Maternity Perinatal Quality Surveillance model for December 2021

	OVERALL	SAFE	EFFECTIVE	CARING	RESPONS	SIVE \	NELL LEI		
CQC Maternity Ratings - last assessed 2018	GOOD	GOOD	GOOD	OUTSTANDING	GOOD)	GOOD		
		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)									
recommend their Trust as	2 2 2 2 2 2 2 2 2 2	de ar raccioes	0, 0	•					
recommend their Trust as	a place to wo	rk or receive	0, 0	•		72%			
recommend their Trust as Proportion of speciality trainees rate the quality of cl	in O&G respoi	nding with 'e	treatment (rep	oorted annually	y)	72%			



Exception report	: based on highlighted	fields in monthly sco	recard (Slide 2)
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Obstetric haemorrhage >1.5L (3.0%, Dec 21)	APGARS <7 at 5 minutes (2.1 % Dec 2	21)	Staffing red flags				
 Improvement made on previous month, remains below revised national rate (>3.6%) Cases reportable via maternity triggers - no lapses in care / learning points identified Division continue the pilot of a care bundle to evaluate the impact 	Quarter cases to be reviewed coll tends- paper to be present to MA	entified no concerns/ poor outcomes. lectively to identify any potential themes/ LC nains within expected range and all cases lible admissions.	 4 staffing incidents reported in month Significant challenges due to short term/ short notice sickness related to COVID-19 Virtual maternity forum cancelled due to staffing pressures. Home Birth Service Due to vacancies and sickness homebirth services remains limited, paper received Board approval. This has been further escalated to the CCG and regionally for awareness. 0 Homebirths conducted in Dec 21 				
FFT (96% Dec 2021)	Maternity Assurance Divisional Work	king Group	Incidents reported Dec 21 (88 no/low harm after review)				
FFT remains improved following revised actions QR codes trial continues as part of action plan to	NHSR	Ockenden	Most reported	Comments			
 improve FFT compliance. Teams reminded monthly about asking patients to complete and all actions being monitored via monthly service line. Action plan reportable to Nursing, Midwifery and 	NHSR year 4 reporting has been paused for three months	Assurance provided by the MAC On-going work continues to	Other (Labour & delivery)	No themes identified			
	in December to support clinical teams	strengthen actions, allowing for current staffing pressures.	Triggers x 12	Various including PPH, term admission			
AHP committee.	Monthly divisional continues in limited capacity	Ockenden part two expected March 22	No incidents reported as 'moderate' harm or above.				

Other

- Staffing incidents increased slightly this month, due to short notice sickness (COVID). Supportive actions taken including cancelation of training (noted within static dashboard figures) temporary suspension of internal and external secondments and specialist Midwives and Matrons working on the clinical rotas.
- Birthrate plus re-implementation final training completed and final stages of testing due to end Dec 21.
- 28.37wte vacancies (19.4%) mainly across the community midwifery service. Active recruitment in place. Challenges currently exacerbated due to Omicron variant, annual leave and vacancies. Risk assessment applied where appropriate to support return to work. RN's utilised on Maternity ward
- No further formal letters received and all women who have a planned homebirth, all women due December and January have been written to by the Head of Midwifery to outline current situation
- Midwifery Continuity of Carer formal data collection paused nationally for three months.



Maternity Perinatal Quality Surveillance scorecard

Sherwood Forest Hospitals CQC Maternity Ratings - last assessed 2018													
CQC Maternity Ratings - last assessed 201													
CQC Maternity Ratings - last assessed 201		RALL	SA	FE	EFFEC	TIVE		CARING		RESPO	NSIVE	WELL LED	
ege Materinty Rutings Tust ussessed 201			GOOD		GOOD			OUTSTANDING		GOOD		GOOD	
			GOOD		GOOD			001317		40.		3005	
Maternity Safety Support Programme	No												
Maternity Quality Dashboard 2020-2021	Alert [nationa I standar d/avera ge	Running Total/ average	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21					
1:1 care in labour	>95%	99.81%	95%	95%	100%	100%	100%	100%					
Women booked onto MCOC pathway			18%	20%	20%	20%	20%						
Women receving MCOC intraprtum			0%	0%	0%	0%	0%						
Total BAME women booked			21%	21%	20%	20%	20%						
BAME women on CoC pathway			5%	15%	15%	15%	15%						
Vaginal Birth			60%	62%	51%	61%	57%	56%					
3rd/4th degree tear overall rate	>3.5%	2.18%	3.00%	2.30%	0.94%	2.11%	3.00%	2.50%					
Obstetric haemorrhage >1.5L	Actual	116	7	8	8	9	10	9					
Obstetric haemorrhage >1.5L	>3.5%	3.24%	2.60%	2.70%	2.51%	2.90%	3.50%	3.00%					
Term admissions to NNU	<6%	3,62%	4.60%	2.10%	2.16%	3.70%	3.20%	3.70%					
Apgar <7 at 5 minutes	<1.2%	1.56%	1.30%	0.68%	1.20%	152%	2.03%	2.10%					
Stillbirth number	Actual	11	1	0.007.	1.20%	0	0	3					
Stillbirth number/rate	0	4.63		Ť	2.176		l – ĭ – l	3,400					
stillbirth number/rate Rostered consultant cover on SBU - hours per weel		60	60	60	60	60	60	5.400					
Dedicated anaesthetic cover on SBU - pw	<10	10	10	10	10	10	10	10					
Midwife / band 3 to birth ratio (establishment)	>1:28	1	1:30.4	1:30.4	1:30.4	1:29	1:29	1:29	l				
Midwife/band 3 to birth ratio (in post)	>1:30		1:31.4	1:31.4	1:31.4	1:29	1:29	1:28	ľ				
Number of compliments (PET)		0	0		0			0					
Number of concerns (PET)		9	2		2	4	0	0					
Complaints		11	1	2	1	3	2	1					
FFT recommendation rate	>93%		91%	91%	92%	88%	96%	96%					
	-												
PROMPT/Emergency skills all staff groups	+		100%	100%	100%	100%	100%	100%					
K2/CTG training all staff groups	_		98%	98%	98%	98%	98%	98%					
CTG competency assessment all staff groups			98%	98%	98%	98%	98%	98%					
Core competency framework compliance			26%	38%	50%	62%	70%	70%					
Progress against NHSR 10 Steps to Safety	<4 <7 7	& above											
Maternity incidents no harm/low harm	Actual	453	84	84	76	63	57	89					
Maternity incidents moderate harm & above	Actual	2	0	0	0	1	1	0					
Coroner Reg 28 made directly to the Trust	1	Y/N	N	N	N	N	N	Ö					
HSIB/CQC etc with a concern or request for action		Y/N	N	V	N	N	N	N					