Sheffield Teaching Hospitals
NHS Foundation Trust

Executive Summary

Report to the Board of Directors

Being Held on 23rd July 2024

Subject	Maternity and Neonatal Safety Report May and June 2024
Supporting TEG Member	Chris Morley, Chief Nurse
Author	Laura Rumsey, Midwifery Director, Andrea Galimberti, Clinical Director Nathan Timmis, Operations Director
Status[1]	N

PURPOSE OF THE REPORT

To present the Maternity and Neonatal Safety Report for May and June 2024. This allows the Board of Directors oversight of specific Perinatal Quality Surveillance Model metrics on a monthly basis, ahead of more detailed analysis in the quarterly report.

KEY POINTS

- The Perinatal Quality Surveillance Model recommends that seven areas are reported monthly to the Board of Directors.
- These areas predominantly relate to harm events, it is important to recognise that harm isn't the only marker of quality, and other important aspects of quality will continue to be covered in the quarterly report.
- During May the Trust reported 5 neonatal deaths and 1 stillbirth.
- During June the Trust reported 5 neonatal deaths and 5 stillbirth.
- There were no referrals to Maternity and Newborn Safety Investigations (MNSI) in May or June 2024.
- There was 1 serious harm event reported during May and 2 serious harm events reported during June.
- There has been one HM Coroner Inquest relating to Maternity and Neonatology in May and no inquests in June 2024 and correspondingly no Regulation 28 issued by HM Coroner's

IMPLICATIONS[2]

Aim of the STHFT Corporate Strategy		✓ **Tick as appropriate**
1	Deliver the Best Clinical Outcomes	✓
2	Provide Patient Centred Services	✓
3	Employ Caring and Cared for Staff	✓
4	Spend Public Money Wisely	
5	Create a Sustainable Organisation	
6	Deliver Excellent Research, Education and Innovation	✓

RECOMMENDATIONS

The Board of Directors are asked to receive and note the contents of the May and June 2024 Maternity and Neonatal Safety Report.

APPROVAL PROCESS

Meeting	**Date**	**Approved Y/N**
Trust Executive Group	17th July 2024	Y
Board of Directors	23rd July 2024	

[1] Status: A = Approval
A* = Approval & Requiring Board Approval
D = Debate
N = Note

[2] Against the six aims of the STHFT Corporate Strategy 'Making a Difference – The next Chapter 2022-27'

1. REPORTING IN RELATION TO MATERNITY AND NEONATAL SAFETY TO THE BOARD OF DIRECTORS

Since May 2022, the Board of Directors had received a report in relation to Maternity and Neonatal Safety. This report was fully aligned to the NHSEI document 'Implementing a revised perinatal quality surveillance model' (December 2020). This was helpful in familiarising the Board with relevant Maternity and Neonatal issues during the period when there was a need to closely monitor the improvements required following the Care Quality Commission (CQC) inspections in 2021.

Since the 2022 inspection of maternity by the CQC, the feedback from stakeholders including the CQC and NHS England is that the service has made significant improvement, with the conditions imposed by the CQC now removed, and the Trust in the process of being removed from the Maternity Services Support Programme. As a result, the report had become less dynamic with fewer changes to report to the Board each month. In addition, as the report was lengthy with quite a lot of repetition it wasn't easy for Directors to draw the salient issues to seek further assurance. Therefore, it was agreed at the Board of Directors in April 2024 that the schedule of reports should be amended to address this issue. By reducing the information required it will also be able to report nearer real time, so from April 2024, monthly reports received by the Board of Directors will contain information from the preceding month.

2. ITEMS REPORTED TO THE BOARD OF DIRECTORS VIA THE MONTHLY MATERNITY AND NEONATAL SAFETY REPORT

The Perinatal Quality Surveillance Model recommends that seven areas are reported monthly to the Board of Directors. These areas predominantly relate to harm events, it is important to recognise that these events are rare as a proportion of the total activity undertaken in the Jessop Wing and that harm isn't the only marker of quality, and other aspects of quality will continue to be covered in the quarterly report.

The quarterly report will continue in a similar format to that which the Board has been receiving monthly, there will be some additional information in relation to service user feedback with information on the Friends and Family Test, complaints and concerns added.

3. MONTHLY MATERNITY AND NEONATAL REPORT FOR MAY AND JUNE 2024

Jessop Wing is committed to providing compassionate bereavement support and care to all women and families experiencing loss of a baby. Following a Stillbirth or Neonatal Death, the Jessop Wing team support all families and follow the National Bereavement Pathway guidance. Ongoing, individualised bereavement support is offered to all mothers and families by the Jessop Wing Bereavement Service. All families are also offered a referral to Maternity and Neonatal Independent Senior Advocate for ongoing support if they wish. This role is part of NHS England improvement scheme led by the Local Maternity and Neonatal System (LMNS).

3.1 Perinatal Mortality Review Tool (PMRT) figures for May 2024

Between 01/05/2024 and 31/05/2024, there were a total of 487 livebirths at Jessop Wing. Over the corresponding period there were also 5 neonatal deaths (NND) and 1 Stillbirth (SB) reported to Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries **(**MBRRACE-UK).

<u>Neonatal deaths (NND)</u>

Four of the Neonatal deaths occurred in babies born between 23 and 28 weeks' gestation. An initial assessment has not identified any care issues for the baby or the mother, although in one case the maternity care was delivered in another unit. All these cases will now be subject to a full multi-disciplinary assessment via PMRT.

One NND occurred in a full-term infant of 12 days of age admitted to Sheffield Children's Hospital at 9 days of age after being found unresponsive at home. An immediate After-Action- Review (AAR) was undertaken to review the care, any immediate learning and advice given throughout this period of time with no identified omissions or missed opportunities.

<u>Stillbirth</u>

1 stillbirth occurred at 27 weeks. There were no immediate care concerns identified at the initial review of this

case, and this case will now also continue to have a full multi-disciplinary review completed as part of the PMRT process.

3.2 Perinatal Mortality Review Tool (PMRT) figures for June 2024

Between 01/06/2024 and 30/06/2024, there were a total of 434 livebirths at Jessop Wing. Over the corresponding period there were also 5 neonatal deaths (NND) and 5 Stillbirths (SB) reported to Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries **(**MBRRACE-UK).

Neonatal deaths (NND)

All of the Neonatal deaths occurred in babies born between 20 and 23 weeks' gestation. An initial assessment has not identified any care issues for the baby or the mother, although in one case the maternity care was delivered in another unit. All these cases will now be subject to a full multi-disciplinary assessment via PMRT.

Stillbirths

Three stillbirths occurred between 24 and 29 weeks of pregnancy.

Two stillbirths occurred at 39 weeks of pregnancy. In one case there was no fetal heartbeat upon arrival, following maternal concerns about fetal movements. There was no identified care issues and all relevant information regarding altered fetal movements had been provided.

In the second case the team were also unable to locate a fetal heartbeat. This case was reported to the Maternity and Newborn Safety Investigations team (MNSI). The family declined the offer of the external investigation and therefore it was declined by MNSI. The family were very happy with the care they received and wished to be left to grieve.

Both these cases will continue to have a full multidisciplinary review completed as part of the PMRT process.

4. MATERNITY AND NEWBORN SAFETY INVESTIGATION (MNSI) AND MATERNITY PATIENT SAFETY INCIDENTS (SI)

MNSI conducts investigations into all maternal deaths of women while pregnant or within 42 days of birth. All intrapartum stillbirths, early neonatal deaths (0-6 days) born at term and all cases of severe brain injury (HIE) diagnosed within first 7 days of life.

STH have referred 0 cases to MNSI in May 2024 and 1 case in June 2024. This case was rejected by MNSI as described in section 3.2.

There have been 0 cases reported in either May or June 2024 for Patient Safety Incident Investigation (PSII) under the new Patient Safety Incident Response Framework (PSIRF).

5. SERIOUS HARM INCIDENTS

There was 1 serious harm event reported during May which is the case reported above of the sad and unexpected death of a baby at 12 days.

There were 2 serious harm event reported during June, one of which is the case reported at 3.2 relating to a stillbirth.

The second event relates to a sudden death of a 1-month-old infant, admitted to Sheffield Children's Hospital after being found unresponsive at home. An immediate local patient safety review was undertaken to review the care, any immediate learning and advice given throughout this period of time with no identified omissions or missed opportunities.

6. MNSI/NHSR/CQC OR OTHER ORGANISATION WITH A CONCERN OR REQUEST FOR ACTION MADE DIRECTLY WITH THE TRUST

There were no concerns or requests for action made to the Trust in May or June 2024 by any external regulator.

7. CORONER'S INQUESTS INCLUDING REG 28 MADE DIRECTLY TO TRUST

There has been 1 HM Coroner inquests relating to Maternity or Neonatology in May 2024. A narrative conclusion was returned in a case of a baby who was born extremely premature and suffered complications as a result which sadly caused her death. No negative findings were made.

There were no inquests relating to Maternity or Neonatology in June 2024 and no Regulation 28 notices issued.