

## Cover Sheet

Public Trust Board Meeting: Wednesday 08 May 2024

TB2024.46

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**Title:** Maternity Services Update Report

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**Status:** For Discussion  
**History:** Regular Reporting  
Maternity Clinical Governance Committee (MCGC) 22/04/24  
Previous paper presented to Trust Board 13/03/2024

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**Confidential:** No  
**Key Purpose:** Assurance

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## **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 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:
  - Receive and note the contents of the update report.
  - Consider how the Board may continue to support the Divisional Teams.

## Contents

Cover Sheet .....	1
Executive Summary .....	2
Maternity Services Update Report .....	4
1. Purpose.....	4
2. Ockenden Assurance visit.....	4
3. Midwifery Led Unit (MLU) Status.....	5
4. Maternity Performance Dashboard .....	5
5. Perinatal Quality Surveillance Model Report.....	6
6. CQC Inspection and Action Plan Update .....	6
7. CQC Maternity Survey 2023 .....	7
8. Maternity Incentive Scheme (MIS) .....	8
9. Maternity Safety Support Programme (MSSP).....	8
10. Three Year delivery plan for maternity and neonatal services .....	8
11. Safeguarding.....	8
12. Antenatal and Newborn Screening.....	9
13. Recommendations .....	10
14. Appendix 1: Maternity Performance Dashboard April 2024 (March data) ...	11
15. Appendix 2: CQC Must and Should Do's .....	27

## Maternity Services Update Report

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### 1. Purpose

1.1. 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
- 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) launched on the 14/02/2024. It went live in the intrapartum setting on the 21/02/2024. The data captured from BadgerNet for March 2024 is a maternity activity snapshot only. There have been data input omissions identified that mean the BadgerNet data capture cannot be wholly accurate. The Digital Team have an action plan in place to help

address and resolve the inconsistency in data input amongst certain staffing groups which will commence week commencing 15/04/24. The aim is for a report to be presented at the Maternity Clinical Governance Committee (MCGC) meeting on the 20 May 2024 in relation to the Ockenden requirements (risk assessment at antenatal care contacts, place of birth suitability, high risk women assigned a named consultant and postnatal admissions).

- Strengthening Midwifery Leadership –All posts have been appointed into. New Head of Midwifery post appointed into and start date planned 28 May 2024. The Deputy Head of Midwifery for Community appointed into substantively start date 07 May 24.

### **3. Midwifery Led Unit (MLU) Status**

- 3.1. In February the homebirth and community service were suspended on one occasion except the Horton Midwifery Led Unit (MLU) however, no women were affected (incident ID 355684).
- 3.2. In March the homebirth and community service were (excluding the Horton MLU) suspended on two occasions (incident ID 361658 and 358727). One woman requested a homebirth that the service was unable to support, and the woman delivered on Delivery Suite. There were no other women affected.
- 3.3. The Trust sought clarification from the Care Quality Commission (CQC) on statutory notifications of temporary service suspensions due to staffing and acuity. The CQC advised that if an incident report is submitted, which in turn will be reviewed by CQC as part of their oversight of the learn from patient safety events (LFPSE) service, if the closure is for less than 12 hours there should be no requirement to complete a statutory notification form.

### **4. Maternity Performance Dashboard**

- 4.1. There were six exceptions reported for the March data, see appendix 1 for further detail.
  - Exception 1: Inductions of labour from iView as a % of mothers birthed shows special cause variation. The induction of labour is flagging as an exception as it has been above the mean for six consecutive months. These inductions are clinically indicated, so therefore cannot be reduced, but it informs acuity within maternity.
  - Exception 2: % completed VTE admission assessments shows special cause concerning variation. Due to challenges with data input in BadgerNet for March 2024, the VTE compliance statistic is very low. This is not an accurate representation of the true compliance of VTE figure. The digital team have agreed actions in progress to address data input and

capture issues. Previous data was pulled from Orbit and was within the target range.

- Exception 3: The neonatal death rate as per 1000 births is calculated quarterly. There was an increase in the neonatal death rate this quarter compared to in Quarter 3 (previously 4.2, currently 6.39).
- Exception 4: The number of HIE cases shows special cause variation due to one reportable case to MNSI.
- Exception 5: There was one woman who had a hospital acquired thrombosis.
- Exception 6: Percentage of Women Booked This Month Who Currently Smoke shows special cause concerning variation.

## 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 February and March 2024 data is being received by the Trust Board and Private Trust Board meeting on 08 May 2024. Both months were previously reported to MCGC in March and April 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 following the CQC inspection in May 2021.

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)	<b>Overdue:</b> 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	<b>Overdue:</b> The Capital Project team are working with suppliers to initiate

Should Do	Actions	Update
	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.	the refurbishments following the funding approval at TME in November. Asbestos survey has been undertaken and work commences at the beginning of May to remove the asbestos on Delivery Suite.

- 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 to the Horton Midwifery Led Unit (MLU) in October 2023. The service has received the final report ([Horton General Hospital CQC Report](#)), and it was published on the 08 March 2024.
- 6.4. This is the first-time maternity services at Horton General Hospital have been rated as a standalone core service. Previously, maternity and gynaecology services were inspected and rated together.
- 6.5. Following the inspection, the rating for the Horton General Hospital as a whole have also changed. The overall rating for the hospital has been amended from ‘Good’ to ‘Requires Improvement’ as have the areas of safe and well-led.
- 6.6. All Horton Maternity staff were invited to a CQC briefing on the 07 March and an overview of the report was presented by the Director of Midwifery. Time was given to the staff to respond and ask any initial questions. A further Horton MLU staff listening, and action planning event was undertaken by the Community Matron on Monday 11 March. Feedback from this session was shared with the Maternity Leadership Team and informed the development of the action plan so far.
- 6.7. There were Six ‘must do’ actions and seven ‘should do’ actions identified from the inspection activity – see appendix 2.
- 6.8. A briefing paper was presented and noted at the Integrated Assurance Committee (IAC) in April which included the action plan for the ‘must do’ actions. The IAC support the development and implementation of the maternity action plan and the associated process for monitoring implementation.

## 7. CQC Maternity Survey 2023

- 7.1. The [CQC Maternity Survey](#) was published on the 09 February 2024. The Trust are working with the Oxford Maternity and Voices Partnership (OMNVP) to develop an action plan.

## **8. Maternity Incentive Scheme (MIS)**

- 8.1. The Maternity Incentive Scheme for Year 6 was released on the 02 April 2024.
- 8.2. The service has received confirmation from NHS Resolutions that following the external verification process, Oxford University Hospitals have met all ten safety actions for year 5 of the Maternity Incentive Scheme. The results were published on the 10 April 2024.
- 8.3. The BOB LMNS reviewed and confirmed that OUHT are fully compliant with the Saving Babies Lives Care Bundle, Version 3 by the end of March 2024 as per the requirements of MIS year 5.
- 8.4. A new Maternity Incentive Scheme lead midwife commenced in post at the end of April 2024 and is arranging meetings with the stakeholders for each of the safety actions.

## **9. Maternity Safety Support Programme (MSSP)**

- 9.1. 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.
- 9.2. The reset and review took place on Monday 25 March 2024 between the Trust and the MIA.
- 9.3. A follow up meeting will take place in four months to review ongoing work in relation to maternity and neonatal services working more collaboratively and the progress of the bereavement room on Delivery Suite.

## **10. Three Year delivery plan for maternity and neonatal services**

- 10.1. 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 and are ongoing.

## **11. Safeguarding**

- 11.1. The hospital IDVA (independent domestic violence advocate) has been recruited and they have started in post. Their training is extensive and ongoing, and they will be on site as soon as the honorary contract has been set up. This will be until March 2025 and then a review of the data collected through the year to secure external funding if successful.
- 11.2. The complexity of maternity cases remains high, there are currently 308 pregnant women and birthing people with a safeguarding concern under the care



of OUH maternity services. Regular supervision sessions are held with hospital and community staff and support given to service users and staff.

11.3. The enhanced care (name TBC) is moving forward, with the job matching process completed for the band 6 midwife role. Internal stakeholder meetings highlighted areas where the roles will become an invaluable resource and the meetings were positive with the workforce, particularly in community, with staff looking forward to the new posts being recruited into. In addition, the structure and model agreed was presented at HAG (Health Advisory Group for Oxfordshire) and was met with again, a very positive and supportive response. An external stakeholder meeting is being held in May.

11.4. A security walk round was carried out with the Matron for Maternity Safeguarding, Matron for intrapartum care, Head of security, Deputy Head of Midwifery and Maternity Directorate Manager. This was in response to incidents regarding access to the wards by high-risk partners or family members. Some recommendations from the walk round have been implemented and there are ongoing projects to improve security including partner wristbands and additional CCTV. There will also be additional safeguarding training for ward clerks.

## 12. Antenatal and Newborn Screening

12.1. The Maternity Clinical Governance Committee received the quarter 3 (01 October 2023 to 31 December 2023) Screening Key Performance Indicators (KPI) at their meeting on the 22 April 2024. The exceptions to the KPI's were as follows:

- ST2 timeliness of antenatal screening – 77.4%. The data is collected from booking and lab data.
- ST3: completion of family origin questionnaire (FOQ) – 97.2 %. No results were delayed as a result of FOQ not being sent with request.
  - NB2: avoidable repeat tests – 2.7%. A significant % are from the neonatal unit. Enhanced training package for NICU staff launched in December 2023.

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

- There were no immediate safety concerns identified.
- There were no recommendations for the newborn and infant physical examination (NIPE).
- There were five urgent recommendations identified and a response with an action plan within 14 working days is required.

12.3. Next Steps:

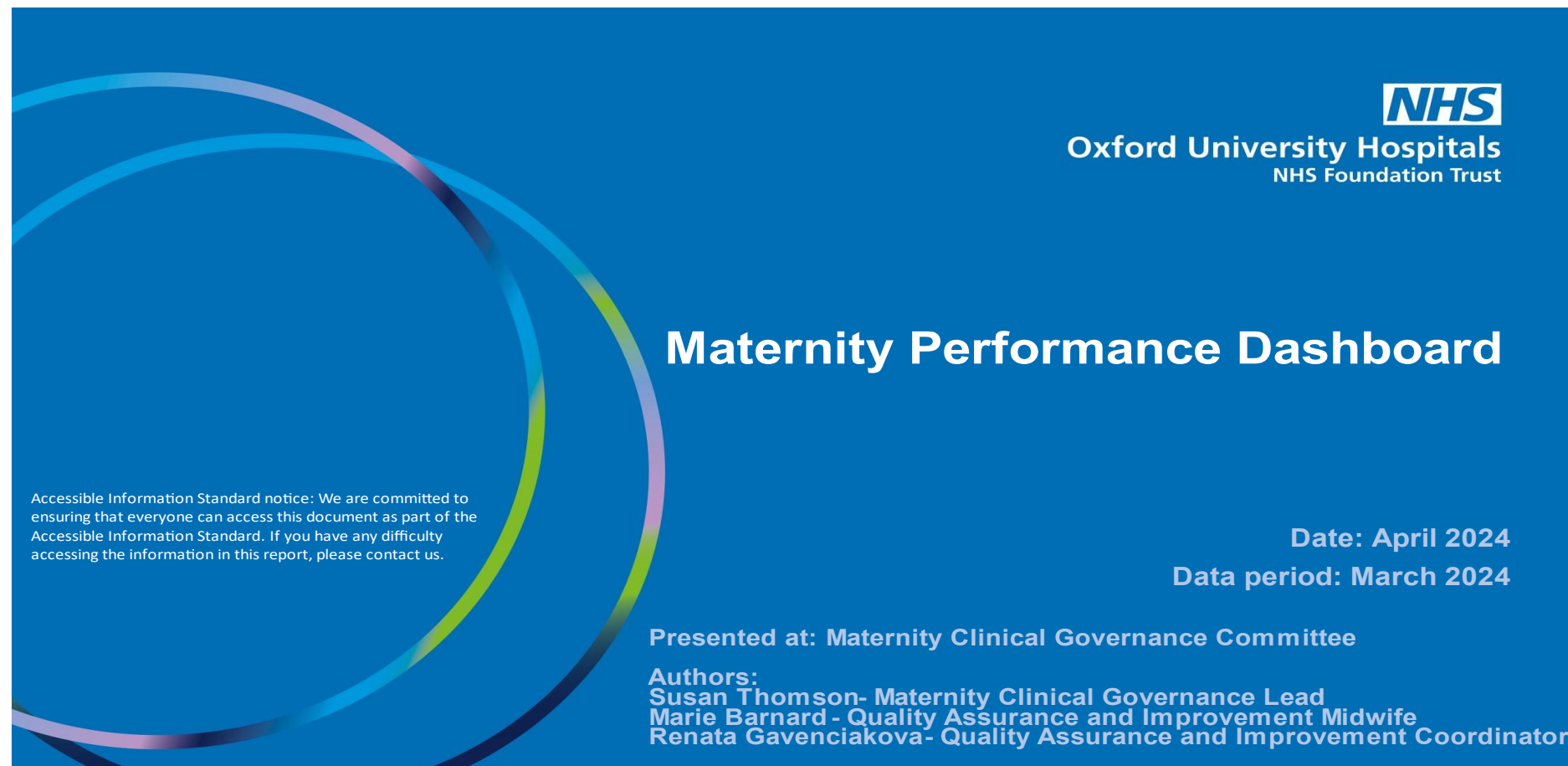
- The Trust will receive the draft report of the visit for accuracy check within 6 weeks.
- The Trust will receive the final report in 10 weeks.
- The Executive Summary will be published on the [www.england.nhs.uk](http://www.england.nhs.uk) website.
- The provider action plan will be required 4 to 6 weeks post final report.
- Commissioner and SQAS will follow up recommendations.
- There will be a formal review at 12 months and a letter to the chief executive.

### **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.

14. Appendix 1: Maternity Performance Dashboard April 2024 (March data)



The cover page features a blue background with a decorative graphic of overlapping circles in shades of blue, purple, and green on the left side. The NHS logo and Oxford University Hospitals NHS Foundation Trust name are in the top right. The title 'Maternity Performance Dashboard' is centered in large white text. Below the title, the date and data period are listed. At the bottom, the authors and the committee are mentioned. An accessible information standard notice is located on the left side.

**NHS**  
Oxford University Hospitals  
NHS Foundation Trust

# Maternity Performance Dashboard

Accessible Information Standard notice: We are committed to ensuring that everyone can access this document as part of the Accessible Information Standard. If you have any difficulty accessing the information in this report, please contact us.

**Date: April 2024**  
**Data period: March 2024**

**Presented at: Maternity Clinical Governance Committee**

**Authors:**  
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Marie Barnard - Quality Assurance and Improvement Midwife  
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## Contents

Item		Page Number
1	Executive Summary	3
2	Indicator overview summary: SPC dashboard	4-5
6	Exception reports	6-10
7	Appendix 1. SPC charts	11-16



## Executive summary, continued

Domain	Performance challenges, risks and interventions
<b>Activity</b>	In March there were 620 mothers birthed which is an increase from 524 in February. There were 734 scheduled bookings undertaken which an increase of 89 from the previous month. 204 caesarean sections were performed in March which is 33.3% of mothers birthed. There is an upward trend in women choosing to book an ELCS as an alternative to having an IOL and this will be monitored. Extra clinics are being arranged and further mitigation will be considered to minimise the impact on service delivery.
<b>Workforce</b>	Midwife: The midwife to birth ratio is 1:23.1. Consultant hours remain at 109. Red flag data for March: The number of hours midwives worked when called into the John Radcliffe on call, this is both hospital and community midwives was 566.3 hours which is an increase from the previous two months. Supernumerary workers within the numbers which relates toward managers, Governance team, Education team and Bereavement team who were asked to support in clinical areas = 74hrs. Administrative staff or support staff unavailable = 8. There were no occasions in March when 1:1 care had not been provided in established labour. There were no occasions in March when the Delivery Suite coordinator was not supernumerary.
<b>Maternal Morbidity</b>	There were 9 - 3rd and 4th degree tears reported in March - as a % of spontaneous vaginal deliveries (SVD) and operative vaginal deliveries (OVD) this equals 1.5%. This is down from 2.4% in February and 2% below the mean. The ethnicities of the women were: 3 White -British, 2 white - other background, 4 Asian origin. The cases are currently being reviewed. There were 10 maternal postnatal readmissions in March and no ICU admissions. The percentage of postpartum haemorrhages (PPH) of >1.5litres for vaginal births was 1.3% as a percentage of mothers birthed. This is a 1.7% decrease from February - this is also below the target of 2.4%. There were 8 women affected. The ethnicities of these women are: 3 - White-British, 2 Asian origin (any other Asian background), 1 Asian (other - Asian British Pakistani); 1 Black (Other - Black Caribbean) and 1 any other ethnicity group. The percentage of PPH of >1.5litres at caesarean section was 0.3% in March, which is a fall of 1% from February. These cases are currently being reviewed. The ethnicities of both women affected were White British. There were 0 admissions to the intensive care unit. 90 women of the 620 women birthed in March had instrumental deliveries.
<b>Perinatal Morbidity and Mortality</b>	There were 3 early neonatal deaths (NND), and 2 stillbirths in March 2024. All neonatal babies who died were extremely premature (21+1 to 22+3) and their parents opted for comfort care which was given. One stillbirth was at term (41+1) and was identified during the mother's labour (intrapartum) and as such has been referred to MNSI. The other stillbirth was at 32 weeks, where the mother had Preeclampsia and raised dopplers. 4 Cases were reviewed in March using the Perinatal Mortality Review Tool (PMRT). All 4 cases were graded A or B (there were no care issues or there were some care issues that did not impact the outcome of the baby). There were 0 maternal deaths reported to MNSI in March, and 1 baby previously reported was found to have HIE. There were 33 term babies unexpectedly admitted to SCBU in March which is a rise from 22 in February. The main reason for admission was respiratory distress, with the main diagnosis at discharge being suspected sepsis. There were 14 babies re-admitted to hospital following discharge.
<b>Maternity Safety</b>	There were 2 cases reported to MNSI in March. One was a stillbirth at 41 + 1 weeks, and one was a term baby who was cooled. We are awaiting confirmation that MNSI will investigate these cases. There were 4 new complaints received in March: Inadequate support provided; attitude of midwives and nurses; mismanagement of labour; communication with patient.
<b>Test Endorsement</b>	The test results compliance for March 2024 is 71.3%. This reflects a very slight decrease of 0.1% from February 2024. The target is 85% This decrease may be partly attributable to the changeover from Cerner to BadgerNet data collection. Although this figure is comparable to last month, it is predicted that there may still be a transient fall in compliance while staff adjust and familiarise with the new method for endorsing results on BadgerNet. The Obstetric lead for MAU has proposed the need for another endorsing push with other members of the senior team and the Digital Team - discussions are in progress to find the best way to implement strategies to help address this issue. 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.
<b>Public Health</b>	The percentage of women initiating breastfeeding was 86% in March, which is above the target of 80%. The infant feeding team continue to monitor this through the Baby Friendly Initiative (BFI) Strategy working group which commenced in May 2023, and data validation continues to improve.
<b>Exception reports</b>	There are 6 exceptions identified from the March 2024 data which are annotated below on Slides 6 to 10.

### Indicator overview summary (SPC dashboard)

ER Exception report

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Mothers Birthed	Mar 24	620	625			623	544	701
Babies Born	Mar 24	617	-			633	554	711
Scheduled Bookings	Mar 24	734	750			706	568	844
Inductions of labour from iView	Mar 24	149	-			146	105	187
Inductions of labour from iView: as a % of mothers bir	Mar 24	24.0% <b>ER</b>	28.0%			23.5%	18.2%	28.8%
Spontaneous Vaginal Births (including breech)	Mar 24	317	-			311	228	394
Spontaneous Vaginal Births (including breech): as a %	Mar 24	51.0%	-			51.2%	44.1%	58.4%
Forceps & Ventouse	Mar 24	90	-			88	59	117
Forceps & Ventouse: as a % of mothers birthed	Mar 24	14.5%	-			14.1%	9.7%	18.6%

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
C-Section	Mar 24	204	-			212	173	250
as % of mothers birthed	Mar 24	33.3%	-			35.2%	29.3%	41.0%
% Emergency c-sections	Mar 24	19.4%	-			19.9%	14.5%	25.4%
% Elective c-sections	Mar 24	12.9%	-			14.2%	10.1%	18.3%
Robson group 1 c-section with no previous births	Jan 24	14.6%	-			13.6%	9.3%	17.8%
Robson group 2 c-section with no previous births	Jan 24	56.0%	-			56.1%	50.1%	62.1%
Robson group 5 c-section with 1+ previous births	Jan 24	78.8% <b>ER</b>	-			82.4%	76.5%	88.3%
Elective CS <39 weeks no clinical indication	Mar 24	0	0			0	-1	1
Prospective Consultant hours on Delivery Suite	Mar 24	109	109			109	109	109
Midwife:birth ratio (1 to X)	Mar 24	23.1	28.0			26.4	22.9	29.8
Maternal Postnatal Readmissions	Mar 24	10	-			8	0	17
Readmission of babies	Mar 24	19	-			19	3	36

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Number of 3rd/4th degree tears amongst mothers bir	Mar 24	9	-			12	-1	24
3rd/4th Degree Tear as % of SVD+OVD	Mar 24	1.5%	3.5%			2.9%	0.2%	5.7%
3rd/4th Degree Tear with unassisted (Normal) births	Mar 24	1.0%	-			2.5%	-1.5%	6.5%
3rd/4th Degree Tear with assisted (Instrumental) birt	Mar 24	1.2%	-			4.5%	-2.8%	11.8%
PPH 1.5L or greater, vaginal births	Mar 24	8	-			13	1	25
PPH 1.5L or greater, vaginal births as % of mothers bir	Mar 24	1.3%	2.4%			2.1%	0.2%	3.9%
PPH 1.5L or greater, caesarean births	Mar 24	2	-			7	-2	16
PPH 1.5L or greater, caesarean births as % of mothers	Mar 24	0.3%	4.3%			1.2%	-0.8%	3.3%
ICU/CCU Admissions	Mar 24	0	-			1	-1	3
% completed VTE admission assessments	Mar 24	96.6% <b>ER</b>	95.0%			96.9%	93.6%	100.2%

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Maternal Deaths: all	Mar 24	0	0			0	0	1
Early Maternal Deaths: Direct	Mar 24	0	0			0	0	0
Early Maternal Deaths: Indirect	Mar 24	0	0			0	0	0
Late Maternal Deaths: Direct	Mar 24	0	0			0	0	0
Late Maternal Deaths: Indirect	Mar 24	0	0			0	0	0
Puerperal Sepsis	Mar 24	13	-			6	-1	13
Puerperal Sepsis as % of mothers birthed	Mar 24	2.0%	1.5%			1.0%	-0.1%	2.0%
Stillbirths (24+0/40 onwards; excludes TOPs)	Mar 24	2	0			2	-2	6
Stillbirths (24+0/40 onwards; excludes TOPs): as rate	Mar 24	2	4			4	0	0
Late fetal losses (delivered 22+0 to 23+6/40; excludes	Mar 24	0	1			0	-2	2

Indicator overview summary (SPC dashboard), *continued*



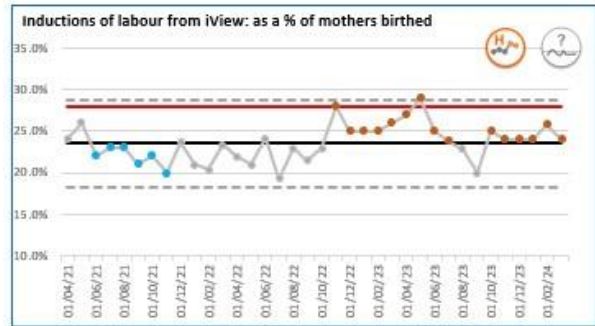
Exception report



KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Neonatal Deaths (born in OUH, up to 28 days)	Mar 24	3	-			3	-2	8
Neonatal Deaths (born in OUH, up to 28 days): Early (1-7 days)	Mar 24	3	-			2	-2	6
Neonatal Deaths (born in OUH, up to 28 days): as rate	Mar 24	6	3			1	-2	5
HIE	Mar 24	1	0			0	0	0
Returns to Theatre: as % of caesarean section deliveries	Mar 24	1.0%	0.0%			0.7%	-0.7%	2.1%
Shoulder Dystocia	Mar 24	12	-			8	0	17
Shoulder Dystocia: as % of births	Mar 24	1.9%	1.5%			1.3%	0.1%	2.5%
Unexpected NNU admissions	Mar 24	33	-			26	8	44
Unexpected NNU admissions: as % of births	Mar 24	5.3%	4.0%			4.0%	1.3%	6.7%
Hospital Associated Thromboses	Mar 24	1	0			0	-1	1
Returns to Theatre	Mar 24	2	0			1	-2	4
Neonatal Deaths (born in OUH, up to 28 days): Late (8-28 days)	Mar 24	0	-			1	-2	3

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Number of SIRIs (now called PSII)	Mar 24	2	0			1	-2	4
Percentage of women booked by 10+0/40	Mar 24	66%	-			69%	63%	76%
Number of Complaints	Mar 24	4	-			8	-3	19
Born before arrival of midwife (BBA)	Mar 24	9	-			6	-3	15
Test Result Endorsement	Mar 24	71.3%	85.0%			74.4%	63.5%	85.3%
Number Of Women Booked This Month Who Current	Mar 24	46	-			51	28	74
Percentage Of Women Booked This Month Who Current	Mar 24	60.0%	ER			8.8%	1.5%	16.1%
Number of Women Smoking at time of Delivery (SAT)	Mar 24	8	-			34	18	49
Percentage of Women Smoking at Delivery (SATOD)	Mar 24	1.3%	8.0%			5.4%	2.8%	8.0%
Percentage of Women Initiating Breastfeeding	Mar 24	86.0%	80.0%			79.7%	70.2%	89.2%

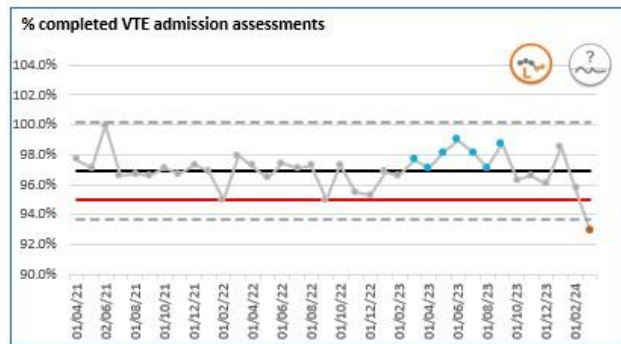
### Maternity exception report (1)



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
Inductions of labour from iView: as a % of mothers birthed shows special cause concerning variation	The induction of labour is flagging as an exception as it is has been above the mean for six consecutive months. These inductions of labour are clinically indicated, so therefore cannot be reduced, but it informs acuity within maternity.			

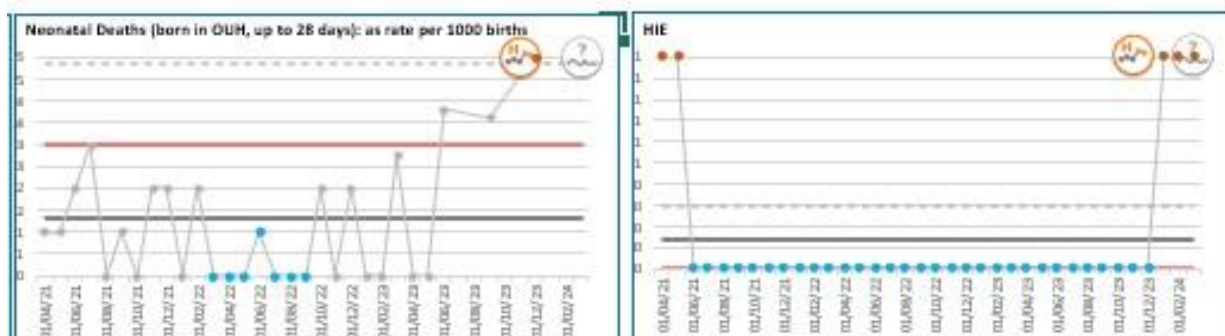


### Maternity exception report (2)



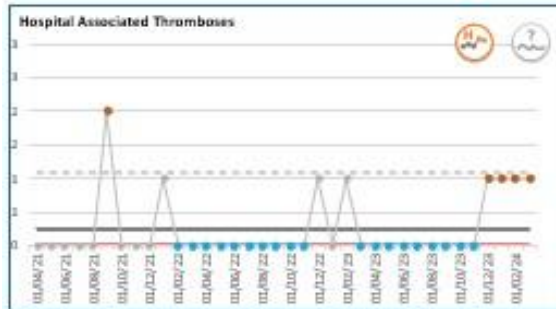
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Timescales to address performance issue(s) and identification of any gaps in assurance	Risk Register score	Data quality rating
% completed VTE admission assessments shows special cause concerning variation	Due to challenges with data input and capture on BadgerNet for March 2024 the VTE compliance statistic is low. This is not an accurate representation of the true compliance of VTE figure. The digital team have agreed actions in progress to address data input and capture issues.	Previous data was pulled from Orbit and was within the target range.		

### Maternity exception report (3)



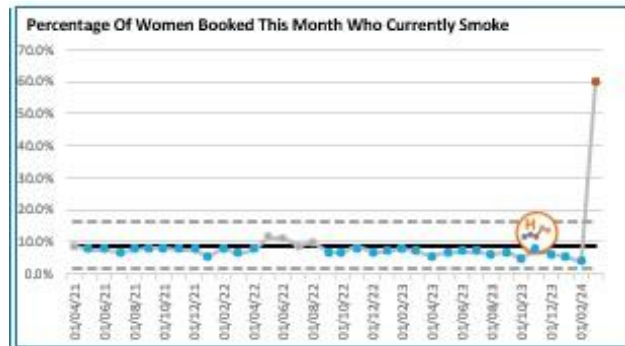
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Timescales to address performance issue(s) and identification of any gaps in assurance	Risk Register score	Data quality rating
The Neonatal Death rate as per 1000 births is calculated Quarterly. There was an increase in the neonatal death rate this quarter compared to Quarter 3 (Previously 4.2, Currently 6.39)	There were a total of 11 neonatal deaths this quarter. 7 of these babies were born at an extremely premature gestation (19+0 to 22+6), and 9 of these babies were born following in -utero transfers to the OUH for Tertiary care. The families for 8 of the babies opted for comfort care following neonatal counselling, and as such no resuscitation was attempted. The neonatal deaths included a set of triplets born at 22+6 weeks. Three babies of higher gestations (26+1, 33+0 and 38+2) had congenital abnormalities. This also flagged as an exception in the last quarter, and this will be monitored going forward.			
The number of HIE cases shows special cause variation due to one reportable case to MNSI.	The case was reviewed by the fetal monitoring team as a rapid review.			

### Maternity exception report (4)



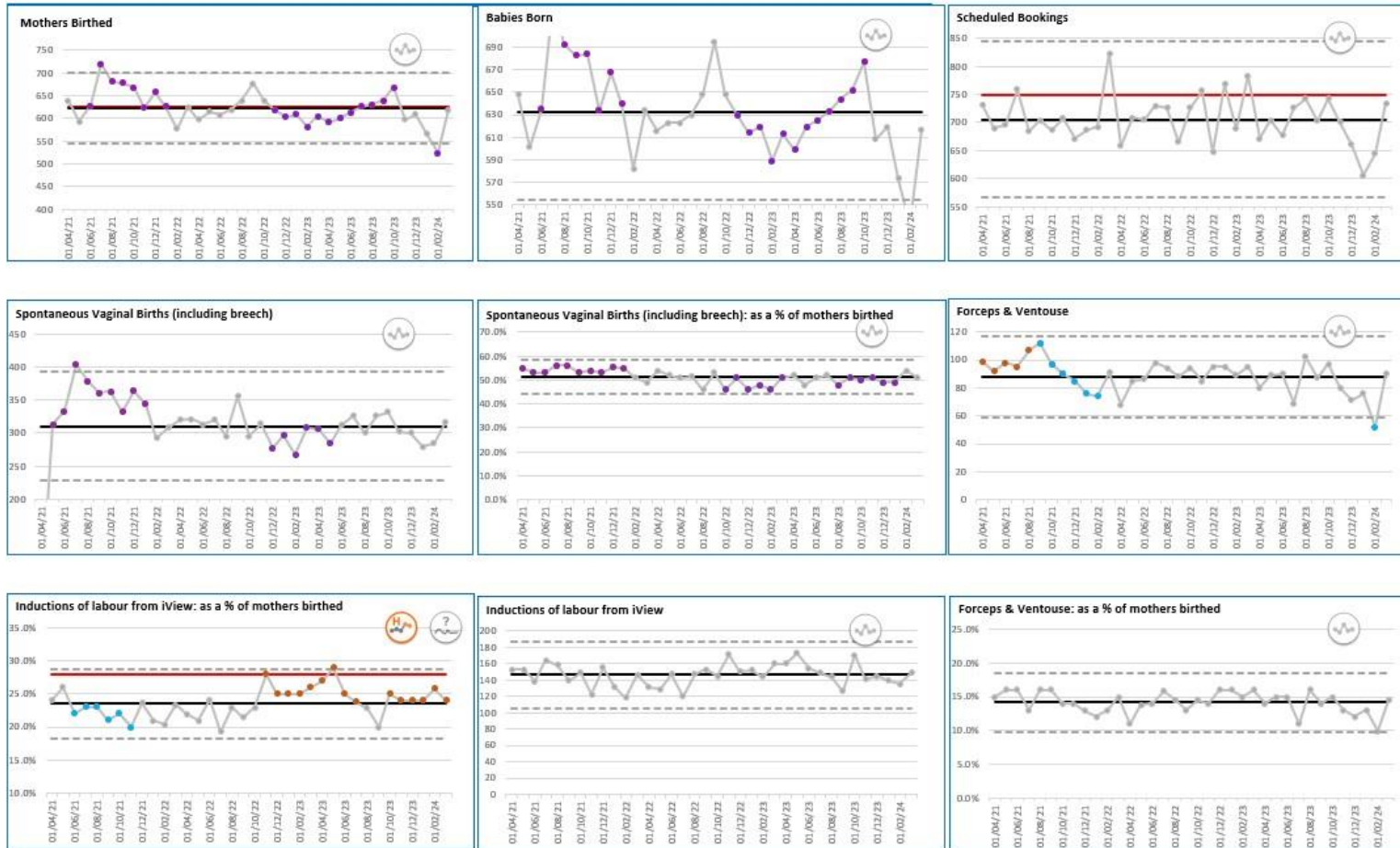
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Timescales to address performance issue(s) and identification of any gaps in assurance	Risk Register score	Data quality rating
There was one woman who had a hospital acquired thrombosis .	This patient was diagnosed with a PE 21 days postnatally following a Neville Barnes Forceps delivery. The patient was prescribed and received appropriate thromboprophylaxis and this has been reported as a 'not potentially preventable' HAT.	No further actions required.		

### Maternity exception report (5)

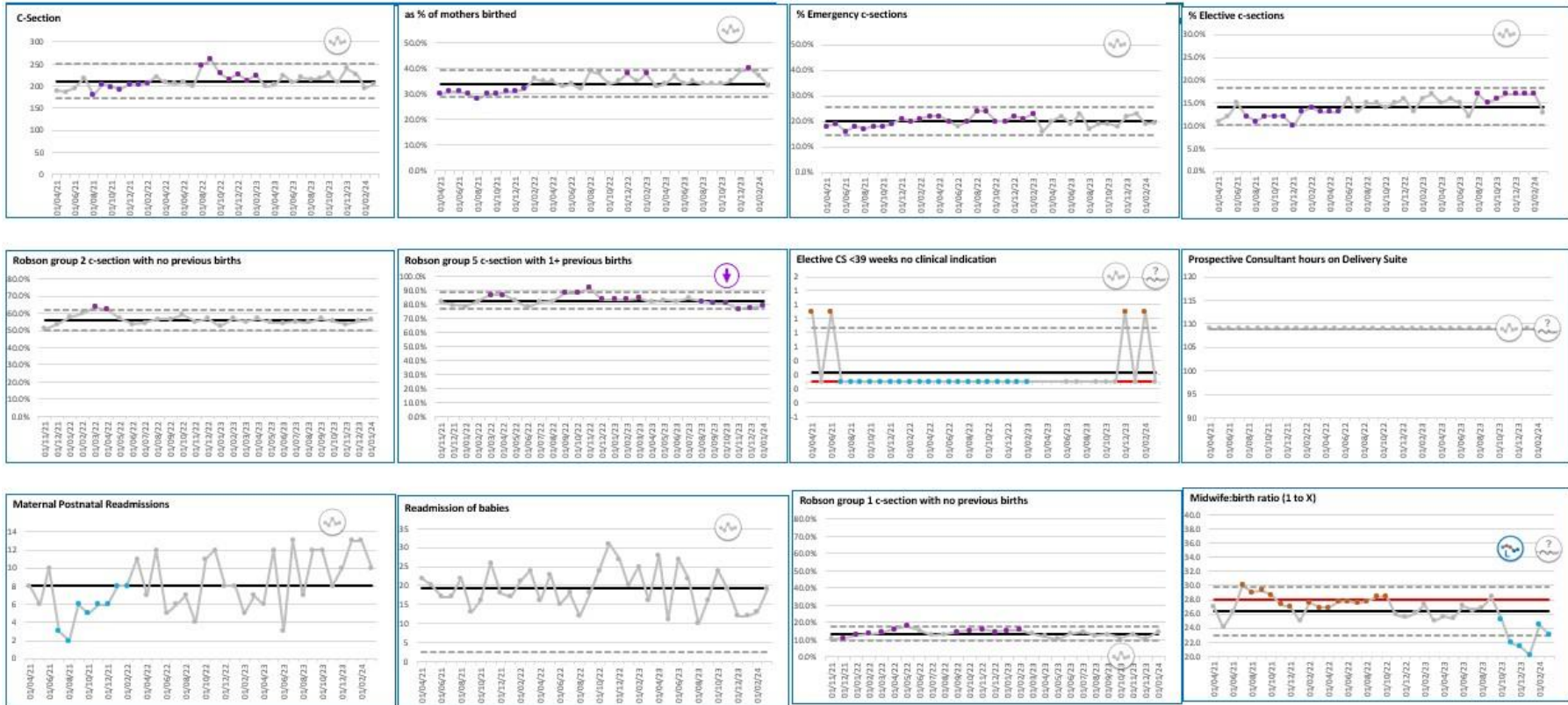


Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Timescales to address performance issue(s) and identification of any gaps in assurance	Risk Register score	Data quality rating
Percentage of Women Booked This Month Who Currently Smoke shows special cause concerning variation	Due to data input and capture on BadgerNet being inaccurate for March 2024 the 'women who currently smoke' compliance statistic is very low. This is not accurate representation of the true compliance of the 'women who currently smoke' figure. The digital team have agreed actions in progress to address data input and capture issues.			

### Appendix 1. SPC charts (1)

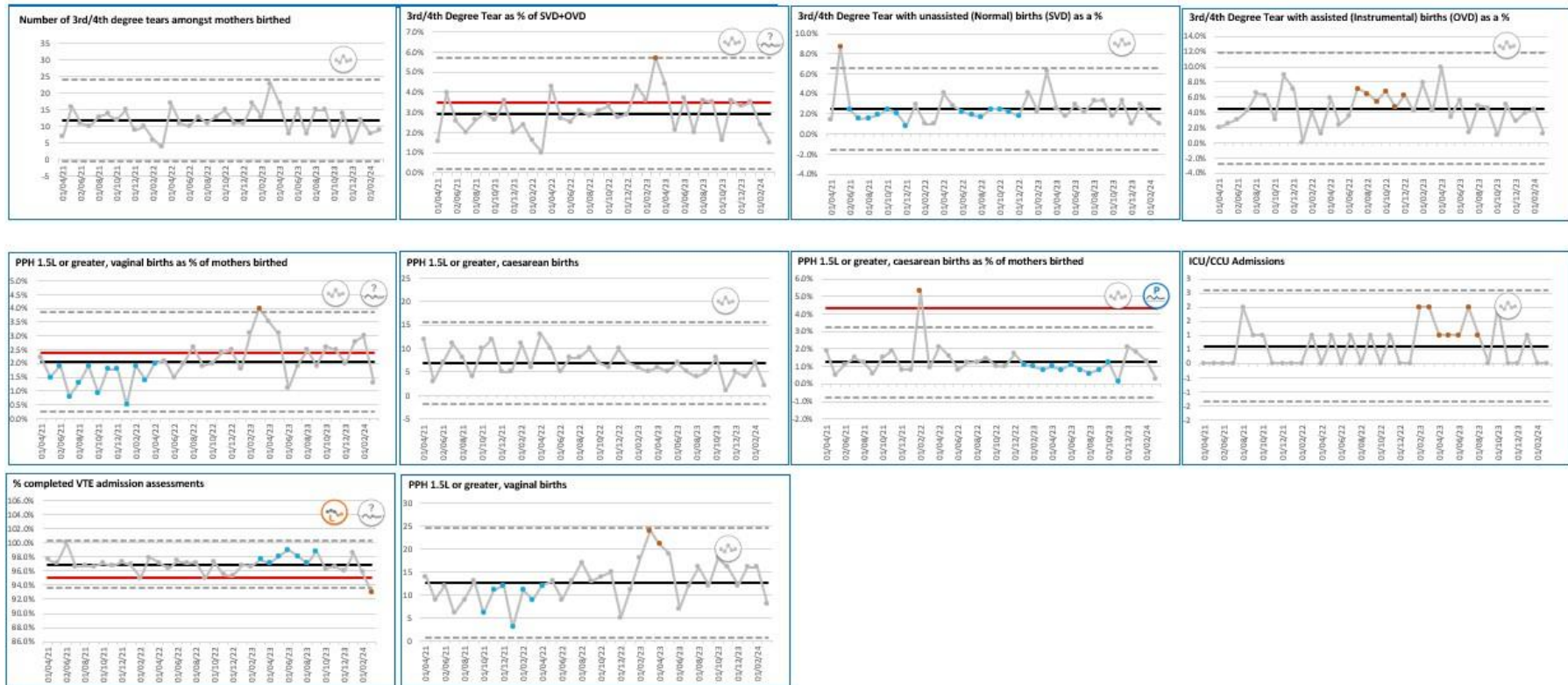


### Appendix 1. SPC charts (2)

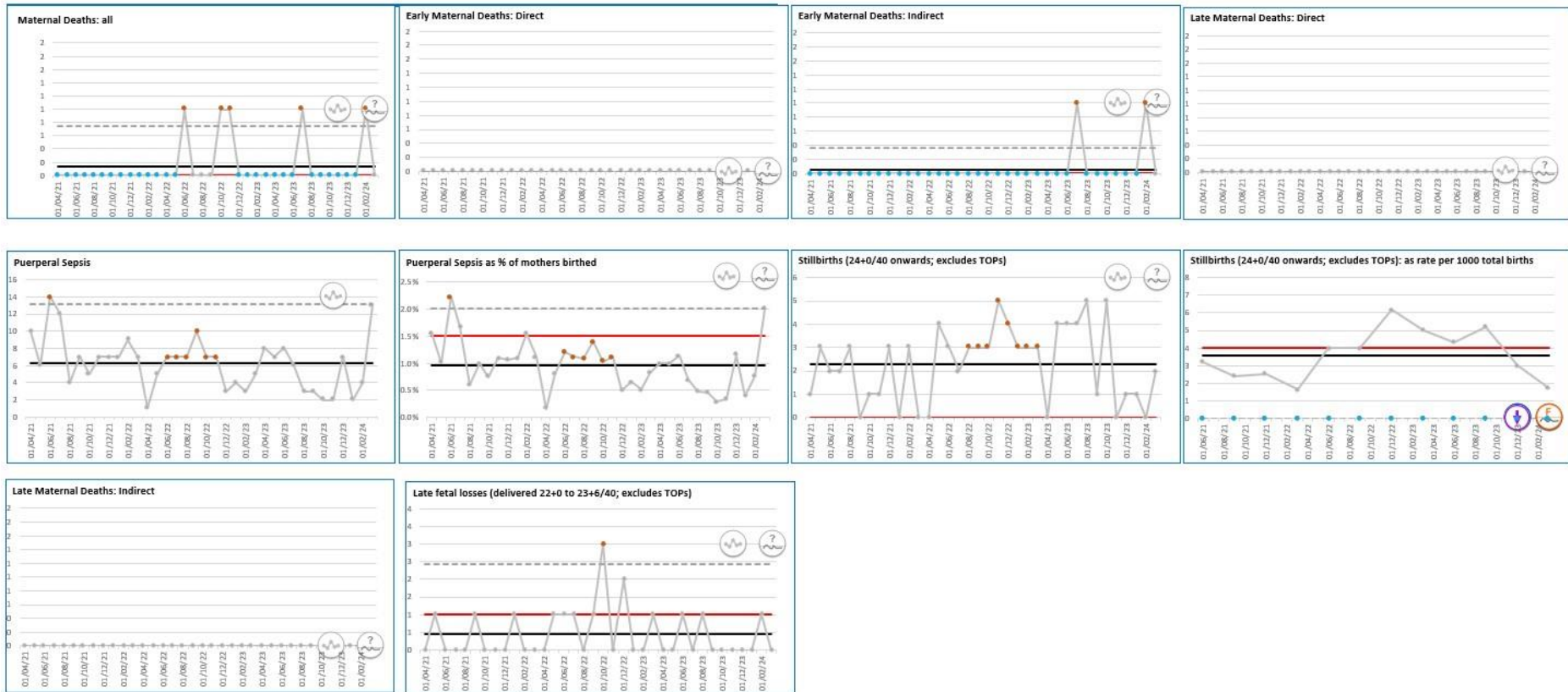




### Appendix 1. SPC charts (3)

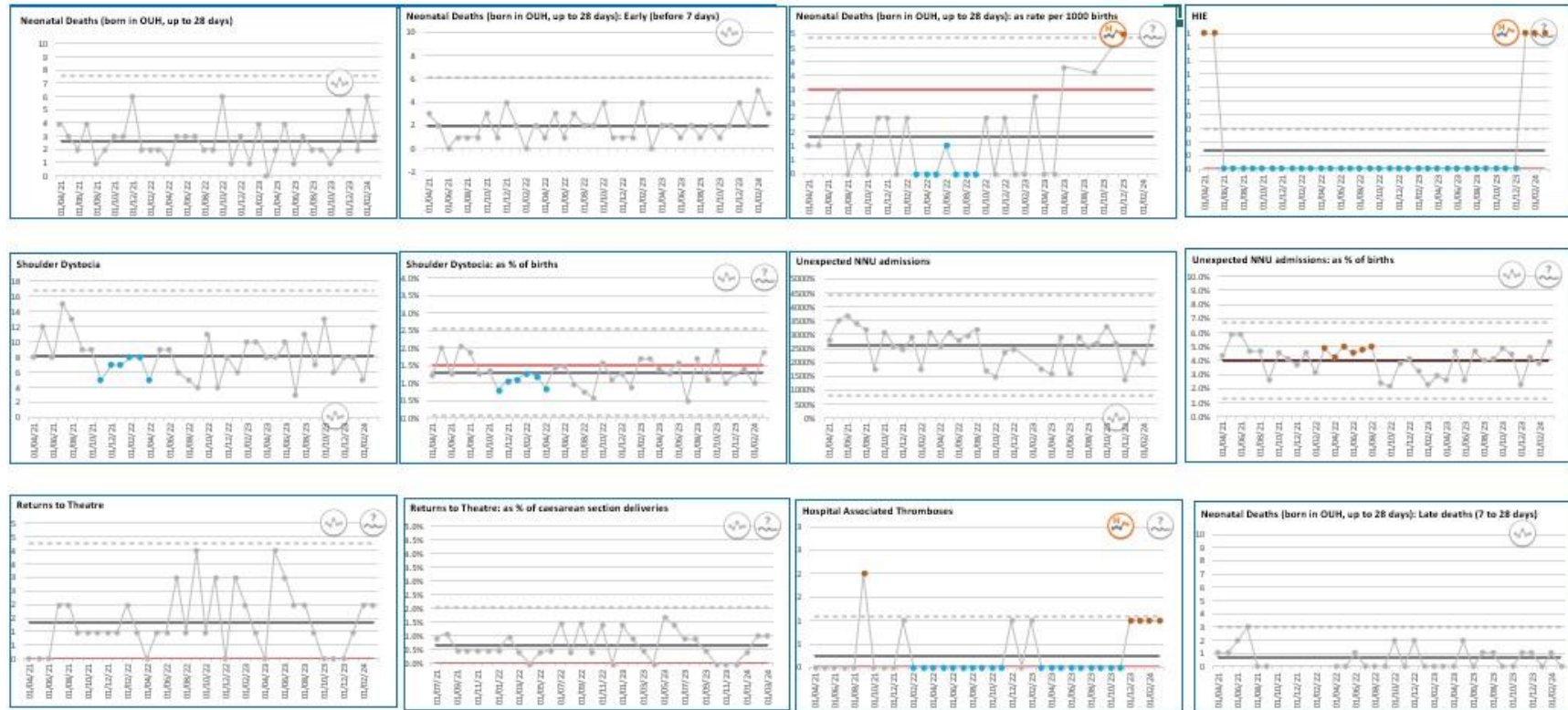


### Appendix 1. SPC charts (4)

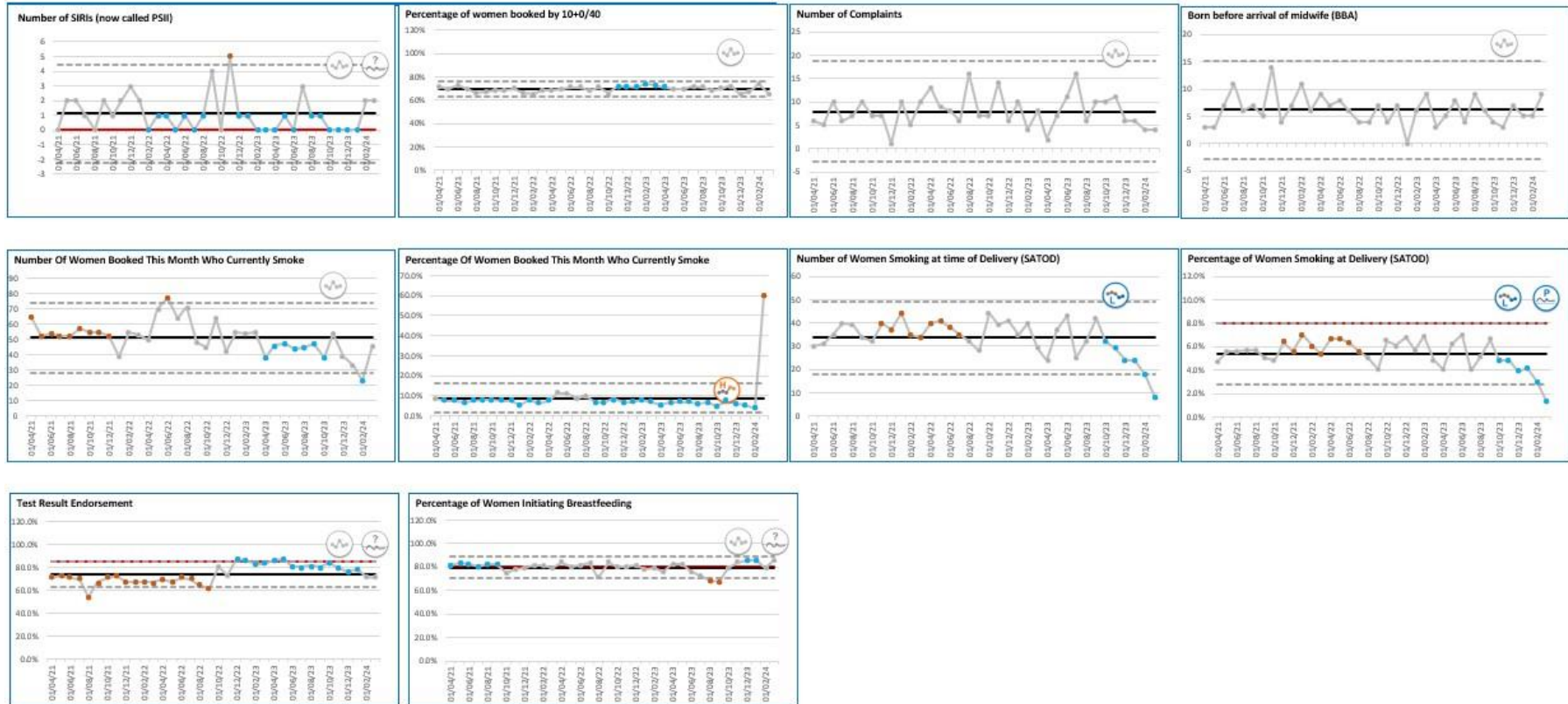




### Appendix 1. SPC charts (5)



### Appendix 1. SPC charts (6)



## 15. Appendix 2: CQC Must and Should Do's

### 15.1. Action the trust MUST take to improve Maternity:

- The trust must ensure that checks of emergency equipment and consumables are carried out thoroughly and identify out of date equipment in order that it can be replaced. Regulation 12(1)(2)(e)
- The trust must ensure staff complete the required risk assessments for women, birthing people and babies and act to remove or minimise any identified risks. Regulation 12(1)(2) (a)(b)
- The trust must that all medicines are in date and stored within the correct temperature range. Regulation 12(1)(2)(g)
- The trust must ensure staff that staff adhere to the policies, procedures, and guidelines in place, including decontamination of the birthing pool. Regulation 17(1)(2)(a)(b)
- The trust must ensure regular audits are completed to ensure patient safety. Regulation 17(1)(2)(a)(b)
- The trust must ensure effective risk and governance systems are implemented which supports safe, quality care within the midwifery led unit. Regulation 17(1)(2)(a)(b)

### 15.2. Action the trust SHOULD take to improve:

- The service should ensure that all staff receive training in correct cleaning of the birthing pool(s) and that the cleanliness is monitored and audited.
- The service should ensure that only midwives provide advice to women and birthing people who contact the unit for advice.
- The service should ensure the staffing model enables staff to follow best practice guidance and supports the availability of a second midwife during the second stage of labour and present at the birth.
- The service should deliver the service in line with its own policy on second midwife presence at deliveries, where practicable.
- The service should carry out a ligature point assessment to determine the likelihood of something being used as a ligature point.

- The service should consider the impact on women and birthing people's dignity in relation to the toilet and shower facilities in the Midwifery Lead Unit.
- The service should consider storing medicines to treat post-partum haemorrhage in a 'grab box'.