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		Compliance against standard completed and uploaded
	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 undertaken
	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. Action plan prepared and uploaded as evidence
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; Reviewed by LMNS in November and all requests completed and uploaded; re-assessment undertaken and >90% will be reviewed in December 2023. Final report to BoD in Jnauary 2024.							
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. On track to complete all elements							
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?										
Technical guidance - FOR INFO ONLY		Note date								

Where can we find guidance regarding this safety action?	Saving Babies' Lives Care Bundle v3: https://www.england.nhs.uk/publication/saving-babies-lives-version-three/ The implementation tool is available at https://future.nhs.uk/SavingBabiesLives and includes a technical glossary for all data items referred to in MSDS Additional resources are in production and will be advertised on this page. Any further queries regarding the tool, please email england.maternitytransformation@nhs.net Any queries related to the digital aspects of this safety action can be sent to NHS Digital mailbox maternity.dq@nhs.net Some data items are or will become available on the National Maternity Dashboard or from NNAP Online For any other queries, please email nhsr.mis@nhs.net	For information							
What is the rationale for the change in evidential requirements to SA6 in Year 5?	The broad principles that will apply to the implementation of the standards detailed in the Saving Babies' Lives Care Bundle (version 3) are: The use of the implementation tool will allow Trusts to track implementation and demonstrate local improvement using the process and outcome indicators within all six elements of the care bundle (for some elements this may only require evidence of a protocol, process, or appointed post). These data will form the basis of compliance with safety action 6 of this version of the maternity incentive scheme. This approach acknowledges the increased number and/or size of elements in this new version of the care bundle.	For information							
What are the indicators for Element 1	Process Indicators 1a. Percentage of women where there is a record of: 1.a.i. CO measurement at booking appointment 1.a.ii. CO measurement at 36-week appointment 1.a.iii. Smoking status** at booking appointment 1.a.iv. Smoking status** at 36-week appointment 1b. Percentage of smokers* that have an opt-out referral at booking to an in-house/in-reach tobacco dependence treatment service. 1c. Percentage of smokers* that are referred for tobacco dependence treatment who set a quit date. Outcome Indicators 1d. Percentage of smokers* at antenatal booking who are identified as CO verified non-smokers at 36 weeks. 1e. Percentage of smokers* that set a quit date and are identified as CO verified non-smokers at 4 weeks. *a "smoker" is a pregnant woman with an elevated CO level (4ppm or above) and identifies themselves as a smoker (smoked within the last 14 days) or has a CO level less than 4ppm but identifies as a smoker (smoked within the last 14 days). **Smoking status relates to the outcome of the CO test (>4ppm) and the enquiry about smoking habits.								
What are the indicators for Element 2	Process Indicators 2a. Percentage of pregnancies where a risk status for Fetal Growth Restriction (FGR) is identified and recorded at booking. (This should be recorded on the provider's MIS and included in the MSDS submission to NHS Digital once the primary data standard is in place.) 2b. Percentage of pregnancies where a Small for Gestational Age (SGA) fetus (between 3rd to <10th centiles) is antenatally detected, and this is recorded on the provider's MIS and included in their MSDS submission to NHS Digital. 2c. Percentage of perinatal mortality cases annually where the identification and management of FGR was a relevant issue (using the PMRT). Outcome Indicators 2d. Percentage of babies <3rd birthweight centile born >37+6 weeks (this is a measure of the effective detection and management of FGR). 2e. Percentage of live births and stillbirths >3rd birthweight centile born <39+0 weeks gestation, where growth restriction was suspected.								
What are the indicators for Element 3	Process Indicators 3a. Percentage of women who attend with Reduced Fetal Movements (RFM) who have a computerised Cardiotocograph (CTG). 3b. Proportion of women who attend with recurrent RFM* who had an ultrasound scan by the next working day to assess fetal growth. Outcome Indicators 3c. Percentage of stillbirths which had issues associated with RFM management identified using PMRT. 3d. Rate of induction of labour when RFM is the only indication before 39+0 weeks' gestation. *There is no accepted definition of what recurrent RFM means; one region of the UK has successfully adopted a consensus definition of two or more episodes of RFM occurring within a 21-day period after 26 weeks' gestation.								
What are the indicators for Element 4	Process Indicators 4a. Percentage of staff who have received training on CTG interpretation and intermittent auscultation, human factors, and situational awareness. 4b. Percentage of staff who have successfully completed mandatory annual competency assessment. 4c. Fetal monitoring lead roles appointed. Outcome Indicators 4d. The percentage of intrapartum stillbirths, early neonatal deaths, and cases of severe brain injury* where failures of intrapartum monitoring are identified as a contributory factor. *Using the severe brain injury definition as used in Gale et al. 201848.								

What are the indicators for Element 5	Process Indicators 5a. Percentage of singleton infants less than 27 weeks of gestation, multiples less than 28 weeks of gestation, or any gestation with an estimated fetal weight of less than 800g, born in a maternity service on the same site as a neonatal intensive care unit (NICU). 5b. Percentage of babies born before 34 weeks of gestation who receive a full course of antenatal corticosteroids within 1 week of birth. 5c. Percentage of babies born before 30 weeks of gestation who receive magnesium sulphate within the 24 hours prior to birth. 5d. Percentage of women who give birth following preterm labour below 34 weeks of gestation who receive intravenous (IV) intrapartum antibiotic prophylaxis to prevent early onset neonatal Group B Streptococcal (GBS) infection. 5e. Percentage of babies born below 34 weeks of gestation who have their umbilical cord clamped at or after one minute after birth. 5f. Percentage of babies born below 34 weeks of gestation who have a first temperature which is both between 36.5–37.5°C and measured within one hour of birth. 5g. Percentage of babies born below 34 weeks of gestation who receive their own mother's milk within 24 hours of birth. 5h. Perinatal Optimisation Pathway Compliance (Composite metric): Proportion of individual elements (5a – 5g above) achieved. Denominator is the total number of babies born below 34 weeks of gestation multiplied by the number of appropriate elements (eligibility according to gestation). To minimise the need for local data collection to support these improvements the formal collection of process measure data can be restricted to the seven interventions listed in this section, the use of volume targeted ventilation and caffeine is recommended but these data are not currently recorded or presented with national datasets. In addition, the gestational limits for some of the indicators and/or the groups studies have been adjusted to align with current nationally collected data (e.g., data on babies born only below 34 weeks or data on the number of babiesreceiving antenatal corticosteroids rather than the number of mothers) Outcome Indicators 5i. Mortality to discharge in very preterm babies (National Neonatal Audit Programme (NNAP) definition) Percentage of babies born below 32 weeks gestation who die before discharge home, or 44 weeks post-menstrual age (whichever occurs sooner). 5j. Preterm Brain Injury (NNAP definition): Percentage of babies born below 32 weeks gestational age with any of the following forms of brain injury: ✓ Germinal matrix/ intraventricular haemorrhage ✓ Post haemorrhagic ventricular dilatation ✓ Cystic periventricular leukomalacia 5k. Percentage of perinatal mortality cases annually (using PMRT for analysis) where								
What are the indicators for Element 6	Process Indicators 6a. Demonstrate an agreed pathway for women to be managed in a clinic, providing care to women with pre-existing diabetes only, where usual care involves joined-up multidisciplinary review (The core multidisciplinary team should consist of Obstetric Consultant, Diabetes Consultant, Diabetes Specialist Nurse, Diabetes Dietitian, Diabetes Midwife) and holistic pregnancy care planning – this should be a one stop clinic where possible and include a pathway for the provision/access to additional support (e.g. asylum support, psychology, mental health) either within the clinic or within a closely integrated service (with shared documentation etc). 6b. Demonstrate an agreed pathway for referral to the regional maternal medicine for women with complex diabetes. 6c. Demonstrate an agreed method of objectively recording blood glucose levels and achievement of glycaemic targets. 6d. Demonstrate compliance with Continuous Glucose Monitoring (CGM) training and evidence of appropriate expertise within the MDT to support CGM and other technologies used to manage diabetes. 6e. Demonstrate an agreed pathway (between maternity services, emergency departments and acute medicine) for the management of women presenting with Diabetic Ketoacidosis (DKA) during pregnancy. This should include a clear escalation pathway for specialist obstetric HDU or ITU input, with the agreed place of care depending on patients gestational age, DKA severity, local facilities, and availability of expertise. Outcome Indicators 6f. The percentage of women with type 1 diabetes that have used CGM during pregnancy – reviewed via the National Pregnancy in Diabetes (NPID) dashboard (aiming for >95% of women). 6g. The percentage of women with type 1 and type 2 diabetes that have had an HbA1c measured at the start of the third trimester (aiming for >95% of women). Compliance data for both outcome indicators should be reported by ethnicity and deprivation to ensure focus on at-risk and under-represented groups.								

What considerations need to be made to ensure timely submission of data to evidence implementation and compliance with locally agreed progress measures?	Currently, SBLCB measures are not shown on the maternity services dashboard, therefore it cannot be used to evidence compliance for SA6. The implementation tool will provide trusts with the means to collate and evidence their SBLCB data.								
Is there a requirement on Trusts to evidence SBLCB process and outcome measures through their data submissions to Maternity Services Data Set?	Trusts should be capturing SBLCB data as far as possible in their Maternity Information Systems/Electronic Patient Records and submitted to the MSDS. MSDS does not capture all process and outcome indicators given in the care bundle. A summary of this appears in the technical appendix for version 2 of the care bundle, available at: https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/maternity-services-data-set/tools-and-guidance 49 Currently, SBLCB measures are not shown on the maternity services dashboard, therefore it cannot be used to evidence compliance for SA6. The implementation tool will provide trusts with the means to collate and evidence their SBLCB data.								
Would a Trust be non-compliant if <60% of smokers set a quit date?	As stated in SA6, 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. The implementation tool will set out the evidence requirement for demonstrating compliance with each intervention. Where element process and outcome measures are listed in the evidence requirement, a performance threshold is recommended, but this is for agreement between a provider and their ICB in view of local circumstances.								
The SBLCBv3 that was published on the 31st May 2023 included a typo in Appendix D Figure 6 with BMI as >18.5kg/m and it is not clear what "other features" mean	This has now been amended and states <18.5kg/m with further clarity provided regarding "other features".								
How do we provide evidence for the interventions that have been implemented?	The evidence requirements for each intervention are set out within the implementation tool. You will need to verify that you have an implemented service locally.								
Will the eLfH modules be updated in line with SBLCBv3?	The SBLCB eLearning for Health modules is currently being updated in line with the latest iteration, Version 3 of the Care Bundle and will include a new section to support implementation of element 6. We have asked for the ultrasound element to be reviewed for its relevance, this was developed separately, and we will make sure the completion of the e learning is focussed on elements 1-6.								

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 completed for the Quadumvirate in Birmingham Nov 2023 and all sessions scheduled to complete. Balance score survey completed; feedback sessions in Nov/Dec. Full report to BoD required in February 2024 as NHSE directive
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		
Technical guidance - FOR INFORMATION			
Where can I find information on HSIB	Information about HSIB and maternity investigations can be found on the HSIB website https://www.hsib.org.uk/ From October 2023 this website will no longer be available and the HSIB maternity programme will be hosted by the CQC. Further details will be circulated once available.		
Where can I find information on the Early Notification scheme?	Information about the EN scheme can be found on the NHS Resolution's website: • EN main page • Trusts page • Families page		

What are qualifying incidents that need to be reported to HSIB/MNSI?	Qualifying incidents are term deliveries (≥37+0 completed weeks of gestation), following labour, that resulted in severe brain injury diagnosed in the first seven days of life. These are any babies that fall into the following categories: • Was diagnosed with grade III hypoxic ischaemic encephalopathy (HIE) [or] • Was therapeutically cooled (active cooling only) [or] • Had decreased central tone AND was comatose AND had seizures of any kind. Once HSIB/MNSI have received the above cases they will triage them and advise which investigations they will be progressing for babies who have clinical or MRI evidence of neurological injury.		
What is the definition of labour used by HSIB and EN?	The definition of labour used by HSIB includes: • Any labour diagnosed by a health professional, including the latent phase (start) of labour at less than 4cm cervical dilatation. • When the mother called the maternity unit to report any concerns of being in labour, for example (but not limited to) abdominal pains, contractions, or suspected ruptured membranes (waters breaking). • Induction of labour (when labour is started artificially). • When the baby was thought to be alive following suspected or confirmed pre-labour rupture of membranes.		
Changes in the EN Reporting requirements for Trusts from 1 April 2022 going forward	With effect from 1 April 2022, Trusts have been required to continue to report their qualifying cases to HSIB via the electronic portal. In addition, Trusts' will need to notify NHS Resolution, via the Claims Reporting Wizard, of qualifying EN cases once HSIB have confirmed 1 April 2022 going forward they are progressing an investigation due to clinical or MRI evidence of neurological injury. The Trust must share the HSIB//MNSI report with the EN team within 30 days of receipt of the final report by uploading the HSIB/MNSI report to the corresponding CMS file via DTS. Trusts are advised they should avoid uploading HSIB/MNSI reports in batches (e.g. waiting for a number of reports to be received before uploading). Once the HSIB/MNSI report has been shared by the Trust, the EN team will triage the case based on the MRI findings and then confirm to the Trust which cases will proceed to a liability investigation.		
What qualifying EN cases need to be reported to NHS Resolution?	Trusts are required to report cases to NHS Resolution where HSIB are progressing an investigation i.e. those where there is clinical or MRI evidence of neurological injury. • Where a family have declined a HSIB investigation, but have requested an EN investigation, the case should also be reported to NHS Resolution. There is more information here: ENS Reporting Guide - July 2023 (for Member Trusts) - NHS Resolution		

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

Implementation Report

Trust	**Wirral University Teaching Hospital NHS Foundation Trust**
Date of Report	**25-Sep-23**
ICB Accountable Officer	
Trust Accountable Officer	**Janelle Holmes, CEO**
LMNS Peer Assessor Names	**Debby Gould, LMNS Q&S Lead**

Background

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

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

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

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

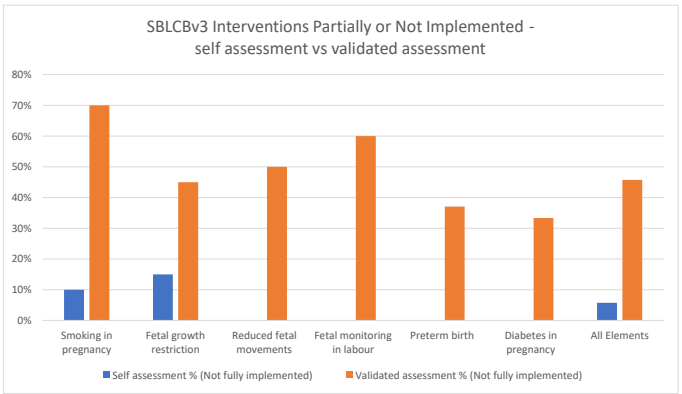
As part of the Three Year Delivery Plan for Maternity and Neonatal Services, all NHS maternity providers are responsible for fully implementing SBLCBv3 by March 2024.

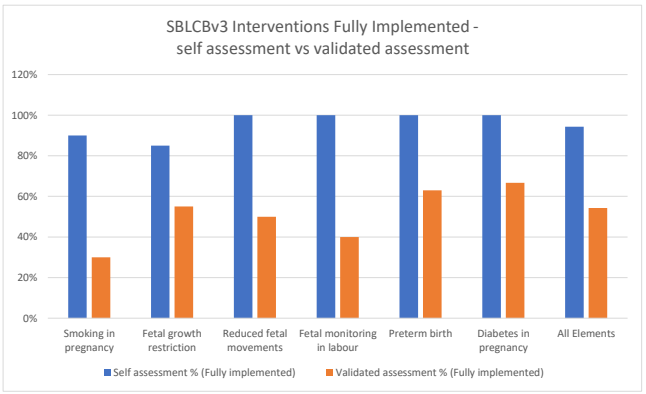
Implementation Grading

Limited Assurance - Activities and control are not suitably designed, or not operating with sufficient effectiveness to provide reasonable assurance that the control environment is effectively managed.

Implementation Progress

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)	NHS Resolution Maternity Incentive Scheme
Element 1	Smoking in pregnancy	Partially implemented	90%	Partially implemented	30%	CNST Not Met
Element 2	Fetal growth restriction	Partially implemented	85%	Partially implemented	55%	CNST Met
Element 3	Reduced fetal movements	Fully implemented	100%	Partially implemented	50%	CNST Met
Element 4	Fetal monitoring in labour	Fully implemented	100%	Partially implemented	40%	CNST Not Met
Element 5	Preterm birth	Fully implemented	100%	Partially implemented	63%	CNST Met
Element 6	Diabetes	Fully implemented	100%	Partially implemented	67%	CNST Met
All Elements	TOTAL	Partially implemented	94%	Partially implemented	54%	CNST Not Met





Action Plan

Element 1

Intervention Ref	Self-Assessment Status	LMNS Validated Assessment Status	LMNS Recommendation of Actions Required	LMNS Suggested Improvement Activity
INTERVENTIONS				
1.1	Fully implemented	Fully implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Guideline meets requirements. Care metrics do not provide detail of smoking interventions assessed. Q2 23/24 Audit meets CO at Booking compliance. Q3 22/23 Audit meets CO at 36/40
1.2	Fully implemented	Partially implemented	Evidence not in place - improvement required.	Guideline meets requirements. No audit visible for this intervention criteria (noted in REF1.2D action plan).
1.3	Fully implemented	Partially implemented	Evidence not in place - improvement required.	Guideline meets requirements. Smoking status at Booking meets compliance in Q2 23/24 audit report. Smoking status at 36/40 does not meet required compliance. No audit visble for smoking status at
1.4	Fully implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Guideline meets requirements. Opt-out referral rate noted at 90% in Q4 22/23 but does not meet required compliance in Q1 or Q2 23/24
1.5	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
1.6	Fully implemented	Partially implemented	Evidence not in place - improvement required.	ABL data does not detail percentages. Additional data neede for April 23 onwards
1.7	Fully implemented	Partially implemented	Evidence not in place - improvement required.	Guideline meets requirements. Awaiting audit as detailed in REF1.7E Action Plan
1.8	Fully implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	0
1.9	Partially implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	0
1.10	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Please note, Pactitioners should complete NCSCT e-learning and assessments annually.

Element 2

Intervention Ref	Self-Assessment Status	LMNS Validated Assessment Status	LMNS Recommendation of Actions Required	LMNS Suggested Improvement Activity
INTERVENTIONS				
2.1	Fully implemented	Partially implemented	Evidence not in place - improvement required.	Audit required
2.2	Fully implemented	Partially implemented	Evidence not in place - improvement required.	Audit required
2.3	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
2.4	Fully implemented	Partially implemented	Evidence not in place - improvement required.	Audit required
2.5	Fully implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	0
2.6	Partially implemented	Partially implemented	Evidence not in place - improvement required.	No confirmation that woman are monitored with a digital device. Needs procurement plan too.
2.7	Fully implemented	Partially implemented	Evidence not in place - improvement required.	Audit required
2.8	Fully implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	0
2.9	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Guideline validadted by LMNS until 31st Jan 2024
2.10	Fully implemented	Partially implemented	Evidence not in place - improvement required.	Audit required
2.11	Fully implemented	Partially implemented	Evidence not in place - improvement required.	Awaiting 90% compliance evidence
2.12	Fully implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	0
2.13	Fully implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	0
2.14	Fully implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	0
2.15	Fully implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	0
2.16	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
2.17	Fully implemented	Fully implemented	0	Multiple pregnancy going out of date 30th November 2023. Twins Trust audit could not open. LMNS aware of compliance through QSSG therefore compliant
2.18	Partially implemented	Partially implemented	0	Audit required
2.19	Partially implemented	Partially implemented	Evidence not in place - improvement required.	Need audit report not a screen shot
2.20	Fully implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	0

Element 3

INTERVENTIONS				
3.1	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
3.2	Fully implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Please clarify Numerator and Denominator for USS audit (?75% compliant as only 3 of 4 eligble women had USS). Add to action plan if reuired. Please note REF3.2N only contains front page.

Element 4

INTERVENTIONS				
4.1	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
4.2	Fully implemented	Partially implemented	Evidence not in place - improvement required.	Audit required for 4.2 column B Risk assessment at start of labour
4.3	Fully implemented	Partially implemented	Evidence not in place - improvement required.	Compliance for fresh eyes audit is 78% needs to be 89% and audit of structured escalation process needs to be added.
4.4	Fully implemented	Partially implemented	Evidence not in place - improvement required.	Audit of CTG fresh eyes is non compliant - it needs another audit
4.5	Fully implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	0

Element 5

INTERVENTIONS				
5.1	Fully implemented	Fully implemented	Evidence not in place - improvement required.	Midwife JD not loaded to 5.1B in another folder
5.2	Fully implemented	Partially implemented	Evidence not in place - improvement required.	Need risk assessment
5.3	Fully implemented	Partially implemented	Evidence not in place - improvement required.	Audit required as at 5.3 column G
5.4	Fully implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	0
5.5	Fully implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	0
5.6	Fully implemented	Fully implemented	0	Twins trust audit unable to open but LMNS aware of compliance through QSSG.
5.7	Fully implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	Evidence noted in 1.1. Progress with Early Pregnancy Intervention in C&M pathway
5.8	Fully implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	0
5.9	Fully implemented	Partially implemented	Evidence not in place - improvement required.	Audit required
5.10	Fully implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	0
5.11	Fully implemented	Partially implemented	0	Guideline - booking policy and risk assessment needs to be uploaded. MSU audit not uploaded. No action plan.
5.12	Fully implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	0
5.13	Fully implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	0
5.14	Fully implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	0
5.15	Fully implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	0
5.16	Fully implemented	Partially implemented	Evidence not in place - improvement required.	Cannot open the minutes so no evidence
5.17	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
5.18	Fully implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	0
5.19	Fully implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	0
5.20	Fully implemented	Partially implemented	Evidence not in place - improvement required.	Audit suggest upload NMAP neonatal data audit. This currently C+M data not Wirral specific
5.21	Fully implemented	Partially implemented	Evidence not in place - improvement required.	Mag Sulph data meets compliance on NWODN dashboard. Brain injury data outstanding
5.22	Fully implemented	Partially implemented	Evidence not in place - improvement required.	Audit suggest upload NMAP neonatal data audit. This currently C+M data not Wirral specific
5.23	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
5.24	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0

5.25	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
5.26	Fully implemented	Partially implemented	Evidence not in place - improvement required.	Need audit with intervention as at 5.26 column G
5.27	Fully implemented	Partially implemented	Evidence not in place - improvement required.	Audit suggest upload NMAP neonatal data audit. This currently C+M data not Wirral specific

Element 6

INTERVENTIONS				
6.1	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
6.2	Fully implemented	Partially implemented	Evidence not in place - improvement required.	Audit required
6.3	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
6.4	Fully implemented	Partially implemented	0	Awaiting upload of Audit
6.5	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
6.6	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0

Ockenden - Minimum evidence requirements					
SECTION 1: Immediate and Essential Actions 1 to 7				**Assessment Criteria**	**Minimum Evidence Requirements**
Immediate and Essential Action 1: Enhanced Safety					
IEA 1	**Q1**	Clinical change where required must be embedded across trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g. through maternity dashboards. This must be a formal item on LMS agendas at least every 3 months.		**Confirmation of a Maternity Services Dashboard** **Confirmation this is seen by the LMNS at least Quarterly**	• SOP required which demonstrates how the trust reports this both internally and externally through the LMS. • Submission of minutes and organogram, that shows how this takes place. • Minutes and agendas to identify regular review and use of common data dashboards and the response / actions taken. • Dashboard to be shared as evidence.
	Q2	External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death.		**Confirmation of external specialist opinion on reviews**	• Policy or SOP which is in place for involving external clinical specialists in reviews. • Audit to demonstrate this takes place.
	Q3	All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months		Confirmation that SI **GO TO Trust Board** (nab not a sub group of board such as Quality group) Confirmation that a *SUMMARY* of SI key issues goes to Trust Board Confirmation that SI **GO TO LMNS Board** Confirmation that a **SUMMARY** of SI key issues goes to LMNS Board Each of the above happen **quarterly**	• Submit SOP • Submission of private trust board minutes as a minimum every three months with highlighted areas where SI's discussed • Individual SI's, overall summary of case, key learning, recommendations made, and actions taken to address with clear timescales for completion
Link to Maternity Safety actions:					
IEA 1	**Q4**	Action 1	Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?	**Confirmation that PMRT is undertaken** see PMRT Tab	• Local PMRT report. PMRT trust board report. Submission of a SOP that describes how parents and women are involved in the PMRT process as per the PMRT guidance. • Audit of 95 % of PMRT completed demonstrating meeting the required standard including parents notified as a minimum and external review.
	Q5	Action 2	Are you submitting data to the Maternity Services Dataset to the required standard?	**Confirmation that Monthly score card completed** (13 mandatory criteria)	• Evidence of a plan for implementing the full MSDS requirements with clear timescales aligned to NHSR requirements within MIS.
	Q6	Action 10	Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification scheme?	Confirmation that **100% of** cases are reported to HSIB & NHS Resolution	• Audit showing compliance of 100% reporting to both HSIB and NHSR Early Notification Scheme.
Link to urgent clinical priorities:					
IEA 1	**Q7**	(a)	A plan to implement the Perinatal Clinical Quality Surveillance Model	Confirmation that Trust / LMNS / ICS responsibilities of the model are implemented	• Full evidence of full implementation of the perinatal surveillance framework by June 2021. • Submit SOP and minutes and organogram of organisations involved that will support the above from the trust, signed of via the trust governance structure. • LMS SOP and minutes that describe how this is embedded in the ICS governance structure and signed off by the ICS.
	Q8	(b)	All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB	Confirmation that SI go to Trust Board (nab not a sub group of board such as Quality group) **Confirmation that SI go to LMNS Board** **Each of the above happen Monthly**	• Submit SOP • Submission of private trust board minutes as a minimum every three months with highlighted areas where SI's discussed • Individual SI's, overall summary of case, key learning, recommendations made, and actions taken to address with clear timescales for completion
Immediate and Essential Action 2: Listening to Women and Families					
IEA 2	**Q9**	Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards.		No expectation that this action is met - national guidance awaited	
	Q10	The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome.		No expectation that this action is met - national guidance awaited	
	Q11	Each Trust Board must identify a non-executive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions.		Confirmation of an identified Trust Board Non Exec	• Name of NED and date of appointment • Evidence of ward to board and board to ward activities e.g. NED walk arounds and subsequent actions • Evidence of NED sitting at trust board meetings, minutes of trust board where NED has contributed • Evidence of how all voices are represented: • Evidence of link in to MVP; any other mechanisms • NED JD
Link to Maternity Safety actions:					
IEA 2	**Q12**	Action 1	Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?	Confirmation that PMRT is undertaken Confirmation that Parents are involved	• Local PMRT report. • PMRT trust board report. • Submission of a SOP that describes how parents and women are involved in the PMRT process as per the PMRT guidance. • Audit of 95% of PMRT completed demonstrating meeting the required standard including parents notified as a minimum and external review.
	Q13	Action 7	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?	Confirmation of approach to gathering Service User feedback (i.e. 15 steps / FFT / You Said We Did) **AND** MVP in place that **COPRODUCES** services	• Please upload your CNST evidence of co-production. If utilised then upload completed templates for providers to successfully achieve maternity safety action 7. CNST templates to be signed off by the MVP. • Evidence of service user feedback being used to support improvement in maternity services (E.G you said, we did, FFT, 15 Steps) • Clear co-produced plan, with MVP's that demonstrate that co production and co-design of service improvements, changes and developments will be in place and will be embedded by December 2021.
	Q14	Action 9	Can you demonstrate that the Trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?	Identified Safety Champions **WORKING WITH** Exec and Non Exec Board Leads for Maternity	• SOP that includes role descriptors for all key members who attend by-monthly safety meetings. • Log of attendees and core membership. • Action log and actions taken. • Minutes of the meeting and minutes of the LMS meeting where this is discussed.
Link to urgent clinical priorities					
IEA 2	**Q15**	A	Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services.	Same score as Q13	• Please upload your CNST evidence of co-production. If utilised then upload completed templates for providers to successfully achieve maternity safety action 7. CNST templates to be signed off by the MVP. • Evidence of service user feedback being used to support improvement in maternity services (E.G you said, we did, FFT, 15 Steps) • Clear co produced plan, with MVP's that demonstrate that co-production and co-design of all service improvements, changes and developments will be in place and will be embedded by December 2021.

	Q16	B	In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service	Confirmation of an identified Trust Board Executive Director **AND** a Non Executive Director	• Name of ED and date of appointment • Name of NED and date of appointment • Evidence of participation and collaboration between ED, NED and Maternity Safety Champion, e.g. evidence of raising issues at trust board, minutes of trust board and evidence of actions taken Role descriptors
Immediate and essential action 3: Staff Training and Working Together					
IEA 3	**Q17**	Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year.		**Training together:** Confirmation of MDT training **AND** this is validated through the LMNS x 3 per year	• Submit training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements. • Submit evidence of training sessions being attended, with clear evidence that all MDT members are represented for each session. • LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation describes as checking the accuracy of the data. • Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place. • A clear trajectory in place to meet and maintain compliance as articulated in the TNA.
	Q18	Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward.		**Working together:** Confirmation of **ALL** criteria requested	• SOP created for consultant led ward rounds. • Evidence of scheduled MDT ward rounds taking place since December, twice a day, day & night. 7 days a week (e.g. audit of compliance with SOP)
	Q19	Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only (e.g. Maternity Safety Fund, Charities monies, MPET/SLA monies etc that is specifically given for training)		Confirmation of ring fenced Maternity training budget	• Evidence that additional external funding has been spent on funding including staff can attend training in work time. • Evidence of funding received and spent. • Confirmation from Directors of Finance • Evidence from Budget statements. • MTP spend reports to LMS
Link to Maternity Safety actions:					
	Q20	Action 4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	See Section 2	**See section 2**
IEA 3	**Q21**	Action 8	Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?	90% achieved on MDT training of all Staff groups (Obstetrics / Anaesthetists / Maternity / Neonates / Support Workers)	• Submit training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements. • Submit evidence of training sessions being attended, with clear evidence that all MDT members are represented for each session. • LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation describes as checking the accuracy of the data. Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place. • A clear trajectory in place to meet and maintain compliance as articulated in the TNA. • Attendance records - summarised
Link to urgent clinical priorities					
	Q22		Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.	See Q18	• SOP created for consultant led ward rounds. • Evidence of scheduled MDT ward rounds taking place since December 2020 twice a day, day & night; 7 days a week (E.G audit of compliance with SOP)
IEA 3	**Q23**		The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place	See Q17	• Submit training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements. • Submit evidence of training sessions being attended, with clear evidence that all MDT members are represented for each session. • LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation described as checking the accuracy of the data. • Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place. • A clear trajectory in place to meet and maintain compliance as articulated in the TNA.
Immediate and essential action 4: Managing Complex Pregnancy					
IEA 4	**Q24**	Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre.		Agreement reached on Criteria for referral to Mat Med Specialist Centre	• SOP that clearly demonstrates the current maternal medicine pathways that includes: agreed criteria for referral to the maternal medicine centre pathway. • Audit that demonstrates referral against criteria has been implemented that there is a named consultant lead, and early specialist involvement and that a Management plan that has been agreed between the women and clinicians
	Q25	Women with complex pregnancies must have a named consultant lead		Named consultant lead for all women identified = Yes	• SOP that states that both women with complex pregnancies who require referral to maternal medicine networks and women with complex pregnanices but who do not require referral to maternal medicine network must have a named consultant lead. • Audit of 1% of notes, where all women have complex pregnancies to demonstrate the woman has a named consultant lead.
	Q26	Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team		Referenced to specialist involvement AND management plans developed	• SOP that identifies where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the teams. • Audit of 1% of notes, where women have complex pregnancies to ensure women have early specialist involvement and management plans are devloped by the cinical team in consulation with the woman.
Link to Maternity Safety actions:					
IEA 4	**Q27**	Action 6	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?	Confirmation of compliance with **ALL** elements	• SOP's • Audits for each element. • Guidelines with evidence for each pathway
Link to urgent clinical priorities:					
IEA 4	**Q28**	A	All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place.	Confirmation of consultant lead **AND** regular Audit of Compliance in place	• SOP that states women with complex pregnancies must have a named consultant lead. • Submission of an audit plan to regularly audit compliance
	Q29	B	Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres	Confirmation that Trust is developing their local actions as part of an agreed Network approach	• The maternity services involved in the establishment of maternal medicine networks evidenced by notes of meetings, agendas, action logs. • Criteria for referrals to MMC • Agreed pathways
Immediate and essential action 5: Risk Assessment Throughout Pregnancy					

IEA 5	**Q30**		All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional	Risk Assessment at **EVERY** AN Contact	• SOP that includes definition of antenatal risk assessment as per NICE guidance. • How this is achieved within the organisation. • What is being risk assessed. • Review and discussed and documented intended place of birth at every visit. • Personal Care and Support plans are in place and an ongoing audit of 1% of records that demonstrates compliance of the above.
	Q31		Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.	Review of place of birth in risk assessment at **ALL** AN contacts	• SOP that includes review of intended place of birth. • Personal Care and Support plans are in place and an ongoing audit of 1% of records that demonstrates compliance of the above. • Out with guidance pathway. • Evidence of referral to birth options clinics
Link to Maternity Safety actions:					
IEA 5	**Q32**	Action 6	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?	See Q27	• SOP's • Audits for each element • Guidelines with evidence for each pathway
Link to urgent clinical priorities:					
IEA 5	**Q33**		A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance.	Are PCSPs in place **AND** are they audited	• SOP to describe risk assessment being undertaken at every contact. • What is being risk assessed. • How this is achieved in the organisation. • Review and discussed and documented intended place of birth at every visit. • Personal Care and Support plans are in place and an ongoing audit of 5% of records that demonstrates compliance of the above. • Example submission of a Personalised Care and Support Plan (It is important that we recognise that PCSP will be variable in how they are presented from each trust)
Immediate and essential action 6: Monitoring Fetal Wellbeing					
	Q34		All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal wellbeing.	**BOTH** MW and Obstetrician in place	• Name of dedicated Lead Midwife and Lead Obstetrician • Copies of rotas / off duties to demonstrate they are given dedicated time. • Examples of what the leads do with the dedicated time E.G attendance at external fetal wellbeing event, involvement with training, meeting minutes and action logs. • Incident investigations and reviews
IEA 6	**Q35**		The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on: - Improving the practice of monitoring fetal wellbeing - Consolidating existing knowledge of monitoring fetal wellbeing - Keeping abreast of developments in the field - Raising the profile of fetal wellbeing monitoring - Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported - Interfacing with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice. - The Leads must plan and run regular departmental fetal heart rate (FHR) monitoring meetings and cascade training. - They should also lead on the review of cases of adverse outcome involving poor FHR interpretation and practice. - The Leads must ensure that their maternity service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 and subsequent national guidelines.	JD fulfils **ALL** criteria	• Job Description which has in the criteria as a minimum for both roles and confirmation that roles are in post • Improving the practice & raising the profile of fetal wellbeing monitoring • Consolidating existing knowledge of monitoring fetal wellbeing • Keeping abreast of developments in the field • Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported e.g clinical supervision • Interface with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice. • Plan and run regular departmental fetal heart rate (FHR) monitoring meetings and training. • Lead on the review of cases of adverse outcome involving poor FHR interpretation and practice.
Link to Maternity Safety actions:					
	Q36	Action 6	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?	See Q27	• SOP's • Audits for each element • Guidelines with evidence for each pathway
IEA 6	**Q37**	Action 8	Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?	See Q21	• Submit training needs analysis (TNA) that clearly articulates the expectation of all professional groups in attendance at all MDT training and core competency training. Also aligned to NHSR requirements. • Submit evidence of training sessions being attended, with clear evidence that all MDT members are represented for each session. • LMS reports showing regular review of training data (attendance, compliance coverage) and training needs assessment that demonstrates validation describes as checking the accuracy of the data. • Where inaccurate or not meeting planned target what actions and what risk reduction mitigations have been put in place. • A clear trajectory in place to meet and maintain compliance as articulated in the TNA. • Attendance records - summarised
IEA 6					
	Q38		Implement the saving babies lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.	See Q34	• Name of dedicated Lead Midwife and Lead Obstetrician • Copies of rotas / off duties to demonstrate they are given dedicated time. Examples of what the leads do with the dedicated time E.G attendance at external fetal wellbeing event, involvement with training, meeting minutes and action logs. • Incident investigations and reviews
Immediate and essential action 7: Informed Consent					
IEA 7	**Q39**		All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.	**ALL** place of birth information easily accessible	• Information on maternal choice including choice for caesarean delivery. • Submission from MVP chair rating trust information in terms of: accessibility (navigation, language etc) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps, websites.
	Q40		All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care	**ALL** information is easily accessible	• Information on maternal choice including choice for caesarean delivery. • Submission from MVP chair rating trust information in terms of: accessibility (navigation, language etc) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps, websites.
	Q41		Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care	Confirmation that trust **HAS** a method of recording decision making processes that includes women's participation & informed choice	• SOP which shows how women are enabled to participate equally in all decision making processes and to make informed choices about their care. And where that is recorded. • An audit of 1% of notes demonstrating compliance. • CQC survey and associated action plans
	Q42		Women's choices following a shared and informed decision-making process must be respected	Reference made to how Women's choices are respected and evidenced	• SOP to demonstrate how women's choices are respected and how this is evidenced following a shared and informed decision-making process, and where that is recorded. • An audit of 5% of notes or a total of 150 which is ever the least from january 2021, demonstrating compliance, this should include women who have specifically requested a care pathway which may differ from that recommended by the clinician during the antenatal period, and also a selection of women who request a caesarean section during labour or induction. • CQC survey and associated action plans
Link to Maternity Safety actions:					
IEA 7	**Q43**	Action 7	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?	See Q13	• Please upload your CNST evidence of co-production. If utilised then upload completed templates for providers to successfully achieve maternity safety action 7. CNST templates to be signed off by the MVP. • Evidence of service user feedback being used to support improvement in maternity services (E.G you said, we did, FFT, 15 Steps) • Clear co produced plan, with MVP's that demonstrate that co production and co-design of all service improvements, changes and developments will be in place and will be embedded by December 2021.
Link to urgent clinical priorities:					

IEA 7	**Q44**	Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. An example of good practice is available on the Chelsea and Westminster website.	All information **ON** trust website	• Gap analysis of website against Chelsea & Westminster conducted by the MVP • Co-produced action plan to address gaps identified • Information on maternal choice including choice for caesarean delivery. • Submission from MVP chair rating trust information in terms of: accessibility (navigation, language etc) quality of info (clear language, all/minimum topic covered) other evidence could include patient information leaflets, apps, websites.

SECTION 2: WORFORCE PLANNING			Assessment Criteria	Minimum evidence requirements
Link to Maternity Safety Actions:				
Q45	Action 4	Can you demonstrate an effective system of clinical workforce planning to the required standard	Midwifery workforce planning system **in PLACE**	• Most recent BR+ report and board minutes agreeing to fund. • Evidence of reviews 6 monthly for all staff groups and evidence considered at board level. • Consider evidence of workforce planning at LMS/ICS level given this is the direction of travel of the people plan
Q46	Action 5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Confirmation of a maternity workforce gap analysis **AND** a plan in place (with confirmed timescales) to meet BR+ standards	• Most recent BR+ report and board minutes agreeing to fund.
Midwifery Leadership				
Q47	Please confirm that your Director/Head of Midwifery is responsible and accountable to an executive director		Evidence the Director/Head of Midwifery responsible and accountable to an executive Director	• HoM/DoM Job Description with explicit signposting to responsibility and accountability to an executive director
Q48	Describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care: 1. A Director of Midwifery in every trust and health board, and more Heads of Midwifery across the service 2. A lead midwife at a senior level in all parts of the NHS, both nationally and regionally 3. More Consultant midwives 4. Specialist midwives in every trust and health board 5. Strengthening and supporting sustainable midwifery leadership in education and research 6. A commitment to fund ongoing midwifery leadership development 7. Professional input into the appointment of midwife leaders		**Meets ALL** that apply **Note - Trusts would not lead on actioning all seven steps**	• Gap analysis completed against the RCM strengthening midwifery leadership: a manifesto for better maternity care • Action plan where manifesto is not met
NICE Guidance related to maternity				
Q49	We are asking providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. Where non-evidenced based guidelines are utilised, the trust must undertake a robust assessment process before implementation and ensure that the decision is clinically justified.		**ALL** guidance assessed & implemented = Yes (GREEN)	• SOP in place for all guidelines with a demonstrable process for ongoing review. • Audit to demonstrate all guidelines are in date. • Evidence of risk assessment where guidance is not implemented.

	Three Year Single Delivery Plan for Maternity and Neonatal Services - June 2023							
	Theme1: Listening to and working with women and their families with compassion				RAG Rating	Lead	Review Date	Comments / Lead Progress
	Objective 1: Care that is personalised	Personalised care gives people choice and control over how their care is planned and delivered. It is based on evidence, what matters to them, and their individual risk factors and needs	**1**	Women experience care that is always kind and compassionate. They are listened and responded to. Open and honest ongoing dialogue between a woman, her midwife, and other clinicians, to understand the care she wants, any concerns she may have, and to discuss any outcomes that are not as expected. All women are offered personalised care and support plans which take account of their physical health, mental health, social complexities, and choices. Plans consider inequalities in the broadest sense, including protected characteristics and Core20PLUS5. The care plan includes a risk assessment updated at every contact, including when the woman is in early or established labour.		JL	No further action	COC Patient survey Debrief clinics to go through pregnancy outcomes. Birth Options clinic to evidence discussion of women's preferences Examples of care plans; PMH plans; Risk assessment audits Look at further improving inequalities as per equity and equality plan – Consultant Midwife to support with MNVP involvement.
			2	Women receive care that has a life course approach and preventative perspective, to ensure holistic care for women and the best start in life for babies. This includes NHS-led smoke-free pregnancy pathways to provide practical support for pregnant women who are smokers, and evidence-based information about screening and vaccination		AK/ER	31/5/23	Evidence of smoking cessation midwife/work with ABL. Use of NRT. ANNB Screening Programme QA: ANNB Screening action plan to further review screening information
			3	Women have clear choices, supported by unbiased information and evidence- based guidelines. Information is provided in a range of formats and languages, uses terminology in line with the Rebirth report, and is co-produced.		AK/ER	31/12/23	No specific work done with Rebirth report – review of same. Clear choices and information is in place including the updated/revamped website. Continue to work with MNVP re equity and equality to ensure all people receive information they understand.
			4	All women have equitable access to specialist care, including perinatal mental health services, perinatal pelvic health services, maternal and foetal medicine networks, and neonatal care, when needed		JKL	31/10/23	All services with guidelines are in place except perinatal pelvic health services – same being introduced; Set up a perinatal pelvic health service and work closely with LMNS re guidance/requirements; funding secured and JD to be matched; initial discuss with PPHS lead and service to be set up at WUTH
			5	Women experience personalised, joined-up, high-quality care right through to the postnatal period with handover to health visiting services and a GP check 6-8 weeks after birth. They are provided with practical support and information that reflects how they choose to feed their babies.		DF	31/10/23	Processes in place although clarity needed regarding 6-8week GP check post pandemic; Check with HV team re GP follow up check
			6	Parents are partners in their baby's care in the neonatal unit through individualised care plans utilising a family integrated care approach, together with appropriate parental accommodation.		ST/AMC	No further action	FI Care review undertaken with action plan developed following feedback positive in May 2022; repeated in May 2023 and GREEN accreditation achieved
			7	Compassionate and high-quality care for bereaved families including appropriate accommodation, which is easily accessible but separate from maternity and neonatal units		AK/ER	No further action	Bereavement midwife in post. Bereavement Suite on site. Use of Ron McDonald House is also an option that is used
	Objective 2: Improve equity for mother and babies	The NHS approach to improving equity (Core20PLUS5) involves implementing midwifery continuity of carer, particularly for women from minority ethnic communities and from the most deprived area It is the responsibility of trusts to: Provide services that meet the needs of their local populations, paying particular attention to health inequalities. This includes facilitating informed decision-making, for example choice of pain relief in labour where we know there are inequalities, ensuring access to interpreter services, and adhering to the Accessible Information Standard in maternity and neonatal settings. 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	**8**	To reduce inequalities for all in access, experience and outcomes		JL	30/4/24	Equity and Equality plan developed by LMNS following gap analysis which the Trust completed. Further work re equality to be undertaken
			9	Targeted support where health inequalities exist in line with the principles of proportionate universalism		JL	30/6/24	MCoC teams to be set up as a wraparound service but the support is already in place from these Leads; MCoC teams in place and embedded in the identified areas; plan for McCoy to be the default model by June 2024 and subject to safe staffing and additional funding
			10	Services listen to and work with women from all backgrounds to improve access, plan and deliver personalized care. Maternity and Neonatal voice partnerships ensure all groups are heard, including those most at risk of experiencing health inequalities.		JL	No further action	
			11	The NHS collaborates with local authority services, other public sector organisations (NHS Constitution Principle 5, 2021) to address the social determinants of health, which are a significant driver of health inequalities (WHO, 2022)		JL/DF	30/6/24	Maternity services to work with PLACE; LMNS and ICB leads to progress
			12	In spring 2023, publish the National Review of Health and Social Care in Women's Prisons. This review covers maternity and perinatal services		JL/MR	30/6/24	To achieve requirement to work with the LMNS to meet and no local prisons feed into WUTH; consider a SoP with safeguarding midwife involvement
	Objective 3: Work with service users to improve care	Acting on the insights of women and families improves services. Co-production is beneficial at all levels of the NHS and is particularly important for those most at risk of experiencing health inequalities (NICE, 2018). Involving service user representatives helps identify what needs to improve and how to do it. This is done through maternity and neonatal voices partnerships (MNVPs) and by working with other organisations representing service users	**13**	MVNPs listen to and reflect the views of local communities. All groups are heard, including bereaved families.		JL	No further action	Equity and Equality plan developed by LMNS following gap analysis which the Trust completed. Further work re equality to be undertaken as detailed above
			14	MNVPs have strategic influence and are embedded in decision making		JL	No further action	MIS evidence supports work and undertaken and co-production
			15	MNVPs have the infrastructure they need to be successful. Workplans are funded. MNVP leads, formally MVP chairs, are appropriately employed or remunerated and receive appropriate training, administrative and IT support.		JL	31/1/24	MNVP embedded; full funding of post with agreed workplan from ICB awaited
	Theme 2: Growing, retaining and supporting workforce				RAG Rating	Lead	Review Date	Comments / Lead Progress
	Objective 4: Grow our workforce	The maternity and neonatal workforce encompasses a wide range of professions, including midwives, maternity support workers, obstetricians, anaesthetists, neonatologists, neonatal nurses, sonographers, allied health professionals, and psychologists. Growing our workforce requires the tailoring of interventions to professional groups, career stage, and local requirements	**16**	Workforce capacity to grow as quickly as possible to meet local needs.		JL	No further action	Workforce plan in place with report to Board every 6 months
			17	Local and national workforce planning to utilise evidence-based tools, endorsed by NICE or the National Quality Board (NQB), that allow for medical and social complexity, training,		JL	No further action	Nursing and Medical workforce planning tools used. BR+ Report in date. Also work with regional Leads
			18	Aligned local and national strategies supporting recruitment to those vacant posts identified through workforce planning		JL	No further action	No specific work done with Rebirth report – review of same. Clear choices and information is in place including the updated/revamped website. Continue to work with MNVP re equity and equality to ensure all people receive information they understand.
	Objective 5: Value and retain our workforce	Our maternity and neonatal staff perform critical, life-changing work every day. We must ensure they are valued and have a fulfilling and sustainable career within the NHS. We need to do more to improve the experience of all our staff, to retain them within the NHS	**19**	Staff feel valued at all stages of their career. This includes support to get off to a good start, opportunities for progression and flexible working, and support when approaching retirement age to allow staff to continue to use their skills and experience.		JL	No further action	
			20	All staff are included and have equality of opportunity		JL	No further action	
			21	A safe environment and inclusive culture in which staff feel empowered and supported to take action to identify and address all forms of discrimination		JL/MP/MS/AK	30/6/24	Scope survey undertaken for Maternity and Neonates; feedback sessions in November 2023
	Objective 6: Invest in skills	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	**22**	All staff are deployed to roles where they can develop and are empowered to deliver high quality care. Specialist roles within each profession, for example the labour ward coordinator, have a job description, orientation package, appropriate training, and ongoing development		JL	No further action	Evidence collated for Ockenden improvement plan

	Invest in skills	training and competency assessment currently exists	23	All staff have regular training to maintain and develop their skills in line with their roles, career aspirations, and national standards. Training is multi-disciplinary wherever practical to optimise teamworking		JL	No further action	TNA in place and reviewed annually
	Theme 3: Developing and sustaining a culture of safety, learning and support				RAG Rating	Lead	Review Date	Comments / Lead Progress
	Objective 7: Developing a positive safety culture		24	All staff working in and overseeing maternity and neonatal services: -Are supported to work with professionalism, kindness, compassion, and respect. Are psychologically safe to voice their thoughts and are open to constructive challenge. -Receive constructive appraisals and support with their development. -Work, learn and train together as a multi-disciplinary team across maternity and neonatal care.		JL	No further action	MDT training in place. TNA supports training requirements incl psychological safety. Appraisal process in place with good compliance monitored at Board level.
			25	Teams value and develop people from all backgrounds and make the best use of their diverse skills, views, and experiences.		JL	No further action	Training in place to support
			26	There is a shared commitment to safety and improvement at all levels, including the trust board, and attention is given to 'how' things are implemented not just 'what'		JL	No further action	Evidenced through safety champions meetings. Newly formed divisional MatNeo Assurance Board
			27	Instances of behaviour that is not in line with professional codes of conduct, are fairly addressed before they become embedded or uncontrollable.		JL	No further action	Trust training and policies support professional behaviour/s. Disciplinary processes support appropriate action when needed
			28	Systems and processes enable effective coordination, rapid mobilisation, and supportive communication based on agreed principles. The team can escalate concerns and, should there be a disagreement between healthcare professionals, they will be supported by a conflict of clinical opinion policy		JL	No further action	Policy in place – provided for Ockenden evidence
			29	Staff investigating incidents are provided with appropriate training, while those staff affected by an incident are offered timely opportunity to debrief		JL/MD	No further action	Training in place for staff and this is reviewed and provided by the Trust Governance team
	Objective 8: Learning and improving	Staff working in maternity and neonatal services have an appreciation and understanding of 'what good looks like.' To promote safer care for all, we must actively learn from when things go well and when they do not. To do this, we need a continuous learning and improvement approach, from teams to ICBs	30	Our ambition is framed by the patient safety incident response framework (PSIRF) which provides a consistent approach across clinical specialties, including for maternity and neonatal services		JL/MD	31/3/24	PSIRF launched in the Trust September 2023. national guidance awaited specific for maternity services
			31	The Healthcare Safety Investigation Branch undertake investigations of incidents which meet their criteria		JL/MD	No further action	HSIB quarterly meetings take place and Trust evidenced 100% reporting by the Trust
	Objective 9: Support and oversight	While some trusts and ICSs do effectively support their maternity and neonatal services to improve and change; others do not. Good oversight is about understanding the issues leaders face and helping to resolve them, and having clear systems in place that promote timely escalation and intervention before serious problems arise	32	Robust oversight through the perinatal quality surveillance model (POSM) that ensures concerns are identified early, addressed, and escalated where appropriate		JL	No further action	Evidence Monthly PQSM report to Board with quarterly detailed maternity /neonatal reports presented
			33	Well led services, with additional resources channelled to where they are most needed		JL	No further action	CQC visit supported well led service at last inspection. Other evidence / outcomes also support
			34	Leadership for change, with a focus on ensuring new service models have the right building blocks for high quality care, especially the workforce.		JL/NP/MS/SR	31/12/24	Leadership training in place and underway x various programmes for Senior Leaders. Quad perinatal leadership programme
	Theme 4: Standards and structures that underpin safer, more personalised and more equitable care				RAG Rating	Lead	Review Date	Comments / Lead Progress
	Objective 10: Standards to ensure best practice	Advances in clinical practice have been crucial in the improvement in maternity and neonatal outcomes over the last decade. Better Births also identified that variation in protocols, policies, and standards between services creates additional burden and hinders the ability to work together to provide effective care.	35	Consistent implementation of nationally defined best practice with due regard to the needs of local populations to reduce variation and inequalities		JL/MS/MD	31/3/24	MIS year 5 and SBLv3 to be implemented following publications as of 31/5/23
			36	Healthcare professionals have access to shared standards and guidelines, including transfer, transport, and referral protocols, so that clinical teams across the ICS work to the same definitions of best practice		JL	31/7/24	Ongoing work with ICB; timeframes to be set
			37	Where local policy varies from national standards, this is subject to careful local scrutiny through governance processes. The whole multidisciplinary team is involved when developing local guidance			No further action	Processes in place to ensure MDT are involved with developing local policy
			38	Policies and guidelines recognise women as the decision-makers in their maternity care and are not used to prevent women from seeking care that is outside these guidelines			No further action	Policy in place and women are supported by the consultant midwife/Obstetric/Neonatal Leads
			39	Neonatal care is provided in units with clear designation of the level of care to be provided. Units work together across ODNs to optimise capacity and ensure care can be provided in the right place for very pre-term or very sick babies			No further action	Policy in place and women are supported by the consultant midwife/Obstetric/Neonatal Leads
	Objective 11: Data to inform learning	The Kirkup report highlighted the need for accurate, up to date data to highlight safety issues promptly. Such data enables providers to learn and act. Work is underway to review what data is needed for monitoring, and in the meantime, the NHS should continue to use the data it already collects	40	Standardised data is collected in a consistent way, primarily through the Maternity Services Data Set. Additional data collections are minimised, to focus on gathering the right data to drive insights, understanding and assurances			No further action	MSDS submitted in addition to completion of a local and regional dashboard
			41	Monitoring trends at both national and local level is enabled by analysing data from different sources alongside themes from MBRRACE-UK , and the national clinical audits patient outcome programme reports			No further action	LMNS support in leading on monitoring trends regionally. Outlier reports are presented to Board quarterly; Improvement plans are developed to address any outlier reports
			42	The national maternity dashboard provides demographic data, clinical quality improvement metrics and national maternity indicators enabling trusts and LMNSs to benchmark their services and inform continuing quality improvement work			No further action	Data submitted to national dashboard. Given limited metrics the national dashboard is not currently reviewed – work to be identified to address an improvement moving forwards.
	Objective 12: Make better use of digital technology	Digital technology will make it easier for women to access the information they need and for services to offer safe and personalised care. There is currently significant variation in the use of digital technology. While some maternity services remain almost entirely paper-based, others support personalised care with apps and benefit from an integrated electronic patient record (EPR).	43	Women can access their records and interact with their digital plans and information to support informed decision-making. Parents can access neonatal and early years health information to support their child's health and development. Information meets accessibility standards, with non-digital alternatives available for those who require or prefer them		JL/NP	31/12/24	Processes in place for women to access their records electronically – work to progress to roll out patient portal.
			44	All clinicians are supposed to make best use of digital technology with sufficient computer hardware, reliable Wi-Fi, securing networks and training			No further action	Full IT system in place and supported with equipment
			45	Organisation's enable access to key information held elsewhere internally or by partner organisations, such as other trusts and GP practices			No further action	Work across Wirral with the introduction of the single care record is supporting this

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 users requested access accoringly; awaiting feedbeck when dashboard will be able to be utilised
	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 users requested access accoringly; awaiting feedbeck when dashboard will be able to be utilised
	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	No serious incidents reported in October 2023
	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; submitted to LMNS and compliance has been returned at 55%; 70% required - identified audits and improvements identified to resubmit by 27th November 2023
	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 staff	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 completed for MatNeo and cultural conversations commencing over x 4 sessions; Requirement to report to BOD Feb 2024
	CQC National survey	no	Will be included in report on publication
	Feedback via Deanery, GMC, NMC	no	x 5 Registras on maternity leave; deanary escalation and a request to offer support
	Poor staffing levels	no	All vacacnies have been recruited into for Band 5 and Band 6 midwives; further retirements anticipated later and in the year. New starters have start dates in Sept/Oct 2023. >2% vacancy rate
	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 MNSI 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
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. 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; Governance structure reviewed and W&S Matron for Maternity to be advertised to meet maternity self assessment tool and lead on SBL and CNST as part of role
	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

OCTOBER 2022-OCTOBER 2023

ANNUAL REPORT

NHS
Wirral University Teaching Hospital
NHS Foundation Trust

Contents

Letter from our Chair

This year has been a hugely successful year of growth for our Maternity Neonatal Voices Partnership (MNVP). We are delighted to start this year's Annual Report by sharing that in August, we received a rating of Outstanding from the Care Quality Commission. . This is a fantastic recognition of the work of our MNVP, but most importantly, it emphasizes how vital it is that we are hearing and properly listening to the voices of women and birthing people.

We have been leading on mental health, neonatal experiences, tackling health inequalities and leading on equity for all in maternity care We end this year knowing that women and birthing peoples' voices are valued in our community. We go into 2023/24 lifting this voice and ensuring that it is heard and acted upon.

As an MNVP, we have held a number of service user and community meetings this year, to ensure that we remain a safe space for women and birthing people to provide feedback to Wirral University Teaching Hospital and Health Visiting.

Reports have been published this year which detail the sometimes very harrowing experiences of families. We know that areas of the population face worse experiences due to their ethnicity or through deprivation. I want to stress that our role as an MNVP is to uplift your voice, enable it to be heard and ensure that we are challenging and bringing service user experience to the forefront of every conversation, so that you are at the heart of service design. Services should be equitable, safe and compassionate for all. It is an absolute privilege to be leading Wirral MNVP. I want to thank everyone who has supported us, completed surveys, shared our posts, attended our meetings and promoted the MNVP this last year.

We know that our MNVP has more work to do; we know it is intrinsic that we are part of our community, and we look forward to building on plans for this in 2023/24.

Victoria Walsh

After careful consideration and with a mix of emotions, I want to share that I will be stepping down from my role as Lead. It has been an incredible journey working alongside this dedicated team, and I am immensely grateful for the opportunity to serve in this capacity. I have learned and grown so much during my time as Lead, and I will cherish the memories and experiences forever. I want to extend my heartfelt thanks to each and every one of you for your unwavering support, collaboration, and dedication to our shared mission. Your hard work and commitment have made a lasting impact, and I have no doubt that you will continue to achieve great things in the future. While I will no longer be in this role, I look forward to staying connected and witnessing the continued success of our team. Thank you for everything.

Letter from the Senior Midwifery Team

“As the Director of Midwifery, I am immensely proud of what Wirral University Teaching Hospital Maternity Neonatal 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. A CQC inspection in April 2023 reported outstanding practice and an excellent relationship at WUTH with the Maternity Neonatal Voice Partnership (MNVP) in supporting women and birthing people. 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 and Neonatal Transformation continues. I would like to thank everyone who has contributed to the workstreams with energy and commitment during challenging times. Maternity and Neonatal Voices Partnerships (MNVP) 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 MNVP Chair has created a collaborative exchange of ideas leading to changes that are service user influenced, and where possible service user led. MNVP 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. Maternity and Neonatal 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.”
Jo Lavery
Divisional Director of Nursing & Midwifery (Women’s and Children’s Division)

“Working in collaboration with Wirral MNVP this year has enabled us to continue to involve our service users in many aspects of our maternity and neonatal services and developments.
In my role as Consultant Midwife I have worked closely with the lead, Victoria, using social media and listening events to regularly communicate with our service users, complete actions for service improvements following feedback from the ‘15 steps of maternity’ and provide a regular and accessible presence for our service users to gain ad hoc support when needed. I am immensely proud of the collaborative working between WUTH and Wirral MNVP, which was recognised as an area of outstanding practice in our recent CQC inspection, as it enables us to develop and improve our services in line with what our service users want and need.”
Dr Angela Kerrigan (PhD)
Consultant Midwife

“Over the lasty 12 months, the partnership working with the MNVP has continued to ensure that the voice of the service user is heard, and how this can influence change within our services.
The importance of working so closely with Maternity Neonatal Voice partnership has allowed for quick resolution to queries by service users which improves working relationships all round. This relationship was recognised when the maternity service was inspected by the CQC in April this year. Over the coming year I hope to continue with our close working relationship with the MNVP chair and service users to continue to improve and develop our services. I would like to place on record our thanks and gratitude to Victoria who after almost 6 years as chair of the Maternity Voice Partnership for Wirral is leaving for pastures new. Her dedication to the role to ensure that voice of the service user is heard and that services continue to improve, have been paramount to the success of the role.”
Dave Farmer
Head of Midwifery

Letter from the Senior Midwifery Team

As the Associate Director of Nursing for children and Neonatal services, I can see the contribution that the Maternity Neonatal Voices Partnership has made to families and neonates at Wirral University teaching Hospital. Having a friendly and approachable peer in the MVNP Chair, for families to speak to either face to face or via social media platforms provides families with opportunities to have the voice of the neonate and family contribute to quality patient outcomes and service improvements. As a level three neonatal unit, we support families from many geographical areas of the northwest and the MNVP chair can and has acted as a supportive communicator enabling families to link with organisation and services outside the Wirral. This is a service that has had a positive impact on neonatal services."

Angela McDonald
Associate Director of Nursing for Children and Neonates

Letters from our wider network

‘We value our relationship with Wirral Maternity Voices Partnership voice. This has been integral in how we can further work together in understanding experiences and influencing improvement for Maternity services on Wirral. The breadth of feedback received from the MVP has seen direct improvements in services for women and their families because 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. We have jointly worked on a number of local events in clinical settings & the community. This has strengthened voices and improved conversations using this approach. We would like to that Wirral MVP for their assistance with with the research Healthwatch Wirral conducted with Healthwatch England in relation to Maternal mental health. This insight gathered has helped feed into supporting to shape NHS services, with NHS England recently announcing improvements to maternity and neo-natal services.
https://www.healthwatch.co.uk/blog/2023-06-19/stories-new-mothers-accessing-maternal-mental-health-services
We look forward to continuing to work with the MVP keeping birth givers & their families at the heart. This last year the Programme Developer for Patient Experience and Nurse Quality presented to the Maternity EDS review meeting on the work WUTH were doing around Equality and Diversity. The C&M Equalities reviewers commended the positive engagement work, insight and support from the MVP and Healthwatch partnership. Healthwatch Wirral and WMVP will continue to collaborate on the maternity button on the Healthwatch Wirral feedback centre, providing this focused space for new parents to feedback on services that they access as part of their maternity journey. We trust Wirral MVPs viewpoint and appreciate the additional rich insight they provide based upon experiences, their feedback is well respected and is always influential.”

https://speakout.healthwatchwirral.co.uk/services/maternity
Micha Woodworth - HealthWatch Wirral

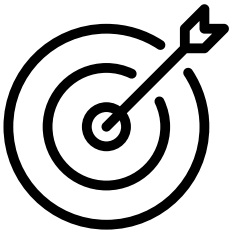
“During the initiation of peer support in the neonatal units of Cheshire and Merseyside, Victoria demonstrated remarkable proactivity and support in informing the public about the availability of this service and facilitating introductions to relevant professionals. She also ensured we were informed about pertinent events we could participate in. We extend our gratitude”
Sarah Elliott - Koala North West Neonatal Peer Support Volunteer Coordinator

“Wirral Mencap were delighted to launch their Support for Parents with Learning Disabilities and Additional Needs Project in May this year. WMNV Partnership have been a truly collaborative partner in this project from the outset: This initial input has been invaluable to our project, as we haven’t previously worked closely with many of the practitioners we met through WMNV, so their input helped ensure we have got the project off to a successful start, and we have stronger links across these networks.
Many thanks
Tina Phelan - Information, Advice & Advocacy Manager Mencap Wirral

About Us

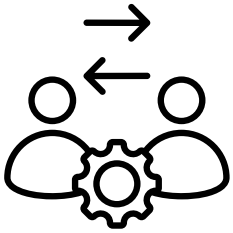
Our vision is simple

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

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.



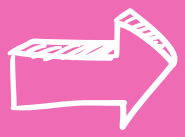
Our approach

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

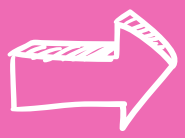
We are always listening. Our team use multiple approaches to ensure we hear a wide range of voices and give involvement opportunities to as many people as possible. We run community events, use online surveys, are active on social media and attend groups, clinics and events across Wirral.

Reflecting on our 2022/23 priorities



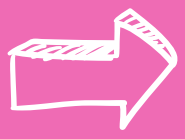
Share quarterly reports, sharing the latest feedback to the Maternity Senior Leadership Team, ICB Commissioner and other stakeholders.

Every quarter, we have produced a report on the feedback we receive from women, birthing people and their families from a range of surveys. These have included Induction of Labour (IOL), Antenatal Care, Infant Feeding, Young Parents Experience, Maternity Call Bell, Theatre Recovery, Sexual Health, Neonatal and Perinatal Mental Health. These reports are submitted to the Maternity Senior Leadership Team, ICB Commissioner and published on the MNVP website and social media platforms. Each quarter, the MNVP looks through the themes, alongside the Maternity Senior Leadership Team, ICB Commissioner and other invested stakeholders. Agreed themes are then used to coproduce ideas and solutions with women, birthing people, health care professionals and community stakeholders.



Create stronger relationships with local voluntary sector organisations and community leaders to increase the diversity of our membership so that it is reflective of the local population.

To create stronger connections with local voluntary sector organisations and community leaders and make our membership more diverse, we've been actively collaborating with groups like Wirral Multicultural Organisation, Healthwatch Wirral, Mencap Wirral, St James Centre, and The Hive: Wirral Youth Zone. We've hosted listening events to hear from women and birthing people, gaining valuable insights into their experiences. Additionally, we've organised special events to mark important occasions like Infant Mental Health Week, Maternal Mental Health Week, and our 5th Anniversary as an MNVP. In our commitment to engagement, we've also participated in events organised by other groups, such as Koala North West and the Children's Centres, fostering a sense of unity and understanding within our local community.



Increase our social media following of expectant parents to ensure our following reflects current users of maternity services.

To expand our social media presence among expectant parents and ensure our following mirrors the current users of maternity services, we've developed a comprehensive communications strategy in collaboration with Wirral University Teaching Hospital's Communications Team and Consultant Midwife. As part of this effort, we've transitioned from live streams on social media to curating an informative library of videos hosted on our YouTube Channel. This shift was prompted by a noticeable decline in engagement during live streams. To maximise our impact, we've harnessed the social media expertise of our dedicated volunteers, enabling us to employ these platforms more effectively in reaching and connecting with expectant parents.

Coproduction and Engagement Activities

October 2022

WUTH Patient Experience WELCOME Group
1001 Days Network
Maternal WellBeing LMNS Event
Ronald McDonald House Collaboration Meeting
1st year Student Midwives meeting at University of Chester
Damibu Project Started
Safety Champion Meeting and Walk about
Smoking in Pregnancy Task and Finish Group
Perinatal mental Health Meeting
Bridge Forum Meeting
LMNS Infant Feeding Meeting

November 2022

LMNS MNVP PreBoard Meeting
Smoking in Pregnancy Wirral group
1001 Days Network
Damibu Project Ongoing
LMNS LGBTQIA+ Meeting
Attended Mums Matter Group
Milk Bank at Chester Collaboration
Maternity Support Worker Study Day
Listening Event
Bridge Forum Meeting
CCCC Collaboration
Postnatal Contraception Meeting
Smoking in Pregnancy Task and Finish Group
LMNS Infant Feeding Meeting
Partnership Inclusion Forum
MNVP Quarterly Meeting

December 2022

Ronald McDonald House Collaboration Meeting
Damibu Project Ongoing
Smoking in Pregnancy Wirral group
15 Steps of Maternity (WUTH)
HealthWatch Wirral Maternal Mental health Project
1001 Days Network
CCCC Collaboration
Attended Mums Matter Group
Patient Safety Partners CoDesign Workshop
Women's Health Planning
Postnatal Contraception Meeting
Smoking in Pregnancy Task and Finish Group

January 2023

WUTH Patient and Family Experience Group
1001 Days Network
15 Steps Feedback Meeting
Postnatal Contraception
WUTH EDS 2022
LMNS MNVP PreBoard Meeting
Perinatal mental Health Meeting
Smoking in Pregnancy Wirral group
Smoking in Pregnancy Task and Finish Group
Maternal Medicine Network
Bridge Forum Meeting
Partnership Inclusion Forum
The Hive: Wirral Youth Zone Listening Event
Women's Health Network
Children's Fair
LMNS Infant Feeding Meeting
St James Centre Collaboration

February 2023

Seacombe Birth Centre Coffee Morning
Maternity Personalised Care Training Development Workshop
BEE Wirral Collaboration
NWAS Collaboration
1001 Days Network
Postnatal Contraception
Bridge Forum Meeting
WUTH Patient and Family Experience Group
Smoking in Pregnancy Wirral group
LMNS Infant Feeding Meeting

March 2023

Seacombe Birth Centre Coffee Morning
Smoking in Pregnancy Task and Finish Group
MNVP Quarterly Meeting
Safety Champion Meeting and Walk about
Listening Event
LGBTQIA+ and Perinatal Mental Health Training
Hoylake Parade Community Fair
15 Steps of Maternity - Seacombe Birth Centre
Bridge Forum Meeting
WUTH Patient and Family Experience Group
LMNS Infant Feeding Meeting
Attended Mums Matter Group
SIDS and Safer Sleep training
Wirral Multicultural Organisation Collaboration
Women's Health and Maternity Meeting

April 2023

Seacombe Birth Centre Coffee Morning
Safety Champion Meeting and Walk about
BEE Wirral Easter Fair
Maternal Mental Health Meeting
Neonatal Ambassador Programme Training
Wirral Multicultural Organisation Collaboration
Perinatal Mental Health Meeting
Smoking in Pregnancy Wirral group
Smoking in Pregnancy Task and Finish Group
LMNS Infant Feeding Meeting
St James Centre Collaboration
BEE Wirral Collaboration
Bridge Forum Meeting
Maternal Medicine Network

May 2023

Maternal Mental Health event
Callister Garden Collaboration
WUTH Patient and Family Experience Group
Mencap Supporting Parents Meeting
Safety Champion Meeting and Walk about
Milk Bank at Chester Collaboration
OptiBreech Meeting
Podcast with Liverpool Community Radio
Bridge Forum Meeting
Movement and Bloom Collaboration
LMNS Infant Feeding Meeting
Smoking in Pregnancy Wirral group

June 2023

OptiBreech Meeting
WUTH Inclusive Promise Group Workshop
Antenatal Survey Result meeting
Koala North West Infant Mental Health Awareness Week Collaboration
HeathWatch Wirral Collaboration
Infant Mental Health Awareness Week Event - Callister Garden
Equilibrium CIC Collaboration
LMNS Infant Feeding Meeting
Bridge Forum Meeting
MNVP Quarterly Meeting

July 2023

PMRT Learning
Attended Mums Matter Group x2
LMNS MNVP PreBoard Meeting
LMNS 3 Year Plan - Senior Leaders Development Day
Wirral Perinatal Mental Health Network
Postnatal Contraception Meeting
Children's Fair
Foundations in Patient Leadership Programme
Family Fun Day Involve North West
Bridge Forum
Maternal Medicine CoProduction Reference group
Smoking in Pregnancy Wirral group
LMNS Infant Feeding Meeting

August 2023

WUTH Communications Team Collaboration x3
Seacombe Family Hub launch
WUTH Patient and Family Experience Group
Koala North West Walk in Birkenhead Park
Koala North West Neonatal Lead Collaboration
Children's Centre Fun Day x2

September 2023

Maternal Medicine CoProduction Reference group x 4
Seacombe Birth Centre Coffee Morning
Maternity and NNU Q&S Assurance Board
Safety Champion Meeting and Walk about
Consultant Midwife Perinatal Health Awareness Collaboration
Sexual Health Collaboration with Maternity Ward Manager
Postnatal Contraception Meeting
Koala North West Neonatal Group
Smoking in Pregnancy Wirral group
LMNS Infant Feeding Meeting
Koala North West Breastfeeding Group
MNVP Transition and Support Event
Korn Leadership Programme Meeting

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 and Healthwatch Wirral.
• 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
- Mencap Wirral
- Wirral Multicultural Organisation
- Wirral Change
- Merseyside Society for the Deaf
- Cheshire and Merseyside (C&M) Perinatal Mental Health Team
- Sexual Health Team and GP Champion for Sexual Health
- Wirral University Teaching Hospital Patient and Family Engagement Group
- MAMA Academy
- Innovation Agency
- Local Maternity and Neonatal System
- Koala North West
- Wirral Children’s Centres

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.

We Said, We Did

TOGETHER WE HAVE:

- MNVP Lead 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 MNVP website and social media accounts.
- Communication Strategy Developed
- Social media platforms (Facebook, Instagram and Twitter) utilised. Email, website, digital feedback form and surveys which are monitored.
- Carried out 15 Steps of Maternity services at Wirral University Teaching Hospital and Seacombe Birth Centre completed.
- Discussed the need for improvements to Breast feeding support and Tongue Tie observation.
- Hosted a number of listening events and two mental health events.
- We continued to host fortnightly livestreams on Social Media until Summer 2023, with a move to collaborate making pre-recorded videos for 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.
- 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 numerous training events to improve knowledge of maternity systems.
- We have supported our partners at Koala North West.
- 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.

Maternity Governance

Maternity Safety Champions operate at every level within a Trust, regionally, and nationally. They serve as advocates for safety, forging strong partnerships, fostering the professional cultures necessary for improved care delivery, and playing a central role in ensuring that mothers and infants continue to receive the highest level of safe care by embracing best practices.

Wirral MNVP actively participates in meetings held at Wirral University Teaching Hospital, with a primary focus on placing the service user's voice at the heart of decision-making processes and providing constructive challenges. Additionally, we play a crucial role in maintaining transparent quality assurance and oversight. During these meetings, we thoroughly assess serious incident investigations, gather insights from complaints, and engage in discussions covering staffing, training, and ideas for enhancing quality.

Throughout the year, Wirral MNVP has played a significant role in reviewing and developing guidelines related to various aspects of maternity care, such as multiple pregnancies, breech births, triage procedures, management of reduced fetal movements, caesarean sections, pre-labour rupture of membranes at term, antenatal care, risk assessment, handling COVID-19 in pregnancy, managing shoulder dystocia, and providing epidural analgesia for labour pain.

Feedback Summaries

Induction of Labour

Throughout the year, the key focus area was the Induction of Labour (IOL). Service users emphasised the need for improved information delivery about what to expect during IOL and better communication between staff members. The degree to which service users felt heard by midwives significantly influenced their overall experience, though regrettably, many did not feel heard. Patients' experiences with induction were diverse. Some found it successful and well-explained, while others felt rushed and experienced a lack of communication. Issues related to staffing and information were highlighted, with a desire for more comprehensive discussions of available options. Although positive mentions were made about staff care, the need for enhanced anxiety support and improved communication remained key areas of emphasis.

Antenatal Clinic

In 2023, the key focus area was the Antenatal Clinic. Service users' feedback, accounting for 64.7% of their experiences this year, highlighted several aspects. They consistently rated the ANC waiting area at 4 or below out of 5, with most users giving it a score of 4. The lower scores were attributed to concerns about the clinic's environment, temperature, and privacy issues. Additional feedback in September 2023 underscored some ongoing issues. Patients found the new seating arrangement peculiar, as it faced away from scan rooms. Service users noted variations in staff friendliness during antenatal scans, and there were concerns about inconsistent consultant care. Experiences with the Maternity Delivery Unit (MDU) varied from efficient to long wait times. Overall, the view of antenatal care at Arrowe Park in 2023 was mixed, but largely positive, with a general call for better communication and increased consistency in care delivery.

Infant Feeding

Throughout the year, the primary focus area was Infant Feeding. Service users expressed a desire for more comprehensive information about the practical aspects of breastfeeding and its potential impact on mental health. They also emphasized the need for clear guidance on where to access support, both during the antenatal and postnatal periods. Patients consistently called for more consistent information and support in breastfeeding. Some encountered challenges with hospital support, citing issues with reliability and conflicting advice. Clear guidance was seen as essential in these cases. However, positive experiences were also reported, particularly when supported by dedicated teams, such as Jill from the infant feeding team, which contributed to successful breastfeeding outcomes.

Forward View

Our workplan for 22/23 includes:

Wirral MNVP aims to support the maternity and neonatal teams at Wirral University Teaching Hospital to deliver safer, more personalised, and fairer for women, birthing people, babies, and families.
Wirral MNVP is an integral stakeholders who will continue to support the development of these services. We listen to individuals and families who have used or are using maternity and neonatal services, members of the maternity and neonatal workforce, leaders and commissioners of services, NHS systems and regional teams to ensure we are all working collaboratively. Next year Wirral MNVP will be:

- Listening to and working with women, birthing people and families, with compassion
- Growing, retaining, and supporting the workforce
- Developing and sustaining a culture of safety, learning, and support
- Contribute to standards and structures that underpin safer, more personalised, and more equitable care.

Delivering this plan will continue to require the dedication of everyone working in NHS maternity and neonatal services in Wirral University Teaching Hospital, Wirral MNVP and volunteers who are working tirelessly to support women, birthing people and families and improve care.


Elevate the
of Patients


healthwatch
Wirral


Wirral Maternity Voices Partnership
Who we are
How we can help you
What we want to hear about
We would love to hear from you
Here's how to get in touch
Healthwatch Wirral