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

Maternity Safety Support Programme	Yes

QUARTER 4 - 2025					January	February	March	Comment
1.	**PMRT**	Findings of review of all perinatal deaths using the real time data monitoring tool	Stillbirths		0			**January** : There were no stillbirth reported in Janaury.(There was 1 Neonatal Death Sath patient 22+6) Baby was born at SaTH at 22+6 weeks gestation, was transferred to a tertiary unit for ongoing care, and passed away at 1 day old. The death is recorded as a neonatal death for SaTH, but the tertiary unit will be leading on the PMRT.
			Late fetal losses >22 wks		0			
			Neonatal Deaths		1			
2.	**MNSI**	Findings of review of all cases eligible for referral to MNSI			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.*** **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 of therapeutic cooling. This will enable clinicians to evaluate that a baby is stable enough to commence treatment with therapeutic cooling.
3.	**PSII & AAR**	Findings of all PSII/AAR **Neonates**			0			**January:** There were no formal learning responses commissioned for neonatal in January
3a.	**PSII & AAR**	Findings of all PSII/AAR **Maternity**			0			**January:** There were no formal learning responses commissioned for Maternity in January
3b.	**INCIDENTS**	**Neonates:** The number of incidents recorded as Moderate Harm or above and what actions are being taken			0			**January:** There were no incidents with moderate harm or above in January
3c.	**INCIDENTS**	**Maternity**: The number of incidents recorded as Moderate Harm or above and what actions are being taken			12			**January:** There were 7 incidents logged as moderate harm, 2 as severe harm and 2 as a death in January. 1 IUFD at 18 weeks 1 Preterm 22+6 weeks transferred to Level 3 units and sadly died 1 Bladder injury in emergency section, patienrt had had 3 previous sections. 2 Category 1 Caesaren Section (1 case was also PPH over 1500mls) 2 PPH over 1500mls 1 Hospital Acquired PU Cat 3 - 1 Treatment/surgery problems- patient 5 days postnatal episitomy wound infected 1 MOH 2500mls 1 Diagnosis -diagnosis wrong - Nuliparous patient assessed antenally - Patient diagnosed with severe pre-eclampsia requiring multiple antihypertensive agents at 25 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%			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	95.65%			
			Midwives	PROMPT	98.35%			
				NLS	97.11%			
				Fetal Monitoring	97.72%			
			Other Drs	PROMPT	100%			
				Fetal Monitoring	100%			
			Neonatal Nurses	NLS	96.00%			
			Anaesthetists	PROMPT	100.00%			
			WSAs/MSW	PROMPT	95.83%			
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		99%			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%			
			Fill rates Delivery Suite RM		D- 96% N-84%			
			Fill rates Postnatal RM Fill rates Antenatal RM		D-127% N-99%			
			Obstetric Cover on D Suite		100%			

4.	**SERVICE USER FEEDBACK**	Service User Voice Feedback from MNVP and UX system achievements (*To note feedback one month behind)*	**January** 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 to improve the response rates. "I Support SaTH" Facebook page. I would like say a huge thank you to the midwives who safely delivered our son, and the teams on NICU and postnatal ward. After a scary start due to fluid on his lungs and rapid breathing once on the postnatal ward, followed by a couple of days in NICU having blood tests, drainage tubes from his stomach, x-rays, high-flow oxygen and various other tests for suspected infection, he has settled in amazingly well at home and is now thriving! The entire maternity and neonatal team we came into contact with were amazing, knowledgeable and understanding of how worrying and stressful this situation was as parents, and they couldn't do enough to ensure that we were fully informed of what was going on and kept us reassured. I would like say a huge heartfelt thank-you to midwives and who safely delivered our new grandson [in January] and the team in NICU. After a scary start due to fluid on his lungs that was spotted within minutes of his birth and swiftly dealt with, a couple of days spent in NICU with various blood tests and X-ray little [baby] is now safely at home with his doting parents. We are so grateful to all of those involved and would like you to know how amazing and brilliant you are. It is only when things like this happen that you realise how knowledgeable, professional and truly special the whole midwifery and neonatal team are. Thank you all so much Massive thank you to the midwife's during my long labour & birth [in December] when baby […] was born via emergency section Especially to who was with me her whole shift and managed to break my tricky waters we did laugh and to the lovely midwife chole who took over in the morning and monitored me and baby well and soon realised things wasn't going to plan. She held my hand during my emergency c section which I was then put under general anaesthetic for and comforted me when I was so scared when I was being put to sleep your both amazing thank you so much The Shrewsbury and Telford Hospital NHS Trust Maternity Information Hub Facebook page / Maternity and Neonatal Voices Partnership Shropshire and Telford & Wrekin Facebook page. Thank you, Thursday posts were not shared by the MNVP, in January 2025.			
5.	**STAFF FEEDBACK**	Staff feedback from Bi-monthly frontline champion and walkabouts *(CNST requirement quarterly)*	Antenatal/ Postnatal			
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			No immediate safety recommendations have been received by the Trust.
7.	**Coroner Reg 28**	Coroner Regulation 28 made directly to Trust	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			
9.	**Category 1 Caesarean sections**	Delays to Cat 1 CS>30 minutes and outcomes	0			**January:** No delays
10.	**Category 2 Caesarean sections**	Delays to Cat 2 CS>75minutes and outcomes	8			This month there was a common theme in the delays of category 2 caesarean section. 37.5% delay due transfer into theatre, 50% theatre acuity and 12.5% completing sepsis screeening. Three babies were transferred to neonatal unit. Two due to gestation and one for IV ABX but did not require admission. The primary reason for category two c/s was delay in 1st stage of labour. Shortest delay 13min, longest delay 110min. All neonates had a apgar over 7 at 5minutes and an aterial cord gas PH over 7.0
11.	**Supernuamary Status of the Coordinator**	**Neonates**				An on-going audit of the supernumary status of the Nurse in Charge on Neonates will commence from 1st March 2025
12.	**Delay in Neonatal Antibiotics**	Number of babies that had delayed antibiotics (Not within the golden hour)	0			All antibiotic treatment will be monitored to review the length of time taken between the decision to treat time and administration time to ensure that we are compliant to the golden hour. The antibiotics sticker for the patient notes will be relaunched From 1st March alongside documentation on the medical handover to aid auditing. This is a short term solution whilst a new prescription chart is designed which will encorporate a designated box for antibiotics stating the descisin to treat time and time of first dose.
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)*