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#stillbirth

Maternity and Children Quality Improvement Collaborative (MCQIC)

MCQIC Webinar

Using the Perinatal Mortality Review Tool (PMRT) as a quality improvement (QI) aide

15 September 2021

Welcome and introduction

Prof Alan Cameron (Chair)

MCQIC Obstetric Clinical Lead

Healthcare Improvement Scotland

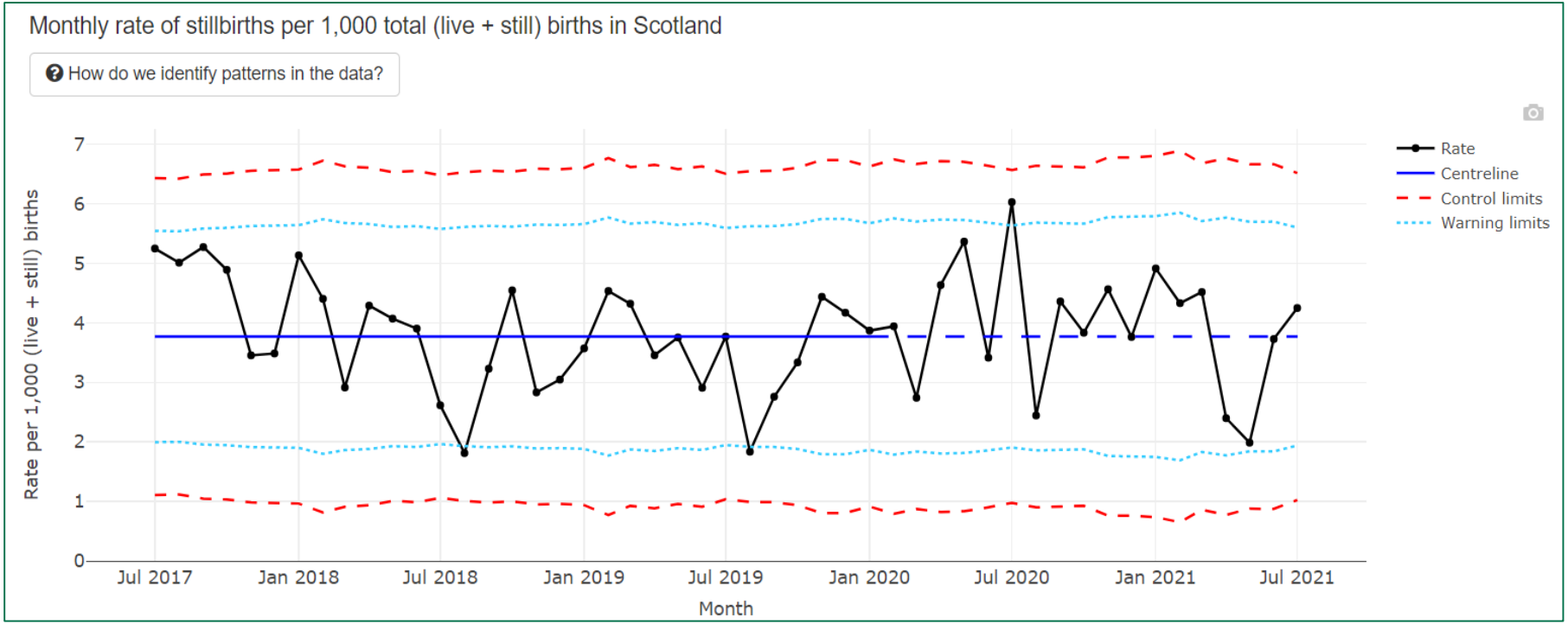
Aims of the webinar

- To understand how to use the PMRT as a QI aide.
- To consider where the PMRT sits in the QI journey in relation to pregnancy outcomes.
- To support continuous learning and improvements in relation to perinatal deaths.

Agenda

Time	Topic	Lead
11.00-11.05	Welcome and introductions	**Prof Alan Cameron (Chair)** MCQIC Obstetric Clinical Lead Healthcare Improvement Scotland
11.05-11.25	Using the PMRT as a QI aide	**Prof Jenny Kurinczuk** Professor of Perinatal Epidemiology, University of Oxford National Programme Lead MBRRACE-UK/PMRT
11.25-11.50	Q&A session with Prof Jenny Kurinczuk	**Prof Alan Cameron**
11.50-12.05	Maternity and Neonatal (Perinatal) Adverse Event Review Process for Scotland	**Dr Corinne Love** Senior Medical Officer, Maternity and Women's Health, Scottish Government **Dr Edile Murdoch** Consultant Neonatologist, Clinical Director, Women and Children's, NHS Lothian
12.05-12.10	Q&A session with Dr Corinne Love & Dr Edile Murdoch	**Prof Alan Cameron**
12.10-12.15	Next steps: Future webinars and close	**Prof Alan Cameron**

Rate of Stillbirths – Public Health Scotland



Using the PMRT as a QI aide

Prof Jenny Kurinczuk

Professor of Perinatal Epidemiology

University of Oxford

National Programme Lead MBRRACE-UK/PMRT

PMRT
Supporting high quality local perinatal reviews

MBRRACE-UK
Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK

Using the Perinatal Mortality Review Tool (PMRT) as a quality improvement aide

MBRRACE-UK - Surveillance data supporting quality improvement

Prof Jenny Kurinczuk

National Programme Lead MBRRACE-UK/PMRT

On behalf of the MBRRACE-UK/PMRT Collaboration

The PMRT – a tool designed to facilitate…

- Comprehensive and robust review of the care of babies who die:
  - Late miscarriages/ late fetal losses (22^{+0} to 23^{+6})
  - Stillbirths
  - Neonatal deaths (up to 28 days after birth)

  [Can be used to review post-neonatal deaths (later than 28 days after birth) following neonatal care]

  [Excluding deaths following termination of pregnancy and community deaths]

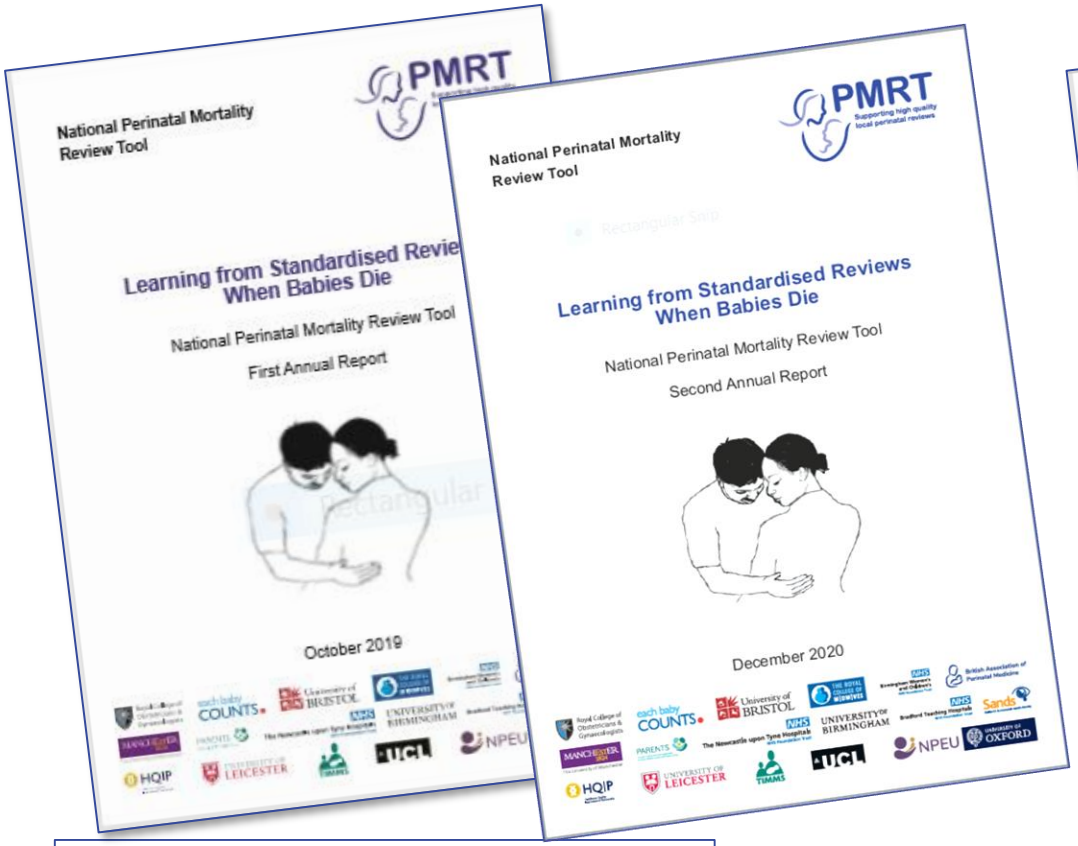
- To support standardised, systematic, multi-disciplinary review of the whole pathway of care from pre-conception and booking through to the death, bereavement care and follow-up

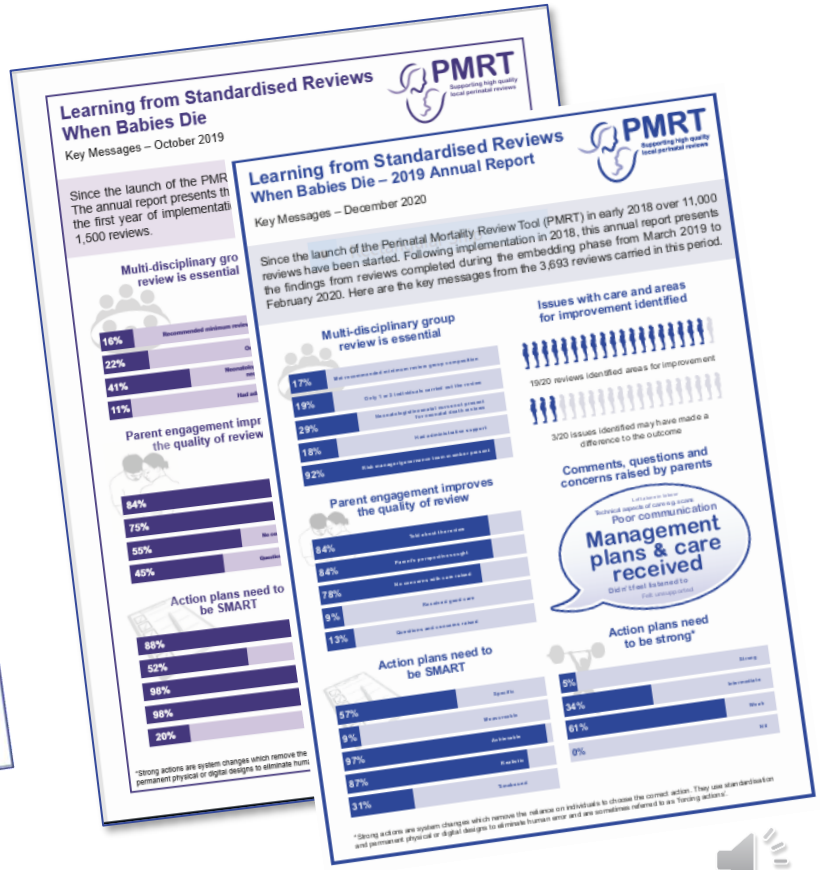
- Inclusion of parents' perspectives in the review process and consideration of any concerns or questions they may have about their care

Using the PMRT as a quality improvement aide

- All perinatal deaths will be reviewed in an objective, robust, multi-disciplinary and standardised way using an on-line tool – review quality will improve
- Parents' views of their care will be incorporated and they'll receive a full, plain English, explanation as to why their baby died (accepting that it is not always possible to determine why some babies die)
- We'll learn more about why babies die – develop action plans - FEED INTO QI ACTIVITIES
- And be able to target resources towards causes and address any shortfalls in care at local, network and national levels - FEED INTO QI ACTIVITIES
- The learning and good practice will be able to be shared
- The goal being a reduction in the number of babies who die

Annual reports





https://www.npeu.ox.ac.uk/pmrt/reports

PMRT in Scotland

- The PMRT was launched in Scotland at the start of March 2018 (>1mth later that E&W)

- All Health Boards in Scotland have registered to use the PMRT

- Since the launch as of 6th Sept 2021 a total of 14,417 reviews have been started or completed – 673 (5%) of them in Scotland

PMRT – use in Scotland in 2019

- In England, Scotland, Wales and Northern Ireland overall – deaths in 2019:
  - For deaths across the four countries in 2019 a review using the PMRT was **started** on **92%** of all deaths:
    - **95%** of all stillbirths
    - **87%** of all neonatal deaths

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    - **95%** of all stillbirths
    - **87%** of all neonatal deaths

- All Health Boards (excluding the Islands) in Scotland have started at least one review
  - For deaths in Scotland in 2019 a review using the PMRT was **started** on **78%** of deaths:
    - **82%** of all stillbirths in Scotland
    - **70%** of all neonatal deaths in Scotland

Parent Engagement

Parents whose baby has died have the greatest stake in understanding what happened and why their baby died.

Mothers are the only people who were present for the whole of the pregnancy and know what care they received.

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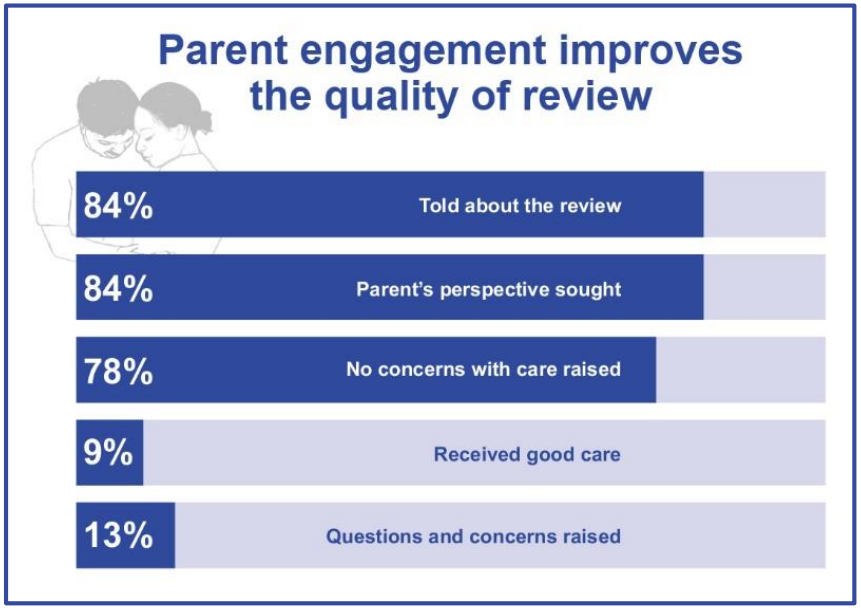
Mothers are the only people who were present for the whole of the pregnancy and know what care they received.

Engaging bereaved parents in the review process and including their views and any concerns and questions they have about their care will enhance the review process and ensure that from the outset the review addresses the parents' questions.

Engagement of parents in the review process will aid quality improvement

Parent Engagement – UK wide 2019



- 84% of parents had been told a review of their care and that of their baby was being carried out.
- For 84% of reviews, parents' perspectives and any concerns about their care and the care of their baby had been sought.
- This represent a considerable improvement in parent awareness of reviews and recording of parental concerns compared with the findings of earlier MBRRACE-UK Confidential Enquiries and the Each Baby Counts programme.

Findings from Scottish reviews – action plans

Reviews undertaken in 2019:

- **225** deaths of which
  - 187 (**83%**) **deaths were reviewed** and the **review was completed** – has to be completed to analyse the action plans.
  - 38 **(17%) deaths** the **started but not completed**
  - Issues identified in Scotland were no different to the issues identified across the UK
  - Issue relevance for prioritisation of actions and QI – see the 2020 annual report for the current figures – publication 14th October 2021

Antenatal Care Issues – most common UK-wide

Issue Categories	Number and percentage of reviews (N=1,500) n (%)	Number of issues relevant to the outcome (N=883) n (%)	Number of issues not relevant to the outcome (N=2,555) n (%)
Smoking assessment and management of exposure to tobacco smoke	604 (40%)	113 (13%)	556 (22%)
Inadequate growth surveillance	384 (26%)	269 (30%)	262 (14%)
Assessment and management of aspirin requirement	339 (23%)	66 (7%)	278 (11%)
Inadequate investigation or management of reduced fetal movements	230 (15%)	142 (16%)	188 (7%)
Not offered routine MSU at booking	222 (15%)	<10	213 (8%)

Relevant to general care:
Smoking and aspirin need

Relevant to the outcome for the baby:
Growth surveillance and management of reduced fetal movement

Intrapartum Care Issues – most common UK-wide

Issue Categories	Number and percentage of Reviews (N=1,500) n (%)	Number of issues relevant to the outcome (N=346) n (%)	Number of issues not relevant to the outcome (N=1,033) n (%)
Issues with monitoring of the mother	604 (40%)	113 (13%)	556 (22%)
No assessment of mother's risk status or inadequate management at the start of her care in labour or during the course of her labour	384 (26%)	269 (30%)	262 (14%)
Staffing issues	339 (23%)	66 (7%)	278 (11%)
Issues with communication with mothers with poor/no English	230 (15%)	142 (16%)	188 (7%)
Fetal monitoring issues	222 (15%)	<10	213 (8%)

Relevant to general care: Maternal and fetal monitoring, and staffing

Relevant to the outcome for the baby: Maternal assessment and communication

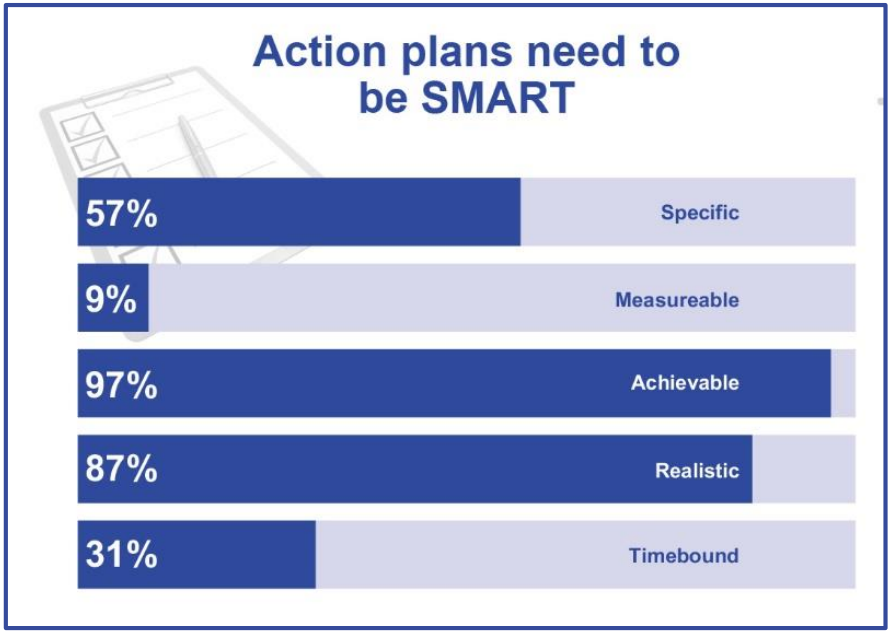
Neonatal Care Issues – most common UK-wide

Issue Categories	Number and percentage of Reviews (N=346) n (%)	Number of issues relevant to the outcome (N=81) n (%)	Number of issues not relevant to the outcome (N=907) n (%)
Inadequate documentation - Resus – 172 (50%) - Neonatal care – 35 (10%) - Transfer to neonatal unit – 25 (7%) - Transfer to another unit – 14 (4%)	185 (53%)	32 (40%)	579 (64%)
Thermal management issues - Transfer to neonatal unit – 47 (14%) - Resus – 18 (5%) - Neonatal care – 14 (4%)	61 (18%)	14 (17%)	60 (7%)
Issues with respiratory management during resuscitation	56 (16%)	<10	54 (6%)

Relevant to general care: Documentation and respiratory management during resusc

Relevant to the outcome for the baby: Temperature management

‘SMART’ Action Plans – UK wide



SMART action plan example:

“The parents were not told that a review of their care and that of their baby is being carried out…… This needs to be discussed at the time of birth. Bereavement Leads and Risk and Patient Safety Manager will make contact with the parents to discuss any concerns or issues relating to their care that they wish to have addressed…….This has now been incorporated into the checklist used at the point of care for pregnancy loss in July 2018.”

Action plan example that is NOT SMART:

“Discussed at consultant meeting and plans made to embed the practice of debrief and documentation of same in these circumstances.”

‘Strong’ Action Plans – UK wide

*‘Strong’ actions are:

system-level changes which reduce the reliance on individuals to choose the correct action by using standardised and permanent physical or digital designs to eliminate human error. (VA Center for Patient Safety)

‘Weak’ action plan example:

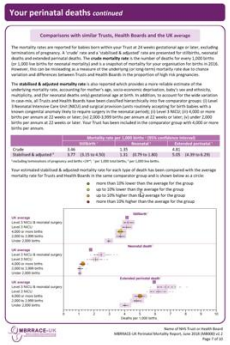
“There is no evidence in the notes that this mother was asked about domestic abuse at booking… Community midwives will be reminded that they are required to ask at booking and other visits where possible. Reminder to go in governance newsletter.”

‘Strong’ action plan example:

“This mother presented with reduced fetal movements, scans and and/or other investigations were indicated but were not carried out…Scan referral form completed on DAU but didn’t get to the scan department - new radiology process in place from Sept 2018 for electronic referrals.”

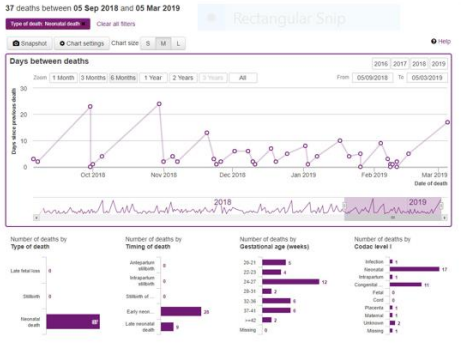
Tools available to health boards to support QI

Your Data



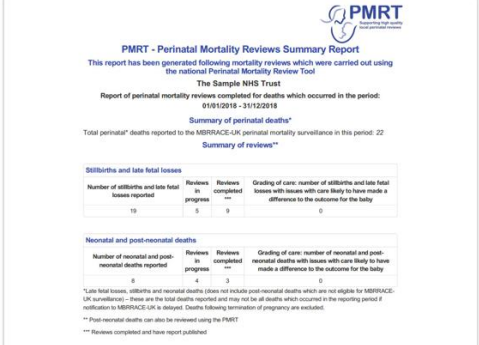
Perinatal Surveillance Reports

Access customized versions of the annual perinatal surveillance reports, containing additional information specific to your Trust/Health Board.



Real-time data monitoring

Monitor, select and summarise the perinatal deaths reported to MBRRACE-UK for your organisation. This tool uses real-time surveillance data from the MBRRACE-UK



Perinatal Mortality Reviews Summary Report and Data extracts

You can now produce a report which provides a summary of reviews completed using the PMRT.

Health board-level report for individual HBs are made available to HBs at the time the national report is published

RDM Tool is constantly available & presents real-time data and so relies on prompt notification of deaths

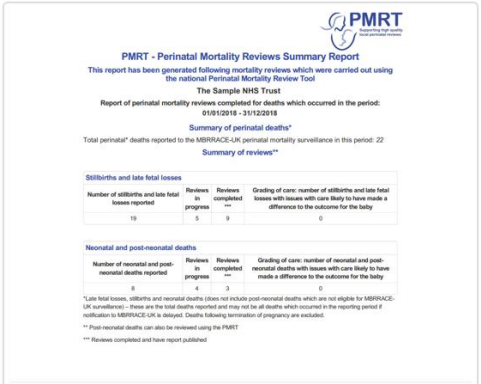
PMRT summary reports includes all reviews of deaths completed for any period of time - are constantly available

Tools available to health boards

Your Data

These reports can be downloaded from the PMRT by any registered users for a user defined period of time

Summary of issues with care identified in a group of reviews – highlights issues which are repeated – supports prioritisation and QI action



PMRT - Perinatal Mortality Reviews Summary Report

This report has been generated following mortality reviews which were carried out using the national Perinatal Mortality Review Tool

The Sample NHS Trust

Report of perinatal mortality reviews completed for deaths which occurred in the period: 01/01/2018 - 31/12/2018

Summary of perinatal deaths*

Total perinatal* deaths reported to the MBRRACE-UK perinatal mortality surveillance in this period: 22

Summary of reviews**

Stillbirths and late fetal losses

Number of stillbirths and late fetal losses reported	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
19	5	9	0

Neonatal and post-neonatal deaths

Number of neonatal and post-neonatal deaths reported	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
8	4	3	0

*Late fetal losses, stillbirths and neonatal deaths (does not include post-neonatal deaths which are not eligible for MBRRACE-UK surveillance) – these are the total deaths reported and may not be all deaths which occurred in the reporting period if notification to MBRRACE-UK is delayed. Deaths following termination of pregnancy are excluded.

** Post-neonatal deaths can also be reviewed using the PMRT

*** Reviews completed and have report published

Perinatal Mortality Reviews Summary Report and Data extracts

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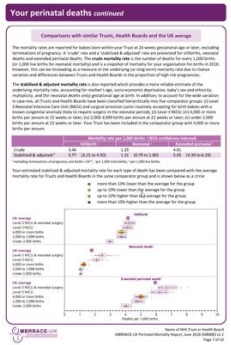


Perinatal Surveillance Reports

Access customized versions of the annual perinatal surveillance reports, containing additional information specific to your Trust/Health Board.

Ten page detailed reports about the births and deaths in each individual health board

Reports will be made available in early October 2021 prior to the national report release

Health board-level report for individual HBs are made available to HBs at the time the national report is published

Perinatal surveillance summary report

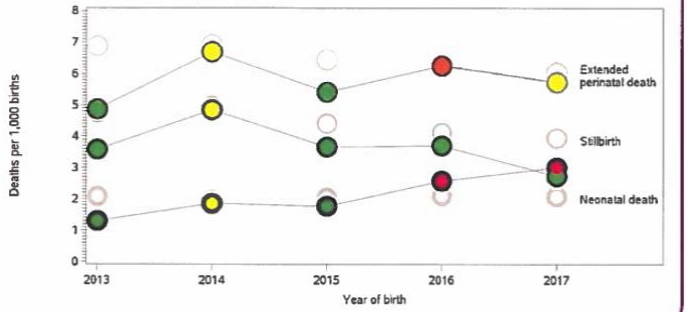
Example of the data available to health boards in summary report – once a year

Mortality rates over time

Crude mortality by year of birth

Crude mortality rates for each type of death compared to the average mortality rate for Trusts and Health Boards in the same comparator group (shown in grey) by year of birth.

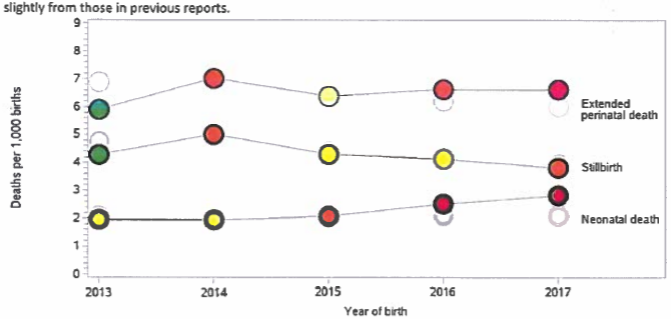
Due to updates to the data, these results might differ slightly from those in previous reports.



Stabilised & adjusted mortality by year of birth

Stabilised & adjusted mortality rates for each type of death compared to the average mortality rate for Trusts and Health Boards in the same comparator group (shown in grey) by year of birth.

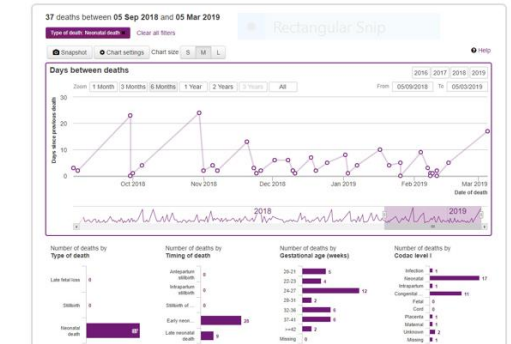
Due to updates to the data and improvements to the statistical methodology used, these results might differ slightly from those in previous reports.



Data are effectively retrospective – published in October 2019

Tools available to health boards

Your Data

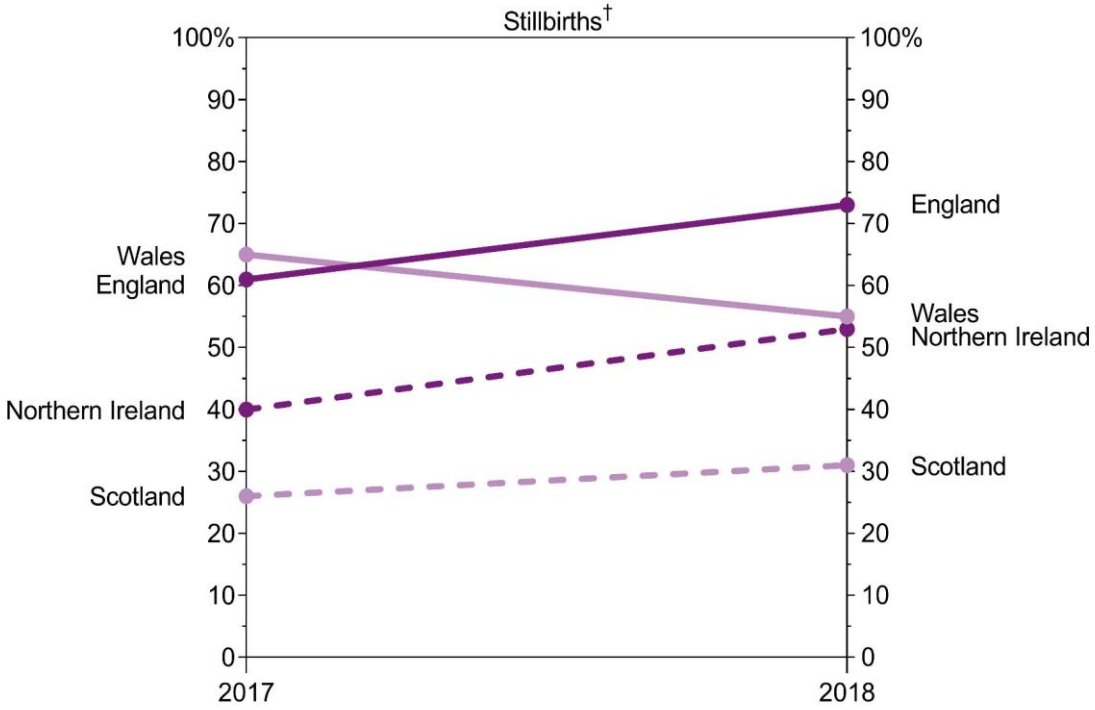


Real-time data monitoring

Monitor, select and summarise the perinatal deaths reported to MBRRACE-UK for your organisation. This tool uses real-time surveillance data from the MBRRACE-UK

RDM Tool is constantly available & presents real-time data and so relies on prompt notification of deaths

Timeliness of reporting deaths

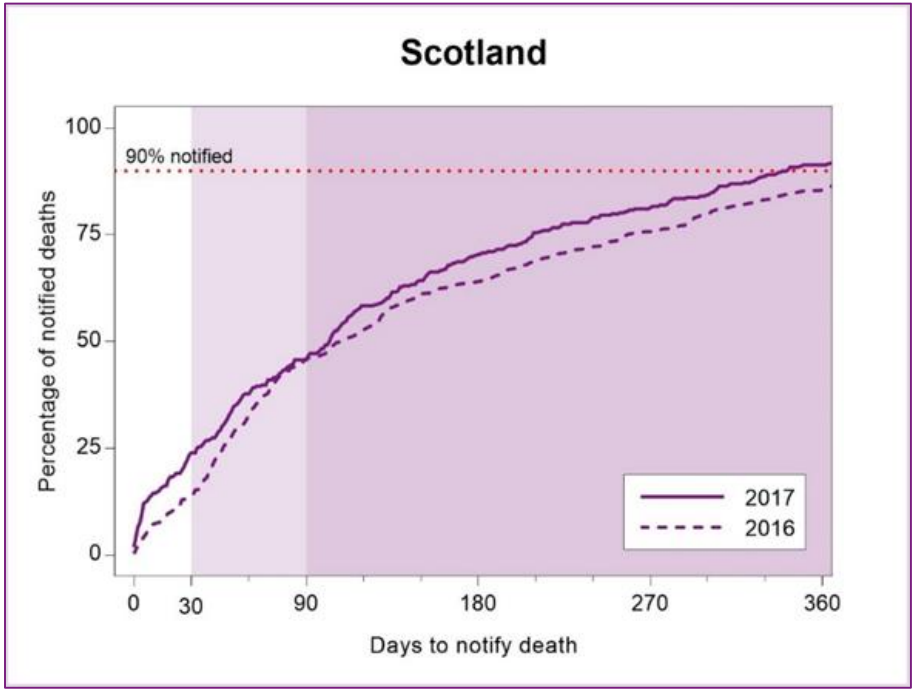


MBRRACE-UK benchmark was to notify death within 30 days

In 2017 it took 342 days to notify 90% of the deaths in Scotland

For 2018 deaths in Scotland:
≤30 days: 36% (25% in 2017);
31-90 days: 22%;
More than 90 days: 42%.
13% of deaths were not notified – identified by MBRRACE-UK from linkage

MBRRACE-UK why prompt notification matters



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Tools available to health boards

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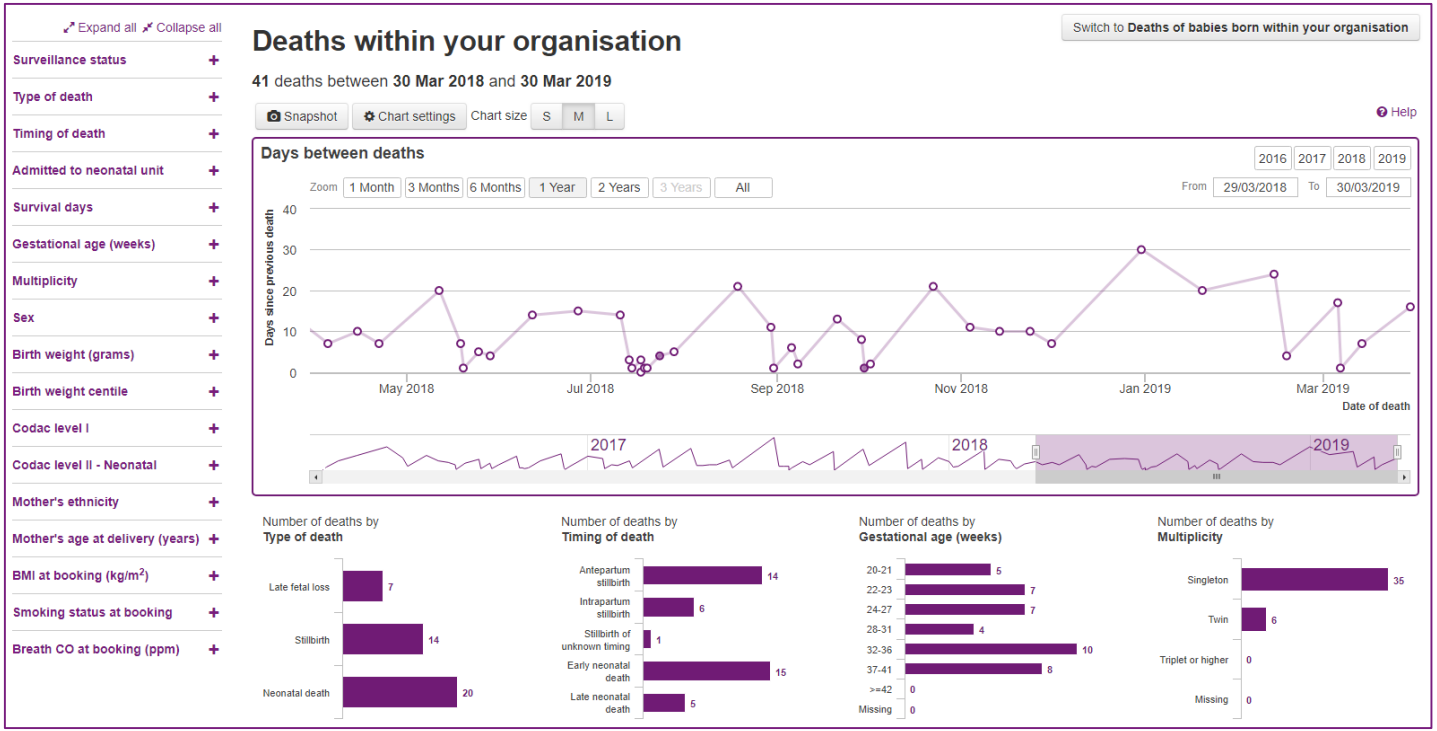
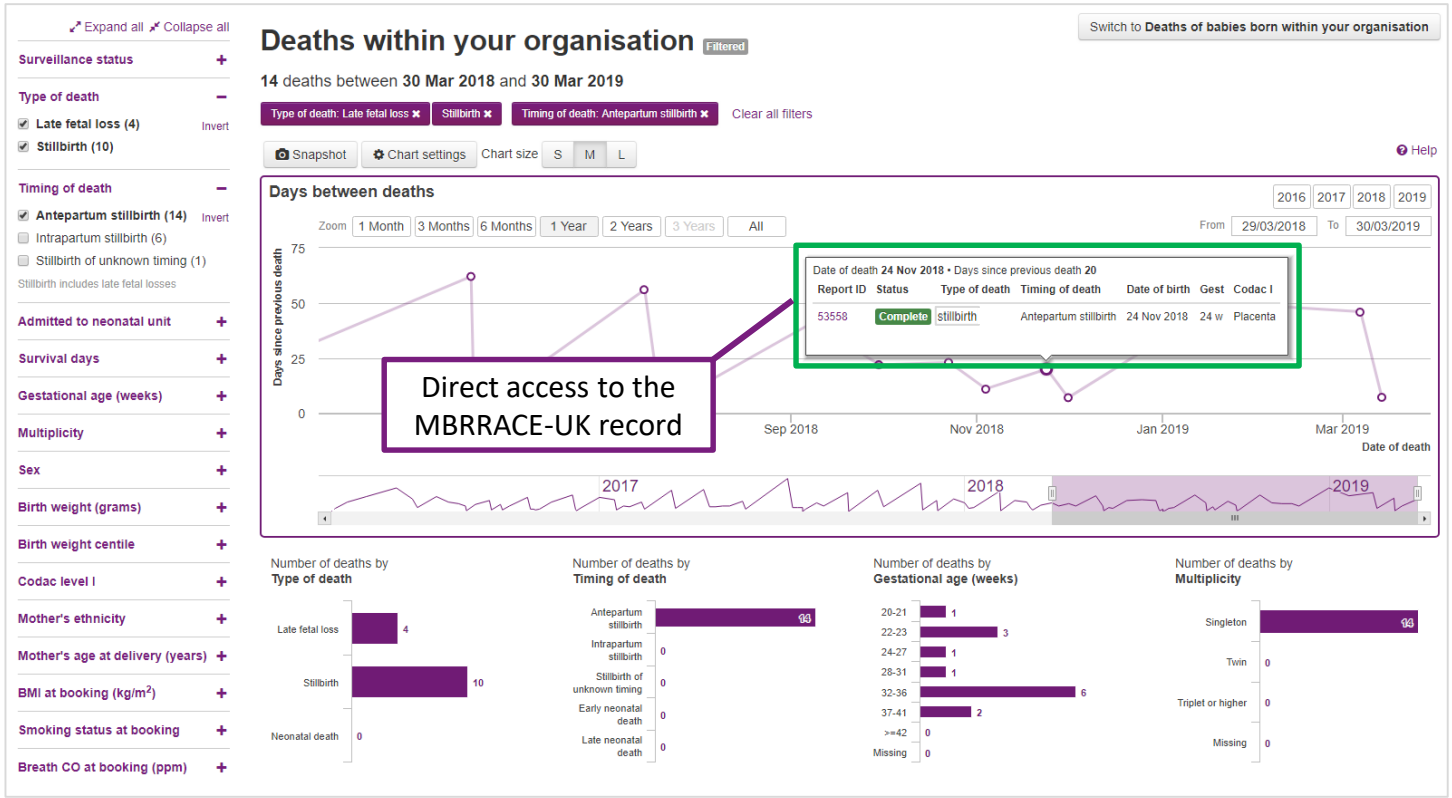
RDM Tool is constantly available & presents real-time data and so relies on prompt notification of deaths

MBRRACE-UK why prompt notification matters

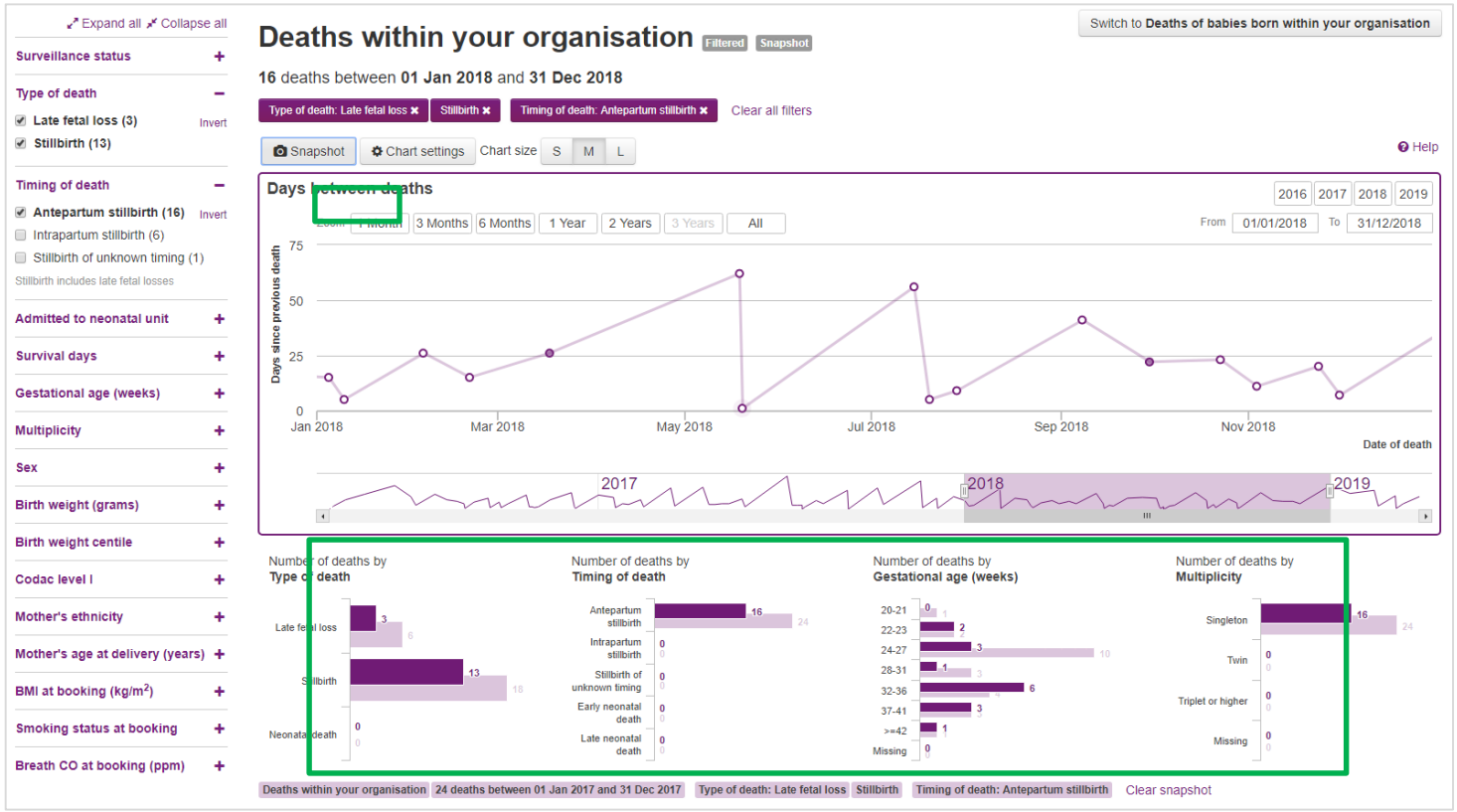
Real-time Data Monitoring Tool (RDMT) – based on surveillance data



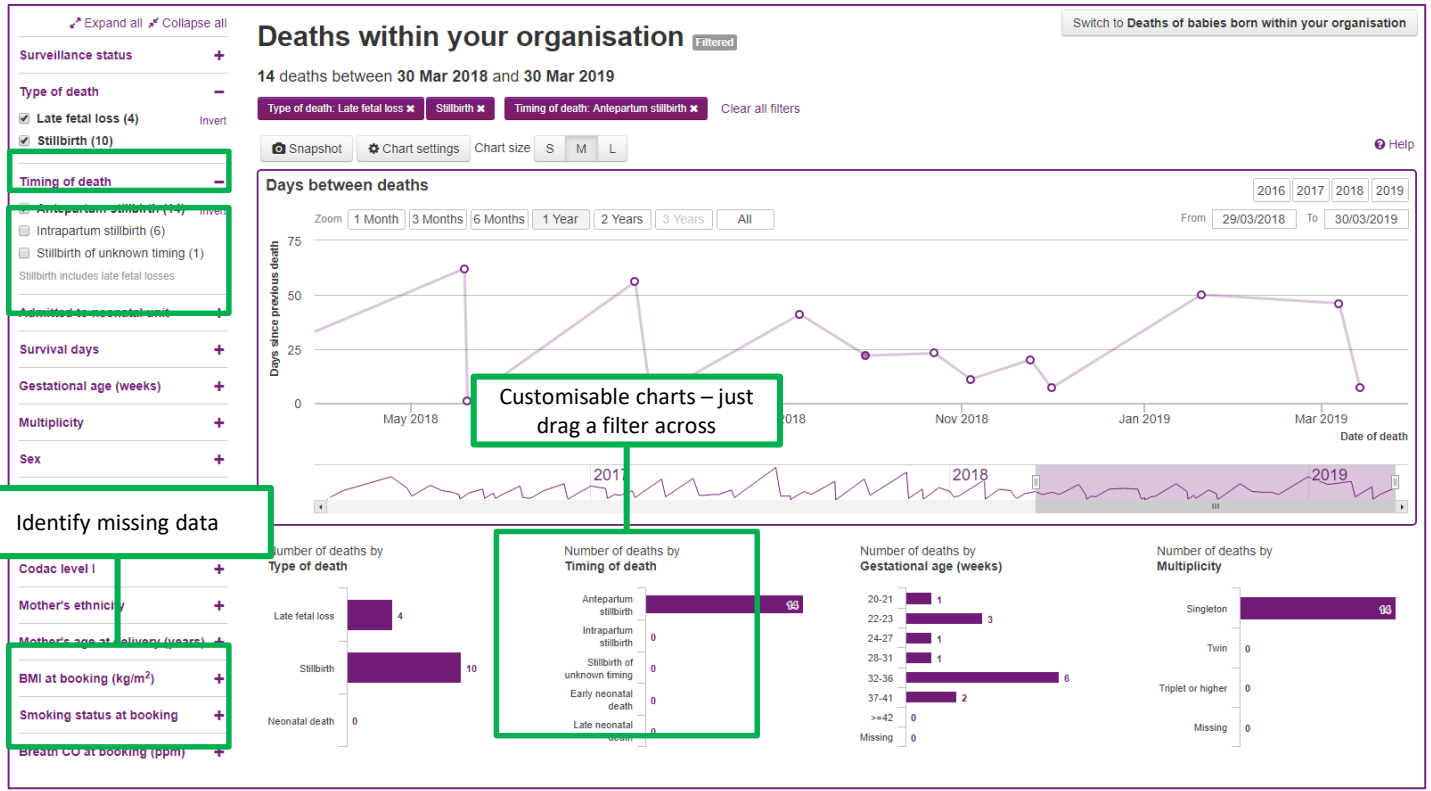
Detailed information available for each death



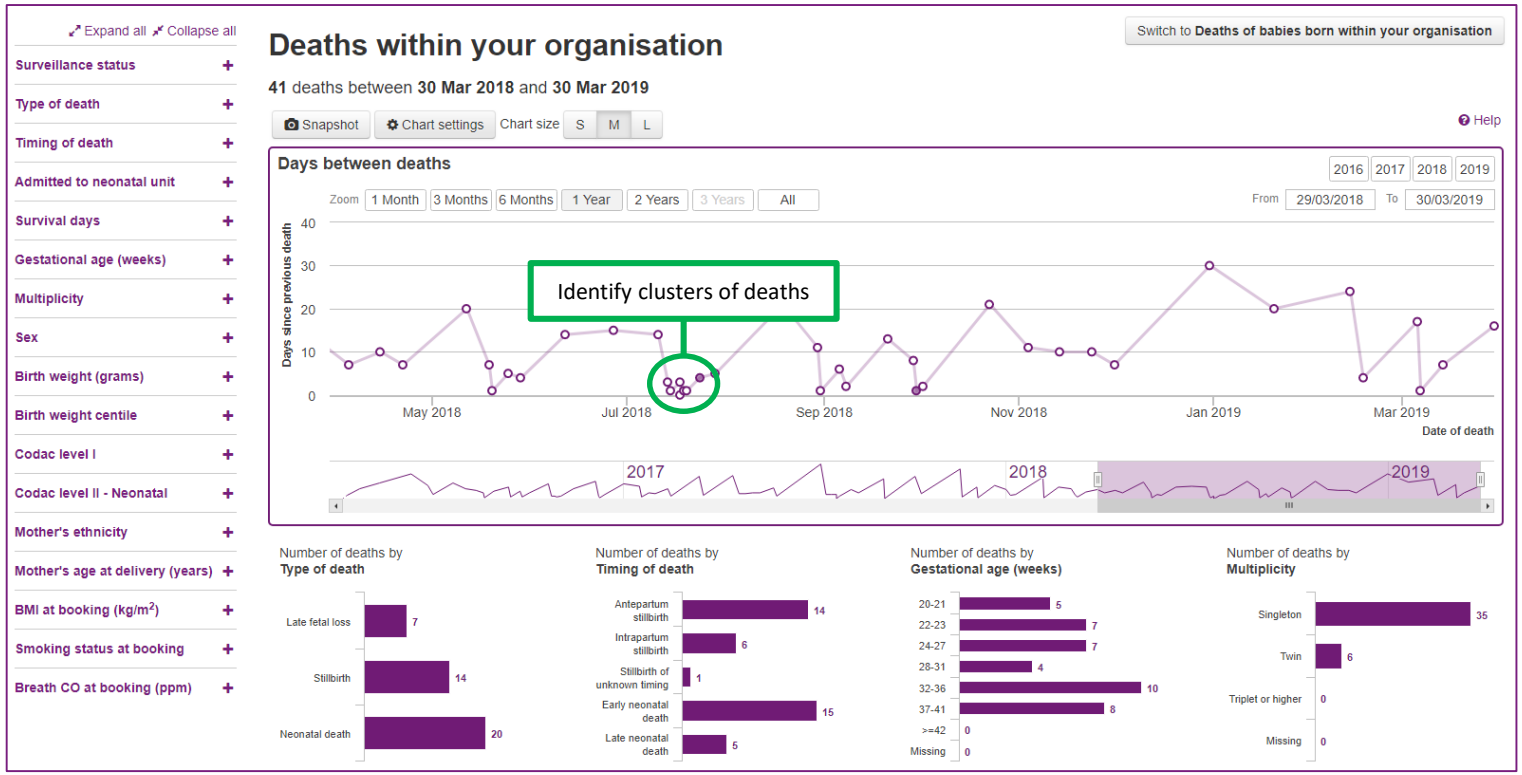
Ability to make comparisons, e.g. between time periods



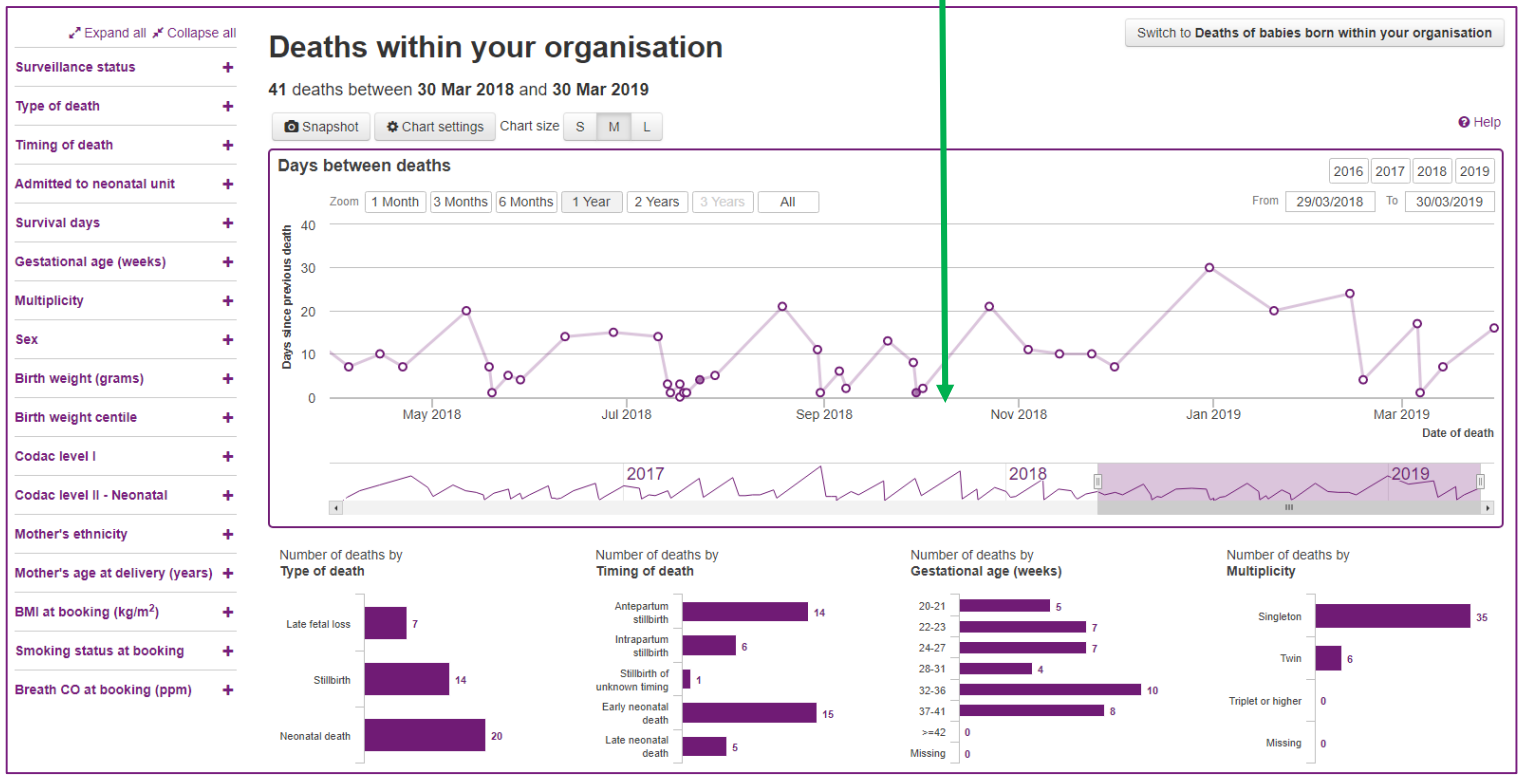
Filters allows focus on specific types of death e.g. antepartum stillbirth



Identify clusters of deaths – enable investigation



Monitor the impact of quality improvement activities



Summary

1. Summary reports from PMRT reviews are available for baby deaths across a period of time as well as the reports from individual baby death reviews
2. Summary reports include the issues identified in the reviews which can be used to prioritise QI activities for both issues of direct relevance to individual deaths and of care in general which needs to be improved
3. We recommend developing action plans which are ‘SMART’ and ‘strong’ focusing on system level activities rather than the actions of individuals
4. The real time data monitoring tool can be used to examine the patterns of deaths occurring in your health board, identify clusters of deaths and assess the impact of quality improvement activities – to be of value this requires PROMPT NOTIFICATION OF DEATHS – benchmark is now 7 days.

Resources

Materials to support parent engagement in reviews:

Available: https://www.npeu.ox.ac.uk/pmrt/parent-engagement-materials

Sands podcast outlining the value of parent engagement in the perinatal review process: https://www.youtube.com/watch?v=Nq4eFQYOqCA

Dissemination and engagement events

MBRRACE-UK Perinatal virtual conference 2021

Virtual conference

Presenting the MBRRACE-UK Perinatal Report 2021

Wednesday 13th October 2021

We are pleased to be able to let you know that bookings are now open!

Visit the event booking site to book your place now!

At this virtual conference we will present:

- The National Perinatal Mortality Surveillance for Births in 2019
- Further insights into inequalities in perinatal mortality
- The National Perinatal Mortality Review Tool Third Annual Report
- PMRT parent engagement resources
- Findings from the Sands survey of parents' experiences of review
- Assessing signs of life in births before 24 weeks gestation – a clinical guide
- Findings from the study of neonatal COVID-19 in the United Kingdom

[MBRRACE-UK Perinatal virtual conference 2021 | NPEU (ox.ac.uk)]

Dissemination and engagement events

MBRRACE-UK 'Saving Lives, Improving Mothers' Care' virtual conference 2021

Virtual conference

Presenting the MBRRACE-UK 'Saving Lives, Improving Mothers' Care' Report 2021

Thursday 11th November 2021

We are pleased to be able to let you know that bookings are now open!

Visit the event booking site to book your place now!

At this virtual conference we will present the findings of the 8th MBRRACE-UK report of Saving Lives, Improving Mothers' Care: findings of the surveillance of maternal mortality in the UK 2017-19 and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Death and Morbidity 2017-2019.

The causes of maternal deaths covered in this report are deaths from:

- Psychiatric causes
- Thrombosis and thromboembolism
- Malignancy
- Homicides

MBRRACE-UK Perinatal virtual conference 2021 | NPEU (ox.ac.uk)

Acknowledgements

Funders

PMRT is commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of:

- Department of Health and Social Care (England)
- NHS Wales
- Health and Social Care Division of the Scottish Government

MBRRACE-UK/PMRT collaboration

MBRRACE-UK
Jenny Kurinczuk
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David Field
Marian Knight
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Peter Brocklehurst
Sara Kenyon
Bradley Manktelow
Janet Scott
Lucy Smith
Peter Smith
Derek Tuffnell
Sarah Prince (RCOG/PMRT Fellow)

Each Baby Counts, RCO
Hannah Knight
Alan Cameron
Zarko Alfirevic
Marian Knight

British Association of Peri
Medicine
Karen Luyt

PARENTS study team
Dimitrios Siassakos
Claire Storey
Alex Heazell

Royal College of Midwives
Zeenath Uddin

Chair of the DH/Sands group
Scotland
Tracey Johnston

Being Open
Edile Murdoch

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- Katy Evans
- Meg Evans
- David Field
- Charlotte Gibson
- Alex Heazell
- Tracey Johnston
- Sara Kenyon
- Jenny Kurinczuk
- Liz Langham
- Karen Luty
- Kirsteen Mackay
- Helen McElroy
- Brian Magowan
- David Millar
- Edile Murdoch
- Miguel Neves
- Santosh Pattnayak
- Sarah Prince
- Coralie Rogers
- Dimitrios Siassakos
- Peter Smith
- Claire Storey
- Melanie Sutcliffe
- Suzanne Sweeney
- Gail Thomas
- Derek Tuffnell
- Jonathan Wyllie

Q&A with Prof Jenny Kurinczuk

Maternity and Neonatal (Perinatal) Adverse Event Review Process for Scotland

Dr Corinne Love

Senior Medical Officer

Scottish Government

Dr Edile Murdoch

Consultant Neonatologist

Clinical Director, Women and Children's

NHS Lothian

The Scottish Government
Riaghaltas na h-Alba

Maternity and Neonatal (Perinatal) Adverse Event Review Process for Scotland

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Presentation outline

- Why have a perinatal adverse event guidance
- Document journey
- Key challenges
- Implementation

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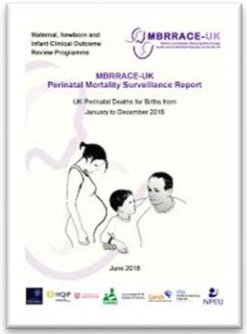
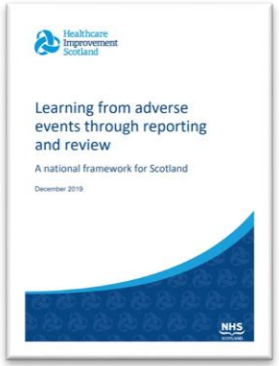
Why do we need perinatal adverse event guidance?

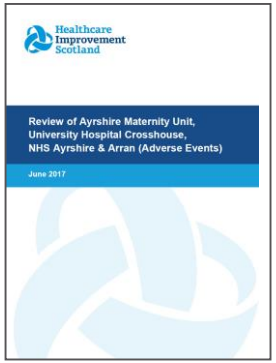
- National Framework (HIS)
- Recognise the need to do this well
- Maternity specific national reports support a process
- Variations in how reviews are carried out and how families/staff involved
- Lack of confidence in process
- No regional/national learning

British Association of Perinatal Medicine

PMRT
Supporting high quality local perinatal reviews



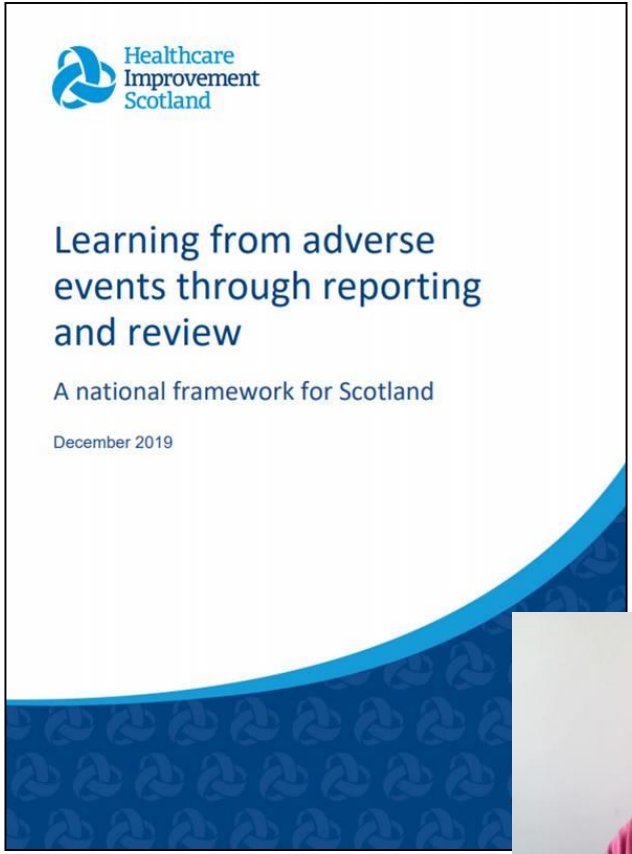




Why do we need perinatal adverse event guidance?

- HIS Framework is generic – not specialty specific
- Everyone knows what they should do
- Don't always know how to do it well
- Aim to pull together all best practice and provide specialty specific guidance

Don Berwick
'*The best way to reduce harm …..is to embrace wholeheartedly a culture of learning.'*



Document journey

2016
Scottish Stillbirth Group

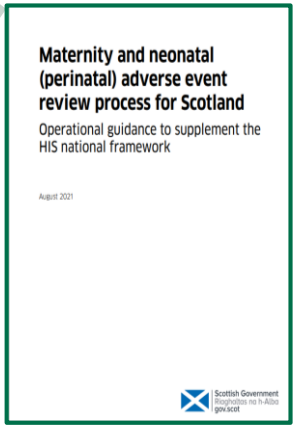
2017
The Best Start

2017-2019
HIS Being Open Pilot
PMRT launch
A&A Pilot
NES/ HIS/ Crown Office

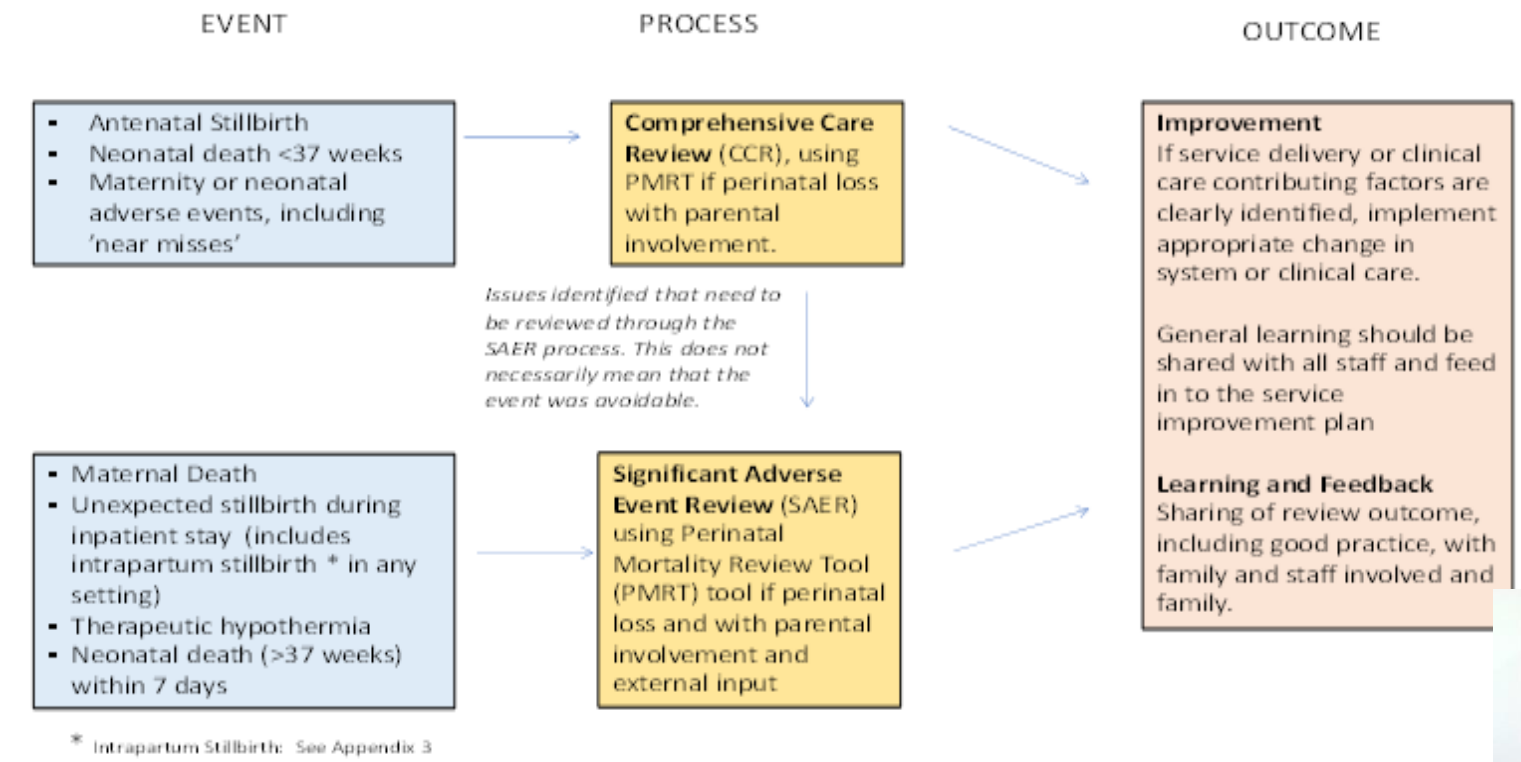
2020-21
COVID

HIS/NES/PNN
Crown Office
Stillbirth Group
SAMD/ SEND/ CD's/ HOM's
Best Start Programme Board
Scottish Government Ministers

September 2021



Event, review, improvement



Key challenges

- **Delivering the review**
  - Descriptors for adverse event and type of review
  - Organisation of panels and external input
  - Training
  - Sharing learning

- **Involving families and staff**

Category of event and level of review

Category of adverse events	Level of Review	Review Team
1	Significant Adverse Event Review (SAER)	Full review team
2	Comprehensive care review (CCR) or local management team review	Service manager with multidisciplinary team input.
3	Local Review	Managers/staff locally

External input and governance

	SAER	Perinatal mortality review (PMRT)*	Comprehensive Care Review (local management review)	Local Review
	Category 1	Category 1 or 2	Category 2	Category 3
External	✓	✓	1-2x yr	x
Governance (including report sign off)	Health Board Governance Structure		Perinatal services management/ clinical governance structures	Perinatal services management/ clinical governance structures

Category of event and level of review

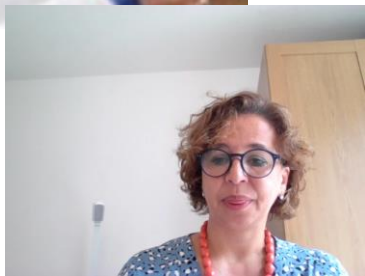
- Antenatal Stillbirth. This is a category 2 event and will need a CCR/LMT level of review using the PMRT with reporting to maternity CMT for closure.

- Large PPH. This is a category 2 event and will need a CCR/LMT level of review with reporting to maternity CMT for closure.

- An intrapartum stillbirth. This is a category 1 event and will need an SAER level of review with reporting to the HB for closure.

Key challenges

- Involving families
  - *How to talk to families*
  - *How to explain the review*
  - *How to involve families in the review*
  - *Key contact*
  - *How do you feedback to families*



Involving families

Steps	Goal
1, 2	*Helps the family manage and deal with distress from the event by reducing uncertainty, providing continuity, being open and honest and providing an apology*
3. Allocate a key contact for the family	
4. Discuss the review process with the family and how they can be involved	
5. Ongoing involvement of family with review process	
6. Sharing review findings	

Next steps

- **Supporting Health Board partnerships**
  - Joint panel reviews and process coordination
- **Supporting community practice**
  - Sharing process improvements
  - Training in review process
  - Training in communication with families

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EC4H EFFECTIVE COMMUNICATION FOR HEALTHCARE

NHS Education for Scotland

Next steps

- Launch September 2021
- Feedback from maternity and neonatal services and families to inform implementation
- Working with Perinatal Network to support implementation and learning
- Learning event November 2021

Q&A with Dr Corinne Love & Dr Edile Murdoch

Next steps

Upcoming confirmed Webinars:

- MCQIC Neonatal Care, *topic TBC*, 2nd November 2021
- Essentials of Safe Care, 17th November 2021
- MCQIC Maternity Care, *topic TBC*, 14th December 2021

17 September 2021 World Patient Safety Day

Look out for tweets from @mcqicspsp

9-15 October Baby Loss Awareness Week

Keep in touch

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@mcqicspsp

To find out more visit ihub.scot

“We hope you enjoyed today’s webinar.

Thank you for finding time to attend.”