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

Sherwood Forest Hospitals NHS Foundation Trust

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 (Apr 2.51%)

- Improvement made on previous month, remains below revised national rate (>3.6%)
- Cases reportable via maternity triggers - no lapses in care / learning points identified
- First regional meeting attend and actions taken

APGARS <7 at 5 minutes (0.84%, Apr 22)

- Rate improved and below national threshold for reporting, noted no adverse incident, cases or term admissions within this number.
- Deep dive paper presented to MAC in May- action plan commenced from findings

Staffing red flags

- 2 staffing incidents reported in month
- Challenges due to recent sickness related to COVID-19 significantly improved.

Home Birth Service

- Due to vacancies homebirth services remains limited as per Board approval. This has been further escalated to the CCG and regionally for awareness.
- 1 Homebirth conducted in Ape 22, plan in place to re-start the full service in Quarter 2 22-23

FFT (89% Apr 22)

- FFT remains improved following revised actions
- New system being implemented in May which may cause disruption.
- Service User Representative in post and providing additional pathways for maternal feedback through Maternity and Neonatal Safety Champions Meeting

Maternity Assurance Divisional Working Group

NHSR	Ockenden
• NHSR year 4 MIS re launched, working group re-established and 360 assurance commissioned. • Evidence to be taken through MAC prior to Board.	• Final Ockenden report released 31/03/22. 15 additional IEA's for all Trust nationally to work towards. • Separate paper provided to board

Incidents reported Apr 22 (58 no/low harm, 1 as moderate)

Most reported	Comments
Other (Labour & delivery)	No themes identified
Triggers x 13	Cases included, PPH, term admission,
One Moderate case reported	

Other

- Staffing incidents remain static, review of 21-22 birth rate underway. BR+ revised establishment review started anticipated completion end o f June 22.
- LMNS quality insight visit final report provided, overall positive report. For the recommendations made action plans are underway within division, to note none of these are immediate safety concerns or recommendations.
- Active recruitment continues, Matron for Maternity Governance appointed and Matron for Intrapartum Care and Community are live.
- No further formal letters received and all women who have a planned homebirth, all women due June and July have been written to by the Head of Midwifery to outline current situation
- Midwifery Continuity of Carer formal data collection paused nationally, LMNS regional submission on track for 15th June 2022 with a Year 1 focus on system alignment of digital workstream
- Moderate case taken to Trust scoping, category 1 LSCS delay in transfer to theatre for Divisional investigation.

Maternity Perinatal Quality Surveillance scorecard

Sherwood Forest Hospitals
NHS Foundation Trust

CQC Maternity Ratings - last assessed 2018	GOOD		GOOD		GOOD		OUTSTANDING	GOOD		
Maternity Safety Support Programme	No									
Maternity Quality Dashboard 2020-2021	**Alert [national standard/average**	**Running Total/ average**	**Sep-21**	**Oct-21**	**Nov-21**	**Dec-21**	**Jan-22**	**Feb-22**	**Mar-22**	**Apr-22**
1:1 care in labour	>95%	99.81%	100%	100%	100%	100%	100%	100%	100%	100%
Women booked onto MCOC pathway			20%	20%	20%					
Women reccving 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%
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%
Obstetric haemorrhage >1.5L	Actual	116	8	9	10	9	6	8	7	6
Obstetric haemorrhage >1.5L	>3.5%	3.24%	2.51%	2.90%	3.50%	3%	2.12%	3.30%	2.60%	2.20%
Term admissions to NNU	<6%	3.62%	2.16%	3.70%	3.20%	3.70%	5.00%	3.50%	3.50%	1.60%
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%
Stillbirth number	Actual	11	1	0	0	3	1	1	1	0
Stillbirth number/rate	0	4.63	2,176			3,400			3,727	
Rostered consultant cover on SBU - hours per week	<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
Midwife / band 3 to birth ratio (establishment)	>1:28		1:30.4	1:29	1:29	1:29	1:29	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
Number of compliments (PET)		0	0	0	0	0	0	0	1	1
Number of concerns (PET)		9	2	4	0	0	0	0	2	2
Complaints		11	1	3	2	1	1	1	2	1
FFT recommendation rate	>93%		92%	88%	96%	96%	92%	91%	90%	89%
PROMPT/Emergency skills all staff groups			100%	100%	100%	100%	100%	100%	100%	100%
K2/CTG training all staff groups			98%	98%	98%	98%	98%	98%	98%	98%
CTG competency assessment all staff groups			98%	98%	98%	98%	98%	98%	98%	98%
Core competency framework compliance			50%	62%	70%	70%	81%	81%	88%	95%
Progress against NHSR 10 Steps to Safety	<4 <7 7 & above									
Maternity incidents no harm/low harm	Actual	540	76	63	57	89	83	45	69	58
Maternity incidents moderate harm & above	Actual	6	0	1	1	0	1	1	1	1
Coroner Reg 28 made directly to the Trust		Y/N	N	N	N	0	0	0	0	0
HSIB/CQC etc with a concern or request for action		Y/N	N	N	N		N	N	N	N