Maternity Perinatal Quality Surveillance model for May 2022

	OVERALL	SAFE	EFFECTIVE	CARING	RESPONSIVE	WELL LED			
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)									
						72%			
Proportion of speciality trainee rate the quality of				•	•	89.29%			



		05.2570							
Exception report based on highlighted fields in monthly scorecard (Slide 2)									
3 rd and 4 th Degree Tears (6.2% May 2022)	Moderate Reportable Case (May 202	2)	Staffing red flags (May 2022)						
 First time since July 21 that the rate has exceed the national standard. Deep dive review commenced of all cases. Noted that all 3rd and 4th Degree tears are reportable via Datix, none have been rated as moderate or above. 	Duty of Candour and bereavement		 1 staffing incident reported in the month No further issues raised around staffing, aligned with the successful recruitment and ongoing re-designed preceptorship programme. Home Birth Service 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. 2 Homebirth conducted in May 22, plan in place to re-start the full service on the 1st Sept 2022- aligned with NUH 						
FFT (88% May 2022)	Maternity Assurance Divisional Worl	king Group	Incidents reported May 2022 (69 no/low harm, 1 as moderate)						
 FFT remains improved following revised actions New system implementation delayed- to observe the impact Service User Representative in post and providing additional pathways for maternal feedback 	NHSR	Ockenden	Most reported	Comments					
	 NHSR year 4 relaunched on the 6th of May 2022 	Initial 7 IEA- MVP engagement ensure final IEA is 86% completed	Other (Labour & delivery)	No themes identified					
	 Divisional working group re- commenced, amber rating due to reporting timeframes 	 plan underway for final action Final 15 IEA, 10 have been peer assessed with plan for the final 5 	Triggers x 16 Cases included, PPH, term admis and 3 rd /4 th degree tears						
			One incident reported as 'moderate'						

Other

- Apgar scoring and MoH removed from the exception report due to consecutive month of green reporting, to monitor.
- Active recruitment continues, Matron for Intrapartum and Community and Outpatients recruited into. Open day on June completed and a further 12 WTE newly qualified midwives recruited- acute
 maternity fully recruited in Sept 2022.
- No formal letters received and all women who have a planned homebirth, all women due June and July have been written to by the Director of Midwifery to outline current situation.
- Midwifery Continuity of Carer system submission made on the 16th of June 2022- awaiting national feedback



Maternity Perinatal Quality Surveillance scorecard

	OVERALL	SA	FE	EFFECTIVE	CARING		RESPONSIVE			WE	LL LED
	GOOD	GO	OD	GOOD	OUTSTA	ANDING	GOOD			G	OOD
Maternity Safety Support Programme	No					· · · ·					
Maternity Quality Dashboard 2020-2021	Alert [nationa l standar dłavera ge	Running Total/ average	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
1:1 care in labour	>95%	99.81%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Women booked onto MCOC pathway			20%	20%	20%						
Women recoving MCOC intraprtum			0%	0%	0%						
Total BAME women booked			20%	20%	20%						
BAME women on CoC pathway			15%	15%	15%						
Spontaneous Vaginal Birth			51%	61%	57%	56%	63%	61%	59%	55%	60%
3rd/4th degree tear overall rate	>3.5%	2.18%	0.94%	2.11%	3.00%	2.50%	2.78%	2.52%	2.90%	3.00%	6.20%
Obstetric haemorrhage >1.5L	Actual	116	8	9	10	9	6	8	7	6	9
Obstetric haemorrhage >1.5L	>3.5%	3.24%	2.51%	2.90%	3.50%	3%	2.12%	3.30%	2.60%	2.20%	3.20%
Term admissions to NNU	<6%	3.62%	2.16%	3.70%	3.20%	3.70%	5.00%	3.50%	3.50%	1.60%	4.00%
Apgar <7 at 5 minutes	<1.2%	1.56%	1.20%	1.52%	2.03%	2.10%	1.90%	1.80%	2.00%	0.84%	0.40%
Stillbirth number	Actual	11	1	0	0	3	1	1	0	1	2
Stillbirth number/rate	0	4.63	2.176			3.400			3.727		
Rostered consultant cover on SBU - hours per we		60	60	60	60	60	60	60	60	60	60
Dedicated anaesthetic cover on SBU - pw Midwife / band 3 to birth ratio (establishment)	<10	10	10 1:30.4	10 1:29	10 1:29	10 1:29	10 1:29	10 1:22	10 1:22	10 1:22	10 1:22
Midwife / band 3 to birth ratio (establishment)	21:20		1:30.4	1:20	1:20	1:23	1:23	1:22	1:22	1:22	1:22
Midwife/ band 3 to birth ratio (in post)	>1:30		1:31.4	1:29	1:29	1:28	1:28	1:24	1:24	1:24	1:24
Number of compliments (PET)		0	0	0	0		0	0	1	1	
Number of concerns (PET)		9	2	4	0	0	0	0		2	
Complaints		11	1	3	2	1	1		2	1	0
FFT recommendation rate	>93%		92%	88%	96%	96%	92%	91%	90%	89%	88%
											_
PROMPT/Emergency skills all staff groups			100%	100% 98%	100%	100%	<u>100%</u> 98%	100%	100%	100%	94%
K2/CTG training all staff groups			98% 98%	98%	98% 98%	98%	98%	98% 98%	98% 98%	98% 98%	98% 98%
CTG competency assessment all staff groups			98% 50%	98% 62%	98%. 70%	98% 70%	98%. 81%	98% 81%		98%	98%
Core competency framework compliance			50%	62%	70%	70%	81%	81%	88'%	95%	95%
Progress against NHSR 10 Steps to Safety	<4 <7 7	& above									
Maternity incidents no harm/low harm	Actual	610	76	63	57	89	83	45	69	58	70
Maternity incidents moderate harm & above	Actual	7	0	1	1	0	1	1	1	1	1
Coroner Reg 28 made directly to the Trust		Y/N	Ň	N	N	Ō	0	0	0	0	0
HSIB/CQC etc with a concern or request for actio	n	Y/N	N	N	N		N	N	N	N	N