Saving Babies Lives

Reducing Stillbirth

10% card payments discount*

15% group booking discount**

Wednesday 25th January 2023 **Virtual Conference**

Chair & Speakers include:

Professor Alex Heazell
Clinical Director
Tommy's Stillbirth Research Centre
St Mary's Hospital, Manchester

Professor Asma Khalil
Consultant Obstetrician and Lead, Multiple Birth and Maternal Fetal Medicine Teams
St George's University Hospitals NHS Foundation Trust

Marc Harder
NBCP Lead
Sands

HEALTHCARE CONFERENCES UK

Supporting Organisations:

APP Action on Postpartum Psychosis

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"The impact of death or serious health complications suffered as a result of maternity care cannot be underestimated. The impact on the lives of families and loved ones is profound and permanent…Going forward, there can be no excuses, Trust boards must be held accountable for the maternity care they provide."
The Ockenden Report: Independent Review of maternity services at The Shrewsbury and Telford Hospital NHS Trust 30th March 2022

"In 2020, 1 in every 225 pregnancies ended in stillbirth. 2,638 babies were stillborn in 2020 in the UK. The stillbirth rate in England and Wales is 3.8 stillbirths per 1,000 total births. Approximately 7 babies were stillborn every day Croatia, Poland and Czech Republic all have better stillbirth rates than UK."
Tommy's 2022

"Meeting revised NHS target of 50% reduction in stillbirths by 2025 requires much more work"
Professor Elizabeth Draper, Professor of Perinatal and Paediatric Epidemiology The Infant Mortality and Morbidity Studies Team, University of Leicester & MBRRACE-UK collaborators, May 2021

"The Leads must ensure that their maternity service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 and subsequent national guidelines."
Ockenden Report: Independent Review of maternity services at The Shrewsbury and Telford Hospital NHS Trust 30th March 2022

"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

"Sufficient protected time must be allocated for training across all maternity specialisms including routine refresher courses as well as multidisciplinary team training, particularly in emergency drills."
Ockenden Report: Independent Review of maternity services at The Shrewsbury and Telford Hospital NHS Trust 30th March 2022

There is wide variation in stillbirth and premature birth rates throughout the UK. This is not due to differences in the characteristics of local populations or a lack of research or clinical guidelines, but is instead a result of variation in the way that guidelines are implemented locally."
Tommy's November 2021

This conferences focuses on the important issue of Saving Babies Lives: Reducing Stillbirth, implementing Version 2, and looking ahead to Version 3 of the Saving Babies Lives Care Bundle, and accelerating action to achieve 50% reductions in stillbirth by 2025. The conference will also reflect and focus on implementing the recommendations from the Final Ockenden Report published in March 2022. 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 2025.

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
- Develop a strategy to achieve 50% reductions in stillbirth by 2025
- Reflect and implement the recommendations of the 2022 Ockenden Report relevant to stillbirth
- Learn from outstanding practice in delivering the Saving Babies Lives Care Bundle Version 2, and look ahead to Version 3
- Reflect on national developments and learning from MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits & Confidential Enquiries
- Learn about effective, evidence based strategies for stillbirth prevention
- Improve care and support for women from diverse communities and reduce inequality
- Improve the way you investigate and learn using the National Perinatal Mortality Review Tool
- 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
- Supports CPD professional development and acts as revalidation evidence. This course provides 5 Hrs training for CPD subject to peer group approval for revalidation purposes

10.00 AM Chair's Welcome and Introduction

Professor Alex Heazell *Clinical Director,* Tommy's Stillbirth Research Centre St Mary's Hospital, Manchester

10.10 A Lived Experience Perspective

David Monteith
Father & Founder
Grace in Action

- a personal story of stillbirth
- what organisations and individuals can do to support women and their families
- additional considerations when contemplating another pregnancy
- delivering information to parents in a non-biased and non-fearful way

10.40 Saving Babies Lives: National Developments

Professor Alex Heazell
Clinical Director
Tommy's Stillbirth Research Centre St Mary's Hospital, Manchester

- Saving Babies Lives: national update
- learning from the Ockenden Report and implementing recommendations
- develop a strategy to achieve 50% reductions in stillbirth by 2025
- looking ahead to SBLv3 – when can we expect this and what will change?

11.10 A Human Factors approach to preventing Stillbirth

Dr Gabby Bambridge
Consultant Obstetrician & Labour Ward Lead
Kingston Hospital NHS Foundation Trust

- changing behaviour, improving team working, flattening the hierarchy, improving communications and developing situational awareness
- the role of human factors in improving patient safety
- our experience

11.40 Comfort Break and Virtual Networking

12.00 Saving Babies Lives & Learning from Covid-19

Professor Asma Khalil
Consultant Obstetrician and Lead, Multiple Birth and Maternal Fetal Medicine Teams
St George's University Hospitals NHS Foundation Trust

- saving babies lives, monitoring and fetal growth surveillance during the Covid-19 pandemic
- implications of Covid-19 on reducing preterm births
- understanding the increase in stillbirths during the pandemic
- learning from the pandemic: promoting care seeking in pregnant women

12.30 Improving practice and outcome: impact of a stillbirth prevention programme

Gaynor Armstrong
Women's & Children's Risk Manager and Quality & Safety Lead
and Wendy Taylor SBLCB Lead Midwife
University Hospital Coventry & Warwickshire NHS Trust

- risk factors associated with stillbirth
- assessment and management of fetal growth restriction
- the role of training, evidence based guidelines and audit
- monitoring adherence to SBL Care Bundle and looking ahead to V3
- how we have helped to reduce stillbirth rates in our organization

13.00 Lunch Break & Virtual Networking

PM Chair's Welcome and Introduction

Mr Perbinder Grewal *General & Vascular Surgeon, Human Factors & Patient Safety Trainer, and Emotional Intelligence Practitioner*

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

Marc Harder
NBCP Lead
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
- why is it important to engage parents in perinatal mortality reviews?
- small group discussion and feedback: what are professional experiences of the barriers and facilitators to parent engagement in review?

14.15 Case study: Delivering a service to support the mental health and psychological wellbeing during and following stillbirth

Dr Samantha Day *Clinical Lead*
with Alison Rea *Specialist Bereavement Midwife*
Birmingham and Solihull Maternal Mental Health Service

- practicalities and critical elements of the service
- improving maternal mental health and supporting psychological wellbeing after stillbirth
- our experience

14.45 Reducing stillbirth: How can we optimise Intrapartum Fetal Monitoring training and competency assessment?

Dr Louise Webster
Chair, London Perinatal Morbidity and Mortality Working Group
Clinical Lecturer, Kings College London

- improving fetal surveillance and monitoring
- the saving babies lives care bundle: ensuring effective implementation
- stillbirth, Covid-19, and the Covid-19 vaccine
- training and educating staff to ensure competence
- our experience

15.15 Questions and Answers followed by Comfort Break

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

Prof Lucy Smith
Professor of Perinatal Health
The University of Leicester

- learning from the National Perinatal Mortality Surveillance for Births
- using local MBRRACE-UK data for real time monitoring
- recognising issues of inequality
- an update on the National Perinatal Mortality Review Tool
- implications for practice and maternity care

16.00 A medico-legal perspective on preventing Still Birth Claims

Sandra De Souza
Solicitor
Alexandra Highfield
Solicitor
Irwin Mitchell LLP

- 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

16.30 Close

There will be time for Question & Answers after each session

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Venue
This virtual conference will include a live stream on Zoom, interactive breakout sessions and resources available on a secure landing stage for three months after the event date.

Date
Wednesday 25th January 2023

Conference Fee

- ☐ £295 + VAT (£354.00) for NHS, Social care, private healthcare organisations and universities.
- ☐ £250 + VAT (£300.00) for voluntary sector / charities.
- ☐ £495 + VAT (£594.00) for commercial organisations.

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