Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Trust Board Meeting in Public: Wednesday 8 March 2023

TB2023.30

Title:	**Maternity Service Update Report**

Status:	**For Discussion**
History:	**Regular report. Previous paper presented to Trust Board January 2023**

Board Lead:	**Chief Nursing Officer**
Author:	**Niamh Kelly- Maternity Safety, Risk and Compliance Lead** **Milica Redfearn – Acting Director of Midwifery**
Confidential:	**No**
Key Purpose:	**Assurance**

Executive Summary

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

    - Ockenden Assurance Visit
    - Midwifery Led Unit (MLU) status
    - Maternity dashboard development status
    - Perinatal Quality Surveillance Model Report
    - CQC inspection action plan update
    - Maternity Development Programme
    - CNST Scorecard
    - Maternity Incentive Scheme Year 4
    - Maternity Safety Support Programme (MSSP)
    - Maternity Digital Project

2. A presentation was made to the Public Trust Board by the Director of Midwifery and the Clinical Director on 18 January 2023 declaring compliance with all ten Safety Actions. The Board declaration form was submitted to NHS Resolution by the deadline of 2 February 2023.

Recommendations

3. The Trust Board is asked to:

    a. Receive and note the contents of the update report.

    b. Consider how the Board may continue to support the Divisional Teams.

Contents

Maternity Service Update Report

1. Purpose

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

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- Midwifery Led Unit (MLU) status
- Maternity performance dashboard
- Perinatal Quality Surveillance Model Report
- CQC inspection action plan update
- Maternity Development Programme
- CNST Scorecard
- Maternity Incentive Scheme (MIS) Year 4
- Maternity Safety Support Programme (MSSP)
- Maternity Digital Project

1.2. As part of the Trust's commitment to the provision of high quality safe and effective care to maternity service users, there are a variety of different maternity governance requirements that the Board are required to receive and discuss.

1.3. These requirements include reporting against regulatory and professional standards each of which have a range of different reporting deadlines.

2. Ockenden Assurance visit

2.1. Following on from the Ockenden Assurance insight visit that took place on the 10 June 2022, the Trust received the final report on the 18 August 2022.

2.2. The action plan is being monitored through the Maternity Clinical Governance committee and then upward through existing governance processes. In relation to the specific immediate and essential actions (IEAs), please note the outstanding actions are:

- IEA 5 – Risk Assessments throughout Pregnancy. The audit on the antenatal risk assessments is in progress and will be reported to Maternity Clinical Governance Committee on the 27 February 2023. These will be in turn reported as part of the service papers presented to Divisional and Trust Clinical Governance Committees.
- IEA 7 – Informed Consent. The CQC Maternity Survey Action Plan was approved at MCGC in November 2022 and is currently being updated following the publication of the results of the 2022 CQC Maternity Survey that was published in January 2023. The Trust website is currently being updated to ensure pathways of care are clearly described, in written information in formats consistent with NHS policy. The maternity voices partnership (MVP) had previously undertaken a gap analysis and the collaboration has led to the co-production of an action plan in place to address these. An update is provided at the Maternity Clinical Governance Committee monthly.

- Strengthening Midwifery Leadership –ongoing recruitment to vacant posts. All aspiring Band 7 midwife's and above have been offered leadership programmes which consist of the iCare leadership course, Florence Nightingale course and the NHS Academy Elizabeth Garrett Anderson MSc. There are senior members of the team on or about to commence all programmes.

3. Midwifery Led Unit (MLU) status

3.1. Since the last report to the Trust Board intrapartum care has continued to be provided alongside a wide range of services to women and their families across the county with 8 women and birthing people having their babies at Wantage and Cotswold Birth Centre since reopening in January.

3.2. As reported to Maternity Clinical Governance Committee on 27 February 2023 homebirths and intrapartum care at the MLUs were suspended on one occasion overnight at the beginning of January. There were no women affected by the closures and intrapartum care was not affected at the Horton MLU.

4. Maternity Performance Dashboard

4.1. The new maternity performance dashboard was approved at the Maternity Clinical Governance Committee (MCGC) in November 2022 and the first report was presented at the Integrated Assurance Committee (IAC) in December 2022 (IAC2022.75). It will be presented every month to either the Integrated Assurance Committee or Public Trust Board.

4.2. The current dashboard may be seen in appendix 1 and exceptions to note are:

4.3. Exception 1 – the number of inductions of labour increased to 144. Performance has exhibited special cause variation due to successive periods of performance (>6months) above the mean of 144. The maternity team will continue to monitor the inductions of labour (IOL). Work in progress on the IOL pathway.

4.4. Exception 2 – The percentage of emergency caesarean sections was 21% which is above the average of 19%. The obstetric team will continue to monitor the emergency caesarean section (CS) rate. Business case being prepared for Trust Management Executive (TME) to address the increase in CS rate.

4.5. Exception 3 – The percentage of post-partum haemorrhages (PPH) 1.5litres or greater for vaginal births as a percentage of mothers birthed was greater than 1.8%. There were 34 postpartum haemorrhages reviewed in January – 21 were graded as an A (no care issues identified; appropriate guidelines followed).

There were 13 graded as a B - (care issues identified – did not impact the care or management). Improvements identified: to reinforce the importance of using PPH proformas and the documenting accurate time of medications given. Positive learning identified: evidence of measuring blood loss, timely major haemorrhage call.

4.6. Exception 4 – In January there were three stillbirths reported. All stillbirths have an initial review by an obstetrician to see if there are any immediate care concerns. They are reported to MBRRACE using the perinatal mortality review tool (PMRT). All cases are reviewed by a multidisciplinary team using the PMRT.

5. Perinatal Quality Surveillance Model Report

5.1. In part fulfilment of the requirements from Ockenden actions the Board is asked to note that the Perinatal Quality Surveillance Model (PQSM) report is reported monthly to MCGC.

5.2. The Perinatal Quality Surveillance Model (PQSM) report for quarter 3 is being received by the Trust Board at its private meeting on 8 March 2023, having been previously reported to Maternity Clinical Governance Committee in January 2023 and it is a standing agenda item at the Maternity Safety Champions meetings.

6. CQC Inspection and Action Plan Update

6.1. Since the last report to the Trust Board one action has been completed and three actions remain overdue, the updates for which can be seen on the table below.

Must Do	Actions	Update
3	The service must ensure women are risk assessed at every appointment during their pregnancy and document that their risk has been reviewed	**Overdue:** Audit currently underway in relation to the NICE Antenatal Care guideline. This will be reported to MCGC in February 2023 and to the Clinical Improvement Committee (CIC) in March.
Should Do	**Actions**	**Update**
11	The service should consider the environment to ensure women and their families are always treated with respect and dignity.	**Overdue:** This relates to the long-term major capital Investment estates plan required to design and build a new Women's centre - the layout of which would enable further prioritisation of the privacy and dignity of service users. Estates plan is part of maternity development programme and capital programme considerations but no further update in terms of new building/refurbishment.
12	12.4 Business plan to be developed and approved to enable two existing birthing rooms on the periphery of the delivery suite footprint to be converted into a bespoke bereavement suite, optimising the rebirth environment for women and their families.	**Overdue:** Costs and outline plan for an improvement to the existing bereavement suite on delivery Suite is underway however this is reliant on capital funding. Charitable funds are engaged in the process.
16	16.3 Consider examples of good practice Trustwide to standardise the metrics displayed for consistent messaging to staff and service users rotating through different practice areas.	A new Maternity Safety Noticeboard has been co-produced with staff in maternity and the maternity voices partnership (MVP). These will be launched in March 2023 in the clinical areas.

6.2. 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.

7. Maternity Development Programme (MDP)

7.1. Work continues on each of the workstreams in the MDP. Progress being made with maternity culture and MDP with positive signs that staff turnover and sickness is reducing (maternity recently come off the Trust top 10 directorates under HR monitoring). Key headlines comprise:

7.2. The OUH Maternity Charter, called *Our Maternity Compact* was launched on the 13 January 2023. As part of our collective efforts to make our maternity service a better place to work and be cared for, we heard the views of staff on the attitudes, behaviours, and culture they experience every day, during our 'Co-creating our Maternity Culture' session in November 2022 to build the Maternity Charter.

7.3. The Marketing and Communications manager has commenced work in the Trust in January 2023.He has been developing the Maternity Bulletin for launch early March.

7.4. The programme is currently in Phase 4 of the timeline and is on track.

8. Clinical Negligence Scheme for Trusts (CNST) Scorecard

8.1. As part of the Trust's commitment to learning from incidents, claims, compliments, and complaints, the CNST scorecard for 2022 was presented by Solicitors from DAC Beechcroft and the Head of Legal Services at the Safety Champions meeting on the 03 February 2023.

8.2. There were three new claims since the 2021 scorecard was published. A comparison of themes from 2016 and 2018 demonstrated that CTG traces interpreted as fetal when it was maternal. There is a fetal wellbeing team who undertake training with staff as part of a mandated maternity training week. If an incident occurs where fetal monitoring has been identified as an issue, the fetal wellbeing team meet with the staff involved to identify learning needs and facilitate action planning.

8.3. All new obstetric claims received by the Trust are considered against incident and complaint data and reported through the Directorate and Divisional Quality Reports monthly. Immediate learning actions are disseminated via departmental and community matrons, and recurring themes subject of 'at a glance' style learning or factored into the next available training session as part of the core competency framework.

8.4. The NHS Resolutions Early Notification (EN) team undertook a thematic review into cases for the Oxford University Hospitals NHS foundation Trust in June 2021 due to concerns raised regarding themes emerging from Healthcare Safety Investigation Branch (HSIB) investigations. The cases reviewed were from 2017 to 2021. The thematic review considered two main categories of care: A) care provided to the mother, B) care

provided to the baby. The themes and actions were reviewed to identify the learning, and an action plan developed as a response to NHS Resolutions. The draft action plan will be presented at MCGC on the 27 February 2023.

9. Maternity Incentive Scheme

9.1. A presentation was made to the Public Trust Board by the Director of Midwifery and the Clinical Director on 18 January 2023 declaring compliance with all ten Safety Actions. The Board declaration form was submitted to NHS Resolution by the deadline of 2 February 2023.

9.2. Work will continue against the requirements of the year four scheme and reported through the Maternity Clinical Governance Committee monthly. We await national publication of the Year 5 scheme, which is expected in March 2023.

9.3. **Safety Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?** The quarterly mortality report for quarter 3 is being received by the Trust Board at its private meeting on 08 March 2023, having been previously reported to Maternity Clinical Governance Committee in January 2023 and it is a standing agenda item at the Maternity Safety Champions meetings.

9.4. **Safety Action 2: Maternity Services Data Set (MSDS):** The Trust continues to submit data to the MSDS.

9.5. **Safety Action 3: Transitional care services to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal Units' (ATAIN) programme?** The Maternity and Neonatal teams are meeting fortnightly in relation to transitional care (TC). They are currently formulating a business case for funding for TC. An ATAIN paper is presented at MCGC monthly and is a standing agenda item at the monthly Safety Champions meeting. Cases from quarter 3 were discussed at a separate ATAIN meeting on the 30 January 2023. In quarter 3 there was a total of 58 babies born at OUH who were unexpectedly admitted to the special care baby unit (SCBU).

9.6. **Safety Action 4a - Obstetric Workforce:** Maternity services continue to collate evidence to demonstrate engagement with the RCOG document for consultants' attendance at specific incidents.

9.7. **Safety actions 5 – Midwifery workforce:** A Midwifery Staffing paper was received by Trust Board in January 2023 for quarter 1 and quarter 2. A paper covering quarter 3 and 4 will be submitted to MCGC in April 2023

then to Trust Board in May 2023. The Birth Rate Plus tool was completed in December 2022 and this has identified a requirement of 23.38 additional midwives based on birth rate and acuity of women. A business case to support this is in progress.

9.8. **Safety Action 6 – Saving Babies Lives Care Bundle 2:** The Saving Babies' Lives Care Bundle version 2 (SBLCB v2) Survey 7 was noted at the Trust Board in January.

9.9. **Safety Action 7 – Maternity Voices Partnership (MVP):** The MVP continue to work closely with the Maternity team. Feedback is provided as part of the Perinatal Quality Surveillance Report (PQSM) that is reported monthly to MCGC. The MVP chairperson attended the Trust Patient Safety Incident Framework (PSIRF) Stakeholder consultation event on 20 February 2022. They continue to be involved in a range of different projects within maternity.

9.10. **Safety Action 8 – Training:** The training weeks continue monthly in maternity. Training compliance is reported monthly via the quality report and the PQSM which is reported monthly to MCGC. A quarterly report for quarter 3 is being received by the Trust Board at its private meeting on 8 March 2023, having been previously reported to Maternity Clinical Governance Committee in January 2023 and it is a standing agenda item at the Maternity Safety Champions meetings.

9.11. **Safety Action 9 – Safety Champions:** The maternity safety champions have been undertaking safety champions walk rounds monthly. Feedback from these is shared with staff locally. The feedback is included as part of the PQSM. The Safety Champions continue to meet monthly with the Board Level Safety Champions.

9.12. **Safety Action 10 – Reporting Cases to HSIB and NHS Resolutions as part of the Early Notification (EN) scheme:** The maternity safety team report all eligible cases to HSIB and the EN scheme. There were no cases reported to HSIB in January. All eligible cases are reported to the SIRI forum. They are noted in the quality reports and the PQSM.

10. Maternity Safety Support Programme (MSSP)

10.1. Maternity Services are currently working with the Maternity Improvement Advisor (MIA) and the Division to embed the MSSP exit criteria into the Maternity Development Programme.

10.2. The Trust Board will be appraised of this as the work evolves.

11. Maternity Digital Project

11.1. The digital transformation project with Badgernet is underway with go-live planned for October 2023.

11.2. The project team have setup working groups to progress workflow and technical requirements for the project.

11.3. New Maternity digital team members have started in their roles.

11.4. Key tasks completed:

- Local Badgernet Server base builds completed.
- RAID log baselined.
- Project Initiation Documentation drafted.
- Clinical Working Group established.
- System Demos completed.
- Individual workflow mapping group meetings scheduled.
- Regular technical group meetings initiated.
- Initial CTG meetings with University and Suppliers

11.5. Risk and Issues:

- Dawes Redman CTG Analysis is used by the trust through the Huntleigh Centrale system which is hosted by the Oxford University (OU) Research team. We need to discuss the new workflow / technical solution to determine whether this can be supported. The Operational Service Manager (OSM) and the Maternity Clinical Director have met with eh CEO of Huntleigh on the 24 February 2023. Huntleigh will bring forward a proposal for a new relationship within the next month.
- Staff resource availability and capacity
- Project Budget was based on 10 month implementation timeline, the revised timeline is now 12 months, there is a risk that there could be a budget deficit if proper financial planning is not completed.

12. Recommendations

12.1. The Trust Board is asked to:

12.1..1. Receive and note the contents of the update report.

12.1..2. Consider how the Board may continue to support the Divisional Teams.

Oxford University Hospitals
NHS Foundation Trust

Maternity Performance Dashboard

(TB2023.30a)

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March 2023

Data period: January 2023

Presented at Board Date 8th March 2023

Authors: Niamh Kelly – Clinical Governance Manager Maternity and Jane Waddington – Performance Manager

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Oxford University Hospitals NHS Foundation Trust

Executive summary

Oxford University Hospitals
NHS Foundation Trust

Notable Successes

- The reopening of the Cotswold Birth Centre and the Wantage Midwifery Led Unit (MLU) to intrapartum births on the 09 January 2023. There has been 8 women and birthing people given birth at these MLU's since they reopened.
- Progress being made with maternity culture and the Maternity Development Plan (MDP) with positive signs that staff turnover and sickness is reducing (maternity recently come off the Trust top 10 directorates under Human Resources (HR) monitoring).
- A triage midwife has been appointed for the Maternity Assessment Unit. A second post is being recruited to.
- The OUH Maternity Charter, called Our Maternity Compact was launched on the 13 January 2023.
- The Trust declared compliance with all 10 Maternity Incentive Scheme Safety Actions. The Board declaration form was submitted to NHS resolutions by the deadline of the 02 February 2023.
- The Marketing and Communications manager has commenced work in the Trust in January 2023.He has been developing the Maternity Bulletin for launch early March.
- Digital transformation project with Badgernet is underway with go-live planned for October 2023

Executive summary, continued

Oxford University Hospitals NHS Foundation Trust

Domain	Performance challenges, risks and interventions
Activity	There was a total number of 609 mothers birthed in January which is similar to previous months. The number of Inductions of labour from iView increased to 152. The IOL's are reviewed at the safety huddle each morning and prioritised. Work in progress to review the IOL pathway. The obstetric team will continue to monitor the emergency caesarean section (CS) rate. Business case being prepared for the business planning group meeting prior to it going to TME to address the increase in CS rate.
Workforce	Prospective consultant hours on Delivery Suite was 109 in January. Midwife to birth ratio was 1:26.1. Staff turnover and sickness is reducing.
Maternal Morbidity	In January there was a higher number of 3rd and 4th degree tears. These are reviewed using the proformas on Ulysses and learning shared with the clinical areas. There were 34 postpartum haemorrhages reviewed in January – 21 were graded as an A (no care issues identified; appropriate guidelines followed). There were 13 graded as a B - (care issues identified – did not impact the care or management). Improvements identified: to reinforce the importance of using PPH proformas and the documenting accurate time of medications given. Positive learning identified: evidence of measuring blood loss, timely major haemorrhage call.
Perinatal Morbidity and Mortality	There were 3 intrauterine deaths reviewed in January and one neonatal death. Overall, we have had a very good standard of care, with few aspects of care needing improvement identified, none of which were relating to the outcome. There were no cases of HIE 2 or 3. There was 20 unexpected term admissions to the special care baby unit (SCBU). The positive learning identified from the reviews of the term admissions to SCBU was there was early social worker involvement in a complex case and good evidence of shared decision making. Improvements required were in relation to the importance of documenting verbal duty of candour and making every contact count in monitoring psychological wellbeing.
Re-admissions	There were eight maternal postnatal readmissions in January. These were related to hypertension, sepsis, abdominal pain and chest pain. There were no hospital acquired thromboses. There were three returns to theatre which have been reviewed and were unavoidable.
Maternity Safety	There was one new serious incident that required investigation (SIRI) related to bladder distension postnatally. The investigation is in progress. There were 10 complaints received in January and these are being reviewed.
Test Endorsement	Test result endorsement is above 85%. Work continues with the quality improvement project.
Public Health	There was a decrease in the percentage of women initiating breastfeeding in January. Staff continue to attend the infant feeding training.
Exception reports	Induction of labour, emergency caesarean section rate, post-partum haemorrhages and stillbirths

Indicator overview summary (SPC dashboard)

ER Exception report

KPI	Latest month	Measure	Target	Assurance	Varriation	Mean	Lower process limit	Upper process limit
Mothers birthed	Jan 23	609	625			634	554	714
Babies born	Jan 23	619	-			645	564	725
Scheduled Bookings	Jan 23	768	750			710	576	845
ER Inductions of labour from iView	Jan 23	152	-			144	99	189
Inductions of labour from iView: as % of mothers birt	Jan 23	25.0%	28.0%			22.7%	16.6%	28.8%
Spontaneous Vaginal Births (including breech)	Jan 23	296	-			330	257	402
Spontaneous Vaginal Births (including breech): as % o	Jan 23	48.0%	-			51.9%	44.5%	59.4%
Forceps & Ventouse	Jan 23	95	-			91	69	113
Forceps & Ventouse: as % of mothers birthed	Jan 23	16.0%	-			14.3%	10.6%	18.1%

KPI	Latest month	Measure	Target	Assurance	Varriation	Mean	Lower process limit	Upper process limit
C-Section	Jan 23	212	-			220	178	262
as % of mothers birthed	Jan 23	35.0%	-			35.3%	29.3%	41.4%
ER % Emergency c-sections	Jan 23	21.0%	-			19.9%	16.0%	23.8%
% Elective c-sections	Jan 23	13.0%	-			14.3%	10.2%	18.4%
Robson group 1 c-section with no previous births	Aug 22	0	-			0	0	0
Robson group 2 c-section with no previous births	Aug 22	56.4%	-			56.7%	48.9%	64.5%
Robson group 5 c-section with 1+ previous births	Aug 22	1	-			1	1	1
Elective CS <39 weeks no clinical indication	Nov 22	0.0%	0.0%			0.0%	0.0%	0.0%
Prospective Consultant hours on Delivery Suite	Jan 23	109	109			109	109	109
Midwife:birth ratio (1 to X)	Jan 23	26.1%	28.0%			27.3%	24.3%	30.3%

KPI	Latest month	Measure	Target	Assurance	Varriation	Mean	Lower process limit	Upper process limit
3rd/4th Degree Tear	Jan 23	17	-			12	2	21
3rd/4th Degree Tear as % of SVD+OVD	Jan 23	4.3%	3.5%			2.8%	0.4%	5.1%
3rd/4th Degree Tear with unassisted births (SVD)	Jan 23	4.1%	-			2.4%	-1.4%	6.3%
3rd/4th Degree Tear with assisted births (OVD)	Jan 23	4.2%	-			4.6%	-1.9%	11.1%
ER PPH 1.5L or greater, vaginal births as % of mothers bi	Jan 23	1.8%	2.4%			1.8%	0.1%	3.4%
PPH 1.5L or greater, caesarean births as % of mother	Jan 23	1.1%	4.3%			1.4%	-1.1%	3.9%
ICU/CCU Admissions	Dec 22	0	-			0	-1	2
% completed VTE admission assessments	Jan 23	96.8%	95.0%			96.9%	93.7%	100.0%

KPI	Latest month	Measure	Target	Assurance	Varriation	Mean	Lower process limit	Upper process limit
Maternal Deaths: all	Jan 23	0	-			0	0	1
Early Maternal Deaths: Direct	Jan 23	0	0			0	0	0
Early Maternal Deaths: Indirect	Jan 23	0	-			0	0	0
Late Maternal Deaths: Direct	Jan 23	0	-			0	0	0
Late Maternal Deaths: Indirect	Jan 23	0	-			0	0	0
Puerperal Sepsis	Jan 23	4	0			7	0	14
Puerperal Sepsis as % of mothers birthed	Jan 23	0.7%	1.5%			1.1%	-0.1%	2.2%
ER Stillbirths (24+0/40 onwards; excludes TOPs)	Jan 23	3	0			2	-2	6
ER Stillbirths (24+0/40 onwards; excludes TOPs): as rate	Dec 22	6	-			3	#DIV/0!	#DIV/0!
Late fetal losses (delivered 22+0 to 23+6/40; exclude	Jan 23	0	1			1	-2	3

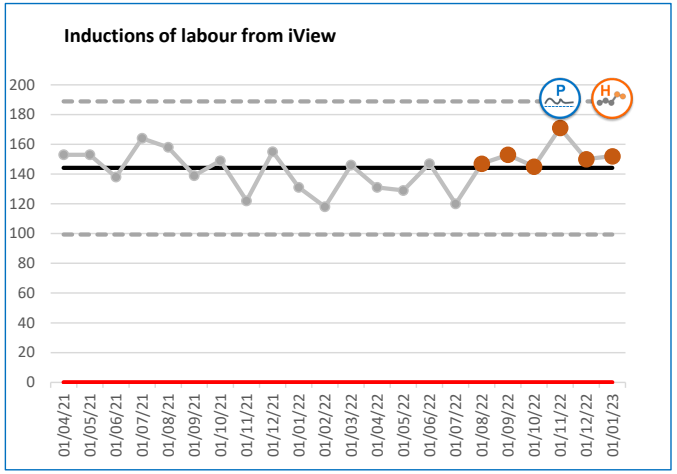
Indicator overview summary (SPC dashboard), *continued*

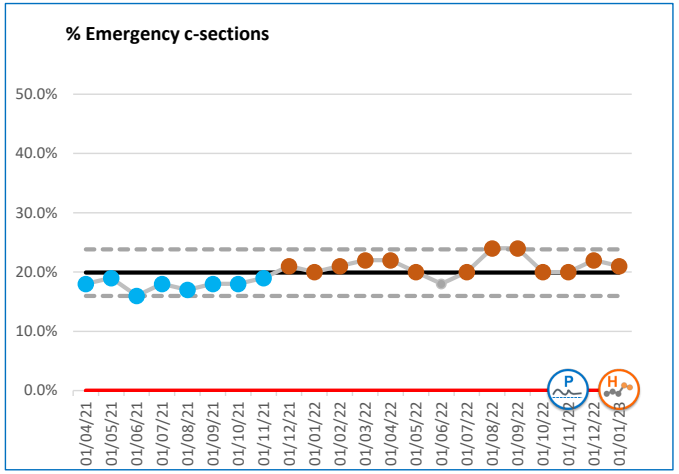
ER Exception report

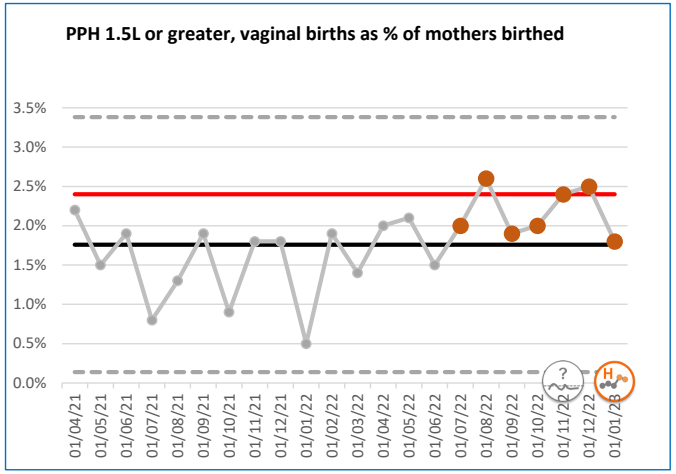
KPI	Latest month	Measure	Target	Assurance	Varriation	Mean	Lower process limit	Upper process limit
Neonatal Deaths (born in OUH, up to 28 days)	Jan 23	1	-			3	-1	7
Neonatal Deaths (born in OUH, up to 28 days): Early (	Jan 23	1	-			2	-2	6
Neonatal Deaths (born in OUH, up to 28 days): as rate	Jan 23	0.0	-			0.9	-2.3	4.0
HIE 2	Jan 23	0	0			0	0	0
HIE 3	Jan 23	0	0			0	0	1
Shoulder Dystocia: as % of births	Jan 23	0.9%	1.5%			1.3%	0.2%	2.3%
Unexpected NNU admissions: as % of births	Jan 23	3.2%	4.0%			4.2%	1.7%	6.6%
Hospital Associated Thromboses	Jan 23	0	0			0	-1	1
Returns to Theatre	Jan 23	3	0			1	-2	4
Returns to Theatre: as % of caesarean section deliver	Jan 23	1.4%	-			0.7%	-0.9%	2.3%

KPI	Latest month	Measure	Target	Assurance	Varriation	Mean	Lower process limit	Upper process limit
Number of SIRI	Jan 23	1	-			1	-3	6
Number of Divisional Investigations	Jan 23	0	-			0	-1	1
Number of Complaints	Jan 23	10	-			8	-3	20
Born before arrival of midwife (BBA)	Jan 23	0	-			6	-3	16
Test Result Endorsement	Jan 23	86.1%	85.0%			70.6%	57.2%	84.1%
Number Of Women Booked This Month Who Current	Jan 23	55	-			56	32	80
Percentage Of Women Booked This Month Who Curr	Jan 23	7.1%	-			7.9%	4.6%	11.2%
Number of Women Smoking at Delivery	Jan 23	35	0			37	25	49
Percentage of Women Smoking at Delivery	Jan 23	5.7%	8.0%			5.8%	3.8%	7.8%
Percentage of Women Initiating Breastfeeding	Jan 23	78.0%	80.0%			80.2%	71.7%	88.7%
Percentage of women booked by 10+0/40	Jan 23	71.1%	0.0%			69.1%	63.5%	74.8%

Maternity exception report (1)

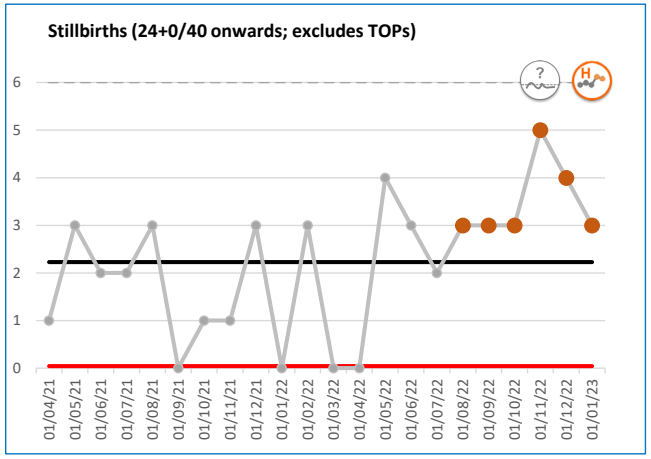


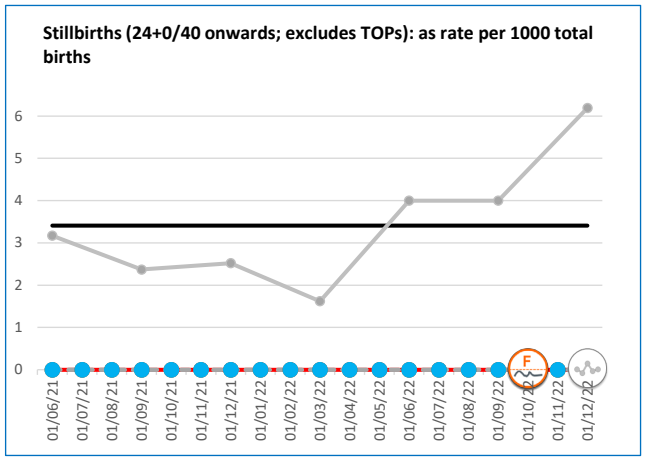




Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Timescales to address performance issue(s) and identification of any gaps in assurance	Risk Register score	Data quality rating
In January the number of **Inductions of labour from iView** increased to 152. Performance exhibited special cause variation due to successive periods of performance (>6 months) above the mean of 144.	The IOL's are reviewed at the safety huddle each morning and prioritised. The maternity team will continue to monitor the inductions of labour (IOL). Work in progress on the IOL pathway.			
In January the percentage of **Emergency C-Sections** was 21%. Performance exhibited special cause variation due to the indicator being above the average of 19.9%.	The obstetric team will continue to monitor the emergency caesarean section (CS) rate. Business case being prepared for the business planning group to address the increase in CS rate.			
In January the percentage of **PPH 1.5L or greater, vaginal births as a percentage of mothers birthed** was 1.8%. Performance exhibited special cause variation due to successive periods of performance (>6 months) above the mean but in January the indicator met the mean of 1.8%.	There were 34 postpartum haemorrhages reviewed in January – 21 were graded as an A (no care issues identified; appropriate guidelines followed). There were 13 graded as a B - (care issues identified – did not impact the care or management). Improvements identified: to reinforce the importance of using PPH proformas and the documenting accurate time of medications given. Positive learning identified: evidence of measuring blood loss, timely major haemorrhage call.			

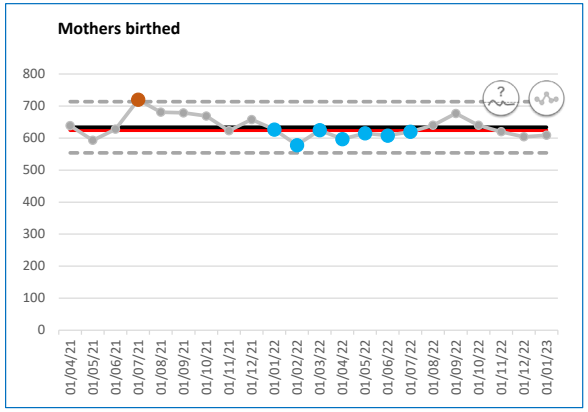
Maternity exception report (2)

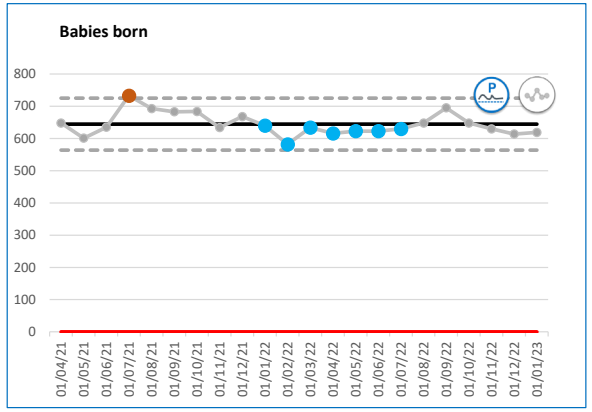


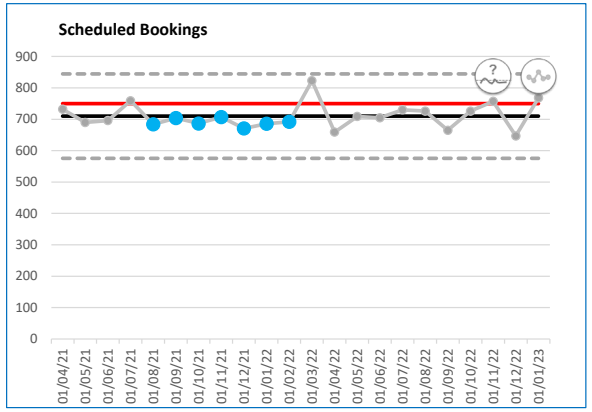


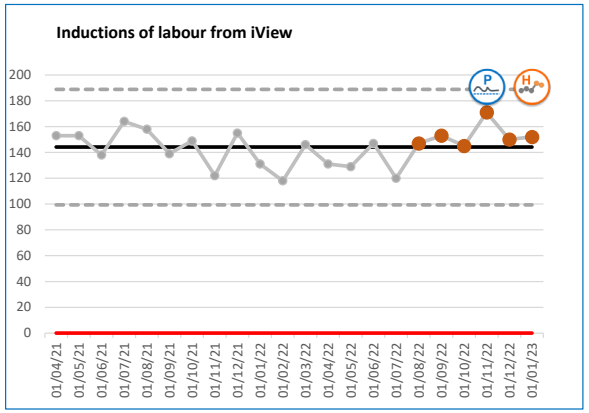
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Timescales to address performance issue(s) and identification of any gaps in assurance	Risk Register score	Data quality rating
In January 3 **Stillbirths** were reported. Performance exhibited special cause variation due to successive periods of performance (>6 months) above the mean of 2.	All stillbirths have an initial review by an obstetrician to see if there are any immediate care concerns. They are reported to MBRRACE using the perinatal mortality review tool (PMRT). All cases are reviewed by a multidisciplinary team using the PMRT.			
Stillbirths reported as a rate per 1000 total births exhibit common cause variation but are consistently failing the target of zero percent.				

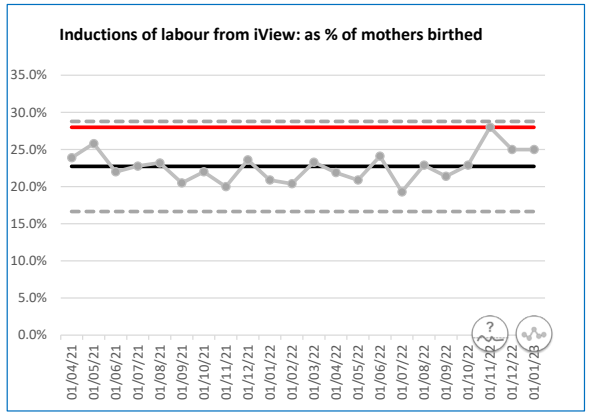
Appendix 1. SPC charts (1)

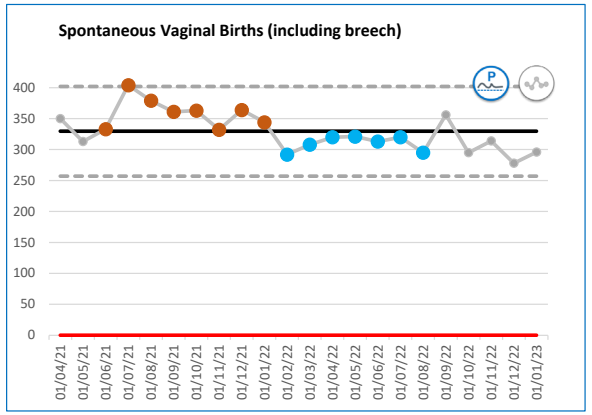


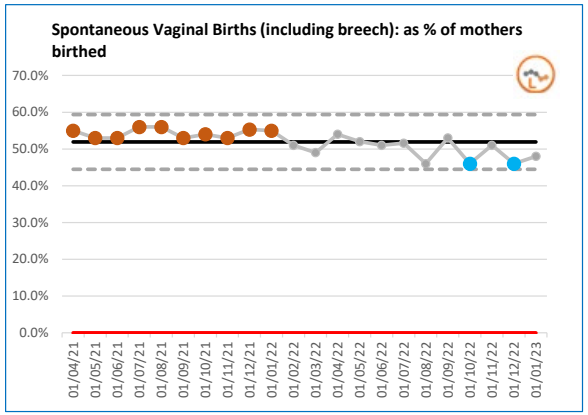


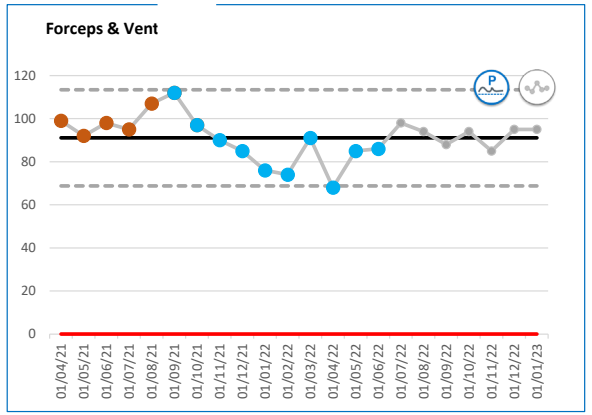


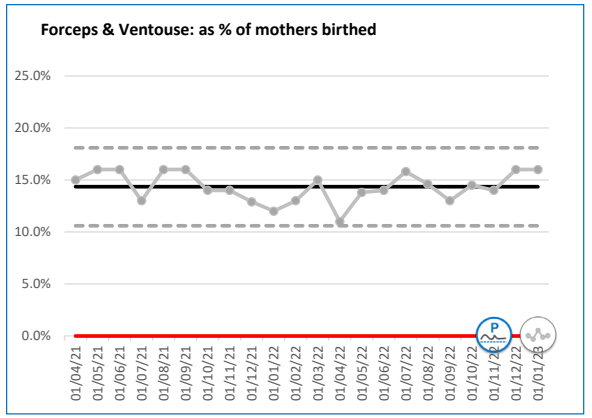




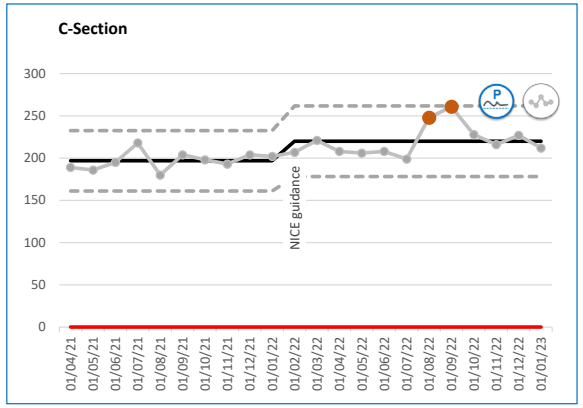


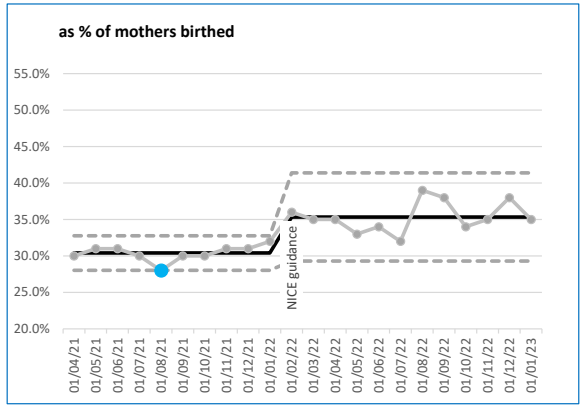


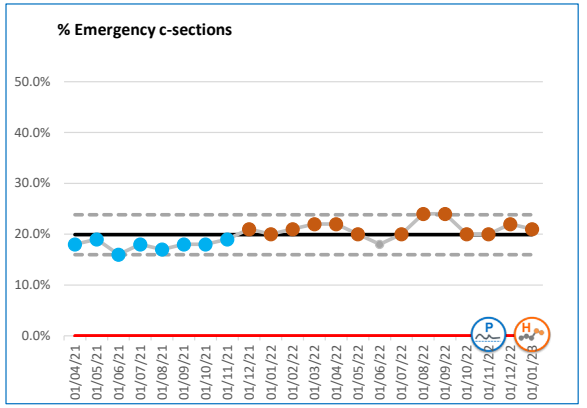


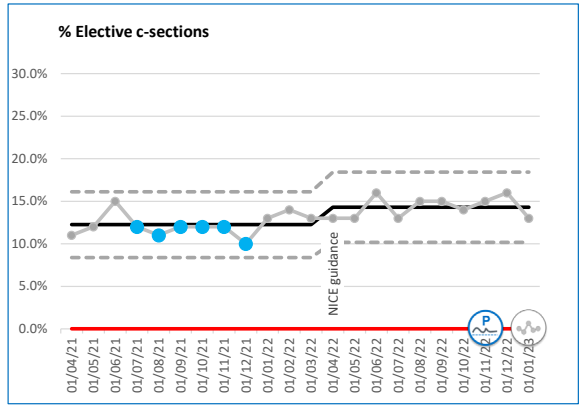


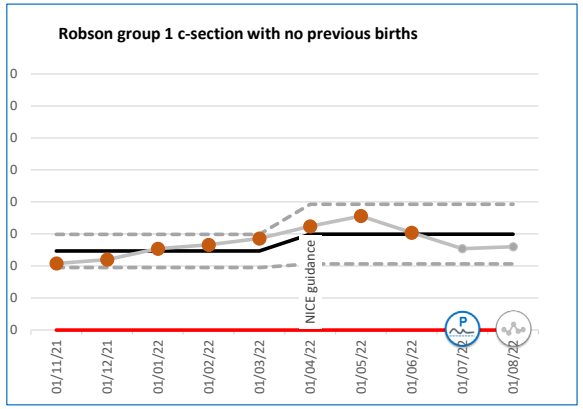
Appendix 1. SPC charts (2)

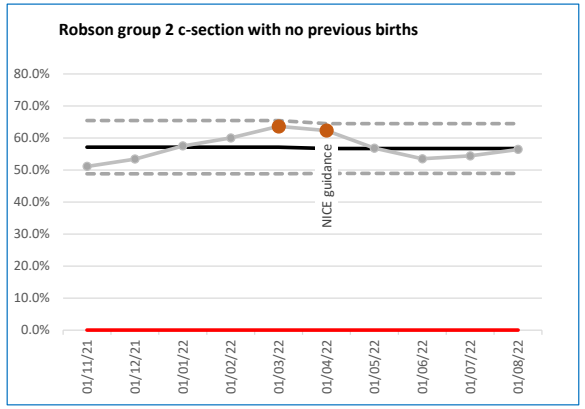


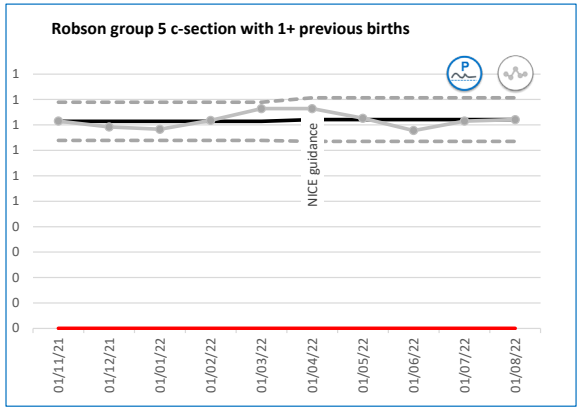


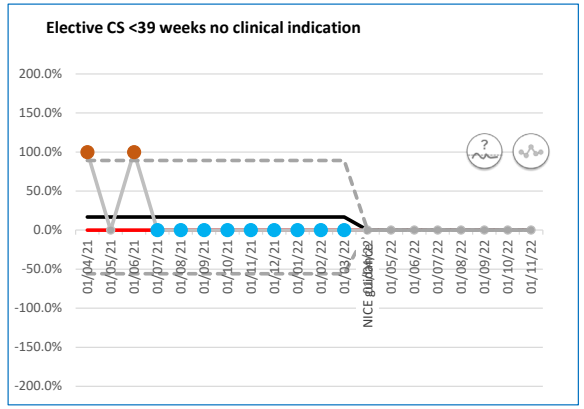


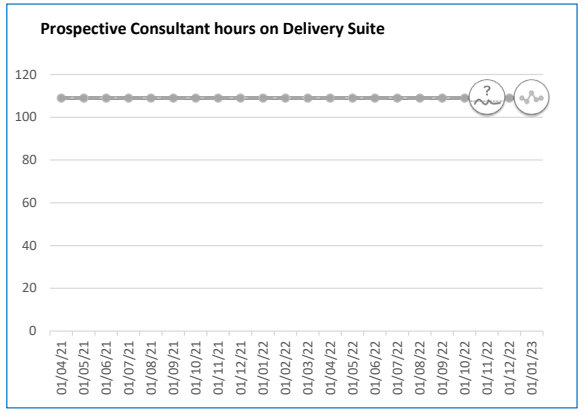


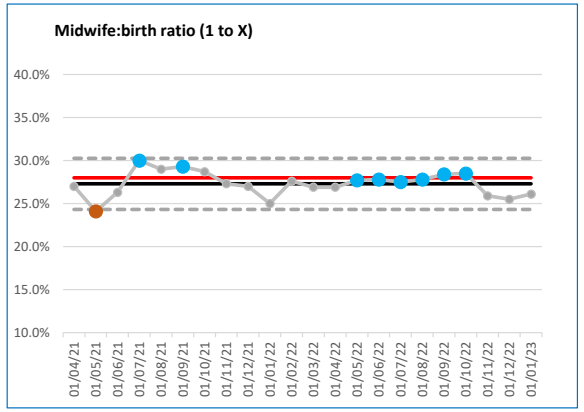




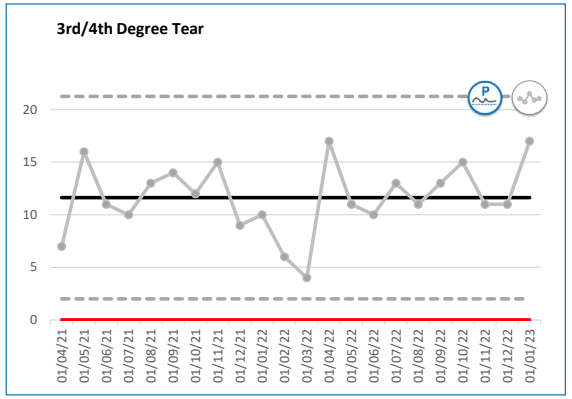


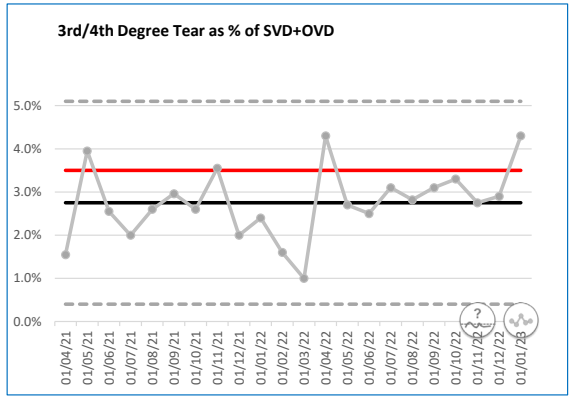


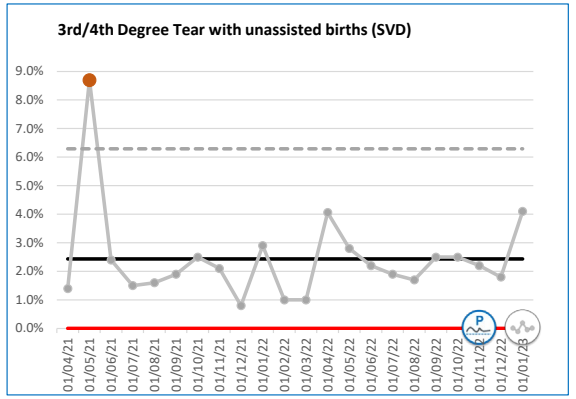


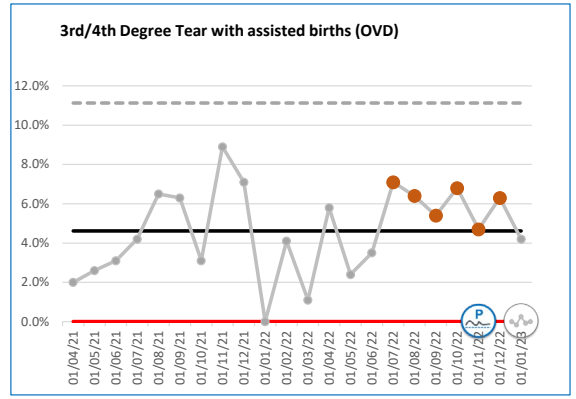


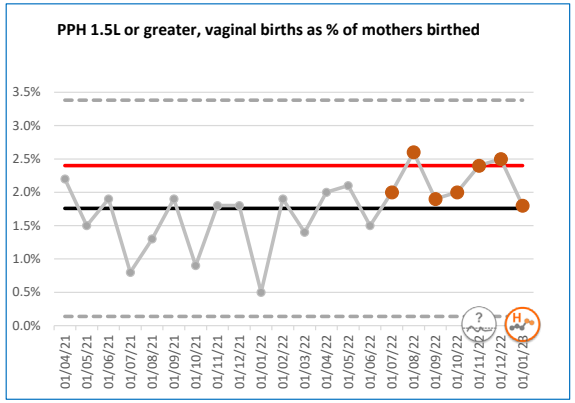
Appendix 1. SPC charts (3)

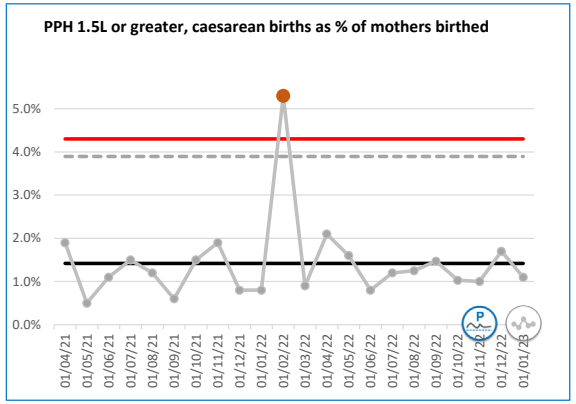


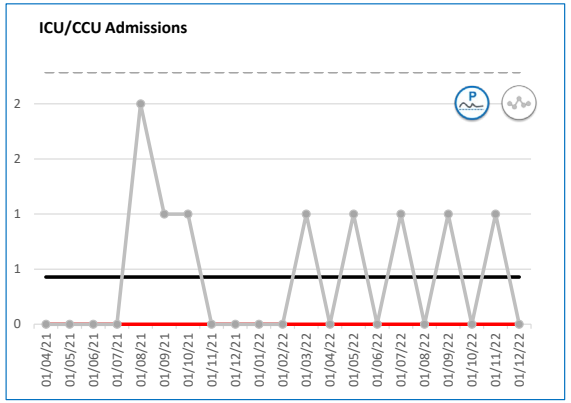


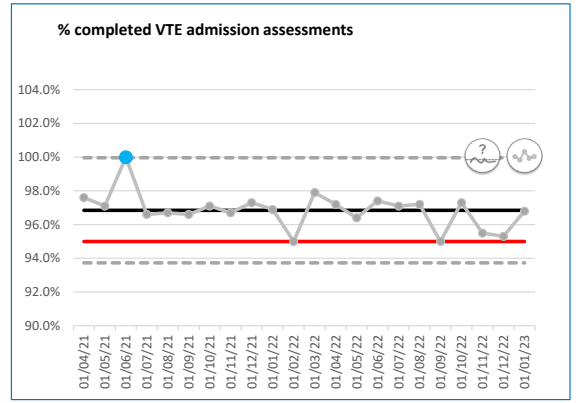




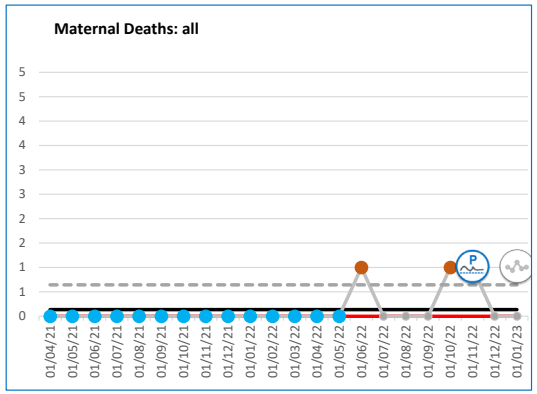


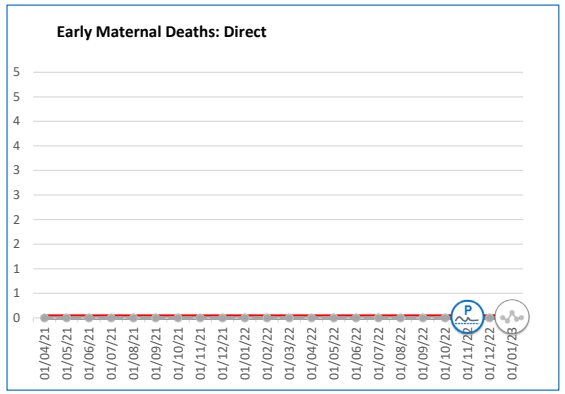


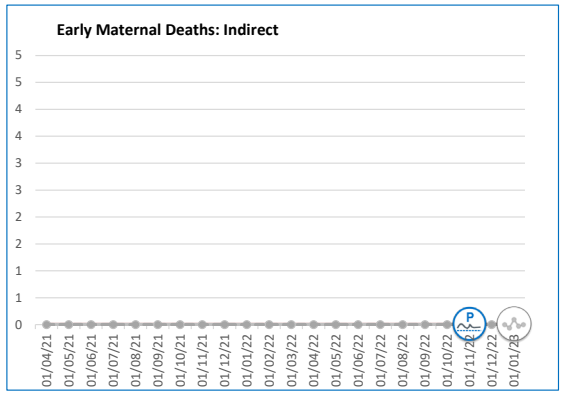


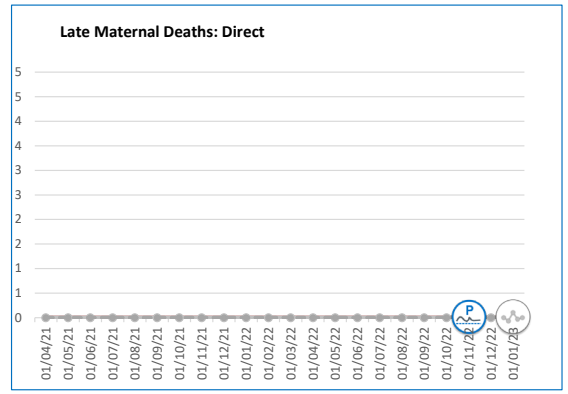


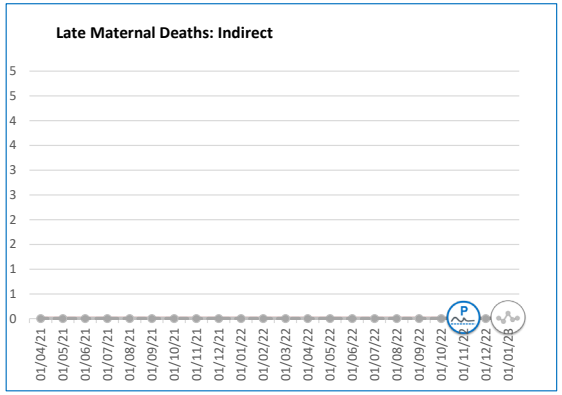
Appendix 1. SPC charts (4)

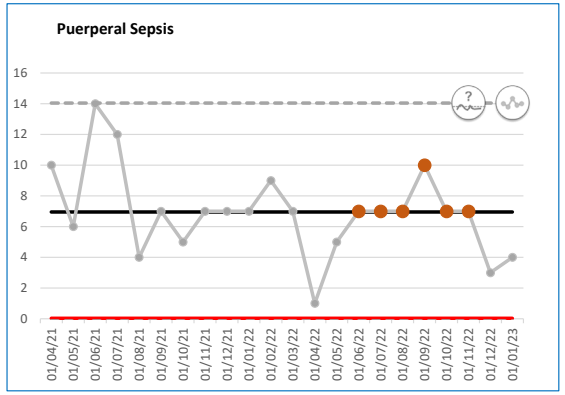


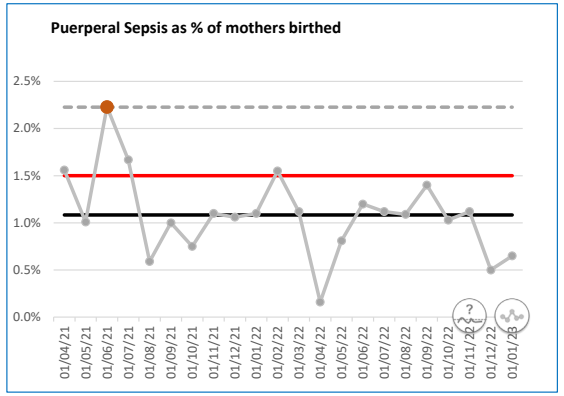


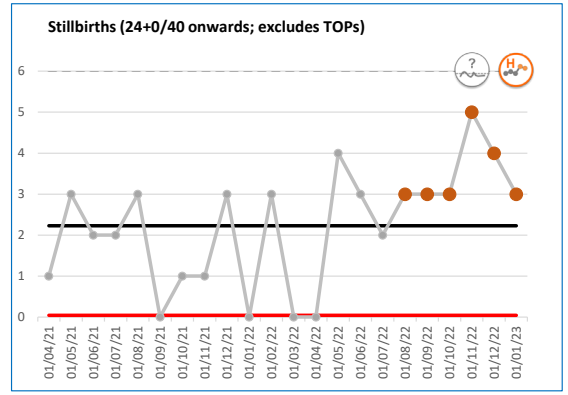


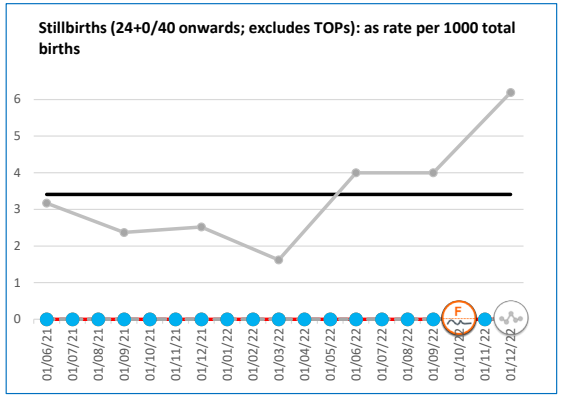


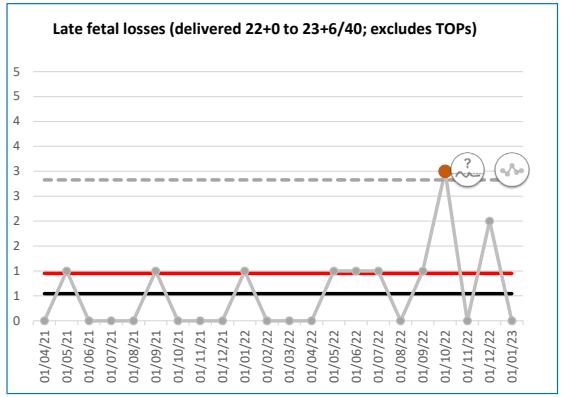




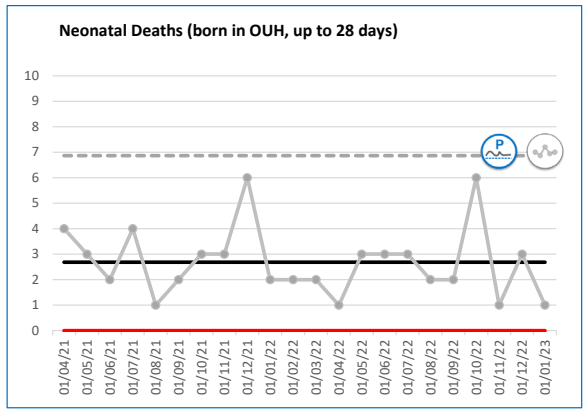


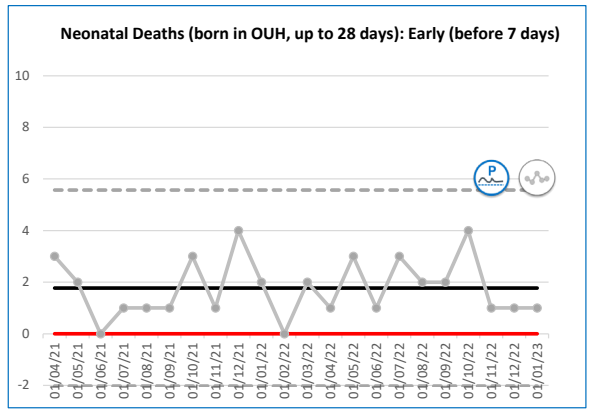


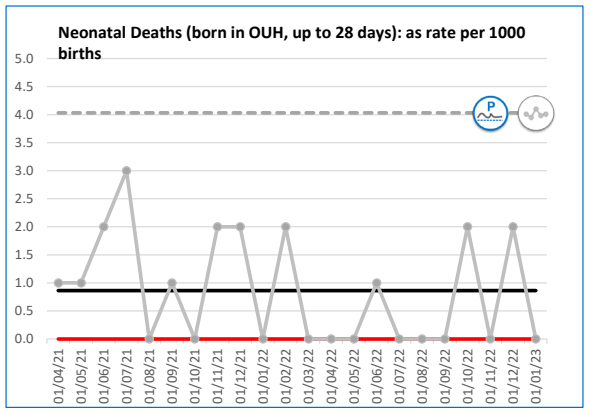


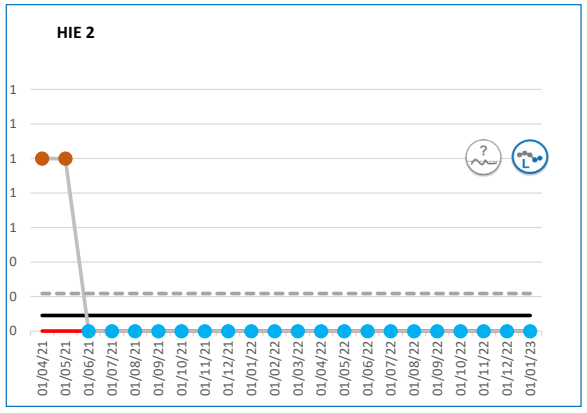


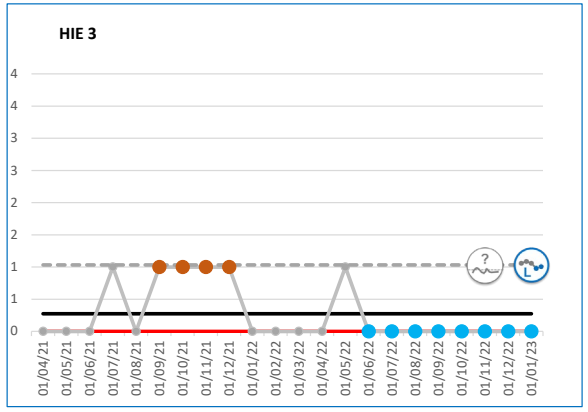
Appendix 1. SPC charts (5)

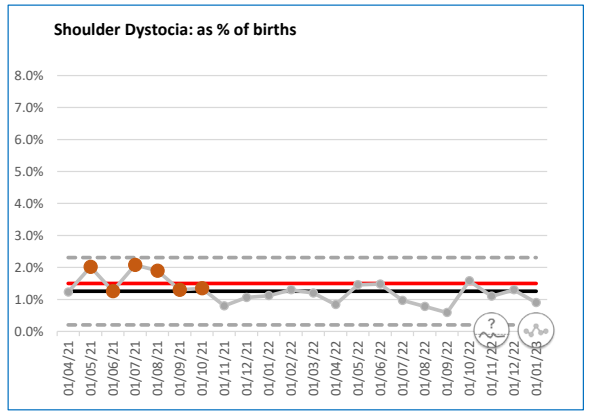


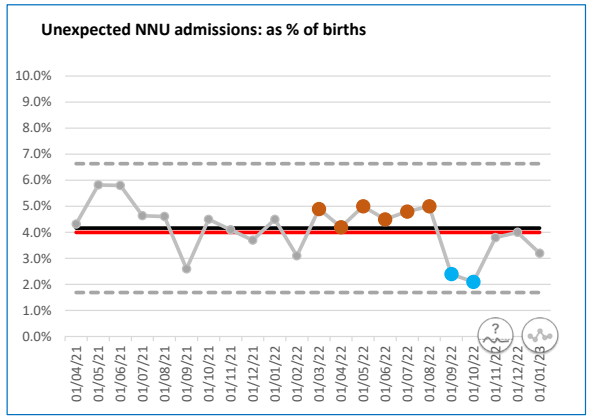


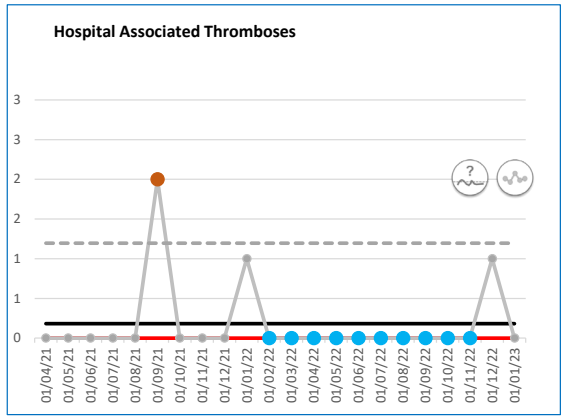


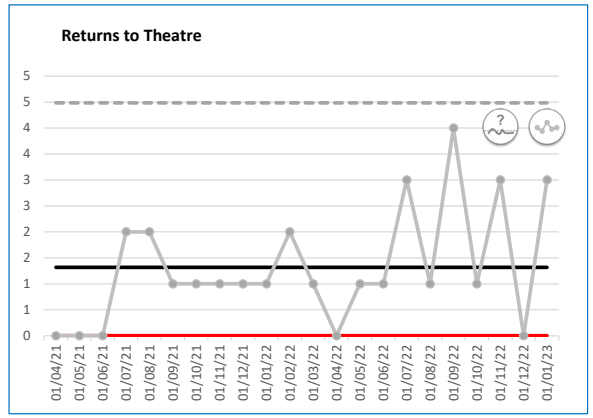


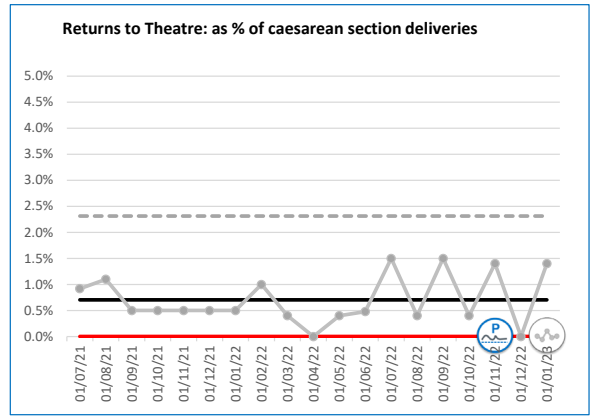












Appendix 1. SPC charts (6)