University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Quality and Outcomes Committee on Tuesday 24th May 2022

Report Title	**Maternity Perinatal Quality Surveillance Matrix and Maternity Incentive Scheme (MIS) Monthly Update**
Report Author	[redacted]
Executive Lead	[redacted]

1. Report Summary

This report provides the board monthly oversight with regard to the safety matrices of our maternity and neonatal services for the month of April 2022. This report is a standing agenda item as per the recommendations set out in the Maternity Incentive Scheme (MIS) Year 4 and the NHS England report, *Implementing a revised perinatal quality surveillance model.*

2. Key points to note

(Including decisions taken)

Strengths:

- Implementation of Continuity of Carer (CoC) presently 48%, with BAME at 63.6% and IMD 1(most deprived) at 78%.
- We received 12 formal compliments, all were for NICU (themes were clinical care/help and support/staff attitude)
- There have been no new Healthcare Safety Investigation Branch (HSIB) cases
- The maternity systems data set (MSDS) quality metrics achieving 10 out of the 11 measures. Use of the personalised care and support plan is unable to be recorded due to insufficient numbers in the data set. The personalised care plans are being revised by the local maternity system (LMS) as they are deemed not fit for purpose as women/midwives are not using the tool as intended.

Weaknesses:

- Lack of appropriate capacity to manage the current and increasing number of planned (“elective”) caesarean sections
- Sporadic capacity issues with the flow of inductions (to match increasing demand)
- Ongoing lack of appropriate antenatal scan capacity to manage implementation of some specific scan pathways for large or small for gestational age (LGA/SGA) babies in line with Royal College of Obstetricians and Gynaecologists (RCOG) guidance, due to difficulties with recruitment and retention of sonographers
- Obstetric emergency and fetal monitoring training is not compliant with the 90% target for all staff groups. Extra sessions are being scheduled. All midwives are booked on sessions and will be compliant at the end of the reporting period. There is a plan for all new doctors to do training when they start the new rotation in August 2022.

- Saving Babies Lives Care Bundle 2 (SBLCBv2) – the challenge is to complete all the audits due to capacity constraints in QPS team. New team members have been recruited and there is a plan to reinstate audits by end of June.
- The connectivity issues and capacity constraints within the community midwifery teams to input data into the Maternity Careflow system is a risk associated with a potential failure of MIS clinical negligence scheme for trusts (CNST). MIS allows for manual audit but expects data to be entered electronically. This has been escalated and is on the risk register.

Opportunities:

- Multidisciplinary team (MDT) review of final Ockenden report, collaboration across LMS with shared reporting proforma. Leads assigned to review and progress individual actions.
- Following release of 2021 National Maternity Survey, our UHBW results **were worse** than most trusts for 3 questions, which relate to care at home, and **were somewhat worse** than most trusts for 2 questions relating to patients being involved in decision making about their care and information given about mental health after having a baby. In response to this, an MDT meeting was held, and an action plan drafted to develop and make improvements. From this a monthly 'women's experience group' has been re-instated with MVP (maternity voices partnership) representation to take and monitor actions and improvements. North Bristol have been asked to join the group due to the crossover of the services and women giving birth at UHBW but being cared for by NBT community midwives and vice versa.
- Following recent NICU Getting It Right First Time (GiRFT) review, the service will develop a plan to review all under 27-week premature babies not birthed at St Michael's, whose admission was declined in utero. The aim will be to identify the cause of refusals, which might be anticipated to be CDS and /or NICU capacity constraints. Our Neonatal Operational Delivery Network (ODN) is an outlier for under extreme prematurity delivering in the wrong place (i.e. not co-located with a Level 3 neonatal unit). We need to understand and include how we record in-utero transfer requests, and how consistently this is recorded.
- We will also review all extreme premature births who require advance resuscitation as NICU is an outlier for resuscitation events requiring adrenaline and cardiac massage.
- Avoiding term admission to the neonatal unit (ATAIN) Q3 audit - 52% of all term admissions had a primary cause aligned to ATAIN themes. Actions from review were:
    - Review of o2 saturation monitors on Central Delivery Suite (CDS) (availability)
    - Production of neonatal encephalopathy guideline (support of babies staying on transitional care for observations to reduce NICU admission)

- Staff concerns shared monthly with the Maternity and Neonatal Safety Champions and actions fed back to staff, current themes continue to include:
    - Staffing, staff off with covid impact on staffing levels and challenges to get cover
    - Transitional Care extra equipment such as second resuscitaire and sats monitors
    - Pressure to take babies on transitional care ward at limit of criteria
    - Lack of progress with the planned Level E refurbishment

Threats:

- The connectivity issues and capacity constraints within the community midwifery teams to input data into the Maternity Careflow system is a risk associated with a potential failure of clinical negligence scheme for trusts (CNST). This has been escalated and is on the risk register. Manual audits permitted by CNST to replace electronic data entry to be re-instated June 2022.
- The service will require an extra 16.1 WTE midwives in the funded establishment to achieve Continuity of Carer as default model of care in April 2023; an action plan has been escalated to Trust Board.
- Risk to continued planned roll out of Continuity of Carer due to vacancies; there will be 6.7 WTE vacancies in the community from start of May due to resignations and 2 midwives have retired. Recruitment on-going.
- As part of our continual risk assessment four CoC teams continue to run, two teams have been paused until staff have been recruited to fill newly vacant posts. Ockenden report has suggested the continual roll out of CoC should be suspended if safety cannot be assured with regards to staffing. UHBW have risk assessed and are able to continue with 4 teams.
- Birthrate Plus (midwifery workforce assessment tool) review has been undertaken and the draft results will be discussed with the Birth rate plus team on the 7th of June 2022 to confirm any deficit of midwifery numbers recommended to be funded to the establishment to meet the current demand and acuity.
- Ongoing lack of appropriate antenatal scan capacity to manage implementation of some specific scan pathways for large or small for gestational age (LGA/SGA) babies in line with RCOG guidance, due to difficulties with recruitment and retention of sonographers
- Ockenden safety action recommends two MDT consultant led ward rounds on CDS (central delivery suite) day and night. Presently the Consultant undertakes two ward rounds during the day, but the Consultant is not present at the ward round at night. A regional bid for funding (Ockenden funding) was unsuccessful. Alternative rostering arrangements are being reviewed.

Areas of excellence

UHBW midwifery, neonatal and obstetric teams have showed and continue to show remarkable resilience during these testing Covid times. Staff have shown exemplary teamwork and professionalism, being flexible to ensure safety of services during staffing

absence, with often last-minute changes to working patterns. Services maintained throughout pandemic. The value of our proactive practice educational facilitators (PEFs) has proven immensely successful in supporting rotational midwives, new starters, and junior staff, ultimately this will reduce turnover at a time when every member of staff counts.

Excellent engagement with executive team. In response to Ockenden 2, all the non-executive directors visited the St Michael's site on the 10 May 2022 and were shown around the unit and were able to speak with front line staff. This gave them an opportunity to be made aware of our successes and challenges. The Regional Maternity Team are visiting St Michael's to undertake an Ockenden Insight visit the end of May.

3. Risks
If this risk is on a formal risk register, please provide the risk ID/number.

The risks associated with this report include:

1. 3343 - delayed elective LSCS
2. 2264 - delayed induction of labour
3. 5652 - Risk that St Michael's Hospital (STMH) cannot offer an induction of labour (IOL) at 41 weeks as recommended by NICE guidelines
4. 33/3623/988 - NICU staffing/BAPM
5. 3553 Risk that the trust will not achieve CNST safety standards
6. 4810 Risk that if the trust does not achieve continuity of carer we will not achieve CNST safety standards
7. 3643 Risk that patient care will be compromised if remote IT access is not improved to provide a reliable accessible secure system

4. Advice and Recommendations
*(Support and Board/Committee decisions requested)***:**

- This report is for **Assurance.**

5. History of the paper
Please include details of where paper has previously been received.

Quality Assurance Committee	**20/05/2022**