Maternity Perinatal Quality Surveillance model for November 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)						

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Massive Obstetric Haemorrhage (Oct 3.7%)	Elective Care	Midwifery & Obstetric Wor	kforce	Staffing red flags (Oct 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 Apr-23 May-23 Jun-23 Jul-23 Aug-23 Sep-23 Oct-23 	 Elective Caesarean (EL LSCS) Increased service demand sustained in October Service now running 5 days to support demand. Induction of Labour (IOL) IOL work presented to LMNS IOL Lead Midwife role extended to support QI projects- rate remains stable 	 Current vacancy rate 3.2%, New recruited Midwives now onsite and in preceptorship programme We have recruited into the vacancy and the new starters start in post over the next three months. Recruited into the 2 vacant Obstetric posts for Fetal and Maternal Medicine, one now in post the second starting in the new year. 		 32 staffing incident reported in the month. No harm related Noted increase in Datix numbers, reviewed and related to high activity through triage Suspension of Maternity Services One suspension of services within October Home Birth Service 45 Homebirth conducted since re-launch 			
Third and Fourth Degree Tears (Oct 3.9%)	Stillbirth rate (1.2/1000 births)	Maternity Assurance		Incidents reported Oct 2023 (128 no/low harm, 2 moderate or above*)			
 Increased rate noted cases under review Pelvic Lead Appointed for SFH- working to 	 No stillbirth reported in October Rate remains below the national ambition 	NHSR	Ockenden	Most reported	Comments		
of 4 5.00% 3rd/4th Degree Tears 4.00% MBF	of 4.4/1000 births	 Working commenced flash reports to MAC/QC Additional sign off meetings planned 	Initial 7 IEA- 100% compliant		MOH, Cat 1 LSCS		
			 Positive initial feedback from the Ockenden. 	Triggers x 20			
		Submission due 2 nd of Feb 2024	Report received and response/ action plan to be approved at MAC	2 Incidents reported as 'moderate or above', see below			

Other

- Two cases reported at moderate= awaiting MDT verification of harm and onwards reporting.
- Letter received from MNSI regarding the catastrophic case reported in September 2023. Letter responded within timeframes; themes support the rapid review concerns. Investigation ongoing.
- One suspension of service, unit declared however where unable to transfer women to any neighbouring units. No cases with harm reported within the suspension.

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Maternity Perinatal Quality Surveillance scorecard

Quality Metric	Standard	Running Total/ average	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Trend
1:1 care in labour	>95%	100.00%	100%	100%	100%	100%	100%	100%	100%	
	29376	100.00%								
Spontaneous Vaginal Birth			55%	54%	43%	56%	56%	55%	53%	\sim
3rd/4th degree tear overall rate	<3.5%	3.80%	3.40%	3.50%	3.60%	4.60%	4.50%	3.50%	3.90%	\sim
3rd/4th degree tear overall number		39	6	7	6	8	6	6	7	\sim
Obstetric haemorrhage >1.5L number		64	13	19	9	6	11	6	11	\sim
Obstetric haemorrhage >1.5L rate	<3.5%	3.40%	4.80%	6.10%	3.10%	2.10%	4.20%	2.00%	3.70%	\sim
Term admissions to NICU	<6%	3.10%	1.30%	2.00%	3.20%	5.40%	3.40%	3.40%	3.70%	\langle
Stillbirth number		2	1	0	1	0	1	0	0	$\sim\sim$
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	60	
Dedicated anaesthetic cover on SBU - pw	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	
Midwife/ band 3 to birth ratio (in post)	<1:30		1:29	1:29	1:29	1:29	1:29	1:29	1:29	
Number of compliments (PET)		15	2	2	3	2	3	3	4	\sim
Number of concerns (PET)		7	2	1	1	1	1	1	2	
Complaints		2	0	0	0	0	1	1	1	
FFT recommendation rate	>93%		89%	90%	90%	89%	91%	91%	90%	\sim

External Reporting	Standard	Running Total/ average	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Trend
Maternity incidents no harm/low harm	Standard	629	58	78	85	86	85	107	130	menu
Maternity incidents moderate harm & above		8	0	1	1	0	1	3	2	~
Findings of review of all perinatal deaths using the real		To date all cases reportable to PMRT are within reporting timeframes.								
time monitoring tool	Oct-23									
		3 current live cases with MNSI, 1 report returned for Trust/LMNS sign off. 2 remain under investigation.								
Findings of review all cases eligible for referral to MNSI	Oct-23									
Service user voice feedback	Oct-23	Work presented to the LMNS, IOL Lead Midwife role extended to support improvement work.								
Staff feedback from frontline champions and walk-abouts	Oct-23	Additonal LSCS underway following feedback from previous walkrounds and supporting high activity.								
HSIB/CQC/NHSR with a concern or request for action		Y/N	N	N	N	N	N	N	Y	
Coroner Reg 28 made directly to the Trust		Y/N	0	0	0	0	0	0	0	
Progress in Achievement of CNST 10		7 & above								