Cover page	
Meeting	Public Trust Board
Paper Title	Perinatal Mortality Review Tool report
Date of meeting	6th February 2020
Date paper was written	28th January 2020
Responsible Director	Director of Nursing
Author	Risk Lead Midwife Director of Midwifery
Executive Summary	
The report has been prepared and presented for Trust Board assurance that all stillbirths and neonatal deaths are reviewed consistently using the national electronic online tool The Perinatal Mortality Review Tool (PMRT). This is in line with the recommendations outlined in NHS Resolution Maternity Incentive Scheme to continue to support the delivery of safer maternity care. The report confirms that the service is using the tool to the required standard as required by the incentive scheme and also identifies learning to improve.	
Previously considered by	Care Group Board 28/01/20

The Board (Committee) is asked to:			
☐ Approve	☑ Receive	☐ Note	☐ Take Assurance
To formally receive and discuss a report and approve its recommendations or a particular course of action	To discuss, in depth, noting the implications for the Board or Trust without formally approving it	For the intelligence of the Board without in-depth discussion required	To assure the Board that effective systems of control are in place

Link to CQC domain:				
☑ Safe	☑ Effective	☑ Caring	☑ Responsive	☑ Well-led

Link to strategic objective(s)	*Select the strategic objective which this paper supports* ☑ PATIENT AND FAMILY Listening to and working with our patients and families to improve healthcare ☑ SAFEST AND KINDEST Our patients and staff will tell us they feel safe and received kind care ☐ HEALTHIEST HALF MILLION Working with our partners to promote 'Healthy Choices' for all our communities ☑ LEADERSHIP Innovative and Inspiration Leadership to deliver our ambitions ☐ OUR PEOPLE Creating a great place to work
Link to Board Assurance Framework risk(s)	1204

Equality Impact Assessment	◉ Stage 1 only (no negative impact identified) ○ Stage 2 recommended (negative impact identified and equality impact assessment attached for Board approval)
Freedom of Information Act (2000) status	◉ This document is for full publication ○ This document includes FOIA exempt information ○ This whole document is exempt under the FOIA
Financial assessment	

Main Paper

Situation

NHS Resolution is operating a third year of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care.
The required standards are:

Safety Action 1: Are you using the perinatal mortality review tool to review perinatal deaths to the required standard?

The standard is detailed below:

- A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from Friday 20 December 2019 will have been started within four months of each death. This includes deaths after home births where care was provided by your trust staff and the baby died.

- At least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in your trust, including home births, from Friday 20 December 2019 will have been reviewed using the PMRT, by a multidisciplinary review team. Each review will have been completed to the point that at least a PMRT draft report has been generated by the tool, within four months of each death.

- For 95% of all deaths of babies who were born and died in your trust from Friday 20 December 2019, the parents were told that a review of their baby's death will take place, and that the parents' perspectives and any concerns they have about their care and that of their baby have been sought. This includes any home births where care was provided by your trust staff and the baby died.

- Quarterly reports have been submitted to the trust Board that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the trust maternity safety champion.

Background

The Perinatal Mortality Review Tool, launched in 2018, aims to support objective, robust and standardised reviews to provide answers for bereaved parents about why their baby died. It also aims to ensure local and national learning to improve care and ultimately prevent future deaths.

The PMRT has been designed to support review of the following perinatal deaths:
- Late miscarriages (also referred to as late fetal losses) where the baby is born between 22+0 and 23+6 weeks of pregnancy showing no signs of life
- All stillbirths where the baby is born from 24+0 gestational weeks showing no signs of life
- All neonatal deaths where the baby is born alive from 22+0 weeks and dies up to 28 days after birth
- Post-neonatal deaths where the baby is born alive from 22+0 weeks and dies after 28 days of birth following neonatal care; the baby may have died in hospital, or may have died in a hospice or at home following palliative care

The PMRT does not support the review of perinatal deaths where the death meets the criteria above but:
- The death follows a legal termination of pregnancy
- The baby was discharged home, had not received neonatal care but died up to 28 days after birth
- The baby was discharged home well, had not received neonatal care but died after 28 days after birth

Assessment

A review of 95% of all deaths of babies suitable for review using the Perinatal Mortality Review Tool (PMRT) occurring from 20 December 2019 have been started within 4 months of each death.
*Note this data reported also includes deaths from October, November as well as December 2019.

	Number of cases	Number of PMRT started	% Compliance
2019 Quarter 3 stillbirths	5	5	100%
2019 Quarter 3 Neonatal Deaths	0	NA	100%
Overall compliance 100%			

At least 50% of all deaths who were born and died at your Trust (including home births that died) from 20th December 2019 will have been reviewed by a multidisciplinary team with each review completed to the point that a draft report has been generated, within four months of each death.
*Note this data reported also includes deaths from October, November as well as December 2019.

Cases	Number of cases	Draft report generated	% Compliance
2019 Quarter 3 stillbirths	5	5	100%
2019 Quarter 3 Neonatal Deaths	0	NA	100%
Overall compliance 100%			

In 95% of all deaths of babies who were born and died in your trust the parents were told that a review of their baby's death will take place and that their perspective and any concerns about their care and that of their baby have been sought.

	Number of cases	Parents review and questions answered	% Compliance
2019 Quarter 3 Stillbirths	5	4 families were informed, 1 family declined all contact with the Trust and any further investigations and is therefore not included	100%
2019 Quarter 3 Neonatal Deaths	0	NA	100%
Overall compliance 100%			

Quarterly reports have been submitted to the trust Board that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the trust maternity safety champion.

This will be the first report submitted to Trust Board for Q3 2019/2020. The Board level safety

champion is present at Trust Board Meeting

Actions

All cases will be reviewed at the multi-disciplinary Perinatal Mortality meeting.

Issue raised:

The progress of the mothers labour was not recorded on a partogram in 2 cases:

Action:

A review of the bereavement pathway is being undertaken

Delivery Suite Co-ordinators will lead and support the Midwives caring for bereaved parents, ensuring that documentation is filled in appropriately

Issue raised:

The process for referring women in for ultrasound scans from a community satellite clinic is not robust

Action:

An immediate change to the process has been instigated, women are referred directly to the Consultant Unit for a face to face meeting with the on call Consultant Obstetrician where all paper and electronic records can be viewed.

Recommendation
Recommendation: The Board are requested to note the content of this paper. The Board will receive a quarterly report.