University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Quality and Outcomes Committee on Tuesday 26th April 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 March 2022.

2. Key points to note

(Including decisions taken)

Strengths:

- implementation of Continuity of Carer (CoC) presently 53.7%, with BAME at 64.2% and IMD 1(most deprived) at 81.2%
- We received 15 formal compliments, all were for NICU
- The fetal monitoring week 28th March to raise awareness with staff involved with interpreting cardiotocographs (CTGs) was very well attended and great feedback from staff
- There have been no new HSIB cases

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 RCOG guidance, due to difficulties with recruitment and retention of sonographers

Opportunities:

- [redacted] Risk form at booking has been updated to be easier for admin staff to see referrals required
- MDT review of final Ockenden report, collaboration across LMS with shared reporting proforma. Leads assigned to review and progress individual actions.

- 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
    - 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). We are unlikely to achieve with the present IT failures in community. This has been escalated and is on the risk register. CNST has been suspended for 3 months from 23 December 2021 which will help with extra time to resolve data entry compliance issues. No update regarding re-instatement from MIS at time of report
- 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.

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 <u>previously</u> been received.**
N/A

Acronym/Term	Explanation commonly used terms
UHBW	University Hospitals Bristol and Weston NHS Foundation Trust
LMS	Local Maternity System (UHBW and NBT)
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
ABC	Ashcombe Birth Centre (based on Weston site)
LLETZ	large loop excision of the transformation zone, colposcopy procedure of the cervix