East Suffolk and North Essex NHS Foundation Trust

Quality and Patient Safety Committee

Report Title:	Compliance with CNST Maternity Safety Standard
Executive/NED Lead:	Darren Darby, Chief Nurse Hussein Khatib, NED
Report author(s):	Amanda Price-Davey – Director of Midwifery
Previously considered by:	Women's and Children's Divisional Management Team

☑ **Approval** ☐ **Discussion** ☐ **Information** ☐ **Assurance**

Executive summary

NHS Resolution is operating year five of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) to continue to support the delivery of safer maternity care.

This paper sets out the Trust's current position on Safety Action 9:

Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?

Reporting period 30th May 2023 to 1st February 2024 (there are sub dates within the standards

Required standard A (1st August 2023 for approval by regional chief midwife)

All six requirements of Principle 1 of the Perinatal Quality Surveillance Model must be fully embedded.

This includes evidence to demonstrate;

- Does your Trust have evidence that a non-executive director (NED) has been appointed and is working with the Board safety champion to address quality issues?
- Does your Trust have evidence that a review of maternity and neonatal quality is undertaken by the Trust Board at every Trust Board meeting, as a minimum bi-monthly, using a minimum data set to include a review of the thematic learning of maternity serious incidents.
- Do you have evidence that the perinatal clinical quality surveillance model has been reviewed in full in collaboration with the local maternity and neonatal system (LMNS) lead and regional chief midwife? And does this evidence show how Trust-level intelligence is being shared to ensure early action and support for areas of concern or need.

Required standard B

Evidence that discussions regarding safety intelligence; concerns raised by staff and service users; progress and actions relating to a local improvement plan utilising the Patient Safety Incident Response Framework are reflected in the minutes of Board, LMNS/ICS/ Local & Regional Learning System meetings.

Do you have evidence that Trust's claims scorecard is reviewed alongside incident and complaint data? Scorecard data is used to agree targeted interventions aimed at improving patient safety and reflected in the Trust's Patient Safety Incident Response Plan. These quarterly discussions must be held at least twice in the MIS reporting period at a Trust level quality meeting. This can be a Board or directorate level meeting.

Required standard C

Evidence that the Maternity and Neonatal Board Safety Champions (BSC) are supporting the perinatal quadumvirate in their work to better understand and craft local cultures.

Evidence to include;

- Have you submitted the evidence that both the non-executive and executive maternity and neonatal Board safety champion have registered to the dedicated FutureNHS workspace with confirmation of specific resources accessed and how this has been of benefit?
- Have there been a minimum of two quarterly meetings between board safety champions and quadumvirate members between 30 May 2023 and 1 February 2024?
- Have you submitted evidence that the meetings between the board safety champions and quad members have identified any support required of the Board and evidence that this is being implemented?

Action Required of the Performance Committee
To consider and approve the contents of the report.

Link to Strategic Objectives (SO)		**Please tick**
SO1	Keep people in control of their health	☑
SO2	Lead the integration of care	☑
SO3	Develop our centres of excellence	☐
SO4	Support and develop our staff	☐
SO4	Drive technology enabled care	☐

Risk Implications for the Trust *(including any clinical and financial consequences)*	If the Trust is unable to meet the expectations of the CNST SA9 the risk is non-compliance against the standards.
Trust Risk Appetite	Quality: The board will take minimal risks when it comes to patient safety, patient experience or clinical outcomes. Its

	tolerance for risk taking will be limited to decisions where the impact is low and the potential mitigations are strong
Legal and regulatory implications *(including links to CQC outcomes, Monitor, inspections, audits, etc)*	MIS applies to all trusts that deliver maternity services and are members of CNST. If ESNEFT is unable to meet the requirements of the MIS then there is an increased risk of breaches to the Fundamental Standards and associated Regulations as outlined in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2015.
Financial Implications	Risk to reputation and subsequent financial loss by not meeting the incentive scheme standards
Equality and Diversity	No specific E & D risks identified

1. Narrative summary

A review of the PQSM framework was undertaken and submitted to the Regional Chief midwife, this was approved on 29th June 2023 in advance of the 1st August deadline) **Evidence file 0.1)** . Along with the approval she did make some suggestions for improvement. In light of this a further System wide review was undertaken with oversight from the SNEE LMNS Safety forum. Evidence of the changes made and how each Trust meets this new model is in evidence **files 0.2 – 0.2.3**.

Evidence of the appointment of a NED as Board level Safety Champion and chair of the Quality sub board Committee QPS, is included in **evidence files 0.3** Along with other Safety champions in the Know your Safety champions posters which are displayed in all clinical areas **(evidence 0.3.1)**

The rest of the standard A is evidenced in the table below as there is a multitude of evidence required to demonstrate conversations that are happening at Trust level.

Maternity safety reported to Board at least bi-monthly	**Evidence by month**							
	June 2023	July 2023	August 2023	September 2023	October 2023	November 2023	December 2023	January 2024
Incidents, PSiis, themes and actions arising	Patient Safety Report pages 16-23 of IPR Includes Claims scorecard review **Evidence 0.4**	Patient Safety report pages 20-27 **Evidence 0.4.1**		Patient Safety Report pages 18-32 **Evidence 0.4.2** CEG Division exception report	Integrated Patient Safety & Experience Report pages 15-23 **Evidence 0.4.6**	PMRT Q2 and ATAIN Q1 report to Trust Board **Evidence 0.4.8** Trust PSR **Evidence 0.4.20**	Mat Neo sharing Safety Intelligence **Evidence 0.4.10**	Maternity update for PSG (Dec) and Trust Board January 2024 **Evidence 0.4.13** ATAIN Q2 report

				Evidence 0.4.4	Maternity update to Board **Evidence 0.4.9**			
Service user feedback	Patient Safety Report pages 16-23 of IPR	Patient Safety report pages 20-27		EBED CKI to Trust Board **Evidence 0.4.5** CEG Division exception report	Integrated Patient Safety & Experience Report pages 15-23	Patient Experience report Oct to Nov Board **Evidence 0.4.21** (maternity survey results) **Evidence 0.4.14**	Mat Neo CKI **Evidence 0.4.11** Mat Neo sharing Safety Intelligence	Patient Experience divisional exception report TBC
Workforce	Patient Safety Report pages 16-23 of IPR	Patient Safety report pages 20-27 Full workforce Review to Trust Board		EBED CKI to Trust Board Including governance deep dive and workforce review	Integrated Patient Safety & Experience Report pages 15-23	Full Clinical Workforce + Maternity update to Trust Board **Evidence 0.4.7**	EBED CKI **Evidence 0.4.11**	CNST sign off SA4 and SA5 Full workforce Reports to Trust Board
Staff Training	Patient Safety Report pages 16-23 of IPR	Patient Safety report pages 20-27		Patient Safety Report pages 18-32 (CCFv2)	Integrated Patient Safety & Experience Report pages 15-23	Maternity update to Trust Board **Evidence 0.4.7** CCFv2	Mat Neo sharing Safety Intelligence	CNST sign off to Trust Board including SA8
Staff feedback from front line champions		Mat Neo Minutes **Evidence 0.4.15**		Mat Neo Minutes **Evidence 0.4.17** Walk around feedback Chief Nurse **Evidence 0.4.18**	Maternity Health and Safety concerns **Evidence file 0.8**	Mat Neo meeting minutes (staff concerns raised) **Evidence 0.4.14**	Mat Neo sharing Safety Intelligence Mat Neo CKI Rapid Quality Review **Evidence 0.4.19**	Mat Neo Sharing intelligence form walk around on 21/12/23 TBC

Standard B

Evidence around safety intelligence as required in standard B is also included in A where intelligence has been shared at Board level. In addition to this PSIRF plans are discussed with LMNS/ICB through the Safety Forum, chaired by the Clinical Lead for the LMNS and are detailed in **evidence files 0.5 – 0.5.8**

ESNEFT have attended and contributed to the System wide learning events in SNEE and collaboratively with MSE as well. **Evidenced with file 0.5.9**

Evidence of the Trust using the Claims score card alongside incident data can be seen in the June Patient safety report **(evidence file 0.4).** The legal team also present quarterly to Divisional Board, so that discussions around triangulating data can happen at divisional level. **Evidenced in files 0.9 and 0.9.1**

In additional to this we held an extraordinary Mat Neo meeting of Safety Champions on 12th July specifically to focus on reviewing the claims score card as safety champions to ensure good triangulation of data. **Evidence 0.9.2**

Standard C is evidenced by way of emails confirming that all Board level champions had joined the Futures platform in the required timeframes. Also included is a later joining for our New Chief Nurse, who joined the organisation after this deadline but is also now signed up. **Evidence files 0.6 – 0.6.3**

There have been 5 meetings between the safety champions and the quadumvirate and these are evidenced in the safety champion Mat Neo meetings **Evidence 0.4.15 – 0.4.19**

We also had an additional extra ordinary meeting on 12th July 2023 to specifically discuss claims and ensure triangulation of data.

Evidence to demonstrate where support is required has been through our two routes, both our interaction with the Aqua programme and the training and support being accessed through this route, evidence for this can be found in **files 0.7 and 0.7.1**; but also specifically around the challenges raised with our lifts and the associated risks on our Ipswich site. Evidence for this is detailed in **file 0.8.**

2. Conclusions

We believe the Trust is compliant with safety action 9 within CNST Year 5.

3. Evidence	
0.1	Approval by Regional Chief Midwife of PQSM review
0.2	Agenda - Safety Forum 29 Nov 23
0.2.1	PQSM evidence update Nov 23
0.2.2	PQSM 6 monthly evidence review for next Safety Forum (1)
0.2.3	PQSM 6 monthly evidence review for next Safety Forum (2)
0.3	email to clarify NED appointed as Maternity Safety Champion and chair of Quality sub board committee QPS
0.3.1	Know your safety champions poster

0.4	Patient Safety report June 2023
0.4.1	Patient Safety report July 2023
0.4.2	Patient Safety report September 2023
0.4.4	CEG Division Exception Report Sept 23 WC v3 DMT approved
0.4.5	Trust Board 070923 Item 2.4 EBED Programme Board
0.4.6	Integrated Patient Safety Experience Report for October 2023
0.4.7	Maternity update to Trust Board 2023
0.4.8	021123 AGENDA Trust Board (Public) v4
0.4.9	Maternity update to Board October 2023
0.4.10	Mat Neo sharing safety intelligence- Nov 23 v2
0.4.11	Amalgamated Mat Neo CKI November 23
0.4.12	EBED CKI November 2023
0.4.13	Maternity Update for PSG Dec 23 v2 APD approved
0.4.14	Extraordinary Mtg Draft Minutes 28 November v2
0.4.15	Mat Neo Meeting minutes - July 2023
0.4.16	Mat Neo CKI August 2023
0.4.17	Mat Neo Final Minutes - 24 August 2023
0.4.18	Mat Neo walk around feedback 28 September
0.4.19	RQRM Nov 2023 final 1
0.4.20	Trust PSR WC November 23 v8 - DMT approved (002)
0.4.21	PEG Report - Nov 2023 - staff and patient feedback
0.5	PSIRF update to LMNS - April 2023
0.5.1	PSIRF update to LMNS - May 2023
0.5.2	PSIRF update to LMNS - June 2023
0.5.3	PSIRF update to LMNS - July 2023
0.5.4	PSIRF update to LMNS - August 2023
0.5.5	PSIRF update to LMNS - September 2023
0.5.6	PSIRF update to LMNS - October 2023
0.5.7	PSIRF update to LMNS - November 2023
0.5.8	PSIRF update to LMNS - December 2023
0.5.9	Agenda SNEE MSE shared learning event 12 10 23

0.6	email from AT re-joining future platforms
0.6.1	email from DT re-joining future platforms
0.6.2	email from HK re-joining future platforms
0.6.3	email from DD re-joining future platforms
0.7	email demonstrating engagement with AQUA programme Mat Neo Measurement Programme Common Themes
0.7.1	Aqua's visit to East Suffolk
0.8	Maternity Health & Safety concerns
0.9	Claims and litigation report Q1 2023
0.9.1	Claims and litigation Deep Dive Q2 2023
0.9.2	Extraordinary Maternity and Neonatal Meeting minutes 12th July 2023