North West Anglia NHS Foundation Trust

REPORT TO TRUST BOARD (PUBLIC)

TITLE	Perinatal Mortality Report
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DATE OF MEETING	9 February 2021
PRESENTED FOR	Discussion/ Assurance

PURPOSE OF THE REPORT

To provide information to the Trust Board regarding Perinatal Mortality

EXECUTIVE SUMMARY

Safety Action One of the Maternity Incentive Scheme is in relation to utilising the National Perinatal Review Tool (PMRT) and ensuring that the Organisation receive quarterly reports. The quarterly reports should include details of all the deaths reviewed and consequent action plans.

This report presents Quarter 3 2020/20221 perinatal mortality data for NWAFT and the lessons learnt as part of undertaking Perinatal Mortality Reviews.

COMMITTEES/SUBGROUP WHERE THIS ITEM HAS BEEN CONSIDERED

Quality Assurance Committee, Maternity Strategic Leadership Board, Maternity Safety Champions Meeting

RECOMMENDATIONS

The Board is requested to note the content of the report and the improvement action being undertaken by the Trust

STRATEGIC GOALS THIS REPORT SUPPORTS *(Check all that apply)*

Delivering outstanding care and experience	√
Recruiting developing and retaining our workforce	
Improving and developing our services and infrastructure	√

Working together with local health and social care providers	
Delivering financial sustainability	

RISKS RELEVANT TO THE PAPER

Risk ID	Risk Description
none	

OTHER IMPLICATIONS OF THE PAPER

Legal/ Regulatory Relevance:	*Regulation 12 : Safe Care,, Regulation 18: Appropriate staffing, Regulation 17 Good Governance Fundamental Standards of Care Part 3 Health and Social Care Act, 2008 (updated 2014)*
NHS Constitution Delivery	The NHS aspires to the highest standards of excellence and professionalism
Freedom of Information Release	This report can be released under the Freedom of information Act 2000

Equality and Diversity Implications *(Check all that apply)*								
Age	Gender	Ethnicity	Disability	Pregnancy/ Maternity	Marriage/ Civil Partnership	Religion/ Belief	Sexual Orientation	Gender Reassignment
☐	☐	☐	☐	**X**	☐	☐	☐	☐
No Equality and Diversity Implications								

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1. Introduction

The NHS Long Term Plan reaffirmed the Department of Health's commitment to halve stillbirth and neonatal mortality by 2025. Whilst giving birth in the UK is largely safe, reports over the past decade have highlighted significant discrepancies in the quality of care provided. The recent MBRRACE-UK confidential enquiries reported that between 60-80% of term deaths might have been prevented. It is therefore critical for services to undertake robust reviews and learn lessons to reduce the number of parents who experience such a tragic loss. This provides the foundation to why Perinatal Mortality Reviews are included as Safety Action One of the Maternity Incentive Scheme (CNST) and that quarterly board reports are integral to that action point.

2. Definitions

Perinatal mortality refers to the number of **stillbirths and deaths in the first week of life** (early neonatal mortality).

Stillbirth: A stillbirth is when a baby is born dead after 24 completed weeks of pregnancy.

Neonatal Death: Is a baby born at any time during pregnancy who lives, even briefly, but dies within 4 weeks of being born.

3. Perinatal Mortality Review Tool

The Perinatal Mortality Review Tool (PMRT) is a standardised approach that is utilised by maternity units in England, Wales and Scotland. The tool aims to support a systematic, multidisciplinary, high quality review of the circumstances and care leading up to and surround each stillbirth and neonatal death, and the deaths of babies who die in the post-neonatal period, having received neonatal care.

The process includes active communication with parents to ensure that they are informed that a review of their care and that of their baby will be carried out and how they can contribute to the process. They will receive a report which includes meaningful, plain language of why their baby died, if possible, and include a grading of care provided.

The PMRT provides data at a Trust Level so site level data is not provided.

4. Perinatal Mortality from 1st October to the 31st December 2020

During the period 1st October to the 31st December 2020, NWAFT reported seven stillbirths and late fetal losses to MBRRACE with all requiring a PMRT review. Of those seven, 3 reviews have been completed, 3 are in progress and one is due to start but they are all within the timeframe of four months. Additionally four neonatal and post-neonatal deaths were reported of which 2 reviews were required and are in the process of being completed within the timeframe of 4 months. Table one

below summarises the perinatal mortality reviews completed for cases that occurred between 1st October and 31st December 2020.

Table One: Report of Perinatal Mortality Reviews completed for deaths that occurred in the period of 1/10/2020 to 31/12/2020

Stillbirths and late fetal losses

Number of stillbirths and late fetal losses reported	Not supported for Review	Reviews in progress	Reviews completed ***	Grading of care: number of stillbirths and late fetal losses with issues with care likely to have made a difference to the outcome for the baby
7	0	3	3	0

Neonatal and post-neonatal deaths

Number of neonatal and post-neonatal deaths reported	Not supported for Review	Reviews in progress	Reviews completed ***	Grading of care: number of neonatal and post-neonatal deaths with issues with care likely to have made a difference to the outcome for the baby
4	2	2	0	0

Of the three stillbirths that were reviewed, two babies were term and sadly died in the antenatal period and one baby was born between 32 and 36 weeks gestation. The causes of death include feto-maternal haemorrhage, placental origin and ascending infection

Post-mortems were offered to all parents though declined in two situations and placental histology was undertaken in all cases.

All parents were provide an opportunity to discuss their views and concerns which were included in the review.

5. Learning from the Reviews

The multi-professional review group assessed that in two of the cases that issues with care identified in the review may have made a difference to the outcome of the babies.

The summary of the grading is outlined below:

Table 2: Grading of Care

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
STILLBIRTHS & LATE FETAL LOSSES							
Grading of care of the mother and baby up to the point that the baby was confirmed as having died:							
A - The review group concluded that there were no issues with care identified up the point that the baby was confirmed as having died	0	0	0	0	0	0	0
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	0	0	0	0	1	1
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	0	0	1	1	2
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
Grading of care of the mother following confirmation of the death of her baby:							
A - The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby	0	0	0	0	0	1	1
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother	0	0	0	0	1	0	1
C - The review group identified care issues which they considered may have made a difference to the outcome for the mother	0	0	0	0	0	1	1
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0

Themes identified include incurred risk assessment at booking and that the care pathway was inappropriate for the women's correct risk allocation. Learning has been shared with the midwifery and obstetric team; however given that this theme is with one of the immediate actions outlined in the Ockenden Report (2020); further improvement work is planned including audit and full implementation of the personalised care and support plans. Additionally, the maternity digital record system is being explored to see if it can strengthen the risk assessment process.

In two cases, it was reported by the review panel that the COVID 19 pandemic may have possibly adversely affected how the woman access care. For example, one woman was noted to be pregnant by the Health Visitor who was visiting a sibling. The woman was 34 weeks pregnant. The Maternity Service has reviewed the United Kingdom Obstetric Surveillance System Report on Coronavirus which highlighted inequalities for women from a BAME background and subsequently, the Maternity Team are progressing a BAME improvement plan.

Additionally in two cases, ultrasound scans were not performed when small for gestational age was suspected. In response, the Maternity Service is currently reviewing local guidelines following the recent publication of revised Growth Assessment Protocol guidance from the Perinatal Institute.

6. Stillbirth Rate

The rolling Stillbirth rate is monitored by site and as an overall Trust. For Hinchingbrooke the rolling Stillbirth rate for 2020 was 0.5 per 1000, 2.7 for Peterborough and overall 2.0 for NWAFT against a national average for England of 3.8 per 1000 births (ONS data for 2019 published 2020)

7. Maternity Incentive Scheme Standards

Year Three Maternity Incentive Scheme specifies in safety action one that Trusts should utilise the national Perinatal Mortality Review Tool. The Trust has maintained full compliance during quarter 3 fully compliant as outlined below.

Table Three: Maternity Incentive Scheme Year 3 Safety Action Three

Indicator/ Standard	Compliant Y/N
All perinatal deaths eligible to be notified to MBRRACE-UK from Thursday 1 October 2020 onwards must be notified to MBRRACE-UK within seven working days and the surveillance information where required must be completed within four months of the death.	Yes
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 to Wednesday 30 September 2020 will have been started by Thursday 31 December 2020. This includes deaths after home births where care was provided by Trust staff and the baby died.	Yes
A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from Thursday 1 October 2020 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.	Yes
At least 75% 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 to Friday 31 July 2020 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 by Thursday 31 December 2020.	Yes
At least 40% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births, from Saturday 1 August 2020 to Thursday 31 December 2020 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.	Yes
For 95% of all deaths of babies who were born and died in the Trust from Friday 20 December 2019, the parents will have been 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 Trust staff and the baby died. If delays in completing reviews are anticipated parents should be advised that this is the case and be given a timetable for likely completion.	Yes
Quarterly reports will have been submitted to the Trust Board from Thursday 1 October 2020 onwards that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety champion.	Yes

Summary

The report summarises the use of the Perinatal Mortality Review Tool which aims to reduce the number of babies who sadly die from preventable factors. It is important

that for each parent that has lost a baby that maternity services actively learn and improve to prevent another parent experiencing that tragic loss. This report summarises the learning identified and action taken. It is acknowledged that further improvement work is required and this is ongoing.