Sheffield Teaching Hospitals
NHS Foundation Trust

Executive Summary

Report to the Board of Directors

Being Held on 29 November 2022

Subject	Maternity & Neonatal Safety Report
Supporting TEG Member	Chris Morley, Chief Nurse
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Status[1]	A

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 September– 31st September 2022.

The report will provide an oversight position on:

- Maternity Incentive Scheme (MIS) Year 4
- Perinatal Quality Surveillance Model (PQSM)
- Health Care Safety Investigation Branch (HSIB) investigations
- Serious Incidents (SI)
- Midwifery Continuity of Carer (CoC)
- Training
- Maternity Dashboard
- Maternity Improvement Advisor (MIA) Thematic Review
- Maternity Safety Champions activities
- Workforce: Maternity and Neonatal Staffing
- Care Quality Commission (CQC) Review
- Compliance with the Immediate and Essential Actions (IEAs) outlined in Part One of the Ockenden Report

KEY POINTS

Key Risks

No new risks have been identified this month; therefore the key risks remain:

- That a maternity specific information system is not in place at the Jessop Wing. As previously reported to mitigate the risk of multiple systems being used it has been agreed that; the Jessop Maternity Information System (JMIS) should be used principally to support the collection of data for the Maternity Specific Data Set (MSDS) and other national data reporting only; and that all outpatient and inpatient care records will be paper based, the only exception being telephone triage. These changes are being implemented through a phased approach.

- The work on sharing historical Perinatal Mortality Review Tool (PMRT) reports not shared with families continues. The first cohort Dec 2019-Dec 2020 is essentially complete. Further work continues via a weekly task and finish group on reports that haven't yet been shared from Jan 2021 onwards.

- Progress is being made in addressing the Serious Incident investigation backlog, external maternity

governance support continues. A comprehensive tracker has been developed to support timely ongoing reviews.

- CQC **must do** action plan agreed and being implemented by the triumvirate as part of the Maternity Improvement Programme.

Improvements

New areas to highlight since the previous report:

- 11 newly qualified midwives are now in post. 5 more to start in November. We have retained all 14 of the 2021 cohort of newly qualified midwives.
- Following BR + full assessment report a midwifery workforce review has been drafted for discussion and agreement.
- External senior maternity governance support continues now increased to 0.6 WTE.
- ATAIN data-(Avoiding Term Admissions Into Neonatal Units) the Jessop Wing has a sustained term admission rate to the Neonatal Unit (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. This position was maintained in September with the term admissions rate at 4.3%

Improvements previously reported which continue to be embedded:

- The use of the electronic SitRep (Situation Report) allowing enhanced oversight of staffing, women awaiting Induction of Labour (IOL), activity and acuity in Maternity and Neonatal Services. Twice daily position now reported. Birth Rate+ (BR+) acuity score is included in this update.
- Fetal surveillance matron commenced during October and is completing her induction.
- Retention midwife commenced in post September 2022 has helped develop the plan on retention including supporting early career midwives, international midwives and Maternity Support Worker (MSW) development.
- 2nd cohort of MSW apprentices continue on the course which started in September.
- Fetal monitoring and PROMPT compliance figures remain at over 90% for midwives.
- Weekly task and finish group continues to meet to resolve PMRT backlog and provide progress reports fortnightly to triumvirate.
- SI tracker utilised to develop timely completion of SI reports alongside a process agreed for current PMRT reports.
- Following the launch of the use of the Birmingham Specific Obstetric Triage System (BSOTS) on 5th September, the percentage of women having a BSOTS rapid review completed is currently 95%.

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	Create a Sustainable Organisation	✓
6	Deliver Excellent Research, Education & Innovation	✓

RECOMMENDATIONS

The Board of Directors are asked to receive and discuss the content of the report particularly noting, the changes to documentation ahead of the deployment of an end-to-end maternity information system, and the introduction of BSOTS to improve safety for women attending for triage.

APPROVAL PROCESS

Meeting	Date	Approved Y/N
TEG	16.11.2022	Y
Board of Directors	29.11.2022	

[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). The report covers the period September 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).

New data from MBRRACE evaluating perinatal mortality rates in the UK for the year 2020 demonstrates a continued downward trend with stillbirth, (any baby loss from 24 weeks gestation) at 3.33 per 1000 births and the neonatal death rate at 1.53 deaths per 1000 live births. As a comparator in tertiary referral units with a level 3 NICU and neonatal surgery the average rates are 3.52 stillbirths per 1000 births and 2.37 neonatal deaths per 1000 live births. MBRRACE data does not include fetocide.

For Quarter 2 2022/23 the Trust stillbirth rate (minus fetocide) was 3.9 per 1000 births. Quarter 1 2022/23 was 4.3 per 1000

Quarter 2 Neonatal deaths will be reported in next board report due to time lag between reporting and extracting data.

A review of maternity governance processes and practices was undertaken in March 2022, by the Maternity Improvement Advisor (MIA) team. It was highlighted that PMRT reports from 2019 to 2022 had not been consistently shared with families. A process for contacting women is embedded. The work now is to ensure all PMRT reviews and reports are completed.

The PMRT workplan and progress is managed by a weekly task and finish group and the work is now divided into 4 phases.

Phase 1 from 22nd December 2019 – 31st December 2020

57/58 families have now been contacted and offered a copy of the PMRT report. There is 1 outstanding case that does not have a published report available, the clinical notes for this case are missing, we are working through a process to get this report completed without the notes.

Phase 2 from 1st January 2021 – 31st December 2021

The progress of all outstanding reports has been reviewed and reports that are near completion fast tracked.
Total number of cases = **73**

- Stillbirths/late fetal loses (SB/LFL) = **32**
- Neonatal Deaths (NND) = **41** (7 of which were ex-utero transfers)

38 cases at the Review started stage
32 cases at Writing report stage
3 cases at Pre-publish stage

Phase 3 January 1st-5th May 2022
Confirmation of numbers in this cohort:
Total number of cases = **28**

- Stillbirths/late fetal loses =**12**
- Neonatal death =**16**

1 case not yet reviewed
22 cases at review started stage
5 cases at writing report stage
0 cases at pre-publish stage

Phase 4 May 6th until present day
A process for PMRTs is agreed which will follow the appropriate process and a tracker is in place to ensure that there is timely sharing of reports with families.

2.1 PMRT figures

Between 01/09/2022 and 30/09/2022 Jessop Wing reported 2 stillbirths, 1 late fetal loss and 2 neonatal deaths to MBRRACE-UK.

- 2 antenatal stillbirths were reported, one baby born at 26 weeks gestation, one baby born at 29 weeks gestation. The deaths were notified, and surveillance completed within the specified timescale.

- 1 late fetal loss at 22 weeks gestation was reported.

- 1 live baby born at 34 weeks gestation was an early neonatal death following in utero twin pregnancy transfer from a cross border hospital.

- 1 live born baby at 40 weeks was transferred from a cross border hospital ex utero in poor condition. The baby did not respond to treatment and sadly died shortly after arrival. The case has been reported to HSIB by the cross-border Trust who provided both antenatal and intrapartum care. The baby's death has been notified to MBRRACE-UK. The infant's death has also been notified to the Child Death Overview Panel (CDOP) and the HM Coroner.

Patient Safety Reviews have been completed for eligible cases and they are awaiting Perinatal Mortality Panel review. In each case the care provided to the mother and her unborn baby is reviewed using the national Perinatal Mortality Review Tool (PMRT). 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.

- No maternal deaths were reported to MBRRACE UK this month.

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.

3.2 Total STH HSIB cases to September 2022

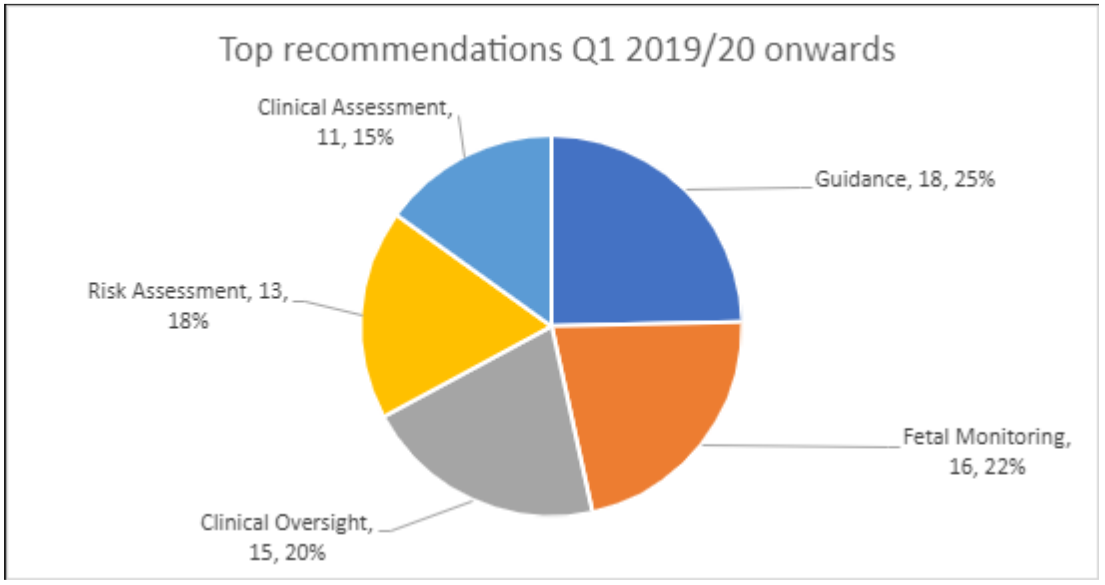
HSIB cases to date	September 2022
Total referrals since 2019	57
Referrals / cases rejected	17
Total investigations to date	40
Total investigations completed	35
Current active cases	5
Exception reporting (more than 6 months)	2 (linked cases)

3.3 HSIB Investigation active case progress update

No final investigation reports have been received by the Trust.

One case has been reported to HSIB in September 2022; a baby born in poor condition following a spontaneous vaginal birth at 41 weeks. The baby required a period of resuscitation and therapeutic cooling. The baby was diagnosed with hypoxic ischaemic encephalopathy (HIE) and therefore met the criteria to be reported to HSIB.

The Maternity Service continues to receive regular investigation progress updates from HSIB. An HSIB Quarterly Update Review meeting was held at the Jessop Wing on 12th September 2022. Senior members of Jessop Wing Maternity Service, Trust Executive team, HSIB, Local Maternity and Neonatal System and NHS England attended to review progress with HSIB reported cases and progress of HSIB action plans. The meeting was very positive, the top 5 recommendations following HSIB investigations from Q1 2019-20 onwards were discussed, see below. The themes are reflected in on going improvement work, including fresh eyes reviews, BSOTS and multi-disciplinary training.



Jessop Wing are on track to declare compliance with NHS Resolution Maternity Incentive Scheme (MIS) Safety Action 10, HSIB reporting standards. This will be included as part of the Trust Board final MIS Year 4 submission declaration to NHS Resolution on 2nd February 2023.

Table 3. HSIB Investigation Report September 2022

Ref	HSIB Reference	HSIB Criteria	Progress
W259661	MI-005710 MI- 006528 **The two cases are the same family.** Incident date 27/12/21 - baby 08/02/22 - mother	Cooled Baby Maternal Death	Combined draft report panel scheduled for 11 October 2022. The combined report to includes case MI-006528. Draft report received by Trust for factual accuracy checks. The family have requested a tripartite meeting with HSIB and Maternity Representatives. A meeting date will be scheduled after 10th November at the family's request.
W266190	MI-008645 Incident date 14/04/2022	Intrapartum Stillbirth	A draft report has been completed and family accuracy comments have been received by HSIB Comments will be reviewed at a factual accuracy review meeting (FARM) on 13 October and a response will then be sent Reporting Deadline 20th October 2022
W266515	MI-008638	Cooled Baby	Draft report is with the family for factual accuracy checking. Comments due by 4 October 2022. The final report will be shared with the Trust and family once comments have been received. Reporting Deadline 20th October 2022.
W432848	MI-014145	HIE	Some medical records sent to HSIB. Chronology in progress. First clinical advice meeting (SMART1) arranged for 26 October 2022. Plan to arrange a date to meet face to face with the family.

3.4 Coroner's Inquests including Reg 28 made directly to Trust

There is one inquest awaiting a hearing date. This case relates to extreme prematurity, pre-labour premature rupture of membranes and incorrect expected date of delivery on JMIS leading to no resuscitation following spontaneous birth at 22+1 weeks gestation (incorrectly recorded as 21+6 weeks gestation). A serious incident investigation is ongoing in line with the Trust serious incident framework.

An inquest is scheduled to be held on 24th and 25th November 2022, this case relates to a pre-term delivery by caesarean section. This also an SI.

Evidence was resubmitted for the concluded inquest on 21 July 2022 regarding delayed diagnosis of maternal pancreatitis which was required as part of a delayed regulation 28 decision. Information was submitted on the 30th September 22 and the coroner has made no further requests of the Trust. The case is now closed

A further inquest hearing which concluded on the 12th October 2022 resulted in no actions for the Trust and a short narrative of natural causes given.

3.5 Maternity Serious Incidents

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

4 incidents were reported to the Trust Serious Incident Group in September 2022

- 1 incident will be investigated by HSIB as reported above.
- 3 incidents have been notified to ICB and are being investigated within the Department.

Serious Incidents continue to be reported to SYB LMNS Quality and Safety Group and up through Yorkshire and the Northeast (NE) Perinatal Quality Surveillance Group (PQSG) for regional oversight.

Serious Incident Investigations Report September 2022

ID	STEIS Ref	Incident Description
432848	2022/19589	Following a spontaneous vaginal birth at 41+6 weeks, a baby was born in poor condition and required prolonged resuscitation. Following transfer to NNU the baby required therapeutic cooling and the incident was reported to HSIB.
432707	2022/20057	A woman with a previous history of DVT and renal disease was transferred to Critical Care following return to theatre for laparotomy following Category 2 Caesarean section and suspected sepsis.
433672	2022/22629	A woman was admitted to Critical Care following 11,000ml PPH during elective Caesarean section at 30+2 weeks for a known placenta percreta.
433764	2022/22626	A postnatal woman had an unplanned admission to Critical Care with sepsis.

Progress of Serious Incident Investigations

- 36 Serious Incident investigations in progress
- 13 legacy incidents reported prior to 01/04/2022 in progress
- 23 Serious Incidents reported after 01/04/2022 in progress
- 5/36 have been submitted to the Trust Serious Incident Group for final approval. 4 of the investigation reports are related to legacy incidents reported prior to 01/04/2022.

3.6 Serious Incidents in progress

Serious Incident Status

The table below shows there are 36 open Serious Incident investigations. Of these 25 have agreed extensions with the Integrated Care Board due to factors affecting capacity to complete the investigation.

	New Serious Incidents reported in month	**4**
	Serious Incidents closed in month (*SIG approved subject to minor amends*)	**5**
	Incidents in progress (*includes new Sis reported within the month*)	**36**
	Out of internal reporting deadline	**31**
	Out of external reporting deadline for ICB	**25**
	Incidents with external deadline extensions.	**25**
	Incidents closed by ICB	**0**

- 4 SI investigations in progress have incident dates over 12 months from the time of reporting.
- 1 report is completed in draft and is awaiting quality assurance review before submission for Departmental approval.
- 2 investigations are in draft and awaiting further comments from the investigators.
- 1 case has been circulated to the staff involved for factual accuracy.

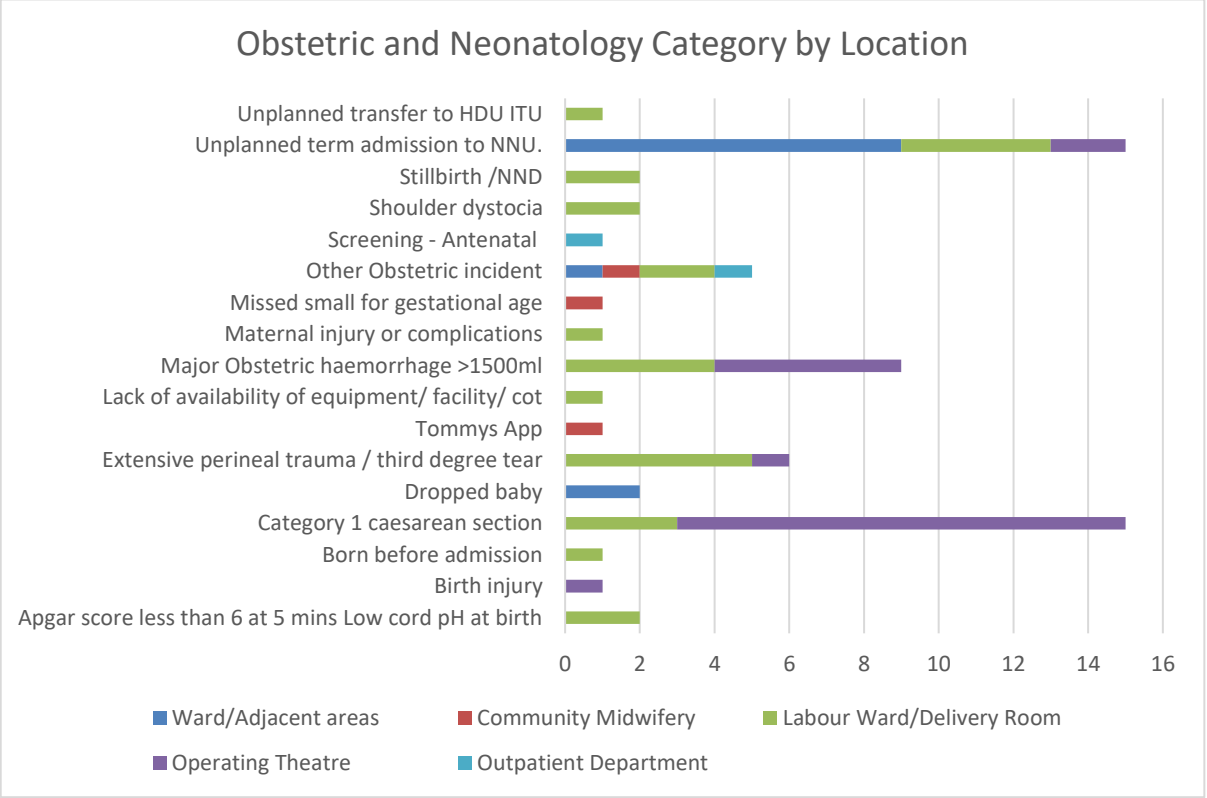
- 8 HSIB completed investigations and supporting action plans are to be shared with the Integrated Care Board. Supporting action plans have been developed for the remaining 5 cases and summary reports are being prepared for the ICB.

- 5 SI investigations have been completed and the final reports submitted to the Serious Incident Group for approval before submission to the NHS South Yorkshire Integrated Care Board.

3.7 Overview of Incidents reported in September 2022

158 obstetric incidents were reported through Datix in September 2022. There has been a decline in the number of incidents reported this month from 211 in August 2022. Maternity Quality and Safety Team are monitoring the rates of reporting.

Obstetric, Gynaecology and Neonatology Category Themes-September 2022



- 66 pregnancy and birth incidents were reported under the obstetric neonatal category in September 2022.
- 15 incidents relate to category 1 caesarean section and have been reported for monitoring and audit purposes.
- 15 incidents relate to unanticipated admission of a term infant to NNU. All of the incidents have been reviewed under the ATAIN review programme.
- 9 incidents relate to major obstetric haemorrhage and are reported for monitoring and audit purposes.
- 2 incidents of babies being dropped on the antenatal and postnatal wards were reported. One incident on the antenatal ward involved the precipitate birth of a baby following IOL. The midwife immediately responded when the family called for assistance, however the baby was born before the midwife was present. The second case concerned a father who fell asleep and accidentally dropped his baby. The incidents did not result in harm to either baby.
- 1 infant received a laceration to the head following a caesarean section

3.8 Incident Grading of Harm / Impact –for all incidents reported in September 2022

Row Labels	1 – No Harm / Impact	2 – Low Harm / Impact	3 – Moderate Harm / Impact	4 – Severe Harm/ Impact	Total
September 2022	31	99	26	1	157

Severe Harm Incidents.

1 woman with a history of DVT and renal disease was transferred to ITU following deterioration in her condition due to suspected sepsis. A serious incident investigation has been commenced to review the care provided and identify any opportunities for learning or improvement.

Moderate Harm Incidents

- 26 Moderate harm incidents reported
- 15/26 incidents were unplanned term admissions to NNU. All cases have been reviewed as part of the ATAIN programme
- 1 HSIB investigation declared following the birth of a baby at 41+6 weeks who was born in poor condition following a spontaneous vaginal birth
- Following review 2 cases were reported as Serious Incident (SI)
    - following the admission to ITU of a woman following major obstetric haemorrhage in the presence of a known placenta percreta.
    - following the unplanned admission to ITU of a woman with sepsis secondary to chorioamnionitis
- 4 incidents will be reviewed through the PMRT process following 3 fetal losses and 1 neonatal death
- 4 incidents were reviewed at a Patient Safety Review Meeting.

4. CONTINUITY OF CARE (COC)

As previously discussed in view of the continued national workforce challenges facing maternity services there is no longer a target date for services to deliver Midwifery Continuity of Carer (MCoC) and local services will instead be supported to develop local plans. This was enacted on 21st September 2022 and recognises that the top priority must be to ensure the right workforce is in place for women and babies across England.

At the heart of the MCoC model is the vision that women should have consistent, safe and personalised maternity care, before, during and after the birth. It is a model of care provision that is evidence-based. It can improve the outcomes and experiences for most women and babies, especially women of Black, Asian and minority ethnic backgrounds and those living in the most deprived neighborhoods.

The MCoC model is still an important ambition for STH once recruitment and midwifery vacancy levels have stabilised. MCoC will be revisited as part of the NHS SYB Equity Plan to improve outcomes for those most of risk of perinatal and maternal morbidity and mortality.

5. TRAINING DATA – MAY TO SEPTEMBER 2022

Mandatory Training / JSET Maternity Services September 2022 - Medical					
	Medical Consultants and Trainees				
	May	June	July	August	September
Data Security and Information Governance - Level 1 (1 Yearly)					
% Compliance achieved	88%	90%	90%	90%	96%
Equality & Diversity: General Awareness - Level 1 (3 Yearly)					
% Compliance achieved	93%	95%	96%	98%	98%
Fire Safety Theory - Level 1b (1 Yearly)					
% Compliance achieved	90%	91%	94%	88%	92%
Health Safety & Welfare Level 1 (3 Yearly)					
% Compliance achieved	93%	95%	96%	100%	100%
Infection Prevention and Control - Level 2 (1 Yearly)					
% Compliance achieved	88%	90%	92%	88%	94%
Moving and Handling - Level 2a (4 Yearly)					
% Compliance achieved	86%	81%	90%	86%	86%
Resuscitation: Adult Basic Life Support - Level 2a (1 Yearly)					
% Compliance achieved	88%	90%	92%	90%	88%
Safeguarding Children & Young People - Level 2 (3 Yearly)					
% Compliance achieved	93%	96%	94%	98%	98%
Safeguarding Children & Young People - Level 3 (3 Yearly)					
% Compliance achieved	67%	100%	100%	100%	100%
Safeguarding Vulnerable Adults - Level 2 (3 Yearly)					
% Compliance achieved	91%	93%	94%	98%	98%

Mandatory Training / JSET Maternity Services Compliance Trajectory September 2022 – Midwifery					
90% Compliance Target for all courses	2022				
	May	Jun	Jul	Aug	Sep
Conflict Resolution (Trajectory)					
% Compliance achieved	85.34%	81.98%	80.00%	79.72%	80.62%
Data Security and IG L1 (Trajectory)					
% Compliance achieved	75.66%	83.72%	87.14%	90.28%	92.70%
Equality & Diversity L1 (Trajectory)					
% Compliance achieved	99.12%	99.13%	99.14%	99.17%	98.31%
Fire Safety Theory L1b (Trajectory)					
% Compliance achieved	75.07%	82.56%	85.71%	89.72%	91.57%
Health Safety & Welfare (Trajectory)					
% Compliance achieved	99.71%	99.71%	98.57%	98.89%	98.31%
Infection Prevention (Trajectory)					
% Compliance achieved	74.19%	82.85%	85.43%	88.61%	90.45%
Moving & Handling L1 (Trajectory)					
% Compliance achieved	98.83%	98.55%	98.00%	100.00%	100.00%
Moving & Handling L2b (Trajectory)					
% Compliance achieved	41.64%	46.51%	91.43%	91.85%	90.06%
Resuscitation: ABLS L2a (Trajectory)					
% Compliance achieved	69.73%	77.71%	78.16%	84.27%	86.65%
Resuscitation: NLS L2 (Trajectory)					
% Compliance achieved	65.18%	78.35%	82.14%	86.92%	88.72%
Safeguarding Children L1 (Trajectory)					
% Compliance achieved	92.11%	88.46%	100.00%	96.43%	96.72%
Safeguarding Children L2 (Trajectory)					
% Compliance achieved	100.00%	100.00%	60.00%	50.00%	72.22%
Safeguarding Children L3 (Trajectory)					
% Compliance achieved	74.90%	72.18%	72.08%	75.32%	71.94%
Safeguarding Adults L2 (Trajectory)					
% Compliance achieved	95.74%	95.10%	91.95%	93.18%	91.80%
Mental Capacity Act - Level 2a (3 Yearly)					
% Compliance achieved	63.50%	69.50%	73.28%	76.12%	78.98%
Deprivation of Liberty - Level 2b (3 Yearly)					
% Compliance achieved	63.80%	70.67%	74.43%	78.93%	81.82%

JSET Maternity Services September 2022 - Medical consultants and Trainees					
Obstetric Emergency Drills (PROMPT)	May	Jun	Jul	Aug	Sep
% Compliance achieved	83%	85%	71%	82%	87%
Fetal Monitoring					
% Compliance achieved	90%	97%	93%	92%	90%

JSET Maternity Services September 2022 - Midwifery					
Obstetric Emergency Drills (Trajectory)	May	Jun	Jul	Aug	Sep
% Compliance achieved	78.76%	85.23%	90.53%	91.54%	92.54%
Fetal Monioring (Trajectory)					
% Compliance achieved	80.80%	93.80%	94.14%	94.30%	95.00%

As previously discussed the audience for safeguarding and the level of safeguarding training for midwives has been altered which has affected the planned trajectory.

The OGN three focused areas continue to be Obstetric Emergency Drills (PROMPT), Fetal Monitoring (K2 training package) and Neonatal Life Support (NLS). These three areas were identified as the greatest focus for improvement to ensure the quality and safety of maternity services.

Midwifery compliance for PROMPT and fetal monitoring is being maintained at 90%.

NLS compliance is increasing slowly, attendance is being prioritised and staff offered additional hours to incentivise attendance.

As previously discussed medical compliance for PROMPT has been affected by changeover of medical staff and staffing issues, the interim Clinical Director has oversight of this situation and is prioritising the allocation of staff to training as staffing issues allow.

6. JESSOP WING - MATERNITY DASHBOARD (MAY – SEPTEMBER 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.

Commencing from the 15th February 2022, the caesarean section rate data will not be used as a maternity services quality metric.

Following receipt of communication from NHS England in February 2022, 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 maternity provider organisations (parity, number of fetuses, 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

Robson groups 1, 2 and 5 are those that we know can be reported and have been advised that they are seen as the categories that are most influenced by clinical practice. These are also the mandated fields for the Maternity Services Data Set. The figures in our dataset gives the percentage caesarean section rate as per each Robson criterion as follows:

(1) Nulliparous (not previously given birth), singleton (single fetus), cephalic (head down) at term (≤37 Weeks) births in spontaneous labour having an emergency caesarean section
(2) Nulliparous, singleton, cephalic terms births with an induced labour having an emergency caesarean or a pre labour caesarean
(5) Previous caesarean section, singleton, cephalic term births having a planned or emergency caesarean section

Whilst caesarean section rates are no longer reported with a target or as part of an improvement aim, the Robson group offers a better like for like comparator compared to one crude caesarean section rate. In particular the rate of emergency caesarean section in Robson Group 1 should be similar from one organisation to another. This is also important for providing women with meaningful provider level statistics.

Jessop Wing - Maternity Dashboard (May to September 2022)

Antenatal	Green	Amber	Red	May 22	Jun 22	Jul 22	Aug 22	Sep 22
Community First Visits				554	497	516	541	536
Community First Visits Within 10 Weeks %	$n \geq 90$	$75 \leq n < 90$	$n < 75$	75.45	69.62	74.22	71.16	70.15
Smokers at Community First Visit %	$n \leq 6$			11.01	8.65	8.53	9.06	9.51
Clinic First Visits				513	466	454	498	524
Clinic First Visits Under 13 Weeks %				63.16	65.24	63.88	60.84	65.46
Clinic First Visits Smoker %	$n \leq 6$			10.14	11.37	10.35	10.44	9.92
Clinic First Visits CO Measured %				6.63	34.12	42.29	32.53	51.91
Clinic First Visits CO ≥ 4ppm				0	15.72	13.54	16.05	12.87
Community 36 Week Visits CO Measured %				36.83	51.58	55.86	43.38	55.82
Community 36 Week Visits CO ≥ 4ppm				13.79	10.71	12.71	10.78	10.7
CO reduced below 4ppm by 36 weeks %				0	13.33	0	0	0
Deliveries	**Green**	**Amber**	**Red**	**May 22**	**Jun 22**	**Jul 22**	**Aug 22**	**Sep 22**
Total Deliveries (mothers)				475	434	515	475	484
Registerable Births				483	441	528	486	489
Elective C Section Deliveries %				17.05	18.66	13.59	16.84	17.77
Emergency C Section Deliveries %				23.16	24.65	23.69	26.95	23.55
Assisted Deliveries %				9.26	8.53	11.26	11.16	9.3
Inductions %	$n \leq 32.8$			25.68	27.88	24.47	25.47	26.65
Waterbirths				17	11	18	10	13
Homebirths				10	9	6	8	7
Born Before Arrival (BBA)				3	4	8	0	4
APGAR 0-6 %				3.38	2.09	2.13	1.92	2.7
Low birthweight (≤ 2500g) %				7.87	9.98	10.98	14.61	9
Under 3rd Centile delivered at 38wks+ %				70.59	65.22	72.41	42.31	71.43
Singleton Livebirths < 30wks with $MgSO_4$ %				83.33	83.33	100	100	100
Preterm births %				4.53	8.17	6.01	9.17	5.93
Singleton births 16w - 23+6 %				0.43	0.71	0.2	0.43	0.42
Singleton births 24w - 36+6 %				4.29	8.75	6.37	9.7	6.3
PPH ≥ 1500ml %	$n < 3$	$3 \leq n \leq 5$	$n > 5$	4.22	4.41	3.69	4.23	3.94
3rd and 4th degree tears (all) %				4.03	3.21	2.29	3.28	2.63
3rd and 4th degree tears (Normal) %	$n < 3$	$3 \leq n \leq 4$	$n > 4$	3.04	2.2	1.2	3.54	2.23
3rd and 4th degree tears (Assisted) %	$n < 5$	$5 \leq n \leq 9$	$n > 9$	9.3	8.33	7.14	2.17	4.76
Smokers At Delivery %	$n \leq 6$			9.07	10.67	7.18	8.88	7.68
First Feed Breastmilk %	$n \geq 75$	$70 \leq n < 75$	$n < 70$	71.16	66.13	67.05	64.52	68.79
Robson Group 1 having LSCS %				27.27	31.25	24.42	27.4	21.95
Robson Group 2 having LSCS %				60.76	56.45	54.02	67.47	58.06
Robson Group 5 having LSCS %				74.32	82.67	76.39	79.73	86.11
VBAC (Local) %				25	22.47	20.99	19.1	12.5
VBAC (NHSD) %				17.07	23.81	21.57	19.15	8.33

Jessop Wing - Maternity Dashboard (May to September 2022)								
Neonatal	**Green**	**Amber**	**Red**	May 22	Jun 22	Jul 22	Aug 22	Sep 22
Neonatal Unit Admissions				46	50	41	60	42
Neonatal Unit Admissions %				9.54	11.44	7.81	12.45	8.62
Neonatal Unit Admissions at Term				24	27	14	26	20
Neonatal Unit Admissions at Term %				4.98	6.18	2.67	5.39	4.11
Mortality	**Green**	**Amber**	**Red**	May 22	Jun 22	Jul 22	Aug 22	Sep 22
Stillbirths				1	4	3	4	2
Stillbirths ‰ (per thousand)	$n \leq 2.55$			2.07	9.07	5.68	8.23	4.09
Stillbirths at Term				1	1	0	1	0
Stillbirths at Term ‰ (per thousand)				2.07	2.27	0	2.06	0
Feticide (Stillbirth)				0	2	0	2	1
Stillbirths excluding feticide ‰ (per thousand)				2.07	4.54	5.68	4.12	2.04
Neonatal Deaths				4	3	3	4	
Neonatal Deaths ‰ (per thousand)	$n \leq 1.45$			8.3	6.86	5.71	8.3	
Neonatal Deaths ≥ 24 weeks				3	2	2	4	
Neonatal Deaths ≥ 24 weeks ‰ (per thousand)				6.22	4.58	3.81	8.3	
Neonatal Deaths at Term				1	0	0	2	
Neonatal Deaths at Term ‰ (per thousand)				2.07	0	0	4.15	
LW Assessment	**Green**	**Amber**	**Red**	May 22	Jun 22	Jul 22	Aug 22	Sep 22
Calls to Triage Service				2906	2861	3252	3077	2778
LWAU Admissions				1051	1038	1180	1060	1100
LWAU Rapid Reviews %	$n \geq 95$	$80 \leq n < 95$	$n < 80$	95.81	93.06	94.49	96.04	95.36
LWAU Rapid Review Time (mins)	$n \leq 30$	$30 < n \leq 45$	$n > 45$	32	30	33	23	20
Other	**Green**	**Amber**	**Red**	May 22	Jun 22	Jul 22	Aug 22	Sep 22
Readmissions				14	13	17	22	10

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.

NHS Resolution has launched a further revised update in October 22. The scheme's submission deadline has been extended from 5th January 2023 to 12 noon on the 2nd February 2023.

Interim timeframes within each of the safety actions have also been reviewed and extended. The scheme's conditions have also been reviewed and strengthened in some areas. The new conditions include the following additional requirements: The declaration form to be submitted to Trust Board with an accompanying joint presentation detailing position and progress with maternity safety action by the Director of Midwifery 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.

7.2 Current CNST position

	Safety Action	Sept 22	Confidence for compliance by Jan 5th 2023	Notes
1	Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?			Reporting dates missed on Y4 tracker.
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?			Evidence available
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?			Evidence available
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?			Workforce plan in progress
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?			BR+ assessment undertaken workforce plan in progress
6	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version two?			Element 1 - Not meeting the required standard. Element 2 - Unable to report metric (not collected in MIS). Audit of Q1 to be completed by end of Sept 22. Element 3 - Audit of Q1 to be completed by end of Sept 22. Element 4 - Compliant. Element 5 - Not meeting the required standard.
7	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?			Evidence available
8	Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4?			PROMPT - Not meeting the required standard. CTG - Compliant. NLS - Not meeting the required standard.
9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?			The Maternity and Neonatal Safety Report is a component of this evidence.
10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) scheme for 2021/22?			Evidence available

8. BOARD LEVEL SAFETY CHAMPIONS MEETINGS

The role of this group is to share and as necessary escalate locally identified issues to the board via the executive board member who is the named Maternity & Neonatal Safety Champion.

Specific responsibilities are:

- To review and summarise published national reports, providing assurance that all actions required locally are being monitored and completed in the required timescales
- To review inspection reports and any feedback from women and their families
- To receive the quarterly Yorkshire and Humber Maternity Dashboard and review the benchmarked position
- To report by exception any concerns on local patient safety
- 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)
- To report on progress with achieving aims of the Maternity & Neonatal Transformation and LMS

The inaugural meeting was held on July 14th where the Maternity Safety Plan, Ockenden report, Perinatal Clinical Quality Surveillance, LMNS updates Maternity and Neonatal Health service collaborative, staff feedback, patient experience plan and ATAIN were discussed.

Feedback from staff generated during the Board level Safety Champion walk round in September 2022 included:

- Issues with correct contact details for General Practitioners particularly to bypass the patient contact numbers to facilitate rapid and effective communication. This feedback has been actioned and updated contact information and bypass numbers are now available for staff. This change has received positive feedback from staff.

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.

There continue to be vacancies in the midwifery workforce, however, RM and RN fill rates are predominantly greater than 90%. There has been an increase in the bank fill rate for midwives mainly due to Jessop Wing Staff doing extra hours.

Jessop Wing Fill Rates										
	May		June		July		August		September	
	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night
Labour Suite	93.00%	95.20%	95.70%	91.90%	93.50%	88.20%	95.3%	86.9%	100.2%	83.9%
Rivelin	89.40%	98.60%	87.60%	100.30%	90.40%	93.80%	86.5%	93.6%	103.6%	100.3%
Norfolk	117.50%	92.20%	110.50%	95.00%	103.10%	103.60%	104.9%	101.7%	104.6%	115.2%
Whirlow	111.40%	101.90%	119.60%	105.10%	115.50%	102.70%	113.6%	108.2%	108.3%	115.0%
NICU	82.50%	86.40%	80.30%	82.30%	89.00%	85.20%	92.4%	88.5%	91.8%	87.0%

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

Where there are identified challenges to safe staffing the following steps are taken:

- Request midwifery staff undertaking specialist roles to work clinically
- Elective workload prioritised to maximise available staffing
- Managers at Band 7 level and above work clinically
- Reallocate staffing to ensure one to one care in labour and dedicated supernumerary labour ward co-ordinator roles are maintained
- The on-call midwives from the community to support labour ward during times of escalation.
- Request additional support from the on-call midwifery leadership team.
- Enhanced NHSP rate continues
- Use of Agency Midwives
- Supporting midwives by using Registered Nurses (RN) as part of the skill mix to enhance safety in postnatal and Advanced Obstetric Care Unit (AOCU) environments.

All the above actions are designed to maximise staffing into critical functions to maintain safe care for the women and their babies. It is preferable to have higher fill rates during the night-time when there is less support available from specialist midwives and managers.

Actions taken to support safe staffing are captured in the live Birth-rate Plus (BR+) web-based acuity tool. The BR+ acuity tool is used across 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. The Birthrate Plus acuity app data can be used to facilitate triangulation of incidents, complaints, with maternity workforce Red flags, as highlighted below.

Analysis of Maternity Red Flags for Labour ward September 22

Number & % of Red Flags Recorded

From 01/09/2022 to 30/09/2022

RF1	Delayed or cancelled time critical activity	14
RF2	Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	2
RF3	Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	0
RF4	Delay in providing pain relief	1
RF5	Delay between presentation and triage	8
RF6	Full clinical examination not carried out when presenting in labour	0
RF7	Delay between admission for induction and beginning of process	6
RF8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	0
RF9	Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	0
RF10	Shift leader not supernumerary/supervisory	5
	Total	36

Each red flag category is then explored by the matron to look at patterns and possible improvement work.

RF10 shift leader not supernumerary/supervisory

Date **Time**	**Red Flag**	**Acuity**	**Investigation**
3/9/22 10.00	Coordinator not supernumerary (5)	-1.7	Due to sickness on Level 3 (antenatal and postnatal wards) x1 Midwife pulled to Labour Ward and co-ordinator has oversight of 2 Post Natal(PN) women with a 3rd year student
3/9/22 14.00		-1.5	Shift leader overseeing 1 PN patient awaiting transfer to Norfolk Ward
6.9.22 22.00		-2.9	no information explaining the context, used as a learning point for staff becoming familiar with the system.
27/9/22 22.00		-0.4	Co Ordinator caring for a postnatal woman
28/9/22 02.00		-2.7	Coordinator caring for PN women

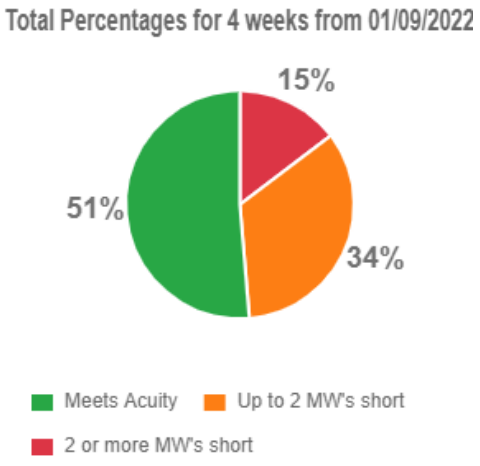
The day to day and weekly acuity enables triangulation with incidents and complaints.

	15/09/2022	16/09/2022	17/09/2022	18/09/2022	19/09/2022	20/09/2022	21/09/2022
02:00	4.80	1.80		-0.10	0.80	2.20	-1.40
06:00	3.80	1.15	0.70	1.40	1.35	4.40	1.10
10:00	4.00	0.50	0.70	1.25	1.15	2.65	-0.90
14:00	2.10	0.35		0.15	0.20	2.90	
18:00	1.50			-1.00	0.90	0.80	-0.50
22:00	-0.30	3.30	1.60	-0.20	-0.10	-1.20	-0.80

Download

	Thu	Fri	Sat	Sun	Mon	Tue	Wed
	22/09/2022	23/09/2022	24/09/2022	25/09/2022	26/09/2022	27/09/2022	28/09/2022
02:00		1.50	0.00	-2.75	1.25	1.30	-2.70
06:00	0.95	-1.10	0.60	-2.05	0.00	0.40	-3.00
10:00	1.05	2.95	2.30	-0.35	1.60	-0.30	-2.70
14:00	-0.60	2.90	-0.90	-1.50	1.55	-1.10	-0.15
18:00	-2.60	1.20		-1.70	-1.40	-0.10	-2.10
22:00	-5.40	-2.80	-2.80	-1.45		-0.40	-4.40

Monthly acuity view



The breakdown of staffing shortfalls provides narrative to inform the workforce review and to ensure efficient rostering.

Number & % of Staffing Factors Recorded

From 01/09/2022 to 30/09/2022

SF1	Unexpected MW absence/sickness	62
SF2	Unable to fill vacant shifts	81
SF3	Midwife on transfer duties	3
SF4	MW redeployed to other area	11
SF5	Support staff less than rostered numbers	62
SF6	CoC MW available	0
SF7	CoC MW not available	0
SF8	No Nurse available for AOCU	3
SF9	Planned staff relocated to wards	2
SF10	1 RGN AOCU	15
SF11	2RGN AOCU	2
	Total	241

The monthly report to the Director of Midwifery also includes actions taken and an action plan going forward

Further initiatives to enhance the maternity workforce include:

- Five Registered Nurses (RN) on the Neo Natal Unit started Qualified in Specialty (QIS) training in September and a further five are due to start Foundation training (pre-QIS) in October.
- A Fetal surveillance matron has been successfully appointed and commenced in post 10th October 2022.
- An 8a Education and Practice development matron has been appointed to support education and the support of staff across the unit.
- A rolling recruitment advert for experienced AFC band 5/6 midwives continues.
- 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. 16 NQM's have accepted roles at JW.
- NHSE funded (2 years), Recruitment and Retention, Pastoral Support Midwife AFC band 7 role now in post.
- HEE funded Registered Midwife shortened course for STH Registered Nurses to start in March 2023.
- Discussion around a midwifery apprentice course to enhance the inclusivity of midwifery training opportunities in the system is on-going.
- Recruitment of 15 WTE AFC band 2 Clinical Support Workers (CSW) who will undertake the AFC band 3 Maternity Support Worker (MSW) apprentice course at Sheffield College. Now in post, course started September 2022.
- Recruitment of 12 WTE International Recruited (IR) Registered Midwives (RM)s. The first IR

midwife has passed her OSCE and is continuing a period of supportive practice. Two IR midwives scheduled to arrive in November 2022 and four further IR midwives in January 2023.

- Reintroduction and communication of family friendly/flexible work patterns. Midwifery leaver rates have reduced.
- Work continues to review, develop and improve current skill mix practices in the Jessop Wing. Key principles to observe when incorporating maternity support workers and RNs in the maternity workforce skill mix is to utilise skills to complement maternity care and are not a substitute for RMs. BR+ recommendations reflect that 20 - 25% of midwifery time spent delivering postnatal care in hospital and community can be safely, and without reducing quality, be delivered by a MSW or Registered Nurse (RN) (hospital setting only).

Obstetric Workforce Current-no change from previous report

Gaps:

Number of posts	Reason for gap	Resident Night Rota
2	Maternity Leave	Yes
2	Phased return – no clinical work or resident nights	Yes
1	Long Term Sick	Yes
1	Funded vacancy – recently advertised	Yes
1	Phased return - no clinical work	No

Recruitment:

Currently working with an agency to secure the most appropriate locum colleagues, prior to advertising again for substantive posts.

Mitigation:

- 3 Locum Consultants in place (2 contribute to resident night rota)

Registrar Level

Current Gaps:

WTE	Level	Reason for gap	Labour Ward On Call
2.0	ST3+	Training programme gap	Yes
0.2	ST1/2	Training programme gap	Yes

Recruitment:

Post	Interview date	Outcome
Staff Grade Specialty Doctor	4th July 2022	1 candidate to commence January 23 A further candidate has withdrawn

Mitigation:

- ST3+ - existing team being utilised to cover Labour Ward / On Call gaps at the detriment to gynaecology clinic/activity

9.2 Neonatal Workforce-no change from previous report

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) completed a workforce review which showed deficits in staffing. Significant progress has been achieved with the following appointments.

All 11 International Recruited (IR) RNs are now working as RNs

6 newly qualified RNs have just started in post, 2 of whom are already qualified in specialty

5 new QIS have qualified

2 IR RN have commenced the QIS pathway

2 new trainee Advanced Neonatal Nurse Practitioners (ANNP) have started university

1 external ANNP has been recruited and has a start date.

3 new IR RNs have been allocated to start end of Oct 22

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

Jessop Wing maternity and neonatal services continue to have a collaborative 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
- Chief Nurse and Interim Director of Midwifery support for increased financial renumeration for MVP Chairpersons raised with CCG (now ICB) colleagues. Additional funding now confirmed.
- Co-production work:
    - Designing bed boards for clinical areas
    - Developing a new website/ coproducing films following the pregnancy journey with an ethos of being multicultural, equity and inclusivity
    - Co-producing an infographic showing birth outcomes for sharing with service users and staff
- Supporting the PMRT process of communication with families where a PMRT report had not been shared.
- MVP members attendance at maternity governance meetings.
- Co-design of patient information leaflets May 2022 onward.
- Planned MVP attendance at all interviews of senior midwifery positions.

The Sheffield MVP Programme has recently been awarded an extra £19k this year, bringing total available funding to £25k for this year to support achievement of work plan.

Following a previous MVP meeting the need to progress the Estates improvement plan to improve the environment was noted. The Estates Director has finalised an action plan with work planned to update the environment on all levels of the Jessop Wing.

11. CARE QUALITY COMMISSION (CQC)

11.1 Maternity Action Plan/ Birmingham Symptom Specific Obstetrics Triage System (BSOTS)

The Birmingham Symptom Specific Obstetrics Triage System (BSOTS) was successfully launched on 5th September 2022. As described previously, BSOTS standardises the care received and timely risk

assessment of women attending the Labour Ward Assessment Unit now renamed the Maternity Assessment Centre (MAC). The MAC Lead Midwives have undertaken clinical pathway training with midwives and obstetric staff prior to the launch.

Estates work has provided a monitoring bay for 4 women, a dedicated triage / rapid review clinical room and new office with set up aligned with BSOTs flow. The Jessop Maternity Information System (JMIS) logs the time of a mothers arrival and clinical triage outcome. The BSOTS pathway and patient record is paper based to ensure a complete contemporaneous clinical picture for clinical risk assessment.

Progress with BSOTS will continue to be reflected and monitored with the other CQC must do actions in the Maternity Quality & Safety Improvement Programme.

The maternity dashboard in section 6 shows the footfall through triage and the percentage of women having a BSOTS rapid review completed, currently 95%. The aim is for all rapid reviews to be done within 15 minutes of arrival into triage. Data for BSOTS is reviewed weekly, in September the average time for a rapid review was 20 mins, with a range of 55-68% of women being seen within 15 minutes. This excludes women who have a clinical condition which requires urgent and immediate assessment and management as these women are admitted straight to labour ward.

11.2 CQC escalations

For the month of September 2022 there were no issues raised with the Trust by the CQC. Although it should be noted that the Maternity Service was reinspected by the CQC. There were no issues highlighted about the Maternity Service as part of the immediate feedback, the report following this inspection is expected in the forthcoming months.

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

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

A current state self-assessment exercise was undertaken by the Triumvirate and the Maternity Improvement Advisor in addition to a review of the evidence provided to date. This has resulted in a robust plan to progress and evidence the Trust's position at pace. All evidence to support the self-assessment is being stored in one central location with live links inserted into the overall Maternity Improvement Programme tracker, which incorporates the Ockenden IEAs.

Work has now begun on the 15 IEAs from the final Ockenden report.

Progress has been made on:

- The production and further development of this Maternity and Neonatal Safety Report, presented monthly by the Clinical Director, Midwifery Director, and the Operations Director to the Board of

Directors meeting.

- The Maternity Dashboard
- On-going development of MVP relationship and Jessop Wing website due to go live by end of year.
- Refreshed Maternity Safety Champions programme and schedule of meetings, with Terms of reference, agenda, and infographic for all clinical areas.
- Launch of BSOTS
- Audit of "Fresh Eyes" fetal surveillance compliance and escalation commenced in May, reflecting standards from SBLvs2 and CNST MIS Year 4.
- New Fetal Surveillance 8a matron role now in post
- Intense support and effort to improve the Governance processes around Serious Incident reporting and investigating
- Refresh of the Training Needs Analysis (TNA)
- The Trust has been fully involved with the Networked Maternal Medicine service and will now focus on local Standard Operating Procedures to support this service once it is operational.

Full compliance with all Ockenden IEA's will continue to be challenged by the on-going lack of an integrated and effective Maternity Information System (MIS) to both guide practice, record evidence of actions undertaken and report on compliance through robust audits.

Final Business case currently being written to detail the case for investment in an appropriate MIS. As agreed by the Maternity Improvement Board, from September, a full paper based end to end maternity record (hand held record) is in place, including paper documentation for BSOTS, this will facilitate a complete pregnancy history for clinicians to risk assess and plan care safely.

In addition, the backlog and on-going capacity and process issues around Serious Incidents (SI's) – notably the Perinatal Mortality Review Tool (PMRT) and Health Services Investigation Board (HSIB) cases – remain a significant factor in our non-compliance, despite plans being in place to remedy this.

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:

a. Reducing harm through learning from serious incidents and litigation claims
b. 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.

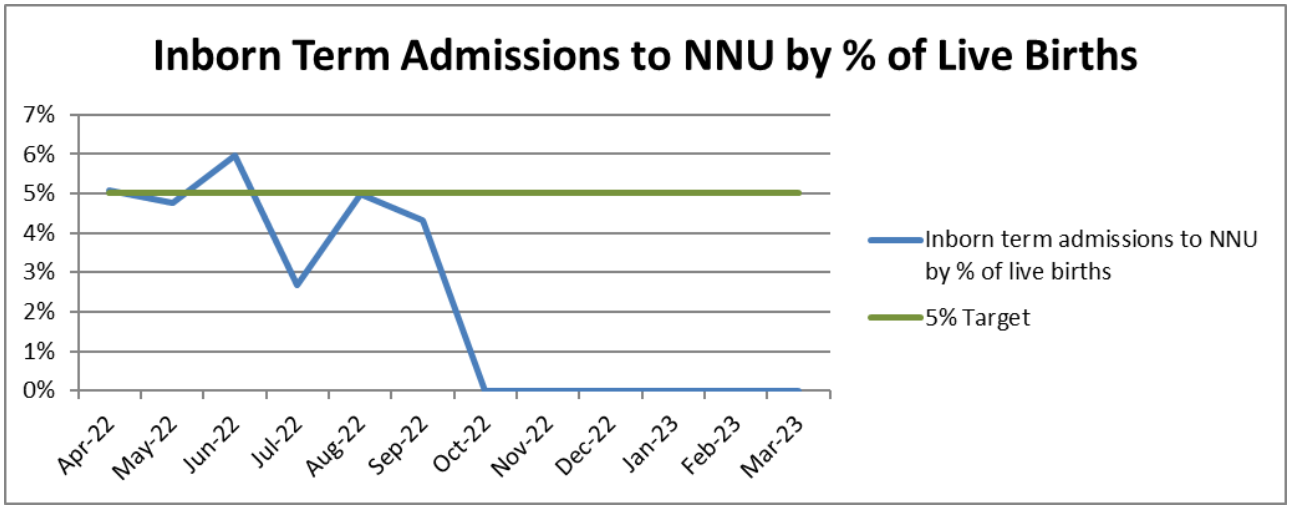
13.3 Jessop Wing Transitional Care

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 Quality Improvement dashboard. Actions are developed and agreed to address any themes highlighted by the review process and reflects the requirements outlined in the year four Maternity Incentive Scheme. 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.

- For September 2022 the term admission rate to NNU remained below the SY&B LMNS target of <5% at 4.3%
- Of the 21 term admissions 3 were excluded from the review process as were admitted due to congenital anomalies.
- Of the 18 babies reviewed by the ATAIN team 4 were considered to be potentially avoidable admissions
- Of the 4 considered potentially avoidable 1 was admitted with hypoxic ischaemic encephalopathy and is an HSIB investigation and 1 has been escalated to the quality and safety team to explore potential missed opportunity to act on a maternal tachycardia and clinical reference to maternal infection

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:

a. A Final Business Case is being prepared for a Maternity specific information system as this is not currently in place, and this has been identified as a barrier to progressing improvements at pace.

A full paper-based end to end maternity record (hand held record) is in place, this will facilitate a complete pregnancy history for clinicians to risk assess and plan care safely.

b. Training compliance in the three priority areas continue to improve, together with improvements across a number of other training areas
c. A plan is in place to ensure that historical PMRT reports not shared with families is addressed on a case-by-case basis.
d. External maternity governance support to help recover the backlog of SI investigations and upskill the maternity governance team is ongoing.
e. A key element of the CQC must do action plan is to ensure the completion of risk assessments for women on arrival via the implementation of BSOTS. This is now in place and has been positively received.

APPENDIX 1

Trust: Sheffield Teaching Hospitals NHS Foundation Trust September 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	0	0	0	0	0	0			
2. Findings of review of all cases eligible for referral to HSIB	No cases reviewed	1	0	0	Process in place, findings progressed through action planning	Process in place, findings progressed through action planning			
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	See section 3.6	See section 3.6	Section 3.6	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	See section 5	See section 5	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	See section 9	See section 9	See section 9	See section 9			
3.Service User Voice Feedback	See section 10	See section 10	See section 10	See section 10	See section 10	See section 10			
4.Staff feedback from frontline champion and walk-abouts				YES		YES			
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	HSIB-0 CQC-3 NHSR-0	HSIB-0 CQC-1 NHSR-0	HSIB-0 CQC-0 NHSR-0	HSIB-0 CQC-0 NHSR-0			
6.Coroner Reg 28 made directly to Trust	2	0	0	0	0	0			
7.Progress in achievement of CNST 10	To be assessed	In progress	In progress	In progress	In progress	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