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Saving Babies Lives

Reducing Still Birth

Thursday 11 July 2019 The Studio Conference Centre Manchester

Speakers include:

David Monteith
Father and Founder
Grace in Action

Prof Jason Gardosi
Director
Perinatal Institute
Birmingham

Prof Alex Heazell
Clinical Director,
Quality Improvement Lead
Tommy's Stillbirth Research Centre,
St Mary's Hospital, Manchester

Sands
Stillbirth & neonatal death charity

Tommy's
Funding research
Saving babies' lives

MAMA Academy
Helping Babies Arrive Safely

GIA
@GraceinAct

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"Great care also means safe care, but sadly too many women are still suffering the unimaginable tragedy of losing a child. We are committed to saving 4,000 lives by 2025 by halving stillbirths, maternal and infant deaths and serious brain injuries in new-borns." *Department of Health 30 December 2018*

"The first version of the Saving Babies' Lives Care Bundle appears to have contributed to the stillbirth rate in England falling to a historical low."
NHS England 15 March 2019

This conferences focuses on the important issue of Saving Babies Lives: Reducing Stillbirth, and implementing the March 2019 Version 2 of the Saving Babies Lives Care Bundle. The stillbirth rate in the UK is high relative to other similar European Countries, it has been demonstrated that the implementation of key interventions can lead to reductions in the stillbirth rate in line with the national ambition to reduce the number of stillbirths, neonatal deaths, maternal deaths and brain injuries that occur during or soon after birth by 50% by 2030 and by 20% by 2020.

"The success of the Saving Babies' Lives Care Bundle version 2 ultimately rests on its implementation. It was heartening to see so many maternity services enthusiastically implement version one with some achieving dramatic reductions in mortality. The NHS Long Term Plan reiterates the NHS's commitment to a 50% reduction in stillbirth, maternal mortality, neonatal mortality and serious brain injury and a reduction in preterm birth rate, from 8% to 6%, by 2025."
Matthew Jolly National Clinical Director for Maternity and Women's Health, NHS England, March 2019

"This second version of the Saving Babies' Lives Care Bundle heralds a significant commitment to meet the national ambition set by the Secretary of State, recently reiterated in the NHS long-term plan, to achieve a 50% reduction in the rate of pre-term and stillbirths in the UK by 2025."
Professor Lesley Regan President, Royal College of Obstetricians and Gynaecologists, 13 March 2019

The Each Baby Counts Report released on 13 November 2018 shows that different care might have led to a different outcome in almost three quarters of stillbirths, neonatal deaths and severe brain injuries included in the review. There was an average of seven contributory factors per incident and this shows the complex relationship between clinical and non-clinical factors. In almost half (45%) of the affected babies, guidelines and best practice were not followed.

"Sadly this latest report from Each Baby Counts shows that different care might have made a difference to the outcome for almost three-quarters of affected babies. This highlights that much work is still needed to ensure healthcare professionals are supported to implement recommendations. We are committed improving maternity safety and want to do everything possible to prevent these tragedies that can have a life-long and devastating impact on families." *Mr Edward Morris, Co-Investigator of Each Baby Counts and Vice President of the Royal College of Obstetricians and Gynaecologists,November 2018*

"Variations in rates between Trusts and Health Boards remain, although the variation in the stillbirth rate between Trusts and Health Boards delivering similar levels of care is now less marked than in the past. Nevertheless, there is still room for improvement as our average rate of stillbirths and neonatal deaths is still higher than in many other similar European countries. This fact, together with the findings from recent MBRRACE-UK confidential enquiries, suggest that with further improvements to the organisation and systems of care provided to mothers and their babies, a continuing reduction mortality rates is indeed possible." *MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK, 15th June 2018*

"All hospitals should carry out local reviews on every death to understand what happened, why the death occurred and how they can improve care to prevent similar deaths in the future" *MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK, 2018*

This conference will enable you to:

- Network with colleagues who are working to deliver best practice in the prevention of stillbirth
- Reflect on the Lived Experience of losing a baby through stillbirth
- Explore the changes outlined in version 2 of the Saving Babies Lives Care Bundle
- Learn from outstanding practice in delivering the Saving Babies Lives Care Bundle Version 2 and Every Baby Counts
- Reflect on national developments and learning from MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK
- Improve the way you investigate and learn using the National Perinatal Mortality Review Tool
- Develop your skills in the Effective Implementation of the Saving Babies Lives Care Bundle
- Understand how you identify and improve the management of risk factors
- Identify key strategies for learning from perinatal mortality reviews at a local level
- Ensure you implementing the latest evidence to reduce Stillbirth as a result of incidents during labour
- Understand how you can better support women and families following stillbirth
- Self assess and reflect on your own practice

10.00 Chair's Welcome & Introduction

John Tomlinson *Consultant in Obstetrics and Gynaecology* Royal Bolton Hospital and *Chair* Strategic Clinic Network Stillbirth Working Group

10.10 Learning from MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries

Dr Lucy Smith
Senior Research Fellow, NIHR Fellow & MBRRACE-UK Collaborator
Department of Health Sciences, University of Leicester

- learning from the National Perinatal Mortality Surveillance for Births
- an update on the National Perinatal Mortality Review Tool
- implications for practice and maternity care

10.40 Saving Babies Lives v2: National Developments

Myles Taylor
President British Maternal and Fetal Medicine Society
and *Consultant Obstetrician and Gynaecologist*
Royal Devon and Exeter Hospital

- Saving Babies Lives Version 2: national update

11.10 EXTENDED SESSION: Stillbirth: Death by another name

David Monteith
Father and Founder
Grace in Action

- a personal story
- what organisations and individuals can do to support women and their families
- additional considerations when contemplating another pregnancy

11.50 Question and answers, followed by tea & coffee at 12.00

12.20 EXTENDED SESSION: Reducing stillbirth Effective Implementation of the Saving Babies Lives Care Bundle v2

Prof Jason Gardosi
Director
Perinatal Institute Birmingham

- reducing stillbirth what works?
- the saving babies lives care bundle: ensuring effective implementation
- challenges and successes
- lessons from an early adopter site
- interactive self assessment session

13.00 Question and answers, followed by lunch at 13.10

14.00 EXTENDED SESSION: Improving support for women and families following stillbirth

Marc Harder
NBCP Lead
and Nileema Vaswani
Bereavement Support Services Manager, Sands

- ensuring effective implementation of the national bereavement care pathway
- supporting parents after a loss of a baby through stillbirth
- longer term support
- supporting parents during further pregnancies

15.00 Prevention and management of risk factors

Prof Alex Heazell
Clinical Director
Tommy's Stillbirth Research Centre St Mary's Hospital, Manchester
St. Mary's Hospital lowered the average number of stillbirths by 19% from 2012 to 2017

- identification of women at risk
- raising awareness of reduced fetal movement
- risk assessment and surveillance for fetal growth restriction
- our experience at St Mary's

15.30 Question and answers, followed by tea & coffee at 15.40

16.00 Improving practice and outcomes: demonstrating the impact

John Tomlinson
Consultant in Obstetrics and Gynaecology Royal Bolton Hospital
and *Chair* Strategic Clinic Network Stillbirth Working Group

- how we have worked to provide support for women to help reduce smoking in pregnancy, developing customised growth charts to help monitor baby growth, providing specialist advice and information around fetal movement and specialist training for staff to monitor baby's heart rate during labour
- changing culture and practice
- the reduction in our stillbirth rate

16.30 Learning from perinatal mortality reviews at a local level

Louise Brodrick
Lead Bereavement Midwife
Barking, Havering and Redbridge University Hospitals NHS Trust

- ensuring systematic, multidisciplinary, high quality review of care when a stillbirth death occurs
- using the National Perinatal Mortality Review Tool
- involving parents in the review
- .ensuring the lessons are learned and shared
- a case study of a review at Barking, Havering and Redbridge

17.00 Question and answers, followed by close

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Saving Babies Lives: Reducing Still Birth

Thursday 11 July 2019

Manchester Conference Centre Manchester

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For more information contact Healthcare Conferences UK on **01932 429933** or email **jayne@hc-uk.org.uk**

Venue
The Studio Conference Centre, 51 Lever St, Manchester M1 1FN, Phone: +44 800 028 6694
A map of the venue will be sent with confirmation of your booking.

Date Thursday 11 July 2019

Conference Fee

- ☐ £365 + VAT (£438.00) for NHS, Social care, private healthcare organisations and universities.
- ☐ £300 + VAT (£360.00) for voluntary sector / charities.
- ☐ £495 + VAT (£594.00) for commercial organisations.

The fee includes lunch, refreshments and a copy of the conference handbook. VAT at 20%.

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