



## Perinatal Mortality Surveillance Report

### UK Perinatal Deaths for Births from January to December 2015

## Understanding what we do and why?

Frequently Asked Questions to inform parents, families and the general public

### 1. Why do you report by Commissioning Organisations, Trusts and Health Boards, Neonatal Networks, Local Authorities, Sustainability and Transformation Plan Footprints?

The report is aimed at a variety of audiences in order to provide them with useful information for planning and delivering high quality maternity and neonatal care.

- The Commissioning Organisations in our report are responsible for buying (“commissioning”) maternity care on behalf of their local population.
- The Trusts (in England and Northern Ireland) and Health Boards (in Scotland and Wales) are responsible for delivering maternity and neonatal care for their patients. These Trusts and Health Boards are organised into larger ‘Networks’ in order to ensure that a full range of care is available to everyone.
- The Local Authorities are responsible for improving the health of their local population; including children’s public health services from pregnancy to age 5, including health visiting.
- The Sustainability and Transformation Plans are five-year plans developed by NHS providers in England in collaboration with CCGs, local authorities, and other health and social care providers, to improve quality of care, health and wellbeing, and efficiency of services based on local needs. The plans are built around forty-four areas known as the geographical ‘footprints’.
- The Neonatal Networks are groups of Trusts and Health Boards organised into larger ‘Networks’ in order to ensure that a full range of neonatal care is available to all babies.

Of course, many other people are concerned about rates of stillbirth and neonatal death around the UK, from parents who have themselves experienced the stillbirth or death of a baby, to organisations working as advocates for improving maternity and neonatal care, families and parents-to-be, as well as the general public. We hope that the information in our report is useful for everyone.

## 2. There are 3 types of deaths presented in the report. Why?

The report provides rates for stillbirths and neonatal deaths (deaths within the first 28 days of life) and also for these deaths combined; known as 'extended perinatal death'. It is useful to both commissioners of health care and healthcare professionals to know if any of these rates fail to reach either local or national targets for reduction. This is because the things that might influence higher rates of death in certain areas, and the work that health services are doing to ensure there are strategies in place to avoid preventable deaths, will be different dependent on how and when the baby died.

## 3. Which maps and tables would be most useful to look at?

As a member of the public you will probably find mortality rates by place of birth most useful. These are the mortality rates for **Trusts and Health Boards** and are shown in the maps and tables on pages **56-73** of the report.

## 4. Why isn't my local maternity unit listed in the report?

Across the UK, hospitals are organised into Trusts and Health Boards. In some cases this may be only one hospital and for others two or more. We present the data by Trusts and Health Boards, as this is how care is organised and funded.

## 5. Why do you present both "crude" and "stabilised and adjusted" mortality rates, and what do these mean?

In the MBRRACE-UK report the "crude" mortality rate is simply the number of deaths for every 1,000 births within each organisation. This is a commonly used measure for mortality and is informative, in that it describes exactly what happened for births in 2015.

However, some organisations have a high proportion of mothers in their local populations who are at particularly high risk of their baby dying before or shortly after birth. There are many reasons why some mothers are at higher risk, including for example being over the age of 40, living in poverty or being pregnant with twins or triplets. These differences in risk between different women mean that even if the care for any particular group of mothers was identical in two organisations, the organisation with the larger proportion of mothers at high risk would have the higher "crude" mortality rates.

In order to try to overcome this issue, and report a fairer comparison between health providers, we report "stabilised & adjusted" mortality rates as well as the crude rate. This stabilisation and adjustment, as far as is possible, takes into account such differences between populations.

## **6. Why do the number of deaths in the MBRRACE-UK report not match those in official government publications?**

Official government publications include all legally registered deaths. In the MBRRACE-UK report we have not included any of the deaths occurring before 24 weeks of pregnancy in the main tables and maps in chapters 3, 4 and 5 and the appendices, or any deaths as a result of a medical termination of pregnancy.

## **7. What does it mean if my Trust or Health Board has a red dot?**

If your Trusts or Health Board has a red dot this does not necessarily mean that they are providing poor quality care. It may reflect the high risk women delivering in their hospital and the higher risk babies they are caring for. However, if a Trust or Health Board has been allocated a red dot in the report, we recommend they look in detail at all of the deaths – this is called a local ‘review’ – to understand why their mortality rate is more than 10% higher than other similar Trusts and Health Boards.

## **8. Why is the cause of death for so many babies classified as “unknown”?**

Many stillbirths and neonatal deaths happen when the pregnancy was considered to be “low risk” and there were no indications before the baby was born that the baby might die. In these situations, it can be difficult to give an exact cause for the baby’s death without further detailed information, such as examining the placenta and/or a post-mortem. Even after detailed tests the cause of death for many stillbirths remains unknown.

## **9. What are the benefits of examination of the placenta by a specialist pathologist?**

The detailed examination of the placenta by a specialist pathologist might answer important questions about the cause of death and means that care for the mother in any future pregnancy can be better targeted at any issues she may have. The examination might highlight whether the blood flow to the baby was poor, for example, or whether there were any problems with the umbilical cord, or whether infection contributed to the baby’s death.

## **10. Why should I consider consenting to a post-mortem examination for my baby?**

While examination of the placenta can provide important information it does not give as much detail as a full post-mortem examination. The idea of consenting to a post-mortem on your baby and understanding what this entails, at such a difficult time, can be

distressing. However, the information you will receive from a post-mortem can help confirm a diagnosis about why your baby died, change a diagnosis, or provide new information even if the diagnosis is already known. It may also help health professionals in thinking about how any future pregnancy you may want to plan might be managed. Information about why some babies die is also helpful in helping health service providers understand how to look after certain women and their babies in the future, to prevent deaths. For more information please follow the link to the Sands leaflet “Deciding on a post-mortem”:

<https://www.uk-sands.org/support/practical-information/deciding-on-a-post-mortem>