East Suffolk and North Essex NHS Foundation Trust

Trust Board

2 November 2023

Report Title:	PMRT reporting Quarter 2 2023/2024 Maternity Safety Standard #1 – Use of the National Perinatal Mortality Review Tool.
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Previously considered by:	

☑ **Approval** ☐ **Discussion** ☑ **Information** ☑ **Assurance**

Executive summary
In order to meet the requirements of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme Safety Action 1, NHS Trusts are required to have in place quarterly reporting to Trust Boards, demonstrating that the National Perinatal Mortality Review Tool (PMRT) is being used to review perinatal deaths, to the required standard. **Year five of the Maternity Incentive Scheme launched in May 2023. The requirements set out in the revised scheme are as follows:** a) All eligible perinatal deaths should be notified to MBRRACE-UK within seven working days. For deaths from 30 May 2023, MBRRACE-UK surveillance information should be completed within one calendar month of the death. b) For 95% of all the deaths of babies in your Trust eligible for PMRT review, parents should have their perspectives of care and any questions they have sought from 30 May 2023 onwards. c) For deaths of babies who were born and died in your Trust multi-disciplinary reviews using the PMRT should be carried out from 30 May 2023. 95% of reviews should be started within two months of the death, and a minimum of 60% of multi-disciplinary reviews should be completed to the draft report stage within four months of the death and published within six months. d) Quarterly reports should be submitted to the Trust Executive Board from 30 May 2023. The report is intended to provide assurance that the required standards have been met, and to advise on the progress of each review, together with lessons learned and conclusions drawn from the quarterly data.
Action Required of the Board
To receive for assurance and approve the contents

Link to Strategic Objectives (SO)	**Please tick**

SO1	Keep people in control of their health	☑
SO2	Lead the integration of care	☐
SO3	Develop our centres of excellence	☑
SO4	Support and develop our staff	☐
SO4	Drive technology enabled care	☐

Risk Implications for the Trust (including any clinical and financial consequences)	If we do not have effective safety standards and assurance mechanisms in place, we cannot demonstrate learning from perinatal loss and provide assurance to parents and families that we have responded to any concerns.
Trust Risk Appetite	Quality: The board will take minimal risks when it comes to patient safety, patient experience or clinical outcomes. Its tolerance for risk taking will be limited to decisions where the impact is low and the potential mitigations are strong
Legal and regulatory implications (including links to CQC outcomes, Monitor, inspections, audits, etc.)	Requirement to complete reviews on all perinatal losses, assessing the care against the national standards to enable learning to be identified at local and national levels. This will enable the Trust to provide safer care and provide patients with the best possible experience.
Financial Implications	Risk to reputation and subsequent financial loss by not meeting the incentive scheme standards
Equality and Diversity	No E&D implications identified

Quarter 2 2023/2024

Compliance with year 5 for to date

Initiative	% Compliance	RAG
All eligible deaths to be notified to MBBRACE- UK within seven working days	100%	
Surveillance information must be completed within one month	100%	

95% of cases will have been started within 2 months of the death	100%	
*60% of all deaths have been reviewed and drafted within four months.	33% to date No foreseen delays with achieving this.	
*60% of all deaths have been published within six month.	0% to date, no issues expected.	
95% of parents will have been told of the review	100%	

*New standards for CNST this year so only came into effect from 31st May 2023. Of the estimated 10 cases which needed to be drafted within 4 months, 3 are completed and 7 are scheduled, all are on track for completion. There is one case which isn't expected to meet the six month publication deadline, due a delay in the coroner releasing the PM report, however, we will still meet the standard, as would be 90% compliant.

Summary of Stillbirths and Neonatal Death (NND) for Q2 2023/2024.

From July to September there were 2 reportable termination of pregnancy for fetal anomalies which resulted in NND. These did not require full PMRT.

There were 2 reportable neonatal deaths requiring full PMRT.

- In both cases parents were fully counselled that fetal anomalies meant baby would require palliative care at birth but decided to continue with their pregnancy.

There were 8 reportable IUFD.

These are made up of 5 loses due to congenital abnormalities and complications surrounding development and 3 loses later in pregnancy.

Quarter 2 compliance with standards.
PMRT standards A

All eligible perinatal deaths should be notified to MBRRACE-UK within seven working days

Standard B

95% of Parents were informed 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	Number of cases notified to MBRRACE-UK	Number of PMRT reviews requiring surveillance.	% Compliance
Termination of pregnancy July-September 2023	2	2	NA (TOP do not need to have further information beyond reporting)	100%
Stillbirths, July-September 2023	8	8	8	100%
Neonatal Deaths July-September 2023	2	2	2	100%
Overall Compliance	12	12	10	100%

	Number of cases	Parents perspectives sought	Compliance
PMRT cases	10	10	100%

Standard C

95% of all deaths of babies, suitable for review using the PMRT, from 30th May 2022 will have been started within two months of the death. A minimum of 60% will be at the draft report stage within 4 months and published by 6 months

	Number of cases	Reported started within 2 months	Compliance	Drafted within 4 months	Compliance	Published at 6 months	Compliance
Stillbirths	8	8	100%	Scheduled	-	Scheduled	-
Neonatal death	2	2	100%	Scheduled	-	Scheduled	-
Total overall	10	10	100%				

All cases are yet to have an MDT but will be scheduled as and when results returned. There are no foreseen delays at present to indicate a concern with meeting the deadlines.

Standard D

Quarterly reports submitted to Trust executive board – this is the second quarterly report under the new standards submitted to the divisional management team for inclusion at Trust board.

Learning form reviews

Early incidental findings have been extracted from the reviews conducted so far. It has highlighted an issue with following up of urine infections and ensuring a test is conducted to confirm treatment.

There is inconsistency in the panel of bloods run cross site and some are not being processed despite request. This has prompted a review of the blood panel and discussion with haematology colleagues to agree the most appropriate samples be run.

Summary and key highlights/ escalations from Q2

Issue	Mitigation	Timescales
Failsafe reporting does not allow visibility of <24 week IUD's which require reporting.	Verbal handover of any reportable incidents occurs at the daily safety huddles which triggers the requirement for a Datix. Potential human error remains a risk, reviewing further potential for failsafe measures	12/2023
Provision of bereavement services following different models on each site	This is the focus of a service review to align.	April 2024
Resource required for PMRT function	Increased workload is factored into workforce and governance review to ensure it remains appropriate.	Jan 2024

Highlights

- All cases within quarter 2 have been completed to the standard set out in the maternity incentive scheme year 5 for safety action 1, as detailed on the first page of this report. The drafting and completion of the reports is ongoing, however the Governance Manager does not foresee any issues with completion in the required timeframe.
- The meetings continue to be scheduled as a standard meeting every other Friday afternoon for 2 hours where we can review up to 3 cases at a time.
- Membership of the panel continues to be good with regular attendance from external members and other stakeholders. Good lines of communication have been opened with the Essex child death review team and in response to the learning highlighted in the last report training is being rolled out. The CDR team are planning to train all coordinators, matrons and bleep holders on the resource folders they have prepared which will ensure the process of referral and management of child death is appropriate.