University Hospitals Bristol and Weston NHS Foundation Trust

Meeting of the Quality and Outcomes Committee on 17th December 2021

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 from the month of November 2021

2. Key points to note

(Including decisions taken)

- There were 13 Datix related to workforce (10 service provision/2 staffing/1 treatment or procedure) including 5 related to multiple delayed IOL /2 related to non-compliance with British Association of Perinatal Medicine (BAPM) standards. One Datix reported a community midwife who was unable to leave central delivery suite (CDS) due to workload and so was unable to provide continuity of care (CoC) to four of her postnatal patients in the community. This is an accepted risk of the CoC model.
- UHBW Maternity attempted to divert / are on divert ***once*** during the reported period.
- Total LSCS (lower section caesarean section) rate in November up at 37.7%. The emergency rate decreased in November to 22.4% from 25.3% in October. The data quality is still being reviewed with support from Business Intelligence Unit; please note the changed figures from last month's report on the matrix.
- [redacted]
- No HSIB (healthcare safety investigation branch) cases in November
- [redacted]
- 12 perinatal deaths since November 1st to 15th December, speaking to the Registrar they have noticed a rise across the area. All deaths have been reviewed for immediate learning by senior midwife and consultant. No themes have emerged. To consider if there is any link with Covid or vaccination, question not included on PMRT (perinatal mortality review tool).
- Staff concerns shared monthly with the Maternity and Neonatal Safety Champions and actions fed back to staff, current themes continue to include:
- Staffing
- Capacity- delayed Induction of labour (IOL)
- Estates on level E
- Risk to CNST (clinical negligence scheme for trusts) compliance, there was a delayed reporting of a late termination of pregnancy in November. The processes have been reviewed and enhanced to reduce the risk of another breach. The connectivity issues and capacity constraints within the community midwifery teams to input data into the Maternity Medway system is a risk that we will fail 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. NHS Digital have been notified of widespread failure in provider connectivity (BT issue) which effects data entry to system C (digital providers of maternity electronic system).

- Sickness in rotas, consultants acting down to cover and cross cover to maintain safe service. Obstetric Senior Registra (SR) rota at 7.7 WTE, should 9WTE.NICU Tier 2 rota, down to 6.6 WTE of 9 WTE, running at 2/3 of the trainee numbers we should have. The Deanery did not give us the expected numbers. Existing team have been picking up lots of extra locums shifts, but some shifts in the day have not been covered and the consultant team has stretched to cover, and we have had several nights where consultants have acted down. We will remain below the ideal 9.0 WTE until the March rotation.
- Midwives are having to do more newborn examinations (NIPE 's) because of absence of NICU doctors
- 53% qualified in speciality (QIS) trained (BAPM standard 70%). In the first half of next year we will drop to 45% with those on maternity leave. To try and tackle this we are in communication with [redacted] Recruitment Matron, regarding a specific QIS advert but these are rarely successful and are training 11 within the unit (3 currently on a course in Birmingham and 8 starting the January course in Bristol).
- A risk is being added to the register regarding the inability to offer IOL according to NICE guidelines due to capacity (physical space and staffing).
- Ongoing pressure for elective LSCS at STMH, with a case for further capacity to be raised through the 2022/23 OPP for consideration
- A MDT (multidisciplinary team) deep dive was undertaken into recent incidents which involved cardiotocograph (CTG) interpretation and escalation. From this further actions were assigned to improve dissemination of learning and past actions presented to evidence progress. Meeting minutes and actions to be shared with THQ safety team. [redacted] attended on behalf of THQ safety team and felt assured of all the work that has and continues to be undertaken.
- CTG and escalation focus week planned for New Year to highlight challenges staff have with CTG interpretation and how to remove these barriers. This idea was shared with the Local Maternity System(LMS), learn and support meeting last week and this action to be shared city wide to support collaborative working and learning together as an LMS
- Continuing to implement requirements for Ockenden, our final phase 2 report in response to Ockenden has been re-graded as 80% compliant following a review with the Regional Team

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**
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	**17/12/2021**

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.