Maternity Perinatal Quality Surveillance model – launch Jan 2021

	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 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%

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National position & overview

- The model describes a standard data set for Trust Board overview
- There is scope for local amendments (additions) provided the minimum data set is covered
- Obstetric haemorrhage and term admissions/low Apgars are reviewed weekly at Triggers and escalated as required to Trust scoping/external review
- Maternity FFT is reported separately via the Board SOF
- There are a number of items which require narrative rather than graphic benchmarking and these are described below

Findings of review of all perinatal deaths using the national monitoring tool	All cases eligible for referral to HSIB	Progress in achievement of NHSR/MIS Yr 3
All perinatal deaths are reported using the national tool – full review can take 4-6 months depending on whether post mortem findings are awaited. Early learning/actions are identified via normal governance routes (see above). Four members of the maternity team are registered as reporters on the NPMRT This item is reflected in Safety Standard 1 of the NHSR MIS Yr 3.	Since reporting commenced in November 2018, SFH have reported eight cases to HSIB. Six cases have been finalised and full reports returned. One case has been discontinued due to no family consent. One case is ongoing. Early learning/actions are identified via normal governance routes and HSIB investigations are tracked through Trust channels. National HSIB themes are benchmarked by the maternity governance midwives and reported to divisional governance. HOM & divisional safety champions meet quarterly with regional HSIB lead, and HOM receives monthly progress reports.	There are 10 safety actions and these have undergone two revisions since they were launched in December 2019. Latest final reporting deadline is July 2021. Four actions are ready for sign off (Actions 1; 3; 5; 7) Two actions await external deadlines of Dec 20 and April 21 (Actions 2; 10) Four actions have further work/data collection ongoing: 4: Medical/anaesthetic/neonatal workforce 6: Saving Babies Lives Care Bundle v2 8: MDT training 9: Maternity Safety Champions

Maternity Perinatal Quality Surveillance scorecard

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	Perinatal Quality Surveillance scorecard	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
Perinatal	Red flags: 1:1 care in labour not provided	0	3	0	0	0	1	0	1	1	0
	3rd/4th degree tear overall rate	>3.5%	2.07%	3.20%	2.63%	0.37%	2.11%	2.68%	2.42%	1.02%	2.37%
	Obstetric haemorrhage >1.5L	Actual	82	7	15	13	21	8	7	11	9
	Obstetric haemorrhage >1.5L	<2.6%	4.14%	2.49%	5.64%	4.80%	7.37%	2.68%	2.42%	3.75%	3.56%
	Term admissions to NNU	Actual	63	12	5	5	7	9	9	16	6
	Apgar <7 at 5 minutes	<1.2%	1.15%	1.77%	0.74%	1.09%	0.70%	1.00%	1.36%	1.36%	2.73%
	Stillbirth number	Actual	6	1	0	1	0	1	0	1	2
	Stillbirth number/rate	>4.4/1000	1.996			2.413			1.135		
Workforce	Rostered consultant cover on SBU - hours per week	<60 hours	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
	Midwife / band 3 to birth ratio (establishment)	>1:28		1:30.4	1:28.4	1:27.8	1:30.4	1:30	1:28.5	1:28.5	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	1:29
	Acute Maternity unfilled prospective RM shifts	160 pcm									
	Maternity Ward 1-4 staff members short (BR+ acuity tool)	Actual				29%			48%		
Feedback	Number of compliments (PET)			0	0	0	1	2	1	4	2
	Number of concerns (PET)			1	3	1	2	5	0	0	3
	Complaints			0	1	0	2	2	1	1	0
	FFT response rate	>50%	7%	0%	7%	3%	31%	3%	5%	6%	3%
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						
	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.						
	CTG competency assessment all staff groups										
	Core competency framework compliance			Core competency framework launched December 2020 - for inclusion in maternity TNA for 21/22							
	Coroner Reg 28 made directly to the Trust		Y/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