

Maternity Perinatal Quality Surveillance model for April 2021



Sherwood Forest Hospitals
NHS Foundation Trust

CQC Maternity Ratings - last assessed 2018	OVERALL GOOD	SAFE GOOD	EFFECTIVE GOOD	CARING OUTSTANDING	RESPONSIVE GOOD	WELL LED GOOD
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2019	
Proportion of midwives responding with 'Agree' or 'Strongly Agree' on whether they would recommend their Trust as a place to work or receive treatment (reported annually)	72%
Proportion of speciality trainees in O&G responding with 'excellent or good' on how they would rate the quality of clinical supervision out of hours (reported annually)	89.29%

Exception report based on highlighted fields in monthly scorecard (Slide 2)

Obstetric haemorrhage >1.5L (1.99% Feb 21)	Stillbirths (4.63/1000 vs national target <4.4/1000)	FFT recommendation rate	
<ul style="list-style-type: none"> Data quality review shows duplication of reporting of MOH on Datix Actual numbers = 5 in month All undergo MDT review at weekly triggers No lapses in care identified 	<ul style="list-style-type: none"> Noted at divisional governance and maternity safety champions meeting Detailed review in progress for sharing with Quality Committee All cases appropriately referred for national reporting and external review Notify LMNS Board 	<ul style="list-style-type: none"> Response rate and recommendation rate slightly improved this month – exception report via SOF 	
Training compliance / CTG competency assessment	Progress against NHSR/10 Steps to Safety (revised submission deadline 15 July 2021)	Incidents reported February 2021 (63 all no/low harm after review)	
<ul style="list-style-type: none"> Good progress continues with increased engagement across the MDT NHSR technical guidance amended to remove compliance trajectories 	<ul style="list-style-type: none"> Review and reporting schedule now confirmed Peer/external evidence review arranged Technical guidance updated again March 21 	Most reported 'Labour & delivery'	Comments
		PPH>1.5L	Some duplication in reporting, no themes identified
		Triggers x 5	See 'triggers' list for maternity
		One incident (staff fall in car park) reported as 'severe harm' – staff member had minor treatment, now back at work.	

HSIB/CQC concern or request for action

- No new CQC requests in February
- Increase in access to FTSU Guardian after targeted Maternity presence; cases reviewed and addressed on individual basis and relate to staff wellbeing rather than patient safety
- All HSIB investigations and reports now complete; no safety recommendations made after latest investigation; await Trust sign off.

Maternity Perinatal Quality Surveillance scorecard

CQC Maternity Ratings - last assessed 2018	OVERALL GOOD	SAFE GOOD	EFFECTIVE GOOD	CARING OUTSTANDING	RESPONSIVE GOOD	WELL LED GOOD
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Maternity Safety Support Programme No

Maternity Quality Dashboard 2020-21		Alert [national standard/average where available]	Running Total/average	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21		
Perinatal	1:1 care in labour	>95%	99.81%	100%	100%	100%	99.66%	100%	99.66%	99.66%	99.66%	100%	99.66%	100%			
	3rd/4th degree tear overall rate	>3.5%	2.01%	3.20%	2.63%	0.37%	2.11%	2.68%	2.42%	1.02%	2.37%	2.32%	0.84%	2.82%			
	Obstetric haemorrhage >1.5L	Actual	116	7	15	13	21	8	7	11	9	8	8	9			
	Obstetric haemorrhage >1.5L	<2.6%	3.89%	2.49%	5.64%	4.80%	7.37%	2.66%	2.42%	3.75%	3.56%	3.09%	3.36%	3.63%			
	Term admissions to NNU	<6%	3.29%	4.24%	1.84%	1.82%	2.44%	3.00%	3.06%	5.44%	2.34%	4.59%	4.20%	1.99%			
	Apgar <7 at 5 minutes	<1.2%	1.46%	1.77%	0.74%	1.09%	0.70%	1.00%	1.36%	1.36%	2.73%	2.30%	3.35%	0.00%			
	Stillbirth number	Actual	9	1	0	1	0	1	0	1	2	2	1	2			
	Stillbirth number/rate	>4.4/1000	4.63			2.413			1.135			3.173					
Workforce	Rostered consultant cover on SBU - hours per week	<60 hours	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			
	Midwife / band 3 to birth ratio (establishment)	>1:28		1:30.4	1:28.4	1:27.8	1:30.4	1:30	1:26.5	1:26.5	1:26.4	1:26.5	1:24.6	1:30			
	Midwife / band 3 to birth ratio (in post)	>1:30		1:31.4	1:30	1:29.9	1:31.4	1:29	1:29.7	1:29.7	1:28.4	1:29.7	1:25.7	1:25.7			
Feedback	Number of compliments (PET)			0	0	0	1	2	1	4	2	1	1	1			
	Number of concerns (PET)			1	3	1	2	5	0	0	3	2	1	2			
	Complaints			0	1	0	2	2	1	1	0	0	2	0			
	FFT recommendation rate	>93%		89%	100%	100%	99%	93%	93%	87%	83%	83%	76%	88%			
Training	All training suspended during Covid.																
	PROMPT/Emergency skills all staff groups			94%	MDT training re-launched with PROMPT programme. All staff booked to complete by March 21							15%	39%	58%	100%		
	K2/CTG training all staff groups			88%	CTG training re-launched with K2 programme & revised competency assessment framework. All staff booked to complete by March 21.							36%	45%	75%	100%		
	Core competency framework compliance			Core competency framework launched December 2020 - for inclusion in maternity TNA for 21/22													
Reporting	Progress against NHSR 10 Steps to Safety	<4 <7 & above															
	Maternity incidents no harm/low harm	Actual	699	60	45	60	54	59	83	52	68	95	61	62			
	Maternity incidents moderate harm & above	Actual	3	0	0	2	0	0	0	0	0	0	0	1			
	Coroner Reg 28 made directly to the Trust	Y/N	N	N	N	N	N	N	N	N	N	N	N	N			
	HSIB/CQC etc with a concern or request for action	Y/N	N	N	N	N	N	N	N	N	N	Y	Y	N			