Meeting title:	Trust Board **Trust Board public paper H**					
Date of the meeting:	11 September 2026					
Title:	**UHL Perinatal Report** (Perinatal Assurance Committee highlights and July 2026 Perinatal Scorecard)					
Report presented by:	Julie Hogg, Chief Nurse Danni Burnett, Director of Midwifery and Deputy Chief Nurse					
Report written by:	Danni Burnett, Director of Midwifery and Deputy Chief Nurse					
Action – this paper is for:	Decision/Approval		Assurance	X	Update	X
Which Group Priorities does this link to	Transform patient care	X	Strengthen our culture	X	Deliver our financial plan	X
Where this report has been discussed previously	Final Perinatal Assurance Committee in Common (PACiC) on 2 September 2026, ahead of the UHL and UHN governance separation and transition to organisation-specific assurance arrangements.					

To your knowledge, does the report provide assurance or mitigate any significant risks? If yes, please detail which
The report provides reasonable assurance that UHL's core perinatal governance, safety and improvement controls are established and that the July 2026 quality and safety position remained broadly stable despite sustained operational pressure. Material residual risks remain in maternity triage, obstetric and neonatal workforce resilience, estate and capacity, digital and analytical capability, consistent interpreter access, postnatal experience and compassionate debriefing. These risks are under active oversight through PSIP, the UHL Perinatal Assurance Committee, Trust Leadership Team, Quality Committee and quarterly Board reporting.

Impact assessment
The assurance approach is expected to have a positive impact on safety, quality, experience, workforce culture and equity by strengthening listening and escalation routes, Board oversight, triangulation of outcome and experience data, and evidence that learning changes practice. No adverse equality impact is anticipated. The report recognises continuing variation in access, experience and outcomes, including late booking, perineal trauma, language access and infant mortality risks, and supports targeted action through the developing Perinatal Health Equity Partnership, MNVP, community engagement and improved demographic reporting.

Appendices
Appendix 1 UHL Perinatal Assurance Committee and Priority Action Summary Appendix 2 UHL July 2026 Perinatal Performance Summary Appendix 3 UHL Perinatal Scorecard

Glossary

The following glossary and acronym guide is included to support readability and consistent interpretation of terms used throughout this report and its appendices.

Glossary	Meaning
Ward-to-Board assurance	A clear reporting route showing how risks, concerns and performance information are identified in clinical services and escalated through governance structures to Trust Boards.
Unwarranted variation	Differences in outcomes, experience or processes that cannot be explained by population need or case mix alone and may indicate improvement opportunities.
Case mix	The complexity, acuity and characteristics of the women and babies cared for by a service, which can influence outcomes and demand.
Care bundle	A set of evidence-based actions which, when delivered consistently together, improve the reliability and quality of care.
Deep-dive review	A focused review of an issue, outcome or service area to better understand causes, themes and required actions.

Acronyms

Acronym	Meaning
PAC	Perinatal Assurance Committee
PSIP	Perinatal Safety Improvement Programme
MIS	Maternity Incentive Scheme
PMRT	Perinatal Mortality Review Tool
MNSI	Maternity and Newborn Safety Investigations
FFT	Friends and Family Test
OPEL	Operational Pressures Escalation Level
ARM	Artificial Rupture of Membranes
MAU	Maternity Assessment Unit
ATAIN	Avoiding Term Admissions Into Neonatal units
EPR	Electronic Patient Record
FDP	Federated Data Platform
ODN	Operational Delivery Network
PPH	Postpartum Haemorrhage
OASI	Obstetric Anal Sphincter Injury
CTG	Cardiotocography
NNAP	National Neonatal Audit Programme
SPEN	Strategic Executive Information System for patient safety event notification
MatNeoIST	Maternity and Neonatal Improvement Support Team
MatNeoPREM	Maternity and Neonatal Patient Reported Experience Measure

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

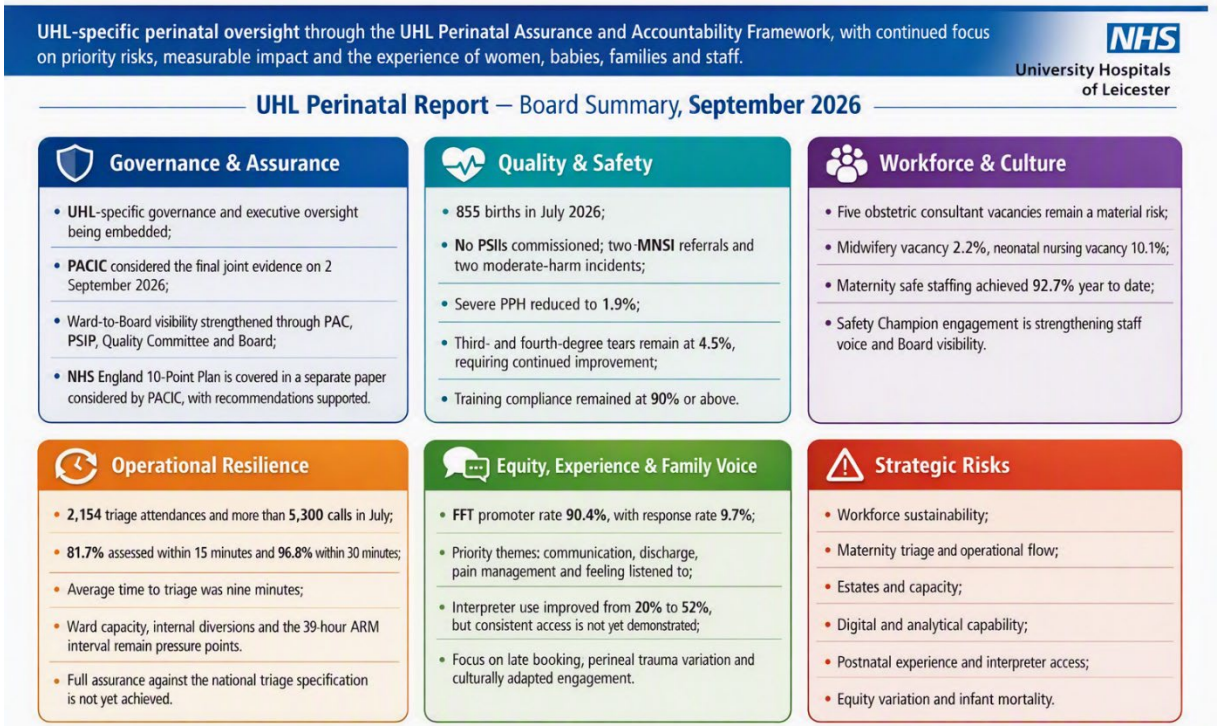
TRUST BOARD

11 SEPTEMBER 2026

UHL PERINATAL REPORT

PURPOSE OF THE REPORT

To provide the Board with an up-to-date UHL assessment of maternity and neonatal safety, quality, workforce, operational performance, experience, equity and improvement. The paper consolidates intelligence considered at the final Perinatal Assurance Committee in Common on 2 September 2026, ahead of the decoupling of UHL and UHN perinatal governance and transition to organisation-specific assurance arrangements. It also reflects the refined UHL Perinatal Assurance and Accountability Framework, the July 2026 Perinatal Scorecard and the August Director of Midwifery highlight report.



RECOMMENDATION

The Board is asked to **NOTE** the national shift from assurance that plans exist to evidence that change is embedded, reliable and improving outcomes and experience.

The Board is asked to **NOTE** that further information on the NHS England 10-Point Plan is provided in a separate paper, which was considered by PACiC and whose recommendations were supported. Within this paper the Board is asked to **RECEIVE** the maternity-triage deep dive and require completion of the residual improvement plan before full national specification assurance is claimed.

The Board is asked to **SUPPORT** the workforce, medical leadership, analytical, digital, estates, quality-improvement, communications and programme capacity required for delivery, including validation of the indicative maternity-triage investment requirement.

The Board is asked to **REQUIRE** quarterly assurance on perinatal improvement, measurable impact, risks, mitigations and areas requiring corporate or Board intervention.

The Board is asked to **ENDORSE** impact-led assurance, including maternity and neonatal metrics in the Integrated Performance Report, quarterly triangulation of outcomes, experience, workforce, culture and equity, and direct testing with women, families and staff of whether improvement is visible and sustained.

1. PERINATAL SERVICES SUMMARY

UHL's July 2026 perinatal position remained broadly stable, with 855 babies born, 100% one-to-one care in labour, no PSIIs commissioned, two MNSI referrals and two moderate-harm incidents. Severe postpartum haemorrhage reduced to 1.9%, breastfeeding initiation increased to 79.6%, and maternity training compliance remained at 90% or above. Demand and capacity pressures persisted, including increased OPEL 3 episodes, ward capacity constraints, internal service diversions and a rise in the average interval from decision for artificial rupture of membranes to completion to 39 hours.

The Perinatal Assurance Committee in Common (PACiC) met for the final time on 2 September 2026 before the formal separation of UHL and UHN perinatal governance. The Committee considered the transition arrangements and a substantial UHL evidence base, including the refined UHL Perinatal Assurance and Accountability Framework, maternity-triage deep dive, homebirth and care outside guidance review, pelvic health provision, July scorecard, PSIP assurance, MIS Year 8 evidence and Safety Champion intelligence. The NHS England 10-Point Plan was considered as a separate paper and its recommendations were supported.

The decoupling strengthens local executive ownership and Board accountability, with UHL's refined framework establishing a clearer line of sight from point of care through divisional governance, PSIP and the UHL Perinatal Assurance Committee to Trust Leadership Team, Quality Committee and Board. Collaboration with UHN will continue where it adds value, including reciprocal learning, benchmarking, specialist pathways, mortality review, peer assurance and implementation of national requirements.

During the transition, assurance will focus on continuity of oversight, clear accountability, reliable escalation and whether change is visible to women, babies, families and staff. Quarterly reporting will triangulate outcomes, experience, workforce, culture, access and equity, with transition risks monitored to avoid any loss of governance clarity or assurance.

2. PERINATAL SURVEILLANCE HIGHLIGHTS

a. Workforce and Culture

Registered midwifery vacancy was 2.26% and neonatal nursing vacancy 10.11% in July, with maternity minimum safe staffing achieved on 92.7% of occasions year to date. Neonatal tier

1 and tier 2 medical staffing were 98% and 90% respectively. However, the maternity medical workforce remains a material structural risk, with five consultant vacancies and programmed-activity gaps affecting sustainable senior cover, planned care and specialist services. External establishment modelling, continued recruitment and a costed transformation plan are required.

Safety Champion walkarounds and wider listening activity indicate growing staff engagement and openness, with 50 actions completed and 11 remaining open from 2026 activity. Staff continue to raise concerns about medical staffing, maternity and neonatal capacity, facilities and involvement in service change. UHL's culture and organisational development work, restorative approaches, leadership visibility and Freedom to Speak Up routes remain important controls.

b. Operational Performance and Flow

Maternity triage remained busy in July, with 2,154 attendances and 5,633 calls. Performance improved to 81.7% assessed within 15 minutes and 96.8% within 30 minutes; average time to triage was nine minutes. Operational pressure included three obstetric unit suspensions, five obstetric service diversions and four midwifery-led unit suspensions. The detailed cross-site review confirms 24/7 access, a single point of contact, embedded BSOTS and established governance, but full assurance against the national specification cannot yet be claimed.

Residual triage gaps include the 15-minute standard, timely medical review, separation of planned and urgent activity, workforce resilience, equity data, accessible environments, partner interfaces and digital handover.

Induction of labour (IOL) remains a material operational and experience risk. Over recent months, induction activity has remained high, with the latest rate reaching 37%. Whilst induction activity has increased, the mode-of-birth profile among induced women appears broadly stable, with no obvious visual evidence of a corresponding increase in caesarean section births. However the average interval from the decision to undertake artificial rupture of membranes to completion increased to 39 hours, reflecting sustained demand, bed and workforce constraints and competing clinical priorities, with potential consequences for women's experience, timely care and wider maternity flow. Current maternal and neonatal outcome for IOL pathways measures remain reassuring: 99.1% of babies had an Apgar score of five or more at five minutes, average blood loss was 511 ml against a target of 545 ml, and there was no clear increase in neonatal admission rates. The available data therefore indicate service pressure without evidence of deterioration in these outcome measures. As an immediate mitigation, additional bed capacity is currently being utilised on the adjoining ward at Leicester General Hospital. Options are being actively explored to maintain this arrangement and create further capacity. The pathway requires continued enhanced oversight, stronger demand-and-capacity management and triangulation of delays with incidents, clinical outcomes, complaints and real-time feedback to identify any emerging safety signal and confirm whether the additional capacity is improving timeliness and experience.

c. Experience and Engagement

Maternity FFT response was 9.7% and the promoter rate 90.4% in July. Antenatal and postnatal feedback remained largely positive, but recurring themes across complaints and Birth Reflections were communication, information sharing, delays, discharge, compassion, pain management and not feeling listened to. Data-quality issues within FFT categorisation are being corrected, and automated text messaging, community collection routes and the co-produced patient-experience action plan are being progressed.

Interpreter use improved from 20% to 52% following deployment of mobile video-interpreting equipment, but consistent access has not yet been demonstrated. The developing Perinatal Health Equity Partnership, MNVP and community partners will provide a clearer route for women and families to shape service design and improvement, including targeted work on postnatal care, communication and consent, induction of labour and discharge planning.

d. Quality and Outcomes

Clinical quality indicators remained predominantly within common-cause variation. July recorded two stillbirths, three early neonatal deaths, two MNSI referrals and no PSIIs. Severe PPH improved to 19 per 1,000 births, below the historic mean of 31.3 per 1,000; preterm birth was 65.43 per 1,000 within common-cause variation; and breastfeeding initiation improved to 79.6%. Apgar below 7 at five minutes was 12 per 1,000 and remained a discrete special-cause safety signal requiring focused review rather than evidence of broad deterioration. Third- and fourth-degree tears remained at 4.5%, above the previous 12-month average of 2.9%. Communication, handover, fetal surveillance, documentation and escalation remain the principal learning themes.

UHL remains on track for MIS Year 8 across all six core safety actions. MDT simulation and newborn life support compliance were both 95%, with fetal-monitoring training at 90%. Saving Babies' Lives implementation was 97% overall, with continued focus on fetal growth restriction, preterm birth and data reliability following the EPR transition. The June Peri-Prem bundle reported five of eight measures on target; the material gaps were magnesium sulphate at 50% against an 85% target, intrapartum antibiotics at 33.3% against 85%, and caffeine within 24 hours at 43.8% against 95%. These measures require continued case review, pathway reliability work and governance oversight.

Neonatal assurance remains mixed but improving. UHL is a positive outlier for developmental follow-up at two years and first-day consultant review; necrotising enterocolitis reduced from 13.2% to 6.3%. Breast-milk feeding at day two remains an alarm outlier at 63.4% and requires continued improvement. Full-term neonatal admission was 6.4%, marginally above the 6% benchmark, with ongoing surveillance of respiratory admissions, thermoregulation, early feeding and neonatal stabilisation. Prevention also requires focus: RSV uptake was 38.1%, pertussis uptake 66.5%, and BCG uptake 47.5% against an 80% target. Actions include stronger call and recall, improved access and documentation, opportunistic vaccination and BCG staffing resilience.

The new and emerging **Maternity Inclusivity Dashboard** provides an important population-health and equity perspective, enabling UHL to assess whether outcomes are experienced

consistently across the diverse communities it serves. Of recorded births, 48.5% were to women identifying as White, 34.2% to women identifying as Asian or Asian British, and 7.1% to women identifying as Black or Black British. These broad dashboard categories do not fully capture individual identity or lived experience, but they reinforce the need for clinical pathways, communication and improvement programmes to be culturally responsive and equitable.

Severe perineal trauma demonstrates observed variation between ethnic groups. Women from Asian or Asian British backgrounds accounted for 56.2% of recorded third- and fourth-degree tears and White women 28.4%; this is influenced by the relative size of each population group, making rate-based analysis the more meaningful assessment. The highest observed rates were among women recorded within the dashboard category “Other ethnic group” at 3.7%, followed by women from Asian or Asian British backgrounds at 3.2%, compared with 1.1% among White women and 1.6% among Black or Black British women. These descriptive findings identify variation requiring further investigation; they do not demonstrate that ethnicity itself is the cause. Further work is underway to ensure due consideration for case mix, deprivation, access, experience, clinical pathways, data quality and the relatively small numbers within some groups.

The dashboard also shows observed variation in major postpartum haemorrhage of more than 1,500 ml between ethnic groups. Although this view does not provide a single overall rate, the findings support continued monitoring of maternal morbidity and further analysis of case mix, clinical pathways, access, deprivation and wider determinants that may contribute to differences in risk. Rates based on small numbers should be interpreted cautiously and tracked over time before conclusions are drawn.

Importantly, the dashboard combines ethnicity with Index of Multiple Deprivation (IMD) profiling, allowing the Trust to consider the interaction between ethnicity, deprivation and outcomes rather than interpreting ethnicity in isolation. This supports identification of communities that may experience multiple forms of disadvantage and more targeted service improvement and population-health intervention, while avoiding assumptions about individuals based solely on group-level data. Overall, the dashboard is assisting us to strengthen assurance by moving beyond aggregate performance to test whether outcomes are achieved equitably. Aggregate outcomes remain broadly reassuring, but these averages may mask important variation between population groups. The observed variation in severe perineal trauma and maternal morbidity therefore requires further investigation, targeted improvement and evaluation of impact. This work supports wider commitments to reducing health inequalities, improving equity of access and experience, and delivering culturally responsive maternity care. Leicester City’s infant mortality position remains a major system priority, with linked work focused on earlier identification of vulnerability, care navigation, pre-conception care and culturally adapted support.

3. ADDITIONAL PERINATAL HIGHLIGHTS

UHL’s homebirth and care outside guidance service is mature and broadly compliant, with 24/7 provision, monthly multidisciplinary review, individualised care planning and positive outcomes. Further standardisation is required in MDT terms of reference, ambulance communication, digital and offline documentation, competency expectations and formal legal oversight. The UHL Perinatal Pelvic Health Service remains a strong, largely compliant

multidisciplinary model, with rising referrals, low waiting times and positive NHS England assurance.

4. PERINATAL SURVEILLANCE AND ASSURANCE FOR ESCALATION

The following was highlighted by PACIC as requiring oversight and continued Board visibility. These are not presented as new concerns, but as the areas where sustained grip, assurance and evidence of impact are required:

- delivery of the NHS England 10-Point Plan, as set out in the separate paper considered by PACiC, whose recommendations were supported;
- workforce sustainability, particularly five obstetric consultant vacancies, neonatal nursing resilience and sustainable senior cover;
- operational flow, including sustained induction-of-labour demand at 37% and the 39-hour average ARM interval; SPC analysis and current maternal and neonatal measures remain reassuring, but experience, timeliness and any emerging safety signal require continued oversight. Additional beds are currently being used on the adjoining ward at Leicester General Hospital while options are actively explored to sustain and expand this capacity;
- clinical learning in fetal surveillance, communication, handover, documentation, perineal trauma and consistent evidence that review actions change practice;
- experience and equity, including low FFT response, postnatal experience, interpreter access, late booking, ethnic variation in perineal trauma and infant mortality;
- corporate enablers, including estate and capacity, digital handover, analytical capability, demographic segmentation and validated investment plans.

These risks will be overseen through the refined UHL Perinatal Assurance and Accountability Framework, including the UHL Perinatal Assurance Committee, PSIP, divisional governance, Trust Leadership Team, Quality Committee and quarterly Board reporting. The transition from PACiC to separate UHL and UHN governance will be monitored to maintain continuity of oversight, with immediate escalation where evidence does not support confidence, risk remains sustained despite controls or local mitigation is insufficient.

APPENDIX ONE — UHL Perinatal Assurance and Priority Action Summary

NHS England 10-Point Plan	The final PACiC meeting took place on 2 September 2026 ahead of the decoupling of UHL and UHN perinatal governance. PACiC considered and supported the transition to organisation-specific oversight and the refined UHL Perinatal Assurance and Accountability Framework. Further information on the NHS England 10-Point Plan is provided in a separate paper, which was considered by PACiC and whose recommendations were supported.
Maternity triage	Core model established; partial assurance against the full national specification. Priority actions are recovery of the 15-minute standard, timely medical review, improved flow, separation of planned and urgent activity, stronger workforce, equity data, accessibility and digital handover. Interim PAC and Board reassessment: February 2027.
Workforce, experience and equity	Medical and neonatal resilience remain material risks. Priorities are establishment modelling, a costed workforce plan, recruitment, 24/7 resilience, delivery of co-produced postnatal and communication actions, consistent interpreter access, demographic analysis and direct testing of change with women, families and staff.

APPENDIX TWO — UHL July 2026 Perinatal Performance Summary

Activity	855 births; 2,154 triage attendances; 5,633 triage calls; increased OPEL 3 incidents; three obstetric unit suspensions, five obstetric service diversions and four midwifery-led unit suspensions.
Safety and outcomes	No PSIIs commissioned; two MNSI referrals; two moderate-harm incidents. Severe PPH was 19 per 1,000 births and below the historic mean; Apgar below 7 at five minutes was 12 per 1,000 and remained a focused special-cause safety signal; preterm birth was 65.43 per 1,000 within common-cause variation; breastfeeding initiation was 79.6%; and full-term neonatal admission was 6.4%.
Workforce and training	Registered midwifery vacancy 2.26%; neonatal nursing vacancy 10.11%; safe maternity staffing 92.7% year to date; MDT simulation and NLS compliance both 95%. Peri-Prem performance was five of eight measures on target, with gaps in magnesium sulphate 50% against 85%, intrapartum antibiotics 33.3% against 85%, and caffeine within 24 hours 43.8% against 95%.
Triage and experience	81.7% assessed within 15 minutes and 96.8% within 30 minutes; average time to triage nine minutes. Induction activity remains high at 37%, with an average ARM interval of 39 hours. SPC analysis shows expected variation rather than significant deterioration, and outcomes remain reassuring: 99.1% Apgar ≥5 at five minutes, average blood loss 511 ml against a 545 ml target, and no clear increase in neonatal admissions. Additional bed capacity is being used on the adjoining ward at Leicester General Hospital, with

	options actively explored to maintain and expand capacity. FFT response was 9.7% and promoter rate 90.4%; recurring themes were communication, delays, discharge, pain management and feeling listened to.
Prevention and immunisation	RSV uptake was 38.1%, pertussis uptake 66.5%, and BCG uptake 47.5% against an 80% target. Priority actions are stronger call and recall, improved access and documentation, opportunistic vaccination and BCG staffing resilience.
Equity	UHL serves a diverse maternity population: 48.5% of recorded births were to women identifying as White, 34.2% to women identifying as Asian or Asian British and 7.1% to women identifying as Black or Black British. The highest observed severe perineal trauma rates were among women recorded within the dashboard category "Other ethnic group" at 3.7% and women from Asian or Asian British backgrounds at 3.2%, compared with 1.1% among White women. These descriptive findings do not demonstrate causation and require further analysis of case mix, deprivation, access, clinical pathways, data quality and small numbers. Observed variation in major PPH also requires continued review, while combined ethnicity and IMD profiling supports targeted inequality-reduction action.

Positive Assurance	**Priority Actions and Escalations**
• Core perinatal governance and improvement arrangements are established. • MIS Year 8 is on track and Section 29A is complete. • The homebirth and care outside guidance model is mature and the pelvic health service is largely compliant. • Triage access, BSOTS and governance are embedded. • Safety Champion engagement is strengthening point-of-care-to-Board visibility.	• Maintain oversight of the NHS England 10-Point Plan through the separate assurance paper considered by PACiC, whose recommendations were supported. • Finalise the medical workforce model and costed plan. • Validate the triage investment requirement and deliver the specification improvement plan. • Establish the Perinatal Health Equity Partnership and embed IPR metrics and quarterly impact reporting. • Escalate immediately where evidence cannot support confidence, risk remains sustained despite controls, or corporate, system or regional intervention is required.

Data-quality note: scorecard figures are sourced from Badgernet following transition to the Electronic Patient Record. Validation remains ongoing.

University Hospitals of Leicester NHS Trust

Perinatal Quality Assurance Scorecard

July 2026

Data presented in this scorecard is sourced from Badgernet following the Trust's transition to a new Electronic Patient Record system. Data quality assurance and validation are ongoing as part of this transition. The figures shown represent the best available data at the time of reporting and may be subject to minor revision as validation continues.

CONTENTS

SUMMARY

University Hospitals of Leicester NHS Trust

July performance was broadly stable despite sustained demand and capacity pressure. Safety surveillance identified two MNSI referrals, no commissioned PSIIs and two moderate-harm incidents, with no evidence of broader service deterioration. Most clinical indicators remained within common-cause variation, while breastfeeding initiation improved and stillbirths, severe postpartum haemorrhage and smoking prevalence reduced. The principal operational risks are more OPEL 3 incidents, bed-pressure-driven internal diverts and a 39-hour average delay from the decision to perform ARM to completion. Workforce risk is concentrated in neonatal nursing vacancies and rising sickness, although minimum safe maternity staffing was achieved 92.7% YTD. Patient satisfaction remained high, but low response rates and recurring feedback on communication, consent, postnatal support, induction and discharge limit assurance.

Clinical Quality and Safety
Safety surveillance did not indicate broader deterioration: two MNSI referrals were made, no PSIIs were commissioned and two moderate-harm incidents were confirmed. Thematic learning centres on the management of complex clinical care and is being triangulated through the Perinatal Safety Improvement Programme. The priority is to translate this learning into focused actions and track evidence of reduced avoidable harm.

Outcomes
Most indicators remain within common-cause variation, with improved breastfeeding initiation and reductions in stillbirths, severe postpartum haemorrhage and smoking prevalence. Low Apgar scores below 7 at five minutes have increased but remain comparable to or better than national benchmarks and are under review. Higher preterm birth reflects UHL's complex pregnancy and specialist referral casemix; education, referral pathways and quality surveillance remain the improvement focus.

Workforce
Maternity staffing remains comparatively resilient: midwifery vacancy was 1.8% and minimum safe staffing was achieved 92.7% YTD. The main workforce risks are a 10% neonatal nursing vacancy rate and rising sickness across neonatal nursing and midwifery. Medical staffing and single-site consultant cover were sustained; recruitment, succession planning and validation of establishment data remain priorities.

Training and Compliance
MIS Safety Action 8 training compliance remained consistent; the next step is to establish a midpoint assessment in line with national guidance. Two cross-site postpartum haemorrhage skills drills have been completed, alongside term neonatal admission reviews, October OASI-week planning and implementation of Gynaecology EJR training. Reduced maternity and neonatal education staffing is a delivery risk, with secondment and vacancy replacement planned as mitigation.

Operational and Capacity
Demand remained high, with 2,154 triage attendances, 5,347 calls and more OPEL level 3 incidents. Despite this pressure, 81% of BSOTS assessments were completed within 15 minutes and mean triage time improved to 9 minutes. Bed constraints increased internal diverts, although red-flag incidents remained stable and there were no failures to maintain supernumerary coordination or 1:1 care in labour. The clearest operational concern is the 10-hour rise in average ARM delay to 39 hours, which requires urgent pathway review.

Experience
Experience remains mixed. Satisfaction was high at 90.4% and women praised staff compassion and support, but low response rates limit assurance. Complaints and Birth Reflections consistently identify communication, consent, delays, discharge and feeling listened to as improvement priorities. Work with women, families and the MNVP is co-producing action on postnatal care, induction and discharge, alongside better feedback-data quality and participation.

JULY 2026 AT A GLANCE

AVERAGES PER DAY

BOOKINGS	BIRTHS
32	28

BABIES BORN

855

PREV. 12 MONTH AV. 798

BIRTH LOCATION

LRI	LGH	HOME
507	348	24

3RD & 4TH DEGREE TEARS

4.5%

June 4.5%

1.9%

BLOOD LOSS >1,500MLS

June 2.8%

430 GIRLS

425 BOYS

PREV. 12 MONTH AVERAGE
382 GIRLS, 414 BOYS

6.4%

Jun 7.5%

FULL TERM BABIES ADMITTED TO NNU

427 CAESAREAN SECTIONS

	JULY	PREV 12 MTH. AV.
ELECTIVE	149 (17.7%)	141 (17.8%)
EMERGENCY	278 (33.1%)	231 (29.1%)

INDUCTION OF LABOUR (IOL)

34.8% PREV. 12 MONTHS – 30.6%

SETS OF TWINS

20

SETS OF TRIPLETS

1

ASSISTED BIRTHS

85

VENTOUSE	FORCEPS
14	71

PREV. 12 MONTH AV.

VENTOUSE	FORCEPS
29	63

BREASTFEEDING INITIATION

79.6%

PREV. 12 MONTHS – 46.3%

NHS

JULY 2026 AT A GLANCE

95%

MDT CLINICAL SIMULATION TRAINING COMPLIANCE (YTD)

Exc Med. Staff starting >1st Jul 25

June- 95% ▲

100%

YEAR 7 MATERNITY INCENTIVE SCHEME 10 SAFETY ACTIONS

2

MNSI REPORTABLE CASES & REFERRED

June - 1 ▲

9.7%

June 6.5% ▼

MATERNITY FRIENDS & FAMILY TEST (RESPONSE RATE)

WORKFORCE POSITION

MIDWIVES	2.3%
CONSULTANT OBSTETRICIAN	7 WTE
NEONATAL NURSES	10.1%
NEONATAL TIER 1	98% staffed
NEONATAL TIER 2	90% staffed

2 MODERATE INCIDENTS

June - 5 ▼

90.4%

June 96.1% ▼

MATERNITY FRIENDS & FAMILY TEST (PROMOTER RATE)

NEWBORN LIFE SUPPORT TRAINING COMPLIANCE (YTD)

95%

June– 95% ▲

0 PATIENT SAFETY INCIDENT INVESTIGATIONS (PSII)

June- 0 ◀▶

0 CORONER'S REGULATION 28

June - 0 ◀▶

MINIMUM SAFE STAFFING MET (MATERNITY YTD)

92.7%

June– 93.4%

1:1 CARE IN LABOUR **100%**

June100% ◀▶

NHS

IN FOCUS – Clinical Quality Surveillance

Data sourced from Badgernet
Validation is ongoing following EPR transition

NHS University Hospitals of Leicester NHS Trust

Summary

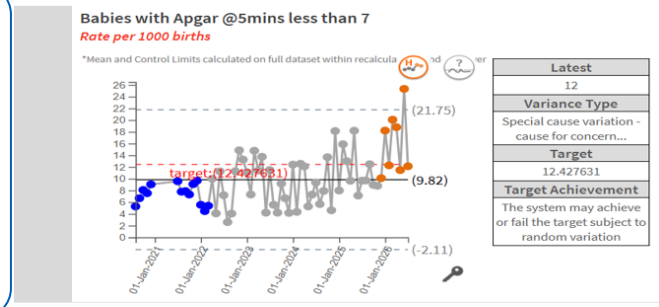
Overall surveillance remains stable, but low Apgar scores are a discrete adverse signal requiring focused action. Severe PPH has improved to 19 per 1,000 and preterm birth has returned to expected variation. Stillbirths and smoking remain low, breastfeeding initiation continues to improve, and small rises in BMI >35 and perineal tears remain within common-cause variation.

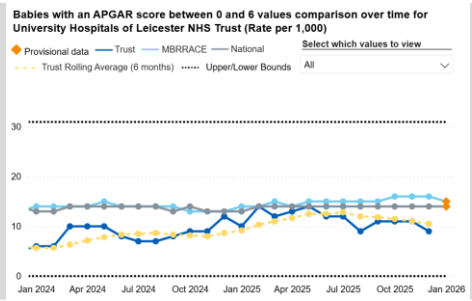
Apgar <7 at five minutes — adverse signal

Signal. Latest SPC performance is 12 per 1,000 and remains special-cause variation—a focused safety signal rather than evidence of broad deterioration.

Context. National comparison remains broadly aligned; Badgernet validation continues following the EPR transition.

Action. Complete follow-up from the March deep dive and June review, focusing on elective caesarean births and ATAIN themes, with actions tracked through clinical governance.



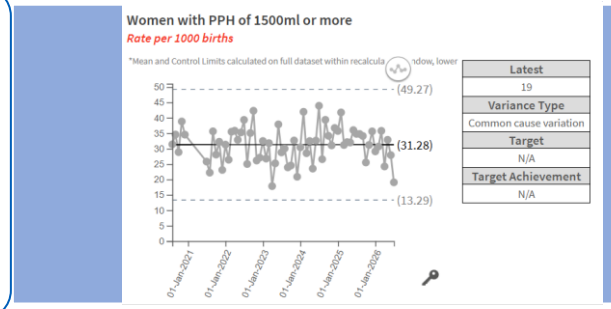


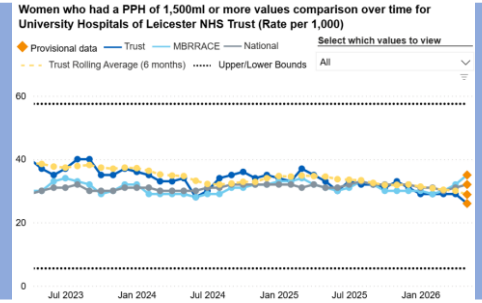
Severe PPH — sustained improvement

Assurance. The severe PPH rate is 19 per 1,000 births—common-cause variation and materially below the historical mean of 31.3 per 1,000.

Context. UHL continues to track favourably against the national comparison.

Action. Sustain improvement through the PPH Working Party and continued implementation of Element 5 of the Maternity Care Bundle.



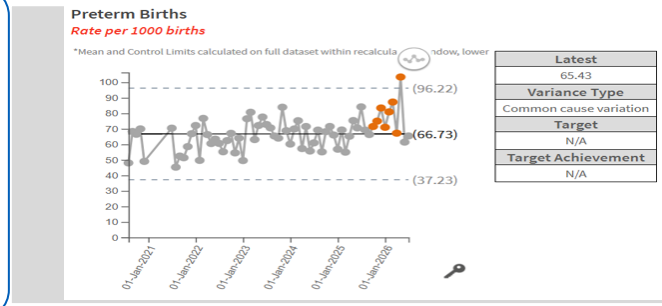


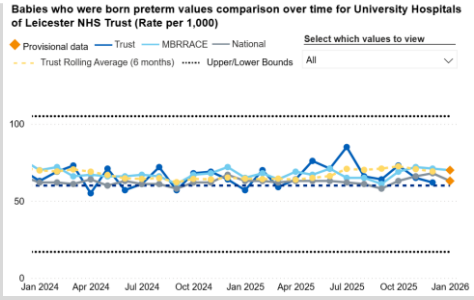
Preterm births — returned to expected range

Position. The latest rate fell to 65.43 per 1,000 and has returned to common-cause variation after recent high points.

Why this remains important. A significant proportion is iatrogenic and reflects complex maternal and fetal conditions, alongside UHL's regional role in preterm birth, fetal medicine and tertiary neonatal care.

Action. Continue education, strengthen referral pathways and information sharing, and monitor specialist referrals including Shirodkar cerclage.

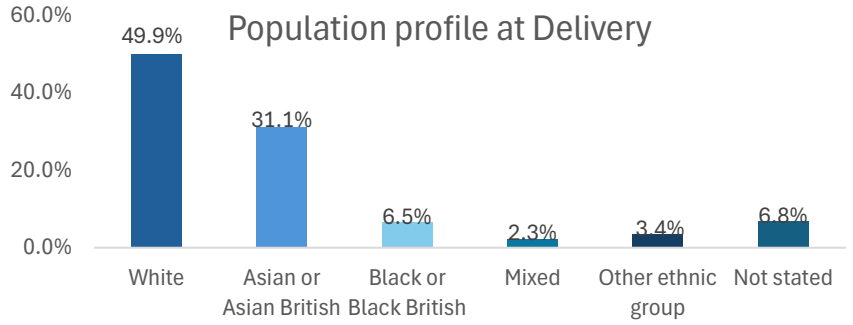


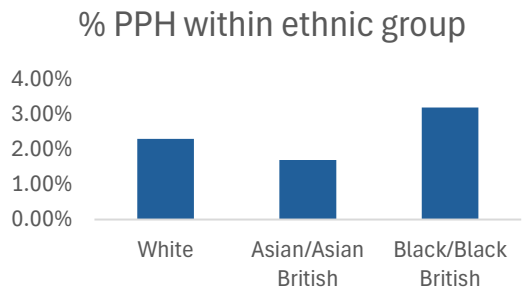


EQUITY AND POPULATION

Data sourced from Badgernet. Validation is ongoing following EPR transition.

University Hospitals of Leicester NHS Trust



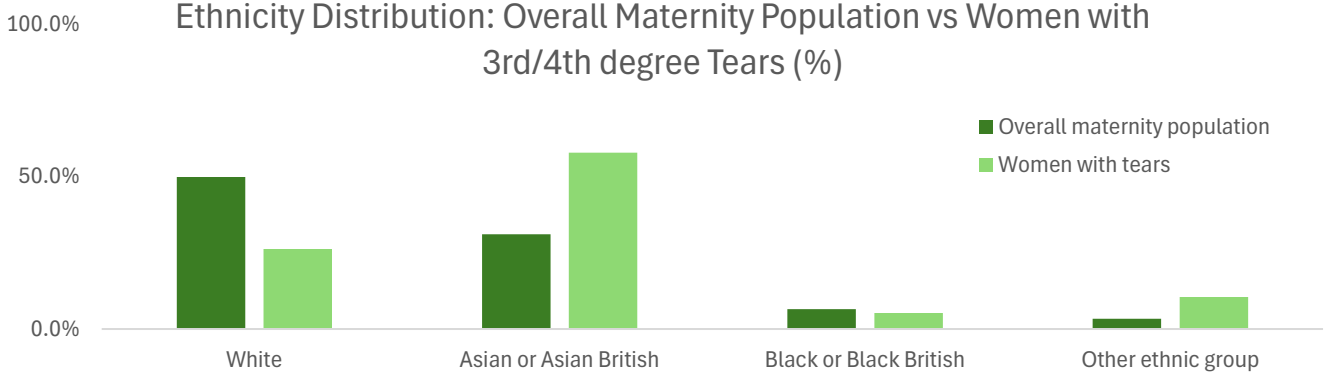


Population & PPH — monitor an emerging disparity

Finding. White women represent 49.9% of bookings and Asian or Asian British women 31.1%; ethnicity is not stated for 6.8%. PPH affected 1.9% overall and was highest among Black or Black British women at 3.2%, versus 2.3% for White and 1.7% for Asian or Asian British women.

Interpretation. The Black rate is based on two cases, so this is an early signal—not yet evidence of a sustained disparity.

Action. Continue monthly review and improve completeness of ethnicity recording to strengthen assurance.



Perineal tears — disproportionate

Finding. Asian or Asian British women account for 57.9% of tear cases (11 of 19), compared with 31.1% of the maternity population. Their within-group tear rate was 3.85%, versus 1.29% for White women.

Interpretation. This is a disproportionate and warrants focused review. The Other ethnic group rate was higher at 6.6%, but reflects only two cases among 30 women.

Action. Review case mix and care-pathway factors, and continue monitoring before drawing firm conclusions from small numbers.

Late booking — clearest access inequality

Finding. Late booking was highest among Black or Black British women at 38%—17 percentage points above White women (21%) and more than four times the Mixed ethnicity rate (9%).

Priority. This is the clearest equity signal on the slide and supports targeted work to understand and reduce barriers to timely antenatal access for Black women.

Data quality. Late booking was also 28% where ethnicity was not stated; improving recording at booking is essential for reliable targeting and assurance.

CLINICAL QUALITY AND SAFETY

NHS University Hospitals of Leicester NHS Trust

1. HEADLINE ASSURANCE (July 2026)

MNSI Referrals (Maternity & Newborn)

2 referred

vs Jun 2026: 1 ↗

Accepted **2**

vs Jun 2026: 1 ↗

PSII Investigations Commissioned

0

vs Jun 2026: 0 →

Perinatal Mortality (Jul 2026 YTD)

2 Stillbirths

3 Early neonatal deaths (19+1 to 26+3 weeks)

vs Jun 2026 YTD: 9 losses

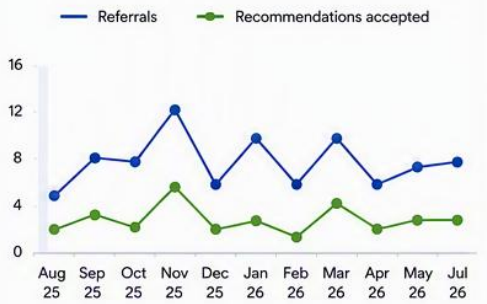
PMRT Reviews Completed

92% within 6 weeks

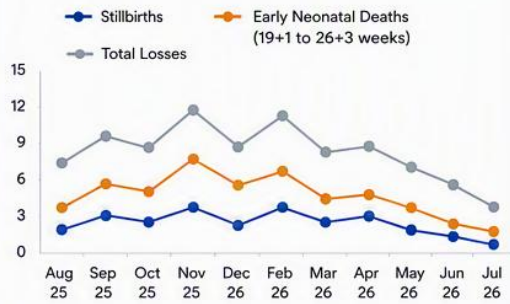
vs Jun 2026: 90% ↗

2. KEY TRENDS (Rolling 12 months)

MNSI Referrals and Recommendations



Perinatal Losses (Rolling 12 months)



Two referrals in July; both accepted and under review. Recommendations will be monitored to completion.

Five losses (2 stillbirths and 3 early neonatal deaths) in July YTD. Prematurity continues to be the predominant theme.

3. BOARD ASSURANCE SUMMARY

Current Assurance

- Robust mortality surveillance and PMRT review processes remain in place.
- Independent scrutiny is provided through MNSI, CDOP, external peer review and MBRRACE-UK.
- Provisional 2025 and early 2026 data suggest improving neonatal mortality compared with previous years.
- No evidence of widespread or systemic care-quality concerns has been identified through local or external review.

Key Risks and Exceptions

- Neonatal mortality remains above peer-group averages in published MBRRACE-UK data.
- MBRRACE-UK adjusted outcomes may not fully reflect the complexity of UHL's tertiary referral population.
- Emerging improvement seen in provisional 2025–26 data remains subject to national validation and risk adjustment.
- Prematurity continues to be the predominant theme associated with perinatal mortality.

Actions and Oversight

- Targeted work continues on prematurity, fetal surveillance and complex pathway handovers.
- OASI reduction activity includes education, awareness and dedicated OASI week in October.
- Learning from MNSI, PMRT, complaints, claims and incidents is being triangulated to drive improvement.
- Progress and impact monitored through Executive Quality Governance and Maternity Quality & Safety Committee.

4. MATERNITY SERVICES CQC RATINGS

Trust Site	Overall rating	Safe	Effective	Caring	Responsive	Well-led
Leicester Royal Infirmary (LRI)	●	●	●	●	●	●
Leicester General Hospital (LGH)	●	●	●	●	●	●

KEY: ● Good ● Requires improvement ● Inadequate

Ratings published: 22 May 2024

Data source: UHL local reporting systems and MBRRACE-UK (provisional). Data subject to validation and national risk adjustment.

Dashboard updated: 21 August 2026

WORKFORCE - Overview

University Hospitals of Leicester NHS Trust

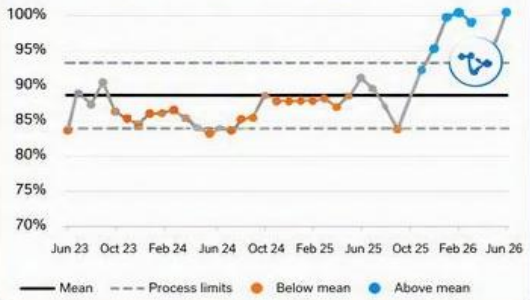
NEONATAL NURSE ESTABLISHMENT (WTE)
% of required establishment
95.8% ↑
vs May 2026: 92.6%

OBSTETRIC SHORTFALLS
% of staffing shortfalls impacting patient care
0.6% ↓
vs May 2026: 1.0%

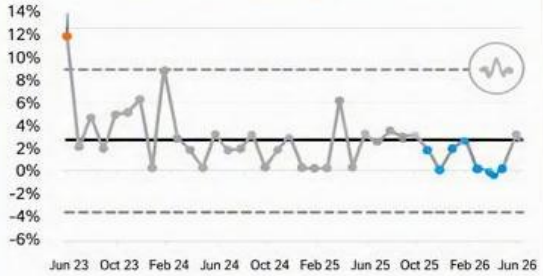
REGISTERED MIDWIFERY VACANCIES (WTE)
% of total funded posts
2.7% ↓
vs May 2026: 3.5%

MIDWIFERY SAFE STAFFING
% of planned hours
93.8%
– vs May 2026: 93.1%

1. UHL Total Neonatal Nurse Staffing (WTE) In Post as %age of Required Establishment (BAPM Workforce Tool)



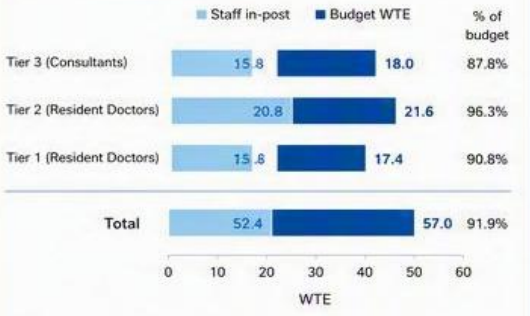
2. Obstetric Staffing Shortfalls (SitRep) % where there were Staffing Shortfalls AND these were impacting Patient Care



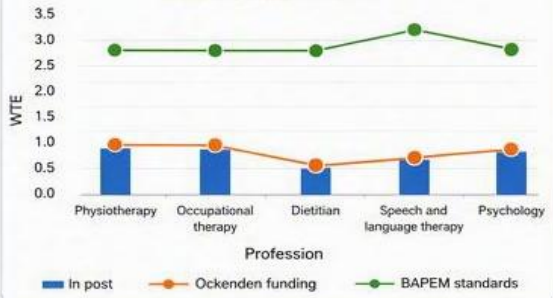
3. Registered Midwifery Posts Vacant as %age of Total Funded Posts (WTE)

4. Non-registered Midwifery Posts Vacant as %age of Total Funded Posts (WTE)

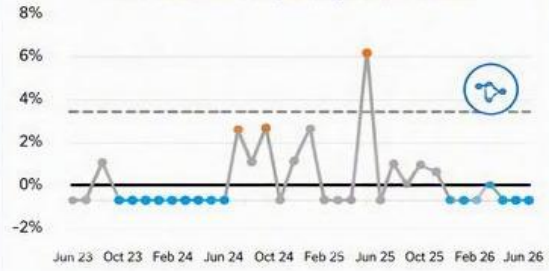
5. Neonatal Medical Workforce – Dec 2024 (WTE)



6. AHP Profession Workforce (WTE) In Post vs 2023 Ockenden Funding and BAPEM Standards



7. Anaesthetic Staffing Shortfalls (SitRep) % where there were Staffing Shortfalls AND these were impacting Patient Care



KEY

- Mean
- Process limits (3σ)
- Above mean
- Below mean
- Data points

Control chart interpretation

- Common cause (no significant change)
- Special cause (significant change)

EXECUTIVE INTERPRETATION

- Neonatal nurse establishment continues to improve and is above the target level.
- Obstetric and anaesthetic staffing shortfalls impacting patient care are low and have improved.
- Registered midwifery vacancy levels have reduced and remain below the target threshold.
- Non-registered midwifery vacancies show an upward trend and are an emerging area of pressure.
- Midwifery safe staffing remains broadly within the 90–95% range, around the target level.

OPERATIONAL & CAPACITY SUMMARY

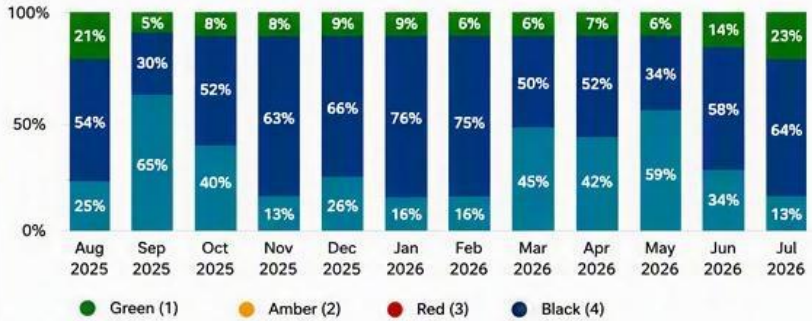
MATERNITY SERVICES PERFORMANCE OVERVIEW

Reporting period:
01 Jul – 31 Jul 2026

NHS
University Hospitals of Leicester
NHS Trust

1 DEMAND & ACUITY

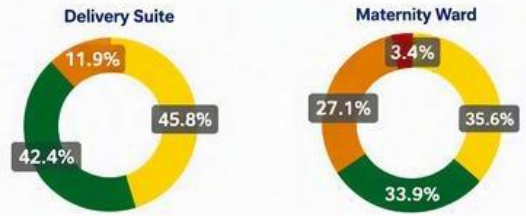
Acuity by RAG Status (% of submissions)



Source: OPEL Maternity Status – % of submissions

2 CAPACITY

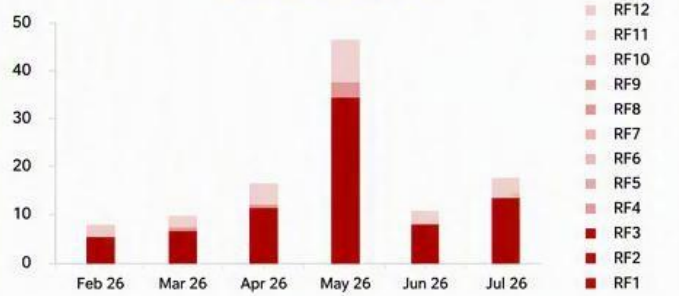
Bed Capacity



- Yes – ward beds available and no delays in admission or transfers
- Yes – reduced ward bed capacity but no impact on inpatient flow
- Yes – limited ward beds available impacting on inpatient flow
- No – no ward beds available and no planned discharges

3 SAFETY

Midwifery Red Flag Events



Source: Local Red Flag Register

EFFICIENCY & TIMELINESS

Average volume of calls to triage **5,633** Last month: 5,524	Average call response time for triage **2mins 2secs** Last month: 2mins 5secs	Categorised on adm. (triage within target) **1,752** **(97.0%)**	Average talk time for triage **3mins 21secs** Last month: 3mins 25secs
Triage Attendances **2,154** Last month: 2,154	Average time from attendance to triage **9.0 mins** Last month: 9.8 mins	Triaged within 15 minutes **81.7%** Last month: 78.7%	Seen within 30 Minutes **96.8%** Last month: 96.4%
Patients requiring medical care and seen by a doctor **95.4%**	Avg. wait time to see a doctor **1 hour, 45 mins**	Avg. wte from ARM decision to perform **39 hours** Last month: 25 hours	Maternal Request for CS during IOL **4.4%** Last month: 5.2%

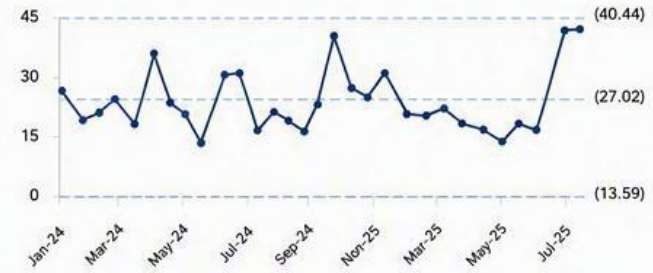
Bed Capacity Snapshot (end of period)
*Includes beds with limited capacity

Delivery Suite Beds	Maternity Ward Beds	Escalation Status
Available: 11.9%	Available: 39.0%*	Level 2 (Amber)

TRIAGE & IOL PERFORMANCE

Average Length of Time Between Decision Made to Perform ARM and ARM Performed (hours)

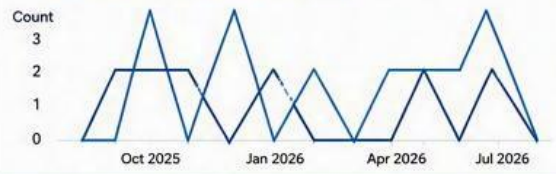
*Mean and Control Limits calculated on full dataset within recalculation window



Latest
39
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

SERVICE DISRUPTION (OBSTETRIC-LED SERVICES ONLY)

Service Suspensions (obstetric-led services only)



	Count	% of reporting days
Obstetric-led maternity services suspended	3	4.9%
Obstetric-led maternity services diverted	5	8.2%
Homebirth services suspended	0	0.0%
MLU suspended	4	6.6%

Source: OPEL (Obstetric-led)

WHAT THE DATA IS TELLING US

- Telephone triage activity increased but attendances remained static; triage within 15 minutes of arrival improved slightly to 81.7%.
- Delivery suite bed capacity is generally stable, although maternity ward capacity continues to experience periods of pressure.
- Red flag incidents rose slightly in May; supernumerary status and coordination maintained throughout July.
- Average time to decision to undertake ARM increased by 10 hours to 39 hours, reflecting higher levels of activity.
- Service suspensions increased: 3 obstetric unit suspensions (4.9%), 5 obstetric service diversions (8.2%), 4 MLU suspensions (6.6%).

WHAT WE NEED TO FOCUS ON

- Reducing time from decision to perform ARM through pathway and capacity review
- Sustaining improved performance against the 15-minute triage standard
- Optimising use of MDAU and wider capacity across sites
- Continuing transition to Single Point of Contact model
- Supporting workforce recruitment and succession planning

WHAT IS GOING WELL

- Enhanced triage performance, reflecting more efficient patient assessment and flow
- Supporting the long-term sustainability of specialist services through ongoing succession planning and workforce development
- Sustained trajectory to increase the Qualified in Specialty (QIS) neonatal nursing workforce
- Positive recruitment and reduced vacancies of Midwives and Neonatal Nurses
- Oversight of red flags and Matron validation of Birthrate plus acuity scoring

TRAINING AND COMPLIANCE

University Hospitals of Leicester NHS Trust

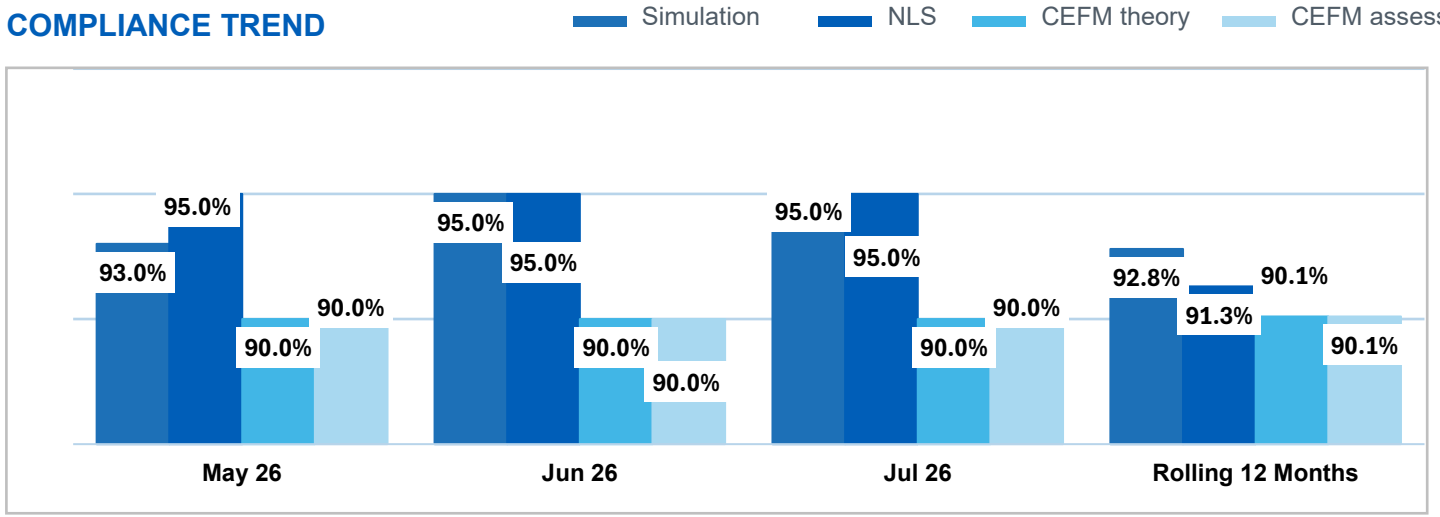
INDICATORS
4 / 4
at or above target

SIMULATION
95%
July attendance

NLS
95%
July attendance

CEFM
90.1%
rolling 12 months

COMPLIANCE TREND



Key performance indicator	Target	May-26	Jun-26	Jul-26	Rolling 12 months
Annual MDT clinical simulation	90%	93%	95%	95%	92.8%
NLS training	90%	95%	95%	95%	91.3%
CEFM training · theory	90%	90%	90%	90%	90.1%
CEFM training · assessment	90%	90%	90%	90%	90.1%

Compliance is stable – continue to sustain performance, act on learning and protect delivery capacity

Performance remains secure. All three MIS targeted-training areas remain above 90%; simulation and NLS reached 95% in July, with NLS improving on earlier months.

Oversight must continue. Track stable improvement and agree the SA8 MIS mid-point assessment, while managing reduced education capacity through recruitment and planned cover.

NEXT 90 DAYS

01 Convert learning — complete term-infant neonatal admission reviews and take two thematic reviews to ATAIN QI for SMART actions and oversight.

02 Standardise practice — deliver OASI week with PSIP in October and progress the move from local MEOWS to national MEWS.

03 Protect capacity — advertise the vacant 0.80 WTE education role and secure a neonatal education secondment for maternity-leave cover.

RECENT PROGRESS

NEWTT2 went live on Maternity EPR on 1 June 2026, with communications and clinical support continuing; gynaecology training and cross-site PPH drills have also restarted.

SAFETY ACTIONS

University Hospitals of Leicester NHS Trust

CORE ACTIONS
6 / 6
on track

SBL IMPLEMENTATION
97%
Q3 overall

ELEMENTS TO CLOSE
2
at 95% and 96%

NEXT REVIEW
AUG 2026
Q4 2025/26

MATERNITY IMPROVEMENT SCHEME · YEAR 8

Core safety action	MIS standards	What good looks like	Status
A. Workforce and Capacity	7	49	On Track
B. Training	5	33	On Track
C. Learning from Reviews and Investigations	6	36	On Track
D. Service User Voice, Experience and Equity	2	13	On Track
E. Care Bundles	3	22	On Track
F. Governance, Oversight and Culture	4	24	On Track

YEAR 8 FOCUS

More focused and proportionate. Six core actions concentrate attention on workforce, learning, clinical standards, culture and women's experience.

Greater local accountability. Trusts have more flexibility to act on local priorities while retaining Board oversight.

LAUNCHED 2 APRIL 2026

SAVING BABIES' LIVES · Q3

Element	Self		LMNS/ICB		MIS status
Smoking in Pregnancy	Fully	100%	Fully	100%	On Track
Fetal Growth Restriction	Partly	95%	Partly	95%	On Track
Reduced Fetal Movements	Fully	100%	Fully	100%	On Track
Fetal Monitoring in Labour	Fully	100%	Fully	100%	On Track
Preterm Birth	Fully	96%	Partly	96%	On Track
Diabetes	Fully	100%	Fully	100%	On Track
All Elements	Partly	97%	Partly	97%	On Track

PRIORITY ACTIONS

01 Close fetal growth restriction to 100%. Complete the PlGF quality-control review with Sheffield and confirm the implementation plan.

02 Close preterm birth to 100%. Use weekly Neonatal MDT review and monthly QUAD reporting to maintain oversight.

03 Prepare Submission 10. Q4 2025/26 evidence is due in August 2026.

EXPERIENCE OF CARE

NHS University Hospitals of Leicester NHS Trust

ANTENATAL
94.7%
57 responses

LABOUR & BIRTH
87.5%
144 responses · improving 3 months

POSTNATAL WARD
93.8%
80 responses

JULY FFT RESPONSE RATE
9.7%
against 25% target

Complaints & concerns	May-26	Jun-26	Jul-26	26/27 YTD
Maternity	9	22	16	57
Neonatal	0	1	2	3

Family & Friends Test	Target	National	May-26	Jun-26	Jul-26	26/27 YTD
Maternity FFT % Responses	25%	13%	11.8%	6.5%	9.7%	10.1%
Maternity FFT % of Promoters	96%	93%	89.1%	96.1%	90.4%	91%

Birth Reflections	May-26	Jun-26	Jul-26
Number of appointments	36	44	38
% attended within 12 months of birth or currently pregnant	83.3%	100%	81.6%

WHAT FEEDBACK IS TELLING US

Communication and listening remain the common thread. Women describe feeling unheard, unmet expectations and disempowerment.

Delays and quality of care remain visible. Pain management and epidural waits continue to feature in Birth Reflections.

Confidence in the signal is constrained. Response coverage is uneven, and MAU attribution is distorting pathway scores.

ACTION NOW

01 Correct routing — move surveys to the right maternity stage.

02 Increase reach — automated texts and community-midwife lanyard cards.

03 Deliver shared priorities — postnatal support, communication and consent, induction and discharge.

PATIENT VOICE

"Everyone was very friendly, efficient and provided the best care for me and my baby."
Maternity Assessment Unit, LRI

"All my concerns were taken seriously... Couldn't have asked for a better experience."
Delivery Suite, LGH

SPOTLIGHT ON… Meet the Expert

University Hospitals of Leicester NHS Trust

JULY 2026 · NSPCC NATIONAL TRAINING CENTRE, LEICESTER

Families left informed, reassured and more confident about the journey ahead.

Maternity and partner services came together in one welcoming space, helping expectant parents ask questions, discover support and understand their choices from pregnancy through birth and beyond.

100+ women and families attended the third event

A growing route to trusted advice and stronger connections with local families.

WHAT FAMILIES GAINED

One place, many services. Families spoke directly with maternity and partner teams, including support they had not previously known about.

Practical, focused advice. Breakout sessions on infant feeding and pelvic floor health created space for detailed, informal conversations.

Choices made tangible. A birthing-pool demonstration and direct access to home-birth and birth-centre teams helped families compare options.

> *"We've been able to speak to experts, get trusted advice and learn about services we didn't even know existed. We feel much more confident and reassured about what's ahead."*
>
> **— Event attendee**

APPENDICES

Clinical Quality Metrics Summary

University Hospitals of Leicester NHS Trust

The service is managing higher activity while several experience, prevention and neonatal measures remain below benchmark.

Demand increased **855 births**	+61 vs previous month; 90 preterm births vs 64; stillbirths reduced from 3 to 2.
Care experience is mixed **100% one-to-one**	Vaginal birth 48.7% vs 42% national; early feed/skin-to-skin 57.7% vs 74.2%.
Core quality gaps need focus **3 Peri-Prem measures below target**	Magnesium sulphate 50% vs 85%; antibiotics 33.3% vs 85%; caffeine 43.8% vs 95%.
Prevention & staffing **RSV 38.1% | BCG 47.5%**	Pertussis is stronger at 66.5%; staffing delivery is 92.7% midwifery and 81.5% neonates.

Leadership focus — **Close the Peri-Prem and vaccination gaps • sustain breastfeeding improvement • reconcile homebirth/BBA figures before assurance reporting.**

Source: figures reported in this presentation. Badgernet validation is ongoing following EPR transition.

CLINICAL CARE SCORECARD

University Hospitals of Leicester NHS Trust

Maternal and neonatal care

Measure	Current	Comparator
Vaginal birth rate	**48.7%**	National 42%
One-to-one care in labour	**100%**	National 51%
Feed & skin-to-skin <1 hr	**57.7%**	National 74.2%
NNU ATAIN, full-term	**6.4%**	National 6.0%
Apgar <7 at 5 min	**3.9%**	Reported rate
Antenatal screening	**97.8%**	National ~97.9%
Breastfeeding initiation	**79.6%**	Prev. 79.2%
Breastfeeding at 10 days	**37.7%**	Prev. 34.2%
Breastfeeding at HV transfer	**42.0%**	Prev. 39.3%
Maternal readmissions	**26**	Prev. 32

Peri-Prem bundle (June 2026)

Measure	Current	Comparator
Antenatal steroids	**64.3%**	Target 40%
Magnesium sulphate	**50.0%**	Target 85%
Intrapartum antibiotics	**33.3%**	Target 85%
Optimal cord management	**87.5%**	Target 68%
Normothermia within 1 hr	**81.3%**	Target 65%
Born in the right place	**100%**	Target 100%
Caffeine within 24 hr	**43.8%**	Target 95%
Early breast milk <24 hr	**50.0%**	Target 25%
Babies <34 weeks	**16**	Monthly cohort
Bundle summary	**5 on track / 3 below**	Reported status

On track / improving **Watch** **Gap**

Source: figures reported in this presentation. Badgernet validation is ongoing following EPR transition.

ACCESS, WORKFORCE & PREVENTION

University Hospitals of Leicester NHS Trust

Demand & homebirth

Total births	**855**	Prev. 794
Preterm births	**90**	Prev. 64
Stillbirths	**2**	Prev. 3
Bookings	**981**	Prev. 1,048
Missed ANC appts.	**745**	Prev. 767
Expected Birth	**794**	Aug-26 forecast
Homebirth bookings	**59**	Prev. 58
Homebirths	**22 / 24**	Slides 2 / 1
BBAs	**2 / 3**	Slides 2 / 1
MDT / care plans	**24 / 24**	Reported counts
Intrapartum transfers	**5**	38% reported

Workforce

Midwifery staffing	**92.7%**	Prev. 93.4%
Neonatal staffing	**81.5%**	Prev. 79.9%
LRI midwifery sickness	**4.96%**	1-month lag
LRI neonatal sickness	**7.01%**	1-month lag
LGH midwifery sickness	**9.78%**	1-month lag
LGH neonatal sickness	**5.59%**	1-month lag
Reg. midwife vacancies	**10**	2.26%
Non-reg. midwife vacancies	**7.74**	6.19%
Reg. neonatal vacancies	**12.86**	10.11%
Non-reg. neonatal vacancies	**1.9**	9.83%

Immunisation

RSV – UHL	**38.1%**	61.9% not given
RSV – LGH	**39.1%**	Site uptake
RSV – LRI	**37.1%**	Site uptake
Pertussis – UHL	**66.5%**	Mean 51.6%
Pertussis – LGH	**68.7%**	Common cause
Pertussis – LRI	**64.5%**	Special cause ↑
BCG uptake	**47.5%**	Target 80%

VIPs administration and BCG staffing actions are intended to improve access, call/recall and consistency.

Highest workforce pressures: LGH midwifery sickness and neonatal vacancy rates.

Source: figures reported in this presentation. Badgernet validation is ongoing following EPR transition.

SURVEILLANCE SIGNALS

University Hospitals of Leicester NHS Trust

The latest charts show improvement in smoking measures and breastfeeding, with an adverse signal for low Apgar scores.

Antenatal

BMI >35 at booking
11.5%
Common cause

Smoking at booking
4.1%
Special-cause improvement

Current smoker at delivery
2.8%
Special-cause improvement

Monitor through routine SPC review; investigate sustained or special-cause signals.

Intrapartum

3rd/4th degree tears
45 / 1,000
Common cause

PPH ≥1,500ml
19 / 1,000
Common cause

Breastfeeding
90%
Special-cause improvement

Monitor through routine SPC review; investigate sustained or special-cause signals.

Outcomes

Apgar <7 at 5 min
12 / 1,000
Special-cause for review

Preterm births
65.43 / 1,000
Common cause

Stillbirths
5 / 1,000
Common cause

Prioritise review of the Apgar signal while monitoring preterm and stillbirth variation.

Source: embedded SPC charts in this presentation. Rates and periods are as displayed in the source charts.

WHAT WE ARE DOING

University Hospitals of Leicester NHS Trust

Three coordinated workstreams are addressing clinical reliability, multidisciplinary learning and vaccination access.

Peri-Prem reliability

Antibiotics & steroids

Review post-EPR variation and February's small cohort (n=4); continue app, M&M and bi-weekly MDT reviews.

Grab Boxes

Launch in all clinical areas with family information, colostrum-collection kits and the updated Peri-Prem guidance.

Cord management

Embed Huddles & Cuddles, neonatal scrub and CPAP with intact-cord stabilisation.

Temperature & early milk

Maintain non-disposable thermometers on all LRI resuscitaires; expand breast-pump capacity and improve feeding rooms.

Simulation & MDT learning

Hospital drills | 22 & 25 June

LRI and LGH simulations focused on major obstetric haemorrhage, escalation and MDT working.

Learning into practice

Reinforce consistent PPH-proforma use, involve Blood Bank in future drills and retain MOH in mandatory MDT emergency training.

Homebirth drill | 30 June

Practised PPH, shoulder dystocia, breech, suturing, newborn life support and maternal collapse in water; no additional learning needs identified.

Next cycle

Repeat drills in the new programme.

Immunisation access

RSV | UHL 38.1%

Improve access, documentation and opportunistic vaccination across both sites. Deploy the VIPs Administrator to strengthen call/recall and reduce declines and DNAs.

Pertussis | UHL 66.5%

Monitor whether LRI's improvement (64.5%) is sustained and drives a wider UHL shift; LGH is currently 68.7%.

BCG | below target

Strengthen BCG-team staffing so the UHL offer is consistent, while continuing routine variation monitoring.

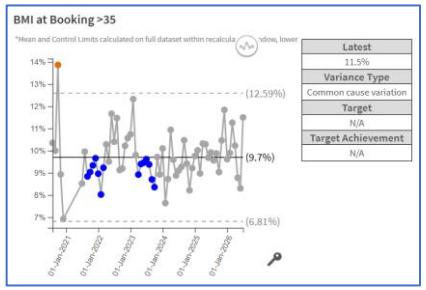
Assurance

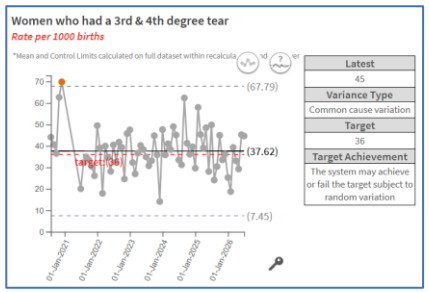
Track uptake through governance and SPC.

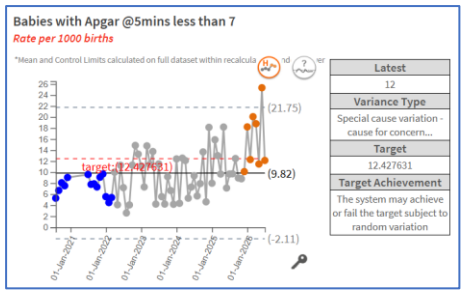
Source: UHL maternity and neonatal action updates supplied for this presentation.

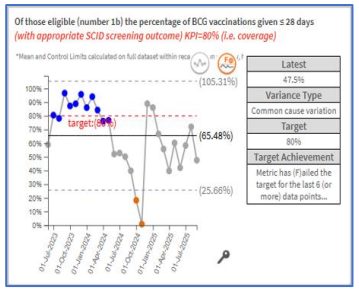
TRENDS: CLINICAL QUALITY SURVEILLANCE

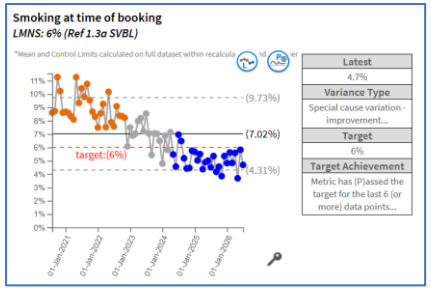
NHS University Hospitals of Leicester NHS Trust

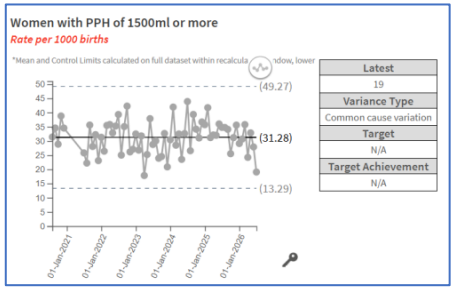


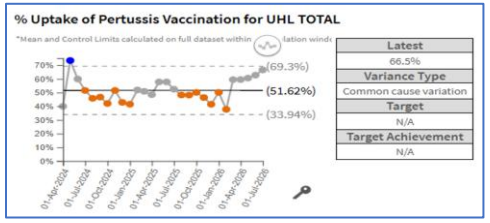


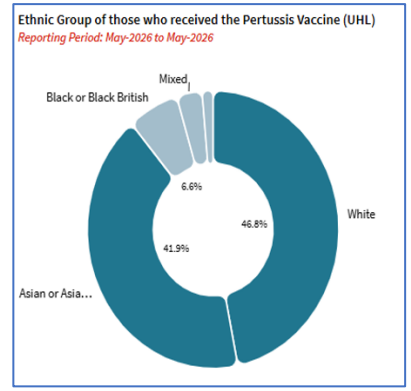


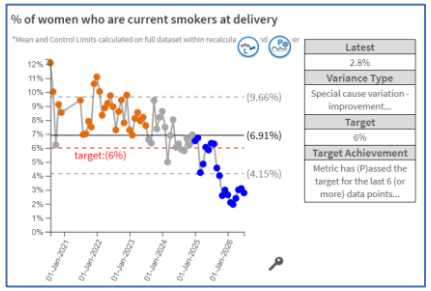


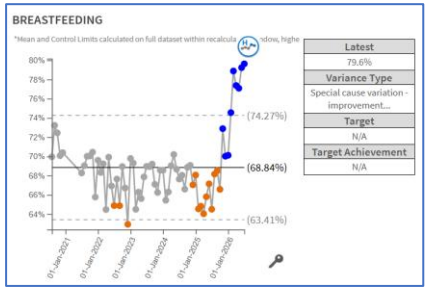


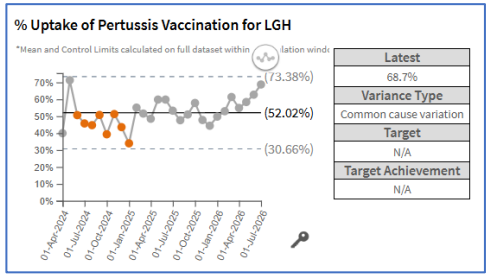


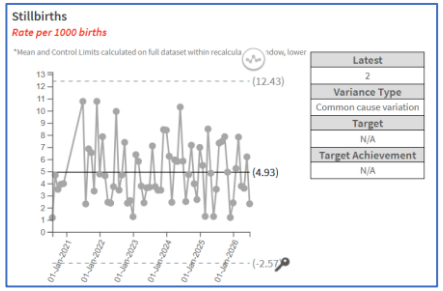


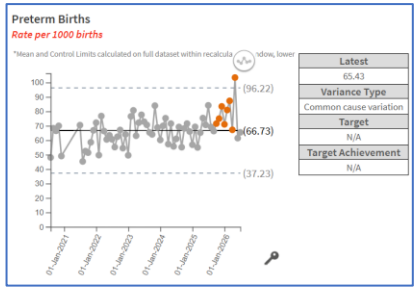


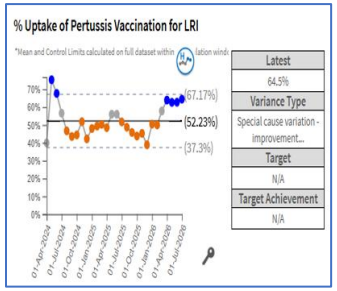












Data sourced from Badgernet. Validation is ongoing following EPR transition.

INTERPRETING DATA

Throughout this series of slides, we display data that shows you how we are performing in the current month and across time.
We primarily do this through single data points on the 'At a Glance' slides and Statistic Process Control (SPC) charts.
On this slide, we describe **single data points.**

A single data point is indicative of a single month only.

These values should not be interpreted in isolation, even if they seem especially high or low in comparison to previous months. In this situation, the SPC chart (covered on the next slide) will help us understand whether a particular value represents a significant change.

The arrow indicator (where present) shows you how the value compares to the value for that same measure in the previous month, and whether that value is better than last month's (green) or worse than last month's (red).

Sometimes a measure will appear both as a single data point and an SPC chart within these slides. You may notice that the numbers do not align for the same month for that same measure. Good spot! This is because we may calculate a measure differently, depending on what we are trying to measure.

Single data points
these reflect local calculations. They will not exclude specific populations, unless there is a specific reason to do so.

SPC charts
these will be calculated in line with standard national calculations so that we can compare ourselves meaningfully to other Trusts. These calculations may exclude certain categories of people.

INTERPRETING DATA

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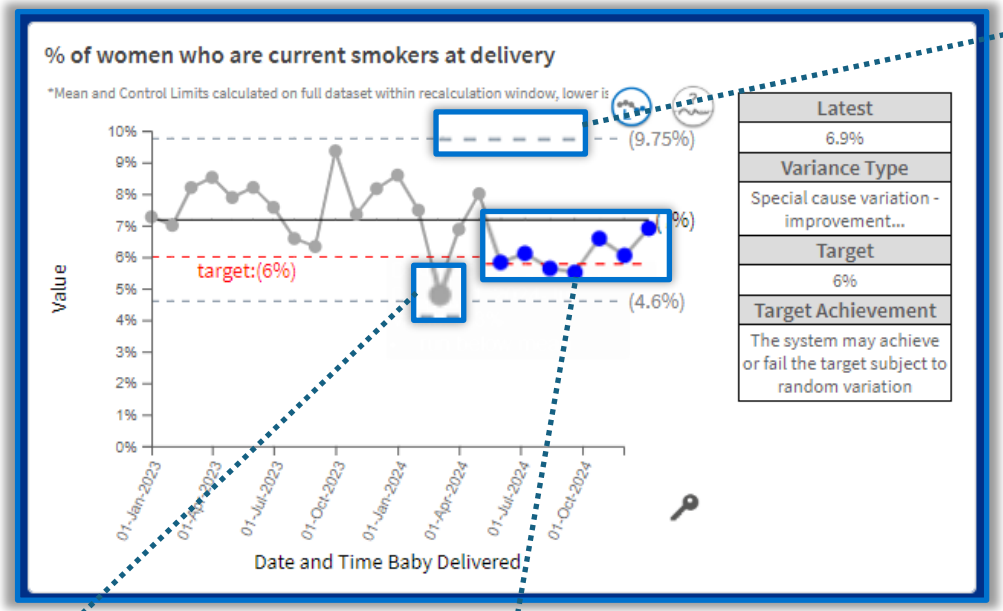
COLOUR GUIDE
Red: area for focus
Amber: monitor
Green: on track/improving

SPC charts are widely used across the NHS to measure changes in data over time.
There is **strong evidence** that these provide a **better basis for decision making** versus isolated data points.



An SPC chart has **three reference lines** that allow you to interpret variation in the data. The **central reference line** shows the average (sometimes the median). The **upper and lower reference lines** show the process limits. These limits are defined by the variability in the data itself. Roughly 99% of the values should fall inside process limits. Sometimes there is also a **target line** – this shows the target that we are aiming to achieve for a given measure.

Common cause variation: a single value that looks abnormally high or low, but remains within process limits, is due to **common cause variation**. This means that it is not statistically significant as an isolated value and can be explained by usual variance in the system.

Special cause variation: this represents a value or trend that is likely to be **statistically significant** and therefore **not due to normal variation**. In our slides, these will be highlighted in **blue**. There are 4 different kinds of special cause variation:

1. **6 or more consecutive points above or below the mean line**
2. **A single data point outside the control limits**
3. **6 or more consecutive points increasing or decreasing**
4. **2 out of 3 consecutive points close to the process limit**

GLOSSARY OF TERMS

NHS
University Hospitals of Leicester
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Abbr.	Meaning	Abbr.	Meaning	Abbr.	Meaning
ARM	Artificial rupture of membranes	**LRI**	Leicester Royal Infirmary	**OPEL**	Operational Pressures Escalation Levels
ATAIN	Avoiding Term Admissions into Neonatal Units	**MDAU**	Maternity Day Assessment Unit	**PlGF**	Placental growth factor
BCG	Bacillus Calmette–Guérin vaccination	**MDT**	Multidisciplinary team	**PMRT**	Perinatal Mortality Review Tool
BMI	Body mass index	**MEOWS**	Modified Early Obstetric Warning Score	**PPH**	Postpartum haemorrhage
BSOTS	Birmingham Symptom-specific Obstetric Triage System	**MEWS**	Maternity Early Warning Score	**PSII**	Patient Safety Incident Investigation
CEFM	Continuous electronic fetal monitoring	**MIS**	Maternity Incentive Scheme	**PSIP**	Perinatal Safety Improvement Programme
CPAP	Continuous positive airway pressure	**MLU**	Midwifery-led unit	**QIS**	Qualified in Specialty (neonatal nursing)
CTG	Cardiotocography	**MNSI**	Maternity and Newborn Safety Investigations	**RSV**	Respiratory syncytial virus
CQC	Care Quality Commission	**MNVP**	Maternity and Neonatal Voices Partnership	**SBL**	Saving Babies' Lives Care Bundle
EPR	Electronic patient record	**MOH**	Major obstetric haemorrhage	**SPC**	Statistical process control
FFT	Friends and Family Test	**NLS**	Newborn Life Support	**UHL**	University Hospitals of Leicester NHS Trust
IOL	Induction of labour	**NNU**	Neonatal unit	**WTE**	Whole-time equivalent
LGH	Leicester General Hospital	**OASI**	Obstetric anal sphincter injury	**YTD**	Year to date