Meeting title:	Public Trust Board **public Trust Board paper I1**
Date of the meeting:	3 November 2022
Title:	UHL Maternity Perinatal Quality Surveillance Scorecard
Report presented by:	
Report written by:	Kerry Williams, Head of Midwifery John Barnett, Business Intelligence Specialist

Action – this paper is for:	Decision/Approval		Assurance	x	Update	X
Where this report has been discussed previously						

To your knowledge, does the report provide assurance or mitigate any significant risks? If yes, please detail which
The report provides a monthly update of the maternity scorecard, presenting data against key performance indicators and exception report highlighting areas of underperformance and associated actions for improvement.

Impact assessment
N/A

Acronyms used:
Please see abbreviations commonly used in maternity reports

Purpose of the Report

The scorecard is produced in line with the Perinatal Quality Surveillance Model designed by NHSE to support sharing safety intelligence from floor to board.

Executive Summary

The scorecard includes 5 areas of focus:

- Patient Safety
- Workforce
- Training
- Friends and Family
- Outcomes

The scorecard provides monthly data with trends since March 2022. The exception report highlights actions to improve compliance against each underperforming metric.

There are 6 areas of challenge:

- Moderate incidents
- Midwife vacancies
- Staff training compliance
- Friends and family footfall
- % blood loss greater than 1500ml
- % 3rd and 4th degree tears

Recommendation

The Trust Board are asked to be assured by the progress to date and note the areas where improvement is required.

Maternity Perinatal Quality Surveillance Scorecard - W&C CMG Month 6 (September) 2022-23

	National Target / Alert Level	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	2022-23 TOTAL / AVERAGE (YTD)	Variation - 12 month period / SPC
PATIENT SAFETY										
Total deliveries (LRI, LGH, SMBC, HB & BBA)	Actual	842	787	809	786	781	850	823	4836	
No. of hospital deliveries at LRI (excl HB & BBA)	Actual	473	463	440	443	431	495	455	2727	
No. of hospital deliveries at LGH (excl HB & BBA)	Actual	344	305	344	315	312	326	343	1945	
No. of hospital deliveries at SMBC Plus HB & BBA	Actual	25	19	25	28	38	29	25	164	
SIs (Obstetrics)	Actual	2	3	1	3	5	1	1	14	
SIs (Neonatology)	Actual	0	0	1	0	0	0	0	1	
Number of Still births - overall total	Actual	5	2	3	3	8	4	3	20	
Still births as %age of Total Deliveries	<0.45%	0.6%	0.3%	0.4%	0.4%	1.0%	0.5%	0.4%	0.4%	
HSIB Referrals	Actual	2	1	0	4	5	1	0	13	
Moderate Incident	Actual	9	5	5	8	5	8	6	7	
Coroner Regulation 28 Requests	Actual	0	0	0	0	0	0	0	0	
WORKFORCE										
Funded Midwife to Birth ratio (UHL complete care) - 1	>1:26.4	1:27.0	1:25.5	1:25.5	1:25.5	1:25.5	1:25.6	1:25.6	1:25.5	
Midwife Vacancies (%)	Actual				14.4%	13.6%	13.6%	15.2%	14.2%	
1 to 1 Care in Labour	Actual	100%	100%	100%	100%	100%	100%	100%	100%	
TRAINING										
% of All Staff attending Annual MDT Clinical Simulation	Actual	78%	81%	83%	86%	88%	87%	90%	86%	
% of All Staff attending NLS Training	Actual	88%	83%	76%	84%	92%	93%	92%	87%	
% of All Staff attending CEFM Training (Theory)	Actual	94%	82%	91%	93%	92%	96%	95%	92%	
% of All Staff attending CEFM Training (Assessment)	Actual	92%	81%	91%	93%	92%	96%	94%	91%	
FRIENDS AND FAMILY										
Maternity Friends & Family - Footfall	>=30% (UHL Target)	19.3%	17.4%	19.7%	15.4%	19.0%	18.3%	22.0%	18.6%	
Maternity Friends & Family - percentage of promoters	>=96% (UHL Target)	96.3%	96.6%	97.3%	95.7%	95.4%	95%	97%	96.1%	
OUTCOME										
Spontaneous Deliveries %	Alert if <51%	47.4%	48.2%	47.3%	46.4%	49.7%	50.0%	44.8%	47.7%	
Caesarean Section Rate - total	Alert if >23%	41.6%	38.5%	39.6%	38.2%	38.7%	38.2%	41.6%	39.1%	
% Blood loss greater than 1500 ml (as a % of total deliveries)	<3.6% (Local Target <=2.7%)	3.3%	2.9%	3.7%	2.9%	4.0%	2.7%	2.9%	3.2%	
% 3rd & 4th degree tears (as a % of total vaginal deliveries)	Alert if >3.6%	1.8%	3.7%	3.3%	2.7%	3.7%	3.0%	3.9%	3.4%	
% of Full term babies admitted to NNU NB:Figures from January 2019 reflect ATAIN: Term admissions to NNU as % of UHL Term births	ATAIN Target <6.0%	4.42%	4.42%	3.31%	5.86%	3.99%	3.51%	4.87%	4.36%	

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Maternity Perinatal Quality Surveillance Scorecard – Exception Report
October 2022 (September data)

Metric underperformed	Driver for underperformance	Actions to address the underperformance
Patient Safety		
Moderate incident	• 6 moderate harms reported in September • 1 reviewed and downgraded	• Completed rapid review on 4 of 5 moderate incidents. 1 outstanding is 4th degree tear for consultant review • 1 case taken to perinatal risk group (PRG) no concerns identified about management of care with no recommendations • Remaining cases being discussed at PRG in October • All cases received verbal duty of candour • 1 case referred to HSIB, but was declined as MRI normal • Cluster review to be arranged for 3 Massive Obstetric Haemorrhage with hysterectomies
Workforce		
Midwife vacancies	• Midwifery vacancy 66.71 WTE • Vacancy rate impacting on staff morale, retention and service delivery	• Empowering voices programme commenced at LRI, commissioned further review for LRI and community • 27 newly qualified midwives due to start around November/December 2022 • 2 further external candidates to be interviewed • 2 international midwives to commence in November plus 2 more to interview • Matron for safe staffing post out to advert
Training		
% staff attending MDT simulation training % staff attending CEFM training	• CNST requirement >90% compliance for each staff group	• Engagement from anaesthetic staff to improve compliance • NHSR contacted to review update on compliance indicator changed in October 22
Friends and family		
Maternity Friends & Family - Footfall	• Footfall below UHL target of 30% • Poor compliance with collection in community due to national change of 36-week collection metric	• Team leads encouraging completion at meetings, this has seen slight increase for September. • Community matron to scope text process with patient experience team
Outcomes		
% Blood loss greater than 1500 ml % 3rd & 4th degree tears	• Likely to coincide with Increase in numbers of caesarean sections • National outlier for 3rd & 4th degree tear rates identified through benchmarking	• Work in progress to implement OBS Cymru programme to reduce postpartum haemorrhage • Perineal tears workstream focusing on education and prevention care bundle to improve outcomes