Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Public Trust Board Meeting: Wednesday 11 September 2024

TB2024.73

Title:	**Maternity Services Update Report**

Status:	**For Discussion**
History:	**Regular Reporting**
	Maternity Clinical Governance Committee (MCGC) 27/08/24
	Previous paper presented to Trust Board 10/07/2024

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Confidential:	**No**
Key Purpose:	Assurance

Executive Summary

1. This paper provides an update to the Trust Board on maternity related activities. The key points are summarised below:
2. Three-Year Delivery Plan for Maternity and Neonatal Services: The report outlines progress on the three-year delivery plan and provides an update on progress related to listening to women, workforce, culture and leadership, and standards.
3. Maternity Safety Support Programme: Significant progress has been made on the Maternity Safety Support Programme, including the establishment of a senior midwifery leadership team and the ongoing refurbishment of an intrapartum bereavement room.
4. Thematic Review of the Keep the Horton Group Maternity Dossier: The Trust thoroughly reviewed and analysed the anonymised cases from the Keep the Horton General Campaign Group's Birth Trauma Dossier. The report thoroughly assessed the quality of maternity care and identified areas for improvement. The Trust has engaged with the Keep the Horton Campaign Group regarding the dossier and a meeting scheduled alongside ICB colleagues to discuss the response to the dossier and associated action plan. The OMNVP has been actively involved and engaged throughout this process and will be involved in the codesign of the improvement actions.
5. Review of the Safety, Quality and Experience of Maternity Services: The Trust has initiated a structured review of its Maternity Services over the past 48 months to assess quality, safety, and overall experience. The review will be complete by the end of September 2024.
6. Maternity Incentive Scheme Risks: The report identifies three main risk areas in the Maternity (and Perinatal) Incentive Scheme. Action plans are in place or in development to progress towards compliance.
7. Antenatal and Newborn Screening Assurance Visit: An action plan addressing the recommendations from the Antenatal and Newborn Screening Assurance Visit has been developed, approved, and shared with NHS England.

Recommendations

8. The Trust Board is asked to:
    - Receive and note the contents of the update report.

Contents

1. Purpose

1.1. The aim of this paper is to provide an update to the Trust Board on the following maternity related activities:

- Three-year Single Delivery Plan for Maternity and Neonatal Services
- Year 6 Maternity (and Perinatal) Incentive Scheme (MPIS)
- Maternity Safety Support Programme (MSSP)
- Thematic Review of the Keep the Horton Group Maternity Dossier
- Review of the Safety, Quality and Experience of Maternity Services
- Maternity Performance Dashboard
- CQC Action plan update
- Antenatal and Newborn (ANNB) Screening
- Midwifery Led Unit (MLU) status
- Perinatal Quality Surveillance Model Report
- Maternity Safeguarding

2. Three Year delivery plan for Maternity and Neonatal Services

2.1. The three-year single delivery plan for maternity and neonatal services was published on March 30, 2023. A summary of progress against each of the themes is summarised below:

Theme 1: Listening to Women

2.1.1 The maternity and neonatal team meets monthly with the Oxfordshire Maternity and Neonatal Voices Partnership (OMNVP) and the patient experience team to review and triangulate themes from complaints and feedback to co-produce and develop actions to address areas of concern.

2.1.2 The Equality, Diversity, and Inclusion (EDI) midwives have been working with local Tetum-speaking pregnant women on antenatal classes as part of the Early Lives Equal Start project. This includes visits to the maternity unit for these women.

2.1.3 The EDI midwives have been providing training for midwives and support workers on how to assess black and brown skin tones. This training aligns with national efforts to improve maternity and neonatal

assessment by considering skin colour, specifically focusing on the application for women, birthing people, and babies from diverse backgrounds.

2.1.4 Pregnant women and birthing people have been issued with free SIM cards, data, unlimited minutes and texts for up to 12 months in response to digital inclusion.

2.1.5 Work has been undertaken with the patient experience team to enhance interpreter services as circa. 2.3% of Oxford residents either cannot speak English or do not speak it well.

Theme 2: Workforce

2.1.6 Staff engagement sessions in June and July continued, with all midwifery staff invited to attend. The topics covered included summer staffing planning and cultural improvement work.

2.1.7 Workforce meetings were held to assess and update each area's budgeted Birthrate Plus establishment and reconfigure the maternity rosters accordingly.

2.1.8 Work continues regarding the review of on-call service in maternity, midwife rotation, and return-to-work evaluations.

Theme 3: Culture and Leadership

2.1.9 The perinatal quadrumvirate has participated in the national leadership programme, which aims to foster a positive safety culture, create psychologically safe working environments, and develop compassionate leadership to improve the workplace.

2.1.10 The EDI midwives have completed "Active Bystander Training" and are now implementing the training for all maternity staff. Additionally, they have provided annual anti-racism training for year 3 Midwifery students.

2.1.11 Weekly maternity leadership walk-arounds are now embedded across the service and provide a regular leadership presence that facilitates open communication with staff and fosters a culture of transparency and trust.

Theme 4: Standards

2.1.12 Saving Babies Lives Care Bundle version 3 has been implemented, and compliance has been reported as part of the Maternity (and Perinatal) Incentive Scheme. The service has been working collaboratively with the BOB LMNS on this work.

2.1.13 Staff are now using digital notes (BadgerNet) in maternity, all women and birthing people should be on the digital system by October 2024.

2.1.14 The Trust Assurance Team and Corporate Nursing have established an Evidence Group to work with the Maternity Services to ensure evidence is robust and validated and that there is a framework for monitoring progress against action plans, with clear and timely escalation if progress is not achieved as expected.

3. Maternity (and Perinatal) Incentive Scheme (MPIS)

2.2 MPIS is reported monthly through MCGC and is a regular agenda item at the monthly Maternity and Neonatal Safety Champions meetings for review, progress and escalation as appropriate.

2.3 The Trust is on track to be complaint with 7 of the safety actions. The 3 safety actions summarised below are at risk of non-compliance and all have action plans in place to ensure progress towards compliance:

2.3.1 Safety Action 3 – Transitional Care. Currently tube feeding has been suspended due to staffing and additional training requirements. The transitional care guideline has been amended to reflect current practice and to allow the training and staffing model for transitional care to be addressed.

2.3.2 Safety Action 4 – Neonatal Medical Workforce: For year 6 of the scheme, the service is required to demonstrate progress against the year 5 action plan outlining plans for an increased medical workforce. The clinical leads are working to develop a business case that provides a stepped approach to increased staffing.

2.3.3 Safety Action 6 – Saving Babies Lives Care Bundle version 3, element 1: There are several areas of element 1 that involves CO monitoring where the Trust is below compliance. New CO monitors have been ordered and will be distributed and be in place by the end of August. This will support improved compliance. An action plan has been submitted to the LMNS to support Q1 submission.

4. Maternity Safety Support Programme (MSSP)

4.1. Maternity Services are currently working with the Maternity Improvement Advisor (MIA). The Trust has made significant progress on the programme and a review of the Trust's progress on the MSSP is scheduled for November 2024 alongside the ICB. A summary of recent progress is outlined below:

4.1.1 Senior Midwifery Team: The senior midwifery leadership is now fully established, and the new Head of Midwifery (HoM) and Deputy Head of Midwifery (Dep HoM) are now in post

4.1.2 Intrapartum Bereavement Room: This work has progressed well. Asbestos removal work has been completed, and the final refurbishing and soundproofing of the room is scheduled for September and will be completed in November 2024.

4.1.3 Maternity and Neonatal Governance and Operational Delivery Group: The trust established a joint Maternity and Neonatal Governance and Operational Delivery Group in May 2024. The committee has a joint work program focused on improving the quality of care and ensuring the best outcomes for mothers and newborns.

4.1.4 Badgernet: Badgernet, the new Maternity Information System, has been implemented, and work continues to refine and update data extraction from the new system.

5. Thematic Review of the Keep the Horton Group Maternity Dossier

4.2 The Trust thoroughly reviewed and analysed the anonymised cases from the Keep the Horton General Campaign Group's Birth Trauma Dossier. The report thoroughly assessed the quality of maternity care and identified areas for improvement.

4.3 The report outlines actions to improve access to care for high risk birthing people, enhancing postnatal care and reviewing the Maternity Service within Banbury. The response has been presented at Trusts Integrated Assurance Committee, LMNS/ICB and the NHSE Regional Team. The report has received positive feedback from internal and external stakeholders for its openness, transparency and commitment to improve service delivery.

4.4 The Trust has engaged with the Keep the Horton Campaign Group regarding the dossier in July 2024 and has a further meeting scheduled alongside ICB colleagues to discuss the response to the dossier and associated action plan. The Trust also updated and met with the Health Overview and Scrutiny Committee (HOSC) in July and has appraised them of the dossier and the planned response. The OMNVP has been actively involved and engaged throughout this process and will be involved in the codesign of the improvement actions.

6. Review of the Safety, Quality and Experience of Maternity Services

6.1. The Trust has commenced a structured review of its Maternity Services over the last 48 months. The aim of the review is to document the progress made by the Maternity Service in terms of quality, safety, and overall experience during the past four years.

6.2. The process involves examining a wide range of data and information to assess how it aligns with policy, professional guidelines, and other evidence sources. This review will also look at incidents, key learning and actions taken, as well as evidence of assurance and continuity to identify any gaps, along with feedback from complaints. Additionally, it will examine how individuals and families are involved in key decisions.

6.3. The review will assess whether the lessons learned have been effectively implemented and if there are any areas where improvements are required in terms of clinical practice, governance, and accountability.

6.4. The report will be completed by the end of September 2024.

7. Maternity Performance Dashboard

7.1. There were five exceptions reported for the July data, see Appendix 1 for further detail, mitigations, and improvement actions.

8. Perinatal Quality Surveillance Model Report

8.1. One of the requirements from Ockenden actions and the Maternity (and Perinatal) Incentive Scheme is that the Board is informed of the Perinatal Quality Surveillance Model (PQSM) report, which is delivered monthly to MCGC.

8.2. The Perinatal Quality Surveillance Model (PQSM) report for June and July will be presented to the Private Trust Board meeting on 11 September 2024. Both months were reported through MCGC in July and August and are a regular agenda item at the monthly Maternity and Neonatal Safety Champions meetings.

9. CQC Action Plan Update

9.1. In the Horton Midwifery Led Unit CQC action plan there are six ‘Must Do’ actions and seven ‘Should Do’ actions. Four of the ‘Must Do’ actions around risk assessments, medication storage, regular audit completion and governance processes have been completed with ongoing monitoring. The two outstanding actions are in progress and relate to adding resuscitaires and emergency trolley checks to ‘My Kit Checks’, and estates work to accommodate the new birthing pool.

9.2. In relation to the ‘Should Do’ actions, there are outstanding actions related to ligature risk assessments and ensuite facilities are part of the progressive capital investment plan.

9.3. Maternity Services, the Trust Assurance Team and Corporate Nursing have established an Evidence Group to continuously monitor and evaluate the progress and effectiveness of the CQC action plan.

9.4. The Evidence Group will work with the Maternity Service to ensure evidence is robust and validated, and that a clear framework for monitoring progress against action plans, with clear and timely escalation if progress is not achieved as expected.

9.5. There are two should do actions related to estates from the 2021 CQC inspection of the Maternity at the JRH. The should do action of the provision of a bereavement room on Delivery Suite has commenced and is expected to be completed by November 2024.

9.6. Progress against the CQC action plan is reported through existing governance processes, which include Maternity Clinical Governance Committee (MCGC), SuWOn Divisional Clinical Governance Committee and the Trust Clinical Governance Committee (CGC) as part of the quality reports and includes the recent Horton CQC action plan.

10. Antenatal and Newborn Screening

10.1. Following the Antenatal and Newborn Screening (ANNB) Assurance Visit to maternity services on the 23 April 2024, the service received the final report on the 01 July 2024. An action plan is in place to address the 36 recommendations which includes the five urgent recommendations following the receipt of the final report.

10.2. The action plan was approved at the Trust Management Executive (TME) on the 29 August and has been shared with NHS England. The actions have been uploaded to the “Action Plan” module on Ulysses.

10.3. Progress against the ANNB action plan is reported through existing governance processes, which include Maternity Clinical Governance Committee (MCGC), SuWOn Divisional Clinical Governance Committee and the Trust Clinical Governance Committee (CGC) as part of the quality reports.

10.4. Maternity Services, the Trust Assurance Team and Corporate Nursing have established an Evidence Group to continuously monitor and evaluate the progress and effectiveness of the ANNB action plan.

11. Maternity Safeguarding

11.1. Maternity Safeguarding have been accepted onto the Oxfordshire domestic abuse strategic board and will lead on domestic abuse for the trust.

11.2. Maternity safeguarding represents OUH on the PAUSE project strategic board. PAUSE is a national organisation, financially supported by Oxfordshire County Council, that works to improve the lives of women who have had – or are at risk of having – more than one child removed from their care, and the services and systems that affect them. Collaborative projects on the support for this cohort of women in Oxfordshire including additional community support is ongoing and part of the enhanced care midwifery model being discussed at present.

11.3. A child safeguarding rapid review was held by the Oxfordshire Children Safeguarding Board (OSCB) and attended by Maternity Safeguarding. The national panel for safeguarding practice reviews did not feel the need for an additional investigation due to the initial report highlighting excellent multi agency working. A PSII (no.2425-001) has been commenced and the interim report presented to SLIC on 11 July 2024.

11.4. In conjunction with the OSCB, Oxfordshire children's social care, Turning Point addiction services and Thames Valley Police, additional processes are being created to provide an improved level of support during the period from birth to separation, prior to a court order being sought. A task and finish group has been commenced and will produce an action plan with recommendations for each agency.

12. Midwifery Led Unit (MLU) Status

12.1. In June, there were three occasions where we were unable to support home births in the community due to staffing and acuity issues. Escalation processes were appropriately activated, and those women affected gave birth safely in an alternative provision.

12.2. In July the service was able to support 100% of births in the community, preserving woman's preferred place of birth.

13. Conclusion

13.1. This report provides an on essential maternity activity which includes the CQC action plan update, Maternity and Perinatal Incentive Scheme (MPIS), and Antenatal and Newborn Screening Services. It summarises the findings and recommendations as well as the actions taken by the service to address them.

13.2. The report aims to assure the Trust Board of the Maternity service delivery and performance.

14. Recommendations

14.1. The Trust Board is asked to:

- Receive and note the contents of the update report.

Oxford University Hospitals
NHS Foundation Trust

Maternity Performance Dashboard

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Date: August 2024

Data period: July 2024

Presented at: Maternity Clinical Governance Committee

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Notable Successes

- Fetal wellbeing team were runners up in a poster presentation of their Fetal Monitoring Audit for Baby Lifeline, for their continued work in fetal monitoring education and safe CTG interpretation.
- Two Community MSWs have won a Regional Chief Midwifery Award to be presented in September
- A monthly Maternity Risk Committee established to review, monitor and escalate risks dynamically and will feed into MCGC and Trust governance processes
- Safely reduced outstanding Ulysses by over 60%
- Completion of the KTHG Birth Trauma Dossier Trust response.

Executive summary

Oxford University Hospitals NHS Foundation Trust

Domain	Performance challenges, risks and interventions
Activity	There were 623 mothers who gave birth in July, which is lower than 660 in June. 718 planned bookings were completed, which is 52 less than the previous month. In July, 236 caesarean sections were carried out, which made up 37.9% of the mothers who gave birth this is slightly higher than the previous month.
Workforce	The midwife-to-birth ratio was 1:26. The service continues with a robust recruitment and retention plan to align with the recommended Birthrate Plus uplift. A daily meeting ensures safe staffing across the service, supports mitigation and triggers escalation where required. There was no occasions when 1:1 care was not provided for women in established labour and no occasions when the delivery suite coordinator was not working in a supernumerary capacity. There was a slight increase of on-call hours worked, 287.3, compared to 277 the previous month. The number of occasions where staff were moved from offices/specialities to support in clinical areas was 172 in July which is reduced from 209 occasions in June. There were 29 red flags raised for delays in the Induction of Labour process above 24 hours due to staffing and capacity challenges. 12 Ulysses were submitted in respect of staffing concerns around tactical daily staff movements to address acuity, compared with 32 submitted in the previous month.
Maternal Morbidity	In July 2024, 11 women experienced third-degree tears, with 2.8% occurring during normal or assisted vaginal births, a 0.3% increase from June 2024. The ethnic backgrounds included White British (n=5), White and Asian (n=1), Pakistani (n=1) , Black Caribbean (n=1) , Other (n=1) and Not Stated (n=2). The rate of heavy bleeding (PPH) of at least 1.5 litres after vaginal births was 1.9% (n=12 women) of the total births in July 2024 – this is 1% lower than in June and below the MBRRACE target of 2.4%. The women's ethnic categories were: White British (n=6), Asian/other (n=1), Bangladeshi (n=1), Mixed/other (n=1), White other (n=2), Any other ethnic group (n=1). The rate of PPH for caesarean sections, the PPH rate was 1.6% (n=10 women) of the total births in July 2024 – this is a 0.1% increase from June 2024. The women's ethnic backgrounds were: White British (n=5), Asian/other (n=1), Bangladeshi (n=1), Indian (n=1), not stated (n=2). 10 women were readmitted postnatally for a range of conditions including suspected sepsis and secondary haemorrhage.
Perinatal Morbidity and Mortality	In July, two perinatal mortality cases were reviewed. One was a term stillbirth at 41+4 weeks where no care concerns were identified. The other was an intrauterine death at 36+6 weeks, presumed due to placental abruption, where care concerns were identified. The care prior to the death was graded D due to a missed opportunity for admission, and care during labour and post-birth was graded C. The review findings and feedback has been shared with the family through a debrief meeting. An action plan is being developed to address these concerns which will be overseen by patient safety team. 23 term babies were unexpectedly admitted to special care following birth in July. 15 babies were admitted with respiratory distress, 3 were admitted in poor condition following birth, 1 was admitted with low temperature. 2 babies were admitted following falls (both cases reported via Ulysses and investigated) and 2 babies were admitted with suspected HIE (both cases reported to MNSI, details below.)
Maternity Safety	In July, two cases were referred to Maternity and Newborn Investigations: one involved an unexpected postnatal neonatal collapse of a term baby, and the other was a baby who met criteria for therapeutic cooling following an emergency caesarean birth. 222 incidents were reported via Ulysses, including 58 moderate harm cases such as PPH >1.5 litres, OASI, and unexpected admissions to SCBU. Of the moderate harm incidents reviewed over the month of July, the majority had no care concerns, while 3 were graded C with action points to address care concerns, including individual staff reflections. It should be noted that classification of moderate harm incidents includes customary maternity events such as post-partum haemorrhage, where harm is not suffered by the patient and as such the number can be misrepresentative. Positive aspects of care included good teamworking, adherence to emergency algorithms and guidance, swift recognition of abruption and sub-acute hypoxia, good evidence of antenatal counselling and discussion during antenatal period and evidence of excellent discussion with service users. Conversely, areas for improvement included completion of BadgerNet documentation, professional curiosity around pain assessment; timely recognition of blood loss and confidence in the use of resuscitaires.

Executive summary (continued)

Oxford University Hospitals NHS Foundation Trust

Domain	Performance challenges, risks and interventions
Test Endorsement	Test Result endorsement is at 78.89%. This reflects a significant increase of 14.63%.
Patient Experience	In July 2024, 16 complaints were received, maternity complaints often involve multiple factors across pregnancy, delivery, and postnatal care, requiring a multidisciplinary response. The service is working towards complaint resolution within 25 days by acknowledging and appointing a lead investigator on the first day and are now holding weekly MDT meetings, chaired by the deputy head of midwifery, to review all complaints. Common themes include compassionate communication, staff attitude, and delays in pain relief and nutrition. Initiatives to improve service include a postnatal working group and triangulating complaint themes with patient safety data to expediate shared learning. The Friends and Family Test (FFT) will be reinstated and monitored. A new monthly patient experience forum chaired by OMNVP has also been introduced to show service improvements based on feedback, complaints, and engagement.
Staff Experience (Cultural Improvement work)	The service remains dedicated to providing an outstanding staff experience by fostering environments where employees feel safe, valued, supported, and motivated. The cultural improvement efforts, backed by the Maternity Development Programme, have significantly reduced staff turnover and boosted satisfaction. Recently engaged, new senior leaders are continuing these efforts while acknowledging ongoing challenges. Focusing on staff retention, a proactive strategy is ongoing and efforts to optimise service rosters are also in progress, as flexibility and fairness in work schedules will also enhance staff experience. Regular feedback sessions and staff listening events are now standard practices. Fortunately, incidents involving assault, aggression, and violence are rare. Aligned with the 'No Excuses campaign,' staff are encouraged not to tolerate abusive behaviour and to report it appropriately.
Public Health	The percentage of women initiating breastfeeding in July 2024 was 85.65%, which is above of the target of 80%. The infant feeding team continue to monitor this through the Baby Friendly Initiative (BFI) Strategy working group which commenced in May 2023, and data validation continues to improve.
Exception reports	There are 5 exceptions identified from the July 2024 data which are annotated below on Slides 8 to 11.

Indicator overview summary (SPC dashboard)

ER Exception report

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KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Mothers Birthed	Jul 24	623	625			625	548	702
Babies Born	Jul 24	629	-			635	557	713
Scheduled Bookings	Jul 24	718	750			708	570	846
Inductions of labour (IOL)	Jul 24	154	-			148	107	190
Inductions of labour (IOL) as a % of mothers birthed	Jul 24 ER	24.7%	28.0%			23.8%	18.4%	29.1%
Spontaneous Vaginal Births SVD (including breech)	Jul 24	312	-			313	232	394
Spontaneous Vaginal Births SVD (including breech): a	Jul 24	50.1%	-			51.3%	44.4%	58.2%
Forceps & Ventouse/Instrumental Deliveries (OVD)	Jul 24	81	-			88	58	119
Number of Instrumental births/Forces & Ventouse as	Jul 24	13.0%	-			14.1%	9.5%	18.7%
SVD + OVD Total	Jul 24	393	-			399	317	481

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Caesarean Section (CS)	Jul 24	236	-			214	176	251
Number of CS births as a % of mothers birthed	Jul 24	37.9%	-			35.2%	29.3%	41.0%
Number of Emergency CS	Jul 24	129	-			125	111	138
Emergency CS births as a %	Jul 24	20.7%	-			19.9%	14.8%	25.0%
Number of Elective CS	Jul 24	107	-			89	23	155
Elective CS births as a %	Jul 24	17.2%	-			14.4%	10.1%	18.6%
Robson Group 1 c-section with no previous births a %	Jul 24	7.9%	-			13.3%	7.7%	18.9%
Robson Group 2 c-section with no previous births a %	Jul 24	59.8%	-			55.0%	45.1%	64.9%
Robson Group 5 c-section with 1+ previous births a %	Jul 24 ER	90.2%	-			79.3%	60.4%	98.1%
Elective CS <39 weeks no clinical indication	Jul 24 ER	1	0			0	-1	1

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Prospective Consultant hours on Delivery Suite	Jul 24	109	109			109	109	109
Midwife:birth ratio	Jul 24	26.0	22.9			26.5	22.7	30.2
Maternal Postnatal Readmissions	Jul 24	10	-			8	0	16
Readmission of babies	Jul 24	23	-			19	4	35
3rd/4th Degree Tears amongst mothers birthed	Jul 24	11	-			12	-1	25
3rd/4th degree tears as a % of SVD+OVD	Jul 24	2.8%	3.5%			3.0%	-0.1%	6.0%
3rd/4th degree tears Vaginal(SVD)	Jul 24	7	-			8	-6	23
3rd/4th degree tears Instrumental(OVD)	Jul 24	4	-			4	-4	13
3rd/4th Degree Tear with unassisted (Normal) births	Jul 24	1.8%	-			2.5%	-1.5%	6.5%
3rd/4th Degree Tear with assisted (Instrumental) birt	Jul 24	1.0%	-			4.2%	-2.6%	10.9%

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
PPH 1.5L or greater, vaginal births	Jul 24	12	-			13	1	25
PPH 1.5L or greater, vaginal births as a % of mothers b	Jul 24	1.9%	2.4%			2.1%	0.3%	3.9%
PPH 1.5L or greater, caesarean births	Jul 24	10	-			7	-1	15
PPH 1.5L or greater, caesarean births as a % of mother	Jul 24	1.6%	4.3%			1.2%	-0.7%	3.1%
ICU/CCU Admissions	Jul 24	0	-			1	-1	2
% completed VTE admission	Jul 24 ER	88.2%	95.0%			95.4%	90.7%	100.1%
Maternal Deaths: All	Jul 24	0	-			0	0	1
Early Maternal Deaths: Direct	Jul 24	0	-			0	0	0
Early Maternal Deaths: Indirect	Jul 24	0	-			0	0	0
Late Maternal Deaths: Direct	Jul 24	0	-			0	0	0
Late Maternal Deaths: Indirect	Jul 24	0	-			0	0	0

Indicator overview summary (SPC dashboard), *continued*

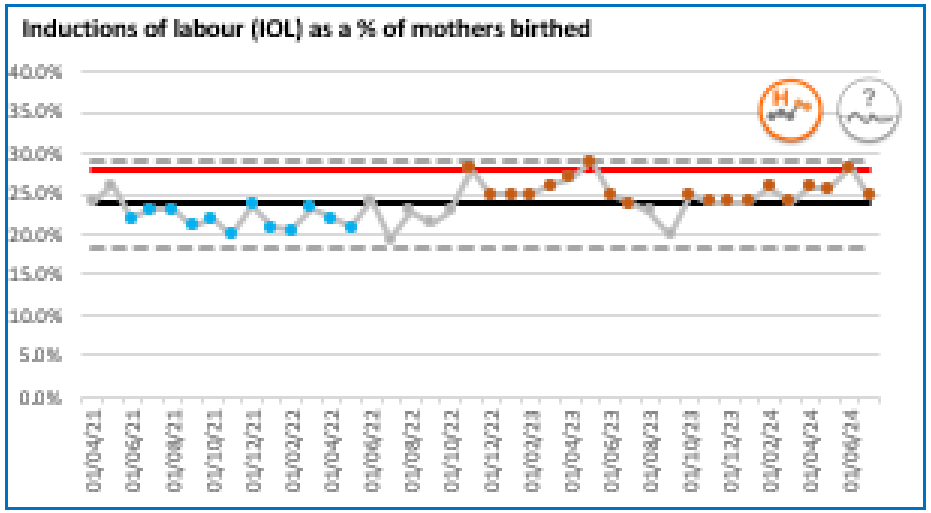
ER Exception report

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Puerperal Sepsis	Jul 24	2	-			6	-1	13
Puerperal Sepsis as a % of mothers birthed	Jul 24	0.3%	1.5%			0.9%	-0.2%	2.1%
Stillbirths (24+0/40 onwards; excludes TOPs)	Jul 24	2	-			2	-2	6
Stillbirths (24+0/40 onwards; excludes TOPs): as rate	Jun 24	3	4			4	#N/A	#N/A
Late fetal losses (delivered 22+0 to 23+6/40; excludes	Jul 24	0	1			0	-1	2
Neonatal Deaths (born in OUH, up to 28 days) All	Jul 24	1	-			2	-2	7
Neonatal Deaths (born in OUH, up to 28 days): Early (	Jul 24	1	-			2	-2	6
Neonatal Deaths (born in OUH, up to 28 days): Late de	Jul 24	0	-			1	-2	3
Neonatal Deaths (born in OUH, up to 28 days): as rate	Jun 24	1	3			1	-2	5
HIE ER	Jul 24	1	0			0	0	1

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Shoulder Dystocia	Jul 24	4	-			8	0	17
Shoulder Dystocia as a % of babies born	Jul 24	0.6%	1.5%			1.3%	0.1%	2.6%
Unexpected NNU admissions	Jul 24	23	-			25	7	44
Unexpected NNU admissions as a % of babies born	Jul 24	3.7%	4.0%			3.9%	1.2%	6.7%
Hospital Associated Thromboses	Jul 24	1	0			0	-1	1
Returns to Theatre	Jul 24	3	0			1	-2	4
Returns to Theatre as a % of caesarean section delive	Jul 24	1.3%	0.0%			0.7%	-0.7%	2.1%
Number of PSII	Jul 24	1	0			1	-2	4
Number of Complaints	Jul 24	17	-			8	-3	19
Born before arrival of midwife (BBA)	Jul 24	5	-			6	-2	15

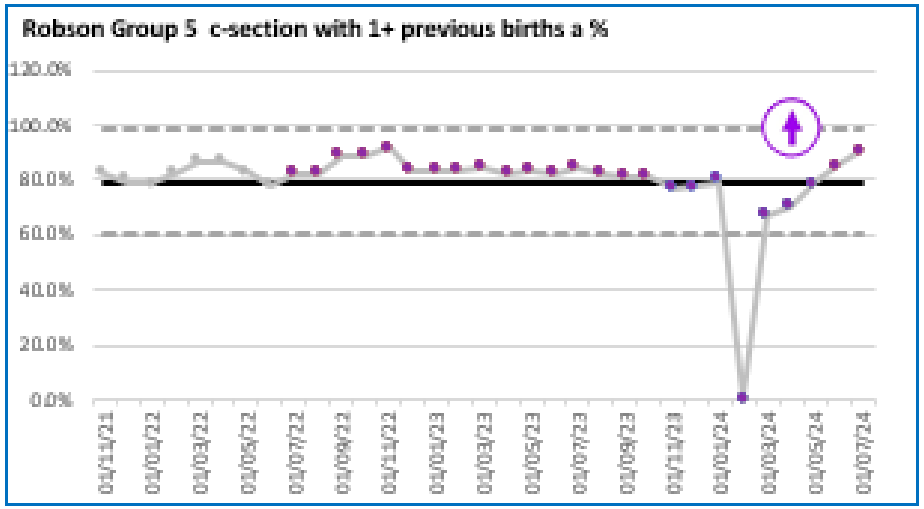
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Test Result Endorsement	Jul 24	78.9%	85.0%			74.3%	62.0%	86.6%
Number Of Women Booked This Month Who Current	Jul 24	4	-			47	24	71
Percentage Of Women Booked This Month Who Curre	Jul 24	0.6%	-			6.8%	3.5%	10.0%
Number of Women Smoking at Delivery	Jul 24	30	-			32	16	48
Percentage of Women Smoking at Delivery	Jul 24	5.0%	8.0%			5.2%	2.5%	7.8%
Number of women with a live birth	Jul 24	620	-			608	502	715
Number of Woman with a live birth Initianing Breastf	Jul 24	531	-			495	231	760
Percentage of Women Initiating Breastfeeding	Jul 24	86%	-			80%	71%	90%
Number of women booked by 10+0/40	Jul 24	439	-			387	241	533
Percentage of women booked by 10+0/40	Jul 24	61%	-			68%	59%	77%

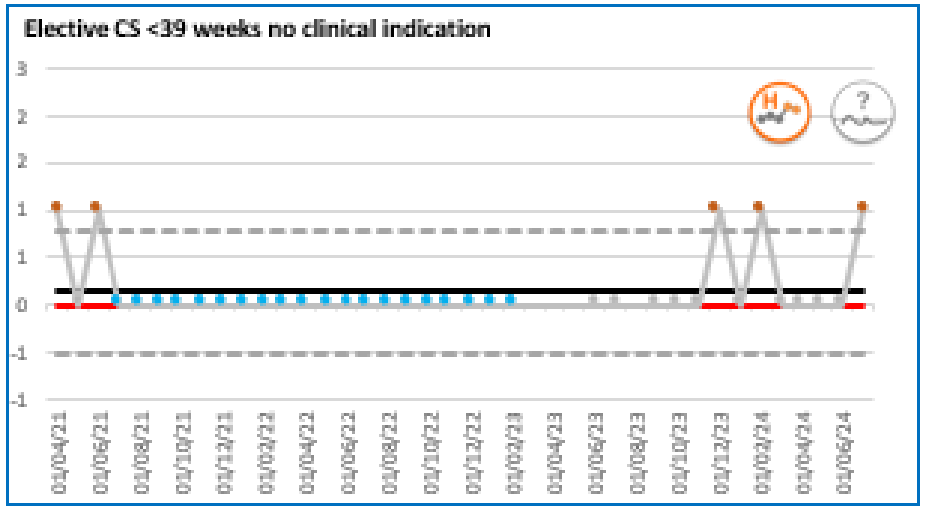
Maternity Exception Report (1)



Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Timescales to address performance issue(s) and identification of any gaps in assurance	Risk Register score	Data quality rating
Induction of labour (IOL) as a % of mothers birthed shows special cause concerning variation. Since August 2023, monthly audits of labour inductions have shown that 94 to 96% are medically indicated and nationally recommended. Although the induction rate varies monthly, this likely reflects changes in the risk profiles of the women giving birth. Timely induction of labour is a key strategy to reduce stillbirth, and research indicates that hospitals with higher induction rates have lower risks of adverse birth outcomes.	There is no national target for IOL, however this data informs the acuity of the maternity service. The Quality team, along with the obstetric clinical governance lead are exploring the adequacy of OUH local target. All induction of labours are clinically indicated and are reviewed daily and are triaged by the obstetric team.	Daily review and prioritisation of induction of labour list at the delivery suite safety huddle by the multidisciplinary team. This is an ongoing quality priority which is monitored monthly at the Intrapartum Group and Maternity Clinical Governance Committee. A Ulysses is also raised where an induction is delayed.	20	N/A

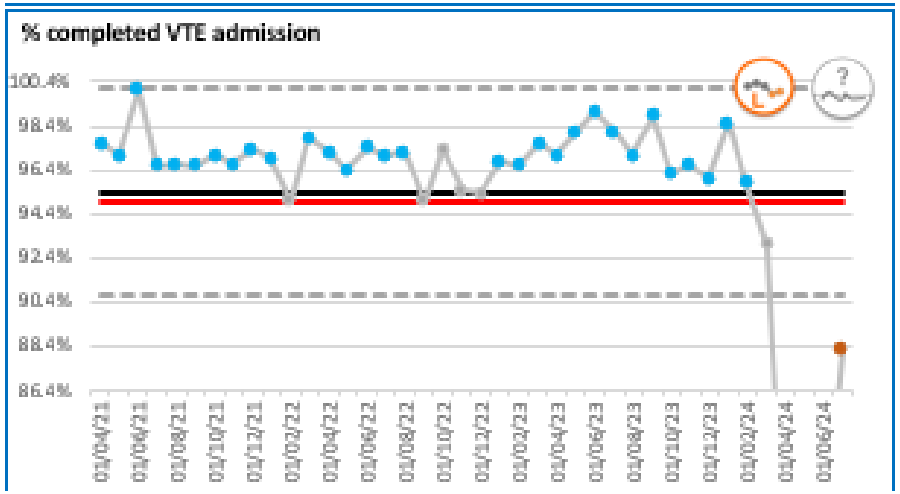
Maternity Exception Report (2)





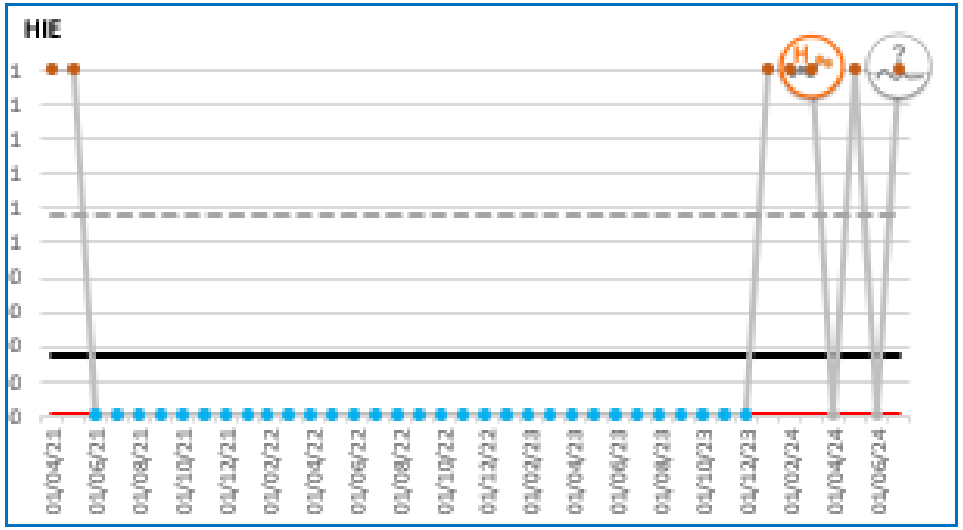
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Timescales to address performance issue(s) and identification of any gaps in assurance	Risk Register score	Data quality rating
Robson Group 5 c-section with 1+ previous births as % shows special cause improve variation An elective caesarean section (CS) was performed at 38 weeks and 6 days, just before the weekend, despite local guidelines recommending planned CS at 39 weeks or later. The case involved a woman with a prior CS and current placenta praevia. This instance was reviewed by the MCGC chair and a Consultant Obstetrician, highlighting a special cause for variation in the procedure timing.	This case will be highlighted to the obstetric team, as it is not usual practice to offer CS earlier than 39/40. This is unlikely to be a recurrent exception.	N/A	N/A	

Maternity Exception Report (4)



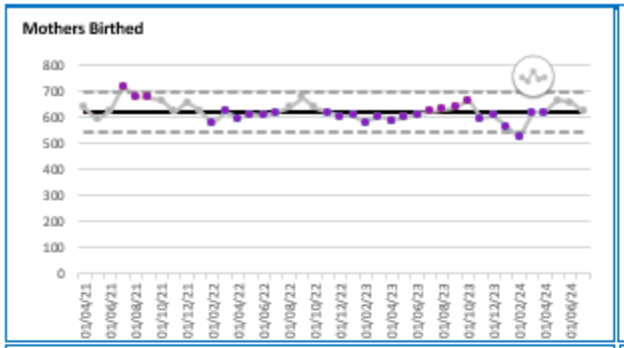
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Timescales to address performance issue(s) and identification of any gaps in assurance	Risk Register score	Data quality rating
% completed VTE admission shows special cause concerning variation. VTE in June was 79% and has increased to 88.2% in July. The trust target is 95%. Whilst our performance falls below the trust's target, there has been an increase in compliance from the previous month and we expect this upwards trajectory to continue.	• A reminder added to BadgerNet that it is an individual's responsibility to check and complete tasks on the 'things to do list' which is located in the patient record. • The digital midwife has produced a training video on how to complete VTE assessment on BadgerNet. • Other strategies to continue to improve compliance include reminders issued at the Incident Review meetings as well as the implementation of a working group. • Weekly monitoring of compliance and analysis of the present month's data indicates that further rise in the August statistic is predicted (CQUIN target: >95% compliance).	Review performance in August 2024	N/A	

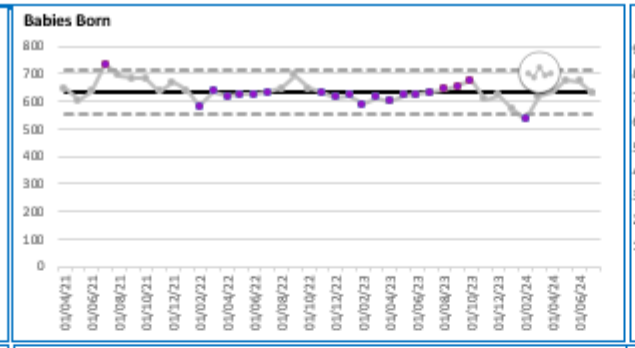
Maternity Exception Report (5)

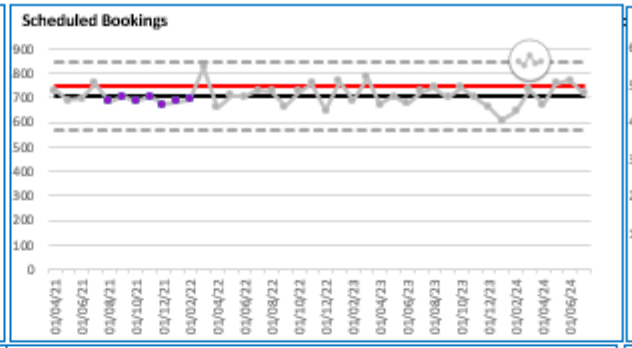


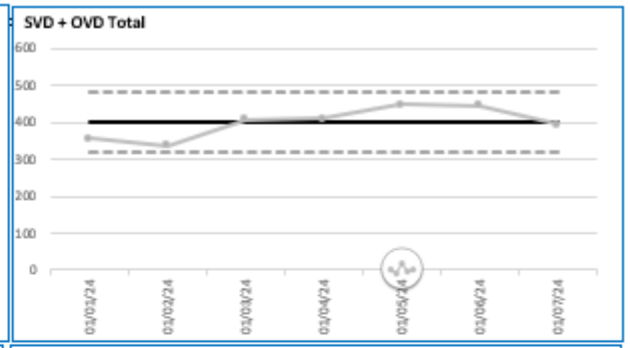
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Timescales to address performance issue(s) and identification of any gaps in assurance	Risk Register score	Data quality rating
HIE Shows special cause concerning variation There was one confirmed case of HIE. This was an unexpected postnatal neonatal collapse at 2 hours of life, following an uncomplicated and uneventful vaginal birth in the midwifery led unit of a term infant to a well woman. Following a successful resuscitation, the baby sadly died aged 9 days.	• No immediate care concerns have been identified on a rapid review and there has been a Joint Agency Review of the case. • Referred to the Coroner for investigation and to the MNSI who will also undertake a review. • Family have been informed of the processes and have been supported by the bereavement team, the neonatal team and have ongoing support in the community.	N/A	N/A	N/A

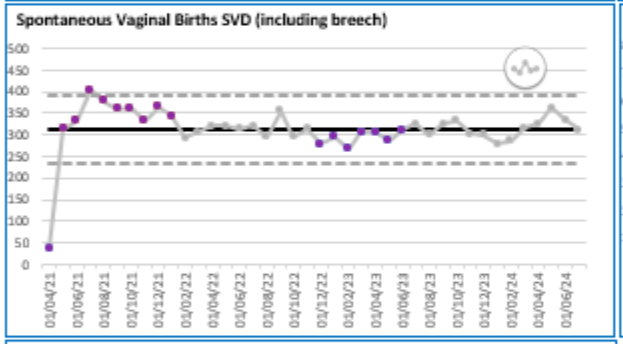
Appendix 1. SPC charts (1)

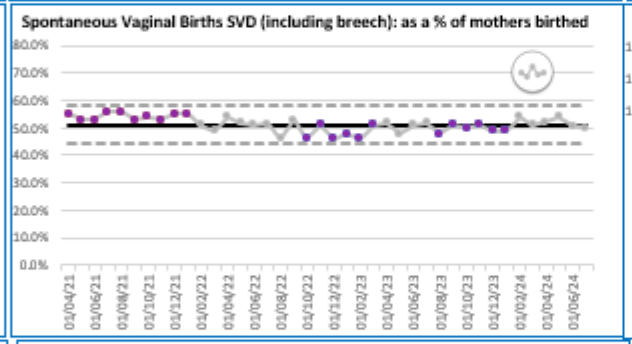


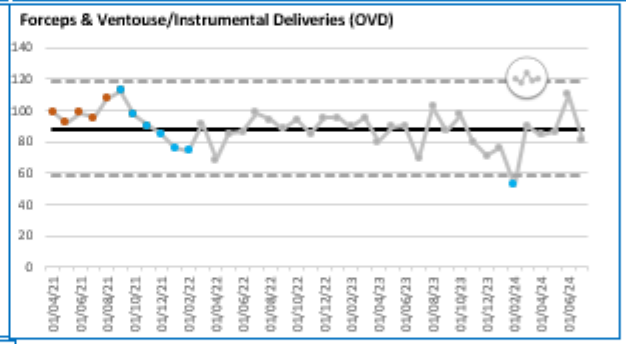


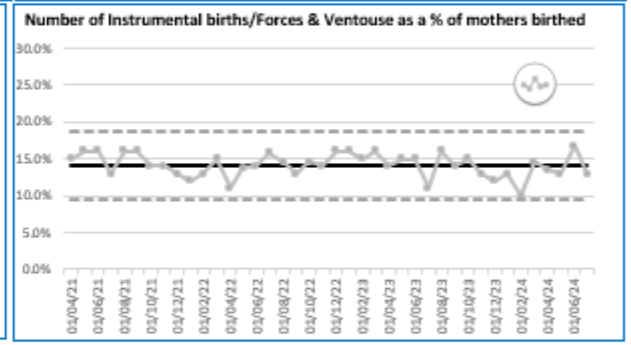


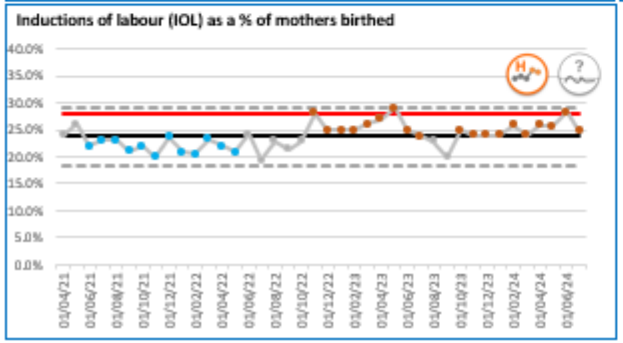


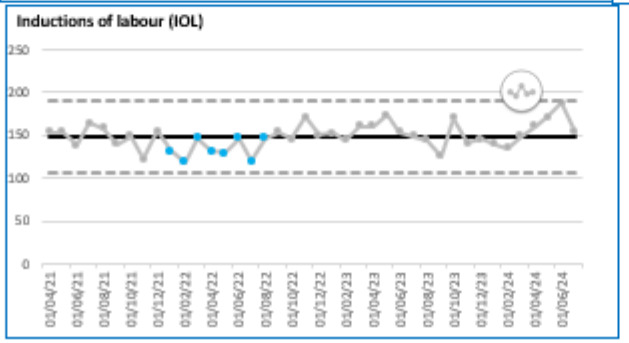




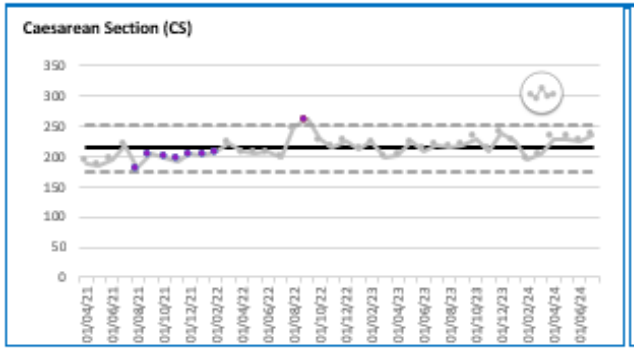


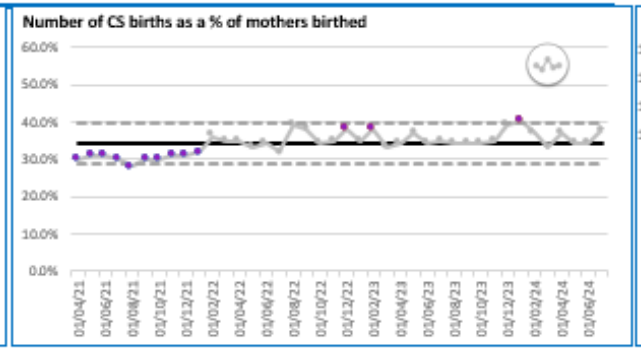


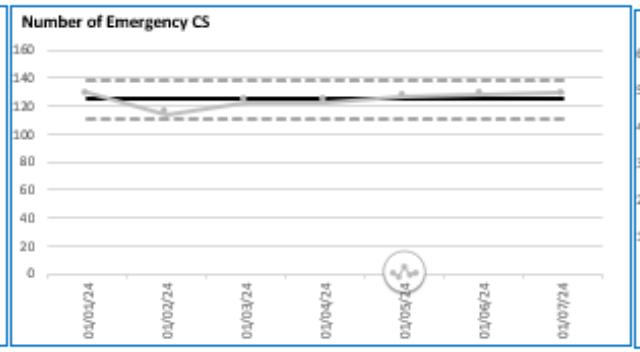


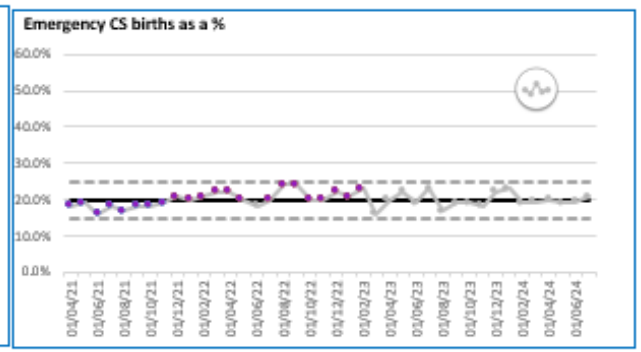


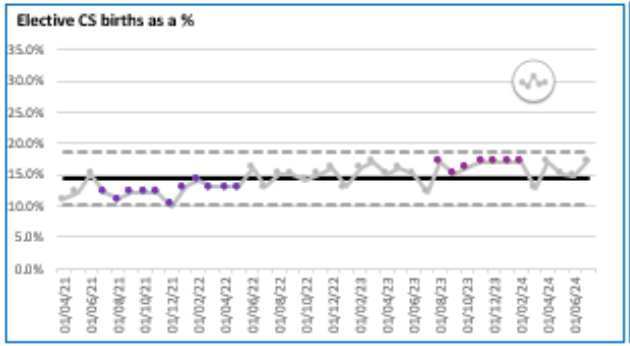
Appendix 1. SPC charts (2)

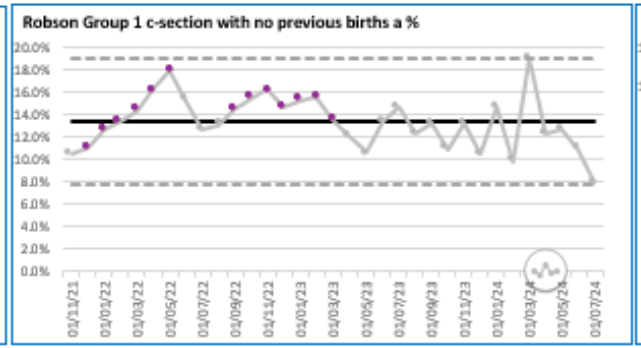


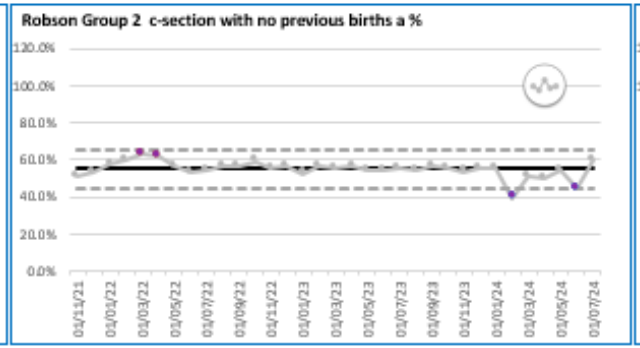


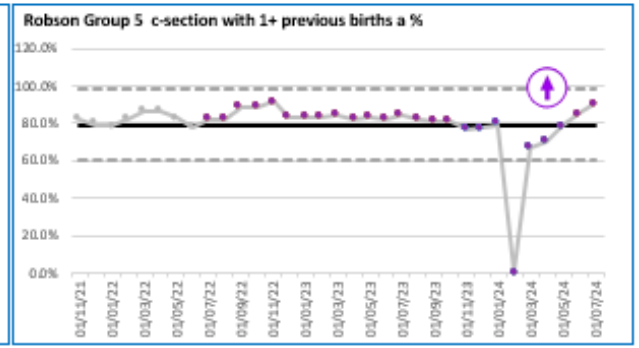


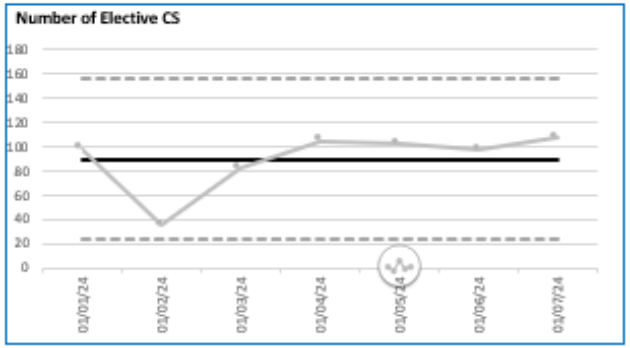


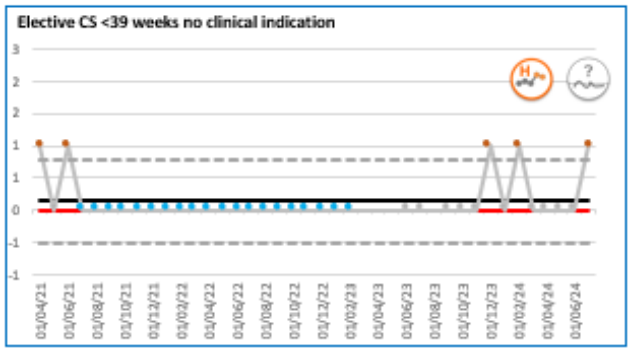




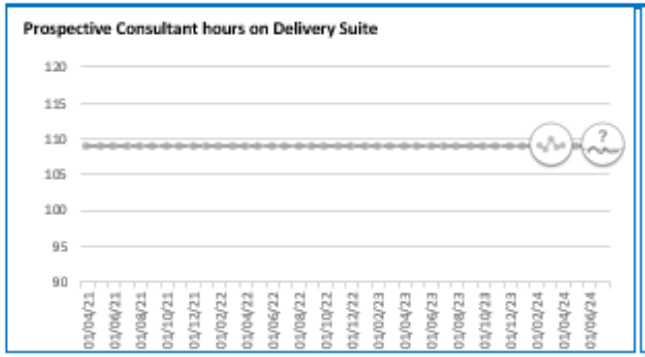


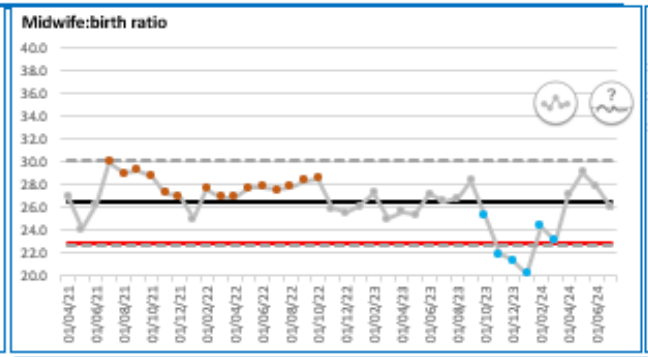


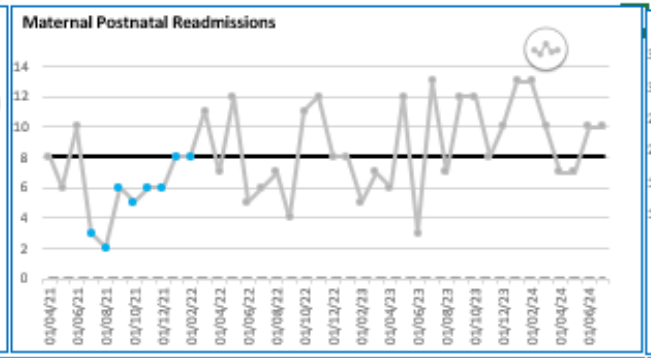


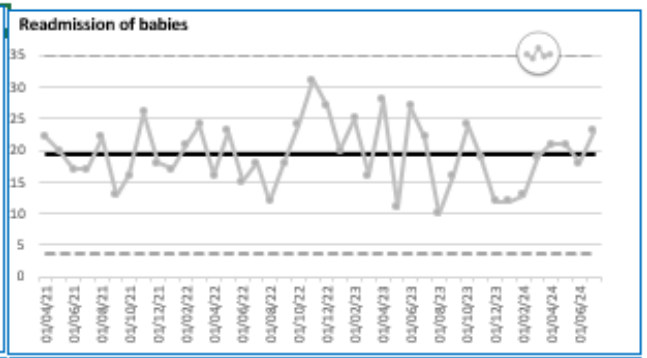


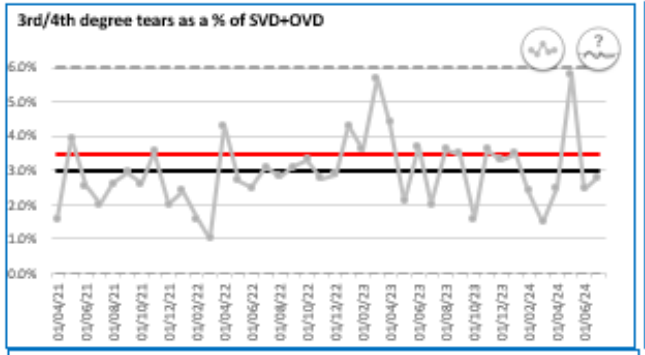
Appendix 1. SPC charts (3)

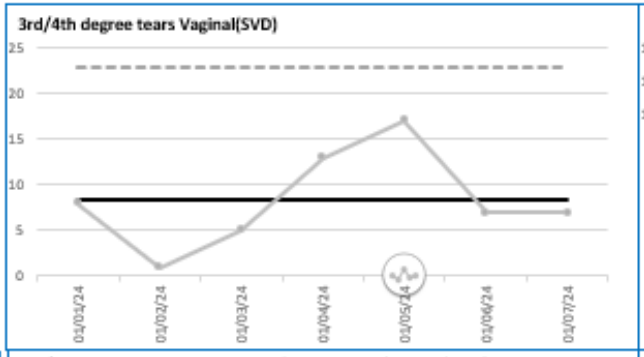


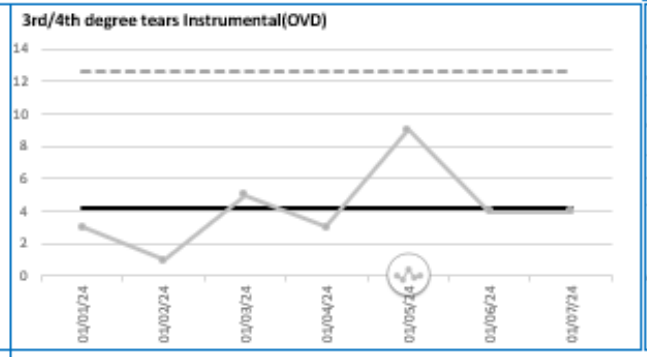


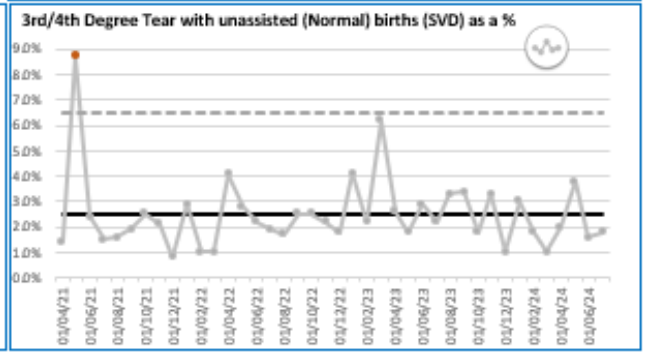


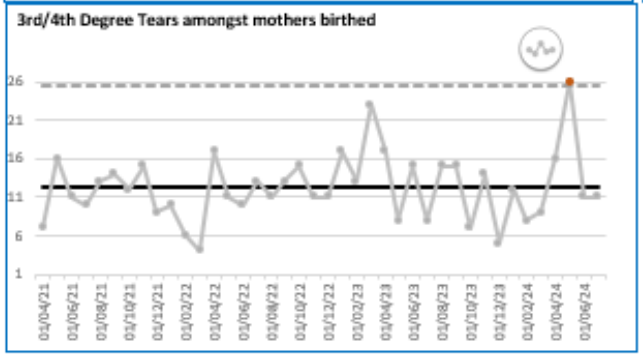


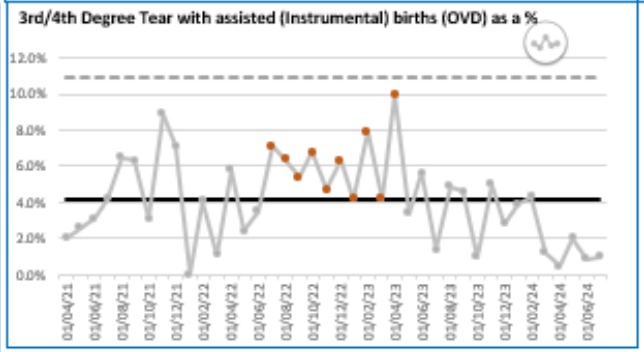




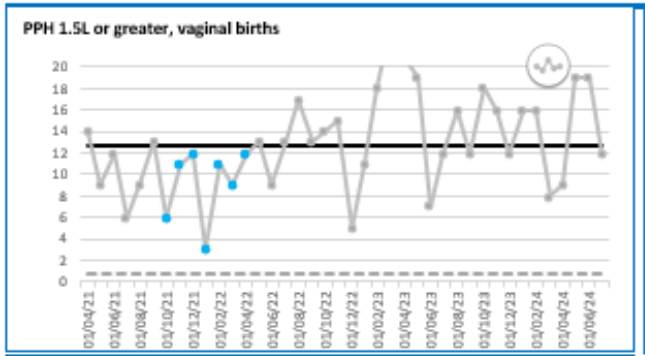


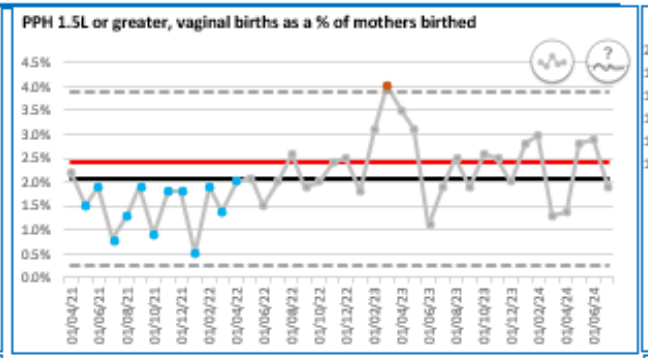


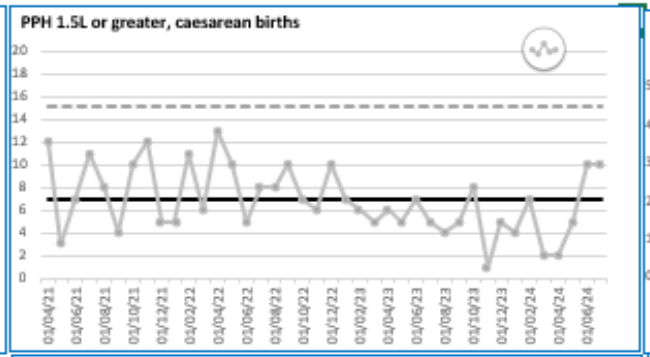


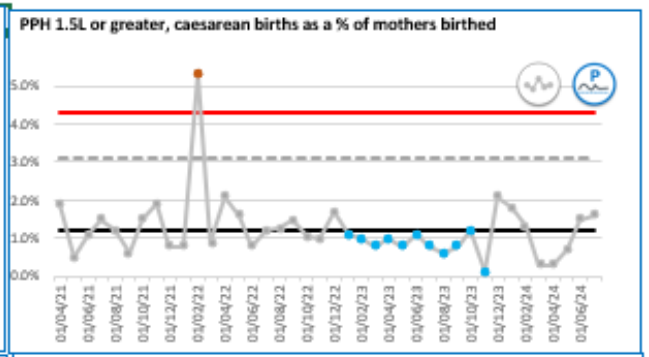


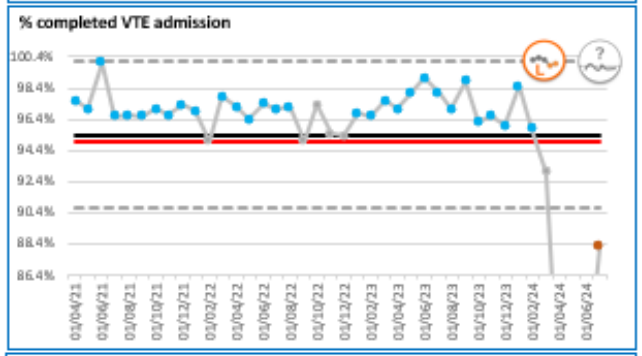
Appendix 1. SPC charts (4)

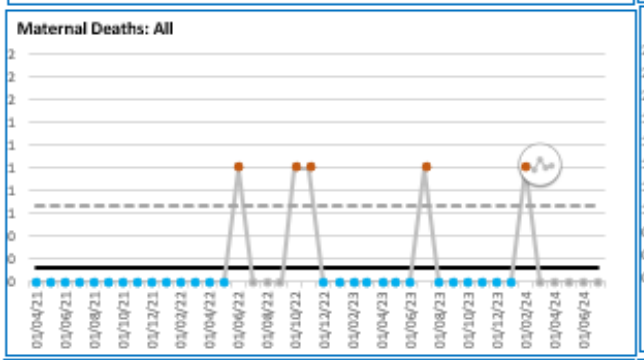


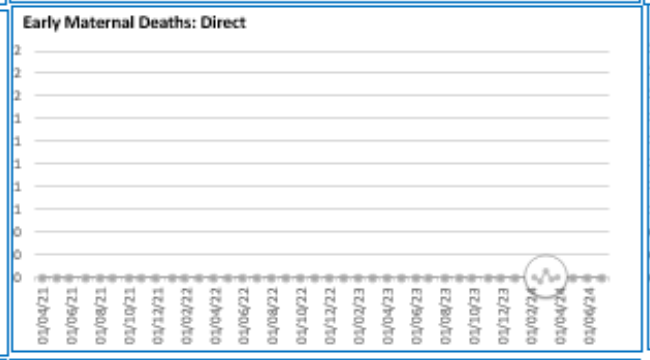


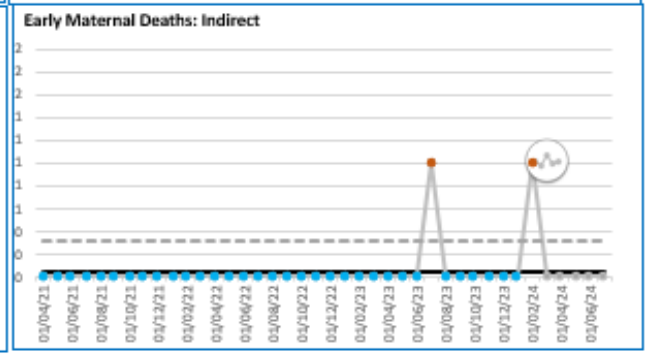


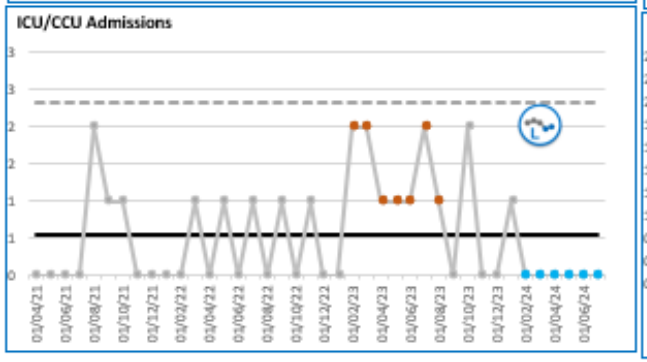


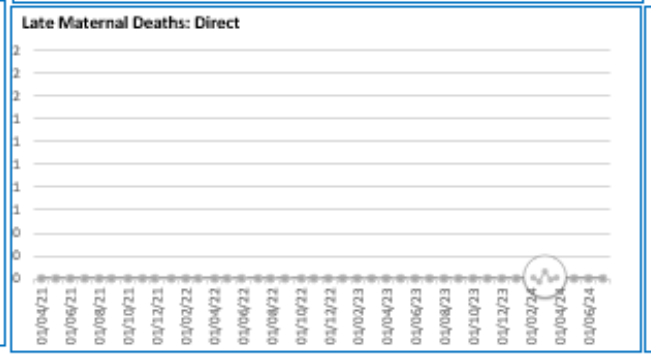


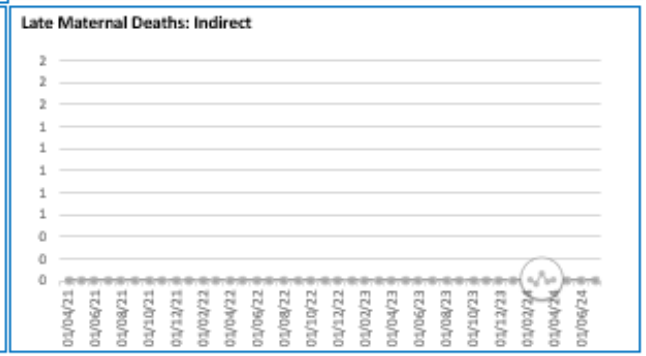




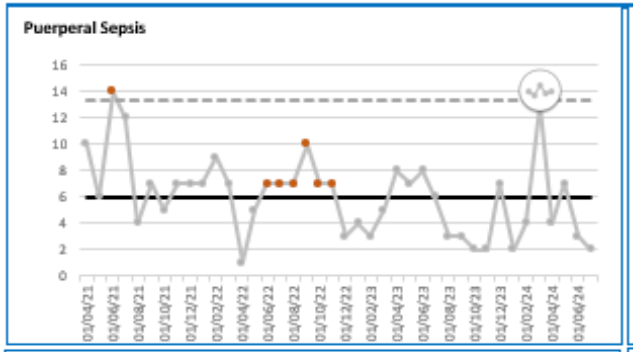


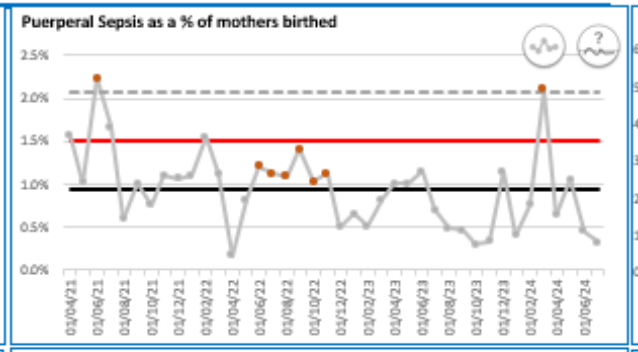


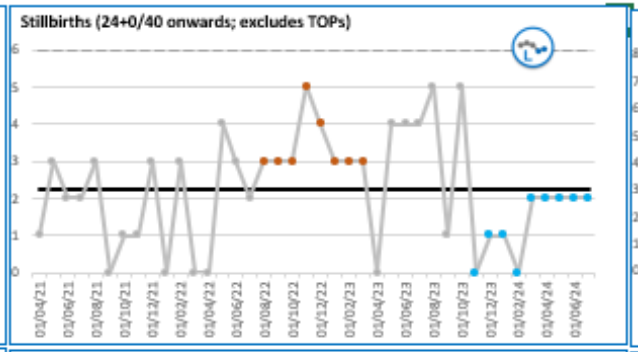


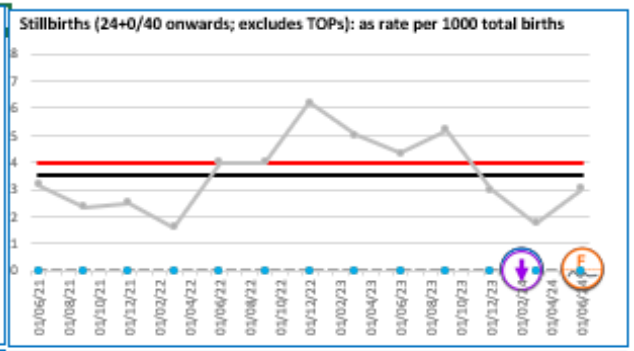


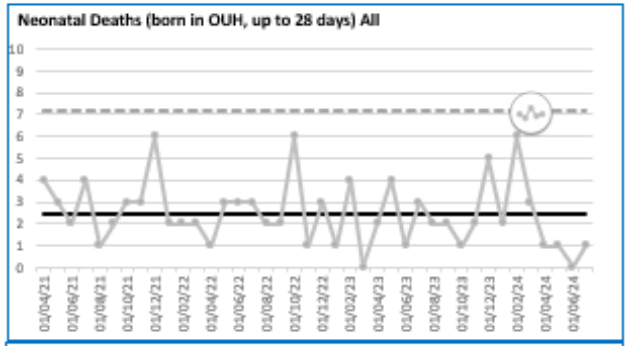
Appendix 1. SPC charts (5)

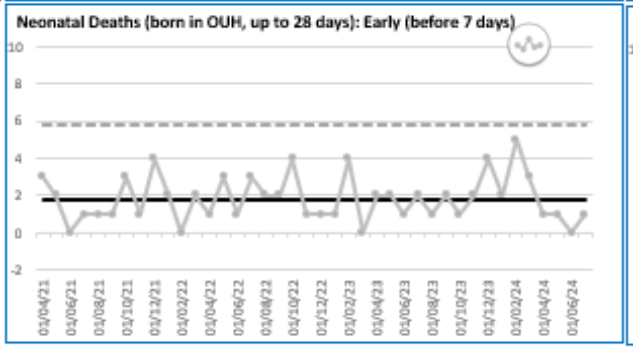


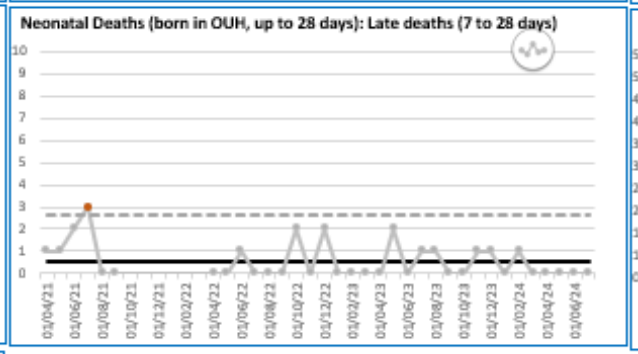


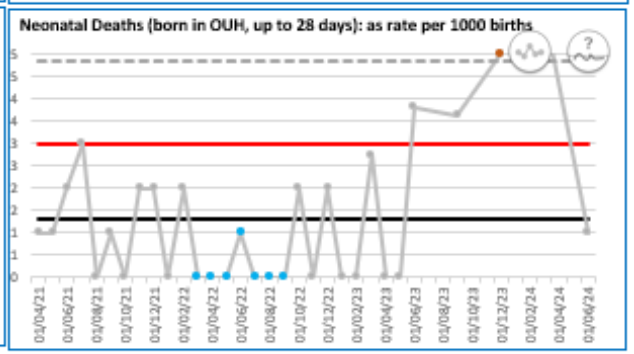


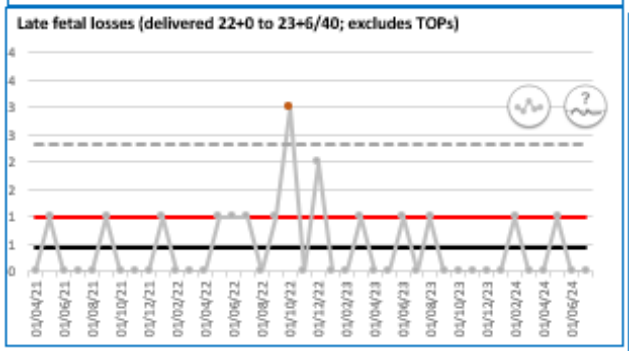


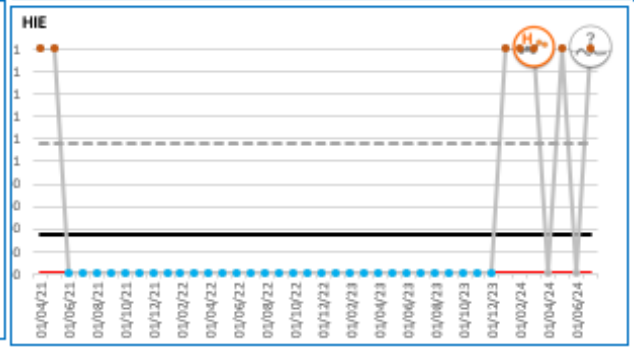




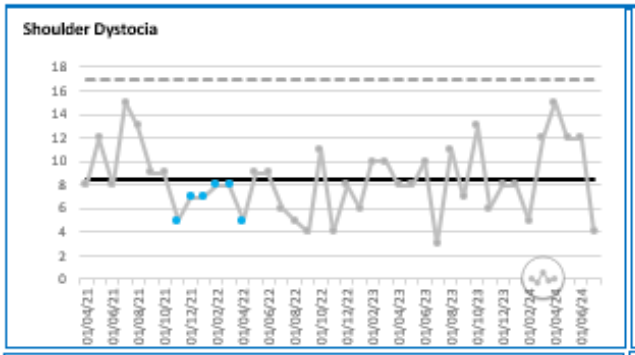


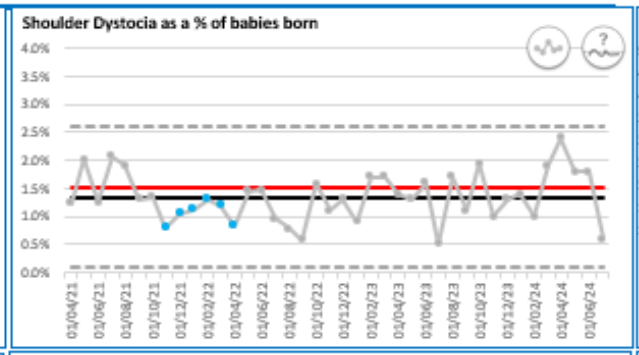


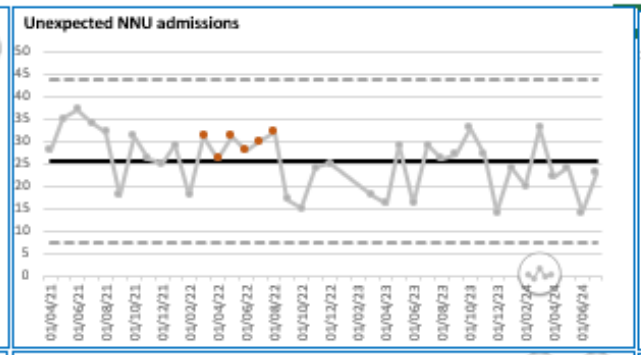


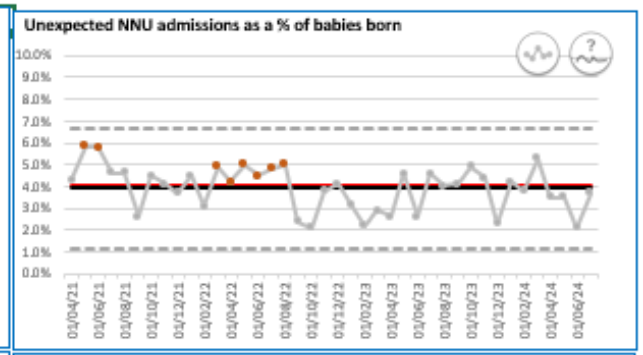


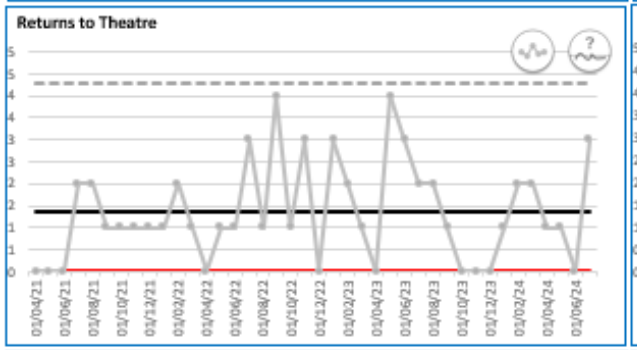
Appendix 1. SPC charts (6)

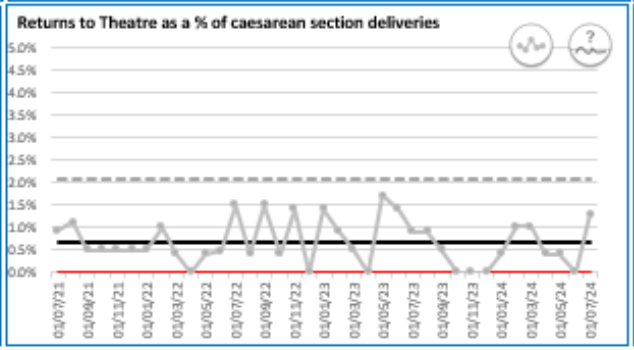


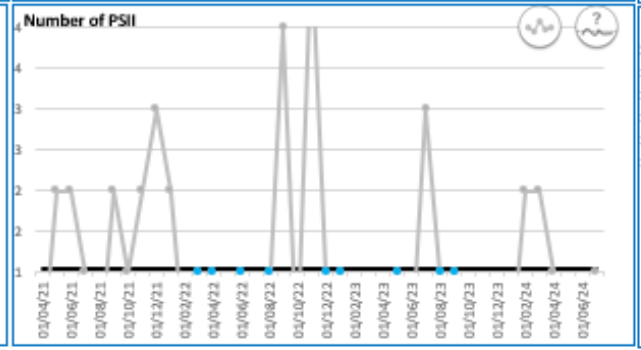


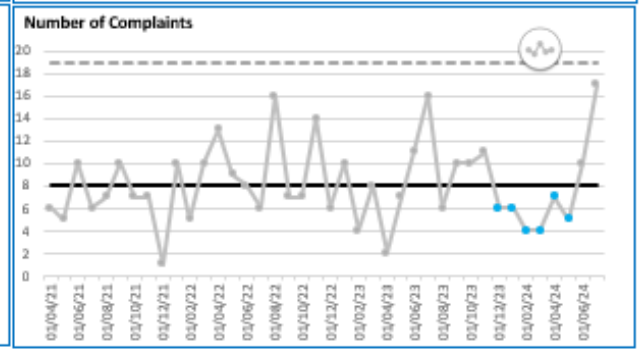


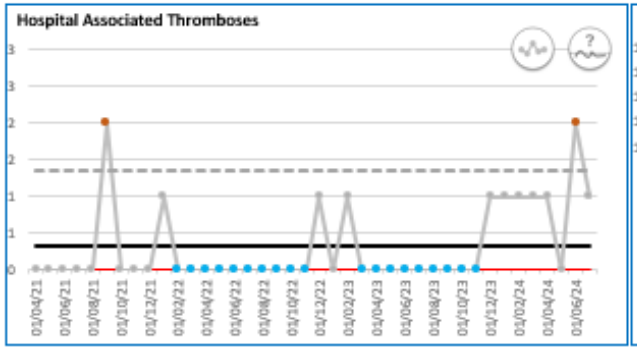


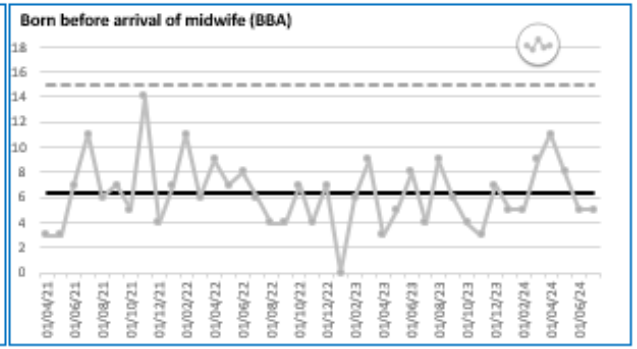












Appendix 1. SPC charts (7)