Perinatal Mortality Review Board:
A robust system for reduction of avoidable perinatal deaths

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Background

- Annual Delivery rate between 5400-6000 births
- MBBRACE Report
- Extended perinatal mortality rate (per 1000 births):
- 2013 – 6.49, 2014 – 6.96, 2015- 6.10
- Trust Data – 2016- 5.6
- Perinatal Mortality Rate consistently higher than national average (more than or upto10% above group average)

Trust Board recommendation

- SWBH Maternal and Perinatal Quality Plan
- Vision for a quantifiable and progressive reduction on avoidable perinatal deaths.
- Financial and board level support for multi-disciplinary panel for systematic review process ensuring wider sharing of learning

Existing Review Process

- Joint monthly perinatal mortality meetings chaired by an obstetric consultant
- Details of cases with adverse outcome presented
- Following discussion grading of the care decided by obstetric and neonatal consultants in the meeting

Formation of multi-disciplinary panel

- Key driver is the national ambition to reduce stillbirths by 20% by 2020 and 50% by 2030
- Review of cases using a standardised, systematic approach, with input from the dedicated team

Multidisciplinary board

- Obstetric consultant, Neonatology consultant,
- Lead midwife for the board,
- Member of the Risk/Governance team,
- Maternity matrons
- Bereavement specialist midwives,
- and Trainee representative

Methodology

- Monthly meeting
- PMRT tool-Cases presented and discussed
- Grading of care- majority of votes
- In absence of consensus- escalated
- Action plan generated and followed within a specific time period by appropriate lead

Sharing of learning points

The learning points are presented in

- Monthly Perinatal Mortality meetings
- Mandatory Midwifery Training day
- Quality Improvement Half Day
- Common themes- Hypertension in pregnancy, Reduced Fetal Movement, Fetal Growth Restriction
- Guidelines updated & Teaching for junior doctors

Improvement of Outcome Measures

	Number of Still birth and neonatal death	CESDI Classification 2 and 3	MBRRACE Classification C and D
Jan-Apr 2017	20	2 cases- CESDI 2 3 cases- CESDI 3	
Jan-Apr 2018	10		2 cases of DA

50% reduction of cases
5% reduction in cases with suboptimal care

Future

- Peer Review has been introduced in June meeting (Risk Midwife from a local unit)
- A patient representative will join the board from July 2018 meeting

This objective review will go a long way to improve perinatal outcome

Sandwell and West Birmingham Hospitals NHS Trust