The Royal Wolverhampton NHS Trust

Perinatal Mortality Report Clinical Negligence Scheme for Trust CNST Safety Action 1

5 August 2019

Agenda Item No: 7.3.2

The Royal Wolverhampton NHS Trust

Trust Board Report

Meeting Date:	5 August 2019
Title:	Perinatal mortality report Clinical Negligence Scheme for Trusts CNST safety action 1
Executive Summary:	NHS Resolution is operating a second year of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care. This report contains quarterly reports that require submission to the board regarding the details of all perinatal deaths and any action plans from 12th of December to June 19. **Safety Action 1: Are you using the perinatal mortality review tool to review perinatal deaths to the required standard?** a) A review of 95% of all deaths of babies suitable for review using the Perinatal Mortality Review Tool (PMRT) occurring from 12 December 2018 have been started within 4 months of each death. b) At least 50% of all deaths who were born and died at your Trust (including home births that died) form 12th December 2018 will have been reviewed by a multidisciplinary team with each review completed to the point that a draft report has been generated, within four months of each death. c) In 95% of all deaths of babies who were born and died in your trust (including any home births where the baby died) from Wednesday 12 December 2018, the parents were told that a review of their baby's death will take place and that their perspective and any concerns about their care and that of their baby have been sought. d) Quarterly reports have been submitted to the trust board that include details of all deaths reviewed and consequent action plans.
Action Requested:	To receive and note the report

Report of:	Tracy Palmer, Head of Nursing Midwifery Women's and Neonatal services
For the attention of the Board. • **Alert** • **Assure** • **Advise**	To Assure the Board that safety action 1 standards a – d have been met
Author: **Contact Details:**	Tracy Palmer Head of Midwifery Women's and neonatal services. Tel: 01902 695162 Email: tracypalmer@nhs.net
Links to Trust Strategic Objectives	1. Create a culture of compassion, safety and quality. 2. Proactively seek opportunities to develop our services
Resource Implications:	Workforce.
Public or Private: **(with reasons if private)**	Public
CQC Domains	**Safe:** patients, staff and the public are protected from abuse and avoidable harm. **Effective:** care, treatment and support achieves good outcomes, helping people maintain quality of life and is based on the best available evidence. **Caring:** staff involve and treat everyone with compassion, kindness, dignity and respect. **Responsive:** services are organised so that they meet people's needs. **Well-led:** the leadership, management and governance of the organisation make sure it's providing high-quality care that's based around individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture
Appendices/ **References/** **Background Reading**	1 – Perinatal reports – update position NHS Resolution; Maternity Incentive Scheme – year two (2019)

CNST STANDARD 1
Update Position 18th June 2019

a) review of 95% of all deaths of babies suitable for review using the Perinatal Mortality Review Tool (PMRT) occurring from Wednesday 12 December 2018 **have been started within four months** of each death.

	Number of cases	**Number of PMRT started**	**% compliance**
Stillbirths 2018	2	2	100%
Stillbirths 2019	5	5	100%
Neonatal Deaths 2018	1	1	100%
Neonatal Deaths 2019	6	6	100%
Overall % compliance for stillbirths & NND 18/6/19	14	14	100%

b) **At least 50%** of all deaths of babies who were **born and died** in your trust (including any home births where the baby died) from Wednesday 12 December 2018 will have been reviewed, by a multidisciplinary review team, with each review completed to the point that a **draft report has been generated, within four months of each death.**

	Number of cases	**Draft Report generated**	**% compliance**
Neonatal Deaths 2018	1	1	100%
Neonatal Deaths 2019	6	3	50%
Overall % compliance for stillbirths & NND	7	4	57%

b) In 95% of all deaths of babies who were **born and died in your trust** (including any home births where the baby died) from Wednesday 12 December 2018, **the parents were told that a review of their baby's death will take place and that their perspective and any concerns about their care and that of their baby have been sought.**

	Number of cases	**Parents Review & Questions answered**	**% compliance**
Neonatal Deaths 2018	1	1	100%
Neonatal Deaths 2019	5	5	100%

d) Quarterly reports have been submitted to the trust Board that include details of all deaths reviewed and consequent action plans – completed to date

Stillbirth

- December 2018, January February, & March completed
- April, May, June – to be completed in July

Neonatal Death

- December 2018, January February, & March completed
- April, May, June – to be completed in July

Stillbirths 12th of December to 31st March

There have been 3 stillbirths within the time period of 12th December and 31st March.
All cases were discussed and the Perinatal Mortality Review Tool (PMRT) has been completed.
2 cases were issued with an NPSA grade of 0 – no issues with the care provided.
1 case was assigned NPSA grades of 1 – incidental finding which would not have made any difference to the outcome.

Lessons learned from reviews / NPSA grade 1
There was documentation error on Badgernet Electronic Pregnancy record – this has been raised with staff member.

Neonatal Deaths – 12th December to 31st March
There were 5 neonatal deaths
2 deaths were due to extreme prematurity
3 were due to congenital abnormality

Lessons learned from reviews / NPSA codes.
All NN deaths between 12th December and March 31st were grade NPSA 0 – no issues with the care provided.