### Maternity Perinatal Quality Surveillance model for June 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	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 April data (Slide 2)										
Massive Obstetric Haemorrhage (Apr 4.7 %)	Stillbirth rate 2022/23 (4.0/1000 birt	ths)	Staffing red flags (Apr 2022)							
Increase in cases this month, no harm attributed and team are monitoring.     ICB request for system to review cases/ plan improvement trajectory through system quality and safety meeting given the regional position-meeting on-going	movement, intrauterine fetal dea • SFH stillbirth rate, for year 22/23	below the national ambition of 4.4/1000 inue to work and support the national,	4 staffing incident reported in the month.     No harm related  Suspension of Maternity Services      No suspension of services within April 23  Home Birth Service     23 Homebirth conducted since re-launch, 5 completed in April							
Elective Care	Maternity Assurance Divisional Work	king Group	Incidents reported Apr 2023 (58 no/low harm, 0 moderate or above)							
Elective Caesarean section commenced, refining work underway however noting daily	NHSR	Ockenden	Most reported	Comments						
<ul> <li>improvements and no cancelations noted.</li> <li>Induction of Labour, delays improved revised QI work ongoing around the supportive MDT meeting</li> </ul>	Bid for funding supported by NHSR awaiting final	Initial 7 IEA- final IEA is 100% compliant following evidence	Other (Labour & delivery)	No themes identified						
	<ul> <li>confirmation of the amount.</li> <li>No dates yet for Year 5- working group on pause until confirmed.</li> </ul>	review at LMNS panel     Three year neonatal plan launch     and ongoing work with the LMNS     to look at local deliverables	Triggers x 12	No themes outside of the "trigger" list						
		Next regional insight visit planned for Oct 23	No incidents reported as 'moderate'							

#### Other

- 3<sup>rd</sup> and 4<sup>th</sup> Degree tears improved this month, to monitor.
- SBLCB, remain complaint anticipated launch of version 3 imminently due out secondment role out to recruit to sup[port the delivery of the 2024 ambition
- National Midwifery Officer team onsite to present x2 awards on the 16<sup>th</sup> of May 2023

7



## Maternity Perinatal Quality Surveillance scorecard

# Sherwood Forest Hospitals NHS Foundation Trust

#### **Maternal Perinatal Quality Surveillance Scorecard**

Quality Metric	Standard	Running Total/ average	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	Trend
1:1 care in labour	>95%	99.81%	100%	100%	100%	100%	100%	100%	100%	100%	
Spontaneous Vaginal Birth			55%	55%	54%	43%	56%	56%	55%	60%	
3rd/4th degree tear overall rate	<3.5%	2.18%	2.40%	4.30%	2.80%	1.80%	3.10%	5.60%	3.50%	3.30%	~~
3rd/4th degree tear overall number		46	4	8	6	2	5	9	6	6	~~~
Obstetric haemorrhage >1.5L number		59	9	9	14	14	5	5	5	13	
Obstetric haemorrhage >1.5L rate	<3.5%	3.24%	3.20%	3.90%	4.60%	4.80%	3.90%	2.00%	1.90%	4.70%	/
Term admissions to NICU	<6%	3.62%	3.10%	1.30%	2.00%	3.20%	5.40%	3.40%	3.40%	4.00%	
Stillbirth number		8	2	0	2	2	2	0	1	1	<
Stillbirth rate	<4.4/1000	4.63	3.300			3.240			4.000		
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)		0	2	2	2	3	2	3	3	6	
Number of concerns (PET)		9	1	2	1	1	1	1	1	1	
Complaints		11	0	0	0	0	0	0	0	0	
FFT recommendation rate	>93%		91%	89%	90%	90%	89%	91%	91%	91%	<u></u>

External Reporting	Standard	Running Total/ average	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Feb-23	Feb-23	Trend
Progress against NHSR 10 Steps to Safety	<4 <7 7 & above										
Maternity incidents no harm/low harm		595	96	72	80	79	64	70	64	70	}
Maternity incidents moderate harm & above		0	0	0	0	0	0	0	0	0	
Coroner Reg 28 made directly to the Trust		Y/N	0	0	0	0	0	0	0	0	
HSIB/CQC etc with a concern or request for action		Y/N	N	N	N	N	N	N	N	N	