Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Trust Board Meeting in Public: Wednesday 9 July 2025

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Title:	**Maternity Services Update Report**

Status:	**For Discussion**
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	Maternity Clinical Governance Committee (MCGC) 09/06/2025
	Previous paper presented to Trust Board 14/05/2025

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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. **NHS England Southeast Region Rapid Quality Review:** In April 2025, NHS England's Southeast Region conducted a rapid quality review of maternity services. The Trust received the report from the review in May which concluded that there is a clear commitment to enhancing maternity care and ensuring positive outcomes for mothers and babies. The stakeholders present at the review confirmed that significant progress has been made in improving services, noting that the Trust has been both engaged and transparent in its approach. No new issues or actions were identified by any stakeholders or regulators.
4. **NHS England Southeast Region Insight Visit:** The Trust took part in the NHS England Southeast Region Insight visit, which occurred on the same day as the rapid quality review. The insight visit assessed progress regarding the "must-dos" and "should-dos" identified in the most recent CQC inspection of Trust maternity services and assess progress toward achieving key deliverables within the Maternity and Neonatal 3-year delivery plan at both the provider and system levels. The insight report is expected to be completed by the end of June.
5. **Maternity (Perinatal) Incentive Scheme (MPIS)**: The Trust has received confirmation from NHS Resolutions that they have passed all 10 Safety Actions for year 6 of the MPIS. An update is provided as part of the Perinatal Quality Surveillance Model (PQSM) report on the Maternity (Perinatal) Incentive Scheme.
6. **Antenatal and Newborn (ANNB) Screening Assurance:** Following the Antenatal and Newborn (ANNB) Screening Assurance Visit, 28 out of 36 recommendations from the Screening Quality Assurance Service (SQAS) have been closed. Eight remain open, with completion date on schedule for July 2025.

Recommendations

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

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Maternity Services Update Report

1. Purpose

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

- Three-year Single Delivery Plan for Maternity and Neonatal Services
- Maternity (Perinatal) Incentive Scheme (MPIS) year 7
- Maternity Safety Support Programme (MSSP)
- Maternity Performance Dashboard
- Perinatal Quality Surveillance Model Report
- CQC Action plan update
- Antenatal and Newborn (ANNB) Screening
- Midwifery Led Unit (MLU) status
- Safeguarding

2. Three Year delivery plan for Maternity and Neonatal Services

2.1. 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

2.2. 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.

2.3. The Maternity and Neonatal Voices Partnership (MNVP) lead has been appointed into at the end of May 2025.

2.4. In relation to achieving the standard of the UNICEF UK Baby Friendly Initiative (BFI) for infant feeding, or an equivalent initiative, by March 2027: Maternity Services is at BFI level 2 and neonates are at BFI Level 3. Trusts are classified as having achieved the standard when they have achieved the "Gold Award", "Full accreditation. The infant feeding post has been recruited into.

Theme 2: Workforce

2.5. The current vacancy for Midwifery is 12.78 WTE (Whole Time Equivalent), with no vacancies in Nursing and 8.74 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, human resources (HR) representatives and the legacy midwife. The Quarter 3 & 4 24/25 Safe Staffing paper will be presented to Trust Board in July 25.

2.6. Ensure junior and SAS obstetricians and neonatal medical staff have appropriate clinical support and supervision in line with RCOG guidance and BAPM guidance, respectively. There is further work required for education supervision for non-trainee doctors.

Theme 3: Culture and Leadership

2.7. Maternity and Neonatal Safety Champions conduct regular walk rounds, and on April 16, 2025, they visited the Transitional Care Unit (TCU) on Level 5 and the Neonatal Unit (NNU).

2.8. All staff are invited to join an open monthly meeting with the Director of Midwifery. This gives staff opportunity to connect, share ideas, and be part of important conversations.

2.9. The first Maternity Unit Meeting took place on April 7th. This meeting, which will occur on a quarterly basis, is organised by the Maternity triumvirate to disseminate information, reflect on both challenges and achievements, and provide an open forum for questions and discussion.

2.10. The service has now delivered two very successful Schwartz Rounds and are a structured forum where healthcare staff from all disciplines come together to discuss the emotional and social aspects of working in healthcare. These rounds provide a safe space for staff to share their experiences, reflect on their work, and support each other. The goal is to enhance staff well-being, promote compassionate care and improve teamwork and communication within the healthcare setting.

2.11. Work is ongoing in relation to ensuring staff are supported by clear structured routes for the escalation of clinical concerns.

Theme 4: Standards

2.12. 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 national MEWS and NEWTT 2 have not been implemented. Nationally the pilot for NEWTT is due to commence and the pilot of MEWS will not open until September.

2.13. The maternity self-assessment tool has been completed, and this will be used to inform maternity and neonatal safety improvement plans.

3. Maternity (Perinatal) Incentive Scheme (MPIS)

3.1. An update is provided as part of the Perinatal Quality Surveillance Model (PQSM) report on the Maternity (Perinatal) Incentive Scheme.

4. NHS England Southeast Region Rapid Quality Review

4.1. On April 28, 2025, NHS England's Southeast region conducted a rapid quality review of maternity services at Oxford University Hospital (OUH). The review was chaired by the Regional Chief Nurse and included representatives from various organisations and regulatory bodies. These included the NHS England Southeast Regional Maternity and Neonatal Team, the BOB Integrated Care Board (ICB), the NHS England Maternity Safety Support Programme (MSSP), the Care Quality Commission (CQC), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), the NHS England Workforce Training and Education Team, and the Maternity and Neonatal Safety Investigation (MNSI) Team.

4.2. The review concluded that there is a clear commitment to enhancing maternity care and ensuring positive outcomes for mothers and babies. Stakeholders present at the review confirmed that significant progress has been made in improving services, noting that the Trust has been both engaged and transparent in its approach. No new issues or actions were identified by any stakeholders or regulators.

4.3. The review highlighted that the Trust has a comprehensive understanding of the areas in maternity care that require improvement and emphasised the effective processes that have been implemented to address and monitor these issues.

4.4. On May 8, 2025, the Trust received a summary and actions from the Rapid Quality Review. The report highlights that the Trust has a clear understanding of the areas in its maternity services that need improvement. These areas include addressing delays in the induction of labour, managing the increase in caesarean section rates, enhancing risk assessments, and improving the overall patient experience.

4.5. In addition, the review highlighted a priority action for the BOB ICB to conduct a comprehensive review of all maternity services, including Midwifery Led Units (MLUs), across the BOB system within the next 12 months.

4.6. Finally, the review indicated that the Trust should prepare to transition from the Maternity Safety Support Programme (MSSP) to the Enhanced Support and Oversight Framework (ESOF) by June 2025.

4.7. Stakeholders, including Care Quality Commission, Nursing Midwifery Council, General Medical Council and Maternity Neonatal Voices Partnership, highlighted having no immediate concerns.

5. NHS England Southeast Region Insight Visit

5.1. The Trust took part in the NHS England Southeast Region Insight visit, which occurred on the same day as the rapid quality review.

5.2. The insight visit assessed progress regarding the "must-dos" and "should-dos" identified in the most recent CQC inspection of Trust maternity services and assess progress toward achieving key deliverables within the Maternity and Neonatal 3-year delivery plan at both the provider and system levels.

5.3. The insight report is expected to be completed by the end of June.

6. Maternity Performance Dashboard

6.1. There were 7 exceptions reported for the May data, see Appendix 1 for further detail, mitigations, and improvement actions. The dashboard includes data relating to the activity in the community.

7. Perinatal Quality Surveillance Model Report

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

8. CQC Action Plan Update

8.1. 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 on the 29 May 2025.

8.2. 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.

8.3. 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 in progress due to ongoing building works which are due to be completed at the end of June. The risk assessment completion will follow.

8.4. The new birthing pool at the Horton went live in April 2025.

8.5. 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.

9. Antenatal and Newborn (ANNB) Screening

9.1. The ANNB team met with NHSE on the 16 May to review progress on the action plan.

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

9.3. The Screening Quality Assurance Service (SQAS) have closed 28 recommendations so far. There are 08 that remain open, the completion deadline is the 03 July 2025.

9.4. The Trust Assurance Team met with the Maternity team in May to monitor and evaluate the progress of the effectiveness of the action plan. The next Evidence group meeting is on the 30 June 2025.

9.5. 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.

10. Maternity Safeguarding

10.1. Following the summer period, the Maternity Safeguarding and Mental Health team is planning to launch a series of ‘Lunch and Learn’ case discussion sessions. These informal, interactive sessions will provide a valuable platform to reflect on and discuss recent complex cases, identify areas of excellent practice, and facilitate shared learning across the maternity and neonatal teams.

10.2. Each session will include participation from both maternity and neonatal services and will regularly feature guest speakers, including social workers, addiction specialists, and other key professionals involved in perinatal care. The sessions aim to:

- Promote multi-disciplinary learning and discussion.
- Cascade messages and lessons learned from serious incidents.
- Disseminate relevant national learning and guidance updates.
- Support ongoing improvement in safeguarding practice and mental health care during the perinatal period.

10.3. These sessions are intended to strengthen professional knowledge, improve inter-agency collaboration, and ultimately enhance outcomes for women, babies, and families.

10.4. Preparations are underway for a comprehensive multi-agency pre-birth audit aimed at assessing adherence to the updated Oxfordshire Safeguarding Children Board Pre-Birth Guidance, which was collaboratively developed by Oxfordshire Children's Social Care (CSC) and Maternity Safeguarding, with significant input from partner agencies including BOB ICB (Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board), Thames Valley Police (TVP), and Oxfordshire County Council (OCC).

10.5. The audit is designed to ensure the guidance is being consistently implemented across services, particularly in supporting early identification, planning, and intervention in pregnancies where additional safeguarding needs are identified. It will involve a joint review of casework and practice across all agencies to evaluate multi-agency effectiveness, communication, and decision-making.

10.6. Scoping work for the audit will take place over the coming months, with a target completion date in October 2025. The findings will be presented and discussed at a face-to-face shared learning event, providing an opportunity for reflection, learning, and strengthening of collaborative working across all involved services.

11. Midwifery Led Unit (MLU) Status

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

11.2. In April 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.

12. Conclusion

12.1. This report provides an update on essential maternity activity which includes the CQC action plan update, Maternity (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.

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

13. Recommendations

13.1. 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: June 2025

Data period: May 2025

Presented at: Maternity Clinical Governance Committee

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Executive Summary

Executive Summary

Six hundred twenty-nine women birthed in OUH in May 2025, and there were 674 bookings for antenatal care.

Notable Successes

- There were two Daisy Awards presented to midwives, Nicola Bean, who works in the Maternity Observation, and Shannon Russell, who works in the Bicester community team.
- The first day of the pilot program, "Cervical Length Scanning Training for Doctors," was a success. Eight doctors scanned 46 pregnant volunteers, supervised by four consultants who specialise in preventing preterm births. The project is funded by Health Innovation Oxford and Thames Valley. The organisers plan to hold two additional sessions at OUH and two at Stoke Mandeville Hospital.

Executive summary

Domain	Performance challenges, risks and interventions
Activity	In May 629 mothers gave birth at OUH, which is 38 more than the previous month. A total of 259 caesarean sections were performed, representing 41.2% of all births. Of the mothers, 68 (11%) gave birth in midwifery-led settings, while 26 (4%) were in community settings, including home births. Additionally, 42 women (6%) delivered at the Spires alongside the midwifery unit. Two women (0.3%) had home births, 19 women (3%) were at freestanding midwifery units in Wantage, Wallingford, and Chipping Norton, and 7 women (1.1%) gave birth at the Horton freestanding midwifery unit.
Workforce	The birth-to-midwife ratio was 1:25.51, reflecting an increase compared to April due to a higher number of births. The team maintained a vigilant approach to ensure that planned staffing levels aligned with actual needs, holding daily safe staffing meetings to address and mitigate any issues. The service continued to implement a strong recruitment and retention plan, conducting over 20 interviews in May. Throughout the month, there were no instances when 1:1 care was not provided for women in established labor, nor were there occasions when the delivery suite coordinator was not working in a supernumerary capacity. There was an increase in the number of on-call midwifery hours used, rising from 78 in April to 159 in May. The number of occasions when staff did not have a break decreased slightly to 67 from April. There were 23 delays in the induction of labor exceeding 24 hours, an increase of 13 from April.
Maternal Morbidity	In May 2025, the overall rate of third-degree tears among mothers who had a vaginal birth was 2.05% (n=8), which includes both unassisted spontaneous vaginal deliveries (SVD) and assisted deliveries using forceps or ventouse. This rate falls within the national average of 0% to 8%. For unassisted (spontaneous) vaginal births, including breech deliveries, the rate of third-degree tears was 2.2% (n=7). The ethnic backgrounds of these women were as follows: White British (n=5) and Not Stated (n=2). In assisted vaginal births (using forceps or ventouse), the rate of third-degree tears was 1.3% (n=1), with the ethnic background of this woman being Indian (n=1). In May 2025, the rate of postpartum haemorrhage (PPH) of 1500 ml or more among mothers who had an assisted vaginal birth was 0.6% (n=4). This figure is below the national mean of 2.8% reported by the National Maternity and Perinatal Audit (NMPA). The ethnic backgrounds of these mothers were as follows: White-Other (n=2), Not Stated (n=1), and Indian (n=1). For mothers who had an unassisted vaginal birth in the same month, the rate of PPH of 1500 ml or more was 1.3% (n=8), which is again below the NMPA national mean of 2.8%. The ethnic backgrounds of these mothers included: British (n=4), Asian-Other (n=1), Indian (n=1), White-Other (n=1), and Not Known (n=1). In May 2025, the rate of postpartum haemorrhage (PPH) of 1.5 litres or more among mothers who had a caesarean section was 1.1%, which corresponds to 7 cases out of the total number of mothers. This reflects a decrease of 0.3% compared to April 2025 and is significantly lower than the national mean of 4.75% reported by the NMPA. The ethnic backgrounds of the women were as follows: British (1), Asian-Other (1), White-Other (2), White and Black Caribbean (1), and Not Stated (2).
Perinatal Morbidity and Mortality	In May 2025, one case was reviewed using the Perinatal Mortality Review Tool. This case involved a baby who sadly passed away at 25+6 weeks due to a known cardiac abnormality. The care provided was graded as B and A, respectively. In May, there were 20 full-term babies unexpectedly admitted to the neonatal unit, which represents a 30% decrease compared to April. All cases are reviewed through the Avoiding Term Admissions to Neonatal Units (ATAIN) framework. Recent educational interventions have included training on neonatal temperature control and improvements to the ambient temperature in the observation area.
Maternity safety	In May 2025, the maternity service submitted a total of 218 patient safety reports via the Ulysses system. Out of these, 48 incidents were classified as causing moderate harm, which represents 22% of all reported patient safety incidents. Among the 48 moderate harm incidents, there were 8 related to obstetric anal sphincter injuries (OASI), 15 involving major post-partum haemorrhage (PPH), and 20 related to unexpected term admissions. Additionally, 2 incidents were reclassified as 'minor harm' because they did not meet the criteria for 'moderate harm'. Appropriate learning responses were implemented in line with the Patient Safety Incident Response Framework (PSIRF) principles to ensure that actions and interventions were taken thoughtfully and on a case-by-case basis. There were three suspected cases of Hypoxic-Ischemic Encephalopathy (HIE), all involving babies who were admitted to the neonatal unit for therapeutic cooling. The first two cases (referred to as Case 1 and Case 2) occurred within 24 hours of each other in early May. Both cases underwent MRI scans, which showed no evidence of HIE. Case 1 has been accepted by the MNSI, while Case 2 is still awaiting a decision from the parents. The third case (Case 3) happened in late May and also had an MRI that revealed no evidence of HIE. However, Case 3 has not been formally referred to the MNSI since we are still waiting for parental consent. The immediate learnings from a rapid review of these cases emphasise the importance of maintaining continuous fetal monitoring, avoiding a task-focused approach, and ensuring prompt escalation and timely review.

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, therefore this is reported one month retrospectively. The result endorsement for April 2025 demonstrated an increase on the previous month to 86.3%. This continues to be a focus area and targeted work is ongoing to engage individuals to improve compliance.
Service User Experience	In May 2025, 10 complaints were received. Feedback centred around key themes of communication and patient experience in ultrasound. Of the 10 complaints received, 60% (n=6) were white British ethnicity, 10% (n=1) Asian or Asian British – Indian, 10% (n=1) Asian or Any Other Asian and 20% (n=2) were of other, not stated. Collaborative work is underway with the Health Inclusion group to review ethnicity data and identify improvement interventions for any disproportionately represented groups. Focused work to improve experience for service users in ultrasound with higher BMIs is underway with education for staff on avoiding insensitive terminology, replacing with clear, empathetic language and provision of accurate information. In May, the service received 102 responses for the Friends and Family Test (FFT). 90% were positive responses with 33% of the positive themes related to care, attention and support on the postnatal ward. Good communication and positive attention from staff was the feedback for Delivery Suite, and there was reports of an excellent immunisation and BCG service with reassuring staff who had time to care and support informed choice. Conversely, length of stay on the Maternity Assessment Unit (MAU) whilst waiting for results prior to discharge was identified as an area that required improvement. This will be fed into the Triage improvement project. 'Say on the Day' devices have now been installed in the Maternity Ultrasound Departments and are available in different languages. 205 responses were received in May with 99% positive feedback. Comments centred around kindness and compassion and excellent communication, which is contrary to the complaints received. The rapid responder role hosted by the safety team continues to receive positive feedback from service users and their families. Providing timely opportunities to understand and reflect on their experience of care when they have suffered a poor outcome such as OASI, this gives an extended duty of candour provision and should over time lead to a reduction in complaints and litigation
Staff Experience (Cultural Improvement work)	The service remains committed to providing staff a safe, supportive environment which motivates the team to deliver care aligned with the Trust values. The service is responsive to "say on the day" feedback from staff with PMAs now coordinating the triangulation and response. Results from the Trust's staff survey have been released, there was a low turn out of just over 40% from Maternity with positives noted around learning and development opportunities and a zero tolerance to discrimination. Areas for improvement were also identified around performing additional duties and reasonable adjustments. The Growing Stronger Together Programme has been launched to support the collaborative development of solutions in response to the survey. Progress will be monitored and reported through SUWON and Maternity Governance channels. Aligned to this programme of work, existing wellbeing tools such as access to PMA's, psychological support and Schwartz rounds continue to be offered as part of the permanent suite of wellbeing interventions.
Public Health	For the month of May 2025, 90.54% of women-initiated breast feeding , this is an increase of 0.54% on the previous month and remains higher than the national average rate of 73.4%. The two vaccines available from the immunisation hubs are respiratory syncytial virus (RSV) and Pertussis (Whooping Cough). Feedback continues to be positive from service users regarding the flexibility of the immunisation drop-in service based in both the John Radcliffe and Horton.
Exception reports	7 exceptions were identified from the May 2025 data which are annotated below on Slides 8 to 11.

Indicator overview summary (SPC dashboard)

ER Exception report

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Mothers Birthed	May 25	629	625			622	539	704
Babies Born	May 25	647	-			632	547	716
Scheduled Bookings	May 25	674	750			705	559	850
Inductions of labour (IOL)	May 25	197	-			150	107	194
Inductions of labour (IOL) as a % of mothers birthed	May 25	31.3%	28.0%			24.2%	18.8%	29.6%
Spontaneous Vaginal Births SVD (including breech)	May 25	314	-			312	235	388
Spontaneous Vaginal Births SVD (including breech): a	May 25	49.9%	-			51.1%	44.2%	58.0%
Forceps & Ventouse/Instrumental Deliveries (OVD)	May 25	76	-			87	57	117
Number of Instrumental births/Forces & Ventouse as	May 25	12.1%	-			13.9%	9.6%	18.2%
SVD + OVD Total	May 25	390	-			391	311	472

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Caesarean Section (CS)	May 25	259	-			217	176	259
Number of CS births as a % of mothers birthed	May 25	41.2%	-			35.2%	29.3%	41.0%
Number of Emergency CS	May 25	149	-			126	93	159
Emergency CS births as a %	May 25	23.7%	-			20.1%	14.9%	25.3%
Number of Elective CS	May 25	110	-			99	60	138
Elective CS births as a %	May 25	17.5%	-			14.9%	10.9%	18.9%
Robson Group 1 c-section with no previous births a %	May 25	13.6%	-			13.3%	7.2%	19.4%
Robson Group 2 c-section with no previous births a %	May 25	60.2%	-			56.0%	44.5%	67.5%
Robson Group 5 c-section with 1+ previous births a %	May 25	86.9%	-			79.5%	62.4%	96.7%
Elective CS <39 weeks no clinical indication	May 25	0	0			0	-1	1

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Prospective Consultant hours on Delivery Suite	May 25	109	109			109	109	109
Midwife:birth ratio	May 25	25.5	22.9			26.1	22.1	30.0
Maternal Postnatal Readmissions	May 25	6	-			8	-1	17
Readmission of babies	May 25	13	-			19	4	35
3rd/4th Degree Tears amongst mothers birthed	May 25	8	-			12	0	25
3rd/4th degree tears amongst mothers birthed as a %	May 25	2.1%	3.5%			3.0%	0.0%	6.0%
3rd/4th degree tears following unassisted Vaginal bir	May 25	7	-			9	-1	18
3rd/4th degree tears following unassisted Vaginal bir	May 25	2.2%	-			2.6%	0.4%	4.8%
3rd/4th degree tears following an Instrumental vagin	May 25	1	-			4	-3	10
3rd/4th degree tears following an Instrumental vagin	May 25	1.3%	8.0%			4.6%	-4.1%	13.3%
PPH equal to or greater than 1.5L following an instrun	May 25	4	-			8	2	14
PPH equal to or greater than 1.5L following an instrun	May 25	0.6%	-			1.3%	0.3%	2.3%

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
PPH 1.5L or greater, vaginal births (unassisted)	May 25	8	-			12	0	24
PPH 1.5L or greater, vaginal (unassisted) births as a %	May 25	1.3%	2.4%			2.0%	0.2%	3.8%
PPH 1.5L or greater, caesarean births	May 25	7	-			7	-1	15
PPH 1.5L or greater, caesarean births as a % of mother	May 25	1.1%	4.3%			1.2%	-0.6%	3.0%
ICU/CCU Admissions	May 25	0	-			1	-1	2
% completed VTE admission	May 25	91.3%	95.0%			94.7%	90.2%	99.1%
Maternal Deaths: All	May 25	0	-			0	0	1
Early Maternal Deaths: Direct	May 25	0	-			0	0	0
Early Maternal Deaths: Indirect	May 25	0	-			0	0	0
Late Maternal Deaths: Direct	May 25	0	-			0	0	0
Late Maternal Deaths: Indirect	May 25	0	-			0	0	0

Indicator overview summary (SPC dashboard), *continued*

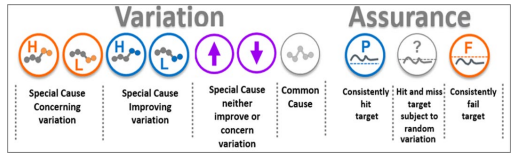
ER Exception report

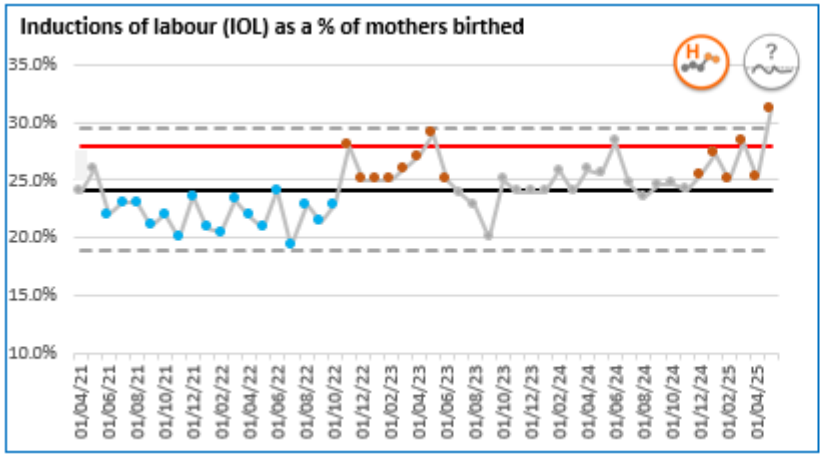
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Puerperal Sepsis	Apr 25	2	-			5	-2	13
Puerperal Sepsis as a % of mothers birthed	Apr 25	0.3%	1.5%			0.8%	-0.3%	2.0%
Stillbirths (24+0/40 onwards; excludes TOPs)	May 25	3	-			2	-2	6
Stillbirths (24+0/40 onwards; excludes TOPs): as rate	Mar 25	5	0			3	#N/A	#N/A
Late fetal losses (delivered 22+0 to 23+6/40; excludes	May 25	1	1			0	-1	2
Neonatal Deaths (born in OUH, up to 28 days) All	May 25	1	-			2	-2	6
Neonatal Deaths (born in OUH, up to 28 days): Early (	May 25	0	-			2	-2	5
Neonatal Deaths (born in OUH, up to 28 days): Late de	May 25	1	-			1	-2	3
Neonatal Deaths (born in OUH, up to 28 days): as rate	Mar 25	2	3			1	-2	5
HIE	May 25	3	0			0	0	1

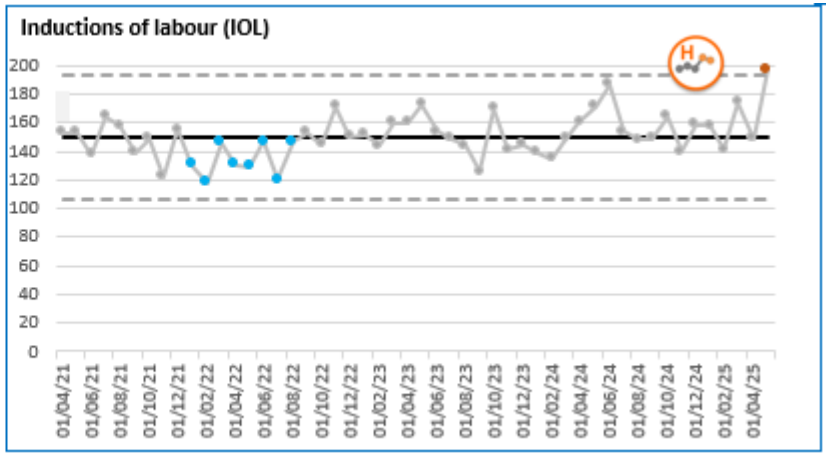
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Shoulder Dystocia	May 25	9	-			8	0	17
Shoulder Dystocia as a % of babies born	May 25	1.4%	1.5%			1.4%	0.1%	2.6%
Unexpected NNU admissions	May 25	20	-			25	7	43
Unexpected NNU admissions as a % of babies born	May 25	3.1%	4.0%			3.9%	1.1%	6.7%
Hospital Associated Thromboses	May 25	1	0			0	-1	1
Returns to Theatre	May 25	3	0			1	-2	4
Returns to Theatre as a % of caesarean section delive	May 25	1.2%	0.0%			0.7%	-0.8%	2.1%
Number of PSII	May 25	0	0			1	-2	4
Number of Complaints	May 25	10	-			8	-3	20
Born before arrival of midwife (BBA)	May 25	4	-			6	-2	14

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Test Result Endorsement	Apr 25	86.3%	85.0%			76.6%	65.3%	87.9%
Number Of Women Booked This Month Who Current	May 25	28	-			43	21	65
Percentage Of Women Booked This Month Who Curre	May 25	4.2%	-			6.2%	3.0%	9.4%
Number of Women Smoking at Delivery	May 25	32	-			32	15	49
Percentage of Women Smoking at Delivery	May 25	5.1%	8.0%			5.1%	2.3%	7.9%
Number of women with a live birth	May 25	624	-			607	502	712
Number of Woman with a live birth Initianing Breastf	May 25	565	-			520	359	680
Percentage of Women Initiating Breastfeeding	May 25	91%	80%			82%	73%	91%
Number of women booked by 10+0/40	May 25	420	-			421	216	626
Percentage of women booked by 10+0/40	May 25	62%	-			67%	58%	76%

Maternity Exception Report (1)

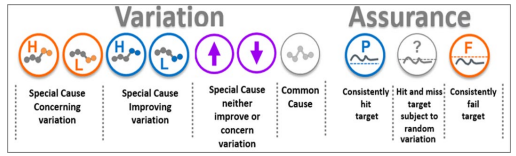


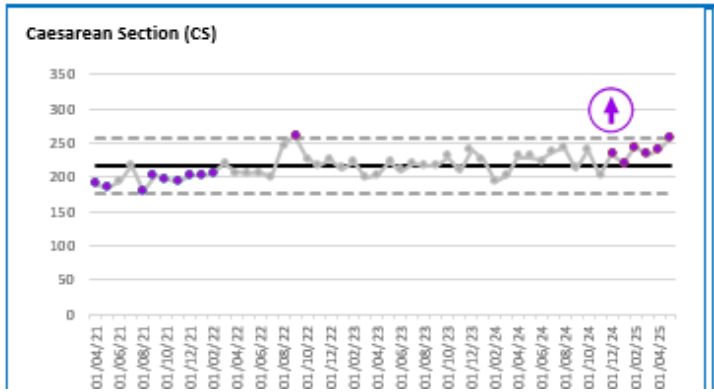


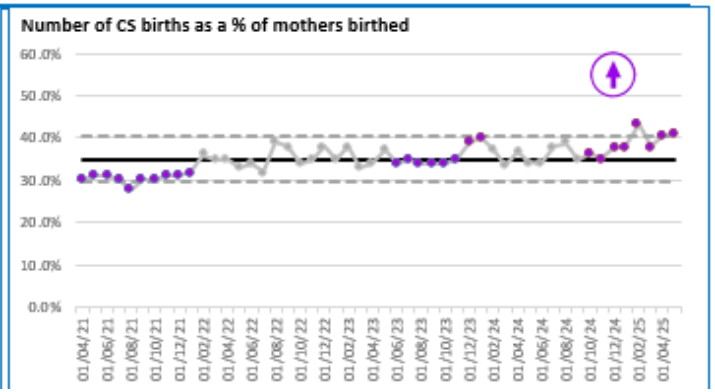


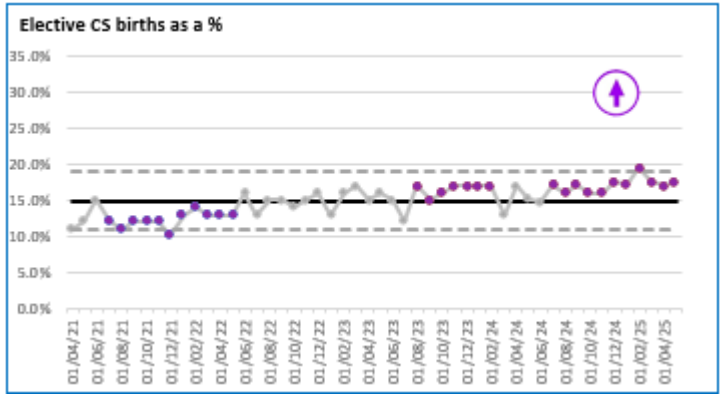
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Timescales to address performance issue(s) and identification of any gaps in assurance	Risk Register score	Data quality rating
Induction of labour (IOL) and induction of labour as a % of mothers birthed shows a special cause concerning variation	As in previous months the % of IOL has flagged as an exception. The 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. 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 with a focus on the following areas: • Optimisation of midwifery staffing through improved escalation pathways • Adjusting the target on the performance dashboard. • A standardised approach to Induction of Labour (IOL) Shared Principles Framework has been introduced • Recognising and recording delays from 6 hours • Review of induction methods to include outpatient option	Progress and monitoring of any action plans will be reported monthly at Maternity Clinical Governance Committee. Updates anticipated at June MCGC: • Introduction of 'delay in IOL escalation pathway' for midwifery and medical staffing • Feedback from '6 hour delay' trigger		

Maternity Exception Report (2)



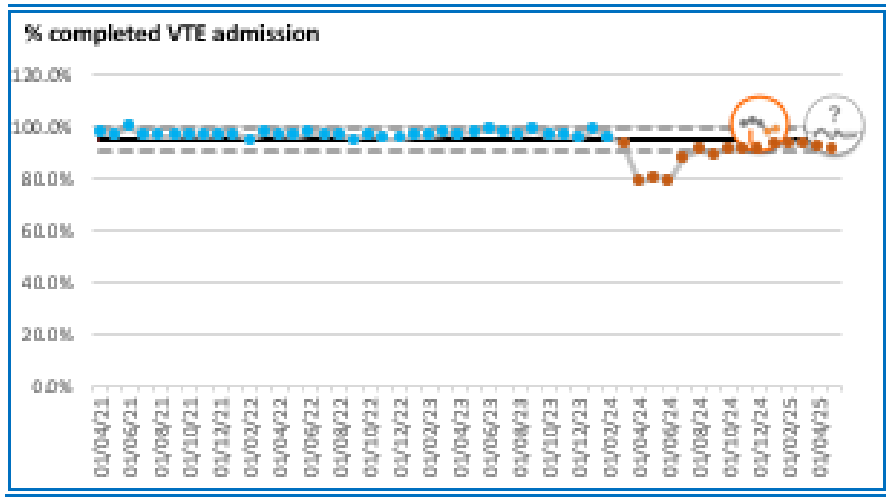


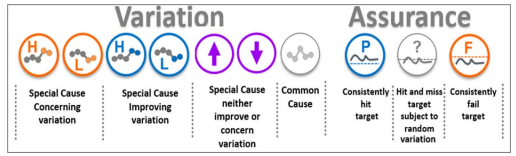




Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Timescales to address performance issue(s) and identification of any gaps in assurance	Risk Register score	Data quality rating
Caesarean section, Number of CS births as a % of mothers birthed and Elective CS births as a % shows a special cause, neither improves or concerns 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.	A business case proposing substantive solution to increased capacity was reviewed and agreed by Executive Board in April, substantive recruitment for weekend lists is now underway and updates will be reported monthly via Maternity Clinical Governance and Maternity Directorate Performance meetings		

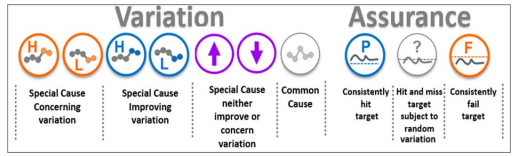
Maternity Exception Report (4)

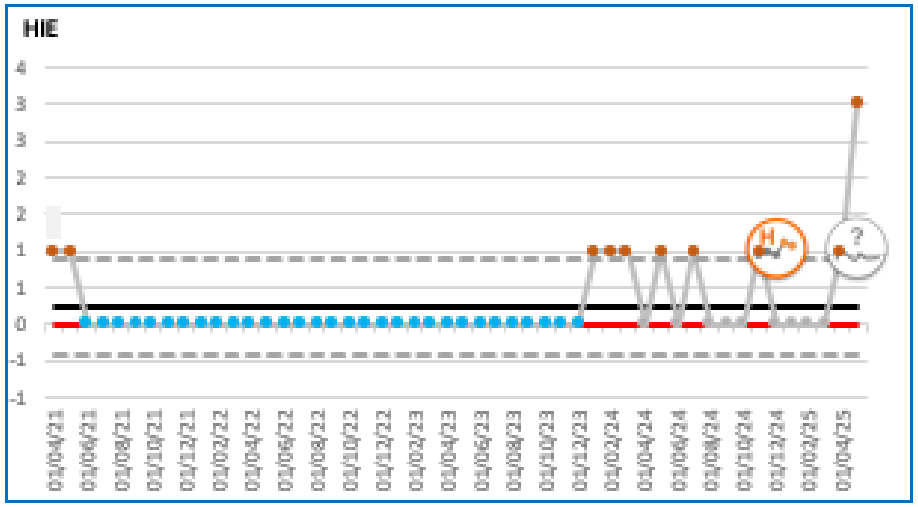




Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Timescales to address performance issue(s) and identification of any gaps in assurance	Risk Register score	Data quality rating
% completed VTE admission shows a special cause concerning variation	There has been a slight decrease in compliance by >1% on the previous month. A mulitdisciplinary VTE task and finish group has been established. This group will oversee improvement work with the objective of achieving 100% compliance of timely and accurate VTE assessment. Current focus is as follows: • Prompt review of existing VTE guideline – an MDT review is underway • Digital review of BadgerNet V's Cerner VTE assessment tool to ensure fit for purpose • Ongoing additional audit	Progress and monitoring of any action plans will be reported monthly at Maternity Clinical Governance Committee. Expected updates due at June MCGC: • Outcome of completed audits • Status of updated VTE guideline including digital version		N/A

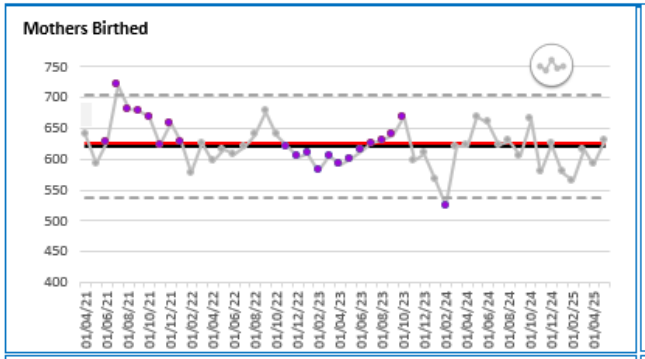
Maternity Exception Report (5)

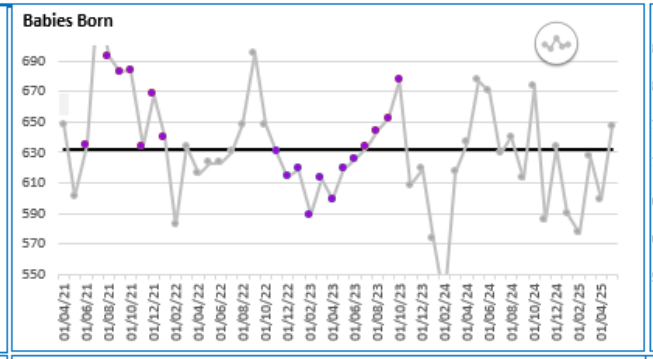


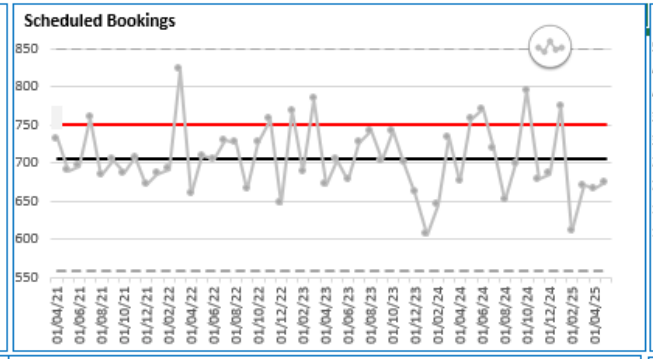


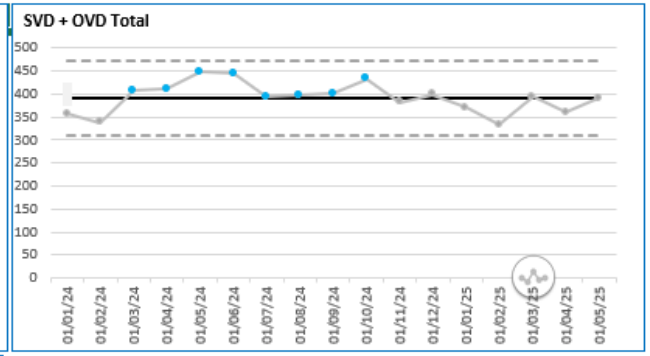
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Timescales to address performance issue(s) and identification of any gaps in assurance	Risk Register score	Data quality rating
HIE shows a special cause concerning variation	There were three cases of suspected HIE, all relating to term babies who were admitted to the neonatal unit for therapeutic cooling. Two cases occurred in early May within 24 hours of each other. Both cases had an MRI with no evidence of HIE. The third case occurred in late May, fortunately this MRI has also come back with no evidence of HIE. Immediate learnings from rapid review are around maintaining continuous fetal monitoring contact, avoiding a task focused approach and prompt escalation with timely review.	A thematic review is underway of the three incidents – due for completion 11th June 2025. All cases have been referred to MNSI, both verbal and written duty of candour have been undertaken and all families have been offered support from the midwifery and neonatal teams. 1 case has been accepted for investigation with the further 2 awaiting MNSI assessment and/or parental consent. Decisions anticiapted by mid-June 2025.		

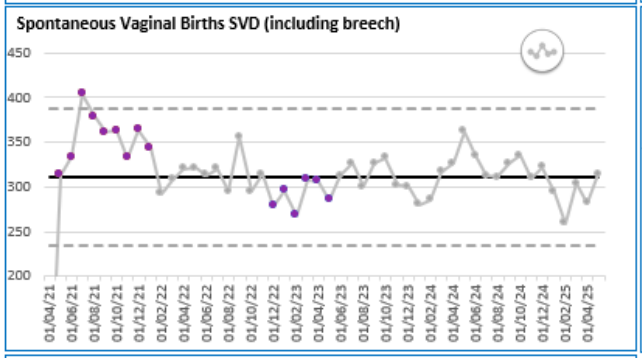
Appendix 1. SPC charts (1)

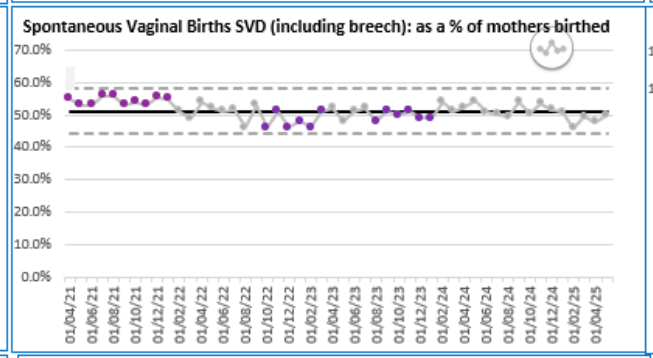


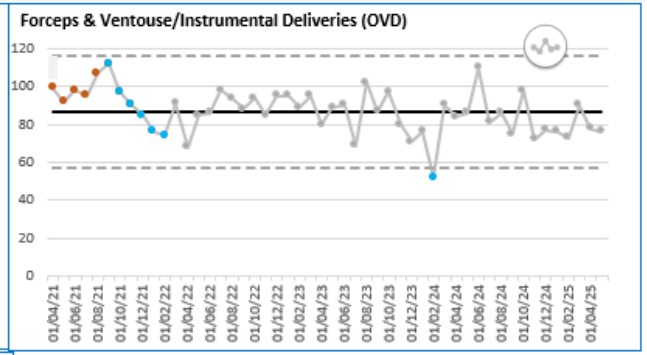


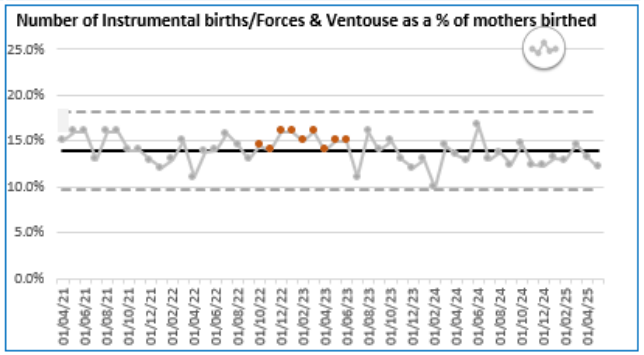


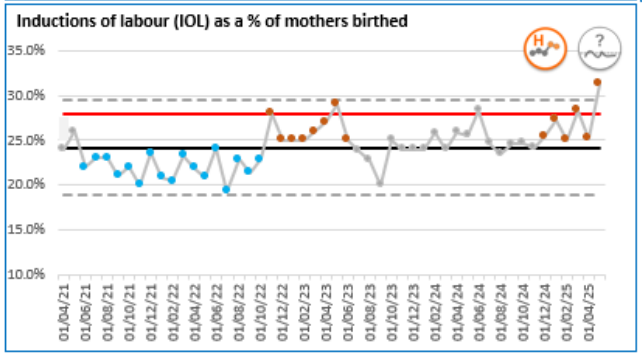


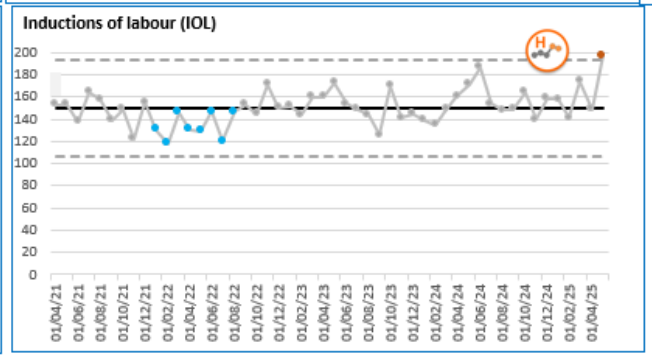




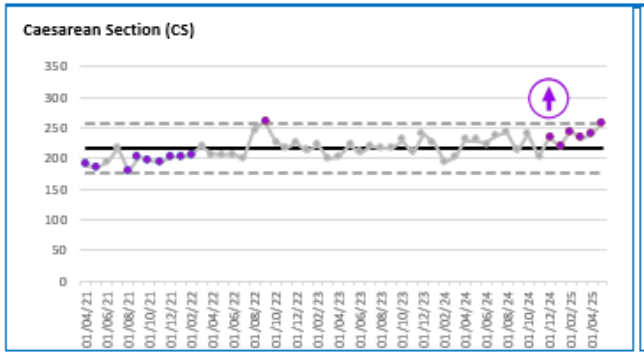


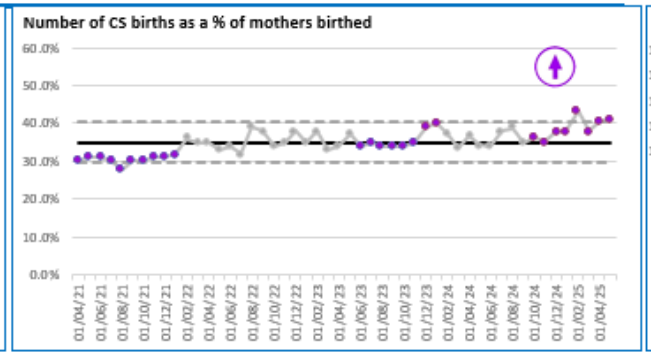


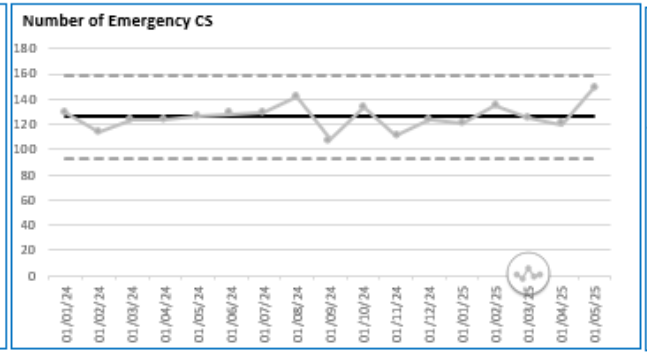


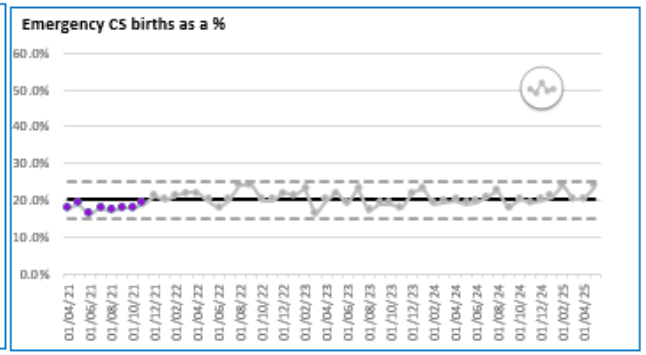


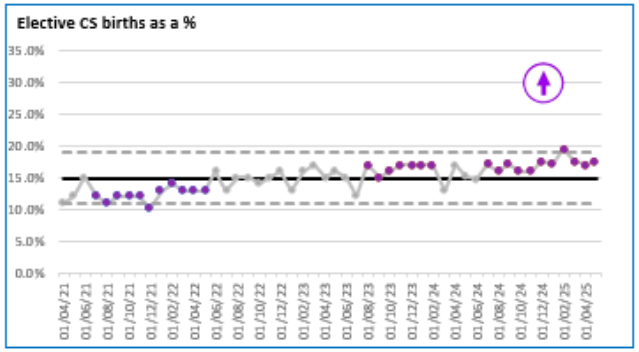
Appendix 2. SPC charts (2)

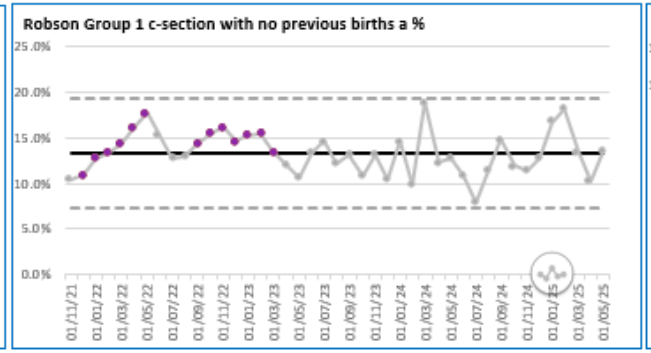


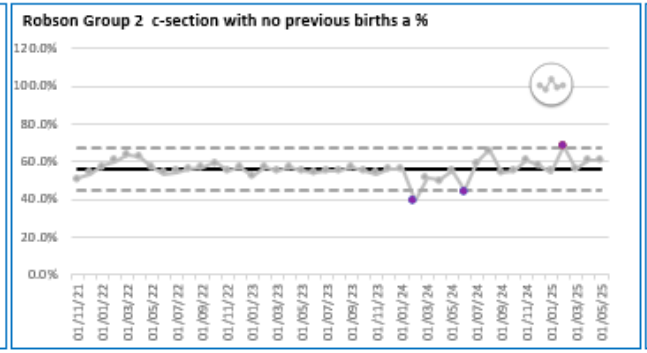


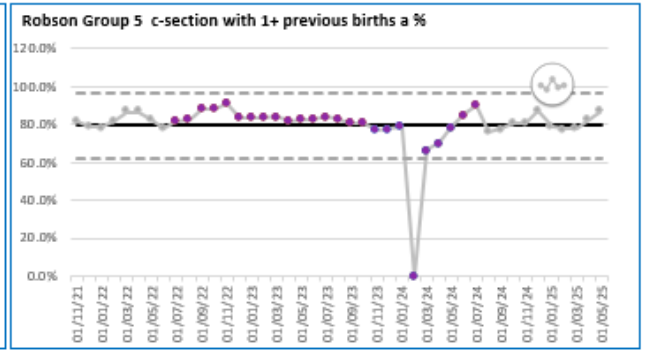


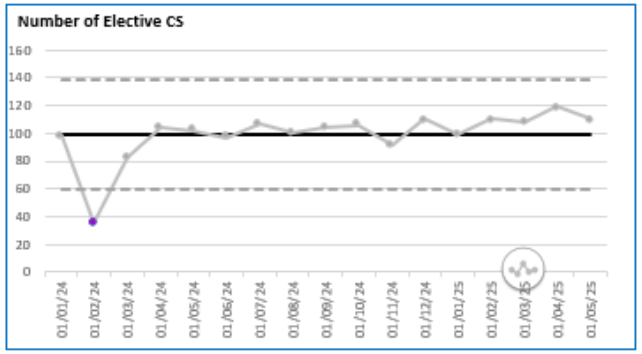


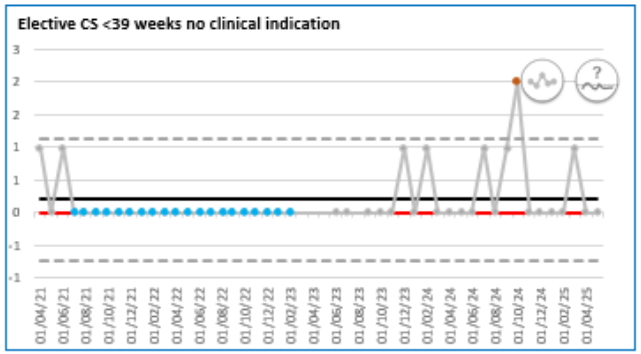




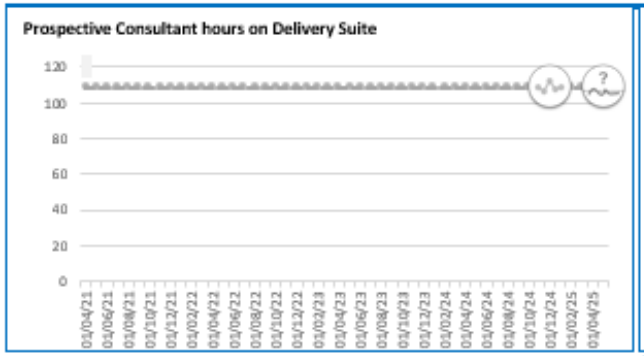


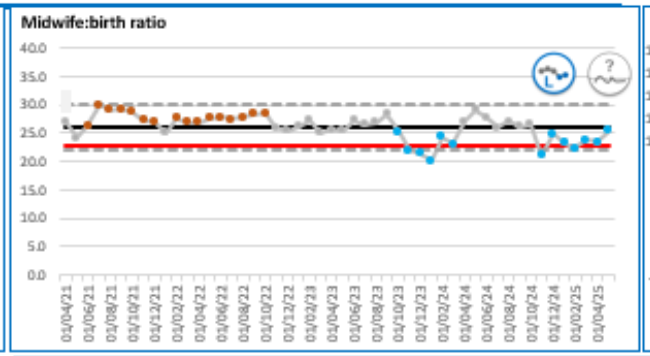


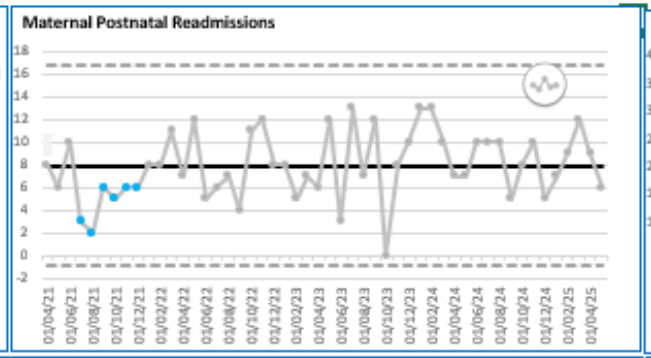


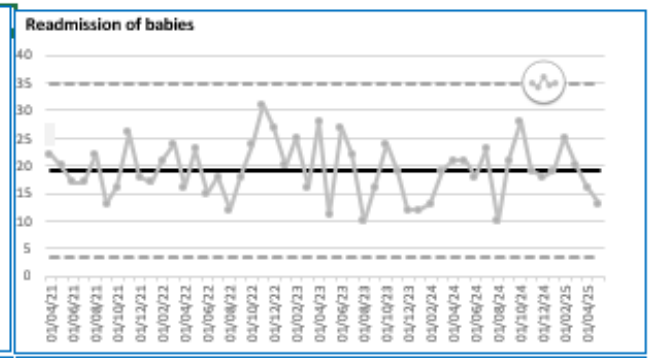


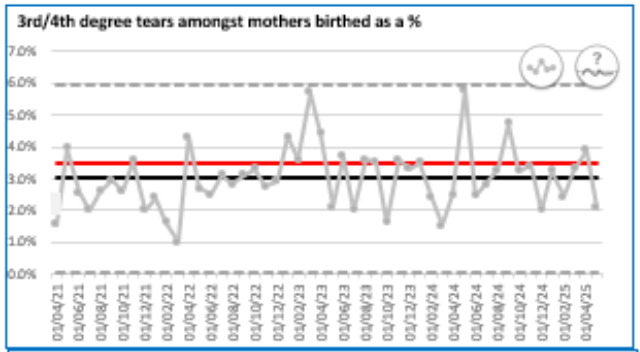
Appendix 3. SPC charts (3)

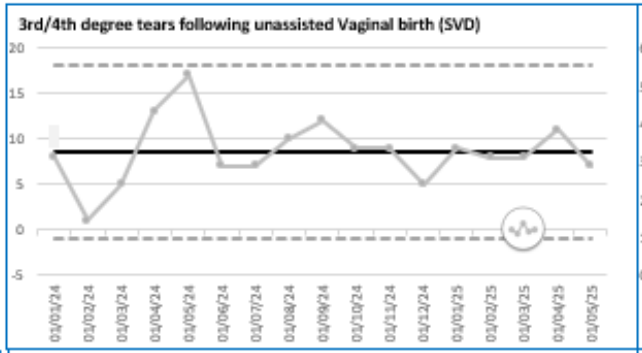


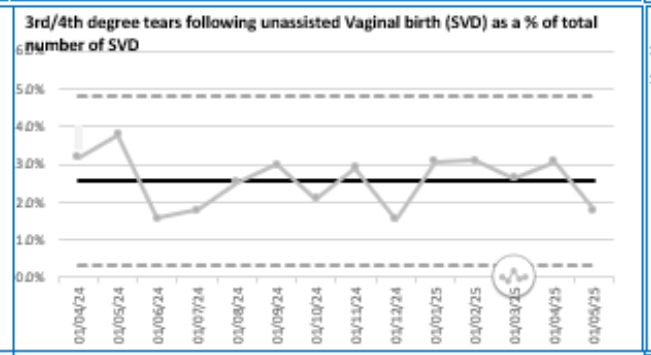


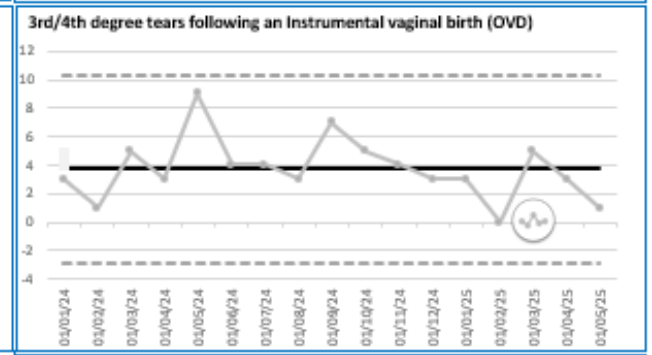


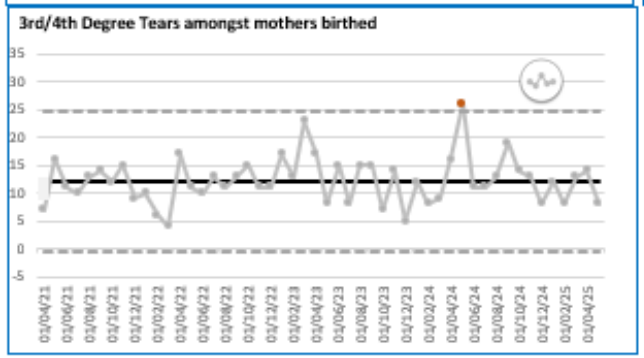


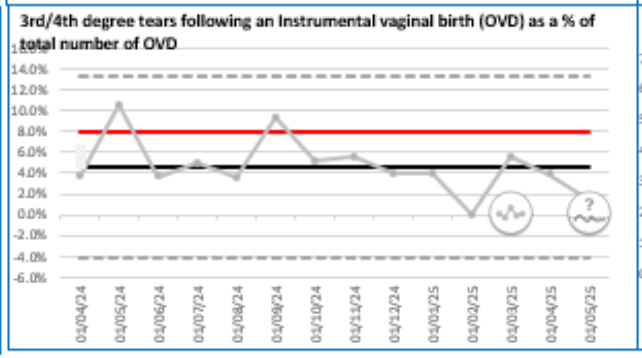


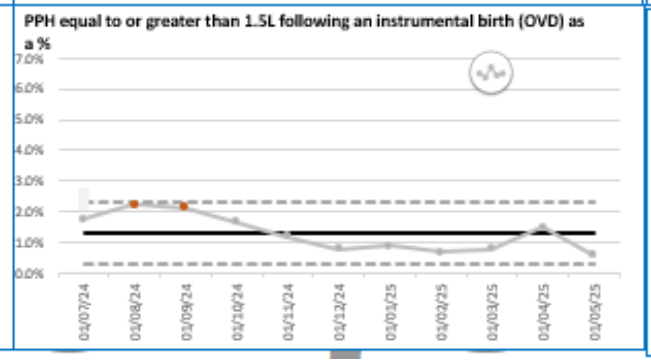


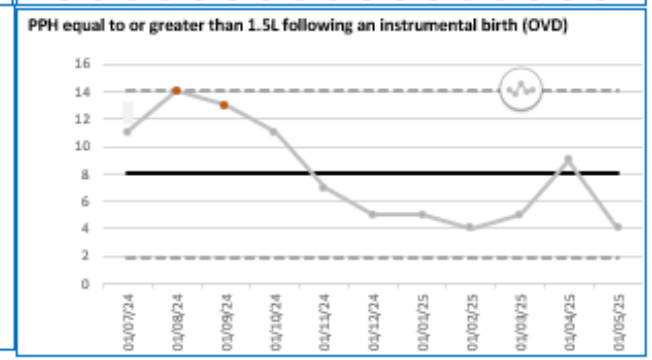




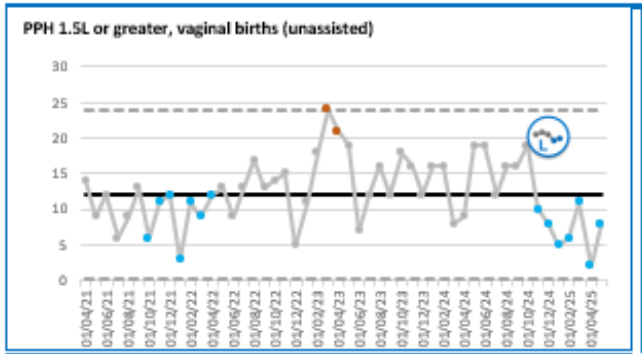


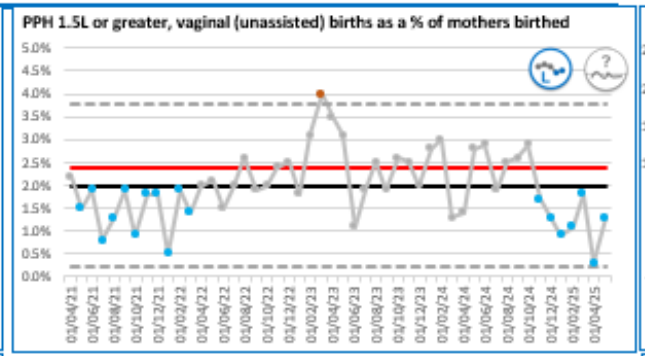


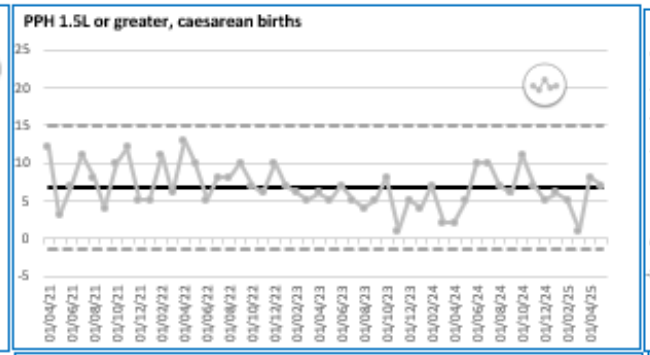


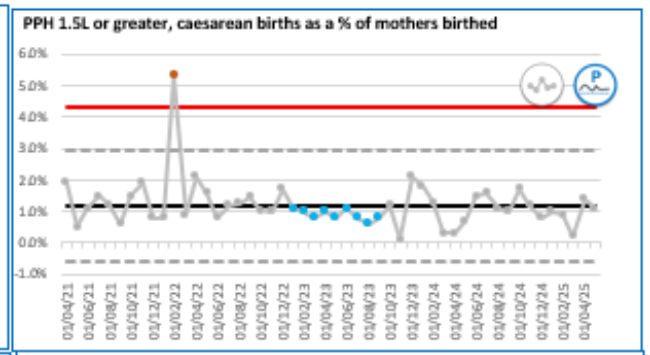


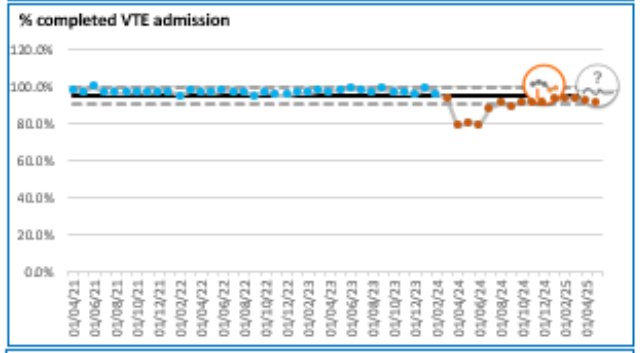
Appendix 4. SPC charts (4)

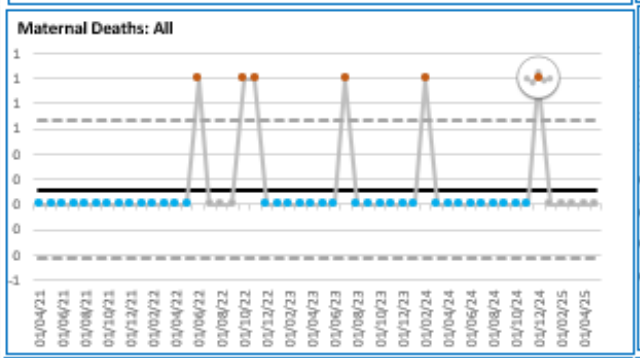


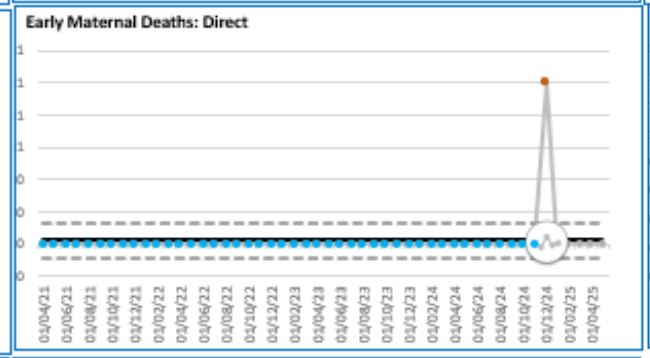


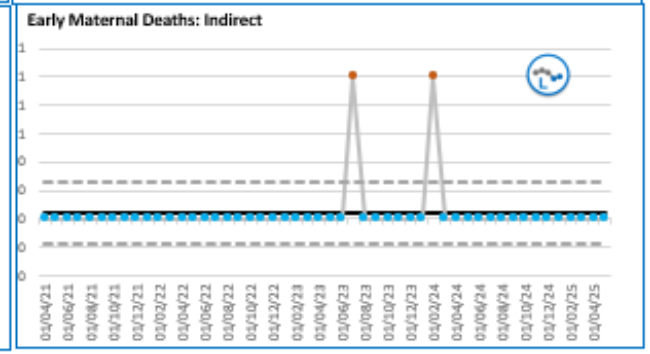


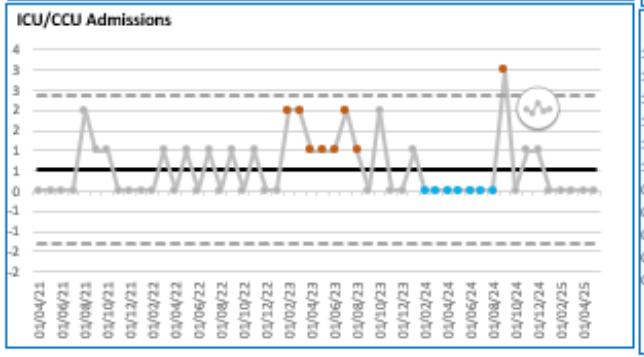


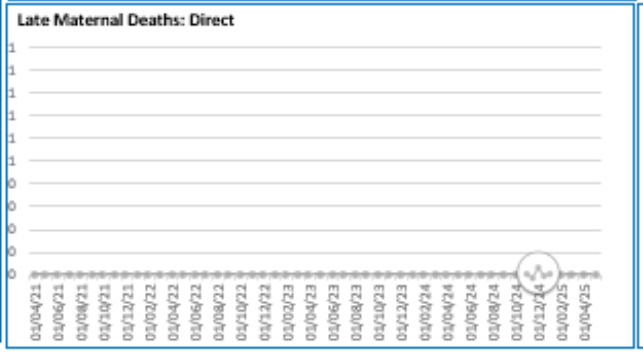


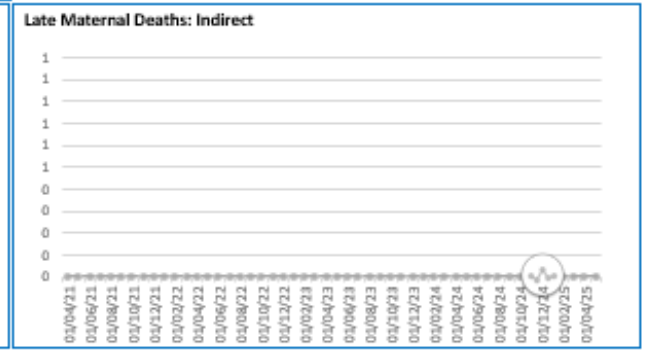




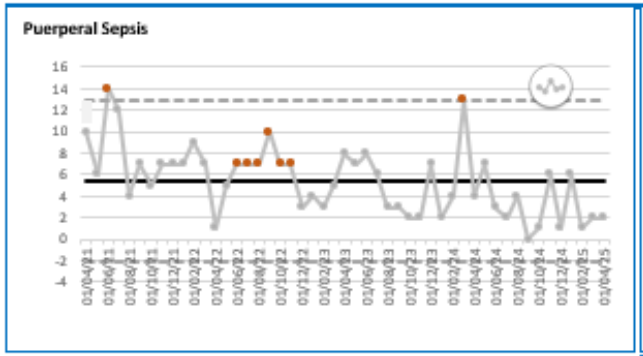


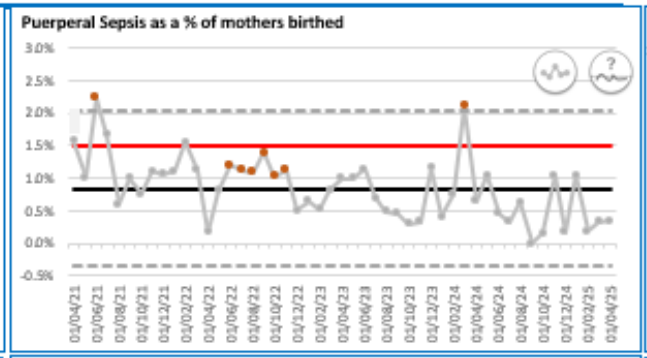


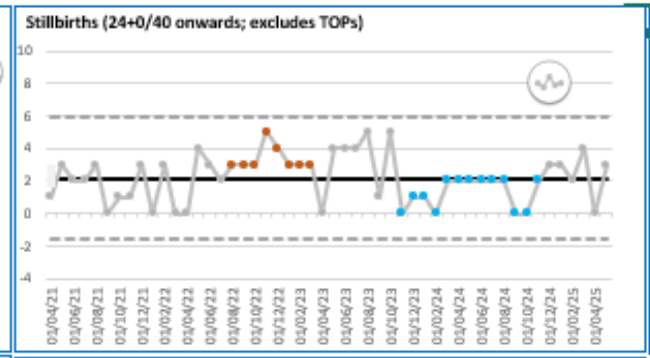


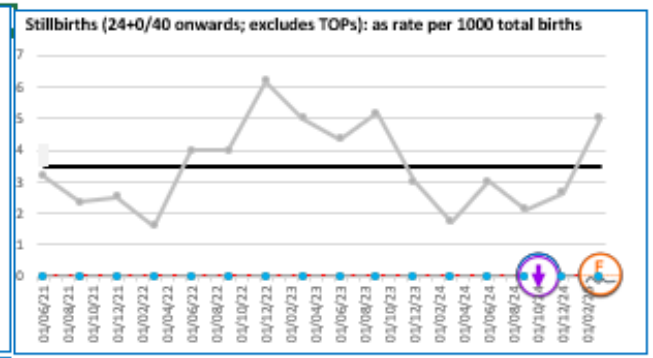


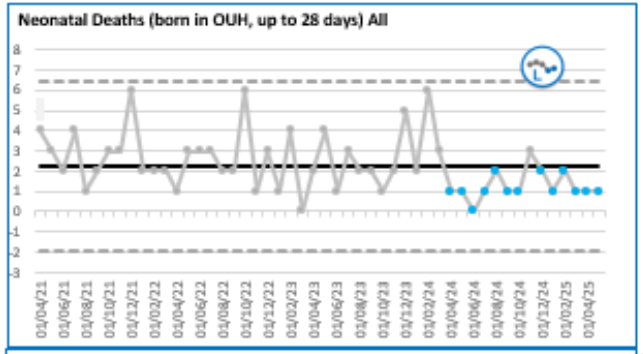
Appendix 5. SPC charts (5)

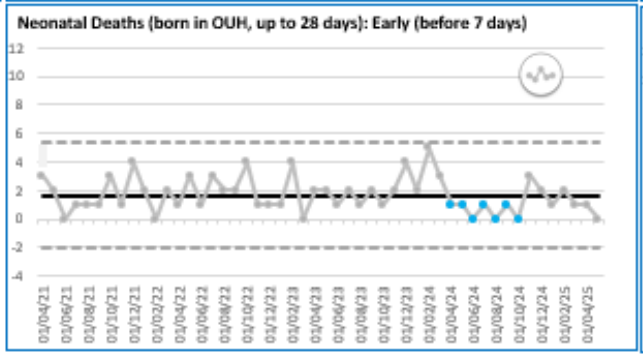


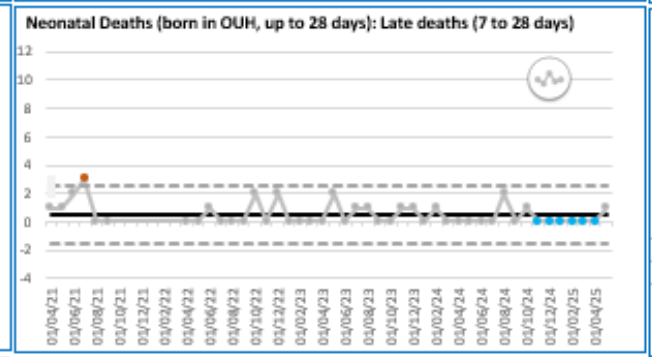


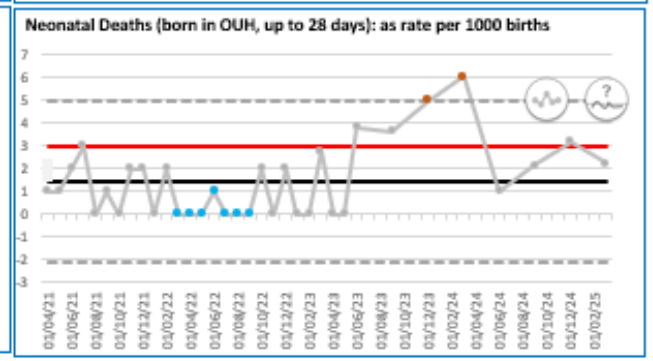


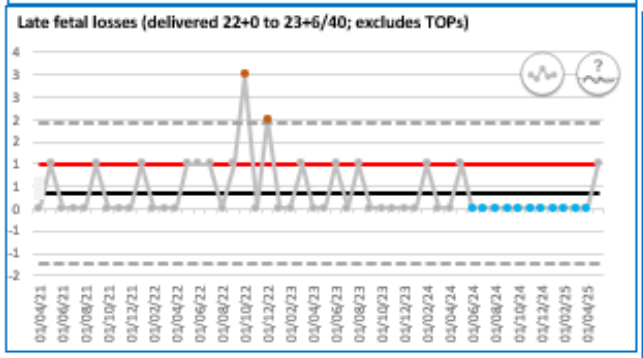


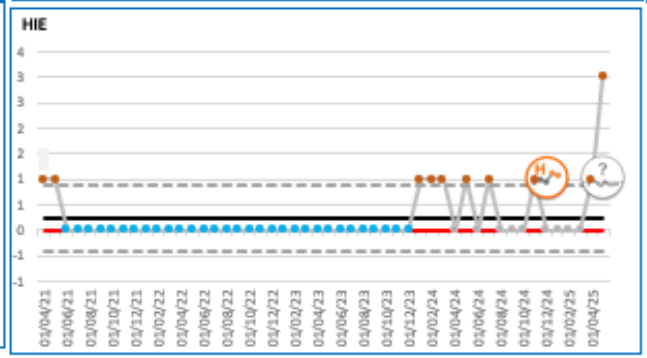




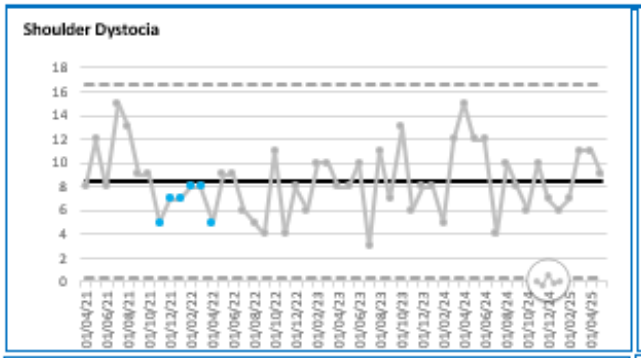


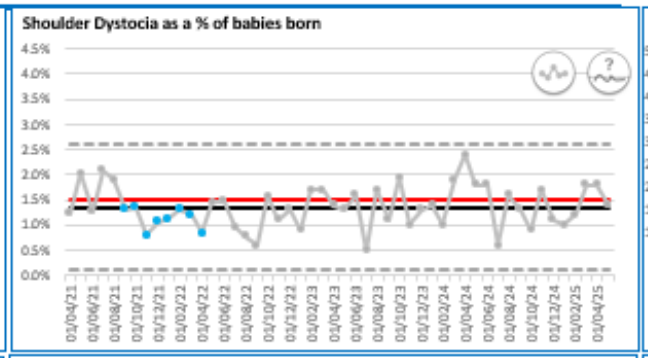


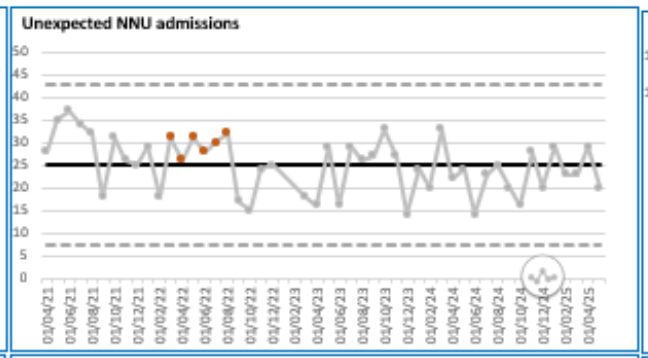


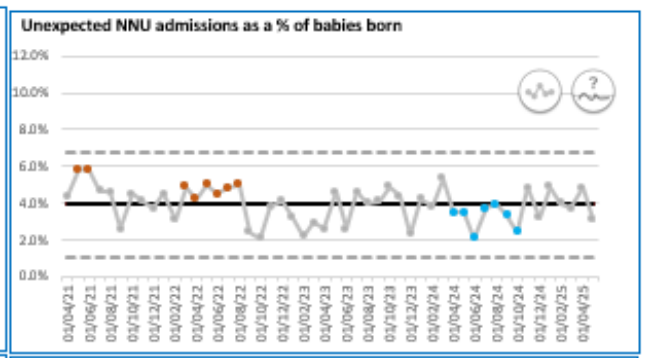


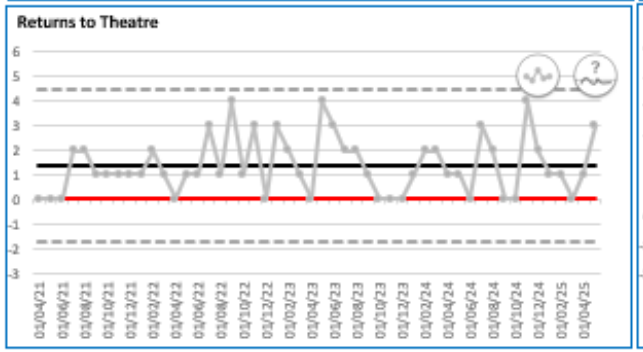
Appendix 6. SPC charts (6)

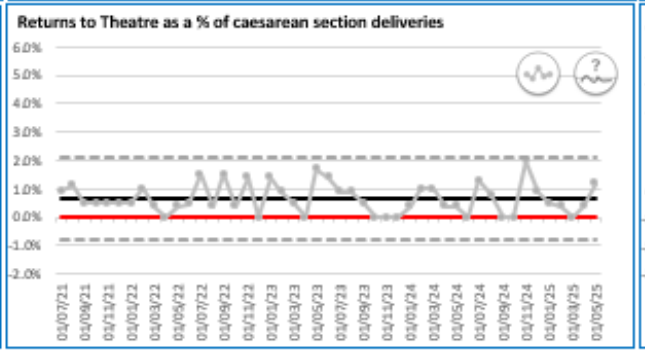


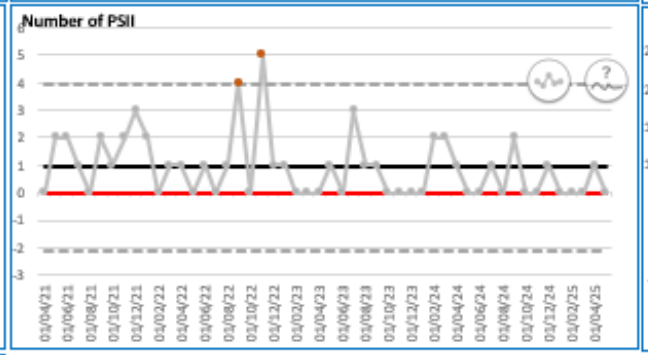


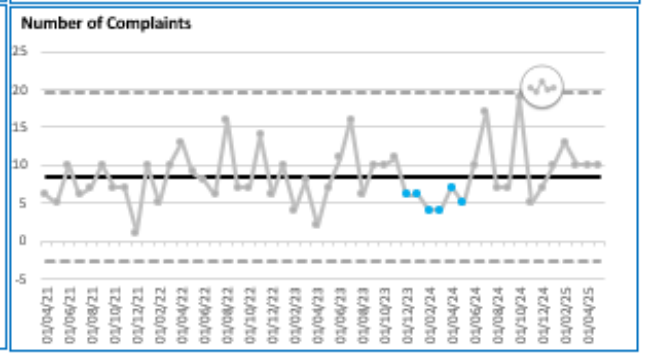


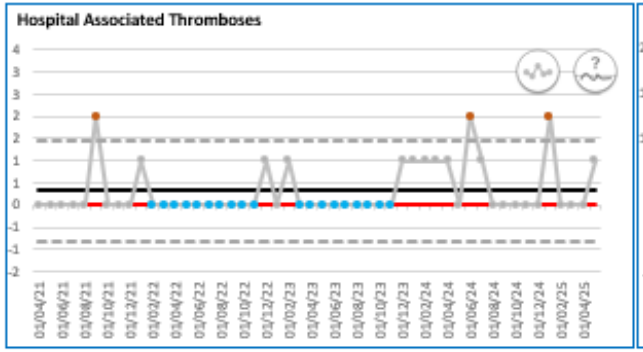


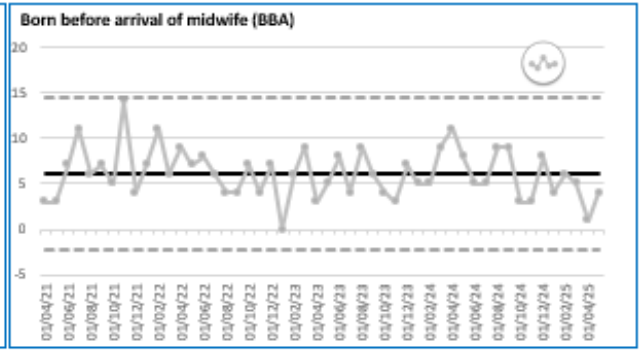




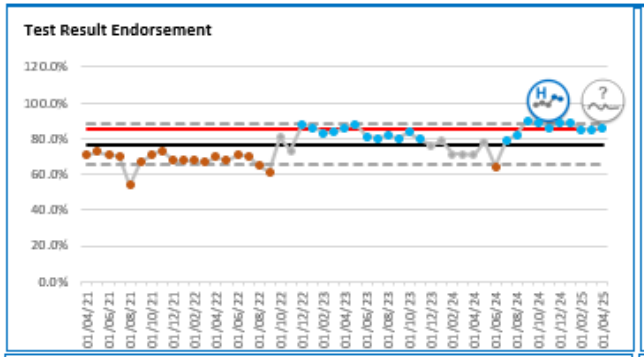


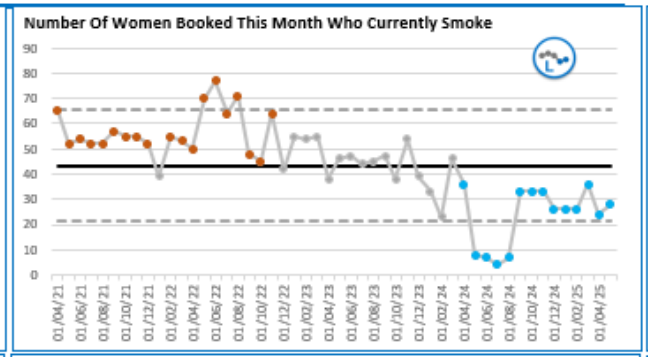


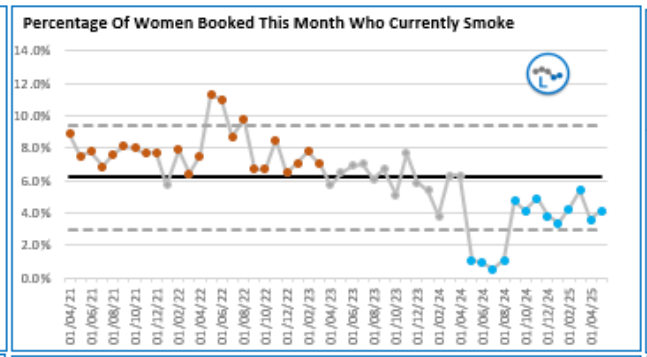


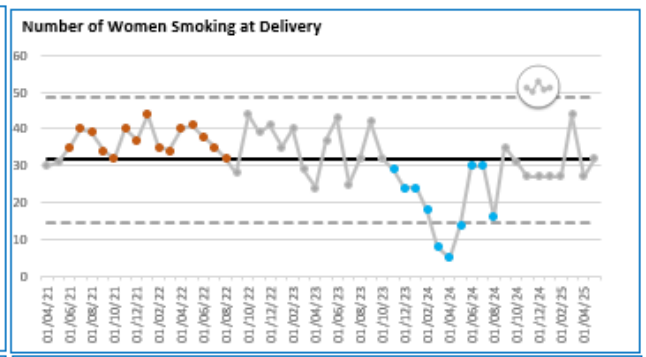


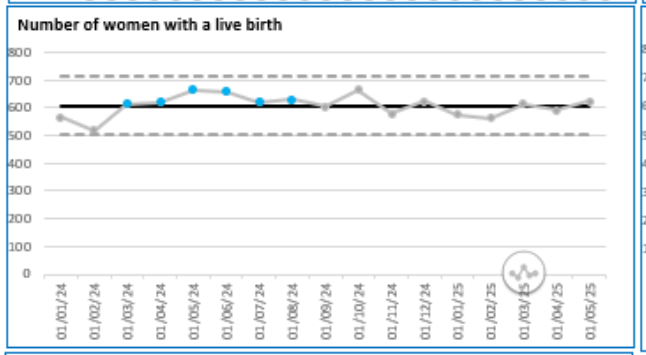
Appendix 7. SPC charts (7)

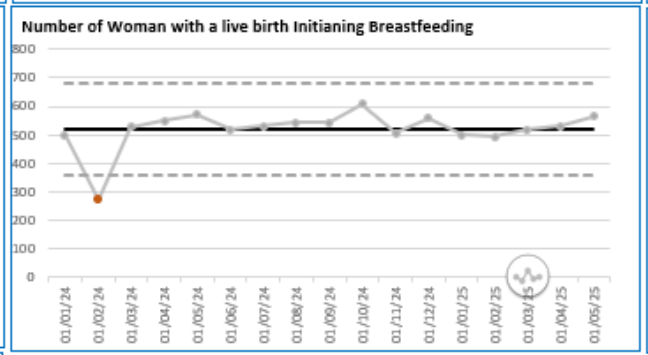


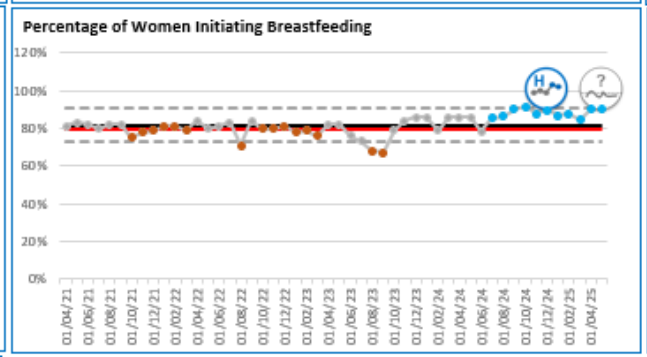


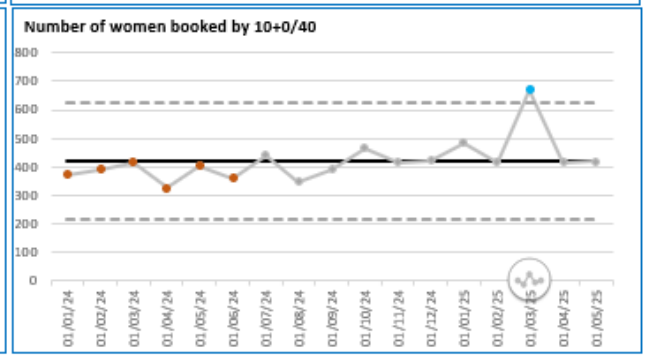


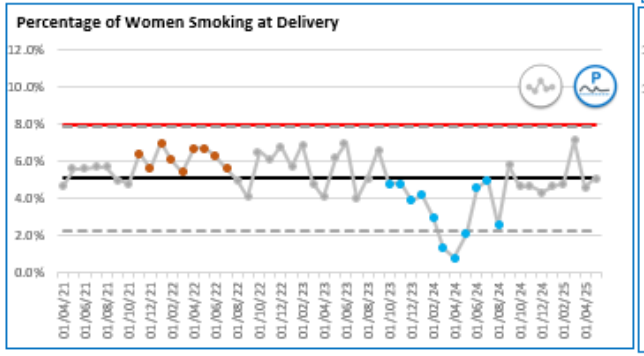


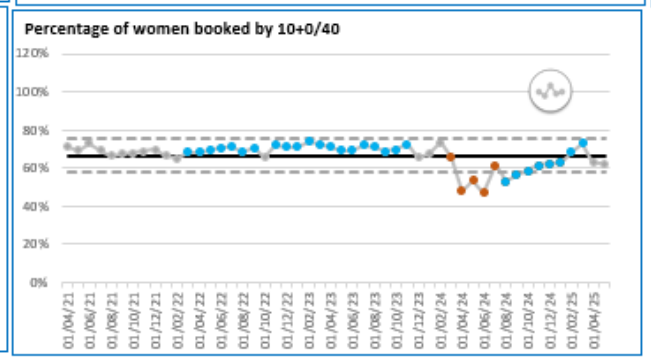












Appendix 1: Categories used for grading of care for perinatal mortality reviews (PMR)

- 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.