

Maternity Perinatal Quality Surveillance model for September 2023



Sherwood Forest Hospitals
NHS Foundation Trust

CQC Maternity Ratings- assessed 2023	Overall Good	Safe Requires Improvement	Effective Good	Caring Outstanding	Responsive Good	Well led 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 or 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 of hours (reported annually)						89.2%

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

<p>Massive Obstetric Haemorrhage (Aug 4.2%)</p> <ul style="list-style-type: none"> Rise in cases this month, reviewed and no harm, themes or trends. 	<p>Elective Care</p>	<p>Midwifery Workforce</p>	<p>Staffing red flags (Aug 2022)</p>									
	<ul style="list-style-type: none"> Elective Caesarean (EL LSCS) <ul style="list-style-type: none"> Continued increased challenges this month associated to IA, additional lists planned. Increased service demand in Sept, additional list planned. Induction of Labour (IOL) <ul style="list-style-type: none"> Lead Midwife continuing with the QI to improve the service QI work to be presented to the LMNS 	<ul style="list-style-type: none"> Current vacancy rate 4.2% , 16 newly recruited Midwives commenced in post 4th Sept Risk due to high number of expected Maternity Leave-paper presented to People Committee , for approval through TMT 	<ul style="list-style-type: none"> 6 staffing incident reported in the month. No harm related <p>Suspension of Maternity Services</p> <ul style="list-style-type: none"> No suspension of services within August <p>Home Birth Service</p> <ul style="list-style-type: none"> 40 Homebirth conducted since re-launch First year re-start paper to be presented to MAC 									
<p>Third and Fourth Degree Tears (Aug 4.5%)</p>	<p>Stillbirth rate (4.0/1000 births)</p>	<p>Maternity Assurance</p>		<p>Incidents reported Aug 2023 (85 no/low harm, 1 moderate or above)</p>								
<ul style="list-style-type: none"> Rate remains above threshold, no themes or trends identified. Perinatal Pelvic Health Service workstreams now in place. 	<ul style="list-style-type: none"> No stillbirth reported in August Rate remains below the national ambition of 4.4/1000 births MBRRACE-UK report released, noted national increase in still birth in 2021 	<p>NHSR</p> <ul style="list-style-type: none"> Working commenced flash reports to MAC/QC Additional sign off meetings planned Submission due 2nd of Feb 2024 	<p>Ockenden</p> <ul style="list-style-type: none"> Initial 7 IEA-100% compliant Regional insight visit rescheduled for the 9th of Oct 2023 due to IA 	<table border="1"> <thead> <tr> <th>Most reported</th> <th>Comments</th> </tr> </thead> <tbody> <tr> <td></td> <td>MOH, third degree tears</td> </tr> <tr> <td>Triggers x 16</td> <td>No incidents required external escalations</td> </tr> <tr> <td colspan="2">1 incidents reported as 'moderate', awaiting MDT review to verify at time of report</td> </tr> </tbody> </table>	Most reported	Comments		MOH, third degree tears	Triggers x 16	No incidents required external escalations	1 incidents reported as 'moderate', awaiting MDT review to verify at time of report	
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Other

- Staffing paper in regards to higher than expected maternity leave presented through People Committee on the 26th of Sept, noting this paper outlines additional measures to support current mitigations in place and requires TMT sign off on October the 11th.
- SBLCB, new template completed and submitted to the LMNS on schedule, awaiting national feedback around the evidence uploaded. No concerns raised through internal governance process.
- Entonox working group continues to progress through the actions

Maternity Perinatal Quality Surveillance scorecard

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	Jul-23	Aug-23	Trend
1:1 care in labour	>95%	99.81%	100%	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%	47%	
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%	4.60%	4.50%	
3rd/4th degree tear overall number		46	4	8	6	2	5	9	6	6	7	6	8	6	
Obstetric haemorrhage >1.5L number		59	9	9	14	14	5	5	5	13	19	9	6	11	
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%	4.20%	
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%	4.00%	
Stillbirth number		12	2	0	2	2	2	0	1	1	0	1	0	1	
Stillbirth rate	<4.4/1000		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	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		1:27	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	1:29	
Number of compliments (PET)		40	2	2	2	3	2	3	3	6	9	1	3	3	
Number of concerns (PET)		13	1	2	1	1	1	1	1	1	2	1	1	0	
Complaints		8	1	0	1	0	0	1	1	0	1	1	0	2	
FFT recommendation rate	>93%		91%	89%	90%	90%	89%	91%	91%	91%	90%	90%	90%	92%	

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	Jul-23	Aug-23	Trend
Maternity incidents no harm/low harm		595	96	72	80	79	64	70	64	70	77	85	84	85	
Maternity incidents moderate harm & above			0	0	0	0	0	0	0	0	3*	1	2	1*	
Findings of review of all perinatal deaths using the real time monitoring tool	Aug-23	PMRT - One reportable case IUFD at 25 weeks gestation, low PAPPa-mom and bilateral talipes attended routine appointment and no fetal heart rate detected. Case opened within the correct time frames. PMRT review meeting completed drafted reports, no initial learning identified. Previously issue around partogram improved with No cases met reportable thresholds in August. One case currently active (early neonatal death reported in March). Two cases completed in 2023, one with no safety recommendations, one with 3 relating to escalations, clinical and risk assessment. Action plans have been completed and are monitored through governance													
Findings of review all cases eligible for referral to HSIB	Aug-23														
Service user voice feedback	Aug-23	MWP service user walkround completed and action plan tracked through MNSC. Work continues around focused induction of labour plan following previous feedback. QI work on this to be presented at LMNS PSRG meeting.													
Staff feedback from frontline champions and walk-about	Aug-23	Feedback this month focused on the improvements within the staffing levels and support for preceptorship midwives. Positive feedback received for the EL LSCS list and the ongoing work to embed the service.													
HSIB/CQC/NHSR with a concern or request for action		Y/N	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	0	
Progress in Achievement of CNST 10		<4 <7 7 & above													