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

Implementation Report

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

Background

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

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

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

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

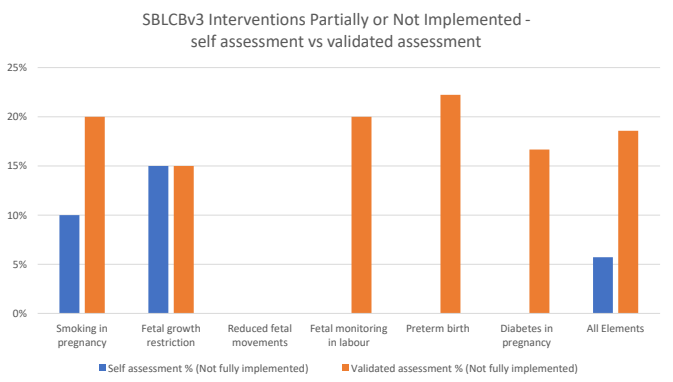
As part of the Three Year Delivery Plan for Maternity and Neonatal Services, all NHS maternity providers are responsible for fully implementing SBLCBv3 by March 2024.

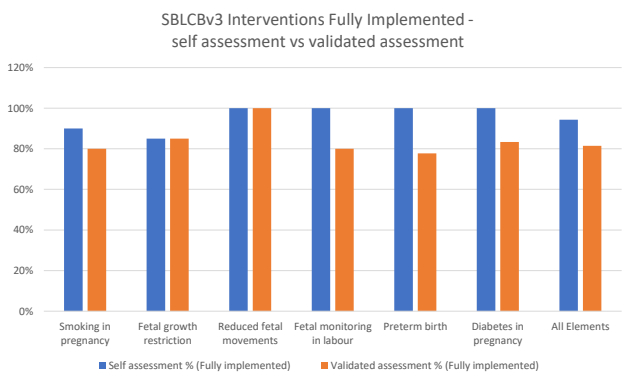
Implementation Grading

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

Implementation Progress

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)	NHS Resolution Maternity Incentive Scheme
Element 1	Smoking in pregnancy	Partially implemented	90%	Partially implemented	80%	CNST Met
Element 2	Fetal growth restriction	Partially implemented	85%	Partially implemented	85%	CNST Met
Element 3	Reduced fetal movements	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 4	Fetal monitoring in labour	Fully implemented	100%	Partially implemented	80%	CNST Met
Element 5	Preterm birth	Fully implemented	100%	Partially implemented	78%	CNST Met
Element 6	Diabetes	Fully implemented	100%	Partially implemented	83%	CNST Met
All Elements	TOTAL	Partially implemented	94%	Partially implemented	81%	CNST Met





Action Plan

Element 1

Intervention Ref	Self-Assessment Status	LMNS Validated Assessment Status	LMNS Recommendation of Actions Required	LMNS Suggested Improvement Activity
INTERVENTIONS				
1.1	Fully implemented	Fully implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	Guideline meets requirements. Care metrics do not provide detail of smoking interventions assessed. Q2 23/24 Audit meets CO at Booking compliance. Q3 22/23 Audit meets CO at 36/40
1.2	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Guideline meets requirements. July-Sept audit noted and compliant at 92%
1.3	Fully implemented	Partially implemented	Evidence not in place - improvement required.	Guideline meets requirements. Smoking status at Booking meets compliance in Q2 23/24 audit report. Smoking status at 36/40 does not meet required compliance (70% in May 2023). REF1.3F contains
1.4	Fully implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	Guideline meets requirements. Opt-out referral rate noted at 100% in May 2023. REF1.4F does not contain data fro June 2023 onwards.
1.5	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
1.6	Fully implemented	Partially implemented	Evidence not in place - improvement required.	REF1.6N noted. 39% set quit date and 23% achieved a 4 week quit. These meet required compliance. No data seen for outcome indicator 1d
1.7	Fully implemented	Fully implemented	Evidence not in place - improvement required.	Guideline meets requirements. Audit noted as compliant in REF1.7F
1.8	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Compliance noted at 87%.
1.9	Partially implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Compliane noted at 87%. Please consider VBA training for wider MDT
1.10	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Please note, Pactitioners should complete NCSCT e-learning and assessments annually.

Element 2

Intervention Ref	Self-Assessment Status	LMNS Validated Assessment Status	LMNS Recommendation of Actions Required	LMNS Suggested Improvement Activity
INTERVENTIONS				
2.1	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	REF2.1D noted as 100% compliant in Q2
2.2	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Audit noted as 100% compliant in Q2
2.3	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
2.4	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Audit noted as 100% compliant in Q2
2.5	Fully implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	0
2.6	Partially implemented	Partially implemented	Focus required on quality improvement intiatives to meet recommended standard.	Guideline needs to state that BP should be recorded using a digital monitor that has been validated. REF2.6D plan noted. REF2.6C not in evidence folder
2.7	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Audit noted as 100% compliant in Q2
2.8	Fully implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	0
2.9	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Guideline validadted by LMNS until 31st Jan 2024
2.10	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Audit noted as 100% compliant in Q2 (please note this is labelled as 2.7 in table of REF2.1D)
2.11	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Compliance noted in REF2.11D
2.12	Fully implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	0
2.13	Fully implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	0
2.14	Fully implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	0
2.15	Fully implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	0
2.16	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
2.17	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
2.18	Partially implemented	Partially implemented	0	Audit required. Action plan noted.
2.19	Partially implemented	Partially implemented	Focus required on improvement of audit levels to meet implementation ambitions and LMNS trajectories.	REF2.19D noted. Antenatal detection of SGA noted as 57% for Q3 of 2023 which did not meet previous compliance rate (75%). Suggest formal audit report to capture both audit requirements of 2.19
2.20	Fully implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	0

Element 3

INTERVENTIONS				
3.1	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
3.2	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	New USS audit noted as REF3.2I with 94% compliance

Element 4

INTERVENTIONS				
4.1	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
4.2	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	80% compliant in September 2023 and 83% compliant in October 2023.
4.3	Fully implemented	Partially implemented	Focus required on quality improvement intiatives to meet recommended standard.	No audit identified for this intervention. Email form Ocotber noted that this is a new initiative being implemented. Suggest upload of sticker/fresh eyes to evidence wellbeing assessment
4.4	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Audit compliant at 90% in September 2023 and 92% in October 2023.
4.5	Fully implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	0

Element 5

INTERVENTIONS				
5.1	Fully implemented	Partially implemented	Focus required on quality improvement intiatives to meet recommended standard.	Confirmation required if high risk midwife is named lead for preterm birth/perinatal optimisation- JD unclear
5.2	Fully implemented	Partially implemented	Evidence not in place - improvement required.	Outcome indicator 5L- need MSDS data. PMRT report noted. Outcome Indicator 5i- ODN dashboard noted as 6% average
5.3	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	100% compliance achieved July/Aug/Sept 23
5.4	Fully implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	0
5.5	Fully implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	0
5.6	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
5.7	Fully implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	Evidence noted in 1.1. Progress with Early Pregnancy Intervention in C&M pathway
5.8	Fully implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	0
5.9	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	60% compliance noted as per REF5.9 July/Aug/Sept 23
5.10	Fully implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	0
5.11	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Guideline as REF5.3A (page 5). MSU audit 100% compliant in July/Aug/Sept 23.
5.12	Fully implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	0
5.13	Fully implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	0
5.14	Fully implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	0
5.15	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
5.16	Fully implemented	Partially implemented	Evidence not in place - improvement required.	Audit required
5.17	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Optimisaton tool states 73% compliant for October 23
5.18	Fully implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	0
5.19	Fully implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	Optimisaton tools states 100% compliance in October 23
5.20	Fully implemented	Partially implemented	Evidence not in place - improvement required.	100% compliance in Optimisation tool October 2023. Data also required for steroids >7days before birth
5.21	Fully implemented	Partially implemented	Evidence not in place - improvement required.	Optimisation tool shows 100% compliance of Mag Sulph in October 23. No NNAP report uploaded to assess rate of brain injury
5.22	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Optimisation tool show 100% compliance in October 23
5.23	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Optimisation tool shows 100% compliance in October 23
5.24	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Optimisation tool shows 71% compliance in October 23

5.25	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	Optimisation toll shows 86% compliance in October 23
5.26	Fully implemented	Partially implemented	Evidence not in place - improvement required.	Need audit with intervention as at 5.26 column F
5.27	Fully implemented	Fully implemented	Focus required on quality improvement intiatives to meet recommended standard.	ODN Dashboard shows 83% compliance in 23/24 Q1

Element 6

INTERVENTIONS				
6.1	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
6.2	Fully implemented	Partially implemented	Evidence not in place - improvement required.	Audit noted in REF6.2H. Audit 1 states 'offered CGM' but audit requires 'used CGM'. Bar charts are unclear as appears like only 50% of the 20 cases are compliant. Intervention 6.2.2 refers to staff
6.3	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
6.4	Fully implemented	Fully implemented	0	90% compliant in Q2 of 2023
6.5	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0
6.6	Fully implemented	Fully implemented	Fully meets standard - continue with regular monitoring of implementation.	0

Ockenden Essential Actions - April 2022

			1: WORKFORCE PLANNING AND SUSTAINABILITY	RAG Rating	Lead	Review Date	Comments / Lead Progress
			Full workforce review required in 2022 - Priority to Neonatal and Obstetric Workforce with focus on additional governance related work and training. Neonatal nursing workforce reviewed and additional funding via NODN secured. Midwifery staffing reviewed with BR+ however as per ask re increased uplift for additional training PER HEAD COUNT not wte sme to be reviewed as a priority.				
1: WORKFORCE PLANNING AND SUSTAINABILITY	The recommendations from the Health and Social Care Committee Report: The safety of maternity services in England must be implemented.	**1**	The investment announced following our first report was welcomed. However to fund maternity and neonatal services appropriately requires a multi-year settlement to ensure the workforce is enabled to deliver consistently safe maternity and neonatal care across England.		JL	31/3/23	Neonatal service Staffing Review undertaken and bid for national monies successful.: Adam Brown with Angela MacDonald. Anaesthetic staffing review to be undertaken :Medical & Anaesthetic staffing review to be undertaken: Alice Arch. Libby Shaw and Mustafa Sadiq. Midwifery Staffing review undertaken but same to be reviewed and updated pending CoC model: Debbie Edwards and Jo Lavery. Deadline - July 2022. Staffing review given reduction in substantive NHSE funding indicates that with further implementation of Continuity of Carer there will be a small deficit circa 5wte midwives/MSWs).
		2	Minimum staffing levels should be those agreed nationally, or where there are no agreed national levels, staffing levels should be locally agreed with the LMNS. This must encompass the increased acuity and complexity of women, vulnerable families, and additional mandatory training to ensure trusts are able to safely meet organisational CNST and CQC requirements.		JL	31/3/23	Dependant on midwifery model which will dictate the staffing required. From the last BR+ review staffing was identified as appropriate with the additional funding from NHSE to support complaince with BR+ findings. Workforce paper being produced to outline the deficit in staffing should continuity of carer be delivered at 100%. This will also go to Board of Directoprs to update.
		3	Minimum staffing levels must include a locally calculated uplift, representative of the three previous years' data, for all absences including sickness, mandatory training, annual leave and maternity leave.		JL	31/3/23	Local uplift to be calculated and compared to BR+ staffing requirements. The uplift of 24% is in keeping with national guidance/local LMNS calculation.
		4	The feasibility and accuracy of the BirthRate Plus tool and associated methodology must be reviewed nationally by all bodies. These bodies must include as a minimum NHSE, RCOG, RCM, RCPCH.				Recommendation reviewed - WUTH to await Regional / National review which is currently ongoing.
			Essential Action : Training				
			Work to update orientation packages for |Band 7 staff with process to allocate a mentor. Decision re NQM with NHSE as moreof a risk. Additional work re support for senior leaders.				
	We state that the Health and Social Care Select Committee view that a proportion of maternity budgets must be ring-fenced for training in every maternity unit should be implemented	**5**	All trusts must implement a robust preceptorship programme for newly qualified midwives (NQM), which supports supernumerary status during their orientation period and protected learning time for professional development as per the RCM (2017) position statement for this.		SW/JL	31/3/23	National programme being developed however robust preceptorship in place currently. For review once national work completed and recommendation made. Current robust programme in palce and embedded.
		6	All NQMs must remain within the hospital setting for a minimum period of one year post qualification. This timeframe will ensure there is an opportunity to develop essential skills and competencies on which to advance their clinical practice, enhance professional confidence and resilience and provide a structured period of transition from student to accountable midwife.		TBC	31/3/23	Recommendation reviewed - WUTH ready however awaiting Regional / National review
		7	All trusts must ensure all midwives responsible for coordinating labour ward attend a fully funded and nationally recognised labour ward coordinator education module, which supports advanced decision-making, learning through training in human factors, situational awareness and psychological safety, to tackle behaviours in the workforce.		TBC	31/3/23	Shift Coordinators have attended development Programmes including Hiuman Factors training however National Programme awaited. Completion of any national prohramme to be agreed. D
		8	All trusts to ensure newly appointed labour ward coordinators receive an orientation package which reflects their individual needs. This must encompass opportunities to be released from clinical practice to focus on their personal and professional development.		JL/SW	31/3/23	Orientation pack currently in use but same to be reviewed nationally and to include study time for profrssional development. To continue with current process in the interim.
		9	All trusts must develop a core team of senior midwives who are trained in the provision of high dependency maternity care. The core team should be large enough to ensure there is at least one HDU trained midwife on each shift, 24/7.		JL	30/8/22	EMC Team based on DS and all midwives have undergone recognised specific HDU training.
		10	All trusts must develop a strategy to support a succession-planning programme for the maternity workforce to develop potential future leaders and senior managers. This must include a gap analysis of all leadership and management roles to include those held by specialist midwives and obstetric consultants. This must include supportive organisational processes and relevant practical work experience		JL	31/3/23	Workforce strategy in place however this will be reviewed and include reference to leadership roles. Compl;etion date - September 2022; leadership programmes and initiiatves in place
		11	The review team acknowledges the progress around the creation of Maternal Medicine Networks nationally, which will enhance the care and safety of complex pregnancies. To address the shortfall of maternal medicine physicians, a sustainable training programme across the country must be established, to ensure the appropriate workforce long term.		JL/MS/LMNS	31/3/23	Recommendation reviewed - WUTH ready however awaiting Regional / National review
			2: SAFE STAFFING				
			Escalation policy to be further reviewed re risk assessment specifically for medical Process re assessing staffing in place but review will provide further assurance. This includes review of rotas for Obs and Gynae. RCOG tool to be used once introduced to assess medical staffing. Progress with the roll out of the				
2: SAFE STAFFING	All trusts must maintain a clear escalation and mitigation policy where maternity staffing falls below the minimum staffing levels for all health professionals.	**1**	When agreed staffing levels across maternity services are not achieved on a day-to-day basis this should be escalated to the services' senior management team, obstetric leads, the chief nurse, medical director, and patient safety champion and LMS.		JL	31/3/23	Escalation processes in place and the number of diverts is included on the maternity dashboard. Staffing related incident forms reviewed and reported monthly. Staffing reviewed and reported monthly with Chief Nurse oversight.
		2	In trusts with no separate consultant rotas for obstetrics and gynaecology there must be a risk assessment and escalation protocol for periods of competing workload. This must be agreed at board level.		JL,MS & LS	30/4/23	Completed
		3	All trusts must ensure the labour ward coordinator role is recognised as a specialist job role with an accompanying job description and person specification.				Specific job description in place with personal specification. JD has been through matching process.
		4	All trusts must review and suspend if necessary the existing provision and further roll out of Midwifery Continuity of Carer (MCoC) unless they can demonstrate staffing meets safe minimum requirements on all shifts. This will preserve the safety of all pregnant women and families, which is currently compromised by the unprecedented pressures that MCoC models place on maternity services already under significant strain.		JL/DF	31/3/23	Debbie Edwards and Jo Lavery have reviewed staffing establishments as detailed above - staffing previously has supported CoC - withold complete roll out but continue with partial roll out pending staffing review. Further team to go out in January 2023. Review of national guidance in Febryary 2023 re next steps.
		5	The reinstatement of MCoC should be withheld until robust evidence is available to support its reintroduction	N/A	JL	31/3/23	Final position statement on this to be formalised nationally - completion date awaited. Locally MCofC is not withheld - meeting compliance as per staffing numbers.
		6	The required additional time for maternity training for consultants and locally employed doctors must be provided in job plans. The protected time required will be in addition to that required for generic trust mandatory training and reviewed as training requirements change.		JL/NP/JL	31/3/23	Job plans review in progress Natalie Park, Jon Lund, Mustafa Sadiq and Libby Shaw.to finalise. Review 31/3/23.
		7	All trusts must ensure there are visible, supernumerary clinical skills facilitators to support midwives in clinical practice across all settings.				Facilitators in post to support - guidance awaited re what should be included. Date TBCSarah Weston, Ali Campion, Jo Allen and Karen Cullen
		8	Newly appointed Band 7/8 midwives must be allocated a named and experienced mentor to support their transition into leadership and management roles.		JL/DF	31/3/23	Process to be reviewed and agreed with L&D Team within the Trust. Also include specific requirements for appraisals and support for leadership training eg Top Leaders; 4 C's
		9	All trusts must develop strategies to maintain bi-directional robust pathways between midwifery staff in the community setting and those based in the hospital setting, to ensure high quality care and communication.				CoC - Engagement, listening events, one-to-one meetings, Block C update, Senior midwife meeting joint with all leads.
		10	All trusts should follow the latest RCOG guidance on managements of locums. The RCOG encourages the use of internal locums and has developed practical guidance with NHS England on the management of locums. This includes support for locums and ensuring they comply with recommended processes such as pre-employment checks and appropriate induction.		JL/MS/LS	31/3/23	Locum pack developed and shared across C&M- Libby Shaw and Mustafa Sadiq to check RCOG guidance for locum guidance to further support current process. Locum pack and Gapa analysis required with assurance mechanisms. Review following any additional NHSE recomendations.
			3: ESCALATION AND ACCOUNTABILITY				
			Processes in place - same to be auditted with clear SOPs.				
3: ESCALATION AND ACCOUNTABILITY	Staff must be able to escalate concerns if necessary There must be clear processes for ensuring that obstetric units are staffed by appropriately trained staff at all times. If not resident there must be clear guidelines for when a consultant obstetrician should attend.	**1**	All trusts must develop and maintain a conflict of clinical opinion policy to support staff members in being able to escalate their clinical concerns regarding a woman's care in case of disagreement between healthcare professionals		JL/LS/MS	31/12/22	Guidance in place but standalone policy with flowcharts required. Libby Shaw developing SOP as per EBC Guidance. Completion date July 2022.
		2	When a middle grade or trainee obstetrician (non-consultant) is managing the maternity service without direct consultant presence trusts must have an assurance mechanism to ensure the middle grade or trainee is competent for this role		JL/LS/MS	31/3/23	Mustafa Sadiq and Libby Shaw to lead on embedding the Locum package being embedded and evidence of assurance
		3	Trusts should aim to increase resident consultant obstetrician presence where this is achievable		JL/MS/LS	31/3/23	Ward round take place at weekend, twice daily however resident consultant presence not in place 24/7; Added to Risk Register inview of non-compliance but review completed by WUTH therefore no further action required at present.
		4	There must be clear local guidelines for when consultant obstetricians' attendance is mandatory within the unit				Guidance in place / in policy
		5	There must be clear local guidelines detailing when the consultant obstetrician and the midwifery manager on-call should be informed of activity within the unit.		JL/MS/LS/NP	31/3/23	Partial guidance in place and currently no dedicated maternity on call rota in place as Trust on call provides OOH cover. Specific Maternity on call put on hold pending further advice and guidance from NHSE in February 2023.
			4. Clinical governance and leadership				

			Review of additional resource as detailed above to support. Training in place but to be formalised/audited.				
4 : CLINICAL GOVERNANCE-LEADERSHIP	Trust boards must have oversight of the quality and performance of their maternity services. In all maternity services the Director of Midwifery and Clinical Director for obstetrics must be jointly operationally responsible and accountable for the maternity governance systems.	**1**	Trust boards must work together with maternity departments to develop regular progress and exception reports, assurance reviews and regularly review the progress of any maternity improvement and transformation plans			31/3/23	Mat Neo agenda is in place and other QI work is reported in Governance meetings but there is limited Board oversight - same to be reviewed. Maternty safety champions and regular board meetings. Processes embedded - review in March 2023.
		2	All maternity service senior leadership teams must use appreciative inquiry to complete the National Maternity Self-Assessment Tool if not previously done. A comprehensive report of their self-assessment including governance structures and any remedial plans must be shared with their trust board			31/3/23	Self-assessment tool completed with actons in place and presented to Board. However same to be reviewed following Ockenden and an updated self assessment to go to Board in January 2023
		3	Every trust must ensure they have a patient safety specialist, specifically dedicated to maternity services				In place. Structure organogram required
		4	All clinicians with responsibility for maternity governance must be given sufficient time in their job plans to be able to engage effectively with their management responsibilities		MS/LS	31/3/23	In self-assessment tool to include neonates and anaesthetists. Only obstetric time currently supported. Completion date - July 2022; reviwing additional PA's and funding to achieve
		5	All trusts must ensure that those individuals leading maternity governance teams are trained in human factors, causal analysis and family engagement.		JL	31/3/23	Staff currently trained however review of staff group required and additional training to be identified. For further review in March 2023.
		6	All maternity services must ensure there are midwifery and obstetric co-leads for developing guidelines. The midwife co-lead must be of a senior level, such as a consultant midwife, who can drive the guideline agenda and have links with audit and research.				Multi-discipinary leads in place. Consultant Midwife coleads with audit/research.
		7	All maternity services must ensure they have midwifery and obstetric co-leads for audits		MS/LS/JL	31/3/23	Audit plan in place - same to be strengthened for Maternity and Neonates.Obstetric leads in place but midwifery leads for the audit plan to be agreed with Mustafa Sadiq Completion date - June 2022.
			5: CLINICAL GOVERNANCE - INCIDENT INVESTIGATING AND COMPLAINTS				
			Robust governance processes in place - same to be reviewed with MVP Chair				
5: CLINICAL GOVERNANCE – INCIDENT INVESTIGATION AND COMPLAINTS	Incident investigations must be meaningful for families and staff and lessons must be learned and implemented in practice in a timely manner.	**1**	All maternity governance teams must ensure the language used in investigation reports is easy to understand for families, for example ensuring any medical terms are explained in lay terms.				In place and evidenced. Robust process for reviewing documents before they are sent to families.
		2	Lessons from clinical incidents must inform delivery of the local multidisciplinary training plan.				In place in various forums both internal and external to the Trust
		3	Actions arising from a serious incident investigation which involve a change in practice must be audited to ensure a change in practice has occurred.		CC/JL	31/12/22	Implementation of actions recorded and monitored however audit of same to be reviewed.Link with audit plan
		4	Change in practice arising from an SI investigation must be seen within 6 months after the incident occurred.		JL/CC	31/12/22	Learning put in place immediately. - evidenced on individual reports.
		5	All trusts must ensure that complaints which meet SI threshold must be investigated as such				Clear MDT process in place - SI Panel. Process embedded.
		6	All maternity services must involve service users (ideally via their MVP) in developing complaints response processes that are caring and transparent				Complaint response processes in place however MVP to review and to identify improvements to further strengthen the process
		7	Complaints themes and trends must be monitored by the maternity governance team.				Processes currently in place to incorportae all patient feedback - LEAP to include Feedback Friday - positive and negative feedback and trends to be communicated to all staff.
			6: LEARNING FROM MATERNAL DEATHS				
6: LEARNING FROM MATERNAL DEATHS	Nationally all maternal post-mortem examinations must be conducted by a pathologist who is an expert in maternal physiology and pregnancy related pathologies. In the case of a maternal death a joint review panel/investigation of all services involved in the care must include representation from all applicable hospitals/clinical settings.	**1**	NHS England and Improvement must work together with the Royal Colleges and the Chief Coroner for England and Wales to ensure that this is provided in any case of a maternal death.		TBC	31/3/23	Recommendation reviewed - WUTH ready however awaiting Regional / National review
		2	This joint review panel/investigation must have an independent chair, must be aligned with local and regional staff and seek external clinical expert opinion where required.		TBC	31/3/23	Recommendation reviewed - WUTH ready however awaiting Regional / National review
		3	Learning from this review must be introduced into clinical practice within 6 months of the completion of the panel. The learning must also be shared across the LMS.		TBC	31/3/23	Recommendation reviewed - WUTH ready however awaiting Regional / National review
			7: MULTIDISCIPLANRY TRAINING				
			MDT in place - same to be extended and recorded (ad hoc drills)				
7: MULTIDISCIPLINARY TRAINING	Staff who work together must train together Staff should attend regular mandatory training and rotas. Job planning needs to ensure all staff can attend. Clinicians must not work on labour ward without appropriate regular CTG training and emergency skills training	**1**	All members of the multidisciplinary team working within maternity should attend regular joint training, governance and audit events. Staff should have allocated time in job plans to ensure attendance, which must be monitored.		JL/CC/MS/LS	31/3/23	Midwifery and middle grades involved in audit - need to expand to neonatal evidence of same and allocated time to be evidenced.
		2	Multidisciplinary training must integrate the local handover tools (such as SBAR) into the teaching programme at all trusts.				SBAR in all training including neonates. Audit of same to be further improved.
		3	All trusts must mandate annual human factor training for all staff working in a maternity setting; this should include the principles of psychological safety and upholding civility in the workplace, ensuring staff are enabled to escalate clinical concerns. The content of human factor training must be agreed with the LMS.				For all staff attend human factors training however guidance re content awaited from LMNS
		4	There must be regular multidisciplinary skills drills and on-site training for the management of common obstetric emergencies including haemorrhage, hypertension and cardiac arrest and the deteriorating patient.		JL/SW	31/3/23	PROMPT includes all of these topics however all staff groups including neonatal staff to be included in PROMPT - same to be reviewed after national recommendation/s.
		5	There must be mechanisms in place to support the emotional and psychological needs of staff, at both an individual and team level, recognising that well supported staff teams are better able to consistently deliver kind and compassionate care.				Jo Allen support for NQM. PMAs. NWAS has toolkit for staff Contact Steph Heyes. Discussed psychological support that was available in ITUs during Covid pandemic - that there was psychological support present at work.This helped staff to attend work becuase they knew the support would be there.
		6	Systems must be in place in all trusts to ensure that all staff are trained and up to date in CTG and emergency skills.				Karen Cullen in post for CTG / Fetal Physiology in addition to Ali Campion and Libby Shaw.
		7	Clinicians must not work on labour wards or provide intrapartum care in any location without appropriate regular CTG training and emergency skills training. This must be mandatory				PROMPT, K2, fetal physiology, CiF meetings. Pass mark for CTG assessment is mandated and reviewed monthly.
			8: COMPLEX ANTENATAL CARE				
			Review of High Risk team and support to implement MMN links. Review of preconceptual care and further progress in secondary care.				
8: COMPLEX ANTENATAL CARE	Local Maternity Systems, Maternal Medicine Networks and trusts must ensure that women have access to pre-conception care.Trusts must provide services for women with multiple pregnancy in line with national guidance Trusts must follow national guidance for managing women with diabetes and hypertension in pregnancy	**1**	Women with pre-existing medical disorders, including cardiac disease, epilepsy, diabetes and chronic hypertension, must have access to preconception care with a specialist familiar in managing that disorder and who understands the impact that pregnancy may have.		JL	31/3/23	Do not currently offer routine pre conception care. Will discuss regionally at what can be offered - will look at what high risk team could provide. Completion date - July 2022; Plan to be developed; Two consultants currently have pre-conception clinics and any referrals sent are accommodated from a specialist referral; Pre-conception counselling education with GP's
		2	Trusts must have in place specialist antenatal clinics dedicated to accommodate women with multifetal pregnancies. They must have a dedicated consultant and have dedicated specialist midwifery staffing. These recommendations are supported by the NICE Guideline Twin and Triplet Pregnancies 2019		JL	31/3/23	Twins Trust coming in multi-pregnacy clinic - Mustafa Sadiq is lead.
		3	NICE Diabetes and Pregnancy Guidance 2020 should be followed when managing all pregnant women with pre-existing diabetes and gestational diabetes.			31/3/23	Guidance in place - to link wth Rachel Tildesley and Lauren Evertts. Need to look at audit to support compliance. For FAAP 2023
		4	When considering and planning delivery for women with diabetes, clinicians should present women with evidence-based advice as well as relevant national recommendations. Documentation of these joint discussions must be made in the woman's maternity records.			31/3/23	In place but could be subject to audit to demonstrate compliance. For FAAP 2023
		5	Trusts must develop antenatal services for the care of women with chronic hypertension. Women who are identified with chronic hypertension must be seen in a specialist consultant clinic to evaluate and discuss risks and benefits to treatment. Women must be commenced on Aspirin 75-150mg daily, from 12 weeks gestation in accordance with the NICE Hypertension and Pregnancy Guideline (2019).			31/3/23	Guidance in place to support this practice - specific clinic to be reviewed. Audit compliance in March 2023. For FAAP 2023
			9: PRETERM BIRTH				
			Both 9 + 10 are in place - audit of processes needed				
9: PRETERM BIRTH	The LMNS, commissioners and trusts must work collaboratively to ensure systems are in place for the management of women at high risk of preterm birth. Trusts must implement NHS Saving Babies Lives Version 2 (2019)	**1**	Senior clinicians must be involved in counselling women at high risk of very preterm birth, especially when pregnancies are at the thresholds of viability.				Policy in place with clear guidance.
		2	Women and their partners must receive expert advice about the most appropriate fetal monitoring that should be undertaken dependent on the gestation of their pregnancies and what mode of delivery should be considered.				Guidance discussed at time dependant on individual situation. Guidance in place re type of monitoring as per gestation of pregnancy.
		3	Discussions must involve the local and tertiary neonatal teams so parents understand the chances of neonatal survival and are aware of the risks of possible associated disability.				Regional policy - link in with Angela MacDonald and Sanjeev Rath re any further update
		4	There must be a continuous audit process to review all in utero transfers and cases where a decision is made not to transfer to a Level 3 neonatal unit and when delivery subsequently occurs in the local unit.				Current review of Level 3 neonatal services however as WUTH Level 3 currently this is not applicable.
			10: LABOUR AND BIRTH				
		1	All women must undergo a full clinical assessment when presenting in early or established labour. This must include a review of any risk factors and consideration of whether any complicating factors have arisen which might change recommendations about place of birth. These must be shared with women to enable an informed decision re place of birth to be made				Practice in place - Demonstrated in care metrics

10: LABOUR AND BIRTH	Women who choose birth outside a hospital setting must receive accurate advice with regards to transfer times to an obstetric unit should this be necessary. Centralised CTG monitoring systems should be mandatory in obstetric units	**2**	Midwifery-led units must complete yearly operational risk assessments.		JL/DF	31/3/23	In place however annual check for 2023 to be undertaken for Deacombe and Eden Suite.
		3	Midwifery-led units must undertake regular multidisciplinary team skill drills to correspond with the training needs analysis plan		JL/DF	31/3/23	All staff included in PROMPT training however schedule of drills to be recorded and ad-hoc taken forward
		4	It is mandatory that all women who choose birth outside a hospital setting are provided accurate and up to date written information about the transfer times to the consultant obstetric unit. Maternity services must prepare this information working together and in agreement with the local ambulance trust		DE/JL	31/3/23	Transfer policy in place regionally and adopted locally - same reviewed and updated with NWAS.
		5	Maternity units must have pathways for induction of labour, (IOL). Trusts need a mechanism to clearly describe safe pathways for IOL if delays occur due to high activity or short staffing.				Pathways in place - same being reviewed regionally.
		6	Centralised CTG monitoring systems must be made mandatory in obstetric units across England to ensure regular multi-professional review of CTGs		DE	31/3/23	Purchase of system currently being undertaken. Procurement in progress once approved at CMG meeting. IT support required and request for same requested. Review March 2023.
11: OBSTETRIC ANAESTHESIA							
			Close links with Anaesthetic leads with compliance to standards - same to be auditted				
11: OBSTETRIC ANAESTHESIA	In addition to routine inpatient obstetric anaesthesia follow-up, a pathway for outpatient postnatal anaesthetic follow-up must be available in every trust to address incidences of physical and psychological harm.Documentation of patient assessments and interactions by obstetric anaesthetists must improve. The determination of core datasets that must be recorded during every obstetric anaesthetic intervention would result in record-keeping that more accurately reflects events.Staffing shortages in obstetric anaesthesia must be highlighted and updated guidance for the planning and provision of safe obstetric anaesthesia services throughout England must be developed.	**1**	Conditions that merit further follow-up include, but are not limited to, postdural puncture headache, accidental awareness during general anaesthesia, intraoperative pain and the need for conversion to general anaesthesia during obstetric interventions, neurological injury relating to anaesthetic interventions, and significant failure of labour analgesia		JL/NP/JL	31/3/23	Alice Arch overview: If a post-operative debrief would be useful these can be arranged to be purely or involve a Consultant Anaesthetist and we do this for lots of patients already - we usually offer this at 6-8 weeks post event unless the patient requests it to be earlier or later - and these patients can be referred to the Obstetric Anaesthetic Assessment clinic if they present in subsequent pregnancies; Assurance process developing
		2	Anaesthetists must be proactive in recognising situations where an explanation of events and an opportunity for questions may improve a woman's overall experience and reduce the risk of long-term psychological consequences.		JL/NP/JL	31/3/23	Currently being undertaken but need to review guidance to ensure all criteria included with audit of same. Completion date - July 2022; part of assurance process 11.1
		3	All anaesthetic departments must review the adequacy of their documentation in maternity patient records and take steps to improve this where necessary as recommended in Good Medical Practice by the GMC		NP/JL/JL	31/3/23	Documentation is recorded in maternity record hwoever need to review audit process. Completion date - July 2022; part of assurance process 11.1; part of assurance process 11.1
		4	Resources must be made available for anaesthetic professional bodies to determine a consensus regarding contents of core datasets and what constitutes a satisfactory anaesthetic record in order to maximise national engagement and compliance.			TBC	Recommendation reviewed - WUTH ready however awaiting Regional / National review
	Obstetric anaesthesia staffing guidance to include:	**5**	The role of consultants, SAS doctors and doctors-in-training in service provision, as well as the need for prospective cover, to ensure maintenance of safe services whilst allowing for staff leave.		NP/JL/JL	31/3/23	Staff who do not do regular Obstetric Anaesthesia sessions want to do a Consultant Accompanied CPD session in Obstetric Anaesthesia to keep skills up to date we are more than happy to facilitate this - and several people have already taken up this opportunity. Process to be reviewed. Completion date - July 2022; assurance process to be developed
		6	• The full range of obstetric anaesthesia workload including, elective caesarean lists, clinic work, labour ward cover, as well as teaching, attendance at multidisciplinary training, and governance activity.		JL/JL/NP	31/3/23	Staffing of same to be reviewed. Completion date - July 2022; assurance process to be developed
		7	• The competency required for consultant staff who cover obstetric services out-of hours, but who have no regular obstetric commitments.		JL/JL/NP	31/3/23	As point 5; assurance process to be developed
		8	• Participation by anaesthetists in the maternity multidisciplinary ward rounds as recommended in the first report		JL/JL/NP	31/3/23	All anaesthetists attend PROMPT MDT training; assurance process to be developed
12: POSTNATAL CARE							
			Audit and review of processes / policies re postnatal care				
12: POSTNATAL CARE	Trusts must ensure that women readmitted to a postnatal ward and all unwell postnatal women have timely consultant review.Postnatal wards must be adequately staffed at all times	**1**	All trusts must develop a system to ensure consultant review of all postnatal readmissions, and unwell postnatal women, including those requiring care on a non maternity ward		JL	31/3/23	Process in place - document to be developed to support process
		2	Unwell postnatal women must have timely consultant involvement in their care and be seen daily as a minimum		JL	31/3/23	Process in place - document to be developed to support process
		3	Postnatal readmissions must be seen within 14 hours of readmission or urgently if necessary		JL	31/3/23	Process in place - document to be developed to support process
		4	Staffing levels must be appropriate for both the activity and acuity of care required on the postnatal ward both day and night, for both mothers and babies.				Acuity tool used and effective
13: BEREAVEMENT CARE							
13. BEREAVEMENT CARE	Trusts must ensure that women who have suffered pregnancy loss have appropriate bereavement care services.	**1**	Trusts must provide bereavement care services for women and families who suffer pregnancy loss. This must be available daily, not just Monday to Friday.				Bereavement midwife in post but works Monday to Friday. EMC team upskilled and shift coordinators. With development of bereavement champions in teams. Cover available 24/7
		2	All trusts must ensure adequate numbers of staff are trained to take post-mortem consent, so that families can be counselled about post-mortem within 48 hours of birth. They should have been trained in dealing with bereavement and in the purpose and procedures of post-mortem examinations.				EMC staff and coordinators - can be inlcuded in development package for coordinators
		3	All trusts must develop a system to ensure that all families are offered follow-up appointments after perinatal loss or poor serious neonatal outcome				In place - dual with obstetrics and neonates
		4	Compassionate, individualised, high quality bereavement care must be delivered for all families who have experienced a perinatal loss, with reference to guidance such as the National Bereavement Care Pathway				Pathway in place and in use.
14: NEONATAL CARE							
			Close links with NODN to progress - this links in with the regional transformational work with Exec input to support				
14: NEONATAL CARE	There must be clear pathways of care for provision of neonatal care. This review endorses the recommendations from the Neonatal Critical Care Review (December 2019) to expand neonatal critical care, increase neonatal cot numbers, develop the workforce and enhance the experience of families. This work must now progress at pace.	**1**	Neonatal and maternity care providers, commissioners and networks must agree on pathways of care including the designation of each unit and on the level of neonatal care that is provided.				Guidance in place
		2	Care that is outside this agreed pathway must be monitored by exception reporting (at least quarterly) and reviewed by providers and the network. The activity and results of the reviews must be reported to commissioners and the Local Maternity Neonatal Systems (LMS/LMNS) quarterly.			31/3/23	Recommendation reviewed - WUTH ready however awaiting Regional / National review
		3	Maternity and neonatal services must continue to work towards a position of at least 85% of births at less than 27 weeks gestation taking place at a maternity unit with an onsite NICU.				This is a unit with onsite Level 3 NICU
		4	Neonatal Operational Delivery Networks must ensure that staff within provider units have the opportunity to share best practice and education to ensure units do not operate in isolation from their local clinical support network. For example senior medical, ANNP and nursing staff must have the opportunity for secondment to attend other appropriate network units on an occasional basis to maintain clinical expertise and avoid working in isolation.			31/3/23	Recommendation reviewed - WUTH ready however awaiting Regional Neonatal ODN Guidance
		5	Each network must report to commissioners annually what measures are in place to prevent units from working in isolation.			31/3/23	Recommendation reviewed - WUTH ready however awaiting Regional Neonatal ODN Guidance
		6	Neonatal providers must ensure that processes are defined which enable telephone advice and instructions to be given, where appropriate, during the course of neonatal resuscitations. When it is anticipated that the consultant is not immediately available (for example out of hours), there must be a mechanism that allows a real-time dialogue to take place directly between the consultant and the resuscitative team if required.		JL	31/3/23	Evidence of this happening in practice to be confirmed and to be followed up with Angela McDonald, Adam Brown and Sanjeev Rath
		7	Neonatal practitioners must ensure that once an airway is established and other reversible causes have been excluded, appropriate early consideration is given to increasing inflation pressures to achieve adequate chest rise. Pressures above 30cmH2O in term babies, or above 25cmH2O in preterm babies may be required. The Resuscitation Council UK Newborn Life Support (NLS) Course must consider highlighting this treatment point more clearly in the NLS algorithm.		JL	31/3/23	NLS Guidance followed - action to be followed up with neonatal team
		8	Neonatal providers must ensure sufficient numbers of appropriately trained consultants, tier 2 staff (middle grade doctors or ANNPs) and nurses are available in every type of neonatal unit (NICU, LNU and SCBU) to deliver safe care 24/7 in line with national service specifications.		AB/ AK	31/3/23	Staffing review undertaken as above -Adam Brown and Anand to feedback to DMB.
15: SUPPORTING FAMILIES							
			Ensure support covers maternity and neonatal care/services				
15: SUPPORTING FAMILIES	Care and consideration of the mental health and wellbeing of mothers, their partners and the family as a whole must be integral to all aspects of maternity service provisionMaternity care providers must actively engage with the local community and those with lived experience, to deliver services that are informed by what women and their families say they need from their care	**1**	There must be robust mechanisms for the identification of psychological distress, and clear pathways for women and their families to access emotional support and specialist psychological support as appropriate.		AK	31/3/23	Perinatal mental health team in post. GIRFT identified need for neonatal support. This is in place regionally
		2	Access to timely emotional and psychological support should be without the need for formal mental health diagnosis, as psychological distress can be a normal reaction to adverse experiences.		AK	31/3/23	Perinatal mental health team in post with further support from Psychiatric Liason team..
		3	Psychological support for the most complex levels of need should be delivered by psychological practitioners who have specialist expertise and experience in the area of maternity care		AK	31/3/23	Psychiatric liaison team and dedicated psychologist to support. WUTH also involved in regional project to further enhance PMH support.

	Three Year Single Delivery Plan for Maternity and Neonatal Services - June 2023								
	Theme1: Listening to and working with women and their families with compassion				RAG Rating	Lead	Review Date	Comments / Lead Progress	
	Objective 1: Care that is personalised	Personalised care gives people choice and control over how their care is planned and delivered. It is based on evidence, what matters to them, and their individual risk factors and needs	**1**	Women experience care that is always kind and compassionate. They are listened and responded to. Open and honest ongoing dialogue between a woman, her midwife, and other clinicians, to understand the care she wants, any concerns she may have, and to discuss any outcomes that are not as expected. All women are offered personalised care and support plans which take account of their physical health, mental health, social complexities, and choices. Plans consider inequalities in the broadest sense, including protected characteristics and Core20PLUS5. The care plan includes a risk assessment updated at every contact, including when the woman is in early or established labour.		JL	No further action	CQC Patient survey Debrief clinics to go through pregnancy outcomes. Birth Options clinic to evidence discussion of women's preferences Examples of care plans; PMH plans; Risk assessment audits Look at further improving inequalities as per equity and equality plan – Consultant Midwife to support with MNVP involvement.	
			2	Women receive care that has a life course approach and preventative perspective, to ensure holistic care for women and the best start in life for babies. This includes NHS-led smoke-free pregnancy pathways to provide practical support for pregnant women who are smokers, and evidence-based information about screening and vaccination		AK/ER	31/5/23	Evidence of smoking cessation midwife/work with ABL. Use of NRT. ANNB Screening Programme QA: ANNB Screening action plan to further review screening information	
			3	Women have clear choices, supported by unbiased information and evidence- based guidelines. Information is provided in a range of formats and languages, uses terminology in line with the Rebirth report, and is co-produced.		AK/ER	31/12/23	No specific work done with Rebirth report – review of same. Clear choices and information is in place including the updated/revamped website. Continue to work with MNVP re equity and equality to ensure all people receive information they understand.	
			4	All women have equitable access to specialist care, including perinatal mental health services, perinatal pelvic health services, maternal and foetal medicine networks, and neonatal care, when needed		JKL	31/10/23	All services with guidelines are in place except perinatal pelvic health services – same being introduced; Set up a perinatal pelvic health service and work closely with LMNS re guidance/requirements; funding secured and JD to be matched; initial discuss with PPHS lead and service to be set up at WUTH	
			5	Women experience personalised, joined-up, high-quality care right through to the postnatal period with handover to health visiting services and a GP check 6-8 weeks after birth. They are provided with practical support and information that reflects how they choose to feed their babies		DF	31/10/23	Processes in place although clarity needed regarding 6-8week GP check post pandemic; Check with HV team re GP follow up check	
			6	Parents are partners in their baby's care in the neonatal unit through individualised care plans utilising a family integrated care approach, together with appropriate parental accommodation.		ST/AMC	No further action	FI Care review undertaken with action plan developed following feedback positive in May 2022: repeated in May 2023 and GREEN accreditation achieved	
			7	Compassionate and high-quality care for bereaved families including appropriate accommodation, which is easily accessible but separate from maternity and neonatal units		AK/ER	No further action	Bereavement midwife in post. Bereavement Suite on site. Use of Ron McDonald House is also an option that is used	
	Objective 2: Improve equity for mother and babies	The NHS approach to improving equity (Core20PLUS5) involves implementing midwifery continuity of carer, particularly for women from minority ethnic communities and from the most deprived area It is the responsibility of trusts to: Provide services that meet the needs of their local populations, paying particular attention to health inequalities. This includes facilitating informed decision-making, for example choice of pain relief in labour where we know there are inequalities, ensuring access to interpreter services, and adhering to the Accessible Information Standard in maternity	**8**	To reduce inequalities for all in access, experience and outcomes		JL	30/4/24	Equity and Equality plan developed by LMNS following gap analysis which the Trust completed; Further work re equality to be undertaken	
			9	Targeted support where health inequalities exist in line with the principles of proportionate universalism		JL	30/6/24	MCoC teams to be set up as a wraparound service but the support is already in place from these Leads; MCoC teams in place and embedded in the identified areas; plan for McCoy to be the default model by June 2024 and subject to safe staffing and additional funding	
			10	Services listen to and work with women from all backgrounds to improve access, plan and deliver personalized care. Maternity and Neonatal voice partnerships ensure all groups are heard, including those most at risk of experiencing health inequalities.		JL	No further action		
			11	The NHS collaborates with local authority services, other public sector organisations (NHS Constitution Principle 5, 2021) to address the social determinants of health, which are a significant driver of health inequalities (WHO, 2022)		JL/DF	30/6/24	Maternity services to work with PLACE; LMNS and ICB leads to progress	
			12	In spring 2023, publish the National Review of Health and Social Care in Women's Prisons. This review covers maternity and perinatal services		JL/MB	30/6/24	To achieve requirement to work with the LMNS to meet and no local prisons feed into WUTH: consider a SoP with safeguarding midwife involvement	
	Objective 3: Work with service users to improve care	Acting on the insights of women and families improves services. Co-production is beneficial at all levels of the NHS and is particularly important for those most at risk of experiencing health inequalities (NICE, 2018). Involving service user representatives helps identify what needs to improve and how to do it. This is done through maternity and neonatal voices partnerships (MNVPs) and by	**13**	MVNPs listen to and reflect the views of local communities. All groups are heard, including bereaved families.		JL	No further action	Equity and Equality plan developed by LMNS following gap analysis which the Trust completed; Further work re equality to be undertaken as detailed above	
			14	MNVPs have strategic influence and are embedded in decision making		JL	No further action	MIS evidence supports work and undertaken and co-production	
			15	MNVPs have the infrastructure they need to be successful. Workplans are funded. MNVP leads, formally MVP chairs, are appropriately employed or remunerated and receive appropriate training, administrative and IT support.		JL	31/1/24	MNVP embedded; full funding of post with agreed workplan from ICB awaited	
	Theme 2: Growing, retaining and supporting workforce				RAG Rating	Lead	Review Date	Comments / Lead Progress	
	Objective 4: Grow our workforce	The maternity and neonatal workforce encompasses a wide range of professions, including midwives, maternity support workers, obstetricians, anaesthetists, neonatologists, neonatal nurses, sonographers, allied health professionals, and psychologists. Growing our workforce requires the tailoring of interventions to professional groups, career stage, and local requirements	**16**	Workforce capacity to grow as quickly as possible to meet local needs.		JL	No further action	Workforce plan in place with report to Board every 6 months	
			17	Local and national workforce planning to utilise evidence-based tools, endorsed by NICE or the National Quality Board (NQB), that allow for medical and social complexity, training,		JL	No further action	Nursing and Medical workforce planning tools used. BR+ Report in date. Also work with regional Leads	
			18	Aligned local and national strategies supporting recruitment to those vacant posts identified through workforce planning		JL	No further action	No specific work done with Rebirth report – review of same. Clear choices and information is in place including the updated/revamped website. Continue to work with MNVP re equity and equality to ensure all people receive information they understand.	
	Objective 5: Value and retain our workforce	Our maternity and neonatal staff perform critical, life-changing work every day. We must ensure they are valued and have a fulfilling and sustainable career within the NHS. We need to do more to improve the experience of all our staff, to retain them within the NHS	**19**	Staff feel valued at all stages of their career. This includes support to get off to a good start, opportunities for progression and flexible working, and support when approaching retirement age to allow staff to continue to use their skills and experience.		JL	No further action		
			20	All staff are included and have equality of opportunity		JL	No further action		
			21	A safe environment and inclusive culture in which staff feel empowered and supported to take action to identify and address all forms of discrimination		JL/NP/MS/AK	30/6/24	Score survey undertaken for Maternity and Neonates; feedback sessions in November 2023	
	Objective 6:	Staff feel valued when they are supported to develop. We are investing in our staff by ensuring they have ongoing training and	**22**	All staff are deployed to roles where they can develop and are empowered to deliver high quality care. Specialist roles within each profession, for example the labour ward coordinator, have a job description, orientation package, appropriate training, and ongoing development		JL	No further action	Evidence collated for Ockenden improvement plan	

Wirral University Teaching Hospital NHS Foundation Trust

Appendix 4 – Midwifery Staffing Update

Board of Directors in Public

06 March 2024

Title	Midwifery Staffing Update
Area Lead	Dr Nikki Stevenson, Executive Medical Director, Deputy Chief Executive Officer (CEO)
Author	Jo Lavery, Divisional Director of Nursing & Director of Midwifery (Women's and Children's)
Report for	Information

Executive Summary and Report Recommendations

Executive Summary

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

As part of the Maternity Incentive Scheme (MIS) published in July 2023 there is a requirement to provide the Trust Board evidence the midwifery establishment is reflective of the evidence-based process (BR+). This will be included in the Monthly Maternity Report to Board of Directors twice per annum in 2023 and is anticipated to be a requirement for MIS Year 6.

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

It is recommended that the Committee:

- Note the report

Key Risks

This report relates to these key risks:

BAF references 1,2,4 and 6

Positives:

- The Trust has several processes that review and record patient quality indicators, incidents and patient experience metrics monthly against staffing data to identify emerging risk/s. This includes a monthly midwife to birth ratio recorded on the maternity dashboard.
- The Trust fulfils its duty to undertake 6 monthly establishment reviews including an update on midwifery staffing. The Trust has also supported a BR+ review every 5 years as a minimum and as was last performed in Spring 2021 and plans to repeat end of 2024/early 2025.

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

Negatives:

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

Contribution to Integrated Care System objectives (Triple Aim Duty):	
Better health and wellbeing for everyone	Yes
Better quality of health services for all individuals	Yes
Sustainable use of NHS resources	Yes

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

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

	It is proposed that these reports will further inform and provide assurance regarding safe maternity staffing and will provide assurance to all Maternity Safety Champions including the Executive and Non-Executive Safety Champions who are required to have oversight, assurance, and visibility of safe staffing within the maternity service.
1.2	**Current position** The RCM strongly recommends using Birthrate Plus® (BR+) to undertake a systematic assessment of workforce requirements, since BR+ is the only recognised national tool for calculating midwifery staffing levels. Whilst birth outcomes are not influenced by staff numbers alone, applying a recognised and well-used tool is crucial for determining the number of midwives and support staff required to ensure each woman receives one-to-one care in labour. Birthrate Plus® has been used in maternity units ranging from stand-alone community/midwifery led units through to regional tertiary centres, with birth rates ranging from only 10 births annually through to those that have in excess of 9000 births. In addition, it caters for the various models of care in existence, including a traditional model, community-based teams and continuity of carer/caseload teams. Birthrate Plus® is the most widely used tool for workforce assessment classifying women and babies according to their needs and using clinical outcome data to calculate the numbers of midwives required to provide inpatient/outpatient antenatal care, intrapartum and postnatal care in either WUTH, community or neighbouring maternity unit. The method used works out the clinical establishment based on agreed standards of care and specialist needs and then includes the midwifery management and specialist roles required to manage maternity services. The recommendation is to provide total care to women and their babies throughout the 24 hours 7 days a week inclusive of the local % for annual, sick & study leave allowance and for travel in community**.** In March 2023 Birthrate Plus were requested to review the report due to reduced birth rate and to confirm the required staff to move from 55% of women receiving continuity of carer to 100%, scanning capacity along with the activity on the delivery suite including supporting a Level 3 NNU and of area women choosing to birth at WUTH. There were no changes to the report other than adding an additional midwife for scanning capacity as demand continues to increase in line with NICE guidance. There is an internal plan to repeat Birthrate Plus 2024/25. In 2023 WUTH maintained low vacancy rates and the majority of months was less that 2%. Current vacancy rate is 1.8% with additional funding received specifically to invest into Maternity continuity of Carer (MCoC).
1.3	**Maternity Incentive Scheme (MIS) Safety Action 5 Required Standards:** 1. The midwifery coordinator in charge of labour ward must have supernumerary status to ensure there is oversight of all birth activity within the service. There were 14 occasions over 6 months throughout the 24 hour reporting period from July to December 2023 the midwifery coordinator reported being unable to maintain supernumerary status. This is reported as short-term until the interim plan of the caseload

	being handed over with the initiation of the continuity midwife arriving or escalation processes followed to ensure further midwifery staff to rectify and ensure the midwifery co-ordinator resumes oversight of all the birth activity within the service. 2. Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall in staff. The maternity service has robust escalation processes to manage short falls in staffing level during periods of high acuity. 3. The midwife: birth ratio The midwife to birth ratio is reported monthly within the maternity dashboard and has been RAG rated green during the period from July to December 2023 in line with NICE guidance and safe maternity staffing levels. 4. The percentage of specialist midwives employed and mitigation to cover inconsistences. Birthrate plus incorporates a review of specialist midwives employed and the roles are in line with the recommended 10%. The trust has recruitment the additional Pelvic Specialist Midwife post (0.4WTE) in line with the recurrent funding received from NHSE as supported from the Three-Year delivery plan. 5. The provision of all women receiving one to one midwifery care in active labour is reported at care in labour. Maternity services from the period July to December 2023 reports via the Birthrate plus platform 100% of women receiving one to one care in active labour.
1.4	**Continuity of Carer:** The paper is explicit in the need to for Trusts to provide a model of care providing continuity of carer to women during the whole maternity episode. This model of care was initially detailed in Better Births in 2016 and included in the National Maternity Transformation Programme given its evidence based providing improved outcomes for mums and babies. The target date to deliver 100% continuity of carer had been removed, instead providers were requested to develop local plans that work for them ensuring staffing requirements are met along with an upskilled workforce. WUTH submitted a plan with an ambition to achieve by in 2024, however due to funding not being secured for the additional workforce a revised target date has not been set. The benefits of a woman being cared for by the same team of midwives throughout her pregnancy including the delivery and following cannot be underestimated. Clinical outcomes are improved with this model of care, with women reporting positive birth experiences and with the woman less likely to experience postnatal illness. A woman who receives care from a known midwife is more likely to: • Have a vaginal birth • Have fewer interventions during birth • Have a more positive experience of labour and birth • Successfully breastfeed her baby • Cost the health system less

	• Less likely to experience pre-term birth • Less likely to lose their baby before 24 weeks gestation Considering pre-term birth alone, it is well evidenced that the high rates of morbidity and mortality arising from preterm birth impose a considerable burden on finite health care resources. Preterm infants are at increased risk of a range of adverse neonatal outcomes including chronic lung disease, severe brain injury, retinopathy of prematurity, necrotizing enterocolitis and neonatal sepsis. In later life, preterm infants are at increased risk of motor and sensory impairment, learning difficulties and behavioural problems. The economic consequences include the costs of neonatal care as well as the costs associated with living with disabilities. There is a substantial literature on the short and (to a lesser extent) long term clinical consequences of prematurity. The total cost of preterm birth to the public sector has been estimated to be £2.946 billion. The average cost of a pre-term birth and the provision of care is £100,000k which considers 4 weeks ITU care, 4 weeks HDU care and 2 weeks SCBU prior to discharge. This does not include the financial burden of complex investigations, tests and the long term. The incremental cost per preterm child surviving to 18 years compared with a term survivor was estimated at £22885. The corresponding estimates for a very and extremely preterm child were substantially higher at £61781 and £94740, respectively. The Trust has six embedded teams and a further four teams is required to roll out the full model. This is dependent on the funding to increase staffing levels and has been identified from within the maternity service investment, however, a small shortfall persists.
1.5	**NHSE Bid** The planning Guidance for 2021-22 specifically referenced additional funding for maternity services of £95million – Service Development Funding (SDF) extending to £137million in 2022-23. A detailed bid based on midwifery staffing requirements was submitted to NHSE for consideration given the requirements outlined in the Ockenden report. WUTH was successful in its bid to secure additional funding however, the process for distributing Ockenden funding changed between 2021/22 and 2022/23. In order to ensure recurrent funding, the monies were distributed regionally on a fair shares basis, and has been allocated to the ICB rather than directly to individual Trusts resulting in a mismatch to the funding allocated last year. Funding allocated to Cheshire & Merseyside ICB for 2022/23 is £3,731,000 which is slightly more than the total FYE allocated to all C&M Trusts last year, however, is the decision regarding the allocation of funding sits with the ICB and the LMNS in deciding which is the best and most sustainable way to split this funding between Trusts. The recurrent funding received in 2022/23 totalled £488k (in line with the revised allocation from the ICB), therefore there has been a deficit of £180k which has been met. A review in conjunction with the Finance Business Manager has taken place and it has been confirmed the budgeted and recruited Midwives of 10.10 WTE continues to be in line with the original bid at £474K. It has been confirmed this recurrent funding will support Band 5 midwives with the usual enhancement arrangement and therefore there is no further deficit as originally anticipated. Please see table below:

Budget 2022/23	
WTE	£
10.10	474,012

The explanation for this is the original bid was costed at mid-point Band 6 and the appointments have been at the bottom of a Band 5 scale.

1.6 **Findings**

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

Based on initial 2020 activity and delivering 36% Continuity of Carer the clinical total recommended for Wirral University Teaching Hospitals NHSFT is 137.61WTE, of this 123.85WTE are Registered Midwives bands 5 -7 and 13.76WTE are MSWs providing postnatal care (on the ward/community). This equates to a total of 151.37WTE. The comparative current funded establishment is 141.23WTE which meant there was a variance of 10.14WTE as funded.

Based on current activity and delivery of 45-51% Continuity of Carer the clinical total recommended for Wirral University teaching Hospital is 141.42 WTE, of this 123.49 WTE are Registered Midwives Band 5-7 and 17.93 WTE MSW's providing post-natal care (on the ward/community). Band 8 roles have not been included as they are specialty roles and do not contribute to the delivery of MCoC.

The current establishment in accordance with Birth rate plus confirms and provides assurance of safe staffing levels to deliver MCoC up to 75%, currently approx. 60-65%% of women are in the model of care.

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

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

Additional WTE required to meet 100% Continuity of Carer - Table 1

- The current establishment as funded has enable WUTH to safely deliver MCoC to 60-65% in socially deprived and vulnerable areas.
- The costing of 10.83 WTE midwives at bottom Band 6 would be £591k and would support full roll out of full MCoC ensuring an equitable service and reduce the risk of two models of midwifery care. Some funding to meet the deficit has been

	identified via NHSE additional funding received into the Trust with a current live recruitment advert. The funding is not guaranteed to be recurrent and to date the funding to deliver as the default model and national ambition has not been identified. • Options were explored to address the shortfall including the option of utilising surplus monies from CNST rebate. • MCoC deliverables are a safety action of the Maternity Incentive Scheme (MIS) and is anticipated to be in Year 6 supporting financial income to the Trust, however the technical detail has not been published and expected Spring 2024. • The additional posts created were all been filled with newly qualified midwives following student expansion regionally. There is progression of international recruitment of midwives regionally but to date this is not a requirement of WUTH, due to the effective recruitment and retention of midwives. • NHSE have indicated that organisations who continue to implement the MCoC model and will be a priority for the allocation of any additional funding along with the Trust plan to have as the default model in 2024. • Midwifery apprentice schemes are being progressed regionally along with an 18-month conversion courses (Nurse (RN) to Midwife (RM).
1.7	**Conclusion** The deficit of 10.83 wte midwives if funded was secured will continue to provide the continuity of carer model of care as part of the consideration given to overall cost savings and clinical outcomes. The LMNS acuity staffing reports will be used to inform the 6 monthly maternity staffing paper and midwifery staffing establishment review to the Board of Directors. The deficit to continue to deliver MCoC as the default model is supported and consideration is given to utilising part of the MIS scheme investing into maternity services to continue to meet all the safety actions. Overall maternity staffing vacancies are nationally reporting well below the average and <2%.

2	**Implications**
2.1	**Patients** • There is significant risk to patient care and safety in having two models of care as an equitable service is not being delivered. • WUTH have one of the lowest levels of stillbirth rates in the region and nationally. Local research has identified significant benefits for patients including less likely to lose a baby or have a pre-term baby under 24 weeks. • Patient experience within MCoC teams is positive and there have been no relating complaints to the model of care.
2.2	**People** • It would not be safe or possible to continue the roll out of this model without securing the additional resource in line with the Birthrate plus recommendations.

	• A two-model approach to midwifery care impacts on wellbeing and employee experience. Internal escalation process is utilised to mitigate. However, this is not sustainable.
2.3	**Finance** • The financial impact to deliver the model of care has been identified as £591k.
2.4	**Compliance** • Better Births (2016) recommendations is to improve continuity of carer, teams have been set up across Wirral University Teaching Hospital (WUTH) with a continued plan to roll out continuity of carer to all women booking for maternity in line with the national drive subject to exploring and identifying the additional funding.

2023 Maternity Survey: Early release of CQC benchmark results

This report provides benchmark results for Wirral University Teaching Hospital NHS Foundation Trust, in advance of publication of the 2023 maternity survey. It contains the scoring and 'banding' (how your trust performed compared to other trusts across England), but does not include the lowest & highest scores for England. These results can only be shared at official publication of the survey results.

By sharing results now, you will be able to see how your trust performed on individual questions in advance of the publication.

If you require any assistance, have any queries, or would like to provide feedback on the format of this report, please contact the CQC Surveys Team at: patient.survey@cqc.org.uk.

2023 Maternity Survey

The 2023 maternity survey involved 121 NHS trusts in England. All NHS trusts providing maternity services that had at least 300 live births were eligible to take part in the survey. Women aged 16 years or over who had a live birth between 1st and 28th February 2023 (and January if a trust did not have a minimum of 300 eligible births in February, or March if responding as part of the sample boost of ethnic minority respondents) were invited to take part in the survey. Fieldwork took place between May and August 2023. Almost 19,000 responses were received from respondents in the core sample, an adjusted response rate of 43%[1].

The maternity survey first ran in 2007 with other surveys being carried out in 2010, 2013, 2015, 2017, 2018, 2019, 2022 and 2023. The questionnaire underwent a major redevelopment ahead of the 2013 survey so results for 2023 are **only comparable** with 2013, 2015, 2017, 2018, 2019, 2021 and 2022.

CQC will use the results from the survey to build an understanding of the risk and quality of services and those who organise care across an area. Where survey findings provide evidence of a change to the level of risk or quality in a service, provider or system, CQC will use the results alongside other sources of people's experience data to inform targeted assessment activities

[1]The 'adjusted' response rate is reported. The adjusted base is calculated by subtracting the number of questionnaires returned as undeliverable, or if someone had died, from the total number of questionnaires sent out. The adjusted response rate is then calculated by dividing the number of returned useable questionnaires by the adjusted base.

Antenatal and postnatal care

Some respondents may have experienced antenatal and postnatal care in different trusts. This may be for many reasons such as having to travel for more specialist care or due to variation in service provision across the country.

Trusts were therefore asked to carry out an 'attribution exercise' to identify individuals in their sample that were likely to have received their antenatal and postnatal care from the trust. This was done using either electronic records or residential postcode information.

The survey results contained in this report include only those respondents who were identified as receiving care at this trust. Trusts that did not provide attribution data do not receive results on the antenatal and postnatal sections of the survey.

Data is provided voluntarily, and not all trusts provided this data. The antenatal and postnatal care questions are therefore benchmarked against those other trusts that also provided this information.

Making fair comparisons between trusts

People's characteristics, such as age and number of previous births can influence their experience of care and the way they report it. For example, older people tend to report more positive experiences than younger people. Since trusts have differing profiles of people who use their services, this could potentially affect their results and make trust comparisons difficult. A trust's results could appear better or worse than if they had a slightly different profile of people.

To account for this, we 'standardise' respondent data to ensure that a trust does not appear better or worse than another due to its respondent profile. For maternity surveys, we standardise by age and parity (whether or not a mother has given birth previously).

Scoring

For each question in the survey that can be scored, individual responses are converted into scores on a scale of 0 to 10. For each question, a score of 10 is assigned to the most positive response and a score of 0 to the least positive. The higher the score, the better the trust's results.

It is not appropriate to score all questions because some of them do not assess a trust's performance.

Interpreting your data

The better and worse categories, displayed in the column with the header '2023 Band' in the tables below, are based on an analysis technique called the 'expected range'. It determines the range within which your trust's score could fall without differing significantly from the average score of all trusts taking part in the survey. If the trust's performance is outside of this range, its performance is significantly above or below what would be expected. If it is within this range, we say that its performance is 'about the same'.

Where a trust's survey results have been identified as better or worse than the majority of trusts, it is very unlikely that these results have occurred by chance. If your trust's results are 'about the same', this column will be empty.

If fewer than 30 respondents have answered a question, a score will not be displayed for this question. This is because the uncertainty around the result is too great.

Trend data

Scores from the previous survey are displayed where available. In the column with the header 'Change from 2022' arrows indicate whether the score for the 2023 survey has increased significantly (up arrow), decreased significantly (down arrow) or has not significantly changed from 2022 (no arrow). A statistically significant difference means that the change in the result is unlikely to be due to chance.

Significance is tested using a two-sample t-test. Please note that historical comparisons are not provided for section scores as the questions contained in each section can change.

Where a result for 2022 is not shown, this is because the question was either new in 2023, or the question wording and/or response options have been changed. Comparisons are also not shown if a trust has merged with another trust(s) since the 2022 survey, or if a trust committed a sampling error in 2022.

Further information

The full national results will be available on the CQC website later this year, together with the technical document which outlines the survey methodology and the scoring applied to each question: www.cqc.org.uk/maternitysurvey

Results for Wirral University Teaching Hospital NHS Foundation Trust: Executive Summary

Respondents and response rate

- 115 Wirral University Teaching Hospital NHS Foundation Trust patients responded to the survey
- The response rate for Wirral University Teaching Hospital NHS Foundation Trust was 38.59%

Banding

Better

Your trust's results were much better than most trusts for **0** questions.

Your trust's results were better than most trusts for **3** questions.

Your trust's results were somewhat better than most trusts for **0** questions.

Worse

Your trust's results were much worse than most trusts for **0** questions.

Your trust's results were worse than most trusts for **0** questions.

Your trust's results were somewhat worse than most trusts for **2** questions.

Same

Your trust's results were about the same as other trusts for **49** questions.

Tables of Results

Table 1: The start of your care in pregnancy

Question	Respondents	2023 Score	2023 Band	2022 Score	Change from 2022
B3.Were you offered a choice about where to have your baby?	99	3.7		3.5	
B4.Did you get enough information from either a midwife or doctor to help you decide where to have your baby?	105	6.7		6.3	

Table 2: Antenatal check-ups

Question	Respondents	2023 Score	2023 Band	2022 Score	Change from 2022
B7.During your antenatal check-ups, did your midwives or doctor appear to be aware of your medical history?	106	6.5	Somewhat worse	6.0	
B8.During your antenatal check-ups, were you given enough time to ask questions or discuss your pregnancy?	111	9.0		8.5	
B9.During your antenatal check-ups, did your midwives listen to you?	111	9.1		8.7	
B10.During your antenatal check-ups, did your midwives ask you about your mental health?	111	8.7		7.0	↑

Table 3: During your pregnancy

Question	Respondents	2023 Score	2023 Band	2022 Score	Change from 2022
B11.Were you given enough support for your mental health during your pregnancy?	74	8.8		7.5	↑
B12.During your pregnancy, if you contacted a midwifery team, were you given the help you needed?	103	8.5		8.6	
B13.Thinking about your antenatal care, were you spoken to in a way you could understand?	112	9.4		9.5	
B14.Thinking about your antenatal care, were you involved in decisions about your care?	109	9.1		8.7	
B15.During your pregnancy did midwivesprovide relevant information about feeding your baby?	110	6.6		6.0	
B16.Did you have confidence and trust in the staff caring for you during your antenatal care?	112	8.6		8.2	
B17.Thinking about your antenatal care, were you treated with respect and dignity?	112	9.3		8.9	
B18.If you raised a concern during your antenatal care, did you feel that it was taken seriously?	72	8.4			

Table 4: Your labour and birth

Question	Respondents	2023 Score	2023 Band	2022 Score	Change from 2022
C4.Before you were induced, were you given appropriate information and advice on the benefits associated with an induced labour?	42	8.2			
C5.And before you were induced, were you given appropriate information and advice on the risks associated with an induced labour?	42	6.9		5.9	
C6.Were you involved in the decision to be induced?	42	8.1		7.7	
C7.At the start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?	71	8.4		8.4	
C8.Do you think your healthcare professionals did everything they could to help manage your pain during labour and birth?	84	7.5			
C9.If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?	114	9.4		8.9	

Table 5: Staff caring for you

Question	Respondents	2023 Score	2023 Band	2022 Score	Change from 2022
C10.Did the staff treating and examining you introduce themselves?	112	9.0		9.1	
C12.Were you (and / or your partner or a companion) left alone by midwives or doctors at a time when it worried you?	115	7.6		7.4	
C13.If you raised a concern during labour and birth, did you feel that it was taken seriously?	72	8.2		7.0	
C14.During labour and birth, were you able to get a member of staff to help you when you needed it?	111	8.9		8.5	
C15.Thinking about your care during labour and birth, were you spoken to in a way you could understand?	115	9.3		9.2	
C16.Thinking about your care during labour and birth, were you involved in decisions about your care?	111	8.4		8.4	
C17.Thinking about your care during labour and birth, were you treated with respect and dignity?	115	9.0		9.0	
C18.Did you have confidence and trust in the staff caring for you during your labour and birth?	115	8.6		8.7	
C19.After your baby was born, did you have the opportunity to ask questions about your labour and the birth?	104	5.8		6.6	

Table 5: Staff caring for you *(continued)*

Question	Respondents	2023 Score	2023 Band	2022 Score	Change from 2022
C20.During your labour and birth, did your midwives or doctor appear to be aware of your medical history?	104	6.9	Somewhat worse	7.4	
C21.Thinking about your care during labour and birth, were you treated with kindness and compassion?	115	8.8			

Table 6: Care in hospital after birth

Question	Respondents	2023 Score	2023 Band	2022 Score	Change from 2022
D2.On the day you left hospital, was your discharge delayed for any reason?	114	6.7		6.6	
D3.If you needed attention while you were in hospital after the birth, were you able to get a member of staff to help you when you needed it?	102	7.0		6.8	
D4.Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?	113	7.2		7.3	
D5.Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?	114	8.1		8.3	
D6.Thinking about your stay in hospital, if your partner or someone else close to you was involved in your care, were they able to stay with you as much as you wanted?	106	9.6	Better	9.4	
D7.Do you think your healthcare professionals did everything they could to help manage your pain in hospital after the birth?	111	7.2			
D8.Thinking about your stay in hospital, how clean was the hospital room or ward you were in?	114	9.3		9.0	

Table 7: Feeding your baby

Question	Respondents	2023 Score	2023 Band	2022 Score	Change from 2022
E2.Were your decisions about how you wanted to feed your baby respected by midwives?	97	9.1		9.3	
E3.Did you feel that midwives and other health professionals gave you active support and encouragement about feeding your baby?	94	7.8		8.1	

Table 8: Care at home after the birth

Question	Respondents	2023 Score	2023 Band	2022 Score	Change from 2022
F1.Thinking about your postnatal care, were you involved in decisions about your care?	92	8.7		8.5	
F2.If you contacted a midwifery or health visiting team, were you given the help you needed?	79	9.3	Better	8.8	
F5.Would you have liked to have seen or spoken to a midwife...	97	7.6		7.3	
F6.Did the midwife or midwifery team that you saw or spoke to appear to be aware of the medical history of you and your baby?	84	8.0		7.6	
F7.Did you feel that the midwife or midwifery team that you saw or spoke to always listened to you?	97	9.1		8.5	
F8.Did the midwife or midwifery team that you saw or spoke to take your personal circumstances into account when giving you advice?	91	8.6		8.5	
F9.Did you have confidence and trust in the midwife or midwifery team you saw or spoke to after going home?	96	8.7		8.6	
F11.Did a midwife or health visitor ask you about your mental health?	97	9.8		9.6	
F12.Were you given information about any changes you might experience to your mental health after having your baby?	95	7.9		7.1	

Table 8: Care at home after the birth *(continued)*

Question	Respondents	2023 Score	2023 Band	2022 Score	Change from 2022
F13.Were you told who you could contact if you needed advice about any changes you might experience to your mental health after the birth?	88	9.3	Better	7.5	↑
F14.Were you given information about your own physical recovery after the birth?	96	7.2		6.9	
F15.In the six weeks after the birth of your baby did you receive help and advice from a midwife or health visitor about feeding your baby?	87	7.3		7.2	
F16.If, during evenings, nights or weekends, you needed support or advice about feeding your baby, were you able to get this?	39	7.0		5.9	
F17.In the six weeks after the birth of your baby did you receive help and advice from health professionals about your baby's health and progress?	90	8.3		8.4	

Table 9: Section Scores

Section	2022 Score	Band
1. The start of your care in your pregnancy	5.2	
2. Antenatal check-ups	8.3	
3. During your pregnancy	8.6	
4. Your labour and birth	8.1	
5. Staff caring for you	8.2	
6. Care in hospital after the birth	7.9	
7. Feeding your baby	8.4	
8. Care at home after birth	8.3	Somewhat better

Table 10: Demographic information

Characteristic	Percent
Total respondents	115
Response rate	38.6
Parity	
Primiparous	53.0
Multiparous	47.0
Age	
16-18	0.0
19-24	6.1
25-29	19.1
30-34	34.8
35+	40.0
Ethnicity	
White	90.4
Multiple ethnic groups	3.5
Asian or Asian British	5.2
Black or Black British	0.9
Arab or other ethnic group	0.0
Not known	0.0

Table 11: Demographic information

Characteristic	Percent
Religion	
No religion	52.2
Buddhist	0.9
Christian	41.7
Hindu	0.9
Jewish	0.0
Muslim	2.6
Sikh	0.0
Other religion	0.9
Prefer not to say	0.9
Sexuality	
Heterosexual/straight	93.9
Gay/lesbian	2.6
Bisexual	1.7
Other	0.0
Prefer not to say	1.7
Gender	
Gender same as sex at birth	99.1
Gender not the same as sex at birth	0.9
Prefer not to say gender	0.0

NHS Maternity Services Survey 2023 Benchmark Report

Wirral University Teaching Hospital NHS Foundation Trust

Contents

Background and methodology

This section includes:

- explanation of the NHS Patient Survey Programme
- information on the 2023 Maternity Survey
- a description of key terms used in this report
- navigating the report

Background and methodology

The NHS Patient Survey Programme

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

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

As part of the NPSP, the Maternity Survey was first carried out in 2007. The 2023 Maternity Survey will be the tenth carried out to date. The CQC use the results from the survey in the regulation, monitoring and inspection of NHS trusts in England.

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

The 2023 Maternity Survey

The survey was administered by the Coordination Centre for Mixed Methods (CCMM) at Ipsos. A total of 63,271 people who used maternity services were invited to participate in the survey across 121 NHS trusts.

Completed responses were received from 25,515 maternity service users, an adjusted response rate of 41%.

Individuals were invited to participate in the survey if they were aged 16 years or over at the time of delivery and had a live birth at an NHS Trust between 1 February and 28 February 2023. If there were fewer than 300 people within an NHS trust who gave birth in February 2023, then births from January were included.

In larger trusts, all eligible individuals from ethnic minority backgrounds, who had a live birth between 1 and 31 January and 1 and 31 March 2023 were invited to participate. A full list of eligibility criteria can be found in the survey sampling instructions.

Fieldwork took place between May and August 2023.

Trend data

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

Analysis conducted prior to the 2021 survey, concluded that this change in methodology did not have a detrimental impact on trend data. Therefore, data from the 2022 survey and subsequent years are comparable with previous years, unless a question has changed or there are other reasons for lack of comparability such as changes in organisation structure of a trust.

Where results are comparable with previous years, a section on historical trends has been included. Where there are insufficient data points for historical trends, significance testing has been carried out against 2022 data.

Further information about the survey

- For published results for other surveys in the NPSP, and for information to help trusts implement the surveys across the NPSP, please visit the NHS Surveys website.
- To learn more about CQC's survey programme, please visit the CQC website.

Background and methodology (continued)

Antenatal and Postnatal data

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

- antenatal care
- labour and birth
- postnatal care

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

When answering survey questions about labour and birth we can be confident that in all cases respondents are referring to the trust from which they were sampled. It is therefore possible to compare results for labour and birth across all 121 NHS trusts that took part in the survey.

Trusts were asked to carry out an "attribution exercise", where each trust identifies the individuals in their sample that are likely to have also received their antenatal and postnatal care from the trust. This is done using either electronic records or residential postcode information. This attribution exercise was first carried out in the 2013 survey. In 2023, 121 of the 121 trusts that took part in the survey completed this exercise.

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

Limitations of this approach

Data is provided voluntarily. In 2023, all trusts provided this data. The antenatal and postnatal care sections of this report are therefore benchmarked against all trusts that provided the required information.

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

Key terms used in this report

The ‘expected range’ technique

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

Standardisation

Demographic characteristics, such as age can influence care experiences and how they are reported. Since trusts have differing profiles of maternity service users, this could make fair trust comparisons difficult. To account for this, we ‘standardise’ the results, which means we apply a weight to individual patient responses to account for differences in profiles between trusts. For each trust, results have been standardised by parity (whether or not a service user has given birth previously) and age of respondents to reflect the ‘national’ age distribution (based on all respondents to the survey). This helps ensure that no trust will appear better or worse than another because of its profile of maternity service users and enables a fairer and more useful comparison of results across trusts. In most cases this standardisation will not have a large impact on trust results.

Scoring

For selected questions in the survey, the individual (standardised) responses are converted into scores, typically 0, 5, or 10 (except for questions B3 and D8). A score of 10 represents the best possible result and a score of 0 the worst. The higher the score for each question, the better the trust is performing. Only evaluative questions in the questionnaire are scored. Some questions are descriptive, and others are ‘routing questions’, which are designed to filter out respondents to whom subsequent questions do not apply (for example C3). These questions are not scored. Section scoring is computed as the arithmetic mean of question scores for the section after weighting is applied.

Trust average

The ‘trust average’ mentioned in this report is the arithmetic mean of all trusts’ scores after weighting is applied.

Suppressed data

If fewer than 30 respondents have answered a question, no score will be displayed for that question (or the corresponding section the question contributes to). This is to prevent individual responses being identifiable.

Further information about the methods

For further information about the statistical methods used in this report, please refer to the survey technical document.

Using the survey results

Navigating this report

This report is split into **five** sections:

1. Background and methodology – provides information about the survey programme, how the survey is run and how to interpret the data.

2. Headline results – includes key trust-level findings relating to the service user who took part in the survey, benchmarking, and top and bottom scores. This section provides an overview of results for your trust, identifying areas where your organisation performs better than the average and where you may wish to focus improvement activities.

3. Benchmarking – shows how your trust scored for each evaluative question in the survey, compared with other trusts that took part; using the 'expected range' analysis technique. This allows you to see the range of scores achieved and compare yourself with the other organisations that took part in the survey. Benchmarking can provide you with an indication of where you perform better than the average, and what you should aim for in areas where you may wish to improve. Only trusts that provide data on antenatal and/ or postnatal care and have sufficient respondent numbers are also provided with survey results for antenatal and postnatal care within this report.

4. Trends over time – includes your trust's mean score for each evaluative question in the survey. This is either shown as a historical trend chart or a significance test table, depending on the availability of longitudinal data.

Where possible, significance testing compares the mean score for your trust in 2022 to your 2023 mean score. This allows you to see if your trust has made statistically significant improvements between survey years.

Historical trends are presented where data is available, and questions remain comparable for your trust. Trends are presented only where there are at least five data points available to plot on the chart. Historical trend charts show the mean score for your trust by year, so that you can see if your trust has made improvements over time. They also include the national mean score by year, to allow you to see whether your performance is in line with the national average or not.

Significance test tables are presented where there are less than 5 data points available, and questions remain comparable between 2022 and 2023.

5. Appendix – includes additional data for your trust; further information on the survey methodology; interpretation of graphs in this report.

Using the survey results (continued)

How to interpret the graphs in this report

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

The two chart types used in the section 'benchmarking' use the 'expected range' technique to show results. For information on how to interpret these graphs, please refer to the Appendix.

Other data sources

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

- Full national results; A-Z list to view the results for each trust; technical document: http://www.cqc.org.uk/maternitysurvey
- National and trust-level data for all trusts who took part in the 2023 Maternity Survey: https://nhssurveys.org/surveys/survey/04-maternity/year/2023. Full details of the methodology for the survey, instructions for trusts and contractors to carry out the survey, and the survey development report can also be found on the NHS Surveys website.
- Information on the NHS Patient Survey Programme, including results from other surveys: www.cqc.org.uk/content/surveys
- Information about how the CQC monitors services: https://www.cqc.org.uk/what-we-do/how-we-use-information/using-data-monitor-services

Headline results

This section includes:

- information about your trust population
- an overview of benchmarking for your trust
- the top and bottom scores for your trust

Who took part in the survey?

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

300 invited to take part

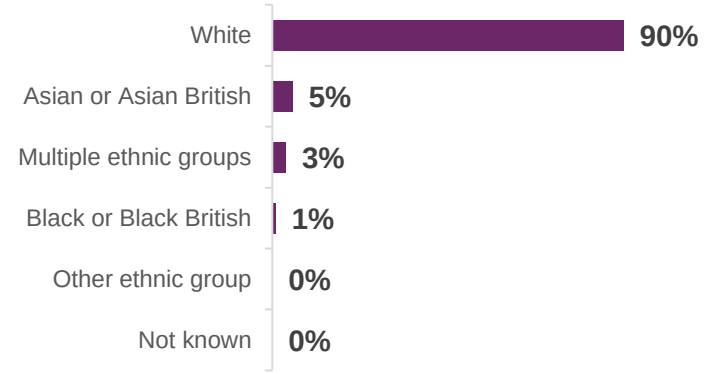
115 completed

39% response rate

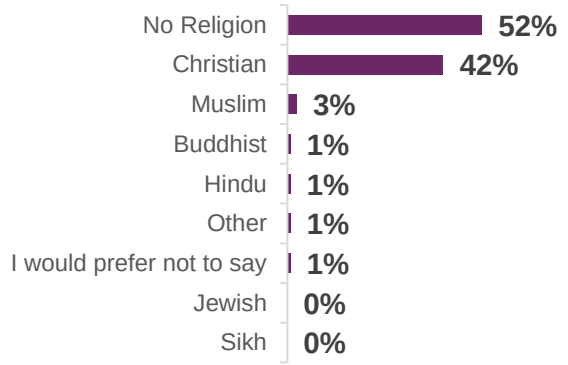
41% average trust response rate

43% response rate for your trust for 2022

ETHNICITY



RELIGION



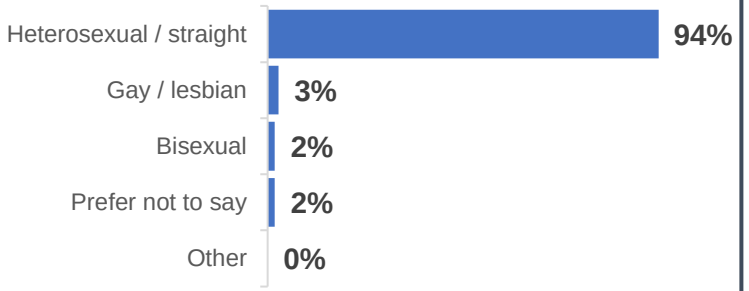
PARITY

How many babies have you given birth to before this pregnancy?

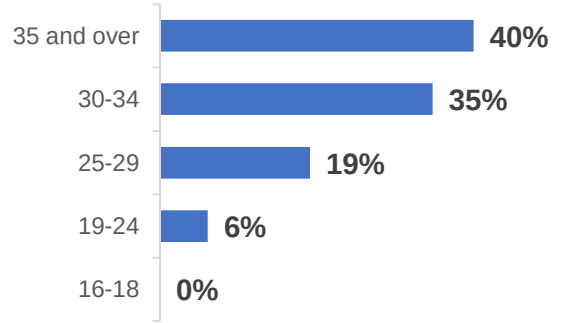
of respondents gave birth to **their first baby.**

SEXUALITY

Which of the following best describes how you think of yourself?



AGE

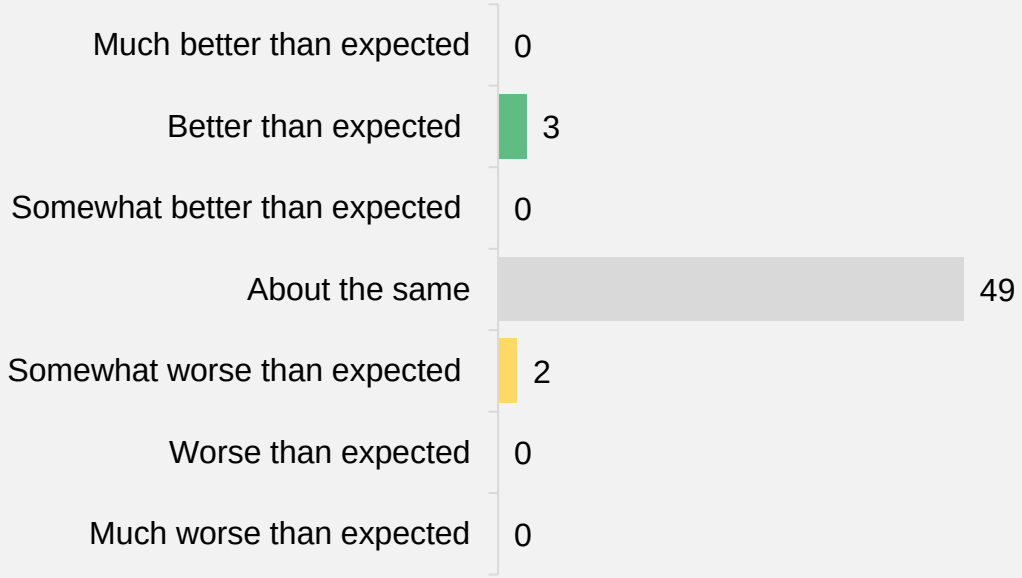


Please note that demographic information is unweighted.

Summary of findings for your trust

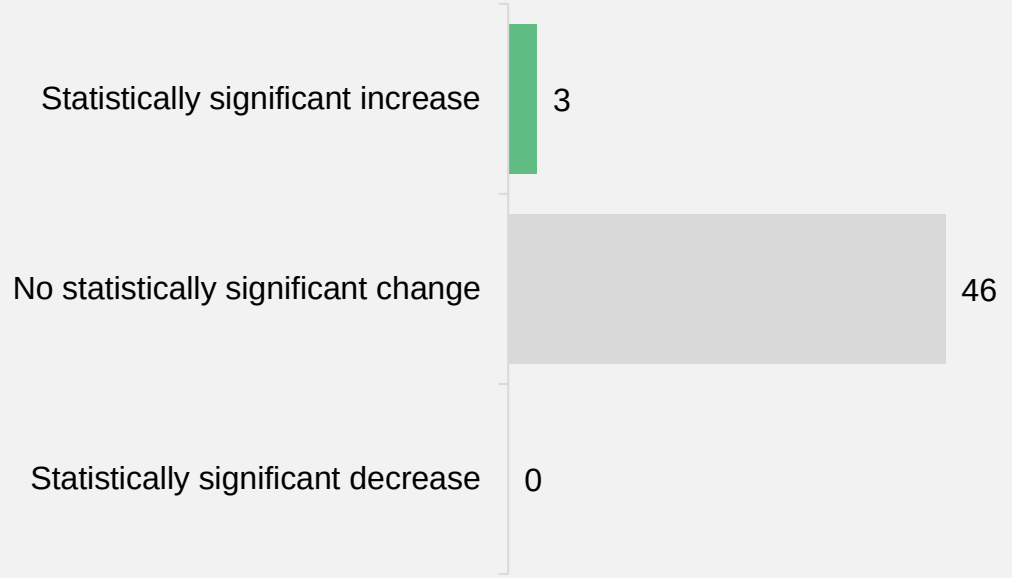
Comparison with other trusts

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



Comparison with results from 2022

The **number of questions** in this report where your trust showed a statistically significant increase, decrease, or no change in scores compared to 2022 results.



For a breakdown of the questions where your trust has performed better or worse compared with all other trusts, please refer to the appendix section "comparison to other trusts".

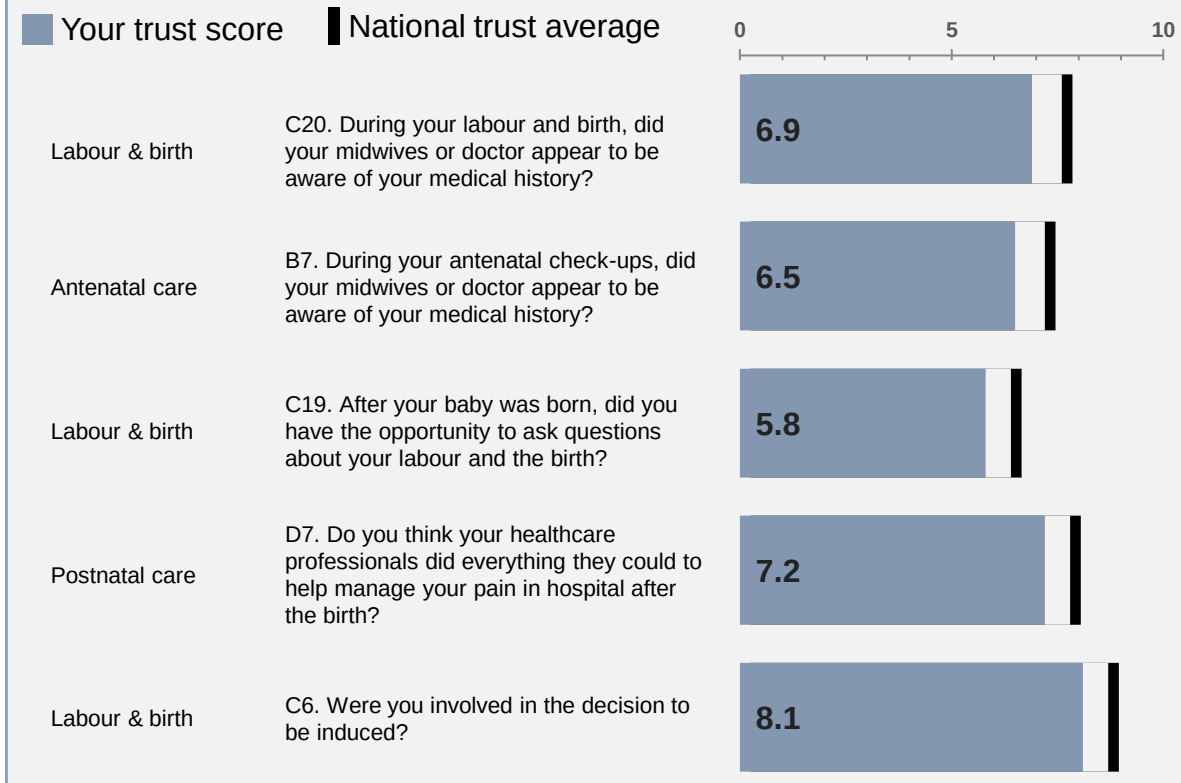
Best and worst performance relative to the trust average

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

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

Top five scores (compared with average trust score across England)

Bottom five scores (compared with average trust score across England)



Benchmarking

This section includes:

- how your trust scored for each evaluative question in the survey, compared with other trusts that took part
- an analysis technique called the ‘expected range’ to determine if your trust is performing about the same, better or worse compared with most other trusts
- for more guidance on interpreting these graphs, please refer to the appendix

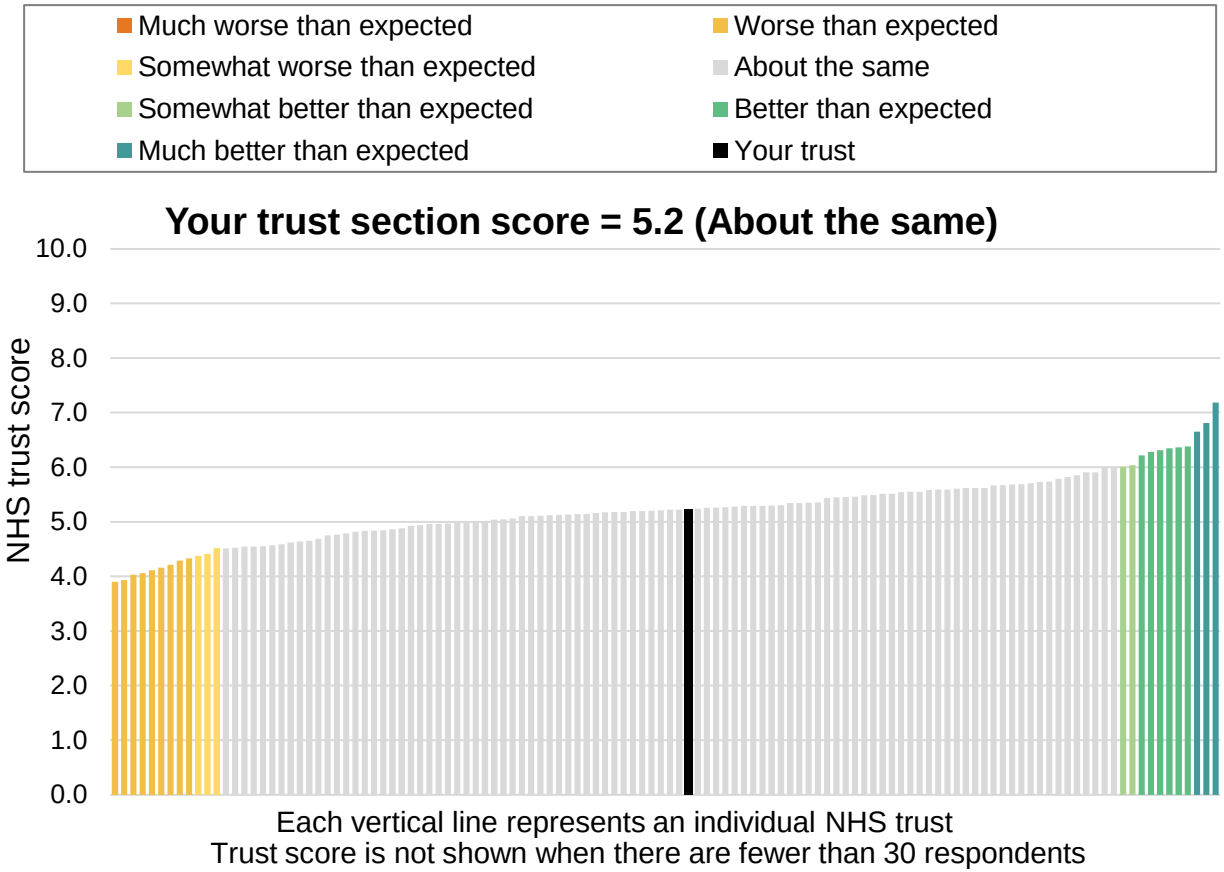
Benchmarking

Antenatal care

The start of your care during pregnancy

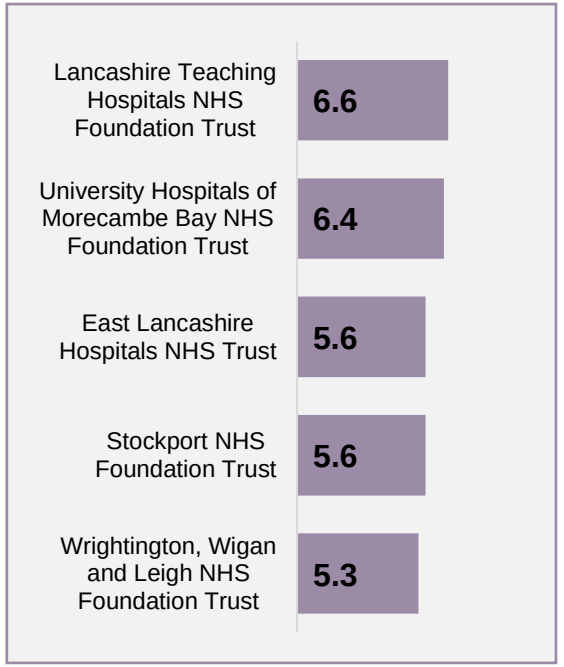
Section score

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

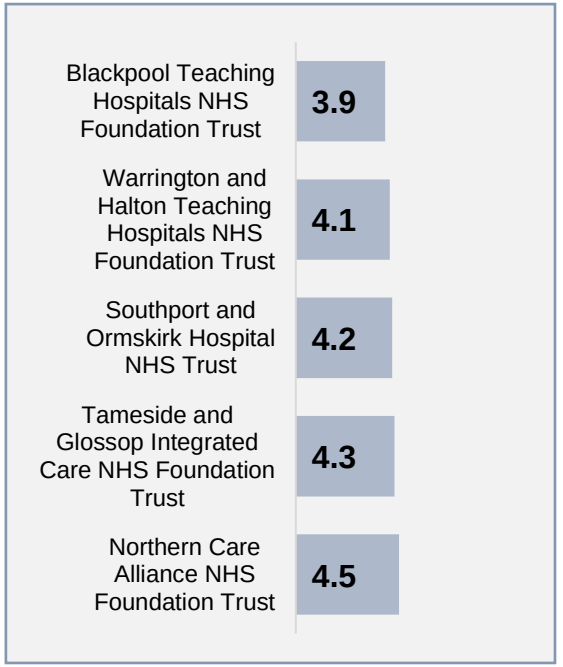


Comparison with other trusts within your region

Trusts with the highest scores



Trusts with the lowest scores



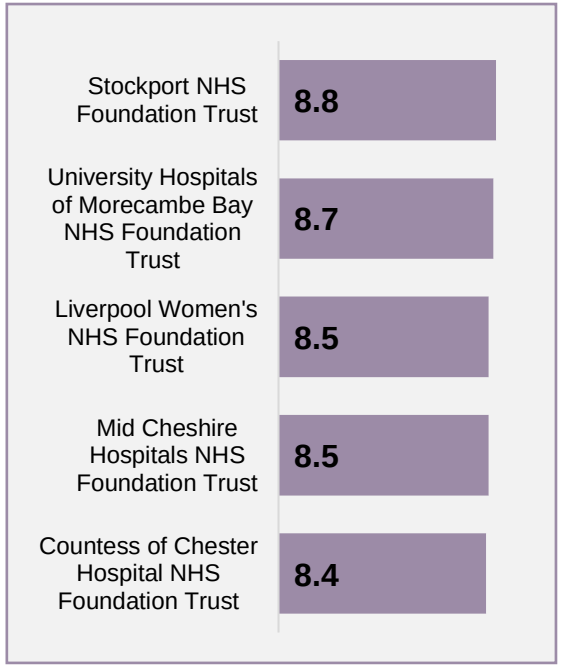
Antenatal check-ups

Section score

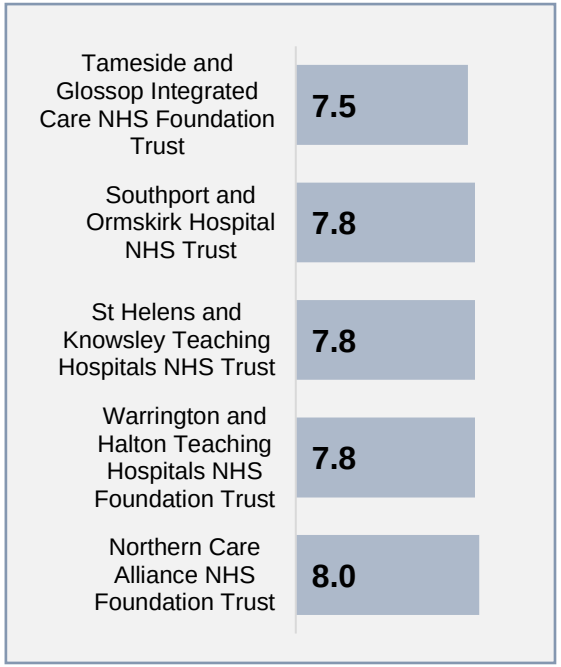
This shows the range of section scores for all NHS trusts included in the survey that submitted attribution data for antenatal care received. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'antenatal check-ups' is calculated from questions B7 to B10. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. The 'expected range' analysis technique takes into account the number of respondents for each trust, and the scores for all trusts. As a result, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Comparison with other trusts within your region

Trusts with the highest scores



Trusts with the lowest scores



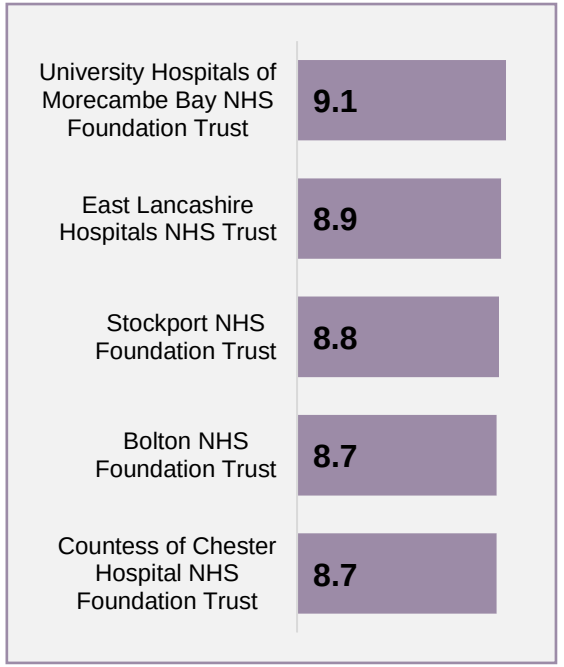
During your pregnancy

Section score

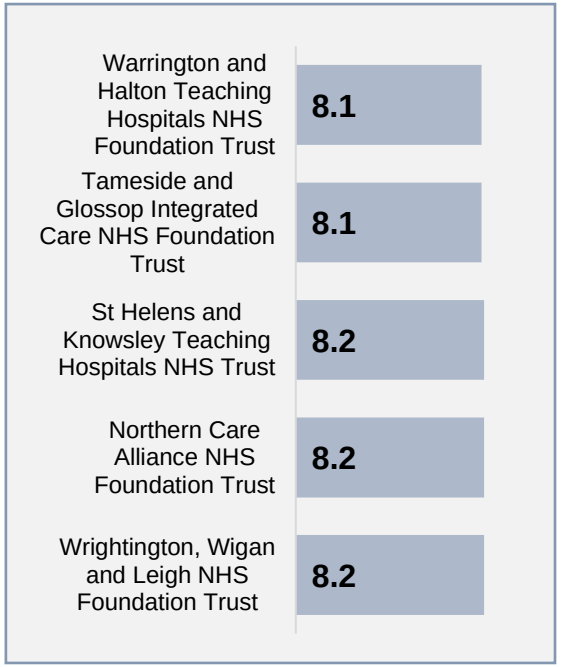
This shows the range of section scores for all NHS trusts included in the survey that submitted attribution data for antenatal care received. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'during your pregnancy' is calculated from questions B11 to B18. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. The 'expected range' analysis technique takes into account the number of respondents for each trust, and the scores for all trusts. As a result, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Comparison with other trusts within your region

Trusts with the highest scores

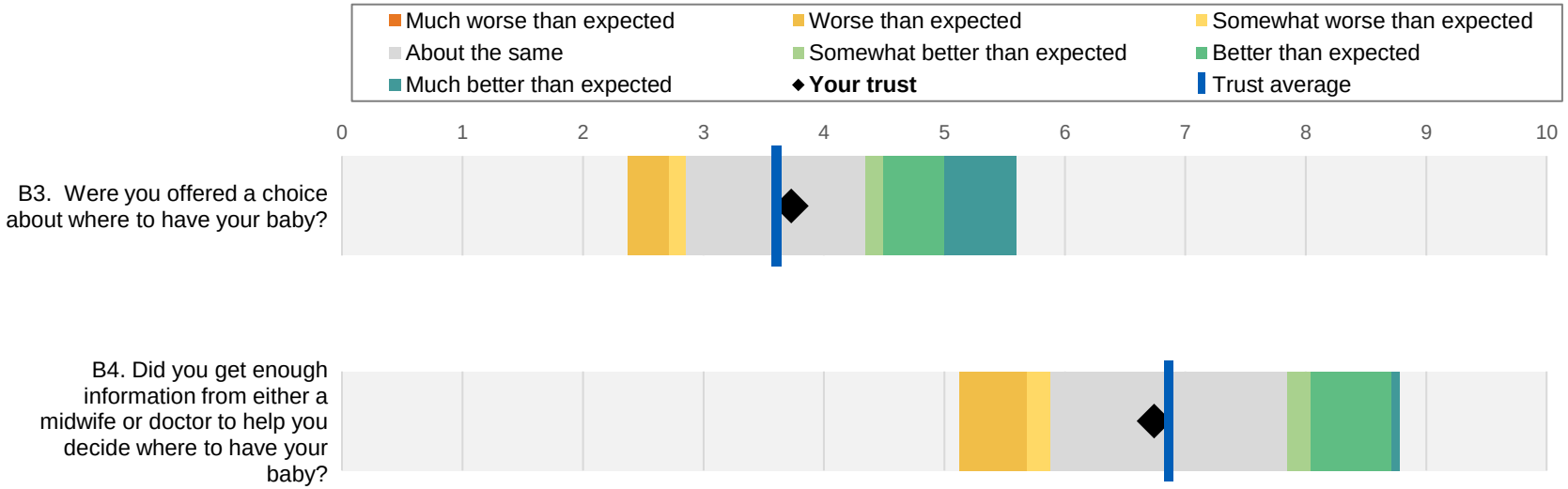


Trusts with the lowest scores



Benchmarking - Antenatal care

Question scores: Start of your pregnancy



		All trusts in England		
Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
99	3.7	3.6	2.4	5.6
105	6.7	6.9	5.1	8.8

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

Benchmarking - Antenatal care (continued)

Question scores: Antenatal check-ups

			All trusts in England		
	Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
Somewhat worse	106	6.5	7.2	5.7	8.5
About the same	111	9.0	9.0	8.1	9.7
About the same	111	9.1	9.1	8.4	9.7
About the same	111	8.7	8.5	7.0	9.6

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

Benchmarking - Antenatal care (continued)

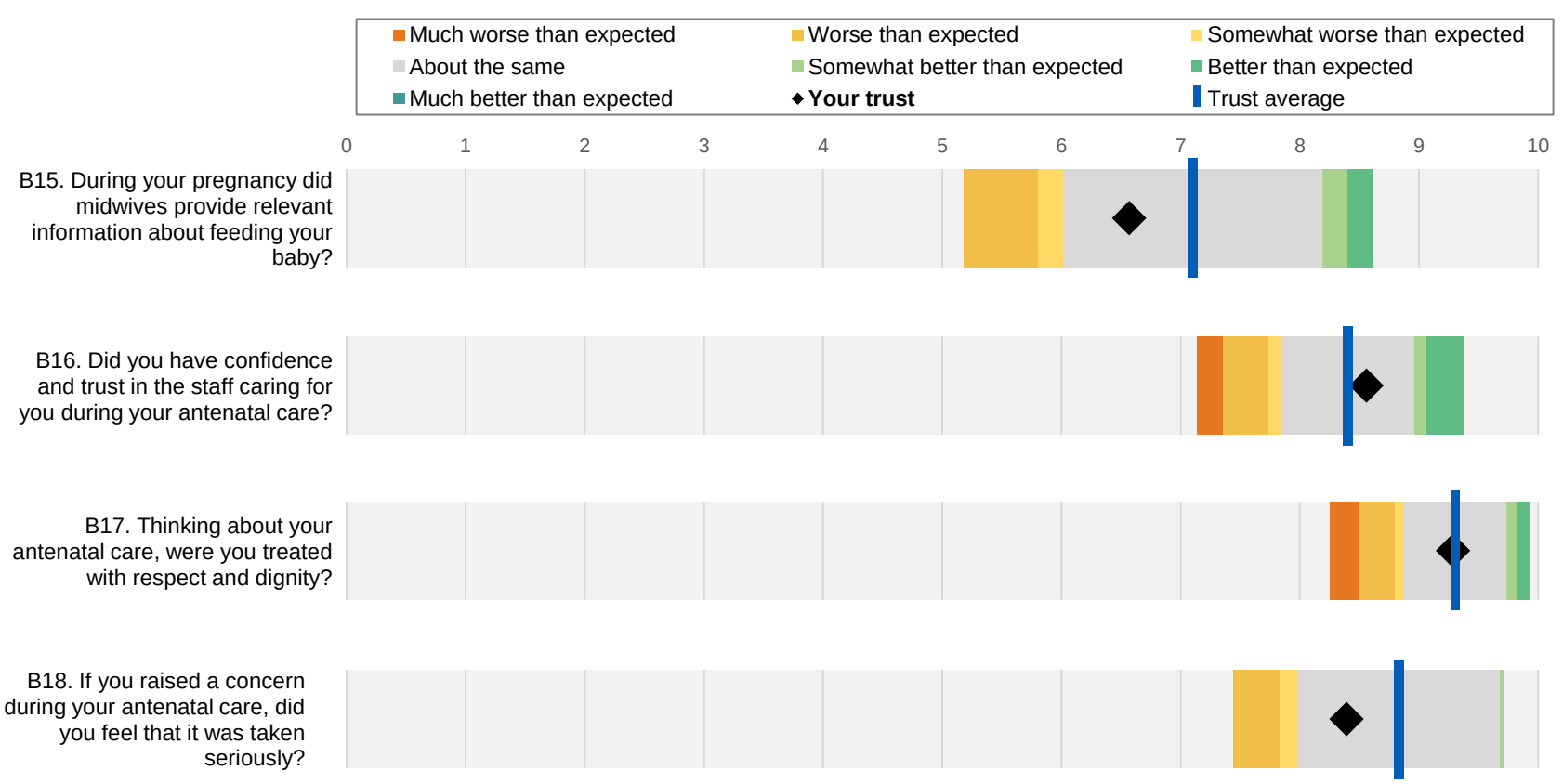
Question scores: During your pregnancy

			All trusts in England			
	Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score	
B11. Were you given enough support for your mental health during your pregnancy?	74	8.8	8.8	7.6	9.7	About the same
B12. During your pregnancy, if you contacted a midwifery team, were you given the help you needed?	103	8.5	8.4	7.1	9.3	About the same
B13. Thinking about your antenatal care, were you spoken to in a way you could understand?	112	9.4	9.4	8.8	9.9	About the same
B14. Thinking about your antenatal care, were you involved in decisions about your care?	109	9.1	8.9	8.2	9.6	About the same

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

Benchmarking - Antenatal care (continued)

Question scores: During your pregnancy



			All trusts in England		
	Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
B15. During your pregnancy did midwives provide relevant information about feeding your baby?	110	6.6	7.1	5.2	8.6
B16. Did you have confidence and trust in the staff caring for you during your antenatal care?	112	8.6	8.4	7.1	9.4
B17. Thinking about your antenatal care, were you treated with respect and dignity?	112	9.3	9.3	8.3	9.9
B18. If you raised a concern during your antenatal care, did you feel that it was taken seriously?	72	8.4	8.8	7.4	9.7

About the same

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

Benchmarking

Labour and birth

NHS

CareQuality Commission

Ipsos

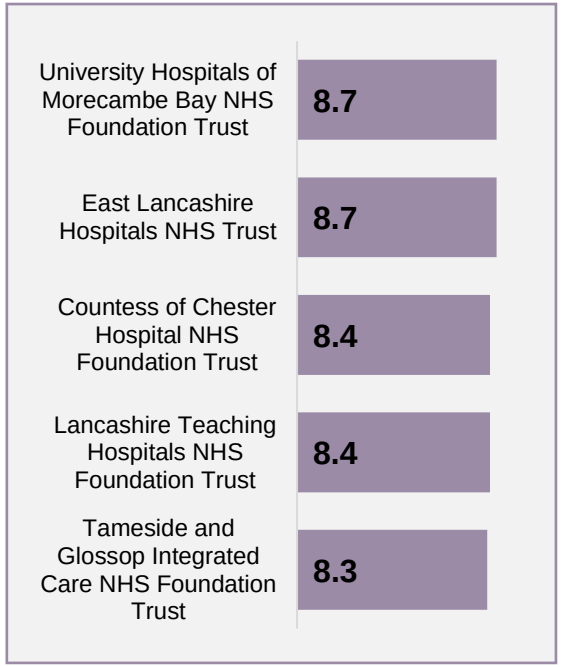
Your labour and birth

Section score

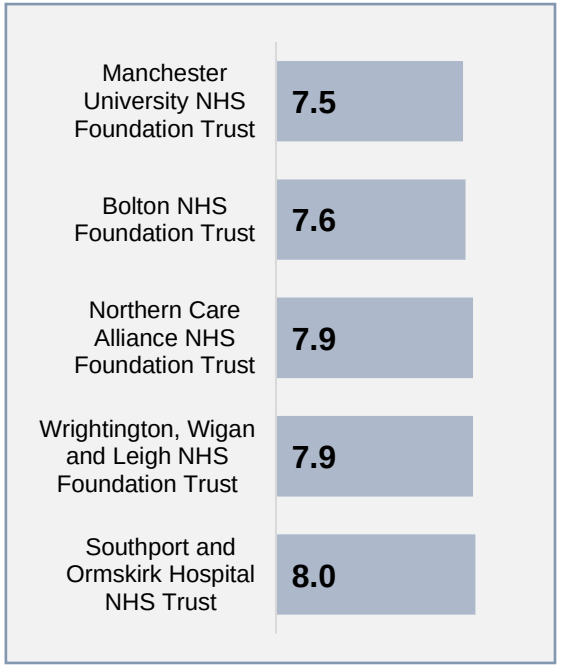
This shows the range of section scores for all NHS trusts included in the survey. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'your labour and birth' is calculated from questions C4 to C9. The colour of the line denotes whether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

Comparison with other trusts within your region

Trusts with the highest scores



Trusts with the lowest scores



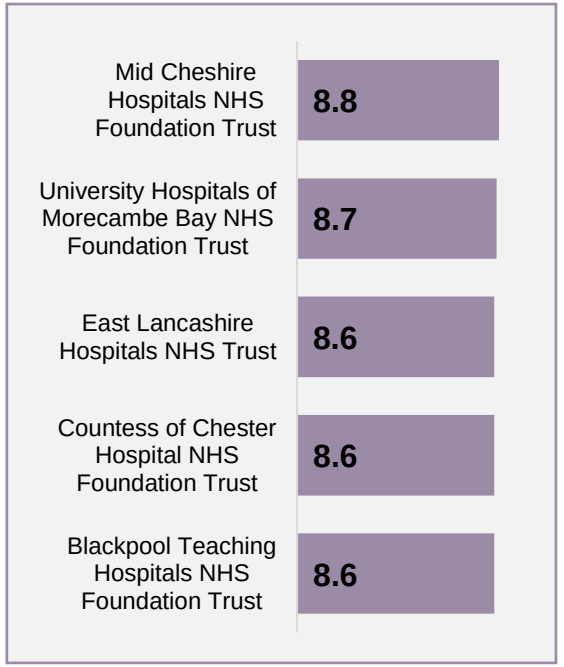
Staff caring for you

Section score

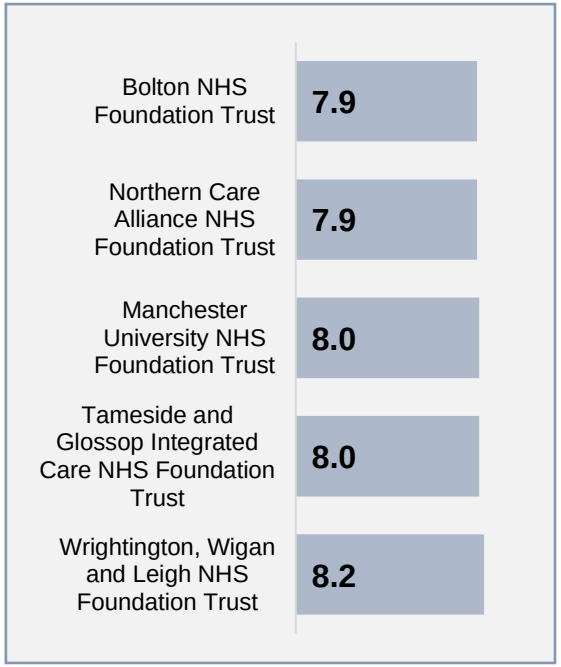
This shows the range of section scores for all NHS trusts included in the survey. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'staff caring for you' is calculated from questions C10 and C12 to C21. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. The 'expected range' analysis technique takes into account the number of respondents for each trust, and the scores for all trusts. As a result, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Comparison with other trusts within your region

Trusts with the highest scores



Trusts with the lowest scores



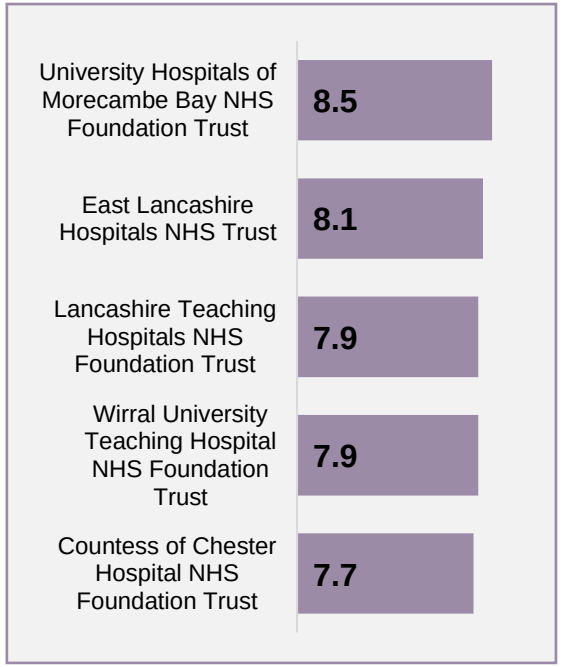
Care in the ward after birth

Section score

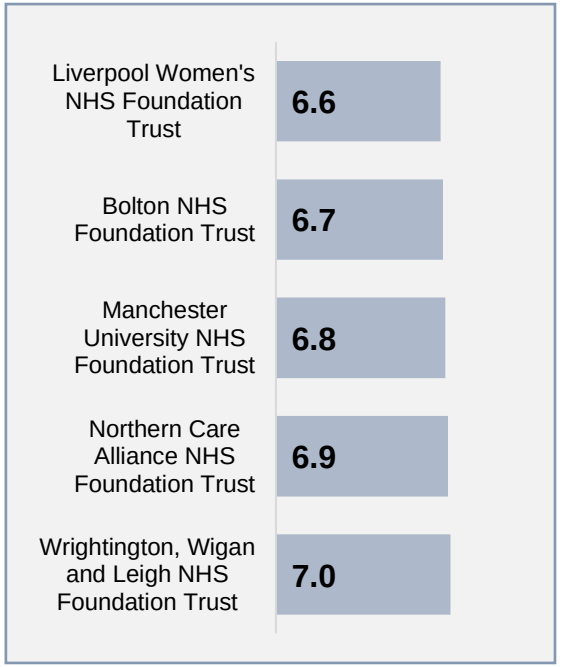
This shows the range of section scores for all NHS trusts included in the survey. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'care in the ward after birth' is calculated from questions D2 to D8. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. The 'expected range' analysis technique takes into account the number of respondents for each trust, and the scores for all trusts. As a result, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Comparison with other trusts within your region

Trusts with the highest scores

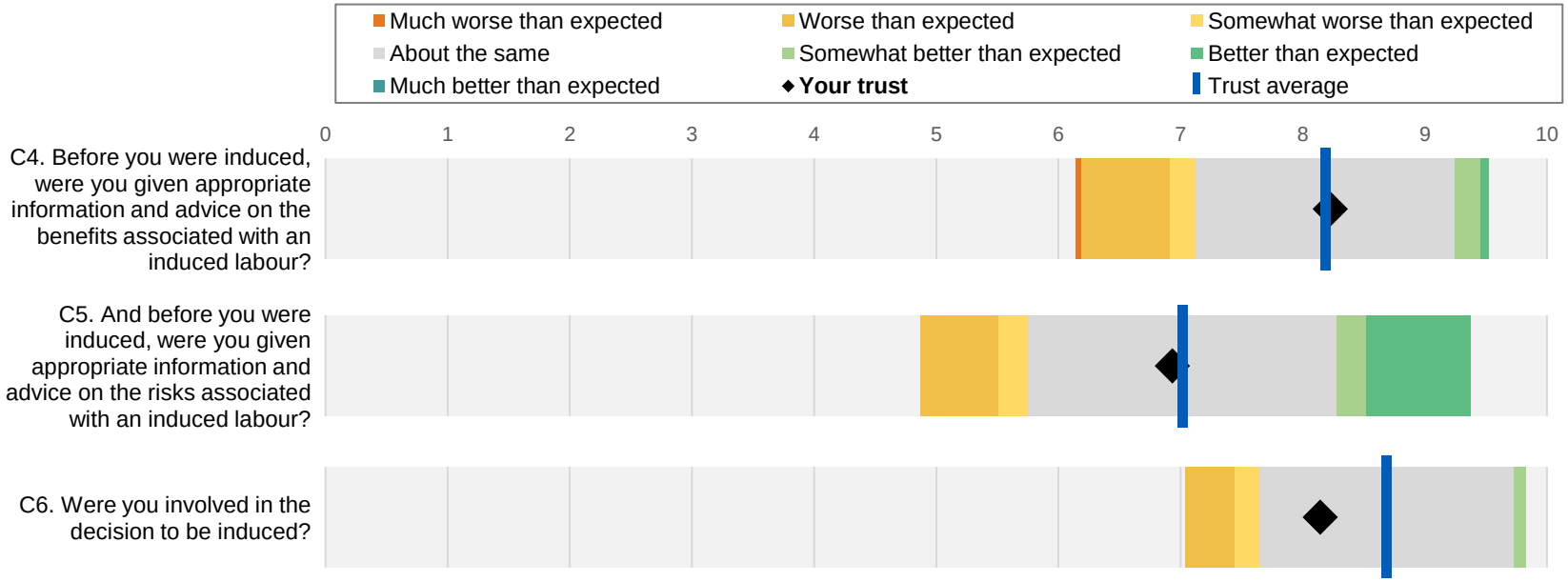


Trusts with the lowest scores



Benchmarking - Labour and birth

Question scores: Your labour and birth

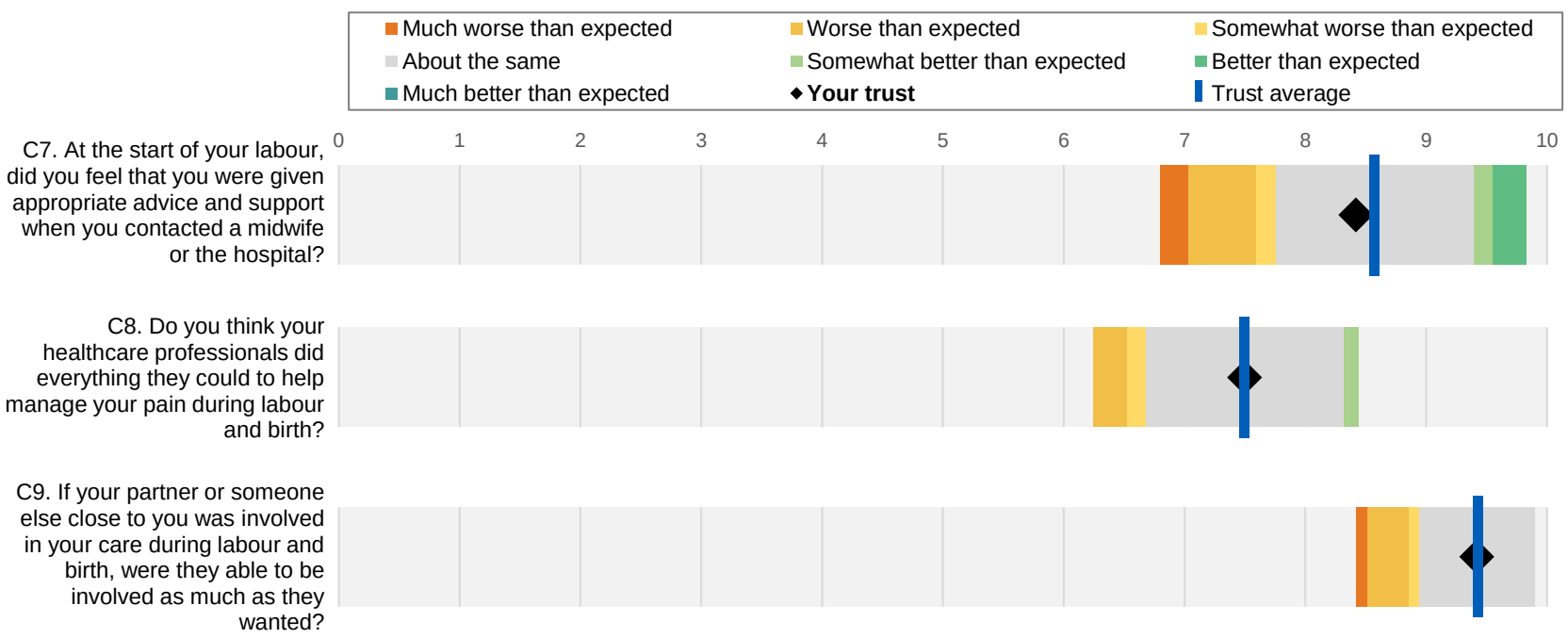


			All trusts in England		
	Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
About the same	42	8.2	8.2	6.1	9.5
About the same	42	6.9	7.0	4.9	9.4
About the same	42	8.1	8.7	7.0	9.8

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

Benchmarking - Labour and birth (continued)

Question scores: Your labour and birth

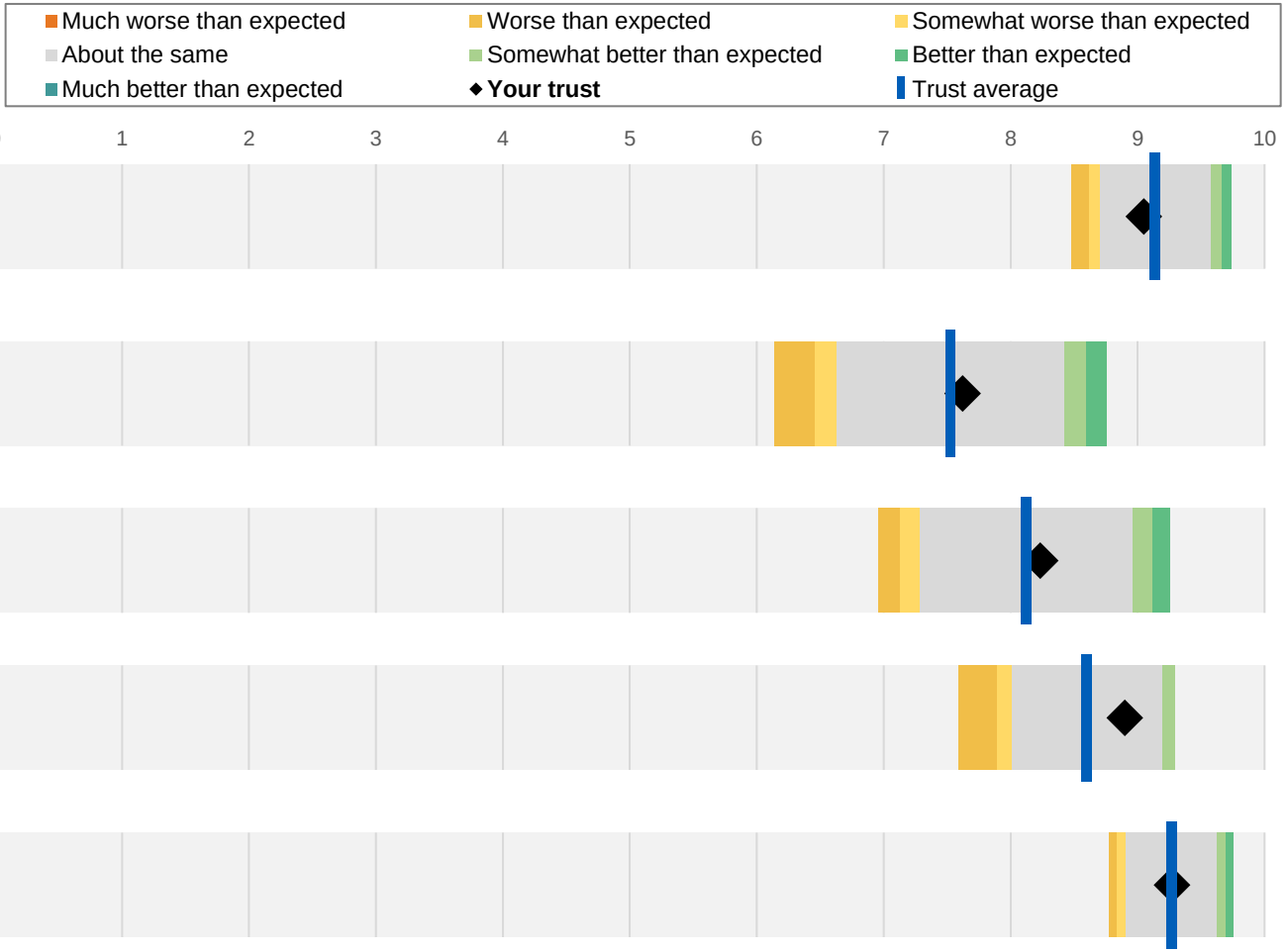


			All trusts in England		
	Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
About the same	71	8.4	8.6	6.8	9.8
About the same	84	7.5	7.5	6.2	8.4
About the same	114	9.4	9.4	8.4	9.9

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

Benchmarking - Labour and birth (continued)

Question scores: Staff caring for you



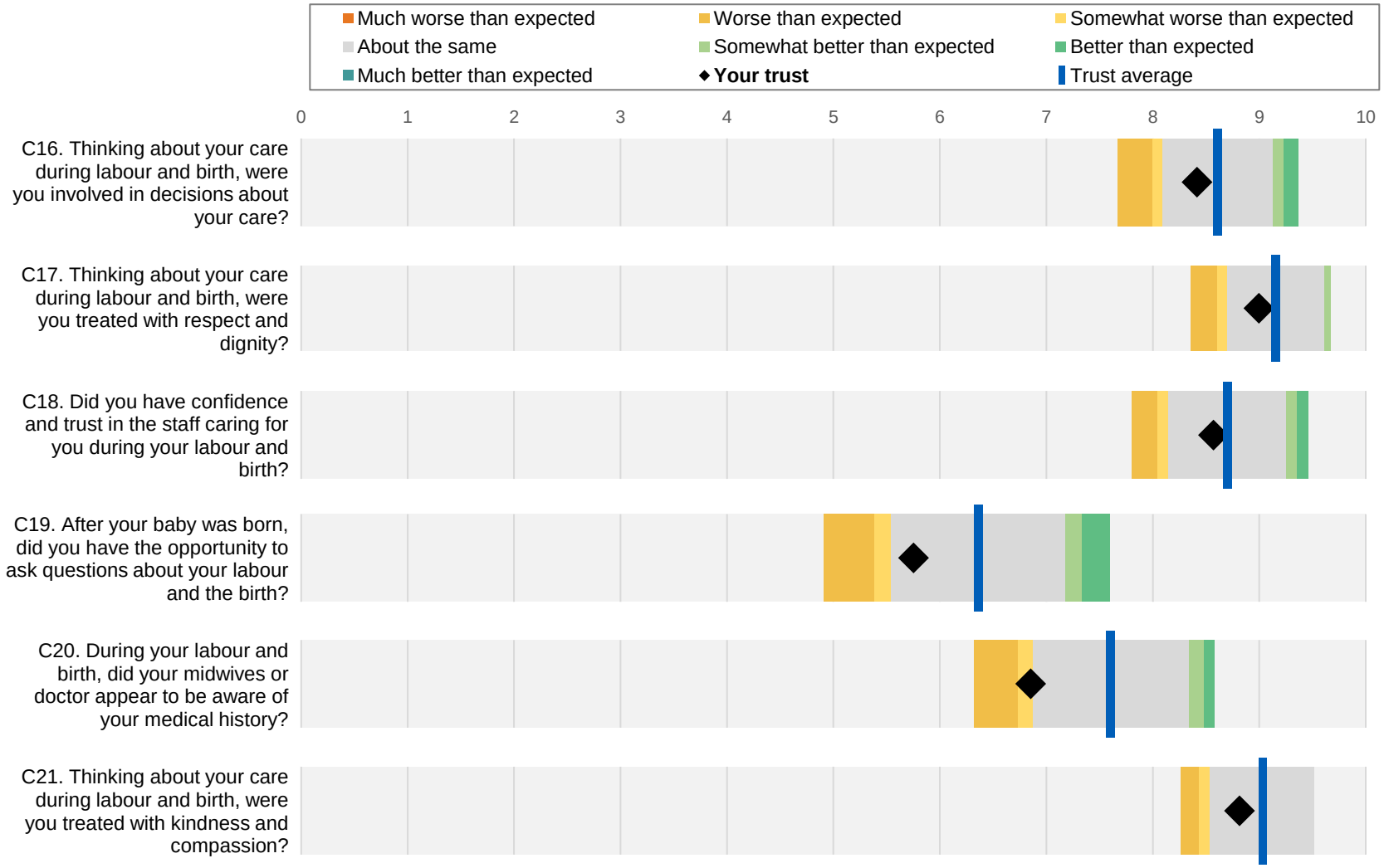
		All trusts in England			
	Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
C10. Did the staff treating and examining you introduce themselves?	112	9.0	9.1	8.5	9.7
C12. Were you (and / or your partner or a companion) left alone by midwives or doctors at a time when it worried you?	115	7.6	7.5	6.1	8.8
C13. If you raised a concern during labour and birth, did you feel that it was taken seriously?	72	8.2	8.1	7.0	9.3
C14. During labour and birth, were you able to get a member of staff to help you when you needed it?	111	8.9	8.6	7.6	9.3
C15. Thinking about your care during labour and birth, were you spoken to in a way you could understand?	115	9.3	9.3	8.8	9.8

About the same

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

Benchmarking - Labour and birth (continued)

Question scores: Staff caring for you



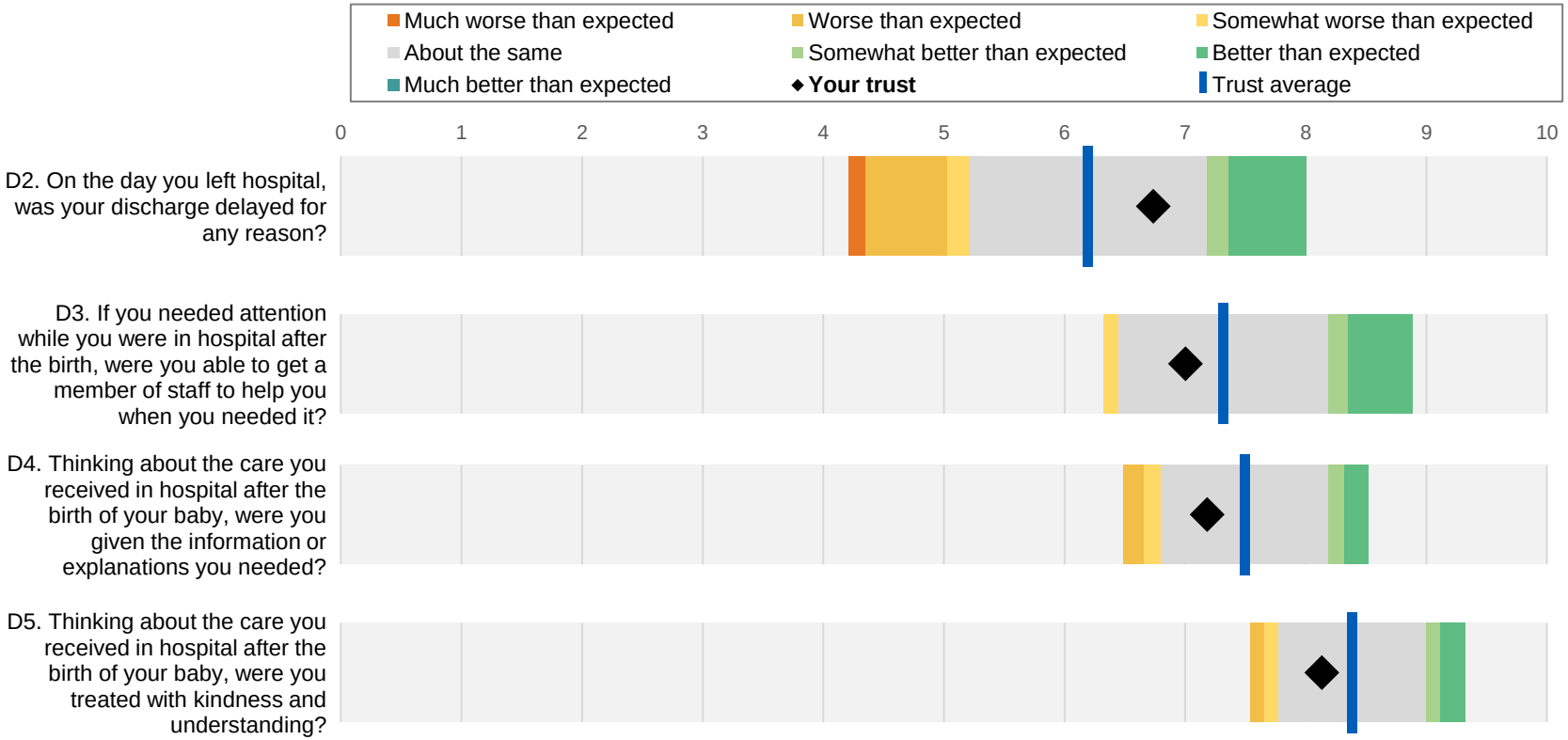
			All trusts in England		
	Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
C16. Thinking about your care during labour and birth, were you involved in decisions about your care?	111	8.4	8.6	7.7	9.4
C17. Thinking about your care during labour and birth, were you treated with respect and dignity?	115	9.0	9.2	8.4	9.7
C18. Did you have confidence and trust in the staff caring for you during your labour and birth?	115	8.6	8.7	7.8	9.5
C19. After your baby was born, did you have the opportunity to ask questions about your labour and the birth?	104	5.8	6.4	4.9	7.6
C20. During your labour and birth, did your midwives or doctor appear to be aware of your medical history?	104	6.9	7.6	6.3	8.6
C21. Thinking about your care during labour and birth, were you treated with kindness and compassion?	115	8.8	9.0	8.3	9.5

About the same
About the same
About the same
About the same
Somewhat worse
About the same

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

Benchmarking - Labour and birth (continued)

Question scores: Care in the ward after birth



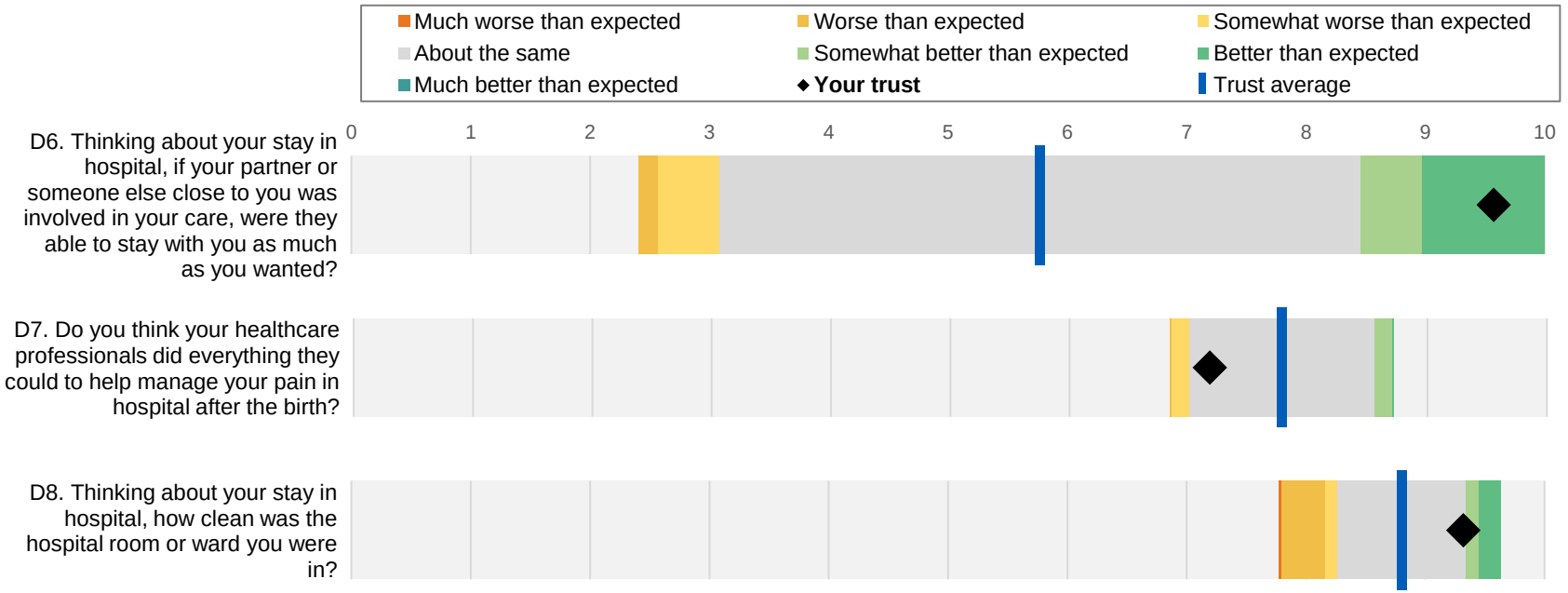
			All trusts in England		
	Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
D2. On the day you left hospital, was your discharge delayed for any reason?	114	6.7	6.2	4.2	8.0
D3. If you needed attention while you were in hospital after the birth, were you able to get a member of staff to help you when you needed it?	102	7.0	7.3	6.3	8.9
D4. Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?	113	7.2	7.5	6.5	8.5
D5. Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?	114	8.1	8.4	7.5	9.3

About the same

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

Benchmarking - Labour and birth (continued)

Question scores: Care in the ward after birth



		All trusts in England		
Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
106	9.6	5.8	2.4	10.0
111	7.2	7.8	6.8	8.7
114	9.3	8.8	7.8	9.6

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

Benchmarking

Postnatal care

NHS

Care Quality Commission

Ipsos

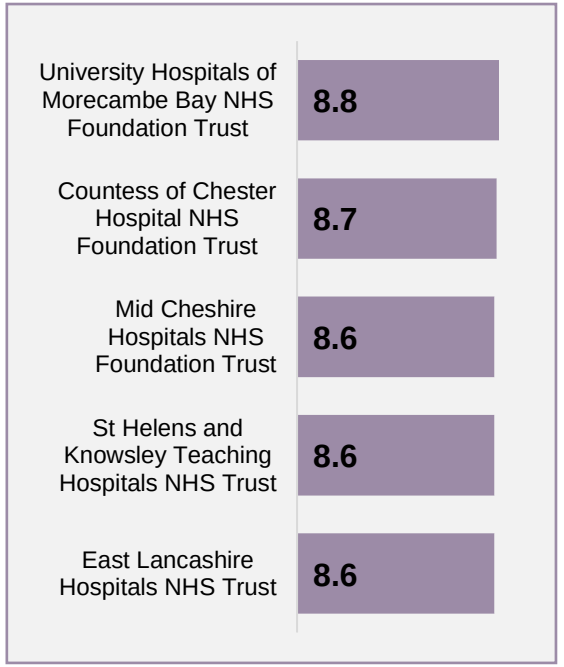
Feeding your baby

Section score

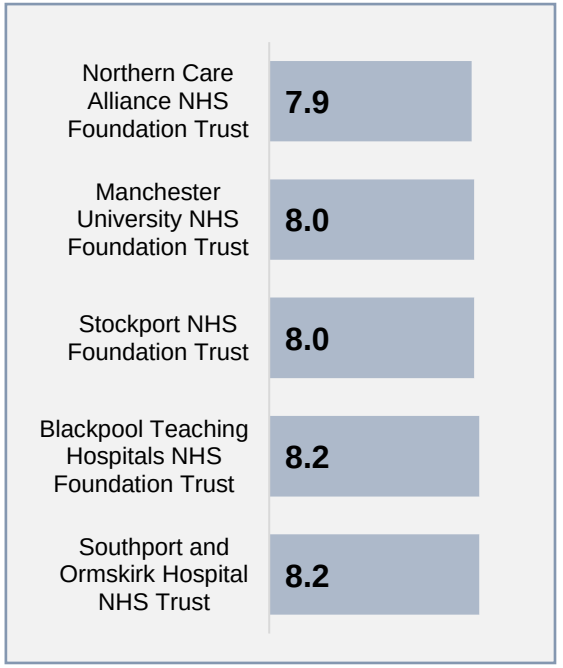
This shows the range of section scores for all NHS trusts included in the survey that submitted attribution data for postnatal care received. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'feeding your baby' is calculated from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

Comparison with other trusts within your region

Trusts with the highest scores



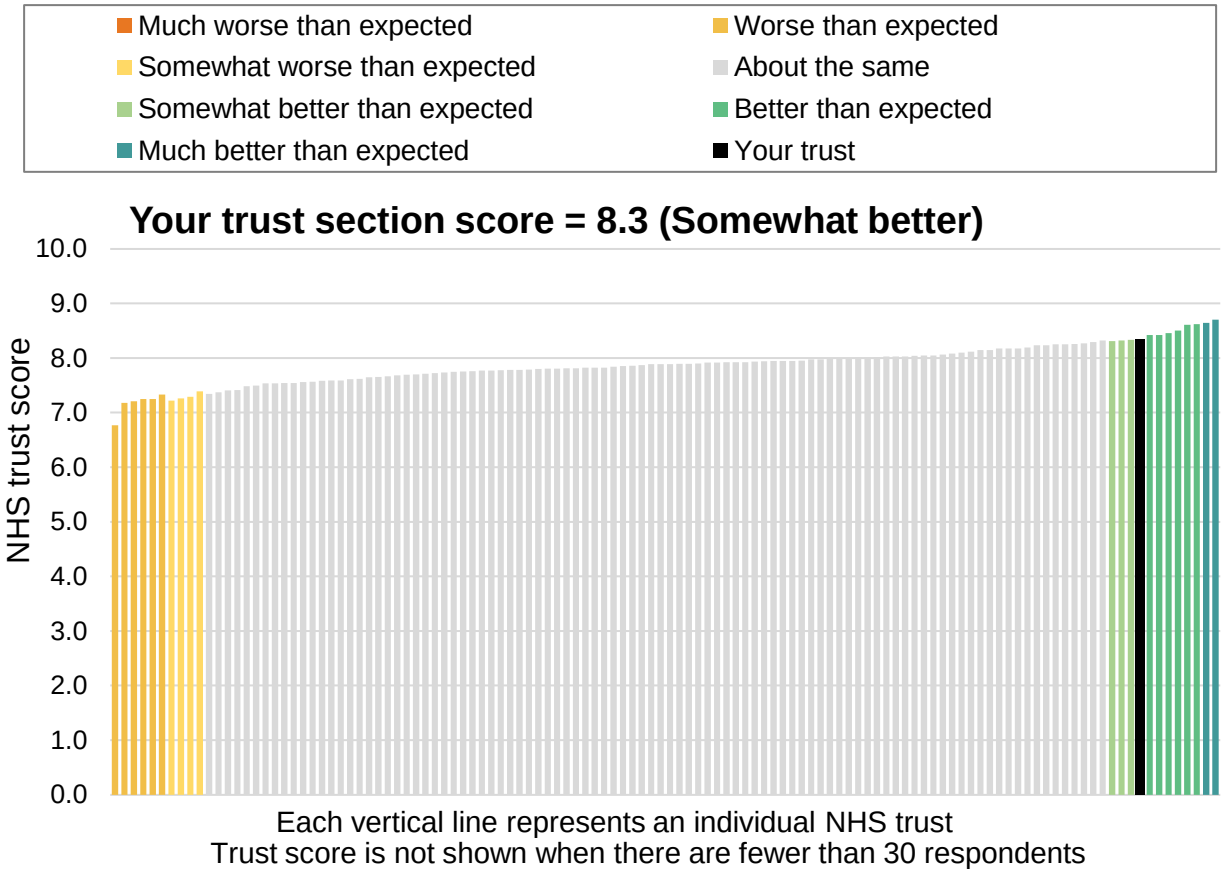
Trusts with the lowest scores



Care at home after birth

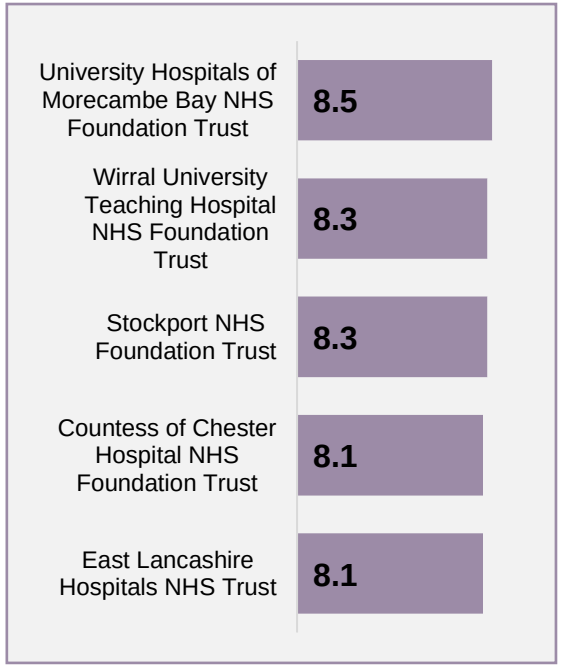
Section score

This shows the range of section scores for all NHS trusts included in the survey that submitted attribution data for postnatal care received. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'care at home after birth' is calculated from questions F1 and F2, F5 to F9 and F11 to F17. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. The 'expected range' analysis technique takes into account the number of respondents for each trust, and the scores for all trusts. As a result, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

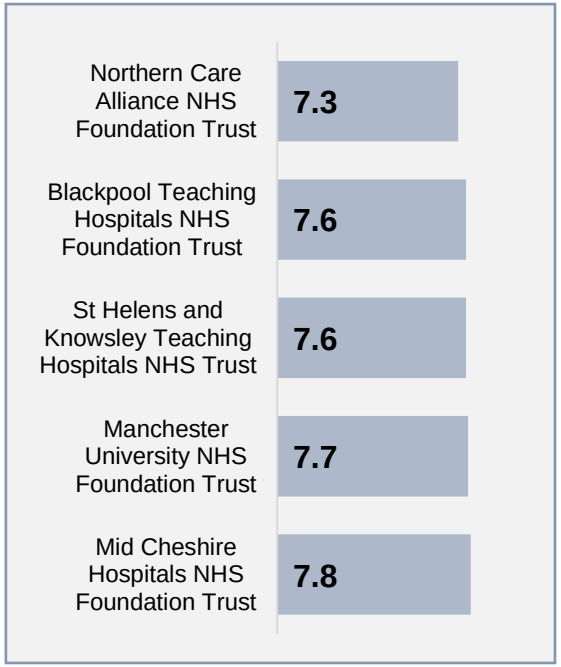


Comparison with other trusts within your region

Trusts with the highest scores

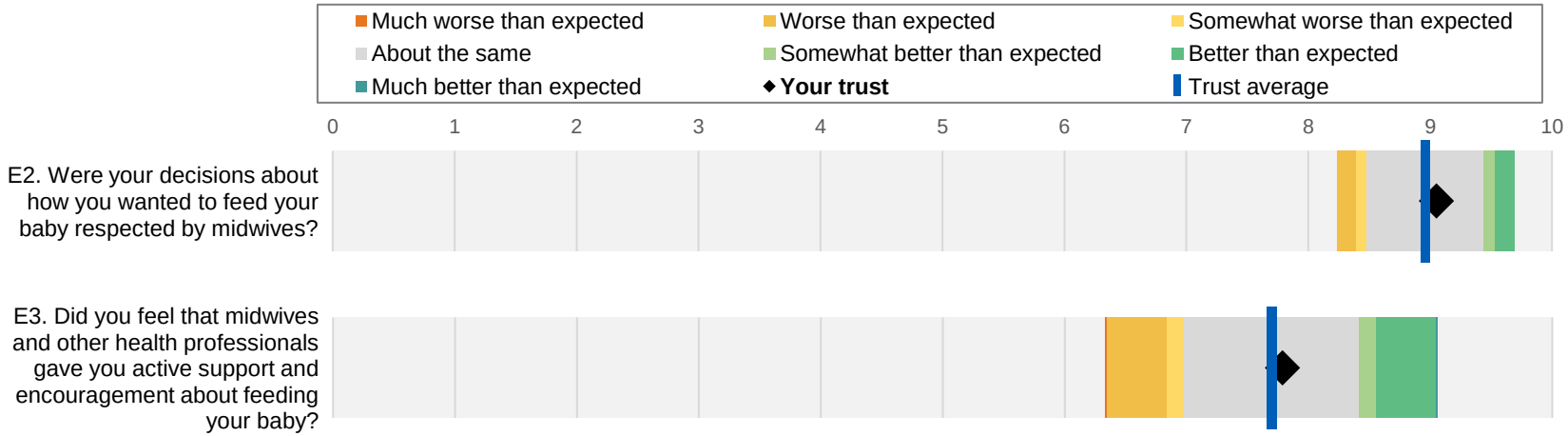


Trusts with the lowest scores



Benchmarking - Postnatal care

Question scores: Feeding your baby

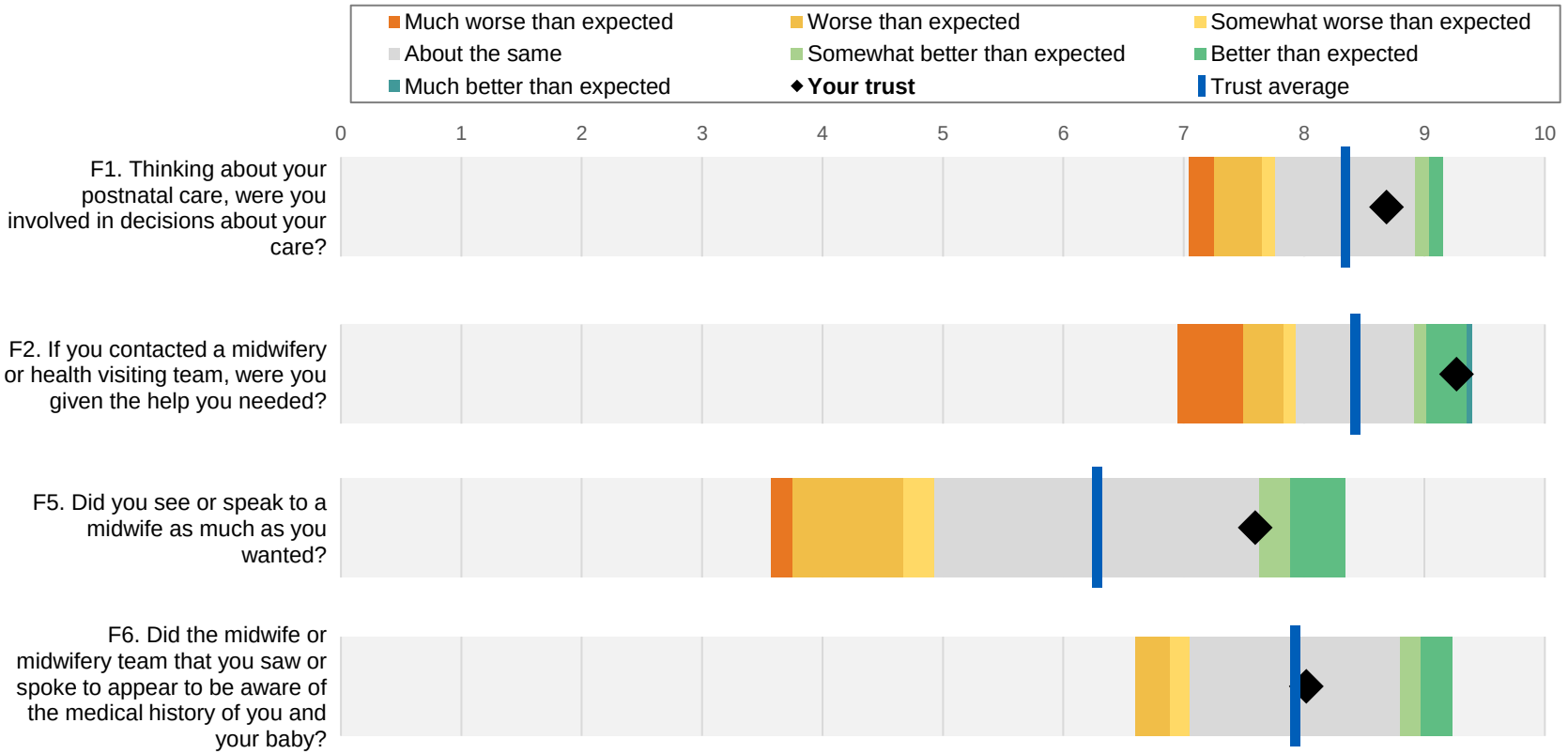


			All trusts in England		
	Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
About the same	97	9.1	9.0	8.2	9.7
About the same	94	7.8	7.7	6.3	9.1

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

Benchmarking - Postnatal care (continued)

Question scores: Care at home after birth

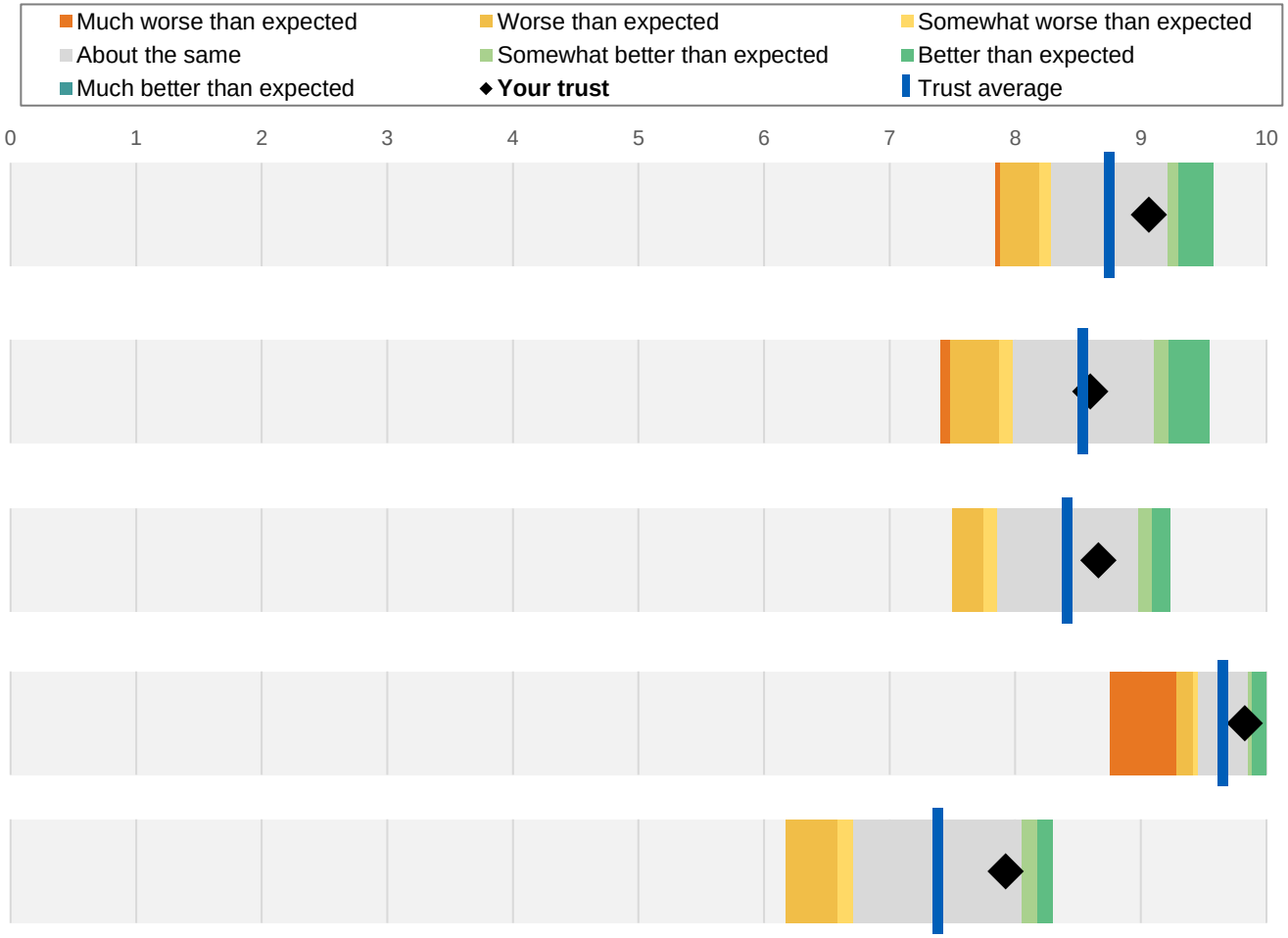


			All trusts in England		
	Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
About the same	92	8.7	8.3	7.0	9.1
Better	79	9.3	8.4	6.9	9.4
About the same	97	7.6	6.3	3.6	8.3
About the same	84	8.0	7.9	6.6	9.2

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

Benchmarking - Postnatal care (continued)

Question scores: Care at home after birth



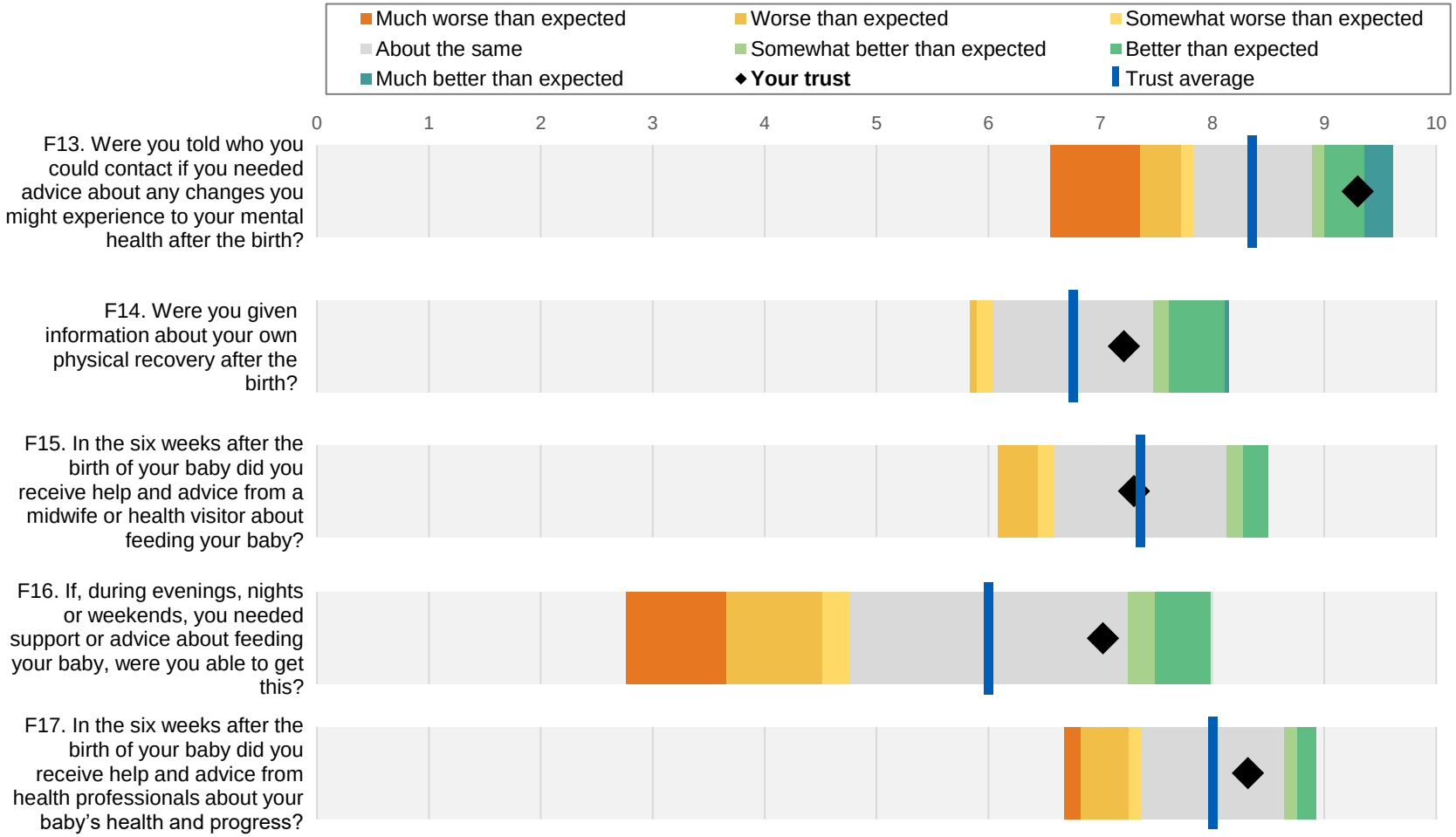
		All trusts in England			
	Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
F7. Did you feel that the midwife or midwifery team that you saw or spoke to always listened to you?	97	9.1	8.7	7.8	9.6
F8. Did the midwife or midwifery team that you saw or spoke to take your personal circumstances into account when giving you advice?	91	8.6	8.5	7.4	9.5
F9. Did you have confidence and trust in the midwife or midwifery team you saw or spoke to after going home?	96	8.7	8.4	7.5	9.2
F11. Did a midwife or health visitor ask you about your mental health?	97	9.8	9.7	8.8	10.0
F12. Were you given information about any changes you might experience to your mental health after having your baby?	95	7.9	7.4	6.2	8.3

About the same

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

Benchmarking - Postnatal care (continued)

Question scores: Care at home after birth



	All trusts in England				
	Number of respondents (your trust)	Your trust score	Trust average score	Lowest score	Highest score
F13. Were you told who you could contact if you needed advice about any changes you might experience to your mental health after the birth?	88	9.3	8.4	6.6	9.6
F14. Were you given information about your own physical recovery after the birth?	96	7.2	6.8	5.8	8.1
F15. In the six weeks after the birth of your baby did you receive help and advice from a midwife or health visitor about feeding your baby?	87	7.3	7.4	6.1	8.5
F16. If, during evenings, nights or weekends, you needed support or advice about feeding your baby, were you able to get this?	39	7.0	6.0	2.8	8.0
F17. In the six weeks after the birth of your baby did you receive help and advice from health professionals about your baby's health and progress?	90	8.3	8.0	6.7	8.9

Better

About the same

About the same

About the same

About the same

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

Trends over time

This section includes:

- your mean trust score for each evaluative question in the survey. This is the average of all scores that maternity service users from your trust provided in their survey response
- where comparable data is available over at least the past five surveys, the trend charts show the mean score for your trust by year. This allows you to see if your trust has made improvements over time
- they also include the national mean score by year, to allow you to see whether your performance is in line with the national average or not
- where consistent data are not available for at least the past five surveys statistical significance testing has been carried out against the 2022 survey results for each relevant question
- for more guidance on interpreting these graphs, please see the next slide

NHS

CareQuality Commission

Ipsos

Trends over time

The following section presents comparisons with previous survey results. Statistically significant differences in the trust mean score between 2022 and 2023 are highlighted to show where there is meaningful change between years.

Historical trend charts are presented when there are at least five data points available to plot on the chart. Five data points may not be available due to:

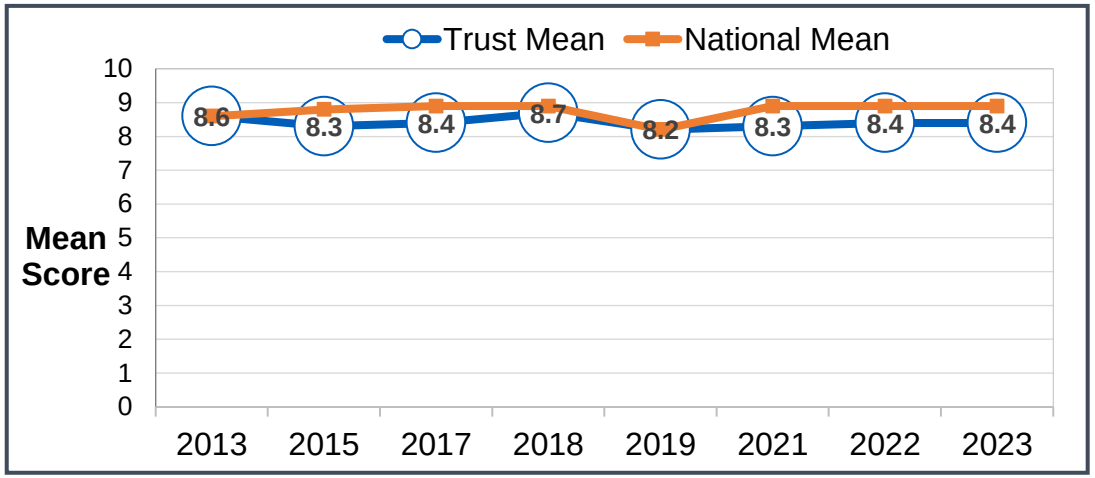
- changes to the questionnaire mean that a question is no longer comparable over time;
- organisational changes which impact comparability of results over time; or,
- historical errors with sampling or issues with fieldwork which impact comparability.

Statistically significant differences in the trust mean score between 2022 and 2023 are highlighted. These are carried out using a two sample t-test. Where a change in results is shown as 'significant', this indicates that this change is not due to random chance, but is likely due to some particular factor at your trust. Significant increases are indicated with a filled green circle, and significant decreases are in red.

Where comparable data is not available, statistical significance test tables are provided. Statistically significant changes in your trust score between 2022 and 2023 are shown in the far right column 'Change from 2022 survey', significant increases are indicated with a green arrow and significant decreases are indicated with a red arrow.

The following questions were new or changed for 2023 and therefore are not included in this section: B18, C4, C8, C21 and D7.

Historical trend chart example



Significance test table example

		2023 Trust Score	2022 Trust Score	No. of respondents	Change from 2022 survey
The start of your care in pregnancy					
B4.	Did you get enough information from either a midwife or doctor to help you decide where to have your baby?	4.3	7.1	178	▼

Trends over time

Antenatal care

Trends over time - Antenatal care

There are some questions in this section where data is not comparable prior to 2022. The following table displays changes since 2022, and whether those changes are statistically significant.

Much worse than expected	Worse than expected	Somewhat worse than expected	About the same	Somewhat better than expected	Better than expected	Much better than expected

		2023 Trust Score	2022 Trust Score	No. of respondents in 2023	Change from 2022 survey
The start of your care in pregnancy					
B3.	Were you offered a choice about where to have your baby?	3.7	3.5	99	
B4.	Did you get enough information from either a midwife or doctor to help you decide where to have your baby?	6.7	6.3	105	
B7.	During your antenatal check-ups, did your midwives or doctor appear to be aware of your medical history?	6.5	6.0	106	

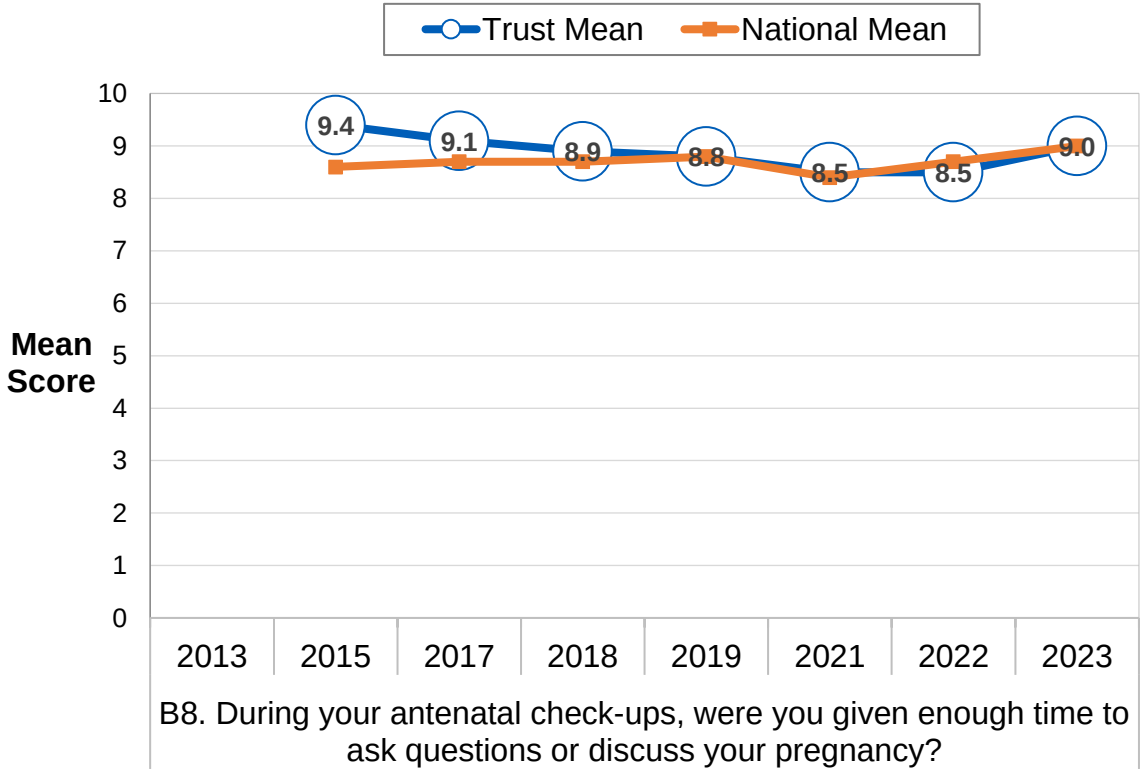
▼▲ Significant difference between 2023 and 2022

Blank No Significant difference between 2023 and 2022

Trends over time - Antenatal care (continued)

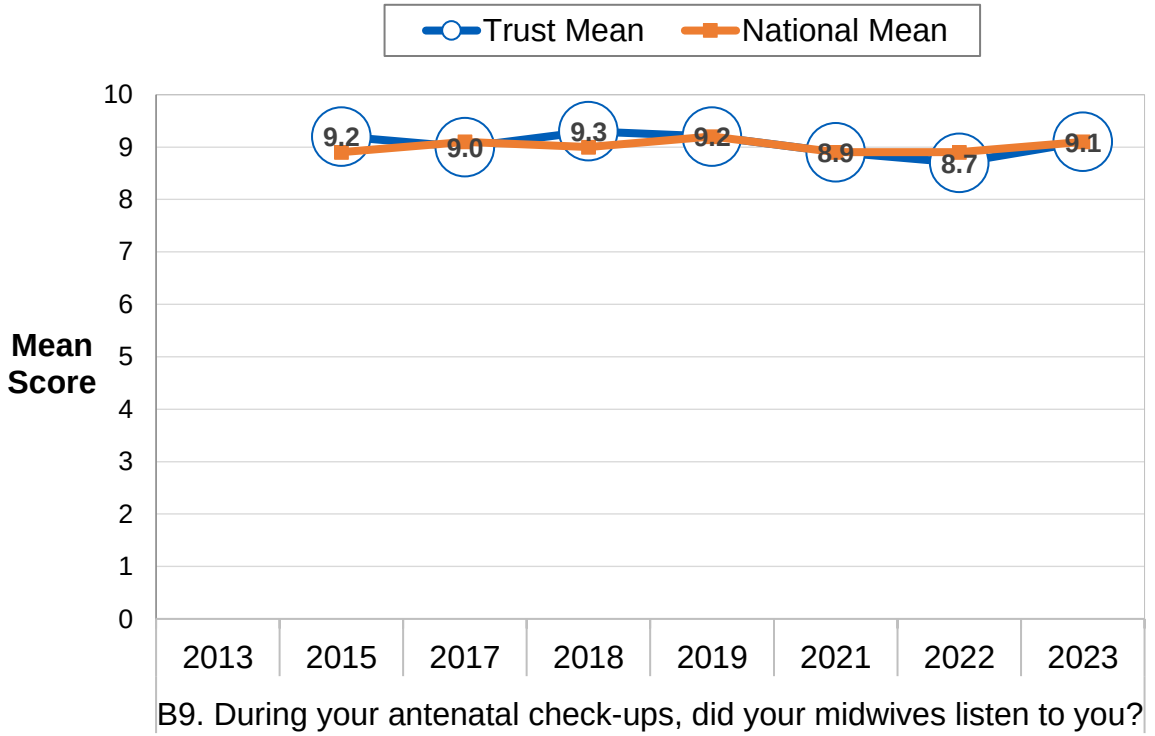
The following charts show how results have changed over time for questions where there are 5 years or more of comparable data.

Antenatal check-ups



B8. During your antenatal check-ups, were you given enough time to ask questions or discuss your pregnancy?

Please note: *no data available for some years*



B9. During your antenatal check-ups, did your midwives listen to you?

Please note: *no data available for some years*

This shows a significant increase in the trust mean for this question for 2023 compared to 2022

This shows a significant decrease in the trust mean for this question for 2023 compared to 2022

Trends over time - Antenatal care (continued)

There are some questions in this section where data is not comparable prior to 2022. The following table displays changes since 2022, and whether those changes are statistically significant.

Much worse than expected	Worse than expected	Somewhat worse than expected	About the same	Somewhat better than expected	Better than expected	Much better than expected

		2023 Trust Score	2022 Trust Score	No. of respondents in 2023	Change from 2022 survey
Antenatal check-ups					
B10.	During your antenatal check-ups, did your midwives ask you about your mental health?	8.7	7.0	111	▲

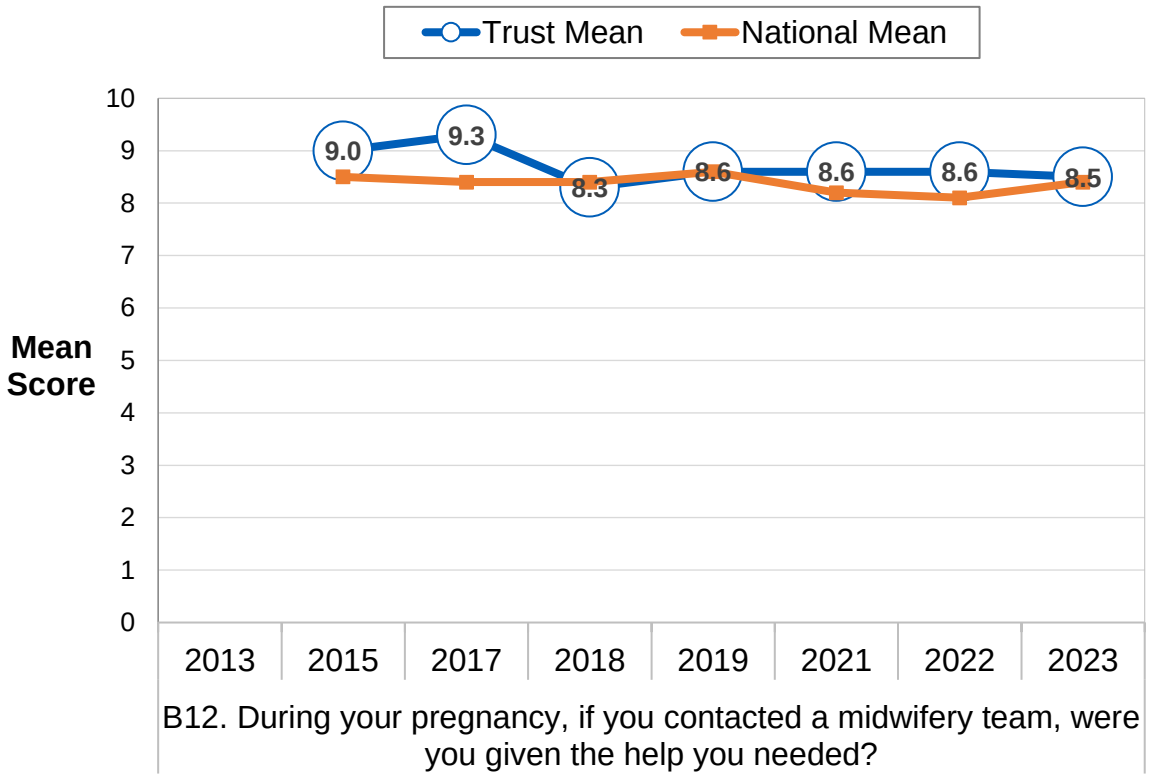
▼▲ Significant difference between 2023 and 2022

Blank No Significant difference between 2023 and 2022

Trends over time - Antenatal care (continued)

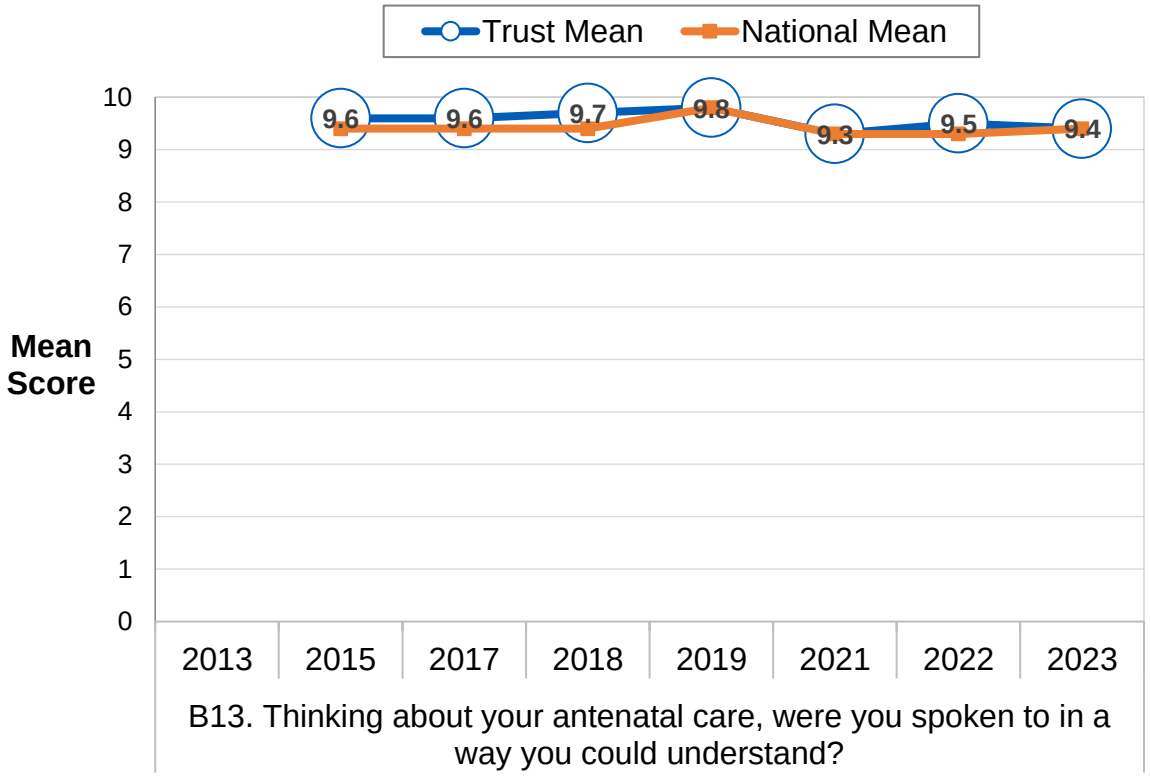
The following charts show how results have changed over time for questions where there are 5 years or more of comparable data.

During your pregnancy



B12. During your pregnancy, if you contacted a midwifery team, were you given the help you needed?

Please note: *no data available for some years*



B13. Thinking about your antenatal care, were you spoken to in a way you could understand?

Please note: *no data available for some years*

This shows a significant increase in the trust mean for this question for 2023 compared to 2022

This shows a significant decrease in the trust mean for this question for 2023 compared to 2022

Trends over time - Antenatal care (continued)

There are some questions in this section where data is not comparable prior to 2022. The following table displays changes since 2022, and whether those changes are statistically significant.

Much worse than expected	Worse than expected	Somewhat worse than expected	About the same	Somewhat better than expected	Better than expected	Much better than expected

		2023 Trust Score	2022 Trust Score	No. of respondents in 2023	Change from 2022 survey
During your pregnancy					
B11.	Were you given enough support for your mental health during your pregnancy?	8.8	7.5	74	▲
B14.	Thinking about your antenatal care, were you involved in decisions about your care?	9.1	8.7	109	
B15.	During your pregnancy did midwives provide relevant information about feeding your baby?	6.6	6.0	110	
B16.	Did you have confidence and trust in the staff caring for you during your antenatal care?	8.6	8.2	112	
B17.	Thinking about your antenatal care, were you treated with respect and dignity?	9.3	8.9	112	

▼▲ Significant difference between 2023 and 2022

Blank No Significant difference between 2023 and 2022

Trends over time

Labour and birth

Trends over time - Labour and birth

There are some questions in this section where data is not comparable prior to 2022. The following table displays changes since 2022, and whether those changes are statistically significant.

Much worse than expected	Worse than expected	Somewhat worse than expected	About the same	Somewhat better than expected	Better than expected	Much better than expected		2023 Trust Score	2022 Trust Score	No. of respondents in 2023	Change from 2022 survey
Your labour and birth											
C5.	And before you were induced, were you given appropriate information and advice on the risks associated with an induced labour?							6.9	5.9	42	
C6.	Were you involved in the decision to be induced?							8.1	7.7	42	

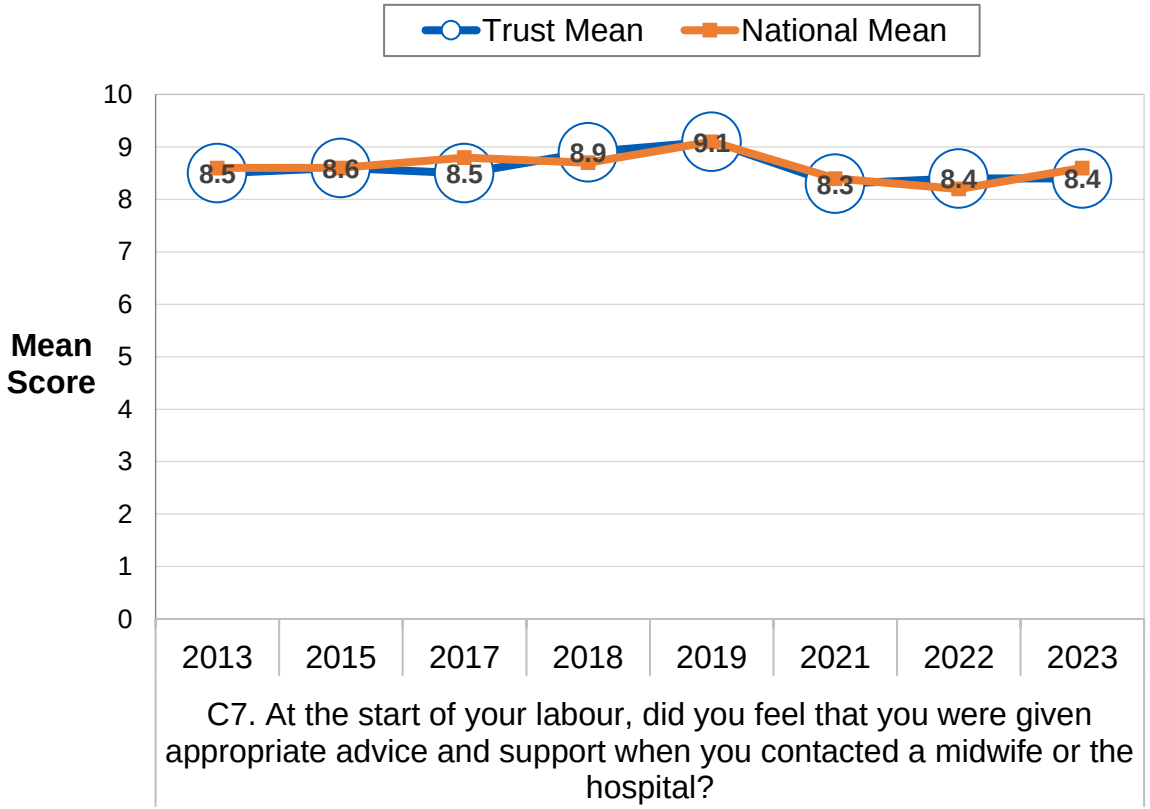
▼▲ Significant difference between 2023 and 2022

Blank No Significant difference between 2023 and 2022

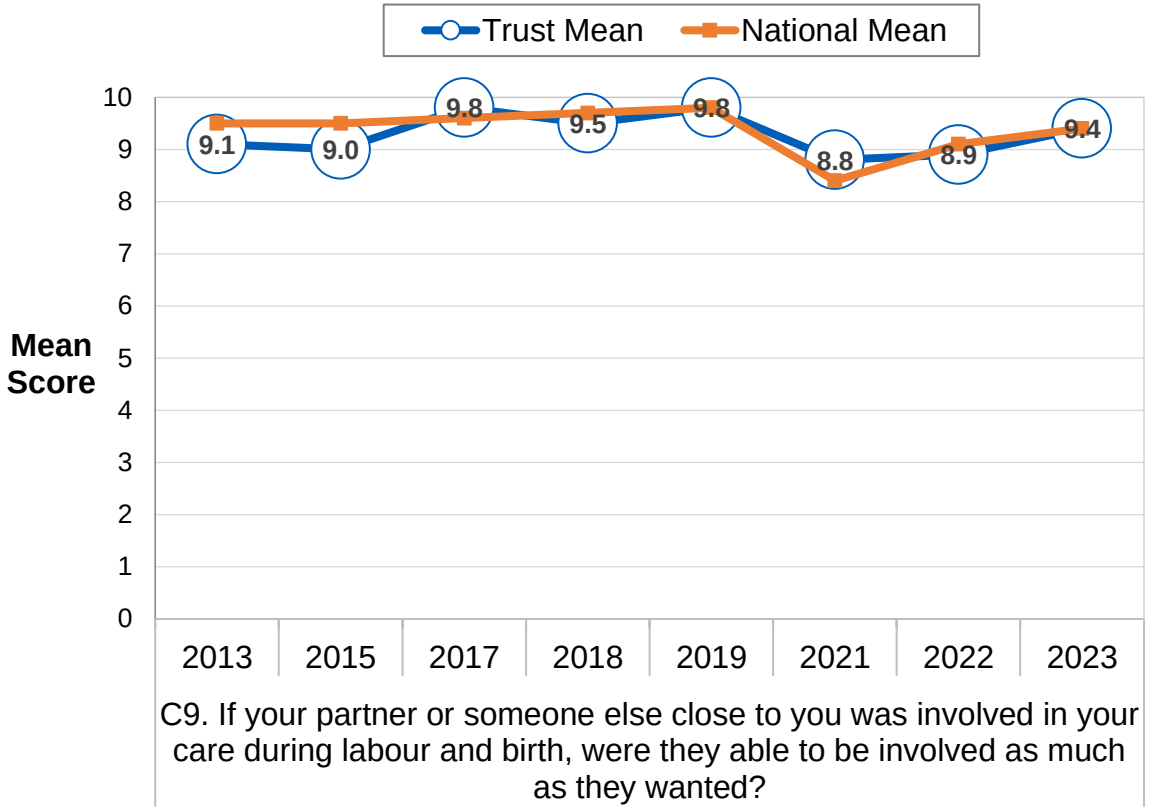
Trends over time - Labour and birth (continued)

The following charts show how results have changed over time for questions where there are 5 years or more of comparable data.

Your labour and birth



C7. At the start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?



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

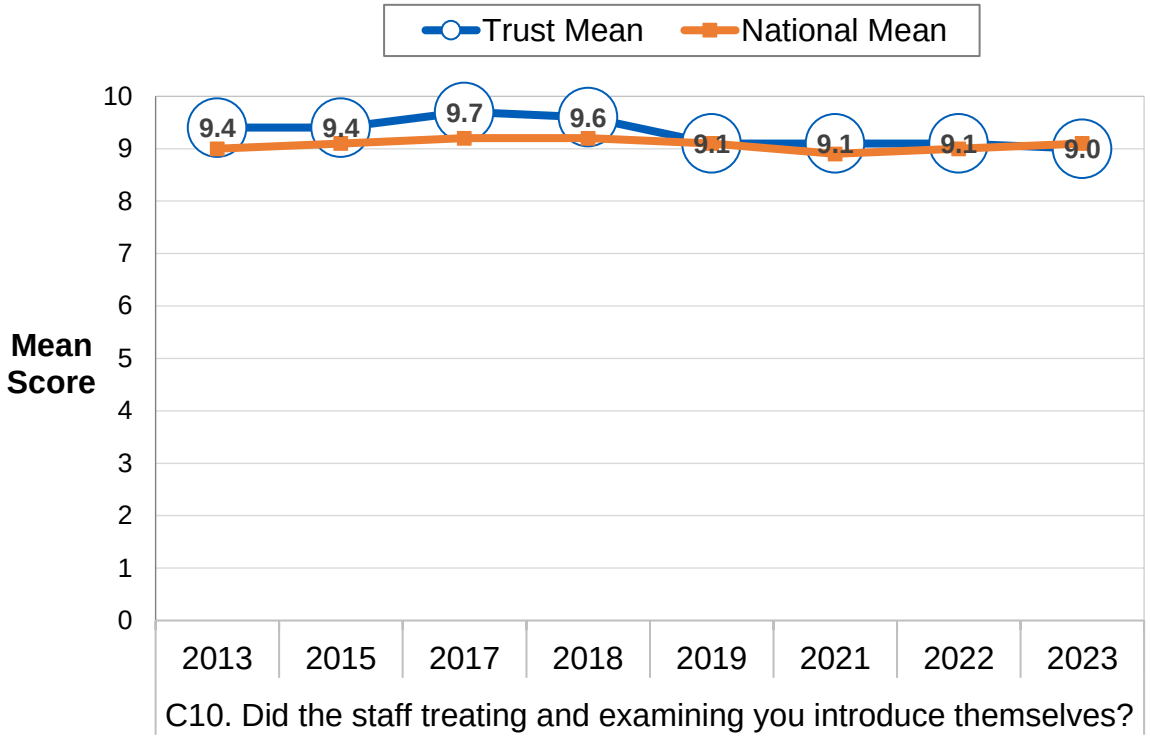
This shows a significant increase in the trust mean for this question for 2023 compared to 2022

This shows a significant decrease in the trust mean for this question for 2023 compared to 2022

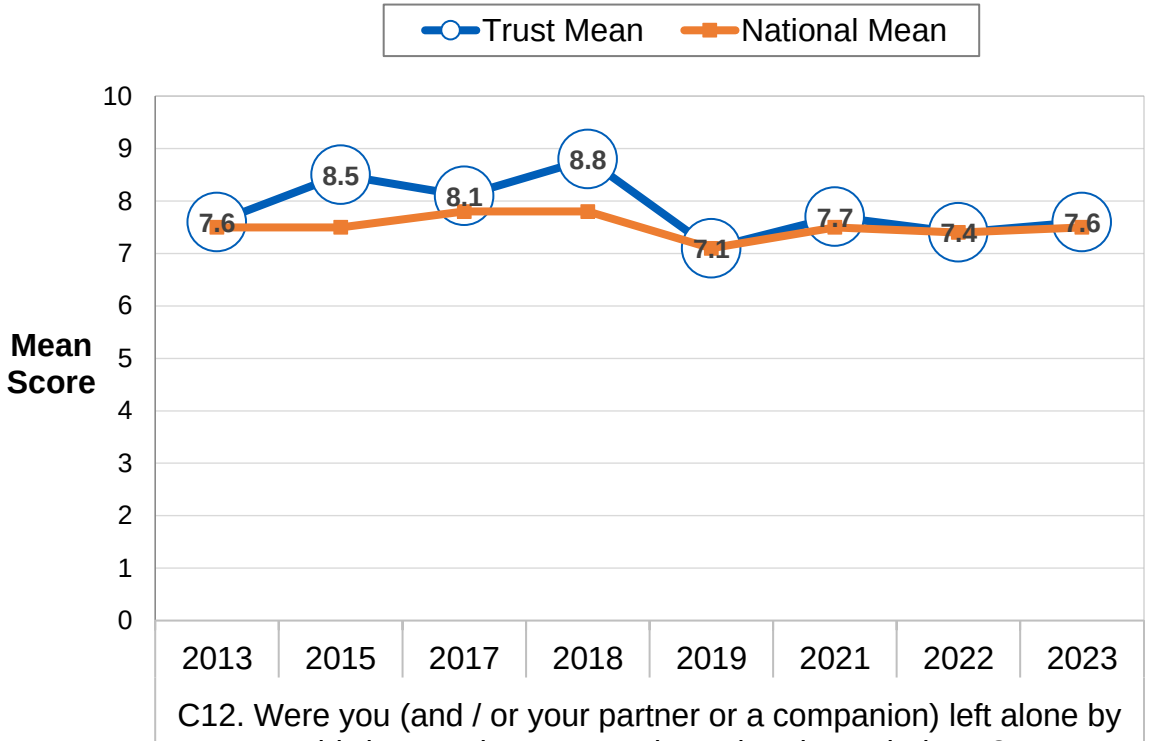
Trends over time - Labour and birth (continued)

The following charts show how results have changed over time for questions where there are 5 years or more of comparable data.

Staff caring for you



C10. Did the staff treating and examining you introduce themselves?



C12. Were you (and / or your partner or a companion) left alone by midwives or doctors at a time when it worried you?

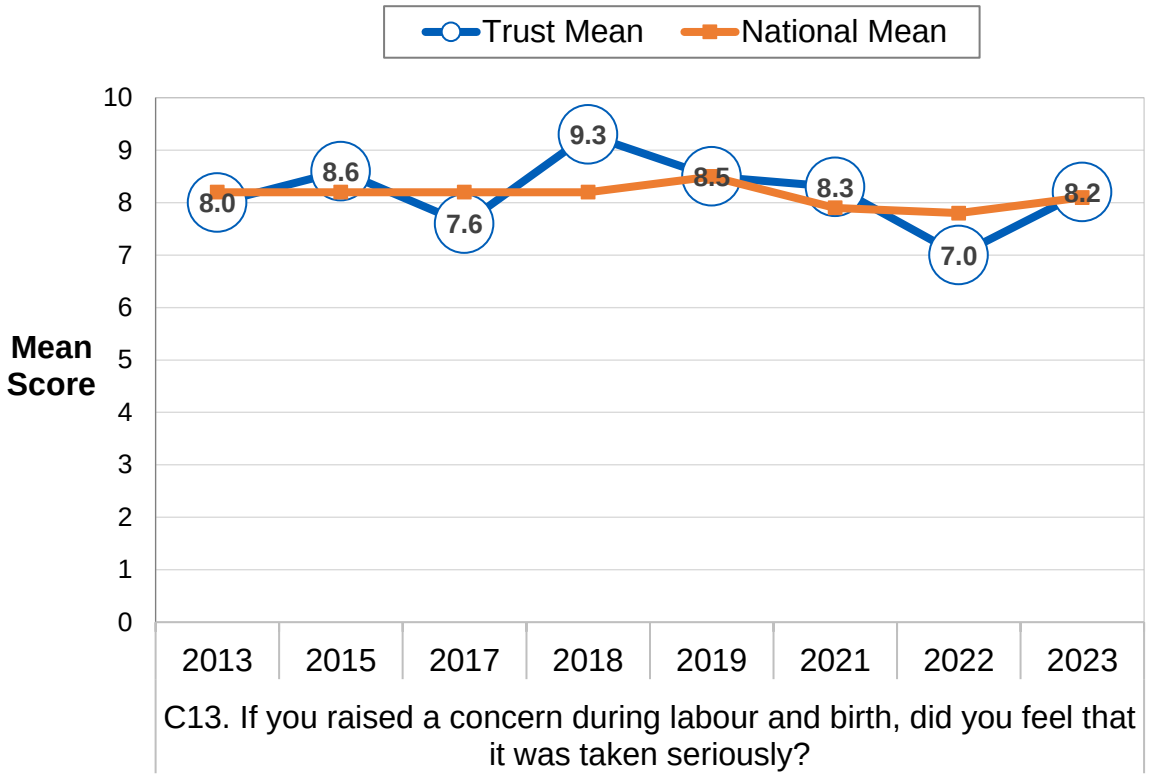
This shows a significant increase in the trust mean for this question for 2023 compared to 2022

This shows a significant decrease in the trust mean for this question for 2023 compared to 2022

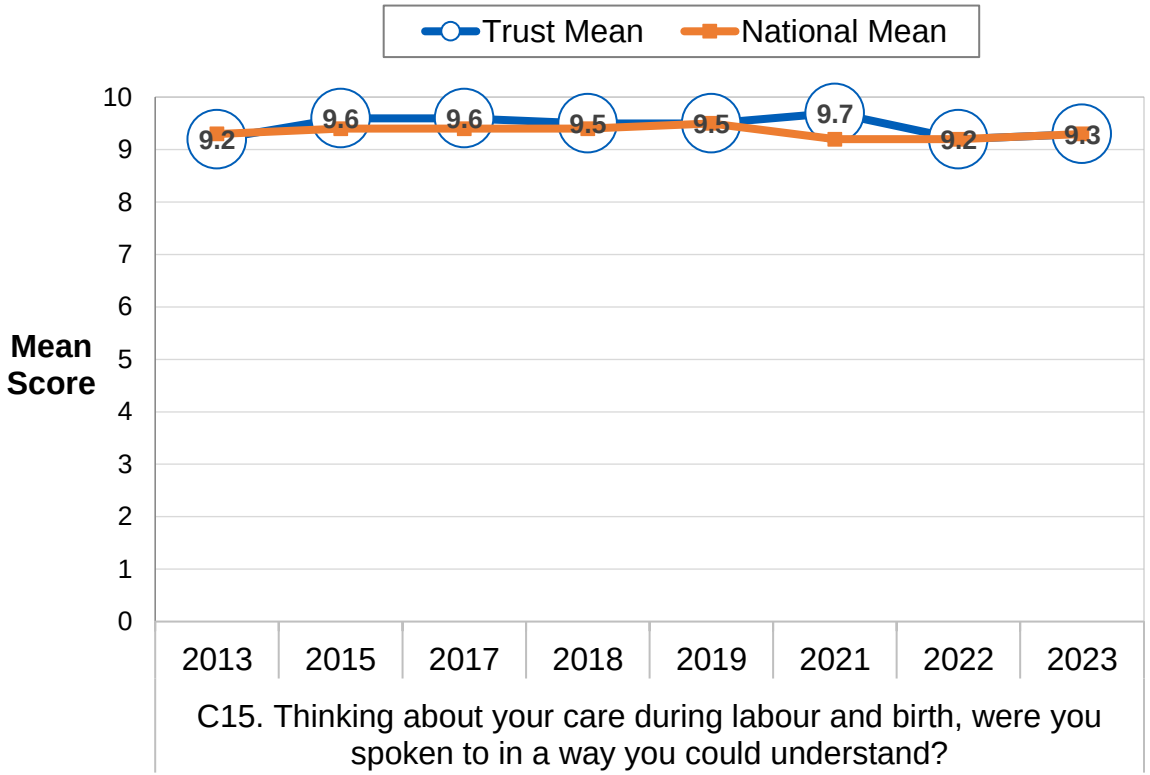
Trends over time - Labour and birth (continued)

The following charts show how results have changed over time for questions where there are 5 years or more of comparable data.

Staff caring for you



C13. If you raised a concern during labour and birth, did you feel that it was taken seriously?



C15. Thinking about your care during labour and birth, were you spoken to in a way you could understand?

This shows a significant increase in the trust mean for this question for 2023 compared to 2022

This shows a significant decrease in the trust mean for this question for 2023 compared to 2022

Trends over time - Labour and birth (continued)

There are some questions in this section where data is not comparable prior to 2022. The following table displays changes since 2022, and whether those changes are statistically significant.

Much worse than expected	Worse than expected	Somewhat worse than expected	About the same	Somewhat better than expected	Better than expected	Much better than expected

		2023 Trust Score	2022 Trust Score	No. of respondents in 2023	Change from 2022 survey
Staff caring for you					
C14.	During labour and birth, were you able to get a member of staff to help you when you needed it?	8.9	8.5	111	
C16.	Thinking about your care during labour and birth, were you involved in decisions about your care?	8.4	8.4	111	

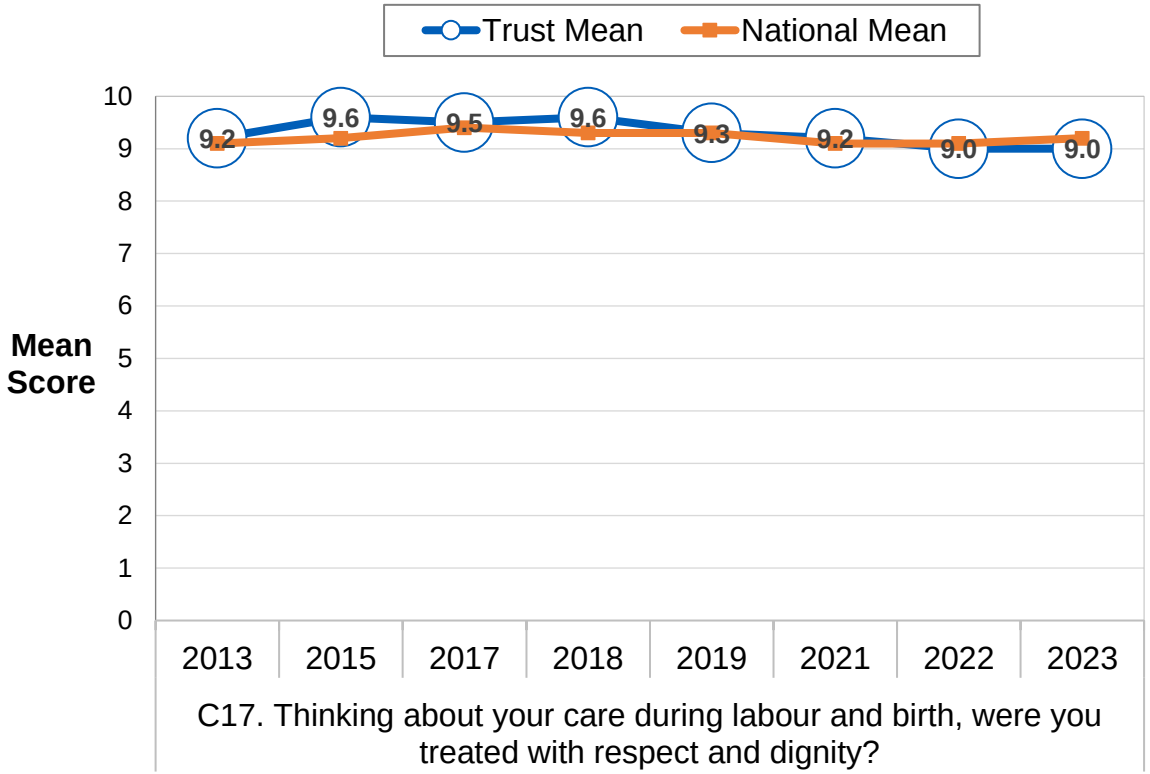
▼▲ Significant difference between 2023 and 2022

Blank No Significant difference between 2023 and 2022

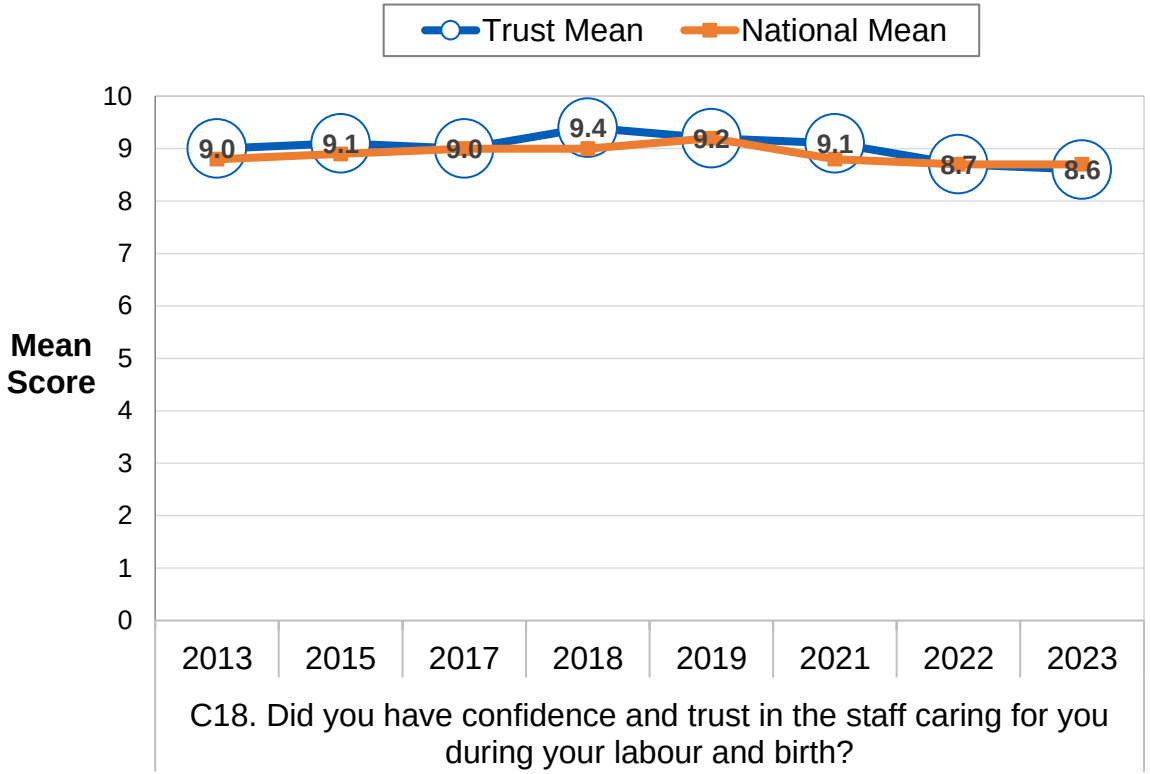
Trends over time - Labour and birth (continued)

The following charts show how results have changed over time for questions where there are 5 years or more of comparable data.

Staff caring for you



C17. Thinking about your care during labour and birth, were you treated with respect and dignity?



C18. Did you have confidence and trust in the staff caring for you during your labour and birth?

This shows a significant increase in the trust mean for this question for 2023 compared to 2022

This shows a significant decrease in the trust mean for this question for 2023 compared to 2022

Trends over time - Labour and birth (continued)

There are some questions in this section where data is not comparable prior to 2022. The following table displays changes since 2022, and whether those changes are statistically significant.

Much worse than expected	Worse than expected	Somewhat worse than expected	About the same	Somewhat better than expected	Better than expected	Much better than expected		2023 Trust Score	2022 Trust Score	No. of respondents in 2023	Change from 2022 survey
Staff caring for you											
C19.	After your baby was born, did you have the opportunity to ask questions about your labour and the birth?							5.8	6.6	104	
C20.	During your labour and birth, did your midwives or doctor appear to be aware of your medical history?							6.9	7.4	104	

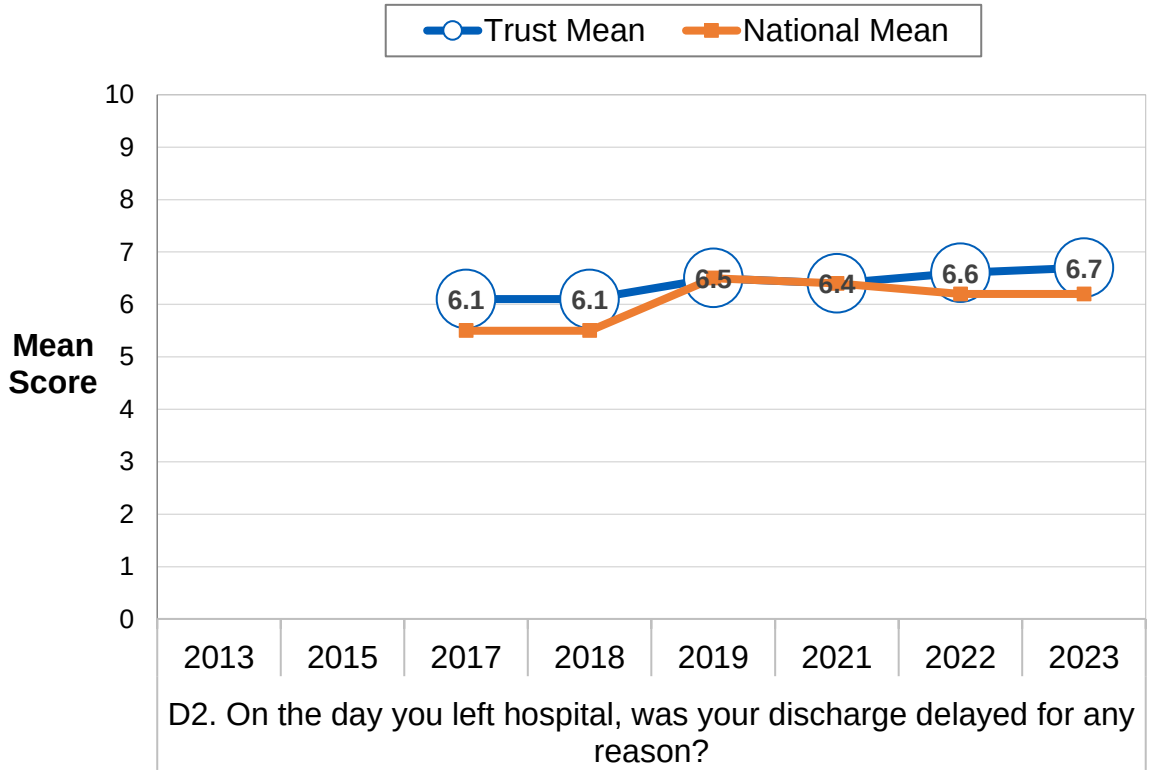
▼▲ Significant difference between 2023 and 2022

Blank No Significant difference between 2023 and 2022

Trends over time - Labour and birth (continued)

The following charts show how results have changed over time for questions where there are 5 years or more of comparable data.

Care in the ward after birth



Please note: *no data available for some years*

This shows a significant increase in the trust mean for this question for 2023 compared to 2022

This shows a significant decrease in the trust mean for this question for 2023 compared to 2022

Trends over time - Labour and birth (continued)

There are some questions in this section where data is not comparable prior to 2022. The following table displays changes since 2022, and whether those changes are statistically significant.

Much worse than expected	Worse than expected	Somewhat worse than expected	About the same	Somewhat better than expected	Better than expected	Much better than expected	2023 Trust Score	2022 Trust Score	No. of respondents in 2023	Change from 2022 survey
Care in the ward after birth										
D3. If you needed attention while you were in hospital after the birth, were you able to get a member of staff to help you when you needed it?							7.0	6.8	102	

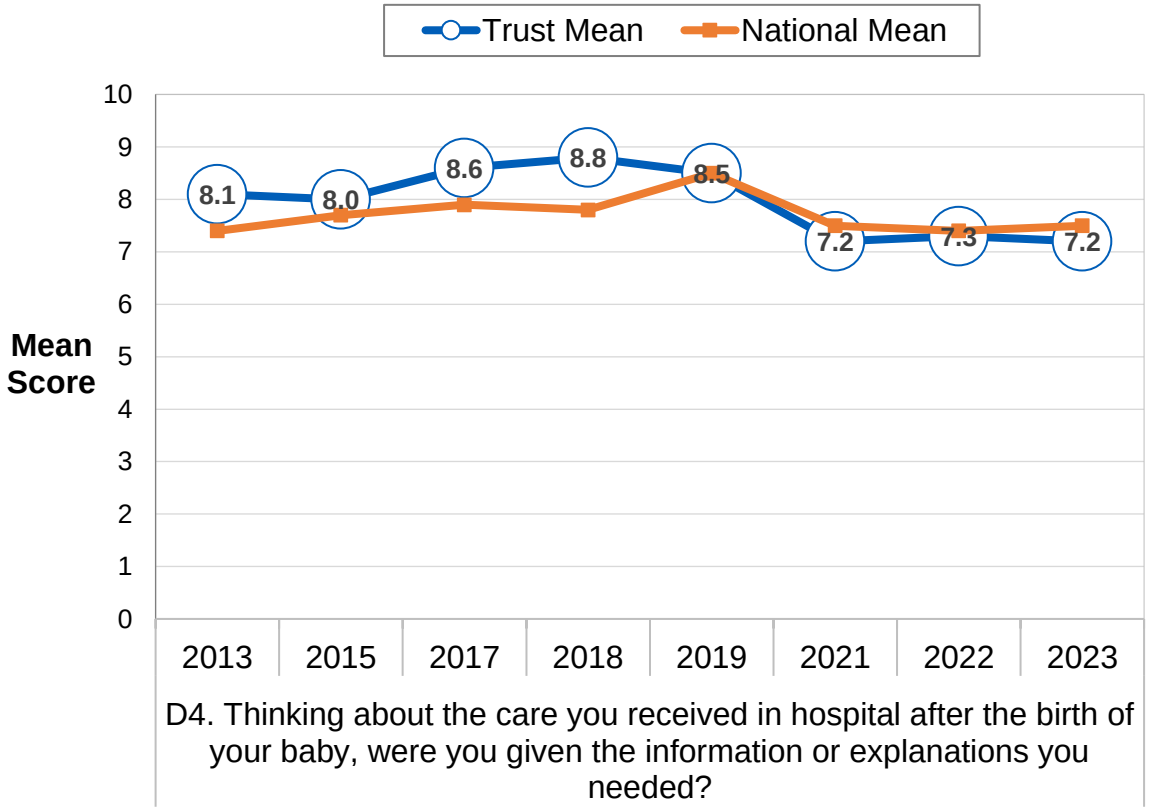
▼▲ Significant difference between 2023 and 2022

Blank No Significant difference between 2023 and 2022

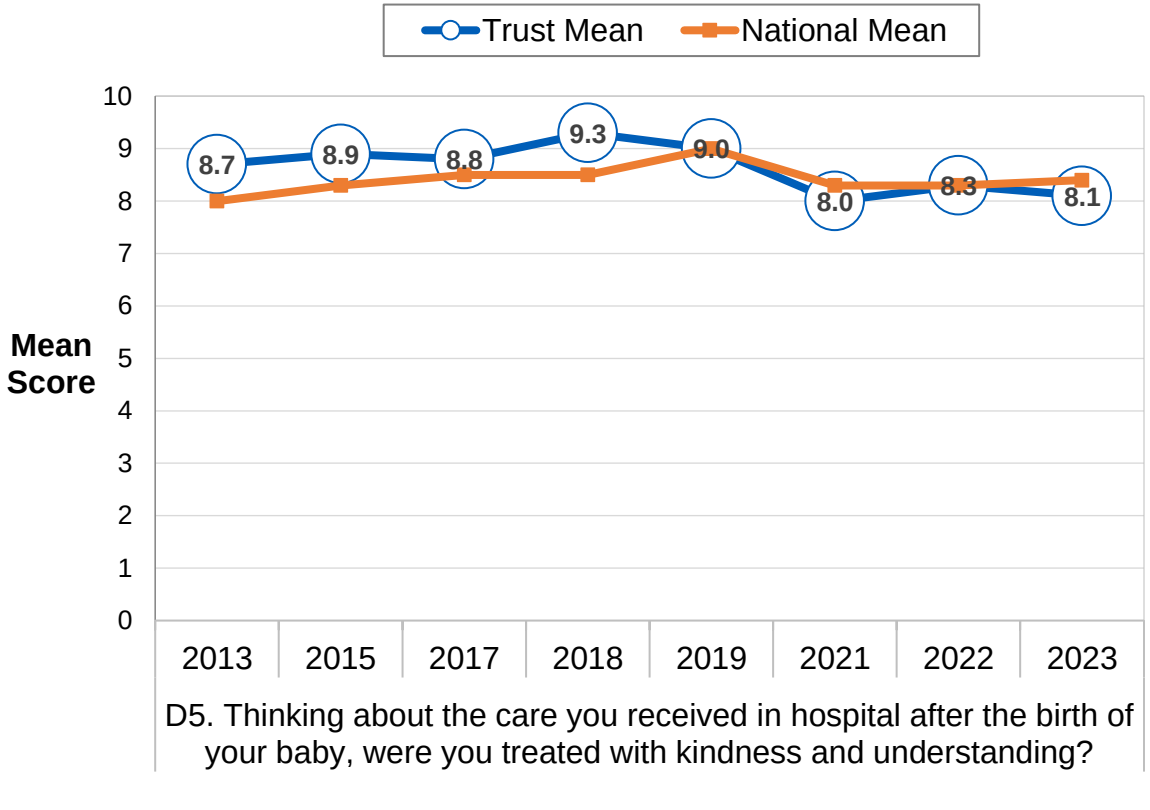
Trends over time - Labour and birth (continued)

The following charts show how results have changed over time for questions where there are 5 years or more of comparable data.

Care in the ward after birth



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



D5. Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?

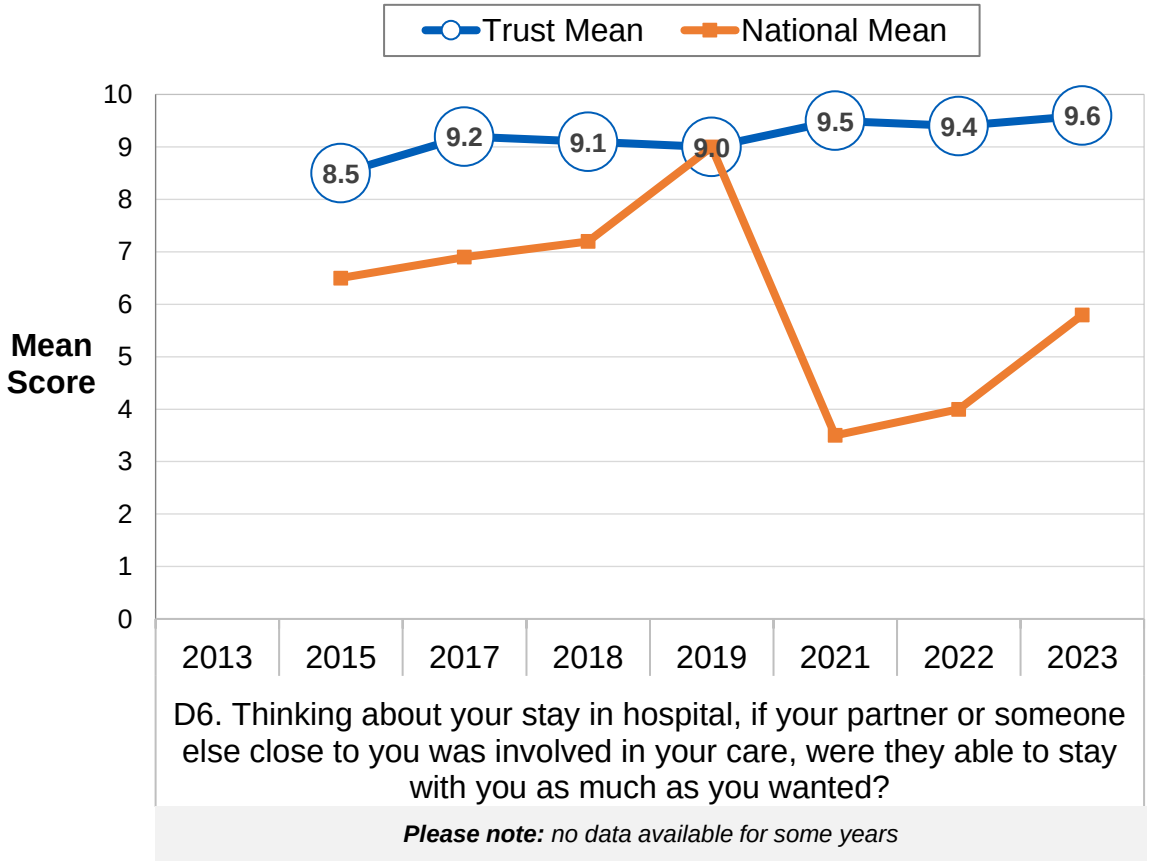
This shows a significant increase in the trust mean for this question for 2023 compared to 2022

This shows a significant decrease in the trust mean for this question for 2023 compared to 2022

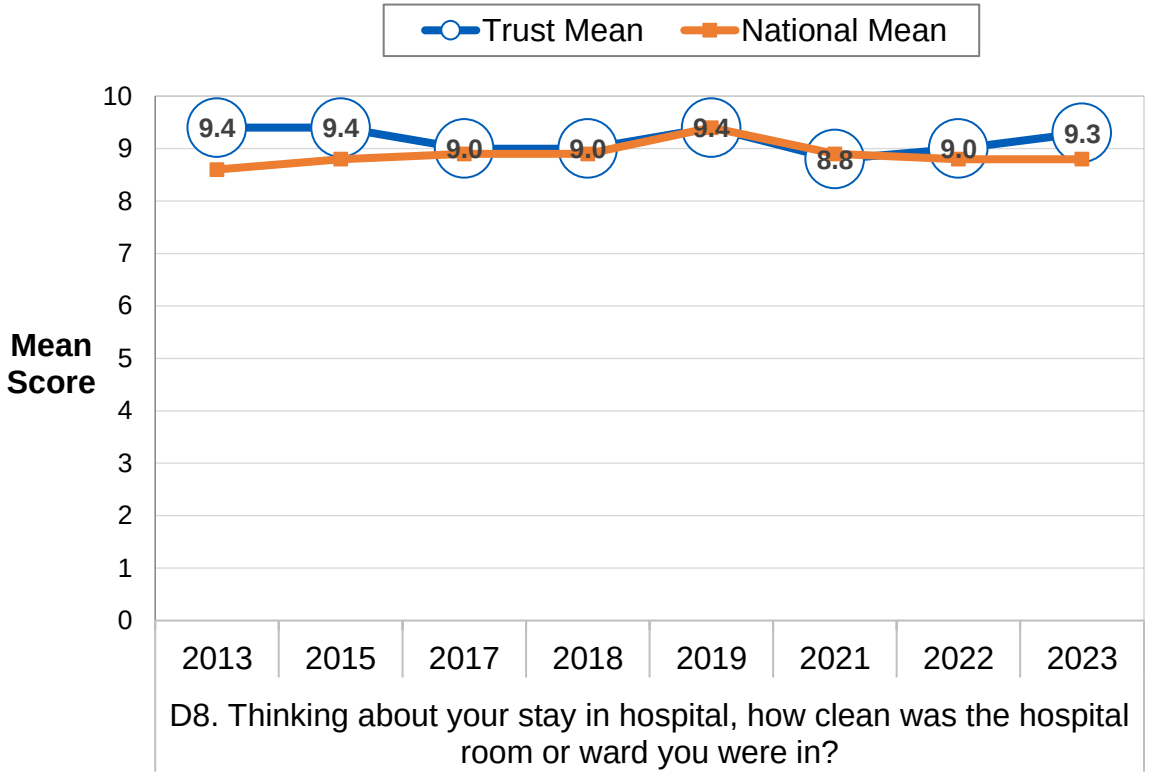
Trends over time - Labour and birth (continued)

The following charts show how results have changed over time for questions where there are 5 years or more of comparable data.

Care in the ward after birth



D6. Thinking about your stay in hospital, if your partner or someone else close to you was involved in your care, were they able to stay with you as much as you wanted?



D8. Thinking about your stay in hospital, how clean was the hospital room or ward you were in?

Please note: *no data available for some years*

This shows a significant increase in the trust mean for this question for 2023 compared to 2022

This shows a significant decrease in the trust mean for this question for 2023 compared to 2022

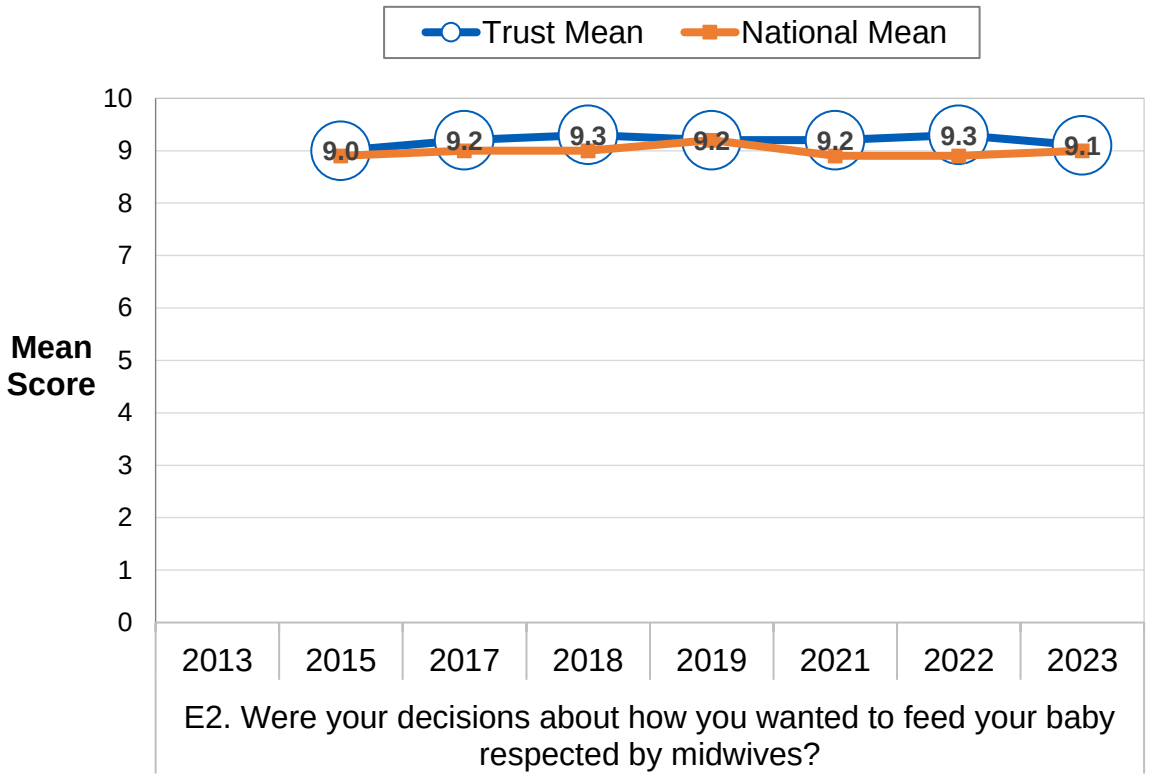
Trends over time

Postnatal care

Trends over time - Postnatal care

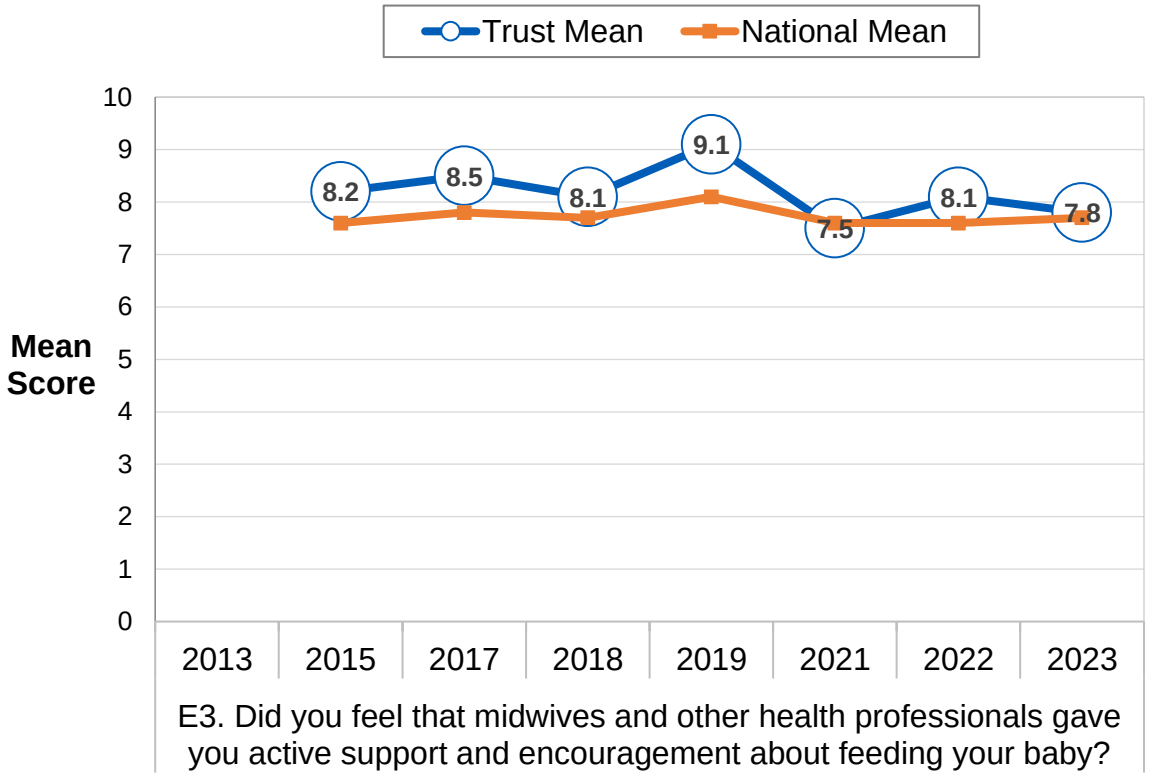
The following charts show how results have changed over time for questions where there are 5 years or more of comparable data.

Feeding your baby



E2. Were your decisions about how you wanted to feed your baby respected by midwives?

Please note: *no data available for some years*



E3. Did you feel that midwives and other health professionals gave you active support and encouragement about feeding your baby?

Please note: *no data available for some years*

This shows a significant increase in the trust mean for this question for 2023 compared to 2022

This shows a significant decrease in the trust mean for this question for 2023 compared to 2022

Trends over time - Postnatal care (continued)

There are some questions in this section where data is not comparable prior to 2022. The following table displays changes since 2022, and whether those changes are statistically significant.

Much worse than expected	Worse than expected	Somewhat worse than expected	About the same	Somewhat better than expected	Better than expected	Much better than expected	2023 Trust Score	2022 Trust Score	No. of respondents in 2023	Change from 2022 survey
Care at home after the birth										
F1.	Thinking about your postnatal care, were you involved in decisions about your care?						8.7	8.5	92	
F2.	If you contacted a midwifery or health visiting team, were you given the help you needed?						9.3	8.8	79	

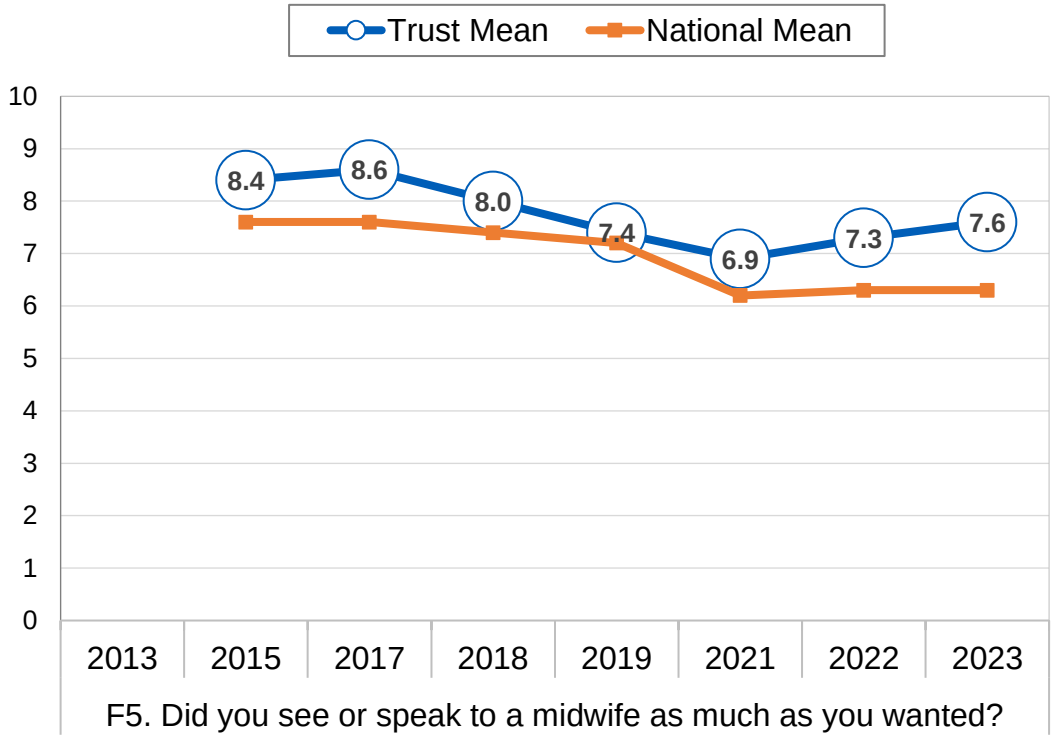
▼▲ Significant difference between 2023 and 2022

Blank No Significant difference between 2023 and 2022

Trends over time – Postnatal care (continued)

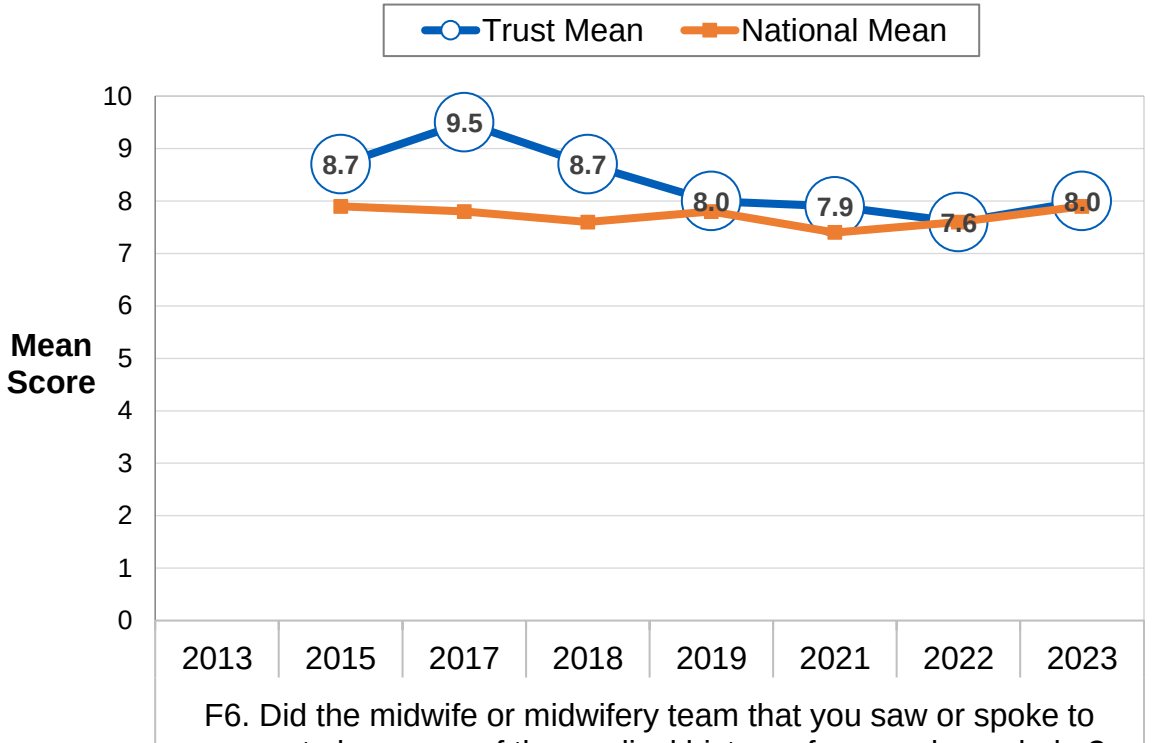
The following charts show how results have changed over time for questions where there are 5 years or more of comparable data.

Care at home after the birth



F5. Did you see or speak to a midwife as much as you wanted?

Please note: *no data available for some years*



F6. Did the midwife or midwifery team that you saw or spoke to appear to be aware of the medical history of you and your baby?

Please note: *no data available for some years*

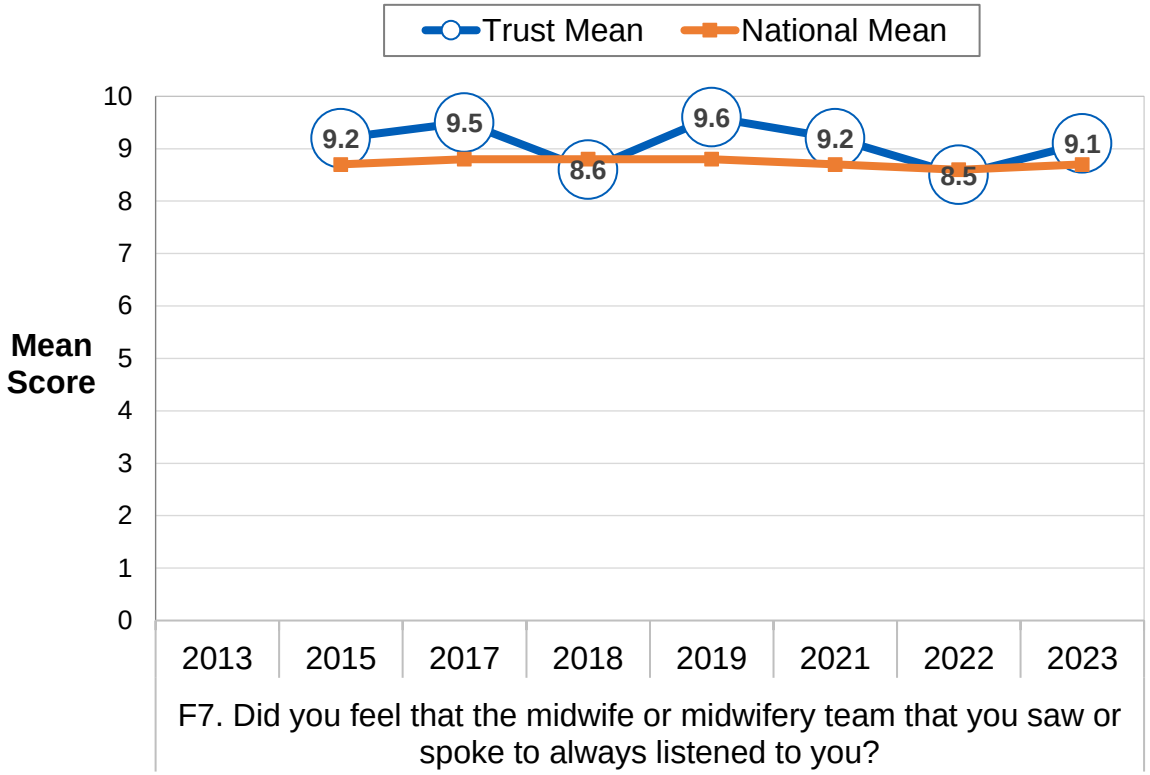
This shows a significant increase in the trust mean for this question for 2023 compared to 2022

This shows a significant decrease in the trust mean for this question for 2023 compared to 2022

Trends over time - Postnatal care (continued)

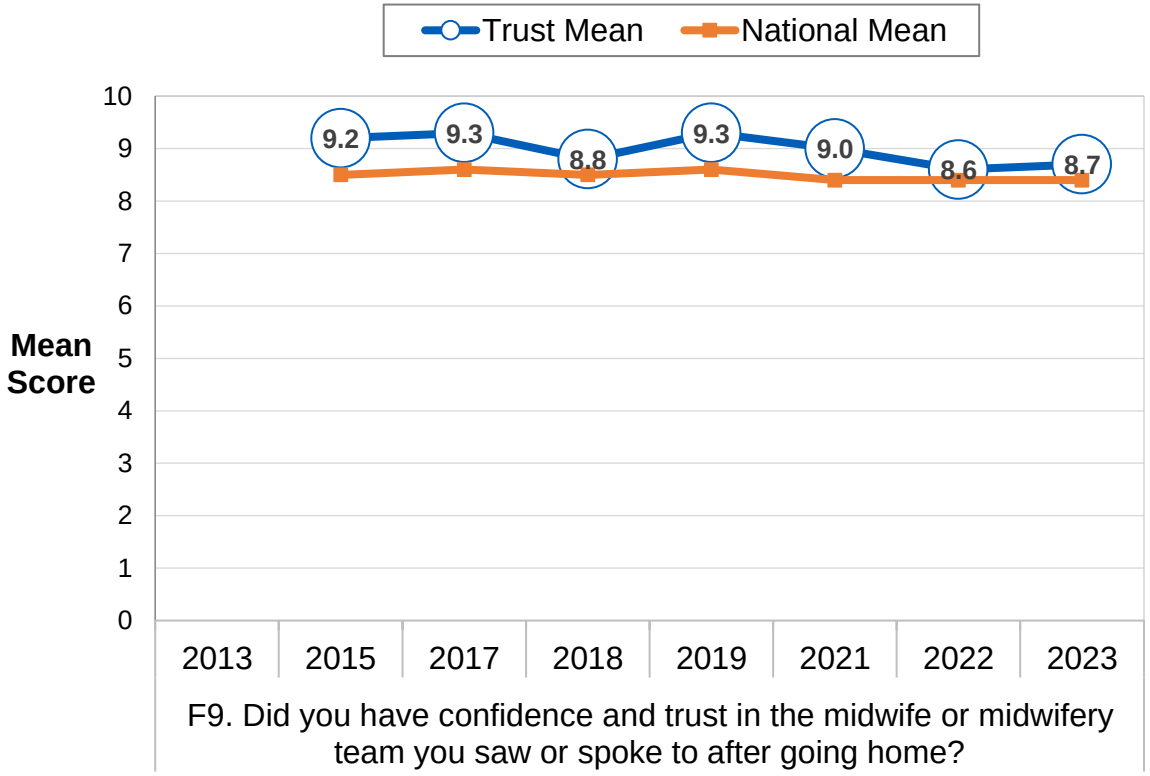
The following charts show how results have changed over time for questions where there are 5 years or more of comparable data.

Care at home after the birth



F7. Did you feel that the midwife or midwifery team that you saw or spoke to always listened to you?

Please note: *no data available for some years*



F9. Did you have confidence and trust in the midwife or midwifery team you saw or spoke to after going home?

Please note: *no data available for some years*

This shows a significant increase in the trust mean for this question for 2023 compared to 2022

This shows a significant decrease in the trust mean for this question for 2023 compared to 2022

Trends over time - Postnatal care (continued)

There are some questions in this section where data is not comparable prior to 2022. The following table displays changes since 2022, and whether those changes are statistically significant.

Much worse than expected	Worse than expected	Somewhat worse than expected	About the same	Somewhat better than expected	Better than expected	Much better than expected		2023 Trust Score	2022 Trust Score	No. of respondents in 2023	Change from 2022 survey
Care at home after the birth											
F8.	Did the midwife or midwifery team that you saw or spoke to take your personal circumstances into account when giving you advice?							8.6	8.5	91	
F11.	Did a midwife or health visitor ask you about your mental health?							9.8	9.6	97	
F12.	Were you given information about any changes you might experience to your mental health after having your baby?							7.9	7.1	95	

▼▲ Significant difference between 2023 and 2022

Blank No Significant difference between 2023 and 2022

Trends over time - Postnatal care (continued)

There are some questions in this section where data is not comparable prior to 2022. The following table displays changes since 2022, and whether those changes are statistically significant.

Much worse than expected	Worse than expected	Somewhat worse than expected	About the same	Somewhat better than expected	Better than expected	Much better than expected

		2023 Trust Score	2022 Trust Score	No. of respondents in 2023	Change from 2022 survey
Care at home after the birth					
F13.	Were you told who you could contact if you needed advice about any changes you might experience to your mental health after the birth?	9.3	7.5	88	▲
F14.	Were you given information about your own physical recovery after the birth?	7.2	6.9	96	
F16.	If, during evenings, nights or weekends, you needed support or advice about feeding your baby, were you able to get this?	7.0	5.9	39	

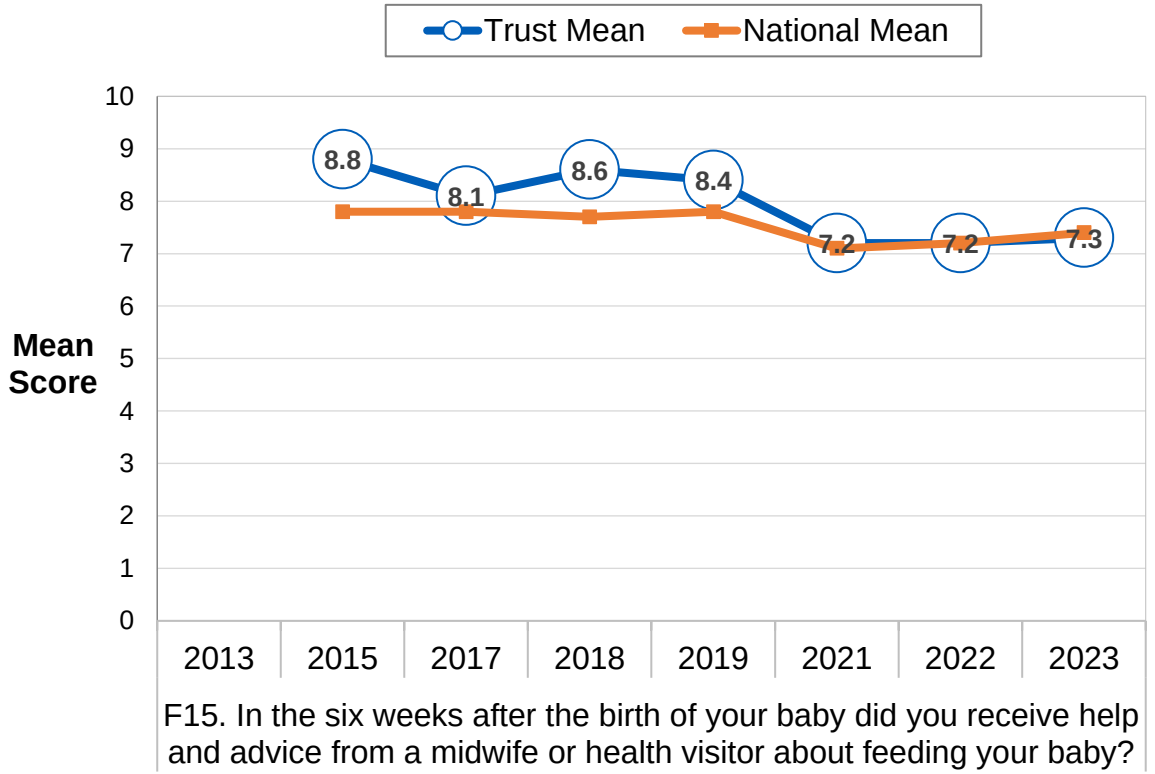
▼▲ Significant difference between 2023 and 2022

Blank No Significant difference between 2023 and 2022

Trends over time - Postnatal care (continued)

The following charts show how results have changed over time for questions where there are 5 years or more of comparable data.

Care at home after the birth



F15. In the six weeks after the birth of your baby did you receive help and advice from a midwife or health visitor about feeding your baby?

Please note: *no data available for some years*

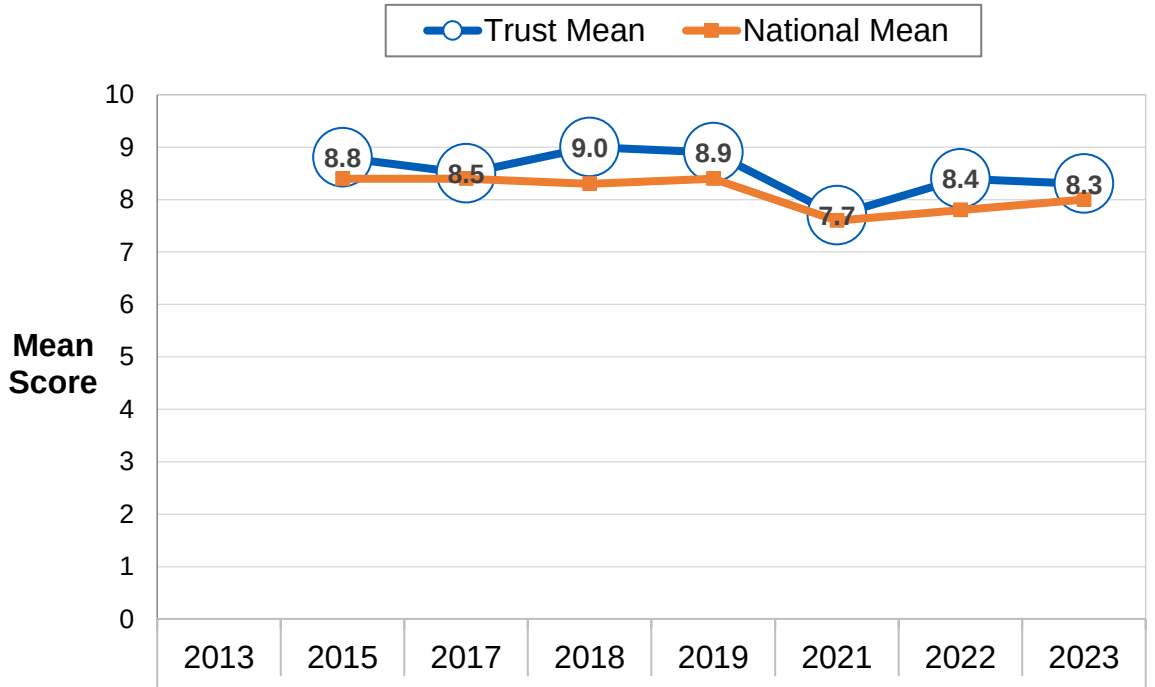
This shows a significant increase in the trust mean for this question for 2023 compared to 2022

This shows a significant decrease in the trust mean for this question for 2023 compared to 2022

Trends over time - Postnatal care (continued)

The following charts show how results have changed over time for questions where there are 5 years or more of comparable data.

Care at home after the birth



F17. In the six weeks after the birth of your baby did you receive help and advice from health professionals about your baby's health and progress?

Please note: *no data available for some years*

This shows a significant increase in the trust mean for this question for 2023 compared to 2022

This shows a significant decrease in the trust mean for this question for 2023 compared to 2022

Appendix

Comparison to other trusts

The questions at which your trust has performed worse compared with most other trusts are listed below. The questions where your trust has performed about the same compared with most other trusts have not been listed.

Much worse than expected	Worse than expected
• Your trust has not performed “much worse than expected” for any questions.	• Your trust has not performed “worse than expected” for any questions.

Comparison to other trusts

The questions at which your trust has performed somewhat better or worse compared with most other trusts are listed below. The questions where your trust has performed about the same compared with most other trusts have not been listed.

Somewhat worse than expected	Somewhat better than expected
• B7. During your antenatal check-ups, did your midwives or doctor appear to be aware of your medical history? • C20. During your labour and birth, did your midwives or doctor appear to be aware of your medical history?	• Your trust has not performed “somewhat better than expected” for any questions.

Comparison to other trusts

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

Better than expected	Much better than expected
• D6. Thinking about your stay in hospital, if your partner or someone else close to you was involved in your care, were they able to stay with you as much as you wanted? • F2. If you contacted a midwifery or health visiting team, were you given the help you needed? • F13. Were you told who you could contact if you needed advice about any changes you might experience to your mental health after the birth?	• Your trust has not performed “much better than expected” for any questions.

NHS Maternity Survey 2023

Results for Wirral University Teaching Hospital NHS Foundation Trust

Where maternity service users' experience is best

- ✓ Partners or someone else involved in the service user's care being able to stay with them as much as the service user wanted during their stay in the hospital.
- ✓ Maternity service users being able to see or speak to a midwife as much as they wanted during their care after birth.
- ✓ Maternity service users being able to get support or advice about feeding their baby during evenings, nights, or weekends, if they needed this.
- ✓ Maternity service users being told who they could contact if they needed advice about any changes they might experience to their mental health after the birth.
- ✓ Maternity service users being given the help they need when contacting a midwifery or health visiting team after the birth.

Where maternity service users' experience could improve

- ○ Midwives or doctors appearing to be aware of the medical history of the service user during labour and birth.
- ○ Midwives or the doctor appearing to be aware of service users' medical history during antenatal check-ups.
- ○ Maternity service users having the opportunity to ask questions about their labour and the birth after the baby was born.
- ○ Maternity service users feeling that healthcare professionals did everything they could to manage their pain in hospital after the birth.
- ○ Maternity service users being involved in the decision to be induced.

These questions are calculated by comparing your trust's results to the average of all trusts who took part in the survey. "Where maternity service users experience is best": These are the five results for your trust that are highest compared with the average of all trusts who took part in the survey. "Where maternity service users experience could improve": These are the five results for your trust that are lowest compared with the average of all trusts who took part in the survey.

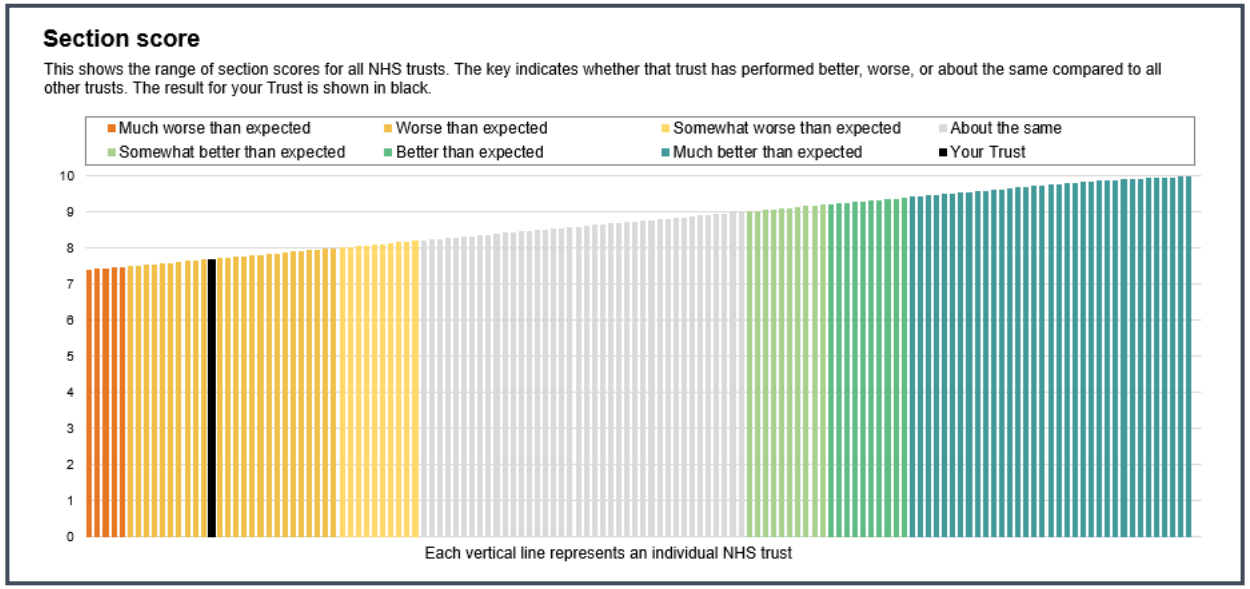
This survey looked at the experiences of individuals in maternity care who gave birth between January and March 2023 at Wirral University Teaching Hospital NHS Foundation Trust. Between May and August 2023, a questionnaire was sent to 300 individuals. Responses were received from 115 individuals at this trust. If you have any questions about the survey and our results, please contact [NHS TRUST TO INSERT CONTACT DETAILS].

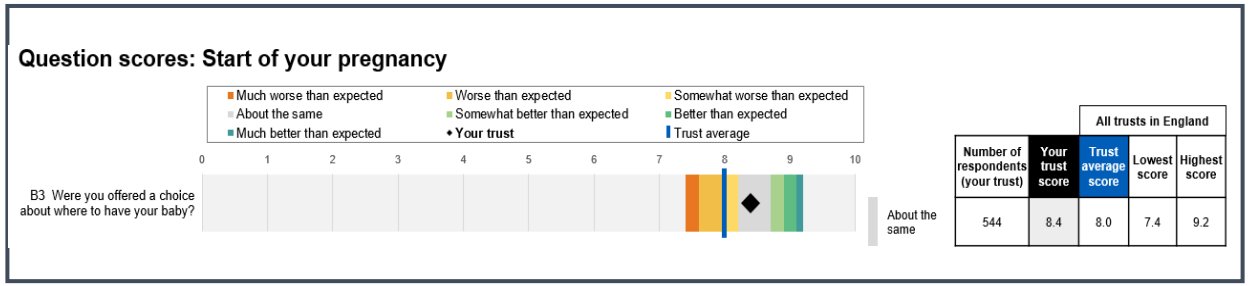
How to interpret benchmarking in this report

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

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

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





How to interpret benchmarking in this report (continued)

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

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

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

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

Please note, the benchmark bandings were updated for the 2021 survey to provide a greater level of granularity in the expected range score. The 2023 survey uses the same approach.

Additional information on the ‘expected range’ analysis technique can be found in the survey technical report on the NHS Surveys website.

An example of scoring

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

Calculating an individual respondent's score

The following provides an example for the scoring system applied for each respondent. For question B7 "During your antenatal check-ups, did your midwives or doctor appear to be aware of your medical history?":

- The answer code "Yes, always" would be given a score of 10, as this refers to the most positive patient experience possible.
- The answer code "Yes, Sometimes" would be given a score of 5, as it is placed at an equal interval along the scale.
- The answer code "No" would be given a score of 0, as this response reflects considerable scope for improvement.
- The answer codes "Don't know / can't remember" would not be scored, as they do not have a clear bearing on the trust's performance in terms of the people who use maternity services experiences.

Calculating the trust score for each question

The weighting mean score for each trust, for each question, is calculated by dividing the sum of the weighting scores for a question by the weighted sum of all eligible respondents to the question for each trust. Weighting is explained further in the quality and methodology report.

Calculating the section score

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

For further information

Please contact the Coordination Centre for Mixed Methods at Ipsos.

MaternityCoordination@ipsos.com

PERINATAL CULTURE AND LEADERSHIP DEVELOPMENT PROGRAMME TIMELINE

NHS England

practive

KORN FERRY
BE MORE THAN

1 QUAD LEADERSHIP DEVELOPMENT

A 6 month programme comprising:

- Welcome event
- 3 modules (face-to-face)
- 4 action learning sets (3 virtual, 1 f-2-f)
- Leadership perspectives (self directed strengths based facilitated 360)

2 CULTURE SURVEY

A 3 - 4 month process covering:

- Identifying local champions to support culture survey and debrief process
- Mapping
- Going live with the survey
- 6 week 'live' period
- Results

3 CULTURAL CONVERSATIONS

A 4 - 5 month process comprising:

- Quad development sessions
- Team conversations
- Quad check-ins
- Improvement planning

YOUR SELF-ORGANISATION

- Continue meetings and conversations as Quad and with Board Safety Champions
- Peer support from action learning set
- Continue conversations about culture in your teams
- Continue working on improvement priorities
- Provision of practical support / tools for teams and leaders to use when planning improvement

Appendix 8 Perinatal Clinical Surveillance Quality Assurance Report Jan 2024

Theme	Area requiring further enquiry or shared intelligence	Outlier	Evidence
Clinical Care	Outlier for rates of stillbirth as a proportion of births	Yes	No escalation from SCN / LMNS on outlier report; internal thematic review being undertaken; NW region outlier report no longer published and NW Regional dashboard now available however discusssed regionally as Data to May 2023 and decision awaited on key reporting metrics and also data collection methodology; all users requested access accoringly; awaiting feedbeck when dashboard will be able to be utilised
	Outlier for rates of neonatal deaths as a proportion of birth	na	No escalation from SCN / LMNS on outlier report; internal thematic review being undertaken; NW region outlier report no longer published and NW Regional dashboard now available however discusssed regionally as Data to May 2023 and decision awaited on key reporting metrics and also data collection methodology; all users requested access accoringly; awaiting feedbeck when dashboard will be able to be utilised; thematic review requested as 3 term still births in Q3/Q4 of 2023
	Rates of HIE where improvements in care may have made a difference to the outcome	na	Very low rates of HIE, sitting way below the lower control limit for the region. No current cases
	Number of SI's	na	No serious incidents reported in January 2024
	Progress on SBL care bundle V3	no	SBLv3 launched and continued to be a key safety action of MIS Year 5 which was signed off as complaint meeting 81% (>70% was the requirement); Audits and evidence to be submitted by 16/2/24 for LMNS review and ambition to achieve 100% compliance by 31/3/24
	Outlier for rates of term admissions to the NNU	na	The rate of avoidable term admissions; regular multi-disciplinary reviews of care take place; NW region outlier report no longer published and awaiting national guidance on monitoring processes
Service user and st	MNVP or Service User concerns/complaints not resolved at trust level	no	Not an outlier regarding the number of complaints; to date all complaints have been addressed for maternity in the target timeframesand there is nil to escalate
	Trainee survey	no	No update this month
	Staff survey	no	Trust Staff Survey completed and divisional response has included staff engagement and continuation with the Pulse surveys; Score survey completed for MatNeo and cultural conversations commencing over x 4 sessions; Requirement to report to BOD Feb 2024
	CQC National survey	no	Published Feb 2024 and included within BoD report
	Feedback via Deanery, GMC, NMC	no	Nil to esclate
	Poor staffing levels	no	All vacancies have been recruited into for Band 5 and Band 6 midwives; further retirements anticipated later and in the year. Current vacancy rate 1.8%
	Delivery Suite Coordinator not super nummary	no	Super nummary status is maintained for all shifts
Leadership and relationships	New leadership within or across maternity and/or neonatal services	no	Nil of note; full establishment; governance structure review and revised structure implemented to meet requirements and maternity self assessment tool and continue to meet Ockenden Part 1
	Concerns around the relationships between the Triumvirate and across perinatal services	no	Good working relationship between the teams /Directorates
	False declaration of CNST MIS	no	MIS Year 5 submission and declaration submitted by 12 noon on 1st February 2024; Awaiting Year 6 publication
	Concerns raised about other services in the Trust e.g. A&E	no	Nil of note
	In multi-site units - concerns raised about a specific unit i.e. Highfield/CoC teams	no	Nil to report this month; funding options explored; 6 teams in total and two approach model in place; comparison data / research underway
Safety and learning culture	Lack of engagement in MNSI or ENS investigation	no	Good engagement processes in place with north west team leader. Monthly reports received of ongoing cases and recent discussions regarding the process of arbitration with regional lead. Quarterly regional meetings arranged with excellent MDT attendance. Quarterly meeting held in Feb 2023; site visit May 2023; nil to escalate
	Lack of transparency	no	Being open conversations are regularly had and 100% compliance with duty of candour evident
	Learning from SI's, local investigations and reviews not implemented or audited for efficacy and impact	no	Robust processes following lessons learned from all PSSI's, local reviews, rapid evaluations of care, complaints and compliments. Engagement with staff to assess and improve how learning is shared. Patient experience strategy in progress.
	Learning from Trust level MBRRACE reports not actioned	no	All reports receive a gap analysis to benchmark against the recommendations
	Recommendations from national reports not implemented	no	All reports receive a gap analysis to benchmark against the recommendations. No exceptions to report. Three year single delivery plan for maternity and neonatal services published 31th March 2023 - gap analysis in progress and will monitored via WUTH CG structure and BoD
Incident reporting	Low patient safety or serious incident reporting rates	no	Consistent rates of reporting across the speciality groups. Regular training takes places on the importance of incident reporting, underpinning the Trust stance of safe reporting and non-punitive culture
	Delays in reporting a SI where criteria have been met	no	Robust SI process and SI framework followed with timely reporting of all cases that meet the SI framework; PSIRF with effect from 1/9/2023
	Never Events which are not reported	no	No maternity or neonatal never events in January 2024
	Recurring Never Events indicating that learning is not taking place	no	N/a
	Poor notification, reporting and follow up to MBRRACE-UK, NHSR ENS and HSIB	no	Excellent reporting within the required timescales
Governanc e processes	Unclear governance processes		Clear governance processes in place that follow the PSIRF framework - Within division there is maternity and neonatal review of governance processes: 3 separate meetings. Staff are informed of top risks and incident themes. Governance notice boards updated and newsletters disseminated. Additional quality assurance framework agreed with effect from June 2023 to give the BoD addiitonal assurances in monitoring of MIS, Three year delivery plan etc. Governance structure strengthened
	Business continuity plans not in place	no	Business continuity plans in place
	Ability to respond to unforeseen events e.g. pandemic, local emergency	no	Nil to report this month
CQC inspection and DHSC or NHSE/I request for support	DHSC or NHS England Improvement request for a Review of Services or Inquiry	no	Nil to report this month
	An overall CQC rating of Requires Improvement with an Inadequate rating for either Safe and Well-Led or a third domain	no	CQC reports published for maternity sites Seacombe Birth Centre and APH site for the domains Safe and Well led; both sites were rated 'GOOD'
	An overall CQC rating of Inadequate	no	N/a
	Been issued with a CQC warning notice	no	N/a
	CQC rating dropped from a previously Outstanding or Good rating to Requires improvement in the safety or Well-Led domains	no	N/a
	Been identified to the CQC with concerns by HSIB	no	N/a

Overview Report
SCORE Survey Culture and Engagement Survey Results

Wirral University Teaching Hospital NHS FT

Survey Period: Oct 2023

Total work settings surveyed: 13

Current period response rates:

- Wirral University Teaching Hospital NHS FT: 26%

Survey results are increasingly accurate as response rates (RR) rise.

We do not report work setting data with response rates <40% or with fewer than 5 responses.

At 40-60% RR, the data requires other corroboration (i.e. interviews of staff).

At >60% RR, the data depicts an accurate image of a work setting.

Safe & Reliable HEALTHCARE

The Value of an Integrated Survey

- The SCORE survey measures important dimensions of organizational culture. The core instrument integrates safety culture, local leadership, learning systems, resilience / burnout and work-life balance. The full instrument integrates employee engagement as well.

- The insights are critical for organizational improvement and the ability to drive habitual excellence.

- Specific actions can be taken to leverage organizational strengths and address areas of fundamental opportunity.

Safe & Reliable HEALTHCARE

Why are Culture and Engagement Important?

- They reflect the behaviors and beliefs within an organization.

- There are behaviors that create value individually, for the patient and the organization.

- There are behaviors that create unacceptable risk.

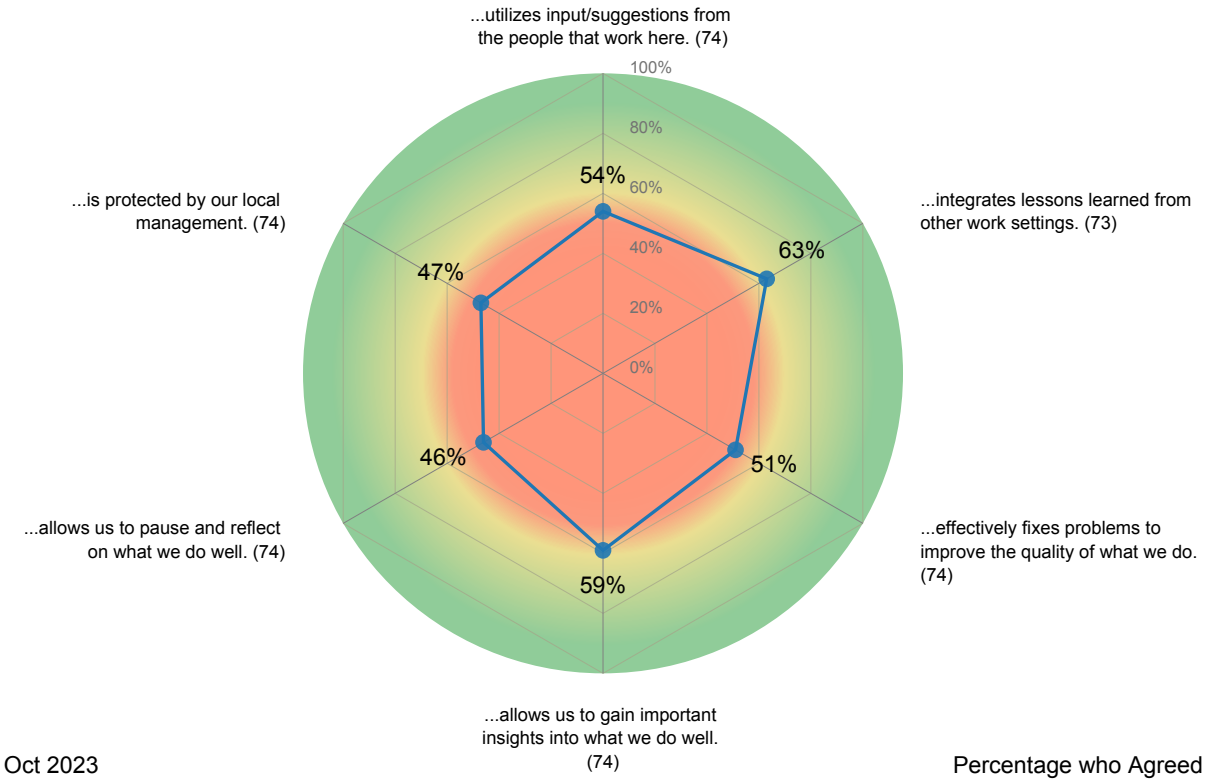
- These attitudes and behaviors are reflected in how people interact with each other both internally and externally with patients and their families.

- Culture and Engagement are the social glue.

Safe & Reliable HEALTHCARE

Wirral University Teaching Hospital NHS FT
Improvement Readiness Domain

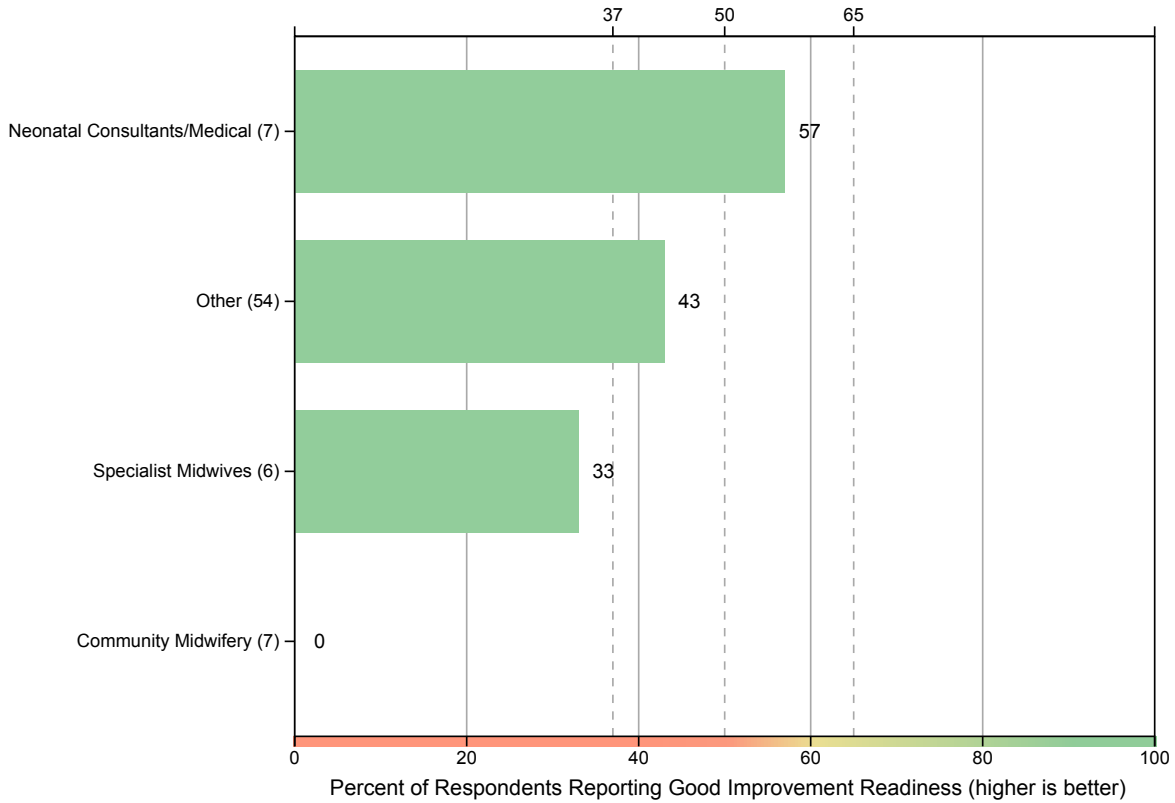
In this work setting, the learning environment...



Source Data: Oct 2023
Institution: Wirral University Teaching Hospital NHS FT
Work Setting(s): All Work Settings
Position(s): All Positions

Percentage who Agreed slightly or Agreed strongly with each question or Disagreed slightly or Disagreed strongly if reversed.

Improvement Readiness by Work Setting

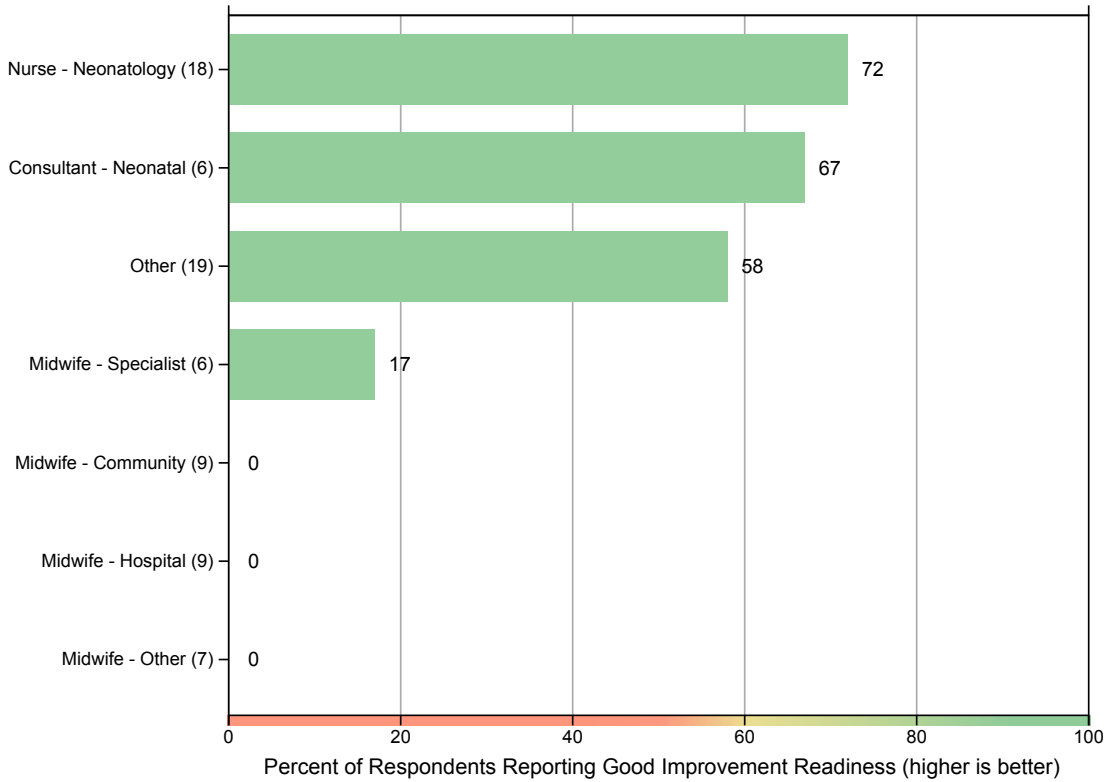


Benchmarks: 2021 UK Q1
25th: 37% 50th: 50% 75th: 65%
Percent Positive Percentile(s)
n = 30800 responses
From 1130 surgery/ward/unit

Source Data: Oct 2023
Institution: Wirral University Teaching Hospital NHS FT
Work Setting(s): All Work Settings
Position(s): All Positions

Safe & Reliable HEALTHCARE

Improvement Readiness by Position



Source Data: Oct 2023

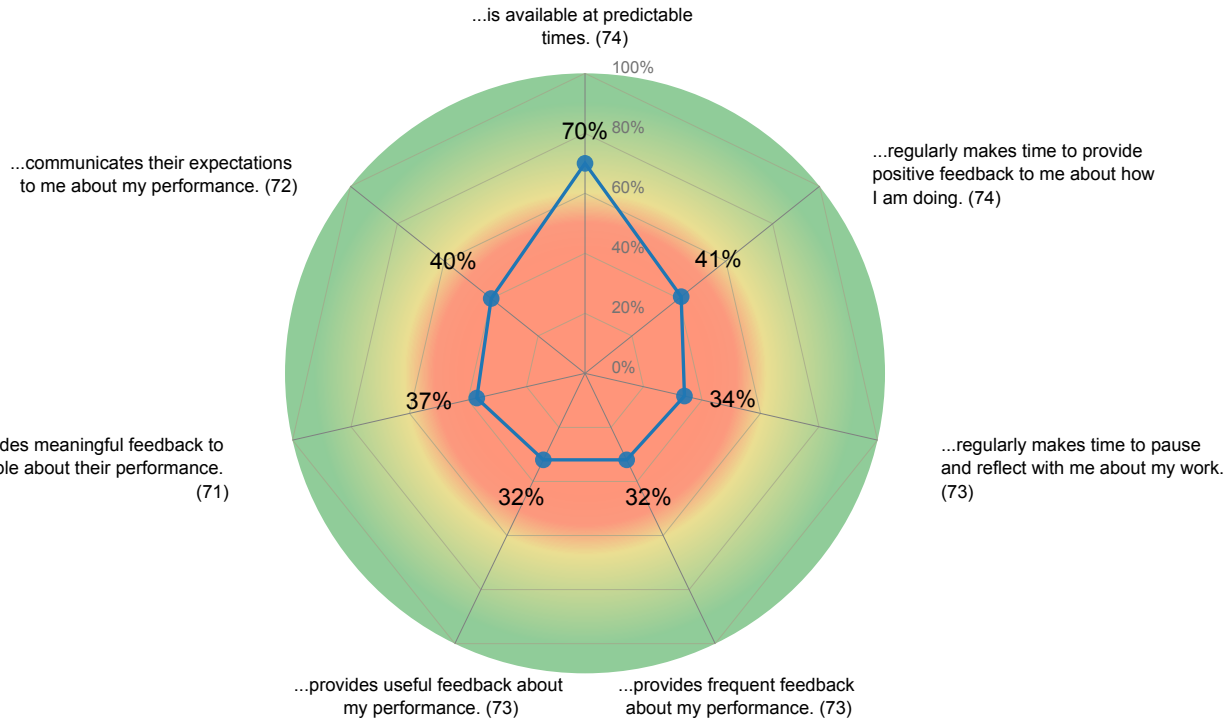
Institution: Wirral University Teaching Hospital NHS FT

Work Setting(s): All Work Settings

Position(s): All Positions

Wirral University Teaching Hospital NHS FT
Local Leadership Domain

In this work setting, local leadership...

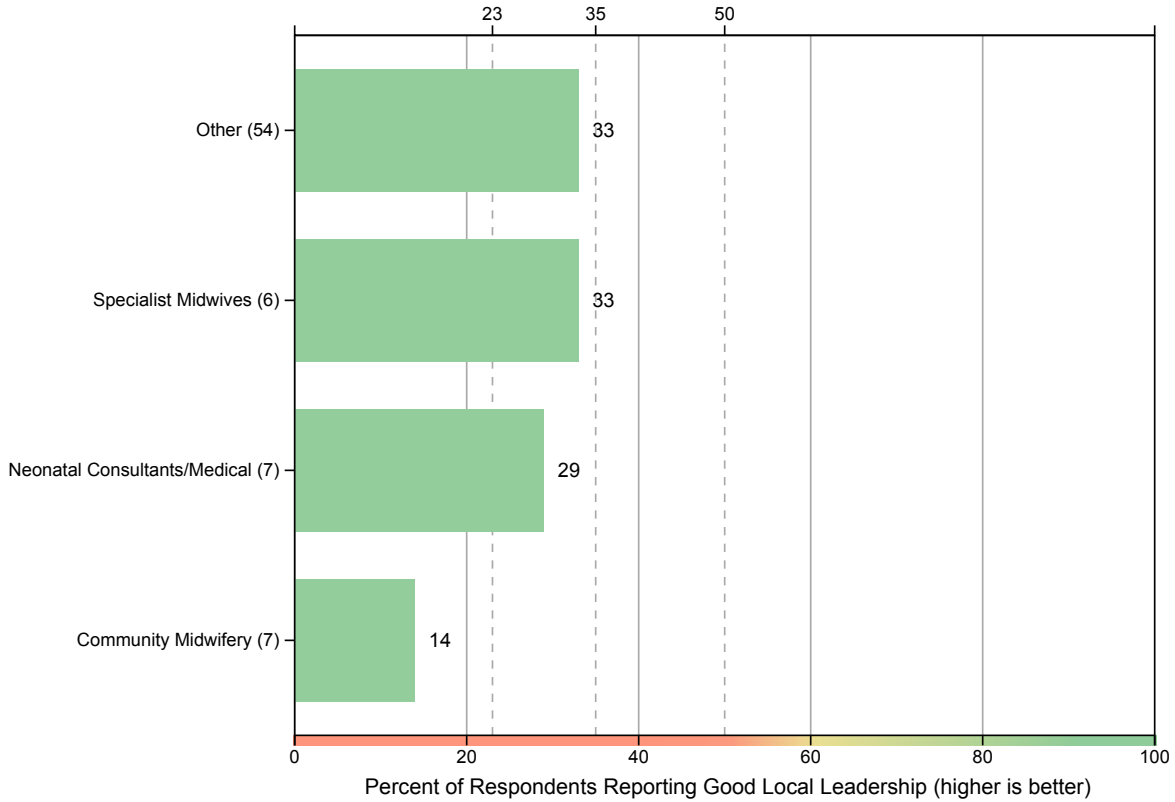


Source Data: Oct 2023
Institution: Wirral University Teaching Hospital NHS FT
Work Setting(s): All Work Settings
Position(s): All Positions

Percentage who Agreed slightly or Agreed strongly with each question or Disagreed slightly or Disagreed strongly if reversed.

Safe & Reliable HEALTHCARE

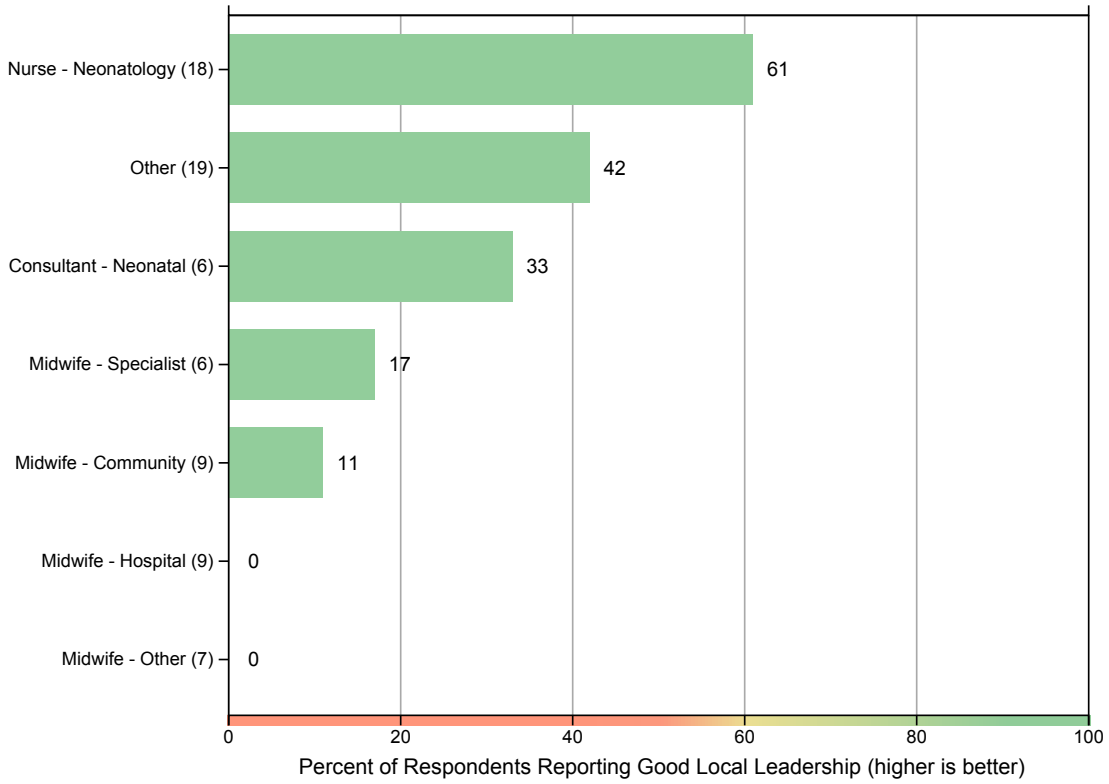
Local Leadership by Work Setting



Benchmarks: 2021 UK Q1
25th: 23% 50th: 35% 75th: 50%
Percent Positive Percentile(s)
n = 30635 responses
From 1128 surgery/ward/unit

Source Data: Oct 2023
Institution: Wirral University Teaching Hospital NHS FT
Work Setting(s): All Work Settings
Position(s): All Positions

Local Leadership by Position



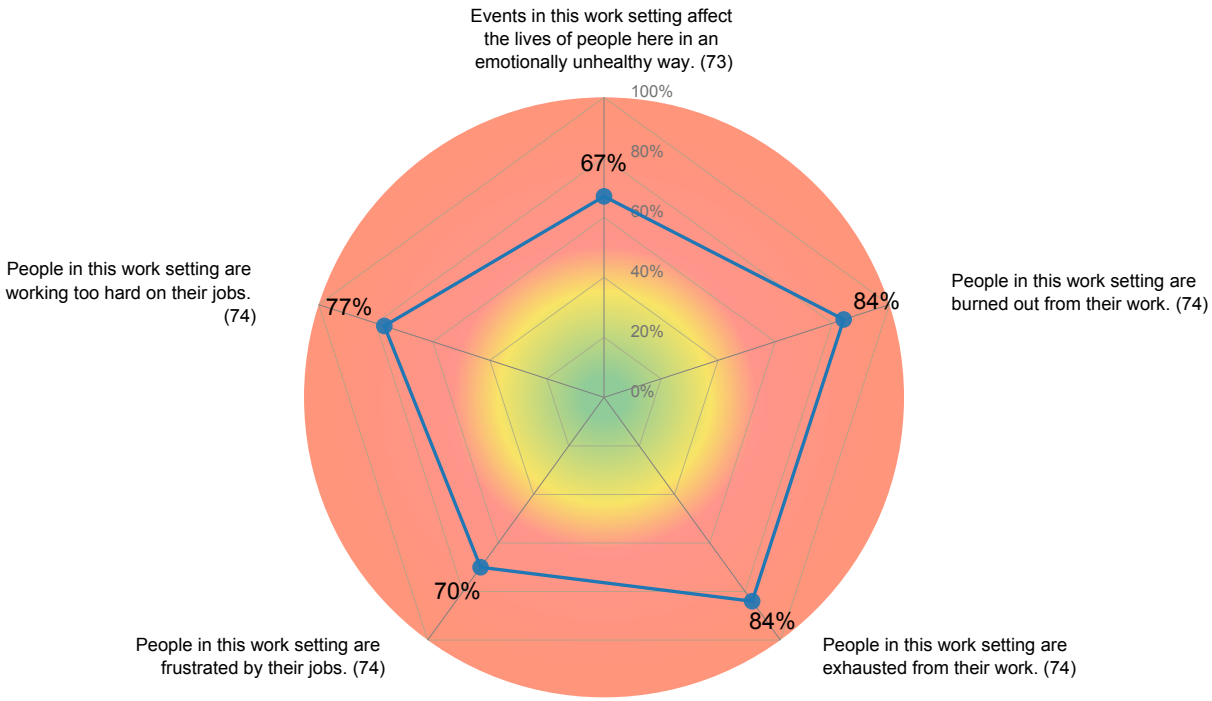
Source Data: Oct 2023

Institution: Wirral University Teaching Hospital NHS FT

Work Setting(s): All Work Settings

Position(s): All Positions

Wirral University Teaching Hospital NHS FT
Burnout Climate Domain

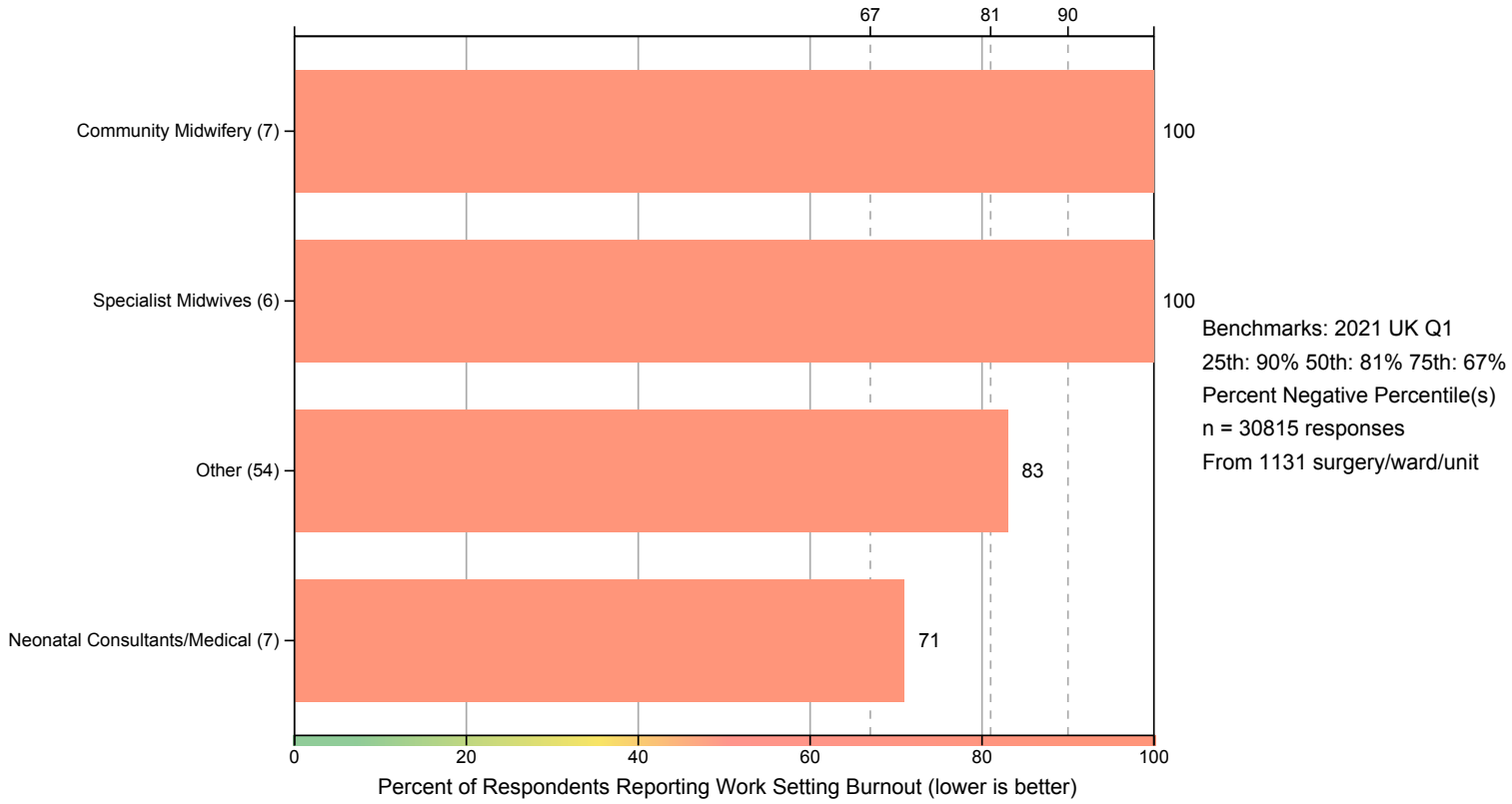


Source Data: Oct 2023
Institution: Wirral University Teaching Hospital NHS FT
Work Setting(s): All Work Settings
Position(s): All Positions

Percentage who Agreed slightly or Agreed strongly with each question or Disagreed slightly or Disagreed strongly if reversed.

Safe & Reliable HEALTHCARE

Burnout Climate by Work Setting



Benchmarks: 2021 UK Q1
25th: 90% 50th: 81% 75th: 67%
Percent Negative Percentile(s)
n = 30815 responses
From 1131 surgery/ward/unit

Source Data: Oct 2023
Institution: Wirral University Teaching Hospital NHS FT
Work Setting(s): All Work Settings
Position(s): All Positions

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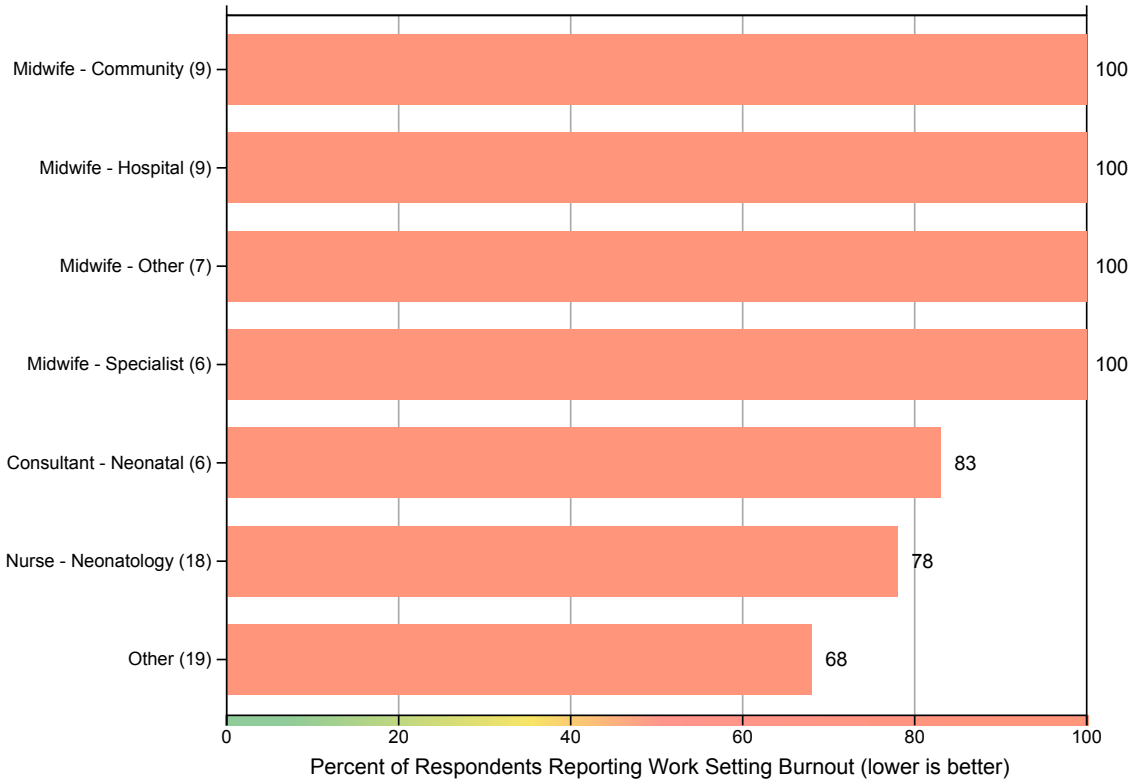
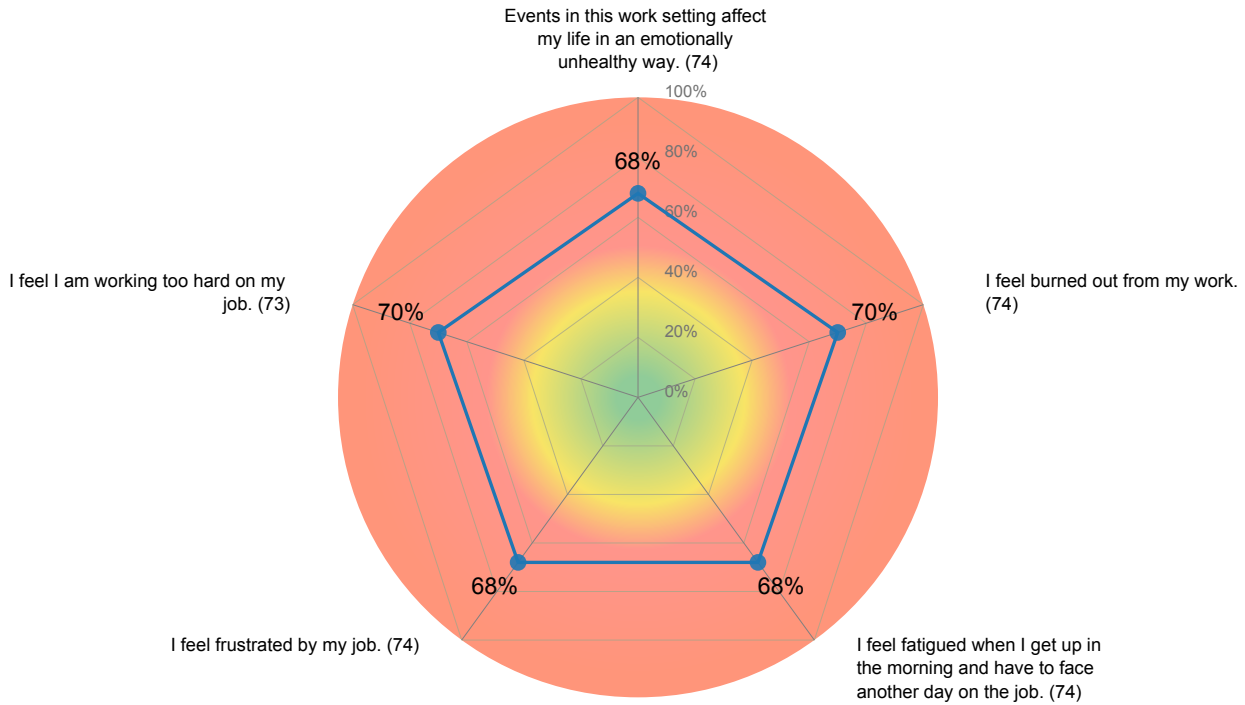
Burnout Climate by Position



Source Data: Oct 2023
Institution: Wirral University Teaching Hospital NHS FT
Work Setting(s): All Work Settings
Position(s): All Positions

Wirral University Teaching Hospital NHS FT
Personal Burnout Domain

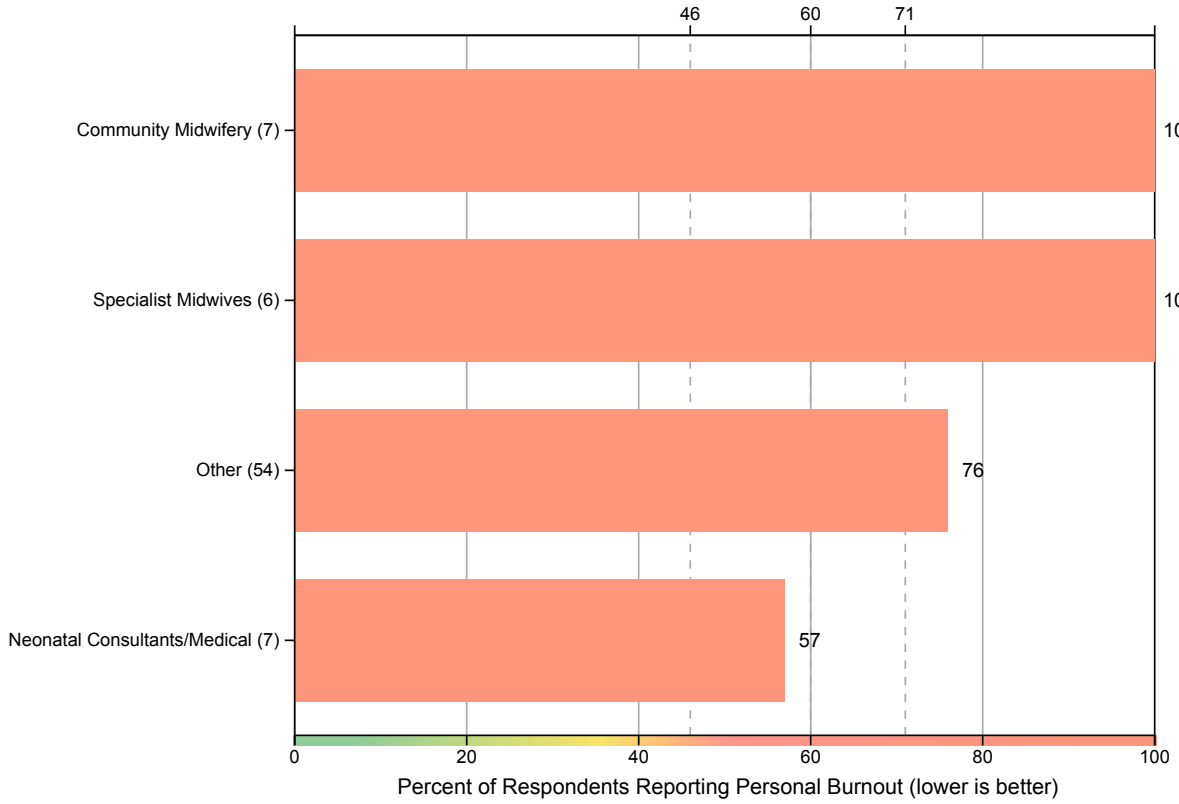


Source Data: Oct 2023
Institution: Wirral University Teaching Hospital NHS FT
Work Setting(s): All Work Settings
Position(s): All Positions

Percentage who Agreed slightly or Agreed strongly with each question or Disagreed slightly or Disagreed strongly if reversed.

Safe & Reliable HEALTHCARE

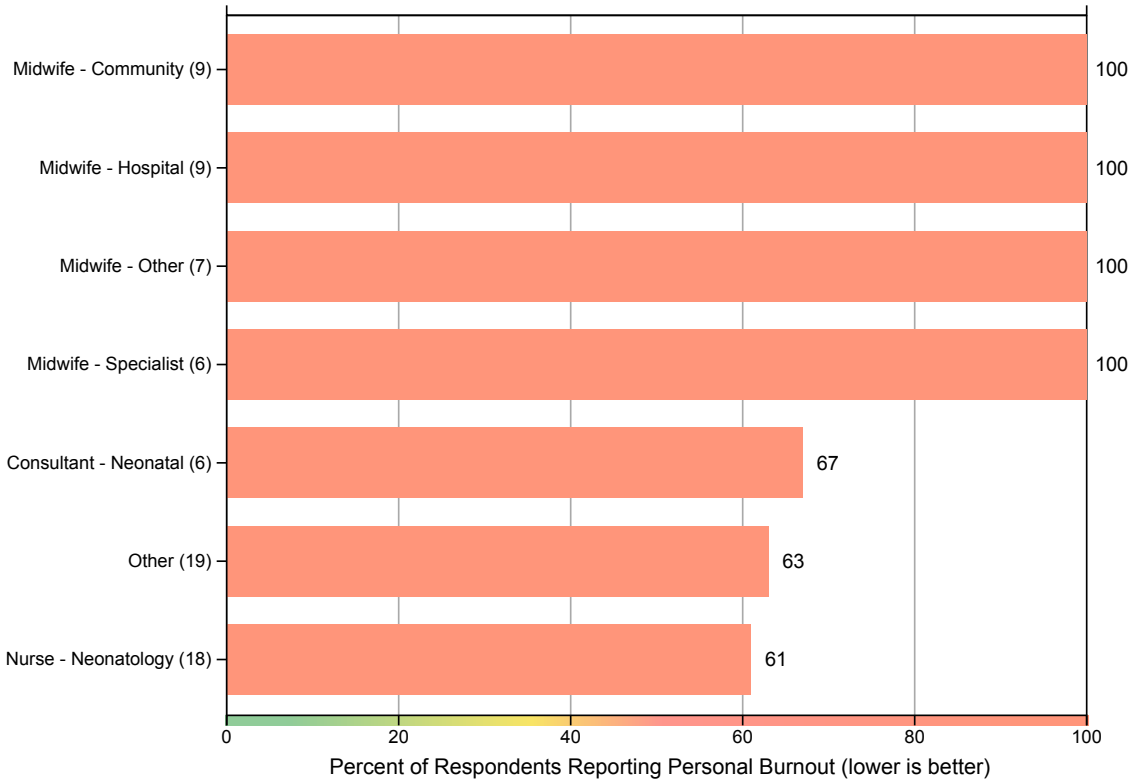
Personal Burnout by Work Setting



Benchmarks: 2021 UK Q1
25th: 71% 50th: 60% 75th: 46%
Percent Negative Percentile(s)
n = 30835 responses
From 1130 surgery/ward/unit

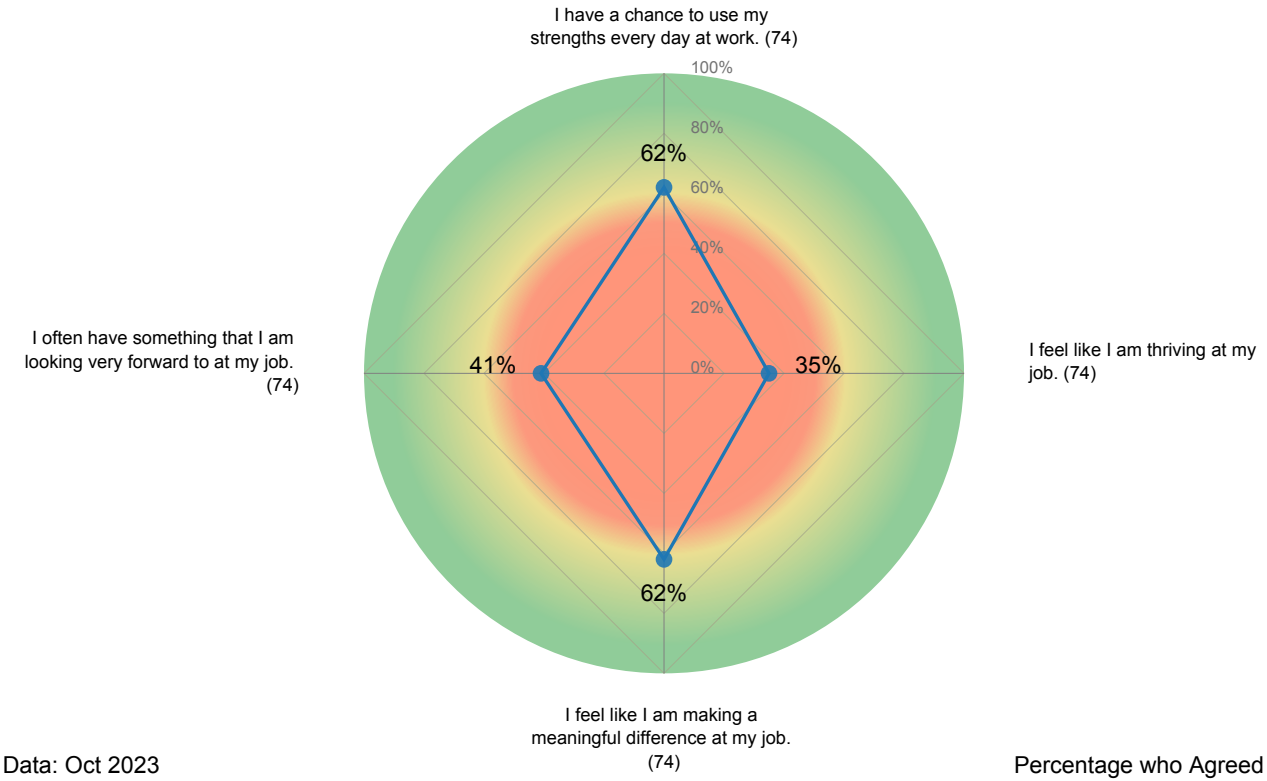
Source Data: Oct 2023
Institution: Wirral University Teaching Hospital NHS FT
Work Setting(s): All Work Settings
Position(s): All Positions

Personal Burnout by Position



Source Data: Oct 2023
Institution: Wirral University Teaching Hospital NHS FT
Work Setting(s): All Work Settings
Position(s): All Positions

Wirral University Teaching Hospital NHS FT
Emotional Thriving Domain

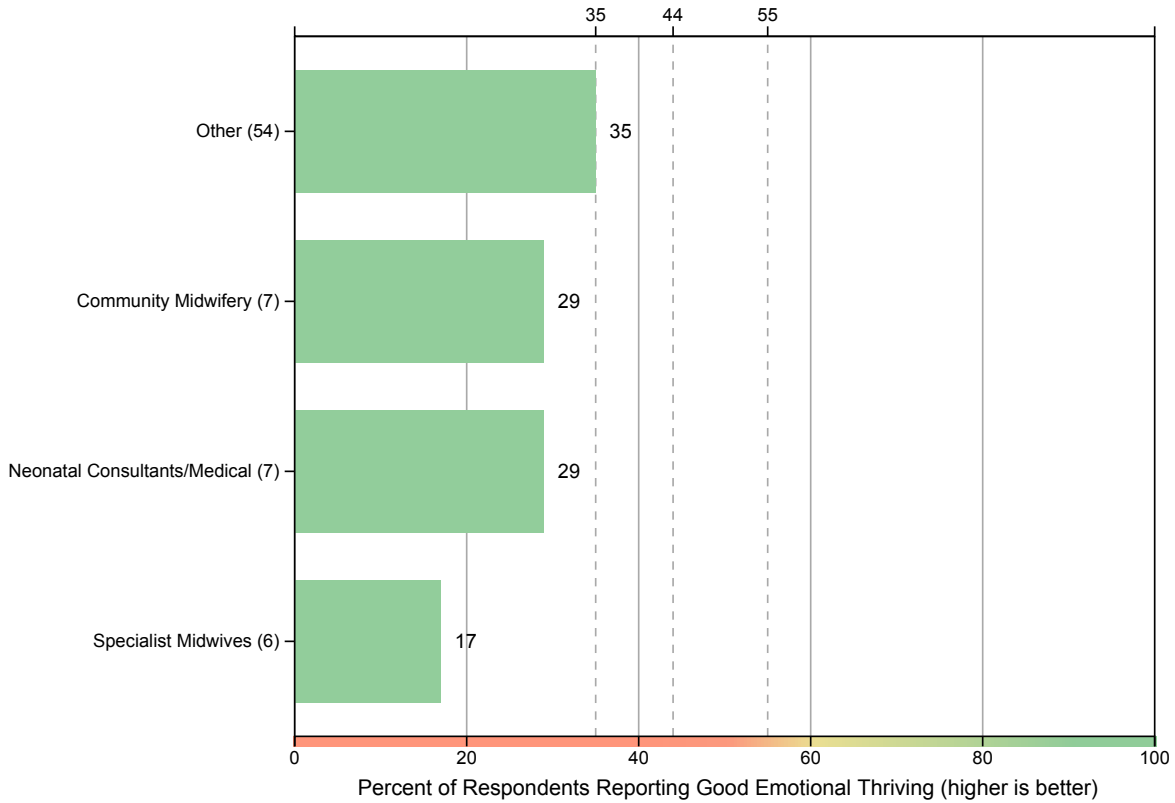


Source Data: Oct 2023
Institution: Wirral University Teaching Hospital NHS FT
Work Setting(s): All Work Settings
Position(s): All Positions

Percentage who Agreed slightly or Agreed strongly with each question or Disagreed slightly or Disagreed strongly if reversed.

Safe & Reliable HEALTHCARE

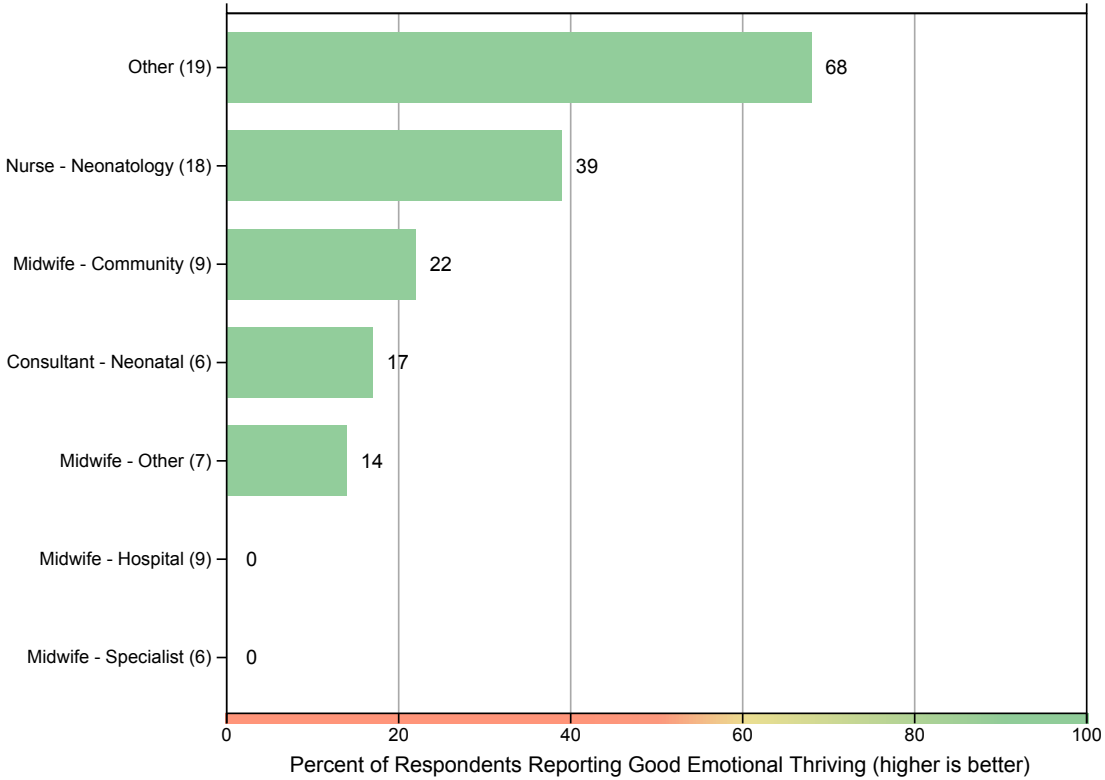
Emotional Thriving by Work Setting



Benchmarks: 2021 UK Q1
25th: 35% 50th: 44% 75th: 55%
Percent Positive Percentile(s)
n = 15253 responses
From 584 surgery/ward/unit

Source Data: Oct 2023
Institution: Wirral University Teaching Hospital NHS FT
Work Setting(s): All Work Settings
Position(s): All Positions

Emotional Thriving by Position



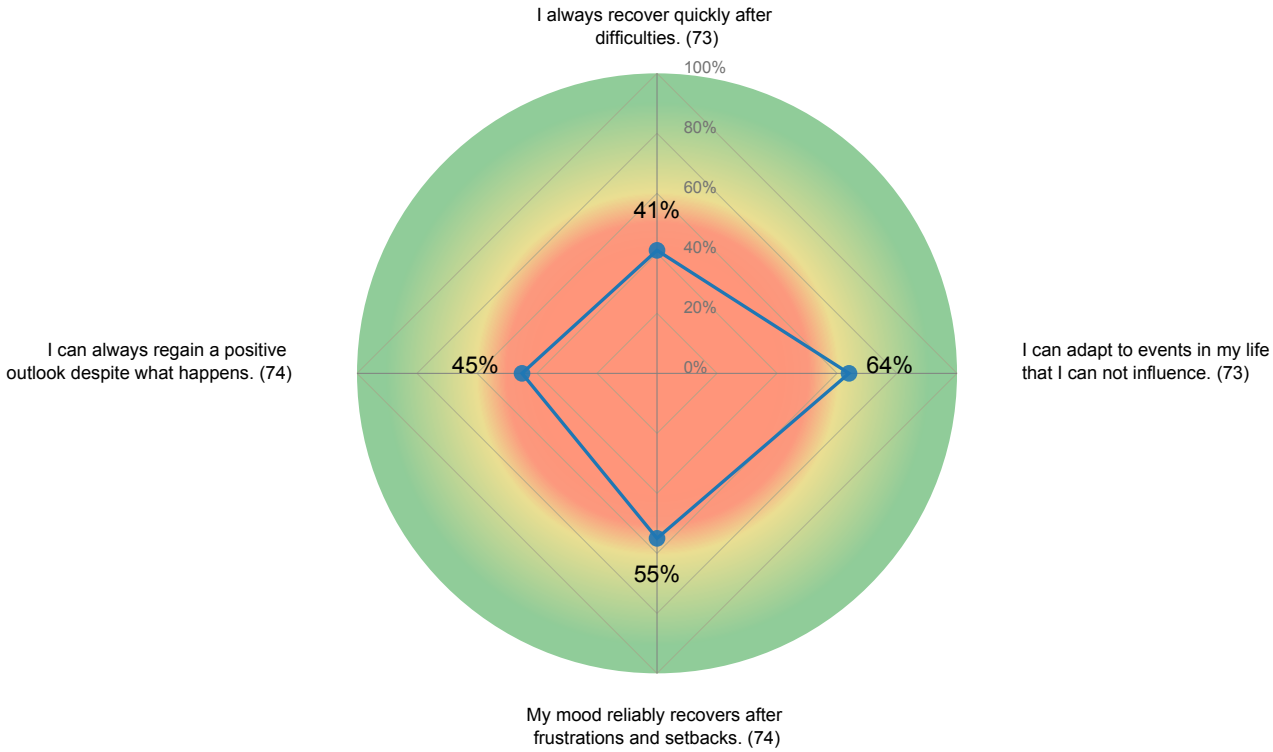
Source Data: Oct 2023

Institution: Wirral University Teaching Hospital NHS FT

Work Setting(s): All Work Settings

Position(s): All Positions

Wirral University Teaching Hospital NHS FT
Emotional Recovery Domain

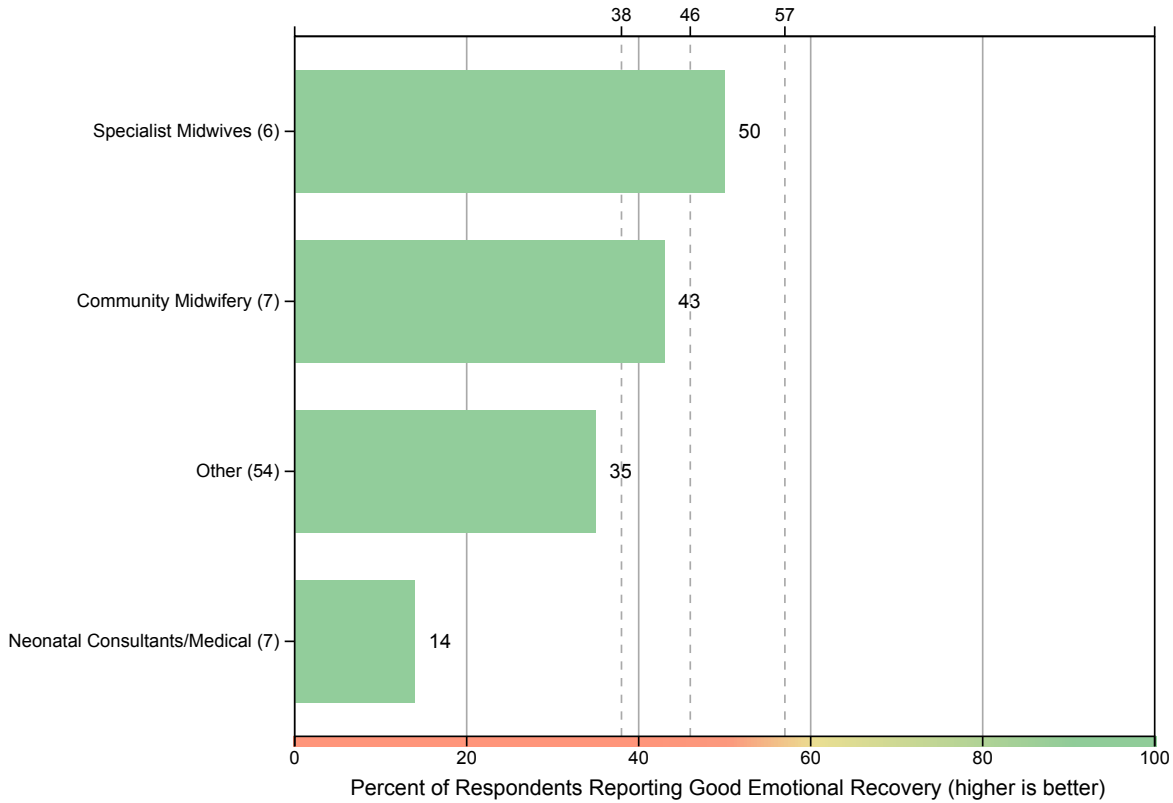


Source Data: Oct 2023
Institution: Wirral University Teaching Hospital NHS FT
Work Setting(s): All Work Settings
Position(s): All Positions

Percentage who Agreed slightly or Agreed strongly with each question or Disagreed slightly or Disagreed strongly if reversed.

Safe & Reliable HEALTHCARE

Emotional Recovery by Work Setting

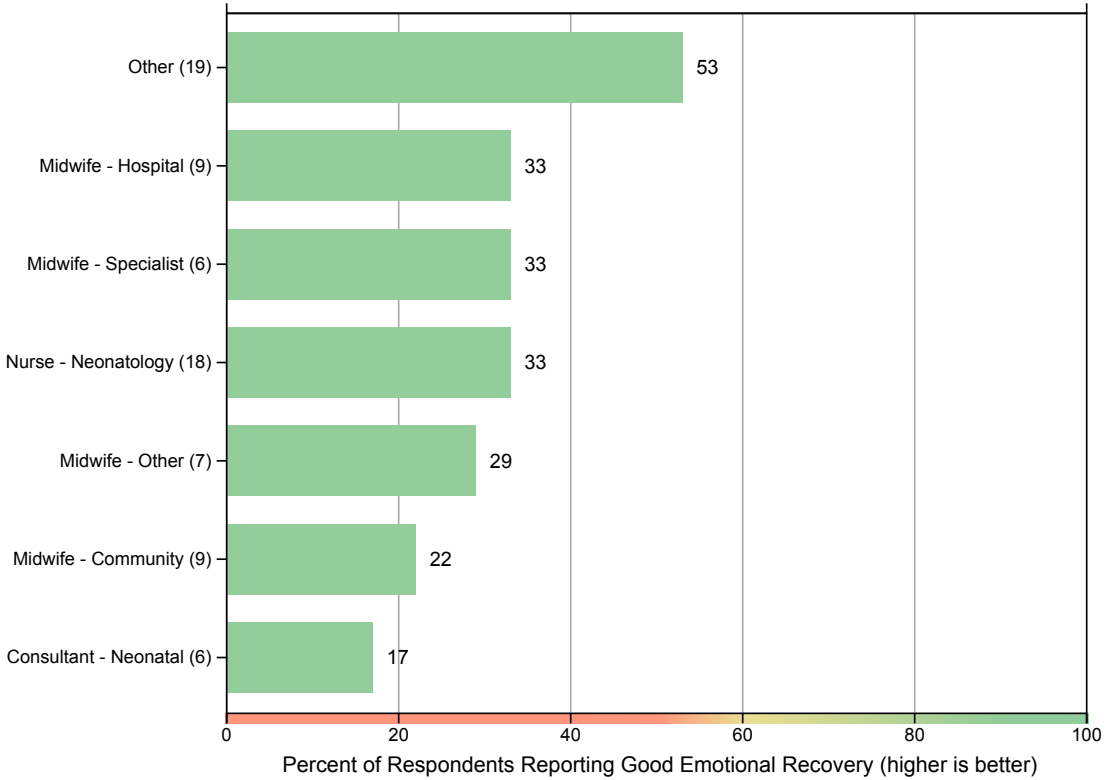


Benchmarks: 2021 UK Q1
25th: 38% 50th: 46% 75th: 57%
Percent Positive Percentile(s)
n = 15279 responses
From 585 surgery/ward/unit

Source Data: Oct 2023
Institution: Wirral University Teaching Hospital NHS FT
Work Setting(s): All Work Settings
Position(s): All Positions

Safe & Reliable HEALTHCARE

Emotional Recovery by Position



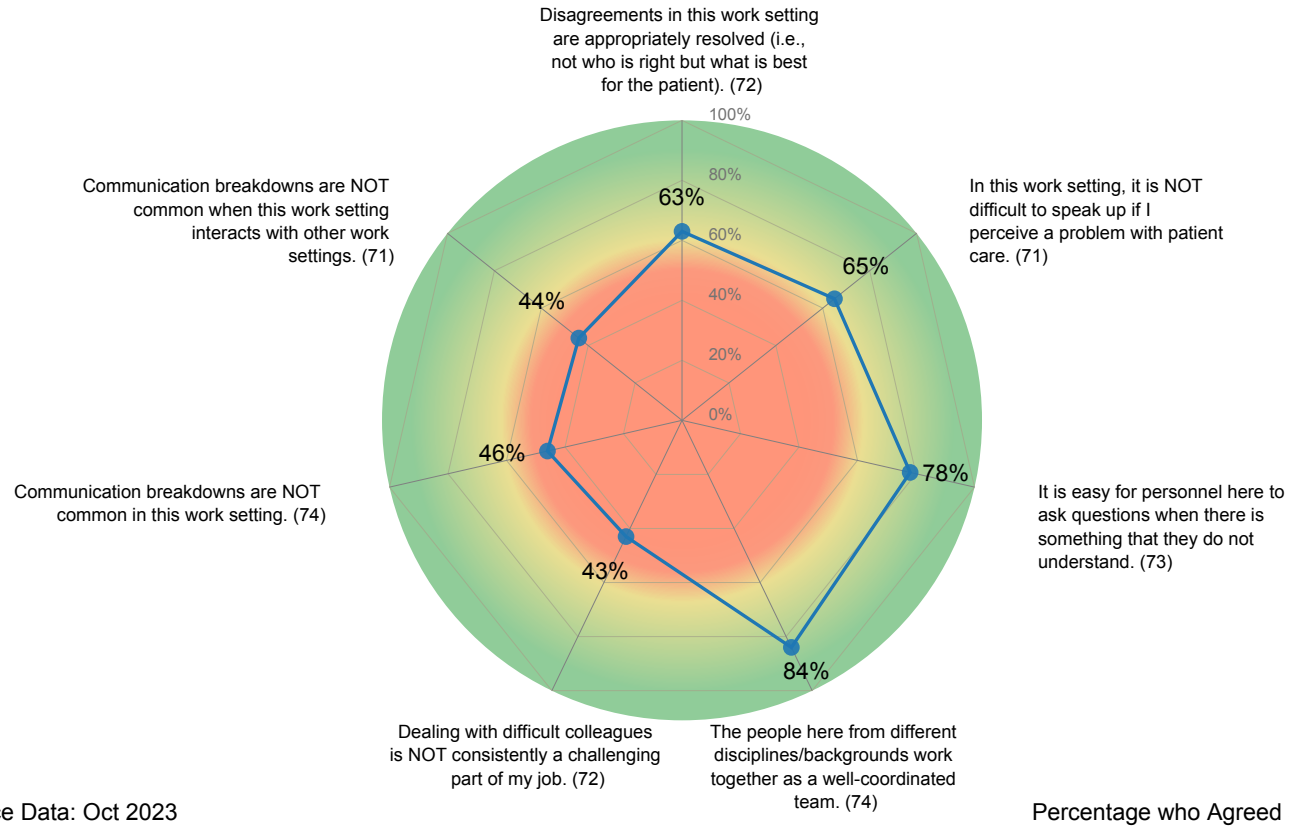
Source Data: Oct 2023

Institution: Wirral University Teaching Hospital NHS FT

Work Setting(s): All Work Settings

Position(s): All Positions

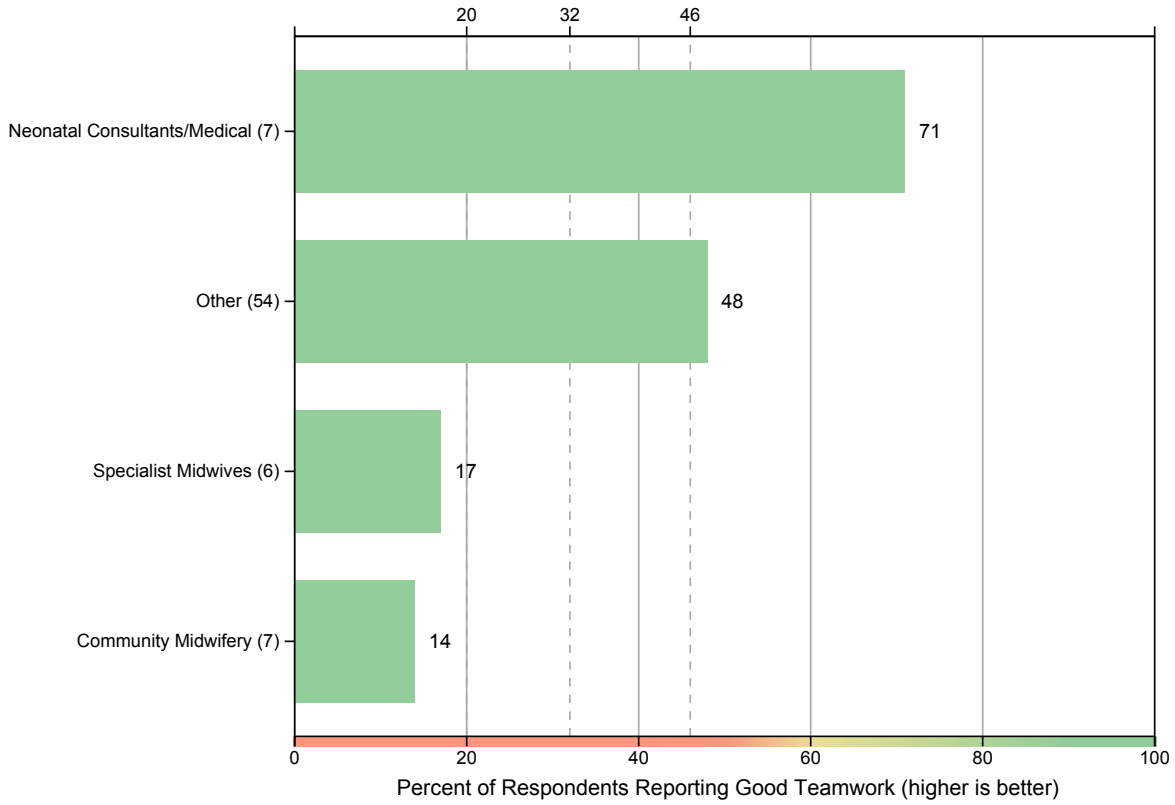
Wirral University Teaching Hospital NHS FT
Teamwork Domain



Source Data: Oct 2023
Institution: Wirral University Teaching Hospital NHS FT
Work Setting(s): All Work Settings
Position(s): All Positions

Percentage who Agreed slightly or Agreed strongly with each question or Disagreed slightly or Disagreed strongly if reversed.

Teamwork by Work Setting

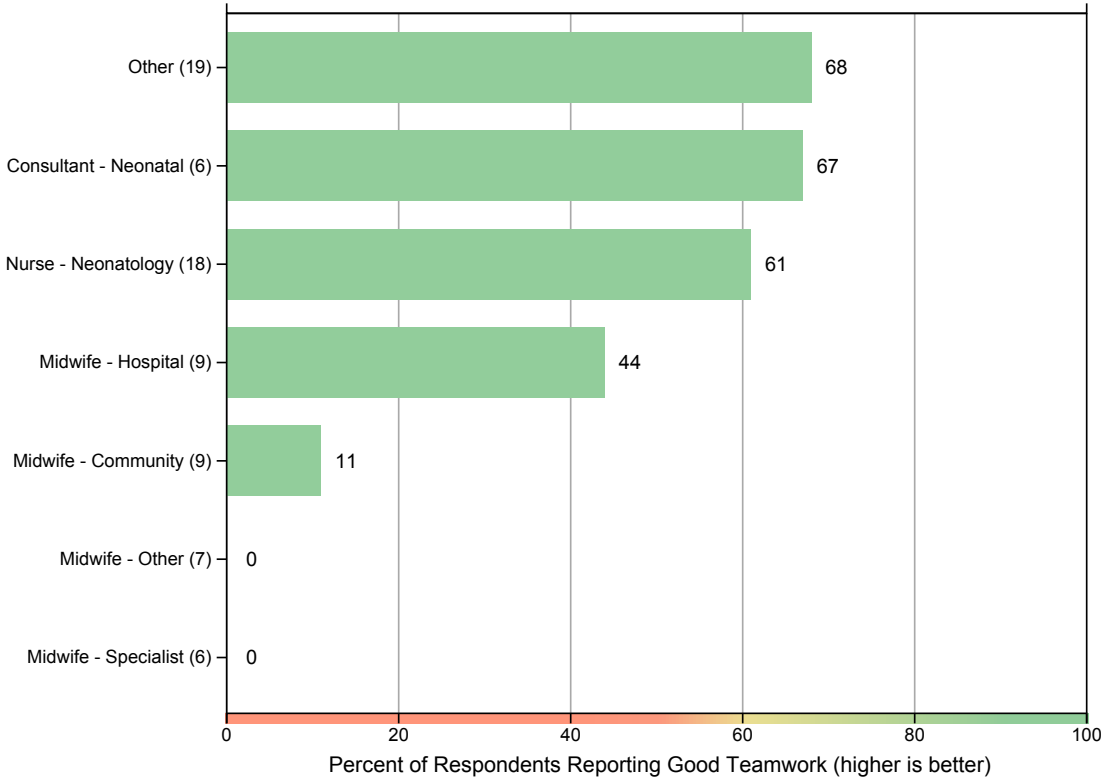


Benchmarks: 2021 UK Q1
25th: 20% 50th: 32% 75th: 46%
Percent Positive Percentile(s)
n = 30837 responses
From 1132 surgery/ward/unit

Source Data: Oct 2023
Institution: Wirral University Teaching Hospital NHS FT
Work Setting(s): All Work Settings
Position(s): All Positions

Safe & Reliable HEALTHCARE

Teamwork by Position



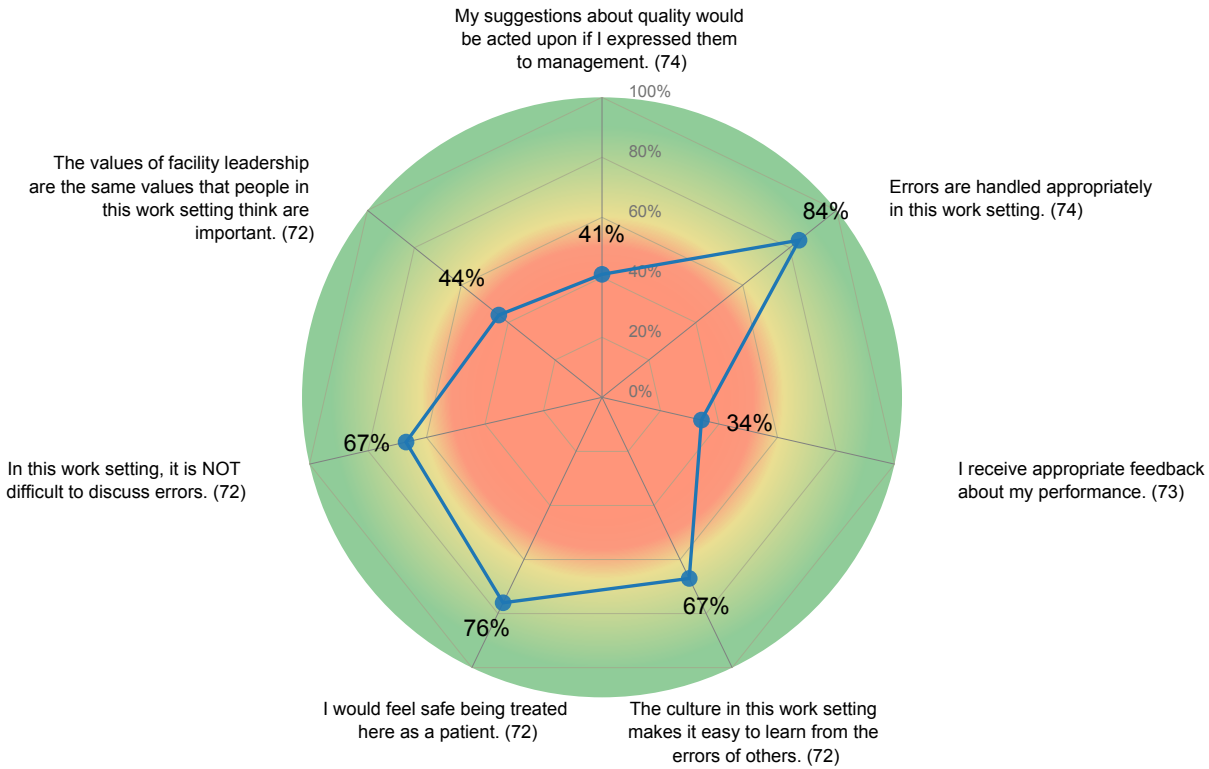
Source Data: Oct 2023

Institution: Wirral University Teaching Hospital NHS FT

Work Setting(s): All Work Settings

Position(s): All Positions

Wirral University Teaching Hospital NHS FT
Safety Climate Domain

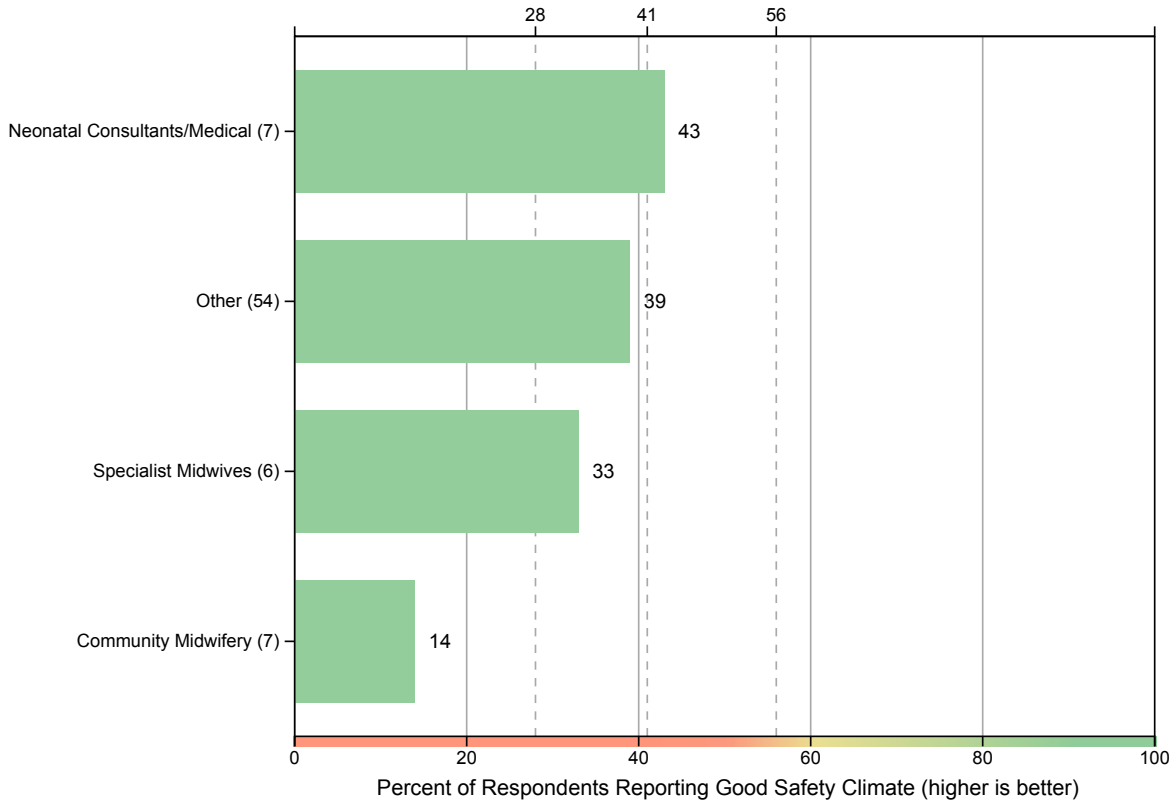


Source Data: Oct 2023
Institution: Wirral University Teaching Hospital NHS FT
Work Setting(s): All Work Settings
Position(s): All Positions

Percentage who Agreed slightly or Agreed strongly with each question or Disagreed slightly or Disagreed strongly if reversed.

Safe & Reliable HEALTHCARE

Safety Climate by Work Setting

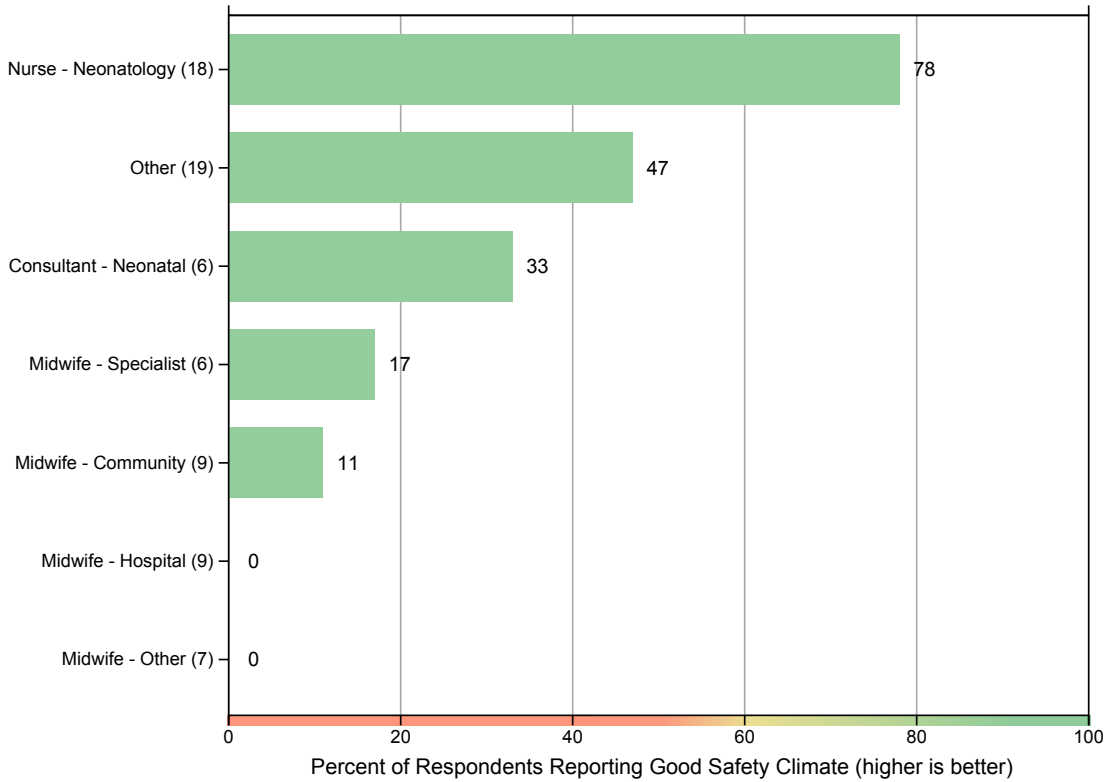


Benchmarks: 2021 UK Q1
25th: 28% 50th: 41% 75th: 56%
Percent Positive Percentile(s)
n = 30810 responses
From 1132 surgery/ward/unit

Source Data: Oct 2023
Institution: Wirral University Teaching Hospital NHS FT
Work Setting(s): All Work Settings
Position(s): All Positions

Safe & Reliable HEALTHCARE

Safety Climate by Position



Source Data: Oct 2023

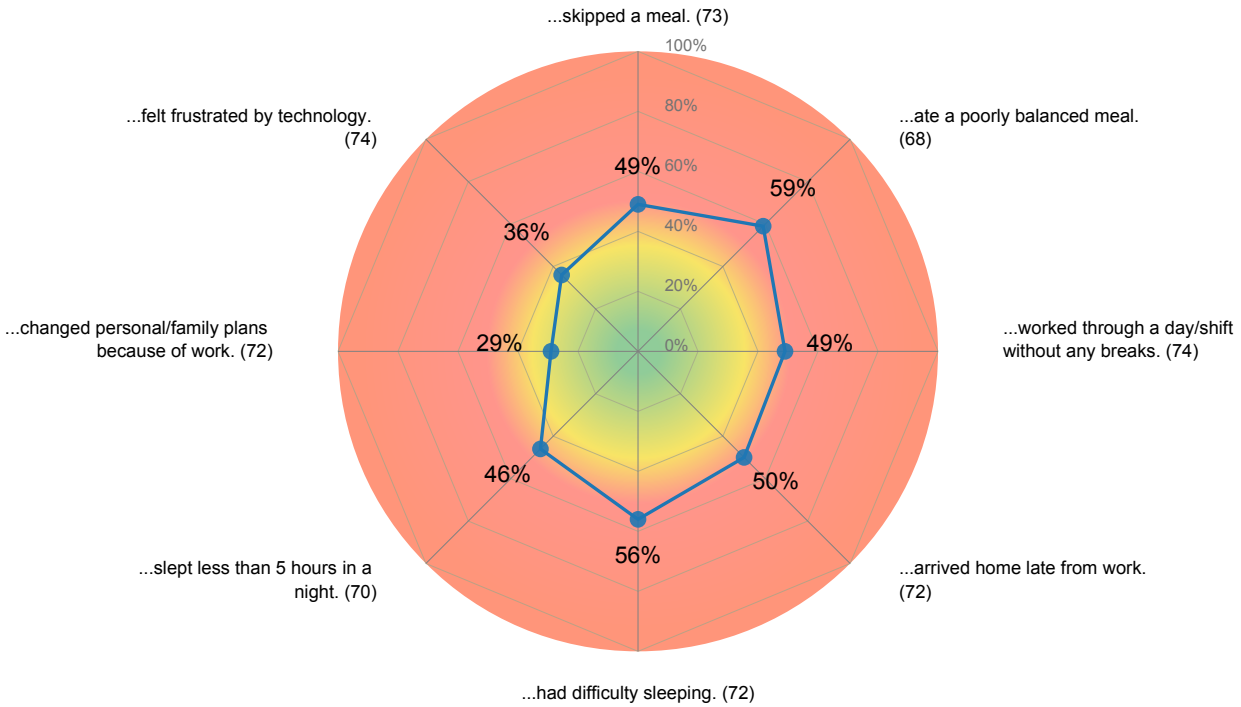
Institution: Wirral University Teaching Hospital NHS FT

Work Setting(s): All Work Settings

Position(s): All Positions

Wirral University Teaching Hospital NHS FT
Work-Life Balance Domain

In the past work week...

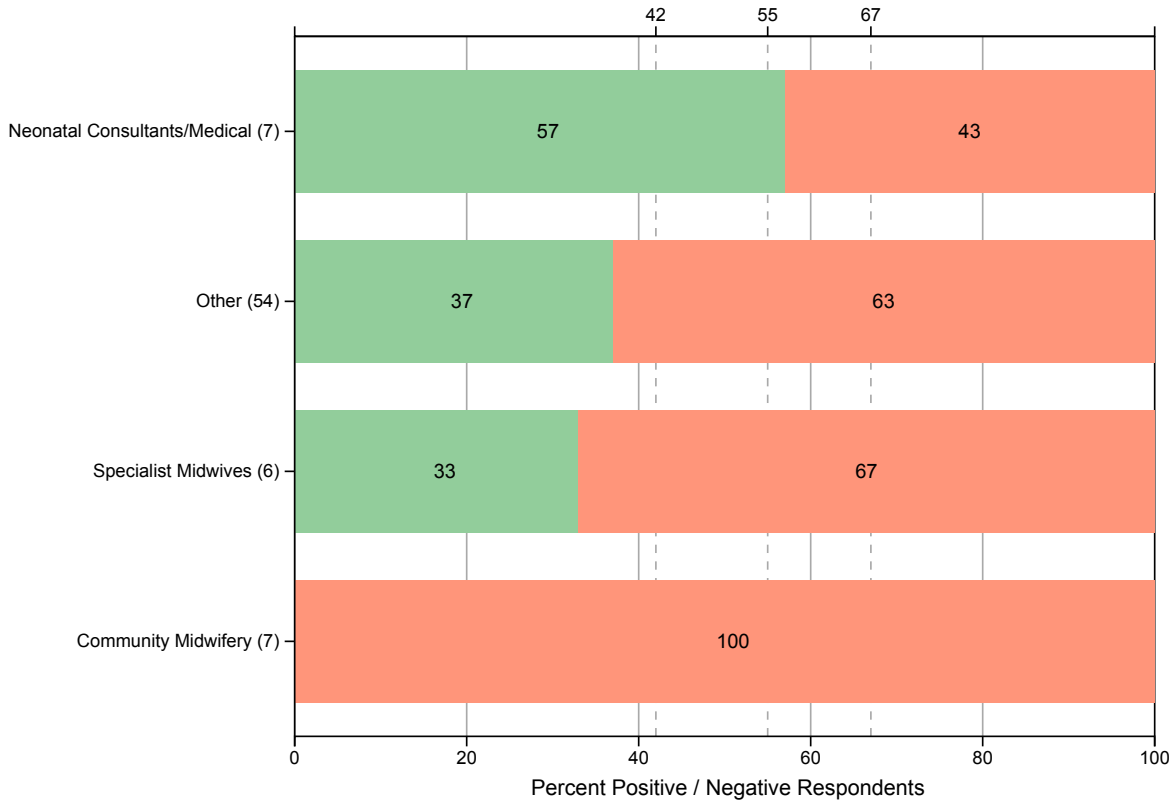


Source Data: Oct 2023
Institution: Wirral University Teaching Hospital NHS FT
Work Setting(s): All Work Settings
Position(s): All Positions

Percentage who said each event happened 3 or more times per week.

Safe & Reliable HEALTHCARE

Work-Life Balance by Work Setting

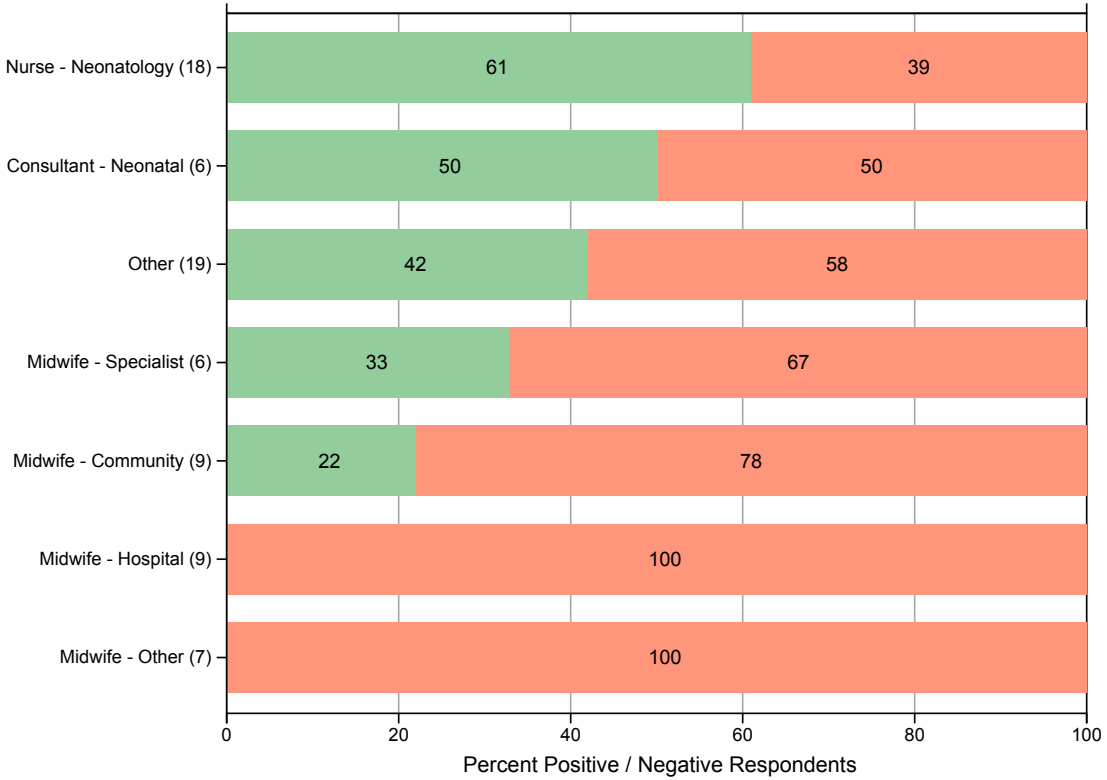


Benchmarks: 2021 UK Q1
25th: 42% 50th: 55% 75th: 67%
Percent Positive Percentile(s)
n = 30311 responses
From 1126 surgery/ward/unit

Source Data: Oct 2023
Institution: Wirral University Teaching Hospital NHS FT
Work Setting(s): All Work Settings
Position(s): All Positions

Safe & Reliable HEALTHCARE

Work-Life Balance by Position



Source Data: Oct 2023
Institution: Wirral University Teaching Hospital NHS FT
Work Setting(s): All Work Settings
Position(s): All Positions

Domain Scores - A Picture of the Organization

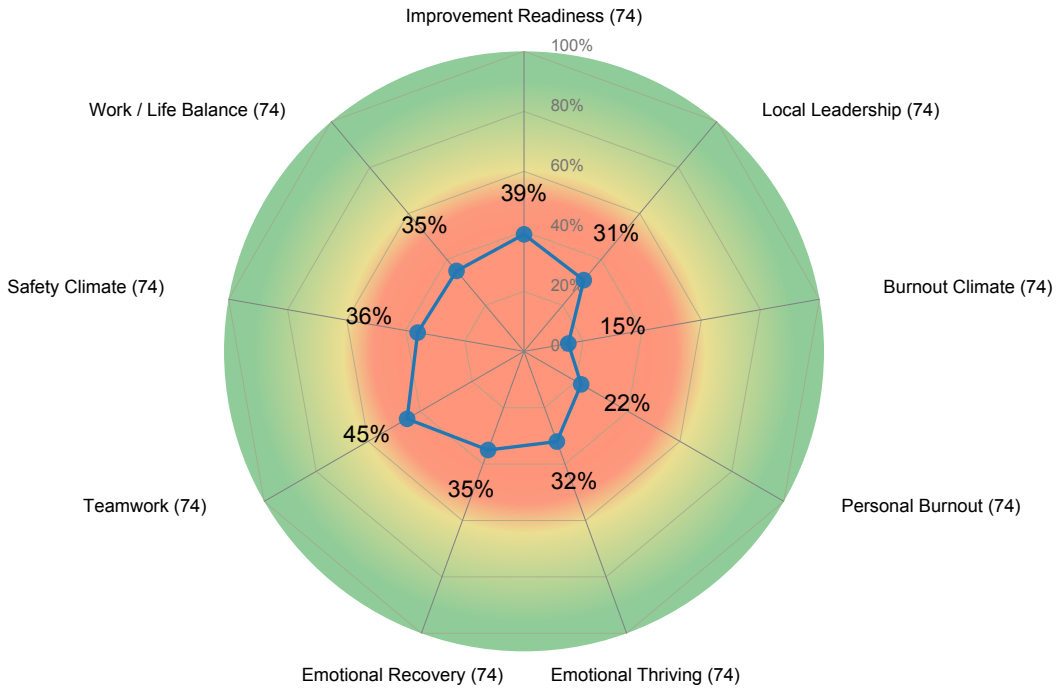
- Please remember domains are composed of groups of questions, and respondents very often answer individual questions differently.

- This phenomenon, known as cultural instability, results in domain scores being lower than individual question scores.

- That is why it is really important to examine the SCORE data at an individual question level.

Safe & Reliable HEALTHCARE

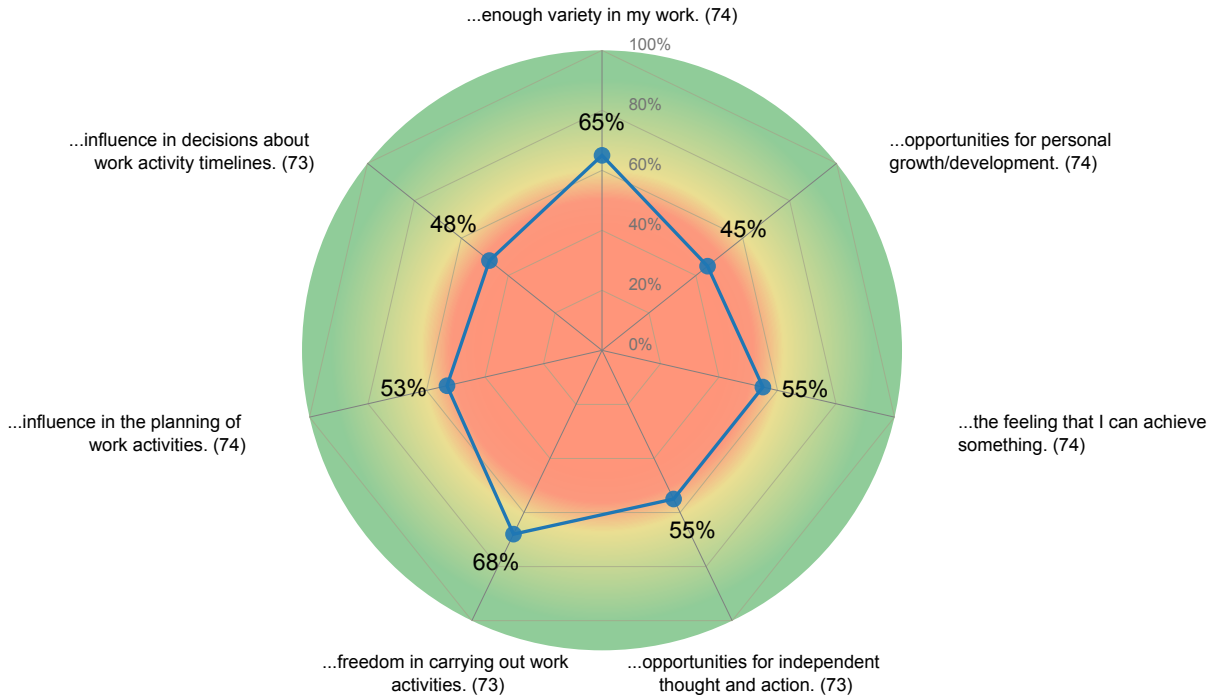
Wirral University Teaching Hospital NHS FT
All Culture Domains



Source Data: Oct 2023
Institution: Wirral University Teaching Hospital NHS FT
Work Setting(s): All Work Settings
Position(s): All Positions

Wirral University Teaching Hospital NHS FT
Growth Opportunities Domain

With respect to the growth opportunities in this work setting I have...

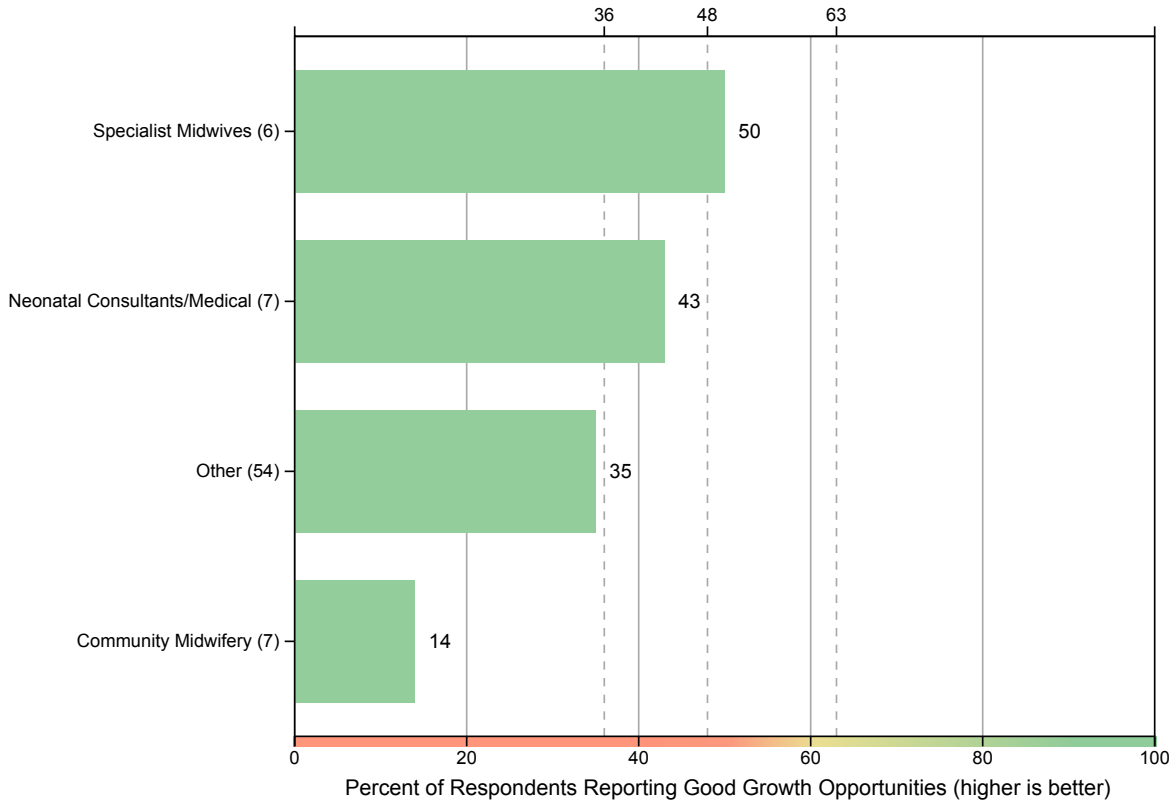


Source Data: Oct 2023
Institution: Wirral University Teaching Hospital NHS FT
Work Setting(s): All Work Settings
Position(s): All Positions

Percentage who Agreed slightly or Agreed strongly with each question or Disagreed slightly or Disagreed strongly if reversed.

Safe & Reliable HEALTHCARE

Growth Opportunities by Work Setting



Benchmarks: 2021 UK Q1
25th: 36% 50th: 48% 75th: 63%
Percent Positive Percentile(s)
n = 28357 responses
From 1064 surgery/ward/unit

Source Data: Oct 2023
Institution: Wirral University Teaching Hospital NHS FT
Work Setting(s): All Work Settings
Position(s): All Positions

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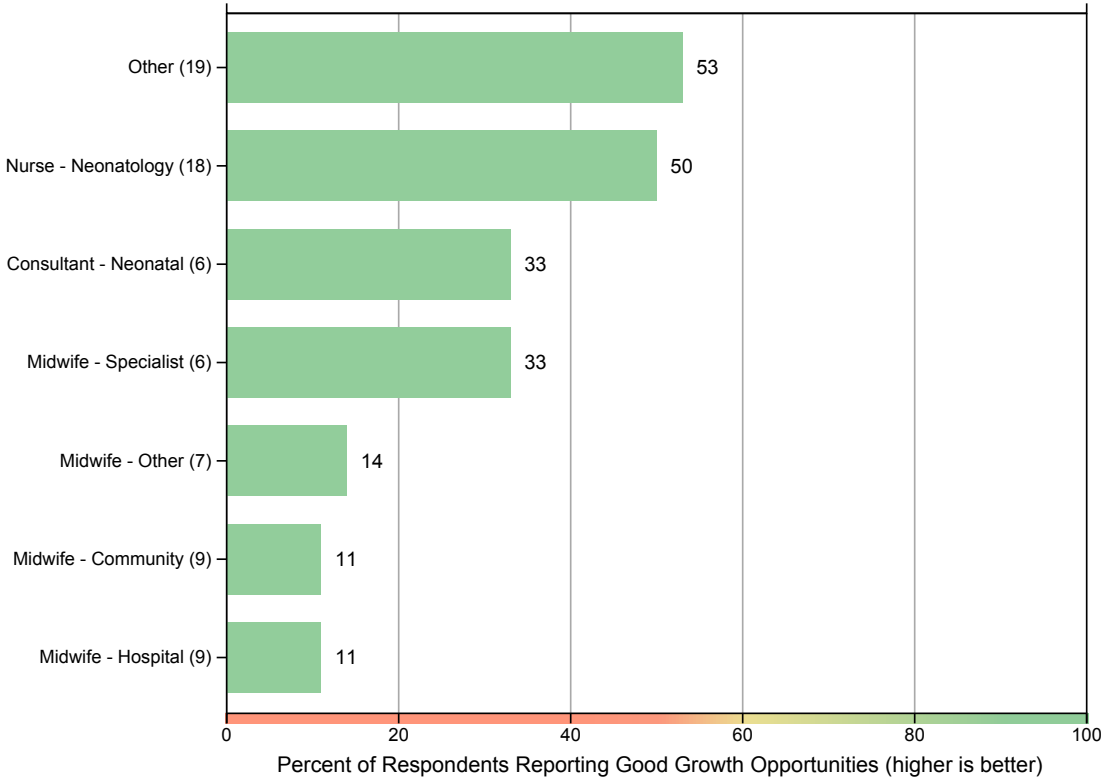
Growth Opportunities by Position



Source Data: Oct 2023

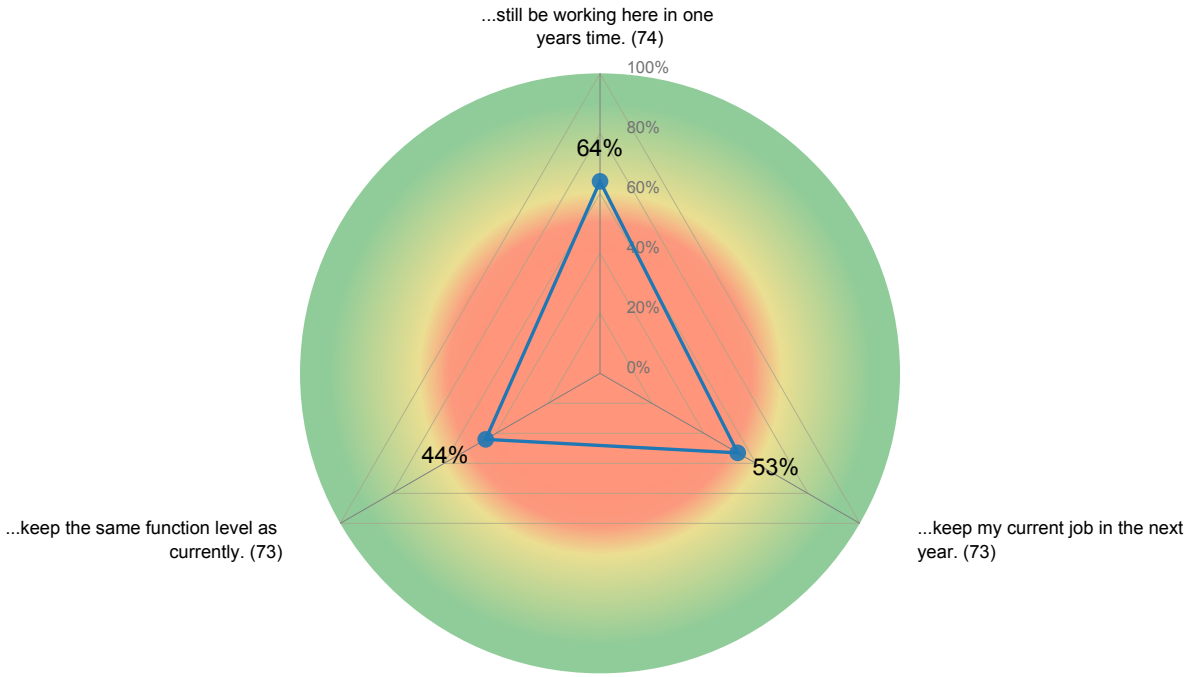
Institution: Wirral University Teaching Hospital NHS FT

Work Setting(s): All Work Settings

Position(s): All Positions

Wirral University Teaching Hospital NHS FT
Job Certainty Domain

With respect to job-related uncertainty about the future in this work setting, I feel certain that I will...



Source Data: Oct 2023
Institution: Wirral University Teaching Hospital NHS FT
Work Setting(s): All Work Settings
Position(s): All Positions

Percentage who Agreed slightly or Agreed strongly with each question or Disagreed slightly or Disagreed strongly if reversed.

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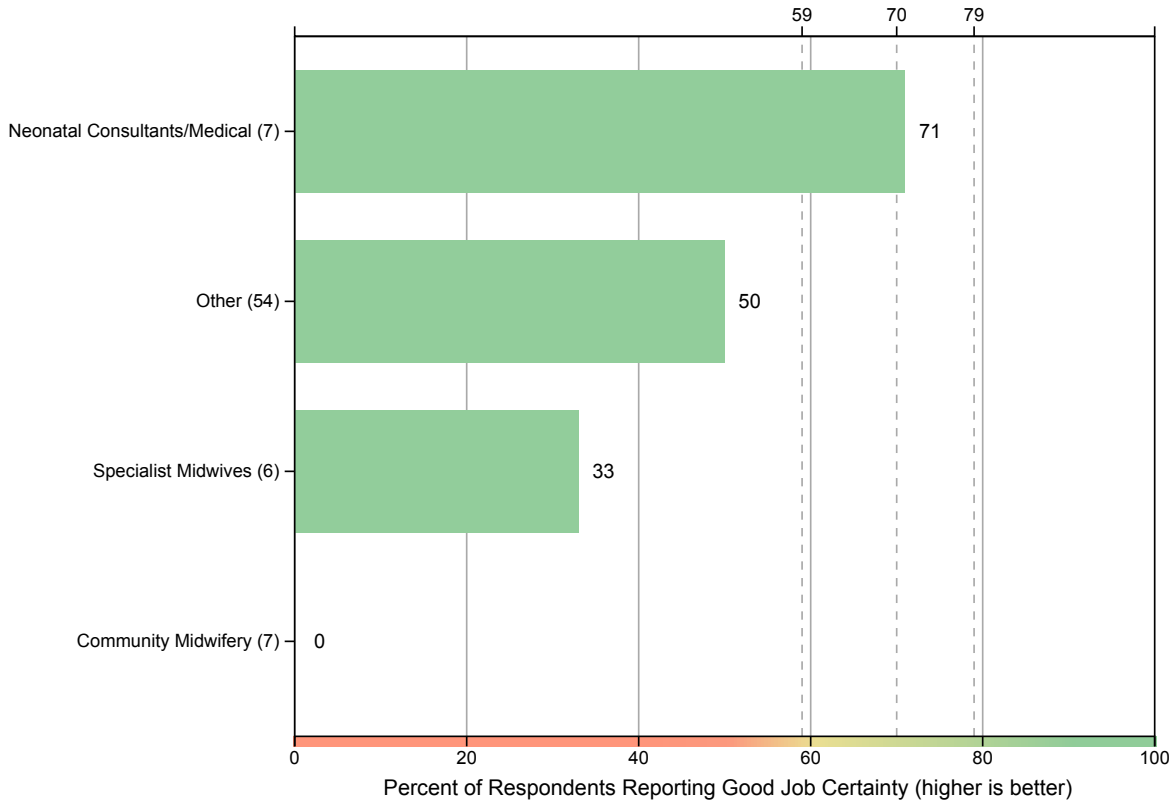
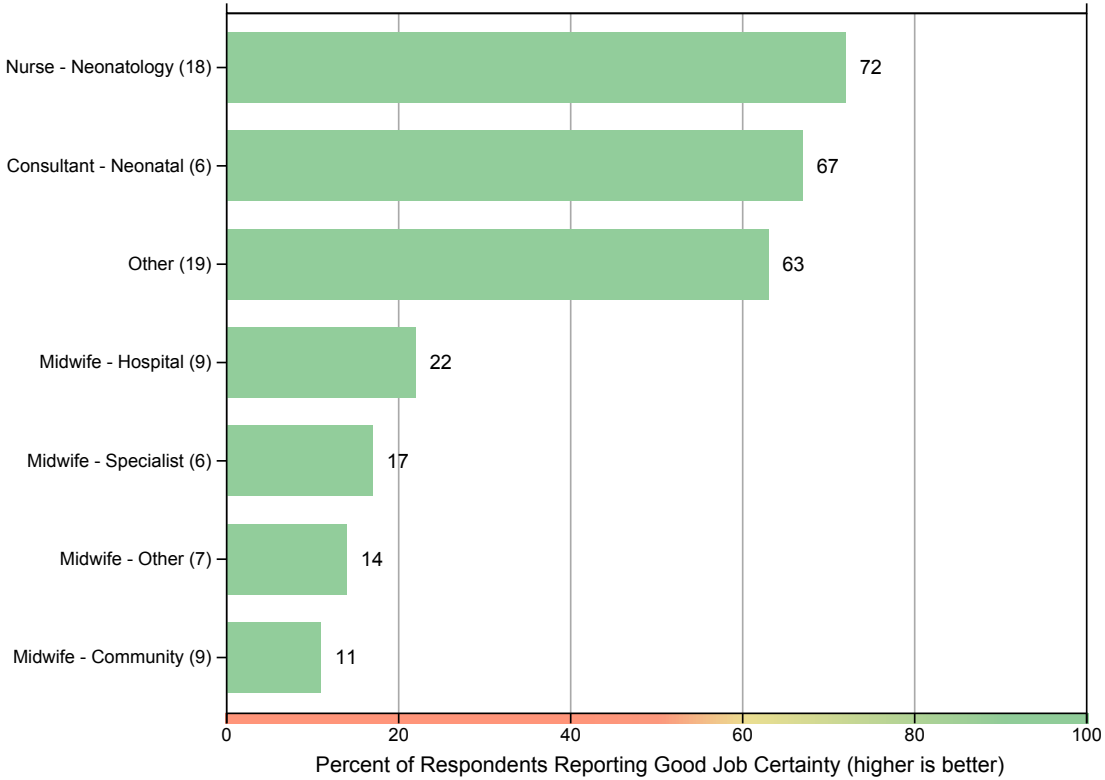
Job Certainty by Work Setting



Benchmarks: 2021 UK Q1
25th: 59% 50th: 70% 75th: 79%
Percent Positive Percentile(s)
n = 27892 responses
From 1062 surgery/ward/unit

Source Data: Oct 2023
Institution: Wirral University Teaching Hospital NHS FT
Work Setting(s): All Work Settings
Position(s): All Positions

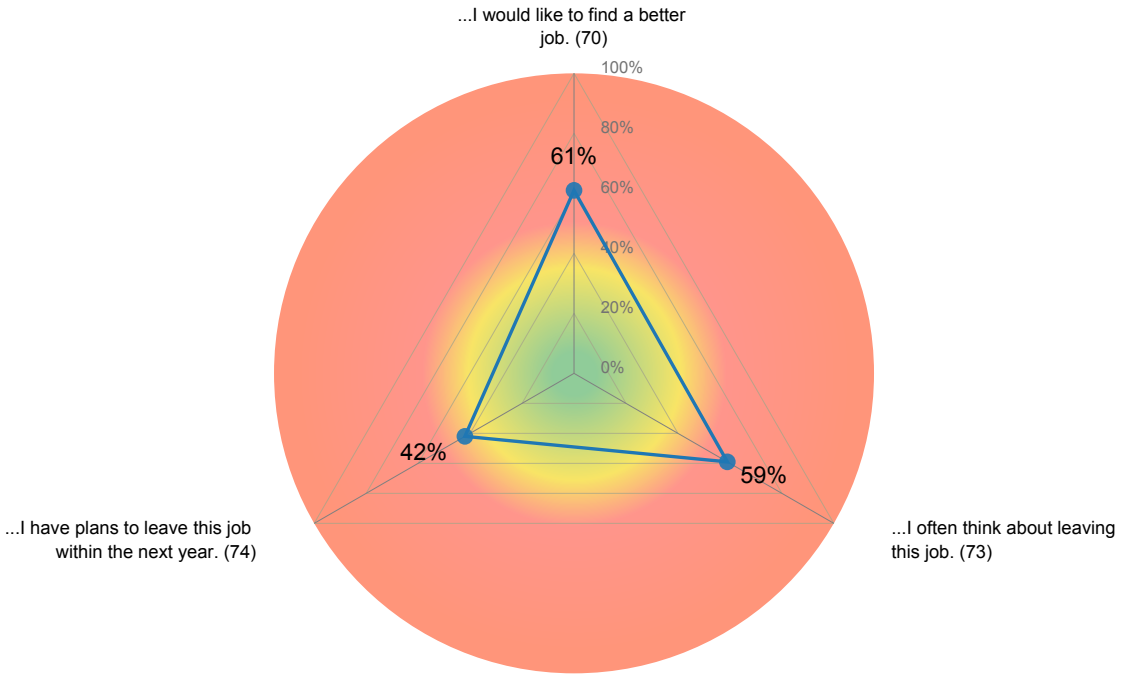
Job Certainty by Position



Source Data: Oct 2023
Institution: Wirral University Teaching Hospital NHS FT
Work Setting(s): All Work Settings
Position(s): All Positions

Wirral University Teaching Hospital NHS FT
Intentions to Leave Domain

With respect to my intentions to leave this organization...



Source Data: Oct 2023
Institution: Wirral University Teaching Hospital NHS FT
Work Setting(s): All Work Settings
Position(s): All Positions

Percentage who Agreed slightly or Agreed strongly with each question or Disagreed slightly or Disagreed strongly if reversed.

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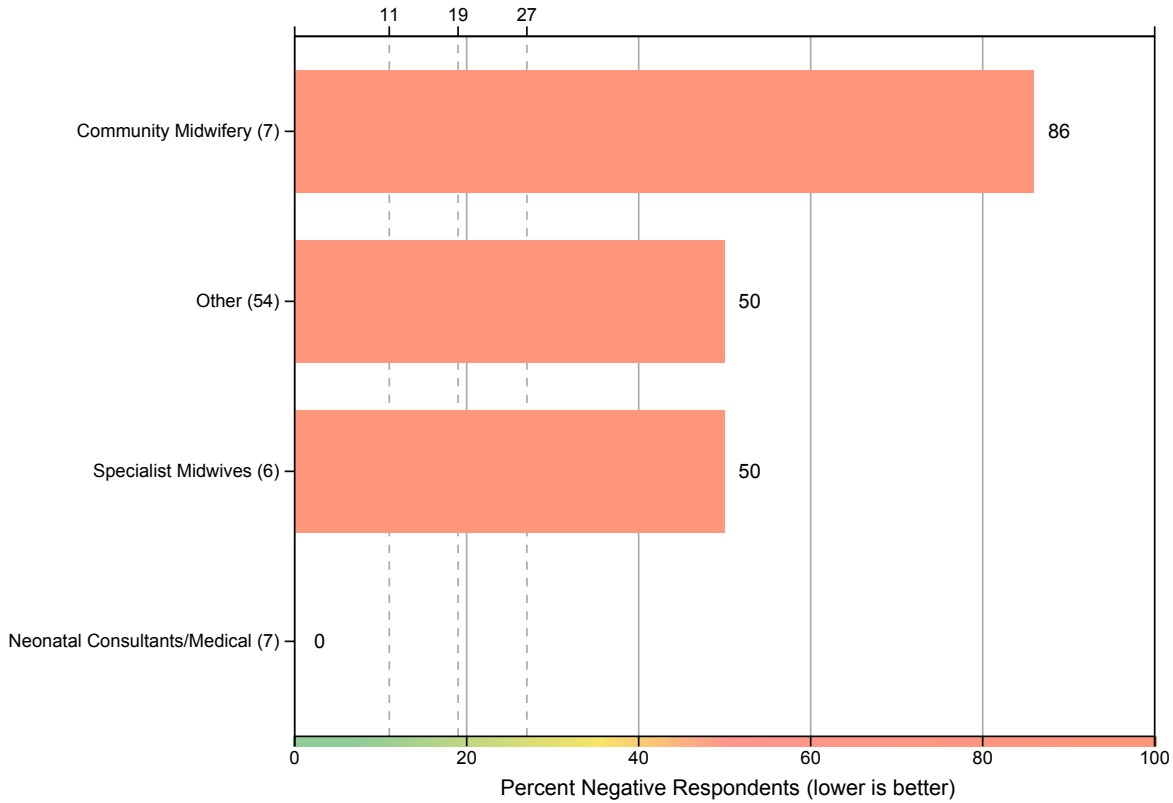
Intentions to Leave by Work Setting



Benchmarks: 2021 UK Q1
25th: 27% 50th: 19% 75th: 11%
Percent Negative Percentile(s)
n = 27291 responses
From 1061 surgery/ward/unit

Source Data: Oct 2023
Institution: Wirral University Teaching Hospital NHS FT
Work Setting(s): All Work Settings
Position(s): All Positions

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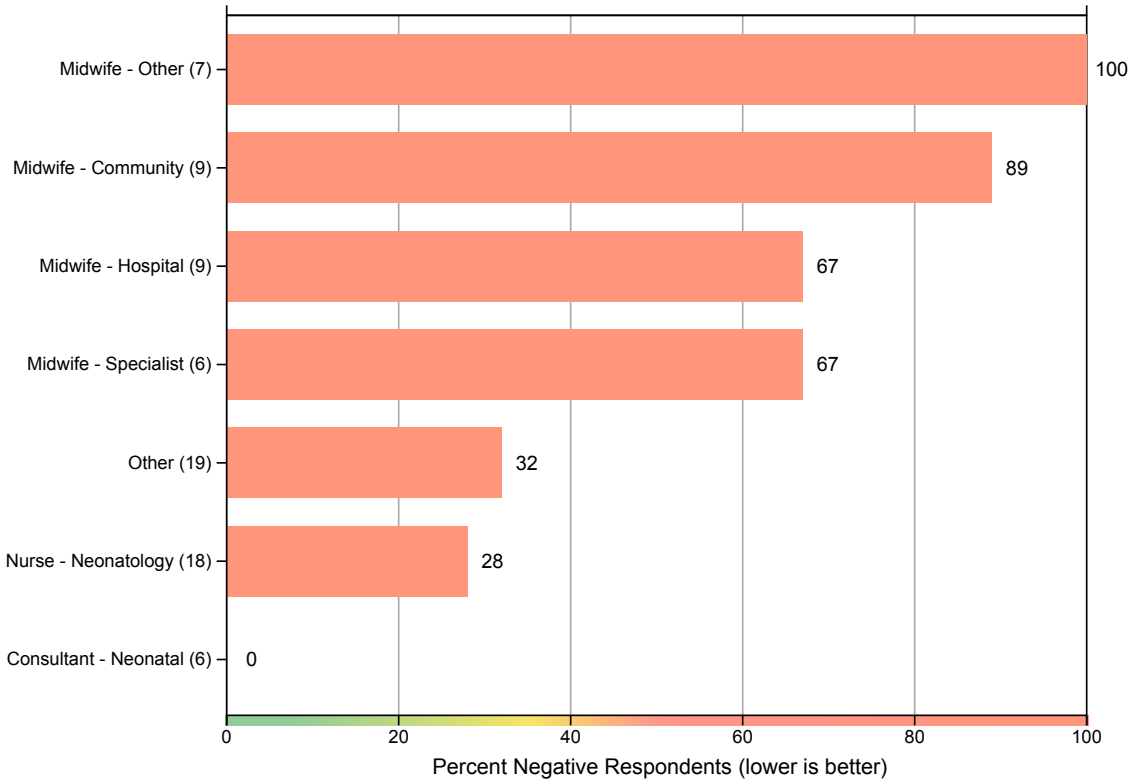
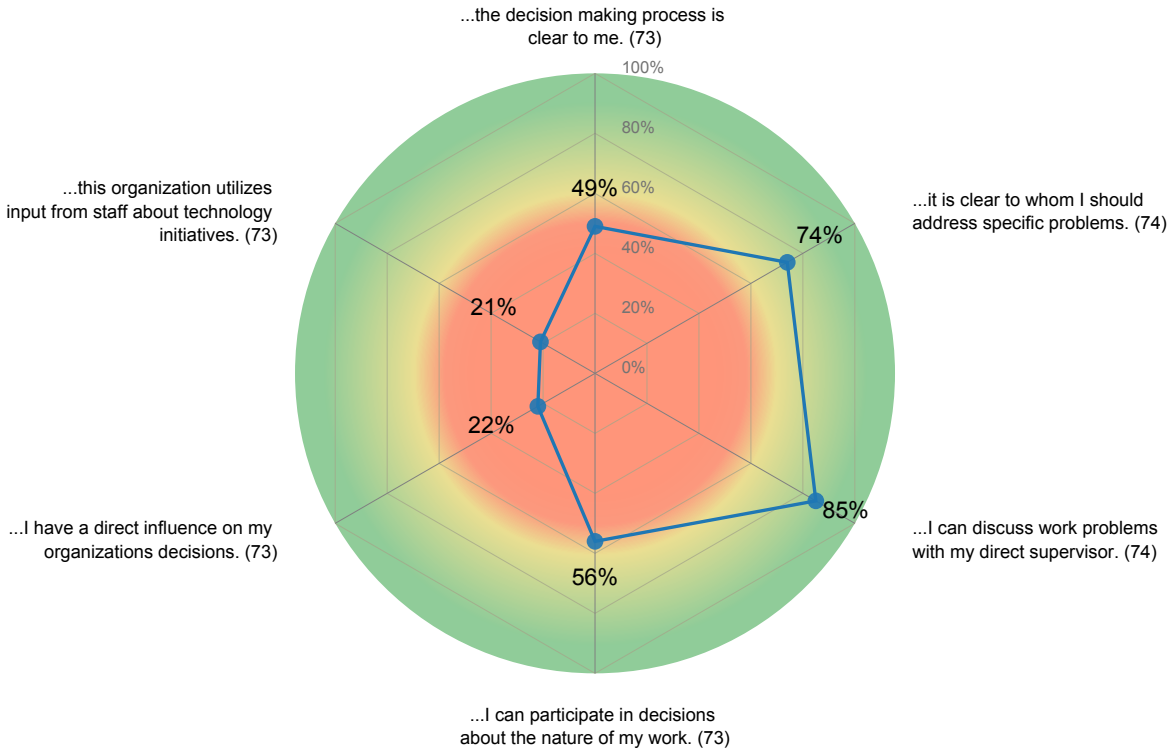
Intentions to Leave by Position



Source Data: Oct 2023
Institution: Wirral University Teaching Hospital NHS FT
Work Setting(s): All Work Settings
Position(s): All Positions

Wirral University Teaching Hospital NHS FT
Decision Making Domain

With respect to the participation in decision making that I experience here...



Source Data: Oct 2023
Institution: Wirral University Teaching Hospital NHS FT
Work Setting(s): All Work Settings
Position(s): All Positions

Percentage who Agreed slightly or Agreed strongly with each question or Disagreed slightly or Disagreed strongly if reversed.

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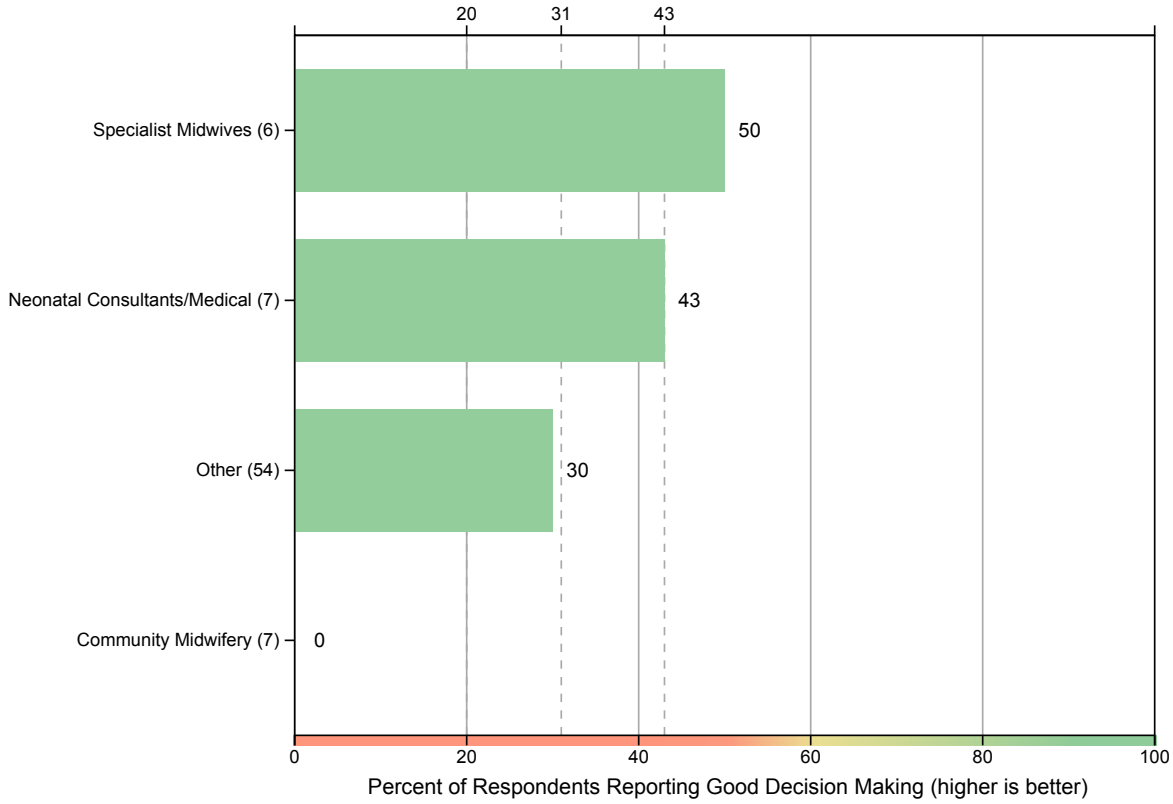
Decision Making by Work Setting



Benchmarks: 2021 UK Q1
25th: 20% 50th: 31% 75th: 43%
Percent Positive Percentile(s)
n = 28342 responses
From 1064 surgery/ward/unit

Source Data: Oct 2023
Institution: Wirral University Teaching Hospital NHS FT
Work Setting(s): All Work Settings
Position(s): All Positions

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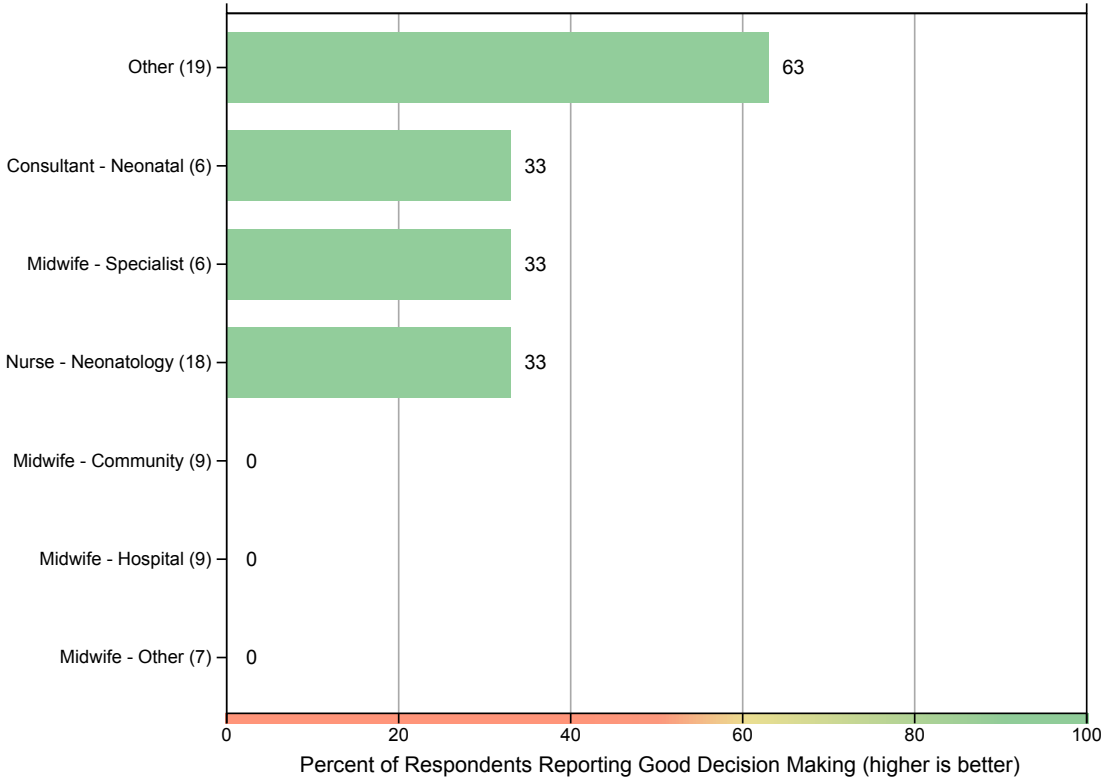
Decision Making by Position



Source Data: Oct 2023

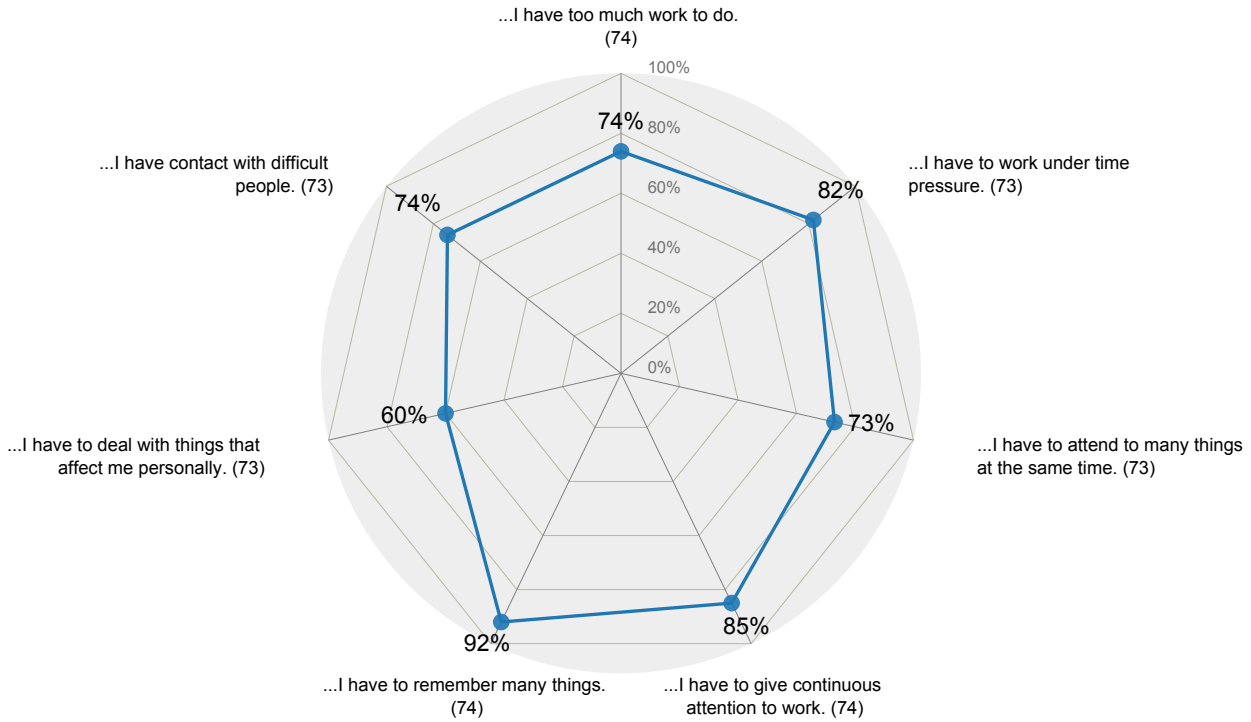
Institution: Wirral University Teaching Hospital NHS FT

Work Setting(s): All Work Settings

Position(s): All Positions

Wirral University Teaching Hospital NHS FT
Workload Strain Domain

With respect to the workload in this work setting...



Source Data: Oct 2023
Institution: Wirral University Teaching Hospital NHS FT
Work Setting(s): All Work Settings
Position(s): All Positions

Percentage who Agreed slightly or Agreed strongly with each question or Disagreed slightly or Disagreed strongly if reversed.

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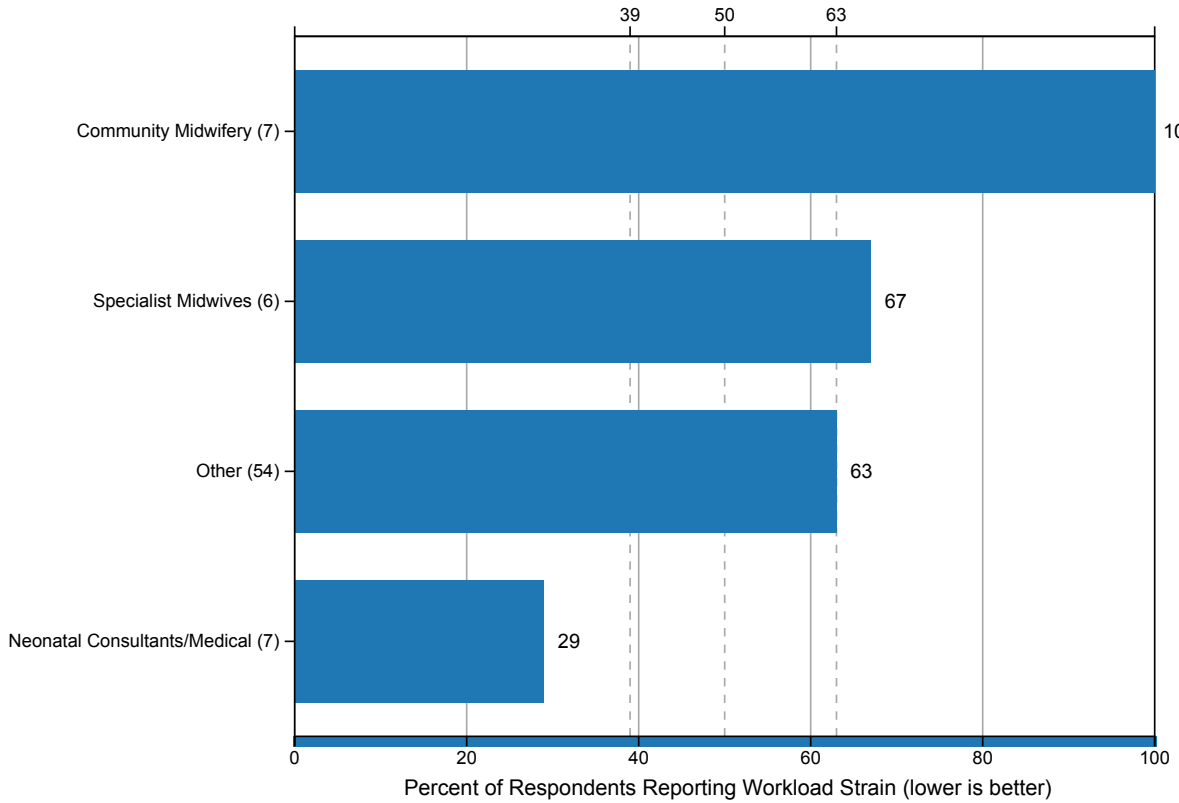
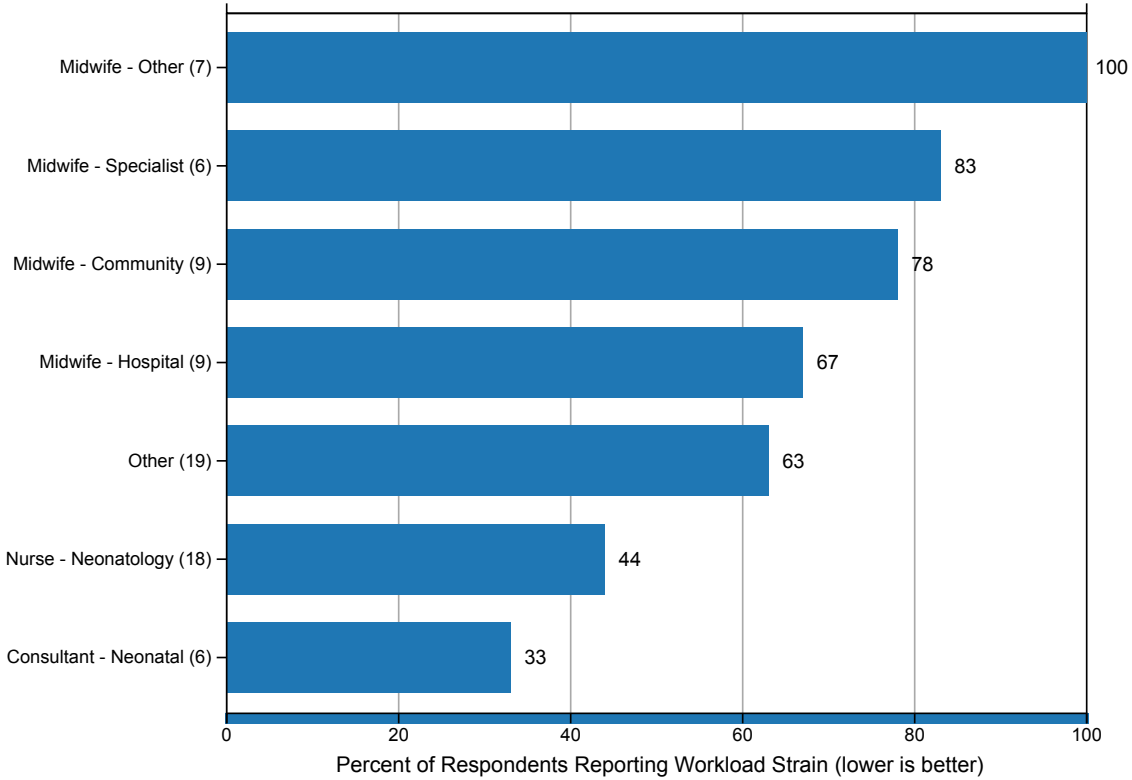
Workload Strain by Work Setting



Benchmarks: 2021 UK Q1
25th: 63% 50th: 50% 75th: 39%
Percent Strained Percentile(s)
n = 28376 responses
From 1065 surgery/ward/unit

Source Data: Oct 2023
Institution: Wirral University Teaching Hospital NHS FT
Work Setting(s): All Work Settings
Position(s): All Positions

Workload Strain by Position



Source Data: Oct 2023
Institution: Wirral University Teaching Hospital NHS FT
Work Setting(s): All Work Settings
Position(s): All Positions

Domain Scores - A Picture of the Organization

- Please remember domains are composed of groups of questions, and respondents very often answer individual questions differently.

- This phenomenon, known as cultural instability, results in domain scores being lower than individual question scores.

- That is why it is really important to examine the SCORE data at an individual question level.

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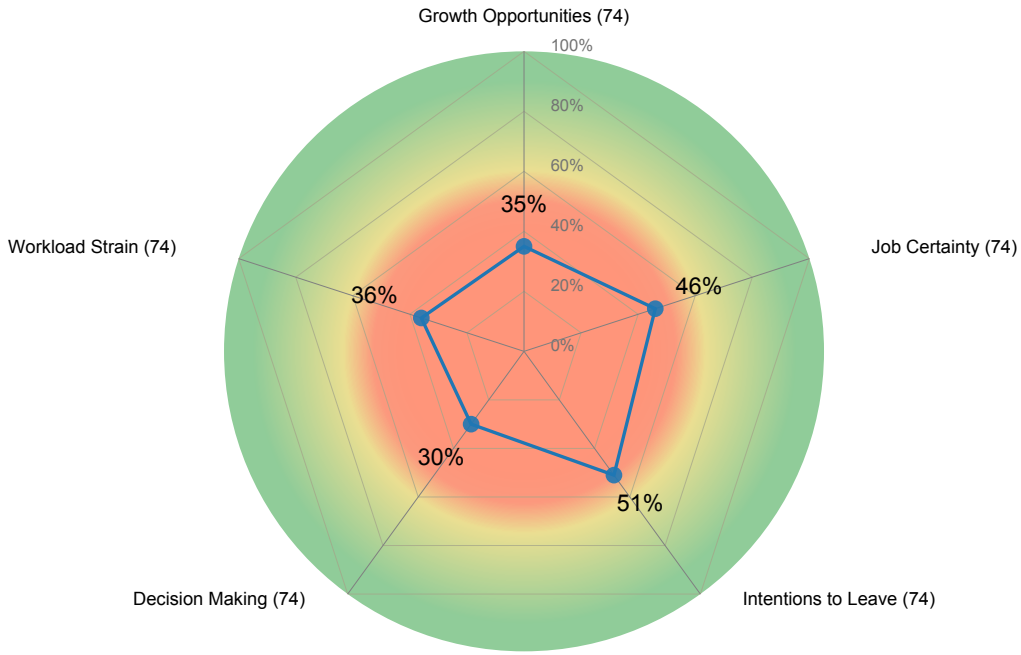
Wirral University Teaching Hospital NHS FT
All Engagement Domains



Source Data: Oct 2023
Institution: Wirral University Teaching Hospital NHS FT
Work Setting(s): All Work Settings
Position(s): All Positions

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