The Regional Perinatal Governance Group
1 year on

- Who?
- Why?
- How?
- What ?
- Where ?

Membership

Maternity and neonatal clinical governance teams

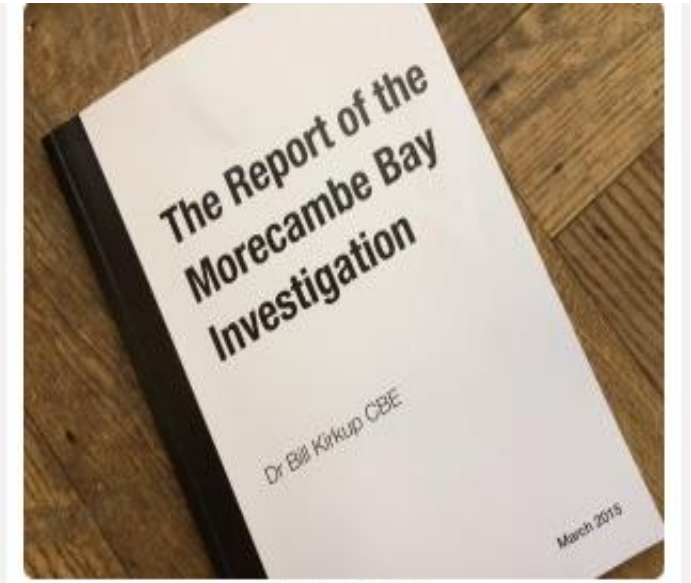
- Frimley Health Hospitals
- Royal Berkshire Hospitals
- Buckinghamshire Hospitals
- Oxford U Hospitals
- Milton Keynes U Hospitals.

Invited representatives

- HSIB
- MMBRACE
- Neonatal clinical Network
- Maternity network
- AHSN
- Legal services

Lay member recruited in January 2019

Background



Kirkup Report.

- NHS England set a national ambition to reduce stillbirth, neonatal brain injury and neonatal death rates by 50% by 2025 (NHS Long Term Plan, Saving Babies Lives V2 and Each Baby Counts).
- restructuring of the maternity care provision into Local Maternity Systems (LMS), Maternity and Neonatal Networks known as Operational Delivery Networks (ODN) and Local Learning Systems.
- Strategies to help standardise and improve investigations. HSIB , PNMRT
- Neonatal National Audit (NNA), ATAIN, BiRP.
- QI projects Maternity Neonatal Collaboration
- Maternity Incentive scheme

Maternity units no longer working in isolation.

Healthcare Safety Investigation Branch (HSIB)

All term babies (at least 37+0 completed weeks of gestation) born following labour, who have one of the below outcomes.

- Intrapartum stillbirth Where the baby was thought to be alive at the start of labour but was born with no signs of life.
- Early neonatal death When the baby died within the first week of life (0-6 days) of any cause.
- Severe brain injury diagnosed in the first seven days of life.

Perinatal Mortality Review Panels

- Multidisciplinary
- Family involvement
- External reviewer
- Online tool
- Safety action 1 maternity incentive scheme

Grading of care

3 areas of care reviewed

Graded A to D

How

- Bench marking exercise
- Training
- Understanding HSIB/PNMR
- Sharing individual /joint cases at regional learning events
- Reviewing themes from PMR and HSIB investigations

Shared Learning

- Cases presented at group meetings
- Cases presented at the local shared learning events for maternity
- Cases taken to the regional ED patient safety events
- Neonatal cases presented nationally with Safety medicine alert.

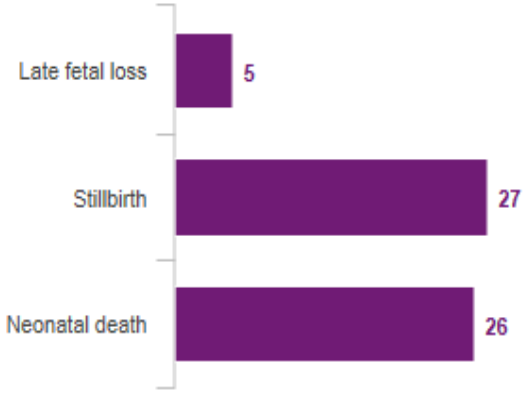
Perinatal Mortality Review

2019

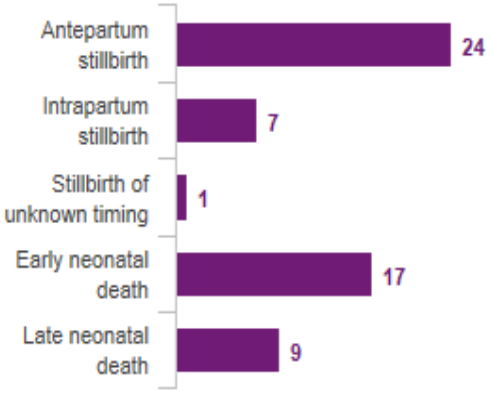
OUH

Oxford Data (53 cases)

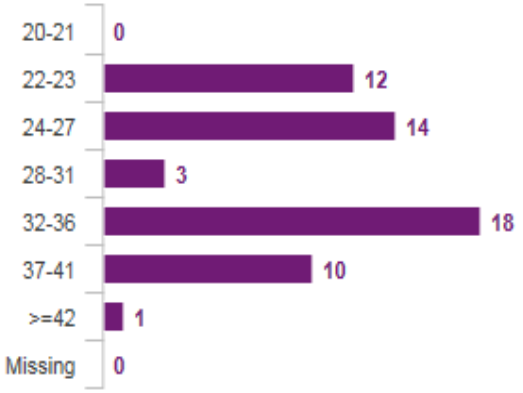
Number of deaths by
Type of death



Number of deaths by
Timing of death

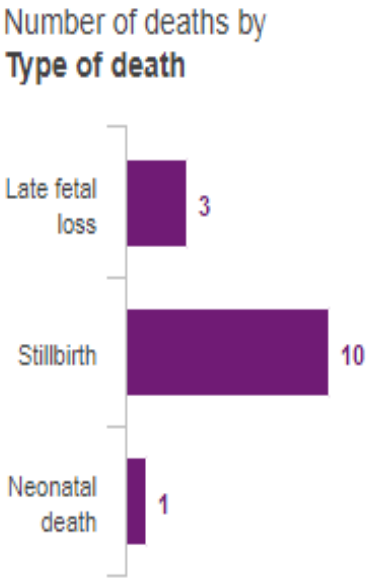


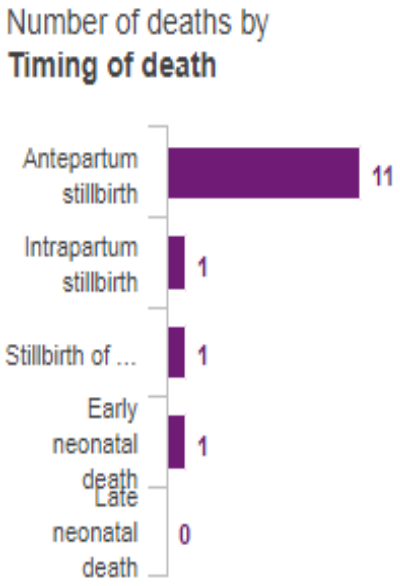
Number of deaths by
Gestational age (weeks)

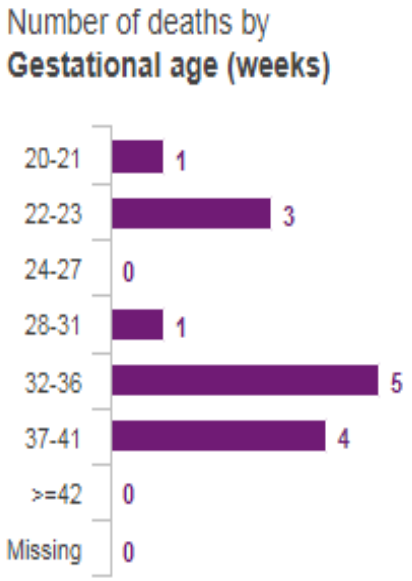


Bucks

Bucks Data (11 cases)







MKUH

Summary information for the babies who died in this period and for whom a review of care has been completed – number of babies (N = 14)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
Late Fetal Losses (<24 weeks)	0	4	--	--	--	--	4
Stillbirths total (24+ weeks)	0	0	3	2	3	2	10
Antepartum stillbirths	*0*	*4*	*3*	*2*	*3*	*2*	*14*
Intrapartum stillbirths	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Timing of stillbirth unknown	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Early neonatal deaths (1-7 days)*	0	0	0	0	0	0	0
Late neonatal deaths (8-28 days)*	0	0	0	0	0	0	0
Post-neonatal deaths (29 days +)*	0	0	0	0	0	0	0
Total deaths reviewed	0	4	3	2	3	2	14

- 0 cases graded “D”
- 11 cases graded “C”
- 20% graded “A”

Themes

- Lack of recognition of a deteriorating patient
- Delay in recognising and acting on chorionamnitis
- Reluctance to expedite delivery of extreme prematurity.
- Failure to plan and follow recommendation for management of suspected IUGR
- Failure to provide appropriate ANC for women with a history of preterm labour.
- No local Perinatal pathologist
- CO screening at booking
- Asking DV questions at booking
- Lack of evidence of written advice re fetal movements
- Use of partogram for woman with IUD

Actions

regional

- Regional review of ED maternity guidelines completed in Trusts (OUH/MK)
- Update of regional guidelines and pathways of the management threatened labour/pre labour rupture of membranes in cases of extreme prematurity
- Introduction of preterm labour clinics through out the region.
- Development of partogram for woman with IUD
- Write to Mmbrace re local perinatal pathologist

local

- New pathway for recording DV
- Exploring other ways to provide written information re fetal movements
- Review local guidelines

HSIB

- 39 cases reported to HSIB since July 2018
- 14 reviews returned (draft and completed)

Themes from HSIB investigations

Antenatal

Risk assessment

- Telephone triage assessment to prompt staff to take appropriate action
- Information given to women with diabetes
- Recognising deterioration in condition

Management of pre-labour SROM

Intrapartum

CTG monitoring

- Training
- Use of fresh eyes stickers
- Lack of equipment

Categorisation of CS and instrumental delivery

- Poor communication
- Lack of consistency
- Emergency calls for teams

Use of MEOWS chart

- Multiple charts
- Not plotted

Postnatal

Recognition of deterioration mother/baby

- MEOWS/NEOWs
- Readmission pathways

Communication to parents

- Post natal follow up for mothers following referral to tertiary centres
- Written information after poor outcome e.g. .shoulder dystocia

General

Contingency plans

- when IOL booking appointments limited or unavailable
- when the service is at capacity
- Consideration of experience of staff when allocated in times of escalation

Documentation

- Neonatal real time documentation at resuscitation
- Process for ensuring completeness of notes

Equipment

- Availability of CTG monitoring equipment
- CO monitors

Where next?

Clinical Networks /AHSN

- Preterm labour clinics
- Categorisation of emergency CS and instrumental delivery
- Continue refining preterm pathways
- Education initiatives e.g. (award winning IA)
- Digital records (MEOWS)
- Patient information
- May have other ideas from themes

Regional perinatal governance group

- Strengthen external scrutiny at PMRT
- Regional HSIB/PNMR themes/report
- Need to consider how we share learning from SIRI`s that haven`t been through PMRT or HSIB
- Agree a clear pathway/strategy to share investigation reports and action plans between Trusts, the to LMS and Clinical networks
- Maternity Dashboard

Is it worthwhile?

Thankyou