MBRRACE-UK
Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK
OCTOBER 2017 NEWSLETTER 15

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

MBRRACE-UK Report Launch Meetings

November and December 2017

We will be holding three report launch meetings

London – Tuesday 28th November 2017

MBRRACE-UK Perinatal Mortality Confidential Enquiry into Term Intrapartum Stillbirths and Intrapartum Related Neonatal Death

Manchester – Thursday 7th December 2017

Dublin – Monday 11th December 2017

MBRRACE-UK Perinatal Mortality Confidential Enquiry

and

Saving Lives, Improving Mothers' Care

Early Bird bookings are closed

Full price booking will be from 18th October 2017 until 14th November 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(s)

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 National Perinatal Epidemiology Unit

Call for Maternal Morbidity Confidential Enquiries Topics

In addition to carrying out confidential enquiries into maternal deaths, as part of the MBRRACE-UK programme we undertake confidential enquiries into a rolling programme of selected maternal morbidity topics. The topics are chosen from proposals which can be made by any individuals and organisations.

We would like to invite new proposals from individuals and organisations for the maternal morbidity confidential enquiry which will run during 2019 and report in 2020. This invitation will be open from now until 31st December 2017.

If you are interested in proposing a topic please go to: ***https://www.npeu.ox.ac.uk/mbrrace-uk/topics.*** Any topic can be proposed provided that it is a topic suitable for investigation using the confidential enquiry methodology. An example of a successful topic proposal is given alongside the topic proposal form which should be completed in order to submit a topic for consideration.

Perinatal Case Checking

Perinatal case checking for perinatal deaths of births in 2016 is underway. This is the opportunity for Trusts and Health Boards to check that all their perinatal deaths have been notified to MBRRACE-UK, that the information provided is complete and accurate, and that we have the correct total number of births for each Trust and Health Board.

It is essential that this information is checked and accurate as this forms the basis of all the analysis that we do. If deaths are missed or we have the wrong number of births it will affect the perinatal mortality rates which we calculate, particularly at a Trust and Health Board level.

The case checking period is also the time where details of the deaths should be finalised, including updating the cause of death following any post-mortem investigations. Again, we use this information in our analyses and it is essential that we are using the correct information.

Case checking is happening entirely through the MBRRACE-UK on-line data entry system this year and registered users are able to log on to the system and see the details for their Trust and Health Board. The deadline for completion is the **17th November 2017**. Once the deadline is reached we will assume that the data for individual Trusts and Health Boards has been checked and the numbers we have are correct. We will not be able to make any changes after this date.

National Pregnancy in Diabetes Audit

The National Pregnancy in Diabetes (NPID) Audit aims to support clinical teams to deliver better care and outcomes for women with diabetes who become pregnant. The report for 2016 has been published and is available at: ***http://content.digital.nhs.uk/npid***

New Developments

Local Reviews of Perinatal Deaths

New confidential enquiry has started: Enhancing the Safety of Midwifery-led birth Enquiry (ESMiE)

A new confidential enquiry (ESMiE) has started. This ESMiE enquiry is reviewing intrapartum-related perinatal deaths in births planned in midwifery-led settings in England and Wales and we hope to include Scotland in the New Year. This is closely related to the topic of this year's MBRRACE-UK perinatal confidential enquiry, but ESMiE will focus specifically on perinatal deaths that occur in births planned in midwifery units and at home. The aim of the enquiry is to find out if there were avoidable or remediable factors involved in the care provided and to use the findings to identify ways of preventing future similar deaths. 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 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.

ESMiE is funded by the Department of Health (DH) and is being undertaken by the National Perinatal Epidemiology Unit (NPEU) at the University of Oxford in collaboration with MBRRACE-UK at the University of Leicester. The procedures for requesting case notes will be similar to the MBRRACE-UK enquiries, and ESMiE will use the same procedures as MBRRACE-UK to maintain confidentiality and to carry out the panel reviews. The only difference that will be noticeable to Trusts and Health Boards is that as a separately funded service evaluation ESMiE is able to provide reimbursement for the time involved in copying notes (£50 per case).

You can find out more about ESMiE on the NPEU website:***https://www.npeu.ox.ac.uk/esmie there is also information*** about ESMiE on the MBRRACE-UK webpages: ***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: mbrrace-uk@npeu.ox.ac.uk

The National Maternity and Perinatal Audit

The National Maternity and Perinatal Audit (NMPA) is a new large scale audit of NHS maternity services across England, Scotland and Wales. The NMPA is a 'sister' project to the MBRRACE-UK programme, having also been commissioned by the Healthcare Quality Improvement Partnership (HQIP) under the Maternal, Newborn and Child Health Framework.

The NMPA aims to complement the work of MBRRACE-UK by evaluating a range of care processes and outcomes in order to identify good practice and areas for improvement in the care of women and babies looked after by NHS maternity services.

The NMPA recently published its first organisational report providing comprehensive information on how maternity and perinatal care is delivered across all settings in England, Scotland and Wales. You can read the report and compare information by trust/board:
http://www.maternityaudit.org.uk/Audit/Charting/Organisational

The first report containing the audit's clinical findings will be launched on 9th November 2017. It will publish a number of key interventions and outcome measures that can be used to identify unexpected variation between service providers or regions. Book your free place at the launch events being held in London and Glasgow by going to the RCOG events webpage:
https://www.rcog.org.uk/en/courses-exams-events/store/

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 MBRRACE-UK collaboration along with other collaborators from Each Baby Counts, the British Association of Perinatal Medicine, the Royal College of Midwives, the PARENTS study team and the DH/ Sands Task and Finish Group have been commissioned to develop and implement the National Perinatal Mortality Review Tool (PMRT). The PMRT will be wholly integrated into the MBRRACE-UK perinatal data collection system. The project is funded by the Department of Health and the Scottish and Welsh Governments and will be free to use.

The aim of the PMRT programme (***https://www.npeu.ox.ac.uk/pmrt***) is to iteratively develop, pilot and support the implementation of standardised perinatal mortality reviews across NHS maternity and neonatal units in England, Scotland and Wales. Following the principle of 'review once, review well' the tool will support:

- Systematic, multidisciplinary, high quality review of care when a stillbirth or infant death occurs;
- A structured process of review, learning, reporting and 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;
- Reaching a clear understanding of why each baby died, accepting that this may not always be possible;
- Production of a report for parents which includes a plain English explanation of why their baby died;
- Other reports from the tool which will enable organisations providing and commissioning care to identify emerging themes across a number of deaths to support learning and changes in the delivery and commissioning of care to improve future care and prevent the future deaths which are avoidable;
- Production of national reports of the themes and trends associated with perinatal deaths to enable national lessons to be learned from the nationwide system of reviews.
- Parents whose baby has died have the greatest interest of all in the review of their baby's death. Alongside the national annual reports a lay summary of the main technical report will be written specifically for families and the wider public. This will help local NHS services and baby loss charities to help parents engage with the local review process and improvements in care.

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, 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.