MBRRACE-UK
Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK
FEBRUARY 2016 NEWSLETTER 10

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

MBRRACE-UK Perinatal Mortality Surveillance Report for 2014 Births

The report will be launched at the **Royal College of Obstetricians and Gynaecologists, London**

Tuesday 17 May 2016

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

Enquiries and abstract submissions to: **Faye Anderton**
Email: *conference@npeu.ox.ac.uk* **Tel:** 01865 289710.

This year we have a call for abstracts describing local, regional or national activities in relation to reducing stillbirths and neonatal deaths which deal with any of the following:

Prevention and Management of Risk Factors

Local Activities to Reduce Perinatal Deaths including Reviewing Cases

Local Activities to Support Bereaved Parents

Sharing Good Practice

Five of the abstracts will be selected for a '5 slides 10 minute' oral platform presentation (the five presenters selected will be given **a free place at the meeting**). Other abstracts will be selected for poster presentation.

Two prizes will be presented, one each for the oral presentations and the poster presentations.

We have also introduced **Early Bird booking which will close on 31st March 2016.**

The Early Bird prices will be:

Medically qualified delegates:	£120 per person
Midwives, nurses, students, researchers, voluntary sector:	£80 per person

Full price booking will be from 1st April to 10th May 2016:

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

Abstract submission closing date: 1st March 2016

Perinatal Mortality Surveillance update

The upcoming MBRRACE-UK Perinatal Mortality Surveillance Report for 2014 Births – for publication in May 2016

In order for the information in the report to be as accurate as possible, we will provide you with an opportunity to review the data for your organisation prior to its inclusion in the report. **In early February Lead Reporters will be provided with a summary of the information we have on the births in 2014 which occurred in their organisation and the associated perinatal deaths reported to MBRRACE-UK**. This information will be accessible through the MBRRACE-UK online reporting system. A clickable list of MBRRACE Case IDs for these deaths will be available to help you review the information which will be included in the MBRRACE-UK Perinatal Mortality Surveillance Report.

The MBRRACE-UK Perinatal Mortality Surveillance Report for births in 2014 will include mortality rates reported at national, regional, and Trust and Health Board level. Reports for individual Trusts and Health Boards will be accessible to registered reporters via the MBRRACE-UK online reporting system **a week before the national MBRRACE-UK Perinatal Mortality Surveillance Report is launched on 17 May.**

New additions to help you with data entry……

Some local reporters use a paper version of the online data collection form which can be used to collect data from the medical case notes in the clinical setting. A new PDF version incorporating all of the recent changes is available to download and print from the FAQs section of the MBRRACE-UK website

https://www.npeu.ox.ac.uk/mbrrace-uk/faqs

The MBRRACE-UK on-line reporting system allows you to access information relating to local cases from the 'Perinatal and Infant Death' home screen. In addition to the 'traffic light' lists, case list summaries and overview counts can be accessed by clicking on 'Reports'. A new feature has been added to sort all of these lists by clicking on the list heading. Clicking on the same heading again, changes the order between ascending and descending. You can use this to find cases from a particular year, or from a particular hospital, or to distinguish between cases of stillbirth or neonatal death.

The next perinatal confidential enquiry will be……

Intrapartum stillbirths and intrapartum related neonatal deaths (up to 28 days after birth)

We are currently recruiting members for our Topic Expert Group and also members for our case review panels for the enquiry. If you would like to participate please contact your professional organisation:

RCM/RCOG/NNA/BAPM/BMFMS/BRIPPA

who will forward nominations to the MBRRACE-UK perinatal team.

Highlighting Lessons for Antenatal Care

from the Confidential Enquiry into Term, Singleton, Normally-formed Antepartum Stillbirth

Missed Opportunity: Developing Diabetes in Pregnancy

- Glucose tolerance testing not offered in cases with an identified risk factor and so there was no opportunity for closer monitoring

Recommendation:

All Units should implement national guidance for the identification and screening of women at risk of developing gestational diabetes.

Missed Opportunity: Monitoring Growth

- Woman's abdomen not measured to check how her baby was growing
- Measurements not plotted on a graph
- Woman not referred for closer monitoring when the baby's growth didn't follow a normal pattern

Recommendation:

All Units should implement national guidance regarding the routine monitoring of growth by symphysis fundal height measurement and plotting the results at each antenatal appointment from 24 weeks' gestational age onward.

Missed Opportunity: Identifying Reduced Fetal Movements

- Not investigating when a woman presents with concerns about her baby's movements
- Misinterpreting the fetal heart trace
- Not responding appropriately to additional risk factors, including the woman returning with further concerns about her baby's movements

Recommendation:

All Units should implement national guidance regarding the management of reduced fetal movements and the identification of additional risk factors.

Missed opportunity: Learning lessons from local case review

- No evidence of a local review having been carried out for three quarters of stillbirths
- Where a review was conducted very few followed national guidance or involved the parents' view of care

Recommendation:

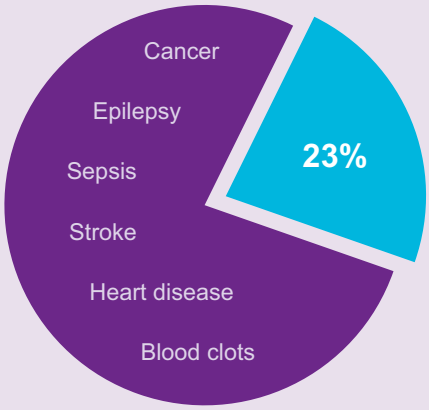
All Units should conduct multidisciplinary review of ALL term stillbirths following the standards recommended by the Department of Health and Sands Task and Finish group.

Copies of the full report, lay summary and infographic can be downloaded from:
https://www.npeu.ox.ac.uk/mbrrace-uk/reports

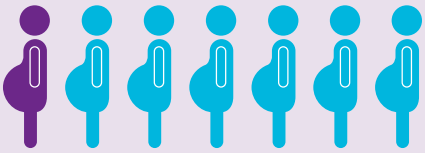
Highlighting Lessons for Maternal Care

from Saving Lives, Improving Mothers' Care 2015

Mental health matters



Almost **a quarter** of women who died between six weeks and one year after pregnancy died from **mental-health related causes**



1 in 7 women died by **Suicide**

Severe Maternal Mental Illness

Red flag signs for severe maternal mental illness requiring urgent senior psychiatric review:

- New thoughts of violent self harm
- Sudden onset or rapidly worsening mental symptoms
- Persistent feelings of estrangement from their baby

The treatment of cancer in pregnancy

- In most circumstances, pregnant women with cancer should be treated in the same way as women who are not pregnant
- Treatment for cancer does not usually require early delivery

Venous thromboembolism

- All women should undergo documented risk assessment in early pregnancy or pre-pregnancy
- This should be repeated intrapartum or postpartum
- Women should be discharged home with the full postnatal course of low molecular weight heparin (LMWH)

Domestic abuse

- Staff need to be alert to the signs of domestic abuse
- Women should be given the opportunity to talk about domestic abuse in a secure environment
- Staff should be aware of local pathways of care once domestic abuse has been disclosed

Copies of the full report, lay summary and infographic can be downloaded from:
https://www.npeu.ox.ac.uk/mbrrace-uk/reports

MBRRACE-UK team

E: mbrrace-uk@npeu.ox.ac.uk

T: 01865 289715 (Maternal Team, Oxford) **T:** 0116 252 5425 (Perinatal Team, Leicester)

www.npeu.ox.ac.uk/mbrrace-uk

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.