Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Trust Board Meeting in Public: Wednesday 12 July 2023

TB2023.72

Title:	**Maternity Service Update Report**

Status:	**For Discussion**
History:	**Regular report.** **Maternity Clinical Governance Committee (MCGC) 26/06/2023. Previous paper presented to Trust Board May 2023**

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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 dashboard development status
    - Perinatal Quality Surveillance Model Report
    - CQC inspection action plan update
    - Maternity Development Programme
    - NHS Resolutions Response
    - Maternity Incentive Scheme Year 4
    - 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

Recommendations

2. 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.

Contents

1. Purpose

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

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- Maternity performance dashboard
- Perinatal Quality Surveillance Model Report
- CQC inspection action plan update
- Maternity Development Programme
- NHS Resolutions Response
- Maternity Incentive Scheme (MIS) Year 4
- Maternity Safety Support Programme (MSSP)
- Three year single delivery plan for maternity and neonatal services
- CQC outlier for midwifery led unit

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 that took place on the 10 June 2022 and the Trust received the final report.

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

2.3 IEA 7 – Informed Consent. Work continues on the actions from the CQC Maternity Survey Action Plan which was approved at MCGC in November 2022. Following the publication of the results of the 2022 CQC Maternity Survey that was published in January 2023, the action plan has been updated and co-produced with the Maternity and Neonatal Voices Partnership (MNVP) and is expected to be approved at the MCGC meeting on the 26 June 2023.

2.4 Work continues on the action plan that had been co-produced with the MNVP to update the Trust website to ensure pathways of care are clearly described, in written information in formats consistent with NHS policy is underway. This action plan has been revised (version 3) and an update is provided at the Maternity Clinical Governance Committee monthly.

2.5 Strengthening Midwifery Leadership – ongoing recruitment to vacant posts. All aspiring Band 7 midwife's and above have been offered leadership programmes which consist of the iCare leadership course and the Florence Nightingale course. Three members of staff have been accepted onto the NHS Academy Elizabeth Garrett Anderson MSc through the

apprenticeship programme this year – two of these commenced the course in June 2023. The secondment of the Midwifery senior leadership team has been extended to the 30 November 2023 to support continued stability for the Maternity service. One Deputy Head of Midwifery has returned from her secondment to the BOB LMNS. OUHT Maternity are also progressing a Band 2 to 9 succession planning pathway as part of the Single Delivery Plan (SDP).

3. Midwifery Led Unit (MLU) status

3.1 Since the last report to the Trust Board in May 2023, intrapartum care has continued to be provided alongside a wide range of services to women and their families across the county.

3.2 Community births were suspended on three occasions in April and on two occasions in May due to acuity. There were three women who did not receive their preferred choice of place of birth. There were no women affected by the closures and intrapartum care was not affected at the Horton MLU.

4. Maternity Performance Dashboard

4.1 The maternity performance dashboard may be seen in appendix 1 and the exceptions to note are:

4.2 Exception 1 – The number of Mothers birthed exhibited special cause variation due to seven consecutive points below the average. Additionally, the number of Mothers birthed was below the target of 625.

4.3 Exception 2 - The number of babies born exhibited special cause variation due to seven consecutive points below the average.

4.4 Exception 3 – Induction of Labour (IOL) as % of mothers birthed is showing special cause variation due to being consistently above the mean for the past 6 months.

4.5 Exception 4 - Spontaneous Vaginal Births (including breech): as a percentage of mothers birthed was 48%. Performance exhibited special cause variation due to the indicator being below the mean of 52.1% but above the upper process limit of 44.5%.

4.6 Exception 5 - Stillbirths (as rate per 1000) is reported quarterly and not reported for May. This is exhibiting common cause variation and is currently showing that it has failed to reach the target. However, as this is a quarterly review, we will have a more accurate measure reported in the July report at the end of quarter 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 April & May data 2023 is being received by the Trust Board at its private meeting on 12 July 2023 (paper TBC2023.55), having been previously reported to Maternity Clinical Governance Committee in June 2023 and it is a standing agenda item at the Maternity Safety Champions meetings.

6. CQC Inspection and Action Plan Update

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

6.2 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 but no further update in terms of new building/refurb as this requires significant capital investment and this is not currently available.
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:** Capital projects team, Oxford hospitals charity and Delivery Suite matron are creating a business case for the bereavement room refurb on Delivery Suite. This will be contingent on capital funding being available for the project to proceed. There are planned weekly meetings in June 2023 between Maternity and the Estates team to progress this.

6.3 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.

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

6.5 Matrons walk rounds as part of the process to ensure the prevention and detection of the spread of infection in all areas.

6.6 Ensure new starters undertake the PGD competency to maintain compliance levels of >90%

6.7 The Maternity Safety display boards have been ordered and will be in place in July.

7. Maternity Development Programme (MDP)

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

7.2 The Maternity Bulletin which was launched in March 2023 has been renamed to “And Breath” in May. This has been distributed to staff monthly and has been positively received.

7.3 The clinical governance deep dive commenced in April 2023 and the last session was held on the 16 June 2023.

7.4 The birthing pool has been installed in Delivery Suite in May.

7.5 Six “Say on the Day” system devices are now deployed, four in staff rooms on Maternity levels and two in Community hubs so staff can rate their shift. Staff working in other areas where there is no device situated can access the system via a QR code so they can scan with their phone and leave feedback.

8. NHS Resolution Response

8.1 The NHS Resolution Early Notification (EN) team undertook a thematic review into cases for the Oxford University Hospitals NHS foundation Trust in June 2021 due to concerns raised regarding themes emerging from Healthcare Safety Investigation Branch (HSIB) investigations. The cases reviewed were from 2017 to 2021. The thematic review considered two main categories of care: A) care provided to the mother, B) care provided to the baby. The themes and actions were reviewed to identify the learning, and an action plan developed as a response to NHS Resolutions.

8.2 The reported action plan provides assurance that the themes raised have been or are planned to be addressed as part of our organisations commitment to learning from incidents in pursuit of our vision for compassionate excellence.

8.3 The action plan will continue to be monitored through internal governance processes.

8.4 In May, the Trust has received an outcome letter from NHSR acknowledging the Trust’s response. They were supportive of the work carried out which was outlined in the Trust response.

9. Maternity Incentive Scheme

9.1 Notification has been received from NHS Resolution that OUHT successfully passed Year 4 of the Maternity Incentive Scheme (MIS). This is a great achievement as nationally, only 52% of Trusts achieved full compliance with the Scheme. The Trust received a reimbursement of their initial outlay (10% of the precept payment) to take part in the Scheme. Additionally, a bonus payment was received by the Trust for successful completion.

9.2 Year 5 of the Maternity Incentive Scheme was launched on the 31 May 2023 and a scoping exercise is underway to map the new requirements of the Scheme against what is already embedded as ‘Business as Usual’. Due to the late launch date, there is a short time frame to complete the evidence gathering. The Trust will need to declare compliance by 12.00hrs on 01 February 2024. This will require all final evidence to be presented to MCGC on 18 December and Trust Board on 17 January 2024 (deadline for final paper on the 10 January

2024). If any adjustment is required to this timeline, extraordinary meetings will be scheduled in order to meet the reporting requirements.

9.3 A challenge was received in relation to OUHT's declaration of compliance for Safety Action 2, Year 4 of the Maternity Incentive Scheme on the 21 June 2023 from NHS Resolution (NHSR). All evidence pertaining to this Safety Action was submitted to NHSR for scrutiny and confirmation has been received that OUHT are 100% compliant.

9.4 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. Alongside MIS, Saving Babies Lives Care Bundle Version 3 (SBLCBv3) was also launched at the same time. This included a new section on Diabetes. SBLCBv3 is encompassed within Safety Action 6 of the MIS and compliance against the requirements will be managed within this project.

Safety Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?

9.5 The quarterly mortality report for quarter 1 will be received by the Trust Board at its private meeting in September 2023.

Safety Action 2: Maternity Services Data Set (MSDS):

9.6 The Trust continues to submit data to the MSDS in accordance with requirements. This Safety Action will be reviewed in detail with the key stakeholders in June 2023.

Safety Action 3: Transitional care services to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal Units' (ATAIN) programme?

9.7 The Maternity and Neonatal teams are meeting fortnightly in relation to transitional care (TC). They are currently formulating a business case for funding for an expansion to the capability of TC on Level 5 Women's Centre to include the provision of naso-gastric tube feeding. To date, TC has been measured as a 'service' and not a 'location'. However, due to a concerted effort by the working group (neonatal and maternity), the Transitional Care bays are being officially opened on Level 5 in August 2023. This will ensure a comfortable, well resourced space in which to keep mothers and babies together whilst in hospital. An ATAIN paper is presented at MCGC monthly and is a standing agenda item at the monthly Safety Champions meeting.

Safety Action 4a - Obstetric Workforce:

9.8 Maternity services continue to collate evidence to demonstrate engagement with the RCOG document for consultants' attendance at specific incidents. This Safety Action will be reviewed in detail with the key stakeholders in June 2023.

Safety actions 5 – Midwifery workforce:

9.9 A Midwifery Staffing paper was received by Trust Board in January 2023 for quarter 1 and quarter 2. A paper covering quarter 3 and 4 will be submitted to MCGC in June 2023 prior to submission to the Trust Board in July 2023. The Birth Rate Plus tool was completed in December 2022 and this has identified a requirement of 23.38 additional midwives based on birth rate and acuity within the service. A business case to support this is in progress.

Safety Action 6 – Saving Babies Lives Care Bundle 3:

9.10 Version 3 of the Saving Babies' Lives Care Bundle (SBL v3) was published on the 01 June 2023. There is a 6th element added to this related to Diabetes. The required standard is to provide assurance to the Trust Board and the Integrated Care Board (ICB) that the Trust is on track to fully implement all six elements of SBLv3 by March 2024. Compliance with this element will be coordinated by the project lead for the Maternity Incentive Scheme with support from the clinical lead for each element.

Safety Action 7 – Maternity & Neonatal Voices Partnership (MNVP):

9.11 The MNVP continue to work closely with the Maternity team. Feedback is provided as part of the Perinatal Quality Surveillance Report (PQSM) that is reported monthly to MCGC. The MNVP have co-produced the action plan in response to the CQC Maternity Survey that was published in January 2023.

Safety Action 8 – Training:

9.12 The training weeks continue monthly in maternity. Training compliance is reported monthly via the quality report and the PQSM which is reported monthly to MCGC. A report with data for April and May is being received by the Trust Board at its private meeting on 12 July 2023 (paper TBC2023.55), having been previously reported to Maternity Clinical Governance Committee in June 2023 and it is a standing agenda item at the Maternity Safety Champions meetings. Fortnightly meetings are underway to ensure data is captured in a timely way to prove ongoing compliance with this Safety Action.

Safety Action 9 – Safety Champions:

9.13 The maternity safety champions have been undertaking safety champions walk rounds monthly. Feedback from these is shared with staff locally. The feedback is included as part of the PQSM. The Safety Champions continue to meet monthly with the Board Level Safety Champions. There is a requirement that the Trust Claims Scorecard be reviewed alongside incident and complaint data by 17th July 2023. This is outside of the schedule for the Maternity Safety Champions meeting and an extraordinary meeting will be convened prior to this date to meet this requirement. One further meeting will be required prior to submission to NHSR.

Safety Action 10 – Reporting Cases to HSIB and NHS Resolutions as part of the Early Notification (EN) scheme:

9.14 The maternity safety team report all eligible cases to HSIB and the EN scheme. All eligible cases are reported to the SIRI forum. They are noted in the quality reports and the PQSM.

10. Maternity Safety Support Programme (MSSP)

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

10.2 The MIA is continuing to work with the Maternity Clinical Governance team to undertake the deep dive into clinical governance which commenced at the end of April 2023 and the final session was held on the 16 June 2023.

10.3 There has been a representative from the Maternity and Neonatal Voices Partnership (MNVP) at the majority of the Clinical Governance Deep Dive meetings.

10.4 Currently awaiting the recommendations from the deep dive.

11. Three Year delivery plan for maternity and neonatal services

11.1 The Three year delivery plan for maternity and neonatal services was published on the 30 March 2023 called the Single Delivery Plan. This has been shared with the neonatal team and gynae team.

11.2 The Trust has received technical guidance in relation to the SDP. Work streams have commenced.

11.3 There is a further highlight report to be published from the National team in relation to the SDP at the end of June which is expected to give further guidance in how the deliverables will be achieved which will assist with the gap analysis.

Theme 1: Listening to women

11.4 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) and is planned to be launched end of June/beginning of July.

11.5 The MNVP have been working with maternity staff to co-produce the action plan following the recent CQC Maternity Survey results. The chairperson for the MNVP attends the MCGC meetings. She has also been involved in the Maternity deep dive that has recently been undertaken.

11.6 There is MNVP attendance at internal Maternity meetings, involvement in the recruitment of staff and quality improvement projects across the service.

11.7 A workstream has commenced related to achieving the standard of the UNICEF UK Baby Friendly Initiative (BFI) for infant feeding.

Theme 2 – Workforce

11.8 Staffing requirements have been reviewed through the benchmarking tool Birth Rate plus and the latest analysis in February 2023 was that acuity is increasing therefore there is a need for an uplift in midwifery staffing of 22.38 wte.

11.9 There is a newly recruited dedicated recruitment and retention team in place within maternity.

11.10 BOB LMNS workstream has commenced in relation to developing a succession plan for bands 2 to 9.

11.11 Continued development of staff at all levels.

Theme 3 – Culture and Leadership

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

11.13 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.

11.14 Involve the MNVP in developing the trust's complaints process, and in the quality safety and surveillance group that monitors and acts on trends. There is a meeting planned to look at how the service triangulates the MNVP feedback, the feedback from the Friends and Family Test (FFT) and themes from complaints.

11.15 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

11.16 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 2023.

11.17 A meeting has been arranged in relation to adopting the national MEWS however the NEWTT 2 tool also needs to be in place by March 2025.

11.18 There is a plan to introduce a new Digital Maternity record in October 2023 called BadgerNet into Maternity.

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

12.1 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.

12.2 On investigation it was noted that the birth occurred overnight. The circumstances that occurred related to a woman who was in labour and asked to attend the Maternity Assessment Unit (MAU) for review. Their route was blocked by an accident, and they were re-routed to Wallingford as the safest option as delivery was imminent. On-call midwives and an ambulance crew were mobilised, but the baby was delivered prior to their arrival assisted by the duty Maternity Support Worker (MSW).

12.3 Concerns were raised that the MSW was left in a vulnerable position and that the situation was not safe. Immediate actions to mitigate this occurring again have been made, and this is under constant review.

12.4 There is now consistency across the service on how the birth centres are staffed out of hours and will not affect any services that we provide. A letter has been drafted by the service in response to the concern raised to the CQC.

13. Recommendations

13.1 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

(TB2023.72)

June 2023

Data period: May 2023

Presented at Public Trust Board

Authors: Niamh Kelly – Maternity Safety, Risk & Compliance Lead

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Notable Successes

- In May the Trust were notified by NHS Resolution that we had achieved compliance with all ten safety actions for year 4 of the Maternity Incentive Scheme. This is a great achievement as nationally, only 52% of Trusts achieved full compliance with the Scheme.
- On the 9th of June 2023 OUHT received full reimbursement of its initial outlay to participate in the Year 4 of the Scheme, and a bonus payment for successful completion.
- The birthing pool on Delivery Suite was reopened in May 2023
- Six "Say on the Day" devices were deployed for staff in Maternity for them to give feedback on their shift
- Perinatal mental health e-learning programme has expanded to include two new sessions for parent-infant practitioners and their colleagues in specialist perinatal mental health services

Executive summary, continued

Domain	Performance challenges, risks and interventions
Activity	In May there was a total of 600 mothers birthed. There were 704 scheduled booking undertaken. There was a slight increase in the number of inductions of labour from iView as a % of mothers birthed.
Workforce	Midwife: birth ratio was 1:26.4. In May we had 311.43 midwives in post which was unchanged from the April data. However, during May we had 44.96 wte midwives unavailable for work. The unavailability relates to maternity leave, career breaks, sickness and clinical unavailability due to pregnancy and covid restrictions. The red flags in May were: staff moved between speciality areas = 32, supernumerary workers within the numbers = 11, administrative or support staff unavailable = 5, staff unable to take recommended meal breaks = 64, staff working over their scheduled finish time = 34, delay of 2 hours or more between admission for induction and beginning of process (number of days) = 21, number of women delayed during IOL process = 93, 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 SN = 0
Maternal Morbidity	In May there were 26 postpartum haemorrhages of >1.5litres reviewed using proformas on Ulysses. Fifteen were graded as an A - there were no care issues identified, and eleven graded a B – care issues identified but did not impact the care or management. There were eleven 3rd and 4th degree tears reviewed – two graded as an A, eight graded as a B and one graded as a C – care issues identified that may have impacted the care or management. This case was discussed at SIRI forum on the 8th June and a local investigation at moderate level impact was agreed.
Perinatal Morbidity and Mortality	There were three cases reviewed using the Perinatal Mortality Review (PMR) tool in May. They were graded as an A or a B. There were no recurring themes identified. There was an increase in the term admissions to SCBU in May – from 2.6% to 4.6%. There were eighteen cases reviewed using the proformas on Ulysses. Six of these were graded as an A and 12 were graded as a B. There was one graded as a C graded. This case was discussed at the SIRI forum on the 01/06/2023 and a local investigation at moderate level was decided. The main reason for most of the babies being admitted to SCBU was suspected sepsis. Some are discharged to the postnatal ward on a 5-day course of intra-venous antibiotics, which following a neonatal team review, are completed as an outpatient. There was one cases reported to HSIB in May related to a sad intrauterine death at term.
Re-admissions	There were 12 maternal postnatal readmissions in May. The reasons for this were abdominal pain, hypertension, sepsis and a wound review. There were four return to theatres and one of the women was admitted to the Adult Intensive Care Unit (AICU) following her return to theatre due to a major haemorrhage. There were no care concerns identified that would have prevented her return to theatre. This case was noted at the SIRI forum on the 15/06/2023. Investigations still in progress of the other three return to theatres.
Maternity Safety	There was one case reported as a SIRI which is the case that was reported to HSIB. There were eight complaints received and these related to mismanagement of labour x 3, inadequate support provided, accuracy of health records, accuracy of health records, discharged at inappropriate hour, delay or failure in ordering tests and access to treatment or drugs.
Test Endorsement	Test result endorsement was at 88%. 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.
Public Health	The percentage of women initiating breastfeeding has increased to 82%. The infant feeding team will continue to monitor this.
Exception reports	The number of Mothers birthed exhibited special cause variation due to seven consecutive points below the average as did the number of babies born. Induction of Labour (IOL) as % of mothers birthed is showing special cause variation due to being consistently above the mean for the past 6 months. Spontaneous Vaginal Births (including breech): as a percentage of mothers birthed was 48%. Performance exhibited special cause variation due to the indicator being below the mean of 52.1% but above the upper process limit of 44.5%.

Indicator overview summary (SPC dashboard)

ER Exception report

KPI	Latest month	Measure	Target	Assurance	Varriation	Mean	Lower process limit	Upper process limit
ER Mothers birthed	May 23	600	625	?	L	628	553	703
ER Babies born	May 23	619	-	P	L	639	562	715
Scheduled Bookings	May 23	704	750	?		710	563	857
Inductions of labour from iView	May 23	173	-	P		146	105	188
ER Inductions of labour from iView: as % of mothers b	May 23	29.0%	28.0%	?	H	23.3%	17.8%	28.9%
ER Spontaneous Vaginal Births (including breech)	May 23	285	-	P	L	324	253	394
Spontaneous Vaginal Births (including breech): as	May 23	48.0%	-	P		51.5%	44.0%	59.0%
Forceps & Ventouse	May 23	89	-	P		91	68	113
Forceps & Ventouse: as % of mothers birthed	May 23	15.0%	-	P		14.4%	10.8%	18.1%

KPI	Latest month	Measure	Target	Assurance	Varriation	Mean	Lower process limit	Upper process limit
C-Section	May 23	224	-	P		218	177	260
as % of mothers birthed	May 23	37.0%	-	P		35.4%	28.8%	41.9%
% Emergency c-sections	May 23	22.0%	-	P		20.0%	15.1%	24.9%
% Elective c-sections	May 23	16.0%	-	P		14.8%	10.5%	19.1%
Robson group 1 c-section with no previous births	Feb 23	15.5%	-	P		15.1%	11.7%	18.5%
Robson group 2 c-section with no previous births	Feb 23	57.0%	-	P		56.4%	48.4%	64.5%
Robson group 5 c-section with 1+ previous births	Feb 23	83.3%	-	P		84.3%	76.3%	92.3%
Elective CS <39 weeks no clinical indication	Feb 23	0.0%	0.0%	?		0.0%	0.0%	0.0%
Prospective Consultant hours on Delivery Suite	May 23	109	109	?		109	109	109
Midwife:birth ratio (1 to X)	May 23	26.4%	28.0%	?		27.1%	24.1%	30.2%

KPI	Latest month	Measure	Target	Assurance	Varriation	Mean	Lower process limit	Upper process limit
3rd/4th Degree Tear	May 23	8	-	P		12	1	23
3rd/4th Degree Tear as % of SVD+OVD	May 23	2.1%	3.5%	?		2.9%	0.3%	5.6%
3rd/4th Degree Tear with unassisted births (SVD)	May 23	1.8%	-	P		2.6%	-1.8%	6.9%
3rd/4th Degree Tear with assisted births (OVD)	May 23	3.4%	-	P		4.9%	-2.7%	12.5%
PPH 1.5L or greater, vaginal births as % of mothers	May 23	3.1%	2.4%	?		2.0%	0.3%	3.7%
PPH 1.5L or greater, caesarean births as % of moth	May 23	0.8%	4.3%	P		1.3%	-0.8%	3.5%
ICU/CCU Admissions	May 23	1	-	P		1	-1	2
% completed VTE admission assessments	May 23	98.1%	95.0%	?		96.9%	94.0%	99.8%

KPI	Latest month	Measure	Target	Assurance	Varriation	Mean	Lower process limit	Upper process limit
Maternal Deaths: all	May 23	0	-	P	L	0	0	1
Early Maternal Deaths: Direct	May 23	0	0	P		0	0	0
Early Maternal Deaths: Indirect	May 23	0	-	P		0	0	0
Late Maternal Deaths: Direct	May 23	0	-	P		0	0	0
Late Maternal Deaths: Indirect	May 23	0	-	P		0	0	0
Puerperal Sepsis	May 23	6	-	P	L	7	0	13
Puerperal Sepsis as % of mothers birthed	May 23	1.0%	1.5%	?	L	1.0%	0.0%	2.1%
Stillbirths (24+0/40 onwards; excludes TOPs)	May 23	4	0	?		2	-2	6
ER Stillbirths (24+0/40 onwards; excludes TOPs): as ra	Mar 23	5	0			4	#DIV/0!	#DIV/0!
Late fetal losses (delivered 22+0 to 23+6/40; exclu	May 23	0	1	?		1	-2	3

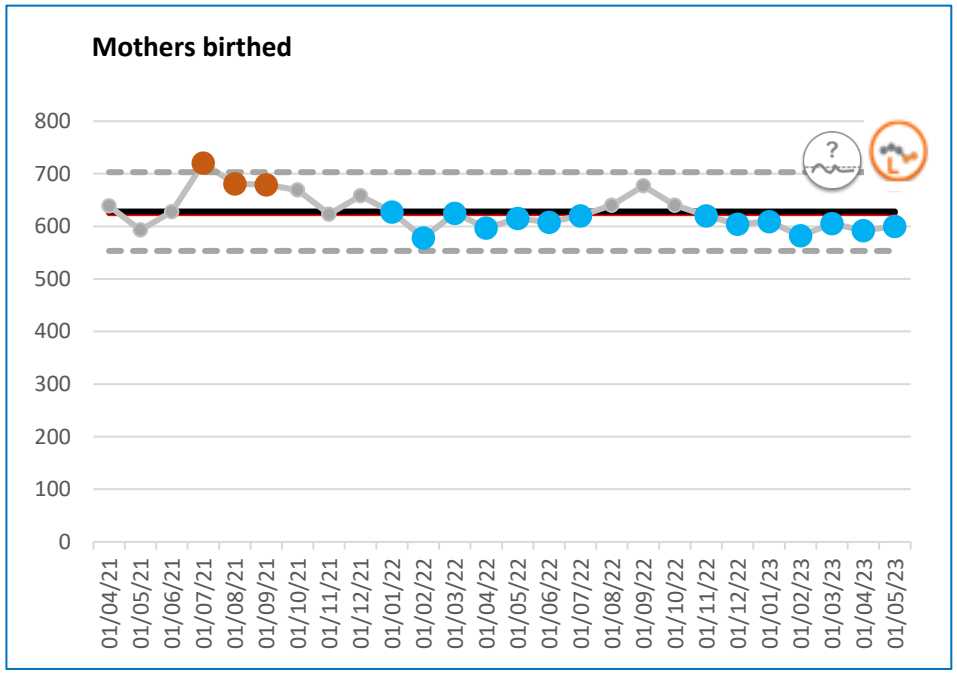
Indicator overview summary (SPC dashboard), *continued*

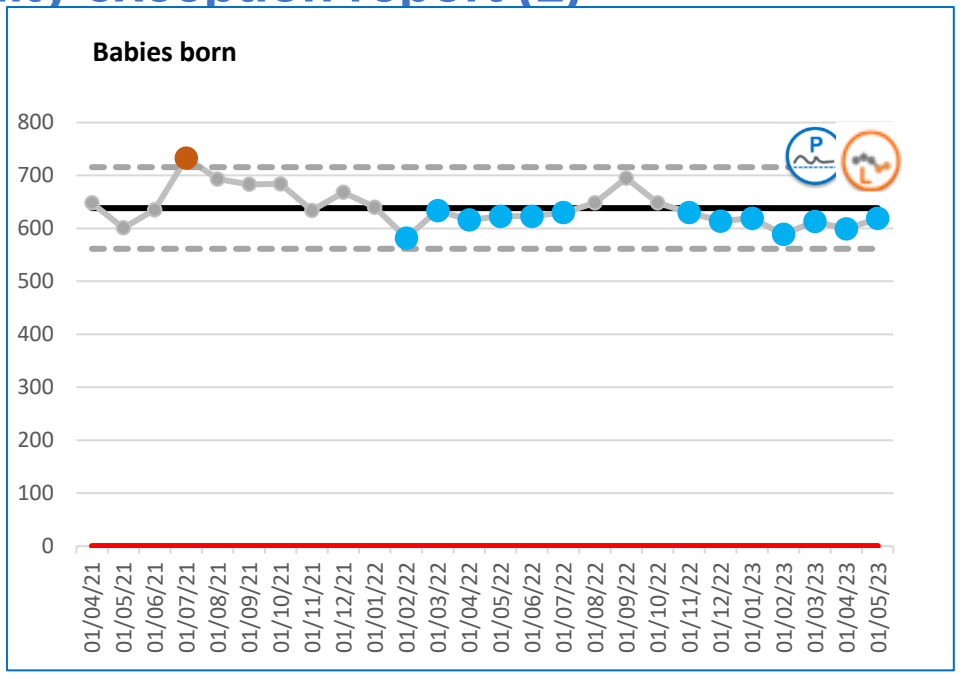
ER Exception report

KPI	Latest month	Measure	Target	Assurance	Varriation	Mean	Lower process limit	Upper process limit
Neonatal Deaths (born in OUH, up to 28 days)	May 23	4	-	P		3	-2	7
Neonatal Deaths (born in OUH, up to 28 days): Earl	May 23	2	-	P		2	-2	6
Neonatal Deaths (born in OUH, up to 28 days): as r	May 23	2	-	P		1	-3	4
HIE 2	May 23	0	0	?	L	0	0	0
HIE 3	May 23	0	0	?	L	0	0	1
Shoulder Dystocia: as % of births	May 23	1.3%	1.5%	?		1.3%	0.3%	2.3%
Unexpected NNU admissions: as % of births	May 23	4.6%	4.0%	?		4.0%	1.5%	6.5%
Hospital Associated Thromboses	May 23	0	0	?		0	-1	1
Returns to Theatre	May 23	4	0	?		1	-2	5
Returns to Theatre: as % of caesarean section deliv	May 23	1.7%	-	P		0.7%	-1.0%	2.4%

KPI	Latest month	Measure	Target	Assurance	Varriation	Mean	Lower process limit	Upper process limit
Number of SIRI	May 23	1	-	P	L	1	-3	5
Number of Divisional Investigations	May 23	0	-	P		0	-1	1
Number of Complaints	May 23	7	-	P		8	-4	20
Born before arrival of midwife (BBA)	May 23	5	-	P		6	-3	16
Test Result Endorsement	May 23	88.0%	85.0%	?	H	72.9%	60.8%	85.0%
Number Of Women Booked This Month Who Curre	May 23	46	-	P		55	32	77
Percentage Of Women Booked This Month Who Cu	May 23	6.5%	-	P		7.7%	4.6%	10.9%
Number of Women Smoking at Delivery	May 23	37	0			36	22	50
Percentage of Women Smoking at Delivery	May 23	6.2%	8.0%	?		5.7%	3.4%	8.1%
Percentage of Women Initiating Breastfeeding	May 23	82.0%	80.0%	?		80.2%	72.0%	88.3%
Percentage of women booked by 10+0/40	May 23	69.2%	0.0%			69.5%	64.0%	75.0%

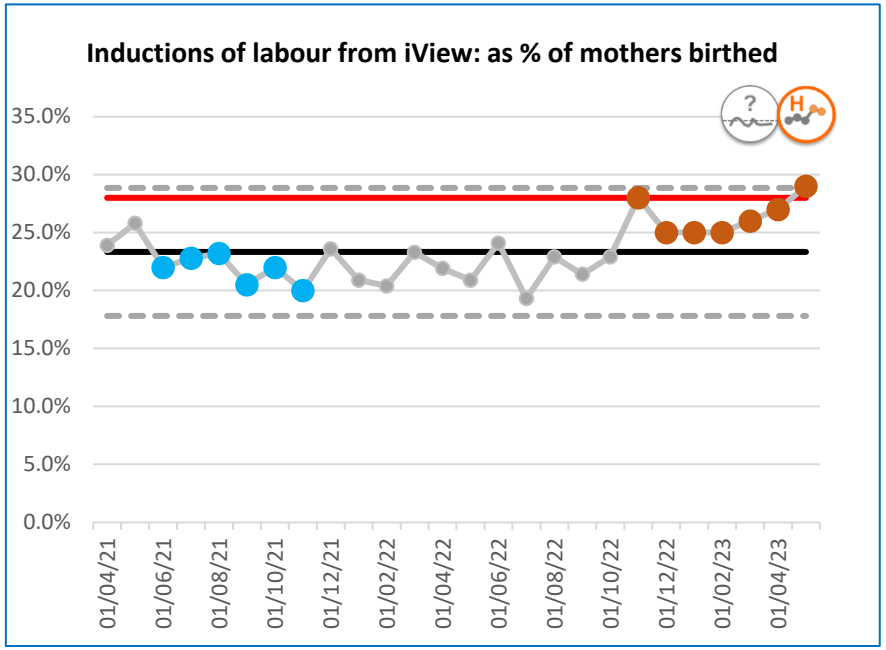
Maternity exception report (1)

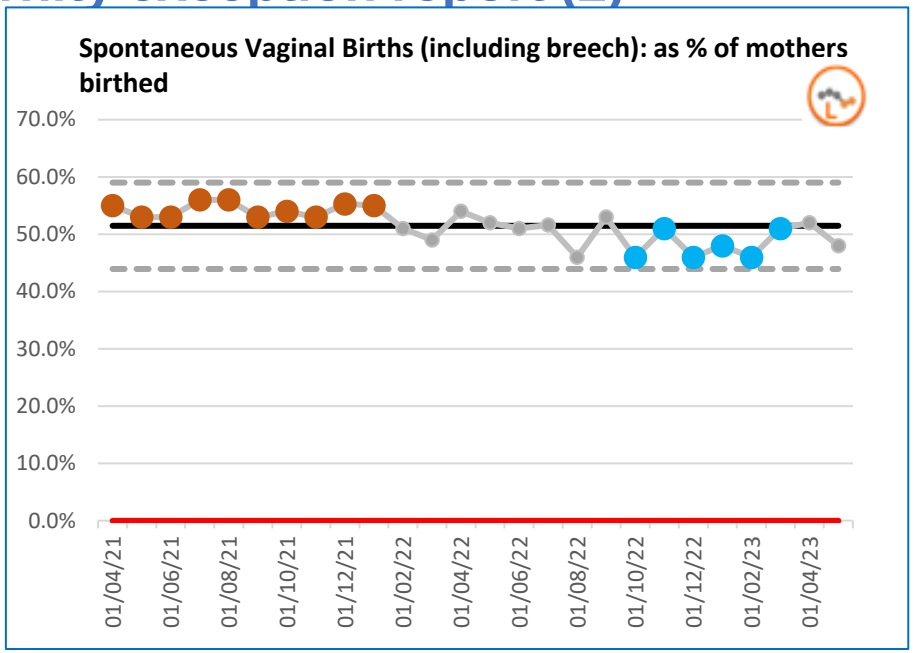




Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Timescales to address performance issue(s) and identification of any gaps in assurance	Risk Register score	Data quality rating
The number of Mothers birthed exhibited special cause variation due to seven consecutive points below the average. Additionally, the number of Mothers birthed was below the target of 625.	Although the birthrate is falling and this is a national trend, we have reviewed our staffing requirements through the benchmarking tool BirthRate plus and the latest analysis in February 2023 was that acuity is increasing therefore there is still a need for an uplift in midwifery staffing.	Business case to support recommendations in progress	N/A	
The number of babies born exhibited special cause variation due to seven consecutive points below the average.	Same as above			

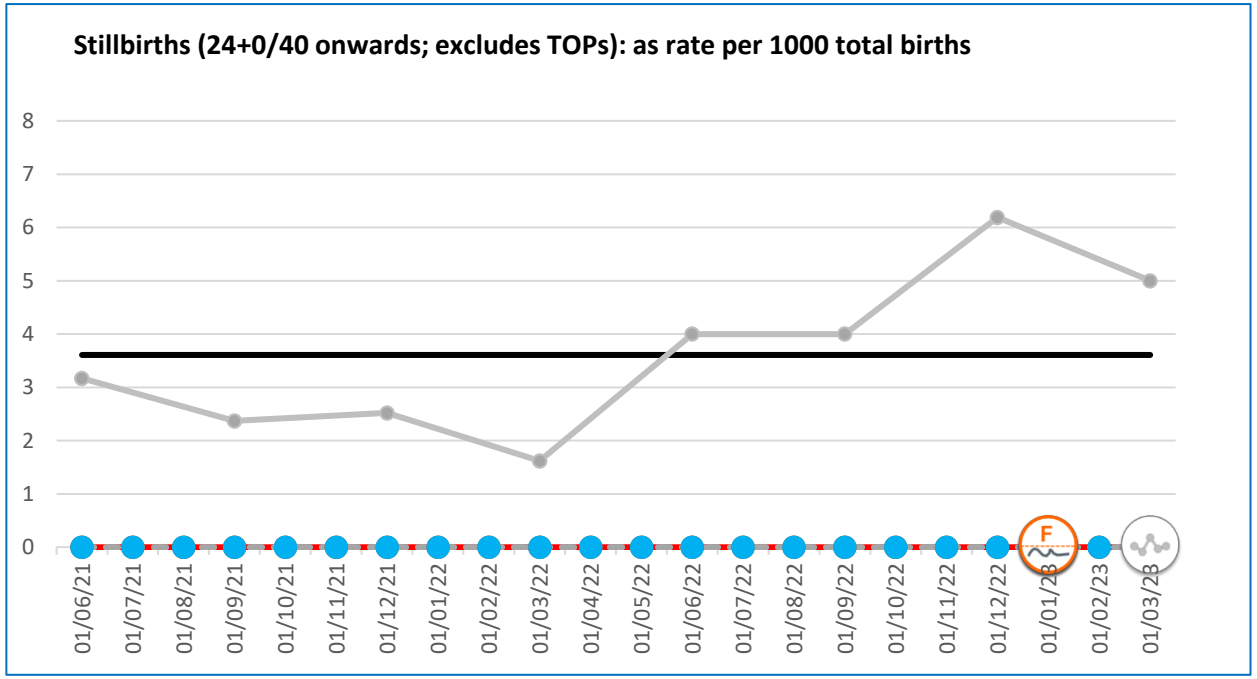
Maternity exception report (2)





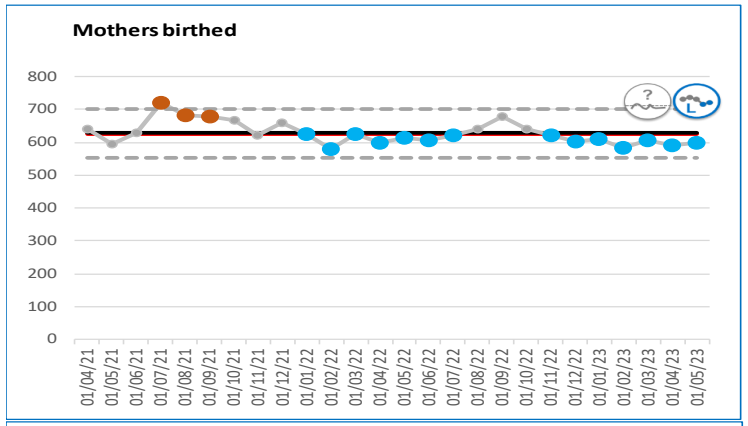
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Timescales to address performance issue(s) and identification of any gaps in assurance	Risk Register score	Data quality rating
IOL as % of mothers birthed is showing special cause variation due to being consistently above the mean for the past 6 months.	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.	Ongoing and monitored daily at the safety huddle on Delivery Suite	N/A	
In May Spontaneous Vaginal Births (including breech): as a percentage of mothers birthed was 48%. Performance exhibited special cause variation due to the indicator being below the mean of 52.1% but above the upper process limit of 44.5%.	This coincides with the increase in the caesarean section (CS) rate partly due to an increase in the maternal request for CS. Mode of birth is no longer an NHS target. We expect to see a higher caesarean section rate and a lower vaginal birth rate as a consequence of NICE guidance that is more supportive of maternal choice related to CS. The increase in the CS rate requires increased capacity and demand in the CS pathway and a proposal is being written. There is a plan for the paper to be presented at the Business Planning group in July prior to TME.	Three months	15	

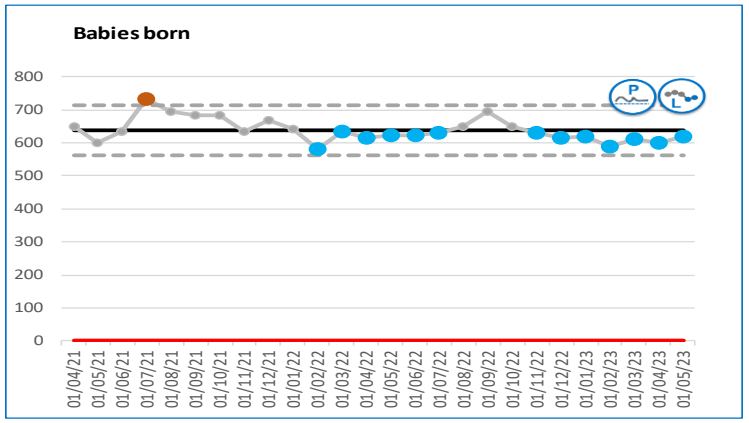
Maternity exception report (3)

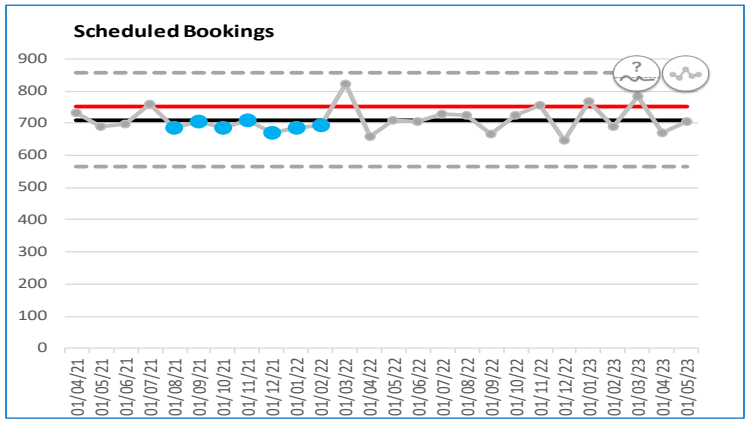


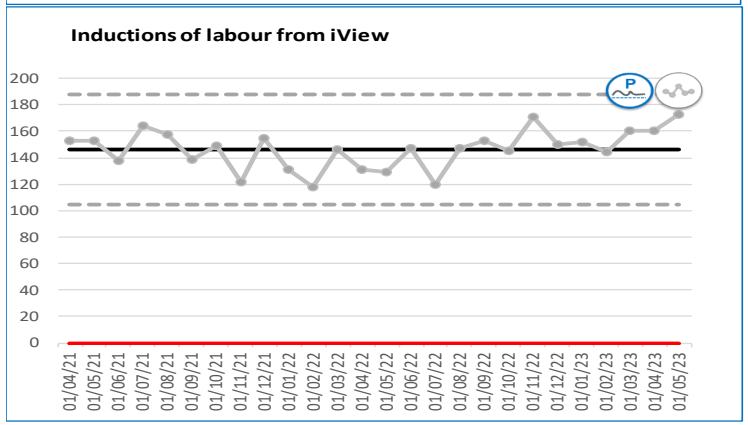
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Timescales to address performance issue(s) and identification of any gaps in assurance	Risk Register score	Data quality rating
Stillbirths (as rate per 1000) is reported quarterly and not reported for May. This is exhibiting common cause variation and is currently showing that it has failed to reach the target. However, as this is a quarterly review, we will have a more accurate measure reported in the July report at the end of quarter 1.				

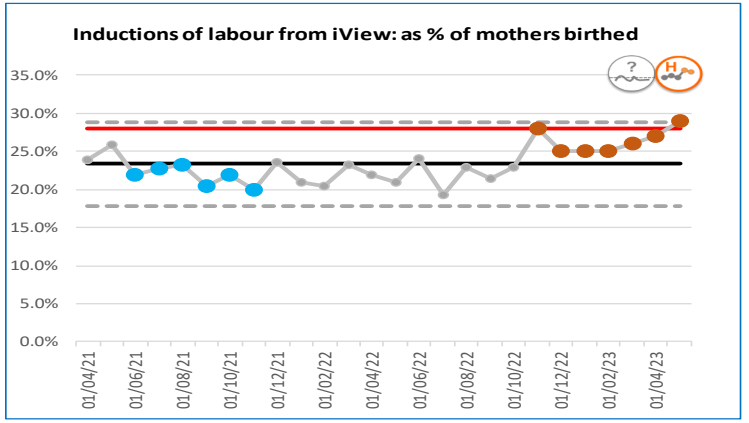
Appendix 1. SPC charts (1)

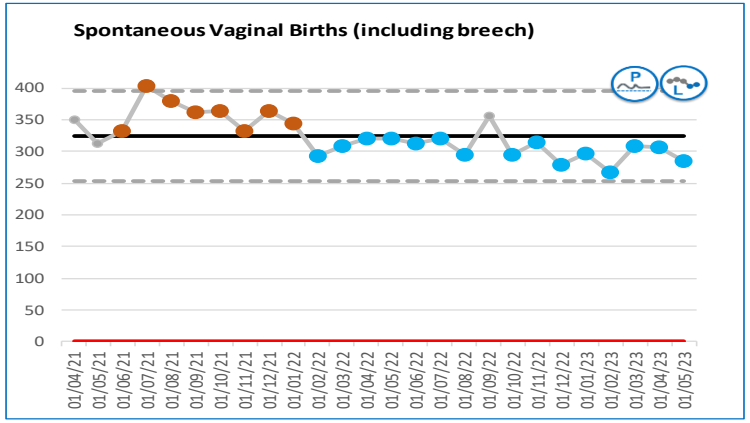


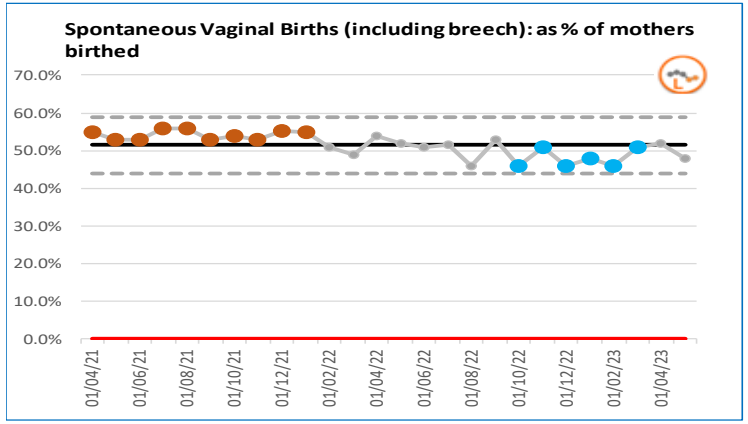


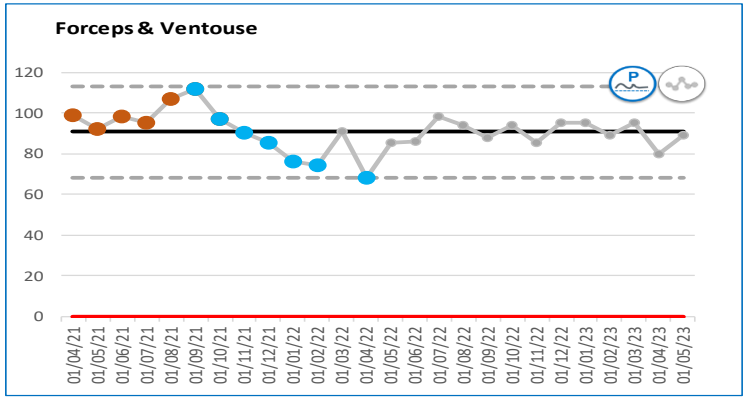


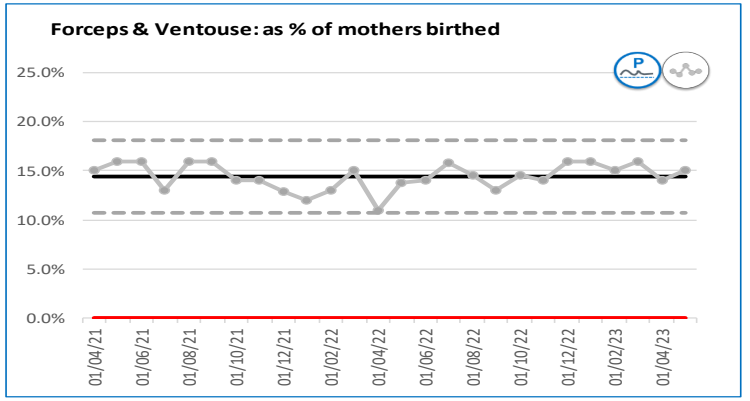




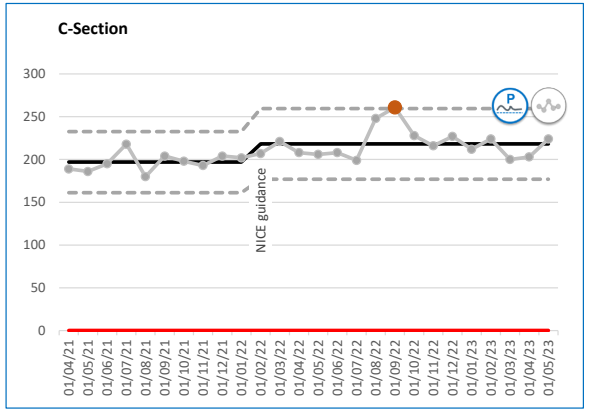


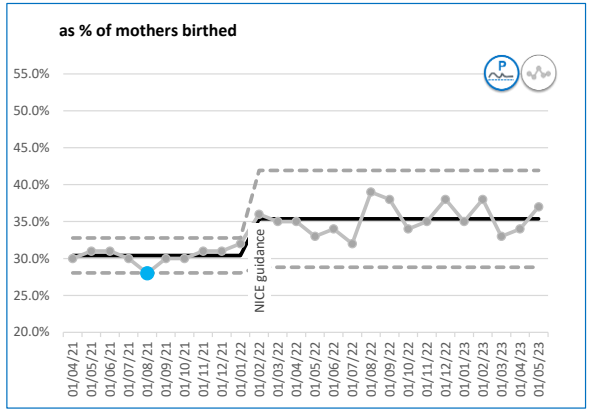


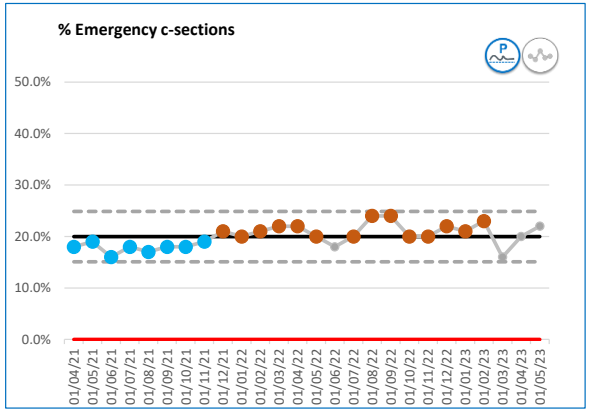


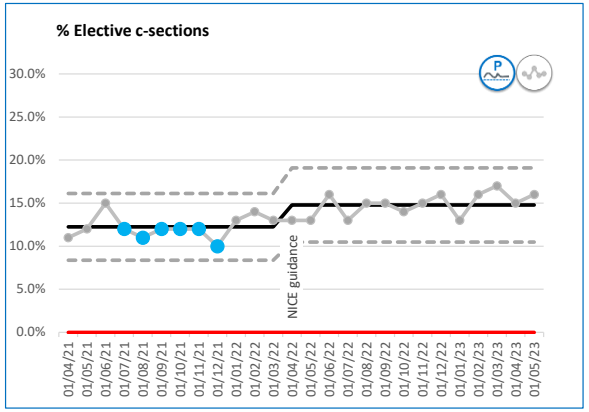


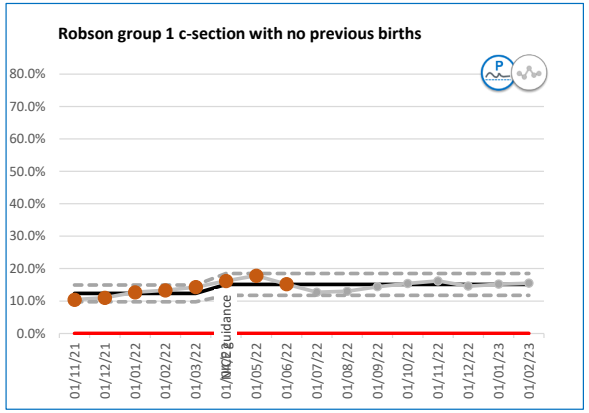
Appendix 1. SPC charts (2)

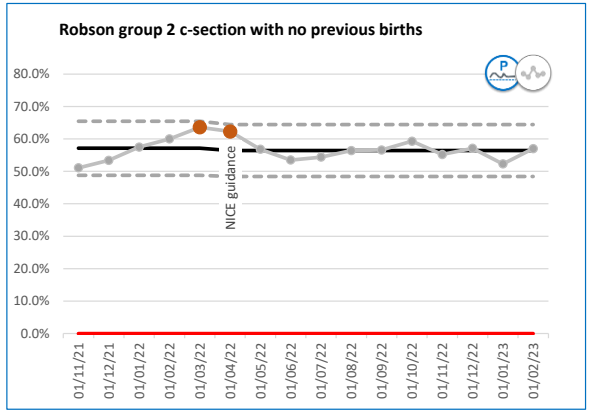


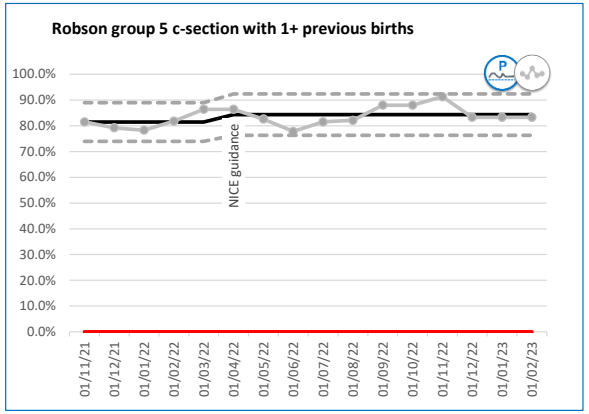


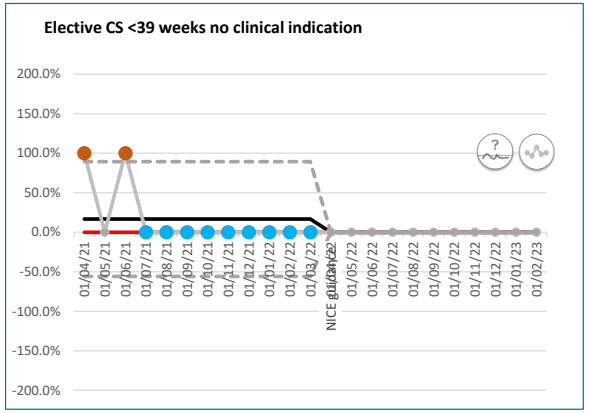


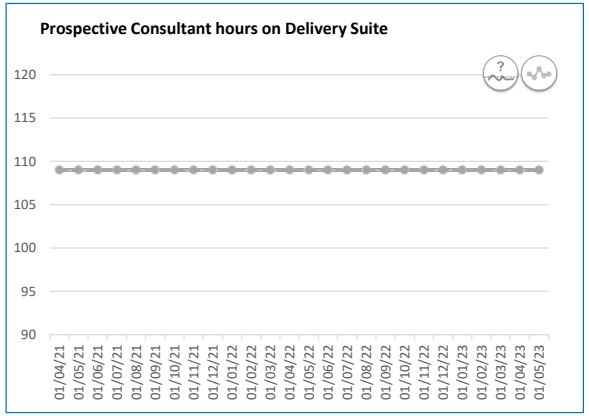


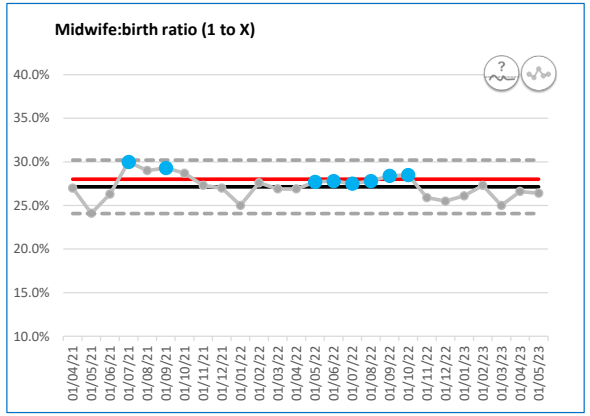




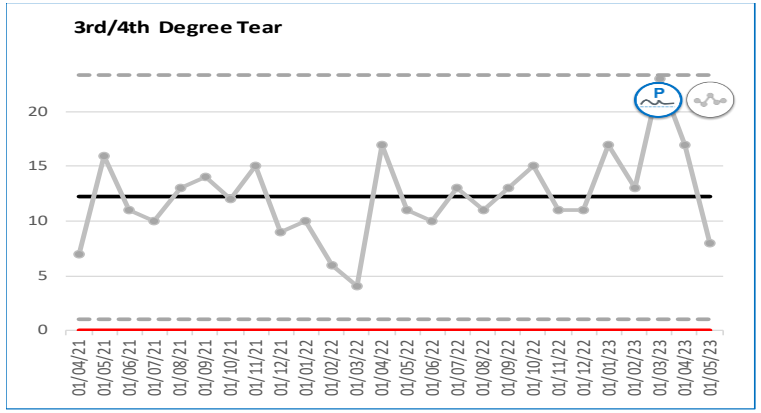


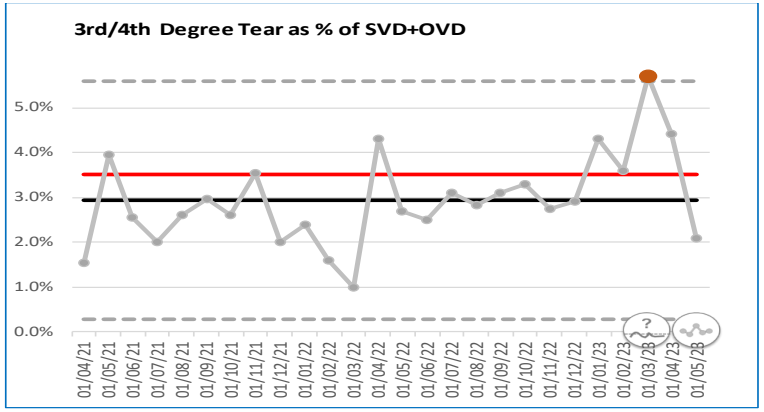


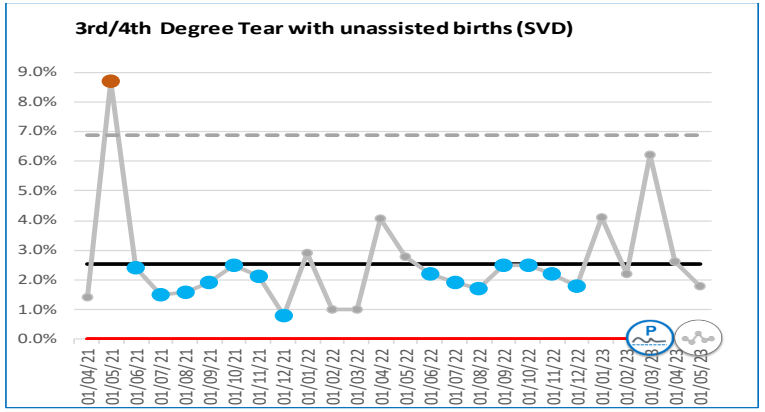


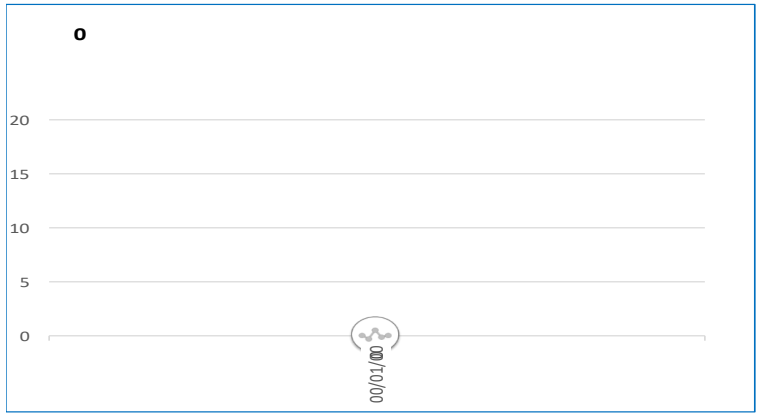


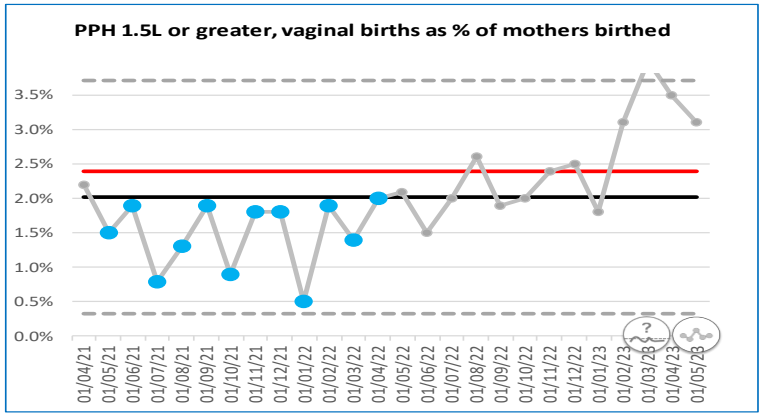
Appendix 1. SPC charts (3)

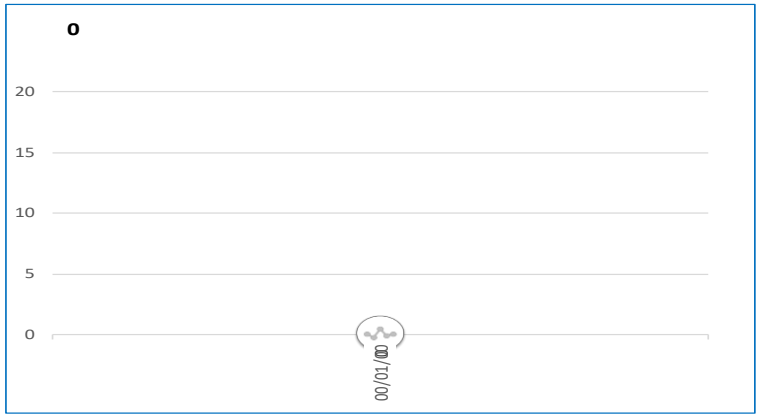


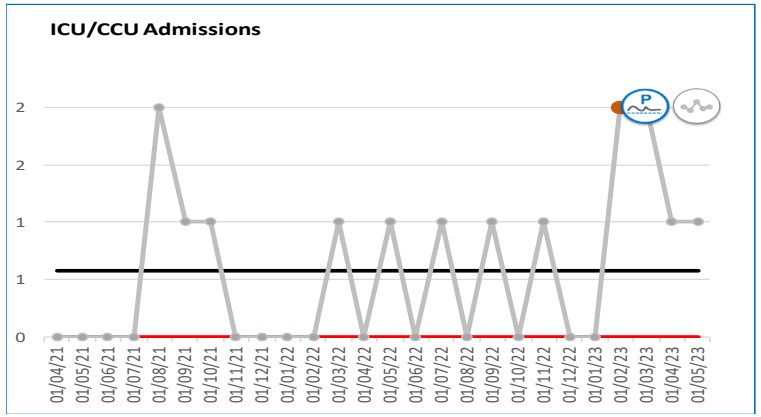


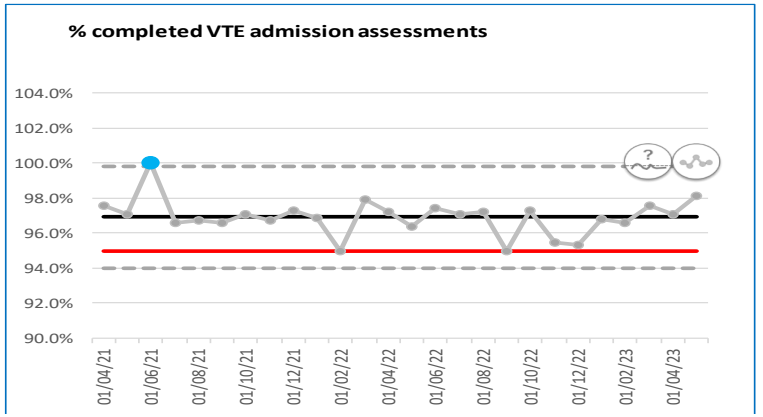




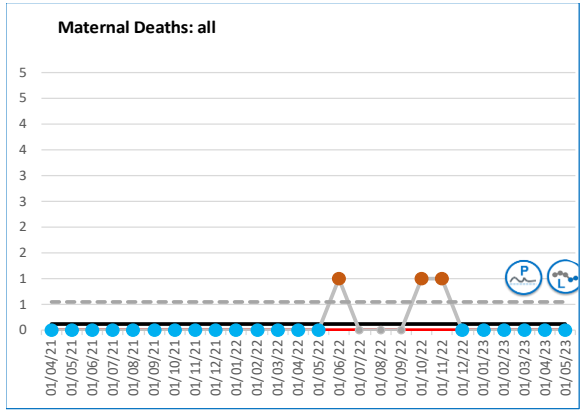


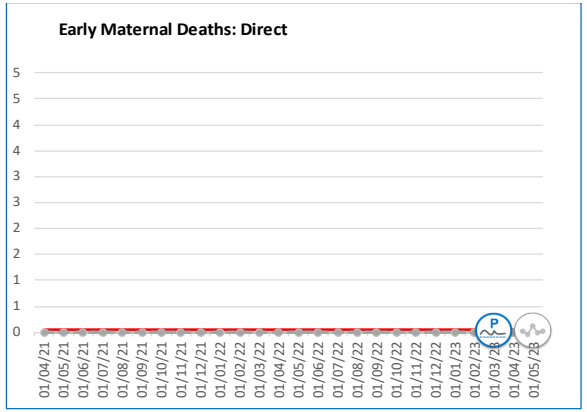


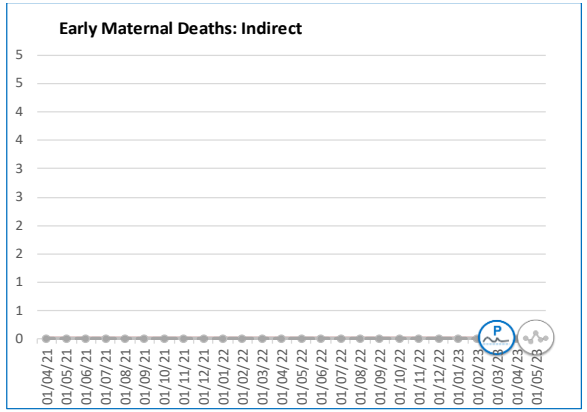


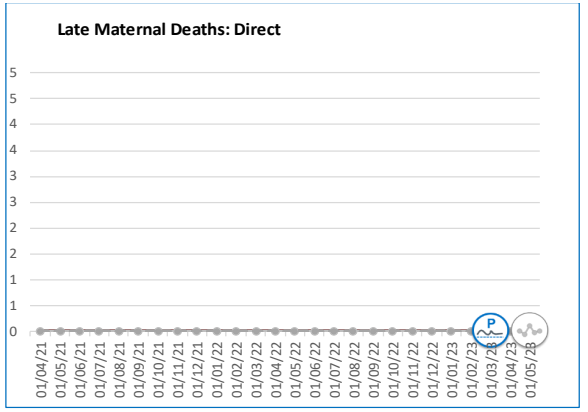


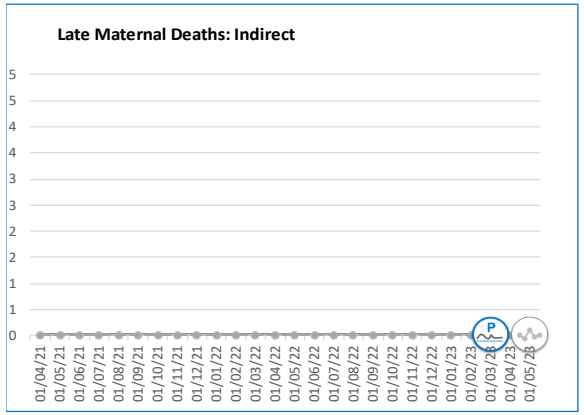
Appendix 1. SPC charts (4)

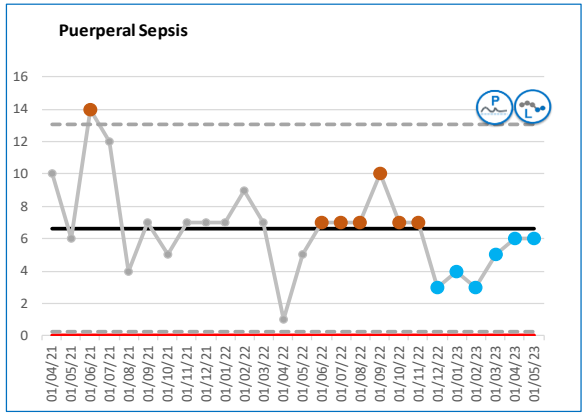


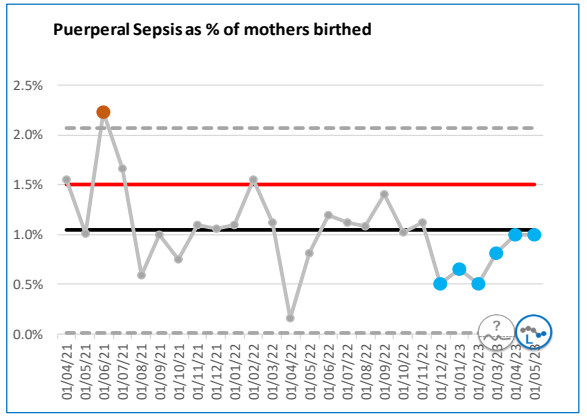


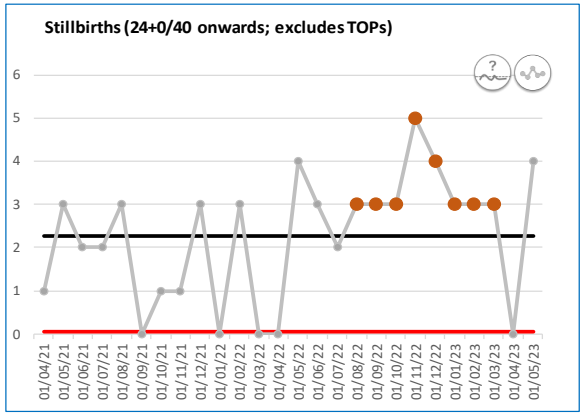


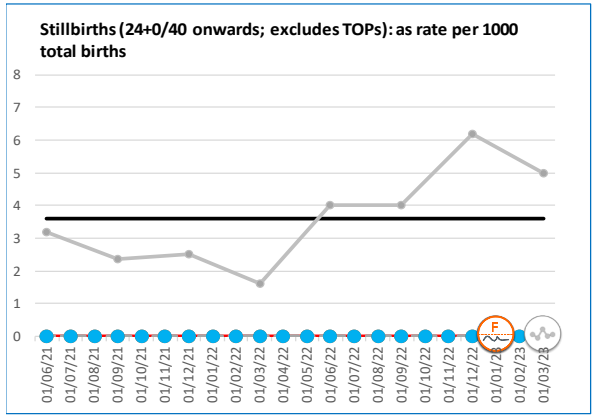


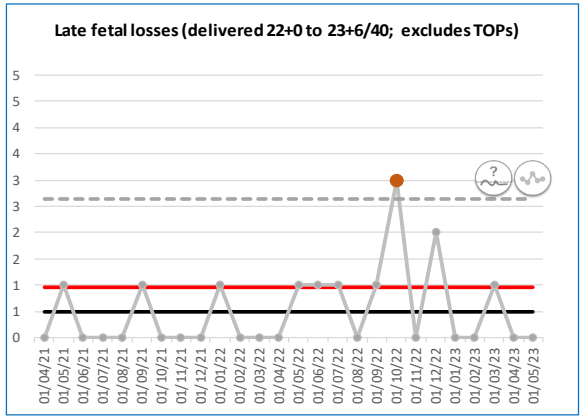




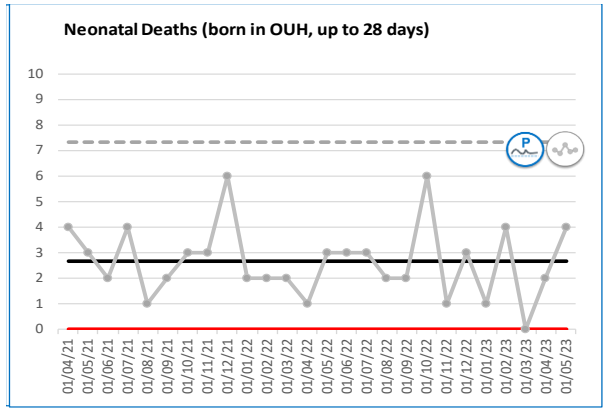


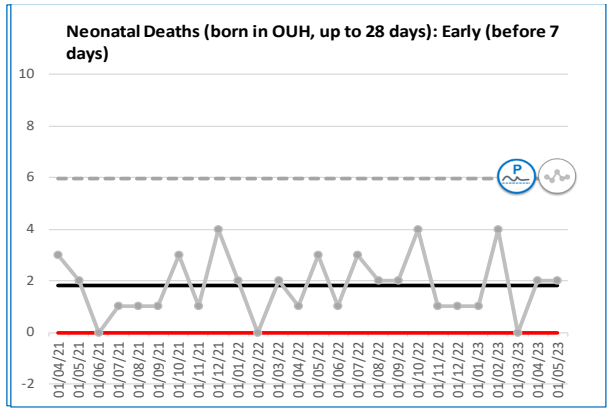


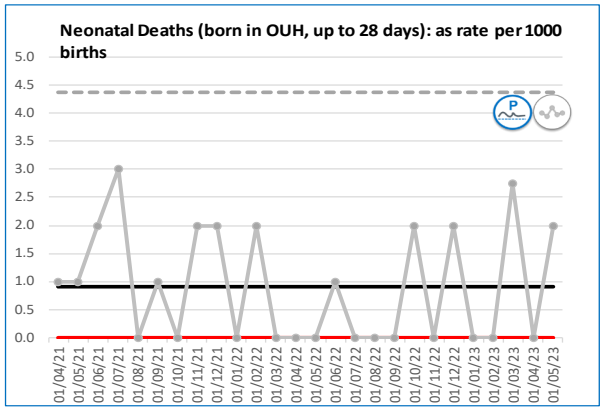


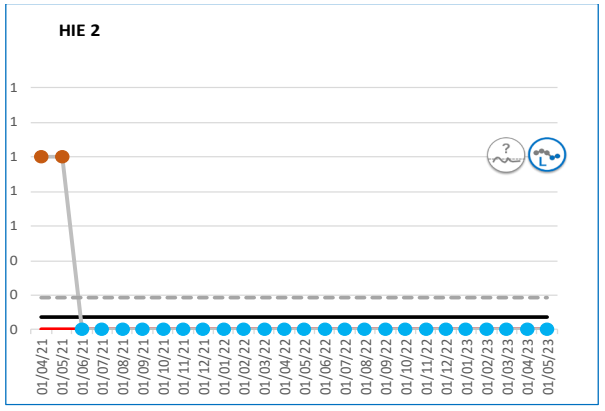


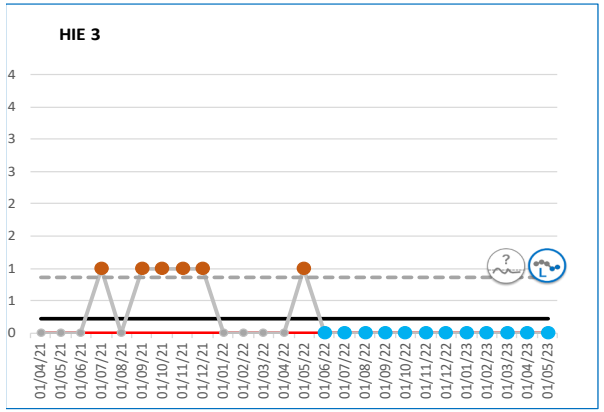
Appendix 1. SPC charts (5)

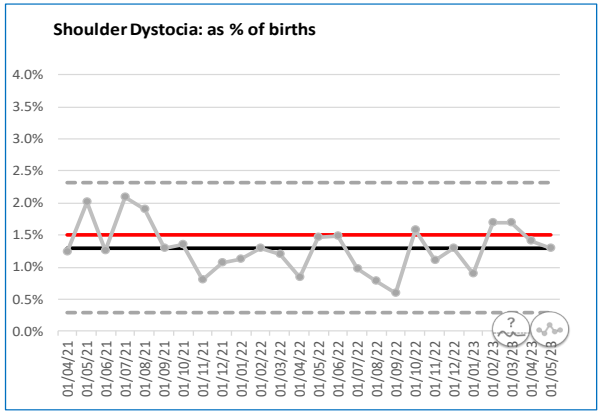


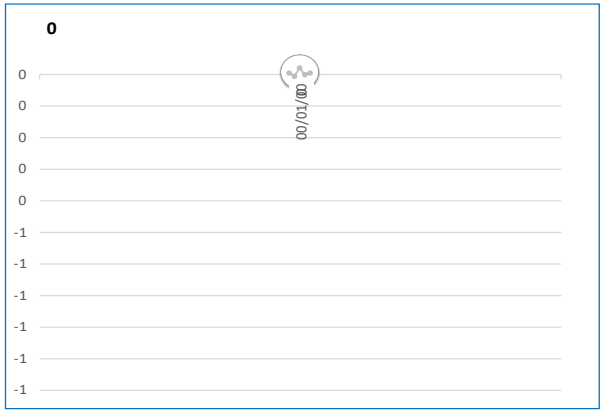


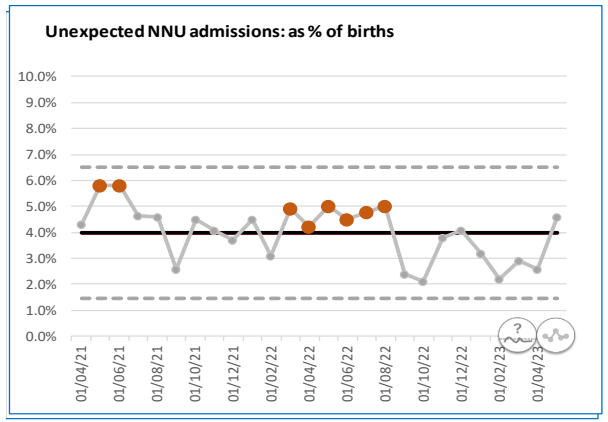


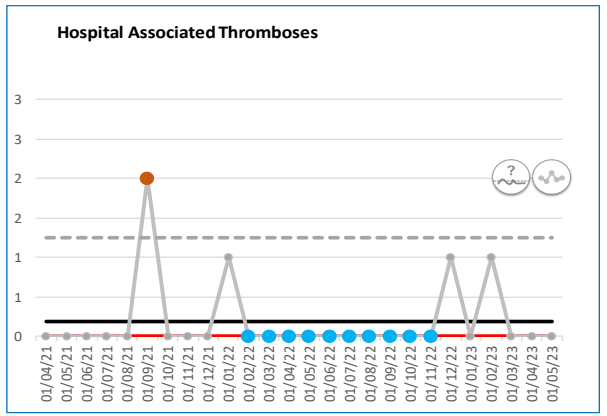


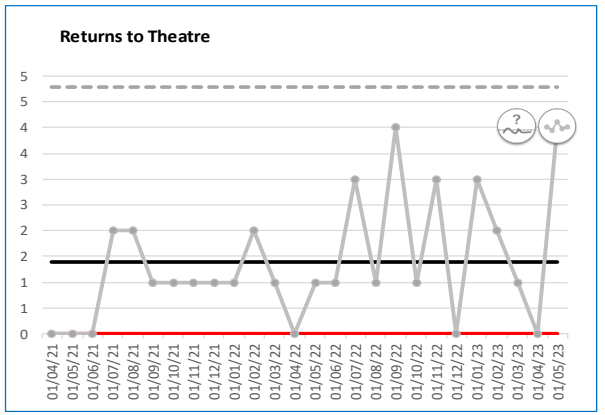


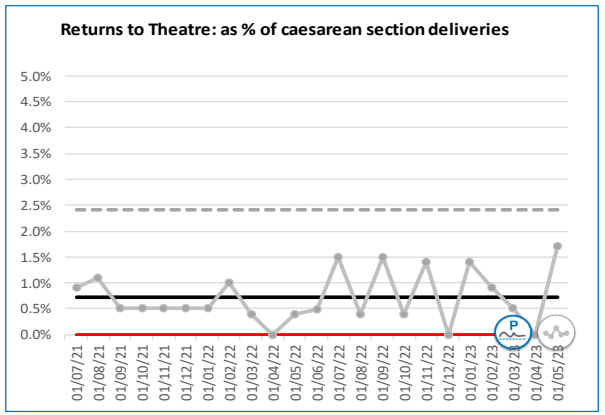












Appendix 1. SPC charts (6)