# Safety Action 1 of the Maternity Incentive Scheme for England, FAQs

These FAQs are designed to supplement (not replace) the technical guidance provided by NHS Resolution to support Staff in Trusts in England involved in ensuring that their Trust meets Safety Action 1 of the NHS Resolution Maternity Incentive Scheme: Maternity incentive scheme - NHS Resolution. You should read both sets of guidance.

## Contents

# Technical issues and updates

**What should we do if we experience technical issues with using PMRT?**

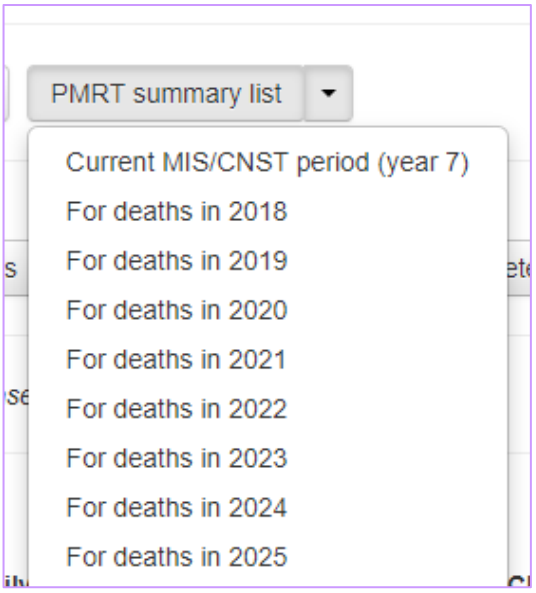
All Trust staff are reminded to contact their IT department regarding any technical issues in the first instance. If this cannot be resolved, then the issue should be escalated to MBRRACE-UK. This can be done through the 'contact us' facility within the MBRRACE-UK/PMRT system or by emailing us at: mbrrace.support@npeu.ox.ac.uk

**If there are any updates on PMRT for the maternity incentive scheme where will they be published?**

Any updates on the PMRT or the MBRRACE-UK notification and surveillance in relation to the maternity incentive scheme safety action 1 will be communicated via NHS Resolution email and will also be included in the PMRT 'message of the day'.

# Monitoring progress of achievement of SA1 standards

To monitor your trust's progress against SA1 standards, you can download a report via the PMRT case management screen, by going to: **Manage cases > PMRT summary list > Current MIS/CNST period**




This is a list of ALL deaths notified by the Trust, **at the point when the report is generated.**

**It includes all deaths** that are suitable for review using the PMRT **as well as those** which are not (for example, terminations of pregnancy). For each death, the report details the current status of each element of SA1 and includes deadlines where relevant.

We recommend that you use this report to monitor progress throughout the year, and not just when the end of year return is due for submission to NHS Resolution.

# The verification period for SA1

### What is the period for verification for SA1 and has this changed?

The verification period for SA1 is now annual and follows from the completion of each yearly iteration of the MIS. SA1 continues to apply between each years' MIS programme. This means that there are no breaks in the requirement to achieve the SA1 standards from the point that each years' MIS is launched. Any changes to the standards will be announced as each MIS iteration is launched and the date that any changes apply will be specified. This means that at the conclusion of each MIS year, all activities to meet that year's SA1 standards should continue until the launch of the next year's scheme.

# Guidance for SA 1(a) – notify all eligible deaths

### Which perinatal deaths must be notified to MBRRACE-UK?

Details of which perinatal death must be notified to MBRRACE-UK are available on the MBRRACE website.

### Where are perinatal deaths notified?

Notifications of deaths must be made, and surveillance forms completed, using the MBRRACE-UK reporting website.

NHS England have been developing the 'Submit a Perinatal Event Notification' (SPEN) system which is planned for release in 2025. Once this is released, notifications of all deaths in England must be made through SPEN, and this information will then be automatically passed to MBRRACE-UK (and then for neonatal deaths, automatically to the local CDOP and the NCMD – see below).

Once the SPEN is in operation, it will still be necessary to log on to the MBRRACE-UK website to complete the surveillance information, to use the Perinatal Mortality Review Tool (PMRT),

the Real-time Data Monitoring Tool, the case management system and to download the reports and data which are available on the MBRRACE-UK website.

### Should we notify all babies who die at home?

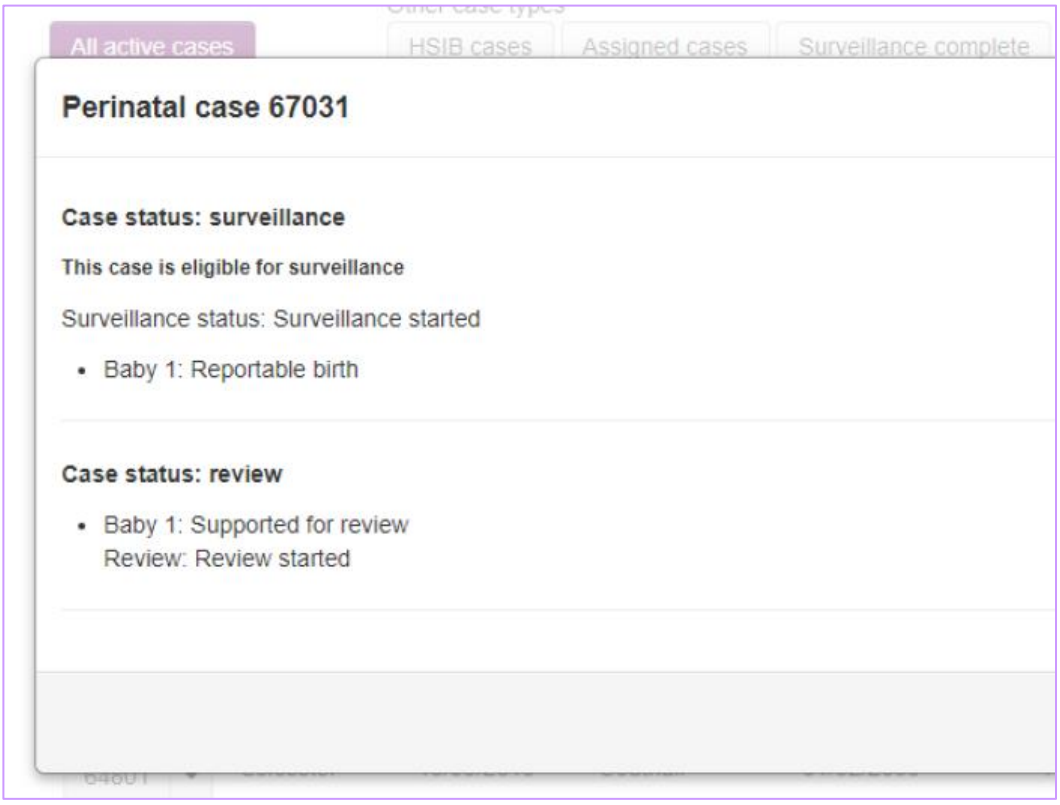
Your Trust and those babies who die at home having been discharged from your Trust of which you are made aware must submit notification and surveillance information for babies who died after a home birth where care was provided.

Babies who die at home where your Trust did not provide any care (e.g. unattended stillbirth following a concealed pregnancy) but the mother and baby are brought to your Trust after the birth must also be notified by your Trust.

### What is the time limit for notifying a perinatal death to MBRRACE-UK?

All perinatal deaths eligible to be reported to MBRRACE-UK must be notified to MBRRACE-UK within seven working days of the death.

When a notification is complete the notification status on the MBRRACE-UK online system will show whether surveillance (and review) is required for each case. This is available from the case management screen by clicking on the Case ID and selecting 'Notification Status'.



## What are the statutory obligations to notify neonatal deaths?

The Child Death Review Statutory and Operational Guidance (England) sets out the obligations for notification of neonatal deaths. Neonatal deaths occurring in your Trust must be notified to Child Death Overview Panels (CDOPs) within two working days of the death (where working days are regarded as Monday to Friday). If the neonatal death occurs after the baby has been transferred for palliative care (either to a hospice or home) you must notify the death within two working days of being made aware of the death. This guidance is available at: https://www.gov.uk/government/publications/child-death-review-statutory-and-operational-guidance-england

MBRRACE-UK is now the mechanism for reporting neonatal deaths to the relevant CDOP and the National Child Mortality Database (NCMD). The notification of a neonatal death to MBRRACE-UK will automatically be notified to the local CDOP and the NCMD using the Cascade system. Cascade will continue to operate unchanged once the SPEN system is in place.

## What is the time limit for completing the surveillance information for MBRRACE-UK?

Following notification within seven working days of the perinatal death, we advise you to complete the surveillance information as soon as possible. As the surveillance information is transferred from the surveillance form into the PMRT (but not vice versa), it is beneficial for the surveillance form to be completed as soon as possible so that the PMRT review can be started as soon as possible without needing to duplicate information.

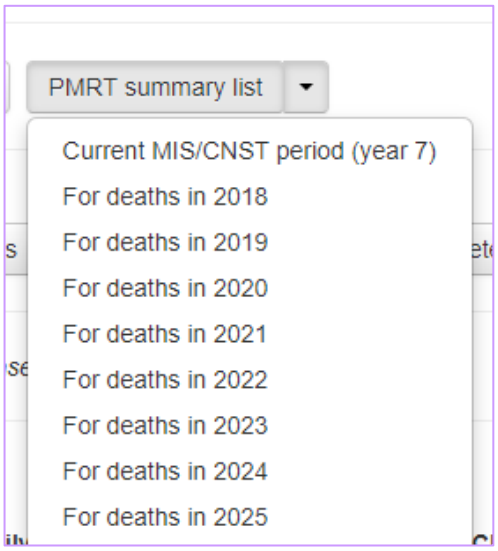
If post-mortem results or results of other investigations are not available and the final cause of death is not confirmed, indicate this in Section 5.1C of the surveillance form, complete the rest of the information, and close the surveillance form.

Once the additional information and the final cause of death is known and confirmed as part of the PMRT review discussion, the surveillance reporter should re-open the surveillance form, update the relevant sections and close it again. You can reopen the form via the “Case actions” menu on the surveillance case management screen.

## How can we keep a check on which of our deaths require surveillance?

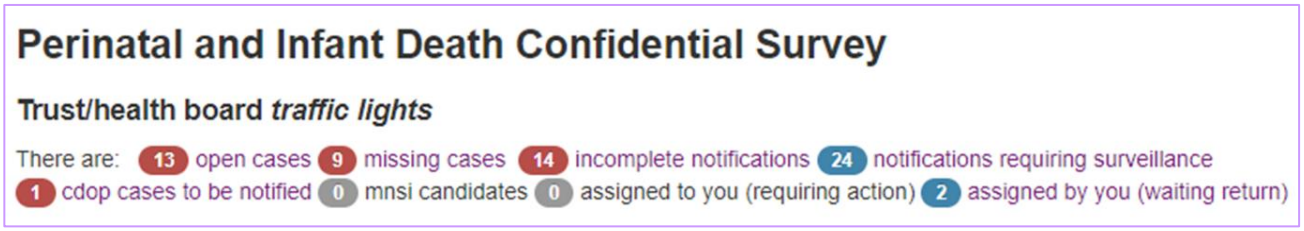
You can keep a check on which of your deaths require surveillance information to be completed using the case management system.

There is a report under 'Case summary list' on the MBRRACE-UK case management screen entitled 'Current MIS/CNST period'.




This includes ALL deaths in your Trust which have been notified to MBRRACE-UK and shows the status of the surveillance if required. This will also indicate if surveillance is required and not started/completed. The surveillance case management screen also displays the surveillance status for each death.

The 'traffic lights' at the top of the Perinatal Surveillance home screen will show you counts for cases require attention. Clicking on the traffic light will take you to a list of those cases.




# Guidance for SA1(b) – seek parents' view of care

**We have informed parents that a local review will take place and they have been asked if they have any feedback or questions about their care. However, this information is recorded in another data system and not the clinical records. What should we do?**

In order that parents' feedback, perspectives, and any questions or concerns they have about their care can be considered during the review this information needs to be incorporated as part of the review and entered into the PMRT. If this information is held in

another data system it needs to be brought to the review meeting, included in the PMRT and considered as part of the review discussion.

The importance of parents' feedback and questions is highlighted by their inclusion as the first set of questions in the PMRT.


Materials to support parent engagement in the local review process are available on the PMRT website at: www.npeu.ox.ac.uk/pmrt/parent-engagement-materials

# Guidance for SA1(c) – review the death and complete the review

### Which perinatal deaths must be reviewed to meet safety action one standards?

The following deaths should be reviewed to meet safety action one standards:

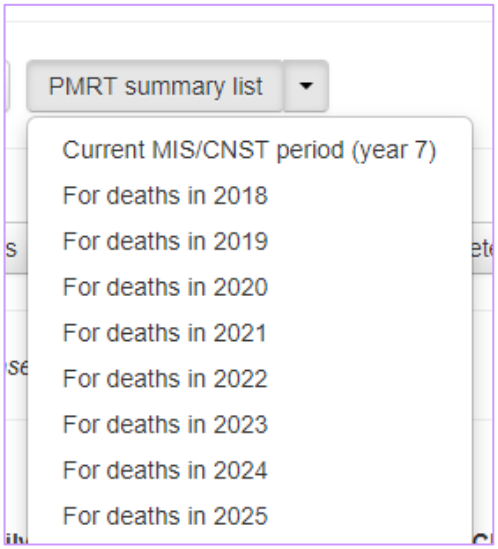
- Late miscarriages/ late fetal losses (22+0 to 23+6 weeks' gestation)
- Stillbirths (from 24+0 weeks' gestation, or 500g if gestation is unknown)
- Neonatal death from 22 weeks' gestation (or 500g if gestation is unknown)) up to 28 days after birth

While it is possible to use the PMRT to review post neonatal deaths (from 29 days after births) this is NOT a requirement to meet SA1.

### How can we keep a check on which of our deaths are suitable for review using the PMRT and their review status?

Within the PMRT, users can generate a report for their Trust by going to:

**Manage cases > PMRT summary list > Current MIS/CNST period**



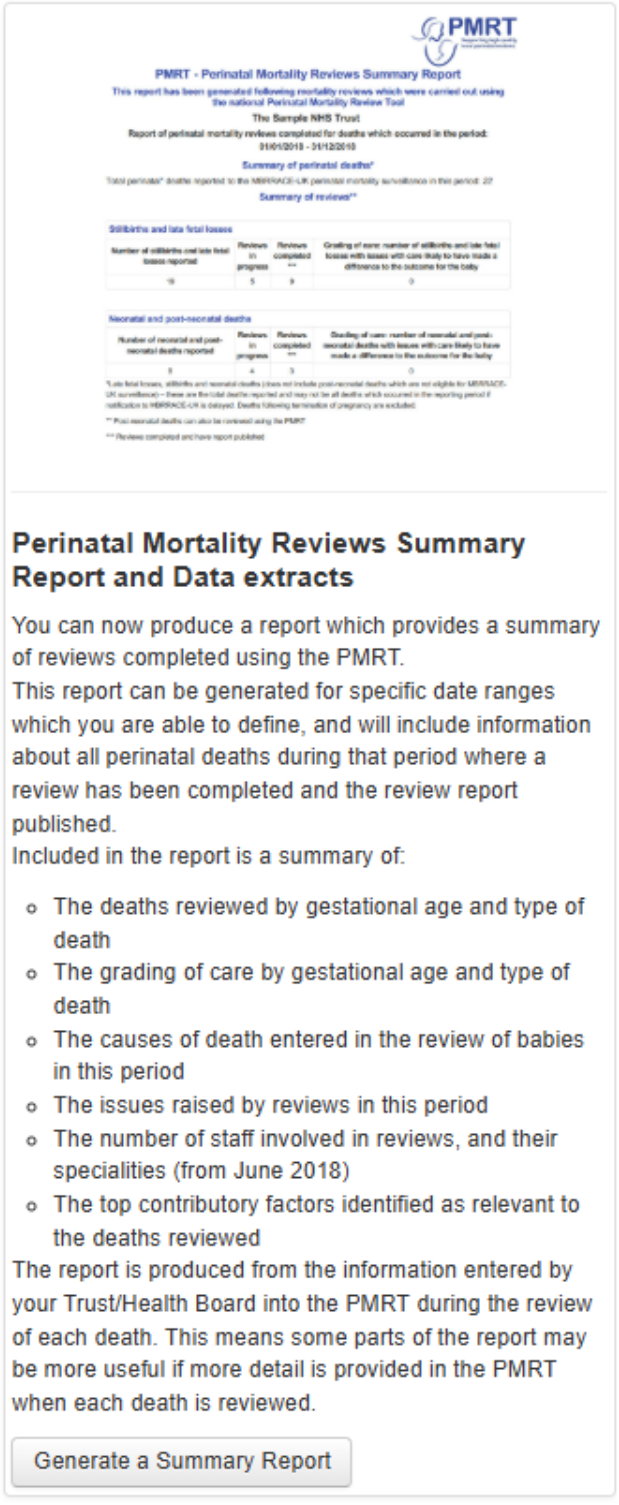

This is a list of ALL deaths notified by the Trust, **at the point when the report is generated. It includes all deaths** that are suitable for review using the PMRT **as well as those** which are not (for example, terminations of pregnancy).

# Guidance for SA1(d) – quarterly reports to Trust Board/Trust Executive

### Can the PMRT help by providing a quarterly report that can be presented to the Trust Board?

Authorised PMRT users can generate reports for their Trust, summarising the results from completed reviews of deaths which occurred during user-defined time periods. These are available from: **Your Data > Perinatal Mortality Reviews Summary Report and Data extracts**. See the screenshot below. Click on the 'Generate a summary report' button.

These reports can be used as the basis for the quarterly Trust Board reports and should be discussed with the Trust maternity safety champion.



PMRT - Perinatal Mortality Reviews Summary Report

This report has been generated following mortality reviews which were carried out using the national Perinatal Mortality Review Tool

The Sample NHS Trust

Report of perinatal mortality reviews completed for deaths which occurred in the period:

Summary of perinatal deaths*

Summary of reviews**

Stillbirths and late fetal losses

| Number of stillbirths and late fetal losses reported | Reviews in progress | Reviews completed *** | Grading of care: number of stillbirths and late fetal losses with cares likely to have made a difference to the outcome for the baby |
|---|---|---|---|
| 18 | 5 | 9 | 0 |

Neonatal and post-neonatal deaths

| Number of neonatal and post-neonatal deaths reported | Reviews in progress | Reviews completed *** | Grading of care: number of neonatal and post-neonatal deaths with cares likely to have made a difference to the outcome for the baby |
|---|---|---|---|
| 8 | 4 | 3 | 0 |

*Late fetal losses, stillbirths and neonatal deaths (does not include post-neonatal deaths which are not eligible for MBRRACE-UK surveillance) – these are the total deaths reported and may not be all deaths which occurred in the reporting period if notification to MBRRACE-UK is delayed. Deaths following termination of pregnancy are excluded.

** Post-neonatal deaths can also be reviewed using the PMRT

*** Reviews completed and have report published

## Perinatal Mortality Reviews Summary Report and Data extracts

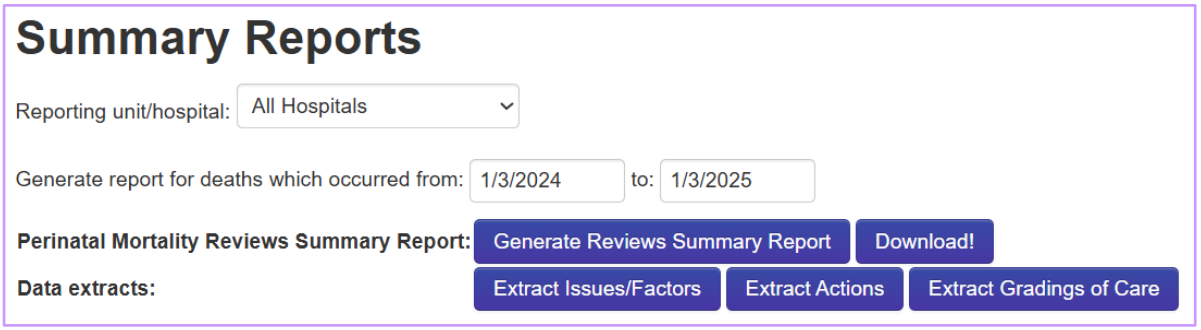
You can now produce a report which provides a summary of reviews completed using the PMRT.
This report can be generated for specific date ranges which you are able to define, and will include information about all perinatal deaths during that period where a review has been completed and the review report published.
Included in the report is a summary of:

- The deaths reviewed by gestational age and type of death
- The grading of care by gestational age and type of death
- The causes of death entered in the review of babies in this period
- The issues raised by reviews in this period
- The number of staff involved in reviews, and their specialities (from June 2018)
- The top contributory factors identified as relevant to the deaths reviewed

The report is produced from the information entered by your Trust/Health Board into the PMRT during the review of each death. This means some parts of the report may be more useful if more detail is provided in the PMRT when each death is reviewed.

Generate a Summary Report

Please note that these reports will only show summaries, issues and action plans for reviews of deaths which **occurred during the time period** specified by the person downloading the report and that have been **completed and published**. Therefore, the time period selected may need to relate to an earlier period than the current quarter and may lag behind the current quarter by up to six months to ensure there is time for the review to have been carried out and completed.



## Summary Reports

Reporting unit/hospital: All Hospitals

Generate report for deaths which occurred from: 1/3/2024 to: 1/3/2025

**Perinatal Mortality Reviews Summary Report:** Generate Reviews Summary Report | Download!

**Data extracts:** Extract Issues/Factors | Extract Actions | Extract Gradings of Care