Southern Health and Social Care Trust

COVER SHEET

Meeting and Date of meeting	Governance Committee 7th September 2023		
Title of paper	Perinatal Mortality Report for SHSCT 2021 (MBRRACE)		
Accountable Director	Name	Cathrine Reid	
	Position	Director of Surgical & Clinical Services (SCS)	
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This paper sits within the Trust Board role of:		Accountability	
This paper is presented for:		Information	

Links to Trust Corporate Objectives	☒	Promoting Safe, High Quality Care
	☐	Supporting people to live long, healthy active lives
	☐	Improving our services
	☐	Making best use of our resources
	☐	Being a great place to work – supporting, developing and valuing our staff
	☐	Working in partnership

The report author will complete this report cover sheet fully. The Accountable Director must satisfy themselves that the cover sheet is accurate and fully reflects the report. The expectation is that the Accountable Director has read and agreed the content (cover sheet and report).

Its purpose is to provide the Trust Board/Committee with a clear summary of the report/paper being presented, how it impacts on the people we serve and the key matters for attention and the ask of the Trust Board/Committee

1. Detailed summary of paper contents:

The Maternal, Newborn and Infant Clinical Outcome Review Programme, delivered by MBRRACE-UK, is commissioned by the Healthcare Quality Improvement Partnership (HQIP) as part of the National Clinical Audit and Patient Outcomes Programme (NCAPOP). HQIP is led by a consortium of the Academy of Medical Royal Colleges, the Royal College of Nursing, and National Voices. Its aim is to promote quality improvement in patient outcomes. The Clinical Outcome Review Programmes, which encompass confidential enquiries, are designed to help assess the quality of healthcare, and stimulate improvement in safety and effectiveness by systematically enabling clinicians, managers, and policy makers to learn from adverse events and other relevant data. The Maternal, Newborn and Infant Clinical Outcome Review Programme is funded by NHS England, NHS Wales, the Health and Social Care division of the Scottish Government, the Northern Ireland Department of Health, and the States of Jersey, Guernsey, and the Isle of Man.

Each year MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) publish a report that outlines the causes of all stillbirths (SB) and neo-natal deaths (NND) in babies that are birthed after 22 weeks.

2. Areas of improvement/achievement:

Total number of births in 2021 SHSCT:

	DHH	CAH	Total
Mothers that birthed	1968	3240	5208
Twins	40	92	132
Triplets	0	3	3
Babies birthed	2008	3335	**5343** (24% of birth rate in NI)

The following definitions are used to define cases:

A **still birth** is a baby born at or after 24+0 weeks gestational age showing no signs of life, irrespective of when the death occurred.

A **neo-natal death** is a liveborn baby (born at 20+0 weeks gestational age or later, or with a birthweight of 400g or more where an accurate estimate of gestation is not available), who died before 28 completed days after birth.

Total Number of Stillborn & Neo-natal Deaths in 2021 in SHSCT:

	Stillbirths	NND	Total
DHH	9	2	11
CAH	13	9	22
Total	**22**	**11**	**33** (2020 –Total: 38)

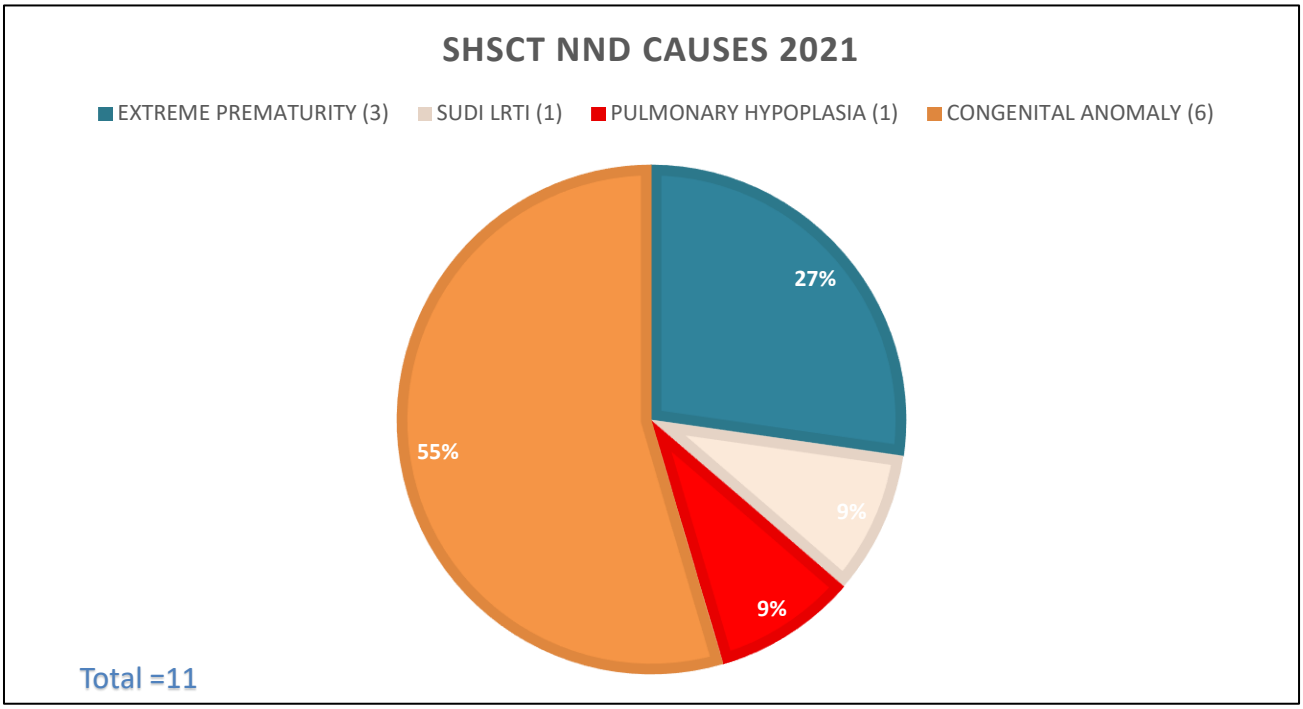
There is a full report that will be in September 2023**,** initial information suggests the following across NI.

Comparison across NI of extended perinatal mortality rate for 2021:

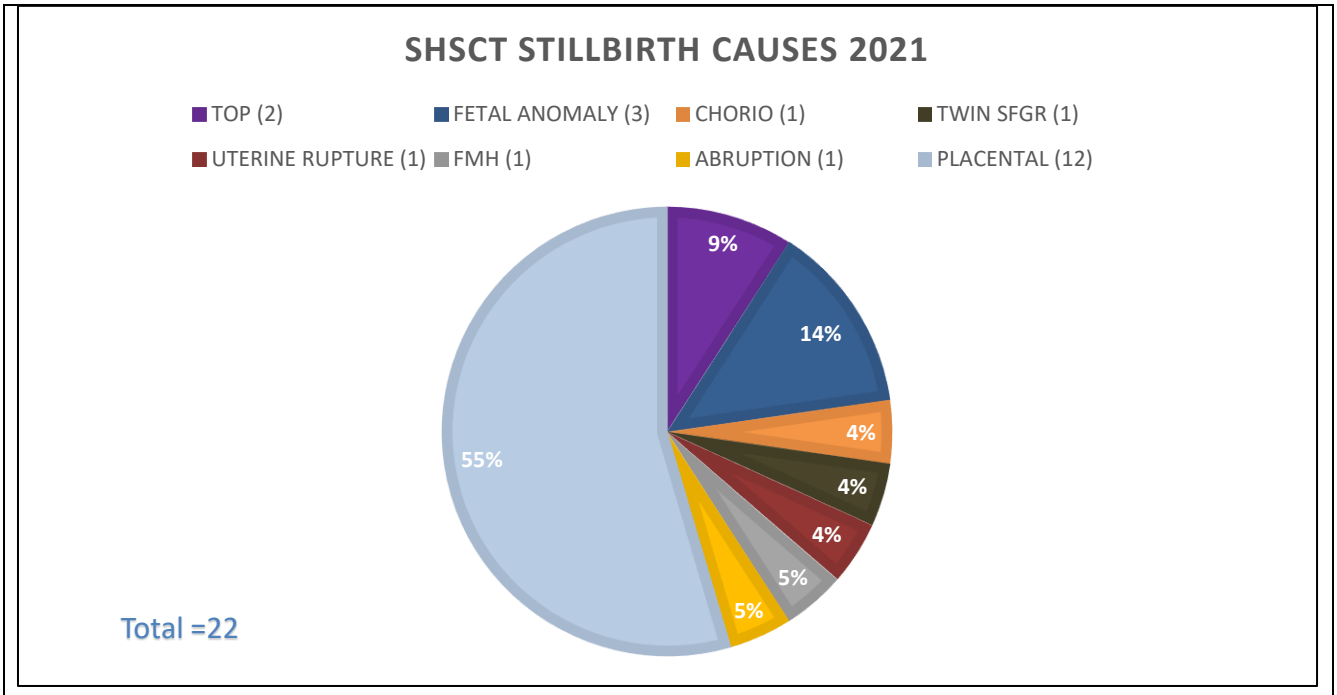
Extended perinatal death rate: stillbirth or neonatal death per 1000 births				
BHSCT	**SET**	**NHSCT**	**WHSCT**	**SHSCT**
8.17	4.70	4.77	4.10	**4.62** (2020 rate- 4.64)

All cases within the SHSCT of SB or NND are reviewed using the Perinatal Mortality Review Tool (PMRT). The following is a summary of the outcomes of this review process.

Causes of NND in 2021:



Causes of SB in 2021 in SHSCT:



Following review of all Stillbirth and NND the following outcomes were recorded:

Grade of care following Perinatal Mortality Review Tool (PMRT)	Stillbirths	Neonatal Deaths
A - no care issues identified	3	4
B - care issues identified but made no difference to outcome	10	4
C - care issues identified that may have made a difference	7	1
D - care issues that likely to have made a difference to outcome	0	0

Some of the learning identified from cases graded C with actions taken:

- Missed Small for Gestational Age (SGA) baby with no resource to review scan images – resource to purchase Viewpoint software package now secured with rolling programme on implementation in place.
- Inappropriate management of IUGR – Policy reviewed
- No Dawes Redman used for AN sinusoidal CTG – included in CTG case study training
- Patient non-compliant with diabetic care and should not have been offered virtual reviews, suboptimal treatment of UTI – continues to be a challenge due to increasing demand and complexity
- Required more frequent scanning due to multiple risk factors, SGA not detected- unable to review images – as point 1

- Patient felt staff unsupportive and didn't feel listened too – individual reflection
- No bereavement suite, delay in t/f baby to Alder Hey- Belfast not contacted until baby ready to leave our hospital which is not the process . – Bereavement Suite now in place from 2023.
- PN bloods not signed off or actioned, no bereavement suite – as above.
- None of these cases reached SAI threshold, PMRT investigation is of a standard equal to a SAI level 2 as it is a root cause analysis of human, care and service delivery factors which is completed by a MDT.

3. Areas of concern/risk/challenge:

- Smoking continues to be a risk factor in 25% of all reported SB & NND, 6.3% of all pregnant women in SHSCT report smoking tobacco.
- The Perinatal Institute recommends that vaping be treated the same as smoking as a risk factor for IUGR, but recognises that as there is very little evidence around vaping, this is at each Trust's discretion. Currently we don't collect data for vaping, or include it in antenatal education for women.
- 50% of all SB Babies are low birth weight (IUGR) they are plotting their growth on the 10th centile.

Achievements in 2021:

- Follow-up policy implemented for women who do not attend appointments, as this was identified as a risk factor in previous reports.
- Process updated and dedicated sessions for laboratory investigation follow up
- Updated process in place to ensure placental analysis in place as appropriate
- Assessment of fetal growth (GROW) continues for all women.
- Saving Babies' Lives (SBL) care bundle version 2 partially implemented. MDT staff education sessions mandatory for all obstetricians and midwives. Age of ultrasound scanners continues to be a challenge across SHSCT and obstetric imaging review for NI recommendations in terms of training in ultrasound not fully endorsed or resourced.
- Way of analysing CTGs changed regionally – Physiological CTG adopted across NI
- Establishment of dedicated antenatal clinic for East Timorese women (population with higher medical, obstetric and social complexities).

Challenges for team:

- Pre-term birth prevention clinic not in place due to resources – this is a regional issue with BHSCT being only location to date this clinic implemented.
- Improved facilities required for CAH Day Obs Unit (patients with complexities identified at structural scan inc. Fatal Fetal Abnormality). The current facility is 1 large room with a pop up divider, there is challenge to afford women the privacy that they require as it is an open plan environment. Plans in draft to try to reconfigure OP area to accommodate single cubicles.
- Upgrade of scanners to link with Viewpoint archiving software on-going – pilot commencing in September 2023.
- Access to trained sonographers (medical and non-medical) – a regional challenge
- New SBL bundle v3 imminent recognised that no resource has been identified as yet to implement this care bundle – this will be part of the Regional Maternity Collaborative agenda.

4. Impact: Provide details on the impact of the following and how. If this is N/A you should explain why this is an appropriate response.	
Corporate Risk Register	The risks associated are listed on the IMWH risk register as ID 4173 – CAH DOU current clinical space is not configured to meet patient need in terms of privacy. ID 4092 – Inability to store images for future review ID 3759 – Diabetic Antenatal Clinic increased demand and complexity ID 4278 – challenges to maintain consultant staffing in SHSCT
Board Assurance Framework	This highlight report is to provide assurance to the Governance Committee and Senior Leadership Team of the mortality rates reported within maternity services and that a review is completed into each case with learning implemented by the team and shared as appropriate regionally.
Equality and Human Rights	N/A