Bradford Teaching Hospitals
NHS Foundation Trust

Meeting Title	Board of Directors		
Date	16 November 2023	Agenda item	Bo.11.23.3

MATERNITY AND NEONATAL (PERINATAL) BOARD ASSURANCE– AUGUST/SEPTEMBER 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 approval	
Previously discussed at/informed by	Details of any consultation	
Previously approved at:	e.g. Academy / ETM / CSU group	**Date**
	Quality and Patient Safety Academy	September and October 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 Maternity and Neonatal Safety Investigations (MNSI) formerly 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 Maternity and Neonatal Safety Investigations (MNSI) and internal Serious Incident (SI) reports.

Meeting Title	Board of Directors		
Date	16 November 2023	Agenda item	Bo.11.23.3

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.

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 August and September 2023 activity, was presented and key elements discussed including:

- The number of harms occurring in August and September, including stillbirths, hypoxic ischaemic encephalopathy (HIE), neonatal deaths, and number of MNSI and SI cases were discussed.
- Completed MNSI and internal investigations/SI reports closed in August and September were discussed including learning and progress on actions.
- September QPSA was provided with the key headlines from the SCORE cultural survey.
- September QPSA was asked to note that the Perinatal Leadership Quad joined the August bi-monthly perinatal safety Champion meetings and that there were no safety escalations requiring support from Board.
- September Academy was asked to note that there will be a system wide thematic review of 4 indirect maternal deaths by suicide, and 1 attempted suicide occurring in 2020-2023. Any findings/recommendations will be shared at a future QPSA meeting. A further summary of maternal deaths in the last 3 years was also provided to October Academy.
- August and September Maternity Training Compliance was presented and discussed respectively at September and October QPSAOctober QPSA were provided with an update on progress with the Three Year Plan for Maternity and Neonatal Services, including some of the areas which may need Board level support in the future.
- October Academy was asked to note appendix 5, the quarterly Board level report and implementation plan for Saving Babies' Lives Care Bundle Version 3, which has had external review from LMNS and ICB representatives. The opinion is that It is anticipated that the Trust will be able to demonstrate 50% compliance in each element and 70% compliance overall across all 6 elements by the next meeting in December.

Meeting Title	Board of Directors		
Date	16 November 2023	Agenda item	Bo.11.23.3

- September and October QPSA were both informed of the ongoing challenges achieving 1:1 care in labour due to ongoing staffing pressures and high activity and acuity.

Recommendation

- Trust Board to approve that they are assured that QPSA have reviewed and discussed the contents of the August and September Maternity and Neonatal (Perinatal) Services Update Papers, as a committee of the Board with delegated authority. Appendices 1 and 2.
- Trust Board to approve that they are assured that QPSA have reviewed the Quarter 2 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.
- Closed Trust Board to note appendices 3 and 4 describing the stillbirths, HIE and neonatal deaths occurring in August and September 2023 and both newly reported and ongoing investigations.
- Trust Board to acknowledge that Appendix 4a, completed internal incident report including learning, was shared with October QPSA and is available for the attention of Closed Board.
- Trust Board to approve appendix 5, the quarterly Board level report and implementation plan for Saving Babies' Lives Care Bundle Version 3, which has had external review from LMNS and ICB representatives. The opinion is that It is anticipated that the Trust will be able to demonstrate 50% compliance in each element and 70% compliance overall across all 6 elements by the submission date.
- Trust Board to acknowledge that QPSA agreed that they were assured with the content of the papers and information presented in September and partially assured in October although no specific issues were raised, or requests for further information/clarification.Trust Board is asked to seek clarification from the Chair of QPSA, that the PMRT quarterly report was approved, as this is a compliance requirement for the Maternity Incentive Scheme, year 5.
- Trust Board to receive and acknowledge the accompanying presentation including update on progress with delivery of the Three Year Plan for Maternity and Neonatal Service.

Risk assessment						
Strategic Objective	Appetite (G)					
	Avoid	Minimal	Cautious	Open	Seek	Mature
To provide outstanding care for our patients, delivered with kindness			g			

Meeting Title	Board of Directors		
Date	16 November 2023	Agenda item	Bo.11.23.3

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?	☒	☐	☐
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)
☐	☒	☐	☐

Meeting Title	Board of Directors		
Date	16 November 2023	**Agenda item**	**Bo.11.23.3**

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 Maternity and Neonatal Safety Investigations (MNSI) formerly 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 MNSI 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.

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 August and September 2023 (appendices 1 and 2):

The August and September updates and associated appendices were respectively discussed at September and October QPSA. To note that October QPSA was held on 1 November.

The key elements of the paper discussed included:

- The number of harms occurring in August and September, including stillbirths, hypoxic ischaemic encephalopathy (HIE), neonatal deaths (NND), maternal deaths, and number of MNSI and SI cases were discussed and are available to Closed Trust Board as appendices 3 and 4.There was 1 completed Internal report including learning, shared in October (appendix 4a).
- October QPSA received the Quarter 2 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.
- Maternity Training Compliance is now presented to QPSA on a monthly basis rather than quarterly. Both September and October 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 this is being monitored closely. The service received notification in October that NHS Resolution has revised the compliance threshold to 80% of all eligible staff groups due to pressures as a result of ongoing Industrial Action. This increases the likelihood of meeting the standard.
- September QPSA was provided with the key headlines from the SCORE cultural survey. 41% response rate overall. Staff responded positively to the unit being:
    - Positive safety culture
    - Improvement ready
    - Providing a good work life balance
    - Positive regarding job certainty
    - Intention to leave was low
    - Good opportunity for growth

- Areas for improvement:

    - Staff rated emotional recovery related to work as low
      The next steps will be to share the high level feedback with the wider team before commencing smaller focus groups to look at any improvement work the wider team wish us to consider.

- September QPSA was asked to note that the Perinatal Leadership Quad joined the August bi-monthly perinatal safety Champion meetings and that there were no safety escalations requiring support from Board.

- September Academy were asked to note that there will be a system wide thematic review of 4 indirect maternal deaths by suicide, and 1 attempted suicide occurring in 2020-2023. Any findings/recommendations will be shared at a future QPSA meeting. An initial meeting with system leads has occurred and it was agreed that a learning event will be held in the New Year. A further summary of maternal deaths in the last 3 years was also provided to October Academy.

- October QPSA were provided with an update on progress with the Three Year Plan for Maternity and Neonatal Services Compliance with the long standing Maternity Incentive Scheme 10 safety actions will support delivery of the plan in many areas. However, there are a number of areas which will prove challenging and may require Board level support.

    - Achieve UNICEF accreditation- will involve a significant training input additional to the Core Competency Framework requirements.
    - Progression of further Maternity Continuity of Carer teams when safe staffing achieved and sustained.
    - Equality Lead within the service.
    - Development of an in house equality dashboard and an improvement plan based on findings- will need support from BI and Digital colleagues.
    - MNVP involvement in co-production of services - ongoing challenges with the current ICP resource available to support Bradford and Airedale.

- October Academy were asked to note appendix 5, the quarterly Board level report and implementation plan for Saving Babies' Lives Care Bundle Version 3, which has had external review from LMNS and ICB representatives. The opinion is that It is anticipated that the Trust will be able to demonstrate 50% compliance in each element and 70% compliance overall across all 6 elements by the next meeting in December.

- September and October QPSA were both informed of the ongoing challenges achieving >90% 1:1 care in labour, including the proposed improvement actions to address including:

    - Matron for inpatient wards working with the teams to identify inefficiencies which may be impacting on flow.
    - Birth Rate Plus commences in November to recalculate acuity of women using the service and the midwifery establishment required to deliver safe services.
    - Ongoing midwifery and support staff recruitment.

- September QPSA reported and recorded that they were assured by the papers, presentation and discussion. There was nothing identified requiring escalation to Board.
- October QPSA verbally reported that they had some assurance from the report, presentation and discussion. It was not clear what elements of the information they were unassured or concerned by. However, there was nothing identified at the meeting requiring onward escalation to Board. As a minimum, the service respectfully asks that Board seeks clarification from the Chair of QPSA, that the PMRT quarterly report was approved, as this is a compliance requirement for the Maternity Incentive Scheme, year 5.

3 RECOMMENDATIONS

- Trust Board to approve that they are assured that QPSA have reviewed and discussed the contents of the August and September Maternity and Neonatal (Perinatal) Services Update Papers, as a committee of the Board with delegated authority. Appendices 1 and 2.
- Trust Board to approve that they are assured that QPSA have reviewed the Quarter 2 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.
- Closed Trust Board to note appendices 3 and 4 describing the stillbirths, HIE and neonatal deaths occurring in August and September 2023 and both newly reported and ongoing investigations.
- Trust Board to acknowledge that Appendix 4a, completed internal incident report including learning, was shared with October QPSA and is available for the attention of Closed Board.
- Trust Board to acknowledge that QPSA agreed that they were assured with the content of the papers and information presented in September and partially assured in October although no specific issues were raised, or requests for further

information/clarification.Trust Board is asked to seek clarification from the Chair of QPSA, that the PMRT quarterly report was approved, as this is a compliance requirement for the Maternity Incentive Scheme, year 5.

4 Appendices

- Appendix 1, Maternity and Neonatal Services Update Paper, August 2023
- Appendix 2, Maternity and Neonatal Services Update Paper, September 2023
- Appendix 3, Closed Board Harms August 2023
- Appendix 4 and 4a, Closed Board Harms September 2023 and completed HSIB report
- Appendix 5, Board Report and Action Plan on Implementation of the Saving Babies' Lives Care Bundle (Version 3)