MBRRACE-UK
Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK
JULY 2014 NEWSLETTER 06

MBRRACE-UK: Delivering the UK-wide Maternal, Newborn and Infant Clinical Outcome Review Programme

Announcing...

Launch meetings for the first MBRRACE-UK reports

We are pleased to announce that bookings are now open for the meetings to launch the first MBRRACE-UK reports.

- Future Mother 2014 - Lessons learned to inform future maternity care from the UK and Ireland Confidential Enquiry into Maternal Deaths and Morbidity 2009-2012
  Meetings: London 9th December 2014*; Edinburgh 12th December 2014; Belfast 22nd January 2015**
- Report of the 2013 Perinatal Confidential Enquiry: Congenital Diaphragmatic Hernia
  Meetings: Birmingham 11th December 2014; Belfast 22nd January 2015**

All events are free on a first come first served basis.

To make a booking go to: https://www.npeu.ox.ac.uk/mbrrace-uk/bookings

* This event is partially sponsored by the RCOG

** This event is wholly sponsored by PHA and NIMACH

2014 Perinatal Confidential Enquiry - recruitment of panel members

We are setting up the 2014 confidential enquiry looking at the care and treatment of women/parents who experience an:

Antepartum stillbirth of a normally formed fetus at term (>37^{+0} weeks' gestation)

The enquiry will identify and review the current standards of care for this group of women/parents and we are currently recruiting clinicians for the case review panels. We have received an enthusiastic response, but we would like to encourage as many experienced obstetricians, maternal medicine specialists and community midwives to participate as possible. We will be holding a series of one day enquiry panel meetings between September 2014 and February 2015. For further information please contact Ms Carol Liptrot, MBRRACE-UK Midwifery Advisory, MBRRACE-UK Leicester office, by email at: cl335@leicester.ac.uk

A very big thank you to all of the units who have worked hard to provide the data collected so far.

Thank you also to all of the clinicians who have adopted the role of MBRRACE-UK lead user.

University of Oxford · University of Leicester · TIMMS · University of Birmingham · Sands Stillbirth & neonatal death charity · UCL · University of Liverpool · npeu National Perinatal Epidemiology Unit

Maternal Data Collection and the Confidential Enquiries

Maternal data collection timelines

In order to improve data collection and case completeness for the future confidential enquiry reports it is essential that all maternal deaths are reported to us within seven working days of the death occurring. We then ask that the surveillance form, local clinician details and the woman's medical records are returned to us within a month of her death. We also expect the local clinician statements to be completed within a month of being requested by the MBRRACE-UK office.

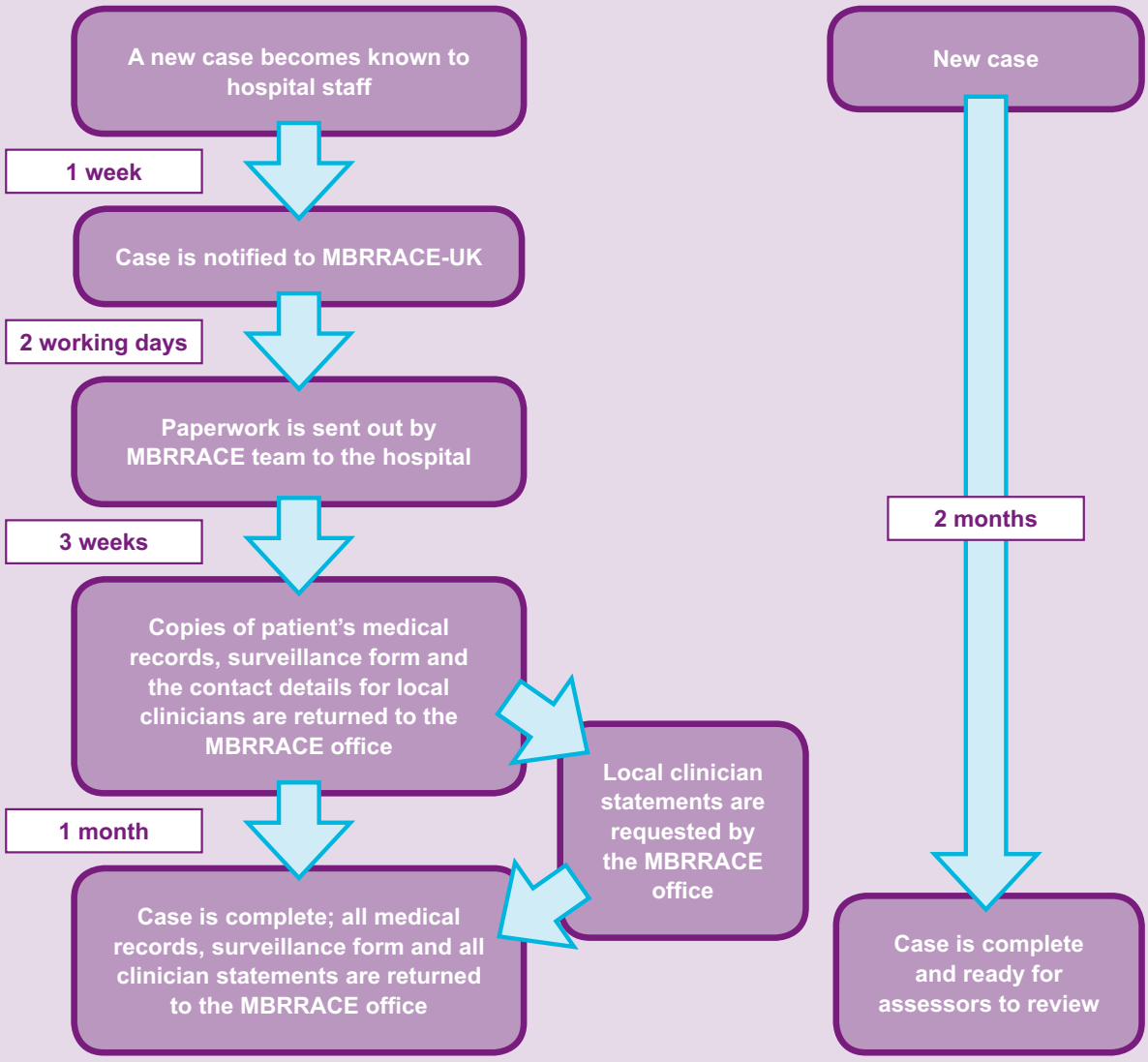
To help you meet the these deadlines and to ensure that all maternal cases are complete and ready for assessment within 2 months of notification at the latest, you will shortly be receiving automatic reminders for any outstanding documents that have not been returned to us within the indicated timelines.

Please do let us know of any staff changes and changes in your contact details to ease communication.

Case ascertainment for 2013

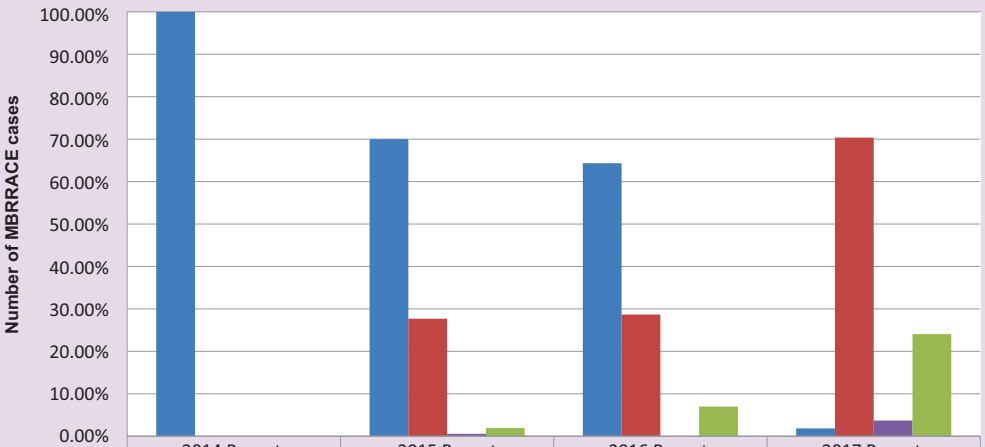
The Oxford MBRRACE-UK office will soon start contacting individual Trusts/Health Boards to ascertain any remaining maternal deaths that occurred in 2013. So far, we estimate that around 80% of the expected number of deaths have been reported for last year. We urge all the remaining Units which have had deaths not yet notified to contact the Oxford MBRRACE-UK office as soon as possible so that we can start the process of confidential enquiry on time.

To report a maternal death, please ring the Oxford MBRRACE-UK office on: 01865 289715



Completeness of maternal case notes for MBRRACE-UK confidential enquiry: Breakdown by case status and year of report allocation

Updated on 1 July 2014

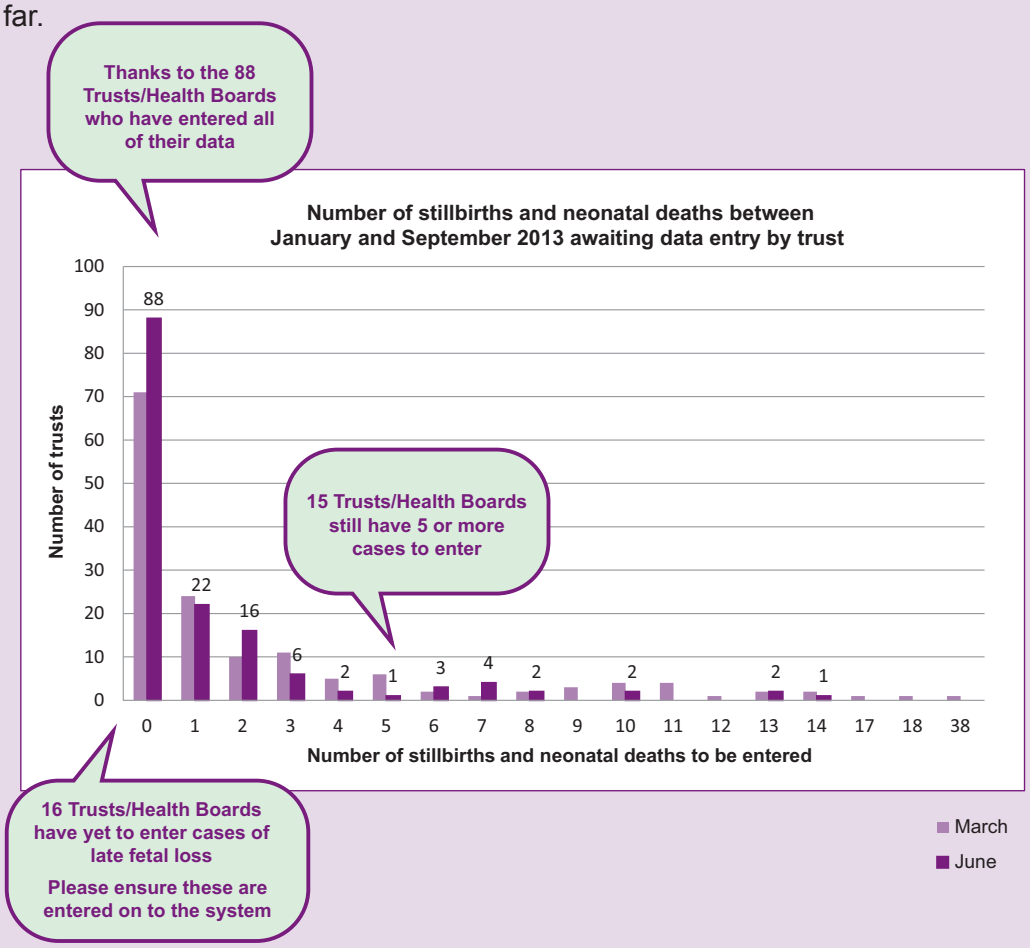


	2014 Report	2015 Report	2016 Report	2017 Report
Complete	100.00%	70.00%	64.34%	1.85%
Incomplete	0.00%	27.69%	28.67%	70.37%
Reported	0.00%	0.38%	0.00%	3.70%
Requested	0.00%	1.92%	6.99%	24.07%

Perinatal Data Collection

Update on perinatal data entry

The MBRRACE-UK Perinatal Death On-line Surveillance System has now been in operation for over a year. All UK Trust/Health Boards are now regularly reporting cases via the MBRRACE-UK system. In order for the annual report generated from the data to be as useful as possible all UK cases should be reported within 3 months of the death occurring wherever possible. The graph below illustrates the progress so far.



For those of you who regularly report cases of perinatal death using the MBRRACE-UK system – some helpful suggestions:

Assigning cases

We realise that it may prove difficult to collect data for those cases which are transferred to, or from, another Trust/Health Board. To make this easier we have provided a facility which allows users to temporarily assign a case to the other Trust/Health Board in order to complete any missing data. This may prove particularly helpful to the Trusts/Health Boards which have Children's Hospitals where users might not have access to maternal records. However, the responsibility for reporting the case still remains with the Trust/Health Board where the death occurred.

Re-opening cases – amendments, corrections

We have also developed the facility for users to reopen their own cases: either to amend their entries (e.g. add information from the Post-Mortem report), or correct errors and omissions. The system asks users for a reason for reopening the case and this is then logged.

Avoiding duplication

We would like to avoid cases being entered onto the MBRRACE-UK system more than once. Ways to minimise duplication include:

- Always search for date of birth or the mother's NHS/CHI number before starting a new case. Any matching cases will then be listed for you to view.
- Ensure that data entry is completed within 3 months of the death occurring in order to prevent the MBRRACE-UK missing-case tracking system generating a duplicate record; apologies that the tracking system has been unavoidably delayed in Scotland but this will be up and running very shortly.
- Only start a new case for deaths which occur in your Trust/Health Board. Other Trust/Health Boards may be temporarily assigned the data entry form, e.g. the hospital of birth, in order to complete data entry for aspects of care but they should not start the case.
- When deaths of twins or triplets from the same pregnancy occur in different Trusts/Health Boards please start a case for the death which occurred in your Trust/Health Board but please notify the MBRRACE-UK team of any other deaths from that pregnancy of which you are aware so that we can make adjustments in our analysis.

Support

If you are encountering problems with data entry into the MBRRACE-UK system please contact us:

E: mbrrace-uk@npeu.ox.ac.uk
T: 01865 289715 (Oxford) 0116 252 5425 (Leicester)

MBRRACE-UK team **E:** mbrrace-uk@npeu.ox.ac.uk **T:** 01865 289715 (Oxford) 0116 252 5425 (Leicester)

HQIP Healthcare Quality Improvement Partnership

The Maternal, Newborn and Infant Clinical Outcome Review programme, delivered by MBRRACE-UK, is commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England, NHS Wales, the Health and Social care division of the Scottish government, the Northern Ireland Department of Health, Social Services and Public Safety (DHSSPS), the States of Jersey, Guernsey, and the Isle of Man.

MBRRACE-UK Meet the collaborators -
Scan the QR code for more details of the people involved.

www.npeu.ox.ac.uk/mbrrace-uk