Appendix 1 Perinatal Clinical Surveillance Quality Assurance Report				
Theme	**Detail of metrics used for WUTH Perinatal Quality and Safety Model (PQSM)**	**Number**	**RAG**	**Narrative / Actions taken**
Clinical Care	Number of stillbirths	0		No still births
	Number of neonatal deaths (before 28days) at WUTH	0		No NNU deaths
	Number of maternal deaths (up to 28 days following delivery)	0		No maternal deaths
	Post partum haemorrhage >1500mls	6		All reviewed via CIF process; no issues in care identified; 3% of women
	Rates of HIE where improvements in care may have made a difference to the outcome	0		No HIE
	Number of occasions where the Delivery Suite Coordinator is not supernumerary at start of shift	0		100% compliant
	Number of times when the Delivery Suite Coordinator is not supernumerary for a period of one hour or more during a shift	0		Maintain shift leader to be supernumery at start of shift and throughout as best practice
	% Compliance of 1:1 care in labour	100%		Data captured via 4 hourly BR Plus activity/acuity, achieved 100% of time, escalation processes followed to revert to supernumerary status within 1 hour
	%Consultant presence at delivery when indicated (as per RCOG Guidance)	100%		Monthly audit as per RCOG guidance and guidance updated to reflect RCOG; submitted as part of MIS Year 6
	Midwifery staffing is below BR+ Acuity	Yes		P/N Ward acuity consistently in the Red RAG rating for acuity/activity; BR Plus report awaited
	Midwifery staff absence rate in month (sickness)	7.00%		Trust processes implemented and additional support offered by HR for hot spot areas; above Trust recommended target
	Midwifery vacancy rate	<3%		Low vacancy rate consistently reported; 3.96 wte vacancy permanent
	Midwife : Birth ratio	01:26		Within parameters
	Number of times transfer in to the Neonatal unit for Level 3 care has been declined to internal transfer	1		Nil
	Number of times transfer in to the Neonatal unit for Level 3 care has been declined to external transfer	2		Declined due to acuity and staffing level x 1; inappropriate criteria x 1 (TWINs contracting)
	BAPM compliance - Neonatal medical staff	Partial		Consultant recruited; org change underway for 24/7 cover at weekends to achieve BAPM compliance
	BAPM compliance - Neonatal nursing staff	Yes		Workforce report to BoD annually demonstrates compliance
	Number of times Maternity unit has been on divert/closed to admissions	0		Nil
	Total number of Red Flags reported	17		Theme: delay in providing pain relief
Service user e	Staff survey	37%		Divisional compliance for 2024 staff survey 37%, midwifery staff groups below national average, requires improvement
	CQC National survey	Yes		Published and action plan in place; repeat due Feb 2025; report to BoD at next quarterly report
	SCORE Survey	Yes		Participated in 2024; facilitated workshops and ongoing action plan
	Feedback via Deanery, GMC, NMC	No		Nil of note
	%Consultant presence at delivery when indicated (as per RCOG Guidance)	100%		Monthly audit as per RCOG guidance and guidance updated to reflect RCOG; submitted as part of MIS Year 6
Leadership and relationships	New leadership within or across maternity and/or neonatal services	Yes		Delivery Suite Manager - started 17/3/25
	Concerns around the culture / relationships between the Triumvirate and across perinatal services	Nil		Good working relationships between teams / directorates
	False declaration of CNST MIS	No		MIS Year 6 to be submitted by 3/3/25; manual validation being requested for Safety Action 1; MIS Year 7 due to be launched April 2025
	Concerns raised about other services in the Trust impacting on maternity /neonatal services e.g. A&E	No		Nil of note
	Concerns raised about a specific unit e.g. Highfield Birthing Unit	Yes		Maternity ward concerns re: staff attitude, poor food options and inadequate pain relief; action plan and close weekly monitoring; co-production with MNVP
Safety and learning culture	Lack of engagement in MNSI or ENS investigation	No		Positive feedback quarterly review meetings and transparency through number of rejected cases
	Lack of transparency	No		Robust governance processes
	Learning from PSII's, local investigations and reviews not implemented or audited for efficacy and impact	No		Learning shared internally and via MNSG (NW region)
	Learning from Trust level MBRRACE reports not actioned	No		Nil of note
	Maternity/Neonatal Safety Champion concern; negative feedback; escalation	Nil		Regular safety champion meetings and walkabouts; all feedback actioned and feedback given
	Recommendations from national reports not implemented	Yes		CQC inspection publication action plan in progress to address quality improvements in line with recommendations; report to BoD quarterly progress
Incident reporting	Number of PSIRF reported incidents graded moderate or above	1		Reporting for Feb 2025
	Number of Maternity or Neonatal PSII's	0		Robust PSIRF framework followed
	Number of cases referred to MNSI	1		x2 active, x2 in draft and x2 final reports received
	Delays in reporting a PSSI where criteria have been met	0		N/A
	Never Events which are not reported	0		N/A
	MNSI/NHSR/CQC with a concern raised or a request for information	0		N/A
	Recurring Never Events indicating that learning is not taking place	0		N/A
	All safety action 1 report to MBBRACE within timeframe to include FQ's	Yes		Since data entry error all cases and FQ's reported as MIS timescales
	Poor notification, reporting and follow up to MBRRACE-UK, NHSR ENS and HSIB	0		N/A
Governanc e processes	Unclear governance processes / Business continuity plans not in place	Nil		Clear governance processes in place following PSIRF; awaiting revised publication for maternity services expected 2025; LMNS feedback required assurance of governance referrals to external organisations are made by maternity MDT team and not central governance
	Ability to respond to unforeseen events e.g. pandemic, local emergency	Yes		Maternity and Neonatal services responded to a major incident with
	Number of maternity/neonatal risks on the risk register overdue	0		
	Number of maternity/neonatal risks on the risk register with a score >12	11		NNU estates and IPC - plans to address; all reviewed up-to-date with mitigation and actions
CQC inspection and DHSC or NHSE/I request for support	DHSC or NHS England Improvement request for a Review of Services or Inquiry	No		Nil to report this month
	Coroner Regulation 28 made direct to Trust	No		CQC reports published in April 2023 'GOOD' for maternity services
	An overall CQC rating of Requires Improvement with an Inadequate rating for either Safe and Well-Led or a third domain	No		N/A
	CQC Rating overall	GOOD		N/A
	Been issued with a CQC warning notice	No		N/A
	CQC rating dropped from a previously Outstanding or Good rating to Requires improvement in the safety or Well-Led domains	No		N/A
	Been identified to the CQC by HSIB with concerns	No		N/A

Maternity (Perinatal) Incentive Scheme (MIS) Year 7

What to expect – An overview of changes

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

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

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

MIS Year 7 audit/compliance tool

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

Overview of progress on MIS year 7 safety action requirements

*Mandated Safety Action Requirements:

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

Key:

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

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

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

MIS FutureNHS workspace

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

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

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

MIS Year 7 online launch event

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

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

Year 7 - The ten safety actions

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

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

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

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

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

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

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

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

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

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

Obstetric Workforce

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

Neonatal Workforce

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

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

- No change.

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

- No change.

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

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

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

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

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

Safety action 9: Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?

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

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

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

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

Implementation Report

Trust	**Wirral University Teaching Hospital NHS Foundation Trust**
Date of Report	
ICB Accountable Officer	
Trust Accountable Officer	
LMNS Peer Assessor Names	

Background

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

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

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

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

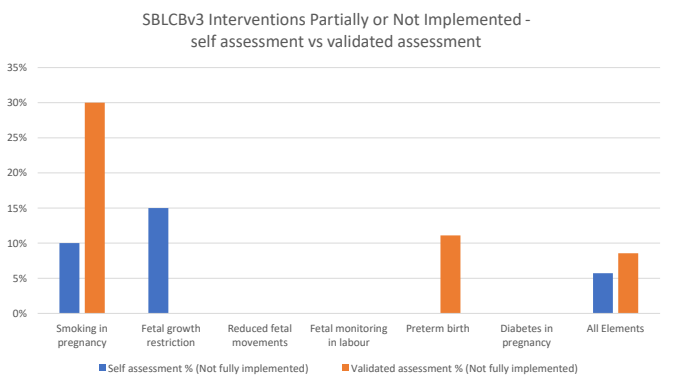
As part of the Three Year Delivery Plan for Maternity and Neonatal Services, all NHS maternity providers are responsible for fully implementing SBLCBv3 by March 2024.

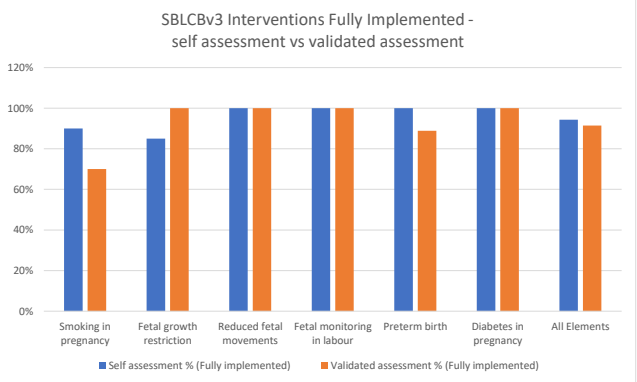
Implementation Grading

Significant Assurance - Except for specific weaknesses identified the activities and controls are suitably designed and operating with sufficient effectiveness to provide reasonable assurance that the control environment is effectively managed.

Implementation Progress

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)	NHS Resolution Maternity Incentive Scheme
Element 1	Smoking in pregnancy	Partially implemented	90%	Partially implemented	70%	CNST Met
Element 2	Fetal growth restriction	Partially implemented	85%	Fully implemented	100%	CNST Met
Element 3	Reduced fetal movements	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 4	Fetal monitoring in labour	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 5	Preterm birth	Fully implemented	100%	Partially implemented	89%	CNST Met
Element 6	Diabetes	Fully implemented	100%	Fully implemented	100%	CNST Met
All Elements	TOTAL	Partially implemented	94%	Partially implemented	91%	CNST Met





Action Plan

Element 1

Intervention Ref	Self-Assessment Status	LMNS Validated Assessment Status	LMNS Recommendation of Actions Required	LMNS Suggested Improvement Activity
INTERVENTIONS				
1.1	Fully implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Trust SOP meets requirements (due for review in Sept 26). MSDS DQ check passed in Nov 24.
1.2	Fully implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	50% compliant in local audit for Dec 24 which falls below compliance threshold.
1.3	Fully implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Smoking status at Booking: Oct 24- 100%, Nov 24-100%, Dec 24 (mixed sample & only smokers)- 100%
1.4	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	WUTH dashboard states Sep 24-95% and Dec 24-100%. Audit in REF1.3 states 100% in Dec 24.
1.5	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Direct supply NRT provided by in-reach service
1.6	Fully implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	Setting a quit date: WUTH dashboard states Oct 24-43.7%, Nov 24-40%, Dec 24-24.2% (ABL data suggests Dec 24- 19.3%)
1.7	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	WUTH dashboard states Oct 24-80%, Nov 24-100%, Dec 24-100%.
1.8	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Midwifery Study Day presentation noted (VBA & CO monitoring). Session also delivered to MDT on PROMPT. Training compliance posters state 91% compliance on Midwifery
1.9	Partially implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Midwifery Study Day presentation noted (VBA & CO monitoring). Session also delivered to MDT on PROMPT. Training compliance posters state 91% compliance on Midwifery
1.10	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Certificates noted in previous submissions. Please note, Practitioners should complete NCSCT e-learning and assessments annually (Jen and Claire due to re-complete in Nov 25).

Element 2

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

Element 3

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

Element 4

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

Element 5

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

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

Element 6

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

Appendix 4 - Maternity Programme On-line Portal (MPOP)

Objective	Deliverables	Minimum evidence requirements for LMNS to gain assurance	LMNS Q2 Feedback	Q3 Update	Q3 Provider BRAG Rating	Q3 LMNS is assured ?	LMNS Q3 Feedback	Q4 Update	LMNS Q4 Feedback
Objective 1: Care that is personalised	Is PCSP training included in the TNA?	1) LMNS to review each TNA and confirm the inclusion of PSCP training for each provider. 2) If the provider declares non compliance, LMNS to agree a completion date with the provider. If the provider is not compliant by the agreed date a recovery plan will need to be agreed between the LMNS and the provider	Update required for Q3 Partial Assurancein Q1 - Need further detail re ccf	Further evidence/detail included as evidence to include TNA 2025		Y	TNA received - Trust to add date on TNA cover sheet for Q4		
	Are Personalised care audits being undertaken regularly?	1) Provider to submit a copy of the audit schedule to the LMNS for review. 2) LMNS to provide reassurance at MPOP that the audit schedule has been submitted and includes PCSP audits.	Update required for Q3 - Trust to upload additonal evidence (e.g. forward audit schedule and recent audit data)			Y	Evidence sent to LMNS PCSP Workstream Lead (Lara Jones).		
	Is the trust in a position to roll out MCoC?	1) Where the provider states they are in a position to roll out MCoC in line with the principles of safe staffing https://www.england.nhs.uk/wp-content/uploads/2022/09/B2011-Midwifery-Continuity-of-Carer-letter-210922.pdf The minimum evidence requirement is an up to date MCoC Plan confirming the 13 building blocks are in place. 2) Provider to share Plan with the LMNS and reassurance provided to the regional team at the MPOP meeting, that it has been reviewed.	Update required for Q3			Y	LMNS Assured		
	Number of EMCoC teams operating in line with national guidance?	1) Provider to confirm number of EMCoC teams in place operating in line with national guidance. 2) LMNS to review evidence of EMCoC meetings where EMCoC teams are discussed or alternatively submit tracker which demonstrates EMCoC teams are in place. 3) Provider EMCoC progress report to be provided by LMNS at MPOP.	Update required for Q3	5 MCoC teams embedded in the areas of vulnerability / social deprivation		Y	LMNS Assured		
	Number of EMCoC teams planned to be rolled out in line with national guidance?	1) LMNS to confirm assurance arrangements in place for future number of teams to be rolled out in line with national guidance. 2) LMNS to review evidence of MCoC meetings where EMCoC teams are discussed or alternatively submit tracker which demonstrates EMCoC teams are in place. 3) As above LMNS to provide progress update for each provider at MPOP.	Update required for Q3	5 MCoC teams embedded in the areas of vulnerability / social deprivation		Y	Assured due to evidence presented by Trust monthly to ECOC lead		
	Has the trust achieved UNICEF BFI accreditation?	1) Each provider to provide a copy of the BFI accreditation status for Maternity and Neonates to the LMNS. 2) If provider does not have full accreditation, the LMNS should review and monitor evidence of the provider's schedule and plan for full achievement by 2027 3) If a provider has a certificate of accreditation action and dates for stage 1 this should be shared with the LMNS. 4) If provider is at stage 1, evidence and dates are required for planned stage 2 accreditation and so on until the provider can demonstrate full accreditation. 5) Once a provider has achieved full accreditation, evidence of their sustainability plans with annual audit schedule is required and should be submitted to the LMNS. 6) LMNS to provide progress update for each provider at MPOP.	Update required for Q3 Partial Assurance in Q1 Maternity is stage 3 Neonatal not accredited - raised PO	Maternity is stage 3 and application has been submitted for NNU - 2 year plan with training commenced and 1wte in post to lead; on tack to deliver in timeframe		Y	For Q4 Provider is to confirm assessment dates from UNICEF - and to upload copy of the UNICEF requested action plan (was to be submitted to UNICEF) by 10th Jan		

Objective 2: Improve equity for mothers and babies	Does the trust provide access to interpreter services, which adheres to the Accessible Information Standard?	1) A copy of the provider guideline/algorithm/SOP/operational plan for the use of interpreters that is clearly mapped against the Accessible Information Standard, should be shared with the LMNS. 2) LMNS to provide reassurance to the MPOP that they are assured each provider is compliant with the Accessible Information Standard. 3) Where a provider is identified as non-compliant the LMNS will set target dates for compliance with the provider and monitor accordingly. 4) LMNS to provide progress updates to MPOP.	Update required for Q3 No assurance in Q1: no interpreter policy received.	Interpretation policy uploaded as evidence		Y	Draft Tust wide policy uploaded as eveidence. Provider to check if it meets accesible information standards for Q4. In the meantime provider will contact neighbouring Trust to review their Interpreter policy.		
	Is data collected and disaggregated based on population groups?	1) LMNS to confirm the provider's EPR system has the capability to collect and disaggregate data based on population groups. (both ethnicity & deprivation) 2) Where a provider demonstrates non-compliance, LMNS to agree a recovery plan for compliance and monitor accordingly. 3) LMNS to provide progress updates to MPOP.	Update required for Q3 Partial Assurance in Q1 - more evidence required.	Data collected includes age, ethnic minority, marital status, postcode, language/s spoken and other data as per MSDS requirements. Analysis examples uploaded as evidence		Y	LMNS Assured		
Objective 3: Work with service users to improve care	Are service users involved in quality, governance, and co-production when planning the design and delivery of maternity and neonatal services?	1) LMNS to review the provider's MNVP annual workplan and gain assurance that the NMVP are involved in quality, governance, and co-production when planning the design and delivery of maternity and neonatal service. 2) Where a provider demonstrates non compliance, LMNS to agree target dates for compliance and monitor accordingly. 3) LMNS to provide reassurance to MPOP that this measure is embedded in the organisation.	Q1 - LMNS in receipt of MNVP Workplan; MNVP lead in post for 16 hours per week	Evidence submitted as Safety Action 7 and compliance signed off for MIS Year 6		Y	LMNS Assured		
	Date of last BR+	1) Provider to submit copy of the latest BR+ report to LMNS. 2) BR+ compliance to be discussed with MPOP	LMNS Assured in Q1	Assured: June 2021 New BR+ scheduled for January 2025. BR plus commenced in June 2023; final report expected Feb 2025		Y	Assured will require submission of BR plus recent report in QTR 4		
	Funded to BR+ establishment	Where a provider is not compliant with establishment recommendations in BR+ : 1) Gap analysis of variance between current budgeted establishment vs BR+ recommendations to be reviewed by the LMNS. 2) Business case to meet BR+ establishment to be reviewed by the LMNS. 3) Copy of the risk assessment where an executive board does not support the findings of the BR+ report to be reviewed by the LMNS.	LMNS Assured in Q1 - Funded to establishment	Remain funded to current BR plus workforce and all funded posts (non-recurrent) Trust has agreed to recruit to all posts permanently increasing current establishment. Minutes of meeting can be uploaded at Q4		Y	LMNS Assured in Q1 - Funded to establishment		
	Planned date of next BR+	1) Planned date of next BR+ report to be agreed with the LMNS. 2) BR+ compliance to be discussed with MPOP	Update required for Q3	Underway - awaiting report; data collection for accuracy has taken longer than expected and due by end Feb 2025		Y	Assured will require submission of BR plus recent report in QTR 4		
	Bi-Annual workforce plan for maternity and neonates including obstetrics in place?	1) LMNS to confirm that the Bi-annual workforce plan includes maternity, neonates and obstetrics has been submitted to board. 2. LMNS to confirm date for next bi-annual plan submission to board.	LMNS Assured in Q1 - Workforce plan provided	Workforce plan submitted; no further action		Y	LMNS Assured in Q1 - Workforce plan provided		

Objective 4: Grow our workforce	Does the annual workforce plan include support for newly qualified staff and midwives who wish to return to practice?	1) LMNS to review the annual workforce plan and confirm if it includes support for newly qualified staff and midwives who wish to return to practice. 2) LMNS to provide updates to MPOP where compliance not achieved.	Update required for Q3	Evidence uploaded to support RTP; in 2025 annual workforce plan will include support for newly qualified staff and RTP midwives		Y	Provider to upload an updated Maternity Workplan in Q4 which will include additional information from BR+ Report.		
	MW Vacancy Rate (please provide additional narrative to support data)	1) LMNS to undertake quarterly review of Maternity Workforce PWR data. 2) LMNS to discuss plan to improve vacancy rates with provider 3) LMNS to provide reassurance to MPOP that plan is in place to reduce vacancy rate.	Trust to input PWR date from Q3 and beyond	PWR data uploaded as received; LMNS will discuss distribution with NWMO		Y	Provider to upload Business Case which supports PWR narrative.		
	MW Leaver Rate (please provide additional narrative to support data)	1) LMNS to undertake quarterly review of Maternity Workforce PWR data. 2) LMNS to discuss plan to improve leaver rates with provider. 3) LMNS to provide reassurance to MPOP that plan is in place to reduce leaver rate.	Trust to input PWR date from Q3 and beyond	PWR data uploaded as received; LMNS will discuss distribution with NWMO		Y	Provider to upload Business Case which supports PWR narrative.		
	MW Turnover Rate (please provide additional narrative to support data)	1) LMNS to undertake quarterly review of Maternity Workforce PWR data. 2) LMNS to discuss plan to improve turnover rate with provider. 3) LMNS to provide reassurance to MPOP that plan is in place to reduce turnover.	Trust to input PWR date from Q3 and beyond	PWR data uploaded as received; LMNS will discuss distribution with NWMO		Y	Provider to upload Business Case which supports PWR narrative.		
	MW Sickness Rate (please provide additional narrative to support data)	1) LMNS to undertake quarterly review of Maternity Workforce PWR data. 2) LMNS to discuss plan to improve turnover rate with provider. 3) LMNS to provide reassurance to MPOP that plan is in place to reduce turnover.	Trust to input PWR date from Q3 and beyond	PWR data uploaded as received; LMNS will discuss distribution with NWMO		Y	Provider to upload Business Case which supports PWR narrative.		
	Obstetric Consultant Vacancy Rate (please provide additional narrative to support data)	1) LMNS to undertake quarterly review of Maternity Workforce PWR data. 2) LMNS to discuss each plan to improve obstetric consultant vacancy rate with provider. 3) LMNS to provide reassurance to MPOP that plans are in place to reduce obstetric consultant vacancy rate.	Trust to input PWR date from Q3 and beyond	PWR data uploaded as received; LMNS will discuss distribution with NWMO		Y	DoM confirmed for the financial year 24/25 there is 1 WTE consultant gap from November 1st 2024 which is now recruited too and planned start date from 1st April 2025.		
	MSW Vacancy Rate (please provide additional narrative to support data)	1) LMNS to undertake quarterly review of Maternity Workforce PWR data. 2) LMNS to discuss plan to improve MSW vacancy rate with provider. 3) LMNS to provide reassurance to MPOP that plans are in place to reduce MSW vacancy rate.	Trust to input PWR date from Q3 and beyond	PWR data uploaded as received; LMNS will discuss distribution with NWMO		Y	Provider to upload Business Case which supports PWR narrative.		
	Is there a retention midwife in post? (please provide additional narrative to support data)	1) Provider to provide confirmation of Retention Midwife in post (name, job title and WTE) 2) LMNS to review Job description 3) If the provider is non compliant LMNS to confirm if the national NHSE Retention funding was received by provider? If YES LMNS should confirm what has the funding been utilised for and evidence of this being approved by the Trust Board to be provided to the LMNS. 4) LMNS to provide reassurance to MPOP	Update required for Q3 Partial Assurance in Q1 - JD needs strengthening to include retention	JD updated and uploaded as evidence		Y	LMNS assured a Retention Midwife is in post, while recognising operational issues due to Bereavement Leave the LMNS is satisfied with mitigation measures in place with support by PDM.		

Objective 5: Value and retain our workforce	Does the trust have a retention improvement action plan?	1) LMNS to review provider Retention Improvement Action Plan for assurance. 2) LMNS to agree monitoring to ensure the improvement plan remains on track. 3) LMNS to provide reassurance to MPOP	Update required for Q3 Partial Assurance in Q1 - No improvement plan attached but evidence in document that compliance achieved; vacancy rate <2% no further actions identified; rolling recruitment campaigns continue	Vacancy rate continues at <2%; rolling recruitment campaign and Trust agreed business case to increase establishment		Y	Provider to upload Business Case which supports narrative for this deliverable.		
	Is there a plan in place to reduce workforce inequalities?	1) If yes LMNS to review the workforce inequalities plan for assurance 2) If no LMNS/ICB to work with the provider and agree a time frame for the development of a workforce equalities plan 3) LMNS to provide reassurance to MPOP As a minimum each provider needs to provide evidence of a baseline of staff in post by ethnic group in order to monitor any positive improvements	Evidence received inequalities plan	Evidence uploaded		Y	Trust Wide Policy nothing specific for maternity. LMNS assured		
	Is the trust signed up to the North West Black, Asian, and Minority Ethnic Assembly Anti-racist Framework?	1) LMNS to review the provider's self assessment status against the framework for assurance. 2) LMNS to seek evidence of annual action plan to attain accreditation including evidence that it has been reported at board to ensure delivery and commitment. 3) LMNS to provide reassurance to MPOP https://www.england.nhs.uk/north-west/wp-content/uploads/sites/48/2023/07/The-North-West-BAME-Assembly-Anti-racist-Framework-FINAL.pdf	Evidenced received - LMNS assured but would like to see self-assessment	Self assessment uploaded as evidence		Y	LMNS assured evidence reviewed: certificate of recognition, EDI and standard report. Trust to upload self assessment in Q4		
	Do the trust have a mechanism to identify and address issues highlighted in student and trainee feedback surveys?	1) LMNS to confirm with provider what mechanisms are in place to identify and address issues highlighted in student and trainee feedback surveys? - (This could be NTS NETS or PARE placement feedback)? 2) LMNS to provide reassurance to MPOP	Update required for Q3 Partial Assurance in Q1 - WUTH need to explain what is being done with the feedback	Workforce plan submitted; no further action		Y	Evidence reviewed WUFT one of the top performers in NW. Provider to upload Board Report for Q4 demonstrating that survey results have been communicated to Board.		
	Does the trust offer a preceptorship programme to every newly registered midwife, with supernumerary time during orientation and protected development time?	1) LMNS to review provider's preceptorship programme and confirm it includes: a) length of preceptorship period b) length of supernumerary period c) the supernumerary period being applied to each clinical rotation during the preceptorship programme d) minimum expectation of all clinical areas during the preceptorship period 2) LMNS to confirm an target date for compliance is in place where all of the above are not included in the preceptorship policy 3) LMNS to provide reassurance to MPOP	Update required for Q3 Partial Assurance in Q1 - Require Preceptorship pack as evidence	Further evidence uploaded		Y	Preceptorship pack received.		
	Do the trust offer newly appointed Band 7 and 8 midwives support with a mentor?	If the provider reports Yes: 1) LMNS should seek evidence in the form of a SOP or alternative. If the provider reports No: 1) LMNS to discuss challenges and barriers to provision with provider and agree plan for delivery 2) LMNS to provide progress update to MPOP for non compliance	SOP received	No further action		Y	Evidence reviewed and assured		

	Does the trust have a leadership succession plan which reflects the ethnic background of the wider workforce? .	1) LMNS to review provider leadership succession plan, and gain assurance that it reflects the ethnic background of the wider workforce. 2) LMNS to discuss and agree completion date for plan with provider where this is not yet in place. 3) LMNS to provide progress update to MPOP	Update required for Q3 Partial Assurance in Q1 - elements relating to ethnicity require strengthening			Y	Minimal evidence received provider to upload Black, Asian, Minority Self assessment tool in Q4 which will support evidence of this deliverable.		
Objective 6: Invest in skills	Does the trust's TNA align with the core competency framework?	1) Provider to submit TNA including CCF alignment details - LMNS to review and confirm compliance - LMNS to agree target date for compliance and monitor where necessary 2) LMNS to provide re-assurance to MPOP. https://www.england.nhs.uk/long-read/core-competency-framework-v2-minimum-standards-and-stretch-targets/	Update required for Q3 Partial Assurance - Need further detail re ccf	TNA 2025 uploaded		Y	Require final ratified TNA to be submitted in QTR4		
	Do junior and SAS obstetricians and neonatal medical staff meet RCOG and BAPM guidance for clinical and support supervision?	1) Provider to provide evidence to LMNS that junior and SAS obstetricians and junior neonatal medical staff meet RCOG and BAPM guidance for clinical and support supervision 2) LMNS to provide assurance to MPOP	Update required for Q3 Partial Assurance in Q1 - Require more evidence.	Evidence uploaded		Y	Provider to submit Neonatal Workforce Paper which includes MIS SA5.		
	Do temporary medical staff covering middle grade rota possess an RCOG certificate of eligibility for short-term locums?	It is a statutory requirement that all middle grade temporary medical staff working within maternity services should provide an RCOG certificate of eligibility to the provider 1) LMNS to seek assurance from provider that the CD holds RCOG certificates for all short term locum doctors 2) LMNS to reassurance to MPOP	Update required for Q3	Locums not utilised at WUTH		Y	Confirmation received from Trust no Locums utilised. LMNS assured.		
Objective 7: Develop a positive safety culture	Do maternity and neonatal leads have time within their job plan to access training and development, Including time to engage stakeholders, and MNVP leads?	1) If provider reports YES - LMNS to gain assurance by reviewing evidence how much time allocated in job plan and of achievement and confirm reassurance. 2) if provider reports NO - LMNS to provide support to the provider to become compliant. 3) LMNS to provide quarterly updates at MPOP re non-compliance.	LMNS Assured in Q1	No further action at Q3		Y	LMNS assured in Q1		
	Have senior leaders attended national leadership programmes this year, including board maternity and neonatal safety champions?	provider to share with LMNS names, job titles and dates of training attended, to include non exec board level safety champion & board level safety champion, e.g. chief nurse	Update required for Q3 LMNS Assured but Trust required to confirm dates	Commenced programme April 2023 into 2024; all members completed full programme; continues support from Amanda Andrews in 2025		Y	LMNS Assured in Q3		
	Does the trust board support the implementation of a focused plan to improve and sustain maternity and neonatal culture and regularly review progress?	1) Provider to submit evidence of board agendas/minutes where QIP is discussed to LMNS for review. 2) LMNS to provide reassurance at MPOP meetings.	LMNS Assured in Q1	No further action at Q3		Y	LMNS assured in Q1		
	Is there a clear and structured route for the escalation of clinical concerns? (i.e. Each Baby Counts: Learn and Support escalation toolkit).	1) If escalation policy is in place - LMNS to review for assurance . 2) LMNS to ensure escalation policy includes EBC learning and support escalation toolkit 3) If no escalation policy/it does not meet compliance standard - LMNS to support provider to develop policy which the LMNS will maintain oversight. 4) LMNS to provide reassurance to MPOP	LMNS Assured Q1	No further action at Q3		Y	LMNS assured in Q1		

	Is there a Freedom to Speak Up Guardian?	1) If YES - FTSU JD to be reviewed by the LMNS. 2) If NO - action plan detailing when the FTSU guardian will be in place required. 3) Action plan to be monitored by the LMNS with regional oversight at MPOP	LMNS Assured	No further action at Q3		Y	LMNS assured in Q1		
	Is there a FTSU training module for staff?	Minimum evidence requirement - Induction training manual or equivalent 1) If YES - provider to provide evidence of FTSU training module or equivalent (no further monitoring) 2) If NO - provider to develop action plan with date for when the FTSU will be included in the induction training manual or equivalent. 3) Action plan to be monitored by the LMNS with regional oversight at MPOP	Update required for Q3 Partial Assurance in Q1 - Need to see evidence of the content of the training	Evidence uploaded		Y	Ongoing review of evidence required. Provider to upload evidence link for Q4.		
Objective 8: Learn and improve	Has the trust implemented PSIRF?	1) If provider reports PSIRF implemented, LMNS to review the PSIRF plan. LMNS to confirm if the PSIRF plan includes a chapter for maternity. 2) If provider reports PSIRF not in place - LMNS to monitor and offer support to attain full implementation 3) Action plan to be monitored by the LMNS with regional oversight at MPOP	PSIRF implemented but no maternity chapter. Maternity chapter anticipated Q3 24/25, until this is released LMNS will deem this assured.	No further action; all evidence uploaded as current PSIRF		Y	LMNS assured PSIF Policy in place - Maternity Chapter currently paused by NHS Regional Team.		
	Is there a formal structure to review and share learning? (with agreed timescales)	This should be included in the PSIRF plan: Minimum evidence requirement - LMNS to review provider PSIRF plan for assurance 1) If PSIRF plan include a formal structure to review and share learning which includes timeframes - no further monitoring required 2) If plan does not include structure to review LMNS to support providers to achieve 3YD plan measure 3) LMNS to provide quarterly update at MPOP where provider not compliant.	LMNS Assured in Q1 - Included in Incident policy - Trust and Maternity Risk Management Strategy.	No further action at Q3		Y	LMNS Assured in Q1 - Included in Incident policy - Trust and Maternity Risk Management Strategy.		
	Has the organisation established effective, kind, and compassionate processes to respond to families who experience harm or raise concerns about their care?	Minimum evidence requirement: - LMNS to review if the provider has an established effective, kind, and compassionate processes to respond to families who experience harm or raise concerns about their care. 1) PSIRF plan should include a FLO - YES/NO 2) LMNS to provide assurance update at MPOP on processes in place	LMNS Assured in Q1	No further action at Q3		Y	LMNS Assured - There is no specific FLO role but the role is built into specialised JDs		
	Has the organisation adopted a single point of contact process for families where ongoing dialogue is required with the trust?	Minimum evidence requirement - This measure should be included in the PSIRF plan. LMNS to review PSIRF plan to confirm that a single point of contact process for families has been embedded. 1) If YES - No further updates required at MPOP unless process changes. 2) If No - Date to be provided when process will be in place. LMNS to monitor progress. 3) LMNS to provide assurance updates at MPOP	LMNS Assured in Q1 - Dedicated Lead	No further action at Q3		Y	LMNS Assured in Q1 - Dedicated Lead		

	Is the organisation sensitive to culture, ethnicity, and language when responding to incidents?	Minimum evidence requirement - this measure should be included in the PSIRF plan. LMNS to review PSIRF plan to confirm the plan includes a chapter on how to support a family whose first language is not English, when they are involved in a serious event. 1) The PSIRF plan should include a chapter around language barriers a) If YES - LMNS to provide reassurance at MPOP b) IF NO - LMNS to agree a date with provider when this will be achieved, provide ongoing monitoring 2) LMNS to provide quarterly progress updates at MPOP.	Update required for Q3	All Trust policies/evidence uploaded as evidence		Y	Confirmation received from DoM regarding Cerna Data requests.		
	Is there a process of triangulation of outcomes data, staff, and MNVP feedback, audits, incident investigations, and complaints, as well as learning from where things have gone well?	Minimum evidence requirement, If the trust has stated YES, the LMNS needs to understand what the process is discuss at MPOP. 1)NO - The LMNS to support the trust with the development of a process to triangulate outcome data, staff and MNVP feedback, audits, incident investigations and complaints as well as learning from when things have gone well. Target dates for completion need to be agreed with the provider. 2) YES - If the LMNS are assured that the process is embedded 3) LMNS to provide re-assurance at MPOP that they are satisfied that this measure has been implemented and is being sustained.	LMNS Assured in Q1 - Multiple minutes from assurance minutes reviewed	No further action at Q3		Y	LMNS Assured in Q1 - Multiple minutes from assurance minutes reviewed		
Objective 9: Support and oversight	Does the organisation share open and honest information on the safety, quality, and experience of their services?	1) Where provider self assesses YES - LMNS need to understand what this looks like and gain assurance that the process is embedded 2)Where provider self assesses NO - LMNS to monitor progress, set target dates to meet this requirement 3) LMNS to provide quarterly updates to MPOP.	LMNS Assured in Q1	No further action at Q3		Y	LMNS Assured in Q1		
	Does the organisation regularly review the quality of maternity and neonatal services?	Minimum evidence requirement - Maternity Dashboard - Other quality monitoring processes. If YES 1) LMNS to explore how this is achieved. Evidence of the use of Maternity Safety Dashboard 2) LMNS to confirm assurance at MPOP that provider is regularly reviewing the quality of their maternity and neonatal services. If NO 1) LMNS to support the organisation to establish and regularly review quality and safety of services 2) LMNS to provide quarterly updates to MPOP on progress	LMNS Assured in Q1 - Monthly Quality Surveillance tool goes to Board monthly as per Safety Action 9 - MIS Year 5.	Evidence continues to be uploaded as evidence		Y	LMNS Assured in Q1 - Monthly Quality Surveillance tool goes to Board monthly as per Safety Action 9 - MIS Year 5.		
	Have maternity safety champions been appointed, including NED?	1) If YES - Provider to submit Names and titles of safety champions and JDs to LMNS for review 2) If NO - Provider to confirm dates when they will be in post, reason not in post. 3) LMNS to monitor progress and provide update at MPOP	Update required for Q3 Partial Assurance in Q1 - Safety Champions names received but LMNS require JD	JD's uploaded		P	Trust to upload Chief Nurse JD for Q4		
	Has the quadrumvirate been appointed?	1) If YES - Provider to submit Names and titles of quadrumvirate for assurance 2) If NO - Provider to confirm dates when they will be in post, reason not in post. 3) LMNS to monitor progress and provide update at MPOP	LMNS Assured in Q1	No further action at Q3; no changes to quad		Y	LMNS Assured in Q1		

	Are MNVPs involved in the development of the organisations complaints process?	Minimum evidence requirement - minutes of provider meetings confirming involvement 1) If YES - LMNS to review notes from meetings where MNVP was present during this discussion. 2)If NO - LMNS to discuss when will this be achieved with provider. Dates to be added to action plan. 3) LMNS to monitor progress and provide update at MPOP	Update required for Q3 Partial Assurance in Q1	Evidence uploaded		Y	LMNS assured - DoM confirmed MNVPs understand complaint themes.		
	Are MNVPs involved in the quality, safety and surveillance group that monitors and acts on trends.	Minimum evidence requirement - Terms of Reference and minutes for provider meetings 1) If YES - LMNS to review minuted attendance for the MNVP 2) If NO - LMNS to discuss when this will be achieved with provider with dates added to action plan 3) LMNS to provide reassurance at MPOP	Update required for Q3 Partial Assurance - Require meeting minutes	Evidence uploaded		Y	LMNS assured and are satisfied the MNVP, DoM, HoM, CN, NED and Neonatologist are included in safety walkabout. Minutes uploaded as evidence.		
	Is FTSU data reported to board and acted upon?	Minimum evidence requirement - minutes of Board meetings with evidence of how data is acted upon. If YES 1) Minutes from board meeting 2) Evidence of how data is acted upon? If NO 1) LMNS to agree with provider when will this be achieved and dates to be added to action plan LMNS to monitor progress 2) Provide quarterly update at MPOP	LMNS Assured in Q1- Trust Policy supports process	No further action at Q3;		Y	LMNS Assured in Q1- Trust Policy supports process		
Objective 10: Standards to ensure best practice	Has the organisation implemented version 3 of the Saving Babies' Lives Care Bundle?	Minimum evidence requirement - Provider's latest submission to the SBL implementation HUB Q4 23/24 If YES - LMNS to review latest submission If NO - 1) LMNS to agree with provider when this will be achieved and dates to be added to action plan 2) LMNS to monitor progress 3) Provide quarterly update at MPOP	LMNS Assured June 2024 96%	Achieved 87-97%; quarterly submission and reviews as evidence		Y	LMNS Assured June 2024 96%		
	Is the organisation on track to adopt the national MEWS and NEWTT-2 tools by March 2025?	Minimum evidence requirement - self assessment Where provider reports YES - LMNS to continue support and report to MPOP on exception basis. Where a provider reports NO - 1) LMNS to consider barriers to implementation of the national roll out of MEWS and NEWTT- 2) Provide progress updates quarterly at MPOP	Update required for Q3 Partial Assurance in Q1 - More evidence required.	Awaiting confirmation from Cerner Millenium how to build into IT system as electronic record; Risk on register to support position		P	Will require more evidence once confirmation from provider external digital provider in QTR 4		
	Does the organisation regularly review and act on local outcomes including stillbirth, neonatal mortality and brain injury, and maternal morbidity and mortality to improve services?	Minimum evidence requirement: Narrative on what this looks like and SOP. Where provider reports YES - LMNS to review SOP and examples of reviews for assurance. Where provider reports NO - LMNS to provide assurance that they are supporting the provider to achieve this measure. LMNS to provide progress updates at MPOP	LMNS Assured in Q1	No further action		Y	assured as of QTR1		

	Has the organisation completed the national maternity self-assessment tool? .	Minimum evidence requirement - LMNS to review provider's maternity self-assessment tool YES 1) submission of the maternity self-assessment tool 2) LMNS to review the quality and effectiveness of the self-assessment tool i.e. is it being utilised as an iterative process and updated regularly, who has oversight and what meeting is it discussed at NO 1) LMNS needs to agree target date for provider to complete the self-assessment tool and submit for review 2) LMNS to monitor progress against completion and provide update at MPOP	Update required for Q3	Evidence uploaded to include BOD papers who have oversight		Y	LMNS Assured in Q3		
Objective 11: Data to inform learning	Does the organisation have a process for reviewing available data which draws out themes and trends and identifies and addresses areas of concern including consideration of the impact of inequalities?	Minimum evidence requirement : Provider use of dashboard If YES 1) LMNS to review dashboard including where data is reviewed, frequency of review meetings and by whom 2) LMNS to confirm it includes measures for inequalities? If NO - LMNS to monitor progress against completion and agree improvement plan with provider and provide update at MPOP	Update required for Q3	Evidence to support current position uploaded		Y	LMNS assured - DoM confirmed Cerner can run reports on women with social deprivation backgrounds.		
	Does the organisation have a system that ensures high-quality submissions to the Maternity Services Data Set?	Minimum evidence requirement - Provider to submit MSDS data via the Strategic Data Collection Service in the Cloud (SDCS Cloud) using a registered account. If YES 1) LMNS to confirm evidence of SDCS account 2) Provider to submit monthly scorecard as evidence	Update required for Q3	MSDS scorecard reflects system is operational; all 11 criteria met		Y	LMNS Assured		
	Does the organisation have robust processes in place to ensure referrals to NHSR, MNSI, and the National Perinatal Epidemiology Unit?	Minimum evidence requirement : Guideline which demonstrates process for reporting If YES - provider to submit guideline If NO- provider to agree when guideline will be in place and target dates to be added to action plan LMNS to monitor progress and provide updates at MPOP	Update required for Q3	Evidence uploaded		Y			
Objective 12: Make better use of digital technology in maternity and neonatal services	Does the organisation have a digital maternity strategy and digital roadmap?	Minimum evidence requirement : Digital Maternity Strategy If YES - provider to submit copy of strategy to LMNS If NO - provider to agree when strategy will be in place with target dates to be added to action plan LMNS to monitor progress and provide updates at MPOP	LMNS Assured in Q1	No further action at Q3		Y	LMNS Assured in Q1		
	Is the digital strategy and roadmap being implemented?	Minimum evidence requirement : Progress reports on digital roadmap delivery against strategy If YES - provider to submit updates of progress to LMNS for review If NO - provider to agree with LMNS when progress will be made with target dates added to action plan LMNS to monitor progress and provide updates at MPOP	LMNS Assured in Q1	No further action at Q3		Y	LMNS Assured in Q1		
	Does the organisation have an EPR system that complies with national specifications and standards, including the Digital Maternity Record Standard and the Maternity Services Data Set?	1)Provider to confirm with LMNS details of EPR system is in place. 2)LMNS to confirm whether EPR system complies with digital maternity record standard. LMNS to provide progress updates to MPOP where non compliance for provider.	LMNS Assured in Q1	No further action at Q3		Y	LMNS Assured in Q1		

Wirral University Teaching Hospital NHS Foundation Trust

Meeting Name: Board of Directors

Date of Meeting: 2nd April 2025

Title	National Education and Training Survey 2024 Midwifery Student results
Area Lead	Jo Lavery, Director of Nursing and Midwifery for Women's and Children's
Author	Sarah Weston, Practice Development Midwife
Report for	Information

Executive Summary and Report Recommendations

The National Education Training Survey (NETS) is an annual national survey open to all undergraduate and postgraduate students and trainees undertaking a practice placement or training post in healthcare, as part of their education and training programme. This provides a unique multi-professional insight, into the experience of the current and future healthcare workforce learning and working in services across the country.

In 2024,16 WUTH Pre registration Midwifery learners/trainees participated in the survey out of a possible 21. (First year students were not eligible to participate as they had not yet been out to placement)

The results highlight areas for celebration, as well as suggestions for further improvement included as recommendations.

Celebrations:

The survey questions relate to the NHS England education quality domains and the scores are benchmarked against both the national average and service average.

- WUTH Pre-registration Midwifery had the highest results in comparison with neighbouring trusts Countess of Chester, Warrington and Halton Teaching Hospitals NHS Foundation, Liverpool Women's NHS & Mid Cheshire Hospitals NHS in the following areas:
  Bullying & harassment
  Facilities
  Induction
  Overall experience
  Quality of care
  Raising concerns
  Teamwork
  Workload

- 88% of Pre-registration Midwifery students would recommend WUTH for their training placement
- 94% of Pre-registration Midwifery students would recommend WUTH for care of family & friends

Recommendations:

- Continue to promote Health & wellbeing opportunities
- Continue to promote raising concerns / discrimination
- Facilitate learning opportunities to enable students to feel clinically confident.

- Prepare for NETS 2025 with the aim to increase uptake.

Key Risks
This report relates to these key risks: • Recruitment and retention of learners/trainees.

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

Governance journey			
Date	**Forum**	**Report Title**	**Purpose/Decision**
March 2025	Divisional Quality Board	NETS Education Governance Report	Information

1	Narrative
1.1	**Background:** The NETS has been running annually since 2019 and remains the only national survey which captures the experiences of all healthcare trainee's and student's, specifically in relation to the education and training environment. Following feedback each year, improvements have been made to the questions and structure of the survey. In 2023, questions relating to sexual safety were introduced to measure the impact of the recently launched Sexual Safety Charter. In addition to this, there were also updated options for protected characteristics, which help to explore and improve quality through the lens of equality, diversity, and inclusion (EDI) contributing to our annual Deans' EDI Report. The NETS aims to provide a valuable insight into the quality of education and training and measures whether the standards set out in our Education Quality Framework are met. In doing so, it helps to meet the statutory responsibility for the continuous improvement of healthcare education and training, which is essential for creating a highly skilled and motivated workforce, improving retention and recruitment, as well as supporting the delivery of the Long-Term Workforce Plan.

1.2 2024 Survey Data:

Neighboring trusts:

2024 | National Education and Training Survey | Education Quality Reporting Data Tool

Introduction | Region | Organisation | Professional Group | **Subject / Specialism** | Questions

Respondents 154

> Subject / Specialism by Organisation > Current Year

Open Filter Panel

Organisation	Subject and Specialism	Bullying & Undermining	Discrimination	Facilities	Induction	Overall Experience	Quality of Care	Raising Concerns	Sexual Safety	Supervision	Teaching & Learning	Teamwork	Wellbeing	Workloa
Countess of Chester Hospital NHS Foundation Trust, CH2 1UL	Midwifery	79.63%	90.74%	63.46%	80.09%	68.46%	66.54%	81.48%	97.59%	63.94%	66.9%	70.83%	78.85%	62.96%
Liverpool Women's NHS Foundation Trust, L8 7SS	Midwifery	64.81%	88.19%	74.31%	83.33%	77.64%	68.47%	72.22%	96.57%	73.44%	75%	74.65%	72.86%	55.56%
Mid Cheshire Hospitals NHS Foundation Trust, CW1 4QJ	Midwifery	82.44%	96.43%	65.18%	83.48%	83.21%	74.2%	85.71%	98.51%	73.61%	76.71%	82.14%	75%	62.5%
Warrington and Halton Teaching Hospitals NHS Foundation Trust, WA5 1QG	Midwifery	79.08%	95.47%	65.12%	79.26%	69.47%	68.59%	78.01%	99.47%	66.03%	59.97%	77.13%	70.93%	59.57%
Wirral University Teaching Hospital NHS Foundation Trust, CH49 5PE	Midwifery	86.46%	93.75%	75%	85.94%	84.06%	76.25%	79.17%	100%	74.22%	71.09%	83.59%	68.75%	68.75%

National picture:

	bullying & undermining	discrimination	facilities	induction
Lowest result from all hospitals	33%	50%	36%	39%
Wirral University teaching hospital	86.40%	93.75%	75%	85.94%
National figure	73%	89.70%	61%	75%

Reasons learners wish to carry on training at WUTH:

2024 | National Education and Training Survey | Education Quality Reporting Data Tool

Introduction | Region | Organisation | Professional Group | Subject / Specialism | **Questions**

Respondents 16

> Questions > Current Year > Proportion Considering Leaving | Reasons given by Learners

Open Filter Panel

Reasons given to NOT continue training	Learners Choosing this Reason	% Learners Choosing this Reason

Reasons Given to carry on training	Learners Choosing this Reason	% Learners Choosing this Reason
Supportive learning environment	12	85.71%
Adequate education / teaching / coaching	11	78.57%
Adequate supervision by educator	11	78.57%
Learning opportunities available	11	78.57%
Adequate supervision of clinical duties	10	71.43%
Quality of patient care	10	71.43%
Supportive colleagues	10	71.43%
This placement felt inclusive	9	64.29%
High quality induction	7	50.00%
High quality handovers	6	42.86%
Work was at the right level	6	42.86%
Flexible or agile working approach	5	35.71%
Geographical location	4	28.57%
This placement positively impacted my health and wellbeing	3	21.43%

1.3 Recommendations:

Recommendation	How
Engage with Trust colleagues working on staff wellbeing and staff survey results to share any mutual learning	-Liaise with Trust senior leaders responsible for the staff survey to understand any common themes.

	Continue to promote Health & wellbeing opportunities	-Dedicated section in induction booklet -Well being drop ins for students
	Continue to promote raising concerns / discrimination	-Dedicated section in induction booklet -Well being drop ins for students
	Facilitate learning opportunities to enable students to feel clinically confident.	-Look at MDT working with other professionals
	Prepare for NETS 2025 with the aim to increase the uptake	Preparation for 2025 is underway to ensure maximum learner engagement.
1.4	**Resources:** Microsoft Power BI Midwifery NETs Results 2024.pptx	

2	**Implications**
2.1	**Patients** • Students who are able to raise concerns safely (when required), are likely to feel more empowered to provide excellent care.
2.2	**People** • High quality learning environments that are welcoming, will help people to feel valued and will support recruitment and retention within the Organisation, as well as having a positive impact upon staff and student wellbeing.
2.3	**Finance** • High quality learning environments will support increasing placement capacity, which generates finance from the education contract and student data collection tool (NHS England)
2.4	**Compliance** • Support the delivery of the NHS England Quality Framework for Healthcare Placements ensuring that placements are offered as per the education contract. • Supports the NHS Long Term Plan and People Plan.

Wirral University Teaching Hospital NHS Foundation Trust

MBRRACE-UK perinatal mortality report: 2023 births

This report concerns stillbirths and neonatal deaths among the 2,933 babies born within your Trust in 2023. It includes details of the stillbirths and neonatal deaths for births that occurred in your Trust in 2023, as well as background information on all births.

- Birth numbers are obtained from routine data sources and may not match locally recorded numbers.
- Births before 24 completed weeks gestational age and all terminations of pregnancy are EXCLUDED.
- Neonatal deaths are reported by place of birth, irrespective of where the death occurred, as denominator data on the place of care is not available for all births.

Key messages

All deaths

1. Your stabilised & adjusted stillbirth rate is **3.62 per 1,000 total births**. This is around the average for similar Trusts & Health Boards.
2. Your stabilised & adjusted neonatal mortality rate is **1.69 per 1,000 live births**. This is lower than the average for similar Trusts & Health Boards.
3. Your stabilised & adjusted extended perinatal mortality rate is **5.27 per 1,000 total births**. This is around the average for similar Trusts & Health Boards.

Excluding deaths due to congenital anomalies

1. Your stabilised & adjusted stillbirth rate excluding deaths due to congenital anomalies is **3.29 per 1,000 total births**. This is around the average for similar Trusts & Health Boards.
2. Your stabilised & adjusted neonatal mortality rate excluding deaths due to congenital anomalies is **1.31 per 1,000 live births**. This is around the average for similar Trusts & Health Boards.
3. Your stabilised & adjusted extended perinatal mortality rate excluding deaths due to congenital anomalies is **4.59 per 1,000 total births**. This is around the average for similar Trusts & Health Boards.

Full details of your perinatal mortality rates can be found on page 2.

Recommended actions

The stabilised & adjusted mortality rates for your Trust were similar to, or lower than, those seen across similar Trusts and Health Boards. However, if the aspiration of your Trust is to seek rates comparable with the best performing countries, for example those in Scandinavia, ensure that a review using the Perinatal Mortality Review Tool (PMRT) has been carried out for all the deaths in this report to assess care, identify and implement service improvements to prevent future similar deaths.

Definitions

Late fetal loss:	A baby born between 22 and 23 completed weeks gestational age showing no signs of life, irrespective of when the death occurred.
Stillbirth:	A baby born at or after 24 completed weeks gestational age showing no signs of life, irrespective of when the death occurred.
Neonatal death:	A live born baby who died up to 28 completed days after birth.
Extended perinatal death:	A stillbirth or neonatal death.

1. Your perinatal mortality rates

The mortality rates are reported for babies born within your Trust at 24 completed weeks gestational age or later, excluding terminations of pregnancy. The **crude mortality rate** is the number of deaths for every 1,000 births (or 1,000 live births for neonatal mortality) and is a snapshot of mortality for your organisation for births in 2023. However, this can be misleading as a measure of the underlying (or long-term) mortality rate due to chance variation and differences between Trusts and Health Boards in the proportion of high risk pregnancies. The **stabilised & adjusted mortality rate** provides a more reliable estimate of the underlying mortality rate, accounting for mother's age, socio-economic deprivation, baby's sex and ethnicity, multiplicity, and (for neonatal deaths only) gestational age at birth. While it is not possible to adjust for all potential risk factors, these measures do provide an important insight into the perinatal mortality for births within your Trust in 2023.

To account for the wide variation in case-mix, all Trusts and Health Boards have been classified hierarchically into five comparator groups: (i) Level 3 Neonatal Intensive Care Unit (NICU) and surgical provision; (ii) Level 3 NICU; (iii) 4,000 or more births per annum at 22 weeks or later; (iv) 2,000-3,999 births per annum at 22 weeks or later; (v) under 2,000 births per annum at 22 weeks or later**.**

Your Trust has been included in the comparator group with a Level 3 NICU.

Perinatal mortality (all deaths)

Type of death	Number	Crude rate	Stabilised & adjusted rate (95% C.I.)		Comparison to the average for similar Trusts & Health Boards
Stillbirth	**10**	**3.41**	**3.62**	**(3.03 to 4.40)**	**Up to 5% higher or up to 5% lower**
Neonatal	**4**	**1.37**	**1.69**	**(1.11 to 2.62)**	**More than 5% and up to 15% lower**
Extended perinatal	**14**	**4.77**	**5.27**	**(4.49 to 6.67)**	**Up to 5% higher or up to 5% lower**

Perinatal mortality (excluding deaths due to congenital anomalies)

Type of death	Number	Crude rate	Stabilised & adjusted rate (95% C.I.)		Comparison to the average for similar Trusts & Health Boards
Stillbirth	**8**	**2.73**	**3.29**	**(2.46 to 4.39)**	**Up to 5% higher or up to 5% lower**
Neonatal	**4**	**1.37**	**1.31**	**(0.90 to 1.94)**	**Up to 5% higher or up to 5% lower**
Extended perinatal	**12**	**4.09**	**4.59**	**(3.62 to 6.03)**	**Up to 5% higher or up to 5% lower**

Comparisons with similar Trusts and Health Boards

Your estimated stabilised & adjusted mortality rate for each type of death has been compared with the average mortality rate for Trusts and Health Boards in the same comparator group and is shown below as a coloured circle:

- more than 15% lower than the average for the group
- more than 5% and up to 15% lower than the average for the group
- up to 5% higher or up to 5% lower than the average for the group
- more than 5% higher than the average for the group

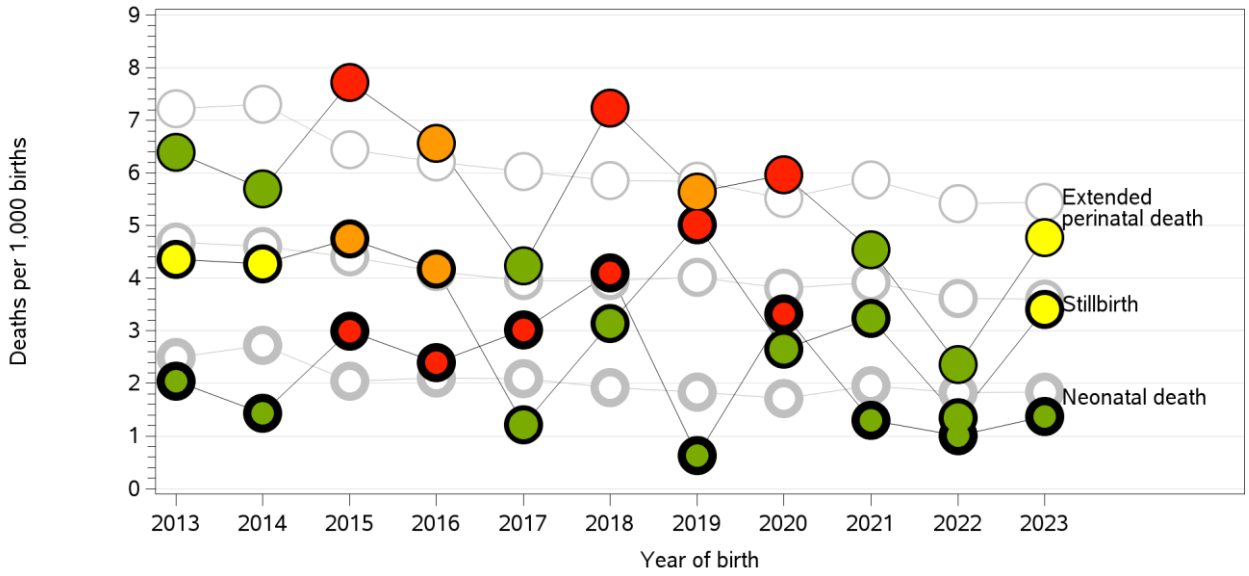
Trusts and Health Boards whose mortality rates are marked ● or ● should carry out an initial investigation of their data quality and possible contributing local factors that might explain the high rate. Irrespective of where they fall in the spectrum of national performance all Trusts and Health Boards should use the national PMRT to review all their stillbirths and neonatal deaths.

2. Mortality rates over time

Crude mortality by year of birth (all deaths)

Crude mortality rates for each type of death compared to the average mortality rate for Trusts and Health Boards in the same comparator group (shown in grey) by year of birth.

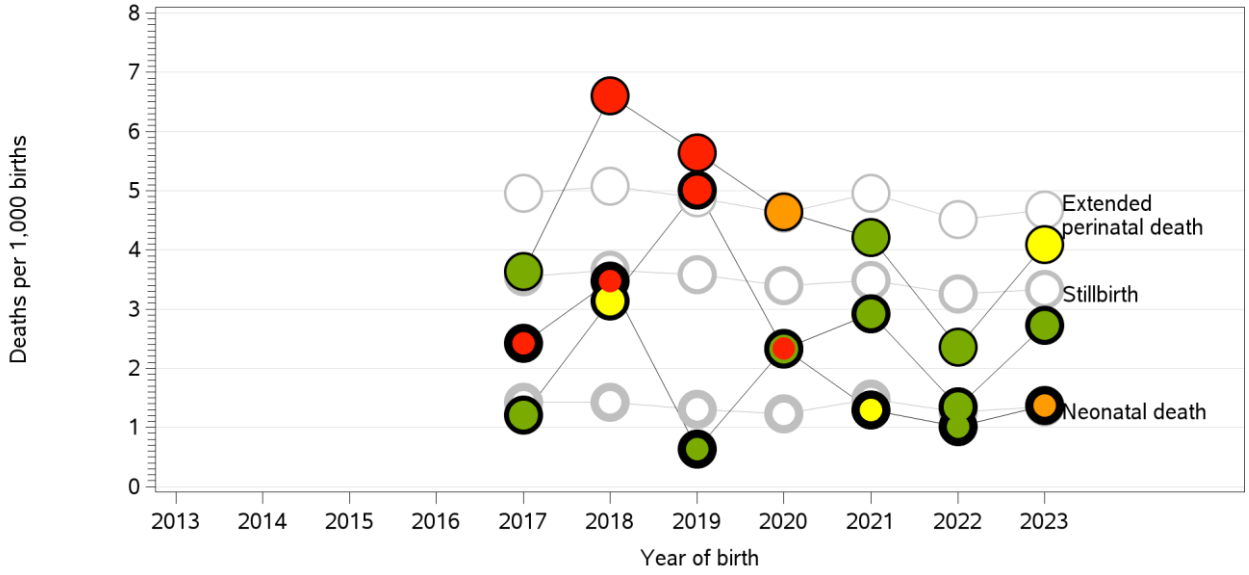
Due to updates to the data, these results might differ slightly from those in previous reports.



Crude mortality by year of birth (excluding deaths due to congenital anomalies)

Crude mortality rates for each type of death, excluding deaths due to congenital anomalies, compared to the average mortality rate for Trusts and Health Boards in the same comparator group (shown in grey) by year of birth. Rates are reported from 2017 onwards.

Due to updates to the data, these results might differ slightly from those in previous reports.

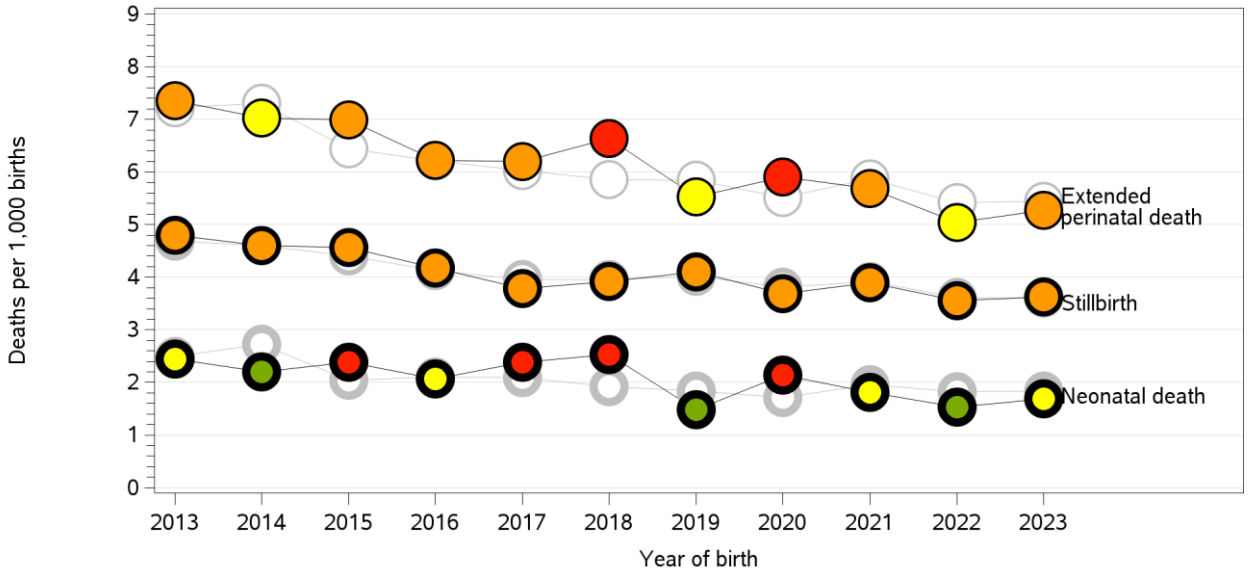


Mortality rates over time *continued*

Stabilised & adjusted mortality by year of birth (all deaths)

Stabilised & adjusted mortality rates for each type of death compared to the average mortality rate for Trusts and Health Boards in the same comparator group (shown in grey) by year of birth.

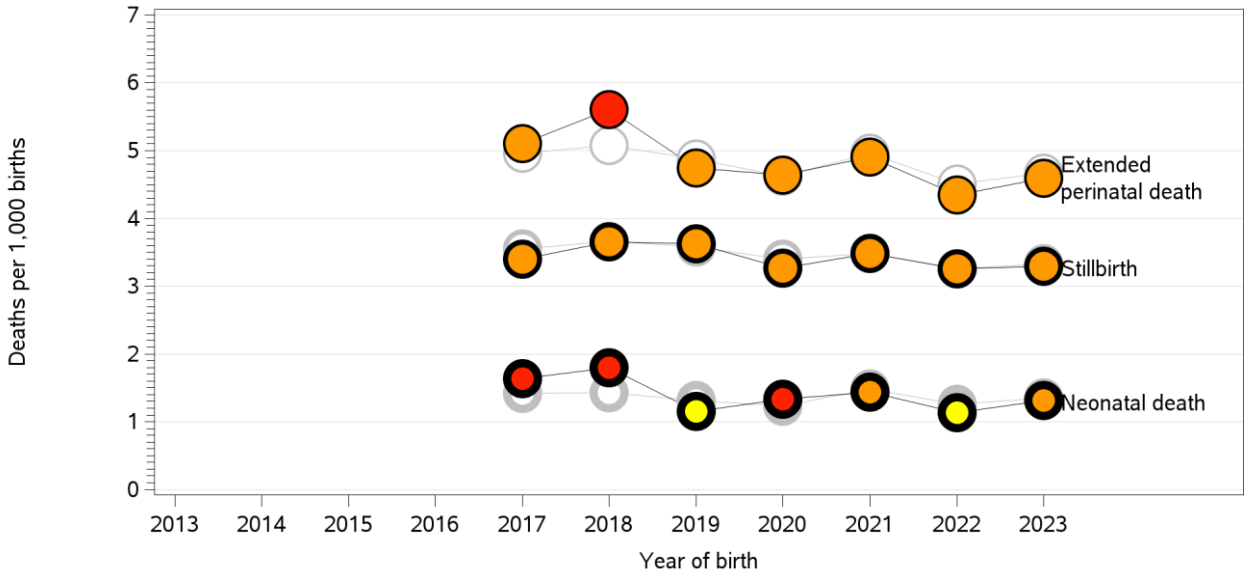
Due to updates to the data and improvements to the statistical methodology used, these results might differ slightly from those in previous reports.



Stabilised & adjusted mortality by year of birth (excluding deaths due to congenital anomalies)

Stabilised & adjusted mortality rates for each type of death, excluding deaths due to congenital anomalies, compared to the average mortality rate for Trusts and Health Boards in the same comparator group (shown in grey) by year of birth. Rates are reported from 2017 onwards.

Due to updates to the data and improvements to the statistical methodology used, these results might differ slightly from those in previous reports.



3. Your perinatal deaths

Deaths of babies born within your Trust

The crude mortality rates reported here are for babies born within your Trust, excluding births before 24 weeks gestational age and all terminations of pregnancy, together with the equivalent UK-wide rates.

These rates are subject to random variation, especially when the number of deaths is small. Stabilised & adjusted mortality rates are presented on page 2 which provide more reliable estimates of the underlying (long-term) mortality rates for your Trust.

Rates per 1,000 births		Stillbirths						Neonatal Deaths				Extended perinatal deaths	
		Antepartum		Intrapartum		Unknown		Early		Late			
Your Trust	*Rate (N)*	2.0	(6)	0.7	(2)	0.7	(2)	0.7	(2)	0.7	(2)	4.8	(14)
UK-wide	*Rate*	2.8		0.3		0.1		1.0		0.6		4.8	

The rates of extended perinatal death for your Trust, by gestational age at delivery, are shown below. Equivalent UK-wide rates are also shown for comparison.

Rates per 1,000 births		Extended perinatal deaths by gestational age									
		$24^{+0} – 27^{+6}$		$28^{+0} – 31^{+6}$		$32^{+0} – 36^{+6}$		$37^{+0} – 41^{+6}$		≥ 42^{+0}	
Your Trust	*Rate (N)*	111.1	(3)	55.6	(2)	5.3	(1)	3.0	(8)	0.0	(0)
UK-wide	*Rate*	323.3		98.4		17.4		1.6		2.1	

Place of neonatal death by gestational age

In the table below, information is shown that differentiates between the neonatal deaths of live born babies who were born and subsequently died within your Trust and those who were born within your Trust but died elsewhere. The percentage and number of babies in each group is shown by gestational age at birth.

Place of Death		Gestational group									
		$24^{+0} – 27^{+6}$		$28^{+0} – 31^{+6}$		$32^{+0} – 36^{+6}$		$37^{+0} – 41^{+6}$		≥ 42^{+0}	
Within your Trust	*% (N)*	100%	(1)		(0)	0%	(0)	100%	(2)		(0)
Outside your Trust	*% (N)*	0%	(0)		(0)	100%	(1)	0%	(0)		(0)

Post-mortem

The percentage of stillbirths and neonatal deaths for which parents were offered a post-mortem examination is given below, differentiating between those who were born and subsequently died within your Trust and those who were born within your Trust but died elsewhere.

For births within your Trust, a post-mortem was offered for 100% of stillbirths and 100% of neonatal deaths, compared with 97% and 91% UK-wide.

Place of Death		Post-mortem offered (as % of deaths)			
		Stillbirths		Neonatal Deaths	
Within your Trust	*% (n/N)*	100%	(10/10)	100%	(3/3)
Outside your Trust	*% (n/N)*	Not applicable		100%	(1/1)
UK-wide	*%*	97%		91%	

The percentage of post-mortems offered or for which consent was obtained and where the cause of death was reported to MBRRACE-UK as Unknown is shown below. You should ensure that the cause of death on the MBRRACE-UK data reporting system is updated once the post-mortem results are known.

Cause of death		Post-mortem			
		Offered		Consent obtained	
Unknown	*% (N)*	100%	(7/7)	86%	(6/7)

Your perinatal deaths *continued*

Cause of death

The tables below describe the cause of death reported to MBRRACE-UK for stillbirths which occurred in your Trust and for neonatal deaths of babies who were born in your Trust. They are listed by the primary categories of the 'Cause Of Death & Associated Conditions' (CODAC) system of death classification.

Congenital anomaly is reported as the cause of death for all deaths where a congenital anomaly is coded as either the primary cause of death or an associated condition.

In order to ensure accurate, consistent reporting using the CODAC system of death classification, Trust and Health Board Perinatal Review groups should focus on the quality of cause of death coding.

			Infection		Neonatal		Intrapartum		Congenital anomaly		Fetal	
Stillbirths	Your Trust	*% (N)*	10.0%	(1)	0.0%	(0)	0.0%	(0)	20.0%	(2)	0.0%	(0)
	UK-wide	%	2.8%		1.2%		1.3%		8.4%		5.0%	
Neonatal Deaths	Your Trust	*% (N)*	0.0%	(0)	25.0%	(1)	0.0%	(0)	0.0%	(0)	0.0%	(0)
	UK-wide	%	8.2%		40.1%		1.2%		35.0%		3.5%	

			Cord		Placental		Maternal		Unknown		Missing	
Stillbirths	Your Trust	*% (N)*	0.0%	(0)	30.0%	(3)	0.0%	(0)	40.0%	(4)	0.0%	(0)
	UK-wide	%	5.6%		35.3%		3.4%		34.3%		2.9%	
Neonatal Deaths	Your Trust	*% (N)*	0.0%	(0)	0.0%	(0)	0.0%	(0)	75.0%	(3)	0.0%	(0)
	UK-wide	%	0.0%		2.1%		0.8%		7.3%		1.9%	

Babies born at 22 to 23 weeks gestational age

It is vital for MBRRACE-UK to be able to present perinatal mortality rates from 22 weeks gestational age onwards, as recommended by the World Health Organization, in order that UK rates can be compared internationally. As there is no statutory registration of late fetal losses at 22 and 23 weeks gestational age, it is essential that your Trust ensures that there is a rigorous system for reporting these deaths to MBRRACE-UK.

The number of late fetal losses at 22 and 23 weeks gestational age reported by your Trust for babies born in 2023 was 1. Please continue to review this information in order to ensure that all late fetal losses are reported to MBRRACE-UK.

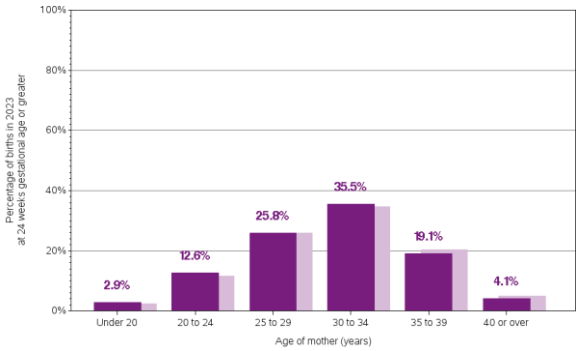
		Deaths of babies born at 22 to 23 weeks gestational age	
		Late fetal losses	Neonatal deaths
Your Trust	*N*	1	1

4. Your births

Age of mother

The proportion of mothers aged 35 years old or older was lower than that of the UK as a whole: 23.2% versus 25.4%.

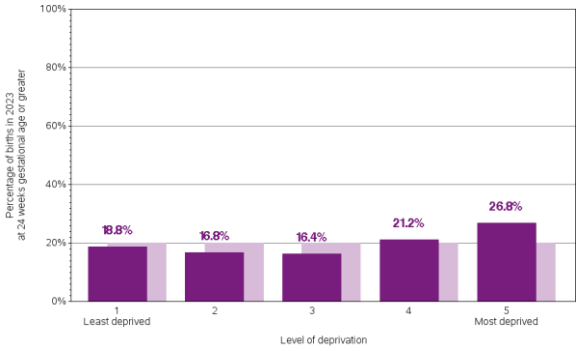
In the national MBRRACE-UK Perinatal Mortality Surveillance Report it was shown that mortality rates were higher for babies born to mothers under 25 and over 34 years of age compared to mothers aged from 25 to 34 years old.



Socio-economic deprivation

This graph shows the distribution of births by level of deprivation, based on the postcode of the mother's residence and using the Children in Low-Income Families Local Measure.

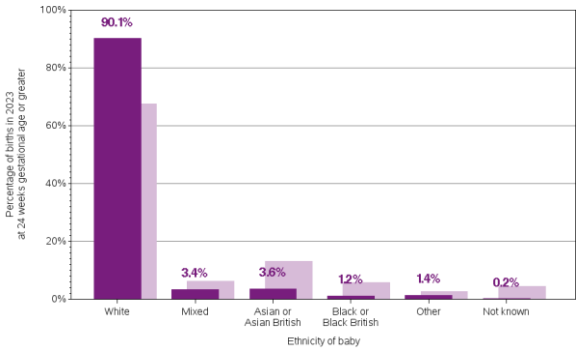
The mothers giving birth in your Trust lived in areas of similar deprivation to those giving birth across the UK as a whole.



Ethnicity of baby

The proportion of babies of non-White ethnicity was considerably lower than that of the UK as a whole: 9.6% versus 28.0%.

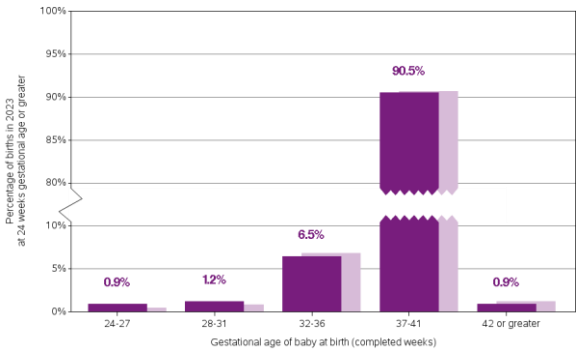
Across the UK the babies were of the following ethnicities: 67.5% White; 6.2% Mixed; 13.2% Asian or Asian British; 5.8% Black or Black British; 2.8% other; 4.4% not known.



Gestational age

In your Trust, 27 babies (0.9%) were born at 24 to 27 weeks gestational age, higher than the 0.4% seen in the UK as a whole. There was also a higher percentage of babies born at 28 to 31 weeks compared with the national average: 1.2% versus 0.8%.

In addition, 27 babies (0.9%) were born post-term (42 weeks or greater), a lower percentage than the UK average of 1.2%.

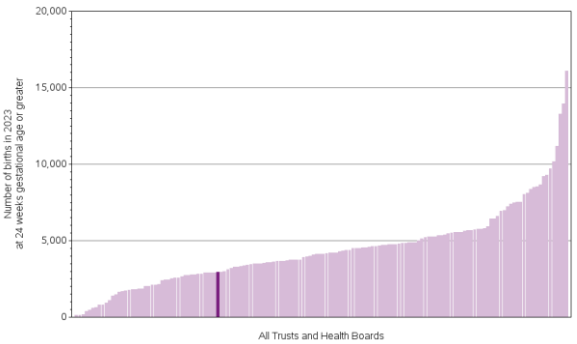


Your births *continued*

Number of births

There were 2,933 births in your Trust at 24 weeks gestational age or later, excluding terminations of pregnancy.

The purple line in the graph opposite shows that the number of births in your Trust puts you in the lowest third of all Trusts and Health Boards in the UK.



Percentage of births taking place in your Trust by commissioning organisation

The table below provides the percentage and number of births in your Trust at 24 weeks gestational age or later from each of the commissioning organisations for which over 1% of their births at 24 weeks gestational age or later occurred within your Trust. These organisations are Sub-Integrated Care Boards (Sub-ICBs) in England, Health Boards in Scotland and Wales and Local Commissioning Groups (LCGs) in Northern Ireland.

In total, the births from these organisations accounted for 97.9% of your births at 24 weeks gestational age or later in 2023.

Commissioning organisation	% Births (N)	Commissioning organisation	% Births (N)
1. NHS Cheshire and Merseyside ICB - 12F	92.1% (2596)	2. NHS Cheshire and Merseyside ICB - 27D	4.1% (274)

5. Data reporting

Completeness of key data items for DEATHS AT YOUR TRUST

It is vital that complete, accurate data is reported to MBRRACE-UK. For births in 2023, we received 98% of information on key data items for the deaths which occurred within your Trust.

The tables below provide details of completeness for key items in the data collection form. While the rest of this report concerns babies born within your Trust, these tables show the overall completeness of data for **deaths at your Trust no matter where they were born**. The percentage of data reported is given for each item, together with a coloured diamond denoting the level of completeness:

- ♦ less than 70.0% complete
- ♦ 70.0% to 84.9% complete
- ♦ 85.0% to 96.9% complete
- ♦ 97.0% to 99.9% complete
- ♦ 100% complete

These data items have been assessed as they are all readily available and essential to the accurate reporting of extended perinatal mortality for your Trust. For those items scoring red, orange or yellow it is essential that completeness is improved. Achieving this may well require collaboration with receiving and referring units.

Mother's details	Completeness	
Name	100.0%	♦
UK-wide	100.0%	
Postcode of residence	100.0%	♦
UK-wide	100.0%	
Ethnicity	100.0%	♦
UK-wide	97.0%	
Age	100.0%	♦
UK-wide	100.0%	

Birth	Completeness	
Type of onset of labour	100.0%	♦
UK-wide	98.8%	
Actual place of birth	100.0%	♦
UK-wide	99.5%	
Date and time of birth	100.0%	♦
UK-wide	99.4%	
Final mode of birth	100.0%	♦
UK-wide	99.4%	

Booking and antenatal care [note 1]	Completeness	
Smoking	100.0%	♦
UK-wide	97.6%	
Body mass index	100.0%	♦
UK-wide	100.0%	
Intended type of care at booking	93.7%	♦
UK-wide	95.5%	
Estimated date of delivery	100.0%	♦
UK-wide	100.0%	

Baby's outcome	Completeness	
Date death confirmed [note 2]	100.0%	♦
UK-wide	100.0%	
Whether alive at onset of care [note 2]	80.0%	♦
UK-wide	95.4%	
Whether admitted to NNU [note 3]	100.0%	♦
UK-wide	99.6%	
Main cause of death	100.0%	♦
UK-wide	97.4%	

Baby's characteristics	Completeness	
Birth weight	81.2%	♦
UK-wide	98.9%	
Gestational age at birth	100.0%	♦
UK-wide	99.2%	

Note 1: Excluding mothers reported as never booked.
Note 2: This data item is collected for stillbirths only.
Note 3: This data item is collected for neonatal deaths only.

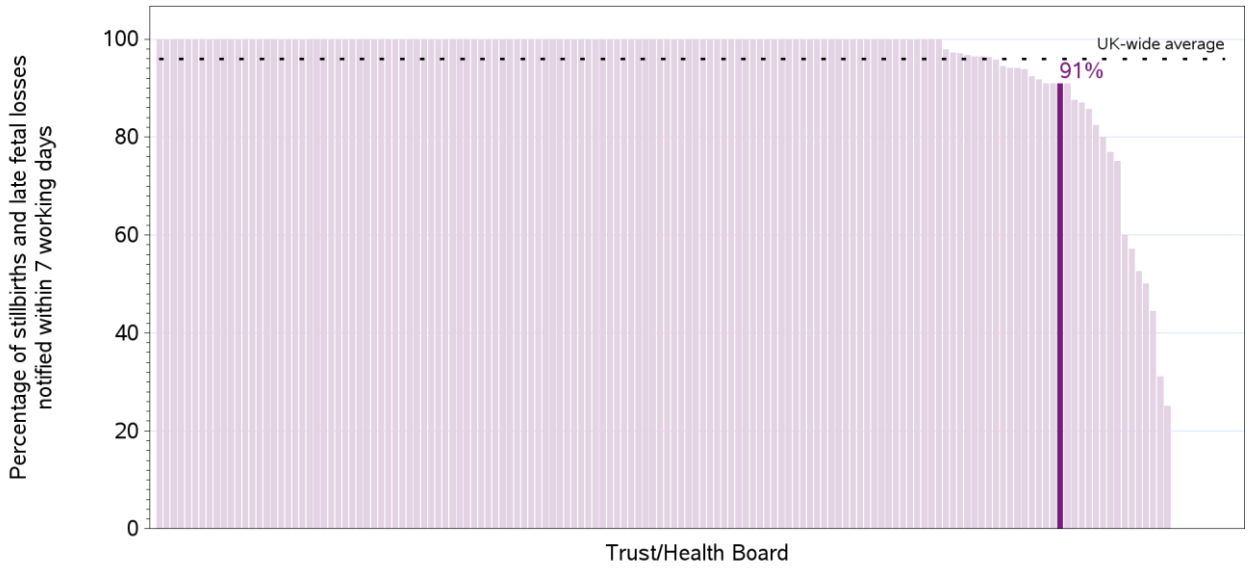
Percentage of deaths notified by your Trust within 7 working days

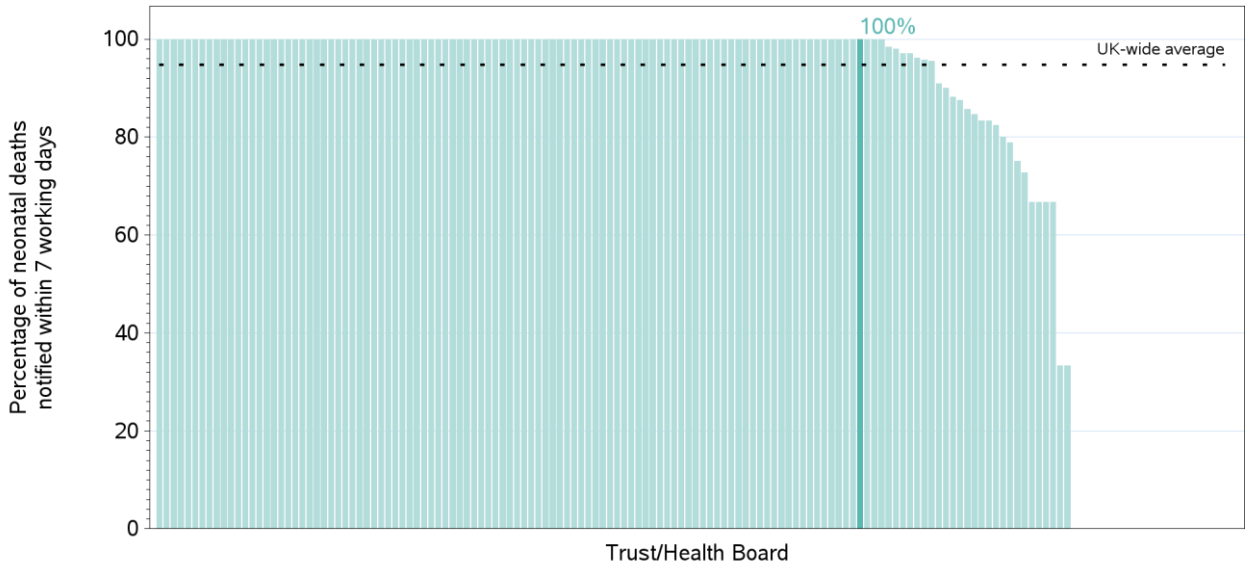
The MBRRACE-UK timeliness benchmarks for the notification of deaths and completion of surveillance data are:

1) All deaths should be **notified** to MBRRACE-UK within 7 working days of the death occurring. The full surveillance data does not have to be complete at this point.

2) Trusts and Health Boards should aim to **complete** surveillance data entry for each death within 90 days of the death occurring. The final cause of death can be updated at a later date, if necessary.

The graphs below show the percentage of stillbirths & late fetal losses and neonatal deaths notified by your Trust within the 7 working days benchmark period.





About this report

MBRRACE-UK

This report presents one element of the work of MBRRACE-UK, a collaboration led from the National Perinatal Epidemiology Unit at the University of Oxford, with members from the University of Leicester (who lead the perinatal aspects of the work), University of Birmingham, Chelsea and Westminster Hospital NHS Foundation Trust, The Newcastle upon Tyne Hospitals NHS Foundation Trust, National Maternity Voices and Sands.

MBRRACE-UK is commissioned by the Healthcare Quality Improvement Partnership on behalf of NHS England, the Welsh Government and, with some individual projects, other devolved administrations and Crown Dependencies.

Data sources

Deaths were reported to MBRRACE-UK by the Trust or Health Board where the death occurred. The information about births was obtained from routine sources – the Office for National Statistics, Personal Demographics Service, National Records of Scotland, Public Health Scotland, Northern Ireland Maternal and Child Health, States of Guernsey Health and Social Services Department, and States of Jersey Health Intelligence Unit. Home births are reported where the birth was registered via a Trust or Health Board. Births and deaths are attributed according to the configuration of Trusts and Health Boards on 1 September 2024.

Deaths from all causes except termination of pregnancy are reported, including those resulting from congenital anomalies. The information in this report may not match other locally or nationally reported rates, as births before 24 weeks gestational age have been excluded from most tables due to differences in reporting by Trusts and Health Boards. Further details on the methods we have used are included in the Technical Manual.

Deaths included in this report

The MBRRACE-UK real-time data monitoring tool (RTDM) can be used to identify the deaths included in this report by selecting "Born within your trust/HB" as the trust/health board of birth. The RTDM uses live surveillance data on perinatal deaths where the baby was born at, or died at your Health Board, and is available to anyone registered to use the MBRRACE-UK reporting system.

Data viewer

The MBRRACE-UK Data Viewer can be used to view data on a map and compare perinatal mortality rates for the organisations responsible for the commissioning and provision of care.

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