Learning from Standardised Reviews When Babies Die

PMRT
Supporting high quality local perinatal reviews

Second Annual Report

Executive Summary – December 2020

Background

In 2012 the need to improve the quality of reviews of every perinatal death was identified and a Department of Health/Sands Task and Finish Group was convened leading to the concept of a national perinatal mortality review tool.

Commissioned in 2016, the national Perinatal Mortality Review Tool (PMRT) places at its core the fundamental aim of supporting objective, robust and standardised review to provide answers for bereaved parents about why their baby died. A secondary, but nonetheless important, aim is to ensure local and national learning to improve care and ultimately prevent future baby deaths.

The national PMRT was developed with clinicians and bereaved parents in 2017 and launched in England, Wales and Scotland in early 2018; it was subsequently adopted in Northern Ireland in autumn 2019. Unlike other review or investigation processes, the PMRT makes it possible to review every baby death, after 22 weeks' gestation, and not just a subset of deaths. For 92% of parents the PMRT process will likely be the only review of their baby's death they will receive.

Further refinement and development of the PMRT continued through 2019 and 2020. Recent developments include mechanisms to produce a single integrated report where care of the mother and/or baby was provided by more than one organisation avoiding multiple reviews and reports which may have contradictory elements and findings.

In addition, the tool was adapted in mid-2020 to enable the impact of SARS-CoV-2 on service delivery to be reflected in reviews. Future changes, currently in development, focus on reducing administrative workload by minimising duplication of data provision to meet other requirements, including direct notification of deaths, provision of review findings and additional data to Child Death Overview Panels and the National Child Mortality Database in England via the PMRT. This new capability for England will be released in 2021.

This second annual report builds on the first annual report and presents an analysis of reviews carried out from March 2019 to February 2020 representing the early stages of embedding the PMRT processes. The findings, from England, Scotland and Wales, in this second period are compared with the findings from the first annual report which covered the implementation phase of the PMRT. It is evident from this comparison that the process of improving the quality of reviews and actions developed, maximising the learning and improving care, continues.

Royal College of Obstetricians & Gynaecologists
each baby COUNTS
University of BRISTOL
THE ROYAL COLLEGE OF MIDWIVES
NHS Birmingham Women's and Children's NHS Foundation Trust
British Association of Perinatal Medicine
MANCHESTER 1824 The University of Manchester
PARENTS
NHS The Newcastle upon Tyne Hospitals NHS Foundation Trust
UNIVERSITY OF BIRMINGHAM
NHS Bradford Teaching Hospitals NHS Foundation Trust
Sands Stillbirth & neonatal death charity
HQIP Healthcare Quality Improvement Partnership
UNIVERSITY OF LEICESTER
TIMMS
UCL
NPEU
UNIVERSITY OF OXFORD

Since the PMRT was only adopted in Northern Ireland in autumn 2019, relatively few reviews were conducted in Northern Ireland during the period of analysis reported here, furthermore this was the implementation phase for Northern Ireland and thus it is not appropriate to make comparisons with the data from the other three nations who are in the embedding phase of PMRT use.

It remains the case that the PMRT is only a tool, and will therefore, only be as good as the information that is put into it and the way it is used. If it is to achieve the original vision set out by the Task and Finish Group in 2012, it is up to Trusts and Health Boards to improve the way it is supported and implemented.

Findings

This report presents data from the 3,693 reviews which were completed between March 2019 and February 2020 and thus follows on from the first annual report.

Since it was launched all Trusts and Health Boards across England, Wales, Scotland and Northern Ireland have engaged with the PMRT and by 30th November 2020 over 11,000 reviews had been started or completed using the tool. This represents reviews of the care started for an estimated 83% of all babies who died in the perinatal period comprising 86% of stillborn babies and those who were miscarried in the late second trimester, and 78% of babies who died in the neonatal period.

Multidisciplinary review

The review process should be multidisciplinary to reflect the professionals caring for mothers, babies and their families, and recommendations regarding the constitution of PMRT review groups have been provided. However, the majority of reviews (83%) continue to be carried out by groups which do not include the minimum recommended number of staff fulfilling appropriate roles. In addition about one in five of the reviews were reported as being carried out by only one or two individuals. This does not constitute a robust multidisciplinary review process and furthermore is not an improvement from the early PMRT implementation period. It is important that the number and role of staff involved in a review is recorded accurately, not least to demonstrate the engagement of staff in this key aspect of care and learning. It also ensures the quantification of the person-time resource required to conduct high quality reviews so that this activity is prioritised.

The involvement of a relevant professional external to the Trust or Health Board as part of the PMRT review team is also recommended. In this period 19% of reviews, compared with 9% previously involved an external member. Whilst this represents an improvement the vast majority of reviews still did not involve someone, as recommended by the Kirkup inquiry1, who can provide a ‘fresh eyes’ independent perspective to the review of care which was provided; this needs to be addressed moving forward.

Review of care when a baby dies should be universally regarded as part of routine maternity and neonatal care and should be resourced appropriately. This means including time to participate in reviews in job plans for consultants and prioritising the time required by other staff to participate in reviews; this is a particular issue for those acting as external members of review teams in other Trusts/Health Boards. Resourcing is also required for supporting parents through the PMRT process and for the vital administrative support needed to reduce the burden of tasks for other staff. Whilst the proportion of reviews with administrative support increased from 11% in the previous report to 18%, four in five reviews nevertheless appear to lack this type of support.

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1 Kirkup B. The Report of the Morecambe Bay Investigation. London: The Stationery Office. 2015.

On a more positive note an increasing proportion of reviews were conducted by review groups which included a member of the local governance/risk management team (92%) and/or a service manager (40%). This would suggest that the PMRT is more embedded in the local governance processes and there is a greater likelihood of the action plans developed in the review being translated into service improvements.

Parent engagement

It was reported that overall parents had been told in 84% of instances that a review of their care and that of their baby would be carried out. This represents an improvement from 75% in the previous report and is a considerable improvement in parent awareness of reviews compared with earlier MBRRACE-UK Confidential Enquiries and the Each Baby Counts programme. Whilst not all bereaved parents will wish to engage with the review process beyond knowing that it is taking place and being given the results, it is nevertheless surprising that not all parents in this period, for whom a review was conducted, were told that a review would take place.

Fewer than a quarter of parents were reported to have indicated that they had no questions or concerns about their care they wanted the review to address, this was nearly double the proportion in the first period. The PMRT 'Parent Engagement' materials released halfway through this second period clearly had limited impact. It is acknowledged that engaging parents in a meaningful way requires additional resources, but the PARENTS study has shown that more meaningful the engagement the more likely that important lessons for care will be identified in the review.

Issues with care identified

Over 90% of reviews identified at least one issue with care, with an average of four issues per death reviewed. This was unchanged from the findings in the first annual report.

Issues with care relevant to the outcome affected many aspects of care throughout the maternity and neonatal pathway. However, the reviews highlighted particular issues with antenatal care concerning inadequate growth surveillance; delays in diagnosis or inappropriate management of significant medical/surgical/social problems during pregnancy; inadequate investigation or management of reduced fetal movements; inadequate smoking prevention and access to smoking cessation services; and late pregnancy booking or unbooked pregnancies. Of note, fetal growth surveillance, management of reduced fetal movement and smoking prevention were evident as particular issues in the first annual report and are addressed by the second version of the NHS England Saving Babies' Lives Care Bundle.

Issues concerning monitoring of both mother and baby during labour, birth and shortly after birth were highlighted in this and the previous report. Staffing issues related to care in labour and birth were more prominent in this second annual report. During neonatal care a need to improve documentation, particularly in relation to resuscitation of the baby, was once again highlighted, as was a requirement to optimise thermal management at all stages of neonatal care. In addition issues with respiratory management during resuscitation were newly identified in this reporting period.

Overall grading of care

Review groups are asked to provide a holistic grading of the care provided at each stage of the care pathway at the end of each review. For 57% of stillbirths and late miscarriage the grading indicated that there were no issues with care during pregnancy, labour and birth that would have affected the outcome for the baby. For a further 27% issues were identified which would have had no effect on the outcome and in only 16% of reviews were issues identified that may or would have made a difference to the outcome. The respective proportions for neonatal deaths including neonatal care were 47%, 40% and 12%. These figures represent a very modest shift from the first annual report.

This suggests that despite identifying some issues with care during the review process, in the vast majority of instances the multidisciplinary review teams have concluded that the majority of deaths occurred despite care that was deemed appropriate. These figures contrast with those from the recent perinatal confidential enquiries and the Each Baby Counts programme and it seems unlikely that the difference is entirely due to the fact the enquiries and Each Baby Counts have focused solely on term, normally formed babies whose deaths would be anticipated as avoidable. It is still early days in terms of embedding the PMRT; it remains to be seen whether there is a further shift in grading in future reports as the local review groups better fulfil the PMRT recommended criteria of being truly multidisciplinary, involving an external reviewer, engaging parents meaningfully in a way that invites probing questions, and undertaking increasingly robust self-examination.

Contributory factors

The majority of factors contributing to the issues identified related to a failure to follow or an absence of guidelines, policies and procedures; also identified were the clinical condition of the mother and/or baby, communication problems and organisational structures. Communication issues in particular predominated in all categories of contributory factors for all aspects of neonatal care from resuscitation through to end of life care.

Action plans

Across the 3,693 reviews a total of 14,325 issues were identified and a total of 8,146 contributory factors requiring action were identified and incorporated into action plans. Findings from a sample of action plans indicated that the majority of action plans were SMART[2]. The most frequent problem when action plans were not SMART was that the actions were not measurable. However, despite being largely SMART only 5% of the actions planned were 'strong' [3], although a greater proportion compared with the last annual report were of 'intermediate' strength. There remains a central focus on modifying the actions of individuals through training and communications to staff rather than introducing systems and processes focused on 'strong' changes with 'forcing' features which remove a reliance on individuals to choose the correct action, and places emphasis on system-wide improvement.

Conclusions

This report enables comparison between the findings from the first annual report during the PMRT implementation phase to this second report during the early part of the embedding phase. The PMRT is now being used to review the majority of perinatal deaths in England, Wales, Scotland and Northern Ireland.

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[2] SMART – Specific, Measureable, Achievable, Realistic, Time-bound.

[3] The strength of an action describes how well the action would eliminate human error. Strong actions are system changes which remove the reliance on individuals to choose the correct action. They use standardisation and permanent physical or digital designs to eliminate human error and are sometime referred to as 'forcing' actions [1].

Bereaved parents have the greatest stake in the findings of the review and their needs should be at the centre of the review. We anticipate that appropriately resourced implementation of the PMRT pathway for parent engagement and supporting resource materials, embedded within the PMRT, will increase meaningful parental involvement, as well as improve the overall quality of reviews.

There have been improvements in the constitution of multidisciplinary review groups nevertheless a substantial proportion of death are still reviewed by only one or two individuals which does not constitute a robust review process. Administrative support is lacking in the main and the involvement of an independent external member to provide a 'fresh eyes' perspective is limited. Review of care when a baby dies should be universally regarded as part of routine maternity and neonatal care and should be resourced appropriately.

There have only been modest shifts in the holistic grading of care suggesting that the discipline of robust self-examination is still in the early stages of development in many units. The involvement of a greater proportions of members of the governance/risk teams and service managers in the process of review is a more positive development as it is likely to increases the chances that the action plans developed by the review group will be translated into practice. Local summary review reports and this national report can form the basis of prioritisation of investment in service improvement activities. The strength of action plans developed remains of concern with a continued focus on relatively weak actions rather than strong, system level actions designed to reduce human error.

Recommendations

1. Improve the engagement of parents in reviews by standardising and resourcing local processes to ensure all bereaved parents are told a review will take place and have ample opportunities at different stages to discuss their views, ask questions and express any concerns as well as positive feedback they have about the care they received.
   Action: Trusts and Health Boards, staff caring for bereaved parents
2. Provide adequate resourcing of multidisciplinary PMRT review teams, including administrative support.
   Action: Trusts and Health Boards, Service Commissioners
3. Improve the process of PMRT review by involving sufficient members of multidisciplinary internal staff and an external member as part of the PMRT review team.
   Action: Trusts and Health Boards, regional support systems and organisations e.g. Local Maternity Systems in England, Service Commissioners
4. Improve the quality of service improvements as a consequence of reviews by developing 'strong' actions targeted at system level changes and audit their implementation and impact.
   Action: PMRT review teams, governance teams in Trusts and Health Boards, Service Commissioners
5. Use the local PMRT summary reports and this national report as the basis to prioritise resources towards key aspects of care identified as requiring action.
   Action: Trusts and Health Boards, Service Commissioners, regional support systems, e.g. Local Mater nity Systems in England, Governments and national service organisations
6. Conduct research into new interventions that may be required to address issues with care identified in the PMRT report.
   Action: Research funding organisations and researchers

Full report

The full report is available to download at: *https://www.npeu.ox.ac.uk/pmrt/reports*

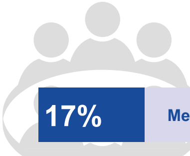
Learning from Standardised Reviews
When Babies Die – 2019 Annual Report

Key Messages – December 2020

PMRT
Supporting high quality
local perinatal reviews

Since the launch of the Perinatal Mortality Review Tool (PMRT) in early 2018 over 11,000 reviews have been started. Following implementation in 2018, this annual report presents the findings from reviews completed during the embedding phase from March 2019 to February 2020. Here are the key messages from the 3,693 reviews carried in this period.

Multi-disciplinary group review is essential



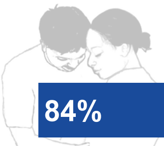
- **17%** Met recommended minimum review group composition
- **19%** Only 1 or 2 individuals carried out the review
- **29%** Neonatologist/neonatal nurse not present for neonatal death reviews
- **18%** Had administrative support
- **92%** Risk manager/governance team member present

Issues with care and areas for improvement identified

19/20 reviews identified areas for improvement

3/20 issues identified may have made a difference to the outcome

Parent engagement improves the quality of review

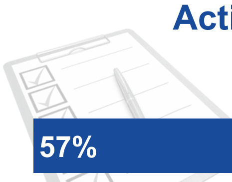


- **84%** Told about the review
- **84%** Parent's perspective sought
- **78%** No concerns with care raised
- **9%** Received good care
- **13%** Questions and concerns raised

Comments, questions and concerns raised by parents

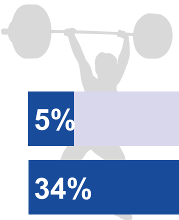
Left alone in labour
Technical aspects of care e.g. scans
Poor communication
Management plans & care received
Didn't feel listened to
Felt unsupported

Action plans need to be SMART



- **57%** Specific
- **9%** Measureable
- **97%** Achievable
- **87%** Realistic
- **31%** Timebound

Action plans need to be strong*



- **5%** Strong
- **34%** Intermediate
- **61%** Weak
- **0%** Nil

*Strong actions are system changes which remove the reliance on individuals to choose the correct action. They use standardisation and permanent physical or digital designs to eliminate human error and are sometimes referred to as 'forcing actions'.