

Review of Maternity Services 2007

SCORED ASSESSMENT

Queen Elizabeth Hospital Kings Lynn
NHS Trust (The)

COMP. SET: England
YEAR(S): 2007
DATABASE: mt_dbasev46.xls

About this report

The review of maternity services is a stand-alone component of the Healthcare Commission's annual health check. This report summarises the results for your chosen trust and includes details of the scoring methodology, together with the rationale for and definition of each indicator.

Background

The indicators included in the scored assessment are chosen so that they:

- cover the key issues in the performance framework for the topic, including value for money
- include areas where trusts are improving and developing and where performance variations are wide so that the poorer performers can learn from the levels achieved by the best.

For more details about the background to the review go to:

<http://www.healthcarecommission.org.uk/serviceproviderinformation/reviewsandstudies/servicereviews/ahpmethodology/maternityservices.cfm>

Organisations that are assessed

All English trusts (as constituted at the end of April 2007) that directly provided obstetric services as part of their maternity service were eligible for scoring and are included. There are two acute trusts providing maternity services only in midwifery units which were not matched with another acute trust to form a combined unit (see below) for scoring, so they are excluded because they do not meet the criteria for inclusion (only part of the assessment framework would be relevant to them).

Where the maternity service is provided by more than one organisation for a community, a score has been produced and presented for the community served. This approach has been taken for two communities where a PCT runs a midwifery delivery unit and an acute trust runs other obstetric and midwifery delivery units in the same area. Where two trusts are being assessed together data has been combined and then scored. Where PCTs provide some of the antenatal care, the trusts providing the intrapartum care were asked to include information on these services in their data.

Scoring methodology

The full scoring methodology is set out in a separate document (Scoring the Maternity Service Review, Policy statement, August 2007) which can be found on the review webpage (see link above). This section is a summary of that and references are made to it where more detail is available. Readers who wish to gain a deeper understanding of the principles underlying scoring should refer to this document.

The assessment framework

The scored indicators are set within an assessment framework grouped under the three themes, 'clinical focus', 'women centred care' and 'efficiency and capability' (see below), each of which is given equal weight in the final scoring. Questions are used throughout the assessment framework to help provide clarity about the scope of what is being considered. Thus an indicator can be presented as an answer or part answer to a question. Building the assessment framework around these themes ensures the assessment is balanced.

Does the Trust provide a high quality value for money maternity service?	OVERALL ASSESSMENT Average Score	Excellent 3.287
---	--	--------------------

Score (out of 5)

<u>Clinical focus</u> Does the trust have strong processes and practices to ensure the maternity service is safe and effective?	Theme Assessment	3.5
Are there high standards of antenatal monitoring?	Indicator 1: Women not receiving NICE recommended number of antenatal appointments	3
How effective is the test and screening programme?	Indicator 2: Availability of NICE recommended screening	3
Are there appropriate levels of intervention during delivery?	Indicator 3: Appropriate use of caesarean sections	3
Are there good outcomes from delivery?	Indicator 4: Maternal Morbidity	3
Are there high standards of post-natal care?	Indicator 5: Postnatal care of women and babies	4
Is there adequate service provision for additional needs?	Indicator 6: Progress on implementing Mental Health NICE guidance	5
Do staff have adequate training and recent experience?	Indicator 7: Extent that staff are trained in core maternity skills	3
Does the trust have a strong Safety culture?	Indicator 8: Teamworking and Supervision	4

<u>Women Centred Care</u> Are women informed, counselled and supported to ensure that they have a positive maternity experience?	Theme Assessment	3.25
How readily can women access maternity care and information?	Indicator 9: Average time between first making contact and booking appointment	3
How much choice do women have in how their antenatal care is provided?	Indicator 10: Choice and continuity for antenatal care	3
How much choice do women have for tests and scans?	Indicator 11: % Women offered an informed choice for screening tests	3
Do antenatal classes meet women's and their partners' needs?	Indicator 12: % of women attending NHS antenatal classes who wanted to	2
How much choice do women have in the delivery of their babies?	Indicator 13: Extent of choice in labour	3
How well are women supported to care for their babies?	Indicator 14: Support for infant feeding	3
How effective is the discharge process?	Indicator 15: Quality of support in caring for the baby after discharge	5
Are stakeholders engaged effectively to help improve services?	Indicator 16: Stakeholder involvement in service planning and evaluation	4

<u>Efficiency and Capability</u> Is there adequate funding to provide an acceptable service and are management and improvement processes ensuring women get the best care for the money spent?	Theme Assessment	3.111
Is there adequate staffing?	Indicator 17: Staffing levels Indicator 18: Integration of support workers	4 2
What is the cost per delivery?	Indicator 19: Average cost per delivery Indicator 20: Delivery of hospital based antenatal care	4 2
What is the capacity to record activity and plan?	Indicator 21: Data quality	4
Are there adequate facilities and are service configured to use these effectively?	Indicator 22: Appropriate involvement of obstetricians and midwives in antenatal care Indicator 23: % women who considered their length of stay was about right Indicator 24: Homeliness of delivery rooms Indicator 25: Women's view of cleanliness of delivery and postnatal areas	2 5 2 3

Scoring individual indicators

Each indicator is scored on a scale of 1 to 5 with 1 representing poor performance and 5 the best performance. Indicators are built to use the full scoring range so all indicators have an equal weight within the assessment framework. A score of 3 is set to represent the acceptable level of performance where standards exist and an average performance otherwise.

There are 25 scored indicators in the review, enough so that if one indicator is not robust for a particular trust its overall effect will be small, but not too large to over complicate the framework and run the risk of duplicating key issues. Where possible absolute thresholds have been chosen in preference to those based on relative thresholds for defining indicator scores. These are based on published literature and guidelines, recognised by those delivering maternity services.

Where standards do not exist or are only applicable to part of the scoring (e.g. a basic standard is defined but exceptionally good performance should also be recognised) relative scoring has been based on the following rules applied in the order given:

- 1) Look for logical breaks in the distribution that indicate significant changes in performance so that the threshold relates to a clear change in performance.
- 2) For any remaining thresholds use fixed percentages of the distribution which are based on the principle that a score of 3 represents average performance. These percentages depend on the nature of the indicator and are explained in detail in 'Scoring the Maternity Service Review, Policy statement, August 2007'. Once these percentages are established, a further check is carried out to identify any more logical breaks in performance nearby that should be used in preference, in line with rule 1.

Trusts with missing or invalid data are given the lowest score for the indicator affected. Results for each indicator are given in this report.

Deriving theme scores

Once the assessment framework is in place and each indicator is scored then the indicators in each theme are aggregated by means of an average to give a value on the continuous range from 1 through to 5.

Deriving the overall score for the review

At topic level the theme values are again averaged to provide a value on the continuous range from 1 through to 5. This value is then transformed to give an assessment on a four-point scale - weak, fair, good, excellent as used for other components of the annual health check. The final score thresholds are set taking into account the value for acceptable or average performance and the number of indicators in the assessment framework. These thresholds are fixed prior to inspection of the final distribution of topic scores so that the thresholds are absolute rather than relative. This is done in two stages.

- 1) Given that a score of 3 has been set as acceptable / average performance for each indicator, a trust whose overall review score is 3 or above has performed at or above average. The threshold between fair and good is therefore set at the value of 3.
- 2) The threshold between Fair and Weak for the maternity review is set at 2.74 and between good and excellent is set at 3.26 (see Appendix B of 'Scoring the Maternity Service Review, Policy statement, August 2007' for details).

An assessment of weak implies that the trust is lagging considerably behind other trusts in some key delivery areas. It does not in itself suggest unacceptable practice for the topic as a whole. Some trusts will score poorly for some indicators and highly on others. Similarly those scoring excellent are ahead of other trusts but still have scope for improvement. Some trusts may have been judged as weak predominately because of data completion problems, which prevents us from assessing their services in any other way.

Understanding the results for your organisation

The table on page three sets out the list of scored indicators included and the scores for your chosen organisation. The following pages consider each scored indicator in turn with details of the rationale and definition of the indicator. Your chosen organisation's score for each indicator is given in the indicator title. The charts that follow the definition illustrate the distribution of values or scores for the constituent parts for each indicator. The position of your chosen organisation within most charts is shown by the asterisk below the horizontal axis and the vertical red line. The thin black vertical lines on the chart indicate the boundaries of the scoring bands. In categorical charts the value for your chosen organisation is given with the words 'this site' in brackets against the response that applies to your organisation. Beside or below each chart is additional information that includes:

- *Component indicator value* - your chosen organisation's score on that indicator. If the indicator is applicable but the organisation has failed to provide complete or valid data needed for its calculation, the lowest score for that indicator is awarded, and no data will be presented on the chart or in the component indicator value.
- *Component indicator direction* – the order of the scoring bands from the left to the right of the chart. For example, "5 → 1"-indicates that the highest value of the indicator on the left attracts the highest score of 5.
- *Source of the data* - The Maternity Review Trust Questionnaire, the Survey of Recent Mothers, the National Staff Survey or HES datasets, together with relevant question numbers.

Clinical Focus: Indicator 1 - Women not receiving NICE recommended number of antenatal checks (Score 3)

Rationale

NICE antenatal guidance identifies a baseline schedule for antenatal appointments for women. The number of appointments in this schedule are shown below relative to gestation length.

Gestation length at birth	Minimum appointments for primip	Minimum appointments for multip
37 – 38	7	5
39 – 40	8	6
41	9	6
42 +	10	7

It is important for the health of the mother and the baby that these appointments take place and appropriate care is provided. This indicator tests whether women, who make contact prior to 16 weeks (the time when a series of appointments following booking should start) and who deliver beyond 36 weeks gestation, receive an appropriate number of antenatal appointments.

Measurement and scoring

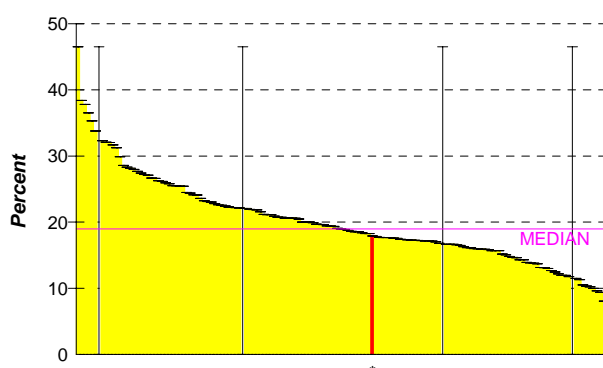
The survey of mothers asked women about the number of appointments in the ranges none, 1-6, 7-9 and 10-14. Hence, it is possible to test for women who clearly did not get the appropriate number of appointments but we cannot precisely test for the number of women who got the appropriate number of appointments.

% Women reporting an inappropriate number of antenatal appointments =
 (Primips who deliver prior to week 42 who had < 7 appointments and those who deliver after week 41 who report less than 10 appointments plus multiples who report no appointments and those delivering after week 41 who report 1 to 6 appointments) / (Women who have made contact) * 100

Exclude women who have not made contact with the service prior to week 16 and / or who deliver before week 37.

Scoring thresholds are set at clear breakpoints where they exist (33) otherwise at standard percentile thresholds for a continuous indicator which are 6.25% (11.54), 31.25% (16.79) and 68.75% (22.08).

Fig 1: Women not receiving NICE recommended number of antenatal checks



Indicator (MTR11A1) value 17.92

Indicator direction 1→5

Source: Survey of recent mothers Question B9

Queen Elizabeth Hospital Kings Lynn vs England

Clinical Focus: Indicator 2 - Availability of NICE recommended screening (Score 3)

Rationale

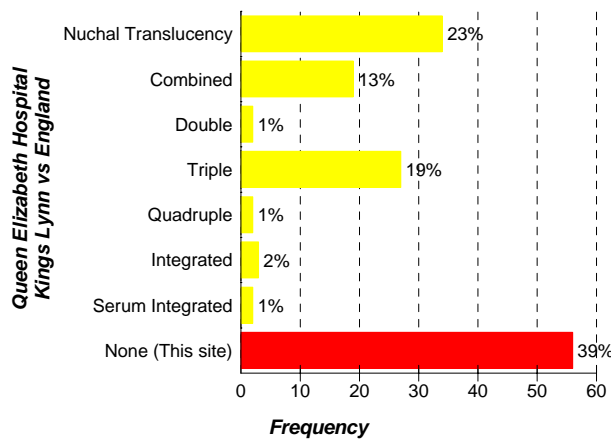
The NICE antenatal guidelines identify that women should be offered both a dating scan and a fetal anomaly scan. The dating scan provides important information that will affect clinical decisions, in particular, induction and timings for screening tests. The fetal anomaly scan allows medical conditions to be detected early and appropriate decisions to be made by the prospective parents and clinicians. Trusts should be encouraging high take-up of scans.

NICE guidance also identifies, based on National Screening Committee guidance, tests with sufficient quality to be used for Down's Syndrome screening and the areas to be explored in the fetal anomaly scan. It is important that trusts offer high quality screening.

Measurement and scoring

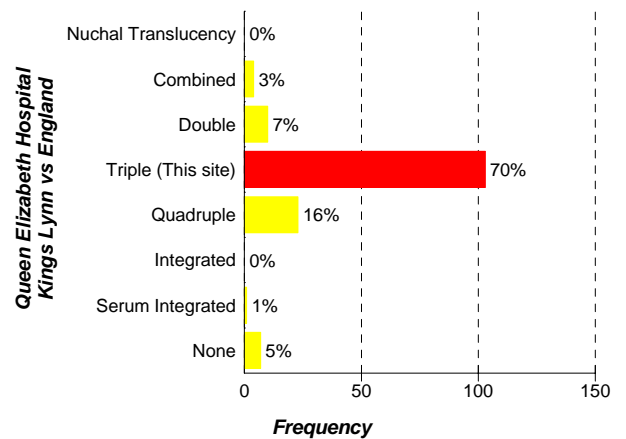
- Start at 1 point
- If the Down's Syndrome test offered to **all** women meets the new criteria of a detection rate above 75% and a false positive rate of less than 3% (the combined test, the quadruple test, the integrated test, the integrated serum test) then add 1 point (see Fig 2a, 2b and 2c)
- If the fetal anomaly scan contains all the 11 items listed in NICE guidance add 1 point (Fig 2d)
- If % women having dating scan (Women reporting they had a dating scan (B18a=1) / Women answering question B18a*100) is greater than or equal to the median (91.82) then add 1 point (Fig 2e).
- If % women having fetal anomaly scan (Women reporting they had an anomaly scan (B19a=1) / Women responding to question B19a*100) is greater than or equal to the median (98.61) then add 1 point (Fig 2f).

Fig 2a: Main Down's syndrome test available prior to 14 weeks



Indicator (MTR12D7) value None
 Source: Trust questionnaire question F4

Fig 2b: Main Down's syndrome test available at weeks 14 to 20

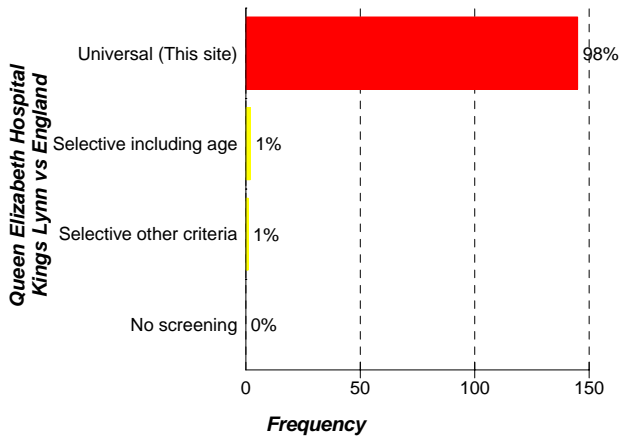


Indicator (MTR12D8) value Triple
 Source: Trust questionnaire question F4

Figures 2a to 2c show the percentage of organisations giving each of the possible responses with the response for your organisation highlighted by the bar showing as a different colour.

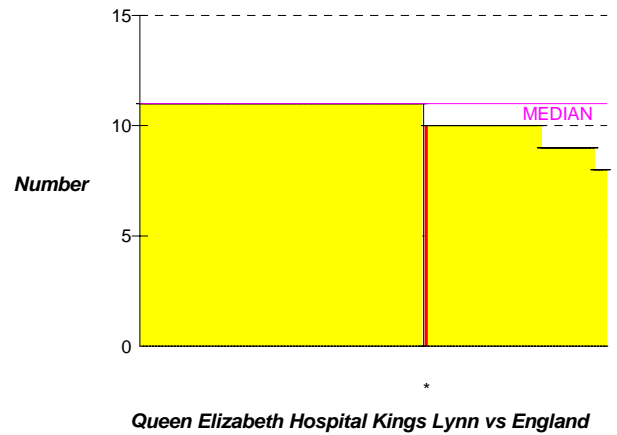
Clinical Focus: Indicator 2 - Availability of NICE recommended screening - Continued

Fig 2c: Extent of women offered Down's syndrome tests



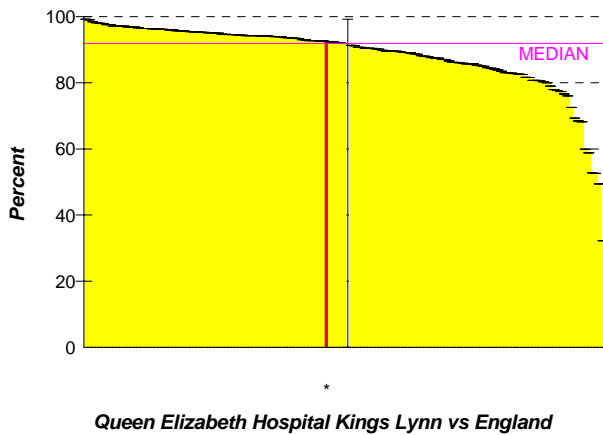
Indicator (MTR12D9) value Universal
 Source: Trust questionnaire question F4

Fig 2d: No. of attributes checked in fetal anomaly scan (max 11)



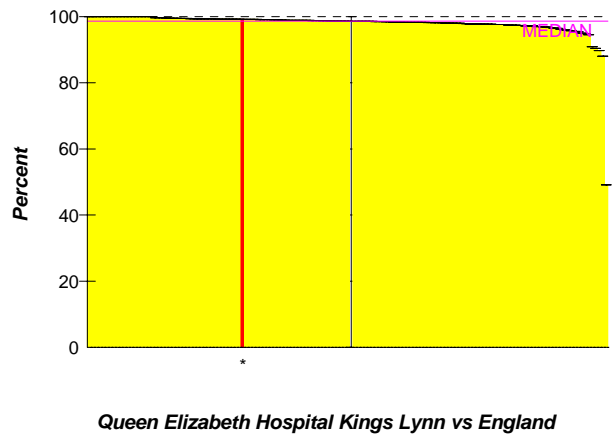
Indicator (MTR12C6) value 10
 Indicator direction 1→0
 Source: Trust questionnaire question F5

Fig 2e: % woman having dating scan in survey



Indicator (MTR12B6) value 92.5
 Indicator direction 1→0
 Source: Mother's survey question B18

Fig 2f: % woman having fetal anomaly scan in survey



Indicator (MTR12C4) value 99.17
 Indicator direction 1→0
 Source: Mother's survey question B19

Clinical Focus: Indicator 3 - Appropriate use of caesarean sections (Score 3)

Rationale

In England there has been an increasing trend in the proportion of women whose babies were delivered by caesarean section. Trusts serve different populations and their caesarean rates may not be directly comparable as it is affected by, for example, ethnicity, age and complicating conditions according to the population served. There are some known interventions which tend to reduce caesarean rates and this indicator considers trust practice in the two areas of; turning breech babies using External Cephalic Version (ECV) and offering vaginal birth to eligible women who have had a previous caesarean. Decisions about caesareans are influenced by a woman's previous history, considering the caesarean rate for primips removes this effect.

Measurement and scoring

- Start at 1 point
- If trust have been able to provide data on vaginal birth after caesarean, ECV turn rates or caesarean rate for primips add 1 point.
- If caesarean rate for a primip ((sum of delivery units non-elective caesarean deliveries for primips + sum of delivery units elective caesarean deliveries for primips) / (sum of units in trust deliveries for primips) *100) is less than or equal to median (24.38) add 1 point (Fig 3a).
- If % women who have previously had a caesarean who have a vaginal birth (vaginal births for women who had had previous caesarean / Women with previous caesarean * 100) is greater than or equal to median rate (31.53) add 1 point (Fig 3b).
- If % of women who are diagnosed with a singleton breech prior to labour who undergo ECV (Breeches identified at 36 weeks and beyond where ECV attempted / Breeches identified at 36 weeks and beyond * 100) is greater than or equal to median (27.09) then add 1 point (Fig 3c)

Fig 3a: % primips having caesarean

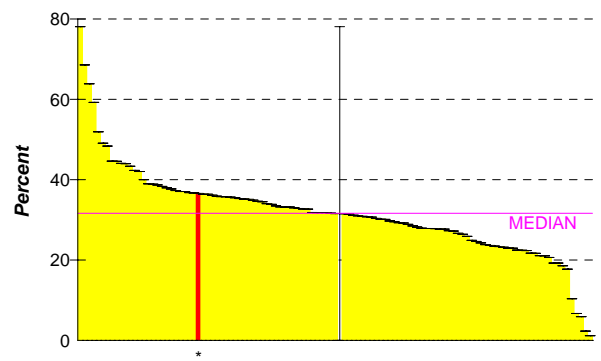


Queen Elizabeth Hospital Kings Lynn vs England

Indicator (MTR14D15) value
Indicator direction 0➔1

Source: Trust questionnaire question Q3

Fig 3b: VBAC (vaginal birth after caesarean) rate

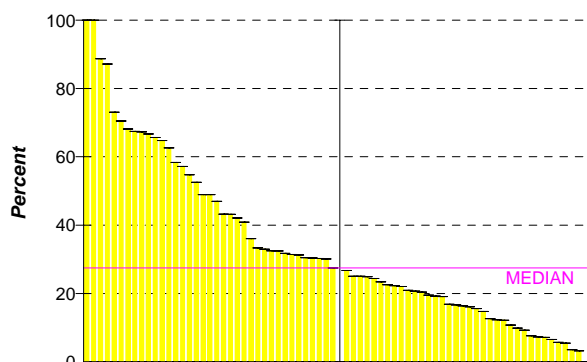


Queen Elizabeth Hospital Kings Lynn vs England

Indicator (MTR14D7) value 36.58
Indicator direction 1➔0

Source: Trust questionnaire question 15

Fig 3c: % singleton breech babies at 36 weeks where ECV attempted



Queen Elizabeth Hospital Kings Lynn vs England

Indicator (MTR14E1) value
Indicator direction 1➔0

Source: Trust questionnaire question 16

Clinical Focus: Indicator 4 - Maternal morbidity (Score 3)

Rationale

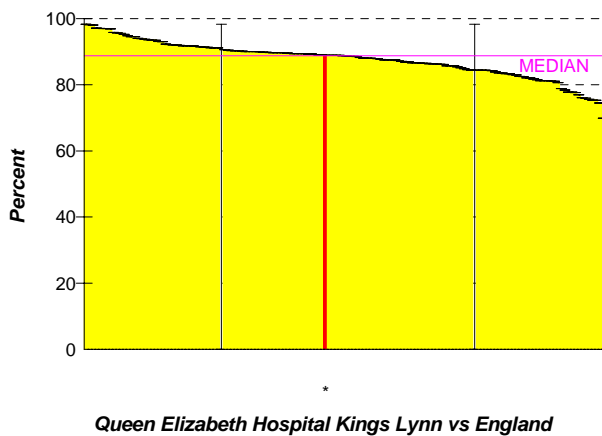
Post-partum haemorrhages can occur, but trusts can better manage the outcomes if they identify women with the highest risk and counsel them on the most appropriate 'birth choices'. Trusts should have appropriate policies and procedures and inclusion of haemorrhage management in 'skills and drills' training.

It is important that all women are made as comfortable as possible after their baby is delivered. It is expected that any perineal tear will be repaired in a timely manner with no women experiencing particularly long waits for suture.

Measurement and scoring

- Start at 1 point:
- If the Percentage of women who received a tear sutured within 1 hour (Number of women who were stitched within 1 hour / Number of women who needed to be stitched *100) is at or above the bottom 25th percentile (84.43) add one point and if its above the 75th percentile (91.11) add a further point (fig 4a).
- If trust has been able to provide data on women with a postpartum haemorrhage of at least 2500ml add 1 point
- If the percentage of women with haemorrhage experiencing excessive blood loss (Women with a postpartum haemorrhage of at least 2500ml) / (Total women delivered) *100) is at or below the median (0.1939) add 1 point (Fig 4b).

Fig 4a: % women with episiotomy or tear sutured in <=1 hour

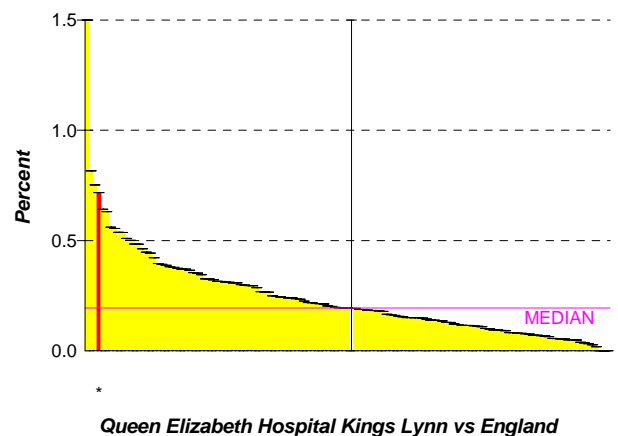


Indicator (MTR15A5) value 88.89

Indicator direction 2→0

Source: Mother's survey question C18

Fig 4b: % Women with a primary postpartum haemorrhage of 2500ml or more



Indicator (MTR15A7) value 0.7178

Indicator direction 0→1

Source: Trust questionnaire question 18, 12

Clinical Focus: Indicator 5 - Postnatal care of women and babies (Score 4)

Rationale

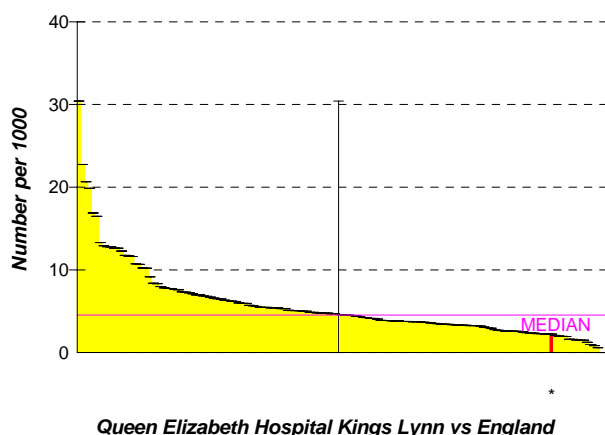
The NSF states that midwifery-led services should provide for the mother and baby for at least a month after birth or discharge. The number of contacts that take place will be dependent on individual need but if the expected minimum number of visits is three then the average for all trusts can be expected to be above three as extra support is given to mothers with additional needs. The level of support required may be expected to change with women's experience so the indicator is standardised for parity. Women's physical and emotional health should be checked prior to discharge from hospital and again at around 6 weeks and a complete examination of the baby should take place within 72 hours of birth. It would be concerning if a significant number of women and / or babies are being re-admitted following discharge.

The majority of women will receive their postnatal care from the same organisation which cared for them during labour and delivery. Where women are discharged into the care of another organisations midwifery service the discharging organisation needs to ensure that both mother and baby are fit for discharge and communicate with the women's local maternity service in a timely manner to ensure appropriate postnatal care is given. Midwifery services should be working closely and co-operatively where there is cross-boundary care to ensure an appropriate level of care is given.

Measurement and scoring

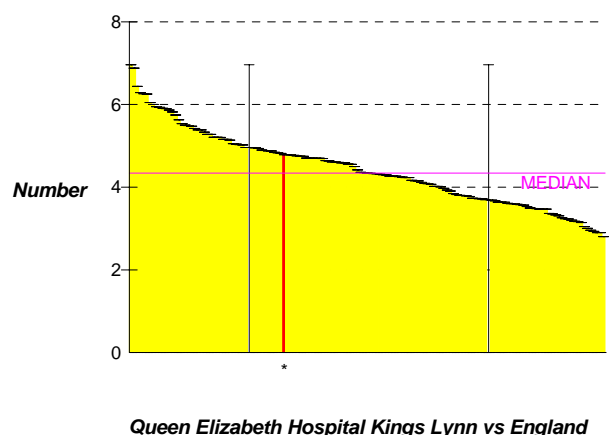
- Start at 1 point
- If re-admission of mothers within 2 weeks of giving birth (Women re-admitted as an emergency to any hospital within 2 weeks of delivering (HES data for April to September 2006) / Women delivering in trust (HES data for April to September 2006) *1000) is less than or equal to 4.57 add 1 point (Fig 5a).
- If contacts with midwives following discharge from postnatal ward (National proportion of primips * Trust average number of midwife contacts for primips + National proportion of multips * Trust average number of midwife contacts for multips) is greater than or equal to the 25th percentile (3.70) add 1 point and if its above the 75th percentile (4.96) add a further point (Fig 5b).
- If admissions of babies at age 2 days or greater with jaundice or hypernatraemic dehydration (Babies with jaundice or Hypernatraemic Dehydration admitted aged 2 days or greater (HES data for April to September 2006) / Babies born in trust (HES data for April to September 2006) *1000) is less than or equal to median (8.12) add 1 point (Fig 5c).

Fig 5a: Women re-admitted within 2 weeks of discharge



Indicator (MTR16B1) value 2.23
 Indicator direction 0→1
 Source: HES

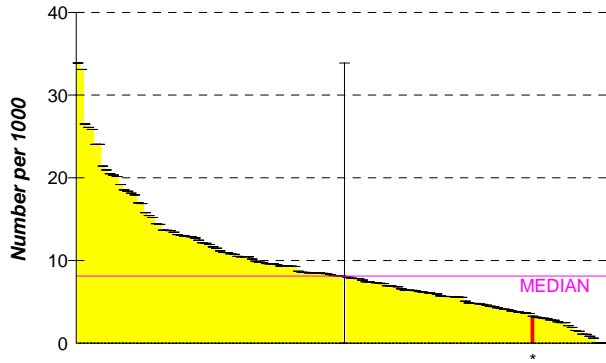
Fig 5b: Average number of contacts with midwife after going home



Indicator (MTR16C9) value 4.788
 Indicator direction 2→0
 Source: Mother's survey question H3, J1 and J2

Clinical Focus: Indicator 5 - Postnatal care of women and babies - Continued

Fig 5c: Babies re-admitted with jaundice or dehydration at 2 days or more



Queen Elizabeth Hospital Kings Lynn vs England

Indicator (MTR16D1) value 3.272

Indicator direction 0→1

Source: HES

Clinical Focus: Indicator 6 - Progress on implementing mental health NICE guidance (Score 5)

Rationale

The importance of identifying and managing psychological health of women was identified in the NSF as being critical to the child as well as the mother. It states that post-natal depression can lead to insecure attachment, cognitive development deficits and affect the psychiatric well-being of the child. Trusts should have sufficient inpatient psychiatric mother and baby treatment capacity. Recent NICE guidance has re-enforced the importance of perinatal mental health services.

Measurement and scoring

Mother and baby unit beds per 1000 deliveries is calculated by using information provided in Trust questionnaire question C4 on nearest mother and baby unit and information obtained from mental health units on the number of places at each mother and baby unit. The beds per 1000 deliveries at the mother and baby unit have been identified and are reported for the trusts identified nearest unit.

- Start at 1 point
- If a specialist perinatal service is available add 1 point and if this includes a psychiatrist add a further point (Fig 6a).
- If booking documentation covers areas identified in NICE guidance (women’s history, family history and women’s current emotional stability) add 1 point (fig 6b)
- If the number of available Mother and baby unit beds per 1000 deliveries at the nearest unit to which the community refers is greater than or equal to median (0.1826) add 1 point (Fig 6c).

Fig 6a: Provider of perinatal mental health service

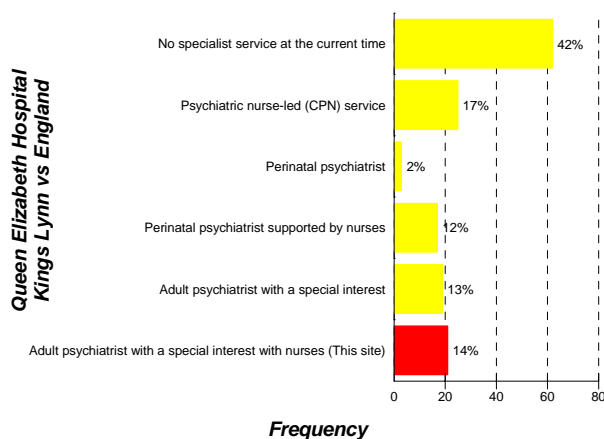
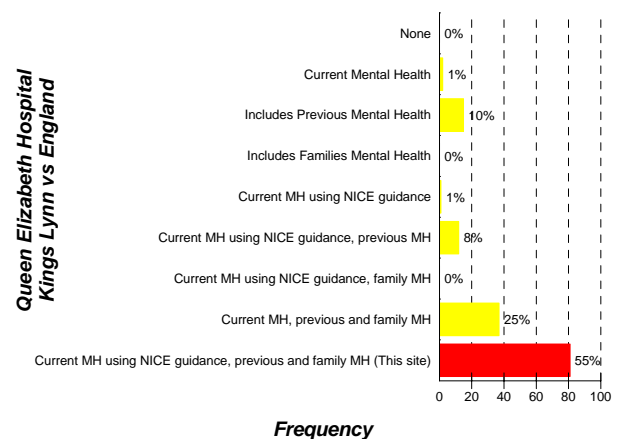


Fig 6b: Mental health subjects covered in booking appointment



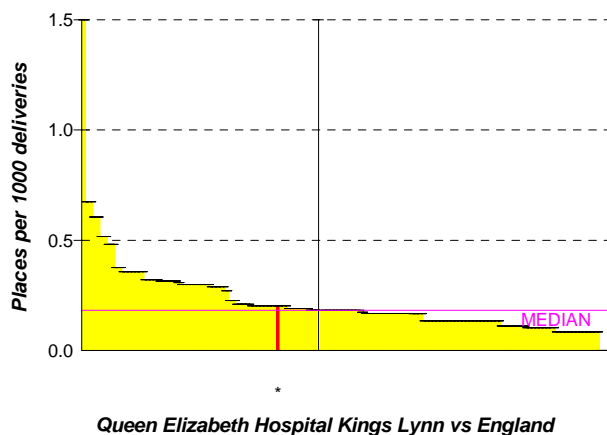
Indicator (MTR17B1) value Adult psychiatrist with a special interest with nurses

Source: Trust questionnaire question C3

Indicator (MTR17A3) value Current MH using NICE guidance, previous and family MH

Source: Trust questionnaire question C5

Fig 6c: Places per 1000 deliveries pa in nearest mother and baby unit



Indicator (MTR17B2) value 0.2022

Indicator direction 1→0

Source: Trust questionnaire question C4

Figures 6a and 6b show the percentage of trusts giving each of the possible responses with the response for your trust highlighted by the bar showing as a different colour.

Clinical Focus: Indicator 7 - Extent that staff are trained in core maternity skills (Score 3)

Rationale

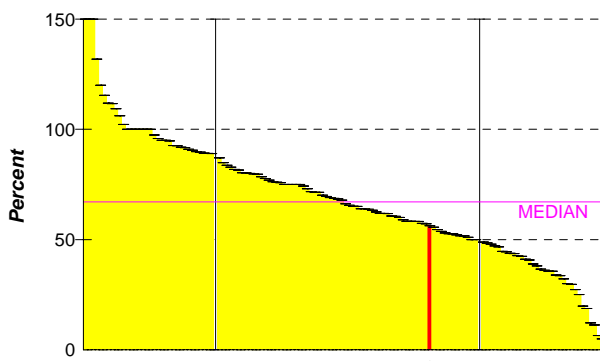
To provide a 'safe service' it is necessary for staff to maintain a level of competency. CNST identifies that staff should attend training on the management of labour, fetal heart rate auscultation and CTG interpretation every 6 months and annual skills drill and appropriate resuscitation training every 12 months.

Measurement and scoring

Trusts should have identified staff who have attended advanced neonatal training as having attended both basic training and advanced training

- Start at 1 point
- If comprehensiveness of obstetrician training (Number of obstetric doctors who have attended training in CTG in the last 6 months + Number of obstetric doctors who has attended training in skills and drills in the last year + Number of obstetric doctors who has attended adult resuscitation training in the last year + Number of obstetric doctors who has attended neonatal resuscitation training in the last year) / (4 * number of obstetric doctors) is greater than the 25th percentile (50) add 1 point and above the 75th percentile (88.02) add a further point (Fig 7a).
- If comprehensiveness of midwives training (Number of midwives who have attended training in CTG in the last 6 months + Number of midwives who has attended training in skills and drills in the last year + Number of midwives who has attended adult resuscitation training in the last year + Number of midwives who has attended neonatal resuscitation training in the last year) / (4 * number of midwives) is greater than 64 add 1 point and above 91.3 add a further point (Fig 7b).

Fig 7a: Extent that obstetricians are trained in core maternity skills



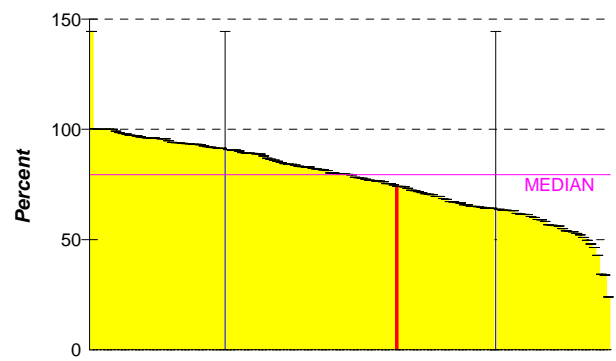
Queen Elizabeth Hospital Kings Lynn vs England

Indicator (MTR18A3) value 56.25

Indicator direction 2→0

Source: Trust questionnaire questions B3, B4

Fig 7b: Extent that midwives are trained in core maternity skills



Queen Elizabeth Hospital Kings Lynn vs England

Indicator (MTR18A4) value 74.11

Indicator direction 2→0

Source: Trust questionnaire questions B3, B4

Note: Score greater than 100% are possible on this indicator as staff retire, resign and are replaced.

Clinical Focus: Indicator 8 – Teamwork and supervision (Score 4)

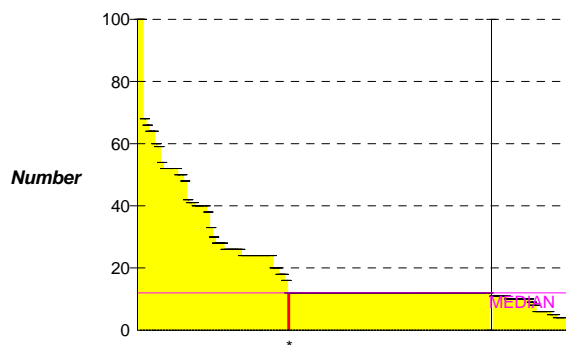
Rationale

Investigations have highlighted teamworking as important for delivering high quality care. Teams who are working well are expected to meet together and train together. It is also important that trusts learn from incidents. The supervision of midwives exists to ensure self-regulation of the profession happens. This function is there in statute to ensure public protection. Each practising midwife has a named supervisor covering her main area of practice who is there to provide advice, guidance and support. The NMC recommends that supervisors have caseloads of no greater than 1:15.

Measurement and scoring

- Start at 1 point
- If the number of multidisciplinary risk meetings in a year is greater than or equal to 12 add 1 point (Fig 8a).
- If the number of training courses identified in question B4 which are jointly trained is greater than or equal to the median (5) add 1 point (Fig 8b).
- If % of midwives who report from the NHS staff survey that they work in a well structured team is greater than or equal to 50% add 1 point (Fig 8c).
- If the midwives per supervisor of midwives (Midwives as reported in question B3 / Supervisors of midwives as reported in question B1) is less than or equal to 15 add 1 point (Fig 8d).

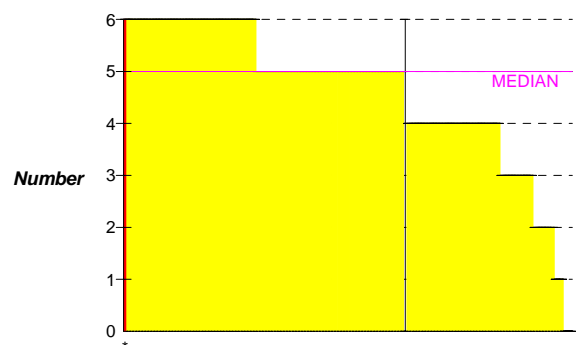
Fig 8a: Number of multi-disciplinary risk meetings in year



Queen Elizabeth Hospital Kings Lynn vs England

Indicator (MTR19A2) value 12
 Indicator direction 1→0
 Source: Trust questionnaire question B6

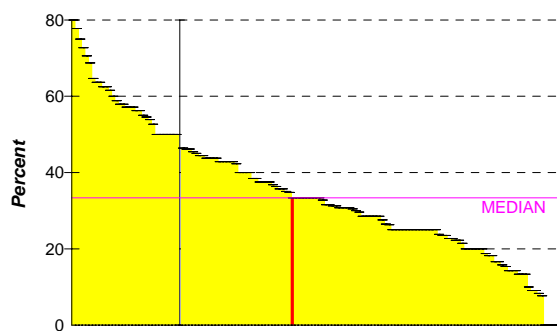
Fig 8b: Number of courses jointly attended (max 6)



Queen Elizabeth Hospital Kings Lynn vs England

Indicator (MTR19F2) value 6
 Indicator direction 1→0
 Source: Trust questionnaire question B4

Fig 8c: % Midwives reporting working in a well structured team environment



Queen Elizabeth Hospital Kings Lynn vs England

Indicator (MTR19F5) value 33.33
 Indicator direction 1→0
 Source: National Staff survey

Fig 8d: Midwives per supervisor of midwives



Queen Elizabeth Hospital Kings Lynn vs England

Indicator (MTR19H1) value 8.4
 Indicator direction 0→1
 Source: Trust questionnaire questions B1, B3

Women Centred Care: Indicator 9 - Average time between making first contact and booking appointment (Score 3)

Rationale

NICE identifies that booking appointments should occur prior to 12 weeks. It is important that women have made contact with the maternity service as early as possible to ensure the highest quality of care and access to appropriate screening and testing and the provision of early advice for a healthy pregnancy and baby. The first screening tests should take place from week 8 (sickle cell and thalassaemia) and so any women making contact prior to 8 weeks should ideally be booked by week 8 so appropriate screening can be scheduled.

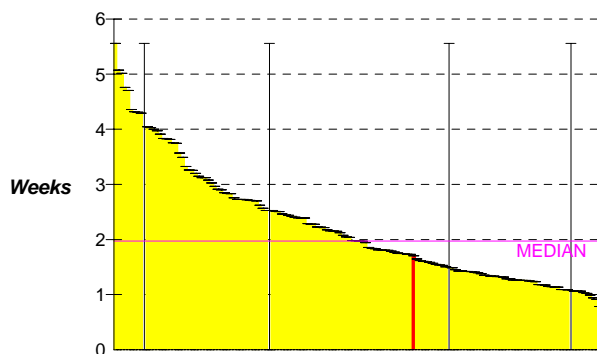
Measurement and scoring

Time in weeks between first contact and booking appointment for a woman = If first contact takes place prior to 8 weeks then if booking takes place at 8 weeks or less take the time to appointment as 0, otherwise take the difference between the booking appointment (weeks pregnant) and 8. In all other cases take the difference in weeks between booking appointment and first contact.

Average time in weeks between first contact and booking appointment = Average of the time in weeks between first contact and booking appointment for a woman as defined above for all women whose survey responses identified the week of booking and the week of first contact and where the booking appointment is in the same week or later than the first contact.

Scoring thresholds are set at clear breakpoints where they exist (4.1) otherwise at standard percentile thresholds for a continuous indicator which are 6.25% (1.07) , 31.25% (1.49) and 68.75% (2.528).

Fig 9: Average time between making first contact and booking appointment



Indicator (MTR22C6) value 1.702

Indicator direction 1 → 5

Source: Mother's survey questions B4 and B2

Queen Elizabeth Hospital Kings Lynn vs England

Women Centred Care: Indicator 10 - Choice and continuity for antenatal care (Score 3)

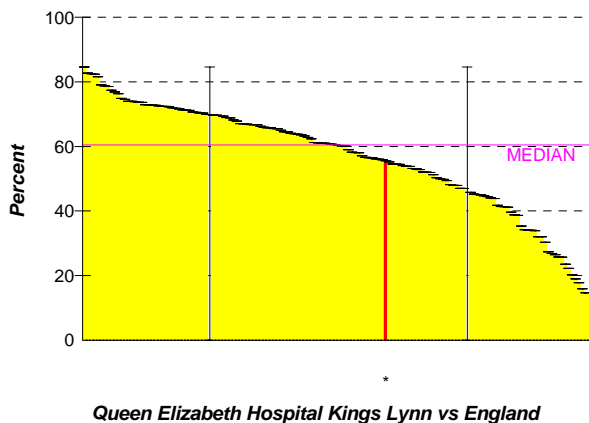
Rationale

Women should have an opportunity to build up a relationship with the staff caring for them during their pregnancy as this will enable effective clinical monitoring and a relationship of trust to develop. The National Service Framework states that 'All women are offered the support of a named midwife throughout pregnancy'. If women are offered choice in where they can receive their antenatal care this can make it easier for women to attend appointments.

Measurement and scoring

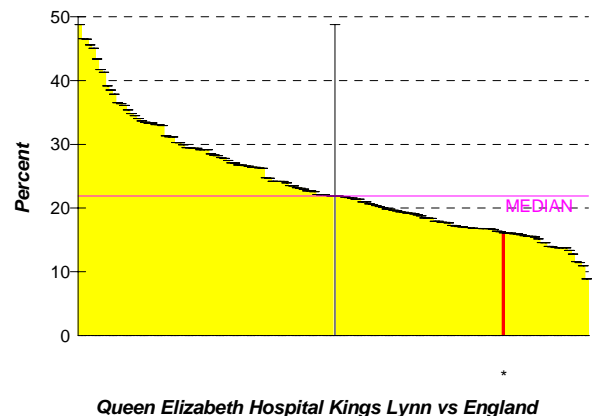
- Start at 1 point
- If the % of women seeing the same midwife for antenatal check-ups (Number of women who answered that they had seen the same midwife for antenatal checks most or every time / Number of women seeing a midwife more than once *100) is in the top 25% (46.9) add 1 point and if it is in the top 75% (69.8) add a further point (Fig 10a).
- If % of women given a choice of where check-ups took place (Number of women who answered that they had been given a choice on where antenatal check-ups took place / Number of women responding on whether they had a choice on where antenatal check-ups took place*100) is at or above the median (21.89) add 1 point (Fig 10b).
- If the trust always provides women with a named midwife for their antenatal and postnatal care add 1 point (Fig 10c).

Fig 10a: % women reporting they mostly saw the same midwife for check-ups



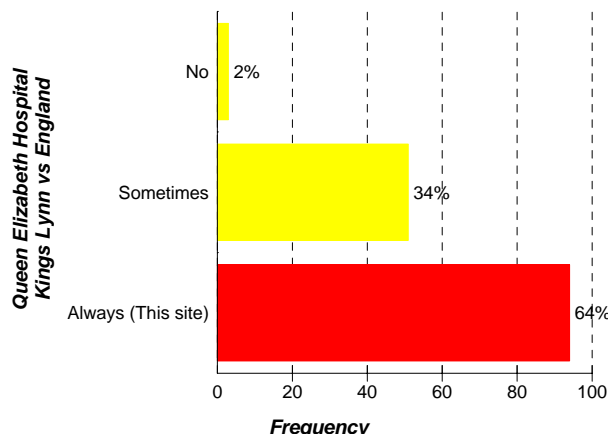
Indicator (MTR24C8) value 55.56
Indicator direction 2 → 0
Source: *Mother's survey question B13*

Fig 10b: % women given a choice of where check ups took place



Indicator (MTR24B1) value 16.1
Indicator direction 1 → 0
Source: *Mother's survey question B10*

Fig 10c: Is the named midwife the same for antenatal and postnatal care?



Indicator (MTR23A12) value Always
Source: *Trust questionnaire question G3*

Figures 10c shows the percentage of trusts giving each of the possible responses with the response for your trust highlighted by the bar showing as a different colour.

Women Centred Care: Indicator 11 - % women offered an informed choice for screening tests (Score 3)

Rationale

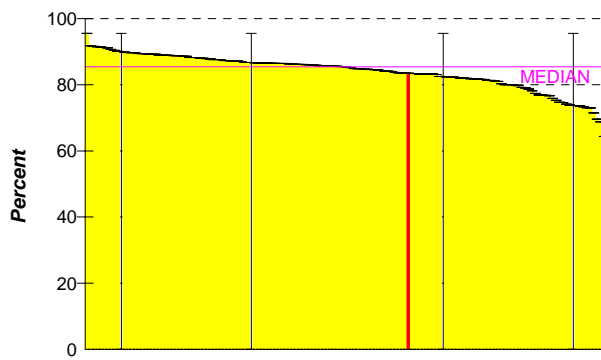
NICE states that women should be offered the choice about having appropriate screening tests. To make an informed choice women should receive adequate explanation of why they are being offered the test.

Measurement and scoring

% Women offered informed choice for screening tests = (Women who had a choice for Down's syndrome screening + Women given reasons for having Down's syndrome test + Women who had a choice for Dating scan + Women given reasons for having the dating scan + Women who had a choice for anomaly scan + Women given reasons for having this scan)/(Women who answered question on choice for Down's syndrome screening + women who answered if they had a choice for the dating scan + women who answered if they had a choice for the fetal anomaly scan + Women who answered if reasons given for Down's syndrome screening + women who answered if reasons given for the dating scan + women who answered if reasons given for the fetal anomaly scan))*100

Scoring thresholds are set at clear breakpoints where they exist otherwise at standard percentile thresholds for a continuous indicator which are 6.25% (73.74), 31.25% (82.42), 68.75% (86.69) and 93.75% (90.05).

Fig 11: % women offered an informed choice for screening tests



Indicator (MTR25A1) value 83.48

Indicator direction 5→1

Indicator MT25A1, Source: Mother's survey Questions B16, B17, B18b, B18c, B19b and B19c

Queen Elizabeth Hospital Kings Lynn vs England

Women Centred Care: Indicator 12 - % women attending NHS antenatal classes who wanted to (Score 2)

Rationale

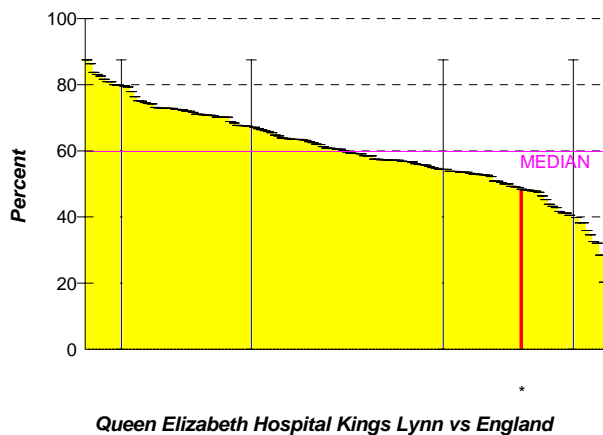
The NICE antenatal care guideline states that pregnant women should be offered opportunities to attend antenatal classes and have written information about antenatal care. The NSF states that good antenatal care for all women and their partners will include access to parenting education and preparation for birth at classes or through other means.

Measurement and scoring

% of women attending antenatal classes = $\frac{\text{women who attended trust antenatal classes}}{\text{women who attended antenatal classes} + \text{women who did not attend classes because they were not offered or they were all booked up}} \times 100$

Scoring thresholds are set at clear breakpoints where they exist otherwise at standard percentile thresholds for a continuous indicator which are 6.25% (39.96), 31.25% (54.39), 68.75% (67.32) and 93.75% (79.74).

Fig 12: % women attending NHS antenatal classes who wanted to



Indicator (MTR26D1) value 48.39

Indicator direction 5→1

Source: *Mother's survey question B23*

Women Centred Care: Indicator 13 - Extent of choice in labour (Score 3)

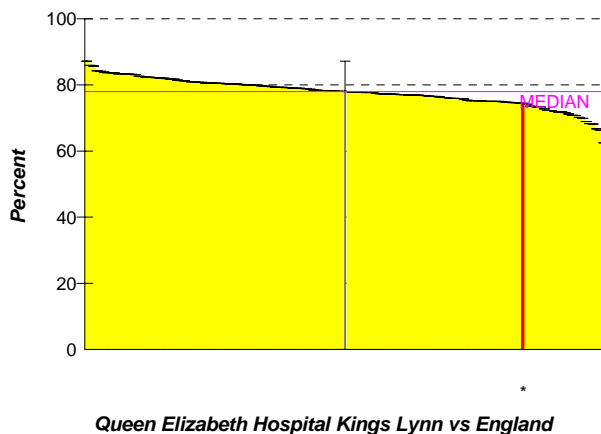
Rationale

The NSF states that women should have choices of methods of pain relief during labour, including non-pharmacological options. In addition it states that women should be able to do what feels right for them during labour and delivery with health professionals supporting their wishes wherever possible. Women should feel supported throughout the birth and just after the birth.

Measurement and scoring

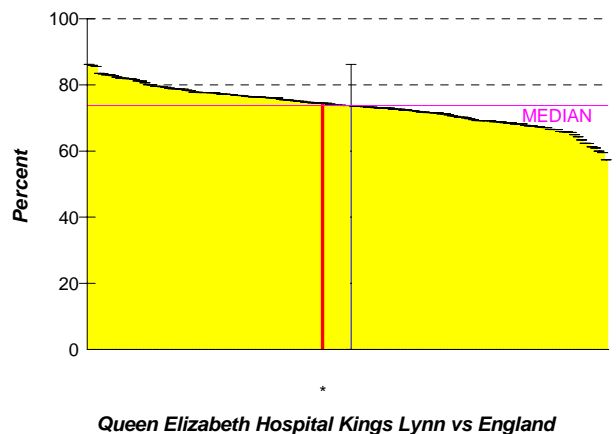
- Start at 1 point
- If the percentage of women receiving the pain relief they wanted in labour $((1 * \text{number of women who definitely got the relief they wanted} + 0.5 * \text{number of women who got the pain relief they wanted to some extent}) / (\text{women who responded for pain relief either yes, definitely or to some extent or no}) * 100)$ is greater than or equal to the median (77.95) add 1 point (Fig 13a).
- If the percentage of women able to move around in labour $((1 * \text{number of women who answered most of the time} + 0.5 * \text{number of women who answered some of the time}) / (\text{women who responded on moving around most or some of the time or No not at all}) * 100)$ is greater than or equal to the median (73.73) add 1 point (Fig 13b).
- If the percentage of women left alone and worried about this during labour and / or shortly after birth $((\text{Women indicating they were left alone and worried}) / (\text{women indicating they were left alone and worried and those that indicated that they were never worried by being left alone}) * 100)$ is less than or equal to 34 (clear breakpoint) score 1 point and if it is less than or equal to 20 (clear breakpoint) score an additional 1 point (Fig 13c).

Fig 13a: % women who got the pain relief they wanted



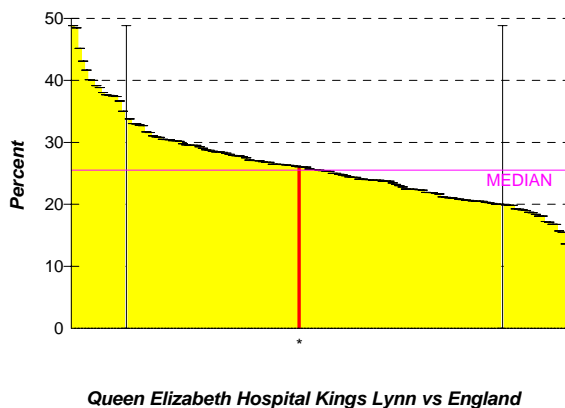
Indicator (MTR27E1) value 74.43
Indicator direction 1 → 0
Source: *Mother's survey question C8*

Fig 13b: % of women able to move around some of the time in labour



Indicator (MTR27G1) value 74.51
Indicator direction 1 → 0
Source: *Mother's survey question C5*

Fig 13c: % women left alone, and worried, in labour or shortly after the birth



Indicator (MTR27K1) value 26.05
Indicator direction 0 → 2
Source: *Mother's survey question C25*

Women Centred Care: Indicator 14 - Supporting for infant feeding (Score 3)

Rationale

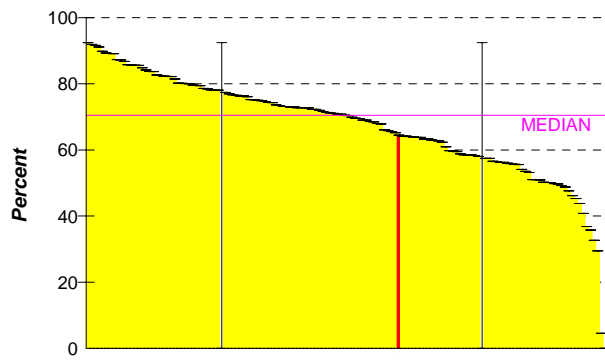
The NSF states that there is clear evidence that breastfeeding has positive health benefits for both mother and baby in the short and long term and is important for addressing national targets on infant mortality and health inequalities. Women should be aware of the benefits of breastfeeding and should be supported in infant feeding whatever their choice on how to feed.

Measurement and scoring

Extent that women feel supported in infant feeding = $(1 * (\text{women who always received consistent advice} + \text{women who always received practical help} + \text{women who always received active support and encouragement}) + 0.5 (\text{women who generally received consistent advice} + \text{women who generally received practical help} + \text{women who generally received active support and encouragement})) / (\text{women who needed consistent advice} + \text{women who needed practical help} + \text{women who needed support and encouragement}) * 100$

- Start at 1 point
- If the % women breastfeeding (Number of women who initiated breastfeeding / Number of women delivered * 100) is at or above 58 add 1 point and if it is at or above 78 add a further point (Fig 14a).
- If the extent that women feel supported in infant feeding is at or above the 25th percentile (55) add 1 point and if it is at or above the 75th percentile (62.6) add a further point (Fig 14b).

Fig 14a: % women who initiated breastfeeding



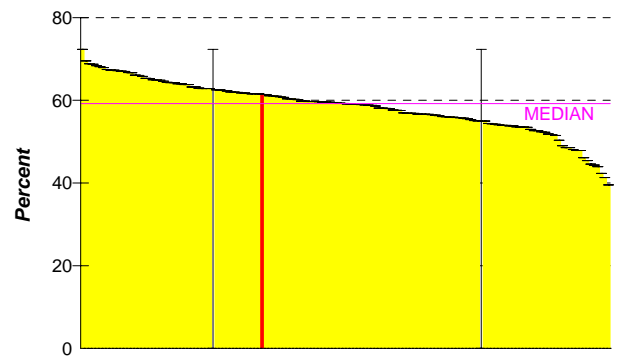
Queen Elizabeth Hospital Kings Lynn vs England

Indicator (MTR28A1) value 64.42

Indicator direction 2→0

Source: Trust questionnaire questions R8, Q3

Fig 14b: % of women who reported good advice, help and support on infant feeding



Queen Elizabeth Hospital Kings Lynn vs England

Indicator (MTR28A8) value 61.41

Indicator direction 2→0

Source: Mother's survey question F4

Women Centred Care: Indicator 15 - Quality of support in caring for the baby after discharge (Score 5)

Rationale

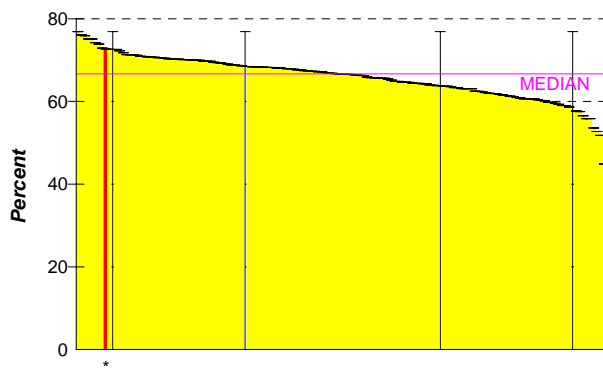
The first few weeks of caring for a new baby can be a worrying time. Good support can be essential to help parents care for and become confident in caring for their new baby. The majority of women will receive their postnatal care from the same organisation which cared for them during labour and delivery. Where women are discharged into the care of another organisations midwifery service the discharging organisation needs to ensure that both mother and baby are fit for discharge and communicate with the women's local maternity service in a timely manner to ensure appropriate postnatal care is given. Midwifery services should be working closely and co-operatively where there is cross-boundary care to ensure an appropriate level of care is given.

Measurement and scoring

Quality of support in caring for the baby after discharge = $(1 * (\text{Women reporting good support for crying} + \text{Women reporting good support on sleep positions} + \text{Women reporting good support for feeding} + \text{Women reporting good support for skin care} + \text{Women reporting good support on baby health and progress}) + 0.5 * (\text{Women reporting some support for crying} + \text{Women reporting some support on sleep positions} + \text{Women reporting some support for feeding} + \text{Women reporting some support for skin care} + \text{Women reporting some support on baby health and progress})) / (\text{Women responding support required for crying} + \text{Women responding support required for sleep positions} + \text{Women responding support required for feeding} + \text{Women responding support required for skin care} + \text{Women responding support required for baby health and progress}) * 100$

Scoring thresholds are set at clear breakpoints where they exist otherwise at standard percentile thresholds for a continuous indicator which are 6.25% (57.96), 31.25% (63.74), 68.75% (68.57) and 93.75% (72.60).

Fig 15: Quality of support in caring for the baby after discharge



Queen Elizabeth Hospital Kings Lynn vs England

Indicator (MTR28B1) value 72.73

Indicator direction 5→1

Source: Mother's survey question H6

Women Centred Care: Indicator 16 - Stakeholder involvement in service planning and evaluation (Score 4)

Rationale

To develop services which meet the needs of the local community it is important that there is adequate engagement with local stakeholders. PCTs and Trusts have been encouraged to set up a forum which includes service users, these are often called Maternity Service Liaison Committees (MSLCs). Where appropriate these groups may cover communities which are served by more than one trust so may have membership from more than one trust.

Measurement and scoring

- Start at 1 point
- if % of women (service users), primary care and stakeholder representatives on MSLC ((Women members + PCT members + stakeholder members) / (Consultant members + junior medical members + midwife manager members + midwife supervisor members + other midwife members + paediatrician members + Women members + PCT members + stakeholder members + other trust representatives) * 100) is greater than or equal to 40 and there is at least one primary care representative add 1 point (Fig 16a).
- If the number of minority groups represented on the MSLC is greater than or equal to 2 add 1 point (Fig 16b).
- If the number of meetings in last year is greater than or equal to 4 add 1 point (Fig 16c).
- If recommendations from the MSLC have been shared with trust board (or appropriate subcommittee) in last year add 1 point (Fig 16d).

If there are no trust representatives the trust cannot be considered to belong to a MSLC and will score the lowest score of 1.

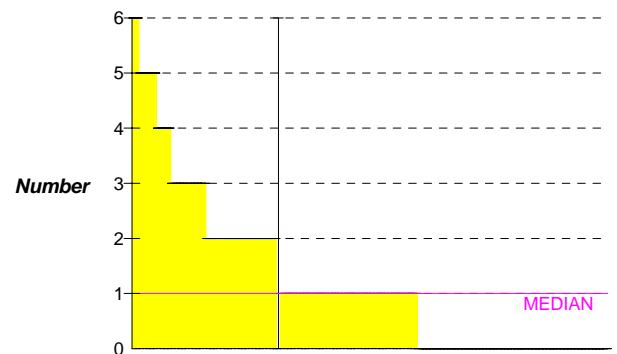
Fig 16a: % women and primary care representatives and stakeholders on the MSLC



Queen Elizabeth Hospital Kings Lynn vs England

Indicator (MTR29C1) value 52.38
 Indicator direction 1 → 0
 Source: Trust questionnaire question A3

Fig 16b: Number of minority groups represented on MSLC

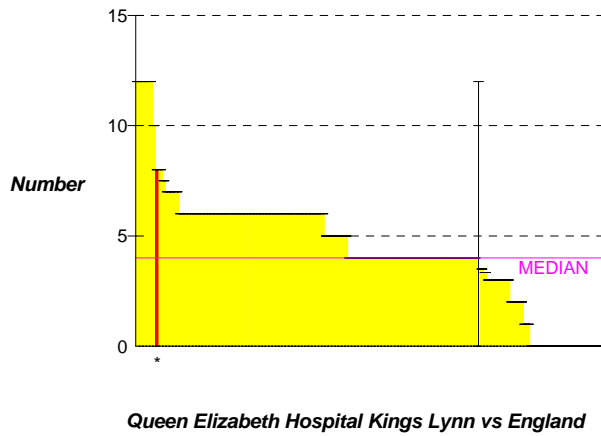


Queen Elizabeth Hospital Kings Lynn vs England

Indicator (MTR29C2) value 0
 Indicator direction 1 → 0
 Source: Trust questionnaire question A3

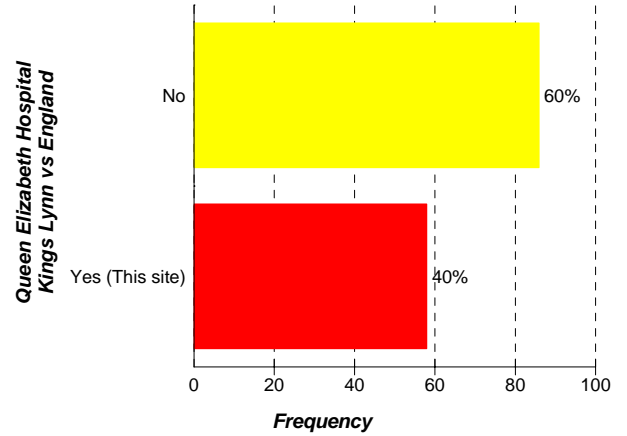
Women Centred Care: Indicator 16 - Stakeholder involvement in service planning and evaluation - Continued

Fig 16c: Number of MSLCs held in last year



Indicator (MTR29C4) value 8
 Indicator direction 1 → 0
 Source: Trust questionnaire question A3

Fig 16d: Did MSLC share any recommendations with board in last year



Indicator (MTR29C5) value Yes
 Source: Trust questionnaire question A3

For your MSLC you have reported 3 PCT members and 10 trust members.

Figures 16d shows the percentage of organisations giving each of the possible responses with the response for your organisation highlighted by the bar showing with (This site) against it.

Efficiency and Capability: Indicator 17 - Staffing levels (Score 4)

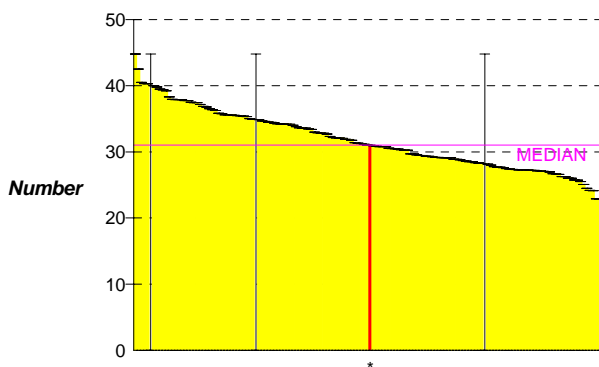
Rationale

The unit should have an appropriate number of staff to support their deliveries. 'Safer Childbirth' has identified that for consultant obstetricians there should be at least 40 hours presence on obstetric units with less than 5000 deliveries and 60 hours or more on units with 5000 deliveries or over. 'Safer Childbirth' has also identified that there should be 10 programmed activities for consultant anaesthetists on obstetric units.

Measurement and scoring

- Start at 1 point
- If whole time equivalent midwives in post per 1000 deliveries ((Sum for all units of total midwives in post + (Sum for all units of agency midwives hours in March + Sum for all units of bank midwives hours in March + Sum for all units of midwives overtime hours in March) / 142.5) / Total women delivered * 1000) is greater than or equal to the 25th percentile (28.13) add 1 point and if it is less than or equal to 40 but above the 75th percentile (34.90) add a further point (Fig 17a).
- For obstetric units if the number of hours consultant presence is at least 40 hours for each unit with less than 5000 deliveries and 60 hours for each obstetric unit with 5000 or more deliveries add 1 point (Fig 17b).
- If all obstetric units have consultant anaesthetist PAs greater than or equal to 10 add 1 point (Fig 7c).

Fig 17a: Midwives per 1000 deliveries

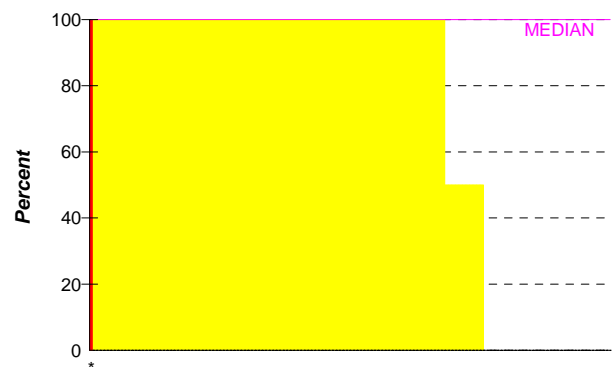


Queen Elizabeth Hospital Kings Lynn vs England

Indicator (MTR33A3) value 31.01
Indicator direction 1,2,1,0

Source: Trust questionnaire questions N1,N3, I2

Fig 17b: % obstetric units with appropriate consultant obstetrician presence

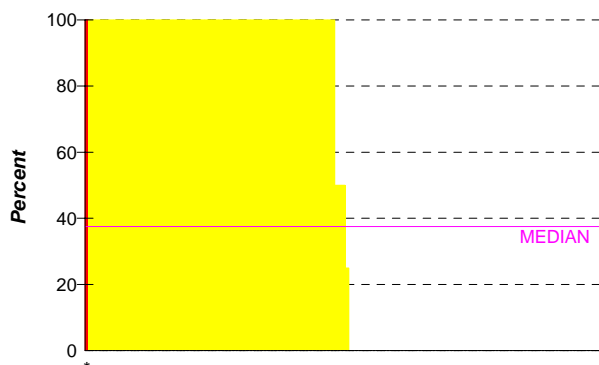


Queen Elizabeth Hospital Kings Lynn vs England

Indicator (MTR33E11) value 100
Indicator direction 1→0

Source: Trust questionnaire question Q5

Fig 17c: % obstetric units where consultant anaesthetist PAs greater than or equal to 10



Queen Elizabeth Hospital Kings Lynn vs England

Indicator (MTR33E6) value 100
Indicator direction 1→0

Source: Trust questionnaire question N5

Efficiency and Capability: Indicator 18 - Integration of support workers (Score 2)

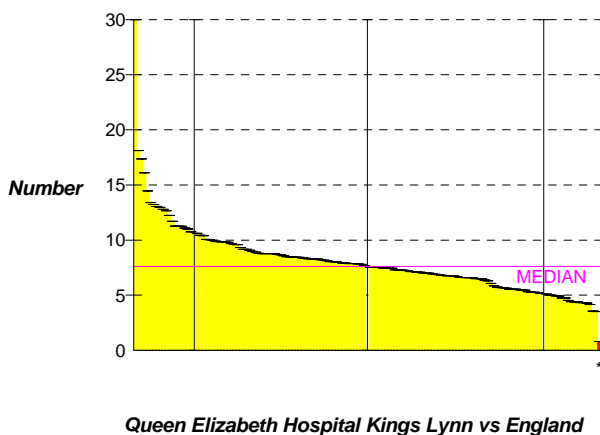
Rationale

Training and qualifications have been developed to allow new ways of working in maternity. Appropriately trained support workers in maternity can provide care which may previously have required a midwife which can lead to more time being spent with women and a more cost effective service.

Measurement and scoring

- Start at 1 point
- If support workers per 1000 deliveries ((Sum for all units of total support workers in post + (Sum for all units of agency support workers hours in March + Sum for all units of bank support workers hours in March)/142.5)) / Total women delivered * 1000) are at or above the percentile representing 12.5% (5.12) add 1 point, above the median (7.534) add a further point and above the percentile representing 87.5% (10.68) add a further point (Fig 18a).
- If the range of activities support workers are involved in (Number of the 17 listed activities which support workers carry out (Housekeeping, Clerical duties, Audit, Portering, Support community groups, Undertake tests, Give health advice, Vital sign observation, Antenatal classes, Support women in labour, Washing women after birth, Theatre assistants, Second person at home birth, Baby care support, Support Infant feeding, Baby discharge clinic, Postnatal drop in clinics)) is greater than or equal to the median (12) add 1 point (Fig 18b).

Fig 18a: Maternity support workers per 1000 deliveries

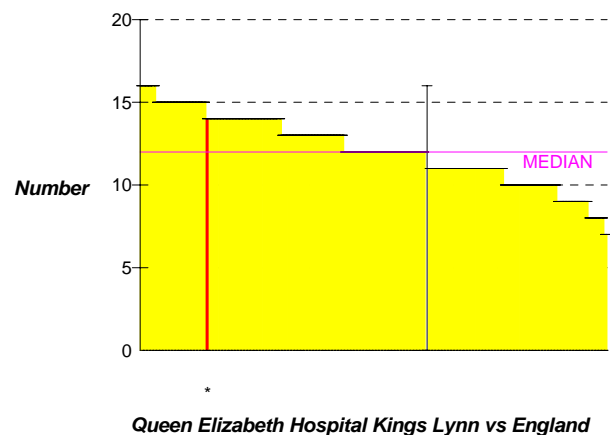


Indicator (MTR33B1) value 0.8075

Indicator direction 3 → 0

Source: Trust questionnaire question N1, N3, I2

Fig 18b: Tasks supported by midwife support workers (max 17)



Indicator (MTR33B3) value 14

Indicator direction 1 → 0

Source: Trust questionnaire question B2

Efficiency and Capability: Indicator 19: Average cost per delivery (Score 4)

Rationale

The cost of intrapartum care could be expected to be similar across trusts. Costs should be managed to an acceptable level commensurate with the provision of a safe service.

Measurement and scoring

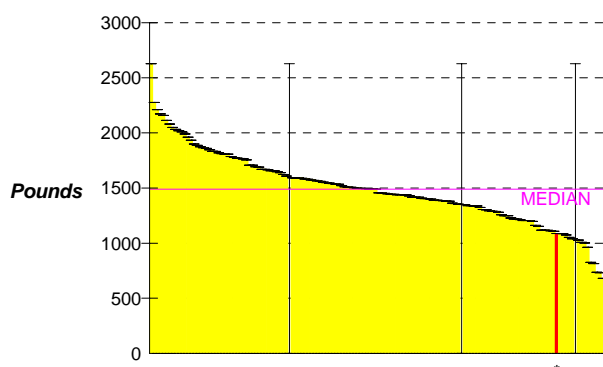
Standardised average cost per delivery =
 national proportion of deliveries which are vaginal deliveries without complications x trust cost of vaginal delivery without complications
 + national proportion of deliveries which are vaginal deliveries with complications x trust cost of vaginal delivery with complications
 + national proportion of deliveries which are assisted vaginal deliveries without complications x trust cost of assisted vaginal delivery without complications
 + national proportion of deliveries which are assisted vaginal deliveries with complications x trust cost of assisted vaginal delivery with complications
 + national proportion of deliveries which are caesarean deliveries without complications x trust cost of caesarean delivery without complications
 + national proportion of deliveries which are caesarean deliveries with complications x trust cost of caesarean delivery with complications

Where national proportion of deliveries are determined from the national distributions as reported in reference cost data for 2006 as low cost should not be achieved through insufficient staffing.

- Start at 1 point
- If reference costs have been provided add 1 point
- If standardised average cost per delivery is at or below 1600 add 1 point, if at or below the percentile for 31.25% (1351) add a further point and at or below the percentile for 6.25% (1029) add a further point (Fig 19).

Any trust who has a midwife staffing level below the 25th percentile for midwives per 1000 deliveries will be restricted to not score above 3 (see indicator 17 for relevant chart).

Fig 19: Average cost per delivery



Queen Elizabeth Hospital Kings Lynn vs England

Indicator (MTR34B1) value 1088

Indicator direction 0→3

Source: Reference costs

Efficiency and Capability: Indicator 20 - Delivery of hospital based antenatal care (Score 2)

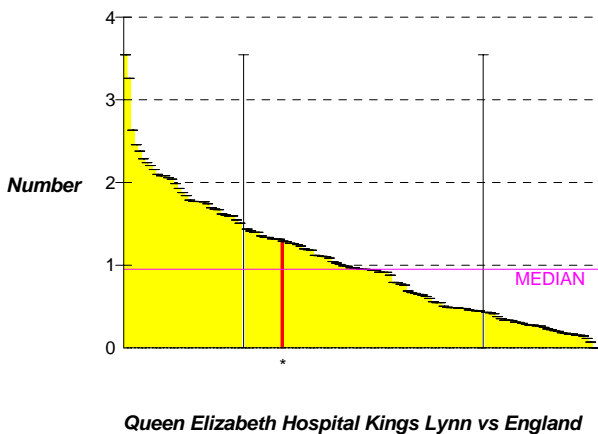
Rationale

Antenatal care represents a significant cost in maternity services and trusts need to develop cost effective services which meet the clinical need, in particular ensuring appropriate levels of antenatal admissions and access to appropriate support and care when a problem occurs. The development of day assessment facilities can help to reduce the number of antenatal admissions during pregnancy. This is beneficial for women as they are able to return to their own home and is also cost-effective for the service provider and commissioner.

Measurement and scoring

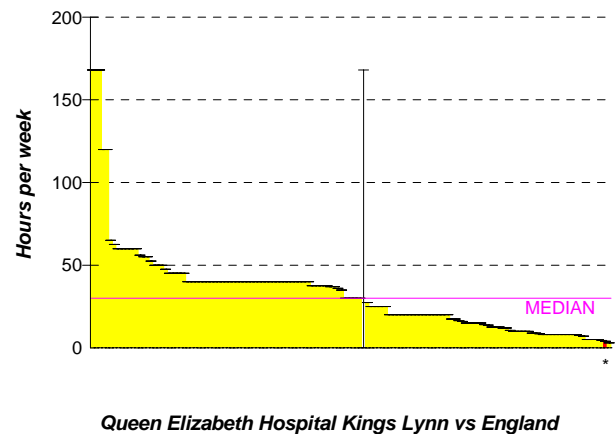
- Start at 1 point
- If antenatal admission per woman (number of antenatal admissions / number of women delivered) is less than or equal to the 75th (1.454) percentile add 1 point and if it is less than or equal to the 25th percentile (0.44) add a further point (Fig 20a).
- If opening hours of early pregnancy unit is greater than or equal to median (30) add 1 point (Fig 20b).
- If opening hours of day assessment pregnancy unit per week is greater than or equal to 40 add 1 point (Fig 20c).

Fig 20a: Antenatal admissions per delivery



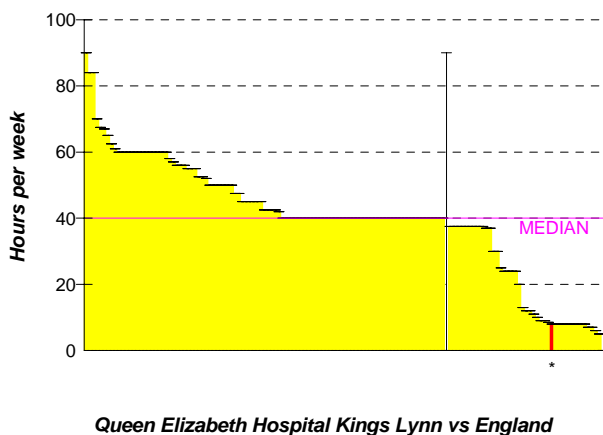
Indicator (MTR31D1) value 1.292
 Indicator direction 0→2
 Source: Trust questionnaire question P2,I2

Fig 20b: Weekday opening hours of the early pregnancy unit



Indicator (MTR36B5) value 4
 Indicator direction 1→0
 Source: Trust questionnaire question O1

Fig 20c: Weekday opening hours of the day assessment pregnancy unit



Indicator (MTR36B7) value 8
 Indicator direction 1→0
 Indicator MT36B7, Source: Trust questionnaire question O1

Efficiency and Capability: Indicator 21 - Data quality (Score 4)

Rationale

To be able to manage performance maternity related data should be routinely collected and analysed. In order to benchmark services national datasets must be populated with high quality data. Trusts should have been routinely providing maternity datasets through clearnet.

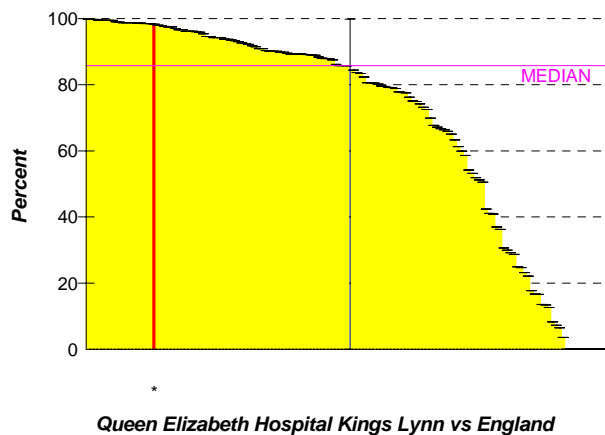
Measurement and scoring

Trusts will be scored based on their ability to provide data in this review on the ethnicity of women and on baby outcomes and on the HES assessment of the quality of data on women and on babies in the 2005/6 HES dataset (source:

www.hesonline.org.uk/Ease/servlet/ContentServer;jsessionid=rfqyxrwmf1?siteID=1937&categoryID=452)

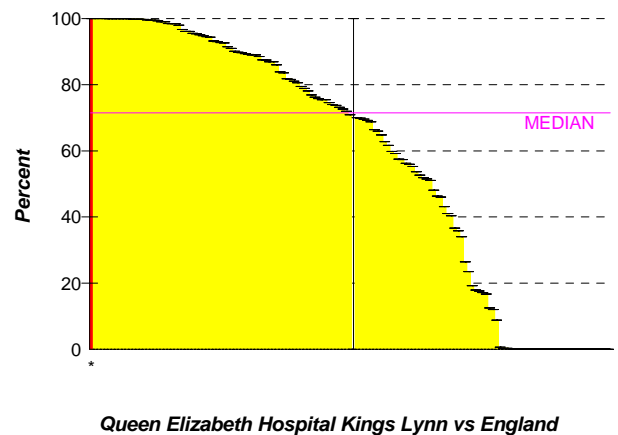
- Start at 1 point
- If the % of complete maternal records for 11 data items in HES as published in the DQI reports is greater than or equal to median (85.75) add 1 point (Fig 21a).
- If the % of complete baby records for 11 data items in HES as published in the DQI reports is greater than or equal to median (71) add 1 point (Fig 21b).
- If the % of women where ethnicity is not known ((Women with no ethnic code)/(White women + Asian women + Black women + Chinese women + Mixed women + Women with no ethnic code)*100) is less than or equal to the median (4.20) add 1 point (Fig 21c).
- If there is data for three or more of the four baby morbidity outcomes at trust level add 1 point

Fig 21a: Completeness of HES maternity data



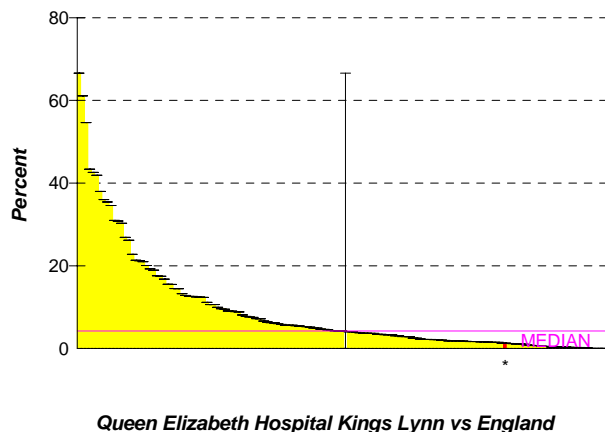
Indicator (MTR35A1) value 98.3
Indicator direction 1➔0 *Source: HES*

Fig 21b: Completeness of HES baby data



Indicator (MTR35A2) value 100
Indicator direction 1➔0 *Source: HES*

Fig 21c: % of women with no ethnic coding



Indicator (MTR32C5) value 1.247
Indicator direction 0➔1
Source: Trust questionnaire question D4

Baby morbidity Outcomes

Another measure of trust ability to record information is the ability to provide data on perinatal outcomes. From data provided by the trust we deduced that:

- % of babies born with APGAR scores less than 7 minutes at 5 minutes for babies born beyond 34 weeks is: 1.633
- % babies born at 34 weeks or more who were intubated is:
- % babies with neonatal encephalopathy (stages 2-3) is:
- % babies with meconium aspiration is:

If any indicator values are missing in the above statement, it means that data is missing in trust questionnaire question I10.

Efficiency and Capability: Indicator 22 - Appropriate involvement of obstetricians and midwives in antenatal care (Score 2)

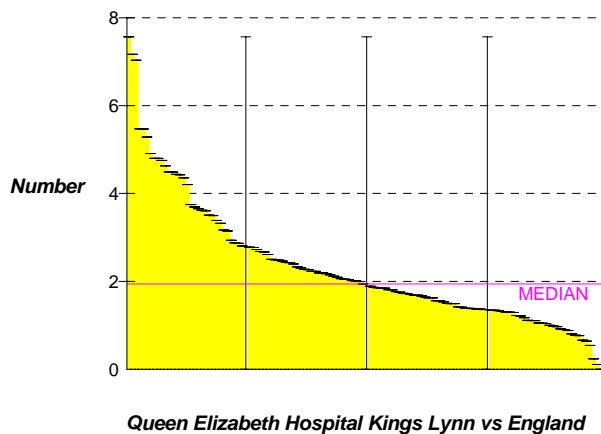
Rationale

The NSF asks providers to ensure that staff actively promote midwife-led care to all women who have been appropriately assessed. Wherever possible antenatal care should be managed by midwives with women being referred to obstetricians when particular high risk issues requiring obstetric input are identified. The risk factors present in the population served may have some influence on the number of women eligible for midwife-led care. Women should be referred back to midwife-led care wherever possible.

Measurement and scoring

- Start at 1 point
- If average antenatal obstetric attendances per booked woman is at or above 25th percentile (1.35) add 1 point (Fig 22a).
- If average antenatal obstetric attendances per booked woman is at or below the 75th percentile (2.80) and at or above the median (1.9) add 1 point (Fig 22a).
- If % of women only managed by midwives (Number of women who had antenatal care only for midwives / Number of women who had antenatal care from midwives, GPs or hospital doctors *100) is at or above 25th percentile (24.18) add 1 point (Fig 22b)
- If % of women only managed by midwives is at or above 75th percentile (45.16) (Fig 22b) and average antenatal obstetric attendances per booked woman (Number of antenatal obstetric attendances / Number of women booked) is at or above 0.9 (i.e. no evidence of under referral) (Fig 22a) add 1 point

Fig 22a: Average antenatal obstetric attendances per booked women

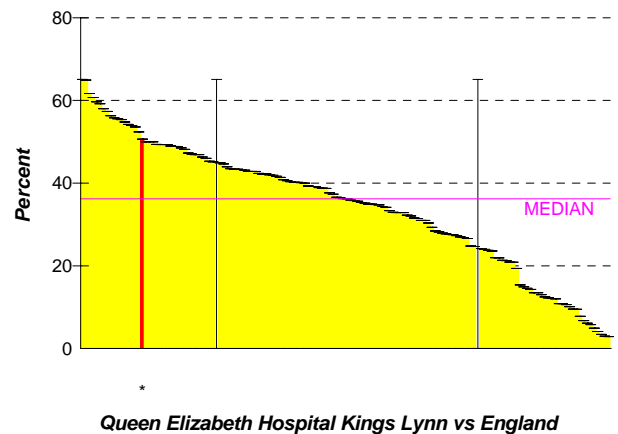


Indicator (MTR11B5) value

Indicator direction 1,2,1,0

Source: Trust questionnaire questions G7 and P1

Fig 22b: % women seeing only midwives for check ups



Indicator (MTR24C7) value 50.65

Indicator direction 2→0

Source: Mother's survey question B11

Efficiency and Capability: Indicator 23 - % women who considered their length of stay was about right (Score 5)

Rationale

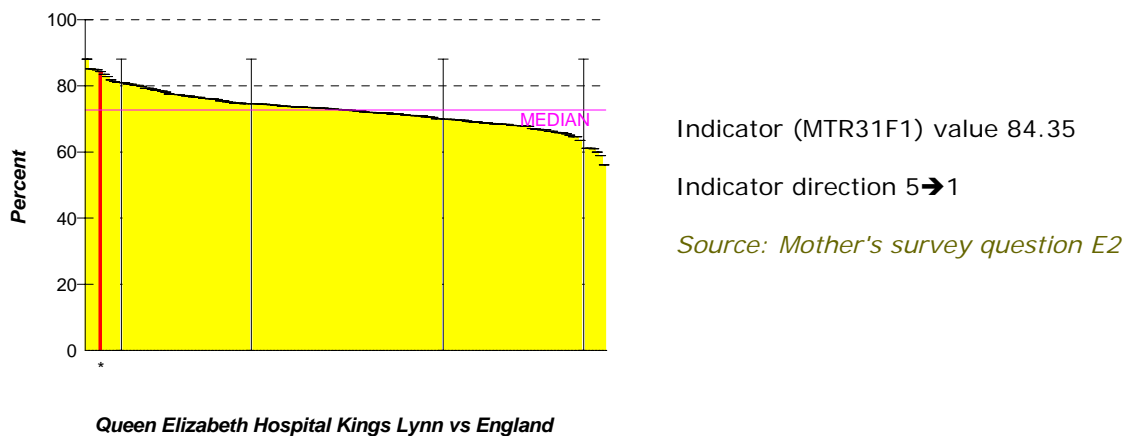
The postnatal care that women receive should be individualised to meet their needs. It is important that women should leave hospital only when they feel they have had sufficient opportunity to recover and that they have adequate support to feel confident in taking care of their baby. Equally, effective discharge processes should ensure that there are no unnecessary delays when it is time for women to go home.

Measurement and scoring

Women satisfied with their length of stay = Number of women who have indicated their length of stay was about right / Number of women who reported their length of stay was too long, too short or about right * 100

Scoring thresholds are set at clear breakpoints where they exist (62) otherwise at standard percentile thresholds for a continuous indicator which are 31.25% (69.93), 68.75% (74.57) and 93.75% (80.97).

Fig 23: % women who considered their length of stay was about right



Efficiency and Capability: Indicator 24 - Homeliness of delivery rooms (Score 2)

Rationale

A less clinical birthing environment will help re-enforce birth as a natural experience and the delivery room should be made as comfortable as possible for all women. This may be conducive to an atmosphere supporting more natural birth with less intervention. Being able to move around and get a comfortable position can help in the management of pain, as can immersion in water during labour.

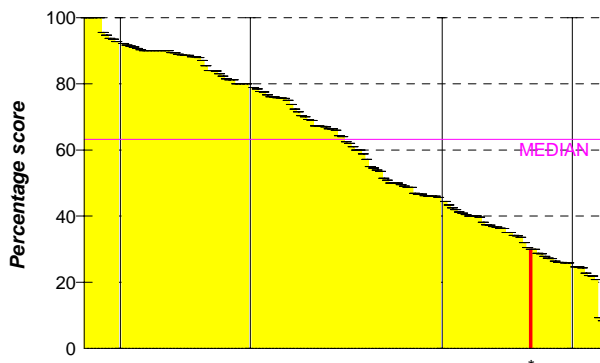
Measurement and scoring

Trusts have identified the number of delivery rooms with different en-suite specifications. They have then gone on to identify, for four features which can make a room more comfortable, the presence of these features in their delivery rooms.

% points achieved = $(3 * (\text{Number of rooms with just toilet ensuite}) + 6 * (\text{Number of rooms with toilet and either a bath / shower or pool ensuite}) + \text{Number of rooms where clinical equipment can be hidden} + \text{Number of rooms with a comfortable chair in the room} + \text{Number of rooms with space for a birthing mat} + \text{Number of rooms with at least one natural birthing aid allocated for the room from bars and ropes}) / (10 * \text{Number of delivery rooms})$

Scoring thresholds are set at clear breakpoints where they exist otherwise at standard percentile thresholds for a continuous indicator which are 6.25% (24.92), 31.25% (44.72), 68.75% (79.72) and 93.75% (92.66).

Fig 24: Homeliness of delivery rooms



Queen Elizabeth Hospital Kings Lynn vs England

Indicator (MTR36E5) value 30

Indicator direction 5→1

Source: Trust questionnaire question 04

Efficiency and Capability: Indicator 25 - Womens view of cleanliness of delivery and postnatal areas (Score 3)

Rationale

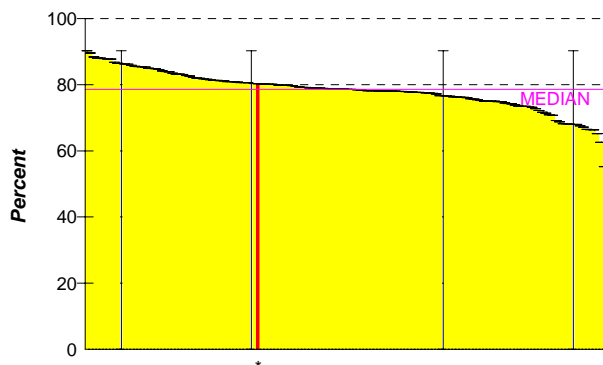
Women have provided their view of the cleanliness of rooms and facilities on the delivery suite and in the postnatal wards. Cleanliness was identified as an issue particularly for disabled parents who often prefer to undertake some tasks on the floor.

Measurement and scoring

Women have provided assessments of the cleanliness of ward and toilets in delivery suite and postnatal wards. Women's assessments for these four areas on cleanliness are scored as 1/3 point for not very clean, 2/3 for fairly clean, 1 for very clean. Women's overall rating of cleanliness is the total points received by a trust divided by points available (maximum 4 points for each women), expressed as a percentage.

Scoring thresholds are set at clear breakpoints where they exist otherwise at standard percentile thresholds for a continuous indicator which are 6.25% (68.00), 31.25% (76.64), 68.75% (80.53) and 93.75% (86.43).

Fig 25: Womens view of cleanliness of delivery and postnatal areas



Indicator (MTR3611) value 80.24

Indicator direction 5→1

Source: *Mother's survey questions C6, E9*

Queen Elizabeth Hospital Kings Lynn vs England