APPENDIX 5

CQC Maternity Ratings	Overall	Safe	Effective	Caring	Well-Led	Responsive
SaTH	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Good

Maternity Safety Support Programme	Yes

QUARTER 4 - 2023				January	February	March	Comment
1.	**PMRT**	Findings of review of all perinatal deaths using the real time data monitoring tool	Stillbirths	0	1	2	100% compliance for reporting to MBRRACE within 7 working days and informing families that a PMRT review will take place and letters sent regarding the review. **January** - 1 MTOP/SB - Large cyctic non functioning kidneys diagnosed at 35 weeks. Oligohyramnious from 32 weeks. Learning identified from IRM stated that although it would not have changed the outcome, earlier referral to FMS would have mean't a sooner diagnosis for this family. MTOP and gave birth at 37 weeks. No PMRT review required. PM report outstanding. **February -** Attended routine community midwife appointment and unable to auscultate FH, IUD diagnosed in triage via USS at 28 weeks. MBRRACE referral made and PMRT review outstanding but planned for March 2024. PM report outstanding. **March -** Referral from community midwife from Powys, woman attended an appointment reporting reduced fetal movements, fetal heart rate was absent upon auscultation. Case 2. (24+2 weeks gestation). Routine antenatal clinic appointment reported reduced fetal movements, the fetal heart rate was absent upon auscultation. Both cases will be reviewed at PMRT in April. 1 Late Fetal Loss at 22w 4d - IUD diagnoised following admission to triage with RFM. Referred to MBRRACE and PMRT outstanding but planned for
			Late fetal losses >22 wks	1	0	0	
			Neonatal Deaths	0	0	0	
2.	**MNSI**	Findings of review of all cases eligible for referral to MNSI		0	2	0	MNSI Current cases • M1-032592 HIE/Cooling – Staff interviews completed, reported expected February 2024. • M1-034688 HIE/Cooling Uterine Rupture - no acts or omissions of care were identified in the multidisciplinary (MDT) reviews. Investigation continues staff interviews completed **2 cases referred in February: Case 1. Eclampsia (cooling case) Normal MRI case rejected/ Case 2: Rapid Birth (cooling case) MRI normal (pending decision)**
3.	**PSII & AAR**	Findings of all PSII/AAR **Neonates**		0	0	0	1 ongoing Serious Incident for Neonatal 2023/19809: Hospital acquired infection. Serratian - Following PMRT in January it was graded as D and identified area of concerns for Mums care in Triage and inpatient stay. It was agreed that this would be included in final report. The Neonatal aspect of the report is complete. An obstetric/triage expert is being identified to complete the areas of concern raised in the PMRT. Once completed this will be added to the Final Report.
3a.	**PSII & AAR**	Findings of all PSII/AAR **Maternity**		0	0	0	The 3 ongoing Serious Incidents Investigations for Maternity remain: 1. 2022/22648: HIE Therapeutic Hypothermia Treatment.Previously significantly overdue, the final SI report has been completed and presented at RALIG of 4th of January. Report sent to ICB for consideration for closure, closure agreed. 2. 2023/11850: Maternity Impacted fetal head. Awaiting completion of the report to include final obstetric input. There has been lack of engagement from an external consultant awaiting their input has caused significant delay. This was escalated to senior management and a plan is in place to reallocate to an internal Obstetrician. The patient has been contacted, informed of investigation progress and apologies given for the delay. 3. 2023/2606: T-incision. Maternity affecting mother. Report has been completed by the Investigating Officer report was presented at the Divisional Oversight & Assurance Group (DOAG) on 16th January. Report currently being amended in response to the comments and challenges from the division. Aim to recirculate back through DOAG and then RALIG by end of February
3b.	**INCIDENTS**	**Neonates:** The number of incidents recorded as Moderate Harm or above and what actions are being taken		0	0	0	There were no incidents reported moderate Harm or above
3c.	**INCIDENTS**	**Maternity**: The number of incidents recorded as Moderate Harm or above and what actions are being taken		2	3	2	**January** All moderate harm or above incidents reviewed at weekly IRM (Incident Review Meeting). **Incident 1** After Action Review was commissioned in January 2024: Patient had planned elective caesarean section for DCDA twins, high risk for postnatal haemorrhage. Initial section was uneventful, proceed to have secondary PPH of 5.5litres, 2 returns to theatre on with total hysterectomy on 2nd return to theatre. Learning was identified around the recognition, escalation, and management of the PPH. Trained facilitator has been allocated, review will be shared on completion. **Incident 2:** Neonatal Injury from Forceps birth, ATAIN review completed. **February** Case 1: Hysterectomy Elective CS managed well. Case2. Eclampsia Case 3. MNSI cooling (Rapid Birth) **March** are graded as moderate harm, they are both PPH > 1500ml. Both incidents are being reviewed by the MDT and learning identified.
			PROMPT	91%	100%	100%	A minimum of 90% compliance is required for PROMPT, NLS and Fetal Monitoring training as part of the Maternity Incentive Scheme reporting.

3d.	**TRAINING**	Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training	Obstetricians	Fetal Monitoring	95%	100%	100%	The Education team continue to ensure that all medical staff are booked to attend FMT and where compliance does not meet the requirements, a process for escalation to the Medical Director is in place. A full review of the training guideline is in progress along with the 3 yr local training plan to meet the requirements of the CNST MIS Safety Action 8. International Recruitment is now in place to support the current workforce and 10 Internationally Educated Midwives have been recruited and are registered with the NMC.
			Midwives	PROMPT	97%	97%	97%	
				NLS	93%	92%	93%	
				Fetal Monitoring	97%	96%	96%	
			Other Drs	PROMPT	100%	100%	100%	
				Fetal Monitoring	96%	100%	100%	
			Neonatal Nurses	NLS	100%	100%	100%	
			Anaesthetists	PROMPT	97%	91%	92%	
			WSAs/MSW	PROMPT	93%	93%	91%	
3e	**STAFFING**	Minimum safe staffing in maternity services to include Obstetric cover on the Delivery Suite, gaps in rotas and midwife minimum safe staffing planned cover versus actual prospectively	Maty Del Suite positive acuity		71%	59%	81%	NB: the D**el Suite positive acuity figure** is the 'end of month rate' reported each month on maternity dashboard and not the rolling 13 wk rate.
			Maty 1:1 care in labour		100%	100%	100%	
			Fill rates Delivery Suite RM		D 89/N 69	D89/N69	D82/N67	
			Fill rates Postnatal RM Fill rates Antenatal RM		D100/N 89	D100/N89	D93/N65	
			Obstetric Cover on D Suite		100%	100%	100%	
4.	**SERVICE USER FEEDBACK**	Service User Voice Feedback from MNVP and UX system achievements	To note - there are no further updates for the UX system, as this has now been stood down and superseded by the Patient Experience Group.					
5.	**STAFF FEEDBACK**	Staff feedback from Bi-monthly frontline champion and walkabouts *(CNST requirement quarterly)*	Scanning and Outpatients PRH		No Walkabout	Scanning and Outpatients		'Our Staff Said, We Listened' feedback posters with updates for staff from the walkabouts are distributed widely via email and on display
6.	**EXTERNAL**	Requests from an external body (MNSI/NHSR/CQC or other organisation) with a concern or request for immediate safety actions made directly with Trust	0		0	0		The last safety recommendation reported by MNSI was in 2022 and this is related to an aspect of escalation for medical review. Neonatal Review
7.	**Coroner Reg 28**	Coroner Regulation 28 made directly to Trust	0		0	0		To note - there have been no Regulation 28s since May 2021.
8.	**SA 10 CNST**	Progress in achievement of CNST Safety Action 10	✓ Compliant		✓ Compliant	✓ Compliant		**No investigations have been published and there are no safety recommendations**. There have been no safety recommendations in any reports published in the last year. The last was made in April 2022. 50% of SaTH investigations to date have had no safety recommendations from MNSI compared to national figure of 15%
9.	**Category 1 Caesarean sections**	Delays to Cat 1 CS>30 minutes and outcomes	4		2	0		January , no adverse outcomes February no adverse outcomes March no cases
10.	**Category 2 Caesarean sections**	Delays to Cat 2 CS>75minutes and outcomes	9		12	15		January ,Delays relate to theatre team briefings, theatres in use, 1 case awaiting blood products and 1 was an administration error. There were no poor outcomes to patients as a result of the delays, this is being monitored closely with ongoing work February: . There were no poor outcomes to patients as a result of the delays, this is being monitored closely with ongoing work surrounding the inclusion of a third theatre, new SOP in progress pertaining to transfer to theatre and introduction of a third March: There were no poor outcomes to patients as a result of the delays, this is being monitored closely with ongoing work surrounding the inclusion of a new SOP pertaining to transfer to theatre and introduction of a third theatre included in the new Hospital Transformation Programme.
11.	**ECLAMPSIA**	Number of women who developed eclampsia	0		1	0		MNSI referral declined due to normal MRI, Learning: early escalation to anaesthetic team. Antenatal care episodes x3 missed proteinuria.
Proportion of midwives responding with 'Agree or Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment								44.3% for Maternity Services published 2023
Proportion of specialty trainees in Obs & Gynae responding with 'excellent or good' on how they would rate the quality of clinical supervision out of hours								Reported annually - 87% *(source GMC National Trainees Survey 2022)*