MBRRACE-UK
Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK
SEPTEMBER 2016 NEWSLETTER 12

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

Saving Lives, Improving Mothers' Care

Surveillance of maternal deaths in the UK 2012-2014 and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-2014

This report will be launched at

Royal College of Obstetricians and Gynaecologists, London
Wednesday 7th December 2016

and

Royal College of Physicians and Surgeons of Glasgow
Friday 9th December 2016

The topics covered in this report include: Cardiac disease, pre-eclampsia, early pregnancy deaths and lessons for intensive care. There will also be updates at the meeting on sepsis and epilepsy.

To register follow the link from: ***https://www.npeu.ox.ac.uk/mbrrace-uk/bookings***
Enquiries to: **Faye Anderton**
Email: ***conference@npeu.ox.ac.uk***
Tel: 01865 289710

Early bird booking will close on 12th October 2016:

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

Full price bookings will be from 13th October until 30th November:

Medically qualified delegates:	£140 per person
Midwives, nurses, students, researchers, voluntary sector:	£100 per person

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

Perinatal mortality surveillance

With the successful launch of the most recent Perinatal Mortality Surveillance Report in May, 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**.

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.

Please can you also check if you have any deaths that have been reported to MBRRACE more than once (duplicates); if you identify any duplicate entries please let us know the MBRRACE-UK ID number of the record which is to remain and the ID number of the record to be removed either by emailing ***mbrracele@npeu.ox.ac.uk*** or phoning 0116 252 5425.

It is also important that all cases are completed and closed. If you need information from another Trust/ Health Board please use the case assignment facility to assign the case to the lead reporter in the relevant Trust/Health Board. If you have already assigned a case to another Trust /Health Board and are waiting for the data to be completed and the case reassigned to your Trust/Health Board, the MBRRACE-UK team can help you. 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.

If you need any help please contact us by email at: ***mbrracele@npeu.ox.ac.uk*** or telephone: 0116 252 5425.

Maternal Confidential Enquiries Update

Call for topic proposals for the 'maternal morbidity' confidential enquiry in 2018 – now open

As part of the maternal confidential enquiries we undertake maternal 'morbidity' confidential enquiries as a rolling programme of selected topics.

We would like to invite new topic proposals from individuals and organisations for the maternal morbidity confidential enquiry which will run during 2018 and report in 2019. This invitation will be open from now until 31st December 2016. For more information about how to propose a topic go to: ***https://www.npeu.ox.ac.uk/mbrrace-uk/topic-proposals***

Electronic case ascertainment for 2015 maternal deaths

We shall shortly be 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 that the Maternal Trust Leads completed and sent to the Oxford office by post, 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 Information about how to use the system to check all your maternal deaths will follow shortly.

Sharing practice

To continue the sharing of practice from the Perinatal Mortality Surveillance 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 article was included in the July newsletter number 11: ***https://www.npeu.ox.ac.uk/mbrrace-uk/newsletters*** and further articles will be included in subsequent newsletters.

The impact on a DGH stillbirth rate of implementing from 2011 measures subsequently recommended in the 2015 MBRRACE-UK report on antepartum stillbirths

Burton Stillbirth Review Group, Burton Hospitals NHS Foundation Trust

Burton Hospital is a DGH with currently around 3,500 deliveries/year. Our stillbirth rate almost doubled between 2007 and 2010. A proactive approach to investigating potential causes for this enabled us to identify the following key themes, all of which were subsequently described in the 2015 term antepartum stillbirth report, and find local solutions to improve outcome:

- Absent/inadequate management plans – a new antenatal booking referral form which clearly identifies risk factors has helped us prioritise consultant review and ensure that all women meeting NICE criteria for screening for diabetes in pregnancy have GTT appointment/s made at the time of their dating scan.
- Poor antenatal detection of SGA fetuses – in addition to longstanding use of customised growth charts we now continue serial scans (every 3-4 weeks) for high risk women until 39+ weeks, and offer growth scans to women with biometry below 5th centile at their anomaly scan. We currently detect 40% babies born SGA antenatally, one of the highest rates in the UK.
- Reduced fetal movements (RFM) – we stress to all women the importance of reporting RFM promptly, facilitated by multilingual advice stickers, and have a comprehensive care pathway for women with RFM including strict criteria for appropriate medical review and a low threshold for delivery at term. This has led to an increase in our induction rate but no significant increase in our caesarean section rate.

Since 2011, we have carried out a multidisciplinary case review for every stillbirth, with lessons learned disseminated widely. We believe that the above actions have all contributed to the sustained fall we have seen in our stillbirth rate over the last 4 years, to a level well below the UK average.

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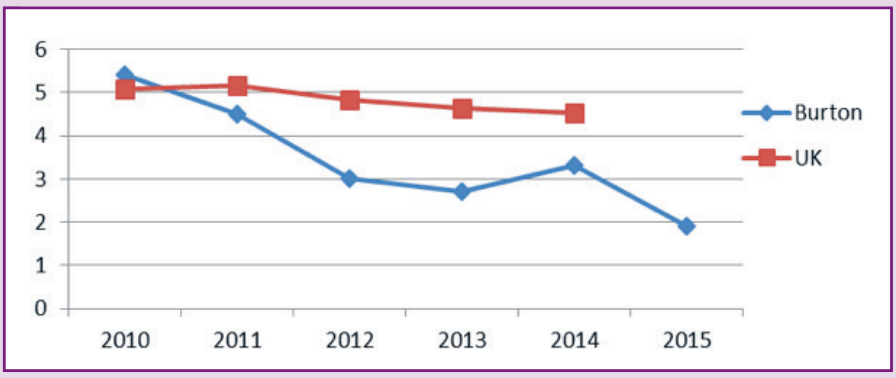

Stillbirth Rate per 1000 births in Burton and UK 2010-2015

Sharing practice

The GooD (General ownership of Diabetes) pregnancy guide

Basildon and Thurrock University Hospitals NHS Foundation Trust

Inspiration: A rising prevalence of gestational diabetes outstripped the capacity of our specialist clinics, causing our diabetes related perinatal mortality to peak in 2013. The need for a cost effective solution fuelled a vision for basic management of diabetes to become an integral component of core working skills for all maternity staff.

Innovation: A new shared care framework that features a service 'hub' of Midwife Led Diabetes Telephone clinics (tele-clinics), enabling safe transfer of certain aspects of care to standard antenatal clinics, including community based clinics. Other components include raising public and provider awareness, patient group sessions and newly developed decision support aids.

Benefit: Improved operational efficiency and sustainability through partnership evidenced by: a 60% reduction in the number of overbooked specialist clinics, no diabetes related perinatal deaths since November 2014, 40% reduction in macrosomia rate, improved user satisfaction and increase in staff confidence, despite further increases in total case load by 17%.

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Forever Photos: Implementing a sensitive photography service in maternity

University Hospitals Coventry and Warwickshire NHS Trust

Perinatal loss is a unique type of loss in that there are very few, if any tangible memories of the baby. Staff can play a vital part in helping parents to create positive memories by offering physical keepsakes of their baby and creating opportunities to interact. Studies have shown that not having the opportunity to create memories and to keep mementos is associated with higher levels of stress and anxiety in parents in the future.

Purpose: As many parents will cherish and treasure photographs that are taken of their baby for the rest of their lives, and these photographs can make a contribution to how they come to terms with their loss, the quality of the photographs is extremely important.

Goal: In recognition of the significance tangible memories have in supporting families coming to terms with their loss over a lifetime, I developed the 'Forever Photos' project. Forever Photos is a package of initiatives that aims to give midwives the skills and confidence they need to provide parents with a range of high quality photos of their baby that are sensitive and meaningful.

Benefits: The project involves a workshop using dolls and props which allows the midwives to practice taking photos in acted out role play. This gives them the skills and confidence to know that they can do this in a real setting. We have so far trained 40 midwives who have become 'Memory Makers' and are on hand to support staff who have not yet had the training. Evaluation of the training has demonstrated that Midwives' confidence in suggesting poses has increased along with an increase in confidence about the use of props, in arranging shots for photographic effects and in initiating discussion with parents on the value of mementoes.




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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.