Trust Board Paper G

Meeting title:	Trust Board					
Date of the meeting:	14 November 2024					
Title:	September 2024 Perinatal Quality Surveillance Scorecard					
Report presented by:	Julie Hogg, Chief Nurse / Danni Burnett, Director of Midwifery					
Report written by:	Danni Burnett, Head of Midwifery / Jonathan Cusack, Clinical Director					
Action – this paper is for:	Decision/Approval		Assurance	x	Update	x
Where this report has been discussed previously	Maternity Assurance Committee (MAC) 5 November 2024					
To your knowledge, does the report provide assurance or mitigate any significant risks? If yes, please detail which						
Maternity safety and improving quality is a national priority and concern. The perinatal surveillance scorecard provides oversight of the quality and safety of the service at UHL. Current Clinical Management Group (CMG) risks indicate challenges around workforce and culture, please read this report alongside corporate risks to consider any additional actions and mitigations.						

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 focuses on safety, workforce, experience, outcomes and training.

Summary

Addressing the perinatal workforce gaps continues to be the underpinning feature of the perinatal safety improvement plan. There is evidence that the efforts to close the workforce gap are having a positive impact:

- Managing operational demand with a significant reduction in the number of reportable red flags and redeployment episodes however an increase was noted during September.
- Improving % of Family and Friends Test (FFT) since December 2023 however recent declines correlating with an increase in staff sickness
- Maintenance of 1:1 care in labour
- Bookings before 10weeks in Leicestershire (county) at a YTD 76.7% with improvements noted in Leicester County and targeted outreach to communities in the City.
- % of women referred for support who are smoking at booking at YTD 85.7% (100% for previous two months) with smoking rates at birth continuing to decline
- % of full-term babies admitted to the neonatal unit has improved sustaining a below target position for 5 months with the exception of September, further work is underway to analyse the impact of launching the Newborn Early Warning Track & Trigger Tool
- Breastfeeding initiation rates (within 48hours) have improved and sustained currently at YTD 79.3% which continue into babies that are fully or partially breastfed at 6-8weeks (52.9% May 2023 compared to 62.1% May 2024)

- The Induction of Labour Quality Improvement initiative continues to evolve and embed, there are notable improvements in the volume of delays however work continues in partnership with families and key stakeholders to focus on continued improvement and experience. Staffing factors impacted on delays during September and tactical decisions to redeploy staff to maintain safety were enacted.
- UHL continues to see a reduction in the number of safety recommendations being made.

Positive steps are being taken to reduce perineal trauma and major obstetric haemorrhage incidents which particularly saw an increase in September. A new specialist team and pathway came into force during August for perinatal pelvic health and it is anticipated that there will be a positive impact in improving outcomes – raising awareness, roll out education, making data count to inform trend analysis, and embedding an evidence-based care bundle which aligns with pre-registration training.

Development of the perinatal insight dashboard and updated perinatal surveillance scorecard continues with new data views and reporting to be phased in during Quarter 3 (2024/2025) and a plan to be fully adopted by Quarter 4. This will provide a more dynamic perspective data which will fully support the service to 'make data count'; monitoring outcomes to inform change.

The Maternity Assurance Committee (MAC) have oversight of audit results which demonstrate positive trends with Risk Assessments being completed at every contact (above 90% since January 2024), Personalised Care and Support Plans in place (>80% since March 2024), and improvements seen in compliance (since February 2024) on Consultants 'Must Attending'.

Midwifery planned v's actual staffing has improved since February 2024 at Leicester General and April 2024 at Leicester Royal. The uplifted establishment review (following the BirthRate Plus® workforce assessment) does directly link to the increase in vacancies in recent months with a current vacancy of 9%. UHL has welcomed 40 midwives during 2024 and there continues to be a pipeline of 38 more midwives to commence in Quarter 3 & 4 (2024/2025). There are zero consultant obstetrician vacancies. The proportion of Qualified in Speciality (QIS) nurses in neonates improved in August with 8 nurses completing the course. 13 nurses have been identified to commence the QIS course. 6.6wte registered nurses (including 1 QIS trained) have been recruited which has reduced the vacancy to 9%. Turnover continues to decrease over the past 8 months (12.2% January 2024 compared to 5.7% in August 2024 at Leicester Royal, and 10% January 2024 compared to 3.5% at Leicester General).

During September 2024 there was one case which met the criteria for referral to the Maternity and Newborn Safety Investigations programme (MNSI) and 0 Safety Recommendations received.

UHL is progressing Year 6 Maternity Incentive Scheme and associated safety actions alongside efforts to improve staff and service experience. Education and training plans are in place and progressing to address work towards compliance levels.

Recommendations

The Trust Board is asked to:

- Note the perinatal quality surveillance metrics and the plans to continue improvement across the service

University Hospitals of Leicester NHS Trust

Perinatal Quality Assurance Scorecard

September 2024

Contents

Overall Summary

Workforce

Safety

Patient Experience

Staff Feedback

Progress Against Maternity Incentive Scheme

Hot Topics

MONTH AT A GLANCE

September 2024

33 Moderate Incidents

Aug – 24

0 Patient Safety Incident Investigations (PSII)

Aug – 0

1 MNSI reportable cases & referred

Aug – 1

0 Coroner's Regulation 28

Aug – 0

100% 1:1 care in labour

Aug – 0

75% MDT clinical simulation training compliance (YTD)

Aug – 75%

80% newborn life support training compliance (YTD)

Aug – 82%

17.3% Maternity Friends & Family Test (response rate)

Aug – 16.6%

93.5% Maternity Friends & Family Test (promoter rate)

Aug – 93.9%

2.5% blood loss >1,500mls

Aug – 1.9%

5.8%
3rd & 4th degree tears

Aug – 3.1%

7.7% full term babies admitted to NNU

Aug – 4.89%

On Track for all 10 Maternity Incentive Scheme Y6 Safety Standards

Aug – On Track

98.29%
minimum safe staffing met (Maternity YTD)

Aug – 97.97%

Vacancy Rate
Midwives **9.0%**
Obstetric **0 wte**

Aug – 8.8%

MATERNITY ACTIVITY AT A GLANCE

September 2024

During September 2024 (on average) 35 antenatal bookings were made, and 28 babies were born per day

1,041 Bookings

Prev. 12-month average 1,122

837 Babies Born

Prev. 12-month average
825 Births

340 Births at LGH
485 Births at LRI
12 Births at St Mary's
27 Born at Home

Prev. 12-month average
340 Births at LGH
440 Births at LRI
8 Births at St Mary's &
18 at Home

32.0% Induction of Labour (IOL)

Prev. 12 months – 32.6%

97 Assisted Births
37 Ventouse
60 Forceps

Prev. 12-month average
36 Ventouse
63 Forceps

384 Caesarean Sections

144 (16.7%) Elective
240 (27.8%) Emergency

Prev. 12-month average
17.3% Elective
26.1% Emergency

77.2%
Breastfeeding Initiation

Prev. 12 months – 79.3%

PERINATAL QUALITY SCORECARD SUMMARY

Overview

September saw a busy month with 837 babies born, 47 more than the previous reporting period. St Mary's and the Home Birth team welcomed 39 babies. The increased activity did have an impact on the operational demand with a reduced number of periods in 'green' escalation and notable delays for women / birthing people booked for an induction of labour (IOL). The average length of time between decision for artificial rupture of membranes (ARM) and actual time of ARM is one of the measures for a delay, this was particularly impacted in the final week with staffing factors (sickness) contributing to 69% of the delays. Redeployment to ensure safe staffing was necessary to reduce delays. Reportable red flags continues to improve.

Overall			
	Leicester General Hospital	Requires Improvement	14/06/2024
	Leicester Royal Infirmary	Requires Improvement	14/06/2024
	St Mary's Birth Centre	Good	20/09/2023
Safe			
	Leicester General Hospital	Requires Improvement	14/06/2024
	Leicester Royal Infirmary	Requires Improvement	14/06/2024
	St Mary's Birth Centre	Good	20/09/2023
Caring			
	Leicester General Hospital	Good	12/03/2018
	Leicester Royal Infirmary	Good	05/02/2020
Responsive			
	Leicester General Hospital	Good	12/03/2018
	Leicester Royal Infirmary	Good	05/02/2020
Effective			
	Leicester General Hospital	Good	12/03/2018
	Leicester Royal Infirmary	Good	05/02/2020
Well led			
	Leicester General Hospital	Requires Improvement	14/06/2024
	Leicester Royal Infirmary	Requires Improvement	14/06/2024
	St Mary's Birth Centre	Requires Improvement	20/09/2023

Quality & Safety

Zero (0) Patient Safety Incident Investigations (PSII) have been reported. 1 case referred to and accepted by MNSI and
1 final report was received from MNSI with 0 safety recommendations. 33 moderate reportable datix incidents reported with 57% relating to perineal trauma.

Outcomes

Perineal trauma incidents are the most reportable incidents with a refined quality improvement project in place supported by a new Perinatal Pelvic Health Specialist Team. Unexpected admissions of full-term babies to NNU has also increased this month, but remains below target overall, NEWTT2 (Newborn Early Warning Track & Trigger Tool) launched on 1 September therefore the impact of this is currently being analyzed to understanding correlations. Whilst bookings at 10weeks has improved there continues to be close surveillance on stillbirth rates and postpartum heamorrhage.

Experience

Family and Friends (FFT) promoter scores are in the interquartile for promoter score and upper quartile when compared nationally. Improving the postnatal pathways with a move to 24hr visiting and partners staying overnight from 1 October is the focus. This is coupled with addressing concerns flagged through complaints / concerns referencing 'noise' on the wards. Feedback and planning of services continues being sought through the LLR Maternity & Neonatal Voices Partnership to ensure cocreation and coproduction of services

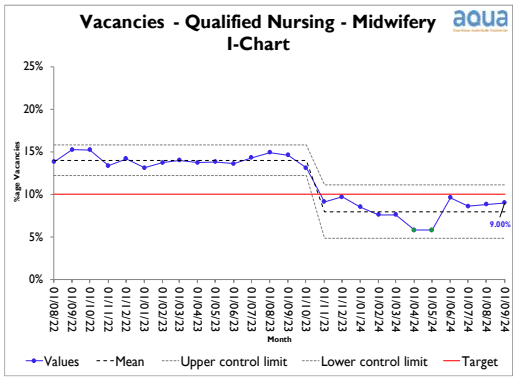
Training

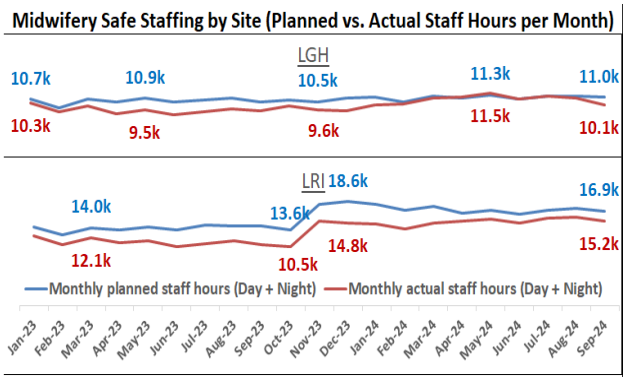
NEWTT successfully launched. Collaboration with UoL and StoneyGate has supported the roll out of the Empathy Programme with positive engagement and feedback from teams. Progress continues for ensuring a complaint position for multidisciplinary training with a Q3 focus on anaesthetic teams.

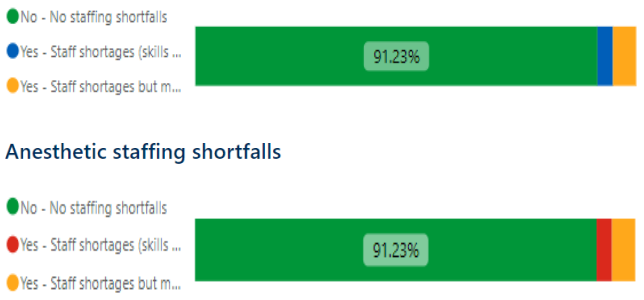
Workforce

There are zero vacancies for consultants across maternity services with a slight expected increase in midwifery vacancies to 9% reflecting the increase in establishment. UHL have welcomed 40 midwives in 2024 with 38 more due to start. The no. of Qualified in Specialty (QIS) is at 53% with a reducing vacancy rate at 9%

Workforce (Maternity)







IN SUMMARY

What Is The Data Telling Us?

- Vacancies for midwifery expected to rise before further improvements noted due to the increase in the budgeted establishment following recommendations from the BirthRate Plus® workforce assessment.
- Staff redeployment has increased to 23 occasions (redeployment from Ward 22 and Community 1). This was an increase (16 previous month) and agreed management actions due to IOL delays and safe staffing decisions.
- 0% vacancy for obstetricians, however work under way to create 4 additional posts from within current establishment through the review of job plans
- Anesthetic and Obstetric shortfalls significantly better than overall regional position (81%)

What Is Going Well?

- Midwifery recruitment strong pipeline, working towards being close to full establishment at LGH site and further reduction of vacancies at LRI site and Community by the end of the year
- Reduced agency usage across Midwifery
- Turnover rates continue to reduce overall across maternity
- Collaboration with Stoney Gate as part of the Empathetic Care Programme with positive uptake and feedback – training now completed with a further day planned for January.
- Staff survey launched with good completion rates within the first few weeks. Much improved on last year.
- Acuity training completed for Matrons, ward Leaders and Labour Ward Coordinators.

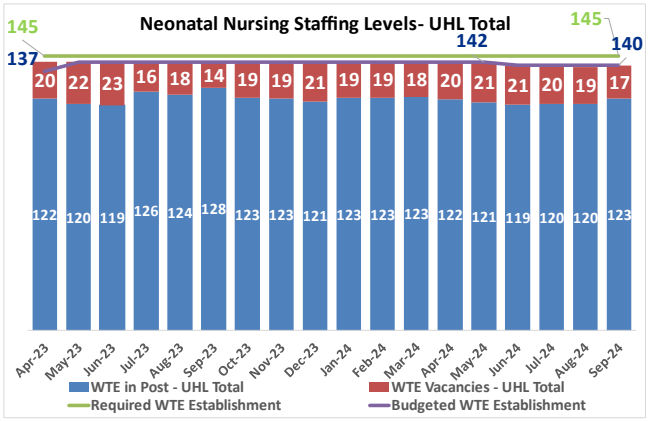
What Do We Need To Focus On ?

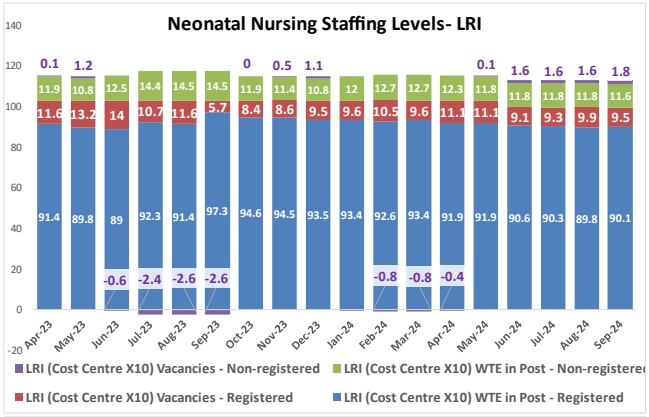
- Focus on Maternity Support Worker (MSW) recruitment – interviews scheduled
- Working towards Pathway to Excellence® accreditation (next phase Leicester General)
- Refreshed workforce plan for Maternity and Neonates (Quarter 3)
- Implementation of the Labour Ward Coordinator and Maternity and MSW competency / development frameworks
- Launch of Safer Learning Environment Charter (SLEC) – see Hot Topics
- Building cross-site resilience and strengthening of relationships
- Establishment reviews for all services with the Chief Nurse planned for October
- Recruitment to key leadership roles (deputy head of operations, matron's and ward leads)

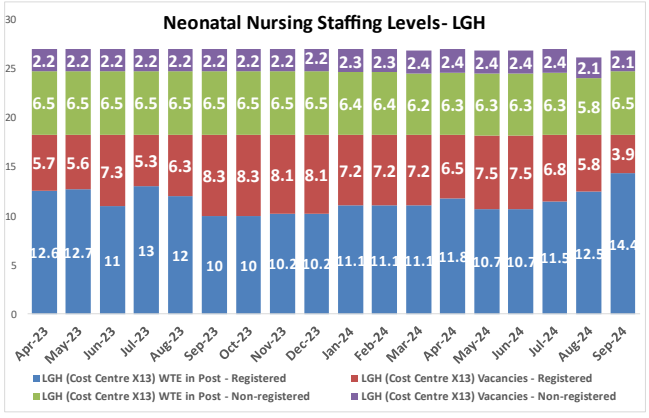
Where Do We Want To Be?

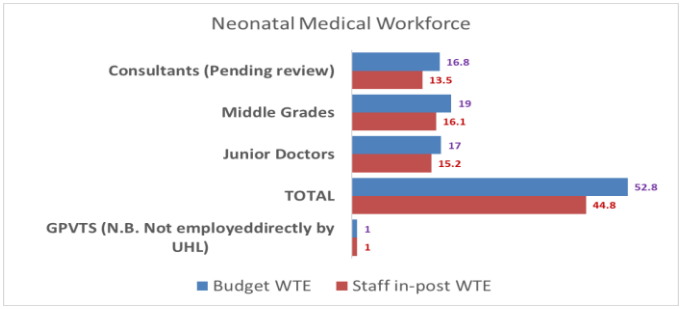
- Improved continuity of care across the whole maternity pathway
- Sustain and continue to improve retention rates for the pipeline staff expected
- Significantly reduced temporary staffing spend
- Improved conversion rates for students
- All Matrons, Managers and LWC to access BR+ acuity tool refresh training

Workforce (Neonatology)









IN SUMMARY

What Is The Data Telling Us?

- Neonatal nurses in post has increased with an improved vacancy rate (9%)
- Qualified in Specialty (QIS) trained nurses reduced slightly to 53% due to the recruitment of non-QIS nurses against a target of 70%.

What Is Going Well?

- Increase clinical band 7 workforce to two staff per shift at LRI site – recruitment almost completed to all posts.
- Turnover rates continue to reduce being less than half of that reported
- Good engagement with Neonatal Operational Delivery Network (ODN)
- NN recruitment to embed STORK Education (interactive empowerment programme for families)

What Do We Need To Focus On?

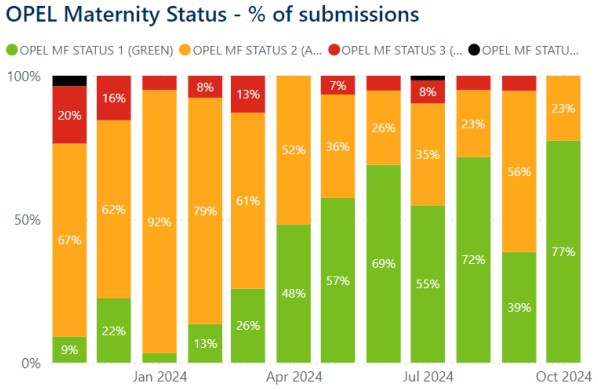
- Continue recruitment campaign and strengthen the pipeline for medical and nursing
- Deliver on the trajectory to work towards the British Association of Perinatal Medicine (BAPM) standards for current beds and a planned increase of beds. This includes supporting 16 training places per year
- Increase the capacity of the education team to support bedside teaching and recruitment to the Education posts
- Empowering Voices (culture and listening programme) action plan with a focus on leadership, staffing levels and education.
- Develop Allied Health Professionals (AHP) business case to support the service
- Band 7 coordinator development

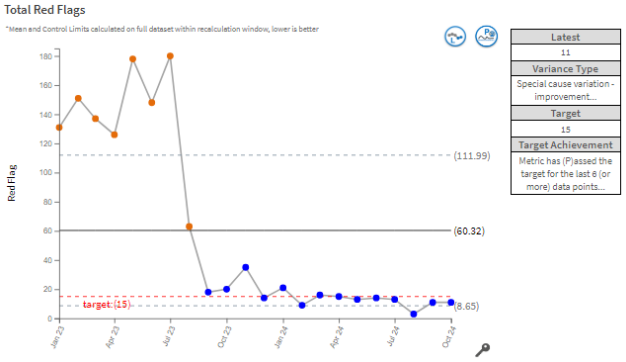
Where Do We Want To Be?

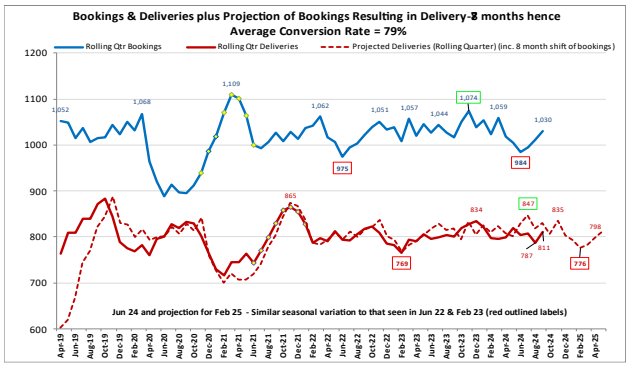
- Good staff retention within the service
- Using the Clinical Reference Group (CRG) workforce tool to support incremental workforce expansion to reach a capacity of 48 cots
- Staffing levels and QIS trained nurse levels for the unit to be compliant with BAPM standards
- A clear trajectory of nurse, medical, and AHP recruitment to close the vacancy gap

Overall Summary

Maternity Inpatient Operational Activity







IN SUMMARY

What Is The Data Telling Us?

- OPEL 2 submissions increased to 56% due to staffing shortfalls and bed capacity across the department
- Septembers booking and delivery activity has maintained at a steady rate this following closely along the predicted forecast.
- The target set for red flags has been met again by not exceeding the recommended target of 15
- During the month there was 1 internal divert and 1 period of suspending the homebirth team to maintain 1:1 care in labour

What Is Going Well?

- Elective sections continue to run efficiently with the support of additional lists when required and managing deliveries
- Maternity continue at 100% for providing 1:1 care for women and birthing people in established labour
- A new Maternity Day Assessment Unit (mDAU) is planned to officially open at the end October

What Do We Need To Focus On?

- Progressing work on the single point of contact to improve timely access and maternity navigation
- As part of the opening of the new LGH theatres support and education is in place as part of providing postoperative enhanced recovery
- Focus on the impact of the implementation of NEWTT (Newborn Early Warning System Trigger & Track) on admissions to NNU plus perinatal inpatient length of stay
- Redeployment decisions to be made by Matron of the Day or senior on call managers
- Adopting SHREWD reporting tool and aligning perinatal intelligence across systems

Where Do We Want To Be?

- To maintain safe staffing levels across both units
- Sustained periods in positive acuity
- Maintain 1:1 care and improve continuity in the inpatient area

Safety Incident Reporting

Key Performance Indicator	2021-2022	2022-2023	2023-2024	YTD 2024-2025
MNSI Referrals (Eligible Cases)	24	16	18	5
MNSI Referrals (Referred & Accepted)	16	12	11	3
MNSI Referrals (Declined by HSIB)	4	4	4	1
MNSI Referrals (Declined / Consent withdrawn)	4	1	4	1
MNSI Total Safety Recommendations*	34	12	9	5

* Safety Recommendations are based on date of Report completion

September 2024
1 case met MNSI criteria
0 MNSI Safety Recommendations
0 Non MNSI Serious Incidents
0 Never Events
33 Moderate Incidents
0 Coroner Reg 28

IN SUMMARY

What Is The Intelligence Telling Us?

- 0 (zero) Patient Safety Incident Investigations (PSII - as per PSIRF) reported
- 1 case referred to Maternity and Newborn Safety Investigation (MNSI) branch in September 2024
- 1 MNSI final report was received in August with 0 (zero) MNSI Safety Recommendations
- 33 Moderate Incidents reported: 9 related to postpartum (PPH) /major obstetric haemorrhage (MOH) and 19 related to perineal trauma
- 3 reported moderate incidents relate to uterine rupture

What Is Going Well?

- While there has been a slight increase (n=2) in the number of incidents related to PPH/MOH, focused communication around appropriate grading of these incidents has seen a positive impact in line with PSIRF
- Reducing number of cases meeting MNSI criteria and MNSI Safety Recommendations from final reports

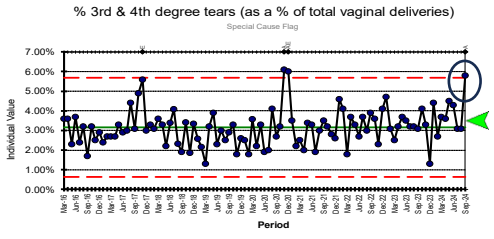
What Do We Need To Focus On?

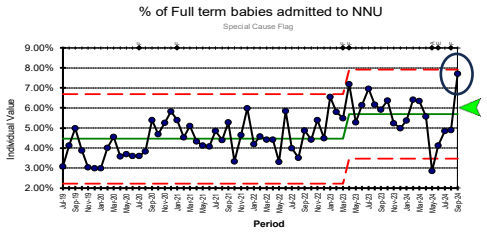
- Embedding evidence-based care bundles to address obstetric anal sphincter injury (OASI) incidences. This includes antenatal awareness and preventative actions. A new Perinatal Pelvic Health Service launched in August and further work is being undertaken to understand data and opportunities for improvement. Work has also commenced with the universities to ensure clinical education around OASI is aligned
- 3 uterine rupture incidents occurred in month therefore a case review has been commissioned as per PSIRF to identify any underlying themes
- Prompt learning as part of the Perinatal Mortality Reviews

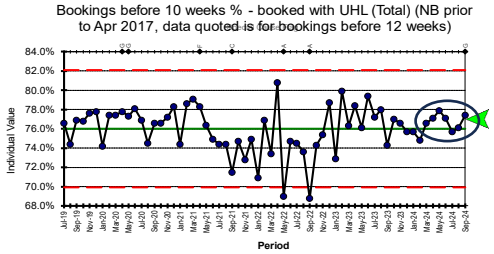
Where Do We Want To Be?

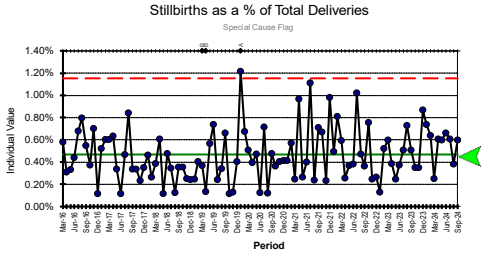
- Continue working towards zero MNSI Safety Recommendations as part of improvement and learning culture
- To use MNSI safety prompts to enhance learning and identify key safety areas
- Comprehensive training for healthcare practitioners, patient education, empowerment and advocacy resulting in reduced perineal trauma
- Continue to support clinical areas to embed PSIRF and promote greater engagement with families and workforce. Using review and reflection to individualise the required support

Safety Maternity Clinical Outcomes









Key Performance Indicator	Target	Benchmark	Jul-24	Aug-24	Sep-24	YTD
Spontaneous Deliveries %	Actual	47%	44.0%	43.1%	42.3%	43.4%
Caesarean Section Rate - total	Actual	41%	42.2%	42.8%	46.3%	44.3%
% Blood loss greater than 1500 ml (as a % of total deliveries)	Alert if >3.6%	*3.0%	3.2%	1.9%	2.5%	2.4%
% 3rd & 4th degree tears (as a % of total vaginal deliveries)	Alert if >3.6%	*2.8%	3.1%	3.1%	5.8%	4.1%
% of Full term babies admitted to NNU NB:Figures from January 2019 reflect ATAIN: Term admissions to NNU as % of UHL Term births	Alert if >6%		4.86%	4.89%	7.70%	5.02%
Bookings before 10 weeks % - booked with UHL (Total) NB prior to Apr 2017, data quoted is for bookings before 12 weeks	>77% (UHL Target)	*61%	75.7%	76.1%	77.4%	76.70%
% of women smoking at booking referred (Number of women referred as % of those smoking at time of booking less those	95%		69%	100%	100%	86%
% of women smoking at delivery	Alert if >6%	8%	5.8%	5.8%	5.7%	7.11%
Still births as %age of Total Deliveries	<0.45%	0%	0.61%	0.38%	0.60%	0.58%

*UHL KPIs do not exactly match National Comparator

IN SUMMARY

What Is The Data Telling Us?

- Slight increase in the number of births resulting in blood loss >1500mls
- Significant increase in the % of women sustaining perineal trauma (noted as a special cause deterioration)
- The % of full-term babies admitted to the neonatal unit has increased in month
- For the third month the % of women smoking at delivery continues to be within the target range
- Increase in the stillbirth rate - initial case reviews indicate no immediate safety concerns or themes however close surveillance through the PMRT process.
- Vacancies in the community teams are impacting on improving the target to ensure bookings take place before 10 weeks

What Is Going Well?

- The improvement in the number of women referred to tobacco cessation services and a reduction in smoking rates at delivery reflects positively on public health practices.
- Continued slight increase in the number of bookings before 10 week's gestation, community engagement work continues to further improve

What Do We Need To Focus On?

- Impact of NEWTT (Newborn Early Warning System Trigger & Track) on admissions to NNU plus inpatient length of stay
- Community engagement to improve earlier access to booking, plus recruitment to community midwifery teams
- Perinatal Mortality Review Team to continue to monitor stillbirth rate identifying themes and learning at the earliest opportunity
- Several approaches needed to improve the incidence and outcomes of perineal trauma. Prevention, education, clinical practice and postpartum care

Where Do We Want To Be?

- Improve outcomes and experience for women, birthing people and their families. Reduction in the number of stillbirths and neonatal deaths, perineal trauma, excessive blood loss, smoking in pregnancy, number of babies admitted to the neonatal unit
- Improved access and personalised care and support plans for all
- Focused on addressing health inequalities and health equity
- Embedding care bundles to ensure sustained improvements (OASI and OBS Cymru)

Maternity & Neonatal Experience

Family & Friends Test (FFT)	UHL Target	National	JuL-24	Aug-24	Sep-24	2024-25 YTD
Maternity Friends & Family % of Responses	25%	13%	18.6%	16.6%	17.3%	17.8%
Maternity Friends & Family % of Promoters	96%	93%	94.8%	93.9%	93.5%	94.3%

Complaints & Concerns	Jul-24	Aug-24	Sep-24	2024/25 YTD
Maternity	5	9	10	47
Neonatal	2	1	1	7

Compliments

"My midwife was extremely caring and informative. Always took good care and listened to my concerns. I am very grateful"

"Everyone has been very supportive. The midwives, consultants and anesthetists were all incredible and took excellent care of us. Could not have done it without them"

"From arrival, I felt heard and listened to. Throughout my labour I felt empowered to deliver my son in my preferred way and was supported at every step to enable this to happen"

"I was able to have the same midwife throughout my journey antenatal and postnatal. This made me feel at ease and listened to and supported"

IN SUMMARY

What Is The Data Telling Us?

- Increase of 1 maternity complaints compared to previous month
- Concerns include delays in care, visiting times, inaccurate records, and postnatal experience
- Neonatal complaints remain low
- Increase in the number of FFT responses with the promotor rate remaining stable. UHL is in the upper quartile with the mean for England at 13%
- Noisy postnatal wards, partners not able to stay overnight, estates (small bed spaces), communication issues identified in FFT comments

What Is Going Well?

- New 'name boards' on wards to facilitate women/birthing people understanding who their named midwife is on shift
- Extended times for parent-led ward rounds on neonatal unit to enable more parents to be involved
- Launch of Newborn Early Warning Trigger and Track (NEWTT2) to promote consistency and to ensure families concerns are taken into consideration regarding the care of their baby

What Do We Need To Focus On?

- Partners will be facilitated to stay overnight from 1st October; close monitoring of the impact when considering noisy ward environments
- Improving information provided to women, birthing people and their families prior to discharge home so they are supported to recognise concerns and understand how to seek help
- Encouraging women, birthing people and their families to provide feedback about all services
- New digital information sharing screens in the clinical areas

Where Do We Want To Be?

- Open, empathetic and accountable for patient experiences
- Women and birthing people to feel empowered in their journeys, safe in our care and feel able to communicate their needs and wishes through multiple methods
- Provide care that is flexible and meets individual needs
- When concerns or complaints are raised, response processes are caring and transparent

Maternity & Neonatal Feedback (Staff)

Safety Champion Feedback – September 2024 Update

What Are Staff Telling Us?
Fair allocation of shift lead to ensure there is close monitoring of workload and demands

What Action are We Taking?
Escalated to the senior nursing / midwifery leadership team with plans to work with teams and shared decision-making councils on solutions

What Are Staff Telling Us?
Improve the availability of feeding information for staff and families

What Action are e Taking?
Digital boards will incorporate proactive sharing of information. Further work is required with the MNVP to develop accessible resources

IN SUMMARY

What Is Going Well?

- 'You said, We did' and Safety Champion Board in place
- Empathy Champion Steering Group has been set up with a plan to take the lead on a range of initiatives to improve and strengthen empathy across teams
- Publication of Posters to promote service users booking to birth at St Mary's Birth Centre led to an increase of births at the centre. This helps to balance operational demands across the service and to increase birth options for our service users
- Communications Manager started to support with digital screen roll out and content to be included to compress the paper/poster content for patients and staff on the walls in clinical areas.

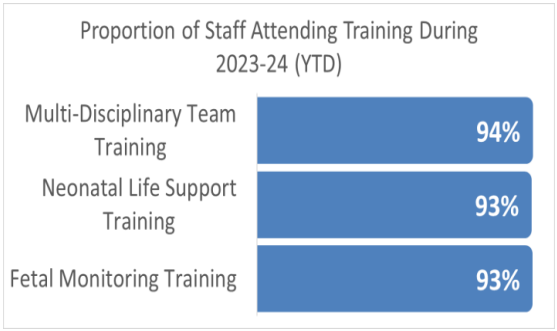
What Do We Need To Focus On?

- MNVP & Trade Sexual Health completed the 15 Steps walk around with the Safety Champions – await the findings
- Digital Boards to be placed in all clinical areas to help with information providing
- Recruitment into Safety Champion
- Improve attendance at staff forums
- Student sign in sheet oversight and improved collaborative working with universities

Where Do We Want To Be?

- Build a more empathic and compassionate workforce to the benefit of patients and staff
- Improved service user experience: families to receive high quality care which is personalized and inclusive
- Safe Learning Environments initiative to be implemented

Workforce Training Summary



Key Performance Indicator	Target	Jul-24	Aug-24	Sep-24	Rolling 12 Months
% of All Staff attending Annual MDT Clinical Simulation	90%	65.0%	75.0%	75%	80.8%
% of All Staff attending NLS Training	90%	73.0%	82.0%	80.0%	83.8%
% of All Staff attending CEFM Training (Theory)	90%	84.0%	83.0%	84.0%	88.3%
% of All Staff attending CEFM Training (Assessment)	90%	83.0%	83.0%	84.0%	88.2%

IN SUMMARY

What Is The Data Telling Us

- **MDT Training Compliance**: Overall compliance on target to meet 90%- with targeted action plans
- **NLS Compliance:** On target to meet 90% compliance in all staff groups
- **Fetal Monitoring Compliance:** On target to meet 90% compliance in all staff groups

What Is Going Well

- Empathy Training in partnership with StoneyGate and UoL
- Successful launch of NEWTT2 and training days for maternity support workers
- Launch Grow 2.0 (software to enhance patient safety as part of monitoring fetal growth)
- 8 Successful candidates identified for a Professional Midwifery Advocate (PMA) Course
- All areas of mandatory training are >70% compliance

What Do We Need To Focus On

- Monitoring of the training recovery plan
- Ongoing Fire Safety Training
- Ongoing NEWTT training for all staff
- Supporting ward leaders and staff to reach Trust Targets for Mandatory training in all areas
- Development of a programme of insitu and live clinical scenarios

Where Do We Want To Be

- MIS compliance: 90% compliance achieved across all staff groups by 30 November 2024
- >90% Compliance in mandatory training
- Staff to feel valued and supported with meaningful development plans and training opportunities

Maternity Incentive Scheme Progress

SA1: Perinatal Mortality
- Progress monitored via national MBRRACE tool and CNST compliance database
- Compliant across requirements
- ¼ report presented to MAC in Nov 24

SA2: Maternity Services Dataset
- Data received from NHS England via provisional indicative figures report (PIF) shows 100% compliance with both requirements for Jul 2024 (the data to be considered)

SA3: Transitional Care (TC) and ATAIN
- TC plan to go to MAC and LMNS in Nov for acceptance. Outline business case socialized with W&C CMG Ops team.
- ATAIN QI plan (reducing hypoglycaemia etc) accepted by Safety Champions and will go to MAC and LMNS in Nov

SA4: Clinical Workforce Planning
- Obstetric workforce –audits to test compliance with locums complete
- Consultant attendance 100% for all months YTD bar May (98%) – action plan pending
- Neonatal Workforce action plans to achieve BAPM compliance being progressed through Workstream 2. Deadline: Dec 24

SA5: Midwifery Workforce Planning
- Midwifery staffing establishment review completed and additional funding secured
- 6-monthly update to be supplied in Nov
- Compliance with 1:1 care in established labour for year to date
- Compliance with supernumerary labour ward coordinator for year to date

SA6: Saving Babies' Lives (v3)
- Assurance meeting held with LMNS in May, Jul and Sep (overall >80% compliance
- Insights dashboard to support monitoring under development ready for PSIPG acceptance
- LMNS to confirm satisfaction with position at Nov 24 meeting

SA7: Maternity and Neonatal Voices Partnership
- Evidence of MNVP engagement continues as part of Workstream 1
- Annual CQC survey results action plan being progressed
- Quad meeting held in Sept 24 over and above MAC and walkabouts / dropins.

SA8: Multidisciplinary team training
- Focus on increasing compliance rates across all requirements – mproving trend
- Some risks to delivery, especially Anaesthetist consultants' compliance with MDT obstetric emergencies – recovery plan being produced
- Focus on ensuring plan continually updated with rotational doctors intake

SA9: Safety Champions and Board Assurance
- Review of perinatal surveillance undertaken monthly by Trust Board
- Safety intelligence shared with LMNS via Perinatal Surveillance Group
- Engagement sessions with staff continue monthly with outcomes visible on 'You Said, We Did' boards and drop-in calls
- Neonatal nursing champion now in post

Year 6 standards released on 2 April 2024
Assessment period 2 April – 30 November 2024
UHL required to report compliance by 3 March 2025

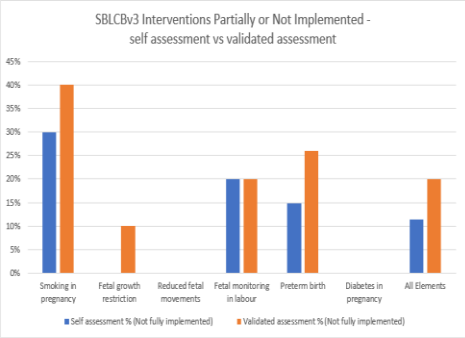
10 Safety Actions

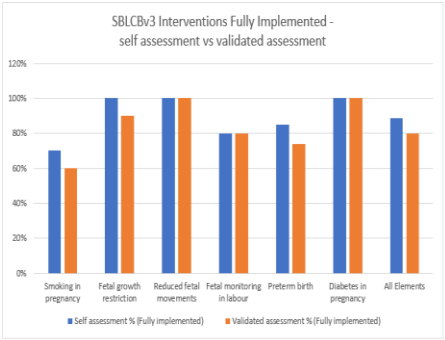
SA10: MNSI and Early Notification Case Referrals
- 7 cases referred to MNSI per eligibility criteria and 2 ENS cases report to NHS Resolution between Dec 2023 – September 2024
- Compliance maintained to date
- 100% compliance maintained for Duty of Candour

Saving Babies Lives V3 Progress

LMNS assurance reviews planned for all in October 2024

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)	NHS Resolution Maternity Incentive Scheme
Element 1	Smoking in pregnancy	Partially implemented	70%	Partially implemente	60%	CNST Met
Element 2	Fetal growth restriction	Fully implemented	100%	Partially implemente	90%	CNST Met
Element 3	Reduced fetal movements	Fully implemented	100%	Fully implemente	100%	CNST Met
Element 4	Fetal monitoring in labour	Partially implemented	80%	Partially implemente	80%	CNST Met
Element 5	Preterm birth	Partially implemented	85%	Partially implemente	74%	CNST Met
Element 6	Diabetes	Fully implemented	100%	Fully implemente	100%	CNST Met
All Elements	TOTAL	Partially implemented	89%	Partially implemente	80%	CNST Met





Element 1- smoking In pregnancy

- Further work on-going to establish the management of the service when launched in December 24. On track for launch and working with Public health midwife to align data sources
- Working with Maternity CURE Project lead to develop a job description Maternity Tobacco Dependency and Treatment Service Lead

Element 2: Fetal Growth restriction

- KPIs to be established to correlate not performing PGLF to outcomes Increase stretch target to 90% on implementation tool
- Ongoing audit into IOL for suspected SGA to see where improvements can be made; awaiting target to be set for improvement – GROW 2.0 launched in September
- Ongoing work with perinatal institute around improvement work by audit Midwife

Element 3- Reduced fetal movements

- Fully compliant – ongoing audit of next working day USS for recurrent altered fetal movements currently 100%

Element 4-Fetal Monitoring

- Ongoing monthly audits in place to inform compliance of fresh eyes standards deeper dive for 3 months completed and presented to women's board agreement of audit standards to take to next SVBL review meeting

Element 5: Preterm birth

- Funding approved for QI team for element 5 including PA time for lead obstetric consultant and increased hours for Specialist Midwife roles
- Robust SMART QI action plan around data interpretation and trajectories to be developed with MDT Multiple pregnancy audit in progress.
- QI lead neonatal nurse now in post
- Dashboard around Data for element 5 being development and reviewing assurance

Element 6 – Diabetes

- Fully compliant – ongoing monitoring of audits as per SBL tool

Appendices

Hot Topic

IN SUMMARY

Why are we doing it?

- Created in response to healthcare learners' feedback on their clinical experiences in maternity services, highlighted in the Kirkup (2015 and 2022) and Ockenden (2020 & 2022)
- Supports the development of positive safety cultures and continuous learning across all learning environments in the NHS
- Aligned to the NHS People Promise in recognition that learners are vital to the workforce and are included in the promises we must all make to each other, to improve everyone's experience of working in the NHS

What is going well?

- SLEC soft launch during September
- Plans for formal launch event facilitated by NHS England Midlands Workforce, Training, and Education (WTE) team in October 2024 – positive feedback on the numbers booked on to the sessions
- Students and Midwives referencing SLEC principles in everyday practice

What Do We Need To Focus On?

- Hold learner listening events in the next 2 months with support to release leaners from HEIs to identify SLEC priorities / learner groups / placement providers
- Collaborate with colleagues across all professions to ensure feedback, insight, and evidence gained is used to improve and standardise learner experience throughout placement providers
- Work closely with NHS Midlands WTE sharing learning to improve learning environments, reduce learner attrition, improve retention
- Accelerate implementation aligning with the Empowering Voices action plans and NETS survey
- Communication campaign across the service

Next steps?

- Develop a robust project plan to ensure the coordination and embedding of the SLEC into placements
- Complete a matrix self-assessment tool to assist in identifying any gaps in SLEC delivery
- Identify suitable actions and interventions to fill any gaps in delivery of SLEC
- Develop and monitor progress towards robust metrics (qualitative and quantitative) to ensure delivery of all aspects of SLEC interventions – Oversight through the Perinatal Safety Improvement Programme

Safe Learning Environment Charter

Our Voice, Our Experience, Our Future Workforce

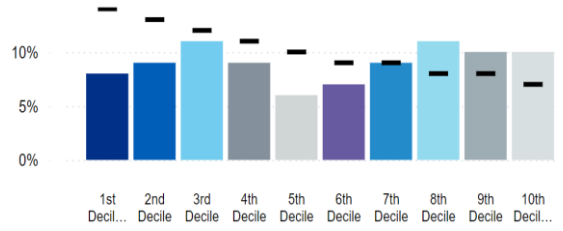
Performance Overview

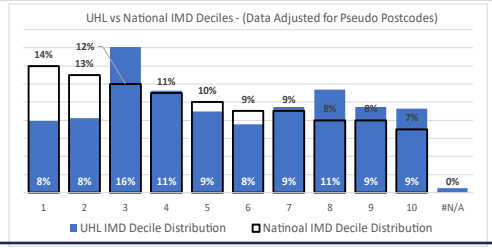
Benchmarking Outcomes (July 2024 Latest Data)

Index of Deprivation of Mother at Booking.

UHL (8%*) has a lower proportion of bookings from mothers in the most deprived areas when compared to the average of all providers across England (14%).

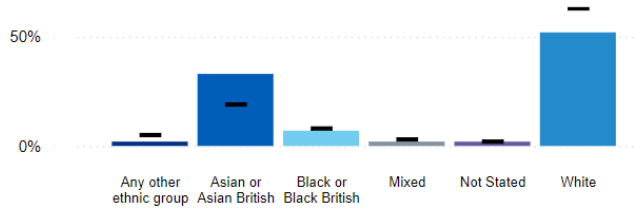
*Data issues are causing MSDS to under-representing LLR Deprivation levels. Data adjusted to account for this shows a significant increase in the 3rd & 4th most deprived deciles





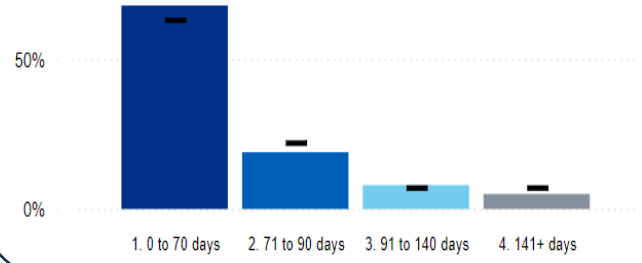
Ethnicity at Booking

UHL has a higher proportion of bookings from mothers with Asian or Asian British ethnicity (33%) and a correspondingly lower proportion with White ethnicity (52%) than the average across all providers (19% and 63% respectively).



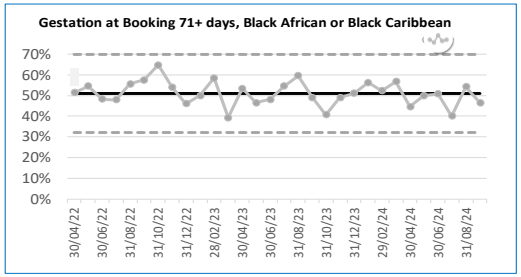
Gestational Age at Booking

UHL (68%, coloured blocks) completes a higher proportion of bookings by 70 days than the average of all Providers in England (63%, Black line).



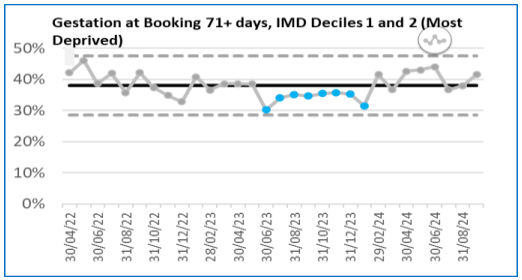
Variation in Late Bookings by Ethnic Group

UHL Late Bookings (71+ Days) are most prevalent amongst the Black African or Black Caribbean populations (50%) vs. Asian Indian, Bangladeshi or Pakistani (34%) and White British (25%).



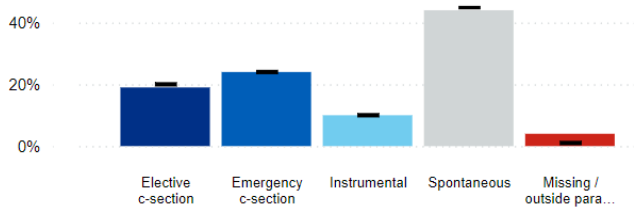
Variation in Late Bookings by IMD Decile

Mothers booking with UHL are more likely to experience Late Bookings (71+ Days) in the most deprived areas (38%) vs. the least deprived (27%).



Method of Delivery

UHL is in line with national average (10%) for instrumental delivery and emergency C-Sections (24%) but has slightly lower rates of Elective C-section (19% vs 20%) and Spontaneous Deliveries (44% vs 45%) than the average of all providers nationally.



(Benchmarking Data from National Maternity Dashboard, NHS Digital Month of Mar 2024) https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/maternity-services-data-set/maternity-services-dashboard

Performance Overview

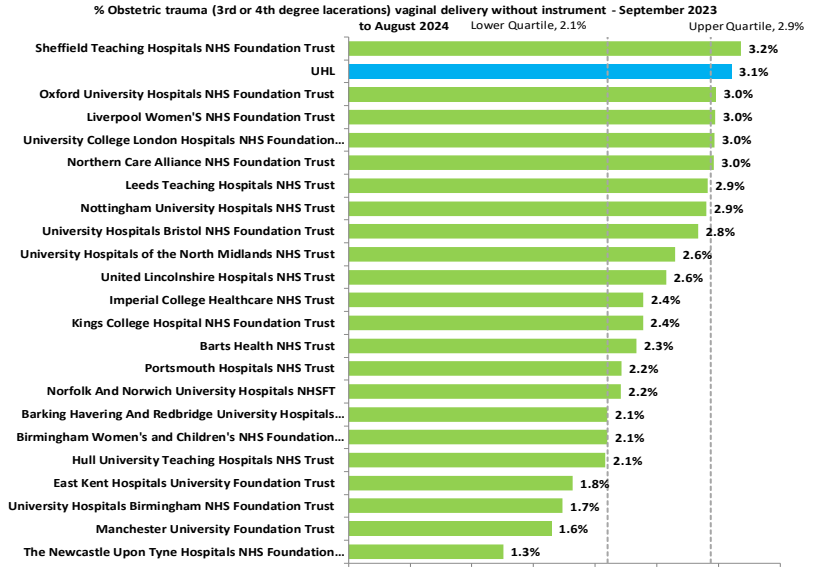
Benchmarking Outcomes (August 2024 Latest Data)

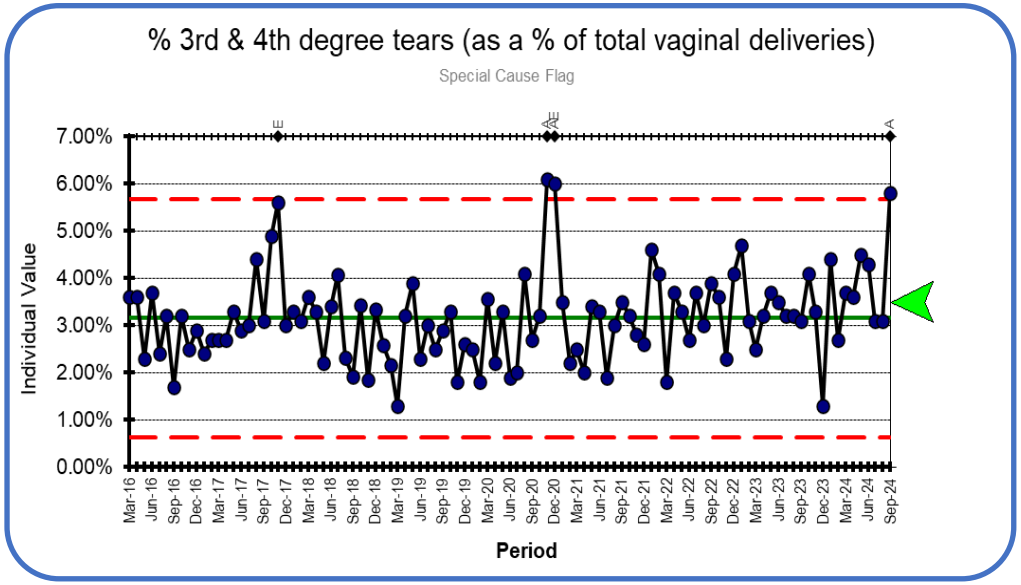
Obstetric Trauma (3rd or 4th degree lacerations) Vaginal Delivery Without Instruments

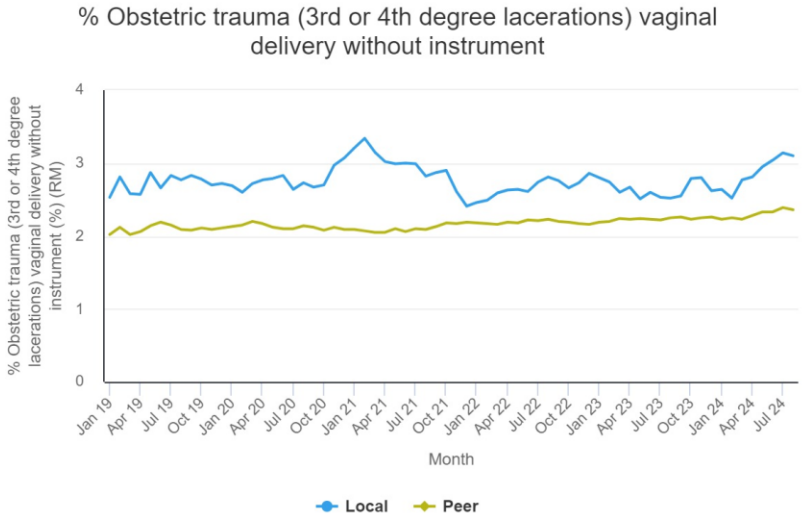
Special Cause – Increase. September rate (5.8%) above limit expected to result from natural variation. Results had been with expected limits since Dec 2020
The mean remains below the target (3.6%).

Benchmarking – Specialist Teaching Hospitals plus service selected peers

UHL mean rate over the period Sep 23 to Aug 24 (3.1%) is in the upper quartile and second highest amongst the peer group.
The Times series chart shows the peer mean (green line) has increased slowly over time. UHL rate (blue line) has seen an increase trend since Mar 24.







HES Statistics via CHKS – August 2024 figures, https://icompare.chks.co.uk/