## Maternity Perinatal Quality Surveillance model for July 2022

	OVERALL	SAFE	EFFECTIVE	CARING	RESPONSIVE	WELL LED	
CQC Maternity Ratings - last assessed 2018	GOOD	GOOD	GOOD	OUTSTANDING	GOOD	GOOD	
		2019	1				
Proportion of midwives resp	onding with	'Agree' or 'S	trongly Agree	e' on whether	they would		
recommend their Trust a	_	_			•		
						72%	
Proportion of speciality trained	s in 086 ros	nonding with	h 'aveallant a	ar good! on be	+b.o		
Proportion of speciality trainee rate the quality of				_	•		
rate the quality of	cca. sape		3ou.s (.ep.	orted armaan	,,	89.29	



xception report based on highlighted fields in monthly scorecard (Slide 2)									
3 <sup>rd</sup> and 4 <sup>th</sup> Degree Tears (2.84% Jul 2022)	Stillbirth rate year to date (3.1/1000	births)	Staffing red flags (Jul 2022)						
Rate below national threshold.     Deep dive review into cases have found no themes or trends.	ambition of 4.4/1000 birth with Ju	e now returned below the national uly reporting 1 cases. d through the governance process, no	<ul> <li>5 staffing incident reported in the month, one related to high acuity leading to declared suspension of services.</li> <li>Due to regional capacity, no local units were unable to accept women in labour. Appropriate actions were taken inline with the supporting SOP.</li> <li>No harm related incidents reported.</li> <li>Home Birth Service</li> <li>Due to vacancies and sickness homebirth services remains limited as per Board approval.</li> <li>1 Homebirth conducted in July 22, plan in place to re-start the full service on the 18<sup>th</sup> Sept 2022</li> </ul>						
FFT (94% Jul 2022)	Maternity Assurance Divisional Work	king Group	Incidents reported Jul 2022 (105 no/low harm, 2 as moderate)						
FFT remains improved following revised actions     New system implementation delayed     Service User Representative in post and providing additional pathways for maternal feedback	NHSR	Ockenden	Most reported	Comments					
	NHSR year 4 relaunched on the 6 <sup>th</sup> of May 2022, divisional	Initial 7 IEA- final IEA is 86%     Regional quarterly LMNS panel	Other (Labour & delivery)	No themes identified					
	<ul> <li>working group supporting</li> <li>Current challenge around resource to help deliver particularly with business unit</li> </ul>	now in place to review additional evidence submitted  • Final 15 IEA, 14 have been peer assessed with plan for the final 1	Triggers x 15	Themes includes Category 1 LSCS, 3 <sup>rd</sup> and 4 <sup>th</sup> degree tears and PPH					

## Other

- Increased birth-rate for July 316 births. Significantly increased on previous years average of 290 births.
- Two cases reported as moderate- one reviewed at MDT incident meeting and no further action required as low harm, the second an unplanned admission to ITU will be taken through Trust Scoping
- CQC enquiry received in July 2022- responded and closed.
- No formal letters received and all women who have a planned homebirth, all women have been written to by the Director of Midwifery to outline current situation.
- Midwifery Continuity of Carer system submission made on the 16<sup>th</sup> of June 2022- still no national feedback received.



## Maternity Perinatal Quality Surveillance scorecard

Sherwood Forest Hospitals										
OVERALL		SAFE EFFECTIVE		E CARING		RESPONSIVE			V	VELL LED
QC Maternity Ratings - last assessed 2018	GOOD	GOOD	GOOD	OUTSTANDING		GOOD			GOOD	
Maternity Quality Dashboard 2020-2021		Alert [nationa I standar d/avera ge	Running Total/ average			Mar-22	-	,		Jul-22
1:1 care in labour		>95%	99.81%	100%	100%	100%	100%	100%	100%	100%
Women booked onto MCOC paths	way									
Women receving MCOC intraprtu	m									
Total BAME women booked										
BAME women on CoC pathway										
Spontaneous Vaginal Birth				63%	61%	59%	55%	60%	60%	60%
3rd/4th degree tear overall rate		>3.5%	2.18%	2.78%	2.52%	2.90%	3.00%	6.20%	3.72%	2.84%
Obstetric haemorrhage >1.5L		Actual	116	6	8	7	6	9	7	7
Obstetric haemorrhage >1.5L		>3.5%	3.24%	2.12%	3.30%	2.60%	2.20%	3.20%	2.45%	2.45%
Term admissions to NNU		<6%	3.62%	5.00%	3.50%	3.50%	1.60%	4.00%	2.60%	2.60%
Apgar <7 at 5 minutes		<1.2%	1.56%	1.90%	1.80%	2.00%	0.84%	0.40%	1.20%	1.20%
Stillbirth number		Actual	11	1	1	0	1	2	2	1
Stillbirth number/rate		0	4.63			3.727			5.952	
Rostered consultant cover on SBI			60	60	60	60	60	60	60	60
Dedicated anaesthetic cover on S		<10	10	10	10	10	10	10	10	10
Midwife / band 3 to birth ratio (es	stablishment)	>1:28		1:29	1:22	1:22	1:22	1:22	1:24.5	1:27
Midwife/band 3 to birth ratio (in post)		>1:30		1:28	1:24	1:24	1:24	1:24	1:26.5	1:29
Number of compliments (PET)		+	0	0	0	1	1	1	1	
Number of concerns (PET)			9	0	0	2	2	1	0	
Complaints			11	1	1	2	1	0	2	
FFT recommendation rate		>93%		92%	91%	90%	89%	88%	88%	94
PROMPT/Emergency skills all staff groups				100%	100%	100%	100%	94%	95%	95
K2/CTG training all staff groups				98%	98%	98%	98%	98%	98%	98:
CTG competency assessment all staff groups				98%	98%	98%	98%	98%	98%	98
Core competency framework compliance				81%	81%	88*%	95%	95%	95%	95
Progress against NHSR 10 Steps t	o Safety	<4 <7 7	& above							
Maternity incidents no harm/low harm		Actual	529	83	45	69	58	70	99	105
Maternity incidents moderate harm & above		Actual	7	1	1	1	1	1	1	1
Coroner Reg 28 made directly to the Trust			Y/N	0	0	0	0	0	0	0
HSIB/CQC etc with a concern or request for action			Y/N	N	N	N	N	N	N	Ý