Maternity Perinatal Quality Surveillance model for December 2023

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						
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						
quality of clinical supervision out if hours (reported annually)						

Exception report based on highlighted fields in monthly scorecard using November data (Slide 2 & 3)

Massive Obstetric Haemorrhage (Nov 4.8%) Elective Care		Midwifery & Obstetric Wor	rkforce	Staffing red flags (Nov 2023)			
Rise in cases this month, reviewed and no harm, themes or trends. Plan to present at PSIRG for a thematic review Obstetric haemorrhage >1.5L Obstetric haemorrhage >1.5L Obstetric haemorrhage >1.5L Standard <3.5% Obstetric haemorrhage >1.5L rate Standard <3.5%	Elective Caesarean (EL LSCS) Increased service demand sustained in November Service running 5 days to support demand and plans in place to support IA Perfect fortnight completed; feedback commenced Induction of Labour (IOL) IOL Lead Midwife role extended, rate remains stable Next phase of reviewing outpatient IOL to commence	 Current vacancy rate 3. Midwives now onsite as programme We have recruited into new starters start in posmonths. Recruited into the 2 vac Fetal and Maternal Met the second starting in the 	the vacancy and the st over the next three cant Obstetric posts for dicine, one now in post	51 staffing incident reported in the month. No harm related Noted increase in Datix numbers, reviewed and related to high activity through triage. NEW RCOG guidance benchmarked and will reduce Datix reporting Suspension of Maternity Services One suspension of services within November, short duration due to no local support, full capacity plans operationalised. Home Birth Service 46 Homebirth conducted since re-launch			
Third and Fourth Degree Tears (Nov 5.2%)	Stillbirth rate (1.2 /1000 births)	Maternity Assurance		Incidents reported Nov 2023 (156 no/low harm, 2 moderate or above*)			
Increased rate noted cases under review Pelvic Lead Appointed for SFH- working to	No stillbirth reported in November Rate remains below the national ambition	NHSR	Ockenden	MDT reviews	Comments		
support the additional service/ clinics 3rd/4th Degree Tears 5.00% 4.00% 3.00% 1.00% Apr. May. Jun. Jul-23 Aug. Sep. Oct Nov. 23 23 23 23 23 23 23 23 23 23 23 23 23 2	of 4.4/1000 births (SFH rate 1.7/1000)	Working commenced flash reports to	Initial 7 IEA- 100% compliant	Triggers x 28	MOH, Cat 1 LSCS		
	MBRRACE-UK report released, noted national increase in still birth in 2021	 MAC/QC Additional sign off meetings planned Submission due 2nd of Feb 2024 	Plans for system oversight for 3 year plan in place, which will incorporate the IEA's	2 Incidents reported as 'moderate or above', see comments below for details.			

Other

- Two cases reported at moderate, both MOH and are awaiting MDT verification of harm
- Increased births in November n=316 approximately 50 more births than average November, Maternity monthly dashboard now includes triage and LSCS data breakdown
- Mandatory training remains above 90% threshold for all staff groups



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	Trend
1:1 care in labour	>95%	100.00%	100%	100%	100%	100%	100%	100%	100%	100%	
Spontaneous Vaginal Birth			55%	54%	43%	56%	56%	55%	55%	51%	~
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%	\sim
3rd/4th degree tear overall number		55	6	7	6	8	6	6	7	9	~~
Obstetric haemorrhage >1.5L number		90	13	19	9	6	11	6	11	15	~~
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%	~~~
Term admissions to NICU	<6%	3.10%	1.30%	2.00%	3.20%	5.40%	3.40%	3.40%	3.70%	3.00%	
Stillbirth number		3	1	0	1	0	1	0	0	0	VV_
Stillbirth rate	<4.4/1000				2.200			1.700			
Rostered consultant cover on SBU - hours per week	60 hours	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	
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	
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	
Number of compliments (PET)		23	2	2	3	2	3	3	4	4	
Number of concerns (PET)		9	2	1	1	1	1	1	2	0	_
Complaints		3	0	0	0	0	1	1	1	0	
FFT recommendation rate	>93%		89%	90%	90%	89%	91%	91%	90%	91%	~~

		Running Total/									
External Reporting	Standard	average	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Trend
Maternity incidents no harm/low harm		787	58	78	85	86	85	107	130	158	
Maternity incidents moderate harm & above		10	0	1	1	0	1	3	2	2	~~
Findings of review of all perinatal deaths using the real		To date all cases reportable to PMRT are within reporting timeframes inline with MIS									
time monitoring tool	Sep-23										
		Three current live cases with MNSI, one report completed and agended for the next LMNS SI meeting									
Findings of review all cases eligible for referral to MNSI	Sep-23										
Service user voice feedback	Sep-23	Focused month on pain relief, excellent feedback for antenatal education, work to review information leaflets									
Staff feedback from frontline champions and walk-abouts	Sep-23	High activity remains the focus, QI work on LSCS concluded and staff debriefing and action plan to commence									
HSIB/CQC/NHSR with a concern or request for action		Y/N	N	N	N	N	N	N	Υ	N	
Coroner Reg 28 made directly to the Trust		Y/N	0	0	0	0	0	0	0	0	
Progress in Achievement of CNST 10 <4 <7 7 & abo		7 & above									