From the Chief Medical Officer
Professor Sir Michael McBride

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

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Our Ref: HSS(MD)4/2025
Date: 30 January 2025

HSS(MD)4/2025

FOR ACTION
Chief Executives, Public Health Agency/HSC Trusts/NIAS
(for onward distribution to:
Medical Directors
Directors of Maternity Services
Directors of Nursing
Heads of Midwifery)
Chief Operating Officer, SPPG
GP Medical Advisers, SPPG
All General Practitioners and GP Locums (for onward distribution to practice staff)
OOHs Medical Managers (for onward distribution to staff)
Chief Executive, NIMDTA
Chief Executive, RQIA

PLEASE SEE ATTACHED FULL CIRCULATION LIST

Dear Colleague

MBRRACE-UK PERINATAL SURVEILLANCE REPORT

MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries) and the MBRRACE-UK/PMRT collaboration have recently published the perinatal mortality surveillance: UK perinatal deaths for births from January to December 2022 report. A copy of the full report and Trust level data can be accessed here:

State of the nation report | MBRRACE-UK (le.ac.uk)

The actions below should be considered along with the actions in our letter of 27 July 2023 (**Annex A**) that refers to the May 2023 'data only' MBRRACE-UK report.

ACTION REQUIRED

Chief Executives of HSC Trusts should:

- Consider the key findings and recommendations set out in this report and bring these to the attention of relevant staff to further inform service improvements and developments

Deputy Secretary, Strategic Performance and Planning Group should:

- Disseminate this letter to all relevant staff including those in primary care to further inform commissioning and improvement of services.
- Report progress on the required actions through the established arrangements **of the "SPPG Overarching Comprehensive Report on SPPG Safety and Quality Processes"**

Chief Executive Officer, PHA should:

- Disseminate this circular to all relevant PHA staff.
- Continue to work with SPPG colleagues to report progress on the required actions through the established arrangements for 6-monthly updates on Clinical Outcome Review Programme (CORP) Reports.

Chief Executive, RQIA should:

- Disseminate this letter to all relevant staff and Independent Sector providers.

ef Executive, NIMDTA should:

- Disseminate this letter to doctors in training in all relevant specialties.

MBRRACE-UK PERINATAL SURVEILLANCE REPORT

This report focuses on the surveillance of all late fetal losses, stillbirths and neonatal deaths in the UK in 2022.

The report found that:

- Stillbirth and extended perinatal mortality rates decreased across the UK in 2022, following the increases seen in 2021. There was a small increase in neonatal mortality in the UK in 2022.
- Northern Ireland had a stillbirth rate of 3.49 per 1,000 total births in 2022, lower than the NI rate of 4.09 in 2021. The UK rate in 2022 was 3.35.
- Northern Ireland had the highest neonatal mortality rate of the four UK countries in 2022, at 2.29 per 1,000 live births. This was lower than the NI rate of 2.46 in 2021. The UK rate in 2022 was 1.69.

The following recommendations highlight actions to improve outcomes through optimised pathways, rigorous reviews and targeted action:

a. Ensure neonatal intensive care capacity and resources reflect the increase in the numbers of babies born before 24 completed weeks gestational age receiving survival-focused care.

b. Support external clinical input into the rigorous review of all stillbirths and neonatal deaths across the UK, to identify learning and common themes related to clinical care and service provision, delivery and organisation.

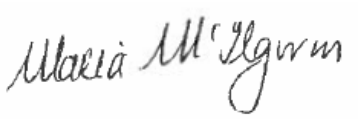
c. Ensure healthcare providers adopt and use the British Association of Perinatal Medicine (BAPM) Perinatal Optimisation Pathway, to improve preterm outcomes.

d. Continue to develop and implement targeted action, at national and organisational levels, to support the reduction of direct and indirect health inequalities.

e. Review perinatal pathology services as a national priority and ensure equity of access to all modalities of post-mortem examination.

The report and its recommendations will assist all those engaged in ensuring a healthy pregnancy and providing our newborns with the best possible start in life. Providers should use the report in the assessment of their current position regarding ongoing improvements and to build on that work to further improve outcomes for mothers and babies in Northern Ireland.

Yours sincerely



Professor Sir Michael McBride
Chief Medical Officer

Ms Maria McIlgorm
Chief Nursing Officer

Circulation List

Director of Public Health/Medical Director, Public Health Agency (*for onward distribution to all relevant health protection staff*)
Assistant Director Public Health (Health Protection), Public Health Agency
Director of Nursing, Public Health Agency
Assistant Director of Pharmacy and Medicines Management, SPPG *(for onward distribution to Community Pharmacies)*
Directors of Pharmacy HSC Trusts
Director of Social Care and Children, SPPG
Family Practitioner Service Leads, SPPG *(for cascade to GP Out of Hours services)*
Medical Directors, HSC Trusts *(for onward distribution to all Consultants, Occupational Health Physicians and School Medical Leads)*
Nursing Directors, HSC Trusts *(for onward distribution to all Community Nurses, and Midwives)*
Directors of Children's Services, HSC Trusts
RQIA (*for onward transmission to all independent providers including independent hospitals*)
Joe Brogan, Assistant Director, Head of Pharmacy and Medicines Management, Strategic Planning and Performance Group (SPPG) (*for onward distribution to SPPG Pharmacy and Medicines Management Team and community pharmacists*)
Regional Medicines Information Service, Belfast HSC Trust
Regional Pharmaceutical Procurement Service, Northern HSC Trust
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Maurice Devine, Open University
Professor Paul McCarron, Head of School of Pharmacy and Pharmaceutical Sciences, Ulster University
Professor Gavin Andrews, Head of School, School of Pharmacy, QUB
Postgraduate Pharmacy Dean, NI Centre for Pharmacy Learning and Development, QUB
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Raymond Curran, Head of Ophthalmic Services, SPPG *(for distribution to Community Optometrists)*
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Clinical Advisory Team
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Dr Camille Harron, NIMDTA
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Prof Alan Smyth, QUB
Prof Louise Dubras, Ulster University
Coroners Service for NI
Donna Britton, SPPG

This letter is available on the Department of Health website at https://www.health-ni.gov.uk/topics/professional-medical-and-environmental-health-advice/hssmd-letters-and-urgent-communications

Annex A

From the Chief Medical Officer
Professor Sir Michael McBride
and the Chief Nursing Officer Ms Maria McIlgorm

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

For Action by:

Chief Executives, HSC Trusts for cascade to:
Medical Directors
Directors of Maternity Services
Directors of Nursing
Heads of Midwifery
Supervisors of Midwives
Chief Executive, PHA
Deputy Secretary, SPPG

Castle Buildings
Stormont Estate
Belfast BT4 3SQ

Tel: 028 90 520563
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Date: 27th July 2023

For Information to: Distribution as listed at the end of this letter

Dear Colleagues

MBRRACE-UK 2021 PERINATAL MORTALITY DATA - ONLY RELEASE

MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries) has recently published a data only release on perinatal deaths which occurred in the UK during 2021. This has been made available already to the Public Health Agency (PHA), and, via PHA to Trusts for consideration and relevant action. The full MBRRACE-UK report will be published later this year (anticipated in September 2023).

The 2021 data release can be accessed below
https://www.npeu.ox.ac.uk/mbrrace-uk#mbrrace-uk-perinatal-mortality-surveillance-uk-perinatal-deaths-for-births-from-january-to-december-2021

This year MBRRACE-UK has also undertaken a trend analysis of the perinatal mortality rates at Trust /Health Board level over the past 3 years and has notified all UK Trusts /Health Boards where their trend data indicates that perinatal mortality appears concerning during this period. As part of existing data sharing arrangements, the Public Health Agency has already received this information for Trusts in NI and has sent on to Trusts for consideration and relevant action.

The conditions applied by MBRRACE-UK to indicate an apparent increase in perinatal mortality are as follows:

- A Trust's stabilised and adjusted rate has consistently worsened when compared to similar trusts and health boards over the last three years.
- A Trust's stabilised and adjusted rate has been more than 5% higher than the average for similar trusts and health boards for each of the last three years.
- A Trust's stabilised and adjusted rate has worsened by two or three categories since the previous MBRRACE-UK report.

I welcome this enhanced reporting and believe it will help to drive safety and support improvements in maternity and newborn services in Northern Ireland.

ACTION REQUIRED

Chief Executives of HSC Trusts:

- Ensure the actions required in the Departmental letter of 6 January 2023 regarding MBRRACE-UK perinatal mortality reports have been taken forward (link below) .https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-hss-md-1-23.pdf

- Where a Trust has been notified by MBRRACE-UK (via existing arrangements with the Public Health Agency) that it meets one or more of the conditions listed above, Trusts should:

i) Ensure that the notification is reported to, and discussed by the Trust Executive Teams and the Trust Boards to ensure appropriate improvement action and follow-up is taken.

ii) Report the notification and progress on the required actions to SPPG through the established arrangements for 6-monthly updates on Clinical Outcome Review Programme (CORP) Reports.

Deputy Secretary, Strategic Performance and Planning Group:

- Disseminate this letter to all relevant staff to further inform commissioning and improvement of services.

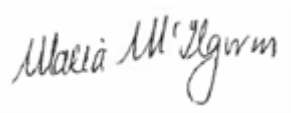
- Where a Trust has been notified by MBRRACE-UK (via existing arrangements with the Public Health Agency) that it meets one or more of the conditions listed above, assess the actions taken and report progress through the existing arrangements for 6-monthly updates on Clinical Outcome Review Programme (CORP) Reports, taking escalation steps where necessary.

Chief Executive, Public Health Agency:

- Where a Trust has been notified by MBRRACE-UK (via existing arrangements with the Public Health Agency) that it meets one or more of the conditions listed above, work with SPPG colleagues to assess the actions taken and report progress through the established arrangements for 6-monthly updates on Clinical Outcome Review Programme (CORP) Reports, taking escalation steps where necessary.

- Receive notification from MBRRACE-UK of NI Trusts which meet the above conditions defined by MBRRACE-UK. Carefully monitor this and all relevant data relating to stillbirths and neonatal deaths at both Northern Ireland and individual Trust level. Consider all relevant escalation steps where necessary.

Yours sincerely



Professor Sir Michael McBride
Chief Medical Officer

Ms Maria McIlgorm
Chief Nursing Officer

For Information to:
Chief Executive RQIA
Executive Medical Director /Director of Public Health, PHA
Director of Nursing & AHPs, PHA
Director of Performance Management, SPPG
Safety and Quality Alerts, SPPG
Donna Britton, SPPG
Prof Donna Fitzsimons, Head of Nursing & Midwifery, QUB
Prof Pascal McKeown, Head of Medical School, QUB
Dr Sonja McIlfatrick, Head of School of Nursing, UU
Post Graduate Dean, NIMDTA
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Coroners Service for Northern Ireland