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

Maternity Safety Support Programme	Yes

QUARTER 3 - 2024/2025				October	November	December	Comment
1.	**PMRT**	Findings of review of all perinatal deaths using the real time data monitoring tool	Stillbirths	0	3		**October:** 31 weeks gestation - admitted to delivery suite with symptoms of infection, raised baseline on CTG. Decision for category 2 caesarean section. Baby required significant resuscitation carried out including inflation breaths, ventilation breaths, intubation attempts x3, cardiac compressions, adrenaline, glucose, bicarbonate, chest x-ray, needle aspiration, video laryngoscope, UVC, IV fluids, blood transfusion. Significant difficulties in achieving ventilation, unable to stabilise x2 consultants were present during the resuscitation. Decision taken for reorientation of care. Baby will follow PMRT process **November:** SaTH reported 3 cases to MBRRACE in November and will be leading on the PMRT reviews: 1 stillbirth at 38 weeks and 5 days self-referred to triage with Reduced fetal movements and no FH on USS. No signs of labour on admission, therefore, does not meet criteria for MNSI referral. 1 stillbirth at 38 weeks and 3 days self-referred to triage with Reduced fetal movements and no FH on USS. No signs of labour on admission, therefore, does not meet criteria for MNSI referral. 1 stillbirth at 37 weeks and 6 days self-referred to triage with suspected labour, reduced fetal movements and no FH on USS. She reported that she believed she was in labour and, therefore, meets criteria for MNSI referral. A baby born at SaTH at 26 weeks and 5 days was subsequently transferred and died at New Cross Hospital, PMRT review by the New Cross team. SaTH will offer input into this review.
			Late fetal losses >22 wks	0	0		
			Neonatal Deaths	1	1		
2.	**MNSI**	Findings of review of all cases eligible for referral to MNSI		0	1		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. **October: There were no referrals to MNSI in October** 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. 20-point action plan had been agreed at RALIG – Action submitted on Datix and added to MIRM tracker oversight and monitoring to be presented at November Maternity Governance **November:** 1 incident was referred to MNSI in November 2024 and was accepted for review. 1 stillbirth at 37 weeks and 6 days self-referred to triage with suspected labour, reduced fetal movements and no FH on USS. She reported that she believed she was in labour and, therefore, meets criteria for MNSI referral. 1 final MNSI report was received in November with 3 safety recommendations: 1. The Trust to ensure that the resources and tools within their local guidance are available for use on the labour ward to support the assessment and calculation of blood loss. 2. The Trust to ensure that the local pathway for the management of massive blood loss in the neonate is embedded into practice to support timely emergency escalation, haematology support and blood product replacement. 3. The Trust to ensure that all actions have been taken to investigate and manage neonatal blood loss prior to consideration and commencement
3.	**PSII & AAR**	Findings of all PSII/AAR **Neonates**					**October**: There were no formal learning responses commissioned for neonatal in October **November:**
3a.	**PSII & AAR**	Findings of all PSII/AAR **Maternity**		0	1		**October: There were no formal learning responses commissioned for neonatal in October.** **November:** 1 SI was finalised in November 2024. This was the last of the pre-PSIRF investigations for maternity/neonates. The following recommendations were made: 1. To provide individual learning for the midwife who took the obstetric triage call on the 11th of September 2023. 2. Obstetric Triage - To monitor the Datix incident reporting system at the weekly maternity risk meeting to review any calls made to triage and a non-invitation of a woman to attend triage where harm or potential harm may have occurred and to act on those findings. 3. To review the current maternity electronic Badgernet system where calls to triage are recorded to understand if the tool can be developed to provide support and guide midwives to make the correct decision for who should or should not attend triage for review and assessment. 4. Continuation and completion of the IPC action plan [made after initial investigation of serratia infection. 5. The Microbiology Department to store neonatal Serratia positive samples to enable future typing if required
3b.	**INCIDENTS**	**Neonates:** The number of incidents recorded as Moderate Harm or above and what actions are being taken		3	0		**October:** There were 3 incidents reported 1 Severe and 2 Death – all incidents related to the same patient 31 weeks gestation - admitted to delivery suite with symptoms of infection, raised baseline on CTG. Decision for category 2 caesarean section. Baby required significant resuscitation carried out including inflation breaths, ventilation breaths, intubation attempts x3, cardiac compressions, adrenaline, glucose, bicarbonate, chest x-ray, needle aspiration, video laryngoscope, UVC, IV fluids, blood transfusion. Significant difficulties in achieving ventilation, unable to stabilise x2 consultants were present during the resuscitation. Sadly, decision taken to reorientation of care. Baby will follow PMRT process **November:** There were no incidents with moderate harm or above in November.
3c.	**INCIDENTS**	**Maternity**: The number of incidents recorded as Moderate Harm or above and what actions are being taken		10	15		**October:** There were 11 Incidents reported 8 Moderate and 2 Severe 5 PPH over 1500ml Delay in CAT 2 Section - Severe CAT 1 Caesarean Section for abruption Birth Injury - Brusing to right side of baby face following NBF delivery 1 3rd Degree Tear - Repaired under spinal anaesthetic in theatre. 1 4th Degree Tear following NBFD without Episiotomy head delivered rapidly and no time for episiotomy by obstetrician increased to severe harm from moderate **November:** There were 13 incidents logged as moderate harm, 1 as severe harm and 1 as a death in November. 1 was a delay in care - delayed bladder care in the postnatal period. 4 were PPHs > 1500ml 1 was a delay in cat 2 caesarean section 1 was a blood sampling error. 1 was a term IUD 1 was a transfer to ITU 2 were shoulder dystocias 2 were category 1 caesarean sections. 1 was a breakdown of a caesarean section wound with bowel extrusion. Four of the incidents were linked to one patient who had a term IUD, placental abruption, MOH and transfer to ITU.
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%		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.
			Obstetricians – Fetal Monitoring	96.29%	100%		
			Midwives – PROMPT	98.37%	97%		
			Midwives – NLS	96.33%	94%		
			Midwives – Fetal Monitoring	99.09%	97%		
			Other Drs – PROMPT	100%	100%		
			Other Drs – Fetal Monitoring	100%	100%		
			Neonatal Nurses – NLS	86.00%	97%		
			Anaesthetists – PROMPT	87.09%	100%		
			WSAs/MSW – PROMPT	97.40%	94%		
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	88%	94%		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%		
			Fill rates Delivery Suite RM	D- 89% N- 79%	D- 87% N-86%		
			Fill rates Postnatal RM Fill rates Antenatal RM	D- 129% N- 119%	D 114% N- 106%		
			Obstetric Cover on D Suite	100%	100%		

4.	**SERVICE USER FEEDBACK**	Service User Voice Feedback from MNVP and UX system achievements	**October :** Of the 680 eligible patients 14 responses received; this gives a response rate of 2.06%. There were 6 responses for antenatal and 1 response were received for postnatal, other responses were from the MLU/Community. All 12 responses were submitted as "Very Good." There were 2 responses that were "Poor/Very Poor" both related to antenatal. An improvement project is currently in progress to utilise QR codes on patient lockers and ward areas, to allow people to access the FFT in digital format. •ommunity midwifes have been kind and caring throughout our interactions. reassured and answered our questions clearly .my wife and I felt really well looked after •** thoughtful and looked my wife really well. really nice and kind staff •ll the midwives and msw on postnatal following a very unexpected and extended stay were so helpful and supportive. I wish to thank all that were working •was looked after so well by every member of staff during a traumatic and unexpected delivery			
5.	**STAFF FEEDBACK**	Staff feedback from Bi-monthly frontline champion and walkabouts *(CNST requirement quarterly)*	Walkabout Ludlow	No Walkabout		'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		No immediate safety recommendations have been received by the Trust.
7.	**Coroner Reg 28**	Coroner Regulation 28 made directly to Trust	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		
9.	**Category 1 Caesarean sections**	Delays to Cat 1 CS>30 minutes and outcomes	2	1		**October** This was a multiple pregnancy, there was a 2 and 4 minute delay from decision to delivery. The electronic notes have been reviewed at length. There was a 17 minute interval from decision to transfer to theatre, which causes the **November** There was 1 delay in category 1 caesarean sections in the month of November. The reason for the delay was to stabilize the patient with a blood transfusion prior to the procedure.
10.	**Category 2 Caesarean sections**	Delays to Cat 2 CS>75minutes and outcomes	12	11		**October** The reason for delays were transfer to theatre, theatre acuity and awaiting manternal blood results. A SOP is to be implemented regarding the process of transferring. There is also discrepancy in classifactions. this has **November** A thematic review continues to be undertaken highlighting the rationale for any delay, with monthly reports noting trends and themes, presented at Maternity Governance meetings. The themes for the month of November were due to transfer to
11.	**ECLAMPSIA**	Number of women who developed eclampsia	0	0		**October:** No cases identified **November:** 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)*