Appendix 1 - Perinatal Clinical Surveillance Quality Assurance Report Oct 2024

Theme	Area requiring further enquiry or shared intelligence	Outlier	Evidence
Clinical Care	Outlier for rates of stillbirth as a proportion of births	No	No escalation from SCN / LMNS on outlier report; internal thematic review being undertaken; NW region outlier report no longer published and NW Regional dashboard now available however discusssed regionally as Data to 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; no further trends identified as an outlier in 2024; new C&M data provided and validity underway in October 2024
	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 PSII's	na	No PSSI's reported in October 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 Q1 (April-June 2024) of 97%; compliance will be monitored by LMNS quarterley and updates provided to BoD 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 which was completed and evidence within meeting minutes
	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 >1%; all new qualified midwives commenced in Sept 2024; x 4 due to commence in Jan 2025; maternity funding application being made for posts to be recuited into substantive and permanent contracts
	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; 5 teams in total and two approach model in place; comparison data / research underway; one team disbanded in July 2024
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. Quarterley meetings held with MNSI
	Lack of transparency	no	Being open conversations are regularly had and 100% compliance with duty of candour evident
	Learning from PSII'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; CQC National Maternity Report published 20/09/24 reviewed and gap analysis prepared - to be shared with BoD at next quarterley meeting
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 PSSI where criteria have been met	no	Robust PSIRF framework followed with timely reporting of all cases that meet the PSSI framework; PSIRF with effect from 1/9/2023; feedback given from national visit to ensure decisions of the process are within the specialities of the division
	Never Events which are not reported	no	No maternity or neonatal never events in October 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
Governanc e 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 inspection and DHSC or NHSE/I request for support	DHSC or NHS England Improvement request for a Review of Services or Inquiry	no	Nil to report this month
	An overall CQC rating of Requires Improvement with an Inadequate rating for either Safe and Well-Led or a third domain	no	CQC reports published for maternity sites Seacombe Birth Centre and APH site for the domains Safe and Well led; both sites were rated 'GOOD'
	An overall CQC rating of Inadequate	no	N/a
	Been issued with a CQC warning notice	no	N/a
	CQC rating dropped from a previously Outstanding or Good rating to Requires improvement in the safety or Well-Led domains	no	N/a
	Been identified to the CQC with concerns by HSIB	no	N/a

Overview of progress on safety action requirements

Safety Action Requirements:

Safety Action	Red	Amber	Green	Blue	Total Requirements
1	0	0	6	0	6
2	0	0	0	2	2
3	0	0	2	2	4
4	0	6	14	0	20
5	0	0	5	0	5
6	0	0	6	0	6
7	0	0	7	0	7
8	0	6	12	0	18
9	0	0	8	0	8
10	0	1	7	0	8
Total	0	13	67	4	84

Key:

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

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.

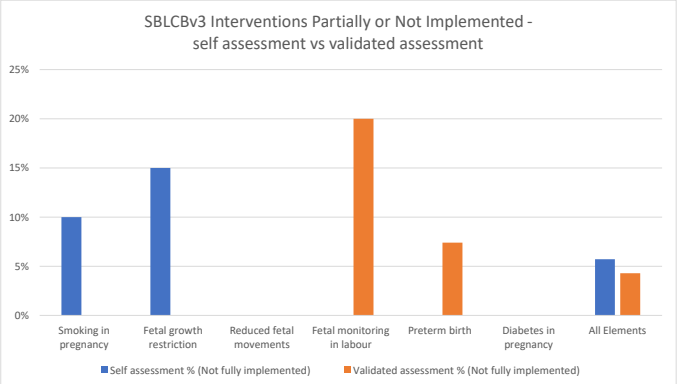
As part of the Three Year Delivery Plan for Maternity and Neonatal Services, all NHS maternity providers are responsible for fully implementing SBLCBv3 by March 2024.

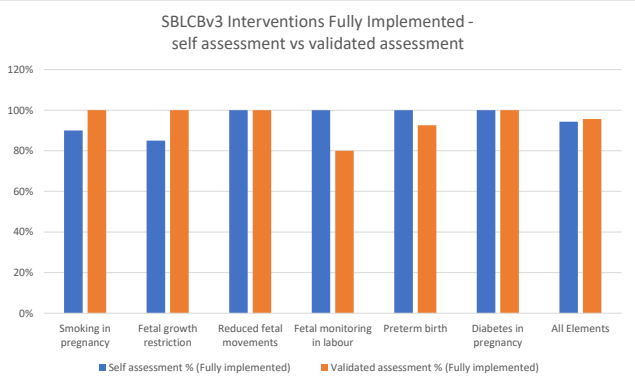
Implementation Grading

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%	Partially implemented	80%	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	96%	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 Feb 24. Snapshot audit shows 100% compliance of CO at booking in April 24. Snapshot audit shows 100% compliance of CO at 36 weeks in April
1.2	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	April 24 audit- 60% (6 of 10 smokers)
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 April 24 snapshot audit. Smoking status at 36/40 noted at 87% in April 24 snapshot audit.
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 April 24 audit so therefore compliant.
1.5	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	NRT supplied by in-reach service
1.6	Fully implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	WUTH audit shows 28% set quit date in April 24. ABL data shows 23% set quit date in March 24. WUTH audit shows 17% achieved a 4 week quit in March 24. ABL
1.7	Fully implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	Clarification received regarding feedback process in collaboration with ABL. WUTH audit shows 92% had feedback in Jan 24, 90% in Feb 24 and
1.8	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Updated Training compliance noted-96.5% in April 24
1.9	Partially implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Updated Training compliance noted-96.5% in April 24
1.10	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Certificates noted in previous submissions. Please note, Practitioners should complete NCSCT e-learning and assessments annually.

Element 2

Intervention Ref	Self-Assessment Status	LMNS Validated Assessment Status	LMNS Recommendation of Actions Required	LMNS Suggested Improvement Activity
INTERVENTIONS				
2.1	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Noted as 100% compliant in March and April 24
2.2	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Noted as 100% compliant in Jan 24. Compliance fell to 90% in Feb/March/April 24 and requires improvement
2.3	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	See element 1
2.4	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Audit noted as 100% compliant Jan-April 24
2.5	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	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 Jan-April 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 Jan-April 24
2.11	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Overall staff 96% compliance in March and April 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.	Q1 of 2024- 46.2% noted in GROW report 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 53.3% for Q1 of 2024 which meets compliance.
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.	Guideline and Tommys leaflet noted in previous submissions.
3.2	Fully implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	Computerised CTG audit in April 24 was 100% compliant. USS audit in April 24 was 100% compliant.

Element 4

INTERVENTIONS				
4.1	Fully implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	4a (Study Day and K2)- As of April 24: Midwives (93%)150/160, Rotational dr's-(80%) 12/15 and Consultants (92%)13/14 therefore 88% overall which falls below compliance at present.
4.2	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	March 24 audit shows 95% compliance
4.3	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	PMRT presentation noted- 1 case had learning from fetal surveillance issues between Jan-March 24.
4.4	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Audit 80% compliant in March 24. Compliance of 100% in April 24.
4.5	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Evidenced in previous submission. Email noted to confirm all roles remain filled.

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	Focus required on quality improvement intiatives to meet recommended standard.	Births 16+0-23+6 was 0% in Jan-April 24 (WUTH SBL dashboard)- LMNS query if this data is accurate Births 24+0-36+6 was 0% in Jan-April 24 (WUTH SBL dashboard)-
5.3	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	100% compliance achieved Feb-April 24
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	Not implemented	Evidence not in place - improvement required.	Shortage of testing kits noted. Please note TVCS my be used with our without qfFN
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 noted. WUTH SBL dashboard shows 85% Jan 24, 100% Feb and March 24, 95% in April 24.
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.	Staffing paper noted. CoC powerpoint presentation noted.
5.15	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
5.16	Fully implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	WUTH SBL dashboard shows 98% in March 24, 100% in April 24, 100% in May 24 (audit sample 27+1 to 34+0). Trust aware of audit requirements as per NWNODN for ongoing
5.17	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Optimisaton tool states 77% in Feb 24
5.18	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
5.19	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Optimisaton tools states 100% compliance in Feb 24
5.20	Fully implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	44% in March 24 Data also required for steroids >7days before birth
5.21	Fully implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	Optimisation tool shows 100% compliance with Mag Sulph in Feb 24 Q1 of 2024 NNAP report shows IVH-6.7%, CPVL-0%, PVHD-6.7% in 2023.
5.22	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Optimisation tool shows 100% in Feb 24
5.23	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Optimisation tool shows 78% in March 24
5.24	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Optimisation tool shows 86% in Feb 24 and 83% in April 24

5.25	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Optimisation tool shows 78% in March 24
5.26	Fully implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	NWODN Action Plan noted. VTV internal audit noted (100% Feb-April 24)
5.27	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Optimisation tool shows 100% in Feb 24

Element 6

INTERVENTIONS				
6.1	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Evidenced in previous submission
6.2	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	CGM Audit 100% complaint Jan-March 24. Staff training certificates noted in previous submission (MWs trained
6.3	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Evidenced in previous submission
6.4	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	100% compliant in Jan-March 24
6.5	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Evidenced in previous submission
6.6	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Evidenced in previous submission

Appendix 4 Ockenden Essential Actions

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

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.	**2**	When a middle grade or trainee obstetrician (non-consultant) is managing the maternity service without direct consultant presence trusts must have an assurance mechanism to ensure the middle grade or trainee is competent for this role		Mustafa Sadiq and Libby Shaw to lead on embedding the Locum package being embedded and evidence of assurance
		3	Trusts should aim to increase resident consultant obstetrician presence where this is achievable		Ward round take place at weekend, twice daily however resident consultant presence not in place 24/7; Added to Risk Register inview of non-compliance but review completed by WUTH therefore no further action required at present.
		4	There must be clear local guidelines for when consultant obstetricians' attendance is mandatory within the unit		Guidance in place / in policy
		5	There must be clear local guidelines detailing when the consultant obstetrician and the midwifery manager on-call should be informed of activity within the unit.		Partial guidance in place and currently no dedicated maternity on call rota in place as Trust on call provides OOH cover. Specific Maternity on call put on hold pending further advice and guidance from NHSE in February 2023.
4. Clinical governance and leadership					
			Review of additional resource as detailed above to support. Training in place but to be formalised/auditted.		
4 : CLINICAL GOVERNANCE-LEADERSHIP	Trust boards must have oversight of the quality and performance of their maternity services. In all maternity services the Director of Midwifery and Clinical Director for obstetrics must be jointly operationally responsible and accountable for the maternity governance systems.	**1**	Trust boards must work together with maternity departments to develop regular progress and exception reports, assurance reviews and regularly review the progress of any maternity improvement and transformation plans		Mat Neo agenda is in place and other QI work is reported in Governance meetings but there is limited Board oversight - same to be reviewed. Maternty safety champions and regular board meetings. Processes embedded - review in March 2023.
		2	All maternity service senior leadership teams must use appreciative inquiry to complete the National Maternity Self-Assessment Tool if not previously done. A comprehensive report of their self-assessment including governance structures and any remedial plans must be shared with their trust board		Self-assessment tool completed with actons in place and presented to Board. However same to be reviewed following Ockenden and an updated self assessment to go to Board in Sept 2024 to provide continued assurance
		3	Every trust must ensure they have a patient safety specialist, specifically dedicated to maternity services		In place. Structure organogram required
		4	All clinicians with responsibility for maternity governance must be given sufficient time in their job plans to be able to engage effectively with their management responsibilities		In self-assessment tool to include neonates and anaesthetists. Only obstetric time currently supported. Completion date - July 2022; reviwing additional PA's and funding to achieve
		5	All trusts must ensure that those individuals leading maternity governance teams are trained in human factors, causal analysis and family engagement.		Staff currently trained however review of staff group required and additional training to be identified. For further review in March 2023.
		6	All maternity services must ensure there are midwifery and obstetric co-leads for developing guidelines. The midwife co-lead must be of a senior level, such as a consultant midwife, who can drive the guideline agenda and have links with audit and research.		Multi-discipinary leads in place. Consultant Midwife coleads with audit/research.
		7	All maternity services must ensure they have midwifery and obstetric co-leads for audits		Audit plan in place - same to be strengthened for Maternity and Neonates.Obstetric leads in place but midwifery leads for the audit plan to be agreed with Mustafa Sadiq Completion date - June 2022.
5: CLINICAL GOVERNANCE - INCIDENT INVESTIGATING AND COMPLAINTS					
			Robust governance processes in place - same to be reviewed with MVP Chair		
5: CLINICAL GOVERNANCE – INCIDENT INVESTIGATION AND COMPLAINTS	Incident investigations must be meaningful for families and staff and lessons must be learned and implemented in practice in a timely manner.	**1**	All maternity governance teams must ensure the language used in investigation reports is easy to understand for families, for example ensuring any medical terms are explained in lay terms.		In place and evidenced. Robust process for reviewing documents before they are sent to families.
		2	Lessons from clinical incidents must inform delivery of the local multidisciplinary training plan.		In place in various forums both internal and external to the Trust
		3	Actions arising from a serious incident investigation which involve a change in practice must be audited to ensure a change in practice has occurred.		Implementation of actions recorded and monitored however audit of same to be reviewed.Link with audit plan
		4	Change in practice arising from an SI investigation must be seen within 6 months after the incident occurred.		Learning put in place immediately. - evidenced on individual reports.
		5	All trusts must ensure that complaints which meet SI threshold must be investigated as such		Clear MDT process in place - SI Panel. Process embedded.
		6	All maternity services must involve service users (ideally via their MVP) in developing complaints response processes that are caring and transparent		Complaint response processes in place however MVP to review and to identify improvements to further strengthen the process
		7	Complaints themes and trends must be monitored by the maternity governance team.		Processes currently in place to incorportae all patient feedback - LEAP to include Feedback Friday - positive and negative feedback and trends to be communicated to all staff.
6: LEARNING FROM MATERNAL DEATHS					
6: LEARNING FROM MATERNAL DEATHS	Nationally all maternal post-mortem examinations must be conducted by a pathologist who is an expert in maternal physiology and pregnancy related pathologies. In the case of a maternal death a joint review panel/investigation of all services involved in the care must include representation from all applicable hospitals/clinical settings.	**1**	NHS England and Improvement must work together with the Royal Colleges and the Chief Coroner for England and Wales to ensure that this is provided in any case of a maternal death.		Recommendation reviewed - WUTH ready however awaiting Regional / National review
		2	This joint review panel/investigation must have an independent chair, must be aligned with local and regional staff and seek external clinical expert opinion where required.		Recommendation reviewed - WUTH ready however awaiting Regional / National review
		3	Learning from this review must be introduced into clinical practice within 6 months of the completion of the panel. The learning must also be shared across the LMS.		Recommendation reviewed - WUTH ready however awaiting Regional / National review
7: MULTIDISCIPLANRY TRAINING					
			MDT in place - same to be extended and recorded (ad hoc drills)		
7: MULTIDISCIPLINARY TRAINING	Staff who work together must train together Staff should attend regular mandatory training and rotas. Job planning needs to ensure all staff can attend. Clinicians must not work on labour ward without appropriate regular CTG training and emergency skills training	**1**	All members of the multidisciplinary team working within maternity should attend regular joint training, governance and audit events. Staff should have allocated time in job plans to ensure attendance, which must be monitored.		Midwifery and middle grades involved in audit - need to expand to neonatal evidence of same and allocated time to be evidenced.
		2	Multidisciplinary training must integrate the local handover tools (such as SBAR) into the teaching programme at all trusts.		SBAR in all training including neonates. Audit of same to be further improved.
		3	All trusts must mandate annual human factor training for all staff working in a maternity setting; this should include the principles of psychological safety and upholding civility in the workplace, ensuring staff are enabled to escalate clinical concerns. The content of human factor training must be agreed with the LMS.		For all staff attend human factors training however guidance re content awaited from LMNS
		4	There must be regular multidisciplinary skills drills and on-site training for the management of common obstetric emergencies including haemorrhage, hypertension and cardiac arrest and the deteriorating patient.		PROMPT includes all of these topics however all staff groups including neonatal staff to be included in PROMPT - same to be reviewed after national recommendation/s.
		5	There must be mechanisms in place to support the emotional and psychological needs of staff, at both an individual and team level, recognising that well supported staff teams are better able to consistently deliver kind and compassionate care.		Jo Allen support for NQM. PMAs. NWAS has toolkit for staff Contact Steph Heyes. Discussed psychological support that was available in ITUs during Covid pandemic - that there was psychological support present at work.This helped staff to attend work becuase they knew the support would be there.
		6	Systems must be in place in all trusts to ensure that all staff are trained and up to date in CTG and emergency skills.		Karen Cullen in post for CTG / Fetal Physiology in addition to Ali Campion and Libby Shaw.
		7	Clinicians must not work on labour wards or provide intrapartum care in any location without appropriate regular CTG training and emergency skills training. This must be mandatory		PROMPT, K2, fetal physiology, CIF meetings, Pass mark for CTG assessment is mandated and reviewed monthly.
8: COMPLEX ANTENATAL CARE					
			Review of High Risk team and support to implement MMN links. Review of preconceptual care and further progress in secondary care.		
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	**1**	Women with pre-existing medical disorders, including cardiac disease, epilepsy, diabetes and chronic hypertension, must have access to preconception care with a specialist familiar in managing that disorder and who understands the impact that pregnancy may have.		Do not currently offer routine pre conception care. Will discuss regionally at what can be offered - will look at what high risk team could provide. Completion date - July 2022; Plan to be developed; Two consultants currently have pre-conception clinics and any referrals sent are accommodated from a specialist referral; Pre-conception counselling education with GP's
		2	Trusts must have in place specialist antenatal clinics dedicated to accommodate women with multifetal pregnancies. They must have a dedicated consultant and have dedicated specialist midwifery staffing. These recommendations are supported by the NICE Guideline Twin and Triplet Pregnancies 2019		Twins Trust coming in multi-pregnacy clinic - Mustafa Sadiq is lead.
		3	NICE Diabetes and Pregnancy Guidance 2020 should be followed when managing all pregnant women with pre-existing diabetes and gestational diabetes.		Guidance in place - to link wth Rachel Tildesley and Lauren Evertts. Need to look at audit to support compliance. For FAAP 2023

	guidance Trusts must follow national guidance for managing women with diabetes and hypertension in pregnancy	4	When considering and planning delivery for women with diabetes, clinicians should present women with evidence-based advice as well as relevant national recommendations. Documentation of these joint discussions must be made in the woman's maternity records.		In place but could be subject to audit to demonstrate compliance. For FAAP 2023
		5	Trusts must develop antenatal services for the care of women with chronic hypertension. Women who are identified with chronic hypertension must be seen in a specialist consultant clinic to evaluate and discuss risks and benefits to treatment. Women must be commenced on Aspirin 75-150mg daily, from 12 weeks gestation in accordance with the NICE Hypertension and Pregnancy Guideline (2019)		Guidance in place to support this practice - specific clinic to be reviewed. Audit compliance in March 2023. For FAAP 2023
9: PRETERM BIRTH					
			Both 9 + 10 are in place - audit of processes needed		
9: PRETERM BIRTH	The LMNS, commissioners and trusts must work collaboratively to ensure systems are in place for the management of women at high risk of preterm birth. Trusts must implement NHS Saving Babies Lives Version 2 (2019)	1	Senior clinicians must be involved in counselling women at high risk of very preterm birth, especially when pregnancies are at the thresholds of viability.		Policy in place with clear guidance.
		2	Women and their partners must receive expert advice about the most appropriate fetal monitoring that should be undertaken dependent on the gestation of their pregnancies and what mode of delivery should be considered.		Guidance discussed at time dependant on individual situation. Guidance in place re type of monitoring as per gestation of pregnancy.
		3	Discussions must involve the local and tertiary neonatal teams so parents understand the chances of neonatal survival and are aware of the risks of possible associated disability.		Regional policy - link in with Angela MacDonald and Sanjeev Rath re any further update
		4	There must be a continuous audit process to review all in utero transfers and cases where a decision is made not to transfer to a Level 3 neonatal unit and when delivery subsequently occurs in the local unit.		Current review of Level 3 neonatal services however as WUTH Level 3 currently this is not applicable.
10: LABOUR AND BIRTH					
10: LABOUR AND BIRTH	Women who choose birth outside a hospital setting must receive accurate advice with regards to transfer times to an obstetric unit should this be necessary. Centralised CTG monitoring systems should be mandatory in obstetric units	1	All women must undergo a full clinical assessment when presenting in early or established labour. This must include a review of any risk factors and consideration of whether any complicating factors have arisen which might change recommendations about place of birth. These must be shared with women to enable an informed decision re place of birth to be made		Practice in place - Demonstrated in care metrics
		2	Midwifery-led units must complete yearly operational risk assessments.		In place however annual check for 2023 to be undertaken for Deacombe and Eden Suite.
		3	Midwifery-led units must undertake regular multidisciplinary team skill drills to correspond with the training needs analysis plan		All staff included in PROMPT training however schedule of drills to be recorded and ad-hoc taken forward
		4	It is mandatory that all women who choose birth outside a hospital setting are provided accurate and up to date written information about the transfer times to the consultant obstetric unit. Maternity services must prepare this information working together and in agreement with the local ambulance trust		Transfer policy in place regionally and adopted locally - same reviewed and updated with NWAS.
		5	Maternity units must have pathways for induction of labour, (IOL). Trusts need a mechanism to clearly describe safe pathways for IOL if delays occur due to high activity or short staffing.		Pathways in place - same being reviewed regionally.
		6	Centralised CTG monitoring systems must be made mandatory in obstetric units across England to ensure regular multi-professional review of CTGs		Completed and implemented
11: OBSTETRIC ANAESTHESIA					
			Close links with Anaesthetic leads with compliance to standards - same to be auditted		
11: OBSTETRIC ANAESTHESIA	In addition to routine inpatient obstetric anaesthesia follow-up, a pathway for outpatient postnatal anaesthetic follow-up must be available in every trust to address incidences of physical and psychological harm.Documentation of patient assessments and interactions by obstetric anaesthetists must improve. The determination of core datasets that must be recorded during every obstetric anaesthetic intervention would result in record-keeping that more accurately reflects events.Staffing shortages in obstetric anaesthesia must be highlighted and updated guidance for the planning and provision of safe obstetric anaesthesia services throughout England must be developed.	1	Conditions that merit further follow-up include, but are not limited to, postdural puncture headache, accidental awareness during general anaesthesia, intraoperative pain and the need for conversion to general anaesthesia during obstetric interventions, neurological injury relating to anaesthetic interventions, and significant failure of labour analgesia		Alice Arch overview: If a post-operative debrief would be useful these can be arranged to be purely or involve a Consultant Anaesthetist and we do this for lots of patients already - we usually offer this at 6-8 weeks post event unless the patient requests it to be earlier or later - and these patients can be referred to the Obstetric Anaesthetic Assessment clinic if they present in subsequent pregnancies; Assurance process developing
		2	Anaesthetists must be proactive in recognising situations where an explanation of events and an opportunity for questions may improve a woman's overall experience and reduce the risk of long-term psychological consequences.		Currently being undertaken but need to review guidance to ensure all criteria included with audit of same. Completion date - July 2022; part of assurance process 11.1
		3	All anaesthetic departments must review the adequacy of their documentation in maternity patient records and take steps to improve this where necessary as recommended in Good Medical Practice by the GMC		Documentation is recorded in maternity record hwoever need to review audit process. Completion date - July 2022; part of assurance process 11.1; part of assurance process 11.1
		4	Resources must be made available for anaesthetic professional bodies to determine a consensus regarding contents of core datasets and what constitutes a satisfactory anaesthetic record in order to maximise national engagement and compliance.		Recommendation reviewed - WUTH ready however awaiting Regional / National review
	Obstetric anaesthesia staffing guidance to include:	5	The role of consultants, SAS doctors and doctors-in-training in service provision, as well as the need for prospective cover, to ensure maintenance of safe services whilst allowing for staff leave.		Staff who do not do regular Obstetric Anaesthesia sessions want to do a Consultant Accompanied CPD session in Obstetric Anaesthesia to keep skills up to date we are more than happy to facilitate this - and several people have already taken up this opportunity. Process to be reviewed. Completion date - July 2022; assurance process to be developed
		6	• The full range of obstetric anaesthesia workload including, elective caesarean lists, clinic work, labour ward cover, as well as teaching, attendance at multidisciplinary training, and governance activity.		Staffing of same to be reviewed. Completion date - July 2022; assurance process to be developed
		7	• The competency required for consultant staff who cover obstetric services out-of hours, but who have no regular obstetric commitments.		As point 5; assurance process to be developed
		8	• Participation by anaesthetists in the maternity multidisciplinary ward rounds as recommended in the first report		All anaesthetists attend PROMPT MDT training; assurance process to be developed
12: POSTNATAL CARE					
			Audit and review of processes / policies re postnatal care		
12: POSTNATAL CARE	Trusts must ensure that women readmitted to a postnatal ward and all unwell postnatal women have timely consultant review.Postnatal wards must be adequately staffed at all times	1	All trusts must develop a system to ensure consultant review of all postnatal readmissions, and unwell postnatal women, including those requiring care on a non maternity ward		Process in place - document to be developed to support process
		2	Unwell postnatal women must have timely consultant involvement in their care and be seen daily as a minimum		Process in place - document to be developed to support process
		3	Postnatal readmissions must be seen within 14 hours of readmission or urgently if necessary		Process in place - document to be developed to support process
		4	Staffing levels must be appropriate for both the activity and acuity of care required on the postnatal ward both day and night, for both mothers and babies.		Acuity tool used and effective
13: BEREAVEMENT CARE					
13. BEREAVEMENT CARE	Trusts must ensure that women who have suffered pregnancy loss have appropriate bereavement care services.	1	Trusts must provide bereavement care services for women and families who suffer pregnancy loss. This must be available daily, not just Monday to Friday.		Bereavement midwife in post but works Monday to Friday. EMC team upskilled and shift coordinators. With development of bereavement champions in teams. Cover available 24/7
		2	All trusts must ensure adequate numbers of staff are trained to take post-mortem consent, so that families can be counselled about post-mortem within 48 hours of birth. They should have been trained in dealing with bereavement and in the purpose and procedures of post-mortem examinations.		EMC staff and coordinators - can be inlcuded in development package for coordinators
		3	All trusts must develop a system to ensure that all families are offered follow-up appointments after perinatal loss or poor serious neonatal outcome		In place - dual with obstetrics and neonates

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

Recommendation reviewed - WUTH ready however awaiting Regional / National Guidance
Fully Embedded
On target to achieve; no risks
Partially Compliant
Non Compliant/risk identified on risk register
NOTE: Completion dates are provisional pending detailed improvement plan.

	Appendix 5 Three Year Single Delivery Plan for Maternity and Neonatal Services							
	Theme1: Listening to and working with women and their families with compassion				RAG Rating	Lead	Review Date	Comments / Lead Progress
	Objective 1: Care that is personalised	Personalised care gives people choice and control over how their care is planned and delivered. It is based on evidence, what matters to them, and their individual risk factors and needs	1	Women experience care that is always kind and compassionate. They are listened and responded to. Open and honest ongoing dialogue between a woman, her midwife, and other clinicians, to understand the care she wants, any concerns she may have, and to discuss any outcomes that are not as expected. All women are offered personalised care and support plans which take account of their physical health, mental health, social complexities, and choices. Plans consider inequalities in the broadest sense, including protected characteristics and Core20PLUS5. The care plan includes a risk assessment updated at every contact, including when the woman is in early or established labour.		JL	No further action	CQC Patient survey Debrief clinics to go through pregnancy outcomes. Birth Options clinic to evidence discussion of women's preferences Examples of care plans: PMH plans; Risk assessment audits Look at further improving inequalities as per equity and equality plan – Consultant Midwife to support with MNVP involvement.
			2	Women receive care that has a life course approach and preventative perspective, to ensure holistic care for women and the best start in life for babies. This includes NHS-led smoke-free pregnancy pathways to provide practical support for pregnant women who are smokers, and evidence-based information about screening and vaccination.		AK/ER	No further action	Evidence of smoking cessation midwife/work with ABL. Use of NRT. ANNB Screening Programme OA: 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: language
			4	All women have equitable access to specialist care, including perinatal mental health services, perinatal pelvic health services, maternal and foetal medicine networks, and neonatal care, when needed		JKL	No further action	All services with guidelines are in place except perinatal pelvic health services – same being introduced. Set up a perinatal pelvic health service and work closely with LMNS re guidance/requirements; funding secured and ID to be matched; initial discuss with PSHC lead and service to be set up at WUTH in post within on 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	31/10/24	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: Ensuring women are involved in 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	8	To reduce inequalities for all in access, experience and outcomes		S	30/9/24	Equity and Equality plan developed by LMNS following gap analysis which the Trust completed. Further work re equality to be undertaken as detailed above
			9	Targeted support where health inequalities exist in line with the principles of proportionate universalism		S	30/11/24	MPoP teams to be set up as a proportionate service but the support is already in place from these Leads: MPoP teams in place and embedded in the identified areas; review MPoP
			10	Services listen to and work with women from all backgrounds to improve access, plan and deliver personalised care. Maternity and Neonatal voice partnerships ensure all groups are heard, including those most at risk of experiencing health inequalities		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	31/10/24	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/ME	30/9/24	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	Working in the margins of women and families improves services. Co-production is beneficial at all levels of the NHS and is particularly important for those most at risk of experiencing health inequalities (NICE, 2018). Involving service user representatives helps identify what needs to improve and how to do it. This is done through maternity and neonatal voices partnerships (MNVPs) and by working with other organisations	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	MS evidence supports work and undertaken and co-production
			15	MNVPs have the infrastructure they need to be successful. MNVPs are funded. MNVP leads, formally MVP chairs, are appropriately employed or remunerated and receive appropriate training, administrative and IT support		JL	No further action	MNVP embedded; full funding of post with agreed workplan from ICB awaited; local workplan in place
	Theme 2: Growing, retaining and supporting workforce				RAG Rating	Lead	Review Date	Comments / Lead Progress
	Objective 4: Grow our workforce	The maternity and neonatal workforce encompasses a wide range of professions, including midwives, maternity support workers, obstetricians, anaesthetists, neonatologists, neonatal nurses, sonographers, allied health professionals, and psychologists. Growing our workforce requires the tailoring of interventions to professional groups, career stage, and local requirements	16	Workforce capacity to grow as quickly as possible to meet local needs.		S	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.		S	No further action	
			20	All staff are included and have equality of opportunity		S	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	Ongoing annually	Score survey undertaken for Maternity and Neonates: feedback sessions in November 2023; staff engagement April 2024
	Objective 6: Invest in skills	Staff feel valued when they are supported to develop. We are investing in our staff by ensuring they have ongoing training and career development opportunities. Effective training of frontline clinicians in technical and non-technical skills has been shown to	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		S	No further action	Evidence collated for Ockenden improvement plan
			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		S	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.		S	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.		S	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'		S	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.		S	No further action	Trust training and policies support professional behaviours. 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		S	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		S /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		S /DC	No further action	PSIRF launched in the Trust September 2023; national guidance awaited specific for maternity services: embedded
			31	The Healthcare Safety Investigation Branch undertake investigations of incidents which meet their criteria		S /MP	On further action	MNSI quarterly meetings take place and Trust evidenced 100% reporting by the Trust
	Objective 9: Support and oversight	While some trusts and ICSs do effectively support their maternity and neonatal services to improve and change; others do not. Good oversight is about understanding the issues leaders face and helping to resolve them, and having clear systems in place that promote timely escalation and intervention before serious problems arise	32	Detect maternity threats the perinatal quality surveillance model (PQSM) that ensures concerns are identified early, addressed, and escalated where appropriate		S	On further action	Evidence Monthly PQSM report to Board with quarterly detailed maternity /neonatal reports presented
			33	Well led services, with additional assurance channelled to where they are most needed		S	On further action	CDC 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		S /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		S /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		S	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.		S	On further action	Processes in place to ensure MDT are involved with developing local policy
			38	Policies and guidelines recognise women as the decision-makers in their maternity care and are not used to prevent women from seeking care that is outside these guidelines		AK/ER	On further action	Policy in place and women are supported by the consultant midwife/Obstetric/Neonatal Leads
			39	Neonatal care is provided in units with clear designation of the level of care to be provided. Units work together across ODNs to optimise capacity and ensure care can be provided in the right place for very pre-term or very sick babies		Leads	No further action	Policy in place and women are supported by the consultant midwife/Obstetric/Neonatal Leads
	Objective 11: Data to inform learning	The Kirkup report highlighted the need for accurate, up to date data to highlight safety issues promptly. Such data enables providers to learn and act. Work is underway to review what data is needed for monitoring, and in the meantime, the NHS should continue to use the data it already collects	40	Standardised data is collected in a consistent way, primarily through the Maternity Services Data Set. Additional data collections are minimised, to focus on gathering the right data to drive insights, understanding and assurances		S	No further action	MSDS submitted in addition to completion of a local and regional dashboard
			41	Monitoring trends at both national and local level is enabled by analysing data from different sources alongside themes from MBRRACE-UK , and the national clinical audits, patient outcome programme reports		DC	On 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 continuous quality improvement work		S /DC	On 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 how users' needs are met. While some maternity services remain almost entirely paper-based, others support personalised care with apps and benefit from an integrated electronic patient record	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		S /HW	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 supported 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

Appendix 6

Options Appraisal

Maternity Models of Care

Project Name:	Options appraisal for the roll out of Maternity Continuity of Carer as the default model at WUTH	Date:	April 2024

Background:

As part of regular reporting to the Board of Directors a Midwifery staffing paper was presented in July 2023 which received support to progress with the roll out of Maternity Continuity of Carer.

Continuity of Carer:

The paper was explicit in the need for Trusts to provide a model of care providing continuity of carer to women during the whole maternity episode. This model of care was initially detailed in Better Births in 2016 and included in the National Maternity Transformation Programme given its evidence based providing improved outcomes for mums and babies. The target date to deliver 100% continuity of carer had been removed, instead providers were requested to develop local plans that work for them ensuring staffing requirements are met along with an upskilled workforce. WUTH has submitted a plan with an ambition to achieve this by June 2024, however date has been reviewed due to both not being able to identify recurrent funding and would rely on the next cohort of midwives qualifying. In April 2024 verbal discussion has been held re: clarification of the ambition from the national team and this is awaited.

The benefits of a woman being cared for by the same team of midwives throughout her pregnancy including the delivery and following cannot be underestimated. Clinical outcomes are improved with this model of care, with women reporting positive birth experiences and with the woman less likely to experience postnatal illness.

A woman who receives care from a known midwife is more likely to:

- Have a vaginal birth
- Have fewer interventions during birth
- Have a more positive experience of labour and birth
- Successfully breastfeed her baby
- Cost the health system less
- Less likely to experience pre-term birth
- Less likely to lose their baby before 24 weeks gestation

Considering pre-term birth alone, it is well evidenced that the high rates of morbidity and mortality arising from preterm birth impose a considerable burden on finite health care resources. Preterm infants are at increased risk of a range of adverse neonatal outcomes

including chronic lung disease, severe brain injury, retinopathy of prematurity, necrotizing enterocolitis and neonatal sepsis. In later life, preterm infants are at increased risk of motor and sensory impairment, learning difficulties and behavioural problems. The economic consequences include the costs of neonatal care as well as the costs associated with living with disabilities.

There is a substantial literature on the short and (to a lesser extent) long term clinical consequences of prematurity. The total cost of preterm birth to the public sector has been estimated to be £2.946 billion. The average cost of a pre-term birth and the provision of care is £100,000k which considers 4 weeks ITU care, 4 weeks HDU care and 2 weeks SCBU prior to discharge. This does not include the financial burden of complex investigations, tests and the long term. The incremental cost per preterm child surviving to 18 years compared with a term survivor was estimated at £22885. The corresponding estimates for a very and extremely preterm child were substantially higher at £61781 and £94740, respectively.

The RCM strongly recommends using Birthrate Plus® (BR+) to undertake a systematic assessment of workforce requirements, since BR+ is the only recognised national tool for calculating midwifery staffing levels.

Whilst birth outcomes are not influenced by staff numbers alone, applying a recognised and well-used tool is crucial for determining the number of midwives and support staff required to ensure each woman receives one-to-one care in labour.

Birthrate Plus® has been used in maternity units ranging from stand-alone community/midwifery led units through to regional tertiary centres, with birth rates ranging from only 10 births annually through to those that have in excess of 9000 births. In addition, it caters for the various models of care in existence, including a traditional model, community-based teams and continuity of carer/caseload teams.

Birthrate Plus® is the most widely used tool for workforce assessment classifying women and babies according to their needs and using clinical outcome data to calculate the numbers of midwives required to provide inpatient/outpatient antenatal care, intrapartum and postnatal care in either WUTH, community or neighbouring maternity unit.

WUTH last carried out Birthrate plus on 2021 with a summary review in 2022. In view of increased rates of Induction of labour, caesarean sections, two midwives required in Triage since CQC report and current position a review along with potential repeat has been requested in 2024. There is a requirement under Ockenden to undertake at least every 5 years.

Continuity of Carer

At WUTH there are five MCoC teams working across the Wirral and predominantly in the areas of social deprivation and vulnerable birthing people, recently reduced from six teams. The agreed staffing model is 7-9 WTE per team dependent on caseload to achieve the 1:36 ratio.

The first continuity teams commenced in early 2018 known as the Highfield team providing community and home births with an additional team rolled out in 2019 and the further four teams

between 2020 and February 2024. The most recent team was paused in July 2023 due to the ongoing challenges that were presented by higher rates of sickness absence, a period of high acuity and vacancies which although were recruited into the midwives were all newly qualified completing in September 2023.

Currently there are two maternity models of care in place at WUTH which does impact on differences in type, timing and delays in care which are challenging and upsetting for women, their families and our staff. It is also recognised that there have been delays in care for women on the induction of labour pathway which has had an impact on their experience, and that the health and wellbeing of the team is affected when frequently working with higher levels of acuity.

Continuity of Carer remains a key element of the Maternity Transformation Plan and in Year 6 Maternity Incentive Scheme there are no reportable requirements.

Newly Qualified Midwives

Over the last three years the maternity service has supported 10 NQMs to complete the 12-month preceptorship programme in a MCoC team and there are currently 8 on this programme. As part of this programme the NQM spends allocated on call shifts in the inpatient service to ensure that the NQM develops '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'

The Trust has six embedded teams and a further three teams are required to roll out the full model. This is dependent on the funding to increase staffing levels and has been identified from within the maternity service investment.

The BR+ Report was based on a 24% uplift to reflect the additional training requirements included in Year 4 of the MIS, (which equated to an additional 40hours per annum per midwife) and was based on the following:

Based on initial 2020 activity and at the time delivering 36% Continuity of Carer the birth rate plus report and findings were based on a two-model approach and the date to revert to the previous traditional model of midwifery has not been analysed there for the options presented will be in line with BR plus options.

Birth rate plus is required to be repeated every 5 years and WUTH's data is based on 2020 data. It is planned to be repeated later 2024/early 2025. It is likely in view of birthing people's complex needs, new NICE guidelines, the consistent rising induction of labour rates and caesarean sections rates along with the CQC assurances that were given to have two midwives in triage at times of high acuity (no increase to establishment) the recommended funded workforce would increase further.

Table 1 summarises further the comparison between Birthrate Plus WTE with current funded WTE.

	BIRTHRATE PLUS WTE Bands 3 to 7	CURRENT FUNDED WTE Bands 3 to 7	VARIANCE with current WTE
Core Services and with Continuity Teams at 55%	138.69	141.42	+2.73
Core Services and with Continuity Teams at 75%	142.81	141.42	-1.39
Core Services and with Continuity Teams at 100%	152.25	141.42	-10.83

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During March WUTH following staff raising concern re: escalation, burnout, and low staff morale. The Director of Midwifery held a listening event which was well attended by 50 members of the maternity staff to share their views and experiences. Minutes are included at Appendix 1.

As a result of the listening event an action plan was developed at Appendix 2 and a working group of midwives to review the options and models of care for women and birthing people considering pro's, con's and risks.

Birthrate Plus is recommended to be repeated approx. three yearly and data collection will commence in June 2024 with a revised reported expected November 2024.

Option 1: Remain working towards continuity of carer as the default model for women/birthing people	
Details	The current funded establishment is 141.41wte midwifery staff groups (Band 3 – 7) and this was increased by 10.4wte post Ockenden with recurrent monies which enabled WUTH to safely commence the roll out of MCoC to achieve and work towards at least 75% of birthing people being offered an MCoC model of care. WUTH currently has 6 MCoC teams delivering the recommended model of care to approx.50-55% of women across the Wirral in socially deprived areas. MCoC as a default model would meet the national ambition for all birthing people to be on the pathway and in line with birth rate plus an investment of 10.83 wte (Band 3-7) would be required.

	Further direction is awaited from the national team to clarify details of the transformation for maternity models of care.

Pros	• Provides MCoC to all birthing people and their families across the Wirral.
	• Delivers the improved outcomes for women as underpinned by the evidence.
	• Continue to work towards delivery of the national ambition 'default model of care for all eligible women (if this remains the case).
	• Funding is being deposited to the Trust to support the MCoC model.
	• Increased opportunity to recruit in particularly newly qualified midwives who wish to work within the model of care.
	• Retention of current midwives working in MCoC model.
	• Evidence of low sickness levels amongst MCoC midwives which has been as low as 1.17%.
	• Turnover low in staff group and remained RAG rated Green during 2023.
	• Availability of MCoC staff to provide support to the inpatient service when in escalation; staff available for patients opposed to staffing a building.
	• Model of care positively received and supported by local women as reported in MNVP survey.
	• Delays in induction would reduce further.
	• All women would have equity and a fair approach to better outcomes.
	• WUTH would be considered outstanding (national driver /ambition).
	• Perception of improved staffing levels in the inpatient area.
	• Skilled workforce in all areas of midwifery care to include antenatal, intrapartum and postnatal.
	• All women on the same model of care.
	• Midwifery skills enhance in antenatal, intrapartum and postnatal care.
	• Staff accounts included:-
	  ○ Ability to be flexible and elements of micromanagement removed
	  ○ Flexible working
	  ○ Job satisfaction
	  ○ Having a community hub supports maintaining the caseload with a flexible approach to care provision
	  ○ Enables relationship building with women
	  ○ Highfield team could only continue if able to work in a MCoC model
	  ○ Change in rota patterns would support burnout
	  ○ Work-life balance could be enhanced / supported

Cons	• Reduces continuity for women/birthing people not on the pathway. • Increased escalation to MCoC teams and inability to protect. • Current working patterns cause burnout. • Two models of care being offered.

	• Delays in induction possible and more likely if do not reach the default model position.
	• Staff Accounts included: -
	  ○ Limited protected time for admin and safeguarding follow ups.
	  ○ Continue to take work home and tendency to work on days off.
	  ○ Mixed days and nights would not be sustainable in one working week (could be addressed with revised rota).
	  ○ Experience of burnout in times of high acuity and utilisation for escalation.
	  ○ Staff feel obliged to remain in unit to care for other women/birthing people if acuity high/ and or staffing levels inadeqaute
	  ○ Delivery suite shift leaders have to co-ordinate the shift and attendance of team midwives when in labour (time consuming).
	  ○ Some staff have raised they don't wish to work on-call patterns.
	  ○ Pay does not reflect an inpatient model
	  ○ Annual leave request approval less likely as part of a small team

Risks	• When vacancies arise in the workforce recruitment applications and recruitment is reliant on newly qualified midwives creating a junior workforce. • MCoC model is only sustainable if newly qualified midwives can join teams following recruitment and/or increase time frame for any planned future roll out to meet national ambition. • The midwifery workforce is not available to achieve the model / ongoing recruitment challenges which would impact on the model not being sustainable long term.
Costs	• There is would be an additional cost to the division to roll out MCoC as the default model which has been costed at £591k to increase establishment in line with Birthrate plus.

Option 2: Remain with current continuity of carer teams for women/birthing people with a focus on enhanced/vulnerable (current model)	
Details	The current funded establishment is 141.41wte midwifery staff groups (Band 3 – 7) and this was increased by 10.4wte post Ockenden with recurrent monies which enabled WUTH to safely commence the roll out of MCoC to achieve and work towards at least 75% of birthing people being offered an MCoC model of care. WUTH currently has 5 MCoC teams delivering the recommended model of care to approx.50-55% of women across the Wirral in socially deprived areas. To continue with the current MCoC model would meet the adjusted national ambition for women/birthing people from vulnerable and social deprivation.

	Further direction is awaited from the national team to clarify details of the transformation for maternity models of care. The current five post code teams focus on the women/birthing in the majority of these areas.

Pros	• Provides MCoC to birthing people and their families across the Wirral in vulnerable groups.
	• Delivers the improved outcomes for women as underpinned by the evidence.
	• Can reconsider on completion of the Birthrate plus report due end of 2024 if continue to work towards delivery as default model of care for all eligible women is achievable.
	• Funding is being deposited to the Trust to support the MCoC model and would be sustained with the five teams.
	• Increased opportunity to recruit in particularly newly qualified midwives who wish to work within the model of care.
	• Retention of current midwives working in MCoC model.
	• Evidence of low sickness levels amongst MCoC midwives which has been as low as 1.17%.
	• Turnover low in staff group and remained RAG rated Green during 2023.
	• Availability of MCoC staff to provide support to the inpatient service when in escalation; staff available for patients opposed to staffing a building.
	• Model of care positively received and supported by local women as reported in MNVP survey.
	• WUTH would be considered outstanding (national driver /ambition).
	• Skilled workforce in all areas of midwifery care to include antenatal, intrapartum and postnatal.
	• Midwifery skills enhance in antenatal, intrapartum and postnatal care.
	• Staff accounts included:-
	  ○ Ability to be flexible and elements of micromanagement removed
	  ○ Flexible working
	  ○ Job satisfaction
	  ○ Having a community hub supports maintaining the caseload with a flexible approach to care provision
	  ○ Enables relationship building with women
	  ○ Highfield team could only continue if able to work in a MCoC model
	  ○ Change in rota patterns would support burnout
	  ○ Work-life balance could be enhanced / supported

Cons	• Reduces continuity for women/birthing people not on the pathway; mitigation would be required to ensure those women/birthing people were not on the pathway receive antenatal and postnatal continuity. • Escalation processes to include community model and continuity teams • Some current working patterns cause burnout; flexible working has been mitigated to reduce this.

	• Two models of care being offered.
	• Delays in induction possible and maybe more likely if do not reach the default model position.
	• Staff Accounts included: -
	  ○ Limited protected time for admin and safeguarding follow ups.
	  ○ Continue to take work home and tendency to work on days off.
	  ○ Mixed days and nights would not be sustainable in one working week (could be addressed with revised rota).
	  ○ Experience of burnout in times of high acuity and utilisation for escalation.
	  ○ Staff feel obliged to remain in unit to care for other women/birthing people if acuity high/ and or staffing levels inadequate.
	  ○ Delivery suite shift leaders have to co-ordinate the shift and attendance of team midwives when in labour (time consuming).
	  ○ Some staff have raised they don't wish to work on-call patterns.
	  ○ Pay does not reflect an inpatient model.
	  ○ Annual leave request approval less likely as part of a small team

Risks	• When vacancies arise in the workforce recruitment applications and recruitment is reliant on newly qualified midwives creating a junior workforce. • MCoC model is only sustainable if newly qualified midwives can join teams following recruitment and/or increase time frame for any planned future roll out to meet national ambition.
Costs	• There is no additional cost to the division at present, funding would be sustained which equates to £240k per annum.

Option 3: Return to a traditional community / inpatient model of care	
Details	Midwifery led models provide care from the same midwife where possible during pregnancy and the postnatal period. WUTH provided this model up until the recommendations of Better Births (2016) to roll out MCoC teams. During the roll out there has remained traditional community midwifery models. The Birth Rate plus report of 2021 did not include this model as a default.
Pros	• Would provide one model of care to women/birthing people and their families across the Wirral. • Increased opportunity to recruit into different roles within midwifery to include inpatient core and community Midwifery.

	• Midwife staff groups would more options to work in midwifery areas of choice.
	• It is anticipated retention of midwives would be more likely although not proven.
	• Model provides antenatal and postnatal continuity.
	• Reduction in induction of labour delays.
	• Staff Accounts included: -
	  ○ Model would offer more structure and would know your working week plan
	  ○ Protected time off
	  ○ Remove the anxiety of on calls
	  ○ Increased flexible working
	  ○ Staff upskilled in all areas of midwifery
	  ○ Impact on shift leaders ability to co-ordinate and additional support would be required
	  ○ If on-call and utilised for escalation impact on workload following day and safety

Cons	• No evidence the model delivers the improved outcomes for women as underpinned by the evidence.
	• The model would not mee the national ambitions to work towards delivery of continuity of carer models for those women eligible women.
	• The workforce is skilled to specific areas of midwifery.
	• The funding being deposited to the Trust to support the MCoC model would be lost.
	• Staff accounts included:-
	  ○ Less flexibility to working pattern as a structured model.
	  ○ Required to be in the workplace more working days in a rostered week.
	  ○ Reduced pay and less enhancements received.
	  ○ Use of own car and impact of fuel prices; mileage does not cover travel expenses.
	  ○ Less flexibility to pick up NHSP shifts.
	  ○ Escalation in this model causes anxiety as can become deskilled on labour ward

Risks	• Junior workforce in place to meet the safety of this model. • Do not have assurances the workforce is available to deliver this model of care. • Would not meet the national agenda and all current funding awarded for MCoC teams would be lost.
Costs	• The model has not been reviewed or costed.

Option 4: Deliver a Hybrid Maternity Continuity of Carer Model (known as team midwifery)	
Details	The current funded establishment is 141.41wte midwifery staff groups (Band 3 – 7) and this was increased by 10.4wte post Ockenden with recurrent monies which enabled WUTH to safely commence the roll out of MCoC to achieve and work towards at least 75% of birthing people being offered an MCoC model of care. WUTH currently has 6 MCoC teams delivering the recommended model of care to approx.60-62% of women across the Wirral in socially deprived areas. The current model offers a two-model approach. A hybrid model could offer an adapted continuity of carer model. The cost and staffing levels of this model have not yet been completed and are due by the end of the month with support from the Regional Chief Midwife.
Pros	• Would provide CoC to all women/birthing people and their families across the Wirral including some of the most vulnerable. • Delivers the improved outcomes for women as underpinned by the evidence. • Funding is being deposited to the Trust to support the MCoC model and would continue as the model would meet the national ambition. • Inpatient staffing will be supported as more staff will work shifts and be available to all women whether on their caseload or not. • Continue to work towards delivery of the national ambition 'default model of care for all eligible women. • Increased opportunity to recruit in particularly newly qualified midwives who wish to work within the model of care. • Retention of current midwives working in CoC model. • Would enable recruitment campaigns to include continuity care midwife, inpatient midwife and potentially community midwife attracting applications and meeting staff preferences. • Lower sickness rates evidenced. • Flexible working achieved within the teams. • Turnover low in staff group and remained RAG rated Green during 2023. • Availability of CoC staff to provide support to the inpatient service when in escalation; staff available for patients opposed to staffing a building. • Model of care positively received and supported by local women as reported in MNVP survey. • High proportion of workforce are skilled workforce in all areas to include antenatal, intrapartum and postnatal. • Reduction in induction of labour delays • Staff Accounts included: - ○ Model would offer more structure and would know your working week plan

	○ Protected time off ○ Remove the anxiety of on calls ○ Increased flexible working ○ Staff upskilled in all areas of midwifery ○ Impact on shift leaders' ability to co-ordinate and additional support would be required ○ If on-call and utilised for escalation impact on workload following day and safety ○ Balanced pay
Cons	• Staff Accounts included: - ○ Limited protected time for admin and safeguarding follow ups. ○ Continue to take work home and tendency to work on days off. ○ Delivery suite shift leaders have to co-ordinate the shift and attendance of team midwives when in labour (time consuming). ○ Reduced autonomy to manage caseload flexibly.
Risks	• Differing models of care available to women based on postcode unless able to deliver as default model. • An increase of staff would be required to achieve this model and may not meet preferences. • When vacancies arise in the workforce recruitment applications and recruitment is reliant on newly qualified midwives creating a junior workforce. • MCoC model is only sustainable if newly qualified midwives can join teams following recruitment and/or increase time frame for any planned future roll out to meet national ambition. • Inpatient rotas will not demonstrate any increase in daily safe staffing levels. • Attrition of current MCoC workforce as neighbouring Trust offering incentives to midwives to join CoC/community teams .
Costs	• There is would be an additional cost to the division to roll out MCoC as the default model which has been costed at £591k to increase establishment. This model is likely to be similar and require additional funding.

Option 5: Deliver continuity of carer to enhanced / vulnerable women	
Details	There remains a national requirement where the building blocks exist including safe staffing levels and an upskilled workforce to deliver an enhanced maternity continuity of carer model to women /birthing people. This would include the most vulnerable women the evidence indicates do have better outcomes. Examples would be BAME community, non-English speaking and those from the most socially deprived. Initial data collection would indicate approx. 700-800 women per year requiring at least 3 MCoC teams.
Pros	• Provides MCoC to the most vulnerable women/birthing people across the Wirral. • Delivers the improved outcomes for women as underpinned by the evidence. • Continue to work towards current national ambition for all eligible vulnerable women to be offered a McoC model of care. • The funding being deposited to the Trust to support the MCoC model roll out would still be received but reduced. • Increased opportunity to recruit into different areas of midwifery included community, continuity and inpatient models. • Retention of current midwives working in MCoC model. • Evidence of low sickness levels amongst MCoC midwives currently at 1.17%. • Turnover low in staff group and remained RAG rated Green during 2023. • MCoC staff would be protected from escalation and only utilised in extreme circumstances. • Model of care positively received and supported by local women as reported in MNVP survey. • Increase in continuity for women/birthing people not on the pathway. • Delays in induction would reduce further. • All women would have equity and a fair approach to better outcomes. • WUTH would be considered outstanding (national driver /ambition). • Perception of improved staffing levels in the inpatient area. • Reduction in escalation
Cons	• The reduction in funding would impact in a reduction in staff. • Increased escalation to MCoC teams and inability to protect. • Current working patterns cause burnout • Two models of care being offered. • Escalation would return to the community workforce. • Deskilled staff to specific areas. • Staff Accounts included: - ○ Reduced caseloads would be required to meet enhanced/vulnerable needs.

	○ Likely to have a heavy workload of safeguarding in each team as will not be widely spread. ○ Challenging to allocate women/birthing people and would require an implemented pathway/criteria to follow. ○ Extended appointments for women/birthing people would be required. ○ May not capture all eligible women/birthing people. ○ Reduced job satisfaction and potential burnout.
Risks	• Differing models of care available for women and a continued two-tier model • May not meet workforce preferences and will most likely require an organisation change to achieve.
Costs	• The model was deemed achievable in line with last Birthrate plus report and the establishment is in place to implement a revised MCoC model.

Appraisal of options:

The following table provides overview and assessment of the potential benefit/s and impact of each of the options outlined above. The scoring matrix used is detailed below which looks at the benefit, impact, risk and financial consequence of each option.

OPTION	PRO'S	CON's	RISK's	FINANCE	TOTAL SCORE
1	3	2	1	1	7
2	3	3	1	1	8
3	2	2	1	1	6
4	2	2	2	1	7
5	3	3	2	1	9

Scoring Matrix: Pro's *1 -3 = no benefit; limited benefit; several benefits.*
Con's *1 – 3 = several negative impacts; limited impact; minimal impact.*
Risk*/s 1 – 3 = several risks; limited risk; minimal risk.*
Finance *1 – 3 = No financial gain; limited financial gain; significant financial gain/ impact.*

Preferred Option:

The preferred option from a clinical provision and in consideration of the appraisal is Option 2 or 5 with a continued focus on supporting women/birthing people with evidence-based practice and improved outcomes for those in vulnerable and social deprivation. Option 2 would have the least

disruption to staff and has been recommended in conjunction with the regional team whilst we await BR Plus data is collated and the national ambition is clarified further.

There is potential for additional income if either of the models could be offered to women.

When this paper is finalised, there will be a clear presentation to seek Executive and Board of Directors support.

Conclusion:
Whilst considering all the above options it is clear that the overall preferred option is 2. **Recommendation:** Support the recommendation to continue with current MCoC teams. ***Written by: Jo Lavery, Divisional Director of Nursing and Midwifery (W&C)*** ***Updated: April 2024***

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Appendix 7

Midwifery Continuity of Carer

v

Traditional midwifery care

A comparison of models

2023

Dr Angela Kerrigan - Consultant Midwife

October 2024

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Midwifery Continuity of Carer

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Women who received continuity of midwifery care

7 X MORE LIKELY TO BE ATTENDED AT BIRTH BY A KNOWN MIDWIFE

16% LESS LIKELY TO LOSE THEIR BABY

19% LESS LIKELY TO LOSE THEIR BABY BEFORE 24 WEEKS

15% LESS LIKELY TO HAVE REGIONAL ANALGESIA

24% LESS LIKELY TO EXPERIENCE PRE-TERM BIRTH

16% LESS LIKELY TO HAVE AN EPISIOTOMY

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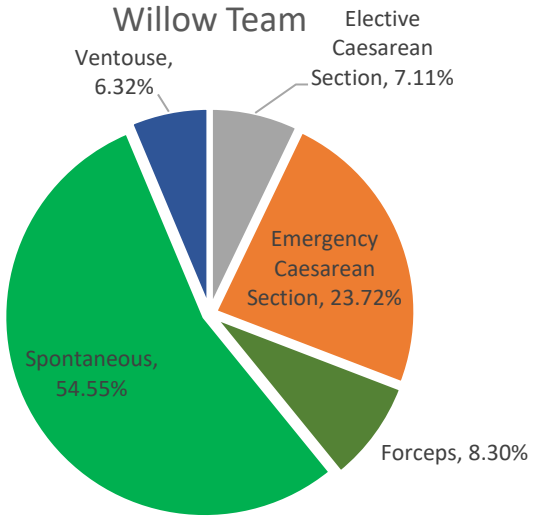
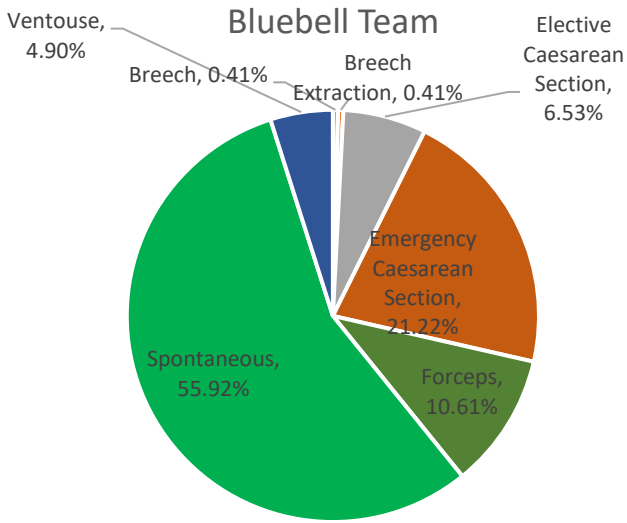
What did we do?

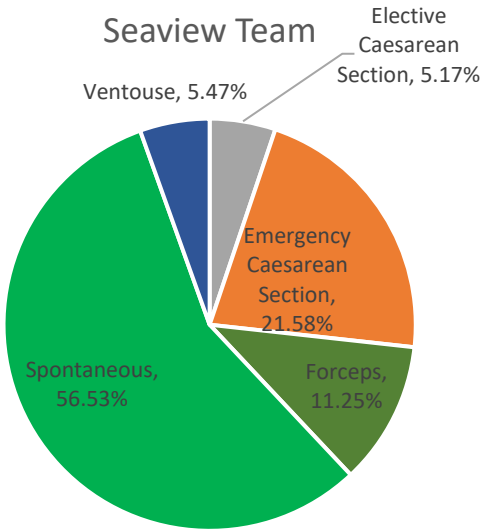
- Data 1/1/23 – 31/12/23 from cerner millenium
- 2929 births included
- Analysed using descriptive statistics
  - Mode of birth
  - IOL
  - Gestation
  - Livebirth
  - Perineal trauma
  - Infant feeding
  - SATOD
  - Intraprtum CoC

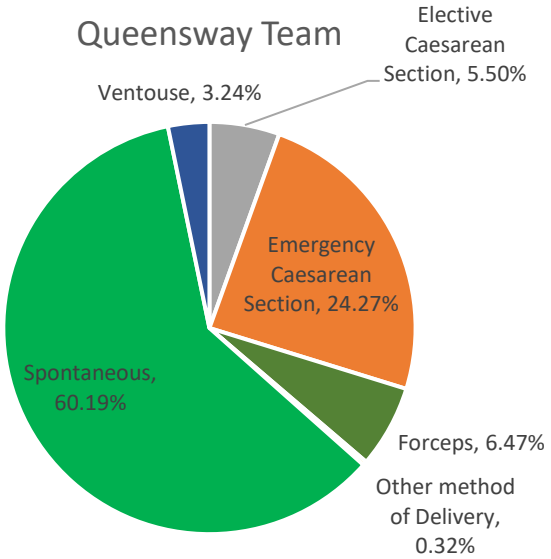
Mode of birth





Mode of birth





Mode of birth

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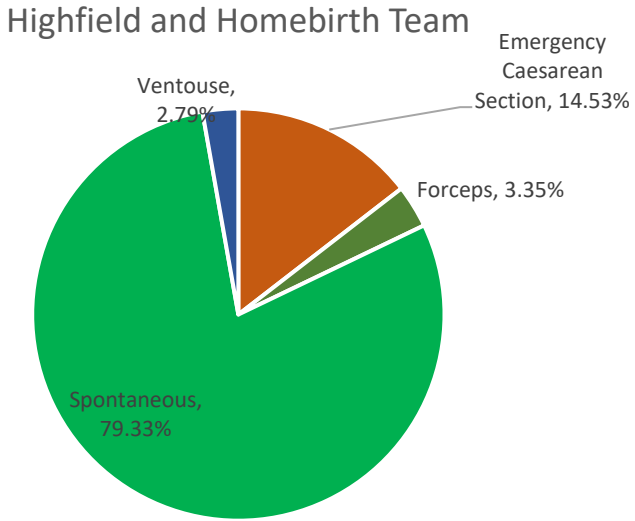

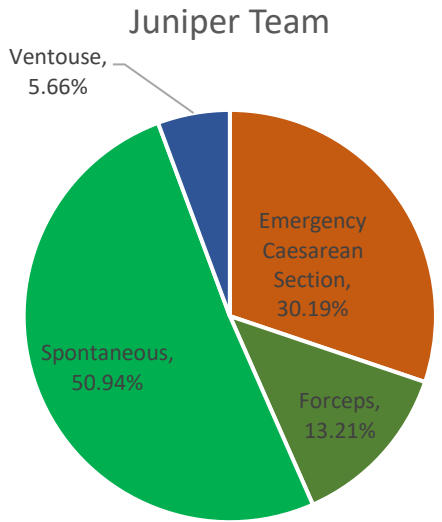

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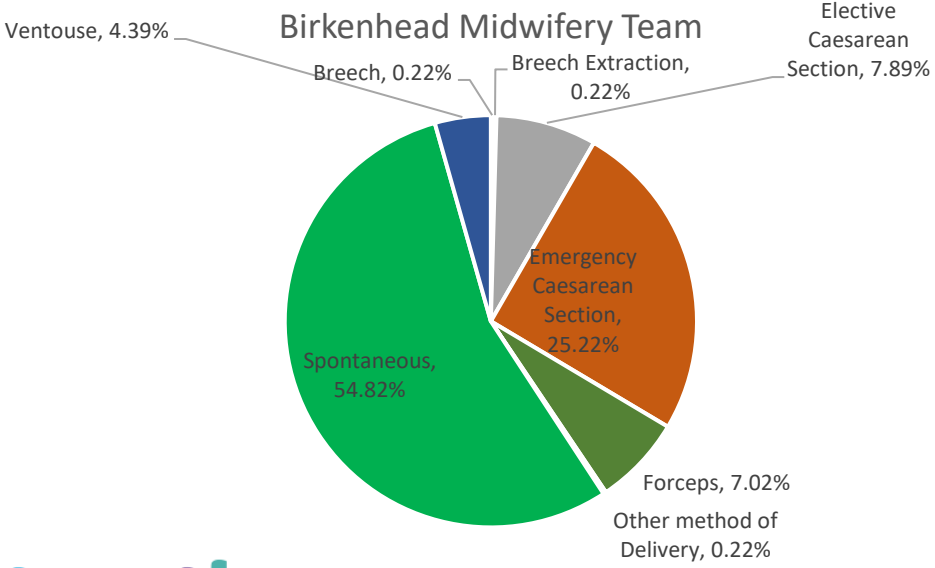
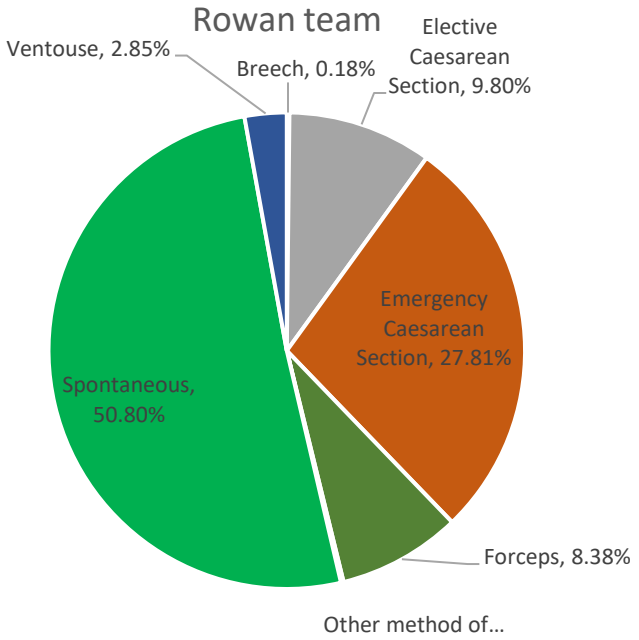
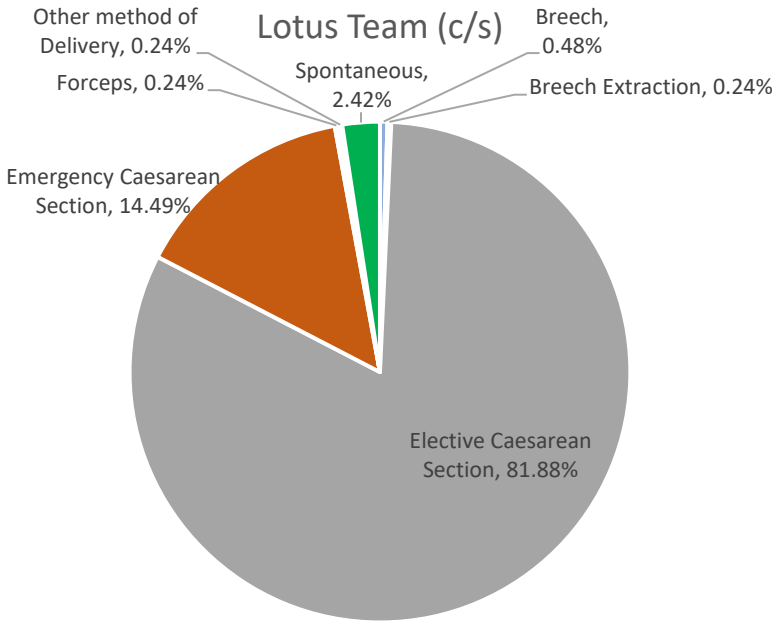
Mode of birth





Mode of birth



Induction of labour

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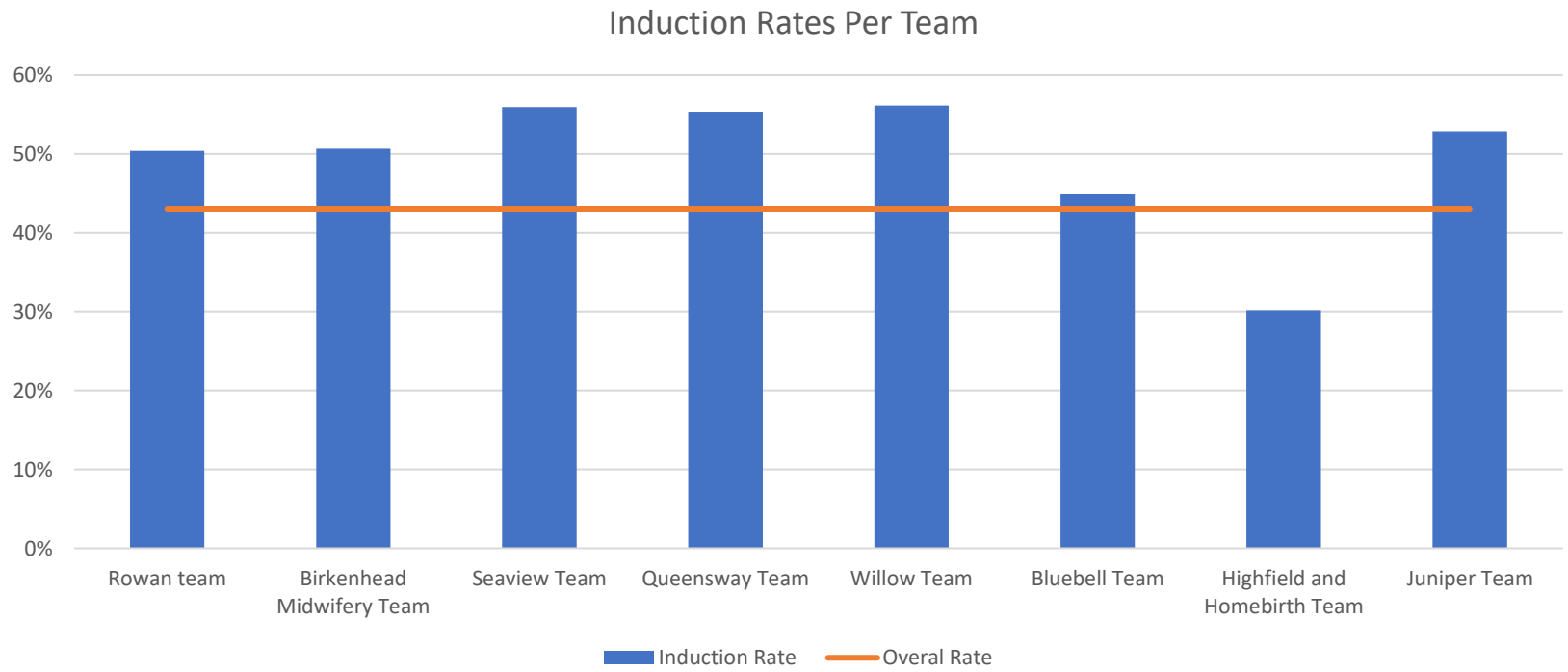

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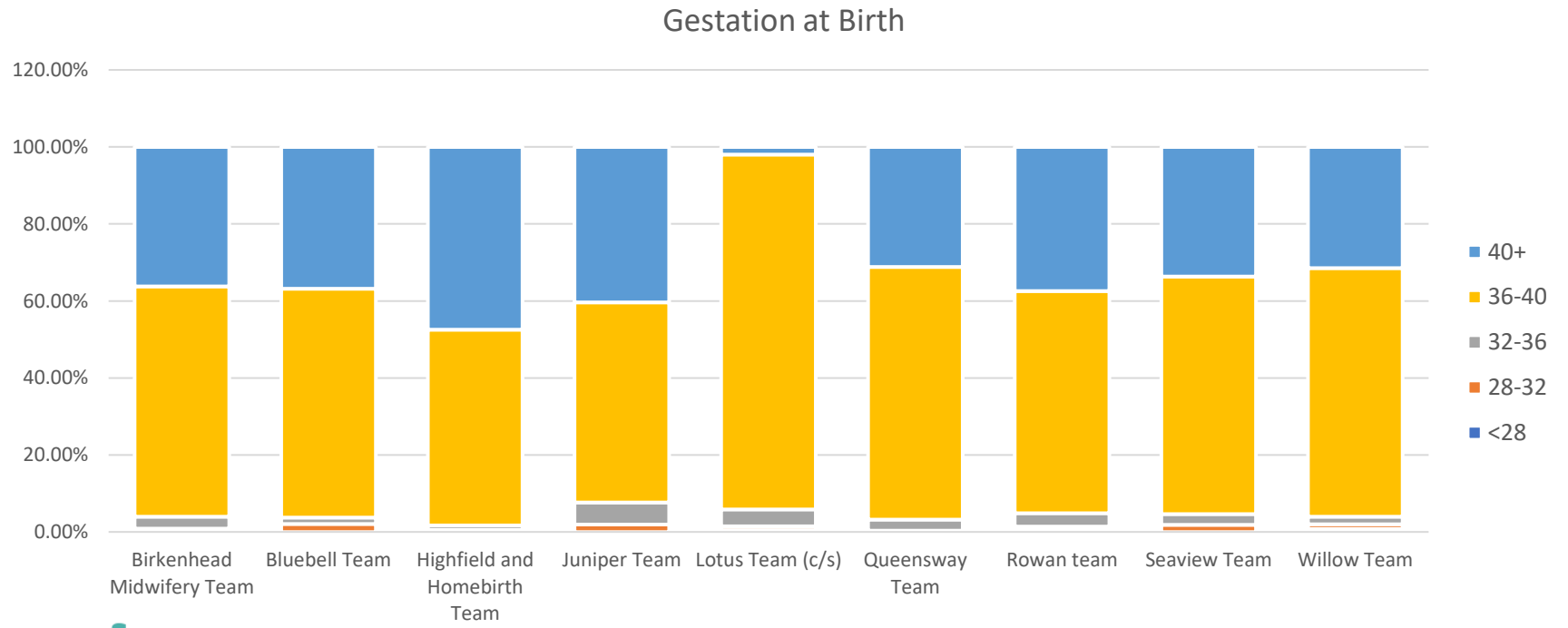
Gestation at birth

Wirral University Teaching Hospital NHS Foundation Trust



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Gestation at birth

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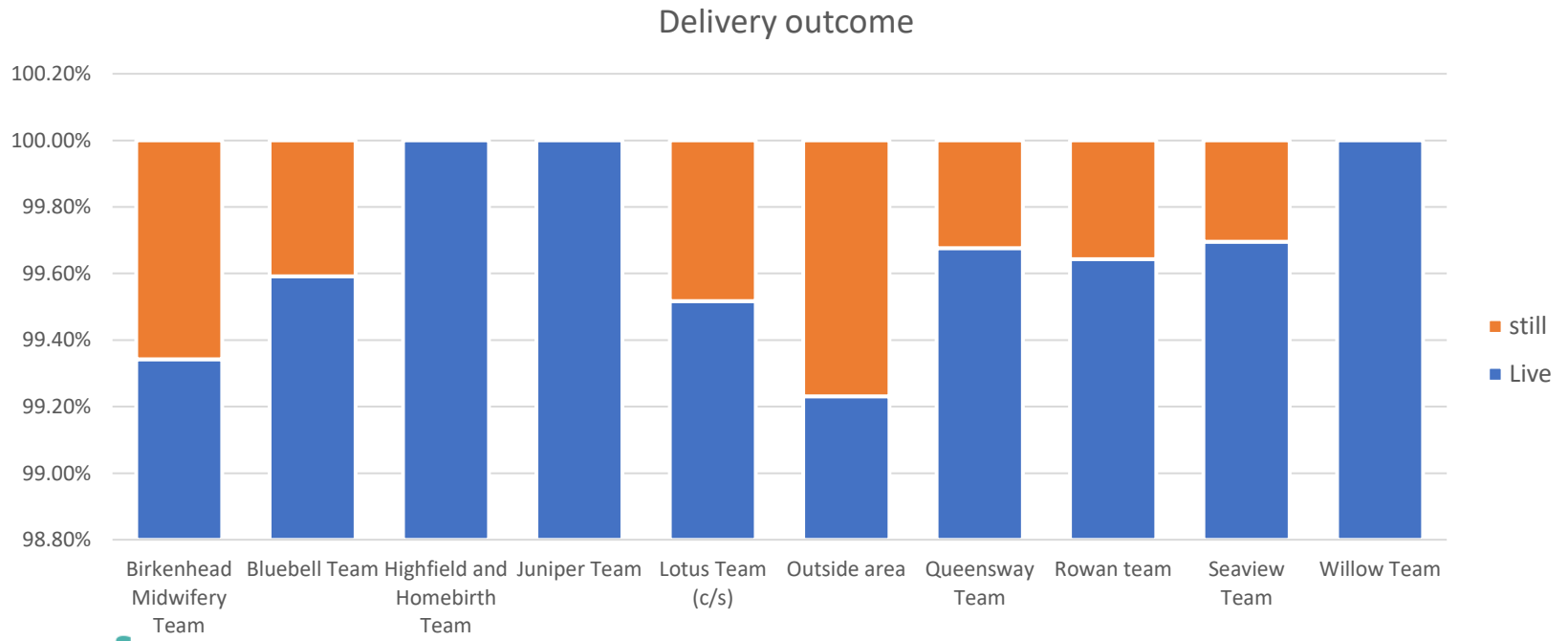
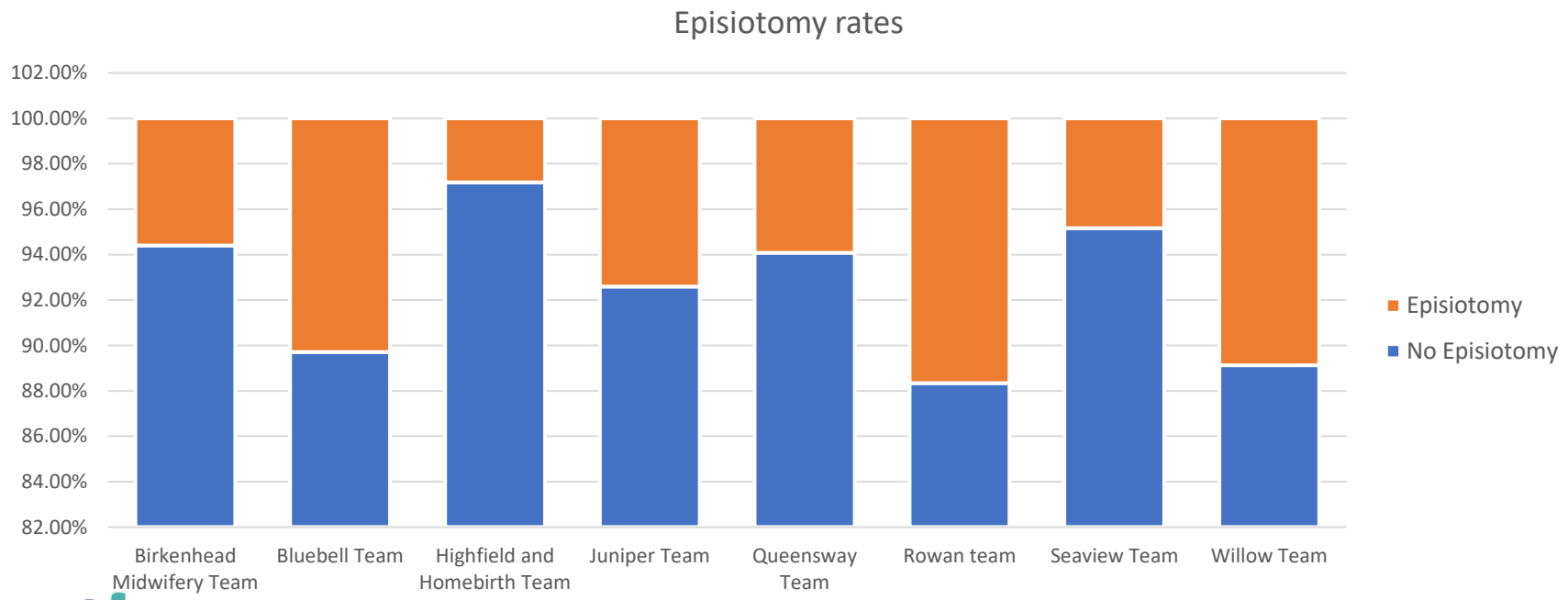
Team	Gestation <28	28-32	32-36	36-40	40+
Birkenhead Midwifery Team	0.67%	0.22%	3.11%	59.78%	36.22%
Bluebell Team	0.00%	2.09%	1.67%	59.41%	36.82%
Highfield and Homebirth Team	0.00%	0.56%	1.13%	50.85%	47.46%
Juniper Team	0.00%	1.92%	5.77%	51.92%	40.38%
Lotus Team (c/s)	0.49%	0.98%	4.39%	92.20%	1.95%
Queensway Team	0.00%	0.32%	2.92%	65.58%	31.17%
Rowan team	0.72%	0.72%	3.42%	57.73%	37.41%
Seaview Team	0.00%	1.85%	2.78%	61.73%	33.64%
Willow Team	0.80%	1.20%	1.99%	64.54%	31.47%
Grand Total	**0.40%**	**0.94%**	**3.00%**	**64.73%**	**30.94%**

Livebirth rate

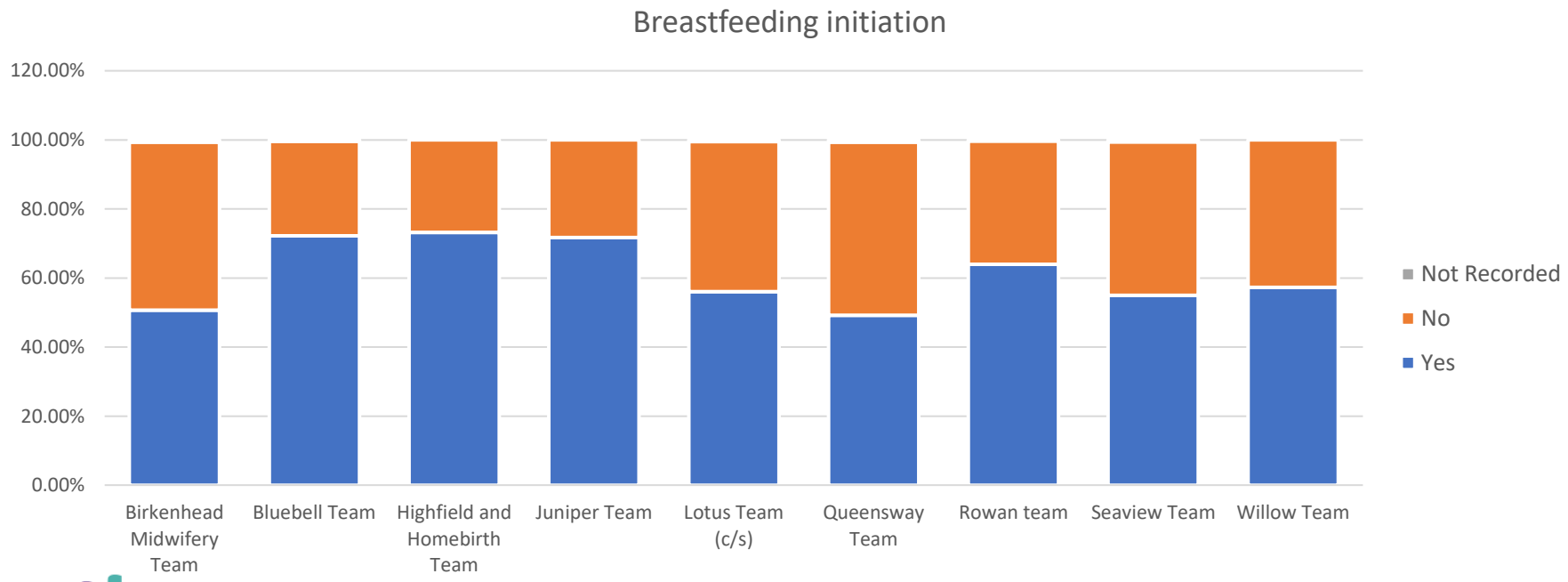


Perineal trauma - episiotomy

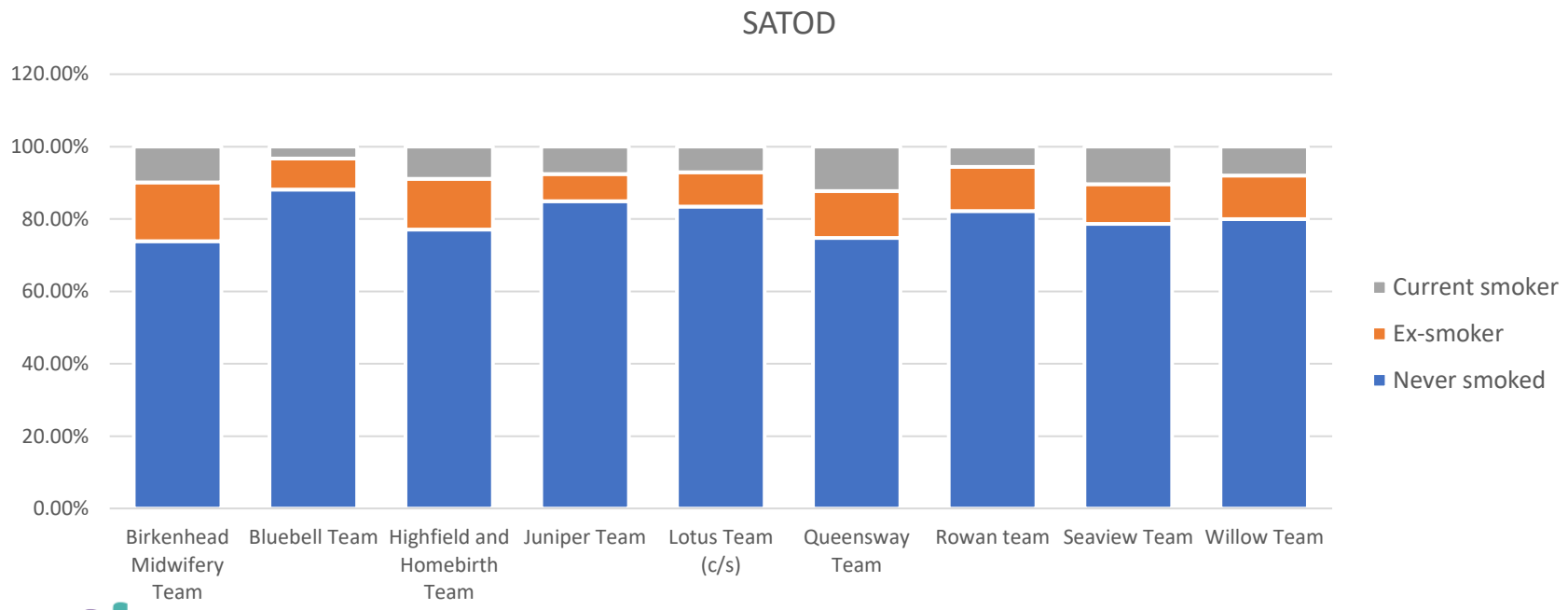
Wirral University Teaching Hospital
NHS Foundation Trust



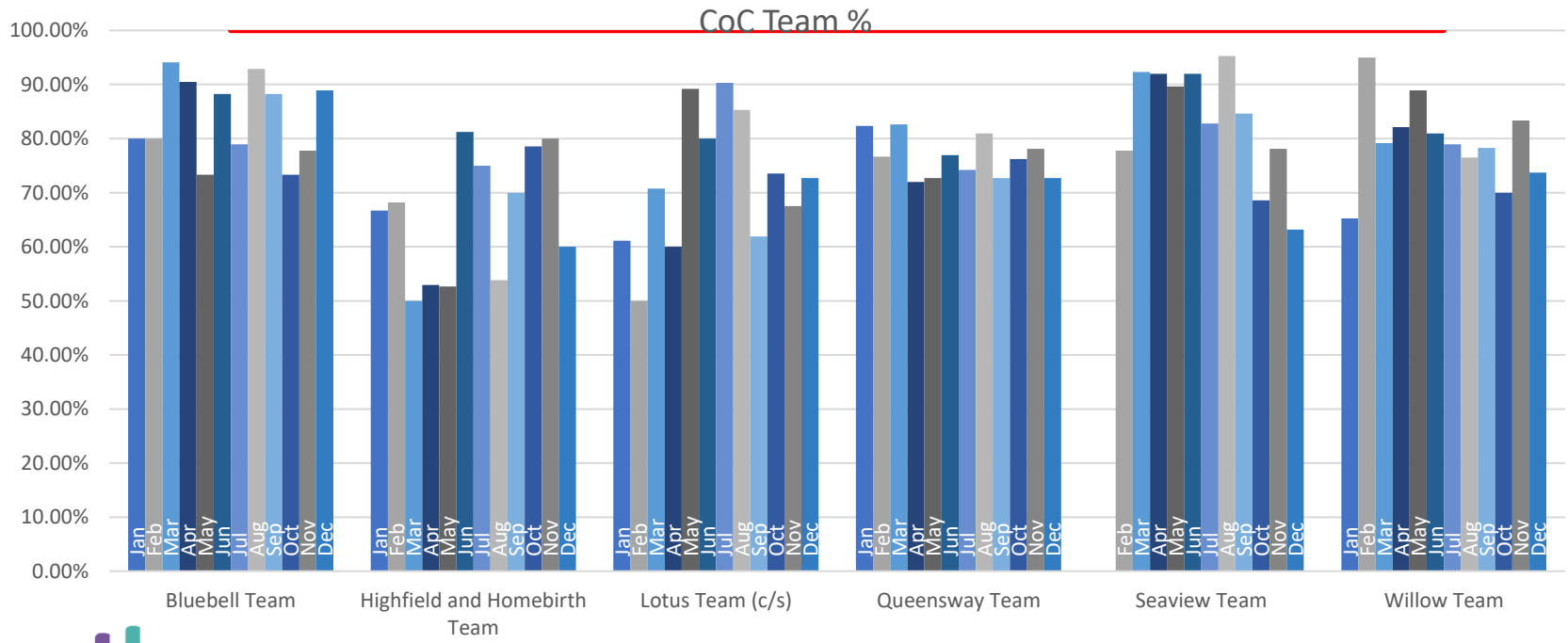
Infant feeding



SATOD


SATOD
120.00%
100.00%
80.00%
60.00%
40.00%
20.00%
0.00%
Birkenhead Midwifery Team
Bluebell Team
Highfield and Homebirth Team
Juniper Team
Lotus Team (c/s)
Queensway Team
Rowan team
Seaview Team
Willow Team
Current smoker
Ex-smoker
Never smoked

Intrapartum Continuity of Carer



- Some outcomes reflect those demonstrated in the Cochrane review
  - higher rates of spontaneous vaginal birth in all MCoC teams (2016 review)
  - Lower rates of emergency caesarean section (2016 review)
  - No difference in preterm birth across all gestations (2023 review)
  - Pregnancy loss occurred across both models (2023 review)

- Some outcomes were contrary to the Cochrane evidence
  - No difference in instrumental birth rates between the two models of care, with rates varying between the teams and models.
  - No difference in episiotomy rates

- Public health outcomes reflect the socio-economic background of the women


THANK
You!

National review of maternity services in England 2022 to 2024

Our national review of maternity services in England, 2022 to 2024.

Download an easy read version of this report

What maternity services are like in England - September 2024 (Easy Read)
20240919-NationalMaternityReport-EasyRead.pdf
File title
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Keywords
easy read

Summary

The quality and safety of maternity services have remained under scrutiny in recent years. While a series of high-profile investigations identified key failings at specific NHS trusts, our National maternity inspection programme – an inspection of all hospital maternity locations that had not been inspected since before March 2021 – has shown many of the issues raised are widespread across England.

While we identified pockets of excellent practice, we are concerned that too many women and babies are not receiving the high-quality maternity care they deserve. Of the 131 locations we inspected between August 2022 and December 2023, almost half were rated as requires improvement (36%) or inadequate (12%). Only 4% of services were rated as outstanding and 48% were rated as good. At 12 locations, ratings for being well-led dropped by 2 ratings levels and at 11 locations, ratings for being safe dropped by 2 levels.

The safety of maternity services remains a key concern, with no services inspected as part of our inspection programme rated as outstanding for being safe. Almost half (47%) were rated as requires improvement for the safe key question, while 35% were rated as good and 18% were rated as inadequate. Where we had the most concerns, we used our enforcement powers to require trusts to make significant improvements to protect people from risk of harm.

While many of the issues we highlight in this report are systemic, with the right culture, services can improve and learn from one another. Alongside this report, we have worked with providers, maternity staff and stakeholder organisations to develop some additional resource materials which can be implemented at trust-level. These resources are available on our website and are aimed at maternity service staff at all levels to help support their efforts to deliver high-quality care and make improvements where needed.

In this report we refer to 'women', but we recognise that some transgender men, non-binary people and people with variations in sex characteristics or who are intersex may also use maternity services and experience some of the same issues.

Responding and learning from incidents

More work is needed to improve the way services report, learn and communicate with women following patient safety incidents. Although most services managed patient safety incidents well, we are concerned about the potential normalising of serious harm in maternity. For maternity staff, well recognised complications such as postpartum haemorrhages may be common and do not always constitute a patient safety event. However, the impact on women can be significant. We are concerned that women do not always receive the information they need to process what has happened to them and make informed decisions about future pregnancies.

Risk assessment and triage

We found significant variation for maternity triage as there are no national targets or standards for this area, and many of our inspections were carried out before the Royal College of Obstetricians and Gynaecologists (RCOG) released its Good Practice Paper on Maternity Triage in December 2023. Research by the Sands and Tommy's Joint Policy Unit supports this, showing that "guidance on how and when to contact triage is not clear and consistent between services". While a 'one size fits all approach' may not be appropriate across all services, we are concerned that not everyone received a safe and timely assessment. We found instances where the triage phone went unanswered and when people arrived at hospital, issues with staffing and the triage environment meant some women were not assessed in a timely way. In some cases, delays in triage were so severe that women discharged themselves before being seen by a midwife or doctor

Recruitment and retention of staff

Our programme identified chronic issues around recruitment and retention of the maternity workforce as a key issue affecting the quality of care that women receive. It is vital that maternity services can recruit to maintain safe staffing levels in line with national standards. Staff should then be supported to carry out their roles with the appropriate levels of training. With high numbers of midwives being driven away from the profession by current pressures, leaders must prioritise the wellbeing of staff to foster an open and supportive culture. There is also work to be done to future-proof the workforce and attract students to a career in midwifery, as data from UCAS shows midwifery applications for June 2024 were at their lowest for more than 6 years.

Estates and environment

Unsuitable maternity estates emerged as another key barrier to high-quality care. We found some maternity units were not fit for purpose, as they lacked space and facilities and, in a small number of cases, appropriate levels of potentially life-saving equipment. Additional capital investment is needed to ensure women receive safe, timely care in an environment that meets their needs.

Inequalities and racism

We found significant differences in the way trusts collect and use demographic data to address health inequalities in their local populations. Reducing inequalities is imperative in saving lives and preventing harm to people with protected characteristics. Without national guidelines, we are concerned that trusts have no way of effectively evaluating whether initiatives to make maternity care more equitable are driving much-needed change. This is unacceptable given that, according to MBRRACE-UK data published in January 2024, Black women are still 2.8 times more likely to die during or up to 6 weeks after pregnancy compared with women in White ethnic groups. The data also showed that Asian women are 1.7 more times likely to die during the same period. Concerningly, we also found some trusts where both staff and people who were using the service experienced discrimination because of their ethnic background, or issues associated with having English as a second language or not their preferred language.

Communication with women and families

Communication with women and their families is not always good enough, particularly for those with protected equality characteristics. This affects their ability to consent to treatment and can perpetuate levels of fear and anxiety. Through our Give feedback on care service, many women told us that a lack of communication negatively affected their birth experiences. A cultural shift is needed so that all women are given the information they need, in a way they understand it, to make informed decisions and consent to treatment.

Foreword

Every pregnant woman wants a positive birth experience – and every member of staff working in a maternity service wants to provide safe, high-quality care. In most situations that's what happens, but sadly, it's not always the case. For some families who are impacted by poor maternity care, the damage is irrevocable. No family should ever have to suffer in this way and everyone working in the health and care system has a responsibility to do all they can to prevent it happening.

Maternity services have been and continue to be under significant scrutiny. In recent years, several high-profile investigations have highlighted worryingly similar failings - a sobering reminder that efforts to improve have not yet done enough to address the underlying issues preventing safe, high-quality care being delivered every time.

In 2020 we shared our concerns about the variation in quality and safety of maternity services across the country in a briefing paper Getting safer faster: key areas for improvement in maternity services. Those concerns were further evidenced a year later in our thematic report on 'Safety, equity and engagement in maternity services', and more recently CQC State of Care reports have singled out maternity as a service that has seen a marked deterioration in ratings over time.

It was within this context that we introduced a targeted national maternity inspection programme. The programme aimed to provide an up-to-date assessment of maternity care across England – and to explore what lies behind the lack of progress in some services. It began in August 2022 and involved on-site assessments of all hospital maternity locations that had not been inspected and rated since before March 2021.

This report brings together the findings from inspections of 131 hospital maternity units carried out as part of that programme, setting out the key themes, evidence of good practice and the common areas of concern. It makes recommendations for NHS trusts, the wider system and national bodies.

Our programme of inspections has shown that there are hospitals providing good maternity care and we found some excellent practice. However, we also identified some common issues and concerns that too many women and babies are not always receiving the high-quality service they should expect.

Sadly, we found that the failings uncovered by Donna Ockenden and Dr Bill Kirkup following their reviews of maternity in individual trusts are not isolated. Many of the factors apparent at East Kent and Shrewsbury and Telford are more widespread. Key issues continue to impact quality and safety – and disappointingly, none of them are new. Poor management of incidents with limited learning when things go wrong, failure to ensure safe and timely assessment at triage, unsuitable estates and access to essential equipment, a lack of oversight from trust Boards and significant challenges in recruiting and retaining staff.

We know the inequalities in outcome and additional risks experienced by women from Black and ethnic groups are well documented, yet we found huge differences in the way trusts collect and use demographic data to try to address those disparities. Significant concerns also remain regarding the quality of communication with women and their families, and a failure to engage with and listen to their needs.

These findings are all too familiar - so why do they persist and what is stopping us from moving forward? We need to be more honest about the reality of the problem and recognise that we all have a role to play to ensure sustainable improvement. This starts with a robust focus on safety where the culture that prevails does not accept risks as the norm and where staff are supported to deliver the high-quality care they want to provide. The recommendations made in this report aim to help us achieve that goal and to ensure good safe care for mothers and babies of today and in the future.

This report sets out some hard-hitting findings. However, this should not detract either from the positive steps that have already been taken to support change or from recognition of the dedication and commitment of the maternity workforce. Our findings show that the work to help improve safety already underway needs to continue and that there are specific issues that must be tackled as part of NHS England's three-year delivery plan for maternity. The findings also underline why it's so important that we encourage staff and services to take learning from CQC inspections that identify good care. Alongside this report we have published a number of new online resources intended to do just that by sharing what is working well as a source of practical guidance and support.

Without action, the danger is that poor care and preventable harm will become normalised. We cannot and must not let that happen.

We would like to express our sincere thanks to all those who have contributed to this report, In particular, our thanks go to all the families who shared their experiences with us to help ensure safer, better care in the future.

Recommendations

For NHS trusts

We recommend NHS trusts ensure all women leave hospital with the information they need to be able to process their experience and have an opportunity to make arrangements to speak to a member of the multidisciplinary team about their birth within a realistic timeline. Women whose cases are referred to a review panel should have the right to attend the panel and the opportunity to co-produce improvements for future reviews.

For NHS trusts and integrated care boards (ICBs)

We recommend NHS trusts and integrated care boards:

- Improve their collection of demographic data, including information on ethnicity and levels of deprivation, to improve outcomes for women.
- Ensure that demographic data, including ethnicity data, is always considered when reviewing patient safety incidents and action is taken where risks are identified.
- Ensure that there are clear policies and procedures on the collection of demographic information and staff understand the importance of how this data can be used to improve outcomes for women.

For NHS England

We recommend NHS England:

- Develops guidance and definitions of a patient safety event, where something unexpected or unintended happens in maternity services, ensuring reporting in line with Learn from Patient Safety Events (LFPSE), to tackle the issue of inconsistency in interpretation.
- Oversees the performance of maternity triage services to enable trusts to benchmark and improve. This is in line with the Royal College of Obstetricians and Gynaecologists (RCOG) recommendation to introduce "an agreed national standard and reporting tool for maternity triage, similar to that used in emergency medicine." As outlined by RCOG, metrics should include "staffing requirements, agreed audit standards reported nationally, and frameworks for improvement."
- Has oversight of gaps in middle-grade rotas and the proportion of time spent by consultants covering them. This supports recommendations in the Ockenden Review to introduce nationally agreed minimum levels of medical staff to cover the full range of maternity services at all times.
- Works with the Nursing and Midwifery Council and Royal College of Obstetricians and Gynaecologists to establish a minimum national standard for midwives delivering high dependency maternity care.
- Ensures trusts are proactively managing succession planning in midwifery services and, In line with recommendations from Leadership for a collaborative and inclusive future review, supports midwifery and obstetric staff to become effective future leaders.

For the Department of Health and Social Care (DHSC)

We recommend DHSC:

- Provides additional capital investment in maternity services to ensure that women receive safe, timely care in an environment that protects their dignity and promotes recovery.
- Works with NHS England to ensure that this additional investment is ring-fenced and maternity services receive the investment they need.

For the Royal College of Obstetricians and Gynaecologists

We recommend the Royal College of Obstetricians and Gynaecologists takes our findings in relation to the surgical first assistant role in maternity services so that it is in line with the requirements set out by the Royal College of Surgeons.

For the Nursing and Midwifery Council

We recommend that the Nursing and Midwifery Council uses findings from our report to review their proficiency standards for midwives.

Methodology and evidence used

We inspected hospital maternity units that had not been inspected since before 2021, focusing on the safe and well-led key questions. The findings in this report are based on inspections of 92 NHS trusts across 131 locations. Overall ratings were determined using our ratings principles.

Inspectors working on the programme received additional training and structured support to prepare for the role This included briefings on the maternity pathway from midwives and senior specialists in our secondary care team. This covered what to expect when on site and the terminology used, as well as opportunities to shadow other inspectors and work with specialist advisors on site. Inspectors received specific guidance and used standardised templates to promote consistency, and could access additional support from a remote senior specialist at all times.

In 2019/20, we carried out 9 pilot inspections to develop a focused approach to inspecting maternity services. Learning from the pilots informed the National maternity inspection programme.

The aims of the National maternity inspection programme were to:

- show how services are responding to current challenges and what extra help they may need
- give women and their families an up-to-date view of the quality of maternity care at their local hospital trust
- show hospitals an objective assessment of what they are doing well and how they can improve
- help CQC understand what is working well so we can share good practice to help services learn and improve
- show where national action is needed to combat the challenges facing services.

This report explores the findings from our inspection programme to give a national view of the current state of maternity services in England. Evidence used in this report includes:

- inspection reports (thematic analysis of the first 85 published inspection reports alongside engagement with the inspection teams involved in all 131 inspections)

- responses received through our Give feedback on care service (around 10,000 maternity responses analysed for the report)
- open responses to the 2023 Maternity survey (around 1,250 responses)
- interviews with 10 midwives and 10 obstetricians from ethnic minority backgrounds
- focus groups with maternity leaders and frontline staff across 16 trusts to help us understand how trusts were ensuring that women from ethnic minority backgrounds had equitable access to pain relief.

As part of the programme, we commissioned THIS Institute to evaluate how we carried out the inspection programme and identify where we can improve. The final section of this report summarises this evaluation.

Safety

The National maternity inspection programme has identified widespread issues affecting the quality and safety of maternity services in England.

In the programme, we rated 47% of services as requires improvement or inadequate. Many of our concerns are not new – in our Getting safer faster: key areas for improvement in maternity services report, we highlighted that maternity services stood out from other services as not making safety improvements fast enough. Similarly, our Safety, equity and engagement in maternity services report identified that issues such as poor relationships between obstetric and midwifery teams, and failure to engage with and listen to local women, continue to affect the safety of some hospital maternity services.

Throughout the programme, the safety of women using maternity services has remained a key concern. This is reflected in our ratings, as no service was rated outstanding for being safe. In fact, for the safe key question, the majority of services were rated as requires improvement (47%), while 35% were rated as good and 18% were rated as inadequate. Where we had the most concerns, we used our enforcement powers to require trusts to make significant improvements to protect people from risk of harm.

We found a range of issues affected how safe services were. These ranged from compliance with training requirements, particularly in key areas such as measuring babies' heart rates and safeguarding, to how well services identified and managed the risk of deterioration in both women and babies. We also found concerns in relation to infection prevention and control in some services, with poorly maintained estates adding to their inability to provide safe care to women (see the Estates section of this report).

Throughout the programme, our inspection teams received high levels of challenge from some leaders working across the sector, which led to concern that poor care within maternity is being normalised. But all services must recognise the long-term, significant impact that pregnancy and birth can have on women. Many women told us about how their mental health had suffered before, during and after birth. In the UK, 4% to 5% of women develop post-traumatic stress disorder (PTSD) every year after giving birth and data from MBRRACE-UK shows that although extended perinatal mortality rates decreased across the UK in 2022, they remain higher than in both 2019 and 2020.

Many of the issues we highlight in this report present serious risks to safety, such as unacceptable levels of variation in key areas such as triage However, in this section we look specifically at the way services reported, learned from and communicated with women following incidents.

Incident reporting

Although most services managed patient safety incidents well, more work is needed in this area to ensure that where women suffer serious harm in maternity services do not go unreported and are graded correctly. Issues and inconsistencies around incident reporting were identified as concerns in Dr Bill Kirkup's report on maternity services in East Kent.

We are concerned that a lack of reporting – either because of a recognised complication that the trust does not believe meets the definition of a patient safety incident or that staff are overstretched – is leading to harm becoming normalised and opportunities for learning being missed.

For most of the inspection programme, services were reporting incidents to the National Reporting and Learning System (NRLS) – a central database for all patient safety incident reports. NRLS defines a patient safety incident as "any unintended or unexpected incident(s) that could have, or did, lead to harm for one or more person(s) receiving NHS funded healthcare." Towards the end of the programme, NHS England introduced the new Learn from Patient Safety Events (LFPSE) service and guidance, which has replaced the NRLS. This provides clearer definitions and distinguishes between physical and psychological harm.

Recognised complications may be common for staff and may not always meet NHS England's definition of a patient safety incident, which means they do not always need to be reported to NRLS or LFPSE. However, these complications can have a significant and long-lasting impact on women, and trusts have a statutory duty to notify CQC of such events. Trusts can do this through LFPSE and should monitor and respond to trends in these commonly occurring obstetric complications at a local level.

Many services did not have this oversight of commonly occurring obstetric complications. We found that services often had to access several different dashboards to get an overall picture of patient-related outcomes, which could at times be contradictory and unclear. In addition, we found inconsistencies in how trusts managed key metrics such as blood loss. Despite available guidance, not all services were measuring blood loss in all deliveries. This risks potential under-reporting and could mean national dashboard comparisons are less meaningful for oversight and improvement. We also found some services did not report all incidents of delays in care and controls of postpartum haemorrhage.

Not reporting incidents at a local level suggests a tendency for services to accept that maternity incidents are inevitable and that nothing in a woman's care or treatment may have contributed to them. But this is not always the case. Previous successful initiatives have shown that incidents such as shoulder dystocia, where a baby's shoulder becomes stuck, can be preventable. For example, in 2000, North Bristol NHS Trust introduced simulation training to reduce shoulder dystocia. Since training was introduced, the trust believes that no babies have suffered permanent injuries. We also know that the likelihood and impact of postpartum haemorrhages can be effectively reduced with good antenatal monitoring of haemoglobin levels. Our concerns are reinforced by the recent Birth Trauma Inquiry, Ending the Postcode Lottery for Perinatal Care, which described a "maternity system where poor care is all-too-frequently tolerated as normal".

While we recognise that postpartum haemorrhages (PPH) are not entirely preventable, services need to use evidence-based practice and guidance to optimise outcomes for women and acknowledge the impact that it can have on them. In addition, we know that women from Black and Asian backgrounds have an increased risk of PPH. Perinatal care for women from ethnic minority backgrounds should focus on preventative measures to optimise outcomes. However, as highlighted in our section on inequalities, not all services we inspected were monitoring outcomes by ethnicity.

Pressures on staff

When a patient safety incident occurred, most services managed this well in line with national guidance. However, we were concerned to find instances of patient safety incidents going unreported to NRLS because of time constraints. We found a significant number of incidents were not reported as staff were overstretched. Until more action is taken to ensure that incidents are recorded properly, and in a timely way, opportunities for improvement can be missed. Services rated as good and outstanding have a culture where incident reporting is encouraged, and feedback loops and improvement actions are normalised.

Maternity services tend to generate a significant number of incidents compared with other areas within a trust, and our inspection programme found that the size and make-up of governance teams were not always sufficient. Services often did not involve risk and governance managers, meaning midwifery staff were required to review incidents themselves. We were concerned about the impact of this on the quality and speed of reviews and the knock-on effect on staffing levels if midwives do not have protected time to review incidents. We consider this in more detail in the section on staffing.

Grading of incidents

As well as problems with reporting incidents, we are also concerned about variation in the way incidents were graded. The final report of the Ockenden review highlighted the importance of correctly grading patient safety incidents, ensuring the level of harm recorded reflects the actual harm the patient suffered.

NRLS states :

> "Maternity, fetal and neonatal incidents such as intrauterine deaths should be reported to the NRLS, however a degree of harm of death should only be chosen if it is considered that a patient safety incident, such as an omission in care during the antenatal period, has led to or contributed to the death. The degree of harm can be amended and re-uploaded to the NRLS after further investigation."

The way trusts and clinicians interpreted NRLS guidance on reporting incidents varied. While this variation exists, there is room for confusion, loss of learning and potential harm. Grading incidents based on whether omissions in care contributed to them, as outlined by the NRLS, does not take into consideration the actual physical and psychological harms that women experienced.

We saw evidence of this from incidents that are defined as 'major obstetric emergencies' (including uterine inversion and major haemorrhages over 2 litres) regularly being graded as no harm or low harm. Incidents graded as lower harm might mean opportunities to investigate and learn are missed. It could also result in no follow-up care or monitoring being organised, which may harm mothers and their babies. For example, one service used the perinatal mortality review tool, which showed an incident was graded less severely than it should have been. The trust originally highlighted that care issues 'may' have made a difference to the outcome for the baby, but a further review showed these issues were 'likely' to have made a difference.

We know that traumatic birth experiences can have a significant lasting impact on women and their families. Through our review, people told us about their experiences and the impact on them:

> "This experience [was] not one I wish to ever have to go through again, this will be my first and LAST baby. When I think of my birth experience and the aftercare, I cry every time, it was purely awful."

> "I am now undergoing therapy for PTSD... I find it incredibly traumatic to explain what happened in detail."

> "I would love another baby at some point but am emotionally scarred and find the whole ordeal difficult to talk about so this is something I am very concerned about."

LFPSE defines a patient safety incident as “something unexpected or unintended that could have or did lead to harm for one or more patients”. Recording guidance states, “if in doubt, it is always better to record a patient safety incident using the available information and best judgement”.

The guidance advises that where an unintended or unexpected outcome has been observed, but there is any uncertainty about whether an unintended or unexpected incident has occurred, the event should always be recorded to LFPSE to support national learning.

The new Patient Safety Incident Response Framework (PSIRF), introduced during the programme, moves away from the grading of incidents and prioritises compassion and engagement with the people involved in patient safety incidents. It also has a focus on improvement. We will monitor how trusts implement and use PSIRF in future inspections and ensure that harm and trauma are still given the appropriate consideration.

Our inspections found that even in a very defined system such as the previous serious incident framework, there was variation and under-reporting. Under PSIRF, providers should agree their incident response plan with their integrated care board (ICB). We will assess how trusts have done this, looking specifically at plans for maternity and neonatal services.

Investigating and learning from incidents

We expect leaders and staff to have a good understanding of service improvement, using processes to ensure that incidents are learned from. Leaders should encourage reflection and collective problem-solving.

While we found some pockets of good practice, the overall picture of how services investigated incidents was mixed. We were encouraged to find some services with midwives who specialised in learning from incidents and action plans being developed as areas were identified for improvement.

At some services, managers reviewed incidents potentially related to inequalities (see the inequalities section for more information). For example, one trust interrogated data to identify the impact of ethnicity on outcomes. Following this, the service recommended increased scanning for Pakistani women after data revealed they have a higher risk of having babies that are Small for Gestational Age (SGA). At another service, following a baby abduction incident, an abduction policy was implemented and security staff were employed. The service also introduced 2-hourly security rounds and a sign in register.

Our improvement resource provides more information on how services learned from incidents well. However, this good practice was not consistent across services. An investigation by MSNI into one service noted that staff did not acknowledge the needs of people with a learning disability using the maternity service.

We also found that delays in the reviewing process meant learning from incidents was slow-paced and learning was not always shared effectively with staff. Concerningly, in a small number of cases, it was not clear whether the service had produced any ongoing action plans or monitoring. In other instances, action plans were not up to date, or did not fully reflect the findings of the reported incident.

These issues expand beyond maternity services. A study published in the Journal of Patient Safety found that too often hospitals develop action plans with weak or ineffective interventions, which can fail to address key issues and result in significant gaps in translating investigations into meaningful improvement. It found plans typically included individual-focused interventions, even when problems were systemic.

Although we saw pockets of outstanding practice in many areas, there is a need to support trusts to adopt solutions that are working well in other maternity services. The lack of a system-wide approach to sharing learning is preventing maternity services from driving improvement by implementing strategies and interventions that work well elsewhere.

There are opportunities in the Patient Safety Incident Response Framework (PSIRF) to improve the way maternity services identify and embed learning from incidents through directing investigation resources towards incidents that they can learn most from. At one PSIRF early adopter site, we found the trust had created a continuous improvement and learning team that comprised midwives, patient safety and quality improvement practitioners. This team reviewed all incidents reported as moderate or above in the previous serious incident framework and identified learning opportunities. We welcome the increased focus on quality improvement and compassionate involvement of those affected by patient safety incidents.

Some serious events in maternity services have national requirements for reporting, such as intrapartum stillbirths and maternal deaths, which are reportable to the Maternity and Newborn Safety Investigations programme (MNSI). However, additional metrics for serious maternal morbidity outcome would improve oversight. These could include maternal admissions to the intensive therapy unit, returns to theatre, and maternal collapse.

Transparency and accountability

While recognised complications such as postpartum haemorrhages, obstetric anal sphincter injury (OASI), or shoulder dystocia do not always constitute a patient safety incident and may be recognised by staff as complications, it is vitally important to acknowledge the trauma experienced by the woman at the centre of each incident. Women need to understand what has happened to them, their recovery, and any potential impact on future pregnancies, but we are concerned that this does not always happen. Although research has identified improvement in this area, it shows there is still work to be done to make sure families are involved in investigations. Like other national reports, we heard through our Give feedback on care service that women did not always get a timely debrief or explanations of events, and this had had a negative impact on them.

Under the Health and Social Care Act 2008 Regulation 20: duty of candour requires providers to act in an open and transparent way. It aims to protect people's right to openness and transparency from their health or care provider and encourages families to talk about their experiences openly and without fear as they begin healing. This can also help build people's understanding of risk in future pregnancies. But the duty of candour only applies in certain situations, and we are concerned that when incidents are out of scope of the duty of candour, women do not always receive the debrief they need to process what has happened to them.

As well as the statutory duty of candour for all health and care providers, there is also a wider professional duty to be open and honest following incidents where the statutory duty of candour does not apply. The Nursing and Midwifery Council and the General Medical Council issued joint guidance on the professional duty of candour. The guidance is not intended for circumstances where a patient's condition gets worse due to the natural progression of their illness. It applies when something happens with a patient's care, and they suffer harm or distress as a result. There are opportunities to develop the principles of being open and honest with women in all scenarios, including after recognised complications of pregnancy.

We noted that in some trusts, staff can view potential complications as being normal – particularly during the intrapartum phase (during labour). However, we know from speaking to women who have experienced trauma that some of these 'normal' complications can have a significant impact. For example, although a grade 3 perineal tear may not warrant a patient safety incident, nor would it necessarily require the duty of candour to be instigated, it is vital that women still have the opportunity to discuss what happened, why it happened, and what it means for their future.

Through our Give feedback on care service, women told us about the impact of their traumatic birth experiences:

> "I'm still traumatised, developed high level of anxiety and obsessive thoughts..."

> "However after the traumatic time… even now 3 months on I am very upset about this… the first few weeks of my baby's life were marred by flashback."

> "I have been left with trauma. Worst experience of my life."

We also found that potentially serious incidents such as massive obstetric haemorrhage were normalised by many services if they perceived that they had 'managed' everything in line with guidance (generally either the Royal College of Obstetricians and Gynaecologists' Prevention and Management of Postpartum Haemorrhage guidelines or the All Wales Maternity & Neonatal Network Guidelines on Prevention and Management of Postpartum Haemorrhage). Despite a number of services thematically reviewing incidents, we found this did not always translate into learning and improvement, such as a reduction in rates of PPH. In addition, even though services may have 'managed' an episode of haemorrhage well, a review and explanation of events would still be vital to help women to process their experience.

In many cases, managers involved women and their families in the investigation of incidents, which is a key part of incident response under PSIRF. We also heard about the importance of compassionate staff who provide people with clear information in a supportive setting:

> "The team have been incredibly kind with our questions and making the next steps very clear, which makes them less daunting… They've really validated our experience and helped us to feel like what we are going through matters."

We found examples of good practice where services applied duty of candour and issued letters in the first language of the family affected by the incident , but this was not always the case. We found evidence of inequality in how some services reviewed incidents. For example, in one service there were potential delays to the duty of candour process because the women involved did not speak English. It is vital that women are given the opportunity to be involved in investigations concerning their care. Not having English as a first language should not exclude people from being part of this important process.

At another service, we found good practice such as appointing a family liaison midwife to provide continuity of support throughout the process and auditing compliance with the duty of candour. But we also saw in a significant number of services that, although staff apologised following incidents, they were not always open and transparent with women and their families. Moreover, staff did not always provide clear information on the reason why things happened. Similarly, we identified occasions where women and families who were affected by serious incidents had not been involved in the investigation process, or their involvement was delayed. Through our Give feedback on care service, we have heard from women who are still waiting for answers and want to ensure mistakes are not repeated:

> "I had a traumatic labour which resulted in a uterine inversion. I was rushed to theatre to be operated on, could not bond with my new baby and had to have a blood transfusion... We have since been into hospital for a meeting to discuss what happened but I still have no answers and I was meant to be contacted to have another meeting with a midwife and all these months later I am still waiting. I think the service I received was absolutely atrocious in what should have been a wonderful experience. The surgeon was amazing and so were some of the nurses on the ward. I hope something will be done about the care I received as I know I am not the only one and I wouldn't recommend to anyone."

Through our engagement with families who have suffered a bereavement, we heard concerns about the lack of a complaint route, as services like PALS do not look into complaints where a patient has died. Family members also explained that policies and procedures following a loss can be left to staff to interpret, echoing our concerns around variation in the quality of follow up and communication. The families suggested that people affected by maternity failings should be involved in delivering training to midwives to ensure all families receive clear information and appropriate care in the future.

A pilot of Maternity and Neonatal Independent Senior Advocates started recently in England. The role has been introduced to support women and families affected by problems in maternity care. Maternity and Neonatal Independent Senior Advocates will help ensure that the voices of women and families are listened to and acted on. They will play an important part in ensuring women understand what has happened to them.

We recommend NHS trusts ensure all women leave hospital with the information they need to be able to process their experience and have an opportunity to make arrangements to speak to a member of the multidisciplinary team about their birth within a realistic timeline. Women whose cases are referred to a review panel should have the right to attend the panel and the opportunity to co-produce improvements for future reviews.

We recommend NHS England develops guidance and definitions of a patient safety incident, where something unexpected or unintended happens in maternity services, in line with the Patient Safety Incident Response Framework (PSRIF), to tackle the issue of inconsistency in interpretation.

Triage

Maternity triage is an important first step for women who have an emergency or concern during their pregnancy (including early labour) or post-birth, offering advice, assessment and prioritisation.

On contacting the service, midwifery staff will carry out a preliminary assessment of their condition to determine the urgency of the situation and decide what further action is needed. In maternity services, the first assessment is often carried out over the telephone and includes:

- advising when women should make their way to their chosen birthing unit because they are in labour
- suggesting they should call back for further review
- making sure women are seen urgently if they have an obstetric issue that needs assessment, such as bleeding or if they have reduced fetal movements.

Despite being the first point of call when women have concerns, research by the Sands and Tommy's Joint Policy Unit found that guidance about how and when to contact triage is not consistent between services. It found “concerning levels of variation” about key topics including bleeding, waters breaking and reduced fetal movements.

Issues around assessments and the prioritisation of clinical risk have been highlighted in previous national reports, dating back several years. With no national targets or standards for operating maternity triage services, our inspection programme found significant variation. While a ‘one size fits all’ approach may not be appropriate across all services, we are concerned that not everyone received a safe and timely assessment, as many services developed their own tools, processes, and standard operating procedures. We found a lack of consistency across services and many were not able to audit the effectiveness of their triage system.

Consistency in this area would provide frontline staff with clarity when caring for women and babies.

Issues with triage emerged as an early finding from the programme. Following the first 20 inspections, we highlighted concerns around:

- patient prioritisation
- timeliness for initial assessment
- oversight of those waiting
- staff training and competence.

Unsafe practice in maternity triage went on to form the basis of 81% of enforcement actions issued to providers and was recognised as a safety concern in around a third of our inspections overall. Through our Give feedback on care service, we heard that women and babies were exposed to potential harm by delays in triage. Many women told us they had experienced significant delays in triage, even when they had been told they would need an urgent medical review because they had presented with high-risk scenarios.

All the obstetric services we inspected offered a form of triage service. Standalone midwifery-led units offer a limited dedicated triage service, with phone numbers to the main units. One service that did not offer a triage service provided a maternity helpline for women who needed advice.

Triage services also varied in terms of opening hours, with some services open 24 hours a day, 7 days a week , and others operating between a given time, often during daytime hours. Where the dedicated triage service was closed through the night, most services offered telephone triage and/or a triage system operated by a different department within the maternity service, such as the delivery suite.

As there was no national mandate during the programme, we did not apply a single criterion for assessing triage across inspections. Instead, we judged safety against the trust's own declared criteria for time to first triage and best practice guidelines. For example, we expected to see a rapid review by a midwife for a woman attending the service in an unscheduled way. Proactive services had introduced an electronic safety in triage system to enable consistent professional assessment and recording of the assessment to determine the immediate action needed according to clinical urgency.

Many of our inspections were carried out before the Royal College of Obstetricians and Gynaecologists (RCOG) released its Good Practice Paper on Maternity Triage in December 2023. The paper acknowledges that implementing the recommendations will require significant system-level change and investment, and a commitment to multidisciplinary working to improve local pathways.

As RCOG's good practice paper points out, maternity triage systems evolved to mitigate against urgent attendances diverting intrapartum teams from caring for people in labour. It highlights, that "unlike general emergency departments, they have developed without appropriate organisational and clinical systems in place to prioritise the clinical urgency of the women presenting". We found this to still be the case.

Triage attendance is not monitored nationally but trusts have told us, using their own data, that they have seen an increase in the number of women who attend the maternity unit with concerns about their pregnancy. While there are many contributory factors, such as access to primary care, or the increase in women with multiple morbidities who become pregnant , a knock-on effect is the additional pressure on triage in maternity services. Sometimes this means services struggle to keep pace with demand and assess people in a timely way.

There is a need for national data collection and analysis about the number of women attending maternity units for triage to monitor themes and trends.

Telephone triage

In the same way that people use NHS 111 when they need general medical help, the first step for women who have a concern or emergency linked to their pregnancy is often to call a triage phone line. RCOG's Good Practice Paper on Maternity Triage recommends that services should have well-defined pathways and dedicated telephone lines where calls are answered promptly. It highlights that telephone triage is complex as there is no clinical assessment, instead it relies on a person's individual account, which can be affected by the person answering the telephone.

Most services inspected operated a dedicated telephone triage service monitored by midwives. We saw pockets of good practice, such as staff trained in telephone triage and measures to ensure lines were monitored. The improvement resource published along with this report provides more information on the areas of good practice in telephone triage that we identified.

However, as highlighted in the Staffing section, low levels of staffing prevented some services from implementing measures like this. We saw instances where the telephone triage midwife was moved to a busier department, leaving telephone triage unmonitored. This puts women and babies at risk of harm if calls are not answered and means vital early warning signs could be missed. One service did not have a dedicated telephone triage line, which led to a congested main hospital telephone line and delayed women getting through to the telephone triage midwife. On this inspection, we also observed the midwife leaving the phone line unattended and a call was not answered.

We also found services did not always monitor their triage telephone line in terms of the number of calls waiting and call drop-offs to understand the levels of activity. This information could have helped services to gauge the volume of calls to provide enough staff to manage the phone lines accordingly.

At one service that did monitor call numbers and waiting times, we were encouraged to see that data on abandoned calls was reviewed on a weekly basis. More information on this can be found in our improvement resource.

We also saw some services using a paper-based triage prioritisation tool. This was far less reliable, resulting in inconsistencies and confusion between staff while increasing the risk of poor outcomes for women.

Through our Give feedback on care service we heard how issues with the telephone triage line can affect women:

> "The triage phone line was not working properly, but it was not clear whether any staff were available to talk to. Because of this I was delayed in going to the hospital in person. When I arrived at the hospital (I went as I had concerns about my baby) I waited 107 minutes before I was seen. It turned out my baby was in distress so I had to have a cat 1 emergency c section delivering my baby at 34 weeks."

> "The initial phone call was helpful and provided advice and told to ring when contractions closer together. Tried to call at this point when I was scared, worried and also bleeding and not knowing what I was doing. Unable to get through for over 30mins. When I did get through I was told that despite having close together contractions that they didn't sound bad enough and that I needed to wait until they were toe-curling and couldn't talk through them (again as a first time mum you don't know what to expect)."

We know that calls to triage are often time-sensitive and calls going unanswered, or lines being frequently engaged could present a real risk to the safety of mothers and their babies.

In-person triage

On arrival at a maternity unit, face-to-face triage is carried out according to a trust's own policy. RCOG's Good Practice Paper on Maternity Triage recommends that a brief assessment is performed by a midwife within 15 minutes of arrival. Then, staff should determine the urgency in which people need to be seen in a standardised way. This assessment should ensure consistency in the way different midwives assess risk and should include physiological assessment using a modified early obstetric or maternal early warning score.

There are a number of tools available for identifying and monitoring risk including:

- BSOTS – Birmingham Symptom-Specific Obstetric Triage System (recommended in the RCOG's Good Practice Paper)
- MEOWS - Modified Early Obstetric Warning Score
- RAG - Red Amber Green
- SBAR - Situation, Background, Assessment, Recommendation.

Like telephone triage, we found similar variation in how services operated in-person triage services. Some services had effective processes and were able to triage a high rate of women within the RCOG-recommended 15-minute guideline. This usually involved staff using a recognised tool for evaluating risk and prioritisation of women, which was reviewed regularly. As we discuss in the sections on staffing and estates,, services with effective triage systems had adequate staffing levels and space to manage flow of people into the service.

Several services did not routinely complete risk assessments on arrival and did not use formal tools or processes to effectively triage women. In one service, it was not clear how long people had been waiting, and in others, ineffective tools and processes led to delays in accessing care. We frequently found gaps in risk assessments and examples of poor record-keeping, which could pose risks for women.

Another service had a chaotic environment, where triage systems and processes were not well managed, which led to long delays. It was also concerning to visit services where staff had access to a risk assessment tool but did not always use it. On one inspection, staff did not always record a priority score , meaning the service could not be assured that all staff had enough information on high risk women and babies.

In a couple of services a RAG system was used to understand women's immediate needs, but the tool did not give target timescales for medical staff to review. At one of these services, there were no processes or guidelines in place to aid prioritisation and ensure women were seen and treated in a timely way, meaning staff had to use their clinical judgement to do this.

Triage environment

The environment is an important factor in the safe and effective running of a triage service. Health Technical Memorandum guidance outlines that maternity units should be designed to ensure a clear flow of women through triage and onto the labour ward. The location of the triage area should enable quick transfers in an emergency. Good maternity triage areas provide space for people to discuss concerns in private, as well as allowing birthing partners and families to stay while assessments are carried out.

We found that many maternity triage areas had dedicated rooms and areas that gave people privacy for initial assessments, but not all triage environments were designed in a way that kept women safe. While we found one example of a service improving its triage area to ensure safer assessments and improve patient flow (see our improvement resource for more information) , others continued to triage women in areas that were cramped, crowded, and lacked privacy.

At one service, inspectors could hear all information requested and shared during telephone calls. This included identifiable information such as the caller's name and date of birth, and perhaps most worryingly, meant that sensitive information such as safeguarding concerns could not be discussed in confidence. Small triage areas can also cause issues with patient flow. A lack of space for triage had been identified as a risk by many services and was included on their service risk register.

The location of the triage area in the hospital itself was another important factor in being able to provide women with safe, high-quality care . For example, having the triage area close to the labour ward enabled quick transfers in an emergency at one service , which helped reduce the risk of poor outcomes related to deterioration. Another trust relocated its triage service closer to the midwifery unit (see our improvement resource for further information).

We were concerned that in some services, the location of waiting areas posed increased risks to women. Waiting areas out of the direct line of sight of clinical triage staff, for example in a corridor outside a triage unit, meant staff could not carry out continuous observation to identify any deteriorations in condition. We heard how this negatively affected one woman's experience:

> "We were left on the corridor in between triage and the delivery suites for 2 hours with no pain relief and nobody checked on us during this time."

Where women were not in the direct line of sight of clinical staff, we were also concerned about how clinical staff could be summoned in the event of deterioration. At one service, this was compounded by a lack of information for women on how to seek support if their health deteriorated. In another service, while triage was located on the delivery suite, the rapid assessment room was in the midwife-led unit, in a separate area of the maternity unit. This meant the triage midwife would need to leave to go to rapid assessment, leaving other women unattended and increasing their workload.

In some cases, it was extremely concerning to hear about women going into labour and giving birth in maternity triage because of delays in transfer from maternity triage to the delivery suite. As well as putting women in a frightening situation, this poses a safety risk as triage areas may lack appropriate equipment, such as neonatal resuscitation and emergency obstetric equipment. This can be vital if people give birth quickly and experience complications.

Where our inspectors raised concerns about the physical environment and the impact it had on women, leaders in some services acted by submitting improvement plans to try to combat risk and improve the physical triage environment . However, we were also told in some cases there was little more that could be done because of the physical constraints of the estate.

Triage staffing

During our inspections we saw how the availability of staff played a significant role in how well services were able to triage women. The Royal College of Obstetricians and Gynaecologists (RCOG) states that maternity triage should be staffed by "appropriately trained midwifery staff whose primary responsibility is to assess women both by telephone and in-person". In many services, we found a dedicated team of suitably trained and competent midwives. However, issues with workforce management and staffing numbers contributed to delays in women's assessment and treatment, which could put them at risk of harm.

When women arrived at triage, many services did not have enough midwives to carry out initial assessments, which led to an increase in the length of time people waited to be triaged. In some services, this affected the flow of women coming through the triage service, as well as increasing the risk of deterioration.

In some cases, delays in triage were so severe that women discharged themselves before being seen by a midwife or doctor. This is unacceptable – these women clearly had concerns that prompted them to go to hospital, so waiting for long periods (in some cases 6 hours) and leaving before a medical review presents safety risks for both the mother and baby. Concerningly, one service did not have systems and processes in place to follow up women who left the triage unit without a review to ensure they were safe.

We also found that midwives were often re-allocated to different maternity departments during quieter triage periods, which frequently led to delays when triage became busier and they were then a midwife short. At one service, the labour ward co-ordinator was tasked with allocating staff from the delivery suite to work in triage. This meant staffing in triage depended on the activity and acuity on the labour ward. At busy times, the triage service would then be under-staffed, posing a risk to women.

We also found that staffing issues meant that staff who had not received sufficient training in triage filled the roles of experienced and trained staff. For example, at one service staff told us they worked in triage but had not received training on the triage system. We found particular concerns around the availability of appropriately trained doctors. In some cases, the required number of doctors had not been allocated to triage in line with the acuity of patients, and in others, the skills and experience of the doctor on duty did not meet the women's needs (see the staffing section for other examples where staff were covering for roles that are outside of their training).

We found some positive examples where leaders were supportive of triage-specific training. Triage wait times, as well as compliance with national and local guidelines, were better in these services (see our improvement resource for further details.)

Staffing levels also meant that the quality of care in triage varied between day and night. There were often fewer members of staff on shift during the night, meaning those working had higher workloads. Concerningly, this could mean that women receiving care in triage during the night did not always receive the same level of care and attention as those being treated during the day. In some services during the night, delivery suite staff who did not have access to the same training as triage midwives were expected to cover the triage telephone. Staff at one service told us there were times when they were alone during night shifts and their duties included answering the telephone, initial triage assessments and providing ongoing care to women.

Issues with triage are unlikely to be overcome by frontline staff alone and there is also a role for national policy to support trust boards and integrated care systems to address inconsistencies in prioritisation and escalation by implementing standardised systems.

We recommend NHS England oversees the performance of maternity triage services to enable trusts to benchmark and improve. This is in line with the Royal College of Obstetricians and Gynaecologists (RCOG) recommendation to introduce "an agreed national standard and reporting tool for maternity triage, similar to that used in emergency medicine." As outlined by RCOG, metrics should include "staffing requirements, agreed audit standards reported nationally, and frameworks for improvement."

Inequalities and racism

We remain concerned about the inherent inequalities in access to maternity services, experience and outcomes for women, and the safety risks this presents.

We stressed the ongoing inequity in maternity services in both our Safety, equity and engagement in maternity services report and our 2022/23 State of Care report.

The most recent MBRRACE-UK data, published in January 2024, showed that, compared with women from white ethnic groups, Black women were 2.8 times more likely to die during or up to 6 weeks after pregnancy, and Asian women were 1.7 more times likely to die during the same period. The National Maternity and Perinatal Audit's report on inequalities highlighted further disparities. It showed that compared with women in white ethnic groups:

- South Asian or Black women were more likely to have babies born early or small for gestational age (SGA)
- Stillbirth rates were high for babies born to women from South Asian and Black ethnic groups and for those in the most deprived areas
- South Asian women are also at higher risk of perineal tears and major obstetric haemorrhage.

The inspection programme highlighted that while some trusts are taking action to address issues with inequality, much more needs to be done to ensure maternity services are accessible and meet people's needs at all stages of pregnancy and birth. Everyone deserves safe care and the inherent inequalities faced by some groups are unacceptable.

We found some evidence of how different units were attempting to reduce the impact of inequalities, but this was not consistent across services. Examples of good practice often focused on:

- mental health support
- support for women who were living in poverty
- awareness and inclusion of ethnic and cultural diversity .

For example, one service introduced several initiatives to address barriers face by the community it served. These included establishing an antenatal and postnatal clinic in a hotel housing asylum seekers and creating communication cards for women who did not speak English as a first language. More examples can be found in our improvement resource.

However, without the right data, it is difficult for trusts to evaluate whether initiatives are driving much needed change. In addition, many of the issues we raise in this report meant some services were operating in crisis mode. While day-to-day issues are important, services must not lose sight of the ongoing systemic issues such as the inequalities that we know can have a significant and unacceptable effect on people's care. Reducing inequalities is imperative in saving lives and preventing harm to people with protected characteristics.

Concerningly, we also found some trusts where both staff and people using the service experienced discrimination because of their ethnic background, or issues associated with having English as a second language or that was not their preferred language.

Women's experience of racism

In our 2022/23 State of Care report, we found that care for people using maternity services was affected by racial stereotypes. This has also been reported in The FiveXMore Black Maternity Experience Survey. During our inspection programme, it was concerning to hear about incidents of racism experienced by women. We heard from people who felt staff were neglectful and rude towards them:

> "The problems started when I was moved to the postnatal ward. Staff were racist, rude and couldn't care less. They didn't listen to my concerns as a new mum and were desperate to discharge me even when I told them that my baby had only fed once in 36 hours since birth."

> "One nurse even told me I'm over-reacting after having some concerns over my baby knowing full well, I'm a first time mother, my clothes were all over the floor because I couldn't bend. However, another woman who happened to be White across the room got every help she could get. I feel this was very disheartening because I was there suffering. I believe it was racial abuse. A Black woman on the same ward got the same treatment as me. I felt ignored, neglected and ridiculed."

These examples are supported by our interviews with midwives and obstetricians from ethnic minority groups. Staff identified an issue around a lack of respect for women from ethnic minority backgrounds, with 'dismissive', 'disrespectful', and 'patronising' used to describe the tone of interactions.

Through the interviews, we heard about the safety implications when women were not supported to understand information or communicate their feelings, needs or questions. These ranged from not having the information they need about their own or their baby's health, to very serious physical and emotional trauma with long-lasting effects.

Failing to hear concerns and respond appropriately can have devastating consequences. As a result of one inspection, we issued a Warning Notice where we had concerns that a Black African woman had not been assessed appropriately despite attending triage multiple times. Sadly, this case resulted in a stillbirth. In another case, a review by the Healthcare Safety Investigation Branch (HSIB, now known as the Maternity and Newborn Safety Investigations or MNSI) into the death of a baby raised concerns that the mother's ethnicity affected the care she received. The mother asked for help but was dismissed.

Equity in access to pain relief during labour and after birth has also been identified as an issue nationally. During our inspection programme, our Medicines Optimisation team held a series of focus groups with maternity leaders and frontline staff across 16 trusts. The aim was to help us understand what trusts were doing to ensure that women from ethnic minority backgrounds had equitable access to pain relief.

We asked how trusts audited people's outcomes and experiences of pain and pain relief. Most did not audit this at all, and in those that did undertake epidural audits, ethnicity was not recorded as part of this.

A study published in the Journal of the Association of Anaesthetists looked at disparities in the delivery of anaesthetic care between different ethnic groups. A spinal anaesthetic for caesarean birth means the baby is exposed to the lowest amount of medication and the mother can participate in the baby's birth. However, the study found Caribbean (Black or Black British) women were more likely than British White women to be given general anaesthesia for elective and emergency caesarean births (58% and 10% respectively).

Further research is needed to better understand the underlying causes of these disparities to see whether improvements can made to reduce any inequalities in the different types of pain relief and anaesthesia provided.

A recent MBRRACE-UK study reported that identifying and responding to language needs was insufficient among women from all ethnic groups, highlighting inconsistent provision of independent interpreters. The research also advised that family members and healthcare staff (who are not employed for their language skills or as interpreters) were inappropriately used instead. As outlined in the section of this report on communication, this is not in line with guidance from the National Institute for Health and Care Excellence (NICE), which states that interpreters should be independent.

Access to interpreting services

English as a second language was also a noticeable theme throughout our inspections. We found various examples where interpreting and translation services were available, including BSL (British Sign Language) interpreting services. The use of these services meant women had relevant information in their first language, or preferred form of communication, so they could make informed and safe choices about their pregnancies and births. We also found examples of services that sent duty of candour letters in the woman's first language after an incident, ensuring that all women and birthing people were adequately informed and involved in the reviewing process of serious incidents.

However, we inspected some services where leaders had made an active decision to keep hospital signage in English only, despite the wide range of languages spoken and understood by women accessing the service. Limited access to relevant information can potentially result in harm to women and babies. We found a service where incidents that were recorded were linked to poor outcomes due to lack of interpreting services. One report also described instances of discrimination, where staff made "inappropriate comments" about women who did not speak English as a first language.

NHS services have a statutory obligation under the Equality Act 2010 to have "due regard" to eliminating discrimination and advancing equality, and access to interpreting services is an important way to deliver this. Good quality interpreting services are also vital for services to meet the regulations covering person-centred care and consent to care and treatment. Providing high-quality interpretation and translation services is an important part of ensuring that women receive the right care, with informed consent, and have improved health outcomes. All the services we inspected had arrangements to provide interpreting services. However, we have concerns that they had not always considered specific aspects to meet the women's needs.

Staff experiences of racism in maternity services

There is a need for action to proactively support maternity staff from ethnic minority groups to ensure a diverse workforce that is representative of the community it serves. We visited some services where staff felt they were discriminated against because of their race and ethnic backgrounds. Staff at one service told us they felt that they were treated differently because of the colour of their skin and at another service, described episodes of racism.

In this example, even though episodes of racism had been reported, no action had been taken to address the issues, which suggests a poor culture around responding to concerns. Discrimination against staff in minority ethnic groups was linked to episodes of bullying and harassment. At one inspection, this was reflected in the trust-level Workforce Race Equality Standard (WRES) data.

Again, this was supported by our research into the experiences of midwives and obstetricians from ethnic minority groups. Interviewees described feeling "ignored, dismissed or effectively punished by negative treatment" when they spoke up about unfairness. Participants overwhelmingly felt that when they spoke up, issues were "swept under the carpet" or only addressed superficially, with a lack of genuine accountability and organisations adopting a defensive position.

On inspections, we also heard concerns from staff at one trust that job opportunities were not made transparent or equally accessible to all staff, with those from ethnic minority backgrounds feeling less able to access senior and board level roles. Through our research, we heard about midwives from ethnic minority groups whose confidence was undermined when applying for promotions, which is compounded where they do not see people from ethnic minorities in senior roles:

> "Being in interviews – it was always, 'you were very close, you just were not quite there'. If you are having this throughout your career, you start to believe it – you think, maybe I am only suitable for a certain role. And when you lose confidence, you don't perform as well or you stop aspiring."

Although examples of such discriminatory behaviour were limited during our inspections, they are completely unacceptable and raise important concerns about the inclusion, dignity, and safety of staff from ethnic minority groups in the workplace. Through interviewing staff in our research, longer-serving staff told us that things had improved over time for staff from ethnic minority groups. But interviewees described a culture in which it is normalised for people from ethnic minority groups to tolerate discrimination from colleagues, such as microaggressions, and not being made to feel like part of the team.

Using demographic data

Research by THIS Institute confirms that people from ethnic minority backgrounds may have distinctive health needs that maternity services do not consistently meet effectively. It is essential that a maternity service understands the needs of its local population to provide everyone with safe and effective care. Demographic data is vital to achieve this. However, there is currently huge variation in the way trusts collect and use demographic data to address health inequalities and access, experiences and outcomes from using their services and evaluate progress in this area. Having a national-level picture, along with guidance that could be tailored at trust level, would allow services to understand the data they have and use the metrics to improve access and outcomes.

Local systems have an important role to play in addressing unwarranted variations in population health. As discussed in our 2022/23 State of Care report, systems must work to reduce inequalities in people's access to care, their experiences and outcomes. As part of our new responsibilities to assess whether integrated care systems (ICSs) are meeting the needs of their local populations, we will be looking at whether different parts of the system are working together to achieve this.

Through our maternity inspection programme, we were pleased to find evidence at trust level that some leaders understood how various protected equality characteristics may affect treatment and outcomes for women and babies. This awareness was translated into monitoring outcomes and taking action on the findings and even, in some cases, commissioning research , to make services more responsive and appropriate for people's needs. (See more information on these initiatives in our improvement resource.)

But we remain concerned about a data gap at trust-level, which could be preventing trusts from making improvements. We have previously highlighted the need for services to use ethnicity data to review safety outcomes for women from ethnic minority groups. However, during the programme we saw this did not always happen.

Some managers collected information about ethnicity and other protected equality characteristics to identify themes and trends related to inequalities when reviewing incidents. But there are opportunities to review data relating to people with protected characteristics throughout the maternity pathway – not just when patient safety incidents happen.

By looking at other areas, such as the effectiveness of national approaches to improving outcomes, services would be able to gain insight that may not be available from incident data and ultimately improve outcomes. Without this demographic data, many services had no way to analyse whether national approaches, such as NHS England's Saving babies' lives requirements, were reaching those most in need of support in their local communities. Applying a blanket approach may not always be effective. The Marmot review recommends that while action should be universal, the scale and intensity should be proportionate to the level of disadvantage, known as 'proportionate universalism'.

As reported by THIS Institute, clinical guidelines and tools used in maternity services are not always sufficiently sensitive to the needs of different groups. To mitigate the risk of discrimination, there may be a need to adapt guidelines and how they are applied. For example, the NHS Race and Health Observatory recently called for new assessments for newborns from ethnic minority backgrounds. It highlighted that the Apgar score – a scoring system to evaluate the health of newborns – was developed based on white European babies, with some guidance referencing that a baby's skin should be "pink all over." Applying this guidance to babies from ethnic minority backgrounds can lead to inaccurate assessments and poorer outcomes.

We saw some evidence of services adapting guidelines and processes in this way, but this was not always the case. One service amended triage guidelines to have a low-risk threshold to invite women with English as a second language into the unit for face-to-face triage, recognising that language barriers can make telephone triage services less effective.

Engaging with local communities

The role of a maternity and neonatal voices partnership (MNVP) is to ensure the voices of women are heard, and to communicate back to staff and stakeholders to plan, review and improve local services. Where these relationships worked especially well, services built a relationship with the MNVP that allowed people to have their voices heard by their trust, to drive meaningful change and co-produce services or resources.

However, we previously highlighted in our Safey, equity and engagement in maternity services report that MNVPs were not always representative of the local community and we are concerned that in some areas, this issue persists. For the partnership to be successful, services must be proactive in gathering feedback from all women who use services. As stated in NHS England guidance, "effective MNVPs will reflect the ethnic diversity of the local population and reach out to seldom heard groups, including those most at risk of experiencing health inequalities, parents with experience of neonatal care, and bereaved families." It is vital that these services are funded appropriately to enable MNVP chairs to reach those most in need of support.

We also found some examples where the relationships between the MNVP and the maternity service were not as strong as they could have been. To enable the work of the MNVP to be meaningful, there needs to be authentic commitment from leaders within maternity services.

We recommend NHS trusts and integrated care boards:

- Improve their collection of demographic data, including information on ethnicity and levels of deprivation, to improve outcomes for women.
- Ensure that demographic data, including ethnicity data, is always considered when reviewing patient safety incidents and action is taken where risks are identified.
- Ensure that there are clear policies and procedures on the collection of demographic information and staff understand the importance of how this data can be used to improve outcomes for women.

Estates

Many maternity services inspected were appropriate for people's needs and kept them safe in line with national guidance, but this was not always the case. Too many maternity units are currently not fit for purpose, lacking space, facilities, and in a small number of cases, the appropriate levels of potentially life-saving equipment.

We are concerned about the serious safety risks this presents for women and babies. Common issues found on inspections included:

- a lack of space to accommodate necessary equipment and meet people's needs
- generally ageing environment and facilities, including issues with temperature and ventilation
- a lack of capacity in theatres
- a lack of adequate bereavement provision.

As well as presenting risks to women, unsuitable maternity environments can make it difficult for staff to provide the level of care they want to deliver. As highlighted by the Royal College of Midwives, a human factors approach can help improve safety in maternity care and is about "making the right thing to do, the easiest thing to do". It identifies a range of factors that affect safety and performance, such as:

- equipment should be easy to use and staff should receive training on how to use it
- noise levels and distractions should be monitored to help create a productive working environment
- working patterns, breaks, staff access to nutrition and hydration should be considered to prevent fatigue.

Research has also highlighted the benefits of shared social spaces, where staff can debrief and decompress after complex clinical situations.

However, as we highlight in this section, we found issues with equipment and ward environments which affected both staff and women using services.

Access to equipment and theatres

It is vital that maternity services have the right amount of equipment, and that all equipment is kept in good condition to maximise outcomes for women and babies. We were therefore concerned to find that a small number of services were missing required equipment, including a shortage of cardiotocograph machines used to measure babies' heart rates. Worryingly, we also found a lack of resuscitation equipment at several trusts. While there are no national guidelines for the number of standard items of resuscitation equipment that should be available, NICE guidance outlines that all birth settings should have facilities for resuscitation. These issues could have a devastating impact on neonatal and maternal outcomes.

We also issued Warning Notices on some trusts that failed to carry out regular checks on emergency equipment or did not adequately document that equipment had been checked. In addition, at one service we found a lack of clarity among staff about who was responsible for ensuring emergency equipment was safe and ready to use. This meant it was often misplaced or untidy. Conversely, only a few services had invested in replacement programmes for ultrasound scanners, neonatal resuscitaires and cardiotocography equipment to minimise these risks.

We also heard concerns about call bells. Although we found call bells were within easy reach in most maternity services and staff responded quickly when called, in a few services they were not working or only working intermittently. One antenatal ward did not have a call bell system in place. In other instances, we observed staff being slow to respond to buzzers. One person told us about having to verbally call for help when in distress or during an emergency as the call bell had failed and staff did not respond. Another person told us they were not able to reach their call bell with the sides up on their bed.

As well as a lack of equipment in some services, we also found issues with theatre capacity. It is essential that maternity services have access to dedicated operating theatres for planned and emergency caesareans as well as obstetric surgical procedures. All services we inspected had at least one dedicated obstetric theatre located within the maternity department, in line with national guidance. Most services had at least 2 operating theatres dedicated to maternity services, which were available for both planned and emergency caesarean sections as well as obstetric surgical procedures. One service responded to our recommendations made in a previous report by improving and future-proofing its maternity theatre provision.

However, in some cases, maternity theatres were out of use because of concerns about space and infection control. This meant that caesarean sections took place in the main theatre, and women and their partners had to walk through corridors and surgical wards for their procedure.

We found that where services did not have access to at least 2 dedicated maternity theatres, there were significant risks of delays to emergency caesarean sections due to lack of theatre capacity. Some trusts managed this risk by having separate surgical lists in the main hospital theatres for planned caesarean sections, keeping a maternity theatre free for emergencies.

Unsuitable ward environments

Many women told us they were unhappy with the hospital environment. Some concerns related to sensory issues, for example people complained of noisy and sometimes overheated wards. Additionally, we heard about unsuitable spaces for labour and postnatal recovery, as well as a lack of bed space.

Several people told us about uncomfortable ward environments, which were stuffy and unpleasant to be in. Fewer people reported feeling cold, but one person described a negative experience when they were placed in a storage cupboard with their baby because there was no space on the postnatal ward:

After my emergency c-section the ward was full. I was freezing from the operation and me and my baby were wheeled into a storage closet with air conditioning blasting. My baby then became cold and unwell and needed to be put under a lamp once we got into the ward... I became deeply distressed and wanted to leave.

Issues with ventilation or a lack of scavenging systems to remove harmful residual medical gases from the air meant that Entonox (as the trade name for gas and air) could not be used in all birthing rooms at one service. National guidance states that Entonox should be available for pain relief in all settings and our 2022 Maternity survey found it was used by 76% of women.

Through our Give feedback on care service, several women explained how the lack of space on wards affected their experiences. We heard of women in labour being placed in the same ward as postnatal patients, or postnatal patients being placed in a triage area because of a lack of appropriate space:

While being in Ward 9 before having my baby I was on the same ward as women who have had their babies already, which to me is unacceptable. I had bad contractions back then and was in pain which is not ideal for either me or women who've had their babies to be in such an atmosphere. The reason I was there was because there was no space in the labour ward, which is what I was told, and I find that appalling.

Furthermore, like other parts of the NHS, maternity services are under increasing pressure and sometimes there is more demand than a service has capacity for. Maintaining good and efficient flow requires a trust-wide culture of safe and efficient patient care. During some inspections we saw how staff spent time dealing with issues around flow in the maternity service specifically, which were not part of the wider trust's capacity management. We suggest maternity services should be included as part of the whole trust-wide capacity and flow processes so that appropriate skills and support can be obtained, releasing clinical staff to focus on managing clinical risk.

Several maternity services had completed self-harm and ligature assessments within all environments to meet the needs of pregnant women at risk of self-harm. Some services coupled this with further actions aimed at reducing risks that were identified, such as staff training around caring for women at risk of suicide.

National guidance on the design of maternity units stresses the importance of security to protect babies and families. We noted issues related to tailgating, whereby it was possible for people to enter a unit without passing any sort of security clearance by directly following close behind someone who had been admitted, which posed a clear safety risk.

Privacy, dignity and hygiene

The experience of giving birth can leave women feeling at their most vulnerable and it is therefore important that ward environments are set up to protect their privacy and dignity. This includes having easy access to ensuite bathroom facilities. While most services inspected had provision for women to have access to ensuite bathroom facilities during labour and postnatally, we inspected some services with limited access to toilets and showers. Some services lacked ensuite rooms in delivery suites, meaning women had to walk through a ward to use communal toilets and showers during labour.

Issues with ward layouts and a lack of space also meant there was a risk that people could overhear confidential conversations. For example, one service did not have a dedicated space for staff to discuss sensitive issues with women, making it difficult to maintain confidentiality during handovers to the birth centre. As highlighted in the triage section, we found that cramped triage areas also compromised women's privacy.

Women also told us about overcrowded and cramped ward environments, which meant they did not have enough space to get changed or attend to their babies. Some people said that beds were placed very close together on wards, which made it difficult to move around with reduced mobility, and again, made it difficult to have conversations in private. This led us to be concerned that people sometimes found it difficult to get the rest and privacy that they needed during their stay at the hospital.

Many women complained about a lack of hygiene in maternity units. For example, we heard several comments about inadequate toilet and shower facilities. Some of the comments related to unclean and dirty bathrooms, such as blood on the floor that had not been cleaned, or urine samples being left in the toilets. Several people also expressed concern about the hospital's failure to change bed sheets. Some people reported having to lie in blood-stained sheets for hours; in some cases, they said that bed linen was not changed for several days. This is particularly unhygienic, given that they were likely to be still bleeding after giving birth and wished to rest in a clean bed. Lack of bedding was also a concern. In one case, someone was asked to bring their own pillow, as the hospital was under-resourced and could not supply one:

> "I had to take my own pillow into theatre for the operation (they asked me to as they had none). This is NOT a reflection on the staff – more on the under-resourced NHS."

Poor hygiene standards sometimes resulted in a lack of dignity for women, who told us that a hospital's failure to clean facilities meant that partners were sometimes called on to clean up, in the absence of staff, or to help change bed sheets due to understaffing:

> "No-one changed the mat on my bed for hours which was soaked in blood, plus no-one changed my sanitary pad at all the whole time I was there. So my husband had to change it, which shouldn't really happen."

Bereavement provision

Pregnancy loss is devastating for parents. Through the inspection programme, we observed the impact of different ward environments and bereavement provision on this experience. We found a high level of variability in the quality of bereavement suite facilities. Where they were good, refurbishment was often funded by hospital charities or community fundraising.

To reduce the potential for bereaved families encountering or overhearing new and expectant parents, national guidance is clear that families should have a private and comfortable space to grieve their loss. We found that most maternity services had a dedicated space for women and families, often located in a private area away from labour and antenatal wards. Some services had clothing designed for very small babies and cold cots so that parents could spend time with their babies and say goodbye.

However, where bereavement suite facilities were available, they were not always in line with the National Bereavement Pathway recommendations. For example, we inspected several services whose bereavement suites were not soundproofed. In one case, where the bereavement rooms were in the labour ward, bereaved parents experiencing baby loss were being cared for in the middle of a labour ward surrounded by the sights and sounds of newborn babies. In 2 services, the location of bereavement suites was within antenatal and early pregnancy units, with bereaved and grieving families meeting pregnant women in attendance. The location of these facilities was challenging for grieving women and their families and did not adhere to current national guidelines.

Several people in these situations explained how the negative psychosocial impact of antenatal environments made their experience worse. Numerous people described having to sit in waiting areas with other 'happily' pregnant women as a triggering and traumatic experience. Many women felt that these locations were unsupportive of their loss, further highlighting their emotional pain and adding to the difficulties they were yet to face.

We recommend DHSC:

- Provides additional capital investment in maternity services to ensure that women receive safe, timely care in an environment that protects their dignity and promotes recovery.
- Works with NHS England to ensure that this additional investment is ring-fenced and maternity services receive the investment they need.

Communication

Effective communication is vital to ensure women are supported to make informed decisions and feel listened to if they raise concerns.

NICE guidance states that services should use clear language, provide timely information and offer regular opportunities for questions. It also highlights the importance of considering people's individual needs and preferences.

In our 2022/23 State of Care report, we identified poor communication as an emerging theme from our initial inspections. Now that the programme has finished, we remain concerned that communication is not always good enough, particularly for those with protected characteristics under the Equality Act. Communication is also often the subject of formal complaints received by services, who have a responsibility to ensure all women are given the information they need, in a way they understand it, to make informed decisions and consent to treatment.

Communication challenges

In the feedback we received on inspections and through our Give feedback on care service, negative comments about communication during the maternity pathway outweighed positive comments. Many people told us that a lack of information negatively affected their maternity experiences and sometimes resulted in different birth outcomes than they had envisaged or hoped for:

> "Communication should just be better, it would help if the staff remembered that it might be all routine for them, but for patients it's very much a new and potentially traumatic time. And communicating in a sensitive way goes a long way."

> "Nothing was explained to us at all. Everyone we spoke to had traumatic births during this period. We had been warned that they leave you and ignore you completely, which they did. You have to shout to have someone come and look at you, and fight to be heard."

Many people highlighted poor communication during the antenatal pathway, noting they were not given enough time to ask questions. We also heard that staff did not always provide enough information about the harms and risks associated with their pregnancy. Some of these people told us about how they were made to feel like an inconvenience:

> "They honestly made me feel like I was inconveniencing them and they were rushing through patients. They didn't take time to ask if I was OK and explain what ANYTHING meant. One even scared the life out of me by misdiagnosing me, luckily me and my midwife caught the discrepancy and queried it. I feel they speak to me as if I'm incompetent and unable to comprehend and then tell me to forget it and not worry when I ask genuine questions/worries."

In addition, several people told us they felt "fobbed off" and lost trust in the people caring for them:

> "Some of the midwives don't listen to your concerns and you feel like you're always being fobbed off or your concerns aren't being listened to..."

> "I asked several times to be examined, to which I was told there was no need! I couldn't even sit down my baby had dropped so low, at 7ish I had a bad bleed so someone finally come and examined me and was told I was 7cm!! I had been saying for hours I was progressing and was fobbed off."

This feedback is supported by the findings of our 2023 Maternity survey, which found a 5-year downward trend for respondents saying they were 'always' given the information and explanations they needed while in hospital after the birth. This year's results found 60% of respondents reporting that they 'always' received the information and explanations they needed, compared with 65% in 2018.

Communication around induction of labour was a key issue. Inductions are often offered when babies are overdue or if there is a risk to their health. While inductions are becoming more common, it is vital that staff recognise that the process can be difficult for women as some may be disappointed about being induced and the process can be painful. Effective communication therefore plays a key role in shaping the experience.

Inductions are often planned in advance and while it may be medically appropriate for someone to wait to be induced, we found that this is not always explained to women. Some women felt they were given insufficient information to understand the reason for delaying an induction, which increased their anxiety about the consequences for their health and their baby.

On a broader level, a lack of mental health support during the maternity pathway emerged as a theme from our analysis of experiences received through Give feedback on care. Despite a recent focus on perinatal mental health, including in the NHS Long Term Plan, many women felt better communication could have reduced their anxiety. People explained that pregnancy and birth is an overwhelming experience and without clear communication, levels of anxiety can increase. Again, it is important that staff recognise this and care for women in a holistic way to improve the overall experience of having a baby.

Listening to women and families

It is essential that women feel listened to by staff, especially when they are in pain. From April 2024, the first phase of the introduction of Martha's Rule will be implemented in the NHS. This will allow patients and families to request a review if they feel their concerns are not being listened to. In maternity services, it may help women make sure that their concerns are heard, as during the programme, we were concerned to hear about instances where people felt that staff did not listen to their requests for pain relief. In some cases, this resulted in poor pain management during birth.

> "The staff weren't listening to my worry of not having pain relief and managing without an epidural with my mental health as well as my physical health. By the time the midwife took me over to the room, my labour was unbearably painful, and I was told that it was too late for the epidural. I gave birth with no pain relief – not even paracetamol and I was very disappointed and frustrated that they didn't listen to me when I knew what my body was going to do."

> "I was not listened to by the healthcare professionals during my labour and they were not managing my pain. I was left for several hours despite asking for help."

One woman we spoke with felt her concerns about pain may have been dismissed because staff knew she had not given birth before:

> "When I first went into labour I contacted [name of hospital] for advice. I contacted them 4 times as I was in agony with the pain but was told to stay at home because it was my first child. I felt I had been stereotyped because it was my first child and didn't know how much pain I would be in. When I eventually arrived at hospital after deciding just to go in because I was in so much pain I was actually 7cm dilated."

Even when women asked for help to manage their pain, they were sometimes not given the help they asked for. Through our research interviewing midwives and obstetricians from ethnic minority groups, we heard how false beliefs around physical characteristics and symptoms can mean some people are denied pain relief. Interviewees reported hearing racial bias in pain assessment, for example:

> "Black women have thicker skin, so they are less likely have a tear after delivery."

> "You are African, you are tough – you don't need pain relief, get on with it."

Stereotyping and a lack of cultural awareness can significantly affect people's experience of care, as we outline in the section of this report on inequalities.

People whose first language is not English face additional inequalities. Access to and the quality of interpreting services varied and continues to be a theme in patient safety incidents nationally. We found some pockets of good practice, for example in one service, the Non-English-Speaking Team (NEST) hosted an antenatal clinic using translation services with midwifery and consultant support. Home visits could be arranged and information was provided in the woman's first language, allowing people to make the right choice for themselves and their babies.

However, our interviews with midwives and obstetricians from ethnic minority groups highlighted that having poor or no spoken English was associated with worse experiences of care:

> "My summary is, if you are White you will get good care. If you are not White but you speak English, it's OK, you will get what you need. If you have poor English – it's going to be the very basic standard."

This supports the findings of our Safety, equity and engagement in maternity services report. In this, we reported variation in how well maternity services tailored communications and engaged with women whose first language is not English.

NICE guidance is clear that maternity services should ensure that reliable interpreting services are available when needed and that interpreters should be independent, rather than using a family member or friend.

Interviewees also called for staff to do more to ensure that people understand the information they provide:

> "Staff need to be very mindful that you will get people nodding their head but not understanding. And instead of just choosing to accept that, staff need to make sure that they have understood."

Communication between staff

Multiple studies have shown a link between effective communication and safety in maternity services. Teamwork, co-operation and positive working relationships combined with effective co-ordination are also 2 of the 7 features of safe maternity services identified in research by THIS Institute. Where staff communicated effectively, people told us this had a positive impact on their experience.

> "My second midwife [name] was brilliant, I witnessed a team who worked seamlessly together, handing over information about my care which made me feel confident in the continuity of the high standards of care I was receiving."

On all our inspection visits we reviewed the quality of communication and co-ordination at morning multidisciplinary handover meetings on labour wards. These meetings are critical for staff to understand how to manage current risks across the unit. They are also an opportunity for staff to share learning.

A small number of women explained how poor staff handovers had a detrimental impact on their care – notably access to pain relief:

> "The lack of continuity of care was also a contributing factor to my difficult delivery and eventual caesarean. There was little handover between most clinicians during my delivery and no handover between 2 clinicians, this also led to difficulties and unnecessary pain."

> "There was no consistency of care during labour. I had the gel and my contractions were really painful and I could tell that the baby was on the way. The midwife wasn't listening to us and actively put off examination due to a change-over of staff."

We also heard from several people who had to repeat information about their medical history, or preferences about their care because of a disconnect between staff:

> "I saw a different doctor from the diabetic team for every appointment, so I had to tell each one my history."

> "There was also a disconnect between consultants, midwives and obstetricians, all of whom seemed to have a different opinion on induction timings."

NICE published guidance on information sharing during the postnatal period. It states that when women are transferring between services, relevant information should be shared between healthcare professionals to support their care.

Informed choice and consent

It is essential that women are clear about the risks and benefits of different birthing choices and treatment options. Staff also need to ensure the language they use is accessible so that women know what to expect when they consent to procedures and examinations. Everyone has a right to physical autonomy and integrity, and good communication is vital in empowering people to make informed decisions about their care.

When we found good examples of communication and information-sharing, women praised clear and transparent explanations from staff, which meant that they were able to make more informed choices:

> "My husband said that the day my son was born, the maternity department was very busy but I was completely oblivious to this as not one midwife or doctor made me feel like this, I felt like everyone gave me the time I needed and we were able to discuss

> options, ask questions and make plans about our care."

> "I had loads of questions and anxieties regarding pain relief and labour, and they were able to answer all of my questions and made me feel at ease. I felt as though I was in good hands."

However, this was not always the case. For example, one person told us about feeling a lack of choice about being induced:

> "I was induced. It did feel as though I was being 'told' that I had to be induced. When I expressed my reluctance for an induction a consultant was sent to speak to me. It would have been more helpful to understand the clinical rationale and risk vs benefits of induction versus waiting. The only explanation I received was that 'baby is to term and it won't affect baby being born early'. I felt this could have been explained more thoroughly and would help me to make an informed decision rather than feeling 'forced'."

In our interviews with midwives and obstetricians from ethnic minority backgrounds, staff identified other factors, along with language barriers, which can lead to a lack of choice. This included cultural perceptions of authority, where people from some ethnic minority groups may be more inclined (or perceived by staff to be more inclined) to accept the advice of health professionals without questioning it. Concerningly, interviewees also suggested that staff may not always offer choice, because they know they will not be challenged. Perhaps most worryingly, we also heard about perceptions around who is 'entitled' to care, and this sometimes affected the level of choice offered.

In our Safety, equity and engagement in maternity report, we found many services had worked together with the Maternity and Neonatal Voices Partnership (MNVP) to engage their local community, including reviewing communications and online content. We were encouraged to see evidence through our inspection programme that this has continued. We found some services worked with local MNVPs to improve informed choice and consent by co-producing information on induction of labour including leaflets and information videos.

Accessing digital maternity records

In line with recommendations in NHS England's 3-year delivery plan most services have adopted digital records and have maternity records apps to enable women to view their records at home. We heard a few positive comments about the functionality of the maternity records apps and how it contributed positively to the maternity experience as people could access their records, store their birth plan and receive reminders about upcoming appointments.

However, a small number of women discussed their frustration with the maternity records app. For example, we heard that when it was not updated, this meant there was insufficient information about their antenatal care and tests. This could lead to miscommunication and anxiety where test results were only communicated through the app if midwives and nurses remembered to release the information:

> "The [maternity records app] does not update and let patients know about the care and tests they have received. This left me very anxious during my first few appointments and being pregnant for the first time."

The use of digital technology is not always inclusive. In our Safety, equity and engagement in maternity report, and through our engagement with MNVPs, Five X More and National Maternity Voices, we heard concerns that reliance on digital technology to engage women and provide them with the information they needed could exclude women who do not have the access to, or skills to use, digital technology.

Staffing

Concerns around staffing in midwifery are not new and have been well publicised. The additional scrutiny of maternity services following high-profile investigations including Shrewsbury and Telford Hospital and East Kent Hospitals has compounded this, with staff feeling pressured to go the extra mile.

In our 2022/23 State of Care report, we looked at the impact of pressures on staff on both the maternity workforce and people using services. We highlighted that while people using services appreciated that maternity staff were often doing their best despite being very busy, people often felt they were not a priority and did not get the help they needed.

Throughout our national maternity inspection programme, we have seen staff going above and beyond to provide compassionate care for women and their families under difficult circumstances. Despite this, we continued to find that many women were not receiving safe care because of the pressures on staff. Staff also told us that this meant they were not always able to provide the care they wanted to deliver.

Staffing levels

As the demand for maternity services continues to increase, the staffing levels need to keep pace with the changes to keep women and babies safe. Staffing levels depend on the acuity of individuals and the numbers of women needing care. During the programme, services used Birthrate Plus, a midwifery-specific national tool for calculating staffing levels and recommended numbers of midwives.

Delays in improving levels of staff affects the ability to provide safe, effective care. Pressures on staff, who told us they did not always feel respected or supported, meant that care was sometimes task-focused rather than patient-focused.

To keep people safe and ensure that people receive consistently safe, good quality care, we expect services to ensure there are appropriate staffing levels and skill mix. Through our inspection programme, we found variation in this area. Some services had good oversight of staffing levels. Managers in these services reviewed and adjusted staffing levels and skill mix in line with NHS best practice, with services often having enough staff with the right qualifications, skills, and experience to keep women safe.

We found that many services had a clear escalation policy to manage staff shortages and reduced bed capacity. This gave managers an awareness and oversight of staffing needs in each service area, so they could provide appropriate cover as necessary. Where managers identified the need for additional staff, members of staff could be moved between service areas, they could access on-call staff or community midwives could be recalled. However, this could affect women's choices, for example, they may need to suspend homebirth services. At one service, it was incredibly concerning to see how redeploying staff left one midwife caring for 13 mothers and babies on the postnatal ward. Following this inspection, we issued a Warning Notice, requiring the trust to make significant improvements.

Staff who were redeployed told us they were often moved to unfamiliar areas, which they felt affected their ability to care for women and their babies. We also heard that there was not always a sense of teamwork between units, which could make redeployment difficult for staff.

We found care was not always person-centred or dignified because of a lack of staff. For example, we heard from women who felt maternity staff were overstretched and overworked:

> "It was very obvious at times the staff were under pressure to manage all the patients on the labour ward. I noticed staff being pulled from the postnatal ward to work in other areas…. I felt sorry for them. I've heard from friends who have experienced the same as me. Not enough staff but everyone trying hard."

> "The triage midwife also spent a lot of time out of the room, looking for someone to hand over to, but everyone was in theatres. This meant it was just me and my partner left alone in the room, for long stretches during the birth. The triage midwife came back into the room for the final stage of the birth, but the labour midwife missed it entirely, due to being in theatres with other women. I totally understand that there were other women who needed her more than me, but for me, it felt out of control and unsafe."

A few services that struggled to maintain safe staffing levels indicated staffing shortages as a primary risk on the risk register. As highlighted in the section on leadership and culture, board-level oversight of key issues such as staffing is vital in enabling leaders to make effective decisions and drive real improvement for women. The importance of board-level oversight was also highlighted in the final report of the Ockenden review, which found that a lack of understanding by the board of issues and concerns resulted in neither effective change nor the development of accountable implementation.

Not having enough staff affected the quality of care they were able to provide and put women at risk. For example, at one service we heard how it was a normal occurrence for induction of labours to be delayed due to staffing issues. In some services, we found women having to wait for long periods for transfer to a labour ward once the induction process had started, and in some cases, there was a lack of effective monitoring during periods of delay. Trusts should be making sure women and their babies are observed closely and that regular assessments are carried out to identify and prioritise those at greatest risk. Where we have found concerns about delayed treatment – including induction of labour – we were clear with trusts that effective oversight of the issue is vital and that all action possible must be taken to mitigate any risk and keep people using the service safe.

Staff acting beyond the scope of their clinical practice

The complexity of maternity care has increased in recent years, with higher numbers of women needing higher levels of care, including high dependency care. As highlighted by the Royal College of Midwives, this demands more of the maternity workforce. Services need staff with the skills and expertise to look after people at each part of the pathway – from antenatal to triage, labour, and postnatally. At every stage, staff play a critical role in ensuring the safety of both mothers and babies, identifying early warning signs and making sure people understand what is happening to them. We know that the number of women with complex medical histories is increasing, which increases risk. In the UK, 1 in 5 pregnant women have multiple pre-existing long-term conditions. Studies have shown that maternal multiple long-term conditions are associated with adverse outcomes. Modern day maternity services have not always kept up with this change.

We were encouraged to see that a number of services, while recognising that midwives provide specialist care, also opted to provide training in high dependency care, which aligns to the midwifery proficiency standards. This enabled women who needed more intensive levels of observation (for example, those who had a postpartum haemorrhage) to stay close to their baby while being treated on the maternity unit.

There are currently no national training requirements for midwives in providing high dependency maternity care, which is defined by RCOG as "an intermediate level of care for pregnant or recently pregnant women where a higher level of observation, monitoring and interventions can be provided than on a ward but not requiring high dependency care/organ support." This is unlike general nursing, where there are competency packages and recognised training packages to ensure staff are appropriately trained to provide this level of care. While some trusts have intensive care outreach services that can care for women when they have babies, these generally provide advice rather than physical care.

Issues with staffing levels were leading to staff having to perform tasks or cover for roles that are outside of their training and not in line with national guidance. Although services were successful in developing innovative solutions to redeploy staff, in others this put women at risk. For example, we were concerned to see instances of unregistered staff acting as Surgical First Assistant (SFA)or scrub nurses, without proven competency.

We would expect everyone performing the SFA role to have completed training in line with national guidelines. We questioned if this practice was replicated in other NHS inpatient services, but were told it was unique to maternity. This is concerning, given procedures such as a caesarean section require the same level of skill and competence as any other surgery.

We identified staffing issues across the workforce, and problems were not limited to midwifery staffing. Where there were low numbers of staff, one trust used Foundation Year 1 (FY1) doctors interchangeably with more experienced FY2 doctors. It is important that services recognise that the FY1 training year is designed to enable medical graduates to begin to take supervised responsibility for patient care. They are not interchangeable with FY2 doctors who have developed more independence.

There were also some services who diversified their workforce by recruiting registered nurses to carry out tasks which fall outside of the protected function of the midwife role which makes it a criminal offence (other than in an emergency or during training) for any person other than a registered midwife or registered medical practitioner to attend to a woman in childbirth. Service leaders need to be assured that these registered nurses are not working outside their scope of practice, and how service delivery and outcomes are monitored in practice.

Training and development

The Health and Social Care Act states that "staff must receive the support, training, professional development, supervision and appraisals that are necessary for them to carry out their role and responsibilities."

While we saw evidence of good practice, we were concerned that staffing pressures meant midwives and junior doctors sometimes missed out on mandatory training and other learning and development opportunities because of the intensity and inflexibility of their rota. For example, staff discussed not receiving training to use the triage system.

In a number of services we found compliance levels for mandatory training were below the trusts' targets. Not completing mandatory training can negatively affect the safety of women and babies.

In one service, only 39% of staff had completed the Perinatal Institute's growth assessment protocol training, and 51% of all staff groups had completed the fundal height measurement training. This was against the trust target of 90%. The training supports staff in correctly identifying if babies are the expected size against gestational age. At the trust, we saw a number of incidents that demonstrated missed opportunities to identify babies who were small for gestational age.

Worryingly, we saw varying levels of completion rates of maternal and newborn life support training for midwifery staff, with low rates of completion in immediate life support (53%) and newborn life support (56%). This meant service leaders could not be assured all staff were suitably trained to respond to life-saving emergency situations, putting women and babies in their care at an unacceptable risk. In addition, we found a number of examples when staff were unable to describe the process of a birthing pool evacuation in an emergency or locate the necessary equipment.

Some junior doctors told us the intensity of their rota provided them with little or no learning and development opportunities as caring for women took priority. We also found the current workforce challenges meant supervision meetings and annual appraisal meetings were often postponed due to clinical work taking priority.

Junior medical staff told us that the inflexibility of their rota meant they were not always provided with protected or paid time for teaching, including mandatory training, and they felt expected to complete relevant training in their own time.

Staff wellbeing

As reported in our 2022/23 State of Care report, high demand and more pressure on services is continuing to affect the health and wellbeing of staff across all areas we inspect. In 2022/23, we continued to see high sickness rates for staff, with a high proportion of staff saying they felt sick as a result of work-related stress.

Throughout the maternity inspection programme, staff absence caused by sickness and other reasons such as maternity leave, has been a key barrier preventing services from reaching full staffing capacity. While many factors can contribute to high rates of staff sickness and absence, we identified some themes including stress, COVID-19-related absence, and short and long-term sickness.

Low staffing numbers because of high sickness rates can put additional pressure on staff who are able to work, contributing to low morale, exhaustion, and increasing the risk of burnout. Many members of staff told us that a lack of breaks and meal breaks was common, especially during night shifts. Some staff told us they felt unable to stop for a break due to safety concerns from staffing levels. We also heard about staff working late and/or working additional unpaid hours to support the safety of women. This is supported by a recent survey by the Royal College of Midwives, which showed that midwives and maternity support workers are working 100,000 unpaid hours a week to support maternity services. In addition, 87% of respondents did not feel their workplace had safe staffing levels.

While staff told us they had identified and reported these issues to managers and leaders, some said they felt their concerns were dismissed and ignored. It was concerning to hear from staff who felt that their job had become harder and that they were “pushed to the brink” and “emotionally exhausted”.

We expect providers to care about and promote the wellbeing of staff to enable them to provide, safe, effective, person-centred care. Some services were taking action to improve how they support staff, for example by introducing wellbeing coaches, employee support services and guidance on managing stress. However, it was not clear on the impact of these strategies on staff absence and sickness levels.

Workforce planning and recruitment

Recruitment and retention of staff remains a chronic issue for maternity services and presents a major national concern. It is vital that services can recruit to maintain safe staffing levels. Staff then need to be supported to carry out their roles with the appropriate levels of training on an ongoing basis.

Retaining staff is perhaps an even greater challenge. Sustainable improvement in this area requires further investment to support the wellbeing of staff, enable them to provide the level of care they want to deliver, and prevent them from being driven away by current pressures.

The Royal College of Midwives (RCM) has warned that staffing is the most important issue, which is placing unacceptable levels of pressure on staff and compromising the safety and quality of care for women. These issues extend to recruiting students to join the profession and there is work to be done to future-proof the maternity workforce, with data from UCAS showing that midwifery applications for June 2024 were at their lowest for more than 6 years.

Throughout our inspection programme, we have continued to see high numbers of vacancies. In some cases, services lacked enough maternity staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and provide the right care and treatment.

NHS Resolution's Maternity Incentive Scheme is a financial incentive programme that aims to enhance maternity safety within NHS trusts and encourage them to implement essential safety measures. The scheme has numerous requirements for trusts to ensure effective midwifery workforce planning. However, we found some services had not fulfilled these requirements, for example by not following best practice when calculating the midwifery staffing.

Services identified high staff turnover as being associated with a lack of opportunities to progress to other roles. Although staff were promoted at one service, we still found issues with staffing shortages as the service had not replaced midwives it had promoted.

In an attempt to combat some of these issues, in 2022/23, the government announced that all maternity units would be given additional funds to increase supernumerary capacity and improve support for midwives, with a continued focus on retention and pastoral support activities. The majority of units we visited had a recruitment and retention midwife in post, whose role included:

- providing pastoral support to the workforce
- attracting new staff through proactive succession plans to address shortfalls in staff numbers and skills mix
- working with matrons and midwives to identify where improvements could be made to support staff retention.

Some recruitment and retention midwives collated themes from staff exit interviews to drive improvement. At one service, 18 members of staff who planned to leave had been retained as the recruitment midwife had identified what staff need and ensured the availability of clinical development opportunities.

In contrast to staff shortages, several services were found to have low vacancy rates and limited staff turnover, although no reason was provided as to how the service achieved this.

Reporting red flag events

The National Institute for Health and Care Excellence (NICE) guideline 4 'Safe midwifery staffing for maternity settings' describes a midwifery 'red flag' event as "a warning sign that something may be wrong with midwifery staffing" such as delays in medical reviews and maternity triage difficulties. Nearly all the services we inspected reported maternity red flag staffing incidents in line with these guidelines. However, we saw inconsistencies in how these were recorded, monitored and mitigated. We noted that a few services had no red flag incidents within the reporting timeframe.

In addition, it was not always possible to identify in trusts' board papers whether maternity red flags were presented to the board. This could mean that boards were not fully appraised of the safety concerns women were experiencing.

We saw that maternity red flags were primarily associated with delays in care, with most red flag events identified as delays to induction of labour where one-to-one care was unavailable, or staffing or bed availability that was considered to compromise safe infant delivery for women. Some services aimed to prevent future red flag events through a review of planned admissions, enabling transparent conversations about activities within all units and discussing red flag incidents at safety champion and governance meetings to identify themes and learning.

Medical staffing

Reviews by doctors in triage are often compromised because middle grade rotas are hard to fill. The middle grade cover for triage is often (but not always) from the intrapartum team, who will prioritise intrapartum over triage unless the case is very urgent. Often, these doctors are also covering gynaecology emergencies from the emergency department. There is no dedicated national model of obstetric cover.

All units we inspected had adjusted the level of consultant cover to meet the requirements set out in the Ockenden Review recommendation to have 2 ward rounds in a 24-hour period. However, as we highlighted in our interim blog, we are concerned that the cover model is often fragile, and the rotas rely on every consultant being available and establishing a culture of escalation for support. While funding was provided following the Ockenden report, it was not enough to meet the demand from trusts.

We recommend NHS England:

- Has oversight of gaps in middle-grade rotas and the proportion of time spent by consultants covering them. This supports recommendations in the Ockenden Review to introduce nationally agreed minimum levels of medical staff to cover the full range of maternity services at all times.
- Works with the Nursing and Midwifery Council and Royal College of Obstetricians and Gynaecologists to establish a minimum national standard for midwives delivering high dependency maternity care.

We recommend the Royal College of Obstetricians and Gynaecologists takes our findings in relation to the surgical first assistant role in maternity services so that it is in line with the requirements set out by the Royal College of Surgeons.

We recommend that the Nursing and Midwifery Council uses findings from our report to review their proficiency standards for midwives.

Leadership and culture

Effective leadership, governance and culture can drive and improve the delivery of high-quality, person-centred maternity care and help to drive a culture of safety and improvement.

The first Ockenden review into maternity services at Shrewsbury and Telford Hospital NHS Trust highlighted the need for strengthening leadership and oversight, preventing toxic cultures and fostering more collaborative approaches in maternity services. Similarly, Dr Bill Kirkup identified a culture of denial and described 'a resistance change' in his investigation into maternity failings at East Kent Hospitals University NHS Foundation Trust. To drive meaningful change and address systemic issues, a joined-up approach from organisations, colleges and system leaders is essential.

Our inspection programme supported these findings, demonstrating the importance of strong leadership and an inclusive culture. We found that many of the issues raised in these reviews of individual trusts not only persist but are widespread.

We observed a wide range of maternity service leaders who demonstrated dedication and passion in making their service effective in caring for women and babies, but the quality of leadership remained varied. We identified numerous factors involved in effective leadership, including:

- a stable leadership team, with consideration of succession planning and backfilling to enable seamless provision of services
- leaders with the capacity to support service development, address issues in a timely way and drive continuous improvement
- a detailed understanding of immediate issues and priorities faced by the service to form the basis of an effective management plan
- a leadership team that is accountable for acting on risks identified and making tangible improvements
- supportive and approachable leaders who listen to staff and act on what they hear in a way that the workforce recognises
- regular and clear communication and transparency from leaders.

In his report into failings at East Kent, Dr Bill Kirkup highlighted "the divergence of objectives of different groups" as an issue that is particularly striking in maternity care. He highlighted a "struggle for 'ownership' of maternity care" where "rather than contributing as equal partners, midwives may be encouraged to see themselves as being 'there for women', defending them from the 'medicalisation' of maternity care" and putting them in conflict with obstetricians. We saw one instance of a team not working holistically, which we escalated to the trust leadership team when identified and issued a Warning Notice to drive urgent action.

In maternity services, it is vital that multidisciplinary teams work towards the same aim – safe care for women and babies throughout the maternity pathway. As previously seen in the East Kent report, divisions within professions can place women at a greater risk of harm.

Culture

An open and positive culture can demonstrate examples of teamwork, professionalism, and listening to women. Healthy cultures, where staff feel supported and empowered to thrive, improve staff retention and are crucial to ensuring high-quality, safe care for people.

We expect leaders at all levels to understand the context in which they deliver care, treatment and support, and to embody the cultures and values of their organisation. They should have the skills, knowledge, experience and credibility to lead effectively, with integrity, openness and honesty. Good leadership is vital in creating an inclusive team culture with effective communication, escalation and clear routes of accountability. This is necessary for good clinical care for women and helps to drive a culture of safety and improvement.

In our Safety, equity and engagement in maternity services report, we found variation in the culture of services we inspected. There was evidence of poor working relationships between obstetric and midwifery teams in some services, staff did not always feel valued, and some services could not demonstrate a clear culture of learning.

Throughout our inspection programme, we were encouraged to find examples of leaders taking responsibility for providing a safe service, often seeking external support and guidance and being open to scrutiny at all levels. However, more work is needed to ensure these cultural values are present in every service.

In many maternity services, we observed a positive, just and learning culture of reporting incidents and near-misses, with staff encouraged to raise concerns without fear. For example, one service shared regular newsletters and posters of 'you said we did' with staff and patient feedback from recent visits from non-executive directors. This is vitally important, as a poor culture can mean staff do not feel confident to speak up and issues can become exacerbated. A positive culture is also marked by the quality of interpersonal relationships in a service. We were encouraged to visit multiple services where staff reported feeling respected, supported and valued by their colleagues. More examples can be found in our improvement resource.

Unfortunately, not all services demonstrated these values. For example, at one service, staff spoke of low morale and described a blame culture, where managers did not listen to their concerns. We are concerned that while these cultures persist, services will not be able to address issues raised in reports such as the Ockenden review, and ultimately, families will continue to suffer. We heard that a decline in enthusiasm, burnout and low morale were having a negative impact on culture.

As highlighted in the section of this report on inequalities, staff feeling ignored or dismissed emerged as a theme in our interviews with midwives and obstetricians from ethnic minority backgrounds. When staff do not feel empowered to speak up, or their concerns are dismissed it can be indicative of a closed culture, in which people are more at risk of deliberate or unintentional harm. Any service that delivers care can have a closed culture and we monitor for signs or risk factors associated with closed cultures throughout our inspection activity.

Some trusts recognised that they needed to address cultural issues. For example, one trust that had recently been through significant structure changes made sure staff had a common purpose of providing safe, quality maternity care.

Throughout our inspection programme we came across leaders at all levels who challenged our findings. We heard from some leaders that our inspection reports were contributing to poor morale among maternity staff, making it even more challenging to recruit. In contrast, we heard from staff who wanted to share their experiences, and in some cases thanked us for going into their services and highlighting areas for improvement.

There is no doubt that maternity services receive a great deal of publicity and much of that describes poor experiences and, at times, devastating outcomes. Some women told us they are frightened of what might happen if things go wrong. This is unacceptable.

We heard an overwhelming message from trusts' maternity leaders that they did not want any more recommendations on what they need to do to improve. However, as our report highlights, on a national level there are some fundamentals of care that need systemic improvement. Until these are addressed, women and babies will not consistently receive the level of safe care they should be entitled to and the level of care that staff want to be able to deliver every time.

Visibility of leaders

In our Safety, equity and engagement in maternity services report, we previously raised concerns about a lack of clear, consistent and visible leadership. When we assess whether services are well-led, we expect leaders at every level to be visible and lead by example, modelling inclusive behaviours. This can help make staff feel supported in their role and enable them to escalate concerns promptly to improve outcomes for women and their babies.

We were encouraged to see examples of visible leadership on many inspections, which are outlined in our improvement resource. Several trusts benefitted from the use of maternity safety champions. These were introduced as part of the Safer maternity care action plan, where maternity clinical networks were asked to designate a maternity safety champion to promote learning, seek out best practice and share it across the system. At one service, the board safety champion ran regular open forums both virtually and in the maternity unit to gather feedback from staff and listen to their concerns or queries. They were regularly visible and approachable on the wards, taking a proactive stance in maintaining and improving standards of care.

However, on several occasions, we heard about leaders who were not always visible. At one trust this meant that not being present prevented them from recognising the scale of issues the service faced. Here, safety champions had limited, superficial knowledge of the service and executive leaders failed to recognise the severity of issues faced within maternity. The impact of this lack of oversight and visibility was clear on our inspection – the delivery suite was chaotic and not having clear organisation or leadership hindered a calm and systematic way of working.

Information sharing

Information sharing is paramount for safe and effective care. Without it, leaders may be hampered in their ability to make effective decisions. At ward-level, when caring for women, it is essential that staff communicate well, especially during handovers, to make sure they are aware of potential risks and can deliver compassionate care.

Throughout the programme, we saw examples of good information sharing between staff and managers, but we are concerned that leaders do not always have a full picture of their service and may miss opportunities to learn. At one hospital, there were clear communication systems for sharing information from ward level to service managers, who were routinely available to respond to any issues. In addition, meeting minutes and information on notice boards displayed positive feedback to staff.

Another service had a risk and governance midwife who was responsible for sharing learning from incidents. At a different service, sharing information was an important element in safeguarding training and included examples of harm, how incidents were reported in the trust, and actions that had been taken as a result.

Reporting incidents is key to providing leaders with a clear picture of their service. Although we saw evidence of trust boards being presented with incident data, this was usually limited to incidents graded moderate and above. Given the potential issues with the grading of incidents outlined in the safety section, we are concerned that trust boards may not have the full picture of maternity incidents, themes and trends. This presents a missed opportunity for boards to check and challenge, and limits the ability of services to learn and improve.

In addition, we found no regional or local oversight of incidents reported and graded by perinatal services. NHS England regional midwifery teams, integrated care boards (ICBs) and local maternity and neonatal systems (LMNS) do not have access to the NRLS data set. Again, this could mean a missed opportunity for analysing trends, identifying inequalities and benchmarking at a local or national level.

Leadership decision-making

Clear oversight of challenges enables leaders to identify issues, make effective decisions and drive meaningful change. While we saw evidence of strong leadership and good decision-making at several trusts, we also found examples of poor decision-making and issues with vacancies within leadership teams.

One service exemplified how effective leadership, governance and culture can drive and improve the delivery of high-quality, person-centred care. Here, staff at all levels demonstrated commitment to sharing data and using information proactively to drive internal decision making as well as system-wide working and improvement. Another service had a clearly defined management and leadership structure, led by a triumvirate comprising a divisional director, midwifery director, and associate medical director for obstetrics, gynaecology and neonatology. This helped leaders to make effective decisions based on a clear understanding of the challenges faced by the service.

However, we also saw instances of poor decision-making, which was sometimes compounded by a lack of leadership support and communication. For example, a small number of services did not always collect and analyse reliable data, which meant they were unable to make effective decisions and drive improvements. We also saw evidence of a lack of decision-making where, following a period of instability within the leadership structure across the trust, a number of senior posts remained vacant. This led to delays in implementing improvements.

Leadership vacancies for maternity services are a problem. We saw a high turnover of staff in senior leadership roles in some trusts. We could also correlate this with our ratings of the well-led key question. Maternity services usually have a head of midwifery and/or a separate director of midwifery who reports to the trust's chief nurse. In addition, there are maternity leadership roles in ICBs, NHS England's regional teams and other bodies such as MNSI, and NHS Resolution. Some midwives expressed concern that there was only a finite pool of capable leaders, which makes recruiting for these posts challenging. While there is no doubt maternity services need leaders who understand the complexities of delivering a safe maternity service, there may be a further argument to explore the greater need for effective, strong compassionate leaders, supported by maternity experts.

Leadership response to staff concerns

The final report of the Ockenden review highlighted that many members of staff reported a fear of speaking out as well as a culture of 'them and us' between midwifery and obstetric staff. As we previously raised in our Safety, equity and engagement in maternity services report, the result of this is 'working in a silo', which can have a hugely detrimental impact on women, particularly when concerns need to be escalated. During the inspection programme, although we found some good examples of leaders engaging with staff about their concerns, this was not always the case. Where there was a failure to listen and respond to issues about safety, this put women and babies at risk of preventable harm.

But it was encouraging to see instances of leaders being responsive to concerns.This included holding listening events, displaying 'you said, we did' posters and at one service, having non-executive directors undertake regular safety walkabouts to give staff an opportunity to voice concerns.

A key component of an open culture is creating an environment where staff feel supported to raise concerns. We were pleased to see many members of staff feeling able to speak to leaders about difficult issues and incidents. Issues were raised through a number of routes, including Freedom to Speak Up teams, guardians or ambassadors, who supported staff when they wished to voice their concerns.

However, on a small number of inspections we found that while some staff felt that they could speak up when they needed to, not all of them felt that leaders always listened to them or felt confident that the organisation would address their concerns. This could contribute to a poorer culture where staff are deterred from raising concerns in the future, and ultimately opportunities to improve care may be missed.

At another service, we were concerned to hear that staff had raised issues directly to senior leaders several times regarding safety and staffing levels, but did not see the quick action or improvement they had expected. A similar picture emerged at another service, where we heard there was sometimes unkindness between staff and that following incidents, leaders did not provide compassion and support.

Governance

Effective governance structures support the flow of information from frontline staff to senior managers and trust boards, ensuring leaders have the insight needed to make effective decisions and vital improvements. While some of the services we inspected had clear and established governance processes in place, this varied between trusts. Without effective governance processes, leaders do not have oversight of the risks and issues in maternity services and cannot address them in a timely way.

In a small number of services with limited oversight at board level, opportunities to address issues were missed. This meant, for example, that leaders only heard about the impact of an understaffed triage and delays in medical care when staff raised concerns, rather than regularly monitoring key areas on an ongoing basis using performance metrics. A review of board papers for 7 NHS trusts by the Sands and Tommy's Policy Unit raised questions over the ability of boards to fully understand the performance of maternity units. It highlighted a need to step back and reflect on metrics over a longer timeframe, as well as ensuring sufficient time for meaningful scrutiny.

While some trusts had well-established maternity governance teams, in other services, the teams were under-resourced. This was sometimes because of staffing pressures and the need to redeploy governance teams to provide frontline care. There are further opportunities to explore the skill mix within governance teams and make use of generalist risk and governance expertise when required. At times, we found an over-reliance on using midwives rather than recognising the different benefits that a non-maternity team member who is trained in the fundamentals of governance and risk can contribute.

Many of the concerns we identify in this report are about the fundamentals of safe care and treatment and are similar to the requirements in any other healthcare service.

Vision and strategy

It is vital that leaders ensure there is a shared strategy, and that staff understand and support the vision, values and strategic goals. Staff need to be clear on how their role helps in achieving these goals and be motivated to work towards them. Where staff had the opportunity to develop the strategy at a local level, this resulted in an engaged and motivated workforce, with staff who not only understood the service's vision and how to apply it to their roles, but were also able to explain the vision to women.

In a small number of services, we were concerned to find an absence of a maternity-specific vision and strategy, or that the overall trust vision and values did not include maternity services. The nature of maternity care means that attempting to apply broad visions of principles is likely to be an ineffective approach and could fail to recognise the unique position of women using maternity services. Having a specific maternity strategy helps staff ensure their services are responsive, evidence-based, and sustainable. In a minority of cases, although services had a strategy, they failed to communicate it well to staff, meaning they were prevented from understanding how their work contributed to the wider vision.

Gathering feedback and handling complaints

As a regulator, we believe people using care services, their carers, families, friends and advocates are the best sources of evidence about their lived experiences of care, and we champion this in our work. We are also clear about our expectation of services: providers should make it easy for people to share feedback or raise complaints about their care, treatment and support.

In several services, we were encouraged to see how staff effectively handled feedback from their investigation of incidents, both internal and external to the service. At one service, the governance midwife collated feedback to identify themes or trends related to health inequalities and included these in staff training and feedback sessions. At several other services, staff knew how to acknowledge complaints and women received a response from managers after the investigation into their complaint.

Conversely, in a smaller number of services, feedback was not handled as well. For example, at one service, there was limited evidence that changes had been made following feedback. At a different service, we were concerned to hear that senior staff sometimes took several months to review feedback, with staff reporting limited meaningful action and improvement following feedback. A lack of serious consideration of feedback or delay in taking action presents a missed opportunity for trusts to make vital improvements at an earlier stage of risk of harm and increases the likelihood of mistakes being repeated.

We urge system leaders to prioritise improvements in maternity services, both from a cultural and financial perspective, to drive much-needed change.

> We recommend NHS England ensures trusts are proactively managing succession planning in midwifery services, and, in line with recommendations from Leadership for a collaborative and inclusive future review, supports midwifery and obstetric staff to become effective future leaders.

Evaluation of the programme

As part of our work, we commissioned The Healthcare Improvement Studies Institute (THIS Institute) at University of Cambridge, with RAND Europe to evaluate our inspection programme and to identify where we can improve.

The evaluation had 2 objectives:

- to characterise what good safety culture looks like in maternity services and the factors underpinning it
- to evaluate the national maternity inspection programme to maximise learning.

Here, we look at the findings from the programme evaluation.

THIS Institute interviewed CQC inspectors, staff managing the programme and staff from inspected provider organisations (23 interviews in total). They also reviewed internal and external programme documents, including anonymised inspection notes, and undertook a literature review of the evidence for regulation with a particular focus on inspection.

Key findings from the evaluation include:

- The programme ensured that maternity remains a high priority in NHS trusts and gave greater momentum to current improvement initiatives.
- Our focus on equality and diversity further highlighted these issues in maternity settings. Although inspectors were keen to include these considerations in their inspections, the focus was brought in later in the programme. Therefore, assessment materials were not always designed in a way that made it easy for inspectors to consistently capture relevant information.

- The programme placed demands on maternity services, which sometimes struggled to provide the information we requested at short notice ahead of inspections. Our inspection visits were perceived to add to already high levels of scrutiny from regulatory and quasi-regulatory bodies.
- The scale of issues identified on inspection meant that the process was more involved than had been anticipated – both for services and for CQC colleagues. The programme was planned and delivered very quickly, which also introduced challenges.
- Some staff in maternity services said they were uncertain about the effectiveness of the inspection process, which made them question the consistency and validity of the ratings produced in some cases. Staff told us this was partly because of how they perceived the inspectors used discretion when making judgements, and that they felt the reasoning behind judgements was not always made transparent. Some staff also shared that including inspectors in the programme who had less direct maternity expertise and experience might have resulted in judgements they felt to be less robust.

Following the evaluation and feedback from inspectors, we are exploring what changes we can make to improve inspections of maternity services.

The role of inspection

The National Maternity Inspection Programme used inspection as the primary tool for gathering evidence. The evaluation therefore focused on the role of inspection as an effective regulatory tool.

From the evidence reviewed, the evaluation reported general agreement that inspection is a vital part of effective and accurate regulation, since some aspects of quality, safety, culture and leadership are difficult to assess through secondary sources. To gather enough evidence across the wide range of factors that contribute to high-quality care, inspections need to use methods that look at specific and observable activities as well as more complex features such as culture, vision and innovation.

The evaluation highlights the benefits of principle-based inspection, rather than inspection that is based on the use of strict rules and prescriptive standards. Principle-based inspection allows inspected organisations to respond to regulators in flexible, adaptive, and reasonable ways. It empowers professionals to take ownership while also supporting inspectors to exercise discretion. However, in applying discretion, the consistency of inspections may be challenged.

Going forward, inspections will remain an important part of how we regulate. Since delivering the National Maternity Inspection Programme, we have moved to our new assessment approach. As part of this approach, we'll gather evidence to support our judgements in a variety of ways and at different times – not just through on-site inspections. This means inspections will support this activity, rather than being our primary way to collect evidence. We know that observational methods, such as inspection, have a clear role in capturing evidence about cultures in care settings. The findings from the National Maternity Inspection Programme presented in this report suggest there is a clear need to continue to use inspection as part of our assessment of maternity settings.

The learning from the evaluation has given us helpful principles to consider when delivering inspections. This includes how we might use additional checks and balances to review judgements made by inspectors.

Learning opportunities

In addition to considerations for how we undertake inspection activity well, the evaluation has helped shape the following learning opportunities:

- Improve the alignment with other oversight bodies, including those who provide improvement support, to reduce demands on services. This can include careful consideration of the scheduling of visits and timing of information requests. It could also involve timely data sharing between us and other bodies to enable comprehensive judgements of risk that tell the whole story.
- Identify opportunities to use data that is specific to maternity services and distinct from data at trust level to help us delve deeper into risks and issues in a more targeted way. This will help us with our continuous monitoring of risk and reduce the scale of issues uncovered in inspection.
- Continue to improve how we assess equality and diversity in maternity settings to ensure this remains a central focus and key priority for services. This can include improving internal processes and systems for evidence gathering of specific equality and diversity information.
- Focus on building trust and positive relationships with maternity settings to encourage regulation to be seen as a factor that contributes to improvement. Positive feedback from inspected trusts as part of the programme welcomed kindness from inspectors and a thoughtful and supportive approach.
- Share more information with providers due to be inspected as part of focused programmes to create shared expectations and improved awareness of the information we will be reviewing.
- Improve how we plan focused programmes to ensure there is sufficient time to provide further learning and development opportunities to inspectors who have less experience in specialised settings and to ensure we can secure the involvement of specialist advisors.

Despite the challenges, regulation remains critical in maintaining safe levels of care and driving improvements in sectors like maternity, where we know systemic issues persist. We have a clear role in outlining the quality of care that people should expect and holding services to account if they fail to meet these standards. Learning from this evaluation will help us to carry out this role in the future.

Wirral University Teaching Hospital NHS Foundation Trust

Appendix 9 CQC National Review of Maternity Services in England 2022-2024 Report: GAP Analysis

Title of report:	**National Review of Maternity Services In England 2022 to 2024 (CQC)** - **Maternity Improvement Resource**	**Link to report**	Recommendations - Care Quality Commission (cqc.org.uk) Maternity improvement resource - Care Quality Commission (cqc.org.uk)
Date report received:	**19/09/2024**		
Review Lead:	Danielle Chambers, Quality and Safety Matron for Maternity Services	**Date completed:**	24/9/2024
Compliance Status Please highlight:	**Partially compliant**		

This exercise has been conducted to understand our current position at WUTH against the 'Maternity Improvement Resource'. This resource was developed by CQC following their National Review of Maternity Services in England 2022-2024.

4 Main themes were identified by CQC nationally:

- Triage
- Incidents
- Leadership and Culture
- Health Equity

The following table outlines CQC expectations surrounding these themes going forward, our current position as a trust in relation to these and what improvements are required locally to be fully compliant with the hallmarks of a good maternity service as outlined within the resource. This report is applicable to maternity services. In this report we refer to 'women', but we recognise that some transgender men, non-binary people and people with variations in sex characteristics or who are intersex may also use maternity services and experience some of the same issues. As areas have demonstrated partial compliance, this document is accompanied by actions to support delivery of compliance.

No.	Standard	Compliance	Evidence of compliance	Action	Owner	Date due
Triage: Telephone Triage						
1.	There is standardised documentation to minimise the risk of potential error.		Triage telephone call log in alignment with BSOTS/RCOG as per triage guideline.	No further action		
2.	There is a dedicated telephone triage line, which is in a protected place and as an emergency line 24 hours a day. There are continuity plans in place in the event of staff absence.		Triage telephone line in place 24/7. Escalation procedure in place in event of staff absence.	Explore the option of a protected room opposed to a hub; suggested FMU area to be utilised and Pink notes room to become office space	Ali Campion (AMP) / Dawn D'arcy (ANC Manager)	31/03/25
3.	Telephone triage call answering and abandonment rates are monitored.			To explore with Cisco lead if this an option and report available	Jo Lavery, Divisional Director of Midwifery	31/12/24
4.	Documentation on the call and advice given is recorded, with the ability to monitor repeat callers to identify deteriorations in condition.		Paper Record in place at present; IT, Cerner and BSOT's	BSOT's paperwork to be electronic would be the preferred option and to be explored	Ali Campion (AMP)	31/03/25
5.	Telephone triage calls are audited cyclically to ensure compliance with the trust policy, and improvements implemented when needed.		Consider feasibility of call recording feature for triage to enable audit and also use of these when investigating clinical incidents.	No further action		
Triage: In-person triage						

6.	A prompt and brief assessment within 15 minutes, including a physiological assessment using a standardised obstetric early warning score.		Triage guidance stipulates prompt and brief assessment within 15 minutes of arrival. This is as per BSOTS. A.Campion (AMP) completes monthly audit which includes initial assessment times.	Please ensure monthly stats are shared with governance team so that these can be monitored and shared up to quad and board level. Consider monthly triage stats infographic.		
7.	Triage assessment and prioritisation is carried out by clinical staff who are trained in triage.		Included in preceptorship; Block C, PROMPT annually and additional individual as required	Ensure continues annually	Sarah Weston (Practice Development Midwife)	Ongoing
8.	The seated waiting area is in the direct line of sight of clinical staff.		On going assessments take place within designated waiting room following initial assessment	Review current layout of triage and feasibility to improve waiting area visibility.	Ali Campion (AMP) / Dawn D'arcy (ANC Manager)	31/12/25
9.	There should be standardised assessment, investigations, and ongoing management processes.		Triage guideline utilises BSOTS standardised assessment, investigations and ongoing management processes. BSOTS proformas available within triage.	No further action		
10.	Contemporaneous documentation using standard templates.			No further action		
11.	Centralised monitoring of activity within triage to monitor the flow through the department.		White board in situ and central monitoring	No further action		

12.	The activity within maternity triage is included with the maternity safety huddle, and triage activity is included in the consultant led ward rounds twice a day.		Middle grade (ST1-2) to cover on the rota maternity triage/MDU core hours to achieve Gold standard RCOG guidance Safety huddle to be implemented on triage	Business case for medical staffing Interim solution to ensure consultant on call attends triage. Implement safety huddle daily	Lucy Kilgallon (Directorate Manager) / Mustafa Sadiq (Obs Consultant) Dawn D'arcy (ANC Manager) / Kirsty Chambers (Matron)	31/03/25 31/10/24
13.	Information about women's triage care and treatment, and their outcomes, is routinely collected and monitored. This information is used to improve care. Outcomes for women who use services are positive, consistent and meet expectations. Feedback is actively sought from women and staff to improve the service.		Audit monthly; FFT in place; 15 steps annually; MNVP feedback	No further action		

14.	Accurate and up-to-date information about triage services is audited and escalated so that there is board oversight of activity and the effectiveness of maternity triage. Audit data is used to improve care and treatment within the triage service, including call answering and abandonment rates in telephone triage.		Audited; included in Quality Assurance report	No further action		
Managing Safety Incidents						
15.	Staff are encouraged to report any safety incident without fear for reprisal and provided with the time to do so.		Information/resources shared on all annual staff updates and induction education sessions surrounding no blame culture, just culture, systems-based approach to investigation and positive impact of high reporting. Positive feedback provided to those who report incidents. Re-assured no wrong route to reporting. PSIRF fully embedded within trust.	No further action		
16.	There is an open and transparent safety culture, encouraged throughout the service. All staff understand and fulfil their responsibilities in raising concerns and report incidents and near misses. All		Safety culture actively promoted at annual training updates and safety champions walk abouts. Freedom to speak up guardian services advertised and promoted.	No further action		

	staff are fully supported when they do so.					
17.	When reporting incidents and near misses, protected equality characteristics of the woman are recorded routinely and considered as part of the review to identify themes and trends.		Protected characteristics are included within the Ulysses incident reporting system although these are not a mandatory field so are not always captured. Although these are considered as part of the review processes, we need to strengthen our evidence of this.	Add to all reviews section: Protected characteristics?/Where protected characteristics considered to have had an impact on care? Improve data collection on protected characteristics in respect of promoting staff to enter these on Ulysses and ensuring they are captured when this has not been done. Include within a monthly quality assurance report	Joy Watkinson, (Risk Midwife)	31/12/24
18.	When reviewing safety outcomes, trends are identified for women from ethnic minority groups and action is taken to respond to any risk factors.		In respect of safety outcomes these are currently captured via our local dashboards, however they are not currently correlated against ethnicity.	Review current dashboard to consider how we can best capture outcomes in relation to ethnicity.	Jo Lavery (Director of Midwifery)/Jo Silcock, (Data Analyst)	31/12/24
19.	All maternity staff understand the importance of collecting demographic information and how it is used to improve outcomes for women.		Included in PROMPT and Trust mandatory training	No further action		

20.	The maternity service breaks down data by levels of deprivation and targets improvement initiatives to areas with the highest deprivation.		Continuity of carer model mapping exercise completed to ensure teams targeting areas of highest deprivation.	Explore to strengthen data monitoring of deprivation. Suggestion that deprivation scoring be introduced into booking appointment and reports can be accessed	Angela Kerrigan, (Consultant Midwife)	31/01/25
21.	When something does not go as planned, a thorough review or investigation is undertaken and involves all relevant staff, the woman, and their family.		PSIRF fully embedded. Staff involved in incidents are invited to REC meetings. The woman and family are asked for their viewpoints following events, but this is ad hoc and not currently captured formally in process.	Consider PIL for patients and families involved in incidents.	Danielle Chambers, (Quality and Safety Matron for Maternity Services).	31/12/24
22.	Questions of the woman and their family should be answered in full as part of the review process.		This is fully embedded within the PMRT process, as all families are offered at least 2 opportunities to ask questions. This however needs formalising at REC level.	Introduce process for obtaining family questions to be incorporated into REC process.	Danielle Chambers, (Quality and Safety Matron for Maternity Services).	31/12/24
23.	Women leave hospital with all the information they need to be able to process their individual birth experience. If a woman requests a conversation with a member of the multi-disciplinary team about their birth prior to them leaving hospital, this should happen. However, when this is unachievable, women should be informed of the next opportunity for this conversation to happen.		Debrief offered prior to discharge; offered by community / continuity midwife; Birth option and debrief clinics available by appointment via pathway	No further action		

24.	For those cases referred to a review panel, women are invited to attend and supported to co-produce improvements for future service provision and reviews.		As part of current PMRT process women and families are not invited routinely to attend review panels, however if this is requested it is facilitated. Patients and families have some input into producing improvements through their PMRT feedback forms, however co-production of improvements and reviews could be strengthened.	Review current patient correspondence surrounding PMRT panel reviews to incorporate options for patients and families to attend the reviews. Review current process to ensure families are able to review draft PMRT reports prior to finalisation. Include section in family feedback form for them to provide recommendations on future improvements.	Hannah Blake, Bereavement Midwife / Joy Watkinson, Risk Midwife.	30/11/25
25.	The maternity service actively participates in learning with other providers within the local maternity and neonatal system.		Senior attendance at MNSOG meetings whereby cases/learning from across local maternity and neonatal system is shared. Themes are identified and helps to direct areas of focus.	No further action		
26.	Learning is communicated widely and through a variety of different methods to support improvements in throughout the trust, as well as services within the local maternity and neonatal system.		Learning templates and reports from incidents are shared locally an up to board through patient safety learning panel, trust mortality group and also via board level assurance reports. Service leads attend regional meetings to share learning.	No further action		

27.	External safety events and patient safety alerts are considered and reviewed by the service and shared with staff.		Any national learning reports receive benchmarking exercises and action plans to address. Safety events and learning are shared amongst all teams via safety huddles, quality assurance report, learning and development pages etc.	No further action		
28.	Improvements made following learning from reviews within the service, trust or the wider local maternity and neonatal system, the resulting changes are monitored through audit and the effectiveness is reviewed.		Current audit response is limited due to limited resources within team.	Audit of improvements require to monitor effectiveness and close the loop	Danielle Chambers, (Quality and Safety Matron for Maternity Services).	31/01/25
Healthcare Equity						
29.	The needs and preferences of different women with protected characteristics under the Equality Act are considered when planning, delivering and coordinating the maternity service.		Development of personalised care plans and works ongoing to deliver training	Action plan underway	Angela Kerrigan	31/01/26
30.	Maternity services collaborate with other services and providers to provide a holistic package of support for women.		Collaboration with a range of specialist services	No further action		
31.	The maternity service liaises with women, their families and carers to ensure all partners are informed of any diverse needs that should to be addressed.		Embedded in practice	No further action		

32.	Any reasonable adjustments are made and communicated, and action is taken to remove barriers when women struggle to access services.		Partially compliant; assurance required on consistency for all women; MCoC teams in place for majority of vulnerable women / birthing people	Audit current position to identify any improvements and potential changes to current pathways (utilise auditable standards)		
33.	The maternity service routinely collects and uses ethnicity data as part of their incident reporting process. When reviewing safety outcomes, trends are identified for women from ethnic minority groups and action is taken to respond to any risk factors.			Review ulysees incident form to mandate field	Joy Watkinson, Risk Midwife.	31/03/24
34.	All maternity staff understand the importance of collecting demographic information, and how it is used to improve outcomes for women.			No further action		
35.	The maternity service breaks down data by levels of deprivation and targets improvement initiatives to areas with the highest deprivation.			No further action		
36.	The provision of translation and interpretation services is readily available for women whose first or preferred language is not English or those who are deaf. Adjustments are made for women who are unable to read.			No further action		

37.	Maternity services actively promote equality and diversity within their workforce. If there are any areas of inequality identified action is taken to remove them. Staff, including those with protected characteristics under the Equality Act, feel they are treated equitably.		EDI Trust strategic agenda	No further action		
38.	Maternity leaders at all levels promote equality and diversity. They encourage pride and positivity in the maternity service and focus attention on the needs and experiences of women who use the service.			No further action		
39.	Behaviour and performance that are inconsistent with the vision and values is identified and dealt with swiftly and effectively, regardless of seniority.			No further action		
40.	A full and diverse range of people's views and concerns is encouraged, heard and acted on to shape services and culture.			No further action		
41.	The service proactively engages and involves all staff (including those with protected equality characteristics), and ensures that the voices of all staff are heard and acted on to shape services			No further action		

	and culture.					
Leadership and Culture						
42.	The leadership, governance and culture of the service promote the delivery of high-quality person-centred care.			No further action		
43.	Maternity leaders should have the experience, capacity, capability and integrity to ensure that the maternity strategy can be delivered and risks to performance addressed.			No further action		
44.	Maternity leaders at every level, including board safety champions, should be visible and approachable. Compassionate, inclusive and effective leadership is sustained through a leadership strategy and development programme and effective selection, deployment and support processes and succession planning.			No further action		

45.	The maternity leadership should be knowledgeable about issues and priorities for the quality and sustainability of their maternity services, understand the challenges and act to address them.			No further action		
46.	There is a clear statement of vision and values within the maternity service, which is driven by quality and sustainability. The vision and values have been translated into a robust and realistic maternity specific strategy with well-defined objectives, which are achievable and relevant. The vision, values and strategy should have been coproduced with women and staff. The maternity strategy should be aligned to local maternity and neonatal system (LMNS) and integrated care system (ICS) plans in the wider health and social care economy and services are planned to meet the needs of women.			No further action		
47.	Progress against delivery of the maternity strategy is monitored and reviewed, and there is evidence of this.			No further action		

48.	All staff in the maternity service know, understand and support the maternity specific vision, values and strategic goals and their role in achieving them.			No further action		
49.	Maternity leaders consistently demonstrate and encourage compassionate, inclusive and supportive relationships among staff so that they feel respected, valued and supported. Maternity leaders should at every level: live the vision and embody shared values prioritise high-quality, sustainable and compassionate care promote equality and diversity.			No further action		
50.	Pride and positivity are encouraged within the maternity service with a focus on the needs and experiences of women and their families. Where behaviours and performance are inconsistent with the maternity vision and values they should be swiftly identified and dealt with effectively, regardless of seniority.			No further action		
51.	Maternity leadership actively promotes staff empowerment to drive improvement, and raising concerns is encouraged and valued.			No further action		

52.	Maternity leaders promote and actively contribute to an environment of continuous learning.			No further action		
53.	There is a psychologically safe environment that enables maternity staff to actively raise concerns and leaders ensure they are supported.			No further action		
54.	Candour, openness, honesty, transparency, and challenges to poor practice are the norm.		Duty of candour evidence FTSU Included on annual training	No further action		
55.	Concerns are investigated sensitively and confidentially, and lessons learned are shared through a variety of methods and acted on.		L&D Social media platforms PMa reflection	No further action		
56.	When something goes wrong, women receive a sincere and timely apology and are told about any actions being taken to prevent the same happening again.		Embedded in practice	No further action		
57.	The maternity team demonstrate a collective responsibility of care, where conflicts are resolved quickly and constructively and responsibility is shared.			No further action		
58.	Maternity staff at every level are supported in their development and this includes high-quality appraisal and career		Appraisals >90% within maternity; succession planning plan in place; opportunities for career	No further action		

	conversations.		progression			
59.	Equality and diversity are actively promoted within the maternity service, the cause of any workforce inequality are identified and action taken to address these. All maternity staff, including those with protected characteristics under the Equality Act, feel they are treated equitably.			No further action		

To: Jo Lavery, Director of Midwifery

Cc: Samantha Westwell, Chief Nurse
Mustafa Sadiq, Obstetric Clinical Lead
Katherine Wilkinson, Head of Midwifery

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28 October 2024

Dear Jo and Team

Thank you so much for hosting our Regional Maternity Team annual visit on the 23 October 2024. It was a fantastic opportunity for us to hear directly from the team about your journey over the last 12 months, celebrate improvements in your services as well as hear about your plans for the coming year.

It is clear from your presentations there has been a huge amount of work going on throughout the maternity services. We were particularly impressed with the work shared in relation to the bereavement services, research projects, your governance process and team / structure noting that this remains directly under your leadership as we would expect and always recommend. We did however highlight some areas of focus requiring further review pertaining to the new PSIRF guidance regionally for maternity services.

We were very impressed by the commitment and engagement of your NED safety champion and really welcomed the update he provided; it was very reassuring. It was also an honour to be able to present Kat with her MSW CMidO award and hear about the amazing work she is doing supporting service users in the community.

We were grateful that Steph, your MNVP lead, was able to join us for the day too. Ensuring service users are at the heart of everything we do is key to improving services and experiences for all. It was good to hear directly from Steph about some of the challenges and successes she was able to share with us. We felt privileged to hear her personal story and her unique perspective on your maternity services. It was great to see, even after a short space of time in post, she is having such a profound impact and is already truly embedded into the team.

During our feedback we shared how positive the visit had been. It was clear from the time we spent together that you are a cohesive, collaborative and well-functioning Quad and senior leadership team. We also acknowledge some of the challenges you are currently facing with increasing rates in Induction of Labour and categorisation of caesarean sections when elective demand is high. We suggested that this is area where further data is required.

We also raised that the portfolio of the Associate Director of Nursing and Midwifery (ADNM) for Women and Children's is extensive, and we would welcome understanding more about the leadership structure which supports the function of this role, or the consideration of reviewing the size of this current portfolio when maternity services continue to be under the spotlight for safety and quality, both locally, regionally and nationally. We are aware there is

a Head of Midwifery but would be keen to understand if similar posts are in place in the other specialities that the ADNM is responsible for as a minimum.

An area we would like you to pay some further attention to is that of the triage service as we felt there were some urgent gaps that need to be closed regarding to this care pathway, including:

- Telephone Triage including dedicated midwife / 3rd midwife for triage
- Triage waiting room including eyes on or intentional rounding
- Location of Triage, especially out of hours, not collocated to the Labour ward

Our final point related to midwifery staffing. We were concerned that the establishment set through BirthRate+ (BR+) is no longer enough for the acuity and complexity of your service. We discussed that you have a BR+ assessment in progress, which is great news. However, we reminded you that BR+ is the minimum establishment requirement and you will need to ensure your professional judgement is included in any request for an increase in establishment from the Board.

Thank you again for sharing all the excellent initiatives and improvements. We were really impressed with all the hard work, dedicated and passion from the leadership team and this is reflected in staff we had the pleasure to meet on the day.

If you could share your presentation from the day for our records, we would be extremely grateful, and please do not hesitate to contact the team is there is anything we can do to support you and your team.

Sincerely

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