MBRRACE-UK Healthcare Improvement Strategy

V1 – December 2024

Introduction

The Maternal, Newborn and Infant Clinical Outcome Review Programme (MNI-CORP) is commissioned by the Healthcare Quality Improvement Partnership (HQIP) as part of the wider National Clinical Audit and Patient Outcomes Programme (NCAPOP). Since 2012, MNI-CORP has been delivered by the MBRRACE-UK collaboration based at the National Perinatal Epidemiology Unit at the University of Oxford. MBRRACE-UK collaborates with clinicians, patient group and service user organisations, government representatives, policy makers and wider stakeholders to ensure that the MNI-CORP programme is quality assured and that the aims and objectives continue to have impact at a personal, local and national level.

Since 2012, MBRRACE-UK has produced 11 Saving Lives, Improving Mothers' Care annual reports into maternal deaths and morbidity, two rapid reports on COVID-19 related and associated maternal deaths, 10 perinatal mortality surveillance reports and seven perinatal confidential enquiry reports. Coinciding with these reports, MBRRACE-UK has produced multiple recommendations, infographics, lay summaries, local trust and health board reports, data briefs and executive summaries.

MBRRACE-UK endeavours are informed by feedback from clinicians, service users, commissioners and policy makers and efforts are constantly made to improve outputs, reduce the workload associated with submitting data and release data earlier for enhanced surveillance.

Overarching healthcare improvement aim:

The overarching healthcare improvement aim of MBRRACE-UK is to conduct maternal and perinatal mortality surveillance and confidential enquiries to quantify and assess the quality of maternity, neonatal and other services relevant to pregnant and postpartum women and newborn babies. This is in order to stimulate healthcare improvements in clinical quality and safety by enabling clinicians, managers, commissioners and policy makers to learn systematically from adverse events, reduce inequalities and attain parity of esteem.

Overarching programme objectives and approach to quality improvement:

The objectives of this programme of work are to:

- Assess the quality and safety of maternity and infant services
- Support improvements in service quality through national learning
- Produce evidence-based recommendations and good practice points
- Influence clinical practice, service provision, health policy and clinical education

It is our aim that through these objectives the UK will see reductions in maternal and perinatal mortality and fewer disparities in mortality based on ethnicity, deprivation and other characteristics.

Our healthcare improvement goals will be achieved through three approaches: improvements in MBRRACE-UK programme delivery, assessment of engagement and impact and enhanced communication of findings. All healthcare improvements goals will be further refined iteratively in discussion with all our collaborators. This includes clinical experts, a service user representative from the National Maternity Voices Partnership and several 3rd sector stakeholder representatives from Sands, the baby loss charity. We also continue to work alongside other 3rd sector and professional stakeholder organisations to produce and review programme methodology and outputs.

Improving the delivery of the MBRRACE-UK programme to achieve its goals

National:

- Robust and independent national maternal and perinatal mortality surveillance
    - Including annual review and update of surveillance data items collected to ensure the most complete and accurate data
- Leading timely confidential enquiries of all maternal deaths during pregnancy and up to one year postpartum, topic-specific severe maternal morbidity and topic-specific confidential enquiries of stillbirths, infant deaths and severe infant morbidity
- Assess quality of care against guidance and standards to identify areas of improvement for service delivery
- Meetings with independent advisory group comprised of expert clinicians and policy makers to select clinically relevant and impactful topics for maternal morbidity confidential enquiries and perinatal confidential enquiries
- Production of national recommendations based on the SMART framework that have the capacity to influence policy and practice guidance and improve the quality of care
- Meeting with NHS England and other funders or stakeholders to ensure that recommendations are appropriately actioned and targeted
- Expansion of data collection to include pre-hospital records so that all aspects of care, including those outside of maternity and neonatal services, can be considered when evaluating quality of care
- Production of standardised and comprehensive training materials for confidential enquiry assessors to improve the quality of reviews
- Earlier release of national data including more timely production of the annual perinatal surveillance report and production of a maternal mortality data brief as soon as denominator data is available

Regional and local:

- Minimisation of data burden and effort required by clinicians within trusts through integration with similar systems (Cascade integration, SPEN)
- Earlier release of retrospective data at a trust and health board level through organisation-specific reports
- Managing the Real Time Data Monitoring (RTDM) tool, which allows for local review of perinatal deaths as soon as they occur and permits trusts and health boards to monitor patterns and trends in order to support the identification of local healthcare quality improvement opportunities
- Working alongside local trusts and health boards to understand how the RTDM tool can best be used to support quality improvement

- Expanding the use of the RTDM tool to ICBs, networks and regions to provide higher-level oversight of trends within trusts and health boards
- Production of clinical messages aimed at promoting local quality improvement through messaging directed at healthcare providers

Encouraging engagement to improve implementation of MBRRACE-UK findings and recommendations

National:

- Encouraging implementation of best practice by contributing evidence to guidelines (e.g. NICE, SIGN etc.) and stimulating production of guidance where none exists
- Signposting examples of best practice and available resources to improve service specifications (e.g. Maternal Medicine Network (MMN) specifications)
- Monitoring updates to national guidance and policy to track impact of MBRRACE-UK recommendations
- Participating in groups involved in service delivery to present findings and recommendations and influence top-down strategies (e.g. RCOG Patient Safety Committee, NHS England's Equity and Equality Steering Group, NHS England's Maternity and Neonatal Stakeholder Council)
- Presentation of MBRRACE-UK findings and recommendations through two annual meetings and as part of a free online course

Regional and local:

- Integrate MBRRACE-UK reporting within existing and planned national services to reduce data burden and enhance engagement
    - Integration of the reporting system with Child Death Overview Panels (CDOPs) will require earlier reporting of neonatal deaths within 48 working hours
    - Participation in the Submit a Perinatal Event Notification (SPEN) alongside NHS England, MNSI and NHS Resolution, which will enable the single notification of a perinatal death and reduce the information trusts and health boards are required to provide
    - Incorporation of the RTDM tool with NHS England's Maternity Outcome Signalling System (MOSS) that will mandate the use of the tool and help ensure all trusts and health boards are made aware of perinatal deaths occurring in their units when they happen
- Targeting recommendations to support and optimise the training of health professionals
- Engaging with professional contacts in UK maternity and neonatal services to support dissemination of MBRRACE-UK findings and identify local QI activities

Communication strategy to support our healthcare improvement activities

National, regional, local:

- Regularly reviewing and updating website content to ensure information about the programme, contact information and reports are easily accessible
- Improving our online presence and social media engagement to facilitate dissemination of report findings and promote MBRRACE-UK's objectives

- Work with 3rd sector stakeholders and PPI partners to maximise communication opportunities and reach those experiencing inequities, living socially complex lives and those with medical and mental health conditions
- Review and co-develop public facing outputs including lay summaries and infographics with 3rd sector stakeholders and PPI partners to ensure public messaging is clear and appropriate