Learning from Standardised Reviews When Babies Die

First Annual Report

Executive Summary – October 2019

PMRT
Supporting high quality local perinatal reviews

Background

The need to improve the quality of reviews of perinatal deaths was identified in 2012. A Department of Health/ Sands Task and Finish group was convened and the concept of a national perinatal mortality review tool was established. 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 second, but nonetheless important, aim is to ensure local and national learning to improve care and ultimately prevent future deaths.

The national PMRT was developed with clinicians and parents in 2017 and launched in early 2018; further refinement and development continued through 2019 and future developments are planned.

This report presents the findings from the first 1,500 reviews completed during the first year of use of the PMRT and so represents the early stages of implementation of both a formal review process for some Trusts and Health Boards, and the use of a standardised tool for case review for the vast majority. The journey to embed the PMRT, improve the quality of reviews and maximise learning continues.

Findings

Since it was launched all Trusts and Health Boards across England, Wales and Scotland have engaged with the PMRT and by 10th September 2019 over 6,300 reviews had been started or completed using the tool. This represents review of an estimated 88% of all eligible perinatal deaths comprising 90% of stillbirths and late miscarriages, and 83% of neonatal deaths.

Multidisciplinary review

Multidisciplinary review is key to the review process. Recommendations regarding the composition of PMRT review groups were provided by the PMRT team. In this period the majority of reviews were not carried out by review groups consisting of the minimum recommended number of staff fulfilling the appropriate roles. One in five of the reviews were reported as being carried out by only one or two individuals which does not constitute a robust multidisciplinary process.

The involvement of a professional external to the Trust or Health Board as part of the PMRT review team is also recommended to give a ‘fresh eyes’ perspective to the review process. In this period less than 10% of reviews involved an external member, which needs to be addressed moving forward.

Review of the 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. Support for parents also needs to be adequately resourced. Administrative support is also vital to reduce the burden of tasks for other staff, but this support was generally lacking for the first 1,500 reviews with administrative support only recorded for 11% of reviews. It is possible that the numbers and roles of staff present at review group meetings have been under-recorded by PMRT users. It is important that this is recorded accurately, not least to demonstrate the engagement of staff in this important aspect of care, but also to quantify the person resource required to conduct high quality reviews with parent engagement.

Parent engagement

It was reported that overall 84% of parents had been told that a review of their care and that of their baby was being carried out. This represents a considerable improvement in parent awareness of reviews from the findings of earlier MBRRACE-UK Confidential Enquiries and the Each Baby Counts programme.

Less than half of all parents were reported to have indicated that they had any questions or concerns about their care. However, this was prior to the release of the PMRT 'Parent Engagement' materials developed using the findings from the PARENTS study results from the University of Bristol and the 'Being Open' process in Scotland. With better advice and support for health professionals on when and how to engage parents in reviews, now available on the PMRT website, a greater proportion of parents in the future may feel able to ask questions and provide their perspective about their care.

Issues with care identified

Over 90% of reviews identified at least one issue with care, with an average of four issues per death reviewed.

In about 60% of reviews the overall grading of care during pregnancy, labour and birth indicated there were no issues with care that would have affected the outcome for the baby with a similar proportion for the postnatal care for babies born alive who died after birth. In 25% there were issues with care, but they would have made no difference to the outcome for the baby Only a small proportion of reviews indicated, through the grading, that different care may or would have a made a difference to the outcome: 13% in relation to pregnancy care; 10% in relation to care during labour and birth; and 9% in relation to neonatal care. This is a reminder that in the majority of cases death occurred despite care that was deemed appropriate following review. It is still early days in terms of embedding the PMRT; it remains to be seen whether there is a shift in grading in future reports as the local review groups better fulfil the PMRT recommended criteria for being multidisciplinary and/or issues are dealt with so they don't continue to be issues in the future.

Issues with care relevant to the outcome affected many aspects of care throughout the maternity and neonatal pathway. However, the reviews highlighted in particular issues concerning smoking, specifically carbon monoxide monitoring and access to smoking cessation services; inadequate fetal growth surveillance; the management of reduced fetal movements; and the assessment of the need for maternal aspirin during pregnancy. Of note these are addressed by version two 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, as were inadequate documentation, particularly during resuscitation of the baby, and poor thermal management at all stages of neonatal care.

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 priorities.

Action plans

Across the 1,500 reviews a total of 3,010 issues with contributory factors requiring action were identified and incorporated into action plans. The majority of action plans were 'SMART'. The most frequent problem when action plans were not SMART was that the actions were not measurable or time-bound. Moreover, only 10% of the actions planned were 'strong', that is they were 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.

User feedback

Responses to a formal user survey indicate the majority of respondents felt that the PMRT provides a more structured approach to review which has improved communication with parents and enabled them to identify areas of care to be improved with actionable learning points. Furthermore, they indicated that they felt that all these aspects would improve further in the future with increasing familiarity with the tool.

Since the PMRT requires all aspects of the care pathway to be systematically reviewed, users reported that they had identified issues with care that they would not have identified using their previous method of review.

Conclusions

For the first time, a national tool to reduce variation in and improve the quality of reviews conducted when babies die is now available. The reports available from the PMRT system enable comparison of issues with care across individual deaths reviewed within organisations which, together with this national report, provide a basis for prioritisation of resources to support improvements in care likely to have the greatest impact on reducing perinatal deaths.

Designed with parents at its heart, the PMRT also provides for the first time, a systematic means of engaging parents in reviews and ensuring that their perspectives of their care and any questions and concerns they have are considered as part of the review of their care from the outset.

This report presents findings from the early stages of the implementation of the PMRT. With increasing familiarity with the tool and the support of the 'Parent Engagement' materials it seems reasonable to anticipate improvements in all aspects of review, not least the meaningful engagement of parents. This will help ensure that parents' need for as much information as possible about why their baby died will be increasingly met.

Recommendations

1) Improve the recording of the staff involved in PMRT reviews

   Action: PMRT review teams

2) Improve the engagement of parents in reviews making sure they have ample opportunities at different stages after their bereavement to discuss their views, ask questions and express any concerns they have about the care they received

   Action: Staff caring for bereaved parents

3) Provide adequate resourcing of PMRT review teams

   Action: Local Trust and Health Boards, Service Commissioners

4) Involve an external member as part of the PMRT review team

   Action: Local Trust and Health Boards, regional support systems and organisations e.g. Local Maternity Systems in England

5) Improve the quality of the actions planned to ensure that the majority of actions are 'strong'[1] and result in system level changes

   Action: PMRT review teams, local governance teams in Trusts and Health Boards

6) Use the local summary reports and this national report as the basis to prioritise resources towards the aspects of care identified as having issues

   Action: Local Trusts and Health Boards, Service Commissioners, regional support systems, e.g. Local Maternity Systems in England, Governments and national service organisations

7) 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*

1 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].

Learning from Standardised Reviews When Babies Die

Key Messages – October 2019

PMRT
Supporting high quality local perinatal reviews

Since the launch of the PMRT in early 2018 over 6,300 reviews have been started. The annual report presents the findings from the first 1,500 reviews completed during the first year of implementation. Here are some of the key messages from the first 1,500 reviews.

Multi-disciplinary group review is essential

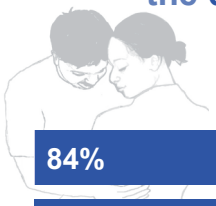
- 16% Recommended minimum review group composition
- 22% Only 1 or 2 individuals
- 41% Neonatologists not present for neonatal death reviews
- 11% Had administrative support

Issues with care and areas for improvement identified

9/10 reviews identified areas for improvement

1/10 issues identified may have made a difference to the outcome

Parent engagement improves the quality of review

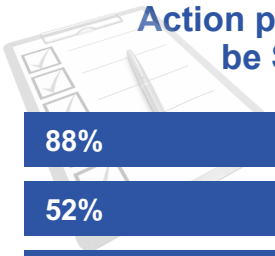


- 84% Told about the review
- 75% Parent perspectives sought
- 55% No concerns with care raised
- 45% Questions and concerns raised

Comments, questions and concerns raised by parents

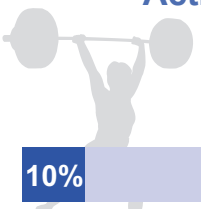
Sense something was wrong
Well supported
Declined further investigations
Labour care
Diagnosis known
The future
Maternal guilt
Why?
Distrust of health system
Culture within unit
Antenatal care

Action plans need to be SMART



- 88% Specific
- 52% Measurable
- 98% Achieveable
- 98% Realistic
- 20% Timebound

Action plans need to be strong*



- 10% Strong*
- 17% Intermediate
- 57% Weak
- 16% 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 sometime referred to as 'forcing' actions