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Gillian Martin MSP
Convener for Health, Social Care and Sport Committee

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30 September 2022

Dear Gillian,

You may be aware that earlier in the year, I committed to further investigating a higher than expected rise in the neonatal mortality rate, as published in the Public Health Scotland (PHS) Covid-19 Wider Impacts Dashboard.

I am writing to inform you that the Scottish Government has commissioned Healthcare Improvement Scotland (HIS) to lead a national review to understand any contributing factors to the national increase in neonatal mortality seen during 2021/22.

The review will cover reported neonatal deaths across Scotland between 1 April 2021 and 31 March 2022 and be informed by relevant data and clinical expertise. It will also take account of data from local NHS Board reviews of neonatal deaths, that have been undertaken using the standardised Perinatal Mortality Review, or alternative local review tool. In addition, some of the deaths may also be subject to a Significant Adverse Event Review. It will assess and determine whether there are any themes, underlying causes or safety factors that have contributed to the increased neonatal mortality rate, from both a clinical and system perspective. Key learning points will be identified and recommendations for improvements in the quality of care will be made. The review will not duplicate any matters which are, or have been, the subject of other review, investigation or audit processes. In particular, it will not duplicate or carry out further reviews of individual neonatal deaths.

Information about the review will be published on the HIS website. Families who may be affected by the announcement can seek support should they wish to do so and a number of organisations who are able to offer help are set out at: Support if a child or baby dies - mygov.scot and on the National Bereavement Care Pathways Scotland website at: Signposting support | SANDS (nbcpscotland.org.uk). We will also write to NHS Boards to

inform them of this Review to seek their support and highlight our expectations that they complete the Perinatal Mortality Review Tool and where appropriate the Maternity and Neonatal (Perinatal) Adverse Event Review Process for Scotland. As part of this communication, we will also re-iterate the importance of local services supporting those families who will be affected by the review.

The review will be conducted by an expert group, chaired by Dr Helen Mactier, a recently-retired consultant neonatologist with over twenty years' experience at Princess Royal Maternity Hospital in Glasgow and President of the British Association of Perinatal Medicine (BAPM) 2019-22.

The Scottish Government continues to work with NHS Boards and stakeholders to improve maternity outcomes. For example, in partnership with senior leaders and clinicians, we are prioritising improvements to care in maternity services through the implementation of our Best Start programme, including continuing with roll out of Continuity of Carer. This intervention has the potential to deliver significantly improved relationships and improved outcomes in care for women and babies. Our Maternity and Children's Quality Improvement Collaborative (MCQIC), part of the Scottish Patient Safety Programme, continues to work with NHS Boards to drive continuous improvement in maternity and neonatal care across Scotland. This includes work to reduce the rates of stillbirth and postpartum haemorrhage. In addition, one year ago we launched Scotland's first national Maternity and Neonatal Adverse Event Review Process to support a consistent approach to perinatal adverse event reviews, aligned to a process of national learning to drive high quality care and involve and support affected families.

Regards,

Maree Todd MSP

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