

Moving towards standardised perinatal mortality review

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High-quality review was identified as the 'key to improving care' in Sands' 2012 report: *Preventing babies' deaths: what needs to be done*. Importantly, the aim is not simply to gather data, but to undertake a meaningful review from which problem areas can be identified and changes to practice made. Good review is essential to inform parents fully about the circumstances of their baby's death, and should provide an opportunity to capture the parents' perspective of their care.

Recent national reports calling for a standardised perinatal mortality review process, include: the MBRRACE-UK 2013 Perinatal Mortality Surveillance report; the Kirkup Report of the Morecambe Bay Enquiry (2015); and the National Maternity Review (2016).

The Perinatal Mortality Review Task and Finish Group was convened by Sands and the Department of Health (DH), England, in 2012. Chaired by Dr Tracey Johnston and with representation from a range of organisations (Box 1), and observers from the devolved governments, the Group met throughout 2013 to develop a robust framework of questions to support local multidisciplinary team (MDT) reviews when a baby dies perinatally. A call was made through BMFMS for existing review pro formas: 12 examples were received, collated and benchmarked against the Standardised Clinical Outcome Review (SCOR) framework and the MBRRACE-UK Perinatal Death data set. The principles of review identified by the Group are shown in Box 2, and draw on the essential elements described by Flenady et al.¹

The Group reached consensus on the finalised framework, designed to guide the MDT through a comprehensive, effective and focused review covering:

- ▶ Demographic information
- ▶ Intrapartum care
- ▶ Neonatal care
- ▶ Postnatal/follow-up care
- ▶ Professional issues.

It was envisaged that the core data set would be developed as a web tool for ease of use, would include a taxonomy and grading of care and would generate an action plan for improvements to care. The data set was submitted to the DH in March 2014 and funding for a standardised web tool was announced in November 2015.

Reference
1. Flenady V et al. Stillbirths: the way forward in high-income countries. *Lancet* 2011;377:1703–17.

Box 1

Organisations represented on the Perinatal Mortality Review Task and Finish Group

- ▶ Royal College of Gynaecologists and Obstetricians (RCOG)
- ▶ Royal College of Midwives (RCM)
- ▶ British Maternal and Fetal Medicine Society (BMFMS)
- ▶ British Association of Perinatal Medicine (BAPM)
- ▶ Healthcare Quality Improvement Partnership (HQIP)
- ▶ NHS Litigation Authority (NHSLA)
- ▶ Perinatal Institute (PI)

Box 2

Essential elements of Perinatal Mortality Review

1. There should be comprehensive and robust review of all perinatal losses from 22+0 days gestation until 28 days after birth, excluding termination of pregnancy and those with a birth weight <500g (but organisations should aspire to include these also)
2. Such review should be conducted using a standardised nationally accepted tool, ideally web-based, that includes a system for grading quality of care linked to outcomes
3. A multidisciplinary group should review each case at a meeting where time is set aside for doing the work
4. There should be scope for parental input into the process from the beginning
5. The outcome of individual reviews should be shared with the parents/families in a timely and sensitive manner
6. There should be a quality control/review process with both internal and external peer review of cases
7. Action plans generated by such reviews must be implemented and monitored
8. There should be biannual reporting to the relevant Trust committee, with evidence of organisational learning
9. These reports should feed up regionally, potentially to the NHS CB Senates, and nationally, potentially to the national Oversight Group, to allow benchmarking and publication of results, to ensure national learning

Supporting anyone affected by the death of a baby, working to improve bereavement care and promoting research to reduce the loss of babies' lives