

Meeting Title	Board of Directors		
Date	11.05.23	Agenda item	Bo.5.23.13a

MATERNITY AND NEONATAL (PERINATAL) BOARD ASSURANCE – FEBRUARY/MARCH 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:	<i>e.g. Academy / ETM / CSU group</i>	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 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.

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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.

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 February and March 2023 activity, was presented and key elements discussed including:

- The number of harms occurring in February and March, including stillbirths, hypoxic ischaemic encephalopathy (HIE), neonatal deaths, and number of HSIB and SI cases were discussed.
- Completed HSIB and internal investigations/SI reports closed in February and March were discussed including learning and progress on actions.
- Details of 5 neonatal deaths occurring in February and assurance that there are no emerging themes and trends.
- The Perinatal Mortality Review Tool (PMRT) quarterly report including learning, required to demonstrate compliance with safety action 1 of the Maternity Incentive Scheme.

Recommendation

- Trust Board to be assured that QPSA have reviewed and discussed the contents of the February and March Maternity and Neonatal (Perinatal) Services Update Papers, as a committee of the Board with delegated authority.
- Trust Board to be assured that QPSA have reviewed the March PMRT quarterly report including learning, required to demonstrate compliance with safety action 1 of the Maternity Incentive Scheme as a committee of the Board with delegated authority.
- Closed Trust Board to note appendices 1 and 2 describing the stillbirths, HIE and neonatal deaths occurring in January 2023 and both newly reported and ongoing investigations.
- Closed Trust Board to note appendices 1a, 1b and 2a, completed HSIB/SI reports including recommendations.

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Risk assessment						
Strategic Objective	Appetite (G)					
	Avoid	Minimal	Cautious	Open	Seek	Mature
To provide outstanding care for our patients, delivered with kindness			g			
To deliver our financial plan and key performance targets			g			
To be one of the best NHS employers, prioritising the health and wellbeing of our people and embracing equality, diversity and inclusion					g	
To be a continually learning organisation and recognised as leaders in research, education and innovation				g		
To collaborate effectively with local and regional partners, to reduce health inequalities and achieve shared goals					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
High Level Risk Register and / or Board Assurance Framework Amendments	<input type="checkbox"/>	<input type="checkbox"/>
Quality implications	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Resource implications	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Legal/regulatory implications	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Equality Diversity and Inclusion implications	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Performance Implications	<input type="checkbox"/>	<input checked="" type="checkbox"/>

Regulation, Legislation and Compliance relevance
NHS England: (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 England Effective Use of Resources: Choose an item.
Other (please state):

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Relevance to other Board of Director's academies: (please select all that apply)			
People	Quality & Patient Safety	Finance & Performance	Other (please state)
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

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quarterly Perinatal Mortality Review Tool reports, quarterly Avoiding Term Admissions Into Neonatal Units (ATAIN) reports, 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.

Maternity and Neonatal Update February and March 2023:

The February and March updates and associated appendices were respectively discussed at March and April QPSA.

The key elements of the paper discussed included:

- The number of harms occurring in February and March, 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 appendices 1 and 2. There were 2 completed HSIB or internal SI reports to share with Academy or Board in February (appendices 1a and 1b) and 1 HSIB report shared in March (Appendix 2a).
- March QPSA was informed of 5 neonatal deaths occurring in February. Academy was assured that the cases had been reviewed as a cluster and no emerging themes and trends were identified, with no safety concerns highlighted.
- April QPSA reviewed and approved the PMRT quarterly report including learning, required to demonstrate compliance with Safety Action 1 of the Maternity Incentive Scheme. Learning themes for this reporting period include lack of evidence of written communication being provided for a number of topics including reduced fetal movements, condition specific information and in regard to whether parents' religious, spiritual or cultural needs were taken into consideration at the time of bereavement. The Bereavement Specialist Midwife is currently updating the bereavement checklist to ensure that this is considered and has designed 'reminder' posters for the bereavement storage area as an aide memoir.

3	RECOMMENDATIONS
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- Trust Board to approve that they are assured that QPSA have reviewed and discussed the contents of the February and March Maternity and Neonatal (Perinatal) Services Update Papers, as a committee of the Board with delegated authority.

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- Trust Board to approve that they are assured that QPSA have reviewed the March PMRT quarterly report including learning, required to demonstrate compliance with safety action 1 of the Maternity Incentive Scheme as a committee of the Board with delegated authority.
- Closed Trust Board to note appendices 1 and 2 describing the stillbirths, HIE and neonatal deaths occurring in January 2023 and both newly reported and ongoing investigations.
- Closed Trust Board to note appendices 1a, 1b and 2a, completed HSIB/SI reports including recommendations.

4	Appendices
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- Appendix 1, 1 a and 1b, Closed Board Harms February 2023 and completed HSIB/SI reports.
- Appendix 2 and 2a, Closed Board Harms March 2023 and completed HSIB report.