Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Public Trust Board Meeting: Wednesday 13 March 2024

TB2024.23

Title:	**Maternity Services Update Report**

Status:	**For Discussion**
History:	**Regular Reporting**
	Maternity Clinical Governance Committee (MCGC)
	Previous paper presented to Trust Board 17/01/2024

Board Lead:	**Chief Nursing Officer**
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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 Performance Dashboard
    - Perinatal Quality Surveillance Model Report
    - CQC inspection action plan update
    - CQC Maternity Survey 2023 publication
    - Maternity Development Programme (MDP)
    - NHS Resolutions Response
    - Maternity Incentive Scheme Year 5
    - Maternity Safety Support Programme (MSSP)
    - Three-year delivery plan for maternity and neonatal services
    - Safeguarding
    - Antenatal and Newborn Screening

Recommendations

2. The Trust Board is asked to:
    - Note the contents of the update report.
    - Consider how the Board may continue to support the Divisional Teams.

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Maternity Services Update Report

1. Purpose

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- Maternity performance dashboard
- Perinatal Quality Surveillance Model Report
- CQC inspection action plan update
- CQC Maternity Survey 2023 publication
- 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
- Safeguarding
- Antenatal and Newborn Screening

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. The Ockenden Assurance insight visit took place on the 10 June 2022 and the Trust received the final report with associated recommendations.

2.2. 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 5 – The new digital system (BadgerNet) was launched on the 14 February for antenatal care with the remaining areas going live during the following

week which will facilitate the audit of ongoing risk assessments to be undertaken.

- Strengthening Midwifery Leadership –The secondment of the Midwifery senior leadership team has been extended to the 28 February 2024 to support continued stability for the Maternity service. All posts have been appointed into. New Head of Midwifery post appointed into and start date planned for approx. May 24. The Deputy Head of Midwifery for Community appointed into substantively start date May 24, and the current interim deputy of Midwifery remains in post until then.

3. Midwifery Led Unit (MLU) Status

3.1. In December there were no closures of community or homebirth services.

3.2. In January the homebirth and community service were suspended on one occasion (Horton Midwifery Led Unit) however, no women were affected.

4. Maternity Performance Dashboard

4.1. There were two exceptions reported for the January data.

4.1.1. Exception 1: One was for neonatal deaths born in OUH up to 28 days of delivery. This data is measured over a quarter and showed special cause variation with 8 deaths during that period.

4.1.2. Exception 2: There was a case of HIE following a vaginal breech birth. (See appendix 1).

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 December 2023 and January 2024 data is being received by the Trust Board and Private Trust Board meeting on 13 March 2024. Both months were previously reported to MCGC in January and February and remains a standing agenda item at the monthly Maternity and Neonatal Safety Champions meetings.

6. CQC Inspection and Action Plan Update

6.1. Since the last report to the Trust Board, two actions remain overdue relating to Estates, the updates for which can be seen on the table below.

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, optimising the rebirth environment for women and their families.	**Overdue:** The Capital Project team are working with suppliers to initiate the refurbishments following the funding approval at TME in November. Currently awaiting asbestos survey and schedule for the works.

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.

6.3. There was a CQC visit undertaken at the Horton Midwifery Led Unit (MLU) in October 2023. The service has received the draft report to check for factual accuracies and comments have been returned.

7. CQC Maternity Survey 2023

7.1. The CQC Maternity Survey was published on the 09 February 2024. The Trust maternity services have achieved excellent results and show the significant service development undertaken. The table below shows the overall results, calculated by comparing the Trust's results to the national Trust average.

Where maternity service users experience is best	Where maternity service users experience could improve
Maternity service users being offered a choice about where to have their baby during their antenatal care.	Partners or someone else involved in the service user's care being able to stay with them as much as the service user wanted during their stay in the hospital.
During antenatal check-ups, maternity service users being given enough information from either a midwife or doctor to help decide where to have their baby.	Maternity service users(and/or their partner or a companion) being left alone by midwives or doctors at times when it worried them during labour and birth.

The midwife or midwifery team appearing to be aware of the medical history of the service user and baby during care after birth.	Maternity service users being able to get a member of staff to help when they needed it while in hospital after the birth.
During pregnancy, maternity service users receiving the help they needed when they contacted a midwifery team.	Maternity service users being involved in the decision to be induced.
Maternity service users feeling that if they raised a concern during their antenatal it was taken seriously.	Maternity service users being given appropriate information and advice on the benefits associated with an induced labour, before being induced.

8. Maternity Development Programme (MDP)

8.1. The MDP celebration took place on the 03 November 2023 several members of the team were in attendance and showcased the projects that they had been working on and what had been achieved over the past 18 months.

8.2. On the 12 February 2024 it was agreed by the Chief Nurse and the Chief Operating Officer that the MDP has achieved its aims, and due to the positive progress, that has been made through the programme, it can be stood down. No further meetings are planned, and this initiative is now closed.

9. NHS Resolution Response

9.1. The outstanding actions from the NHS Resolutions (NHSR) action plan have been added to Ulysses ‘Action Planning’ section.

9.2. All actions have been completed and the evidence uploaded onto Ulysses.

10. Maternity Incentive Scheme (MIS)

10.1. At the Trust Board on the 17 of January 2024 OUHT presented that we were fully compliant with all ten safety actions of the Maternity Incentive Scheme, Year 5, with action plans in place to mitigate the two exceptions:

10.2. Junior Neonatal Medical Workforce does NOT meet BAPM standards regarding medical cover at night-time and weekends. An action plan to address this was noted at the Trust Board on 17 January 2024, and was also submitted to the LMNS Board and ODN. This will meet the requirements for the Scheme.

10.3. Neonatal Nursing Workforce – does NOT meet BAPM standards due to deficiencies in staffing establishment. The Neonatal workforce calculator went to the Trust Board reading room 08 November 2023. This shows that the funding is compliant with in accordance with the BAPM Nurse Staffing Standards. An action plan has been developed to show progress with recruitment against funded establishment.

11. Maternity Safety Support Programme (MSSP)

11.1. 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.

11.2. The action plan from the Maternity Clinical Governance Deep Dive was ratified at MCGC in November 2023.

11.3. The actions were uploaded into the “Action Plan” section on Ulysses under process map specific workstreams.

11.4. The action plan is being overseen by the Deputy Head of Midwifery for Acute & Tertiary Services.

11.5. There will be a monthly action plan update at MCGC.

12. Three Year delivery plan for maternity and neonatal services

12.1. 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.

12.2. Theme 1: Listening to Women

- The Personalised Care and Support Plan (PSCP) developed in conjunction with the Berkshire, Oxfordshire and Buckinghamshire (BOB) Local Maternity and Neonatal System (LMNS) and the service was launched in September 2023. This has been distributed to the community teams to give to women and birthing people at booking. There is an opportunity for women and birthing people to give feedback on the PSCP at 17 weeks, 35 weeks and after the birth via a QR code which is collected by the BOB LMNS. The BOB LMNS are undertaking the initial audit of their usage and will report back we are awaiting the timeframe of this.
- The OUH has been chosen as a pilot site for Advance Communication for Personalised Care for Maternity and Neonatal Services. There is a 2-day course starting in March 2024.
- The NHS 15 Steps Challenge took place in November and is a ‘first impressions’ survey to assess clinical areas from a senses/instinctual perspective. Initial feedback was positive, and the full report was received in January 2024. The service is working with the OMNVP on the actions.
- A workstream has commenced for achieving the UNICEF UK Baby Friendly Initiative (BFI) for infant feeding. Progress of this project will be

monitored through a task and finish group and will be reported through MCGC.

- The Maternity service, the Oxford Maternity and Neonatal Voices Partnership (OMNVP) are meeting monthly to triangulate the feedback received to look at themes and what actions need to be taken.

12.3. Theme 2 – Workforce

- The BirthRate+ midwifery staffing tool was recalculated in 2022 and an uplift of 22.38wte midwives, recommended. The business plan to support this was approved at the Trust Board in November 2023. A recruitment plan has commenced to achieve the uplift recommendation and includes both the additional Clinical Midwifery matron and Head of Midwifery post; clinical inpatient midwives and Maternity Support Workers. The new Clinical Midwifery matron and the Head of Midwifery posts have been recruited into.
- The Equity, Diversity and Inclusion (EDI) Midwives have been providing learning sessions for staff on assessing women, birthing people and babies with dark and brown skin tones. Feedback will be assessed and reported to MCGC in March 2024.

12.4. Theme 3 – Culture and Leadership

- Continue embedding and sustainability work from the Maternity Development Programme and future strategic direction of the maternity services.
- 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.

12.5. Theme 4 – Standards

- One of the deliverables of the SDP is to implement Saving Babies Lives Care Bundle version 3 (SBLCBv3) by March 2024. This also forms Safety Action 6 of Year 5 of the Maternity Incentive Scheme (MIS) and is overseen by the MIS Lead. The required evidence has been uploaded to the NHS Futures platform on the SBLCBv3 toolkit and progress meetings are held with the LMNS monthly. The LMNS have reviewed the evidence that has been submitted on the toolkit as part of the MIS compliance review. OUH are currently 73% compliant overall and at least 50% compliant in each of the six elements. OUHT is on track to achieve full compliance by end of March 2024. Once implemented the plan is to build on the percentage compliance as agreed across the LMNS. Progress is reported monthly as part of the MIS update at MCGC. The next quarterly meeting with the LMNS is on the 18 March 2024.

- A meeting has been arranged in January 2024 to pilot the national Maternity Early Warning Score initially within the Observation Area. There is a working party looking at the implementation of NEWTT 2 tool is recommended to be in place by March 2025.
- The planned launch of the Maternity Digital to BadgerNet was due to take place at the beginning of February. However, due to a period of instability in the national BadgerNet platform the Maternity Digital team, Maternity senior management and Trust senior management took the difficult decision for patient safety to revert to pre-BadgerNet workflows. Specifically, this meant reverting to documentation on paper and Millennium EPR to allow staff to work unhindered by the current challenges. The project go-live has been relaunched on the 14/02/2024.

13. Safeguarding

13.1. Maternity Safeguarding cases continue to be very complex with multiple disadvantages present within families including mental health, domestic abuse and substance use. The recent merging of these specialist support midwives within one team is proving to be effective and initial feedback from midwives and external agencies is extremely positive. The plans for the vulnerable women/enhanced care team in community will extend this collaborative working and link the community and hospital services for vulnerable families. The advert for the IDVA post for maternity, being funded by the Standing together charity and Oxfordshire County Council, closes for short listing imminently, it is still hoped this post can commence by the end of Q4.

13.2. During January there were two very high-risk cases of domestic abuse and the safety of the victim-survivor, and her baby were paramount. The senior team, security and ward clerk manager were alerted prior to admission with photos of the perpetrators. An additional layer of security was added in the form of password protection to ensure no unauthorised visitors were allowed access. Feedback provided from the woman herself and her family, following her discharge from maternity, was praise for how safe she felt as an inpatient and how seriously it was taken.

13.3. The OUH Safeguarding Matron, along with input from the Buckinghamshire and Berkshire safeguarding midwives, gave a presentation to 133 GPs across the BOB regarding communication between midwives and primary care. The presentation followed by discussion focused on how to improve this since many community midwives in Oxfordshire were asked to leave GP surgeries due to the demands on space and capacity for GPs. This was a positive meeting with plans for moving this forward agreed with the Named GP for safeguarding within Oxfordshire.

14. Antenatal and Newborn Screening

14.1. The Maternity Clinical Governance Committee received the annual Screening Report at the meeting on the 22 January 2024 along with the Quarter 2 key performance indicators (KPI's). The exceptions to the KPI's were as follows:

- St3 : completion of family origin questionnaire (FOQ) – 98.1%. No results were delayed as a result of FOQ not being sent with request.
- NB2 : avoidable repeat tests – 2.8%. A significant % are from the neonatal unit. There is a plan in place to increase training and supervision in neonates.
- FA2 coverage : 20 week screening scan – 98.4%.
  - 25 women declined NHS scan as they were having a private scan
  - 2 declined screening
  - 4 women tested outside timeframe due to DNA initial appointments

14.2. The quarterly Antenatal and Newborn Screening board meeting took place in January 2024.

14.3. The Screening Quality Assurance Service (SQAS) has planned a quality assurance (QA) visit to the Oxford University Hospitals NHS Foundation Trust antenatal and newborn screening programmes on the 23 April 2024.

14.4. The evidence requested for the visit has been uploaded by the 13 February 2024.

14.5. The final agenda will be sent out ahead of the meeting on the 26 March 2024.

14.6. The draft report will be sent to the Trust for factual accuracy on the 04 June 2024.

14.7. The final report will be issued following accuracy check on the 02 July 2024.

15. Recommendations

15.1. 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.

Oxford University Hospitals
NHS Foundation Trust

Maternity Performance Dashboard

TB2024.23 Appendix

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February 2024

Data period: January 2024

Presented at: Maternity Clinical Governance Committee

Author: Susan Thomson, Maternity Clinical Governance Lead

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Oxford University Hospitals NHS Foundation Trust

Executive summary

Oxford University Hospitals NHS Foundation Trust

Notable Successes

- Congratulations to the Maternity Digital Team who have worked tirelessly to bring BadgerNet into maternity; Their support during the antenatal roll-out of BadgerNet has been invaluable, and the team have shown great resilience despite the high acuity and numerous unforeseen technical issues.
- Maternity has launched an ‘in-house’ Parent Education Course. This initiative is being led by Sophie McAllister (consultant midwife) with workshops run by Grania Foster, Emma Rhodes and Camila Alves. Some excellent feedback has been received so far.
- Following the successful roll-out of the Transitional Care Unit on Level 5, more than 80% of registered staff have now been trained to deliver naso-gastric tube feeding and the first baby has successfully been fed by this method on the ward.
- Maternity have successfully recruited a new Head of Midwifery and Deputy Head of Midwifery. Both appointments are from outside of OUHT and we look forward to the skills and knowledge they will bring.
- MyMynd, the ‘supporting staff wellbeing’ app pilot has gone live in Maternity.
- OUHT have had their first two apprentice midwives start their training at Winchester University.

Executive summary, continued

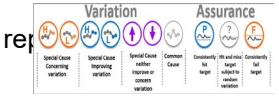
Oxford University Hospitals NHS Foundation Trust

Domain	Performance challenges, risks and interventions
Activity	In January there were a total of 568 mothers birthed. There were 606 scheduled booking undertaken which is a reduction of 55 from the previous month. The service received 188 referrals for elective caesarean section (ELCS) in January compared to 176 in December. 28 women booked in for an ELCS during January were cancelled as they had already delivered, and a total of 102 ELCS were performed during that month. There are more women choosing to book an ELCS as an alternative to having an IOL and this trend will be monitored.
Workforce	Midwife: birth ratio was 1:20:2. Consultant hours 109.
Maternal Morbidity	3rd and 4th degree tears as a % of spontaneous/other vaginal delivery was 3.5% in January as a percent of mothers birthed. This is within the acceptable range. Of the 12 incidents reported in January. 7 were White-British, 4 were of Asian origin, and one did not state their ethnicity. These are currently being reviewed. There were 13 maternal postnatal readmissions in January. The percentage of postpartum haemorrhages (PPH) of >1.5litres was 2.8% in January as a percent of mothers birthed. This has remained unchanged from December. There were 21 women affected: 11 women were white British, 2 White (any other background), 3 were of an Asian origin, 1 of Black African origin and 4 did not state their ethnicity. 10 cases were instrumental deliveries, and 7 were following spontaneous vaginal delivery. These are currently being reviewed. There were 13 maternal postnatal readmissions and 1 admission to the intensive care unit.
Perinatal Morbidity and Mortality	There were two neonatal deaths, and one intrauterine death in January. One was 22 + 6 weeks, and the other 33+0 weeks. The IUD was at 25+1 weeks. 7 cases were reviewed through the perinatal mortality review tool (PMRT) of which 1 was provisionally graded as an A (subject to local Trust review) meaning that no care issues were identified; and 6 were graded as B, meaning that the review group identified care issues which they considered would have made no difference to the outcome. The NND rate has flagged as an exception which is explained below. There were three babies reported to MNSI (Previously HSIB) in January. There were 24 babies admitted to SCBU in January. The main reason for admission was respiratory distress, with the main diagnosis at discharge being suspected sepsis. One baby has confirmed HIE. One baby was cooled but subsequently had a normal MRI. There were 14 term admissions reviewed in January: 9 were graded as an A (no care issues identified); 4 were graded as a B (care issues identified but they did not impact the care or management); and one was graded a C (Care issues identified that may have impacted the care or management). Positive observations were; Appropriate escalation from MAU immediately to theatre where required and; reasonable adjustments made for neurodiverse people. Learning included the importance of documenting any fetal movements discussion antenatally and; women should be given written information in a format that they understand. There were 12 postnatal readmissions in January. 10 were for jaundice, one for weight loss and one for suspected observations.
Maternity Safety	There were no PSII's declared in January. There were 6 new complaints received in January. Missed or incorrect diagnosis; Mismanagement of labour; Delay in giving information/results; Post treatment complications; and discharged too early.
Test Endorsement	Test result endorsement decreased to 78.5% in January which is an increase from 76.4% in December. The target is 85%. An Endorsing Results checklist and Reference Index has been written and should assist staff in endorsing results contemporaneously in line with Trust safety incentives. Maternity continues to educate staff to improve results.
Public Health	The percentage of women initiating breastfeeding was 86% in January, which is the same as December, and continues the significant improvement from 67% in September, The infant feeding team continue to monitor this through the Baby Friendly Initiative (BFI) Strategy working group which commenced in May 2023, and data validation continues to improve.
Exception reports	There are two reportable exceptions identified from the January 2024 data which are annotated below on Slides 7 and 8.

Indicator overview summary (SPC dashboard)

ER

Exception rep



KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Mothers Birthed	Jan 24	568	625			626	554	698
Babies Born	Jan 24	573	-			636	563	709
Scheduled Bookings	Jan 24	606	750			707	571	843
Inductions of labour from iView	Jan 24	139	-			146	104	188
Inductions of labour from iView: as a % of mothers bi	Jan 24	24.0%	28.0%			23.4%	18.1%	28.7%
Spontaneous Vaginal Births (including breech)	Jan 24	279	-			311	226	396
Spontaneous Vaginal Births (including breech): %	Jan 24	49.0%	-			51.2%	44.3%	58.1%
Forceps & Ventouse	Jan 24	76	-			89	63	115
Forceps & Ventouse: as a % of mothers birthed	Jan 24	13.0%	-			14.3%	10.2%	18.3%

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
C-Section	Jan 24	227	-			213	175	250
as % of mothers birthed	Jan 24	40.0%	-			35.2%	29.3%	41.0%
% Emergency c-sections	Jan 24	23.0%	-			20.0%	14.6%	25.4%
% Elective c-sections	Jan 24	17.0%	-			14.1%	10.1%	18.1%
Robson group 1 c-section with no previous births	Nov 23	13.1%	-			13.6%	9.8%	17.5%
Robson group 2 c-section with no previous births	Nov 23	53.6%	-			56.1%	49.9%	62.4%
Robson group 5 c-section with 1+ previous births	Nov 23	76.7%	-			82.8%	76.6%	89.0%
Elective CS <39 weeks no clinical indication	Jan 24	0	0			0	0	1
Prospective Consultant hours on Delivery Suite	Jan 24	109	109			109	109	109
Midwife:birth ratio (1 to X)	Jan 24	20.2	28.0			26.5	23.3	29.8
Maternal Postnatal Readmissions	Jan 24	13	-			8	-1	17
Readmission of babies	Jan 24	12	-			19	2	36

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
3rd/4th Degree Tear	Jan 24	12	-			12	-1	25
3rd/4th Degree Tear as % of SVD+OVD	Jan 24	3.5%	3.5%			3.0%	0.2%	5.7%
3rd/4th Degree Tear with unassisted births (SVD)	Jan 24	3.0%	-			2.6%	-1.6%	6.7%
3rd/4th Degree Tear with assisted births (OVD)	Jan 24	3.9%	-			4.6%	-2.8%	12.0%
PPH 1.5L or greater, vaginal births	Jan 24	16	-			13	0	25
PPH 1.5L or greater, vaginal births as % of mothers bir	Jan 24	2.8%	2.4%			2.1%	0.3%	3.8%
PPH 1.5L or greater, caesarean births	Jan 24	4	-			7	-2	16
PPH 1.5L or greater, caesarean births as % of mothers	Jan 24	1.8%	4.3%			1.3%	-0.7%	3.3%
ICU/CCU Admissions	Jan 24	1	-			1	-1	3
% completed VTE admission assessments	Jan 24	96.6%	95.0%			97.1%	94.0%	100.1%

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Maternal Deaths: all	Jan 24	0	0			0	0	1
Early Maternal Deaths: Direct	Jan 24	0	0			0	0	0
Early Maternal Deaths: Indirect	Jan 24	0	0			0	0	0
Late Maternal Deaths: Direct	Jan 24	0	0			0	0	0
Late Maternal Deaths: Indirect	Jan 24	0	0			0	0	0
Puerperal Sepsis	Jan 24	2	-			6	0	13
Puerperal Sepsis as % of mothers birthed	Jan 24	0.4%	1.5%			0.9%	0.0%	1.9%
Stillbirths (24+0/40 onwards; excludes TOPs)	Jan 24	1	0			2	-2	7
Stillbirths (24+0/40 onwards; excludes TOPs): as rate	Dec 23	3	4			4	#N/A	#N/A
Late fetal losses (delivered 22+0 to 23+6/40; excludes	Jan 24	0	1			0	-1	2

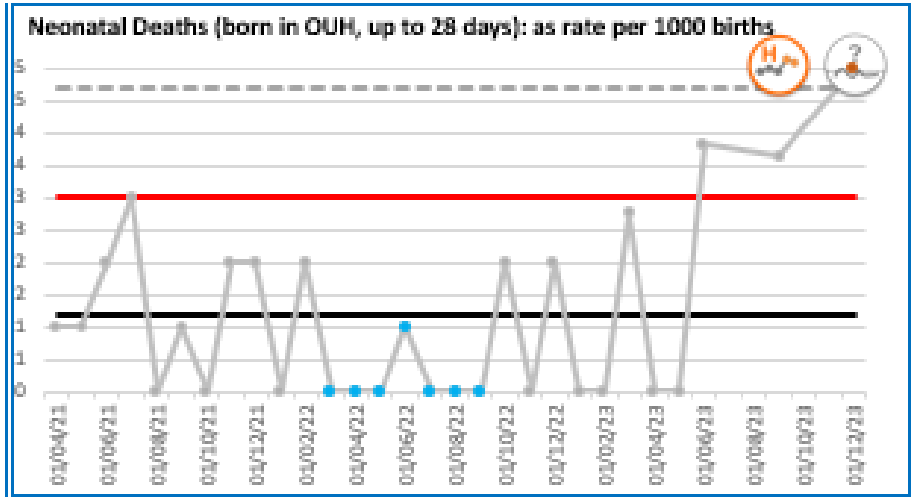
Indicator overview summary (SPC dashboard), *continued*

ER Exception report

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Neonatal Deaths (born in OUH, up to 28 days)	Jan 24	2.0	-			2.6	-2.2	7.4
Neonatal Deaths (born in OUH, up to 28 days): Early (	Jan 24	2	-			2	-2	6
Neonatal Deaths (born in OUH, up to 28 days): a e	Dec 23	5	3	H		1	-2	5
HIE	Jan 24	1	0	H		0	0	0
Returns to Theatre: as % of caesarean section deliver	Jan 24	0.4%	0.0%			0.7%	-0.8%	2.1%
Shoulder Dystocia	Jan 24	8	-			8	0	16
Shoulder Dystocia: as % of births	Jan 24	1.4%	1.5%			1.3%	0.1%	2.5%
Unexpected NNU admissions	Jan 24	24	-			26	8	44
Unexpected NNU admissions: as % of births	Jan 24	4.2%	4.0%			4.0%	1.3%	6.7%
Hospital Associated Thromboses	Jan 24	1	0			0	-1	1
Returns to Theatre	Jan 24	1	0			1	-2	4

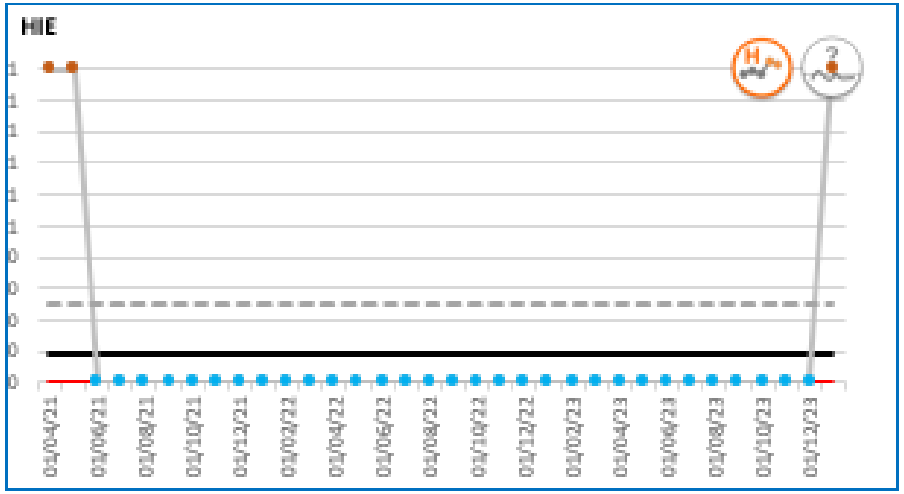
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Number of SIRI	Jan 24	0	0	L		1	-2	4
Percentage of women booked by 10+0/40	Jan 24	67%	-			69%	64%	75%
Number of Complaints	Jan 24	6	-			8	-3	19
Born before arrival of midwife (BBA)	Jan 24	5	-			6	-3	15
Test Result Endorsement	Jan 24	78.5%	85.0%	H		74.6%	63.6%	85.6%
Number Of Women Booked This Month Who Current	Jan 24	33	-			52	30	74
Percentage Of Women Booked This Month Who Curr	Jan 24	5.4%	-			7.4%	4.3%	10.5%
Number of Women Smoking at Delivery	Jan 24	24	-	L		35	20	50
Percentage of Women Smoking at Delivery	Jan 24	4.2%	8.0%			5.6%	3.1%	8.1%
Percentage of Women Initiating Breastfeeding	Jan 24	86.0%	80.0%	H		79.5%	70.6%	88.4%

Maternity exception report (1)



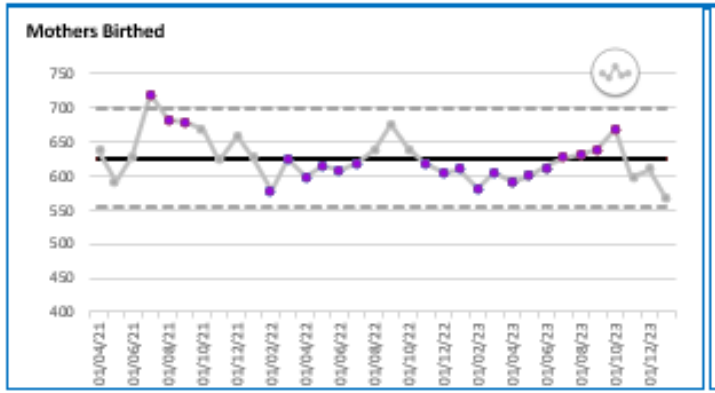
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Timescales to address performance issue(s) and identification of any gaps in assurance	Risk Register score	Data quality rating
Neonatal Deaths (born in OUH, up to 28 days) as rate per 1000 births shows special cause concerning variation.	This rate is calculated Quarterly. In Quarter 3 there were 8 neonatal deaths of babies born in OUHT. 3 of these babies had congenital abnormalities diagnosed in pregnancy, and two of them had an antenatal palliative care plan in place at the time of birth. 4 babies were under 24 weeks gestation at the time of birth (2x 22+1, 1x 22+3, and 1x23+5). 2 babies were born at OUHT following transfer to JR for Tertiary care.	N/A as no performance issues identified. All NND's go through a thorough Perinatal Mortality Review.	N/A	Assured

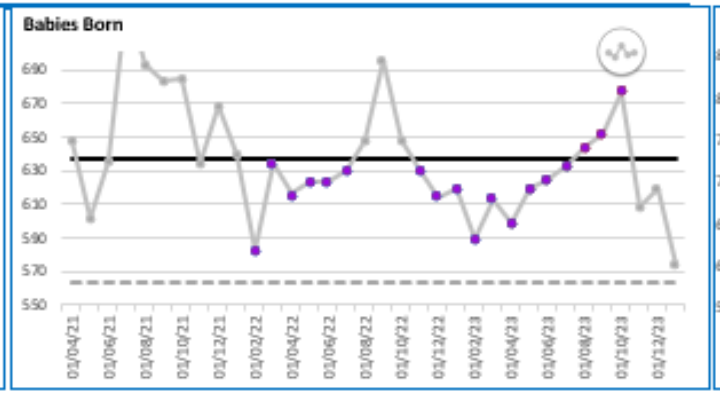
Maternity exception report (2)

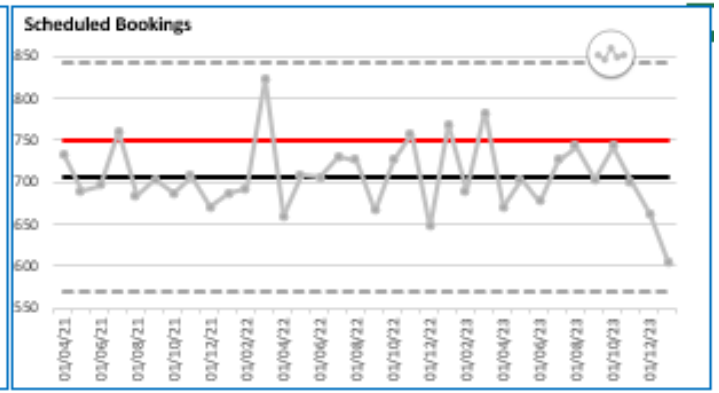


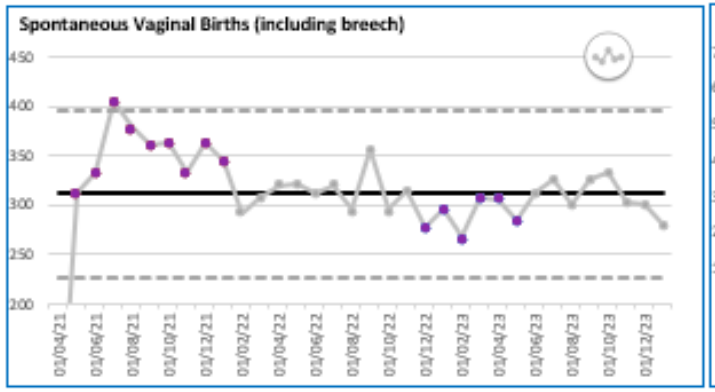
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Timescales to address performance issue(s) and identification of any gaps in assurance	Risk Register score	Data quality rating
The HIE shows special cause concerning variation. The target for this is set at zero.	This will be subject to a local investigation. This was a baby born in poor condition via a breech vaginal delivery. Full resuscitation was commenced and the baby was subsequently cooled. Found to have HIE, diagnosed on MRI.	Investigation ongoing. Noted at SLIC and PSII. MNSI have accepted the case with parental consent.	N/A	Assured

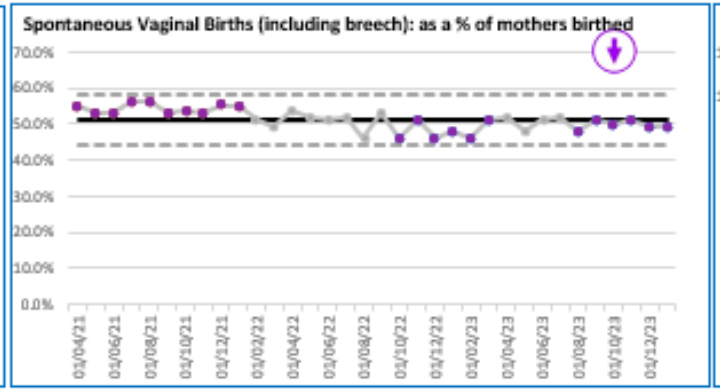
Appendix 1. SPC charts (1)

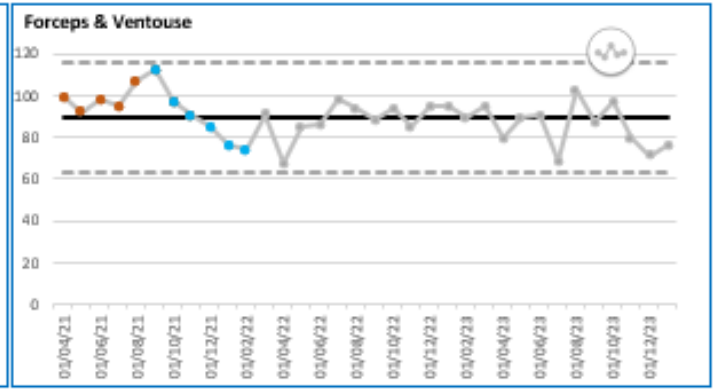


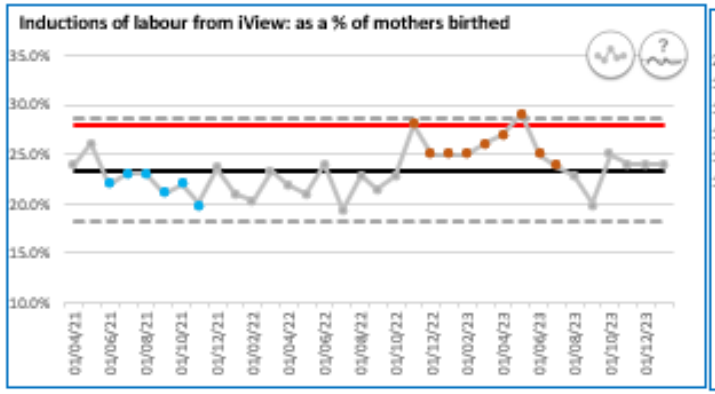


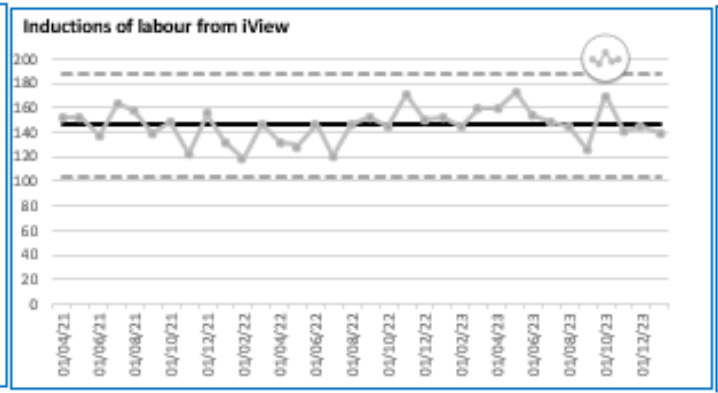


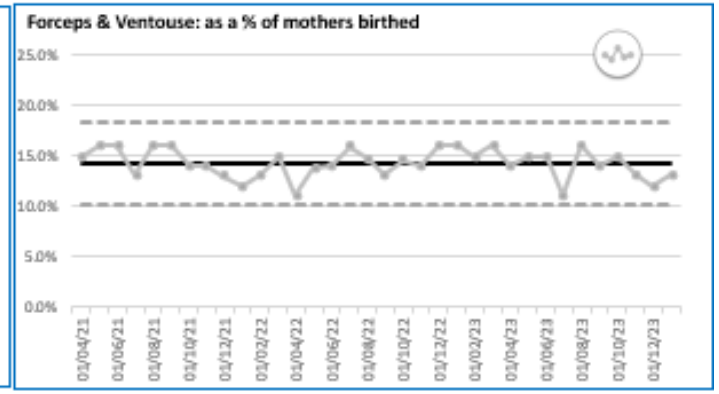












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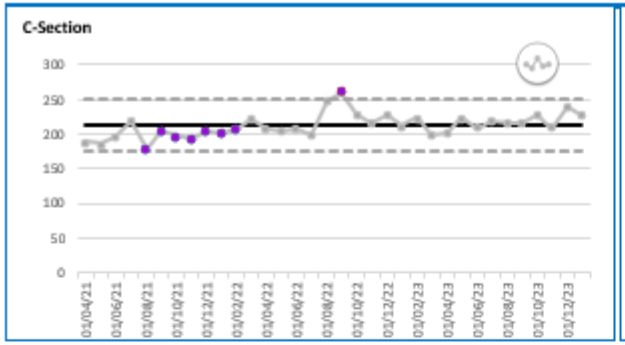
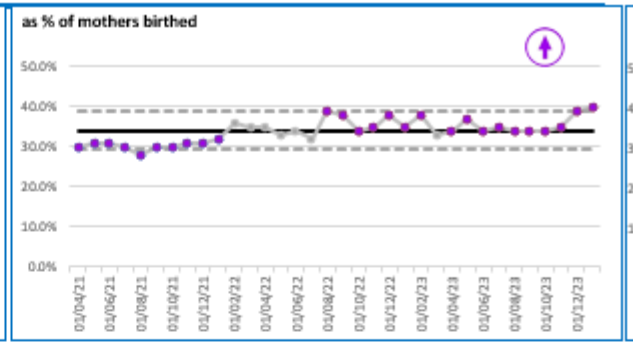
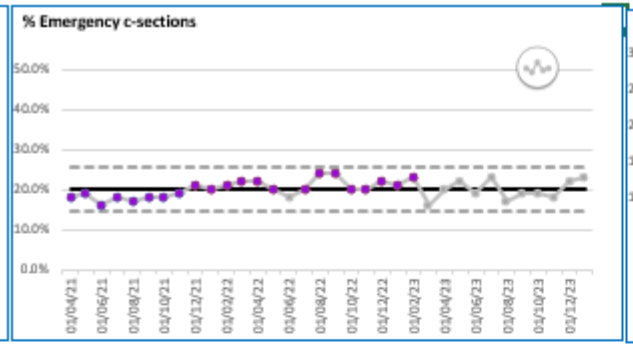
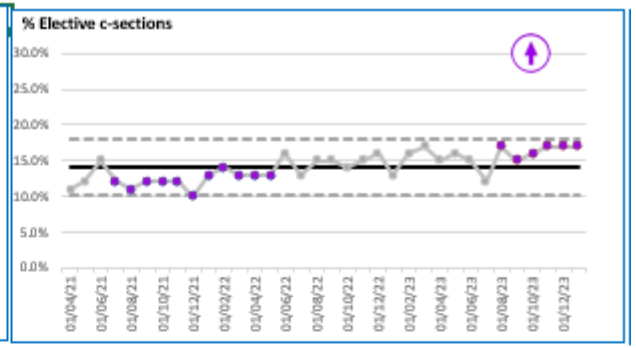
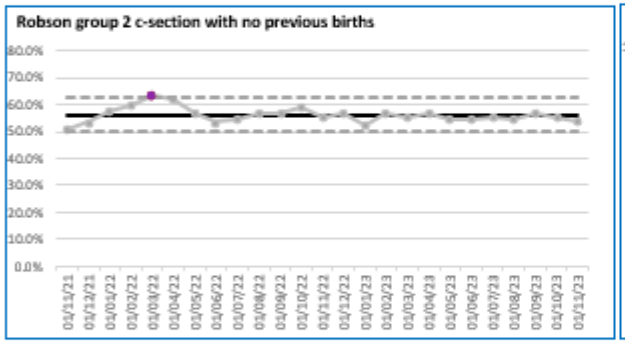
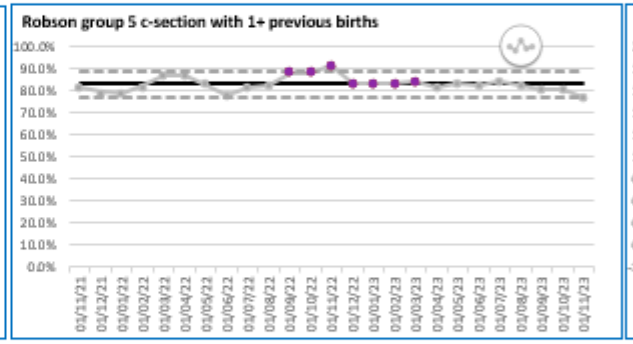


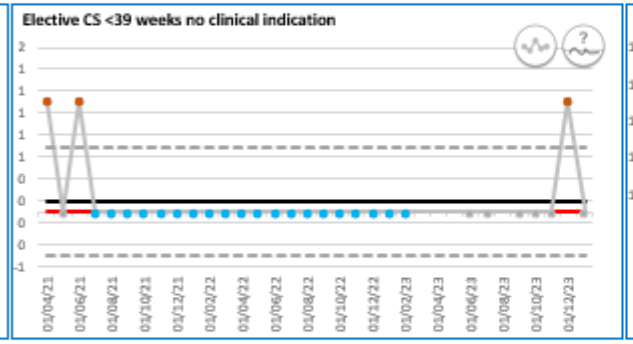


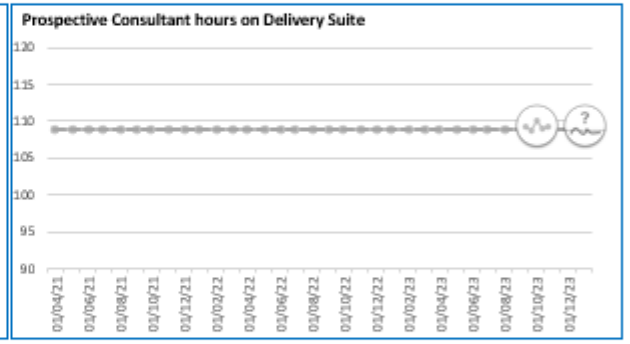


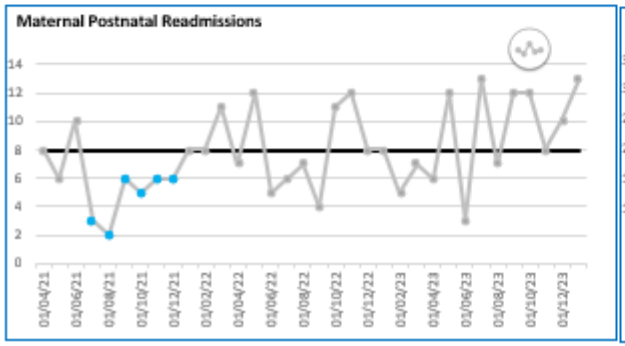


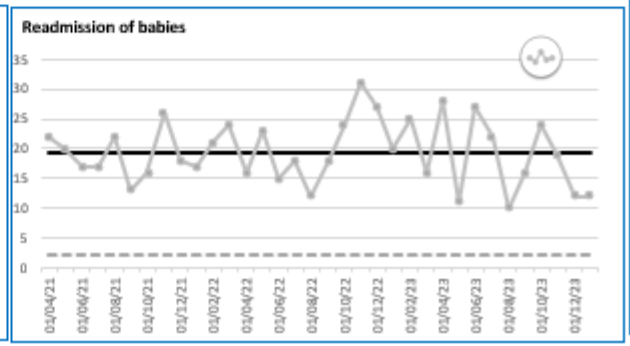


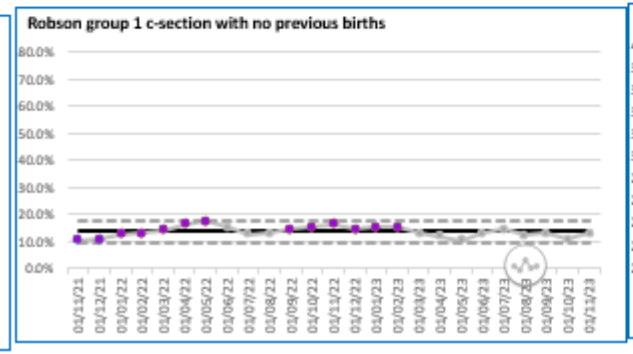


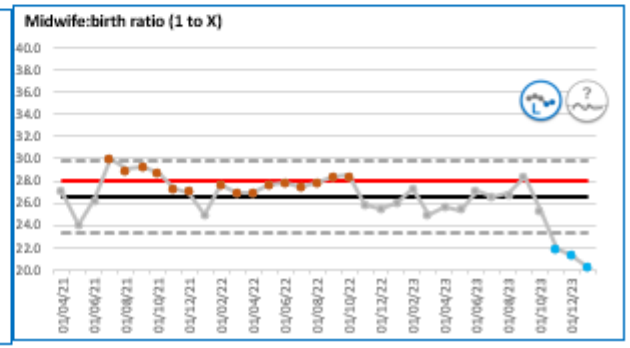




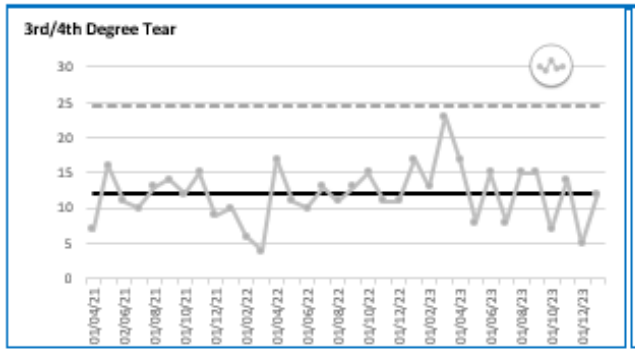


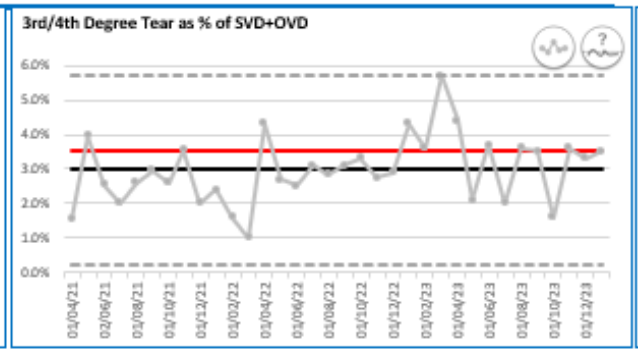


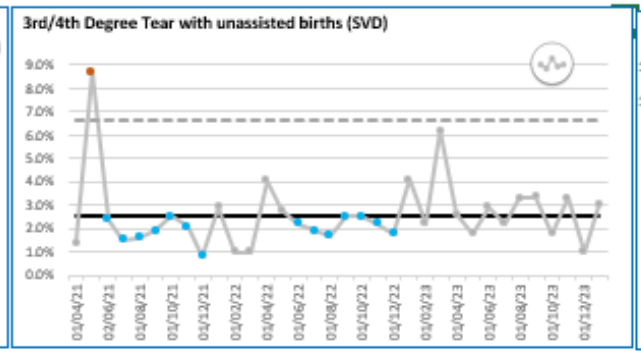


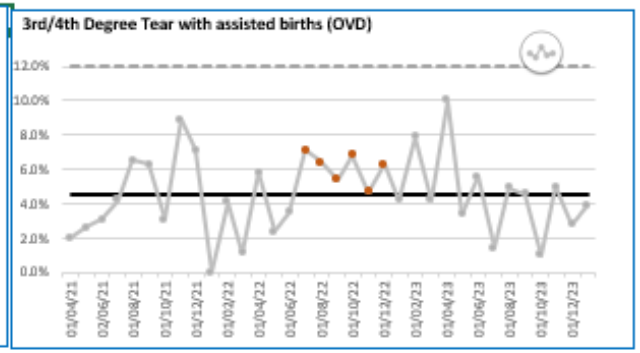


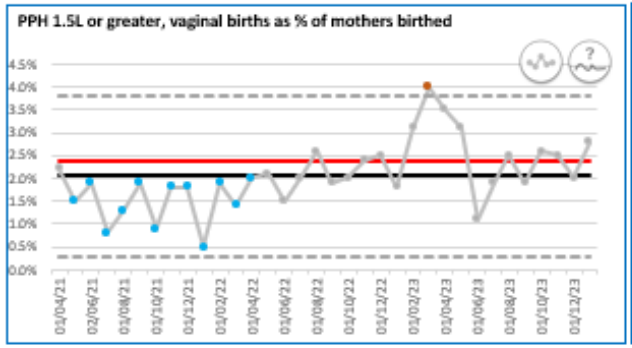
Appendix 1. SPC charts (3)

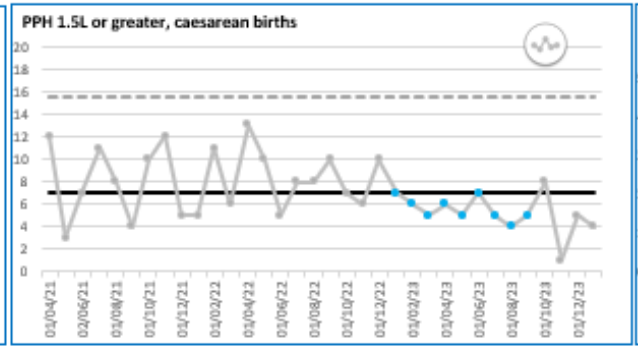


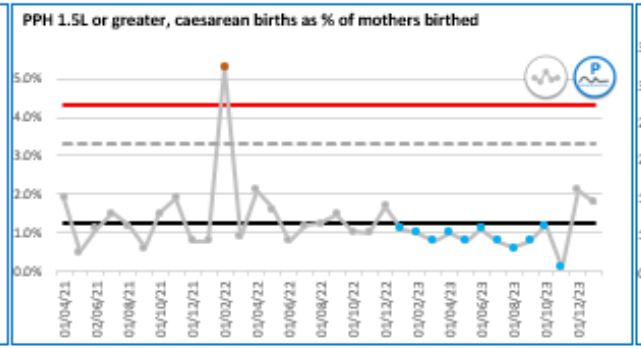


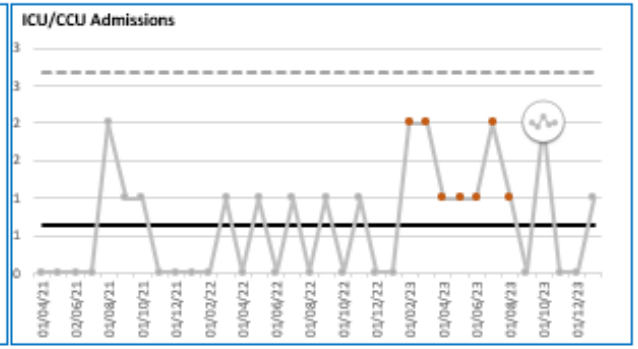


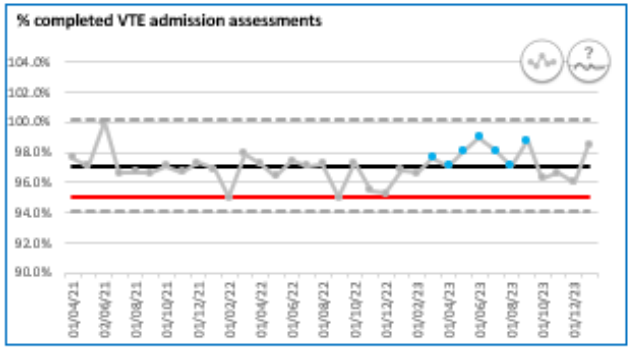


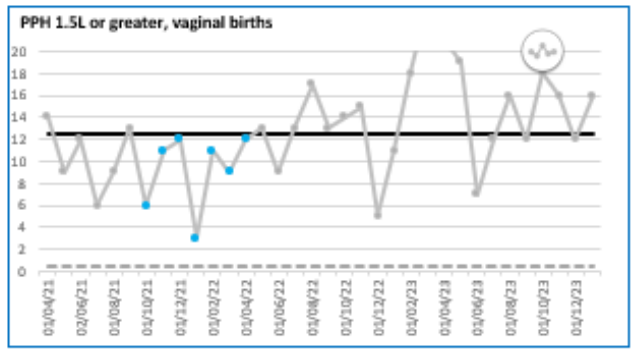




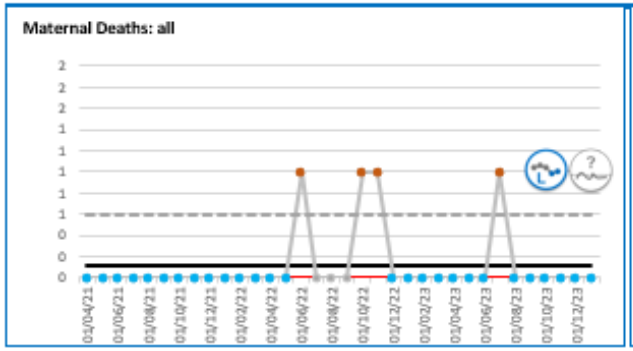


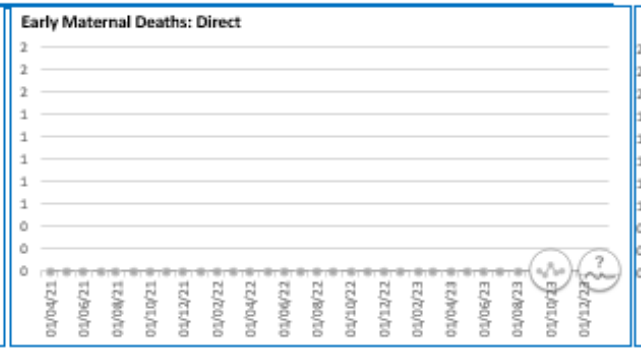


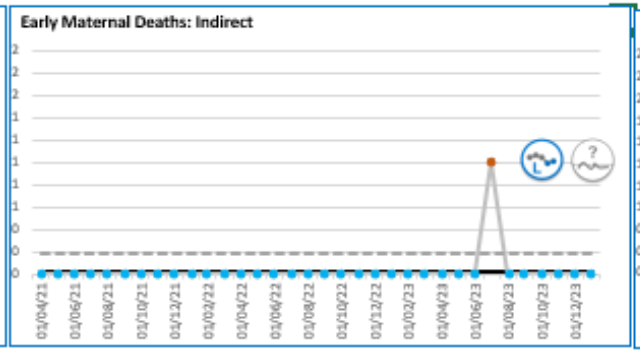


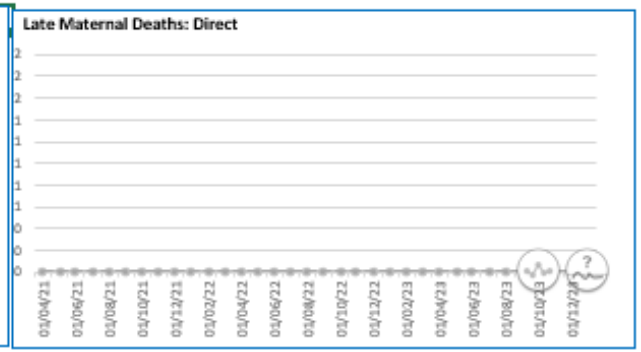


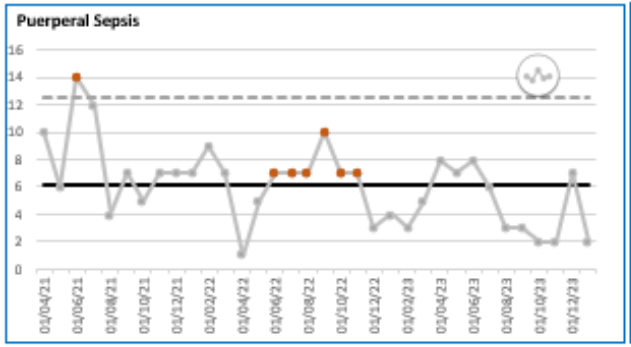
Appendix 1. SPC charts (4)

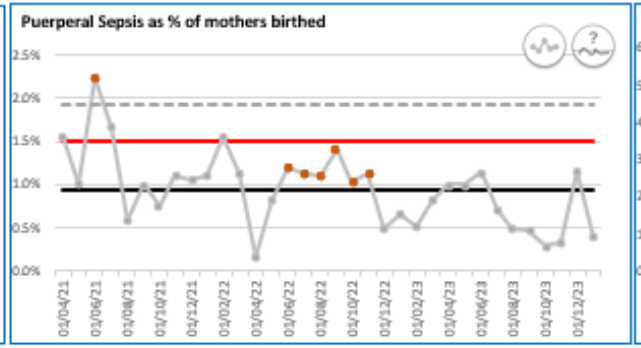


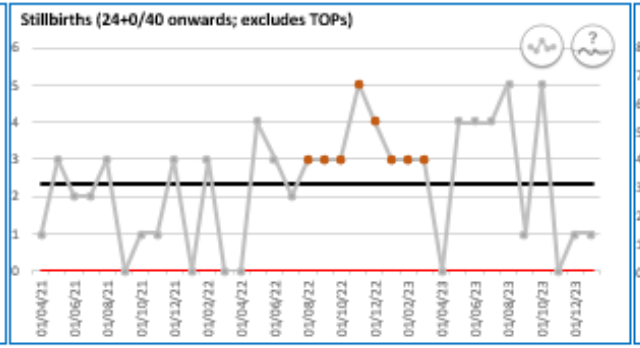


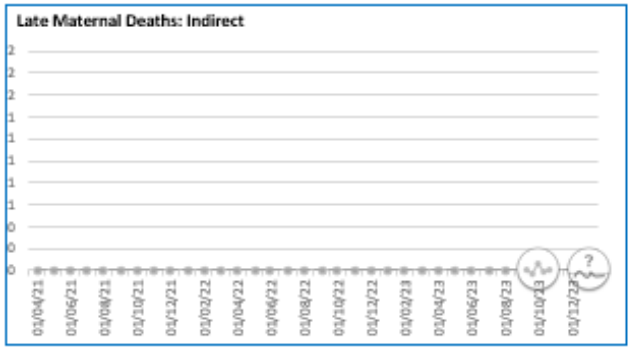


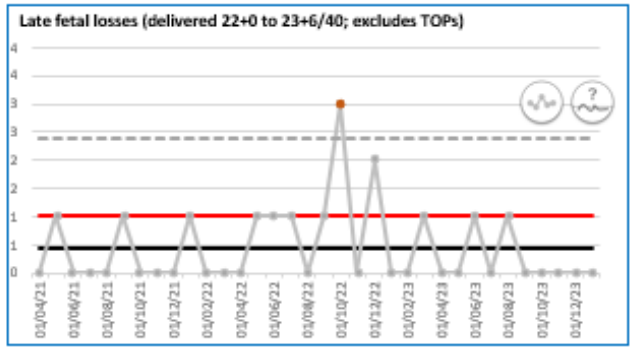




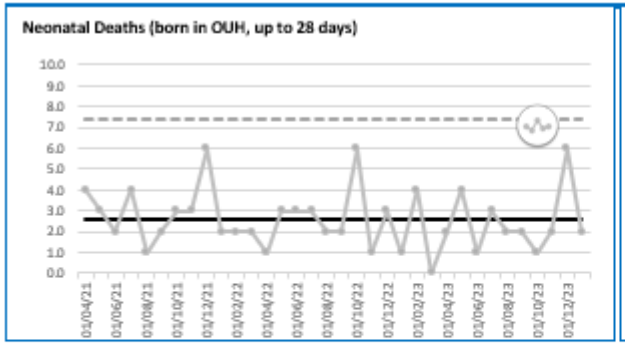


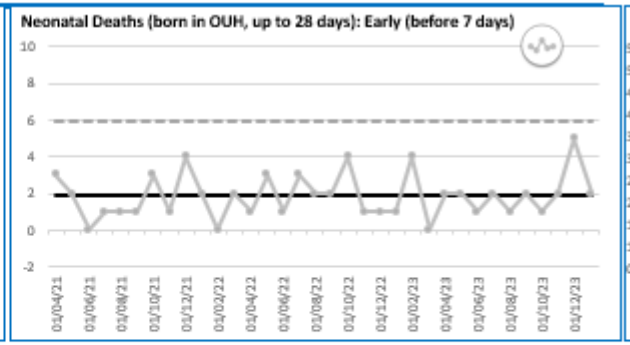


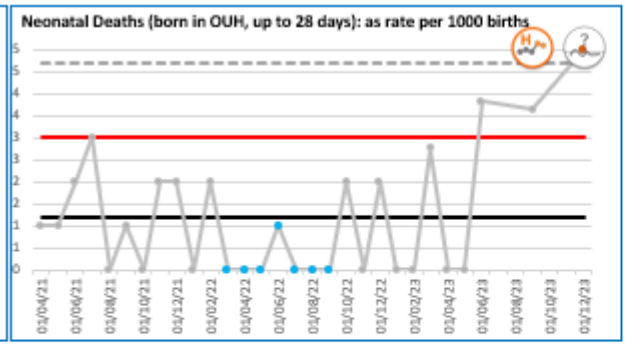


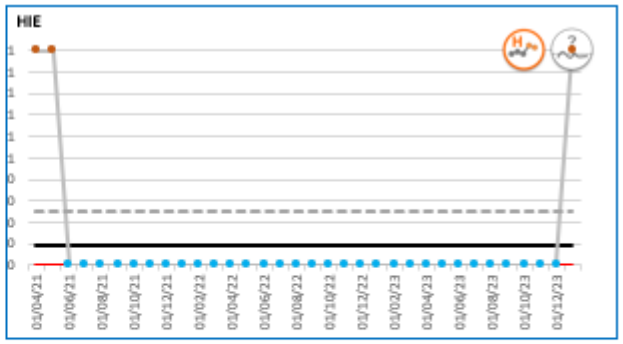


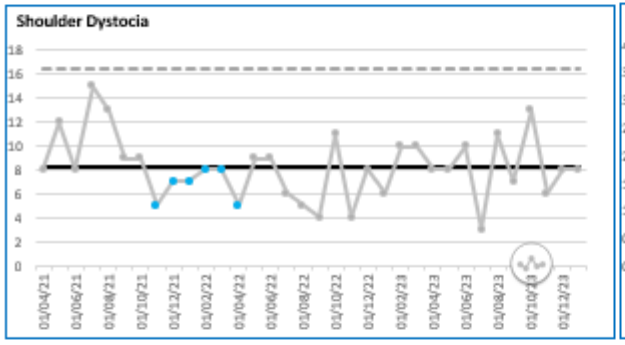
Appendix 1. SPC charts (5)

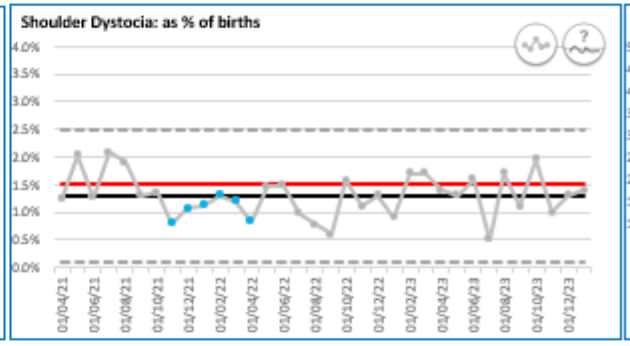


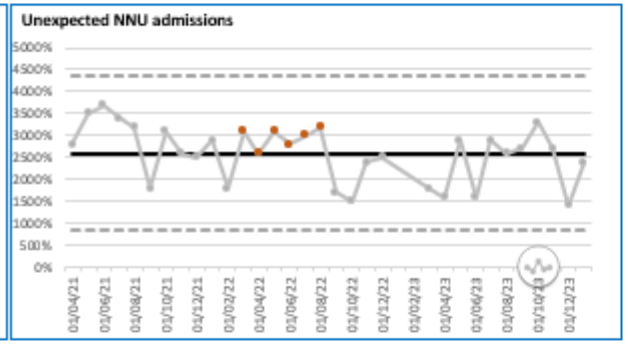


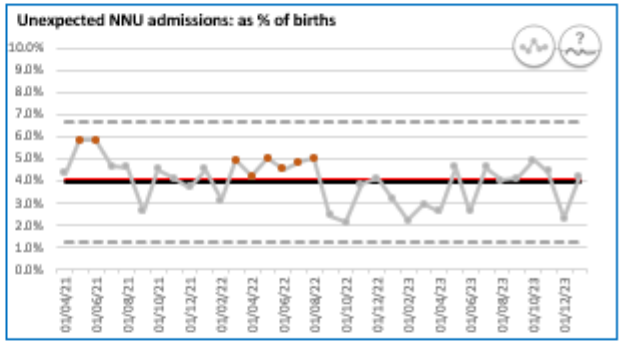


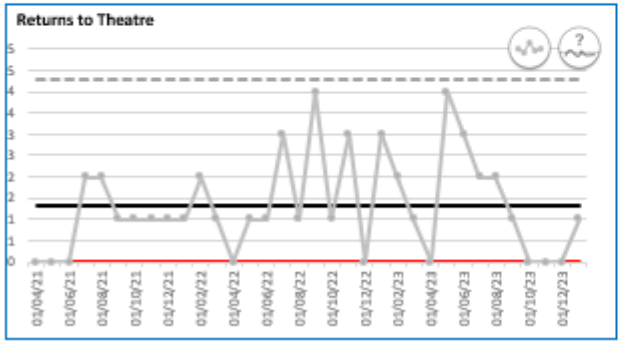


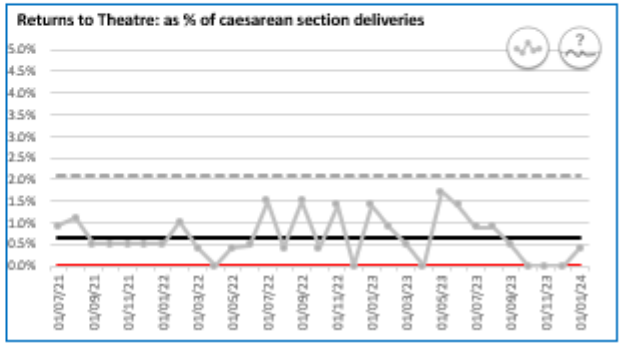


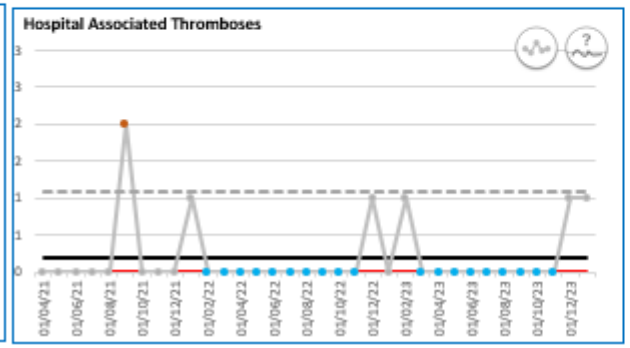




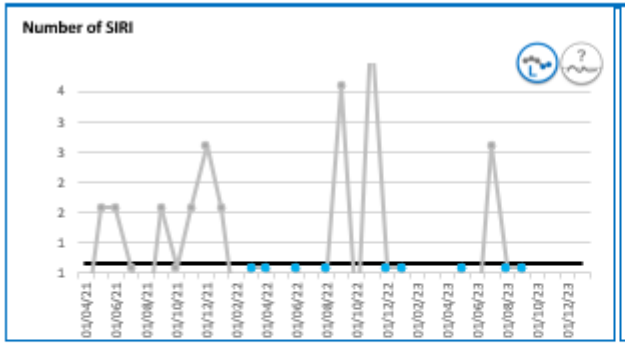


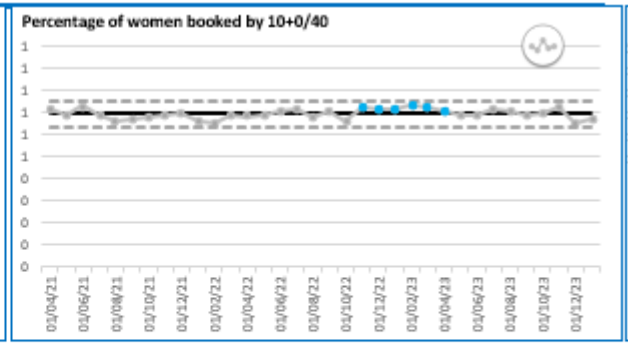


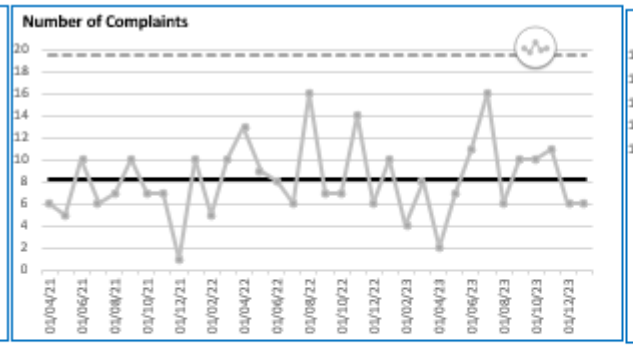


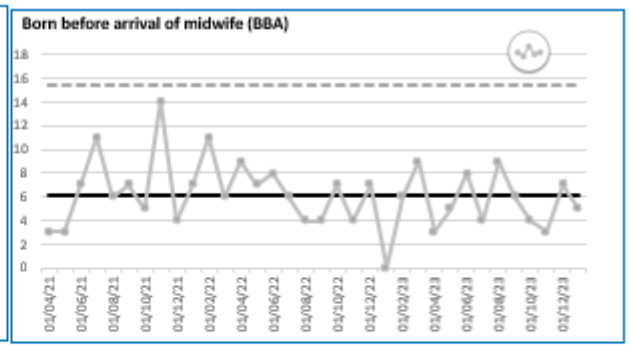


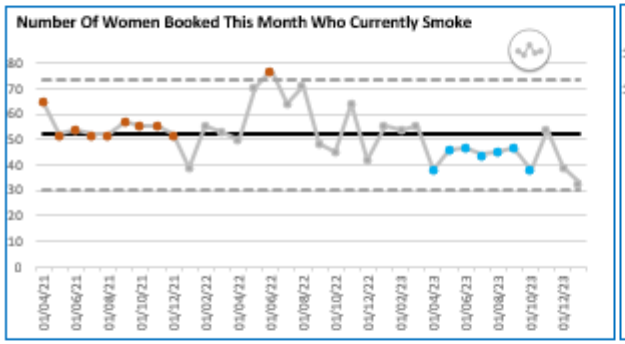
Appendix 1. SPC charts (6)

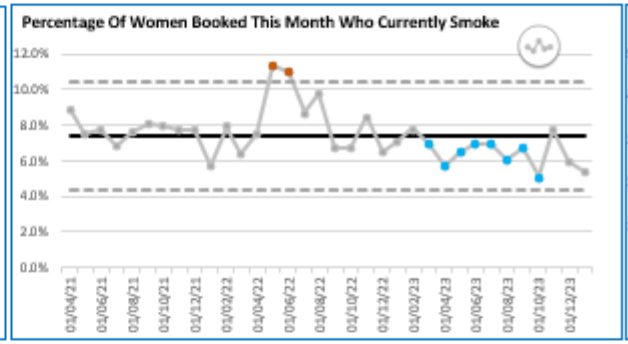


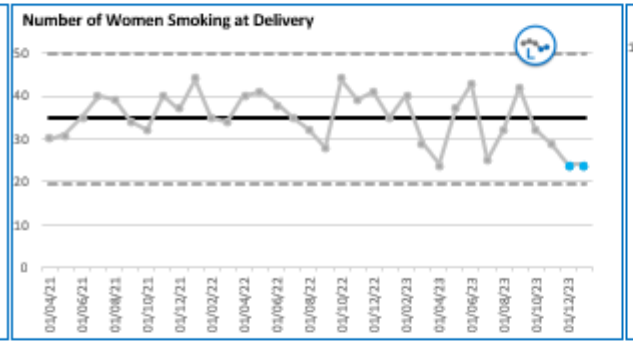


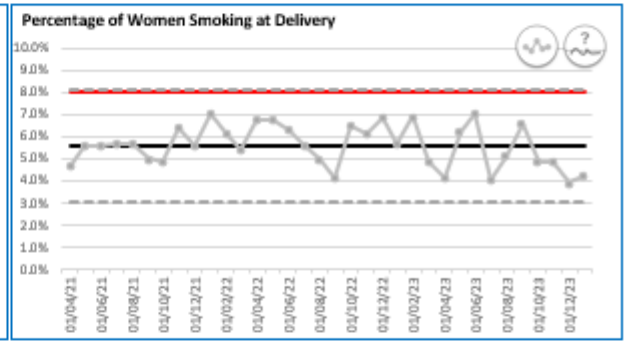


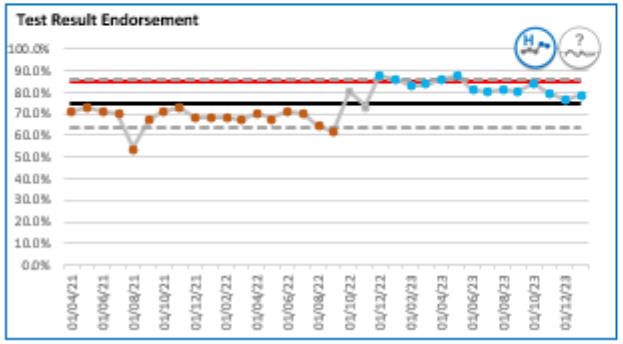


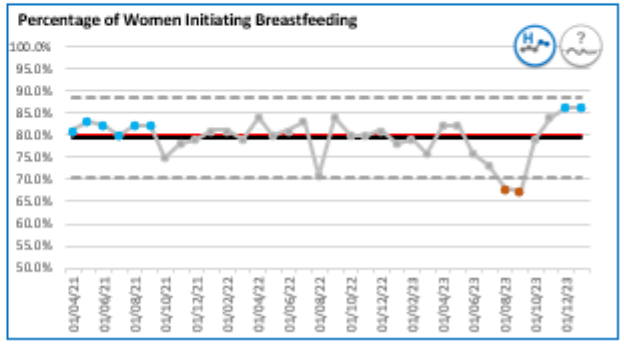












Gradings of Care for PMRT, Post partum haemorrhage (PPH), 3rd and 4th Degree Tears, Term Admissions to SCBU

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