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

Maternity Safety Support Programme	Yes

QUARTER 2 - 2024/2025				July	August	September	Comment
1.	**PMRT**	Findings of review of all perinatal deaths using the real time data monitoring tool	Stillbirths	1	0	2	**July** 1 stillbirth took place in July - the mother was referred to maternity triage with an unstable lie at 40 weeks gestation and no fetal heart was heard on arrival in maternity triage. The IUD was confirmed on scan and the baby born two days later. **August** There were no stillbirths, late fetal losses, or neonatal deaths at SaTH in the month of August. 1 woman booked with SaTH had a stillbirth out of area and we will participate in a joint PMRT review. 1 woman booked with SaTH had a neonatal death after an IUT and birth at 23+1. We will participate in a joint PMRT review. **September** 2 stillbirths took place in September. One woman had an stillbirth at home at 34+ weeks gestation she had made no contact with Maternity serivces to alert them to labour starting. A joint agency review was completed the following day and a PMRT is planned. One woman attended maternity triage with reduced fetal movements at 31+ weeks gestation and was diagnosed with an intrauterine fetal loss. 1 late fetal loss took place in September. The woman attended maternity triage with reduced fetal movements for 5 days and was diagnosed with an intrauterine fetal death.
			Late fetal losses >22 wks	0	0	1	
			Neonatal Deaths	0	0	0	
2.	**MNSI**	Findings of review of all cases eligible for referral to MNSI		1	0	0	***1 safety action was received in May 2024 - The Trust ensures that mothers with moderate or severe continuous abdominal pain are observed and monitored as part of an ongoing holistic assessment.*** **July** 1 referral was made to MNSI in July - a baby was born in poor condition at home after a planned home birth, required active resuscitation and transfer to ED, was noted to have seizure activity on arrival to the NNU. Baby was actively cooled and has since had a normal MRI. The case was referred to MNSI and accepted due to concerns regarding the delay in transfer from RSH to PRH. **August** There were no referrals to MNSI in the month of August. **September** There were no referrals to MNSI in September 1 final MNSI report was received with 6 safety recommendations: 1. The Trust to ensure that a robust system is in place for women with gestational diabetes to trigger a face-to-face specialist review when there are concerns with engagement and reduced compliance with blood glucose testing, in order to provide ongoing support to mothers, with timely commencement of medication when required. 2. The Trust to provide mothers with accurate personalised information and to ensure their understanding of this, to enable them to make an informed choice regarding mode of birth. 3. The Trust to ensure they have consistent guidance to support clinicians in planning care when there are signs of chronic hypoxia on a cardiotocograph prior to the onset of labour. 4. The Trust to ensure that staff use and understand the checklist for determining if chronic hypoxia or pre-existing fetal injury is present to ensure that there is a consistent assessment of and management of CTG findings. 5. The Trust to review the process of the fresh eyes CTG reviews in labour to ensure they are independent and effective, to optimise the opportunity for recognising fetal heart rate abnormalities. 6. The Trust to ensure that clinicians are supported to follow guidance and commence variable rate insulin infusion when required while caring for women with diabetes in labour.
3.	**PSII & AAR**	Findings of all PSII/AAR **Neonates**		0	0	0	**July** There were no formal learning responses commissioned for neonatal in July. **August** There were no formal learning responses commissioned for neonatal in August **September** There were no formal learning responses commissioned for neonatal in September

3a.	**PSII & AAR**	Findings of all PSII/AAR **Maternity**			0	0	0	**July** There were no formal learning responses commissioned for maternity in July. 1 SI was agreed for closure with monitoring in July. The learning identified was: > Improved fluid balance monitoring and escalation of deterioration is required. > Oxytocin management and reviews of delay in labour to be improved. > Prevention and training on management of impacted fetal heads at caesarean section to be developed. > Implementation of the new Maternal Sepsis Guideline. **August** There were no formal learning responses commissioned in August and no final reports were shared, **September** There were no formal learning responses commissioned in September.
3b.	**INCIDENTS**	**Neonates:** The number of incidents recorded as Moderate Harm or above and what actions are being taken			1	4	0	**July** 1 moderate harm incident was reported in July. This was in relation to a baby who did not receive IV glucose for 1.5 hours due to an error. **August** 4 moderate harm incidents were reported in August. - 1 was a missed MSU result that was no actioned for several weeks and baby subsequently admitted to paeiatrics for IV antibiotics. - 3 Datix' were submitted for a term admission to the neonatal unit following caesarean birth. Baby required intubation, nitric oxide, and transfer to a PICU for excalated care and ECMO. Baby remains in PICU and continues to receive ECMO. **September** No incidents were reported with moderate harm level or above.
3c.	**INCIDENTS**	**Maternity**: The number of incidents recorded as Moderate Harm or above and what actions are being taken			11	10	12	**July** There were 10 moderate Datix' and 1 death in July. The death was the stillbirth reported above. The moderate Datix' were in relation to several themes including MOH, term admissions to the NNU, low cord gases, and return to theatre. Two of these were linked to the MNSI referral above. Learning regarding recognition, management, and escalation of abnormal FH has been shared and teaching implemented regarding intermittend auscultation. **August** There were 10 moderate harm Datix' reported in August. These were in relation to sevreal themes including MOH, term admission to the NNU, unexpected breech birth, and communication issues between specialties and departments. **September** There were 9 moderate harm Datix' reported in September. The themes were term babies admitted to the neonatal unit, massive obstetric haemorrhage, OASI, shoulder dystocia, and babies born in poor condition. There were 2 severe harm Datix' reported in September One was related to blood loss of 3700ml following birth, the other was related to a woman with sepsis who was also declining care. There was one death reported on Datix in September. This was a woman who attended with RFM for 6 days an was diagnosed with an intrauterine death at 22+5 weeks gestation.
3d.	**TRAINING**	Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training	Obstetricians	PROMPT	100%	100%	100%	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.
				Fetal Monitoring	96%	95%	94%	
			Midwives	PROMPT	97%	98%	98%	
				NLS	94%	94%	93%	
				Fetal Monitoring	97%	98%	97%	
			Other Drs	PROMPT	100%	93%	100%	
				Fetal Monitoring	95%	100%	100%	

			Neonatal Nurses	NLS	100%	100%	96%	
			Anaesthetists	PROMPT	75%	79%	74%	
			WSAs/MSW	PROMPT	94%	96%	95%	
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		82%	89%	78%	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- 90% N-82%	D-91% N77%	D- 84% N-77%	
			Fill rates Postnatal RM Fill rates Antenatal RM		D- 117% N- 96%	D-115% N-85%	D- 114% N-95%	
			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)*	**July-** Poster updated and sent through governance		August- Poster for matenrity approved	Walkabout delivery suite		'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		No immediate safety recommendations have been received by the Trust.
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		
9.	**Category 1 Caesarean sections**	Delays to Cat 1 CS>30 minutes and outcomes	0		0	0		**July-** No cases identified **August-** No cases identified **September-** No cases identified
10.	**Category 2 Caesarean sections**	Delays to Cat 2 CS>75minutes and outcomes	9		10	13		**July-** There were a few reasons for a delay in casrean section: Transfer to theatre, patient request and theatre actuity. All cases reviced had no adverse outcomes for the enonates/ All term noentes born had an apgar or 7 or above at ten minutes of age **August-** A thematic review continues to be undertaken highlighting the rationale for any delay, with monthly reports noting trends and themes, being presented at Matenity Governance meetings. The themes for the month of August were due to transfer to theatre **September-** A thematic reviews continues to be undertaken highlighting the rational for delay. The themes for the month of Septmber, 77% transfer to theatre in a timely manner and 23% theatre acuity .
11.	**ECLAMPSIA**	Number of women who developed eclampsia	0		0	0		**July-** No cases identified **August** - no cases identified **September -** No cases identified
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)*