MBRRACE-UK 2018 surveillance report June 2018

This is the fourth year MBRRACE-UK has been reporting on stillbirths and the deaths of newborns in the UK. This year's report collects information on babies who were born in 2016 but died either before they were born or shortly after birth.

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 eachother 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.

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

Sands
Stillbirth & neonatal death charity

Key findings for babies born in 2016

- 780,043 babies were born in 2016
- 3,065 were stillborn (died before birth after 24 weeks of pregnancy)
- A further 889 died between 22 and 24 weeks' gestation
- 1,337 died in the first four weeks of life (after 24 weeks' gestation)
- 70% of stillbirths or deaths happened before 37 weeks of pregnancy
- 1 in 6 babies who died had a congenital anomaly that was likely to be fatal
- The UK stillbirth rate fell between 2013 and 2016 to around 3.9 stillbirths for every 1,000 births, but remained much the same between 2015 and 2016
- The stillbirth rate in twins fell by 44% and the death of newborn twins reduced by a third between 2014 and 2016
- Overall 300 fewer babies died either before or shortly after birth in the 4 years between 2013 and 2016, but that fall occurred mostly before 2016

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

What is MBRRACE-UK?

MBRRACE-UK stands for **Mothers and Babies Reducing Risk through Audit and Confidential Enquiries.** It is a collaboration of researchers, clinicians and Sands. We are lay representatives and aim to bring the parent voice to the heart of the work influencing its focus and ensuring its findings and messages are shared widely. 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.

What does MBRRACE-UK say about baby deaths, why they vary and who's at risk?

MBRRACE-UK adjusts the information it collects on stillbirths and baby 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. Variation in rates of baby deaths between units, however, was not so great this year, once these factors were taken into account.

This year's report focuses on the need to understand why babies die before 37 weeks gestation, on how public health messaging around lifestyle risks such as smoking and obesity could be tackled, and the need to address the issue of inequality, where one woman's risk is greater than another's, because of issues they can't control such as ethnicity or poverty.

MBRRACE-UK'S recommendations:

- 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 PMRT below). Parents should be offered the opportunity to give their perspective of care to the review of their baby's death.
- Those commissioning healthcare for pregnant women should address **inequalities** and focus on ways to support the most vulnerable women and their babies, to reduce their risk of dying.
- There needs to be continued focus on **public health issues** such as obesity and smoking. One in 5 women whose baby dies smokes.
- Given that there's less variation between units in rates of baby death in the UK in 2016, **a national forum** of governments, professional bodies and advisors needs to decide what is a sensible benchmark to monitor deaths against in future, so that units know whether they are improving or not.

What Sands says

"It's extremely welcome news that the rate of baby deaths has fallen in the four years since MBRRACE-UK has been reporting. It's particularly good to see a record breaking fall in twin stillbirths which have almost halved from 2014. It is, however, saddening, that today's report shows there was little change in the rate and overall number of babies who died between 2015 and 2016. It's still the case that almost 15 babies died every day in the UK either before, during or shortly after birth in 2016. And it remains to be seen whether national targets in reducing deaths can be reached. The rate of stillbirths has been falling by a modest 2.4% every year since 2010. If the Secretary of State's ambition to halve stillbirths by 2025 it to be achieved, that annual decline will have to improve to 4%, and the same is true for newborn deaths.

"In the last decade Sands has played a key role in raising awareness of just how many babies die every day in the UK. Our stillbirth rate in particular has remained relatively high among similarly wealthy countries[1]. This has resulted in numerous NHS initiatives to improve safety and women's experiences of care, including the Maternity Transformation Programme, with 9 individual workstreams around improving maternity for women in England, and the Saving Babies Lives' Care Bundle. The Maternity and Children Quality Improvement Collaborative programme in Scotland; Safer Pregnancy Wales and the Northern Ireland Maternal and Infant Steering Group, are all focused on reducing deaths. We very much hope that these programmes will result in real change in 2017 and 2018 and that the necessary resources are made available to ensure these initiatives have real impact on saving lives.

"The effective use of Perinatal Mortality Review Tool (PMRT) which has now rolled out across England, Scotland and Wales will be key to ensuring that every baby death is investigated to understand what

[1]The Lancet Stillbirth Series, January 2016

happened, so parents receive answers about why their baby died and organisations learn from deaths, and know where to improve care for future families. Engaging parents in the review of their baby's death is a principle of the PMRT, but it is important to note that this will put pressure on staff time and resources.

"Today's report reminds us too that the wider societal picture is vital to saving lives. Poverty, inequality, ethnicity all increase a woman's risk of losing her baby, as do smoking and obesity. This is MBRRACE-UK's 4th annual report and, between the lines, it iterates once again that until we have a healthier, better informed, and more equal society, some women will remain at greater risk than others."

June is Sands awareness month and this year we are 40 years old. For our Finding the Words Campaign launched this month we are calling on everyone in society to help break the wall of silence around baby loss. For more information go to:

www.sands.org.uk/about-sands/media-centre/news/2018/06/sands-launches-findingthewords-campaign

Since the last report published in 2017

A new national tool, the **Perinatal Mortality Review Tool (PMRT)** for carrying out good-quality hospital reviews began rolling out in 2018. We know from research (www.npeu.ox.ac.uk/mbrrace-uk/reports) also run by MBRRACE-UK that 6 out of 10 stillbirths that happen at term and 3 out of 4 deaths, occurring as a result of something going wrong in labour and delivery close to a baby's due date, might have been avoided with better care. We also know from research carried out by the **Each Baby Counts** initiative (www.rcog.org.uk/eachbabycounts) that the vast majority of hospital reviews focusing on why a baby dies are poor.

The PMRT, developed from groundwork established over years by Sands and the Department of Health, is free to use in England, Scotland and Wales. 90% of Trusts and Health Boards are now using it. Crucially, it will support ways to engage parents in the review of their baby's death so they are part of the process should they wish to be. For more information on the PMRT go to: **www.npeu.ox.ac.uk/pmrt/programme**

Sands has begun rolling out the **National Bereavement Care Pathway**, funded by the Department of Health and the Scottish Government, to ensure all parents get equal and high quality care when their baby dies. For more information go to: **www.sands.org.uk/professionals/projects-improve-bereavement-care/national-bereavement-care-pathway**

A new **national working group** has been set up by MBRRACE-UK to establish agreement about the principles that should be used by all professionals for determining signs of life in babies born before 24 weeks of gestation. Sands will be adding the voice of parents to the working group.

In his **Maternity Safety Strategy** published in 2017, the Secretary of State for Health moved forward the target to reduce baby deaths by 5 years to 2020. The strategy is published here: **https://bit.ly/2MUntk1**

Manchester University has been evaluating the impact of **NHS England's Saving Babies' Lives Care Bundle** in 19 units in England where the bundle has been implemented. The bundle reinforces how to achieve quality of care, both in antenatal care and in care in labour and delivery. Aspects of the SBLCB are being used in 130 units across England. Results will be published in the summer. Full details of the bundle are here: **www.england.nhs.uk/wp-content/uploads/2016/03/saving-babies-lives-car-bundl.pdf**