Maternity Perinatal Quality Surveillance model for May 2021

Sherwood Forest Hospitals
NHS Foundation Trust

	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%

Exception report based on highlighted fields in monthly scorecard (Slide 2)

Obstetric haemorrhage >1.5L (2.09% March 21)

- Improvement seen this month after data quality review
- Continue to monitor trend
- Remains reportable via maternity triggers

Stillbirths (5.14/1000 in month vs national target <4.4/1000)

- Data shared with LMNS Board via safety scorecard
- Potential link with Covid changes to the ultrsaound scanning pathway recommended by the RCOG. Business as usual schedule anticipated to recommence from May

Staffing red flags

- 14 staffing incidents reported in month
- Monitored through local governance including issues & action plans
- Patient safety red flags (per NICE) do not reflect staff morale/engagement concerns. All low or no patient harm
- Work on-going to explore and improve the experience of colleagues.

CQC enquiries

- ENQ-9258539760 requesting submission of progress against STEIS action plans - complete

Maternity Assurance Divisional Working Group

NHSR	Ockenden
• Evidence platform created • Peer review & external auditor engaged • Commence final review April/May • Sign off July	• Divisional working group TOR agreed • First meeting held 16.04.21 • Reports to Maternity Assurance Committee

Incidents reported March 2021 (67 all no/low harm after review)

Most reported	Comments
Emergency CS (Labour & delivery)	Some duplication in reporting, no themes identified
Triggers x 5	Various including perineal trauma; late bookers; screening delays
One incident reported ‘moderate;’ low harm on MDT review	

Other

- Quarterly Review Meeting with HSIB Maternity team – no on-going cases at present
- Engagement with Shrewsbury and Telford Hospitals now gaining momentum
- Opportunity to bid for additional funding against Ockenden recommendations with short timeframe

Maternity Perinatal Quality Surveillance scorecard

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NHS Foundation Trust

	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 2020-21	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	Dec-20	Jan-21	Feb-21	Mar-21
Perinatal	1:1 care in labour	>95%	99.81%	100%	100%	100%	99.66%	100%	99.66%	99.66%	99.66%	100%	99.66%	100%	99%
	3rd/4th degree tear overall rate	>3.5%	2.18%	3.20%	2.63%	0.37%	2.11%	2.68%	2.42%	1.02%	2.37%	2.32%	0.84%	2.82%	2.84%
	Obstetric haemorrhage >1.5L	Actual	116	7	15	13	21	8	7	11	9	8	8	5	6
	Obstetric haemorrhage >1.5L	<2.6%	3.24%	2.49%	5.64%	4.80%	7.37%	2.68%	2.42%	3.75%	3.56%	3.09%	3.38%	%	2.09%
	Term admissions to NNU	<6%	3.62%	4.24%	1.84%	1.82%	2.44%	3.00%	3.06%	5.44%	2.34%	4.59%	4.20%	1.99%	4.18%
	Apgar <7 at 5 minutes	<1.2%	1.56%	1.77%	0.74%	1.09%	0.70%	1.00%	1.36%	1.36%	2.73%	2.30%	3.35%	0.00%	0.70%
	Stillbirth number	Actual	11	1	0	1	0	1	0	1	2	2	1	1	1
	Stillbirth number/rate	>4.4/1000	4.63			2.413			2.235			7.198			5.148
Workforce	Rostered consultant cover on SBU - hours per week	<60 hours	60	60	60	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	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	1:26.4	1:28.5	1:24.6	1:30	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	1:28.4	1:29:7	1:25.7	1:25.7	1:31
Feedback	Number of compliments (PET)			0	0	0	1	2	1	4	2	1	1	1	3
	Number of concerns (PET)			1	3	1	2	5	0	0	3	2	1	2	1
	Complaints			0	1	0	2	2	1	1	0	0	2	0	1
	FFT recommendation rate	>93%		89%	100%	100%	99%	93%	93%	87%	83%	83%	76%	88%	90%
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*							15%	39%	58%	81%
	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.*							36%	45%	75%	95%
	CTG competency assessment all staff groups											0%	11%	53%	98%
	Core competency framework compliance			Core competency framework launched December 2020 - for inclusion in maternity TNA for 21/22											
Reporting	Progress against NHSR 10 Steps to Safety	<4 <7 7 & above													
	Maternity incidents no harm/low harm	Actual	766	60	45	60	54	59	83	52	68	95	61	62	67
	Maternity incidents moderate harm & above	Actual	4	0	0	2	0	0	0	0	0	0	0	1	1
	Coroner Reg 28 made directly to the Trust		Y/N	N	N	N	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	Y	Y	N	Y