Maternity Perinatal Quality Surveillance model for September 2024

CQC Maternity	Overall	Safe	Effective	Caring	Responsive	Well led		
Ratings- assessed	Good	Requires	Good	Outstanding	Good	Good		
2023		Improvement						
Unit on the Maternity	Improvemen	No						



Unit on the Maternity Improvement Programme No	
2022/23	
Proportion of Midwives responding with Agree" or "Strongly Agree" on whether they would recommend	74.9%
their Trust as a place to work of receive treatment (reported annually)	
Proportion of speciality trainees in O&G responding with "excellent or good" on how they would rate the	89.2%
quality of clinical supervision out if hours (reported annually)	

Exception report including highlighted fields in monthly scorecard using August data (Slide 2)

Exception report including nighlighted fields in monthly scorecard using August data (Slide 2)												
Massive Obstetric Had	emorrhage (August 5.1%)	Elective Care	Midwifery & Obstetric	Workforce	Staffing red flags (August 2024)							
	continues, reviewed eting- no themes, trends on needed.	First month of electronic diary complete – review of impact anticipated but initial feedback is positive Induction of labour (IOL)	4 wte vacancies Band 4 MSW and H	ce — recruiting into rrent at 6.5% blanned for September — oM overseeing HEE	6 staffing incidents reported No harm reported related to staffing red flags Full review of acute rosters and staffing metrics underway Suspension of Maternity Services							
Stillbirth Rate (Augus	t rate 3.1/1000)	Outpatient training complete – IOL champions on every shift	Strategy for B2/B3 responsibilities. Replanned for MSW C	view and launch	4 diverts reported in August Home Birth Service							
2 Stillbirths reported i through PMRT, no fur at present.	n August. Reported ther escalations required	Delays in commencing and proceeding with IOL increasing – review planned for September to identify themes and solutions	November • No obstetric vacand	cy .	4 Homebirths in August. Emerging risk to HB service due to expected maternity leave- divisional review and planning underway							
Complaints, Compliments and FTT	MDT Training Compliance (Target 90%)	Saving Babies Lives	Maternity Assurance		Incident reported August 2024 (169 no/low harm, 1 moderate or above*)							
1 complaint received	90% for August additional spaces	Saving Babies Lives Care Bundle Version 3 LMNS validated % of Interventions fully	NHSR	Ockenden	MDT reviews	Comments						
 FFT response rate below target – focus 	for September created to accommodate	All elements 87 Element 1 - Smoking 80 Element 2 - Fetal Growth Restriction 95	Year 6 MIS now live Fortnightly task	Initial 7 IEA- 100% compliant	Triggers	14 cases reviewed						
with Ward and Team Leads with support from MNVP to improve	staff escalated during high acuity	Element 3 - Reducted fetal movements Element 4 - Fetal monitoring Element 5 - Preterm birth Element 6 - Diabetes Overall implementation level Partially implemented - CNST (yr 5) met	Fortnightly task and finish group progressing No immediate challenges anticipated	System reporting for Three-Year Delivery plan in development	* 1 moderate or above – to be taken through N review.							

Other:

- Regulation 28 report submitted to Coroner within timeframe, immediate actions taken and ongoing actions in progress within systems and regional team.
- Increased birth rate noted in August, unpredicted and associated with Pre-Term birth.
- Decrease in FTT rate in consecutive month, to be explored.



Maternity Perinatal Quality Surveillance scorecard

		Running Total/															
Quality Metric	Standard	average	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Trend
1:1 care in labour	>95%	100.00%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
Spontaneous Vaginal Birth			56%	56%	55%	55%	51%	53%	47%	56%	49%	49%	48%	48%	46%	48%	~
3rd/4th degree tear overall rate	<3.5%	3.50%	4.60%	4.50%	3.50%	3.90%	5.20%	2.40%	3.00%	5.00%	2.10%	6.00%	4.50%	3.00%	2.80%	4.70%	$\sim \sim$
3rd/4th degree tear overall number		79	8	6	6	7	9	4	5	8	3	11	8	4	4	7	$\sim\sim$
Obstetric haemorrhage >1.5L number		127	6	11	6	11	15	17	13	6	9	9	9	11	9	15	∼
Obstetric haemorrhage >1.5L rate	<3.5%	3.90%	2.10%	4.20%	2.00%	3.70%	4.80%	5.70%	4.00%	2.60%	3.40%	2.60%	2.90%	4.70%	3.10%	5.10%	$\sim\sim$
Term admissions to NICU	<6%	3.10%	5.40%	3.40%	3.40%	3.70%	3.00%	3.10%	3.00%	2.80%	3.80%	2.60%	4.00%	2.90%	4.70%	4.00%	~~~
Stillbirth number		10	0	1	0	0	0	2	1	2	1	0	1	1	0	2	~~~
Stillbirth rate	<4.4/1000				1.700			2.300			3.100			2.300			
Rostered consultant cover on SBU - hours per week	60 hours	60	60	60	60	60	60	60	60	60	60	60	60	60	60	60	
Dedicated anaesthetic cover on SBU - pw	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	
Midwife / band 3 to birth ratio (establishment)	<1:28		1:27	1:27	1:27	1:27	1:27	1:27	1:27	1:27	1:27	1:27	1:27	1:27	1:22	1:22	
Midwife/ band 3 to birth ratio (in post)	<1:30		1:29	1:29	1:29	1:29	1:29	1:29	1:29	1:29	1:29	1:29	1:29	1:29	1:23	1:23	
Number of compliments (PET)		38	2	3	3	4	4	3	2	3	4	5	4	1	2	2	\sim
Number of concerns (PET)		9	1	1	1	2	0	1	1	1	1	0	0	4	1	0	~~/
Complaints		6	0	1	1	1	0	0	1	0	0	1	1	0	1	1	\triangle
FFT recommendation rate	>93%		89%	91%	91%	90%	91%	90%	90%	90%	90%	90%	91%	91%	88%	89%	<u>/</u> ~
		Running Total/															
External Reporting	Standard	average	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Trend

		Running Total/															
External Reporting	Standard	average	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Trend
Maternity incidents no harm/low harm		1339	86	85	107	130	158	94	148	102	102	95	130	102	125	169	_^^_
Maternity incidents moderate harm & above		10	0	1	3	2	2	1	1	0	0	0	0	0	2	1	/
the fact that the same of																	
HSIB/CQC/NHSR with a concern or request for action		Y/N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	
Coroner Reg 28 made directly to the Trust		Y/N	0	0	0	0	0	0	0	0	0	0	0	1	1	0	
Progress in Achievement of MIS YEAR 6	<4 <7	7 & above															