Maternity Perinatal Quality Surveillance model for November 2021

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 (3.57%, Nov 21)

- Improvement made on previous month, remains below revised national rate (>3.6%) dashboard amends pending.
- Cases reportable via maternity triggers - no lapses in care / learning points identified
- Deep dive table for Dec QC, approved via MAC
- Division have signed up to pilot a care bundle to evaluate the impact

APGARS <7 at 5 minutes (2.03 % Nov 21)

- Rate increased for second consecutive month.
- Deep dive performed on cases for Oct cases, no concerns/ poor outcomes. To be reviewed with Nov cases for any potential themes/ trends.
- Term admission data for Oct remains within expected range and all cases reviewed were deemed unavoidable admissions.
- One term baby required transfer out for cooling following a sudden and unanticipated obstetric emergency.

Staffing red flags

- 2 staffing incidents reported in month
- Virtual maternity forum continued, positive feedback received in response to the improvements made.

Home Birth Service

- Due to vacancies and sickness homebirth services remains limited, paper received Board approval. This has been further escalated to the CCG and regionally for awareness.
- 2 Homebirths conducted in Nov 21 (annual rate 1.3%)

FFT (96% Nov 2021)

- FFT improved following revised actions
- QR codes trial continues as part of action plan to improve FFT compliance.
- Teams reminded monthly about asking patients to complete and all actions being monitored via monthly service line.
- Action plan reportable to Nursing , Midwifery and AHP committee.

Maternity Assurance Divisional Working Group

NHSR	Ockenden
• NHSR year 4 criteria has been received. Monthly divisional meeting reinstated and will be tracked through MAC. • Revision of guidance provided, working group review to action	• Assurance provided by the MAC • Initial submission feedback received, correlates to SFH gap analysis • On-going work continues to strengthen actions, allowing for current staffing pressures.

Incidents reported Nov 21 (57 no/low harm after review)

Most reported	Comments
Other (Labour & delivery)	No themes identified
Triggers x 14	Various including PPH, term admission

One incidents reported as ‘moderate’ harm or above. Taken through Trust Scoping and reported externally via HSIB & STEIS

Other

- Staffing incidents reduced again this month, notable difference in reduction of Datix where shifts where staffing is below the agreed minimum levels- anticipated increase in Dec Datix and actions currently underway. Birthrate plus re-implementation due to complete end of Dec.
- 28.37wte vacancies (19.4%) mainly across the community midwifery service. Active recruitment in place . Challenges currently exacerbated due to track and trace issues, annual leave and vacancies. Risk assessment applied where appropriate to support return to work. RN’s utilised on Maternity ward
- No further formal letters received and all women who have a planned homebirth during November & December have been written to by the Head of Midwifery to outline current situation
- One case presented to Scoping suspected HIE. Meets reporting criteria to HSIB, both Mum and Baby have been subsequently discharged home, investigation on-going.

Maternity Perinatal Quality Surveillance scorecard

NHS
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
Maternity Safety Support Programme	No					

Maternity Quality Dashboard 2020-2021	Alert [national standard/average	Running Total/ average	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21
1:1 care in labour	>95%	99.81%	100%	99.66%	100%	99%	100%	95%	95%	95%	95%	100%	100%	100%
Women booked onto MCOC pathway							19%	19%	21%	18%	20%	20%	20%	20%
Women receving MCOC intraprtum							6%	6%	1%	0%	0%	0%	0%	0%
Total BAME women booked							25%	25%	21%	21%	21%	20%	20%	20%
BAME women on CoC pathway							5%	5%	5%	5%	15%	15%	15%	15%
Vaginal Birth			58%	56.90%	56%	59%	58%	53%	58%	60%	62%	51%	61%	57%
3rd/4th degree tear overall rate	>3.5%	2.18%	2.32%	0.84%	2.82%	2.84%	1.10%	2.46%	0.68%	3.00%	2.30%	0.94%	2.11%	3.00%
Obstetric haemorrhage >1.5L	Actual	116	8	8	5	6	10	13	9	7	8	8	9	10
Obstetric haemorrhage >1.5L	<2.6%	3.24%	3.09%	3.38%	%	2.09%	3.70%	4.56%	3.08%	2.60%	2.70%	2.51%	2.90%	3.50%
Term admissions to NNU	<6%	3.62%	4.59%	4.20%	1.99%	4.18%	5.00%	5.10%	4.60%	4.60%	2.10%	2.16%	3.70%	3.20%
Apgar <7 at 5 minutes	<1.2%	1.56%	2.30%	3.35%	0.00%	0.70%	0.73%	1.37%	1.69%	1.30%	0.68%	1.20%	1.52%	2.03%
Stillbirth number	Actual	11	2	1	1	1	0	0	0	1	0	1	0	0
Stillbirth number/rate	0	4.63	7.198			5.148			0.000			2.176		
Rostered consultant cover on SBU - hours per week	<60	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		1:28.5	1:24.6	1:30	1:30	1:30.4	1:30.4	1:30.4	1:30.4	1:30.4	1:30.4	1:29	1:29
Midwife/ band 3 to birth ratio (in post)	>1:30		1:29:7	1:25.7	1:25.7	1:31	1:31.4	1:31.4	1:31.4	1:31.4	1:31.4	1:31.4	1:29	1:29
Number of compliments (PET)			1	1	1	3	1	0	0	0	0	0	0	0
Number of concerns (PET)			2	1	2	1	3	5	3	2	1	2	4	0
Complaints			0	2	0	1	0	0	3	1	2	1	3	2
FFT recommendation rate	>93%		83%	76%	88%	90%	84%	91%	88%	91%	91%	92%	88%	96%
PROMPT/Emergency skills all staff groups			15%	39%	58%	81%	100%	100%	100%	100%	100%	100%	100%	100%
K2/CTG training all staff groups			36%	45%	75%	95%	98%	98%	98%	98%	98%	98%	98%	98%
CTG competency assessment all staff groups			0%	11%	53%	98%	98%	98%	98%	98%	98%	98%	98%	98%
Core competency framework compliance							6%	14%	20%	26%	38%	50%	62%	70%
Progress against NHSR 10 Steps to Safety	<4 <7 7 & above													
Maternity incidents no harm/low harm	Actual	356	95	61	62	67	71	72	115	84	84	76	63	57
Maternity incidents moderate harm & above	Actual	2	0	0	1	1	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	Y	Y	N	Y	N	N	N	N	Y	N	N	N