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%

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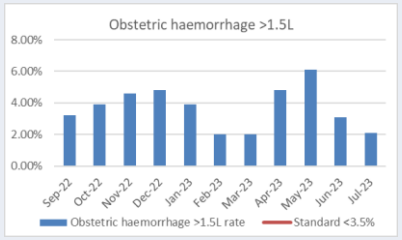
Exception report based on highlighted fields in monthly scorecard using July data (Slide 2 & 3)

Massive Obstetric Haemorrhage (Jul 2.1%)

- Decrease in cases this month



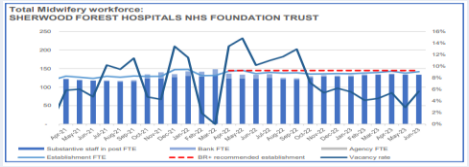
Elective Care

Elective Caesarean (EL LSCS)
- Slides presented to the MNSC
- Staff and Service user feedback obtained
- Positive improvements seen

Induction of Labour (IOL)
- IOL, delays improved
- Lead Midwife continuing with the QI to improve the service

Midwifery Workforce

- Current vacancy rate 5.7% , recruited -planned induction for 4th of Sept
- Risk due to high number of expected Maternity Leave-paper for People Committee on 26th of Sept



Staffing red flags (Jul 2022)

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

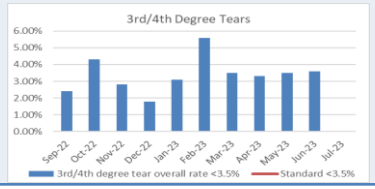
Suspension of Maternity Services

- No suspension of services within for July

Home Birth Service
- 36 Homebirth conducted since re-launch
- Potential risk to service outlined within the paper going to People Committee

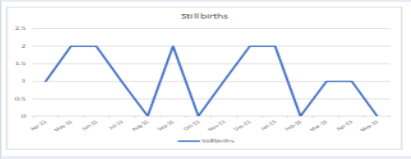
Third and Fourth Degree Tears (Jun 3.6%)

- 3.6% in Jun 2023 (Jul unavailable)
- New Perinatal Pelvic Health Service formed, SFH have key membership and aligns to NHS long term plan.



Stillbirth rate (4.0/1000 births)

- No stillbirth reported in July
- Rate remains below the national ambition of 4.4/1000 births



Maternity Assurance

NHSR	Ockenden
• Working commenced flash reports to MAC/QC • Submission due 2nd of Feb 2024	• Initial 7 IEA- 100% compliant • Next regional insight visit planned for 4th of Oct 2023

Incidents reported in Jul 2023 (84 no/low harm, 2 moderate or above)

Most reported	Comments
	MOH, term admissions
Triggers x 16	No incidents required external escalations
1 incidents reported as 'moderate', for PSIRG discussion and thematic review paper	

Other

- SBLCB, risk identified around the procurement of equipment within element 3- raised to regional and national teams
- Entonox working group continues to progress through the actions agreed following the report.

Maternity Perinatal Quality Surveillance scorecard

Sherwood Forest Hospitals
NHS Foundation Trust

Quality Metric	Standard	Running Total/ average	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Trend
1:1 care in labour	>95%	99.81%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
Spontaneous Vaginal Birth			55%	55%	54%	43%	56%	56%	55%	60%	60%	50%	51%	
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	6	
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%	2.10%	
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%	5.20%	
Stillbirth number		8	2	0	2	2	2	0	1	1	0	1	0	
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	60	
Dedicated anaesthetic cover on SBU - pw	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	
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	
Number of compliments (PET)		0	2	2	2	3	2	3	3	6	9	1	3	
Number of concerns (PET)		9	1	2	1	1	1	1	1	1	2	1	1	
Complaints		11	0	0	0	0	0	0	0	0	0	0	0	
FFT recommendation rate	>93%		91%	89%	90%	90%	89%	91%	91%	91%	90%	90%		

External Reporting	Standard	Running Total/ average	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Trend
Maternity incidents no harm/low harm		595	96	72	80	79	64	70	64	70	77	85	84	
Maternity incidents moderate harm & above		0	0	0	0	0	0	0	0	0	3*	1	2	
Findings of review of all perinatal deaths using the real time monitoring tool	May-23	PMRT- No repotable cases in May, case reported in April has report in draft. No intial learning identifed. Previously issue around partogram improved with digital notes.												
Findings of review all cases eligible for referral to HSIB	May-23	No cases met reportable threasholds in May. One case currently active (early neonatal death reported in March). Two cases reviwed 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	May-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	May-23													
HSIB/CQC/NHSR with a concern or request for action		Y/N	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	0	
Progress in Achievement of CNST 10	<4 <7 7 & above													