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

Maternity Safety Support Programme	Yes

		QUARTER 1 - 2024		April	May	June	
1.	PMRT	Findings of review of all perinatal deaths using the real time data monitoring tool	Stillbirths	0	0	1	100% compliance for reporting to MBRRACE within 7 working days, informing families that a PMRT review will take place, and letters being sent regarding the review. **April** ENND at 29w 3d, known significant exomphalos and comfort care initiated. Baby died on day of birth. PMRT review awaited. ENND at 37w 2d IOL followed by Cat 1 LSCS for placental abruption. Baby died day 1. PMRT and MNSI reviews awaited. **May** There were no neonatal deaths at SaTH in May 2024.
			Late fetal losses >22 wks	0	0	0	
			Neonatal Deaths	2	0	0	
2.	MNSI	Findings of review of all cases eligible for referral to MNSI		<u>3 Referrals</u> 2 accepted 1 declined	0 Referrals	1 Referral	**April** In total, there were 3 Maternity and Newborn Safety Investigations (MNSI) referrals completed for the month of April, 1 case was declined, and the other 2 cases met were accepted for investigation. One baby was transferred for therapeutic hypothermia and one baby who passed away on day 1 of life. There are two other ongoing cases where the reports have been received from MNSI for factual accuracy. Any findings and learning will be shared. **May** One report was finalised and returned to the trust in May 2024. The Trust received 1 safety recommendation - **"The Trust ensures that mothers with moderate or severe continuous abdominal pain are observed and monitored as part of an ongoing holistic assessment.**"
3.	PSII & AAR	Findings of all PSII/AAR **Neonates**		0	0	0	There were no new PSSI/AARs for Neonates, however one SI is ongoing. This review focuses on the mother's care in maternity triage and will be published as part of an investigation completed for baby.
3a.	PSII & AAR	Findings of all PSII/AAR/MDT **Maternity**		1 PSII 0 AAR	1 PSII 1 MDT	0	**April** PSSI - There was 1 PSII commisioned in April which relates to one of the cases accepted by MNSI (CTG management and escalation). AAR - There were no maternity AARs commissioned in April. One was commissioned in January to identify learning around the recognition, escalation and management of deteriorating patients and the AAR took place on 15th April. The report is still underway and learning will be shared once approved. **May** 1 PSII commissionned in May 2024 - MNSI referral in April 2024. PSII raised 20/05/2024. 1 MDT commissioned in May 2024 - Delayed diagnosis of fetal anaemia. Incident took place in March, but a delay took place due to notes being transported to Birmingham in error. June No PSII, AAR, or MDT was commisioned for maternity in June 2024.
3b.	INCIDENTS	**Neonates:** The number of incidents recorded as Moderate Harm or above and what actions are being taken		1	0	0	**April** There was one incident recorded as Moderate Harm - this was a neonatal death which will be reviewed in full via PMRT and MNSI. **June** There were no moderate harm or above incidents for June
3c.	INCIDENTS	**Maternity**: The number of incidents recorded as Moderate Harm or above and what actions are being taken		13	19	10	**April** Moderates -13 - There were 2 therapeutic hypothermia incidents, 1 was accepted and the other rejected by MNSI (normal MRI, Mum and baby well and discharged home) PPH over 1500ml x 1 Passive / Active cooling commenced x2 Neonatal Death >=23 weeks gestation x1 Caesarean section - Category 1 x1 Medication Administration x 1 Trauma to Bladder or other organs x 1 Transfer to ITU/HDU x 1 Shoulder dystocia x 1 CDOP notification (child death overview process) x 1 Missed screening x 1 Unexpected admission to NNU x 1 Apgar score <7 at 5 minutes x 1 **May** Moderates -19 4 Caesarean section - Category 1 4 PPH over 1500ml 2 Trauma to Bladder or other organs 1 Apgar score <7 at 5 minutes 1 Birth injury (e.g. laceration, BPI, fracture) 1 Complication of procedure 1 Cord PH <7.05 arterial, or <7.1 venous 1 Cord prolapses 1 Failed instrumental/second stage Caesarean 1 Other airway problems with anaesthetic 1 Possible delay or failure to implement care 1 Shoulder dystocia (re-instated from 5.10 20) **June** 1 severe incident - MNSI referral 37/40 baby with hypoglycaemia and seizure activity, abnormal MRI. MNSI proceeding with case 9 moderate harm incidents 1 safeguarding 1 PPH 1 baby skin laceration 1 arm injury in ITU 1 cord prolapse 2 Post natal admissions with sepsis
			PROMPT	100%	96%	100%	

No.	Area	Measure	Staff group / Indicator	Training	Apr	May	Jun	Comments
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%	91%	A minimum of 90% compliance is required for PROMPT, NLS and Fetal Monitoring training as part of the Maternity Incentive Scheme reporting. 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. The ward managers are meeting with the Education Lead monthly to monitor compliance 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. 3 out of 10 midwives have completed their supernumary period and are now onto the preceptorship programme.
			Midwives	PROMPT	99%	98%	98%	
				NLS	95%	93%	94%	
				Fetal Monitoring	99%	97%	96%	
			Other Drs	PROMPT	100%	100%	100%	
				Fetal Monitoring	87%	100%	96%	
			Neonatal Nurses	NLS	100%	100%	100%	
			Anaesthetists	PROMPT	78%	78%	76%	
			WSAs/MSW	PROMPT	93%	90%	93%	
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		64%	85%	85%	NB: the Del 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-70%	D- 86% N-79%	D- 87% N-74%	
			Fill rates Postnatal RM Fill rates Antenatal RM		D- 101% N-91%	D- 101% N-92%	D-106% N93%	
			Obstetric Cover on D Suite		100%	100%	100%	
4.	**SERVICE USER FEEDBACK**	Service User Voice Feedback from MNVP			**April** Friends & Family Tests - PRH Consultant Led Unit - Doctors and Midwives were amazing. Antenatal - very caring, made me feel comfortable and at home. Postnatal - friendly, reassuring, supportive. MNVP Thank You Thursdays - Grateful to all professionals involved in my care. Every single midwife was kind and compassionate. Particular thank you to midwives and student midwife who cared for e during the labout and birth as they were simply amazing and enabled me to have a wonderful, rlaxed and positive birth experience. Cannot fault any aspect of their care. **June** support with going to hospital from midwife, to care during birth and afterwards with additional support in theatre delivering placenta were all fantastic. nothing was too much trouble and felt completly reassured throughout Everyone very friendly and helpful. Very pleased. However parking charges and availability terrible I have been treated with dignity and respect by everyone on the ward. Nothing has been too much trouble and everyone is very friendly. I have been very well cared for by genuine compassionate people			
5.	**STAFF FEEDBACK**	Staff feedback from Bi-monthly frontline champion and walkabouts *(CNST requirement quarterly)*			Oswestry Midwifery Led Unit	No Walkabout	Neonatal Unit	'Our Staff Said, We Listened' feedback posters with updates for staff from the walkabouts are distributed widely via email and on display on noticeboards in midwifery/ward/unit areas. **June-** •Neonatal Badgernet EPR is on the digital road map but no funding identified and so this is not timetabled. •Concerns expressed that position for patient safety specialist for maternity has not been approved and the impact on family liaison, especially with MNSI investigations. •Two recent neonatal life support update training days have been cancelled
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	1	0	Issues with guidance and fetal monitoring remain the most common theme from safety recommendations nationally, regionally and locally. SATH's most recent safety recommendation was in April 2022 in relation to escalation. This reflects the hard work of promoting and facilitating all staff to attend mandatory MDT study days and overall ensuring a positive working safety culture. We are expecting to receive safety recommendation from the two reviews currently shared for factual accuracy.
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			0	0	0	**April**- No cases **May**- No cases **June**- No cases
10.	**Category 2 Caesarean sections**	Delays to Cat 2 CS>75minutes and outcomes			9	0	7	**April** There were no poor outcome to patients as a result of delays, this is being monitored closely. A SOP pertaining to transfer to theatre has been produced and is availble on the intranet and introduction of a third theatre involved in the new Hopsital Transformation Programme **May**- No cases identified **June** -There were no poor outcome to patients as a result of the delays. The themes for the delays are : Transfer to theatre, Patient declining procedure, Delay in siting spinal anaesthesia, Awaiting blood results and Theatre acuity.
11.	**ECLAMPSIA**	Number of women who developed eclampsia			0	0	0	**April**- No cases **May**- No cases **June**- No cases
Proportion of midwives responding with 'Agree or Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment								43.3% Maternity Services punlished 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 - 86% (source GMC National Trainees Survey 2023 page 8) Down 1% from 2022 *https://www.gmc-uk.org/-/media/documents/national-training-survey-2023-initial-findings-report_pdf-101939815.pdf*