Meeting Date	**21 December 2021**	**Agenda Item**	**5.1**
Report Title	Update for Maternity Services' Risk register		
Report Author	Susan Jose Head of Midwifery		
Report Sponsor	Gareth Howells, Executive Director of Nursing and Patient Experience (Interim)		
Presented by	Susan Jose Head of Midwifery		
Freedom of Information	Open		
Purpose of the Report	To provide the Quality and Safety Committee with an update in relation to the maternity service risk register.		

Key Issues	• The maternity service maintains a service specific risk register
	• Regular risk register review meetings are held with the senior maternity team for review and update
	• There are currently 19 open risks and one new risk for acceptance by the service group
	• 11 risks score ≥ 20. Of the 11 risks
	  ○ 4 risks are on the Health Board risk register
	  ○ 4 risks are specifically related to service delivery during the Covid 19 pandemic
	  ○ 3 risks are related to workforce and environment		

Specific Action Required ***(please choose one only)***	**Information**	**Discussion**	**Assurance**	**Approval**
	☐	☐	☒	☐

Recommendations	Members are asked to: **NOTE** the contents of the report and support the ongoing risk mitigation measures.

MATERINTY SERVICES RISK REGISTER UPDATE

1. INTRODUCTION

The purpose of the paper is to provide the Quality and Safety Committee with an update in relation to the maternity service risk register.

2. BACKGROUND

The maternity service governance framework includes the maintenance of a service specific risk register, which is monitored and reviewed within the Maternity Service Quality and Safety meeting, with exception reporting to the NPT & Singleton Service Group. A Risk register review meeting is held every 6-8 weeks and is chaired by the Head of Midwifery or Lead Midwife for Quality Safety & Risk, a new role developed in response to the RCOG/RCM Cwm Taf Report (2019).

When a risk is identified that impacts on the safety of the care and service provided a risk assessment is completed and submitted to the Risk register group and the NPT & Singleton Service Group for acceptance. The Grading appointed to each risk is agreed by the senior maternity team and wider service group delivery team as appropriate.

There are currently 19 open risks on the maternity risk register. At the time of preparing this report 11 risks are currently rated ≥ 20. This report will provide an update on the 11 risks within the High Risk category and will include the four risks accepted onto the health board risk register.

3. GOVERNANCE AND RISKS

Maternity Risk 2788 (HBR 81) -Critical Staffing levels Midwifery. (Risk rating (RR) 25)

On the 24th September 2021 the critical midwifery staffing level was raised to a risk rating of 25. A full briefing paper related to this risk was presented to the Q&S committee 26th October 2021, (appendices). At the time of preparing this report midwifery unavailability remains in excess of 30% overall with the community midwifery service most adversely impacted with unavailability over 40%. The actions and mitigation set out in the report presented on the 26th October 2021 continue to be enforced. The next review date for reinstating homebirth and Neath Port Talbot Birth Centre services will be 4th January 2022.

Maternity Risk 1605 (HBR 63) – Screening for Fetal Growth Assessment in line with Gap/Grow (RR 20)

There is evidence of the link between small for gestational age fetus and stillbirths. Seven incidents are linked to this risk in 2020 and 6 incidents linked to the risk in 2021

year to date. In 2020 two women experienced stillbirth where serial growth scans may have identified a small for gestational age fetus, leading to an altered plan of care.

The Welsh Government have mandated Health Boards to provide their ultrasound scan service in line with the Perinatal Institute Growth Assessment Programme (Gap). It was identified the capacity for providing the GAP was not available within the radiology service. A working group convened and developed an action plan to increase scan capacity through the provision of ultrasound training for midwives to deliver third trimester scans in line with GAP. Two midwives commenced training in January 2021 and will complete their practical assessment in January 2022. Following a preceptorship period they will provide service scan lists commencing April 2022. Third trimester scan capacity will increase by more than 4000 scans per annum. The priority group to offer serial growth scans will be for all women who smoke.

HEIW have provided a further two places, fully funded, on the University West of England (UWE), ultrasound training course for midwives commencing January 2022. The business case for the backfill for the two midwives is in preparation to ensure midwifery staffing is not impacted by this opportunity. A bid for funding for a second ultrasound scan machine has been uploaded to the capital SharePoint in order to fully support this training.

In October 2021 ultrasound scan for fetal anomaly scanning (conducted by radiology) was increased to 30 minute time slots in line with Antenatal Screening Wales Standards. This further reduced third trimester scan capacity between 20-25 appointments per week

It is anticipated the maternity service will be in a position to offer all women ultrasound scans in line with the GAP programme by April 2023.

<u>Maternity Risk 329 (HBR 65) – Lack of central CTG Monitoring on Labour wards (RR 20)</u>

The Business case for a central monitoring system has been in circulation for a number of years. Healthcare Inspectorate Wales (2020), Phase One report for maternity services in Wales recommend all Health Boards "*consider the introduction of live stream CTG monitoring in all units*". This will support clinicians in decision making in relation to CTG interpretation. The benefit of a central monitoring system include, inbuilt computerised interpretation of CTG recording, remote access to CTG recordings for providing clinical opinion from senior members of the obstetric and midwifery team and safe storage of CTG recordings for 25 years.

A procurement process has been completed with a preferred provider for a central monitoring system identified (K2). The system is a maternity service wide system to ensure all CTG recordings completed in the Health Board maternity service are maintained in electronic format for 25 years and will support training education and learning opportunities. The K2 system provides a full electronic copy of intrapartum

care records alongside the GP that will support incident reviews, complaint response and claim management.

The K2 system supports integration with administration systems and clinical systems, which has proven benefits for information sharing across the maternity team and speciality services. An example of this currently in use in England is an interface with "*Badgernet",* the neonatal electronic record and the Child Health electronic system, which will ensure prompt generation of an NHS number for baby.

The business case has been fully prepared and updated for submission to BCAG in December 2021.

Linked records related to this risk include two redress and four open claims, where concern of CTG interpretation is a factor in care provision.

Maternity Risk 2595 (HBR 74) – Delay in Induction of Labour

Safe midwifery staffing for maternity settings (NICE 2015) state the midwife in charge should look out for 'red flag events'. These are signs that there may not be enough midwives to give women and babies the care they need. Red Flag events include a delay in commencing induction of labour. NICE Inducing Labour guideline (2021) states women with pre labour rupture of membranes at term (at or after 37+0) should be offered a choice for expectant management for up to 24 hours or induction of labour as soon as possible. An incident report is submitted for all women who are not transferred to Labour Ward within 24 hours of pre-labour rupture of membranes.

Womens experience of induction of labour is a theme identified in Womens feedback and complaints received by the service. Delay in induction of labour is multi-factorial and include issues such as midwifery staffing levels, Labour Ward capacity and acuity and Neonatal Unit capacity and acuity.

The 2020 Birthrate+ compliance report identifies the requirement for an additional midwife on a daily basis for the antenatal ward area where induction of labour is commenced.

The datix system identifies 89 incidents have been linked to this risk during 2021. A review of each care episode is completed to ensure the outcome for women and babies is not impacted by delay. The majority of cases result in no harm with one incident being managed under redress

Daily acuity is reported to the senior midwifery team (or out of hours) the on-call manager for Women and Childrens services to support in time of high acuity. The manager on call will support with the redeployment of staff and liaise with neighbouring health boards on a case by case basis to prevent delay for ongoing induction of labour.

Maternity Risk 1354 – Birthrate+ compliance

All maternity services in Wales must be Birthrate+ compliant (Welsh Government 2019). A national workstream for a bespoke Birthrate+ model for Wales is currently ongoing with input from the Head of Midwifery in each Health Board.

The most recent Birthrate+ calculation for Swansea Bay UHB reported in November 2020, with a shortfall of 10.43WTE against budgeted establishment. The budgeted establishment does not include Band 5 graduate midwives who are employed each year and are required to complete a national preceptorship programme.

In 2021, eleven graduate midwives were employed via the streamlining process. Initially appointed to 22.5 substantive hours with a temporary increase to full-time hours until March 2022 to support the current critical midwifery staff unavailability (Risk 2788)

A workforce plan is in preparation to assess the current midwifery staff position with a medium to long term plan for clinical and specialist midwifery roles. This plan will link with the all Wales Birthrate+ working group.

Maternity Risk 2697 – Split site working

Intrapartum Maternity services for Swansea Bay UHB are located in Singleton and Neath Port Talbot Hospitals. Critical care services are located in Morriston Hospital. Critically unwell pregnant and postnatal women are required to transfer to Morriston Hospital for critical care, a high-risk transfer due to the complexities of care involved. Delay in transfer may cause significant harm or death for a woman and/or her baby. Since October 2020, six women have been transferred from Singleton Hospital to Morriston Hospital for ongoing care in the intensive care unit.

Alternatively, pregnant women or newly birthed mothers admitted directly to Morriston critical care services do not have immediate access to an obstetrician leading to potential delays in care.

Where it is recognised women are at risk for needing critical care during the perinatal period plans are made for women to birth in Cardiff who have obstetric, neonatal and critical care services in one building.

The solution for this risk is to relocate maternity and neonatal services to Morriston Hospital which will require significant infrastructure and funding.

Maternity Risk 2007 – Obstetric Theatre availability

Two Obstetric theatres are located on the Labour ward in Singleton Hospital. The theatres are managed by the maternity team, with a dedicated theatre team including anaesthetic cover available 24/7 for the main theatre. There is no dedicated team for opening a second theatre should an emergency arise. The lead Obstetrician must

consider the safety of all women who are admitted in labour ward and report their decision-making is impacted by the availability of a theatre team to open a second theatre in an emergency situation.

Seven incident reports submitted since September 2020 are linked to this risk. Two of the incidents are being supported through redress due to delays in care outside of standard practice.

A working group supported by maternity and theatre staff groups are preparing an options appraisal paper for all issues related to staffing and governance of obstetric theatres which will report to the Service Groups Delivery Units by April 2022

Maternity Risk– COVID-19 specific risks related to Maternity Services

- 2473 – inability to provide mandatory training updates
- 2472 – increased risk to safeguarding systems due to no face to face home visits
- 2470 – antenatal care surveillance with reduced face to face contact and reduced ultrasound scan schedules
- 2469 – delays in intrapartum care pathways due to IP&C procedures

During the Covid-19 Pandemic, temporary care pathways were introduced to reduce the risk of transmission of Covid-19 and protect vulnerable pregnant women. The pathways were in line with guidance from the Royal College of Obstetrics and Gynaecology.

In line with the critical staffing review dates consideration will be made to de-escalate from the Covid-19 pathways toward care pathways in line with NICE Antenatal care (2021).

4. FINANCIAL IMPLICATIONS

The financial implications are accounted for within the Service Group. The Service Group is mitigating the risks associated with staff shortages through the use of the newly developed Midwifery Bank, enhanced overtime and agency. As a result of the ongoing absence due to staff shielding, maternity leave, short and long term sickness, annual leave, fluctuating surge capacity and acuity the costs associated with the mitigations are likely to continue and pose a significant financial challenge for the Service group this financial year.

5. RECOMMENDATIONS

Members are asked to:

NOTE the contents of the report and support the ongoing risk mitigation measures.

Governance and Assurance		
Link to Enabling Objectives ***(please choose)***	**Supporting better health and wellbeing by actively promoting and empowering people to live well in resilient communities**	
	Partnerships for Improving Health and Wellbeing	☐
	Co-Production and Health Literacy	☐
	Digitally Enabled Health and Wellbeing	☒
	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	
	Best Value Outcomes and High Quality Care	☒
	Partnerships for Care	☒
	Excellent Staff	☒
	Digitally Enabled Care	☐
	Outstanding Research, Innovation, Education and Learning	☐
Health and Care Standards		
(please choose)	Staying Healthy	☒
	Safe Care	☒
	Effective Care	☒
	Dignified Care	☒
	Timely Care	☒
	Individual Care	☒
	Staff and Resources	☒

Quality, Safety and Patient Experience
The patient experience, incidents and complaints and claims are linked to the risk register as appropriate. Themes and trends are identified to risk score as appropriate.
Financial Implications
Representation will be made to the executive board for support with improvement initiatives to provide care in line with national standards and recommendations. Relocation of maternity services to co-locate with critical care services will require health board strategy and central funding and support from Welsh Government
Legal Implications (including equality and diversity assessment)
Incident and complaints and will be managed in accordance with the Civil Procedure Rules of the NHS Concerns, Complaints and Redress Arrangements Wales Regulations 2011.
Staffing Implications
Risks related to workforce will be reviewed within the maternity service, Service Group and wider stakeholder departments. All Wales recommendations will be included in the workforce plan for maternity staff
Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)
No Implications.

Report History	Monthly via the Q&SGG
Appendices	Appendix 1