Appendix 1

Theme	Detail of metrics used for WUTH Perinatal Quality and Safety Model (PQSM)	Number	RAG	Narrative / Actions taken
Clinical Care	Number of stillbirths	2		REC completed and referred x 1 referred to MNSI as the other case not eligible
	Number of neonatal deaths (before 28days) at WUTH	2		x 1 Extreme prematurity, all governance process initiated; x 1 5 Day P/N community death
	Number of maternal deaths (up to 28 days following delivery)	1		x1 P/N 12//52 Maternal death; REC held and reported via MBBRACE
	Post partum haemorrhage >1500mls	8		x 8 reported; all have had full reviews via the CIF process and have been managed in line with policy
	Rates of HIE where improvements in care may have made a difference to the outcome	0		No HIE
	Number of occasions where the Delivery Suite Coordinator is not supernumerary at start of shift	0		100% compliant
	Number of times when the Delivery Suite Coordinator is not supernumerary for a period of one hour or more during a shift	0		Maintain shift leader to be supernumery at start of shift and throughout as best practice
	% Compliance of 1:1 care in labour	100%		Data captured via 4 hourly BR Plus activity/acuity, achieved 100% of time, escalation processes followed to revert to supernumerary status within 1 hour
	%Consultant presence at delivery when indicated (as per RCOG Guidance)	100%		Monthly audit as per RCOG guidance and guidance updated to reflect RCOG; submitted as part of MIS Year 6
	Midwifery staffing is below BR+ Acuity	Yes		P/N Ward acuity consistently in the Red RAG rating for acuity/activity; BR Plus report received in March 2025 and staffing levels suboptimal; business case required to support an increase in establishment; recruitment underway
	Midwifery staff absence rate in month (sickness)	3.78%		Trust processes implemented and additional support offered by HR for hot spot areas; above Trust recommended target; national rate 5.0% and reported as below
	Midwifery vacancy rate	10.00%		Low vacancy rate consistently reported; 9.32wte at interview stage and some are fixed term appointments
	Midwife : Birth ratio	01:27		Within parameters
	Number of times transfer in to the Neonatal unit for Level 3 care has been declined to internal transfer	0		Nil
	Number of times transfer in to the Neonatal unit for Level 3 care has been declined to external transfer	0		Nil
	BAPM compliance - Neonatal medical staff	Yes		Consultant recruited; org change underway for 24/7 cover at weekends to achieve BAPM compliance
	BAPM compliance - Neonatal nursing staff	Yes		Workforce report to BoD annually demonstrates compliance
	Number of times Maternity unit has been on divert/closed to admissions	0		Nil; mutual aid requested
	Total number of Red Flags reported	21		Theme: delay in providing pain relief; improvement noted from previous months
Service user e	Staff survey	37%		Divisional compliance for 2024 staff survey 37%, midwifery staff groups below national average, requires improvement; action plan produced with key priorities; focus on 2025 survey and objective to increase response rate
	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	No		
	Concerns around the culture / relationships between the Triumvirate and across perinatal services	Nil		Good working relationships between teams / directorates
	False declaration of CNST MIS	No		MIS Year 6 submitted by 3/3/25; appeal relaing to data transcription error with Safety Action 1 - appeal rejected; MIS Year 7 launched April 2025
	Concerns raised about other services in the Trust impacting on maternity /neonatal services e.g. A&E	No		Nil of note
	Concerns raised about a specific unit e.g. Highfield Birthing Unit	No		Nil of note
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	2		Reporting for September 2025
	Number of Maternity or Neonatal PSII's	0		No new PSII's for maternity; x 1signed off for NNU
	Number of cases referred to MNSI	1		x 1 New referral
	Delays in reporting a PSSI where criteria have been met	0		N/A
	Reported Never Events	0		Nil for maternity
	Never Events which are not reported	0		N/A
	MNSI/NHSR/CQC with a concern raised or a request for information	0		N/A
	Recurring Never Events indicating that learning is not taking place	0		N/A
	All safery action 1 report to MBBRACE within timeframe to include FQ's	Yes		Since data entry error all cases and FQ's reported as MIS timescales
	Poor notification, reporting and follow up to MBRRACE-UK, NHSR ENS and HSIB	0		N/A
Governanc e processes	Unclear governance processes / Business continuity plans not in place	Nil		Clear governance processes in place following PSIRF; awaiting revised publication for maternity services expected 2025; LMNS feedback required assurance of governance referrals to external organisations are made by maternity MDT team and not central governance
	Ability to respond to unforeseen events e.g. pandemic, local emergency	Yes		Maternity and Neonatal services responded to a critical incident decelared at WUTH in relation to sterile services
	Number of maternity/neonatal risks on the risk register overdue	0		Nil overdue
	Number of maternity/neonatal risks on the risk register with a score >12	32		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 MNSI with concerns	No		N/A

Red indicates not-compliant
Amber indicates partial compliance / work underway
Green indicates meets compliance
Blue indicates for information and no metric parameter

Trust Board sign-off requirements for MIS year 7

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

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

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

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

Trust Clinical Claim Scorecard - Guidance Sheet

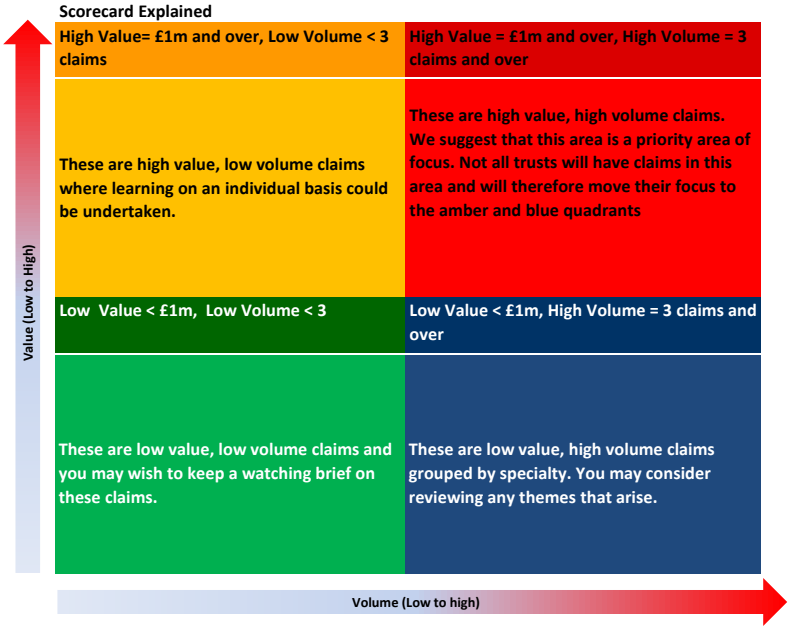
NHS Resolution

Wirral University Teaching Hospital NHS Foundation Trust

The data presented in these spreadsheets is provided to Trusts to consider their claims and learning that can be determined by using different approaches according to the quadrant description presented below.

Selection Criteria: CNST claims received with an Incident Date between 01/04/2015 and 31/03/2025
Total number of claims for this Trust: 417. Total value of claims for this Trust £143,263,183
Data correct at: 30/06/2025

Scorecard Explained



Qualifications for the Data Presented in this Scorecard

1. Criteria for Claims Selection
The data has been extracted from the NHS Resolution Claims Management System (CMS). It covers the years detailed above in the "Selection Criteria" section. A claim will appear if the incident occurred within those years. Note that Early Notification Scheme matters have been excluded unless they have become a claim.

Note that the following tables on the Specialty Summary tab exclude claims with an incident status-
a) "Volume of claims by Incident Year"
b) "Current Status"
c) "Claim Outcomes"

2.The value of a claim is the total of:
The amount paid in damages, claimant costs, defence costs and, for open claims, the estimated value of the claim at the time when the data was taken from CMS. The date in which the data was taken from CMS is defined "Data Correct at" section.

3. Data Groupings
Claims within Obstetric specialty may contain some Gynaecological claims. These can be identified in the "Specialty" column in the zone data sheet.

4.Claim Volume
The Specialty Scorecard **excludes** claims with zero costs associated as at snapshot date, thus the total number of claims may not equal the total number of claims Incident in the last 10 Financial Years ."

5.Other info
As this is based on incident years this will not match other publications such as Factsheet 5.

Due to the time lag for cases being reported, the most recent years will show less cases than earlier years.
These reports are not fixed due to using incident date so should only be used for in depth analysis rather than reporting.
If combining with other data sets please do not use the most recent years as these will not be complete yet due to the time lag.

If you want a full list of claims between score cards please use the claims download function on the Extranet where you can get a complete dataset.

Graphs Blue Zone sheet
Due to the wide range of coded Injuries and Causes that claims populating this category posesses, graphs on this sheet (Graphs Blue Zone) have been limited to the top 25 Causes and Injuries.

Specialty Summary
This is designed to give an overview of your red, yellow, green and blue zone specialties.
Pick the specialty from the drop down and it will calculate with the relevant information.
This gives a summary that can be used to take clinical teams through their claims.
Please PDF it before sending it out.

Note that for the Claim Outcome table represents claims that have as at the snapshot date the status of "Closed - Nil Damages", "Settled - Damages Paid" or "Periodical Payments"

Specialty Claims List
This is designed to give you a claims list from a specific specialty.
Pick the specialty in the pivot table and it will give you the claims with some of the basic details.
This can be used to take clinical teams through their claims.
Please PDF it before sending it out.

This document has been coproduced in response to questions and feedback from systems about the MNVP attendance at PMRT panels.

Before discussing PMRT involvement, it is essential to recognise that meaningful and safe service user voice participation at trust level, relies on a **properly commissioned and structurally supported Maternity & Neonatal Voices Partnership (MNVP)**. This includes having an employed, appropriately trained and supported MNVP lead.

Clear guidance has been set out in NHS England MNVP Guidance and Supporting Materials together with MIS Year 7, and the Maternity and Neonatal Three Year Delivery Plan.

According to NHS England MNVP Guidance, appropriately commissioned MNVPs have:

- A staffing structure that includes a highly skilled, knowledgeable and appropriately experienced MNVP lead who is embedded within the perinatal leadership team of the provider (Minimum expected requirement - AfC 8a 0.7 WTE), plus neonatal lead, engagement leads and project and admin support - the MNVP support staff may well work across more than one provider within an ICB.
- A clear service specification and contract agreed with the ICB or Local Maternity and Neonatal System.
- A dedicated budget that covers salaries, engagement activities, supervision, training, and travel. (Examples suggest ~£130,000–150,000 per MNVP is required.)
- Access to shared digital infrastructure, NHS email address, and secure data storage.
- A named line manager and access to professional supervision separate from management.

Why this matters:

- MNVP leads need autonomy, clear governance arrangements, and stability to work safely in emotionally complex spaces.
- Without the proper foundation, trusts risk breaching IG principles and negatively impacting MNVP leads.
- Proper commissioning ensures MNVP leads can participate as equals at a senior level.

Only once an MNVP operates as per the guidance should consideration be given to appropriately and effectively involving the MNVP Lead in PMRT. If an MNVP isn't operating **fully** in line with the guidance, to comply with MIS Safety Action 7, trusts should escalate via PQOM and develop an action plan with their ICB.

For trusts who already have an MNVP operating in line with guidance, more detailed information about MNVP leads' involvement in PMRT, including more detail around participation and voting where trusts vote, is in development and will be shared. MNVP leads are full and complete members of the PMRT panel alongside clinical members. They are expected to fully participate in the discussion and grading of care decisions as well as identifying learning and agreeing actions in the same way.