

Maternity Perinatal Quality Surveillance model for April 2022



Sherwood Forest Hospitals
NHS Foundation Trust

CQC Maternity Ratings - last assessed 2018	OVERALL	SAFE	EFFECTIVE	CARING	RESPONSIVE	WELL LED
	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)	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 (Mar 3%)	APGARS <7 at 5 minutes (2%, Mar 22)	Staffing red flags		
<ul style="list-style-type: none"> 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 have signed up to regional pilot- first planning meetings on hold for April 22 	<ul style="list-style-type: none"> Rate, remains over national threshold, noted no adverse incident, cases or term admissions related to this rate. Board are reminded that over-reporting will result in enhanced observation of the baby Deep dive paper on agenda for MAC in May 2022 	<ul style="list-style-type: none"> 4 staffing incidents reported in month Challenges due to short term/ short notice sickness related to COVID-19 persist but with an improving position. <p>Home Birth Service</p> <ul style="list-style-type: none"> Due to vacancies and sickness homebirth services remains limited as per Board approval. This has been further escalated to the CCG and regionally for awareness. 1 Homebirth conducted in Mar 22, plan in place to re-start the full service in Quarter 2 22-23 		
FFT (90% Mar 22)	Maternity Assurance Divisional Working Group		Incidents reported Mar 22 (69 no/low harm, 1 as moderate)	
<ul style="list-style-type: none"> FFT remains improved following revised actions New system being implemented in April which may cause disruption. CQC annual maternity feedback survey received, Trust results remain the same as other units, noting the COVID challenges, action plan made from findings. Service User Representative in post and providing additional pathways for maternal feedback 	NHSR	Ockenden	Most reported	Comments
	<ul style="list-style-type: none"> NHSR year 4 reporting has been paused – re-launch due Mid-April 22 Confirmation received that SFH was successful in obtaining the Year 3 rebate 	<ul style="list-style-type: none"> One year on submission completed 15/04/22. Final Ockenden report released 31/03/22. 15 additional IEA's for all Trust nationally to work towards. Separate paper provided to board 	Other (Labour & delivery)	No themes identified
			Triggers x 14	Cases included, PPH, term admission, category 1 LSCS
One incident reported as 'moderate'				

Other

- Staffing incidents remain static, review of 21-22 birthrate underway. Noted an increased and revised BR+ report to be completed on the 26/04/22
- LMNS quality insight visit planned for the 20/04/22 as part of the year one national Ockenden recommendations. Positive feedback received.
- Active recruitment continues, Matron for Maternity Governance post closed, strong applications.
- No further formal letters received and all women who have a planned homebirth, all women due April and Mau have been written to by the Head of Midwifery to outline current situation
- Midwifery Continuity of Carer formal data collection paused nationally, LMNS work ongoing for Year 1 plans for transformation, Year 1 focus on system alignment of digital workstream
- Moderate case taken to Trust scoping, for local investigation and learning. Delay in category One LSCS timeframes.

Maternity Perinatal Quality Surveillance scorecard

	OVERALL	SAFE	EFFECTIVE	CARING	RESPONSIVE	WELL LED					
CQC Maternity Ratings - last assessed 2018	GOOD	GOOD	GOOD	OUTSTANDING	GOOD	GOOD					
Maternity Safety Support Programme	No										
Maternity Quality Dashboard 2020-2021	Alert [national standard /average where]	Running Total/ average	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
1:1 care in labour	>95%	99.81%	95%	95%	100%	100%	100%	100%	100%	100%	100%
Women booked onto MCOG pathway			18%	20%	20%	20%	20%				
Women receiving MCOG intrapartum			0%	0%	0%	0%	0%				
Total BAME women booked			21%	21%	20%	20%	20%				
BAME women on CoC pathway			5%	15%	15%	15%	15%				
Spontaneous Vaginal Birth			60%	62%	51%	61%	57%	56%	63%	61%	59%
3rd/4th degree tear overall rate	>3.5%	2.18%	3.00%	2.30%	0.94%	2.11%	3.00%	2.50%	2.78%	2.52%	2.90%
Obstetric haemorrhage >1.5L	Actual	116	7	8	8	9	10	9	6	8	7
Obstetric haemorrhage >1.5L	>3.5%	3.24%	2.60%	2.70%	2.51%	2.90%	3.50%	3%	2.12%	3.30%	2.60%
Term admissions to NNU	<6%	3.62%	4.60%	2.10%	2.16%	3.70%	3.20%	3.70%	5.00%	3.50%	3.50%
Apgar <7 at 5 minutes	<12%	1.56%	1.30%	0.68%	1.20%	1.52%	2.03%	2.10%	1.90%	1.80%	2.00%
Stillbirth number	Actual	11	1	0	1	0	0	3	1	1	1
Stillbirth number/rate	>4.4/1000	4.63			2.176			3.400			3.727
Rostered consultant cover on SBU - hours per	<60 hours	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
Midwife 7 band 3 to birth ratio (establishment)	>1:28		1:30.4	1:30.4	1:30.4	1:29	1:29	1:29	1:29	1:22	1:22
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	1:28	1:24	1:24
Number of compliments (PET)		0	0	0	0	0	0	0	0	0	1
Number of concerns (PET)		9	2	1	2	4		0	0	0	2
Complaints		11	1	2	1	3	2	1	1	1	2
FFT recommendation rate	>93%		91%	91%	92%	88%	96%	96%	92%	91%	90%
PROMPT/Emergency skills all staff groups			100%	100%	100%	100%	100%	100%	100%	100%	100%
K2/CTG training all staff groups			98%	98%	98%	98%	98%	98%	98%	98%	98%
CTG competency assessment all staff groups			98%	98%	98%	98%	98%	98%	98%	98%	98%
Core competency framework compliance			26%	38%	50%	62%	70%	70%	81%	81%	88%
Progress against NHSR 10 Steps to Safety	4 <7 7 & above										
Maternity incidents no harm/low harm	Actual	626	84	84	76	63	57	89	83	45	69
Maternity incidents moderate harm & above	Actual	5	0	0	0	1	1	0	1	1	1
Coroner Reg 28 made directly to the Trust	Y/N	N	N	N	N	N	N	0	0	0	0
HSIB/CQC etc with a concern or request for action	Y/N	N	Y	N	N	N	N	N	N	N	N