MBRRACE-UK
Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK
MARCH 2018 NEWSLETTER 16

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

MBRRACE-UK Perinatal Report Launch Meeting

The Studio - Birmingham
15th June 2018

At this meeting we will:

Launch the findings of the national Perinatal Mortality Surveillance for Births in 2016

Launch a HealthTalk website exploring parents' lived experiences of losing a baby between 20 and 24 weeks of pregnancy

Provide an update on the national Perinatal Mortality Review Tool

and

The SPiRE study team will present preliminary findings from the Stillbirth Care Bundle evaluation

There will be an opportunity for delegates to present a poster covering local, regional or national activities in relation to reducing stillbirths and neonatal deaths. Please submit any abstracts covering the following topics:

- Prevention and management of risk factors;
- Activities to reduce perinatal deaths including perinatal mortality reviews;
- Implementation of the stillbirth care bundle;
- Activities to support bereaved parents;
- Sharing good practice;
- Any other related topic.

Early Bird bookings are available until 3rd May 2018
Medically qualified delegates: £120 per person
Midwives, nurses, students, researchers, voluntary sector: £80 per person

Full price bookings will be from 4th May 2018 until 1st June 2018:
Medically qualified delegates: £140 per person
Midwives, nurses, students, researchers, voluntary sector: £100 per person

Prices include the registration, refreshments, lunch and a summary copy of the Surveillance report

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

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 national Perinatal Mortality Review Tool (PMRT) was launched in January and is freely available to all Trusts and Health Boards in England, Wales and Scotland. The PMRT is wholly integrated into the bespoke, web-based MBRRACE-UK system. Whilst there is some overlap in the questions presented in the PMRT and the surveillance data, this is limited and **Trusts/Health Board need to continue to complete the surveillance data** even when they are reviewing all their perinatal deaths eligible for surveillance using the PMRT.

The PMRT has been designed to support local perinatal mortality review groups to conduct systematic, standardised perinatal reviews of all stillbirths and neonatal deaths of babies born at 22+0 week onwards and babies who die in the post-neonatal period having received neonatal care. The PMRT has been designed with user and parent involvement and includes the capacity to incorporate the parents' perspectives of their care to ensure these are considered in the review process. More information and support for implementation is available at ***https://www.npeu.ox.ac.uk/pmrt***

Following the principle of 'review once, review well' the tool supports:

- Systematic, multidisciplinary, high quality review of care when a stillbirth or neonatal death occurs;
- A structured process of review, learning, reporting and development of 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 to ensure that their perspectives' of their care are considered in the review process;
- Reaching a clear understanding of why each baby died, accepting that this may not always be possible;
- Production of a report of the review.

In addition to reports of the review of the care for individual babies who die, the PMRT will also generate reports for hospitals to consider at Board level and reports for other organisations involved in providing and commissioning care. These will enable organisations to identify themes across a number of deaths to support learning and system level changes in the delivery and commissioning of services to improve future care and prevent future deaths which are avoidable. We are working with PMRT users to ensure that these reports provide the information that they need to support service improvements and commissioning.

The vast majority of Trusts and Health Boards have registered to use the PMRT and over half have started at least one review. In England, Trusts that are able to demonstrate compliance with 10 criteria announced by the Secretary of State in November will be entitled to at least a 10% reduction in their CNST maternity contribution. The first of these criteria is the use of the national PMRT to review perinatal deaths.

We recognise that implementation is a learning curve and welcome feedback as to how we can improve the tool and develop it to work better for you: ***mbrrace.support@npeu.ox.ac.uk***

Royal College of Obstetricians & Gynaecologists · each baby COUNTS · MANCHESTER 1824 The University of Manchester · PARENTS · University of BRISTOL · THE ROYAL COLLEGE OF MIDWIVES · NHS Birmingham Women's and Children's NHS Foundation Trust · British Association of Perinatal Medicine

HQIP · UNIVERSITY OF LEICESTER · TIMMS · UNIVERSITY OF BIRMINGHAM · Sands Stillbirth & neonatal death charity · NHS Bradford Teaching Hospitals NHS Foundation Trust · NPEU · UNIVERSITY OF OXFORD

Saving Lives, Improving Mothers' Care – Confidential Enquiry into Maternal Morbidity and Mortality

Report launch – date for your diary
1st November 2018
Birmingham

We will be launching the 2018 report of the surveillance and confidential enquiries into maternal deaths and serious maternal morbidity later this year. In this years' report, as well as the annual surveillance figures, the confidential enquiries cover: deaths from psychiatric causes, deaths due to thrombosis and thromboembolism, late and coincidental deaths. Lessons to prevent future maternal morbidity and mortality will also come from the morbidity enquiry into massive obstetric haemorrhage.

Call for Maternal Enquiries Assessors

We are just starting work on the upcoming maternal morbidity enquiry into breast cancer in pregnancy. We are keen to recruit oncologists to assess the oncology care given to this group of women during and after pregnancy. Please can you let us know about any local oncologist you know who would be interested in participating in this confidential enquiry: ***mbrrace-uk@npeu.ox.ac.uk***

We are also keen to recruit new physician assessors in any field relevant to maternity care but in particular physicians whose expertise covers the main causes of maternal death: malignancy, cardiac, neurological, infectious diseases, or those with a focus on acute or obstetric medicine.

Perinatal Deaths 2017 – Case Chasing

Perinatal case chasing for the perinatal deaths to births in 2017 is underway. We are able to identify missing deaths from routine sources of data and currently estimate that there were nearly 480 perinatal deaths up to September 2017 which have not yet been reported to us through the MBRRACE-UK perinatal mortality surveillance system.

If you are an MBRRACE-UK reporter and your Trust/Health Board has not submitted information about all your perinatal deaths for births up to September 2017, a list of potential missing cases will have appeared in your traffic light list on the MBRRACE-UK system. Please check these cases to identify any deaths which are not eligible for MBRRACE-UK surveillance, deaths which you have already reported (duplicates) to us, and any eligible deaths which you have not yet reported. Please let us know about the first of these two and then complete the surveillance information for those deaths which are eligible that you have not yet reported.

It is essential that all eligible deaths are reported and we have complete information about each case as this forms the basis of all the analysis that we do and if deaths are missed it will affect the perinatal mortality rates which we report both nationally and locally.

Updates

Enhancing the Safety of Midwifery-led birth Enquiry (ESMiE)

The new ESMiE confidential enquiry of term intrapartum stillbirths and intrapartum related neonatal deaths is well underway. We have run seven enquiry panels, with five more planned, and to date have reviewed 36 perinatal deaths where the onset of care in labour was in a midwifery led setting: at home, in a freestanding or an alongside midwifery unit. This enquiry follows on from the main MBRRACE-UK report published in November last year. 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 main 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. The procedures for requesting case notes is similar to the MBRRACE-UK enquiries, and ESMiE will use the same processes as MBRRACE-UK to maintain confidentiality and to carry out the panel reviews.

ESMiE Enhancing the Safety of Midwifery-Led Birth Enquiry

More information is available at: ***https://www.npeu.ox.ac.uk/esmie*** and ***https://www.npeu.ox.ac.uk/mbrrace-uk/research/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: ***mbrracele@npeu.ox.ac.uk***

each baby COUNTS

Joint NMPA and EBC launch – save the date – 15th November 2018

NMPA National Maternity & Perinatal Audit

A joint launch meeting for the National Maternal and Perinatal Audit and Each Baby Counts will be held in London on the 15th November 2018. Bookings will open shortly. In the meantime you can sign up for the newsletters at:

Each Baby Counts: ***http://dotmailer-surveys.com/9715n0df-25xs887***

National Maternity and Perinatal Audit: ***http://r1.dotmailer-surveys.com/9715n0df-c726gx01***

National Pregnancy in Diabetes Audit

The National Pregnancy in Diabetes (NPID) audit is currently collecting data for all 2018 pregnancies (Jan – Dec 2018). There is no report in 2018 with the next report in 2019 covering pregnancies for 2017 and 2018. New measures will be introduced on NHS choices in 2019 that will show the Trusts that are outliers for the audit in the form of a composite measure. The exact content is yet to be finalised but NHS Digital will be sending more information out soon on how this will look and what you can do to ensure that your service is not an outlier.

NHS Digital

If you have any questions contact: Carla Howgate, NPID Audit Manager or Andrew Whitehead, NPID Audit Coordinator: ***npid@nhs.net***

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, 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.