Bradford Teaching Hospitals
NHS Foundation Trust

Meeting Title	Board of Directors		
Date	21.09.23	Agenda item	Bo.9.23.12

MATERNITY AND NEONATAL (PERINATAL) BOARD ASSURANCE – JUNE/JULY 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:	e.g. Academy / ETM / CSU group	**Date**
	Quality and Patient Safety Academy	July and August 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 June and July 2023 activity, was presented and key elements discussed including:

- The number of harms occurring in June and July, including stillbirths, hypoxic ischaemic encephalopathy (HIE), neonatal deaths, and number of HSIB and SI cases were discussed.
- June QPSA were informed that there was to be a 'Deep Dive' of HIE cases occurring in 2022/23 as we have identified ourselves as a possible outlier. This will has been deferred from July due to holidays and a multidisciplinary review arranged for September.
- Completed HSIB and internal investigations/SI reports closed in June and July were discussed including learning and progress on actions.
- The PMRT quarterly report including learning, required to demonstrate compliance with safety action 1 of the Maternity Incentive Scheme presented to July QPSA.
- The ATAIN/TCU quarterly report, required to demonstrate compliance with safety action 3 of the Maternity Incentive Scheme presented to August Academy.
- June and July Maternity Training Compliance was presented and discussed respectively at July and August QPSA.
- July QPSA were informed that the CSU has an emerging concern regarding the Core Competency Framework training requirements and the significant increase required for each midwife to meet compliance.
- A Maternity Incentive Scheme, Year 5, position was presented to the Executive Team Meeting on 7 August.

Recommendation

- Trust Board to approve that they are assured that QPSA have reviewed and discussed the contents of the June and July Maternity and Neonatal (Perinatal) Services Update Papers, as a committee of the Board with delegated authority. Appendices 1 and 2.
- Trust Board to note that a multidisciplinary team review of the 2022/23 HIE cases will take place in September and findings presented to October QPSA.
- Trust Board to approve that they are assured that QPSA have reviewed the June

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Perinatal Mortality Review Tool (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.

- Trust Board to approve that they are assured that QPSA have reviewed the July 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.
- Closed Trust Board to note appendices 3 and 4 describing the stillbirths, HIE and neonatal deaths occurring in June and July 2023 and both newly reported and ongoing investigations.
- Closed Trust Board to note appendices 3a, 3b and 4a completed HSIB/SI reports including recommendations.
- Trust Board to note that concerns regarding meeting the Core Competency Framework training requirements was reported to June QPSA and subsequently presented to Executive Team Meeting as part of the Maternity Incentive Scheme, Year 5 update.
- Trust Board to note appendix 5, Maternity Incentive Scheme, Year 5, position presentation, discussed at Executive Team Meeting on 7 August, and the current prediction that the Trust will not be in a position to declare full compliance in February 2024.

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?	☒	☐	☐
Is there any other national benchmarking data relevant to the content of this paper?	☒	☐	☐

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Is the Trust an outlier (positive or negative) for any benchmarking data relevant to the content of this paper?	☒	☐	☐

Risk Implications (see section 5 for details)	**Yes**	**No**
High Level Risk Register and / or Board Assurance Framework Amendments	☐	☐
Quality implications	☒	☐
Resource implications	☐	☒
Legal/regulatory implications	☐	☒
Equality Diversity and Inclusion implications	☒	☐
Performance Implications	☐	☒

Regulation, Legislation and Compliance relevance
NHS England: (please tick those that are relevant) ☒Risk Assessment Framework ☒Quality Governance Framework ☐Code of Governance ☐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)
☐	☒	☐	☐

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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 Updates June and July 2023 (Appendices 1 and 2):

The June and July updates and associated appendices were respectively discussed at July and August QPSA.

The key elements of the paper discussed included:

- The number of harms occurring in June and July, 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 3 and 4. There was 1 internal SI reports to share with Academy and Board in July (Appendix 3a), 1 HSIB report (Appendix 3b) and 1 Internal report shared in July (Appendix 4a).
- Review of Yorkshire and Humber regional data for cases of Hypoxic Ischaemic Encephalopathy (HIE) occurring in 2022/23, suggests that BTHFT is an outlier. QPSA noted that a multidisciplinary team 'deep dive' will take place in July and the findings shared with September Academy. Due to summer holidays and industrial action this has been deferred until September with an update to QPSA in October.
- July QPSA received the Perinatal Mortality Review Tool, Quarterly report, including learning. This is required to demonstrate compliance with Safety Action 1 of the Maternity Incentive Scheme, Year 5. QPSA noted that the service has either met, or is within timeframe to meet the standard.
- July QPSA was informed that the CSU has an emerging concern regarding the Core Competency Framework training requirements and the significant increase required for each midwife to meet compliance. This is a component of the Maternity Incentive Scheme, and was subsequently included in a position presentation to Executive Team Meeting in August.
- Maternity Training Compliance is now presented to QPSA on a monthly basis rather than quarterly. Both July and June QPSA were assured that there is ongoing scrutiny regarding PROMPT compliance, particularly around anaesthetic compliance which is below the expected position. A recovery plan is in place and any concerns will be escalated to QPSA and Board as necessary.
- August 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. The multidisciplinary team review processes of ATAIN/TCU data

is currently being reviewed and strengthened to ensure that both maternity and neonatal services are equally engaged and invested in the process.

- The Maternity Incentive Scheme, Year 5, predicted compliance position was presented to Executive Team Meeting on 7 August (Appendix 5). ETM were appraised that there is a high level of confidence that 7 of the safety actions will be achieved, moderate confidence that 1 will be achieved, and low confidence regarding 2 safety actions. This is a financial risk to the organisation and may attract scrutiny regarding safety measures. Board level sign off of the action plans relating to the safety actions not achieving full compliance will be required in January prior to February submission, to provide assurance of any mitigation in place and any challenges requiring Board level support.

3 RECOMMENDATIONS

- Trust Board to approve that they are assured that QPSA have reviewed and discussed the contents of the June and July Maternity and Neonatal (Perinatal) Services Update Papers, as a committee of the Board with delegated authority. Appendices 1 and 2.
- Trust Board to note that a multidisciplinary team review of the 2022/23 HIE cases will take place in September and findings presented to October QPSA.
- Trust Board to approve that they are assured that QPSA have reviewed the June Perinatal Mortality Review Tool (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.
- Trust Board to approve that they are assured that QPSA have reviewed the July 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.
- Closed Trust Board to note Appendices 3 and 4 describing the stillbirths, HIE and neonatal deaths occurring in June and July 2023 and both newly reported and ongoing investigations.
- Closed Trust Board to note Appendices 3a, 3b and 4a completed HSIB/SI reports including recommendations.
- Trust Board to note that concerns regarding meeting the Core Competency Framework training requirements was reported to June QPSA and subsequently presented to Executive Team Meeting as part of the Maternity Incentive Scheme, Year 5 update.
- Trust Board to note appendix 5, Maternity Incentive Scheme, Year 5, position presentation, discussed at Executive Team Meeting on 7 August, and the current prediction that the Trust will not be in a position to declare full compliance in February 2024.

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4 Appendices

- Appendix 1, Maternity and Neonatal Services Update Paper, June 2023
- Appendix 2, Maternity and Neonatal Services Update Paper, July 2023
- Appendix 3, 3a and 3b, Closed Board Harms June 2023 and completed HSIB/SI reports
- Appendix 4 and 4a, Closed Board Harms July 2023 and completed HSIB report
- Appendix 5, Maternity Incentive Scheme, Year 5, position presentation