Maternity Perinatal Quality Surveillance model for January 2024

| 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 November data (Slide 2 & 3)

Midwifery & Obstetric Workforce Staffing red flags (Dec 2023) Massive Obstetric Haemorrhage (Dec 5.7%) **Elective Care** · 15 staffing incident reported in the month, Rise in cases this month, reviewed and no Elective Caesarean (EL LSCS) Current vacancy rate (PWR data) Midwifery harm, themes or trends. Increased service demand sustained in workforce 0.6%, newly recruited Midwives now decrease on previous month Rapid review for PSIRG on 25th January December onsite and in induction programme. No harm related 2024, no themes or trends, areas of Perfect fortnight feedback- action plan MSSW recruitment live now. Decrease in Datix numbers, attributed to the prompt identification and action noted. made priority digitisation of referrals and confirmation of current staffing model for MDT scheduling Maternity supported by the RCOG guidance. Obstetric Haemorrhage > 1.5L LSCS data under review using Robson 10 Staffing (Regional rate methodology **Suspension of Maternity Services** 0.00% 11.51% Obstetrician vacancy rate Obstetrician vacancy band >5% less than national rate • One suspension of services within December, Induction of Labour (IOL) MSW vacancy rate 18.69% 14.11% Non-medical and outpatient IOL to short duration due to no local support, full MSSW vacancy banding >=5% but <10% higher than national rate commence March 2024 capacity plans operationalised. Midwives vacancy rate 2.18% Digital referrals now live >5% less than national rate **Home Birth Service** Midwives vacancy banding 49 Homebirth conducted since re-launch, 4 delivered at home in December **Saving Babies Lives** Stillbirth rate (1.2 /1000 births) **Maternity Assurance Incidents reported Dec 2023** (91 no/low harm, 1 moderate or above*) Saving Babies Lives Care Bundle Version 3 Two stillbirth reported in December and Ockenden NHSR MDT reviews Comments reported through the PMRT All elements Element 1 - Smoking Self-declaration-full Initial 7 IEA-Triggers x 28 MOH, Cat 1 LSCS Rate remains below the national ambition Element 2 - Fetal Growth Restriction compliance for Yr 5 100% compliant of 4.4/1000 births (SFH rate 2.3/1000) Element 3 - Reducted fetal movements · Trust Board sign off Plans for system Element 4 - Fetal monitoring 100 1 Incidents reported as 'moderate or above' MBRRACE-UK report released, noted completed oversight for 3-Element 5 - Preterm birth Sepsis case currently awaiting MDT review. 03/01/2024 year plan in national increase in still birth in 2021. Element 6 - Diabetes 83 Executive LMNS place, which will actions taken to review themes within the Overall implementation level incorporate the

Partners sign off

IEA's

16/01/2024

Other

Increased births continued into December, approximately 30 more births than average December, predicted for January should settle-SMT monitoring.

national report

- Mandatory training, Trust and Maternity specific remains above 90% threshold for all staff groups
- Additional resource for review into Friends and Family feedback within maternity-feedback will be provided to the Maternity and Neonatal Safety Champions.



Maternity Perinatal Quality Surveillance scorecard

| | | Running Total/ | | | | | | | | | | |
|---|-----------|----------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|
| Quality Metric | Standard | average | Apr-23 | May-23 | Jun-23 | Jul-23 | Aug-23 | Sep-23 | Oct-23 | Nov-23 | Dec-23 | Trend |
| 1:1 care in labour | >95% | 100.00% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | |
| Spontaneous Vaginal Birth | | | 55% | 54% | 43% | 56% | 56% | 55% | 55% | 51% | 53% | ~~~ |
| 3rd/4th degree tear overall rate | <3.5% | 3.80% | 3.40% | 3.50% | 3.60% | 4.60% | 4.50% | 3.50% | 3.90% | 5.20% | 2.40% | |
| 3rd/4th degree tear overall number | | 55 | 6 | 7 | 6 | 8 | 6 | 6 | 7 | 9 | 4 | ~~ |
| Obstetric haemorrhage >1.5L number | | 90 | 13 | 19 | 9 | 6 | 11 | 6 | 11 | 15 | 17 | ~~~ |
| Obstetric haemorrhage >1.5L rate | <3.5% | 3.40% | 4.80% | 6.10% | 3.10% | 2.10% | 4.20% | 2.00% | 3.70% | 4.80% | 5.70% | ~~ |
| 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% | |
| Stillbirth number | | 5 | 1 | 0 | 1 | 0 | 1 | 0 | 0 | 0 | 2 | ~~~ |
| Stillbirth rate | <4.4/1000 | | | | 2.200 | | | 1.700 | | | 2.300 | |
| Rostered consultant cover on SBU - hours per week | 60 hours | 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 | |
| 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 | |
| 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 | |
| Number of compliments (PET) | | 26 | 2 | 2 | 3 | 2 | 3 | 3 | 4 | 4 | 3 | |
| Number of concerns (PET) | | 10 | 2 | 1 | 1 | 1 | 1 | 1 | 2 | 0 | 1 | \sim |
| Complaints | | 3 | 0 | 0 | 0 | 0 | 1 | 1 | 1 | 0 | 0 | |
| FFT recommendation rate | >93% | | 89% | 90% | 90% | 89% | 91% | 91% | 90% | 91% | 90% | ~~~ |

| | $\overline{}$ | $\overline{}$ | | | | | | | | | | |
|--|---------------|--|--------|--------|--------|--------|--------|--------|--------|--------|--------|-------|
| | | Running Total/ | | | | | | | | | | |
| External Reporting | Standard | average | Apr-23 | May-23 | Jun-23 | Jul-23 | Aug-23 | Sep-23 | Oct-23 | Nov-23 | Dec-23 | Trend |
| Maternity incidents no harm/low harm | | 881 | 58 | 78 | 85 | 86 | 85 | 107 | 130 | 158 | 94 | |
| Maternity incidents moderate harm & above | | 11 | 0 | 1 | 1 | 0 | 1 | 3 | 2 | 2 | 1 | ~~ |
| Findings of review of all perinatal deaths using the real | | To date all cases reportable to PMRT are within reporting timeframes inline with MIS, deadline for 12th met | | | | | | | | | | |
| time monitoring tool | Dec-23 | | | | | | | | | | | |
| | | Three current live cases with MNSI, one report completed and agended for the next LMNS SI meeting in Jan 24 | | | | | | | | | | |
| 1 | 1 | | | | | | | | | | | |
| Findings of review all cases eligible for referral to MNSI | Dec-23 | | | | | | | | | | | |
| | | | | | | | | | | | | |
| Service user voice feedback | Dec-23 | New recliner chairs on site, launch planned with MVP but partners now staying overnight following feedback | | | | | | | | | | |
| | | | | | | | | | | | | |
| Staff feedback from frontline champions and walk-abouts | Dec-23 | QI around triage focus on re-locating triage from the birthing unit, Trust support for this for space allocation | | | | | | | | | | |
| HSIB/CQC/NHSR with a concern or request for action | | Y/N | N | N | N | N | N | N | Υ | N | N | |
| Coroner Reg 28 made directly to the Trust | | Y/N | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| Progress in Achievement of CNST 10 | <4 <7 | 7 & above | | | | | | | | | | |