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

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

## Perinatal Mortality Surveillance Update

Summer is now well and truly underway and after the successful launch of the Perinatal Mortality Surveillance Report for babies born in 2014, we are now turning our attention to the data for births in **2015** in preparation for the closure of the database on **Monday 3rd October 2016**. As in previous years, we will soon start the countdown to the deadline for reporting perinatal deaths, when reminders will be sent weekly to the lead reporter(s) for your Trust/Health Board.

We would like to encourage all MBRRACE-UK registered reporters to check as soon as possible that all perinatal deaths for 2015 have been reported for their organisation. In particular please ensure that all births at 22 and 23 weeks of gestation in 2015 who were not alive at birth or who did not survive the neonatal period have been reported to MBRRACE-UK. This is vital so that all UK perinatal deaths from 22 weeks of gestation onwards can be included in next year's perinatal mortality surveillance report.

In addition you should ensure that there are no deaths that have been reported to MBRRACE more than once. There are various reasons why duplicate cases arise and if you identify such entries please let us know the MBRRACE-UK ID number of the record which is to **remain** and the MBRRACE-UK ID number of the record to be **removed** and **why** either by emailing ***mbrracele@npeu.ox.ac.uk*** or telephoning 0116 252 5425.

It is also important that all cases are completed and closed. Where the information about individual cases on the system is incomplete this is sometimes the result of additional clinical information being required from another Trust/Health Board. In these circumstances please use the case assignment facility to assign the case to the lead reporter in the relevant Trust/Health Board. The MBRRACE-UK team will be happy to assist you with this process if necessary. If you have already assigned a case to another Trust /Health Board and you are waiting for the data to be completed and the case reassigned to your Trust/Health Board, the MBRRACE-UK team can help you. Again please contact us either by email at ***mbrracele@npeu.ox.ac.uk*** or telephone 0116 252 5425. Another common reason for cases being classified as incomplete is the delay before hospital post-mortem or coroner/procurator fiscal reports are available. In these circumstances please close the case and then update the data on the MBRRACE-UK system once the additional information becomes available.

Please don't forget that all perinatal deaths for babies born in 2016 should be reported **within 3 months of the death occurring**, or as soon as possible.

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

# Launch of the Perinatal Mortality Surveillance Report – May 2016

Around 250 midwives, consultants, other health professionals, academics and representatives from the charitable sector attended our Perinatal Mortality Surveillance Report Launch event on May 17th at the Royal College of Obstetricians & Gynaecologists in London.

The meeting was opened by Ben Gummer, Parliamentary Under-Secretary of State for Care Quality, who later tweeted:

Ben Gummer @ben4ipswich May 17

Important ***@mbrrace*** report shows tackling variation is key to ensuring ***#NHSMaternity*** is world-leading + far fewer families lose a loved one.

For the first time we introduced a poster session at the meeting designed to highlight the range of local, regional and national initiatives towards to reducing stillbirths and neonatal deaths and for providing high quality care when these occur. We received over 60 abstracts and shortlisted 34 for display. The sheer popularity of the session combined with the number of poster boards did mean that the rooms were a little crowded – we're sorry if it felt a little claustrophobic!

The majority of attendees took the opportunity to walk round and view the posters and the feed-back comments from delegates were extremely positive. Five abstracts were also selected for a '5-slide 10 minute platform presentation'. The presentations were of exceptional quality and from our evaluation findings were extremely well received by delegates.

**Prizes were awarded to:**

Danya Bakhbakhi, C Storey, C Burden, F Jones, F Yoward, D Siassakos, North Bristol NHS Trust and the University of Bristol. "Parents' Active Role & ENgagement in Their Stillbirth/Perinatal death review (PARENTS Study)." (Platform presentation prize).

Katy Evans Mary Gardner, Diana Downs, Melanie Robson, Julie Harland, Debra Young & Sally Bryant, Taunton "Making Stillbirths Count." (Poster prize).

Tracey J Glanville, Agnes D K Woodhouse, Leeds teaching Hospital Trust. "Reducing stillbirth by 60% In Leeds - Working as a multidisciplinary team." (Poster prize).

Sam Collinge, University Hospitals Coventry & Warwickshire NHS Trust. "Forever Photos – implementing a sensitive photography service in maternity." (Highly commended poster)

Wendy Oakley, Katharina Anwar, Burton Hospital NHS Foundation Trust. "The impact on a DGH stillbirth rate of implementing from 2011 measures subsequently recommended in the 2015 MBRRACE-UK report into antepartum stillbirths." (Highly commended poster)

Claire Worthington, Jo Macleod, Kate Rosati, Royal Surrey County Hospital. "Bobble hat care bundle." (Highly commended poster)

Professor Jenny Kurinczuk summed up the day by saying "The report has been exceptionally well received and it is clear from what the Minister said in his opening address that it is having an impact at the highest level in government. From the presentations during the day and the poster on display it is also clear that the findings are having an impact at the grass roots - we can ask for nothing more. This has all been possible because of the dedication of everyone who works providing data to MBRRACE-UK directly, indirectly or helping out; for this we are most grateful."

# Sharing practice

To continue the sharing of practice for the launch meeting in May we have uploaded copies of the posters on our website at: ***https://www.npeu.ox.ac.uk/mbrrace-uk/sharing-practice***

The presentations from the meeting, including the submitted platform presentations, are also available on the website at: ***https://www.npeu.ox.ac.uk/mbrrace-uk/presentations***

So that more people can access information about the local work which was highlighted at the launch meeting we have asked the authors whose abstracts were chosen for a platform presentation or whose poster won a prize to write a short article describing their work. The first one is included here and further articles will be included in subsequent newsletters.

**Use of an integrated care pathway for families who experience a stillbirth. Greater Manchester, Lancashire and South Cumbria Strategic Clinical Network (SCN) Special Interest Group into Stillbirth**


For women and families who experience intra-uterine fetal death and stillbirth, several reports in the last few years have noted that poor or insensitive care adds significantly to parents' distress. Good care should be universal and should not depend on where a mother happens to live or is cared for. A multi-professional group was convened in 2012 in the North West of England to address this goal. We aimed to enable optimal management of stillbirth, reduce variation in care across the strategic clinical network (SCN) footprint, ensure evidenced based best practice, standardise investigations and co-ordinate compassionate, holistic and patient focused care.

An integrated care pathway (ICP) for management was produced, supported by a clinical guideline. These were largely based on the RCOG Greentop Guideline No 55.

The ICP and guideline has been implemented in all 13 obstetric units in the footprint of the SCN and was positively received by staff. An audit of care was performed prior to and following the introduction of the ICP. Implementation of the pathway has been shown to improve provision of clinical care, notably induction of labour has changed from diverse regimes to a single standard regime and information is given to parents more consistently.

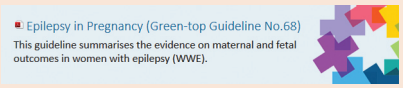
The ICP and clinical guideline have enabled care for bereaved families to be standardised and improved in our SCN. There has been refinement of these documents with version 2 ICP and guideline now being used. If NHS Maternity Units consider this may assist their care the group are willing to share their documentation.

Contacts:
**John Tomlinson:** *John.Tomlinson@boltonft.nhs.uk* **Joanne Langton:** *Joanne.Langton@nhs.net*

## New guideline and advice for women with epilepsy in pregnancy

In June 2016 the RCOG released the Epilepsy in Pregnancy (Green-top Guideline No.68):

***https://www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg68/***




At the same time they released a leaflet which provides advice for women on epilepsy in pregnancy:

***https://www.rcog.org.uk/en/patients/patient-leaflets/epilepsy-in-pregnancy/***


## Sepsis in pregnancy toolkits

In July 2016 the UK Sepsis Trust released six new clinical toolkits specific to sepsis in pregnancy and the postpartum period These are available to download at: ***ow.ly/pxIX302c4uG*** The toolkits are for maternal sepsis telephone triage, community midwives, ambulance services, GPs, ED/AMU as well as in hospital.

# Maternal mortality and confidential enquiries update

### Maternal Morbidity Confidential Enquiry 2017 – Postpartum Psychosis

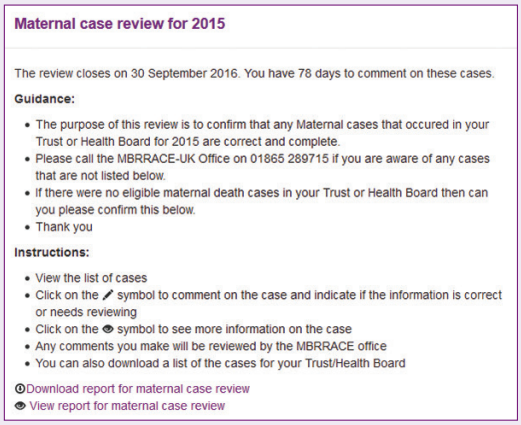
One of the aspects of the MBRRACE-UK work involves carrying out a series of topic-specific confidential enquiries into severe maternal morbidity and postpartum psychosis was a topic chosen for inclusion in the 2017 maternal report. A random sample of women with postpartum psychosis has been selected for confidential review.

The team in Oxford office, led by Marketa Laube, has started contacting Maternity Units where these cases occurred, asking them to provide us with copies of the case records and details of the local clinicians involved in the women's care. You will only be contacted if a case has been selected from your hospital and we will be in touch in the next three months. As part of the data collection process for this enquiry we will also contact Mental Health Trusts and GP practices to provide us with relevant medical records for review.

All the information received will be collated, fully anonymised, and subject to expert review using the same methodology as for the maternal deaths. The results will be published in the 2017 report.

### Electronic case ascertainment for 2015 maternal deaths

In summer 2016, Marketa and her team in Oxford will also start contacting all Trusts/Health Boards to confirm the ascertainment of all maternal deaths that occurred in 2015 across the UK. In previous years this was done using a paper form, however, this year the annual case review of maternal deaths will be carried out electronically using the MBRRACE-UK reporting website accessible at ***https://www.mbrrace.ox.ac.uk***




All users registered on the MBRRACE-UK online system as 'Maternal Leads' will have access to their Trust's cases and will be able to confirm and/or flag cases to us. You will receive an email with instructions and details on how to register and access the website. If you are not yet registered on the MBRRACE-UK online system and would like to be or you want to make sure you have the correct user profile, please contact the Oxford Office by phone or email and we will be happy to assist you.

We also urge all Units that have had deaths not yet notified to contact the Oxford MBRRACE-UK office on 01865 289715 to report a maternal death. Please remember to report every maternal death within 7 days from the incident and to return the surveillance form and copies of all the case notes within 21 days from notification.

**SAVE THE DATES: MBRRACE-UK Saving Lives, Improving Mothers' Care Report Launch 2016**

**Wednesday 7th December – Royal College of Obstetricians & Gynaecologists, London**

**Friday 9th December – Royal College of Physicians & Surgeons, Glasgow**

To register your interest, please contact Faye Anderton ***conference@npeu.ox.ac.uk*** or keep an eye on our website ***www.npeu.ox.ac.uk/mbrrace-uk/bookings*** **Earlybird bookings is now open.**


**MBRRACE-UK team**

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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.