Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Trust Board Meeting in Public: Wednesday 13 September 2023

TB2023.92

Title:	**Maternity Service Update Report**

Status:	**For Discussion**
History:	**Regular report.**
	Maternity Clinical Governance Committee (MCGC) 21/08/2023.
	Previous paper presented to Trust Board July 2023

Board Lead:	**Chief Nursing Officer**
Author:	**Milica Redfearn – Acting Director of Midwifery**
	Niamh Kelly- Maternity Safety, Risk and Compliance Lead
	Susan Thomson – Maternity Clinical Governance Lead

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
    - NHS Resolutions Response
    - Maternity Incentive Scheme Year 5
    - Maternity Safety Support Programme (MSSP)
    - Three-year delivery plan for maternity and neonatal services
    - CQC enquiry for lone working for Maternity Support Workers at Wallingford Midwifery Led Unit
    - Obstetric Anal Sphincter Injury (OASI)
    - MBRRACE – UK Perinatal Mortality Report: 2021 Data

Recommendations

2. 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

- 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 performance dashboard
    - Perinatal Quality Surveillance Model Report
    - CQC inspection action plan update
    - Maternity Development Programme
    - NHS Resolutions Response
    - Maternity Incentive Scheme (MIS) Year 5
    - Maternity Safety Support Programme (MSSP)
    - Three-year single delivery plan for maternity and neonatal services
    - CQC outlier for Midwifery Led Unit
    - Obstetric Anal Sphincter Injury (OASI)
    - MBRRACE – UK Perinatal Mortality Report: 2021 Data

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

2. Ockenden Assurance visit

- The Ockenden Assurance insight visit took place on the 10 June 2022 and the Trust received the final report with associated recommendations.
- The action plan is being monitored through the Maternity Clinical Governance Committee (MCGC) and then upward through existing governance processes. In relation to the specific immediate and essential actions (IEAs), please note the outstanding actions are:

    - IEA 7 – Informed Consent. Work continues on the CQC Maternity Survey Action Plan that was co-produced with the MNVP and approved at the Maternity Clinical Governance Committee (MCGC) on the 26 June 2023. The action plan has been added to the "Action Planning" section on Ulysses to monitor progress with the actions. This action plan will also be shared with the BOB LMNS as part of Safety Action 7 of the Maternity Incentive Scheme following ratification at MCGC. Work continues on updating the Trust website to ensure pathways of care are clearly described, with written information in formats consistent with NHS policy. An update is provided at the Maternity Clinical Governance Committee monthly on version 3 of the action plan.

- Strengthening Midwifery Leadership – Director of Midwifery post out to advert. Once recruited into, this will support the stabilisation of the senior midwifery leadership team. The secondment of the Midwifery senior leadership team has been extended to the 30 November 2023 to support continued stability for the Maternity service. There is ongoing recruitment to vacant posts. All aspiring Band 7 midwives and above have been offered leadership programmes which consist of the iCare leadership course and the Florence Nightingale course.

3. Midwifery Led Unit (MLU) status

- Since the last report to the Trust Board in July 2023, intrapartum care has continued to be provided alongside a wide range of services to women and their families across the county.
- Community births were suspended on three occasions in June and on one occasion in July due to acuity. There were two women in June and one in July who did not receive their preferred choice of place of birth. There were no women affected by the closures and intrapartum care. The Horton Midwifery Led Unit (MLU) was closed on 1 occasion in June overnight and no women were affected.

4. Maternity Performance Dashboard

- The maternity performance dashboard may be seen in Appendix 1 and the exceptions to note are:
- Exception 1 – The number of Mothers birthed exhibited special cause variation due to being nine consecutive points below the average. However, numbers have risen for three consecutive months and are now above the target of 625.
- Exception 2 - The number of babies born exhibited special cause variation due to being below the mean of 638, although there has been on an upward trend for more than six consecutive months.
- Exception 3 – Inductions of labour totalled 23.8%. The indicator exhibited special cause variation as it has remained above the mean for over eight consecutive months. However, the indicator remains below the threshold of 28% and is currently showing a downward trend.
- ICU/CCU Admissions totalled 2 in July. The indicators exhibited special cause variation and remain above the mean but below the upper process limit.
- Exception 5 - There was one Maternal Death reported in July.
- Exception 6 - In July Test Result Endorsement was 80.3%. The indicator exhibited special cause variation following nine continuous months above the mean of 73.2%. In June the indicator did not meet the target of 85%

- Exception 7 - In July there was a reduction in the percentage of women initiating Breast Feeding to 69%. The indicator exhibits special cause variation and has breached the lower process control of 70.7%.
- Actions being taken towards mitigating these exceptions where appropriate can be seen in Appendix 1 below.

5. Perinatal Quality Surveillance Model Report

- 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.
- The Perinatal Quality Surveillance Model (PQSM) report for June and July data 2023 is being received by the Trust Board at its private meeting on 13 September 2023, having been previously reported to Maternity Clinical Governance Committee in August 2023 and it is a standing agenda item at the Maternity Safety Champions meetings.

6. CQC Inspection and Action Plan Update

- Since the last report to the Trust Board there are two actions remain overdue related to Estates, the updates for which can be seen on the table below.
- Maternity have received confirmation from the Trusts CQC inspector that the OUH maternity service will be reviewed as part of the current CQC maternity review.

Should Do	Actions	Update
11	11.1 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 (all known risks to be reflected in the relevant risk registers)	**Overdue:** Estates plan is part of maternity development programme. There is currently no significant capital investment available to progress this for the foreseeable future.
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,	**Overdue:** Business case has been submitted to the Capital Management Group (09/08/2023). Total cost is circa £200K. Circa £22k to be funded via charitable funds. Remaining to be funded via capital. Awaiting decision.

Should Do	Actions	Update
	optimising the rebirth environment for women and their families.	

- 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.
- The following areas from the previous action plans have been identified as areas that require strengthening:

- Matrons walkarounds as part of the process to ensure the prevention and detection of the spread of infection in all areas including Maternity. These previously were reported through the MyAssurance app but are currently undertaken via a QR code in Microsoft Teams and reported through MCGC monthly until the facility is available through Ulysses.
- Ensure new starters undertake the PGD competency to maintain compliance levels of >90%
- The Maternity Safety display boards are now in place in Maternity and are updated by the area managers (Appendix 2).

7. Maternity Development Programme (MDP)

- Work continues on each of the workstreams in the MDP.
- There is a MDP celebration planned for October 2023 to demonstrate what has been achieved over the past year and to look at what the service plan to achieve over the next 12 months.

8. NHS Resolution Response

- The outstanding actions from the NHS Resolutions (NHSR) action plan have been added to Ulysses 'Action Planning' section.
- There are currently 12 actions to complete (9 for Maternity and 3 for neonates). They are all being progressed and on-track for completion by 31/12/2023.
- Progress is monitored through MCGC.

9. Maternity Incentive Scheme

- Year 5 of the Maternity Incentive Scheme was launched on the 31 May 2023, followed by a revised version on 1 July 2023 following challenge from some Trust's including OUHT regarding accuracy and reporting deadlines. A scoping exercise

has been undertaken to map the new requirements of the Scheme against what is already embedded from Year 4. The Trust is required to present the evidence towards compliance by 12.00hrs on 1 February 2024. This will require all final evidence to be presented to MCGC on 18 December 2023 and Trust Board on 17 January 2024.

- The ten Safety Actions are broadly similar to Year 4 of the Scheme, and it assumes a seamless continuation of delivery from Year 4 into Year 5. As part of Safety Action 6, a new reporting tool has been launched to map the evidence for the Saving Babies Lives Care Bundle Version 3 (SBLCBv3).
- It has been identified that in order to be compliant with the Scheme, business cases and funding will be required to meet the appropriate level of junior doctor cover within neonates (Safety Action 4) and in-house provision for smoking cessation (Safety Action 6, Element 1). These have been highlighted to the Trust Assurance Team who will oversee the progress of these areas of risk to compliance.
- OUHT are fully engaged with their colleagues both nationally and within the BOB LMNS to assess compliance with the Scheme. NHS England have been invited to scrutinise the evidence collated prior to the September Trust Board to ensure that OUHT remain on-track to declare full compliance again this year. All key stakeholders are fully engaged with the Scheme and fortnightly compliance meetings have been recommenced.
- The bonus payment for successfully passing Year 4 is still outstanding but this is expected by September 2023.
- An update on the ten Safety Actions forms Appendix 3 of this report.

10. Maternity Safety Support Programme (MSSP)

- 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.
- The MIA has undertaken a deep dive into clinical governance which ran over the period 26 April 2023 to 16 June 2023. A report outlining the key recommendations has been presented to MCGC and a meeting to prioritise these recommendations is planned for 08/09/2023.
- The behavioural framework was promoted during the introduction to each session.
- The Deep Dive was supported by the Quality Improvement Programme Manager from the Trust Transformation Team who produced the process maps.
- The sessions were attended by a variety of staff, across the MDT. The team were particularly grateful for the valuable input of the MVP and Neonatal Voices who joined the sessions.

- The overall recommendations were reported to MCGC on the 21 August 2023.

11. Three Year delivery plan for maternity and neonatal services

- The Three year delivery plan for maternity and neonatal services was published on the 30 March 2023 called the Single Delivery Plan. Work streams have commenced. There is a plan to use the "Action Planning" module on Ulysses to monitor the action plan:

Theme 1: Listening to women

- The Personalised Care and Support Plan (PSCP) has been developed in conjunction with the Berkshire, Oxfordshire and Buckinghamshire (BOB) Local Maternity and Neonatal System (LMNS) is due to be launched on the 15 September starting with the Lotus Team and Florence Park midwives and then it will move onto the other teams. When this is in place, it will be added to the audit action plan.
- The MNVP have worked with maternity staff to co-produce the action plan following the recent CQC Maternity Survey results. The action plan has been added to the "Action Planning" module on Ulysses. This will be added to the Safety Champions agenda for the September meeting and will be monitored monthly. This will be sent to the BOB LMNS for approval as part of Safety action 7 of the Maternity Incentive Scheme.
- A workstream has commenced related to achieving the standard of the UNICEF UK Baby Friendly Initiative (BFI) for infant feeding.

Theme 2 – Workforce

- A Birth Rate plus paper has been written which is being presented to the Business Planning group meeting in August 2023. This is following the latest analysis of the Birth Rate plus benchmarking tool in February 2023 which demonstrated that there is a need for an uplift in midwifery staffing of 22.38 wte.
- 1.0 WTE Equity, Diversity and Inclusion (EDI) Midwife from June 2023 working alongside Transformation midwife

  EDI annual Staff Survey
  NHS employee HEALTHCARE PASSPORT rolled out in the interim. To be replaced by 'Reasonable Adjustment Passport' next year once completed by Human Resources (HR).
  Creation of a staff focused EDI working group
  EDI champions being implemented in all areas of Maternity
  Equity teaching sessions on annual Oxford Maternity Update day (OXMUD).
- Diversity and Inclusion visual statements (everyone is welcome posters and Leadership pledges) have been displayed within Maternity.

  Active Bystander training package to be delivered to all staff in Maternity

Creation of a system for reporting and investigating concerns of racism and division of a clear pathway for Maternity

Theme 3 – Culture and Leadership

- Continue embedding and sustainability work from the Maternity Development Programme and future strategic direction of the maternity services. There is a celebration day planned for October 2023 to look back on the past year at what has been achieved and to look the team are planning on achieving over the next 12 months.
- Maternity services to look at introducing a clear and structured role for the escalation of clinical concerns based on the framework such as the Each Baby Counts: Learn & Support escalation toolkit.
- A meeting has been held to look at how the service triangulates the MNVP feedback, the feedback from the Friends and Family Test (FFT) and themes from complaints.
- All staff will have a mandatory requirement to attend Cultural Competency training the business case to support this was presented by the OUH Maternity service to the LMNS and were awarded the money. The LMNS are now keen to roll out this training to all providers within the BOB.

Theme 4 – Standards

- As previously mentioned in the paper in relation to the Maternity Incentive Scheme, one of the deliverables is to implement Saving Babies Lives Care Bundle version 3 by March 2024. This will be monitored through the NHS Futures platform.
- Training on the new digital system BadgerNet has commenced for staff with an implementation date of November 2023.

12. CQC enquiry related to Lone Working of Maternity Support Workers (MSW) at Wallingford Midwifery Led Unit

In June 2023 a complaint was received by OUHT in relation to a birth that had occurred at Wallingford Midwifery Led Unit without a midwife present, leaving the midwifery support worker (MSW) feeling vulnerable. This has been investigated and appropriate mitigation put in place. In July 2023, the CQC responded that they were satisfied with the mitigation and action plan, and the case has been closed.

13. Obstetric Anal Sphincter Injuries (OASI)

13.1 A review has been undertaken of 44 cases of women who had a 3rd or 4th degree tear perineal trauma that were reported via Ulysses from the 01 February to 30 April 2023.

13.2 This was presented at MCGC on the 21 August 2023 and will be reported at the Trust Clinical Improvement Committee (CIC) meeting in September.

13.2 The areas for focus and next steps that have been identified are:

- Antenatal education – ensure women are being given information at this stage. Work with the community midwifery (CMW) teams, development of new pelvic health service
- Work with urogynaecology colleagues re. education/training.

Second stage care focus – how can we facilitate warm compresses every time; role of second midwife in room; ensure good positioning and good communication whilst pushing.
Assessment of perineum re. use of episiotomy and education/ training and support for this.
Ensure documented debrief at time of event.

13.3 The majority of these measures have already been implemented (ongoing since March 2023) and a significant improvement is notable in the data. Work continues to ensure that good practice is embedded to sustain this improvement.

14. MBRRACE – UK Perinatal Mortality Report: Analysis of 5 year Data 2017 – 2022

Key Messages

All Deaths:

- Your stabilised & adjusted stillbirth rate is 4.09 per 1000 total births which has increased by 0.41 in 2020. This is within group average of similar Trusts & Health Boards.
- Your stabilised & adjusted neonatal mortality report is 2.57 per 1000 total births which has increased by 0.73 in 2020. This is within group average of similar Trusts & Health Boards.
- Your stabilised & adjusted extended perinatal mortality rate is 6.64 per 1000 total births this is within group average of similar Trusts & Health Boards.
- Care concerns graded C or D which may have or likely to have made a difference to the outcome are reducing.

Excluding deaths due to congenital anomalies

- Your stabilised & adjusted stillbirth rate excluding deaths due to congenital anomalies is 3.65 per 1,000 total births. This is within the average for similar Trusts & Health Boards

- Your stabilised & adjusted neonatal mortality rate excluding deaths due to congenital anomalies is 1.58 per 1,000 live births. This is more than 5% higher than group average of similar Trusts & Health Board.
- Your stabilised & adjusted extended perinatal mortality rate excluding deaths due to congenital anomalies is 5.25 per 1,000 total births. This is around the average for similar Trusts & Health Boards.

15. Recommendations

The Trust Board is asked to:

Receive and note the contents of the update report.

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

Appendix 1

Oxford University Hospitals
NHS Foundation Trust

Maternity Performance Dashboard

August 2023

Data period: July 2023

Presented at Public Trust Board

Author: Susan Thomson, Maternity Clinical Governance Lead

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Executive summary

Oxford University Hospitals NHS Foundation Trust

Notable Successes

- Maternity Support Worker Sue O'Sullivan was celebrated in a surprise presentation at the Horton Hospital. Sue was presented with a Reporting Excellence award by Professor Meghana Pandit, our Chief Executive Officer. Sue was nominated by a colleague as she was recognised as going above and beyond to care for vulnerable women at the antenatal clinic for asylum seekers.

- Maternity remains the area with the highest number of Excellence Reports in the Trust. 43 Excellence Reports were submitted in July 2023. The themes reported were compassionate care; going above and beyond; and teamworking. The area with the most Excellence Reports completed was Delivery Suite.

- The Maternity EPR Badgernet Project is well underway. A large number of clinical staff have already undertaken their training. Digital Drop-ins continue to be a great resource for staff to receive support around the upcoming change.

- Congratulations to the obstetric team who won First Prize at the RCOG World Congress for their 'Reducing Surgical Site Infections in Caesarean Section' Care Bundle. There was a great deal of competition for this prize so this to be commended.

- Since the Ulysses project for Maternity commenced in June 2023, the number of overdue Ulysses within the 2022-23 financial year has reduced from 1050 to 75. Midwife Sandra Oakes has taken on this project and led it with positivity and efficiency. A summary of thematic learning for each area is due to be presented to MCGC in September 2023. The themes from closing the outstanding 2021/2022 Ulysses are due to be presented to MCGC in August 2023.

- The ATAIN Quarter 1 meeting was held on the 31st July 2023. Most cases of neonatal admissions that were reviewed were graded as A/B (unavoidable). Only one admission was noted to have been avoidable. Learning from all admissions, has been fed back to the multidisciplinary team. The ATAIN Action Plan was approved by the attendees and it has been published in the monthly ATAIN report for compliance monitoring.

- The Maternity Safety Boards have gone up in all areas across Maternity and have been well received. The Perinatal Risk Co-ordinators are providing "Learning of the Week" messages to allow areas to update their boards on a regular basis to ensure maximum use.

- The Maternity Bulletin 'And Breathe' has been a resounding success and celebrates everything 'maternity' but is also one conduit for learning to be devolved across the Directorate.

Executive summary, continued

Oxford University Hospitals NHS Foundation Trust

Domain	Performance challenges, risks and interventions
Activity	In July there was a total of 626 mothers birthed. There were 726 scheduled booking undertaken. There was a 1.2% drop in the number of inductions of labour from iView as a % of mothers birthed compared to June data.
Workforce	Midwife: birth ratio was 1:28.58. The total actual establishment for July was 310.11 midwives, which is an increase of 3.73 from the June data. On average there were 37.52wte midwives unavailable to work due to maternity leave, sickness and career breaks. Delayed Inductions of Labour reached 7 on 3 occasions and 0 on 6 occasions. The Red flags for July were: staff moved between speciality areas = 49, supernumerary workers within the numbers = 38, administrative or support staff unavailable = 4, staff unable to take recommended meal breaks = 70, staff working over their scheduled finish time = 30. Delay of 2 hours or more between admission for induction and beginning of process= 25 days. Number of women delayed during IOL process = 96. Any occasion when 1 midwife is not able to provide continuous one to one care and support to a woman during established labour = 0, Delivery Suite coordinator not supernumerary = 0. Overall, there was an increase in the number of staff who missed both their break and finished late. Maternity declared Level 3 (Red) on five occasions.
Maternal Morbidity	The percentage of 3rd and 4th degree tears as a % of spontaneous/other vaginal delivery has fallen from 3.7% in June to 2.0% in July following successful intervention. There were 43 postpartum haemorrhages of >1.5litres reviewed using proformas on Ulysses. 32 were graded as an A - there were no care issues identified and 11 graded as a B – care issues identified but did not impact the care or management. There were 16 3rd and 4th degree tears reviewed – 8 graded as an A and 8 graded as a B. Both areas have been registered as QI projects and data collection to support is in progress.
Perinatal Morbidity and Mortality	There were six cases reviewed using the PMRT in July. 1 case was graded A, and 5 cases graded B. Overall, there has been very good standard of care, with few aspects of care needing improvement identified. There were 2 recurring issues identified: (1) There is no evidence in the notes that this mother was asked about domestic abuse at booking (3 cases out of 6) and (2) The mother booked late (2 out of 6). The impact of these issues have been reviewed and found not to have affected the mothers' care. There was an increase in the number of term admissions to SCBU – 4.6% in July, from 2.6% in June. There were 24x cases reviewed using the proformas on Ulysses. 16x of these were graded as an A and 7x were graded as a B, and 1x graded as a C. There were no D grades.
Re-admissions	There were 13 maternal postnatal readmissions in July. The reasons for these were PV bleed x3, Sepsis (including mastitis) x5, hypertension x4 and wound review (re-suturing) x1. There were two returns to theatre, one following an MOH resolved by removal of retained products under GA; and the second following a PPH which also required removal of retained products. Two women were admitted to ICU: One following a seizure postnatally, and second following an MOH from a cervical tear following a precipitous labour on DS.
Maternity Safety	There were 3 SIRI's declared in July, all of which are also HSIB referrals. One was a maternal death following her transfer from Great Western Hospital and subsequent terminal cancer diagnosis. Her baby also died. Two were cases of babies being cooled on the neonatal unit. There were 16 new complaints received in July which is the highest level recorded since the peak in August 2022. There were no clear themes identified but examples of issues raised were; delay in answering call bells on level 5; lack of communication in general, and specifically, lack of communication to women around the induction of labour process.
Test Endorsement	Test result endorsement was down to 80.9% in July, from 81.5% in June. As part of the quality improvement project an Endorsing Results checklist and Reference Index has been written and approved. This is a guide to help promote and assist staff in endorsing results contemporaneously in line with Trust safety incentives. This will be closely monitored for improvement.
Public Health	The percentage of women initiating breastfeeding has decreased to 69% which is a 7% fall from June. The infant feeding team will continue to monitor this through the Baby Friendly Initiative (BFI) Strategy working group which commenced in May 2023. One factor is that data is taken from only one field in EPR for this statistic. Work will be undertaken to examine the data collection and reporting.
Exception reports	The number of Mothers birthed exhibited special cause variation due to being nine consecutive points below the average. However, this has risen over the last three months and is now above the target. The related indicator of babies born has risen over the last six months but also remains below the mean. Induction of Labour (IOL) as % of mothers birthed is showing special cause variation due to being consistently above the mean for the past 8 months. ICU admissions showed exhibited special cause variation for being above the mean for the last six months. Maternal death exhibited special cause variation for being above the mean.

Indicator overview summary (SPC dashboard)

ER Exception report

KPI	Latest month	Measure	Target	Assurance	Varriation	Mean	Lower process limit	Upper process limit
Mothers birthed (ER)	Jul 23	626	625			627	556	699
Babies born (ER)	Jul 23	633	-			638	565	710
Scheduled Bookings	Jul 23	726	750			710	566	853
Inductions of labour from iView	Jul 23	149	-			147	106	188
Inductions of labour from iView: as % of mother (ER)	Jul 23	23.8%	28.0%			23.4%	17.8%	29.0%
Spontaneous Vaginal Births (including breech)	Jul 23	326	-			312	219	405
Spontaneous Vaginal Births (including breech): as %	Jul 23	52.0%	-			51.5%	44.1%	58.9%
Forceps & Ventouse	Jul 23	69	-			90	67	113
Forceps & Ventouse: as % of mothers birthed	Jul 23	11.0%	-			14.3%	10.5%	18.1%

KPI	Latest month	Measure	Target	Assurance	Varriation	Mean	Lower process limit	Upper process limit
C-Section	Jul 23	220	-			218	177	258
as % of mothers birthed	Jul 23	35.0%	-			35.3%	28.9%	41.7%
% Emergency c-sections	Jul 23	23.0%	-			20.0%	14.8%	25.3%
% Elective c-sections	Jul 23	12.0%	-			14.6%	10.2%	19.1%
Robson group 1 c-section with no previous births	Feb 23	15.5%	-			15.1%	11.7%	18.5%
Robson group 2 c-section with no previous births	Feb 23	57.0%	-			56.4%	48.4%	64.5%
Robson group 5 c-section with 1+ previous births	Feb 23	83.3%	-			84.3%	76.3%	92.3%
Elective CS <39 weeks no clinical indication	Jul 23	0.0%	0.0%			0.0%	0.0%	0.0%
Prospective Consultant hours on Delivery Suite	Jul 23	109	109			109	109	109
Midwife:birth ratio (1 to X)	Jul 23	28.6%	28.0%			27.3%	24.1%	30.4%

KPI	Latest month	Measure	Target	Assurance	Varriation	Mean	Lower process limit	Upper process limit
3rd/4th Degree Tear	Jul 23	8	-			12	0	24
3rd/4th Degree Tear as % of SVD+OVD	Jul 23	2.0%	3.5%			2.9%	0.1%	5.7%
3rd/4th Degree Tear with unassisted births (SVD)	Jul 23	2.2%	-			2.6%	-1.6%	6.7%
3rd/4th Degree Tear with assisted births (OVD)	Jul 23	1.4%	-			4.8%	-2.9%	12.4%
PPH 1.5L or greater, vaginal births as % of mothers bi	Jul 23	1.9%	2.4%			2.0%	0.1%	3.8%
PPH 1.5L or greater, caesarean births as % of mother	Jul 23	0.8%	4.3%			1.3%	-0.7%	3.4%
ICU/CCU Admissions (ER)	Jul 23	2	-			1	-1	2
% completed VTE admission assessments	Jul 23	98.1%	95.0%			97.0%	94.2%	99.9%

KPI	Latest month	Measure	Target	Assurance	Varriation	Mean	Lower process limit	Upper process limit
Maternal Deaths: all (ER)	Jul 23	1	-			0	0	1
Early Maternal Deaths: Direct	Jul 23	0	0			0	0	0
Early Maternal Deaths: Indirect (ER)	Jul 23	1	-			0	0	0
Late Maternal Deaths: Direct	Jul 23	0	-			0	0	0
Late Maternal Deaths: Indirect	Jul 23	0	-			0	0	0
Puerperal Sepsis	Jul 23	5	-			7	0	13
Puerperal Sepsis as % of mothers birthed	Jul 23	0.7%	1.5%			1.0%	0.0%	2.0%
Stillbirths (24+0/40 onwards; excludes TOPs)	Jul 23	4	0			2	-1	6
Stillbirths (24+0/40 onwards; excludes TOPs): as rate	Jun 23	4	4			4	#DIV/0!	#DIV/0!
Late fetal losses (delivered 22+0 to 23+6/40; exclude	Jul 23	0	1			1	-2	3

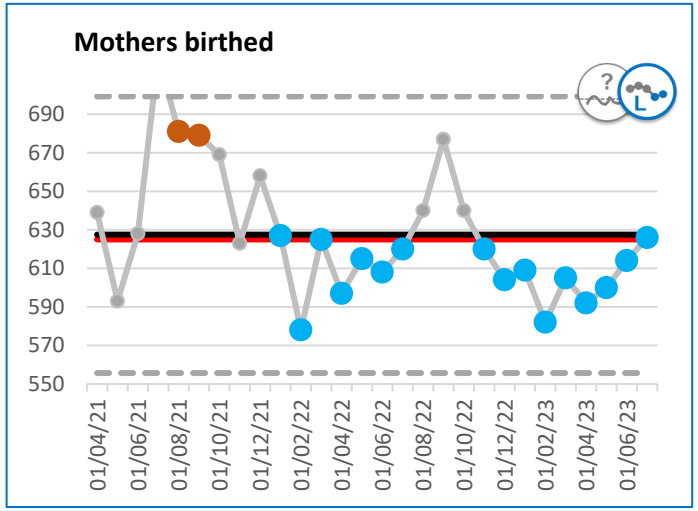
Indicator overview summary (SPC dashboard), *continued*

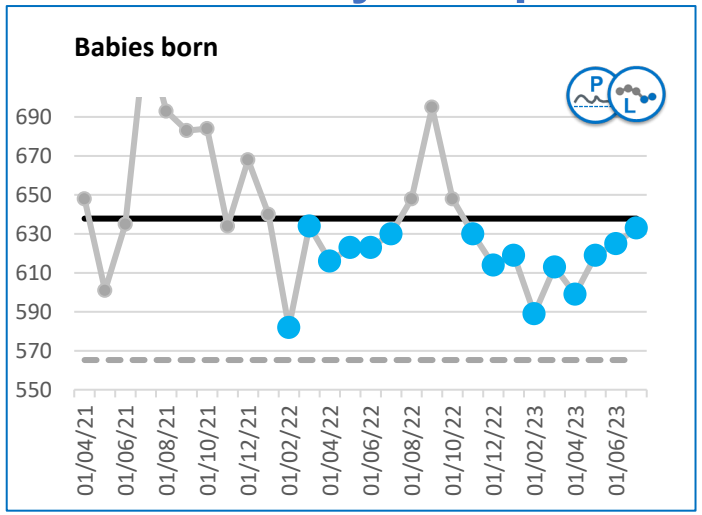
ER Exception report

KPI	Latest month	Measure	Target	Assurance	Varriation	Mean	Lower process limit	Upper process limit
Neonatal Deaths (born in OUH, up to 28 days)	Jul 23	3	0			3	-2	7
Neonatal Deaths (born in OUH, up to 28 days): Early (	Jul 23	2	0			2	-2	6
Neonatal Deaths (born in OUH, up to 28 days): as rate	Jul 23	0	3			1	-3	5
HIE 2	Jul 23	0	0			0	0	0
HIE 3	Jul 23	0	0			0	0	1
Shoulder Dystocia: as % of births	Jul 23	0.5%	1.5%			1.3%	0.2%	2.4%
Unexpected NNU admissions: as % of births	Jul 23	4.6%	4.0%			4.0%	1.2%	6.7%
Hospital Associated Thromboses	Jul 23	0	0			0	-1	1
Returns to Theatre	Jul 23	2	0			1	-2	5
Returns to Theatre: as % of caesarean section deliver	Jul 23	0.9%	-			0.8%	-0.9%	2.4%

KPI	Latest month	Measure	Target	Assurance	Varriation	Mean	Lower process limit	Upper process limit
Number of SIRI	Jul 23	3	0			1	-3	5
Number of Divisional Investigations	Jul 23	1	0			0	-1	1
Number of Complaints	Jul 23	16	0			8	-4	20
Born before arrival of midwife (BBA)	Jul 23	4	0			6	-3	16
Test Result Endorsement ER	Jul 23	80.3%	85.0%			73.4%	61.5%	85.4%
Number Of Women Booked This Month Who Current	Jul 23	44	0			54	32	76
Percentage Of Women Booked This Month Who Curr	Jul 23	7.0%	0.0%			7.7%	4.7%	10.6%
Number of Women Smoking at Delivery	Jul 23	25	0			36	21	51
Percentage of Women Smoking at Delivery	Jul 23	4.0%	8.0%			5.7%	3.2%	8.2%
Percentage of Women Initiating Breastfeeding ER	Jul 23	69.0%	80.0%			79.6%	70.7%	88.5%
Percentage of women booked by 10+0/40	Jul 23	71.9%	0.0%			69.6%	64.2%	75.0%

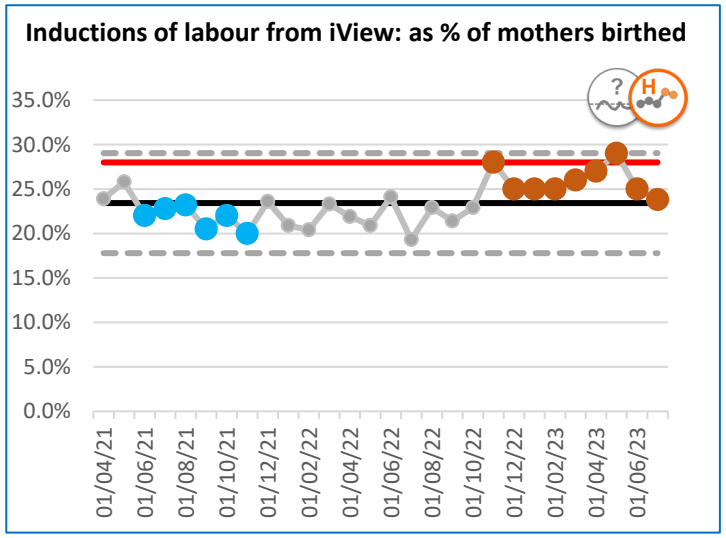
Maternity exception report (1)

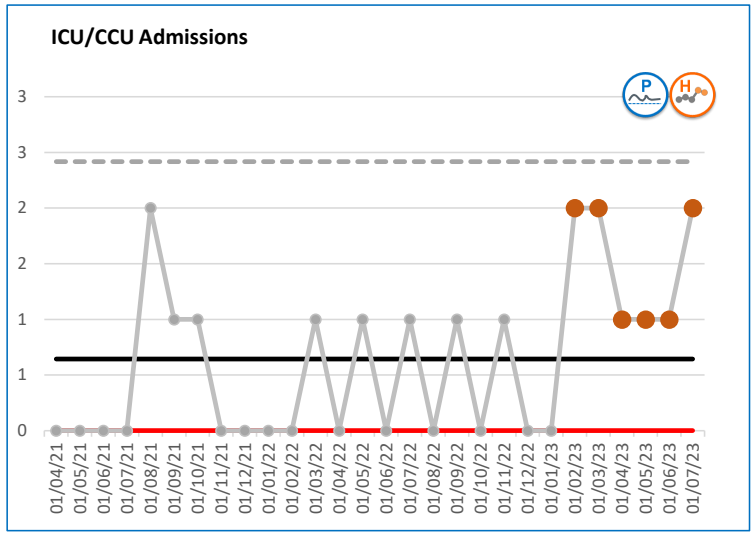




Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Timescales to address performance issue(s) and identification of any gaps in assurance	Risk Register score	Data quality rating
The number of Mothers birthed exhibited special cause variation due to nine consecutive points below the average. However, the number of Mothers birthed has seen a rise for three consecutive months and was above the target of 625. The related indicator of babies born also exhibited special cause variation with over six months' performance on an upward trend but remains below the mean of 638.	OUHT have seen a reduction in birthrate overall which is aligned to the national trend. However, for the last three consecutive months the service has seen an upward trend in the number of births. As previously noted, it is nationally recognised that factors such as the Covid pandemic and the current economic crisis have impacted whether people have brought forward or delayed increasing their families. Acuity remains high. The SVD rate is down, however, the induction of labour rate and caesarean section rate continues to rise. This upward trend in acuity continues to support the business case for the recommended uplift in Midwifery staffing.	A Birth Rate plus paper has been written which is being presented to the Business Planning group meeting in August 2023. This is following the latest analysis of the Birth Rate plus benchmarking tool in February 2023 which demonstrated that there is a need for an uplift in midwifery staffing of 22.38 wte.	BAF 4	Satisfactory *Standard operating procedures in place, training for staff completed and service weekly validation of data entry, but no Corporate or independent audit yet undertaken for fuller assurance*

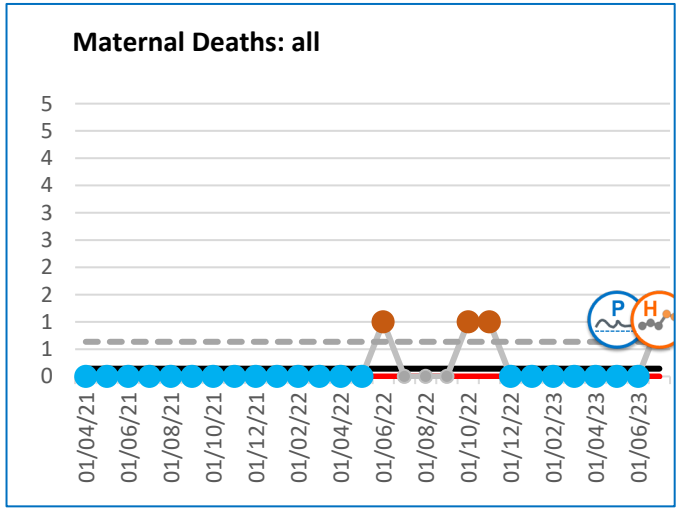
Maternity exception report (2)

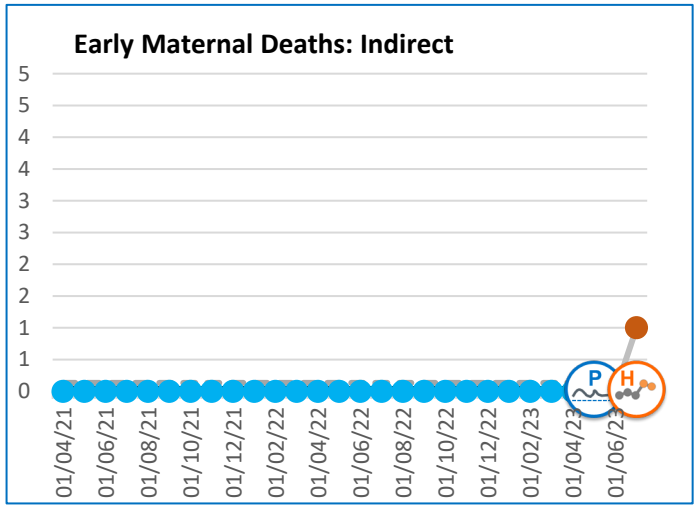




Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Timescales to address performance issue(s) and identification of any gaps in assurance	Risk Register score	Data quality rating
In July, Inductions of labour totalled 23.8%. The indicator exhibited special cause variation as it has remained above the mean for over eight consecutive months. However, the indicator remains below the threshold of 28% and is currently showing a downward trend.	This is an appropriate rate of induction and is not a safety issue. The IOL list is reviewed daily to appropriately prioritise women and birthing people on the IOL pathway to ensure safety is maintained. Work is continuing to ensure that delays in IOL are minimised.	Ongoing and monitored daily at the safety huddle on Delivery Suite	N/A	
ICU/CCU Admissions totalled 2 in July. The indicators exhibited special cause variation and remain above the mean but below the upper process limit.	There were two admissions to ICU in July 2023: Case 1: A woman experienced a heavy bleed following a precipitous birth on delivery suite. Following an EUA in theatre, bleeding was diagnosed to be coming from cervical trauma. There were little surgical options due to the nature of the bleeding, so priority was to continue correction of coagulopathy and reassess. Overall, management was appropriate, and the excellent multidisciplinary working is evident. Case 2: A woman experienced a seizure following the delivery of her baby by caesarean section. No cause has been found for the fit, the woman has been referred to the neurology team.	No care concerns identified. No care concerns identified.	20	

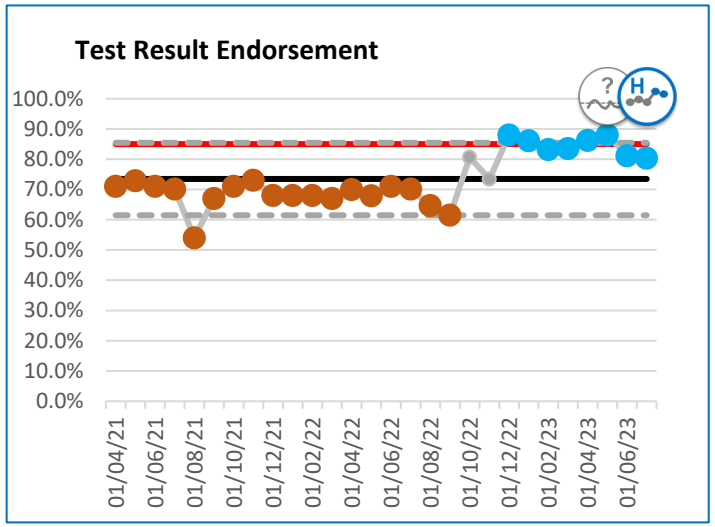
Maternity exception report (3)

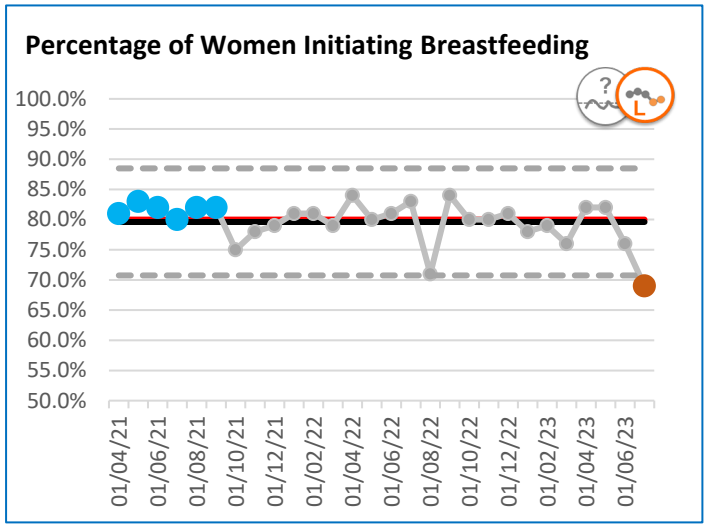




Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Timescales to address performance issue(s) and identification of any gaps in assurance	Risk Register score	Data quality rating
There was one Maternal Death reported in July.	There was one maternal death in July 2023. The woman was transferred in at 25 + 3 weeks gestation. To ensure anonymity, further detail can be found in the Confidential Trust Board papers. Follow up: An After Action Review took place together with the transferring hospital. Staff were supported by Professional Midwifery Advocates.	No care concerns were identified.		

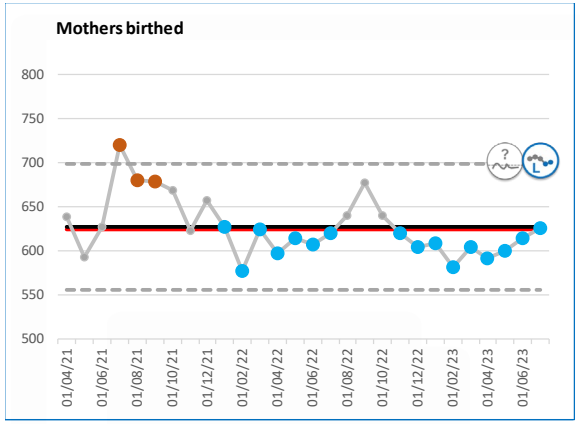
Maternity exception report (4)

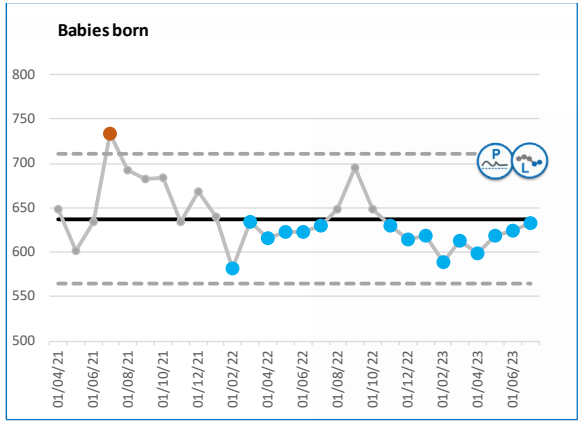


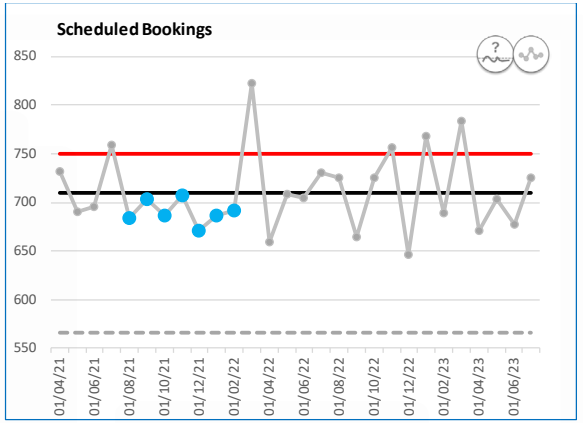


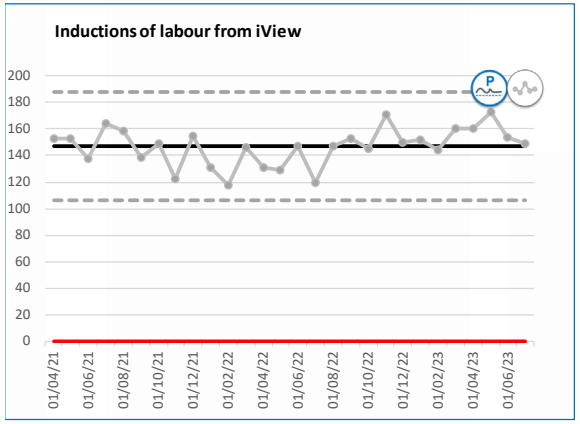
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Timescales to address performance issue(s) and identification of any gaps in assurance	Risk Register score	Data quality rating
In July Test Result Endorsement was 80.3%. The indicator exhibited special cause variation following nine continuous months above the mean of 73.2%. In June the indicator did not meet the target of 85%	As part of the quality improvement project an Endorsing Results checklist and Reference Index has been written and approved. This is a guide to help promote and assist staff in endorsing results contemporaneously in line with Trust safety incentives. This was highlighted at MCGC in July 2023 and has been reinforced at the Maternity Senior Leadership team meeting. It is also an improvement message for the Maternity Safety boards on all areas including community.	December 2023	BAF 4	*Not yet assured*
In July there was a reduction in the percentage of women initiating Breast Feeding to 69%. The indicator exhibits special cause variation and has breached the lower process control of 70.7%.	There has been a 7% fall this month in women initiating breastfeeding. Work is ongoing with the Infant Feeding Team running daily 'Early Days Information Sessions' (EDIS) which cover feeding. Antenatal education is covered by the National Childbirth Trust. It has been confirmed that the obstetric nurses receive training at the same level as Maternity Support Workers. It has been noted that the percentage is higher each month in the maternity infographic published in the maternity bulletin and on Facebook by OMNVP. This is because, whilst the data source is the same, and additional field of 'breastfeeding at discharge' is included in the figures where it is missing in the 'breastfeeding initiation at birth' field. This is only where the information states 'exclusive breastfeeding'. These fields are not mandatory on EPR but will be when Badgernet is launched in November 2023, leading to more accurate data.	Badgernet launch in November 2023	BAF 4	*Not yet assured*

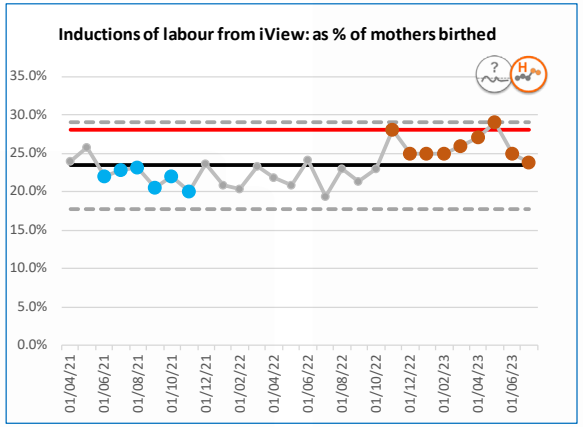
Appendix 1. SPC charts (1)

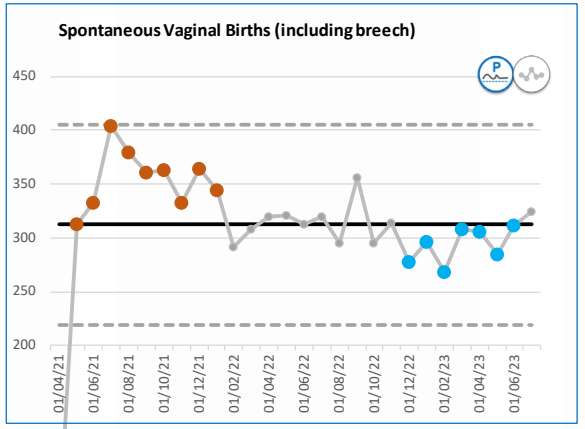


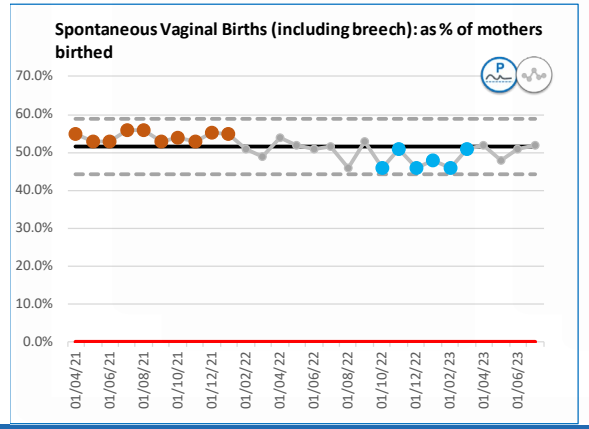


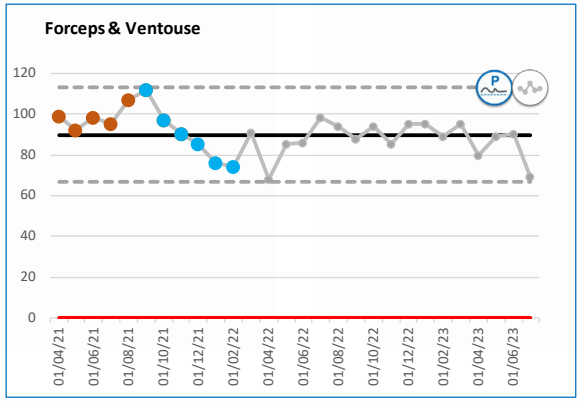


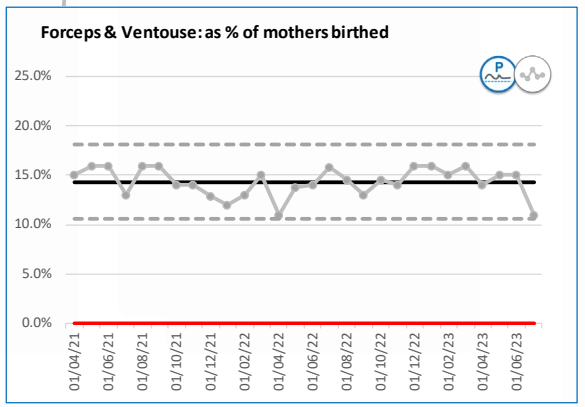




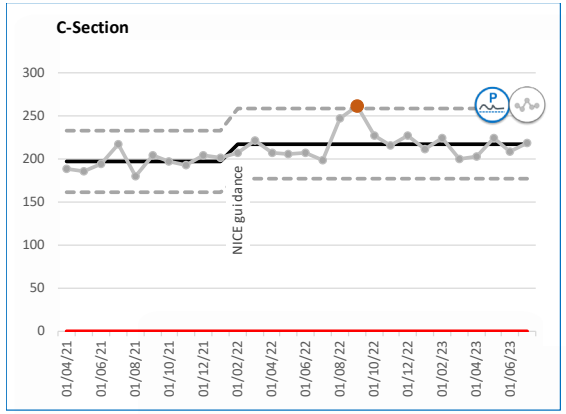


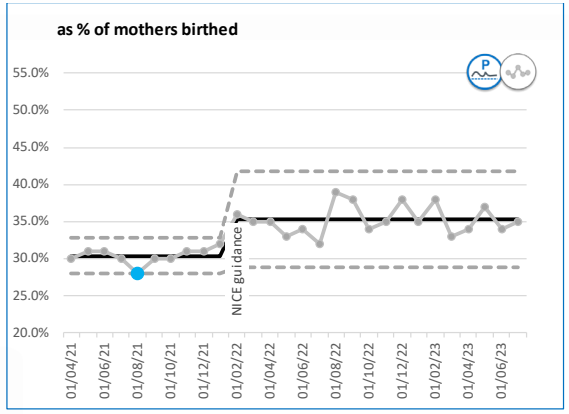


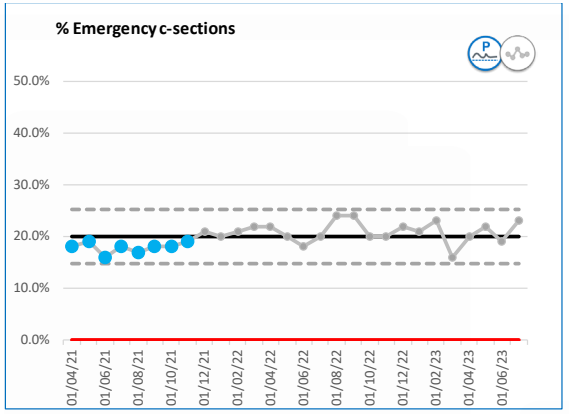


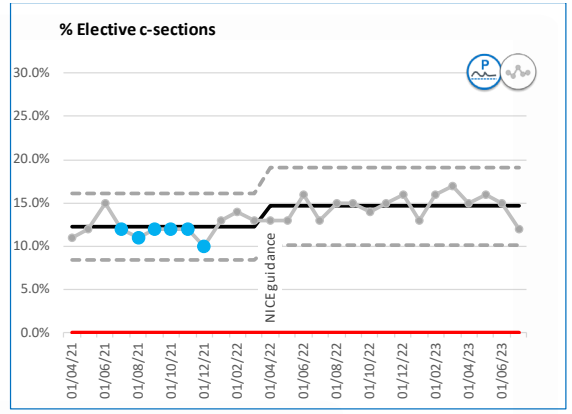


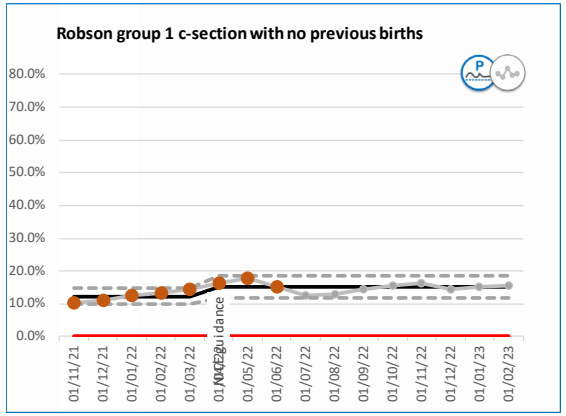
Appendix 1. SPC charts (2)

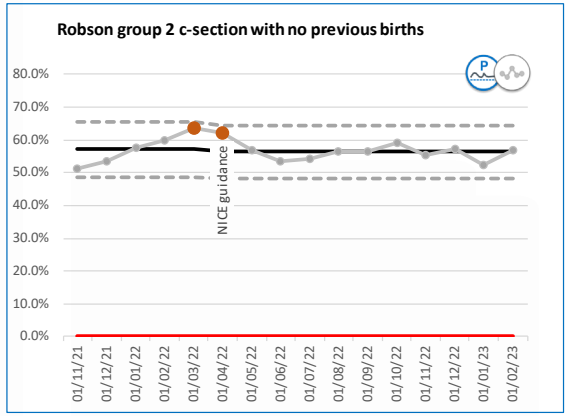


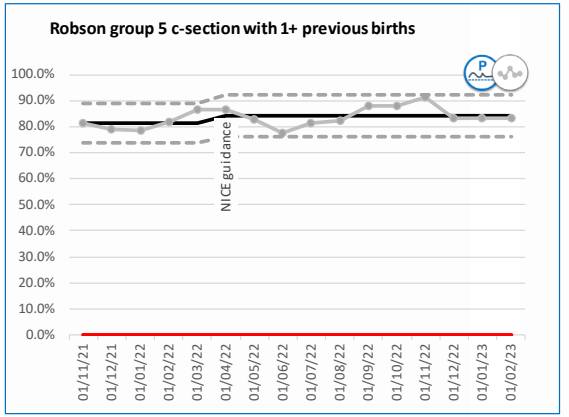


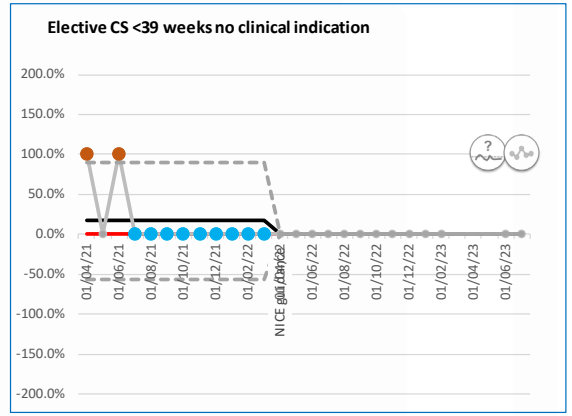


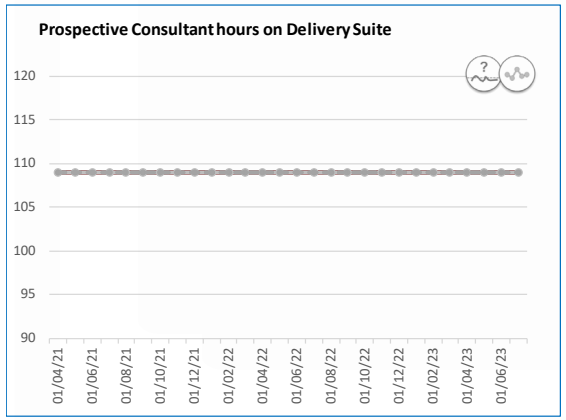


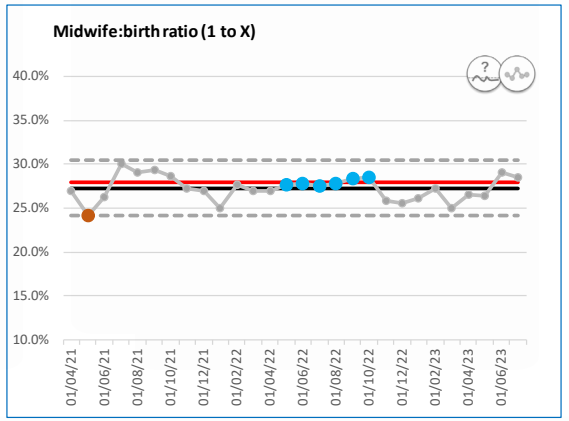




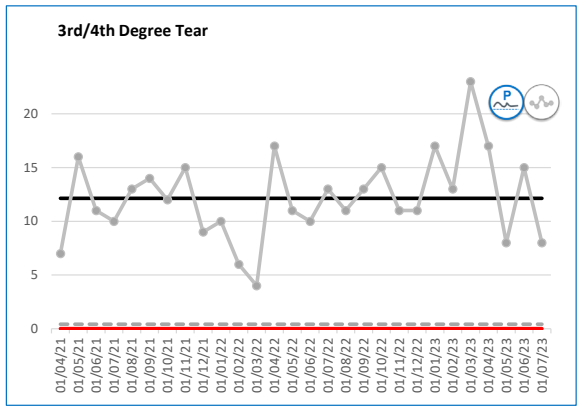


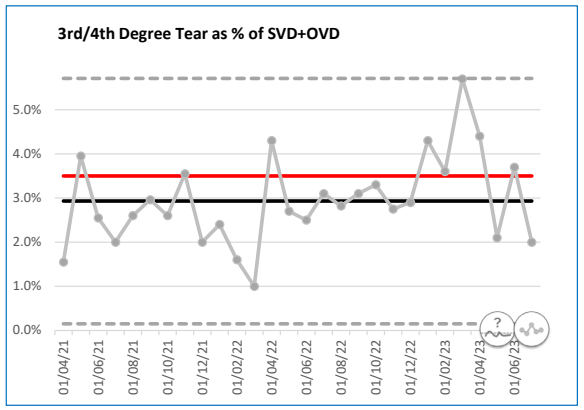


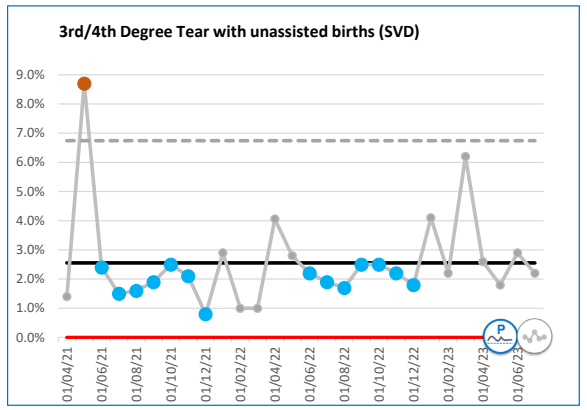


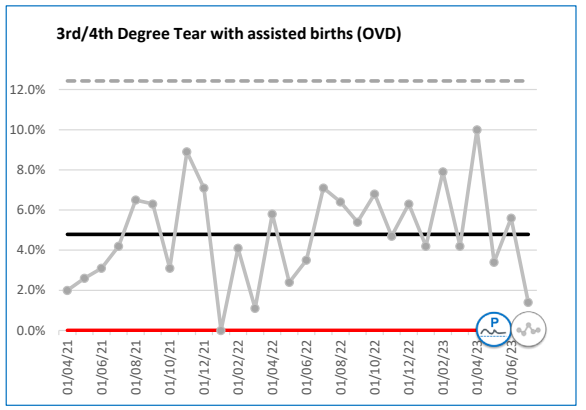


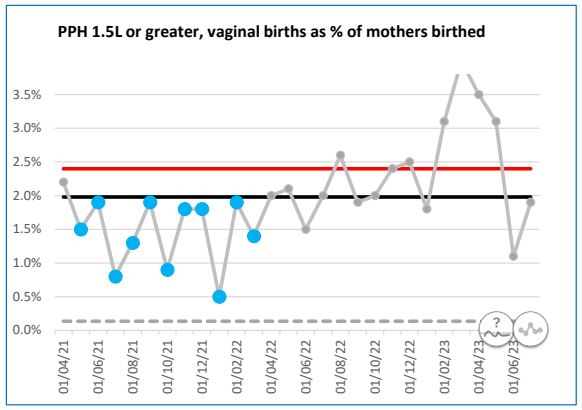
Appendix 1. SPC charts (3)

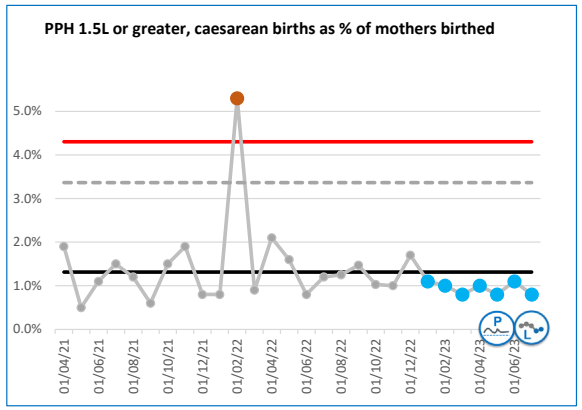


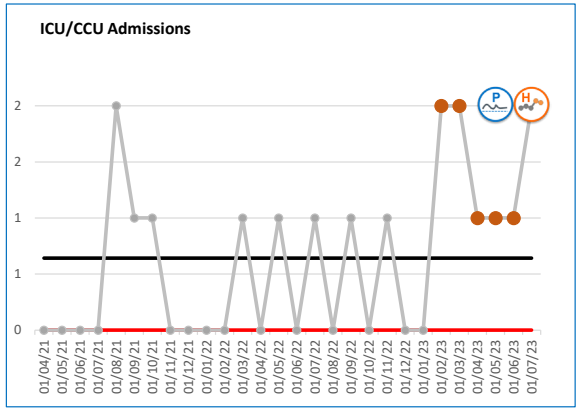


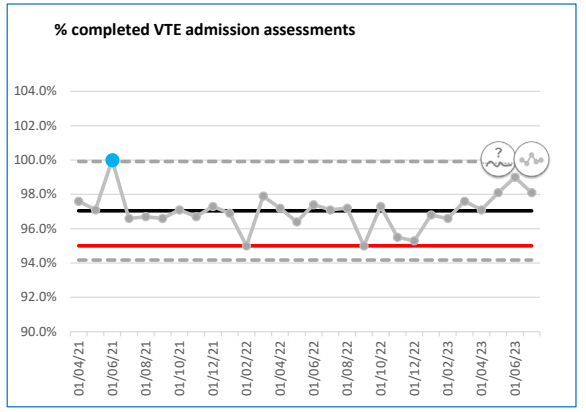




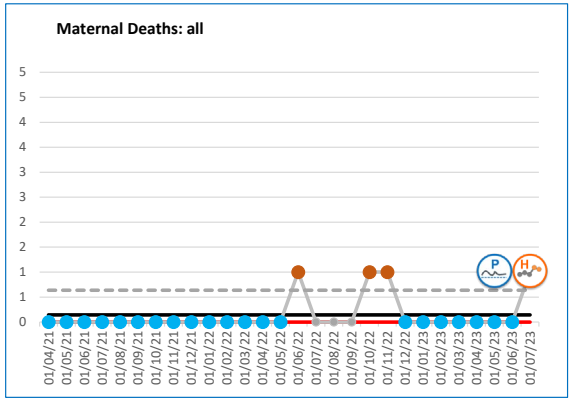


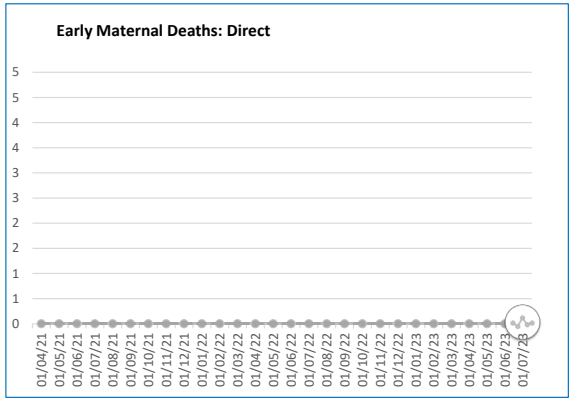


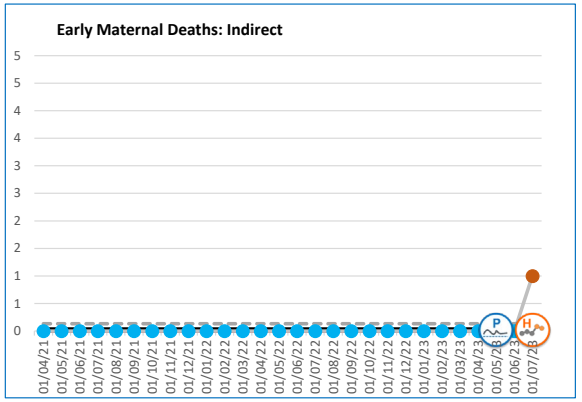


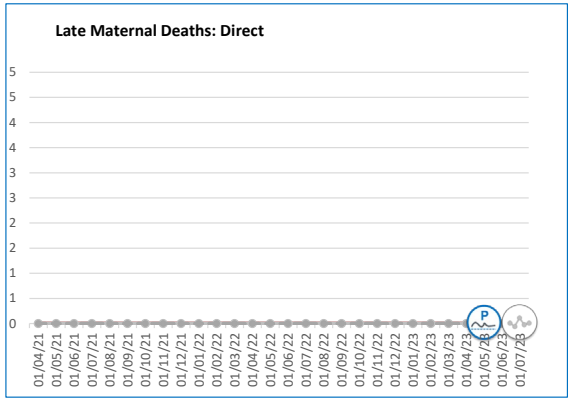


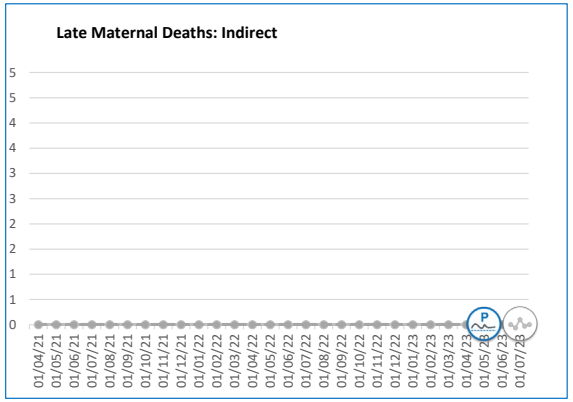
Appendix 1. SPC charts (4)

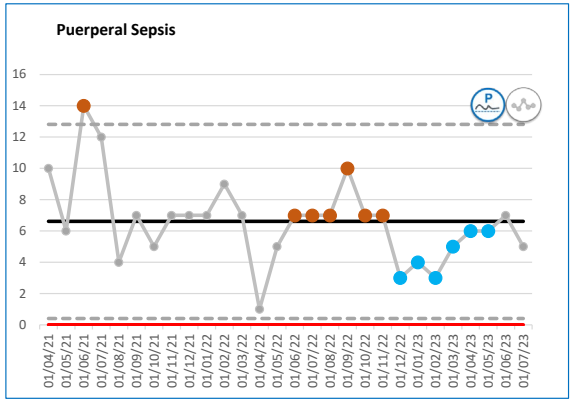


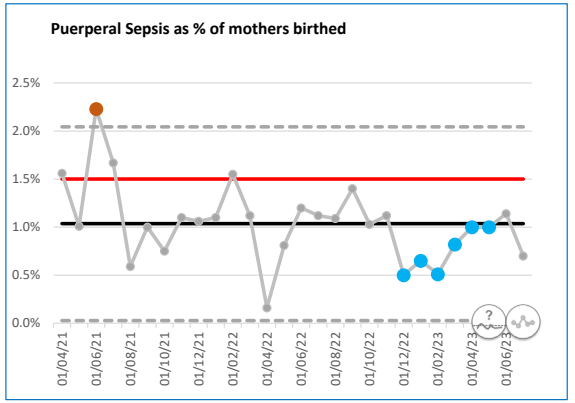


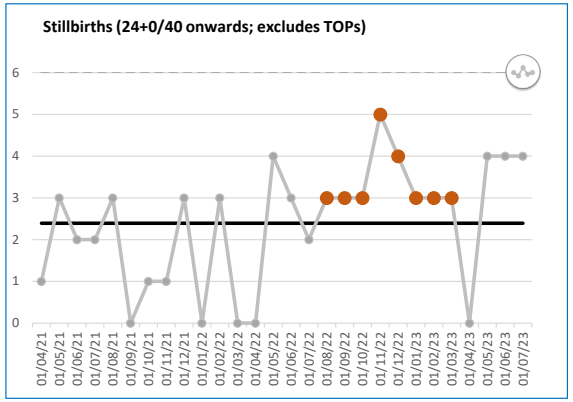


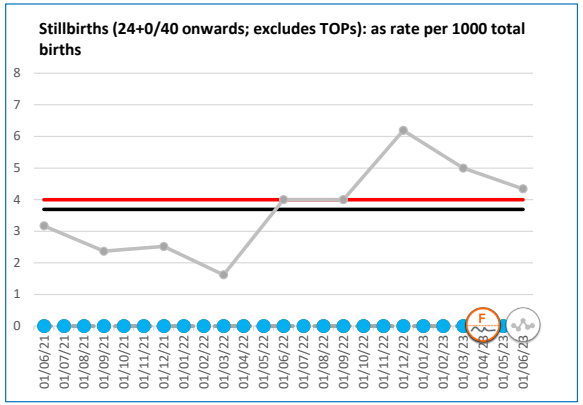


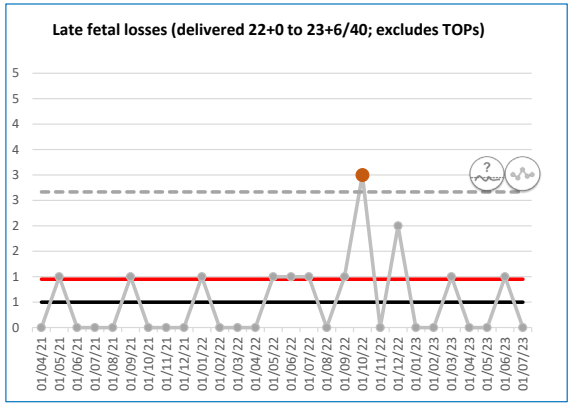




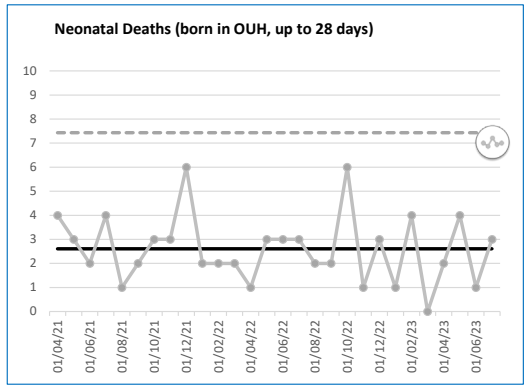


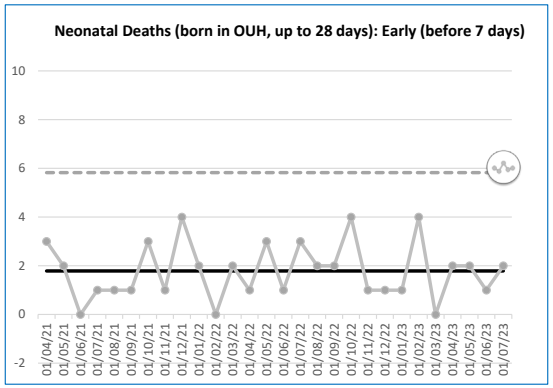


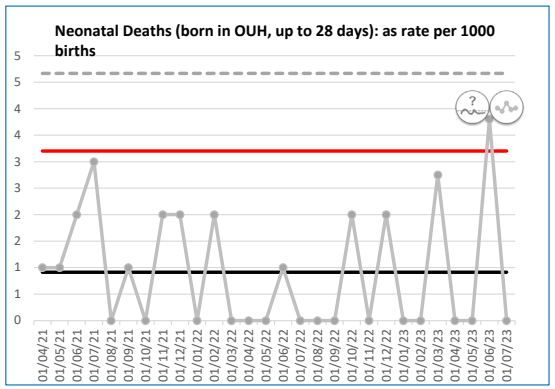


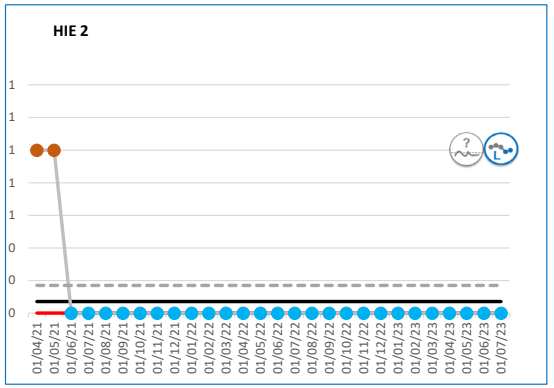


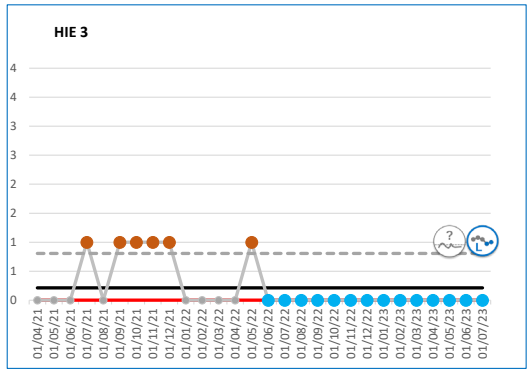
Appendix 1. SPC charts (5)

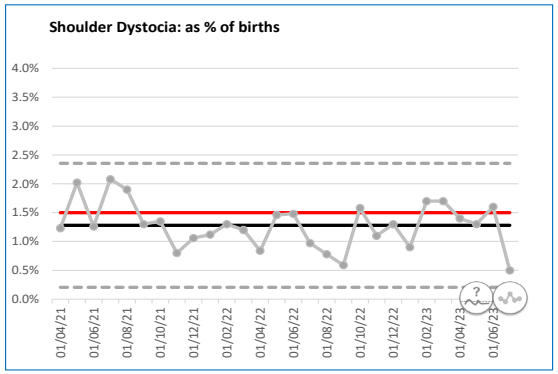


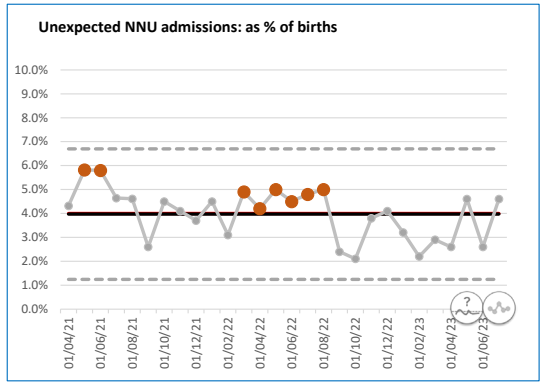


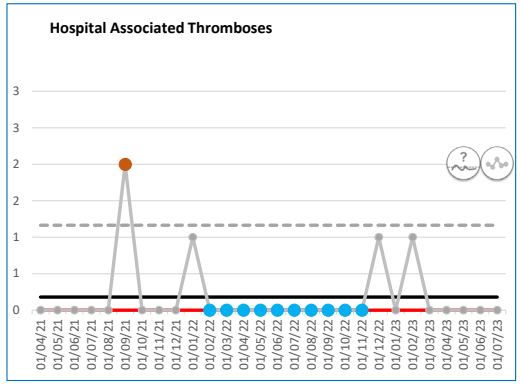


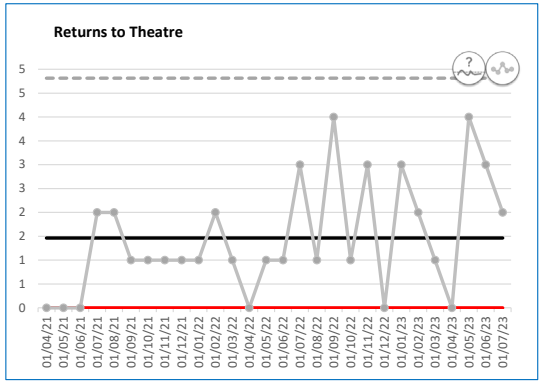


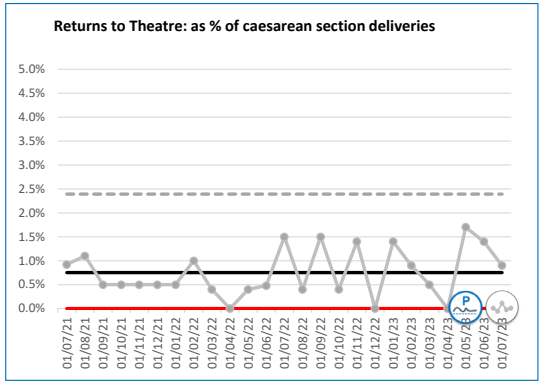




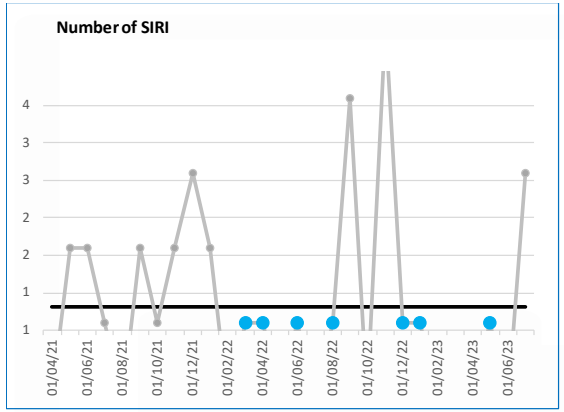


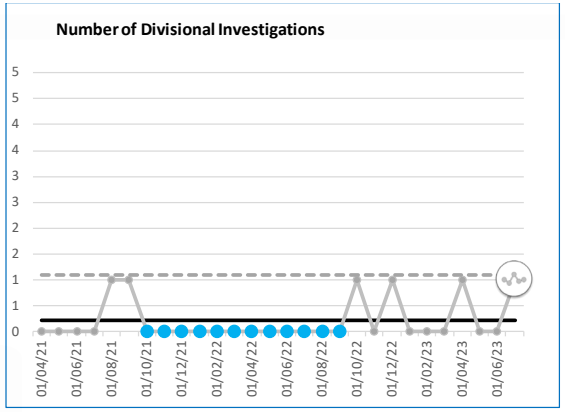


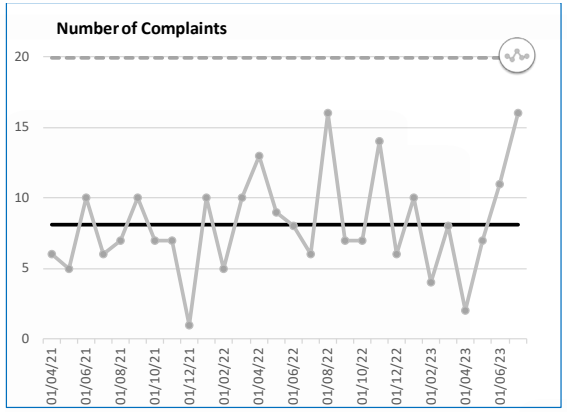


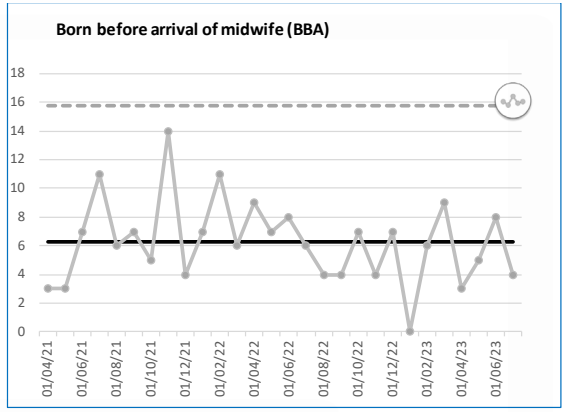


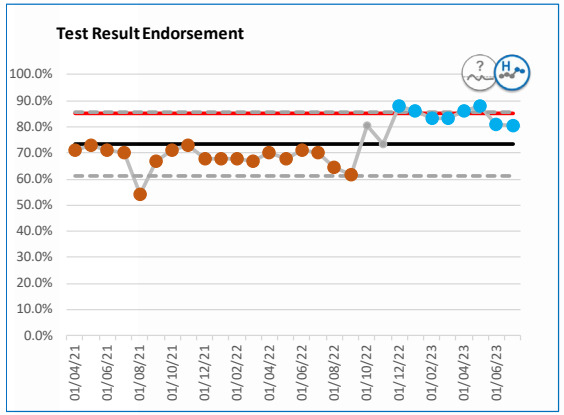
Appendix 1. SPC charts (6)

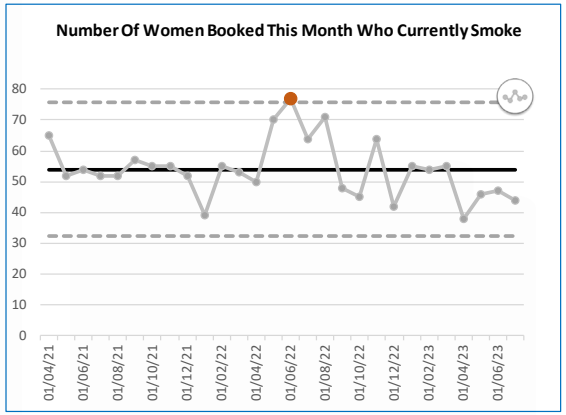


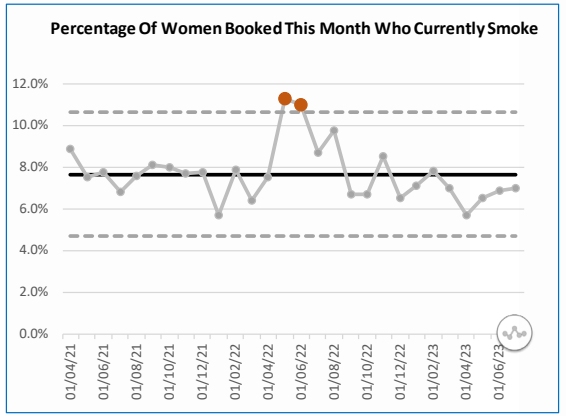


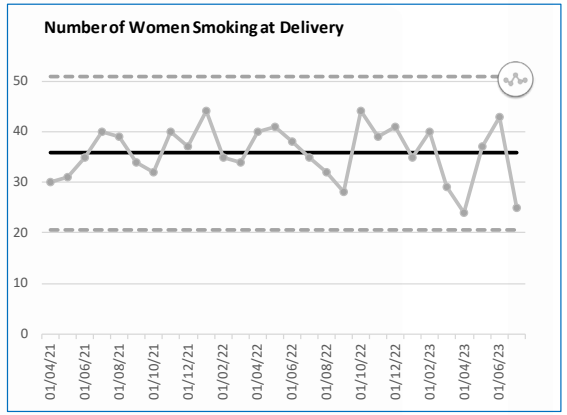


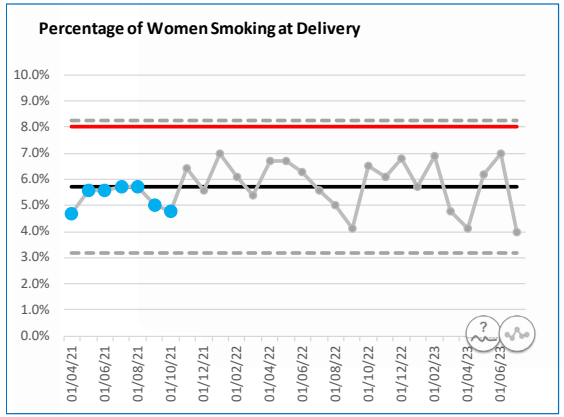


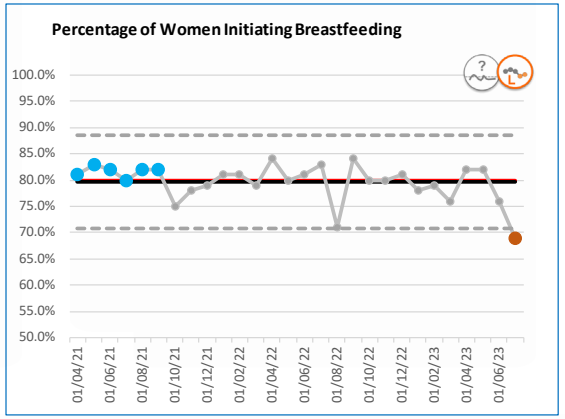


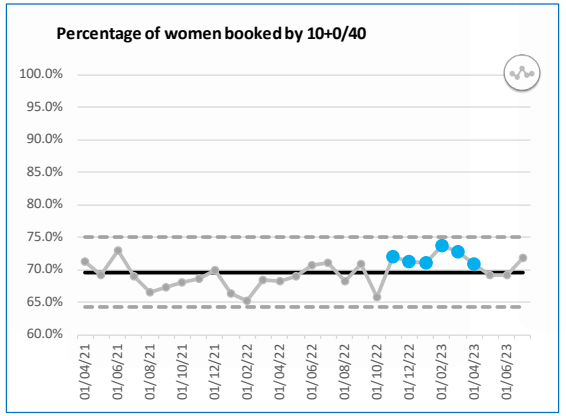










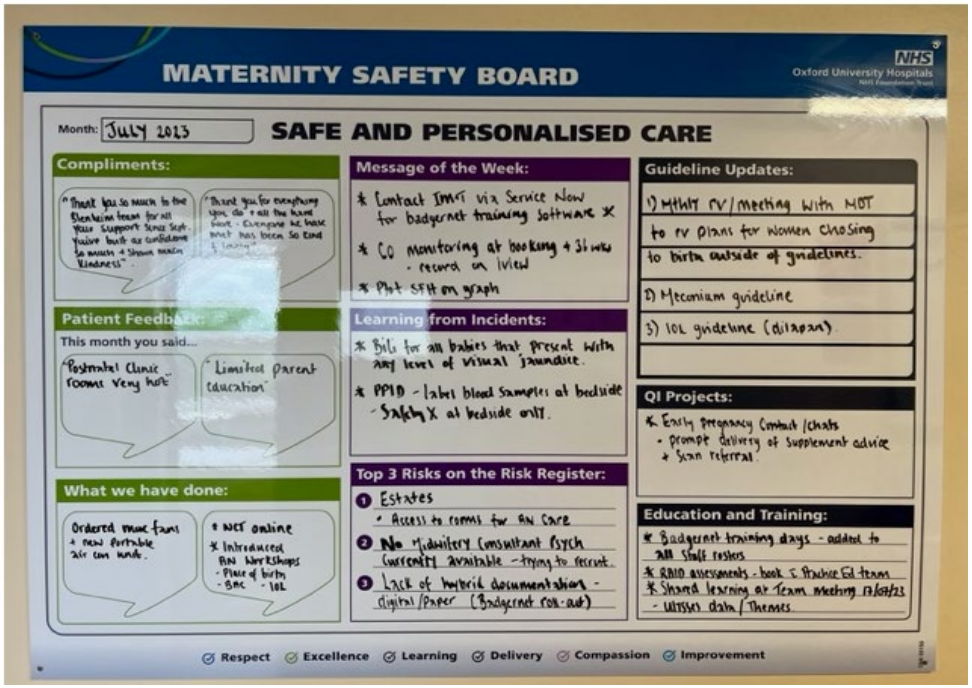


Gradings of Care for PMRT, Post partum haemorrhage (PPH), 3rd and 4th Degree Tears, Term Admissions to SCBU

A - No care issues identified; appropriate guidelines followed
B - Care issues identified - did not impact the care or management
C - Care issues identified - that may have impacted the care or management
D - Care issues identified - That did impact the care or management

Appendix 2: Maternity Safety Display Board

This is an example Maternity Safety Display Board from July 2023. These boards are in all areas of Maternity and are available to staff and public. This is divided into three columns. Column 1 details any feedback and compliments we have received and what we have done to respond to these. Column 2 details 'Message of the Week', any learning from incidents and the top three risks for Maternity on the Risk Register. Column 3 details any recent Guideline updates, Quality Improvement Projects and updates for training and education. Each Safety Board is the responsibility of the Ward Managers and is a visual way of keeping staff and public up to date.



Appendix 3 Maternity Incentive Scheme Compliance Dashboard – July/August 2023

Safety action	Update	RAG rating
1.Are you using the National Perinatal Mortality Review Tool to review deaths to the required standard?	So far, 100% of parents have been informed/are on track to be informed of the review and their perspective sought. 100% of reviews so far have been started within two months, Draft reports: 100% either closed or on track to be closed in time. Final reports: 100% either closed or on track to be closed in time	On track to be compliant
2.Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	The Trust continues to submit data to the MSDS in accordance with requirements. At present OUHT are on track to pass July 2023 MSDS data. Flex data for July 2023 has been submitted.	On track to be compliant
3.Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?	Transitional care (TC) is fully implemented and to further enhance the service, a dedicated bay on Level 5 was launched on in August 2023. The Maternity and Neonatal teams are meeting fortnightly in relation to TC. They are currently formulating a business case to expand services to include naso-gastric tube feeding. An ATAIN paper is presented at MCGC monthly and is a standing agenda item at the monthly Safety Champions meeting. ATAIN Summary: The Quarter 1 meeting was held on the 31st July 2023. There were representatives from the midwifery team, maternity practice education, obstetrics, neonatal and fetal wellbeing. There were a total of 61 admissions in the quarter. There were a total of 45 Ulysses reviewed for the quarter, mostly graded A/B (unavoidable) and one case graded C (avoidable). Presentations were provided to the group relating to the Service Evaluation of the Fresh Eyes tool and the learning presented to the Falls Summit in June 2023. The action plan was reviewed.	On track to be compliant
4.Can you demonstrate an effective system of clinical workforce planning to the required standard?	Benchmarking meetings arranged for Obstetric medical workforce and Neonatal medical and nursing workforce. The Neonatal Safety Champion has produced a business plan regarding shortalls in the Neonatal Medical Workforce.	On track to be compliant
5.Can you demonstrate an effective system of midwifery workforce	On track to be compliant if business case for staffing budget is approved.	On track to be compliant

planning to the required standard?		
6.Can you demonstrate that you are on track to compliance with all elements of the Saving Babies Lives Care Bundle Version 3?	Saving Babies Lives Care Bundle, Version 3 launched 1st June 2023, including a new Element, Diabetes. The Maternity Incentive Scheme require evidence of implementation of the care bundle by March 2024. Implementation of 70% of interventions across all 6 elements, and implementation of at least 50% of interventions within each individual element is required to prove compliance with the Scheme. A meeting with all key stakeholders are in progress. Funding concerns have been raised regarding Element 1 – Smoking. OUHT are moving towards an in-house stop smoking service; however, the Public Health midwives have been budgeted to provide around 60 women with Nicotine Replacement Therapy (NRT). It has been noted that as many as 400 women may need this service and need funding. This is currently being explored and has been escalated to the Assurance Team for support. OUHT are in close contact with colleagues in Buckinghamshire and Berkshire to ensure a unified approach towards evidence submission. All other elements within Saving Babies Lives and on track to comply.	On track to be compliant
7. Listen to women, parents and families using maternity and neonatal services and coproduce services with users	Currently MNVP are on track to comply with the required standards. Feedback is provided as part of the Perinatal Quality Surveillance Report (PQSM) that is reported monthly to MCGC.	On track to be compliant
8.Can you evidence the following 3 elements of the local training plans and 'in-house', one day multi professional training?	The Core Competency Framework, Version 2 launched 31st May 2023. The midwifery Practice Development (PD) team are on track to comply. Still awaiting a meeting with the Practice Development team for the Nurses. Due to Doctor strikes, there have been a cancellation of PROMPT on two occasions. The PD team are working hard to ensure that consultant Anaesthetists attend before 1st December 2023. A challenge has gone in to NHS Resolution for extenuating circumstances to be taken into account when assessing compliance.	On track to be compliant
9.Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and	Safety Champions: The maternity safety champions have been undertaking safety champions walkarounds monthly. Feedback from these is shared with staff through the Maternity Bulletin and at Governance meetings. The feedback is included as part of the PQSM. The Trust Claims Scorecard is discussed at Trust level against current incident and complaint data.	On track to be compliant

neonatal safety and quality issues?		
10.Have you reported 100% if qualifying cases to HSIB and to NHS Resolution's Early Notification Scheme?	All HSIB applicable cases have been referred and have been accepted for review. For these cases, duty of candour and HSIB information was provided prior to the referral being completed.	On track to be compliant