Maternity & Neonatal Clinical Governance Meetings December 2024

Agenda item				
Report Title	CNST MIS Safety Action 1 - PMRT			
Executive Lead	Paula Gardner, Interim Executive Director of Nursing			
Report Author	Silje Almklow, Divisional Quality Governance Lead			
	Link to strategic goal:		**Link to CQC domain:**	
	Our patients and community		Safe	**√**
	Our people		Effective	√
	Our service delivery	√	Caring	√
	Our governance	√	Responsive	√
	Our partners		Well Led	**√**
	Report recommendations:		**Link to BAF / risk:**	
	For assurance	**√**		
	For decision / approval		**Link to risk register:**	
	For review / discussion			
	For noting			
	For information	√		
	For consent			
Presented to:	Maternity Governance Meeting December 2024			
Executive summary:	SaTH is a participant in year 6 of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS), which is operated by NHS Resolution (NHSR) and supports the delivery of safer maternity care. This paper sets out SaTH's completion status against safety action 1 which must be approved by the Board of Directors.			
Recommendations for the Committee	The Committee is asked to: Receive the report in line with Safety Action 1.			
Appendices	PMRT board report 08/12/2023-30/11/2024 PMRT action tracker			

1.0 Introduction

1.1 SaTH is a member of the Clinical Negligence Scheme for Trusts Maternity Incentive Scheme (CNST MIS). Which is regulated by NHS Resolution (NHSR) and is designed to support the delivery of safer maternity care.

1.2 The scheme incentivises ten maternity safety actions. Trusts that can demonstrate that they have achieved all ten safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds.

1.3 The purpose of this paper is to provide the Board of Directors with an update against safety action 1: "Safety Action 1: **Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths from 8 December 2023 to 30 November 2024 to the required standard?"**

2.0 Required Standards

2.1 Safety action 1 is made up of the following standards which need to be evidenced against:

a) Notify all deaths: All eligible perinatal deaths should be notified to MBRRACE UK within seven working days.
b) Seek parents' views of care: For at least 95% of all the deaths of babies in your Trust eligible for PMRT review, Trusts should ensure parents are given the opportunity to provide feedback, share their perspectives of care and raise any questions and comments they may have from 8 December 2023 onwards.
c) Review the death and complete the review: For deaths of babies who were born and died in your Trust multi-disciplinary reviews using the PMRT should be carried out from 2 April 2024; 95% of reviews should be started within two months of the death, and a minimum of 60% of multi-disciplinary reviews should be completed and published within six months.
d) Report to the Trust Executive: Quarterly reports should be submitted to the Trust Executive Board on an on-going basis for all deaths from 8 December 2023.

3.0 Minimum Evidence Required for Trust Board

Notifications must be made, and surveillance forms completed using the MBRRACE-UK reporting website (see technical guidance regarding the introduction of the NHS Submit a Perinatal Event Notification system - SPEN). The PMRT must be used to review the care and reports about individual deaths should be generated via the PMRT.

A report should be received by the Trust Executive Board each quarter that includes details of the deaths reviewed, any themes identified and the consequent action plans. The report should evidence that the PMRT has been used to review eligible perinatal deaths and that the required standards a), b) and c) have been met. For standard b) for any parents who have not been informed about the review taking place, reasons for this should be documented within the PMRT review.

NHS Resolution will use data from MBRRACE-UK/PMRT, to cross-reference against Trust self-certifications. MBRRACE-UK/PMRT will take the data extract for verification on 1 February 2025.

4.0 Qualifying cases

Standards A, B and C are evidenced in the below table. The cases highlighted in green have been completed and published. The first three rows in white have been discussed in a PMRT meeting and are awaiting placental histology/post-mortem results prior to being published. All cases have had an initial MDT review in the weekly incident review meeting.

MBRRACE Number	Date of loss	Type of event	7 days - notify MBRRACE	Parent's views Verbal	Parent's views Letter	Initial review date	Date of PMRT meeting	Date PMRT published	MDT	External member present
90933/1	18/12/2023	SB	18/12/2023	18/12/2023	28/12/2023	09/01/2024	17/01/2024	30/01/2024	Yes	Yes
91636/1	30/01/2024	LFL	31/01/2024	30/01/2024	08/02/2024	21/02/2024	20/03/2024	25/03/2024	Yes	Yes
91966/1	16/02/2024	SB	19/02/2024	19/02/2024	29/02/2024	18/03/2024	20/03/2024	25/03/2024	Yes	Yes
92385/1	14/03/2024	SB	15/03/2024	14/03/2024	27/03/2024	18/04/2024	18/04/2024	03/07/2024	Yes	Yes
92440/1	18/03/2024	SB	18/03/2024	22/03/2024	27/03/2024	02/04/2024	15/05/2024	24/06/2024	Yes	Yes
92914/1	18/04/2024	NND	19/04/2024	19/04/2024	08/05/2024	30/04/2024	17/07/2024	24/07/2024	Yes	Yes
92915/1	19/04/2024	NND	19/04/2024	19/04/2024	08/05/2024	23/04/2024	20/06/2024	03/07/2024	Yes	Yes
93568/1	30/05/2024	LFL	31/05/2024	31/05/2024	14/06/2024	24/06/2024	15/08/2024	19/11/2024	Yes	Yes

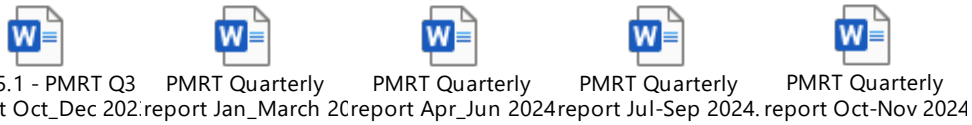
93799/1	14/06/2024	SB	14/06/2024	19/06/2024	28/06/2024	25/06/2024	15/08/2024	18/09/2024	Yes	Yes
94316/1	13/07/2024	SB	16/07/2024	23/07/2024	08/08/2024	16/07/2024	18/09/2024	27/09/2024	Yes	Yes
95124/1	12/09/2024	SB	12/09/2024	12/09/2024	07/10/2024	13/09/2024 JAR meeting	20/11/2024		Yes	Yes
95236/1	20/09/2024	SB	20/09/2024	23/09/2024	26/09/2024	08/10/2024	17/10/2024		Yes	Yes
95376/1	13/09/2024	LFL	30/09/2024	30/09/2024	21/10/2024	09/10/2024	17/10/2024		Yes	Yes
95544/1	09/10/2024	NND	10/10/2024	14/10/2024	23/10/2024	14/10/2024	19/12/2024		Yes	Yes
95933/1	05/11/2024	SB	06/11/2024	08/11/2024	02/12/2024	19/11/2024	Scheduled for Jan 2025			
96092/1	16/11/2024	SB	19/11/2024	19/11/2024	05/12/2024	26/11/2024	Scheduled for Feb 2025			
96096/1	16/11/2024	SB	19/11/2024	18/11/2024	02/12/2024	26/11/2024	Scheduled for Jan 2025			

4.1 MDT working and external representation on the panel

13 PMRT cases have been completed during the reporting period and we can confirm that 100% of the reviews were completed with an MDT panel and external representation. We currently have a mutual agreement with another Trust who provide consultant presence for our PMRT review meetings.

5.0 Report to the Trust Executive: Quarterly reports should be submitted to the Trust Executive Board on an on-going basis for all deaths from 8 December 2023.

Below are the quarterly reports that were submitted for the time period December 2023 to September 2024. The quarter 3 report will be shared in governance meetings in January 2025, a preliminary quarter 3 report and Board report has been included to cover the reporting period (30th November 24).



Below are the Board reports that were submitted for the time period December 2023 to September 2024. The Board report for Quarter 3 will be shared in governance meetings in January 2025.

6.0 Summary

a) All eligible deaths were notified to MBRRACE UK within seven working days.
b) All parents were contacted, informed of the review, and asked for their views of the care they received.
c) All eligible deaths were reviewed in an MDT forum using the PMRT tool. 100% of cases were started within two months of the deaths and 100% of multi-disciplinary reviews were completed and published within six months.
d) Quarterly PMRT reports and Board reports were submitted to the Trust Executive Board on an on-going basis for all deaths from 8 December 2023.

7.0 Actions requested of the Board

The Board of Directors is asked to note the content of this paper which evidences delivery of the required standards to achieve safety action 1 of Year 6 of the CNST Maternity Incentive Scheme.

Appendix 1: PMRT action tracker – open actions

Action highlighted are duplicate actions to meet several recommendations.

Action ID	Description	Specialty	Synopsis	Due date	Reporting/ Monitoring requirements	Progress	RAG Rating
10938	learning from PMRT case - Surgical abdomen concerns - governance presentation for M&M	Neonatology	There were concerns regarding the abdomen and appropriate plans were made, but a surgical opinion should have been sought. If there were concerns regarding a surgical abdomen, then the advice from a surgeon at the tertiary centre should be sought.	30/04/2024	Governance presentation	19.1.24 - QGT action review - JB to send evidence for closure. 27.03.24 ANNP to provide face to face presentation (Mortality case study theme) 06/12/2024 - SUA QGT An email was sent 15/11/2024 to chase a presentation for this case, no reply has been received. A further email has been sent to chase a presentation as a matter of urgency. 30.5.24 - QGT review with LD - LD to liaise with ANNP regarding action and evidence for closure.	
10939	learning from PMRT case - share learning re. blood products for fluid boluses	Neonatology	Consideration of using blood products for fluid boluses after having received multiple boluses of sodium chloride (separate action assigned to Deepal Vithange for review of guideline for possible updating to include this)	30/04/2024	Governance presentation	19.1.24 - QGT action review - JB to send evidence for closure. 27.03.24 JD ANNP to present face to face presentation (Mortality case review theme) 06/12/2024 - SUA QGT An email was sent 15/11/2024 to chase a presentation for this case, no reply has been received. A further email has been sent to chase a presentation as a matter of urgency. 30.5.24 - QGT review with LD - LD to liaise with ANNP regarding action and evidence for closure.	
10940	learning from PMRT case - Learning to be shared in departmental meeting.	Neonatology	Action for Dr Deepal Vithanage (Datix log in required - email of action sent to him 16/8/23) - Review guidance for possible updating in considering the following - Consideration of using blood products for fluid boluses after having received multiple boluses of sodium chloride (dissemination of learning action assigned to Dr Jennifer Brindley - Governance Feedback)	30/04/2024		19.1.24 - QGT action review - learning from incident to be presented at departmental teaching. JB to send evidence for closure. 27.03.24 JD ANNP to present face to face presentation (Mortality case review theme) 06/12/2024 - SUA QGT An email was sent 15/11/2024 to chase a presentation for this case, no reply has been received. A further email has been sent to chase a presentation as a matter of urgency. 30.5.24 - QGT review with LD - LD to liaise with ANNP regarding action and evidence for closure.	

10941	learning from PMRT case - escalation of care	Neonatology	Earlier opportunities were seen to discuss with a level 3 NICU consultant regarding care - dissemination of learning from case and review of policy regarding escalation of care. Review identified she was managed appropriately locally despite this	30/04/2024	Governance presentation	19.1.24 - QGT action review - JB to send evidence for closure. 27.03.24 JD ANNP to present face to face presentation (Mortality case review theme) 06/12/2024 - SUA QGT An email was sent 15/11/2024 to chase a presentation for this case, no reply has been received. A further email has been sent to chase a presentation as a matter of urgency. 30.5.24 - QGT review with LD - LD to liaise with ANNP regarding action and evidence for closure.	
10943	learning from PMRT case - earlier arterial access	Neonatology	Earlier arterial access should have been achieved once commenced in inotropes. Dissemination of learning and review of hypotension guideline. noted that hourly cuff blood pressures were being undertaken.	30/04/2024	Governance presentation	19.1.24 - QGT action review - to be added to learning review. JB to send evidence. 27.03.24 JD ANNP to present face to face presentation (Mortality case review theme) 06/12/2024 - SUA QGT An email was sent 15/11/2024 to chase a presentation for this case, no reply has been received. A further email has been sent to chase a presentation as a matter of urgency. 30.5.24 - QGT review with LD - LD to liaise with ANNP regarding action and evidence for closure.	
10944	learning from PMRT case - *Radiology action* emergency cranial US scans	Neonatology	Emergency cranial US scans undertaken locally need uploading to PACS system so images can be transferred to other hospitals rather than print-outs being in the notes. Radiology required to provide CRIS log ins to neonatal consultants and provide training on how to upload scans to PACS	30/04/2024		19.1.24 - QGT action review - CRIS access requested for all medical staff in NNU. Training requested. 30.5.24 - QGT review with LD - consultant review required. 06/12/2024 - SUA QGT Update chased from the neonatal CDs regarding cranial ultrasounds/PACS/CRIS access.	
11756	PMRT - learning review to be generate and include learning re documentation of differential diagnoses considered	Neonatology	there was an early management plan but plan was not appropriate, not relevant to the outcome but action is required	30/04/2024	plans were made to meet the baby's needs, There was no documentation of the possible causes of baby's illness. Such an approach would have helped focus on appropriate investigations and Management	19.1.24 - QGT action review - to be included in the learning review once joint PMRT is completed. PMRT planned for 20/2/2024 25/10/2024 - SUA JB to include differential diagnosis as a requirement for BadgerNet documentation. NNAP action plan. Evidence to be provided. 30.5.24 - QGT review with LD - consultant review required. 06/12/2024 - SUA QGT NNAP action plan is being generated and will be monitored via the MNTP.	

12030	debrief to staff following hot/cold	Neonatology	It is not possible to assess from the notes whether following the resuscitation of the baby a rapid safety focused resus de-brief with the staff involved was carried out	30/04/2024	Relevant SOP/Guidance in place so Neonatal ward manager, DDDN and Neonatal Consultant will highlight them through safety huddles to ensure staff are aware of process	SOP for debrief to be reviewed and relaunched once approved 30.5.24 - QGT review with LD - LD to confirm if SOP is being developed. 25/10/2024 - SUA SOP in place - neonatal team debrief flowchart - November 2019. Due for update December 2024. The use of the hot debrief proforma to be included in the SOP. 06/12/2024 - SUA QGT The majority of consultants on the neonatal unit have received hot debrief training and have access to the Hot debrief proforma and flowchart. This is now in use. The process will be included in the guidance when it is updated (due December 2024)	
12032	Management in first hour	Neonatology	The management of the baby in the first hour on the neonatal unit was not appropriate Highlight the need for aggressive management of abnormal glucose levels in babies with HIE.	30/04/2024	Mortality and Morbidity meeting	Retrospective audit of all babies with HIE admitted past 1st Jan 23- 1/1/24 to review glucose levels/ventilation strategy / metabolic management 30.5.24 - QGT review with LD - consultant review required. 25/10/2024 - SUA Consultant SD to be contacted to review audit position and action plan. 06/12/2024 - SUA QGT Further email sent to chase the outcome of the audit and the action plan.	
11757	Respiratory Management - documentation of rationale	Neonatology	The Respiratory Management of the baby during first 24hrs of arrival on NNU was not appropriate	31/05/2024	not relevant to the outcome but action is needed. Consideration should have been given for intubation of the baby following the poor gas in the morning prior to transfer. If a considered decision was made to continue with non invasive respiratory support then the rationale should have been documented	19.1.24 - QGT action review - baby on CPAP, transport team did 2 gases on arrival. Await PMRT review. Case requires joint PMRT review. 30.5.24 - QGT review with LD - consultant review required. 25/10/2024 - SUA NNAP action plan to include documentation prompts for BadgerNet - to include differential diagnosis, clear management plans, and rationale. 06/12/2024 - SUA QGT NNAP action plan is being developed and will be monitored via the MNTP.	
15552	guideline for reviewing and actioning results	Obstetrics/Maternity	This mother had anaemia (Hb <85 g/l) during her pregnancy which was not managed according to national or local guidelines	31/08/2024	Screening guideline to be updated. Weekly safety brief to be completed and learning included in the PMRT learning slides.	Action re-assigned to screening midwife as screening guideline under review 06/12/2024 - SUA QGT The screening guideline is due to go out for comment shortly and is planned to go through maternity governance in January 2025.	

15700	This mother was not offered routine booking blood tests	Obstetrics/Maternity	The booking bloods and screening tests should be offered at the first contact for women booking for maternity care late in pregnancy. Guidelines are being reviewed to agree on the definition for late booking and the process for caring for any woman booking late.	31/08/2024		06/12/2024 - SUA The screening guideline is under review and due to go out for comment. It is expected to go through maternity governance in January 2025.	
15703	Screening for haemoglobinopathies was indicated but not offered to this mother	Obstetrics/Maternity	The booking bloods and screening tests should be offered at the first contact for women booking for maternity care late in pregnancy. Guidelines are being reviewed to agree on the definition for late booking and the process for caring for any woman booking late.	31/08/2024		1/8/24 Screening guideline under review by specialist screening midwife. 06/12/2024 - SUA QGT The screening guideline is due to go out for comment shortly and is planned for maternity governance in January 2025. 06/12/2024 - SUA QGT The guideline is due to go out for comment. Expected to go through maternity governance in January 2025.	
16341	PMRT RB 94316 - Tea trolley teaching sessions focused on bereavement care	Obstetrics/Maternity	The mother's progress in labour was not monitored on a partogram. Tea trolley teaching sessions to be carried out during baby loss awareness week - focus on bereavement care.	31/10/2024		06/12/2024 - SUA QGT The tea trolley teaching sessions have been delayed due to capacity in the bereavement team. Teaching planned for January 2025.	
16334	PMRT CB 92914 - scenario to be added to study days regarding labour monitoring and documentation	Obstetrics/Maternity	The mother's progress in labour was not monitored on a partogram. This mother was in preterm labour/threatened preterm labour but was not offered magnesium sulphate for fetal neuroprotection when this was indicated During this mother's labour maternal observations, commensurate with her level of risk and national guidelines, were not carried out. It was not possible to tell from the documentation if the interpretation of the fetal heart rate monitoring in established labour was correct. Scenario to be added on the EFM/PROMPT/bereavement study days regarding task focus and themes regarding labour monitoring and documentation in unusual situations such as stillbirth or abnormalities. Learning to be shared on huddles. Situational awareness study day for coordinators.	30/11/2024		Due date amended due to delay in adding the action to Datix. Bereavement is being added as a scenario for mandatory training days. Discussions ongoing with the obstetric team.	

16862	PMRT 93165 JK - Additional training for staff regarding domestic abuse	Paediatrics	There is no evidence in the notes that this mother was asked about domestic abuse at booking. Additional monitoring of QA questions is being rolled out and additional training is being implemented for staff. Training being added to mandatory training days. White ribbon day being celebrated, support from the HIDVA, posters and information being shared. Additional monitoring of QA compliance being added to governance papers.	31/01/2025		06/12/2024 - SUA QGT A meeting took place with the safeguarding team in November 2024 to discuss the approach to improved compliance with QA questions during pregnancy. Further teaching and monitoring of compliance is being arranged.	
16864	PMRT 93165 JK - Feed back the suspected diagnosis to the patient to ensure adequate follow up	Paediatrics	The mother had liver disease during her pregnancy which was not managed according to national or local guidelines. Contact to be established with the woman to share the suspected diagnosis of Acute Fatty Liver of Pregnancy to ensure adequate follow up and pre-conception planning for future pregnancies. Note: patient is currently abroad.	31/01/2025			
16852	PMRT RO 94316 - Review and analyse data on QA questions during pregnancy.	Obstetrics/Maternity	The PMRT review identified that the QA questions was not asked regularly during pregnancy in line with guidance. Work is ongoing to improve compliance. A review of data on BadgerNet is to be completed to identify the rate of compliance, areas of concern, and to generate an action plan for improvements.	06/02/2025			
16863	PMRT 93165 JK - Acute Fatty Liver of Pregnancy Guideline	Paediatrics	This mother had liver disease during her pregnancy which was not managed according to national or local guidelines SaTH - Lack of local guideline for acute fatty liver - guideline to be developed. Guideline to be shared from BWH. Guideline lead to be identified and guideline to be developed.	28/02/2025			

Action tracker – closed actions as of 06/12/2024.

Closed actions as of 06.12.2024.xlsx