Maternity Perinatal Quality Surveillance model for May 2023

Sherwood Forest Hospitals
NHS Foundation Trust

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

	2019
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)	72%
Proportion of speciality trainees in O&G responding with 'excellent or good' on how they would rate the quality of clinical supervision out of hours (reported annually)	89.29%

Exception report based on highlighted fields in monthly scorecard using March data (Slide 2)

Massive Obstetric Haemorrhage (Mar 1.9%)

- Maintained improved position this month
- ICB request for system to review cases/ plan improvement trajectory through system quality and safety meeting given the regional position- meeting pending

Stillbirth rate Q4 (3.6/1000 births)

- Once reportable case in March, known complex pregnancy and pre-natal diagnosis attend with altered fetal movement and IUFD diagnosed.
- SFH stillbirth rate, for year 22/23 below the national ambition of 4.4/1000 birth (SFH rate 4.0)

Staffing red flags (Mar 2022)

- 6 staffing incident reported in the month.
- No harm related

Suspension of Maternity Services

- No suspension of services within March 23

Home Birth Service

- 17 Homebirth conducted since re-launch

Elective Care

- Elective Caesarean section working groups continues to review plan for the beginning of May to embed the next step of plan- looking at increasing the number of lists (am Tue-Fri)
- Induction of Labour, delays noted through daily sit rep due to high periods of capacity- no harm reported.

Maternity Assurance Divisional Working Group

NHSR	Ockenden
• Bid for funding supported by NHSR awaiting final confirmation of the amount. • No dates yet for Year 5- working group on pause until confirmed.	• Initial 7 IEA- final IEA is 91% compliant following evidence review at LMNS panel • Final evidence listed for next quarterly panel. • Awaiting single delivery plan for further Ockenden update

Incidents reported Mar 2023 (64 no/low harm, 0 moderate or above)

Most reported	Comments
Other (Labour & delivery)	No themes identified
Triggers x 14	No themes outside of the "trigger" list
No incidents reported as 'moderate'	

Other

- Baby born requiring cooling and subsequent transfer out tertiary unit, sadly died. Case reportable to HSIB, Coroner but not NHSR. Family support through Bereavement team.
- 3rd and 4th Degree tears improved this month, to monitor.
- Regional OPEL scoring tool now live, feedback ongoing. SFH aligning local policy to system.

Maternity Perinatal Quality Surveillance scorecard

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Maternity Quality Dashboard 2022/2023	Alert	Running Total/ averag	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Quality Metric										
1:1 care in labour	>95%	99.81%	100%	100%	100%	100%	100%	100%	100%	100%
Spontaneous Vaginal Birth			58%	55%	55%	54%	43%	56%	56%	55%
3rd/4th degree tear overall rate	>3.5%	2.18%	6.30%	2.40%	4.30%	2.80%	1.80%	3.10%	5.60%	3.50%
3rd/4th degree tear overall rate		46	12	4	8	6	2	5	9	6
Obstetric haemorrhage >1.5L	Actual	116	3	9	9	14	14	5	5	5
Obstetric haemorrhage >1.5L	>3.5%	3.24%	1.10%	3.20%	3.90%	4.60%	4.80%	3.90%	2.00%	1.96%
Term admissions to NNU	<6%	3.62%	3.70%	3.1%	1.30%	2.00%	3.20%	5.40%	3.40%	3.40%
Stillbirth number	Actual	11	0	1	0	2	2	2	1	1
Stillbirth number/rate	0	4.63		3.300			3.240			3.623
Rostered consultant cover on SBU - hours per week	hours	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
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
Number of compliments (PET)		0	1	2	2	2	3	2	3	6
Number of concerns (PET)		9	0	1	2	1	1	1	1	1
Complaints		11	0	0	0	0	0	0	0	0
FFT recommendation rate	>93%		91%	91%	89%	90%	90%	89%	91%	90%
Saving Babies Lives										
Element 1- Smoke Free Pregnancy										
Element 2- Fetal Growth Restriction										
Element 3- Reduced Fetal Movement										
Element 4- Fetal Mointering										
Element 5- Reducing preterm births										
MDT Training										
PROMPT/Emergency skills all staff groups										
CTG training all staff groups										
CTG competency assessment all staff groups										
Core competency framework compliance										
External Reporting										
Progress against NHSR 10 Steps to Safety	<4 <7 7 & above									
Maternity incidents no harm/low harm	Actual	0	72	96	72	80	79	64	70	64
Maternity incidents moderate harm & above	Actual	0	0	0	0	0	0	0	0	0
Coroner Reg 28 made directly to the Trust		Y/N	0	0	0	0	0	0	0	0
HSIB/CQC etc with a concern or request for action		Y/N	N	N	N	N	N	N	N	N