Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Public Trust Board Meeting: Wednesday 10 July 2024

TB2024.65

Title:	**Maternity Services Update Report**

Status:	**For Discussion**
History:	**Regular Reporting**
	Maternity Clinical Governance Committee (MCGC) 24/06/24
	Previous paper presented to Trust Board May 08/05/2024

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Confidential:	**No**
Key Purpose:	Assurance

Executive Summary

This paper provides an update to the Trust Board on maternity related activities. They key points are summarised below:

1. Ockenden Assurance Visit: The report provides an update on the progress on immediate and essential actions (IEAs) for improving risk assessment at every antenatal contact. The compliance rate for this requirement is 93% and strengthened midwifery leadership by filling all positions.
2. Midwifery Led Unit (MLU) status: Community services were suspended four times in April and May 2024, affecting one woman who delivered on the Delivery Suite.
3. Maternity Performance Dashboard: The report presents the Maternity Performance Dashboard for May 2024, which shows five exceptions dashboard provides details on the exceptions, the mitigations, and the improvement actions taken by the service.
4. CQC inspection action plan update: Progress on the CQC action plan, which was developed following the CQC inspection in May 2021. The two actions remaining should do actions that are overdue relate estates. The service is working with the Trust Assurance Team and Corporate Nursing to monitor and evaluate the effectiveness of the CQC action plan. The report highlights the Evidence Group that has been established to ensure a clear framework for monitoring progress.
5. Maternity (and Perinatal) Incentive Scheme (MPIS): The report outlines the status of the Maternity Incentive Scheme for Year 6, which consists of 10 safety actions. The report states that the service is compliant with most of the safety actions, except for Safety Action 4, which requires a business case for the neonatal medical workforce.
6. Antenatal and Newborn Screening Assurance Visit. The service has received five urgent recommendations from the Antenatal and Newborn Screening Assurance Visit screening visit. An action plan is in place to address the recommendations.

Recommendations

7. The Trust Board is asked to:

    - Receive and note the contents of the update report.

Contents

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:

- Ockenden Assurance Visit
- Midwifery Led Unit (MLU) status
- Maternity performance dashboard
- Perinatal Quality Surveillance Model Report
- CQC inspection action plan update
- Maternity Incentive Scheme (MIS) Year 5
- Maternity Safety Support Programme (MSSP)
- Three-year Single Delivery Plan for Maternity and Neonatal Services
- Safeguarding
- Antenatal and Newborn Screening

2. Ockenden Assurance visit

2.1. The Trust received the final report and recommendations from the Ockenden Assurance insight visit on 10 June 2022. The Maternity Clinical Governance Committee (MCGC) monitors the progress of the action plan and reports it through the established governance channels. The following are the outstanding immediate and essential actions (IEAs):

7.1.1 IEA 5: The service can now generate a report from the new digital system (BadgerNet) to ensure a risk assessment is conducted at every antenatal contact. The compliance rate for this requirement is 93% and was reported to the Maternity Clinical Governance Committee (MCGC) in May 2024 as part of the regular reporting process.

7.1.2 Strengthening Midwifery Leadership: All positions have been successfully filled, and the new Head of Midwifery and Deputy Head of Midwifery commenced in post in May 2024.

3. Midwifery Led Unit (MLU) Status

3.1 Community services were suspended three times in April. This affected the birth experience of one woman who delivered on the Delivery Suite.

3.2 Community services were suspended once in May and no women were impacted.

4. Maternity Performance Dashboard

4.1. There were five exceptions reported for the May data, see appendix 1 for further detail, mitigations, and improvement actions.

5. Perinatal Quality Surveillance Model Report

5.1. One of the requirements from Ockenden actions is that the Board is informed of the Perinatal Quality Surveillance Model (PQSM) report, which is delivered monthly to MCGC.

5.2. The Perinatal Quality Surveillance Model (PQSM) report for April and May data will be presented to the Private Trust Board meeting on 10 July 2024. Both months were reported through MCGC in May and June and are a regular agenda item at the monthly Maternity and Neonatal Safety Champions meetings.

6. CQC Inspection and Action Plan Update

6.1. Since the last report to the Trust Board, two actions remain overdue relating to Estates, the updates for which can be seen on the table below following the CQC inspection in May 2021.

Should Do	Actions	Update
11	11.1 Long term major capital Investment estates plan required to design and build a new Women's centre - the layout of which would enable further prioritisation of the privacy and dignity of service users (all known risks to be reflected in the relevant risk registers)	**Overdue:** Estates plan is part of maternity development programme. However, there is no substantial capital investment to advance this in the near future.
12	12.4 Business plan to be developed and approved to enable two existing birthing rooms on the periphery of the delivery suite footprint to be converted into a bespoke bereavement suite, optimising the birth environment for women and their families.	**Overdue:** Asbestos removal on Delivery Suite happened in May for the bereavement suite project.

6.2. Progress against the CQC action plan is reported through existing governance processes, which include Maternity Clinical Governance Committee (MCGC), SuWOn Divisional Clinical Governance Committee and the Trust Clinical Governance Committee (CGC) as part of the quality reports and includes the recent Horton CQC action plan (see appendix 2).

6.3. Updated progress on the CQC Action plan was provide to the Integrated Assurance Committee in June 2014.

6.4. Maternity Services, the Trust Assurance Team and Corporate Nursing have established an Evidence Group to continuously monitor and evaluate the progress and effectiveness of the CQC action plan.

6.5. The Evidence Group will work with the Maternity Service to ensure a clear framework for monitoring progress against action plans and ensure that prompt action is taken if progress is not achieved as expected.

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

7.1. The Maternity Incentive Scheme for Year 6 was released on the 02 April 2024.

7.2. Safety Action 1: The quarter 4 Perinatal Mortality Report will be presented to the confidential Trust Board on the 10 July 2024.

7.3. Safety Action 2: Since the move of the electronic patient records to BadgerNet, some data has been added retrospectively.

7.4. Safety Action 3: The Quarter 4 ATAIN meeting was held on the 17 June 2024 and the updated action plan will be noted at MCGC on the 22 July 2024.

7.5. Safety Action 4: The business case related to the neonatal medical workforce is being presented at the Business Planning Group. This is a risk on the neonatal risk register (risk ID 2241).

7.6. Safety Action 5: The Midwifery Staffing paper for quarter 3 and quarter 4 will be presented to the Trust Board on the 10 July 2024.

7.7. Safety Action 6: The BOB LMNS have reviewed the quarter 4 data for the Saving Babies Lives Care Bundle Version 3. This was received by the Maternity Clinical Governance Committee (MCGC) on the 24 June 2024. The quarter 4 review is compliant with the BOB LMNS standards and is included as an appendix in the Perinatal Quality Surveillance Model (PQSM) report that is being received by the Confidential Trust Board on the 10 July. Some of OUH compliance percentages have been increased in line with the improvement trajectory for MPIS year 6.

- The Fetal Medicine team are in the process of requesting an exemption against SBLCBv3 2.1 with regards to women having a risk assessment for aspirin at booking.

7.8. Safety Action 7: The BOB LMNS have agreed funding for the Maternity and Neonatal Voices Partnership (MNVP). The service continues to work closely with the MNVP.

7.9. Safety Action 8: The training programme runs from September to July each year. The training figures are provided as part of the Perinatal Quality Surveillance Model (PQSM) Report, which is being received by the confidential Trust Board on the 10 July.

7.10. Safety Action 9: The confidential Trust Board receives the PQSM as part of this safety action. Actions from the safety champions walk rounds are shared as part of this report. They are shared with staff via the staff magazine.

7.11. Safety Action 10: There are no anticipated concerns.

8. Maternity Safety Support Programme (MSSP)

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

8.2. The MIA visited the unit on the 21 June 2024 and met with the team to review the actions from the clinical governance deep dive that was undertaken last year.

8.3. The regional chief midwife Kaye Wilson visited the unit and met with staff on the 13 June 2024

9. Three Year delivery plan for Maternity and Neonatal Services

9.1. The Three-year delivery plan for maternity and neonatal services was published on the 30 March 2023 called the Single Delivery Plan. Work streams have commenced and are ongoing.

9.2. Progress against the CQC action plan is reported through existing governance processes, which include Maternity Clinical Governance Committee (MCGC), SuWOn Divisional Clinical Governance Committee and the Trust Clinical Governance Committee (CGC) as part of the quality reports.

10. Safeguarding

10.1 The HOPE box project is an intervention to help support women who are separated from their baby close to birth due to safeguarding concerns. The service has bene successful in completing the site readiness paperwork and in conjunction with Lancaster University and NHSE will be implementing these into practice following funding allocation and training.

11. Antenatal and Newborn Screening

11.1 The Antenatal and Newborn Screening (AANB) Assurance Visit to maternity services took place on 23 April 2024. No immediate safety concerns were identified, and no recommendations were made for the newborn and infant physical examination (NIPE).

11.2 However, five urgent recommendations were identified. These recommendations include implementing a process to identify and manage screening safety incidents, clarifying the process for identification and escalation of risks in antenatal and newborn screening, reviewing the mandatory screening training, and ensuring that community midwives have training for the delivery of the screen positive pathway for sickle cell and thalassaemia.

11.3 Following consultation on factual accuracy the Trust received the final report on the 01 July 2024.

11.4 An action plan is in place to address the five urgent recommendations and progress monitored through existing governance processes, MCGC and Trust Management Executive (TME).

11.5 A paper is being prepared for the Trust Management Executive (TME) at the end of July to update on the completion of the action plan.

12. Conclusion

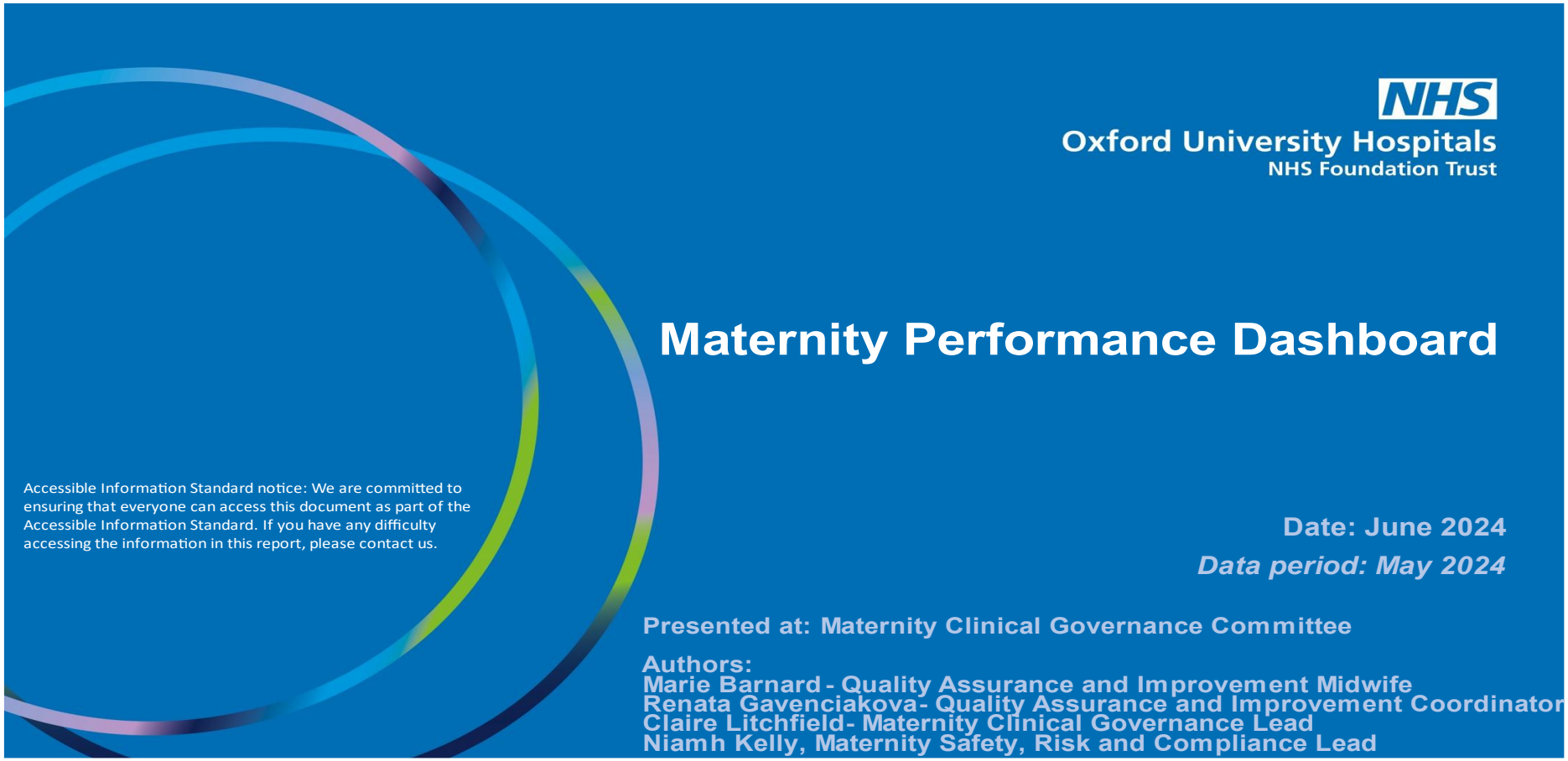
This report provides an on essential maternity activity which includes the CQC action plan update, Maternity Perinatal Incentive Scheme (MPIS), Antenatal and Newborn Screening Services, summarises the findings and recommendations as well as the actions taken by the service to address them. The report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

13. Recommendations

13.1. The Trust Board is asked to:

- Receive and note the contents of the update report.

14. Appendix 1: Maternity Performance Dashboard June 2024 (May data)



Executive Summary

Notable Successes

- Community midwives Valarie Whitlow and Louise Grenstead have been nominated for the Staff Recognition Awards – many congratulations!
- Congratulations to midwives Rachel Pitson, Katy Hoare, Mel Cox and Carina Okiki for their presentations at the NMAHPPS Showcasin g event. Rachel won best oral presentation on the day.
- Consultant Midwives Sophie McAllister and Claire Litchfield have published a paper in the international journal “Birth” about their work in the Birth Choices Clinic.

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Executive summary part 1

Oxford University Hospitals NHS Foundation Trust

Domain	Performance challenges, risks and interventions
Activity	In May there were 669 mothers birthed which is an increase from 622 in April. There were 757 scheduled bookings undertaken which is an increase of 82 from the previous month . 229 caesarean sections were performed in May which accounted for 34.2% of mothers birthed. There is a slight downward trend in women choosi ng to book an ELCS as an alternative to having an IOL - this trend is being monitored and reviewed. Extra clinics are being arranged, and further mitigation is being considered to minimise the impact on service delivery.
Workforce	Midwife: birth ratio is 1:29 which is consistent with the previous month. Consultant hours remain at 109. There was one occasion in May when the coordinator of the Delivery Suite had to assume clinical responsibilities, as she had to care for a postnatal (PN) woman until the community midwife on call arrived. The hou rs provided by on call staff increased from April. The number of staff who had to be relocated from offices or specialities, or who missed their breaks or finished late, decreased slightly. 7.5% of th e shifts for the in -patient areas had the sufficient number of staff for the shift.
Maternal Morbidity	There were twenty -six 3rd degree tears reported in May 2024. 5.8 % of these were sustained during spontaneous vaginal deliveries (SVD) and operative vaginal deliveries (OVD). This is an increase of 3.3 % from April 2024 and is 2.3% above the mean target. Of these 26 cases the ethnicities of the women were: 11 - White British, 2 - White – other background, 1 - Any other ethnic group, , 4 - Asian other, 1 – Chinese, 2 - Pakistani, 1 - White and black Caribbean, 4 - Not stated. The cases are currently be ing reviewed. The percentage of postpartum haemorrhages (PPH) equal to or greater than 1.5 litres for vaginal births was 2.8 % as a percentage of mothers birthed (19 women). This is a 1.4 % increase from April and is above the MBRRACE target of 2.4% and triggers as a red flag. The ethnicities of the women were: 6 - White British, 2 - white other, 2 - Asian other, 1 – Indian, 2 – Pakistani, and 6 were not stated. The percentage of PPH of >1.5 litres at caesarean section was 0.7% (5 women) of mothers birthed in May 2024 which is a 0.4% increase from April 2024. The ethnicities of the women were: 3 White British, 2 – Black African. The clinical leads reviewed these cases. Any themes identified were escalated an d actioned accordingly. There were no admissions to ICU in May 2024. There were 7 maternal postnatal readmissions in May 2024. There were no hospital associated thrombosis (HAT) reported in May 20 24.
Perinatal Morbidity and Mortality	There were four perinatal deaths in May 2024, including: Two stillbirths at 33+6 and 24+6 weeks of gestation, One late fetal loss at 23+1 weeks of gestation, One early neonatal death at 22+6 weeks of gestation. The Perinatal Mortality Review Panel will review these cases in the upcoming weeks. The panel reviewed two cases in May 2024, which occurred in April 2024. Both cases were stillbirths, at 33+4 and 36+5 weeks o f gestation. No care issues were identified that could have changed the outcomes. There were 24 term babies unexpectedly admitted to SCBU in May 2024, similar to April 2024. The main reason and diagnoses wer e: Respiratory distress and Suspected sepsis There were 21 babies re -admitted to hospital after discharge.
Maternity Safety	Two newborns with suspected hypoxic -ischemic encephalopathy (HIE) were referred to the Maternal and Neonatal Safety Improvement (MNSI) program after being admitted to the Special Care Baby Unit (SCBU). MNSI accepted one case for review, while the other case did not meet the eligibility criteria. A rapid revi ew of the fetal monitoring and clinical care was conducted for both cases. Five formal complaints were received in relation to perinatal care.

Executive summary part 2

Oxford University Hospitals NHS Foundation Trust

Domain	Performance challenges, risks and interventions
Test Endorsement	Test Result endorsement is at 78.2% and is showing as an exception for May 2024.
Robson 10 Criteria	There were no exceptions for Robson 10 criteria for May 2024.
Public Health	The percentage of women initiating breastfeeding in May 2024 was 85.9%, which is above the target of 80%. The infant feeding (BFI) Strategy working group which commenced in May 2023, and data validation continues to improve. team continue to monitor this through the Baby Friendly Initiative
Exception reports	There are 5 exceptions identified from the May 2024 data which are annotated below on Slides 8 to 12.

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 24	669	625			624	546	702
Babies Born	May 24	677	-			634	556	713
Scheduled Bookings	May 24	757	750			706	566	847
Inductions of labour (IOL)	May 24	171	-			147	107	187
Inductions of labour (IOL) as a % of mothers birthed	May 24	25.6%	28.0%	ER		23.6%	18.5%	28.8%
Spontaneous Vaginal Births SVD (including breech)	May 24	362	-			312	231	394
Spontaneous Vaginal Births SVD (including breech): a	May 24	54.1%	-			51.4%	44.4%	58.3%
Forceps & Ventouse/Instrumental Deliveries (OVD)	May 24	86	-			88	60	116
Number of Instrumental births/Forces & Ventouse as	May 24	12.9%	-			14.1%	9.8%	18.4%

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Caesarean Section (CS)	May 24	229	-			213	175	251
Number of CS births as a % of mothers birthed	May 24	34.2%	-			35.2%	29.3%	41.0%
Emergency CS births as a %	May 24	19.0%	-			19.9%	14.7%	25.1%
Elective CS births as a %	May 24	15.2%	-			14.3%	10.0%	18.6%
Robson Group 1 c-section with no previous births a %	May 24	12.7%	-			13.5%	8.0%	19.1%
Robson Group 2 c-section with no previous births a %	May 24	54.7%	-			55.2%	46.9%	63.5%
Robson Group 5 c-section with 1+ previous births a %	May 24	78.3%	-			78.7%	59.7%	97.8%
Elective CS <39 weeks no clinical indication	May 24	0	0			0	0	1

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Prospective Consultant hours on Delivery Suite	May 24	109	109			109	109	109
Midwife:birth ratio	May 24	29.1	22.9			26.4	22.7	30.2
Maternal Postnatal Readmissions	May 24	7	-			8	0	16
Readmission of babies	May 24	21	-			19	3	35
3rd/4th Degree Tears amongst mothers birthed	May 24	26	-	ER		12	-1	25
3rd/4th degree tears as a % of SVD+OVD	May 24	5.8%	3.5%			3.0%	0.1%	5.9%
3rd/4th Degree Tear with unassisted (Normal) births	May 24	3.8%	-			2.5%	-1.5%	6.5%
3rd/4th Degree Tear with assisted (Instrumental) birt	May 24	2.0%	-			4.3%	-2.7%	11.4%

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
PPH 1.5L or greater, vaginal births	May 24	19	-			13	0	25
PPH 1.5L or greater, vaginal births as a % of mothers b	May 24	2.8%	2.4%			2.1%	0.2%	3.9%
PPH 1.5L or greater, caesarean births	May 24	5	-			7	-2	15
PPH 1.5L or greater, caesarean births as a % of mother	May 24	0.7%	4.3%			1.2%	-0.7%	3.1%
ICU/CCU Admissions	May 24	0	-			1	-1	2
% completed VTE admission	May 24	80.5%	ER 5.0%			96.0%	91.8%	100.3%
Maternal Deaths: All	May 24	0	-			0	0	1
Early Maternal Deaths: Direct	May 24	0	-			0	0	0
Early Maternal Deaths: Indirect	May 24	0	-			0	0	0
Late Maternal Deaths: Direct	May 24	0	-			0	0	0
Late Maternal Deaths: Indirect	May 24	0	-			0	0	0

Indicator overview summary (SPC dashboard), *continued*

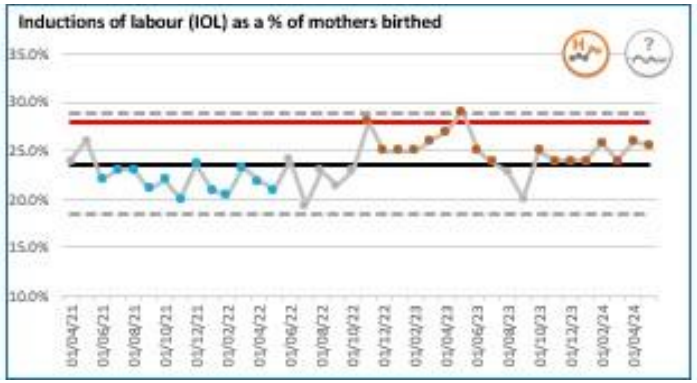
ER Exception report

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Puerperal Sepsis	May 24	7	-			6	-1	14
Puerperal Sepsis as a % of mothers birthed	May 24	1.1%	1.5%			1.0%	-0.2%	2.1%
Stillbirths (24+0/40 onwards; excludes TOPs)	May 24	2	-			2	-2	6
Stillbirths (24+0/40 onwards; excludes TOPs): as rate	Mar 24	2	4			4	#N/A	#N/A
Late fetal losses (delivered 22+0 to 23+6/40; excludes	May 24	1	1			0	-1	2
Neonatal Deaths (born in OUH, up to 28 days) All	May 24	1	-			3	-2	7
Neonatal Deaths (born in OUH, up to 28 days): Early (	May 24	1	-			2	-2	6
Neonatal Deaths (born in OUH, up to 28 days): Late de	May 24	0	-			1	-2	3
Neonatal Deaths (born in OUH, up to 28 days): as rate	Mar 24	6	3			1	-2	5
HIE	May 24	1	ER 0			0	0	0

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Shoulder Dystocia	May 24	12	-			8	0	17
Shoulder Dystocia as a % of babies born	May 24	1.8%	1.5%			1.4%	0.1%	2.6%
Unexpected NNU admissions	May 24	24	-			26	8	44
Unexpected NNU admissions as a % of babies born	May 24	3.5%	4.0%			4.0%	1.3%	6.7%
Hospital Associated Thromboses	May 24	0	0			0	-1	1
Returns to Theatre	May 24	1	0			1	-1	4
Returns to Theatre as a % of caesarean section delive	May 24	0.4%	0.0%			0.7%	-0.7%	2.0%
Number of PSII	May 24	0	0			1	-2	4
Number of Complaints	May 24	5	-			8	-3	18
Born before arrival of midwife (BBA)	May 24	8	-			6	-2	15

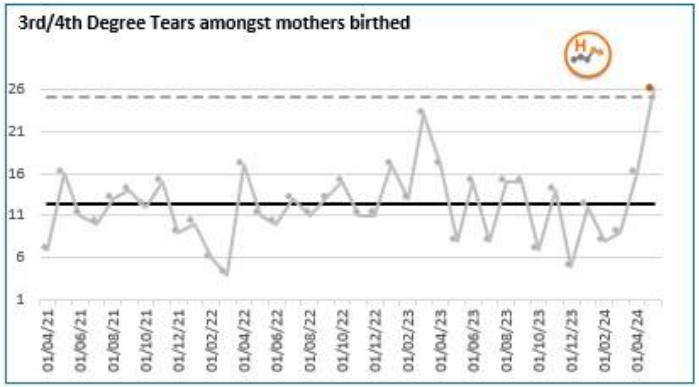
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Test Result Endorsement	May 24	78.2%	85.0%			74.4%	63.5%	85.3%
Number Of Women Booked This Month Who Current	May 24	8	-			49	25	74
Percentage Of Women Booked This Month Who Curr	May 24	1.1%	-			7.1%	3.7%	10.5%
Number of Women Smoking at Delivery	May 24	14	-			32	17	48
Percentage of Women Smoking at Delivery	May 24	2.1%	8.0%			5.2%	2.6%	7.8%
Percentage of Women Initiating Breastfeeding	May 24	86%	-			80%	71%	89%
Percentage of women booked by 10+0/40	May 24	53%	ER -			69%	61%	76%

Maternity Exception Report (1)



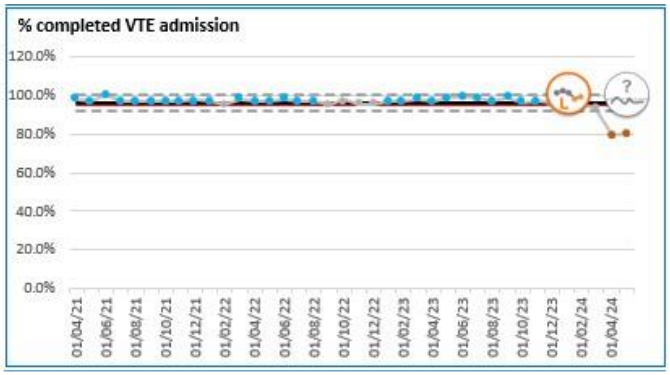
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Timescales to address performance issue(s) and identification of any gaps in assurance	Risk Register score	Data quality rating
Induction of labour (IOL) as a % of mothers birthed shows Special Cause Concerning variation.	The rate of induced labour has consistently been higher than the average for the past seven months both nationally and locally. These inductions are necessary from a clinical standpoint and cannot be reduced, however, they also increase acuity within the maternity department. The increase in the number of inductions can cause delays in the system and also compromise the flow of the service. A subsequent issues can also be an increase in the number of maternal requests for caesarean sections. The Maternity Service is examining the induction process to identify any bottlenecks and subsequent areas for improvement. This will include reviewing resource allocation and staff availability.	Induction of labour list is reviewed daily at the Delivery Suite safety huddle.	20	N/A

Maternity exception report (3)



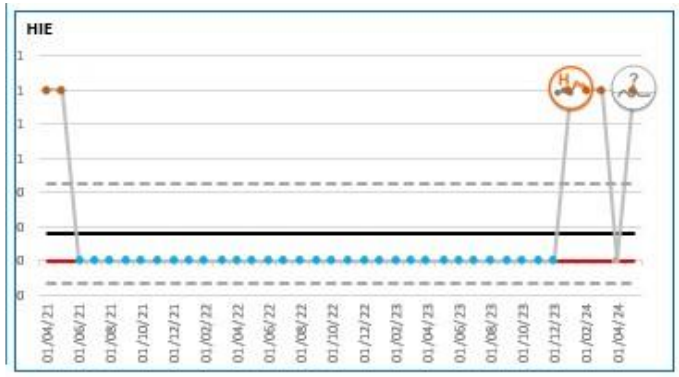
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Timescales to address performance issue(s) and identification of any gaps in assurance	Risk Register score	Data quality rating
3rd/4th Degree Tears amongst mothers birthed shows Special Cause Concerning variation.	Thematic analysis underway using Ulysses incidents raised in relation to these cases. Findings and improvement proposals have been escalated to the intrapartum group for discussion. Any themes/opportunities for learning identified will be actioned accordingly. PEACHES incorporated into preceptorship and QI project planned around hot compresses.	Review next month data	N/A	N/A

Maternity exception report (4)



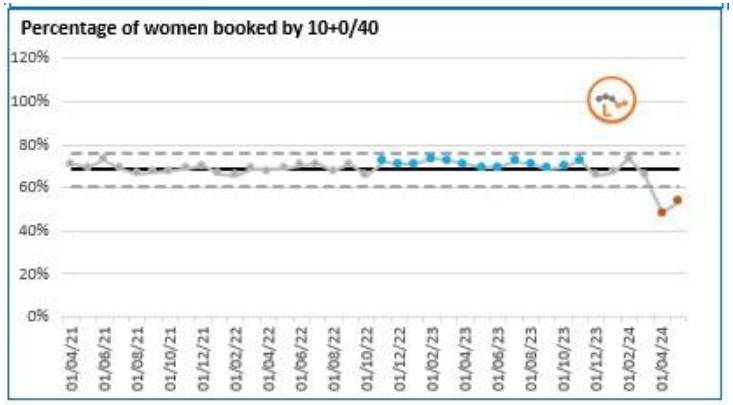
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Timescales to address performance issue(s) and identification of any gaps in assurance	Risk Register score	Data quality rating
% completed VTE admission shows Special Cause Concerning variation.	Due to challenges with data input and capture on Badgernet for May 2024, the VTE compliance statistic is low. This is not an accurate representation of the true VTE compliance figure. The Digital Team have agreed actions which are in progress to address data input and capture issues.	Improved compliance and staff familiarisation with data capture and input on Badgernet predicted to take a further 3 to 6 months.	N/A	N/A

Maternity exception report (5)



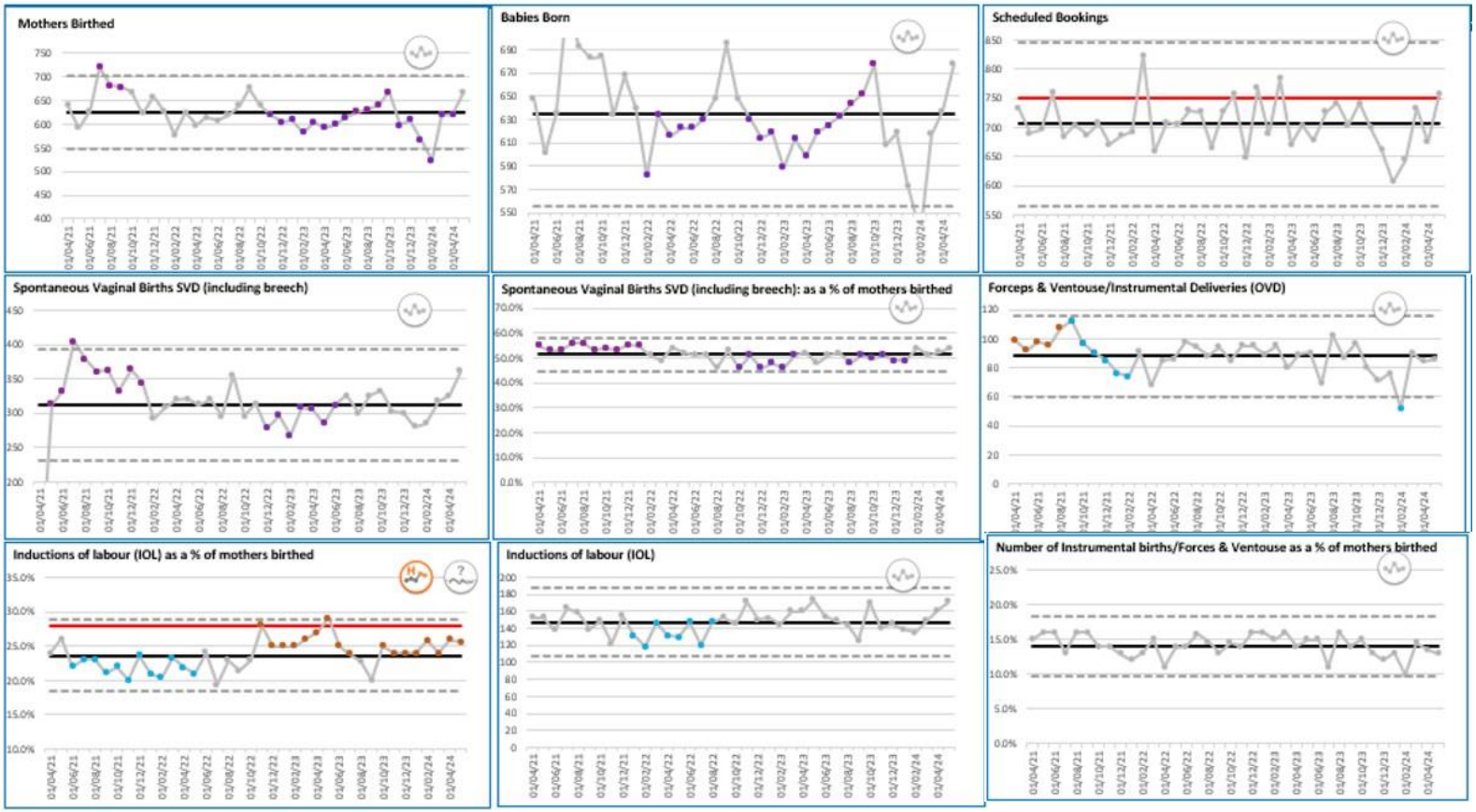
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Timescales to address performance issue(s) and identification of any gaps in assurance	Risk Register score	Data quality rating
HIE shows Special Cause Concerning variation.	During the reporting period, 2 babies were admitted to SCBU with suspected HIE. One case was a baby born vaginally in unexpectedly poor condition on the alongside midwifery unit - this has been reported to MNSI as per protocol. Local rapid review has been undertaken and has identified learning around communication and fetal monitoring. An AAR is scheduled for mid-June. Fortunately the baby was admitted for cooling and has been discharged with a normal MRI. One case was a baby born following an emergency caesarean following concerns identified on an antenatal CTG trace.	All cases of HIE are reported, reviewed and investigated as part of the daily perinatal risk management processes and pathways as per the narrative opposite.	N/A	N/A

Maternity exception report (7)

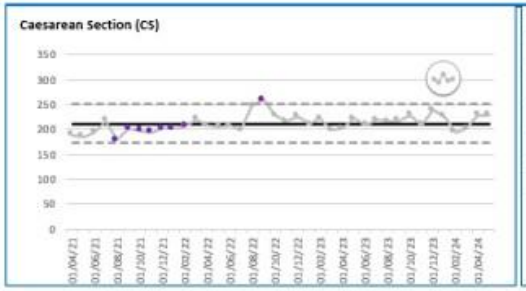


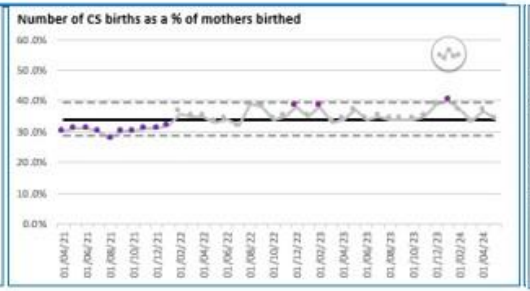
Summary of challenges and risks	Actions to address risks, issues and emerging concerns relating to performance and forecast	Timescales to address performance issue(s) and identification of any gaps in assurance	Risk Register score	Data quality rating
Percentage of women booked by 10+0/40 shows Special Cause Concerning variation.	Causes could be multifactorial, and could include timings of women accessing the service and that there is less capacity to fit women into clinics within this timeframe. Work continues to identify root causes and subsequent quality improvement. This will be continuously monitored through MCGC/local governance processes.	Review in June – further data may be required.	N/A	N/A

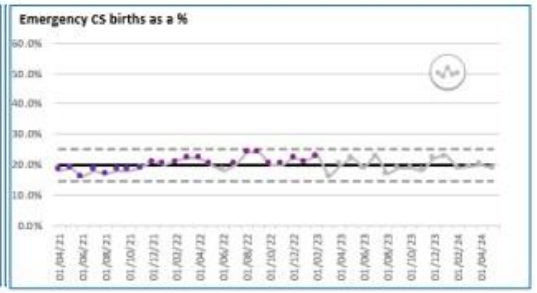
Appendix 1. SPC charts (1)

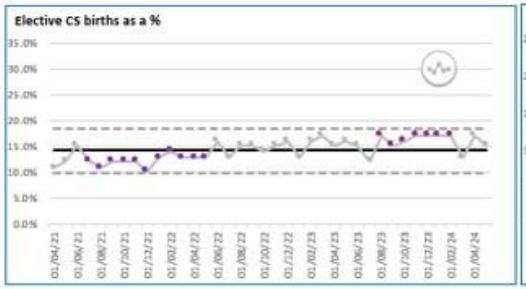


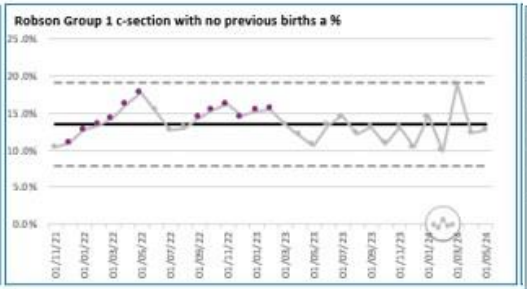
Appendix 1. SPC charts (2)

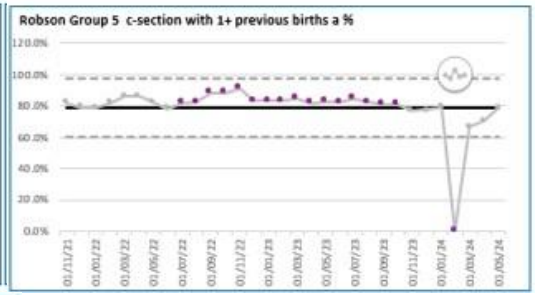


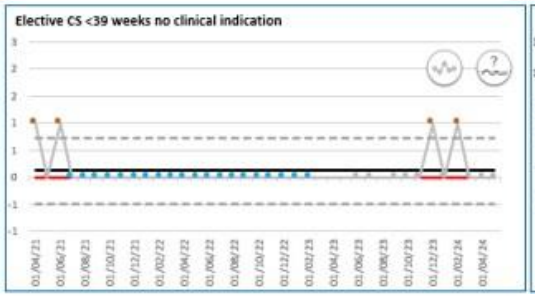


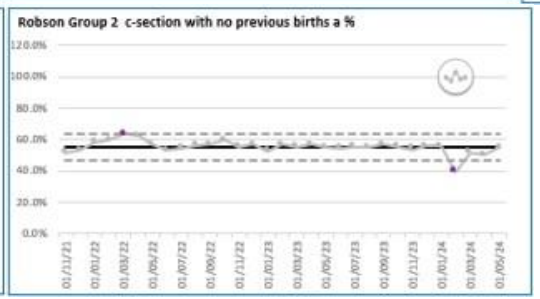












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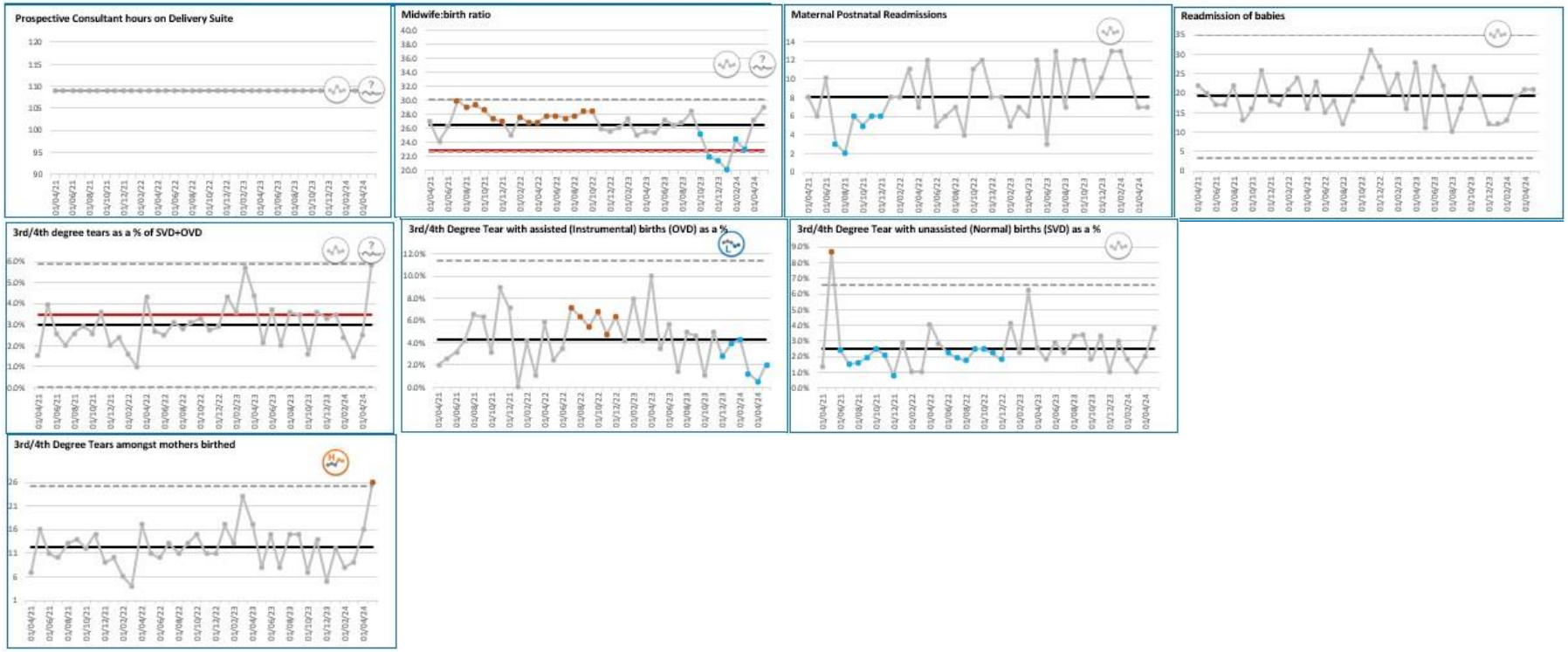

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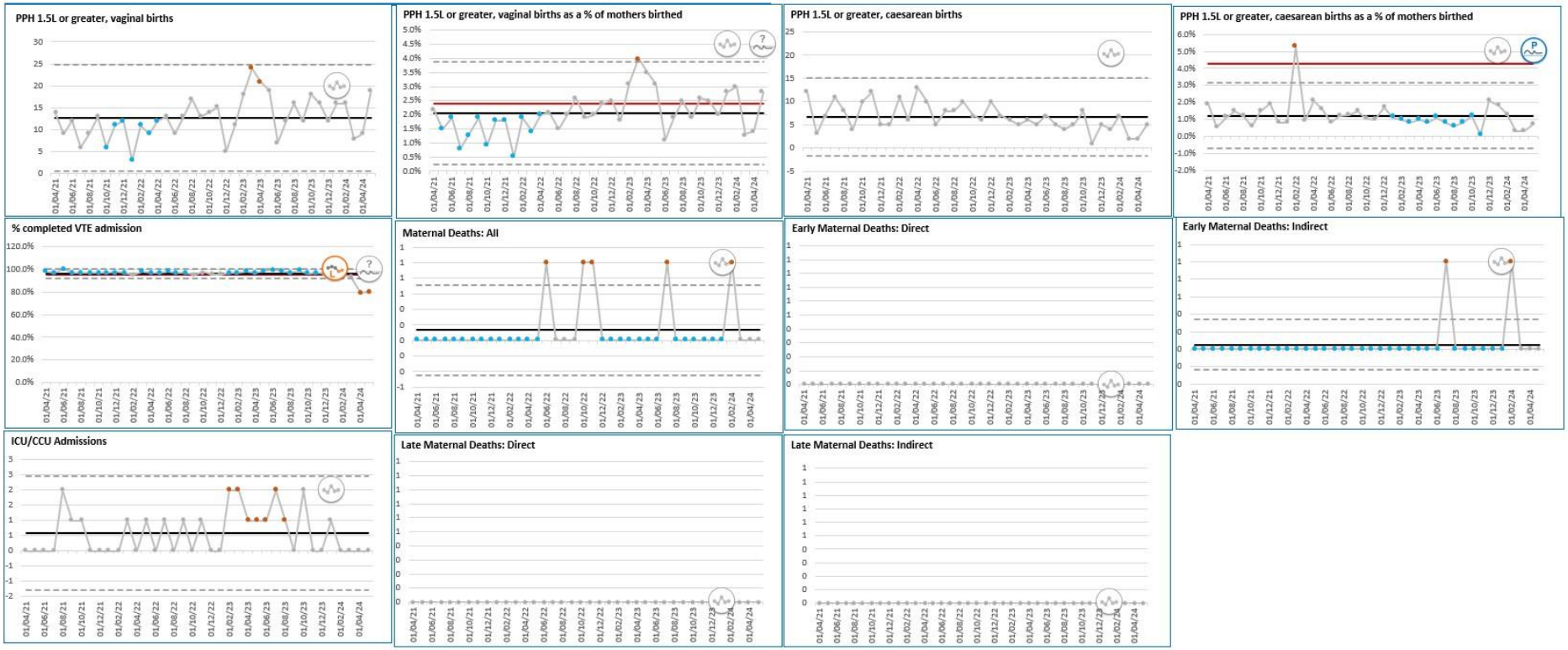

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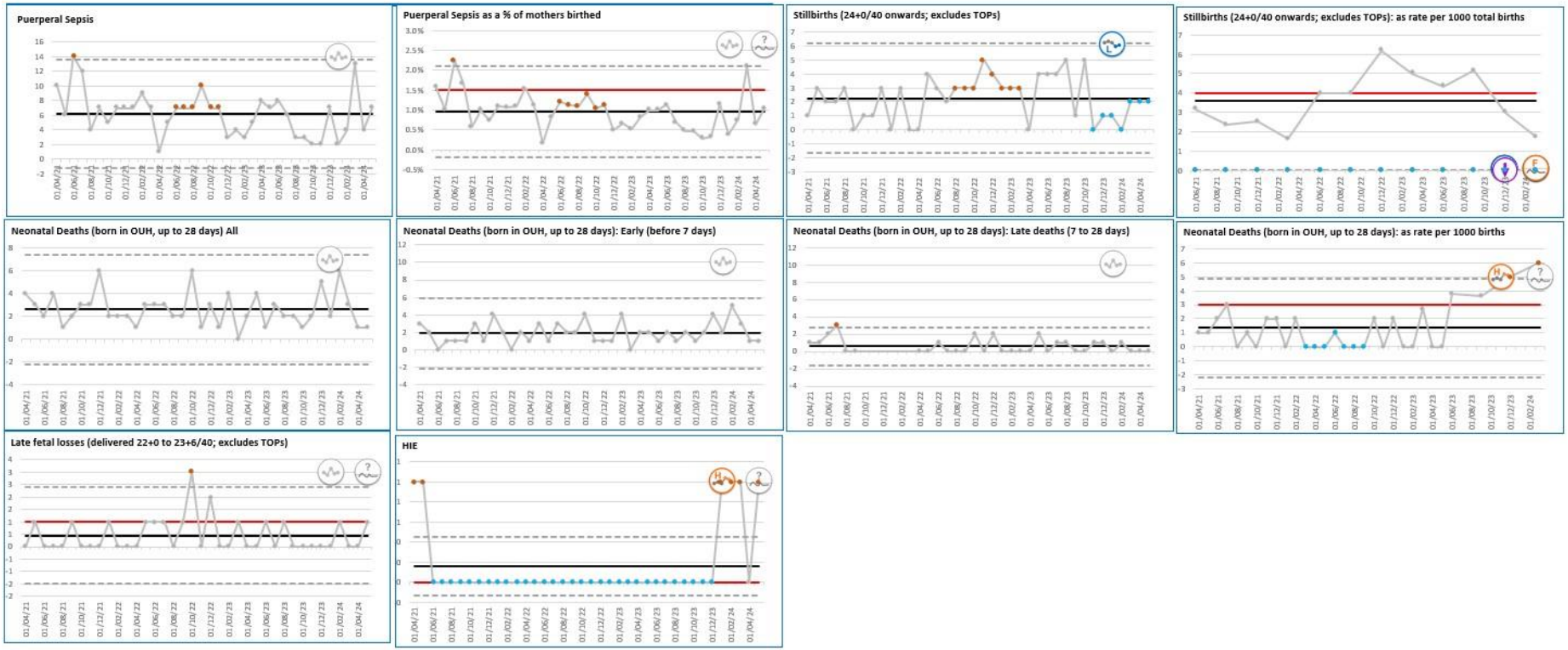

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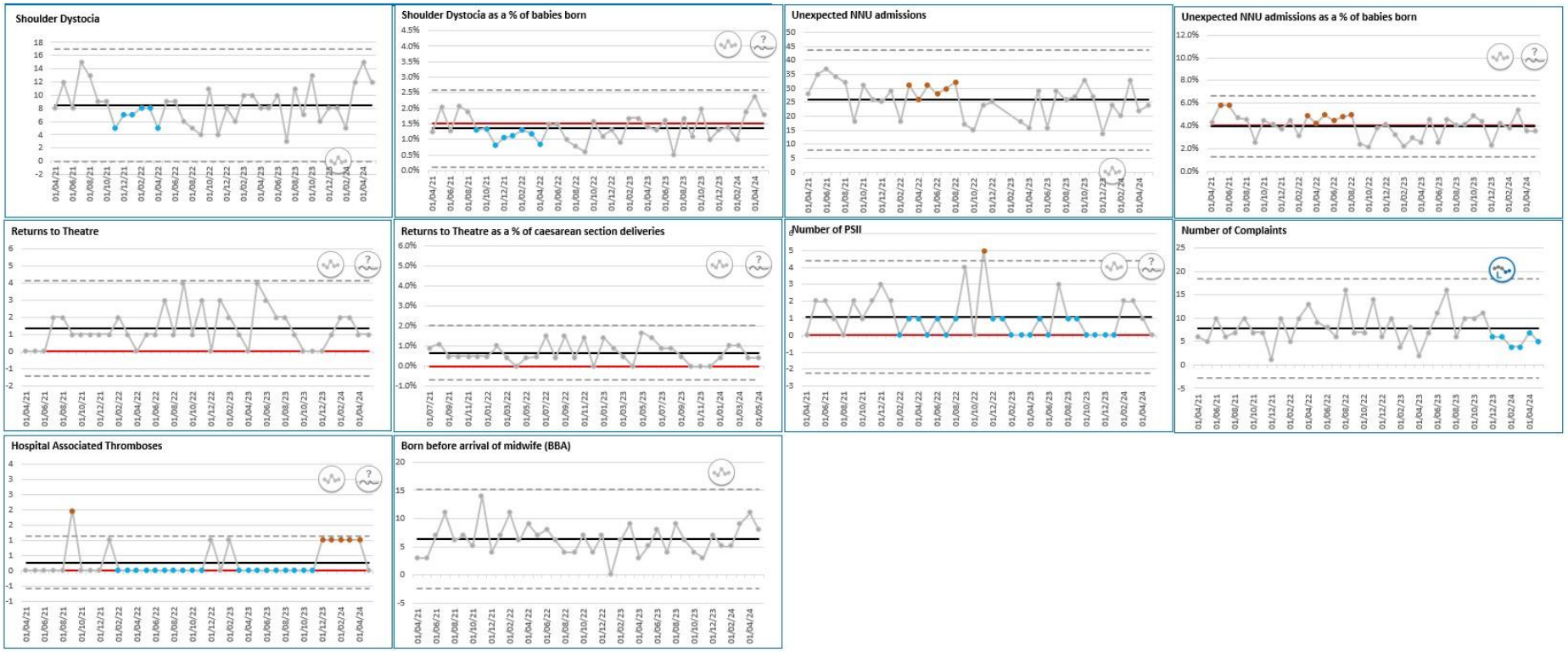

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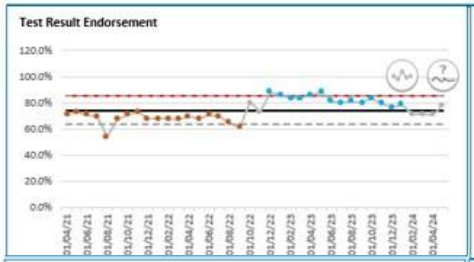

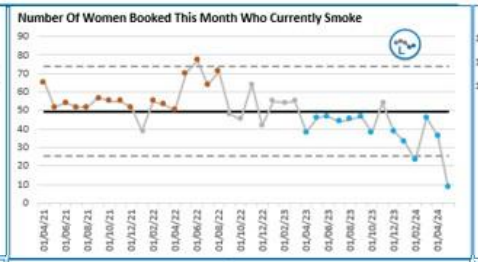

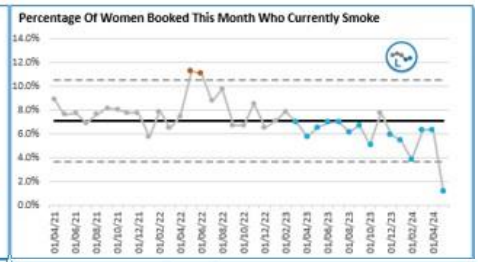

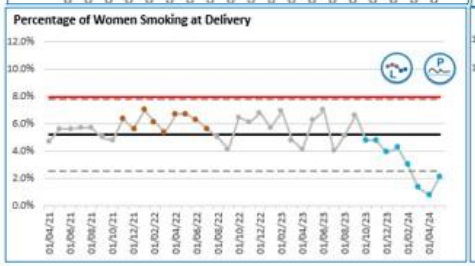

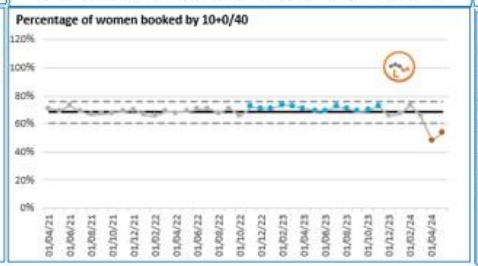

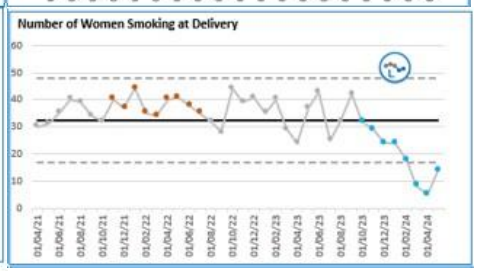

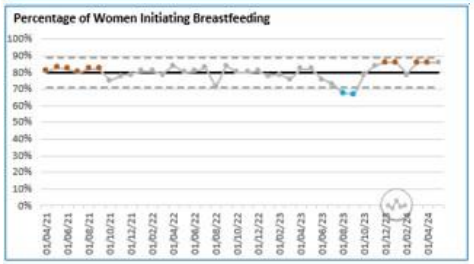

15. Appendix 2: CQC Must Do's

total action	Concern (from CQC report)	Overarching action (s)	End date	Comments
Must Action the trust Must take is necessary to comply with its legal obligations				
1	The trust must ensure that checks of emergency equipment and consumables are carried out thoroughly and identify out of date equipment in order that it can be replaced. Regulation 12(1)(2)(e)	1. Undertake checking of resuscitation trolleys on My Kit Check in accordance with Resuscitation Policy. 2. Continue with work to add the neonatal resus checklists onto the My Kit Check system. 3. Continue to add other emergency trolley checklists onto the My Kit Check system. 4. Matrons to review the checks as part of their Matron's walk rounds.	31/05/2024	**Update June 2024:** 1. Complete: Checks added to My Kit Check - first report came to MCGC in May 2024 - ongoing monthly reporting. 2. In progress: Delivery Suite (DS) matron has been working with the resus team on this and the first resuscitaire will be put on MyKitCheck in June 2024. 3. In progress: Emergency trolleys added to My Kit Check in community. Work continues on this within the JR Maternity site - see spreadsheet for My Kit CHeck with what has been added to MyKitCheck. 4. Complete: Requested separate question added to the Matrons walk round checklist. This goes live on the 01 June 2024 and will be reproted in July. There is an additonal monthly audit on the OUH Assurance Hub on Ulysses for checking the resuscitation trolley. There was an update from Trust CGC in June to say this would be a monthly audit. Staff in maternity have been informed about this audit. One area did not have it on their audit schedule, and this has been added.

2	The trust must ensure staff complete the required risk assessments for women, birthing people and babies and act to remove or minimise any identified risks. Regulation 12(1)(2)(a)(b)	1. Risk assessments to be built into Badger Net the new maternity digital record. 2. Ward managers and matrons to undertake reviews of the risk assessments undertaken by pulling a report from Badger Net. 3. Additional audit to be added to Ulysses compliance audit module.	31/05/2024	1. Complete - Risk assessment now built into the antenatal form on Badger Net (the new maternity digital record that went live on 14 February 2024). 2. Complete: First report went to the Maternity Clinical Governance Committee (MCGC) on the 20 May 2024, and this is part of the monthly reporting. 3. Complete - Additional audits added to Ulysses compliance audit module covering: Maternity Triage and Community Labour audit. Results are reported monthly through the Maternity Quality Report. Triage and Community care in labour audit reported monthly in Quality Report to MCGC and as part of the SUWON Quality Report to Trust Clinical Governance Committeee (CGC)

3	The trust must that all medicines are in date and stored within the correct temperature range. Regulation 12(1)(2)(g)	1. Undertake fridge and room temperature checks as per the Trust Safe and Secure Storage of Medicines Policy (S&SSM) and the Cold Chain Pharmaceutical Products in Clinical Areas Procedure. 2. Raise awareness of the Safe and Secure Storage of Medicines policy at the Safety Huddles. 3. Ensure that appropriate action is taken where required, to include the completion of a Ulysses incident report for a breach of the cold chain procedure. 4. Undertake the Trust Safe and Secure Medicine audit as required.	31/05/2024	Ensure staff know about appendix 6, 7, 8 1. Complete - MLU now using Appendix 6: cold chain room temperature monitoring form and Appendix 7: cold chain and room temperature monitoring action log from S&SSM Policy 2. Complete - Staff reminded of policy and procedure and Appendix 8: summary of tasks to support the safe and secure storage of medicines (from S&SSM policy) shared with staff. Updated email sent to the new ward managers. 3. Complete - information disseminated to ward managers about completing a incident report. Continue monitoring monthly and ensure a Ulysses is submitted for temperature breaches. Update: Ulysses not submitted but staff have been reminded. 4. Complete - Areas have recently undertaken the Trust Safe and Secure storage of medicines audit - it will be reported to June MCGC. Trust currently exploring a digital system for monitoring temperature in drug rooms.

4	The trust must ensure staff that staff adhere to the policies, procedures, and guidelines in place, including decontamination of the birthing pool. Regulation 17(1)(2)(a)(b)	1. Disseminate the Trust guidance to staff in relation to pool decontamination. 2. Review assurance processes for monitoring of the pool cleaning process, to be a focus of practice development staff activity. 3. Secure funding for new pool and implement replacement of the birthing pool.	31/05/2024	New birthing pool going through approval process which will reduce IP&C risk and allow for correct cleaning 1. Complete - Pool cleaning guidance has been disseminated and is now displayed within the area that the birthing pool is used. 2. Limited assurance currently - This check will be added to My Kit Check from the 01 July 2024 and will be reported with the August data. 3. In progress - Funding for a new birthing pool has been secured and equipment has been secured. The pool was delivered and is awaiting installation.
5	The trust must ensure regular audits are completed to ensure patient safety. Regulation 17(1)(2)(a)(b)	1. Share the audit schedule with clinical areas. 2. Review what audits are undertaken and share an update with clinical areas. 3. Report monthly through the quality reports that are presented at the Maternity Clinical Governance Committee (MCGC) and the Divisional Reports. 4. Develop and implement maternity service OxSCA programme.	31/05/2024	1. Complete- The audit schedule from the routine audits on Ulysses has been shared with the clinical areas. Rechecked by the matrons in May 2024. Additional work is underway for the Maternity 2024-25 audit schedule. 2. Complete: Additional audits have been created to look at MLU activity (see action 2 above) 3. Complete - New audits have been reported to MCGC 4. Complete - Mini OxSCA visits undertaken and reported to MCGC in April 2024. Action plan commenced. Meeting held with the matrons on the 5th May to review actions. There is a plan to add the actions to Ulysses.

				Note these audits complement scheduled wide national and trust wide audits reported to Clinical Improvement Committee. Note this was discussed at the staff listening.
6	The trust must ensure effective risk and governance systems are implemented which supports safe, quality care within the midwifery led unit. Regulation 17(1)(2)(a)(b)	1. Review the Manager on Call Standard Operating Procedure (SOP). 2. Continue the development of a community dashboard. 3. Additional audits undertaken in relation to Triage and Community Labour audit. 4. Review the audit reports on Ulysses to make them more meaningful to highlight areas that require improvement, and ensure that actions are included in report to MGCG.	31/05/2024	1. Complete - Manager on Call Standard Operating Procedure (SOP) has been reviewed and agreed at MCGC. 2. In progress - work commenced in winter 2023 led by the Consultant Midwife. Due to the change over to BadgerNet in February 2024, work continues on the developemnt of the dashboard related to data collection. 3. See action 2 and 5. 4. Complete - Actions from audits included in the Ulysses compliance are now embedded into this module and reported to MCGC.

16. Appendix 3: ANNB Screening Action Plan

Action No.	Concern (from Antenatal and Newborn Screening Assurance visit)	Overarching action (s)	End date	Comments
1	Implement a process to identify and manage screening safety incidents in line with national guidance 'Managing safety incidents in NHS screening programmes'	1. The Trust will ensure that there is a clear and robust leadership presence within the Screening Team that provides onsite leadership direction and succession planning. 2. The Trust will develop a local SOP for managing ANNB incidents, which covers all the ANNB programme and links in with the Trust Incident policy, which links to the Managing Safety Incidents in NHS screening programmes on the gov. website. This will ensure that all steps of the incident management process are documented and communicated to all relevant stakeholders. 3. Add "Screening" to the "Cause" group under Maternity. Then add the different areas of screening to the "Sub Cause" on Ulysses to make it easier to track incidents. 4. Add screening incidents to the monthly Maternity Quality Report to audit reporting. 5. To encourage a culture of reporting the screening coordinator will identify individuals who require additional training from the screening team in relation to screening incidents. 6. The actions will be monitored through monthly audits.	30/06/2024	1. In progress 2. Complete: SOP has been developed 3. Complete 4. Ongoing monitoring 5. Ongoing 6. Ongoing

2	Document the process for identification and tracking of the cohort through the screening programmes.	1. Update the SOP for “Antenatal Screen Cohort tracking for KPI reporting”. 2. Disseminate the SOP to staff once approved. 3. Ensure that the application of the SOP is monitored through monthly audits.	31/05/2024	1. Complete: SOP updated 2. Complete: This has been disseminated to staff. 3. Ongoing monitoring
3	Clarify the process for identification and escalation of risk and issues in antenatal and newborn screening (ANNB) within the trust.	1. Disseminate the Trust Risk Management policy to the ANNB team. 2. Review meeting agenda and terms of reference for ANNB quarterly meeting and sub meetings to include risk update as an agenda item.	30/06/2024	1. Complete: This has been disseminated to the ANNB team 2. Ongoing: next meeting is in July where they will be approved (last meeting was in April)
4	Review the mandatory screening training pathway for staff including a process to document compliance against training needs.	1. The Practice Development (PD) team will assess and review the existing ANNB training pathway, identify gaps, and evaluate current practice for inclusion in the September 2024 mandatory study days. 2. The PD team will identify which staff need to attend which training and create a standardised system for recording staff training completion and compliance. 3. The Ultrasound Managers at the Horton and the JR will review the mandatory training and maintain a record of training compliance. 4. Quarterly reports on training compliance rates will be presented and discussed as part of maternity governance processes.	30/06/2024	1. Complete 2. Ongoing 3.Ongoing 4. Ongoing
5	Make sure that community midwives have appropriate training for the delivery of the screen positive	1. Develop and implement a training package for community midwifes for the delivery of the screen positive pathway for sickle cell and thalassaemia for staff on the OxMUD study	30/06/2024	1. Complete 2. Ongoing 3.Ongoing 4. Ongoing

	pathway for sickle cell and thalassaemia.	day. 2. Amalgamate the resources on the OUH intranet for screening into one package. 3. Establish a system for ongoing monitoring and evaluation of the training programmes effectiveness. 4. Quarterly reports on training compliance rates will be presented and discussed as part of maternity governance processes.		