University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Quality and Outcomes Committee on Monday 24 January 2022

Report Title	**Maternity Perinatal Quality Surveillance Matrix Monthly Update**
Report Author	[redacted]
Executive Lead	[redacted]

1. Report Summary

This report provides the board monthly oversight with regards to the safety matrixes of our maternity and neonatal services for the month of December 2021

2. Key points to note
(Including decisions taken)

- **Strengths:** implementation of Continuity of Carer (CoC) continues, with BAME at 70.8% and IMD 1(most deprived) at 68.1%
- [redacted]
- [redacted] All deaths have been reviewed for immediate learning by a senior midwife and consultant. No themes have emerged. All perinatal deaths will be reviewed as part of the MDT perinatal review meeting in January; peer trusts have been invited to attend for independent review.
- Staff concerns shared monthly with the Maternity and Neonatal Safety Champions and actions fed back to staff, current themes continue to include:
    - Staffing, effects of Covid absence causing concerns that there could be increased ratios of patients to midwives on the ward.
    - Estates on level E, escalated faulty heating causing cold rooms for patients
    - Incidents of Partners being in the ante natal waiting area have increased again; partners are asked to wait outside and called when their partner is called into to be seen to support social distancing.
- **Risks and Threats;** Risk to maternity incentive scheme (MIS) clinical negligence scheme for trusts (CNST) compliance. 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 CNST. The requirement is for 80% data entry over a 6 month consecutive period which we are unlike to achieve with the present IT failures in community. This has been escalated and is on the risk register. MIS has been suspended for 3 months from 23 December which will help with extra time to resolve data entry compliance issues.
- Risk 5774 added to the risk register regarding the challenges during present Covid pressures for the South West Ambulance Service (SWAST) to be able to provide timely emergency service if a transfer is required for a home birth. Coordinated across

the local maternity system (LMS), women have been informed of risk and recommended to birth in the unit. [redacted]

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

The risks associated with this report include:
3343 delayed elective LSCS
2264 delayed induction of labour
5652 Risk that St Michael's Hospital (STMH) cannot offer an induction of labour (IOL) at 41 weeks as recommended by NICE guidelines
33/3623/988 NICU staffing/BAPM
5774 Risk that operational pressures within SWAST will impact on the ability of UHBW to provide a safe homebirth/ABC birth service

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

- This report is for **Information.**

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

Quality Assurance Committee	**21/01/2022**
Women's Clinical Governance Group	**17/01/2022**

Acronym/Term	Explanation commonly used terms
UHBW	University Hospitals Bristol and Weston NHS Foundation Trust
RCA	Root Cause Analysis
SBAR	Situation, Background, Assessment, Recommendation Handover tool
CTG	Cardiotocograph
MLU	Midwifery Led Unit
DAU	Day Assessment Unit
CDS	Central Delivery Suite
FMU	Fetal Medicine Unit
O&G	Obstetrician and Gynaecologist
PPH	Postpartum Haemorrhage
Hb	Haemoglobin
NBT	North Bristol Trust
MCDA	Monochorionic Diamniotic Twins
TTTS	Twin to twin transfusion syndrome
MA	Maternity Assistant
MDT	Multidisciplinary team; various specialities of doctors/nurses/midwives etc. review cases collaboratively to make collect decisions on care
IOL	Induction of labour
CoC	continuity of carer, pathway of care from 29 weeks pregnancy, birth and postpartum for women to receive care from a known midwife
BAME	Black and minority ethnic category
IMD 1	Index of Multiple Deprivation patients, most vulnerable patients
Inborn babies	Babies who were born in St Michaels Hospital regardless of who the mother was booked under to deliver with originally
Out born babies	Babies who were born in a different unit but were transferred for ongoing neonatal care at St Michaels Hospital
SWAST	South West Ambulance Service