Appendix 1 - Perinatal Clinical Surveillance Quality Assurance Report April 2024

Theme	Area requiring further enquiry or shared intelligence	Outlier	Evidence
Clinical Care	Outlier for rates of stillbirth as a proportion of births	Yes	No escalation from SCN / LMNS on outlier report; internal thematic review being undertaken; NW region outlier report no longer published and NW Regional dashboard now available however discusssed regionally as Data to October 2023 and decision awaited on key reporting metrics and also data collection methodology; all users requested access accoringly; awaiting feedbeck when dashboard will be able to be utilised; external review requested to support rise in still birth rate.
	Outlier for rates of neonatal deaths as a proportion of birth	na	No escalation from SCN / LMNS on outlier report; internal thematic review undertaken and shared with BoD; Decision awaited on key reporting metrics and also data collection methodology; all users requested access accoringly; awaiting feedbeck when dashboard will be able to be utilised.
	Rates of HIE where improvements in care may have made a difference to the outcome	na	Very low rates of HIE, sitting way below the lower control limit for the region. No current cases
	Number of SI's	na	No PSSI's reported in March 2024
	Progress on SBL care bundle V3	no	SBLv3 launched and continued to be a key safety action of MIS Year 5 which was signed off as complaint meeting 81% (>70% was the requirement); Audits and evidencecontinue to be submitted for LMNS review and achieved complaince as at end of March of 97%; compliance will be monitored by LMNS quarterley
	Outlier for rates of term admissions to the NNU	na	The rate of avoidable term admissions; regular multi-disciplinary reviews of care take place; NW region outlier report no longer published and awaiting national guidance on monitoring processes
Service user and st	MNVP or Service User concerns/complaints not resolved at trust level	no	Not an outlier regarding the number of complaints; to date all complaints have been addressed for maternity in the target timeframesand there is nil to escalate
	Trainee survey	no	No update this month
	Staff survey	no	Trust Staff Survey completed and divisional response has included staff engagement and continuation with the Pulse surveys; Score survey completed for MatNeo and cultural conversations commencing over x 4 sessions; Requirement to report to BOD Feb 2024
	CQC National survey	no	Published Feb 2024 and included within BoD report March 2024; action plan progressing; Sample provided for 2024 survey to be pulished early 2025
	Feedback via Deanery, GMC, NMC	no	Nil to esclate
	Poor staffing levels	no	Current vacancy rate is 7wte; predicted further 5wte between now and Nov 2024 due to leavers, retirements and maternity leave. Recruitment campaigns ongoing for Band 5 and Band 6 Midwives; Concern is will be reliant on newly quaified midwives in Sept 2024 leaving gaps between now and then;
	Delivery Suite Coordinator not super nummary	no	Super nummary status is maintained for all shifts
Leadership and relationships	New leadership within or across maternity and/or neonatal services	no	Nil of note; full establishment; governance structure review and revised structure implemented to meet requirements and maternity self assessment tool and continue to meet Ockenden Part 1
	Concerns around the relationships between the Triumvirate and across perinatal services	no	Good working relationship between the teams /Directorates
	False declaration of CNST MIS	no	MIS Year 5 submission and declaration submitted by 12 noon on 1st February 2024 - complaince met; MIS Year 6 publication published April 2024 included within BoD report updates.
	Concerns raised about other services in the Trust e.g. A&E	no	Nil of note
	In multi-site units - concerns raised about a specific unit i.e. Highfield/CoC teams	no	Nil to report this month; funding options explored; 6 teams in total and two approach model in place; comparison data / research underway
Safety and learning culture	Lack of engagement in MNSI or ENS investigation	no	Good engagement processes in place with north west team leader. Monthly reports received of ongoing cases and recent discussions regarding the process of arbitration with regional lead. Quarterly regional meetings arranged with excellent MDT attendance. Quarterly meeting held in Feb 2023; site visit May 2023; nil to escalate
	Lack of transparency	no	Being open conversations are regularly had and 100% compliance with duty of candour evident
	Learning from SI's, local investigations and reviews not implemented or audited for efficacy and impact	no	Robust processes following lessons learned from all PSSI's, local reviews, rapid evaluations of care, complaints and compliments. Engagement with staff to assess and improve how learning is shared. Patient experience strategy in progress.
	Learning from Trust level MBRRACE reports not actioned	no	All reports receive a gap analysis to benchmark against the recommendations
	Recommendations from national reports not implemented	no	All reports receive a gap analysis to benchmark against the recommendations. No exceptions to report. Three year single delivery plan for maternity and neonatal services published 31th March 2023 - gap analysis in progress and will monitored via WUTH CG structure and BoD
Incident reporting	Low patient safety or serious incident reporting rates	no	Consistent rates of reporting across the speciality groups. Regular training takes places on the importance of incident reporting, underpinning the Trust stance of safe reporting and non-punitive culture
	Delays in reporting a SI where criteria have been met	no	Robust SI process and SI framework followed with timely reporting of all cases that meet the SI framework; PSIRF with effect from 1/9/2023
	Never Events which are not reported	no	No maternity or neonatal never events in March 2024
	Recurring Never Events indicating that learning is not taking place	no	N/a
	Poor notification, reporting and follow up to MBRRACE-UK, NHSR ENS and HSIB	no	Excellent reporting within the required timescales
Governance processes	Unclear governance processes		Clear governance processes in place that follow the PSIRF framework - Within division there is maternity and neonatal review of governance processes: 3 separate meetings. Staff are informed of top risks and incident themes. Governance notice boards updated and newsletters disseminated. Additional quality assurance framework agreed with effect from June 2023 to give the BoD addiitonal assurances in monitoring of MIS, Three year delivery plan etc. Governance structure strengthened
	Business continuity plans not in place	no	Business continuity plans in place
	Ability to respond to unforeseen events e.g. pandemic, local emergency	no	Nil to report this month
CQC, HSIB/CB/IB and DHSC or NHSE/I request for support	DHSC or NHS England Improvement request for a Review of Services or Inquiry	no	Nil to report this month
	An overall CQC rating of Requires Improvement with an Inadequate rating for either Safe and Well-Led or a third domain	no	CQC reports published for maternity sites Seacombe Birth Centre and APH site for the domains Safe and Well led; both sites were rated 'GOOD'
	An overall CQC rating of Inadequate	no	N/a
	Been issued with a CQC warning notice	no	N/a
	CQC rating dropped from a previously Outstanding or Good rating to Requires improvement in the safety or Well-Led domains	no	N/a
	Been identified to the CQC with concerns by HSIB	no	N/a

Overview of progress on safety action requirements

Safety Action Requirements:

Safety Action	Red	Amber	Green	Blue	Total Requirements
1	0	6	0	0	6
2	2	0	0	0	2
3	0	2	2	0	4
4	3	14	3	0	20
5	2	3	0	0	5
6	0	6	0	0	6
7	1	5	1	0	7
8	0	17	1	0	18
9	0	8	0	0	8
10	0	8	0	0	8
Total	8	69	7	0	84

Key:

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

PMRT - Perinatal Mortality Reviews Summary Report

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

Wirral University Teaching Hospital NHSFT

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

1/10/2023 to 31/12/2023

Summary of perinatal deaths*

Total perinatal* deaths reported to the MBRRACE-UK perinatal mortality surveillance in this period: *3*

Summary of reviews**

Stillbirths and late fetal losses

Number of stillbirths and late fetal losses reported	Not supported for Review	Reviews in progress	Reviews completed ***	Grading of care: number of stillbirths and late fetal losses with issues with care likely to have made a difference to the outcome for the baby
0	0	0	0	0

Neonatal and post-neonatal deaths

Number of neonatal and post-neonatal deaths reported	Not supported for Review	Reviews in progress	Reviews completed ***	Grading of care: number of neonatal and post-neonatal deaths with issues with care likely to have made a difference to the outcome for the baby
3	0	2	1	0

*Late fetal losses, stillbirths and neonatal deaths (does not include post-neonatal deaths which are not eligible for MBRRACE-UK surveillance) – these are the total deaths reported and may not be all deaths which occurred in the reporting period if notification to MBRRACE-UK is delayed. Deaths following termination of pregnancy are excluded.

** Post-neonatal deaths can also be reviewed using the PMRT

*** Reviews completed and have report published

Report Generated by: Danielle Chambers
Date report generated: 09/05/2024 15:32

Table 1: Summary information for the babies who died in this period and for whom a review of care has been completed – number of babies (N = 1)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
Late Fetal Losses (<24 weeks)	0	0	--	--	--	--	0
Stillbirths total (24+ weeks)	0	0	0	0	0	0	0
Antepartum stillbirths	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Intrapartum stillbirths	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Timing of stillbirth unknown	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Early neonatal deaths (1-7 days)*	0	0	0	1	0	0	1
Late neonatal deaths (8-28 days)*	0	0	0	0	0	0	0
Post-neonatal deaths (29 days +)*	0	0	0	0	0	0	0
Total deaths reviewed	0	0	0	1	0	0	1
Small for gestational age at birth:							
IUGR identified prenatally and management was appropriate	0	0	0	0	0	0	0
IUGR identified prenatally but not managed appropriately	0	0	0	0	0	0	0
IUGR not identified prenatally	0	0	0	0	0	0	0
Not Applicable	0	0	0	1	0	0	1
Mother gave birth in a setting appropriate to her and/or her baby's clinical needs:							
Yes	0	0	0	1	0	0	1
No	0	0	0	0	0	0	0
Missing	0	0	0	0	0	0	0
Parental perspective of care sought and considered in the review process:							
Yes	0	0	0	1	0	0	1
No	0	0	0	0	0	0	0
Missing	0	0	0	0	0	0	0
Booked for care in-house	0	0	0	0	0	0	0
Mother transferred before birth	0	0	0	0	0	0	0
Baby transferred after birth	0	0	0	1	0	0	1
Neonatal palliative care planned prenatally	0	0	0	0	0	0	0
Neonatal care re-orientated	0	0	0	0	0	0	0

*Neonatal deaths are defined as the death within the first 28 days of birth of a baby born alive at any gestational age; early neonatal deaths are those where death occurs when the baby is 1-7 days old and late neonatal death are those where the baby dies on days 8-28 after birth. Post-neonatal deaths are those deaths occurring from 28 days up to one year after birth

Table 2: Placental histology and post-mortems conducted for the babies who died in this period and for whom a review of care has been completed – number of babies (N = 1)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
Late fetal losses and stillbirths							
Placental histology carried out							
Yes	0	0	0	0	0	0	0
No	0	0	0	0	0	0	0
Hospital post-mortem offered	0	0	0	0	0	0	0
Hospital post-mortem declined	0	0	0	0	0	0	0
Hospital post-mortem carried out:							
Full post-mortem	0	0	0	0	0	0	0
Limited and targeted post-mortem	0	0	0	0	0	0	0
Minimally invasive post-mortem	0	0	0	0	0	0	0
External review	0	0	0	0	0	0	0
Virtual post-mortem using CT/MR	0	0	0	0	0	0	0
Neonatal and post-neonatal deaths:							
Placental histology carried out							
Yes	0	0	0	1	0	0	1
No	0	0	0	0	0	0	0
Death discussed with the coroner/procurator fiscal	0	0	0	1	0	0	1
Coroner/procurator fiscal PM performed	0	0	0	1	0	0	1
Hospital post-mortem offered	0	0	0	0	0	0	0
Hospital post-mortem declined	0	0	0	0	0	0	0
Hospital post-mortem carried out:							
Full post-mortem	0	0	0	0	0	0	0
Limited and targeted post-mortem	0	0	0	0	0	0	0
Minimally invasive PMpost-mortem	0	0	0	0	0	0	0
External review	0	0	0	0	0	0	0
Virtual post-mortem using CT/MR	0	0	0	0	0	0	0
All deaths:							
Post-mortem performed by paediatric/perinatal pathologist*							
Yes	0	0	0	0	0	0	0
No	0	0	0	0	0	0	0
Placental histology carried out by paediatric/perinatal pathologist*:							
Yes	0	0	0	0	0	0	0
No	0	0	0	0	0	0	0

*Includes coronial/procurator fiscal post-mortems

Table 3: Number of participants involved in the reviews of late fetal losses and stillbirths without resuscitation (N = 0)

Role	Total Review sessions	Reviews with at least one
Chair	0	0%
Vice Chair	0	0%
Admin/Clerical	0	0%
Bereavement Team	0	0%
Community Midwife	0	0%
External	0	0%
Management Team	0	0%
Midwife	0	0%
Neonatal Nurse	0	0%
Neonatologist	0	0%
Obstetrician	0	0%
Other	0	0%
Risk Manager or Governance Team	0	0%
Safety Champion	0	0%

Table 4: Number of participants involved in the reviews of stillbirths with resuscitation and neonatal deaths (N = 1)

Role	Total Review sessions	Reviews with at least one
Chair	1	100% (1)
Vice Chair	0	0%
Admin/Clerical	0	0%
Bereavement Team	1	100% (1)
Community Midwife	0	0%
External	10	100% (1)
Management Team	0	0%
Midwife	6	100% (1)
Neonatal Nurse	1	100% (1)
Neonatologist	3	100% (1)
Obstetrician	2	100% (1)
Other	3	100% (1)
Risk Manager or Governance Team	1	100% (1)
Safety Champion	0	0%

Table 5: Grading of care relating to the babies who died in this period and for whom a review of care has been completed – number of babies (N = 1)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
STILLBIRTHS & LATE FETAL LOSSES							
Grading of care of the mother and baby up to the point that the baby was confirmed as having died:							
A - The review group concluded that there were no issues with care identified up the point that the baby was confirmed as having died	0	0	0	0	0	0	0
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	0	0	0	0	0	0
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
Grading of care of the mother following confirmation of the death of her baby:							
A - The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby	0	0	0	0	0	0	0
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother	0	0	0	0	0	0	0
C - The review group identified care issues which they considered may have made a difference to the outcome for the mother	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
NEONATAL AND POST-NEONATAL DEATHS							
Grading of care of the mother and baby up to the point of birth of the baby:							
A - The review group concluded that there were no issues with care identified up the point that the baby was born	0	0	0	0	0	0	0
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	0	0	1	0	0	1
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
Grading of care of the baby from birth up to the death of the baby:							
A - The review group concluded that there were no issues with care identified from birth up the point that the baby died	0	0	0	0	0	0	0
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	0	0	1	0	0	1
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
Grading of care of the mother following the death of her baby:							
A - The review group concluded that there were no issues with care identified for the mother following the death of her baby	0	0	0	1	0	0	1
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother	0	0	0	0	0	0	0
C - The review group identified care issues which they considered may have made a difference to the outcome for the mother	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0

Table 6: Cause of death of the babies who died in this period and for whom a review of care has been completed – number of babies (N = 1)

Timing of death	Cause of death
Late fetal losses	**0 causes of death out of 0 reviews**
Stillbirths	**0 causes of death out of 0 reviews**
Neonatal deaths	**1 causes of death out of 1 reviews**
	Upon discussion the review group noted the initial certificate stated: Main Causes(a): Refractory Hypotension Refractory Hyperkalemia Severe Renal Failure Prematurity Other cause(b): Poor condition at birth (No HR, no breathing) needed prolonged CPR with drugs in the post birth period until stabilised Other cause (c) leading to b: Difficult breech delivery: Difficult and delayed delivery of head. Upon discussion and reflection by the panel the death certificate should have been reflective of HIE. At time of review the coroners post-mortem report is still outstanding.
Post-neonatal deaths	**0 causes of death out of 0 reviews**

Table 7: Issues raised by the reviews identified as relevant to the deaths reviewed, by the number of deaths affected by each issue* and the actions planned

Issues raised which were identified as relevant to the deaths	Number of deaths	Actions planned

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

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

Issues raised which were identified as not relevant to the deaths	Number of deaths	Actions planned
A CTG was performed during established labour but the technical quality was poor	1	No action entered
During the resuscitation of the baby surfactant was indicated and given, but was not given at the appropriate dose	1	COCH have received feedback during review meeting that they need to update their guideline with the recent changes surrounding surfactant dosage. To note - this was coincidental learning from LWH external consultant neonatologist and would not have made a difference to the outcome.
It is not possible to assess from the notes whether chest compressions were indicated and administered appropriately during the resuscitation of the baby	1	No action entered
The type of fetal monitoring used in established labour was not appropriate	1	No action entered
This baby was resuscitated and delayed cord clamping was not instituted although this was indicated	1	No action entered

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

Table 9: Top 5 contributory factors related to issues identified as relevant to the deaths reviewed, by the frequency of the contributory factor and the issues to which the contributory factors related

Issue Factor	Number of deaths	Issues raised for which these were the contributory factors

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Wirral University Teaching Hospital NHSFT

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

1/1/2024 to 31/3/2024

Summary of perinatal deaths*

Total perinatal* deaths reported to the MBRRACE-UK perinatal mortality surveillance in this period: 7

Summary of reviews**

Stillbirths and late fetal losses

Number of stillbirths and late fetal losses reported	Not supported for Review	Reviews in progress	Reviews completed ***	Grading of care: number of stillbirths and late fetal losses with issues with care likely to have made a difference to the outcome for the baby
4	0	4	0	0

Neonatal and post-neonatal deaths

Number of neonatal and post-neonatal deaths reported	Not supported for Review	Reviews in progress	Reviews completed ***	Grading of care: number of neonatal and post-neonatal deaths with issues with care likely to have made a difference to the outcome for the baby
3	1	0	1	0

*Late fetal losses, stillbirths and neonatal deaths (does not include post-neonatal deaths which are not eligible for MBRRACE-UK surveillance) – these are the total deaths reported and may not be all deaths which occurred in the reporting period if notification to MBRRACE-UK is delayed. Deaths following termination of pregnancy are excluded.

** Post-neonatal deaths can also be reviewed using the PMRT

*** Reviews completed and have report published

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Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
Late Fetal Losses (<24 weeks)	0	0	--	--	--	--	0
Stillbirths total (24+ weeks)	0	0	0	0	0	0	0
Antepartum stillbirths	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Intrapartum stillbirths	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Timing of stillbirth unknown	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Early neonatal deaths (1-7 days)*	0	0	0	1	0	0	1
Late neonatal deaths (8-28 days)*	0	0	0	0	0	0	0
Post-neonatal deaths (29 days +)*	0	0	0	0	0	0	0
Total deaths reviewed	0	0	0	1	0	0	1
Small for gestational age at birth:							
IUGR identified prenatally and management was appropriate	0	0	0	0	0	0	0
IUGR identified prenatally but not managed appropriately	0	0	0	0	0	0	0
IUGR not identified prenatally	0	0	0	0	0	0	0
Not Applicable	0	0	0	1	0	0	1
Mother gave birth in a setting appropriate to her and/or her baby's clinical needs:							
Yes	0	0	0	0	0	0	0
No	0	0	0	1	0	0	1
Missing	0	0	0	0	0	0	0
Parental perspective of care sought and considered in the review process:							
Yes	0	0	0	1	0	0	1
No	0	0	0	0	0	0	0
Missing	0	0	0	0	0	0	0
Booked for care in-house	0	0	0	1	0	0	1
Mother transferred before birth	0	0	0	0	0	0	0
Baby transferred after birth	0	0	0	0	0	0	0
Neonatal palliative care planned prenatally	0	0	0	0	0	0	0
Neonatal care re-orientated	0	0	0	0	0	0	0

*Neonatal deaths are defined as the death within the first 28 days of birth of a baby born alive at any gestational age; early neonatal deaths are those where death occurs when the baby is 1-7 days old and late neonatal death are those where the baby dies on days 8-28 after birth. Post-neonatal deaths are those deaths occurring from 28 days up to one year after birth

Table 2: Placental histology and post-mortems conducted for the babies who died in this period and for whom a review of care has been completed – number of babies (N = 1)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
Late fetal losses and stillbirths							
Placental histology carried out							
Yes	0	0	0	0	0	0	0
No	0	0	0	0	0	0	0
Hospital post-mortem offered	0	0	0	0	0	0	0
Hospital post-mortem declined	0	0	0	0	0	0	0
Hospital post-mortem carried out:							
Full post-mortem	0	0	0	0	0	0	0
Limited and targeted post-mortem	0	0	0	0	0	0	0
Minimally invasive post-mortem	0	0	0	0	0	0	0
External review	0	0	0	0	0	0	0
Virtual post-mortem using CT/MR	0	0	0	0	0	0	0
Neonatal and post-neonatal deaths:							
Placental histology carried out							
Yes	0	0	0	1	0	0	1
No	0	0	0	0	0	0	0
Death discussed with the coroner/procurator fiscal	0	0	0	0	0	0	0
Coroner/procurator fiscal PM performed	0	0	0	0	0	0	0
Hospital post-mortem offered	0	0	0	1	0	0	1
Hospital post-mortem declined	0	0	0	1	0	0	1
Hospital post-mortem carried out:							
Full post-mortem	0	0	0	0	0	0	0
Limited and targeted post-mortem	0	0	0	0	0	0	0
Minimally invasive PMpost-mortem	0	0	0	0	0	0	0
External review	0	0	0	0	0	0	0
Virtual post-mortem using CT/MR	0	0	0	0	0	0	0
All deaths:							
Post-mortem performed by paediatric/perinatal pathologist*							
Yes	0	0	0	0	0	0	0
No	0	0	0	0	0	0	0
Placental histology carried out by paediatric/perinatal pathologist*:							
Yes	0	0	0	0	0	0	0
No	0	0	0	0	0	0	0

*Includes coronial/procurator fiscal post-mortems

Table 3: Number of participants involved in the reviews of late fetal losses and stillbirths without resuscitation (N = 0)

Role	Total Review sessions	Reviews with at least one
Chair	0	0%
Vice Chair	0	0%
Admin/Clerical	0	0%
Bereavement Team	0	0%
Community Midwife	0	0%
External	0	0%
Management Team	0	0%
Midwife	0	0%
Neonatal Nurse	0	0%
Neonatologist	0	0%
Obstetrician	0	0%
Other	0	0%
Risk Manager or Governance Team	0	0%
Safety Champion	0	0%

Table 4: Number of participants involved in the reviews of stillbirths with resuscitation and neonatal deaths (N = 1)

Role	Total Review sessions	Reviews with at least one
Chair	0	0%
Vice Chair	0	0%
Admin/Clerical	0	0%
Bereavement Team	2	100% (1)
Community Midwife	0	0%
External	1	100% (1)
Management Team	0	0%
Midwife	3	100% (1)
Neonatal Nurse	0	0%
Neonatologist	2	100% (1)
Obstetrician	2	100% (1)
Other	0	0%
Risk Manager or Governance Team	1	100% (1)
Safety Champion	0	0%

Table 5: Grading of care relating to the babies who died in this period and for whom a review of care has been completed – number of babies (N = 1)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
STILLBIRTHS & LATE FETAL LOSSES							
Grading of care of the mother and baby up to the point that the baby was confirmed as having died:							
A - The review group concluded that there were no issues with care identified up the point that the baby was confirmed as having died	0	0	0	0	0	0	0
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	0	0	0	0	0	0
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
Grading of care of the mother following confirmation of the death of her baby:							
A - The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby	0	0	0	0	0	0	0
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother	0	0	0	0	0	0	0
C - The review group identified care issues which they considered may have made a difference to the outcome for the mother	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
NEONATAL AND POST-NEONATAL DEATHS							
Grading of care of the mother and baby up to the point of birth of the baby:							
A - The review group concluded that there were no issues with care identified up the point that the baby was born	0	0	0	1	0	0	1
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	0	0	0	0	0	0
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
Grading of care of the baby from birth up to the death of the baby:							
A - The review group concluded that there were no issues with care identified from birth up the point that the baby died	0	0	0	1	0	0	1
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	0	0	0	0	0	0
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
Grading of care of the mother following the death of her baby:							
A - The review group concluded that there were no issues with care identified for the mother following the death of her baby	0	0	0	1	0	0	1
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother	0	0	0	0	0	0	0
C - The review group identified care issues which they considered may have made a difference to the outcome for the mother	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0

Table 6: Cause of death of the babies who died in this period and for whom a review of care has been completed – number of babies (N = 1)

Timing of death	Cause of death
Late fetal losses	**0 causes of death out of 0 reviews**
Stillbirths	**0 causes of death out of 0 reviews**
Neonatal deaths	**1 causes of death out of 1 reviews**
	a. hypoplastic left heart b. prematurity 29 weeks.
Post-neonatal deaths	**0 causes of death out of 0 reviews**

Table 7: Issues raised by the reviews identified as relevant to the deaths reviewed, by the number of deaths affected by each issue* and the actions planned

Issues raised which were identified as relevant to the deaths	Number of deaths	Actions planned

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

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

Issues raised which were identified as not relevant to the deaths	Number of deaths	Actions planned
This mother did not give birth in a setting appropriate to her and/or her baby's clinical needs	1	No action entered
This mother had an endocrine disorder during her pregnancy and there was a delay in the diagnosis	1	Feedback to GP to investigate reason for delay in actioning raised HBA1C

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

Table 9: Top 5 contributory factors related to issues identified as relevant to the deaths reviewed, by the frequency of the contributory factor and the issues to which the contributory factors related

Issue Factor	Number of deaths	Issues raised for which these were the contributory factors

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

Implementation Report

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

Background

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

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

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

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

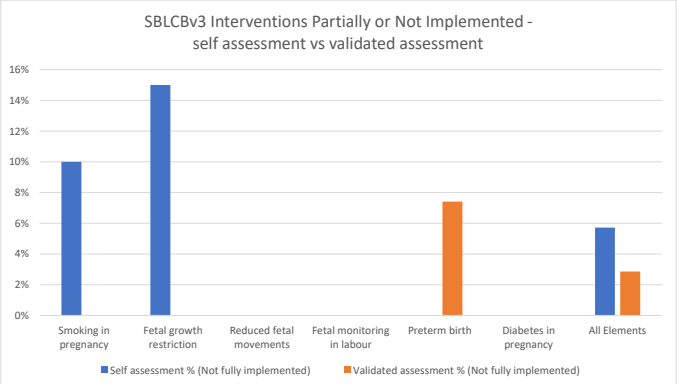
As part of the Three Year Delivery Plan for Maternity and Neonatal Services, all NHS maternity providers are responsible for fully implementing SBLCBv3 by March 2024.

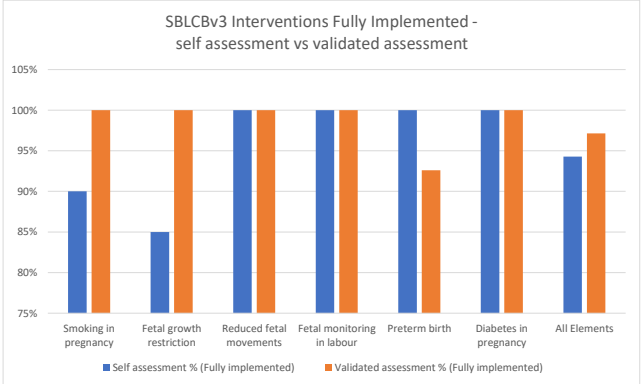
Implementation Grading

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

Implementation Progress

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)	NHS Resolution Maternity Incentive Scheme
Element 1	Smoking in pregnancy	Partially implemented	90%	Fully implemented	100%	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	93%	CNST Met
Element 6	Diabetes	Fully implemented	100%	Fully implemented	100%	CNST Met
All Elements	TOTAL	Partially implemented	94%	Partially implemented	97%	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	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Guideline meets requirements. MSDS DQ check passed in November 23. Jan 24 data- 95% compliance of CO at booking. 89% compliance of CO at 36 weeks.
1.2	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Guideline meets requirements. July-Sept audit noted and compliant at 92%
1.3	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Guideline meets requirements. Smoking status at Booking noted at 100% in Jan 24. Smoking status at 36/40 noted at 89% in Jan 24. Audit noted for smoking status at every contact for pregnant
1.4	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Guideline meets requirements. Opt-out referral rate noted at 100% in Jan 24 so therefore compliant
1.5	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
1.6	Fully implemented	Fully implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	REF1.6N noted. 39% set quit date and 23% achieved a 4 week quit (includes Aug and Sept 23 data). These meet required compliance. Outcome indicator 1d- 40% in Jan 24 meets required compliance.
1.7	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Guideline meets requirements. Audit noted as 100% compliant in REF1.7F (data from July-Sept 23)
1.8	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Updated Training compliance noted. Dec 23- 90% compliance for Midwives/MSW's and 100% compliance for Obstetric consultants working in ANC
1.9	Partially implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Updated Training compliance noted. Dec 23- 90% compliance for Midwives/MSW's and 100% compliance for Obstetric consultants working in ANC
1.10	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Please note, Pactitioners should complete NCSCT e-learning and assessments annually.

Element 2

Intervention Ref	Self-Assessment Status	LMNS Validated Assessment Status	LMNS Recommendation of Actions Required	LMNS Suggested Improvement Activity
INTERVENTIONS				
2.1	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Noted as 100% compliant in Q2 23/24
2.2	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Noted as 100% compliant in Q2 23/24
2.3	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
2.4	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Audit noted as 100% compliant in Q2 23/24
2.5	Fully implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	0
2.6	Partially implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	REF2.6- Guideline updated
2.7	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Audit noted as 100% compliant in Q2 23/24
2.8	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
2.9	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Guideline validadted by LMNS until June 2024
2.10	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Audit noted as 100% compliant in Q2 (please note this is labelled as 2.7 in table of REF2.1D)
2.11	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Overall staff 90% compliance in March 2024
2.12	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
2.13	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
2.14	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
2.15	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
2.16	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
2.17	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
2.18	Partially implemented	Fully implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Q4 of 2023- 45% noted which meets required compliance at present
2.19	Partially implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Antenatal detection of SGA noted as 58% for Q4 of 2023 which meets compliance. GROW report shows babies born < 39 weeks is 11.1% in Q4 of 2023.
2.20	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0

Element 3

INTERVENTIONS				
3.1	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
3.2	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Computerised CTG audit in July/Aug/Sept 23 was 100% compliant. USS audit in July/Aug/Sept 23 was 94% compliant. IOL audit in July/Aug/Sept 23 was 2.2%. PMRT report from July-Sept 23 noted.

Element 4

INTERVENTIONS				
4.1	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Training compliance noted as 90% overall in December 23
4.2	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	80% compliant in September 2023 and 83% compliant in October 2023 (Audits remain valid as within previous 6 months).
4.3	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Audit noted as 100% compliant in December 23
4.4	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Audit 100% compliant in Decmber 23
4.5	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0

Element 5

INTERVENTIONS				
5.1	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	JDs and Job Plans noted for all team members
5.2	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Births 16+0-23+6 was 0% in Oct 23 (data from MSDS) Births 24+0-36+6 was 6.3% in Oct 23 (data from MSDS) PMRT report- annual breakdown of cases in which preterm birth
5.3	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	100% compliance achieved July/Aug/Sept 23.
5.4	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
5.5	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
5.6	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Twins trust audit demonstrates alignment with NICE. Re-audit document noted from September 2023.
5.7	Fully implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	Evidence noted in 1.1. Progress with Early Pregnancy Intervention in C&M pathway
5.8	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
5.9	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	60% compliance noted as per REF5.9 July/Aug/Sept 23.
5.10	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
5.11	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Guideline as REF5.3A (page 5). MSU audit 100% compliant in July/Aug/Sept 23.
5.12	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
5.13	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
5.14	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
5.15	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
5.16	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Audit of 20 cases between Oct-Dec 23- 90% compliant
5.17	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Optimisaton tool states 76% compliant for October 23
5.18	Fully implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	0
5.19	Fully implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	Optimisaton tools states 100% compliance in October, November and December 2023.
5.20	Fully implemented	Partially implemented	Evidence not in place - improvement required.	52% compliance in 2023 (NNAP Powerpoint). 92% compliance noted in Q3 of 23/24 for babies born 22+0-29+6. Data also required for steroids >7days before birth
5.21	Fully implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	ODN Dashboard shows average compliance 97% for Oct,Nov, Dec 2023. 86% overall compliance in 2023 (NNAP Powerpoint). NNAP Powerpoint shows PVL- 7.7% in 2023. IVH- 12.2% in 2023.
5.22	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	ODN Dashboard shows average compliance 44% for Oct,Nov, Dec 2023
5.23	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	ODN Dashboard shows average compliance 85% for Oct,Nov, Dec 2023
5.24	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	ODN Dashboard shows average compliance 65% for Oct,Nov, Dec 2023

5.25	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	ODN Dashboard shows average compliance 84% for Oct,Nov, Dec 2023
5.26	Fully implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	NWODN Action Plan noted
5.27	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	ODN Dashboard shows average compliance 97% for Oct,Nov, Dec 2023

Element 6

INTERVENTIONS				
6.1	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
6.2	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	CGM Audit 100% complaint July/Aug/Sept 23. Q3 CGM audit- please clarify audit 1 comments on page 6. Staff training certificates noted.
6.3	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
6.4	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	90% compliant in Q2 of 23/24. 100% compliant in Q3 23/24
6.5	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
6.6	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0

Appendix 6 Ockenden Essential Actions - May 2024

			1: WORKFORCE PLANNING AND SUSTAINABILITY	RAG Rating	Lead	Target Date	Completion date	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.		JL	30/11/24		Workforce reviews continue 6 monthly to monitor RAG rating of compliance
		2	Minimum staffing levels should be those agreed nationally, or where there are no agreed national levels, staffing levels should be locally agreed with the LMNS. This must encompass the increased acuity and complexity of women, vulnerable families, and additional mandatory training to ensure trusts are able to safely meet organisational CNST and CQC requirements.		JL	30/11/24		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 Neontal consultatn establisgment to demonstrate BAPM compliance
		3	Minimum staffing levels must include a locally calculated uplift, representative of the three previous years' data, for all absences including sickness, mandatory training, annual leave and maternity leave.		JL	31/10/24		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.					
			Essential Action : Training					
			**Work to update orientation packages for	Band 7 staff with process to allocate a mentor. Decision re NQM with NHSE as moreof a risk. Additional work re support for senior leaders.**				
	We state that the Health and Social Care Select Committee view that a proportion of maternity budgets must be ring-fenced for training in every maternity unit should be implemented	**5**	All trusts must implement a robust preceptorship programme for newly qualified midwives (NQM), which supports supernumerary status during their orientation period and protected learning time for professional development as per the RCM (2017) position statement for this.		SW/JL	31/3/23	31/3/23	National programme being developed however robust preceptorship in palce currently. For review once national work completed and recommendation made. Current robust programme in palce and embedded.
		6	All NQMs must remain within the hospital setting for a minimum period of one year post qualification. This timeframe will ensure there is an opportunity to develop essential skills and competencies on which to advance their clinical practice, enhance professional confidence and resilience and provide a structured period of transition from student to accountable midwife.		TBC	31/3/23	31/3/23	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.		TBC	31/3/23	31/3/23	Shift Coordinators have attended development Programmes including Human Factors training however National Programme awaited. Completion of any national prohramme to be agreed. D
		8	All trusts to ensure newly appointed labour ward coordinators receive an orientation package which reflects their individual needs. This must encompass opportunities to be released from clinical practice to focus on their personal and professional development.		JL/SW	31/3/23	31/3/23	Orientation pack currently in use but same to be reviewed nationally and to include study time for profrssional development. To continue with current process in the interim.
		9	All trusts must develop a core team of senior midwives who are trained in the provision of high dependency maternity care. The core team should be large enough to ensure there is at least one HDU trained midwife on each shift, 24/7.		JL	30/8/22	30/8/22	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		JL	31/3/23	31/3/23	Workforce strategy in place however this will be reviewed and include reference to leadership roles. Compl etion date - September 2022 leadership programmes and initiatives 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.		JL/MS/LMNS	31/3/23	31/3/23	Recommendation reviewed - WUTH ready however awaiting Regional / National review
			2: SAFE STAFFING					
			Escalation policy to be further reviewed re risk assessment specifically for medical Process re assessing staffing in place but review will provide further assurance. This includes review of rotas for Obs and Gynae. RCOG tool to be used once introduced to assess medical staffing. Progress with the roll out of the					
2: SAFE STAFFING	All trusts must maintain a clear escalation and mitigation policy where maternity staffing falls below the minimum staffing levels for all health professionals.	**1**	When agreed staffing levels across maternity services are not achieved on a day-to-day basis this should be escalated to the services' senior management team, obstetric leads, the chief nurse, medical director, and patient safety champion and LMS.		JL	31/3/23	31/3/23	Escalation processes in place and the number of diverts is included on the maternity dashboard. Staffing related incident forms reviewed and reported monthly. Staffing reviewed and reported monthly with Chief Nurse oversight.
		2	In trusts with no separate consultant rotas for obstetrics and gynaecology there must be a risk assessment and escalation protocol for periods of competing workload. This must be agreed at board level.		JL MS & LS	30/4/23	30/4/23	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.		JL/KE	31/3/23	31/3/23	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	JL	31/3/23	31/3/23	Final position statement on this to be formalised nationally - completion date awaited. Locally MCofC is not withheld - meeting compliance as per staffing numbers.
		6	The required additional time for maternity training for consultants and locally employed doctors must be provided in job plans. The protected time required will be in addition to that required for generic trust mandatory training and reviewed as training requirements change.		JL/NP/JL	31/3/23	31/3/23	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.		JL/KW	31/3/23	31/3/23	Process to be reviewed and agreed with L&D Team within the Trust. Also include specific requirements for appraisals and support for leadership training eg Top Leaders; 4 C's
		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.		JL	30/4/22	30/4/22	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.		JL/MS/LS	31/3/23	31/3/23	Locum pack developed and shared across C&M- Libby Shaw and Mustafa Sadiq to check RCOG guidance for locum guidance to further support current process. Locum pack and 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		JL/LS/MS	31/12/22	31/12/22	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		JL/LS/MS	31/3/23	31/3/23	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		JL/MS/LS	31/3/23	31/3/23	Ward round take place at weekend, twice daily however resident consultant presence not in place 24/7; Added to Risk Register inview of non-compliance but review completed by WUTH therefore no further action required at present.
		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.		JL/MS/LS/NP	31/3/23	31/3/23	Partial guidance in place and currently no dedicated maternity on call rota in place as Trust on call provides OOH cover. Specific Maternity on call put on hold pending further advice and guidance from NHSE in February 2023.
			4. Clinical governance and leadership					
			Review of additional resource as detailed above to support. Training in place but to be formalised/auditted.					
4 : CLINICAL	Trust boards must have oversight of the quality and performance of their maternity services.	**1**	Trust boards must work together with maternity departments to develop regular progress and exception reports, assurance reviews and regularly review the progress of any maternity improvement and transformation plans					Mat Neo agenda is in place and other QI work is reported in Governance meetings but there is limited Board oversight - same to be reviewed. 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 January 2023
		3	Every trust must ensure they have a patient safety specialist, specifically dedicated to maternity services					In place. Structure organogram required

GOVERNANCE-LEADERSHIP	In all maternity services the Director of Midwifery and Clinical Director for obstetrics must be jointly operationally responsible and accountable for the maternity governance systems.	4	All clinicians with responsibility for maternity governance must be given sufficient time in their job plans to be able to engage effectively with their management responsibilities		MS/LS	31/3/23	31/3/23	In self-assessment tool to include neonates and anaesthetists. Only obstetric time currently supported. Completion date - July 2022; revising 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.		JL	31/3/23	31/3/23	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		MS/LS/JL	31/3/23	31/3/23	Audit plan in place - same to be strengthened for Maternity and Neonates.Obstetric leads in place but midwifery leads for the audit plan to be agreed with Mustafa Sadiq Completion date - June 2022.
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.		**5: CLINICAL GOVERNANCE - INCIDENT INVESTIGATING AND COMPLAINTS**					
			Robust governance processes in place - same to be reviewed with MVP Chair					
		1	All maternity governance teams must ensure the language used in investigation reports is easy to understand for families, for example ensuring any medical terms are explained in lay terms.					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.		JL/CC	31/12/22	31/12/22	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.		JL/CC	31/12/22	31/12/22	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	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.		**6: LEARNING FROM MATERNAL DEATHS**					
		1	NHS England and Improvement must work together with the Royal Colleges and the Chief Coroner for England and Wales to ensure that this is provided in any case of a maternal death.		TBC	31/3/23	31/3/23	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.		TBC	31/3/23	31/3/23	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.		TBC	31/3/23	31/3/23	Recommendation reviewed - WUTH ready however awaiting Regional / National review
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		**7: MULTIDISCIPLANRY TRAINING**					
			MDT in place - same to be extended and recorded (ad hoc drills)					
		1	All members of the multidisciplinary team working within maternity should attend regular joint training, governance and audit events. Staff should have allocated time in job plans to ensure attendance, which must be monitored.		JL/CC/MS/LS	31/3/23	31/3/23	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 trainino 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.		JL/SW	31/3/23	31/3/23	PROMPT includes all of these topics however all staff groups including neonatal staff to be included in PROMPT - same to be reviewed after national recommendation/s.
		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	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		**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.		JL	31/3/23	31/3/23	Do not currently offer routine pre conception care. Will discuss regionally at what can be offered - will look at what high risk team could provide. Completion date - July 2022; Plan to be developed; Two consultants currently have pre-conception clinics and any referrals sent are accommodated from a specialist referral. Pre-conception counselling education with GP's
		2	Trusts must have in place specialist antenatal clinics dedicated to accommodate women with multifetal pregnancies. They must have a dedicated consultant and have dedicated specialist midwifery staffing. These recommendations are supported by the NICE Guideline Twin and Triplet Pregnancies 2019		JL	31/3/23	31/3/23	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 Everitts. 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	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)		**9: PRETERM BIRTH**					
			Both 9 + 10 are in place - audit of processes needed					
		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	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		**10: LABOUR AND BIRTH**					
		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.		JL/DF	31/3/23	31/3/23	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		JL/DF	31/3/23	31/3/23	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		DE/JL	31/3/23	31/3/23	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		DE	31/3/23	31/3/23	Purchase of system currently being undertaken. Procurement in progress once approved at CMG meeting. IT support required and request for same requested. Review March 2023.
11: OBSTETRIC ANAESTHESIA			**11: OBSTETRIC ANAESTHESIA**					
			Close links with Anaesthetic leads with compliance to standards - same to be auditted					

11: OBSTETRIC ANAESTHESIA	In addition to routine inpatient obstetric anaesthesia follow-up, a pathway for outpatient postnatal anaesthetic follow-up must be available in every trust to address incidences of physical and psychological harm.Documentation of patient assessments and interactions by obstetric anaesthetists must improve. The determination of core datasets that must be recorded during every obstetric anaesthetic intervention would result in record-keeping that more accurately reflects events.Staffing shortages in obstetric anaesthesia must be highlighted and updated guidance for the planning and provision of safe obstetric anaesthesia services throughout England must be developed.	**1**	Conditions that merit further follow-up include, but are not limited to, postdural puncture headache, accidental awareness during general anaesthesia, intraoperative pain and the need for conversion to general anaesthesia during obstetric interventions, neurological injury relating to anaesthetic interventions, and significant failure of labour analgesia		JL/NP/JL	31/3/23	31/3/23	Alice Arch overview: If a post-operative debrief would be useful these can be arranged to be purely or involve a Consultant Anaesthetist and we do this for lots of patients already - we usually offer this at 6-8 weeks post event unless the patient requests it to be earlier or later - and these patients can be referred to the Obstetric Anaesthetic Assessment clinic if they present in subsequent pregnancies; Assurance process developing
		2	Anaesthetists must be proactive in recognising situations where an explanation of events and an opportunity for questions may improve a woman's overall experience and reduce the risk of long-term psychological consequences.		JL/NP/JL	31/3/23	31/3/23	Currently being undertaken but need to review guidance to ensure all criteria included with audit of same. Completion date - July 2022; part of assurance process 11.1
		3	All anaesthetic departments must review the adequacy of their documentation in maternity patient records and take steps to improve this where necessary as recommended in Good Medical Practice by the GMC		NP/JL/JL	31/3/23	31/3/23	Documentation is recorded in maternity record hwoever need to review audit process. Completion date - July 2022; part of assurance process 11.1; part of assurance process 11.1
		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.			TBC	TBC	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.		NP/JL/JL	31/3/23	31/3/23	Staff who do not do regular Obstetric Anaesthesia sessions want to do a Consultant Accompanied CPD session in Obstetric Anaesthesia to keep skills up to date we are more than happy to facilitate this - and several people have already taken up this opportunity. Process to be reviewed. Completion date - July 2022; assurance process to be developed
		6	• The full range of obstetric anaesthesia workload including, elective caesarean lists, clinic work, labour ward cover, as well as teaching, attendance at multidisciplinary training, and governance activity.		JL/JL/NP	31/3/23	31/3/23	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.		JL/JL/NP	31/3/23	31/3/23	As point 5; assurance process to be developed
		8	• Participation by anaesthetists in the maternity multidisciplinary ward rounds as recommended in the first report		JL/JL/NP	31/3/23	31/3/23	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		JL	31/3/23	31/3/23	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		JL	31/3/23	31/3/23	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		JL	31/3/23	31/3/23	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 (LMNS/LMNS) quarterly.			31/3/23	31/3/23	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.			31/3/23	31/3/23	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.			31/3/23	31/3/23	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 resuscitative team if required.		JL	31/3/23	31/3/23	Evidence of this happening in practice to be confirmed and to be followed up with Angela McDonald, Adam Brown and Sanjeev Rath
		7	Neonatal practitioners must ensure that once an airway is established and other reversible causes have been excluded, appropriate early consideration is given to increasing inflation pressures to achieve adequate chest rise. Pressures above 30cmH2O in term babies, or above 25cmH2O in preterm babies may be required. The Resuscitation Council UK Newborn Life Support (NLS) Course must consider highlighting this treatment point more clearly in the NLS algorithm.		JL	31/3/23	31/3/23	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.		AB/ AK	31/3/23	31/3/23	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.		AK	31/3/23	31/3/23	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.		AK	31/3/23	31/3/23	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		AK	31/3/23	31/3/23	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 Comoliant
Non Compliant/risk identified on risk register
NOTE: Completion dates are provisional pending detailed improvement plan.

	Appendix 7 - 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	31/5/23	Evidence of smoking cessation midwife/work with ABL. Use of NRT. ANNB Screening Programme QA; ANNB Screening action plan to further review screening information
			3	Women have clear choices, supported by unbiased information and evidence- based guidelines. Information is provided in a range of formats and languages, uses terminology in line with the Rebirth report, and is co-produced.		AK/ER	31/10/24	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; languages
			4	All women have equitable access to specialist care, including perinatal mental health services, perinatal pelvic health services, maternal and foetal medicine networks, and neonatal care, when needed		JKL	28/2/24	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	30/6/24	Processes in place although clarity needed regarding 6-8week GP check post pandemic; Check with HV team re GP follow up check
			6	Parents are partners in their baby's care in the neonatal unit through individualised care plans utilising a family integrated care approach, together with appropriate parental accommodation.		ST/AMC	No further action	FI Care review undertaken with action plan developed following feedback positive in May 2022; repeated in May 2023 and GREEN accreditation achieved
			7	Compassionate and high-quality care for bereaved families including appropriate accommodation, which is easily accessible but separate from maternity and neonatal units		AK/ER	No further action	Bereavement midwife in post. Bereavement Suite on site. Use of Ron McDonald House is also an option that is used
	Objective 2: Improve equity for mother and babies	The NHS approach to improving equity (Core20PLUS5) involves implementing midwifery continuity of carer, particularly for women from minority ethnic communities and from the most deprived area It is the responsibility of trusts to: Provide services that meet the needs of their local populations, paying particular attention to health inequalities. This includes facilitating informed decision-making, for example choice of pain relief in labour where we know there are inequalities, ensuring access to interpreter services, and adhering to the Accessible Information Standard in maternity and neonatal	**8**	To reduce inequalities for all in access, experience and outcomes		JL	30/9/24	Equity and Equality plan developed by LMNS following gap analysis which the Trust completed; Further work re equality to be undertaken
			9	Targeted support where health inequalities exist in line with the principles of proportionate universalism		JL	30/6/24	MCoC teams to be set up as a wraparound service but the support is already in place from these Leads; MCoC teams in place and embedded in the identified areas; 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	30/6/24	Maternity services to work with PLACE; LMNS and ICB leads to progress
			12	In spring 2023, publish the National Review of Health and Social Care in Women's Prisons. This review covers maternity and perinatal services		JL/MB	30/6/24	To achieve requirement to work with the LMNS to meet and no local prisons feed into WUTH; consider a SoP with safeguarding midwife involvement
	Objective 3: Work with service users to improve care	Acting on the insights of women and families improves services. Co-production is beneficial at all levels of the NHS and is particularly important for those most at risk of experiencing health inequalities (NICE, 2018). Involving service user representatives helps identify what needs to improve and how to do it. This is done through maternity and neonatal voices partnerships (MNVPs) and by	**13**	MVNPs listen to and reflect the views of local communities. All groups are heard, including bereaved families.		JL	No further action	Equity and Equality plan developed by LMNS following gap analysis which the Trust completed; Further work re equality to be undertaken as detailed above
			14	MNVPs have strategic influence and are embedded in decision making		JL	No further action	MIS evidence supports work and undertaken and co-production
			15	MNVPs have the infrastructure they need to be successful. Workplans are funded. MNVP leads, formally MVP chairs, are appropriately employed or remunerated and receive appropriate training, administrative and IT support.		JL	31/1/24	MNVP embedded; full funding of post with agreed workplan from ICB awaited; 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/NP/MS/AK	30/6/24	Score survey undertaken for Maternity and Neonates; feedback sessions in November 2023; staff engagement 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	**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	career development opportunities. Effective training of frontline clinicians in technical and non-technical skills has been shown to	**23**	All staff have regular training to maintain and develop their skills in line with their roles, career aspirations, and national standards. Training is multi-disciplinary wherever practical to optimise teamworking		JL	No further action	TNA in place and reviewed annually
	Theme 3: Developing and sustaining a culture of safety, learning and support				RAG Rating	Lead	Review Date	Comments / Lead Progress
	Objective 7: Developing a positive safety culture		**24**	All staff working in and overseeing maternity and neonatal services: -Are supported to work with professionalism, kindness, compassion, and respect. Are psychologically safe to voice their thoughts and are open to constructive challenge. -Receive constructive appraisals and support with their development. -Work, learn and train together as a multi-disciplinary team across maternity and neonatal care.		JL	No further action	MDT training in place. TNA supports training requirements incl psychological safety. Appraisal process in place with good compliance monitored at Board level.
			25	Teams value and develop people from all backgrounds and make the best use of their diverse skills, views, and experiences.		JL	No further action	Training in place to support
			26	There is a shared commitment to safety and improvement at all levels, including the trust board, and attention is given to 'how' things are implemented not just 'what'		JL	No further action	Evidenced through safety champions meetings; Newly formed divisional MatNeo Assurance Board
			27	Instances of behaviour that is not in line with professional codes of conduct, are fairly addressed before they become embedded or uncontrollable.		JL	No further action	Trust training and policies support professional behaviour/s. Disciplinary processes support appropriate action when needed
			28	Systems and processes enable effective coordination, rapid mobilisation, and supportive communication based on agreed principles. The team can escalate concerns and, should there be a disagreement between healthcare professionals, they will be supported by a conflict of clinical opinion policy.		JL	No further action	Policy in place – provided for Ockenden evidence
			29	Staff investigating incidents are provided with appropriate training, while those staff affected by an incident are offered timely opportunity to debrief		JL/DC	No further action	Training in place for staff and this is reviewed and provided by the Trust Governance team
	Objective 8: Learning and Improving	Staff working in maternity and neonatal services have an appreciation and understanding of 'what good looks like.' To promote safer care for all, we must actively learn from when things go well and when they do not. To do this, we need a continuous learning and	**30**	Our ambition is framed by the patient safety incident response framework (PSIRF) which provides a consistent approach across clinical specialties, including for maternity and neonatal services		JL/DC	31/3/24	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	HSIB quarterly meetings take place and Trust evidenced 100% reporting by the Trust
	Objective 9: Support and oversight	While some trusts and ICSs do effectively support their maternity and neonatal services to improve and change; others do not. Good oversight is about understanding the issues leaders face and helping to resolve them, and having clear systems in place that promote timely escalation and intervention before serious problems arise	**32**	Robust oversight through the perinatal quality surveillance model (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	31/12/24	Leadership training in place and underway x various programmes for Senior Leaders, Quad perinatal leadership programme
	Theme 4: Standards and structures that underpin safer, more personalised and more equitable care				RAG Rating	Lead	Review Date	Comments / Lead Progress
	Objective 10: Standards to ensure best practice	Advances in clinical practice have been crucial in the improvement in maternity and neonatal outcomes over the last decade. Better Births also identified that variation in protocols, policies, and standards between services creates additional burden and hinders the ability to work together to provide effective care.	**35**	Consistent implementation of nationally defined best practice with due regard to the needs of local populations to reduce variation and inequalities		JL/MS	31/3/25	MIS year 5 submitted and confirmation of all 10 safety actions; SBLv3 implemented 97%; review of MCoC to address women with inequalities; MIS Year 6 published and in progress
			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	31/10/24	Ongoing work with ICB; timeframes to be set
			37	Where local policy varies from national standards, this is subject to careful local scrutiny through governance processes. The whole multidisciplinary team is involved when developing local guidance			No further action	Processes in place to ensure MDT are involved with developing local policy
			38	Policies and guidelines recognise women as the decision-makers in their maternity care and are not used to prevent women from seeking care that is outside these guidelines			No further action	Policy in place and women are supported by the consultant midwife/Obstetric/Neonatal Leads
			39	Neonatal care is provided in units with clear designation of the level of care to be provided. Units work together across ODNs to optimise capacity and ensure care can be provided in the right place for very pre-term or very sick babies			No further action	Policy in place and women are supported by the consultant midwife/Obstetric/Neonatal Leads
	Objective 11: Data to inform learning	The Kirkup report highlighted the need for accurate, up to date data to highlight safety issues promptly. Such data enables providers to learn and act. Work is underway to review what data is needed for monitoring, and in the meantime, the NHS should continue to use the data it already collects	**40**	Standardised data is collected in a consistent way, primarily through the Maternity Services Data Set. Additional data collections are minimised, to focus on gathering the right data to drive insights, understanding and assurances.			No further action	MSDS submitted in addition to completion of a local and regional dashboard
			41	Monitoring trends at both national and local level is enabled by analysing data from different sources alongside themes from MBRRACE-UK , and the national clinical audits patient outcome programme reports			No further action	LMNS support in leading on monitoring trends regionally. Outlier reports are presented to Board quarterly; Improvement plans are developed to address any outlier reports
			42	The national maternity dashboard provides demographic data, clinical quality improvement metrics and national maternity indicators enabling trusts and LMNSs to benchmark their services and inform continuing quality improvement work			No further action	Data submitted to national dashboard; Given limited metrics the national dashboard is not currently reviewed – work to be identified to address an improvement moving forwards.
	Objective 12: Make better use of digital technology	Digital technology will make it easier for women to access the information they need and for services to offer safe and personalised care. There is currently significant variation in the use of digital technology. While some maternity services remain almost entirely paper-based, others support personalised care with apps and benefit from an integrated electronic patient record (EPR).	**43**	Women can access their records and interact with their digital plans and information to support informed decision-making. Parents can access neonatal and early years health information to support their child's health and development. Information meets accessibility standards, with non-digital alternatives available for those who require or prefer them		JL/NP	31/12/24	Processes in place for women to access their records electronically – work to progress to roll out patient portal.
			44	All clinicians are supposed to make best use of digital technology with sufficient computer hardware, reliable Wi-Fi, securing networks and training			No further action	Full IT system in place and supported with equipment
			45	Organisation's enable access to key information held elsewhere internally or by partner organisations, such as other trusts and GP practices			No further action	Work across Wirral with the introduction of the single care record is supporting this

RAG	Key
Blue	Complete
Green	On track
Amber	On track; risks identified
Red	Off Track

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WOMEN'S EXPERIENCE OF MATERNITY CARE ACTION PLAN (Feedback: MNVP, Healthwatch St Helens, Healthwatch Halton

Appendix 8

	DATE ADDED TO WORK PLAN	RECOMMENDATION	ACTION	WHO	PROGRESS	RAG RATING
1	18/04/2024	MNVP is to participate in and actively influence decision-making on local strategies and policies in maternity and neonatal care.	**North West regional MNVP Leads Meeting**	**Trust, LMNS**	Monthly Meetings	Ongoing
2	18/04/2024	MNVP is to participate in and actively influence decision-making on local strategies and policies in maternity and neonatal care.	**Stakeholders Quarterly Meeting**	ICB, ODN and Trust	Quarterly Meetings	
3	18/04/2024	MNVP is to participate in and actively influence decision-making on local strategies and policies in maternity and neonatal care.	**Fortnightly Maternity Senior Leadership Meeting**	Trust	Fortnightly Meeting	Ongoing
4	18/04/2024	MNVP is to participate in and actively influence decision-making on local strategies and policies in maternity and neonatal care.	**Women's Health Forum (Wirral) and Women's Health and Maternity Forum (WHAM)**	ICB, LMNS and Trust	Monthly Meeting	Ongoing

5	18/04/2024	MNVP is to participate in and actively influence decision-making on local strategies and policies in maternity and neonatal care.	**Safety Champion Meeting**	Trust	Monthly Meeting	
	18/04/2024	MNVP is to participate in and actively influence decision-making on local strategies and policies in maternity and neonatal care.	**Maternal Medicine Network: Co-Production Reference Group**	**Trust, LMNS and ICB**	Monthly meeting	
6	18/04/2024	MNVP is to participate in and actively influence decision-making on local strategies and policies in maternity and neonatal care.	**Public Health Meeting - Smoking, Substance misuse, Teenage Pregnancies, terminations**	**ICB and Trust**	When Requested	
7	18/04/2024	MNVP is to participate in and actively influence decision-making on local strategies and policies in maternity and neonatal care.	Sexual Health Meeting- **Teenage Pregnancies, terminations and contraception**	**ICB and Trust**		
	18/04/2024	MNVP is to participate in and actively influence decision-making on local strategies and policies in maternity and neonatal care.	**Diabetes Workstream MMN**	Trust, LMNS and ICB	Ongoing	
8	18/04/2024	MNVP is to participate in and actively influence decision-making on local strategies and policies in maternity and neonatal care.	**Equity and Equality**	Trust, ICB, ODN and LMNS		On going
	18/04/2024	Supporting Trust	**Improving Infant Feeding Care**	Trust, ODN and LMNS	Ongoing	Ongoing

	18/04/2024	Supporting Trust	**To understand to the north west Neonatal Operation Delivery Network (NWODN), this includes a comprehensive understanding of the roles within NWODN, such as the Care Coordinators and Parent Engagement Lead, and fostering relationships with each, alongside the Parent Advisory Group**	Trust, ODN, ICB and LMNS		
		Supporting Trust	**Supporting CQC maternity survey action plan, focus group and feedback**	Trust, ICB and LMNS	Focus group in May 2024	
	18/04/2024	Supporting Trust	**Safe Sleep initiative**	Trust, LMNS, ODN and ICB		
	18/04/2024	Supporting Trust	**Support in Friends and Family uptake with service users.**	Trust, LMNS and ICB		
9	18/04/2024	MNVP is to engage with and listen to families in their community about their experiences of maternity and neonatal care.	**Visit ANC, Day Ward, Maternity Ward and Neonatal Unit – Weekly 1-2 hours**	ICB, Trust	On going	
10	18/04/2024	MNVP is to engage with and listen to families in their community about their experiences of maternity and neonatal care.	**MNVP Listening Events**	ICB, Trust, LMNS and ODN		

11		MNVP is to engage with and listen to families in their community about their experiences of maternity and neonatal care.	**15 Steps Event – gathering feedback**	**ICB, Trust, LMNS Priority and ODN**		
		MNVP is to engage with and listen to families in their community about their experiences of maternity and neonatal care.	**Minority ethnic groups – working with Wirral Multicultural Organisation/Wirral Change/Heart 4 Refugees to support their service users.**	**Trust, ICB, LMNS and ODN**		
12		MNVP is to engage with and listen to families in their community about their experiences of maternity and neonatal care.	**Seacombe Birth Centre Coffee Mornings**	Trust	On going	
		MNVP is to engage with and listen to families in their community about their experiences of maternity and neonatal care.	**Attend Ronald Mcdonald House Neobabies**	**LMNS, ODN and Trust**		
14		MNVP is to engage with and listen to families in their community about their experiences of maternity and neonatal care.	**Networking with local charities (including attending the charity's events when requested)** **Koala NorthWest** **Little Lungs** **Wirral Mind Mums Matter** **Journeymen** **Bee Wirral**	Trust, ODN, ICB and LMNS		Ongoing

			St James Centre **Tomorrow's Women** **Wirral Multicultural Organisation** **Wirral Change** **Mencap** **Milk Bank at Chester** **Movement and Bloom Social Walks** **Equilibrium**			
		MNVP is to engage with and listen to families in their community about their experiences of maternity and neonatal care.	**Social Media Presence – sharing information, live streams, answering messages**	Trust, ICB, LMNS and ODN		
		MNVP is to engage with and listen to families in their community about their experiences of maternity and neonatal care.	**Attending groups in children's centre, equilibrium, corner house etc.**	Trust, ICB, LMNS and ODN		