Appendix 1

Theme	Detail of metrics used for WUTH Perinatal Quality and Safety Model (PQSM)	Number	RAG	Narrative / Actions taken
Clinical Care	Number of stillbirths	0		No still births
	Number of neonatal deaths (before 28days) at WUTH	0		No NNU deaths
	Number of maternal deaths (up to 28 days following delivery)	0		No maternal deaths
	Post partum haemorrhage >1500mls	0		Nil Reported
	Rates of HIE where improvements in care may have made a difference to the outcome	0		No HIE
	Number of occasions where the Delivery Suite Coordinator is not supernumerary at start of shift	0		100% compliant
	Number of times when the Delivery Suite Coordinator is not supernumerary for a period of one hour or more during a shift	0		Maintain shift leader to be supernumery at start of shift and throughout as best practice
	% Compliance of 1:1 care in labour	100%		Data captured via 4 hourly BR Plus activity/acuity, achieved 100% of time, escalation processes followed to revert to supernumerary status within 1 hour
	%Consultant presence at delivery when indicated (as per RCOG Guidance)	100%		Monthly audit as per RCOG guidance and guidance updated to reflect RCOG; submitted as part of MIS Year 6
	Midwifery staffing is below BR+ Acuity	Yes		P/N Ward acuity consistently in the Red RAG rating for acuity/activity; BR Plus report received in March 2025 and staffing levels suboptimal; business case required to support an increase in establishment
	Midwifery staff absence rate in month (sickness)	5.80%		Trust processes implemented and additional support offered by HR for hot spot areas; above Trust recommended target; national rate 6.0% and reported as below
	Midwifery vacancy rate	3.60%		Low vacancy rate consistently reported; 3.96 wte vacancy permanent; 4.3 wte additional out to advert
	Midwife : Birth ratio	01:26		Within parameters
	Number of times transfer in to the Neonatal unit for Level 3 care has been declined to internal transfer	0		Nil
	Number of times transfer in to the Neonatal unit for Level 3 care has been declined to external transfer	0		Nil
	BAPM compliance - Neonatal medical staff	Yes		Consultant recruited; org change underway for 24/7 cover at weekends to achieve BAPM compliance
	BAPM compliance - Neonatal nursing staff	Yes		Workforce report to BoD annually demonstrates compliance
	Number of times Maternity unit has been on divert/closed to admissions	0		Nil; mutual aid requested
	Total number of Red Flags reported	31		Theme: delay in providing pain relief
Service user e	Staff survey	37%		Divisional compliance for 2024 staff survey 37%, midwifery staff groups below national average, requires improvement; action plan produced with key priorities
	CQC National survey	Yes		Published and action plan in place; repeat due Feb 2025; report to BoD at next quarterly report
	SCORE Survey	Yes		Participated in 2024; facilitated workshops and ongoing action plan
	Feedback via Deanery, GMC, NMC	No		Nil of note
	%Consultant presence at delivery when indicated (as per RCOG Guidance)	100%		Monthly audit as per RCOG guidance and guidance updated to reflect RCOG; submitted as part of MIS Year 6
Leadership and relationships	New leadership within or across maternity and/or neonatal services	Yes		Delivery Suite Manager - started 17/3/25; Q&S Lead Matron out to advert
	Concerns around the culture / relationships between the Triumvirate and across perinatal services	Nil		Good working relationships between teams / directorates
	False declaration of CNST MIS	No		MIS Year 6 submitted by 3/3/25; appeal relaing to data transcription error with Safety Action 1 - appeal rejected; MIS Year 7 launched April 2025
	Concerns raised about other services in the Trust impacting on maternity /neonatal services e.g. A&E	No		Nil of note
	Concerns raised about a specific unit e.g. Highfield Birthing Unit	Yes		Maternity ward concerns re: staff attitude, poor food options and inadequate pain relief; action plan and close weekly monitoring; co-production with MNVP
Safety and learning culture	Lack of engagement in MNSI or ENS investigation	No		Positive feedback quarterly review meetings and transparency through number of rejected cases
	Lack of transparency	No		Robust governance processes
	Learning from PSII's, local investigations and reviews not implemented or audited for efficacy and impact	No		Learning shared internally and via MNSG (NW region)
	Learning from Trust level MBRRACE reports not actioned	No		Nil of note
	Maternity/Neonatal Safety Champion concern; negative feedback; escalation	Nil		Regular safety champion meetings and walkabouts; all feedback actioned and feedback given
	Recommendations from national reports not implemented	Yes		CQC inspection publication action plan in progress to address quality improvements in line with recommendations; report to BoD quarterly progress
Incident reporting	Number of PSIRF reported incidents graded moderate or above	0		Reporting for April 2025
	Number of Maternity or Neonatal PSII's	0		Robust PSIRF framework followed
	Number of cases referred to MNSI	1		x3 active, x2 in draft and x2 final reports received
	Delays in reporting a PSSI where criteria have been met	0		N/A
	Never Events which are not reported	0		N/A
	MNSI/NHSR/CQC with a concern raised or a request for information	0		N/A
	Recurring Never Events indicating that learning is not taking place	0		N/A
	All safery action 1 report to MBBRACE within timeframe to include FQ's	Yes		Since data entry error all cases and FQ's reported as MIS timescales
	Poor notification, reporting and follow up to MBRRACE-UK, NHSR ENS and HSIB	0		N/A
Governanc e processes	Unclear governance processes / Business continuity plans not in place	Nil		Clear governance processes in place following PSIRF; awaiting revised publication for maternity services expected 2025; LMNS feedback required assurance of governance referrals to external organisations are made by maternity MDT team and not central governance
	Ability to respond to unforeseen events e.g. pandemic, local emergency	Yes		Maternity and Neonatal services responded to a major incident with
	Number of maternity/neonatal risks on the risk register overdue	0		Nil overdue
	Number of maternity/neonatal risks on the risk register with a score >12	18		NNU estates and IPC - plans to address; all reviewed up-to-date with mitigation and actions
CQC inspection and DHSC or NHS(E) request for support	DHSC or NHS England Improvement request for a Review of Services or Inquiry	No		Nil to report this month
	Coroner Regulation 28 made direct to Trust	No		CQC reports published in April 2023 'GOOD' for maternity services
	An overall CQC rating of Requires Improvement with an Inadequate rating for either Safe and Well-Led or a third domain	No		N/A
	CQC Rating overall	GOOD		N/A
	Been issued with a CQC warning notice	No		N/A
	CQC rating dropped from a previously Outstanding or Good rating to Requires improvement in the safety or Well-Led domains	No		N/A
	Been identified to the CQC by HSIB with concerns	No		N/A

Trust Board sign-off requirements for MIS year 7

n.b. 'Completed' set to 'No' as defa
Change to 'Yes' and add date whe

	Requirement		Completed	Date
SA1	A quarterly report should be received by the Trust Executive Board each quarter on an ongoing basis that includes details of the deaths reviewed **from 1 December 2024**, any themes identified and the consequent action plans. The report should evidence that the PMRT has been used to review eligible perinatal deaths and that the required standards have been met.	*Q1	No	
		Q2	No	
		Q3 (third report may fall outside MIS reporting period)		
SA3	If not already in place, an action plan should be signed off by Trust and LMNS Board for a move towards the transitional care pathway based on BAPM framework for babies from 34+0 with clear timescales for implementation and progress from MIS Year 6.	By 30/11/25	No	
SA4	Trusts/organisations should implement the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance with Trust Board, Trust Board level safety champions and at LMNS meetings.	By 30/11/25	No	
	Trusts must ensure compliance with Consultant attendance in person to the clinical situations listed in the RCOG workforce document: 'Roles and Responsibilities of the Consultant providing acute care in obstetrics and gynaecology' into their service. Trusts should demonstrate	By 30/11/25	No	
	The Trust is required to formally record in Trust Board minutes whether it meets the relevant BAPM recommendations of the neonatal medical workforce. If the requirements are not met, Trust Board should agree an action plan with updates on progress against any previously developed action plans. This should be monitored via a risk register.	By 30/11/25	No	
	The Trust is required to formally record to the Trust Board minutes compliance to BAPM Nurse staffing standards annually using the Neonatal Nursing Workforce Calculator (2020). If the requirements are not met, Trust Board should agree an action plan with updates on progress against any previously developed action plans. This should be monitored via a risk register.	By 30/11/25	No	
SA5	A midwifery staffing oversight report that covers staffing/safety issues should be received by the Trust Board every 6 months (in line with NICE midwifery staffing guidance), during the maternity incentive scheme year six reporting period.	Q1 & Q2	No	
		Q3 & Q4 (second report may fall outside MIS reporting period)		
	In line with midwifery staffing recommendations from Ockenden, Trust Boards must provide evidence (documented in Board minutes) of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations. Where Trusts are not compliant with a funded establishment based on BirthRate+ or equivalent calculations, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls.	By 30/11/25	No	

SA6	If the SBL Implementation tool is not in use, Trusts should be able to provide a signed declaration from the Executive Medical Director declaring that Saving Babies' Lives Care Bundle, Version 3 is fully / will be in place as agreed with the ICB.	By 30/11/25	No	
SA8	For rotational medical staff that commenced work on or after 1 July 2025 a lower training compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust?	By 30/11/25	No	
SA9	Evidence that a non-executive director (NED) has been appointed and is visibly working with the Board safety champion	By 30/11/25	No	
	Evidence that a quarterly review of maternity and neonatal quality and safety is undertaken by the Trust Board (or an appropriate Trust committee with delegated responsibility) using a minimum data setas outlined in the PQSM . This should be presented by a member of the perinatal leadership team to provide supporting context. This must include a review of thematic learning informed by PSIRF, themes and progress with plans following cultural surveys or equivalent, training compliance, minimum staffing in maternity and neonatal units, and service user voice feedback.	Q1	No	
		Q2	No	
		Q3 (third report may fall outside MIS reporting period)	No	
	Evidence that in addition to the monthly Trust Board/sub-committee review of maternity and neonatal quality as described above, the Trust's claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level Safety Champions at a Trust level (Board or directorate) meeting. Scorecard data is used to agree targeted interventions aimed at improving patient safety and reflected in the Trusts Patient Safety Incident Response Plan. These quarterly discussions must be held at least twice in the MIS reporting period at a Board or directorate level quality meeting.	Q1	No	
		Q2	No	
		Q3 (third report may fall outside MIS reporting period)	No	
	Evidence in the Trust Board minutes that Board Safety Champion(s) are meeting with the Perinatal leadership team at a minimum of bi-monthly (a minimum of three in the reporting period) and that any support required of the Trust Board has been identified and is being implemented.	Apr/May	No	
		Jun/Jul	No	
		Aug/Sep	No	
		Oct/Nov	No	
	Evidence in the Trust Board (or an appropriate Trust committee with delegated responsibility) minutes that progress with the maternity and neonatal culture improvement plan is being monitored and any identified support being considered and implemented.	By 30/11/25	No	
	Evidence in the Board minutes that the Board Safety Champion(s) are meeting with the perinatal 'Quad' leadership team as a minimum of bi-monthly and that any support required of the Board has been identified and is being implemented. There must have been a minimum of 3 meetings held in the MIS reporting period.	Apr/May	No	
		Jun/Jul	No	
		Aug/Sep	No	
		Oct/Nov	No	
SA10	Trust Board must have sight of Trust legal services and maternity clinical governance records of qualifying MNSI/ EN incidents and numbers reported to MNSI and NHS Resolution.	By 30/11/25	No	

	Trust Board must have sight of evidence that the families have received information on the role of MNSI and NHS Resolution's EN scheme.	By 30/11/25	No	
	Trust Board must have sight of evidence of compliance with the statutory duty of candour.	By 30/11/25	No	

NHS Resolution

Maternity (Perinatal) Incentive Scheme

Year Seven v1.0

Conditions of the scheme

Ten maternity safety actions

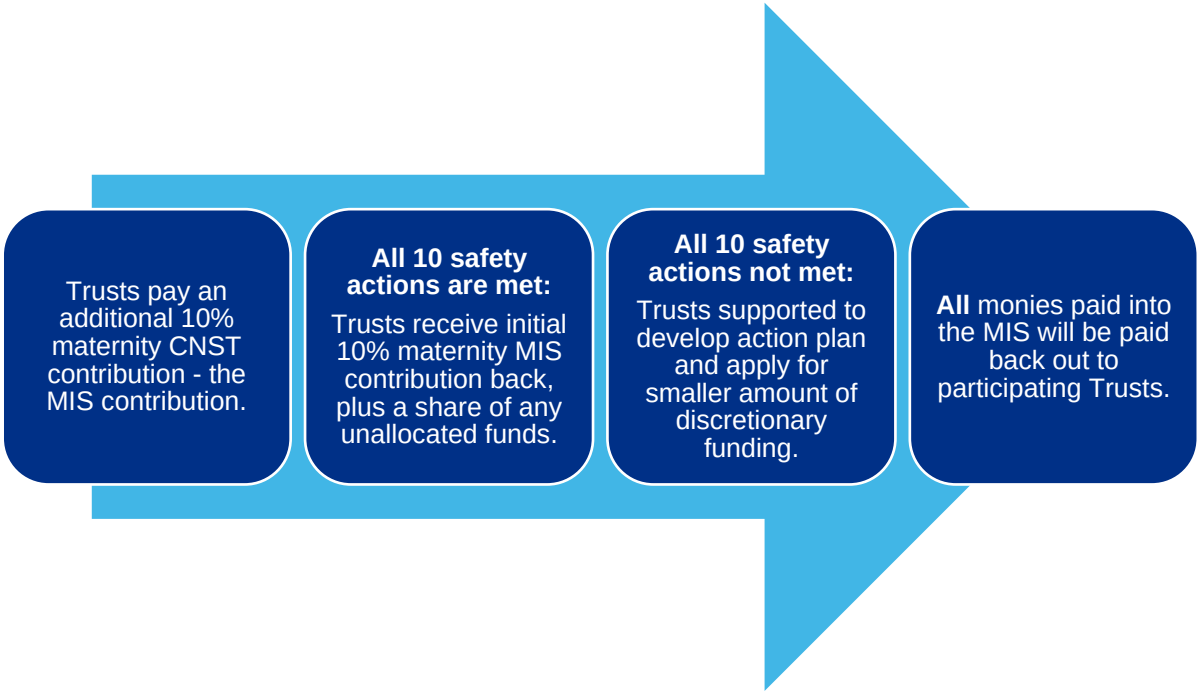
Additional guidance

Contents

Introduction

Now in its seventh year of operation, NHS Resolution's Maternity (Perinatal) Incentive Scheme (MIS) continues to support safer maternity and perinatal care by driving compliance with ten Safety Actions, which support the national maternity ambition to reduce the number of stillbirths, neonatal and maternal deaths, and brain injuries from the 2010 rate by 50% before the end of 2025.

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



The original ten safety actions were developed in 2017 and have been updated annually by a Collaborative Advisory Group (CAG) including NHS Resolution, NHS England, Royal College of Obstetricians and Gynaecologists (RCOG), Royal College of Midwives (RCM), Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE-UK), Royal College of Anaesthetists (RCoA), the Neonatal Clinical Reference Group (CRG), the Care Quality Commission (CQC), the Maternity and Newborn Safety Investigation Programme (MNSI) and service user representatives.

Trusts that can demonstrate they have achieved all ten of the safety actions in full will recover their trust's element of the contribution relating to the CNST MIS fund and this will be returned to the source of the initial CNST payment. They will also receive a share of any unallocated funds.

Trusts that do not meet the ten-out-of-ten threshold will not recover their contribution to the CNST MIS fund but may be eligible for a smaller discretionary payment from the scheme to help to make progress against actions they have not achieved. Such a payment would be at a lower level than the 10% contribution to the MIS fund and is

subject to a cap decided annually by NHS Resolution. The balance of unallocated funds will be shared with the trusts who have achieved all ten safety actions.

MIS year seven: conditions

- To be eligible for payment under the scheme, Trusts must submit their completed Board declaration form to NHS Resolution via nhsr.mis@nhs.net by **12 noon** on **3 March 2026** and must comply with the following conditions:
- Trusts must achieve all ten maternity safety actions.
- The declaration form is submitted to the Trust Board with an accompanying joint presentation detailing position and progress with maternity safety actions by the Director of Midwifery/Head of Midwifery and Clinical Director for maternity services.
- The Trust Board must then give their permission to the Chief Executive Officer (CEO) to sign the Board declaration form prior to submission to NHS Resolution. The Trust Board declaration form must be signed by the Trust's CEO. If the form is signed by another Trust member this will not be considered.
- The Trust's CEO must sign to confirm that:

☑ The Trust Board are satisfied that the evidence provided to demonstrate achievement of the ten maternity safety actions meets the required safety actions' sub-requirements as set out in the safety actions and technical guidance document included in this document.

☑ There are no reports covering either year 2024/25 or 2025/26 that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration from the same time-period (e.g. CQC inspection report, Healthcare Safety Investigation Branch (HSIB)/ MNSI investigation reports etc.). All such reports should be brought to the MIS team's attention before 3 March 2026.

☑ Any reports covering an earlier time-period may prompt a review of a previous MIS submission. *If, following a review of a previous MIS submission, it is found that the Trust was non-compliant then the Trust will immediately return to NHS Resolution that year's MIS funds that were awarded, irrespective of it being a prior financial year.*

- In addition, the CEO of the Trust will ensure that the Accountable Officer (AO) for their Integrated Care System (ICS) is apprised of the MIS safety actions' evidence and declaration form. The CEO and AO must both sign the Board declaration form as evidence that they are both fully assured and in agreement with the compliance submission to NHS Resolution.

The Regional Chief Midwives will provide support and oversight to Trusts when receiving Trusts' updates from Local Maternity and Neonatal System (LMNS) and regional meetings, focusing on themes highlighted when Trusts have incorrectly declared MIS compliance in previous years of MIS.

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

NHS Resolution will publish the outcomes of the MIS verification process, Trust by Trust, for each year of the scheme (updated on the NHS Resolution Website).

External verification

Trust MIS submissions will be subject to a range of external verification points at the end of the submission period. These include cross checking with:

MBRRACE-UK data (safety action 1 standards a, b and c).

NHS England regarding submission to the Maternity Services Data Set (safety action 2, all criteria).

MNSI will cross-check the **National Neonatal Research Database (NNRD)** and **NHS Resolution** will cross-check the **NHS Resolution database** for qualifying MNSI and EN incidents reportable (safety action 10) and externally verify that standards A and B have been met in the relevant reporting period. In addition, for standards B and C(i) there is a requirement to complete the field on **NHS Resolution's Claims Reporting Wizard (CMS)**, whether families have been advised of NHS Resolution's involvement. Completion of this will also be monitored and externally validated.

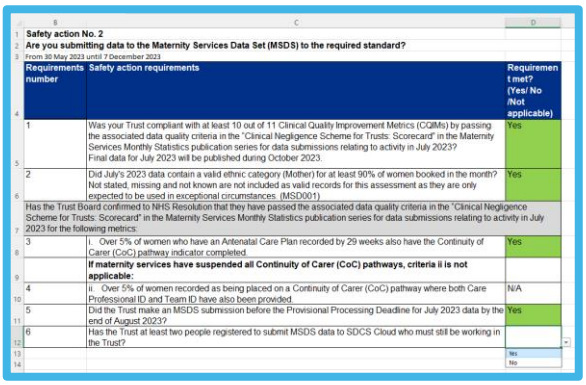
Trust submissions will also be sense checked with the **CQC**, and for any CQC visits undertaken within the time period, the CQC will cross-reference to the MIS via the key lines of enquiry.

Trusts found to be non-compliant following this external verification process cannot report full compliance with the MIS for that year.

Evidence for submission

- The Board declaration form must not include any narrative, commentary, or supporting documents. Evidence should be provided internally in the Trust to support the Trust Board decision only. This will not be reviewed by NHS Resolution unless requested. See 'Reverification'.
- On the Board Declaration form Trusts must declare YES/NO or N/A (where appropriate) against each of the elements within each safety action sub-requirements.

- Only for specific safety action requirements, Trusts will be able to declare N/A (not applicable) against some of the sub requirements.
- The Trust must also declare on the Board declaration form whether there are any external reports which may contradict their MIS submission and that the MIS evidence has been discussed with commissioners.



Safety action No. 2

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

From 30 May 2023 until 7 December 2023

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

Yes
No

- In the event that an MIS submission is found to be knowingly false or misleading, NHS Resolution will escalate the matter to the appropriate regulatory and investigative authorities.
- Trusts will need to report compliance with MIS by **12 noon on 3 March 2026** using the Board declaration form, which will be published on the NHS Resolution website in the forthcoming months.
- The Trust declaration form must be signed by the Trust's CEO, on behalf of the Trust Board and by AO of Clinical Commissioning Group/Integrated Care System.
- The Board declaration form will be made available on the MIS webpage during the MIS reporting period.

'What Good Looks Like'

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

Timescales and appeals

- Any queries relating to the ten safety actions must be sent in writing by e-mail to NHS Resolution via nhsr.mis@nhs.net prior to 3 March 2026.
- The Board declaration form must be sent to NHS Resolution via nhsr.mis@nhs.net between 17 February 2026 and 3 March 2026 at 12 noon. An electronic acknowledgement of Trust submissions will be provided within 48 hours from 3 March 2026.
- Submissions and any comments/corrections received after 12 noon on 3 March 2026 will not be considered.

- The Appeals Advisory Committee (AAC) will consider any valid appeal received from participating Trusts within the designated appeals window timeframe.
- There are two possible grounds for appeal:
    - Alleged failure by NHS Resolution to comply with the published 'conditions of scheme' and/or guidance documentation.
    - Technical errors outside the Trust's control and/or caused by NHS Resolution's systems which a Trust alleges has adversely affected its CNST rebate.
- The NHS Resolution MIS clinical team will review all appeals to determine if these fall into either of the two specified grounds for appeal. If the appeal does not relate to the specified grounds, it will be rejected, and NHS Resolution will correspond with the Trust directly with no recourse to the AAC.
- Any appeals relating to a financial decision made, for example a discretionary payment made against a submitted action plan, will not be considered.
- Appeals must be made in writing to NHS Resolution on the agreed template within two weeks of the final notification of results. Information on how to do this will also be communicated to all Trusts when the confirmed MIS results are sent out.

Trusts who have not met all ten safety actions

Trusts that have not achieved all ten safety actions may be eligible for a smaller amount of funding to support progress. To apply for funding, such Trusts must submit a completed action plan together with their completed Board declaration form by 12 noon on 3 March 2026 to NHS Resolution nhsr.mis@nhs.net.

Action plans submitted must be:

- Submitted on the action plan template in the Board declaration form.
- Signed and dated by the Trust CEO.
- Specific to the action(s) not achieved by the Trust.
- SMART (specific, measurable, achievable, realistic and timely) and must enable the financial calculation of the funding requested.
- Detailed regarding banding and Whole Time Equivalent (WTE). Any new roles to be introduced as part of an action plan must include this information.
- Sustainable - Funding is for one year only, so Trusts must demonstrate how future funding will be secured.
- Only submitted for safety actions that have not been achieved.

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

Reverification

Reverification is initiated if a concern is raised that a Trust Board may have incorrectly declared compliance with one or more of the ten safety actions' sub-requirements within the MIS. This may be identified through whistleblowing or following a CQC report that may call into question the original declaration. This concern may relate to any completed year of the MIS.

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

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

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

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

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

Need Help?

If you have any queries or concerns regarding any aspect of the MIS, please contact the MIS clinical team on nhsr.mis@nhs.net. There is a FutureNHS MIS workspace where queries can be submitted, and additional information and resources will be provided.

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

Safety action 1: Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths that occurred from 1 December 2024 to 30 November 2025 to the required standard?

Required Standard
a) **Notify all death:** All eligible perinatal deaths should be notified to MBRRACE-UK within seven working days. (See technical notes 1 to 5). b) **Seek parents' views of care**: For at least 95% of all the deaths of babies in your Trust eligible for PMRT review, Trusts should ensure parents are given the opportunity to provide feedback, share their perspectives of care and raise any questions and comments they may have from 1 December 2024 onwards. (See technical notes 6 to 8) c) **Review the death and complete the review:** For deaths of babies who were born and died in your Trust from 1st December 2024 onwards multi-disciplinary reviews using the PMRT should be carried out; 95% of reviews should be started within two months of the death, and a minimum of 75% of multi-disciplinary reviews should be completed and published within six months. For a minimum of 50% of the deaths reviewed an external member should be present at the multi-disciplinary review panel meeting and this should be documented within the PMRT**.** (See technical notes 9 to 18) d) **Report to the Trust Executive:** Quarterly reports of reviews of all deaths should be discussed with the Trust Maternity and Board Level Safety Champions and submitted to the Trust Executive Board on an ongoing basis from 1 December 2024. (See technical notes 19 to 20)
Minimum Evidence Requirement for Trust Board
Notifications must be made, and surveillance forms completed using the MBRRACE-UK reporting website (see technical notes 2 & 4 regarding the introduction of the NHS Submit a Perinatal Event Notification (SPEN) system in 2025). The PMRT must be used to review the care and reports about individual deaths should be generated via the PMRT. A report should be received by the Trust Executive Board each quarter 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.
Verification process
Self-certification by the Trust Board and submitted to NHS Resolution using the Board declaration form by **12 noon** on **3 March 2026**.

NHS Resolution will use data from MBRRACE-UK/PMRT, to cross-reference against Trust self-certifications. MBRRACE-UK/PMRT will take the data extract for verification on 3 February 2026. Note that it is essential that the technical notes are consulted to ensure that each standard is fully understood and met, for example, what 'starting a review' means and how this is assessed in the verification process.
Relevant Time period
From 1 December 2024 to 30 November 2025

Link to technical guidance

Safety action 2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

Required Standard
This relates to improving the quality and completeness of the submission to the Maternity Services Data Set (MSDS). 1. July 2025 data contains valid birthweight information for at least 80% of babies born in the month. This requires the recorded weight to be accompanied by a valid unit entry. (Relevant data tables include MSD401; MSD405). 2. July 2025 data contains 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. (Relevant data tables include MSD001; MSD101).
Minimum Evidence 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.
Verification process
All criteria to be self-certified by the Trust Board and submitted to NHS Resolution using the Board declaration form by **12 noon** on **3 March 2026**. NHS England will cross-reference self-certification of all criteria against data and provide this information to NHS Resolution.
Relevant Time period
From 2 April 2025 to 30 November 2025

Link to technical guidance

Safety action 3: Can you demonstrate that you have transitional care (TC) services in place and are undertaking quality improvement to minimise separation of parents and their babies?

Required Standard
a) Pathways of care into transitional care (TC) are in place which includes babies between 34+0 and 35+6 in alignment with the BAPM Transitional Care Framework for Practice **Or** Be able to evidence progress towards a transitional care pathway from 34+0 in alignment with the British Association of Perinatal Medicine (BAPM) Transitional Care Framework for Practice and submit this to your Trust and the neonatal Operational Delivery Network (ODN) on behalf of the LMNS Boards. b) Drawing on insights from themes identified from any term or late preterm admissions to the neonatal unit, undertake or continue at least one quality improvement initiative to decrease admissions and/or length of infant/mother separation. Progress on initiatives must be shared with the Safety Champions and LMNS.
Minimum Evidence Requirement for Trust Board
Evidence for standard a) to include: **For units with TC pathways** • Local policy/pathway of TC admission criteria based on BAPM framework for Transitional Care and meeting a minimum of at least one element of HRG XA04. **For units working towards TC pathways** • An action plan signed off by Trust and the neonatal ODN on behalf of the LMNS Board for a move towards the TC pathway based on BAPM framework for babies from 34+0 with clear timescales for implementation and progress from MIS Year 6.
Evidence for standard b) to include: 1. By 2 September 2025, register the QI project with local Trust quality/service improvement team. 2. By the end of the reporting period, present an update to the LMNS and Safety Champions regarding development and any progress. OR For units continuing a QI project from the previous year, demonstrate progress at 6 months and end of MIS reporting year with updates to LMNS and Safety Champions.
Verification process
Self-certification by the Trust Board and submission to NHS Resolution using the Board declaration form by **12 noon** on **3 March 2026**.
Relevant Time period
From 2 April 2025 to 30 November 2025

Link to technical guidance

Safety action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?

Required Standard
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 certificate of eligibility (CEL) to undertake short-term locums. Please see technical guidance for further details 2) Trusts/organisations should implement the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance to the Trust Board, Trust Board level Safety Champions and LMNS Board. rcog-guidance-on-the-engagement-of-long-term-locums-in-mate.pdf 3) Trusts/organisations should be working towards implementation of the RCOG guidance on compensatory rest where Consultants and Senior Speciality, Associate Specialist 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. **While this will not be measured in Safety Action 4 this year, it remains important for services to develop action plans to address this guidance.** rcog-guidance-on-compensatory-rest.pdf 4) Trusts should ensure they are compliant with Consultant attendance in person to the clinical situations listed in the RCOG workforce document for a minimum of 80% of applicable situations: 'Roles and Responsibilities of the Consultant providing acute care in obstetrics and gynaecology' into their service roles-responsibilities-consultant-report.pdf
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)

c) Neonatal medical workforce

The neonatal unit meets the relevant BAPM national standards of medical staffing.

or

the standards are not met but there is an action plan with progress against any previously developed action plans and monitored via a risk register.

Any action plans should be shared with the LMNS and Neonatal Operational Delivery Network (ODN).

d) Neonatal nursing workforce

The neonatal unit meets the BAPM neonatal nursing standards.

or

the standards are not met but there is an action plan with progress against any previously developed action plans and monitored via a risk register.

Any action plans should be shared with the LMNS and Neonatal ODN.

Minimum Evidence Requirement for Trust Board

Obstetric medical workforce

1) Trusts/organisations should demonstrate their compliance through an audit via Medical Human Resources.

   Information on the 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

2) Trusts should ensure they are compliant with the engagement of long-term locums using the monitoring effectiveness tool contained within the RCOG guidance document (P8).

3) Trusts/organisations should be working towards developing standard operating procedures, to assure Boards that Consultants/senior SAS Doctors working 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 senior 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

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. This can be a representative month of the rota.

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, the Trust Board should agree an action plan and evidence progress against any action plan previously developed to address deficiencies. The agreed action plan should be monitored via a risk register.

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. The agreed action plan should be monitored via a risk register.

A copy of the action plan, outlining progress against each of the actions, should be submitted to the LMNS and Neonatal ODN.

Verification process
Self-certification by the Trust Board and submission to NHS Resolution using the Board declaration form by **12 noon** on **3 March 2026**.
Relevant Time period
From 2 April 2025 to 30 November 2025

Link to technical guidance

Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

Required Standard
a) A systematic, evidence-based process to calculate midwifery staffing establishment has been completed within the last three years. If this process has not been completed within three years due to measures outside the Trust's control, evidence of communication with the BirthRate+ organisation (or equivalent) should demonstrate this. b) Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above. c) The Midwifery Coordinator in charge of labour ward must have supernumerary status; (defined as having a rostered planned supernumerary co-ordinator and an actual supernumerary co-ordinator **at the start of every shift**) to ensure there is an oversight of all birth activity within the service. An escalation plan should be available and must include the process for providing a substitute co-ordinator in situations where there is no co-ordinator available at the start of a shift. d) All women in active labour receive one-to-one midwifery care. e) Submit a midwifery staffing oversight report that covers staffing/safety issues to the Trust Board every six months (in line with NICE midwifery staffing guidance), during the MIS year seven reporting period.
Minimum Evidence Requirement for Trust Board
The midwifery staffing report submitted will comprise evidence to support a, b, c and d progress or achievement. It should include: • 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.

    - The Midwife to birth ratio.

    - 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 on duty at the start of every shift and the provision of one-to-one care in active labour. Must include plan for mitigation/escalation to cover any shortfalls.

Verification process

Self-certification by the Trust Board and submission to NHS Resolution using the Board declaration form by **12 noon** on **3 March 2026**.

Relevant Time period

From 2 April 2025 to 30 November 2025

Link to technical guidance

Safety action 6: Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?

Required Standard
Provide assurance to the Trust Board and ICB that you are on track to achieve compliance with all six elements of the current version of SBLCB v3 through quarterly quality improvement discussions with the ICB.
Minimum Evidence Requirement for Trust Board
Trusts should be able to demonstrate that at least two (and up to three) quarterly quality improvement discussions have been held between the ICB (as commissioner) and the Trust. These discussions should include the following: • Details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element. • 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, neighbouring Trusts and NHS Futures where appropriate. *The Three-Year Delivery Plan for Maternity and Neonatal Services* set out that providers should fully implement Saving Babies Lives Version Three by March 2024. However, where full implementation is not in place, compliance can still be achieved if the ICB confirms it is assured that all best endeavours – and sufficient progress – have been made towards full implementation, in line with the locally agreed improvement trajectory. To support compliance, a national Implementation Tool is available for trusts to use if they wish on the Maternity Transformation Programme's Future NHS platform. If used, the tool can support providers to baseline current practice against SBLCBv3, agree a local improvement trajectory with their ICB, and track progress locally in accordance with that trajectory. Where Trusts are not using the Implementation Tool as evidence of compliance, they should provide a signed declaration from the Executive Medical Director declaring that Saving Babies' Lives Care Bundle, Version 3 is fully / will be in place as agreed with the ICB.
Verification process

Self-certification by the Trust Board and submission to NHS Resolution using the Board declaration form by **12 noon** on **3 March 2026**.
Relevant Time period
From 2 April 2025 to 30 November 2025

Link to technical guidance

Safety action 7: Listen to women, parents and families using maternity and neonatal services and coproduce services with users.

Required Standard

1. Trusts should work with their LMNS/ICB to 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 (published November 2023) including supporting:

   a) Infrastructure
   b) Strategic influence and decision-making.
   c) Engagement and listening to families.

2. Trusts should ensure an action plan is coproduced with the MNVP following annual CQC Maternity Survey data publication (due each January), including joint analysis of free text data, and progress monitored regularly by Safety Champions and LMNS Board.

Minimum Evidence Requirement for Trust Board

1.

a) Evidence of MNVP infrastructure being in place from your LMNS/ICB including all of the following:

- Job descriptions for MNVP team
- Contracts for service or grant agreements
- Budget with allocated funds for IT, comms, engagement, training and administrative support
- Local service user volunteer expenses policy including out of pocket expenses and childcare costs

If the above evidence of an MNVP, commissioned and functioning as per national guidance, is unobtainable, there should be evidence that this has been escalated via the Perinatal Quality Surveillance Model (PQSM) at trust, ICB and regional level.

If evidence for a) cannot be provided, then the escalation route must be followed as stated above.

Evidence requirements for b) and c) are only required if evidence has been provided for a)

b) Terms of Reference and evidence of attendance including minutes/action logs that show the MNVP Lead as a quorate member of trust governance, quality, and

safety meetings at speciality/divisional/directorate level including all of the following:

- Safety Champion meetings
- Maternity quality and safety meetings
- Neonatal quality and safety meetings
- PMRT review meeting
- Patient safety meeting
- Guideline committees

c) Evidence of MNVP engagement with local community groups and charities prioritising hearing from those experiencing the worst outcomes, as per the LMNS Equity & Equality plan.

2) Evidence of an action plan coproduced following joint review of the annual CQC Maternity Survey free text data which CQC have confirmed is available to all trusts free of charge.

Verification process

Self-certification by the Trust Board and submission to NHS Resolution using the Board declaration form by **12 noon** on **3 March 2026**.

Relevant Time period

From 2 April 2025 to 30 November 2025

Link to technical guidance

Safety action 8: Can you evidence the following 3 elements of local training plans and 'in-house', one day multi-professional training?

Required Standard
90% of attendance in each relevant staff group at: 1. Fetal monitoring training 2. Multi-professional maternity emergencies training 3. Neonatal resuscitation training See technical guidance for full details of relevant staff groups. ALL staff working in maternity should attend annual training. A 90% minimum compliance is required for every staff group by the end of the MIS year 7 period (30 November 2025). For rotational medical staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. A commitment and action plan approved by Trust Board must be formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust. It is important for units to continue to implement all six core modules of the Core Competency Framework, but this will not be measured in Safety Action 8.
Minimum Evidence Requirement for Trust Board
*See technical guidance for details of training requirements and evidence.
Verification process
Self-certification by the Trust Board and submission to NHS Resolution using the Board declaration form by **12 noon** on **3 March 2026**.
Relevant Time period
From 1 December 2024 to 30 November 2025

Link to technical guidance

Safety action 9: Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?

Required Standard

a) All Trust requirements of the Perinatal Quality Surveillance Model (PQSM) must be fully embedded with evidence of Trusts working towards the revised Perinatal Quality Oversight Model (PQOM) when published in 2025.

b) The expectation is that discussions regarding safety intelligence take place at the Trust Board (or at an appropriate sub-committee with delegated responsibility), as they are responsible and accountable for effective patient safety incident management and shared learning in their organisation. These discussions must include ongoing monitoring of services and trends, with evidence of reporting/escalation to the LMNS/ODN/ICB/ Local & Regional Learning System meetings.

c) All Trusts must have Maternity and Neonatal Board Safety Champions (BSC) who are actively supporting the perinatal leadership team in their work to better understand and craft local cultures.

Minimum Evidence Requirement for Trust Board

Evidence for point a) and b)

- Evidence that a non-executive director (NED) has been appointed and is working with the BSC to develop collaborative relationships between staff, the frontline Maternity, Neonatal and Obstetric Safety Champions, the Perinatal Leadership Team and the Trust Board to understand, communicate and champion learning, challenges, and best practice.

- Evidence that a review of maternity and neonatal quality and safety is undertaken by the Trust Board (or an appropriate Trust committee with delegated responsibility) using a minimum data set as outlined in the PQSM at least quarterly. This should be presented by a member of the **Perinatal leadership team** to provide supporting context. In line with the PQSM, this must include a review of thematic learning informed by PSIRF, training compliance, minimum staffing in maternity and neonatal units, and service user voice and staff feedback and review of the culture survey or equivalent.

- Evidence of collaboration with the LMNS/ODN/ICB lead(s), showing evidence of shared learning and how Trust-level intelligence is being escalated to ensure early action and support for areas of concern or need, in line with the PQSM.

- Evidence of ongoing engagement sessions with staff as previous years of the scheme. 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 1 July 2025.

- Evidence that in addition to the regular Trust Board/sub-committee review of maternity and neonatal quality as described above, the Trust's claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level Safety Champions at a Trust level (Board or directorate) meeting. Scorecard data is triangulated with other quality and safety metrics to inform targeted interventions aimed at improving patient safety and reflected in the Trusts Patient Safety Incident Response Plan. These quarterly discussions must be held at least twice in the MIS reporting period at a Board or directorate level quality meeting.

Evidence for point c):

Evidence that the Board Safety Champions are supporting their perinatal leadership team to better understand and craft local cultures, including identifying and escalating safety and quality concerns and offering relevant support where required. This will include:

- Evidence in the Trust Board minutes that Board Safety Champion(s) are meeting with the Perinatal Leadership Team and the MNVP lead (where their infrastructure is in, as per safety action 7 place) at a minimum of bi-monthly (a minimum of three in the reporting period) and that any support required of the Trust Board has been identified and is being implemented.
- Evidence in the Trust Board (or an appropriate Trust committee with delegated responsibility) minutes that progress with the maternity and neonatal culture improvement plan is being monitored and any identified support being considered and implemented.

Verification process
All criteria to be self-certified by the Trust Board and submitted to NHS Resolution using the Board declaration form by **12 noon** on **3 March 2026**.
Relevant Time period
From 2 April 2025 to 30 November 2025

Link to technical guidance

Safety action 10: Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigations (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 1 December 2024 to 30 November 2025

Required Standard
(A) Reporting of all qualifying cases to MNSI from 1 December 2024 to 30 November 2025. (B) Reporting of all qualifying EN cases to NHS Resolution's EN Scheme from 1 December 2024 until 30 November 2025. (C) For all qualifying cases which have occurred during the period 1 December 2024 to 30 November 2025, the Trust Board are assured that: i. the family have received information on the role of MNSI and NHS Resolution's EN scheme in a format that is accessible to them[1]; and 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. 1 https://www.england.nhs.uk/about/equality/equality-hub/patient-equalities-programme/equality-frameworks-and-information-standards/accessibleinfo/
Minimum Evidence Requirement for Trust Board
Trust Board sight of Trust legal services and maternity clinical governance records of qualifying MNSI/ EN incidents and numbers reported to MNSI and NHS Resolution. **Trust Board** sight of evidence that the families have received information on the role of MNSI and NHS Resolution's EN scheme. This needs to include reporting where families required a format to make the information accessible to them and should include any occasions where this has not been possible, with a SMART plan to address any challenges for the future. **Trust Board** sight of evidence of compliance with the statutory duty of candour.
Verification process
All criteria to be self-certified by the Trust Board and submitted to NHS Resolution using the Board declaration form by **12 noon** on **3 March 2026**. There is also an external verification process. MNSI will cross-check the National Neonatal Research Database (NNRD) and NHS Resolution will cross-check the NHS Resolution database for qualifying MNSI and EN incidents reportable from 1 December 2024 until 30 November 2025 and will externally verify that standards A and B have been met in the relevant reporting period.

In addition, for standard B and C(i) there is a requirement to complete the field on NHS Resolution's Claims Reporting Wizard (CMS), whether families have been advised of NHS Resolution's involvement, completion of this will also be monitored, and externally validated.
Relevant Time period
From 1 December 2024 to 30 November 2025

Link to technical guidance

Technical Guidance

Technical Guidance for Safety Action 1	
Further guidance and information is available on the PMRT website: Maternity Incentive Scheme FAQs. This includes information about how you can use the downloadable reports from the PMRT case management system to track your notifications, reviews and your progress throughout the year meeting Safety Action 1 standard: www.npeu.ox.ac.uk/pmrt/faqsmis These FAQs are also available on the MBRRACE-UK/PMRT reporting website www.mbrrace.ox.ac.uk	
SA 1(a) – Notify all eligible deaths	
1.Which perinatal deaths must be notified to MBRRACE-UK?	Details of which perinatal deaths must be notified to MBRRACE-UK are available at: www.npeu.ox.ac.uk/mbrrace-uk/perinatal-programme
2.Where are perinatal deaths notified?	Notifications of deaths must be made, and surveillance forms completed, using the MBRRACE-UK reporting website. It is planned that the Submit a Perinatal Event Notification (SPEN) system will be released by NHS England in 2025. Once this is released notifications of deaths must be made through SPEN and this information will be passed to MBRRACE-UK. It will still then be necessary for reporters to log into the MBRRACE-UK/PMRT system to provide the surveillance information, update the notification if required and to use the PMRT.
3.Should we notify babies who die at home?	Notification and surveillance information must be provided for babies who died after a home birth where care was provided by your Trust and those babies who die at home having been discharged from your Trust.
4.What is the time limit for notifying a perinatal death?	All perinatal deaths eligible to be reported to MBRRACE-UK, via SPEN when available, must be notified to MBRRACE-UK within seven working days.
5.What are the statutory obligations to notify neonatal deaths?	The Child Death Review Statutory and Operational Guidance (England) sets out the obligations of notification of neonatal deaths to local Child Death Overview Panels. Neonatal deaths must be notified to Child Death Overview Panels (CDOPs) within two working days of the death (where working days are regarded as Monday to Friday).

	This guidance is available at: https://www.gov.uk/government/publications/child-death-review-statutory-and-operational-guidance-england MBRRACE-UK is now the mechanism for reporting neonatal deaths to the relevant CDOP and the National Child Mortality Database (NCMD). The notification of a neonatal death to MBRRACE-UK will automatically be notified to the local CDOP and the NCMD.
SA 1(b) – Seek parents' view of care	
6.We have informed parents that a local review will take place and they have been asked if they have any feedback or questions about their care. However, this information is recorded in another data system and not the clinical records. What should we do?	In order that parents' feedback, perspectives, and any questions they have can be considered during the review, this information needs to be incorporated as part of the review and entered into the PMRT. So, if this information is held in another data system it needs to be brought to the review meeting, incorporated into the PMRT and considered as part of the review discussion. The importance of parents' feedback and perspectives is highlighted by their inclusion as the first set of questions in the PMRT. Materials to support parent engagement in the local review process are available on the PMRT website at: https://www.npeu.ox.ac.uk/pmrt/parent-engagement-materials
7.We have contacted the bereaved parents and they don't wish to have any involvement in the review process. What should we do?	Following the death of their baby, before they leave the hospital, all parents must be informed that a local review of their care and that of their baby will be undertaken by the Trust. In the case of a neonatal death parents should also be told that a review will be undertaken by the local CDOP. Verbal information should be supplemented by written information. The process of parent engagement should be guided by the parents. Not all parents will wish to provide their perspective of the care they received or raise any questions and/or concerns, but all parents should be given the opportunity to do so. Some parents may also change their mind about being involved and, without being intrusive, they should be given more than one opportunity to provide their feedback and raise any questions and/or concerns they may subsequently have about their care. Materials to support parent engagement in the local review process are available on the PMRT website at:

	https://www.npeu.ox.ac.uk/pmrt/parent-engagement-materials
8.Parents have not responded to our messages and therefore we are unable to discuss their feedback at the review. What should we do?	Following the death of their baby, before they leave the hospital, all parents should be informed that a local review of their care and that of their baby will be undertaken by the Trust. In the case of a neonatal death parents should also be told that a review will be undertaken by the local CDOP. Verbal information should be supplemented by written information. If, for any reason, this does not happen and parents cannot be reached after three phone/email attempts, send parents a letter informing them of the review process and inviting them to be in touch with a key contact, if they wish. In addition, if a cause for concern for the mother's wellbeing was raised during her pregnancy consider contacting her GP/primary carer to reach her. If parents do not wish to input into the review process, ask how they would like findings of the perinatal mortality review report communicated to them. Consider whether parental feedback could be impacted by communication barriers, such as reading level or their first language not being English. For some parents, it may be necessary to give them the opportunity to provide feedback via a number of different methods. Materials to support parent engagement in the local review process, including an outline of the role of key contact, are available on the PMRT website at: https://www.npeu.ox.ac.uk/pmrt/parent-engagement-materials PMRT parent materials have been translated into Welsh and the eleven most common languages spoken other than English. See the notes accompanying the flowchart as well as template letters and ensure engagement with parents is recorded within the parent engagement section of the PMRT.
SA 1(c) – Review the death and complete the review	
9.Which perinatal deaths must be reviewed to meet safety action one standards?	The following deaths should be reviewed to meet safety action one standards: i. Late miscarriages/ late fetal losses (22+0 to 23+6 weeks' gestation)

	ii. Stillbirths (from 24+0 weeks' gestation) iii. Neonatal death from 22 weeks' gestation (or 500g if gestation unknown) up to 28 days after birth While it is possible to use the PMRT to review post neonatal deaths (from 29 days after birth) this is NOT a requirement to meet the safety action one standard.
10.What is meant by "starting" a review using the PMRT?	Starting a review in the PMRT requires the death to be notified to MBRRACE-UK for surveillance purposes, and the PMRT to be used to complete the first review session (which might be the first session of several) for that death. As an absolute minimum all the 'factual' questions in the PMRT must be completed for the review to be regarded as started; it is not sufficient to just open and close the PMRT tool, this does not meet the criterion of having started a review. The factual questions are highlighted within the PMRT with the symbol: FQ If the PMRT is completed for the booking and antenatal management questions this will ensure that all the relevant factual questions have been answered.
11.What does "multi-disciplinary reviews" mean?	To be multi-disciplinary the team conducting the review should include at least one and preferably two of each of the professionals involved in the care of pregnant women and their babies. Ideally the team should also include an external member (see below). Bereavement care staff (Midwives and Nurses) should form part of the review team to provide their expertise in reviewing the bereavement and follow-up care, and advocate for the parents. Unless they have been specifically employed to do so, it should not be the responsibility of bereavement care staff to run the reviews, chair the panels nor provide administrative support. A list of the members needed to conduct a multi-disciplinary review is available here: https://www.npeu.ox.ac.uk/pmrt/implementation-support See www.npeu.ox.ac.uk/pmrt/faqsmis for more details about multi-disciplinary review.
12.Who can be an "external panel member"?	External panel member(s) should be relevant senior clinicians who are currently practicing clinically and work in a hospital external to the trust undertaking the review and external to any trust involved in the care at any stage.

	Their role is to be present at the review panel and actively participate in the review to provide a 'fresh pair of eyes', independent and robust view of the care provided. This may involve challenging the care that was provided. They should be from a relevant specialities (you may require more than one dependent on the details of the case) and should be senior enough to provide challenge where appropriate and should actively participate in the discussions about the care. If more than one Trust is involved in the review, because more than one Trust was involved in the care, none of these staff members are 'external' panel members because they do not provide an independent view of the care. They should not be listed as 'external' members in the participant list. Although the MNVP member (see SA7) may not be employed directly by the Trust they should not be regarded as, nor documented as, an 'external' member. They are present to represent the wider parent voice. To ensure that external members of the review panel are identified as such the 'participant' feature in the PMRT system has been modified so that this is clear. See www.npeu.ox.ac.uk/pmrt/faqsmis for more details of how to identify external participants.
13.What should we do if our post-mortem service has a long turn-around time or a Coronial post-mortem is likely to take a long time?	For deaths where a post-mortem (PM) has been requested (hospital or coronial) and is likely to take more than six months for the results to be available, the PMRT team at MBRRACE-UK advise that you should start the review of the death, complete and publish the report using the information you have available. When the PM results come back you should contact the PMRT team at MBRRACE-UK who will re-open the review so that the information from the PM can be included. Should the PM findings change the original review findings then a further review session should be carried out taking into account this new information. If you wait until the PM is available before starting a review you risk missing earlier learning opportunities, especially if the turn-around time is considerably longer than six months. Where the post-mortem turn-around time is quicker, then the information from the post-mortem can be included in the original review. Families should be kept informed throughout.

14.What is review assignment?	Where care has been provided in more than one Trust, ideally the review should involve all Trusts in a joint meeting. However, this is not always possible. A feature available in the PMRT is the ability to assign reviews to another Trust for review of elements of the care if some of the care for the women and/or her baby was provided in another Trust. For example, if the baby died in your Trust but antenatal care was provided in another Trust you can assign the review to the other Trust so that they can review the care that they provided. Following their review, the other Trust reassigns the review back to your Trust. You can then review the subsequent care your Trust provided. This avoids multiple, and potentially conflicting, reports being produced, the outcomes of which can be confusing for parents. Instead, a single report is produced, covering the care provided by all Trusts, which can then be summarised as a whole for parents.
15.How does 'assigning a review' impact on safety action 1, especially on starting a review?	If you need to assign a review to another Trust this may affect the ability to meet some of the deadlines for starting, completing and publishing that review. This will be accounted for in the PMRT verification process.
16.What should we do if we do not have any eligible perinatal deaths to review within the relevant time period?	If you do not have any babies that have died between 1 December 2024 and 30 November 2025 you should partner-up with a Trust with which you have a referral relationship to participate in case reviews. This will ensure that you benefit from the learning that arises from conducting reviews.
17.What deaths should we review outside the relevant time period for the Year 7 MIS?	Trusts should review all eligible deaths using the PMRT as a routine ongoing process, irrespective of the timeframe and verification process. Notification, provision of surveillance information and reviewing should continue beyond the deadline for completing the year 7 MIS requirements.
18.What happens when an MNSI (formerly HSIB) investigation takes place?	It is recognised that for a small number of deaths (term intrapartum stillbirths and early neonatal deaths of babies born at term) investigations will be carried out by MNSI (formerly HSIB). Your local review using the PMRT should be started (to identify any early and immediate learning which needs to be actioned) but not completed until the MNSI report is complete. You should consider inviting the MNSI reviewers to attend these reviews to act as external members of the review team, thereby enabling the

	learning from the MNSI review to be incorporated into the PMRT review. Depending upon the timing of the MNSI report completion achieving the standards for these babies may therefore be impacted by timeframes beyond the Trust's control. For an individual death you can indicate in the MBRRACE-UK/PMRT case management screen that an MNSI investigation is taking place, and this will be accounted for in the external verification process
SA 1(d) – Report to the Trust Executive Board	
19.Can the PMRT help by providing a quarterly report that can be presented to the Trust Executive Board?	Authorised PMRT users can generate reports for their Trust, summarising the results from completed reviews over a period of time defined by the user. These are available under the 'Your Data' tab in the section entitled 'Perinatal Mortality Reviews Summary Report and Data extracts'. These reports can be used as the basis for quarterly Trust Board reports and should be discussed with Trust Maternity Safety Champions.
20.Is the quarterly review of the Trust Executive Board report based on a financial or calendar year?	This can be either a financial or calendar year. Reports for the Trust Executive Board summarising the results from completed reviews over a period time can be generated within the PMRT, by authorised PMRT users, for a user-defined period of time. These are available under the 'Your Data' tab and the report is entitled 'Perinatal Mortality Reviews Summary Report and Data extracts'. Note that these reports will only show summaries, issues and action plans for reviews that have been completed and published, therefore the time period selected may need to relate to an earlier period than the current quarter and may lag behind the current quarter by up to six months.
Guidance – technical issues and updates	
What should we do if we experience technical issues using PMRT?	All Trusts are reminded to contact their IT department regarding any technical issue in the first instance. If this cannot be resolved, then the issue should be escalated to MBRRACE-UK. This can be done through the 'contact us' facility within the MBRRACE-UK/PMRT system or by emailing us at: mbrrace.support@npeu.ox.ac.uk

If there are any updates on the PMRT for the MIS**, where will they be published?**	Any updates on the PMRT or the MBRRACE-UK notification and surveillance in relation to the MIS safety action 1, will be communicated via NHS Resolution email and will also be included in the MBRRACE-UK/PMRT 'message of the day'.

Link to Safety Action 1

Technical Guidance for Safety Action 2	
For criteria 1 how is the measure constructed?	***Numerator***: Number of MSD401 records in the reporting period with a birth date in the reporting period, with a corresponding MSD405 record in the reporting period where a valid birthweight is recorded. ***Denominator***: Number of MSD401 records in the reporting period with a birth date in the reporting period.
What counts as valid birthweight recording in the MSD405CareActivityBaby table?	A valid birthweight record requires all three of the following: 1. An appropriate birthweight SNOMED code in the MSD405.ObsCode field (see metadata* for list of codes). 2. The numerical birthweight is recorded in the MSD405.ObsValue field. 3. The relevant unit ('G', 'KG', or 'Kilograms') is recorded in the MSD405.UCUMUnit field. The full metadata for this criteria can be found on the Metadata page in the Clinical Negligence Scheme for Trusts Scorecard
Where can I find out further technical information on the above metrics?	Technical information, including relevant MSDSv2 fields and data thresholds required to pass the above metrics can be accessed on NHS Digital's website In the "Meta Data" file (see 'construction' tabs) available within the Maternity Services Monthly Statistics publication series: https://digital.nhs.uk/data-and-information/publications/statistical/maternity-services-monthly-statistics
Where can I find out more about MSDSv2?	https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/maternity-services-data-set
Where should I send any queries?	**On MSDS data** For queries regarding your MSDS data submission, or on how your data is reported in the monthly publication series or on the Maternity Services DashBoard please contact maternity.dq@nhs.net. **For any other queries**, please email nhsr.mis@nhs.net

Link to Safety Action 2

Technical Guidance for Safety Action 3	
What is the definition of transitional care?	Transitional care is not a place but a service (see BAPM guidance) and can be delivered either in a separate transitional care area, within the neonatal unit and/or in the postnatal ward setting. Principles include the need for a multidisciplinary approach between maternity and neonatal teams; an appropriately skilled and trained workforce, data collection with regards to activity, appropriate admissions as per HRGXA04 criteria and a link to community services.
How can we evidence progress towards a transitional care service?	A current action plan with specified timescales and progress against these should be reviewed by the Trust and the neonatal ODN on behalf of the LMNS Boards before the 30 November 2025.
How do we identify our themes of unplanned term admissions?	All term admissions will be reported through DATIX/LFPSE (as per local implementation of PSIRF) and themes identified through this intelligence. ATAIN proforma reviews are no longer mandated.
Late preterm infants are now included- why?	Some units with an established transitional care service may choose to review reasons late preterm infants (34-36+6) are admitted to the neonatal unit (rather than to a transitional care unit). The focus of QI projects should be to reduce infant/mother separation. Routine review of admissions of late preterm infants is not required for this safety action.
Who should be involved in the quality improvement initiatives?	The team should include members of maternity and neonatal multidisciplinary team including liaising with service user representative (MNVP) and support sourced from Trust quality improvement and service improvement teams if required.
How do we register our quality improvement initiative?	This will vary depending on local Trust policy. In the absence of any Trust policy, evidence of registering the quality improvement initiative, could be documented in the Safety Champion minutes.

What is considered as evidence of an update on the quality improvement initiative?	Evidence should include: 1) a presentation to the LMNS which includes an aim statement, measures, change actions and outcomes. 2) Discussion with Safety Champions and noted in the minutes at least once before the end of the reporting period.
Can we continue the QI project commenced in year 6?	Yes, If the QI project undertaken in year 6 is felt to be progressing this safety action, it can continue to be used as a QI project for year 7. However, this should be discussed and agreed with the LMNS and Safety Champion In this case evidence should include 1. Presentation to the LMNS of progress at 6 months and at the end of the reporting period 2. Discussion with Safety Champions and noted in the minutes at least once before the end of the reporting period.
Where can we find additional guidance regarding this safety action?	https://www.bapm.org/resources/24-neonatal-transitional-care-a-framework-for-practice-2017 https://www.e-lfh.org.uk/programmes/avoiding-term-admissions-into-neonatal-units/ Implementing-the-Recommendations-of-the-Neonatal-Critical-Care-Transformation-Review-FINAL.pdf (england.nhs.uk) Framework: Early Postnatal Care of the Moderate-Late Preterm Infant | British Association of Perinatal Medicine (bapm.org) B1915-three-year-delivery-plan-for-maternity-and-neonatal-services-march-2023.pdf (england.nhs.uk) The Handbook of Quality and Service Improvement Tools: the_handbook_of_quality_and_service_improvement_tools_2010-2.pdf (england.nhs.uk)

Link to Safety Action 3

Technical Guidance for Safety Action 4	
a) Obstetric medical workforce guidance	
How can the Trust monitor adherence with the standard relating to short term locums?	Trusts should establish whether any short-term (2 weeks or less) tier 2/3 locums have been undertaken between February and August 2025. Medical Human Resources (HR) or equivalent should confirm that all such locums met the required criteria.
What should a department do if there is non-compliance i.e. locums employed who do not meet the required criteria?	Trusts should review their approval processes and produce an action plan to ensure future compliance.
Can we self-certify compliance with this element of safety action 4 if locums are employed who do not meet the required criteria?	No. An action plan must be developed to prevent this happening in the future, but Trusts would still need to declare non-compliance with this action.
Where can I find the documents relating to short-term locums?	All related documents are available on the RCOG safe staffing page. Safe staffing | RCOG
How can the Trust monitor adherence with the standard relating to long-term locums?	Trusts should use the monitoring/effectiveness tool contained within the guidance (p8) to audit their compliance for each new long-term locum who starts at the Trust over a 6-month period after February 2025 to 30 November 2025.
What should a department do if there is a lack of compliance demonstrated in the audit tool regarding the support and supervision of long-term locums?	Trusts should review their audits and identify where improvements to their process needs to be made. They should produce a plan to address any shortfalls in compliance and assure the Board this is in place and being addressed.
Can we self-certify compliance with this element of safety action 4 if long-term locums are employed	No.

who are not fully supported/supervised?	
Where can I find the documents relating to long-term locums?	All related documents are available on the RCOG safe staffing page. Safe staffing | RCOG
How can the Trust monitor adherence with the standard relating to Standard operating procedures for Consultants and SAS Doctors taking compensatory rest after non-resident on call?	Trusts should have documentary evidence of standard operating procedures and their implementation. Evidence of implementation/compliance could be demonstrated by obtaining feedback from Consultants and SAS doctors about their ability to take appropriate compensatory rest in such situations.
What should a department do if there is a lack of compliance, either no Standard operating procedure or failure to implement such that senior medical staff are unable to access compensatory rest?	Trusts should have a standard operating procedure document regarding compensatory rest. Trusts should identify any lapses in compliance and where improvements to their process needs to be made. They should produce a plan to address any shortfalls in compliance and have this as evidence that they are working towards compliance.
Can we declare compliance with this element of safety action 4 if we do not have a standard operating procedure or it is not fully implemented?	Yes. However, while this will not be measured in Safety Action 4 this year, it remains important for services to develop action plans to address this guidance.
Where can I find the documents relating to compensatory rest for Consultants and SAS Doctors?	All related documents are available on the RCOG safe staffing page. Safe staffing | RCOG
How can the Trust monitor adherence with the standard relating to Consultant attendance out of hours?	Departments can audit Consultant attendance for clinical scenarios or situations mandating their presence in the guidance. Trusts should audit any 3-month period from February 2025 to 30 November 2025 and must be compliant for at least 80% of applicable situations. Departments may also wish to monitor adherence via incident reporting systems.

	Feedback from departmental or other surveys may also be employed for triangulation of compliance.
What should a department do if there is non-compliance with attending mandatory scenarios/situations?	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.
Can we self-certify compliance with this element of safety action 4 if Consultants have not attended all clinical situations on the mandated list?	Yes, as long as compliance can be demonstrated for 80% of applicable clinical situations as detailed in the RCOG roles and responsibilities of the Consultant providing acute care in obstetrics and gynaecology RCOG workforce document.
Where can I find the roles and responsibilities of the Consultant providing acute care in obstetrics and gynaecology RCOG workforce document?	https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/
For queries regarding this safety action please contact: nhsr.mis@nhs.net (MIS Team) or workforce@rcog.org.uk (RCOG).	
b) Anaesthetic medical workforce guidance	
Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1	A duty anaesthetist is immediately available for the obstetric unit 24 hours a day. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patient in order to be able to attend immediately to obstetric patients.
c) Neonatal medical workforce guidance	
Do you meet the BAPM national standards of medical staffing depending on unit designation?	If not, Trust Board should agree an action plan and outline progress against any previously agreed action plans. There should also be an indication as to whether the standards are not met is due to insufficient funded posts or no trainee or/suitable applicant for the post (rota gap) alongside a record of the rota tier affected by the gaps.

	This action plan should be submitted to the LMNS and ODN.
BAPM BAPM_Service_Quality_Standards_FINAL.pdf (amazonaws.com)	
NICU **Neonatal Intensive Care Unit**	All staffing roles should be limited to neonatal care at all levels, i.e. no cross cover with general paediatrics. Trusts that have more than one NNU providing IC or HD care should have separate cover at all levels of medical staffing appropriate for each level of unit. **Tier 1** Rotas should be European Working Time Directive (EWTD) compliant and have a minimum of 8 WTE staff Units with more than 7000 deliveries should have more than one Tier 1 medical support **Tier 2** EWTD compliant rota with a minimum of 8 WTE staff NICUs undertaking more than 2500 IC days per annum should augment their Tier 2 medical cover (more than one staff member per shift) **Tier 3** Minimum of 7 WTE Consultants on the on-call rota with 24/7 availability of a Consultant Neonatologist NICUs undertaking more than 2500 IC days per annum should provide two Consultant led teams during normal working hours. Neonatal Consultant staff should be available on site in all NICUs for at least 12 hours a day,

	generally expected to include two ward rounds/handovers For units undertaking more than 4000 IC days per annum, consideration should be given to 24-hour Consultant presence All NICU Consultants appointed from 2010 should have CCT or equivalent in Neonatal Medicine.
LNU **Local Neonatal Unit**	Where LNUs have a very busy paediatric/neonatal service and/or have neonatal and paediatric services that are a significant distance apart, the above staffing levels should be enhanced. The threshold should be judged and monitored on clinical governance grounds such as the ability consistently to attend paediatric or neonatal emergencies immediately when summoned. Units with more than 7000 deliveries should have more than one Tier 1 medical support. **Tier 1** Rotas should be EWTD compliant and have a minimum of 8 WTE staff who do not cover general paediatrics in addition. **Tier 2** Shared rota with paediatrics as determined by a Trust or Health Board's annual NNU activity, comprising a minimum of 8 WTE staff. **Tier 3** Consultants should have a CCT in paediatrics or CESR in paediatrics or an equivalent overseas neonatal or paediatric qualification and substantial exposure to tertiary neonatal practice at least the equivalent of neonatal SPIN. At least one LNU Tier 3 Consultant should have either a CCT in neonatal medicine or neonatal SPIN module (if this was available during training). All Consultants covering the service must demonstrate expertise in neonatal care (based

	on training, experience, CPD and on-going appraisal).
SCU **Special Care Unit**	**Tier 1** Rotas should be EWTD compliant and have a minimum of 8 WTE staff who may additionally cover paediatrics if this does not reduce safety and quality of care delivery. There should be a resident Tier 1 practitioner dedicated to the neonatal service during weekday day-time hours and an immediately available resident Tier 1 practitioner 24/7. **Tier 2** Shared rota with paediatrics comprising a minimum of 8 WTE staff. Tiers 1 and/or 2 may be able to be covered by appropriately skilled nursing staff **Tier 3** A minimum of 7 WTE Consultants on the on-call rota with a minimum of 1 Consultant with a designated lead interest in neonatology. Tier 3 Consultants should have a Certificate of CCT in paediatrics or Certificate of Eligibility for Specialist Registration (CESR) in paediatrics or an equivalent overseas neonatal or paediatric qualification. They must demonstrate knowledge, skills and CPD appropriate for the level of neonatal care through annual appraisal. Minimum of 1 Consultant with a designated lead interest in neonatology, who should have completed a special interest (SPIN) module in Neonatology*. (if this was available during training)
Our Trust do not meet the relevant neonatal medical standards and in view of this an	There also needs to be evidence of progress against any previously agreed action plans. This will enable Trusts to declare compliance with this sub-requirement.

action plan, ratified by the Board has been developed. Can we declare compliance with this sub-requirement?	
When should the review take place?	The review should take place at least once during the MIS year 7 reporting period.
Which risk register should this be on?	This should be locally decided depending on individual provider arrangements to ensure regular progress and monitoring.
Please access the followings for further information on Standards	BAPM_Service_Quality_Standards_FINAL.pdf (amazonaws.com)
d) Neonatal nursing workforce guidance	
Where can we find more information about the requirements for neonatal nursing workforce?	Neonatal Nurse staffing standards are set out in the BAPM Service and Quality Standards (2022) service-and-quality-standards-for-provision-of-neonatal-care-in-the-uk The Neonatal Nursing Workforce Calculator (2020) should be used to calculate cot side care and guidance for this tool is available here: Guidance-for-Neonatal-Nursing-Workforce-Tool.pdf Access to the tool and more information will be available through your Neonatal ODN Education and Workforce Lead Nurse.
Our Trust does not meet the relevant nursing standards and in view of this an action plan, ratified by the Board has been developed. Can we declare compliance with this sub-requirement?	There also needs to be evidence of progress against any previously agreed action plans. This will enable Trusts to declare compliance with this sub-requirement.

Link to Safety Action 4

Technical Guidance for Safety Action 5	
What midwifery red flag events could be included in six monthly staffing report (examples only)? **We recommend that Trusts continue to monitor the red flags as per previous year and include those in the six-monthly report to the Trust Board, however this is currently not within the minimal evidential requirements but more a recommendation based on good practice.**	• Redeployment of staff to other services/sites/wards based on acuity. • Delayed or cancelled time critical activity. • Missed or delayed care (for example, delay of 60 minutes or more in washing or suturing). • Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication). • Delay of more than 30 minutes in providing pain relief. • Delay of 30 minutes or more between presentation and triage. • Full clinical examination not carried out when presenting in labour. • Delay of two hours or more between admission for induction and beginning of process. • Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output). • Any occasion when one Midwife is not able to provide continuous one-to-one care and support to a woman during established labour. Other midwifery red flags may be agreed locally. Please see the following NICE guidance for further details and definitions: safe-midwifery-staffing-for-maternity-settings-pdf-51040125637
Can the labour ward coordinator be considered to be supernumerary if for example they had to relieve staff for breaks on a shift?	A supernumerary coordinator must be allocated for every shift and must start each shift with protected supernumerary status. It is accepted that there may be short periods when the coordinator is temporarily unavailable due to rapidly changing acuity on the labour ward to ensure safety for women, families and staff in the department. The co-ordinator should exercise professional judgement and escalate, if covering for breaks creates a safety risk to other women on labour ward. As long as there is clear evidence that the local escalation policy has been initiated in these circumstances, and this

	is not a recurrent daily event, Trusts may declare compliance with this standard. If the co-ordinator is regularly required to cover for breaks (more than 2-3 times a week), the Trust should declare non-compliance with the standard and include actions to address this specific requirement going forward in their action plan mentioned in the section above.
What if we do not have 100% supernumerary status for the labour ward coordinator?	An action plan should be produced detailing how the maternity service intends to achieve 100% supernumerary status for the labour ward coordinator which has been signed off by the Trust Board and includes a timeline for when this will be achieved.
What if we do not have 100% compliance for 1:1 care in active labour?	An action plan detailing how the maternity service intends to achieve 100% compliance with 1:1 care in active labour has been signed off by the Trust Board and includes a timeline for when this will be achieved. Completion of the action plan will enable the Trust to declare compliance with this sub-requirement.
What if we have been unable to complete a BirthRate+ review within three years due to measure outside the Trust's control?	If this process was commenced but has not been completed within three years due to measures outside the Trust's control, evidence of communication with the BirthRate+ organisation (or equivalent) should demonstrate this.
What should we do if we disagree with the findings of a BirthRate+ review for our circumstances?	BirthRate+ encourages the use of professional judgement in the final determination of maternity safe staffing levels in line with the safe staffing guideline. Professional judgment on safe staffing numbers / levels is the responsibility of the Director of Midwifery / Head of Midwifery, and any deviation from the findings of the BirthRate+ (or equivalent) should be highlighted and clearly documented in the midwifery staffing oversight report that is shared with Board.

Link to Safety Action 5

Technical Guidance for Safety Action 6	
Where can we find guidance regarding this safety action?	Saving Babies' Lives Care Bundle v3: saving-babies-lives-version-three/ An implementation tool is available for trusts to use if they wish at future.nhs.uk/SavingBabiesLives and includes a technical glossary for all metrics and measures. For any further queries regarding the bundle or tool, please email england.maternitytransformation@nhs.net Any queries related to MSDS issues for this safety action can be sent to NHS Digital mailbox maternity.dq@nhs.net. Some data items are (or will later become available) on the National Maternity Dashboard (Element 1); from NNAP Online (Element 5); and from NPID (Element 6). For any other queries relating to MIS compliance, please email nhsr.mis@nhs.net
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. Where MSDS does not capture all process and outcome indicators given in the care bundle, this is indicated in the Implementation Tool.
What percentage performance is required to be compliant for a given intervention?	Where element process and outcome measures are listed in the evidence requirement of the SBLCB V3 a performance threshold is recommended. However, LMNS/ICBs are able to agree local performance thresholds with a provider in view of local circumstances, and the agreed local improvement trajectory.
How do we provide evidence for the interventions that have been implemented?	Trusts will need to verify with their LMNS/ICB that they have an implemented service locally.
Will the eLfH modules be updated in line with SBLCBv3?	The SBL e-learning for health modules have all been updated to reflect the changes in version 3. A new module for element 6 has also now been developed and published on the e-learning for health site.

Link to Safety Action 6

Technical Guidance for Safety Action 7	
What is the Maternity and Neonatal Voices Partnership?	An MNVP listens to the experiences of women, birthing people and families, and brings together service users, staff and other stakeholders to plan, review and improve maternity and neonatal care. MNVPs ensure that service user voice is at the heart of decision-making in maternity and neonatal services by being embedded within the leadership of provider Trusts and feeding into the local maternity and neonatal system (LMNS). MNVPs ensure service user voice influences improvements in the safety, quality and experience of maternity and neonatal care.
How do we know our MNVP is in line with guidance?	NHS England have published supporting materials including a case study and FAQ for working in line with the guidance here.
We are unsure about the funding for Maternity and Neonatal Voices Partnerships	It is the responsibility of ICBs to: Commission and fund MNVPs, to cover each Trust within their footprint, reflecting the diversity of the local population in line with the ambition above.
What does evidence of MNVP engagement look like?	Engagement can include lots of different methods as detailed in the MNVP Guidance under the section *Engagement and listening to families*. Evidence for this includes: • 15 Steps for Maternity and Neonatal report • MNVP Annual Report • Engagement reports • Expenses paid to service users • List of organisations engaged • Online surveys and feedback mechanisms • Analysis of surveys by demographics of respondents
Why have we removed the need to show evidence of engagement and strategic influence if MNVP infrastructure is not in place?	To enable meaningful, trauma-informed engagement with women and families and to act on what is heard, it is essential that MNVP infrastructure i.e. an adequately funded, employed, trained and supported MNVP team, is in place first. This change reflects feedback from MNVPs who are not adequately resourced to carry out their expected functions in line with the MNVP Guidance.
Why is escalation required where an MNVP is not commissioned and functioning in line with guidance and	Where an MNVP is not adequately funded by the ICB to carry out its functions, there is a risk that Trusts are not adequately listening and acting on safety concerns raised by women and families. Therefore, the Trust must escalate via PQSM to resolve.

what should this look like?	ICBs are expected to develop an action plan with the Trust in response to the escalation and monitor progress through agreed governance processes and via a risk register. Trusts should put mitigating actions in place to listen and coproduce with women and families proportionate to MNVP resourcing available until the MNVP is commissioned in line with guidance. MNVPs are required to be commissioned and function in line with the MNVP Guidance by the end of the Three-Year Delivery Plan (March 26) therefore this will be an expectation for all organisations after this time.

Link to Safety Action 7

Technical Guidance for Safety Action 8	
How will the 90% attendance compliance be calculated?	The training requires 90% attendance of relevant staff groups by the end of the 12-month MIS period at: 1. Fetal monitoring training 2. Multi-professional maternity Emergencies training 3. Neonatal resuscitation Training
Which maternity staff should be included for Fetal monitoring and surveillance (in the antenatal and intrapartum period)?	Staff who have an intrapartum obstetric responsibility (including antenatal and triage) must attend the fetal surveillance training. Maternity staff attendees must be 90% compliant for each of the following groups to meet the minimum standards: • Obstetric Consultants and SAS Doctors. • All other Obstetric Doctors contributing to the obstetric rota (without the continuous presence of an additional resident tier Obstetric Doctor). • Midwives (including Midwifery Managers and Matrons, Community Midwives; Birth Centre Midwives (working in co-located and standalone birth centres and bank/agency midwives). Maternity Theatre Midwives who also work outside of theatres. Staff who do not need to attend include: • Anaesthetic staff • Maternity Critical Care staff (including Operating Department Practitioners, Anaesthetic Nurse Practitioners, Recovery and High Dependency Unit Nurses providing care on the maternity unit) • MSWs • GP and Foundation Level Trainees
Which maternity staff should be included for Maternity emergencies and multi-professional training?	Maternity staff attendees must include 90% of each of the following groups to meet the minimum standards: • Obstetric Consultants and SAS Doctors. • All other Obstetric Doctors including Obstetric Trainees (ST1-7), Sub Speciality Trainees, Locally Employed Doctors (LED), Foundation Year Doctors and GP Trainees contributing to the obstetric rota. • Midwives (including Midwifery Managers and Matrons), Community Midwives; Birth Centre Midwives (working in co-located and standalone birth centres) and bank/agency Midwives. • Maternity Support Workers and Health Care Assistants (to be included in the maternity skill drills as a minimum). • Obstetric Anaesthetic Consultants and autonomously practising Obstetric Anaesthetic Doctors.

	• All other obstetric anaesthetic doctors (staff grades and anaesthetic trainees) who contribute to the obstetric rota. This updated requirement is supported by the RCoA and OAA. • Maternity theatre staff are a vital part of the multidisciplinary team and are encouraged to attend the maternity emergencies and multiprofessional training, however they will not be required to attend to meet MIS year 7 compliance assessment. • Neonatal staff are a vital part of the multidisciplinary team and are encouraged to attend the maternity emergencies and multiprofessional training, however there will be no formal threshold for attendance required to meet MIS year 7 compliance. At least one emergency scenario/drill should be conducted in a clinical area during the whole MIS reporting period, ensuring attendance from the relevant wider professional team, including theatre staff and neonatal staff. The clinical area can be any area where clinical activity takes place e.g. Delivery Suite, Clinic, A&E, theatre, a ward. This should not be a simulation suite.
Training attendance for agency staff	It is the responsibility of the employing agency to provide training for staff, so these staff will not be included in your MIS declaration. However, it is the responsibility of the Trust to ensure that all agency staff have met minimum training requirements before working in the Trust.
Long-term sickness and maternity leave	Any staff absent from work due to long-term sickness (>28 days) or on maternity / parental leave (28 days) will be unable to work clinically or attend training while absent, so these staff will not be included in your MIS declaration while they are absent from work, and for one month after their return. These staff should be prioritised to attend any outstanding training as soon as possible on their return.
Training attendance for rotational medical staff	It is the gold standard that all staff attend training in the unit that they are currently working in, so that they can benefit from local learning and training alongside their multi-disciplinary colleagues, however it is appreciated that this may be especially challenging for rotational staff. In the following circumstances, evidence from rotating resident doctors having completed their training in another maternity unit will be accepted: • Staff must be on rotation.

	• The training must have taken place in any previous Trust on their rotation during the MIS training reporting 12-month period. • Rotational posts must be shorter than 12 months. This evidence may be a training certificate or correspondence from the previous maternity unit. For rotational medical staff that commenced work on or after 1 July 2025 a lower compliance will be accepted. A commitment and action plan must be approved by Trust Board and formally recorded in Trust Board minutes to ensure every staff member has attended all required training within a maximum 6-month period from their start-date with the Trust (but ideally much sooner).
Does the multidisciplinary obstetric emergency training have to be conducted in the clinical area?	Ideally at least one emergency scenario should be conducted in any clinical area as part of each emergency training day. You should aim to ensure that all staff attending emergency training participate in an emergency scenario that is held in a clinical area, but this will not be measured in year 7 of MIS.
Which staff should be included for neonatal resuscitation training?	The staff listed below are required to attend neonatal resuscitation training within MIS year 7: • Neonatal Consultants/SAS Doctors or Paediatric Consultants/SAS Doctors covering neonatal units. • Neonatal resident Doctors (who attend any births) • Neonatal Nurses (Band 5 and above) • Advanced Neonatal Nurse Practitioner (ANNP) • Midwives (including Midwifery Managers and Matrons), Community Midwives, Birth Centre Midwives (working in co-located and standalone birth centres) and bank/agency Midwives. The staff groups below are not required to attend in-house neonatal resuscitation training within this MIS year: • Staff who have already attended a neonatal resuscitation training course consistent with BAPM basic capability Neonatal Airway Capability or above (including external courses such as NLS) during MIS year 7 • NLS instructors that have taught on a course during MIS year 7

	• All Obstetric and Anaesthetic Doctors (Consultants, SAS, LE Doctors and Anaesthetic Trainees) contributing to the obstetric rota. • Maternity Critical Care staff (including Operating Department Practitioners, Anaesthetic Nurse Practitioners, Recovery and High Dependency Unit Nurses providing care on the maternity unit). • Local policy should determine whether Maternity Support Workers are included in basic neonatal resuscitation dependant on their role within the service. • If Nursery Nurses work within the service, this should also be recognised in your local training needs analysis.
Which members of the team can teach basic neonatal resuscitation?	Registered RC-trained NLS instructors should deliver the in-house neonatal resuscitation training annual updates.
What do we do if we do not have enough instructors who are trained as an NLS instructor?	Your Neonatal Consultants and Advanced Neonatal Practitioners (ANNP) will be qualified to deliver the training. You can also liaise with your LMNS to explore sharing of resources. It is recognised that for smaller hospitals, such as those with Special care units, there may be difficulty in resourcing qualified trainers. These units must provide evidence to their Trust Board that they are seeking mitigation across their LMNS and an action plan to work towards qualified NLS instructor status. As a minimum, training should be delivered by someone who holds a valid NLS certificate. Please see the RCUK website for the latest guidance regarding NLS GIC training
Who should attend additional neonatal resuscitation training (such as NLS)?	*A minimum of 90% of paediatric/neonatal staff **who attend neonatal resuscitations unsupervised** should have been trained and assessed in line with the guidance below.* *In line with* The British Association of Perinatal Medicine Neonatal Airway Safety Standard Framework for Practice *(April 2024)* *All neonatal staff undertaking responsibilities as an **unsupervised** first attender / primary resuscitator attending any birth must have reached a minimum of 'basic capability' as described in the BAPM Neonatal Airway Capability Framework.* *No specific training course is mandated. However, the Resuscitation Council UK Neonatal Life Support (NLS) provider certification includes all skills required*

	for Basic capability and most skills required for Standard capability. Staff that attend births **with supervision at all times** will not need to complete this assessment process for the purpose of MIS compliance.
The Core Competencies TNA suggests periods of time for each element of training, e.g. 9 hours for fetal monitoring. Is this a mandated amount of time?	We envisage that the fetal monitoring and obstetric emergencies training will require 1 whole day each. The hours for each element of training can be flexed by the individual Trust in response to their own local learning needs.

Link to Safety Action 8

Technical Guidance for Safety Action 9	
Where can I find additional resources?	NHS England, Perinatal Quality Surveillance Model PSIRF (Patient Safety Incident Response Framework) Maternity and Neonatal Safety Champions Toolkit September 2020 (england.nhs.uk) NHS England » Maternity and Neonatal Safety Improvement Programme The Safety Culture - Maternity & Neonatal Board Safety Champions - FutureNHS Collaboration Platform workspace is a dedicated place for Non-Executive Director and Executive Director maternity and neonatal Board Safety Champions to access the culture and leadership programme, view wider resources and engage with a community of practice to support them in their roles. The Perinatal Culture and Leadership Programme - Maternity Local Transformation Hub - Maternity (future.nhs.uk) is a dedicated space for NHS England's Perinatal Culture and Leadership Programmes, with resources for senior leaders and their teams to support local safety culture work.
Perinatal Leadership Team	
Who is the Perinatal Leadership team and are they different to the Quad?	For the purposes of this safety action, the definition of the Perinatal Leadership Team as described in this document, (also known as the 'Quad') consists of neonatal, obstetric, midwifery and operational leads as a minimum. We recognise there may be additional maternity and neonatal leaders as designated by the Trust, for example a Neonatal Nurse Lead, Anaesthetic Lead or service user / MNVP who may form part of the Perinatal Leadership Team.
Perinatal Quality Surveillance / Oversight Model	
What is the expectation around the Perinatal Quality Surveillance Model?	The Perinatal Quality Surveillance Model (PQSM) must be reviewed and the local governance for sharing intelligence checked, and when needed, updated. • Describe the local governance processes in place to demonstrate how intelligence is shared from the ward to Board. • Formalise how Trust-level intelligence will be shared and escalated with the LMNS/ICB/ODN quality group and from there with regional quality groups which will

	include the Regional Chief Midwife and Lead Obstetrician. • Review the involvement of service user voice leadership in perinatal quality oversight processes and ensure alignment with PQSM A revised version of the PQSM model, to be known as the Perinatal Quality Oversight Model (PQOM) is due to be published in 25/26. Trusts are expected to work to fully embed the PQSM model and evidence work towards implementation of the revised PQOM.
Reporting to Trust Board	
Why has the frequency of the requirement to report to Board changed to quarterly?	To facilitate meaningful discussion, review of data and action, Trusts will now be required to report to their Board at least quarterly. This change reflects feedback received during the development this safety action. Trust board meeting schedules vary and a requirement to report at every meeting may not allow for meaningful discussion and action. Where Trusts are currently reporting to their board more frequently, there is no requirement to reduce the frequency to quarterly. Trusts are encouraged to determine locally if there is a need to report to the Board more frequently.
What do we need to include in the report presented to Board each quarter?	The report should be locally produced as set out in PQSM appx 1. It should include themes identified in line with PSIRF, and actions being taken to support; SUV feedback; staff feedback from frontline Champions' engagement sessions; minimum staffing in maternity and neonatal services and training compliance. Themes and progress with culture improvement plans following local cultural surveys or equivalent should also be included. This may include the SCORE culture survey, any subsequent local culture surveys or qualitative insight, the NHS staff survey, NHS pulse survey, focus groups or suitable alternative. The report can also include additional measures as agreed by the Trust.
What constitutes a Trust Board, can sub committees be categorised as a Board?	In year 6 the standard was updated to reflect that an appropriate Trust Board sub-committee, chaired by a Trust Board member, can be delegated to undertake the monthly review of perinatal safety intelligence reporting. If a sub-committee of the Board undertakes this work, an exception report or highlight report must still be provided to the Board

	including the minimum data set as outlined in the PQSM, and there should be evidence of discussion in the Board minutes.
Culture Surveys	
What is the expectation for Trusts to undertake culture surveys?	Every maternity and neonatal service across England will have participated in the Perinatal Culture and Leadership Programme between 2022-2025. As part of this programme every service completed work to meaningfully understand the culture of their services. This diagnostic was either a SCORE culture survey or an alternative as agreed with the national NHSE team. Diagnostic insights and plans for improvement were to be shared with the Trust Board to enable an understanding and garner support for the work to promote optimal safety cultures, based on the diagnostic findings. The expectation is that all maternity and neonatal services continue paying attention to local cultures and work with their Patient Safety Collaboratives to do this, including considering appropriate interventions to support culture change. The improvement plan should evolve over time in response to updated data and insight and is not something that will ever be 'completed' as culture is ever evolving.
What if our maternity and neonatal services did not undertake the SCORE culture survey as part of the national programme?	The national offer to undertake a SCORE culture survey was a flexible, opt out offer. If your maternity and neonatal services demonstrated that they were already completing work to meaningfully understand local culture, and therefore opted out of the SCORE survey, the expectation is that the Board receives updates on this alternative work. It is important culture improvement work does not stop after formal participation in the national Perinatal Culture and Leadership Programme. The expectation is Trusts work with their Patient Safety Collaboratives to use other data sources, such as the NHS Staff Survey, Pulse Survey's, or suitable local alternatives to continue evolving local culture improvement plans.
Perinatal Culture and Leadership Programme	
Who is expected to have undertaken the Perinatal Culture and Leadership programme?	Senior perinatal leadership teams from all Trusts that have a maternity and neonatal service in England have undertaken the PCLP. This will be representation from the midwifery, obstetric, neonatal, and operational professional groups, usually consisting of the DoM/HoM, Clinical Lead / CD for obstetrics, Clinical Lead for neonates and the Operational Manager.

Safety Champions	
What is the rationale for the Board level Safety Champion safety action?	It is important to ensure all staff are aware of who their frontline and Board Safety Champions are if concerns are to be actively shared. Sharing of insights and good practice between providers, their LMNS, ODN, ICS and regional quality groups should be optimised. The development of a local pathway which describes these relationships, how sharing of information will take place and names of the relevant leaders, will support this standard to realise its aims. The guidance in the link below will support the development of this pathway. Maternity-and-Neonatal-Safety-Champions-Toolkit--2020.pdf
Do both the NED and Executive BSC and all members of the Perinatal Leadership team have to be present at each meeting?	Ideally the meeting would have both Board Safety Champions (BSC) and at least two members of the Perinatal Leadership Team present. If this is not always possible, it would be appropriate for either the Executive or NED BSC and at least one member of the Perinatal Leadership Team to be present, However, the expectation is that each professional group is represented throughout the year, and that the nominated member attending brings all four voices to the conversation. The MNVP play a vital role in developing maternity and neonatal services. Where the infrastructure is in place, MNVP leads should be embedded within the providers leadership team. As stated in SA7 they should be a quorate member of this meeting, sending a deputy member of their team when required. As per SA7, If evidence of an appropriately funded MNVP is not in place and there are meetings when the MNVP is not consistently represented, this should be escalated to Trust board, ICB quality board and regional perinatal team. If quoracy for the meeting is not achieved, Trust's will need to show evidence of how their board safety champions are hearing the voice of families and using this to inform decision making.
What are the expectations of the NED and Exec Board Safety Champion in relation to their support for the Perinatal Culture and Leadership	As detailed in previous year's MIS guidance, regular engagement between Board Safety Champions and senior perinatal leadership teams provides an opportunity to share safety intelligence, examples of best practice, identified areas of challenge and need for support. The meetings should be conducted in an appreciative way, with the perinatal teams being open and transparent and the Board Safety Champions being curious and supportive.

Programme (PCLP), culture surveys and ongoing support for the Perinatal Leadership teams?	
What should be discussed at the bi-monthly meetings between the Board Safety Champion(s) and the Perinatal Leadership teams?	As a minimum the bi-monthly meetings should include the following content: - Ongoing Learning from the Perinatal Culture and Leadership Development Programme and how they are using this locally. - How they plan to continue being curious about their local culture. This may be in the form of pulse surveys, or team check ins. - Progress with interventions relating to culture improvement work, and any further support required from the Board. - Feedback on the support being provided by the Patient Safety Collaboratives - Discussion of any themes from patient feedback, MNVP and complaints. - Escalation and oversight of any concerns or issues raised by staff and resulting actions - Oversight of compliance and progress with CNST, CQC action plans, Ockenden, Kirkup etc
Do the non-executive and executive maternity and neonatal Board Safety Champion have to register to the dedicated FutureNHS workspace to access the resources available this year?	We encourage all NED and Exec Board Safety Champions to register on the Future NHS Safety Culture - Maternity & Neonatal Board Safety Champions - FutureNHS Collaboration Platform workspace. New content and resources are added throughout the year, and we would encourage all BSC's to continue to access the page to benefit from these. You can also reach out to other Board Safety Champions and develop your own community of peer support. However, this will not be a formal requirement in year 7 of the MIS.
We have not continued to undertake feedback	Parts a) and b) of the required standard builds on the previous year requirements of the MIS in building visibility and creating the conditions for staff to meet and establish a relationship with their Board level Safety Champions to raise

sessions with the Board Safety Champion, what should we do?	concerns relating to safety and identify any support required from the Board. Evidence of quarterly staff engagement sessions will need to be provided covering this reporting period, it is expected that there will be at least quarterly sessions organised and widely advertised to staff. This may include the sessions being visible in wards and notice boards. Staff should be supported to engage with these sessions as freely as possible and a record of feedback and actions made available to all staff after the session Part b) requires that progress with actioning named concerns from staff feedback sessions are visible. This builds on requirements made in year three and four of the MIS and the expectation is that this should have been continued.
We are a Trust with more than one site. Do we need to complete the same frequency of engagement sessions in each site as a Trust on one site?	Yes. The expectation is that the same number of engagement sessions are completed at each individual site on a quarterly basis.
What are the expectations of the Board safety Champions in relation to quality improvement work undertaken by the Maternity and Neonatal Quality Improvement Programme?	The Board safety Champions will be expected to continue their support for continuous quality improvement by working with the designated improvement leads to participate and mobilise improvement via the MatNeo Patient Safety Collaboratives. Trusts will be required to undertake improvement including data collection and testing work aligned to the national priorities.
Scorecards	
Where can I find more information re my Trust's scorecard?	More information regarding your Trust's scorecard can be found here.
Why do we need to review the scorecard	The scorecard is a quality improvement tool that provides insight into claims in support of clinical governance and quality assurance in your organisation. It provides details of

quarterly alongside current complaint and incident data?	all CNST claims, combined with data from the EN scheme and can provide a full picture of maternity related claims in your organisation. The scorecard provides 10 years of claims experience allowing the impact of clinical effectiveness and safety interventions to be assessed over time. It should be reviewed alongside other data sets to provide a fuller picture of safety. It highlights themes occurring in claims which can be addressed through staff education and training. The scorecard provides a number of speciality filtered views allowing quick access to the relevant data for your division/speciality. Where data sharing agreements exist, members may share scorecard data to support learning across partnerships, networks and regions. The safety and learning team at NHS Resolution can support you in accessing and using your scorecard, nhsr.safety@nhs.net . A short video on using your scorecard can be found here Videos (resolution.nhs.uk) (Extranet login required). The GIRFT/NHS Resolution Learning from Litigation Claims can be found here Best-practice-in-claims-learning-FINAL.pdf (gettingitrightfirsttime.co.uk) and includes advice on engaging with NHS Resolution Safety and Learning resources, including the scorecard.
Examples have been requested for the scorecards.	The key to making this exercise meaningful is the triangulation of the data. Categorisation of the historical claims on the scorecard and any action taken, then presenting these alongside current incidents and complaints. This allows identification of potential themes or trends, identification of the impact of any learning, and allows you to act quickly if any historical themes re-emerged. NHS Resolution have developed an example template to share, and this can be accessed via the FutureNHS platform Maternity Incentive Team workspace, or the MIS Team can send a copy out on request. NHS Resolution staff are always happy to talk through this process if it is helpful.

Link to Safety Action 9

Technical Guidance for Safety Action 10	
Where can I find information on MNSI?	Information about MNSI and maternity investigations can be found on the MNSI website https://mnsi.org.uk
Where can I find information on the Early Notification scheme?	Information about the EN scheme can be found on the NHS Resolution website: • EN main page • Trusts page • Families page
What are qualifying incidents that need to be reported to 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: (i) when the baby was therapeutically cooled (active cooling only), or (ii) has been diagnosed with moderate to severe encephalopathy, consisting of altered state of consciousness (lethargy, stupor or coma) and at least one of the following: (aa) hypotonia; (bb) abnormal reflexes including oculomotor or pupillary abnormalities; (cc) absent or weak suck; (dd) clinical seizures Trusts are required to report their qualifying cases to MNSI via the electronic portal. Once 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 severe brain injury. * This definition was updated from 1 October 2023. Please see our website for further information, this does not change the cases referred to MNSI.
What is the definition of labour used by MNSI and EN?	The definition of labour used by MNSI and EN 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.
Current reporting requirements to MNSI and NHS Resolution	Trusts are required to report their qualifying cases to MNSI via their reporting portal. In addition, Trusts are required to notify to NHS Resolution, via the Claims Reporting Wizard of qualifying EN cases once MNSI have confirmed they are progressing an investigation due to clinical or MRI evidence of severe brain injury. The Trust must input the MNSI reference number to confirm the investigation is being undertaken by MNSI (otherwise it is rejected). Trusts must also use the EN report form: EN-Report-Form.pdf. Please select Sangita Bodalia, Head of Early Notification (legal) at NHS Resolution on the Claims Reporting Wizard. Once the MNSI final 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. We strongly advise making a note of the Claims Management System (CMS) reference number received once the matter is reported, as this will be confirmation that the case has been successfully reported to NHS Resolution.
Reporting when Submit Perinatal Event Notification (SPEN) is introduced	When the new single reporting system also known as Submit Perinatal Event Notification (SPEN) is implemented (expected sometime in 2025) then Trusts will be required to report eligible cases for MNSI and NHS Resolution via the Submit Perinatal Event Notification (SPEN). Further information will be shared once there is an implementation date for SPEN.
What qualifying EN cases need to be reported to NHS Resolution?	• Trusts are required to report cases to NHS Resolution where MNSI are progressing an investigation i.e. those where there is clinical or MRI evidence of severe brain injury and have a confirmed reference number. • Where a family have declined a MNSI investigation, but have requested an EN investigation, the case should also be reported to NHS Resolution and advised of this reason for reporting. There is more information here: ENS Reporting Guide - December 2023 (for Member Trusts) - NHS Resolution

Cases that do not require to be reported to NHS Resolution	• Cases where families have requested a MNSI investigation where the baby has a normal MRI. • Cases where Trusts have requested a MNSI investigation where the baby has a normal MRI. • Cases that MNSI are not investigating.
What if we are unsure whether a case qualifies for referral to MNSI or NHS Resolution?	If a baby has a clinical or MRI evidence of severe brain injury and the case is being investigated by MNSI because of this, then the case should also be reported to NHS Resolution via the Claims Reporting Wizard along with the MNSI reference number (document the MNSI reference in the "any other comments box").
Who should we contact if we have any queries?	Please contact a member of the Early Notification team to discuss further (nhr.enteam@nhs.net) or MNSI maternity team maternityadmins@mnsi.org.uk.
Candour	Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 provides that a health service body must act in an open and transparent way with relevant persons in relation to care and treatment provided. Regulation 20 In accordance with the statutory duty of candour, in all relevant cases, families should be 'advised of what enquiries in relation to the incident the health body believes are appropriate' – 20(3)(a) and details of any enquiries to be undertaken (20)(4)(b). This includes details of enquiries undertaken by MNSI and NHS Resolution. Assistance can be found on NHS Resolution's website, including the guidance 'Saying Sorry' as well as an animation on 'Duty of Candour' Trust Boards should be aware that if a breach of the statutory duty of candour in relation to a qualifying case comes to light which calls the validity of certification into question this may result in a review of the Trust submission and in addition trigger escalation to the CQC.
Will we be penalised for late reporting?	Trusts are strongly encouraged to report all qualifying cases to MNSI as soon as they occur and to NHS Resolution as soon as MNSI have confirmed that they are taking forward an investigation. NHS Resolution recommend that you report within

	14 days, as this enables NHS Resolution to initiate processes in relation to family engagement. Trusts will meet the required standard if they can evidence to the Trust Board that they have reported all qualifying cases to MNSI and where applicable, to NHS Resolution and this is confirmed with data held by NNRD and MNSI and NHS Resolution. Where qualifying cases are not reported within two years from the date of the incident, these cases will no longer be eligible for investigation under the Early Notification scheme. Please inform NHS Resolution EN team if this occurs.
What do you mean by accessible format?	A holistic view of the family needs should be considered. Accessibility can include (but is not limited to) language, easy read, digital versus printed versions
What happens if we are not able to provide accessible information to the family?	We encourage you to explore options to support the provision of accessible information, and onward escalation where needed. MNSI have initial referral cards and family information available in multiple languages. If the language requested is not available MNSI will translate into the language required. These can be provided on request from your maternity investigator by the Trust. The Board report should outline any occurrences where accessible information could not be provided, reasons and a SMART action plan to address any challenges for the future.
If we are unable to provide information in an accessible way, will we fail the safety action?	You will be able to pass the safety action as long as a SMART action plan has been developed to support addressing any challenges for the future.
Are there any resources from MNSI and NHSR that we can use?	NHS Resolution have produced an animation for families which can be accessed here: Early Notification Scheme animation on Vimeo There is also a page on the NHS Resolution website: Support for families or carers - NHS Resolution MNSI have a family page on their website: For families

Link to Safety Action 10

MIS Year 7 FAQ	
What do you mean by Trust Board?	Unless explicitly stated, Trust Board can be interpreted as 'the Trust Board or appropriate sub-committee with delegated authority' as long as these sub-committees provide Trust Board with output following their review and discussion.
Why aren't we reporting everything directly to Trust Boards?	Trust Boards have a broad scope of responsibility, covering all aspects of the Trust's governance, strategy, and finances. They provide strategic direction and oversight, while sub-committees such as the Quality Governance Committee takes a more hands-on role in monitoring quality and safety performance reviewing and scrutinising operational detail. It is vital that the most pertinent information that is conveyed to Trust Boards is clearly recognised and not lost in the operational detail of reporting. A sub-committee's in-depth examination of data, reports, and practices provides the Board with a clear understanding of the Trust's performance on quality and safety, including any immediate priorities or exceptions.
How can I evidence an appropriate sub-committee?	A Board Assurance Framework should highlight the decision-making processes within a Trust and detail those committees with delegated authority from the Board. Individual Terms of Reference from sub-committees should also contain this information. Minutes of sub-committee meetings should demonstrate that the required discussion around MIS standards have taken place, including any output which will be conveyed to the Trust Board. This must be recognised within Trust Board minutes.
What is a Quality Governance Committee, and how does it differ from a Trust Board?	A Quality Governance Committee (QGC) is a committee of the Trust Board responsible for overseeing the Trust's quality and safety governance arrangements. It provides assurance to the Trust Board that the Trust has robust systems in place to identify, assess, and mitigate risks to patient safety. The QGC also reviews the Trust's quality improvement initiatives and provides recommendations to the Trust Board. The information presented to a QGC will be more detailed and specific than the information presented to the Trust Board. They should receive regular updates on the Trust's performance in key quality and safety areas, as well as specific data on individual incidents and concerns. The QGC should also have the opportunity to discuss the Trust's quality improvement plans and provide feedback and recommendations.

	A QGC is appropriate to review evidence around safety actions, provide additional scrutiny **and then report to the Trust Board, delivering a summary and highlighting any exceptions or particular areas of concern.** **It is important to ensure that this process facilitates Trust Board oversight, rather than replaces it.**
Where can I find more information about Board Reporting via Quality Governance Committees?	Effective Board Assurance Committees Quality Governance in the NHS
Does 'Board' refer to the Trust Board or would the Maternity Services Clinical Board suffice for the Board notification form?	Trust Boards must self-certify the Trust's final MIS declaration following consideration of the evidence provided. It is recommended that all executive members e.g. finance directors are included in these discussions. If subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of governance which we will escalate to the appropriate arm's length body/NHS system leader. We escalate these concerns to the CQC for their consideration if any further action is required, and to the NHS England regional director, the Deputy Chief Midwifery Officer, Regional Chief Midwife and Department of Health and Social Care (DHSC) for information. In addition, we now publish information on the NHS Resolution website regarding the verification process, the name of the Trusts involved in the MIS re-verification process as well as information on the outcome of the verification (including the number of safety actions not passed).
Do we need to discuss this with our commissioners?	Yes, the CEO of the Trust will ensure that the AO for their ICB is apprised of the MIS safety action evidence and declaration form. The CEO and AO must both sign the Board declaration form as evidence that they are both fully assured and in agreement with the evidence to be submitted to NHS Resolution. The declaration form must be signed by both CEO and the AO of Clinical Commissioning Group/Integrated Care System before submission.

What documents do we need to send to you?	The Board declaration form will need to be sent to NHS Resolution. Ensure the Board declaration form has been approved by the Trust Board, signed by the Trust CEO and AO (ICB). Where relevant, an action plan is completed for each action the Trust has not met. **Please send only the Board notification form to NHS Resolution. Do not send your evidence or any narrative related to your submission to NHS Resolution unless requested to do so for the purpose of reverification.** Any other documents you are collating should be used to inform your discussions with the Trust Board. These documents and any other evidence used to assure the Board of your position must be retained. In the event that NHS Resolution are required to review supporting evidence at a later date it must be made available as it was presented to support Board assurance at the time of submission.
Where can I find the Trust reporting template which needs to be signed off by the Board?	The Board declaration Excel form will be published on the NHS Resolution website in 2025 and all Trusts will be notified. It is mandatory that Trusts use the Board declaration Excel form when declaring compliance to NHS Resolution. If the Board declaration form is not returned to NHS Resolution by 12 noon on 3 March 2026, NHS Resolution will treat that as a nil response.
Will you accept late submissions?	We will not accept late submissions. The Board declaration form and any action plan will need to be submitted to us no later than **12 noon on 3 March 2026**. If not returned to NHS Resolution by 12 noon on 3 March 2026, NHS Resolution will treat that as a nil response.
Our Trust has queries, who should we contact?	Any queries prior to the 3 March 2026 must be sent in writing by e-mail to NHS Resolution via nhsr.mis@nhs.net
Please can you confirm who outcome letters will be sent to?	The MIS outcome letters will be sent to Trust's nominated MIS leads.
What if Trust contact details have changed?	It's the responsibility of the Trusts to inform NHS Resolution of the most updated MIS link contacts via the link on the NHS Resolution website.

What if my Trust has multiple sites providing maternity services?	Multi-site providers will need to demonstrate the evidential requirements for each individual site. The Board declaration should reflect overall actions met for the whole Trust.
Will there be a process for appeals this year?	Yes, there will be an appeals process. Trusts will be allowed 14 days to appeal the decision following the communication of results. The AAC will consider any valid appeal received from participating Trusts within the designated appeals window timeframe. There are two possible grounds for appeal: • Alleged failure by NHS Resolution to comply with the published 'conditions of scheme' and/or guidance documentation. • Technical errors outside the Trusts' control and/or caused by NHS Resolution's systems which a Trust alleges has adversely affected its CNST rebate. NHS Resolution clinical advisors will review all appeals to ensure validity, to determine if these fall into either of the two specified Grounds for Appeal. If the appeal does not relate to the specified grounds, it will be rejected, and NHS Resolution will correspond with the Trust directly with no recourse to the AAC. Any appeals relating to a financial decision made, for example a discretionary payment made against a submitted action plan, will not be considered. Further detail on the appeals window dates will be communicated when final results are confirmed and sent to Trusts.
How does the financial element of the scheme work?	NHS Resolution introduced the MIS to support the delivery of safer maternity care through the introduction of an incentive element to contributions to the CNST. NHS trusts that provide maternity services are charged an amount in addition to their CNST maternity contribution for the MIS. Where a trust has successfully demonstrated achievement against the ten safety actions, it will recover its element of MIS contribution that went into the maternity incentive fund, plus a share of any unallocated funds. **This rebate will be returned to the original funding source**. Trusts unable to demonstrate achievement of the ten actions may be able to apply for a lesser sum from the fund to help them achieve any unmet actions.

	Where a reverification of a prior year takes place, if the trust is found to have mis-declared compliance it must immediately repay to NHS Resolution the funds originally awarded for that MIS year. This is irrespective of the reverification being conducted in a different financial year. Any funds retrieved from non-compliant trusts will be redistributed to all trusts that achieved compliance for the applicable MIS year. This redistribution will take place within in the same financial year that NHS Resolution receives the returned funds. As NHS Resolution is not deemed a supplier in this arrangement and the arrangement does not meet the definition of a contract, the monies received from the scheme are considered out of scope of IFRS 15. Instead, they are treated as per IAS 1, in that the receipts of funds are offset against the cost of the scheme. Since the scheme relaunched for 2022/23 compliance with the ten safety actions was assessed in 2024/25. The contributions to the MIS were collected and distributed against achievement of the actions in the 2024/25 financial year.
If we haven't spent our MIS funds, can we carry them over to the next financial year.	You will need to adhere to the relevant statutory accounting standards for NHS bodies that this may fall under. NHS Resolution has no influence over this, and if you need any further guidance on the accounting treatment then we recommend speaking to your regional finance contact at NHS England.
Merging Trusts	Trusts that will be merging during the year seven reporting period (April 2025 – January 2026) must inform NHS Resolution of this via nhsr.mis@nhs.net so that arrangements can be discussed. In addition, Trust's Directors of Finance or a member of the finance team must make contact with the NHS Resolution finance team by email at nhsr.contributions@nhs.net as soon as possible to discuss the implications of the changes in the way maternity services are to be provided. This could have an impact on the contributions payable for your Trust in 2025/26 and the reporting of claims and management of claims going forward.

Maternity (Perinatal) Incentive Scheme (MIS) Year 7

What to expect – An overview of changes

MIS Year 7 document – due for publication on 2 April 2025

We have kept the way the MIS document is presented consistent to support navigation and clarity. We hope this will make it easier to focus on the requirements of the safety standards in the scheme. The primary requirements for each safety action are still at the front of the document, and the technical guidance can be accessed at the back. There is a linked index at the front, and hyperlinks throughout the document enable you to jump to other sections and relevant documents.

The Year 7 document will be published on 2 April 2025. The compliance period will end on 30 November 2025. The submission deadline will be 12:00 midday on 3 March 2026. These timings are consistent with the timings for MIS Year 6.

MIS Year 7 audit/compliance tool

The MIS document will be published with an accompanying audit/compliance tool again this year. The tool has been designed to support you as you work towards compliance with the MIS safety actions. We have highlighted changes to safety actions from Year 6 within the audit tool by highlighting the action number in yellow.

Overview of progress on MIS year 7 safety action requirements

*Mandated Safety Action Requirements:

Safety Action	Red	Amber	Green	Blue	Total Requirements
1	7	0	0	0	7
2	2	0	0	0	2
3	4	0	0	0	4
4	19	0	0	0	19
5	12	0	0	0	12
6	9	0	0	0	9
7	4	0	0	0	4
8	21	0	0	0	21
9	9	0	0	0	9
10	8	0	0	0	8
Total	95	0	0	0	95

Key:

Red	Not compliant
Amber	Partial compliance - work underway
Green	Full compliance - evidence not yet reviewed
Blue	Full compliance - final evidence reviewed

*Non-mandated sctions will not be included in this table.

It is not mandatory to use this tool, but we hope you will find it helpful. The tool has been developed for your internal use only and is not intended for submission to NHS Resolution. It will allow you to track your progress with the actions and record when supporting evidence has been approved and where it is saved. The tool also includes separate lists of actions that are required by Trust Boards and LMNS teams.

MIS FutureNHS workspace

The Maternity Incentive Scheme workspace on the FutureNHS platform will be updated to reflect MIS Year 7. We hope this will continue to provide you with improved access to consistent information and guidance about the scheme in response to any queries. The workspace includes webinars and other resources. It also offers the opportunity to share learning and tools that work well across systems, using examples of best practice / what

good looks like. MIS related questions can be posted to the forums here, and answers will then be visible to all users, however the MIS email address is still available if preferred.

For those that do not wish to join the platform, information will continue to be provided by existing methods. We encourage you to ensure you have joined the MIS contact list to ensure you receive relevant updates relating to the scheme, and please let us know if your contact details or place of work changes.

MIS Year 7 online launch event

NHS Resolution, working in partnership with a range of key organisations, are hosting a free, online event launching Year 7 of the Maternity Incentive Scheme on 28 April 2025 09.00-13.00. This half-day session will provide a crucial update on the scheme's changes and features a range of expert speakers dedicated to supporting perinatal safety.
Live online attendance at this event is now at capacity, but there is a waiting list for tickets in operation via this link. If you have a ticket for this event, but are no longer able to attend, please could you notify us so we can make your space available for others.
A full recording of the event will be available to everyone after the event (with no ticket required to access).

The MIS Team will continue to attend local, regional and national meetings over the coming year to provide updates on the Maternity Incentive Scheme as required. Please contact them on nhsr.mis@nhs.net if this is something you feel would be helpful for your team.

Year 7 - The ten safety actions

We have worked with the Safety Action Leads to maintain a consistent approach, while ensuring that the requirements continue to contribute to improved outcomes for women and families accessing perinatal services. We'd like to take this opportunity to thank those of you in Trusts and ICBs that participated in the external review process during the development of the document.

To aid your forward planning, we have provided a very brief overview of ***any significant changes only*** in this letter. Any aspects of safety actions not directly referenced below may be assumed to be essentially unchanged from Year 6 of the MIS. Further information will be available regarding all the changes within the full published document on 2 April 2025.

Where any elements have been removed from safety actions, you may make a local decision to continue those elements to support best practice, however it will no longer be mandated / reportable as a requirement to meet full MIS compliance.

Safety action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths from 1 December 2024 30 November 2025 to the required standard?

- The rolling compliance period commences immediately following MIS year 6 (in line with previous guidance).
- A minimum of 75% of multi-disciplinary PMRT reviews should be completed and published within six months (increase from 60%).
- For a minimum of 50% of the deaths reviewed an external member should be present at the multi-disciplinary review panel meeting and this should be documented within the PMRT.

Safety action 2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

- Removal of MSDS data quality requirement for 10 out of 11 CQIM metrics.
- July 2025 MSDS data contains valid birthweight information for at least 80% of babies born in the month. This requires the recorded weight to be accompanied by a valid unit entry.

Safety action 3: Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?

- Requirements for pathways of care into transitional care (TC) adjusted to babies between 34+0 and 35+6 in alignment with BAPM wording/standards (previously between 34+0 and 36+6).
- Drawing on insights from themes identified from any term or late preterm admissions to the neonatal unit, undertake or continue at least one quality improvement initiative to decrease admissions and/or length of infant/mother separation.

Safety action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?

Obstetric Workforce

- Trusts should demonstrate compliance with Consultant attendance in person to the clinical situations listed in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' through audit of any 3-month period from February 25 – November 25.

Neonatal Workforce

- Where neonatal (nursing and medical) staffing does not meet the relevant BAPM national standards there is an action plan with progress against any previously developed action plans and this is monitored via a risk register.

Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

- No change.

Safety action 6: Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives (SBL) Care Bundle Version Three?

- No change.

Safety action 7: Listen to women, parents and families using maternity and neonatal services and co-produce services with users.

- If there is insufficient LMNS/ICB commissioned MNVP infrastructure to function as per national guidance, then Trusts must escalate this at Trust, LMNS and regional level via the PQSM. As long as there is clear evidence this escalation has taken place, the Trust will not be required to provide further evidence for this standard.

- If appropriate MNVP infrastructure is in place, there is an explicit requirement for MNVP Lead ToR inclusion as a member at all listed safety and governance meetings.

Safety action 8: Can you evidence the following three elements of local training plans and 'in-house', one day multi professional training?

- Improved technical guidance relating to staff on maternity or long-term sick leave.
- Improved technical guidance in relation to neonatal resuscitation.
- Continuation of training 6-month concession period for rotational medical staff in line with in-year addition to Year 6.

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?

- Evidence that a review of maternity and neonatal quality and safety is undertaken by the Trust Board (or an appropriate Trust committee with delegated responsibility) using a minimum data set as outlined in the PQSM at least quarterly (previously every meeting).
- Perinatal leadership team - Evidence of collaboration with Safety Champions and the LMNS/ODN/ICB lead(s) and including the MNVP Lead (where infrastructure is in place as per SA7)

Safety action 10: Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigations (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 8 December 2023 to 30 November 2024?

- Eligible families must have received information on the role of MNSI and NHS Resolution's EN scheme in a format that is accessible to them.
- Reporting to the Trust Board should include occasions where families required an alternative format to make the information accessible to them and should highlight any occasions where this has not been possible, with a SMART plan to address any challenges for the future.

PMRT - Perinatal Mortality Reviews Summary Report

This report has been generated following mortality reviews which were carried out using the national Perinatal Mortality Review Tool

Arrowe Park Hospital, Wirral University Teaching Hospital NHSFT

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

1/1/2025 to 31/3/2025

There are no published reviews for Arrowe Park Hospital, Wirral University Teaching Hospital NHSFT in the period from 1/1/2025 to 31/3/2025

Report Generated by: Jo Lavery
Date report generated: 23/05/2025 08:58

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	
ICB Accountable Officer	
Trust Accountable Officer	
LMNS Peer Assessor Names	

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.

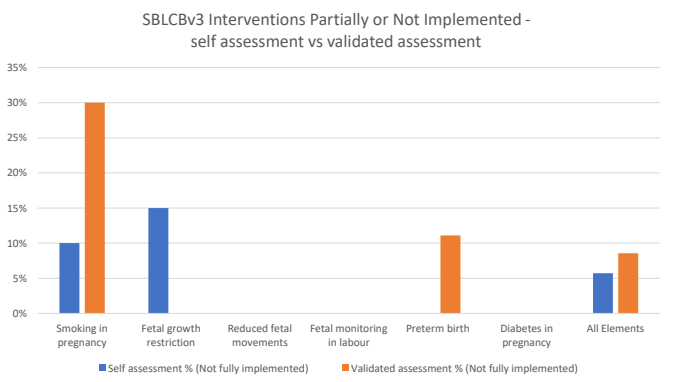
As part of the Three Year Delivery Plan for Maternity and Neonatal Services, all NHS maternity providers are responsible for fully implementing SBLCBv3 by March 2024.

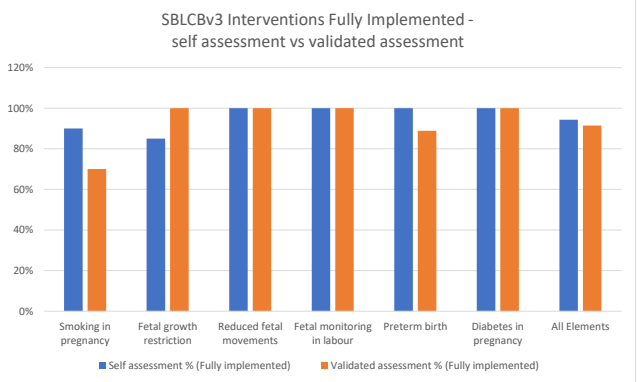
Implementation Grading

Significant Assurance - Except for specific weaknesses identified the activities and controls are suitably designed and 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	70%	CNST Met
Element 2	Fetal growth restriction	Partially implemented	85%	Fully implemented	100%	CNST Met
Element 3	Reduced fetal movements	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 4	Fetal monitoring in labour	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 5	Preterm birth	Fully implemented	100%	Partially implemented	89%	CNST Met
Element 6	Diabetes	Fully implemented	100%	Fully implemented	100%	CNST Met
All Elements	TOTAL	Partially implemented	94%	Partially implemented	91%	CNST 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	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Trust SOP meets requirements (due for review in Sept 26). MSDS DQ check passed in Nov 24.
1.2	Fully implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	50% compliant in local audit for Dec 24 which falls below compliance threshold.
1.3	Fully implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Smoking status at Booking: Oct 24- 100%, Nov 24-100%, Dec 24 (mixed sample & only smokers)- 100%
1.4	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	WUTH dashboard states Sep 24-95% and Dec 24-100%. Audit in REF1.3 states 100% in Dec 24.
1.5	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Direct supply NRT provided by in-reach service
1.6	Fully implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	Setting a quit date: WUTH dashboard states Oct 24-43.7%, Nov 24-40%, Dec 24-24.2% (ABL data suggests Dec 24- 19.3%)
1.7	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	WUTH dashboard states Oct 24-80%, Nov 24-100%, Dec 24-100%.
1.8	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Midwifery Study Day presentation noted (VBA & CO monitoring). Session also delivered to MDT on PROMPT. Training compliance posters state 91% compliance on Midwifery
1.9	Partially implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Midwifery Study Day presentation noted (VBA & CO monitoring). Session also delivered to MDT on PROMPT. Training compliance posters state 91% compliance on Midwifery
1.10	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Certificates noted in previous submissions. Please note, Practitioners should complete NCSCT e-learning and assessments annually (Jen and Claire due to re-complete in Nov 25).

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	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Noted as 100% compliant in March and April 24. Compliance sustained at 100% in May to Oct 24.
2.2	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Noted as 100% compliant in Jan 24. Compliance fell to 90% in Feb/March/April 24 and requires improvement. May 100%, June 95%, Aug 95%, Sept 95% and Oct 95%.
2.3	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	See element 1 evidence. CO and smoking status at 36/40 requires improvement.
2.4	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Oct 24 audit of mixed risk sample shows 100% compliance. Nov 24-100%, Dec 24- 100%
2.5	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Evidenced in previous submission
2.6	Partially implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Guideline updated. Email noted regarding rollout of BP monitors in February 2024.
2.7	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Audit noted as 100% compliant Jan-Dec 24.
2.8	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	PMRT summary slides accessed in Element 3 folder. No cases appear related to FGR management in Q3 24/25.
2.9	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Evidenced in previous submission
2.10	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Audit noted as 100% compliant Jan-Oct 24. Oct 24 audit of low risk sample shows 100% compliance. Nov 24-
2.11	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	November 24- MWs 90% and Obs 100%. Overall= 90% (141 of 156) so compliant at present.
2.12	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Evidenced in previous submission
2.13	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Evidenced in previous submission
2.14	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Evidenced in previous submission
2.15	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Evidenced in previous submission
2.16	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Evidenced in previous submission
2.17	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	As per intervention 5.6: Twins trust Re-audit document noted from September 2023 in evidence archive.
2.18	Partially implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	GAP 1.5 report (line 2C)- Q4 of 2024 was 50% (1 of 2). GAP 2.0 report (line 2c)- Q4 of 2024 shows 41.7% (5 of 12). Merged rate of 43% (6 of 14) so deemed compliant.
2.19	Partially implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	Antenatal detection of SGA- WUTH dashboard states 0% for all of 2024. GAP 1.5 report (line 4A)- Q3 of 2024 was 66.7% and Q4 of 2024 was
2.20	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Evidenced in previous submission

Element 3

INTERVENTIONS				
3.1	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Guideline noted in previous submission and due for review in March 26. LMNS aware updated regional guideline awaits ratification.
3.2	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Computerised CTG snapshot audit of 20 cases in Sept 24- 100% and Oct 24- 100%. Overarching element action plan noted and all actions now blue. Nov 24- 100%, Dec 24- 100%

Element 4

INTERVENTIONS				
4.1	Fully implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	4a (Fetal Surveillance Study Day)- As of Nov 24- Midwives 91%, Consultants 100%, Rotational Drs- 92%. LMNS note compliance has fallen significantly in Dec 24.
4.2	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	SBL dashboard 2024 May 95%, June 100%, July 92%, Aug 90%, Sept 95%, Oct 24-95%. LMNS note audit sample contains highest-risk cohort.
4.3	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	PMRT update noted within Powerpoint presentation- April to June 24, 0% cases relating to fetal monitoring. Q3 PMRT summary powerpoint (located in element 3 folder) shows 1 case had incorrect
4.4	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Local audit shows: CTG Fresh eyes- Oct 24-94%, Nov 24-100%, Dec 24-94% I/A Fresh Ears-Oct 24-Dec 24 100%
4.5	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Confirmation that all staff remain in post noted.

Element 5

INTERVENTIONS				
5.1	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Email confirmation received in Q3 24/25.
5.2	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Births 16+0-23+6: Oct 24- 0.37%, Nov 24-0%, Dec 24-0.42% Births 24+0-36+6: Oct 24-6.36%, Nov 24- 4.32%, Dec 24- 5.5%
5.3	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	100% compliance achieved since March 24. Aug 24- 100%, Sept 24- 100% sustained
5.4	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Evidenced in previous submission
5.5	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Evidenced in previous submission
5.6	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	As per 2.17: Twins trust Re-audit document noted from September 2023 in evidence archive.
5.7	Fully implemented	Fully implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	See evidence in element 1-CO and smoking status at 36/40 requires improvement.
5.8	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Evidenced in previous submission
5.9	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	WUTH using Actim Partus testing. Local audit shows 100% compliance in July- Dec 24
5.10	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Evidenced in previous submission
5.11	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	WUTH SBL dashboard shows 100% compliance sustained between May 24-Nov 24, 95% in Dec 24, 100% in Jan 25.
5.12	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Evidenced in previous submission
5.13	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Evidenced in previous submission
5.14	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Staffing paper and CoC powerpoint presentation noted from previous submission.
5.15	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Evidenced in previous submission
5.16	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	100% compliance sustained between April 24 and Sept 24 (<34/40) Action plan noted.
5.17	Fully implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	NWNODN dashboard shows 43% in July 24, 68% in Aug 24, 63% in Sept 24 and 65% in Oct 24 which falls below required compliance at present.
5.18	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Evidenced in previous submission
5.19	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	NICU level site. WUTH SBL dashboard reports 100% compliance sustained
5.20	Fully implemented	Partially implemented	Evidence not in place - improvement required.	Aug 24- 86%, Sept 24- 83%, Oct 24- 58%, Nov 24-43%, Dec 24-33%. Oct 24 data deemed compliant as within 6 month data period.
5.21	Fully implemented	Partially implemented	Focus required on quality improvement intiatives to meet recommended standard.	WUTH SBL dashboard states 100% compliance April 24-Dec 24 LMNS have accessed the NODN dashboard for Brain Injury and will
5.22	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Aug 24-0%, Sept and Oct 24- 75% Nov 43%, Dec 50%
5.23	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Aug 24- 57%, 67% in Sept 24, 83% in Oct 24. Nov 24- 71%, Dec 24-50%
5.24	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	71% in Aug 24 which meets compliance, 50% in Sept 24, 42% in Oct 24. Nov 24- 71%, Dec 24- 83%

5.25	Fully implemented	Fully implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Aug 24- 29%, Sept 24- 17% and Oct 24- 42%, Nov 24- 0%, Dec 24- 50%. Staff training presentation and patient information leaflet on hand
5.26	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	NWODN Action Plan noted in previous submission. WUTH SBL dashboard states 100% compliance since Feb 24-Dec 24 Nov 24- 100% compliant with VTV as per local audit. Dec 24- 100%
5.27	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	WUTH SBL dashboard states 100% compliance since Feb 24-Dec 24 NWNODN dashboard states 83% in Oct 24, 0% in Nov 24, 100% in Dec 24.

Element 6

INTERVENTIONS				
6.1	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Evidenced in previous submission. Diabetes in pregnancy guideline due for review in Oct 26. Element action plan noted
6.2	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	CGM Audit 100% complaint Oct-Dec 24 (n6). Ethnicity anaylsis noted. LMNS advise inclusion of deprivation decile analysis for next submission.
6.3	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Evidenced in previous submission.
6.4	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Oct-Dec 24 audit (n10) states 100% compliance with HbA1C as appropriate. Additional surveillance for result >48mmol stated as 100%.
6.5	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Evidenced in previous submission
6.6	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Evidenced in previous submission. Trust DKA policy due for review in May 25.

Appendix 8 Ockenden Essential Actions - May 2024

			1: WORKFORCE PLANNING AND SUSTAINABILITY	RAG Rating	Comments / Lead Progress
			Full workforce review required in 2022 - Priority to Neonatal and Obstetric Workforce with focus on additional governance related work and training. Neonatal nursing workforce reviewed and additional funding via NODN secured. Midwifery staffing reviewed with BR+ however as per ask re increased uplift for additional training PER HEAD COUNT not wte sme to be reviewed as a priority.		
1: WORKFORCE PLANNING AND SUSTAINABILITY	The recommendations from the Health and Social Care Committee Report: The safety of maternity services in England must be implemented.	**1**	The investment announced following our first report was welcomed. However to fund maternity and neonatal services appropriately requires a multi-year settlement to ensure the workforce is enabled to deliver consistently safe maternity and neonatal care across England.		Workforce reviews continue 6 monthly to monitor RAG rating of complaince
		2	Minimum staffing levels should be those agreed nationally, or where there are no agreed national levels, staffing levels should be locally agreed with the LMNS. This must encompass the increased acuity and complexity of women, vulnerable families, and additional mandatory training to ensure trusts are able to safely meet organisational CNST and CQC requirements.		Safety Action 4 and 5 met for CNST Year 5 with all evidence submitted and reviewed by the LMNS for sign off. Action plan in place to achieve Safety Action 4 in Year 6 requiring investment into the Neonatal consultant establishment to demonstrate BAPM compliance; approved via EVC and to be advertised
		3	Minimum staffing levels must include a locally calculated uplift, representative of the three previous years' data, for all absences including sickness, mandatory training, annual leave and maternity leave.		Local uplift to be calculated and compared to BR+ staffing requirements. The uplift of 24% is in keeping with national guidance/local LMNS calculation. Update May 2024 - uplift remains 24%; Birth Rate plus full review to be repeated in Summer 2024 and report will be due Autumn 2024
		4	The feasibility and accuracy of the BirthRate Plus tool and associated methodology must be reviewed nationally by all bodies. These bodies must include as a minimum NHSE, RCOG, RCM, RCPCH.		Birthrate+ audit underway and due 30/11/24
			Essential Action : Training		
			Work to update orientation packages for |Band 7 staff with process to allocate a mentor. Decision re NQM with NHSE as moreof a risk. Additional work re support for senior leaders.		
	We state that the Health and Social Care Select Committee view that a proportion of maternity budgets must be ring-fenced for training in every maternity unit should be implemented	**5**	All trusts must implement a robust preceptorship programme for newly qualified midwives (NQM), which supports supernumerary status during their orientation period and protected learning time for professional development as per the RCM (2017) position statement for this.		National programme being developed however robust preceptorship in place currently. For review once national work completed and recommendation made. Current robust programme in palce and
		6	All NQMs must remain within the hospital setting for a minimum period of one year post qualification. This timeframe will ensure there is an opportunity to develop essential skills and competencies on which to advance their clinical practice, enhance professional confidence and resilience and provide a structured period of transition from student to accountable midwife.		Recommendation reviewed - WUTH ready however awaiting Regional / National review
		7	All trusts must ensure all midwives responsible for coordinating labour ward attend a fully funded and nationally recognised labour ward coordinator education module, which supports advanced decision-making, learning through training in human factors, situational awareness and psychological safety, to tackle behaviours in the workforce.		Shift Coordinators have attended development Programmes including Hiuman Factors training however National Programme awaited. Completion of any national prohramme to be agreed. Gap ana
		8	All trusts to ensure newly appointed labour ward coordinators receive an orientation package which reflects their individual needs. This must encompass opportunities to be released from clinical practice to focus on their personal and professional development.		Orientation pack currently in use but same to be reviewed nationally and to include study time for profrssional development. To continue with current process in the interim.
		9	All trusts must develop a core team of senior midwives who are trained in the provision of high dependency maternity care. The core team should be large enough to ensure there is at least one HDU trained midwife on each shift, 24/7.		EMC Team based on DS and all midwives have undergone recognised specific HDU training. May 2024 update - continue to develop team and sustain
		10	All trusts must develop a strategy to support a succession-planning programme for the maternity workforce to develop potential future leaders and senior managers. This must include a gap analysis of all leadership and management roles to include those held by specialist midwives and obstetric consultants. This must include supportive organisational processes and relevant practical work experience		Workforce strategy in place however this will be reviewed and include reference to leadership roles. Compl;eltion date - September 2022; leadership programmes and initiiatves in place
		11	The review team acknowledges the progress around the creation of Maternal Medicine Networks nationally, which will enhance the care and safety of complex pregnancies. To address the shortfall of maternal medicine physicians, a sustainable training programme across the country must be established, to ensure the appropriate workforce long term.		Recommendation reviewed - WUTH ready however awaiting Regional / National review; ZF
			2: SAFE STAFFING		
			Escalation policy to be further reviewed re risk assessment specifically for medical Process re assessing staffing in place but review will provide further assurance. This includes review of rotas for Obs and Gynae. RCOG tool to be used once introduced to assess medical staffing. Progress with the roll out of the		
2: SAFE STAFFING	All trusts must maintain a clear escalation and mitigation policy where maternity staffing falls below the minimum staffing levels for all health professionals.	**1**	When agreed staffing levels across maternity services are not achieved on a day-to-day basis this should be escalated to the services' senior management team, obstetric leads, the chief nurse, medical director, and patient safety champion and LMS.		Escalation processes in place and the number of diverts is included on the maternity dashboard. Staffing related incident forms reviewed and reported monthly. Staffing reviewed and reported monthly with Chief Nurse oversight.C&M escaltion and GOLD
		2	In trusts with no separate consultant rotas for obstetrics and gynaecology there must be a risk assessment and escalation protocol for periods of competing workload. This must be agreed at board level.		Completed
		3	All trusts must ensure the labour ward coordinator role is recognised as a specialist job role with an accompanying job description and person specification.		Specific job description in place with personal specification. JD has been through matching process.
		4	All trusts must review and suspend if necessary the existing provision and further roll out of Midwifery Continuity of Carer (MCoC) unless they can demonstrate staffing meets safe minimum requirements on all shifts. This will preserve the safety of all pregnant women and families, which is currently compromised by the unprecedented pressures that MCoC models place on maternity services already under significant strain.		Jo Lavery and Katherine Wilkinson have reviewed staffing establishments as detailed above - staffing previously has supported CoC - withold complete roll out but continue with partial roll out pending national guidance and regional input. No further teams will be rolled out and an options appraisal prepared to consider next steps.
		5	The reinstatement of MCoC should be withheld until robust evidence is available to support its reintroduction	N/A	Final position statement on this to be formalised nationally - completion date awaited. Locally MCofC is not withheld - meeting compliance as per staffing numbers.
		6	The required additional time for maternity training for consultants and locally employed doctors must be provided in job plans. The protected time required will be in addition to that required for generic trust mandatory training and reviewed as training requirements change.		Job plans review in progress Natalie Park, Jon Lund, Mustafa Sadiq and Libby Shaw.to finalise. Review 31/3/23.
		7	All trusts must ensure there are visible, supernumerary clinical skills facilitators to support midwives in clinical practice across all settings.		Facilitators in post to support - guidance awaited re what should be included. Date TBCSarah Weston, Ali Campion, Jo Allen and Karen Cullen
		8	Newly appointed Band 7/8 midwives must be allocated a named and experienced mentor to support their transition into leadership and management roles.		Process to be reviewed and agreed with L&D Team within the Trust. Also include specific requirements for appraisals and support for leadership training eg Top Leaders; 4 C's
		9	All trusts must develop strategies to maintain bi-directional robust pathways between midwifery staff in the community setting and those based in the hospital setting, to ensure high quality care and communication.		CoC - Engagement, listening events, one-to-one meetings, Block C update, Senior midwife meeting joint with all leads.
		10	All trusts should follow the latest RCOG guidance on managements of locums. The RCOG encourages the use of internal locums and has developed practical guidance with NHS England on the management of locums. This includes support for locums and ensuring they comply with recommended processes such as pre-employment checks and appropriate induction.		Locum pack developed and shared across C&M- Libby Shaw and Mustafa Sadiq to check RCOG guidance for locum guidance to further support current process. Locum pack and Gap analysis required with assurance mechanisms. Review following any additional NHSE recomendations.
			3: ESCALATION AND ACCOUNTABILITY		
			Processes in place - same to be auditted with clear SOPs.		

3: ESCALATION AND ACCOUNTABILITY	Staff must be able to escalate concerns if necessary There must be clear processes for ensuring that obstetric units are staffed by appropriately trained staff at all times. If not resident there must be clear guidelines for when a consultant obstetrician should attend.	**1**	All trusts must develop and maintain a conflict of clinical opinion policy to support staff members in being able to escalate their clinical concerns regarding a woman's care in case of disagreement between healthcare professionals		Guidance in place but standalone policy with flowcharts required. Libby Shaw developing SOP as per EBC Guidance. Completion date July 2022.
		2	When a middle grade or trainee obstetrician (non-consultant) is managing the maternity service without direct consultant presence trusts must have an assurance mechanism to ensure the middle grade or trainee is competent for this role		Mustafa Sadiq and Libby Shaw to lead on embedding the Locum package being embedded and evidence of assurance
		3	Trusts should aim to increase resident consultant obstetrician presence where this is achievable		Ward round take place at weekend, twice daily however resident consultant presence not in place 24/7; Added to Risk Register inview of non-compliance but review completed by WUTH therefore no further action required at present.
		4	There must be clear local guidelines for when consultant obstetricians' attendance is mandatory within the unit		Guidance in place / in policy
		5	There must be clear local guidelines detailing when the consultant obstetrician and the midwifery manager on-call should be informed of activity within the unit.		Partial guidance in place and currently no dedicated maternity on call rota in place as Trust on call provides OOH cover. Specific Maternity on call put on hold pending further advice and guidance from NHSE in February 2023.
4. Clinical governance and leadership					
			Review of additional resource as detailed above to support. Training in place but to be formalised/auditted.		
4 : CLINICAL GOVERNANCE-LEADERSHIP	Trust boards must have oversight of the quality and performance of their maternity services. In all maternity services the Director of Midwifery and Clinical Director for obstetrics must be jointly operationally responsible and accountable for the maternity governance systems.	**1**	Trust boards must work together with maternity departments to develop regular progress and exception reports, assurance reviews and regularly review the progress of any maternity improvement and transformation plans		Mat Neo agenda is in place and other QI work is reported in Governance meetings but there is limited Board oversight - same to be reviewed. Maternty safety champions and regular board meetings. Processes embedded - review in March 2023.
		2	All maternity service senior leadership teams must use appreciative inquiry to complete the National Maternity Self-Assessment Tool if not previously done. A comprehensive report of their self-assessment including governance structures and any remedial plans must be shared with their trust board		Self-assessment tool completed with actons in place and presented to Board. However same to be reviewed following Ockenden and an updated self assessment to go to Board in Sept 2024 to provide continued assurance
		3	Every trust must ensure they have a patient safety specialist, specifically dedicated to maternity services		In place. Structure organogram required
		4	All clinicians with responsibility for maternity governance must be given sufficient time in their job plans to be able to engage effectively with their management responsibilities		In self-assessment tool to include neonates and anaesthetists. Only obstetric time currently supported. Completion date - July 2022; reviwing additional PA's and funding to achieve
		5	All trusts must ensure that those individuals leading maternity governance teams are trained in human factors, causal analysis and family engagement.		Staff currently trained however review of staff group required and additional training to be identified. For further review in March 2023.
		6	All maternity services must ensure there are midwifery and obstetric co-leads for developing guidelines. The midwife co-lead must be of a senior level, such as a consultant midwife, who can drive the guideline agenda and have links with audit and research.		Multi-discipinary leads in place. Consultant Midwife coleads with audit/research.
		7	All maternity services must ensure they have midwifery and obstetric co-leads for audits		Audit plan in place - same to be strengthened for Maternity and Neonates.Obstetric leads in place but midwifery leads for the audit plan to be agreed with Mustafa Sadiq Completion date - June 2022.
5: CLINICAL GOVERNANCE - INCIDENT INVESTIGATING AND COMPLAINTS					
			Robust governance processes in place - same to be reviewed with MVP Chair		
5: CLINICAL GOVERNANCE – INCIDENT INVESTIGATION AND COMPLAINTS	Incident investigations must be meaningful for families and staff and lessons must be learned and implemented in practice in a timely manner.	**1**	All maternity governance teams must ensure the language used in investigation reports is easy to understand for families, for example ensuring any medical terms are explained in lay terms.		In place and evidenced. Robust process for reviewing documents before they are sent to families.
		2	Lessons from clinical incidents must inform delivery of the local multidisciplinary training plan.		In place in various forums both internal and external to the Trust
		3	Actions arising from a serious incident investigation which involve a change in practice must be audited to ensure a change in practice has occurred.		Implementation of actions recorded and monitored however audit of same to be reviewed.Link with audit plan
		4	Change in practice arising from an SI investigation must be seen within 6 months after the incident occurred.		Learning put in place immediately. - evidenced on individual reports.
		5	All trusts must ensure that complaints which meet SI threshold must be investigated as such		Clear MDT process in place - SI Panel. Process embedded.
		6	All maternity services must involve service users (ideally via their MVP) in developing complaints response processes that are caring and transparent		Complaint response processes in place however MVP to review and to identify improvements to further strengthen the process
		7	Complaints themes and trends must be monitored by the maternity governance team.		Processes currently in place to incorportae all patient feedback - LEAP to include Feedback Friday - positive and negative feedback and trends to be communicated to all staff.
6: LEARNING FROM MATERNAL DEATHS					
6: LEARNING FROM MATERNAL DEATHS	Nationally all maternal post-mortem examinations must be conducted by a pathologist who is an expert in maternal physiology and pregnancy related pathologies. In the case of a maternal death a joint review panel/investigation of all services involved in the care must include representation from all applicable hospitals/clinical settings.	**1**	NHS England and Improvement must work together with the Royal Colleges and the Chief Coroner for England and Wales to ensure that this is provided in any case of a maternal death.		Recommendation reviewed - WUTH ready however awaiting Regional / National review
		2	This joint review panel/investigation must have an independent chair, must be aligned with local and regional staff and seek external clinical expert opinion where required.		Recommendation reviewed - WUTH ready however awaiting Regional / National review
		3	Learning from this review must be introduced into clinical practice within 6 months of the completion of the panel. The learning must also be shared across the LMS.		Recommendation reviewed - WUTH ready however awaiting Regional / National review
7: MULTIDISCIPLANRY TRAINING					
			MDT in place - same to be extended and recorded (ad hoc drills)		
7: MULTIDISCIPLINARY TRAINING	Staff who work together must train together Staff should attend regular mandatory training and rotas. Job planning needs to ensure all staff can attend. Clinicians must not work on labour ward without appropriate regular CTG training and emergency skills training	**1**	All members of the multidisciplinary team working within maternity should attend regular joint training, governance and audit events. Staff should have allocated time in job plans to ensure attendance, which must be monitored.		Midwifery and middle grades involved in audit - need to expand to neonatal evidence of same and allocated time to be evidenced.
		2	Multidisciplinary training must integrate the local handover tools (such as SBAR) into the teaching programme at all trusts.		SBAR in all training including neonates. Audit of same to be further improved.
		3	All trusts must mandate annual human factor training for all staff working in a maternity setting; this should include the principles of psychological safety and upholding civility in the workplace, ensuring staff are enabled to escalate clinical concerns. The content of human factor training must be agreed with the LMS.		For all staff attend human factors training however guidance re content awaited from LMNS
		4	There must be regular multidisciplinary skills drills and on-site training for the management of common obstetric emergencies including haemorrhage, hypertension and cardiac arrest and the deteriorating patient.		PROMPT includes all of these topics however all staff groups including neonatal staff to be included in PROMPT - same to be reviewed after national recommendation/s.
		5	There must be mechanisms in place to support the emotional and psychological needs of staff, at both an individual and team level, recognising that well supported staff teams are better able to consistently deliver kind and compassionate care.		Jo Allen support for NQM. PMAs. NWAS has toolkit for staff Contact Steph Heyes. Discussed psychological support that was available in ITUs during Covid pandemic - that there was psychological support present at work.This helped staff to attend work becuase they knew the support would be there.
		6	Systems must be in place in all trusts to ensure that all staff are trained and up to date in CTG and emergency skills.		Karen Cullen in post for CTG / Fetal Physiology in addition to Ali Campion and Libby Shaw.
		7	Clinicians must not work on labour wards or provide intrapartum care in any location without appropriate regular CTG training and emergency skills training. This must be mandatory		PROMPT, K2, fetal physiology, CIF meetings, Pass mark for CTG assessment is mandated and reviewed monthly.
8: COMPLEX ANTENATAL CARE					
			Review of High Risk team and support to implement MMN links. Review of preconceptual care and further progress in secondary care.		
		1	Women with pre-existing medical disorders, including cardiac disease, epilepsy, diabetes and chronic hypertension, must have access to preconception care with a specialist familiar in managing that disorder and who understands the impact that pregnancy may have.		Do not currently offer routine pre conception care. Will discuss regionally at what can be offered - will look at what high risk team could provide. Completion date - July 2022; Plan to be developed; Two consultants currently have pre-conception clinics and any referrals sent are accommodated from a specialist referral; Pre-conception counselling education with GP's

8: COMPLEX ANTENATAL CARE	Local Maternity Systems, Maternal Medicine Networks and trusts must ensure that women have access to pre-conception care.Trusts must provide services for women with multiple pregnancy in line with national guidance Trusts must follow national guidance for managing women with diabetes and hypertension in pregnancy	**2**	Trusts must have in place specialist antenatal clinics dedicated to accommodate women with multifetal pregnancies. They must have a dedicated consultant and have dedicated specialist midwifery staffing. These recommendations are supported by the NICE Guideline Twin and Triplet Pregnancies 2019		Twins Trust coming in multi-pregnacy clinic - Mustafa Sadiq is lead.
		3	NICE Diabetes and Pregnancy Guidance 2020 should be followed when managing all pregnant women with pre-existing diabetes and gestational diabetes.		Guidance in place - to link wth Rachel Tildesley and Lauren Evertts. Need to look at audit to support compliance. For FAAP 2023
		4	When considering and planning delivery for women with diabetes, clinicians should present women with evidence-based advice as well as relevant national recommendations. Documentation of these joint discussions must be made in the woman's maternity records.		In place but could be subject to audit to demonstrate compliance. For FAAP 2023
		5	Trusts must develop antenatal services for the care of women with chronic hypertension. Women who are identified with chronic hypertension must be seen in a specialist consultant clinic to evaluate and discuss risks and benefits to treatment. Women must be commenced on Aspirin 75-150mg daily, from 12 weeks gestation in accordance with the NICE Hypertension and Pregnancy Guideline (2019).		Guidance in place to support this practice - specific clinic to be reviewed. Audit compliance in March 2023. For FAAP 2023
9: PRETERM BIRTH					
			Both 9 + 10 are in place - audit of processes needed		
9: PRETERM BIRTH	The LMNS, commissioners and trusts must work collaboratively to ensure systems are in place for the management of women at high risk of preterm birth. Trusts must implement NHS Saving Babies Lives Version 2 (2019)	**1**	Senior clinicians must be involved in counselling women at high risk of very preterm birth, especially when pregnancies are at the thresholds of viability.		Policy in place with clear guidance.
		2	Women and their partners must receive expert advice about the most appropriate fetal monitoring that should be undertaken dependent on the gestation of their pregnancies and what mode of delivery should be considered.		Guidance discussed at time dependant on individual situation. Guidance in place re type of monitoring as per gestation of pregnancy.
		3	Discussions must involve the local and tertiary neonatal teams so parents understand the chances of neonatal survival and are aware of the risks of possible associated disability.		Regional policy - link in with Angela MacDonald and Sanjeev Rath re any further update
		4	There must be a continuous audit process to review all in utero transfers and cases where a decision is made not to transfer to a Level 3 neonatal unit and when delivery subsequently occurs in the local unit.		Current review of Level 3 neonatal services however as WUTH Level 3 currently this is not applicable.
10: LABOUR AND BIRTH					
10: LABOUR AND BIRTH	Women who choose birth outside a hospital setting must receive accurate advice with regards to transfer times to an obstetric unit should this be necessary. Centralised CTG monitoring systems should be mandatory in obstetric units	**1**	All women must undergo a full clinical assessment when presenting in early or established labour. This must include a review of any risk factors and consideration of whether any complicating factors have arisen which might change recommendations about place of birth. These must be shared with women to enable an informed decision re place of birth to be made		Practice in place - Demonstrated in care metrics
		2	Midwifery-led units must complete yearly operational risk assessments.		In place however annual check for 2023 to be undertaken for Deacombe and Eden Suite.
		3	Midwifery-led units must undertake regular multidisciplinary team skill drills to correspond with the training needs analysis plan		All staff included in PROMPT training however schedule of drills to be recorded and ad-hoc taken forward
		4	It is mandatory that all women who choose birth outside a hospital setting are provided accurate and up to date written information about the transfer times to the consultant obstetric unit. Maternity services must prepare this information working together and in agreement with the local ambulance trust		Transfer policy in place regionally and adopted locally - same reviewed and updated with NWAS.
		5	Maternity units must have pathways for induction of labour, (IOL). Trusts need a mechanism to clearly describe safe pathways for IOL if delays occur due to high activity or short staffing.		Pathways in place - same being reviewed regionally.
		6	Centralised CTG monitoring systems must be made mandatory in obstetric units across England to ensure regular multi-professional review of CTGs		Completed and implemented
11: OBSTETRIC ANAESTHESIA					
			Close links with Anaesthetic leads with compliance to standards - same to be auditted		
11: OBSTETRIC ANAESTHESIA	In addition to routine inpatient obstetric anaesthesia follow-up, a pathway for outpatient postnatal anaesthetic follow-up must be available in every trust to address incidences of physical and psychological harm.Documentation of patient assessments and interactions by obstetric anaesthetists must improve. The determination of core datasets that must be recorded during every obstetric anaesthetic intervention would result in record-keeping that more accurately reflects events.Staffing shortages in obstetric anaesthesia must be highlighted and updated guidance for the planning and provision of safe obstetric anaesthesia services throughout England must be developed.	**1**	Conditions that merit further follow-up include, but are not limited to, postdural puncture headache, accidental awareness during general anaesthesia, intraoperative pain and the need for conversion to general anaesthesia during obstetric interventions, neurological injury relating to anaesthetic interventions, and significant failure of labour analgesia		Alice Arch overview: If a post-operative debrief would be useful these can be arranged to be purely or involve a Consultant Anaesthetist and we do this for lots of patients already - we usually offer this at 6-8 weeks post event unless the patient requests it to be earlier or later - and these patients can be referred to the Obstetric Anaesthetic Assessment clinic if they present in subsequent pregnancies; Assurance process developing
		2	Anaesthetists must be proactive in recognising situations where an explanation of events and an opportunity for questions may improve a woman's overall experience and reduce the risk of long-term psychological consequences.		Currently being undertaken but need to review guidance to ensure all criteria included with audit of same. Completion date - July 2022; part of assurance process 11.1
		3	All anaesthetic departments must review the adequacy of their documentation in maternity patient records and take steps to improve this where necessary as recommended in Good Medical Practice by the GMC		Documentation is recorded in maternity record hwoever need to review audit process. Completion date - July 2022; part of assurance process 11.1; part of assurance process 11.1
		4	Resources must be made available for anaesthetic professional bodies to determine a consensus regarding contents of core datasets and what constitutes a satisfactory anaesthetic record in order to maximise national engagement and compliance.		Recommendation reviewed - WUTH ready however awaiting Regional / National review
	Obstetric anaesthesia staffing guidance to include:	**5**	The role of consultants, SAS doctors and doctors-in-training in service provision, as well as the need for prospective cover, to ensure maintenance of safe services whilst allowing for staff leave.		Staff who do not do regular Obstetric Anaesthesia sessions want to do a Consultant Accompanied CPD session in Obstetric Anaesthesia to keep skills up to date we are more than happy to facilitate this - and several people have already taken up this opportunity. Process to be reviewed. Completion date - July 2022; assurance process to be developed
		6	• The full range of obstetric anaesthesia workload including, elective caesarean lists, clinic work, labour ward cover, as well as teaching, attendance at multidisciplinary training, and governance activity.		Staffing of same to be reviewed. Completion date - July 2022; assurance process to be developed
		7	• The competency required for consultant staff who cover obstetric services out-of hours, but who have no regular obstetric commitments.		As point 5; assurance process to be developed
		8	• Participation by anaesthetists in the maternity multidisciplinary ward rounds as recommended in the first report		All anaesthetists attend PROMPT MDT training; assurance process to be developed
12: POSTNATAL CARE					
			Audit and review of processes / policies re postnatal care		
12: POSTNATAL CARE	Trusts must ensure that women readmitted to a postnatal ward and all unwell postnatal women have timely consultant review.Postnatal wards must be adequately staffed at all times	**1**	All trusts must develop a system to ensure consultant review of all postnatal readmissions, and unwell postnatal women, including those requiring care on a non maternity ward		Process in place - document to be developed to support process
		2	Unwell postnatal women must have timely consultant involvement in their care and be seen daily as a minimum		Process in place - document to be developed to support process
		3	Postnatal readmissions must be seen within 14 hours of readmission or urgently if necessary		Process in place - document to be developed to support process
		4	Staffing levels must be appropriate for both the activity and acuity of care required on the postnatal ward both day and night, for both mothers and babies.		Acuity tool used and effective

13: BEREAVEMENT CARE					
13. BEREAVEMENT CARE	Trusts must ensure that women who have suffered pregnancy loss have appropriate bereavement care services.	**1**	Trusts must provide bereavement care services for women and families who suffer pregnancy loss. This must be available daily, not just Monday to Friday.		Bereavement midwife in post but works Monday to Friday. EMC team upskilled and shift coordinators. With development of bereavement champions in teams. Cover available 24/7
		2	All trusts must ensure adequate numbers of staff are trained to take post-mortem consent, so that families can be counselled about post-mortem within 48 hours of birth. They should have been trained in dealing with bereavement and in the purpose and procedures of post-mortem examinations.		EMC staff and coordinators - can be inlcuded in development package for coordinators
		3	All trusts must develop a system to ensure that all families are offered follow-up appointments after perinatal loss or poor serious neonatal outcome		In place - dual with obstetrics and neonates
		4	Compassionate, individualised, high quality bereavement care must be delivered for all families who have experienced a perinatal loss, with reference to guidance such as the National Bereavement Care Pathway		Pathway in place and in use.
14: NEONATAL CARE					
			Close links with NODN to progress - this links in with the regional transformational work with Exec input to support		
14: NEONATAL CARE	There must be clear pathways of care for provision of neonatal care. This review endorses the recommendations from the Neonatal Critical Care Review (December 2019) to expand neonatal critical care, increase neonatal cot numbers, develop the workforce and enhance the experience of families. This work must now progress at pace.	**1**	Neonatal and maternity care providers, commissioners and networks must agree on pathways of care including the designation of each unit and on the level of neonatal care that is provided.		Guidance in place
		2	Care that is outside this agreed pathway must be monitored by exception reporting (at least quarterly) and reviewed by providers and the network. The activity and results of the reviews must be reported to commissioners and the Local Maternity Neonatal Systems (LMS/LMNS) quarterly.		Recommendation reviewed - WUTH ready however awaiting Regional / National review
		3	Maternity and neonatal services must continue to work towards a position of at least 85% of births at less than 27 weeks gestation taking place at a maternity unit with an onsite NICU.		This is a unit with onsite Level 3 NICU
		4	Neonatal Operational Delivery Networks must ensure that staff within provider units have the opportunity to share best practice and education to ensure units do not operate in isolation from their local clinical support network. For example senior medical, ANNP and nursing staff must have the opportunity for secondment to attend other appropriate network units on an occasional basis to maintain clinical expertise and avoid working in isolation.		Recommendation reviewed - WUTH ready however awaiting Regional Neonatal ODN Guidance
		5	Each network must report to commissioners annually what measures are in place to prevent units from working in isolation.		Recommendation reviewed - WUTH ready however awaiting Regional Neonatal ODN Guidance
		6	Neonatal providers must ensure that processes are defined which enable telephone advice and instructions to be given, where appropriate, during the course of neonatal resuscitations. When it is anticipated that the consultant is not immediately available (for example out of hours), there must be a mechanism that allows a real-time dialogue to take place directly between the consultant and the resuscitating team if required		Evidence of this happening in practice to be confirmed and to be followed up with Angela McDonald, Adam Brown and Sanjeev Rath
		7	Neonatal practitioners must ensure that once an airway is established and other reversible causes have been excluded, appropriate early consideration is given to increasing inflation pressures to achieve adequate chest rise. Pressures above 30cmH2O in term babies, or above 25cmH2O in preterm babies may be required. The Resuscitation Council UK Newborn Life Support (NLS) Course must consider highlighting this treatment point more clearly in the NLS algorithm.		NLS Guidance followed - action to be followed up with neonatal team
		8	Neonatal providers must ensure sufficient numbers of appropriately trained consultants, tier 2 staff (middle grade doctors or ANNPs) and nurses are available in every type of neonatal unit (NICU, LNU and SCBU) to deliver safe care 24/7 in line with national service specifications.		Staffing review undertaken as above -Adam Brown and Anand to feedback to DMB.
15: SUPPORTING FAMILIES					
			Ensure support covers maternity and neonatal care/services		
15: SUPPORTING FAMILIES	Care and consideration of the mental health and wellbeing of mothers, their partners and the family as a whole must be integral to all aspects of maternity service provisionMaternity care providers must actively engage with the local community and those with lived experience, to deliver services that are informed by what women and their families say they need from their care	**1**	There must be robust mechanisms for the identification of psychological distress, and clear pathways for women and their families to access emotional support and specialist psychological support as appropriate.		Perinatal mental health team in post. GIRFT identified need for neonatal support. This is in place regionally
		2	Access to timely emotional and psychological support should be without the need for formal mental health diagnosis, as psychological distress can be a normal reaction to adverse experiences.		Perinatal mental health team in post with further support from Psychiatric Liason team..
		3	Psychological support for the most complex levels of need should be delivered by psychological practitioners who have specialist expertise and experience in the area of maternity care		Psychiatric liaison team and dedicated psychologist to support. WUTH also involved in regional project to further enhance PMH support.

Recommendation reviewed - WUTH ready however awaiting Regional / National Guidance
Fully Embedded
On target to achieve; no risks
Partially Compliant
Non Compliant/risk identified on risk register

NOTE: Completion dates are provisional pending detailed improvement plan.

Appendix 9 Three Year Single Delivery Plan for Maternity and Neonatal Services - May 2024							
Theme1: Listening to and working with women and their families with compassion				RAG Rating	Lead	Review Date	Comments / Lead Progress
Objective 1: Care that is personalised	Personalised care gives people choice and control over how their care is planned and delivered. It is based on evidence, what matters to them, and their individual risk factors and needs	**1**	Women experience care that is always kind and compassionate. They are listened and responded to. Open and honest ongoing dialogue between a woman, her midwife, and other clinicians, to understand the care she wants, any concerns she may have, and to discuss any outcomes that are not as expected. All women are offered personalised care and support plans which take account of their physical health, mental health, social complexities, and choices. Plans consider inequalities in the broadest sense, including protected characteristics and Core20PLUS5. The care plan includes a risk assessment updated at every contact, including when the woman is in early or established labour.		JL	No further action	CQC Patient survey Debrief clinics to go through pregnancy outcomes. Birth Options clinic to evidence discussion of women's preferences Examples of care plans; PMH plans; Risk assessment audits Look at further improving inequalities as per equity and equality plan – Consultant Midwife to support with MNVP involvement.
		2	Women receive care that has a life course approach and preventative perspective, to ensure holistic care for women and the best start in life for babies. This includes NHS-led smoke-free pregnancy pathways to provide practical support for pregnant women who are smokers, and evidence-based information about screening and vaccination		AK/ER	No further action	Evidence of smoking cessation midwife/work with ABL. Use of NRT. ANNB Screening Programme QA; ANNB Screening action plan to further review screening information
		3	Women have clear choices, supported by unbiased information and evidence- based guidelines. Information is provided in a range of formats and languages, uses terminology in line with the Rebirth report, and is co-produced.		AK/ER	30/6/25	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 receiv
		4	All women have equitable access to specialist care, including perinatal mental health services, perinatal pelvic health services, maternal and foetal medicine networks, and neonatal care, when needed		JKL	No further action	All services with guidelines are in place except perinatal pelvic health services – same being introduced; Set up a perinatal pelvic health service and work closely with LMNS re guidance/requirements; funding secured and JD to be matched; initial discuss with PPHS lead and service to be set up at WUTH; in post setting up services
		5	Women experience personalised, joined-up, high-quality care right through to the postnatal period with handover to health visiting services and a GP check 6-8 weeks after birth. They are provided with practical support and information that reflects how they choose to feed their babies		KW	No further action	Processes in place although clarity needed regarding 6-8week GP check post pandemic; Check with HV team re GP follow up check
		6	Parents are partners in their baby's care in the neonatal unit through individualised care plans utilising a family integrated care approach, together with appropriate parental accommodation.		ST/AMC	No further action	FI Care review undertaken with action plan developed following feedback positive in May 2022; repeated in May 2023 and GREEN accreditation achieved
		7	Compassionate and high-quality care for bereaved families including appropriate accommodation, which is easily accessible but separate from maternity and neonatal units		AK/ER	No further action	Bereavement midwife in post. Bereavement Suite on site. Use of Ron McDonald House is also an option that is used
Objective 2: Improve equity for mother and babies	The NHS approach to improving equity (Core20PLUS5) involves implementing midwifery continuity of carer, particularly for women from minority ethnic communities and from the most deprived area It is the responsibility of trusts to: Provide services that meet the needs of their local populations, paying particular attention to health inequalities. This includes facilitating informed decision-making, for example choice of pain relief in labour where we know there are inequalities, ensuring access to interpreter services, and adhering to the Accessible Information Standard in maternity and neonatal settings.	**8**	To reduce inequalities for all in access, experience and outcomes		JL/ER	30/4/25	Equity and Equality plan developed by LMNS following gap analysis which the Trust completed; Further work re equality to be undertaken; WUTH completed; awaiting LMNS update
		9	Targeted support where health inequalities exist in line with the principles of proportionate universalism		No further action	30/11/24	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; review MCoC
		10	Services listen to and work with women from all backgrounds to improve access, plan and deliver personalized care. Maternity and Neonatal voice partnerships ensure all groups are heard, including those most at risk of experiencing health inequalities.		JL	No further action	
		11	The NHS collaborates with local authority services, other public sector organisations (NHS Constitution Principle 5, 2021) to address the social determinants of health, which are a significant driver of health inequalities (WHO, 2022)		JL/KW	No further action	Maternity services to work with PLACE; LMNS and ICB leads to progress; PH g=meeting, familuy hubs, ICB (ID) MNVP, Wirral Place collboration and report; LMNS regular meetings
		12	In spring 2023, publish the National Review of Health and Social Care in Women's Prisons. This review covers maternity and perinatal services		JL/MB	No further action	To achieve requirement to work with the LMNS to meet and no local prisons feed into WUTH; consider a SoP with safeguarding midwife involvement
Objective 3: Work with service users to improve care	Acting on the insights of women and families improves services. Co-production is beneficial at all levels of the NHS and is particularly important for those most at risk of experiencing health inequalities (NICE, 2018). Involving service user representatives helps identify what needs to improve and how to do it. This is done through maternity and neonatal voices partnerships (MNVPs) and by working with other	**13**	MVNPs listen to and reflect the views of local communities. All groups are heard, including bereaved families.		JL	No further action	Equity and Equality plan developed by LMNS following gap analysis which the Trust completed; Further work re equality to be undertaken as detailed above
		14	MNVPs have strategic influence and are embedded in decision making		JL	No further action	MIS evidence supports work and undertaken and co-production
		15	MNVPs have the infrastructure they need to be successful. Workplans are funded. MNVP leads, formally MVP chairs, are appropriately employed or remunerated and receive appropriate training, administrative and IT support.		JL	No further action	MNVP embedded; full funding of post with agreed workplan from ICB awaited; local workplan in place
Theme 2: Growing, retaining and supporting workforce				RAG Rating	Lead	Review Date	Comments / Lead Progress
Objective 4: Grow our workforce	The maternity and neonatal workforce encompasses a wide range of professions, including midwives, maternity support workers, obstetricians, anaesthetists, neonatologists, neonatal nurses, sonographers, allied health professionals, and psychologists. Growing our workforce requires the tailoring of interventions to professional groups, career stage, and local requirements	**16**	Workforce capacity to grow as quickly as possible to meet local needs.		JL	No further action	Workforce plan in place with report to Board every 6 months
		17	Local and national workforce planning to utilise evidence-based tools, endorsed by NICE or the National Quality Board (NQB), that allow for medical and social complexity, training,		JL	No further action	Nursing and Medical workforce planning tools used. BR+ Report in date. Also work with regional Leads
		18	Aligned local and national strategies supporting recruitment to those vacant posts identified through workforce planning		JL	No further action	No specific work done with Rebirth report – review of same. Clear choices and information is in place including the updated/revamped website. Continue to work with MNVP re equity and equality to ensure all people receive information they understand.
Objective 5: Value and retain our workforce	Our maternity and neonatal staff perform critical, life-changing work every day. We must ensure they are valued and have a fulfilling and sustainable career within the NHS. We need to do more to improve the experience of all our staff, to retain them within the NHS	**19**	Staff feel valued at all stages of their career. This includes support to get off to a good start, opportunities for progression and flexible working, and support when approaching retirement age to allow staff to continue to use their skills and experience.		JL	No further action	
		20	All staff are included and have equality of opportunity		JL	No further action	
		21	A safe environment and inclusive culture in which staff feel empowered and supported to take action to identify and address all forms of discrimination		JL/HW/MS/ET	Ongoing annually	Score survey undertaken for Maternity and Neonates; feedback sessions in November 2023; staff enagagement April 2024
Objective 6:	Staff feel valued when they are supported to develop. We are investing in our staff by ensuring they have ongoing training and career	**22**	All staff are deployed to roles where they can develop and are empowered to deliver high quality care. Specialist roles within each profession, for example the labour ward coordinator, have a job description, orientation package, appropriate training, and ongoing development		JL	No further action	Evidence collated for Ockenden improvement plan

Invest in skills	development opportunities. Effective training of frontline clinicians in technical and non-technical skills has been shown to improve outcomes.	**23**	All staff have regular training to maintain and develop their skills in line with their roles, career aspirations, and national standards. Training is multi-disciplinary wherever practical to optimise teamworking		JL	No further action	TNA in place and reviewed annually
Theme 3: Developing and sustaining a culture of safety, learning and support				RAG Rating	Lead	Review Date	Comments / Lead Progress
Objective 7: Developing a positive safety culture		**24**	All staff working in and overseeing maternity and neonatal services: -Are supported to work with professionalism, kindness, compassion, and respect. Are psychologically safe to voice their thoughts and are open to constructive challenge. -Receive constructive appraisals and support with their development. -Work, learn and train together as a multi-disciplinary team across maternity and neonatal care.		JL	No further action	MDT training in place. TNA supports training requirements incl psychological safety. Appraisal process in place with good compliance monitored at Board level.
		25	Teams value and develop people from all backgrounds and make the best use of their diverse skills, views, and experiences.		JL	No further action	Training in place to support
		26	There is a shared commitment to safety and improvement at all levels, including the trust board, and attention is given to 'how' things are implemented not just 'what'		JL	No further action	Evidenced through safety champions meetings; Newly formed divisional MatNeo Assurance Board
		27	Instances of behaviour that is not in line with professional codes of conduct, are fairly addressed before they become embedded or uncontrollable.		JL	No further action	Trust training and policies support professional behaviour/s. Disciplinary processes support appropriate action when needed
		28	Systems and processes enable effective coordination, rapid mobilisation, and supportive communication based on agreed principles. The team can escalate concerns and, should there be a disagreement between healthcare professionals, they will be supported by a conflict of clinical opinion policy.		JL	No further action	Policy in place – provided for Ockenden evidence
		29	Staff investigating incidents are provided with appropriate training, while those staff affected by an incident are offered timely opportunity to debrief		JL/DC	No further action	Training in place for staff and this is reviewed and provided by the Trust Governance team
Objective 8: Learning and Improving	Staff working in maternity and neonatal services have an appreciation and understanding of 'what good looks like.' To promote safer care for all, we must actively learn from when things go well and when they do not. To do this, we need a continuous learning and	**30**	Our ambition is framed by the patient safety incident response framework (PSIRF) which provides a consistent approach across clinical specialties, including for maternity and neonatal services		JL/DC	No further action	PSIRF launched in the Trust September 2023; nataional guidance awaited specific for maternity services; embedded
		31	The Healthcare Safety Investigation Branch undertake investigations of incidents which meet their criteria		JL/MD	No further action	MNSI quarterly meetings take place and Trust evidenced 100% reporting by the Trust
Objective 9: Support and oversight	While some trusts and ICSs do effectively support their maternity and neonatal services to improve and change; others do not. Good oversight is about understanding the issues leaders face and helping to resolve them, and having clear systems in place that promote timely escalation and intervention before serious problems arise	**32**	Robust oversight through the perinatal quality surveillance model (PQSM) that ensures concerns are identified early, addressed, and escalated where appropriate		JL	No further action	Evidence Monthly PQSM report to Board with quarterly detailed maternity /neonatal reports presented
		33	Well led services, with additional resources channelled to where they are most needed		JL	No further action	CQC visit supported well led service at last inspection. Other evidence / outcomes also support
		34	Leadership for change, with a focus on ensuring new service models have the right building blocks for high quality care, especially the workforce.		JL/NP/MS/SR	Ongoing annually	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	31/5/25	MIS year 5 submitted and confrimation of all 10 safety actions; SBLv3 implemented 97%; review of MCoC to address women with inequalities; MIS Year 6 published and in progress; Improve data extraction and analysis sp
		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	31/06/2025	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		JL	No further action	Processes in place to ensure MDT are involved with developing local policy
		38	Policies and guidelines recognise women as the decision-makers in their maternity care and are not used to prevent women from seeking care that is outside these guidelines		AK/ER	No further action	Policy in place and women are supported by the consultant midwife/Obstetric/Neonatal Leads
		39	Neonatal care is provided in units with clear designation of the level of care to be provided. Units work together across ODNs to optimise capacity and ensure care can be provided in the right place for very pre-term or very sick babies		Leads	No further action	Policy in place and women are supported by the consultant midwife/Obstetric/Neonatal Leads
Objective 11: Data to inform learning	The Kirkup report highlighted the need for accurate, up to date data to highlight safety issues promptly. Such data enables providers to learn and act. Work is underway to review what data is needed for monitoring, and in the meantime, the NHS should continue to use the data it already collects	**40**	Standardised data is collected in a consistent way, primarily through the Maternity Services Data Set. Additional data collections are minimised, to focus on gathering the right data to drive insights, understanding and assurances.		JL	No further action	MSDS submitted in addition to completion of a local and regional dashboard
		41	Monitoring trends at both national and local level is enabled by analysing data from different sources alongside themes from MBRRACE-UK , and the national clinical audits patient outcome programme reports		DC	No further action	LMNS support in leading on monitoring trends regionally. Outlier reports are presented to Board quarterly; Improvement plans are developed to address any outlier reports
		42	The national maternity dashboard provides demographic data, clinical quality improvement metrics and national maternity indicators enabling trusts and LMNSs to benchmark their services and inform continuing quality improvement work		JL/DC	No further action	Data submitted to national dashboard; Given limited metrics the national dashboard is not currently reviewed – work to be identified to address an improvement moving forwards.
Objective 12: Make better use of digital technology	Digital technology will make it easier for women to access the information they need and for services to offer safe and personalised care. There is currently significant variation in the use of digital technology. While some maternity services remain almost entirely paper-based, others support personalised care with apps and benefit from an integrated electronic patient record (EPR).	**43**	Women can access their records and interact with their digital plans and information to support informed decision-making. Parents can access neonatal and early years health information to support their child's health and development. Information meets accessibility standards, with non-digital alternatives available for those who require or prefer them		JL/KW	30/9/25	Processes in place for women to access their records electronically – work to progress to roll out patient portal; personalied care plans beig developed; access to app's; access to GROW
		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

Wirral University Teaching Hospital NHS Foundation Trust

Appendix 10

Board of Directors in Public

04 June 2025

Title	Midwifery Staffing Update
Area Lead	Sam Westwell, Chief Nurse
Author	Jo Lavery, Divisional Director of Nursing & Director of Midwifery (Women's and Children's)
Report for	Information

Executive Summary and Report Recommendations

Executive Summary

As part of the Maternity Incentive Scheme (MIS) there is a requirement to evidence a midwifery staffing review therefore the BR+ review of current midwifery staffing within the maternity service will contribute to the compliance with the requirements of the MIS (Year 7).

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

There is a requirement for providers to change the current model of care delivered within maternity services nationally, through the transformation Programme to that of a continuity of carer model. The final BR+ report identifies a need for additional midwifery staffing to enable progression of a continuity of carer model of care.

It is recommended that the Board of Directors:

- Note the report
- Support a statement of case as the agreed plan to the Business Development and Investment Sub Committee (BDISC) recommending the increase in midwifery establishment as outlined in the Birth Rate Plus Workforce review in line with Ockenden requirements and to ensure compliance with Safety Action 5 of the Maternity Incentive Scheme (Year 7).

Key Risks

This report relates to these key risks:

BAF references 1,2,4 and 6

Positives:

- The Trust has several processes that review and record patient quality indicators, incidents and patient experience metrics monthly against staffing data to identify emerging risk/s. This includes a monthly midwife to birth ratio recorded on the maternity dashboard.

- The Trust fulfils its duty to undertake 6 monthly establishment reviews including an update on midwifery staffing. The Trust has also supported a Birth Rate Plus Workforce review at least every 5 years as a minimum, however suggested recommendation is every 3 years.
- The recommendations from the Birth Rate Plus Workforce review received in March 2025.
- The Division uses the Birth Rate Plus acuity tool to undertake acuity and dependency reviews on Delivery Suite every 4 hours. This has been extended for use on the maternity ward and a LMNS regional platform informing staffing, acuity, and dependency.
- The Division has safe staffing governance with a clear process of escalation both locally and across Cheshire and Merseyside.

Negatives:

- The Trust having two models of care for the provision of MCoC which is inequitable, and which has additional implications and risks.

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

Contribution to WUTH strategic objectives:	
Outstanding Care: provide the best care and support	Yes
Compassionate workforce: be a great place to work	Yes
Continuous Improvement: maximise our potential to improve and deliver best value	Yes
Our partners: provide seamless care working with our partners	Yes
Digital future: be a digital pioneer and centre for excellence	No
Infrastructure: improve our infrastructure and how we use it.	No

1	Narrative
1.1	**Background** Birthrate Plus® (BR+) is a framework for workforce planning and strategic decision-making and has been in variable use in UK maternity units since 1988, with periodic revisions as national maternity policies and guidance are published. It is based upon an understanding of the total midwifery time required to care for women and on a minimum standard of providing one-to-one midwifery care throughout established labour. The principles underpinning the BR+ methodology is consistent with the recommendations in the NICE safe staffing guideline for midwives in maternity settings and have been endorsed by the RCM and RCOG. Current processes within the maternity service ensure that on a 24/7 basis staff are deployed effectively within the service, including the flexing of staff across both the acute and community care settings including the maternity continuity of carer teams.

	Staff working on Delivery Suite use an acuity tool that formally assesses acuity on Delivery Suite every 4 hours as a minimum. At times of high acuity, the tool is used more frequently to assess acuity, and reports into a regional platform that was launched in September 2022. Weekly staffing reports are generated from the acuity data, and whilst this does predominantly focus on staffing within Delivery Suite the acuity tool is being expanded to include staffing across all inpatient areas. Monthly staffing reports are generated and shared by the Local Maternity and Neonatal System (LMNS) on this data regionally. It is proposed that these reports will further inform and provide assurance regarding safe maternity staffing and will provide assurance to all Maternity Safety Champions including the Executive and Non-Executive Safety Champions who are required to have oversight, assurance and visibility of safe staffing within the maternity service. Currently the quarterly maternity update to the Board of Directors includes reference to maternity staffing and a Divisional nurse / midwifery staffing update is also included in the 6 monthly midwifery staffing paper that is presented at the Board of Directors meeting.
1.2	**Current position** The RCM strongly recommends using Birthrate Plus® (BR+) to undertake a systematic assessment of workforce requirements, since BR+ is the only recognised national tool for calculating midwifery staffing levels. Whilst birth outcomes are not influenced by staff numbers alone, applying a recognised and well-used tool is crucial for determining the number of midwives and support staff required to ensure each woman receives one-to-one care in labour. Birthrate Plus® has been used in maternity units ranging from stand-alone community/midwifery led units through to regional tertiary centres, with birth rates ranging from only 10 births annually through to those that have in excess of 9000 births. In addition, it caters for the various models of care in existence, including a traditional model, community-based teams and continuity of carer/caseload teams. Birthrate Plus® is the most widely used tool for workforce assessment classifying women and babies according to their needs and using clinical outcome data to calculate the numbers of midwives required to provide inpatient/outpatient antenatal care, intrapartum and postnatal care in either WUTH, community or neighbouring maternity unit. The method used works out the clinical establishment based on agreed standards of care and specialist needs and then includes the midwifery management and specialist roles required to manage maternity services. The recommendation is to provide total care to women and their babies throughout the 24 hours 7 days a week inclusive of the local % for annual, sick & study leave allowance and for travel in community**.** The last full Birthrate Plus full analysis and report was undertaken in 2024 and reviewed the date from a three-month period. It has been noted since the previous Birth Rate plus full analysis reported in 2021, whilst the birth rate has not increased and remained static, women/birthing people have more complex needs. This is in relation to the rising c/section and induction of labour rates. In addition, the most recent analysis has taken

	into account the CQC recommendation to ensure two midwives in maternity triage at all times and a designated telephone triage midwife in weekday core hours.
1.3	**Maternity Incentive Scheme (MIS) Safety Action 5 Required Standards:** 1. The allocated midwifery co-ordinator in charge has been supernumerary at the start of every shift. In the reporting period from July 2024 to December 2024 the midwifery co-ordinator has been supernumerary at the start of every shift. 2. The midwifery coordinator in charge of labour ward must have supernumerary status to ensure there is oversight of all birth activity within the service. There were 4 occasions over 6 months throughout the 24-hour reporting period from July 2024 to December 2024 (Q2 24/25 and Q3 24/25) the midwifery coordinator reported being unable to maintain supernumerary status. This is reported as short-term until the interim plan of the caseload being handed over with the initiation of the continuity midwife arriving or escalation processes followed to ensure further midwifery staff to rectify and ensure the midwifery co-ordinator resumes oversight of all the birth activity within the service. 3. Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall in staff. The maternity service has robust escalation processes to manage short falls in staffing level during periods of high acuity. 4. The midwife: birth ratio The midwife to birth ratio is reported monthly within the maternity dashboard and has been RAG rated green during the period from July – December 2024 in line with NICE guidance and safe maternity staffing levels. 5. The percentage of specialist midwives employed and mitigation to cover inconsistences. Birthrate plus incorporates a review of specialist midwives employed and the roles are in line with the recommended 10%. The trust has recruitment the additional Pelvic Specialist Midwife post (0.4WTE) in line with the recurrent funding received from NHSE as supported from the Three-Year delivery plan. 6. The provision of all women receiving one to one midwifery care in active labour is reported at care in labour. Maternity services from the period January to June 2024 reports via the Birthrate plus platform 100% of women receiving one to one care in active labour.
1.4	**Continuity of Carer:** There is still a requirement for Trusts to provide a model of care providing continuity of carer to women during the whole maternity episode. This model of care was initially detailed in Better Births in 2016 and included in the National Maternity Transformation Programme given its evidence based providing improved outcomes for mums and

	babies. The target date to deliver 100% continuity of carer had been removed, instead providers were requested to develop local plans that work for them ensuring staffing requirements are met along with an upskilled workforce. WUTH had previously submitted a plan with an ambition to achieve by MCoC as the default model by June 2024. Adaptations have been made to the plan in line with the current workforce, safe staffing levels and achieving 50% of women offered this model of care and those in the vulnerable groups are majority included. The benefits of a woman being cared for by the same team of midwives throughout her pregnancy including the delivery and following cannot be underestimated. Clinical outcomes are improved with this model of care, with women reporting positive birth experiences and with the woman less likely to experience postnatal illness. A woman who receives care from a known midwife is more likely to: • Have a vaginal birth • Have fewer interventions during birth • Have a more positive experience of labour and birth • Successfully breastfeed her baby • Cost the health system less • Less likely to experience pre-term birth • Less likely to lose their baby before 24 weeks gestation Considering pre-term birth alone, it is well evidenced that the high rates of morbidity and mortality arising from preterm birth impose a considerable burden on finite health care resources. Preterm infants are at increased risk of a range of adverse neonatal outcomes including chronic lung disease, severe brain injury, retinopathy of prematurity, necrotizing enterocolitis and neonatal sepsis. In later life, preterm infants are at increased risk of motor and sensory impairment, learning difficulties and behavioural problems. The economic consequences include the costs of neonatal care as well as the costs associated with living with disabilities. There is a substantial literature on the short and (to a lesser extent) long term clinical consequences of prematurity. The total cost of preterm birth to the public sector has been estimated to be £2.946 billion. The average cost of a pre-term birth and the provision of care is £100,000k which considers 4 weeks ITU care, 4 weeks HDU care and 2 weeks SCBU prior to discharge. This does not include the financial burden of complex investigations, tests and the long term. The incremental cost per preterm child surviving to 18 years compared with a term survivor was estimated at £22885. The corresponding estimates for a very and extremely preterm child were substantially higher at £61781 and £94740, respectively. The Trust has five embedded teams and at present no further teams are anticipated, however in line with national guidance this will be closely monitored. WUTH has undertaken its own data collection based on models of care and outcomes concluding there were benefits as described in Better Births (2016), however they were not as significant as the RCT's reported in Better Births. Improved outcomes are also mitigated by other initiatives such as Saving Babies Lives. There are currently no plans to roll out any further teams and internal review is underway to the current team's sustainability in line with staffing levels and a continued focus on those women that most benefit. Any proposed changes will take into consideration a balanced perspective with workforce, safety and system capacity.

	It is also important within the model to consider workforce sustainability and midwives report burnout linked to MCoC models and challenges with various ways of working to support work-life balance.
1.5	**NHSE Bid** The planning Guidance for 2021-22 specifically referenced additional funding for maternity services of £95million – Service Development Funding (SDF) extending to £137million in 2022-23. A detailed bid based on midwifery staffing requirements was submitted to NHSE for consideration given the requirements outlined in the Ockenden report. WUTH was successful in its bid to secure additional funding however, the process for distributing Ockenden funding changed between 2021/22 and 2022/23. In order to ensure recurrent funding, the monies were distributed regionally on a fair share basis and has been allocated to the ICB rather than directly to individual Trusts resulting in a mismatch to the funding allocated last year. Funding allocated to Cheshire & Merseyside ICB for 2022/23 is £3,731,000 which is slightly more than the total FYE allocated to all C&M Trusts last year, however, is the decision regarding the allocation of funding sits with the ICB and the LMNS in deciding which is the best and most sustainable way to split this funding between Trusts. The recurrent funding received in 2024/25 totalled £462k (in line with the revised allocation from the ICB). WUTH maternity services were also allocated £165k for Ockenden II workforce to include retention, bereavement services, maternity support work investment, preceptorship and obstetrics. Organisations offering full enhanced maternity care were also allocated funds equating to £240k. The LMNS/ICB have outlined quarterly financial reviews will be undertaken to ensure all LMNS finances have been committed and spent as specified. The funding allocation continued in 2024/25 and there are currently no anticipated changes to the funding allocation for 2025/26.
1.6	**Birth Rate Plus (BR++ Findings** Birthrate Plus. (BR+) is a framework for workforce planning and strategic decision-making and has been in variable use in UK maternity units since 1988, with periodic revisions as national maternity policies and guidance are published. It is based upon an understanding of the total midwifery time required to care for women and on a minimum standard of providing one-to-one midwifery care throughout established labour. The principles underpinning the BR+ methodology is consistent with the recommendations in the NICE safe staffing guideline for midwives in maternity settings and have been endorsed by the RCM and RCOG. Birthrate Plus® is the most widely used system for classifying women and babies according to their needs and using clinical outcome data to calculate the numbers of midwives required to provide intrapartum and postpartum care. The BR+ Report received in March 2025 as per Ockenden requirements to repeat every three years. It was based on a 24% uplift to reflect all the additional training requirements included in the Maternity Incentive Scheme, (which equated to an additional 40hours per annum per midwife).

The results of the report were based on delivering 55% continuity of carer (5 teams), no changes to the number of births, however its accounts for the additional midwifery hours required for the increasing number of women with complex needs, the increasing induction and caesarean section rates. The analysers were also requested to include the requirement for an additional c/section list and telephone triage core weekday hours as recommended in the CQC publication (2024).

Table 1 summarises the comparison between Birthrate Plus WTE recommendation and with current funded WTE in clinical staff

Current WTE	Birthrate Plus WTE	Variance
147.11	156.25	-9.14

The above outlines total recommended midwifery staff numbers (Band 3-7) for Wirral University Teaching Hospital is 156.24wte. Current establishment is 147.11wte, which equates to a shortfall of 9.14wte.

BDISC recently approved a business case to support the funded posts to be recruited into permanently and recurrent, which has supported the recruitment process for 4.3wte Band 5 Midwives and 2.96wte Maternity Support Workers

The shortfall to meet safe clinical staffing levels in 1.88wte.

Table 2 summarises the comparison between Birthrate Plus WTE recommendation and current funded WTE in additional specialist and senior management staffing

Current funded wte	Birthrate Plus wte	WTE Variance
13.72	18.75	-5.03

The above shows the current funded establishment has a small deficit of 5.03wte allocated for specialist roles. Again, the recent business case has supported and

	approved two additional specialist posts which have been recruited to and the overall shortfall is 3.03wte specialist roles. In addition to the shortfall recommendations were made in areas of focus to include a second Matron, Audit and Guideline Midwife, Clinical Governance relating to the workload with Saving Babies Lives and the Maternity Incentive Scheme regulation and requirements. The overall deficit to meet safe maternity staffing levels is 4.91wte (Band 5-8). The current staffing model does not meet the requirements based on the most recent workforce Birthrate Plus recommendations for safe staffing and midwifery staffing. Whilst is it suboptimal the recently approved business case to recruit into all funded posts recurrent and permanently the deficit has been closed significantly. There are no recommendations to make any immediate changes to the current models of maternity care, however, acknowledge a review is being undertaken.
1.7	**Recommendation** The Board is asked to:- • Support the preparation of a detailed Statement of Case for additional midwifery staffing. • Recognise this is as priority workforce investment, essential to delivering safe maternity care and to meet Safety Action 5 of the CNST Maternity Incentive Scheme (MIS), CQC recommendations and addressing work pressures.
1.8	**Conclusion** Maternity services are experiencing caring for an increased number of women with complex needs resulting in a requirement further midwifery care hours. National reviews and regulatory bodies emphasise the critical importance of safe staffing in maternity services to prevent avoidable harm and promote high-quality care. Current Birthrate + modelling identifies a minimal shortfall of 4.96wte midwifery staff to deliver care safely and meet the needs of women and families. Staffing gaps contribute to increased clinical risk, reduced staff wellbeing, and service pressures Options for maternity models of care have been considered and in line with national guidance maternity continuity of carer teams will continue for women/birthing people with enhanced needs. The allocated funding to maternity services will be spent as specified and for its intended purpose to maintain quality and safety.

2	**Implications**
2.1	**Patients**

	• There is some risk to patient care and safety in having two models of care as an equitable service is not being delivered, however positive outcomes are evident in women with enhanced needs being on an MCoC pathway. • Patient experience within both models of care is positive and there have been no relating complaints to either. • Ensuring stability and structure with minimal disruption to both models provide continuity antenatally and postnatally. • Staffing gaps can contribute to clinical risk, delays in care and sustainability of high-quality care. •
2.2	**People** • Below safe staffing levels impact on staff morale, burnout and employee well-being. • A two-model approach to midwifery care impacts on wellbeing and employee experience. Internal escalation process is utilised to mitigate, and revised working patterns/escalation processes have been embedded
2.3	**Finance** • The financial impact to meet safe staffing levels in maternity services will have financial implications.
2.4	**Compliance** • Better Births (2016) recommendations is to improve continuity of carer, teams have been set up across Wirral University Teaching Hospital (WUTH) meeting the current national drive. • The published Birthrate Plus report has ensured WUTH have had a 3 yearly workforce review in line with Ockenden. • The published Birthrate Plus report recommendation has a risk to Safety Action 5 of the CNST MIS in the vent staffing levels are not met or a clear action plan to achieve.

Objective	Deliverables	Minimum evidence requirements for LMNS to gain assurance	LMNS Q2 Feedback	Q3 Update	Q3 Provider BRAG Rating	Q3 LMNS is assured ?	Q3 LMNS BRAG Rating	LMNS Q3 Feedback	Q4 Provider Self Assessment BRAG	Q4 Provider Update
Objective 1: Care that is personalised	Is PCSP training included in the TNA?	1) LMNS to review each TNA and confirm the inclusion of PSCP training for each provider. 2) If the provider declares non compliance, LMNS to agree a completion date with the provider. If the provider is not compliant by the agreed date a recovery plan will need to be agreed between the LMNS and the provider 3) All none compliance actions and agreed recovery plans will be reviewed at each MPOP meeting each quarter.	Update required for Q3 Partial Assurancein Q1 - Need further detail re ccf	Further evidence/detail included as evidence to include TNA 2025		Y	Blue	TNA evidence reviewed and note inclusion of PCSP training	Provider - Blue	No change in Q4
	Are Personalised care audits being undertaken regularly?	1) Provider to submit a copy of the audit schedule to the LMNS for review. 2) LMNS to provide reassurance at MPOP that the audit schedule has been submitted and includes PCSP audits.	Update required for Q3 - Trust to upload additional evidence (e.g. forward audit schedule and recent audit data)			Y	Green	Evidence of PCSP audits obtained via LMNS PCSP Community of Practice Group - . Further information/evidence requested for Q4	Provider - Green	Audit schedule uploaded
	Is the trust in a position to roll out MCoC?	1) Where the provider states they are in a position to roll out MCoC in line with the principles of safe staffing https://www.england.nhs.uk/wp-content/uploads/2022/09/B2011-Midwifery-Continuity-of-Care-letter-210922.pdf The minimum evidence requirement is an up to date MCoC Plan confirming the 13 building blocks are in place. 2) Provider to share Plan with the LMNS and reassurance provided to the regional team at the MPOP meeting, that it has been reviewed.	Update required for Q3			Y	Green	5x CoC Teams currently in place - no further teams planned at present	Provider - Green	No change in Q4
	Number of EMCoC teams operating in line with national guidance?	1) Provider to confirm number of EMCoC teams in place operating in line with national guidance. 2) LMNS to review evidence of EMCoC meetings where EMCoC teams are discussed or alternatively submit tracker which demonstrates EMCoC teams are in place. 3) Provider EMCoC progress report to be provided by LMNS at MPOP.	Update required for Q3	5 MCoC teams embedded in the areas of vulnerability / social deprivation		Y	Green	The Trust have 5 enhanced MCoC teams providing in place, embedded in areas of vulnerability / social deprivation - no further teams planned at present	Provider - Green	No change in Q4
	Number of EMCoC teams planned to be rolled out in line with national guidance?	1) LMNS to confirm assurance arrangements in place for future number of teams to be rolled out in line with national guidance. 2) LMNS to review evidence of MCoC meetings where EMCoC teams are discussed or alternatively submit tracker which demonstrates EMCoC teams are in place. 3) As above LMNS to provide progress update for each provider at MPOP.	Update required for Q3	5 MCoC teams embedded in the areas of vulnerability / social deprivation		Y	Green	The Trust have 5 enhanced MCoC teams providing in place, embedded in areas of vulnerability / social deprivation - no further teams planned at present	Provider - Green	No change in Q4
	Has the trust achieved UNICEF BFI accreditation?	1) Each provider to provide a copy of the BFI accreditation status for Maternity and Neonates to the LMNS. 2) If provider does not have full accreditation, the LMNS should review and monitor evidence of the provider's schedule and plan for full achievement by 2027 3) If a provider has a certificate of accreditation action and dates for stage 1 this should be shared with the LMNS. 4) If provider is at stage 1, evidence and dates are required for planned stage 2 accreditation and so on until the provider can demonstrate full accreditation. 5) Once a provider has achieved full accreditation, evidence of their sustainability plans with annual audit schedule is required and should be submitted to the LMNS. 6) LMNS to provide progress update for each provider at MPOP.	Update required for Q3 Partial Assurance in Q1 Maternity is stage 3 Neonatal not accredited - raised PO	Maternity is stage 3 and application has been submitted for NNU - 2 year plan with training commenced and 1wte in post to lead; on tack to deliver in timeframe		Y	Green	LMNS note that Maternity is at stage 3 and an application has been submitted for NNU Trust to confirm UNICEF assessment dates and to upload a copy of the UNICEF Action Plan in Q4	Provider - Blue	UNICEF Action plan uploaded as evidence
Objective 2: Improve equity for mothers and babies	Does the trust provide access to interpreter services, which adheres to the Accessible Information Standard?	1) A copy of the provider guideline/algorithm/SOP/operational plan for the use of interpreters that is clearly mapped against the Accessible Information Standard, should be shared with the LMNS. 2) LMNS to provide reassurance to the MPOP that they are assured each provider is compliant with the Accessible Information Standard. 3) Where a provider is identified as non-compliant the LMNS will set target dates for compliance with the provider and monitor accordingly. 4) LMNS to provide progress updates to MPOP.	Update required for Q3 No assurance in Q1: no interpreter policy received.	Interpretation policy uploaded as evidence		Y	Green	Draft Trust wide policy submitted as evidence. Provider to confirm if it meets accesible information standards for Q4.	Provider - Green	Confirmation sent post Q3 WUTH meetings accessible standards and uploaded
	Is data collected and disaggregated based on population groups?	1) LMNS to confirm the provider's EPR system has the capability to collect and disaggregate data based on population groups. (both ethnicity & deprivation) 2) Where a provider demonstrates non-compliance, LMNS to agree a recovery plan for compliance and monitor accordingly. 3) LMNS to provide progress updates to MPOP.	Update required for Q3 Partial Assurance in Q1 - more evidence required.	Data collected includes age, ethnic minority, marital status, postcode, language/s spoken and other data as per MSDS requirements. Analysis examples uploaded as evidence		Y	Green	LMNS assured on track, but further evidence required in Q4 (as per Q1 request)	Provider - Green	Examples uploaded as evidence
Objective 3: Work with service users to improve care	Are service users involved in quality, governance, and co-production when planning the design and delivery of maternity and neonatal services?	1) LMNS to review the provider's MNVP annual workplan and gain assurance that the NMVP are involved in quality, governance, and co-production when planning the design and delivery of maternity and neonatal service. 2) Where a provider demonstrates non compliance, LMNS to agree target dates for compliance and monitor accordingly. 3) LMNS to provide reassurance to MPOP that this measure is embedded in the organisation.	Q1 - LMNS in receipt of MNVP Workplan; MNVP lead in post for 16 hours per week	Evidence submitted as Safety Action 7 and compliance signed off for MIS Year 6		Y	Blue	LMNS Assured	Provider - Blue	No change in Q4
Objective 4: Grow our workforce	Date of last BR+	1) Provider to submit copy of the latest BR+ report to LMNS. 2) BR+ compliance to be discussed with MPOP	LMNS Assured in Q1	Assured: June 2021 New BR+ scheduled for January 2025. BR plus commenced in June 2023; final report expected Feb 2025		Y	Green	LMNS Assured, but require Trust to submit BR plus recent report in Q 4	Provider - Blue	BR Plus report (March 2025) uploaded as evidence
	Funded to BR+ establishment	Where a provider is not compliant with establishment recommendations in BR+: 1) Gap analysis of variance between current budgeted establishment vs BR+ recommendations to be reviewed by the LMNS. 2) Business case to meet BR+ establishment to be reviewed by the LMNS. 3) Copy of the risk assessment where an executive board does not support the findings of the BR+ report to be reviewed by the LMNS.	LMNS Assured in Q1 - Funded to establishment	Remain funded to current BR plus workforce and all funded posts (non-recurrent). Trust has agreed to recruit to all posts permanently increasing current establishment. Minutes of meeting can be uploaded at Q4		Y	Green	Trust remain funded to current BR plus workforce and all funded posts (non-recurrent). Trust has agreed to recruit to all posts permanently increasing current establishment. Minutes of meeting to be uploaded at Q4	Provider - Blue	Approved business case uploaded; EARC minutes uploaded
	Planned date of next BR+	1) Planned date of next BR+ report to be agreed with the LMNS. 2) BR+ compliance to be discussed with MPOP	Update required for Q3	Underway - awaiting report; data collection for accuracy has taken longer than expected and due by end Feb 2025		Y	Green	LMNS assured that this is underway. Trust has confirmed awaiting report; data collection for accuracy has taken longer than expected	Provider - Green	Uploaded as evidence
	Bi-Annual workforce plan for maternity and neonates including obstetrics in place?	1) LMNS to confirm that the Bi-annual workforce plan includes maternity, neonates and obstetrics has been submitted to board. 2. LMNS to confirm date for next bi-annual plan submission to board.	LMNS Assured in Q1 - Workforce plan provided	Workforce plan submitted; no further action		Y	Blue	LMNS Assured in Q1 - Workforce plan submitted and reviewed	Provider - Blue	
	Does the annual workforce plan include support for newly qualified staff and midwives who wish to return to practice?	1) LMNS to review the annual workforce plan and confirm if it includes support for newly qualified staff and midwives who wish to return to practice. 2) LMNS to provide updates to MPOP where compliance not achieved.	Update required for Q3	Evidence uploaded to support RTP; in 2025 annual workforce plan will include support for newly qualified staff and RTP midwives		Y	Green	Trust to submit updated Maternity Workplan in Q4, to include additional information from BR+ Report	Provider - Green	Workforce plan uploaded
	MW Vacancy Rate (please provide additional narrative to support data)	1) LMNS to undertake quarterly review of Maternity Workforce PWR data. 2) LMNS to discuss plan to improve vacancy rates with provider 3) LMNS to provide reassurance to MPOP that plan is in place to reduce vacancy rate.	Trust to input PWR date from Q3 and beyond	PWR data uploaded as received; LMNS will discuss distribution with NWMO		Y	Green	Business Case received, which supports PWR narrative	Provider - Green	
	MW Leaver Rate (please provide additional narrative to support data)	1) LMNS to undertake quarterly review of Maternity Workforce PWR data. 2) LMNS to discuss plan to improve leaver rates with provider. 3) LMNS to provide reassurance to MPOP that plan is in place to reduce leaver rate.	Trust to input PWR date from Q3 and beyond	PWR data uploaded as received; LMNS will discuss distribution with NWMO		Y	Green	Business Case received, which supports PWR narrative	Provider - Green	
	MW Turnover Rate (please provide additional narrative to support data)	1) LMNS to undertake quarterly review of Maternity Workforce PWR data. 2) LMNS to discuss plan to improve turnover rate with provider. 3) LMNS to provide reassurance to MPOP that plan is in place to reduce turnover.	Trust to input PWR date from Q3 and beyond	PWR data uploaded as received; LMNS will discuss distribution with NWMO		Y	Green	Business Case received, which supports PWR narrative	Provider - Green	
	MW Sickness Rate (please provide additional narrative to support data)	1) LMNS to undertake quarterly review of Maternity Workforce PWR data. 2) LMNS to discuss plan to improve turnover rate with provider. 3) LMNS to provide reassurance to MPOP that plan is in place to reduce turnover.	Trust to input PWR date from Q3 and beyond	PWR data uploaded as received; LMNS will discuss distribution with NWMO		Y	Green	Business Case received, which supports PWR narrative	Provider - Green	
	Obstetric Consultant Vacancy Rate (please provide additional narrative to support data)	1) LMNS to undertake quarterly review of Maternity Workforce PWR data. 2) LMNS to discuss each plan to improve obstetric consultant vacancy rate with provider. 3) LMNS to provide reassurance to MPOP that plans are in place to reduce obstetric consultant vacancy rate.	Trust to input PWR date from Q3 and beyond	PWR data uploaded as received; LMNS will discuss distribution with NWMO		Y	Green	DoM confirmed that the 1 WTE consultant gap (as of 01.11.24) has now been recruited to, with a planned start date of 01.04.25	Provider - Blue	Fully recruited to establishment
	MSW Vacancy Rate (please provide additional narrative to support data)	1) LMNS to undertake quarterly review of Maternity Workforce PWR data. 2) LMNS to discuss plan to improve MSW vacancy rate with provider. 3) LMNS to provide reassurance to MPOP that plans are in place to reduce MSW vacancy rate.	Trust to input PWR date from Q3 and beyond	PWR data uploaded as received; LMNS will discuss distribution with NWMO		Y	Green	Business Case has been completed by Trust and uploaded, which supports PWR narrative	Provider - Blue	Fully recruited to establishment
	Is there a retention midwife in post? (please provide additional narrative to support data)	1) Provider to provide confirmation of Retention Midwife in post (name, job title and WTE) 2) LMNS to review Job description 3) If the provider is non compliant LMNS to confirm if the national NHSE Retention funding was received by provider? If YES LMNS should confirm what has the funding been utilised for and evidence of this being approved by the Trust Board to be provided to the LMNS. 4) LMNS to provide reassurance to MPOP	Update required for Q3 Partial Assurance in Q1 - JD was strengthening to include retention	JD updated and uploaded as evidence		Y	Green	LMNS Assured - Retention Midwife is in post. However, the LMNS also acknowledge operational issues experienced by the Trust due to bereavement leave (Retention Midwife). However, the LMNS is satisfied with mitigations in place, with support provided by the PDM.	Provider - Green	Post in establishment; post out for internal interest due to long term absence
	Does the trust have a retention improvement action plan?	1) LMNS to review provider Retention Improvement Action Plan for assurance. 2) LMNS to agree monitoring to ensure the improvement plan remains on track. 3) LMNS to provide reassurance to MPOP	Update required for Q3 Partial Assurance in Q1 - No improvement plan attached but evidence in document that compliance achieved; vacancy rate <2% no further actions identified; rolling recruitment campaigns continue	Vacancy rate continues at <2%; rolling recruitment campaign and Trust agreed business case to increase establishment		Y	Green	Business Case received, which supports the narrative for this deliverable	Provider - Green	No change in Q4
	Is there a plan in place to reduce workforce inequalities?	1) If yes LMNS to review the workforce inequalities plan for assurance 2) If no LMNS/ICB to work with the provider and agree a time frame for the development of a workforce equalities plan 3) LMNS to provide reassurance to MPOP As a minimum each provider needs to provide evidence of a baseline of staff in post by ethnic group in order to monitor any positive improvements	Evidence received inequalities plan	Evidence uploaded		Y	Blue	LMNS Assured - Trust wide policy received	Provider - Blue	No change in Q4

Objective 5: Value and retain our workforce	Is the trust signed up to the North West Black, Asian, and Minority Ethnic Assembly Anti-racist Framework?	1) LMNS to review the provider's self assessment status against the framework for assurance. 2) LMNS to seek evidence of annual action plan to attain accreditation including evidence that it has been reported at board to ensure delivery and commitment. 3) LMNS to provide reassurance to MPOP https://www.england.nhs.uk/north-west/wp-content/uploads/sites/48/2023/07/The-North-West-BAME-Assembly-Anti-racist-Framework-FINAL.pdf	Evidenced received - LMNS assured but would like to see self-assessment	Self assessment uploaded as evidence		Y	Green	LMNS Assured - Certificate of Recognition, EDI Bi-annual Report and Workforce Race Equality Standard Report received Trust to submit self-assessment in Q4	Provider - Blue	Evidence submitted
	Do the trust have a mechanism to identify and address issues highlighted in student and trainee feedback surveys?	1) LMNS to confirm with provider what mechanisms are in place to identify and address issues highlighted in student and trainee feedback surveys? - (This could be NTS NETS or PARE placement feedback)? 2) LMNS to provide reassurance to MPOP	Update required for Q3 Partial Assurance in Q1 - WUTH need to explain what is being done with the feedback	Workforce plan submitted; no further action		Y	Green	LMNS note that the Trust is one of the top performers in the North West. Trust to submit Board Report in Q4, to evidence that survey results have been communicated to Board	Provider - Blue	Report to BoD and minutes uploaded as evidence of outstanding practice
	Does the trust offer a preceptorship programme to every newly registered midwife, with supernumerary time during orientation and protected development time?	1) LMNS to review provider's preceptorship programme and confirm it includes: a) length of preceptorship period b) length of supernumerary period c) the supernumerary period being applied to each clinical rotation during the preceptorship programme d) minimum expectation of all clinical areas during the preceptorship period 2) LMNS to confirm an target date for compliance is in place where all of the above are not included in the preceptorship policy 3) LMNS to provide reassurance to MPOP	Update required for Q3 Partial Assurance in Q1 - Require Preceptorship pack as evidence	Further evidence uploaded		Y	Blue	LMNS Assured - Preceptorship Programme in place	Provider - Blue	No change in Q4
	Do the trust offer newly appointed Band 7 and 8 midwives support with a mentor?	If the provider reports Yes: 1) LMNS should seek evidence in the form of a SOP or alternative. If the provider reports No: 1) LMNS to discuss challenges and barriers to provision with provider and agree plan for delivery 2) LMNS to provide progress update to MPOP for non compliance	SOP received	No further action		Y	Blue	LMNS Assured - LMNS note Trust SOP for Band 7 & 8 mentorship as an example of best practice to be shared across the system to support shared learning	Provider - Blue	No change in Q4
	Does the trust have a leadership succession plan which reflects the ethnic background of the wider workforce? .	1) LMNS to review provider leadership succession plan, and gain assurance that it reflects the ethnic background of the wider workforce. 2) LMNS to discuss and agree completion date for plan with provider where this is not yet in place. 3) LMNS to provide progress update to MPOP	Update required for Q3 Partial Assurance in Q1 - elements relating to ethnicity require strengthening			Y	Green	LMNS note Bronze award. However, minimal evidence received - provider to upload Black, Asian and Minority Ethnic Self Assessment Tool in Q4, which will support evidence of this deliverable	Provider - Green	Evidence uploaded
Objective 6: Invest in skills	Does the trust's TNA align with the core competency framework?	1) Provider to submit TNA including CCF alignment details - LMNS to review and confirm compliance - LMNS to agree target date for compliance and monitor where necessary 2) LMNS to provide re-assurance to MPOP. https://www.england.nhs.uk/long-read/core-competency-framework-v2-minimum-standards-and-stretch-targets/	Update required for Q3 Partial Assurance - Need further detail re ccf	TNA 2025 uploaded		Y	Green	Trust to submit final ratified TNA in Q4	Provider - Blue	Final TNA uploaded as evidence
	Do junior and SAS obstetricians and neonatal medical staff meet RCOG and BAPM guidance for clinical and support supervision?	1) Provider to provide evidence to LMNS that junior and SAS obstetricians and junior neonatal medical staff meet RCOG and BAPM guidance for clinical and support supervision 2) LMNS to provide assurance to MPOP	Update required for Q3 Partial Assurance in Q1 - Require more evidence.	Evidence uploaded		Y	Green	Trust to submit Neonatal Workforce Paper, which includes MIS SA5	Provider - Blue	Safety Action 5 compliance signed off; additional NNU consultant in post
	Do temporary medical staff covering middle grade rota possess an RCOG certificate of eligibility for short-term locums?	It is a statutory requirement that all middle grade temporary medical staff working within maternity services should provide an RCOG certificate of eligibility to the provider 1) LMNS to seek assurance from provider that the CD holds RCOG certificates for all short term locum doctors 2) LMNS to reassurance to MPOP	Update required for Q3	Locums not utilised at WUTH		Y	Green	Confirmation received from the Trust that locums are not utilised. However, LMNS will require ongoing assurance that short term locums are not used	Provider - Green	Remains unchanged and no Locums required
Objective 7: Develop a positive safety culture	Do maternity and neonatal leads have time within their job plan to access training and development, including time to engage stakeholders, and MNVP leads?	1) If provider reports YES - LMNS to gain assurance by reviewing evidence how much time allocated in job plan and of achievement and confirm reassurance. 2) if provider reports NO - LMNS to provide support to the provider to become compliant. 3) LMNS to provide quarterly updates at MPOP re non-compliance.	LMNS Assured in Q1	No further action at Q3		Y	Blue	LMNS Assured in Q1 - Job Plans received	Provider - Green	No change in Q4
	Have senior leaders attended national leadership programmes this year, including board maternity and neonatal safety champions?	provider to share with LMNS names, job titles and dates of training attended, to include non exec board level safety champion & board level safety champion, e.g. chief nurse	Update required for Q3 LMNS Assured but Trust required to confirm dates	Commenced programme April 2023 into 2024; all members completed full programme; continues support from Amanda Andrews in 2025		Y	Green	LMNS note all members have completed the full programme, with support from Amanda Andrews to continue in 2025	Provider - Green	No change in Q4
	Does the trust board support the implementation of a focused plan to improve and sustain maternity and neonatal culture and regularly review progress?	1) Provider to submit evidence of board agendas/minutes where QIP is discussed to LMNS for review. 2) LMNS to provide reassurance at MPOP meetings.	LMNS Assured in Q1	No further action at Q3		Y	Green	LMNS assured on track, but further update required in Q4	Provider - Green	
	Is there a clear and structured route for the escalation of clinical concerns? (i.e. Each Baby Counts: Learn and Support escalation toolkit).	1) If escalation policy is in place - LMNS to review for assurance . 2) LMNS to ensure escalation policy includes EBC learning and support escalation toolkit 3) If no escalation policy/it does not meet compliance standard - LMNS to support provider to develop policy which the LMNS will maintain oversight. 4) LMNS to provide reassurance to MPOP	LMNS Assured Q1	No further action at Q3		Y	Green	LMNS note that the Trust uses AID as a toolkit and that the Trust was a pilot site for the introduction nationally of the escalation tool. THis has been rolled out.	Provider - Green	No change in Q4
	Is there a Freedom to Speak Up Guardian?	1) If YES - FTSU JD to be reviewed by the LMNS. 2) If NO - action plan detailing when the FTSU guardian will be in place required. 3) Action plan to be monitored by the LMNS with regional oversight at MPOP	LMNS Assured	No further action at Q3		Y	Blue	Name of FTSU Guardian received and JD for post	Provider - Blue	No change in Q4
	Is there a FTSU training module for staff?	Minimum evidence requirement - Induction training manual or equivalent 1) If YES - provider to provide evidence of FTSU training module or equivalent (no further monitoring) 2) If NO - provider to develop action plan with date for when the FTSU will be included in the induction training manual or equivalent. 3) Action plan to be monitored by the LMNS with regional oversight at MPOP	Update required for Q3 Partial Assurance in Q1 - Need to see evidence of the content of the training	Evidence uploaded		Y	Green	Ongoing review of evidence required. Provider to upload evidence link for Q4.	Provider - Green	
Objective 8: Learn and improve	Has the trust implemented PSIRF?	1) If provider reports PSIRF implemented, LMNS to review the PSIRF plan. LMNS to confirm if the PSIRF plan includes a chapter for maternity. 2) If provider reports PSIRF not in place - LMNS to monitor and offer support to attain full implementation 3) Action plan to be monitored by the LMNS with regional oversight at MPOP	PSIRF implemented but no maternity chapter. Maternity chapter anticipated Q3 24/25, until this is released LMNS will deem this assured.	No further action; all evidence uploaded as current PSIRF		Y	Green	PSIF Policy in place. However, Maternity Chapter currently paused by NHS Regional Team.	Provider - Green	No change in Q4
	Is there a formal structure to review and share learning? (with agreed timescales)	This should be included in the PSIRF plan: Minimum evidence requirement - LMNS to review provider PSIRF plan for assurance 1) If PSIRF plan include a formal structure to review and share learning which includes timeframes - no further monitoring required 2) If plan does not include structure to review LMNS to support providers to achieve 3YD plan measure 3) LMNS to provide quarterly update at MPOP where provider not compliant.	LMNS Assured in Q1 - included in Incident policy - Trust and Maternity Risk Management Strategy.	No further action at Q3		Y	Green	LMNS note included in Trust incident policy and Maternity Risk Management Strategy	Provider - Green	No change in Q4
	Has the organisation established effective, kind, and compassionate processes to respond to families who experience harm or raise concerns about their care?	Minimum evidence requirement: - LMNS to review if the provider has an established effective, kind, and compassionate processes to respond to families who experience harm or raise concerns about their care. 1) PSIRF plan should include a FLO - YES/NO 2) LMNS to provide assurance update at MPOP on processes in place	LMNS Assured in Q1	No further action at Q3		Y	Green	Whilst there is no specific FLO role, the role is built into specialised JDs	Provider - Green	No change in Q4
	Has the organisation adopted a single point of contact process for families where ongoing dialogue is required with the trust?	Minimum evidence requirement - This measure should be included in the PSIRF plan. LMNS to review PSIRF plan to confirm that a single point of contact process for families has been embedded. 1) If YES - No further updates required at MPOP unless process changes. 2) If No - Date to be provided when process will be in place. LMNS to monitor progress. 3) LMNS to provide assurance updates at MPOP	LMNS Assured in Q1 - Dedicated Lead	No further action at Q3		Y	Blue	LMNS Assured - Dedicated Lead in place	Provider - Blue	No change in Q4
	Is the organisation sensitive to culture, ethnicity, and language when responding to incidents?	Minimum evidence requirement - this measure should be included in the PSIRF plan. LMNS to review PSIRF plan to confirm the plan includes a chapter on how to support a family whose first language is not English, when they are involved in a serious event. 1) The PSIRF plan should include a chapter around language barriers a) If YES - LMNS to provide reassurance at MPOP b) IF NO - LMNS to agree a date with provider when this will be achieved, provide ongoing monitoring 2) LMNS to provide quarterly progress updates at MPOP.	Update required for Q3	All Trust policies/evidence uploaded as evidence		Y	Green	Automative data report required - Trust has requested this from Cerner	Provider - Green	
	Is there a process of triangulation of outcomes data, staff, and MNVP feedback, audits, incident investigations, and complaints, as well as learning from where things have gone well?	Minimum evidence requirement, If the trust has stated YES, the LMNS needs to understand what the process is discuss at MPOP. 1)NO - The LMNS to support the trust with the development of a process to triangulate outcome data, staff and MNVP feedback, audits, incident investigations and complaints as well as learning from when things have gone well. Target dates for completion need to be agreed with the provider. 2) YES - If the LMNS are assured that the process is embedded 3) LMNS to provide re-assurance at MPOP that they are satisfied that this measure has been implemented and is being sustained.	LMNS Assured in Q1 - Multiple minutes from assurance minutes reviewed	No further action at Q3		Y	Green	LMNS assured on track, but further update required in Q4	Provider - Green	Further evidence uploaded to demonstrate sustainability
	Does the organisation share open and honest information on the safety, quality, and experience of their services?	1) Where provider self assesses YES - LMNS need to understand what this looks like and gain assurance that the process is embedded 2)Where provider self assesses NO - LMNS to monitor progress, set target dates to meet this requirement 3) LMNS to provide quarterly updates to MPOP.	LMNS Assured in Q1	No further action at Q3		Y	Green	LMNS note that the following is in place to support this deliverable - PSQB and lessons learnt forum, RMC and risk committee, shared learning via C&M MNSG. Examples and flow chart of embedded process received	Provider - Green	No change in Q4
	Does the organisation regularly review the quality of maternity and neonatal services?	Minimum evidence requirement - Maternity Dashboard - Other quality monitoring processes. If YES 1) LMNS to explore how this is achieved. Evidence of the use of Maternity Safety Dashboard 2) LMNS to confirm assurance at MPOP that provider is regularly reviewing the quality of their maternity and neonatal services. If NO 1) LMNS to support the organisation to establish and regularly review quality and safety of services 2) LMNS to provide quarterly updates to MPOP on progress	LMNS Assured in Q1 - Monthly Quality Surveillance tool goes to Board monthly as per Safety Action 9 - MIS Year 5.	Evidence continues to be uploaded as evidence		Y	Green	LMNS note that the Monthly Quality Surveillance tool goes to Board monthly as per Safety Action 9	Provider - Green	No change in Q4
	Have maternity safety champions been appointed, including NED?	1) If YES - Provider to submit Names and titles of safety champions and JDs to LMNS for review 2) If NO - Provider to confirm dates when they will be in post, reason not in post. 3) LMNS to monitor progress and provide update at MPOP	Update required for Q3 Partial Assurance in Q1 - Safety Champions names received but LMNS require JD	JD's uploaded		P	Amber	Trust required to submit Chief Nurse JD in Q4 - agreed at MPOP meeting	Provider - Green	Evidence (JD) uploaded

Objective 9: Support and oversight	Has the quadrumvirate been appointed?	1) If YES - Provider to submit Names and titles of quadrumvirate for assurance 2) If NO - Provider to confirm dates when they will be in post, reason not in post. 3) LMNS to monitor progress and provide update at MPOP	LMNS Assured in Q1	No further action at Q3; no changes to quad		Y	Blue	LMNS Assured in Q1 - names received	Provider - Green	
	Are MNVPs involved in the development of the organisations complaints process?	Minimum evidence requirement - minutes of provider meetings confirming involvement 1) If YES - LMNS to review notes from meetings where MNVP was present during this discussion. 2)If NO - LMNS to discuss when will this be achieved with provider. Dates to be added to action plan. 3) LMNS to monitor progress and provide update at MPOP	Update required for Q3 Partial Assurance in Q1	Evidence uploaded		Y	Blue	LMNS Assured - DoM confirmed MNVPs understand complaint themes	Provider - Blue	Further evidence uploaded
	Are MNVPs involved in the quality, safety and surveillance group that monitors and acts on trends.	Minimum evidence requirement - Terms of Reference and minutes for provider meetings 1) If YES - LMNS to review minuted attendance for the MNVP 2) If NO - LMNS to discuss when this will be achieved with provider with dates added to action plan 3) LMNS to provide reassurance at MPOP	Update required for Q3 Partial Assurance - Require meeting minutes	Evidence uploaded		Y	Green	LMNS note that the MNVP, DoM, HoM, CN, NED and Neonatologist are included in safety champion walk abouts. Minutes uploaded as evidence	Provider - Green	Further evidence uploaded
	Is FTSU data reported to board and acted upon?	Minimum evidence requirement - minutes of Board meetings with evidence of how data is acted upon. If YES 1) Minutes from board meeting 2) Evidence of how data is acted upon? If NO 1) LMNS to agree with provider when will this be achieved and dates to be added to action plan LMNS to monitor progress 2) Provide quarterly update at MPOP	LMNS Assured in Q1- Trust Policy supports process	No further action at Q3;		Y	Green	BOD minutes received - further evidence required in Q4	Provider - Green	Further evidence uploaded
Objective 10: Standards to ensure best practice	Has the organisation implemented version 3 of the 'Saving Babies' Lives Care Bundle?	Minimum evidence requirement - Provider's latest submission to the SBL Implementation HUB Q4 23/24 If YES - LMNS to review latest submission If NO - 1) LMNS to agree with provider when this will be achieved and dates to be added to action plan 2) LMNS to monitor progress 3) Provide quarterly update at MPOP	LMNS Assured June 2024 96%	Achieved 87-97%; quarterly submission and reviews as evidence		Y	Blue	LMNS Assured	Provider - Blue	No change in Q4
	Is the organisation on track to adopt the national MEWS and NEWTT-2 tools by March 2025?	Minimum evidence requirement - self assessment Where provider reports YES - LMNS to continue support and report to MPOP on exception basis. Where a provider reports NO - 1) LMNS to consider barriers to implementation of the national roll out of MEWS and NEWTT- 2) Provide progress updates quarterly at MPOP	Update required for Q3 Partial Assurance in Q1 - More evidence required.	Awaiting confirmation from Cerner Millenium how to build into IT system as electronic record; Risk on register to support position		P	Amber	Trust awaiting confirmation from Cerner following a request for an electronic observation chart – LMNS requested update in Q4	Provider - Amber	No progress; on risk register
	Does the organisation regularly review and act on local outcomes including stillbirth, neonatal mortality and brain injury, and maternal morbidity and mortality to improve services?	Minimum evidence requirement: Narrative on what this looks like and SOP. Where provider reports YES - LMNS to review SOP and examples of reviews for assurance. Where provider reports NO - LMNS to provide assurance that they are supporting the provider to achieve this measure. LMNS to provide progress updates at MPOP	LMNS Assured in Q1	No further action		Y	Green	LMNS note monthly update with Quality Surveillance tool and quarterly PMRT Report as per MIS Year 5	Provider - Green	Further evidence uploaded
	Has the organisation completed the national maternity self-assessment tool? .	Minimum evidence requirement - LMNS to review provider's maternity self-assessment tool YES 1) submission of the maternity self-assessment tool 2) LMNS to review the quality and effectiveness of the self-assessment tool i.e. is it being utilised as an iterative process and updated regularly, who has oversight and what meeting is it discussed at NO 1) LMNS needs to agree target date for provider to complete the self-assessment tool and submit for review 2) LMNS to monitor progress against completion and provide update at MPOP	Update required for Q3	Evidence uploaded to include BOD papers who have oversight		Y	Green	Evidence received including BOD papers who have oversight - further update required in Q4	Provider - Green	Further evidence uploaded
Objective 11: Data to inform learning	Does the organisation have a process for reviewing available data which draws out themes and trends and identifies and addresses areas of concern including consideration of the impact of inequalities?	Minimum evidence requirement : Provider use of dashboard If YES 1) LMNS to review dashboard including where data is reviewed, frequency of review meetings and by whom 2) LMNS to confirm it includes measures for inequalities? If NO - LMNS to monitor progress against completion and agree improvement plan with provider and provide update at MPOP	Update required for Q3	Evidence to support current position uploaded		Y	Green	DoM confirmed Cerner can run reports on women with social deprivation backgrounds - - further update required in Q4		
	Does the organisation have a system that ensures high-quality submissions to the Maternity Services Data Set?	Minimum evidence requirement - Provider to submit MSDS data via the Strategic Data Collection Service in the Cloud (SDCS Cloud) using a registered account. If YES 1) LMNS to confirm evidence of SDCS account 2) Provider to submit monthly scorecard as evidence	Update required for Q3	MSDS scorecard reflects system is operational; all 11 criteria met		Y	Blue	LMNS note MSDS scorecard reflects system is operational; and all 11 criteria have been met	Provider - Blue	No change in Q4
	Does the organisation have robust processes in place to ensure referrals to NHSR, MNSI, and the National Perinatal Epidemiology Unit?	Minimum evidence requirement : Guideline which demonstrates process for reporting If YES - provider to submit guideline If NO- provider to agree when guideline will be in place and target dates to be added to action plan LMNS to monitor progress and provide updates at MPOP	Update required for Q3	Evidence uploaded		Y	Green	Further evidence requested	Provider - Green	Further evidence uploaded
Objective 12: Make better use of digital technology in maternity and neonatal services	Does the organisation have a digital maternity strategy and digital roadmap?	Minimum evidence requirement : Digital Maternity Strategy If YES - provider to submit copy of strategy to LMNS If NO - provider to agree when strategy will be in place with target dates to be added to action plan LMNS to monitor progress and provide updates at MPOP	LMNS Assured in Q1	No further action at Q3		Y	Green	Maternity Digital Strategy received. However, further evidence required in Q4	Provider - Green	Further evidence uploaded
	Is the digital strategy and roadmap being implemented?	Minimum evidence requirement : Progress reports on digital roadmap delivery against strategy If YES - provider to submit updates of progress to LMNS for review If NO - provider to agree with LMNS when progress will be made with target dates added to action plan LMNS to monitor progress and provide updates at MPOP	LMNS Assured in Q1	No further action at Q3		Y	Green	Digital Project Porfolio received. However, further evidence required in Q4	Provider - Green	Further evidence uploaded
	Does the organisation have an EPR system that complies with national specifications and standards, including the Digital Maternity Record Standard and the Maternity Services Data Set?	1)Provider to confirm with LMNS details of EPR system is in place. 2)LMNS to confirm whether EPR system complies with digital maternity record standard. LMNS to provide progress updates to MPOP where non compliance for provider.	LMNS Assured in Q1	No further action at Q3		Y	Green	Cerner Millenium in place. Further evidence required in Q4	Provider - Green	Further evidence uploaded

Appendix 12 Maternity self-assessment tool – Gap Analysis

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

Appendix 12 Maternity self-assessment tool – Gap Analysis

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Maternity services standing item on trust board agenda as a minimum three-monthly Key items to report should always include: • SI Key themes report, Staffing for maternity services for all relevant professional groups • Clinical outcomes such as SB, NND HIE, Attain, SBLCB and CNST progress/Compliance. • Job essential training compliance • Ockendon learning actions		Board papers can be accessed via the website as public. Quarterly update to Board by DoM. NED Safety Champion feeds back to Board monthly by exception.
		Monthly review of maternity and neonatal safety and quality is undertaken by the trust board [Perinatal quality surveillance model]		Perinatal Quality Surveillance report goes to Board monthly.
		There should be a minimum of three PAs allocated to clinical director to execute their role		Initially 2 PA's allocated but 3 allocated in new job plan
	Collaborative leadership at all levels in the directorate/ care group	Directorate structure and roles support triumvirate working from frontline clinical staff through to senior clinical leadership team		Clear structure in place
		Adequate dedicated senior human resource partner is in place to support clinical triumvirate and wider directorate Monthly meetings with ward level leads and above to monitor recruitment, retention, sickness, vacancy and maternity leave		Effective relationship with HR Business Partner and Senior HR advisors – Divisional Surgeries in place as well as regular catch ups with DoM.
		Adequate senior financial manager is in place to support clinical triumvirate and wider directorate		In place, support at monthly Divisional Surgery

Appendix 12 Maternity self-assessment tool – Gap Analysis

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

Appendix 12 Maternity self-assessment tool – Gap Analysis

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Inhouse or externally supported clinical leadership development programme in place		Top Leaders programme, plus externally supported programmes for Midwifery Leaders. Revised programme for senior leaders in 2025
		Leadership and development programme for potential future talent (talent pipeline programme)		Aspiring HOM's programmes completed regionally and nationally.
		Credible organisations provide bespoke leadership development for clinicians/ frontline staff and other recognised programmes, including coaching and mentorship		Directory of Learning & Development opportunities further supports professional development.
	Accountability framework	Organisational organogram clearly defines lines of accountability, not hierarchy		Organisational structure defines clear lines of accountability from ward to Board.
		Organisational vision and values in place and known by all staff		Trust Values in place, known and respected by the teams. Staff held to account to deliver against the values.
		Organisation's behavioural standards framework in place: Ensure involvement of HR for advice and processes in circumstances where poor individual behaviours are leading to team dysfunction. [Perinatal Surveillance model]		As above.

Appendix 12 Maternity self-assessment tool – Gap Analysis

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Maternity strategy, vision and values	Maternity strategy in place for a minimum of 3–5 years		In place and can be evidenced. Regional Strategy being reviewed currently.
		Strategy aligned to national Maternity Transformation Programme, local maternity systems, maternity safety strategy, neonatal critical care review, National Ambition for 2025 and the maternity and children's chapter of the NHS Long Term Plan		In place and can be evidenced.
		Maternity strategy, vision and values that have been co-produced and developed by and in collaboration with MNVP, service users and all staff groups.		MDT approach to strategy production supported. Can be evidenced on request. MNVP Partnership active and meets all requirements of Safety Action in Maternity Incentive Scheme.
		Demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services [Ockenden Assurance]		
		Maternity strategy aligned with trust board LMNS and MNVP's strategies		Maternity Strategy aligned to that of the National Five Year Forward View and other national objectives.
		Strategy shared with wider community, LMNS and all key stakeholders		Completed but not shared widely as separate regional strategy. Trust strategy available on request by external stakeholders including LMNS..

Appendix 12 Maternity self-assessment tool – Gap Analysis

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Non-executive maternity safety champion	Non-executive director appointed as one of the board level maternity safety champions and is working in line with national role descriptor		In place – Mr Steve Ryan.
		Maternity and neonatal safety champions to meet the NED and exec safety champion to attend and contribute to key directorate meetings in line with the national role descriptor		Bi-monthly meetings take place. Job description in place and Safety Champion work log updated with key actions.
		All Safety champions lead quality reviews, e.g. 15 steps quarterly as a minimum involving MNVPs, service users, commissioners and trust governors (if in place)		Regular walkabouts from safety champions, 15 steps repeated in April 2024 and included maternity neonatal and Seaccombe birth, Reports available and action plans in progress. Repeat scheduled for May 2025.
		Trust board meeting minutes reflect check and challenge on maternity and neonatal services from non-executive safety champion for maternity services		Can be evidenced as part of public board papers.
		A pathway has been developed that describes how frontline midwifery, neonatal, obstetric and Board safety champions share safety intelligence from floor to Board and through the local maternity system (LMNS) and MatNeoSIP Patient Safety Networks. [MIS]		Pathway in place and included as evidence for Ockenden.
Multi-professional team dynamics	**Multi-professional engagement workshops**	Planned schedule of joint multi-professional engagement sessions with chair shared between triumvirate, i.e. quarterly audit days, strategy development, quality improvement plans		Monthly audit days, multi-professional encouragement to attend.

Appendix 12 Maternity self-assessment tool – Gap Analysis

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Record of attendance by professional group and individual		Record of attendee's held by clinical governance teams.
		Recorded in every staff member's electronic learning and development record		Initially not recorded on ESR however project undertaken with Trust L&D Team to pilot reporting onto ESR in Maternity Services which is now in place.
	Multiprofessional training programme	Annual schedule of job essential maternity-specific training and education days, that meet the NHS England and NHS Improvement Core Competency framework as a minimum published and accessible for all relevant staff to see		Within ESR and on PROMPT, Block C. TNA in place and shared with LMNS with reporting template.
		A clear Training Needs analysis in place that identifies the minimum hours of training required for each professional group and by grade/ seniority		Recently updated as required for Ockenden
		All staff given time to undertake mandatory and job essential training as part of working hours		As Prompt/Block C plus additional 4 hours to undertake K2
		Full record of staff attendance for last three years		Can be produced on request
		Record of planned staff attendance in current year		Can be produced on request
		Clear policy for training needs analysis in place and in date for all staff groups		As above, updated in 2021

Appendix 12 Maternity self-assessment tool – Gap Analysis

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Compliance monitored against training needs policy and recorded on roster system or equivalent		Discussed and monitored monthly at DMB
		Education and training compliance a standing agenda item of divisional governance and management meetings		As above, in addition also monitored at PSQB, DPR etc.
		Through working and training together, people are aware of each other's roles, skills, and competencies (who does what, how, why and when) and can work effectively together, thus demonstrating "collective competence". [7 Steps]		Can evidence if required – PROMPT supports this requirement. TNA in place outlining requirements of Competency Framework. Quarterly reporting to the LMNS. Reviewed and updated annually.
		Individual staff Training Needs Analysis (TNA) aligned to professional revalidation requirements and appraisal		
	Clearly defined appraisal and professional revalidation plan for staff	All job descriptions identify individual lines of accountability and responsibility to ensure annual appraisal and professional revalidation		Structure/ line of accountability included in the template of each job description.
		Compliance with annual appraisal for every individual		Sustained >88% consistently. Same monitored through DPR.
		Professional validation of all relevant staff supported by internal system and email alerts		In place within ESR

Appendix 12 Maternity self-assessment tool – Gap Analysis

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Staff supported through appraisal and clearly defined set objectives to ensure they fulfil their roles and responsibilities		Robust appraisal system which includes objectives
		Schedule of clinical forums published annually, e.g. labour ward forum, safety summit, perinatal mortality meetings, risk and governance meetings, audit meetings		In place within monthly clinical governance gems newsletter
	Multi-professional clinical forums	HR policies describe multi-professional inclusion in all processes where applicable and appropriate, such as multi-professional involvement in recruitment panels and focus groups		Stakeholder panels take place in all
	Multi-professional inclusion for recruitment and HR processes	Organisational values-based recruitment in place		Vales based questions asked at interview
		Multi-professional inclusion in clinical and HR investigations, complaint and compliment procedures		In place
		Standard operating procedure provides guidance for multi-professional debriefing sessions following clinical incidents or complaints		HOT debrief or After Action Reviews based on NHSE template in place
		Debriefing sessions available for all staff groups involved following a clinical incident and unusual cases in line with trust guideline and policy		As above.
		Schedule of attendance from multi-professional group members available		Record of attendance kept for all debrief sessions
	Multi-professional membership/ representation at Maternity Voices Partnership forums	Record of attendance available to demonstrate regular clinical and multi-professional attendance.		Bi-weekly sessions
		Maternity Voice Partnership involvement in service development, Quality Improvement, recruitment and business planning through co-production and co-design		Abundance of evidence available on request

Appendix 12 Maternity self-assessment tool – Gap Analysis

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Quality improvement plan (QIP) that uses the SMART principle developed and visible to all staff as well as Maternity Voice Partnership/service users		Improvement plan in and SMART principles applied
	Collaborative multi-professional input to service development and improvement	Roles and responsibilities in delivering the QIP clearly defined, i.e. senior responsible officer and delegated responsibility		QI lead in post. Evidence of QIP – MatNeo collaboration.
		Clearly defined and agreed measurable outcomes including impact for women and families as well as staff identified in the QIP		Evidenced in MatNeo work.
		Identification of the source of evidence to enable provision of assurance to all key stakeholders		Evidenced according to QIP – both locally and regionally.
		The organisation has robust repository for collation of all evidence, clearly catalogued and archived that's has appropriate shared access		Divisional Governance team use/store all evidence on shared drive. Same accessible to key staff.
		Clear communication and engagement strategy for sharing with key staff groups		Trust strategy recently updated and staff engagement plan updated within the Division.
		QIP aligned to national agendas, standards and national maternity dataset and national maternity quality surveillance model requirements		Maternity Transformation agenda outlines specific requirements – further supported by NHSE/I regional team and the LMNS.

Appendix 12 Maternity self-assessment tool – Gap Analysis

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Weekly/monthly scheduled multi-professional safety incident review meetings		Weekly for all specialities within W&C
	Multi-professional approach to positive safety culture	Schedule in place for six-monthly organisation-wide safety summit that includes maternity and the LMNS		In place prior to Covid, not reintroduced face to face yet, however Teams Safety Summit held x2 regionally.
		Positive and constructive feedback communication in varying forms		SCORE survey previously undertaken. Repeated as part of leadership programme. Staff engagement survey undertaken annually and gaps actioned accordingly. PULSE survey also quarterly. Action plan for staff survey 2024
		Debrief sessions for cases of unusual or good outcomes adopting safety 2 approach		Audit day and CIF learning. Clinical Gems newsletter for sharing.
		Senior members of staff make sure that more junior staff have opportunities to debrief and ask questions after experiencing complex clinical situations, and that they learn from theirs and others' experience. [7 steps to safety]		In place – same led by Governance

Appendix 12 Maternity self-assessment tool – Gap Analysis

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Schedule of focus for behavioural standards framework across the organisation		team, CI's and ADN/HoM. Trust Vision / Values structure supports standards framework.
	Clearly defined behavioural standards	Application of behavioural standards framework in trust-wide and directorate meetings, with specific elements the focus each month		In place as described above
		Unsafe or inappropriate behaviours are noticed and with HR support corrected in real time, so they don't become normalised. [7 steps]		In place as described above
		All policies and procedures align with the trust's board assurance framework (BAF)		
Governance infrastructure and ward-to-board accountability	**System and process clearly defined and aligned with national standards**	Governance framework in place that supports and promotes proactive risk management and good governance		In place within the Division with clear structure / oversight of maternity services.
		Staff across services can articulate the key principles (golden thread) of learning and safety		Participated in the EBC learn and support work – also discussed on PROMPT and Block C.
		Staff describe a positive, supportive, safe learning culture		Evidenced through staff engagement survey / feedback.
		Robust maternity governance team structure, with accountability and line management to the DoM and CD with key roles identified and clearly defined links for wider support and learning to corporate governance teams		In place as described above.

Appendix 12 Maternity self-assessment tool – Gap Analysis

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Maternity governance structure within the directorate	Maternity governance team to include as a minimum: Maternity governance lead (Current RM with the NMC) Consultant Obstetrician governance lead (Min 2PA's) Maternity risk manager (Current RM with the NMC or relevant transferable skills) Maternity clinical incident leads Audit midwife Practice development midwife Clinical educators to include leading preceptorship programme Appropriate Governance facilitator and admin support		Maternity Governance structure reviewed and Q&S matron and Risk Midwife in post  W&C Structure including Ward Mana
		Roles and responsibilities for delivery of the maternity governance agenda are clearly defined for each team member		Job descriptions clearly articulate roles and responsibilities.
		Team capacity able to meet demand, e.g. risk register, and clinical investigations completed in expected timescales		Difficult at times however clear Trust oversight process through weekly SI panel.
		In date maternity-specific risk management strategy, as a specific standalone document clearly aligned to BAF		Trust Risk Management Strategy which includes Maternity has been updated. and is in place.  maternity-risk-manag ement-strategy-v1-no

Appendix 12 Maternity self-assessment tool – Gap Analysis

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Maternity-specific risk management strategy	Clearly defined in date trust wide BAF		Included in strategy
	Clear ward-to-board framework aligned to BAF	Perinatal services quality assurance framework supported by standardised reporting requirements in place from ward to board		Dashboard in place in addition to Quality Assurance report that goes quarterly to Board of Directors.
		Mechanism in place for trust-wide learning to improve communications		CG Gems, audit day, CIF learning etc,
	Proactive shared learning across directorate	Mechanism in place for specific maternity and neonatal learning to improve communication		Perinatal meeting and sharing of joint learning
		Governance communication boards		In place in all clinical areas.
		Publicly visible quality and safety board's outside each clinical area		Q&S Boards outside all areas – visible to the public.
		Learning shared across local maternity system and regional networks		Submit to LMNS and regional attendance at all SIG's to share learning
		Engagement of external stakeholders in learning to improve, e.g. CCG, Strategic Clinical Network, regional Director/Heads of Midwifery groups		Trust has number of staff who Chair these regional meetings/groups
		Well-developed and defined trust wide communication strategy to include maternity services in place and in date. Reviewed annually as a minimum.		Communication Strategy in place and maternity included

Appendix 12 Maternity self-assessment tool – Gap Analysis

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Multi-agency input evident in the development of the maternity specification	N/A due to ICB introduction / PLACE	ICB/LMNS oversight of maternity services
Application of national standards and guidance	**Maternity specification in place for commissioned services**	Approved through relevant governance process		Process in place between CCG/WUTH. LMNS and ICB will lead from April 2022.
		In date and reflective of local maternity system plan		Specification in place and links in with LMNS plan/Deliverables.
		Full compliance with all current 10 standards submitted		Externally audited by MIAA for assurance
	Application of CNST 10 safety actions	A SMART action plan in place if not fully compliant that is appropriately financially resourced.		Ongoing action plan in place to meet requirements of all ten safety actions. Trust Board updated re progress of same.
		Clear process defined and followed for progress reporting to LMNS, Commissioners, regional teams and the trust board that ensures oversights and assurance before formal sign off of compliance		LMNS have oversight of compliance with MIS safety actions and were provided with Board declaration forms
		Clear process for multi-professional, development, review and ratification of all clinical guidelines		Process in place within the Division.

Appendix 12 Maternity self-assessment tool – Gap Analysis

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

Appendix 12 Maternity self-assessment tool – Gap Analysis

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

Appendix 12 Maternity self-assessment tool – Gap Analysis

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Maternity bereavement services and support available	Bereavement midwife in post		1.0wte equivalent. Work ongoing to further progress support to women/families.
		Information and support available 24/7		Training extended to EMC team and additional Band 6 post advertised to support service
		Environment available to women consistent with recommendations and guidance from bereavement support groups and charities		Butterfly and ApplePip Rooms available 24/7.
		Quality improvement leads in place		Minimal hours currently – same being reviewed in conjunction with MatNeo work.
	Quality improvement structure applied	Maternity Quality Improvement Plan that defines all key areas for improvement as well as proactive innovation		QIP in place linked to Maternity Transformation Programme.
		Recognised and approved quality improvement tools and frameworks widely used to support services		Evidenced through MatNeo work
		Established quality improvement hub, virtual or otherwise		In place as part of MatNeo but same to be further developed.
		Listening into action or similar concept implemented across the trust		LIA type processes in place – use of MatNeo plans/hub.

Appendix 12 Maternity self-assessment tool – Gap Analysis

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

Appendix 12 Maternity self-assessment tool – Gap Analysis

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

Appendix 12 Maternity self-assessment tool – Gap Analysis

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Audit of compliance against above		All safety huddles recorded and documented. Audit to be commenced
		Annual schedule for Swartz rounds in place		Pre Covid this was in place.
	Trust wide Swartz rounds	Multi-professional attendance recorded and supported as part of working time		Process in place Trust wide.
		Broad range of specialties leading sessions		Inclusive of all Divisions.
		Trust-wide weekly patient safety summit led by medical director or executive chief nurse		Pre Covid this was in place.
	Trust-wide safety and learning events	Robust process for reporting back to divisions from safety summit		Process in place – oversight from Governance team.
		Annual or biannual trust-wide learning to improve events or patient safety conference forum		World Patient Safety Day evidenced learning Trust wide.
		Trust board each month opened with patient story, with commitment to action and change completed in agreed timeframes		In place and story shared.
		In date business plan in place		Cycle of business in place for each meeting.
Comprehension of business/	**Business plan in place for 12 months prospectively**	Meets annual planning guidance		In place Trust wide.
		Business plan supports and drives quality improvement and safety as key priority		Trust wide processes in place

Appendix 12 Maternity self-assessment tool – Gap Analysis

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
contingency plans impact on quality. **(i.e. Maternity Transformation plan, Neonatal Review, Maternity Safety plan and Local Maternity System plan)**		Business plan highlights workforce needs and commits to meeting safe staffing levels across all staff groups in line with BR+ or other relevant workforce guidance for staff groups		Compliance with BR+ given current model of care
		Consultant job plans in place and meet service needs in relation to capacity and demand		In place following review
		All lead obstetric roles such as: labour ward lead, audit lead, clinical governance lead and early pregnancy lead are in place and have allocated PAs in job plans		There was disparity in the allocation of PA's – same reviewed as part of the job planning work.
		Business plans ensures all developments and improvements meet national standards and guidance		Operational plan and Strategy supports the MTP and National agenda.
		Business plan is aligned to NHS 10-year plan, specific national initiatives and agendas.		Strategy updated and reflects same.
		Business plans include dedicated time for clinicians leading on innovation, QI and Research		Dedicated research and audit lead. Oversight and Lead for QI.
		That service plans and operational delivery meets the maternity objectives of the Long Term Plan in reducing health inequalities and unwarranted variation in care. Note the Maternity and Neonatal Plans on Pages 12 & 13.		Plans in place to reduce inequalities – further work ongoing to improve same.
Meeting the requirements of Equality and Inequality & Diversity	**That Employment Policies and Clinical Guidance's meet the publication**	Assess service ambitions against the Midwifery 2020: Delivering expectations helpfully set out clear expectations in relation to reducing health inequalities, parts 3.1, 4.1 and 4.3 of the documents.		Employment procedures/processes in place.

Appendix 12 Maternity self-assessment tool – Gap Analysis

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
Legislation and Guidance's.	**requirements of Equity and Diversity Legislation.**	Refer to the guidance from the Royal College of Midwives (RCM) Stepping Up to Public Health, (2017). Utilise the Stepping up to Public Health Model, Table 10 as a template.		Complaint with same and evidenced through Consultant Midwife lead on Public Health agenda.

10 December 2024

Dear Rose,

Baby Friendly Initiative Re-assessment – – Maternity
Wirral University Teaching Hospital

I am writing to enclose a copy of the report of the assessment team to the Baby Friendly Initiative's Designation Committee following your recent assessment. The Designation Committee has agreed with the assessment report findings and would like to see further evidence regarding the unmet standards before we can confirm re-accreditation. This follow should take place within one year by October 2025. If you feel your service will not be ready by this time, please contact the BFI office to discuss the options available.

In order to provide evidence that it has been met in as effective a way as possible, we suggest a combined approach of internal audit results related to the unmet standards of both staff and mothers, alongside a sample of staff and mother interviews by a Baby Friendly assessor conducted remotely. This will enable the sample to be of sufficient size to ensure that the standards are effectively met, whilst keeping the costs to a minimum.

Therefore please can you complete the following:

- Develop an action plan regarding how you plan to address the unmet criteria and send to bfi@unicef.org.uk by 10 January 2024
- Carry out staff audits prior to the follow up assessment on standards not fully met (requirements), to submit to the assessor on the day of the assessment using the attached grid. Regarding the numbers to audit, please interview around 20 staff (this may be less in a small service or more in a large service - in which case please replicate the number interviewed during the assessment).
- Carry out mother audits prior to the follow up assessment on standards not fully met (requirements), to submit to the assessor on the day of the assessment using the attached grid. Regarding mothers, please aim to interview around 15 breastfeeding mothers and (if relevant) around 10 mothers who are formula feeding. For a service with less than 3000 births or more than 6000 births the number maybe less or more, please liaise with your lead assessor.
- For the supplement audits please find attached further information about what is required and a form to use. We ask that you audit your supplements (at least 10 per month) and collate the results to be presented at the same time.
- Consent list of mothers for interview by the UNICEF UK assessor on the follow up assessment date *(Please ensure these contact details are for different mothers to those already internally audited and note that you need to send this list to the office two weeks in advance of the assessment.).* Regarding the numbers, in order to ensure that we can obtain a sufficient sample size on the day, please ensure the list contains at least 75 mothers (average sized service) For a service with less than 3000 births or more than 6000 births the number maybe less or more, please liaise with your lead assessor. For neonatal units please aim for 30-50.

- Please find attached a copy of the follow up application form to complete your audits on, which will be requested prior to the follow up.

Please discuss your audit outcomes in advance of booking a date for the follow up assessment with us.

To arrange a date for the assessment and confirm the cost of the assessment please contact the office so we can look at availability and please do not hesitate to request any assistance and or information as you work towards this goal. We look forward to working with you as you continue to work towards Baby Friendly re-accreditation.

With best wishes,

Anne Woods.

Anne Woods, Deputy Programme Director

The UK Committee for UNICEF (UNICEF UK)
Baby Friendly Initiative

Re-assessment report
Maternity Service

Wirral University Teaching Hospital

on 23-24 October 2024

UNICEF UK Baby Friendly Initiative
1 Westfield Avenue, Stratford, London, E20 1HZ
Tel: 0207 375 6144 bfi@unicef.org.uk
unicef.org.uk/babyfriendly/

Contents

Assessment result

What we found overall:
We found that Wirral University Teaching Hospital has met some but not all of the standards for re-accreditation.

The staff at Wirral University Teaching Hospital are commended for their hard work over the last five years in continuing to support mothers. It was clear to the assessment team, that in many areas pregnant women and new mothers receive a high standard of care.

There is a commitment from managers to support the implementation of Baby Friendly standards. The Infant Feeding Lead is in a full-time substantive post and is supported by a team of 5.5 whole time equivalent support workers, who provide 24-hour cover on the ward. Many mothers spoke highly of the care they had received from the team. The Infant Feeding Lead also works closely with the recently appointed Infant Feeding Lead for the neonatal unit and the health visitor Infant Feeding Lead. The peer support service Lead and children's centre Lead also meet on a regular basis. Data sharing agreements with other services are almost finalised.

During the Covid 19 pandemic a website was set up to provide antenatal information for pregnant mothers. Recently antenatal sessions have been set up. These include breastfeeding sessions, provided by the Infant Feeding Team. These have proved to be very popular, and plans are in place to increase the provision of this service.

However, as outlined below, although many of the standards continue to meet the necessary criteria, some of the standards have not been maintained. The assessment team asks the Designation Committee to consider what actions are required before re-accreditation as a Baby Friendly hospital can take place.

Janette Westman
24 October 2024

It should be noted that this assessment has reviewed care for mothers with a baby in the neonatal unit considering only the support that maternity and NNU staff have provided to support mothers to initiate lactation effectively. More detailed assessment of the care provided to support mothers to establish and maintain lactation and transition to breastfeeding, together with support for parents to build close and loving relationships and be treated as partners in care is assessed as part of the full UNICEF UK Baby Friendly Initiative standards for Neonatal Units. We recommend that all facilities consider implementation of these standards at a time to suit their assessment journey.

What mothers told us

All mothers interviewed were asked to rate their overall satisfaction with the service and given a chance to feedback further comments. The results are presented below:

Overall care from maternity service	% of mothers
Very happy with care – no complaints or comments	72%
Fairly happy or neutral	28%
Unhappy with care overall	0%

"One of the paediatricians was amazing – they told me that me being close to my baby helped with his brain development."

"One MSW at night was pushy about supplementation on night 3."

"The community midwife and feeding team were so supportive with my feeding."

"I felt information provided to first time mums wasn't adequate, no-one checked your knowledge."

"Staff empowered myself and my partner - we felt safe and supported."

"All of the staff were so kind and amazing."

What is *required* before you can progress to full accreditation

Actions that are ***required*** are mandatory if the criteria for Baby Friendly accreditation are to be met and the facility able to maintain full accreditation. If any requirements are made, these are listed below.
The Designation Committee will be asked to consider what additional evidence is required. This may take the form of written evidence or a follow-up assessment that will usually happen within 6 months. Further requirements may be made in the future in relation to any changes made, and in light of practice found or current research evidence.

1. An increase in the number of staff who have attended training is required.

2. We require an increase in the number of staff who can:
- describe how they recognise effective breastfeeding
- describe responsive breastfeeding
- demonstrate an understanding of how to support formula feeding mothers with making up feeds and understand responsive bottle feeding
- discuss the International Code of Marketing of Breastmilk Substitutes.

3. We require an increase in the percentage of mothers who report:
- they had the opportunity for a discussion about feeding their baby and developing a relationship with their baby during pregnancy, which meets their needs
- they have been shown how to hand express breastmilk
- they understood baby led breastfeeding and how to recognise feeding cues
- they had been supported with learning about making up feeds and how to responsively bottle feed their baby
- they had received information about the importance of close and loving relationships.

4. Supplementation with formula is referred to Designation Committee.

How we *recommend* you achieve and maintain the standards

Recommended actions are those that have proven valuable in other units in helping them to achieve and maintain the requirements. In some cases implementation (or not) of these recommendations is likely to make a significant difference to practice and thus to the ability of the facility to achieve and subsequently maintain the Baby Friendly standards. The recommendations made by the assessment team are listed in this report. Further recommendations may be made in the future in relation to any changes made, and in light of practice found or current research evidence.

1. **Standard 1 – Antenatal information**
    - During the Covid 19 pandemic, a website was created to provide information to mothers. Recently antenatal workshops have been reinstated. These include a session by the Infant Feeding Team and are very well attended. In addition, a pilot is taking place to attempt to reach vulnerable women, who would not normally travel to the maternity unit. Whilst these options are commendable, they do not reach all mothers, particularly those mothers who were multiparous. Some of these mothers felt that staff assumed that they already had knowledge, so they did not have an opportunity for meaningful discussions.
    - We strongly recommend that further training takes place, and that staff are encouraged to have a meaningful discussion with all pregnant women about feeding their baby and the importance of developing relationships with their unborn baby.
2. **Standard 3 – Hand expression**
    - Most staff were able to demonstrate how they would support mothers to hand express breastmilk. However, some were unsure about this technique, with some staff sliding their fingers and some thinking that they would rotate around the breast as soon as milk started to flow. We recommend that this topic is revisited in training and that Practical Skills Reviews continue to ensure a more consistent understanding of this.
    - Many mothers interviewed were not offered help with hand expression of breastmilk after their baby was born. Whilst many said that a midwife had mentioned colostrum harvesting in the antenatal period, not all had been shown how to do this. We recommend that if antenatal colostrum harvesting is suggested, a demonstration should be provided for mothers. In addition, after birth staff should check whether mothers know how to do this and offer to show them how to hand express if needed.
3. **Standard 3 – Responsive feeding**
    - Most staff were able to describe baby-led feeding, though some mentioned various lengths of times which should not be exceeded, ranging from 2 to 5 hours. The assessment team considered that this may be related to the use of the reluctant feeder guideline, used on the postnatal ward. Whilst it is important to ensure that newborn babies are well and that breastfeeding is being established effectively, it should be acknowledged that this is temporary and that once feeding is established, most babies

will feed responsively. Mothers should be helped to understand that this means feeding the baby whenever they show signs of hunger and how to recognise feeding cues.
In addition, we recommend further training to enable staff to understand that responsive feeding is more than feeding for hunger, but also part of a reciprocal relationship between a mother and her baby, which includes feeding for hunger, comfort of both mother and her baby, as well as convenience, e.g. prior to a school run, for full breasts, or just because it's a special time for mother and baby to spend together. We highly recommend further training and audit of this criteria.

4. **Standard 3 – Recognising effective feeding**
    - Several staff of all grades and disciplines commented that they would not be worried about a lack of stooling in a baby under 6 weeks old. Some said that they may do a breastfeeding assessment and care plan. The system for charting breastfeeding assessments is electronic, but there is no elimination record on this form. There are however several different tools to complete in addition to the breastfeeding assessment tool. A new IT midwife is due to start work on the Millenium system in November and we strongly recommend that this is addressed, to enable staff to link the lack of stooling to effective feeding when completing the breastfeeding assessment tool. In addition, further training and audit is recommended.

5. **Standard 4 – Maximising breastmilk**
    - Most staff we interviewed understood how to support mothers to maximise breastmilk. Indeed, donor breastmilk is often used in the neonatal unit and on postnatal wards to support those mothers who are struggling with supply or have a baby who is reluctant to feed. However, fewer staff recognised that infant formula supplements could cause allergic sensitisation. Many babies (14) received infant formula supplementation, with a couple at the suggestion of staff. We recommend further training on this subject and the introduction of an ongoing supplementation audit as well as the intermittent audit.

6. **Standard 4 – Support for mothers who are using infant formula**
    - A number of staff interviewed were uncertain about how to make up infant formula safely or were aware that first milks were the only ones that should be used for the first year. Whilst some staff talked about responsive bottle feeding, some demonstrated this technique by holding the doll at the end of their knees and were uncertain about the pacing of feeds. We highly recommend further training and audit of this standard.
    - Only a small number of mothers had been supported with learning about how to sterilise and make up feeds safely, or how to bottle feed their baby responsively. Ward pressures and work plans often mean that support workers don't get around to supporting mothers with bottle feeding. Postnatal group demonstrations are difficult due to the lack of space. Local audit has identified that the bottle-feeding leaflet is often given out with no discussion. We strongly recommend that consideration is given to identify a mechanism which will ensure that all mothers receive this information.

7. **Standard 4 – The International Code of Marketing of Breastmilk Substitutes**

- Most staff considered that advertising in healthcare facilities 'gave the wrong message' to mothers, as it promotes infant formula rather than breastmilk. However, most did not understand that advertising is misleading and implies endorsement of a particular brand or that mothers need unbiased, research-based information. Most staff were unaware of the First Steps Nutrition as a reliable source of information. We recommend further training in this subject, followed by an audit.

8. **Standard 5 – Close and loving relationships**

- Although most staff were able to discuss the importance of close and loving relationships and how to support this, only a few mothers confirmed that this discussion had taken place. When conversations had taken place mothers received useful information, including how close and loving relationships supported brain development. We strongly recommend that staff are encouraged to have this discussion with all mothers, with further audit to monitor the implementation of this criteria.

Paperwork and processes

- The team are highly commended for presenting documents which effectively underpin the Baby Friendly standards. The curriculum was amended immediately prior to this assessment. Audit of staff and mothers will inform how effectively the work is integrated into practice.
- Electronic documentation of antenatal information discussions and breastfeeding assessments do not meet standards (see results grid) we strongly recommend review of this process and audit to assess progress.

Staff training

- The number of staff who have completed the training programme does not meet the requirement. In addition, for many of those who had completed training, this had taken place several years ago.
- Only a small number of neonatal staff have completed any training at all (18%). The neonatal unit have recently appointed an Infant Feeding Lead, who will commence training of all neonatal staff imminently. We strongly recommend that consideration is given to identify how updated training can be given to all maternity staff. This might include the provision of the full 2-day course for staff who have not attended training more recently.

Any additional advisory comments

Advisory suggestions relate to areas where we feel some change would be beneficial or could readily be achieved. They are offered purely as advice and do not affect designation of the facility as Baby Friendly, either now or in the future (unless the assessment criteria nationally are changed, in which case prior notice would be given).

1. Parents currently use dedicated wash hand basins to clean breast pump equipment. Although this has been reviewed by infection control, the assessment team had some concerns as to whether the use of containers for washing up bowls really ensured effective washing of equipment. We would advise evaluating this technique to ensure that all parents are aware of how to clean and store equipment safely.

Achieving Sustainability

UNICEF UK is aiming for the Baby Friendly Initiative standards to become sustainable over time, thereby reducing the need for the current level of continued external re-assessments. In order to achieve this, we anticipate that facilities will start working towards new Achieving Sustainability standards which are summarised below. These standards will help facilities to embed and maintain Baby Friendly practices in the longer term.

For further guidance on Achieving Sustainability and how to implement these standards please visit unicef.uk/sustainability

Themes	Standard/Criteria
Leadership	• Baby Friendly lead/team with sufficient knowledge, skills and capacity • Effective updating for Baby Friendly team • Baby Friendly Guardian in post • Leadership structures support proportionate responsibility and accountability • Managers are educated to support the maintenance of the standards.
Culture	• Support for ongoing staff learning • Mechanisms to support a positive culture • Positive feedback from staff, managers and mothers.
Monitoring	• Robust, consistent monitoring and reporting mechanisms in place • Evidence of analysis and action planning.
Progression	• Demonstrates innovation and progress • Improvement in outcomes • Evidence of integrated working.

Comments:

1. There is currently no Guardian in place, but the team have approached a Board level Executive who will potentially be the Guardian for both the maternity and neonatal unit.
2. The management team has changed recently with the appointment of a new Head of Midwifery and a temporary Matron in post (interviews for a permanent post are taking place shortly). This has impacted on the support mechanism. A meeting has been set up to discuss needs and more regular updates have been identified, with acknowledgment that reporting to Board level is important. There are also plans for the Infant Feeding Lead to attend Maternity and Neonatal meetings to provide regular updates.
3. No manager's training has taken place so far. Both managers and the Infant Feeding Lead expressed that they feel that attendance on further Baby Friendly courses, including the audit

workshop and sustainability training would be useful to the Infant Feeding Lead. The assessment team also feel that that this would be extremely useful.

4. The Infant Feeding Lead is being supported by management to complete Lactation Consultant (IBCLC) qualification.

5. Paediatricians previously had access to the doctor's e-learning pack, but no records were made of completion of training. Subscription to the pack lapsed in January 2024, but further funding has been agreed and completion of the training will be monitored more closely in future. At present the Infant Feeding Leads (maternity and neonatal), have training opportunities with doctors at morning sessions but not everybody attends these. Training is also provided for multidisciplinary staff at PROMPT days. Plans are in place for all future training to take place at induction sessions.

6. A community support team do routine support visits and are heavily involved with infant feeding support. They have been trained to audit by the Infant Feeding Lead and have helped with audits. There are plans for breastfeeding champions to also support with audits in future. They will also help with sharing audit results within their own team. We suggest that after the Infant Feeding Lead has attended audit training, this should be shared with all other staff who are involved in audit of standards to ensure consistency.

7. Morale in the unit is currently low, with staff struggling with workload and burnout and some members of staff have been lost, resulting in difficulties in achieving good skill mixes. A staff survey is currently being conducted, but there is a reluctance amongst staff to complete this. Work has taken place to provide continuity of carer since 2018. This has caused difficulties and is being reassessed to look at any improvement that can be made. However, managers feel that although morale is low, staff do feel able to be honest with feedback and managers are listening to worries.

8. There is evidence of excellent collaboration with the neonatal services, which will be further strengthened with the appointment of the neonatal Infant Feeding Lead. The Infant Feeding Lead also works closely with the health visitor Infant Feeding Lead. The peer support service Lead and children's centre Lead also meet on a regular basis. Data sharing agreements with other services are almost finalised

9. There is a provision of a 24-hour infant feeding support on the postnatal ward, which receives excellent feedback from mothers. Plans are being considered to increase this team to ensure that this support is always available.

10. There is a Ronald McDonald unit in the hospital, which provides accommodation, food and a homely environment to parents who have a baby on the neonatal unit. Many parents utilise this accommodation and feedback is good. However, the footprint of the neonatal unit is a concern, with very little space for parents to be able to stay with their baby at cot side, particularly in the intensive care area. This has been flagged as needing improvement and an extension to the unit is planned.

Progression to the Gold award

Criteria	Result	Standard required
Assessor recommends that the service is able to progress to the Gold Award	Further work to core Baby Friendly standards suggested in advance of progression to the Gold assessment.	

What happens next?

The Designation Committee will consider this report, and you will be informed by letter of what is required. It is most likely however, that a follow up assessment or further evidence will be needed. Plans should be made for this to occur by **October 2025.**

The results in detail

The sample

All staff and mothers were randomly selected for interview:

Number of staff interviewed:	**22+ 5**
Number of mothers interviewed: Breastfeeding Formula feeding With a baby on the neonatal unit	**41** 27 25 (9 from birth) 5

Standard 1 – Antenatal care

Criterion	**Result**	**Standard required**
Staff who were able to give effective information about feeding	95%	80%
Staff who can explain the importance of close relationships	89%	80%
Mothers who confirmed that they had the opportunity for a discussion about feeding their baby	61%	80%
Mothers who confirmed that they had the opportunity for a discussion about the importance of developing a relationship with their unborn baby and that the conversation met their needs	67%	80%

Standard 2 – Care at birth

Criterion	**Result**	**Standard required**
Staff who were able to explain the importance of skin contact and how long it should last and describe how they would support the mother with the first feed	100%	80%

Care at birth (breastfeeding mothers)	Mothers who confirmed that they were able to have skin contact for at least one hour and support to offer the first feed in skin contact	89%	80%
Care at birth (formula feeding mothers)	Mothers who confirmed that they were able to have skin contact for at least one hour and support to offer the first feed in skin contact	100%	80%
Skin contact on the neonatal unit	Mothers who confirmed that they had been able to hold their baby in skin-to-skin contact	100%	80%

Standard 3 – Getting breastfeeding off to a good start

Criterion		**Result**	**Standard required**
Positioning and attachment	Staff who were able to demonstrate/describe how they would support a mother with positioning and attachment	89%	80%
	Mothers who confirmed that they were supported with learning how to position and attach their baby	96%	80%
Hand expression	Staff who were able to demonstrate/describe how they would support a mother with hand expression	82%	80%
	Mothers who confirmed that staff offered to show them how to hand express	72%	80%
Recognising effective feeding	Staff who were able to describe how they would recognise effective feeding	58%	80%
	Mothers who confirmed that they were aware of how to recognise effective feeding	84%	80%
Responsive feeding	Staff who were able to describe baby led feeding and how to recognise feeding cues	95%	80%

	Mothers who confirmed that they understood baby led feeding and how to recognise feeding cues	64%	80%
	Staff who were able to describe responsive feeding	65%	80%
	Mothers who confirmed that they understood responsive feeding	80%	80%
Challenging situations	Staff who demonstrated understanding of how to manage challenging situations	88%	80%
Ongoing support information	Mothers who confirmed that they were aware of support available and how to access this	96%	80%
Breastfeeding assessments	Breastfeeding assessments were carried out	100%	80%
Initiating expressing for mothers with a baby on the neonatal unit	Mothers who confirmed that they had been encouraged to express as soon as possible after the birth	100%	80%
	Mothers who confirmed that they received effective support to express	100%	80%

Standard 4 – Informed decisions regarding the introduction of food or fluids other than breastmilk

Criterion		**Result**	**Standard required**
Maximising breastmilk	Staff who demonstrated understanding of how to support mothers to maximise breastmilk given, including why supplements should be avoided unless clinically indicated	83%	80%
	Mothers who confirmed that their baby had received a supplement Informed maternal decision or clinical indication	4	N/A

	Mothers who confirmed that their baby had received a supplement **Not** informed maternal decision or clinical indication, or care could have been improved	10	0
Formula feeding mothers	Staff who demonstrated understanding of how to support formula feeding mothers with making up feeds	69%	80%
	Mothers who confirmed that they had been supported with learning about making up feeds	33%	80%
	Staff who demonstrated understanding of responsive bottle feeding	76%	80%
	Mothers who confirmed that they had been supported with responsive bottle feeding	64%	80%
Staff who were able to discuss the International Code of Marketing of Breastmilk Substitutes		56%	80%

Standard 5 – Close and loving relationships

Criterion	Result	Standard required
Staff who understood the importance of close and loving relationships and how to support this	95%	80%
Mothers who confirmed that they had received information about the importance of close and loving relationships	66%	80%
Mothers confirmed that they were not separated from their baby	97%	80%

General

Criterion	Result	Standard required

Mothers reported they had a conversation about safer sleep	100%	Advisory only
Mothers reported they received written information or were referred to appropriate websites	97%	

Communication & Culture

Criterion	Result	Standard required
Staff who demonstrate that they could communicate in a mother centred way	85 % Partial 15% No 0%	Yes
Mothers reported that staff were kind and considerate	All of the time 83% Mostly 14% Sometimes 3% Not at all 0%	Achieving Sustainability standard

Supporting information

Criteria	Result	Standard required
Observations within the facility	No advertising	No advertising
Documentation reviewed • Antenatal records • Breastfeeding assessments	Does not meet standards Fully completed= 4, Partial= 3, not completed= 3 Fully completed =4 Not completed =6	Meet standards
Staff who have been orientated to the policy	98%*	80%
Staff who have completed the training programme	63% (78% excluding NNU)	80%
Policies and guidelines	Partial (hypoglycaemia under review)	Meets standards
Written and other information	Meets standards	Meets standards
Mechanisms	Partial	Meets standards
The written curriculum meets the standards	Meets standards	Meets standards

*Figures for orientation to policy only available for midwifery staff

Supplementation
The most recent data provided by the facility is as follows: (Jun 2023 - May 2024)

	Q1	Q2	Q3	Q4
Internal audit data	31%	28%	28%	28%
How rates have changed over time	With an average rate of 29% supplementation for this period of data capture, it shows a very slight reduction from the previous 12 months data which had an average of 32% supplementation.			
Factors which may impact on local rates	There remains a mixed feeding culture present on the Wirral. This is still evident with mothers who plan to breastfeed still bringing in a supply of formula, and often stating they have the intention of offering a bottle with some feeds.			

	Hopefully with the reintroduction of face-to-face parentcraft we can educate further regarding this topic, and if this is a choice how then to maximise breastfeeding for each individual.

Supporting documents

The following list details the documents reviewed as part of this assessment.

Document date	Document title
11/7/23	Newborn feeding policy
	2-day maternity and neonatal running schedule
	2 day maternity running schedule
June 24	Use of domperidone for lactation (draft)
Oct 24	Action plan
	Antenatal conversations
	Breastfeeding assessment tool (UNICEF)
Exp 23	Expressed breastmilk in the neonatal unit/maternity and Children's ward
Rev due May 24	Hypoglycaemia of the newborn
	Training sessions word documents

Background information

Breastfeeding statistics The most recent infant feeding statistics provided by the facility are as follows:				
Age/stage collected	**Feeding category**			
	Full / total breastfeeding	**Partial breastfeeding**	**Formula feeding**	**Unknown**
Initiation	61.0%			
At discharge from hospital	33.0%	53.2%	41.0%	3.0%
Population coverage: 100%				
Period of collection: June 2023-May 2024				
Notes: C1 partial - (includes expressing and giving EBM) C1 - Unknown - (includes those NBM)				

Baby Friendly accreditation history	Re-accredited October 2019 and next re-assessment due October 2022. Full accreditation awarded July 2014 and re-accredited July 2016. Stage 2 accreditation awarded March 2011. Stage 1 accreditation awarded November 2008.
Births per year	2908 (June 23 – May 24)
Facilities	Facilities at the unit include an Antenatal Clinic, Maternity Day Ward, Maternity Triage, Labour ward including IOL bay, midwifery led unit, obstetric led rooms, and a bereavement suite, Maternity ward and level 3 Neonatal unit. Stand alone birth centre.
Local demographics	The Wirral is a peninsula in the Northwest of England. It is bounded by three bodies of water. It is largely divided down the middle between the affluent West Wirral and the more deprived East Wirral. A predominantly white British population crosses all sections of the socio-economic scales. A small mixture of other cultural groups (9%) lives on the Wirral.
Infant Feeding Lead hours	Full time

Any additional support for the Infant Feeding Lead	Neonatal BFI / Infant Feeding Lead commenced June 2024.
Classroom training (hours provided)	Two day for new starters within 6 months of starting (15 hours) One day updates (7.5 hours) Annual update for all midwifery staff (30 mins) Infant feeding included on PROMPT training for all staff, midwifery and medical (incorporated into 45-minute scenario). Paediatric staff training (1 hour) Neonatal medical staff training (30 minutes)
Practical Skills Review (hours provided)	During staff audit or following on from 2-day training.
Training for medical staff (hours provided)	Session given by Infant Feeding Lead during Neonatal/Paediatric induction training Infant feeding included in PROMPT training for all staff, midwifery and medical

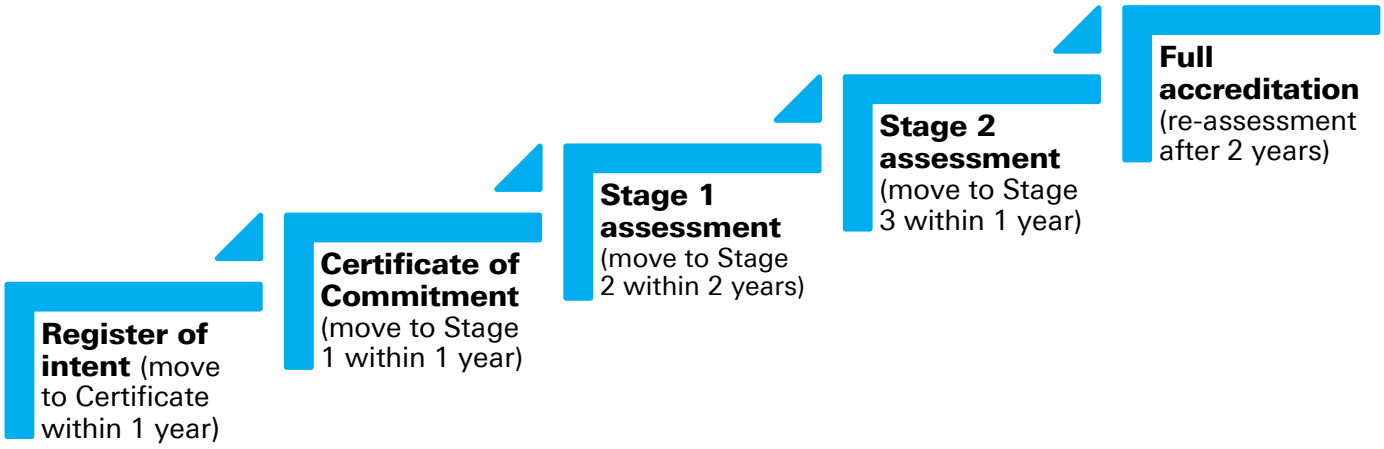
Appendix: About the UK Committee for UNICEF (UNICEF UK) Baby Friendly Initiative

The Baby Friendly Initiative is a worldwide programme of the World Health Organization and UNICEF. It was established in 1992 to encourage maternity hospitals to implement the Ten Steps to Successful Breastfeeding and to practise in accordance with the International Code of Marketing of Breastmilk Substitutes.

The UK Committee for UNICEF (UNICEF UK) Baby Friendly Initiative subsequently extended the principles to include community health-care services and university programmes for midwifery and health visiting/public health nursing.

Initial accreditation as a Baby Friendly facility takes place in three stages:
Stage 1 of the assessment procedure is designed to ensure that the necessary policies, guidelines, information, and mechanisms are in place to allow health care providers to implement the Baby Friendly standards effectively.
Stage 2 involves the assessment of staff knowledge and skills.
Stage 3 assesses the implementation of the Baby Friendly standards in the care of pregnant women and new mothers.
Re-assessment takes place after two years with the aim of ensuring that the standards are maintained. Ongoing assessment is carried out every three-five years with the same goal of ensuring the maintenance of standards.

The work of the Baby Friendly Initiative within the UK is overseen by the Designation Committee, a panel of impartial experts in the field of breastfeeding and neonatal care including representatives from paediatrics, midwifery and health visiting, voluntary organisations and mother support groups as well as representatives from Baby Friendly accredited facilities. The findings from all assessments are reviewed by the Designation Committee in order to ensure consistency and fairness.



NHS North West Neonatal Operational Delivery Network

ANNUAL VISIT 2024

Unit: Arrowe Park
Date: 6th December2024
Attendees from Unit: Hannah Harper Ward manager, Lynsey Wileman Matron, Jo Lavery Divisional Director of Nursing and Midwifery, Helen Ewbank Smith Neonatal Team Leader, Amy Burges BFI Lead, Jen Butler Clinical Psychologist, Sanjeev Rath Clinical Lead for neonates, Ceri Jones Trainee ANNP Rachel Hutton Neonatal Educator, Neil Caldwell Pharmacist, Sarah Thompson Neonatal Consultant ,Kate Hannah Directorate Manager for Children's & Neonatal Services

NWNODN Team: Kelly Harvey, Acting Director – Anand Kamalanathan , Clinical Lead - Heather Martin, Quality Improvement Lead Nurse – Sarah Fullwood, Care Coordinator – Rebecca Hinton, Pharmacist

Arrowe Park Unit Visit 2024

Thank you for selecting a date for your annual unit visit from the NWNODN Team.

One of the key objectives of this visit is to bring back some regular face to face contact with Unit Managers and Clinical Leads.

As a network we have a responsibility to support consistency of standards and activity which improves outcomes across the region.

What we hope to do from the annual visit is to hear from you how things are working, the good things that are happening on your unit, and to see where we can support you best.

Actions to follow up from the 2023 visit

Note - Actions completed at the 2023 review & workforce actions have been removed.
Workforce will be discussed separately as part of the visit.

Subject Area	Discussion/Actions following 2022 Annual Review	Up-Date following 2023 Review	Up-date for 2024 review
Activity Capacity and Demand	Do not meet NCCR requirements for NICU- to continue to engage in NWODN NCCR work Covid impact on staffing reconfigured unit for Isolation- Review requirement for reconfigured isolation rooms.	NCCR discussion regarding new service specification and activity measure. KH updated in conversations happening nationally looking at the challenges of activity measures and other metrics including finance. • ACTION completed:- NS to highlight issues raised at commissioners' methodology subgroup.	APH discussed ICU days below activity measure – this correlates with APH birthrates. KH discussed transformation programme and work moving forward for the neonatal arm. This is work commenced by spec comm with an ODN focus to include all aspects of each providers locality, travel time, data, estates and family experience. Awaiting short list of options and public consultancy. Mortality outliers
Governance	Challenges in accessing external support for PMRT- to work with NWNODN to review this.	KH updated on ODN PMRT external representation plans for April 2024 and Network PA funding allocation.	External PMRT facilitated by NWNODN discussed and advised that all requests for external neonatal PMRT representation should be directed through Laura Kearns. ANNP completes mortality reviews – outstanding mortalities from June
NNAP / Data Entry		SR highlighted issues with repatriations. Repatriation data – NS highlighted the Badgernet ready for discharge tab to enable capture of repatriation challenges at network level. • ACTION:- NWNODN to progress with Repatriation work in 2024 – commenced 2024	Ward manager Hannah Harper regularly attends repatriation group with the network looking at ways of improving repatriation. Jen Butler, unit psychologist also attends. Looking at ways to prepare for repatriation for example adding a slide to the parent tv to promote visits to their unit and also promote the NWNODN website for unit information and tours.

Actions to follow up from the 2023 visit

Note - Actions completed at the 2023 review & workforce actions have been removed.
Workforce will be discussed separately as part of the visit.

Subject Area	Discussion/Actions following 2022 Annual Review	Up-Date following 2023 Review	Up-date for 2024 review
Quality Improvement	Current work focus on reducing BPD – good work so far on DS CPAP and implementing LISA in June to continue Ongoing support is needed for quality nursing roles to support QI Need to have support with data collection and verification.	QI – AP continue to focus working on implementation of FiCare and Matneo projects. • ACTION:- AP to contact ODN to support with JD for FiCare and BFI personnel. AP do not currently have a funded Data person. Internal monthly optimisation audits are manually completed and shared. • ACTION: Review potential of specific data role in the team to focus on data quality and inputting and how data can be used for QI – JD/business case from other units could be requested.	BFI lead now in post 0.8wte. No current Ficare lead funding available however APH have specialist interest group. Lead consultant Sarah Thompson continues to dedicate time to maintaining the culture supported by core nurses. A recent review from the NWNODN team was positive and they felt assured this is embedded in our culture. JD has been completed and job matched at band 6. Workforce being reviewed.
Service User Experience	Continue to develop peer support offer Develop local parent survey to add depth to the parent feedback currently obtained	Peer Support – this is currently offered off site due to challenges with Trust perspectives on volunteer induction. • ACTION:- AM to identify people in trust to join a discussion with KH/SF and Koala NW to understand how APH can progress with this offer as APH are currently the only unit in CM not allowing Koala Volunteers on the unit. Vcreate – AP currently invoiced for Neurological module. • ACTION:- SF to confirm with Vcreate that AP are not invoiced. AP to link with PR with regards to use of the module. HM informed SF/PR of action request.	Following Koala North West funding withdrawal we no longer have PEER supporters visiting the unit, however, the volunteers remain keen and Sarah Thompson is liaising with the volunteer lead for the trust to look at ways of reducing the mandatory training as this has become the barrier. We continue to have Katie Thompson as a volunteer who offers peer support to families twice weekly Surveys include FI care questionnaire, Friends and family test, MNVP seeking patient stories post discharge, QR code for network feedback MNVP has experienced barriers with referring families to patient experience team to share their stories and this is not being following up. Looking at ways to resolve this with the patient experience team.

Actions to follow up from the 2023 visit

North West Neonatal Operational Delivery Network

Subject Area	Discussion/Actions following 2022 Annual Review	Up-Date following 2023 Review	Up-date for 2024 review
Staff Experience	Implement the supernumerary shift co-ordinator role Continue to support quality roles and team development	AP update- there has been a re-structure of senior team which has positively impacted staff morale and reduced sickness and absence rates. The Band 7 tier have attendance at an internal leading services and management course. • ACTION:- Newly appointed ward manager and matron to attend NWNODN unit managers course scheduled for February 2024. Two places were allocated.	Leading teams course completed by all band 7's (5.92wte) as of Sept 24. NWNODN managers course has been completed by Ward Manager and Matron. Plans for further development team include internal leading services course. Band 7 study days continue annually.
Education	Surgical exposure to allow for repatriation to APH of appropriate surgical infants Team to review the NWNODN Education Strategy and how this could be used to support team development as part of the appraisal process.	AP update:- Surgical exposure for staff has been a priority through linking with surgical SIG and other methods of education, internal study days, webinars, pathways. There is a two-person strategy for attendance on QiS. One funded place has been offered from the ODN for 2024. NLS figures are on track	Further funding was awarded from the ODN for 6 QIS places, there are currently 3 staff currently on this programme. There is an ongoing development plan to send two staff on each course. On completion of the course in April this will take us over 70% compliance. We have a band 6 nurse attending the surgical module in AHCH, they will link in with our educator and support further training of our nursing team. We have also added this nurse to the SIG group.

Actions to follow up from the 2023 visit

Subject Area	Discussion/Actions following 2022 Annual Review	Up-Date following 2023 Review	Up-date for 2024 review
Workforce	Continue to work alongside the NWNODN workforce and education lead to ensure monitoring of the NCCR nurse staffing monies are completed as required Medical workforce requires review and full description of challenges and risks. The NWNODN Workforce Strategy may be able to support this. Promotion and development of current staff should be reviewed alongside the NWNODN workforce and education strategies with a clear plan for quality roles such as a FiCare lead. To track the challenge of support for the paediatric ward when this impacts on the neonatal unit achieving BAPM including super numerary shift co-ordinator role. The network will support this as part of tracking the NCCR money AHP workforce requires review. Ad hoc provision without dedicated neonatal funded time does not allow for the full benefit of all AHPs to be realised. To link with network AHPs to understand what is required and gain support for local business case for Physio, Dietetics, SLT and OT .	Medical Workforce – AP remain non- compliant for Tier 3 – case submitted and progressing for funding support to be compliant with CNST action 4. Recruitment of a 7th neonatal consultant. ANNP – issues with managing retention. Discussion raised regarding formal agreement of strategy for leaving cap following ANNP training. Some planning needed regarding the development of current ANNPs to support retention. • **ACTION:** Ensure APH ANNPs link into the NWNODN ANNP Forum. Nursing Workforce – Fully compliant with recruitment. PNA role – LW to identify more staff to complete the course. Paediatric cover – NNU staff covering Paeds is not heavily relied on and cover is reciprocated from Paeds to NNU. AP have developed a package to support new starters to work across disciplines. Whole area Induction booklet to be implemented to introduce staff prior to covering to paediatrics. • **ACTION-** LW to share document with other C+M managers. AHP Workforce:- OT - re-advertised due to lack of interest. Psychology – appointed and due to commence. Pharmacy – statement for business case accepted at panel for children and neonatal pharmacy. Focus over the coming 12months needs to be on capturing the value of new AHP roles and developing business cases for national standards for all AHP groups. NWNODN AHP/Psych and Pharmacist keen to support on this.	8th Consultant recruited and to start in January. 2X staff members on the unit are PNA qualified and we are exploring options to send a third member of staff. Ideally this would be an IR nurse, but due to QIS commitments, maternity leave and health issues this may not be possible therefore are considering opening to all staff. 2 ANNP's trained and a further 2 in training. Paeds and NNU have both supported each other in times of high acuity. NNU always retain their supernumerary coordinator and educator when supporting paediatrics and this is not a regular occurrence OT and psychologist now in post. We also have a volunteer OT to support. The psychologist is heavily utilised by both staff and parents. A new pharmacist has been recruited for both NNU and paediatric ward 0.6wte across both services 0.25 dedicated to NNU. This adds to our current 0.4wte to give overall 0.65wte for the unit. AHP link in with network AHP leads exploring ways to improve our services.

Engagement with the network

Please list ways in which your unit actively engages with the NWNODN. This may include regular attendance at NSG and CEG, SIG membership and attendance, students on FiN and IRFiN and participation at study days, or any other examples you can think of.

Staff have attended both FIN and IR FIN.

QIS rolling programme continues.

We have had 100% attendance at NSG and CEG.

Engagement in managers what's app group.

Manager and Educator away day 24.

Neonatal NWNODN conference attended by ADN Matron, Ward Manager, 3 consultants, ANNP and trainee ANNP.

Improved attendance

Ward manager attending Repatriation group with unit psychologist.

Exception forms returned in a timely manner.

Advice sort at times from Cath Nash, Kelly Harvey and Heather Martin. Sam Parry supported BFI interview panel.

Close communication and escalation forms completed for closures due to IPC outbreak and planned works on the unit.

AHP linking in with AHP network team.

Pharmacist lead with Paddington study and network pharmacist.

Managers course completed by Ward Manager and Matron.

Representation sent to Managers and CSL away day.

Workforce discussions

North West Neonatal Operational Delivery Network

Nursing workforce

WTE needed (against 22/23 activity)	Direct Nursing Budget (WTE)	Direct nurses in post (WTE)
57.57	**60.41**	**56.90**

Funding provided for quality roles .	additional quality roles now in post (WTE)
£30,044.50	**0.5 Risk Post**

No. of qualified PNAs	No. of PNAs in training
2	1 to be identified.

- 1 B5 recruited to post
- 11.5 hrs data nurse link role
- 17 hrs B3 infant feeding support advisor
- Band 2 support worker

Medical Staffing

Tier	Compliance
Tier 1	Yes
Tier 2	Yes
Tier 3	No

T3 presence on the unit NON-Compliant 8th Consultant recruited and to start in January.

2 ANNP's trained and a further 2 in training.

AHPs & Psychological support

AHP role	Ockenden funding allocated	Unit current budget (WTE)	WTE in post	National WTE recommendation
Physio	0	0.1	0	1.4
OT	0.4	0.4	0.4	1.2
Dietitians	0	0.1	0.1	1.46
SLT	0	0	0	0.86
Psychologist	0.5	0.5	0.5	1.4

Pharmacy 8b 0.4 budget 0.4 in Post - Ideal – 1.5
A new pharmacist has been recruited for both NNU and paediatric ward 0.6wte across both services 0.25 dedicated to NNU.

This adds to our current 0.4wte to give overall 0.65wte for the unit.

Identifying unit strengths, weaknesses, opportunities and threats

North West Neonatal Operational Delivery Network

This year's annual visit is to enable units to showcase their progress and successes and whilst providing the opportunity to highlight and discuss any areas of concern.

Therefore, we would like to invite all units to present a SWOT analysis in whatever format you choose to use. It may be a traditional format with one slide per heading or you may wish to combine the weaknesses & threats and strength & opportunities and include some examples of good practice.

We are keen to find out about QI projects linked to clinical outcomes, family care initiatives, education activities, progress with data accuracy and anything else which demonstrates excellence.

We are keen to hear about what **you** are proud of as a unit and look forward to visiting.

EXCELLENCE IN HEALTHCARE

SWOT

NHS North West Neonatal Operational Delivery Network

SWOT	
Strengths	**Opportunities**
• BFI works 30 hrs per week. Supportive in planning for the development of BFI accreditation. Exploring options for band 3 support of this role • Remain green for Ficare. • Responsive to PSIRF implementation with quick completion learning from RECs • Practice educator full time until March following funding received, will return to 30 hours in March 2024. • AHP team: Psychologist, OT, volunteer OT. NNU Pharmacist. • Strong senior leadership team and supportive Quadrumvirate. • Low attrition rates	• Surgical course share learning with all staff to develop surgical skills of the team. • NN digital nurse – exploring options to support this rol from the established workforce. • BFI Accreditation. • PNA 1 additional nurse to enroll. • Potential ITU expansion. • Band specific study days held by practice educator. • Growth of the NNAP roles in the unit
Weaknesses	**Threats**
• Breast milk within 6 hours, requires improvement. • Temperature optimisation outliers, thermal bundle introduced. • Lack of space, impacts on infection rates. This is being explored at executive level. Architect currently scoping feasibility of extending ITU. • Not BFI accredited. • AHP support not enough as per recommendation from Ockendon.	• Senior nurses have moved into quality roles or trainee ANNP leaving a skilled QIS gap and a more junior workforce. • Space on the Neonatal Unit. High acuity linked with increased infection rate. • No dedicated NNU Physiotherapist on the unit however can access Paediatric physio ad hoc. • Not enough dedicated hours for digital nurse to ensure accuracy of badger data.

SUMMARY

Many thanks to the team at APH for a well-attended, welcoming, engaging and enjoyable annual visit.

The unit highlighted several improvements particularly regarding nurse staffing and future link roles as described in the workforce slide. There are developments of quality initiatives regarding family experience including FiCare, Peer support with a focus on peer support for dads, BFI intention, translation services and music therapy. The unit also review data to improve the service and outcomes, such as cancellation of BF study days impacting on results. The NWNODN wish every success for the future BFI intention.

The unit have embedded current AHP roles and both families and staff utilise the psychology provision. It was acknowledged that due to limited psychology provision it is difficult to prioritise due to capacity. There is a focus on building a picture for the future highlighting the ideal team and creation of an action plan. There was also a recognition that paediatrics require psychology support with a vision for future training around trauma informed care for the ongoing care transition from neonatal care to community and beyond. The unit were encouraged to utilise the network FiCare and Trauma informed team. Gaps within AHP provision were discussed alongside the Neonatal Critical Care service specification with a view to adding this to the risk register and preparation of business case in anticipation of future funding.

It was acknowledged that there remains some other challenges regarding medical governance roles, dual roles of matron and governance and lack of educator hours at a B7 level, discussions led to considering these gaps within workforce and linking with the network workforce lead. We also discussed unit closures, how the unit endeavour to remain open to referrals and review unit closures, escalate to board and inform the ODN.

Within the past 12 months it has been noted that there is a clearly defined nursing leadership team. The team highlighted a positive impact of a compassionate leadership approach with improvements in staff morale, appreciation, collaboration and commitment.

Thank you to the team for the continuing service delivery to babies and families and engagement with the network.

ACTIONS:

- ❑ HM to contact NA to ensure APH ANNPs and trainees are included on the ODN ANNP distribution list for the ANNP forum.
- ❑ APH to support repatriations across to other providers utilising ODN website unit tours and Vcreate passport
- ❑ APH to reiterate Your Voice Matters sign up via QR code for survey response.
- ❑ APH to continue to link with ODN workforce lead for guidance and advice on the ideal team
- ❑ APH to consider medical lead governance role within job plans.
- ❑ APH to add gaps in AHP provision to risk register.
- ❑ In view of adherence to national service specification, APH to develop business case for AHP provision.
- ❑ Present thermoregulation bundle with data results 2025.