Maternity Perinatal Quality Surveillance model for August 2024

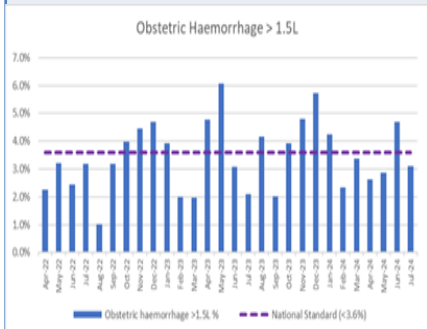
CQC Maternity Ratings- assessed 2023	Overall	Safe	Effective	Caring	Responsive	Well led
	Good	Requires Improvement	Good	Outstanding	Good	Good
Unit on the Maternity Improvement Programme				No		

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%

Exception report including highlighted fields in monthly scorecard using July data (Slide 2)

Massive Obstetric Haemorrhage (July 3.1%)

- MOH surveillance continues, reviewed through MDT meeting- no themes, trends or immediate action needed.
- RCOG quality indicator is 3.6%



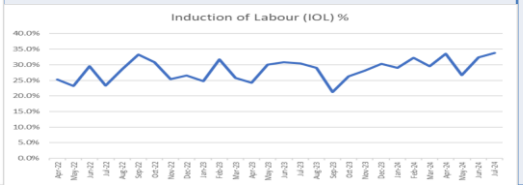
Elective Care

Elective Caesarean (EL LSCS)

- First month of electronic diary complete – review of impact anticipated but initial feedback is positive

Induction of labour (IOL)

- Outpatient training complete – IOL champions on every shift
- Delays in commencing and proceeding with IOL increasing – review planned for September to identify themes and solutions



Midwifery & Obstetric Workforce

Current vacancy rate (PWR data)

- Midwifery workforce 2%, vacancy fully recruited- all expected in post by Jan 25
- MSW recruitment planned for September – 4 wte vacancies
- Band 4 MSW and HoM overseeing HEE Strategy for B2/B3 roles and responsibilities. Review and launch planned for MSW Day in October
- No obstetric vacancy

Staffing red flags (July 2024)

- 6 staffing incidents reported
- No harm reported related to staffing red flags
- Full review of acute rosters and staffing metrics underway

Suspension of Maternity Services

- No suspensions of services in July

Home Birth Service

- 4 Homebirths in July
- Emerging risk to HB service due to expected maternity leave- divisional review and planning underway

Complaints, Compliments and FTT

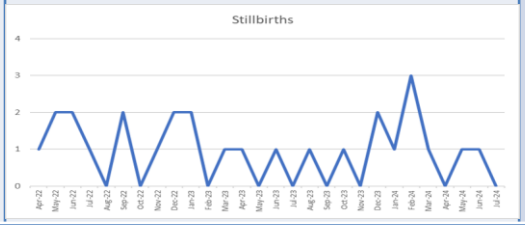
- Deep dive of the data demonstrated 100% of the responses for Postnatal Community would recommend the service

MDT Training Compliance (Target 93%)

- 92.1% for July, additional spaces for September created to accommodate staff escalated during high acuity

Stillbirth rate (YTD 1.7%)

- No stillbirths reported in July.



Maternity Assurance

NHSR	Ockenden
• Year 6 MIS now live • Fortnightly task and finish group progressing • No immediate challenges anticipated	• Initial 7 IEA- 100% compliant • System reporting for Three-Year plan in development

Incidents reported July 2024 (125 no/low harm, 1 moderate or above*)

MDT reviews	Comments
Triggers x 12	

*1 Incident reported as 'moderate or above'

- 20+/40 Neonatal Death (signs of life at birth). Missed opportunity for preterm surveillance as pathway not followed.
- Reviewed at Triggers and further MDT Rapid Review planned as per process

Other:

- 2 PFDS received following cases at Coroner's Court in May and in July. 1 response with legal team, ready for submission, 1 response with HoM being drafted, to legal team by end of August

Maternity Perinatal Quality Surveillance scorecard

Sherwood Forest Hospitals
NHS Foundation Trust

Quality Metric	Standard	Running Total/ average	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-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			56%	56%	55%	55%	51%	53%	47%	56%	49%	49%	48%	48%	46%	
3rd/4th degree tear overall rate	<3.5%	3.50%	4.60%	4.50%	3.50%	3.90%	5.20%	2.40%	3.00%	5.00%	2.10%	6.00%	4.50%	3.00%	2.80%	
3rd/4th degree tear overall number		79	8	6	6	7	9	4	5	8	3	11	8	4	4	
Obstetric haemorrhage >1.5L number		127	6	11	6	11	15	17	13	6	9	9	9	11	9	
Obstetric haemorrhage >1.5L rate	<3.5%	3.90%	2.10%	4.20%	2.00%	3.70%	4.80%	5.70%	4.00%	2.60%	3.40%	2.60%	2.90%	4.70%	3.10%	
Term admissions to NICU	<6%	3.10%	5.40%	3.40%	3.40%	3.70%	3.00%	3.10%	3.00%	2.80%	3.80%	2.60%	4.00%	2.90%	4.70%	
Stillbirth number		10	0	1	0	0	0	2	1	2	1	0	1	1	0	
Stillbirth rate	<4.4/1000				1.700			2.300			3.100			2.300	2.300	
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	1:22	
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	1:23	
Number of compliments (PET)		38	2	3	3	4	4	3	2	3	4	5	4	1	2	
Number of concerns (PET)		9	1	1	1	2	0	1	1	1	1	0	0	4	1	
Complaints		6	0	1	1	1	0	0	1	0	0	1	1	0	1	
FFT recommendation rate - SBU	>93%		89%	91%	91%	90%	91%	90%	90%	90%	90%	90%	91%	91%	88%	

External Reporting	Standard	Running Total/ average	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Trend
Maternity incidents no harm/low harm		1339	86	85	107	130	158	94	148	102	102	95	130	102	125	
Maternity incidents moderate harm & above		10	0	1	3	2	2	1	1	0	0	0	0	0	1	

HSIB/CQC/NHSR with a concern or request for action		Y/N	N	N	N	Y	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	1	1
Progress in Achievement of MIS YEAR 6	<4 <7 7 & above															