Somerset NHS Foundation Trust	
REPORT TO:	Board of Directors
REPORT TITLE:	Maternity & Neonatal Quarter 2 26/27 Quality & Safety Report
SPONSORING EXEC:	Deirdre Fowler, Chief Nurse and Midwife
REPORT BY:	Sally Bryant, Director of Midwifery & Deputy to the chief Nurse & Midwife
PRESENTED BY:	Sally Bryant, Director of Midwifery & Deputy to the chief Nurse & Midwife
DATE:	10 November 2026

Purpose of Paper/Action Required (Please select all that are relevant to this paper)		
☒ For Assurance	☐ For Approval / Decision	☐ For Information

Executive Summary and Reason for Presentation to Committee/Board	To provide assurance on the safety and quality of maternity & neonatal services

Recommendation	The Trust Board is asked to: • Review the Q2 Q&S report • Note actions being taken to address the strategic risks

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Links to Strategic Aims (Please select all that are relevant to this paper)
☒ **Aim 1:** Contribute to improving population health and reduce health inequalities
☒ **Aim 2:** Provide the best care and support to people
☐ **Aim 3:** Strengthen care and support in people's homes and in local communities
☐ **Aim 4:** Respond well to complex needs
☒ **Aim 5:** Support our colleagues to deliver the best care and support through a compassionate, inclusive and learning culture
☒ **Aim 6:** Live within our means and use our resources wisely
☐ **Aim 7:** Transform our services through innovation, research and digital transformation

Implications/Requirements (Please select any which are relevant to this paper)					
☐ Financial	☐ Legislation	☐ Workforce	☐ Estates	☐ ICT	☒ Patient Safety / Quality
Details: Click or tap here to enter text.					

Equality

(Please indicate whether the report has any actual or potential impact on people with protected characteristics and whether an Equality and Quality Impact Assessment (EQIA) has been completed)
This report has been assessed against the Trust's Equality and Quality Impact Assessment (EQIA) Tool and: ☒ No actual or potential adverse impacts on people with protected characteristics have been identified. ☐ Actual or potential impacts on people with protected characteristics have been identified. The following actions are planned to mitigate any identified inequalities: **Details**: Click or tap here to enter text.

Public/Staff Involvement History (Please indicate if any consultation, service user, patient, public or staff involvement has informed any of the recommendations within the report)
MNVP provides service user feedback and work with SFT colleagues as quorate members of all quality & safety meetings within the governance framework

Previous Consideration (Indicate if the report has been reviewed by another Board, Committee or Governance Group before submission to the Board or is a follow up report to one previously considered by the Board – e.g. in Part B)
The report has been reviewed and discussed in the Quality Governance Assurance Committee

Reference to CQC Domains (Please select any which are relevant to this paper)				
☒ Safe	☒ Effective	☒ Caring	☒ Responsive	☐ Well Led

Is this paper clear for release under the Freedom of Information Act 2000?	☒ Yes	☐ No

SOMERSET NHS FOUNDATION TRUST

MATERNITY & NEONATAL QUARTER 2 26/27 QUALITY & SAFETY REPORT

1. BACKGROUND AND PURPOSE

To provide the Board with assurance on the Quarter 2 position for perinatal quality, safety, workforce and leadership, drawing on the October 2026 Perinatal Governance review. The report sets out the principal achievements, current safety and experience indicators, material risks, mitigations and priorities for Quarter 3.

Quarter 2 demonstrates continued progress against the Maternity and Neonatal Improvement Plan, strengthening governance arrangements and delivery of targeted improvement work. Key achievements include:

- Enhanced executive and non-executive oversight through the MatNeo Improvement Board
- Implementation of a Perinatal Leadership Team oversight structure
- Continued achievement of 100% supernumerary labour ward coordinator compliance and 100% one-to-one care in established labour across both sites
- Positive progress within Saving Babies' Lives care bundle workstreams
- Development of a comprehensive thematic review process to triangulate learning across incidents, complaints, PMRT, MNSI and audit activity.

2. KEY LEARNING POINTS

A thematic review of 307 safety events identified three cross-cutting priorities for continued focus:

- Recognition, escalation and clinical decision-making.
- Neonatal and newborn safety.
- Positive family-centred and compassionate care.

Whilst there is significant evidence of learning activity and improvement work, assurance remains partial. Recurring themes continue to highlight challenges in demonstrating that learning has consistently translated into sustained improvements in practice. The service remains focused on strengthening action tracking, evidencing implementation and creating a robust assurance framework that demonstrates impact.

3. AREAS REQUIRING ONGOING OVERSIGHT

Key areas requiring ongoing committee oversight include:

- Workforce resilience, leadership capacity and training compliance.
- Safeguarding training and supervision compliance.
- Neonatal medical leadership arrangements at YDH.