

Standard Operative Procedure for completion of the Perinatal Mortality Review Tool (PMRT) and Terms of Reference

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Approved by:	Paediatric QI Meeting

The purpose of the PMRT which was designed by MBRRACE in 2018, is to facilitate comprehensive, robust and multidisciplinary reviews of all perinatal deaths from 22⁺⁰ gestation, to 28 days after birth, including those babies who die after 28 days following neonatal care.

The aim is to provide a standardised high-quality review of each case, with a grading of the quality of care provided linked to the outcomes. Inclusion of parents perspectives of their care is a central theme to the process, and consideration of any concerns they have regarding their care should be included in the review.

The PMRT facilitates internal and external peer review of cases, with an individualised report for each family, and allows generation of action plans which must be implemented and monitored, but also enables Trust level reporting and demonstration of organisational learning and service improvement.

Regional and national benchmarking and learning through publication of annual reports is also possible to allow themes and trends to be identified. Accurate and timely PMRT completion is also a central aspect of the Trust's compliance with the Maternity Incentive Scheme developed by NHS Resolution and if the process is followed as contained within this SOP, can provide assurance to families and the Trust board that the process is being followed appropriately.

1. Principles for the conduct of local perinatal mortality reviews

- There should be comprehensive and robust reviews of all perinatal deaths from 22+0 days gestation until 28 days after birth, including the death of any baby who dies following care on the neonatal unit following birth but excluding terminations of pregnancy and those babies with a birthweight < 400g

- The reviews should be conducted using a web-based standardised nationally accepted tool (PMRT) including a system for grading quality of care linked to outcomes
 - A multi-disciplinary group should review each case at a meeting where time is set aside for doing the work
 - There should be scope for parental input into the process from the beginning
 - An action plan should be generated from each review (if applicable), implemented and monitored
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- The review should result in a written report which can be shared with the family in a sensitive and timely manner, if they wish
 - Reports should be submitted to the Directorate, Division and Trust Board regularly and both demonstrate, and result in, organisational learning and service improvements
 - Findings from local reviews should feed up regionally and nationally to allow benchmarking and publication of results and ensure national learning

2. The babies whose care should be reviewed using the PMRT

The PMRT should be used to support the review of the following babies:

- All late fetal losses 22⁺⁰ to 23⁺⁶
- All antepartum and intrapartum stillbirths
- All neonatal deaths from birth at 22⁺⁰ to 28 days after birth
- All post-neonatal deaths where the baby is born alive from 22⁺⁰ but dies after 28 days following care in a neonatal unit; the baby may receive palliative care elsewhere (including home) when the baby dies

The PMRT is not designed to replace the Trust incident review process and it is expected that the Comprehensive/Serious Incident Reviews will still continue if required. If care failings are identified, the normal Trust approach should be followed and the PMRT process will assist and augment this.

The PMRT does not prevent referral to HSIB (Healthcare Safety Investigation Body) where the relevant criteria are met, and the PMRT should be completed with involvement of the investigators for cases with HSIB involvement.

The PMRT is not designed to support the review of the following:

- Termination of pregnancy at any gestation
- Babies who die in the community 28 days after birth or later who have not received neonatal care
- Babies with brain injury who survive.

3. Review of babies who have been transferred

Where babies are transferred (either in-utero or after birth) and received care in more than one organisation, it is suggested that care across all hospitals is reviewed and should be carried out as a joint activity where possible, with use of video-conferencing to be considered.

The PMRT completion between collaborating Trusts will be arranged on a case-by-case basis.

4. Multi-disciplinary review group

MBRRACE advise that the review group is multi-disciplinary as the quality of local reviews has been found to be higher than when reviews are completed by one or two people (for example the PMRT champion can also be a midwife). MBRRACE have advised that it is possible for group members to fulfil multiple roles provided these do not result in too small a group of individuals. It is advised if the Chair of the review board is involved in the death, the meeting should be chaired by the Vice-Chair.

The agreed composition of the Perinatal Mortality Review Board (PMRB) for Worcestershire Acute Hospitals NHS Trust is as follows:

Core membership
Roles within the group: <ul style="list-style-type: none"> • Chair • Vice-Chair • Scribe/admin support • PMRT champion
Essential minimum membership of the group (can be more than one present): <ul style="list-style-type: none"> • 2 Obstetricians • Midwifery matron • Neonatologist and neonatal nurse (in all cases where resuscitation was commenced and all neonatal deaths) • Member of the bereavement team • Member of the Risk & Governance team • 1 external panel member* <p>*MBRRACE advise an independent external panel member is included to support a robust review – this member is present to provide a ‘fresh pair of</p>

eyes' and to challenge where complacency and normalcy of service provision has crept in.

Additional members of the healthcare (and wider team) can be invited to attend or contribute on a case by case basis if their input is pertinent to the review.

In order to be quorate for the meetings to take place, the minimum essential requirements detailed above must be present.

5. Organisation and preparation for review meetings:

Members of the review group need to have sufficient time allocated to attend the meeting and undertake any preparation work required. It is proposed that the meetings take place once a month, and where this is not possible, alternative arrangements will be made (for example, in the case of bank holidays, attendees not meeting quorum requirements etc).

6. Stages of the PMRT review process:

- 1) Within 72 hours of a death occurring, incident form will be submitted via Datix and a rapid review (ICR) will be undertaken to ensure no immediate safety concerns are identified – escalation to Divisional Management Team (DMT) and Patient Safety Team will occur if required.
- 2) Members of the obstetric and bereavement team supporting the parents will discuss the PMRT process with them, and document any concerns/questions they have regarding their care. Duty of Candour will be observed if requirements are met. Any concerns or issues will be made available to the PMRT midwife for inclusion in the case review, and escalated as required to senior members of the management team.
- 3) Discussion of case at weekly Quality and Safety meeting with DMT input to decide on level of investigation (if needed) or decision for investigation by PMRT if appropriate, with agreement for timetable – outcome to be recorded on Datix by Governance team.
- 4) Bereavement team or Governance admin support will open case on MBRRACE portal to enable PMRT review to be created.
- 5) Demographic information and basic data to be entered into PMRT review tool prior to complete PMRT review by PMRB.

- 6) Review of case commences by PMRT midwife and Obstetrician, creating a presentation which documents the woman's journey from pre-conception care throughout pregnancy to birth and the postnatal period – if serious concerns are identified at this stage, these will be escalated and investigated as appropriate with input from the Governance and wider team as needed. Parental concerns/input will be included.
- 7) The Bereavement team will inform the parents when the review is expected to take place and will invite any further questions/issues they wish to raise in addition to those already documented; these will be included in the case review.
- 8) Case will be presented to the PMRB with additional information as available (eg. placental histology/post-mortem results) but the review should not be delayed to wait for these.
- 9) If possible, the PMRT will be completed alongside the case presentation and discussion, however, it is recognised that this may not be possible contemporaneously and may need to be entered into the tool retrospectively, using the notes and minutes as documented by the admin support team member.
- 10) The members of the PMRB make a decision based on the information and evidence available as to the care grading based on outcome for the woman and her baby and this is recorded in the PMRT.
- 11) Any issues with care are identified within the tool and addressed as part of the meeting and either an action plan is created, or appropriate mitigation is discussed (for example, not relevant to the outcome and no action needed).
- 12) Action plan is agreed and actions assigned as appropriate.
- 13) A cause of death is to be decided by the review group – it may be necessary to wait for further test results and return to the case review at a later date.
- 14) A draft version of the report is saved (ideally within 4 months of the date of death) and the final version is completed as soon as all additional information is obtained.

15) The parents are informed the review is completed, and a copy of the report made available to them if they wish.

16) The actions from the review are monitored and evidence of completion stored within Datix and the relevant folders.

7. Parental consent for PMRT

Parental consent is not required to enable a review to be carried out. However, using the PMRT means their confidential identifiable information is included in a database which is held by the University of Oxford. MBRRACE have made a successful application to the Confidentiality Advisory Group for England and Wales (17/CAG/0150).

If parents wish to object to this information being held, advice should be sought from MBRRACE via the Governance team and PMRT midwife.

8. Output and shared learning from the PMRB

The opportunity for shared learning and improvements in care for women and their families from the multi-disciplinary PMRT reviews is one of the main aims of the PMRT. It is recommended that the action plans generated from these reviews are SMART (**S**pecific, **M**easurable, **A**chievable, **R**ealistic and **T**ime-Bound) although the Trust recognises that not all actions will be truly 'SMART' but can still have a significant impact on patient care.

The learning and service improvements identified as part of the PMRT process will be shared on a monthly basis at the Perinatal Mortality and Morbidity meetings, as well as at the directorate governance meetings and both medic and midwifery mandatory training.

A quarterly report will be submitted to the Trust Board to provide assurance of the robust process in place and will seek to satisfy the requirements set out for the PMRT process in the Maternity Incentive Scheme run by NHS Resolution.

9. Terms of reference (TOR) – MBRRACE (2018)

The PMRB at Worcestershire Acute Hospitals NHS Trust have opted to use the TOR advised by MBRRACE (2018) as set out below. Any changes or suggested alterations to these are required to be agreed by the quorate members of the PMRB and approved by the Divisional Governance group.

10. References MBRRACE (2018) Guidance for Trusts and Health Boards: Conducting Perinatal Mortality Reviews using the National Perinatal Mortality Review Tool (PMRT) – version 1.2. Oxford. MBRRACE.

Perinatal Mortality Review Meeting Terms of Reference*

[INSERT TRUST/HEALTH BOARD NAME]

The aims of our stillbirth and neonatal mortality review meetings include:

- Identifying the cause of each baby's death by robustly and comprehensively reviewing each case and the quality of care provided;
- Working through the care for each baby who died to identify contributory factors where issues are identified and assessing whether different care may have made a difference to the outcome (grading of care);
- Developing action plans that aim to address the contributory factors identified and achieve organisational change and service improvements;
- Recognising a 'just culture' of accountability for individuals and organisations;
- Incorporating the parents' perspective of their care and addressing any questions and concerns they have;
- Providing parents with a robust explanation of why their baby died (accepting that in all instances, despite full clinical investigations, it is not always possible to determine this) and any implications for future pregnancies;
- Improving the care we provide for mothers, babies and families in the future.

The conduct of our stillbirth and neonatal mortality review meetings include:

- Making every effort to gather the relevant information/evidence about each death in advance of the meeting;
- Attending and arriving on time to the meeting;
- Participating actively in discussions;
- Respecting everyone's ideas and way of expressing them;
- Accepting robust discussion and disagreement;
- Agreeing to be comprehensive, open and transparent throughout;
- Trying as much as possible (recognising this can be challenging) to accept that your own actions can be questioned;
- Respecting the confidentiality of the documents and discussions that take place during the meetings and record/dispose of them appropriately;
- If gaps are identified in the information there may be a need to go away and gather more information before completing the review;
- Using the national Perinatal Mortality Review Tool (PMRT) to support the conduct of each review.

*Modified: World Health Organisation. Making Every Baby Count: audit and review of stillbirth and neonatal death. Geneva: WHO, 2016.