

# Maternity Perinatal Quality Surveillance model for Oct 2024



Sherwood Forest Hospitals  
NHS Foundation Trust

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 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 Sept 2024 data (Slide 2)

Massive Obstetric Haemorrhage (Sept 3.9%)	Elective Care	Midwifery & Obstetric Workforce	Staffing red flags																										
<ul style="list-style-type: none"> <li>MOH surveillance continues, reviewed through MDT meeting- no themes, trends or immediate action needed.</li> </ul>	<p><b>Elective Caesarean (EL LSCS)</b></p> <p><b>IOL</b></p>	<p><b>Current vacancy rate</b></p> <ul style="list-style-type: none"> <li>Midwifery/support worker vacancy 7.3%</li> <li>Mandatory Compliance 92.4%</li> <li>Sickness rate overall 7.0%</li> <li>Parenting leave unavailability 6.5%</li> <li>No obstetric vacancy</li> </ul> <p><b>FFT response rate</b></p> <ul style="list-style-type: none"> <li>Poor response rate continues across service, collaboration with MNVP to understand why and action plan to address to be created from November 2024</li> </ul>	<ul style="list-style-type: none"> <li>12 staff related incidents reported in the month: 2 needlestick, 2 poor staffing/no breaks, 2 suspension of services, 2 staff behaviour</li> </ul> <p><b>Suspension of Maternity Services</b></p> <p><b>Home Birth Service</b></p> <ul style="list-style-type: none"> <li>Emerging risk to service due to expected parenting leave and resignations - divisional review underway</li> </ul>																										
Saving Babies Lives	Stillbirth rate (4.4/1000 births YTD)	Maternity Assurance	Incidents reported Sept 2024; 115 (115 no/low harm, 0 moderate or above*)																										
<p>Saving Babies Lives Care Bundle Version 3</p> <table border="1"> <thead> <tr> <th>LMNS validated % of interventions fully implemented</th> <th></th> </tr> </thead> <tbody> <tr> <td>All elements</td> <td>87 ✓</td> </tr> <tr> <td>Element 1 - Smoking</td> <td>80 ✓</td> </tr> <tr> <td>Element 2 - Fetal Growth Restriction</td> <td>95 ✓</td> </tr> <tr> <td>Element 3 - Reduced fetal movements</td> <td>50 ✓</td> </tr> <tr> <td>Element 4 - Fetal monitoring</td> <td>100 ✓</td> </tr> <tr> <td>Element 5 - Preterm birth</td> <td>85 ✓</td> </tr> <tr> <td>Element 6 - Diabetes</td> <td>83 ✓</td> </tr> <tr> <td>Overall implementation level</td> <td>Partially implemented - CNST (yr 5) met</td> </tr> </tbody> </table>	LMNS validated % of interventions fully implemented		All elements	87 ✓	Element 1 - Smoking	80 ✓	Element 2 - Fetal Growth Restriction	95 ✓	Element 3 - Reduced fetal movements	50 ✓	Element 4 - Fetal monitoring	100 ✓	Element 5 - Preterm birth	85 ✓	Element 6 - Diabetes	83 ✓	Overall implementation level	Partially implemented - CNST (yr 5) met	<ul style="list-style-type: none"> <li>PMRT – no reportable cases for September.</li> </ul> <p>PET – 4 complaints</p> <ul style="list-style-type: none"> <li>Increase in concerns/complaints received in September – however care was provided May-Aug.</li> <li>Awaiting launch of new process/response templates from PET</li> </ul>	<table border="1"> <thead> <tr> <th>NHSR</th> <th>National Reporting</th> </tr> </thead> <tbody> <tr> <td> <ul style="list-style-type: none"> <li>Year 6 MIS now live</li> <li>Initial risk - no mitigations</li> <li>Fortnightly task and finish group progressing</li> </ul> </td> <td> <ul style="list-style-type: none"> <li>Ockenden - Initial 7 IEA- 100% compliant</li> <li>3 yr delivery plan – system plan in development</li> <li>CQC Plan – actions embedded; Peer Review action plan underway</li> </ul> </td> </tr> </tbody> </table>	NHSR	National Reporting	<ul style="list-style-type: none"> <li>Year 6 MIS now live</li> <li>Initial risk - no mitigations</li> <li>Fortnightly task and finish group progressing</li> </ul>	<ul style="list-style-type: none"> <li>Ockenden - Initial 7 IEA- 100% compliant</li> <li>3 yr delivery plan – system plan in development</li> <li>CQC Plan – actions embedded; Peer Review action plan underway</li> </ul>	<table border="1"> <thead> <tr> <th>MDT reviews</th> <th>Comments</th> </tr> </thead> <tbody> <tr> <td>Triggers x 12</td> <td>No themes identified</td> </tr> </tbody> </table> <p>*0 Incidents reported as 'moderate or above' from the cases reviewed. Cases awaiting review at time of writing report.</p>	MDT reviews	Comments	Triggers x 12	No themes identified
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# Maternity Perinatal Quality Surveillance scorecard

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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	Aug-24	Sep-24	Trend	
1:1 care in labour	>95%	100.00%	100%	100%	100%	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%	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%	4.70%	3.90%		
3rd/4th degree tear overall number		79	8	6	6	7	9	4	5	8	3	11	8	4	4	7	6		
Obstetric haemorrhage >1.5L number		127	6	11	6	11	15	17	13	6	9	9	9	11	9	15	12		
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%	5.10%	3.90%		
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%	4.00%	3.90%		
Stillbirth number		10	0	1	0	0	0	2	1	2	1	0	1	1	0	2	2		
Stillbirth rate	<4.4/1000				1.700			2.300			3.100			2.300			4.400		
Rostered consultant cover on SBU - hours per week	60 hours	60	60	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	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	1:22	1:23		
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	1:23	1:24		
Number of compliments (PET)		38	2	3	3	4	4	3	2	3	4	5	4	1	2	2	1		
Number of concerns (PET)		9	1	1	1	2	0	1	1	1	1	0	0	4	1	0	4		
Complaints		6	0	1	1	1	0	0	1	0	0	1	1	0	1	1	0		
FFT recommendation rate	>93%		89%	91%	91%	90%	91%	90%	90%	90%	90%	90%	91%	91%	88%	89%	84%		

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	Aug-24	Sep-24	Trend
Maternity incidents no harm/low harm		1339	86	85	107	130	158	94	148	102	102	95	130	102	125	169	115	
Maternity incidents moderate harm & above		10	0	1	3	2	2	1	1	0	0	0	0	0	2	1	0	
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	N	N	
Coroner Reg 28 made directly to the Trust		Y/N	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0	
Progress in Achievement of MIS YEAR 6	<4 <7 & above																	
Findings of review of all perinatal deaths using the real time	Mar-24	PMRT case are within reporting timeframes inline with MIS, deadline met. Risk to MIS Year 6 mitigated with system plan.																
Findings of review all cases eligible for referral to MNSI	Mar-24	PMRT case are within reporting timeframes inline with MIS, deadline met. Risk to MIS Year 6 mitigated with system plan.																
Service user voice feedback	Mar-24	New MVP roles started, Tara and Emma to support 15 steps work.																
Staff feedback from frontline champions and walk-about	Mar-24	Multiple discussion following Coronal case, actions taken by team as detailed in MNSC paper																

CQC RATINGS (date of inspection 22 November 2022)	OVERALL: GOOD	WELL-LED good	RESPONSIVE good	SAFE requires improvement	CARING good	EFFECTIVE good
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