

Meeting Title	Board of Directors		
Date	13 July 2023	Agenda item	Bo.7.23.10

MATERNITY AND NEONATAL (PERINATAL) BOARD ASSURANCE – APRIL/MAY 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:		Date
	Quality and Patient Safety Academy (QPSA)	May and June 2023

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 April and May 2023 activity, was presented and key elements discussed including:

- The number of harms occurring in April and May, including stillbirths, hypoxic ischaemic encephalopathy (HIE), neonatal deaths, and number of HSIB and SI cases were discussed.
- June Academy noted the 5 stillbirths reported in May and that a table top review of the cases had not identified any emerging themes and trends in addition to the learning and recommendations from the individual cases.
- June Academy received a report regarding 9 neonatal deaths occurring in April and May.
- Completed HSIB and internal investigations/SI reports closed in April and May were discussed including learning and progress on actions.
- The ATAIN/TCU quarterly report, required to demonstrate compliance with safety action 3 of the Maternity Incentive Scheme presented to May Academy.
- May Academy noted the Maternity Training Compliance quarterly report and associated narrative.
- June Academy discussed the final CQC maternity inspection report and approved the associated action plan.

Recommendation

- Trust Board to confirm that they are assured that QPSA have reviewed and discussed the contents of the April and May Maternity and Neonatal (Perinatal) Services Update Papers, as a committee of the Board with delegated authority.
- Trust Board to confirm that they are assured that QPSA have reviewed the April ATAIN/TCU quarterly report including learning, required to demonstrate compliance with safety action 3 of the Maternity Incentive Scheme as a committee of the Board with delegated authority.
- Trust Board to note that there were no elements of the Maternity Incentive Scheme, Year 5, requiring sign off in May.

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- Closed Trust Board to note appendices 1 and 2 describing the stillbirths, HIE and neonatal deaths occurring in April and May 2023 and both newly reported and ongoing investigations
- Closed Trust Board to note appendices 1a and 2a completed HSIB/SI reports including recommendations.
- Trust Board to note that QPSA have received and discussed the final CQC Maternity Inspection Report and associated action plan and that QPSA will monitor progress on the action plan with escalations to Board as necessary.

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"/>

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Performance Implications	<input type="checkbox"/>	<input checked="" type="checkbox"/>
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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):

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"/>

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1	PURPOSE/AIM
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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
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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 April and May 2023:

The April and May updates and associated appendices were respectively discussed at May and June QPSA.

The key elements of the paper discussed included:

- The number of harms occurring in April and May, 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 was 1 internal SI reports to share with Academy and Board in April (Appendix 1a) and 1 Internal report shared in (Appendix 2a).
- June QPSA was informed of 5 stillbirths occurring in May. Academy was assured that the cases had been reviewed in a table top exercise and that no emerging themes and trends were identified in addition to the learning and recommendations from the individual cases.
- June QPSA received a report regarding 9 neonatal deaths occurring in April and May, receiving assurance that the deaths have been reviewed collectively for any emerging themes/trends. The report also compared Bradford data with similar tertiary units in the region and identified that BTHFT is not an outlier.
- May QPSA reviewed and approved the ATAIN/TCU quarterly report including learning, required to demonstrate compliance with Safety Action 3 of the Maternity Incentive Scheme. The Service consistently achieves admission rates well below the 5% national target and review of this quarter has revealed no major changes and no relevant current actions.
- May QPSA were provided with the quarterly Maternity Training Compliance report, including areas for attention and improvement. PROMPT compliance shows a reduction in the number of other obstetric doctors which has dropped to 72.41%. This is due to new GP trainees on the rota who are all booked on upcoming days. Overall obstetric compliance is 81.25%.
- Anaesthetists are 60% compliant as although 4 anaesthetists attended in May, 3 others became non-compliant in May. This has been escalated to the PROMPT anaesthetic lead who has been asked to review the data and escalate further if releasing staff continues to be a challenge.
- June QPSA discussed the publication of the CQC Maternity Inspection report and noted the overall rating which has remained 'requires improvement', but noted the significant improvement from 'inadequate' to 'good' in the well-led domain.

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- The overall report was noted to be positive and reflected the improvements made and sustained since the 2019 inspection.
- June QPSA approved the associated CQC action plan, which contains 2 'must do' recommendations and 5 'should do' recommendations. Progress on the action plan will be monitored at QPSA and escalated to Board accordingly.

3	RECOMMENDATIONS
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- Trust Board to approve that they are assured that QPSA have reviewed and discussed the contents of the April and May Maternity and Neonatal (Perinatal) Services Update Papers, as a committee of the Board with delegated authority.
- Trust Board to approve that they are assured that QPSA have reviewed the April ATAIN/TCU quarterly report including learning, required to demonstrate compliance with safety action 3 of the Maternity Incentive Scheme as a committee of the Board with delegated authority.
- Trust Board to note that there were no elements of the Maternity Incentive Scheme, Year 5, requiring sign off in May.
- Closed Trust Board to note appendices 1 and 2 describing the stillbirths, HIE and neonatal deaths occurring in April and May 2023 and both newly reported and ongoing investigations.
- Closed Trust Board to note appendices 1a and 2a completed HSIB/SI reports including recommendations.
- Trust Board to note that QPSA have received and discussed the final CQC Maternity Inspection Report and associated action plan and that QPSA will monitor progress on the action plan with escalations to Board as necessary.

4	Appendices
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- Appendix 1 and 1a - Closed Board Harms April 2023 and completed HSIB/SI reports.
- Appendix 2 and 2a - Closed Board Harms May 2023 and completed HSIB report.