Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Trust Board Meeting in Public: Wednesday 14 May 2025

TB2025.34

Title:	**Maternity Services Update Report**

Status:	**For Discussion**
History:	**Regular Reporting**
	Maternity Clinical Governance Committee (MCGC) 14/04/2025
	Previous paper presented to Trust Board 12/03/2025

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Confidential:	**No**
Key Purpose:	Assurance

Executive Summary

1. This paper provides an update to the Trust Board on maternity related activities. The key points are summarised below:
2. **Three-Year Delivery Plan for Maternity and Neonatal Services**: The report outlines progress on the three-year delivery plan and provides an update on progress related to listening to women, workforce, culture and leadership, and standards.
3. **Maternity Safety Support Programme (MSSP)**: Significant progress has been made on the MSSP recommendations. The sustainability strategy meeting is planned for April with the BOB ICB and NHS England regional colleagues to ensure ongoing improvements and integrate sustainable practices within maternity services.
4. **MPIS**: Year 7 of the Maternity and Perinatal Incentive Scheme was published on the 02 April 2025. The service is currently reviewing the requirements for this year to identify any gaps and to ensure there is ongoing monitoring and compliance.
5. **Antenatal and Newborn (ANNB) Screening Assurance:** Following the Antenatal and Newborn (ANNB) Screening Assurance Visit, 27 out of 36 recommendations from the Screening Quality Assurance Service (SQAS) have been closed. Nine remain open, with completion date on schedule for July 2025.

Recommendations

6. The Trust Board is asked to:
    - Receive and note the contents of the update report.

Contents

Maternity Services Update Report

Purpose

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

1.2. Three-year Single Delivery Plan for Maternity and Neonatal Services

1.3. Maternity (and Perinatal) Incentive Scheme (MPIS) year 6

1.4. Maternity Safety Support Programme (MSSP)

1.5. Maternity Performance Dashboard

1.6. Perinatal Quality Surveillance Model Report

1.7. CQC Action plan update

1.8. Antenatal and Newborn (ANNB) Screening

1.9. Midwifery Led Unit (MLU) status

1.10. Safeguarding

Three Year delivery plan for Maternity and Neonatal Services

The Three-year Single Delivery Plan for Maternity and Neonatal services was published in March 2023. A summary of progress against each of the themes is summarised below:

Theme 1: Listening to Women

1.11. The Triangulation and Learning Committee (T.A.L.C), including service users and staff, has been meeting monthly. In response to the themes raised, improvements on postnatal wards are ongoing, focusing on 24-hour partner visits and enhanced pain relief.

1.12. The Maternity and Neonatal Voices Partnership (MNVP) chair stepped down from her post at the quarterly MNVP meeting held on the 05 March 2025. The post is currently being recruited to and there is an interim plan for a member of the MNVP to chair the June quarterly meeting and to provide feedback.

Theme 2: Workforce

1.13. The current vacancy for Midwifery is 10.82 WTE (Whole Time Equivalent), with no vacancies in Nursing and 9.26 WTE vacancies for Maternity Support Workers (MSWs). Monthly recruitment efforts are ongoing, with additional midwifery and MSW interviews scheduled. The workforce task and finish

group continue to meet monthly. This includes the leadership team, recruitment and retention team, HR representatives and the legacy midwife.

Theme 3: Culture and Leadership

1.14. Maternity and Neonatal Safety Champions conduct regular walk rounds, and on March 24, 2025, they visited the Transitional Care Unit (TCU) on Level 5 and the Neonatal Unit (NNU).

1.15. Weekly maternity leadership walk-arounds are ongoing and are aligned with the Care Assurance framework. These walk-arounds ensure a consistent leadership presence, which promotes open communication with staff and helps foster a culture of transparency and trust. During these visits, additional questions are posed to gather insights from both service users and staff.

1.16. There is a monthly Maternity Services Update meeting that staff are invited to and give feedback on their areas. There is also a Quarterly Maternity Unit Meeting that all staff are invited to.

1.17. Staff have been identified to participate in the Perinatal Culture and Leadership Community of Practice (PCL CoP) forum to keep culture, quality and safety improvements on the agenda, sharing and building on good practice, learning from each other.

Theme 4: Standards

1.18. Saving Babies Lives Care Bundle version 3 has been implemented and compliance has been reported as part of the Maternity (and Perinatal) Incentive Scheme, safety action 6. The quarter three data has been reviewed by the LMNS and is included in the Perinatal Quality Surveillance Model (PQSM) report that will be presented to the Confidential Trust Board in May.

2. Maternity (and Perinatal) Incentive Scheme (MPIS)

2.1. Year 7 launched on the 02 April 2025. This is currently being reviewed and meetings set up for this year to monitor compliance against the safety actions. Following rapid review, the areas that may pose a compliance risk are:

2.2. Safety Action 1: “External panel member(s) should be relevant senior clinicians who are currently practicing clinically and work in a hospital external to the trust undertaking the review and external to any trust involved in the care at any stage”. This is an MBRRACE requirement and has been updated in year 7. Coordination to achieve with the LMNS and partnership Trusts is already in motion.

2.3. Safety Action 7: The Maternity and Neonatal Voices Partnership (MNVP) to be a quorate member of trust governance, quality and safety meetings at speciality/divisional/directorate level. There is currently no MNVP lead for OUH due to the recent resignation of the Chair, active recruitment is underway.

3. Maternity Safety Support Programme (MSSP)

3.1. Following the last site visit in December areas requiring improvement and escalation as part of the programme within the report by the Maternity Improvement Advisor (MIA) remain mainly as challenges with the Maternity estate and the organisation of Maternity and Neonates in separate divisions. To go some way to addressing this a joint perinatal governance lead has been appointed, and a committee established to connect maternity and neonates. Alongside this the development of a joint Perinatal Quality Surveillance dashboard is ongoing.

3.2. The service has continued to recruit midwives and are on a trajectory to be fully recruited by Q2 2025/26, albeit unavailability remains high.

3.3. The service is preparing for an Insight Visit planned for the 28 April 2025 which will inform the proposed step down from the MSSP.

Maternity Performance Dashboard

3.4. There were four exceptions reported for the March data, see Appendix 1 for further detail, mitigations, and improvement actions. The dashboard includes data relating to the activity in the community.

Perinatal Quality Surveillance Model Report

3.5. The Perinatal Quality Surveillance Model (PQSM) report for February and March will be presented to the Trust Board meeting in May 2025. The data was reported to MCGC in April and is an agenda item at the bi-monthly Maternity and Neonatal Safety Champions meetings.

4. CQC Action Plan Update

4.1. The Maternity Services, in collaboration with the Trust Assurance Team and Corporate Nursing, have continued to meet monthly as part of the Evidence Group to continuously monitor and evaluate the progress and effectiveness of the CQC action plan. The group held a meeting in February and March 2025.

4.2. A clear framework has been implemented for monitoring progress against the action plans, including specific protocols for timely escalation in cases where expected progress is not achieved.

4.3. In the Horton Midwifery Led Unit CQC action plan there were six ‘Must Do’ actions and seven ‘Should Do’ actions outlined. All Horton specific actions have been completed with ongoing monitoring regarding sustained levels of assurance.

4.4. Six 'Should Do' actions have been completed. The remaining action was to undertake a ligature risk assessment in line with the Trust Ligature Risk Assessment. All areas have completed their ligature risk assessments except for Delivery Suite which is due to ongoing building works which are due to be completed at the end of June, risk assessment completion will follow.

4.5. The installation of a new birthing pool at the Horton was completed in November. Final water checks have been completed; however, it has since been identified that additional remedial works are required, and these are ongoing with a target completion date of end of May 2025.

4.6. There is one ‘Should Do’ action related to estates from the 2021 CQC JRH inspection. Action 11 states that “The service should consider the environment to ensure women, and their families are always treated with respect and dignity”. Actions taken to date include room occupancy signage on all doors and privacy curtains in all rooms where women receive care.

4.7. 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.

5. Antenatal and Newborn (ANNB) Screening

5.1. The ANNB team met with NHSE on the 18 March to review progress on the action plan.

5.2. There were 36 recommendations comprising 107 sub actions. Work continues on the action plan.

5.3. The Screening Quality Assurance Service (SQAS) have closed 27 recommendations so far. There are 09 that remain open, the completion deadline is the 03 July 2025.

5.4. The Trust Assurance Team met with the Maternity team twice in March to monitor and evaluate the progress of the effectiveness of the action plan. The next Evidence group meeting is on the 28 April 2025.

5.5. Progress against the ANNB 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. It is also discussed at the Antenatal and Newborn Quarterly Board meetings.

6. Maternity Safeguarding

6.1. Progress and Ongoing Support: The risk associated with the backlog of safeguarding referrals has been significantly reduced. Through focused efforts, including increased time allocated to the box and additional support from the substance use midwife, the referral backlog has decreased from 360 to 155. This has been a positive step in ensuring that referrals are processed in a timely and efficient manner. Ongoing resources are being allocated to this area, with continued support from the trust-wide safeguarding team to ensure that we maintain momentum and continue to reduce the backlog.

6.2. The Maternity Safeguarding team and Mental Health Midwives are developing a Padlet, a digital platform launching in April, to provide comprehensive information on mental health and social support resources across Oxfordshire. This resource aims to help both staff and service users access a variety of services, including talking therapies, crisis support, domestic abuse services, refuges, and infant feeding support groups. By being digital, it ensures equal access for individuals in both urban and rural areas, reducing inequality in service availability.

7. Midwifery Led Unit (MLU) Status

7.1. Since December 2024 there have been no occasions when community services were suspended.

7.2. In March 2025 there were two women who were unable to have their chosen place of birth in the community due to on-call midwives already working at capacity at the time the request was made. Both women experienced positive outcomes and were offered alternative places of birth.

8. Conclusion

8.1. This report provides an update on essential maternity activity which includes the CQC action plan update, Maternity and Perinatal Incentive Scheme (MPIS), and Antenatal and Newborn Screening Services. It summarises the findings and recommendations as well as the actions taken by the service to address them.

8.2. The report aims to assure the Trust Board of the Maternity service delivery and performance.

9. Recommendations

9.1. The Trust Board is asked:

- Receive and note the contents of the update report.

Oxford University Hospitals
NHS Foundation Trust

Maternity Performance Dashboard

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Date: April 2025

Data period: March 2025

Presented at: Maternity Clinical Governance Committee

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Contents

Oxford University Hospitals NHS Foundation Trust

Executive Summary

Executive Summary

615 women birthed in OUH during March 2025 and 670 bookings for antenatal care were scheduled.

Notable Successes

- The Leadership team were named as a winner of the Improving Safety on the Frontline by Investing in the Workforce Award. This was part of the UK MUM (Maternity Unit Marvels) Awards, run by the charity Baby Line.
- Members of the maternity service team, with service user involvement, have had a recent publication in BJOG about navigating care after baby loss to holistically address the needs of families. BJOG - 2025 - Navigating Psychosocial Aspects of Pregnancy Care After Baby Loss A Roadmap for Professionals.

Executive summary

Oxford University Hospitals

Domain	Performance challenges, risks and interventions
Activity	In March, 615 mothers gave birth at OUH, which is 50 more than the previous month. A total of 670 scheduled bookings were completed, an increase of 60 compared to February. There were 233 caesarean sections performed, accounting for 37.9% of the births, which is a decrease of 5.5% from February 2025. A total of 63 (10.2%) women birthed in midwifery led settings with 32 (5.2%) in community settings (including homebirths). An additional 31 women birthed in the Spires alongside midwifery unit (5.04%), 14 (2.3%) were at home, 12 (1.9%) were at freestanding midwifery units (Wantage, Wallingford and Chipping Norton) and 6 (0.9%) at the Horton freestanding midwifery unit.
Workforce	The midwife to birth ratio was 1:23.77. Daily staffing meetings are ongoing to ensure that the service is safely staffed. These meetings facilitate staff movement between areas and trigger escalation when necessary. In March, there were no instances where 1:1 care was not provided for women in established labour, nor were there any occasions when the delivery suite coordinator was not working in a supernumerary capacity. Additionally, there was a reduction in on-call hours used, dropping from 341 hours in February to 202 hours in March. The number of occasions when staff did not receive a break decreased slightly from 102 in February to 100 in March. Furthermore, there were 20 instances of labour induction being delayed by more than 24 hours, a significant improvement from 71 delays in February. Overall, this reflects a positive trend toward improvement.
Maternal Morbidity	In March 2025, the overall rate of third-degree tears among mothers who had a vaginal birth was 3.30% (n=13). This figure falls within the national average, which ranges from 0% to 8%. For unassisted (spontaneous) vaginal births, including breech births, the rate of third-degree tears was 2.63% (n=8). The ethnic backgrounds of these women were as follows: White British (n=4), Not Known (n=2), and Not Stated (n=2).The rate of third-degree tears sustained during assisted (forceps and ventouse) vaginal births was 5.56% (n=5). The ethnic backgrounds of these women were: White British (n=2), Indian (n=2) and Not stated (n=1). In March 2025, the rate of postpartum haemorrhage (PPH) of 1500ml or more among mothers who had assisted vaginal births was 0.8% (n=5). This figure is below the national mean of 2.8% reported by the National Maternity and Perinatal Audit (NMPA). The ethnic backgrounds of these women included: White British (n=2), Chinese (n=1), and White-Other (n=2). For mothers who had unassisted vaginal births in the same month, the rate of PPH of 1500ml or more was 1.8% (n=11), again below the NMPA national mean of 2.8%. The ethnic backgrounds of these mothers included: White British (n=5), Asian-Other (n=2), White-Other (n=1), Black-Other (n=1), Pakistani (n=1), and Not Stated (n=1). Among mothers who had a caesarean section, the rate of PPH of 1.5 litres or more was 0.2% (n=1), which represents a 0.7% increase compared to March 2024 and is below the NMPA national mean of 4.75%. The ethnic background of this mother was Indian (n=1). Please note that ethnicity data is currently under review to identify any disproportionately represented outcomes.
Perinatal Morbidity and Mortality	In March, 4 cases were reviewed using the Perinatal Mortality Review (PMR) process. Two cases related to intrauterine death, prior to the onset of labour. These cases were graded either A or B . One case involved a baby who received palliative care for a known condition and died on day 4 which was graded A. The remaining case was the neonatal death of a baby who was born by caesarean at 27/40 gestation, this was graded B due to some incomplete bereavement paperwork which is now under review. Learning was identified from another case highlighting the need for MAU staff to clearly state, and document, the timeframe in which they expect women to attend.
Maternity safety	In March, 23 full-term babies were unexpectedly admitted to the neonatal unit, which is consistent with the number from the previous month. All cases are being reviewed through the Avoiding Term Admissions to Neonatal Units (ATAIN) program. Recent educational interventions have focused on neonatal temperature control and improving ambient temperature in the observation area. Ongoing temperature spot checks in both the observation area and delivery suite are continuing. In March, a total of 229 patient safety incidents were reported through Ulysses. This included 53 cases of moderate harm, such as post-partum haemorrhage (PPH) exceeding 1.5 liters, obstetric anal sphincter injury (OASI), and unexpected admissions to the Special Care Baby Unit (SCBU). Appropriate learning responses were implemented following the principles of the Patient Safety Incident Response Framework (PSIRF), ensuring that careful and suitable actions were taken on a case-by-case basis. The Maternity Newborn Safety Investigations team (MNSI) accepted two cases for review. The first case involved an intrapartum stillbirth at 39 weeks and 2 days gestation. The second case concerned a baby who needed therapeutic cooling after birth but was later discharged with a normal MRI scan. An initial review did not identify any immediate safety concerns. A joint PSII with the Neonatal team was declared in respect of an unplanned admission to SCBU, involving a baby born by emergency caesarean prior to labour, the baby required resuscitation. This is not a case that will be investigated by the MNSI as the mother was not in labour prior to birth and therefore it was declared a PSII to ensure thorough internal review and parent engagement.

Executive summary (continued)

Domain	Performance challenges, risks and interventions
Test Endorsement	The test result endorsement figure is reported monthly, retrospectively, as the ORBIT system does not update with the final endorsement compliance rate until the 8th of each month. The result endorsement for February 2025 was 84.88%, reflecting a decrease of 3.65%. This continues to be a focus area and targeted work is ongoing to engage individuals to improve compliance.
Service User Experience	In March 2025, ten complaints were received, marking a decrease of 3 on the previous month. Recurring themes included induction of labour (IOL) delays; discharge wait times and access to pain relief in the postnatal setting. Several work streams have been commenced to address these themes, including our IOL task and finish group and the postnatal working party to oversee learning interventions and outcomes. As previously reported, actions such as 24-hour visiting, pharmacy reviews, and discharge coordinator rostering, continue to receive positive feedback with initial formal evaluation planned during Q1. Due to limited responses since the re-launch of the Friends and Family Test (FFT) in February through Microsoft Teams QR codes, an interim tactical plan mobilising volunteers to support the completion of FFT in in-patient areas has been implemented. Approximately 30 responses were obtained in March and review and analysis of this data collection is underway – results and learning responses will be fed into and out from the Triangulation and Learning Committee. The safety team continue to deliver the rapid responder role to families who have been involved in safety incidents. This now includes our patient safety partner, who is joining the maternity incident meeting and visiting families to receive feedback and their reflections on the incidents in line with PSIRF principles. Overall, feedback continues to be positive about the kindness of staff, communication about events and well managed emergency situations. An evaluation of this service is planned for Q1, and a survey has been developed and will be distributed to families who have received the service.
Staff Experience (Cultural Improvement work)	On the 24 March, the Safety Champions Walk-around was conducted by the Director of Midwifery , Children's and Neonatal Matron and Neonatal Unit (NNU) Clinical Lead. Their journey included the Transitional Care Unit (TCU) on Level 5 and the Neonatal Unit (NNU). Overall, the feedback from staff, patients, and parents was overwhelmingly positive, highlighting the culture of psychological safety, excellent care, communication, and support provided within both the TCU and NNU.
Public Health	In March breastfeeding initiation at birth was 84.67% which is above the UK rate of 73-74%. A postnatal newborn readmission audit has been undertaken by the infant feeding team. The main causes of readmission have been either excessive weight loss or jaundice and areas for improvement include a focus on basic infant feeding care before families are discharged and consistent observation and expressing support for new mothers. The three vaccines available from both hubs are RSV, Pertussis (Whooping Cough) and Flu. Covid vaccines ended in January 2025 and Flu has ended on 31st March 2025. The Flu vaccine was given to 714 pregnant women since the service commenced. This is a decrease on previous Flu seasons but is in line with the national decrease in Influenza and Covid vaccine uptake. The immunisation hubs were fully staffed throughout March where 574 vaccines were administered, the second highest total since the service launched September 2024. The Tobacco dependency service continues to thrive with excellent service user feedback received during March. A national incentive scheme that launched on 14/2/25 has been adopted offering £400 in "Love to Shop" vouchers to service users who provide evidence of negative CO monitoring during pregnancy and postnatally. Trusts implementing this scheme have seen a 50% increase in engagement, and our maternity service anticipates similar results. We now have confirmation that this scheme will continue to March 2026.
Exception reports	4 exceptions were identified from the March 2025 data which are annotated below on Slides 8 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 25	615	625			622	540	705
Babies Born	Mar 25	627	-			632	548	716
Scheduled Bookings	Mar 25	670	750			706	555	857
Inductions of labour (IOL)	Mar 25	174	-			149	108	190
Inductions of labour (IOL) as a % of mothers birthed	Mar 25	28.3%	28.0%	H	?	24.0%	19.0%	29.1%
Spontaneous Vaginal Births SVD (including breech)	Mar 25	304	-			312	235	389
Spontaneous Vaginal Births SVD (including breech): a	Mar 25	49.4%	-			51.2%	44.2%	58.2%
Forceps & Ventouse/Instrumental Deliveries (OVD)	Mar 25	90	-			87	57	117
Number of Instrumental births/Forces & Ventouse as	Mar 25	14.6%	-			14.0%	9.6%	18.3%
SVD + OVD Total	Mar 25	394	-			394	313	474

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Caesarean Section (CS)	Mar 25	233	-			216	175	258
Number of CS births as a % of mothers birthed	Mar 25	37.9%	-			35.2%	29.3%	41.0%
Number of Emergency CS	Mar 25	125	-			125	93	156
Emergency CS births as a %	Mar 25	20.3%	-			20.0%	14.8%	25.2%
Number of Elective CS	Mar 25	108	-			97	56	138
Elective CS births as a %	Mar 25	17.6%	-			14.8%	10.7%	19.0%
Robson Group 1 c-section with no previous births a %	Mar 25	13.5%	-			13.4%	7.5%	19.3%
Robson Group 2 c-section with no previous births a %	Mar 25	56.3%	-			55.8%	44.1%	67.5%
Robson Group 5 c-section with 1+ previous births a %	Mar 25	77.9%	-			79.3%	61.8%	96.7%
Elective CS <39 weeks no clinical indication	Mar 25	1	0		?	0	-1	1

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Prospective Consultant hours on Delivery Suite	Mar 25	109	109		?	109	109	109
Midwife:birth ratio	Mar 25	23.8	22.9		?	26.1	22.1	30.1
Maternal Postnatal Readmissions	Mar 25	12	-			8	0	16
Readmission of babies	Mar 25	20	-			19	3	35
3rd/4th Degree Tears amongst mothers birthed	Mar 25	13	-			12	-1	25
3rd/4th degree tears amongst mothers birthed as a %	Mar 25	3.3%	3.5%		?	3.0%	0.0%	6.0%
3rd/4th degree tears following unassisted Vaginal bir	Mar 25	8	-			9	-1	18
3rd/4th degree tears following unassisted Vaginal bir	Mar 25	2.6%	-			2.6%	0.3%	4.9%
3rd/4th degree tears following an Instrumental vagin	Mar 25	5	-			4	-3	11
3rd/4th degree tears following an Instrumental vagin	Mar 25	5.6%	8.0%		?	5.0%	-4.3%	14.2%
PPH equal to or greater than 1.5L following an instrun	Mar 25	5	-	L		8	4	13
PPH equal to or greater than 1.5L following an instrur	Mar 25	0.8%	-	L		1.4%	0.6%	2.1%

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
PPH 1.5L or greater, vaginal births (unassisted)	Mar 25	11	-			13	1	24
PPH 1.5L or greater, vaginal (unassisted) births as a %	Mar 25	1.8%	2.4%		?	2.0%	0.3%	3.8%
PPH 1.5L or greater, caesarean births	Mar 25	1	-			7	-1	15
PPH 1.5L or greater, caesarean births as a % of mother	Mar 25	0.2%	4.3%		P	1.2%	-0.6%	2.9%
ICU/CCU Admissions	Mar 25	0	-			1	-1	2
% completed VTE admission	Mar 25	93.4%	95.0%	L	?	94.8%	90.3%	99.3%
Maternal Deaths: All	Mar 25	0	-			0	0	1
Early Maternal Deaths: Direct	Mar 25	0	-			0	0	0
Early Maternal Deaths: Indirect	Mar 25	0	-	L		0	0	0
Late Maternal Deaths: Direct	Mar 25	0	-			0	0	0
Late Maternal Deaths: Indirect	Mar 25	0	-			0	0	0

Indicator overview summary (SPC dashboard), *continued*

ER Exception report

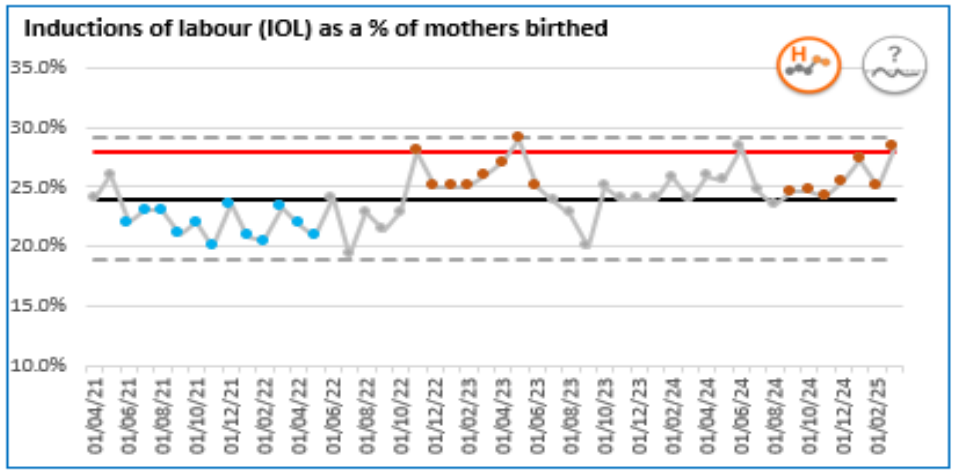
ER ER

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Puerperal Sepsis	Feb 25	1	-			6	-2	13
Puerperal Sepsis as a % of mothers birthed	Feb 25	0.2%	1.5%			0.9%	-0.4%	2.1%
Stillbirths (24+0/40 onwards; excludes TOPs)	Mar 25	4	-			2	-1	6
Stillbirths (24+0/40 onwards; excludes TOPs): as rate	Mar 25	5	0			3	#N/A	#N/A
Late fetal losses (delivered 22+0 to 23+6/40; excludes	Mar 25	0	1			0	-1	2
Neonatal Deaths (born in OUH, up to 28 days) All	Mar 25	1	-			2	-2	7
Neonatal Deaths (born in OUH, up to 28 days): Early (	Mar 25	1	-			2	-2	6
Neonatal Deaths (born in OUH, up to 28 days): Late de	Mar 25	0	-			1	-2	3
Neonatal Deaths (born in OUH, up to 28 days): as rate	Mar 25	2	3			1	-2	5
HIE	Mar 25	0	0			0	0	1

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Shoulder Dystocia	Mar 25	11	-			8	0	17
Shoulder Dystocia as a % of babies born	Mar 25	1.8%	1.5%			1.3%	0.1%	2.6%
Unexpected NNU admissions	Mar 25	23	-			25	7	43
Unexpected NNU admissions as a % of babies born	Mar 25	3.7%	4.0%			3.9%	1.1%	6.7%
Hospital Associated Thromboses	Mar 25	0	0			0	-1	1
Returns to Theatre	Mar 25	0	0			1	-2	4
Returns to Theatre as a % of caesarean section delive	Mar 25	0.0%	0.0%			0.7%	-0.8%	2.1%
Number of PSII	Mar 25	0	0			1	-2	4
Number of Complaints	Mar 25	10	-			8	-3	20
Born before arrival of midwife (BBA)	Mar 25	5	-			6	-2	15

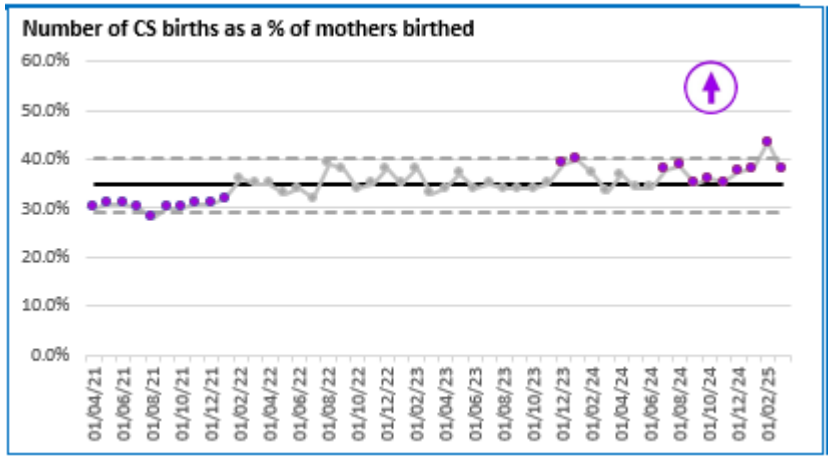
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Test Result Endorsement	Feb 25	84.9%	85.0%			76.2%	64.5%	87.9%
Number Of Women Booked This Month Who Current	Mar 25	36	-			44	22	66
Percentage Of Women Booked This Month Who Curre	Mar 25	5.4%	-			6.3%	3.1%	9.5%
Number of Women Smoking at Delivery	Mar 25	44	-			32	15	48
Percentage of Women Smoking at Delivery	Mar 25	7.2%	8.0%			5.1%	2.3%	7.9%
Number of women with a live birth	Mar 25	613	-			607	498	717
Number of Woman with a live birth Initianing Breastf	Mar 25	519	-			516	341	690
Percentage of Women Initiating Breastfeeding	Mar 25	85%	80%			81%	72%	90%
Number of women booked by 10+0/40	Mar 25	670	-			421	236	607
Percentage of women booked by 10+0/40	Mar 25	73%	-			67%	58%	76%

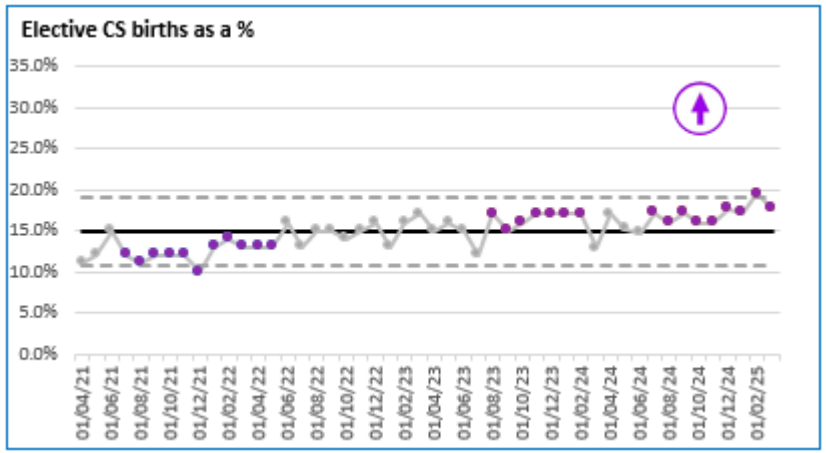
Maternity Exception Report (1)



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
Induction of labour (IOL) as a % of mothers birthed shows special cause concerning variation.	As reported last month, timely induction of labour (IOL) can help reduce stillbirth rates, and research with NMPA shows hospitals with higher induction rates have lower risks at birth. The national average IOL rate has increased to 34% from 20% over ten years and is expected to rise further due to increasing complexity in maternity cases. Therefore, it is proposed to remove the set target for IOL percentage from the Dashboard, while continuing monthly audits which show 94-96% of IOLs are medically indicated and nationally recommended.	A mulitdisciplinary induction of labour task and finish group has been established that will initially focus on the following areas: • Adjusting the target on the performance dashboard. • A standardised approach to Induction of Labour (IOL) Shared Principles Framework has been introduced based on work undertaken in the SE region. • Recognising and recording delays from 6 hours • Review of induction methods to include outpatient option	12	N/A

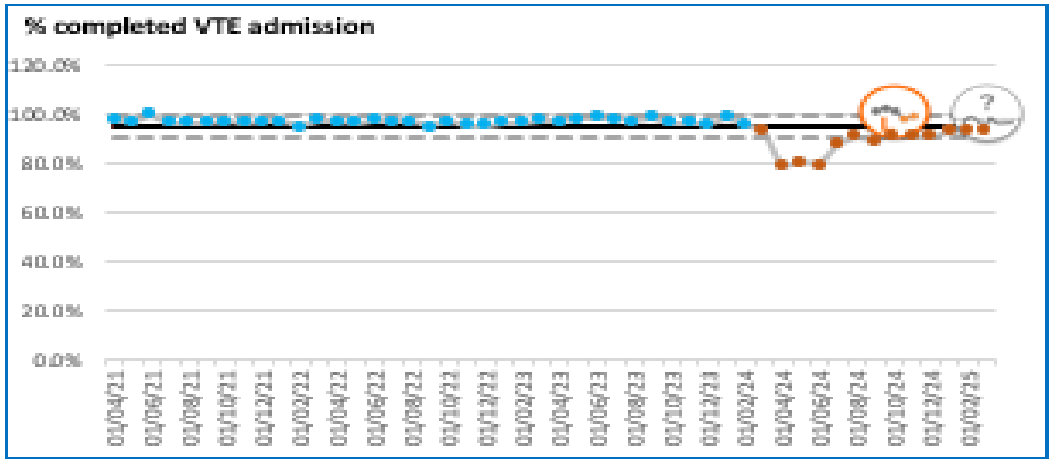
Maternity Exception Report (2)





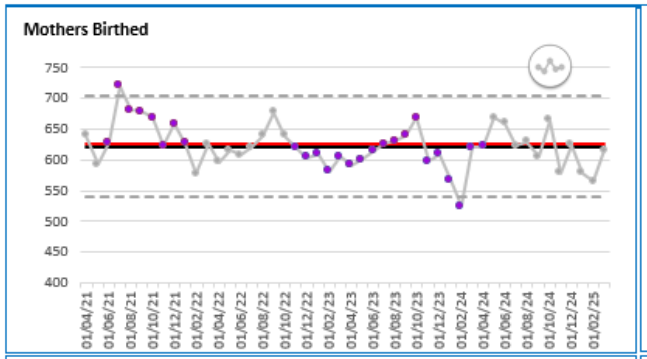
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Timescales to address performance issue(s) and identification of any gaps in assurance	Risk Register score	Data quality rating
Number of CS births as a % mothers birthed shows special cause neither improve or concern variation Elective CS births as a % shows special cause neither improve or concern variation	As reported in previous months there is no national target for caesarean birth and these trends are reflective of national data with increasing demand for caesarean and higher levels of complexity. Capacity to match the demand for the increase in caesarean birth is reflected in the maternity risk register with mitigations in place, such as additional weekend lists.	Business case proposing substantive solution to increased capacity for review by Executive Board – awaiting outcome.		

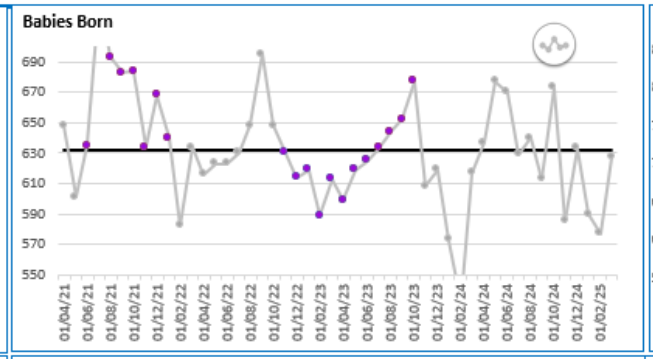
Maternity Exception Report (4)

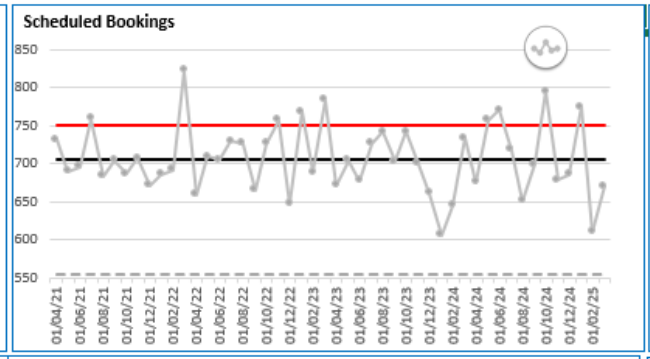


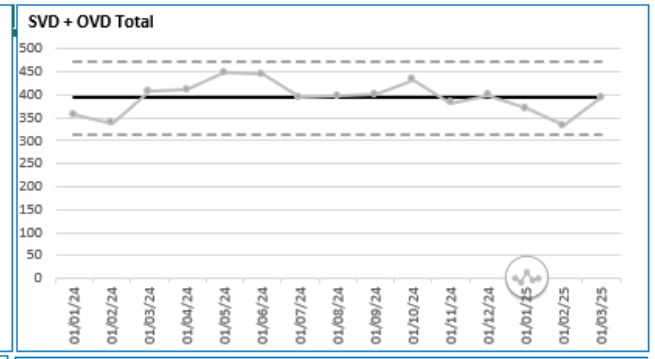
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Timescales to address performance issue(s) and identification of any gaps in assurance	Risk Register score	Data quality rating
% completed VTE admission shows special cause concerning variation.	VTE assessment completion is an emerging risk and an immediate learning response has been the impementaton of a multidisciplinary task and finish group. This group will oversee improvement work with the objective of achieving 100% compliance of timely and accurate VTE assessment. A crucial piece of work is the timely update of the Trust VTE guideline to align with RCOG.	A mulitdisciplinary VTE task and finish group has been established that will initially focus on the following areas: • Prompt review of existing VTE guideline • Digital review of BadgerNet VTE assessment tool to ensure fit for purpose This has been recognised as a priority and updates, progress and monitoring of any action plans will be reported monthly at Maternity Clinical Governance Committee.	N/A	N/A

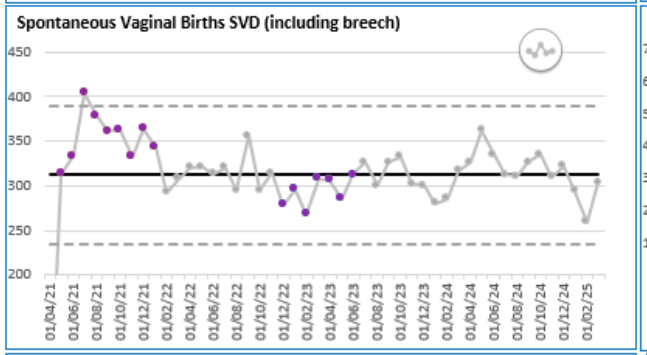
Appendix 1. SPC charts (1)

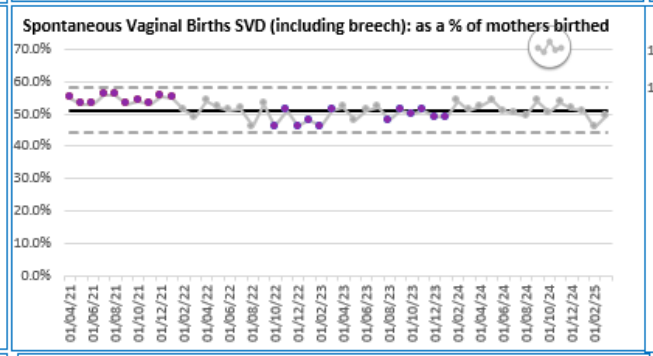


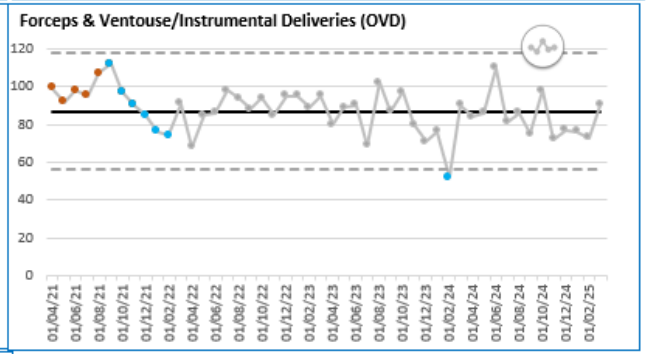


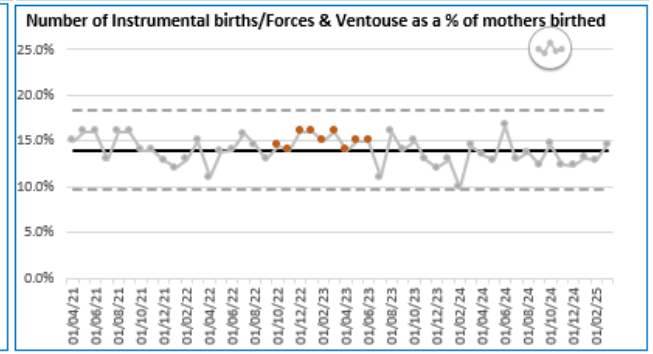


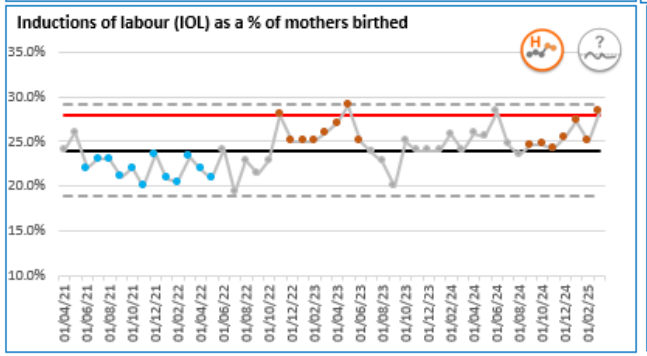


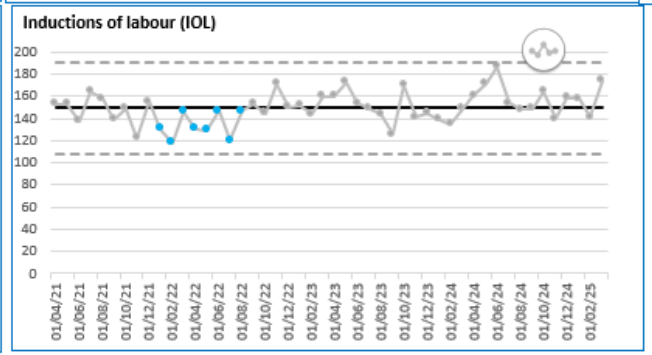




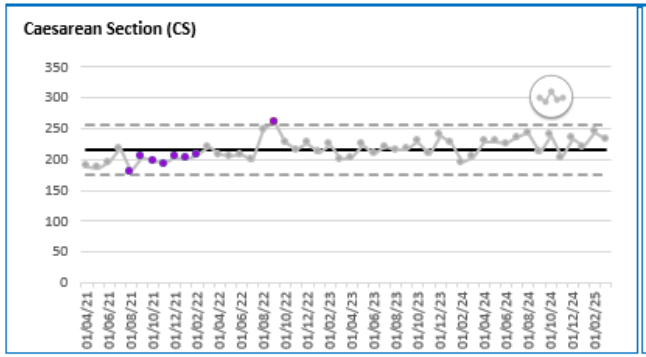


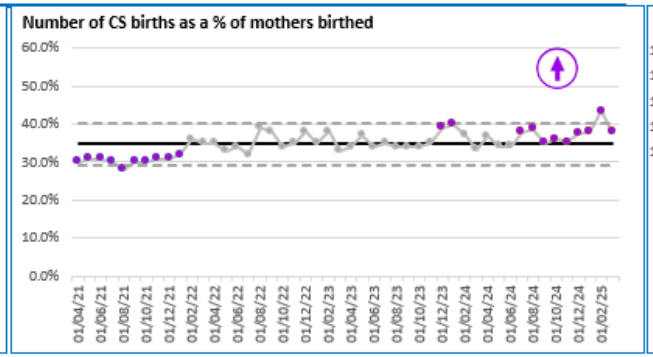


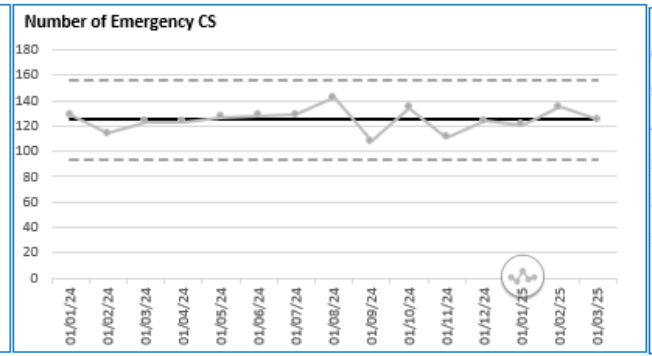


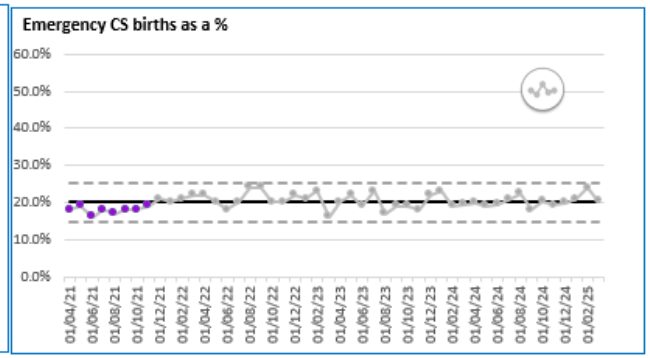


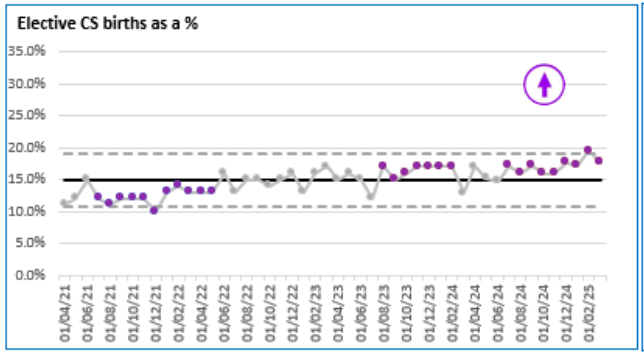
Appendix 2. SPC charts (2)

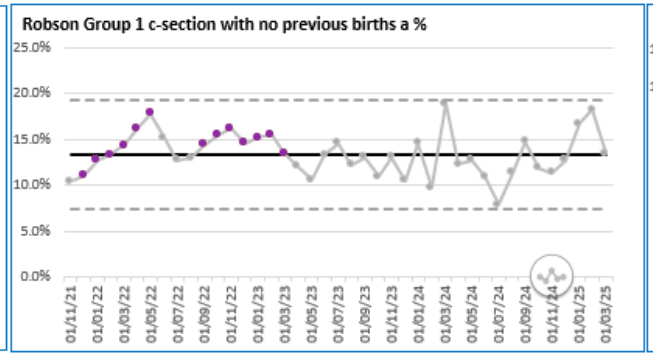


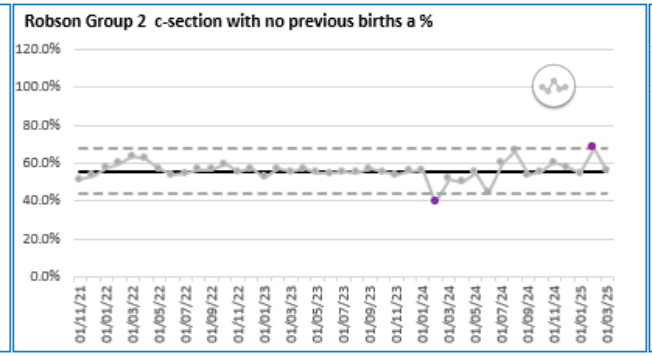


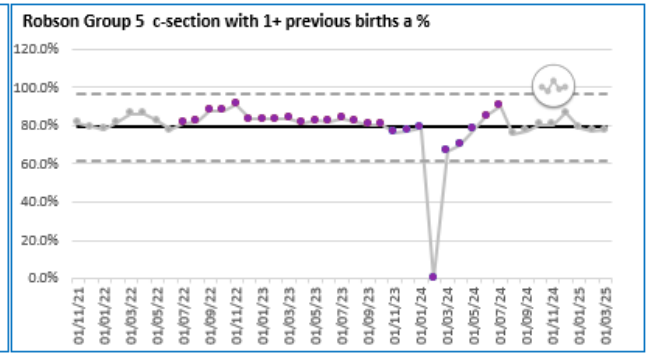


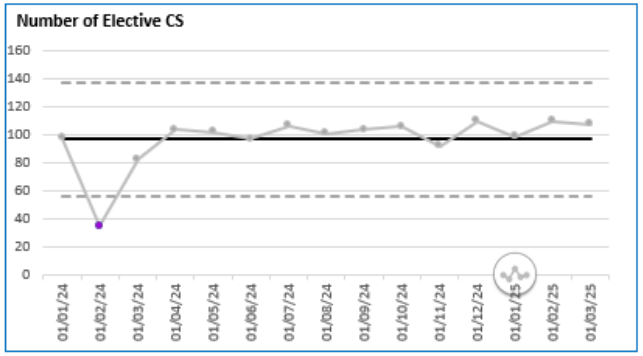


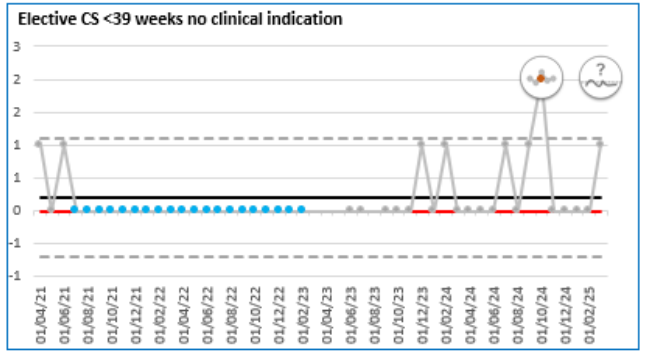




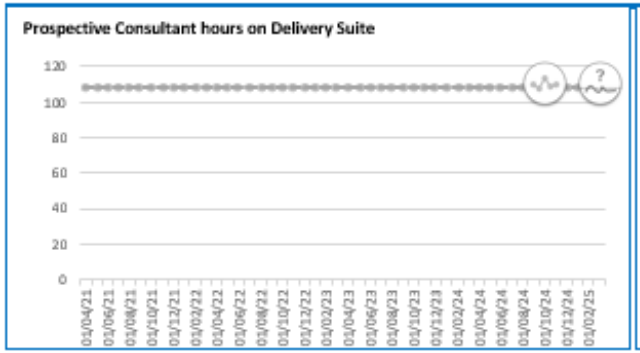


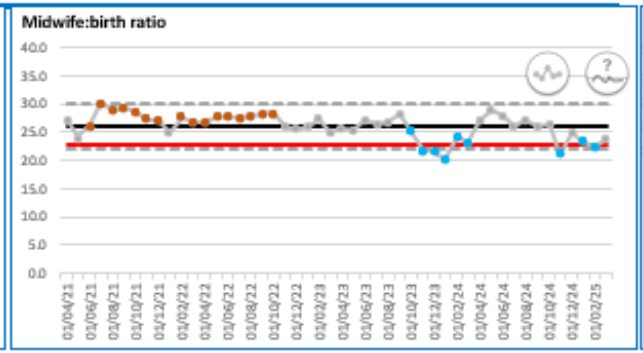


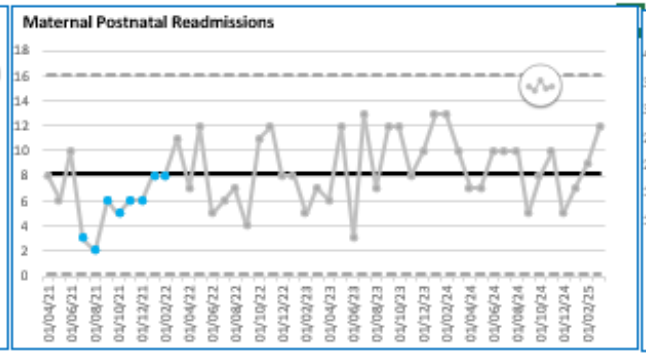


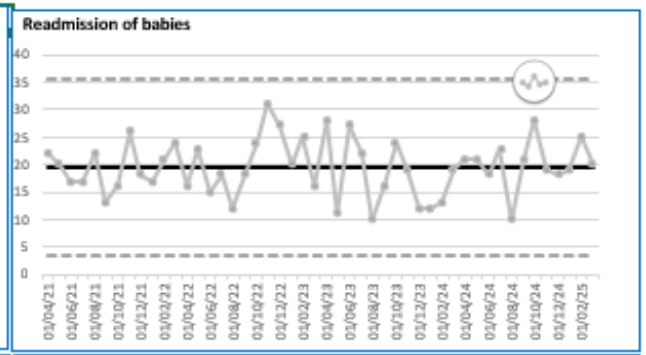


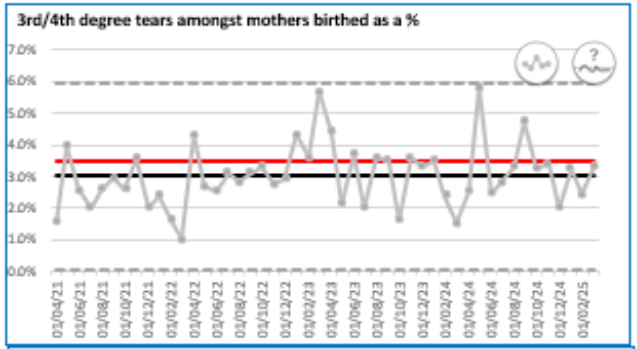
Appendix 3. SPC charts (3)

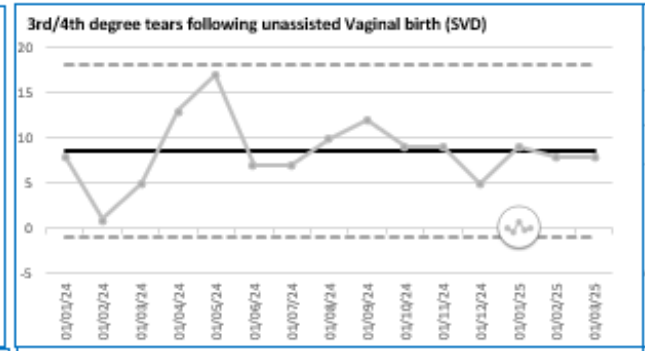


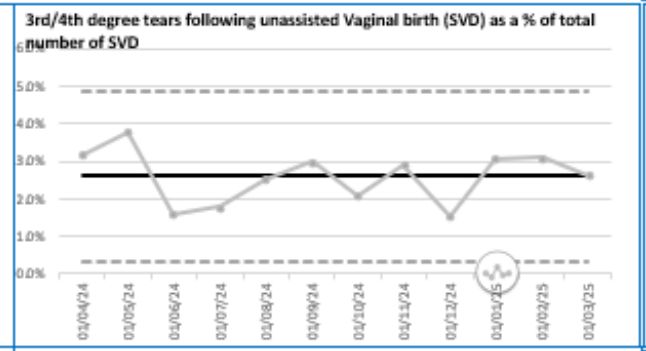


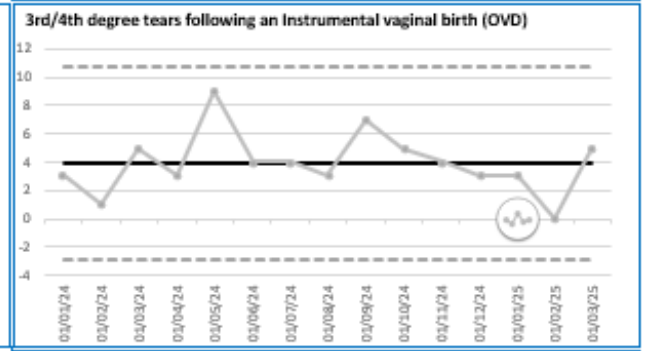


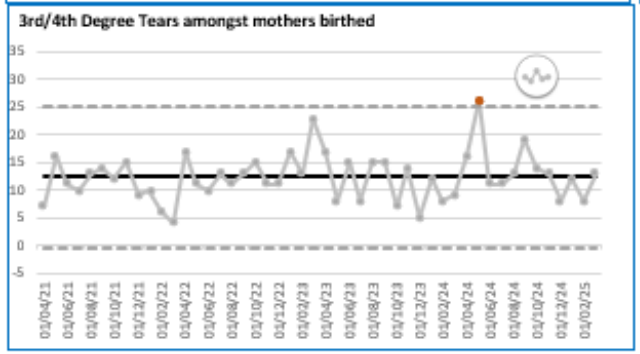


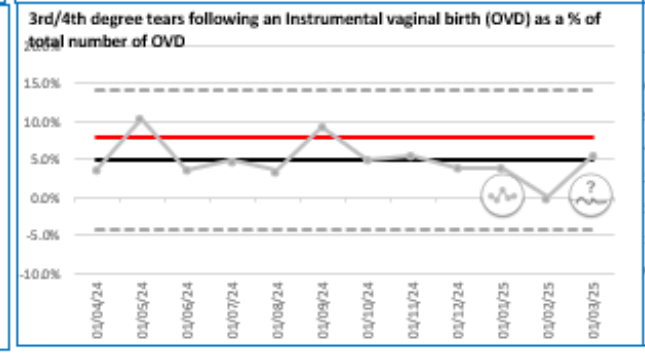


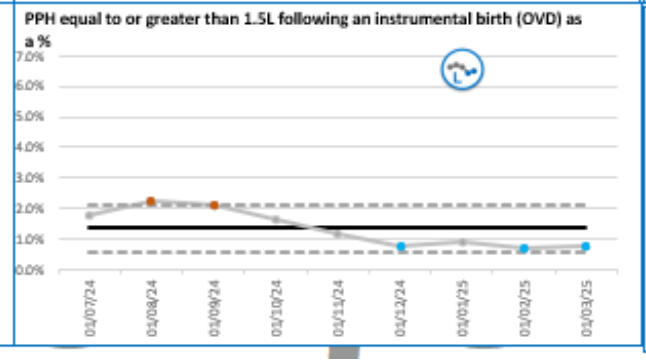


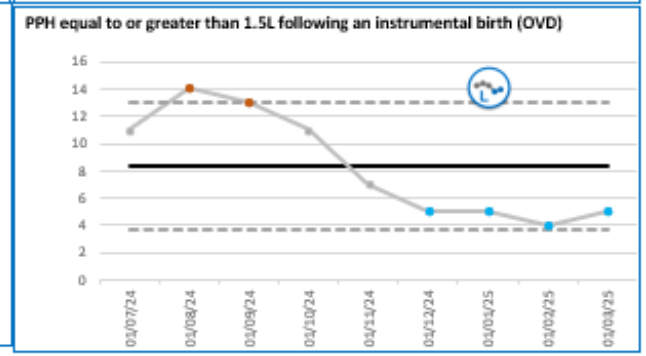




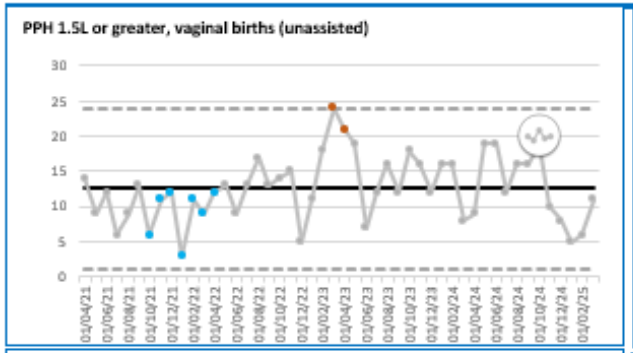


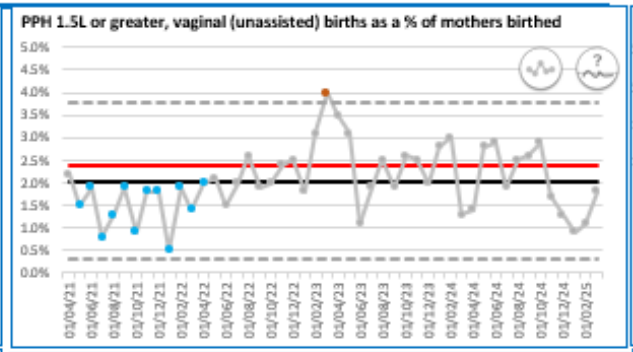


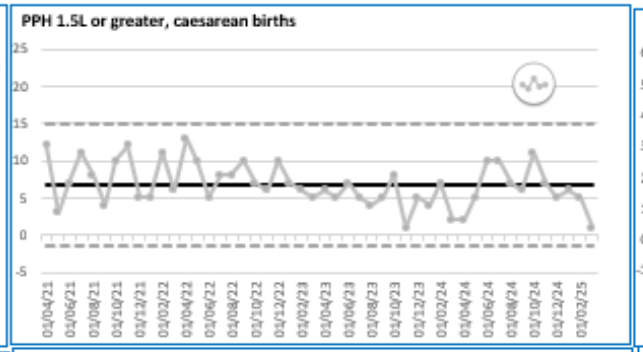


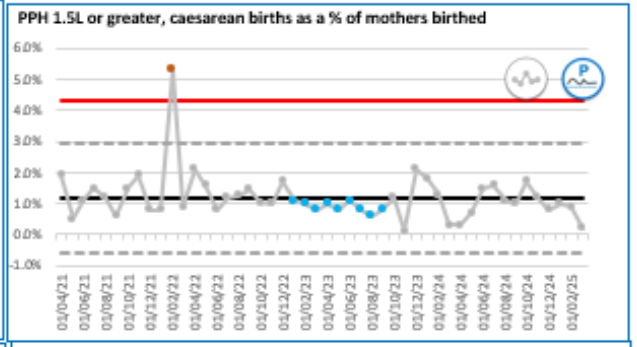


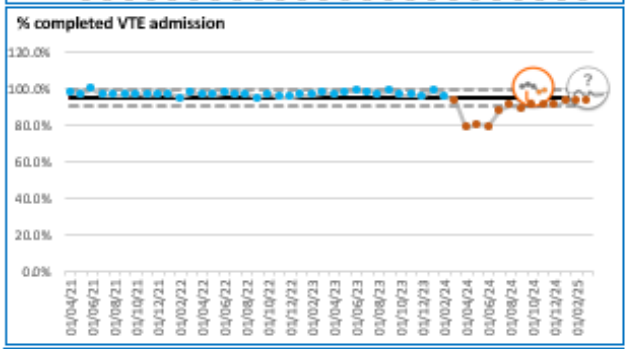
Appendix 4. SPC charts (4)

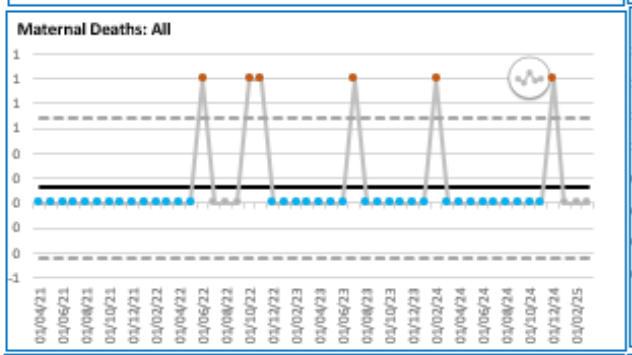


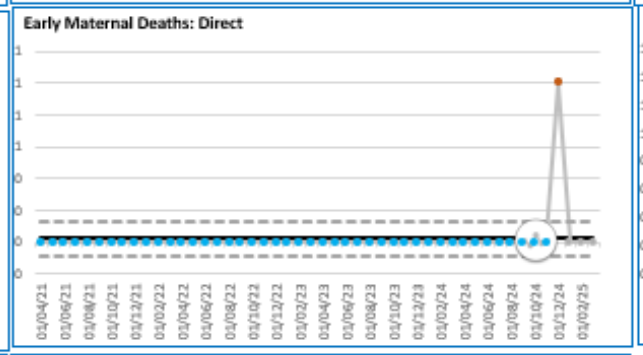


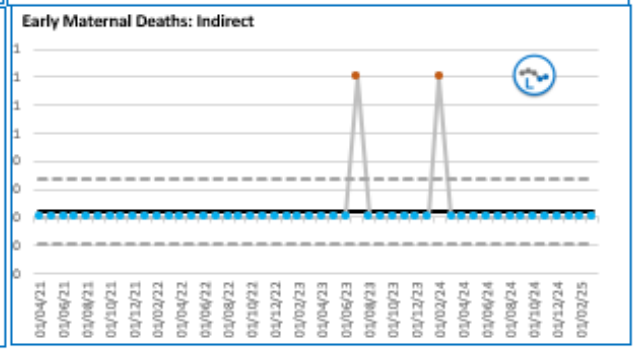


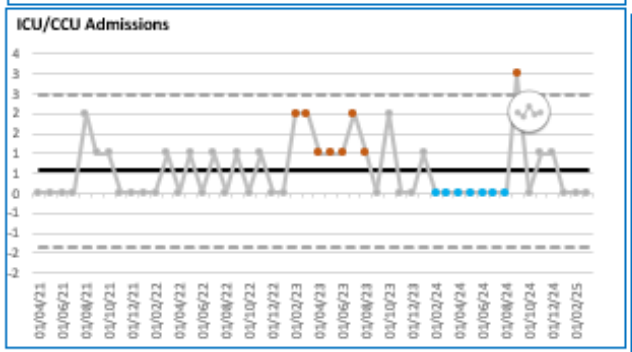


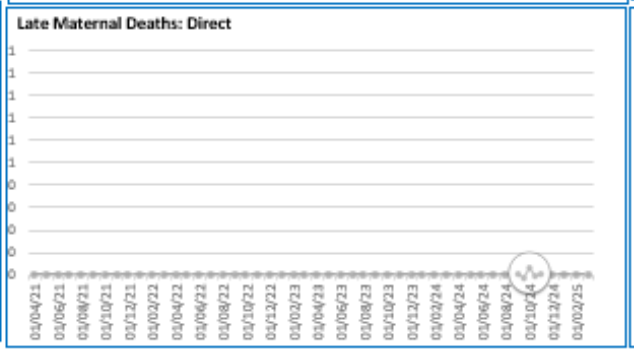


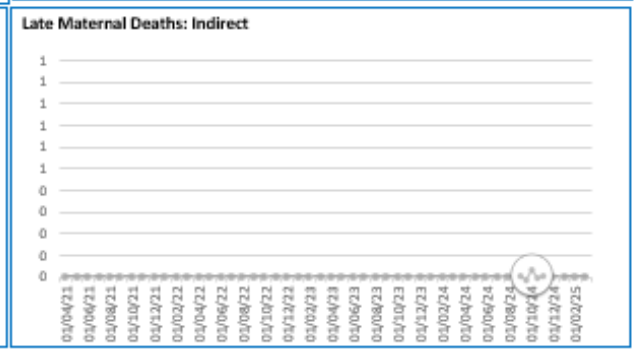




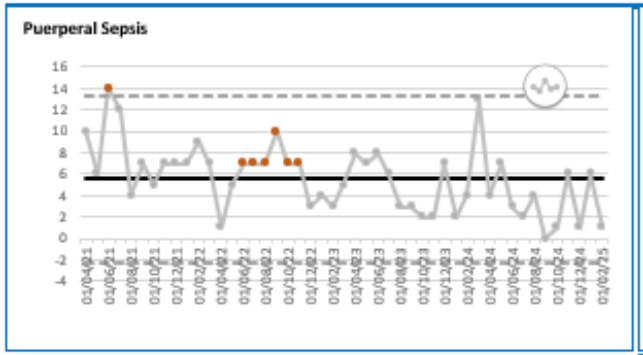


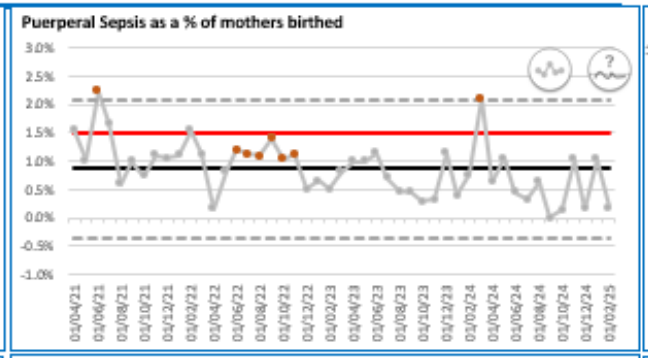


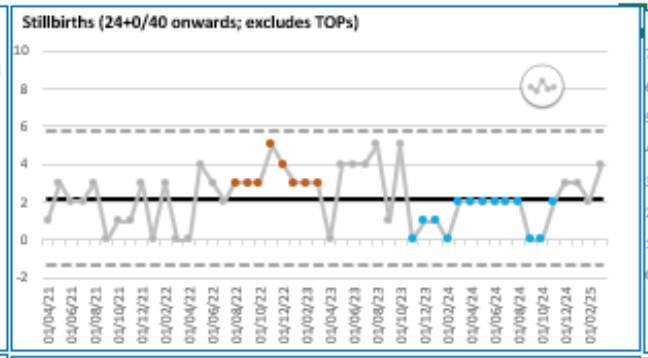


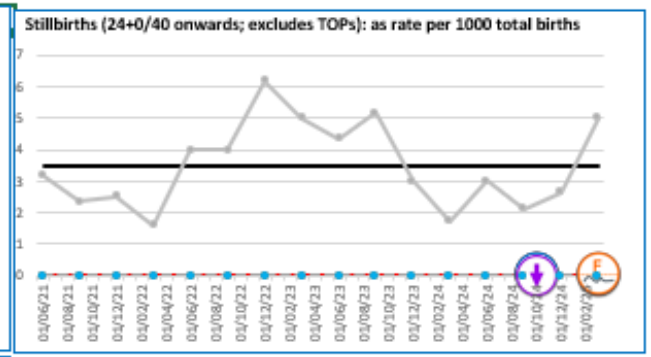


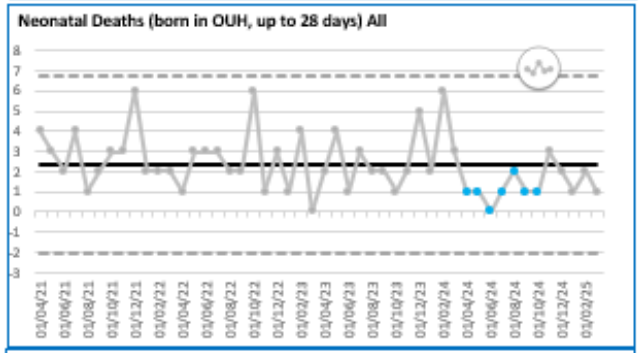
Appendix 5. SPC charts (5)

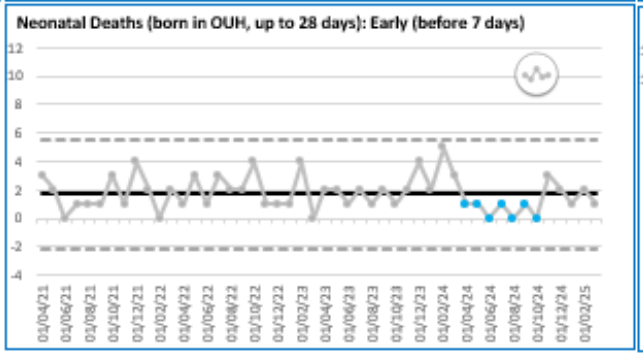


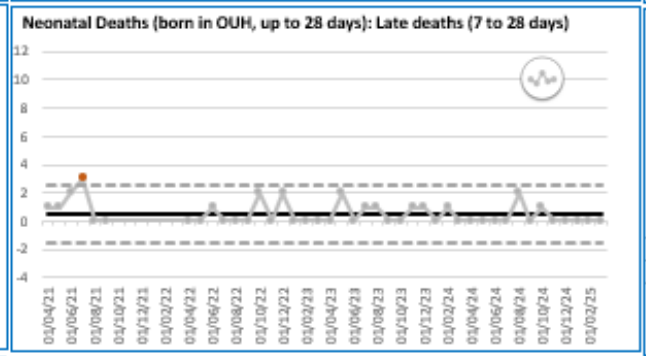


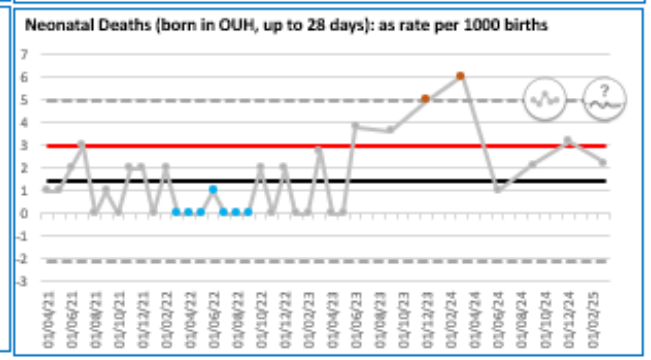


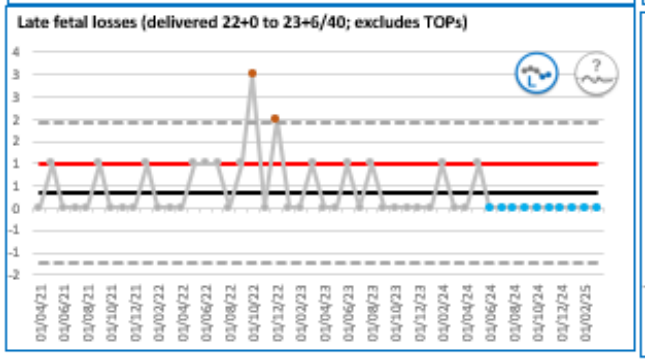


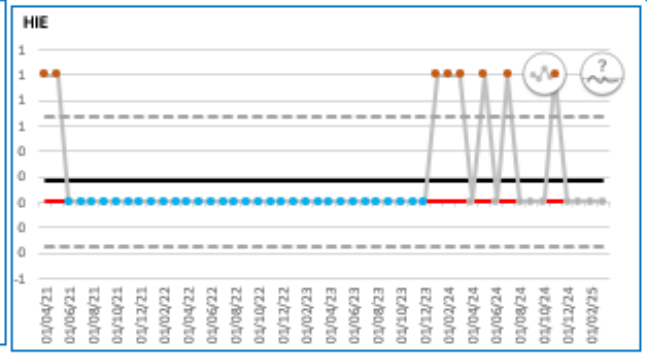




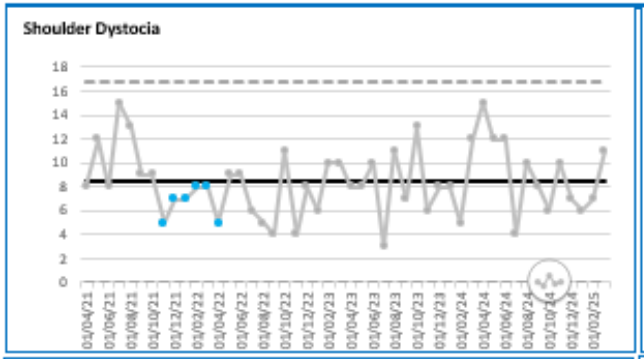


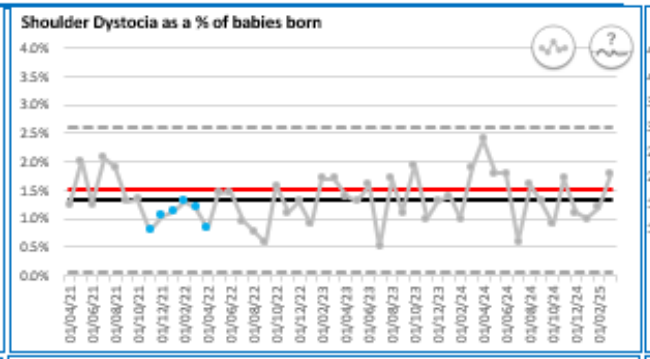


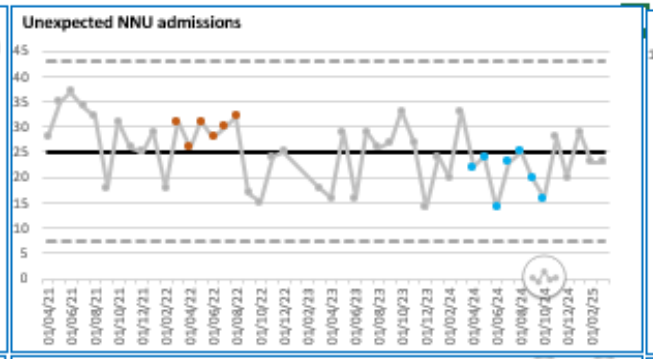


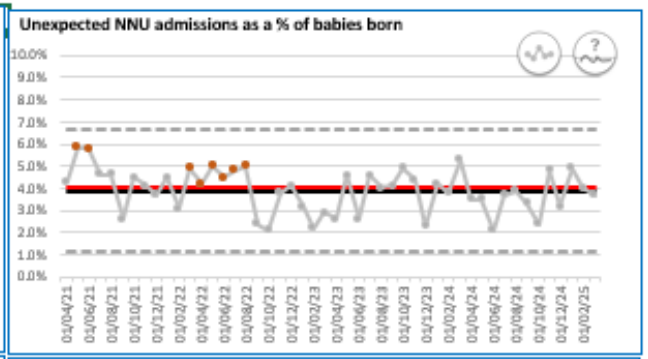


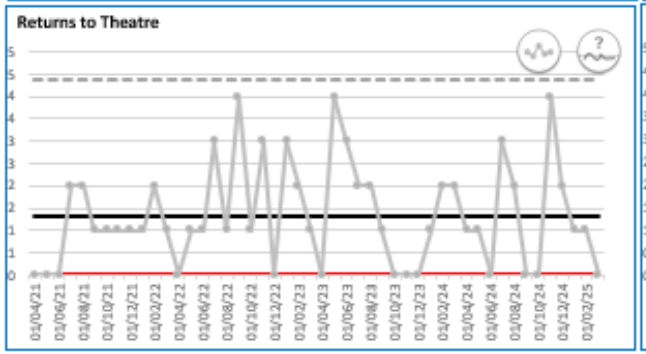
Appendix 6. SPC charts (6)

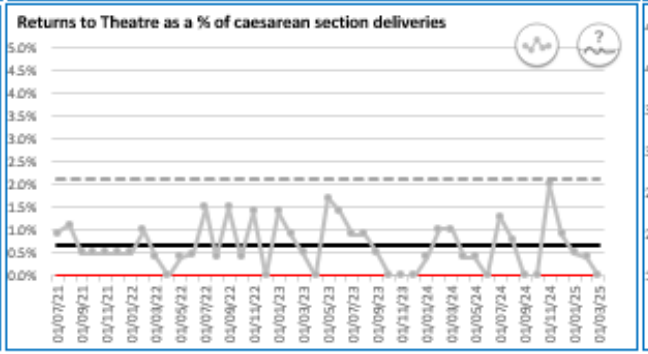


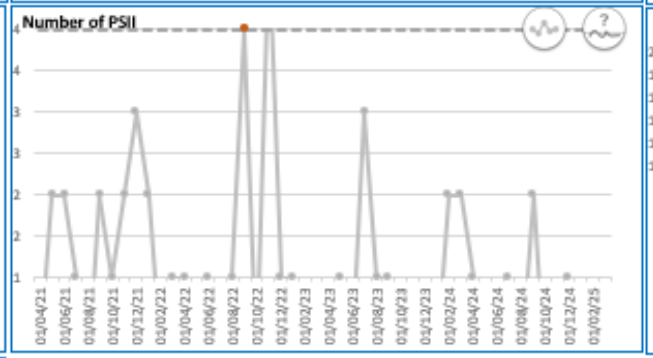


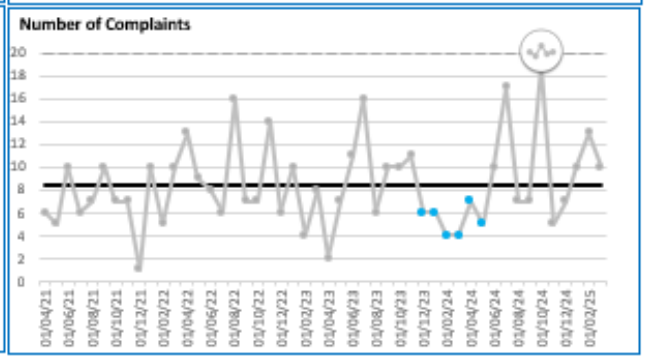


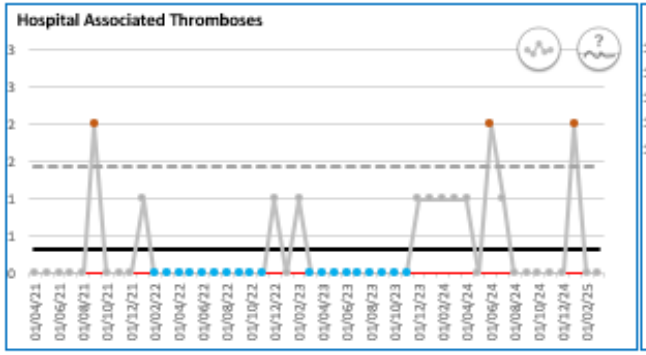


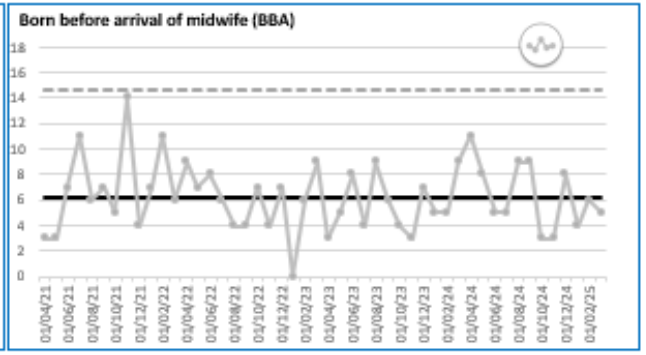




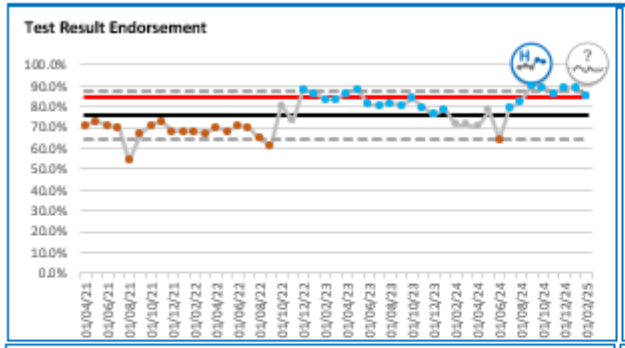


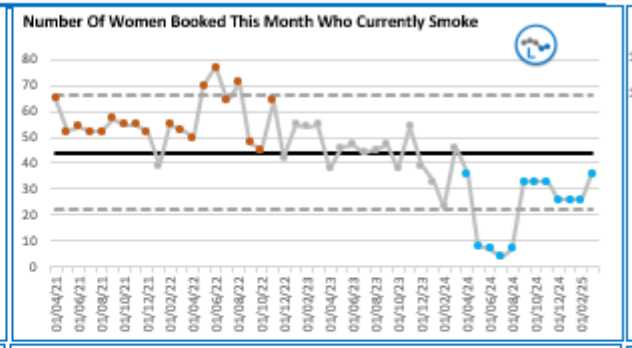


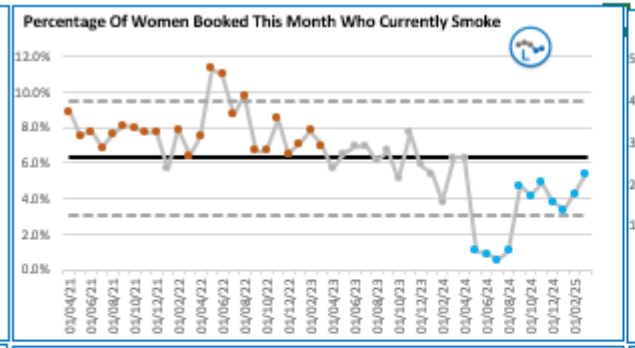


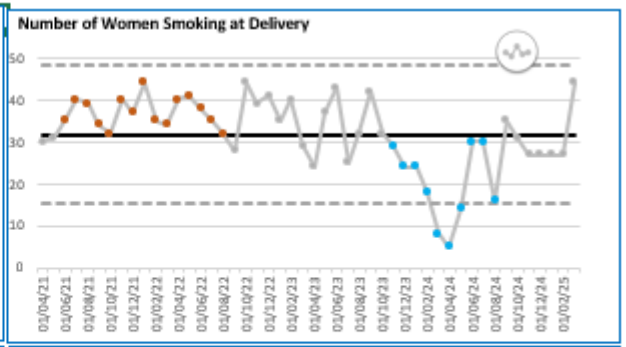


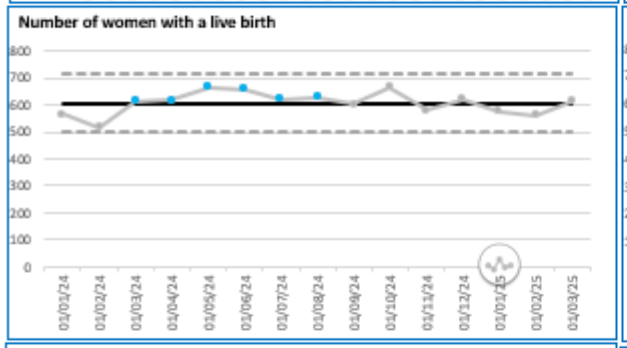
Appendix 7. SPC charts (7)

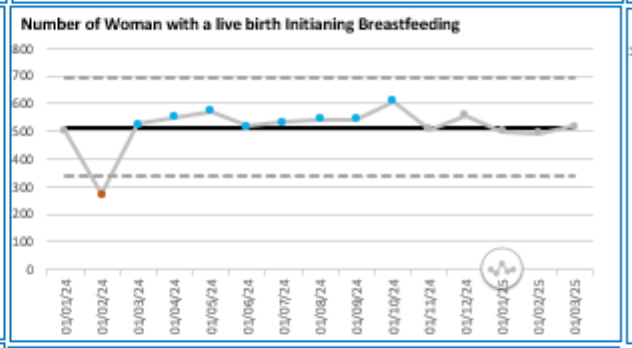


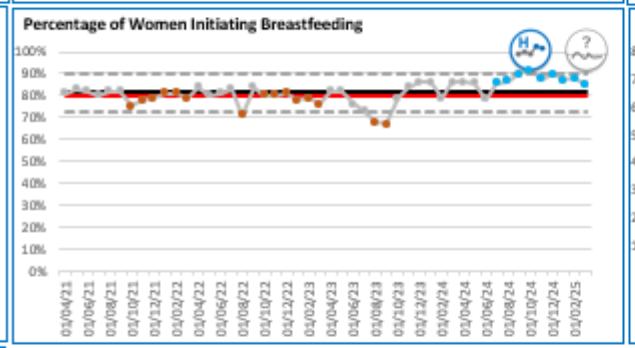


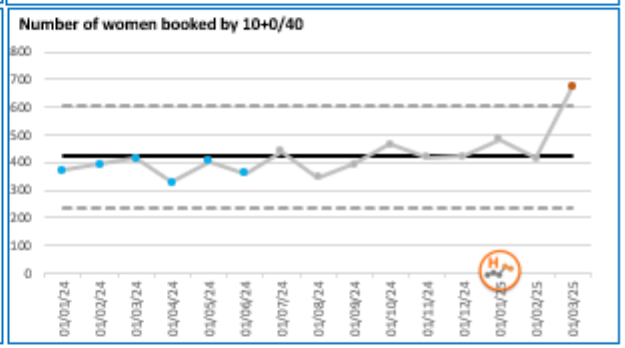


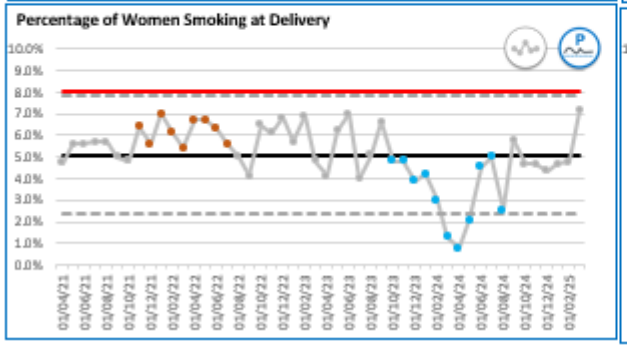


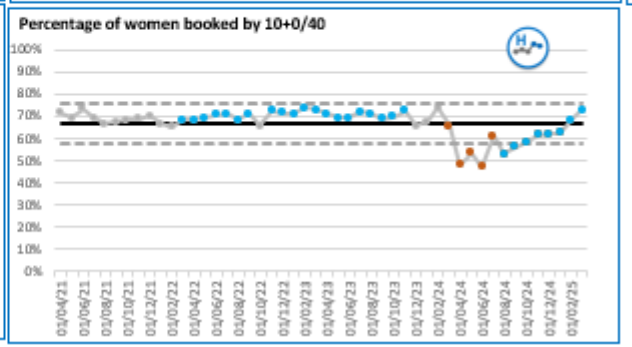












Appendix 1: Categories used for grading of care for perinatal mortality reviews (PMR)

- A – The review group concluded that there were no issues with care identified.
- B – The review group identified care issues which they considered would have made no difference to the outcome.
- C – The review group identified care issues which they considered may have made a difference to the outcome.
- D – The review group identified care issues which they considered were likely to have made a difference to the outcome.