Sheffield Teaching Hospitals NHS Foundation Trust

Executive Summary

Report to the Board of Directors

Being Held on 26 March 2024

Subject	Maternity and 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 January-31st January 2024.

The report will provide an oversight position on:

- Perinatal Quality Surveillance Model (PQSM)
- Maternity and Newborn Safety Investigation (MNSI) investigations
- Serious Incidents (SI)
- Training
- Maternity Dashboard
- Maternity Safety Champions activities
- Workforce: Maternity and Neonatal Staffing
- Care Quality Commission (CQC) Review
- Clinical Negligence Scheme for Trusts (CNST) Year 5
- Saving Babies Lives Care Bundle version 3 (SBLv3)
- The Three-Year Delivery Plan for Maternity and Neonatal Services

KEY POINTS

Key Risks

- There continues to be a vacancy gap between midwifery staff in post and the midwifery establishment, following reassessment through Birthrate plus. However, the gap has been reduced by the recruitment of newly qualified midwives through the Autumn and international midwives during January and February. Overtime incentive payments remain in place for night duty until 31st March 2024, when they will be reviewed again.

Previous reported risks remain unchanged:

- That a maternity specific information system is not in place at the Jessop Wing. Work on the implementation of the Maternity Module as part of the Oracle Cerner Electronic Patient Record continues with implementation scheduled for October 2024.

Improvements

Areas of improvement as highlighted in previous report:

- The Jessop Wing is currently rated as ‘requires improvement’ by the Care Quality Commission (CQC) and a revised action plan has been embedded into the Maternity Improvement Programme.
- Following submission of audit results Maternity has met the requirements for the UNICEF Baby Friendly Initiative stage 3 accreditation pending a site visit expected in May 2024.
- There is currently 2 open SI being led by STH. From January 2024 incidents will be reviewed under the

Patient Safety Incident Response Framework.
- 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%). For the month of January this was 5.3%.
- The combined Friends and Family Test Score for Maternity continues to be reported at over 90%.
- The NHS Maternity Survey 2023 was published on the 9th February showing an improvement in overall positive scores when compared with the 2022 survey results. This positive score change ranks the Jessop Wing as 25 out of the 65 NHS Trusts taking part in the NHS Maternity Survey (previous year 55/65) and the 8th most improved maternity unit when compared with other Trusts.

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.
- There is a staff retention plan to support staff to stay and grow. Pastoral support lead is supporting early career midwives, internationally recruited midwives and Maternity Support Workers (MSW).
- Birmingham Specific Obstetric Triage System (BSOTS) is now embedded on labour ward. Monitoring of performance will continue to be reported.

National Maternity Issues

- The Three Year Delivery Plan for Maternity and Neonatal Services has been launched and incorporates the Ockenden Immediate and Essential Actions (IEAs) work through the Local Midwifery and Neonatal System (LMNS) continues about how trusts will provide assurance against this plan.
- Year 5 Maternity Incentive Scheme (MIS) has now been submitted.

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 and Innovation	✓

RECOMMENDATIONS

The Board of Directors are asked to receive and note the contents of this report.

APPROVAL PROCESS

Meeting	Date	Approved Y/N
TEG	06.3.2024	Y
Board of Directors	26.3.2024	

[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 Three Year Delivery Plan for Maternity and Neonatal Services 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 January 2024.
- The report can also provide evidence towards year 5 of the NHS Resolution (NHSR) Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS).

As previously discussed, the Three Year Delivery Plan for Maternity and Neonatal Services was published by NHS England on 31st March 2023 with the aim of making maternity care safer, more personalised and equitable, outlined in four high level themes. The Three Year Delivery Plan provides maternity services with one improvement plan with the Integrated Care Board (ICB) responsible for regional assurance. The LMNS collaborative board have confirmed that that the reporting on the Ockenden Immediate and Essential Actions will be replaced by the Three Year Delivery Plan. A regional assurance tool for delivery of the Three Year Plan is now aligned to the Maternity Improvement Plan.

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).

All stillbirth and neonatal deaths are reported through the Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries (MBRRACE) PMRT process.

2.1 PMRT figures

Between 01/01/2023 and 31/01/2023 Jessop Wing reported 3 neonatal deaths (NND) and 5 Stillbirth (SB) to MBRRACE-UK.

Neonatal death

- 2 NND occurred due to extreme prematurity at 21 weeks and 23 weeks.
- 2 NND occurred at 27 and 29 weeks, both babies were transferred into the NNU from another maternity unit.

Stillbirth

- 1 SB occurred at term, the other 4 stillbirths occurred at preterm gestations 26, 27, 31 and 33 weeks.

A desktop review has been completed for the 5 stillbirths in January. All cases will have a full multi-disciplinary review completed as part of PMRT process.

3. MATERNITY AND NEWBORN SAFETY INVESTIGATION (MNSI) AND MATERNITY SERIOUS INCIDENTS (SI'S)

MNSI conducts investigations into all maternal deaths of women while pregnant or within 42 days of birth. All intrapartum stillbirths, early neonatal deaths (0-6 days) born at term and all cases of severe brain injury (HIE) diagnosed within first 7 days of life.

3.1 MNSI investigations

The STH quarterly review meetings continue with the next one planned for April.

3.2 MNSI Investigation active case progress update

We have referred 1 case in January 2024, following further investigations this case was subsequently rejected as the baby had normal brain function and no other clinical concerns.

In total there are now 2 open cases currently being investigated by MNSI. These are progressing well with final reports expected in March 24.

3.3 Coroner's Inquests including Reg 28 made directly to Trust.

There have been no Coroner inquests in January 2024.

3.4 Maternity Serious Incidents/Patient Safety Incident Investigations

There have been no cases reported in January 2024 for Patient Safety Incident Investigation (PSII) under the new Patient Safety Incident Response Framework (PSIRF).

Progress of Serious Incident Investigations

- 2 Serious Incident investigations from December 2023 are in progress at time of the report writing.

3.5 Maternity Serious Incident Investigation Trajectory

Serious Incident Status

The table below shows that there are 2 open Serious Incident investigations.

New Serious Incidents reported in month	**0**
Serious Incidents closed in month (*SIG approved subject to minor amends*)	**1**
Incidents in progress (*includes new Sis reported within the month*)	**2**
Out of internal reporting deadline	**0**
Out of external reporting deadline for ICB	**0**
Incidents with external deadline extensions.	**0**

3.6 Overview of Incidents reported in January 2024.

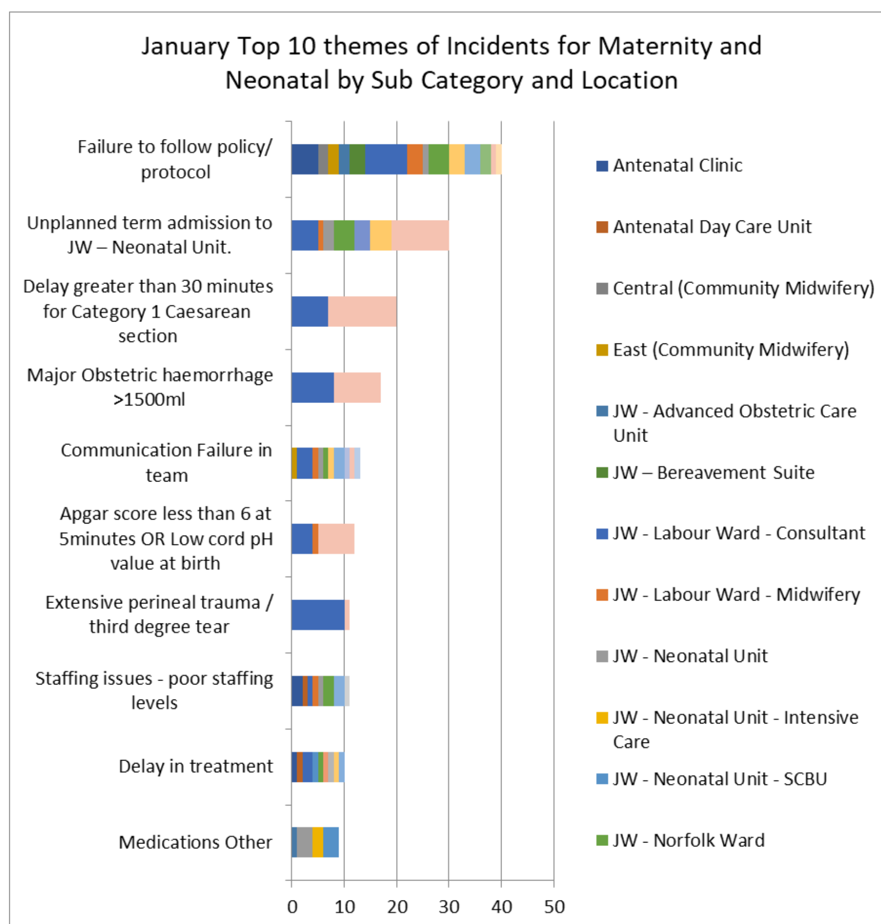
- 272 maternity and neonatal incidents were reported through the Datix incident reporting system during January 2024.

- Failure to follow policy features at the top with 40 incidents. The themes are broad and spread across all areas. Work is currently ongoing to add further assessment boxes to the Datix reporting system to enable more granular analysis. One theme that was noted in January is failure to follow policy relating to Venous Thrombo Embolism (VTE) risk assessment. Following some VTE cases reported in the last quarter of 2023/24 a spot check had already been completed. This is being followed up with a multi-disciplinary team review to update actions and share learning.

- Delay >30 minutes to perform Category 1 Caesarean Section was reported 20 times (22 December). The rate of Postpartum Haemorrhage >1500mls remains stable at 17 when compared to previous months (December 12, November 16).

- Labour Ward areas saw the highest number of incidents reported from all areas at 157 an increase on last month (114) but similar to previous months (November 177, October 151). This is spread across Labour Ward Consultant led, Midwifery Led, Advanced Obstetric Care Unit, Maternity Assessment Unit and Obstetric Theatres.

Incidents reported by location, type and category January 2024



3.7 Actions being taken to address issues arising from Serious Incidents

As previously discussed it has been agreed with the ICB that outstanding actions from historical Serious Incidents and HSIB cases can be revised into a thematic action plan to ensure focussed learning and improvement.

3.8 Incident Grading of Harm / Impact –for all incidents reported in January 2023

Row Labels	1 No Harm / Impact	2 Low Harm / Impact	3 Moderate Harm / Impact	4 Severe Harm/ Impact	2 Catastrophic	Total
January 23	66	186	20	0	0	272

Moderate Harm Incidents by subcategory

There were 20 incidents falling into 4 subcategories, an increase from previous month (10) but similar to previous months (November 22)

Moderate Harm Incidents by Subcategory January 2023	Total
Unplanned Term Admission to NNU	9
Stillbirth/NND	8
Apgar less than 6 at 5 minutes	2
Unplanned transfer to ITU	1
Total	20

Incident themes and actions 2023/24

Themes and actions arising from incidents are usually discussed here quarterly, however in Quarter 3 whilst there have been 3 serious incidents reported, these are very varied in nature and presentation and the completed reports demonstrate appropriate care and management was provided.

With the introduction of PSIRF this section will feature themes and actions following incidents occurring as part of the maternity patient safety profile.

4. TRAINING DATA – January 2024

Training compliance for Trust mandatory training remains under the 90% threshold. A training safety action and a non-compliance report continues to be shared with the senior midwifery team and the clinical director. The audience for Safeguarding Adults level 3 has now been agreed and figures will be reported from next month.

Mandatory training maternity services January 2023	Compliance 90%	Change from previous month
Conflict Resolution - Level 1	88.4%	-1.8%
Data Security and IG - Level 1	82.7%	-2.2%
Equality & Diversity: General Awareness - Level 1	92.5%	0.9%
Fire Safety Theory - Level 1b	83.7%	-0.9%
Health, Safety & Welfare - Level 1	94.8%	-0.4%
Infection Prevention and Control - Level 2	81.9%	+0.8%

Moving and Handling - Level 1 (4 Yearly)	94.6%	1%
Moving and Handling - Level 2b (1 Yearly)	78.3%	-1.1%
Adult Basic Life Support - Level 2a	59.2%	+6.1%
Neonatal Life Support - Level 2c	74.9%	-8.2
Safeguarding Children & Young People - Level 1	95.5%	+0.8%
Safeguarding Children & Young People - Level 2	90%	+12.6%
Safeguarding Children & Young People - Level 3	82.6%	+8.8%
Safeguarding Vulnerable Adults - Level 2	75%	-25%
Safeguarding Vulnerable Adults - Level 3	on	hold
Mental Capacity Act - Level 2a	88.8%	-1.3%
Deprivation of liberty-level 2b	88.6%	-6.5%
Total MT compliance	83.7%	-2.2%

Maternity specific and CNST reportable	Compliance 90%	Change from previous month
Obstetric Emergency Drills (PROMPT)	82.5%	+1.5%
Fetal Monitoring	75.2%	-0.6%
Total Compliance	78.9%	+0.5%

5. JESSOP WING - MATERNITY DASHBOARD (January 23 – January 24)

The Jessop Wing Maternity Dashboard (Appendix 2) reflects data agreed regionally and nationally to assess the Trusts progress against various quality indicators. Data is validated monthly at the Obstetric Gynaecology and Neonatology Directorate Governance meeting. A revised dataset in Statistical Process Control (SPC) format with key Maternity and Neonatal safety data is also included (Appendix 3).

The SPC chart (Appendix 3) shows a sharp increase in the stillbirth rate in January however as discussed previously for the year 2023 there was an overall reduction in the stillbirth rate to 3.76 per 1000 compared to 2022 (5.43 per 1000).

Induction of labour (IOL) statistics are now included in the dashboard. All IOL are RAG rated according to clinical need, each RAG rating has a recommended timeframe for when IOL should have commenced. The compliance percentage relates to the number of women who were induced within the recommended time frame. The data has limitations and is reliant on manual and timely completion by clinicians. A more robust data capture has already been detailed for inclusion in the Maternity Electronic Patient Record and will provide improved oversight and assurance of induction waiting times.

6. NHS RESOLUTION (NHSR)

6.1 Maternity Incentive Scheme (MIS)

Year 5 MIS 10 maternity safety actions have been submitted. There is on-going work around the 10 safety actions in preparation for year 6.

7. 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 and non-executive board members who are the named Maternity & Neonatal Safety Champions.

The next Safety Champion meeting will take place on 1st March 2024

7.1 Learning from Incidents, Complaints and Claims

Learning from significant events continues to be disseminated through multiple formats to facilitate the widest dissemination of information across the services and disciplines.

Recently there has been focused learning on how to deal with a suspected baby abduction. This occurred following a live baby abduction drill designed to test our processes and also the understanding and response of staff. The drill demonstrated areas for learning including how a suspected baby abduction is communicated. As a result, action cards have been updated and staff made aware of how these are accessed. The exact language needed to communicate a suspected abduction to switchboard and ensure an appropriate level of escalation has also been shared with all staff. Learning from the event was disseminated through safety huddles, a Safety Message of the Week email alert and through social media. A follow up drill is planned to ensure learning has been embedded.

8. WORKFORCE

8.1 Midwifery Workforce

There continue to be vacancies in the midwifery workforce with lower fill rates impacting all areas. As discussed before the incentive rate for midwifery staff has been agreed to continue until end of March 2024, after this it will then be reviewed. Admissions to the Neonatal Unit are considered alongside available staffing and support from the regional networks.

As discussed previously actions remain in place to maximise staffing into critical functions to maintain safe care for the women and their babies and night shifts being prioritised. The fill rate data does not reflect unprecedented short term increases in activity and acuity when additional staff are required as part of escalation.

Jessop Wing Fill Rates						
	November		December		January	
	Day	Night	Day	Night	Day	Night
Labour Suite	100.3%	96.2%	105.5%	101.%	103.9%	104%
Rivelin	93.8%	84.1%	90.5%	95%	91.7%	97.1%
Norfolk	105.7%	96.4%	104.5%	96.9%	108.8%	98.2%
Whirlow	99.5%	90.4%	101%	95.9%	95.4%	90.7%
NICU	89.5%	84.5%	86%	86.9%	92%	88.6%

* 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.

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 updated version of the Ward Acuity App for the antenatal ward (Rivelin) and the Postnatal wards (Whirlow and Norfolk) is now operational.

8.2 Obstetric Workforce

Consultant cover is being proactively managed with locum cover and fixed term consultant cover. This is whilst the full requirements of the consultant posts are being finalised.

At Registrar level there is a current gap of 1.4 WTE, any gaps in the obstetric rota are being managed proactively to maintain safe staffing levels.

8.3 Neonatal Workforce

The neonatal unit (NNU) team continues to work toward compliance with the British Association of Perinatal Medicine (BAPM) standards for nursing. As discussed previously the Neonatal Operational Delivery Network (ODN) completed a workforce review which showed deficits in the nurse staffing skill mix. Agency nurses continue to support the staffing challenges, there is a plan in place to increase the number of Qualified in Specialty (QIS) nurses. In addition ICU bed capacity continues to be flexed in the short term to ensure that cots are safely staffed.

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

The Maternity Service continues to actively work with the Sheffield Maternity Voices Partnership (MVP) on a variety of projects. To reflect the ambitions in the Three Year Delivery plan the MVP have now changed their name to Maternity and Neonatal Voices Partnership (MNVP)

The NHS Maternity survey was released in February and work is underway with the MNVP to focus on key areas of improvement. In 2023 there has been an increase in average positives scores when compared to previous years, this positive score change ranks the Jessop Wing as 25 out of the 65 NHS Trusts taking part in the NHS Maternity Survey (previous year 55/65) and the 8th most improved maternity unit when compared with other Trusts. The areas for improvement will focus on induction of labour, information and support around emotional and mental health and availability of support from partner post birth.

An online MNVP meeting took place on 21st February members of the maternity team and the non-executive safety champion attended. There was discussion around 2023 highlights and a look ahead to the priorities for 2024. Feedback from the Firvale community was also presented including a father's experience of neonatal care.

10. CARE QUALITY COMMISSION (CQC)

The CQC 'must do' and 'should do' actions from the 2022 inspection are included within the maternity improvement programme.

10.1 CQC escalations

There were no CQC escalations received in January 2024.

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

As discussed previously the LMNS have confirmed that Ockenden is part of the three year single delivery plan and will not require separate reporting.

An LMNS assurance took place visit on the 6th February 2024 to review progress towards achieving the 12 objectives within the three year single delivery plan. There was positive feedback on the day with the ICB recognising the considerable work that has taken place over the year. A full report is expected in March 24 and will be reported here. This will then take the place of Ockenden compliance reporting.

As discussed previously the current Ockenden position is outlined below with amber areas relating to limitations with providing evidence and completing audit due to the lack of an end to end electronic maternity system.

August 2023 position

STH

August 2023	i	ii	iii	iv	v	vi	vii	viii
1) Enhanced Safety								
2) Listening to women and families								
3) Staff training and MDT working								
4) Managing complex pregnancy								
5) Risk assessment throughout pregnancy								
6) Monitoring								
7) Informed consent								
Workforce								
Guidelines								

IEA 1 (iv) - Amber not green due to a backlog of cases.
IEA 4 (ii) - Amber due to audit / ability to evidence.
IEA 5 (1) - Ability to audit limited due to MIS, manual audits underway to mitigate but doesn't allow for full assurance. MIS launce October 2024.
IEA 6 (iii) - Remains amber due to ability to audit and provide evidence.
IEA 7 - Website now in place with updated information to support choice, focussed and coproduced PCSP available with limited ability to audit (and demonstrate impact)
Workforce - BR+ funded establishment agreed, senior leadership substantive.
Guidelines - robust process to benchmark against national guidance, guidelines tracked, 35/108 still out of date (backlog review) working through review. 5 through governance this month.

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

12.1 The National Ambition

In August 2017 NHS Improvement distributed 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.

12.2 Jessop Wing Transitional Care

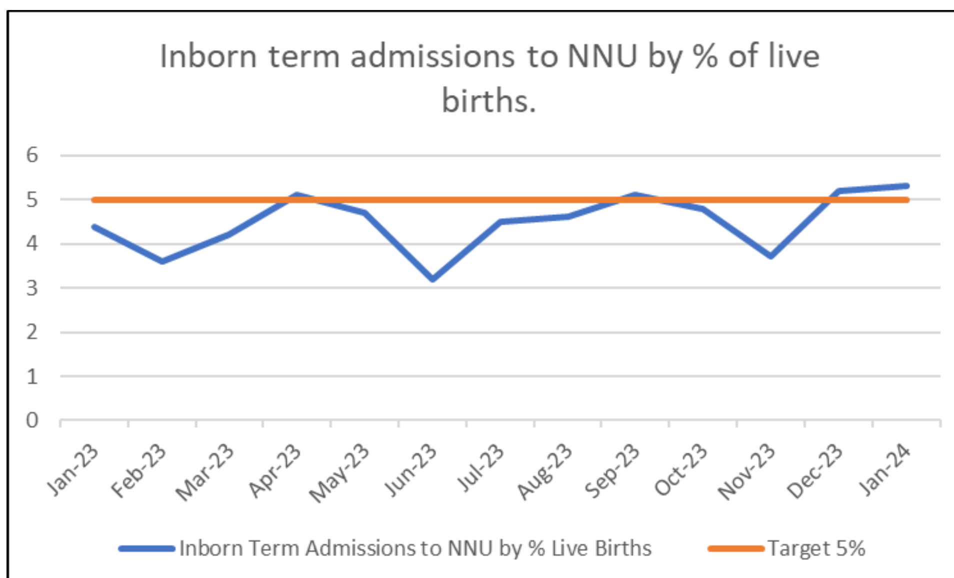
A weekly review of all term admissions is undertaken by the ATAIN team. Collated data is submitted monthly onto the electronic South Yorkshire and Bassetlaw (SYB) Local Maternity and Neonatal System (LMNS) ATAIN Quality Improvement dashboard. Actions are developed and agreed to address any themes highlighted. The action plan triangulates with actions and themes via other governance routes; Quality & Safety Meeting, MNSI, SI reports, CQC recommendations for term admissions. The National aim is to maintain <6% and the LMNS aim is <5% for the year

For January 2024 the term admission rate to the Neonatal Unit was 5.3%.

Of the 27 term admissions 1 was reviewed via Patient Safety Review and 1 was referred to HSIB and subsequently rejected. 7 were assessed as avoidable/potentially avoidable.

ATAIN action plans are reviewed quarterly and presented at Safety Champions Meeting.

Year 2023 – 2024 ATAIN data



13. NHS ENGLAND PERINATAL CULTURE AND LEADERSHIP PROGRAMME

This programme is built around the perinatal quadrumvirate, or ‘quad’, group of senior leaders (The Midwifery Director, Operations Director, Clinical Director and Neonatal Clinical Lead) with the aim of nurturing a positive safety culture, enabling psychologically safe working environments and building compassionate leadership to make work a better place to be and is included in the requirements for CNST Year 5.

As previously discussed, actions from this survey will be amalgamated with the 2023 Trust staff survey on its release to provide Board oversight of the outputs and actions and to ensure alignment of improvement activities.

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. Staffing pressures continue. Actions to address midwifery staffing continue with overtime incentive payments continuing and a proactive recruitment and retention plan.
b. A Maternity specific information system is due to be launched in October 2024 the absence of an appropriate information system has been identified as a barrier to progressing improvements. A full paper-based end to end maternity record (handheld record) is in place, this will facilitate a complete pregnancy history for clinicians to risk assess and plan care safely.
c. Three Year Delivery Plan for Maternity and Neonatal Services has been published and the first assurance visit took place in February.
d. Training compliance is still below 90% a plan is in place to improve attendance, with a particular focus on Obstetric Emergency Drills (PROMPT) and Fetal Monitoring, however staffing challenges have continued.

APPENDIX 1

Trust: Sheffield Teaching Hospitals NHS Foundation Trust 2023/24

CQC Maternity Ratings 2022	**Overall**	**Safe**	**Effective**	**Caring**	**Well-Led**	**Responsive**
	Select Rating:	Select Rating:	Select Rating:	Select Rating:	Select Rating:	Select Rating:
Jessop Wing	Requires improvement	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement

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

	April	**May**	**June**	**July**	**August**	**September**	**October**	**November**	**December**	**January**		
1.Findings of review of all perinatal deaths using the real time data monitoring tool	Section 2	Section 2	Section 2	Section 2	Section 2	Section 2	Section 2	Section 2	Section 2	Section 2		
2. Findings of review of all cases eligible for referral to HSIB	Section 3.1	Section 3.1	Section 3.1	Section 3.1	Section 3.1	Section 3.1	Section 3.1	Section 3.1	Section 3.1	Section 3.1		
Report on: 2a. The number of incidents logged graded as moderate or above and what actions are being taken	Section 3.6	Section 3.6	Section 3.6	Section 3.6	Section 3.6	Section 3.6	Section 3.6	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	Section 5	Section 5	Section 5	Section 5	Section 5	Section 5	Section 5	Section 5	Section 5	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	Section 9	Section 9	Section 9	Section 9	Section 9	Section 9	Section 9	Section 9	Section 9	Section 9		
3.Service User Voice Feedback	Section 10	Section 10	Section 10	Section 10	Section 10	Section 10	Section 10	Section 10	Section 10	Section 10		
4.Staff feedback from frontline champion and walk-abouts	Section 7	Section 7	Section 7	Section 7	Section 7	Section 7	Section 7	Section 7	Section 7	Section 7		
5.HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	None	None	None	None	None	None	None	None	None	None		
6.Coroner Reg 28 made directly to Trust	None	None	None	None	None	None	None	None	None	None		
7.Progress in achievement of CNST 10	Year 4 submitted	Section 6	Section 6	Section 6	Section 6	Section 6	Section 6	Section 6	Section 6	Section 6		

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 specialty 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

Jessop Wing – Maternity Dashboard

APPENDIX 2

Antenatal	Green	Amber	Red	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24
Community First Visits				560	654	517	562	604	524	519	531	556	543	459	638
Community First Visits Within 10 Weeks %	$n \geq 90$	$75 \leq n < 90$	$n < 75$	72.86	71.56	70.6	71.89	75.33	72.14	76.3	74.76	72.48	75.69	70.59	71.47
Smokers at Community First Visit %	$n \leq 6$			7.5	7.95	9.09	7.3	7.62	9.16	8.29	8.1	8.99	5.71	6.32	5.33
Clinic First Visits				473	604	486	555	519	512	526	471	503	498	455	529
Clinic First Visits Under 13 Weeks %				65.12	65.89	60.91	61.62	64.16	65.04	61.79	60.3	57.46	57.83	58.46	54.82
Clinic First Visits Smoker %	$n \leq 6$			8.03	8.44	11.32	9.01	5.97	8.01	9.32	7.64	7.75	9.24	1.98	0
Clinic First Visits CO Measured %				72.73	81.95	85.8	86.67	76.69	81.05	64.64	77.28	79.52	87.35	25.49	0
Clinic First Visits CO ≥ 4ppm				9.01	5.45	6.71	7.28	6.03	5.78	10.59	7.69	5.5	5.98	2.59	
Community 36 Week Visits CO Measured %				65.4	79.21	84.08	82.04	82.79	85.42	89.16	84.64	85.21	86.88	86.32	93.27
Community 36 Week Visits CO ≥ 4ppm				11.17	10.99	10	8.5	11.88	10.8	11.62	9.85	8.53	8.05	9.9	6.96
CO reduced below 4ppm by 36 weeks %				35.29	33.33	35	18.75	10	33.33	26.32	7.69	15.79	22.22	54.55	37.5

Deliveries	Green	Amber	Red	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24
Total Deliveries (mothers)				409	480	407	483	462	443	494	495	475	488	450	508
Registerable Births				413	480	413	492	467	444	501	497	485	486	459	513
Elective C Section Deliveries %				20.05	19.38	17.44	18.01	18.83	19.41	18.42	17.17	19.58	18.85	18.44	18.9
Emergency C Section Deliveries %				25.92	23.54	20.15	25.05	20.56	23.93	26.52	28.69	32	25	24.44	25.79
Assisted Deliveries %				7.33	10	11.79	13.46	12.12	11.06	11.13	13.33	9.26	9.84	11.56	13.58
Inductions %				31.78	31.25	29.48	29.61	26.41	31.6	25.51	22.83	23.58	28.89	28.89	28.35
IOL Red - On Target				86.67	81.82	61.54	50	75	33.33	45.45	80	84.62	60	100	61.54
IOL Amber - On Target				87.93	84.06	84.62	75.61	73.75	80.6	81.33	78.21	71.95	77.65	83.93	88.75
IOL Green - On Target				89.55	95.52	94.55	90.74	90.48	93.51	93.22	80.95	81.03	92.42	84.48	95.16
IOL Not Risk Assessed				20.9	20.11	25	20.43	23.65	14.75	22.04	21.76	11.56	19.9	32	22.89
Waterbirths				15	11	12	15	17	9	14	21	5	9	7	8
Homebirths				2	2	5	7	5	7	3	3	5	5	2	6
Born Before Arrival (BBA)				2	5	3	5	3	1	5	6	2	3	2	3
APGAR 0-6 %				2.87	2.53	2.75	2.73	3.09	3.67	3.3	3.53	21	3.15	1.73	2.97
Low birthweight (≤ 2500g) %				6.54	10.62	10.17	9.96	8.57	9.23	7.39	9.05	10.93	6.38	9.59	10.33
Under 3rd Centile delivered at 38wks+ %					55.56	0	11.11	77.78	27.27	60	57.14	30	40	50	59.09
Singleton Livebirths < 30wks with $MgSO_4$ %				60	71.43	50	75	100	100	66.67	87.5	100	100	100	66.67
Preterm births %				5.21	6.25	9	6.2	6.86	5.34	6.4	7.36	6.49	5.93	7.55	5.24
Singleton births 16w - 23+6 %				0.25	1.48	0.75	0.42	0.66	0.69	0.21	1.02	0.22	2.49	0.46	0.4

Singleton births 24w - 36+6 %				4.95	6.55	8.71	6.75	6.81	5.72	6.37	6.91	6.68	5.2	7.52	5.96
PPH ≥ 1500ml %	$n < 3$	$3 \leq n \leq 5$	$n > 5$	2.69	5.7	2.95	4.99	4.78	4.1	3.04	2.43	5.27	4.38	4.01	3.94
3rd and 4th degree tears (all) %				0.95	5.2	4.27	4.63	2.32	3.42	4.31	3.7	2.28	7.06	2.07	5.32
3rd and 4th degree tears (Normal) %	$n < 3$	$3 \leq n \leq 4$	$n > 4$	0.55	4.85	4.19	3.98	1.44	2.12	3.92	3.83	1.69	5.21	1.59	4.57
3rd and 4th degree tears (Assisted) %	$n < 5$	$5 \leq n \leq 9$	$n > 9$	3.45	6.82	4.65	6.9	5.88	8.89	5.88	3.33	4.88	15.91	3.85	7.58
Smokers At Delivery %	$n \leq 6$			9.05	7.17	9.58	8.52	10	6.38	8.7	6.48	6.96	6.26	8.24	5.71
First Feed Breastmilk %	$n \geq 75$	$70 \leq n < 75$	$n < 70$	72.57	70.71	69.34	71.11	71.34	68.25	71.49	70.91	71.22	72.63	69.87	70.22
Robson Group 1 having LSCS %				32.76	18.18	13.51	22.37	16.67	22.22	26.09	35.16	28.57	29.29	21.52	29.9
Robson Group 2 having LSCS %				63.64	60.19	57.97	59.05	65.38	67.78	67.71	67.01	73.33	63	57.95	63.48
Robson Group 5 having LSCS %				87.14	81.33	80.88	78.26	74.68	78.31	79.52	75.31	81.16	90.91	80.56	77.65
VBAC (Local) %				12.99	20.69	19.75	19.77	26.74	19.39	20.41	22.22	18.18	12.2	17.72	23.23
VBAC (NHSD) %				7.69	14.58	20	17.78	30.77	20	11.76	14.81	18.18	15.79	21.74	20

Neonatal

Neonatal	Green	Amber	Red	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24
Neonatal Unit Admissions				28	43	43	45	35	42	41	61	51	33	42	43
Neonatal Unit Admissions %				6.8	9	10.46	9.22	7.54	9.52	8.23	12.32	10.56	6.79	9.17	8.48
Neonatal Unit Admissions at Term				16	21	19	23	17	21	22	32	24	16	23	27
Neonatal Unit Admissions at Term %				3.88	4.39	4.62	4.71	3.66	4.76	4.42	6.46	4.97	3.29	5.02	5.33

Mortality

Mortality	Green	Amber	Red	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24
Stillbirths				1	2	2	4	3	3	3	2	2	0	1	6
Stillbirths ‰ (per thousand)				2.42	4.17	4.84	8.13	6.42	6.76	5.99	4.02	4.12	0	2.18	11.7
Stillbirths at Term				1	0	0	1	0	1	2	0	0	0	0	1
Stillbirths at Term ‰ (per thousand)				2.42	0	0	2.03	0	2.25	3.99	0	0	0	0	1.95
Feticide (Stillbirth)				0	1	0	2	1	0	1	0	2	0	0	1
Stillbirths excluding feticide ‰ (per thousand)				2.42	2.08	4.84	4.07	4.28	6.76	3.99	4.02	0	0	2.18	9.75
Neonatal Deaths				1	2	7	4	0	3	2	3	0	3	3	
Neonatal Deaths ‰ (per thousand)	$n \leq 1.45$			2.43	4.18	17.03	8.2	0	6.8	4.02	6.06	0	6.17	6.55	
Neonatal Deaths ≥ 24 weeks				0	1	2	4	0	3	1	0	0	1	2	
Neonatal Deaths ≥ 24 weeks ‰ (per thousand)				0	2.09	4.87	8.2	0	6.8	2.01	0	0	2.06	4.37	

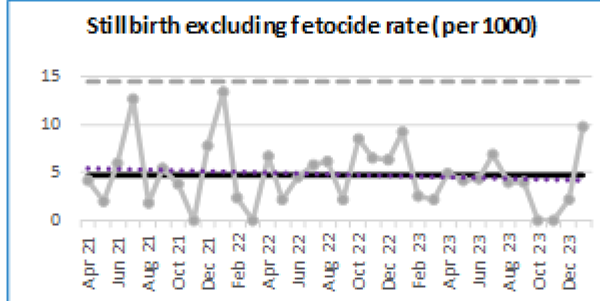
Neonatal Deaths at Term				0	0	0	1	0	1	1	0	0	0	0
Neonatal Deaths at Term ‰ (per thousand)				0	0	0	2.05	0	2.27	2.01	0	0	0	0

LW Assessment	Green	Amber	Red	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24
Calls to Triage Service				2459	2938	2730	2911	2799	3181	3202	3132	3116	2946	2618	3218
LWAU Admissions				961	1168	1088	1214	1168	1245	1351	1322	1293	1191	1124	1328
LWAU Rapid Reviews %	$n \geq 95$	$80 \leq n < 95$	$n < 80$	96.57	97.69	97.61	97.94	97.09	97.27	98.52	97.96	96.67	97.48	96.89	98.12
LWAU Rapid Review Time (mins)	$n \leq 15$	$15 < n \leq 30$	$n > 30$	14	18	15	15	15	22	20	21	19	19	18	19

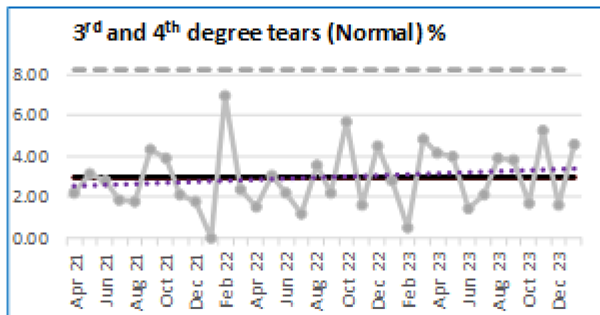
Other	Green	Amber	Red	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24
Readmissions				8	14	17	19	17	25	26	20	16	20	21	

Maternity overview | STH NHS FT Jessop Wing

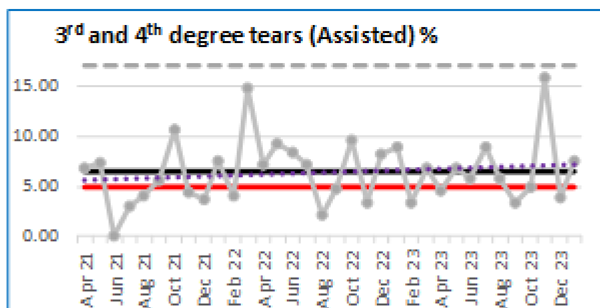
Latest month	01/01/24
Stillbirth excluding fetocide rate (per 1000)	9.75



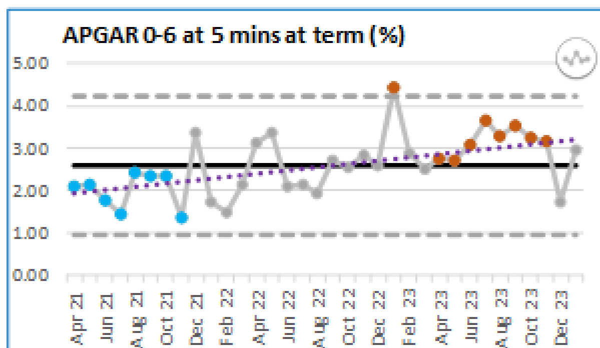
Latest month	01/01/24
3rd and 4th degree tears (Normal) %	4.57

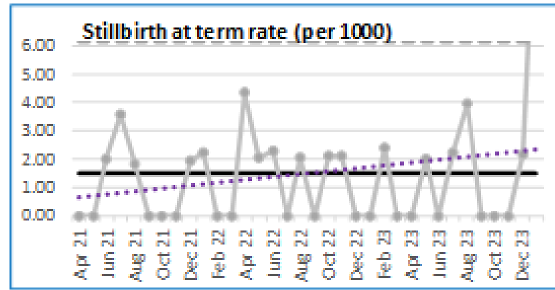


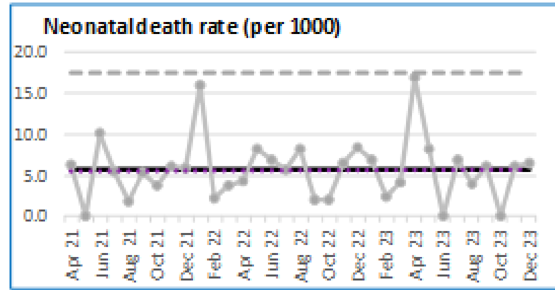
Latest month	01/01/24
3rd and 4th degree tears (Assisted) %	7.58

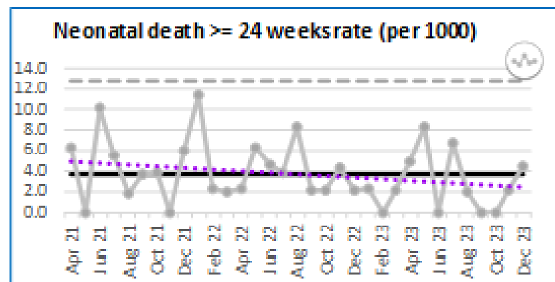


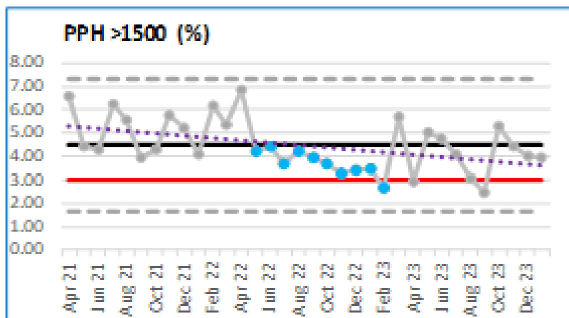
Latest month	01/01/24
APGAR 0-6 at 5 mins at term (%)	3.0



Latest month	01/01/24	
Stillbirth at term rate (per 1000)	11.7	

Latest month	01/12/23	
Neonatal Death rate/1000	6.6	

Latest month	01/12/23	
Neonatal death >= 24 weeks rate (per 1000)	4.4	

Latest month	01/01/24	
PPH >1500 (%)	3.9	

Latest month	01/01/24	
Term admissions to NNU (%)	5.3