MBRRACE-UK
Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK
JULY 2017 NEWSLETTER 14

MBRRACE-UK: Delivering the UK-wide Maternal, Newborn and Infant Clinical Outcome Review Programme

MBRRACE-UK Report Launch Meetings

November and December 2017

We will be holding three report launch meetings

London – Tuesday 28th November 2017

MBRRACE-UK Perinatal Mortality Confidential Enquiry into Term Intrapartum Stillbirths and Intrapartum Related Neonatal Death

Manchester – Thursday 7th December 2017

Dublin – Monday 11th December 2017

MBRRACE-UK Perinatal Mortality Confidential Enquiry

and

Saving Lives, Improving Mothers' Care

Early Bird bookings are available – these will close on 17th October 2017

The Early Bird prices are:
Medically qualified delegates: £120 per person
Midwives, nurses, students, researchers, voluntary sector: £80 per person

Full price booking will be from 18th October 2017 until 14th November 2017:
Medically qualified delegates: £140 per person
Midwives, nurses, students, researchers, voluntary sector: £100 per person

Prices include the registration, refreshments, a sandwich lunch and a copy of the report(s)

To register follow the link from: ***https://www.npeu.ox.ac.uk/mbrrace-uk/bookings***

Abstract submission forms are also available on the booking page.
Enquiries and abstract submissions to: **Kate De Blanger**
Email: ***conference@npeu.ox.ac.uk*** Tel: 01865 289710

University of Oxford · HQIP Healthcare Quality Improvement Partnership · University of Leicester · TIMMS · University of Birmingham · Sands Stillbirth & neonatal death charity · NHS Bradford Teaching Hospitals NHS Foundation Trust · npeu National Perinatal Epidemiology Unit

Perinatal Mortality Surveillance: UK Perinatal Deaths for Births from January to December 2015

Highlighting the Key Messages for Women and Health Professionals

In June we launched the third MBRRACE-UK Perinatal Mortality Surveillance report of deaths for births from January to December 2015. As in previous reports, we have compared the rates of stillbirth and neonatal death focusing on deaths after 24 weeks of pregnancy and excluding those due to terminations of pregnancy.

Out of **782,720** births* in 2015…

3,032 stillbirths | **1,360** neonatal deaths

* of babies delivered from 24 weeks of pregnancy, excluding terminations of pregnancy

There has been an overall fall in the extended perinatal mortality rate due mainly to a fall in stillbirths from 4.20 per 1,000 births in 2013 to 3.87 in 2015, particularly those stillbirths occurring from 32 weeks of pregnancy onwards. However, there has been only a small reduction in the neonatal mortality rate from 1.84 per 1,000 births to 1.74 over the same period. In this report we have explored in further detail mortality due to congenital anomalies.

Improving our understanding – why babies die

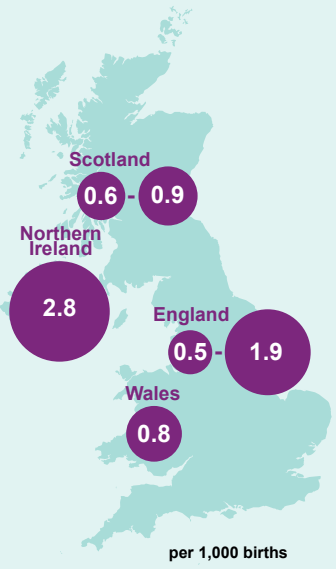
Previous reports have highlighted the number of stillbirths which are unexplained. This has fallen from 49% in 2014 to 42% in 2015. Almost one third of these unexplained stillbirths were identified as potentially having poor growth, highlighting the importance of close monitoring of fetal growth during pregnancy.

At least one in four stillbirths has a placental cause and examination of the placenta does not require parental consent. However, there has been little improvement in the number of placental investigations since 2014. They are carried out for around 89% of all stillbirths, meaning that for at least one in ten stillbirths there is no record of any detailed examination of the placenta. The report recommends placentas are sent for detailed examination if possible, in all cases.

11% of stillbirths did not have placental pathology

Over 700 babies died due to a congenital anomaly

Rates varied widely across the UK



Data by Neonatal Network (England and Scotland) and Country (Wales and Northern Ireland)

In addition, over 850 babies died at 22 and 23 weeks of pregnancy

New Developments

Local Reviews of Perinatal Deaths

One of the key recommendations from the MBRRACE-UK perinatal mortality surveillance reports is that all hospitals should carry out local reviews on every death to understand what happened, why the death occurred and how they can improve care to prevent similar deaths in the future.

PMRT
Supporting high quality local perinatal reviews

The National Perinatal Mortality Review Tool

The MBRRACE-UK collaboration along with other collaborators from Each Baby Counts, the British Association of Perinatal Medicine, the Royal College of Midwives, the PARENTS study team and the DH/ Sands Task and Finish Group have been commissioned to develop and implement the National Perinatal Mortality Review Tool (PMRT). The PMRT will be wholly integrated into the MBRRACE-UK perinatal data collection system and free to use.

The aim of the PMRT programme (***https://www.npeu.ox.ac.uk/pmrt***) is to iteratively develop, pilot and support the implementation of standardised perinatal mortality reviews across NHS maternity and neonatal units in England, Scotland and Wales. Following the principle of 'review once, review well' the tool will support:

- Systematic, multidisciplinary, high quality review of care when a stillbirth or infant death occurs;
- A structured process of review, learning, reporting and actions to improve future care;
- Active communication with parents to ensure they are told that a review of their care and that of their baby will be carried out and how they can contribute to the process;
- Reaching a clear understanding of why each baby died, accepting that this may not always be possible;
- Production of a report for parents which includes a plain English explanation of why their baby died;
- Other reports from the tool which will enable organisations providing and commissioning care to identify emerging themes across a number of deaths to support learning and changes in the delivery and commissioning of care to improve future care and prevent the future deaths which are avoidable;
- Production of national reports of the themes and trends associated with perinatal deaths to enable national lessons to be learned from the nationwide system of reviews.
- Parents whose baby has died have the greatest interest of all in the review of their baby's death. Alongside the national annual reports a lay summary of the main technical report will be written specifically for families and the wider public. This will help local NHS services and baby loss charities to help parents engage with the local review process and improvements in care.

Maternal Morbidity and Mortality Confidential Enquiries

In the December 2017 Saving Lives, Improving Mothers' Care we will report on the confidential enquiries into severe maternal morbidity focusing on women who experienced peripartum psychosis and those who were affected by severe epilepsy during pregnancy, labour and up to 42 days after delivery.

The confidential enquiries of maternal deaths in UK and the Republic of Ireland in the 2017 report will include the lessons learned from the care of women who died from: sepsis, haemorrhage, amniotic fluid embolism, anaesthesia related deaths and deaths from neurological causes. This will be alongside the findings from the surveillance of maternal mortality in the UK 2013-15.

Please note: We will shortly be requesting notes for the next two severe morbidity confidential enquiries of haemorrhage during pregnancy and breast cancer. These cases will be identified from the recent UKOSS studies of these conditions.

New Developments

Local Reviews of Perinatal Deaths

New confidential enquiry starting soon: Enhancing the Safety of Midwifery-led Birth Enquiry (ESMiE)

A new confidential enquiry (ESMiE) will be starting-up this summer. This will review intrapartum-related perinatal deaths in births planned in midwifery-led settings in England and Wales. This is closely related to the topic of this year's MBRRACE-UK perinatal confidential enquiry, but ESMiE will focus specifically on perinatal deaths that occur in births planned in midwifery units and at home. The aim of the enquiry is to find out if there were avoidable or remediable factors involved in the care provided and to use the findings to identify ways of preventing future similar deaths. The reason that a separate enquiry is needed is that some of the lessons learned from births in hospital labour wards (the majority of births in the MBRRACE-UK enquiry) may not directly apply to midwifery-led settings where women generally have to transfer if complications develop and obstetric or neonatal care is needed.

ESMiE
Enhancing the Safety of Midwifery-Led Birth Enquiry

ESMiE is funded by the Department of Health (DH) and will be undertaken by the National Perinatal Epidemiology Unit (NPEU) at the University of Oxford in collaboration with MBRRACE-UK in Leicester. The procedures for requesting case notes will be similar to the MBRRACE-UK enquiries, and ESMiE will use the same procedures as MBRRACE-UK to maintain confidentiality and to carry out the panel reviews. The only difference that will be noticeable to Trusts and Health Boards is that as a separately funded service evaluation ESMiE is able to provide reimbursement for the time involved in copying notes (£50 per case).

You can find out more about ESMiE on the NPEU website: ***https://www.npeu.ox.ac.uk/esmie***

If you have any questions please call Ian Gallimore or Caroline Ellershaw in the MBRRACE-UK office at Leicester on 0116 252 5425 or email: mbrrace-uk@npeu.ox.ac.uk

The Each Baby Counts report 2017 was published on 21st June 2017. Each Baby Counts is the RCOG's national quality improvement programme to reduce the number of babies who die or are left severely disabled as a result of incidents occurring during term labour. The report includes key recommendations on how to improve care based on analysis of the full data for 2015.

For further information go to:
www.rcog.org.uk/eachbabycounts

The National Pregnancy in Diabetes (NPID) Audit Report for 2016 is due to be released on Thursday 12th October 2017. The NPID audits the quality of care and outcomes for women with pre-gestational diabetes who become pregnant with the aim of improving services in the future. The report will be available on the following websites:

www.digital.nhs.uk/npid
www.diabetes.org.uk/About_us/News

MBRRACE-UK team

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HQIP
Healthcare Quality Improvement Partnership

The Maternal, Newborn and Infant Clinical Outcome Review programme, delivered by MBRRACE-UK, is commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England, NHS Wales, the Health and Social care division of the Scottish government, the Northern Ireland Department of Health, Social Services and Public Safety (DHSSPS), the States of Jersey, Guernsey, and the Isle of Man.

The National Perinatal Mortality Review Tool is commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of the Department of Health (England), NHS Wales and the Health and Social Care Division of the Scottish Government.