Cover page	
Meeting	Trust Board
Paper Title	NHS Resolution's Early Notification Scheme/ Clinical Negligence Scheme for Trusts (CNST) Maternity Incentivisation Scheme incorporating Perinatal Mortality Review Tool (PMRT) Quarter 1 2020/21
Date of meeting	30th July 2020
Date paper was written	20th July 2020
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Presenter	Nicola Wenlock, Director of Midwifery

Executive Summary -Situation

This report has been prepared to provide assurance that compliance is being met with 2 of the 10 safety actions set within the NHS Resolution Clinical Negligence Scheme for Trusts (CNST) Maternity Incentivisation Scheme in order to continue to support the delivery of safer maternity care.

The report considers both:

Safety action 1: Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths to the required standard?

Safety action 10: Have you reported 100% of qualifying 2019/20 incidents under NHS Resolution's Early Notification scheme?

The cases that fit the criteria for review using PMRT from Quarter 1 (April, May and June 2020) are:

- 3 stillbirths;
- 3 Neonatal deaths – these babies were born and died at at SaTH
- 0 late fetal losses (22-23+6 weeks gestation)
- 0 qualifying 2020/21 cases for the NHS Early Resolutions Scheme.

Previously considered by	Maternity Governance Group , July 2020

The Board 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)	

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	Completion of the reviews is linked to the Maternity Incentivisation programme.

Situation

Obstetric incidents can be catastrophic and life-changing, with related claims representing the scheme's biggest area of spend. Of the clinical negligence claims notified in 2018/19, obstetrics claims represented 10 percent (1,068) of clinical claims by number, but accounted for 50 per cent of the total value of new claims, £2,465.5 million of the total £4,931.8 million. Now in its third year, the maternity incentive scheme supports the delivery of safer maternity care through an incentive element to trusts contributions to the CNST. This report will focus on 2 of the 10 safety actions agreed with the national maternity safety champions in partnership with the Collaborative Advisory Group (CAG).

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

- 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.

- **Safety action 10:** Have you reported 100% of qualifying 2019/20 incidents under NHS Resolution's Early Notification scheme?

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.

Stillbirths	Number of cases	Number of PMRT started	% Compliance
Quarter 1	3 SB 0 LFL	3	100%
Neonatal Deaths	Number of cases	Number of PMRT started	% Compliance
Quarter 1	3	3	100% compliant
Overall compliance to date 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.

Stillbirths	Number of cases	Draft report generated	% Compliance
Quarter 1	3 SB 0 LFL	3	100%
Neonatal deaths	Number of cases	Draft report generated	% Compliance
Quarter 1	3	1	100% Remaining 2 cases need reports at draft stage by August 2020 (awaiting 1 final post mortem report)
Overall compliance to date 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.**

Stillbirths	Number of cases	Parents review and questions answered	% Compliance
Quarter 1	3 SB 0 LFL	All families informed.	100%
Neonatal deaths	Number of cases	Parents review and questions answered	% Compliance
Quarter 1	3	All families informed	100%
Overall compliance 100%			

- Quarterly reports will be 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.

Quarter 1 report prepared for Maternity Governance and then to be presented at Trust Board.

- Have you reported 100% of qualifying 2019/20 incidents under NHS Resolution's Early Notification scheme?

Acute maternity trusts are required to notify NHS Resolution within 30 days of all babies born at term (≥37 completed weeks of gestation), following labour, that have had a potentially severe brain injury diagnosed in the first seven days of life, based on the following criteria:
• Have been diagnosed with grade III hypoxic ischaemic encephalopathy (HIE); OR
• Were actively therapeutically cooled; OR
• Had decreased central tone AND were comatose AND had seizures of any kind.

NHS Early Resolution's Early Notification Cases	Number of cases	Reason for referral	% Compliance
Quarter 1 2020/2021	0		100%
Overall compliance 100%			

Actions

Actions are listed from PMRT cases reviewed below using the SMART mnemonic acronym incorporating the 5 characteristics: specific; measurable; attainable; relevant and time based.

Action from review of Q1 stillbirth :

During this mothers labour maternal observations, commensurate with her level with her level of risk and national guidelines were not carried out, the partogram was only partially completed.	
S	Full completion of the partogram is expected for a woman in labour, from the onset of established labour or from the administration of the first dose of misoprostol for women with fetal losses.
M	All fetal loss cases are reviewed using PMRT therefore all cases will be measured consistently that this is being completed. Spot checks to be completed by Delivery Suite Managers and Professional Midwifery Advocates weekly of all partograms to ensure that this is not a generalised trend and partograms are started in accordance to guidelines for all women in labour.
A	Midwives should keep clear and accurate records which are relevant to their practice
R	The partogram is a crucial document to provide documentation of the woman's progress during labour.
T	Reviews to be initiated by 31.07.2020

Action from review of Q1 stillbirth

This mother had a risk factor(s) for having a growth restricted baby but serial scans were not performed at correct times/intervals	
S	If a mother fits the criteria for serial scans during pregnancy these should be scheduled and booked for the duration of her pregnancy at the correct intervals until delivery.
M	Women will have appointments pre made and scheduled on the electronic appointment system.
A	Achievable as this electronic system is already in place
R	Relevant as this is fundamental to ensuring that the woman is aware of her schedule of scans and non attendance would flag a "did not attend" alert prompting follow up
T	Block booking of scans has now been started.

Action from review of Q1 NND

There was no documentation that this mother was asked about domestic abuse at booking	
S	If the mother is accompanied at booking the question about domestic abuse may not be asked. There needs to be a robust process whereby this is highlighted as an outstanding question to be asked and recorded at the next appropriate time.
M	All contacts are documented therefore a record of this being asked should be easily recognised.
A	Midwives should keep clear and accurate records which are relevant to their practice and women should be asked at each contact if appropriate.
R	During COVID 19 restrictions women are unaccompanied at appointments therefore this should be realistically achieved.
T	An improvement should be seen by the next quarterly report

A schedule of review dates has been set to ensure monthly meetings are held with the appropriate level of attendees. Historic cases that had been outstanding have now all had a review started.

The live system currently shows 17 cases with reviews started and 6 cases in the report writing stage.

Recommendations

The Board is asked to note the content of the report.