Maternity Perinatal Quality Surveillance model for April 2024

CQC Maternity	Overall	Safe	Effective	Caring	Responsive	Well led	
Ratings- assessed	Good	Requires	Good	Outstanding	Good	Good	
2023		Improvement					
Unit on the Maternity	Improvemen	t Programme		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 March data (Slide 2 & 3)													
Massive Obstetric Haemorrhage (Mar 3.4%)	Elective Care	Midwifery & Obstetric Wor	rkforce	Staffing red flags (Feb 2024)									
Consecutive reduction in cases this month LMNS PQSG meeting to align the PSIRP plans Obstetric haemorrhage >1.5L 0.00% 4.00% 4.00% 0.00% COUNTY Obstetric haemorrhage >1.5L rate Standard <3.5%	Case numbers remain high, additional lit added to extend for a four-week period support Induction of Labour Outpatient trial now started, supportive measure for experience, system alignment and capacity. IOL for end of year average 28% which is positive. Supported role remains in place to support the QI work.	Midwifery workforce 29 staff leaving NHS, adver MSSW recruitment succeappointed. No obstetric vacancy Total Midwifery vacancles 2.0% 126.7	%, recent vacancy due to rt out.	 10 staffing incident reported in the month, same numbers reported on previous month No harm related staffing incident, increase noted in short term sickness/ Datix needed for agency approval. Suspension of Maternity Services One suspension of services within March, duration <6 hours and three women diverted to neighbouring units for clinical assessment. Home Birth Service 57 Homebirth conducted since re-launch, current rate of 1.6% of all births, back to pre-COVID-19 rate. 									
Saving Babies Lives	Stillbirth rate (3.1 /1000 births)	Maternity Assurance		Incidents reported Jan 2024 (133 no/low harm, 1 moderate or above*)									
Saving Babies Lives Care Bundle Version 3 LMNS validated % of interventions fully	One stillbirth reported in March and	NHSR	Ockenden	MDT reviews	Comments								
All elements 87 reported through the PMR 80 PElement 2 - Fetal Growth Restriction 95 For 2023/2024 the rate per	reported through the PMRT • For 2023/2024 the rate per 1000 births is	Confirmation SFH have been successful	Initial 7 IEA- 100% compliant	Triggers x 20	Category 1 LSCS								
	3.1. This is below the national threshold of	in the Year 5 submission • Year 6 MIS now live	System plan in place for 3-year	0 Incidents reported as 'moderate or above'									

Other

• End of year data now being analysed. Birth rate remains static for the year, noticeable monthly variation noted. This data will be fed into the out of area work focus.



Maternity Perinatal Quality Surveillance scorecard

Maternal Perinatal Quality Surveillance Scorecard

		Total/													
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	Trend
1:1 care in labour	>95%	100.00%	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%	{
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%	~
3rd/4th degree tear overall number		71	6	7	6	8	6	6	7	9	4	5	8	3	~~~
Obstetric haemorrhage > 1.5L number		118	13	19	9	6	11	6	11	15	17	13	6	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%	~
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%	}
Stillbirth number		9	1	0	1	0	1	0	0	0	2	1	2	1	}
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	
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)		35	2	2	3	2	3	3	4	4	3	2	3	4	}
Number of concerns (PET)		13	2	1	1	1	1	1	2	0	1	1	1	1	}
Complaints		4	0	0	0	0	1	1	1	0	0	1	0	0	>
FFT recommendation rate	>93%		89%	90%	90%	89%	91%	91%	90%	91%	90%	90%	90%	90%	~~

		Totalf													
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	Trend
Maternity incidents no harm/low harm		1233	58	78	85	86	85	107	130	158	94	148	102	102	
Maternity incidents moderate harm & above		12	0	1	1	0	1	3	2	2	1	1	0	0	~~
Findings of review of all perinatal deaths using the real time		PMRT case an	e within repo	rting timefra	mes inline v	ith MIS, dea	adline met. A	nnual repor	t downlode	d and preser	ited at MAC	for QC in N	/lay.		
monitoring tool	Mar-24														
		Two current live	Two current live cases with MNSI, one report now final, meeting conducted with the family, for LMNS and Trust sign off. One report ongoing investigation.												
Findings of review all cases eligible for referral to MNSI	Mar-24														
Service user voice feedback	Mar-24	Findings from F	Pain relief re	view nresenl	ted to MNSI	C-action pla	n to be com	nleted							
waterous assi soros resussant	1-10-21	· mangs nom		in present				ipiete u.							
Staff feedback from frontline champions and walk-abouts	Mar-24	Staffing reporti	ng higher act	tivitu suppor	ted bu addito	onal staff. W	ork ongoin	g with an ou	it of areal fo	cus.					
HSIB/CQC/NHSR with a concern or request for action		Y/N	N	N	N	N	N	N	Υ	M	N	N	N	N	
Coroner Reg 28 made directly to the Trust		YVN	0	0	0	0	0	0	0	0	0	0	0	0	
Progress in Achievement of CNST 10	₹4 ₹7	7 & above	-	-	-		-	-	-					-	