Maternity Perinatal Quality Surveillance model for May 2024

Other

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



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

Exception report based on highlighted fields in monthly scorecard using April data (Slide 2 & 3) **Elective Care** Midwifery & Obstetric Workforce Staffing red flags (Apr 2024) Massive Obstetric Haemorrhage (Apr 2.6%) Consecutive reduction in cases this month Elective Caesarean (EL LSCS) Current vacancy rate (PWR data) 8 staffing incident reported in the month, same numbers reported on previous month LMNS PQSG meeting to align the PSIRP Monitoring of cases remain, progress to Midwifery workforce 2%, interview day planned MDT booking system. No harm related staffing incident, increase plans May noted in short term sickness/ Datix needed Induction of labour (IOL) MSSW recruitment successful and post for agency approval. Outnatient training commenced appointed. Obstetric Haemorrhage > 1.5L **Suspension of Maternity Services** Caesarean Selection Type breakdown No obstetric vacancy Three suspension of services within April due to capacity. No harm related Datix and all women affected have been supported. 0.0% **Home Birth Service** 64 Homebirth conducted since re-launch, high number conducted in April. Caesarean Section - Category 4 Elective **Saving Babies Lives** Stillbirth rate (3.1/1000 births) **Maternity Assurance** Incidents reported Jan 2024 (133 no/low harm, 1 moderate or above*) Ockenden NHSR MDT reviews Comments Saving Babies Lives Care Bundle Version 3 No stillbirths reported in April All elements Year 6 MIS now live Initial 7 IEA- 100% Triggers x 18 For 2023/2024 the rate per 1000 births is Initial risk identified compliant Element 2 - Fetal Growth Restriction 3.1. This is below the national threshold of through safety action Element 3 - Reducted fetal movements 4.4/1000 O Incidents reported as 'moderate or above' one and seven System reporting Element 4 - Fetal monitoring 100 Flement 5 - Preterm birth around MNVP at for Three-Year 83 PMRT meetingsplan in escalated and Trust development plan in place.



Maternity Perinatal Quality Surveillance scorecard

Maternal Perinatal Quality Surveillance Scorecard

		Totali														
Quality Metric	Standard	average	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	Trend
1:1 care in labour	>95%	100.00%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
Spontaneous Vaginal Birth			55%	54%	43%	56%	56%	55%	55%	51%	53%	47%	56%	49%	49%	}
3rd/4th degree tear overall rate	<3.5%	3.50%	3.40%	3.50%	3.60%	4.60%	4.50%	3.50%	3.90%	5.20%	2.40%	3.00%	5.00%	2.10%	6.00%	~~
3rd/4th degree tear overall number		71	6	7	6	8	6	6	7	9	4	5	8	3	11	}
Obstetric haemorrhage > 1.5L number		118	13	19	9	6	11	6	11	15	17	13	6	9	9	~~
Obstetric haemorrhage > 1.5L rate	<3.5%	3.90%	4.80%	6.10%	3.10%	2.10%	4.20%	2.00%	3.70%	4.80%	5.70%	4.00%	2.60%	3.40%	2.60%	>
Term admissions to NICU	<6%	3.10%	1.30%	2.00%	3.20%	5.40%	3.40%	3.40%	3.70%	3.00%	3.10%	3.00%	2.80%	3.80%	2.60%	
Stillbirth number		9	1	0	1	0	1	0	0	0	2	1	2	1	0	~~
Stillbirth rate	<4.4/1000				2.200			1.700			2.300			3,100		
Rostered consultant cover on SBU - hours per week	60 hours	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	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	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	1:29	
Number of compliments (PET)		40	2	2	3	2	3	3	4	4	3	2	3	4	5	~~~
Number of concerns (PET)		13	2	1	1	1	1	1	2	0	1	1	1	1	0	\sim
Complaints		5	0	0	0	0	1	1	1	0	0	1	0	0	1	2
FFT recommendation rate	>93%		89%	90%	90%	89%	91%	91%	90%	91%	90%	90%	90%	90%	90%	~~

		Total/														
External Reporting	Standard	average	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	Trend
Maternity incidents no harm/low harm		1423	58	78	85	86	85	107	130	158	94	148	102	102	95	_~~
Maternity incidents moderate harm & above		12	0	1	- 1	0	1	3	2	2	1	1	0	0	0	~~~
Findings of review of all perinatal deaths using the real time		PMRT case an	e within repo	rting timefra	imes inline v	vith MIS, de-	adline met. F	MRT prese	ented to QC.	. Risk to MIS	3 Year 6 miti	gated with k	ocal plan.			
monitoring tool	Mar-24			_												
		One live case, 1	ne live case, Two cases presented the LMNS SI group and Trust PSRIG, action plans signed off. Action's ongoing and track through goverance.													
Findings of review all cases eligible for referral to MNSI	Mar-24															
Service user voice feedback	Mar-24	Action plans fro	om recent pa	atient voice/	15 steps mo	onitered thro	ouah MNSC	meetina.								
Staff feedback from frontline champions and walk-abouts	Mar-24	Feedback from	Maternity V	ard in reagr	d pre-packe	d discharge	medication-	action take	en to review	with CSTO.						
HSIB/CQC/NHSR with a concern or request for action		Y/N	N	N	N	N	N	N	Y	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	0	
Progress in Achievement of CNST 10	<4 <7	7 & above														