

Appendix 1				
Theme	Detail of metrics used for WUTH Perinatal Quality and Safety Model (PQSM)	Number	RAG	Narrative / Actions taken
Clinical Care	Number of stillbirths	2	Green	x 1 25/40 and x1 30/40
	Number of neonatal deaths (before 28days) at WUTH	1	Green	Term death, MNSI case; delayed ambulance transfer from home to hospital
	Number of maternal deaths (up to 28 days following delivery)	0	Green	No maternal deaths
	Post partum haemorrhage >1500mls	2	Green	All reviewed via CIF process; no issues in care identified
	Rates of HIE where improvements in care may have made a difference to the outcome	1	Green	No HIE
	Number of occasions where the Delivery Suite Coordinator is not supernumerary at start of shift	0	Green	REC and MNSI: ambulance delay and care withdrawn
	Number of times when the Delivery Suite Coordinator is not supernumerary for a period of one hour or more during a shift	0	Green	Maintain shift leader to be supernumerary at start of shift and throughout as best practice
	% Compliance of 1:1 care in labour	99%	Green	Data captured via 4 hourly BR Plus activity/quality, achieved 100% of time, escalation processes followed to revert to supernumerary status within 1 hour
	% Consultant presence at delivery when indicated (as per RCOG Guidance)	100%	Green	Monthly audit as per RCOG guidance and guidance updated to reflect RCOG; submitted as part of MIS Year 6
	Midwifery staffing is below BR+ Acuity	Yes	Green	P/N Ward acuity consistently in the Red RAG rating for acuity/activity, BR Plus report awaited
	Midwifery staff absence rate in month (sickness)	8.35%	Green	Trust processes implemented and additional support offered by HR for hot spot areas; above Trust recommended target
	Midwifery vacancy rate	<3%	Green	Low vacancy rate consistently reported; 3.96 w/e vacancy permanent
	Midwife : Birth ratio	01.26	Green	Within parameters
	Number of times transfer in to the Neonatal unit for Level 3 care has been declined to internal transfer	0	Green	Nil
	Number of times transfer in to the Neonatal unit for Level 3 care has been declined to external transfer	0	Green	Nil
	BAPM compliance - Neonatal medical staff	Partial	Green	Consultant recruited; org change underway for 24/7 cover at weekends to achieve BAPM compliance
	BAPM compliance - Neonatal nursing staff	Yes	Green	Workforce report to BoD annually demonstrates compliance
	Number of times Maternity unit has been on divert/closed to admissions	0	Green	Nil
	Total number of Red Flags reported	13	Blue	See report
	Service user	Staff survey	37%	Green
COC National survey		Yes	Green	Published and action plan in place; repeat due Feb 2025; report to BoD at next quarterly report
SCORE Survey		Yes	Green	Participated in 2024; facilitated workshops and ongoing action plan
Feedback via Deanery, GMC, NMC		No	Green	Nil of note
% Consultant presence at delivery when indicated (as per RCOG Guidance)		100%	Green	Monthly audit as per RCOG guidance and guidance updated to reflect RCOG; submitted as part of MIS Year 6
Interdisciplinary and relationships	New leadership within or across maternity and/or neonatal services	Yes	Green	Delivery Suite Manager and Ward Manager Band 7 posts out to recruitment; interim measures in place
	Concerns around the culture / relationships between the Triumvirate and across perinatal services	Nil	Green	Good working relationships between teams / directorates
	False declaration of CNST MIS	No	Green	MIS Year 6 to be submitted by 3/3/25; manual validation being requested for Safety Action 1
	Concerns raised about other services in the Trust impacting on maternity /neonatal services e.g. A&E	No	Green	Nil of note
Safety and learning culture	Concerns raised about a specific unit e.g. Highfield Birthing Unit	Yes	Green	Maternity ward concerns re: staff attitude, poor food options and inadequate pain relief; action plan and close weekly monitoring; co-production with MNVP
	Lack of engagement in MNSI or ENS investigation	No	Green	Positive feedback quarterly review meetings and transparency through number of rejected cases
	Lack of transparency	No	Green	Robust governance processes
	Learning from PSIR, local investigations and reviews not implemented or audited for efficacy and impact	No	Green	Learning shared internally and via MMSG (NW region)
	Learning from Trust level MBRRACE reports not actioned	No	Green	Nil of note
Incident reporting	Maternity/Neonatal Safety Champion concerns; negative feedback; escalation	Nil	Green	Regular safety champion meetings and walkabouts; all feedback actioned and feedback given
	Recommendations from national reports not implemented	Yes	Green	COC inspection publication action plan in progress to address quality improvements in line with recommendations; report to BoD quarterly progress
Governance processes	Number of PSIRF reported incidents graded moderate or above	3	Green	Reporting for Jan 2025
	Number of Maternity or Neonatal PSI's	0	Green	Robust PSIRF framework followed
	Number of cases referred to MNSI	1	Green	x 5 ongoing cases
	Delays in reporting a PSI where criteria have been met	0	Green	N/A
	Never Events which are not reported	0	Green	N/A
	MNSI/NHSR/COC with a concern raised or a request for information	0	Green	N/A
	Recurring Never Events indicating that learning is not taking place	0	Green	N/A
	All safety action 1 report to MBRRACE within timeframe to include FQ's	Yes	Green	Since data entry error all cases and FQ's reported as MIS timescales
	Poor notification, reporting and follow up to MBRRACE-UK, NHSR ENS and HSIB	0	Green	N/A
	Unclear governance processes / Business continuity plans not in place	Nil	Green	Clear governance processes in place following PSIRF; awaiting revised publication for maternity services expected 2025; LMNS feedback required assurance of governance referrals to external organisations are made by maternity MDT team and not central governance
Ability to respond to unforeseen events e.g. pandemic, local emergency	Yes	Green	Maternity and Neonatal services responded to a major incident with	
Number of maternity/neonatal risks on the risk register overdue	0	Green	Nil	
Number of maternity/neonatal risks on the risk register with a score >12	11	Green	INWU estates and IPC - plans to address; all reviewed up-to-date with mitigation and actions	
COC Inspection with BSC or NHSR/HSIB request for support	DHSC or NHS England Improvement request for a Review of Services or Inquiry	No	Green	Nil to report this month
	Coroner Regulation 28 made direct to Trust	No	Green	COC reports published in April 2023 'GOOD' for maternity services
	An overall COC rating of Requires Improvement with an Inadequate rating for either Safe and Well-Led or a third domain	No	Green	N/A
	COC rating overall	GOOD	Green	N/A
	Been issued with a COC warning notice	No	Green	N/A
	COC rating dropped from a previously Outstanding or Good rating to Requires improvement in the safety or Well-Led domains	No	Green	N/A
	Been identified to the COC by HSIB with concerns	No	Green	N/A
<p>Red indicates non-compliant Amber indicates partial compliance / work underway Green indicates meets compliance Blue indicates for information and no metric parameter</p>				

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	
LMNS Peer Assessor Names	Debby Gould, LMNS Q&S Lead

Background

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

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

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

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

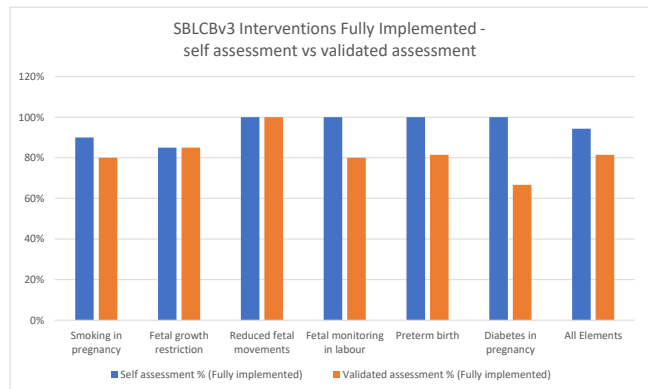
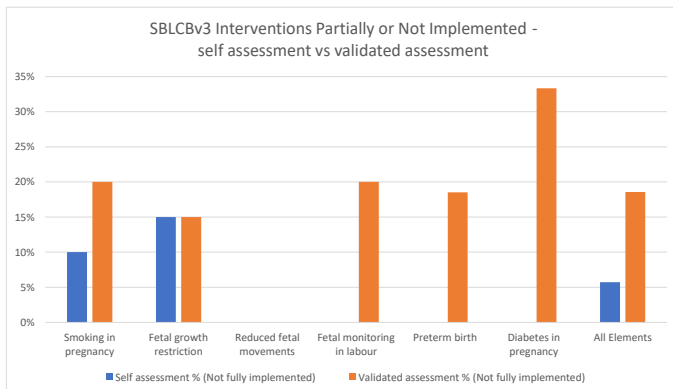
As part of the Three Year Delivery Plan for Maternity and Neonatal Services, all NHS maternity providers are responsible for fully implementing SBLCBv3 by March 2024.

Implementation Grading

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

Implementation Progress

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)	NHS Resolution Maternity Incentive Scheme
Element 1	Smoking in pregnancy	Partially implemented	90%	Partially implemented	80%	CNST Met
Element 2	Fetal growth restriction	Partially implemented	85%	Partially implemented	85%	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	81%	CNST Met
Element 6	Diabetes	Fully implemented	100%	Partially implemented	67%	CNST Met
All Elements	TOTAL	Partially implemented	94%	Partially implemented	81%	CNST Met



Action Plan

Element 1

Intervention Ref	Self-Assessment Status	LMNS Validated Assessment Status	LMNS Recommendation of Actions Required	LMNS Suggested Improvement Activity
INTERVENTIONS				
1.1	Fully implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Trust SOP meets requirements (due for review in Sept 26). MSDS DQ check passed in July 24 (screenshot uploaded by LMNS).
1.2	Fully implemented	Fully implemented	Focus required on quality improvement initiatives to meet recommended standard.	Q1 smokers (reported in Sept 24)- 92%
1.3	Fully implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Smoking status at Booking: Oct 24- 100%, Nov 24-100% Smoking status at 36/40: Sept 24- 79%, Oct 24-74%, Nov 24- 65%.
1.4	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Sept 24- 95%, Oct 24-100%
1.5	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Direct supply NRT provided by in-reach service
1.6	Fully implemented	Fully implemented	Focus required on quality improvement initiatives to meet recommended standard.	Setting a quit date: ABL data shows 28% in July 24, 42% in Aug 24 and 22% in Sept 24. Data meets broad compliance threshold at present. Action plan requires review as all actions currently blue.
1.7	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Aug 24-100%, Sept 24-100% and Oct 24-80%
1.8	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Midwifery Study Day presentation noted (VBA & CO monitoring). Session also delivered to MDT on PROMPT. Training compliance posters state 89% compliance on Midwifery
1.9	Partially implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	PROMPT presentation noted and VBA content included. All MDT staff groups achieving >90% compliance as of end of Nov
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 NCST e-learning and assessments annually (Jen and Claire due to re-complete in Nov 25).

Element 2

Intervention Ref	Self-Assessment Status	LMNS Validated Assessment Status	LMNS Recommendation of Actions Required	LMNS Suggested Improvement Activity
INTERVENTIONS				
2.1	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Noted as 100% compliant in March and April 24. Compliance sustained at 100% in May to Oct 24.
2.2	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Noted as 100% compliant in Jan 24. Compliance fell to 90% in Feb/March/April 24 and requires improvement. May 100%, June 95%, Aug 95%, Sept 95% and Oct 95%.
2.3	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	See element 1 evidence. CO and smoking status at 36/40 requires improvement.
2.4	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Oct 24 audit of mixed risk sample shows 100% compliance. Nov 24-100%, Dec 24- 100%
2.5	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Evidenced in previous submission
2.6	Partially implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Guideline updated. Email noted regarding rollout of BP monitors in February 2024.
2.7	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Audit noted as 100% compliant Jan-Dec 24. Trust to ensure future audits state doppler was completed, not just
2.8	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	PMRT summary slides accessed in Element 3 folder. No cases appear related to FGR management in Q3 24/25.
2.9	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Evidenced in previous submission
2.10	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Audit noted as 100% compliant Jan-Oct 24. Oct 24 audit of low risk sample shows 100% compliance. Nov 24-
2.11	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	November 24- MWs 90% and Obs 100%. Overall= 90% (141 of 156) so compliant at present. LMNS note incorrect percentage of 95% overall in REF2.11.
2.12	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Evidenced in previous submission
2.13	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Evidenced in previous submission
2.14	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Evidenced in previous submission
2.15	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Evidenced in previous submission
2.16	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Evidenced in previous submission
2.17	Fully implemented	Partially implemented	Evidence not in place - improvement required.	As per intervention 5.6: Twins trust Re-audit document noted from September 2023 in evidence archive.
2.18	Partially implemented	Partially implemented	Evidence not in place - improvement required.	Q1 of 2024- 46.2% noted in GROW report which meets required compliance at present. WUTH dashboard states 0% in Dec 24
2.19	Partially implemented	Partially implemented	Evidence not in place - improvement required.	Antenatal detection of SGA- WUTH dashboard states 0% for all of 2024. GAP 1.5 report (line 4A)- Q3 of 2024 was 66.7% and Q4 of 2024 was
2.20	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Evidenced in previous submission

Element 3

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

Element 4

INTERVENTIONS				
4.1	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	4a (Fetal Surveillance Study Day)- As of Nov 24- Midwives 91%, Consultants 100%, Rotational Drs- 92%.
4.2	Fully implemented	Fully implemented	Focus required on quality improvement initiatives to meet recommended standard.	SBL dashboard 2024 May 95%, June 100%, July 92%, Aug 90%, Sept 95%. LMNS note audit sample contains highest-risk cohort.
4.3	Fully implemented	Partially implemented	Focus required on quality improvement initiatives to meet recommended standard.	PMRT update noted within Powerpoint presentation- April to June 24, 0% cases relating to fetal monitoring. No new evidence uploaded.
4.4	Fully implemented	Fully implemented	Focus required on quality improvement initiatives to meet recommended standard.	SBL Dashboard 2024 states April 94%, May 83%, June 90%, July 92%, Aug 82%, Sept 92%.
4.5	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Confirmation received via email.

Element 5

INTERVENTIONS				
5.1	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Email confirmation received in Q3 24/25.
5.2	Fully implemented	Partially implemented	Evidence not in place - improvement required.	Births 16+0-23+6 was 0% in Jan-Dec 24 (WUTH SBL dashboard)- LMNS aware data is inaccurate due to preterm samples used in audits for element 5. Further data required within 5 day window as
5.3	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	100% compliance achieved since March 24. Aug 24- 100%, Sept 24- 100% sustained
5.4	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Evidenced in previous submission
5.5	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Evidenced in previous submission
5.6	Fully implemented	Partially implemented	Evidence not in place - improvement required.	Twins trust Re-audit document noted from September 2023 in evidence archive.
5.7	Fully implemented	Fully implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	See evidence in element 1-CO and smoking status at 36/40 requires improvement.
5.8	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Evidenced in previous submission
5.9	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	WUTH using Actim Partus testing. Local audit shows 100% compliance in July- Dec 24
5.10	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Evidenced in previous submission
5.11	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	WUTH SBL dashboard shows 100% compliance sustained between May 24-Nov 24, 95% in Dec 24, 100% in Jan 25.
5.12	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Evidenced in previous submission
5.13	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Evidenced in previous submission
5.14	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Staffing paper and CoC powerpoint presentation noted from previous submission.
5.15	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Evidenced in previous submission
5.16	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	100% compliance sustained between April 24 and Sept 24 (<34/40) Action plan noted.
5.17	Fully implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	NWNOON dashboard shows 43% in July 24, 68% in Aug 24, 63% in Sept 24 and 65% in Oct 24 which falls below required compliance at present.
5.18	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Evidenced in previous submission
5.19	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	NICU level site. WUTH SBL dashboard reports 100% compliance sustained
5.20	Fully implemented	Partially implemented	Evidence not in place - improvement required.	Aug 24- 86%, Sept 24- 83%, Oct 24- 58%, Nov 24-43%, Dec 24-33% Data also provided for steroids >7days before birth- May 0%, June
5.21	Fully implemented	Partially implemented	Focus required on quality improvement initiatives to meet recommended standard.	WUTH SBL dashboard states 100% compliance April 24-Dec 24 LMNS have accessed the NODN dashboard for Brain Injury and will
5.22	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Aug 24-0%, Sept and Oct 24- 75% Nov 43%, Dec 50%
5.23	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Aug 24- 57%, 67% in Sept 24, 83% in Oct 24. Nov 24- 71%, Dec 24- 50%
5.24	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	71% in Aug 24 which meets compliance, 50% in Sept 24, 42% in Oct 24. Nov 24- 71%, Dec 24- 83%

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

INTERVENTIONS

6.1	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Evidenced in previous submission. Diabetes in pregnancy guideline due for review in Oct 26. Element action plan noted
6.2	Fully implemented	Partially implemented	Evidence not in place - improvement required.	CGM Audit 100% complaint Oct-Dec 24 (n10). Ethnicity and deprivation analysis required.
6.3	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Evidenced in previous submission.
6.4	Fully implemented	Partially implemented	Evidence not in place - improvement required.	Oct-Dec 24 audit (n10) states 86% compliance with HbA1C as appropriate. Additional surveillance for result >48mmol stated as 100%.
6.5	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Evidenced in previous submission
6.6	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Evidenced in previous submission. Trust DKA policy due for review in May 25.

Element 6

		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 compliance
		2	Minimum staffing levels should be those agreed nationally, or where there are no agreed national levels, staffing levels should be locally agreed with the LMNS. This must encompass the increased acuity and complexity of women, vulnerable families, and additional mandatory training to ensure trusts are able to safely meet organisational CNST and CQC requirements.	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; Consultant commenced employment; Organisation change underway to support 24/7 cover at weekends
		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 report due March 2025; delayed due to data requests
Essential Action : Training				
Work to update orientation packages for [Band 7 staff with process to allocate a mentor. Decision re NQM with NHSE as more of 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 place 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 Human Factors training however National Programme awaited. Completion of any national programme 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 professional 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. Completion date - September 2022; leadership programmes and initiatives in place
		11	The review team acknowledges the progress around the creation of Maternal Medicine Networks nationally, which will enhance the care and safety of complex pregnancies. To address the shortfall of maternal medicine physicians, a sustainable training programme across the country must be established, to ensure the appropriate workforce long term.	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 - withhold complete roll out but continue with partial roll out pending national guidance and regional input. No further teams will be rolled out and options appraisal agreed to continue with current 5 teams.
		5	The reinstatement of MCoC should be withheld until robust evidence is available to support its reintroduction	N/A
		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 Helen Walker, Jon Lund, Mustafa Sadiq and Libby Shaw to finalise. Review 31/3/25.
		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; Zero external Locum's used within maternity services
3: ESCALATION AND ACCOUNTABILITY				
Processes in place - same to be audited 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 / in policy

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 in view 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.
		4. Clinical governance and leadership			
Review of additional resource as detailed above to support. Training in place but to be formalised/audited.					
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. Maternity safety champions and regular board meetings. Processes embedded
		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 actions 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
		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; reviewing 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 2025.
		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-disciplinary leads in place. Consultant Midwife coleads with audit/research.
		7	All maternity services must ensure they have midwifery and obstetric co-leads for audits		Annual audit plan in place
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 - PSIRF process embedded.
		6	All maternity services must involve service users (ideally via their MNVP) in developing complaints response processes that are caring and transparent		Complaint response processes in place, MNVP involvement via safety champions and matneo assurance meeting
		7	Complaints themes and trends must be monitored by the maternity governance team.		Processes currently in place to incorporate 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 LMNS.		Recommendation reviewed - WUTH ready however awaiting Regional / National review
7: MULTIDISCIPLINARY 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.
		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.		Various local and trust initiatives
		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 preconception 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-pregnancy 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 with Rachel Tildesley and Lauren Evertt. Compliance reported via SBLv3 Element 6 and has been consistently 100%

	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.		Element 6 audits in place
		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).	Adu	Audit part of SBLv3
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
		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		Reported via BR Plus, no identified concerns
		2	Midwifery-led units must complete yearly operational risk assessments.		Risk assessment in place for all birthing areas including Labour Ward, MLU and Seacombe birth centre
		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
		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 audited					
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.		Completed
		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, audit plan to be developed 2025
		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.		Reported via Maternity incentive scheme - compliance achieved
		7	The competency required for consultant staff who cover obstetric services out-of hours, but who have no regular obstetric commitments.		Reported via Maternity incentive scheme - compliance achieved
		8	Participation by anaesthetists in the maternity multidisciplinary ward rounds as recommended in the first report		All anaesthetists attend PROMPT MDT training; assurance reported via Maternity Incentive Scheme
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		Guidance in place
		2	Unwell postnatal women must have timely consultant involvement in their care and be seen daily as a minimum		Guidance in place
		3	Postnatal readmissions must be seen within 14 hours of readmission or urgently if necessary		Guidance in place
		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 included 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.		Guidance in place
		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.		Level 3 unit at WUTH
		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, Kate Hannah 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 and NNU staff trained in accordance with programme
		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.		Reported to BoD via workforce report annually
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 provision. Maternity 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 Liaison 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 4 - Three Year Single Delivery Plan for Maternity and Neonatal Services - January 2025

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	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 Core20PLUS6. The care plan includes a risk assessment updated at every contact, including when the woman is in early or established labour.	JL	JL	31/3/25	COC Patient survey Debrief clinics to go through pregnancy outcomes. Birth Options clinic to evidence discussion of women's preferences Examples of care plans; PMH plans; Risk assessment audits Look at further improving inequalities as per equity and equality plan – Consultant Midwife to support with MNVP involvement.
	2	Women receive care that has a life course approach and preventative perspective, to ensure holistic care for women and the best start in life for babies. This includes NHS-led smoke-free pregnancy pathways to provide practical support for pregnant women who are smokers, and evidence-based information about screening and vaccination	AK/ER	AK/ER	31/3/25	Evidence of smoking cessation midwife/work with ABL. Use of NRT. ANNB Screening Programme QA. ANNB Screening action plan to further review screening information
	3	Women have clear choices, supported by unbiased information and evidence-based guidelines. Information is provided in a range of formats and languages, uses terminology in line with the Rebirth report, and is co-produced.	AK/ER	AK/ER	31/3/25	No specific work done with Rebirth report – review of same. Clear choices and information is in place including the updated/revamped website. Continue to work with MNVP re equity and equality to ensure all people receive information they understand; language options being developed
	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	JKL	No further action	All services with guidelines are in place except perinatal pelvic health services – same being introduced; Set up a perinatal pelvic health service and work closely with LMNS re guidance/requirements; funding secured and JD to be matched. Initial discuss with PPHS lead and service to be set up at WUTH in joint setting 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	KW	No further action	Processes in place although clarity needed regarding 6-week GP check post pandemic;
	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	ST/AMC	No further action	FI Care review undertaken with action plan developed following feedback positive in 2024. review 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	AK/ER	No further action	Bereavement midwife in post. Bereavement Suite on site. Use of Ronald McDonald House is also an option that is used
Objective 2: Improve equity for mother and babies	8	The NHS approach to improving equity (Core20PLUS6) involves implementing midwifery continuity of care, particularly for women from minority ethnic communities and from the most deprived areas. It is the responsibility of trusts to provide services that meet the needs of their local populations, paying particular attention to health inequalities. This includes facilitating informed decision-making, for example choice of pain relief in labour where we know there are inequalities, ensuring access to interpreter services, and adhering to the Accessible Information Standard in maternity and neonatal	JL	JL	31/3/25	CCOC Patient survey Equity and Equality plan developed by LMNS following gap analysis which the Trust completed. Further work re equality to be undertaken
	9	Targeted support where health inequalities exist in line with the principles of proportionate universalism	JL	JL	No further action	MCoC teams to be set up as a wraparound service but the support is already in place from these Leads; MCoC teams in place and embedded in the identified areas. review MCoC
	10	Services listen to and work with women from all backgrounds to improve access, plan and deliver personalized care. Maternity and Neonatal voice partnerships ensure all groups are heard, including those most at risk of experiencing health inequalities	JL	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	JL/KW	30/4/25	Maternity services to work with PLACE. LMNS and ICB leads to progress
	12	In spring 2023, publish the National Review of Health and Social Care in Women's Prisons. This review covers maternity and perinatal services	JL/MB	JL/MB	30/4/25	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	13	Acting on the insights of women and families improves services. Co-production is beneficial at all levels of the NHS and is particularly important for those most at risk of experiencing health inequalities (NICE, 2016). 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	JL	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 listen to and reflect the views of local communities. All groups are heard, including bereaved families	JL	JL	No further action	MIS evidence supports work and undertaken and co-production
	15	MNVPs have the infrastructure they need to be successful. Work plans are funded. MNVP leads, formally MVP chairs, are appropriately employed or remunerated and receive appropriate training, administrative and IT support	JL	JL	No further action	MNVP embedded, full funding of post with agreed workplan; submitted as part of MIS SA7
Theme 2: Growing, retaining and supporting workforce		RAG Rating	Lead	Review Date	Comments / Lead Progress	
Objective 4: Grow our workforce	16	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	JL	JL	No further action	Workforce plan in place with report to Board every 6 months
	17	Local and national workforce planning to utilise evidence-based tools, endorsed by NICE or the National Quality Board (NQB), that allow for medical and social complexity, training	JL	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	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	19	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	JL	JL	No further action	
	20	All staff are included and have equality of opportunity	JL	JL	No further action	
Objective 6: Invest in skills	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	JL/NP/MS/AK	Ongoing annually	Score survey undertaken for Maternity and Neonates; feedback sessions in November 2023; staff engagement April 2025
	22	All staff are deployed to roles where they can develop and are empowered to deliver high quality care. Specialist roles within each profession, for example the labour ward coordinator, have a job description, orientation package, appropriate training, and ongoing development	JL	JL	No further action	Evidence collated for Ockenden improvement plan
Theme 3: Developing and sustaining a culture of safety, learning and support		RAG Rating	Lead	Review Date	Comments / Lead Progress	
Objective 7: Developing a positive safety culture	24	All staff working in and overseeing maternity and neonatal services: -Are supported to work with professionalism, kindness, compassion, and respect. Are psychologically safe to voice their thoughts and are open to constructive challenge. -Receive constructive appraisals and support with their development. -Work, learn and train together as a multi-disciplinary team across maternity and neonatal care.	JL	JL	No further action	MDT training in place. TNA supports training requirements and psychological safety. Appraisal process in place with good compliance monitored at Board level.
	25	Teams value and develop people from all backgrounds and make the best use of their diverse skills, views, and experiences.	JL	JL	No further action	Training in place to support
	26	There is a shared commitment to safety and improvement at all levels, including the trust board, and attention is given to 'how' things are implemented not just 'what'	JL	JL	No further action	Evidenced through safety champions meetings; Newly formed divisional MatNeo Assurance Board
	27	Instances of behaviour that is not in line with professional codes of conduct, are fairly addressed before they become embedded or uncontrollable.	JL	JL	No further action	Trust training and policies support professional behaviour's. Disciplinary processes support appropriate action when needed

		28	Systems and processes enable effective coordination, rapid mobilisation, and supportive communication based on agreed principles. The team can escalate concerns and, should there be a disagreement between healthcare professionals, they will be supported by a conflict of clinical opinion policy.	JL	No further action	Policy in place – provided for Ockenden evidence
		29	Staff investigating incidents are provided with appropriate training, while those staff affected by an incident are offered timely opportunity to debrief	JL/DC	No further action	Training in place for staff and this is reviewed and provided by the Trust Governance team
Objective 8: Learning and Improving	Staff working in maternity and neonatal services have an appreciation and understanding of 'what good looks like'. To promote safer care for all, we must actively learn from when things go well and when they do not. To do this, we need a continuous learning and	30	Our ambition is framed by the patient safety incident response framework (PSIRF) which provides a consistent approach across clinical specialities, including for maternity and neonatal services	JL/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	JL/MD	No further action	MNSI quarterly meetings take place and Trust evidenced 100% reporting by the Trust Evidence Monthly PQSM report to Board with quarterly detailed maternity /neonatal reports presented
Objective 9: Support and oversight	While some trusts and ICSs do effectively support their maternity and neonatal services to improve and change, others do not. Good oversight is about understanding the issues leaders face and helping to resolve them, and having clear systems in place that promote timely escalation and intervention before serious problems arise	32	Robust oversight through the perinatal quality surveillance model (PQSM) that ensures concerns are identified early, addressed, and escalated where appropriate	JL	No further action	
		33	Well led services, with additional resources channelled to where they are most needed	JL	No further action	CCQ visit supported well led service at last inspection. Other evidence / outcomes also support
		34	Leadership for change, with a focus on ensuring new service models have the right building blocks for high quality care, especially the workforce.	JL/NPMS/SR	31/10/25	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
Objective 10: Standards to ensure best practice	Advances in clinical practice have been crucial in the improvement in maternity and neonatal outcomes over the last decade. Better Births also identified that variation in protocols, policies, and standards between services creates additional burden and hinders the ability to work together to provide effective care.	35	Consistent implementation of nationally defined best practice with due regard to the needs of local populations to reduce variation and inequalities	JL/MS	31/3/25	MIS year 6 submitted and confirmation of 9 safety actions with a manual revalidation requested for SA1: SBLv3 implemented 86-97%; review of MCQC to address women with inequalities; MIS Year 6 evidence complete
		36	Healthcare professionals have access to shared standards and guidelines, including transfer, transport, and referral protocols, so that clinical teams across the ICS work to the same definitions of best practice	JL	30/6/25	Ongoing work with ICB, timeframes to be set
		37	Where local policy varies from national standards, this is subject to careful local scrutiny through governance processes. The whole multidisciplinary team is involved when developing local guidance	JL	No further action	Processes in place to ensure MDT are involved with developing local policy
		38	Policies and guidelines recognise women as the decision-makers in their maternity care and are not used to prevent women from seeking care that is outside these guidelines	AK/ER	No further action	Policy in place and women are supported by the consultant midwife/Obstetric/Neonatal Leads
		39	Neonatal care is provided in units with clear designation of the level of care to be provided. Units work together across ODNs to optimise capacity and ensure care can be provided in the right place for very pre-term or very sick babies.	Leads	No further action	Policy in place and women are supported by the consultant midwife/Obstetric/Neonatal Leads
Objective 11: Data to inform learning	The Kirkup report highlighted the need for accurate, up to date data to highlight safety issues promptly. Such data enables providers to learn and act. Work is underway to review what data is needed for monitoring, and in the meantime, the NHS should continue to use the data it already collects	40	Standardised data is collected in a consistent way, primarily through the Maternity Services Data Set. Additional data collections are minimised, to focus on gathering the right data to drive insights, understanding and assurances.	JL	No further action	MDS 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 audit/patient outcome programme reports	DC	No further action	LMNS support in leading on monitoring trends regionally. Outlier reports are presented to Board quarterly; Improvement plans are developed to address any outlier reports
		42	The national maternity dashboard provides demographic data, clinical quality improvement metrics and national maternity indicators enabling trusts and LMNS to benchmark their services and inform continuous quality improvement work	JL/DC	No further action	Data submitted to national dashboard. Given limited metrics the national dashboard is not currently reviewed – work to be identified to address an improvement moving forwards.
Objective 12: Make better use of digital technology	Digital technology will make it easier for women to access the information they need and for services to offer safe and personalised care. There is currently significant variation in the use of digital technology. While some maternity services remain almost entirely paper-based, others support personalised care with apps and benefit from an integrated electronic patient record (EPR)	43	Women can access their records and interact with their digital plans and information to support informed decision-making. Parents can access neonatal and early years health information to support their child's health and development. Information meets accessibility standards, with non-digital alternatives available for those who require or prefer them	JL/HW	31/12/25	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 5

Board of Directors in Public

05 March 2025

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

Executive Summary and Report Recommendations

Executive Summary

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

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

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

It is recommended that the Board of Directors:

- Note the report

Key Risks

This report relates to these key risks:
BAF references 1,2,4 and 6
Positives:

- The Trust has several processes that review and record patient quality indicators, incidents and patient experience metrics monthly against staffing data to identify emerging risk/s. This includes a monthly midwife to birth ratio recorded on the maternity dashboard.
- The Trust fulfils its duty to undertake 6 monthly establishment reviews including an update on midwifery staffing. The Trust has also supported a BR+ review at least every 5 years as a minimum, however suggested recommendation is every 3 years.
- A full review of workforce is underway by Birth Rate Plus and report is anticipated in March 2025.
- The visit from NHSE in October 2024 and the LMNS is December 2024 both reported suboptimal staffing levels and welcomed the initiation of BR+ workforce model.

- The Division uses the BR+ acuity tool to undertake acuity and dependency reviews on Delivery Suite every 4 hours. This has been extended for use on the maternity ward and a LMNS regional platform informing staffing, acuity and dependency.
- The Division has safe staffing governance with a clear process of escalation both locally and across Cheshire and Merseyside.

Negatives:

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

Contribution to Integrated Care System objectives (Triple Aim Duty):

Better health and wellbeing for everyone	Yes
Better quality of health services for all individuals	Yes
Sustainable use of NHS resources	Yes

Contribution to WUTH strategic objectives:

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

1	Narrative
1.1	<p>Background</p> <p>Birthrate Plus® (BR+) is a framework for workforce planning and strategic decision-making and has been in variable use in UK maternity units since 1988, with periodic revisions as national maternity policies and guidance are published.</p> <p>It is based upon an understanding of the total midwifery time required to care for women and on a minimum standard of providing one-to-one midwifery care throughout established labour. The principles underpinning the BR+ methodology is consistent with the recommendations in the NICE safe staffing guideline for midwives in maternity settings and have been endorsed by the RCM and RCOG.</p> <p>Current processes within the maternity service ensure that on a 24/7 basis staff are deployed effectively within the service, including the flexing of staff across both the acute and community care settings including the maternity continuity of carer teams.</p> <p>Staff working on Delivery Suite use an acuity tool that formally assesses acuity on Delivery Suite every 4 hours as a minimum. At times of high acuity, the tool is used more frequently to assess acuity, and reports into a regional platform that was launched in September 2022. Weekly staffing reports are generated from the acuity data, and whilst this does predominantly focus on staffing within Delivery Suite the acuity tool is being expanded to include staffing across all inpatient areas. Monthly staffing reports are generated and shared by the Local Maternity and Neonatal System (LMNS) on this data regionally.</p>

	<p>It is proposed that these reports will further inform and provide assurance regarding safe maternity staffing and will provide assurance to all Maternity Safety Champions including the Executive and Non-Executive Safety Champions who are required to have oversight, assurance and visibility of safe staffing within the maternity service.</p> <p>Currently the quarterly maternity update to the Board of Directors includes reference to maternity staffing and a Divisional nurse / midwifery staffing update is also included in the 6 monthly nurse staffing paper that is presented at the Board of Directors meeting.</p>
<p>1.2</p>	<p>Current position</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>The method used works out the clinical establishment based on agreed standards of care and specialist needs and then includes the midwifery management and specialist roles required to manage maternity services.</p> <p>The recommendation is to provide total care to women and their babies throughout the 24 hours 7 days a week inclusive of the local % for annual, sick & study leave allowance and for travel in community.</p> <p>The last full Birthrate Plus full analysis and report was undertaken in 2021 and in the last three years women/birthing people have more complex needs. In view of a rising c/section and induction of labour rates along with the CQC recommendation to ensure two midwives in maternity triage at times of high acuity a repeat is underway and a report with recommendations to ensure maternity safe staffing levels is anticipated by March 2025.</p>
<p>1.3</p>	<p>Maternity Incentive Scheme (MIS) Safety Action 5 Required Standards:</p> <ol style="list-style-type: none"> 1. The allocated midwifery co-ordinator in charge is been supernumerary at the start of every shift. <p>In the reporting period from July to December 2024 the midwifery co-ordinator has been supernumerary at the start of every shift.</p>

2. The midwifery coordinator in charge of labour ward must have supernumerary status to ensure there is oversight of all birth activity within the service.

There were 13 occasions over 6 months throughout the 24-hour reporting period from July to December 2024 (Q2 24/25 and Q3 24/25) the midwifery coordinator reported being unable to maintain supernumerary status. This is reported as short-term until the interim plan of the caseload being handed over with the initiation of the continuity midwife arriving or escalation processes followed to ensure further midwifery staff to rectify and ensure the midwifery co-ordinator resumes oversight of all the birth activity within the service.

3. Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall in staff.

The maternity service has robust escalation processes to manage short falls in staffing level during periods of high acuity.

4. The midwife: birth ratio

The midwife to birth ratio is reported monthly within the maternity dashboard and has been RAG rated green during the period from July to December 2024 in line with NICE guidance and safe maternity staffing levels.

5. The percentage of specialist midwives employed and mitigation to cover inconsistencies.

Birthrate plus incorporates a review of specialist midwives employed and the roles are in line with the recommended 10%. The trust has recruitment the additional Pelvic Specialist Midwife post (0.4WTE) in line with the recurrent funding received from NHSE as supported from the Three-Year delivery plan.

6. The provision of all women receiving one to one midwifery care in active labour is reported at care in labour.

Maternity services from the period July to December 2024 reports via the Birthrate plus platform 99% of women receiving one to one care in active labour.

1.4

Continuity of Carer:

The paper is explicit in the need to 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 5 Maternity Continuity of Carer (MCoC) teams meeting 75% of women in vulnerable women/birthing people. There was previously an ambition to achieve by MCoC as the default model by June 2024, however due to staffing levels this was not achieved. Adaptations have been made to the plan in line with the current workforce, safe staffing levels and achieving 50% of women offered this model of care and those in the vulnerable groups are majority included.

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

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

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

Considering pre-term birth alone, it is well evidenced that the high rates of morbidity and mortality arising from preterm birth impose a considerable burden on finite health care resources. Preterm infants are at increased risk of a range of adverse neonatal outcomes including chronic lung disease, severe brain injury, retinopathy of prematurity, necrotizing enterocolitis and neonatal sepsis. In later life, preterm infants are at increased risk of motor and sensory impairment, learning difficulties and behavioural problems. The economic consequences include the costs of neonatal care as well as the costs associated with living with disabilities.

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

The Trust has five embedded teams and at present no further teams are anticipated, however in line with national guidance this will be closely monitored. WUTH has undertaken its own research based on models of care and outcomes which highlighted:-

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

- Have a vaginal birth
- Less likely to have a c/section
- Have a more positive experience of labour and birth
- Successfully breastfeed her baby
- Less likely to experience pre-term birth
- Less likely to lose their baby before 24 weeks gestation
- No differences in episiotomy rates
- No difference in having an assisted delivery

Should any ambition in the future to roll out as the default model funding to increase staffing levels and would be required in line with recommendations from Birthrate Plus.

1.5

NHSE Bid

The planning Guidance for 2021-22 specifically referenced additional funding for maternity services of £95million – Service Development Funding (SDF) extending to £137million in 2022-23. A detailed bid based on midwifery staffing requirements was submitted to NHSE for consideration given the requirements outlined in the Ockenden report.

WUTH was successful in its bid to secure additional funding however, the process for distributing Ockenden funding changed between 2021/22 and 2022/23. In order to ensure recurrent funding, the monies were distributed regionally on a fair share basis, and has been allocated to the ICB rather than directly to individual Trusts resulting in a mismatch to the funding allocated last year.

Funding allocated to Cheshire & Merseyside ICB for 2022/23 is £3,731,000 which is slightly more than the total FYE allocated to all C&M Trusts last year, however, is the decision regarding the allocation of funding sits with the ICB and the LMNS in deciding which is the best and most sustainable way to split this funding between Trusts. The recurrent funding received in 2024/25 totalled £462k (in line with the revised allocation from the ICB). WUTH maternity services were also allocated £165k for Ockenden II workforce to include retention, bereavement services, maternity support work investment, preceptorship and obstetrics. Organisations offering full enhanced maternity care were also allocated funds equating to £240k.

Recurrent funding is anticipated, however not confirmed in writing. A recent business case to the Executive, Assurance and Risk Committee agreed to the recruitment of the following posts permanently: -

Pay -Post Detail	Band	WTE	Annual Cost £	Funding Stream	Contract Status
High Risk Midwife	7	1.00	£57,897	Smoking Cessation	
Improving Screening Uptake Officer	4	0.91	£29,803	Smoking Cessation Ockenden II –	FTC
Retention	7	1.00	£57,897	Workforce Ockenden II –	Permanent
Bereavement	3	0.80	£23,479	Workforce Ockenden II –	FTC
Bereavement	6	1.00	£46,604	Workforce Ockenden II –	
MSWs	3	1.00	£29,598	Workforce Ockenden II –	
Obstetrics Support	3	0.10	£13,398	Workforce	Permanent
Continuity of Carer	3	2.96	£87,611	Ockenden – COC	FTC
Continuity of Carer	5	4.35	£190,053	Ockenden – COC	Permanent
Pre Term Birth	3	0.10	£12,391	NHSE	
Perinatal Pelvic Health Services (PPHS) Specialist Midwife	7	0.40	£25,706	NHSE	Permanent
			£574,437		

Post Detail	Band	Contracted WTE	WTE to be recruited	Total WTE
High Risk Midwife	7		1.00	1.00
Improving Screening Uptake Officer	4	0.91		0.91
Retention	7	1.00		1.00
Bereavement	3	0.80		0.80
Bereavement	6		1.00	1.00
Preceptorship	6			0.00
MSWs	3	1.00		1.00
Obstetrics Support	Cons			0.00
Continuity of Carer	3	2.96		2.96
Continuity of Carer	5		4.35	4.35
Pre Term Birth	Cons			0.00
Perinatal Pelvic Health Services (PPHS) Specialist Midwife	7	0.40		0.40
		7.07	6.35	13.42

The business case has supported the increase of 6.35wte to current establishment anticipated to bridge the gap from the forthcoming BR+ recommendations and ensure safe staffing levels.

1.6

Findings

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 delivering 50% Continuity of Carer the clinical total recommended for Wirral University Teaching Hospitals NHSFT is 137.61WTE, of this 123.85WTE are Registered Midwives bands 5 -7 and 13.76WTE are MSWs providing postnatal care (on the ward/community). This equates to a total of 151.37WTE. The comparative current funded establishment is 141.23WTE which meant there was a variance of 10.14WTE as funded.

Based on current activity and delivery of 50% Continuity of Carer the clinical total recommended for Wirral University teaching Hospital is 141.42 WTE, of this 123.49 WTE are Registered Midwives Band 5-7 and 17.93 WTE MSW's providing post-natal care (on the ward/community). Band 8 roles have not been included as they are specialty roles and do not contribute to the delivery of MCoC.

The current establishment in accordance with Birth rate plus confirms and provides assurance of safe staffing levels to deliver the current MCoC model of care.

Table 1 summarises further the comparison between Birthrate Plus (2021) 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
	<p><i>Additional WTE required to meet 100% Continuity of Carer - Table 1</i></p> <ul style="list-style-type: none"> The NHSE bid supported 10.1WTE funding and WUTH have been able to deliver MCoC to 50-55%. No changes will be made to the current model until the Birthrate plus report is available by March 2025. 			
1.7	<p>Conclusion</p> <p>The current staffing model meets the requirements of the last Birthrate Plus (2021) recommendations for safe staffing. Midwifery staffing is compliant with the recommendation from both Ockenden and Birthrate Plus. In view of changes a repeat is underway and will be available in March 2025 and an update will be included in the next midwifery staffing paper.</p> <p>Options for maternity models of care have been considered and in line with national guidance maternity continuity of carer teams will continue for women/birthing people with enhanced needs.</p> <p>The allocated funding to maternity services have been spent as specified and for its intended purpose to maintain quality and safety.</p>			

2	Implications			
2.1	<p>Patients</p> <ul style="list-style-type: none"> There is some risk to patient care and safety in having two models of care as an equitable service is not being delivered, however positive outcomes are evident in women with enhanced needs being on an MCoC pathway. Patient experience within both models of care is positive and there have been no relating complaints to either. Ensuring stability and structure with minimal disruption to both models provide continuity antenatally and postnatally. 			
2.2	<p>People</p> <ul style="list-style-type: none"> It would not be safe or possible to continue the roll out of this model without securing the additional resource in line with the Birthrate plus recommendations and a skilled workforce. A two-model approach to midwifery care impacts on wellbeing and employee experience. Internal escalation process is utilised to mitigate, and revised working patterns/escalation processes have been embedded 			
2.3	<p>Finance</p> <ul style="list-style-type: none"> The financial impact to deliver the model of care as the default would have financial implications. A business case has been supported to recruit to permanent posts with a financial impact on the trust. 			

	<ul style="list-style-type: none">• Birthrate plus report could recommend a revised staffing model to ensure safe staffing and could have a financial impact.
2.4	Compliance <ul style="list-style-type: none">• Better Births (2016) recommendations is to improve continuity of carer, teams have been set up across Wirral University Teaching Hospital (WUTH) meeting the current national drive.

NHS Maternity Services Survey 2024 Benchmark Report

Wirral University Teaching Hospital
NHS Foundation Trust

The NHS logo, consisting of the letters 'NHS' in white on a blue rectangular background.The Care Quality Commission logo, featuring a stylized white 'Q' icon to the left of the text 'Care Quality Commission'.

Survey
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This work was carried out in accordance with the requirements of the international standard for organisations conducting social research (accreditation to ISO27001:2013; certificate number GB10/80275).

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Background and methodology

This section includes:

- an explanation of the NHS Patient Survey Programme
- information on the 2024 Maternity Survey
- a description of key terms used in this report
- navigating the report

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**Survey
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Background and methodology

The NHS Patient Survey Programme

The NHS Patient Survey Programme (NPSP) collects feedback on adult inpatient care, maternity care, children and young people's inpatient and day services, urgent and emergency care, and community mental health services.

The NPSP is commissioned by Care Quality Commission (CQC); the independent regulator of health and adult social care in England.

As part of the NPSP, the Maternity Survey was first carried out in 2007. The 2024 Maternity Survey will be the eleventh carried out to date. CQC use results from the survey to build an understanding of the risk and quality of services and those who organise care across an area.

To find out more about the survey programme and to see the results from previous surveys, please refer to the section on further information on this page.

The 2024 Maternity Survey

The survey was administered by the Survey Coordination Centre (SCC) at Picker.

A total of 46,687 maternity service users were invited to participate in the survey across 120 NHS trusts.

Completed responses were received from 18,951 maternity service users, an adjusted response rate of 41.2%.

Service users were eligible to participate in the survey if they were aged 16 years or over at the time of delivery and had a live birth at an NHS Trust between 1 February and 29 February 2024. If there were fewer than 300 people within an NHS trust who gave birth in February 2024, then births from January were included. Full sampling criteria can be found in the [sampling instructions](#).

Fieldwork took place between May and August 2024.

Trend data

In 2021, the Maternity Survey transitioned from a solely paper-based methodology to both paper and online. This dual approach was continued in 2022, 2023 and 2024.

Analysis conducted prior to the 2021 survey, concluded that this change in methodology did not

have a detrimental impact on trend data. Therefore, data from the 2013 survey and subsequent years are comparable with previous years, unless a question has changed or there are other reasons for lack of comparability such as changes in organisational structure of a trust.

Where results are comparable with previous years, a section on historical trends has been included. Where there are insufficient data points for historical trends, significance testing has been carried out against 2023 data.

Further information about the survey

- For published results and for more information on the Maternity Survey, please visit the Maternity Survey page on the [NHS Surveys website](#).
- For published results for other surveys in the NPSP, and for information to help trusts implement the surveys across the NPSP, please visit the [NHS Patient Surveys website](#).
- To learn more about CQC's survey programme, please visit the [CQC website](#).

Background and Methodology (continued)

Antenatal and Postnatal data

The Maternity Survey is split into four sections that ask questions about:

- Antenatal care
- Labour and birth
- Postnatal care
- Complaints

It is possible that some maternity service users may have experienced the first three stages of care in different trusts. This may be for many reasons such as moving home, or having to travel for more specialist care, or due to variation in service provision across the country. For the purpose of benchmarking, it is important that we understand which trust the respondent is referring to when they are completing each section of the survey.

When answering survey questions about labour and birth we can be confident that in all cases respondents are referring to the trust from which they were sampled. It is therefore possible to compare results for labour and birth across all 120 NHS trusts

that took part in the survey.

Trusts were asked to carry out an “attribution exercise”, where each trust identifies the individuals in their sample that are likely to have also received their antenatal and postnatal care from the trust. This is done using either electronic records or residential postcode information. This attribution exercise was first carried out in the 2013 survey. In 2024, all of the 120 trusts that took part in the survey completed this exercise.

The survey results contained in this report include only those respondents who were identified as receiving care at this trust.

Limitations of this approach

Data is provided voluntarily. In 2024, all trusts provided this data. The antenatal and postnatal care sections of this report are therefore benchmarked against all trusts that provided the required information.

Some trusts do not keep electronic records of antenatal and postnatal care. Where this is the case, location of antenatal and postnatal care is based on

residential location of respondents. This is not a perfect measure of whether antenatal and postnatal care was received at the trust. For example, respondents requiring specialist antenatal or postnatal care may have received this from another trust. This may mean that some respondents are included in the data despite having received care from another trust.

Key terms used in this report

The 'expected range' technique

This report shows how your trust scored for each evaluative question in the survey, compared with other trusts that took part. It uses an analysis technique called the 'expected range' to determine if your trust is performing about the same, better or worse compared with most other trusts. This is designed to help understand the performance of individual trusts and identify areas for improvement. More information can be found in the [Comparison to Other Trusts](#) section.

Standardisation

Demographic characteristics, such as age, can influence care experiences and how they are reported. Since trusts have differing profiles of maternity service users, this could make fair trust comparisons difficult. To account for this, we 'standardise' the results, which means we apply a weight to individual service user responses to account for differences in demographic profile between trusts.

For each trust, results have been standardised by parity (whether or not a service user has given birth previously) and age of respondents to reflect the 'national' age distribution (based on all respondents to

the survey). This helps ensure that no trust will appear better or worse than another because of its profile of maternity users and enables a fairer and more useful comparison of results across trusts. In most cases this standardisation will not have a large impact on trust results.

Scoring

For selected questions in the survey, the individual (standardised) responses are converted into scores, typically 0, 5, or 10. A score of 10 represents the best possible result and a score of 0 the worst. The higher the score for each question, the better the trust is performing. Only evaluative questions in the questionnaire are scored. Some questions are descriptive (for example A2), and others are 'routing questions', which are designed to filter out respondents to whom subsequent questions do not apply (for example C23). These questions are not scored. Please refer to the [scored questionnaire](#) for further details. Section scoring is computed as the arithmetic mean of question scores for the section after weighting is applied. More information can be found in the [An example of scoring](#) slide.

National average

The 'national average' mentioned in this report is the arithmetic mean of all trusts' scores after weighting is applied.

Suppressed data

If fewer than 30 respondents have answered a question, no score will be displayed for that question (or the corresponding section the question contributes to).

Further information about the methods

For further information about the statistical methods used in this report, please refer to the [survey technical document](#) which is on the 'Analysis and Reporting' section of the 2024 Maternity Survey webpage on the NHS surveys website.

Using the survey results

Navigating this report

This report is split into five sections:

- **Background and methodology** – provides information about the survey programme, how the survey is run, and how to interpret the data.
- **Headline results** – includes key trust-level findings relating to the maternity service users who took part in the survey, benchmarking, and top and bottom scores. This section provides an overview of results for your trust, identifying areas where your organisation performs better than the average and where you may wish to focus improvement activities.
- **Benchmarking** – shows how your trust scored for each evaluative question in the survey, compared with other trusts that took part; using the ‘expected range’ analysis technique. This allows you to see the range of scores achieved and compare yourself with the other organisations that took part in the survey. Benchmarking can provide you with an indication of where you perform better than the average, and what you should aim for in areas where you may wish to improve. Only trusts that provide data on antenatal and/or postnatal care

and have sufficient respondent numbers are also provided with survey results for antenatal and postnatal care within this report.

- **Change over time** – includes your trust’s mean score for each evaluative question in the survey shown in a significance test table, comparing it to your 2023 mean score. This allows you to see if your trust has made statistically significant improvements between survey years.
- **Comparison to Other Trusts** – includes additional data for your trust.

How to interpret the graphs in this report

There are several types of graphs in this report which show how the score for your trust compares to the scores achieved by all trusts that took part in the survey.

The two chart types used in the section ‘Benchmarking’ use the ‘expected range’ technique to show results. For information on how to interpret these graphs, please refer to the [‘How to interpret benchmarking in this report’](#) slides.

Other data sources

More information is available about the following topics at their respective websites, listed below:

- Full national results; technical document: <https://www.cqc.org.uk/publications/surveys/maternity-survey>
- National and trust-level data for all trusts who took part in the 2024 Maternity Survey <https://nhssurveys.org/surveys/survey/04-maternity/year/2024/>. Full details of the methodology for the survey, instructions for trusts and contractors to carry out the survey, and the survey development report can also be found on the NHS Surveys website.
- Information on the NHS Patient Survey Programme, including results from other surveys: www.cqc.org.uk/content/surveys
- Information about how CQC monitors hospitals: <https://www.cqc.org.uk/what-we-do/how-we-use-information/using-data-monitor-services>

Headline results

This section includes:

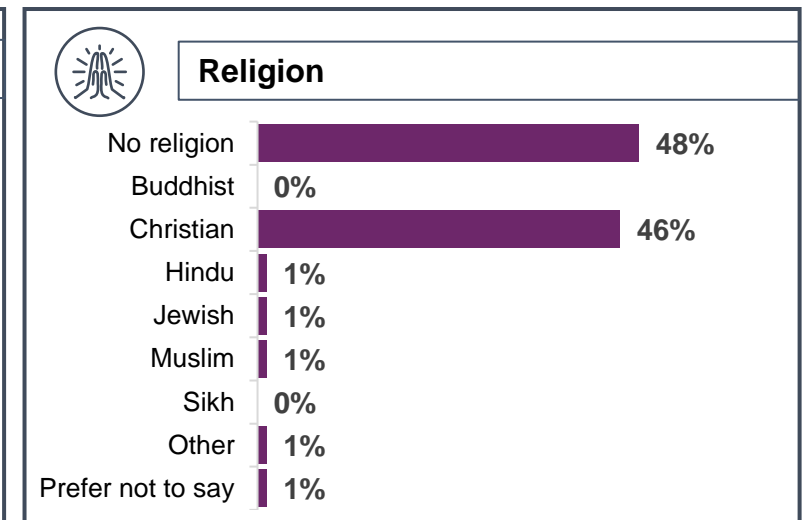
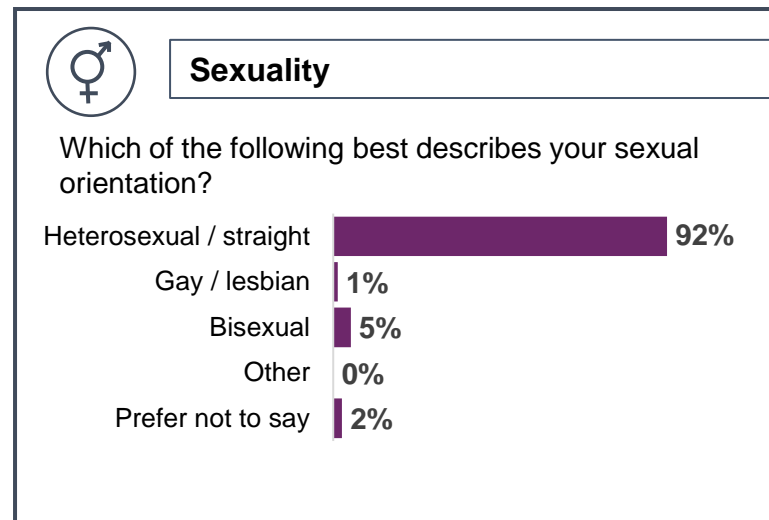
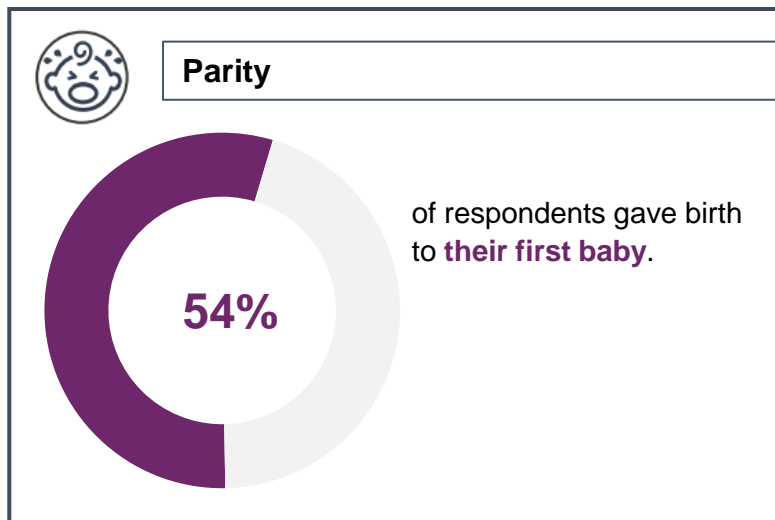
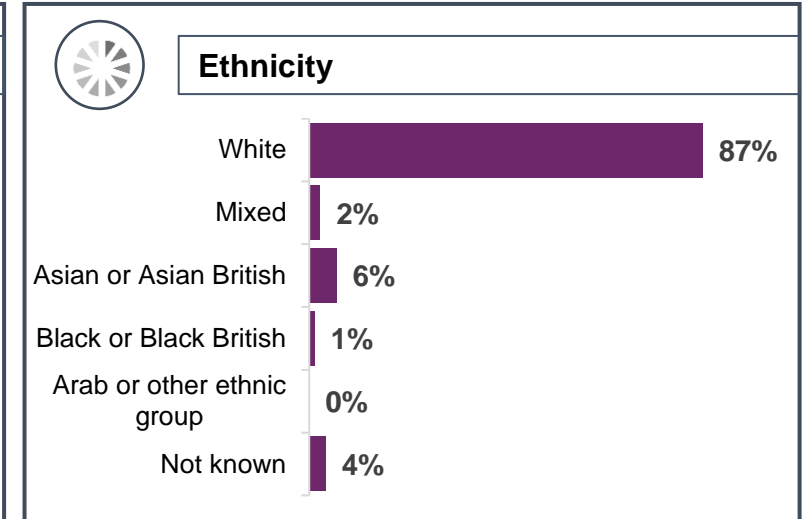
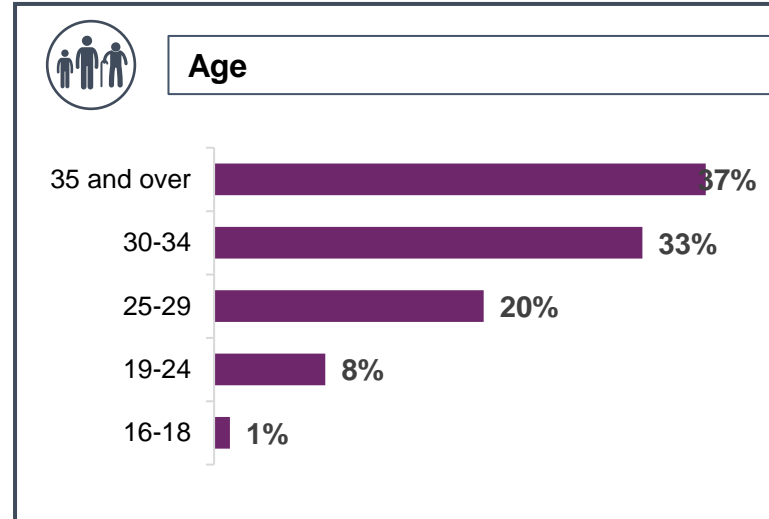
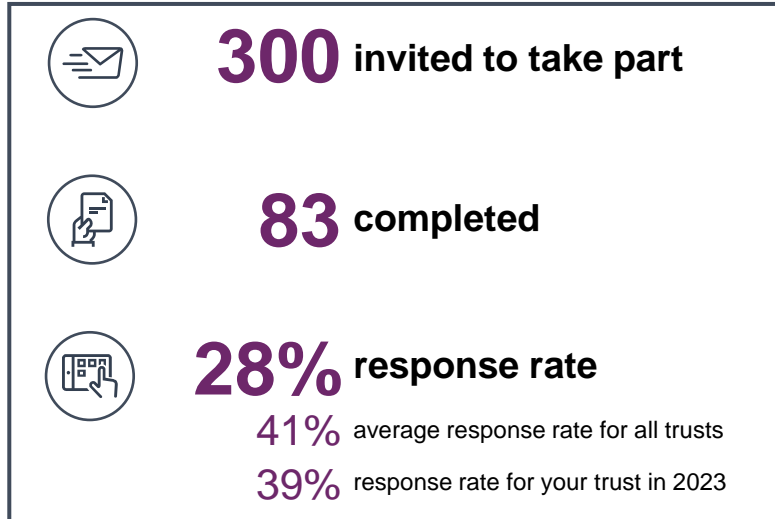
- information about your trust population
- an overview of benchmarking for your trust
- the best and worst scores for your trust

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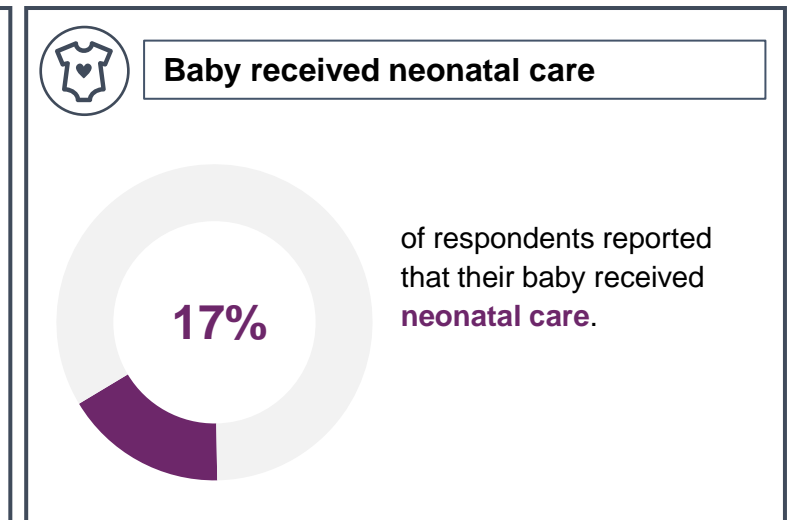
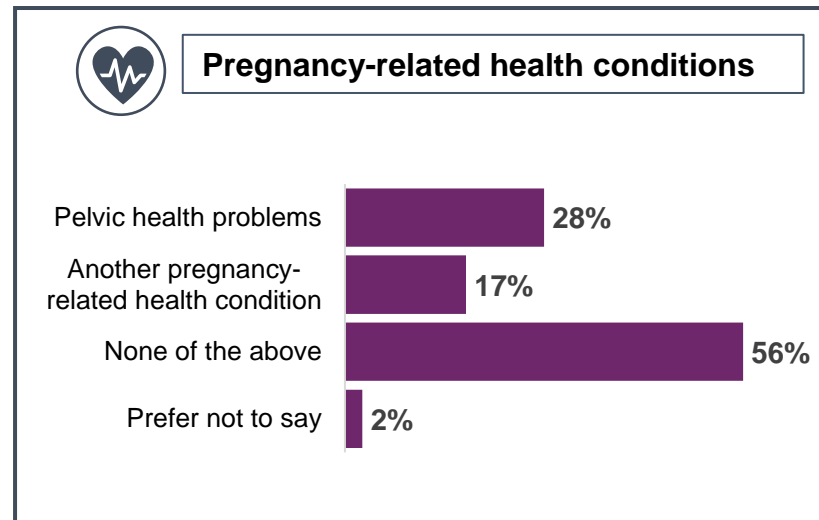
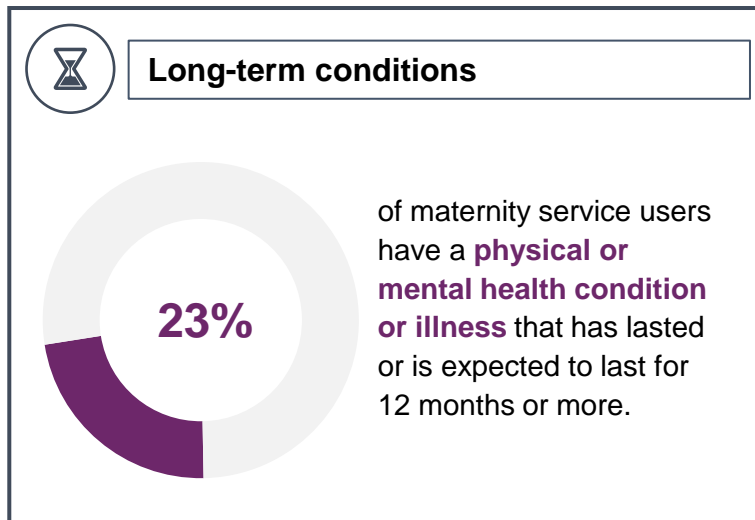
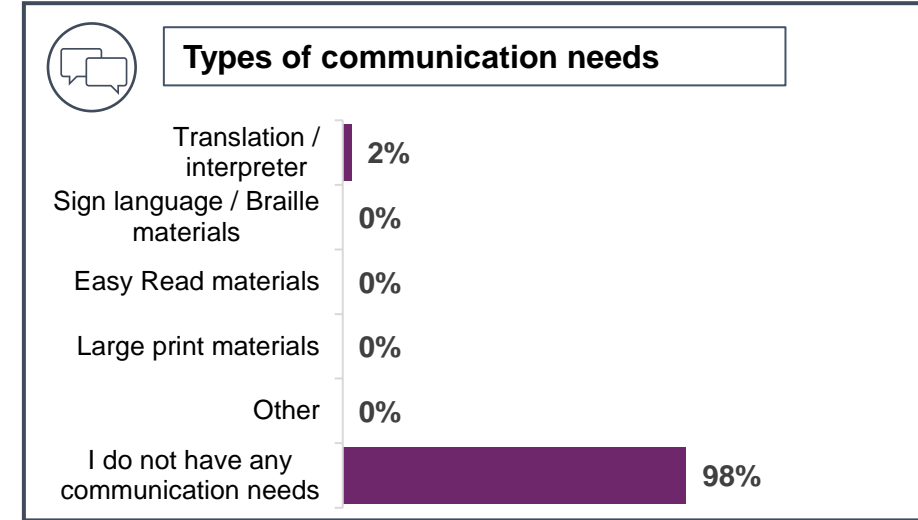
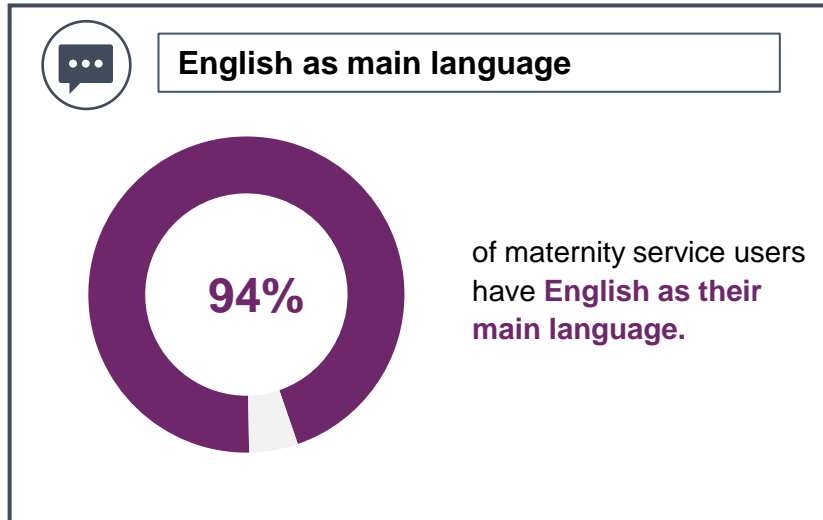
Who took part in the survey?

This slide is included to help you interpret responses and to provide information about the population of maternity service users who took part in the survey.



Who took part in the survey? (continued)

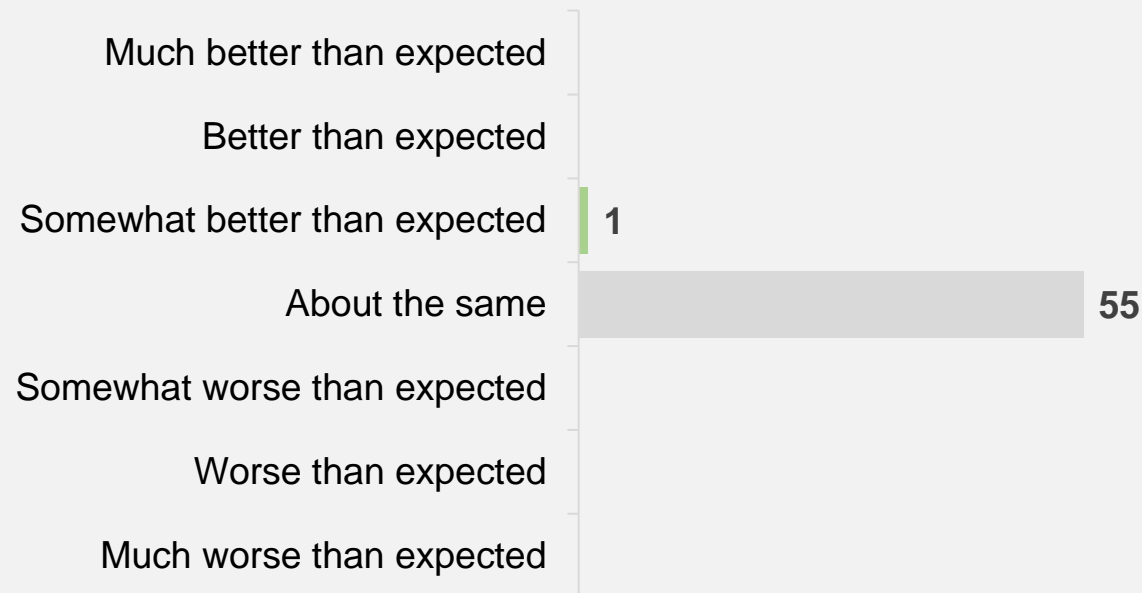
This slide is included to help you interpret responses and to provide information about the population of maternity service users who took part in the survey.



Summary of findings for your trust

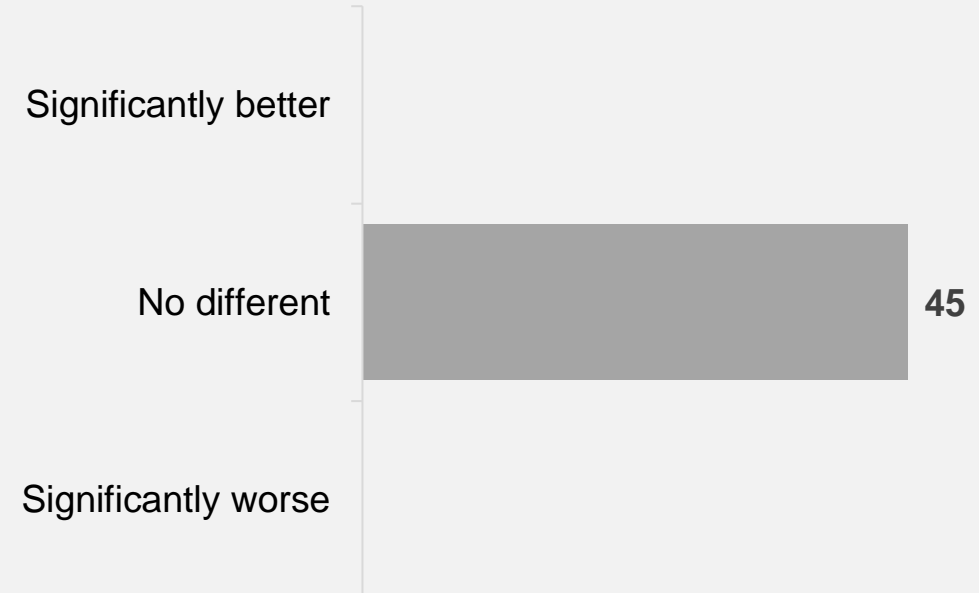
Comparison with other trusts

The **number of questions** at which your trust has performed better, worse, or about the same compared with all other trusts.



Comparison with last year's results

The **number of questions** at which your trust has performed statistically significantly better, significantly worse, or no different than your result from the previous year, 2024 vs 2023.



For a breakdown of the questions where your trust has performed better or worse compared with all other trusts, please refer to the section [“Comparison to Other Trusts”](#).

Best and worst performance relative to the national average

These five questions are calculated by comparing your trust's results to the the average trust score across England.

- **Top five scores:** These are the five results for your trust that are highest compared with the national average. If none of the results for your trust are above the national average, then the results that are closest to the national average have been chosen, meaning a trust's best performance may be worse than the national average.
- **Bottom five scores:** These are the five results for your trust that are lowest compared with the national average. If none of the results for your trust are below the national average, then the results that are closest to the national average have been chosen, meaning a trust's worst performance may be better than the national average.

Top five scores (compared with national average)

■ Your trust score ■ National average

Postnatal Care: Care in the ward after birth

d6. Thinking about your stay in hospital, if your partner or someone else close to you was involved in your care, were they able to stay with you as much as you wanted?

8.8

Postnatal Care: Care in the ward after birth

d2. On the day you left hospital, was your discharge delayed for any reason?

7.2

Postnatal Care: Care at home after birth

f4. Would you have liked to have seen or spoken to a midwife...

7.3

Antenatal Care: During your pregnancy

b11. During your pregnancy, if you contacted a midwifery team, were you given the help you needed?

9.0

Labour and Birth: Your labour and birth

c4. Before you were induced, were you given appropriate information and advice on the risks associated with an induced labour?

8.1

Bottom five scores (compared with national average)

■ Your trust score ■ National average

Labour and Birth: Staff caring for you

c19. After your baby was born, did you have the opportunity to ask questions about your labour and the birth?

5.4

Antenatal Care: During your pregnancy

b14. During your pregnancy did midwives provide relevant information about feeding your baby?

6.5

Labour and Birth: Your labour and birth

c5. Were you involved in the decision to be induced?

7.1

Postnatal Care: Feeding your baby

e3. Did you feel that midwives gave you enough support and advice to feed your baby?

6.9

Labour and Birth: Your labour and birth

c9. The birth of your baby. If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?

9.1

2024 Maternity Survey

Results for Wirral University Teaching Hospital NHS Foundation Trust

Where service user experience is best

- ✓ **Postnatal Care: Care in the ward after birth:** Partner or someone else close to service user was able to stay as much as the service user wanted
- ✓ **Postnatal Care: Care in the ward after birth:** Delays to discharge on the day of leaving hospital
- ✓ **Care after birth:** Frequency of seeing or speaking to a midwife
- ✓ **Antenatal care: During your pregnancy:** If service users contacted a midwifery team, were they given the help they needed
- ✓ **Labour and Birth: Your labour and birth:** Service users given appropriate information and advice on the associated risks with induction

Where service user experience could improve

- **Labour and Birth: The staff caring for you:** Being offered the opportunity to ask questions about the labour and birth
- **Antenatal care: During your pregnancy:** Relevant information provided from midwives to service users about feeding their baby
- **Labour and Birth: Your labour and birth:** Being involved in the decision to be induced
- **Feeding your baby:** Midwives giving enough support and advice to feed their baby
- **Labour and Birth: The birth of your baby:** Partner or someone else close to service user was able to be involved as much as they wanted

These questions are calculated by comparing your trust's results to the national average. "Where service user experience is best": These are the five results for your trust that are highest compared with the national average. "Where service user experience could improve": These are the five results for your trust that are lowest compared with the national average.

This survey looked at the experiences of service users who gave birth at the trust in January and/or February 2024. Between May and August 2024, a questionnaire was sent to 300 recent service users who gave birth at Wirral University Teaching Hospital NHS Foundation Trust. Responses were received from 83 service users at this trust. If you have any questions about the survey and our results, please contact [NHS TRUST TO INSERT CONTACT DETAILS].



Benchmarking

This section includes:

- how your trust scored for each evaluative question in the survey, compared with other trusts that took part
- an analysis technique called the 'expected range' to determine if your trust is performing about the same, better or worse compared with most other trusts

Please note: If data is missing, this is due to a low number of responses.

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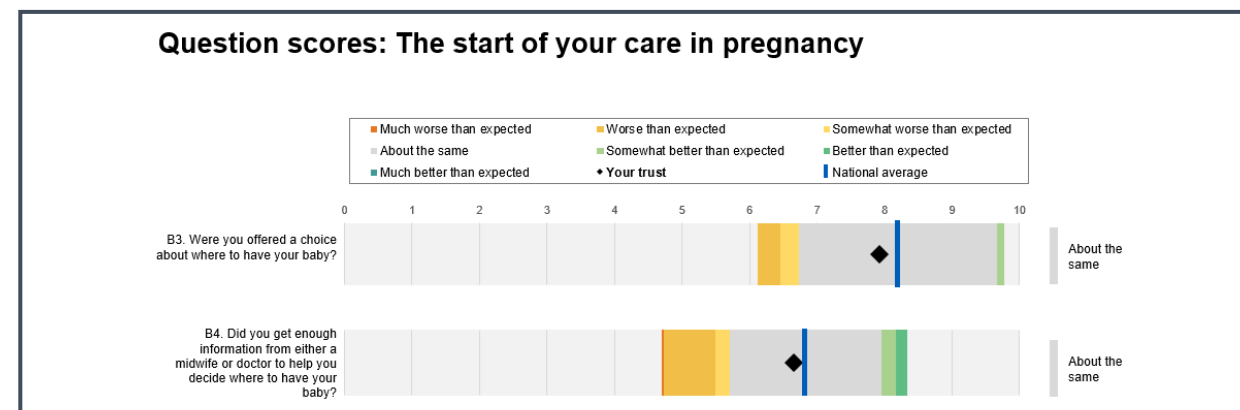
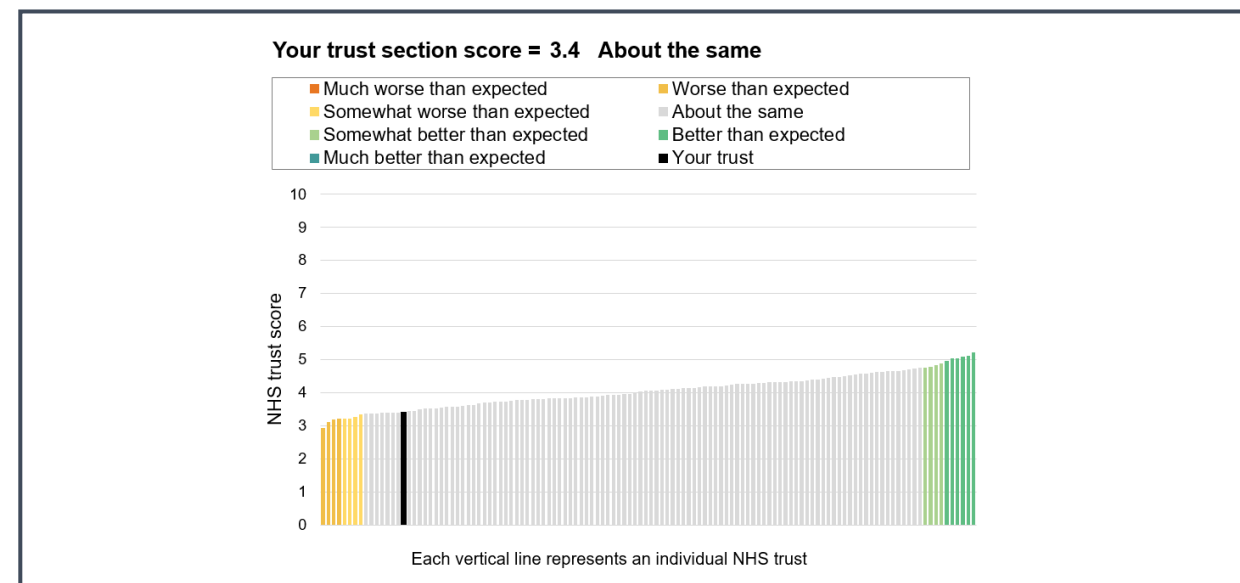
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How to interpret benchmarking in this report

The charts in the 'benchmarking' section show how the score for your trust compares to the range of scores achieved by all trusts taking part in the survey. The black line shows the score for your trust. The graphs are divided into seven sections, comparing the score for your trust to most other trusts in the survey:

- If your trust's score lies in the **dark green section** of the graph, its result is 'Much better than expected'.
- If your trust's score lies in the **mid-green section** of the graph, its result is 'Better than expected'.
- If your trust's score lies in the **light green section** of the graph, its result is 'Somewhat better than expected'.
- If your trust's score lies in the **grey section** of the graph, its result is 'About the same'.
- If your trust's score lies in the **yellow section** of the graph, its result is 'Somewhat worse than expected'.
- If your trust's score lies in the **light orange section** of the graph, its result is 'Worse than expected'.
- If your trust's score lies in the **dark orange section** of the graph, its result is 'Much worse than expected'.

These groupings are based on a rigorous statistical analysis of the data termed the 'expected range' technique.



How to interpret benchmarking in this report (continued)

The 'much better than expected', 'better than expected', 'somewhat better than expected', 'about the same', 'somewhat worse than expected', 'worse than expected', and 'much worse than expected' categories are based on an analysis technique called the 'expected range'. Expected range determines the range within which a trust's score could fall without differing significantly from the average, taking into account the number of respondents for each trust, to indicate whether the trust has performed significantly above or below what would be expected.

If it is within this expected range, we say that the trust's performance is 'about the same' as other trusts. Where a trust is identified as performing 'better' or 'worse' than the majority of other trusts, the result is unlikely to have occurred by chance.

The question score charts show the trust scores compared to the minimum and maximum scores achieved by any trust. In some cases, this minimum or maximum limit will mean that one or more of the bands are not visible – because the range of other bands is broad enough to include the highest or lowest score achieved by a trust this year. This could be because there were few respondents, meaning the confidence intervals around your data are slightly larger, or because there was limited variation between trusts for this question this year.

In some cases, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust. This occurs as the bandings are calculated through standard error rather than standard deviation. Standard error takes into account the number of responses achieved by a trust, and therefore the banding may differ for a trust with a low numbers of responses.

Additional information on the 'expected range' analysis technique can be found in the survey technical report on the [NHS Surveys website](#).

An example of scoring

Each evaluative question is scored on a scale from 0 to 10. The scores represent the extent to which the maternity service user's experience could be improved. A score of 0 is assigned to all responses that reflect considerable scope for improvement, whereas a score of 10 refers to the most positive maternity service user experience possible. Where a number of options lay between the negative and positive responses, they are placed at equal intervals along the scale. Where options were provided that did not have any bearing on the trust's performance in terms of maternity service user experience, the responses are classified as "not applicable" and a score is not given. Similarly, where respondents stated they could not remember or did not know the answer to a question, a score is not given.

Calculating an individual respondent's score

The following provides an example for the scoring system applied for each respondent. For question B11 "During your pregnancy, if you contacted a midwifery team, were you given the help you needed?":

- The answer code "Yes, always" would be given a score of 10, as this refers to the most positive maternity service user experience possible.
- The answer code "Yes, sometimes" would be given a score of 5, as it is placed at an equal interval along the scale.
- The answer codes "No" and "No, as I was not able to contact a midwifery team" would be given a score of 0, as these responses reflect considerable scope for improvement.
- The answer code "I did not contact a midwifery team" would not be scored, as they do not have a clear bearing on the trust's performance in terms of maternity service user experience.

Calculating the trust score for each question

The weighted mean score for each trust, for each question, is calculated by dividing the sum of the weighted scores for a question by the weighted sum of all eligible respondents to the question for each trust. An example of this is provided in the [survey technical document](#).

Calculating the section score

An arithmetic mean of each trust's question scores is taken to provide a score for each section.

Benchmarking

Section 1: Antenatal Care



NHS



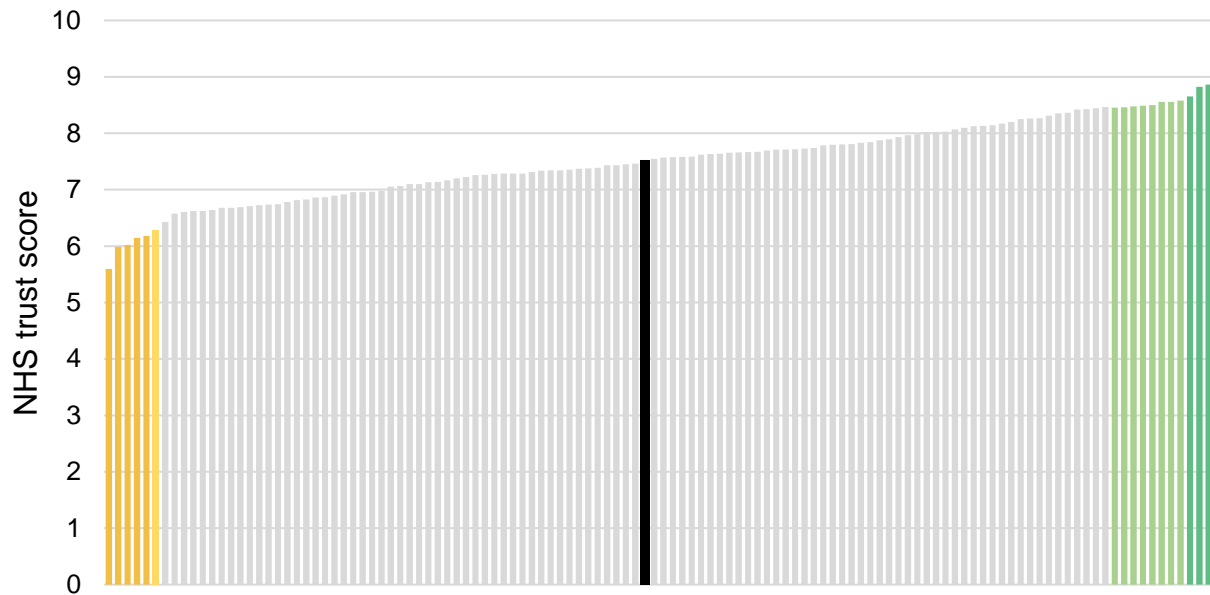
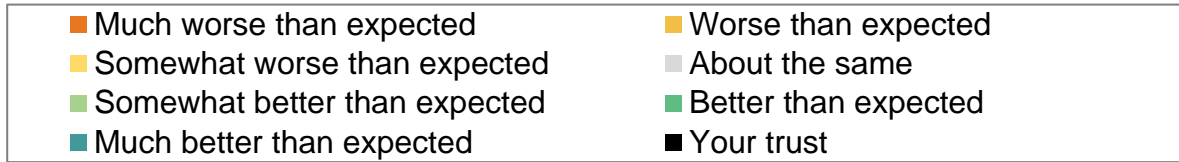
**CareQuality
Commission**

**Survey
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Centre**

The start of your care during pregnancy

This shows the range of section scores for all NHS trusts included in the survey that submitted attribution data for antenatal care received. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'the start of your care during pregnancy' is calculated from questions B3 and B4. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

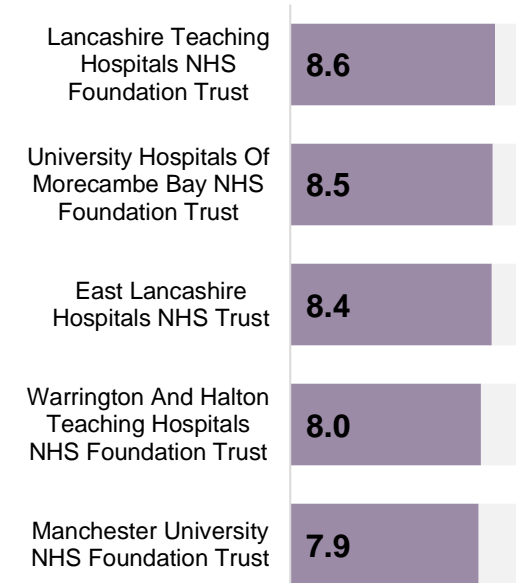
Your trust section score = 7.5 **About the same**



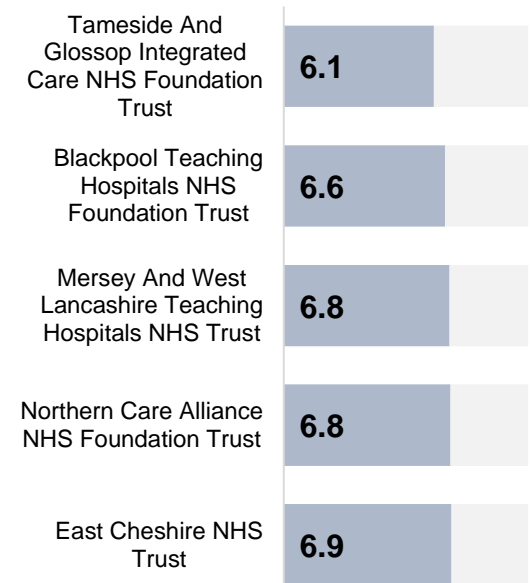
Each vertical line represents an individual NHS trust
Trust score is not shown when there are fewer than 30 respondents

Comparison with other trusts within your region

Trusts with the highest scores

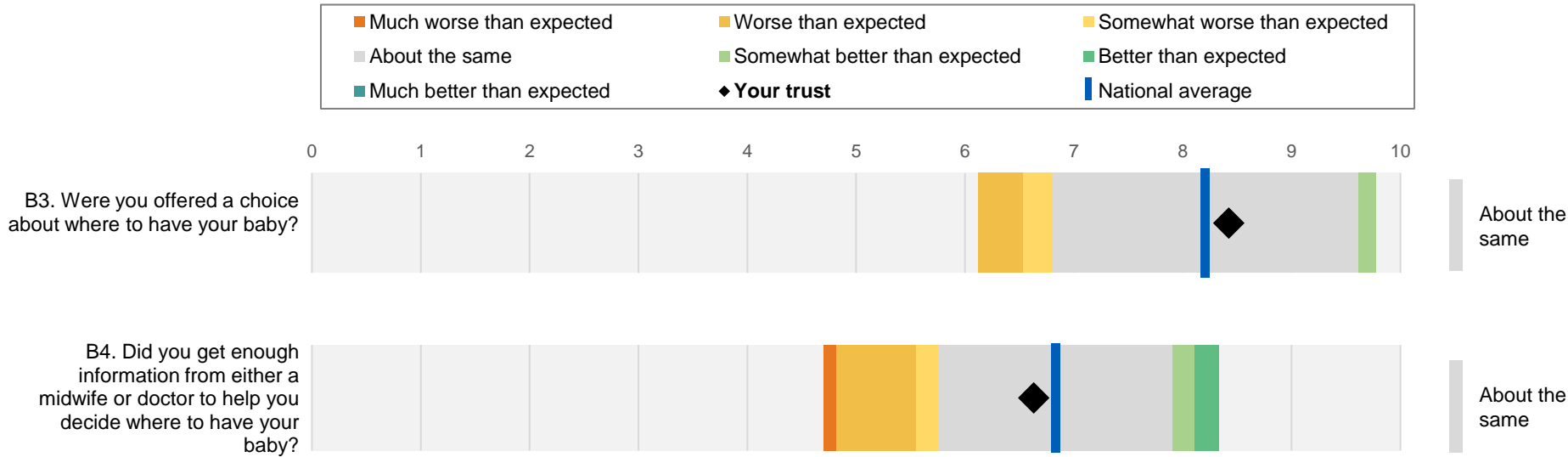


Trusts with the lowest scores



Section 1. Antenatal Care

Question scores: The start of your care in pregnancy



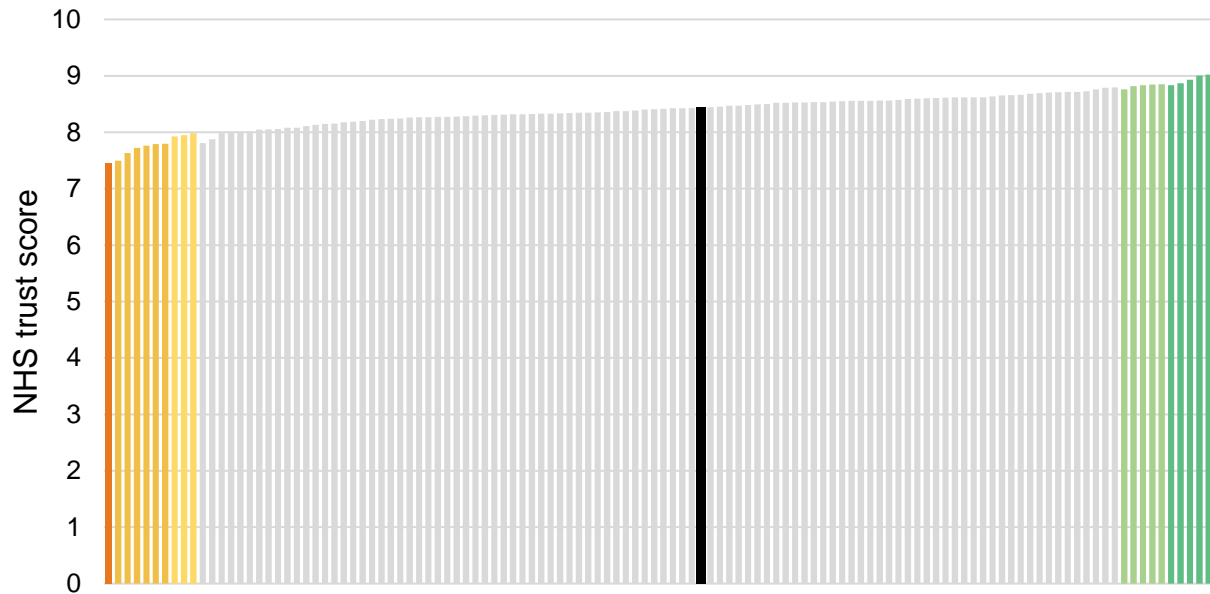
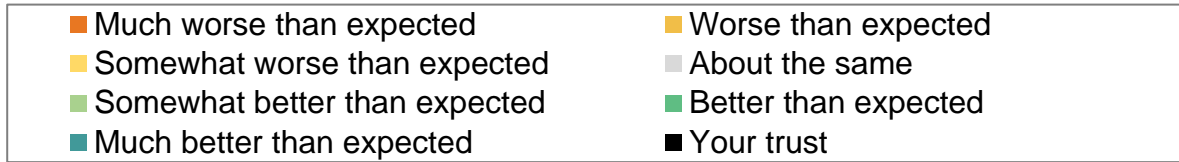
		All trusts in England		
Number of respondents (your trust)	Your trust score	National average score	Lowest score	Highest score
64	8.4	8.2	6.1	9.8
75	6.6	6.8	4.7	8.3

Antenatal check-ups

This shows the range of section scores for all NHS trusts included in the survey that submitted attribution data for antenatal care received. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'antenatal check-ups' is calculated from questions B6 to B9. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 8.4

About the same



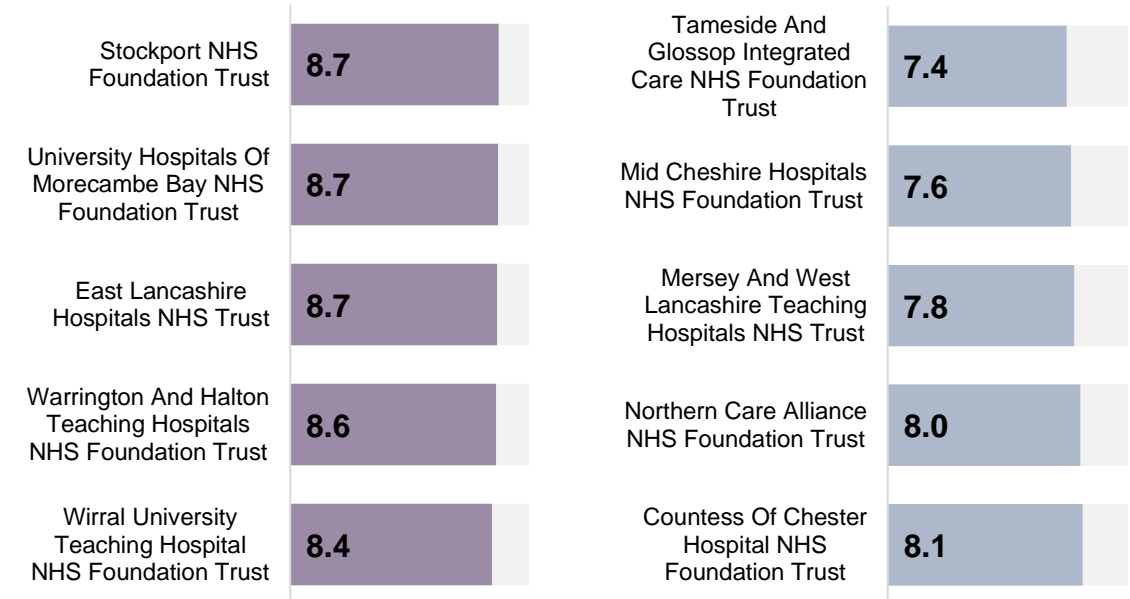
Each vertical line represents an individual NHS trust

Trust score is not shown when there are fewer than 30 respondents

Comparison with other trusts within your region

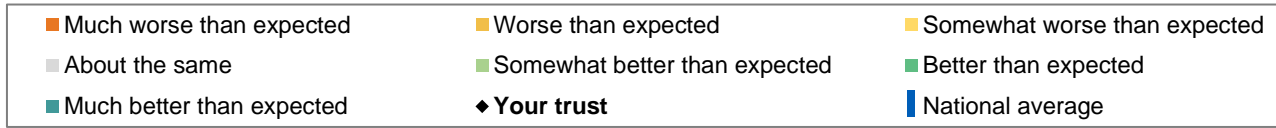
Trusts with the highest scores

Trusts with the lowest scores

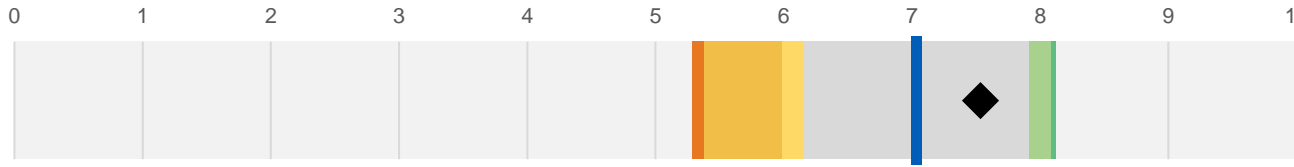


Section 1. Antenatal Care

Question scores: Antenatal check-ups



B6. During your antenatal check-ups, did your midwives or doctor appear to be aware of your medical history?



About the same

Number of respondents (your trust)	Your trust score	All trusts in England		
		National average score	Lowest score	Highest score
77	7.5	7.0	5.3	8.1

B7. During your antenatal check-ups, were you given enough time to ask questions or discuss your pregnancy?



About the same

79	8.8	8.9	7.9	9.6
----	-----	-----	-----	-----

B8. During your antenatal check-ups, did your midwives listen to you?



About the same

78	9.0	9.1	8.2	9.8
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B9. During your antenatal check-ups, did your midwives ask you about your mental health?



About the same

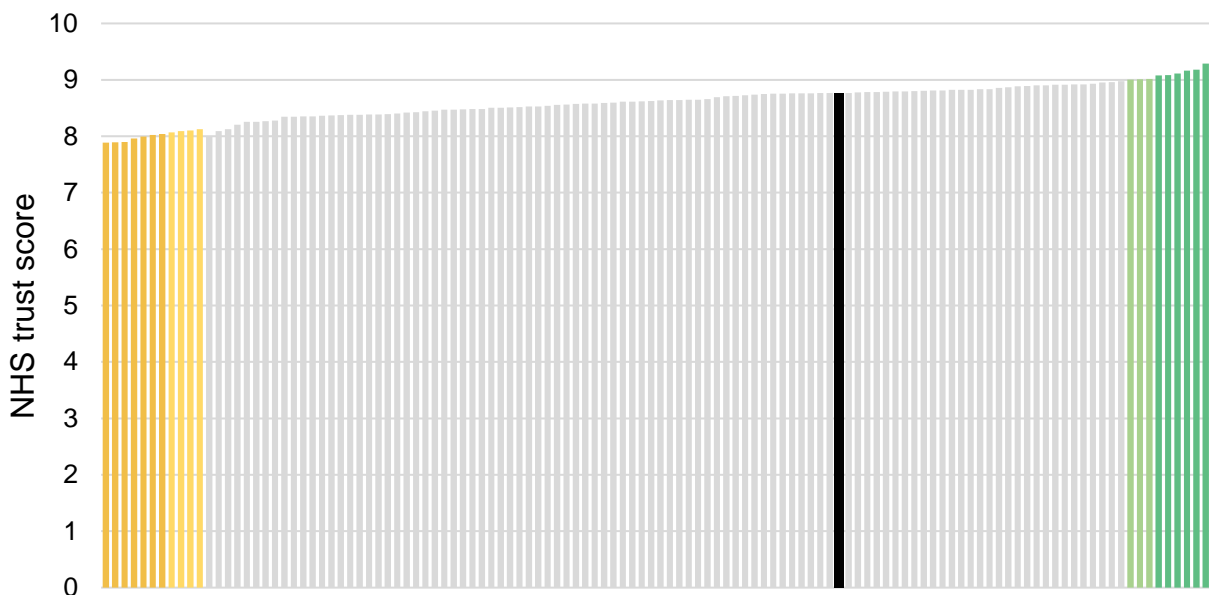
78	8.4	8.6	6.7	9.6
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During your pregnancy

This shows the range of section scores for all NHS trusts included in the survey that submitted attribution data for antenatal care received. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'during your pregnancy' is calculated from questions B10 to B18. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 8.8 **About the same**

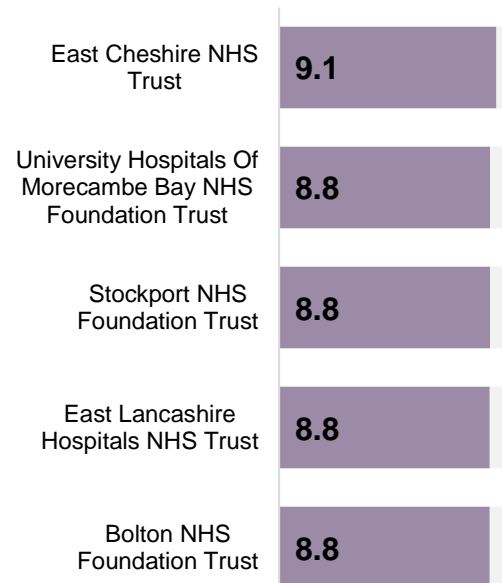
- | | |
|---------------------------------|------------------------|
| ■ Much worse than expected | ■ Worse than expected |
| ■ Somewhat worse than expected | ■ About the same |
| ■ Somewhat better than expected | ■ Better than expected |
| ■ Much better than expected | ■ Your trust |



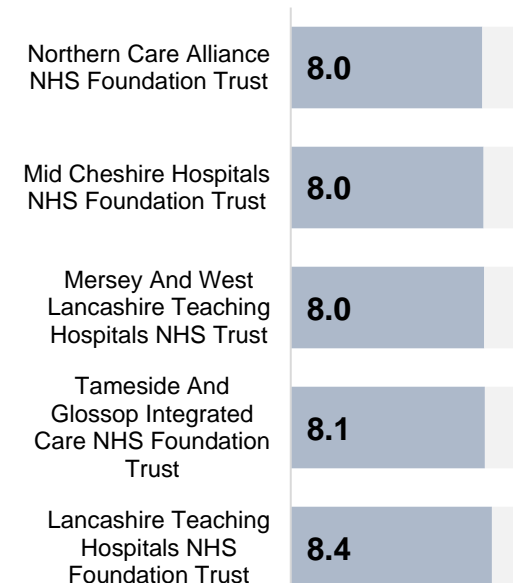
Trust score is not shown when there are fewer than 30 respondents

Comparison with other trusts within your region

Trusts with the highest scores

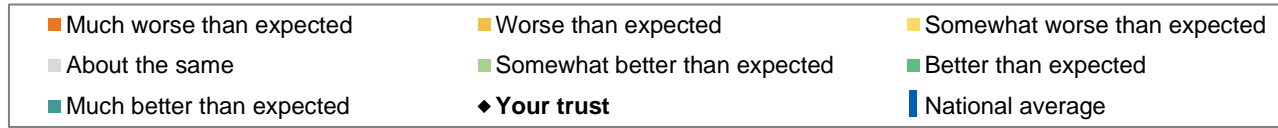


Trusts with the lowest scores

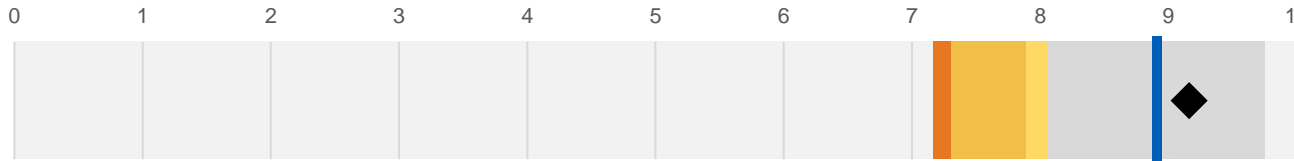


Section 1. Antenatal Care

Question scores: During your pregnancy



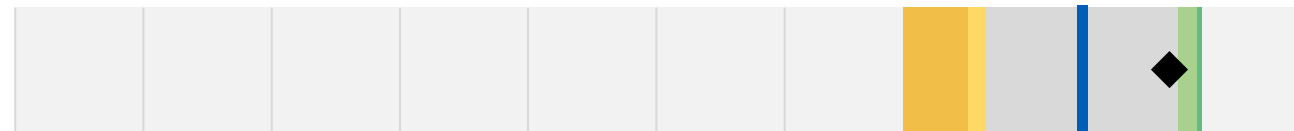
B10. Were you given enough support for your mental health during your pregnancy?



About the same

Number of respondents (your trust)	Your trust score	All trusts in England		
		National average score	Lowest score	Highest score
36	9.2	8.9	7.2	9.8

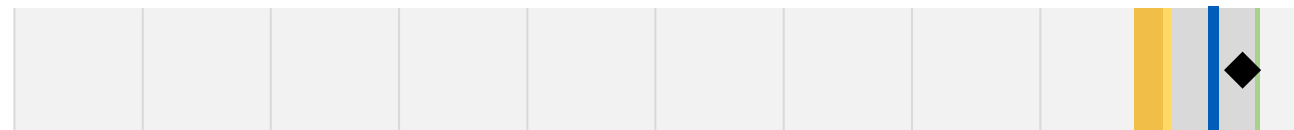
B11. During your pregnancy, if you contacted a midwifery team, were you given the help you needed?



About the same

Number of respondents (your trust)	Your trust score	National average score	Lowest score	Highest score
64	9.0	8.3	6.9	9.3

B12. Thinking about your antenatal care, were you spoken to in a way you could understand?

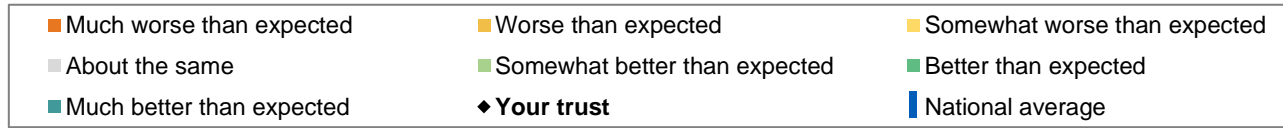


About the same

Number of respondents (your trust)	Your trust score	National average score	Lowest score	Highest score
79	9.6	9.4	8.7	9.7

Section 1. Antenatal Care (continued)

Question scores: During your pregnancy



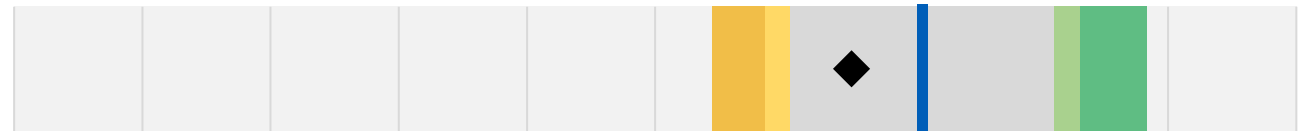
B13. Thinking about your antenatal care, were you involved in decisions about your care?



About the same

Number of respondents (your trust)	Your trust score	All trusts in England		
		National average score	Lowest score	Highest score
78	8.9	8.9	8.0	9.5

B14. During your pregnancy did midwives provide relevant information about feeding your baby?



About the same

Number of respondents (your trust)	Your trust score	National average score	Lowest score	Highest score
75	6.5	7.1	5.4	8.8

B15. Did you have confidence and trust in the staff caring for you during your antenatal care?

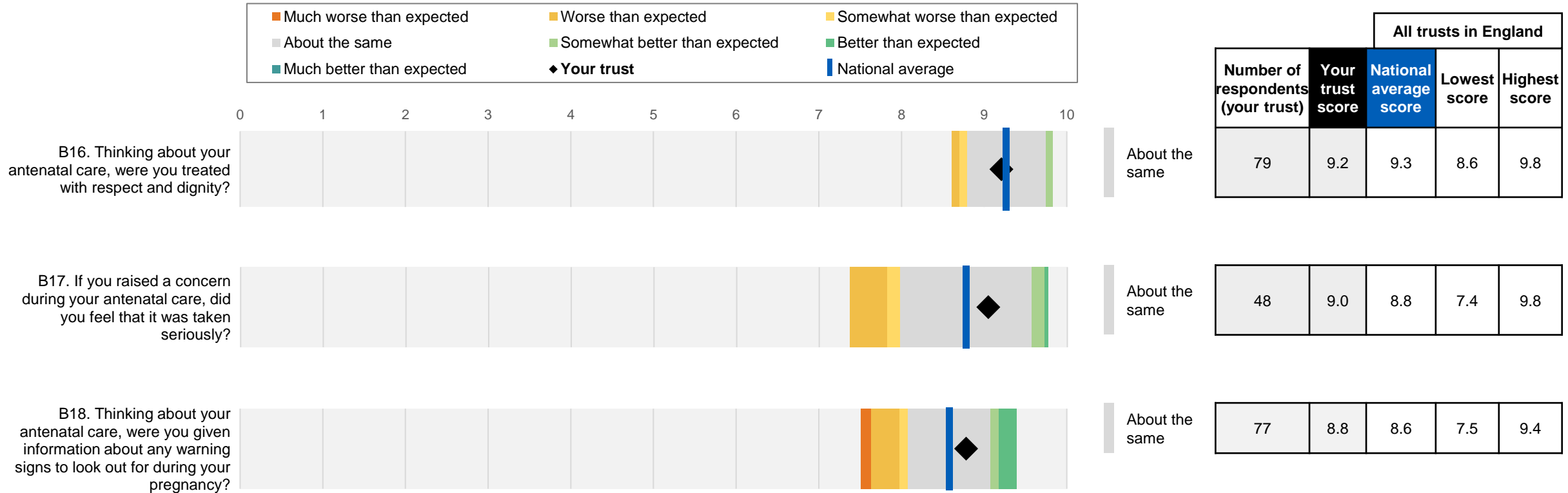


About the same

Number of respondents (your trust)	Your trust score	National average score	Lowest score	Highest score
79	8.6	8.3	7.2	9.3

Section 1. Antenatal Care (continued)

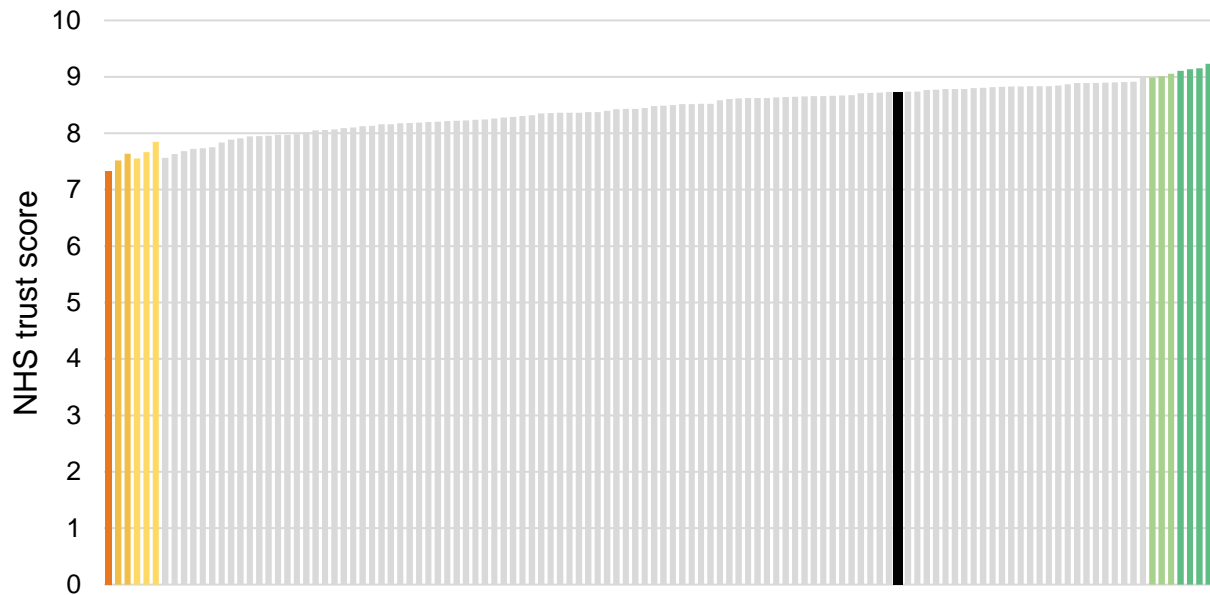
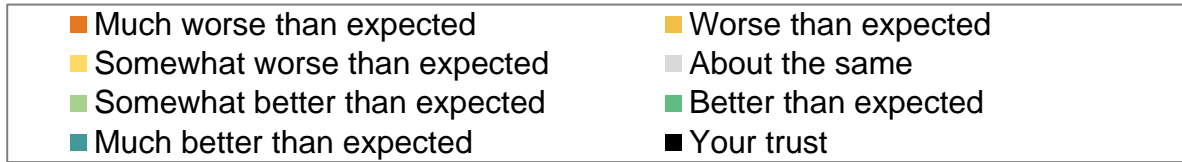
Question scores: During your pregnancy



Triage: Assessment and Evaluation

This shows the range of section scores for all NHS trusts included in the survey that submitted attribution data for antenatal care received. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'triage: assessment and evaluation' is calculated from question B20. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 8.7 **About the same**

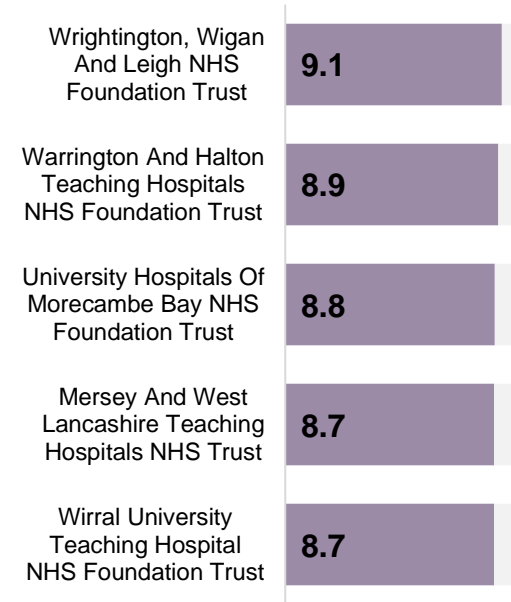


Each vertical line represents an individual NHS trust

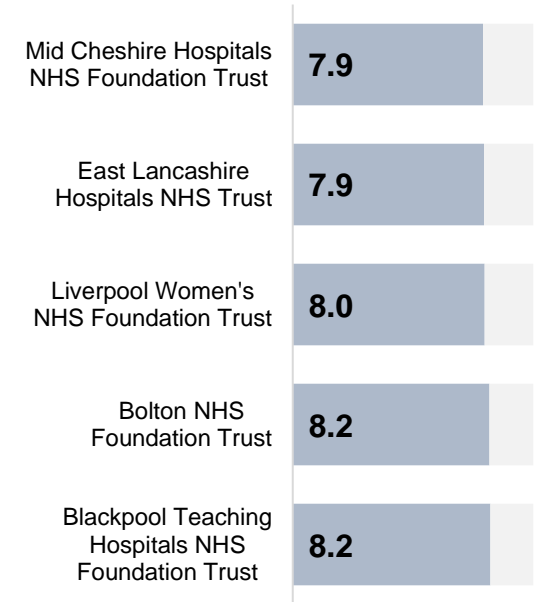
Trust score is not shown when there are fewer than 30 respondents

Comparison with other trusts within your region

Trusts with the highest scores

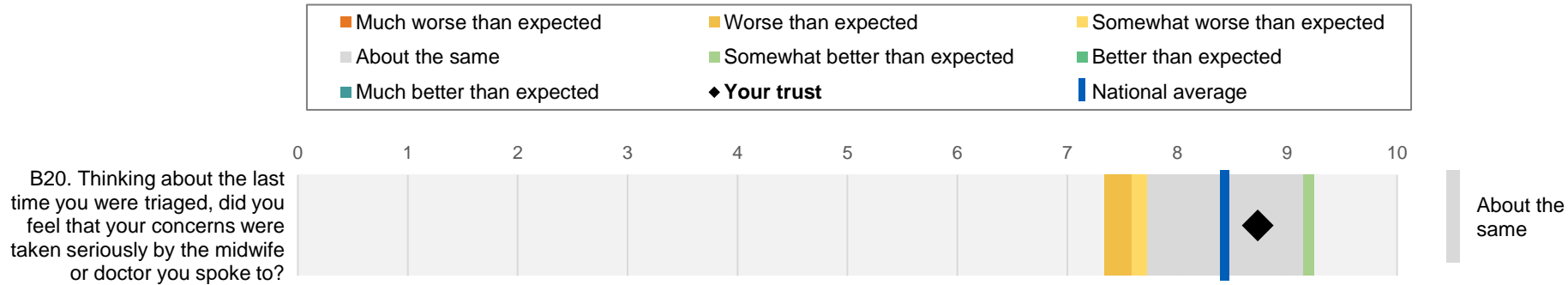


Trusts with the lowest scores



Section 1. Antenatal Care

Question scores: Triage: Assessment and evaluation



Number of respondents (your trust)	Your trust score	All trusts in England		
		National average score	Lowest score	Highest score
63	8.7	8.4	7.3	9.2

Benchmarking

Section 2: Labour and Birth



NHS



**CareQuality
Commission**

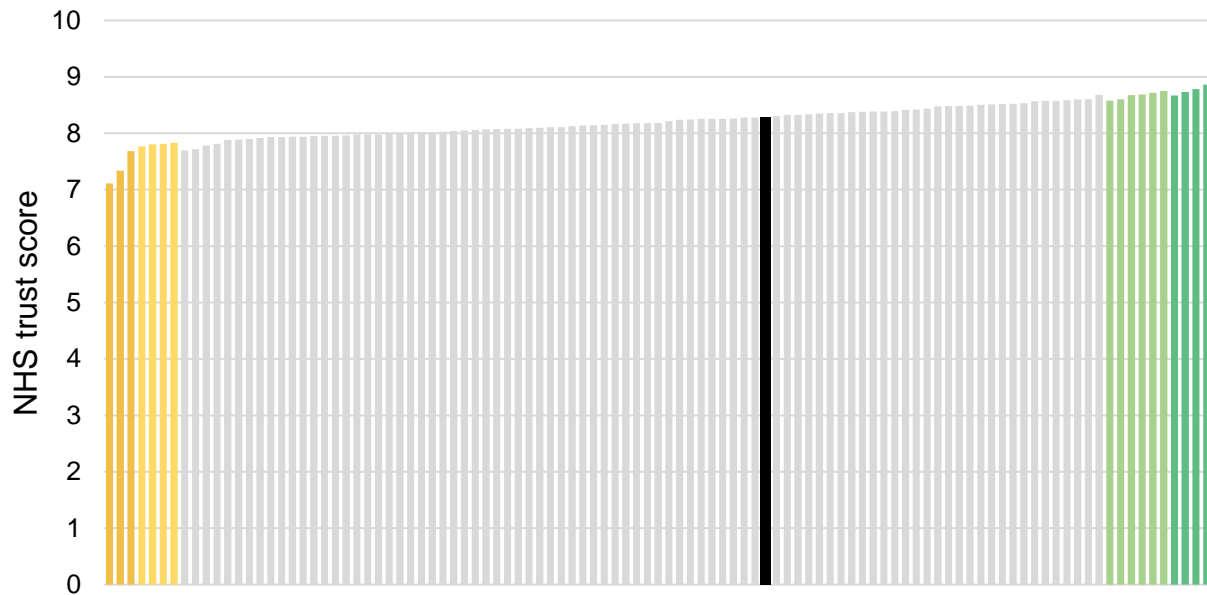
**Survey
Coordination
Centre**

Your labour and birth

This shows the range of section scores for all NHS trusts included in the survey. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'your labour and birth' is calculated from questions C4 to C9. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 8.3 **About the same**

- | | |
|---------------------------------|------------------------|
| ■ Much worse than expected | ■ Worse than expected |
| ■ Somewhat worse than expected | ■ About the same |
| ■ Somewhat better than expected | ■ Better than expected |
| ■ Much better than expected | ■ Your trust |

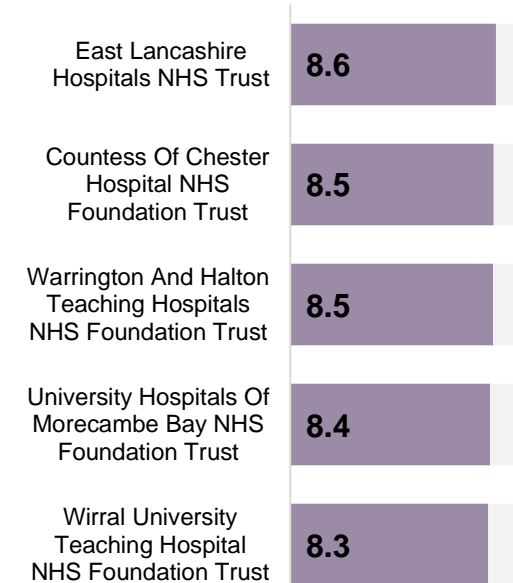


Each vertical line represents an individual NHS trust

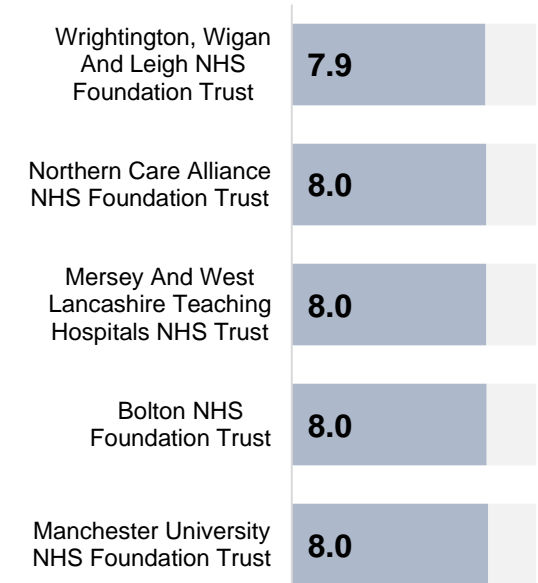
Trust score is not shown when there are fewer than 30 respondents

Comparison with other trusts within your region

Trusts with the highest scores

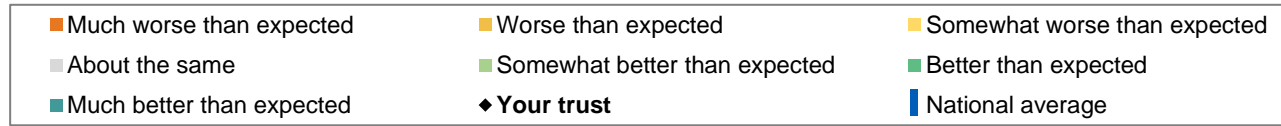


Trusts with the lowest scores



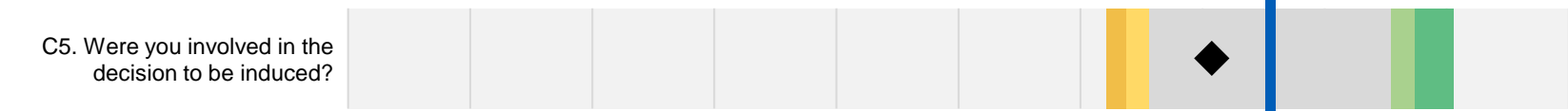
Section 2. Labour and Birth

Question scores: Your labour and birth



		All trusts in England		
Number of respondents (your trust)	Your trust score	National average score	Lowest score	Highest score
35	8.1	7.4	5.7	9.2

About the same



37	7.1	7.6	6.2	9.1
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About the same

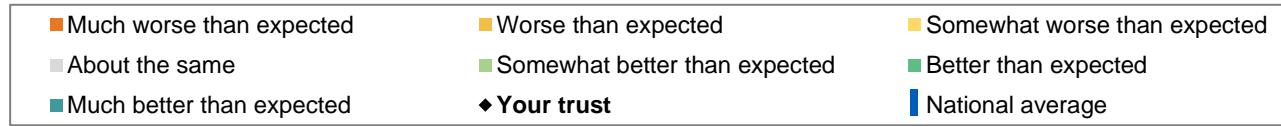


54	8.5	8.4	7.4	9.4
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About the same

Section 2. Labour and Birth (continued)

Question scores: Your labour and birth



C7. During your labour, were you ever sent home when you were worried about yourself or your baby?



About the same

Number of respondents (your trust)	Your trust score	All trusts in England		
		National average score	Lowest score	Highest score
71	9.4	9.0	7.1	9.8

C8. Do you think your healthcare professionals did everything they could to help manage your pain during labour and birth?



About the same

70	7.5	7.5	5.8	8.7
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C9. If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?



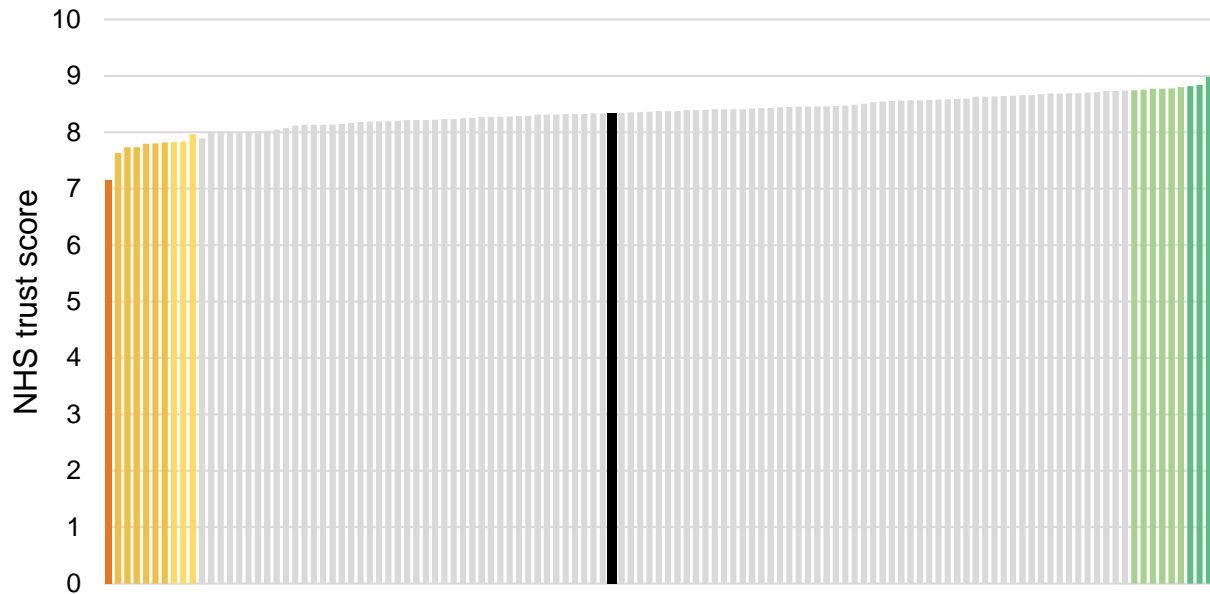
About the same

82	9.1	9.4	8.1	10.0
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Staff caring for you

This shows the range of section scores for all NHS trusts included in the survey. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'staff caring for you' is calculated from questions C10 to C21. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

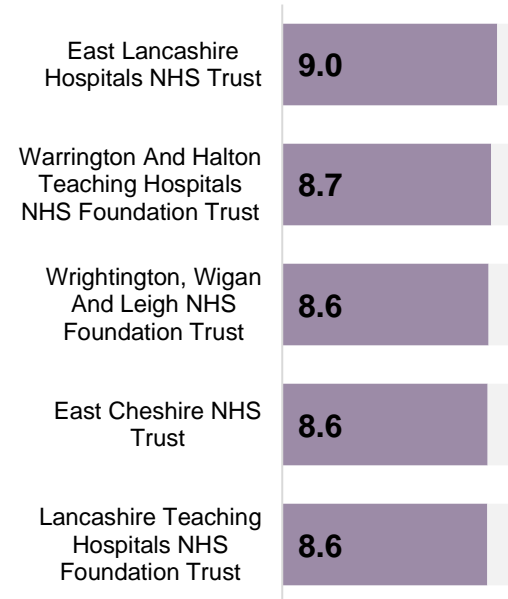
Your trust section score = 8.3 About the same



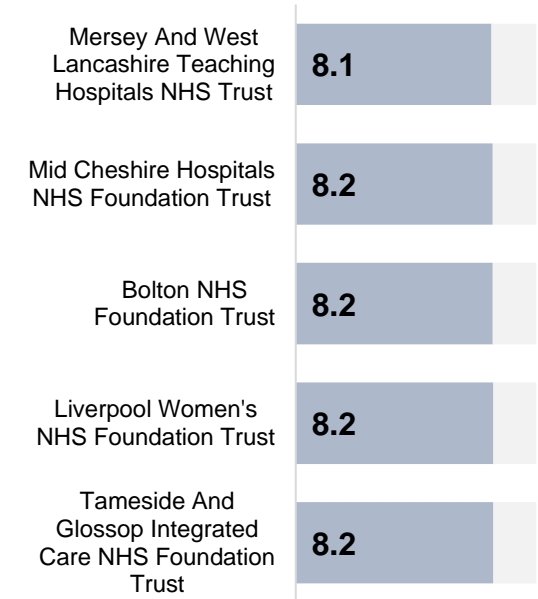
Each vertical line represents an individual NHS trust
Trust score is not shown when there are fewer than 30 respondents

Comparison with other trusts within your region

Trusts with the highest scores

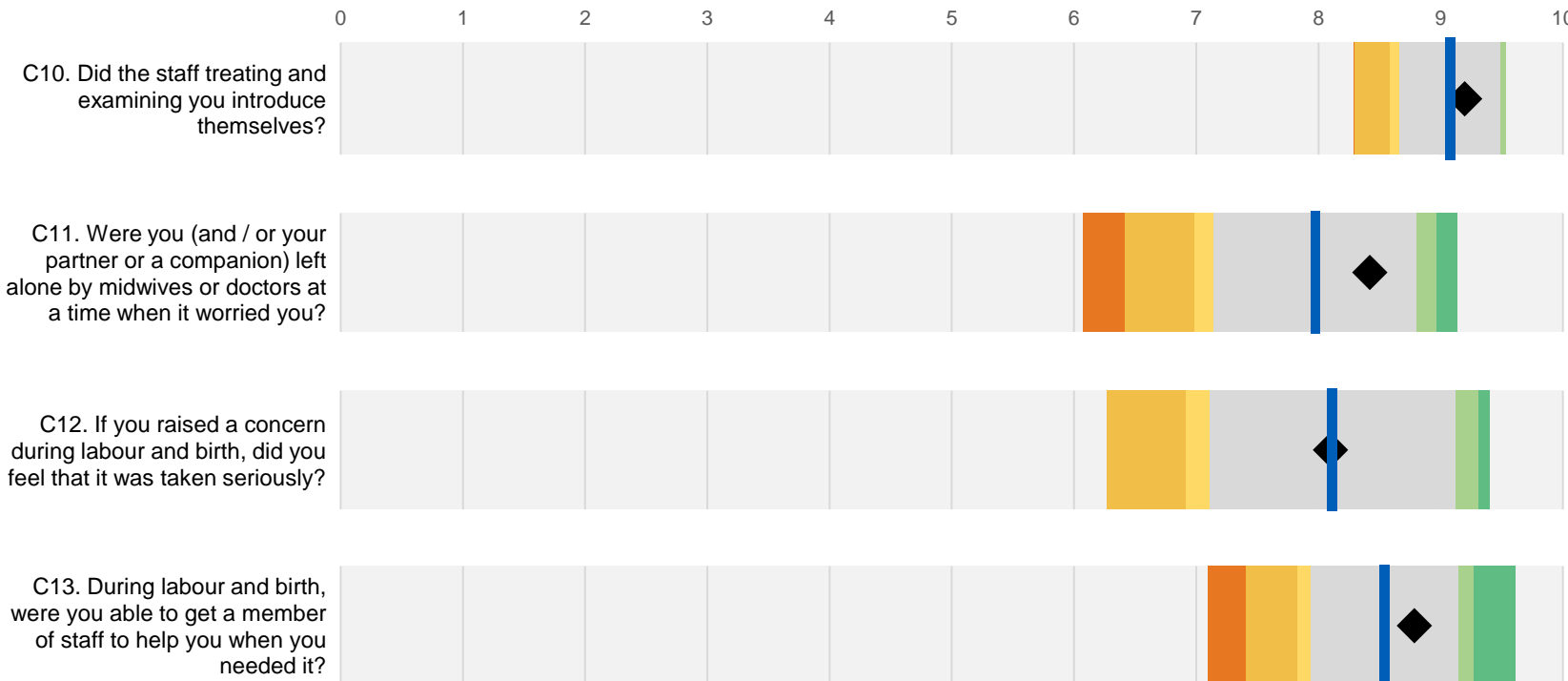
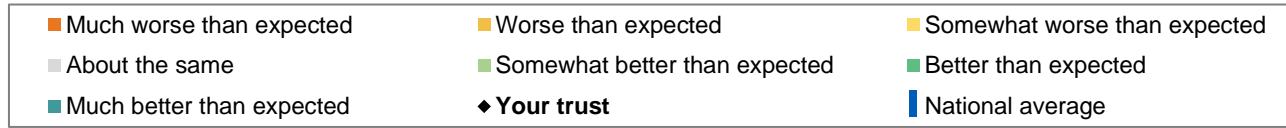


Trusts with the lowest scores



Section 2. Labour and Birth

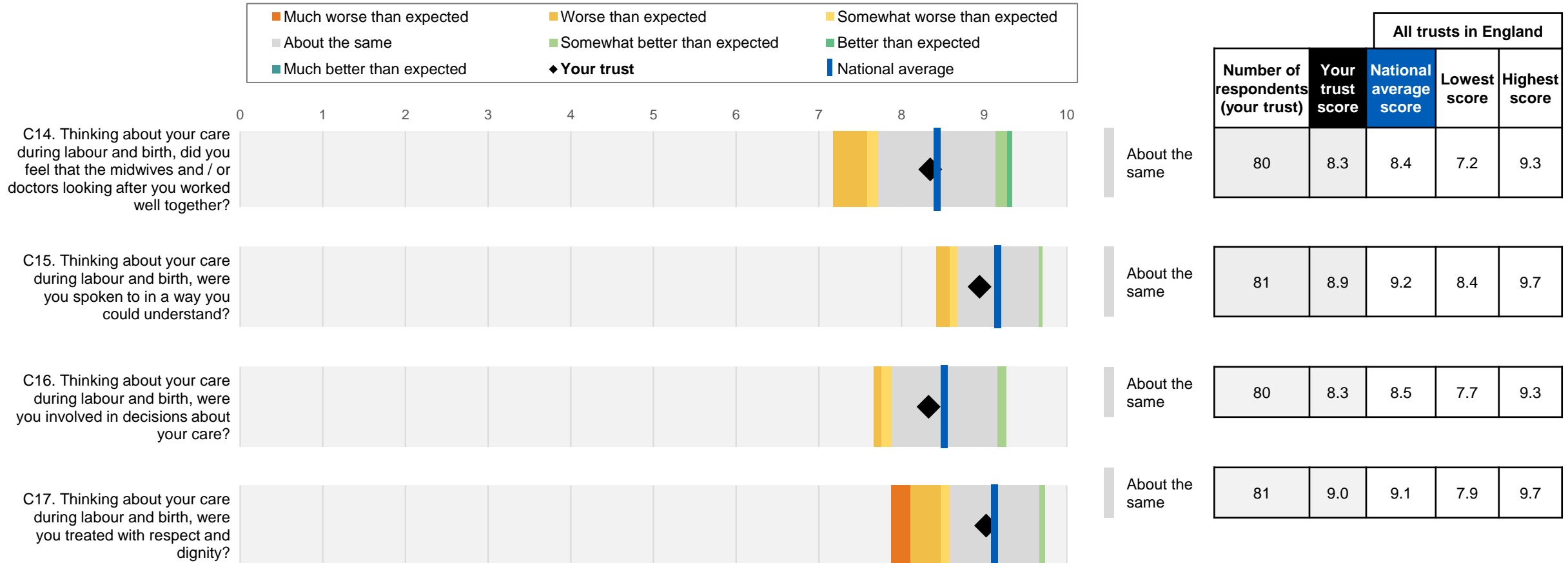
Question scores: Staff caring for you



Number of respondents (your trust)	Your trust score	All trusts in England		
		National average score	Lowest score	Highest score
79	9.2	9.1	8.3	9.5
77	8.4	8.0	6.1	9.1
52	8.1	8.1	6.3	9.4
81	8.8	8.5	7.1	9.6

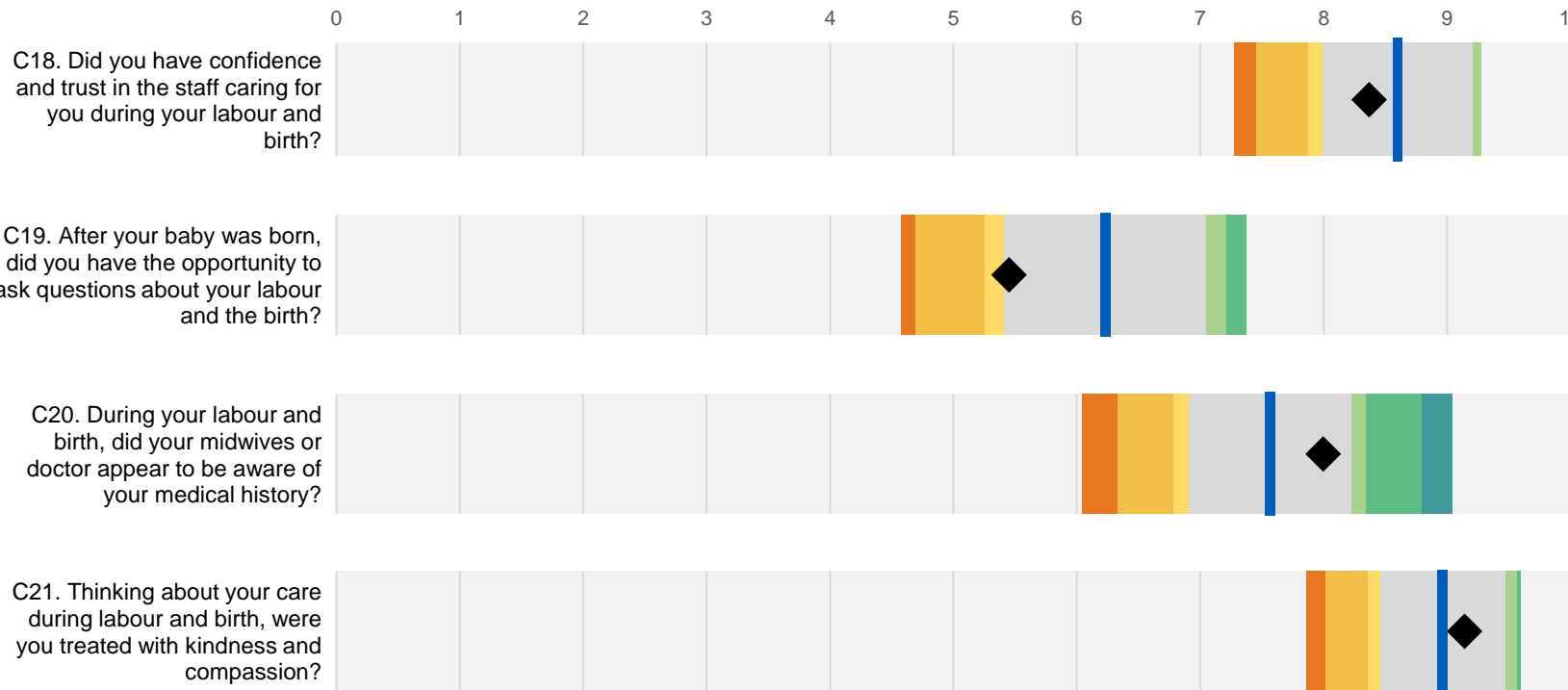
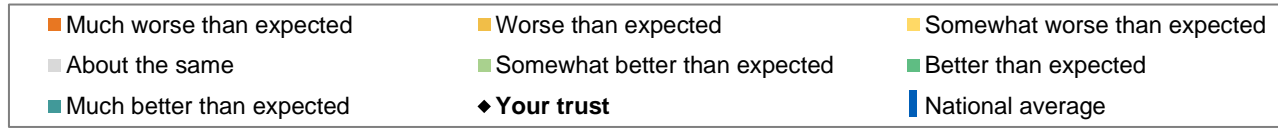
Section 2. Labour and Birth (continued)

Question scores: Staff caring for you



Section 2. Labour and Birth (continued)

Question scores: Staff caring for you



Number of respondents (your trust)	Your trust score	All trusts in England		
		National average score	Lowest score	Highest score
82	8.4	8.6	7.3	9.3
72	5.4	6.2	4.6	7.4
73	8.0	7.6	6.0	9.0
82	9.1	9.0	7.9	9.6

Benchmarking

Section 3: Postnatal Care



NHS



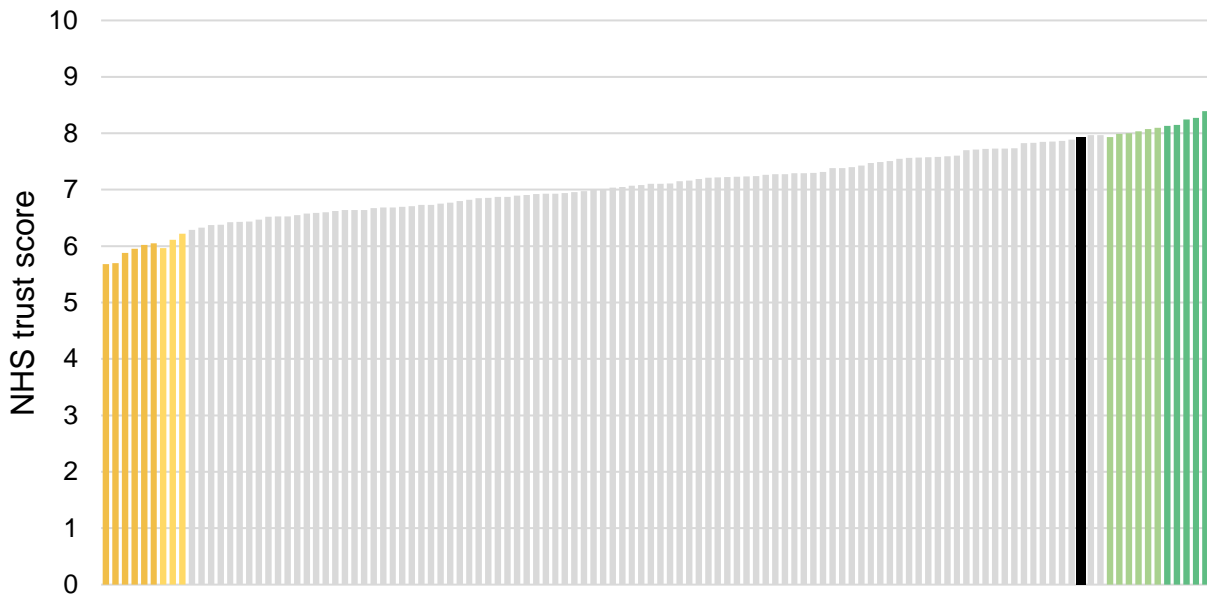
**CareQuality
Commission**

**Survey
Coordination
Centre**

Care in the ward after birth

This shows the range of section scores for all NHS trusts included in the survey. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'care in the ward after birth' is calculated from questions D2 to D7. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 7.9 About the same

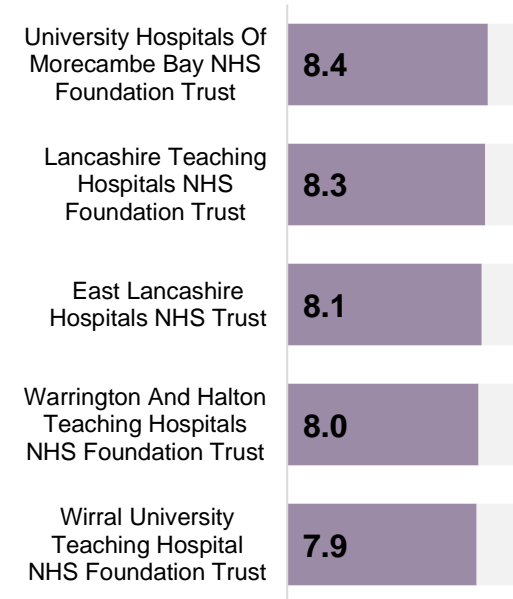


Each vertical line represents an individual NHS trust

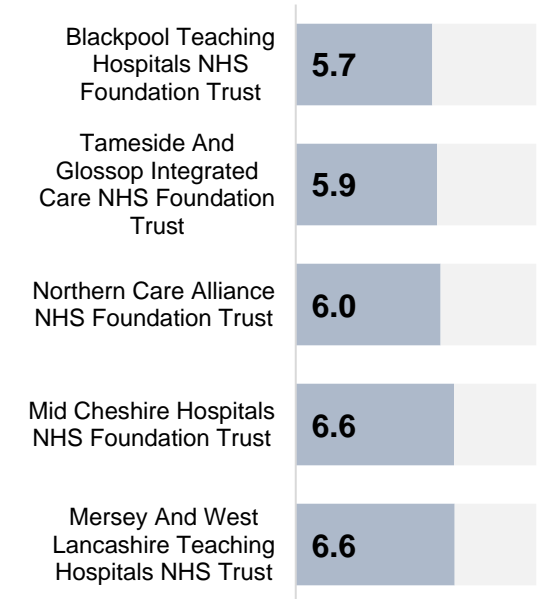
Trust score is not shown when there are fewer than 30 respondents

Comparison with other trusts within your region

Trusts with the highest scores

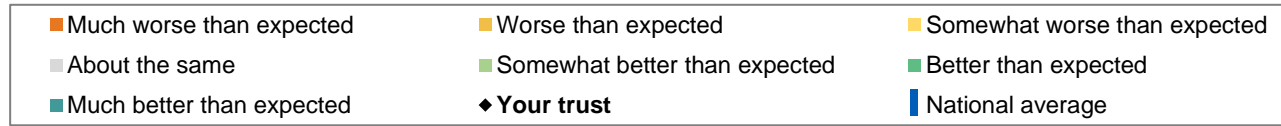


Trusts with the lowest scores

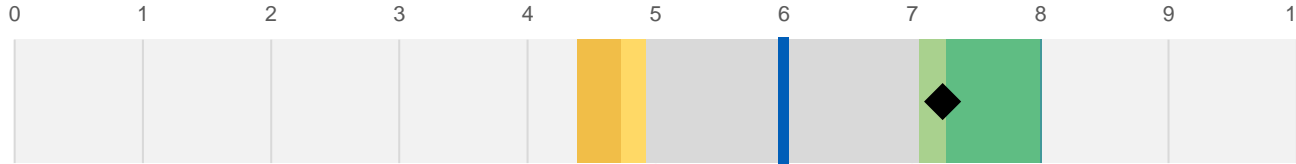


Section 3. Postnatal Care

Question scores: Care in the ward after birth



D2. On the day you left hospital, was your discharge delayed for any reason?



Somewhat better than expected

Number of respondents (your trust)	Your trust score	All trusts in England		
		National average score	Lowest score	Highest score
77	7.2	6.0	4.4	8.0

D3. If you needed attention while you were in hospital after the birth, were you able to get a member of staff to help you when you needed it?



About the same

75	7.4	7.1	5.0	8.7
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D4. Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?

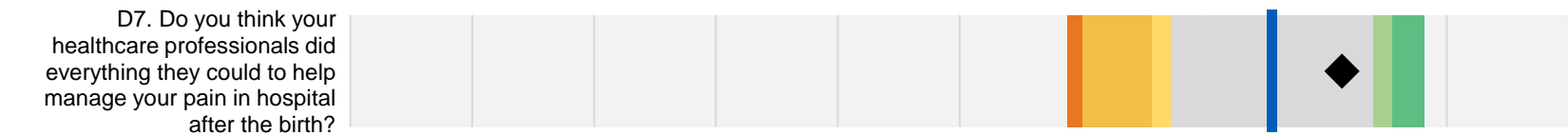
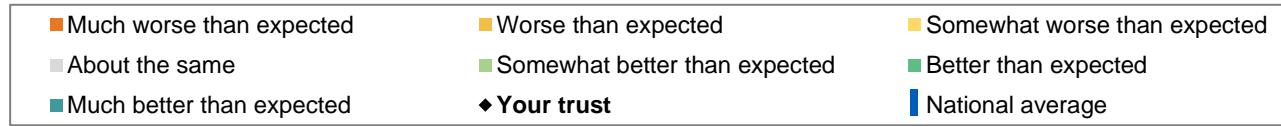


About the same

77	7.6	7.3	5.7	8.2
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Section 3. Postnatal Care (continued)

Question scores: Care in the ward after birth



Number of respondents (your trust)	Your trust score	All trusts in England		
		National average score	Lowest score	Highest score
76	8.4	8.3	6.9	9.1

About the same

76	8.8	6.5	2.3	9.9
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About the same

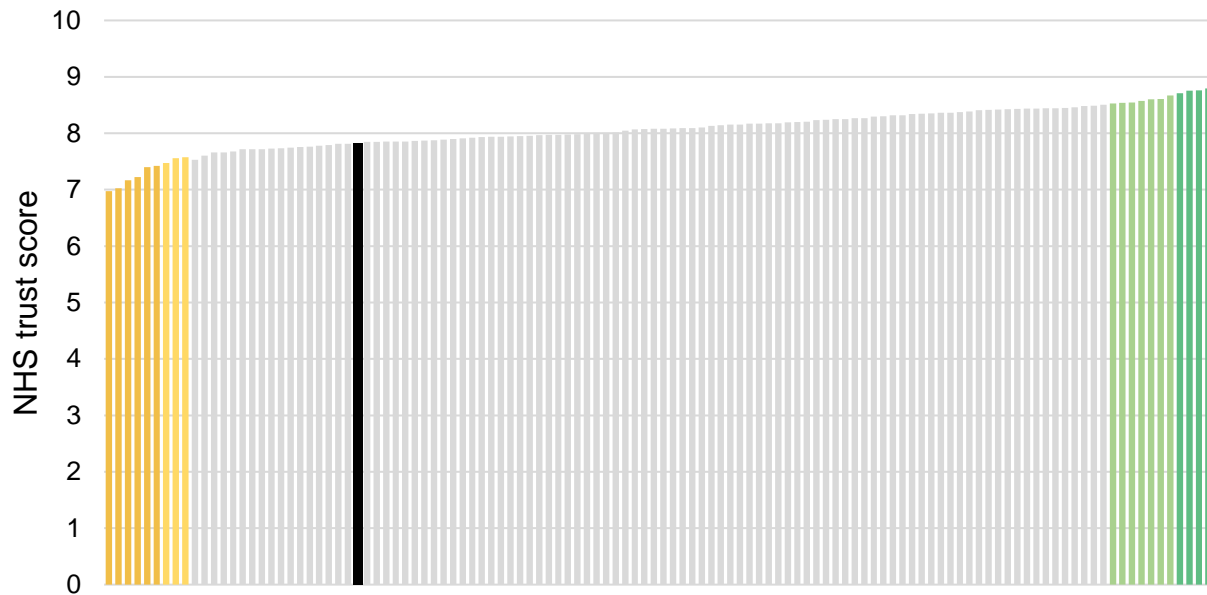
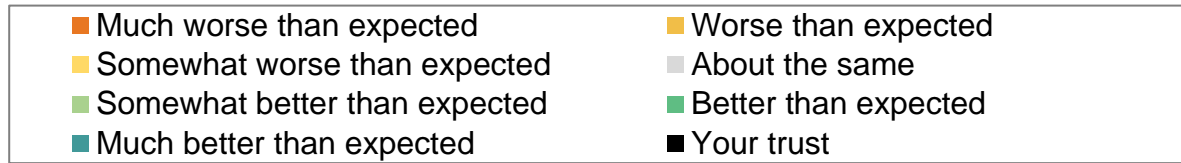
75	8.1	7.6	5.9	8.8
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About the same

Feeding your baby

This shows the range of section scores for all NHS trusts included in the survey that submitted attribution data for postnatal care received. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'feeding your baby' is calculated from questions E2 and E3. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 7.8 About the same

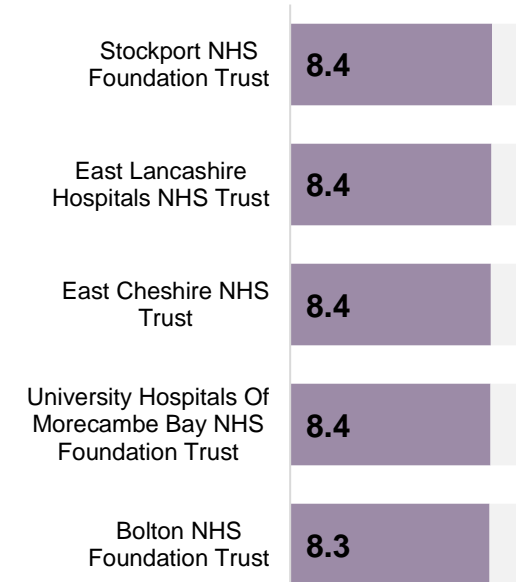


Each vertical line represents an individual NHS trust

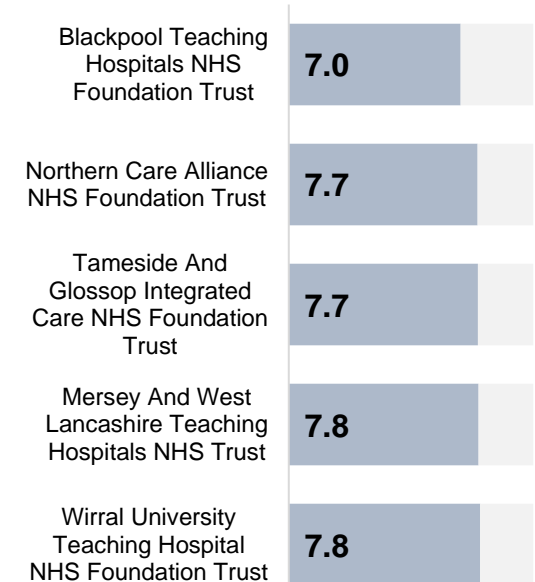
Trust score is not shown when there are fewer than 30 respondents

Comparison with other trusts within your region

Trusts with the highest scores

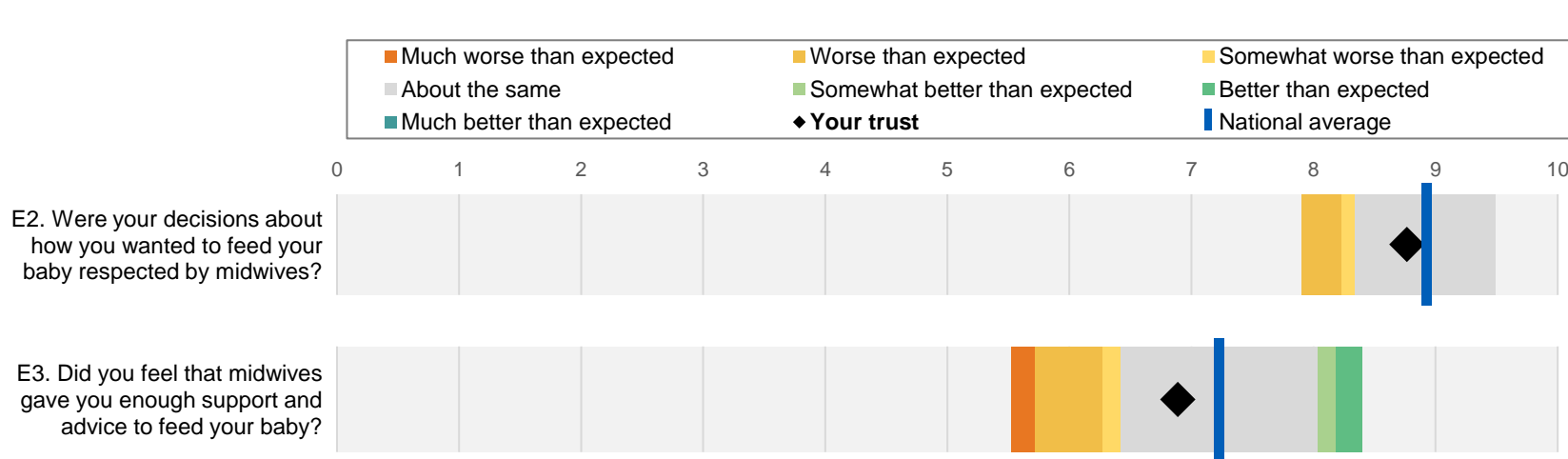


Trusts with the lowest scores



Section 3. Postnatal Care (continued)

Question scores: Feeding your baby



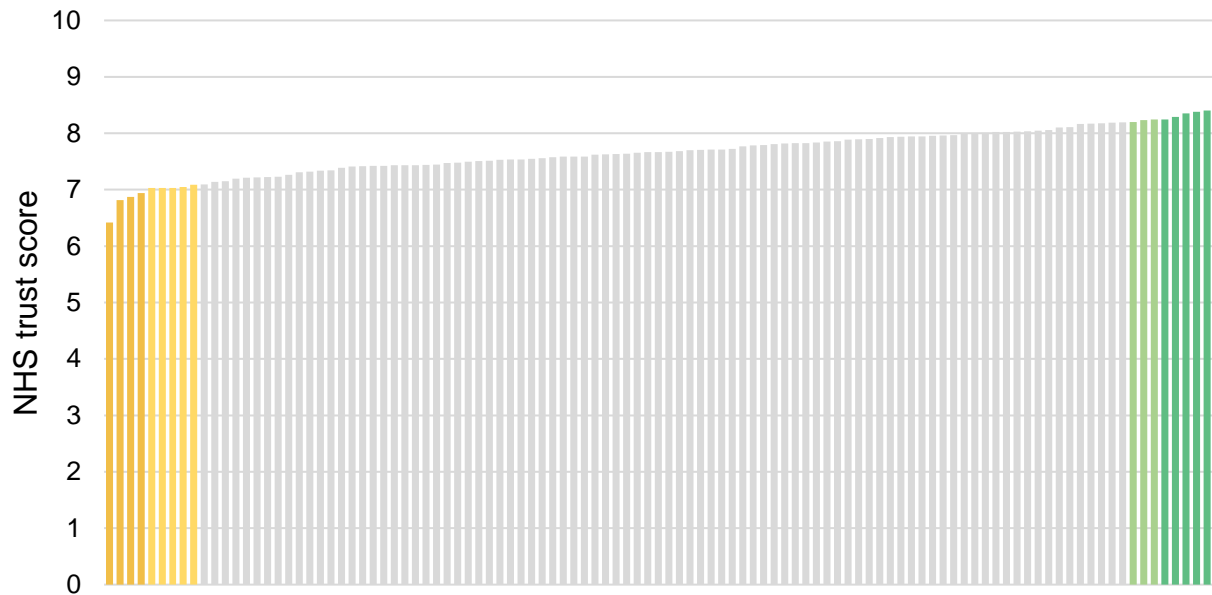
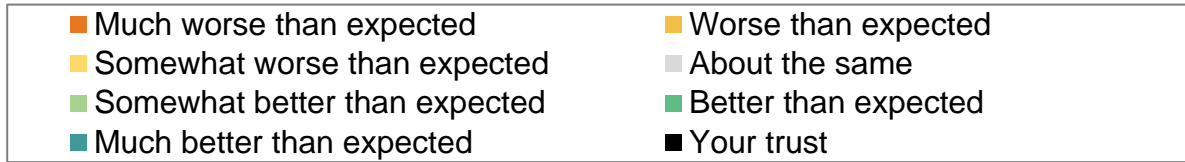
		All trusts in England		
Number of respondents (your trust)	Your trust score	National average score	Lowest score	Highest score
77	8.8	8.9	7.9	9.5
77	6.9	7.2	5.5	8.4

Care at home after birth

This shows the range of section scores for all NHS trusts included in the survey that submitted attribution data for postnatal care received. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'care at home after birth' is calculated from questions F1 and F2, F4 to F8, and F10 to F16. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = -

About the same



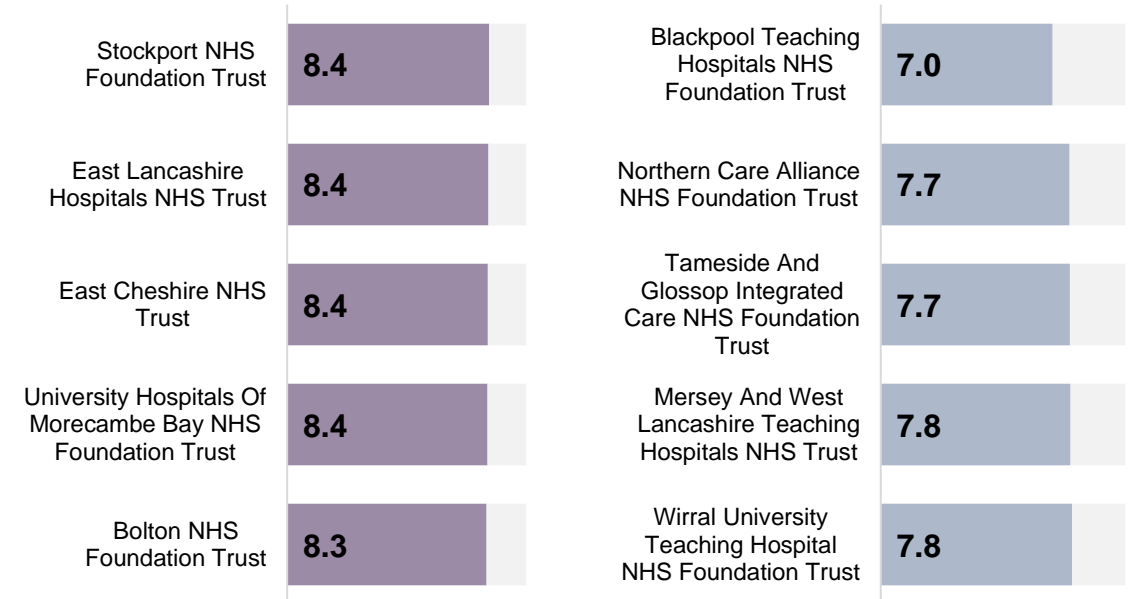
Each vertical line represents an individual NHS trust

Trust score is not shown when there are fewer than 30 respondents

Comparison with other trusts within your region

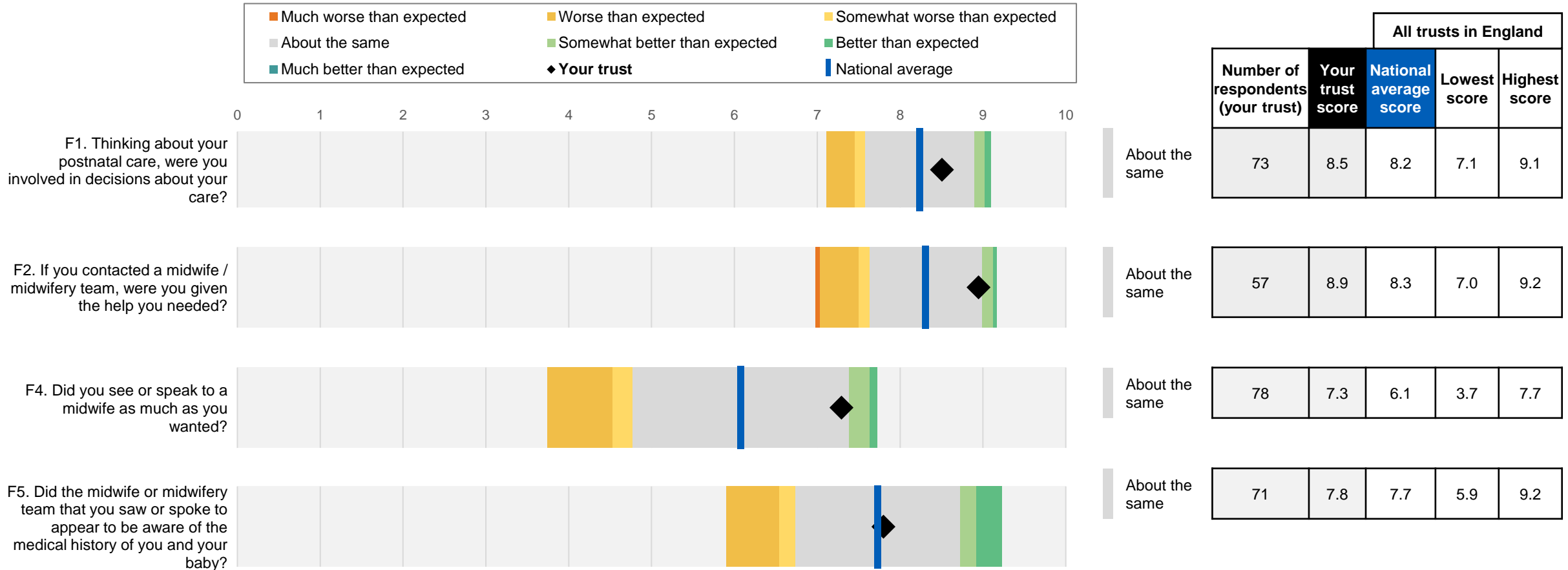
Trusts with the highest scores

Trusts with the lowest scores



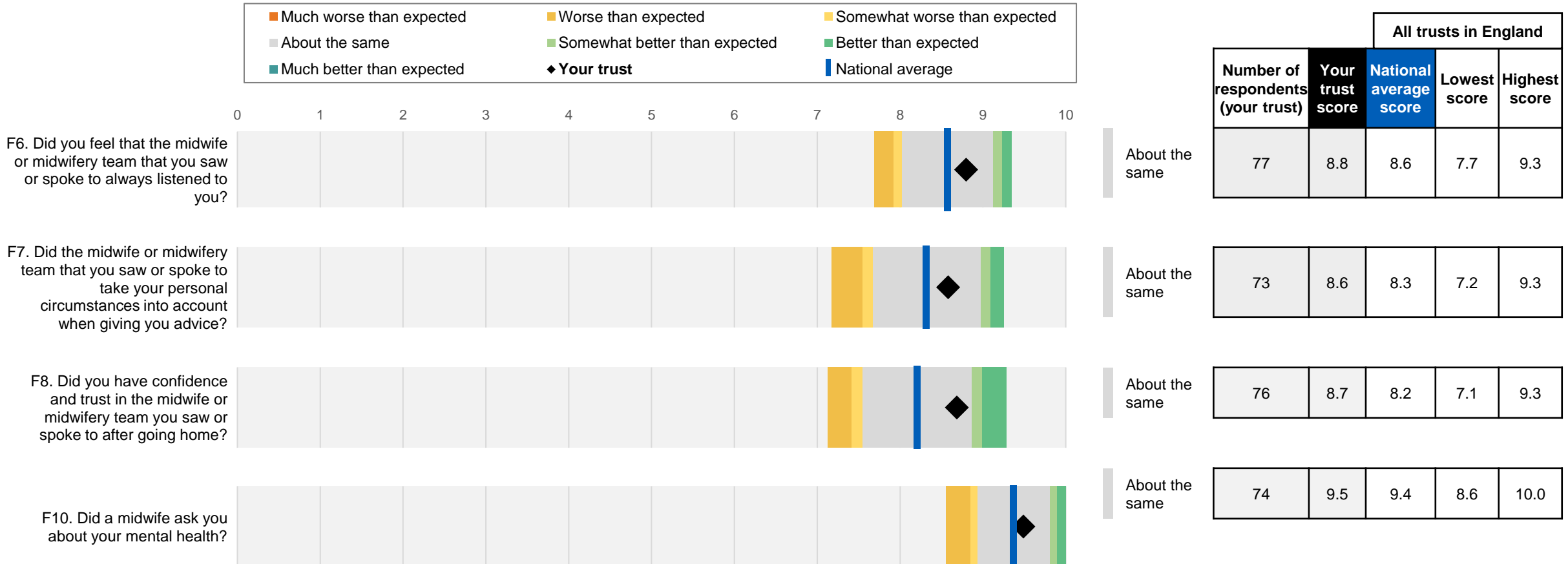
Section 3. Postnatal Care

Question scores: Care at home after birth



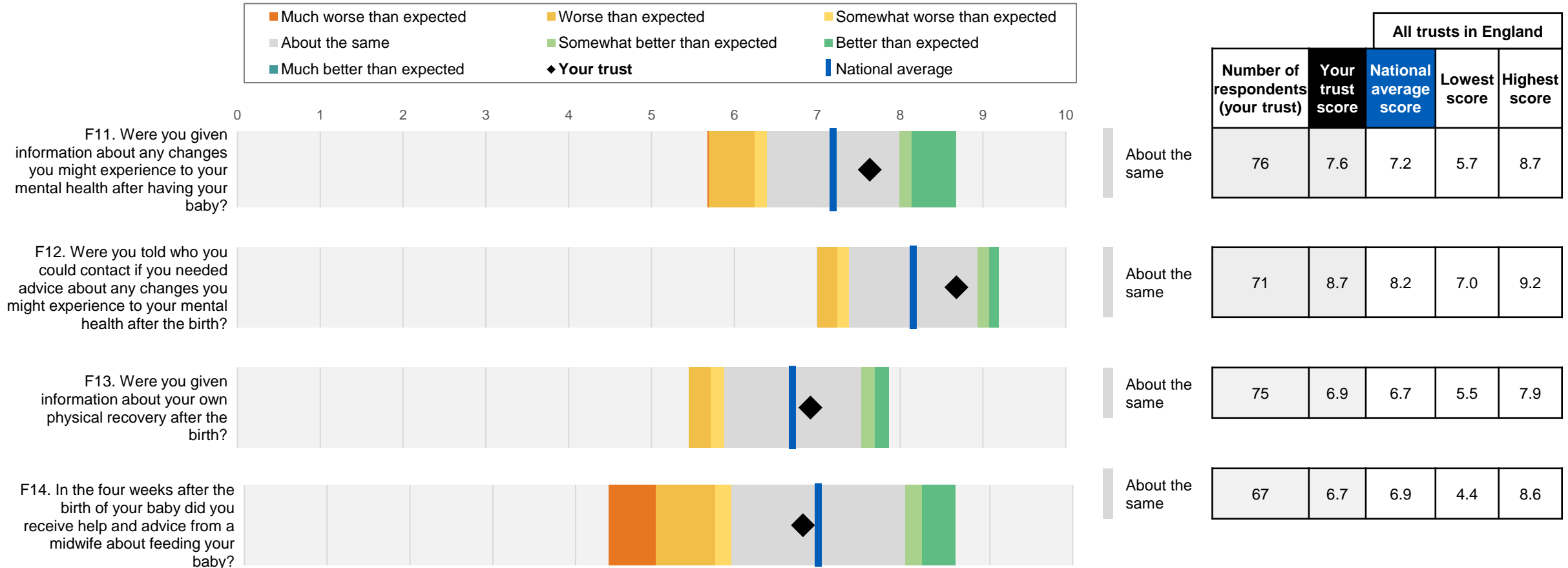
Section 3. Postnatal Care (continued)

Question scores: Care at home after birth



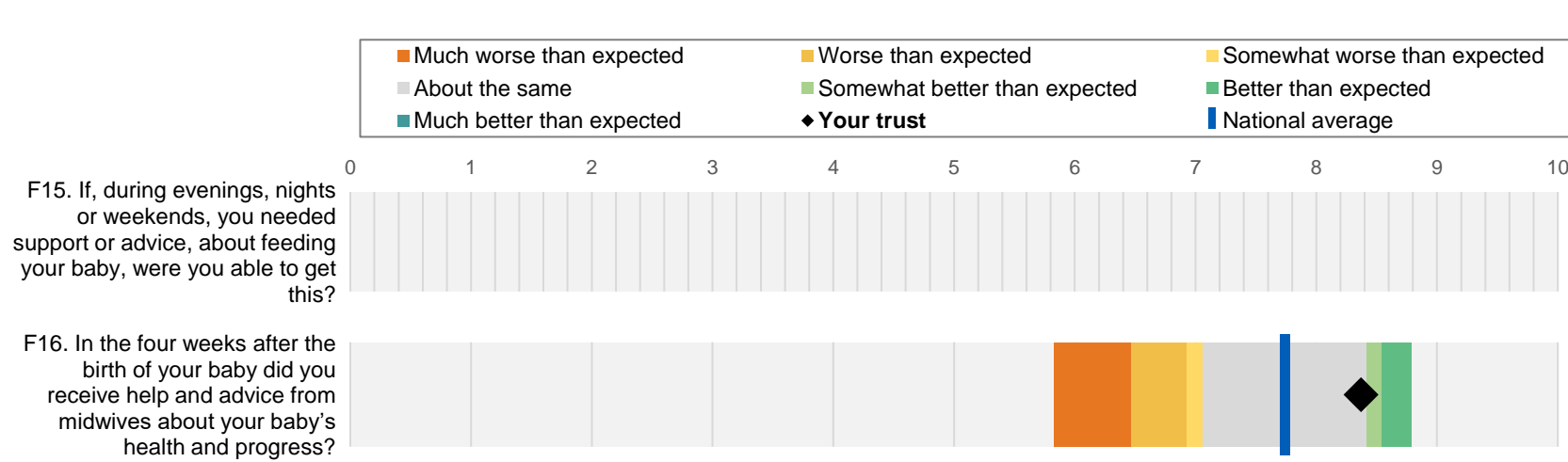
Section 3. Postnatal Care (continued)

Question scores: Care at home after birth



Section 3. Postnatal Care (continued)

Question scores: Care at home after birth



		All trusts in England		
Number of respondents (your trust)	Your trust score	National average score	Lowest score	Highest score
-	-	6.0	4.2	7.8

66	8.4	7.7	5.8	8.8
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About the same

Benchmarking

Section 4: Complaints

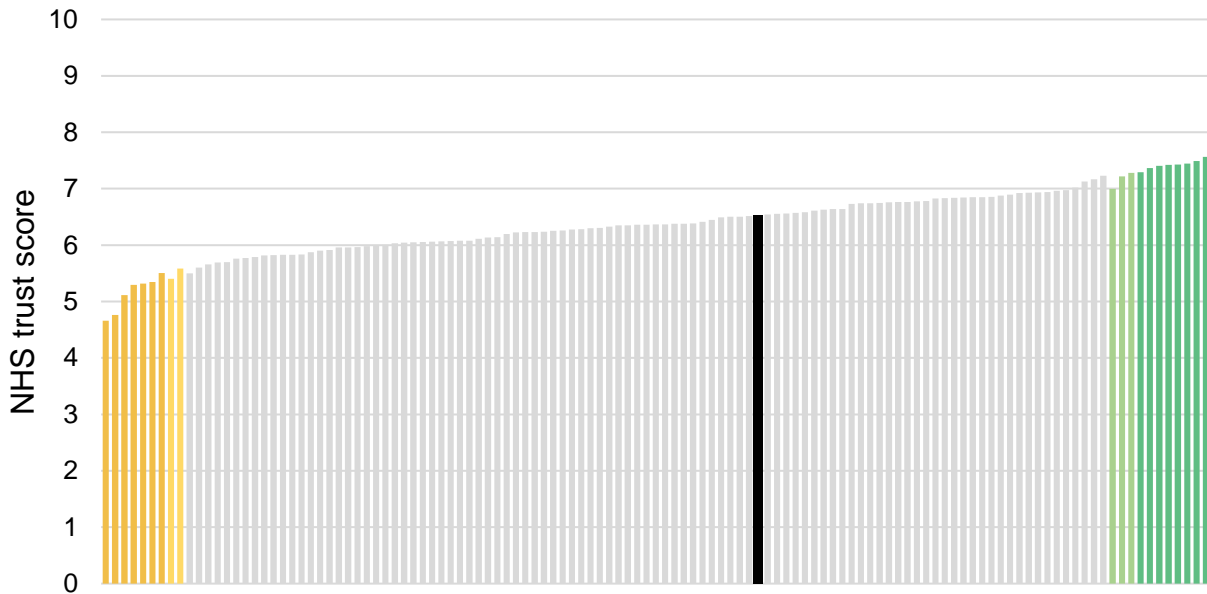
The NHS logo, consisting of the letters 'NHS' in white on a blue rectangular background.The Care Quality Commission logo, featuring a stylized white 'Q' icon to the left of the text 'Care Quality Commission'.

Survey
Coordination
Centre

Complaints

This shows the range of section scores for all NHS trusts included in the survey. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'complaints' is calculated from question F19. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 6.5 About the same

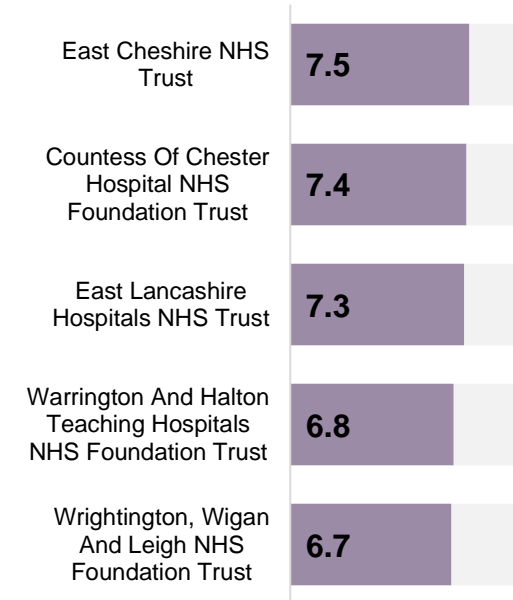


Each vertical line represents an individual NHS trust

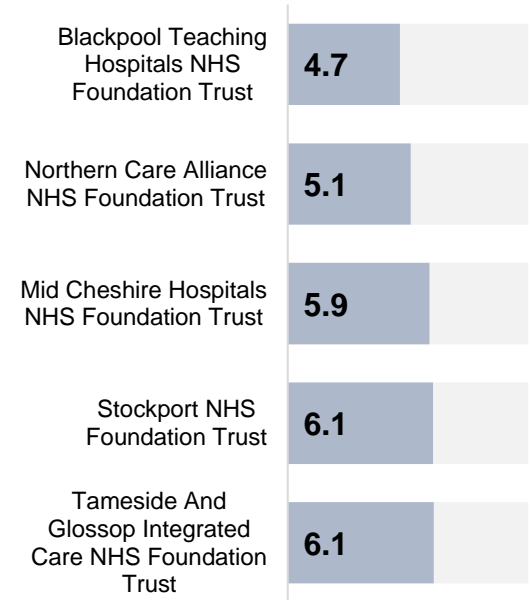
Trust score is not shown when there are fewer than 30 respondents

Comparison with other trusts within your region

Trusts with the highest scores

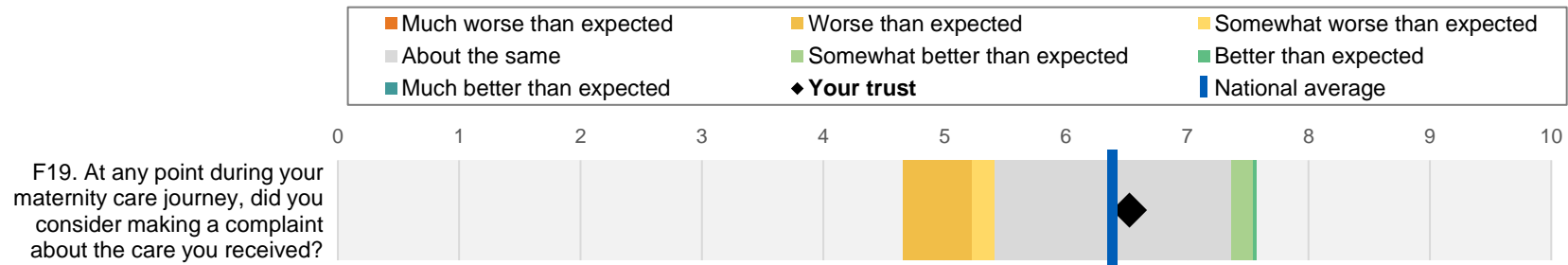


Trusts with the lowest scores



Section 4. Complaints

Question scores



		All trusts in England		
Number of respondents (your trust)	Your trust score	National average score	Lowest score	Highest score
82	6.5	6.4	4.7	7.6

About the same

Change over time

This section includes:

- your mean trust score for each evaluative question in the survey
- where comparable data is available, statistical significance testing using a two-sample t-test has been carried out against the 2023 and 2024 survey results for each relevant question. Where a change in results is shown as ‘significant’, this indicates that this change is not due to random chance, but is likely due to some particular factor at your trust

Please note:

- If data is missing for a survey year, this is due to a low number of responses, or because the trust data was not included in the survey that year, due to sampling errors or ineligibility.
- The following questions were new or changed for 2024 and therefore are not included in this section: B3, B18, B20, C5, C7, C14, E3, F2, F10, F14, F16, G12.

The NHS logo, consisting of the letters 'NHS' in white on a blue rectangular background.The Care Quality Commission logo, featuring a stylized white 'Q' inside a circle followed by the text 'Care Quality Commission'.

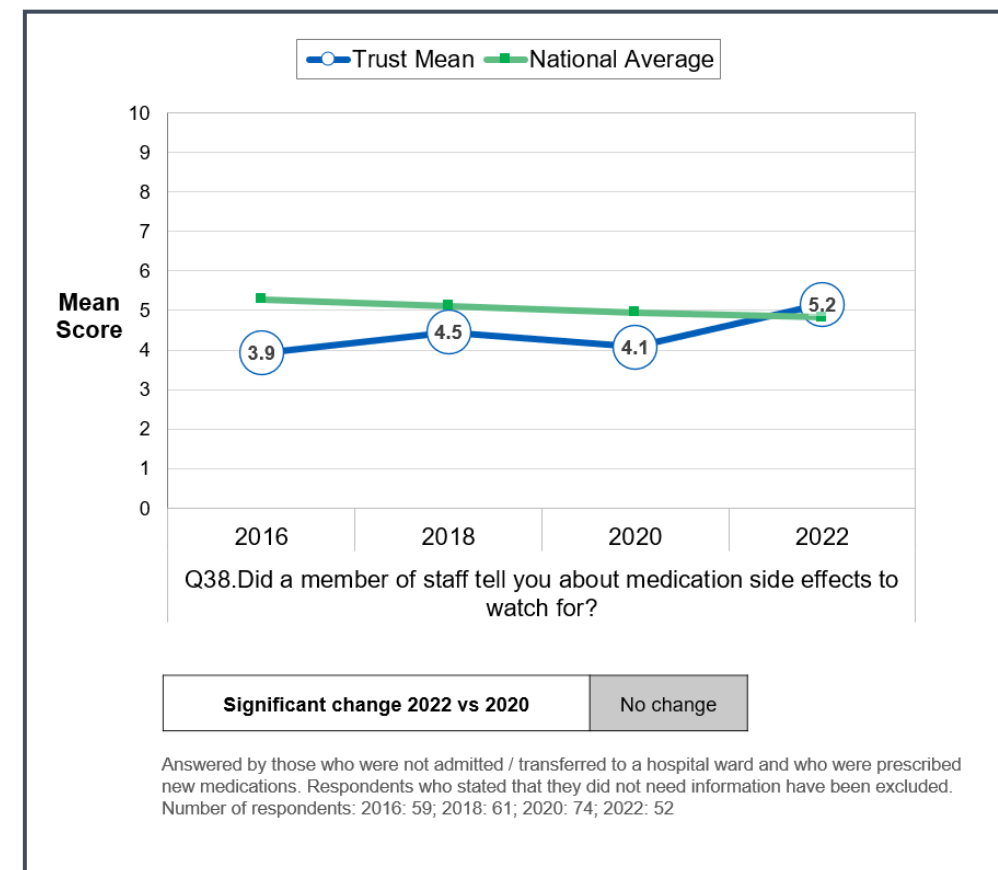
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How to interpret change over time in this report

The charts in the 'change over time' section show how your trust scored in each Maternity survey iteration. Where available, trend data from 2013 to 2024 is shown. If a question only has one data point, this question is not shown. Questions that are not historically comparable are also not shown.

Each question is displayed in a line chart. These charts show your trust mean score for each survey year (blue line). The national average is also shown across survey years, this is the average score for that question across all NHS trusts with a maternity department in England (green line). This enables you to see how your trust compares to the national average. If there is data missing for a survey year, this may be due to either a low number of responses, because the trust was not included in the survey that year, sampling errors or ineligibility.

Statistically significant changes are also displayed in tables underneath the charts, showing significant differences between this year (2024) and the previous year (2023). Z-tests set to 95% significance were used to compare data between the two years (2024 vs 2023). A statistically significant difference means it is unlikely we would have obtained this result if there was no real difference.



Change over time

Section 1: Antenatal Care



NHS

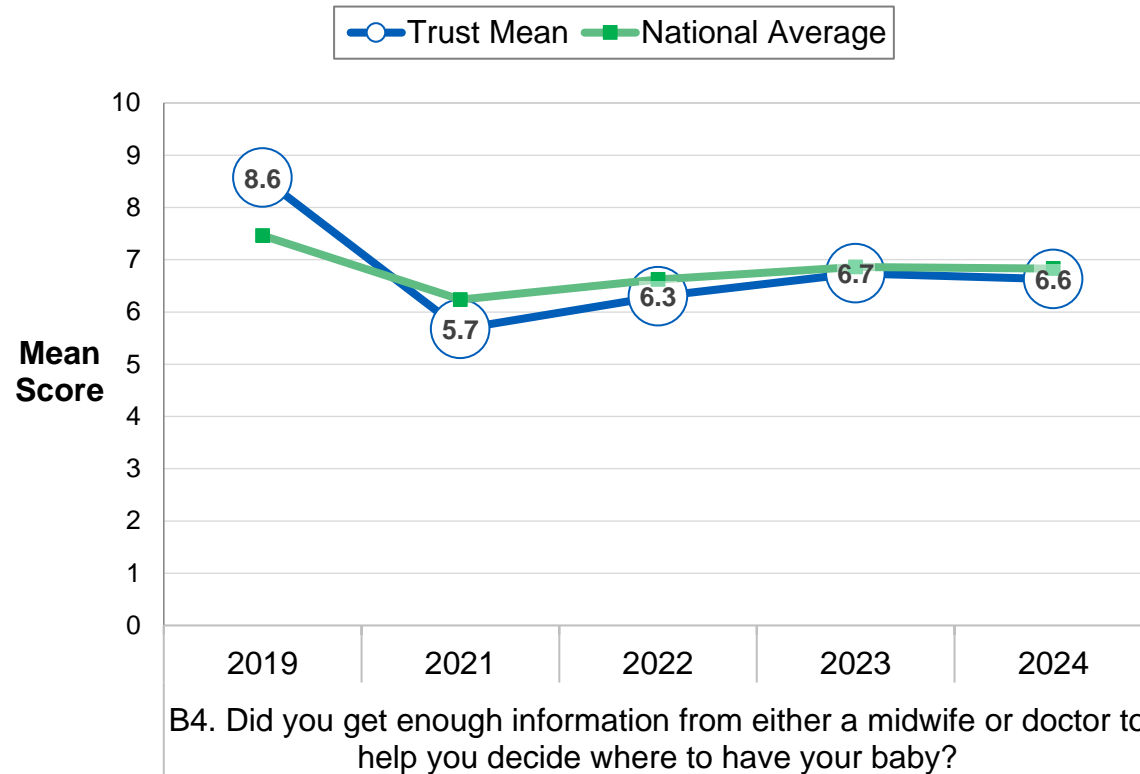


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Section 1. Antenatal Care

The start of your care during pregnancy



Significant change 2024 vs 2023

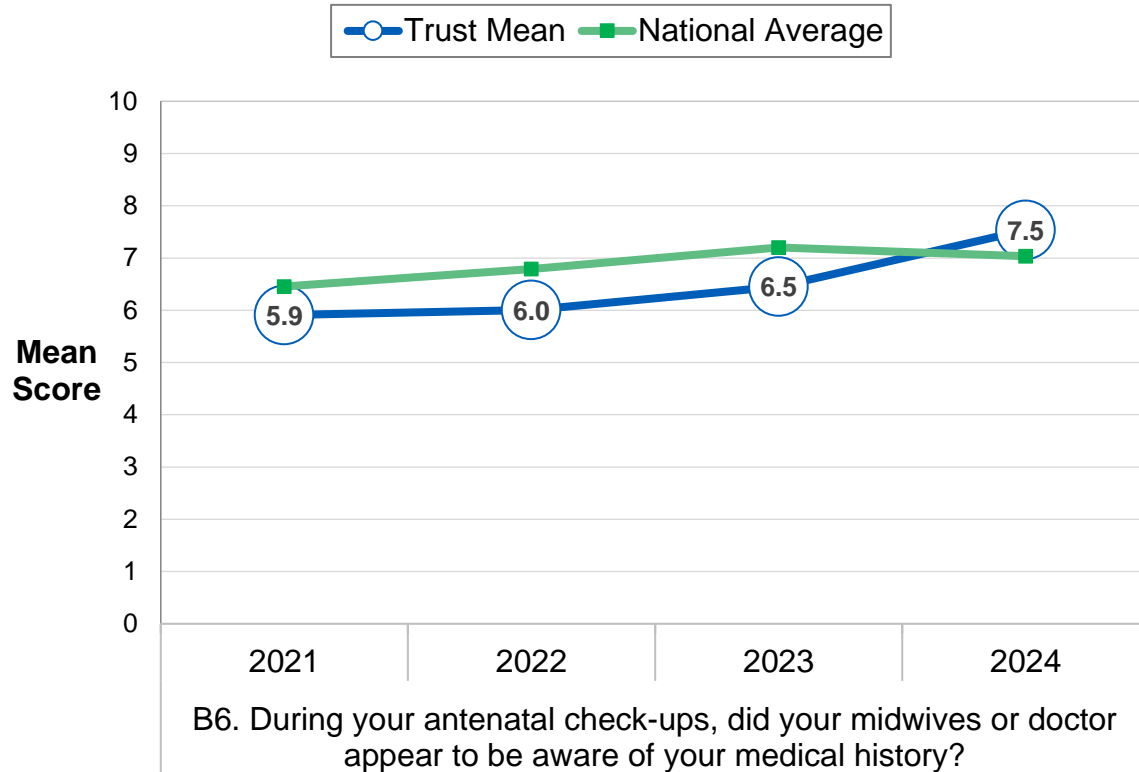
No change

Answered by all. Respondents who stated that they didn't know / couldn't remember have been excluded.

Number of respondents: 2019: 63; 2021: 124; 2022: 110; 2023: 105; 2024: 75

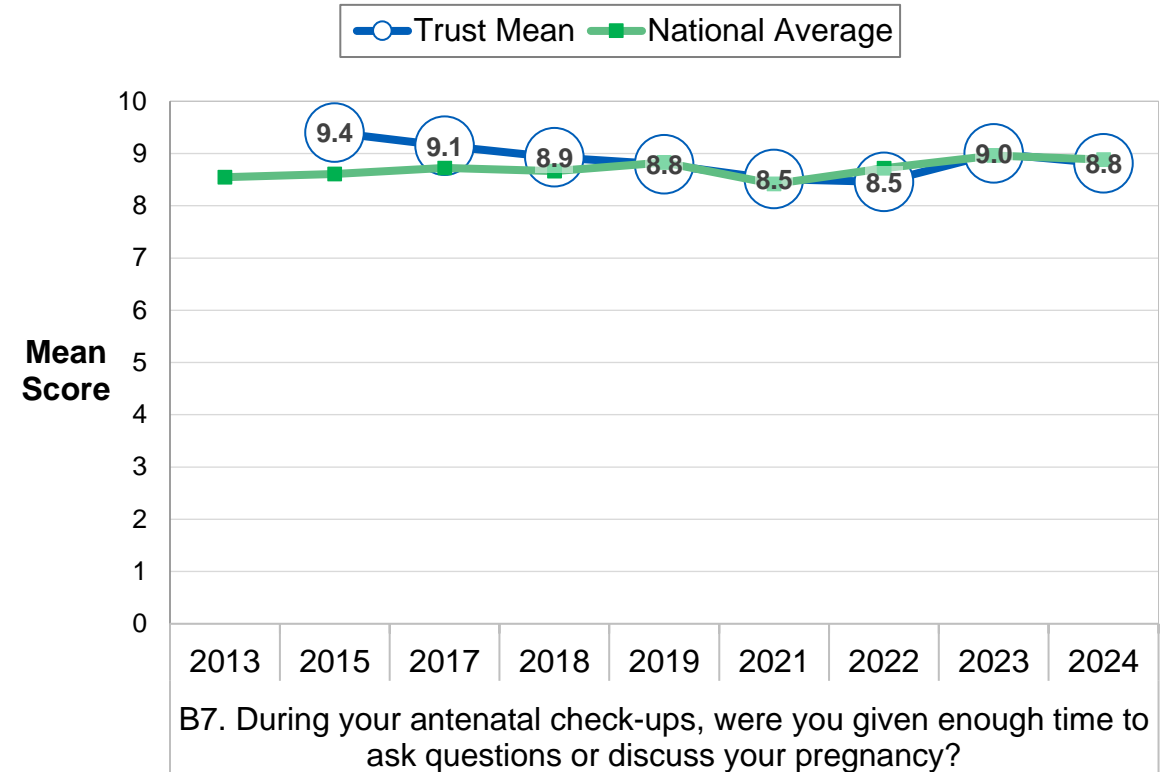
Section 1. Antenatal Care

Antenatal check ups



Significant change 2024 vs 2023 No change

Answered by all. Respondents who stated that they didn't know / couldn't remember have been excluded.
 Number of respondents: 2021: 129; 2022: 115; 2023: 106; 2024: 77

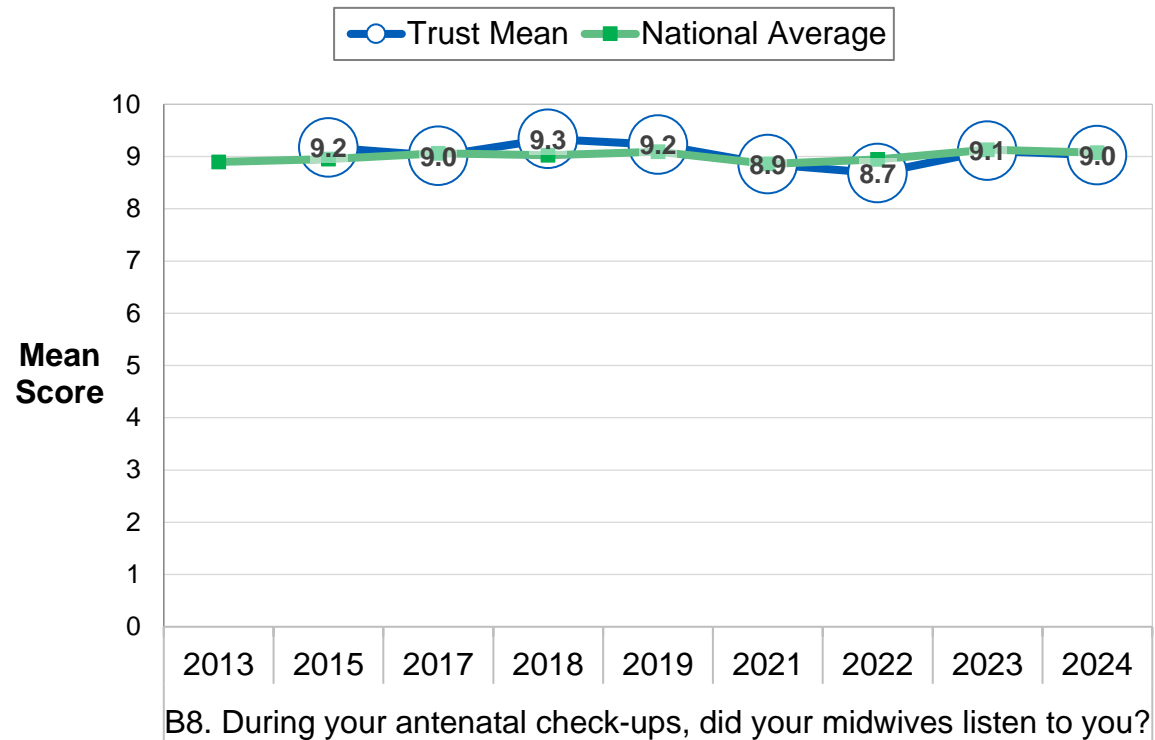


Significant change 2024 vs 2023 No change

Answered by all. Respondents who stated that they didn't know / couldn't remember have been excluded.
 Number of respondents: 2013: -; 2015: 81; 2017: 80; 2018: 74; 2019: 64; 2021: 131; 2022: 117; 2023: 111; 2024: 79

Section 1. Antenatal Care

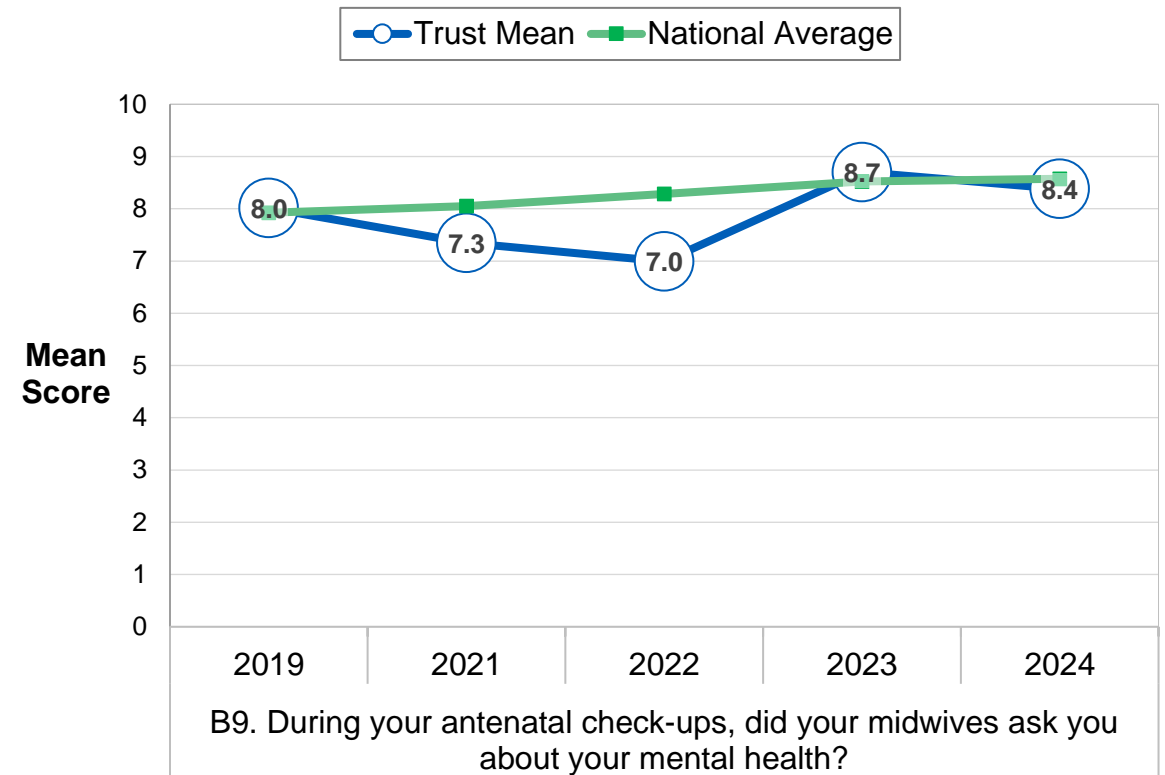
Antenatal check ups



Significant change 2024 vs 2023

No change

Answered by all. Respondents who stated that they didn't know / couldn't remember have been excluded.
Number of respondents: 2013: -; 2015: 81; 2017: 80; 2018: 75; 2019: 64; 2021: 131; 2022: 117; 2023: 111; 2024: 78



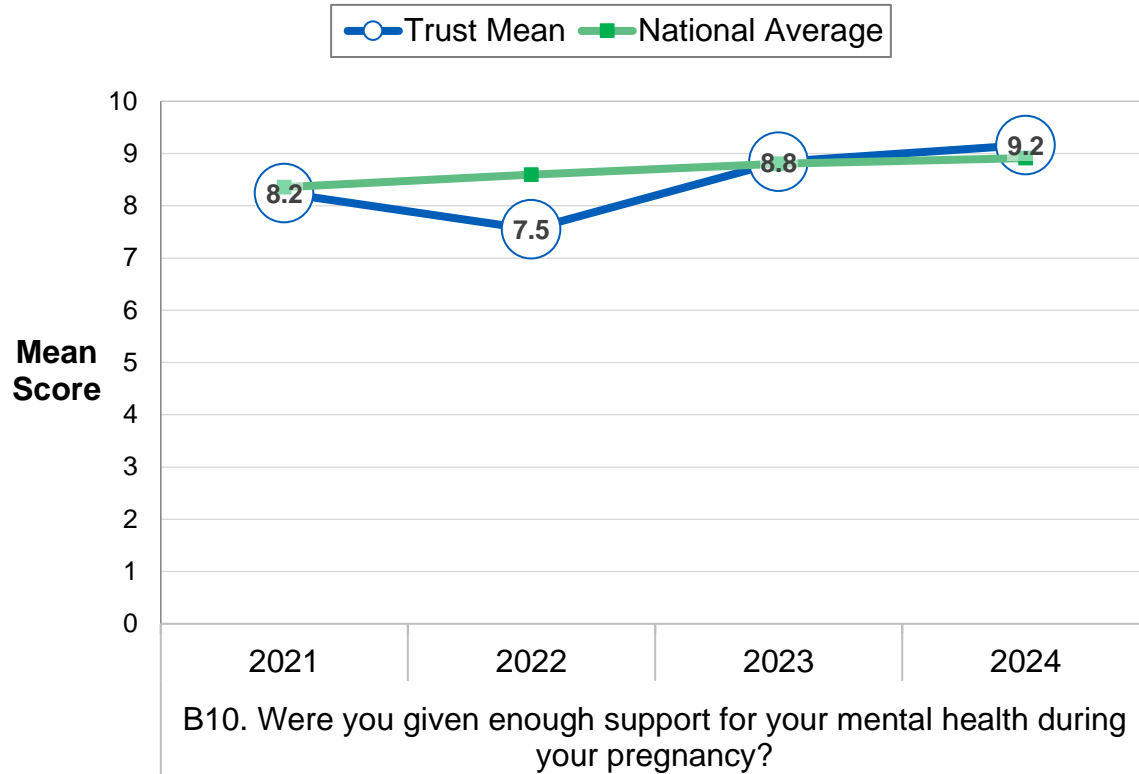
Significant change 2024 vs 2023

No change

Answered by all. Respondents who stated that they didn't know / couldn't remember have been excluded.
Number of respondents: 2019: 63; 2021: 128; 2022: 116; 2023: 111; 2024: 78

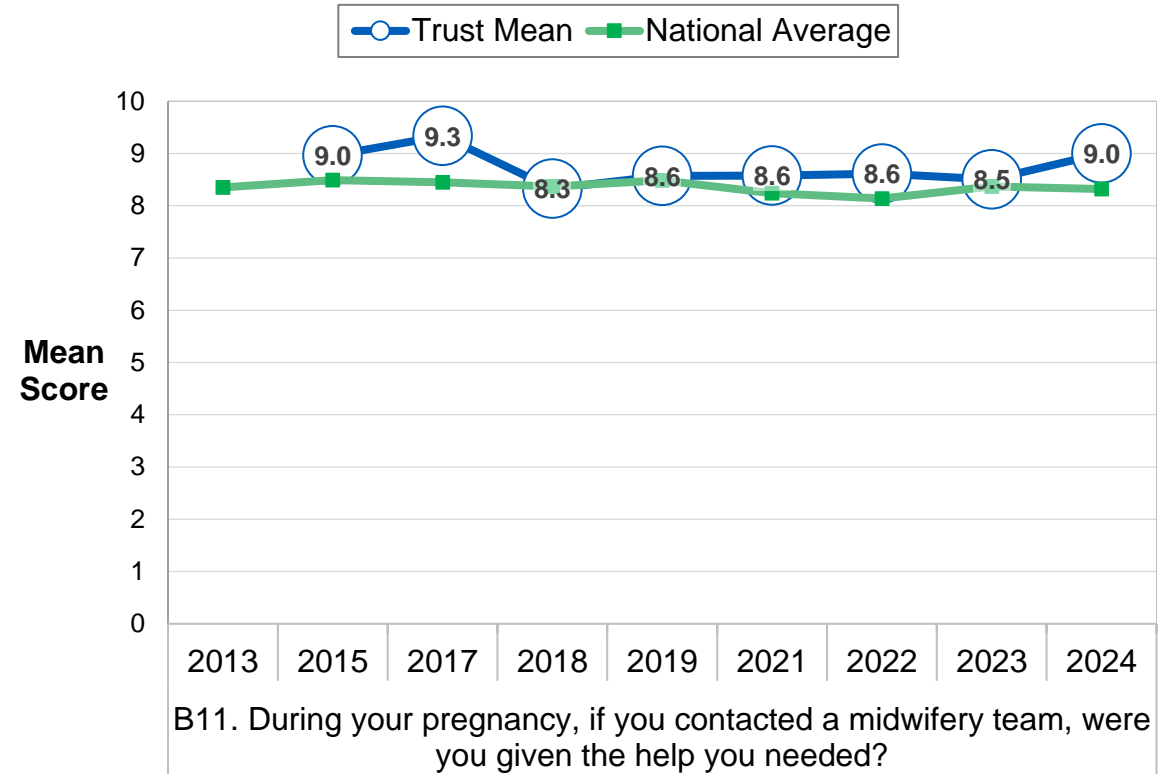
Section 1. Antenatal Care

During your pregnancy



Significant change 2024 vs 2023 No change

Answered by all. Respondents who stated that they didn't know / couldn't remember or did not want / need support have been excluded.
 Number of respondents: 2021: 75; 2022: 70; 2023: 74; 2024: 36

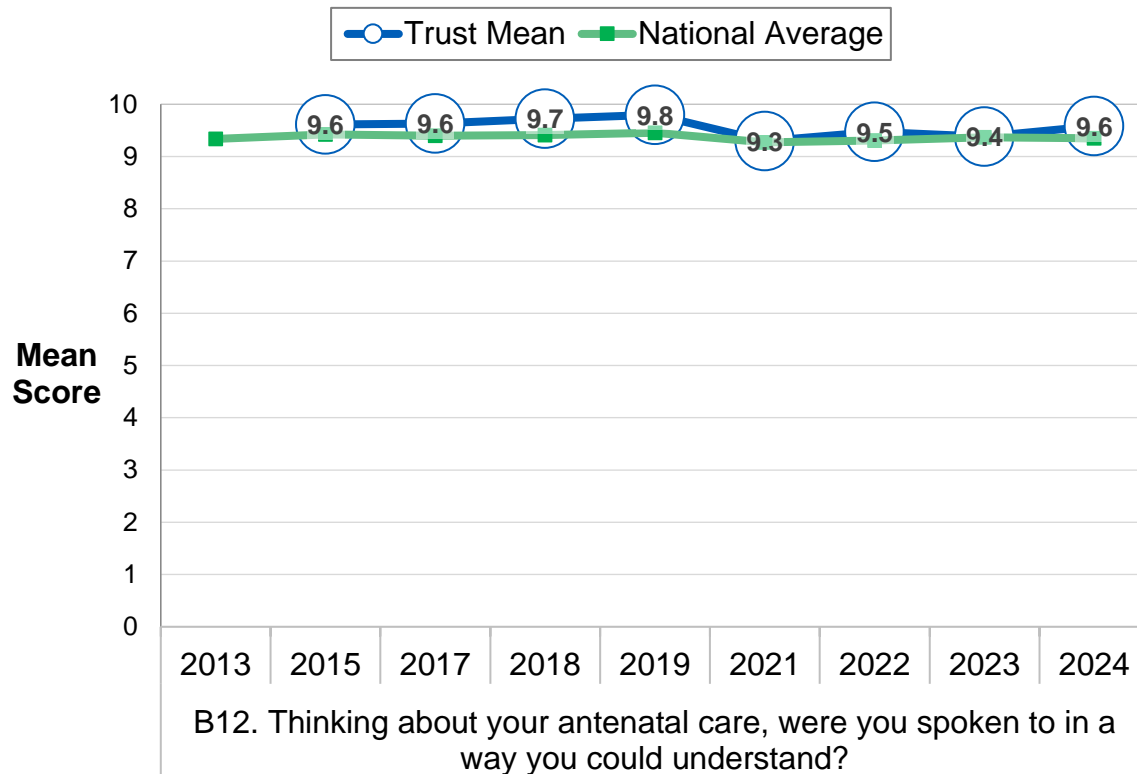


Significant change 2024 vs 2023 No change

Answered by all. Respondents who stated that they did not contact a midwifery team have been excluded.
 Number of respondents: 2013: -; 2015: 62; 2017: 68; 2018: 65; 2019: 55; 2021: 113; 2022: 110; 2023: 103; 2024: 64

Section 1. Antenatal Care

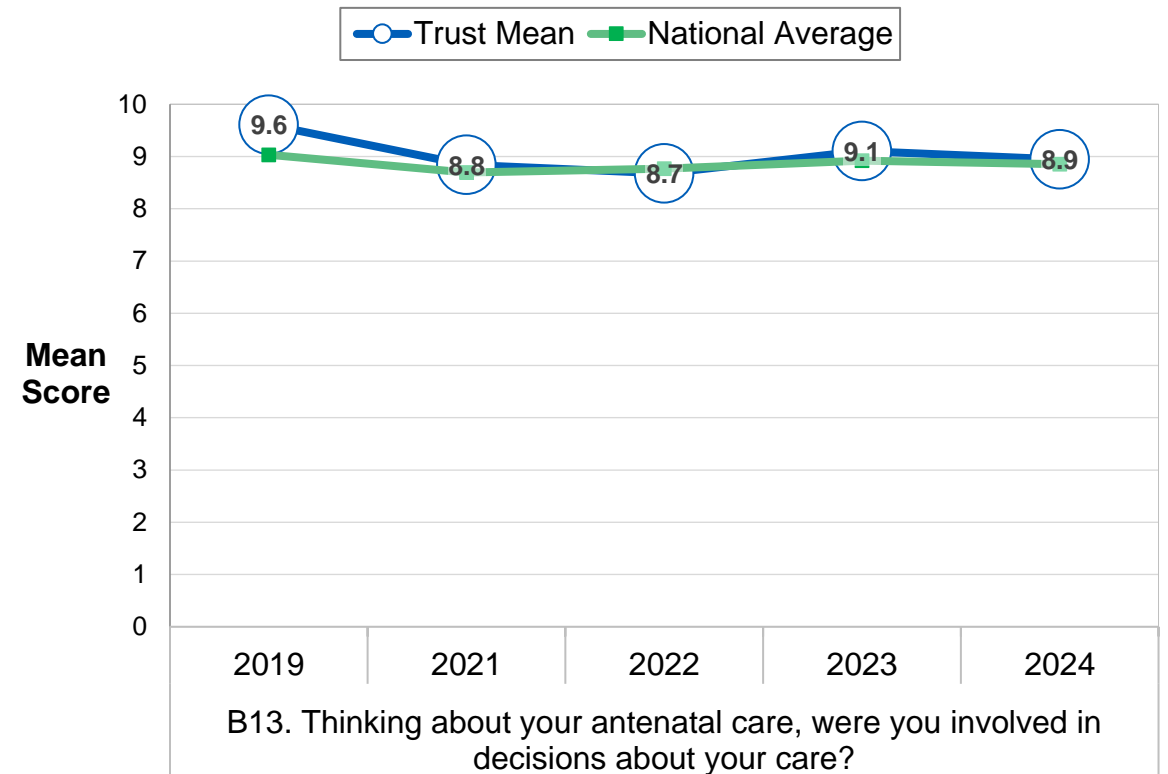
During your pregnancy



Significant change 2024 vs 2023

No change

Answered by all. Respondents who stated that they didn't know or couldn't remember have been excluded.
Number of respondents: 2013: -; 2015: 80; 2017: 81; 2018: 75; 2019: 63; 2021: 131; 2022: 115; 2023: 112; 2024: 79



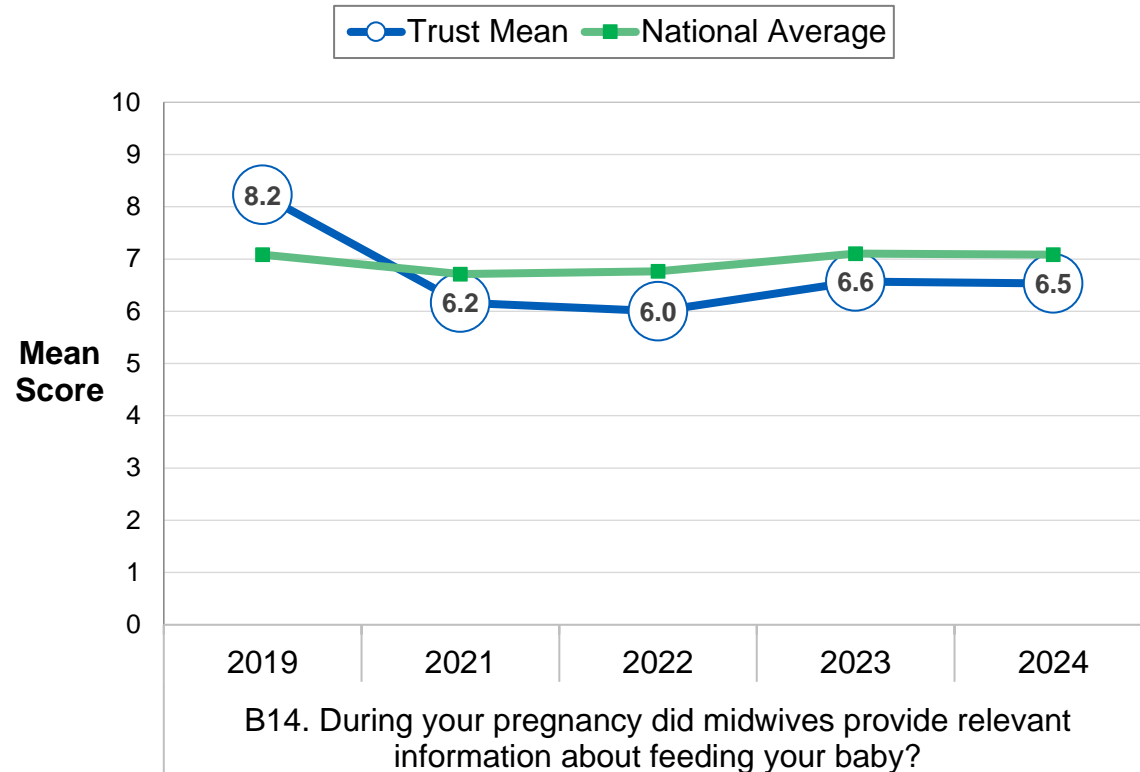
Significant change 2024 vs 2023

No change

Answered by all. Respondents who stated that they didn't know or couldn't remember or did not want / need to be involved have been excluded.
Number of respondents: 2019: 60; 2021: 127; 2022: 117; 2023: 109; 2024: 78

Section 1. Antenatal Care

During your pregnancy

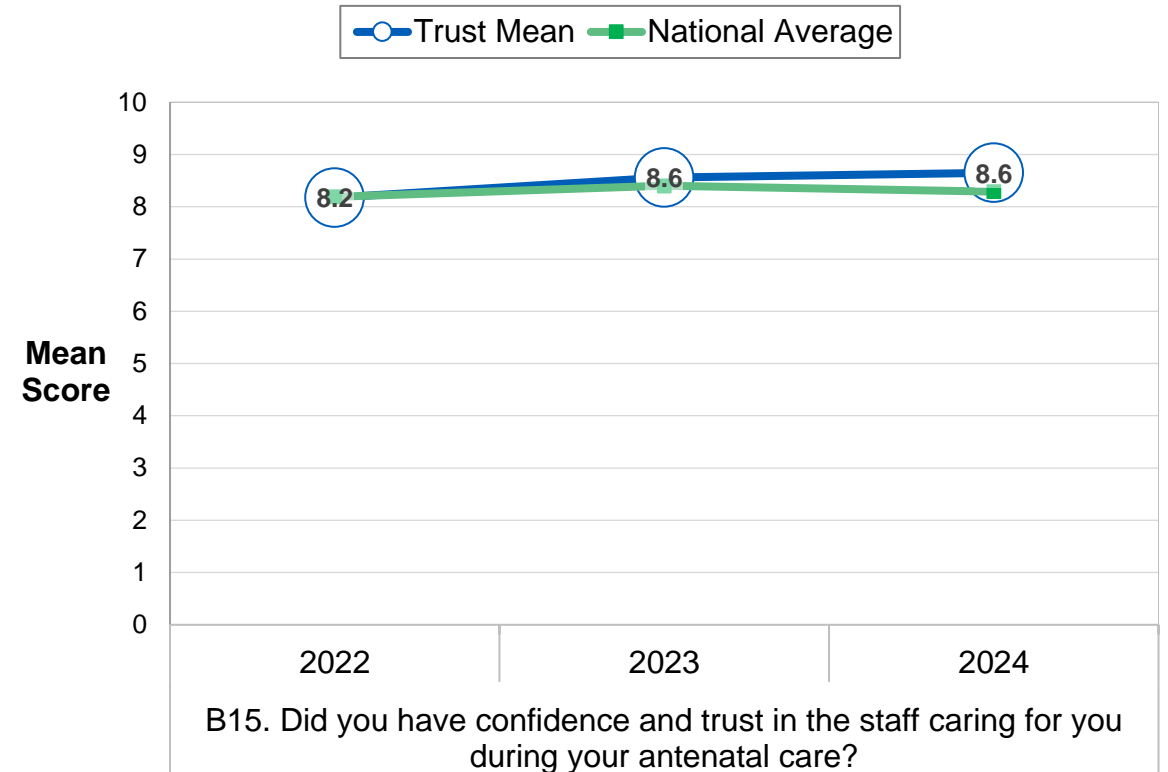


Significant change 2024 vs 2023

No change

Answered by all. Respondents who stated that they didn't know or couldn't remember have been excluded.

Number of respondents: 2019: 62; 2021: 127; 2022: 116; 2023: 110; 2024: 75



Significant change 2024 vs 2023

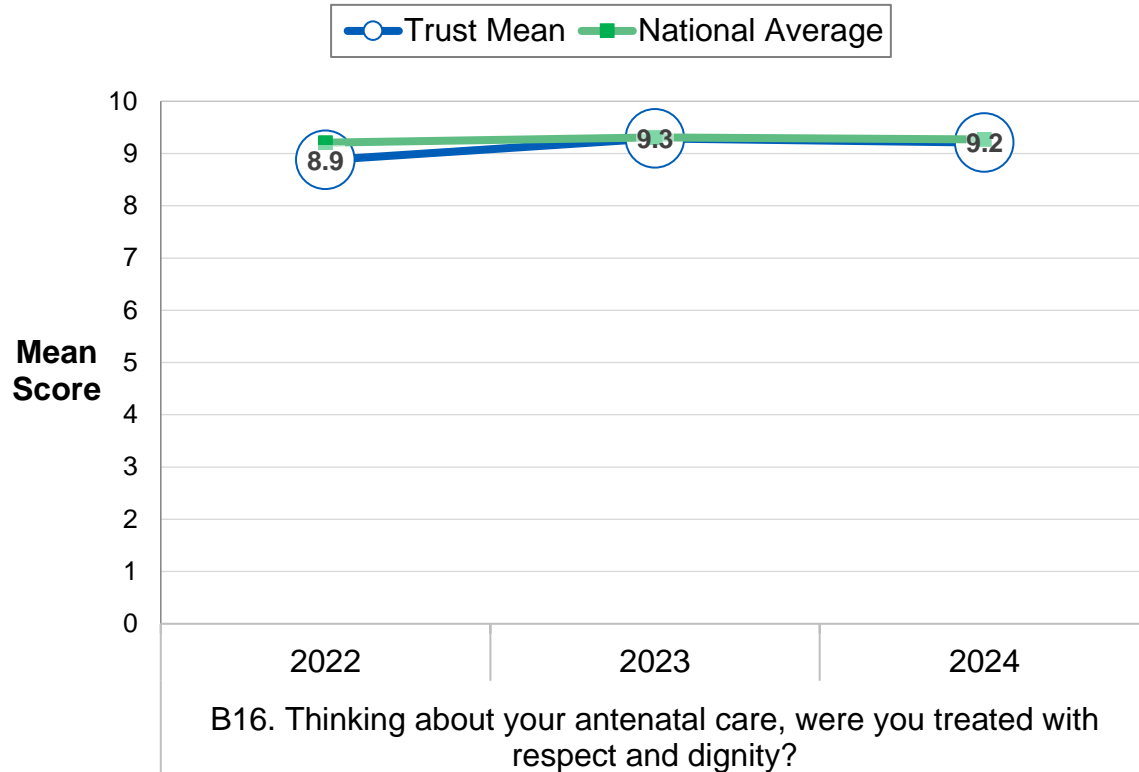
No change

Answered by all. Respondents who stated that they didn't know or couldn't remember have been excluded.

Number of respondents: 2022: 117; 2023: 112; 2024: 79

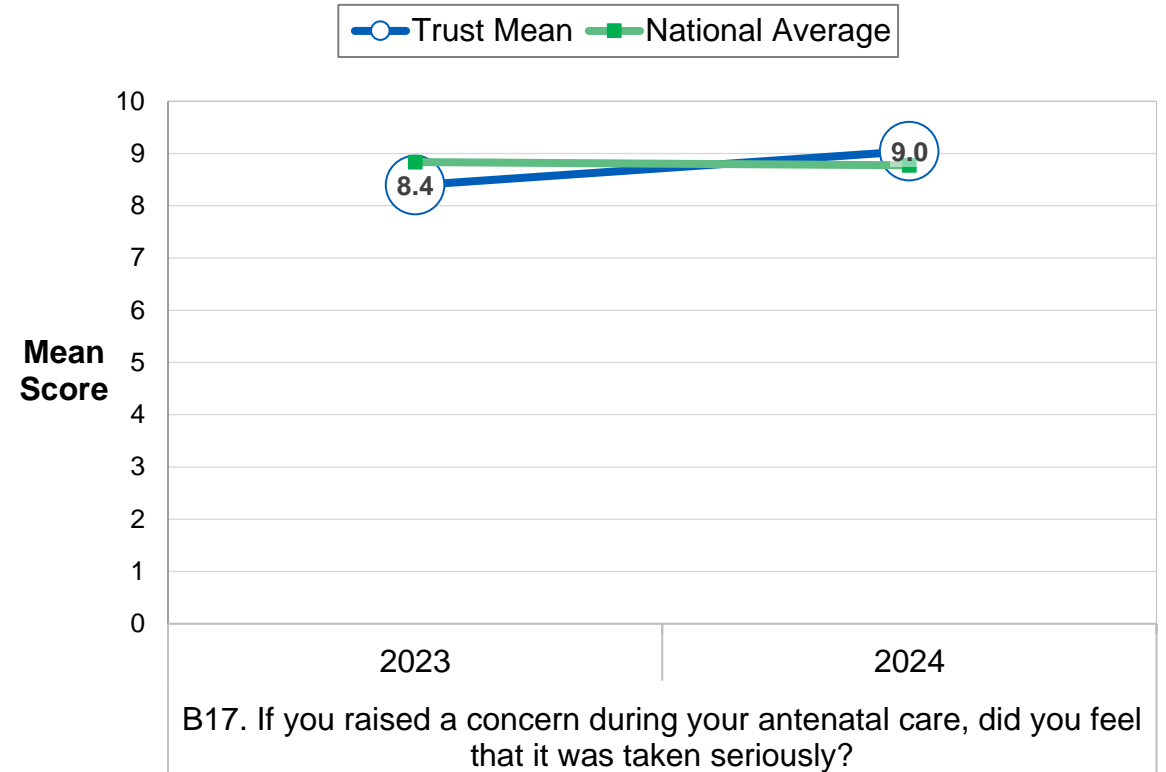
Section 1. Antenatal Care

During your pregnancy



Significant change 2024 vs 2023 No change

Answered by all. Respondents who stated that they didn't know or couldn't remember have been excluded.
 Number of respondents: 2022: 117; 2023: 112; 2024: 79



Significant change 2024 vs 2023 No change

Answered by all. Respondents who stated that they didn't know or couldn't remember have been excluded.
 Number of respondents: 2023: 72; 2024: 48

Change over time

Section 2: Labour and Birth



NHS

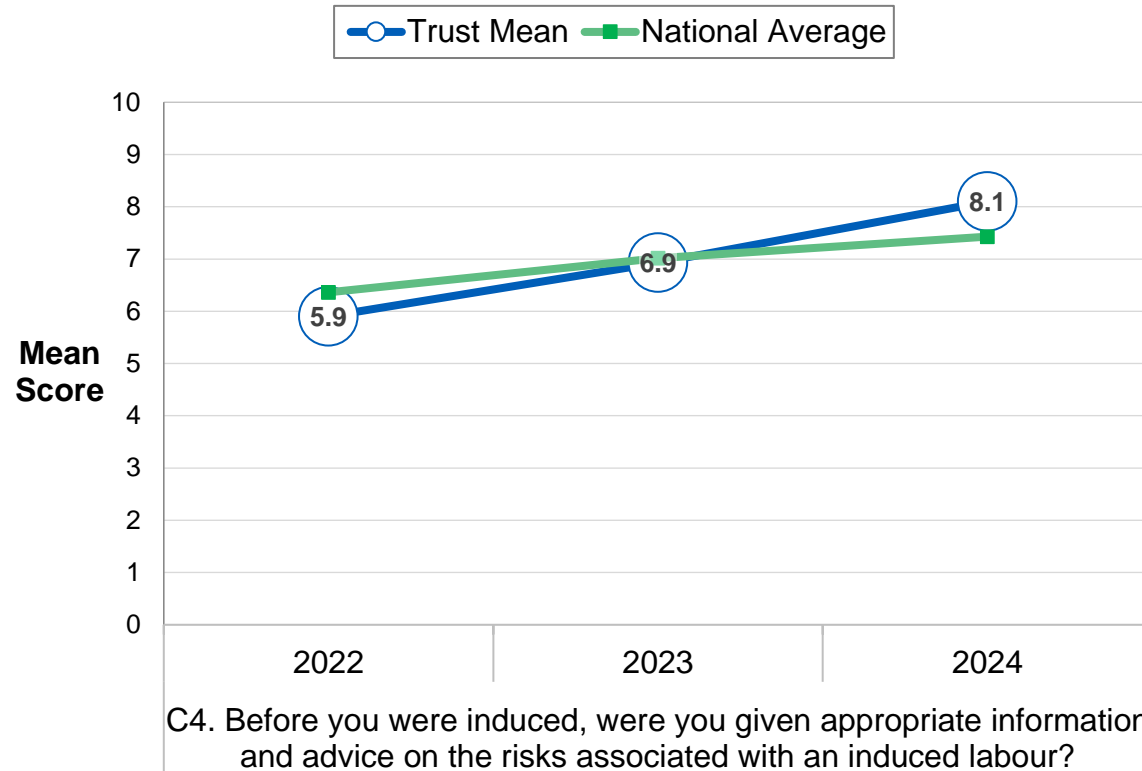


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Section 2. Labour and Birth

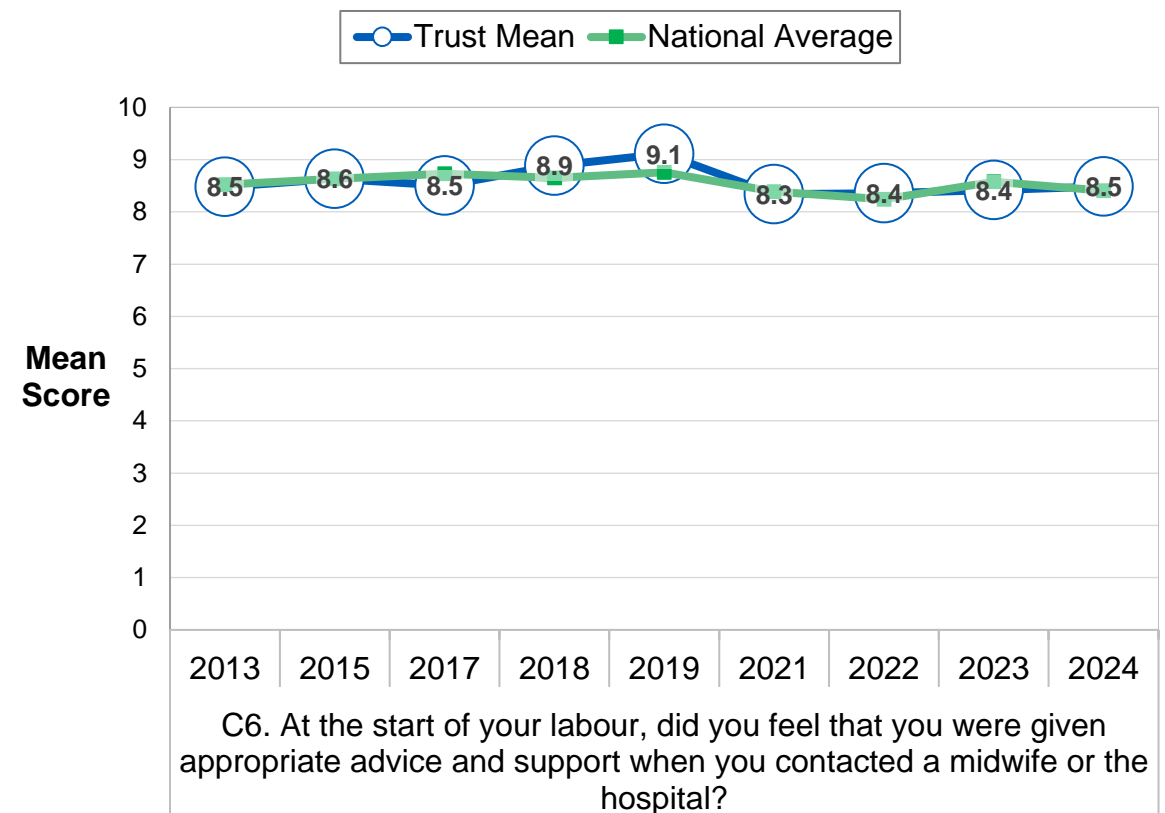
Your labour and birth



Significant change 2024 vs 2023

No change

Answered by those who were induced. Respondents who stated that they didn't know or couldn't remember have been excluded. Note of caution when interpreting the trend data: The 2023 preceding question asking about information and advice on the benefits of an induced labour was removed. Number of respondents: 2022: 37; 2023: 42; 2024: 35



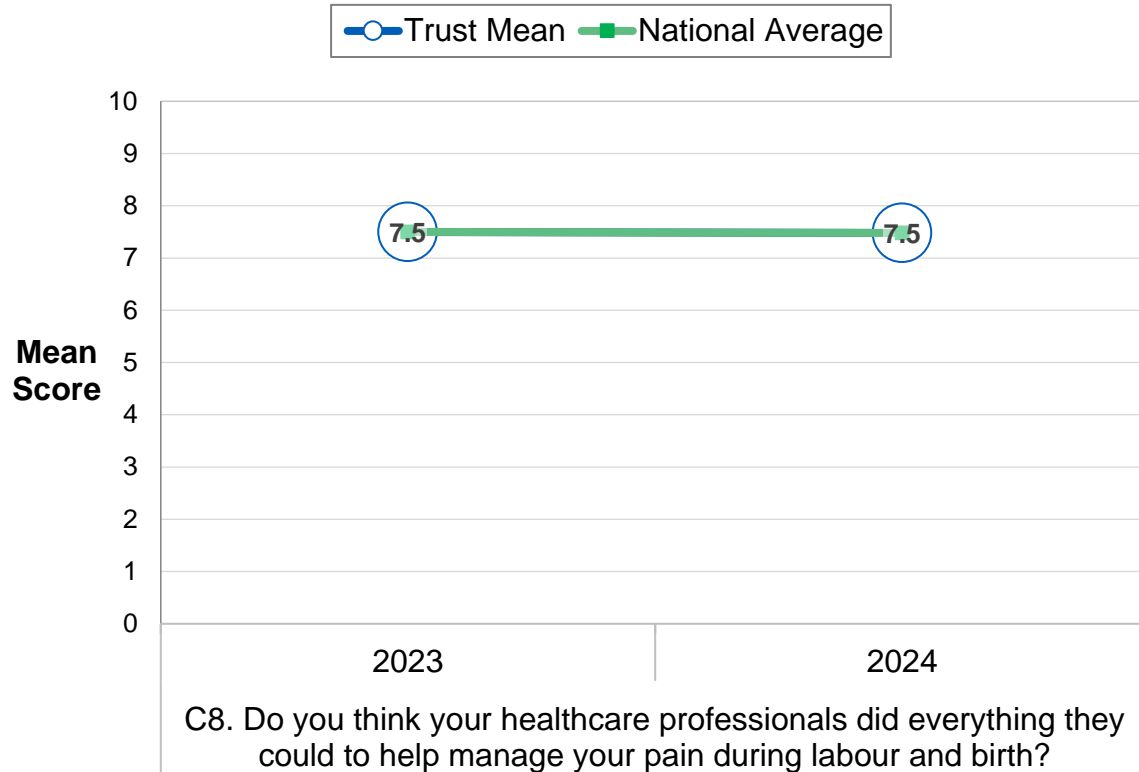
Significant change 2024 vs 2023

No change

Answered by those who went into labour. Respondents who stated that they did not contact a midwife / the hospital have been excluded. Number of respondents: 2013: 80; 2015: 59; 2017: 65; 2018: 60; 2019: 54; 2021: 89; 2022: 77; 2023: 71; 2024: 54

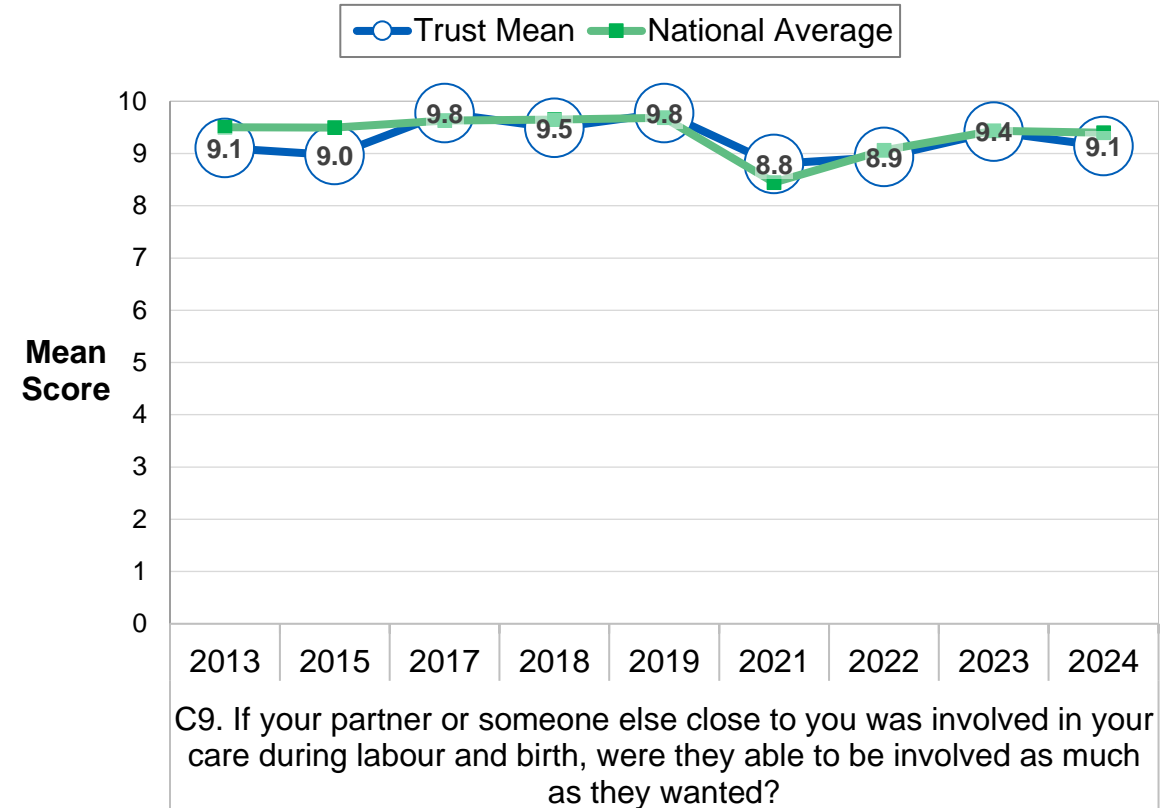
Section 2. Labour and Birth

Your labour and birth



Significant change 2024 vs 2023 No change

Answered by those who had a labour. Respondents who stated that they didn't know or couldn't remember or did not need any help with pain relief have been excluded.
 Number of respondents: 2023: 84; 2024: 70

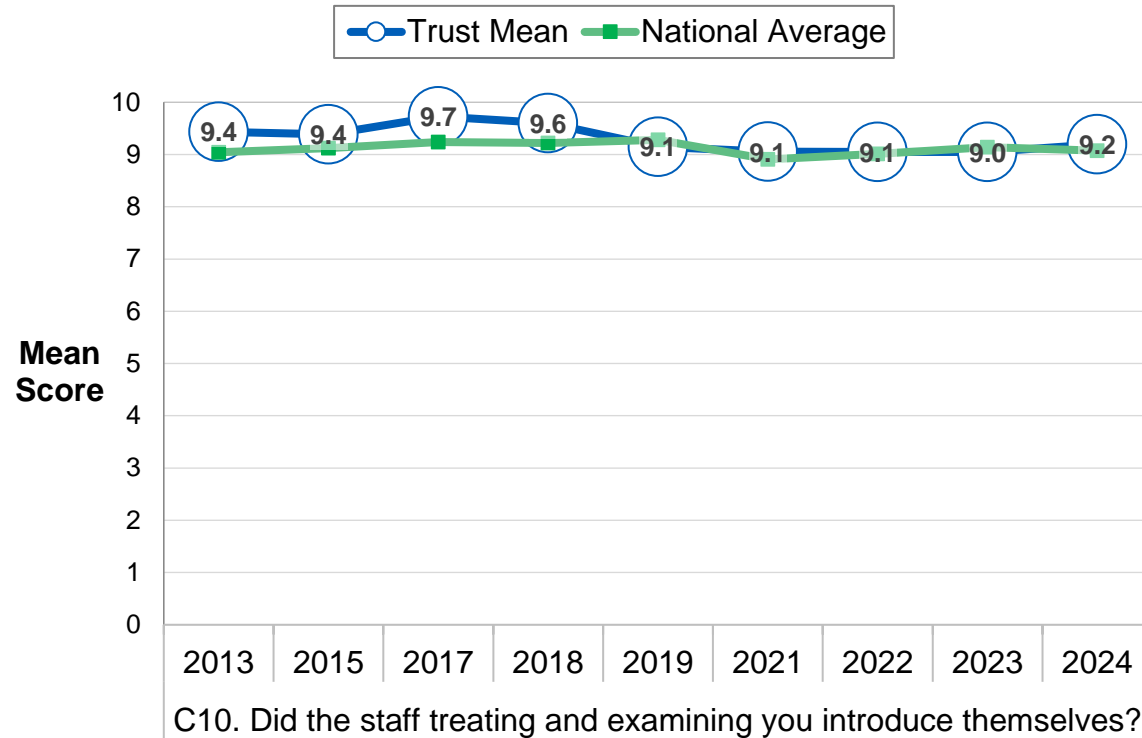


Significant change 2024 vs 2023 No change

Answered by all. Respondents who stated that they did not have a partner / companion with them, did not want their partner / companion to be involved, or that their partner / companion did not want to / could not be involved have been excluded.
 Number of respondents: 2013: 102; 2015: 81; 2017: 87; 2018: 78; 2019: 72; 2021: 131; 2022: 122; 2023: 114; 2024: 82

Section 2. Labour and Birth

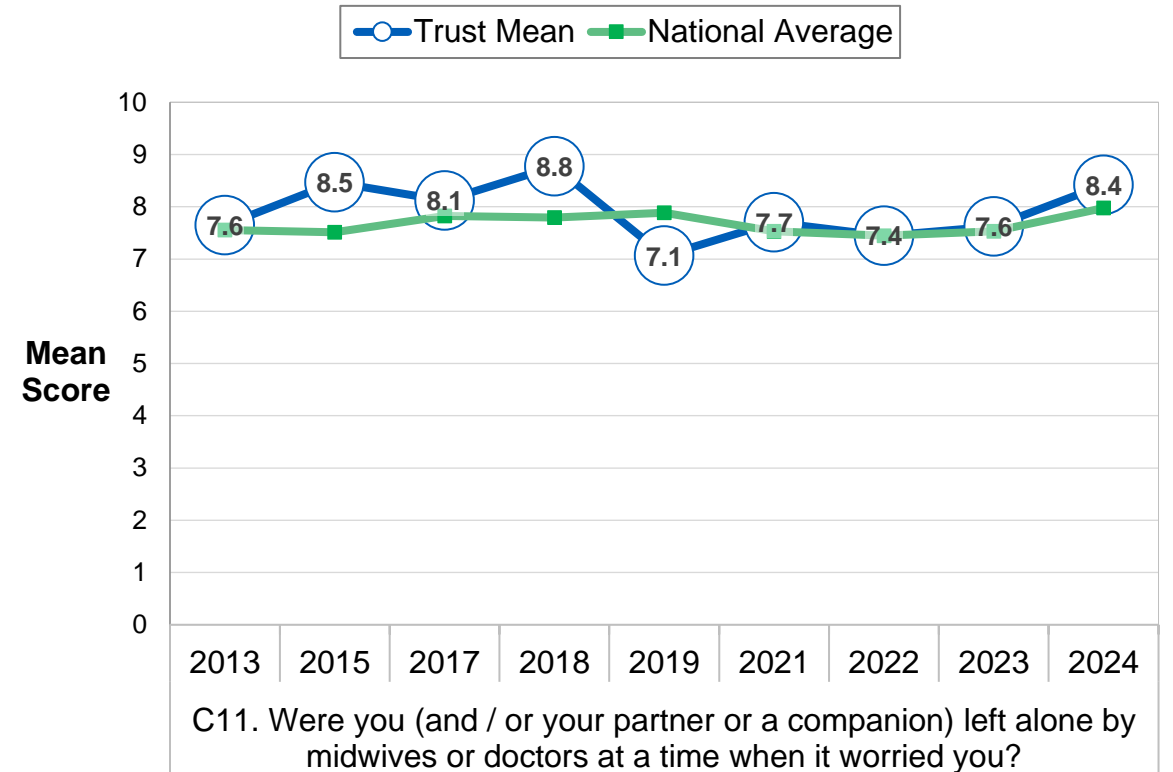
Staff caring for you



Significant change 2024 vs 2023

No change

Answered by all. Respondents who stated that they didn't know or couldn't remember have been excluded.
Number of respondents: 2013: 101; 2015: 80; 2017: 89; 2018: 80; 2019: 71; 2021: 137; 2022: 126; 2023: 112; 2024: 79



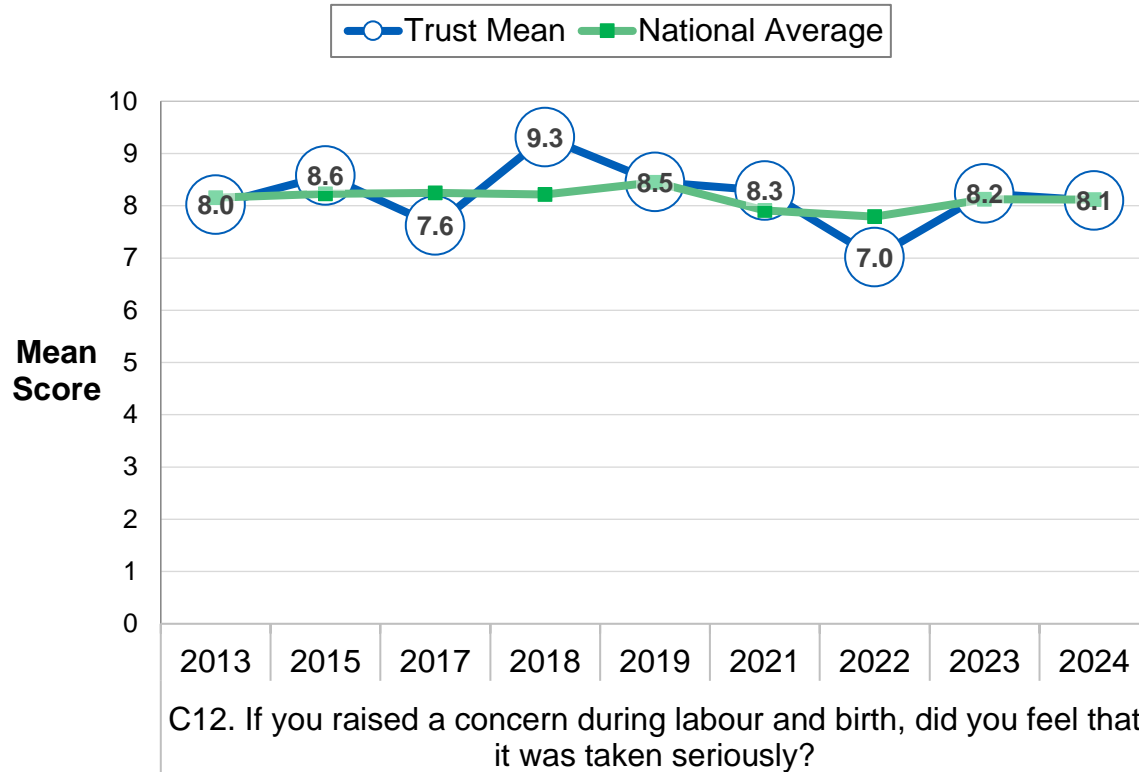
Significant change 2024 vs 2023

No change

Answered by all. Multiple response question: percentages may sum to more than 100.
Number of respondents: 2013: 103; 2015: 79; 2017: 89; 2018: 79; 2019: 73; 2021: 137; 2022: 127; 2023: 115; 2024: 77

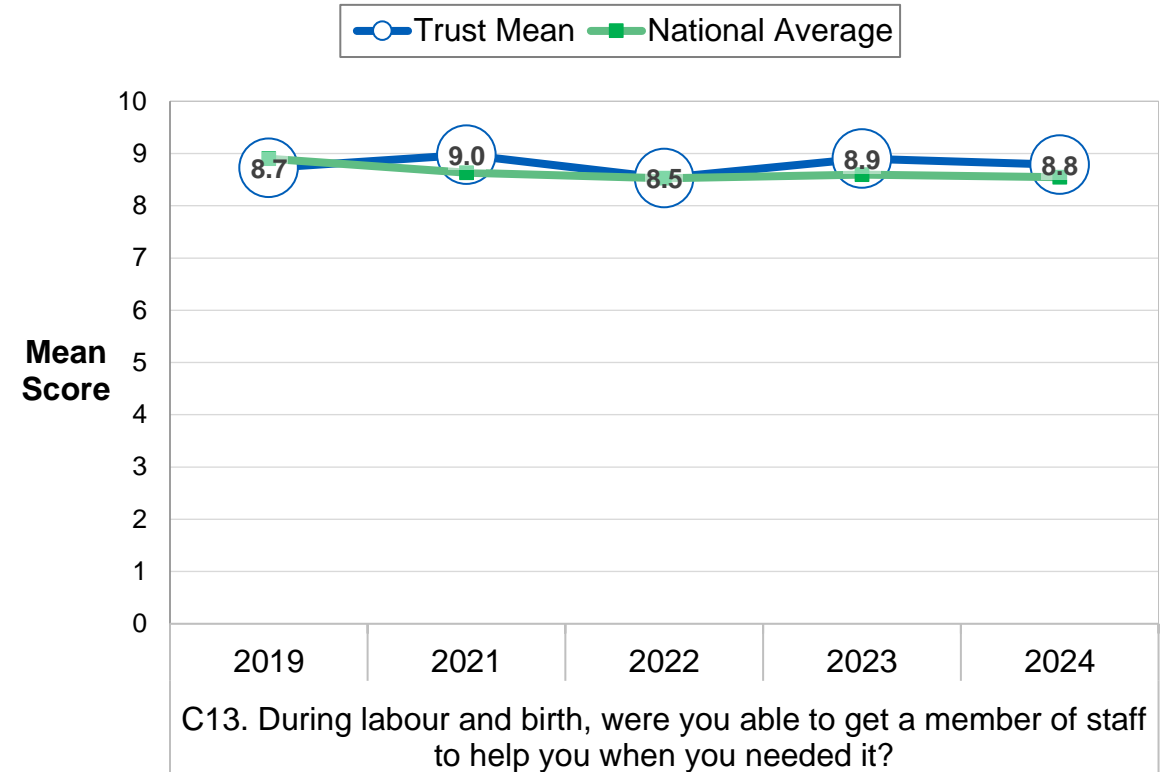
Section 2. Labour and Birth

Staff caring for you



Significant change 2024 vs 2023 No change

Answered by all. Respondents who stated that they did not raise any concerns have been excluded. Number of respondents: 2013: 69; 2015: 56; 2017: 58; 2018: 51; 2019: 50; 2021: 77; 2022: 82; 2023: 72; 2024: 52

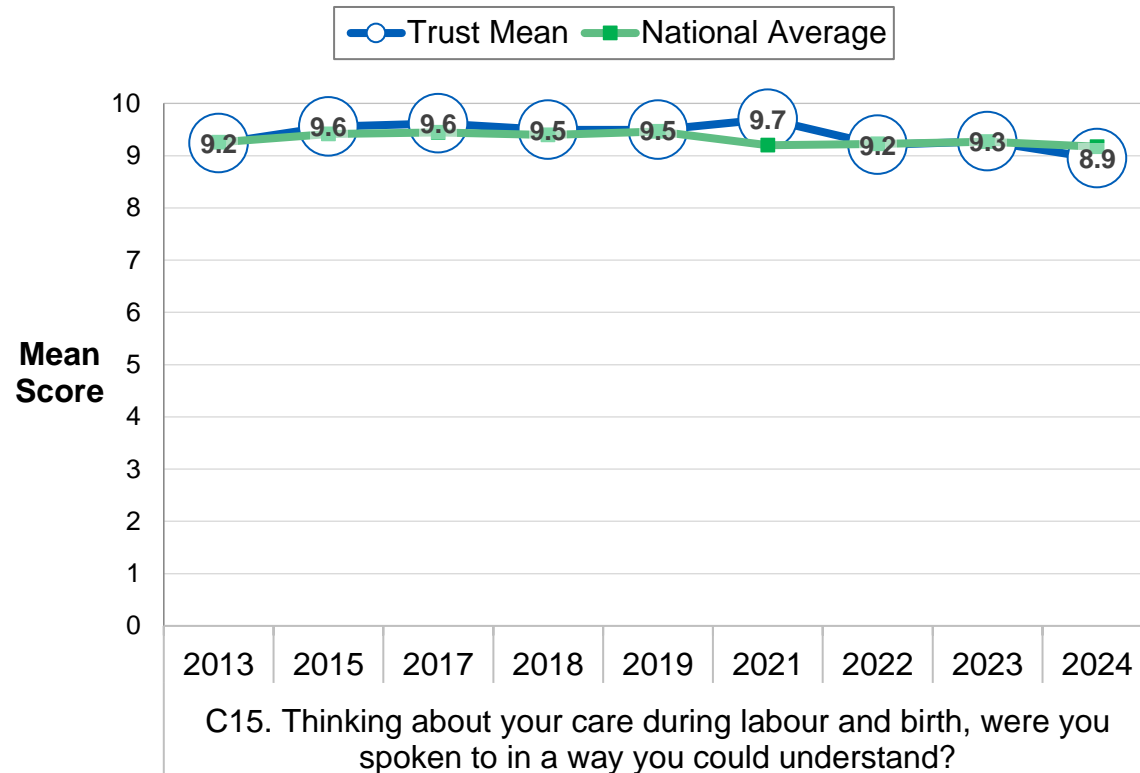


Significant change 2024 vs 2023 No change

Answered by all. Respondents who stated that they didn't know / couldn't remember or did not want / need this have been excluded. Number of respondents: 2019: 71; 2021: 129; 2022: 125; 2023: 111; 2024: 81

Section 2. Labour and Birth

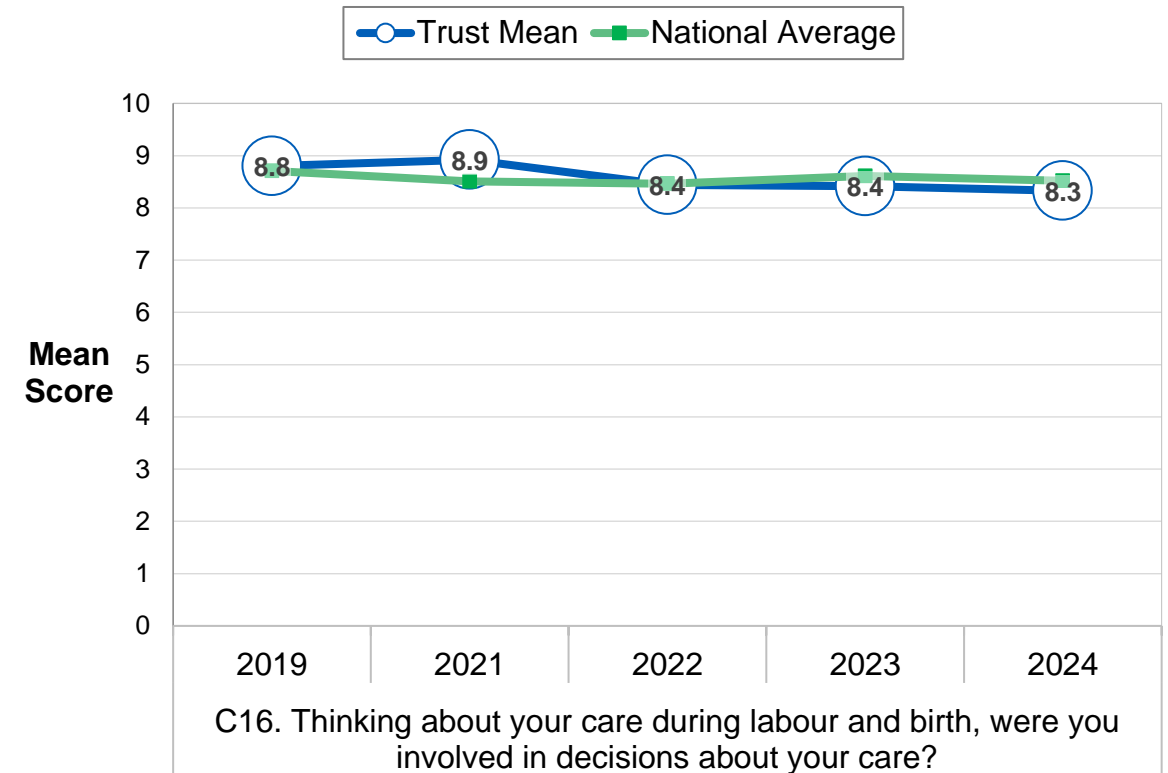
Staff caring for you



Significant change 2024 vs 2023

No change

Answered by all. Respondents who stated that they didn't know or couldn't remember have been excluded.
Number of respondents: 2013: 102; 2015: 81; 2017: 88; 2018: 80; 2019: 73; 2021: 137; 2022: 127; 2023: 115; 2024: 81



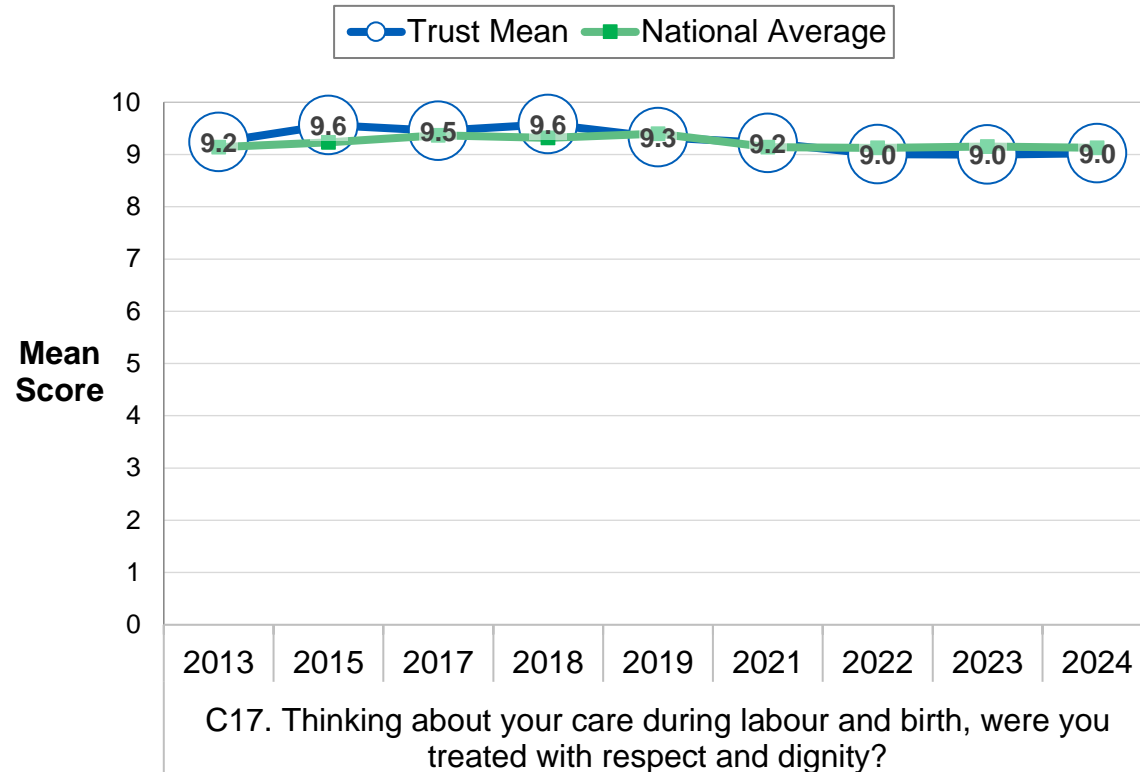
Significant change 2024 vs 2023

No change

Answered by all. Respondents who stated that they didn't know / couldn't remember or did not want / need to be involved have been excluded.
Number of respondents: 2019: 72; 2021: 135; 2022: 126; 2023: 111; 2024: 80

Section 2. Labour and Birth

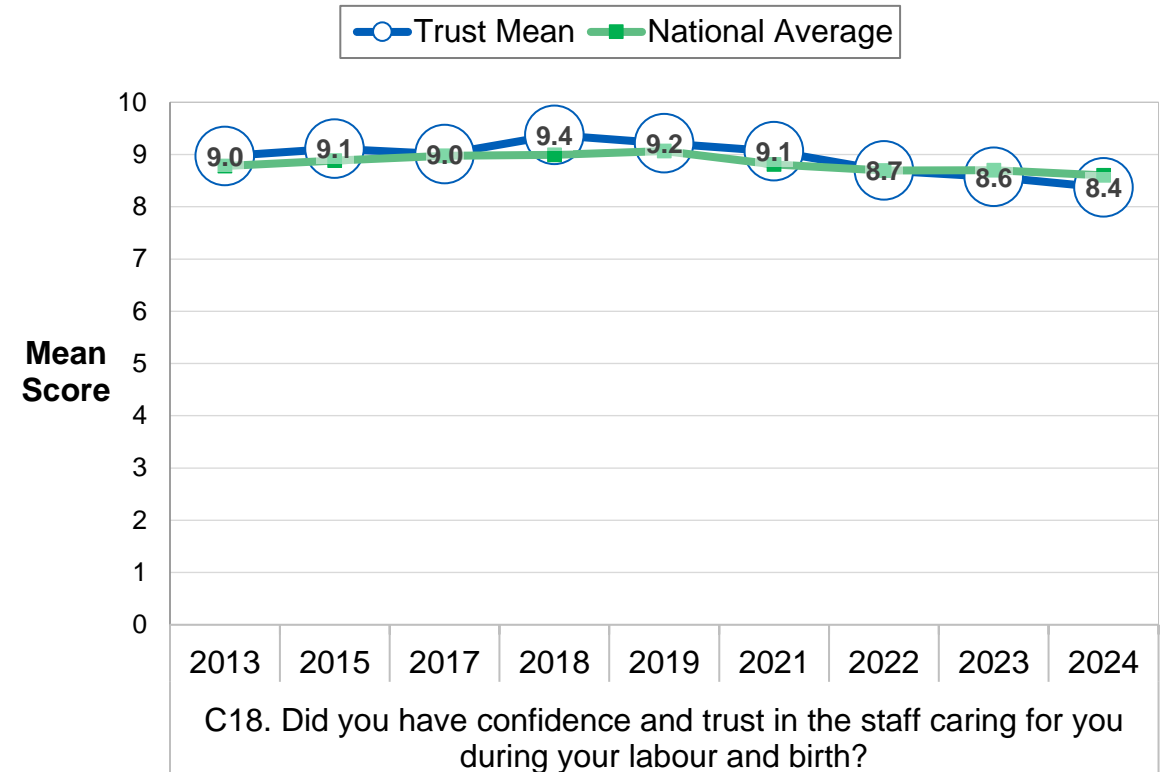
Staff caring for you



Significant change 2024 vs 2023

No change

Answered by all. Respondents who stated that they didn't know or couldn't remember have been excluded.
Number of respondents: 2013: 103; 2015: 81; 2017: 88; 2018: 80; 2019: 73; 2021: 137; 2022: 127; 2023: 115; 2024: 81



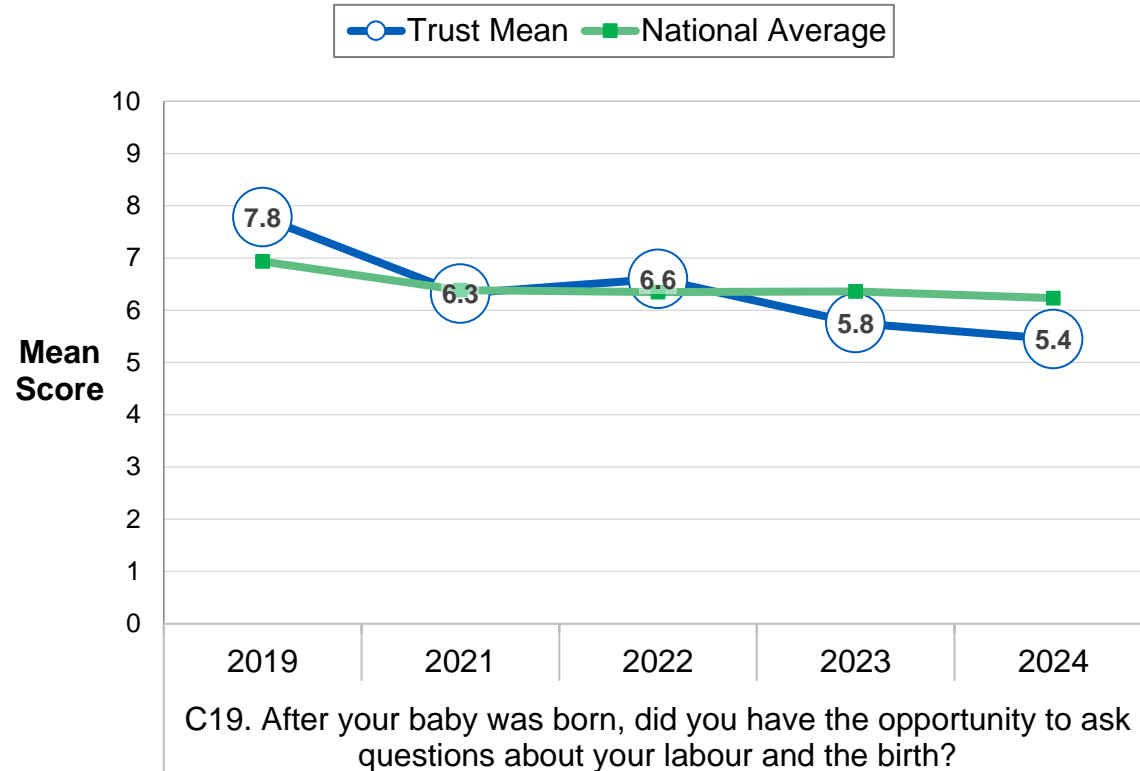
Significant change 2024 vs 2023

No change

Answered by all. Respondents who stated that they didn't know or couldn't remember have been excluded.
Number of respondents: 2013: 102; 2015: 81; 2017: 88; 2018: 80; 2019: 72; 2021: 137; 2022: 127; 2023: 115; 2024: 82

Section 2. Labour and Birth

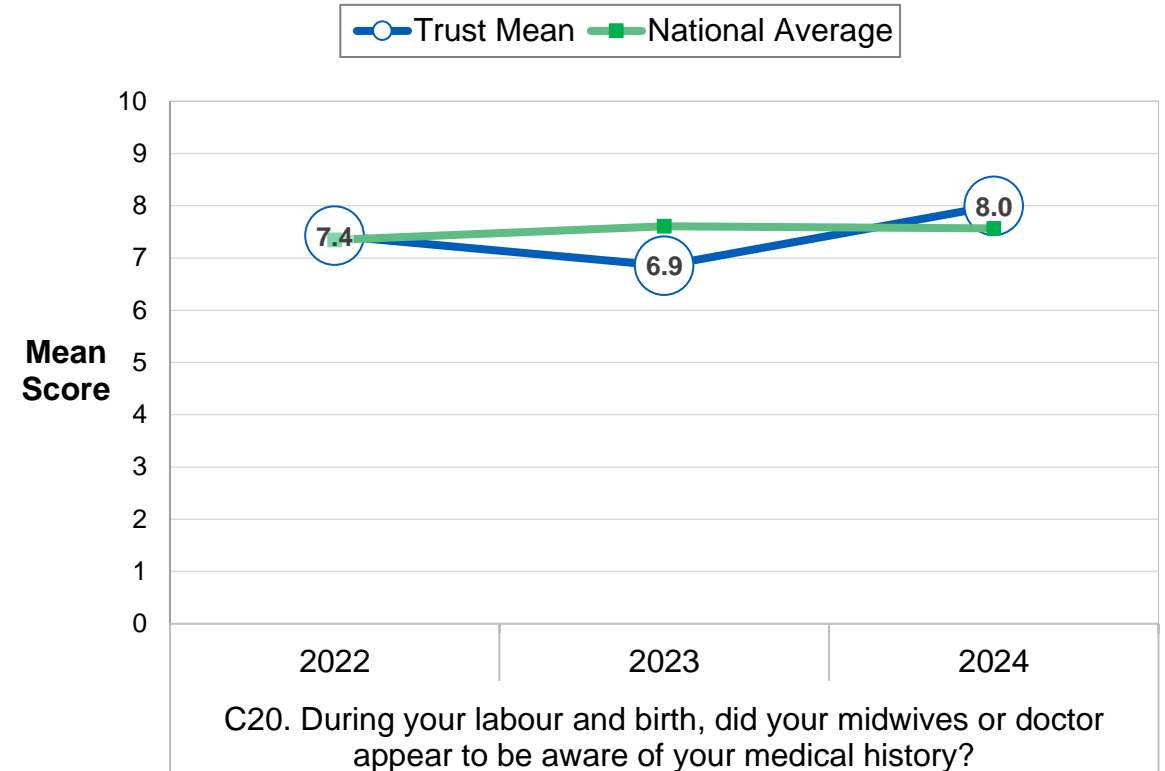
Staff caring for you



Significant change 2024 vs 2023

No change

Answered by all. Respondents who stated that they didn't know / couldn't remember or that they did not want / need this have been excluded.
Number of respondents: 2019: 68; 2021: 115; 2022: 113; 2023: 104; 2024: 72



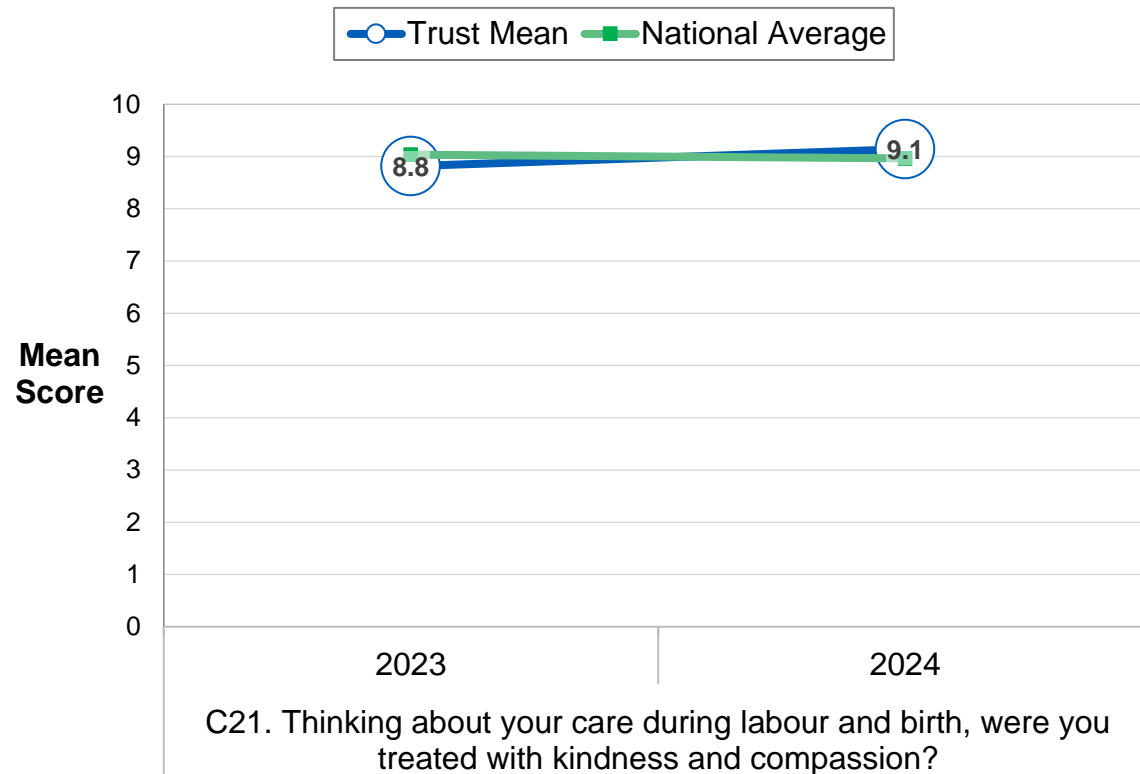
Significant change 2024 vs 2023

No change

Answered by all. Respondents who stated that they didn't know or couldn't remember have been excluded.
Number of respondents: 2022: 112; 2023: 104; 2024: 73

Section 2. Labour and Birth

Staff caring for you



Significant change 2024 vs 2023

No change

Answered by all. Respondents who stated that they didn't know or couldn't remember have been excluded.

Number of respondents: 2023: 115; 2024: 82

Change over time

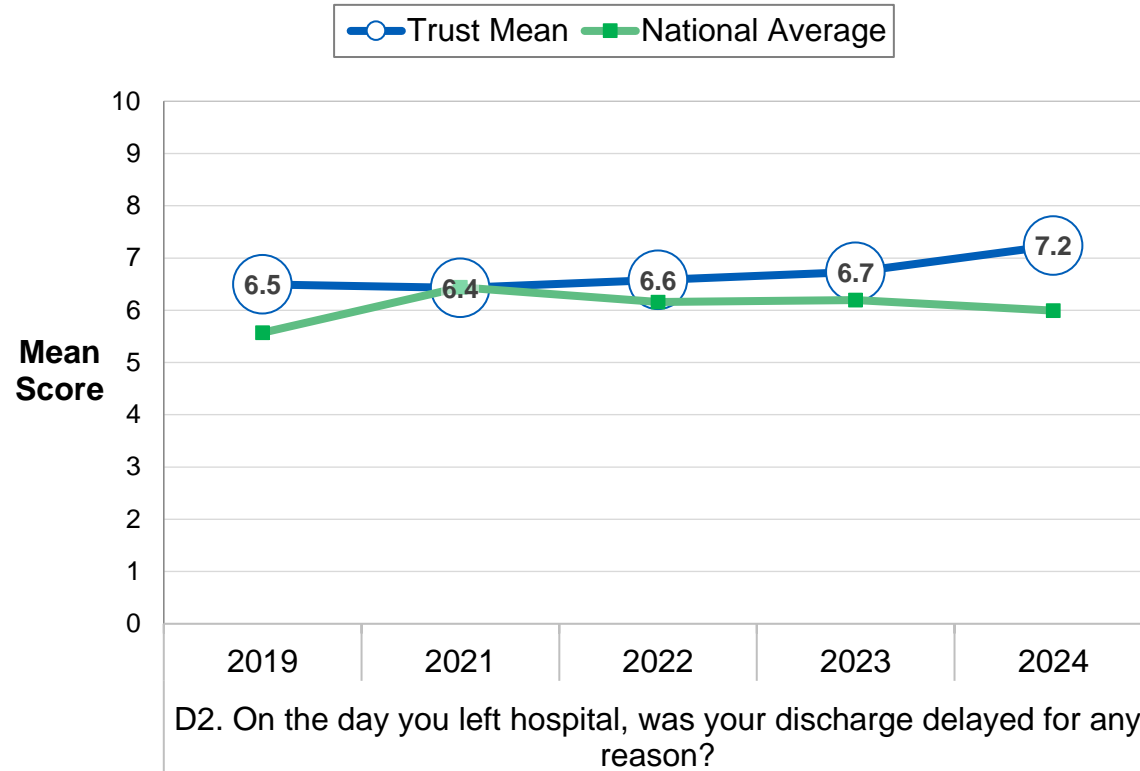
Section 3: Postnatal Care

The NHS logo, consisting of the letters 'NHS' in white on a blue rectangular background.The Care Quality Commission logo, featuring a stylized white 'Q' icon to the left of the text 'Care Quality Commission'.

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Section 3. Postnatal Care

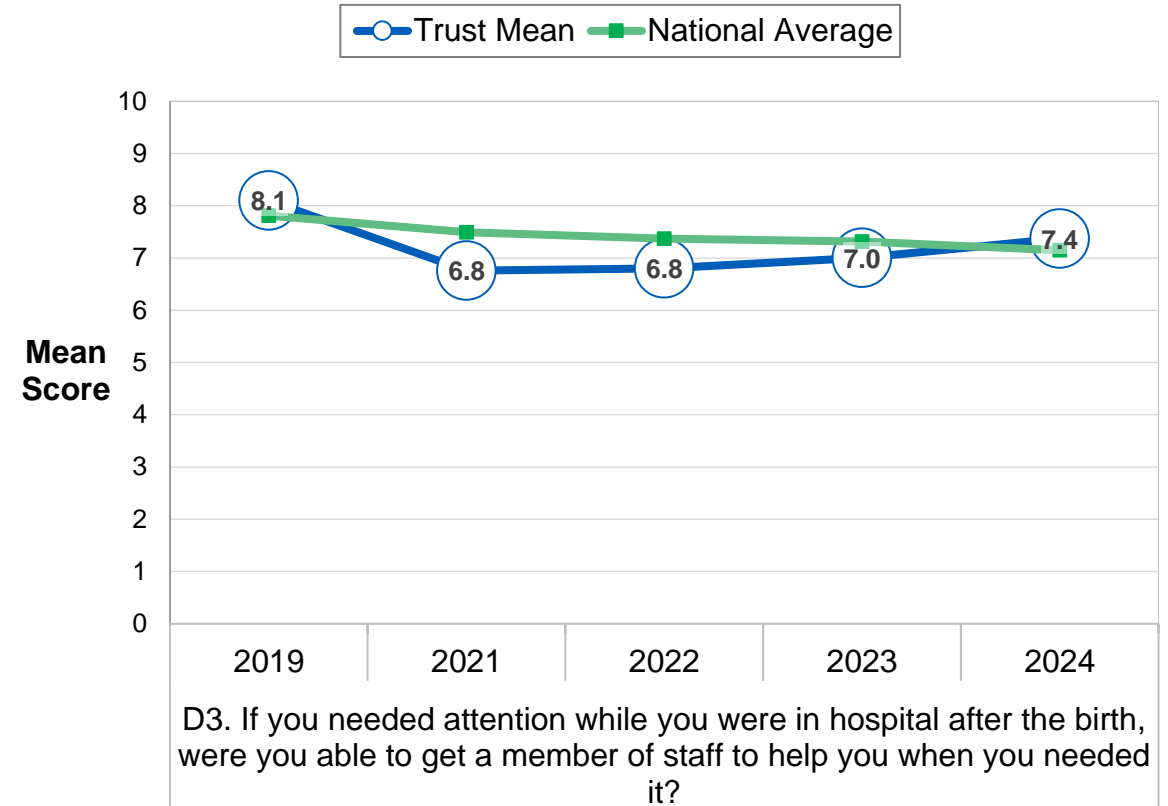
Care in the ward after birth



Significant change 2024 vs 2023

No change

Answered by those who stayed in hospital after the birth or required hospital care after a home birth.
Number of respondents: 2019: 70; 2021: 136; 2022: 122; 2023: 114; 2024: 77



Significant change 2024 vs 2023

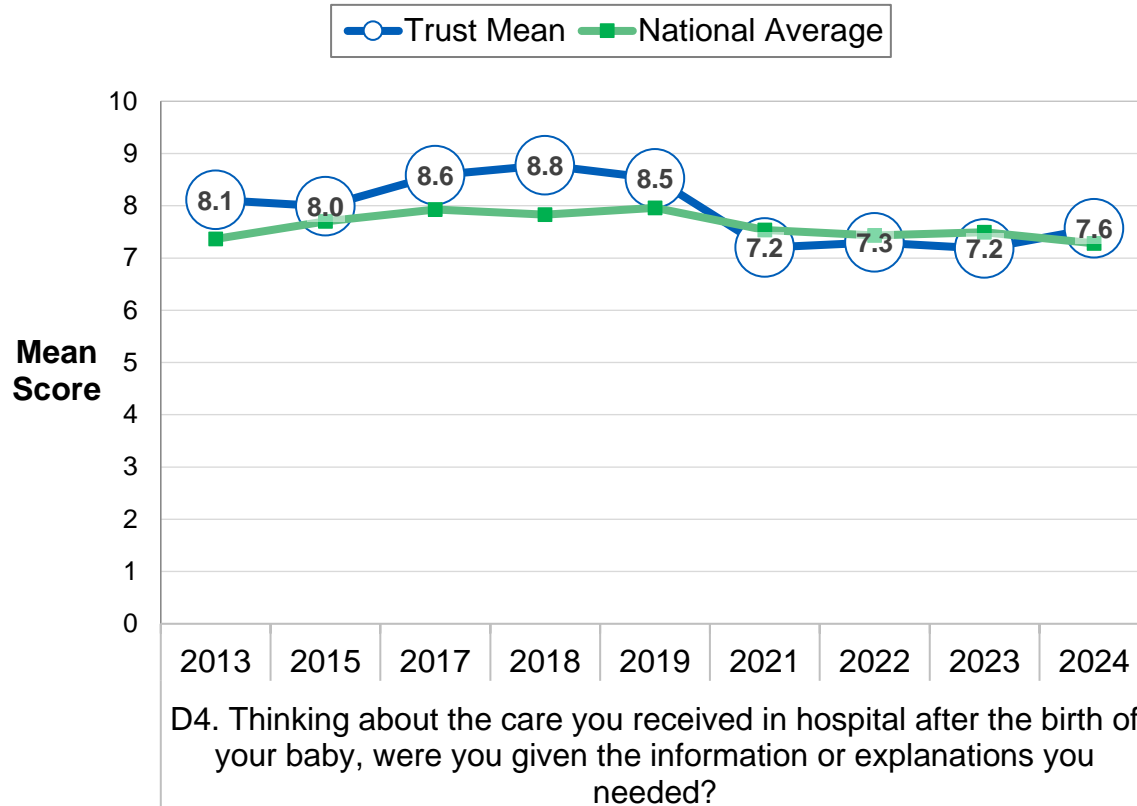
No change

Answered by those who stayed in hospital after the birth or required hospital care after a home birth. Respondents who stated that they didn't know / couldn't remember or did not want / need this have been excluded.

Number of respondents: 2019: 57; 2021: 127; 2022: 116; 2023: 102; 2024: 75

Section 3. Postnatal Care

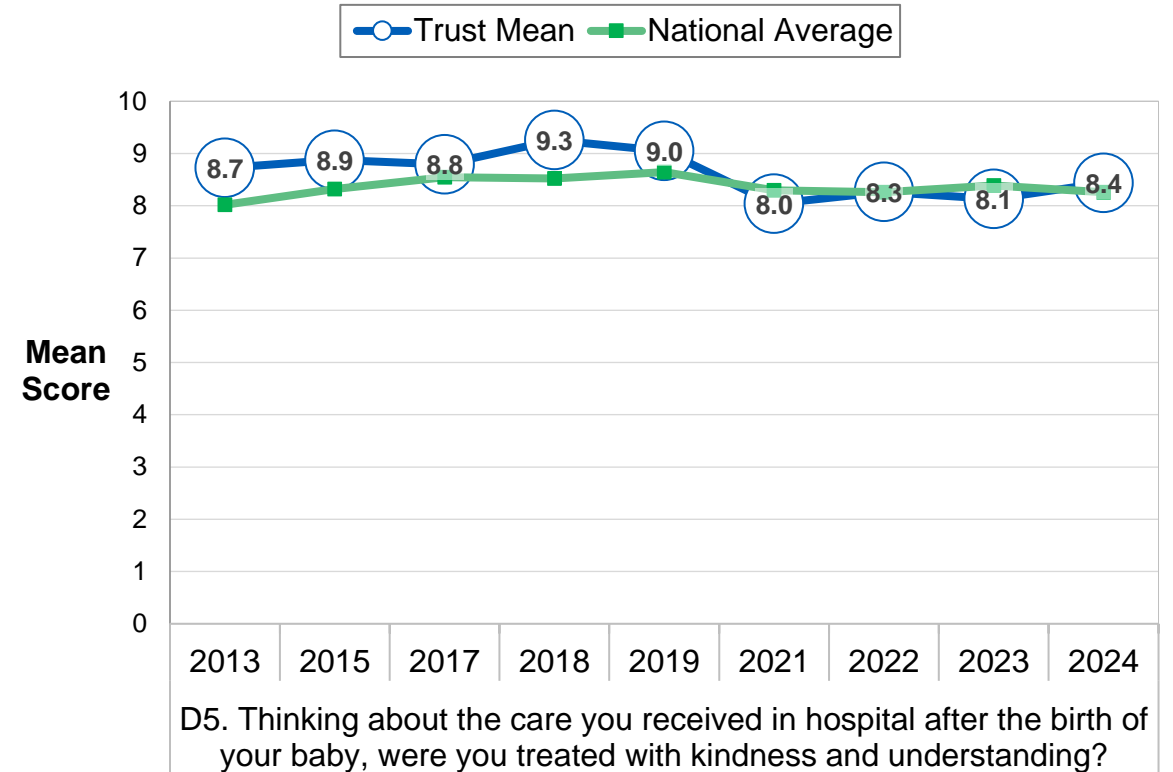
Care in the ward after birth



Significant change 2024 vs 2023

No change

Answered by those who stayed in hospital after the birth or required hospital care after a home birth. Respondents who stated that they didn't know / couldn't remember have been excluded.
Number of respondents: 2013: 103; 2015: 79; 2017: 88; 2018: 79; 2019: 70; 2021: 135; 2022: 121; 2023: 113; 2024: 77



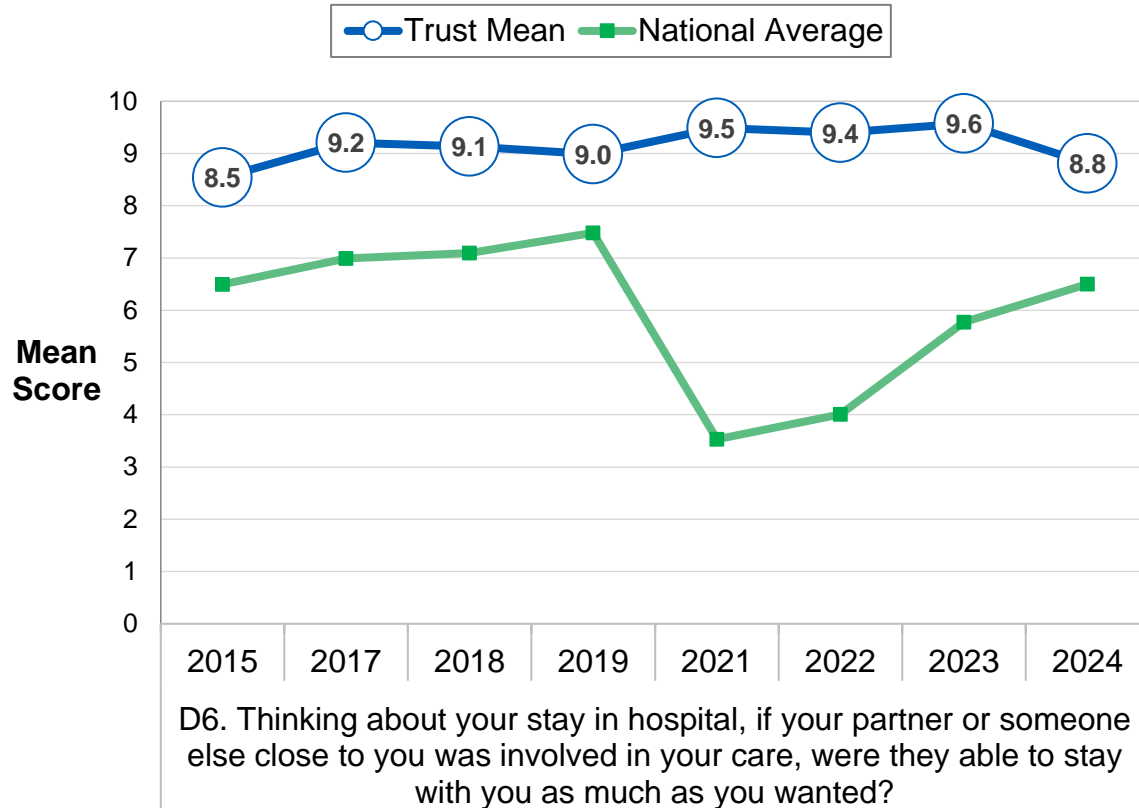
Significant change 2024 vs 2023

No change

Answered by those who stayed in hospital after the birth or required hospital care after a home birth. Respondents who stated that they didn't know or couldn't remember have been excluded.
Number of respondents: 2013: 102; 2015: 78; 2017: 89; 2018: 79; 2019: 71; 2021: 136; 2022: 122; 2023: 114; 2024: 76

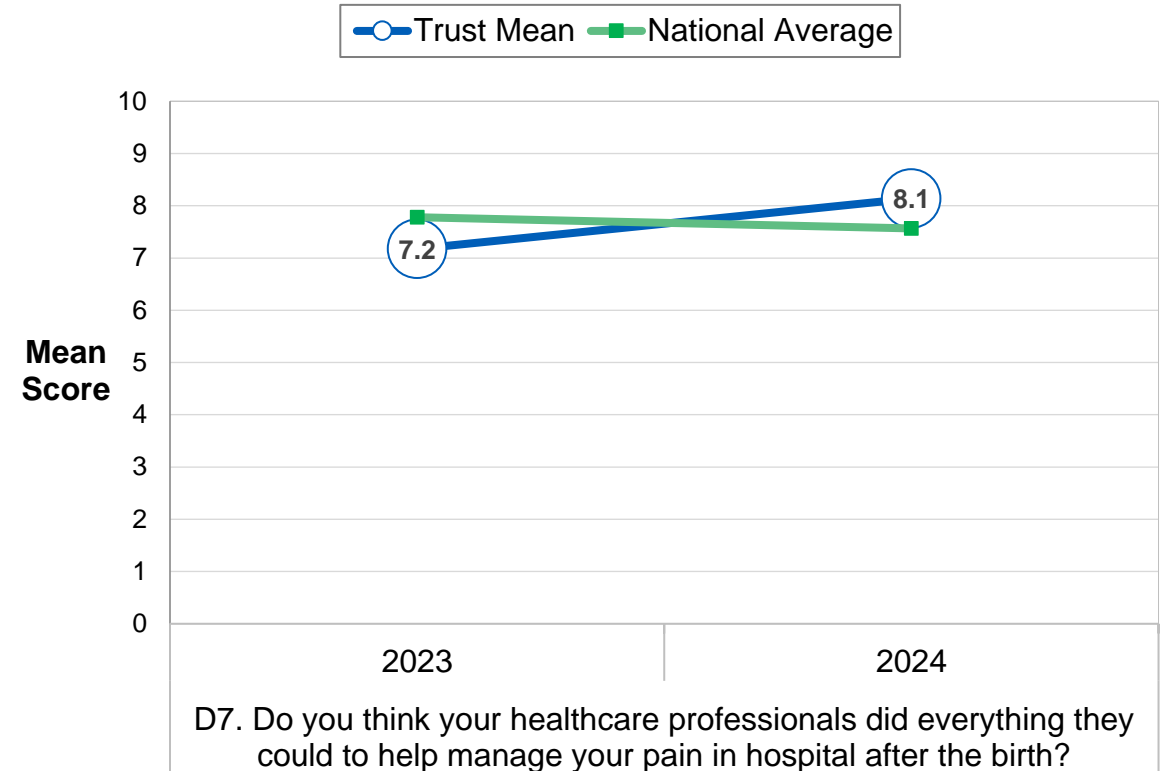
Section 3. Postnatal Care

Care in the ward after birth



Significant change 2024 vs 2023 No change

Answered by those who stayed in hospital after the birth or required hospital care after a home birth. Respondents who stated that their partner / companion was not able to stay for another reason or that they did not have a partner / companion with them have been excluded. Number of respondents: 2015: 74; 2017: 84; 2018: 77; 2019: 68; 2021: 119; 2022: 115; 2023: 106; 2024: 76

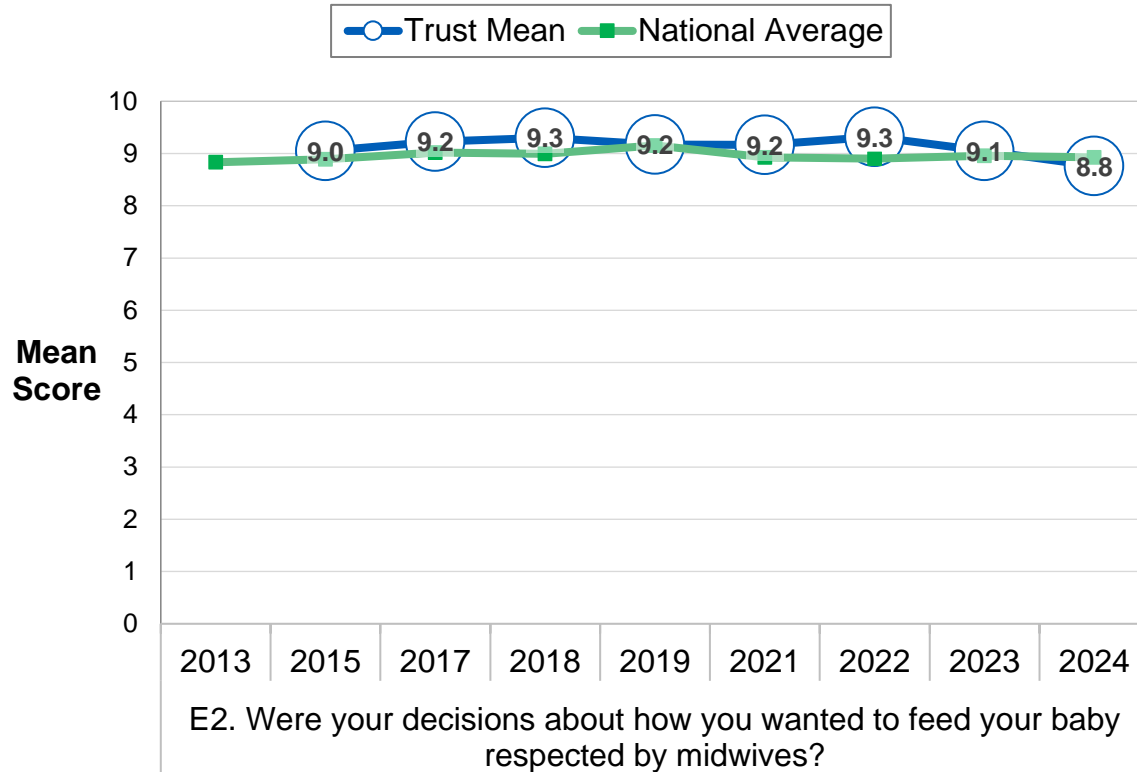


Significant change 2024 vs 2023 No change

Answered by those who stayed in hospital after the birth or required hospital care after a home birth. Respondents who stated that they didn't need any help with pain relief or didn't know / couldn't remember have been excluded. Number of respondents: 2023: 111; 2024: 75

Section 3. Postnatal Care

Feeding your baby



Significant change 2024 vs 2023

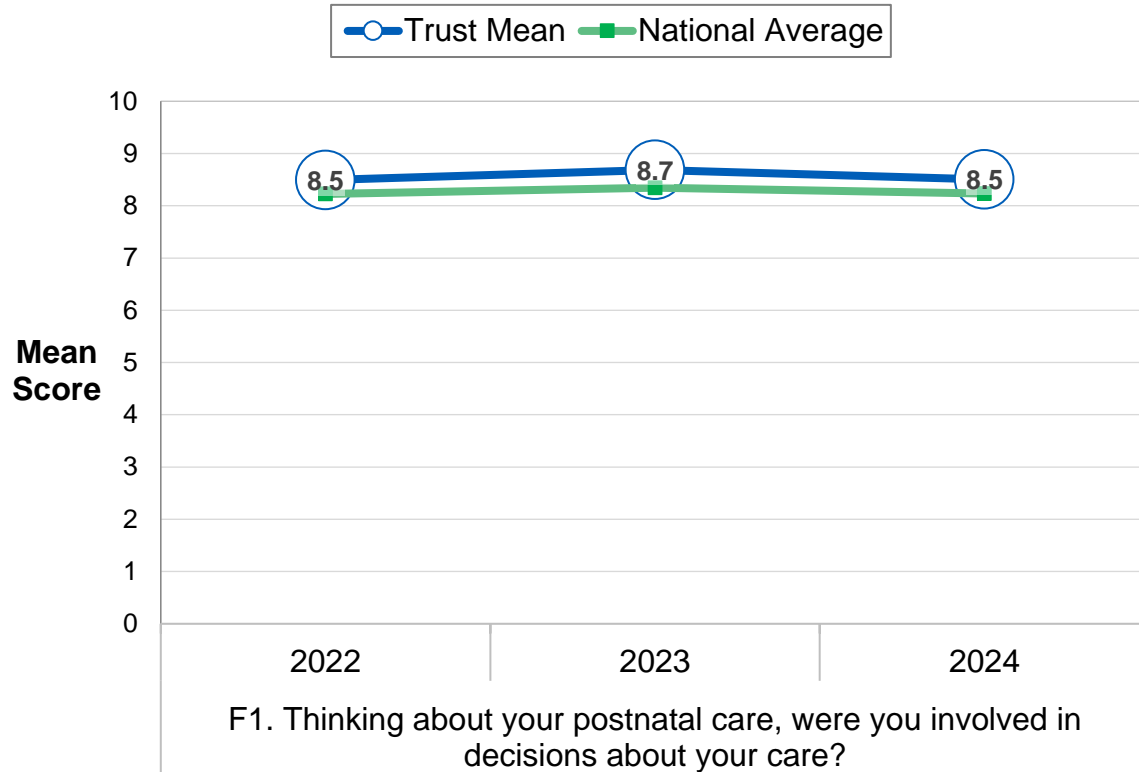
No change

Answered by all. Respondents who stated that they didn't know or couldn't remember have been excluded.

Number of respondents: 2013: -; 2015: 81; 2017: 83; 2018: 76; 2019: 67; 2021: 120; 2022: 123; 2023: 97; 2024: 77

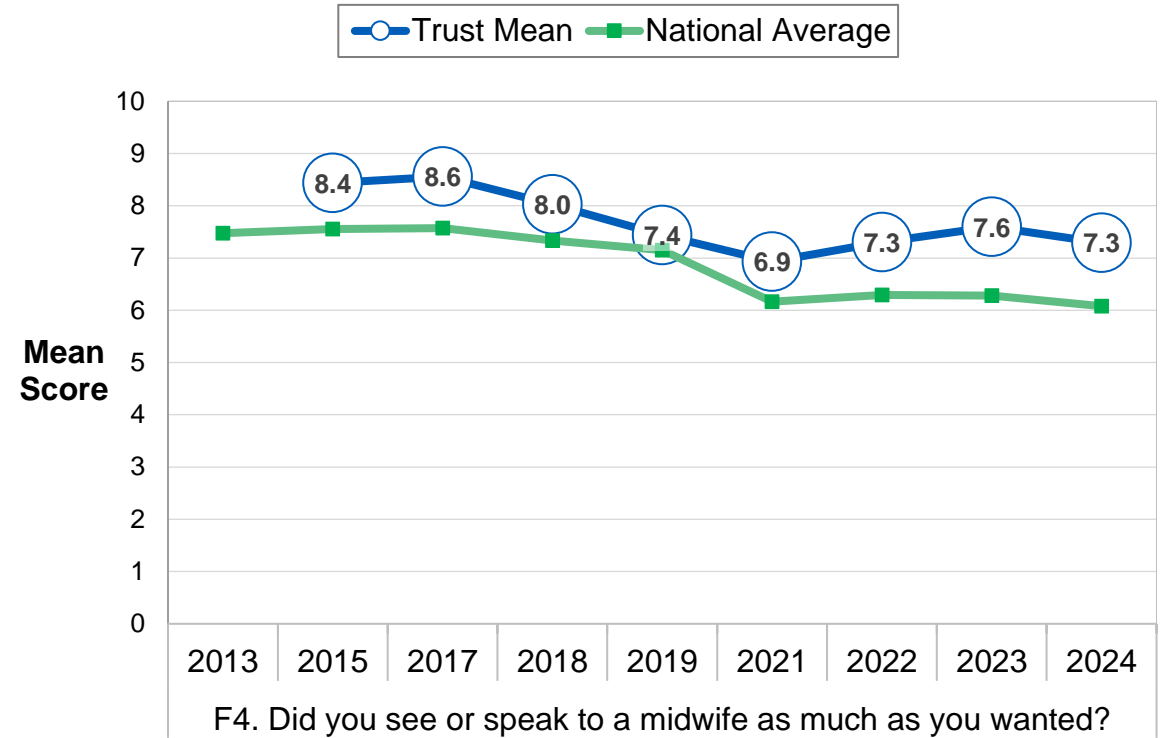
Section 3. Postnatal Care

Care at home after birth



Significant change 2024 vs 2023 No change

Answered by all. Respondents who stated that they didn't know / couldn't remember or did not want/ need to be involved have been excluded.
 Number of respondents: 2022: 117; 2023: 92; 2024: 73

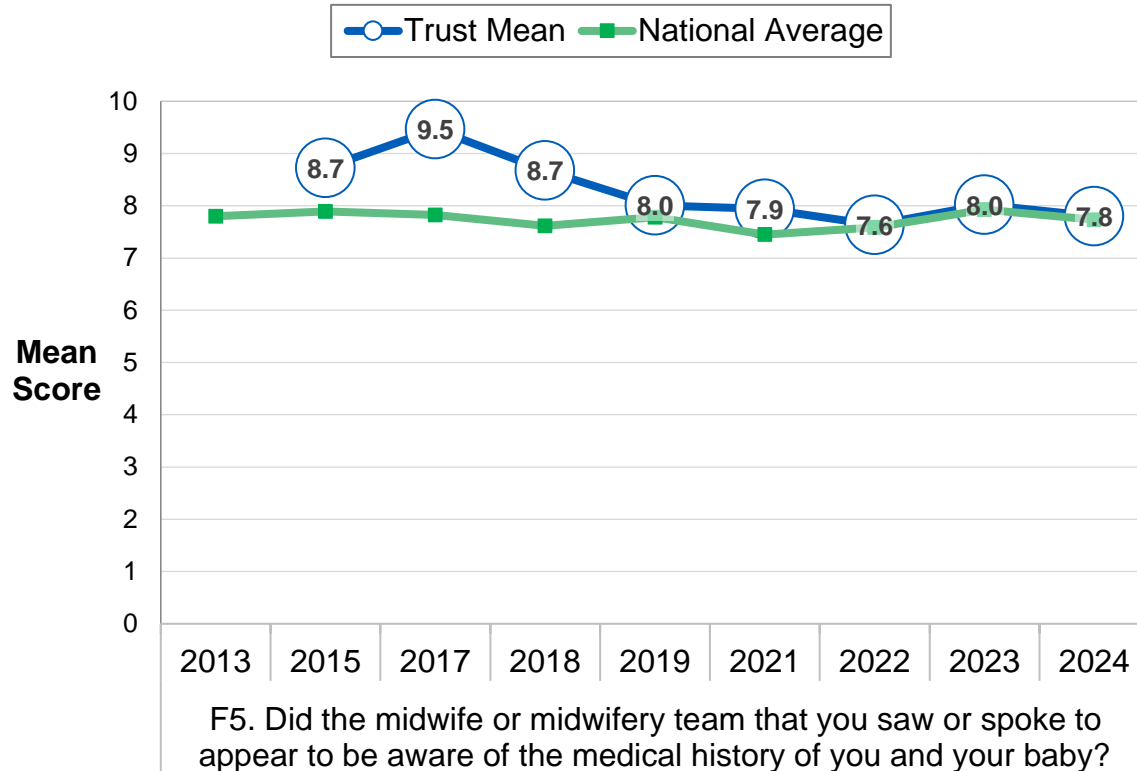


Significant change 2024 vs 2023 No change

Answered by all.
 Number of respondents: 2013: -; 2015: 80; 2017: 83; 2018: 77; 2019: 69; 2021: 118; 2022: 123; 2023: 97; 2024: 78

Section 3. Postnatal Care

Care at home after birth

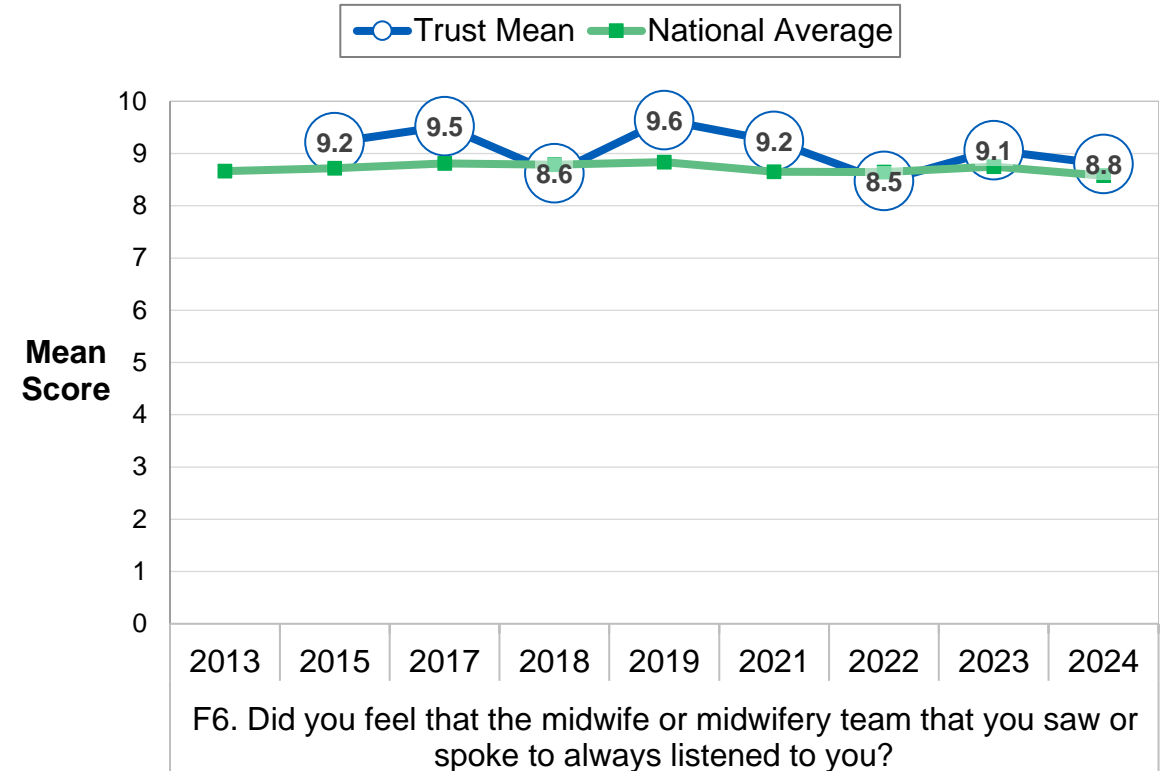


Significant change 2024 vs 2023

No change

Answered by all. Respondents who stated that they didn't know / couldn't remember have been excluded.

Number of respondents: 2013: -; 2015: 78; 2017: 79; 2018: 72; 2019: 60; 2021: 112; 2022: 115; 2023: 84; 2024: 71



Significant change 2024 vs 2023

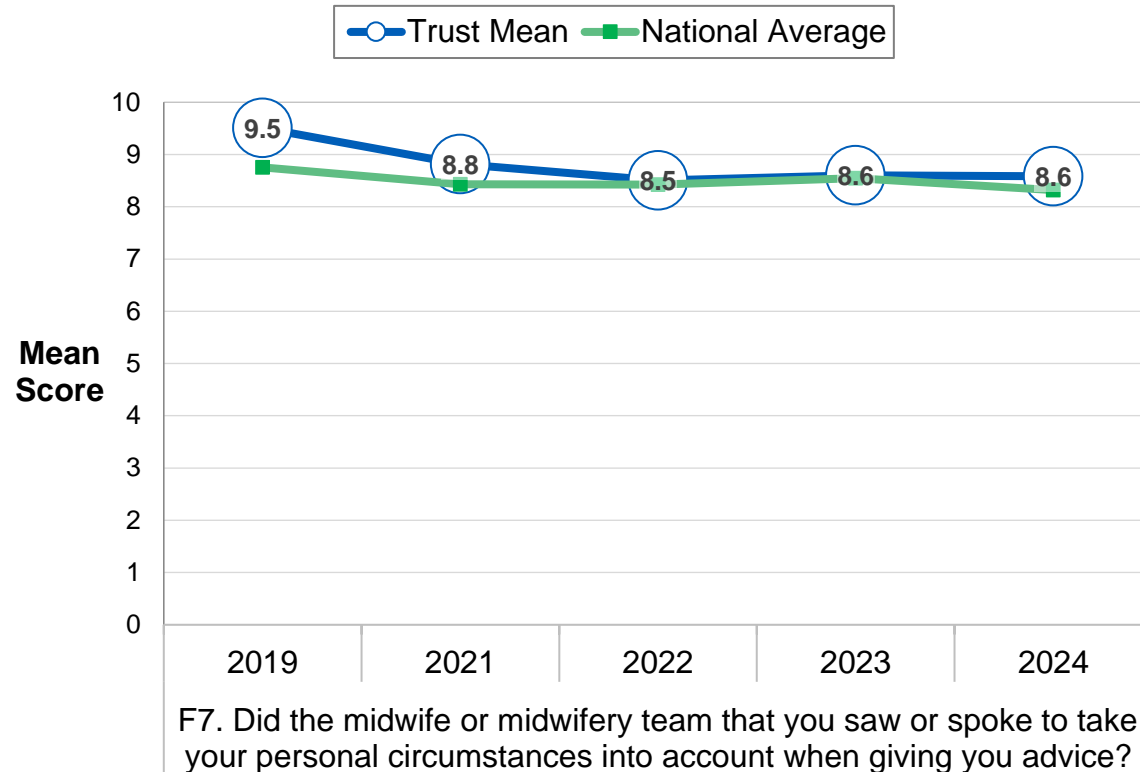
No change

Answered by all. Respondents who stated that they didn't know or couldn't remember have been excluded.

Number of respondents: 2013: -; 2015: 80; 2017: 83; 2018: 77; 2019: 68; 2021: 118; 2022: 122; 2023: 97; 2024: 77

Section 3. Postnatal Care

Care at home after birth

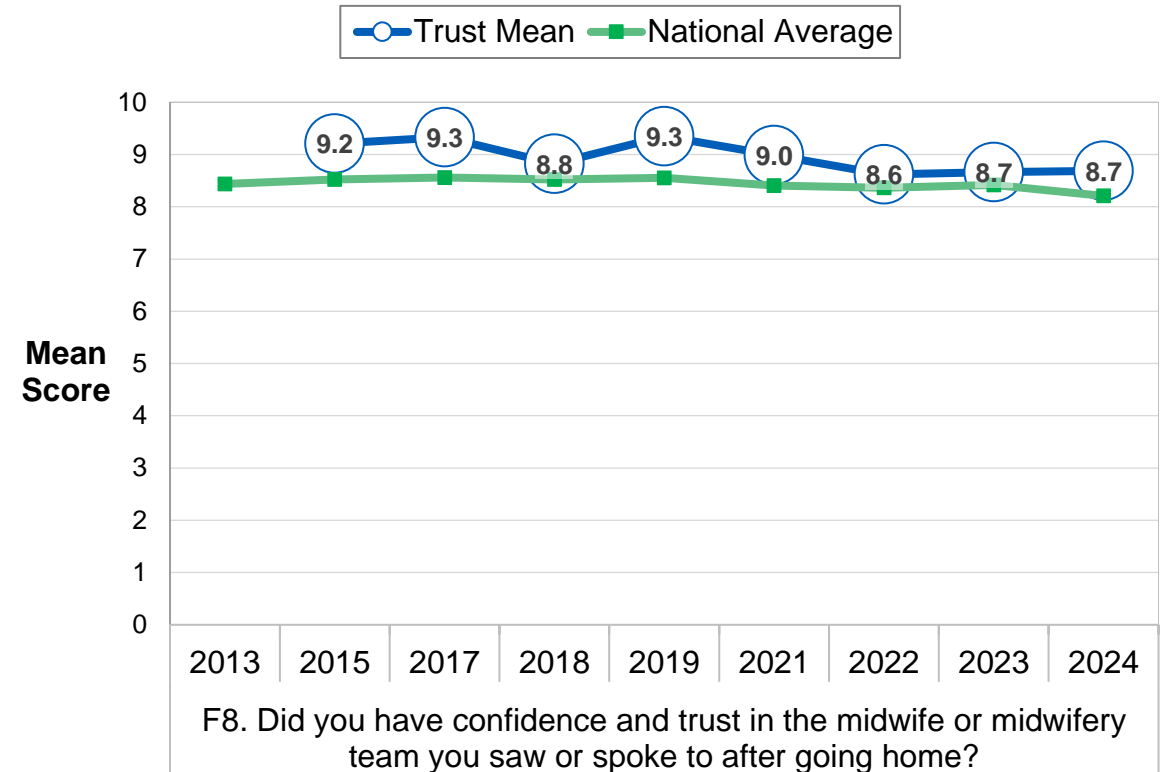


Significant change 2024 vs 2023

No change

Answered by all. Respondents who stated that they didn't know or couldn't remember have been excluded.

Number of respondents: 2019: 64; 2021: 115; 2022: 117; 2023: 91; 2024: 73



Significant change 2024 vs 2023

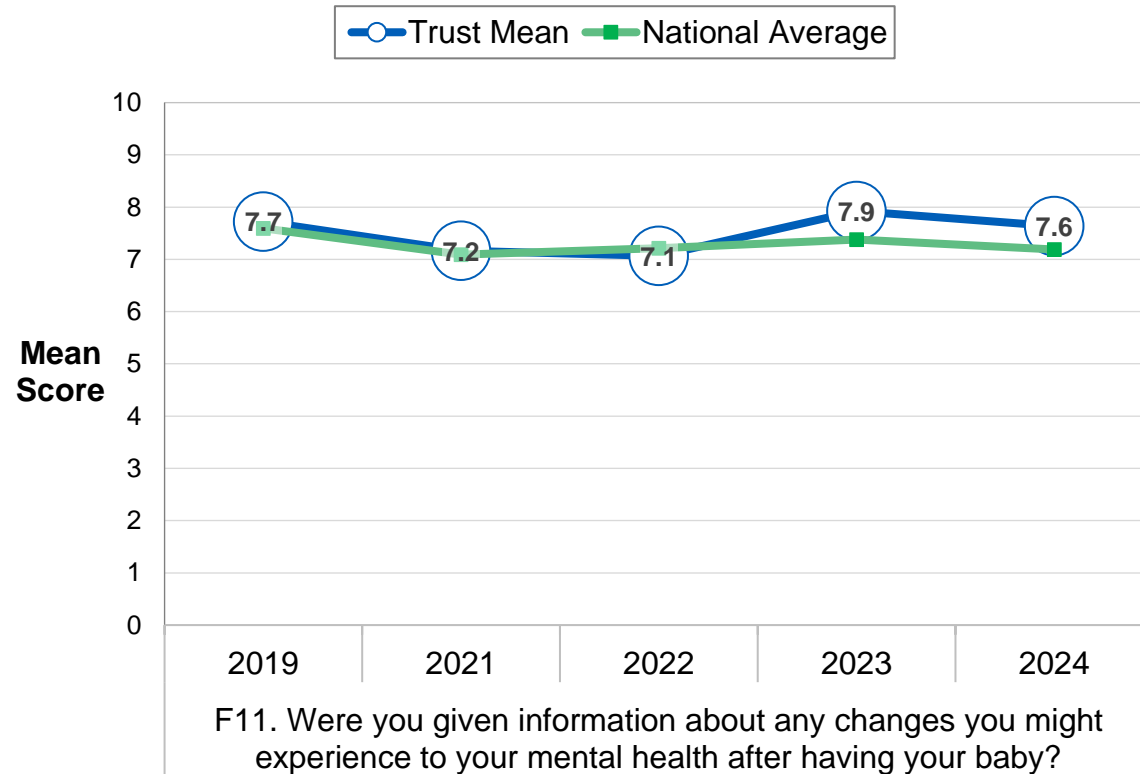
No change

Answered by all. Respondents who stated that they didn't know or couldn't remember have been excluded.

Number of respondents: 2013: -; 2015: 80; 2017: 84; 2018: 77; 2019: 69; 2021: 117; 2022: 122; 2023: 96; 2024: 76

Section 3. Postnatal Care

Care at home after birth

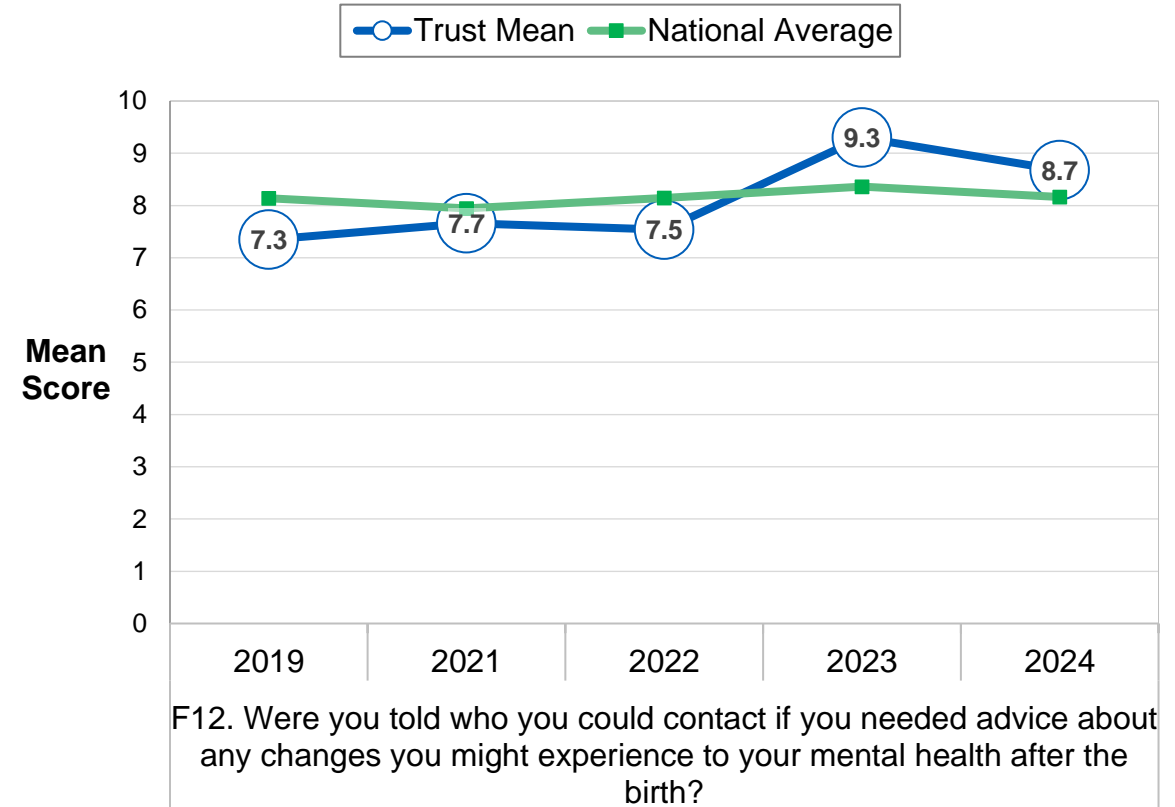


Significant change 2024 vs 2023

No change

Answered by all. Respondents who stated that they didn't know or couldn't remember have been excluded.

Number of respondents: 2019: 65; 2021: 117; 2022: 120; 2023: 95; 2024: 76



Significant change 2024 vs 2023

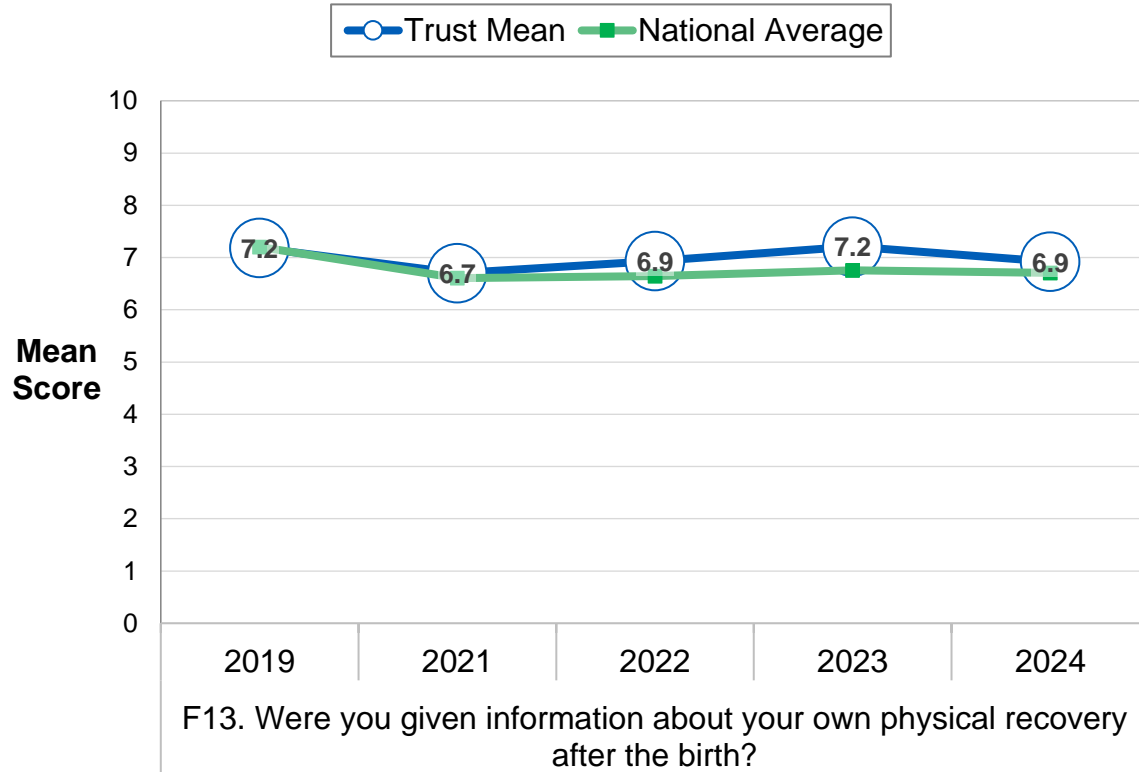
No change

Answered by all. Respondents who stated that they didn't know or couldn't remember have been excluded.

Number of respondents: 2019: 64; 2021: 100; 2022: 111; 2023: 88; 2024: 71

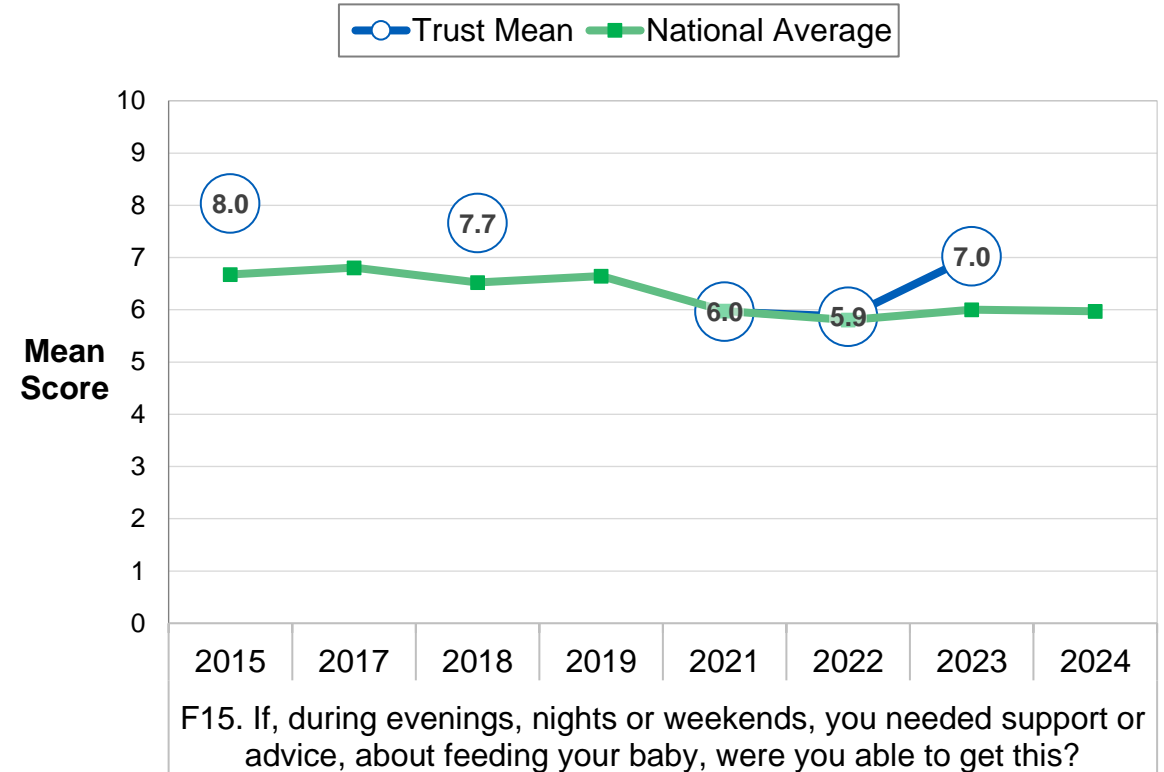
Section 3. Postnatal Care

Care at home after birth



Significant change 2024 vs 2023	No change
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Answered by all. Respondents who stated that they didn't know / couldn't remember or did not need this information have been excluded.
 Number of respondents: 2019: 65; 2021: 118; 2022: 119; 2023: 96; 2024: 75



Significant change 2024 vs 2023	-
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Answered by all. Respondents who stated that they didn't know / couldn't remember or did not need support or advice about feeding their baby have been excluded.
 Number of respondents: 2015: 30; 2017: -; 2018: 31; 2019: -; 2021: 45; 2022: 48; 2023: 39; 2024: -

Change over time

Section 4: Complaints



NHS

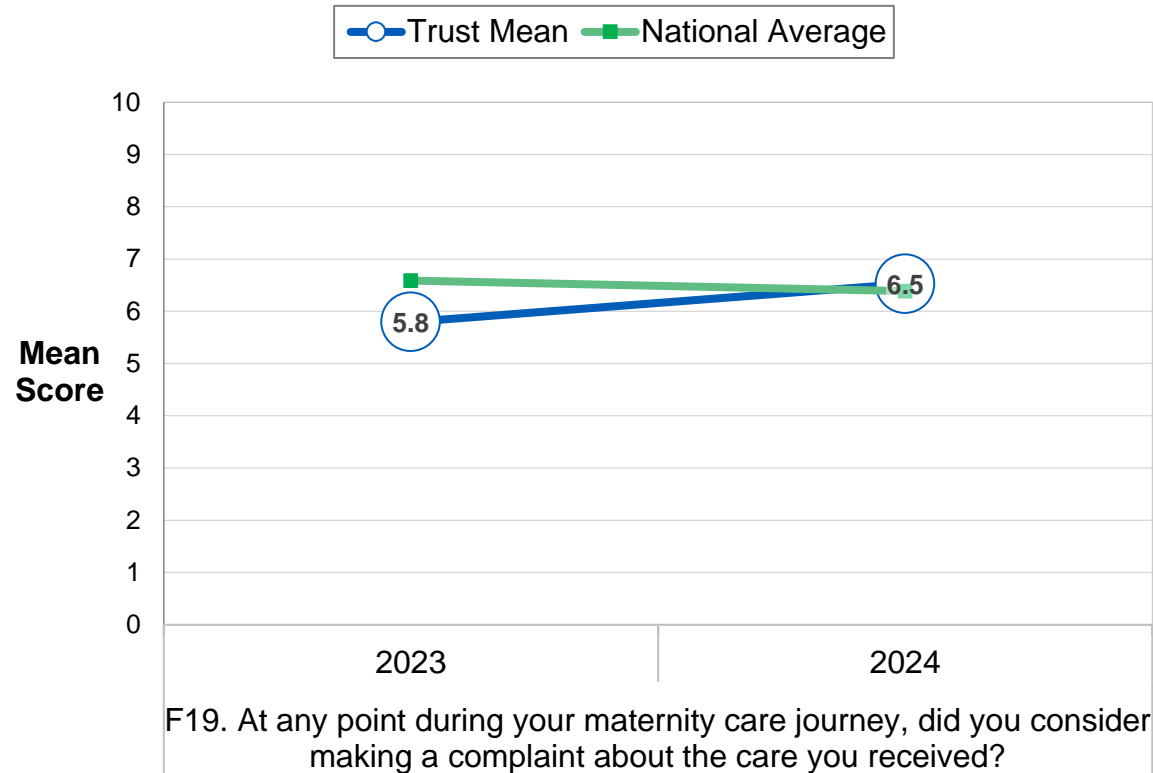


**CareQuality
Commission**

**Survey
Coordination
Centre**

Section 4. Complaints

Complaints



Significant change 2024 vs 2023

No change

Answered by all. Respondents who stated that they didn't know / couldn't remember whether they considered making a complaint have been excluded.
Number of respondents: 2023: 113; 2024: 82

Comparison to Other Trusts



NHS



**CareQuality
Commission**

**Survey
Coordination
Centre**

Comparison to other trusts

The questions where your trust has performed much better when compared with all other trusts are listed below.
The questions where your trust has performed about the same compared with all other trusts have not been listed.

Much better than expected

- No questions for your trust fall within this banding.

Comparison to other trusts

The questions where your trust has performed better than compared with all other trusts are listed below.
The questions where your trust has performed about the same compared with all other trusts have not been listed.

Better than expected

- No questions for your trust fall within this banding.

Comparison to other trusts

The questions where your trust has performed somewhat better when compared with all other trusts are listed below. The questions where your trust has performed about the same compared with all other trusts have not been listed.

Somewhat better than expected

- D2. On the day you left hospital, was your discharge delayed for any reason?

Comparison to other trusts

The questions where your trust has performed somewhat worse when compared with all other trusts are listed below. The questions where your trust has performed about the same compared with all other trusts have not been listed.

Somewhat worse than expected

- No questions for your trust fall within this banding.

Comparison to other trusts

The questions where your trust has performed worse compared with all other trusts are listed below.

The questions where your trust has performed about the same compared with all other trusts have not been listed.

Worse than expected

- No questions for your trust fall within this banding.

Comparison to other trusts

The questions where your trust has performed much worse when compared with all other trusts are listed below.
The questions where your trust has performed about the same compared with all other trusts have not been listed.

Much worse than expected

- No questions for your trust fall within this banding.

For further information

Please contact the Survey Coordination Centre:
maternity@surveycoordination.com

The NHS logo, consisting of the letters 'NHS' in white on a blue rectangular background.The Care Quality Commission logo, featuring a stylized white 'Q' icon to the left of the text 'Care Quality Commission'.

Survey
Coordination
Centre



10 December 2024

Dear Rose,

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

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

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

Therefore please can you complete the following:

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



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

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

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

With best wishes,

Anne Woods.

Anne Woods, Deputy Programme Director



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

Re-assessment report
Maternity Service

Wirral University Teaching Hospital

on 23-24 October 2024

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

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Assessment result

What we found overall:

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

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

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

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

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

Janette Westman
24 October 2024

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

What mothers told us

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

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

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

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

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

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

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

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

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

Actions that are *required* are mandatory if the criteria for Baby Friendly accreditation are to be met and the facility able to maintain full accreditation. If any requirements are made, these are listed below.

The Designation Committee will be asked to consider what additional evidence is required. This may take the form of written evidence or a follow-up assessment that will usually happen within 6 months. Further requirements may be made in the future in relation to any changes made, and in light of practice found or current research evidence.

1. An increase in the number of staff who have attended training is required.
2. We require an increase in the number of staff who can:
 - describe how they recognise effective breastfeeding
 - describe responsive breastfeeding
 - demonstrate an understanding of how to support formula feeding mothers with making up feeds and understand responsive bottle feeding
 - discuss the International Code of Marketing of Breastmilk Substitutes.
3. We require an increase in the percentage of mothers who report:
 - they had the opportunity for a discussion about feeding their baby and developing a relationship with their baby during pregnancy, which meets their needs
 - they have been shown how to hand express breastmilk
 - they understood baby led breastfeeding and how to recognise feeding cues
 - they had been supported with learning about making up feeds and how to responsively bottle feed their baby
 - they had received information about the importance of close and loving relationships.
4. Supplementation with formula is referred to Designation Committee.

How we *recommend* you achieve and maintain the standards

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

1. Standard 1 – Antenatal information

- During the Covid 19 pandemic, a website was created to provide information to mothers. Recently antenatal workshops have been reinstated. These include a session by the Infant Feeding Team and are very well attended. In addition, a pilot is taking place to attempt to reach vulnerable women, who would not normally travel to the maternity unit. Whilst these options are commendable, they do not reach all mothers, particularly those mothers who were multiparous. Some of these mothers felt that staff assumed that they already had knowledge, so they did not have an opportunity for meaningful discussions.
- We strongly recommend that further training takes place, and that staff are encouraged to have a meaningful discussion with all pregnant women about feeding their baby and the importance of developing relationships with their unborn baby.

2. Standard 3 – Hand expression

- Most staff were able to demonstrate how they would support mothers to hand express breastmilk. However, some were unsure about this technique, with some staff sliding their fingers and some thinking that they would rotate around the breast as soon as milk started to flow. We recommend that this topic is revisited in training and that Practical Skills Reviews continue to ensure a more consistent understanding of this.
- Many mothers interviewed were not offered help with hand expression of breastmilk after their baby was born. Whilst many said that a midwife had mentioned colostrum harvesting in the antenatal period, not all had been shown how to do this. We recommend that if antenatal colostrum harvesting is suggested, a demonstration should be provided for mothers. In addition, after birth staff should check whether mothers know how to do this and offer to show them how to hand express if needed.

3. Standard 3 – Responsive feeding

- Most staff were able to describe baby-led feeding, though some mentioned various lengths of times which should not be exceeded, ranging from 2 to 5 hours. The assessment team considered that this may be related to the use of the reluctant feeder guideline, used on the postnatal ward. Whilst it is important to ensure that newborn babies are well and that breastfeeding is being established effectively, it should be acknowledged that this is temporary and that once feeding is established, most babies

will feed responsively. Mothers should be helped to understand that this means feeding the baby whenever they show signs of hunger and how to recognise feeding cues.

In addition, we recommend further training to enable staff to understand that responsive feeding is more than feeding for hunger, but also part of a reciprocal relationship between a mother and her baby, which includes feeding for hunger, comfort of both mother and her baby, as well as convenience, e.g. prior to a school run, for full breasts, or just because it's a special time for mother and baby to spend together. We highly recommend further training and audit of this criteria.

4. Standard 3 – Recognising effective feeding

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

5. Standard 4 – Maximising breastmilk

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

6. Standard 4 – Support for mothers who are using infant formula

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

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

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

8. Standard 5 – Close and loving relationships

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

Paperwork and processes

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

Staff training

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

Any additional advisory comments

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

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

Achieving Sustainability

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

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

Themes	Standard/Criteria
Leadership	<ul style="list-style-type: none"> • Baby Friendly lead/team with sufficient knowledge, skills and capacity • Effective updating for Baby Friendly team • Baby Friendly Guardian in post • Leadership structures support proportionate responsibility and accountability • Managers are educated to support the maintenance of the standards.
Culture	<ul style="list-style-type: none"> • Support for ongoing staff learning • Mechanisms to support a positive culture • Positive feedback from staff, managers and mothers.
Monitoring	<ul style="list-style-type: none"> • Robust, consistent monitoring and reporting mechanisms in place • Evidence of analysis and action planning.
Progression	<ul style="list-style-type: none"> • Demonstrates innovation and progress • Improvement in outcomes • Evidence of integrated working.

Comments:

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

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

- 4.** The Infant Feeding Lead is being supported by management to complete Lactation Consultant (IBCLC) qualification.
- 5.** Paediatricians previously had access to the doctor's e-learning pack, but no records were made of completion of training. Subscription to the pack lapsed in January 2024, but further funding has been agreed and completion of the training will be monitored more closely in future. At present the Infant Feeding Leads (maternity and neonatal), have training opportunities with doctors at morning sessions but not everybody attends these. Training is also provided for multidisciplinary staff at PROMPT days. Plans are in place for all future training to take place at induction sessions.
- 6.** A community support team do routine support visits and are heavily involved with infant feeding support. They have been trained to audit by the Infant Feeding Lead and have helped with audits. There are plans for breastfeeding champions to also support with audits in future. They will also help with sharing audit results within their own team. We suggest that after the Infant Feeding Lead has attended audit training, this should be shared with all other staff who are involved in audit of standards to ensure consistency.
- 7.** Morale in the unit is currently low, with staff struggling with workload and burnout and some members of staff have been lost, resulting in difficulties in achieving good skill mixes. A staff survey is currently being conducted, but there is a reluctance amongst staff to complete this. Work has taken place to provide continuity of carer since 2018. This has caused difficulties and is being reassessed to look at any improvement that can be made. However, managers feel that although morale is low, staff do feel able to be honest with feedback and managers are listening to worries.
- 8.** There is evidence of excellent collaboration with the neonatal services, which will be further strengthened with the appointment of the neonatal Infant Feeding Lead. The Infant Feeding Lead also works closely with the health visitor Infant Feeding Lead. The peer support service Lead and children's centre Lead also meet on a regular basis. Data sharing agreements with other services are almost finalised
- 9.** There is a provision of a 24-hour infant feeding support on the postnatal ward, which receives excellent feedback from mothers. Plans are being considered to increase this team to ensure that this support is always available.
- 10.** There is a Ronald McDonald unit in the hospital, which provides accommodation, food and a homely environment to parents who have a baby on the neonatal unit. Many parents utilise this accommodation and feedback is good. However, the footprint of the neonatal unit is a concern, with very little space for parents to be able to stay with their baby at cot side, particularly in the intensive care area. This has been flagged as needing improvement and an extension to the unit is planned.

Progression to the Gold award

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

What happens next?

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

The results in detail

The sample

All staff and mothers were randomly selected for interview:

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

Standard 1 – Antenatal care

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

Standard 2 – Care at birth

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

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

Standard 3 – Getting breastfeeding off to a good start

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

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

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

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

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

Standard 5 – Close and loving relationships

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

General

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

Communication & Culture

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

Supporting information

Criteria	Result	Standard required
Observations within the facility	No advertising	No advertising
Documentation reviewed <ul style="list-style-type: none"> Antenatal records Breastfeeding assessments 	Does not meet standards Fully completed= 4, Partial= 3, not completed= 3 Fully completed =4 Not completed =6	Meet standards
Staff who have been orientated to the policy	98%*	80%
Staff who have completed the training programme	63% (78% excluding NNU)	80%
Policies and guidelines	Partial (hypoglycaemia under review)	Meets standards
Written and other information	Meets standards	Meets standards
Mechanisms	Partial	Meets standards
The written curriculum meets the standards	Meets standards	Meets standards

*Figures for orientation to policy only available for midwifery staff

Supplementation				
The most recent data provided by the facility is as follows: (Jun 2023 - May 2024)				
	Q1	Q2	Q3	Q4
Internal audit data	31%	28%	28%	28%
How rates have changed over time	With an average rate of 29% supplementation for this period of data capture, it shows a very slight reduction from the previous 12 months data which had an average of 32% supplementation.			
Factors which may impact on local rates	There remains a mixed feeding culture present on the Wirral. This is still evident with mothers who plan to breastfeed still bringing in a supply of formula, and often stating they have the intention of offering a bottle with some feeds.			

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

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

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

Background information

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

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

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

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

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

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

Initial accreditation as a Baby Friendly facility takes place in three stages:

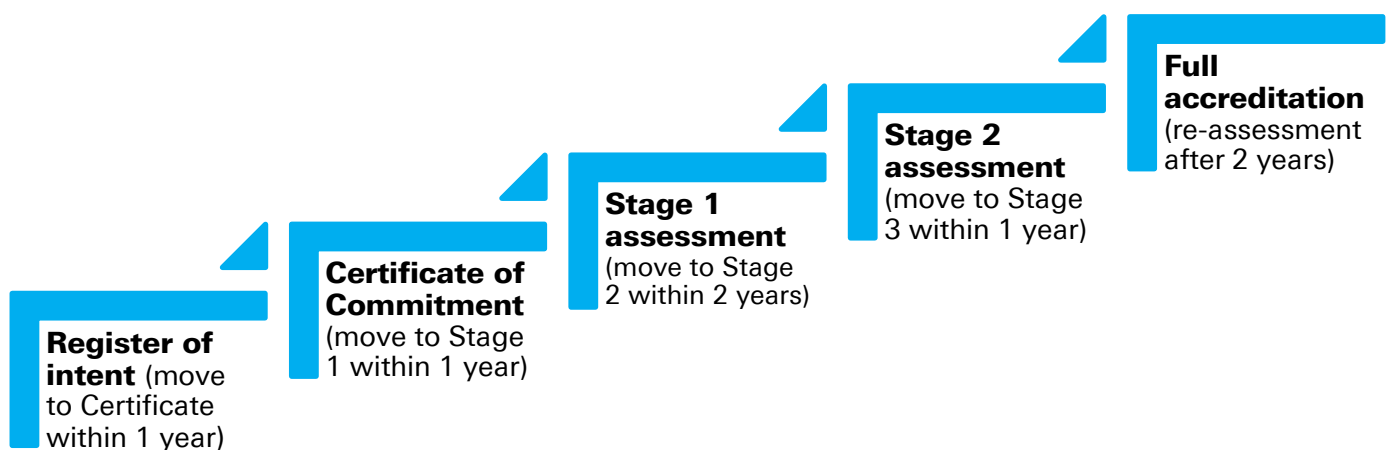
Stage 1 of the assessment procedure is designed to ensure that the necessary policies, guidelines, information, and mechanisms are in place to allow health care providers to implement the Baby Friendly standards effectively.

Stage 2 involves the assessment of staff knowledge and skills.

Stage 3 assesses the implementation of the Baby Friendly standards in the care of pregnant women and new mothers.

Re-assessment takes place after two years with the aim of ensuring that the standards are maintained. Ongoing assessment is carried out every three-five years with the same goal of ensuring the maintenance of standards.

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





13th January 2025

PRIVATE & CONFIDENTIAL

Ms Jo Lavery
Director of Midwifery
Wirral University Teaching Hospital

Dear Jo

Re: LMNS Annual Provider Visit to WHH – 11th December 2024

Thank you for hosting the LMNS Annual visit to your trust. It was a pleasure to meet with you and your teams and we are most grateful for the time given and the very generous hospitality provided.

As outlined in our presentation the visit was a follow on from the original NHSE led Ockenden visits to Trusts in 2022. The role and remit of both NHSE Regional team and the LMNS has changed over this time, and we are now responsible for oversight, support and assurance on behalf of Cheshire and Merseyside ICB.

The annual visit will form part of this role and provides an opportunity to build relationships and to see firsthand the services you provide for the mothers and babies in your care.

Although I did provide some feedback at the end of the day, I am also setting out the comments from the wider visit team below:

Strengths

- The presentation from the Trust was open, transparent and provided additional information on key priorities for the LMNS
- Specific focus on equity and inclusion and enhanced continuity of care with good engagement across communities and connections with Family Hubs and Silver Birch services
- Strong MNVP roles and engagement with community
- Excellent progress on reduction of SATOD from 10.9% to 5.6% noted.
- DoM regular presence at Board and psychological safety for staff to raise issues at Exec and Board level
- Culture and transparent leadership for staff and all were positive and enthusiastic that we met
- Board level safety champion is very engaged, visible and focussed on safety, support and improvement. Good knowledge and experience which is an asset to the service
- Clear ward to Board and Board to Ward processes and communication in place and demonstrated with learning a key focus
- PSIRF process clear and well embedded
- Forward thinking approach to workforce and continuity of care teams, HDU team within labour ward establishments
- Well-developed peer support model for infant feeding

Challenges

- Estate in antenatal areas cramped, outdated posters on walls and no call bells for patients in Triage area
- Triage requires a dedicated phonenumber and should be away from clinical areas and would benefit from the use of electronic whiteboards
- Estate difficult to work in with narrow corridors but large open spaces which could be configured better to rectify some of this
- Unclear where maternity CNST reinvestment is spent and whether this is ringfenced for maternity services improvement as required
- Neonatal service good, estate poor with minimal presence during the visit and within the presentation. Could do to show better connectivity across maternity and neonatal leadership and safety huddles and more senior nurse link roles
- Translation services cited as an issue especially for face-to-face support for women which is a risk given the complexities and diversity of women accessing services
- Possible over-reliance on Board Level Safety Champion to provide assurance for Board for maternity and neonatal services. LMNS will review support for this role across C&M
- DoM portfolio very wide and some concerns noted regarding capacity and support
- Issues regarding Cerner and requirement for paper files

Actions and Next Steps

- Links to be made with Maternal Medicine Network to follow up good practice of HDU roles and explore L7 critical care module
- LMNS team to provide examples of other Trusts providing devices (sims/phones/laptops) to vulnerable women and/or those where English is not their first language
- Follow up with LMNS on Trust Equity plan and development of neurodiversity pathway
- Trust to provide information on CNST reinvestment in maternity services to LMNS
- Estate issues and lack of emergency call bells to be escalated to Trust Executive
- LMNS to support External Reps for PMRT
- LMNS to support with workforce development for ACPs and collaboration with HEIs
- DoM to share Board report on Perinatal Pelvic Health Service with LMNS
- LMNS to follow up with MerseyCare developments on the neurodiversity screening tool
- LMNS to review support for Board level safety champions across C&M
- Regular Communication – Communication and support will be provided via established LMNS meetings and forums, at the request of the Trust and in response to any other requests from NHSE and/or ICB.

I hope that the above feedback is helpful, and the actions reflect your expectations from the feedback session at the end of the visit.

Once again thank you for your support and cooperation and I look forward to working with you and your teams in the future.

Please do not hesitate to contact me with any questions.

Your sincerely



Catherine McClennan
LMNS SRO/ Director for Women's Health and Maternity Programme
Cheshire and Merseyside ICB

CC: Ms Sam Westwell (Chief Nurse)

CC: Dr Libby Shaw (Clinical Lead)

CC: Katherine Wilkinson (Head of Midwifery)



NHS

North West Neonatal

Operational Delivery Network

ANNUAL VISIT 2024

Unit: Arrowe Park

Date: 6th December 2024

Attendees from Unit:

NWNODN Team:

Kelly Harvey, Acting Director – Anand Kamalanathan, Clinical Lead - Heather Martin, Quality Improvement Lead Nurse - Samantha Parry, Care Coordinator – Rebecca Hinton, Pharmacist

Arrowe Park Unit Visit 2024

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

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

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

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

Actions to follow up from the 2023 visit

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

Subject Area	Discussion/Actions following 2022 Annual Review	Up-Date following 2023 Review	Up-date for 2024 review
Activity Capacity and Demand	Do not meet NCCR requirements for NICU- to continue to engage in NWODN NCCR work Covid impact on staffing reconfigured unit for Isolation- Review requirement for reconfigured isolation rooms.	NCCR discussion regarding new service specification and activity measure. KH updated in conversations happening nationally looking at the challenges of activity measures and other metrics including finance. <ul style="list-style-type: none"> ACTION completed:- NS to highlight issues raised at commissioners' methodology subgroup. 	Update to be provided during annual visit
Governance	Challenges in accessing external support for PMRT- to work with NWNODN to review this.	KH updated on ODN PMRT external representation plans for April 2024 and Network PA funding allocation.	Update to be provided during annual visit
NNAP / Data Entry		SR highlighted issues with repatriations. Repatriation data – NS highlighted the Badgernet ready for discharge tab to enable capture of repatriation challenges at network level. <ul style="list-style-type: none"> ACTION:- NWNODN to progress with Repatriation work in 2024 – commenced 2024 	Ward manager Hannah Harper regularly attends repatriation group with the network looking at ways of improving repatriation. Jen Butler, unit psychologist also attends. Looking at ways to prepare for repatriation for example adding a slide to the parent tv to promote visits to their unit and also promote the NWNODN website for unit information and tours.

Actions to follow up from the 2023 visit

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

Subject Area	Discussion/Actions following 2022 Annual Review	Up-Date following 2023 Review	Up-date for 2024 review
Quality Improvement	<p>Current work focus on reducing BPD – good work so far on DS CPAP and implementing LISA in June to continue</p> <p>Ongoing support is needed for quality nursing roles to support QI Need to have support with data collection and verification.</p>	<p>QI – AP continue to focus working on implementation of FiCare and Matneo projects.</p> <ul style="list-style-type: none"> ACTION:- AP to contact ODN to support with JD for FiCare and BFI personnel. <p>AP do not currently have a funded Data person. Internal monthly optimisation audits are manually completed and shared.</p> <ul style="list-style-type: none"> ACTION: Review potential of specific data role in the team to focus on data quality and inputting and how data can be used for QI – JD/business case from other units could be requested. 	<p>BFI lead now in post 0.8wte. No current Ficare lead funding available however APH have specialist interest group. Lead consultant Sarah Thompson continues to dedicate time to maintaining the culture supported by core nurses. A recent review from the NWNODN team was positive and they felt assured this is embedded in our culture.</p> <p>JD has been completed and job matched at band 6.</p> <p>Workforce being reviewed.</p>
Service User Experience	<p>Continue to develop peer support offer Develop local parent survey to add depth to the parent feedback currently obtained</p>	<p>Peer Support – this is currently offered off site due to challenges with Trust perspectives on volunteer induction.</p> <ul style="list-style-type: none"> ACTION:- AM to identify people in trust to join a discussion with KH/SF and Koala NW to understand how APH can progress with this offer as APH are currently the only unit in CM not allowing Koala Volunteers on the unit. <p>Vcreate – AP currently invoiced for Neurological module.</p> <ul style="list-style-type: none"> ACTION:- SF to confirm with Vcreate that AP are not invoiced. AP to link with PR with regards to use of the module. <p>HM informed SF/PR of action request.</p>	<p>Following Koala North West funding withdrawal we no longer have PEER supporters visiting the unit, however, the volunteers remain keen and Sarah Thompson is liaising with the volunteer lead for the trust to look at ways of reducing the mandatory training as this has become the barrier. We continue to have Katie Thompson as a volunteer who offers peer support to families twice weekly</p> <p>Surveys include:FI care questionnaire, Friends and family test, MNVP seeking patient stories post discharge, QR code for network feedback</p> <p>MNVP has experienced barriers with referring families to patient experience team to share their stories and this is not being following up. Looking at ways to resolve this with the patient experience team</p>

Actions to follow up from the 2023 visit

Subject Area	Discussion/Actions following 2022 Annual Review	Up-Date following 2023 Review	Up-date for 2024 review
Staff Experience	<p>Implement the supernumerary shift co-ordinator role</p> <p>Continue to support quality roles and team development</p>	<p>AP update- there has been a re-structure of senior team which has positively impacted staff morale and reduced sickness and absence rates.</p> <p>The Band 7 tier have attendance at an internal leading services and management course.</p> <ul style="list-style-type: none"> ACTION:- Newly appointed ward manager and matron to attend NWNODN unit managers course scheduled for February 2024. Two places were allocated. 	<p>Leading teams course completed by all band 7's (5.92wte) as of Sept 24.</p> <p>NWNODN managers course has been completed by Ward Manager and Matron.</p> <p>Plans for further development team include internal leading services course. Band 7 study days continue annually.</p>
Education	<p>Surgical exposure to allow for repatriation to APH of appropriate surgical infants</p> <p>Team to review the NWNODN Education Strategy and how this could be used to support team development as part of the appraisal process.</p>	<p>AP update:- Surgical exposure for staff has been a priority through linking with surgical SIG and other methods of education, internal study days, webinars, pathways.</p> <p>There is a two-person strategy for attendance on QiS. One funded place has been offered from the ODN for 2024.</p> <p>NLS figures are on track</p>	<p>Further funding was awarded from the ODN for 6 QIS places, there are currently 3 staff currently on this programme. There is an ongoing development plan to send two staff on each course. On completion of the course in April this will take us over 70% compliance.</p> <p>We have a band 6 nurse attending the surgical module in AHCH, they will link in with our educator and support further training of our nursing team. We have also added this nurse to the SIG group.</p>



Actions to follow up from the 2023 visit

Subject Area	Discussion/Actions following 2022 Annual Review	Up-Date following 2023 Review	Up-date for 2024 review
Workforce	<p>Continue to work alongside the NWNODN workforce and education lead to ensure monitoring of the NCCR nurse staffing monies are completed as required</p> <p>Medical workforce requires review and full description of challenges and risks. The NWNODN Workforce Strategy may be able to support this.</p> <p>Promotion and development of current staff should be reviewed alongside the NWNODN workforce and education strategies with a clear plan for quality roles such as a FiCare lead.</p> <p>To track the challenge of support for the paediatric ward when this impacts on the neonatal unit achieving BAPM including super numerary shift co-ordinator role. The network will support this as part of tracking the NCCR money</p> <p>AHP workforce requires review. Ad hoc provision without dedicated neonatal funded time does not allow for the full benefit of all AHPs to be realised. To link with network AHPs to understand what is required and gain support for local business case for Physio, Dietetics, SLT and OT .</p>	<p>Medical Workforce – AP remain non- compliant for Tier 3 – case submitted and progressing for funding support to be compliant with CNST action 4.</p> <p>Recruitment of a 7th neonatal consultant.</p> <p>ANNP – issues with managing retention. Discussion raised regarding formal agreement of strategy for leaving cap following ANNP training. Some planning needed regarding the development of current ANNPs to support retention.</p> <ul style="list-style-type: none"> ACTION: Ensure APH ANNPs link into the NWNODN ANNP Forum. <p>Nursing Workforce – Fully compliant with recruitment.</p> <p>PNA role – LW to identify more staff to complete the course.</p> <p>Paediatric cover – NNU staff covering Paeds is not heavily relied on and cover is reciprocated from Paeds to NNU.</p> <p>AP have developed a package to support new starters to work across disciplines.</p> <p>Whole area Induction booklet to be implemented to introduce staff prior to covering to paediatrics.</p> <ul style="list-style-type: none"> ACTION- LW to share document with other C+M managers. <p>AHP Workforce:-</p> <p>OT - re-advertised due to lack of interest.</p> <p>Psychology – appointed and due to commence.</p> <p>Pharmacy – statement for business case accepted at panel for children and neonatal pharmacy.</p> <p>Focus over the coming 12months needs to be on capturing the value of new AHP roles and developing business cases for national standards for all AHP groups. NWNODN AHP/Psych and Pharmacist keen to support on this.</p>	<p>8th Consultant recruited and to start in January.</p> <p>2X staff members on the unit are PNA qualified and we are exploring options to send a third member of staff. Ideally this would be an IR nurse, but due to QIS commitments, maternity leave and health issues this may not be possible therefore are considering opening to all staff.</p> <p>2 ANNP's trained and a further 2 in training.</p> <p>Paeds and NNU have both supported each other in times of high acuity. NNU always retain their supernumerary coordinator and educator when supporting paediatrics and this is not a regular occurrence</p> <p>OT and psychologist now in post. We also have a volunteer OT to support. The psychologist is heavily utilised by both staff and parents.</p> <p>A new pharmacist has been recruited for both NNU and paediatric ward 0.6wte across both services 0.25 dedicated to NNU. This adds to our current 0.4wte to give overall 0.65wte for the unit.</p>

Engagement with the network

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

Staff have attended both FIN and IR FIN.

QIS rolling programme continues.

We have had 100% attendance at NSG and CEG.

Engagement in managers what's app group.

Manager and Educator away day 24.

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

Improved attendance

Ward manager attending Repatriation group with unit psychologist.

Exception forms returned in a timely manner.

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

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

AHP linking in with AHP network team.

Pharmacist lead with Paddington study and network pharmacist.

Managers course completed by Ward Manager and Matron.

Representation sent to Managers and CSL away day.

Nursing workforce

WTE needed (against 22/23 activity)	Direct Nursing Budget (WTE)	Direct nurses in post (WTE)
57.57	60.41	56.90
Funding provided for quality roles .	additional quality roles now in post (WTE)	
£30,044.50	0.5 Risk Post	
No. of qualified PNAs	No. of PNAs in training	
2	1 to be identified.	

- Notes around nursing workforce to be added post meeting

Medical Staffing

Tier	Compliance
Tier 1	Yes
Tier 2	Yes
Tier 3	No

T3 presence on the unit **NON-Compliant**

Notes around medical staffing to be added post meeting

AHPs & Psychological support

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

Pharmacy 8b 0.4 budget 0.4 in Post
Ideal – 1.5

- Notes around AHPs to be added post meeting



Identifying unit strengths, weaknesses, opportunities and threats

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

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

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

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



**EXCELLENCE IN
HEALTHCARE**

Example SWOT format – Please use any format you prefer



SWOT	
Strengths <ul style="list-style-type: none"> • BFI works 30 hrs per week. Supportive in planning for the development of BFI accreditation. Exploring options for band 3 support of this role • Remain green for Ficare. • Responsive to PSIRF implementation with quick completion learning from RECs • Practice educator full time until March following funding received, will return to 30 hours in March 2024. • AHP team: Psychologist, OT, volunteer OT. NNU Pharmacist. • Strong senior leadership team and supportive Quadrumvirate. • Low attrition rates 	Opportunities <ul style="list-style-type: none"> • Surgical course share learning with all staff to develop surgical skills of the team. • NN digital nurse – exploring options to support this rol from the established workforce. • BFI Accreditation. • PNA 1 additional nurse to enroll. • Potential ITU expansion. • Band specific study days held by practice educator. • Growth of the NNAP roles in the unit
Weaknesses <ul style="list-style-type: none"> • Breast milk within 6 hours, requires improvement. • Temperature optimisation outliers, thermal bundle introduced. • Lack of space, impacts on infection rates. This is being explored at executive level. Architect currently scoping feasibility of extending ITU. • Not BFI accredited. • AHP support not enough as per recommendation from Ockendon. 	Threats <ul style="list-style-type: none"> • Senior nurses have moved into quality roles or trainee ANNP leaving a skilled QIS gap and a more junior workforce. • Space on the Neonatal Unit. High acuity linked with increased infection rate. • No dedicated NNU Physiotherapist on the unit however can access paediatric physio ad hoc. • Not enough dedicated hours for digital nurse to ensure accuracy of badger data.

PMRT - Perinatal Mortality Reviews Summary Report

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

Wirral University Teaching Hospital NHSFT

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

1/10/2024 to 31/12/2024

Summary of perinatal deaths*

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

Summary of reviews**

Stillbirths and late fetal losses				
Number of stillbirths and late fetal losses reported	Not supported for Review	Reviews in progress	Reviews completed and published ***	Grading of care: number of stillbirths and late fetal losses with issues with care likely to have made a difference to the outcome for the baby
4	1	2	1	0

Neonatal and post-neonatal deaths				
Number of neonatal and post-neonatal deaths reported	Not supported for Review	Reviews in progress	Reviews completed and published ***	Grading of care: number of neonatal and post-neonatal deaths with issues with care likely to have made a difference to the outcome for the baby
5	1	4	0	0

*Late fetal losses, stillbirths and neonatal deaths (does not include post-neonatal deaths which are not eligible for MBRRACE-UK surveillance) – these are the total deaths reported and may not be all deaths which occurred in the reporting period if notification to MBRRACE-UK is delayed. Termination of pregnancy are excluded. All other perinatal deaths reported to MBRRACE-UK are included here regardless of whether a review has been started or is published.

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

*** If a review has been started, but has not been completed and published then the information from that review does not appear in the rest of this summary report

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

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

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

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

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

*Includes coronial/procurator fiscal post-mortems

Table 3: Number of participants involved in the reviews of late fetal losses and stillbirths without resuscitation (N = 1)

Role	Total Review sessions	Reviews with at least one
Chair	0	0%
Vice Chair	0	0%
Admin/Clerical	0	0%
Ambulance Team	0	0%
Bereavement Team	2	100% (1)
Community Midwife	0	0%
External	2	100% (1)
Management Team	0	0%
Midwife	7	100% (1)
MNVP Lead	0	0%
Neonatal Nurse	0	0%
Neonatologist	0	0%
Obstetrician	4	100% (1)
Other	0	0%
Risk Manager or Governance Team	3	100% (1)
Safety Champion	0	0%
Sonographer or Radiographer	0	0%

Table 4: Number of participants involved in the reviews of stillbirths with resuscitation and neonatal deaths (N = 0)

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

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

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

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

Timing of death	Cause of death
Late fetal losses	0 causes of death out of 0 reviews
Stillbirths	1 causes of death out of 1 reviews
	Placental abruption a) unwell baby compromised by SVT & ascites
Neonatal deaths	0 causes of death out of 0 reviews
Post-neonatal deaths	0 causes of death out of 0 reviews

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

Issues raised which were identified as relevant to the deaths	Number of deaths	Actions planned
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*Note - depending upon the circumstances in individual cases the same issue can be raised as relevant to the deaths reviewed and also not relevant to the deaths reviewed.

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

Issues raised which were identified as not relevant to the deaths	Number of deaths	Actions planned
This mother booked late. Are there any organisations to consider in relation to her booking late?	1	No action entered
This mother booked late. Did this affect her care?	1	Nil action required - late transfer
This mother was assessed as high risk and in need of aspirin but aspirin was not prescribed	1	Learning to be shared and aspirin protocols for review

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

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

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