

Meeting title:	Public Trust Board Meeting Public Trust Board paper F				
Date of the meeting:	10 August 2023				
Title:	Perinatal Surveillance Scorecard				
Report presented by:	Julie Hogg, Chief Nurse & Danielle Burnett, Director of Midwifery				
Report written by:	Kerry Williams / Rebekah Calladine, Heads of Midwifery				
Action – this paper is for:	Decision/Approval		Assurance	x	Update
Where this report has been discussed previously	UHL Quality Committee				

To your knowledge, does the report provide assurance or mitigate any significant risks? If yes, please detail which
Maternity safety is national priority and concern. The perinatal surveillance scorecard provides oversight of the quality and safety of the service at UHL

Impact assessment
N/A

Purpose of the Report

The scorecard is produced in line with the Perinatal Quality Surveillance Model designed by NHS England to support sharing safety intelligence Board to Frontline / Frontline to Board.

The scorecard includes 5 areas of focus:

1. Safety
2. Workforce
3. Training
4. Experience
5. Outcomes

The scorecard includes the minimum dataset as described within Maternity Incentive Scheme (MIS) as outlined within Slide 17, in addition to local insights.

Perinatal Quality Surveillance Scorecard Summary

In June, the total caesarean section rate was 43.5% of all births with a below than national average for elective caesareans. Induction of Labour (IOL) rates reduced slightly to 26.9%. The % of smokers at booking (8.1%) is below the national average (9.6%). The proportion of bookings completed prior to 10 weeks' gestation 79.4% improved from May and remains above the national average (59%).

UHL is currently progressing towards Year 5 of NHS Maternity Incentive Scheme (MIS) and in month, improved compliance to 4/5 standards of Saving Babies Lives Care Bundle.

The new senior leadership team is in place and progressing towards the new Maternity & Neonatal Improvement Programme highlighting UHLs commitment to providing high-quality, safe, personalised, and inclusive care. The programme will build upon the progress of implementing Donna Ockenden's recommendations and the new 3-year plan for Maternity and Neonatal Service.

Safety: Slight increase in term admissions to NNU, highlighted through ATAIN data and further surveillance in place. 8 stillbirths occurred since 1 April 2023 with 3 reported in June. 5 Serious Incidents (SIs) reported in month with 2 referrals to HSIB. Quality improvement midwife leading working group focusing on improving IOL pathway. In June 100% compliance was recorded for completion of BSOTS paperwork and one-to-one midwifery care. Safe Midwifery staffing levels were met 81% of the time YTD compared to 62% reported regionally.

Workforce: Midwifery vacancies remain at 13.6% whilst Maternity Support Worker vacancies have significantly improved. Midwifery turnover rate remains below national average at 7.4%. Obstetric vacancies remain static across all grades, recruitment continues to address the shortfall with middle grades being the highest deficit. A further two nurses achieved Neonatal Qualified in Speciality (QIS) status in June. UHL remain low in QIS nurses compared to East Midlands average. Sickness for Maternity and Neonates remain static and significantly improved compared to the previous 12 months position.

Training: In June compliance remains at or above 95% for the multi-disciplinary team, Neonatal Life Support (NLS), and Fetal Monitoring training.

Experience: Family & Friends Test (FFT) response rate decreased to 17.3% in June 2023 however the automated text messaging system is due to launch in July. Promoter rate has improved to 99%. Complaint activity saw a slight increase, with 10 received for Maternity and 1 for the neonatal services. Good engagement with Safety Champions continues across maternity and neonates with several actions taken to address challenges around recruitment, retention, equipment, and improving communication.

Outcomes: Quality Improvement projects have shown improvements in several clinical outcome measures: blood loss over >1500mls and perineal trauma both within expected ranges YTD.

Recommendations

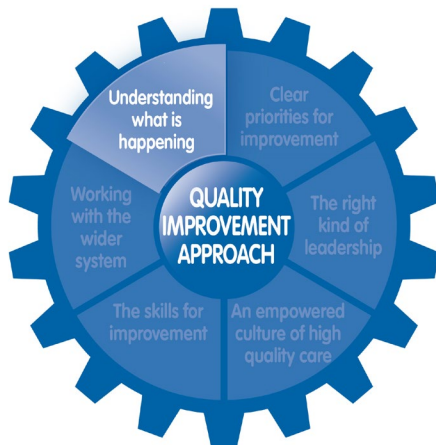
The Trust Board are asked to:

- Be assured by the progress made to date and support the plans for improvement
- To note work is in progress to continue to develop the perinatal quality scorecard in line with MIS
- To note the update on actions taken to separate telephone triage and relaunch BSOTS



Perinatal Quality Assurance Scorecard

June 2023



Contents



Overall
Summary



Safety



Workforce



Patient
Experience



Staff
Feedback



Progress Against
Maternity
Incentive Scheme

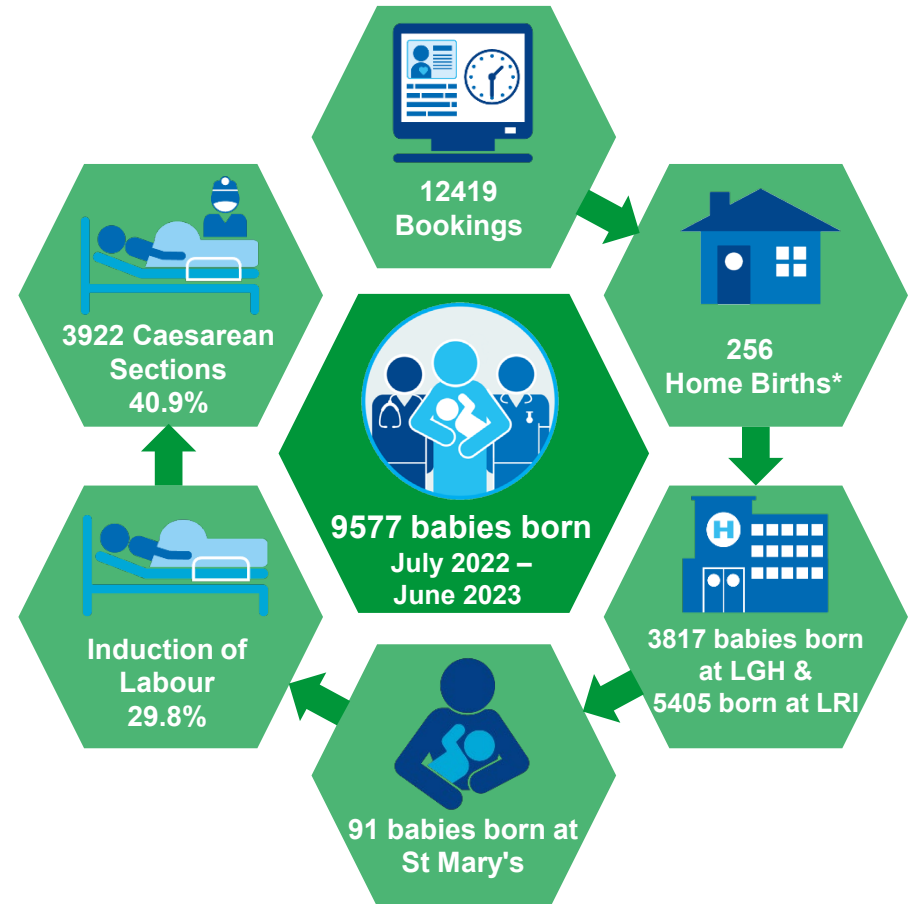
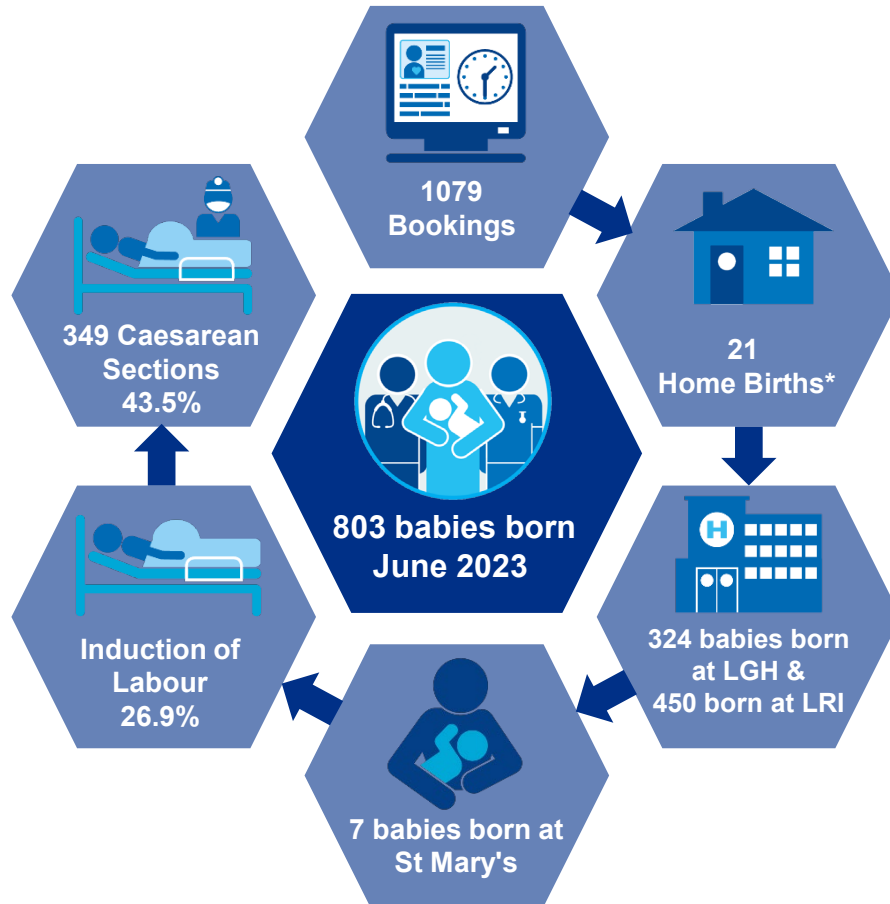


Hot Topics

Overall Summary Maternity Activity

*June 2023 – on average, 36 Antenatal Bookings were made per day.
This rate has only been exceeded on 4 occasions since Jan 2019*

LRI had an increase in activity compared to previous month



Homebirth Rate 2.6% (YTD 3.1%)

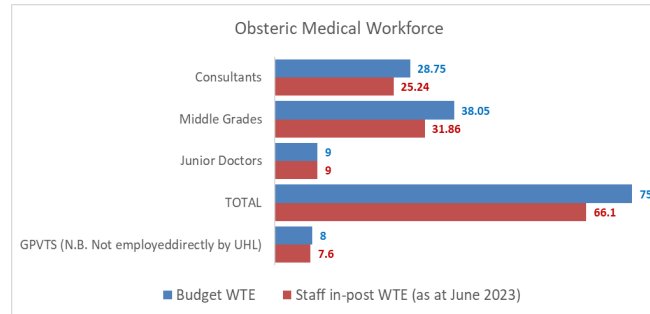
Induction of Labour rates in line with peer Trusts

* Inclusive of homebirths and babies born before arrival (BBA)

Workforce (Maternity)



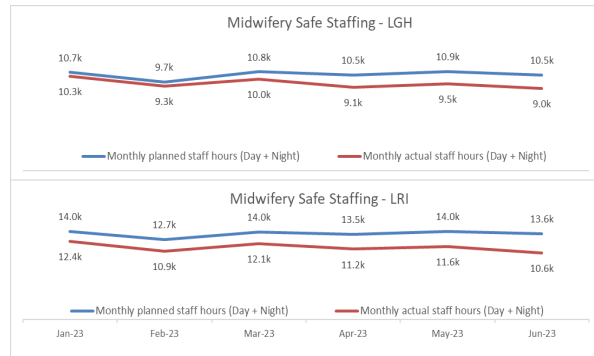
		Apr-23	May-23	Jun-23
Midwifery Safe Staffing (LGH)	Total monthly planned staff hours (Day + Night)	10,464	10,860	10,479
	Monthly actual staff hours (Day + Night)	9,102	9,524	8,966
Midwifery Safe Staffing (LRI)	Monthly planned staff hours (Day + Night)	13,518	14,009	13,627
	Monthly actual staff hours (Day + Night)	11,204	11,610	10,597



Midwife Vacancy 54.9wte (13.6%)

Obstetric Consultant 3.51wte

Support Workers 1.0 wte



IN SUMMARY

What Is The Data Telling Us?

- Midwifery and obstetric vacancy rates remain static
- Midwifery and support work CHPPD remains greater than 9
- 24 New Midwives due to commence in post By Nov 23
- In June Safe Midwifery staffing levels were met 81% of the time YTD compared to 62% reported regionally

What Is Going Well?

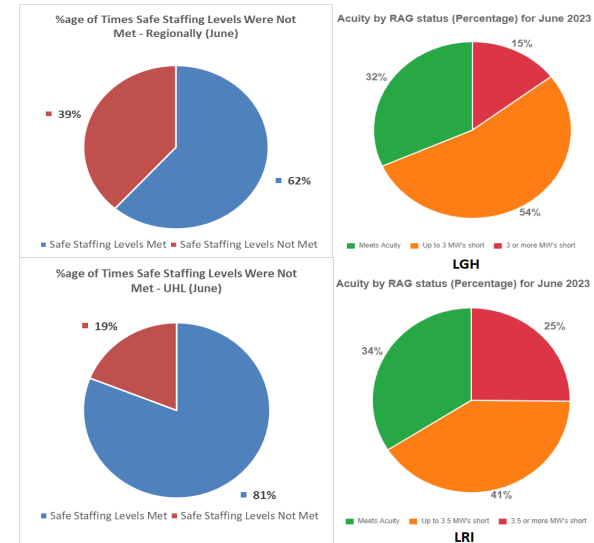
- Midwifery turnover rate remains below national average
- Successful MCA recruitment with conversion to Band 3 MSW role
- Increase in ACP training numbers by including Band 6 midwives
- International Recruitment continues to be successful, 14 in post with 4 in pipeline
- Newly qualified midwives commencing employment as Band 3 MSW's prior to qualification
- There were no gaps in the obstetric rota in June

What Do We Need To Focus On ?

- Launch of Workforce Plan
- Roll out of self-rostering to improve retention of workforce
- Proactive Recruitment (midwives and obstetricians)
- Retention of midwifery students
- Reporting on Neonatal Nursing data

Where Do We Want To Be?

- Implementing high level actions highlighted in workforce plan
- Increase student conversion rates by more than 20% to improve midwifery vacancy rate
- Achieving MIS / Ockenden Compliance with Consultant coverage
- Increasing development opportunities within neonatal nursing
- Increase neonatal nursing establishment



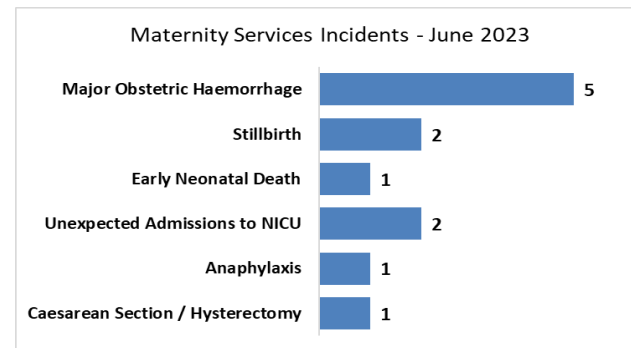
Safety Incident Reporting

Key Performance Indicator	2021-22	2022-23	June 2023
HSIB Referrals (Eligible Cases)	24	19	4 met HSIB criteria
HSIB Referrals (Referred & Accepted)	16	13	5 Serious Incidents
HSIB Referrals (Declined by HSIB)	4	3	0 Never Events
HSIB Referrals (Declined by family / Consent withdrawn)	4	1	13 Moderate Incidents
HSIB Referrals (Total Safety Recommendations*)	34	9	0 Coroner Reg 28

* Safety Recommendations are based on date of Report completion



IN SUMMARY			
What Is The Intelligence Telling Us?	What Is Going Well?		
<ul style="list-style-type: none"> HSIB reportable cases remain down on this time last year. Neonatal death rate remains the same, HIE and cooling significantly reduced compared to this time last year. Risk Assessment at all stages remains a theme across our Serious Incidents, mandated fields are being added into E3 to remind staff. 	<ul style="list-style-type: none"> Neonatal moderate incidents remain low Maintained reduction in the number of HSIB safety recommendations, Refreshed focused and increase in Continuous improvement, 2 newly appointed CI lead midwives now in post 		
What Do We Need To Focus On?	Where Do We Want To Be?		
<ul style="list-style-type: none"> Improving antenatal risk assessment at all stages of pregnancy Referral to community partners in early pregnancy Triangulation with Trust Claims Scorecard (themes from claims & litigation as per Q&S Integrated Report) 	<ul style="list-style-type: none"> Improved confidence in reporting process at ward level through better use of Datix Embedding of early resolution step for low level complaints Maintain downward trends in cases of harm. 		



Implementing Actions / Quality Improvement

- Introduction of USS eReferral to improve responsiveness and safety netting
- LocSSIP generated for neonatal lumbar puncture
- *New* Latent Phase of Labour Guidance
- Theatre Reconfiguration (Estate and Pathways)
- *New* Telephone Triage
- Relaunch of BSOTS (Triage Assessment Tool)
- Education for Neonatal Grunting

Safety Maternity Clinical Outcomes

Key Performance Indicator	Target	Apr-23	May-23	Jun-23	YTD	Trend Actual results expected to be within the dotted lines
Spontaneous Deliveries %	Actual	45.5%	45.3%	43.7%	44.8%	
Caesarean Section Rate - total	Actual	39.7%	43.8%	43.5%	42.4%	
% Blood loss greater than 1500 ml (as a % of total deliveries)	<=2.7% (National Target <3.6%)	2.1%	2.5%	4.0%	2.9%	
% 3rd & 4th degree tears (as a % of total vaginal deliveries)	Alert if >3.6%	3.2%	3.7%	3.5%	3.5%	
% of Full term babies admitted to NNU <small>NB: Figures from January 2019 reflect ATAIN: Term admissions to NNU as % of UHL Term births</small>	6%	7.18%	5.29%	6.16%	6.20%	

IN SUMMARY

What Is The Data Telling Us?

- Top 4 reasons for IOL same as last month; Reduced fetal movements, Pre-labour rupture of membranes, post term dates and Gestational Diabetes
- Slight increase in spontaneous births this month
- Breastfeeding Rates at First Feed 67% and at discharge (37%)
- Blood Loss >1500mls below national target and sustained

What Is Going Well?

- Multi-disciplinary audits
- Continued improvement following quality improvement initiatives, work ongoing to maintain
- Reinvigoration of IOL working group with project support

What Do We Need To Focus On?

- Benchmarking to understand variation (see appendix for further comparison with MBRACE peer and national trends as per February Maternity Services Dashboard (MSDS2))
- Strengthening relationships with 'buddy' units to create opportunities for fresh eyes and shared learning from harm.
- Understanding key changes to MIS yr 5 specifications and implementing

Where Do We Want To Be?

- Improving outcomes for women
- Reduction in reportable incidents
- Triangulation and strengthened approach to 'making data count' to inform pre-conceptual care and public health
- Improved user experience

Maternity & Neonatal Experience



Key Performance Indicator – Family & Friends Test (FFT)	Target	Apr-23	May-23	Jun-23	YTD
Maternity Friends & Family - % of Responses	25%	24.2%	19.5%	17.3%	21.9%
Maternity Friends & Family - % of Promoters	96%	96.3%	95.0%	99.0%	98.0%

Complaints & Concerns	Apr-23	May-23	Jun-23	YTD
Maternity	11	13	10	35
Neonatal	0	3	1	4

Immediate Learning from Complaints / Concerns (June 2023)

- Communication style
- Involvement & Information
- Improved written information

CQC Maternity Survey 2022

✓ Labour and birth	Patient Response 7.6 / 10	Compared with other trusts About the same
✓ Staff caring for you	Patient Response 8.2 / 10	Compared with other trusts About the same
✓ Care in hospital after the birth	Patient Response 6.5 / 10	Compared with other trusts About the same

IN SUMMARY

What Is The Data Telling Us?

- 10 complaints for Maternity Services (5 LRI, 4 LGH, 1 Community/Home)
- % of women who recommend UHL has improved since the previous two months to 99%
- FFT data showing women need more antenatal education regarding latent phase of labour and analgesia options (new website for maternity in progress)
- Neonatal complaints remain low (1 in June)
- Involvement & Inclusion is critical

What Is Going Well?

- Early resolution for maternity complaints which involves an initial telephone call on triage is working well and facilitating quicker resolution. This is being monitored closely to review whether this would be helpful for other specialities.
- 99% of service users said they would recommend UHL to others
- Text messaging service launched to gain feedback from birthing people about the community midwifery care they received
- Staff involved in improving experience (MAU LGH staff have bought a box of books, puzzles etc for patients to use whilst waiting for review)

What Do We Need To Focus On?

- Re-launching Experience Board and ToR to ensure data collection is meaningful and there is robust triangulation between incidents, complaints and FFT data
- Focus on ensuring multiple language for information cascade
- Development of new website focusing on accessibility (QI midwife progressing this)
- Review implementation of walk-arounds to get patient feedback whilst they remain an inpatient
- QI midwife to take ownership and lead Theme 1 (Listening/working with women)

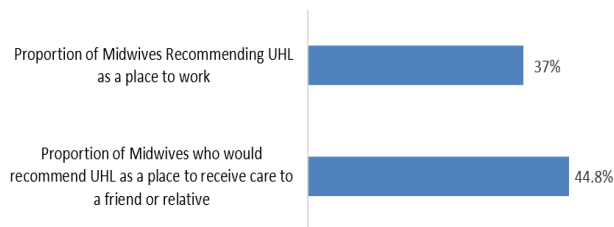
Where Do We Want To Be?

- Women, partners and families feel heard and included in decisions about their care
- Resolve dissatisfaction at the point of care
- Improved work with newly reformed MNVP to support co-creation & co-production of services
- Provide more information/education to women through digital platforms with accessibility for all

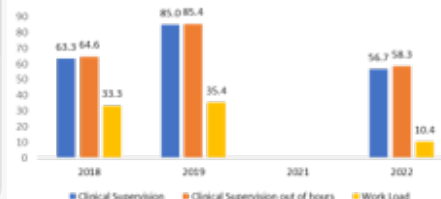
Maternity & Neonatal Feedback (Staff)



NHS Staff Survey Results 2022 - Midwives



Proportion of Specialty Trainees responding with 'excellent or good' on how they would rate the quality of supervision out of hours - GMC Survey Outcomes



Safety Champion Feedback (June 2023 Update)

What Staff Said	Action Taken
Increase capacity of Newborn Infant Physical Examination (NIPE) clinics	<ul style="list-style-type: none"> Capacity increased on 3rd July to ensure all women have access to clinic Reviewing additional NIPE clinic to support vulnerable families
Improve communication with the teams	<ul style="list-style-type: none"> New communications lead in post to support Good staff engagement with new communication strategy Draft communication strategy completed First maternity newsletter in draft
Reduce redeployment of staff from wards and home birth team	<ul style="list-style-type: none"> Local escalation policy updated Action cards completed in draft Reduction in redeployment challenging in month due to operational pressures
Maternity Assessment & telephone Triage – improve pathways	<ul style="list-style-type: none"> BSOTS relaunched in June BSOTS training completed with >90% compliance for all midwifery and medical staff grades

IN SUMMARY

What Is The Intelligence Telling Us?

- Challenges continue with workforce gaps in June affecting increase in redeployment and reduction in staff satisfaction
- Proactively improving leadership oversight through tactical huddles and use of action cards to support during escalation
- Staff continue to be open in sharing feedback with safety champions

What Is Going Well?

- Timely progress being made with safety concerns raised
- 3 new safety champions appointed to cover LRI, LGH & Community
- New communications lead working with staff to coproduce communication channels
- Successful BSOTS relaunch and implementation

What Do We Need To Focus On?

- Increasing community visibility
- Engagement with MNVP to include walkarounds and 15 steps assessments
- Work to reduce number of times staff redeployed
- Improving Induction of Labour pathway

Where Do We Want To Be?

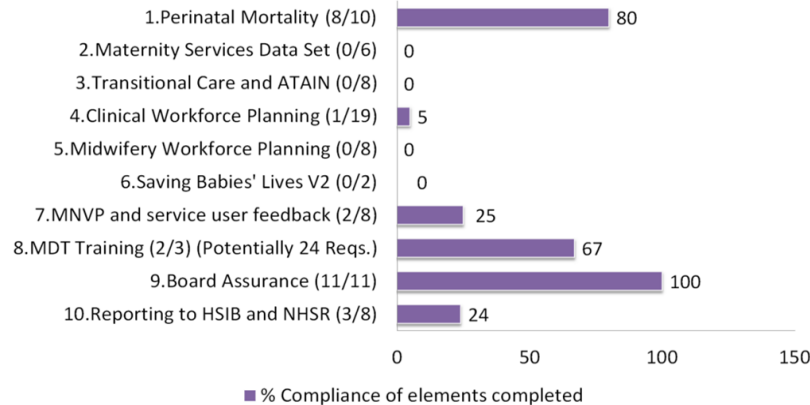
- Teams reporting improvement in communication
- Retain workforce through increase in staff satisfaction
- See reduction in redeployment of workforce to support workplace wellbeing

Maternity Incentive Scheme Progress

Year 5 standards were released on 31 May 2023 with a further update issued on 19 July 2023. The current assessment period runs from 30 May to 7 December 2023. Trusts are required to report compliance by 1 February 2024.



Compliance for Year 5



Saving Babies Lives Care Bundle Version 2 (SBLCBv2):

SBLCB Version 2	Compliance
Reducing smoking in pregnancy	
fetal growth	
Reduced fetal movements	
Fetal monitoring	
Reducing preterm births	

National target for antenatal steroids to support preterm births has been reduced from 80% to 40% in SBLCBv3. Mean for antenatal steroids is 50.4%.

Saving Babies Lives Care Bundle Version 3:

V3 released on 1 June 2023 with updated standards for each element and diabetes care added as a 6th element. A new national implementation tool is now live via the NHS Futures Platform & we will be working collaboratively with our LMNS/ICB partners.

SBLCB Version 3	Compliance
Reducing smoking in pregnancy	
fetal growth	
Reduced fetal movements	
Fetal monitoring	
Reducing preterm births	
Diabetes care	

Safety Actions for Year 5

1. Perinatal Mortality

Progress monitored via national MBRRACE tool. On track with compliance for June 2023.

2. Maternity Services Data Set

July 2023 is our assessment month with provisional submission to be made by 31 August 2023.

3. Transitional Care and ATAIN

Joint pathway / guideline is undergoing further review and approval. Lead QI midwife supporting workstream. New app developed for ATAIN reviews.

4. Clinical Workforce Planning

New audit requirements for obstetric workforce with named individual to be confirmed. Reviewing UHL Trust guidelines for compensatory rest. Neonatal staffing not meeting BAPM standards and action plan to be created.

5. Midwifery Workforce Planning

Workforce plan drafted. Focus on establishment, supernumerary status (100% compliance required), 1:1 care in labour and midwifery staffing oversight report.

6. Saving Babies Lives Care Bundle V3

Implementation tool now live and to work in collaboration with LMNS/ICB. New 6th element – Pre-existing Diabetes. Work continues to embed interventions.

7. MNVP and Service user feedback

MNVP relaunched and work plan agreed. Evidence of co-production ongoing and reviews of themes/subsequent actions monitored by local safety champions.

8. MDT Training

Core Competency Framework V2 being implemented into local training plan. Service user involvement being explored. 90% targets not achieved in June due to Obstetric Consultant attendance.

9. Safety Champions & Board Assurance

Perinatal scorecard has been refreshed. New maternity midwifery safety champions recruited. Safety intelligence presented monthly at Trust Board. Incident and complaints data triangulation with Claims scorecard.

10. Reporting to HSIB and NHSR

On track for compliance for June 2023. Quarterly audit due in July 2023

Hot Topic

Telephone Triage/BSOTS - June Update

BSOTS (Birmingham Symptom Specific Obstetric Triage System)



Recruiting into Single Point of Contact Service (SPOC)

Average 1,180 calls per week

Over 50% calls answered within 1 minute, average time to answer <3 minutes

UHL used as example of excellence for telephone triage by NHSE



Successful re-launch and implementation

100% compliance in BSOTS paperwork pathway (662 admissions)

90% of patients assessed within designated time frame (662 admissions)

Of 151 cases, 13% Orange, 33% Yellow and 54% Green

BSOTS



GREEN

Within 4 hours

YELLOW

Within 1 hour

Priority to be seen

ORANGE

Within 15 minutes

RED

Immediately



Appendices

REFERENCE: MIS Perinatal Scorecard Minimum Data Measures

Minimum Data Measures YEAR 5 MIS	June-23	Maternity Perinatal Quality Surveillance Scorecard - W&C CMG Month 3 (June)								
Findings of review all cases eligible for referral to HSIB.	Slide 5		National target / Alert Level	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	2023-24 TOTAL / AVERAGE (YTD)
The number of incidents logged graded as moderate or above and what actions are being taken	Slide 5	Total deliveries (LRI, LGH, SMBC, HB & BBA)	Actual	782	763	836	775	806	803	2384
Minimum safe staffing in maternity services to include Obstetric cover on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover versus actual prospectively	Slide 4	No. of hospital deliveries at LRI (excl HB & BBA)	Actual	449	432	485	428	449	450	1327
		No. of hospital deliveries at LGH (excl HB & BBA)	Actual	316	305	316	317	319	324	960
		No. of hospital deliveries at SMBC Plus HB & BBA	Actual	17	26	35	30	38	29	97
		SIs (Obstetrics)	Actual	1	1	2	0	2	5	7
Service User Voice feedback	Slide 7	SIs (Neonatology)	Actual	0	0	0	0	0	0	0
Staff feedback from frontline champions and walk-about	Slide 8	Number of Still births - overall total	Actual	1	4	5	3	2	3	8
HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	Awaiting inspection ratings from CQC No HSIB Concerns	Still births as %age of total Deliveries	<0.45%	0.13%	0.52%	0.60%	0.39%	0.25%	0.37%	0.34%
		HSIB Referrals	Actual	1	1	1	0	1	2	3
Coroner Reg 28 made directly to Trust	Slide 5	Moderate Incident	Actual	18	21	15	12	16	13	41
		Coroner Regulation 28 Requests	Actual	0	0	0	0	0	0	0
Progress in achievement of CNST 10	Slide 9	Funded Midwife to Birth ratio (UHL complete care, 1:nn)	>1:26.4	1:23.6	1:23.7	1:23.7	1:23.6	1:23.6	1:23.7	1:23.6
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)	Slide 8	Midwife Vacancies (%)	10%	13.1%	13.7%	14.0%	13.7%	13.8%	13.6%	13.7%
		1 to 1 Care in Labour	Actual	100%	100%	100%	100%	100%	100%	100%
Proportion of specialty trainees in Obstetrics & Gynaecology responding with 'excellent or good' on how would they would rate the quality of clinical supervision out of hours (Reported annually)	Slide 8	% of All Staff attending Annual MDT Clinical Simulation	90%	98%	97%	95%	94%	96%	92%	94%
		% of All Staff attending NLS Training	90%	97%	97%	96%	95%	95%	91%	94%
		% of All Staff attending CEFM Training (Theory)	90%	93%	95%	95%	94%	94%	96%	95%
		% of All Staff attending CEFM Training (Assessment)	90%	93%	95%	95%	93%	94%	95%	94%