University Hospitals of Leicester NHS
NHS Trust

Meeting title:	Public Trust Board	**Public Trust Board paper H**
Date of the meeting:	13 July 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 13, in addition to local insights.

Perinatal Quality Surveillance Scorecard Summary

Over the last 12 months, caesarean section rates have averaged 40.2% of all births with a below than national average for elective caesareans. Induction of Labour (IOL) rates are at 30%. The % of smokers at booking (7.1%) is below the national average (9.6%). The proportion of bookings completed prior to 10 weeks' gestation (73%) is above the national average (59%).

UHL is currently non-complaint in 6 of the 10 Safety Actions as part of Year 4 NHS Maternity Incentive Scheme (MIS) and compliant with 3/5 standards of Saving Babies Lives Care Bundle.

A new senior leadership team is in place and a new Maternity & Neonatal Improvement Programme is to commence in the summer to describe 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: Improvements noted in the number of babies admitted to the Neonatal Unit compared to the previous month, further surveillance in place. 5 stillbirths occurred since 1 April 2023 with 2 reported in May. 2 Serious Incidents (SIs) reported in month with 1 referral to HSIB. Work is underway to transform the Induction of Labour (IOL) pathway. A new Telephone Triage was been established in March 2023 separating activity from the Maternity Assessment Unit, a whole-service single-point of contact is being developed to improve access and responsiveness. Birmingham Symptom Specific Obstetric Triage System (BSOTS) is to be relaunched (June 2023). Throughout May one-to-one care has been maintained and Safe Midwifery staffing levels have been met 66% of the time YTD compared to 64% regionally.

Workforce: Midwifery vacancies remain at 13.7% whilst Maternity Support Worker vacancies have significantly improved. Turnover is at 7.8% for Midwives. Obstetric staffing vacancy is 12.8% vacancies across all grades, with middle grades being the highest deficit. Recruitment is underway for Consultants to address the 3.51wte deficit. Neonatal Quality in Speciality (QIS) nursing ratios remain low at 31.5% compared to East Midlands average of 77.8% per shift. Sickness for Maternity is 5.3% and Neonates 6.5% both seeing slight increases in Q4 (2022/2023) however significantly improved compared to the previous 12months position.

Training: 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 19.5% in May 2023 however actions focusing on uptake of test within the community. Promoter rate remains favourable at 95.7%. Complaint activity remains static, with 8 received in May, themes around appointments and management in care. Staff continued to engage with Safety Champions will several actions taken to address challenges around equipment, care pathways, 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 Board of Directors are asked to:

- Note the areas where improvement is required
- 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

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Perinatal Quality Assurance Scorecard

May 2023

Contents

Overall Summary

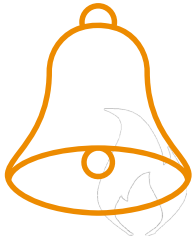
Safety

Workforce

Experience

Colleague Feedback

Progress Against Maternity Incentive Scheme



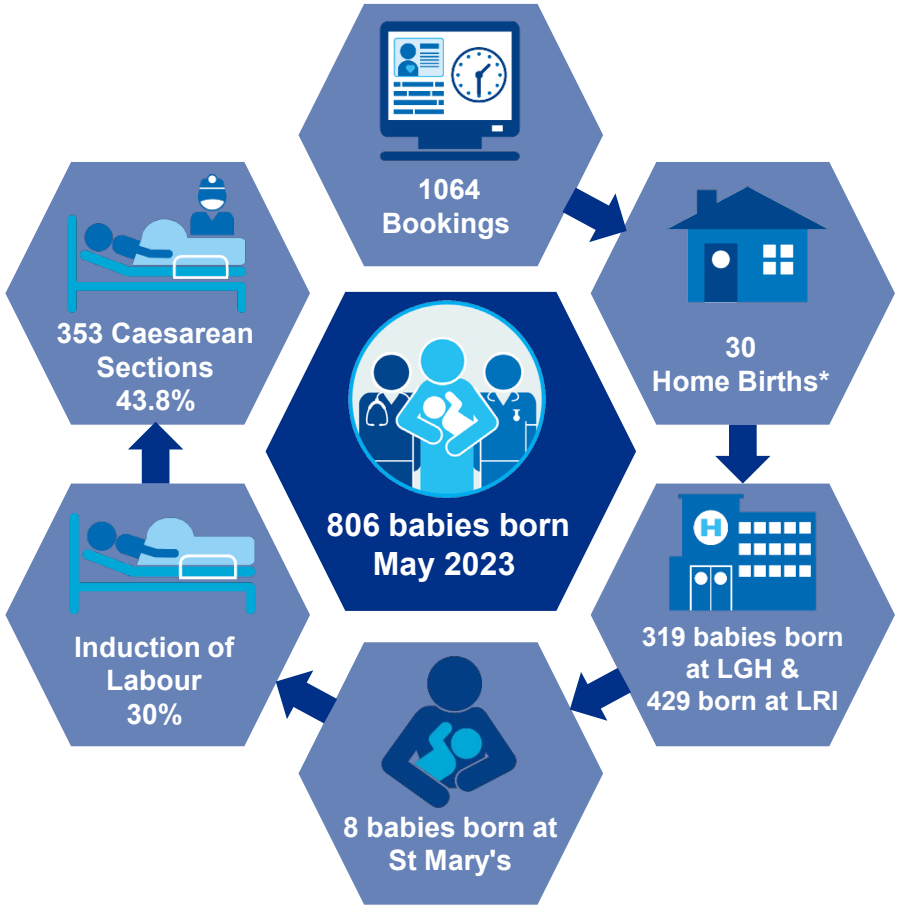
Hot Topics

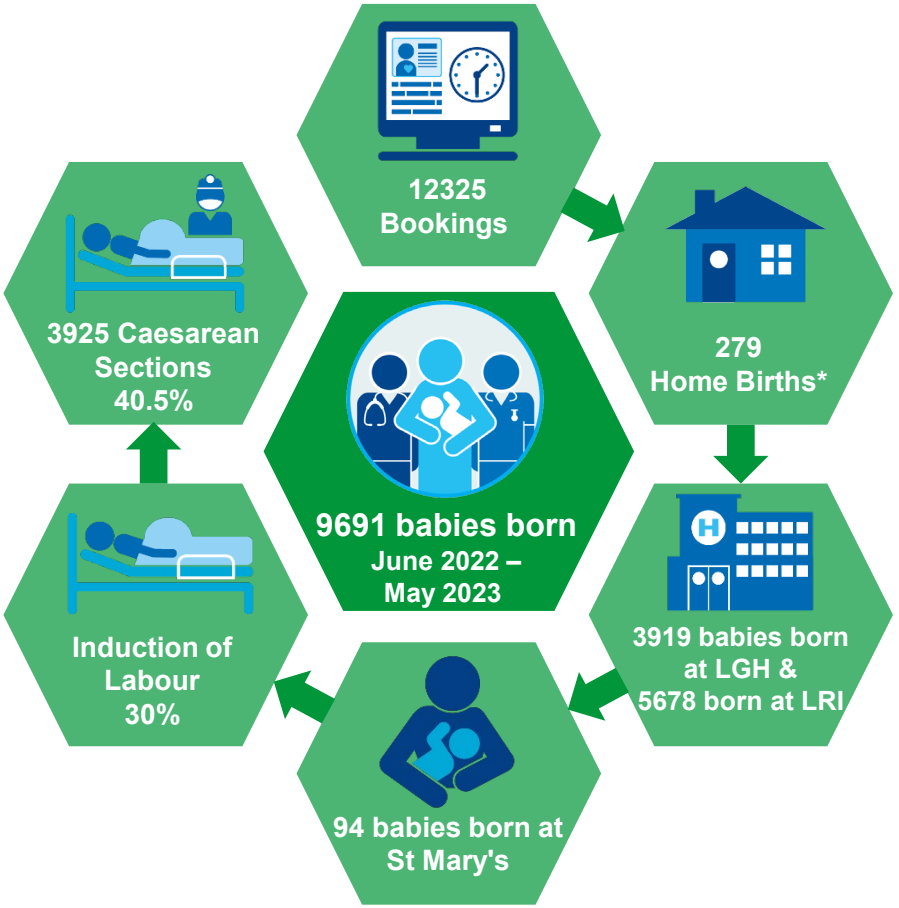
Overall Summary

Maternity Activity

May 2023 had the 2nd highest rate of activity since December 2022

LRI had an increase in activity compared to previous month





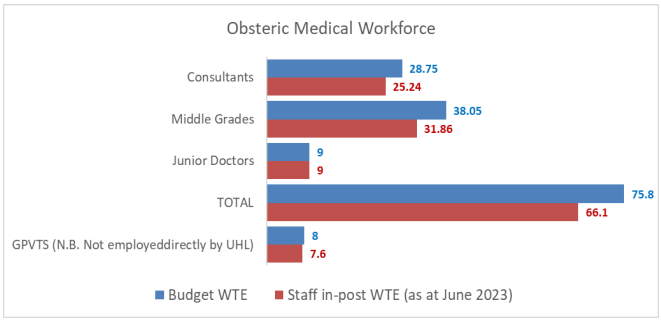
Homebirth Rate 3.6% (YTD 3.3%)

Induction of Labour rates in line with peer Trusts

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

Workforce (Maternity)

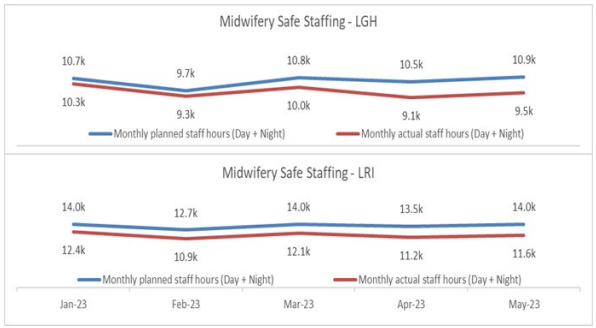
Midwifery Safe Staffing (LGH)	**May 2023 Monthly Actual v's Planned (Hours - Day + Night)**	**10,464**	**10,860**
	Total monthly actual staff hours (Day + Night)	9,102	9,524
Midwifery Safe Staffing (LRI)	Total monthly planned staff hours (Day + Night)	13,517	14,009
	Total monthly actual staff hours (Day + Night)	11,204	11,610

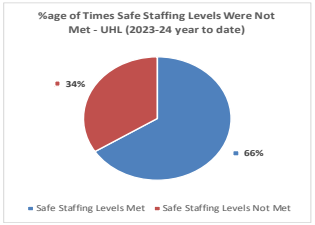


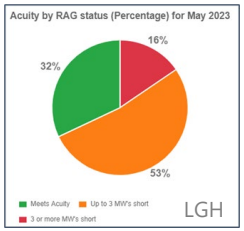
Midwife Vacancy 55.7wte (13.8%)

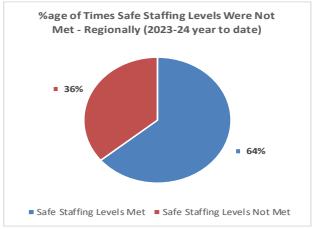
Obstetric Consultant 3.51wte

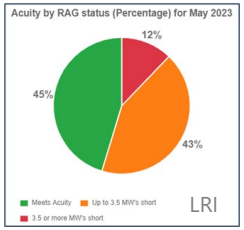
Support Workers -14.8wte (over est.)











IN SUMMARY

What Is The Data Telling Us?

- Midwifery vacancy rate remains static since October 2022
- Continues to be shortfalls in midwifery and obstetric vacancies
- Safe Midwifery staffing levels have been met 66% of the time YTD which is in line with the region at 64%
- Funded MW in post 27.40 and Actual MW in post 23.60 (February 2023)

What Is Going Well?

- Midwifery turnover rate below national average
- Conversion of MCA to MSW role's following completion of AfC Band 3 pathway
- International Recruitment, 10 in post and 11 more in the pipeline
- Stay Conversations / Value You View Interviews
- Leadership Role Opportunities e.g. Lead MW for QI, ACP in training opportunities

What Do We Need To Focus On ?

- Finalising and sharing comprehensive workforce plan (July 2023)
- Proactive Recruitment (midwives and obstetrics)
- Focus on retention of existing staff
- Response to BirthRate Plus Workforce Assessment (expected to complete July 2023)
- Awaiting RCOG Consultant Establishment Recommendations

Where Do We Want To Be?

- Meeting stretch targets highlighted in draft workforce plan
- Increase student conversion rates
- Achieving MIS / Ockenden Compliance with Consultant coverage
- *NEED TO INCORPORATE NEONATAL WORKFORCE*

Safety Incident Reporting

Key Performance Indicator	2021-22	2022-23
HSIB Referrals (Eligible Cases)	24	17
HSIB Referrals (Referred & Accepted)	16	13
HSIB Referrals (Declined by HSIB)	4	3
HSIB Referrals (Declined by family / Consent withdrawn)	4	1
HSIB Referrals (Total Safety Recommendations*	34	9

May 2023

2 HSIB

3 Serious Incidents

0 Never Events

16 Moderate Incidents

* Safety Recommendations are based on date of Report completion

9 HSIB Safety Recommendations 2022-2023

IN SUMMARY

What Is The Intelligence Telling Us?

- Reduction in HSIB reportable cases compared to last year
- Significant reduction in incidents related to HIE/Cooling, whereas Neonatal Deaths and Stillbirth rates remain the same
- Risk Assessment, Adherence to policy / guideline, and Involvement are themes actively being addressed. 3 SR related to IOL guidelines
- Blood loss greater than 1500mls is highest reported moderate incident, followed by perineal trauma and term admissions to NNU
- 36 PMRT cases were reviewed during Q4 - Early Neonatal Deaths (extreme prematurity) and Stillbirths accounted for the highest number of cases . 0 cases reviewed highlighted care delivery concerns which could have made a difference to the outcome

What Is Going Well?

- Neonatal moderate incidents remain low
- Reduction in the number of HSIB safety recommendations, with no cases relating to fetal monitoring
- Refreshed focused and increase in QI

What Do We Need To Focus On?

- Improving antenatal risk assessment at admission
- Digital solutions enablement for reporting such as Nervecentre and Datix
- Cluster review commenced to explore theme around Placenta Accreta (June 2023)
- Triangulation with Trust Claims Scorecard (themes from claims & litigation as per Q&S Integrated Report)
- Full understanding and analysis of 2021 MBRACE Report

Where Do We Want To Be?

- Accurate reporting tools
- Improved confidence in reporting process at ward level through better use of Datix
- Embedding of early resolution step for low level complaints

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

Domain	Key Performance Indicator	Target	Mar-23	Apr-23	May-23	YTD	Assurance	Variation	Trend Actual results expected to be within the dotted lines
Outcome	Spontaneous Deliveries %	Actual	47.7%	45.5%	45.3%	45.4%			
	Caesarean Section Rate - total	Actual	42.6%	39.7%	43.8%	41.8%			
	% Blood loss greater than 1500 ml (as a % of total deliveries)	<=2.7% (National Target <3.6%)	3.3%	2.1%	2.5%	2.3%			
	% 3rd & 4th degree tears (as a % of total vaginal deliveries)	Alert if >3.6%	2.5%	3.2%	3.7%	3.5%			
	% of Full term babies admitted to NNU NB:Figures from January 2019 reflect ATAIN: Term admissions to NNU as % of UHL Term births	6%	5.48%	7.18%	5.29%	6.23%			

IN SUMMARY

What Is The Data Telling Us?

- Top 4 reasons for IOL: Reduced fetal movements (47), Pre-labour rupture of membranes (34), post term dates (9), and Gestational Diabetes (8)
- Breastfeeding Rates at First Feed 63% and at discharge (35%)
- Blood Loss >1500mls below national target and sustained
- Clinical variation with perineal tears and % of full-term babies admitted to NNU

What Is Going Well?

- Multi-disciplinary audits
- Continued improvement following quality improvement initiatives however enhanced surveillance continues

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)
- Focus on continuous improvement, implementing interventions based on learning in relation to perineal trauma and audits from post partum haemorrhage audit
- Understanding of all clinical outcome metrics and measures with improved reporting of impact, with particular focus on diabetes (as per new SBLCBv3)

Where Do We Want To Be?

- Improving outcomes for women
- Reduction in reportable incidents
- Triangulation and strengthened approach to 'making data count' to proactively plan services

Maternity & Neonatal Experience

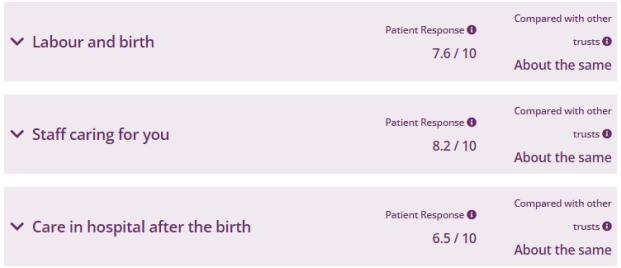
Key Performance Indicator – Family & Friends Test (FFT)	Target	Apr-23	May-23	YTD
Maternity Friends & Family - % of Responses	30%	24.2%	19.5%	21.9%
Maternity Friends & Family - % of Promoters	96%	96.3%	95.0%	95.7%

Complaints & Concerns	Apr-23	May-23	YTD
Maternity	11	13	24
Neonatal	0	3	3

Immediate Learning from Complaints / Concerns (May 2023)

- Documentation
- Appointments
- Involvement & Information
- Management of Care

CQC Maternity Survey 2022



IN SUMMARY

What Is The Data Telling Us?

- 8 complaints for Maternity Services (5 LGH and 3 LRI)
- % of women who recommend UHL remains static around 95-96%
- FFT data showing delay in providing pain relief on postnatal ward – staff redeployment appears to be a contributing factor
- Neonatal complaints remain low
- Involvement & Inclusion is critical

What Is Going Well?

- Neonatal patient feedback remains positive
- Currently trialling Early Resolution with Maternity complaints for quicker resolution and increased responsiveness
- Developing relationship with *New* Maternity & Neonatal Voice Partnership (MNVP)
- Equity & Equality Delivery Actions
- Development of JANAM App & pilot for CardMedic

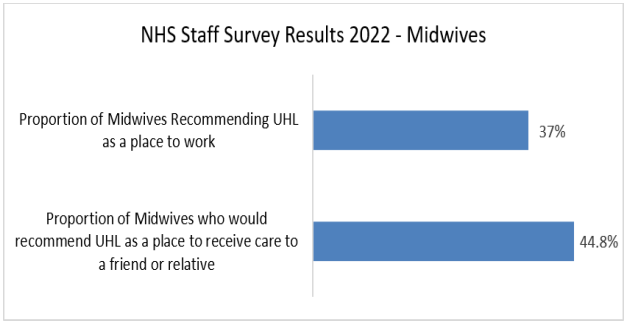
What Do We Need To Focus On?

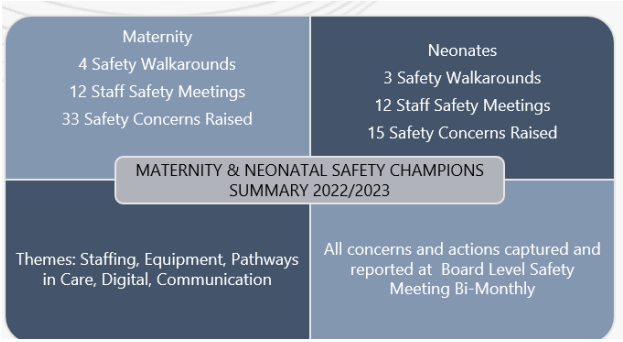
- Implementing digital solutions to improve FFT response rates
- Focus on ensuring multiple language for information cascade
- Development of new Website focusing on accessibility
- Implement real time escalation process for women to raise concerns whilst in hospital

Where Do We Want To Be?

- Women, partners and families feel heard and included in decisions about their care
- Resolve patient dissatisfaction at the point of care
- Improved work with newly reformed MNVP to support co-creation & co-production of services

Maternity & Neonatal Feedback (Staff)





Safety Champion Feedback (May 2023 Update)

Safety Champions – What Staff Said	Safety Champions – Actions Taken
Newborn Infant Physical Examination (NIPE) clinics – We need to increase availability	• Increase of NIPE clinical / practitioner capacity in community • Focus on addressing the needs of vulnerable families
Communication – We need to get better at communicating with teams	• Plans to improve communication and engagement through staff coproduction • Focused support on developing a communication strategy with staff • Greater involvement with QI initiatives
Induction of Labour (IOL) pathways – We need to address the delays	• IOL Working Group re-established (Feb 2023) • Focus on clinical prioritisation and tactical daily oversight • Plans to separate elective activity from the day-to-day operations of labour ward • Need to enhance the overall experience for patients and ensure adequate staffing levels
Redeployment of staff – We need to need reduce redeployment of staff from wards and the home birth team	• Safe Staffing Matron to analyse themes and trends from the acuity tool • Updating local escalation policy • Implementing action cards to assist decision-making
Community Team – We need increased visibility of leaders	• DoM visits scheduled and plan in place for Non-Exec Maternity Safety Champion to visit teams • New Head of Midwifery in post (April 2023) with community within portfolio • Actions arising from Empowering Voices to inform
Maternity Assessment & Telephone Triage – We need improved pathways and separation of services	• BSOTS training plan in place working with Birmingham team • BSOTS relaunch June 2023 • Plans underway to develop Day Assessment Unit to support Maternity Assessment Unit activity

IN SUMMARY

What Is The Intelligence Telling Us?

- Challenges in workforce gaps continuing towards satisfaction in the workplace
- Several opportunities to improve working conditions such as estate and equipment
- Staff are open in sharing feedback with safety champions

What Is Going Well?

- Empowering Voices (Culture) Programme – engagement and involvement
- Engagement with Safety Champions as part of Monthly Sessions / Walkarounds

What Do We Need To Focus On?

- Focus areas from Empowering Voices
  - Culture & Leadership
  - Recruitment & Roles
  - Equipment
  - Systems & Processes
- Leadership & Development Opportunities
- Better Involvement of teams

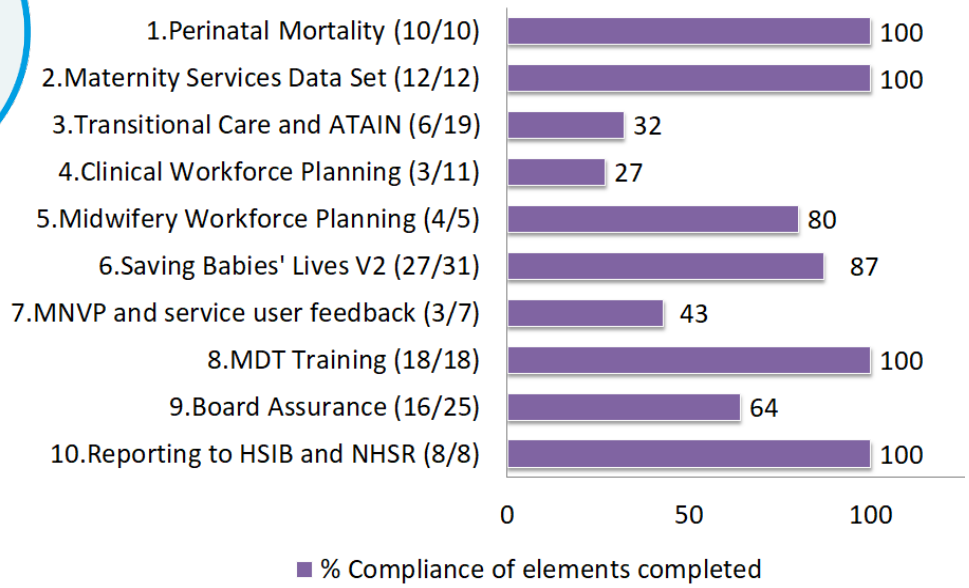
Where Do We Want To Be?

- Teams which feel continuously valued and supported
- Improved staff satisfaction
- UHL to attract and retain based on a comprehensive OD and support package which is bespoke and inclusive

Maternity Incentive Scheme Progress

UHL declared compliance with 2 out of 10 safety actions for Year 4 in January 2023 (Actions 8 & 10), progress has been made for Actions 1 & 2 (April 2023). Year 5 standard issued 31 May 2023 with assurance and data collated July onwards.

Compliance for Year 4



Focus Areas & Actions to Achieve Full Compliance for Year 5:

- **Transitional Care:** workstream established, project lead in place, and project plan being progressed
- **Clinical Obstetric Workforce:** new requirements to be reviewed with lead and audits commenced
- **Saving Babies Lives V3:** 6th element includes Diabetes, actions to be agreed
- **MNVP:** monitor progress against work plan and coproduction, prioritising voices from neonatal and bereaved families and women from BAME backgrounds, UHL short term engagement liaison lead insitu to support
- **MDT Training Plan:** work being undertaken to align current training plan with new framework

Safety Actions for Year 5

1. Perinatal Mortality
Progress monitored via national MBRRACE tool. Robust process in place.

2. Maternity Services Data Set
Test data / KPIs to be reviewed for July data submission.

3. Transitional Care and ATAIN
Focus on implementing the jointly approved pathway, drawing on insights from the year 4 data recording, ATAIN reviews with agreed action plan

4. Clinical Workforce Planning
New audit requirements for obstetric workforce re short- term and long-term locums and compensatory rest. Neonatal staffing to continue meeting BAPM standards or ongoing work against previous action plans.

5. Midwifery Workforce Planning
Workforce plan drafted. Focus on establishment, supernumerary status, 1:1 care in labour and midwifery staffing oversight report.

6. Saving Babies Lives Care Bundle V3
Implementation tool awaited. Work continues to embed interventions – 73 in total

7. MNVP and Service user feedback
MNVP relaunched 31 May 2023 with work plan agreed. Evidence of co-production ongoing.

8. MDT Training
Core Competency Framework V2 being implemented into local training plan. 90% targets being achieved.

9. Safety Champions and Board Assurance
Refresh of perinatal scorecard and safety champion pathway. Safety intelligence to presented at Trust Board .

10. Reporting to HSIB and NHSR
Robust process in place. Quarterly audit due in July 2023

Hot Topic Telephone Triage/BSOTS

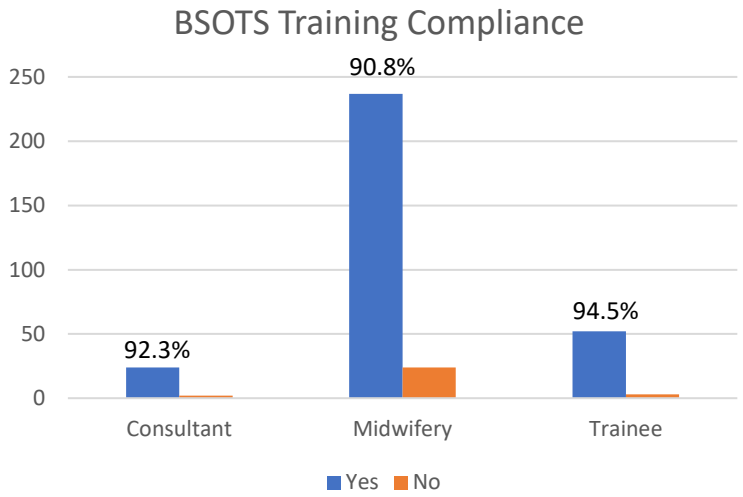
BSOTS (Birmingham Symptom Specific Obstetric Triage System)

Telephone Triage

- Launched April 2023
- Average 1,180 calls per day
- Over 50% calls answered within 1 minute
- Staffed with 2 midwives 7am-11pm

BSOTS

- Re-launch date 13th June 2023
- Training compliance achieved within 6 weeks
- 78.5% of Patients Triaged in 15 minutes in first 2 weeks
- 100% compliance in BSOTS paperwork pathway, in 121 admissions



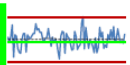
Appendices

REFERENCE: MIS Perinatal Scorecard Minimum Data Measures

Minimum Data Measures YEAR 5 MIS	May-23
Findings of review of all perinatal deaths using the real time data monitoring tool	Slide 5
Findings of review all cases eligible for referral to HSIB.	Slide 5
The number of incidents logged graded as moderate or above and what actions are being taken	Slide 5
Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training	Slide 9
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 8 *Gaps in rota numbers will be available for June data. Please refer to slide 6 for interim narrative*
Service User Voice feedback	Slide 8
Staff feedback from frontline champions and walk-abouts	Slide 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
Coroner Reg 28 made directly to Trust	Slide 5
Progress in achievement of CNST 10	Slide 9
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
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

REFERENCE: MIS Perinatal Scorecard Minimum Data Measures

Maternity Perinatal Quality Surveillance Scorecard - W&C CMG Month 2 (May) 2023-24

	National target / Alert Level	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	2023-24 TOTAL / AVERAGE (YTD)	Variation - 12 month period / SPC
Total deliveries (LRI, LGH, SMBC, HB & BBA)	Actual	792	815	751	782	763	836	775	806	1581	
No. of hospital deliveries at LRI (excl HB & BBA)	Actual	450	452	429	449	432	485	428	449	877	
No. of hospital deliveries at LGH (excl HB & BBA)	Actual	313	334	292	316	305	316	317	319	636	
No. of hospital deliveries at SMBC Plus HB & BBA	Actual	29	29	30	17	26	35	30	38	68	
SIs (Obstetrics)	Actual	0	3	1	1	1	2	0	2	2	
SIs (Neonatology)	Actual	0	0	0	0	0	0	0	0	0	
Number of Still births - overall total	Actual	6	2	2	1	4	5	3	2	5	
Still births as %age of total Deliveries	<0.45%	0.76%	0.25%	0.27%	0.13%	0.52%	0.60%	0.39%	0.25%	0.32%	
HSIB Referrals	Actual	0	0	0	1	1	1	0	1	1	
Moderate Incident	Actual	12	14	8	18	21	15	12	16	28	
Coroner Regulation 28 Requests	Actual	0	0	0	0	0	0	0	0	0	
Funded Midwife to Birth ratio (UHL complete care, 1:nn)	>1:26.4	1:23.9	1:23.8	1:23.7	1:23.6	1:23.7	1:23.7	1:23.6	1:23.6	1:23.6	
Midwife Vacancies (%)	10%	15.2%	13.4%	14.2%	13.1%	13.7%	14.0%	13.7%	13.8%	13.7%	
1 to 1 Care in Labour	Actual	100%	100%	100%	100%	100%	100%	100%	100%	100%	
% of All Staff attending Annual MDT Clinical Simulation	90%	93%	96%	97%	98%	97%	95%	94%	96%	95%	
% of All Staff attending NLS Training	90%	94%	97%	97%	97%	97%	96%	95%	95%	95%	
% of All Staff attending CEFM Training (Theory)	90%	95%	97%	98%	93%	95%	95%	94%	94%	94%	
% of All Staff attending CEFM Training (Assessment)	90%	94%	97%	97%	93%	95%	95%	93%	94%	94%	
Maternity Friends & Family - Footfall	>=30% (UHL Target)	19.5%	16.9%	16.6%	18.0%	18.2%	14.3%	24.2%	19.5%	21.9%	
Maternity Friends & Family - percentage of promoters	>=96% (UHL Target)	93.9%	96.2%	97.8%	97.4%	96.8%	92.7%	96.3%	95%	95.7%	
Spontaneous Deliveries %	Alert if <51%	48.1%	47.5%	45.7%	44.9%	51.9%	47.7%	45.5%	45.3%	45.4%	
Caesarean Section Rate - total	Alert if >23%	40.9%	40.7%	41.4%	43.1%	37.1%	42.6%	39.7%	43.8%	41.8%	
% Blood loss greater than 1500 ml (as a % of total deliveries)	<3.6% (Local Target <=2.7%)	3.8%	3.2%	2.7%	2.8%	2.6%	3.3%	2.1%	2.5%	2.3%	
% 3rd & 4th degree tears (as a % of total vaginal deliveries)	Alert if >3.6%	3.6%	2.3%	4.1%	4.7%	3.1%	2.5%	3.2%	3.7%	3.5%	
% of Full term babies admitted to NNU	ATAIN Target <6.0%	4.41%	5.39%	4.50%	6.55%	5.80%	5.48%	7.18%	5.29%	6.23%	

CQC Rating	Safe	Good	Caring	Responsive	Well-Led	Overall
LRI	Good Feb 2020	Good Feb 2020	Good Feb 2020	Good Feb 2020	Good Feb 2020	Good Feb 2020
LGH	Requires Improvement Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018
St Mary's	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018	Good Mar 2018