There were no episodes this Quarter where a consultant did not meet the required 11 hrs Compensatory Rest.

7.3 Neonatal Staffing

7.3.1 Neonatal Nursing

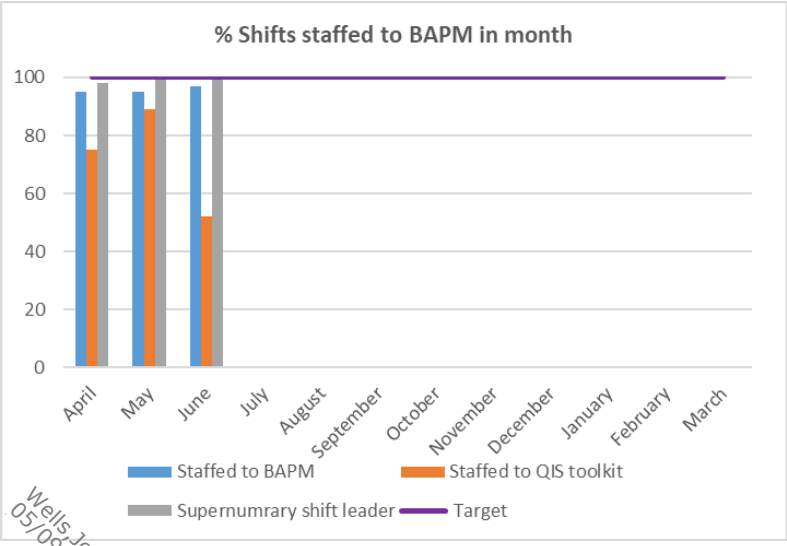
Safe neonatal nurse staffing is monitored by taking the following actions:

- Completion of safe staffing on Badgernet – three times day
- Monitoring nurse patient ratios as per BAPM
- Monitoring staffing red flags as recommended by NICE guidance
- Daily safety huddles
- SitRep report and capacity meetings three times a day
- Monitoring sickness/absence and turnover rates
- Monitoring recruitment/vacancy rates
- Daily escalation - temporary NHSP and Agency staffing
- Monthly safe staffing report to Nursing Workforce Advisory Group (NWAG)
- Monthly safe staffing report to CNO Production Board huddles

The unit provides the following nurse-patient ratios to meet BAPM:

- 1:1 Intensive Care (IC)
- 1:2 High Dependency (HD)
- 1:4 Special Care (SC)
- Supernumerary shift leader

In Q1 of 2025-26, over 95% of shifts were successfully staffed in line with BAPM guidelines, with any shortfalls attributed to high acuity levels. This represents an improvement compared to the previous quarter. The supernumerary status for the shift leader was also achieved. Although staffing compliance with the QIS toolkit dropped to 51.67% in June due to acuity challenges, all shifts remained safe. Escalation protocols were effectively implemented, and no red flags or staffing incidents were reported during the quarter.



% shifts to BAPM recommendation

The number of nurses qualified in specialty achieved the 70% recommended by the end of Q1.

The turnover rate for both registered and non-registered staff remains below the Trust target. Registered nurses have seen an increase in sickness absence this quarter, which is slightly above the Trust target, while non-registered nurses experienced a significant decrease in sickness absence by the end of Q1, which is a positive trend. Staff continue to be directed for health and well-being support.

7.3.2 Neonatal medical staff

Tier One

BAPM recommends units designated as LNUs should have immediately available at least one resident Tier 1 practitioner dedicated to providing emergency care for the neonatal service 24/7.

WAHT has one resident tier 1 practitioner 24/7.

Tier Two

BAPM recommends:

- *LNUs undertaking either >1000 RCDs or >400 IC days annually should strongly consider providing a 24/7 resident Tier 2 dedicated to the neonatal unit and entirely separate from paediatrics.*
- *LNUs should provide an immediately available resident Tier 2 practitioner dedicated solely to the neonatal service at least during the periods which are usually the busiest in a co-located Paediatric Unit, seven days a week.*

Weekdays – there is a resident tier 2 practitioner 09.00-17.00 5 days a week. Thereafter there is a resident tier 2 practitioner across both neonates and paediatrics.

Weekends – 09.00 - 14.00 there is 1 tier 2 practitioner covering neonates and paediatrics. 14.00 - 22.00 there is 2nd tier 2 practitioner solely covering neonates.

The directorate are reviewing the requirements for tier 2 against BAPM to meet recommended workforce.

Tier Three

BAPM recommends LNUs should provide a separate Tier 3 Consultant rota for the neonatal unit.

WAHT provide a separate consultant rota for NNU. We currently have 7wte consultants in post and require 8wte to cover the neonatal rota. We have recently appointed an 8th consultant due to commence in May 2025.

7.3.3 Neonatal AHPs

In 2022, WAHT received funding for 80% WTE to meet the required standards for the provision of Allied Health Professionals (AHPs). AHP services are now operational through a Service Level Agreement (SLA) with Worcestershire Health and Care Trust, delivering measurable benefits across physiotherapy, occupational therapy, speech and language therapy, dietetics, and psychology for our patients. However, a 20% shortfall remains in meeting the recommended AHP workforce levels.

In October 2024, neonatal services underwent peer review by the West Midlands Perinatal Network, which identified the need for improvement in the AHP workforce. It was highlighted that the current staffing does not meet recommended levels, and there is an opportunity to assess workforce requirements to better support outreach, follow-up care, and inpatient services. The Trust is collaborating with the Director of Allied Health Professionals to explore alternative care models and determine service needs. Addressing the workforce shortfall will require additional funding in the future.

8. Service User Feedback

8.1 Maternity& Neonatal Voice Partnership

The audits on feedback for the birth preference cards is underway and will be presented in the next report (Q2). BRAINS is also an ongoing piece of work. Ongoing work concerning the debrief service has led to a new process being embedded from July 2025. The senior midwifery team are now reviewing all requests for debriefs within the newly agreed service specification to ensure that women and their families are seen by the most appropriate clinician. This also will ensure that appropriate onward referrals are made in a timely manner for example, for an obstetric discussion, referral to Beacon Maternal Mental Health or Talking Therapies amongst others. The role of a dedicated 'debrief midwife' will be advertised in due course and will be a substantive part time role, with the ability to offer face to face or virtual appointments across the county.

8.2 Baby Friendly and BLISS Accreditation

The neonatal unit achieved BFI Stage 1 accreditation in 2024 and has submitted its action plans in preparation for the Stage 2 assessment scheduled for July 2025. Meanwhile, the maternity unit remains focused on progressing towards 'GOLD' accreditation although there is no target date set currently.

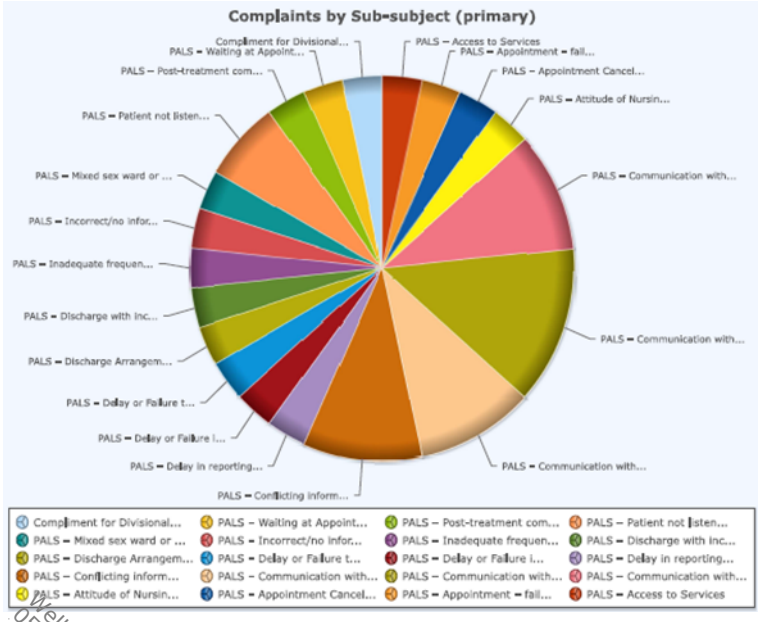
After achieving 'SILVER' accreditation from BLISS and the neonatal team is now actively working towards achieving 'GOLD' status, with the target set for the end of Q3 2025/26

8.3 Complaints and PALS feedback – Maternity and Neonates

There are no specific themes/trends identified in terms of clinical care, but attitude and behaviours of staff that was emerging as a theme in Q4 has not been seen in the recent complaints.

Neonatal: No complaints or PALS received in Q1.

Maternity: In Q1 2025, there were 30 PALS received and are categorised below – the main theme remains communication – recognising this covers a broad spectrum of concerns.



In addition, 17 formal complaints were received:

ID	First received	Specialty	Subject (primary)	Sub-subject (primary)
103074	30/06/2025	Maternity (formerly Obstetrics)	Communications	Communication with patient
101690	29/05/2025	Maternity (formerly Obstetrics)	Clinical Treatment	Incorrect treatment
98943	04/04/2025	Maternity (formerly Obstetrics)	Values and Behaviours (Staff)	Attitude of Nursing Staff/midwives
102179	09/06/2025	Maternity (formerly Obstetrics)	Clinical Treatment	Inadequate pain management
102179	09/06/2025	Maternity (formerly Obstetrics)	Clinical Treatment	Inadequate pain management
103073	30/06/2025	Maternity (formerly Obstetrics)	Clinical Treatment	Delay or failure in observations
100925	30/05/2025	Maternity (formerly Obstetrics)	Consent	Insufficient information provided prior to consent
99873	17/04/2025	Maternity (formerly Obstetrics)	Clinical Treatment	Delay in induction of labour
99536	08/04/2025	Maternity (formerly Obstetrics)	Communications	Communication with patient
102180	09/06/2025	Maternity (formerly Obstetrics)	Clinical Treatment	Surgical site infection / infection to wound
102393	13/06/2025	Maternity (formerly Obstetrics)	Clinical Treatment	Delay in treatment
99508	16/05/2025	Maternity (formerly Obstetrics)	Trust Admin Policies & Procedures (Incl. Patient Records Management)	Accuracy of health records (e.g. errors, omissions, other patient's records in file)
102552	17/06/2025	Maternity (formerly Obstetrics)	Clinical Treatment	Delay or failure in ordering tests
101482	29/05/2025	Maternity (formerly Obstetrics)	Clinical Treatment	Wound dehiscence
101269	19/05/2025	Maternity (formerly Obstetrics)	Patient Care	Failure to provide adequate care (inc. overall level of care provided)
99688	14/04/2025	Maternity (formerly Obstetrics)	Patient Care	Failure to adopt infection control measures
100802	08/05/2025	Maternity (formerly Obstetrics)	Clinical Treatment	Delay in treatment
99600	10/04/2025	Maternity (formerly Obstetrics)	Communications	Conflicting information

Over recent months we have seen an increase in complaints around consent and support for vaginal examination and pain relief/Support in early labour. The antenatal ward have created an action plan to address these findings and the progress of this is monitored at the Senior Midwives Meeting which is held monthly.

9. Safety Champion escalations

The Safety Champions meetings in April and June where both stood down due to acuity and quoracy. Summary of the meeting held is May is below.

Seven people attended a bespoke community teams meeting, and no concerns were raised. Similarly, the same Meadow Birth Centre and theatre staff reported no concerns either.

In Triage, several concerns were noted:

- There were delays in doctor reviews.
- Patients were being seated in the corridor due to a lack of space in the waiting room.
- Inconsistencies were observed in the BSOTS categorisation process.
- The triage phone midwife role was not protected on this day, as the midwife was redeployed to other areas. This was addressed with the senior midwife who made the decision and reminded that this role is ‘ring-fenced’

On the Antenatal Ward (ANW), the following were discussed:

- There were concerns about equipment availability, although new stock was sourced immediately.
- A Band 5 midwife was in charge of the ward, which was discussed with 223.

- A review of the IOL list is planned to take place before the ward round.

Feedback from the Neonatal team was positive. The Peri-Prem board was noted, and the Safety Champions requested further information regarding the areas of low compliance and it was noted that there is currently no Peri-Prem nurse in post however the funding is available and recruitment is planned.

On the Delivery Suite Governance Board, MMT training compliance was reported at 43% and required updating as this was incorrect. Several equipment issues were observed, including a broken trolley and CTG machines. COVID-19 screens remain in place. Additionally, lighting is broken, and room temperatures continue to be a concern in room 4. All of these issues have been added to the action plan for review at the next meeting.

Quad update included:

The first Quad Walkabout was successfully undertaken, with plans now in place to conduct these on a monthly basis. During the visit, all clinical areas were covered, and discussions were held around the importance of ensuring that the Peri-Prem initiative is embedded in Maternity. It was agreed that displaying the Peri-Prem statistics poster on the Antenatal Ward would be a helpful visual aid for staff.

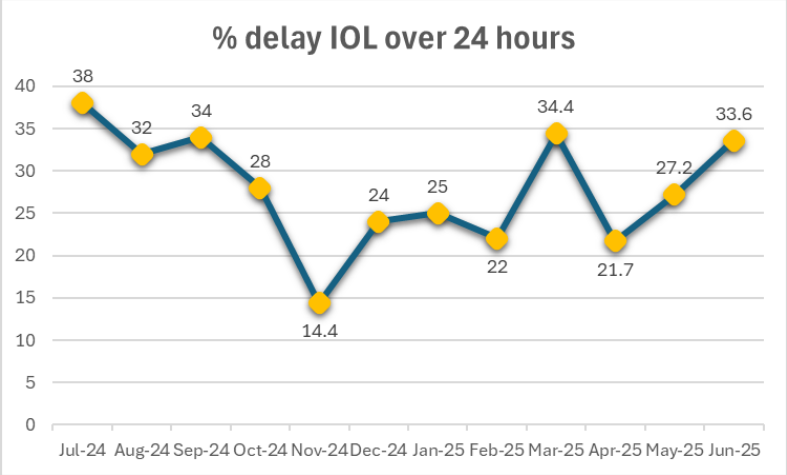
A key point of discussion was the inconsistency in data collection and representation, especially regarding breastmilk administration targets. The BAPM standard recommends administration within six hours, while other metrics allow up to twelve hours. The team explored how best to record and present this data for different forums.

The walkabout also provided a valuable opportunity for staff to put faces to names, strengthening team connections. The Quad is now actively working on actions arising from the staff survey and will be integrating these with the outcomes of the Score survey. Notably, the themes and areas of focus were found to be consistent across both surveys. The Quad is collaborating with HR colleagues to compile and review this information.

9.1 Delays in care

Induction of labour

Delay in induction of labour is now captured on our Perinatal Dashboard. The % of women waiting over 24 hours (awaiting ARM) on the IOL pathway are as follows:



There was a significant increase in delays the last couple of months and this correlates with an increase in birth numbers – June 2025 was our busiest month for births since March 2024.

9.2 Claims scorecard review in conjunction with incidents and complaints

The Q4 claims and learning review is contained within the appendices. Highlights are:

- a stable term admission rate to NNU compared to Q3
- There has been improved documentation for Category 1 and 2 CS following the audit in Q3 meaning the compliance figures for DDI are increasingly reliable.
- Needlestick injuries which was an emerging theme in Q3 has not been sustained in Q4 which is very encouraging.
- PPH >1500ml continues as a theme but it is difficult to benchmark against other units as not all units are currently measuring blood loss and are struggling to find evidence to inform this.

10. HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust

The maternity service was rated as good overall. The safe domain remains at 'requires improvement. All actions are monitored via the COSMOS platform and are discussed at ISAG.

10.1 CQC Rait Tool

Below is a summary of 'Must' and 'Should' Do's by Level of Assurance from the Regulatory Activity Tool (RAIT) produced from the published report 29.11.23. There have been no changes since the previous report.

The only outstanding 'must do' that has not yet been achieved is safeguarding training being above 90% - all others have been achieved with an assurance level of 7.

No of Must Do's by LOA		No of Should Do's by LOA		RAIT Tool Attachment
7	3	7	3	WAHT_RAIT Maternity 09.05.25 ('
6		6		
5	1	5		
4		4		
3		3		
2		2		
1		1		

11. Coroner Regulation 28 made directly to Trust

No regulation 28 regarding maternity or neonatal care was made to the Trust in this month.

12. In-utero and ex–utero activity

The table below summaries the in-utero and ex-utero transfers as per network pathway:

Type of Transfer	Apr-June 2025		Comments
	In	Out	
IUT Transfers for clinical reasons as per network pathway	1	13	1 in requiring level 2 care – Warwick 13 out <27-week and/or <800g pathway
IUT Transfers for non-clinical reasons	7	1	7 in – 5 repatriations & 2 for capacity in Network 1 out to new Cross due to acuity on NNU
IUT Transfers outside of the network	0	3	3 out – 2 to Bristol Southmead & 1 to Oldham due to lack of capacity in Network
Ex-utero Transfers for clinical reasons as per network pathway	0	9	9 out to for clinical reasons
Ex-utero Transfers for non-clinical reasons	6	3	6 in – repatriations 3 out - repatriations
Ex-Utero Transfers out of network	1	0	1 in – Repatriation from John Ratcliffe, Oxford
Delays in transfer in/out	1	0	1 repatriation delay in from Midland met of a Hereford baby due to WRH capacity
IUT or Ex-utero Exceptions	3		IUT transfers out of Network

13. MSSP Report

Formal confirmation of our exit from the MSSP was received in June 2024. A sustainability plan has been agreed and shared at Trust Board. Progress with the plan will be monitored by the ICB and a quarterly update will be provided via this report.

Focus continues on the following actions:

- PDR compliance rates – rates have improved but target still not met.
- Increasing Consultant led theatre lists – recruitment of the maternal medicine consultant post will improve the consultant led lists
- Enact findings of administrative review – a formal management of change process is currently underway to enact the proposed changes
- Review GTT service efficiencies – this service is now being provided in ANC rather than DAU which will improve the utilisation of appointments in DAU.
- Exploration of service improvements at AGH – this will require capital funding to make improvements to the environment

There are no further updates for this month.

14. Evidence of NHSR CNST 10 – Maternity Incentive Scheme

Year 7 MIS scheme was launched on 2nd April 25. The following table is presented quarterly in this report to provide an overall summary of current position. A detailed paper is also produced (and referred to in the table below) containing the mandatory documents that trust board are required to review and formal document that they have been received, reviewed and discussed during QGC meetings quarterly.

Safety Action & Current status		Actions	Evidence for Trust board prescribed in CNST year 7
1	PMRT	• Quarterly reporting in place	See Q4 and Q1 PMRT report embedded in bespoke CNST Q1 report for trust sign off
2	MSDS	• Submission and criteria on track for July 25	
3	ATAIN/ TCU	• Quarterly reporting in place • QI project commenced and registered	
4	Clinical Workforce	• Medical and Midwife Safe Staffing reports in place • NCCR implementation plan BAPM staffing plans continue • Audits for Obstetric Medical staff commenced • Consultant attendance monitored • Clinical Supervision of Locum and Temporary Medical staff in place • Compensatory rest monitoring	See BAPM Action plan embedded in bespoke CNST Q1 report for trust sign off
5	Midwifery Workforce	• Monthly Safe staffing report in place. • Item 7 within report • BR+ tabletop due Jan and July • BR+ Audit currently underway	See Midwifery Safe Staffing Reports and Birthrate + update in bespoke CNST Q1 report for trust sign off
6	Saving Babies Lives	• Quarterly reports in place • NHS Futures Implementation Toolkit continues • Validation with LMNS quarterly next due 19.3.25 • Current level of Compliance 96% Validated by LMNS 25/6/25	See MNVP safety concern in bespoke CNST Q1 report for trust sign off
7	MNVP	• Strategic lead for MNVP (appointed) • MNVP included in Terms of reference as members for, Guidelines, Patient experience, Safety champions, Maternity Governance meetings • CQC action plan 2024 (Picker Survey) agreed at Safety Champions 20.3.24, Maternity Governance on 21.3.25 • Plan to submit safety concern – added to risk register	
8	MDT Training	• CNST compliance across all training progressing. • Item 6 within this report • Areas of Medical staff attending PROMPT and Fetal surveillance Study day concerning – CD aware and actions in place.	
9	Safety Champions/ Perinatal Safety	• Reporting process in place. • Roles embedded and SC meetings working well. • Perinatal Surveillance guideline to be updated in line with yr 7 – and the new Perinatal Model • DMT present at every Safety Champions meeting embedded, Quad now attend bi-monthly, MNVP attendance at every meeting • Summary of Perinatal Culture SCORE and staff survey results being collated into an action plan • Quarterly reporting of Claims Score Card	See Q4 and Q1 Claims score card reports in the bespoke CNST Q1 report for trust sign off
10	NHSR EN Scheme	• Reporting process in place – externally validated. • See monthly table in item 4.2	See MNSI /EN reports April/May/June in the bespoke CNST Q1 report for trust sign off

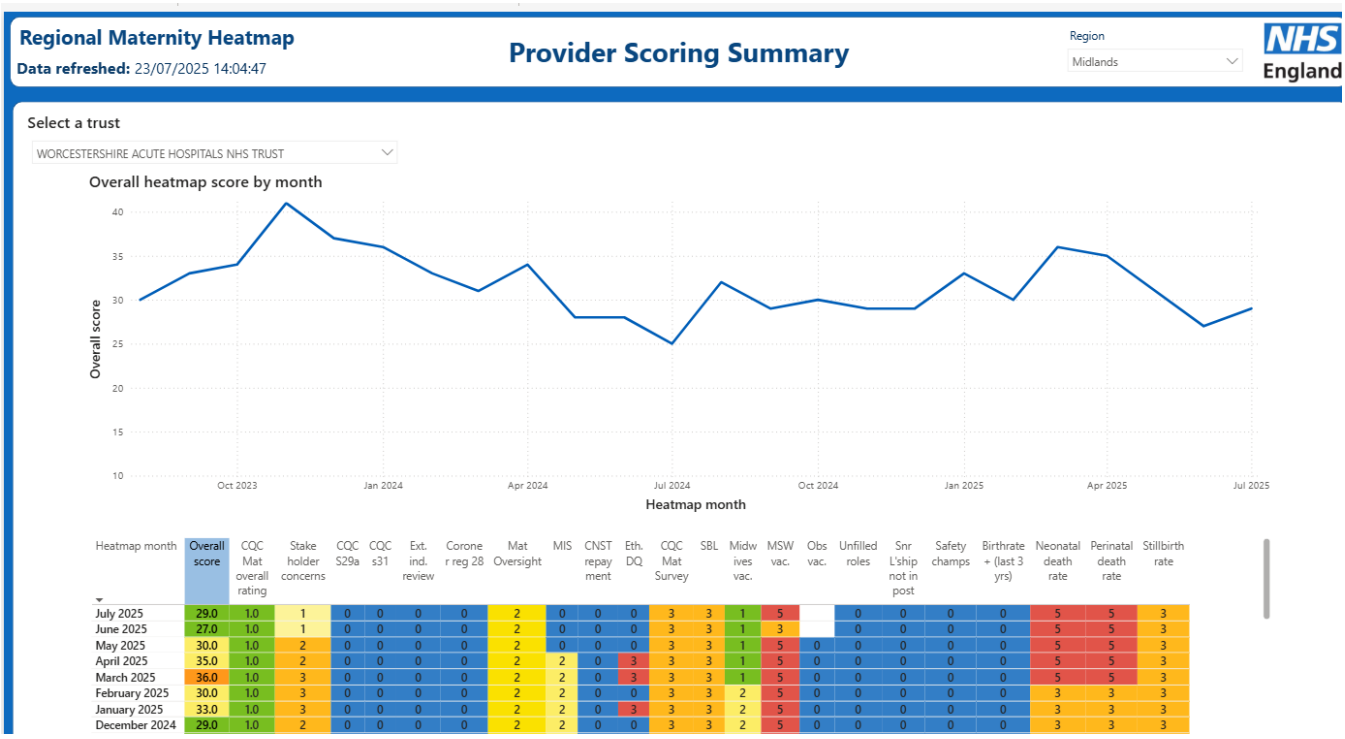
15. Regional Heatmap

The Regional Perinatal Heat map was introduced in October 2023 and tracks 22 quality and safety indicators. This will read the signs of trusts that require additional early intervention and support. It scores

systems and providers to ensure the right level of support is in place to enable focussed quality improvement to address key challenges.

The heat map score is used to determine which systems and trusts are encouraged to take up the offer of regional involvement in system-led insight visits to maternity services and additional regional improvement support. It aligns to the themes of the maternity and neonatal single delivery plan and perinatal quality surveillance model.

The Trust position is as follows:



Heatmap month	Overall score	CQC Mat overall rating	Stake holder concerns	CQC S29a	CQC s31	Ext. ind. review	Coroner reg 28	Mat Oversight	MIS	CNST repayment	Eth. DQ	CQC Mat Survey	SBL	Midwives vac.	MSW vac.	Obs vac.	Unfilled roles	Snr L'ship not in post	Safety champs	Birthrate + (last 3 yrs)	Neonatal death rate	Perinatal death rate	Stillbirth rate
July 2025	29.0	1.0	1	0	0	0	0	2	0	0	0	3	3	1	5		0	0	0	0	5	5	3
June 2025	27.0	1.0	1	0	0	0	0	2	0	0	0	3	3	1	3		0	0	0	0	5	5	3
May 2025	30.0	1.0	2	0	0	0	0	2	0	0	0	3	3	1	5	0	0	0	0	0	5	5	3
April 2025	35.0	1.0	2	0	0	0	0	2	2	0	3	3	3	1	5	0	0	0	0	0	5	5	3
March 2025	36.0	1.0	3	0	0	0	0	2	2	0	3	3	3	1	5	0	0	0	0	0	5	5	3
February 2025	30.0	1.0	3	0	0	0	0	2	2	0	0	3	3	2	5	0	0	0	0	0	3	3	3
January 2025	33.0	1.0	3	0	0	0	0	2	2	0	3	3	3	2	5	0	0	0	0	0	3	3	3
December 2024	29.0	1.0	2	0	0	0	0	2	2	0	0	3	3	2	5	0	0	0	0	0	3	3	3

The score has increased in month as MCA vacancies are also flagging as an area of concern.

The score will reduce by a further 6 points across the next quarter as vacancies are filled. Further score reductions will be achieved if the local perinatal death rate continues to reduce.

16. CCOSMOSS

CCOSMOS is a local acronym for Clinical Negligence Scheme for Trusts (CNST), CQC, Ockenden 1, Single Delivery Plan (SDP), Maternity Self-Assessment Tool, Ockenden 2, Saving Babies Lives (SBL) and Safety Champions. The recommendations/actions (n=505) from all these national documents have been captured within a TEAMs platform to ensure that the directorate can track the progress of actions completed, communicate with leads and demonstrate monthly position/compliance. The level of compliance against these key documents is presented in the table below.

	Q1 April/May/Jun 25-26	Compliant	In progress	Overdue	Not Started	Total	Compliance
C	CNST	2	74	0	12	88	2%↑
C	CQC	22	0	4	0	24	92%↔
O	OCK 1	50	0	0	0	50	100%↑
S	SDP	30	33	1	0	64	47%↑

M	MSAT	151	6	0	0	157	96%↑
O	OCK 2	100	1	0	0	101	99%↑
S	SBL V3	Q4 (24/25) LMNS Validated					96%↑

Conclusion

This report provides a monthly update on key maternity and neonatal safety initiatives which will support WAHT to achieve the national ambition. The report provides the evidence outlined within the revised perinatal surveillance model and will also assist the directorates to collate evidence for NHS Resolutions Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme.

Appendices

1. Q4 24/25 Claims Scorecard
2. Q1 25/26 PMRT summary

Quarter 4 – 2024-2025

Maternity Incentive Scheme – Safety Action 9: Quarterly review of Trust's claims scorecard alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level safety champions at a Trust level (Board or directorate) quality meeting

Worcestershire Acute Hospitals NHS Trust

Claims scorecard – updated by NHSR in June 2023, received by Trusts in November 2023. aim summary on following page)

- The claims scorecard contains all CNST claims with an incident date 01/04/2013 and 31/03/2023
- Q4 reviews the delay or failure in treatment claims, given this is seen both in our reported Q4 incidents and occasionally within our recent complaints.

- There are 5 'red' (high value, high volume) claims within the scorecard relating to fail/delay in treatment; all are currently open.
- One claim is from 2013, two are from 2019, one is from 2020 and one is from 2021.
- 2013 – claim regarding brain damage and epilepsy – this is an old claim and liability has been admitted in 2020 – additional details have been requested
- 2019 – claim regarding psychological damage following shoulder dystocia – claim closed, liability denied.
- 2019 – claim regarding cerebral palsy - claim withdrawn
- 2020 – claim regarding cerebral palsy following homebirth outside of guidance – LOR served, liability denied
- 2021 – claim regarding visual loss secondary to COVID and pancreatitis in pregnancy – claim closed as no further correspondence from claimant.
- From the 'red' claims, there are no evident themes/learning at present – additional detail has been requested for the claim from 2013

- Of the 'blue' (low value, high volume) claims relating to fail/delay in treatment, there are 33.
- 25 have been closed, with 18 having been settled with damages paid. Additional detail has been requested regarding these as they precede 2020
- Five closed and two open claims are related to RPOC which is already being reviewed separately as per Q3 report.
- Of the remaining six open, two have had letters of response repudiated - further action awaited.
- One has been closed with no damages paid.
- Of the remaining three, one relates to mis-management of risk of premature birth – this was investigated at the time as an SI and all learning and actions have been shared and embedded. An offer of settlement has been made.
- One claim relates to mismanagement of labour in 2018 leading to a hysterectomy – some admissions have been made and the draft defence was submitted in May 2025 with outcome awaited.
- One was closed in 2023 with damages paid – the letter of response has been requested to ensure learning has been embedded.

Incidents Q4 24-25

371 incidents reported under maternity and neonates in Q4 24-25 which is a significant increase on Q3

Top 7 sub-categories:
- Unexpected term admissions (33) – *stable rate compared to Q3*
- PPH >1500ml (27)
- Delay in assessment/review (18)
- Maternity staffing issues (19)
- IUD, Stillbirth or Neonatal Death (9)
- Non adherence to plan/pathway (9)
- Cord gases pH <7.1 (8)
- Shoulder dystocia (8)

Complaints Q4 24-25 - 13 received

- Delay or failure in treatment (1)
- Mismanagement of labour (1)
- Attitude of Nursing Staff/midwives (2)
- Delay or failure in acting on test results (1)
- Delay or failure to diagnose (1)
- Lack of suitably trained staff and department remains open (1)
- Delay or failure to diagnose (1)
- Cannula management (1)
- Communication with patient (2)
- Delay or failure in observations (1)
- Failure to follow procedures (1)
- Post-treatment complications (1)

Themes Q4 24-25

- The total number of term admissions in Q4 was 33 which is broadly similar to Q3 – the previous drop in admissions has been sustained which is continued evidence of effective and safe care
- PPH continues as a theme but ObsUK continues to run – it is difficult to benchmark ourselves against other units as not all units are doing measured blood loss which skews the figures – the research team have been asked if we can find some statistics from other units that we can compare against to determine how we are performing.
- We have had no complaints relating to delay in induction of labour again in Q4 which is really positive.
- Sadly Q4 again showed an increase in perinatal mortality though no again attributable harm was noted – all cases have been reviewed in M&N, QSM and PMRT – they feature on the PMRT Q4 report.
- Needlestick injuries which was an emerging theme in Q3 has not been sustained in Q4 which is very encouraging.

Shared Learning Q4 24-25

- All staff reminded to use the Coolsticks when checking epidural blocks (not ethyl chloride)
- Based on feedback from staff and women, the team developed a 'What happens when my catheter is removed?' leaflet that is available on PNW and TCU, and is also translatable via a QR code
- Antenatal CTG monitoring has been changed to start from 26 weeks for all women in line with other Trusts

RCOG clinical escalation toolkit - the maternity team continue to use the RCOG toolkit both clinically and in training –The feedback is that civility and use of critical language is improving – this continues to be reviewed monthly. We have also now started collecting examples of positive escalation and civility as well.

Action Plan Q4 24-25 - Actions that have been completed and require monitoring to ensure embedded are on the following page

Not started | In progress | Complete

Review 'red' claim from 2013 to ensure improved practice and shared learning	SS to coordinate	30.09.25	
Review settled 'blue' claims to ensure learning/actions completed – details requested	SS to coordinate	30.08.25	

Update and information from Q4 2023-2024

Claims scorecard April 13 – March 23 – summary *(NB. It would appear as if some cases have been recategorized from the previous scorecard)*

Top 5 injuries by volume: • Fail/delay in treatment (33) • Fail/delay in diagnosis (8) • Fail to respond to abnormal FHR (5) • Failure to recognise complication of (4) • Inadequate nursing care (3)	**Top injuries by value (14):** • Fail / Delay Treatment (5) • Fail to make response to Abnormal FHR (4) • Fail To Recognise Complication (1) • Failure to interpret USS (1) • Other (bladder damage) (1) • Birth defects (1) • Inappropriate case selection (requested CS – did not happen) (1)
Top causes by volume: • No cases listed	**Top causes by value:** • No cases listed

Learning and Themes Q4 24-25 – update for Q3 in bold - some have and will be monitored through the action plan

- PPH's continue to be reported as expected as part of the ObsUK trial – ongoing work is underway to ensure these are appropriately reviewed without duplicating work to ensure a more streamlined process.
- The emerging theme of **omitted/missed drugs** seen in Q2 **has not been identified in either Q3 or Q4 which is positive**
- NST/CTG update – this continues to be an ongoing issue but the mitigations in place are working well. Escalation to the executive team and board has taken place due to the time being taken to resolve this – it is hoped there will be some positive updates in Q1.
- An audit of CS DDI in Q3 identified some documentation issues where the wrong times had been entered. Learning was shared with all staff, particularly the medical staff, and data quality oversight was been increased – **this has had a positive impact with the quality of documentation being much improved in Q4.**

Action Plan 24-25

Not started	In progress	Complete	Paused

	Action	Date	Initials	Update	
Q3	Detailed review of RPOC claims and any recent events to identify any themes, learning and action points	30.09.25	LV/AFG/ SS to meet	Data requested from legal team	
Q2	Review of handover processes unit wide is required – need standardised approach to handover – QI project identified and planned for early 2025	30.09.25	SS to coordinate	Due to other competing demands this has been paused until later in 2025	
Q2	Ensure all staff aware of translation technology via iPad Discuss with Comms team, LMNS and MNVP around Trust wide message informing patients that staffing can be male and/or female.	15.11.24 30.09.25	LK SS/LK	Partially complete – all staff aware of iPad and translation options Still discussing how to communicate staffing options and situation – MNVP keen to be involved – due date moved again	
Q1	Review guideline to ensure is clear with easy to follow referral pathways	30.09.25	CD/CHC/DA	Preterm Midwife now in post – guideline under review including BUMP pathway	
Q1	Produce SOP for contraindicated medication to ensure all staff aware of need for urgent referral if taken by women and birthing people	30.09.25	SS/DA/ CHC/LW	A SOP has been drafted but this has been paused to prioritise PGDs which needed urgent update – due date moved	

Q1 2025/2026 – Perinatal Mortality Report

This report presents the reviews undertaken for Q1 2025/2026 and any immediate actions identified. Some aspects of the MIS Year 7 safety action 1 have been included in the report for an understanding of ongoing compliance with the scheme throughout the Year 7 reporting period.

Terminations of pregnancy where the baby has been born >22+0 weeks' gestation have been excluded as these are not counted by MBRRACE in their official figures (though a notification is completed) and the PMRT review process is not supported by MBRRACE.

Late fetal losses are pregnancy losses where the baby has been born between 22+0 and 23+6 weeks' gestation, either born with no signs of life at birth, or who have been born alive and have subsequently died. Some of our babies are born alive but on the edge of viability, and resuscitation and ongoing care of these babies, with the parents' consent, is undertaken. However, these babies do not always thrive and survive and sadly die at a later time. Because they are not born at 24+0 weeks' gestation or older, they fall into the late fetal losses category in terms of being counted, though they are also by definition neonatal deaths. They have been captured here under the late fetal losses tab because of the gestation of their birth. MBRRACE supports the use of the PMRT tool for these losses but they are not counted in our official perinatal mortality figures.

Late fetal losses born between 22+0 and 23+6 weeks gestation

MBRRACE Case ID	*Gestation at death (weeks)*	*Level of investigation*	*SA1a – reported in 7 days*	*SA1b - Parents aware of review*	*SA1c – review started within 2 months*	*SA1c - External reviewer*	*Grading of care*	*Actions identified*
98775	23	PMRT	Y	Y	Y	Y	A/A	- None identified

Stillbirths are babies that are born at or after 24+0 weeks' gestational age showing no signs of life, irrespective of when the death occurred.

MBRRACE Case ID	*Gestation at death (weeks)*	*Level of investigation*	*SA1a – reported in 7 days*	*SA1b - Parents aware of review*	*SA1c – review started within 2 months*	*SA1c - External reviewer*	*Grading of care*	*Actions identified*
98405	34	PMRT	Y	Y	Y	NA	Not yet reviewed	- Due to the complexity of the case and availability of PMRT members, this case was not able to be graded in the July meeting, but is timetabled for the August 2025 meeting.
98919	25	PMRT	Y	Y	Y	NA	Not yet reviewed	- Will be reviewed in August 2025
99083	24	PMRT	Y	Y	Y	NA	Not yet reviewed	- Will be reviewed in August 2025

Neonatal deaths refer to a live born baby who died before 28 completed days after birth. These babies are counted by place of birth and not place of death. There are 2 cases where the Trust provided care but the babies were born and died elsewhere; these have been identified below. The responsibility for completion of the PMRT tool lies with the Trust where the baby has died though we review our care provided and allocate a care grading.

Neonatal deaths > 24 weeks where the baby died at WAHT:

None reported in timeframe

Neonatal deaths > 24 weeks where the baby was born at WAHT and has died elsewhere:

None reported in timeframe

Neonatal deaths where the pregnancy was booked at WAHT but the woman was transferred antenatally and the baby was born and died elsewhere:

(NB. These cases are not included in our perinatal mortality numbers but we review the care provided to ensure we identify any lessons to be learnt).

None reported in timeframe

Neonatal deaths where the community midwifery was provided by WAHT but the woman was booked and the baby was born and died elsewhere:

(NB. These cases are not included in our perinatal mortality numbers but we review the care provided to ensure we identify any lessons to be learnt).

None reported in timeframe

NHS
Worcestershire
Acute Hospitals
NHS Trust

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST COVERING REPORT 2025/2026

Report to:	**Public Board**
Date of Meeting:	**09/09/2025**
Title of Report:	CNST MIS Year 7 Quarter 1 Report
Lead Executive Director:	**Chief Nursing Officer**
Author:	Jane Wardlaw – Lead Assurance and Compliance Midwife Justine Jeffery – Director of Midwifery
Reporting Route:	Maternity Governance, W&C Divisional Governance, QGC, LMNS, ICB
Appendices included with this report:	Appendix embedded within table. - Q4 24-25 PMRT case report – Appendix 1a - Q1 25-26 PMRT case report – Appendix 1b - WMNODN Unit Implement Action plan – Appendix 2 - Midwifery Safe Staffing Reports (Included in agenda item 6) - Birthrate + Audit 22 information QGC minutes November 2022 – Included in Nov 2022 Board papers Midwifery Safe Staffing Report October 2022 – Included in Oct 2022 Board papers - Co-produced MNVP and CQC Action plan – Appendix 4 - MNVP (LMNS) workplan analysis – Appendix 5 - Trust Claims Score Card Q4 (Included in agenda item 7) - Maternity Safety Champions May notes – Appendix 6
Purpose of report:	☒ **Assurance** ☒ **Approval** ☐ **Information**

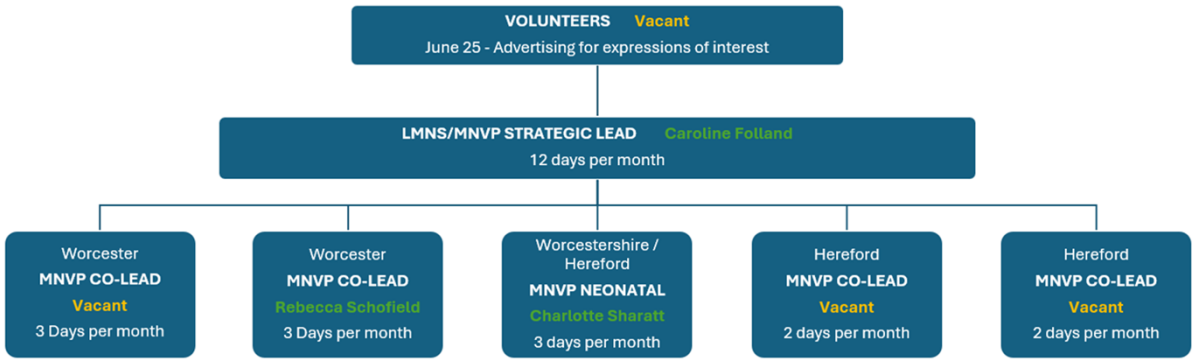
Brief Description of Report Purpose

The NHS Resolution's Maternity Incentive Scheme (MIS) continues to promote safer maternity and perinatal care by encouraging compliance with ten Safety Actions. These actions support the national goal to halve stillbirths, neonatal and maternal deaths, and brain injuries (from 2010 levels) by the end of 2025. The scheme applies to all acute Trusts offering maternity services under the Clinical Negligence Scheme for Trusts (CNST)

This report enables the Board to review, acknowledge, and act on the requirements outlined for Trust board sign-off in the MIS Year 7 guidance.

Recommended Actions required by Board or Committee

Safety Action	Evidence	Required actions and recorded minutes required from QGC.
1	Appendix 1a PMRT Q4 24-25 **Appendix 1b Q1 25-26**	• Acknowledge review in minutes that eligible perinatal deaths and required standards have been met

4	BAPM Action plan – Medical/ ANNP staffing Tier 2 resolution required **Appendix 2 WMNODN Unit Implementation Action plan**	• Committee to acknowledge current position agree the action plan and record in minutes acknowledgement of requirement.
5	Midwifery Safe Staffing reports **Presented to Trust Board**	• Committee to acknowledge review in minutes
5	Birthrate + Audit took place May 22 (report embedded below). *3 yearly review currently being undertaken* **QGC Minutes – November 2022** **Midwifery Safe Staffing Report – October 2022**	• Committee to acknowledge the funded establishment is based on BirthRate+ calculations.
7	CQC Action plan 23 / 24 combined **Appendix 4 MNVP & CCQ Action Plan**	• Committee to acknowledge the receipt of the CQC Co-produced (MNVP and WAHT) Action plan.
7	MNVP Safety Concern (position 30th June 25) **Appendix 5 – MNVP (LMNS) workplan analysis**	• Committee to acknowledge review of safety concern as summarised below
7	- *ICB has statutory responsibility to provide funding* - *ICB recruitment freeze and financial challenge* - *CNST year 7 provides essential requirements to meet standard* - *MNVP current vacancy rate does not allow these requirements to be met* - *Risk register entry completed – 5961* 	
9	Quarterly Perinatal Safety Report received	• Committee to acknowledge review and aligns with the Perinatal Quality Surveillance model
9	Trust Claims Score Card Q4 24-25	• Committee to confirm review and minute that discussions of the actions within Q1 have taken place
9	Safety Champions meeting notes **Appendix 6**	• Committee to confirm review and acknowledge within the minutes that safety champions are meeting with the Perinatal leadership and the Quad team at a minimum of bi-monthly
	• April meeting Cancelled – not quorate • May meeting Quad attended	

	• June meeting Cancelled – maternity acuity *Planned Quad attendance in July and bi-monthly after.*
10	MNSI / EN reports April /May/June 25

- Committee to confirm review of records, that families have received information on the role of MNSI and NHS resolution's EN Scheme and that the duty of candour was performed.

MNSI reference	Date of case	*DOC completed	Stage of investigation
MI-040822	March 2025	Yes	Investigation underway with MNSI – awaiting draft report.
MI-043307/ MI-041974 (rejected)	May 2025	Yes	MNSI initially could not gain consent from parents therefore initial referral rejected but subsequently re-referred as consent gained and investigation in early stages.

**DOC completed – The provides confirmation that the family have received the relevant information regarding the nature of the incident (Duty of Candour disclosure), the role of MNSI and the EN scheme from NHS Resolutions. An example letter template can be found in the CNST compliance table in item 14 – safety action 10.*

Executive Director Opinion[1]

Wells Jo
05/09/2025 10:27:03

[1] Executive director opinion must be included and approved by the director concerned prior to issue, except when the director has given their consent for the report to be released.

Q4 2024/2025 – Perinatal Mortality Report

This report presents the reviews undertaken for Q4 2024/2025 and any immediate actions identified. Some aspects of the MIS Year 7 safety action 1 have been included in the report for an understanding of ongoing compliance with the scheme throughout the Year 7 reporting period.

Terminations of pregnancy where the baby has been born >22+0 weeks' gestation have been excluded as these are not counted by MBRRACE in their official figures (though a notification is completed) and the PMRT review process is not supported by MBRRACE.

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Late fetal losses born between 22+0 and 23+6 weeks gestation

None reported in timeframe

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MBRRACE Case ID	*Gestation at death (weeks)*	*Level of investigation*	*SA1a – reported in 7 days*	*SA1b - Parents aware of review*	*SA1c – review started within 2 months*	*SA1c - External reviewer*	*Grading of care*	*Actions identified*
96721	30	PMRT	Y	Y	Y	Y	A/A	- None identified for WAHT – sent to external Trust where SB was initially identified
96831	31	PMRT	Y	Y	Y	Y	A/A	- None identified
97162	36	PMRT	Y	Y	Y	Y	A/A	- None identified
97173	28	PMRT	Y	Y	Y	Y	TBC	- Likely A/A but sent to level 3 to complete their review of care
97206	24	PMRT	Y	Y	Y	-	Not yet reviewed	- Not yet reviewed
97661	29	PMRT	Y	Y	Y	-	Not yet reviewed	- Not yet reviewed

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97323	30	1	PMRT	Y	Y	Y	Y	B/A/A	- To ensure antenatal CTG guidance updated (has already been re-written and relaunched since case but acknowledged these cases are very difficult) but to include in teaching sessions going forwards

Neonatal deaths where the pregnancy was booked at WAHT but the woman was transferred antenatally and the baby was born and died elsewhere:

(NB. These cases are not included in our perinatal mortality numbers but we review the care provided to ensure we identify any lessons to be learnt).

MBRRACE Case ID	*Gestation at death (weeks)*	*Age at death (days)*	*Level of investigation*	*SA1a – reported in 7 days*	*SA1b - Parents aware of review*	*SA1c – review started within 2 months*	*SA1c - External reviewer*	*Grading of care*	*Actions identified*
97656/1 97656/2	24	7 0	PMRT	Y	Y	Y	-	TBC	- Awaiting PMRT allocation from level 3 unit – initial factual questions completed and returned

Neonatal deaths where the community midwifery was provided by WAHT but the woman was booked and the baby was born and died elsewhere:

(NB. These cases are not included in our perinatal mortality numbers but we review the care provided to ensure we identify any lessons to be learnt).

None reported in timeframe

Q1 2025/2026 – Perinatal Mortality Report

This report presents the reviews undertaken for Q1 2025/2026 and any immediate actions identified. Some aspects of the MIS Year 7 safety action 1 have been included in the report for an understanding of ongoing compliance with the scheme throughout the Year 7 reporting period.

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98775	23	PMRT	Y	Y	Y	Y	A/A	- None identified

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98919	25	PMRT	Y	Y	Y	NA	Not yet reviewed	- Will be reviewed in August 2025
99083	24	PMRT	Y	Y	Y	NA	Not yet reviewed	- Will be reviewed in August 2025

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(NB. These cases are not included in our perinatal mortality numbers but we review the care provided to ensure we identify any lessons to be learnt).

None reported in timeframe

West Midlands Perinatal Network

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Trust	Worcester Hospital	06.05.2025
LMNS	Herefordshire and Worcestershire LMNS	

Neonatal Implementation Plan 2024/2025

Aligning Capacity

Action 1: Review and Invest in Neonatal Capacity

	Action	Lead	Baseline	Trajectory	Current position	RAG	Where do we want to be	What is the gap?	Solutions	Implementation Plan/Actions	2025 Q1	2025 Q2	2025 Q3	2025 Q4	Outcome
1.1	Service Specification Requirements	Becky Williams	1441	>1000	LNU = 500 days of combined ITU/HDU days >1000	Blue	No change	No gap	Already functioning as an LNU	N/A					Completed
1.2	Cot Configuration	Becky Williams	27	27	2 IC, 4 HD, 12 SC, 9 TC	Blue	No change	No gap		N/A					Completed
1.3	Adequate Capacity	Becky Williams	27	27	Adequate capacity	Blue	No change	No gap		N/A					Completed
1.4	Data & Outcomes	Becky Williams	74%	80%	Critical Care days =1,441/SC days = 3,030. Total occupancy 74%	Blue	No change	No gap		N/A					Completed

Action 2: Develop Transport Pathways

	Action	Lead	Baseline	Trajectory	Current position	RAG	Where do we want to be	What is the gap?	Solutions	Implementation Plan/Actions	2025 Q1	2025 Q2	2025 Q3	2025 Q4	Outcome
2.1	National KPI "Mobilisation Time: For time critical transfers the transfer team *mobilises towards the patient within one hour from the start of the referring call (95% of retrievals annually).	NA				Blue									
2.2	National KPI "Referral response time The transport team will arrive with the patient (transfers for uplift of care for intensive care patients) within 3.5 hours of the referring call on 80% of occasions. (Excludes uplifts for planned procedures e.g. PDA Ligation)"	NA				Blue									

Action 3: Develop the Neonatal Nursing Workforce

	Action	Lead	Baseline	Trajectory	Current position	RAG	Where do we want to be	What is the gap?	Solutions	Implementation Plan/Actions	2025 Q1	2025 Q2	2025 Q3	2025 Q4	Outcome
3.1.1	QIS Nurses	Lara Greenway	68%	70%	64.1% QIS in Q4 which is a decrease on previous quarter due to leaver.	Green	Trajectory will be dependent on turnover. QIS training to be completed 12 - 24 months post	2.45wte	Development plans to send Band 5's on QIS course	1.77wte commenced course in Q2 and will qualify at thebeginning of Q1 25-26. . 0.8wte commenced course during Q3 and will qualify in Q2 25-26. 1.0wte Band 6 commencing in post 30.06.2025, totalling 3.57wte.	1.77wte complete course	1.0wte new starter & 0.8wte complete course	0.69wte new starter, 2 staff to commence course	2 staff to commence course	
3.1.2	Registered Nurses	Lara Greenway	33.19wte	33.19wte	31.65wte in post at end of Q4	Green	No vacancies	1.54wte	recruitment	1.69wte Band 6 posts recruited to. 1.0wte starting end of June, 0.69wte starting in a development Band 6 Oct/Nov.					
3.1.3	Registered Nurse Associates		NA	NA						1.0wte commenced Nursing Associate course in Sept 2024					Completed
3.1.4	Non-Registered Workforce	Lara Greenway	11.25wte	11.25wte	11.28wte in post at end of Q4	Blue	11.25wte	No gap	NA						Completed
3.1.5	Supernumerary NIC (ideally B7)	Lara Greenway	0		All shift leaders are Band 6	Blue	All shift leaders are currently Band 6. Band 7 shift leaders are ideal only at present	If Band 7 shift leaders become recommennded this would need funding	Funding	No actions at present as band 6 shift leaders are in place					Completed
3.1.6	Designated Lead Nurse	Lara Greenway	1.0wte	1.0wte	1.0wte Band 7 Ward manager iin post	Blue	1.0wte	No Gap	NA						Completed
3.2	QIS Training	Lara Greenway	2	3	3 staff completing the course during the first half of 2025. 4 staff commencing the course during the second half of 2025.	Green	70%	2.45wte	Send an additional staff member each year. Recruitment	Development & Encouragement of staff not yet QIS. There is a developmet package and process in place.					Completed
3.3	Foundation Training	Lara Greenway			All newly qualified new starters are enrolled onto the Foundation course as part of the development/preceptorship	Blue	Foundation training to be completed within the first 12 months	No gap	NA	NA					Completed
3.4	Education	Lara Greenway	0	1.6	Funding received for an additional 0.4wte Band 6 educator for 12 months, making 1.0wte. This post commences during Q4.	Blue	No change	No gap	NA	NA					Completed
3.4.1	Governance	Lara Greenway	0	0.5wte	0.5wte fixed term, covering maternity leave. Permanent post filled when returns from mat leave.	Blue	Post filled	No gap	NA	NA					Completed
3.4.2	FICare	Lara Greenway	1	1	Funded Band 7 FIC lead in post	Blue	No change	No gap	NA	NA					Completed
3.4.3	Bereavement/Palliative Care	Lara Greenway	0	0	This post is fulfilled as part of the FiCare lead	Blue	No change	No Gap	NA	NA					Completed
3.4.4	Infant Feeding/BFI	Lara Greenway	0	1.0	This post is fulfilled as part of the FiCare lead	Blue	No change	No Gap	NA	NA					Completed
3.4.5	Developmental Care	Lara Greenway	0	0	This post is fulfilled as part of the FiCare lead	Blue	No change	No gap	NA	NA					Completed
3.4.6	Professional Nurse Advocates	Lara Greenway	0	4	2 staff currently PNA's with 2 more staff about to complete course	Blue	4 staff	No gap	NA	NA					Completed

Action 4: Optimise Medical Staffing

	Action	Lead	Baseline	Trajectory	Current position	RAG	Where do we want to be	What is the gap?	Solutions	Implementation Plan/Actions	2025 Q1	2025 Q2	2025 Q3	2025 Q4	Outcome
4.1	Tier 1 Medic/ANNP	Michael Croutear/Dr Wasi Shinwari	BAPM compliance	100%	100% - 1 resident tier 1 available 24/7	Blue	Maintain current position	N/A	N/A						Completed
4.2	Tier 2 Medic/ANNP	Michael Croutear/Dr Wasi Shinwari		100%	There is a resident tier 2 practitioner 09.00-17.00 5 days a week. Thereafter there is a resident tier 2 practitioner across both neonates and paediatrics. 09.00 - 14.00 there is 1 tier 2 practitioner covering neonates and paediatrics. 14.00 - 22.00 there is 2nd tier 2 practitioner solely covering neonates.	Amber	a 24/7 resident Tier 2 dedicated to the neonatal unit and entirely separate from paediatrics.	After 17:00hrs Mon-Fri. 09:00-14:00 and after 22:00hrs at weekends.	Use vacancy from MTI post to increase current 8a ANNP to 8b, who will then join the Tier 2 rota. Look at solutions for further funding of ANNP's.	To develop an 'I have an idea' business case.			x		
4.3	Tier 3	Michael Croutear/Dr Wasi Shinwari		100%	Separate paediatric and neonatal rotas with 8 oncall neonatal consultants doing COW	Blue	Maintain current position	NA	NA				x		Completed
4.5	Designated Lead Consultant	Dr Viviana Weckemann	100%	100%	Lead in Post	Blue									Completed
4.6	Nurse Consultant														

Action 5: Develop Strategies for the Allied Health Professions, Psychology and Pharmacy

	Action	Lead	Baseline	Trajectory	Current position	RAG	Where do we want to be	What is the gap?	Solutions	Implementation Plan/Actions	2025 Q1	2025 Q2	2025 Q3	2025 Q4	Outcome
5.1	Dieticians	Dr Viviana Weckemann/Amrat Mahal	0	1.35wte	NHSEI have funded 80% of recommended wte in November 2022. Funded for 0.4 Band 6 & 0.5 Band 7.	Green	0.5wte Band 6 & 0.6wte Band 7 would be 100% funded	0.1wte Band 6 & 0.1wte Band 7	Recruit AHP's and remainder of the shortfall required funding	Band 7 commenced in November 2023. Band 6 commenced Feb 2024 following mat leave. The gap will require funding to achieve the recommended standard.					
5.2	Occupational Therapists	Dr Viviana Weckemann/Amrat Mahal	0	1.0wte	NHSEI have funded 80% or recommended wte in November 2022. Funded for 0.4 Band 6 & 0.6 Band 7. This is recurrent funding. Recruitment plans commenced	Green	0.5wte Band 6 & 0.8wte Band 7 would be 100% funded	0.1wte Band 6 & 0.2wte Band 7	Recruit AHP's and remainder of the shortfall required funding	Commenced in post May/June 2024					
5.3	Physiotherapists	Dr Viviana Weckemann/Amrat Mahal	0	1.35wte	NHSEI have funded 80% or recommended wte in November 2022. Funded for 0.4 Band 6 & 0.6 Band 7. This is recurrent funding. Recruitment plans commenced	Green	0.5wte Band 6 & 0.8wte Band 7 would be 100% funded	0.1wte Band 6 & 0.2wte Band 7	Recruit AHP's and remainder of the shortfall required funding	Commenced in post May/June 2024					
5.4	Speak & Language Therapists	Dr Viviana Weckemann/Amrat Mahal	0	0.81wte	NHSEI have funded 80% or recommended wte in November 2022. Funded for 0.6wte Band 7. This is recurrent funding. Recruitment plans commenced	Green	0.75wte Band 7 would be 100% funded	0.15wte Band 7	Recruit AHP's and remainder of the shortfall required funding	Commenced in post May/June 2024					
5.5	Pharmacists	Dr Viviana Weckemann/Amrat Mahal	0.25wte	0.25wte	0.25wte provided by the Trust	Blue	NA	No gap							Completed
5.6	Psychologists	Dr Viviana Weckemann/Amrat Mahal	0.6	1	NHSEI have funded 80% or recommended wte in November 2022. Funded for 0.6wte Band 8a. This is recurrent funding. 0.6wte Clinical Psychologist commenced in post on 01.07.2023	Green	1.0wte Band 8a Psychologist would be 100% funded.	0.4wte Band 8a	Recruit further Psychologist role	Commenced in post May/June 2024					
5.7	Follow Up														

Enhancing the Experience of Families

West Midlands Perinatal Network

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Trust	Worcester Hospital	06.05.2025
LMNS	Herefordshire and Worcestershire LMNS	

	Action 6: Develop and Invest in Support for Parents										**Progress**				
	Action	**Lead**	**Baseline**	**Trajectory**	**Current position**	**RAG**	**Where do we want to be**	**What is the gap?**	**Solutions**	**Implementation Plan/Actions**	**2025 Q1**	**2025 Q2**	**2025 Q3**	**2025 Q4**	**Outcome**
6.1	Care Coordinator	NA - Network post				Blue									
6.2	Family Integrated Care	Lara Greenway	1	1	1.0wte FIC lead commenced in post on 26.06.2023	Blue	BLISS & BFI accredited	No gap	Funded post	BFI & BLISS action plans in place	Achieved Silver BLISS & stage 1 BFI	Submitting for Gold BLISS	Submitting for stage 2 BFI		Completed
6.3	Compassionate and personalised care	Lara Greenway	0	2	Developmental care and FIC training delivered on annual Neonatal Training day.	Blue	All staff supported to deliver compassionate care.	4.0wte staff completed PNA training. Recommended 1.2wte				2.0wte completing PNA course			Completed
6.4	Psychological Support	Lara Greenway	0.6	1	0.6wte Psychologist commencing in post on 01.07.2023	Green	NHSEI have funded 80% or recommended wte in November 2022. This is recurrent funding.	20% of funding	Funding required						
6.5	Parent Accommodation	Lara Greenway	2	2	2 parent bedrooms as per ITU cots	Blue	No change	No Gap	NA	None					Completed
6.6	Parent Facilities	Lara Greenway	6	6	Standards all met with flat upgrade	Blue	No further change	No Gap	NA	Flat upgraded during Q1 of 2023					Completed
6.7	Resources for parents	Lara Greenway			Free parking, free meals, accomodation, buddy bed, virtual tour of unit, welcome to unit leaflet, peripremn pssport, Neonatal journey document, Baby diary	Blue									Completed
6.8	Parent education	Lara Greenway			Resus, safe sleeping, car safety, additional training as necessary e.g. NG training	Blue	Comprehensive programme with session at different days/times. MDT involvement including nurses, AHPs and medical team	No Gap							Completed
6.9	Parent/Service user involvement	Lara Greenway			Currently FFT for parent feedback, compliments collection on Datix system. Parent ideas section on improvement ideas board. 15 steps challenge with MNVP. Coffee mornings with Neonatal MNVP link. Parent groups held in the community	Blue		No gap							Completed
6.1	Multidisciplinary education	Lara Greenway	0	1.6	1.6wte clinical Educators now in post	Blue	Induction education for all new staff, annual updates.	No gap	Recruitment	NA					Completed
6.11	Family Support workers		NA	NA											
6.12	UNICEF Baby Friendly Accreditation- Neonatal Standards	Lara Greenway	Stage 1	Stage3	Stage 1 accredidited in Q1 - Submtting for Satge 2 in July 2025	Green	Full accreditation	Accreditation stages	FIC lead appointed	Stage 2 submission arranged for July 2025.			Submit for stage 2 BFI		
6.13	Bliss Baby Charter- Gold Accreditation	Lara Greenway	Silver	Gold	Silver Level - awarded at the beginning of Q4 24-25	Green	Achieve accreditation	Gold	FIC lead appointed	Complete actions and aim for Gold level during Q2 of 2025.		Submit for Gold accreditation			
6.14	Transitional Care	Lara Greenway	9	9	9 bedded Transitional care Unit	Blue	No change	No Gap	NA	NA					Completed

Key:	
Red	Off track requires support
Amber	Off track but within control
Green	On track
Blue	Complete

West Midlands Perinatal Network

Implementing the Recommendation of the Neonatal Critical Care Transformation review: Neonatal Implementation Plan 2020-2025

Trust
LMNS

Neonatal Implementation Plan 2020-2025

Aligning Capacity

Action 1: Review and Invest in Neonatal Capacity

	Action	Lead	Baseline	Trajectory	Current position	RAG	Where do we want to be	What is the gap?	Solutions	Implementation Plan/Actions	Progress 2023 Q1	2023 Q2	2023 Q3	2023 Q4	Outcome
1.1	Service Specification Requirements		100%	0%	LNU - 27 weeks' gestation, 800g minimal weight	Blue	No change	No gap.	None required	Already functioning as LNU; activity appropriate for level					
1.2	Cot Configuration		100%	80%	IC 2, HDU 2, SC 11 (total 15 cots)	Green	IC 1, HDU 2, SC 8 (80% occupancy)	IC -1, HDU 0, SC -3	Describe changes with NTC stage 3 completed.	Important to consider role of TC and physical space needed - see pathway and action plan.					
1.3	Adequate Capacity		100%	100%	Adequate for size of unit and workload	Blue	Change to unit physical layout - reduce barriers	Improve nursing ratios by physical changes to unit	Review possible layout changes to best fit.	Business cases for changes - 1) do nothing, 2) change configuration to accommodate improved ratios ie. Wall removal (IMPACT ASSESSMENT OF WORK DONE)					
1.4	Data & Outcomes				Actual activity - IC 250, HD 514, SC 2047	Blue	Modelled activity - IC 100, HD 526, SC 3030								

Action 2: Develop Transport Pathways

	Action	Lead	Baseline	Trajectory	Current position	RAG	Where do we want to be	What is the gap?	Solutions	Implementation Plan/Actions	Progress 2023 Q1	2023 Q2	2023 Q3	2023 Q4	Outcome
2.1	National KPI "Mobilisation Time: For time critical transfers the transfer team *mobilises towards the patient within one hour from the start of the referring call (95% of retrievals annually).			**95%**	**100%**										
2.2	National KPI "Referral response time The transport team will arrive with the patient (transfers for uplift of care for intensive care patients) within 3.5 hours of the referring call on 80% of occasions. (Excludes uplifts for planned procedures e.g. PDA Ligation)"			**80%**	**85%**										

Develop Expert Neonatal Workforce

Action 3: Develop the Neonatal Nursing Workforce

	Action	Lead	Baseline	Trajectory	Current position	RAG	Where do we want to be	What is the gap?	Solutions	Implementation Plan/Actions	Progress 2023 Q1	2023 Q2	2023 Q3	2023 Q4	Outcome
2.1	QIS Nurses		60%	70%	19.22w.t.e.	Red	17.42w.t.e	minus 1.8w.t.e	natural wastage	monthly review of establishment to remain on track					
2.2	Registered Nurses			70%%	5.77w.t.e	Blue	5.78w.t.e	0.01w.t.e	recruitment	recruit to vacant posts within establishment					
2.3	Registered Nurse Associates					Blue									
2.3	Non-Registered Workforce			30%%	3.28w.t.e	Green	3.85 w.t.e	0.57w.t.e	recruit into post	recruitment in progress					
3.1.5	Supernumerary NIC (ideally B7)			100%%	3.5 wte	Blue	6.5 wte	3.0 wte							
3.1.6	Designated Lead Nurse			100%%	1	Green									
3.2	QIS Training				No one in training	Red	4 wte per year	4 wte							
3.3	Foundation Training			100%	20 wte		34 wte	14.wte							
3.4	Education		100%	100%	100%	Green									
3.4.1	Governance		0%	100%	0	Red	1 wte	1. wte							
3.4.2	FICare		50%	100	0.5 wte	Amber	100%	0.50%							
3.4.3	Bereavement/Palliative Care					Blue									
3.4.4	Infant Feeding/BFI					Blue									
3.4.5	Developmental Care					Blue									
3.4.6	Professional Nurse Associates				0	Blue	0.4 wte								

Action 4: Optimise Medical Staffing

	Action	Lead	Baseline	Trajectory	Current position	RAG	Where do we want to be	What is the gap?	Solutions	Implementation Plan/Actions	Progress 2023 Q1	2023 Q2	2023 Q3	2023 Q4	Outcome
4.1	Tier 1 Medic/ANNP			100%	Dedicated time M-F 9-5.	Green	Staffing as per CCR.	M-F 20 hours gap; W/E 48 hours gap.	ANNP role/medical staffing	Business case - additional hours as per tier 1/ANNP					
4.2	Tier 2 Medic/ANNP			100%	Dedicated time M-F 9-5.	Amber	Staffing as per CCR.	M-F 25 hours gap; W/E 26 hours gap.	ANNP role/medical staffing	Business case - additional hours as per tier 2/ANNP					
4.3	Tier 3		100%	100%	Fully staffed rota at Tier 3 as per requirements	Green	No change	No gap.	None required	None required					
4.5	Designated Lead Consultant		100%	100%%	Lead in Post	Green									
4.6	Nurse Consultant					Blue									

Action 5: Develop Strategies for the Allied Health Professions, Psychology and Pharmacy.

	Action	Lead	Baseline	Trajectory	Current position	RAG	Where do we want to be	What is the gap?	Solutions	Implementation Plan/Actions	Progress 2023 Q1	2023 Q2	2023 Q3	2023 Q4	Outcome
5.1	Dietitians		0%	100%	No dedicated time allocated.	Red	0.47 WTE	0.47 WTE	Embedded Dietetic role on NICU	Business case - allocated dietetic time 0.47 WTE					
5.2	Occupational Therapists		0%	100%	No dedicated time allocated.	Red	0.19 WTE	0.19 WTE	Formal OT role on NICU	Business case - allocated OT time 0.19 WTE					
5.3	Physiotherapists		6%	100%	0.02-0.04 WTE (1-2 hours per week)	Amber	0.33 - 0.55 WTE	0.31 - 0.53 WTE	Increase WTE for physio	Business case - increase allocated time for Physio					
5.4	Speak & Language Therapists		0%	100%	No dedicated time allocated.	Red	0.26 WTE	0.26 WTE	Re negotiate inpatient SALT	Business case and renegotiate with CCG/specialised commissioners					
5.5	Pharmacists		? 50%	100%	Dedicated time but not specified	Amber	0.16 WTE (1 hour 15 minutes/day=6.25 hours/week)	Needs defining	Describe typical input	Review of current practice and requirement.					
5.6	Psychological professionals		0%	100%	Please include: - current wte, - profession (e.g. clinical psychologist, counsellor, child psychotherapist etc), - Whether this is establishment within the team or funded on a fixed term basis e.g. "0.1wte counsellor funded by a charity"		0.5 WTE Clinical Psychologist	0.5 WTE Clinical Psychologist							
5.7	Follow up		0	100%		Red			Clinical Psychologist post to be established in MDT	Business case - allocated Psychology input - OR increase current provision. Role of Specialised commissioning ?					

Enhancing the Experience of Families

Action 6: Develop and invest in Support for Parents

	Action	Lead	Baseline	Trajectory	Current position	RAG	Where do we want to be	What is the gap?	Solutions	Implementation Plan/Actions	Progress 2023 Q1	2023 Q2	2023 Q3	2023 Q4	Outcome
6.1	Care Coordinator		NA	NA	Lead meets bi-monthly with allocated care coordinator. No strategy meetings.	Amber	MDT strategy meeting including management and medical representation to be set up. Care coordinator to be invited.	No strategy.	Set up steering group and hold regular meetings.	Schedule strategy meeting for next month. Invite Jodie Causier to attend.					

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	Trust															
	LMNS															
6.2	Family Integrated Care				Tracking document and action plan developed with ODN Care Coordinator. To be reviewed by strategy group. Poor family presence on ward rounds. No antenatal or pre-transfer preparation for admission.	Amber	All staff to work in partnership with families and to be supported to do so.	Ward rounds not well attended by families.	Develop information about ward rounds, share with families on admission and publicise. Talk to families about barriers to attendance. Consider QI project.	Include action plan review in meeting agenda. Review priorities for the next 6 months. Audit ward round presence.						
6.3	Compassionate and personalised care				Use of Dora interpreting system. Involved with inclusion and equity workstream with maternity. Clinical psychologist commences post in October.	Green	All staff are supported to deliver compassionate care.	No PNAs	Develop PNA role.	Seek expression of interest for PNA training.						
6.4	Psychological Support				Written psychoeducational resources available for families, fortnightly dad's group, half a day from a counsellor	Green	Increase counsellor to two days per week.	0.3 WTE counsellor	Bid approved for charitable funding to increase number of sessions.							
6.5	Parent Accommodation				Adequate Parent accommodation all fit for purpose- only two rooms	Red	Additional 6 bedrooms required	6 rooms	Capital investment- part of unit redevelopment	Business case in progress						
6.6	Parent Facilities				Only one bathroom. No quiet room.	Amber	Adequate facilities for families.	Private room for consultation and quiet time. Additional toilet and shower room.	Office space to be converted- alternate accommodation found.	Office to be moved and converted to a consultation room/quiet space. Small storeroom to be converted to toilet and wet room.						
6.7	Resources for parents				Meal vouchers, welcome bags for new parents, car parking, bus passes and coffee and cake meetings	Blue										
6.8	Parent education				No formal plan for information/education	Red	Comprehensive programme with session at different days/times. MDT involvement including AHPs, medical team and discharge coordinator.	No programme	Ask for support from WMPN Care coordinators.	MDT and care coordinator to develop plan for parent information sessions.						
6.9	Parent/Service user involvement				Currently only FFT for parent feedback. Working with patient experience and MNVP to set a date for a 15 steps event	Red	Regular focus groups and feedback session with current and past parents.		Set up weekly unit walk rounds by unit manager with monthly coffee mornings for current and past parents.	Manager will commence walk rounds from September 1st. To be advertised for staff and parents. Coffee mornings to be held in Faith Centre starting September 14th.						
6.1	Multidisciplinary education		59%	80%	Staff attending network training day. New starters receive information during induction.	Green	Induction education for all new staff, annual updates.	Medical staff and established nursing staff.	Update induction and annual education programmes.	FICare and developmental care to be part of mandatory updates from Sept 2023. Will be included in medical induction from March 2024.						
6.11	Family Support workers		0	1 WTE	None in post	Red	Families to have access to a FSW	Total	Explore possibility of an LMNS-wide role.	LMNS approached for fixed-term funding for a pilot project.						
6.12	UNICEF Baby Friendly Accreditation- Neonatal Standards		Certificate	Stage 1	preparing for 1st baby friendly accreditation breast feeding updates for all HCAs	Green	Gold accreditation	Insufficient time for BFI lead	Increase time for BFI lead	Additional 2 days per month for BFI lead						
6.13	Bliss Baby Charter- Gold Accreditation		Bronze	Silver	At bronze. No staff have protected time to work on this.	Amber	Achieve accreditation	No allocated time.	Staffing improved with recent recruitment.	Working group given allocated time to work on Baby Charter standards						
6.14	Transitional Care				TC regularly closed due to nurse staffing challenges.	Red	Maintain 6 TC cots.	6 WTE nurses/midwives.	Recruitment in progress jointly with maternity service.	Recruitment of new neonatal nurses. Educator developing educational package for neonatal nurses, midwives and support workers.						

6.5	Red	Off track requires support
6..6	Amber	Off track but within control
6..7	Green	On track
	Blue	Complete

No.	Action	Requirement	Source document	
[redacted]	**Action 1: Review and Invest in Neonatal Capacity**			
	Action	**Requirement**	**Source document (if not NCCR)** **https://www.england.nhs.uk/wp-content/uploads/2019/12/Implementing-the-Recommendations-of-the-Neonatal-Critical-Care-Transformation-Review-FINAL.pdf**	
1.1	Service Specification Requirements	The level of your unit and the admission criteria as per specification	B (england.nhs.uk)	
1.2	Cot Configuration	what your current specification is currenrly and hat is required to meet 80% capacity	NCCR GIRFT Ockenden 2	
1.3	Adequate Capacity	Any additional capital required to meet the current capacity. Included useful info from business cases that have been produced.		
1.4	Data & Outcomes	Include activity data IC/HD/SC/TC data from last 3 years and for this baseline the modelled data can be used that you have recieved, this can be updated once we have modelled data on the more recent activity.	Cot reconfiguration unit report	
[redacted]	**Action 2: Develop transport pathways**			
	Action	**Requirement**	**Source document (if not NCCR)** **https://www.england.nhs.uk/wp-content/uploads/2019/12/Implementing-the-Recommendations-of-the-Neonatal-Critical-Care-Transformation-Review-FINAL.pdf**	
2.1	National KPI	Mobilisation Time: For time critical transfers the transfer team *mobilises towards the patient within one hour from the start of the referring call (95% of retrievals annually).	National Implementation Board submission	
2.2	National KPI	Referral response time The transport team will arrive with the patient (transfers for uplift of care for intensive care patients) within 3.5 hours of the referring call on 80% of occasions. (Excludes uplifts for planned procedures e.g. PDA Ligation)	National Implementation Board submission	
	Develop Expert Neonatal Workforce			
[redacted]	**Action 3: Develop the Neonatal Nursing Workforce**			
	Action	**Requirement**	**Source document**	
3.1.1	QIS Nurses	70% of RNs should be QiS	https://www.bapm.org/resources/service-and-quality-standards-for-provision-of-neonatal-care-in-the-uk	
3.1.2	Registered Nurses	A minimum of 70% (Special care) and 80% (LNU and NICU) are Registered nurses.	NCCR	
3.1.3	Registered Nurse Associates	A maximum of 30% (SCU) and 20% (LNU/NICU) of staff can be non-registered (includes RNA's)	NCCR	
3.1.4	Non-Registered Workforce	A maximum of 30% (SCU) and 20% (LNU/NICU) of staff can be non-registered (includes RNA's)	NCCR	
3.1.5	Supernumerary NIC (ideally B7)	Each shift should be led by a senior nurse who has no direct patient care responsibilities	BAPM/NCCR	
3.1.6	Designated Lead Nurse	A Lead responsible for the clinical and professional leadership of the service	BAPM/NCCR	
3.2	Foundation training	All staff should attend a foundation level of training in speciality	NCCR	
3.3	QIS Training	Accredited courses. National work (NHSE WTE group) currently being undertaken to standardise	NCCR/NHSE (WTE)	
3.4	Education	1 wte Educator per 50 head of staff	National Lead Nurse-W&E group https://www.bapm.org/resources/service-and-quality-standards-for-provision-of-neonatal-care-in-the-uk#:~:text=Service%20and%20Quality%20Standards%20for%20Provision%20of%20Neonatal%20Care%20in%20the%20UK%20(PDF	
3.4.1	Governance	0.1 wte per 1000 cot days	National Lead Nurse-W&E group	
3.4.2	FICare	Proposed metric 0.2 wte per 1000 cot days	National Lead Nurse-W&E group	
3.4.3	Bereavement/Palliative Care	Metric awaited	National Bereavement Team formulating- (Alex Mancini-Smith)	
3.4.4	Infant Feeding/BFI	BFI lead must have adequate time to lead the scheme Please include: WTE	UNICEF BFI Standards	
3.4.5	Developmental Care	Proposed metric still in development	National Lead Nurse-W&E group/Lead FICare group	
3.4.6	Professional Nurse Associates	0.2 wte per 20 head of staff	NHSE- CNO office (unpublished)	
[redacted]	**Action 4: Optimise Medical Staffing**			
	Action	**Requirement**	**Source document**	
4.1	Tier 1 medic/ANNP NICU	Tier 1 staff (ANNP or junior doctor ST1-3) should be available 24/7 and have no responsibilities outside of neonatal care	https://www.bapm.org/resources/service-and-quality-standards-for-provision-of-neonatal-care-in-the-uk	
4.1.2	Tier 2 medic/ANNP NICU	Tier 2 staff (ANNP or junior doctor ST4 and above) should be available 24/7 and have no responsibilities outside of neonatal care (including neonatal transport)	GIRFT workforce report 2022	
4.1.3	Tier 3 NICU	Tier 3 (consultant) staff available 24/7 with principle duties, including out of hours cover, are to the neonatal unit		
		Tier 3 (consultant) presence on the unit for at least 12 hours per day (generally expected to include two ward rounds/handovers)		
Activity based Standard -NICU				
4.1.4	Tier 1 >7000 deliveries per year	two dedicated Tier 1 (ANNP or junior doctor ST1-3) 24/7 to support emergency care		
4..1.5	Tier 2 >2500 IC days per year	two dedicated Tier 2 (or resident consultant presence in addition to tier 3 requirements) available 24/7 with duties only on the neonatal unit.		
4.1.6	Tier 3>2500 IC days per year	Presence of at least two consultant led teams during normal daytime hours		
4.1.7	Tier3 >4000 Ic days per year	*consultant presence 24/7 in addition to Tier 2 staffing requirements		
4.1.8	Tier 3>4000 IC days per years (daytime)	*three consultant led teams during normal daytime hours		
LNU				
4.2	Tier 1 medic/ANNP LNU	At least one resident Tier 1 (ANNP or junior doctor ST1-3) practitioner dedicated the providing emergency care for the neonatal service 24/7		
4.2.1	Tier 2 medic/ANNP LNU	Resident Tier 2 (ANNP or junior doctor ST4-8) practitioner dedicated solely to the neonatal service 12 hours a day during the busiest times of the day		
4.2.2	Tier 2 :significant geographical separation between neonatal and paediatric units	The Tier 2 (ANNP or junior doctor ST4-8) practitioner should be immediately available at all times to the neonatal unit and the labour ward. If the site of the paediatric unit makes this immediate response impossible separate Tier 2 rotas are required		
4.2.3	Tier 3 LNU daytime	All consultants on-call for the unit have regular weekday commitments to the neonatal service only (ideally with a 'consultant of the week' system) and all consultants do a minimum of four 'consultant of the week' service weeks per year		
4.2.4	Tier 3 compliance on call	No on-call rota should be more onerous than one in six		
	Activity based Standard -LNU			
4.2.5	Tier 1 medic/ANNP > than 7000 deliveries per year	two dedicated Tier 1 (ANNP or junior doctor ST1-3) 24/7 to support emergency care		
4.2.6	Tier 2 medic/ANNP if EITHER >1500 RCD or >600 IC days per year	Dedicated resident Tier 2 (ANNP or junior doctor ST4-8) practitioner separate from paediatrics 24/7		
4.2.7	Tier 2 compliance if either >1000 RCD or > 400 IC days per year	*24/7 resident Tier 2 (ANNP or junior doctor ST4-8) dedicated to the neonatal unit and entirely separate from paediatrics		
4.2.8	Tier 3 compliance if either > 2000 RCD or >750 IC days per year	separate Tier 3 consultant rota for the neonatal unit		
4.2.9	Tier 3 compliance either more than 1500 RCD or more than 600 IC days per year	* separate Tier 3 consultant rota for the neonatal unit		
4.3	Tier 1 medic/ANNP SCU	Resident Tier 1 (ANNP or junior doctor ST1-3) practitioner dedicated to the neonatal service 8 hours per day/ 7 days per week during peak daytime hours (for standalone SCBUs tier 1 practitioner must be present 24/7)		
4.3.1	Tier 2 medic/ANNP SCU	Tier 2 (ANNP or junior doctor ST4-8) can be shared across a co-located paediatric service but must be immediately available to the neonatal unit for babies requiring respiratory support or those <1.5kg		
4.3.2	Tier 3 SCU	There should be a Lead Consultant for the neonatal service and all consultants should undertake a minimum of continuing professional development (equivalent to a minimum of eight hours CPD in neonatology)		
ALL LEVELS				
4.4	Designated Lead Consultant	A Lead responsible for the clinical and professional leadership of the service		
4.5	Nurse Consultant	No 'requirement however BAPM cite good practice will form part of the BAPM WMPN Workforce Strategy.	https://www.bapm.org/resources/300-advanced-neonatal-nurse-practitioner-capabilities-framework	
[redacted]	**Action 5: Develop Strategies for the Allied Health Professions, Psychology and Pharmacy**			
	Action	**Requirement**	**Source document**	
5.1	Dietitians	Calculate based on cot designation. ITU 0.1 WTE per cot. HDU 0.05 WTE per cot. SC and TC 0.033 WTE per cot. 0.15 additional wte per half day for follow-up/neonatal outreach	Dietetic staffing document, BAPM service spec	Please contact network lead AHPs if you are unsure.
5.2	Occupational Therapists	0.05 WTE per cot. 0.15 additional wte per half day for follow-up	OT staffing document, BAPM service Spec	
5.3	Physiotherapists	0.05 WTE per cot. 0.15 additional wte per half day for follow-up	PT staffing document, BAPM service Spec	
5.4	Speech and Language Therapists	Calculate for total cot activity (IC+HD+SC)/292 (80% cot occupancy) x WTE for each type of neonatal unit - see document for breakdown.	SLT staffing document, BAPM service Spec	
5.5	Pharmacists	Calculate based on cot designation. ITU 0.12 WTE per cot, HDU 0.06 WTE per cot, SC and TC 0.03 WTE per cot (based on a 5-day service). In centres with neonatal ICU or HDU cots, the lead senior pharmacist time should be funded at AFC Band 8a or equivalent as a minimum	NPPG-Neonatal-Staffing-Standards-V2.pdf	
5.6	Psychologists	•Per 20 cots: 1.0 WTE 8a permanent clinical psychology post funded and embedded within the team. Please include: •Current WTE •Profession (e.g. clinical psychologist, counsellor, child psychotherapist) •Funding arrangement (e.g. goodwill, temporary/fixed term, permanent establishment, charitable)	BAPM Quality & Service Standards Psychology Staffing on the Neonatal Unit GIRFT	
5.7	Follow-up	Ensure neurodevelopmental follow up clinics have appropriate AHP staffing and resourcing as recommended in the NICE guideline NG72 by March 2023.	GIRFT workforce report 2022	
	Enhancing the Experience of Families			
[redacted]	**Action 6: Develop and Invest in Support for Parents**			
	Action	**Requirement**	**Source document**	
6.1	Care Coordinator	ODN Care coordinators in post. Each unit has a linked coordinator to support units in the implementation of Family Integrated Care and the achievement of BFI and Bliss accreditation. The linked care coordinator should be a member of the Unit strategy/steering group.	NHS Long-term plan NCCR	Please contact the Care Coordinator team for any additional clarification or evidentiary support
6.2	Family Integrated Care	Integration of the family as primary caregivers. Parents as partners in care through individualised care plans using a FICare approach. Please include details of: •Preparation for admission- antenatal and/or pre-repatriation •Parental involvement during the ward round •Continuing restrictions to parent/sibling/family/support person access to the NNU •MDT steering/strategy group •Frequency of meetings •Frequency of review of the unit FICare tracking tool and action plan •Progress of implementation of parent passport "Our Neonatal Journey" which supports the delivery of personalised care and provides consistency for parents to continue care when moving between units	NCCR GIRFT Three-year delivery plan BAPM Quality & Service Standards BAPM Family Integrated Care Framework https://www.bapm.org/resources/ficare-framework-for-practice	
6.3	Compassionate and personalised care	•Units should provide services that meet the needs of their local populations, paying particular attention to health inequalities and improving equity. This includes facilitating informed decision-making, ensuring access to interpreter services, and adhering to the Accessible Information Standard. •Families should have a form of psychologically informed "individualised care plan" throughout neonatal care. •Units should have a clear means of eliciting and acting on feedback from families regarding the quality and experience of care received, including experiences of compassion, including regular audit. This data should be disaggregated by population groups to monitor differences in experience for woman and babies from different backgrounds. This information should be used to make changes to services and pathways to address any inequity or inequalities identified to improve care. •Units should have a strategy for how to support their staff team to practice in compassionate ways, especially around bereavement care.	Three-year delivery plan Psychology Staffing on the Neonatal Unit NCCR GIRFT BAPM FICare Framework	
6.4	Psychological Support	•Units should be exploring links with local peer support groups and charities •Whole unit team should be accessing training to understand the psychological impact of neonatal admission on families •Whole unit team should be able to access support in applying this understanding (e.g. debrief, reflective practice, clinical supervision, consultation) •Any psychological support should be available for the whole family (including infant, both parents, siblings)	NCCR Three year delivery plan Psychology Staffing on the Neonatal Unit GIRFT	
6.5	Parent Accommodation	•Appropriate facilities on or near the unit that support parents to be resident with their baby for some/all of the 24 hour period. This includes for bereaved families, where accommodation should be easily accessible but separate from the neonatal and maternity units. •Alternative options for families to stay on the unit/at the cot side if their circumstances permit. •1 bedroom per ITU cot •Are bathroom facilities adequate for the size of the Unit/number of resident parents?	NCCR GIRFT 3 year delivery plan BAPM (2021) Optimal Arrangements for Neonatal Intensive Care Units in the UK including guidance on their Medical Staffing Bliss Baby Charter	

6.6	Parent Facilities	•ID card/fingerprint/facial recognition access to NNU •Room for private consultation/quiet space •Private room for expressing and breastfeeding •Facilities to prepare and eat meals •Area for siblings and changing facilities •Secure storage for baby and parent belongings •Comfortable or reclining chair at every bedspace •Privacy screens at each cot space •Fold-out beds for use at the cot-side	NCCR GIRFT 3 year delivery plan BAPM (2021) Optimal Arrangements for Neonatal Intensive Care Units in the UK including guidance on their Medical Staffing Bliss Baby Charter
6.7	Resources for parents	**Financial support** Please include: •Support for travel costs including car parking. Is this free or discounted? (parking should be free for both parents) •Refreshment and meal provision/costs •Signposting to financial support/entitlements e.g. CAB, Family support worker, online resources e.g. Turn to Us, charity funds (local or national) **Technology use** Please include use of: •Facetime (or other) for care planning/consultation when parents are unable to be physically present during ward rounds •V Create •Badger parent report •Can parents access digital neonatal health information to support their baby's health and development (with alternatives available for those who need/prefer them)?	Three year delivery plan GIRFT BAPM (2021) Optimal Arrangements for Neonatal Intensive Care Units in the UK including guidance on their Medical Staffing Bliss Baby Charter
6.8	Parent education	Parents should receive information/education in the specialised needs of their baby. Please include details of MDT information sessions available for parents to access:	NCCR BAPM FICare framework
6.9	Parent/Service user involvement	Families should be involved in quality, governance, and co-production when designing and planning delivery of neonatal services. Please include details about: parent/family focus groups, involvement with the MNVP	NCCR Three-year delivery plan
6.1O	Multidisciplinary education	Neonatal staff to be empowered to deliver kind, compassionate and personalised care by providing the required time, training, tools, and information. All staff regardless of role should receive education in Family Integrated Care and developmental care delivered by an MDT. Minimum target is 80% Please include (by staff group): % of staff accessing: WMPN FICare education % of staff accessing local education 1. FICare 2. Developmental care Details of local educational provision (e.g. length of session, facilitator, induction programme, annual mandatory update)	NCCR Three-year delivery plan The European Standards of Care for Newborn Health (ESCNH) https://newborn-health-standards.org/standards/standards english/
6.11	Family Support workers	No formal requirement. These non-clinical roles should be considered as an adjunct to the MDT with the role including psychosocial support, working with psychological professionals, FICare leads and families to address emotional, practical and financial support needs, e.g. accommodation, meals, and travel, signposting, referrals for early help and charitable funds. Recruitment of Family Support Workers from diverse backgrounds can support the needs of families from those backgrounds, improving equity of access to services.	
6.12	UNICEF Baby Friendly Accreditation- Neonatal Standards	Successful accreditation by March 2027. Please include: •Details of BFI lead (maternity/neonatal) •Current position (e.g. certificate of commitment, stage 1 etc) •If WMPN standardised educational package is in use (wholly/partially/not used)	Three-year delivery plan Service Specifications NCCR GIRFT UNICEF BFI standards
6.13	Bliss Baby Charter- Gold Accreditation	Gold accreditation. Scheme funded by WMPN. MDT input required for successful accreditation. Please include: current position and successes/challenges	NCCR Bliss Baby Charter Standards
6.14	Transitional Care	All units should have transitional care facilities that prevent maternal-infant separation. Consideration should be given as to how partners can be supported to be a primary caregiver	NCCR GIRFT BAPM Quality & Service Standards Maternity Incentive Scheme

CQC Survey Results Feb 23, Feb 24
Action Plan May 2024 amended Feb 2025

Number	Year	Issue Identified	Action	Score	Person Responsible	Outcome Measure	Status	Evidence links
Theme 1 - Providing Service User Information								
TH1.1	2023	Maternity Services users not always feeling that they were given appropriate information and advice on the risks associated with induced labour.	Introduction of '**BRAINS**' decision-making tool. This joint tool to be used for service users and clinicians and be available in all clinical areas.	WAHT Score 5.9 Average trust score 7.0	C Wilson J Wardlaw D Austin	BRAINS Service User Tool BRAINS Training Package **Available in all clinical areas**	* 29.1.25 Brains poster final created * 29.1.25 Pull up Banner created * 31.1.25 SBL Teaching presentations including BRAINS (slide 69), Personalised Care session on MMT includes BRAINS Slide 21.22.23) *Jan 25 - Discussed in LW Forum, MNVP Community Network event and Maternity Governance *Feb 25 Posters ordered and arrived at WAHT *JW and DA created draft BRAINS conversation for consideration * Foundation Group Launch Timeline - Next meeting 16.7.25 (JW unable to attend - to be sent meeting date after this). * Agreed number of staff to be trained and which cohorts before launch * Communications of launch (effective handover, FB, staff mailshot)	
TH1.2	2023	Before being induced were you given appropriate information and advice on the benefits associated with induced labour. **Links with Patient experience meeting Action log - 7**	Introduction of **BRAINs** decision making tool. Increased training for Staff within maternity through maternity mandatory training (MMT) about BRAIN's and how to give service users the information required on IOL for them to make an informed decision.	WAHT Score 7.1 Average trust score 8.2	C Wilson J Wardlaw D Austin H Tipper			
TH1.3A	2024	Offered a choice of where to have baby.	Increased training for maternity staff especially in community and continuity (COC) to ensure staff are confident with discussing place of birth with service users. -Staff signposted to **Place of birth training on eLearning** for health. -Increased training and resources given to community and COC staff by team leads about choice and place of birth.	WAHT Score 73% Average trust score 84%	T Berlett	**Train Staff**	*Community and CoC staff to be signposted to training (Elearning for Health) *Completion of Training to be tracked and agreed process for future training *25.6.25 H Tipper suggested this training could be given on MMT and a BRAINS type conversation could be given as a crib sheet for community midwives. Becky F suggested team meetings could be used to provide the narrative around this. * *JJ did not want this to be mandatory. Would prefer signposting through team meetings.* * Helen T 25.6.25 completed E-learning and found it to be 15 minutes. Concern remains - the amount of e-learning already mandated, the monitoring and recording of training. The package advocates visual aids and prompts cards. Suggest we could devise our own and provide as crib cards for diaries. Good converstion is 4 minutes - HT offered to create video. *TB to complete training and JJ requested via email for her to discuss with Team Leaders for the preference of Helen's suggestion or e-learning.	
TH1.3B			**Birth preferences pilot** A staff survey to determine their knowledge and confidence in discussing place of birth and preferences, as well as their perception of whether they have sufficient time to address these topics within the current appointment structure. **Links with Patient experience meeting Action log - 12**		D Austin	Birth Preferences pilot	*Spring 25 - Pilot commenced with a continuity and community team *Audit of Birth plans completion rate * Staff Survey results *(both available in teams channel - patient experience, birth preferences)* * 20.5.25 Partcipants back from community and continuity leads, entered into excel spreadsheet. * 21.5.25 Meeting with LK and DA to forumlate post BP survey for participants and staff * DA - timeline for completion - 20th August (patient phone calls and staff survey) * 27.6.25 - T Berlett reports mixed feedback at present	
TH1.3C			Ensure links to these sections are added to Badger and signposted as recommended reading in the antenatal timeline.Update the WAHT maternity page under "Your choice of care."		P Orton D Austin	Up-to-date information about birth locations	* April 25 Section started to be drafted by LK * 16.5.25 Information - Meadow, DS and Homebirth approved in goverance * 19.5.25 Approved information sent to Pete-Orton - Awaiting Comms for drafting into webpage format * 14.7.25 - Email sent to Pete Orton regarding update.	
TH1.3D			Ensure up-to-date information is available to service users about **birth locations at WAHT**, to be signposted at booking.Update the Delivery Suite and Meadow sections of the website		P Orton D Austin		* April 25 - information drafted * 16.5.25 - Approved at maternity Governance * 19.5.25 Approved information sent to Pete-Orton - Awaiting Comms for drafting into webpage format	
TH1.3E			Ensure up-to-date information is available to service users about birth locations at WAHT, to be signposted at booking.Add a **Homebirth section to the website**.		P Orton D Austin		* 16.5.25 - Leaflet approved in maternity governance *Leaflet is now published by Ben Payne * Needs to be made into web leaflet * *home birth leaflet is finished but not translatable (therefore waiting for it to be made into a web page)*	
TH1.4A	2024	Given enough information (in hospital after birth.)	Improve the **information given after birth to service users - Mental Health Services** **(REPEATED IN 2023 ACTION THEME MENTAL HEALTH INFORMATION TH 5.1)**	WAHT Score 81% Average trust score 87%	D Austin T Berlet	Postnatal Welcome Pack Website Information P/N Mental health services Leaflet	*Postnatal Welcome pack *WAHT website - updated information on postnatal ward and community postnatal care website *signposted in badger notes under leaflet library *Spring 25 - Leaflet created *16.5.25 - MH Leaflet including information about the debrief service approved in governance * 19.5.25 Email to TB and VP to see what format they wish the leaflet (printed/ on badger/ P/N Ward) * 13.6.25 Added to MMT patient experience presentation - future plans * 13.6.25 - Leaflet live on the website - under emotional health and wellbeing * MH leaflet to be added to the postnatal ward welcome pack - ? if possible to discuss with E Davis. *13.6.25 - Trudy to order Laminated A5 MH leaflets 130. 25.6.25 - TB confirmed will order by end of week. *13.6.25 - Communication needed to community that leaflet is on badger and to signpost in the postnatal period. https://www.worcsacute.nhs.uk/maternity-services/support-at-home/	
TH1.4B			Ensure service users have the opportunity to ask questions after their labour and birth. **REPEATED FROM 2023**		E Davies V Poulter	*Evidence of completed actions from 2023- "After your baby was born, did you have the opportunity to ask questions about you labour and birth."*	https://www.worcsacute.nhs.uk/maternity-services/postnatal/	
TH1.4C	2024	Felt that given appropriate advice and support at the start of labour	Ensure prompt and consistent advice for early labour is being given by **maternity triage**.	WAHT Score 82% Declined from 87% 2023	C Bayliss	TRIAGE additional phone line Core Triage staff	*Evidence of the lauch of - additional phone line - A dedicated telephone triage midwife during peak day time hours - Core triage team	
TH1.4D			Improved patient **information about what to expect during the latent phase of labour and during induction of labour**. Update Induction and latent phase of labour webpage in the intrapartum section of the website. Signpost antenatally through badger and add to recommended reading within the personal timeline.		C Bayliss P Orton	Induction of labour video Webpage updated	*Evidence of the updated induction of latent phase of labour webpage in the intrapartum section of the website (as below) * 4.25 - Latent phase information drafted and for approval in governance 05/25 * 16.5.25 - Leaflet approved in maternity governance * 19.5.25 Leaflet sent to clinical effectiveness team and * 19.5.25 sent to Pete Orton for publishing. Awaiting confirmation of publication * Latent phase leaflet in Badgernet * 13.6.25 - IOL video in place. Needs to be further embedded in the Antenatal part of the website - hasn't been started *(to await the labour and birth webpage to be finished then to ask Pete due to workload)* *Induction of labour video completed	*Evidence of the updated Induction and latent phase of labour webpage in the intrapartum section of the website
Theme 2 - Partners Support								
TH2.1A	2023	Were Partners able to stay with you as much as you wanted	Unrestricted access on the ward for partners is now in place. The MNVP to conduct a short survey to assess awareness and impact of open partner access. Results to be fed back to patient experience midwife.	WAHT Score 4.8 Average Trust Score 5.8	R Stuart	Survey Conducted by MNVP - focus on Partners stay	*Survey conducted and completed May 25 *Finding delivered within the Patient experience meeting on 11th June 25 (awaiting minutes)	
TH2.1B			Ward visiting to be advertised to service users through Badger, Social Media and signposting by Staff antenatally. To include on Postnatal ward website		D Austin	Publicity of Partners visiting on P/N ward	*Evidence of the social media campaign *Evidence of the new information on the P/N ward website	https://www.worcsacute.nhs.uk/maternity-services/postnatal/
TH2.1C			Welcome to the ward information pack. Postnatal ward website to be updated with information about partner visiting times, and what to expect for service users and partners when staying on the ward. Information to be accessed through a QR Code and available in other languages.		D Austin	Ward Information Pack and P/N Ward Website	*Evidence of P/N Ward website and Welcome pack to the P/N ward *Website live from 16.11.24	
Theme 3 - Pain Relief								
TH3.1A	2023	Do you think your healthcare professionals did everything they could to help manage your pain in hospital after the birth. **Links with Patient experience meeting Action log - 5**	Project to Re-introduce self-administered medication/ pain relief (SAM) on the postnatal ward for all women. **REPEATED IN 2024 TH 3.2**	WAHT Score 6.9 Average Trust Score 7.8	D Ausin E Davies V Poulter	**Implement SAM (Self Administration Medication)**	*SAM guideline *SAM patient information sheet *Launch Plan *Evidence of Launch *Evidence of effectiveness of SAM through FFT comments, MNVP, Feedback, Compliants and PALS.	
TH3.1B			Pilot the reintroduction of **drugs rounds four times daily.**		E Davies V Poulter	Drug Rounds reintroduced on P/N Ward	*Evidence of launch of drug rounds on the P/Ward on Effective handover 29.11.24 * Commenced 2.12.24 * 25.6.25 J Jeffery requires assurance from M Stewart that drug round are taking place - suggested via spotchecks * 25.6.25 - JJ confirms that this is mandated	
TH3.1C			Audit and keep under review the implementation of these systems, to identify which is the most effective method of ensuring pain relief is being provided regularly.		E Davies V Poulter	Audit of pain relief on P/N ward	*Evidence of effectiveness of the introduction of drug rounds through FFT comments, MNVP Feedback, complaints and PALs. *No Pain relief feedback from P/N ward in Dec 24/Jan 25	
TH3.2	2024	Professionals did everyone they could to help manage pain after the birth.	Re- introduction of **self-administration of pain relief** on the postnatal ward. (See action from 2023 "Do you think your healthcare professionals did everything they could to help manage your pain in hospital after the birth."	WAHT Score 77% Average Trust Score 87%	D Austin E Davies V Poulter	Implement SAM (Self Administration Medication)	* SAM guideline (changes completed) - Need to go through Governance once Emily has agreed with all leads. * SAM patient information sheet/ Leaflet - Need to go through Governance and be agreed with Emily * 16.5.25 - Drug chart changes approved in maternity Governance. * 11.6.25 - Drug chart presented at Medicines safety and approved. * 10.6.25 - LK meet with ED to hand over project * *Pharmacy only stock a certain amount of drug charts and can't distrubute properly* * *Patient consent/ assessment format complete - will be in paper form* * Process of consent / assessment to take place on delivery suite as very difficult on P/N Ward - Needs to be a meeting with Ward Leads before can go ahead - Emily to lead * Launch Plan * staff training * Evidence of Launch * Evidence of effectiveness of SAM through FFT comments, MNVP, Feedback, Compliants and PALS.	
Theme 4 - Staff availability for Service Users								
TH4.1A	2023	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	**New ward information pack** to include how to ask for help and who is present on the ward and their job role.	WAHT Score 6.5 Average trust Score 7.3	D Austin R Stuart	Ward Information Pack and P/N Ward Website	*Website *Ward Information Pack	
TH4.1B			Audit to be conducted of the **care and comfort (C&C) rounds** on the Postnatal ward. Are they being performed? Review what is involved in these rounds, i.e. pain relief discussed? Develop crib sheet to standardise the C&C rounds and SOP.		E Davies V Poulter M Stewart	Implement Care and Comfort Rounds	* Jan 25 Audit of care and comfort rounds and findings * Feb 25 Care and comfort rounds crib sheet created - Awaiting VP to review, gauge MSW opinion and approve *Care and Comfort rounds SOP - needs to be bed specific not room specific (LK, DA and LG created this and sent to ED and VP on the 21st March and resent on 10th June following meeting with ED) 14.7.25 DA Emailed ED and VP for update * VP to order Care and Comfort rounds plastic slots for bed spaces - ensure has a lid!	
TH4.1C			Information regarding the **C&C rounds to be added to the website**.		D Austin	Care and Comfort Rounds on Website	* Care and Comfort rounds Postnatal Ward website * Care and comfort rounds on ward information pack	
TH4.2A	2023	After your baby was born, did you have the opportunity to ask questions about your labour and birth. **Links with Patient experience meeting Action log - 3**	An opportunity to ask **questions about labour and birth added into the postnatal discharge process** and during service users postnatal community care?	WHAT Score 5.7 Average trust score 6.4	E Davis V Poulter T Berlet C Rayers	**P/N Discharge - Invitation to discuss Labour and Birth**	* To decide and provide evidence of how this is now embedded in discharge process and is discussed during postnatal community care *Postnatal guideline with Discharge checklist to be completed DA *Dec 24 - Discussed with Digital midwives, unable to get to provide via Badgernet.25.6.25 - asked again - Carol to raise this with system C	
TH4.2B			Ensure all women are given the information about the debrief service in community and how to access this, so they are aware of this service before discharge home.		T Berlet	**Signposting for the Debrief service**	*To decide and provide evidence of how the debrief service is signposted during the discharge process *25.6.25 - Becky F provided update - explaining need for clear communication about its purpose and scope to manage expectations. *The focus will be on reflecting on specific aspects of the birthing experience and would not be a series of sessions (a one off discussion with clear pathways for further support if needed)*. Justine suggested finalising a name for the debrief device with the MNVP.	
TH4.2C			Look at the number of women accessing debrief service. Review the referral pathway.		F Pagan R Fox	Service Review of Current debrief service	*Evidence of the number of women accessing the debrief service and what the referral pathway is currently * Meeting held between RF and LK, 1.4.25 - 3.3.25 - 3.2.25 - 14.2.25 - 6.1.25 *4.4.25 Met with Trust psychologist - LK and RF - service needs to fill gap outside of Beacon. Trust psychologist does not agree with referral criteria - needs clear information for patients and expectations * MNVP Community network event discussed debrief service and service user current expectations. * 13.6.25 Job matching for Debrief midwife obtained. * 13.6.25 Written proposal of what the service would offer - Sent to JJ, RF, ST for approval - awaiting response * 13.6.25 - Potential names - Birth reflections/ Birth after thoughts	
TH4.3	2023	Were you given information about your own physical recovery after the birth?	The postnatal ward information pack to include a section on the physical recovery after birth.	WAHT Score 7.2 Average trust score 6.8	D Austin	Physical recovery after birth	*Postnatal Welcome pack *WAHT website - updated information including physical recovery	
TH4.4A	2024	Discharged without delay	Introduction of dedicated NIPE midwives on the postnatal ward that can perform NIPE's on all babies.	WAHT Score 53% Average trust score 58%	E Davies D Austin	NIPE Midwifery rota	*NIPE Midwife rota and NIPE SOP including criteria of which NIPE's midwives can perform *Safe staffing report for postnatal ward	
TH4.4B			Improved staffing on postnatal ward. Postnatal ward to be included in the birth rate plus acuity. **Links with Patient experience meeting Action log - 1 & 5**		J Jeffery R Fox M Stewart V Poulter	P/N staffing	*Maternity Escalation and safe staffing policy - approved 11/24 * Safe Staffing report for Postnatal Ward / Acuity tool - ED to provide information * 25.6.25 - Justine J explained need to improve the accuracy and consistency of the postnatal ward acuity tool before including it in the midwifery safe staffing report. E Davis and matrons to improve completion	
TH4.4C			Enhanced care for Elective caesarean sections		R Marie L Veal MNVP	Enhanced care ELCS	*updated elective caesarean guideline and enhanced care patient information booklet. Approval 10/24	https://www.worcsacute.nhs.uk/leaflets/planned-caesarean-birth-at-worcestershire-royal-hospital-with-enhanced-recovery-information-guide-for-mothers-birthing-people-and-birth-partners/
TH4.4D			To increase the number of qualified Band 3 maternity support workers.		L Grummet	Band 3 Qualified staff members	* Evidence of the number of qualified and the number enrolled on the band 3 training. Desciption of the band 3 roles and the clinical tasks they can undertake	
Theme 5 - Mental Health Information								
TH5.1	2023	Were you told who you could contact if you needed advice about any changes you might experience to your mental health after the birth?	Leaflet to be produced signposting all local mental health services and how and when to access. **(REPEATED IN 2024 ACTION THEME PROVIDING SERVICE USER INFORMATION TH1.4A)**	WAHT Score 7.9 Average trust score 8.4	T Berlett D Austin	Mental Health signposting Leaflet	*Spring 25 - Leaflet created *16.5.25 - MH Leaflet including information about the debrief service approved in governance * 19.5.25 Email to TB and VP to see what format they wish the leaflet (printed/ on badger/ P/N Ward) * 13.6.25 Added to MMT patient experience presentation - future plans * 13.6.25 - Leaflet live on the website - under emotional health and wellbeing * MH leaflet to be added to the postnatal ward welcome pack *13.6.25 - Trudy to order Laminated A5 MH leaflets 130 (£12.50) *13.6.25 - Communication needed to community that leaflet is on badger and to signpost in the postnatal period. * Guideline needs updating - DA awaiting the Mental health midwife return of work	
TH5.2A	2024	Given enough support for mental health during pregnancy.	Review and update the management of mental health issues in pregnancy and referral for mental health services urgent assessment guidelines to ensure staff are following the correct guidance of how to manage mental health concerns in pregnancy.	WAHT Score 83% Average trust score 88%	T Berlett D Austin	Declined letters to include other sources of support	*Evidence of the Updated perinatal mental health "declined" letters from Beacon and PNMH. *Referral criteria for the different support services to be included in the management of mental health issues guideline - awaiting a copy of the letter 16.6.25 (emailed last week) from Caroline Hadley * Mental Health area of website updated. * MH leaflet has QR code to provide information about where to access services.	
TH5.2B			Ensure the referral criteria to mental health services is clear and well signposted to staff to ensure the correct referrals are made.		D Austin	Referral Criteria to mental health services	*Updated Management of mental health issues in pregnancy guideline *Upated referral for mental health services urgnet assessment guideline *Evidence of the referral criteria to mental health services in worcestershire is included in the updated guidelines and re circulated to staff	
TH5.2C			Staff guidance on when to discuss mental health changes and how to refer to mental health support services.		D Austin	**P/N Guideline - when to refer Mental health**	*Update Postnatal care guideline, specifying when to discuss P/N mental health	
TH5.3A	2024	Given information about changes to mental health after having baby	Patient information developed to outline what are "normal" mental health changes after birth and when this deviates from normal. This is to include clear information for service users on when to seek help, where and what postnatal mental health services are available in Worcestershire. **(REPEATED IN 2023 ACTION THEME MENTAL HEALTH INFORMATION)**	WAHT Score 81% declined trust score from 86% (2023)	T Berlet	Mental Health Checklist and signposting referral	*Postnatal Mental health leaflet and website information- to ensure PI is translatable (Action from 2023, "Were you told who you could contact if you needed advice about any changes you might experience to your mental health after the birth?"*	
TH5.3B			Health visitor access to badger notes to have visibility of previous/ current mental health issues and be able to provide the right on-going support and advice after discharge from midwifery care"		Digital Midwives	HV access to Badger	*Evidence of Health visitors access / Date of Launch * Zoe Durall to commence meeting surrounding this on the 26th June 2025. * C Rayers confirmed that health visitors are in the process of gaining access to BadgerNet, which will allow them to provide better support and advice after discharge from midwifery. *14.7.25 Awaiting system C project plan and then timeline can be given. Health and Care Digital team now fully involved	
Theme 6 - Staff aware of service user clinical history								
TH6.1A	2024	Felt midwives aware of medical history (postnatal). **Links with Patient experience meeting Action log - 9**	To ensure all midwives have access and are reviewing women's medical and birth notes before a postnatal check.	77% 2024 declined from 85% 2023	T Berlet B Fox S Tullett	Downloading P/N notes	* Communication to staff about reviewing women's medical and birth * Ensure all community staff have access to VPN/ Offline working and training given if required * P/N guideline * 25.6.25 T Berlet confirmed that all all clinics are working online. B Fox discussed the connectivity issues faced by community staff particularly in Evesham and Pershore. C Rayers confirms that all the training has been put in place to download documents and work offline. S Tullett suggested using the womans WiFi when necessary. B Fox and S Tullett to review the network providers and VPN provision * B Fox confirmed that frustration with technology has been added to the action plan for the SCORE survey - particularly connectivity for the community and staff.	
TH6.1B			To improve continuity of care postnatally in community.		T Berlet	Clinics on PAS	* Continuity of visits roster. Clinics on PAS * Postnatal guideline * 25.6.25 - T Berlet provided update - KTC on PAS, Cathedral nearly complete, Abbey and Avoncroft now on electronic diaries - Plan that all clinics will be moved over by end of the year.	

Worcestershire Acute Hospitals NHS Trust

Theme 1 Providing Service User Information
Theme 2 Partners Support
Theme 3 Pain Relief
Theme 4 Staff availability for Service Users
Theme 5 Mental Health Information
Theme 6 Staff aware of service user clinical history

MNVP/WAHT Patient Experience Meeting
Action Log

Completion Status
Overdue
Scheduled for this meeting
On-going
Action completed
Scheduled beyond date of this meeting

Action Number	CQC Theme	Date	Agenda Item	Information	Action	Owner	Due Date	Comments/ Updates	Status
1	TH4.4B	01/02/2025	MNVP and WAHT	Postnatal feeding support	To start joined up infant feeding meetings- neonatal and maternity.	VP	Jun-25		Scheduled for this meeting
2	NONE		WAHT	Triage survey	LK will liaise with Claire Bayliss to ensure that the women are given the correct information around waiting times/tests. A dedicated Triage team will also be introduced which will help resolve these concerns.	LK/ CB	Oct-25	12/02- Meeting held- Dedicated Triage team to be implimented by 17/03/25. Plans for more training and informtion regarding BSOTs. **09/04/25- Core Triage team in place and additional BSOTs training has been provided. Follow up survey in the Autumn to ensure improvements have been made.**	On-going
3	TH4.2		WRH/MNVP	Debrief service provision	To provide updates about the on-going work with the debrief service	RF	Sep-25	09/04/25-RF and LV working with the Trusts lead pscycologist to developa description of the service and the correct sign posting. Develop the PNW section of the internet page with clear direction for the different debrief services.	On-going
4	NONE	14/08/2024	WAHT	FFT feedback to report accurately on Continuity of carer teams	LK to forward emails and information to CW and RF	LK	Aug-25	**10/24 - LK met with informatics & IT, work is ongoing.** 17/09 LK Meeting with informatics and IT. 11/12 Work on- going. 01/2024 Work on-going. **02/2025** LK to liaise with RF and CW to discuss how best to capture contiunuity feedback.	On-going
5	TH3.1A TH3.2	14/10/2024	MNVP and WAHT	Pain Relief availability on the PN Ward	WAHT to explore and address pain relief accessibility on the ward following an increase in patient feedback of pain relief delays.	LK/ ED	Jun-25	10/24 - Mum packs are in progress, prescription charts will be reprinted with the correct terminology. To launch analgesia at bedside. Work ongoing with midwives on PNW with administering pain relief and reintroducing specific times. 11/12 LK provided an update at PE meeting, SAM work on-going, awaiting pharmacy changes. Drug rounds re launched end of November- confirmed by VP and ED. 01/2024 On-going work to drug charts	Scheduled for this meeting
6	TH4.4B	14/08/2024	MNVP/ WHAT	Staffing numbers on the PN Ward	RF to take forward to next Birthrate Plus meeting for discussion	RF	Jun-25	10/24 - recent recruitment of midwives will help with acuity. Upskilling support workers who will have the majority of shifts on PNW. PNW manager is having clinical days on PNW. 12/24 RF fed back that it has been identified sometimes a reluctance for MW to allocate tasks to MCA's on PN ward, work by VP, LG and ED to address that. Birth rate plus audit in progress. MCA non clinical tasks being reviewed- to see if they can be reallocated to housekeepers etc. Band 3 prioritised to PNW and MW to be re allocated to PN ward when Meadow/ DS isnt busy. 02/2025 •Unit co-ordinators are aware to reallocate staff where possible if very busy on Postnatal ward.	Scheduled for this meeting
7	TH1.2	16/09/2024	MNVP Feedback	Feedback given that a post date woman was not given time and space at WRH to make decision regarding Induction. No IOL risks and benefits discussed.	VP and JJ to speak to Margaret Stewart to explore training and education needs for ANC staff. BRAINS pilot for clinic staff.	VP/JJ	Jun-25	12/24 No update- VP not present at the meeting. 12/02/25- VP noted many changes at WRH ANC- plan to launch BRAINS and reassess. CW to look at what bespoke training may look like for ANC and ANW staff. HT to contact a memeber of the Obstetric Perinatal meeting to explore adding BRAINS to their meetings. HT to create a BRAIN video highlighting a good and bad BRAINS conversation- RS has sent examples. 09/04/25- Arrange a meeting with CW and the implementation group for BRAINS. Establish clear, reasonable time frame for implementation. 15 issues identified furing Community Newtwork Event- pick some issues to tackle as a priority. LV to invite Junior Dr, Middle grade and SHO's to meeting. JT to invite a few Band 5's to meeting.	scheduled for this meeting
8	NONE	18/09/2024	MNVP- 15 Steps	Identified during the 15 steps walk around the Alex that a TV was present in the waiting room ANC but not in use.	WAHT to explore if we can utilise TV's in the ANC waiting rooms across sites to display maternity information for service users.	LK	Dec-24	12/24 LK has put in 2 requests to IT to see if TV's can be utilised for patient information. LK will contact RB- IT. 01/01/2024 Digital team has been in contact and work on-going to look at logistics and cost. **09/04/25- LK to prive JJ with final cost to implement across 3 sites.**	Scheduled for this meeting
9	TH6.1A TH6.1B	14/10/2024	MNVP	Handover between staff to ensure they are aware of womens birth experience/ background.	To investigate how to improve staff knowledge on the PN ward about a womens birth experience.	LK/ ED	Aug-25		On-going
10	NONE	12.02.25	MNVP Feedback	Safeguarding Conversations -	RS to contact Zoe for an update regarding the wider peice of work on safeguarding.	RS/DB	Jun-25		Scheduled for this meeting
11	NONE	09.04.25	MNVP Feedback	Noisy enviornment on PNW	RS/BS to send details for feedabck regarding the incident of the noisy envirmonent,/10+ family members on PNW bay to VP for investigation.	BS/RS	Jun-25		Scheduled for this meeting
12	TH1.3B	09.04.25	MNVP Feedback	Trauma inform birth plan dismissed and patient moved multiple times.	BS to send LK details for investigation.	BS	Jun-25		Scheduled for this meeting
13	NONE	09.04.25	MNVP Feedback	MBC closed over Christmas?	BS to send LK/CB feedback details for investigation.	BS	Jun-25		Scheduled for this meeting
14	NONE	09.04.25	MNVP Feedback	Staff attitude/behaviour	Action plan needed to prevent/ combat bad attitude/behaviuor. RF to add to the agenda for the next Matron meeting.	RF	Aug-25		On-going
15	NONE	09.04.25	MNVP Feedback	Information/ sign posting to Matron/ Ward managers for patients.		VP	Aug-25		On-going

Putting Patients First 4ward

MNVP/WAHT Patient Experience Meeting
Action Log

Completion Status
Overdue
Scheduled for this meeting
On-going
Action completed
Scheduled beyond date of this meeting

NHS Worcestershire Acute Hospitals NHS Trust

Action Ref.	Date	Agenda Item	Information	Action	Owner	Due Date	Comments/ Updates	Status
	14/08/2024	MNVP and FFT Feedback	Contact between patient and baby- if baby is admitted to NNU.	WAHT to explore how to improve the communication between the NNU and PN ward when a mother and baby are separated and how to facilitate a mum going to NNU in a timely manner.	ED/MP	Apr-25	10/24 - meeting held - looking at obtaining new IPads for face time and ongoing investigations into location of a transfer trolley. 10/09 Email sent to MP and ED to set up a meeting to discuss. 11/11 Email sent to ask for update. 13/11 I Pads on order. 11/12 MP confirms Order for IPADS has been put in, awaiting arrival on the ward. 12/2024 Trolley for transfer– difficult to store due to lack of suitable space on Postnatal ward. Considering if this could be requested from stores on an ad hoc basis when needed. 09/04/25- 3 iPads now on NNU with charging dock and stands. Can be used on PNW and TCU. Share good news on social media.	Action Completed
	14/08/2024	WRH	Feedback given that parents with baby on NNU find it difficult to have an empty cot in room	Look at alternative places to store cot	ED	Dec-24	10/24 - LK following this up with ED. 11/11 Email sent to ask for update.11/12 ED has confirmed alternative place to store a cot on PN has been loacted, comms has gone out to staff on EH and FB about removing a cot from the room for mums who's babies are on NNU.	Action Completed
	14/08/2024	MNVP/WAHT	Postnatal Information leaflet	Add information regarding NNU access and diabetic meals to welcome pack.	LK	Dec-24	10/24 - LK has added information into welcome pack; to be reviewed and then sent on to MNVP. 11/11 Added to welcome pack and for governance 15/11. 11/12 LK confirms the welcome pack is present on the ward and the information is now live on the maternity website.	Action Completed
	23.04.2024	MNVP Feedback	Noise levels experienced on TCU	How to aid awareness of nighttime protocol and reducing noise: Current Trust initiative is 'Sleepy eyes' . To look at costings for eye masks	ST	Dec-24	10/24 - Eye masks and ear plugs found to be costly. MP has requested a sound ear for TCU which monitors noise levels and is a good visual aid to keep noise levels at an acceptable level. 24/06/24 ST has requested costings for eye mask. 08/24 NNU have conducted a sound and light audit recently. Feedback from parents about the central desk in TCU being noisy at night. AW and MP has sent out comms to NNU staff. To re look at costings for eye masks/ ear plugs for TCU/ PNW.12/24 Sound ear has just arrived – to be implemented this week. RF advised that that the last PEOG meeting (estates and facilities meeting) –concerns were raised regarding the noise pollution from handheld dispensers particularly in NNU. These are to be replaced with the same models used at AGH as these are nearly silent. 12/02- Sound ear in place for 1 month. One patient noted uncessary chatter on TCU, which has been adressed with staff and no further concerns. Action closed, will be oepned if further feedback received.	Action Completed
	16/10/2024	MNVP Feedback	15 Steps challenge for NNU - verbal feedback received, awaiting written report.	LK to request the written report from Rebecca Stuart.	LK	Dec-24	12/24 RS will send across to MP by the end of December. 15 steps sent to NNU.	Action Completed
	16/09/2024	WAHT Feedback	Postnatal Debrief report	JJ to share quarterly postnatal debrief report with LK	JJ	Dec-24	12/24 Report shared with the MNVP and discussed at PE meeting.	Action Completed
	16/09/2024	MNVP Feedback	Diabetic meal options	Meeting with Head of catering planned: invite Michelle Tongue to meeting	ST	Apr-25	12/24 No update- ST not at PE meeting, for next meeting. 12/02/25- additional meal options have now been impliemented. BF to explore options for designated space in zonal kitchen for diabetic patients to bring their own food. BF to bring an update after the next PEOG meeting, aim to close at the next meeting. 09/04/25- Diabetic meal options available from the zonal kitchen including granary bread and fat free yoghurts. Information leaflets available on the wards.	Action Completed
	16/09/2024	MNVP Feedback	Midwife presence in delivery suite room	Staff to be encouraged to complete notes in the room- to pick up with matron Claire Bayliss	JJ/LK	Jun-25	12/2024 LK has made Clare Bayliss (matron) aware of feedback regarding completing notes in delivery room – this was cascaded to staff. To order additional chairs for delivery suite rooms: LK will chase for an updated from ST. DA and CBe are updating the care in labour guidance.	Action Completed
		WHAT	Triage survey	Survey positives to be collated and shared with staff.	LK/ CB	Feb-25		Action Completed
	23.04.2024	MNVP Feedback	15 Steps report: Differences in service provision across our areas.	To gain an understanding what is happening in each location and the difference in service.	ST/LK	Dec-24	10/24 - LK and ST have met and outlined all service provisions. Has been shared with area leads and will be sent to MNVP for approval. 25/06 Meeting arranged between LK and ST. 10/24- RS asked for progress on this, aim to have for next meet 10/2024. 12/24 LK confirmed this has been sent to MNVP for info	Action Completed
				Order chairs for staff to use in the delivery suite rooms	ST	Feb-25		Action Completed
	16/09/2024	MNVP Feedback	Triage waiting times survey	LK to share with ward manager and relevant colleagues	LK	Dec-24	01/11 Posters in triage, push notification on badger and sent to community teams. //- Discussed at meeting- Closed	Action Completed
	23.04.2024	BSOTS	To introduce a BSOTS explainatory poster for families. Current feedback shows that staff know what colour patients are coded as, but patients are unaware what BSOTS means.	Introduce a poster and send some mockups of colour coded cards that can be given to waitng families.	ST	Oct-24	06/ 2024 MNVP To run a survey- Is the banner enough, what additional info would service users like? 14/08: MNVP will run at survey 10/24. //- Action closed	Action Completed
	28.02.2024	MNVP/WRH	FFT Poster	Becky and Daisy to work on Friends and Family Feedback poster	BS/DB	Dec-24	12/24 Flyer developed and in use.	Action Completed
	28.02.24	MNVP Feedback	Infographics	Caitlin to look at infographics shared by continuity teams to take account of previous discussion about what should/shouldn't be included.	CW	May-24	12/02/25- CW to meet with Bf to identify the issue and resolve. 08/2024: Caitlin has shared first draft with MNVP, MNVP will feed review and feedback.	Action Completed
		MNVP	Feeding support on the ward	Vicky to liase with Claire and feeding team to see what the capacity is in the infant feeding team and what feeding support is in place on the ward. To asertain what volunteers are going into the ward and when.	VP	Dec-24	10/24 - Infant feeding team have noted that the Tongue tie admin requirment is high with processes are being reveiwed. As the breastfeeding support worker is reducing hours, a JD is being put together for a possible Band 3 support worker to support the infant feeding team. Complex feeding referrals for community are in place. The infant feeding team are auditing staff to ensure advice given is correct and up to date.	Action Completed
		MNVP/WRH	Feedback Flyer	Card/ Flyer detailing feedback channels MNVP/ PALS/ Complaints	LK	Dec-24	10/09/2024: Draft designed by LK and sent to MNVP for review. 15/10/2024 Changes made folowing MNVP comments and sent back to MNVP. 12/2024 Flyer has been approved in governance and is now in use.	Action Completed
	23.04.2024	MNVP Feedback	Availability of C Section: Incident where an induction had been booked for a Sat night as the labourer had been advised that no staff member from Continuity team was available during the day.	To investigate incident further.	RF	Aug-24	20/06 RF Emailed for update, going on AL so asked TB to investigate and feedback. 31/07 TB emailed for an update. 14/08: Discussed at PE Meeting- Fed back from RB, Comms gone out staff regarding IOL and all women to be prioritized on clinical need. New IOL booking process on badger.	Action Completed
	23.04.2024	MNVP Feedback	Parent Panel: Action Tracker	To chase outstanding actions	LK	Jun-24	06/2024 Complete	Action Completed
	23.04.2024	MNVP Feedback	Parent Panel: Sent out leaflets to those on the panel but received only 2 responses on the c/section leaflet	To look at the leaflets and give MNVP feedback.	RS	Jun-24	06/2024 Complete	Action Completed
	23.04.2024	MNVP Feedback	Patient Lockers	DB will explore lock boxes as an option and investigate other Trust's practice.	DB	Jul-24	14/10: BD and LK met with CB on the ward. Lock boxes are not required as current locked bedside cabinets are sufficient.	Action Completed
	28.02.2024	WRH	Trust Board Story	Charlotte to see if there is a NICU parent story for board	C	May-24		Action Completed
	28.02.2024	MNVP/WRH	15 Steps Tracker	Daisy and Becky develop tracker for 15 Steps actions	RS/DB	May-24		Action Completed
	28.02.24	LMNS	Team's channel	Becky ask Zoe to set up Teams Channel for the meeting	BS	May-24	05/2024 Complete	Action Completed
	28.02.24	MNVP/WRH	Parent Pannel Tracker	Daisy and Becky develop tracker for parent panel	RS/DB	May-24		Action Completed
		MNVP Feedback	Investigate how other trust signpost BSOT's to their patients	Carol and Davidica to liase through the digital network to find out what other trusts are doing.	CB/DM	Sep-24	14/10 Digital midwives have sent out comms to other trusts, feedback is other trusts have a banner/ poster. Some have info on website too. Agreed the MNVP will run a survey to see if current BSOT's info is enough at WHAT.	Action Completed
	28.02.2024	MNVP Feedback	Complaint	Becky to share complaint to MNVP with Sarah	BS	May-24		Action Completed
	14/08/2024	MNVP	Perinatal Clinic Poster	LK to send poster to RSc to review	LK	Oct-24	10/24 - updated version approved - action complete.	Action Completed
	23.04.2024	MNVP	Perinatal Safety Report	The action plan from the Picker Survey needs to be added	TBC	Sep-24	10/24 Free text has come through and action plan has gone through goverrnance. 08/24 Awaiting free text analysis before CQC plan can go through governance and on the safety report .	Action Completed
	12.02.25	Trust	Family and Friends report accurately reporting	LK to meet with Bf to create an action plan. LK to send FA details of infomatics contact to reselve the missing NNU data issue.	TBC	Jun-25		Action Completed
	12.02.25	MNVP Feedback	Bereavement team: BCH do not inform WRH of bereavement and they do not use Badgernet. Bereavement team to follow up with families.	SS to contact Bearevement team ask them to make contact with the family.	TBC	Jun-25		Action Completed

Task	Responsible Person(s)	Next Steps / Action required By 20th August 2025 - emailed actions on 1.7.25
Provide Jane with the next Foundation meeting (JW unable to attend July's meeting)	Caitlin	Send Jane the following meeting date after the July meeting
Patient Experience Meeting Frequency	Justine	Confirmed to move from bimonthly to quarterly. Update calendar invites and inform all stakeholders.
Place of Birth E-learning Training	Helen, Trudy	25.6.25 – Helen completed training. Took 15 minutes. Suggested Video (4 minutes) and prompt cards for diaries. Trudy to complete e-learning (gauge) and ask TL to discuss with teams for their preference
Mental Health Leaflet	Trudy	Order 130 A5 mental health leaflets. Ensure inclusion in the Post Natal ward pack.
Post Natal Ward Drug Rounds	Margaret, Vicky	Conduct spot checks to ensure consistency. Document findings and address any inconsistencies.
Care and Comfort Rounds	Margaret, Vicky	Ensure documentation is patient-specific, not bed space-specific. Review current documentation practices and provide feedback.
Postnatal Staffing	Margaret, Vicky, Emily	Improve accuracy and consistency of the Postnatal ward acuity tool. JJ unable to complete within the safe staffing report
Post Natal Discharge Checklist	Carol, Davidica	Verify if Badger Net can support the checklist for discussing labour and birth experiences. Liaise with IT or Badger Net support if needed.
Downloading P/N notes	Becky, Sinead, Trudy	Review of both network and VPN providers
Debrief Service Proposal	Becky	Share the proposal with Caroline. Finalise the name for the service.

Workstream/project	Deliverable	Action/s	ICB/Trust	Action Owner	Due	Status	Progress/updates
Introduction of Strategic Lead Role	MIS Year 7 - compliance with Safety Action 7 (released 2/4/25)	Table of requirements as to where we are in line, where we aren't & what isn't clear around MNVP volunteer role	ICB	CF	des-25		submitted in LMNS Team Group
		JD's contracts as required & in place in line with MIS	ICB				6/2/25 Recruitment required as vacancies (Worcs & Herefordshire)
		Training/DBS establish what is required & in place	ICB				6/5/25Cov & Wark DBS required & in place for their Leads who are on ESR & can access SG training
	MNVP resourced & commissioned in line with NHSE MNVP guidance	ICB fully meeting MNVP national guidance	ICB	CF			Recruitment urgently needed. Quoracy in meetings - unclear if this is achieveable across both Trusts. Escalated via Trust Boards
		MNVP quorate/present at CNST required meetings	ICB				Partially completed - no MNVP cover if strategic lead is not available as MNVP leavers not replaced "Single Point of Failure"
		Recruit to fulfill MNVP compliment	ICB				https://hwicb-my.sharepoint.com/:b:/g/personal/caroline_folland_hwccg_nhs_uk/Ebq95oQWLoxBlnRpjGPfyToBilMWYKIIWRgO_utiDiw81Q?e=T8KoOt
	MNVP recruited inline with ICB	Review NHSE PPV guidance and mapping alignment with ICB	ICB	HR Team			
MNVP SUV	Functioning MNVP contributing SUV to Patient Quality & Safety, Experience & reducing Health inequalities inline with MNVP guidance and PQOM guidance t	15 steps	ICB/Trust				Would like to do 15 Steps at Worcs with additional Visit to Redditch - no capacity at present
		Reaching underserved communities to secure SUV from underserved communities	ICB				Herefordshire - no Hfd MNVP. Would like next f2f Community Event in 2026 to be w GRT focus - no capacity at present (Liaising with ICB Pt Engagement Team around support to contact identified families)
		Touchpoint/Insight visits	ICB/Trust				
		Open Access survey					Report shared. Would like to update VCSE at Community Network event next year (This is capacity dependent)
		Listen to Perinatal Mental Health SUV					Linked in with Beacon and inviting to Community events
		Listen to Preterm/PERIPrem SUV/Bereaved					Service user experience to be shared at September Board
		Listen to PPHS service user voice					WVT Social media survey
		Identify learning opportunities from pt voice FM SURVEY & local feedback data with dashboard intelligence https://www.sands.org.uk/sites/default/files/Sands_FetalMovementReport_A4_Apr25.pdf national work contributing to improving local outcomes	ICB				Collaborative work established with Tommy's following local intelligence re SB numbers & SUV re triage
		Collaborating with providers in relation to pt voice (what do they want to know?) - FM/Traige Survey					FM survey https://www.sands.org.uk/sites/default/files/Sands_FetalMovementReport_A4_Apr25.pdf SANDS attending Board
	Perinatal Quality Oversight Mode	Recruitment of MNVP volunteers	ICB/Trust				Proposal to run 5-6 intro to MNVP every yr + 3-4 in depth training sessions for volunteers doing face to face engagement - if we could recruit 8 volunteers (two per session) who can commit to visiting 4-6 baby groups a year that would mean we could cover an additional 30-50 groups per year & build opportunities with more marginalised communities
Personalised care framework/toolkit	Implementation of BRAINS tool	Training in place for all Trust staff	Trust				Informed that Tool will be implemented by end of 2025/early 2026
		Working Group group established to pursue implementation w	Trust				Set up - next meetings in July & Sept 2025
Futher Integration of Neonatal Service User Voice	Co-production & Co-design	Broker relationship with local VCSE	MNVP Neonatal Lead				NN MNVP Lead to link in with local bereavement groups
		Establish feedback loops to share insights & Suggestions via PAG & Little Stars etc	MNVP Lead				
		Understand/share SUV local good practice around PeriPrem	MNVP Neonatal Lead				NN MNVP Lead to develop questions/resource arounf what NN families want/need to know
		Co-production to appropriately name more defined "De-Brief	Trust	MNVPs			
Further Aspirational goals:							These are all necessary - but limited by capacity
Establish digital Open Survey							These are all necessary - but limited by capacity
Establish surveys in other languages							These are all necessary - but limited by capacity
De-Brief service/Birth Trauma - further co-production							These are all necessary - but limited by capacity
Complete MNVP Self assesment Tool		https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Ffuture.nhs.uk%2Fgf2.ti%2Ff%2F989730%2F225302661.3					These are all necessary - but limited by capacity
Plan for additional funding 38k		https://future.nhs.uk/LocalTransformationHub/viewdocument?docid=225311205&done=DOCCreated1&fid=51596752					

NHS
Worcestershire
Acute Hospitals
NHS Trust

15th May 25 (including agenda items 17th April 25)
Monthly Meeting Notes
Maternity and Neonatal Safety Champions
Venue – Teams

Name	Position
Sarah Shingler (SaSh)	Safety Champion – Executive Chief Nurse
Lara Greenway (LGry)	Safety Champion – Matron Neonates
Lorraine Grummett (LGrm)	Safety Champion – Practice Development Midwife
Susie Smith (SuSm) -chair	Governance Lead for Maternity and Neonates
Sue Sinclair (SuSi)	Safety Champion – Non-Executive Director
Becky Fox (BF)	Deputy Director of Midwifery *(Quad)*
Anna Fabre-Gray (AFG)	Safety Champion – Consultant Obstetrician
Nicky Slade (NS) - notes	Divisional Administrator
Apologies	
Sinead Tullett (ST)	Directorate Manager – Maternity *(Quad)*
Jane Wardlaw (JW)	Assurance and Compliance Midwife
Sadie Stringer (SSt)	Safety Champion – Screening Midwife
Laura Veal (LV)	Clinical Director Obstetrics *(Quad)*
Wasiullah Shinwari (WS)	Clinical Director Neonates *(Quad)*
Justine Jeffery (JJ)	Director of Midwifery

Safety Champions	
*Quorum - requires **either** ECN or NED to attend*	
Safety Champion – Executive Chief Nurse	Sue Sinclair (SuSi)
Safety Champion – Non-Executive Director	Sarah Shingler (SaSh)
*Quorum - requires **one** of the remaining Safety Champions*	
Safety Champion – Consultant Obstetrician	Anna Fabre-Gray
Safety Champion - Neonates	Lara Greenway
Safety Champion – Midwifery	Sadie Stringer (SaSt) Lorraine Grummett
Chair, Administration and Presenters	
Governance Lead for Maternity and Neonates	Susie Smith (SS)
Assurance and Compliance Midwife - Chair	Jane Wardlaw
Divisional Administrator	Nicky Slade
MNVP Member	
*Quorum - requires **one** member of MNVP to be present*	
MNVP Member	
Perinatal Leadership Team (PLT) and Quad	
*Quorum requires **one** member of PLT to be present*	

Director of Midwifery (PLT)	Justine Jeffery
Deputy Director of Midwifery *(PLT & Quad)* *	Becky Fox
Directorate Manager – Maternity *(PLT & Quad)* *	Sinead Tullett
Clinical Director Obstetrics *(PLT & Quad)* *	Laura Veal
Clinical Director Neonates *(PLT & Quad)* *	Wasiullah Shinwari

Quad will attend meetings bi-monthly to review the Perinatal Culture and Leadership programme as an additional agenda item

Terms of Reference - TOR - Maternity and Neonatal Safety Champions 08.23.docx

Draft for agreement on 15th May 25 - Terms of Reference - Maternity and Neonatal Safety Champions - May 2025.docx

MNSC 2025 Dates and scheduled attendees.docx

Meeting Minutes

	Item	Action
1	**Welcome and apologies** • SS welcomed all to the meeting. • Apologies as noted above.	
2	**Review of notes from previous meeting** Notes - 20.03.2025 MNS Champions.docx • Approved as an accurate reflection of the meeting.	
3	**Walkabouts** **31.03.25: Continuity of Carer/Community** • LGrm arranged a virtual walkabout via Team's meeting with the Continuity of Carer and Community midwives. • Seven colleagues attended and no concerns were raised. **17.04.25 – Triage and Antenatal Ward** • LGrm and SaSt visited Triage and ANW. • Triage raised a concern regarding the wait for a doctor to review patients.	

- Whilst conducting the walkabout the waiting room was full, and patients were sitting in the corridor. It was noted that some patients had been waiting for over four hours.
- When reviewing the Triage board some inconsistencies were noted regarding BSOTs categorisation.
- ANW staff raised a concern that there was a lack of equipment for maternal observations. This was immediately resolved as staff were advised that in addition to using dyno maps there are also mobile blood pressure kits available.
- Theatre staff had no concerns to report.

15.05.2025 – Meadow Birth Centre, Triage and Antenatal Ward

LGrm, AFG and LG conducted the walkabout.

Triage

Doctor availability for patient review

- The Triage concern around consistency of doctor availability for patient review was raised with the Delivery Suite co-ordinator (223 bleep). It was ascertained that there is an SHO for Delivery Suite and Postnatal Ward. We need to ensure SHO's have an understanding that priority needs to be given to Triage.
- AFG noted that in terms of the medical staff cover, the ANNP role can help with unit flow. There is no one in post currently: one staff member is on maternity leave and the other is completing their training. There is not an allocated triage SHO, but the expectation is that Triage is covered between the delivery suite and postnatal ward SHO – it will be made clear that Triage is the priority.

Triage Board

- AFG advised that the new Triage board is larger and therefore more visible from the corridor. Action has been taken to ensure patient confidentiality: the double door is being closed to segregate the waiting room from the clinical areas, and staff are not using patient's full names on board.

Telephone Triage Midwife

- Staff raised the concern around the inconsistency in cover for the telephone triage midwife. This should be a protected role. For the duration of the walkabout the midwife had been asked to cover some jobs on the postnatal ward.

SS/BF

	Questions/Feedback from the gallery: • SaSh queried if these Triage issues have been fed back to matron Claire Bayliss. LGrm advised that this will be done. • **ACTION** SaSh advised that she would require assurance regarding the actions taken for these issues outside of this meeting. **Antenatal Ward** • LGrm noted that Antenatal Ward had some inconsistency with staffing; colleagues being pulled to other areas. Upon investigation this has been due to a breakdown in communication between 223 and co-ordinators. One antenatal midwife had taken a woman to delivery suite which would have left a Band 5 midwife covering the ward. In this instance an incoming midwife started her shift early to help with acuity. • ANW staff also raised the prioritisation of induction lists. Currently this happens after the ward round takes place, delaying the arrival time of the women. This will be changed to ensure that the decision making for prioritisation is one of the first jobs of the day, ensuring that women can be brought in earlier. AFG confirmed that Matron Claire Bayliss will relay this to the 223 bleep holders and AFG will cascade to obstetric consultant colleagues. **Meadow Birth Centre** • No concerns were raised. **Staffing:** LGrm: while discussing the antenatal ward staffing with the co-ordinator it was noted that: • The two midwives that are covering the elective c-section list are included in staffing numbers. **Questions/Feedback from the gallery:** • SuSi queried the need for two elective c-section midwives: LGrm confirmed that it is a rolling list with midwives taking alternate patients to optimise patient flow. • SuSm advised that 250 more women are being seen in triage compared to a year ago. • LGry noted that the minimum safe staffing level is 16. There are no elective c-sections at the weekend – is there/should there be a different minimum staffing level for weekends.	LGrm

- **ACTION** SaSh requested Maternity Safety champions feedback the issues raised today to Becky Fox.
- **Conclusion:** SaSh will require clarification and assurance by close of play 16.05.25.

Walkabout 12.05.25 – SaSh and SuSi

Neonates

- SaSh and SuSi conducted a walkabout in Neonates and advised that feedback was positive with mums praising the care received.

Cross-site care

- Tetralogy of Fallot twins: mum was very grateful for care received on the Neonatal Unit. Mum has had care across three sites – she is seen at the QE for her congenital heart disease, has had some antenatal scans at Birmingham Women's and antenatal care at WRH. Mum advised that she had transferred her antenatal care to Birmingham Women's hospital. She felt that communication between the three sites could have been better.
  - AFG advised that the twins were delivered at 34/40.
  - DCDA twins were referred to AFG due to history of cardiac disease.
  - Risk of twin-to-twin syndrome was identified, and mum was referred to Birmingham who kept her under their care and saw her every week.
  - Noted that there have been some appointment issues with WRH; mum subsequently transferred care.
  - Acknowledged that shared care can sometimes goes awry.

Peri-prem Performance

- Review of Periprem performance board display which shows that 7% of women had received all interventions and intrapartum antibiotics was at 42% compliance. SaSh asked what steps are being taken to improves this and offer women assurance.
  - LGry noted that Neonates do not currently have a funded Periprem nurse role in addition to the Periprem midwife, obstetrician, and consultant. Hoping to enable this via CNST funding.
  - There is a bi-monthly perinatal directorate meeting which includes the maternity team where compliance is discussed.

SS

- SaSh noted that board needs to reflect the work being done.
- SaSh queried where Periprem compliance is included in board reports presented at QGC. SuSm advised that this is included in the safety report but will double check.
- LGry advise that Periprem data is a consolidation of different aspects and is not done as a consolidated whole. Actions are monitored through NNAP audits
- LGry queried if Periprem data should be displayed in both neonatal and maternity areas.
- **ACTION:** SS will speak with matron Claire Bayliss to confirm what is being done in terms of displaying data from a maternity perspective.

Delivery Suite

Boards

- Boards were observed during the walkabout: Maternity mandatory training was showing at 43% compliance.

Equipment

- A broken trolley was observed in the delivery suite corridor. It was not stable as the missing wheel was on top of the trolley. Small connectors were present which could have been swallowed. Handwritten note attached to say it had been reported but no date. SaSh questioned if the Band 7 had sufficient oversight of this.
- 2 broken CTG machines observed; staff were asked if they had enough machines and SaS/SuSi not assured by the response. The Band 7 could not advise what was happening with broken machines and the timescale for repair.

Room temp/Lighting/Covid Screens

- SaSh/SuSo were advised that room 4 is still very cold despite the windows being replaced but could not be evaluated during the walkabout as the room was in use.
  - LGrm: this has been raised as a concern and Sinead Tullett arranged for Equans to test with thermometers. It was reported that the room was at the correct temperature. (Temperatures were taken around windows) Since meeting it has been established that there is a cold air vent which makes the room feel cold. ST investigating.
- Lighting boards in room 4 were not working properly.

	○ LGrm: Lights in 4 and 8 have been reported to PJ ward manager. • Covid screens in room 8 and 9 were noted to still be in situ. Please advise SaSh if any support is needed to progress the removal.	
4	**COSMOS update** Quarter 4 Q4 24-25 COSMOS - Perinatal Assurance and Compliance (1).docx SS verbalised a summary: please see report link above. • CNSY year 6 validation was 10 out of 10. • Saving Babies Lives completion tool validated by the LMNS for Quarter 3 at 94% • Ockendon 1 completed Ockenden 2 nearing completion. • Maternity self-assessment tool is at 96%.	
5	**Compliance Safety Action 9 – CNST** 20250401 - MIS year 7 Final.pdf - MNVP will be joining our meetings - Quad will move from Quarterly to Bi-monthly joining the meeting (Nicky Slade has forwarded calendar invites) - Perinatal Safety reporting planned to be quarterly.	
6	**PMRT (Q4 due April/May 25)** Q3 24-25 PMRT case report.docx Q4 24-25 PMRT case report.docx SS shared and verbalised a summary: • 6 still births in quarter 4: no emerging themes were noted. • Woman attending triage in a timely manner with reduce fetal movement has been a challenge – unable to establish specific reasons for this. • 1 neonatal death at 30/40. Unusual tumour on face – care has been reviewed. There is some learning around antenatal CTG guidance which has since been updated and republished. • One death of a baby that was booked with WAHT but sadly died elsewhere.	
7	**MNSI (Formerly HSIB) Cases (detail in Perinatal Safety Report) – Verbal update** • One baby born at the end of March that required cooling, the Investigation is underway.	

	• Potentially a second case from last week where a baby required cooling. (Placental abruption) Baby is now doing well.	

8	**ATAIN Action plan /Report (Q4 due April/May 25)**
	ATAIN Report Q4 24-25.docx
	LGry verbalised a summary:
	• Remained well below the 6% benchmark for this quarter at 3.2%.
	• 35 unexpected term admissions out of 1080 live births.
	• Most common location: 18 were admitted from theatre with the highest reason being respiratory related.
	• 14 of the 35 were following emergency c/section, 7 from elective c-sections.
	• Out of those that should have received steroids: 4 had received and 11 did not.
	  ○ Issue noted that the criteria for receiving steroids has changed and compliance has dropped.
	  ○ AFG- the college stance on how to counsel and who should receive has changed. There is a patient information leaflet which is informative but confusing.
	  ○ As a result, there is less of an uptake in the post 34 plus 6 to 37 plus 0 window. This is also replicated nationally.
	  ○ LGry: It has not increased admissions; and respiratory has always been highest reason.
	• Most common gestation for this quarter was 37/40: 16 babies.
	• 3 avoidable admissions – all three were cold babies. 1 baby had not fed for the first 2 hours. Noted to have a 4th cold baby but this would not have prevented admission.
	• Other learning:
	  ○ 1 cooling baby. (MNSI investigation)
	  ○ Steroids – it was difficult to ascertain if the women who did not uptake steroids had received counselling. This has been fed back via the staff newsletter.
	Questions/Feedback from the gallery:
	• SaSh queried if the cold babies were before replacement of the windows in Delivery Suite and/ or if they were born in room 4.
	• **ACTION:** Requested cold babies are tracked to establish timeframe and if they were born in room 4.
		LGry

9	**Risk Register review**	

	SuSm verbalised an update: • Issue with scan capacity. Requirement for Saving babies Lives has put significant pressure on scan department regarding growth scans. The team are working really hard to identify how scan capacity can be optimised. • ASR service reconfiguration is continuing.	
10	**Service Improvements – PSIRF (**Verbal update) • Continue to implement. SS attended an HSIB course regarding the use of SEIPs which was helpful and may be useful for other colleagues across the division.	
11	**Claims scorecard** (Q3 due April 25) Claims and incidents Q3 2024-2025 - draft.pptx SS verbalised a summary. • Incidents: unexpected term admissions were reduced from 54 in Q2 to 31 in Q3. • PPH continues to be the top reason. • Omitted and missed drugs (noted in Q2) was not seen in Q3. • No complaints about delays in induction of labour which had been seen previously. • Changes have been made in how cord bloods are taken which has helped reduce reported issues. • Audit completed for the decision to delivery interval for Q3 where the ideal timeframe was breached. This identified documentation issues – staff reminded of the importance of getting this right. No harm was identified where the time frame was breached. • Claims: o retained products of conception or placentas: a lot of the claims were historic from 2015 – 2021. To identify is there are any more recent claims. • BSOTs audit – a dashboard is being built by informatics to support the time frame to initial midwife assessment. • Intrapartum and antenatal risk assessments are audited each month and are much improved. The launch of physiological CTG has brought further improvements. • Unit wide QI project planned for later in the year regarding hand over processes.	
12	**Patient Experience/MNVP/ CQC Action Plan** • To review next month.	
13	**Key escalations to trust board**	

	SaSh advised that if assurance regarding Triage issues is not sufficient this will need escalating.	
14	**Action plan review** ONGOING ACTION PLAN - MNSChampions .docx	
Quad agenda – attendance Bi – Monthly *As a minimum the following should be included in meeting agenda P 61 CNST Yr 7*		
	SaSh requested written assurance regarding raised Triage issues. **ACTION** BF will speak with AFG/LGrm after this meeting. **Quad Walkabout** • Undertaken first walkabout as a quad – these are now planned on a monthly basis. • All areas were visited, and conversations were held around Neonates: to carry Periprem over into Maternity. The poster that displays Periprem stats will be a helpful aid for staff to have on antenatal ward. Conversation held around the contradictions around the ask for collection and representation of data. For example – there is a difference in targets for giving breastmilk after birth- BAPM standard is within 6 hours and other metrics request within 12 hours. Discussions were held around how best to record and present for the different forums. • The quad walkabout provided an opportunity for staff to put faces to names. • The Quad are now working on the actions arising from the staff survey. The quad will be combining the staff survey work with the outcomes of the Score survey. • Themes and areas of focus were noted to be the same across both surveys. • There were some surprising results within staff survey- particularly around experience of violence and aggression from co-workers. The Quad are working with HR colleagues to compile and review that information.	
15	**Any Other Business** TOR: • reviewed and approved. • MNVP will be joining from next month. • **ACTION:** SS sought clarification if MNVP member is not in attendance will meeting be quorate. Draft - Terms of Reference - Maternity and Neonatal Safety Champions - May 2025.docx	JW

	• New Perinatal Surveillance Model document awaited 25/26	
16	***Meeting Close*** *Date of next meeting –19th June 2025* *Date of next Quad attendance- 17th July 2025*	

Resources for review prior to meeting		Embedded Documents
Local Assurance Reports		
1	ATAIN Action plan	Attached as agenda item
2	PMRT Quarterly report	Attached as agenda item
3	Risk Register	Verbal update as above
4	Ward to Board reports	Awaiting trust template
5	Claims Scorecard – Complaints, Incidents, themes, Learning, Action plan	Attached as agenda item
6	COSMOS Summary	Q4 24-25 COSMOS - Perinatal Assurance and Compliance (1).docx
7	Maternity Infographic	Information produced via dashboard
8	Maternity Training report	See Perinatal Safety Report for latest training figures
9	MBRACE 2022 Report	MBRRACE 2022 report review - FINAL.docx MB278-2022-rep.pdf
10	Dashboard	February-25 Trust & LMNS New Dashboard.xlsx
11	Student Cohorts – Feedback/reports	Practice evaluation Feb 2025 (1).docx Practice evaluation January 2025.docx
12	MNSI (Formerly HSIB) Investigations Home (mnsi.org.uk)	See Perinatal Safety Report for latest information
Local Safety Reports		
1	Perinatal Safety and Incident Report	

	(including HSIB QRM presentation, staffing report, Picker Action Plan, RAIT Tool, Maternity Service Improvement plan, MVP update, Safe staffing, Service user feedback, Perinatal Mortality Rate, ATAIN, InUero and Ex-Utero Transfers, National Neonatal Audit Programme, BFI, BLISS, Patient Experience)	Feb 25 Perinatal Incident report.docx March 25 Perinatal Incident report.docx Feb 2025 Perinatal Safety Report.docx March 2025 Perinatal Safety Report.docx
2	Maternity Safe Staffing Report	Midwifery Safe Staffing Report December 2024.docx 02.08 Midwifery Safe Staffing Report January 2025.docx 02.08 Midwifery Safe Staffing Report February 2025.docx Midwifery Safe Staffing Report March 2025 Final.docx
Maternity and Neonatal Voices Partnership		
1	MNVP CQC (Picker) Action Plan 23-24	Progress with MVP 2023-24 priority action plan July 23.docx Progress with MVP 2023-24 workplan July 23.docx CQC 2023 Action PLan.docx Maternity full CQC report 2023.pptx
1.2	MNVP CQC (Picker) Action Plan 24-25	RWP_RWP50_WORCESTERSHIRE ROYAL HOSPITAL MAT24 Picker Site Report (1).pptx RWP_WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST MAT24 Picker Management Report (4).pptx CQC 2023 2024 Combined action plan.docx
2	MNVP Meeting Minutes / Highlight report to LMNS	Worcs MNVP Highlights Report for September board 24.docx MNVP feedback February 2025.docx

3	MNVP 15 steps	4c. Fifteen Steps for Maternity Report - Re Agenda MVP 15 Steps WRH 29 11 2023.docx Fifteen Steps for Maternity Report - Kidderminster.docx
4	Patient experience	TOR - MNVP - Patient Experience Meeting Final 22.03.24.docx Patient Experience Meeting Agenda Template.docx January Event Feedback report 2025 FINAL.pdf Minutes - 12.02.25 Patient Experience Meeting.docx
People and Culture		
1	Confirmation of booking for Quad	Fw Important dates Perinatal Culture and Leadership Programme - Cohort D.msg
2	PCLP Timeline	PCLP - Programe Timeline.pdf
3	Welcome Pack	PCLP Welcome Document.pdf
Midlands Perinatal Network / MatNeo		
1	W.M MatNeoSip	Midlands MatNeoSIP Network Webinar 01.04.25.pptx
Other reference Documents		
1	You Said We did	Maternity and Neonatal Safety updates June 2023.png Maternity and Neonatal Safety updates October 2023.pdf Maternity and Neonatal Safety update April 2024.pdf Maternity and Neonatal - You said, we did June 24.png Maternity and Neonatal poster AUGUST 24.png Maternity and Neonatal poster OCTOBER 24.png Maternity and Neonatal poster December 24.png Maternity and Neonatal poster Feb 25.pdf You Said, We did - poster April 25 .png
2	Walkabout Template	WALKABOUT - Maternity and Neonatal Safety Walkabout Template proforma 05-25.docx

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST COVERING REPORT 2025/2026

Report to:	**Public Board**
Date of Meeting:	**09/09/2025**
Title of Report:	Winter Plan Board Assurance 25/26
Lead Executive Director:	**Chief Operating Officer**
Author:	Chris Douglas, Chief Operating Officer
Reporting Route:	
Appendices included with this report:	2
Purpose of report:	☐ **Assurance** ☒ **Approval** ☐ **Information**

Brief Description of Report Purpose

The purpose of the report is to provide the Board with the Worcestershire Acute Hospitals plans for the winter period, in the context of the wider system Winter plan. The plan is focussed on the management of patients presenting on the Acute Trust's hospital sites, in the context of system partner commitments to the provision of alternative pathways including a system commitment to reduce footfall but 2% over the period compared to previous years. The report provides information on the plans to manage the flow of patients as well as to provide assurance on schemes planned to mitigate risks ahead of the oncoming Winter.

The presentation attached contains a summary of schemes, challenges and predicted pressures, coupled with system wide scheme overview to manage, what is predicted to be a challenging period for the NHS. The slides detail high level risks to delivery.

All organisations are now required to undertake a pre-Winter stress test exercise in line with national directives. This stress test will inform further mitigation and impact. Worcestershire will be taking part in this exercise on 5 September 2025, with a regional wide stress test planned for 17 September 2025. As a result of these stress tests, additional actions may be added to the winter plan where required.

Our Winter plan includes:

- Operational modelling to deliver the commitments made in the annual plan for 2025/26 to improve our Emergency Access Standard compliance, 45 minute handover and bed occupancy improvements.
- Clinically led schemes to deliver reduced Emergency Department (ED) attendances, emergency admissions, reduce Length of Stay (LoS) across acute and community sites.
- Improved Discharge planning and System partners engagement to reduce delayed discharges
- Deliver 5% improvement in flu vaccination uptake for staff
- Infection Prevention Control (IPC) plans to reduce and manage outbreaks. To ensure staff are trained and to predict the impact of Flu and mitigate with timely vaccination programmes
- Workforce planning and well-being being a key to ensuring our workforce plans remain stable during these months
- Operational Resilience and approach

The introduction of a UEC recovery programme, incorporating a number of key workstreams led by teams as part of our Improvement focus will support in the delivery of mitigating actions and contribute to improving and enhancing flow and managing demand. Whilst the organisation has recently moved from Tier 1 monitoring into Tier 2, the support from the Emergency Care Intensive Support Team (ECIST) will continue, with a focus on effective board rounds, review of pathway processes and recommendations in relation to frailty. These recommendations have been incorporated in plan to support Winter Pressures.

A focus on internal professional standards will be key to a responsive approach and escalation, which will be adopting GIRFT standards of care. This alongside the 30/60/90 day plan actions and ownerships across divisions foster collaborative working and look to a shared approach towards releasing time to care for frontline teams.

The plan is not without risk to delivery, these risks are included and include (and are not limited to):

- Non delivery of schemes
- Increased demand above the levels predicted
- Staff well-being and support, increased sickness
- Cost of Agency and Bank
- Primary Care demand increase
- Use of additional TES spaces and increasing pressure to expand and increase space in ED's, impacting of staff wellbeing, safety and quality
- Lack of estate options for additional capacity if needed
- Bed Occupancy, following modelling work and system wide reconfiguration may not deliver

Recommended Actions required by Board or Committee

The board are asked to approve the Trust's Winter plan for 2025, noting that additional actions may be added following the stress test exercises planned for September 2025, and to approve the Board Assurance Statements for onward submission to NHS England on that basis.

Executive Director Opinion[1]

This Winter Plan is a combined effort and collaborative approach to prepare, assess and plan ahead of our most challenging months. It is built primarily on the programmes of work that the organisation is already taking as part of our UEC improvement focus. There have been a number of opportunities to review schemes and discuss mitigations, including 3P improvement workshops with colleagues, frailty and elderly care workshops across the ICB, the introduction of a robust 30, 60, 90 day plan, Flow, Discharge and streaming Workstreams with a Recovery Board and executive leadership.

Whilst data included in this plan compares activity and performance year on year, the organisation has seen some further improvement this year. Operational teams have focussed on speed of recovery and to ensure that processes are in their best possible position to prepare. Emergency Access Standard remains a challenge and an area of focus for all teams. We continue to work alongside ECIST to adopt recommendations, in particular a key requirement to deliver a robust frailty model and admission avoidance pathways.

There remains an ever increasing financial challenge associated with performance delivery and Winter, one which remains, and could be exacerbated where bed occupancy plans and delivery of system-wide schemes fail to deliver sufficient capacity, which may result in the continued high levels of escalation spaces being required despite positive levels of LoS improvement and reduction in number of patients who are 'discharge ready'

[1] Executive director opinion must be included and approved by the director concerned prior to issue, except when the director has given their consent for the report to be released.

Winter Planning 25/26

Board Assurance Statement (BAS)

NHS Trust

Introduction

1. Purpose

The purpose of the Board Assurance Statement is to ensure the Trust's Board has oversight that all key considerations have been met. It should be signed off by both the CEO and Chair.

2. Guidance on completing the Board Assurance Statement (BAS)

Section A: Board Assurance Statement

Please double-click on the template header and add the Trust's name.

This section gives Trusts the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.

Section B: 25/26 Winter Plan checklist

This section provides a checklist on what Boards should assure themselves is covered by 25/26 Winter Plans.

3. Submission process and contacts

Completed Board Assurance Statements should be submitted to the national UEC team via england.eecpmo@nhs.net by **30 September 2025.**

Provider:	Worcestershire Acute Hospitals NHS Trust

Section A: Board Assurance Statement

Assurance statement	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Governance		
The Board has assured the Trust Winter Plan for 2025/26.	Y	Submitted to Trust Board 09/09/25
A robust quality and equality impact assessment (QEIA) informed development of the Trust's plan and has been reviewed by the Board.	Y	The QEIA has been completed and approved by the CMO and CNO
The Trust's plan was developed with appropriate input from and engagement with all system partners.	Y	System wide approach to Winter Planning undertaken with all organisations contributing to the stress test on 2/9/25
The Board has tested the plan during a regionally-led winter exercise, reviewed the outcome, and incorporated lessons learned.	Y	In depth stress test planning with team on 17/09/25
The Board has identified an Executive accountable for the winter period, and ensured mechanisms are in place to keep the Board informed on the response to pressures.	Y	COO
Plan content and delivery		
The Board is assured that the Trust's plan addresses the key actions outlined in Section B.	Y	
The Board has considered key risks to quality and is assured that appropriate mitigations are in place for base, moderate, and extreme escalations of winter pressures.	Y	Risk to delivery identified in plan and separate risk register for UEC Recovery Board linked to mitigations
The Board has reviewed its 4 and 12 hour, and RTT, trajectories, and is assured the Winter Plan will mitigate any risks to ensure delivery against the trajectories already signed off and returned to NHS England in April 2025.	Y	

Provider CEO name	Date	Provider Chair name	Date

Provider:	Worcestershire Acute Hospitals NHS Trust

Section B: 25/26 Winter Plan checklist

Checklist	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Prevention		
1. There is a plan in place to achieve at least a 5 percentage point improvement on last year's flu vaccination rate for frontline staff by the start of flu season.	Y	
Capacity		
2. The profile of likely winter-related patient demand is modelled and understood, and plans are in place to respond to base, moderate, and extreme surges in demand.	Y	Capacity for surge within plan Surge and Super surge actions included within Trust's Escalation policy and Full Hospital Protocol. Additional out of hospital surge plans included in system wide escalation plans
3. Rotas have been reviewed to ensure there is maximum decision-making capacity at times of peak pressure, including weekends.	Y	Workforce Plan completed by Urgent Care and recruitment agreed, Rota's under rigorous review within Division.
4. Seven-day discharge profiles have been reviewed, and, where relevant, standards set and agreed with local authorities for the number of P0, P1, P2 and P3 discharges.	Y	As part of optimising Discharge to assess pathways
5. Elective and cancer delivery plans create sufficient headroom in Quarters 2 and 3 to mitigate the impacts of likely winter demand – including on diagnostic services.	Y	Ring fenced elective capacity remains in place at Alexandra Hospital, Redditch. In line with previous year plan, all elective activity is expected to continue
Infection Prevention and Control (IPC)		

6.	IPC colleagues have been engaged in the development of the plan and are confident in the planned actions.	Y	IPC Plans incorporated into Winter Plan
7.	Fit testing has taken place for all relevant staff groups with the outcome recorded on ESR, and all relevant PPE stock and flow is in place for periods of high demand.	Y	Plan for completion by 31 October 2025. High risk areas: ED, Paediatrics, ITU
8.	A patient co-horting plan including risk-based escalation is in place and understood by site management teams, ready to be activated as needed.	Y	Plans in place led by Lead IPC nurse
Leadership			
9.	On-call arrangements are in place, including medical and nurse leaders, and have been tested.	Y	Additional layers of senior visibility and extended cover in place
10.	Plans are in place to monitor and report real-time pressures utilising the OPEL framework.	Y	In line with usual operating practice
Specific actions for Mental Health Trusts			
11.	A plan is in place to ensure operational resilience of all-age urgent mental health helplines accessible via 111, local crisis alternatives, crisis and home treatment teams, and liaison psychiatry services, including senior decision-makers.	N/A	
12.	Any patients who frequently access urgent care services and all high-risk patients have a tailored crisis and relapse plan in place ahead of winter.	N/A	

Worcestershire Acute Hospitals NHS Trust Winter Planning & Preparedness 2025/26

Introduction

ICBs and Trusts were asked in the UEC Delivery Plan for 25/26 to develop system-wide winter plans over the summer, which would be ‘stress-tested’ at regional exercises in September. Individual ICB and Trust Boards will be accountable for providing the assurance on their plans, ahead of winter, ensuring plans mitigate against key delivery challenges and risks, and include robust plans under three demand levels: baseline, moderate and extreme.

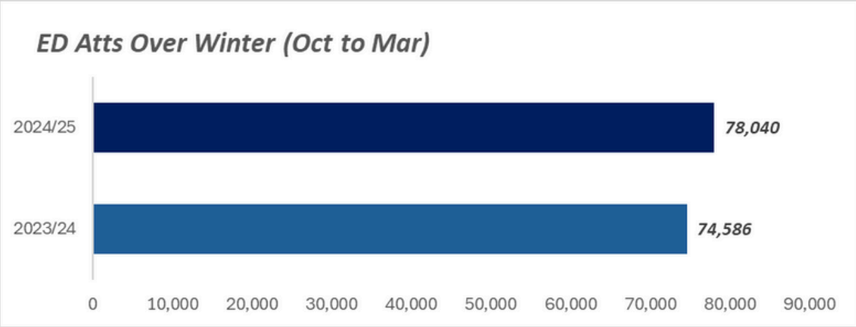
The plan identified 7 priorities that will have the biggest impact on UEC improvement this coming winter.

As a minimum these are:
• patients who are categorised as Category 2 – such as those with a stroke, heart attack, sepsis or major trauma – receive an ambulance within 30 minutes
• eradicating last winter’s lengthy ambulance handover delays to a maximum handover time of 45 minutes
• a minimum of 78% of patients who attend an A&E to be admitted, transferred or discharged within 4 hours
• reducing the number of patients waiting over 12 hours for admission or discharge from an emergency department compared to 2024/25, so that this occurs less than 10% of the time
• reducing the number of patients who remain in an emergency department for longer than 24 hours while awaiting a mental health admission.
• tackling the delays in patients waiting once they are ready to be discharged
• seeing more children within 4 hours

Additionally, the plan asks system leaders to commit to developing and testing collective winter plans, which will be signed off by every board and chief executive within each system by 30 September 2025. NHSE regions will work with local systems and providers on exercises to stress-test and refine their plans during the first week of September for Worcestershire Acute Hospitals NHS Trust and will continue to oversee improvement support to the most challenged organisations in the run up to and throughout this winter.

As a minimum, each plan should show how, by this winter, systems will:
• improve vaccination rates,
• increase the number of patients receiving care in primary, community and mental health settings,
• meet the maximum 45-minute ambulance handover time standard,
• improve flow through hospitals with a particular focus on patients waiting over 12 hours and making progress on eliminating corridor care,
• set local performance targets by pathway to improve patient discharge times and eliminate internal discharge delays of more than 48 hours in all settings.

Learning from Winter 24/25

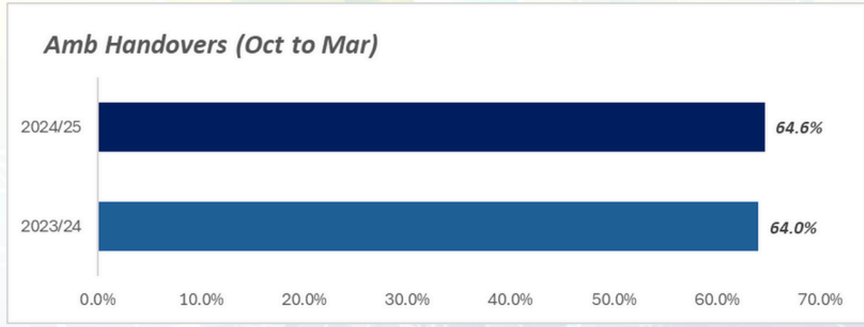


ED Demand:

- 78,040 ED Atts across WRH and Alex in the winter of 24/25
- This compares to 74,586 in 23/24
- This is a 4.6% increase on the previous winter
- This was an additional 19 Pts per day attending ED, predominantly walk in

Emergency Admissions

- 16,757 patients were admitted as an emergency to a Core Adult IP G&A ward across WRH and Alex in the winter of 24/25
- This compares to 15,955 in 23/24 – This was +5% increase.



Ambulance Handovers

- 7,866 Over 45 Minute Ambulance Handovers across WRH and Alex in the winter of 24/25
- This compares to 7,897 in 23/24
- The % within 45 minutes in the winter of 24/25 was 64.6% compared to 64% the previous winter so a 0.6% improvement.

12 Hours in ED from Time of Arrival

- 15,116 patients waited Over 12 hours in ED from time of arrival across WRH and Alex in the winter of 24/25
- This compares to 13,065 in 23/24
- The % Over 12 hours in the winter of 24/25 was 19.4% compared to 17.5% the previous winter, a 2% increase.

The learning from Winter identified the need for enhanced admissions avoidance and the need to increase the opportunities for Single Point of Access and for a fundamental focus on how we collaboratively enhance the process in relation to discharge pathways.

-A focus on UEC transformation, led by the CNO commenced, with the introduction of Pitstop, increased resource into Single Point of Access
-Review into Onward Care Team pathways commenced, and a reconfiguration of this is underway with an aim to reduce the overall stay for patients being discharged
-Urgent Care leadership has expanded, with a focus on a workforce and detailed rota review
-Primary Care streaming reviewed and pilot's in place to test new criteria enhancements and a service relocation and subsequent review in underway
-Urgent Care operational 'rhythm of the day.' robustness tested with daily handover and huddles optimised
-Urgent Care Pilot of a dedicated streamer, with success

Following demonstrable improvement in performance and approach, Worcester Acute Hospitals NHS Trust was moved from Tier 1 into Tier 2 monitoring on?

Performance against plan has continued to improve, despite record increased number of attendances at the front door.

		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Performance of attendances at Type 1,2,3 A&E departments, departing in less than 4 hours (E.M.13)	PLAN	55.0%	57.1%	59.4%	62.9%	66.9%	68.0%	71.1%	74.8%	73.2%	76.0%	76.4%	78.3%
	ACTUAL	60.9%	65.1%	66.1%	66.5%								
Ambulance Handovers - mean handover time (E.B.42)	PLAN	00:47:42	00:46:08	00:41:39	00:39:13	00:40:13	00:42:37	00:47:37	00:45:25	00:49:25	00:45:13	00:38:13	00:42:49
	ACTUAL	00:51:04	00:44:32	00:32:54	00:28:09	00:29:55							
Ambulance Handovers - numbers within 45 mins (internal)	PLAN												
	ACTUAL	65.9%	71.7%	80.8%	84.2%								

There is still work to do to improve our EAS. Our comprehensive plan contains a number of actions, combined with schemes to focus on reducing our overall waits and improve patient experience. Key actions such as the introduction of IPS (GIRFT Standards) will have a fundamental impact as well as focus on enabling assessment areas to function, both of which release flow.