Maternity Perinatal Quality Surveillance model for October 2023

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 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 based on highlighted fields in monthly scorecard using September data (Slide 2 & 3)

Massive Obstetric Haemorrhage (Sep 2.0%)

- Rise in cases this month, reviewed and no harm, themes or trends.

Obstetric haemorrhage >1.5L

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23

(Axis: 0.00% – 7.00%)

Elective Care

Elective Caesarean (EL LSCS)
- Increased service demand in Sept, planned lists to support demand effective

Induction of Labour (IOL)
- Lead Midwife continuing with the QI to improve the service
- QI work to be presented to the LMNS PSQG meeting 01/11/2023

Midwifery Workforce

- Current vacancy rate 3.2% , New recruited Midwives now onsite and in preceptorship programme
- Supported University of Derby with additional student placements

Staffing red flags (Sept 2022)

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

Suspension of Maternity Services

- Two suspension of services within September

Home Birth Service
- 43 Homebirth conducted since re-launch

Third and Fourth Degree Tears (Sep 3.5%)

- Rate within threshold
- Perinatal Pelvic Health Service has first regional face to face to review service specification.

3rd/4th Degree Tears

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23

(Axis: 0.00% – 5.00%)

Stillbirth rate (1.2 /1000 births)

- One stillbirth reported in September, PMRT completed awaiting further review with findings from tests and investigations
- Rate remains below the national ambition of 4.4/1000 births
- MBRRACE-UK report released, noted national increase in still birth in 2021

Maternity Assurance

NHSR	Ockenden
• Working commenced flash reports to MAC/QC • Additional sign off meetings planned • Submission due 2nd of Feb 2024	• Initial 7 IEA- 100% compliant • Positive initial feedback from the Ockenden Insight Visit- formal report to follow

Incidents reported Sept 2023
(110 no/low harm, 3 moderate or above)

Most reported	Comments
	MOH, Cat 1 LSCS
Triggers x 16	No incidents required external escalations
3 Incidents reported as 'moderate or above', see below	

Other

- Two incidents report as moderate are linked regarding twins requiring an exchange transfusion and are currently under investigation. The final incident, a neonatal death, has been reported as catastrophic and is subject to internal and external investigation.
- During the month of September, the Maternity Unit attempted to suspend services, due to high acuity, on two occasions. On both occasions the neighbouring units were unable to support, and the suspension was managed through the current policy. No incidents reported during these time had been reported as moderate or above.

Maternity Perinatal Quality Surveillance scorecard

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Quality Metric	Standard	Running Total/ average	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Trend
1:1 care in labour	>95%	100.00%	100%	100%	100%	100%	100%	100%	
Spontaneous Vaginal Birth			55%	54%	43%	56%	56%	55%	
3rd/4th degree tear overall rate	<3.5%	3.80%	3.40%	3.50%	3.60%	4.60%	4.50%	3.50%	
3rd/4th degree tear overall number		39	6	7	6	8	6	6	
Obstetric haemorrhage >1.5L number		64	13	19	9	6	11	6	
Obstetric haemorrhage >1.5L rate	<3.5%	3.40%	4.80%	6.10%	3.10%	2.10%	4.20%	2.00%	
Term admissions to NICU	<6%	3.10%	1.30%	2.00%	3.20%	5.40%	3.40%	3.40%	
Stillbirth number		2	1	0	1	0	1	0	
Stillbirth rate	<4.4/1000				2.200			1.200	
Rostered consultant cover on SBU - hours per week	60 hours	60	60	60	60	60	60	60	
Dedicated anaesthetic cover on SBU - pw	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	
Midwife/ band 3 to birth ratio (in post)	<1:30		1:29	1:29	1:29	1:29	1:29	1:29	
Number of compliments (PET)		15	2	2	3	2	3	3	
Number of concerns (PET)		7	2	1	1	1	1	1	
Complaints		2	0	0	0	0	1	1	
FFT recommendation rate	>93%		89%	90%	90%	89%	91%	91%	

External Reporting	Standard	Running Total/ average	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Trend
Maternity incidents no harm/low harm		499	58	78	85	86	85	107	
Maternity incidents moderate harm & above		6	0	1	1	0	1	3	
Findings of review of all perinatal deaths using the real time monitoring tool	Sep-23	To date all cases reportable to PMRT are within reporting timeframes- awaiting reports							
Findings of review all cases eligible for referral to MNSI	Sep-23	Three current live cases with MNSI no current completed reports							
Service user voice feedback	Sep-23	Theme around IOL, QI work to be present at LMNS Transformation Board							
Staff feedback from frontline champions and walk-abouts	Sep-23	Improve work around LSCS, reporting higher activity espcially elective work							
HSIB/CQC/NHSR with a concern or request for action		Y/N	N	N	N	N	N	N	
Coroner Reg 28 made directly to the Trust		Y/N	0	0	0	0	0	0	
Progress in Achievement of CNST 10	<4 <7 7 & above								