Sheffield Teaching Hospitals
NHS Foundation Trust

Executive Summary Report

to the Board of Directors

Being Held on 28 March 2023

Subject	Maternity & Neonatal Safety Report
Supporting TEG Member	Chris Morley, Chief Nurse
Author	Laura Rumsey, Interim Midwifery Director, Obstetrics, Gynaecology and Neonatology (OGN), Andrea Galimberti, Clinical Director, OGN and Sue Gregory, Operational Director, OGN
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 2023.

The report will provide an oversight position on:

- Perinatal Quality Surveillance Model (PQSM)
- Health Care Safety Investigation Branch (HSIB) investigations
- Serious Incidents (SI)
- Training
- Maternity Dashboard
- 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.

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

- Progress is being made in addressing the Serious Incident (SI) investigation backlog, external maternity governance support continues. A comprehensive tracker has been developed to support timely ongoing reviews.

Improvements

Areas of improvement as highlighted in previous report:

- The Jessop Wing is now rated as 'requires improvement' by the Care Quality Commission (CQC) and a revised action plan has been embedded into the maternity improvement programme. With work commencing in Q4
- Considerable improvement has been made in resolving the backlog of Serious Incidents with the number of open SI's now at 17.
- 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 2021/22 quarter 3 position is 3.7%

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.
- Staff retention plan is being implemented to support staff to stay and grow. Pastoral support lead is supporting early career midwives, internationally recruited midwives and Maternity Support Workers (MSW).
- PMRT backlog continues to progress with reports fortnightly to triumvirate.
- SI tracker utilised to develop timely completion of SI reports alongside a process agreed for current PMRT reports.
- Birmingham Specific Obstetric Triage System (BSOTS) is now embedded on labour ward, work is on-going to improve the timeliness of the 1st assessment when women arrive in triage.

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 Trust Executive Group are asked to receive and discuss the content of the report.

APPROVAL PROCESS

Meeting	**Date**	**Approved Y/N**
TEG	8th March 2023	Y
Board of Directors	28th March 2023	

[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 January 2023.
- The report can also provide evidence to future iterations of the NHS Resolution (NHSR) Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS).

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 MBRRACE PMRT process.

As discussed previously the primary focus for the service currently is to clear the outstanding serious incident (SI) investigation caseload. Reporting of the Perinatal Mortality Review Tool (PMRT) will continue to focus on the current cases rather than providing detail on the historic backlogs, which continue to be managed. The PMRT workplan to address the historical backlog continues with progress managed by a weekly task and finish group.

Current PMRT cases - May 6th until present day

Cases are presented and discussed weekly at a multi-professional PMRT meeting which includes external clinicians. All women are being contacted once the final report is published and given the option of receiving the report. When the case is also an SI sharing of the PMRT report occurs after or at the same time as the SI depending on individual cases.

2.1 PMRT figures

Between 01/01/2023 and 31/01/2023 Jessop Wing reported 4 stillbirths and 4 neonatal deaths to MBRRACE-UK.

- All 4 stillbirths occurred at preterm gestations of 24 and 25 weeks.

- The neonatal deaths included a baby born at 22 weeks, an intrauterine (IUT) from Doncaster at 24 weeks gestation and an extrauterine transfer (EUT) from Chesterfield died at 26 weeks. In addition, 1 baby died at 10 weeks and 3 days on the NNU this is reported for monitoring purposes only as it falls outside the 28 days PMRT criteria. Best practice recommendations are to review deaths even though they fall outside of the outside of the reporting timeframe.

- No maternal deaths have been reported to MBRRACE

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

HSIB 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.

The scheduled launch of the new Maternity and Newborn Safety Investigations Special Health Authority (MNSI) as a separate body to HSIB which was discussed in last month's board report has now been delayed until October 2023. HSIB investigations will continue as normal.

3.1 HSIB investigations

Themes and trends relating to all HSIB investigations are shared at STH quarterly review meetings, the next meeting is scheduled for 31st March 2023 and finding will be detailed in the relevant board report.

3.2 HSIB Investigation active case progress update

There have been no new referrals to HSIB for the month of January 2023.

The draft final investigation report for MI-014145 has been received by the Trust. There were 3 safety recommendations, actions and learning had already commenced and progress will be monitored as part of the Safety and Quality framework.

As previously reported the Jessop Wing declared compliance with NHS Resolution Maternity Incentive Scheme (MIS) Safety Action 10, HSIB reporting standards.

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

An inquest held on the 10th January 2023 gave a short form conclusion of natural causes. An update is awaited from HMC.

3.4 Maternity Serious Incidents

As discussed above, Serious Incidents are being prioritised through January-March 2023 with a focus on clearing the outstanding back log by 31st March 2023.

7 incidents were reported to the Trust Serious Incident Group (SIG) in January 2023, 5 of the incidents were reported via Datix in December 2022 and presented to SIG in January 2023. All incidents have been notified to the Integrated Care Board (ICB) and are being investigated within the department.

Serious Incidents continue to be reported to the South Yorkshire and Bassetlaw (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 Reported December 2022 and Presented to SIG January 2023

ID	STEIS Ref	Incident Description
W292339	2022/27604	Maternal death 8 months post birth. Reported to Trust by MBRRACE-UK following a scoping exercise. Does not meet HSIB reporting criteria.
W292743	2023/69	Unexpected admission to the neonatal unit of a baby born at 40+5 weeks gestation with suspected

		meconium aspiration and sepsis.
W293969	2023/112	Spontaneous live birth of a baby at 22+6 weeks gestation on the antenatal ward. Neonatal resuscitation was attempted but was unsuccessful.
W294536	2023/404	Neonatal death of baby born at home at 20 weeks gestation. Prior to birth the mother had been discharged from the Labour Ward Assessment Unit.
W294746	2023/366	Baby received overdose of Dopamine on the Neonatal Intensive Care Unit

Serious Incident Investigations Reported and Presented to SIG January 2023

ID	STEIS Ref	Incident Description
W295903	2023/1953	Following an emergency caesarean section for an antepartum haemorrhage at 24 weeks gestation a baby was sadly born showing no signs of life.
W297005	2022/2587	Following induction of labour at 39 weeks gestation a woman had received an overdose of Terbutaline (used to reduce the strength and frequency of contractions). An emergency caesarean section was performed, and a baby was born in good condition. The woman was admitted to Advanced Obstetric Care Unit for additional monitoring

Progress of Serious Incident Investigations

- 17 Serious Incident investigations in progress at time of the report writing.
- 4/17 awaiting final approval from SIG
- 8 reports have been approved by SIG in January 2023.
- A request to remove 1 case from STEIS has been made to the ICB following review of the Serious Incident investigation report by the Serious Incident Group. The report reviewed the care provided to a postnatal woman who was admitted to ICU following the unexpected, delayed awakening from general anaesthesia following caesarean section. The findings of the report concluded the standard of care was in line with Trust and national guidance and recommendations and there were no omissions in care were identified.

3.5 Maternity Serious Incident Investigation Trajectory

The table below shows the trajectory for the completion and final approval of the open Serious Incident investigations.

Weekly meetings, with representation from Maternity and Trust Patient Safety representatives are scheduled with the Quality Director, to discuss progress of the investigations and identify areas where additional support is required.

Serious Incident Status

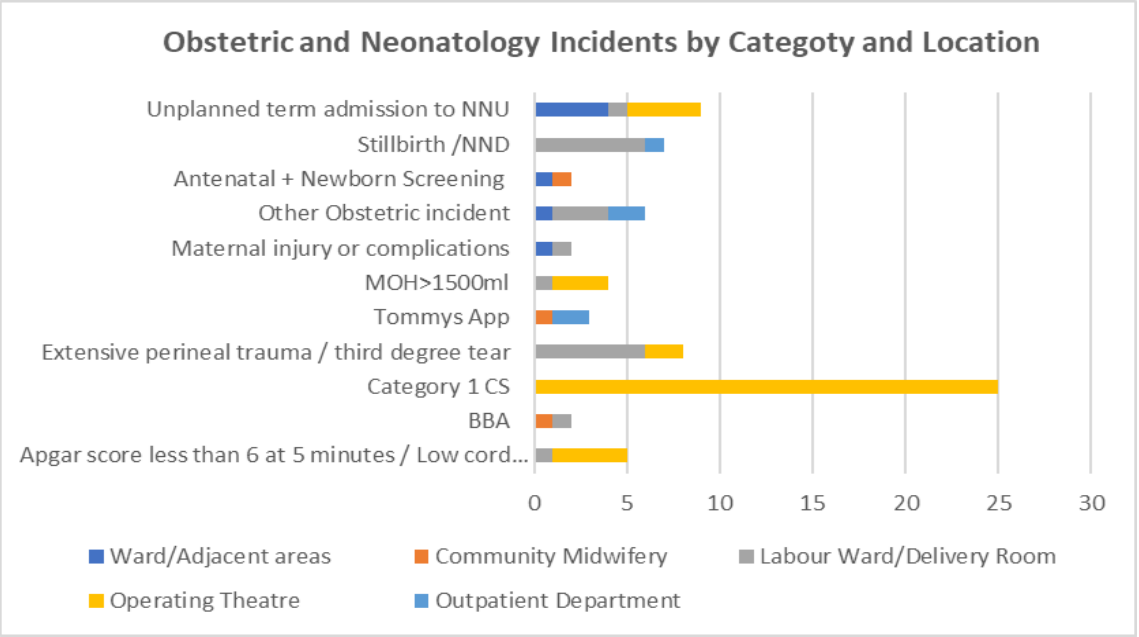
The table below shows that there are 17 open Serious Incident investigations.

New Serious Incidents reported in month	**2**

Serious Incidents closed in month (*SIG approved subject to minor amends*)	**8**
Incidents in progress (*includes new Sis reported within the month*)	**17**
Out of internal reporting deadline	**11**
Out of external reporting deadline for ICB	**9**
Incidents with external deadline extensions.	**9**
Incidents closed by ICB	**0**

3.6 Overview of Incidents reported in January 2023

216 maternity incidents were reported through the Datix incident reporting system during January 2023. Jessop Wing maternity theatres remains the highest reporting area with 74 incidents reported, this is an increase from 58 last month. Labour Ward reported 58 incidents (static) and combined maternity antenatal and postnatal wards 29 incidents.



73 pregnancy and birth incidents were reported under the obstetric neonatal category in January 2023, a reduction from 108 in December 2022.

- Category 1 caesarean section (time critical) remains the top reported incident (25) and as reported last month this is reported for monitoring and audit purposes. This is a decrease from 39 reported incidents in December 2022
- The incidence of Major Obstetric Haemorrhage (MOH) has reduced to 4 compared to 15 in December 2022. This follows a sustained reduction in MOH since introduction of initiatives that include risk assessment of women in labour and responsive management when haemorrhage is first identified.

3.7 Incident Grading of Harm / Impact –for all incidents reported in January 2022

Row Labels	1 No Harm / Impact	2 Low Harm / Impact	3 Moderate Harm / Impact	4 Severe Harm/ Impact	Total
January 2023	51	143	18	4	216

Severe Harm Incidents

- 4 Severe harm incidents were reported for January 23
- A postnatal woman experienced an epileptic seizure and sustained a fractured skull following a fall to the floor. The woman was transferred to ICU where she received care from obstetric and neurology teams. The incident is being reviewed as part of the falls investigation pathway.
- The remaining 3 severe harm incident reports relate to the two serious incidents reported at section 3.4. To note there were 2 incident reports raised in relation to one of those cases.

Moderate Harm Incidents by Type

Moderate Harm Incidents by Type January 2023	Patient incident
Delay in treatment	1
Major Obstetric haemorrhage >1500ml	3
Stillbirth /NND	6
Unplanned term admission to JW – Neonatal Unit.	8
Total	18

4. TRAINING DATA – January 2023

Training compliance for Trust mandatory training remains just below the 90% threshold. As previously discussed, work is on-going to ensure eligible staff are appropriately aligned to PALMS modules. Staffing pressures has affected how many staff can be released. To improve the compliance for PROMPT it has been agreed regionally that trainee obstetricians can complete the training in any SYB Trust. This means they will not automatically be non-compliant when they rotate to a different Trust. Once the training dates attended have been verified the training database will be updated. Staff who are non-compliant for fetal monitoring are being targeted. Some of this reduction is due to a change in training delivery with a new 1 day multidisciplinary fetal monitoring training day which started in December.

A non-compliance report continues to be shared with the senior midwifery team and the clinical director.

Mandatory training maternity services January 2023	Compliance 90%	Change from previous month
Conflict Resolution - Level 1	75.7%	-1.8%
Data Security and IG - Level 1	95%	+0.9%
Equality & Diversity: General Awareness - Level 1	97.8%	-0.1%

Fire Safety Theory - Level 1b	93%	+0.3%
Health, Safety & Welfare - Level 1	98.3%	-
Infection Prevention and Control - Level 2	90%	-0.6%
Moving and Handling - Level 1 (4 Yearly)	100.0%	-
Moving and Handling - Level 2b (1 Yearly)	83.7%	+1.1%
Adult Basic Life Support - Level 2a	88.1%	-1.2%
Neonatal Life Support - Level 2c	91.5%	-
Safeguarding Children & Young People - Level 1	87.7%	-3.8%
Safeguarding Children & Young People - Level 2	79.4%	+1%
Safeguarding Children & Young People - Level 3	69.9%	+4.7%
Safeguarding Vulnerable Adults - Level 2	88%	+0.4%
Mental Capacity Act - Level 2a	85.2%	+1.4%
Deprivation of liberty-level 2b	86.6%	+1.2%
Total MT compliance	88.4%	+0.4%

Maternity specific and CNST reportable	**Compliance 90%**	**Change from previous month**
Obstetric Emergency Drills (PROMPT)	86.8%	+0.5%
Fetal Monitoring	83.2%	-3.9%
Total Compliance	85%	-1.7%

5. JESSOP WING - MATERNITY DASHBOARD (July 22-January 23)

The Jessop Wing Maternity Dashboard (Appendix 2) 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 the OGN Directorate Governance meeting.

Data analysis of the low compliance for women being seen by 10 weeks gestation has shown that there are a number of women either presenting late for booking or that community midwives are receiving late notifications. Further analysis is looking at the time it takes a community midwife to respond to a new booking request, with data broken down into teams. Actions aimed at ensuring women present early in pregnancy are to be discussed and agreed with the Maternity Voices Partnership (MVP).

Data for Labour Ward Assessment Unit shows an improved average wait of 16 min for January 2023, as previously discussed the aim is to meet and maintain this standard within 15 minutes.

6. NHS RESOLUTION (NHSR)

6.1 Maternity Incentive Scheme (MIS)

As discussed previously the work to sustain the year 4 standards will continue as part of the maternity improvement plan in readiness for year 5 MIS when it is launched.

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 last Maternity and Neonatal Safety Champion meeting occurred on February 16th 2023, this included a walk around by the executive and non-executive Maternity and Neonatal Safety Champions to allow staff to raise any concerns. There were no immediate concerns raised by staff on duty, staff

were able to recount lessons learnt from a recent incident and commented that sharing of learning was much improved.

In addition, it was noted that the refit of the entrance to the Jessop Wing was underway, and a volunteer was present to greet and help assure and direct mothers and families. Both these issues had previously been identified by the Safety Champions as areas for further improvements.

7.1 Learning from Incidents, Complaints and Claims

Jessop Wing share learning from events in multiple formats to facilitate the widest dissemination of information across the services and disciplines. These include:

- Weekly Patient Safety Learning Newsletter, this includes QR codes for staff feedback and Guideline of the month.
- Safety Huddles undertaken daily and twice daily on intrapartum and antenatal areas where immediate safety learning from incidents is shared.
- Governance team members are allocated to all ward areas and visit to support ward managers in dissemination of learning and feedback. Closing the Loop format shared via closed Multi-Disciplinary Team Face Book page and email.
- Open Triumvirate Briefing meetings to feedback learning from appropriate incidents, complaints, claims and Maternity Improvement Programme progress.

8. WORKFORCE

8.1 Midwifery Workforce

There continue to be vacancies in the midwifery workforce, however, RM and RN fill rates are predominantly greater than 90%. The incentive rate for staff continues to support this.

A number of on-going actions remain in place 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.

Jessop Wing Fill Rates						
	November		December		January	
	Day	Night	Day	Night	Day	Night
Labour Suite	108.3%	94.7%	100.4%	90.6%	102.8%	98.8%
Rivelin	99.3%	93.2%	91%	97.7%	97.7%	99.9%
Norfolk	113.0%	107.0%	106.3%	113.1%	115.5%	106.8%
Whirlow	114.6%	133.7%	112.8%	112.9%	128.5%	141.1%
NICU	90.5%	84.2%	87.6%	86.9%	93.7%	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 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, and/or complaints, with maternity workforce red flags.

Further initiatives to enhance the midwifery workforce have been included in previous monthly updates.

8.2 Obstetric Workforce

Consultants

Gaps:

Number of posts	Reason for gap	Resident Night Rota
2	Phased return – no clinical work or resident nights	Yes
1	Long Term Sick	Yes

Recruitment:

- 4 fixed term Consultants due to commence over next couple of months.

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

Mitigation:

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

8.3 Neonatal Workforce

The neonatal unit (NNU) team continues 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 continues with a number of appointments discussed in previous reports and an action plan.

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

The MVP have been involved in the recruitment of new midwifery posts as part of a stakeholder group. The newly appointed vice chairs have now started and will be visiting the Jessop Wing on February 23rd this is a chance for staff to meet the new vice chairs and start co-producing work priorities.

10. CARE QUALITY COMMISSION (CQC)

The most recent CQC ‘must do’ and ‘should do’ actions have been initiated and prioritised in Q4 as part of the maternity improvement programme.

10.1 CQC escalations

For the month of January 2023 there were no issues raised with the Trust by the CQC regarding maternity services.

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

Following the confirm and challenge in November 2022 the ICB fed back their findings on 2nd February 2023 which are presented in the table below. The format is different to the data previously presented at board, for consistency this format will now be used. Each of the IEA'S below have a number of individual standards which require to be evidenced through audit. The ICB have RAG rated guidelines as red as they were unable to review this aspect during the visit.

Sheffield Teaching Hospitals	i	ii	iii	iv	v	vi	vii	viii
1) Enhanced Safety								
2) Listening to women and families								
3) Staff training & MDT working								
4) Managing complex pregnancy								
5) RA through pregnancy								
6) Monitoring								
7) Informed Consent								
Workforce								
Guidelines								

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. 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.

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 SYB 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, HSIB, SI reports, CQC recommendations for term admissions.

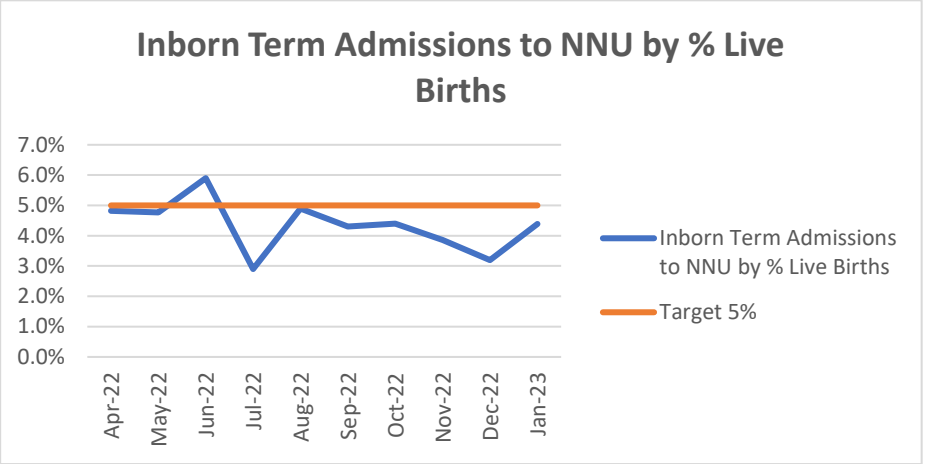
For Q3 the term admission rate was below the SYB LMNS target of <5% at 3.7%. There were 5 themes which form part of an ATAIN action plan. Actions are monitored locally and regionally. Q3 data will be presented at the next safety champions meeting.

For January 2023 the term admission rate to NNU remains below the SY&B LMNS target of 5%.

- Of the 19 term admissions 5 were categorized as potentially avoidable. 1 met the criteria for patient safety review (PSR) and was subsequently declared an SI. The other 4 cases reviewed include 1 missed opportunity to manage maternal infection, 1 respiratory issue due to a general anaesthesia caesarean section, and 2 cases where it was considered baby could have been managed on labour ward.

A newborn care bundle workstream has been established to review the immediate care of the new-born and themes identified from the ATAIN reviews.

Year 2022 – 2023



13. 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 Maternity specific information system is due to be launched in May 2024 this has been identified as a barrier to progressing improvements at pace. 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.
b. Serious Incidents are being prioritised and considerable progress has been made towards clearing the back log by 31st March 2022.
c. Training compliance is still below 90% a plan is in place to improve attendance.

APPENDIX 1

Trust: Sheffield Teaching Hospitals NHS Foundation Trust January 2023

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**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**
1.Findings of review of all perinatal deaths using the real time data monitoring tool	0	0	0	0	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	Process in place, findings progressed through action planning	Process in place, findings progressed through action planning	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	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	See section 5	See section 5	See section 5	See section 5	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	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	See section 10	See section 10	See section 10	See section 10
4.Staff feedback from frontline champion and walk-abouts				YES		YES	No	No	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	HSIB-0 CQC-0 NHSR-0	HSIB-0 CQC-0 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	0	0	0	0
7.Progress in achievement of CNST 10	To be assessed	In progress	In progress	In progress	In progress	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 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

APPENDIX 2
Dashboard CHART

Antenatal	Green	Amber	Red	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23
Community First Visits				516	540	536	569	569	527	622
Community First Visits Within 10 Weeks %	$n \geq 90$	$75 \leq n < 90$	$n < 75$	74.22	71.11	68.47	71.88	72.41	71.35	70.1
Smokers at Community First Visit %	$n \leq 6$			8.53	9.07	9.51	7.38	13.01	9.87	7.56
Clinic First Visits				454	498	524	454	530	477	548
Clinic First Visits Under 13 Weeks %				63.88	60.84	65.46	66.3	63.96	68.34	61.5
Clinic First Visits Smoker %	$n \leq 6$			10.35	10.44	9.92	11.23	7.55	11.32	8.39
Clinic First Visits CO Measured %				42.29	32.53	51.91	69.38	52.45	46.75	52.92
Clinic First Visits CO ≥ 4ppm				13.54	16.05	12.87	12.38	8.99	8.07	7.59
Community 36 Week Visits CO Measured %				55.86	43.38	56.42	65.06	68.86	69.23	68.7
Community 36 Week Visits CO ≥ 4ppm				12.71	10.78	10.58	9.17	13.69	9.33	12.66
CO reduced below 4ppm by 36 weeks %				0	0	0	0	23.08	38.89	27.27

Deliveries	Green	Amber	Red	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23
Total Deliveries (mothers)				515	475	484	469	465	470	434
Registerable Births				528	486	489	473	469	474	437
Elective C Section Deliveries %				13.59	16.84	17.77	15.78	14.19	15.53	16.82
Emergency C Section Deliveries %				23.69	26.95	23.55	18.76	27.1	25.74	27.19
Assisted Deliveries %				11.26	11.16	9.3	14.07	14.19	11.49	12.21
Inductions %	$n \leq 32.8$			24.47	25.47	26.65	26.44	27.74	27.02	29.72
Waterbirths				18	10	13	14	22	14	8
Homebirths				6	8	7	5	11	5	1
Born Before Arrival (BBA)				8	0	4	8	3	6	5
APGAR 0-6 %				2.13	1.92	2.7	2.56	2.85	2.59	4.43
Low birthweight (≤ 2500g) %				10.98	14.61	9	9.51	9.17	10.76	12.36
Under 3rd Centile delivered at 38wks+ %				72.41	42.31	71.43	76.19	50	54.17	30
Singleton Livebirths < 30wks with $MgSO_4$ %				100	100	100	100	100	50	71.43
Preterm births %				6.01	9.17	5.93	5.51	7.49	6.4	7.91
Singleton births 16w - 23+6 %				0.2	0.43	0.42	0.65	0.87	1.3	1.64
Singleton births 24w - 36+6 %				6.37	9.7	6.3	5.87	7.21	6.72	8.22

PPH ≥ 1500ml %	$n < 3$	$3 \leq n \leq 5$	$n > 5$	3.69	4.23	3.94	3.65	3.25	3.43	3.5
3rd and 4th degree tears (all) %				2.29	3.28	2.63	6.53	1.99	5.18	4.04
3rd and 4th degree tears (Normal) %	$n < 3$	$3 \leq n \leq 4$	$n > 4$	1.2	3.54	2.23	5.68	1.57	4.46	2.81
3rd and 4th degree tears (Assisted) %	$n < 5$	$5 \leq n \leq 9$	$n > 9$	7.14	2.17	4.76	9.68	3.33	8.16	8.89
Smokers At Delivery %	$n \leq 6$			7.18	8.88	7.68	6.87	8.66	11.59	9.32
First Feed Breastmilk %	$n \geq 75$	$70 \leq n < 75$	$n < 70$	67.05	64.52	68.79	71.22	74.46	66.81	65.74
Robson Group 1 having LSCS %				24.42	27.4	21.95	11.7	21.05	22.89	19.44
Robson Group 2 having LSCS %				54.02	67.47	58.06	47.92	59	64.29	70.65
Robson Group 5 having LSCS %				76.39	79.73	86.11	77.94	84.75	77.63	73.68
VBAC (Local) %				20.99	19.1	12.5	19.75	16	22.34	26.76
VBAC (NHSD) %				21.57	19.15	8.33	18.42	13.33	14.29	32.43

Neonatal

	Green	Amber	Red	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23
Neonatal Unit Admissions				41	60	42	39	44	39	44
Neonatal Unit Admissions %				7.81	12.45	8.62	8.32	9.44	8.3	10.19
Neonatal Unit Admissions at Term				14	26	20	21	17	17	19
Neonatal Unit Admissions at Term %				2.67	5.39	4.11	4.48	3.65	3.62	4.4

Mortality

	Green	Amber	Red	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23
Stillbirths				3	4	2	4	3	4	5
Stillbirths ‰ (per thousand)	$n \leq 2.55$			5.68	8.23	4.09	8.46	6.4	8.44	11.44
Stillbirths at Term				0	1	0	1	1	0	0
Stillbirths at Term ‰ (per thousand)				0	2.06	0	2.11	2.13	0	0
Feticide (Stillbirth)				0	1	1	0	0	1	1
Stillbirths excluding feticide ‰ (per thousand)				5.68	6.17	2.04	8.46	6.4	6.33	9.15
Neonatal Deaths				3	4	1	1	3	4	
Neonatal Deaths ‰ (per thousand)	$n \leq 1.45$			5.71	8.3	2.05	2.13	6.44	8.51	
Neonatal Deaths ≥ 24 weeks				2	4	1	1	2	1	
Neonatal Deaths ≥ 24 weeks ‰ (per thousand)				3.81	8.3	2.05	2.13	4.29	2.13	
Neonatal Deaths at Term				0	2	0	0	0	0	
Neonatal Deaths at Term ‰ (per thousand)				0	4.15	0	0	0	0	

LW Assessment

	Green	Amber	Red	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23
Calls to Triage Service				3252	3077	2778	2749	2863	2909	2548

LWAU Admissions				1180	1060	1100	1066	1124	1175	966
LWAU Rapid Reviews %	$n \geq 95$	$80 \leq n < 95$	$n < 80$	94.49	96.04	95.36	96.81	96.98	97.02	97
LWAU Rapid Review Time (mins)	$n \leq 15$	$15 < n \leq 30$	$n > 30$	33	23	20	29	22	29	16

Other	**Green**	**Amber**	**Red**	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23
Readmissions				17	22	9	21	24	17	20