2 i.e Diabetes. 90% compliance is required for all elements that featured in CCFv1		
What is the deadline for reporting to NHS Resolution?			

Safety action 9: Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?			
	Year 5	**Compliance with standards**	**Comments / Evidence**
Standard Required			
a)	All six requirements of Principle 1 of the Perinatal Quality Surveillance Model must be fully embedded.		Perinatal Quality Surveillance model (PQSM) enbedded and same is presented to Board monthly however traditionally (up until March 2023) outlier report presented quarterly to Board which is no longer submitted due to no regional dashboard being produced.
b)	Evidence that discussions regarding safety intelligence; concerns raised by staff and service users; progress and actions relating to a local improvement plan utilising the Patient Safety Incident Response Framework are reflected in the minutes of Board, LMNS/ICS/ Local & Regional Learning System meetings.		Maternity processes for investigation are embedded in practice eg HSIB and PMRT> PSIRF training taking place prior to September deadline however further work is required to ensure PSIRF process is appropriately implemented into maternity and neonatal service. Trust SI policy to also include reference to maternity and neonatal sprocesses - comments re same submitted prior to ratification of policy. Concerns re PSIRB escalated regionally and nationally by Regional team. Process introduced at WUTH which will be reviewed in December 2023.
c)	Evidence that the Maternity and Neonatal Board Safety Champions (BSC) are supporting the perinatal quadrumvirate in their work to better understand and craft local cultures.		Work ongoing to ensure this process is embedded. Training date arranged for the Quadumvirate in Birmingham this month (Nov 2023).
Minimum evidential requirement for Trust Board			
	Evidence for point a) is as per the six requirements set out in the Perinatal Quality Surveillance Model and specifically: • Evidence that a non-executive director (NED) has been appointed and is working with the Board safety champion to address quality issues. • Evidence that a monthly review of maternity and neonatal quality is undertaken by the Trust Board, using a minimum data set to include a review of thematic learning of all maternity Serious Incidents (SIs). • To review the perinatal clinical quality surveillance model in full and in collaboration with the local maternity and neonatal system (LMNS) lead and regional chief midwife, provide evidence to show how Trust-level intelligence is being shared to ensure early action and support for areas of concern or need.		
	Evidence for point b) • Evidence that in addition to the monthly Board review of maternity and neonatal quality as described above, the Trust's claims scorecard is reviewed alongside incident and complaints data. Scorecard data is used to agree targeted interventions aimed at improving patient safety and reflected in the Trusts Patient Safety Incident Response Plan. This should continue to be undertaken quarterly as detailed in MIS year 4. These discussions 60 must be held at least twice in the MIS reporting period at a Trust level quality meeting. This can be a Board or directorate level meeting.		
	Evidence for point c): Evidence that the Board Safety Champions have been involved in the NHS England Perinatal Culture and Leadership Programme. This will include: • Evidence that both the non-executive and executive maternity and neonatal Board safety champion have registered to the dedicated FutureNHS workspace to access the resources available. • Evidence in the Board minutes that the Board Safety Champion(s) are meeting with the Perinatal 'Quad' leadership team at a minimum of quarterly (a minimum of two in the reporting period) and that any support required of the Board has been identified and is being implemented.		
Validation process			
	Self-certification to NHS Resolution using the Board declaration form	No Change	
What is the relevant time period?			

	Time period for points a and b) • Evidence of a revised written pathway, in line with the perinatal quality surveillance model, that is visible to staff and meets the requirements detailed in part a) and b) of the action should be in place based on previous requirements. The expectation is that if work is still in progress, this will have been completed by 1st December 2023. • The expectation is that discussions regarding safety intelligence, including the number of incidents reported as serious harm, themes identified, and actions being taken to address any issues; staff and service user feedback; minimum staffing in maternity services and training compliance are continuing to take place at Board level monthly. If for any reason they have been paused, they should be reinstated no later than 1 July 2023. • The expectation is for ongoing engagement sessions with staff as per year 4 of the scheme. If for any reason these have been paused, they should be recommenced no later than 1 July 2023. The reason for pausing feedback sessions should be captured in the minutes of the Board meeting, detailing mitigating actions to prevent future disruption to these sessions. • Progress with actioning named concerns from staff engagement sessions are visible to both maternity and neonatal staff and reflects action and progress made on identified concerns raised by staff and service users from no later than the 17th July 2023. • Evidence that a review of the Trust's claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level safety champions at a Trust level (Board or directorate) quality meeting by 17th July 2023. At least one additional meeting must have been undertaken before the end of the year 5 scheme demonstrating oversight of progress with any identified actions from the first review as part of the PSIRF plan. This should continue to be undertaken quarterly as detailed in MIS year 4. Time period for points c) • Evidence that both the non-executive and executive maternity and neonatal Board safety champion have registered to the dedicated FutureNHS workspace to access the resources available no later than 1 August 2023. • Evidence in the Board minutes that the Board Safety Champion(s) are meeting with the perinatal 'Quad' leadership team as a minimum of quarterly and that any support required of the Board has been identified and is being implemented. There must have been a minimum of 2 meetings held by 1 February 2024	Note dates	
What is the deadline for reporting to NHS Resolution?			
	By 1 February 2024 at 12 noon	Note date	

Safety action 10: Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) (known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023) and to NHS Resolution's Early Notification (EN) Scheme from 6 December 2022 to 7 December 2023?			
	Year 5	**Compliance with standard**	**Comments / evidence**
Standard Required			
a)	Reporting of all qualifying cases to HSIB/ MNSI from 6 December 2022 to 7 December 2023.		Compliance evidenced to date.
b)	Reporting of all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 6 December 2022 until 7 December 2023.		Compliance evidenced to date.
c)	For all qualifying cases which have occurred during the period 6 December 2022 to 7 December 2023, the Trust Board are assured that:		
i	the family have received information on the role of HSIB//MNSI and NHS Resolution's EN scheme; and		Compliance evidenced to date.
ii	there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.		Compliance evidenced to date.
Minimum evidential requirement for Trust Board			
	Trust Board sight of Trust legal services and maternity clinical governance records of qualifying HSIB//MNSI/EN incidents and numbers reported to HSIB//MNSI and NHS Resolution.		
	Trust Board sight of evidence that the families have received information on the role of HSIB/MNSI and EN scheme.		
	Trust Board sight of evidence of compliance with the statutory duty of candour.		
Validation process			
	Self-certification to NHS Resolution using Board declaration form. Trusts' reporting will be cross-referenced against the HSIB/MNSI database and the National Neonatal Research Database (NNRD) and NHS Resolution database for the number of qualifying incidents recorded for the Trust and externally verify that standard a) and b) have been met in the relevant reporting period. In addition, for standard C1 there is a requirement to complete field on the Claims Reporting Wizard (CMS), whether families have been advised of NHS Resolution's involvement, completion of this will also be monitored, and externally validated.		
What is the relevant time period?			
	Reporting to HSIB – from 6 December 2022 to 7 December 2023 Reporting period to HSIB and to NHS Resolution – from 6 Decemb		
What is the deadline for reporting the NHS Resolution?			
	By 1 February 2024 at 12 noon		

Wirral University Teaching Hospital NHS Foundation Trust

Improvement Plan 2023 – Reducing Avoidable Term Admissions into Neonatal Care (ATAIN Programme) and Transitional Care Service at WUTH.

	Improvement identified	Action/s needed	Outcome / comments	Lead	End date	RAG
1)	Review of process within WUTH re reducing avoidable Term Admissions into the Neonatal Unit and into Transitional Care and into the Neonatal Outreach service.	1) Ensure a weekly review of all avoidable and non-avoidable Term Admissions is undertaken 2) Benchmarking and auditing of admissions - ongoing with monitoring through Neonatal ODN and through the Maternity Dashboard outlier reports. 3) Ensure all activity from TC and the Outreach service is being captured to inform practise. 4) Review of action plan and identification of improvements prior to introducing revised meeting structure.	1) Term admission reviews undertaken and reports generated – process reviewed and operational action plan being improved to further capture actions from reviews. Terms of reference reviewed and developed for ATain meeting. 2) Meeting schedule to be confirmed and priority given to Neonatal Lead attending. DE to discuss with Adam Brown re job planning of Neonatologist attending ATain meetings. 2&3) Benchmarking within C&M Region complete and Annual report produced by the Neonatal ODN. Outlier reports evidence low term admission rate. – see action	Danielle Chambers - ATAIN Lead /Risk Midwife	Jan 2023	**B**

	Improvement identified	Action/s needed	Outcome / comments	Lead	End date	RAG
			re development of a separate ATain dashboard to be developed moving forwards (separate action). 3) Submission of data to NHSE and Neonatal ODN regarding Neonatal and Transitional Care activity from Badgernet.			
2)	Service review to be undertaken looking at the Neonatal Outreach Service and the Hospital at Home service to further improve continuity for babies and their families.	1) Service review to be undertaken and a proposal for implementing an improved service to be developed. 2) Oversight of Outreach service activity in reducing the term admission rate in the Trust. Data to be captured on ATain dashboard. 3) Ensure outreach activity is captured on Badgernet to inform NHSE of activity.	1) Data form outreach service to be included in dashboard (see separate action) **dashboards data metrics confirmed and updated** 2) Proposal for integrated neonatal outreach/Hospital at Home service agreed and work progressing to implement. **Service is 1 year in existence (October 23) Fully integrated.** 3) Progress with outreach service to feed into improvement plan.	Angela McDonald – ADN for Children's services	Target date for implementation of H@H: April 2023.	**B**

	Improvement identified	Action/s needed	Outcome / comments	Lead	End date	RAG
			Data for service included on Neonatal dashboard			
3)	Review of staff working within the Transitional Care service within the Trust –	1) Review of the collaborative working between Maternity and Neonatal service in further improving Transitional Care 2) Recruit into vacant NSW posts. 3) Ensure TC is staffed 24/7 and CIF to be completed if unable to achieve.	1) NSWs being recruited into vacant posts. No shifts left uncovered. 2) Identify shifts on TC unfilled and include performance on ATain dashboard (see separate action).	Neonatal & Maternity Matron	Feb 2023	**B**
4)	Ensure all staff working in TC have undertaken the Avoidable Term Admission e learning tool (RCPCH accredited).	1) Provide advice and guidance re staff accessing training 2) Ensure staffing is added to the Neonatal and Maternity TNA. 3) Training/competency for Neonatal Supported Worker role to be developed.	1) Review of staffing compliance against training requirement to be undertaken given recent recruitment. 2) Ensure Training Compliance is captured on training compliance report and is also reported onto Neonatal dashboard 3) Update TNA to include elearning tool for TC staff. 4) NODN have confirmed staff update with required training – ongoing compliance to be	Neonatal & Maternity Matron with Practice Developme nt leads	October 2023	**B**

	Improvement identified	Action/s needed	Outcome / comments	Lead	End date	RAG
			monitored on dashboard (actioned)			
5)	Report and monitor indication/s for any term admission to the Neonatal Unit - look at the utilisation of the Ulysee's system to report and generate actions against each review identifying themes and updating improvement plan.	1) Ensure all term admissions are reported onto Ulysee's. 2) Report to be generated by Corporate Governance team to identify detail of the admission and actions taken to minimise risk of term admission/s. 3) Update improvement plan after each meeting and identify audit, improvement / actions accordingly.	1) Trust report/summary on term admissions generated by corporate governance team. Process for managing term admissions utilising ulysees in place. 2) Dashboard to be developed – see below/separate action. 3) Quarterly Divisional term admission review reports, audits and recommendations / action plans to continue and feed into one improvement plan.	Danielle Chambers - ATAIN Lead /Risk Midwife	Feb 2023	**B**

	Improvement identified	Action/s needed	Outcome / comments	Lead	End date	RAG
6)	Identify audit of practices in TC to identify further area/s for improvement eg management of jaundice, hypoglycaemia, respiratory problems.	1) Review term admission reviews and identify area for improvement 2) Develop improvement plan and identify topics for audit and ensure the audit/s are included in the quarterly Atain report. 3) Communication of Atain findings including any audit undertaken to the wider team to inform policy change/improvements in practice.	1) Quarterly Atain reports including any audit detail. – 2023-24. 2) Improvement plan to be updated and reviewed in meetings including clinical governance and safety champion meetings. 3) Audit findings/presentation.	Danielle Chambers - ATAIN Lead /Risk Midwife	October 2023	**B**
7)	Communicate newly appointed ATAIN leads in the Division: Governance; Nursing/Midwifery and Medical Leads – both in Neonatal & Obstetric services. Neonatal and Maternity Safety Champion/s	1)Clinical Gems to highlight the ATAIN work and Leads/role 2) Development of Communication Board for ATAIN/TC outcomes. 3) Develop ATain dashboard for discussion with Leads as per separate action. 4) Develop poster to display leads.	1) Clinical Gems newsletter 2) ATAIN communication Board on the Neonatal unit and TC area of the Maternity Ward. 3) Dashboard development – see below	Danielle Chambers - ATAIN Lead /Risk Midwife	Feb 2023	**B**
8)	Ensure the ATAIN improvement plan is supported by the Trust	1) Update of the ATAIN Improvement / Action plan	1) ATAIN action plan for 2023 circulated to team.	Jo Lavery - Director of Midwifery	Feb 2023	**B**

	Improvement identified	Action/s needed	Outcome / comments	Lead	End date	RAG
	Safety Champions, Divisional Management Board, Trust Board, NODN, C&M LMNS and forms part of the evidence for the NHS CNST Incentive Scheme	2) Submission of ATAIN action plan to PSQB, Q&S Committee and Board of Directors. 3) Submission of ATAIN action plan to C&M Local Maternity & Neonatal System (LMNS) 4) Submission of MIS to Board outlining compliance with Safety Standard 3	2) PSQB/Quality Committee agenda and minutes referencing CNST Incentive Scheme paper 3) Board of Directors minutes demonstrating that they oversight of CNST Incentive scheme and Safety Action 3 compliance. 4) MIS signed off and NODN confirmed compliance with safety action 3.			
9)	Development of an ATain dashboard (added as an additional section on Neonatal Dashboard) to include key metrics for communicating performance of Atain.	1) Meeting to be set up with Joe Silcock – Divisional Analyst to pull together existing data into a stand alone dashboard 2) Identify metrics to be included on the dashboard. 3) Circulate dashboard out for comments once developed. 4) Dashboard to be discussed in ATain meetings, safety champion meeting and clinical governance meetings	1) Meeting arranged for ADN and HoM to meet with Joe Silcock to discuss dashboard development (meeting planned October 23) However prior to the meeting taking place a review of the current neonatal dashboard took place and Atain performance to stay on neonatal dashboard with total number of term admissions;	Angela McDonald – ADN for Children's services & Dave Farmer HoM	Nov 2023	G

	Improvement identified	Action/s needed	Outcome / comments	Lead	End date	RAG
			avoidable and unavoidable term admissions being included with narrative against each.			
10)	Policy for Transitional Care to be reviewed and updated and to include escalation of care / capacity.	1)Policy to be reviewed by all members of the ATain membership and discussed at ATain group 2) Ratify revised policy in CG meeting and implement revised changes in practice 3) Maternity and Neonatal review of policy indicated.	Current policy for Transitional Care updated and is currently out for final comments. Final document to go to next CG meeting for ratification. Policy ratified.	Debbie Edwards /Danielle Chambers - ATAIN Lead /Risk Midwife	May 2023	**B**
11)	Review of current environment for transitional care.	1) Signage to identify designated TC area 2) Feedback from service users re TC facilities – involve MNVP and staff	Improvement to current identification of TC area to be identified. Fifteen steps undertaken however clarity regarding Transitional Care area signage to be discussed with MNVP Chair	HoM	Dec 2023	G
12)	Review staff competency re	1) Ensure staff identified are signed off for IV competency	Competency for the administration of intravenous drugs in place – same to be used to upskill	HoM / Maternity Matron with	Dec 2023	G

	Improvement identified	Action/s needed	Outcome / comments	Lead	End date	RAG
	administration of IV antibiotics	2) Look at expanding the number of staff able to administer intravenous antibiotics to the neonate. 3) Review policy in line with above.	additional midwives working on the maternity ward. Trust policy regarding intravenous drugs administration to be used to support this practice.	Practice Development leads		
13)	Quarterly Atain report to go to Maternity & Neonatal Assurance Board for information /oversight	1) Agenda to include quarterly report in April (Q1); July(Q2); Oct (Q3) and Jan (Q4).	Reports for 2023 to MatNeo Assurance Board in November 2023	Jo Lavery (DoM)	Nov 2023	B

OCTOBER 2021-OCTOBER 2022

WIRRAL MVP

ANNUAL REPORT

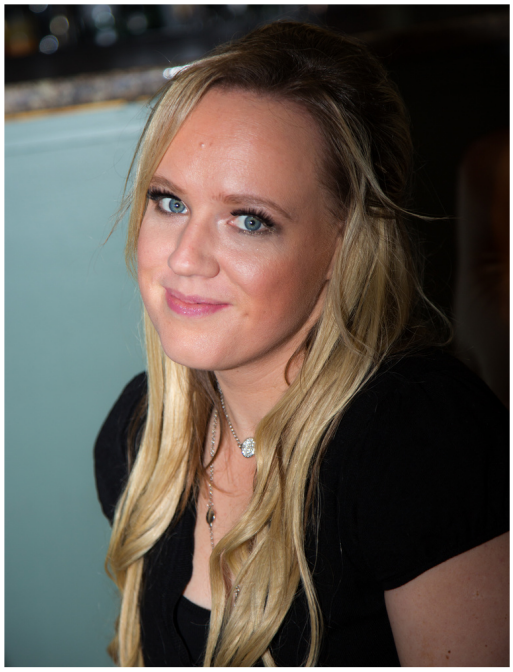
NHS
Wirral University Teaching Hospital
NHS Foundation Trust

Contents

Letter from our Chair

I had hoped that I would not have to mention COVID in this report apart from in terms of pandemic recovery and getting back to business as usual. Unfortunately, COVID continued to impact on how we function and continued to challenge maternity and neonatal services to their limit during 2021 and as I write now in November 2022, we are just starting to think about life post COVID. Nevertheless, we have made some huge progress this year and have achieved some big things. This was my fourth year as Chair of Wirral MVP and as I take some time to reflect on the priorities we set ourselves at the end of last year along with the challenges we have faced, I can't help but feel proud and incredibly thankful for the support and hard work of so many wonderful colleagues, volunteers and members of the community. This year we have been able to really concentrate on the sustainability and robustness of Wirral MVP, we have significantly expanded our team which has allowed us to have more meaningful involvement as well as evidence the impact we have had. Our role with safety, governance and quality surveillance within maternity services has really grown this year and I expect it to continue to grow into 22/23. Providing this transparency, assurance and scrutiny is something that I, as a chair, am really passionate about and believe we must ensure all learning from complaints, incidents and feedback is shared, used to inform training and leads to meaningful change with the service to improve the safety of care for all.

Victoria Walsh
Wirral Maternity Voices Partnership Chair



Victoria Walsh

“

I am proud to champion co-production that is meaningful, inclusive and sustainable, to support the transformation of maternity services for all women, birthing people and families across Wirral.

Letter from the Senior Midwifery Team

As the Head of Midwifery and recently appointed Director of Midwifery, I am immensely proud of what Wirral University Teaching Hospital Maternity Voices Partnership has achieved over the last 12 months. I would like to thank everyone who has contributed to this workstream with energy and commitment over this challenging period. The WUTH Maternity and Neonatal System has been working closely with the MVP to ensure that local voices are heard and feed into any new initiatives. This is something that will remain a focus as Maternity Transformation continues.
Maternity Voices Partnerships (MVP) are a key element to institute co-production in maternity services with women and their families and are vital to ensuring that current and recent service user's experiences are used effectively to improve maternity services. The MVP Chair has created a collaborative exchange of ideas leading to changes that are service user influenced, and where possible service user led. MVP has a key role in the local implementation of Better Births to ensure locally we are meeting the needs and expectations of local women by seeking feedback, providing representation, and facilitating co-production at every opportunity."
Jo Lavery
Divisional Director of Nursing & Midwifery (Women's and Children's Division)

"Wirral Maternity Voices is an extremely valuable partnership, as it enables close collaboration with our service users in order to ensure the maternity service reflects their needs. Over the last 12 months we have continued our close collaboration and co-production, including; regular communications with service users through live social media updates, face to face listening events across Wirral, 15 steps to maternity, surveys about current maternity care and areas for improvement and co-production of a number of new initiatives. The MVP allows close and regular communication between the maternity team and the service users, with the Chair providing dedicated advocacy and support for our service users. The collaborative initiatives between Wirral MVP and the maternity service at WUTH have been recognised by the regional NHS team as areas of good practice and we are very proud to have the opportunity to share our good practice both regionally and nationally."
Dr Angela Kerrigan (PhD)
Consultant Midwife

As a new member of the Management team at the Wirral University Teaching Hospital I would like to comment of my first impressions of the Maternity Voices Partnership (MVP), and how impressed I have been in the way that that the partnership working is embedded into the service. I am looking forward to continuing working closely with the Maternity Voices Partnership, ensuring that the service users voices are heard and that they continue to have an active role in service development. Thank you for the support that MVP has given to myself and look forward to continuing the close working relationship over the next 12 months.
Dave Farmer
Head of Midwifery

Letters from our wider network

‘The Wirral Maternity Voices Partnership voice is an integral part of commissioning and service improvement for Maternity services on Wirral. I value the breadth of feedback received from the MVP and have seen direct improvements in services for women and their families as a result of issues raised by the MVP. A good example of this, is improving information for women on what they can expect as they move along the maternity pathway, with the MVP jointly hosting Facebook Live question and answer sessions with senior representatives from the service responding directly to service users concerns. By establishing a strong social network presence and this joint working approach, the MVP has improved communication of issues important to women and their families on Wirral and facilitated a much speedier flow of information that supports an improved experience of the maternity pathway.
The joint quarterly meetings with the MVP, maternity provider and commissioning provide a great structure to openly share and address issues directly with the service. The MVP have played a key role in sense checking proposed improvements to address areas from the Ockenden Review with regards safety of women as they experience their maternity care, have run events within the community in support of national Baby Week and are now working closely with commissioning in responding to improvements envisaged within the 10 year Women’s Health Strategy for England. I look forward to continuing to work with the MVP on improving services for women and their families on Wirral’.
Ian Davis Commissioning Manager – Planned Care

“Maternity Voices Partnership has become a crucial partner to the Mums Matter programme. It gives mums experiencing PND a way to find their voices during a very vulnerable time. The support and validation they then receive often helps them to begin their healing journey. Without doubt, a large part of this is due to Victoria’s compassionate care and understanding. She shows up in our groups time and time again sharing information about what she does. She is forever inspiring women to speak and be a part of the decision-making process. It’s a wonderfully empowering service and fundamental for some women in understanding their experience”.
Lisa Shannon Mums Matter Coordinator, Wirral Mind

“Throughout our partnership, and collaborative work with Wirral Maternity Voices, we have formed a very strong appreciation of their constructive approach to engaging, listening to, and supporting Wirral’s local pregnant and new parent population. Maternity and additional challenges faced by some in our community is part of Healthwatch Wirral’s priorities as part of Core20PLUS5 which is national approach to inform action to reduce healthcare inequalities at both national and system level. As part of this Healthwatch Wirral and WMVP have collaborated on a new maternity button on the Healthwatch Wirral feedback centre, providing a focused space for new parents to feedback on services that they access as part of their maternity journey. We trust Wirral MVPs viewpoint and value the additional rich insight they provide based upon experiences, their feedback is well respected and is always influential.”
Micha Woodworth on behalf of Healthwatch Wirral

https://speakout.healthwatchwirral.co.uk/services/maternity

Letters from our wider network

Koala North West is hugely grateful for the fabulous working relationship we have with our local maternity voices. Maternity voices work tirelessly to keep professionals across all sectors, up to date, about the important processes and changes made to maternity services following service user feedback.

We have worked very closely over the past few years ensuring that the families Koala North West support are informed of the valuable service they offer, and so many of them have been able to feedback and feel, not only listened to, but often to be the catalyst for change for future care.

Sara Atherton - Development Officer/Breastfeeding/1001 Days Lead Koala North West

Who we are

Wirral Maternity Voices Partnership is an independent multi-disciplinary advisory and action forum with service users at the centre. It uses a formal committee structure, with written agendas and formal minutes of discussions and decisions, and incorporates the principles and practice of participatory co-design and co-production through regular break-out sessions and small group work in order to ensure that the five principles of MVPs are at the core of the commissioning, monitoring and continuous improvement of maternity services.
Founding five principles:

- To understand the importance of staff experiences and how that impacts on experiences for women, families and carers (and vice versa).
- To work together creatively with respect, to develop solutions.
- To use personal experience as evidence.
- To continually focus upon quality improvement with a particular focus on closing inequality gaps.
- To work together as equals, promoting and valuing participation. To listen and seek out the voices of all women, families and carers using maternity services, making sure people from diverse communities have a voice, especially those voices that are difficult to hear. It is funded and supported by Wirral University Teaching Hospital.

The MVP serves the needs of local women and families and the Local Maternity and Neonatal System, including all acute and community services. It links with clinical network(s), to contribute towards and follow regional strategic direction, and links with other MVPs within the LMNS to share good practice. The MVP will listen to and act upon women, family and carer feedback at all stages of the commissioning cycle –from needs assessment to contract management. All members are committed to working in partnership and to implementing woman-centred care. Woman-centred care offers women information, choice, and care based on best available evidence, always respecting their choices and human rights. The MVP is committed to diversity and equal opportunities and upholds women's human rights in pregnancy and childbirth. The MVP is multidisciplinary, so its members will bring with them different beliefs, values and experience. All these perspectives should be valued and respected. Each member should have an equal opportunity to contribute to the MVP discussion and decision-making process. Care will be taken to enable full participation. For example, it is important to check that the terminology MVP member's use is understood by all and clarified if necessary.

Members

Wirral Maternity Voices Partnership Team includes:

• Parents who have accessed maternity care in the last 5 years
• Service user representatives (like Doulas, Antenatal Educators and Lactation Consultants) who have regular contact with those who are pregnant and their families and new parents.
• Representatives from local groups and charities who have an interest in maternity services such as Wirral SANDS, Dadsnet, Milestone Mums, Elsie's Moon, The Birth Trauma Association, Healthwatch Wirral and Dad Matters.
• Director of Midwifery, Head of Midwifery, Consultant Midwife, Quality and Safety Lead, Patient Engagement Team and Midwives and Health Professionals currently providing maternity care including those who work for the Wirral University Teaching Hospital.
• Commissioners of maternity services from Wirral Place (Integrated Care Board)

We are also communicating and engaging with the following professionals and organisations to help develop and improve care:

- Elsie's Moon
- Wirral Mind
- Chester University
- Liverpool John Moore's University
- Wirral Multicultural Organisation
- Wirral Change
- Merseyside Society for the Deaf
- Cheshire and Merseyside (C&M) Perinatal Mental HealthTeam
- C&M Local Maternity System (LMS) Prevent Lead
- Sexual Health Team and GP Champion for Sexual Health
- Wirral University Teaching Hospital Patient Advisory Group
- MAMA Academy
- Innovation Agency
- Local Maternity and Neonatal System

Volunteers

Volunteer recruitment and engagement has been difficult due to COVID restrictions since March 2020, this year restrictions started to lift, and some face-to-face engagement was able to restart. We have run a social media campaign to recruit more volunteers which has been successful, and we have a wide range of volunteers now signed up and able to influence our work. We started to get back out into the community slowly, this began with our Chair attending community groups that were starting back up again after lockdown, these groups were able to be used as focus groups for some of our feedback work. We have now developed a schedule of Wirral MVP run community events in a variety of locations across Wirral, these are informal events where we provide refreshments and activities and use the time to collect general feedback, signpost to support and raise the profile of Wirral MVP within the community. We invite partner organisations such as IAPT services, Koala Northwest and Healthwatch Wirral to support the events.

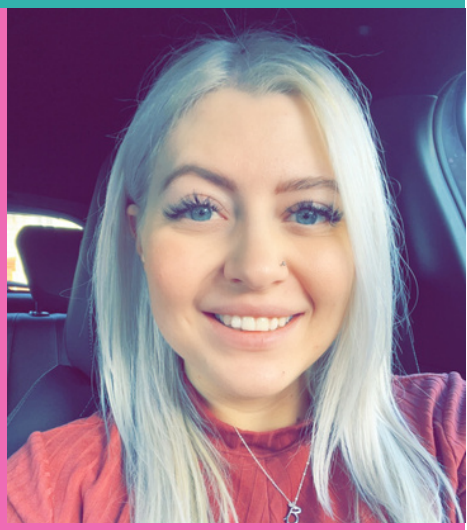
Our volunteer team are at the heart of what we do. We continue to focus on growing our volunteer numbers and are also committed to working towards a more diverse and representative team.

The following page was written and designed by MVP Volunteer Beccy Cave.

Volunteers

Beccy

I am a mum of two, I have a 13 year old Son; and a 9 month old Daughter. I live with my Partner and our two chihuahuas Margot & Bella. I'm 31 years old and I am employed by the Civil Service.



- **Wirral MVP supported me on numerous occasions during my pregnancy. Victoria - our Chair, enabled me to advocate for myself and assisted me with some issues I was facing. Without the MVPs input I don't feel I would have had the support to request the changes to my care.**
- **I joined as a volunteer to help support other families as the service Wirral MVP provides is invaluable and I feel everyone should have access to it.**

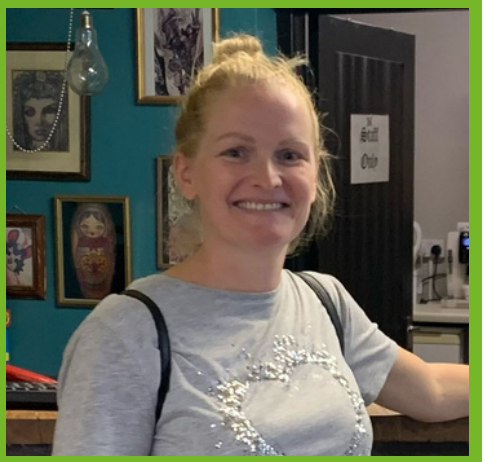
Leanne

I've got a little girl who is 4 and a little boy on the way in February!
I work full time as a mental health researcher exploring a variety topics but I'm particularly interested in maternal mental health.

- **Aside from work, we love to spend our weekends being active with lots of trips to the park, picnics and swimming!**
- **I decided to join MVP to give back to maternity services by sharing my past experiences and helping others to have a voice and share theirs.**

Claire

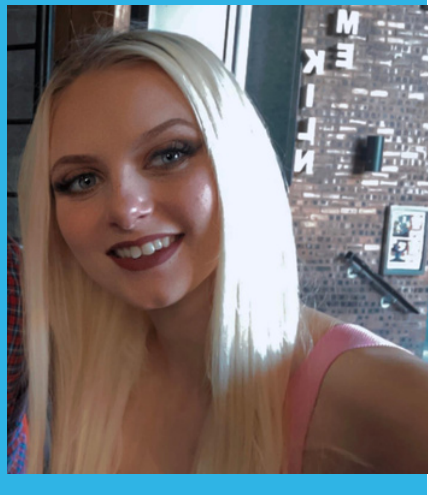
I have 2 daughters; ages 3 and 1 with my partner of 10 years, Scott. We also have a dog called Bruce who is 17



- **I have recently returned to work part time as a HR Advisor, a career I have been building for 17 years.**
- **On my days off work, we spend a lot of time being creative and going on walks and to soft play.**
- **I decided to become an MVP volunteer to help improve the service following on from the pandemic. The MVP helped me during my second pregnancy as there were a lot of restrictions in place at the time and they kept me fully up to speed on this so I could plan for the birth as best as possible.**

Kerry

I have two beautiful babies, a 2 year old Daughter and a 9 month old Son. I am 25 years old, a Uni grad who is currently a stay at home Mum. I am hoping to go back to work in the not too distant future.



- **The MVP helped bring in new protocols in the ward for care after birth after taking on my feedback. The MVP helped me so much in my healing journey after a traumatic birth experience and I will forever be grateful.**
- **I joined to help give back and help other women with their healing journey**

Volunteers

Mike
I have two sons and a pet tortoise called Speedy. I am a teacher in a local special primary school and a DJ on the weekends.

- I chose to volunteer for the MVP after attending the Dad's Comedy night in aid of International Father's Mental Health Day. Having had my own struggles with Mental Health, it's important for me to give peer support to our new dads and partners in Wirral.

Ronan
I have two children, a son and a daughter. My wife is Victoria, the Chair of Wirral MVP. We also have a dog called Roxy. I moved to Wirral from Dublin, Ireland in 2014.

- I chose to volunteer for the MVP to support those with a baby on the Neonatal Unit. I was diagnosed with depression and PTSD after our son was born at 31 weeks gestation. He spent 7 weeks in the Neonatal Unit at Arrowe Park.

OUR VISION, PURPOSE AND APPROACH

Our vision is simple Inclusive, safe, personal and kind maternity care for all in Wirral. Designed, implemented and evaluated in partnership with the communities that receive the care. We believe in transparency, openness and coproduction. Service users and lay people should have oversight of the quality and safety of services as well as the development and transformation

Our purpose is to ensure service user voice is at the centre of decisions, to provide insight and oversight to improvements, quality and safety, and to provide strategic critical friendship to the local Maternity and Neonatal System.

Our approach is that people's views come first – especially those who are often marginalised or ignored by institutions and systems. We positively challenge, question, and support the development and oversight of maternity and neonatal services by raising the voices of service users and supporting service users to be involved.

How we find out what matters to you We are always listening. Our team use multiple approaches to ensure we hear a wide range of voices and give involvement opportunities to as many people as possible. We run community events, use online surveys, are active on social media and attend groups, clinics and events across Wirral.

Find out more about us and the work we do:
Website: wirralmaternityvoi.wixsite.com/wirralmatvoices
Twitter: @VoicesWirral
Facebook: @Wirralmatvoices
Instagram: @wirralmaternityvoices

We Said, We Did

TOGETHER WE HAVE:

- MVP Chair has been able to advocate for service users when needed.
- Quarterly Cycle Created - Gather feedback – Brainstorm Themes & Actions – Formal meeting
- Surveys and polls have been created for the Wirral MVP website and social media accounts.
- Communication Strategy Developed
- Posters/leaflets designed – IOL, CoC.
- Social media platforms (Facebook, Instagram and Twitter) utilised. Email, website, digital feedback form and surveys which are monitored.
- Worked in partnership with the maternity leadership team to restore services.
- Carried out 15 Steps of the Birth Centre March 2021 was completed in a virtual way.
- Discussed the need for improvements to Breast feeding support and Tongue Tie observation.
- Worked in partnership with Dr. Libby Shaw, Consultant Obstetrician and Emma Rohlmann, to improve Induction of Labour and are continuing to develop materials for parents and families, providing information about Induction of Labour.
- We returned to face to face listening events with a walk 'n' talk, comedy night for Dads and two mental health events.
- We continued to host fortnightly livestreams on Social Media.
- Support the Team in completing the Ockenden Requirements (and the East Kent report, including reviewing the WUTH Maternity website and offering suggestions of improvement from service users.
- We have worked with Wirral Multicultural Organisation to improve outcomes for those from the BAME communities as a result of the MBRRACE Report.
- We have worked closely with our counterparts at Healthwatch Wirral to introduce a Maternity 'button' on their feedback centre.
- We have shared what the MVP is and what is means to service users to first year Midwifery Students at the University of Chester.
- We have supported the LMNS and Public Health on the new Smoking in Pregnancy Pathway.
- We have supported the LMNS and Public Health on the new Infant Feeding/Breastfeeding Pathway.
- We have supported the LMNS project for Inclusion. We also sit on the Community Trust Inclusion Partnership.
- We have supported the Lead Midwife for Inequalities.
- We have attended training to learn how to support fathers and their mental health.
- We have supported our partners at Koala North West/1001 Days Project.
- We sit in on the Safety Champions meetings to ensure service user voice is heard by senior staff.
- We have supported Wirral Mind and their Mums Matter course.
- We have supported WUTH in their PROMISES groups.
- We are working with Chester Milk Bank to support the work they do.
- We have supported the Perinatal Mental Health Team, especially with the design of the Silver Birch Hubs.
- Completed the 15 Steps of Maternity at Wirral University Teaching Hospital.

Maternity Governance

Wirral MVP attends meetings within Wirral University Teaching Hospital (Arrowe Park), to ensure service user voice is central in decision making and to provide positive challenge. We also have a role in ensuring transparent quality assurance and oversight. In these meetings we review all serious incident investigations and hear about themes from complaints. We discuss staffing, training and quality improvement ideas.

Examples of guidelines Wirral MVP have been involved in reviewing and developing this year include:

- Multiple pregnancies
- Breech birth
- Triage
- Reduced fetal movements
- Caesarean section
- Pre-labour rupture of membranes at term
- Antenatal care and risk assessment
- Management of COVID-19 in pregnancy
- Shoulder dystocia
- Epidural analgesia for labour pain

FEEDBACK THEMES

Information & education
This includes antenatal education, which was stood down during COVID, accessible leaflets and lack of up-to-date information on the website. This is linked to the information review for the Ockenden response. Service users have told us that they want access to more information to support them in making choices during their maternity journey. They also wanted to be offered support and information about infant feeding, baby care and postnatal recovery

Antenatal Clinic
Overall, service users scored the scanning experience a 3 or above (out of 5) but felt they needed more clarity when given information from specialist clinics especially the Diabetes Clinic.

Obstetric Recovery
Service Users reported that Obstetric recovery staff were very welcoming and safe but felt they needed to be more involved when care is being given to their baby. Support partners felt they needed more support whilst caring for their baby especially if first time parents.

Informed consent and decision making
An ongoing theme is around informed consent and decision making. This includes ensuring informed consent for all interventions, sharing information about risks, benefits and alternatives and the decision of the pregnant woman or person being respected. This feedback was often around membrane sweeps, induction of labour and place of birth. This theme also includes language used by staff and support for those choosing birth outside of local guidelines.

Perinatal Mental Health
Services reported being unsure whether their medication is safe during pregnancy and where to get information from. The majority were spoken to about their mental health from their community midwife. and were also referred on for support.

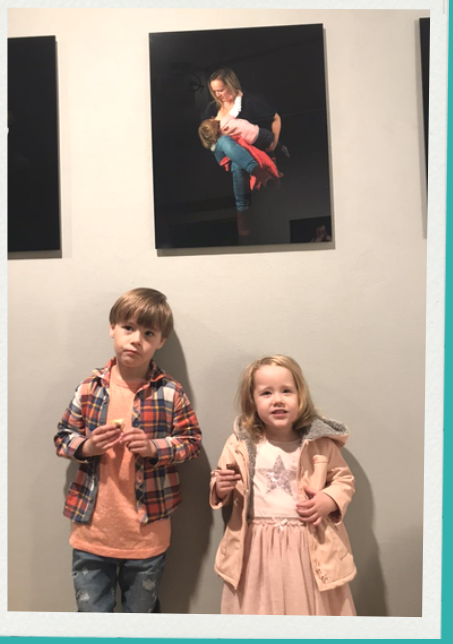
Forward View

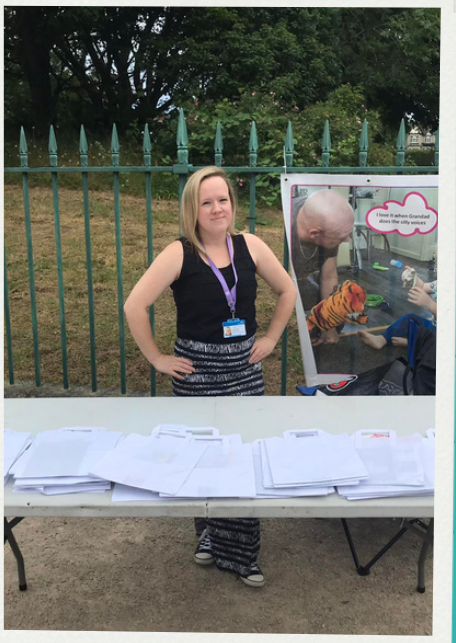
Our workplan for 22/23 includes:

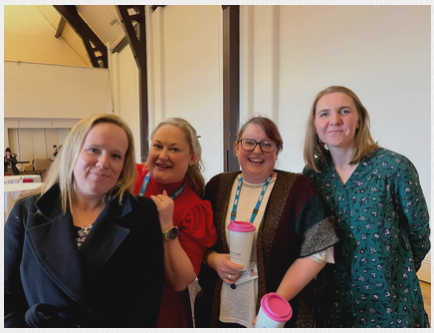
- Ockenden and subsequent report response
- Equity and Equality plans
- Promoting and developing community engagement
- 15 steps report
- Supporting the LMNS on the following:

Breastfeeding/Infant Feeding Task and Finish Group
Smoking in Pregnancy Feeding Task and Finish Group
Inclusion

- Maternity Governance








the
milk bank
at chester


FYT
Foundation Years Trus
Side-by-side with parent
to support the
developme
first five