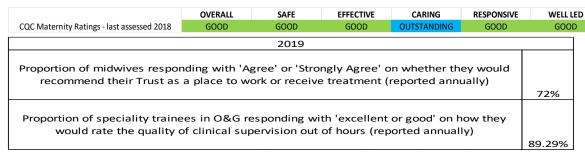
## Maternity Perinatal Quality Surveillance model for January 2023





Exception report based on highlighted fields	Stillbirth rate Q3 (3.2/1000 births)  Staffing red flags (Dec 2022)  • SFH stillbirth rate, for year to date now returned and remains below the national ambition of 4.1/1000 birth  • Two reportable cases for December, reportable to PMRT surveillance tool only at present.  Home Birth Service  • Homebirth services resumed on the 19th of September.  • 10 Homebirth conducted since the writing of the paper  Maternity Assurance Divisional Working Group  Incidents reported Dec 2022  (76 no/low harm 1 moderate or above)						
3 <sup>rd</sup> and 4 <sup>th</sup> Degree Tears (1.83% N=3 Dec 2022)	Stillbirth rate Q3 (3.2/1000 births)		Staffing red flags (Dec 2022)				
Rate back below national threshold.     Deep dive review into cases and comparison to be completed. No identifiable themes are trends found.	national ambition of 4.1/1000 bir Two reportable cases for Decemb	th	<ul> <li>No harm related</li> <li>Home Birth Service</li> <li>Homebirth services resumed on the 19<sup>th</sup> of September.</li> </ul>				
Delays in Elective Care	Maternity Assurance Divisional Work	king Group	Incidents reported Dec 2022 ( 76 no/low harm, 1 moderate or above)				
No delays in EL LSCS     Elective List to commence on the 10 <sup>th</sup> of January	NHSR	Ockenden	Most reported	Comments			
Induction of Labour- no delays reported	NHSR year 4 guidance revised, Interim post in to support	Initial 7 IEA- final IEA is 91% compliant following evidence	Other (Labour & delivery)	No themes identified  Themes includes Category 1 LSCS, 3 <sup>rd</sup> and 4 <sup>th</sup> degree tears and PPH			
	Reporting timeline approved through MAC  No escalations from the task and finish group	review at LMNS panel. • Final 15 IEA, 14 have been peer assessed pause as single oversight framework delayed until Easter 23	Triggers x 15				

## Other

- PPH remains above the national threshold, SFH continue to engage with the regional offer from NHSE for the Obs Cymru care bundle, to monitor as part of the bundle includes accurate measuring of the blood loss which may have increased the rate.
- · One Moderate case reported PPH, reviewed through MDT meeting and harm downgraded with no further action required.
- Apgar's reduced below national reporting levels.
- FFT rate remains improved with QI work, to remain on scorecard.



## Maternity Perinatal Quality Surveillance scorecard

Sherwood Forest Hospitals														
-	OVERALL	SA	FE	E EI		CA	CARING		RESPONSIVE				WELL LED GOOD	
CQC Maternity Ratings - last assessed 2018	GOOD	GOOD GOO		(	GOOD	OUTSTANDING		GOOD						
Maternity Quality Dashboard 2020-2021	Alert [nationa I standar dłavera ge	Running Total/ average	Jan-22	Feb-22	Mar-22	Apr-22	Mag-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-2
1:1 care in labour	>95%	99.81%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Women booked onto MCOC pathway														
Women receving MCOC intraprtum														
Total BAME women booked														
BAME women on CoC pathway														
Spontaneous Vaginal Birth			63%	61%	59%	55%	60%	60%	60%	58%	55%	55%	54%	43%
3rd/4th degree tear overall rate	>3.5%	2.18%	2.78%	2.52%	2.90%	3.00%	6.20%	3.72%	2.84%	6.30%	2.40%	4.30%	2.80%	1.80%
Obstetric haemorrhage >1.5L	Actual	116	6	8	7	6	9	7	7	3	9	9	14	14
Obstetric haemorrhage >1.5L	>3.5%	3.24%	2.12%	3.30%	2.60%	2.20%	3.20%	2.45%	2.45%	1.10%	3.20%	3.90%	4.60%	4.80%
Term admissions to NNU	<6%	3.62%	5.00%	3.50%	3.50%	1.60%	4.00%	2.60%	2.60%	3.70%	3.1%	1.30%	2.00%	3.20%
Apgar <7 at 5 minutes	<1.2%	1.56%	1.90%	1.80%	2.00%	0.84%	0.40%	1.20%	1.20%	1.20%	0.79%	2.10%	2.70%	1.10%
Stillbirth number	Actual	11	1	1	0	1	2	2	1	0	2	0	2	2
Stillbirth number/rate	0	4.63			3,727			5.952			3,300			3,240
Rostered consultant cover on SBU - hours per w	veek <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
Midwife / band 3 to birth ratio (establishment)	>1:28		1:29	1:22	1:22	1:22	1:22	1:24.5	1:27	1:27	1:27	1:27	1:27	1:27
Midwife/band 3 to birth ratio (in post)	>1:30		1:28	1:24	1:24	1:24	1:24	1:26.5	1:29	1:29	1:29	1:29	1:29	1:29
Number of compliments (PET)		0	0	0	1	1	1	1	1	1	2	2	2	
Number of concerns (PET)		9	0	0	2	2	1	0	0	0	1	2	1	
Complaints		11	1	1	2	1	0	2	1	0	0	0	0	
FFT recommendation rate	>93%		92%	91%	90%	89%	88%	88%	94%	91%	91%	89%	90%	90%
PROMPT/Emergency skills all staff groups			100%	100%	100%	100%	94%	95%	95%	95%	96%	92%	94%	
K2/CTG training all staff groups			98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	
CTG competency assessment all staff groups			98%	98%	98%	98%	98%	98%	98%	98%	98%	92%	92%	
Core competency framework compliance			81%	81%	88*%	95%	95%	95%	95%	95%	95%	95%	95%	
Progress against NHSR 10 Steps to Safety	<4 <7 7	& above												
Maternity incidents no harm/low harm	Actual	928	83	45	69	58	70	99	105	72	96	72	80	79
Maternity incidents moderate harm & above	Actual	7	1	43	1	1	10	1	1	0	0	0	0	0
Coroner Reg 28 made directly to the Trust	notual	Y/N	0	0	0	0	0	0	0	0	0	0	0	0
HSIB/CQC etc with a concern or request for acti	on	Y/N	N	N	N	N	N	N	Y	N	N	N	N	N