

**Meeting of the Quality and Outcomes Committee on 26<sup>th</sup> October 2021**

<b>Report Title</b>	<b>Maternity Perinatal Quality Surveillance Matrix Monthly Update</b>
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<b>1. Report Summary</b>
This report provides the board monthly oversight with regards to the safety matrixes of our maternity and neonatal services.
<b>2. Key points to note</b> <i>(Including decisions taken)</i>
<ul style="list-style-type: none"> <li>• Induction of labour (IOL) waiting times still a concern leading to complaints. This is usually because of capacity on CDS. Has been escalated to trust, is on risk register.</li> <li>• Non-compliance in night-time consultant ward rounds noted. No change</li> <li>• There were 26 Datix related to workforce (service provision/staffing) 5 related to delayed IOL /11 related to non-compliance with BAPM standards/9 related to staffing levels and capacity the majority are from theatres due to their need to backfill for a maternity assistant to act as a runner. This role is open for recruitment on CDS. Theatres Datix whenever a second theatre is opened, either because this will delay the elective list or out of hours use.</li> <li>• UHBW Maternity attempted to divert / are on divert <b>once</b> during the reported period.</li> <li>• Exponential trend in September, almost double the number of premature babies born in September compared to August, total LSCS rate up at 36.4% from 33.1% in August</li> <li>• Staff concerns shared monthly with the Maternity and Neonatal Safety Champions and actions fed back to staff, current themes include: <ul style="list-style-type: none"> <li>• Staffing</li> <li>• Capacity- delayed IOL</li> <li>• Estates on level E</li> <li>• Career progression for maternity care assistants</li> </ul> </li> <li>• Following feedback the HoM is coordinating a focus group with our Somali representatives to ensure we continue to receive their feedback and learn how we can improve our offer of care to this population group.</li> <li>• A focus group was undertaken with two of our most deprived midwifery hubs, 7 women attended to feedback how the continuity of carer pathway of care is received. The feedback was universally positive from the women. Further focus groups are planned.</li> </ul>
<b>3. Risks</b> <b>If this risk is on a formal risk register, please provide the risk ID/number.</b>
<b>The risks associated with this report include:</b> <b>3343 delayed elective LSCS</b> <b>2264 delayed induction of labour</b> <b>33/3623/988 NICU staffing/BAPM</b>
<b>4. Advice and Recommendations</b> <i>(Support and Board/Committee decisions requested):</i>

<ul style="list-style-type: none"> <li>This report is for <b>Information</b>.</li> </ul>	
<b>5. History of the paper</b> <b>Please include details of where paper has <u>previously</u> been received.</b>	
<b>Women's Governance</b>	<b>18/10/2021</b>

Recommendation Definitions:

- **Information** - report produced to inform/update the Board e.g. STP Update. No discussion required.
- **Assurance** - report produced in response to a request from the Board or which directly links to the delivery (including risk) of one of the Trust's strategic or operational priorities e.g. Quality and Performance Report. Requires discussion.
- **Approval** - report which requires a decision by the Board e.g. business case. Discussion required.