MBRRACE-UK 2017 'surveillance' report

This is the third year MBRRACE-UK has been reporting. This year's report collects information on babies who were born in 2015 but died either before they were born or shortly after birth. The audit is funded by all four UK governments, and aims to highlight variation across the whole of the UK and show trends over time. Are more or fewer babies dying? Who's most at risk? Understanding these vital questions helps those designing and delivering care understand how and where to improve services for women and their babies.

MBRRACE-UK
Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK

Sands
Stillbirth & neonatal death charity

Researchers collect information on the numbers of babies who die in the UK, and calculate the rate of baby deaths at each trust (in England and Northern Ireland) and health board (Scotland and Wales). They colour-code each rate according to a green, yellow, amber, red traffic light system. Red, for instance, indicates a rate that's more than 10% above average and green more than 10% below average. Rates are also reported according to similar types of services so that places that deliver fewer than 2,000 babies every year can be compared with each other and those places which provide surgery for babies can be compared. This is because in places where there is more specialised care for babies, there are more likely to be babies who are seriously unwell and may die.

Key findings for babies born in 2015

- 782,720 babies were born in 2015
- 3,032 were stillborn (died before birth after 24 weeks of pregnancy)
- 1,360 died in the first four weeks of life
- Around 700 babies died as a result of a congenital anomaly
- Over 850 babies died early in pregnancy from 22-24 weeks
- There's been a steady fall in the stillbirth rate but neonatal deaths have remained largely static for 3 years
- Around 30% of unexplained stillbirths were associated with growth restriction
- Between 2013 and 2015, there was an 8% fall in the rate of babies who died before, during or shortly after birth
- The fall in deaths from 2013 to 2015 is among babies who died towards the end of pregnancy, from 32 weeks gestation onwards.

Sands role in MBRRACE-UK

Sands are lay representatives on the MBRRACE-UK collaboration. We aim to bring the parent voice to the heart of the work influencing its focus and ensuring its findings and messages are shared widely. Sands Chief Executive Clea Harmer co-authored the forward to this year's report.

What does MBRRACE-UK say about variation in the rate of babies who die across the country?

MBRRACE-UK adjusts the information it collects on deaths by allowing for the different kinds of mothers and babies who are cared for in any one place. Mothers who live in socially deprived areas, mothers who are older (over 40), younger (than 20), and particularly mothers who are having twins or multiples, are at increased risk of their baby dying. We also know that babies who are British Black, Black, British Asian or Asian, are at greater risk of dying. This could be for many reasons, including access to services, social deprivation, language barriers, or close relations parenting children in some communities which result in higher rates of fatal congenital anomalies. While MBRRACE-UK is not able to investigate these factors more deeply from the data it collects, establishing how significant these risks are may direct future policy and research.

The report does suggest other complex reasons for some areas having higher rates of deaths. This year's report shows us that there is a 7-fold increase in neonatal deaths due to congenital anomalies in Northern Ireland compared to areas of the south-east of England, for instance. This is due to the law around carrying out terminations in NI. There is also variation in rates of neonatal deaths and late fetal losses before 24 weeks gestation, which suggests these deaths are reported differently across the country.

What does MBRRACE-UK recommend?

- All hospitals must carry out local reviews of individual deaths to understand why the baby died and identify improvements to care where needed as recommended by Sands and the Department of Health (see below)
- There needs to be a renewed focus on reducing neonatal deaths
- Improved research is needed to understand why babies die at earlier gestations before 32 weeks
- A national forum should be set up to establish how to report deaths before 24 weeks gestation in the same way.

What next?

A new national tool, the Perinatal Mortality Review Tool (PMRT) for carrying out good-quality hospital reviews is being developed. This comes from work led by Sands and the Department of Health England on reviewing care and we are part of the team developing the PMRT. It will be available for free in Scotland, Wales and England, by the end of 2017. Research with the Manchester and Bristol Universities PARENTS team, with advice from Sands, will help develop an understanding of how parents might be sensitively engaged in the review process.

www.npeu.ox.ac.uk/pmrt/programme

To see the full report, including maps, and lay summary, visit: www.npeu.ox.ac.uk/mbrrace-uk/reports

What Sands says

The fall in the number and rate of baby deaths is welcome. Over the 3 years from 2013 to 2015 this represents 285 lives. This still means, however, that 15 babies die every day in the UK either before, during or shortly after birth; that's a family tragedy every 96 minutes.

MBRRACE-UK recommends all baby deaths are investigated to understand what happened so parents receive adequate answers about why their baby died. It is also vitally important that organisations learn from deaths and improve care where they can for future families. We know from confidential enquiries, undertaken by MBRRACE-UK, that the lives of 6 out of 10 babies who die before they are born and close to their due date could potentially be saved with improvements to care. We also know from the Each Baby Counts initiative that 75% of labour-related harm and death at term might be avoided with better care but that hospital reviews are not always of good quality and lessons are missed.

Sands also supports the call for a forum to ensure that the way baby deaths before 24 weeks are reported is the same wherever a family lives and looks forward to being an active member of such a forum. This would ensure that families in this situation receive the right bereavement care regardless of where they live.