



Perinatal Mortality Surveillance Report

UK Perinatal Deaths for Births from January to December 2014

Frequently Asked Questions for the general public

1. Why do you report by Commissioning Organisation, Trust and Health Board, Neonatal Network, and Local Authority?

The report is aimed at a variety of audiences in order to provide them with useful information for planning and delivering high quality maternity and neonatal care.

- The Commissioning Organisations in our report are responsible for buying (“commissioning”) maternity care on behalf of their local population.
- The Trusts (in England and Northern Ireland) and Health Boards (in Scotland and Wales) are responsible for delivering maternity and neonatal care for their patients. These Trusts and Health Boards are organised into larger ‘Networks’ in order to ensure that a full range of care is available to everyone.
- The Local Authorities are responsible for improving the health of their local population; including children’s public health services from pregnancy to age 5, including health visiting.

Of course, many other people are interested in stillbirth and neonatal death, including parents, parents-to-be, families, and the general public. We hope that the information in our report is useful for everyone.

2. There are 3 types of deaths presented in the report. Why?

The report provides mortality rates for stillbirths and neonatal deaths (deaths within the first 28 days of life) and also for these two types of deaths combined; known as ‘extended perinatal death’. It is useful to both commissioners of health care and healthcare professionals to know if any of these rates fail to reach either local or national targets. This is because the influencing factors and the strategies and interventions to improve the rates, will be different depending on how and when the baby died.

3. Which maps and tables would be most useful to look at?

As a member of the public you may be most interested in mortality rates by place of birth. The mortality rates for **Trusts and Health Boards** are shown in the maps and tables on pages 48-67 of the report.

4. Why isn't my local maternity unit listed in the report?

Across the UK, hospitals are organised into Trusts and Health Boards. In some cases this may be only one hospital and for others two or more. We present the data in this way, as this is how care is organised and funded.

5. What does “stabilised & adjusted” mean and why do you report the rates in this way?

In the MBRRACE-UK report the 'crude' mortality rate is simply the number of deaths for every 1,000 births within each organisation. This is a commonly used measure for mortality and is informative, in that it describes exactly what happened for births in 2014.

However, some organisations have a high proportion of mothers in their local populations who are at high risk of their baby dying before or shortly after birth. There are many reasons why some mothers are at higher risk, including for example being over the age of 40, living in poverty or being pregnant with twins or triplets. These differences in risk between populations mean that even if the care for any particular group of mothers was identical in two organisations, the organisation with the larger proportion of mothers at high risk would have the higher crude mortality rates.

In order to try to overcome this issue, we report 'stabilised & adjusted' mortality rates which, as far as is possible, take into account such differences between populations.

6. Why do the number of deaths in the MBRRACE report not match those in official government publications?

Official government publications include all legally registered deaths. In the MBRRACE-UK report we have not included any of the deaths occurring before 24 weeks of pregnancy, or any deaths as a result of a medical termination of pregnancy.

7. What does it mean if my Trust or Health Board has a red dot?

Just because Trusts and Health Boards have a red dot, this doesn't mean that they are providing poor quality care. If a Trust or Health Board has been allocated a red dot in the report, we suggest they review all of their deaths to understand why their mortality rate is more than 10% higher than other similar Trusts and Health Boards.

8. Why is the cause of death for so many babies classified as “unknown”?

Many stillbirths and neonatal deaths happen when the pregnancy was considered to be “low risk” and there were no indications before the baby was born that the baby might die. In these situations, it can be difficult to attribute a cause for the baby's death without further detailed information such as placental or post-mortem examination.

9. What are the benefits of examination of the placenta by a specialist pathologist?

The detailed examination of the placenta in the laboratory by a specialist pathologist might answer important questions and help target care for the mother in any future pregnancy. For example, such an examination might highlight whether the blood flow to the baby was poor, whether there were any other problems with the umbilical cord, or whether infection contributed to the baby's death.

10. Why should I consider consenting to a post-mortem examination for my baby?

While examination of the placenta can provide important information it does not give the same level of detail as a full post-mortem examination. The offer of a post-mortem can be distressing and a tough decision to make for bereaved parents. However, the information generated can aid or confirm a diagnosis, change a diagnosis, provide new information even if the diagnosis is known and assess the usefulness of treatments. Answering these questions may reduce the number of reported “unknown” causes of baby deaths and help target care to particular groups of mothers and their babies. For more information please follow the link to the Sands leaflet “Deciding on a post-mortem” <https://www.uk-sands.org/support/practical-information/deciding-on-a-post-mortem>