Nottingham University Hospitals NHS Trust

We Listen We Care

Maternity OSC Report

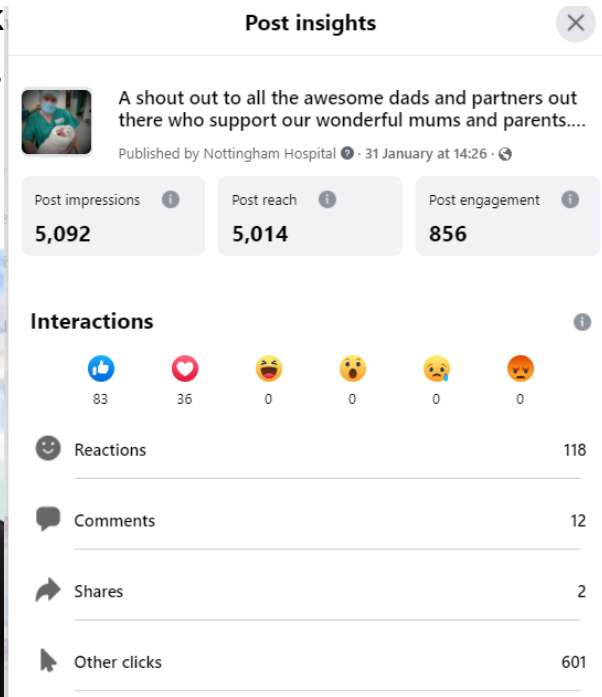
February 2022

Listening to our Families' Voices

We continue to increase our engagement with women and families via different methods – this month we'll focus on social media.

We now have more than 6,000 followers on Facebook. At the end of last year we launched the Maternity Views email address, and encouraged women and families to give themed feedback - in December 52 women contacted us via this method. Our Director of Midwifery also conducts filmed Q&As.

We have a 5* rating on Facebook and a total of 69 reviews to date.



Update of progress in our Maternity Improvement Plan

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Engagement and Inclusion

- Our birth reflections service is up and running for women and their partners

Safe Practice

- Our jaundiced baby policy has been finalised and a new pathway is now in place
- Our virtual ward continues to provide safe care for women who have Covid-19

Equipment

- Training on Bilirubinometers for community staff has been completed and the equipment is now in use

Digital

- Supplier engagement and system demonstration event across NUH and SFH

Staffing

- We are managing staffing on a daily basis as well as forward planning
- We are exploring options of different ways to manage capacity to make the best use of our resources
- All four of the new consultants we recruited in summer 2021 are now in post
- We have recruitment and retention specialist support for maternity to help boost recruitment

Update of progress since last meeting

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Training and Education

- Additional fetal monitoring training is taking place
- Our project to develop our Maternity Support Workers is progressing
- Training on Human Factors is being rolled out

Culture and Leadership

- We've repeated the Psychological Safety Survey
- Leadership development for senior midwives
- Bespoke interventions on team working
- Cultural change programme stage two has been agreed
- Continued to increase the visibility of leaders

Governance

- We have a new Quality Risk and Safety structure in place
- Funding has been received for Maternity Governance Support

Safe Practice – A Case Study

Women and their babies are protected from avoidable harm

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Postpartum Haemorrhage (PPH)

Date	Work done
Jan and Feb 21	Understanding the problem (baseline audit and thematic review of our major PPHs)
Mar 21	4 stage PPH care bundle introduced, including a standardised risk assessment
July 21	Project to optimise antenatal Hb levels
July 21	Project to reduce peripartum blood transfusions
August 21	Project to improve maternal experience. Dissemination of maternal experience survey results with key learning points
September - October	Work to improve uptake of PPH risk assessments and the use of the bundle in women having an ELLSCS

Future priorities:

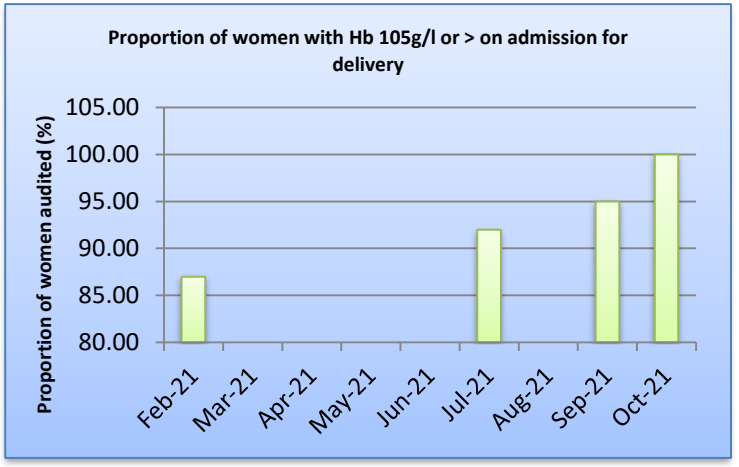
- Continue to promote awareness of PPH management
- Ensure momentum continues with this project

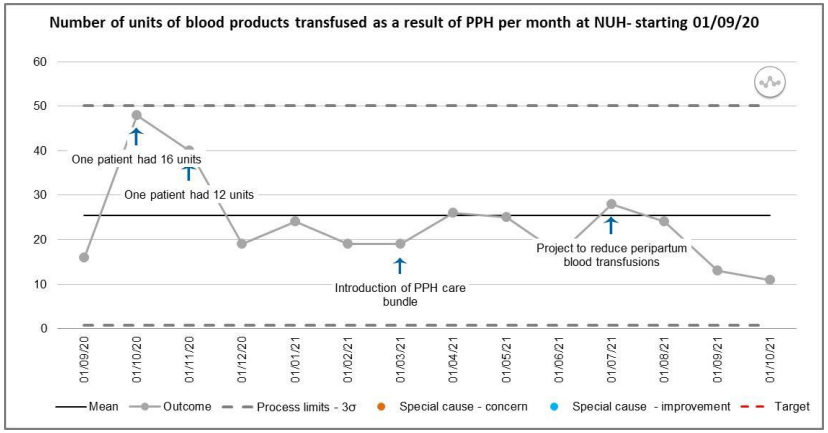
Key risks to delivery – Staffing:

- Project lead due to finish at the end of December
- Because intrapartum notes are paper based there is no way to make PPH risk assessment compulsory therefore approach heavily dependant on engagement and motivation of those delivering care

Results:

- Better use of ferrinject antenatally and peripartum has allowed us to improve the proportion of women with a normal Hb on admission for delivery and has reduced our rate of peripartum blood transfusions secondary to PPH.





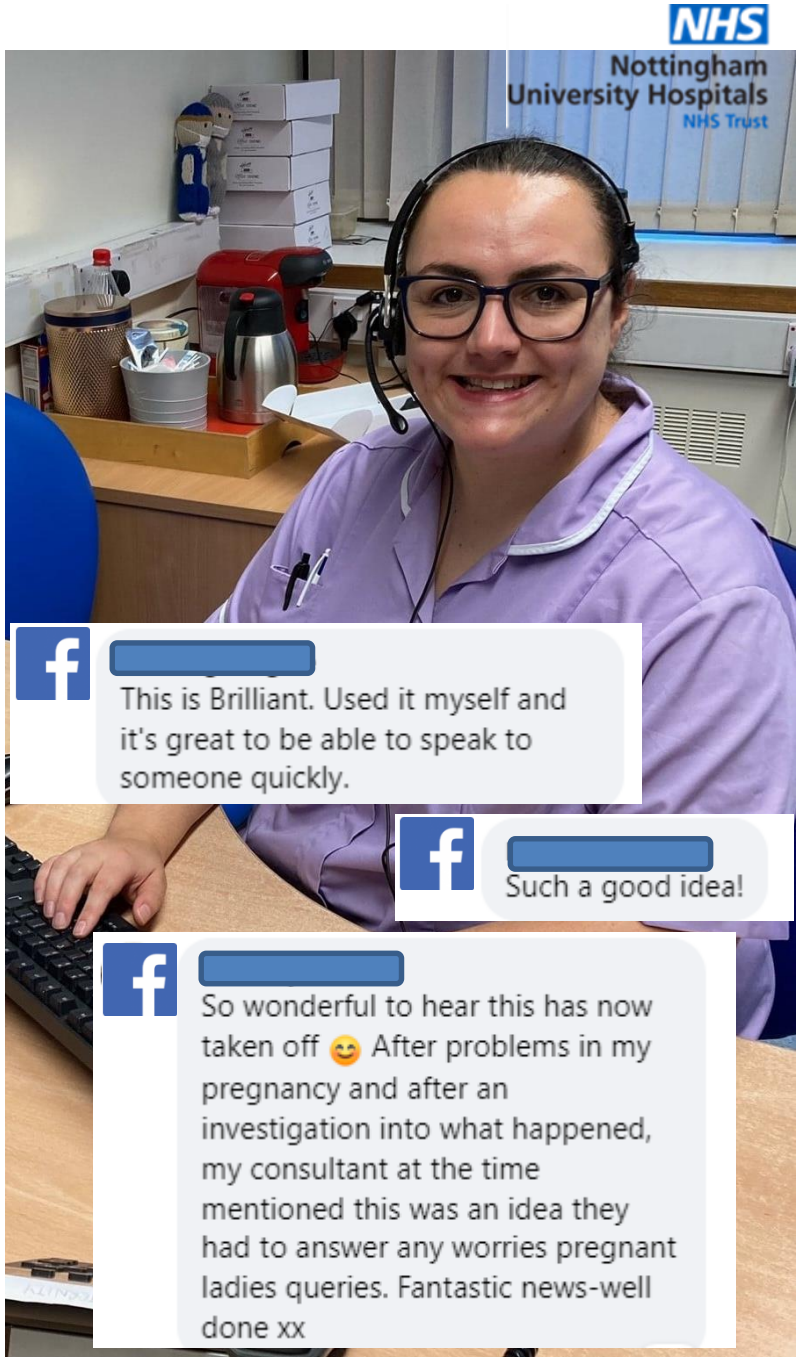
Digital Transformation

Devices:

- 150 new electronic observation devices. Ensuring every member of staff has a dedicated eObs device, plus spares for agency or locum staff
- Every community midwife and support worker now has a laptop and mobile phone

Access:

- We launched the Maternity Advice Line as a single point of contact for women and families looking to get advice. Staffed 24/7 by experts able to escalate problems as required. Data shows us when the key times are that women call, and a triage workflow is in place to help record advice given.



Digital Transformation

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System Improvement:

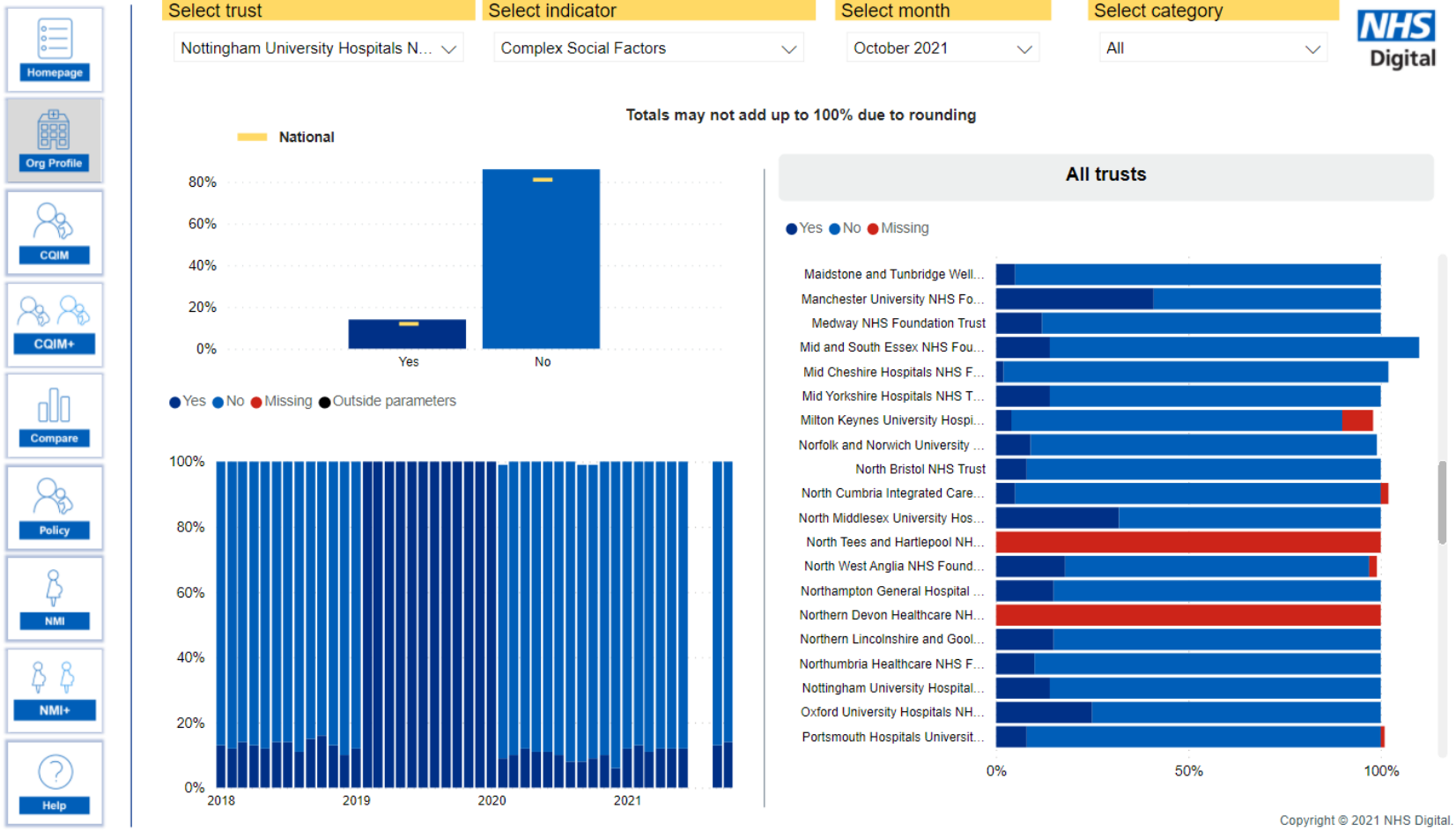
- We've installed new servers for our Maternity Information system so that it works more consistently
- Upgraded to the latest version to ensure compliance with regulation, security and improvements to functionality
- Introduced new workflows that provide better options for women and midwives during the recording of care
- Introduced new mandatory fields within the system to ensure better data quality, more reliable and consistent care and single points of truth for staff to see issues, alerts and comments

Community:

- We've started the transition to use our own Patient Administration System, which will improve accessibility of information, decrease risk to the woman and the Trust, and improve patient experience.

Maternity Dashboard

Nationally comparable maternity data is available here: [Maternity Dashboard]
This is the easiest way to compare our services to units across the country.



Maternity Dashboard – December 2021

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Activity :

	Updated to	Target	Set by	Actual		
+ 1 - Mothers Birthed	31-Dec-2021	-	-	646	Neutral	
+ 4 - % Planned Home Births	30-Nov-2021	3 %	NUH	0.2 %		
+ 193 - Total Born Before Arrival (BBA - midwife not in attendance)	30-Nov-2021	-	-	2	No target	
+ 6 - Antenatal Bookings by Booking Date	31-Dec-2021	-	-	714	Neutral	
+ 9 - % Inductions of Labour	31-Dec-2021	-	-	27.6 %	Neutral	
+ 12 - % Spontaneous Vaginal Delivery	31-Dec-2021	-	-	51.9 %	Neutral	
+ 14 - % Forceps & Ventouse Deliveries	31-Dec-2021	-	-	12.1 %	Neutral	
+ 16 - % C-Section Deliveries	31-Dec-2021	-	-	36.1 %	Neutral	
+ 179 - % Elective C-Section Deliveries	31-Dec-2021	-	-	12.2 %	Neutral	
+ 181 - % Emergency C-Section Deliveries	31-Dec-2021	-	-	23.8 %	Neutral	

Maternity Dashboard

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Maternal Morbidity :

	Updated to	Target	Set by	Actual			
+ 29 - % 3rd and 4th degree tears (Normal Unassisted Deliveries)	31-Dec-2021	2.9 %	NUH	3.9 %			
+ 30 - % 3rd and 4th degree tears (Assisted Deliveries)	31-Dec-2021	6 %	NUH	7.7 %			
+ 32 - % PPH (Post partum haemorrhage) >=1,500ml	31-Dec-2021	2.8 %	NUH	4.3 %			
+ 33 - Maternal ICU admissions in Obstetrics (Number of admissions to intensive/ high dependency care from the maternity unit	31-Dec-2021	1	NUH	0			
+ 34 - % Completed VTE risk assessment at antenatal (full) booking	31-Dec-2021	95 %	NUH	99.1 %			
+ 35 - % of completed VTE risk assessment at delivery	31-Dec-2021	95 %	NUH	98.6 %			
+ 36 - ALL Maternal Deaths (up to 1yr after birth date)	30-Nov-2021	-	-	0		No target	
+ 38 - % Shoulder Dystocia	31-Oct-2021	-	-	2.5 %		No target	
+ 40 - % Puerperal Sepsis	31-Oct-2021	-	-	1.4 %		No target	

Neonatal Outcomes :

	Updated to	Target	Set by	Actual		
+ 43 - Total Stillbirths	31-Dec-2021	-	-	4		No target
+ 44 - Stillbirth rate per 1,000 (Rolling 12 months) ALL NUH	31-Dec-2021	3.8	ONS 2020	5		
+ 48 - Inborn Neonatal deaths within 28 days of birth (24+ weeks gestation)	31-Dec-2021	-	-	0		No target
+ 49 - Neonatal Deaths (born in hospital within 28 days of birth) Rate per 1,000 births	31-Dec-2021	2.8	ONS 2019	2.2		
+ 50 - Inborn Neonatal Deaths, (Liveborn 22-23 weeks gestation within 28 days of birth)	31-Dec-2021	-	-	0		No target
+ 53 - Neonatal Hypoxic-ischemic encephalopathy (Grades 2-3) in Inborn Term Births	31-Dec-2021	-	-	1		No target
+ 54 - Neonatal Hypoxic-ischemic encephalopathy (Grade 2) in Inborn Term Births	31-Dec-2021	-	-	0		No target
+ 55 - Neonatal Hypoxic-ischemic encephalopathy (Grade 3) in Inborn Term Births	31-Dec-2021	-	-	1		No target
+ 57 - % Avoidable Term NNU Admissions	30-Sep-2021	5 %	NUH	18.8 %	Run chart	Run chart
+ 58 - % of inborn term singleton babies with an APGAR score of <7 at 5 minutes	31-Dec-2021	1.2 %	NUH	1.2 %		
+ 59 - Total Babies Birthweight < 3rd centile born at >37 weeks	31-Dec-2021	-	-	7		No target
+ 60 - % Women who have a singleton live birth < 34+0 receiving steroids within seven days prior to birth	31-Dec-2021	-	-	54.5 %		No target
+ 61 - % Women who have a singleton live birth < 32+0 receiving magnesium sulphate for fetal neuro-development prior to delivery	31-Dec-2021	-	-	100 %		No target

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Maternity Dashboard

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Readmissions :

	Updated to	Target	Set by	Actual			
+ 62 - % Maternity (women) re-admissions within 42 days of delivery	31-Oct-2021	3 %	NUH	1.5 %			
+ 63 - Inborn babies readmissions within 28 days of birth	31-Dec-2021	-	-	26		No target	

Quality, Risk, & Safety :

	Updated to	Target	Set by	Actual			
+ 194 - Serious Incidents by date of occurrence	31-Dec-2021	-	-	3		No target	
+ 108 - Serious Incidents by IRM outcome date	31-Dec-2021	-	-	3		No target	
+ 81 - Number of incidents (by reported date)	31-Dec-2021	-	-	210		Neutral	
+ 80 - Number of incidents (moderate harm and above)	31-Dec-2021	-	-	36		Neutral	
+ 79 - Number of incidents (no harm + low harm)	31-Dec-2021	-	-	174		Neutral	
+ 84 - Number of cases reported to HSIB	31-Dec-2021	-	-	1		No target	
+ 85 - Number of NICE Midwifery Staffing Red Flags	-	-	-	-	Run chart	Run chart	
+ 104 - Total medication related incidents	31-Dec-2021	-	-	11		No target	
+ 25 - % 1:1 care in labour	31-Dec-2021	100 %	NUH	98.7 %			

Service Delivery :

	Updated to	Target	Set by	Actual			
+ 75 - Total unit diversions	31-Dec-2021	0	NUH	21			
+ 76 - Total unit closures	31-Dec-2021	-	-	4		No target	
+ 77 - Admission to maternity unit from planned home birth	31-Dec-2021	0	NUH	0			

Patient Experience :

	Updated to	Target	Set by	Actual			
+ 86 - Total complaints	31-Dec-2021	-	-	3		No target	
+ 87 - Total compliments	31-Dec-2021	-	-	2		No target	
+ 88 - Total concerns raised	31-Dec-2021	-	-	5		No target	
+ 89 - FFT Rate – response target 25%	-	-	-	-	Run chart	Run chart	
+ 90 - FFT very good & good	-	-	-	-	Run chart	Run chart	

Public Health :

	Updated to	Target	Set by	Actual			
+ 66 - % Smoking at booking	31-Dec-2021	-	-	9.4 %		No target	
+ 67 - % Smoking at delivery (Delivering Population)	31-Dec-2021	11 %	NUH	12.5 %			
+ 68 - % CO monitoring completed at booking	31-Dec-2021	-	-	49.6 %	Run chart	Run chart	
+ 69 - % of CO reading at 36 weeks	-	-	-	-	Run chart	Run chart	
+ 70 - % women initiating breastfeeding	31-Dec-2021	70 %	NUH	72.1 %			
+ 71 - % Antenatal Bookings by 10 weeks gestation	31-Dec-2021	50 %	NUH	73.5 %			
+ 72 - % Maternity Bookings (by booking date) booked by 12Wks 6 days Gestation (0-12 weeks 6 days)	31-Dec-2021	90 %	NUH	91.3 %			
+ 73 - % Women screened for Sickle Cell/ Thalassaemia by 10 weeks	31-Dec-2020	75 %	NUH	99.9 %	Run chart	Run chart	
+ 74 - % NIPE performed within 72 hours	31-Dec-2021	95 %	NUH	96 %	Run chart	Run chart	

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Workforce :

	Updated to	Target	Set by	Actual		
+ 23 - Births per midwife (midwives in funded establishment)	31-Dec-2021	-	-	1.4	Run chart	Run chart
+ 24 - Births per midwife (midwives in post)	31-Dec-2021	-	-	1.6	Run chart	Run chart
+ 113 - Births per midwife (midwives in post, excluding sickness and maternity leave)	31-Dec-2021	-	-	1.7	Run chart	Run chart
+ 114 - % Sickness for midwifery staffing	31-Oct-2021	-	-	7.4 %		No target
+ 115 - % of shifts covered by temporary staffing	-	-	-	-	Run chart	Run chart
+ 116 - No: uncovered shifts	-	-	-	-	Run chart	Run chart
+ 117 - % turnover of staff within maternity	30-Sep-2021	-	-	4.3 %	Run chart	Run chart
+ 118 - No: contacts with Freedom to Speak up Guardian	31-Dec-2021	-	-	3		No target
+ 119 - % Compliance for appraisals	31-Oct-2021	-	-	63.5 %		No target
+ 120 - No: formal HR investigations	31-Dec-2021	-	-	2		No target
+ 121 - New starters survey (Quarterly)	-	-	-	-	Run chart	Run chart
+ 122 - Leavers survey (Quarterly)	-	-	-	-	Run chart	Run chart
+ 123 - Staff survey engagement rate (annual)	31-Jul-2021	-	-	26 %	Run chart	Run chart
+ 124 - % of staff recommending NUH as a place to work	30-Nov-2021	-	-	54 %	Run chart	Run chart

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Serious Incident Definition

In broad terms, serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response.

Serious Incidents include acts or omissions in care that result in; unexpected or avoidable death, unexpected or avoidable injury resulting in serious harm - including those where the injury required treatment to prevent death or serious harm, abuse, Never Events, incidents that prevent (or threaten to prevent) an organisation's ability to continue to deliver an acceptable quality of healthcare services and incidents that cause widespread public concern resulting in a loss of confidence in healthcare services.

(NHS Serious Incident Framework 2015)

Serious Incidents Reported January – December 2021

Month	Number of Serious Incidents Reported	Number Reported to HSIB
January 2021	4	3
February 2021	6	1
March 2021	1	0
April 2021	7*	1
May 2021	11**	0
June 2021	5***	2

- * 3 incidents relate to Retrospective Review
- ** 3 incidents relate to Retrospective Review
- *** 2 incidents relate to Retrospective Review

Serious Incidents Reported January – December 2021

Month	Number of Serious Incidents Reported	Number Reported to HSIB
July 2021	4*	2
August 2021	2	0
September 2021	3	1
October 2021	3	1
November 2021	3	0
December 2021	3	0

- * 3 incidents relate to Retrospective Review

Serious Incidents

The Healthcare Safety Investigation Branch (HSIB) Maternity investigation programme is part of a national action plan to make maternity care safer. They undertake approximately 1,000 independent maternity safety investigations a year to identify common themes and influence systemic change.

Criteria are:
All term babies (at least 37 completed weeks of gestation) born following labour, who have one of the below outcomes.

- Intrapartum stillbirth (where the baby was thought to be alive at the start of labour but was born with no signs of life)
- Early neonatal death (when the baby died within the first week of life (0-6 days) of any cause).
- Potential severe brain injury
- Maternal deaths

HSIB top Themes from Final Reports	
2020 analysis	**2021 analysis**
Fetal Monitoring	Practice issues
Escalation	Risk assessment
Triage/ management of telephone calls	Escalation
Diagnosis of labour	Systems and Processes
Documentation and ICT systems	Impacts of COVID19
Safe Discharge	Staffing/ Acuity
	Fetal Monitoring