Maternity Perinatal Quality Surveillance model for August 2023

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			

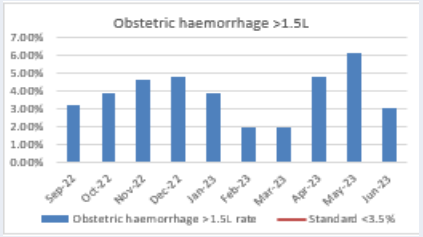
2022/23	
Proportion of Midwives responding with Agree" or "Strongly Agree" on whether they would recommend their Trust as a place to work of receive treatment (reported annually)	74.9%
Proportion of speciality trainees in O&G responding with "excellent or good" on how they would rate the quality of clinical supervision out if hours (reported annually)	89.2%

Sherwood Forest Hospitals NHS Foundation Trust

Exception report based on highlighted fields in monthly scorecard using June data (Slide 2 & 3)

Massive Obstetric Haemorrhage (Jun 3.1%)

- Decrease in cases from previous months, thematic review of cases ongoing.



Elective Care

Elective Caesarean (EL LSCS)

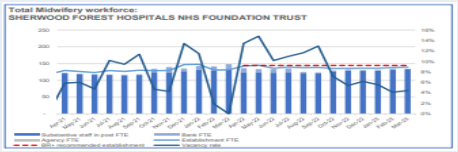
- Work continues around variation.
- Service user feedback obtained

Induction of Labour (IOL)

- IOL, delays improved lead band 6 commenced to support the MDT meetings and exploration of outpatient IOL

Midwifery Workforce

- Current vacancy rate 4.2% (blue line), recruited into -expected start dates in Sept 23
- Risk due to high number of expected Maternity Leave-paper for People Committee prepared.



Staffing red flags (Jun 2023)

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

Suspension of Maternity Services

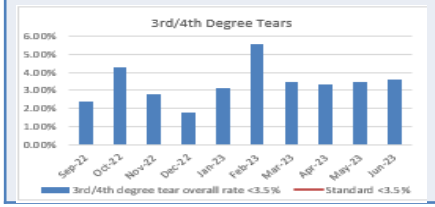
- 1 suspension of services during June

Home Birth Service

- 33 Homebirth conducted since re-launch
- Potential risk to service outlined within the paper going to People Committee

Third and Fourth Degree Tears (Jun 3.6%)

- Slight percentage increase in June
- New Perinatal Pelvic Health Service formed, SFH have key membership and aligns to NHS long term plan.



Stillbirth rate (4.0/1000 births)

- One stillbirth reported in June, escalated to PSIRG and for Divisional Investigation
- Rate remains below the national ambition of 4.4/1000 births

Maternity Assurance

NHSR	Ockenden
• Bid funding received. • Working commenced flash reports to MAC/QC • Submission due 2nd of Feb 2024	• Initial 7 IEA- 100% compliant • Next regional insight visit planned for Oct 23

Incidents reported Jun 2023 (85 no/low harm, 0 moderate or above)

Most reported	Comments
Emergency LSCS and MOH	MOH remains the most frequently reported. Slight increase in EM LSCS in June
Triggers x 9	1 incident required higher escalations
0 incidents reported as 'moderate'	

Other

- SBLCB, remain compliant, new lead in post, version 3 launched working on the Divisional action plan.
- Entonox working group established key action plan, assurance around current exposure but risk to current levels of control. Focus on education, estates and monitoring plan, work underway.
- All staffing incidents were related to acuity and activity. 5 Datix submitted for staffing regarding acuity during the time period of the unit suspension.

Maternity Perinatal Quality Surveillance scorecard

Sherwood Forest Hospitals
NHS Foundation Trust

Quality Metric	Standard	Total/ average	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Trend
1:1 care in labour	>95%	99.81%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
Spontaneous Vaginal Birth			55%	55%	54%	43%	56%	56%	55%	60%	60%	50%	
3rd/4th degree tear overall rate	<3.5%	2.18%	2.40%	4.30%	2.80%	1.80%	3.10%	5.60%	3.50%	3.30%	3.50%	3.60%	
3rd/4th degree tear overall number		46	4	8	6	2	5	9	6	6	7	6	
Obstetric haemorrhage >1.5L number		59	9	9	14	14	5	5	5	13	19	9	
Obstetric haemorrhage >1.5L rate	<3.5%	3.24%	3.20%	3.90%	4.60%	4.80%	3.90%	2.00%	2.00%	4.80%	6.10%	3.10%	
Term admissions to NICU	<6%	3.62%	3.10%	1.30%	2.00%	3.20%	5.40%	3.40%	3.40%	3.40%	3.40%	2.50%	
Stillbirth number		8	2	0	2	2	2	0	1	1	0	1	
Stillbirth rate	<4.4/1000	4.63	3.300			3.240			4.000			2.200	
Rostered consultant cover on SBU - hours per week	60 hours	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	
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	1:24	
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	1:26	
Number of compliments (PET)		0	2	2	2	3	2	3	3	6	9		
Number of concerns (PET)		9	1	2	1	1	1	1	1	1	2		
Complaints		11	0	0	0	0	0	0	0	0	0		
FFT recommendation rate	>93%		91%	89%	90%	90%	89%	91%	91%	91%	90%		

External Reporting	Standard	Total/ average	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Trend
Maternity incidents no harm/low harm		595	96	72	80	79	64	70	64	70	77	85	
Maternity incidents moderate harm & above		0	0	0	0	0	0	0	0	0	3*	0	
Findings of review of all perinatal deaths using the real time monitoring tool	Jun-23	PMRT- One reportable case in June, the case was escalated through PSIRG and is having a Divisional investigaiton alongside PMRT review which is currently ongoing.											
Findings of review all cases eligible for referral to HSIB	Jun-23	No cases met reportable threasholds in May. One case currently active (early neonatal death reported in March). Two cases revived in 2023, one with no safety recommendations, one with 3 relating to escaltions, clinical and risk assessment. Action plans have been comeplted and are monitered through governance											
Service user voice feedback	Jun-23	New role commenced in post within the ICB of the Maternity and Neonatal Independent Senior Advocate to support SFH.											
Staff feedback from frontline champions and walk-abouts	Jun-23	MNSC on the 6th June, feedback around the EL LSCS list, detailed in the exception report. Positive re - aunch of Triage and clear plans for embedding articulated.											
HSIB/CQC/NHSR with a concern or request for action		Y/N	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	
Progress in Achievement of CNST 10	<4 <7 7 & above												