

Meeting Title	Board of Directors		
Date	9 March 2023	Agenda item	Bo.3.23.15

MATERNITY AND NEONATAL (PERINATAL) BOARD ASSURANCE – JANUARY 2023

Presented by	Sara Hollins, Director of Midwifery		
Author	Sara Hollins, Director of Midwifery		
Lead Director	Professor Karen Dawber, Chief Nurse		
Purpose of the paper	To provide Trust Board with the bi-monthly assurance that Quality and Patient Safety Academy, has reviewed, considered and approved the monthly Maternity and Neonatal (Perinatal) Update papers.		
Key control	Identify if the paper is a key control for the Board Assurance Framework		
Action required	For assurance		
Previously discussed at/ informed by	Details of any consultation		
Previously approved at:	Academy/Group	Date	
	Quality and Patient Safety Academy	22/02/23	

Key Options, Issues and Risks

The December 2020, NHS publication 'Implementing a revised perinatal quality surveillance model' set out a number of requirements to ensure that there is Trust Board level oversight of perinatal clinical quality and safety.

The requirements to strengthen and optimise Board oversight for maternity and neonatal safety includes:

- That a monthly review of maternity and neonatal safety and quality is undertaken by the Trust Board.
- That all maternity Serious Incidents (SIs) are shared with Trust Boards and the LMS, in addition to reporting as required to Health Safety Investigation Branch (HSIB).
- To use a locally agreed dashboard drawing on locally collected intelligence to monitor maternity and neonatal safety at board meetings.

The monthly maternity and neonatal services report presented to Quality and Patient Safety Academy (QPSA), ensures that there is a timely and structured reporting mechanism of maternal and neonatal outcomes including learning from incidents, and that QPSA, as a delegated authority of Trust Board has assurance of an open and transparent oversight and scrutiny of perinatal (maternity and neonatal) services. A summary of incidents is provided to Closed Trust Board, in addition to any completed Health Safety Investigation Branch (HSIB) and internal Serious Incident (SI) reports.

The format of the monthly reports supports the Trust level implementation of the Perinatal Clinical Quality Surveillance Model and ensures that key elements of the framework are visible

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and transparent at Trust Board level.

The monthly paper also serves as the main mechanism for QPSA, as a delegated authority of Trust Board, to have oversight of key elements of the NHS Resolution Maternity Incentive Scheme (MIS), throughout the annual reporting period, such as quarterly Perinatal Mortality Review Tool reports, quarterly Avoiding Term Admissions Into Neonatal Units (ATAIN) report, and monthly midwifery and obstetric staffing updates.

This bi-monthly Maternity and Neonatal (Perinatal) Board Assurance paper provides a summary of the key elements of the monthly paper presented and discussed at QPSA, including the approval of any reports required to demonstrate compliance with the annual MIS.

Analysis

The Director of Midwifery and the Chair of QPSA provide Trust Board with the assurance that a monthly review of maternity and neonatal quality and safety relating to January 2023 activity, was presented and key elements discussed including:

- Maternity Incentive Scheme, Year 4, submitted declaring full compliance with all 10 safety actions.
- National Maternity Team approved our exit from the Maternity Safety Support Programme
- The number of harms occurring in January, including stillbirths, hypoxic ischaemic encephalopathy (HIE), neonatal deaths (NND), maternal deaths, and number of HSIB and SI cases were discussed.
- The Avoiding Term Admission into Neonatal Unit (ATAIN) and Transitional Care Unit (TCU) quarter 3 report was presented and discussed including learning.
- The quarterly maternity training compliance report was presented and discussed, including areas where improvement is noted and areas requiring focus.

Recommendation

- Trust Board to approve that they are assured that QPSA have reviewed and discussed the contents of the January Maternity and Neonatal (Perinatal) Services Update Paper, as a committee of the Board with delegated authority.
- Trust Board to approve that they are assured that QPSA have reviewed the ATAIN and TCU quarter 3 report, required to demonstrate compliance with Safety Action 3 of the MIS, as a committee of the Board with delegated authority.
- Trust Board to approve that they are assured that QPSA have reviewed the quarterly Maternity Training Compliance report and discussed both improvements and areas requiring further focus.
- Closed Trust Board to note Appendix 1 describing the stillbirths, HIE and neonatal deaths occurring in January 2023 and both newly reported and ongoing investigations.

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- To note that there were no completed HSIB or internal SI reports for the attention of Trust Board.

Risk assessment						
Strategic Objective	Appetite (G)					
	Avoid	Minimal	Cautious	Open	Seek	Mature
To provide outstanding care for patients			g			
To deliver our financial plan and key performance targets			g			
To be in the top 20% of NHS employers					g	
To be a continually learning organisation				g		
To collaborate effectively with local and regional partners					g	
The level of risk against each objective should be indicated. Where more than one option is available the level of risk of each option against each element should be indicated by numbering each option and showing numbers in the boxes.	Low		Moderate	High	Significant	
	Risk (*)					
Explanation of variance from Board of Directors Agreed General risk appetite (G)						

Benchmarking implications (see section 4 for details)	Yes	No	N/A
Is there Model Hospital data relevant to the content of this paper?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is there any other national benchmarking data relevant to the content of this paper?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is the Trust an outlier (positive or negative) for any benchmarking data relevant to the content of this paper?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Risk Implications (see section 5 for details)	Yes	No	N/A
Corporate Risk register and/or Board Assurance Framework Amendments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quality implications	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Resource implications	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Legal/regulatory implications	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Diversity and Inclusion implications	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Performance Implications	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

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Regulation, Legislation and Compliance relevance			
NHS Improvement: (please tick those that are relevant)			
<input checked="" type="checkbox"/> Risk Assessment Framework		<input checked="" type="checkbox"/> Quality Governance Framework	
<input type="checkbox"/> Code of Governance		<input type="checkbox"/> Annual Reporting Manual	
Care Quality Commission Domain: Choose an item.			
Care Quality Commission Fundamental Standard: Choose an item.			
NHS Improvement Effective Use of Resources: Choose an item.			
Other (please state):			
Relevance to other Board of Director's academies: (please select all that apply)			
People	Quality	Finance & Performance	Other (please state)
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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1 PURPOSE/ AIM

The purpose of the Maternity and Neonatal (Perinatal) Board Assurance paper is to provide Trust Board with the bi-monthly assurance that Quality and Patient Safety Academy as a Committee of Board with delegated authority, has reviewed, considered and approved the monthly Maternity and Neonatal (Perinatal) Update papers and any associated reports required to demonstrate compliance with the Maternity Incentive Scheme (MIS).

2 BACKGROUND/CONTEXT

The December 2020, NHS publication ‘ Implementing a revised perinatal quality surveillance model’ set out a number of requirements to ensure that there is Trust Board level oversight of perinatal clinical quality and safety.

The requirements to strengthen and optimise Board oversight for maternity and neonatal safety include:

- That a monthly review of maternity and neonatal safety and quality is undertaken by the Trust Board.
- That all maternity Serious Incidents (SIs) are shared with Trust Boards and the LMS, in addition to reporting as required to HSIB.
- To use a locally agreed dashboard drawing on locally collected intelligence to monitor maternity and neonatal safety at board meetings.

The monthly maternity and neonatal services report presented to Quality and Patient Safety Academy (QPSA), ensures that there is a timely and structured reporting mechanism of maternal and neonatal outcomes including learning from incidents, and that QPSA, as a delegated authority of Trust Board has assurance of an open and transparent oversight and scrutiny of perinatal (maternity and neonatal) services. A summary of incidents is provided to Closed Trust Board, in addition to any completed Health Safety Investigation Branch (HSIB) and internal Serious Incident (SI) reports.

The format of the monthly reports supports the Trust level implementation of the Perinatal Clinical Quality Surveillance Model and ensures that key elements of the framework are visible and transparent at Trust Board level.

The monthly paper also serves as the main mechanism for QPSA, as a delegated authority of Trust Board, to have oversight of key elements of the NHS Resolution Maternity Incentive Scheme (MIS), throughout the annual reporting period, such as quarterly Perinatal Mortality Review Tool reports, quarterly Avoiding Term Admissions Into Neonatal Units (ATAIN) reports, and monthly midwifery and obstetric staffing updates.

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This bi-monthly Maternity and Neonatal (Perinatal) Board Assurance paper provides a summary of the key elements of the monthly paper presented and discussed at QPSA, including the approval of any reports required to demonstrate compliance with the annual MIS.

Maternity and Neonatal Update January 2023:

The January update and associated appendices were discussed at February QPSA.

The key elements of the paper discussed included:

- The Maternity Incentive Scheme, Year 4, was submitted to NHS Resolution with the organisation declaring full compliance with all 10 safety actions. The service have not been approached for any further information or clarification since submission and are awaiting the outcome.
- On 10 January 2023, the National Maternity Team approved our exit from the Maternity Safety Support Programme. The improvement work undertaken and sustained was noted and commended at regional and national level.
- The number of harms occurring in January, including stillbirths, hypoxic ischaemic encephalopathy (HIE), neonatal deaths (NND), maternal deaths, and number of HSIB and SI cases were discussed and are available to Closed Trust Board as appendix 1. There were no completed HSIB or internal SI reports to share with Academy or Board for January.
- The Avoiding Term Admission into Neonatal Unit (ATAIN) and Transitional Care Unit (TCU) quarter 3 report was presented and discussed including learning. BTHFT consistently achieve a term admission rate well below the national average of <5%. Academy were informed of some of the challenges completing the reviews due to consultant work load and personnel changes within the maternity Quality and Safety team, and that this will be escalated to the Maternity and Neonatal Safety Champions if the situation does not improve.
- The quarterly maternity training compliance report was presented and discussed, including areas where improvement is noted and areas requiring focus. Safeguarding Children compliance was noted to be above the Trust 85% target following a focused push leading up to the CQC inspection. Clarification regarding PROMPT emergency training was provided as although midwifery and obstetric compliance is high, operating department practitioners (ODP) and anaesthetic compliance was noted to be low. It was explained that the Trust has 12 months to achieve 90% compliance in all staff groups and that the new reporting period commenced in January, therefore there are no concerns at this stage

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3 RECOMMENDATIONS

- Trust Board to approve that they are assured that QPSA have reviewed and discussed the contents of the January Maternity and Neonatal (Perinatal) Services Update Paper, as a committee of the Board with delegated authority.
- Trust Board to approve that they are assured that QPSA have reviewed the ATAIN and TCU quarter 3 report, required to demonstrate compliance with Safety Action 3 of the MIS, as a committee of the Board with delegated authority.
- Trust Board to approve that they are assured that QPSA have reviewed the quarterly Maternity Training Compliance report and discussed both improvements and areas requiring further focus.
- Closed Trust Board to note appendix 1 describing the stillbirths, HIE and neonatal deaths occurring in January 2023 and both newly reported and ongoing investigations.
- To note that there were no completed HSIB or internal SI reports for the attention of Trust Board.

4 Appendices

- Appendix 1 Closed Board Harms January 2023.