AIMS For a better birth...

Birth Activists Briefing: Latest data from MBRRACE and the PMRT review

AIMS Journal, 2025, Vol 37, No 2

By The AIMS Campaigns team

MBRRACE Data brief on maternal mortality

In addition to their in-depth reports "Saving Lives, Improving Mothers Care", published each autumn, MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) now publish Data Briefs much earlier in the year. These give a summary of key statistics about the deaths of mothers in the UK. The latest report, covering 2021-23 was published in January 2025 Maternal mortality 2021-2023 | MBRRACE-UK | NPEU

The overall maternal death rate was slightly higher than in the period 2018-20 but the difference is not statistically significant, whether or not deaths from complications of COVID-19 infection are included (12.67 per 100,000 maternities in 2021-23 compared to 10.9 per 100,000 maternities in 2018-20).

However, deaths between six weeks and one year after birth continued to rise and were significantly higher in 2021-23 compared to 2018-20 (though the Data brief does not give these figures). A third of these deaths were related to mental health issues, with roughly equal numbers due to suicide and to other psychiatric causes. This underlines the continuing failure of perinatal mental health services to support women during this late postnatal period as illustrated by the recent report from the Maternal Mental Health Alliance Women in England are suffering due to patchy Maternal Mental Health Service provision.

Stark inequalities in outcomes remain. Black mothers were twice as likely to die as white mothers, and women from the most deprived areas were twice as likely to die as those from the least deprived areas.

The report also notes that compared to women aged 20-24, women aged 35 or older (regardless of ethnicity or socio-economic status) were three times more likely to die.

The Perinatal Mortality Review Tool

The Perinatal Mortality Review Tool (PMRT) is intended "to support objective, robust and standardised local reviews of care when babies die". It has the dual aims of providing answers for bereaved families and ensuring that the findings lead to national and local learning, resulting in improved care.

The National Perinatal Epidemiology Unit (NPEU) collates these reviews and publishes annual reports.

The latest report, published in December 2024, covers 4,311 reviews completed from January 2023 to December 2023.

30% of the reviews identified at least one issue with care that may have made a difference to the outcome for the baby, and 95% identified areas for improvement in care.

The report notes a number of improvements in the conduct of local reviews including:

- Reviews were started for 98% of babies who died in the perinatal period and 96% of those who died in the first four weeks after birth. However, in only 88% of cases was the process completed and a report printed.
- Care is increasingly likely to be graded as C or D ("issue with care found which may, or would likely have, affected the outcome") rather than A ("no issues with care") or B ("issue with care found which would not have impacted the outcome"). The report's authors interpret this as suggesting that units are becoming more self-critical. It's also possible that there is an increasing proportion of cases where better care might have made a difference to the outcome.
- The quality of action plans has improved with more actions graded 'strong' or 'intermediate.' 'Strong' actions are typically a system-level change that removes the need for individual action. However, only 10% of the improvement actions identified were classed as 'strong' and almost half (46%) were considered weak.
- Just over half of reviews now include an external reviewer (a clinician from outside the Trust/Board).
- There has been an increase in the range of healthcare professionals involved in reviews, though this could still be better. There is often a lack of involvement from staff in administrative, risk management and governance roles, which could hinder the development and implementation of effective action plans. For a third of reviews there was no-one from the bereavement team present "to specifically ask questions on behalf of the parents."
- The PMRT collaboration has co-produced a set of resources to support bereaved parents and encourage them to engage with the review process.

AIMS has in the past queried why parents are not permitted to attend the review themselves if they wish, and has been told that this is to ensure that staff are able to speak freely. We are concerned that, although the process says to ensure that parents are "given the opportunity to voice any questions, comments or feedback about what happened to them and their baby and about any aspect of their care", it does not permit parents to challenge the accounts given by staff at the meeting. This seems a serious shortcoming when enquiries into maternity services have found multiple cases of hospitals seeking to deny that there was a problem with the care given. Similarly, although parents are meant to be offered the chance "to meet to discuss the review findings", as well as receiving a written explanation and copy of the report, there seems to be no process for parents to challenge the findings if they disagree with them.

Local teams can use the PMRT system to generate summary reports of review findings over a period and use these as a basis for reporting to the Executive Board. These reports can also flag recurring issues with

no immediate solution, in order to identify resource needs and support a business case.

The PMRT system does not include any follow-up of the implementation of action plans arising from reviews. The PMRT team has therefore conducted a survey and collated examples, that are listed here.

Actions for Birth Activists

You may like to ask your local Trust/Board about how well they conduct PMRT reviews, and what improvement actions they have taken as a result. For example:

- What proportion of reviews include an external reviewer, a member of the bereavement team and staff responsible for risk management and governance?
- Are they using the parent engagement materials developed by the PMRT team?
- Is there a regular report to the Executive Board of findings from PMRT reviews?
- What improvement actions have been implemented as a result of PMRT reviews, and how is the effectiveness of these being monitored?