University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Quality and Outcomes Committee on Tuesday 22nd February 2022

Report Title	**Maternity Perinatal Quality Surveillance Matrix Monthly Update and Response to MBRRACE Report 2019**
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 January 2022 and our Response to MBRRACE Report 2019.

2. Key points to note

(Including decisions taken)

- **Strengths:** implementation of Continuity of Carer (CoC) presently 47.7%, with BAME at 73.2% and IMD 1(most deprived) at 61.4%
- UHBW's response to the 2019 MBRRACE-UK perinatal surveillance report demonstrates that our neonatal mortality rate is below national average
- The MBRRACE report compares St. Michael's NICU to similar units, those who have lower mortality rates than us (Manchester and Glasgow for example). These are much larger departments with many low risk babies (best viewed as units that mirror a merged Southmead and St. Michael's NICU cohort). Those units who have a similar setup to St. Michaels within their city (like Southampton or Cardiff) are much the same to St. Michael's NICU. If we were combined with NBT (their neonatal mortality is >15% lower than average as their patient mix comprises extreme preterm babies only), our numbers would be similar to units like e.g. Manchester
- As a network we are within 5% of the national average, as a local authority we are >15% lower than the national average and at BNSSG level we are 5-10% lower than the national average.
- MBRRACE-UK has recently published the triennial report on findings from review of maternal mortality 2017-19 in the UK. This report has shown that indirect causes of death (non-obstetric causes) continue to contribute to a majority of maternal mortality. Saving Lives, Improving Mothers' Care
  This is in the process of being reviewed as an MDT and will be shared once presented through women's governance.
  The majority of maternal mortality nationally has been due to non-pregnancy related causes (indirect causes), majority of which were attributed to cardiac and neurological causes. Furthermore, thromboembolism was the major cause of pregnancy-related (direct causes) maternal mortality.
- **Opportunities**: [redacted]

- Following a rapid review, several learning points were noted with regards to timely escalation and have been fed back to staff.
- 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.
  - persistent feedback about W76 Transitional Care regarding need for NICU nurse to be pulled back to NICU when NICU short staffed which results in MCA or Midwife having to take individual babies up to NICU for IV drugs, taking them away from the ward. Staff recognise need to keep all areas safe
  - Estates on level E, escalated faulty heating causing cold rooms for patients
- **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.
- Need 16.1 WTE midwives to achieve CoC as default model of care in April 2023, action plan has been escalated to Trust Board
- Risk regarding the challenges during present Covid pressures for the South West Ambulance Service (SWASFT) 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. Datix outcome for all home births during period of risk. Have noticed increase in BBA and late requests for midwifery attendance at home birth. Fortunately, no incidents recorded to date

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 SWASFT 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 **Assurance.**

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

Quality Assurance Committee	**18/02/2022**
Women's Clinical Governance Group	**21/02/2022**

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
BBA	Born Before Arrival (no professional support in attendance)
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
SWASFT	South West Ambulance Service Foundation Trust