Together we care

Blackpool Teaching Hospitals NHS
NHS Foundation Trust

Benchmarking against MBRRACE Perinatal Confidential Enquiry Report 2015

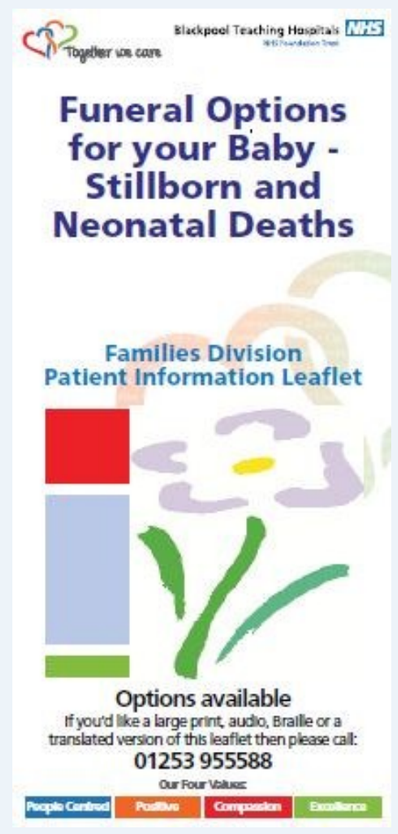
Haslett Elizabeth A, Brooks Carolyn J, Hurst Karen T, Danson-Smith Janet,

Canning Pauline M, Murray Megan B and Amu Johnson.

Background

Blackpool Teaching Hospitals
NHS Foundation Trust
3000 deliveries per annum

Challenges
High Social deprivation
Smoking
Substance misuse
Obesity



Following attendance at the launch day 10th Dec 2015 of the 'MBRRACE- UK Perinatal Confidential Enquiry Report 2015-Term, singleton, normally formed antepartum stillbirth 'in Edinburgh we decided to bench mark the performance of the maternity unit in Blackpool against the report's recommendations.

Blackpool Teaching Hospitals is the maternity unit responsible for providing care for pregnant women from both Blackpool and Fylde & Wyre Clinical Commissioning Groups and the unit delivers approximately 3000 babies per year. Blackpool is an area of high deprivation with challenges from smoking, substance misuse, obesity and mental health and is one of the most deprived towns in the UK.

Method: a multidisciplinary group comprising of medical and midwifery staff met to benchmark stillbirths that had occurred in 2015 against the MBRRACE report. All stillbirths were included >= 24 weeks gestation excluding termination of pregnancy for foetal abnormality. There were 8 cases from 2,999 deliveries. The notes were available for 6 cases. Benchmarking took place against a questionnaire drawn up from MBRRACE recommendations.

We conducted an analysis of 6/8 cases of stillbirth in 2015.

AREAs for Improvement:

- **Plotting of symphysial fundal height on the GROW chart at every antenatal contact from 26 weeks gestation.**
- **A discussion should take place about foetal movements at every antenatal contact from 25 weeks gestation.**
- **A partogram should be used to monitor labour progress following an intrauterine death**

- **A multidisciplinary review should take place with the following conclusions- grading of care, accuracy of documentation, an action plan and these should be shared with the parents.**
- **Community midwife support continue for as long as is required.**

All cases of stillbirth are currently discussed at two multidisciplinary meetings -a case review and the monthly departmental clinical governance meeting. From now on cases will be benchmarked against the questionnaire at the case review and feedback given to the staff involved. Lessons learnt will be sent out in the weekly electronic briefing.

At the departmental governance meeting the result of the benchmarking and recommendations will be presented. The consultant obstetrician concerned will be able to use this information when meeting and corresponding with the parents.

This makes the process transparent allowing for appropriate planning for future pregnancies and improving staff education

Reference

1. MBRRACE—UK 2015 Perinatal Confidential Enquiry—Term Singleton, Normally formed antepartum stillbirth November 2015 http://npeu.ox.ac.uk

STAGE 1

ALL CASES OF STILLBIRTH ARE DISCUSSED AT A MULTIDISCIPLINARY CASE REVIEW. THIS RESULTS IN PARTIAL COMPLETION OF THE BENCHMARKING QUESTIONNAIRE.

STAGE 2

ALL CASES OF STILLBIRTH ARE DISCUSSED AT THE DEPARTMENTAL CLINICAL GOVERNANCE MEETING WHERE CARE IS GRADED AND AN ACTION PLAN IS CREATED.

STAGE 3

PARENTS ARE REVIEWED BY CONSULTANT & GIVEN RESULTS OF ABOVE DISCUSSIONS. PLAN MADE FOR FUTURE PREGNANCY CARE AND DELIVERY.

STAGE 4

LETTER SENT TO PARENTS COPIED TO GP SUMMARISING THEIR MEETING WITH THE CONSULTANT.

Local review of care

For 3/4 stillbirths there was no evidence in the notes that a local review of the care had been carried out. When a review had been done, very few followed standards set out in national guidance or involved parents' views of their care.

MBRRACE - UK 2015 Perinatal Confidential Enquiry