Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Public Trust Board Meeting: Wednesday 15 September 2021

Insert Paper Number

Title:	**Maternity – Overarching Paper: Evidence**
Status:	**For Discussion**
History:	**Maternity Clinical Governance Committee**
Board Lead:	**Chief Nursing Officer**
Author:	**Niamh Kelly, Clinical Governance Manager** **Beatrice Culligan, Deputy Head of Midwifery** **Alison Cuthbertson, Director of Midwifery**
Confidential:	**No**
Key Purpose:	**Assurance**

Contents

1. Appendix A: Maternity Incentive Scheme

Public Trust Board Meeting: Wednesday 15 September 2021

Insert Paper Number

Title:	**Maternity Incentive Scheme Year 4**

Status:	**For Discussion**
History:	**Maternity Clinical Governance**

Board Lead:	**Chief Nursing Officer**
Author:	**Niamh Kelly, Clinical Governance Manager, Clinical Governance**
Confidential:	**No**
Key Purpose:	**Assurance**

Executive Summary

1. This paper is to give an early brief update on the ten maternity safety actions included in the NHS Resolution Maternity Incentive Scheme Year 4 which was launched on 9 August 2021.
2. This paper outlines the significant changes to the Safety Standards of Maternity Incentive Scheme year 4. There is a risk associated with the achievement of year 4 requirements

Recommendations

The Board is asked to note the contents of the update report, and to discuss how the Trust could support the Maternity and Neonatal units with overcoming the challenges that have been identified.

Contents

1.Purpose

1.1. This paper is to give an early brief update on the ten maternity safety actions included in the NHS Resolution Maternity Incentive Scheme Year 4 which was launched on 9 August 2021

2. Background

2.1. NHS Resolution (NHSR) is operating year four of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to support the delivery of safer maternity care. As in previous years, as a member of the CNST Oxford University Hospitals NHS Foundation Trust (OUH FT) will contribute an additional 10% of the CNST maternity premium to the scheme.

2.2. If OUH FT can demonstrate they have achieved full compliance of all the ten safety actions, then the Trust will recover their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds. However, if the Trust cannot demonstrate full compliance with the 10 safety actions, then the Trust will not recover their contribution to the CNST maternity incentive fund but may be eligible for a small discretionary payment from the scheme to help make progress towards meeting the requirements of the actions that were not achieved. This discretionary payment would be at a much lower level than the 10% contributed.

2.3. To be eligible for payment under the scheme, the Trust must submit their completed Board declaration form the NHS Resolution by 12 noon on 30 June 2022. The declaration form must be signed three times and dated by the Trust's Chief Executive Officer (CEO) confirming that:

- The Board is satisfied that the evidence provided to demonstrate achievement of the ten safety actions meets the required standard as set out in the 'Ten maternity safety actions with technical guidance' document (see appendix 1).
- The content of the declaration form must be discussed with the commissioner of the Trust's maternity services.
- There are no reports covering either this year or next that relate to the provision of maternity services that may subsequently provide conflicting information to the Trust's declaration (e.g., CQC inspection report, Healthcare Safety Investigation Branch (HSIB) etc.).

2.4. This paper outlines the required standards for each of the ten safety actions along with the initial evaluation of the current status and level of risk for each standard (see section 3 below).

3. Year 4 Safety Actions

3.1. The Trust was fully compliant with all ten Safety Actions with the re-launched Maternity Incentive Scheme year 3 requirements. The Maternity Incentive Scheme

year 4 shows significant changes to the requirements to meet 10 Safety Standards in comparison to the Maternity Incentive Scheme year 3. The paper will highlight the key changes to the Safety Standards.

3.2. **Safety Action 1**: Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths to the required standard?

The key changes:

- All eligible deaths to be notified to MBRACE-UK within two working days rather than seven and the surveillance information where required must be completed within one month of the death rather than four months.
- A review using the PMRT of 95% of all deaths of babies, suitable for review must have been started within two months of each death
- There is further clarification regarding the multi-disciplinary review and individuals to be involved.

3.3. **Safety Action 2**: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

The key changes:

- Trust has procured a Maternity Information System complying with the forthcoming commercial framework (published by NHSX) and are complying with Information Standard Notices or have a fully funded plan to procure a Maternity Information System from the forthcoming commercial frameworks and comply with the Standard Notices and attend at least one engagement session organised by NHSX. The commercial framework release date is 20 September. Therefore, the solution to procure must come from this framework.
- Assurance that 9 out of 11 Clinical Quality Metrics (CQIMS) have passed the associated data quality criteria of the national Maternity Services Dashboard. This will require the implementation of some digital changes to the existing system.
- Data requirement percentage targets for height, weight, BMI and complex social factors at the first antenatal booking appointment.
- Continuity of carer data regarding the proportion of women placed on CoC pathway by the 28 weeks antenatal appointment and receiving CoC.
- Personalised Care and Support planning at three stages in the pregnancy which includes antenatal care plan by 16+1 weeks gestation, birth care plans by 34+1 weeks gestation and postpartum care plans by 36+1 weeks gestation.

3.4. **Safety Action 3**: Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into the Neonatal units Programme?

Key Changes:

- Pathways of care into transitional care have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies.

- The pathways of care have been fully implemented and is audited quarterly. Audit findings are shared with the neonatal safety campion, Local Maternity and Neonatal Systems (LMNS), commissioners and Integrated Care Systems (ICS) quality surveillance meeting each quarter.
- A data recording process for capturing existing transitional care activity regardless of place or if not already in place, a secondary data recording process is set up to inform future capacity management for late preterm babies who could be cared for in a TC setting.
- LMNS and commissioners to inform capacity planning as part of the family integrated care component of the Neonatal Critical Care Transformation Review and to inform future development to TC to minimise separation of mother and baby.
- Review of term admissions to the neonatal unit to include the number of admissions that would have met the current TC admissions criteria but were admitted to the neonatal unit due to capacity or staffing issues. The review needs to include the number of babies that remained or were admitted to the Neonatal Unit because of their need for nasogastric tube feeding but could have been for on a TC if nasogastric feeding was supported there.

3.5. **Safety Action 4**: Can you demonstrate an effective system of clinical* workforce planning to the required standard?

Key Changes:

- Obstetric consultant team and maternity senior management team should acknowledge and commit to incorporating the principles outlined in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their services.
- To monitor their compliance of consultant attendance for the clinical situations listed in this document when a consultant is required to attend in person.
- A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should always have clear lines of communication to the supervising anaesthetic consultant. They should be able to delegate care for their non-obstetric patients in order to be able to attend immediately to obstetric patients.
- The Trust Board should evidence progress against the action plan developed in year 3 of MIS as well as include new relevant action to address deficiencies for the Neonatal medical and nursing workforce to meet the British Association of Perinatal Medicine (BAPM) national standards for junior medical staffing and nursing standards.

3.6. **Safety Action 5**: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

(Note: requirements are almost identical to MIS year 3 apart from submitting a report every 6 months rather than yearly to the Trust Board)

3.7. **Safety Action 6**: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?

Key changes:

- Submission of the quarterly care bundle surveys to the Trust Board.
- The trust will fail Safety action 6 if the process indicator metric compliance is less than 80% for element 1-Smoking monitoring, element 2-fetal growth restriction monitoring and element 3- reduced fetal movement monitoring. If the process indicator scores are less than 95%, action plan is required to achieve >95%.
- Element 4 – Fetal Monitoring requires the Trust Board to confirm that 90% of eligible staff have attended local multi-professional training annually and have a dedicated Lead Midwife (0.4 WTE) and lead Obstetrician (0.1 WTE) appointed by the end of 2021.
- Element 5 – Premature labour, has been extended to include the percentage of singleton live births occurring more than 7 days after completion of first course of corticosteroids and audit of women booked have been risk assessed for premature labour and referred to the appropriate care pathway. The risk assessment and management in multiple pregnancy complies with NICE guidance or a variant that has been agreed with local commissioners following advice from the provider's clinical network.
- The Trust should specifically confirm that they have a dedicated Lead Consultant Obstetrician with demonstrated experience to focus on and champion best practice in preterm birth prevention.

3.8. **Safety Action 7**: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?

Key Changes:

- The MVP Chair is being renumerated which reflects the time commitment and requirements of the role given and remuneration should take place in line with agreed Trust processes. The service users of the MVP can claim child costs in a timely way. Currently there is no funding for child costs.
- The MVP work programme has been agreed and recorded in the MVP minutes and ratified in the minutes of the LMS board.

3.9. **Safety Action 8**: Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4? In addition, can you evidence at least 90% of each maternity unit staff group have attended an 'in-house' one day multi-professional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and newborn life support, starting from the launch of MIS year 4?

Key Changes:

- Training plan to cover all six core modules of the Core Competency Framework that will span a 3-year time period.

- Multi-professional 'in-house' training day should be reinstated as face-to-face training no later than 30 September 2021. Attendance of 90% of each identified maternity staff groups. This will be challenging due to lack of training venues and potential Covid restrictions.

- Fetal Monitoring and surveillance should be consistent with the Ockenden Report (2021).

- There has been changes to the content of the multi-professional maternity emergencies as set out in the Core Competency Framework. All core competencies should be covered in the three-year period. One of the competencies to include a learning from excellence case study and at least one of the four emergency scenarios should be conducted in the clinical area ensuring full attendance from the relevant wider multi-professional team.

- All staff in attendance at births should attend local neonatal life support training every year. Details of the minimum training requirements are specified including details of the gold standard.

3.10 **Safety Action 9**: Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?

Key Changes:

- Evidence that the revised pathway developed in year 3 that describes how safety intelligence is shared from frontline staff, Board safety champions, between each other, the Board, new local maternity, and neonatal systems (LMNS), regional quality groups involving the Regional Chief Midwife and Lead Obstetrician to ensure early action and support is provided for areas of concern or need in line with the perinatal quality surveillance model.
- Trust's claims scorecard is reviewed alongside incident and complaint data and discussed by Board Level safety champions at Trust level quality meeting each quarter, beginning no later than quarter 3.
- Evidence of an action plan that describes how the maternity service will work towards CoC being the default model of care offered to all women by March 2023.
- Insights from culture surveys undertaken have been used to informal local quality improvement plans by April 2022.

3.11 **Safety Action 10**: Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification scheme for 2021/22?

(Note: requirements are identical to MIS year 3)

4. The next steps

4.1. A detail benchmarking review is underway to assess the service provision against the 10 safety standards published in the Maternity Incentive Scheme year 4. The initial

review has shown that there have been significant changes to many of the 10 Safety Standards requirement in comparison to the Maternity Incentive Scheme year 3. A detailed action plan is in the process of being developed. With the significant changes to the safety standards, there is risk associated with the achievement of year 4 requirements.

5. Conclusion

5.1. This paper outlines the significant changes to the Safety Standards of Maternity Incentive Scheme year 4. There is a risk associated with the achievement of year 4 requirements.

6. Recommendations

6.1. The Board is asked to note the contents of the update report, and to discuss how the Trust could support the Maternity and Neonatal units with overcoming the challenges that have been identified.

Appendix B: Safe Staffing Paper

Public Trust Board Meeting: Wednesday 15 September 2021

Insert Paper Number

Title:	**Safe Staffing Paper Quarter 4**

Status:	**For Information**
History:	**Maternity Clinical Governance Committee**
	Regular Reporting

Board Lead:	**Chief Nursing Officer**
Author:	**Beatrice Culligan**
	Deputy Head of Midwifery – Acute and Tertiary services
Confidential:	**No**
Key Purpose:	**Assurance**

Executive Summary

1. This is the fourth quarterly report which reviews Safe Staffing levels for Maternity.

   The aim of this report is to provide assurance of an effective system of midwifery workforce planning.

2. The report provides assurance of the following:

a	A systematic, evidence-based process to calculate midwifery staffing establishment is complete.
b	The midwifery coordinator in charge of labour ward has supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service
c	All women in active labour receive one-to-one midwifery care
d	A quarterly midwifery staffing oversight report that covers staffing/safety issues is submitted to the Board.

3. The evidence described in this paper provides assurance that OUH FT has an effective system of midwifery workforce planning and monitoring of safe staffing levels from January 2021 to March 2021.

Recommendations

The Trust Board is asked to note the results of this paper.

Maternity – Overarching Paper: Evidence

1. Purpose

The aim of this report is to provide assurance to the Trust Board that there was an effective system of midwifery workforce planning and monitoring of safe staffing levels from January to March 2021. This is a requirement of the NHSLA Maternity Incentive Scheme for safety standard number 5.

2. Background

The NHSLA Maternity Incentive Scheme requires that OUH FT demonstrates an effective system of midwifery workforce planning to the required standard. This report will demonstrate that:

a	A systematic, evidence-based process to calculate midwifery staffing establishment is complete.
b	The midwifery coordinator in charge of labour ward has supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service
c	All women in active labour receive one-to-one midwifery care
d	There is a quarterly midwifery staffing oversight report that covers staffing/safety issues to the Board.

3. Evidence

A clear breakdown of BirthRate Plus® or equivalent calculations to demonstrate how the required establishment has been completed

Following the systematic evidenced based process of BirthRate Plus® tool in 2018, there has been an increase in the midwifery staffing establishment. The current midwifery staffing establishment meets the recommendations of BirthRate Plus® of 1:25. The average midwifery staffing ratio was 1:24.6 in Quarter 4. There has been a review of staffing using the KPMG calculation tool to review staffing establishments. This has led to changes to the staffing establishments in identified clinical areas to ensure the appropriate level of staffing.

3.2 Details of planned versus actual midwifery staffing levels

The midwifery staffing levels are reviewed a minimum of twice a week, to check planned staffing against the agreed establishment for each clinical area. Furthermore, twice a day the Safety Huddle (see appendix 1) reviews the actual midwifery staffing and acuity levels, to ensure a fast response with mitigating actions to address any highlighted staffing shortfall.

The RAG rating agreed at the Safety Huddles is reported to the Trust staffing meeting once a day via dial-in and is updated via email if it changes. There is a robust escalation policy with agreed action pathways to be taken for each rating.

The table below shows the RAG rating for actual midwifery staffing levels for Quarter 4. Green signifies that the maternity service has available beds and appropriate staffing levels for the workload on that particular day.

	RAG Rating			
	GREEN	AMBER	RED	Not Declared
January 2021	23	8	0	0
February 2021	13	11	0	4
March 2021	18	13	0	0

Actions were taken as per Escalation Policy to militate against RAG ratings of Amber. This included “staff movement between areas” and “supernumerary workers within numbers” as reflected in the Red Flags reported, as well addressing staff shortfall by using on-call staff and sourcing additional staff.

3.3 An action plan to address the findings from the full audit or table-top exercise of BirthRate Plus® or equivalent undertaken. Where deficits in staffing levels have been identified, maternity services should detail progress against the action plan to demonstrate an increase in staffing levels and any mitigation to cover any shortfalls

Midwife to Birthing ratios are monitored monthly and report on the maternity dashboard and are reported and reviewed at Maternity/Divisional Clinical Governance. The recent KPMG review of staffing levels, led to adjustments in staffing establishments to ensure clinical areas had the correct staffing establishment to provide safe care.

The Maternity Directorate continues to actively recruit new staff throughout the year. In March, active recruitment of qualifying student midwives commenced. This recruitment campaign is when the majority of our staffing will be recruited

for the Autumn. Approval has been agreed to over recruit by 10% of the establishment to counteract the shortfall in later months.

The table below shows the number of new starters balanced against the numbers of leavers.

Midwives	January 2021	February 2021	March 2021	Total
New Starters	1.8WTE	1.92WTE	0WTE	3.72WTE
Leavers	5.41WTE	2.91WTE	2.8WTE	11.12WTE

An updated action plan can be found in Appendix 2.

3.4 The midwife: birth ratio

The average midwife to birthing ratio for Quarter 4 is 1:24.8 which is aligned to the recommendations from *BirthRate Plus® of 1:25.* However, it is important to note that towards the end of the quarter, the staffing ratio starts to reduce to 1:26.5 as there is an increase in vacancies. To mitigate against any shortfall in staffing, NHSP agency staff is used. The midwife to birth ratio is monitored monthly on the maternity dashboard and reported at the monthly MCGC meeting.

The table below shows the midwife: birth ratio in the period covered by this paper.

	January 2021	February 2021	March 2021
Midwife to Birth Ratio	1:22.9	1:25	1:26.5

3.5 The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate Plus® accounts for 9% of the establishment which are not included in clinical numbers. This includes those in management positions and specialist midwives.

The BirthRate Plus® report recommended that management or specialist midwife roles should not be included in the clinical numbers. The report suggested that management and specialist roles should account for 9% of the establishment.

We continue to review maternity services to ensure the appropriate level of manager and specialist midwives not included in the midwifery numbers, however during the COVID-19 period several manager and specialist midwives were required to work clinically to support safe care provision.

Following a successful consultation in the autumn to restructure the senior midwifery team, the senior team has increased by an additional 1 WTE 8B position. This new position is Deputy Head of Midwifery – Acute and Tertiary services. Unfortunately, two members of the senior team have retired, the Matron for Delivery Suite and Deputy Head of Midwifery and Lead for Community Services. All the posts have been recruited into except for the Deputy Head of Midwifery and Lead for Community Services. Interim arrangements have been put in place to cover community midwifery services.

A consultation to review the Practice Education Team to strengthen training, education and support for clinical staff was completed in February. This includes additional resources for a dedicated Lead Midwife for fetal monitoring as required for Safety Action 6 of the Maternity Incentive Scheme. All positions have been recruited and staff commenced new roles in April 2021.

3.6 Evidence from an acuity tool (which may be locally developed) and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward status and the provision of one-to-one care in active labour and mitigation to cover any shortfalls

The twice daily Safety Huddle (see appendix 1) monitors the supernumerary status of the delivery suite co-ordinator to ensure they have oversight of all birth activity in the service. If there is an occasion when the delivery suite co-ordinator does not have supernumerary status this is escalated to the Maternity Bleep Holder and mitigating action is taken to address the issue and the corresponding Red Flag is uploaded to the electronic Health Roster System. This data is also reviewed at the Maternity Clinical Governance monthly meeting.

In this data period there has been 100% compliance with supernumerary delivery suite co-ordinator status.

3.7 Number of red flag incidents (associated with midwifery staffing) reported in a consecutive six-month time period within the last 12 months, how they are collected, where/how they are reported/monitored and any actions arising.

The agreed staffing Red Flags are listed in appendix 3.

The Red Flag incidents for the Q4 have been outlined in appendix 4.

The bleep holder and area co-ordinators continue to focus each day on ensuring staff are able to take breaks and leave on time.

It should be noted that the Red Flag for staffing includes 'Supernumerary workers within the numbers'; this includes staff who are supernumerary in one clinical area being moved to cover a staffing shortfall in another clinical area where they are able to be counted within the numbers. It also includes staff working in offices or on study leave who are removed to work within the numbers. The data therefore shows a number of occasions where this has flagged but does not indicate that the Delivery Suite Coordinator has stopped being supernumerary, as described above.

To militate against any shortfall in staffing over this period, the 'Flexible Midwifery Pool Scheme' continues. This scheme incentivises staff by paying an enhanced rate to work with the NHSP Bank to work night and weekend shifts which can be challenging to cover. This continued to have a positive impact in the reduction of the number of hours midwives were called in to maternity unit at JR hospital to support service needs.

4. Conclusion

The evidence described in this paper provides assurance that there is an effective system of workforce planning to ensure safe staffing levels.

5. Recommendations

The Trust Board is asked to note the results of this report.

Appendix 1 – Safety Huddle

The Safety Huddle is a multidisciplinary meeting held twice a day, one at 09:30 and one at 16:00 hours. Members of the Maternity Safety Huddle include:

- Director of Midwifery
- Duty Consultant Obstetrician
- Clinical Midwifery Managers for each area (or deputy)
- Duty Consultant Anaesthetist
- 1570 Maternity Bleep Holder
- Midwifery Manager on-call (may represent via telephone)
  Delivery Suite Coordinator

Using the RAG rating system of Red, Amber or Green the safety huddle members will assess the unit's workload, staffing and acuity and declare Maternity's RAG status as follows:

- **Green** signifies that the maternity service has available beds and appropriate staffing levels for the workload
- **Amber** signifies the maternity service is at the upper limits of bed capacity, staffing or activity
- **Red** signifies that there are no available beds, and all available staff are committed to labour care. The service cannot guarantee 1:1 midwifery care in labour or safe staffing in other areas of the service.

Appendix 2 - Action plan from Birthrate Plus® 2020/2021.

Issue	Specific Action Required to achieve standard	Lead	Timescale	Evidence	Outcome
To fully embed the BirthRate Plus Acuity Tool to monitor the acuity to ensure safe staffing levels throughout the 24-hour period.	To cascade and relaunch the tool to all inpatient areas; Antenatal ward Postnatal ward Delivery Suite Observation Area Spires Alongside Midwifery Led Unit Achieve 85% compliance with data collection rate	Matron Maternity Outpatients	March 2021	Weekly sense checks Monthly Acuity Report to MCGC 85% compliance achieved	BirthRate Tool in all inpatient areas. Further work to improve compliance. This work is ongoing
Monitor the midwifery establishment in line with BirthRate Plus	Review area staffing levels using the KPMG tool to ensure appropriate staffing levels in line with BirthRate Plus. To review monthly the midwife to birth staffing ratio on the dashboard and present at MCGC meeting. To regularly review the data from the BirthRate Plus acuity tool to ensure safe staffing levels. Identify risks and mitigate. To annually review the recruitment and retention plan.	Director of Midwifery Senior Midwifery Team Senior Midwifery Team Senior Midwifery Team	December 2020 Rolling programme Rolling programme Rolling programme	Completed tools for all clinical areas with evidence of adjusted staffing. Minutes of monthly MCGC meeting with up-to-date dashboards. Monthly Acuity Report to MCGC Recruitment and retention plan for 2020/2021	Complete

Appendix 3 - Monitoring staffing red flags as recommended by NICE guidance NG4 'Safe Midwifery Staffing for Maternity Settings' (2015)

The agreed staffing red flags were approved and ratified in 2017

- (All Areas) Staff moved between specialty areas
- (All Areas) Supernumery workers within the numbers
- (All Areas) Administrative or Support staff unavailable
- (All Areas) Staff unable to take recommended meal breaks
- (All Areas) Staff working over their scheduled finish time
- (All Areas) Delays in answering call bells
- (All Areas) Delay of more than 30 minutes in providing pain relief
- (All Areas) Delay or omission of regular checks on patients to ensure that their fundamental care needs are met as outlined in the care plan
- (All areas) Beds not open to fully funded number - state number not staffed and reason
- (All areas) Elective activity or tertiary emergency referrals declined

- (Maternity Only) Delay of 30 minutes or more between presentation and triage
- (Maternity Only) Full clinical examination not carried out when presenting in labour
- (Maternity Only) Delay of 2 hours or more between admission for induction and beginning of process
- (Maternity Only) Any occasion when 1 midwife is not able to provide continuous one to one care and support to a woman during established labour.
- (Maternity Only) The Midwifery Labour Ward Coordinator has supernumerary status.

Appendix 4 Maternity Staffing Red Flags uploaded onto Trust system January to March 2021

Red Flags for all areas	January	February	March
	Total	Total	Total
Staff moved between specialty areas	73	75	103
Supernumery workers within the numbers	2	8	1
Administrative or Support staff unavailable	0	0	0
Staff unable to take recommended meal breaks	0	7	2
Staff working over their scheduled finish time	18	6	21
Delays in answering call bells	0	0	0
Delay of more than 30 minutes in providing pain relief	0	0	0
Delay or omission of regular checks on patients to ensure that their fundamental care needs are met as outlined in the care plan	0	0	0
Beds not open to fully funded number - state number not staffed and reason	0	0	0
Elective activity or tertiary emergency referrals declined	0	0	2
Delay of 30 minutes or more between presentation and triage	0	0	0
Full clinical examination not carried out when presenting in labour	0	0	0
Delay of 2 hours or more between admission for induction and beginning of process	10	9	17
Any occasion when 1 midwife is not able to provide continuous one to one care and support to a woman during established labour	0	0	0

6. Appendix C: Spotlight on Maternity

Agenda

- Introduction
- Overview of Activity – what does the landscape look like at OUH
- Case-Mix comparison – how do OUH patients compare to the national average
- Quality and Efficiency Headlines – benchmarked in a table
- Quality and Efficiency Detailed information including outliers
- Positive Messages – where OUH is doing well
- Summary and Conclusion

2 Copyright © Dr Foster | Confidential

HEALTH | dr foster

About Dr Foster

Dr Foster is the leading NHS provider of intelligent analytics and trusted performance improvement partner.

We work with hospitals, CCGs, public health organisations, GP practices, and arm's length bodies (including CQC, NHSE/I), providing healthcare intelligence, risk models and population health analytics.

For GIRFT program we collaborated on their metric methodologies for Obs& Gynae and provide updates.

We remain at the leading edge through strategic partnerships such as with Imperial College.

Our mission is to use data and analytics to support decisions that enable system transformation across healthcare

5 Copyright © Dr Foster | Confidential

HEALTH | dr foster.

Introduction

Healthcare organisations are required to monitor and measure the quality of their maternity services, but measuring quality is complex, and no universal consensus exists on how best to measure it.

It's not always clear what good looks like, due to inconsistent use of

- date ranges and lack of current data
- definitions and use of parameters
- data quality and frontline engagement/understanding.

The clinical spotlight report is designed to bring together high-quality, comparable metrics about NHS obstetrics services in one place for one time period. Allowing you to:

- benchmark against national standards
- identify variation
- support you in pin-pointing areas for improvement in the care of women and babies.

This aligns with the 'Better births-Improving outcomes of maternity services in England' through allowing improved data visualisation and transparency.

4 Copyright © Dr Foster | Confidential

HEALTH | dr foster.

About the data

The analysis in this report is based on HES data from NHS Digital including the HES maternity tail data.

The data period for this report covers national HES data for the period Oct 2019 to Sept 2020 with additional trends included to cover a 3-year period from Oct 2017 to Sept 2020. Any readmission data is derived for the data period July 2019 to Jun 2020.

Data used in the report is based on the four key national data repositories and methodologies including HES, NMPA-RCOG and GIRFT.

Some of the metrics have their own data quality standards as per specific methodologies (GIRFT) and this means that there are a couple of metrics which we have been unable to calculate reliably for this data period due to missing records – these are highlighted.

Data Source: Hospital Episode Statistics (HES) - Admitted Patient Care. Copyright © 2019, re-used with the permission of NHS Digital. All rights reserved.

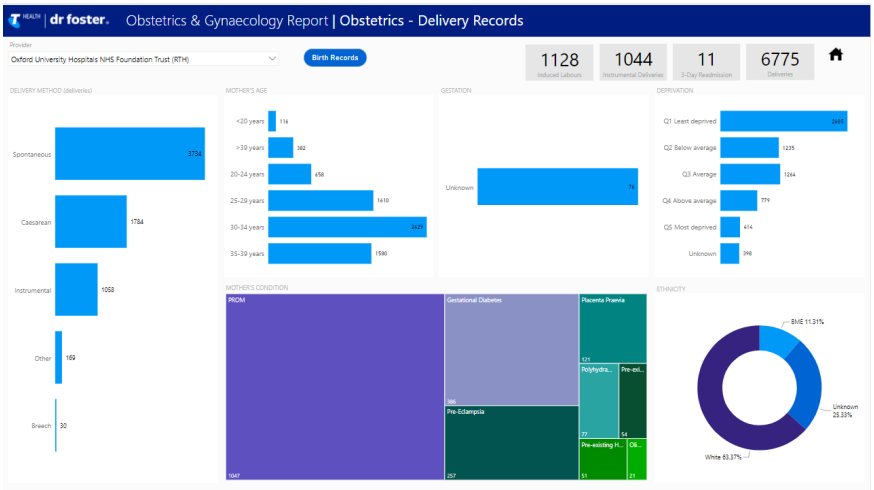
Activity Summary – delivery records

The Trust reports 6775 deliveries in the 12 month period

- 3734 = spontaneous vaginal deliveries.
- 1784 = caesarean section
- 1058 = instrumental deliveries

- 36% (2429) of mothers are aged 30-34yrs
- 40% of mothers fall into 'least deprived' (i.e most affluent) deprivation quintile
- 63.4% of mothers identify as 'white' ethnicity

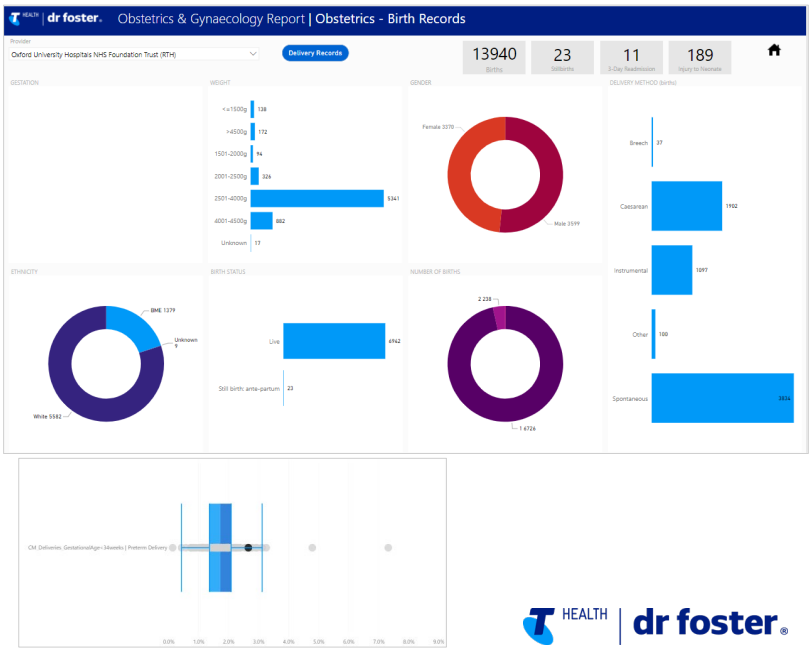
- 15.5% (1047) mothers were diagnosed with Premature rupture of membranes (PROM)
- 5.7% with gestational diabetes
- 3.8% with pre-eclampsia



Activity Summary – birth records

Of the 13940 births per year:

- 5341 (76.6%) babies have a birthweight of 2501-4000g
- 138 (1.98%) babies have a birthweight of <1500g
- 852 (2.66%) of babies are delivered at <34 weeks gestation
- 23 stillbirths have been recorded in the data in the last 12 months



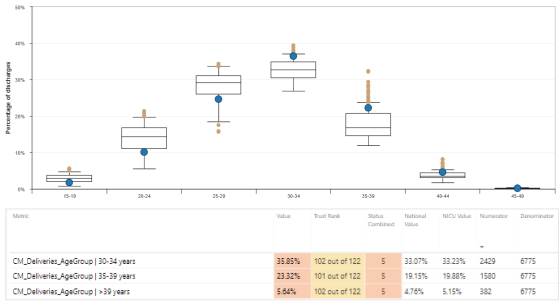
6 Copyright © Dr Foster ¦ Confidential

Case-mix

How do OUH patients compare to the national average…..

Maternal Age

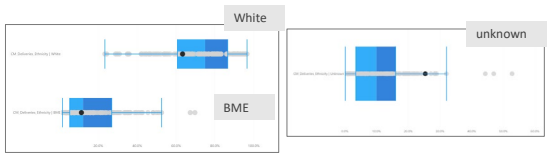
- OUH appears to have older mothers vs. national average
- OUH report 35.85% of mothers being 30-34 years (national average = 33.07%).
- Mothers age 35-39 years account for an overall of 23.3%, (national average of 19%)



Metric	Value	Trust Rank	Status Combined	National Value	NICU Value	Numerator	Denominator
CM_Deliveries_AgeGroup | 30-34 years	35.85%	102 out of 122	5	33.07%	33.23%	2429	6775
CM_Deliveries_AgeGroup | 35-39 years	23.32%	101 out of 122	5	19.15%	19.88%	1580	6775
CM_Deliveries_AgeGroup | >39 years	5.64%	102 out of 122	5	4.76%	5.15%	382	6775

Ethnicity

- OUH records 63.4% of deliveries as ‘white’ ethnicity (national average = 67%)
- 11.31% of records at OUH are coded with an ethnicity of BME. (national average = 21%)
- **25.33% are coded as ‘unknown’** ethnicity which is double the national average rate of 11.83% - this could be data recording issue at OUH?



Metric	Value	Trust Rank	Status Combined	National Value	NICU Value	Numerator	Denominator
CM_Deliveries_Ethnicity | White	63.37%	37 out of 122	2	66.94%	60.24%	4293	6775
CM_Deliveries_Ethnicity | BME	11.31%	59 out of 122	2	21.23%	28.03%	766	6775
CM_Deliveries_Ethnicity | Unknown	25.33%	111 out of 122	5	11.83%	11.74%	1716	6775

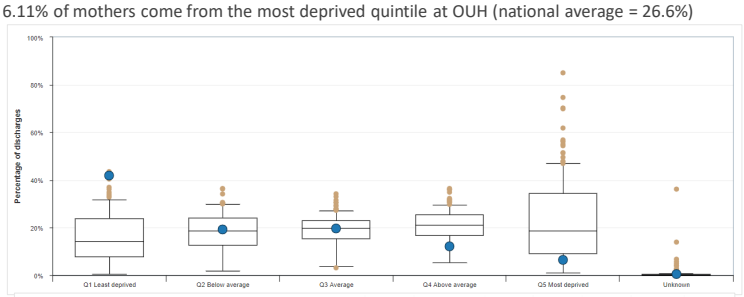
7 Copyright © Dr Foster ¦ Confidential

Case-mix

How do OUH patients compare to the national average…..

Deprivation

- OUH tends to over-index against the 'least deprived' and 'below average deprivation' quintiles. (i.e. mothers are more affluent at OUH than the national average)
- Only 6.11% of mothers come from the most deprived quintile at OUH (national average = 26.6%)



Metric	Value	Trust Rank	Status Combined	National Value	NICU Value	Numerator	Denominator
CM_Deliveries_Deprivation | Q3 Average	18.66%	61 out of 122	3	17.89%	15.86%	1264	6775
CM_Deliveries_Deprivation | Q4 Above average	11.50%	10 out of 122	1	20.20%	19.42%	779	6775
CM_Deliveries_Deprivation | Q5 Most deprived	6.11%	24 out of 122	1	26.64%	35.34%	414	6775

7 Copyright © Dr Foster ¦ Confidential

HEALTH | dr foster

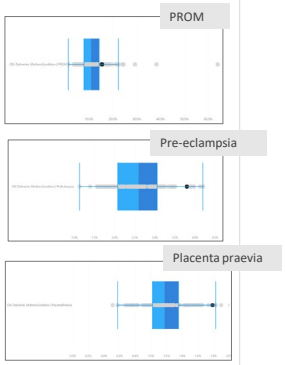
Case-mix

How do OUH patients compare to the national average…..

Mothers Condition

- The conditions data coded to the mother, show that OUH mothers tend to over index for PROM, Pre-eclampsia and placenta praevia
- OUH under indexes for gestational diabetes, abnormal fluid volume, polyhydramnios and oligohydramnios

Metric	Value	Trust Rank	Status Combined	National Value	NICU Value	Numerator	Denominator
CM_Deliveries_MothersCondition | PROM	15.45%	98 out of 121	5	12.12%	12.69%	1047	6775
CM_Deliveries_MothersCondition | PreEclampsia	3.79%	110 out of 121	5	2.62%	2.77%	257	6775
CM_Deliveries_MothersCondition | PlacentaPraevia	1.79%	115 out of 121	5	1.24%	1.32%	121	6775
CM_Deliveries_MothersCondition | GestationalDiabetes	5.70%	25 out of 121	1	8.72%	8.71%	386	6775
CM_Deliveries_MothersCondition | AbnormalFluidVolume	1.45%	21 out of 121	1	3.04%	2.69%	98	6775
CM_Deliveries_MothersCondition | Polyhydramnios	1.14%	36 out of 121	2	2.09%	1.94%	77	6775
CM_Deliveries_MothersCondition | Preexisting diabetes	0.80%	61 out of 121	3	0.88%	1.01%	54	6775
CM_Deliveries_MothersCondition | PreexistingHypertension	0.75%	76 out of 121	3	0.75%	0.85%	51	6775
CM_Deliveries_MothersCondition | Oligohydramnios	0.31%	14 out of 121	1	0.95%	0.76%	21	6775



7 Copyright © Dr Foster ¦ Confidential

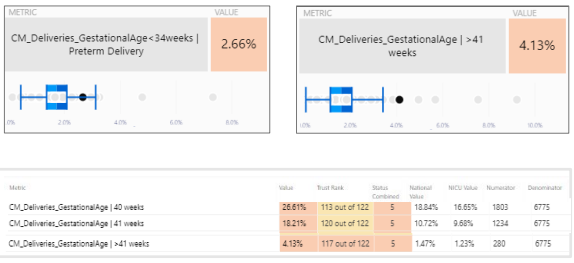
HEALTH | dr foster

Case-mix

How do OUH patients compare to the national average…..

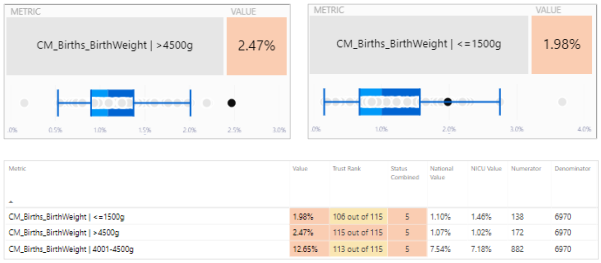
Gestational Age

- OUH tends to have higher percentages of pre-tern <34 weeks gestation babies (2.66%) vs. the average Trust (1.57%)
- The >41 weeks gestation group makes up 4.1% (280) of women delivering at OUH (national average = 1.47%).



Birthweight

- OUH has a higher percentage of neonates born with a birth weight of > 4500g at 2.47% vs. national average of 1.07%
- The Trust also over indexes against low birthweight of <= 1500g with 1.98% of babies at OUH being <= 1500g (vs. 1.1% nationally and 1.46% NICU peer average)



7 Copyright © Dr Foster ¦ Confidential

HEALTH | dr foster

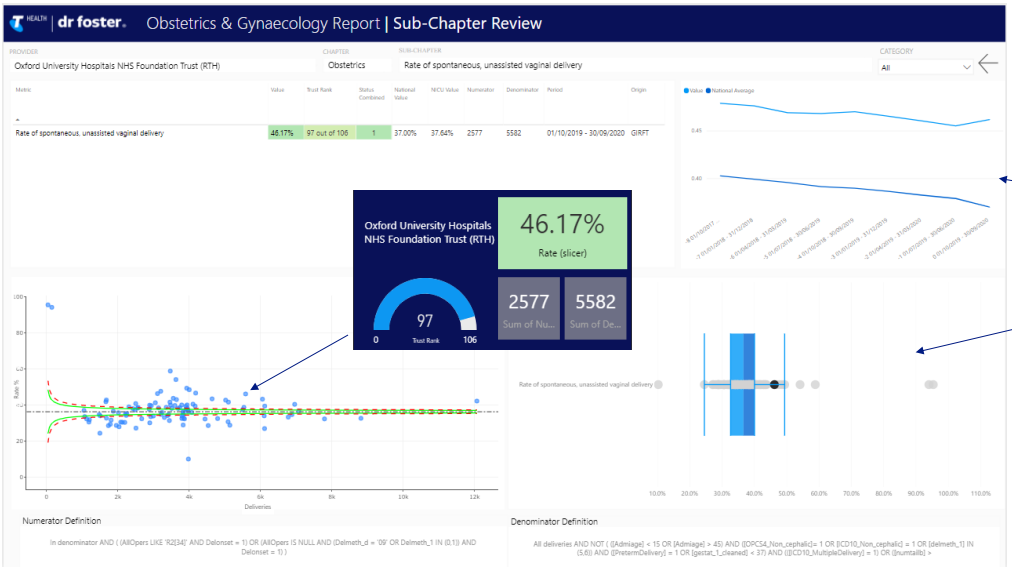
Headlines at a glance

Maternity Headline Metrics (Oct 19 to Sept 20)	Oxford University Hospitals NHS Foundation Trust (%)	National Average (%)
Total Number of deliveries	6775	
Rate of spontaneous unassisted vaginal delivery	46.17	37.00
Rate of instrumental delivery	19.08	15.68
Porportion of instrumental deliveries where ventouse used	18.20	40.59
Proportion of instrumental deliveries where forceps used	81.80	59.44
Rate of pre-labour caesarean section delivery (primiparous)	2.03	5.76
Rate of pre-labour caesarean section delivery (multiparous)	14.60	16.13
Rate of spontaneous labours resulting in emergency c/s: primiparous	5.26	6.68
Rate of spontaneous labours resulting in emergency c/s: multiparous	10.99	12.82
Rate of women with a primary caesarean section who delivered their second baby vaginally	60.16	55.94
Rate of induced labours	29.89	42.60
Rate of Episiotomy carried our during vaginal deliveries	24.79	22.32
Rate of third and fourth degree tears	3.34	3.07
Rate of 3 day Emergency readmissions; mother	0.16	0.15
Rate of puerperal sepsis within (42 days)	3.56	3.46
Neonatal: rate of perinatal mortality	0.54	0.50
Preterm delivery <34 weeks	2.66	1.57
Neonatal diagnoses: rate of selected neonatal infections*	2.37	2.82
Neonatal diagnoses: rate of brachial plexus injury	0.10	0.07
Neonatal complication: rate of hypoxic-ischaemic encephalopathy (HIE)	0.21	0.19
Neonatal diagnoses: rate of 3 day emergency readmission	1.39	2.25
Obstetric diagnoses: % complication of care	0.71	0.47
Obstetric diagnoses: % emergency readmissions within 28 days	4.25	2.76
Obstetric diagnoses: % LOS outliers	6.57	5.21

8 Copyright © Dr Foster ¦ Confidential

HEALTH | dr foster

Rate of spontaneous unassisted vaginal delivery



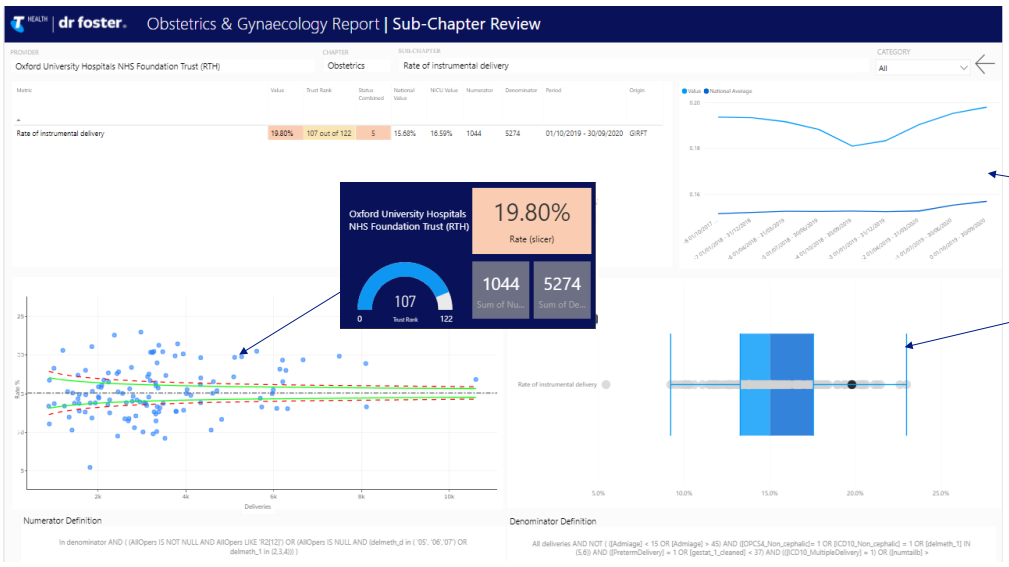
The SVD rate is reducing over the last 3 year period but in line with a national reducing trend. OUH SVD rate is consistently higher than the national average

The rate of 46.17% vs. national average of 37.64% puts OUH in top quartile nationally

 Copyright © Dr Foster ¦ Confidential

HEALTH | dr foster

Rate of instrumental delivery



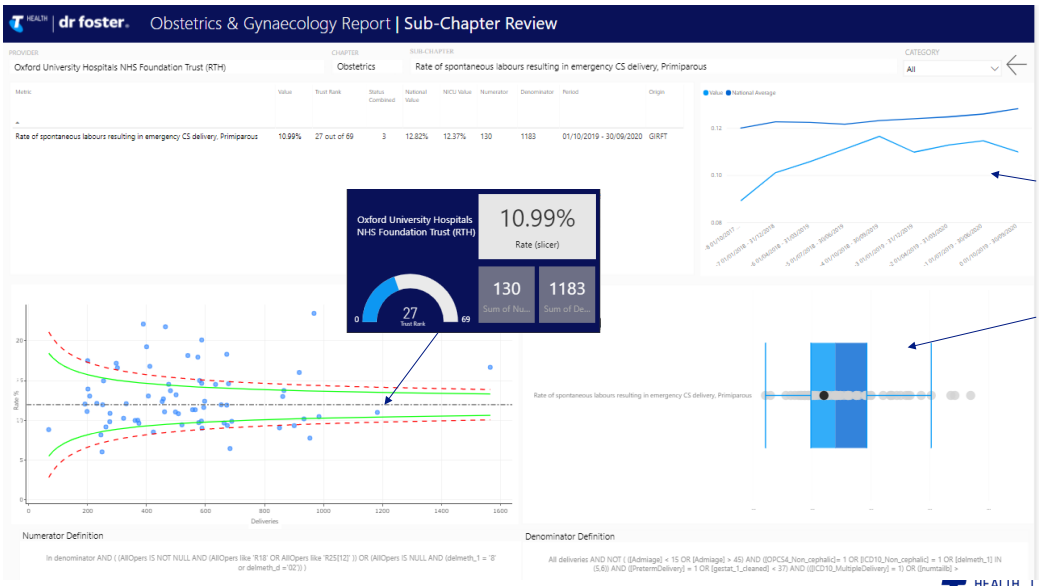
The overall instrumental delivery rate at OUH has been consistently higher than average over the last 3 years. A notable rise has been seen over the last 18 months

The rate of 19.8% vs. national average of 15.68% puts OUH in the top quartile nationally

 Copyright © Dr Foster ¦ Confidential

HEALTH | dr foster

Rate of spontaneous labours resulting in emergency c/s (primip)

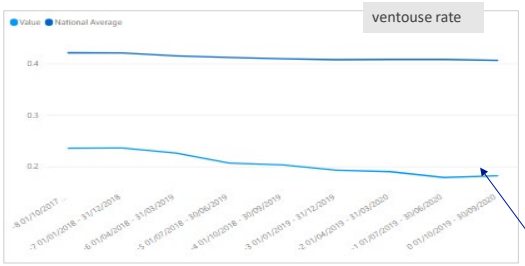


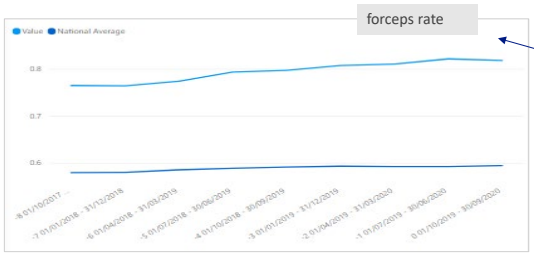
The overall rate at OUH has been consistently lower than average over the last 3 years. A notable rise has been seen over the last 3 years but still remains lower than the national average

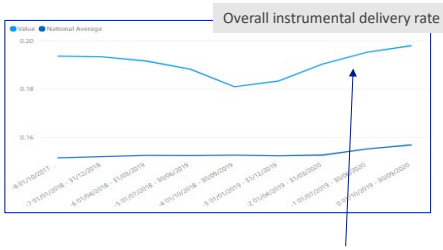
The rate of 10.99% vs. national average of 12.82% puts OUH in the lower end of the interquartile range

9 Copyright © Dr Foster ¦ Confidential

Instrumental Delivery: forceps vs. ventouse





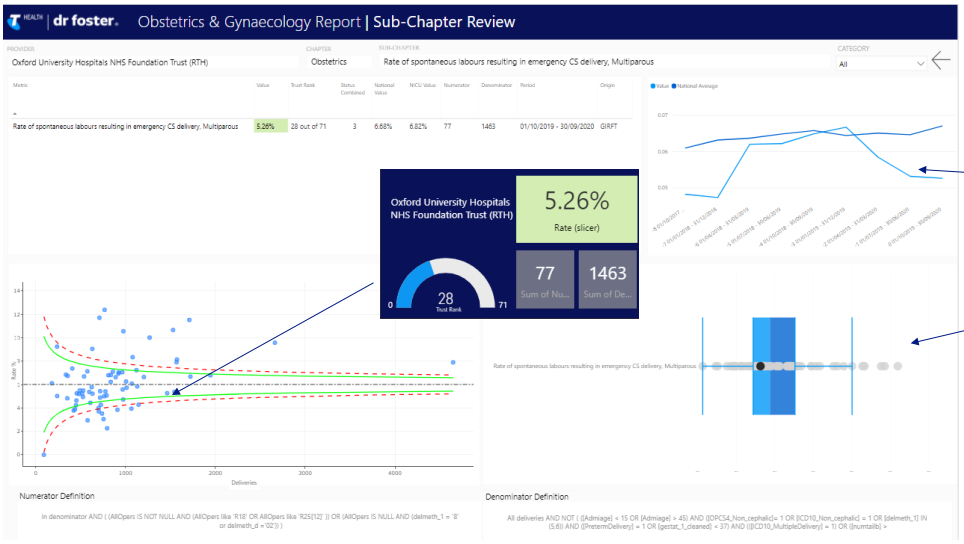


Overall Instrumental delivery rate at OUH is increasing.

Looking at the breakdown of ventouse to forceps delivery it can be seen that over the last 3 years OUH seems to be increasing the preference for forceps delivery over ventouse

9 Copyright © Dr Foster ¦ Confidential

Rate of spontaneous labours resulting in emergency c/s (multip)



The overall rate at OUH has risen and then fallen over the last 3 years quite dramatically compared to the national average – has policy/recording changed?

The rate of 5.26% vs. national average of 6.68 % puts OUH in the lower end of the interquartile range

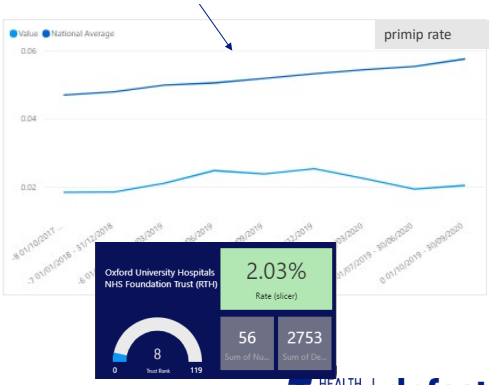
HEALTH | dr foster

Pre-labour caesarean section delivery

Both multip and primp rates of pre-labour caesarean section are lower than the national average. The primip rate has been reasonably stable. The multip rate is increasing over the last 3 years but remains lower than the national average

The multip rate appeared to be increasing. The rate is currently 14.06% vs. national average rate of 16.13%.

The primip pre-labour CS rate remains stable with a rate of 2.03% vs. national average of 5.57%)



HEALTH | dr foster

Overview of delivery type trends

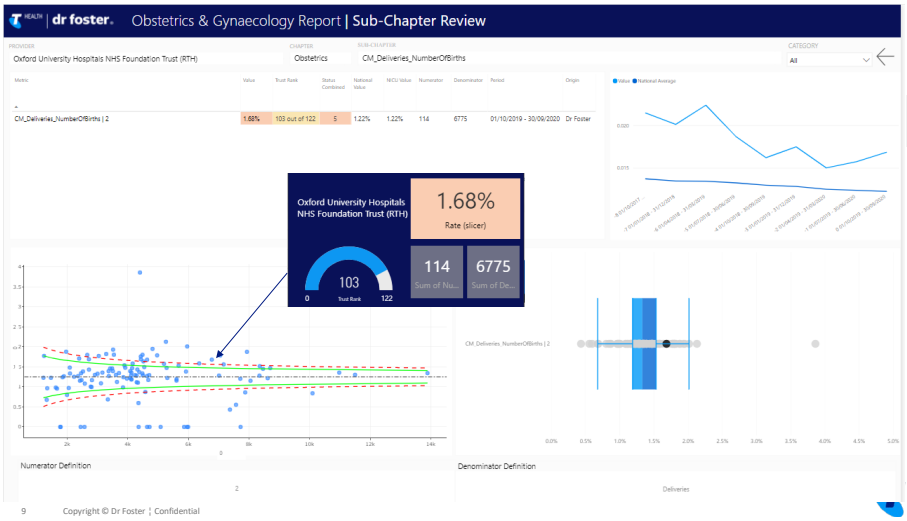
Overall at OUH SVD rate and instrumental delivery rates are consistently higher than the national average with all C/S rates being consistently lower than the national average. A notable change in increasing instrumental delivery is noted over the last 18 months which does correlate with a marked reduction in the emergency C/S rate for multips (primips?)

9 Copyright © Dr Foster ¦ Confidential

HEALTH | dr foster®

Twins

OUH has an elevated number of twin births reported compared to the national average. Overall, the national rate is decreasing and OUH is also decreasing, but OUH has seen two peaks and looks to be rising in the latest quarter.



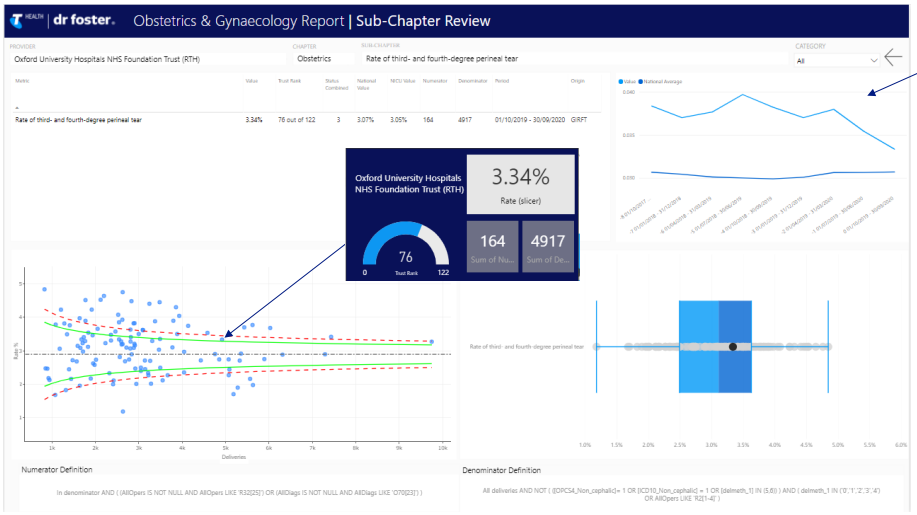
OUH rate = 1.68% (national average = 1.22%)

9 Copyright © Dr Foster ¦ Confidential

HEALTH | dr foster®

Third and fourth degree tears

This metric was developed by GIRFT and incorporates a number of relevant ICD10 codes and OPCS4 codes across the spell. Overall the Trust performs within an expected range for this metric with a rate of 3.34% compared to a national average rate of 3.07%.

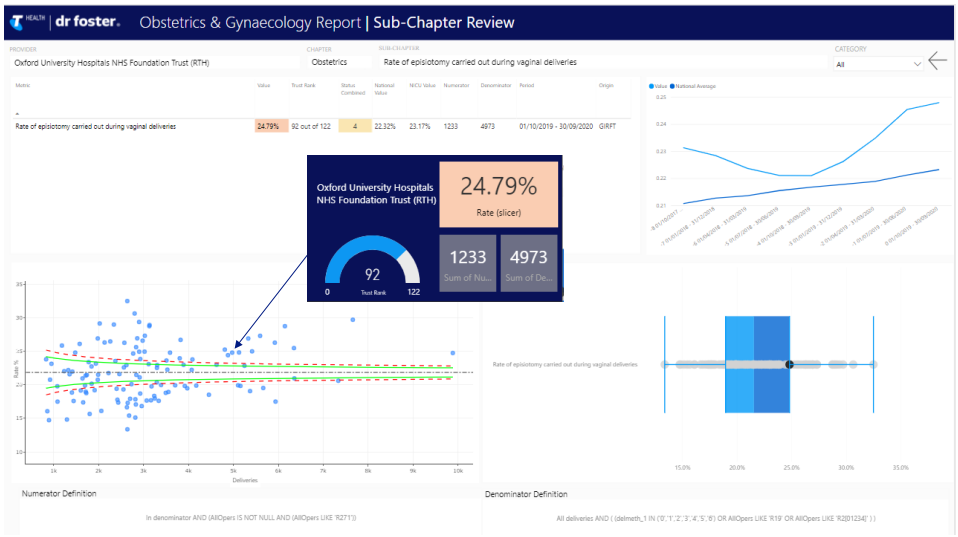


The trend shows that the Trust has decreased tears steadily over the last 3 years but remains higher than average

It is also worth noting that the episiotomy rate is rising and is now higher than the national average (see next slide)

9 Copyright © Dr Foster ¦ Confidential

Episiotomy

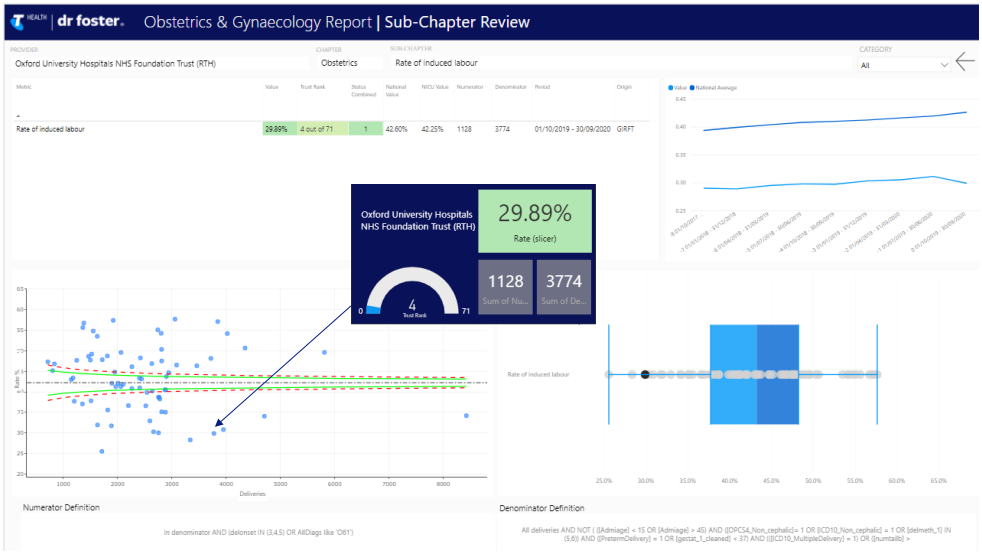


The Trust rate of episiotomy is high at 24.79%
(national average = 22.32%)

The episiotomy trend, after a period of reduction, has started to increase in the last 18 months. This does correlate with the decline in third and fourth degree tears over the same period.

9 Copyright © Dr Foster ¦ Confidential

Induction of labour



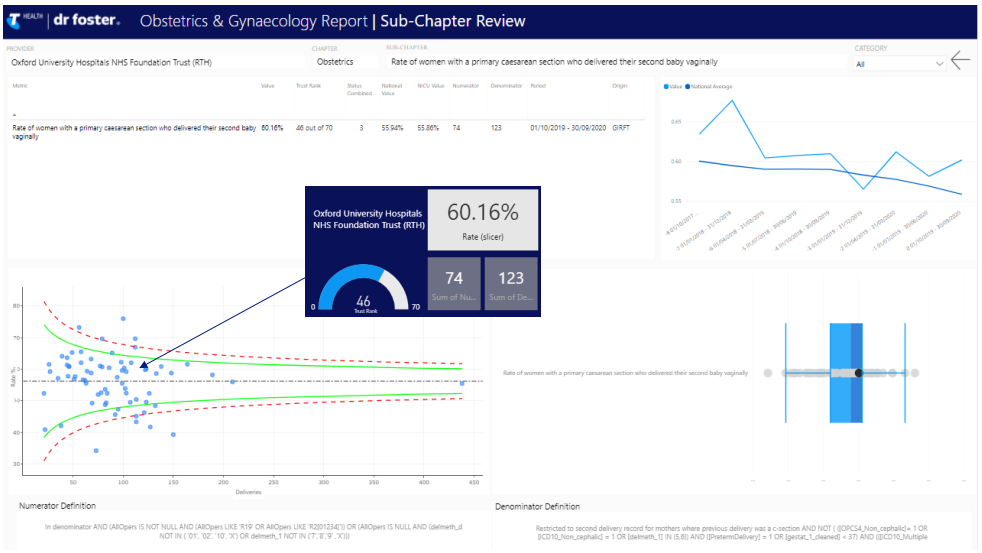
This indicator is a GIRFT metric. The findings show that OUH has a lower induction of labour rate than both the national average and NICU peers.

The Trust induction rate is in the lower quartile nationally and the tend is consistently below average rate

9 Copyright © Dr Foster ¦ Confidential

HEALTH | dr foster.

VBAC second baby



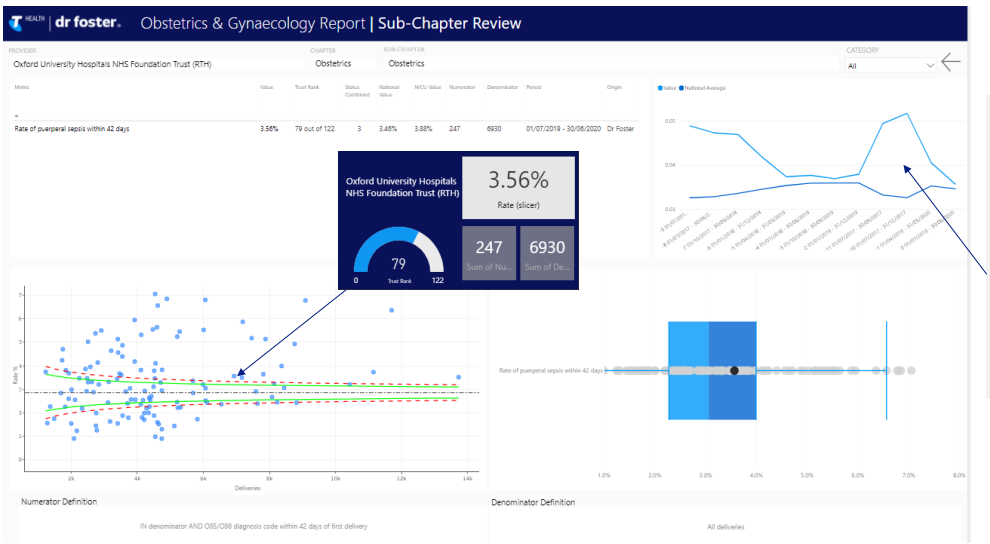
The Trust rate for rate of women with a primary C/S who deliver their second baby virginally is 60.16% which is in-line with the national average of 55.9%.

Both OUH and the national trend is declining with fewer babies being born vaginally than three years ago

9 Copyright © Dr Foster ¦ Confidential

HEALTH | dr foster.

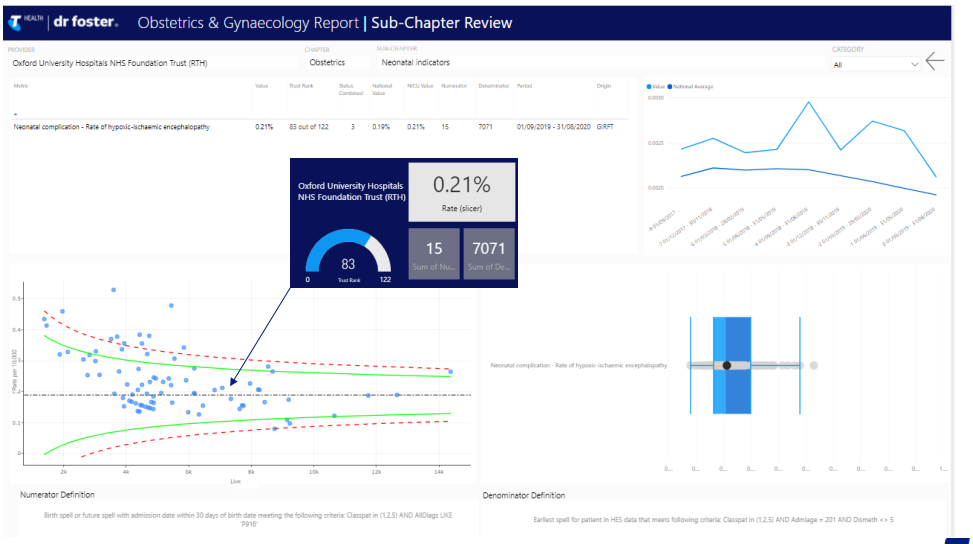
Rate of puerperal sepsis within 42 days



The Trust rate of puerperal sepsis is within the average range at 3.56% (national average = 3.46%).

In the last 12 months it appears that Trust has had a spike in puerperal sepsis which has now resolved, does this resonate with clinicians' experience locally? Could this be a data recording issue?

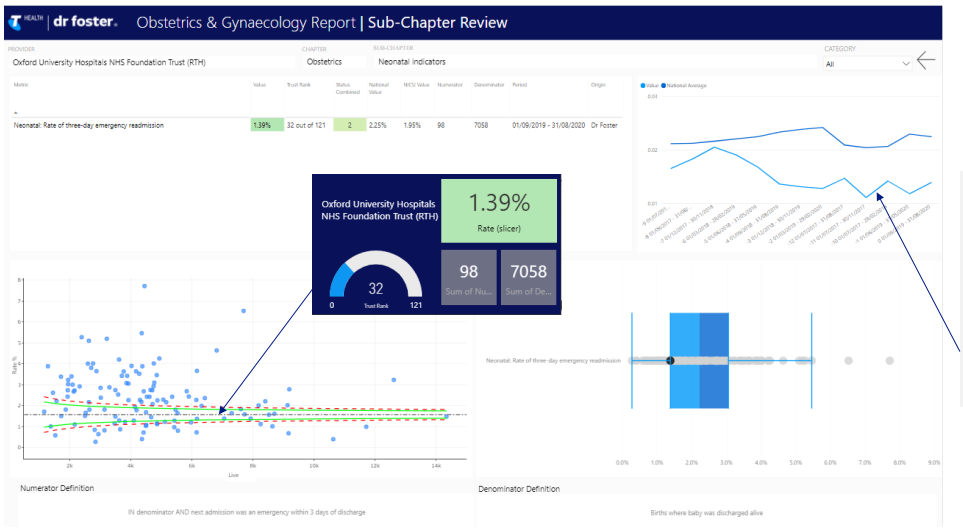
Neonatal indicators: Rate of hypoxic-ischaemic encephalopathy



This indicator is a GIRFT metric. The findings show that OUH has an 'as expected' rate of hypoxic-ischaemic encephalopathy at 0.21% vs. national average of 0.19%

The trend reveals that OUH has been consistently slightly higher than the national average over the last 3 years for this metric. But is in line with the NICU peer group average of 0.21%

Neonatal indicators: Rate of 3 day emergency readmissions

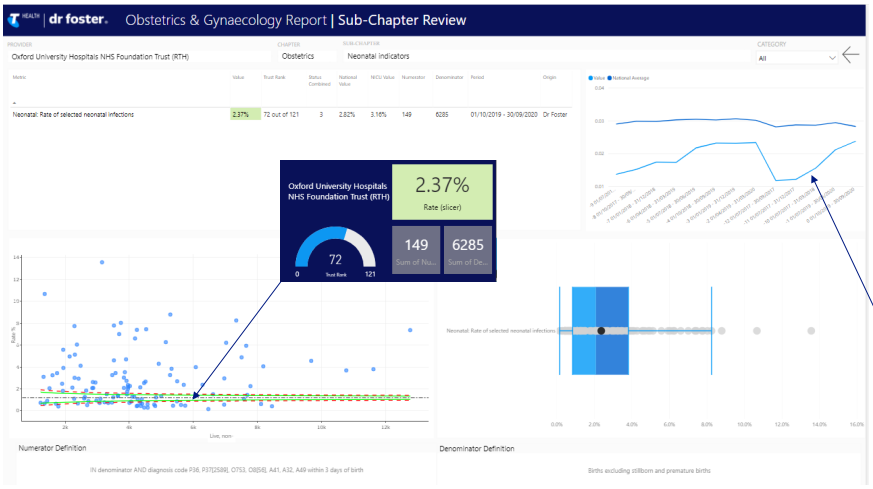


This measure assesses births were baby was discharged alive and the baby went on to have an emergency readmission within 3 days

The trend below shows that OUH has been consistently lower than the national average over the past 3 years and is declining.

9 Copyright © Dr Foster ¦ Confidential

Neonatal indicators: Rate of selected neonatal infections

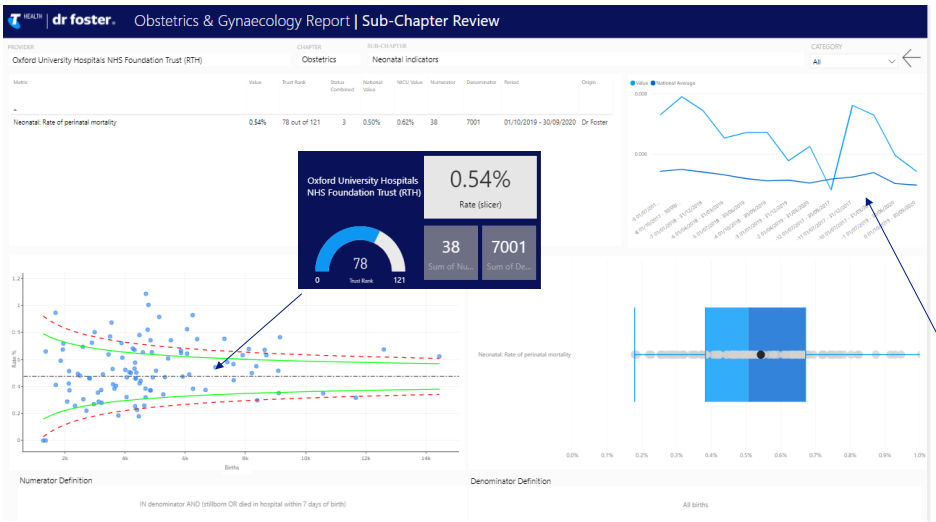


This measure is designed to identify specific neonatal infections, which are reported in neonates within 3 days of birth and include Listeriosis, Other sepsis, Bacterial infection of unspecified site, and Bacterial sepsis of new-born after a single spontaneous vaginal delivery.

The trend below shows that although OUH have been consistently lower than the national average over the past 3 years, in the last 12 months the rate has been steadily increasing. This sudden change may be worthy of further investigation (could this be a result of change in reporting or practice?).

9 Copyright © Dr Foster ¦ Confidential

Neonatal indicators: Rate of perinatal mortality



This measure assesses births from all deliveries who were either stillborn or died in hospital within 7 days of birth

The trend at OUH is consistently higher than the national average which is likely due to the NICU level 3 status but the trend is reducing. There was a peak around a year ago which has now come down.

OUH rate is 0.54% vs. NICU rate of 0.62% (national average is 0.50%)

 Copyright © Dr Foster ¦ Confidential

There are some clear positive messages within the data to focus on:

- The Trust performs well over the majority of indicators despite being a busy multi-sited organisation, a tertiary referral centre and a NICU level 3
- The data overall shows a good depth of coding within the delivery and birth record (however shows higher 'unknown' ethnicity coding which may be a data collection issue).
- The overall rate of babies born vaginally (spontaneous unassisted vaginal deliveries and vaginal instrumental deliveries) is higher than the national average
- The rate of elective and emergency caesarean section is lower than the national average
- The third and fourth degree rate is reducing at OUH
- Maternal and Neonatal emergency readmissions are low
- Perinatal mortality rates are low

 Copyright © Dr Foster ¦ Confidential

Summary and conclusion

Overall the Trust performs well against the majority of metrics and compared to the national average.

- The Trust has a case-mix of mothers who tend to be of older, more affluent and less ethnically diverse than the national average.
- The Trust tends to over-index against both very low birthweight/short gestational age babies but also 40 and 41 week gestation and >4500g babies.
- Mothers at OUH tend to have higher rates of PROM, pre-eclampsia and placenta praevia perhaps likely due to the tertiary referral status of the Trust.
- Despite being a tertiary referral unit, the vaginal delivery rate at OUH is higher than average and the caesarean section rate is lower than average.
- However, both the third and fourth degree tears rate and the episiotomy rate are higher than the national average. ¾ degree tears are reducing but this correlates with a rise in episiotomy rate. Would a further investigation of perineal management be advantageous?
- The neonatal death rate appears to be in line with the national average and lower than NICU peers despite being a centre for more complex mothers and babies

Copyright © Dr Foster ¦ Confidential