NHS
Sheffield Teaching Hospitals
NHS Foundation Trust

Executive Summary

Report to the Board of Directors

Being held on 28 January 2025

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

PURPOSE OF THE REPORT

To present the Maternity and Neonatal Safety Report for December 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 December 2024 the Trust reported 1 neonatal death and 3 stillbirths.
  There were two referrals to Maternity and Newborn Safety Investigations (MNSI) in December 2024.

IMPLICATIONS

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 December 2024 Maternity and Neonatal Safety Report.

Meeting	**Date**	**Approved Y/N**
TEG	22/01/2025	Y
Board of Directors	28/01/2025	

[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

As agreed at the Board of Directors in April 2024 this monthly report reflects the requirements of the Perinatal Quality Surveillance Model.

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.

2. MONTHLY MATERNITY AND NEONATAL REPORT FOR DECEMBER 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. Families are also offered a referral to Maternity and Neonatal Independent Senior Advocates for ongoing support if they wish. This role is part of NHS England improvement scheme led by the Local Maternity and Neonatal System (LMNS).

2.1 PERINATAL MORTALITY REVIEW TOOL (PMRT) FIGURES FOR DECEMBER 2024

Between 01/12/2024 and 31/12/2024, there were a total of 460 livebirths at Jessop Wing.

Over the corresponding period there was 1 neonatal death (NND), and 3 Stillbirth (SB) reported to Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries (MBRRACE-UK).

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

There have been one PMRT reportable NND, as outlined below.

1 NND occurred at 8 days of age following a difficult unplanned birth at home. On arrival, immediate resuscitation occurred and baby was transferred to Neonatal Intensive Care for active cooling, where are a few days they sadly died. Initial review into the care highlighted concerns in the management and care of the mother. Immediate actions have been identified and the case is referred to MNSI and the coroner.

For oversight, a neonatal death occurred in the community at day 4 of birth. The cause of death has not been established, and the investigation is ongoing. Referral was also made to MNSI due to death occurring within 7 days after birth. An immediate review of the case did not identify any concerns in care. This is not reportable by the Jessop Wing to PMRT as the death was diagnosed at a different provider.

<u>Stillbirths</u>

There have been three SBs during December, all 3 stillbirths occurred at or under 30 weeks gestation. Initial reviews of the cases have not identified any concerns in the care and the cases will undergo full multi-disciplinary reviews as part of the PMRT process.

3. MATERNITY AND NEWBORN SAFETY INVESTIGATION (MNSI) AND MATERNITY PATIENT SAFETY INCIDENT INVESTIGATIONS (PSII)

The MNSI conducts investigations into all maternal deaths of pregnant women and or who are within 42 days of birth. This includes all intrapartum stillbirths and 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 referred 2 cases to MNSI in December 2024 as outlined above in the Neonatal Death section.

There were 0 cases reported for Patient Safety Incident Investigation (PSII) under the Patient Safety Incident Response Framework (PSIRF) in December.

4. SERIOUS HARM INCIDENTS

There were 4 serious harm events reported during December which involves 1 of the stillbirths and both Neonatal death cases described above. The fourth case relates to the labour and birth experience of the mother which lead to the Neonatal Death as described above.

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

There was no concerns or requests for action made to the Trust in December 2024 by any external regulators.

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

There were no Coroner's inquests in December 2024. There were no regulation 28 notices issued over this period.