MBRRACE-UK
Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK
FEBRUARY 2017 NEWSLETTER 13

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

Perinatal Mortality Surveillance Report

MBRRACE-UK Perinatal Mortality Surveillance Report
– UK Perinatal Deaths for Births from January to December 2015

This report will be launched at the

Royal College of Obstetricians and Gynaecologists, London
Wednesday 17th May 2017

We are calling for abstracts describing local, regional or national activities from any organisation 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

Up to 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.
Early Bird bookings are available – these will close on 24th March 2017

The Early Bird prices are:
Medically qualified delegates: £120 per person
Midwives, nurses, students, researchers, voluntary sector: £80 per person

Full price booking will be from 25th March to 7th May 2017:
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

To register follow the link from: ***https://www.npeu.ox.ac.uk/mbrrace-uk/bookings***
Enquiries and abstract submissions to: **Dagmar Hutt**
Email: ***conference@npeu.ox.ac.uk*** Tel: 01865 617909
Abstract submission forms are also available on the booking page.

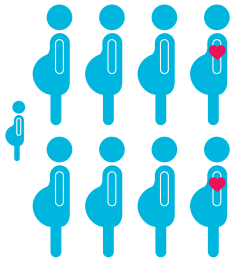
UNIVERSITY OF OXFORD · HQIP Healthcare Quality Improvement Partnership · UNIVERSITY OF LEICESTER · TIMMS · UNIVERSITY OF BIRMINGHAM · Sands Stillbirth & neonatal death charity · NHS Bradford Teaching Hospitals NHS Foundation Trust · npeu National Perinatal Epidemiology Unit

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

Highlighting the Key Messages for women and health professionals

In December we launched the third 'MBRRACE-UK Saving Lives, Improving Mothers' Care' annual report. This report completes the three reports dealing with all the causes of maternal death that would previously have been reported in a single triennial report. We also reported the findings of the confidential enquiry into severe morbidity which reviewed the care of pregnant women with a mechanical heart valve replacement.



8.5 **women** per 100,000 died during pregnancy or up to six weeks after giving birth or the end of pregnancy in 2012 - 14

2 **women** per 100,000 died from **heart** ♥ **disease**

Women known to have **heart disease** are **high risk** and need specialist care

"Red Flag" symptoms which may mean heart disease

- Breathlessness, so you can't lie down, or your breathing is difficult or unusual even when sitting at rest
- Band-like squeezing or a sensation of pressure in your chest, which
  - spreads to your jaw, arm, back or between your shoulder blades
  - makes you nauseous and sweaty

Ectopic pregnancy

You may not realise you are pregnant, so check if you might be pregnant with a pregnancy test.

Look out for symptoms:

- vaginal bleeding that's different from a normal bleed
- pain low in the stomach (abdomen), perhaps on one side
- pain in the tips of the shoulders
- diarrhoea, vomiting (being sick) or constipation
- feeling dizzy or faint

(The Miscarriage Association - miscarriageassociation.org.uk)

Persistent breathlessness when lying flat is **not normal** in pregnancy and may mean heart problems

Good care makes a difference

Less than **1 woman in every million** who gives birth now dies from **pre-eclampsia**, but to detect it blood pressure and urine must be checked at every antenatal visit

Factors which might make you more at risk of pre-eclampsia

- First pregnancy
- Age 40 years or older
- Pregnancy interval of more than 10 years
- Body Mass Index (BMI) of 35 or more
- Family history of pre-eclampsia
- Multiple pregnancy

The full report and lay summary can be downloaded from: ***https://www.npeu.ox.ac.uk/mbrrace-uk/reports***

Slides from the report launch meeting are also available for anyone to use if they are giving a presentation about the report findings: ***https://www.npeu.ox.ac.uk/mbrrace-uk/presentations***

Sharing practice

To continue the sharing of practice from the Perinatal Mortality Surveillance launch meeting in May 2016 we have uploaded copies of the posters to our website at:

https://www.npeu.ox.ac.uk/mbrrace-uk/sharing-practice

Using Innovation to Reduce Term Admissions to SCBU: The Bobble Hat Care Bundle

Royal Surrey County Hospital NHS Foundation Trust

Background: Between 3-5% of term (born ≥37/40) babies are admitted to SCBU each month. As part of a CQUIN target we were challenged to reduce the number of term babies admitted. All of the term admissions to SCBU were analysed by a multidisciplinary team to identify themes and trends. On average, 24% of term admissions were as a consequence of hypothermia and/or hypoglycaemia. A review of practice revealed that babies and mothers were not assessed holistically, and that the babies were becoming hypothermic whilst skin-to-skin and also developing hypoglycaemia.

Actions: A holistic risk assessment tool was introduced which involved assessing both mother and baby. Mothers and babies were categorised using a RAG system. The 'green' group were self-caring, the 'amber' group required additional support and the 'red' group usually required admission to transitional care. The risk assessment included guidelines on frequency of observations and when the family could consider discharge home. Measures to improve skin-to-skin contact were also introduced, including ensuring that all babies have a hat put on as soon as possible after delivery.

Outcome: There was a reduction in the number of term admissions to SCBU for hypoglycaemia or hypothermia from 24% to 11%; since the CQUIN finished we have further reduced this figure to 8.3%.

Contact: Claire Worthington - ***claireworthington@nhs.net***

Guidelines for health professionals who support parents who have had a loss from a multiple pregnancy

Newcastle University, Newcastle upon Tyne Hospitals NHS Foundation Trust and the charity, The Tiny Lives Trust

Background: Parents who lose one baby from a multiple pregnancy experience mixed emotions of enormous grief for the baby who died along with hope and joy at the birth of their surviving baby. Our recent in-depth qualitative study identified that staff lacked confidence in supporting bereaved parents in this situation. In response we have worked with staff and parents to develop guidelines for health professionals working in roles that involve supporting parents after the loss of a baby from a multiple pregnancy.

Actions: We identified a number of behaviours and actions that staff can adopt that parents find helpful around this time and captured these in guidelines: recognising that the pregnancy is a multiple pregnancy; acknowledging the bereavement; providing emotional support to parents; providing appropriate information to parents; providing as much continuity as possible; offering memory making; handling cot occupancy sensitively; and preparing parents for discharge from hospital.

Outcome: The guidelines are available at:
http://research.ncl.ac.uk/multiplebirth/aboutourproject/guidelines/

We are keen to receive any feedback on them. One initiative we have instigated with positive effect is the use of a butterfly symbol placed in the cot of the surviving baby so that staff know that the baby has lost a sibling. Butterfly stickers are available from Dr Nick Embleton

Contacts: Prof. Judith Rankin ***judith.rankin@ncl.ac.uk***,
Dr Nick Embleton ***nicholas.embleton@ncl.ac.uk***

Perinatal mortality surveillance

Survey questionnaire

In the next few weeks, the MBRRACE-UK perinatal team will provide a link to a short questionnaire. The questionnaire will collect information about the impact of the recommendations from the Perinatal Mortality Surveillance Report for 2014 births and the Antepartum Stillbirth Enquiry. This the opportunity for Trusts and Health Boards to demonstrate the improvements which have been made following the findings of the reports. In order to provide an accurate picture of the responses to the MBRRACE-UK recommendations, it would be helpful for all units to participate by completing the questionnaire when the link is made available.

Reporting by place of death

We would like to thank all of the registered reporters who contributed to the 2015 data collection and participated in the recent case review process. This year, the majority of the queries and questions we received during the case review period centred on the responsibility for reporting perinatal deaths. For some reporters there appears to be some confusion as to which Trust or Health Board carries this responsibility. So to clarify: ***the Trust or Health Board where the baby died is responsible for reporting the death to MBRRACE-UK.*** This includes the situation where a baby dies outside of the immediate environment of the hospital. For example where a baby dies following a home birth the Trust or Health Board responsible for providing midwifery care should report the death. Similarly where a baby is discharged to a local hospice for palliative care the neonatal team that organised the transfer of care should report the baby's death if it occurs within 28 days of birth (i.e. is a neonatal death).

Case assignment

Staff caring for a baby in a neonatal unit, or in a children's hospital, may not have ready access to the maternal case notes to complete the antenatal and delivery details. In this circumstance, they will need to enlist the help of the obstetric/midwifery team who provided antenatal care and care during labour and delivery. The MBRRACE-UK online reporting system provides the facility for reporters to assign cases to the reporters in another Trust or Health Board, so that they can complete this information from their records. The MBRRACE-UK Leicester team are very happy to explain how to use the facility and put teams in contact with each other, to enable reporters to work together to complete all the details required for each case.

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, Social Services and Public Safety (DHSSPS), the States of Jersey, Guernsey, and the Isle of Man.