www.npeu.ox.ac.uk/pmrt/faqsmis

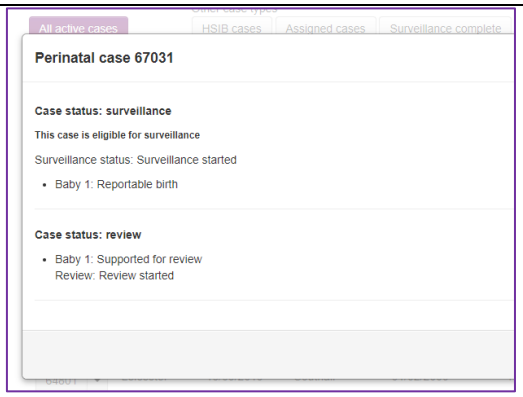
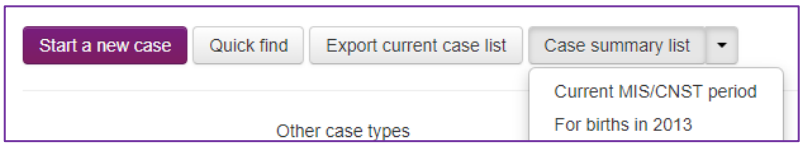
Safety Action 1 of the Maternity Incentive Scheme for England,

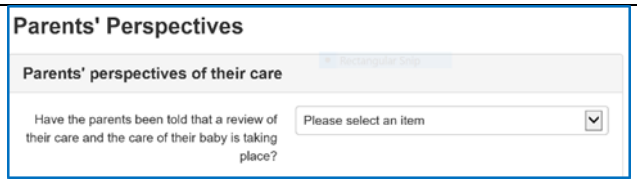
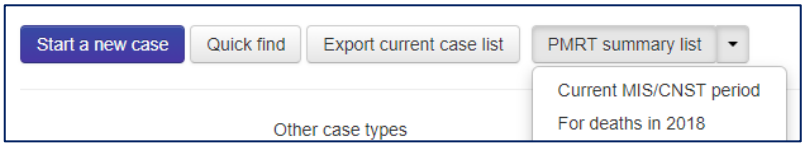
FAQs

These FAQs are designed to supplement the technical guidance provided by NHS Resolution to support Staff in Trusts in England involved in ensuring that their Trust meets Safety Action 1 of the NHS Resolution Maternity Incentive Scheme (MIS): Maternity incentive scheme - NHS Resolution

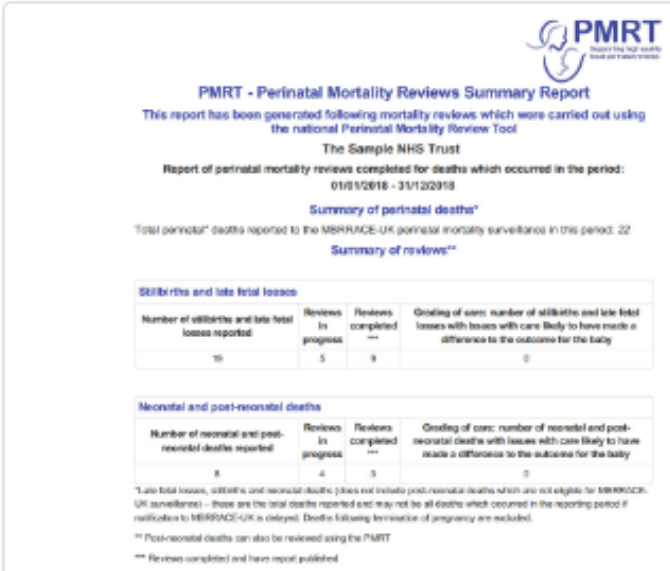
Safety action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?

Technical issues and updates	
What should we do if we experience technical issues with using PMRT?	All Trust staff are reminded to contact their IT department regarding any technical issue in the first instance. If this cannot be resolved, then the issue should be escalated to MBRRACE-UK. This can be done through the 'contact us' facility within the MBRRACE-UK/PMRT system or by emailing us at: mbrrace.support@npeu.ox.ac.uk
If there are any updates on PMRT for the maternity incentive scheme where will they be published?	Any updates to the PMRT or the MBRRACE-UK notification and surveillance in relation to the MIS Safety Action 1, will be communicated via NHS Resolution email and will also be included in the PMRT 'message of the day'.
Change to the verification period for SA1	
What is the period for verification for SA1 and has this changed?	With the start of the year 6 MIS the standards for SA1 will run from the end of year 5 (8th December 2023) for a year. Going forward SA1 will continue on an annual on-going basis.
Guidance for SA 1(a) – notify all deaths	
Which perinatal deaths must be notified to MBRRACE-UK?	Details of which perinatal death must be notified to MBRRACE-UK are available at: https://www.npeu.ox.ac.uk/mbrrace-uk/data-collection
What is the time limit for notifying a perinatal death to MBRRACE-UK?	All perinatal deaths eligible to be reported to MBRRACE-UK must be notified to MBRRACE-UK within seven working days. When a notification is complete the notification status on the MBRRACE-UK on-line system will show whether surveillance (and review) is required for each case. This is available from the case management screen by clicking on the Case ID and selecting 'Notification Status'.

	
What is the time limit for completing the surveillance information for MBRRACE-UK?	Following notification within seven working days of the perinatal death, there is no MIS reporting requirement that the surveillance information is completed within a fixed time period, although this was a previous requirement of the MIS. However, as information is transferred from the surveillance form into the PMRT (but not vice versa) it is beneficial for the surveillance form to be completed as soon as possible and we recommend that the surveillance information is completed within one month of the death. If post-mortem results or results of other investigations are not available and the final cause of death is not confirmed, indicate this in the "Cause of Death/Confirmation of cause of death" section, complete the rest of the information, and close the surveillance form. Once the additional information and the final cause of death is known and confirmed as part of the PMRT review discussion, the surveillance reporter should re-open the form, update the relevant sections and close it again. You can reopen the surveillance form from the case management screen.
How can we keep a check on which of our deaths require surveillance?	There is a report under 'Case summary list' on the MBRRACE-UK case management screen entitled 'Current MIS/CNST period'.  This includes ALL deaths in your Trust which have been notified to MBRRACE-UK and shows the status of the surveillance if required. This will also indicate if surveillance is required and not started/completed.
Guidance for SA1(b) – parent engagement	
We have informed parents that a local review will take place and they have been asked if they have any feedback or questions about their care. However, this	In order that parents' feedback and any questions they have can be responded to this information needs to be incorporated as part of the review and entered into the PMRT. If this information is held in another data system it needs to be brought to the review meeting, included in the PMRT and considered as part of the review discussion. The importance of parents' feedback and questions is highlighted by their inclusion as the first set of questions in the PMRT.

information is recorded in another data system and not the clinical records. What should we do?	 Materials to support parent engagement in the local review process are available on the PMRT website at: https://www.npeu.ox.ac.uk/pmrt/parent-engagement-materials
Guidance for SA1(c) – Review the death and complete the review	
Which perinatal deaths must be reviewed to meet safety action one standards?	The following deaths should be reviewed to meet SA1 standards: •Late miscarriages/ late fetal losses (22+0 to 23+6 weeks' gestation) •Stillbirths (from 24+0 weeks' gestation) •Neonatal death (up to 28 days after birth) While it is possible to use the PMRT to review post neonatal deaths (from 29 days after births) this is NOT a requirement to meet SA1.
How can we keep a check on which of our deaths are suitable for review using the PMRT and their review status?	Within the PMRT, users can generate a report for their Trust by going to: **Manage cases > PMRT summary list > Current MIS/CNST period**  This is a list of ALL deaths notified by the Trust, **at the point when the report is generated. It includes all deaths** that are suitable for review using the PMRT **as well as those** which are not (for example, terminations of pregnancy).
Review assignment	A feature available in the PMRT is the ability to assign reviews to another Trust for review of elements of the care, if some of the care for the woman and/or her baby was provided in another Trust. For example, if the baby died in your Trust but antenatal care was provided in another Trust, you can assign the review to the other Trust so that they can review the care that they provided. Following their review the other Trust can reassign the review back to your Trust. You can then review the subsequent care your Trust provided. Note that any issues with care identified are 'owned' by the Trust that identified them, as are the related action plans, but a single report from the combined review is generated. This ensures that when the report is discussed with the parents all aspects of the care they received can be covered; this should avoid potentially contradictory findings being conveyed and inappropriate advice being given regarding their next pregnancy.
Guidance for SA1(d) – quarterly reports to Trust Board/Trust Executive	
Can the PMRT help by providing a quarterly report that can be	Authorised PMRT users can generate reports for their Trust, summarising the results from completed reviews of deaths which occurred during user-defined time periods. These are available from:

presented to the Trust Board?	**Your Data > Perinatal Mortality Reviews Summary Report and Data extracts** See the screenshot below; click on the 'Generate a summary report' button. These reports can be used as the basis for the quarterly Trust Board reports and should be discussed with the Trust maternity safety champion. Please note that these reports will only show summaries, issues and action plans for reviews of deaths which **occurred during that time period** and that have been **completed and published**. Therefore the time period selected may need to relate to an earlier period than the current quarter and may lag behind the current quarter by up to six months



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 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 fetal 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

You can now produce a report which provides a summary of reviews completed using the PMRT.
This report can be generated for specific date ranges which you are able to define, and will include information about all perinatal deaths during that period where a review has been completed and the review report published.
Included in the report is a summary of:

- The deaths reviewed by gestational age and type of death
- The grading of care by gestational age and type of death
- The causes of death entered in the review of babies in this period
- The issues raised by reviews in this period
- The number of staff involved in reviews, and their specialities (from June 2018)
- The top contributory factors identified as relevant to the deaths reviewed

The report is produced from the information entered by your Trust/Health Board into the PMRT during the review of each death. This means some parts of the report may be more useful if more detail is provided in the PMRT when each death is reviewed.

Generate a Summary Report