Sheffield Teaching Hospitals
NHS Foundation Trust

Executive Summary

Report to the Board of Directors

Being Held on 26 July 2022

Subject	Maternity & Neonatal Safety Report
Supporting TEG Member	Chris Morley, Chief Nurse
Author	Laura Rumsey, Interim Midwifery Director, Obstetrics, Gynaecology and Neonatology (OGN) Andrea Galimberti, Interim Clinical Director, OGN Sue Gregory, Operational Director, OGN
Status[1]	D & N

PURPOSE OF THE REPORT

To present a monthly safety and quality overview of Jessop Wing Maternity and Neonatal Services to the Board of Directors reporting period of 1st May 2022 to 31st May 2022.

KEY POINTS

Key Risks

- The Maternity Improvement Advisor (MIA) team undertook a thematic review of stillbirths over a 13 month period over 2021/22 following a potential concern the Jessop Wing stillbirth rate may be higher than expected in comparison to the national trajectory and comparable tertiary referral units of similar size and demographic. A first draft report was received by the triumvirate in June. Further exploration of the data is required with the MIA team, who are attending the Jessop Wing (JW) week commencing 20th June, prior to agreement of the conclusions and recommendations of the review.
- Maternity specific information system is not in place at JW, identified as a maternity service quality and safety risk by CQC, HSIB, LMNS, and by the Ockenden Assurance visit (06/05/22) panel. This is managed as an extreme risk on the Directorate risk register, with further validation of this risk being undertaken during June. Outline Business case currently being developed to detail the case for investment in an appropriate system.
- Historical Perinatal Mortality Review Tool (PMRT) reports not shared with families from 2019, work is in progress to sensitively communicate this position to all families affected by this omission.
- Serious Incident (SI) investigation backlog remains, improved oversight and early progress noted by the triumvirate. A comprehensive tracker is in place, monitored weekly and shared with the triumvirate.
- CQC **must do** action plan agreed by the triumvirate and is now in progress.

Improvements

- Further development of the electronic SitRep (Situation Report) allowing enhanced oversight of staffing, women awaiting IOL, activity and acuity in Maternity and Neonatal Services. This work has been received positively by the Local Maternity and Neonatal System (LMNS) and is planned for implementation across the wider system.
- Progress in the planned introduction of Birmingham Symptom -specific Obstetric Triage

System (BSOTS)
- Saving Babies Lives, vs2 aligned Fetal surveillance- Fresh Eyes audit tool and audit commenced May '22 to assess categorisation, escalation, and outcomes
- External senior maternity governance support in place 0.4 wte continues, which has resulted in progress with the Serious Incident (SI) investigation backlog.
- Refreshed Maternity Safety Champion schedule including a new term of reference (TOR), agenda, and bimonthly face to face meetings.
- Improvements in training compliance improvements can also be demonstrated in Fetal Surveillance (K2), PROMPT and New-born Life Support (NLS)

Change to timescale under review
- This report covers the month of May, the data only becomes available in early/mid June and whilst that makes the report very timely, it does not enable it to go through all the governance processes that could inform it ahead of discussion at the Board of Directors, notably some directorate governance processes and the Maternity Improvement Board.
- It is recommended that moving forward the report is presented to the Maternity Improvement Board and shared with the Non-Executive Maternity Champion in the month after the month under review and to the Board of Directors the following month.

IMPLICATIONS[2]

Aim of the STHFT Corporate Strategy		✓ Tick as appropriate
1	Deliver the Best Clinical Outcomes	✓
2	Provide Patient Centred Services	✓
3	Employ Caring and Cared for Staff	✓
4	Spend Public Money Wisely	✓
5	Deliver Excellent Research, Education & Innovation	✓
6	Create a Sustainable Organisation	

RECOMMENDATIONS

The Board of Directors are asked to discuss the content of the report and note the recommendation to change the reporting schedule to ensure it can be reviewed at the Maternity Improvement Board prior to the Board of Directors.

APPROVAL PROCESS

Meeting	Date	Approved Y/N
TEG	22/06/2022	Y
Board of Directors	28/06/2022	

[1] Status: A = Approval
A* = Approval & Requiring Board Approval
D = Debate
N = Note

[2] Against the six aims of the STHFT Corporate Strategy 'Making a Difference – The next Chapter 2022-27'

1. REPORT OVERVIEW

This report outlines locally and nationally agreed measures to monitor maternity and neonatal safety, as outlined in the NHSEI document '*Implementing a revised perinatal quality surveillance model'* (December 2020). The purpose of the report is to inform the Local Maternity and Neonatal System (LMNS) Board and the Board of Directors, monthly, of present or emerging safety concerns or activity to ensure safety with a two-way reflection of *Ward To Board* insight across the multi-disciplinary, multi-professional maternity services team. The information within the report will reflect actions in line with the Ockenden Independent Maternity Review (2020), and progress made in response to any identified concerns at provider level.

- Aligned with the Perinatal Quality Surveillance Model (PQSM) Jessop Wing, maternity and neonatal services are required to report information outlined in the data measures proforma monthly to the Board of Directors (appendix 1). This report covers the period May 2022.
- The report also provides evidence to NHS Resolution (NHSR) Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) Year 4.

2. PERINATAL MORTALITY

NHS England set out a national ambition to halve the rates of stillbirth, neonatal deaths, maternal deaths, and brain injuries during birth by 2025, (from a 2010 baseline). In addition, the NHS is working towards an interim ambition of a 20% reduction by 2020.

The national average in England for stillbirth, (any baby loss from 24 weeks gestation), is 3.83 per 1000 births, and 2.88 per 1000 live births for neonatal deaths (a liveborn baby who died before 28 completed days after birth MBRRACE,2021 for all births in 2019).

A review of maternity governance processes and practices was undertaken in March 2022, by the Maternity Improvement Adviser (MIA) team. It was highlighted that Perinatal Mortality Review Toolkit (PMRT) reports from 2019 to 2022 had not been consistently shared with families (This tool was designed to support high quality, standardised, multidisciplinary perinatal reviews observing the principle of 'review once, review well'. Each review considers all care provided leading up to and surrounding each stillbirth or neonatal death.). Work is in progress to sensitively communicate this position to all families affected by this omission. Communication with families has commenced and has been informed in collaboration with the Maternity Voices Partnership (MVP) and will be reported monthly to the Board of Directors through this paper.

A thematic review of all stillbirths occurring over a 13-month period covering 2021/22 was undertaken by the Maternity Improvement Adviser (MIA) team in May 2022. The rationale for the review was a potential concern that the Jessop Wing perinatal death rate may be higher than average when compared to the national trajectory and tertiary referral units of relative size and demographic. A first draft report was received by the triumvirate on 3rd June. Further discussion is planned for week commencing 20th June with the MIA team, this will include a factual accuracy check and feedback from clinicians, prior to agreement of the conclusions and recommendations of the review. The triumvirate are keen to receive and implement any improvement recommendations from the MIA team following the thematic review.

Jessop Wing Maternity Services submits maternity core indicators data, which include outcomes related to stillbirth and perinatal deaths overall each quarter to the Yorkshire and Humber (Y&H) Network and the Local Maternity & Neonatal System (LMNS). Y&H Maternity Dashboard facilitates external monitoring and assurance of maternal and neonatal core indicators across the System and Region. Stillbirth data is submitted quarterly to the regional Networks (Y&H) via the LMNS (SY&B) by all maternity providers in England. Figure 1 demonstrates the Jessop Wing stillbirth rate when

compared to the other South Yorkshire and Bassetlaw Maternity Providers.

Figure.1: First image 2017-2021 South Yorkshire and Bassetlaw (SY&B) LMNS Perinatal Quality Surveillance Report reflecting total /annual stillbirth rate for all stillborn babies /1000 births, published June 2022.

The second image in Figure.1 shows the SY&B LMNS stillbirth rate for Q3.

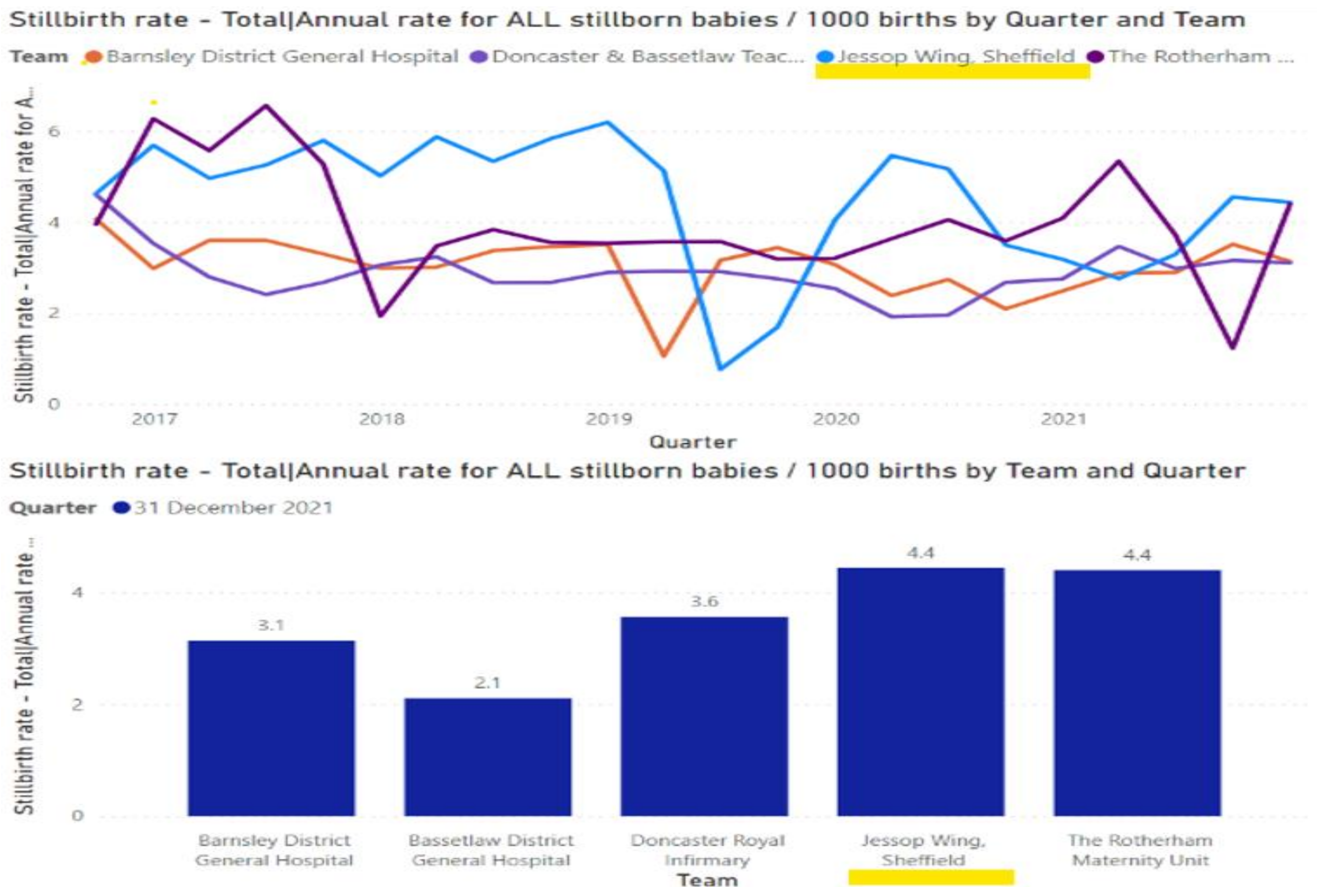


Table 1:Stillbirth rates, excluding congenital anomalies by trust, with a Level 3 NICU & neonatal surgery, North East & Yorkshire. Perinatal Mortality Surveillance Report for births in 2019, published October 2021, MBRRACE-UK.

		Rate per 1,000 births		
		Stillbirth		
			Stabilised & adjusted	
Organisation	Total births	Crude	Rate	(95% CI)
Hull University Teaching Hospitals NHS Trust	5006	3.20	3.20	(2.70 to 3.81)
Sheffield Teaching Hospitals NHS Foundation Trust	6404	3.75	3.22	(2.74 to 3.90)
The Leeds Teaching Hospitals NHS Trust	9038	3.65	3.21	(2.76 to 3.80)

More than 5% higher than the group average | Within 5% of the group average | Between 5 and 15% lower than the group average | More than 15% lower than the group average | Rate suppressed due to small numbers

The latest MBRRACE stillbirth data (from 2019 births) when assessed against two comparator

Trusts in North East & Yorkshire, as above, did not reflect that Jessop Wing, Sheffield Teaching Hospitals, was a significant outlier in stillbirth outcomes when data was stabilised and adjusted for deprivation, ethnicity and maternal age. Nonetheless, the triumvirate await the final and agreed recommendations from the MIA stillbirth thematic review and are committed to implementing any measures that have the potential to improve the quality and safety of maternity and neonatal services.

In May 2022 there was 1 stillborn baby and 4 neonatal deaths reported to MBRRACE-UK.

Date of birth	Gestation	Category	MBRRACE-UK Notification within 7 days	Immediate lessons learned and actions
03/05/2022	26 weeks gestation	Neonatal Death with lung disease of prematurity and extremely low birth weight.	Yes	No immediate learning identified
05/05/2022	23 weeks gestation	Neonatal Death with lung disease of prematurity	Yes	Immediate learning - Tommy's App not completed. Actions – Immediate learning shared with staff. Serious investigation commenced
07/05/2022	37 weeks gestation	Stillbirth following antenatal placental abruption	Yes	Immediate Learning - Delay in reviewing bloods following stillbirth. Actions - Laser poster circulated. Discussions taking place with labs regarding ringing the ward with severely abnormal results. Serious incident commenced as declined HSIB.
09/05/2022	33 weeks gestation	Neonatal Death associated with known congenital abnormality detected in the antenatal period.	Yes	No immediate learning identified
26/05/2022	25 weeks gestation	Neonatal Death with cause unexplained	Yes	Immediate learning – staff to be aware of the need for documentation of communication with parents

In each case the care provided to the mother and her unborn baby will be reviewed using the national Perinatal Mortality Review Tool (PMRT).

3. HEALTHCARE SAFETY INVESTIGATION BRANCH (HSIB) AND MATERNITY SERIOUS INCIDENTS (SI'S)

3.1 Background

HSIB undertake maternity investigations in accordance with the Department of Health and Social Care criteria (Maternity Case Directions 2018). In accordance with these defined criteria, eligible babies include all term babies (at least 37 completed weeks of gestation) born following labour who have one of the following outcomes:

- **Maternal Deaths:** Direct or indirect maternal deaths of women while pregnant or within 42 days of the end of pregnancy
  Intrapartum stillbirth: where the baby was thought to be alive at the start of labour but was born with no signs of life.
- **Early neonatal death:** when the baby died within the first week of life (0-6 days) of any cause.
- **Severe brain injury diagnosed in the first seven days of life, when the baby:**
  - Was diagnosed with grade III hypoxic ischaemic encephalopathy (HIE) or
  - Was therapeutically cooled (active cooling only) or
  - Had decreased central tone and was comatose and had seizures of any kind

Any case referred by the Trust for investigation by HSIB is also automatically logged as a Serious Incident, although the investigation is undertaken by HSIB and not the Trust.

Cases to date	
Total referrals	55
Referrals / cases rejected	14
Total investigations to date	41
Total investigations completed	35
Current active cases	6
Exception reporting (more than 6 months)	0

A total of 55 referrals to HSIB have been made between 2019 – May 2022.

3.2 HSIB Investigation progress update

In May 2022 2 new cases were reported to HSIB and are currently being investigated. Investigations can take up to 6 months to complete.

HSIB Reference	Incident Date	HSIB Criteria	Progress
MI-009294	06/05/2022	Stillbirth	Family have not given consent to be contacted by HSIB. This is now an internal SI investigation.
MI-009431	17/05/2022	Cooled Baby	This case has been rejected by HSIB for further investigation as the family have not given their consent to be contacted by the HSIB Team. A Serious Incident investigation has been commenced by the Jessop Wing in agreement with the family.

3.3 5 HSIB investigations are in progress. The Jessop Wing receive fortnightly investigation incident reporting and progress updates from HSIB.

Ref	HSIB Reference	HSIB Criteria	Progress
W259661	MI-005710 / MI-006528	Cooled Baby / Maternal Death	Staff Interviews in progress
W266190	MI-008645	Intrapartum Stillbirth	Consent received from family. Health records being uploaded to HSIB
W266515	MI-008638	Cooled Baby	Awaiting family consent
W268536	MI-009294	Intrapartum Stillbirth	The family have not given consent for HSIB. They have requested that the trust perform a serious incident investigation – This has been commenced
W269952	MI-009431	Cooled baby	Awaiting family consent

HSIB reporting is included as part of the NHS Resolution Maternity Incentive Scheme (MIS) Year 4 safety actions. Compliance with safety action 10, HSIB reporting standards, will be included as part of the Trust Board final MIS Year 4 submission declaration to NHS Resolution on 5th January 2023.

3.4 Coroner Reg 28 made directly to Trust

There was no regulation 28 received by the Trust in May 2022.

3.5 Maternity Serious Incidents

A Serious Incident(SI) tracker including progress updates, completion timescales and RAG rating has been launched and provides focus for the Governance Team's weekly check in/ update meetings. This has been shared with the triumvirate.

During May 2022 there were 2 Serious Incidents (SI) declared in maternity services. This does not include the 2 HSIB cases reported during the same period that are also classified as SI's.

Serious Incidents (SIs) continue to be reported to Yorkshire & Humber LMNS Quality and Safety Group for regional oversight.

Serious Incident Investigations Report May 2022

Ref	Summary	Progress
W270336	Incident reported for further investigation following the patient safety review of family's concerns that their baby had sustained rib fractures around the time of the caesarean section.	Duty of Candour has been completed with the family. Incident investigators have been appointed and an initial scoping exercise of the circumstances surrounding the incident are underway.
W268022	Birth of a baby at 26 weeks gestation by emergency caesarean section following maternal diagnosis of severe pre-eclampsia. Sadly, the baby died at 4 days of age	Duty of Candour has been completed with the family. Incident investigators have been appointed and an initial scoping exercise of the circumstances surrounding the incident are underway.

	on the neonatal unit. Initial review has identified that the Tommy's App was not completed in a timely manner leading to a delay in prescribing aspirin for a woman identified with risk factors for developing pre-eclampsia in pregnancy	

Serious Incidents in progress

- 25 SI investigations are underway. Progress with the investigations is monitored at a weekly governance meeting to identify any potential delays to reporting timescales or areas of concern for escalation.
- Of the 25 SI investigations,17 investigations are due for final closure between 1st July 2022 – 28th August 2022. These investigations are progressing and are anticipated to meet the reporting deadlines.
- 5 SI investigations have been completed and the final reports submitted to the Serious Incident Group for approval before submission to the CCG.

3.6 Outstanding SI Investigations

3 SI investigations have exceeded the CCG reporting closure deadlines.

Delays incurred with 2 of the cases are related to completion of the investigations by external organisations.

For the first of these cases Jessop Wing recently assumed responsibility for the investigation (a Coroner's Inquest), initially investigated by an external provider organisation. The final report is now complete and will be submitted to the Serious Incident Group for final approval.

For the second delayed case, investigated by an external provider organisation, an action plan in response to the findings of the incident has been completed and will also be submitted to the Serious Incident Group for approval.

The third delayed investigation has a draft report completed. The investigation team are reviewing the report to confirm the root cause and final investigation findings. When finalised the report will be presented at Directorate level for approval prior to submission to the Serious Incident Group for final approval.

3.7 Overview of Incidents reported in May 2022

In May 2022, 325 incidents were reported by OGN through the Datix incident reporting system.

Row Labels	1 – No Harm / Impact	2 – Low Harm / Impact	3 – Moderate Harm / Impact	4 – Severe Harm/ Impact	Total
May 2022	104	192	27	2	325

At the time of reporting 238 incidents are in review, of which.

- 104 incidents are overdue and have passed the 20 day review timescale
- 62 incidents are overdue and have passed the 28 day review timescale

- 3 incidents are overdue and have passed the 35 day review timescale

Plans to allocate a named governance midwife to support an individual ward/ area are under development to ensure a focussed approach to incident review is embedded within the department. Further improvements concerning more timely incident review include clustering incidents for review, for example PPH. This will allow early learning and a reduction in incident closure delays.

- **Incident Grading of Harm / Impact**

- 2 incidents were graded as severe harm/ impact. Both incidents have been reported as Serious Incidents and investigations commenced as highlighted in section 3.5 above.

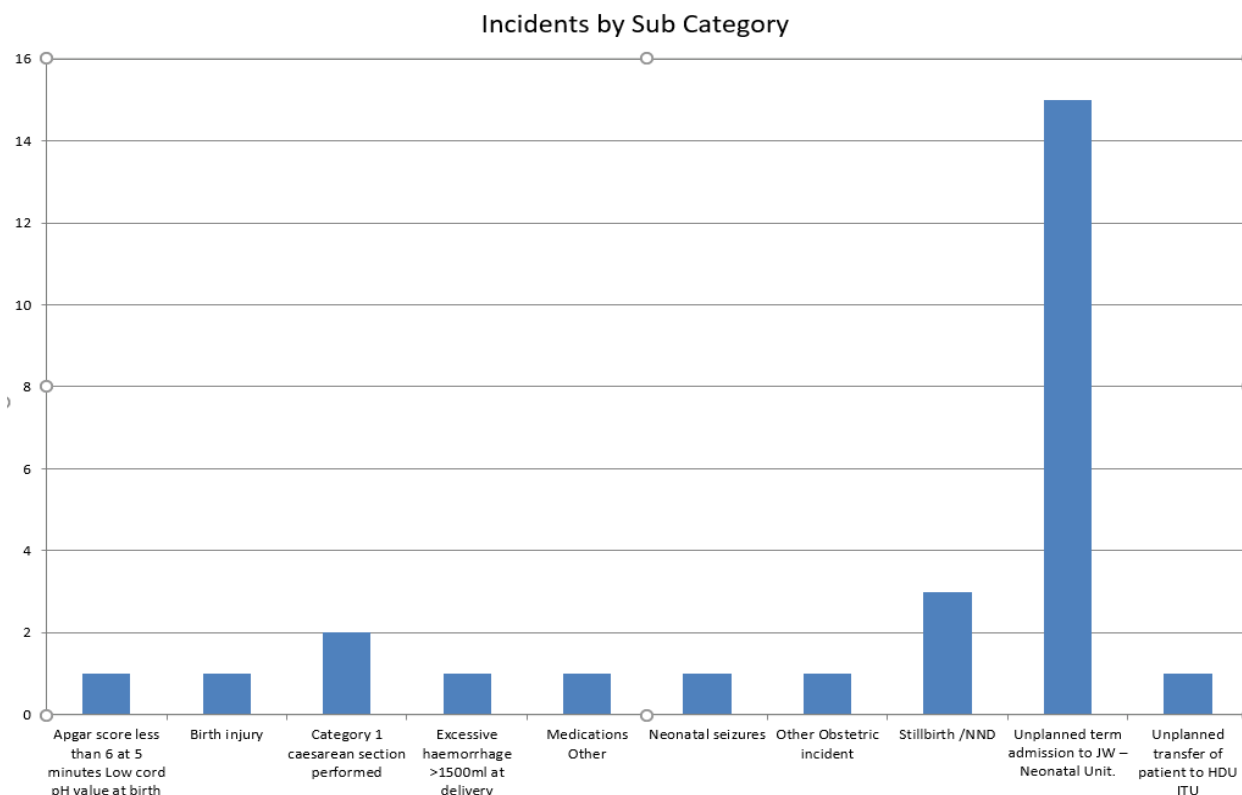
- 27 Incidents were graded as moderate harm/ Impact. Of these:

  - 15 concerned unplanned admission of a term baby to the NNU. All of the cases will be reviewed in detail as part of the Avoiding Term Admissions Into Neonatal Units (ATAIN) review process.

    Please see section 13.3 Jessop Wing Transitional Care for further information on ATAIN reviews.

  - 3 incidents concerned reporting of stillbirth or neonatal death and will be reviewed as part of the perinatal mortality review process.

Moderate Harm Incidents by Subcategory May 2022



4. CONTINUITY OF CARE (COC)

Each Local Maternity & Neonatal System (LMNS) is required to be working towards having 35% of women booked for maternity care on to a CoC pathway. The NHS Long-Term Plan also added that 75% of Black and Asian women should receive continuity of carer by 2024, and this has been made more urgent in light of the increased risk facing Black and Asian women of both poor maternity outcomes and outcomes from COVID-19.

The publication *Delivering Midwifery Continuity of Carer at Full Scale: Guidance on Planning, Implementation and Monitoring* 2021/22 published in October 2021 states that key building blocks should be in place prior to further roll out of CoC as the default model of maternity care. These include:

Safe staffing, staff engagement and education; this supports the current decision at JW to suspend the rollout of CoC until the workforce reflects recommended NICE (2015) and Birthrate Plus (BR+) levels of midwifery staffing within the service. Jessop Wing will continue to report a position monthly to the Board of Directors and LMNS Board.

NHSE & Improvement Regional Midwifery Teams have requested a projected CoC commitment from all maternity providers in England. Jessop Wing will submit a trajectory to the LMNS by 15th June describing the service CoC ambition considering the current midwifery workforce challenges. A full Birthrate Plus assessment is in progress, the final report will underpin all CoC maternity workforce decisions and future planning over the coming two years.

5. TRAINING DATA (JANUARY – APRIL 2022)

Mandatory Training / JSET Maternity Services May 2022 - Medical					
	January	February	March	April	May
Data Security and Information Governance - Level 1 (1 Yearly)					
Target	90%	90%	90%	90%	90%
Total Headcount	50	48	45	40	40
% Compliance achieved	92%	92%	84%	90%	85%
Equality & Diversity: General Awareness - Level 1 (3 Yearly)					
Target	90%	90%	90%	90%	90%
Total Headcount	50	48	45	40	40
% Compliance achieved	94%	94%	93%	90%	93%
Fire Safety Theory - Level 1b (1 Yearly)					
Target	90%	90%	90%	90%	90%
Total Headcount	50	48	45	40	40
% Compliance achieved	88%	90%	82%	93%	85%
Health Safety & Welfare Level 1 (3 Yearly)					
Target	90%	90%	90%	90%	90%
Total Headcount	50	48	45	40	40
% Compliance achieved	96%	98%	98%	93%	95%
Infection Prevention and Control - Level 2 (1 Yearly)					
Target	90%	90%	90%	90%	90%
Total Headcount	50	48	45	40	40
% Compliance achieved	88%	90%	82%	88%	83%
Moving and Handling - Level 2a (4 Yearly)					
Target	90%	90%	90%	90%	90%
Total Headcount	50	48	45	40	40
% Compliance achieved	78%	79%	80%	85%	78%
Resuscitation: Adult Basic Life Support - Level 2a (1 Yearly)					
Target	90%	90%	90%	90%	90%
Total Headcount	50	48	45	40	40
% Compliance achieved	88%	90%	87%	90%	93%

	January	February	March	April	May
Safeguarding Children & Young People - Level 2 (3 Yearly)					
Target	90%	90%	90%	90%	90%
Total Headcount	47	45	43	37	37
% Compliance achieved	96%	96%	93%	92%	92%
Safeguarding Children & Young People - Level 3 (3 Yearly)					
Target	90%	90%	90%	90%	90%
Total Headcount	1	1	1	1	2
% Compliance achieved	100%	100%	100%	100%	100%
Safeguarding Vulnerable Adults - Level 2 (3 Yearly)					
Target	90%	90%	90%	90%	90%
Total Headcount	50	48	45	40	40
% Compliance achieved	94%	94%	93%	93%	95%
Mental Capacity Act - Level 2a (3 Yearly)					
Target			90%	90%	90%
Total Headcount			45	40	4
% Compliance achieved			89%	90%	90%
Deprivation of Liberty - Level 2b (3 Yearly)					
Target			90%	90%	90%
Total Headcount			45	40	40
% Compliance achieved			89%	93%	93%
JSET Maternity Services May 2022 - Medical consultants and Trainees					
Obstetric Emergency Drills (Trajectory)					
Target	90%	90%	90%	90%	90%
Total Headcount	50	48	45	40	40
% Compliance achieved	60%	60%	60%	73%	83%
Fetal Monitoring					
Target	90%	90%	90%	90%	90%
Total Headcount	50	48	45	40	40
% Compliance achieved	90%	85%	84%	88%	90%

Mandatory Training / JSET Maternity Services Compliance Trajectory May 2022 - Midwifery					
90% Compliance Target for all courses	**2022**				
	Jan	**Feb**	**Mar**	**Apr**	**May**
Conflict Resolution (Trajectory)	x	82.88%	82.88%	85.60%	88.04%
% Compliance achieved	75.74%	77.53%	83.20%	82.72%	85.34%
Total Headcount	371	365	363	353	341
Compliant Headcount	281	283	302	292	291
Data Security and IG L1 (Trajectory)	x	77.72%	70.38%	69.29%	65.22%
% Compliance achieved	76.82%	77.81%	76.31%	75.92%	75.66%
Total Headcount	371	365	363	353	341
Compliant Headcount	285	284	277	268	258
Equality & Diversity L1 (Trajectory)	x	90.00%	90.00%	90.00%	90.00%
% Compliance achieved	97.87%	98.36%	98.35%	98.87%	99.12%
Total Headcount	371	365	363	353	341
Compliant Headcount	367	359	357	349	338
Fire Safety Theory L1b (Trajectory)	x	77.05%	69.13%	67.76%	67.49%
% Compliance achieved	76.15%	74.66%	74.79%	73.22%	75.07%
Total Headcount	369	363	361	351	341
Compliant Headcount	281	271	270	257	256
Health Safety & Welfare (Trajectory)	x	90.00%	90.00%	90.00%	90.00%
% Compliance achieved	98.40%	98.36%	98.35%	99.15%	99.71%
Total Headcount	371	365	363	353	341
Compliant Headcount	365	359	357	350	340

	Jan	Feb	Mar	Apr	May
Infection Prevention (Trajectory)	x	75.54%	67.66%	66.85%	65.22%
% Compliance achieved	75.20%	73.28%	73.76%	73.58%	74.19%
Total Headcount	371	363	362	352	341
Compliant Headcount	279	266	267	259	253
Moving & Handling L1 (Trajectory)	x	90.00%	90.00%	90.00%	90.00%
% Compliance achieved	98.38%	98.63%	99.17%	98.58%	98.83%
Total Headcount	371	365	363	353	341
Compliant Headcount	365	360	360	348	337
Moving & Handling L2b (Trajectory)	x	53.31%	56.08%	57.73%	63.26%
% Compliance achieved	52.33%	46.15%	47.51%	40.63%	41.64%
Total Headcount	365	364	362	352	341
Compliant Headcount	191	168	172	143	142
Resuscitation: ABLS L2a (Trajectory)	x	72.65%	64.92%	63.18%	63.54%
% Compliance achieved	72.33%	69.36%	68.91%	67.72%	69.73%
Total Headcount	365	359	357	347	337
Compliant Headcount	264	249	246	235	235
Resuscitation: NLS L2 (Trajectory)	x	61.65%	65.59%	67.38%	73.12%
% Compliance achieved	58.87%	54.21%	56.30%	58.02%	65.18%
Total Headcount	282	273	270	262	247
Compliant Headcount	166	148	152	152	161
Safeguarding Children L1 (Trajectory)	x	90.00%	90.00%	90.00%	90.00%
% Compliance achieved	86.08%	89.61%	88.61%	88.61%	92.11%
Total Headcount	79	77	79	79	76
Compliant Headcount	68	69	70	70	70
Safeguarding Children L2 (Trajectory)	x	75.00%	75.00%	90.00%	90.00%
% Compliance achieved	75.00%	100.00%	100.00%	100.00%	100.00%
Total Headcount	4	3	4	3	2
Compliant Headcount	3	3	4	3	2
Safeguarding Children L3 (Trajectory)	x	90.00%	90.00%	90.00%	89.79%
% Compliance achieved	89.20%	85.61%	81.07%	80.07%	74.90%
Total Headcount	287	285	280	271	263
Compliant Headcount	256	244	227	217	197
Safeguarding Adults L2 (Trajectory)	x	90.00%	90.00%	90.00%	90.00%
% Compliance achieved	98.01%	96.98%	94.26%	95.85%	95.74%
Total Headcount	301	298	296	289	282
Compliant Headcount	295	289	279	277	270
Mental Capacity Act - Level 2a (3 Yearly)			x	54.33%	58.80%
% Compliance achieved			52.51%	57.76%	63.50%
Total Headcount			358	348	337
Compliant Headcount			188	201	214
Deprivation of Liberty - Level 2b (3 Yearly)			x	54.20%	58.12%
% Compliance achieved			52.66%	57.93%	63.80%
Total Headcount			357	347	337
Compliant Headcount			188	201	215

JSET Maternity Services May 2022 - Midwifery

	Jan	Feb	Mar	Apr	May
Obstetric Emergency Drills (Trajectory)	x	71.84%	72.20%	80.50%	85.20%
% Compliance achieved	68.21%	66.06%	64.47%	69.29%	78.76%
Total Headcount	280	277	273	267	259
Compliant Headcount	191	187	176	185	204
Fetal Monitoring (Trajectory)	x	68.75%	61.40%	64.71%	67.46%
% Compliance achieved	66.18%	67.53%	68.54%	70.00%	80.80%
Total Headcount	275	271	267	260	251
Compliant Headcount	182	183	183	182	201

The OGN planned trajectories are focused on initially achieving compliance with Obstetric Emergency Drills (PROMPT), Fetal Monitoring (K2 training package) and Neonatal Life Support training as that has been identified as requiring the greatest focus for improvement to ensure the quality and safety of maternity services. Matrons for each area are undertaking focused 1-1 with staff whose training is overdue to support and facilitate access and time to undertake training during the months May to August 2022. Compliance rates are managed, monitored, and reported weekly to the triumvirate. Significant progress has been made with the fetal monitoring K2 training, the current training compliance position is 81%. The triumvirate are confident the planned trajectory of >90% by the end of June will be achieved.

Training compliance trajectories >90% for PROMPT and NLS by August 22, (additional training days have been introduced) are progressing.

The updated trajectory for midwives and obstetric colleagues has been developed around the principle of preventing harm for women and babies. To do this, priority has been given in the allocation of training to midwives working in the intrapartum environment first, followed by antenatal wards and then other staff.

6. JESSOP WING - MATERNITY DASHBOARD (JANUARY-MAY 2022)

The Jessop Wing Maternity Dashboard and will continue to evolve over time to reflect data agreed regionally and nationally to assess the Trust progress against various quality indicators. Data is validated monthly at OGN Directorate Governance meeting. Thresholds and quality metrics are not present on the Maternity dashboard currently.

Following receipt of communication from NHS England on the 15th February 2022, the caesarean section rate data will not be used as a maternity services quality metric.

The Robson Criteria are now recommended for use to monitor caesarean section activity without attached targets. The Robson Criteria classifies all women into one of 10 categories that are mutually exclusive and, as a set, totally comprehensive.

The categories are based on 5 basic obstetric characteristics that are routinely collected in all maternities (parity, number of foetuses, previous caesarean section, onset of labour, gestational age, and fetal presentation).

The World Health Organisation (WHO) expects the Robson Criteria to support maternity care providers to:

- **I.** Identify and analyse the groups of women which contribute most and least to overall caesarean section rates
- **II.** Compare practice in these groups of women with other units who have more desirable results and consider changes in practice
- **III.** Assess the effectiveness of strategies or interventions targeted at optimizing the use of caesarean section
- **IV.** Assess the quality of care and of clinical management practices by analysing outcomes by groups of women
- **V.** Assess the quality of the data collected and raise staff awareness about the importance of this data, its interpretation and use

Antenatal		Green	Amber	Red		Jan 22	Feb 22	Mar 22	Apr 22	May 22
Community First Visits						596	568	617	492	554
Community First Visits Within 10 Weeks %						70.64	74.82	76.66	77.64	75.99
Smokers at Community First Visit %						6.71	8.45	7.78	7.72	11.01
Clinic First Visits						575	491	589	464	513
Clinic First Visits Under 13 Weeks %						58.78	65.17	64.69	72.2	63.16

Clinic First Visits Smoker %						9.22	9.57	8.32	9.91	10.14
Clinic First Visits CO Measured %						56	32.99	9.34	4.74	6.63
Community 36 Week Visits CO Measured %						40.51	23.05	19.31	15.21	36.51

Deliveries		Green	Amber	Red		Jan 22	Feb 22	Mar 22	Apr 22	May 22
Total Deliveries (mothers)						441	442	511	454	475
Registerable Births						446	444	517	456	483
Elective C Section Deliveries %						18.14	17.87	15.07	17.4	17.05
Emergency C Section Deliveries %						21.09	22.85	23.48	26.43	23.16
Assisted Deliveries %						9.75	11.76	9.78	9.69	9.26
Inductions %						26.3	21.04	25.44	21.81	25.68
Waterbirths						14	14	14	12	17
Homebirths						6	7	5	4	10
Born Before Arrival (BBA)						2	4	5	3	3
APGAR 0-6 %						3.01	2.3	3.23	4.46	3.87
Low birthweight (≤ 2500g) %						9.19	6.98	9.28	10.53	7.87
Term under 3rd Centile %						2.69	3.38	3.29	3.51	2.48
Preterm births %						6.53	5.54	6.25	6.98	4.53
PPH ≥ 1500ml %		$n < 3$	$3 \le n \le 5$	$n > 5$		4.1	6.15	5.33	6.86	4.22
3rd and 4th degree tears (all) %						1.2	6.35	4.36	2.49	4.4
3rd and 4th degree tears (Normal) %		$n < 3$	$3 \le n \le 4$	$n > 4$		0	6.93	2.39	1.51	3.48
3rd and 4th degree tears (Assisted) %		$n < 5$	$5 \le n \le 9$	$n > 9$		7.5	4	14.89	7.14	9.3
Smokers At Delivery %						10.71	7.52	9.27	9.51	9.07
First Feed Breastmilk %						70	71.78	68.47	67.92	71.16
Robson Group 1 having LSCS %						23.81	21.18	17.71	28.72	27.27
Robson Group 2 having LSCS %						50.72	61.29	60.67	64.29	61.25
Robson Group 5 having LSCS %						83.56	70	76.47	76.71	74.32
VBAC (Local) %						19.28	26.83	20.73	21.98	25
VBAC (NHSD) %						8.33	18.52	16.67	14.55	17.07

Neonatal		Green	Amber	Red		Jan 22	Feb 22	Mar 22	Apr 22	May 22
Neonatal Unit Admissions						37	38	64	47	45
Neonatal Unit Admissions %						8.41	8.58	12.38	10.4	9.34
Neonatal Unit Admissions at Term						14	15	30	22	23
Neonatal Unit Admissions at Term %						3.18	3.39	5.8	4.87	4.77

Mortality		Green	Amber	Red		Jan 22	Feb 22	Mar 22	Apr 22	May 22
Stillbirths						6	1	0	4	1
Stillbirths (per 1000 births)						13.45	2.25	0	8.77	2.07
Stillbirths at Term						1	0	0	2	1
Stillbirths at Term (per 1000 births)						2.24	0	0	4.39	2.07
Neonatal Deaths						7	1	2	2	4
Neonatal Deaths (per 1000 births)						15.91	2.26	3.87	4.42	*
Neonatal Deaths ≥ 24 weeks						5	1	1	1	*
Neonatal Deaths ≥ 24 weeks (per 1000 births)						11.36	2.26	1.93	2.21	*

Neonatal Deaths at Term						1	0	0	0	*
Neonatal Deaths at Term (per 1000 births)						2.27	0	0	0	*
* Neonatal death data not complete until 28th of the month post death										
LW Assessment		**Green**	**Amber**	**Red**		Jan 22	Feb 22	Mar 22	Apr 22	May 22
Calls to Triage Service						3390	2683	3236	3011	2906
LWAU Admissions						1165	979	1165	1110	1051
LWAU Rapid Reviews %		$n \geq 95$	$80 \leq n < 95$	$n < 80$		80.86	86.01	92.88	89.82	95.81
LWAU Rapid Review Time (mins)		$n \leq 30$	$30 < n \leq 45$	$n > 45$		65	45	38	38	32

7. NHS RESOLUTION (NHSR)

7.1 Maternity Incentive Scheme (MIS)

Year 4 of the MIS was launched in August 2021. All maternity care providers in England were notified in December 2021 that in recognition of the current pressure on the NHS and maternity services, the majority of reporting requirements demonstrating achievement against the MIS 10 Safety Actions were paused with immediate effect for a minimum of 3 months.

Trusts were asked to continue to apply the principles of the 10 safety actions, given that the aim of the MIS is to support the delivery of safer maternity care. Examples of continuing to apply the principles include undertaking midwifery workforce reviews, ensuring that as far as possible the oversight provided by the maternity, neonatal and board level safety champions continue, as well as using available online training resources.

NHSR relaunched the MIS on 6th May 2022 when updated guidance was published. The scheme's submission deadline has been extended from June 2022 to 5th January 2023 to provide Trusts with extra time to achieve the standards. Interim timeframes within each of the safety actions have also been reviewed and extended. The scheme's conditions have also been reviewed and strengthened. The new conditions include the following additional requirements: The declaration form to be submitted to Trust Board with an accompanying joint presentation detailing maternity safety action by the Midwifery Director and Clinical Director for Maternity Services. The CEO of the Trust will ensure that the Accountable Officer (AO) for their Clinical Commissioning Group/Integrated Care System (CCG/ICB) is appraised on the MIS safety actions' evidence and declaration form. The CEO and AO must both sign the Board declaration form as evidence that they are both fully assured and in agreement with the evidence to be submitted to NHS Resolution.

STH were informed that following a review of the evidence submissions for MIS Year 2, the Trust did not achieve the required standard of evidence compliance. STH/Jessop Wing Maternity services were encouraged to bid for additional compensatory NHSR funding awards to support maternity improvement. MIS Year 2 award bid was successful at £184,000.

7.2 Thematic Review

In November 2021 NHSR undertook a thematic analysis of the cases that Sheffield Teaching Hospitals NHS Foundation Trust (STHNFT) reported to the Early Notification (EN) scheme. The thematic analysis was undertaken in response to the recent Care Quality Commission (CQC) inspection. The purpose of the review was to provide details of the themes on cases reported into the EN scheme, which should be used to inform future quality and safety improvement work within the Trust. The thematic analysis included all the cases reported by the Trust from the beginning of the

scheme to date where there were either medical records or a Healthcare Safety Investigation Branch (HSIB) report available. The five themes include:

- Fetal monitoring
- Neonatal care
- Delay in delivery
- Growth surveillance
- Induction of Labour

The triumvirate are supporting the teams to progress the identified work highlighted in the review. A report was submitted to NHSR on 20th May as requested on the actions being taken in response to the thematic review. NHSR have confirmed receipt of submission.

8. BOARD LEVEL SAFETY CHAMPIONS MEETINGS

A refreshed Maternity Safety Champions programme for Jessop Wing including Terms of Reference (ToR) and a bi-monthly agenda for face-to-face meetings are now complete and will be shared for comment at the June meeting. Monthly Safety Champion engagement meetings/walk rounds are also agreed in diaries for the coming twelve months. An infographic including the photos of all JW Safety Champions, detailing the Safety Champion roles and responsibilities are awaiting printing and lamination for display in all maternity and neonatal clinical areas. The agenda Maternity Safety Champion bimonthly meetings will include:

- Review and summary of published national reports. Providing assurance that all actions required locally are being monitored and completed in the required timescales
- Review of any inspection reports and feedback from women and their families
- Discussion and analysis of the quarterly Yorkshire and Humber Maternity Dashboard and review a JW benchmarked position
- A report by exception of any local patient safety concerns
- To receive and discuss any themes identified from internal sources around mortality and quality improvement
- To report on progress against the Maternity Incentive Scheme (CNST)
- Report on progress against Ockenden 7 IEA's
- To report on progress with achieving aims of the Maternity & Neonatal Transformation and LMNS deliverables.

9. WORKFORCE

9.1 Maternity Workforce

NHS Maternity services have seen significant change and development over the last decade, driven by an ambition and vision to deliver the best care to women, babies and families.
Central to this has been the overarching policy publication of the National Maternity Review (2016) *Better births: improving outcomes of maternity services in England – a five year forward view for maternity care.*
Subsequently, recommendations from the Ockenden Independent Maternity review (December 2020) have further strengthened the requirement for providers and Local Maternity & Neonatal Systems (LMNS's) to provide safe high-quality care; with workforce included as one of the seven immediate and essential action's (IEA's) for staff training and working together. The NHS Planning guidance March 2020/21 have reset these priorities with a focus on LMNS's continuing to drive the Better Births (2016) ambitions including an emphasis on the health and wellbeing of the workforce to ensure a sustainable pipeline of recruitment and subsequent retention of staff.

Table 5 Midwifery staffing fill rates for February - May 2022

Jessop Wing	RM RN Fill Rates							
	February		March		April		May	
	Day	Night	Day	Night	Day	Night	Day	Night
Labour Suite	90.75%	88.6%	92.7%	89.8%	86.5%	85.5%	93%	95.2%
Rivelin	96.2%	98.2%	89.3%	96.7%	97.7%	96.7%	89.4%	98.6%
Norfolk*	91.8%	93.0%	96.1%	98.2%	107.8%	100%	117.5%	92.2%
Whirlow	94.9%	96.9%	97.9%	94.6%	100.7%	100.1%	111.4%	101.9%
RN Fill Rates								
NICU	83.1%	75%	75.5%	73.3%	86.6%	84.3%	82.5%	86.4%

* Norfolk and Whirlow wards are using Registered Nurses (RN) alongside midwives to provide care for post-natal women and their babies.

RM and RN fill rates continue to demonstrate month on month improvement.
The BR+ acuity tool has now been implemented on the Labour suite (Consultant led and Midwifery Led), the antenatal ward, (Rivelin), and the Postnatal wards, (Whirlow and Norfolk). Realtime acuity and activity information is available to maternity services leadership teams on or off site. Teams are being supported to continually improve the quality of data input and they continue to grow in their confidence in using this tool. The matrons for inpatient areas and Labour Suite are working with the Midwifery Director to utilise the Birthrate plus acuity app data to undertake a monthly red flag report which will facilitate triangulation of incidents, complaints, with maternity workforce red flags.

Further initiatives to enhance the maternity workforce include:

- Rolling recruitment for experienced AFC band 5/6 midwives-updated external advert
- LMNS centralised recruitment for newly qualified midwives (NQM's) complete. 28 NQM's offered positions at JW. This position reflects an increase in the number of NQM's requesting to work at JW.
- NHSEI funded (2 years), Recruitment and Retention Pastoral Support Midwife AFC band 7 out to advert.
- HEE funded RM shortened course for STH RNs progress continues in collaboration with Sheffield Hallam University roll out planned for January 2023.
- Recruitment of 13 wte AFC band 2 Clinical Support Workers (CSW) who will undertake the Maternity Support Worker (MSW) apprentice course at Sheffield College. Now in post, course commences August 2022.
- Recruitment of 12 WTE International Recruited (IR) RMs. The first IR midwife arrived at the Jessop Wing at the end of May and is currently undertaking a supported programme of learning in York for a period of one month.
- Reintroduction and communication of family friendly/flexible work patterns.
- Midwifery leaver rates continue to decline.

9.2 Obstetric Workforce

Challenges remain in the Consultant workforce:

- 2 Consultants on Maternity Leave (both participate in the resident nights rota)
- 1 Long Term sickness (participates in resident nights)
- 1 sabbatical – 3 months (health related)
- 2 phased returns from LTS, no clinical work or resident nights at present (both should undertake resident nights)
- 1 funded vacancy (undertakes resident nights)

Mitigation:

- 3 Locum Consultants in place (2 contribute to resident night rota)
- Consultant Obstetrician post out to advert closes 12 June 22
- Consultant Obstetrician with a specialist interest in Maternal Medicine out to advert closes 12

June 22

There are also significant gaps at registrar and Specialist Trainee (ST) 1/2 level across the Directorate;

- 3.8 WTE gap at Registrar level (all contribute to Labour Ward on call)
- 2.0 WTE gap at ST1/2 level.

Mitigation

- ST3 – existing team being utilised to cover Labour Ward / On call gaps at the detriment to gynaecology clinic/activity
- ST1/2 – Locums in post to offset the gap

9.3 Neonatal Workforce

The neonatal unit (NNU) team continue to work toward compliance with the British Association of Perinatal Medicine (BAPM) standards. The neonatal Operational Delivery Network (ODN) has completed a workforce review which shows deficits in staffing. Rolling recruitment is in place and a number of IR RN's have commenced in post in May. Work continues towards achieving 70% of RN staff to be qualified in speciality (QIS).

10. INSIGHTS FROM SERVICE USER ENGAGEMENT AND MATERNITY VOICES PARTNERSHIP CO-PRODUCTION

Jessop Wing maternity and neonatal services continue to have a productive relationship with the MVP in jointly working on the experience of women and families including:

- Overseeing the mechanism for collecting service user feedback: Friends and Family Test; MVP Flyers / posters in clinical areas and information/links to contacting the MVP in handheld records
- Bimonthly minutes of MVP meetings with Terms of Reference.
- Draft annual work plan presented to LMNS MVP forum and evidencing collaboration and co-production
- Successful co-produced recruitment of a second MVP co-chair
- You said we did following a 15 steps assessment undertaken on level 1 (ground floor) in response to negative feedback from service users regarding flow, waiting areas, access to refreshments and patient centred information. Actions include:
    - New seating for Antenatal Clinic ordered, now arrived in May 2022
    - Café seating area and tables have been reinstated to support access to hot and cold refreshments for service users attending Jessop Wing.
    - New artwork being designed and ordered to reflect the Antenatal pathway and provide a more relaxing multicultural and inclusive environment.
- Co-production work:
    - The MVP surveyed women and families concerning the potential return of Bounty services to the Jessop Wing. The overwhelming response from women and families did not support reinstating Bounty.
    - MVP supported the Mama Academy Wellness Wallets for use within the service. The wallets have a QR code that allow women to access maternity safety messages in multiple languages.
    - Designing bed boards for clinical areas
    - Developing a new website/ coproducing films following the pregnancy journey with an ethos of being inclusive.
- Supporting the PMRT process of communication with families to women and families where a PMRT report had not been shared.
- Two MVP members attended the maternity governance meeting in May 2022 for the first time.
- Co-design of patient information leaflets May 2022 onwards

11. CARE QUALITY COMMISSION (CQC)

11.1 Maternity Action Plan

As part of the Trust response to the CQC Well Led Inspection, the must do actions for maternity services have been used to produce an updated action plan These actions have been triangulated with the restrictions imposed on the Trust last March and all those restrictions are covered by the planned actions. It is therefore proposed that moving forwards that this will be the action plan submitted to the CQC each month. This action plan, as part of the Maternity Improvement Programme, is being overseen by the monthly Maternity Improvement Board, chaired by the Chief Executive, in addition to being scrutinised as part of the wider CQC action plan by both the Quality Committee and the Board.

Significant developments have been achieved in the implementation of the Birmingham Symptom-specific Obstetric Triage System (BSOTS), which will support evidence-based, standardised, timely risk assessments for women attending the Labour Ward Assessment Unit (LWAU). A workable interim solution for the identified estate issues are emerging which will facilitate the required additional LWAU clinical assessment areas. Amendments to the Jessop Maternity Information System (JMIS) are in development and will enable the timings of attendances and reviews for women attending LWAU. The Clinical Director has gained agreement from the Consultant Obstetric group to trial new ways of working to enhance senior obstetric presence in LWAU, the antenatal ward and Antenatal Day Assessment Unit. The increased senior obstetric presence will promote flow though the service and reduce delays in obstetric review for women and most importantly improve safety and outcomes.

The Maternity Improvement Programme will be shared at the June Board of Directors meeting by the Chief Nurse. The programme has five workstreams and priority actions, with these actions reflecting the CQC *must do* priorities.

11.2 CQC Enquiry

On April 20th the triumvirate were informed the CQC had received a letter of concern from a mother experiencing delays in her Induction of Labour (IOL) episode of care. A response was written reviewing the mother's care at JW and returned to the CQC within the specified timeframe. The service has not received further feedback from CQC at the time of writing.

12. OCKENDEN REPORT 2020 7 IMMEDIATE AND ESSENTIAL ACTIONS (IEA'S)

An external assurance visit was undertaken on 6th May to review JW progress against the 7 Immediate and Essential Actions (IEAs) from the interim Ockenden Independent Maternity Review report published in December 2020. The review team included the Regional Chief Midwife, Deputy Regional Chief Midwife, representatives from the LMNS, MIA team, and South Yorkshire Integrated Care Board.

Previous assessments of Ockenden compliance have been undertaken by the Local Maternity and Neonatal System (LMNS) programme management office (PMO) and progress was noted across all 7 IEAs.

The 7 IEAs are:

- IEA 1 Enhancing safety by partnership working between trusts to investigate and share learning from serious incidents
- IEA 2 Listening to women and families by having advocates on boards
- IEA 3 More partnership working through a focus on multidisciplinary staff training and twice daily consultant led ward rounds
- IEA 4 Specialist expertise in managing complex pregnancies
- IEA 5 Regular antenatal risk assessments
- IEA 6 Improved fetal monitoring training and embedding of *Fresh Eyes* review and audit.
- IEA 7 Women need to have accurate information to make informed choices to enable informed consent

The regional team have previously confirmed that ongoing review and oversight of all Ockenden IEA's will be through the national Perinatal Quality Surveillance guidance with responsibilities held at trust, LMNS and at regional levels.

High level feedback is expected from the National Maternity team in June. Progress against several elements of the 7 IEA's since the assurance visit can be evidenced.

- The production of this Maternity and Neonatal Safety Report, presented monthly by the Clinical Director and Midwifery Director at the Board of Directors
- Refreshed Maternity Safety Champions programme and schedule of meetings, with ToR, agenda, and infographic for all clinical areas.
- Progress with BSOTS implementation as discussed earlier in the paper
- Audit of "Fresh Eyes" fetal surveillance compliance and escalation commenced in May, reflecting standards from SBLvs2 and CNST MIS Year 4.
- Development and recruitment of new Fetal Surveillance 8a matron role.

13. AVOIDABLE TERM ADMISSIONS INTO THE NEONATAL UNIT (ATAIN)

13.1 The National Ambition

In August 2017 NHSI mandated a Patient safety alert to all NHS Trusts providing maternity care. The safety alert was issued to reduce harm from avoidable admissions to neonatal units for babies born at or after 37 weeks. This fell in line with the Secretary of State for Health's ambition to reduce stillbirth, neonatal brain injury and neonatal death by 50% by 2030.

This ambition is also aligned with the vision created within Better Births (2016), which aims to drive forward the NHS England-led Maternity Transformation Programme, with a key focus on:

- Reducing harm through learning from serious incidents and litigation claims
- Improving culture, teamwork, and improvement capability within maternity units.

13.2 Why is ATAIN important?

There is overwhelming evidence that separation of mother and baby so soon after birth interrupts the normal bonding process, which can have a profound and lasting effect on maternal mental health, breastfeeding, long-term morbidity for mother and child. This makes preventing separation, except for compelling medical reason, an essential practice in maternity services and an ethical responsibility for healthcare professionals.

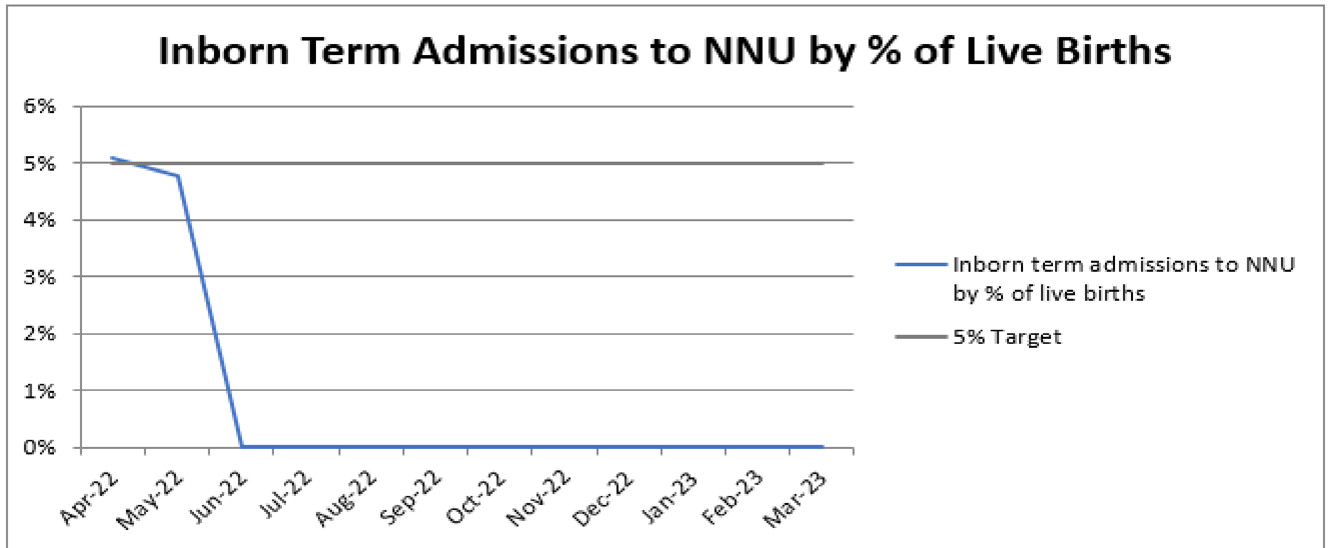
13.3 Jessop Wing Transitional Care

A weekly review of all term admissions is undertaken by the ATAIN team which includes representation from obstetric, maternity, and neonatal services and are classified as an avoidable, or unavoidable admission using the LMNS classification criteria. The collated data is submitted monthly onto the electronic SYB LMNS ATAIN QI dashboard. Actions are developed and agreed to address any themes highlighted by the review process and reflects the requirements outlined in the year four MIS. The action plan triangulates with actions and themes via other governance routes; Quality & Safety Meeting, HSIB, SI reports, CQC recommendations for term admissions.

The Jessop Wing has a sustained term admission rate to NNU as a percentage of live births below the local target of 5% (national aim <6%). The year 2021-2022 overall was 3.6% which was lower than previous years and will have had a positive impact on women, babies, and families.

In quarter 4, for the month of March we saw an increase to 5.8% which remains just below the national aim but above the local target of 5%. For April, the term admission rate was 4.82%, returning below the local target. For the month of May 2022, the term admission rate was 4.77%, again below the local target. Of the 23 term admissions to NNU in May 6 were deemed avoidable on review.

Year 2022 - 2023



14. CONCLUSION

This report has outlined locally and nationally agreed measures to monitor maternity and neonatal safety to inform the Board of Directors of present or emerging safety concerns and the work currently being undertaken to mitigate and address those risks.

In summary the report has identified the following issues to be addressed:

- Jessop Wing stillbirth rate may potentially be higher than expected in comparison to the national trajectory and comparable tertiary referral units of a similar size and demographic. The findings from a thematic review of 13 month's stillbirths in 2021/2022 undertaken by the MIA team have been received by the triumvirate. A factual accuracy check is in progress and will be discussed week commencing 20th June with the MIA team. Recommendations and learning will be shared when they become available.
- An Outline Business Case is being prepared for a Maternity specific information system as this is not currently in place at the JW, and this has been identified as a barrier to progressing some improvements at pace.
- A plan is being implemented to ensure that historical PMRT reports not shared with families is addressed on a case-by-case basis. Communication with affected families has begun.
- External maternity governance support has been secured to help recover the backlog of SI investigations. Improved oversight and early progress noted by the triumvirate.
- A key element of the CQC must do action plan is to ensure the completion of risk assessments for women on arrival to LWAU via the implementation of BSOTS, significant steps towards the implementation of BSOTS has taken place during May.

Previous work undertaken within the Jessop Wing to drive improvements includes:

- The development and launch of an electronic SitRep (Situation Report) allowing enhanced oversight of staffing, women awaiting IOL, activity and acuity in Maternity and Neonatal Services. This work has been received positively by the Local Maternity and Neonatal System (LMNS) and is planned for implementation across the wider system.
- Maternity skill-mix review has commenced to enhance workforce capability and capacity in the service.

APPENDIX Trust: Sheffield Teaching Hospitals NHS Foundation Trust April 2022

CQC Maternity Ratings 2019	**Overall**	**Safe**	**Effective**	**Caring**	**Well-Led**	**Responsive**
	Select Rating:	Select Rating:	Select Rating:	Select Rating:	Select Rating:	Select Rating:
Jessop Wing	Inadequate	Inadequate	Requires improvement	Requires improvement	Inadequate	Inadequate

Maternity Safety Support Programme	Select Y / N	**Yes**

	April	**May**	**June**	**July**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
1.Findings of review of all perinatal deaths using the real time data monitoring tool	No cases reviewed	Cases in progress							
2. Findings of review of all cases eligible for referral to HSIB	No cases reviewed	See section 3							
Report on: 2a. The number of incidents logged graded as moderate or above and what actions are being taken	See section 3.6	See section 3.6							
2b. Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training	See section 5	See section 5							
2c. 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	See section 9	See section 9							
3.Service User Voice Feedback	See section 10	See section 10							
4.Staff feedback from frontline champion and walk-abouts									
5.HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	HSIB-1 CQC-1 NHSR-1	HSIB-0 CQC-0 NHSR-0							
6.Coroner Reg 28 made directly to Trust	2	0							
7.Progress in achievement of CNST 10	To be assessed	In progress							

8.Proportion of midwives responding with 'Agree' or 'Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment (Reported annually)	Reported annually
9.Proportion of speciality trainees in Obstetrics & Gynaecology responding with 'excellent' or 'good' on how they would rate the quality of clinical supervision out of hours (Reported annually)	Reported annually