Maternity Perinatal Quality Surveillance model for June 2022

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

3rd and 4th Degree Tears (3.72% 2022)

- Rate just above national trigger threshold.
- Deep dive review into cases have found no themes or trends. Plan is to observe and action as needed.
- Noted that all 3rd and 4th Degree tears are reportable via Datix, none have been rated as moderate or above.

Stillbirth rate Q1 (5.9/1000 births)

- SFH rate above the national ambition of 4.4/1000 births for this quarter.
- Year end rate for 2021-22 was 2.37/1000
- All cases have been managed through the governance process, two requiring referral to HSIB and two managed through the PMRT process.
- Any immediate actions have been taken, team are awaiting the return of further tests and investigations for the full PMRT review.

Staffing red flags (June 2022)

- 4 staffing incident reported in the month
- No further issues raised around staffing, aligned with the successful recruitment and ongoing re-designed preceptorship programme.

Home Birth Service

- Due to vacancies and sickness homebirth services remains limited as per Board approval. This has been further escalated to the CCG and regionally for awareness.
- 1 Homebirth conducted in Jun 22, plan in place to re-start the full service on the 18th Sept 2022

FFT (88% Jun 2022)

- FFT remains improved following revised actions
- New system implementation delayed
- Service User Representative in post and providing additional pathways for maternal feedback

Maternity Assurance Divisional Working Group

NHSR	Ockenden
• NHSR year 4 relaunched on the 6th of May 2022 • Divisional working group effective, reporting timeline mapped against key meetings	• Initial 7 IEA- final IEA is 86% completed plan underway for final action • Final 15 IEA, 14 have been peer assessed with plan for the final 1

Incidents reported June 2022 (98 no/low harm, 1 as moderate)

Most reported	Comments
Other (Labour & delivery)	No themes identified
Triggers x 18	Cases included, PPH, term admission and 3rd/4th degree tears
One incident reported as 'moderate'	

Other

- One case reported as moderate- taken through Trust Scoping Process, following a panel review for Divisional Report.
- Active recruitment continues. Open day in June completed and a further 12 WTE newly qualified midwives recruited- acute maternity fully recruited in Sept 2022 with plans to target community.
- No formal letters received and all women who have a planned homebirth, all women due in August have been written to by the Director of Midwifery to outline current situation.
- Midwifery Continuity of Carer system submission made on the 16th of June 2022- awaiting national feedback

Maternity Perinatal Quality Surveillance scorecard

Sherwood Forest Hospitals
NHS Foundation Trust

Sherwood Forest Hospitals														
	OVERALL	SAFE	EFFECTIVE	CARING	RESPONSIVE							WELL LED		
CQC Maternity Ratings - last assessed 2018	GOOD	GOOD	GOOD	OUTSTANDING	GOOD							GOOD		

Maternity Quality Dashboard 2020-2021		Alert [national standard/average where available]	Running Total/ average	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
Perinatal	1:1 care in labour	>95%	99.81%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Women booked onto MCOC pathway			20%	20%	20%							
	Women receiving 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%	60%	60%
	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%	6.20%	3.72%
	Obstetric haemorrhage >1.5L	Actual	116	8	9	10	9	6	8	7	6	9	7
	Obstetric haemorrhage >1.5L	>3.5%	3.24%	2.51%	2.90%	3.50%	3%	2.12%	3.30%	2.60%	2.20%	3.20%	2.45%
	Term admissions to NNU	<6%	3.62%	2.16%	3.70%	3.20%	3.70%	5.00%	3.50%	3.50%	1.60%	4.00%	2.60%
	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%	0.40%	1.20%
	Stillbirth number	Actual	11	1	0	0	3	1	1	0	1	2	2
	Stillbirth number/rate	>4.4/1000	4.63	2.176			3.400			3.727			5.952
Workforce	Rostered consultant cover on SBU - hours per week	<60 hours	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
	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	1:22	1:24.5
	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	1:24	1:26.5
Feedback	Number of compliments (PET)		0	0	0	0	0	0	0	1	1	1	1
	Number of concerns (PET)		9	2	4	0	0	0	0	2	2	1	0
	Complaints		11	1	3	2	1	1	1	2	1	0	2
	FFT recommendation rate	>93%		92%	88%	96%	96%	92%	91%	90%	89%	88%	88%
Training	PROMPT/Emergency skills all staff groups			100%	100%	100%	100%	100%	100%	100%	100%	94%	95%
	K2/CTG training all staff groups			98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
	CTG competency assessment all staff groups			98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
	Core competency framework compliance			50%	62%	70%	70%	81%	81%	88*%	95%	95%	95%
Reporting	Progress against NHSR 10 Steps to Safety	<4 <7 7 & above											
	Maternity incidents no harm/low harm	Actual	709	76	63	57	89	83	45	69	58	70	99
	Maternity incidents moderate harm & above	Actual	8	0	1	1	0	1	1	1	1	1	1
	Coroner Reg 28 made directly to the Trust		Y/N	N	N	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	N	N	N