PMRT Parent Engagement Flow Chart Notes

Trusts and Health Boards should ensure the PMRT parent engagement process is aligned with their women's services governance structures

Week 1

Face-to-face discussion with parents about review before discharge should be with a senior member of staff, and NOT a junior staff member. For example, a consultant or experienced member of the Bereavement Team.

Discussion before discharge should be accompanied with written information *Parent information before discharge*.

Key contact should have appropriate skills and training *Key Contact Responsibilities*

Key contact to make parents aware of working days and availability.

Perinatal Mortality Review Lead to organise admin support for key contact.

If there are likely to be other investigations on-going such as a report to coroner/Procurator Fiscal, an HSIB investigation or SAER ensure parents are made aware of the difference between these and the PMRT hospital review and how these will be co-ordinated.

Week 2-3

If, after discharge, parents cannot be reached after 3 phone/email attempts, send *When parents cannot be reached letter* informing parents of the review process and inviting them to be in touch with key contact, if they wish.

If causes for concern for the mother were raised during her pregnancy consider contacting her GP/primary carer to reach her.

If communication challenges are anticipated (such as in cases of domestic violence, where there are cultural sensitivities, or there may be information gatekeepers) try to speak to woman directly.

If parents do not wish to input into the review process ask how they would like findings of the perinatal mortality review report communicated to them: by post, email, telephone call or in a face-to-face meeting. Parents may want more than one form of communication.

Parents review letter after discharge to be addressed to both parents if known, and adapted to number of babies who have died in a multiple pregnancy. Letter to signpost to local and national support.

Ensure *Parent Feedback form stillbirth* or *Parent Feedback form neonatal death* is appropriate for type of loss and is adapted for multiple pregnancies where one or more babies may have died in differing circumstances.

Offer home meeting to go through feedback forms if possible.

Some families may prefer to access forms etc via email or online links - make these available if possible.

Week 3-12

Ensure PMRT team specifically addresses parental questions and perspectives of care.

Perinatal Mortality Review Lead responsible for ensuring any delays, such as findings of the post mortem report, to review report are communicated to parents by email or letter *Keeping in touch with parents*. Key contact may also want to telephone parents directly.

Perinatal Mortality Review team to be aware of what other con-current investigations are taking place, such as HSIB, SAER, coroner or procurator fiscal involvement, and which may cause delays to PMRT report; ensure parents are made aware of any delays.

Ensure any delay to finalising review report does not delay routine clinical post-natal follow-up meeting with consultant which should take place as normal.

Week 4-16

Trusts/Health Boards should aim to complete report by 16 weeks. Parents should be offered opportunity to see consultant earlier but informed that results of review may not be ready.

Use *Plain English PMRT summary/letter guidance* to ensure language summarising review is sensitive and appropriate. Send review summary/letter ahead of meeting to communicate review findings should parents wish.

Face-to-face meeting to explain findings of review should be conducted by a senior member of team, a consultant if relevant, and representatives of the neonatal and obstetric team if applicable.

Key contact should be invited to attend consultant meeting to support parents.

Ensure statutory guidance around being open and honest adhered to:

- Being Open, Scotland

http://www.healthcareimprovementscotland.org/our_work/governance_and_assurance/learning_from_adverse_events/being_open_guidance.aspx

- Regulation 20: Duty of Candour, England

https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-20-duty-candour

- Being Open Duty of Candour, Wales

http://www.wales.nhs.uk/sitesplus/documents/862/244-Beingopendutyofcandourguideline-V2.pdf