MBRRACE-UK

Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK

08

FEBRUARY 2015 NEWSLETTER

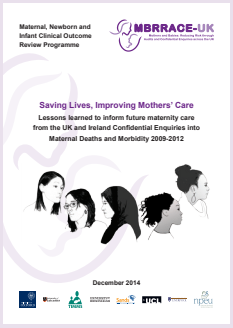
MBRRACE-UK: Delivering the UK-wide Maternal, Newborn and Infant Clinical Outcome Review Programme

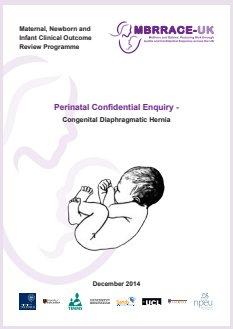
Reasons to celebrate

In December we successfully launched the first two MBRRACE-UK reports from the maternal mortality and morbidity confidential enquiries and the perinatal confidential enquiry.

Saving Lives, Improving Mothers' Care (2014)

Perinatal Confidential Enquiry – Congenital Diaphragmatic Hernia (2014)





The full reports, the lay versions of the reports and an infographic illustrating the headline findings from the maternal report can be downloaded at:

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

It would not have been possible to produce these reports without your personal contribution and the contribution of your organisation; for this we are most grateful.

We are interested in hearing about any impacts that the report findings have had on your personal practice or the organisation of care in your Trust/Health Board. Please let us know about these by email to:

mbrrace-uk@npeu.ox.ac.uk

Perinatal mortality surveillance update

The first MBRRACE-UK Perinatal Mortality Surveillance report will be launched at the Royal College of Obstetricians and Gynaecologist, London on Wednesday 10th June 2015. Invitations went out to lead reporters on 23rd February (one place per hospital initially, on a first come first served basis with places allocated from a reserve list thereafter).

Registration will be via https://mbrrace-surveillance.eventbrite.co.uk

OR

Via email to: mbrrace-events@leicester.ac.uk

Enquiries to: Ian Gallimore 0116 252 5456 (Mon-Fri 9.30 to 12.30)

Coding cause of death

We are setting up a Reporters' Consultation Group in March 2015 and already have obstetricians, neonatologists and midwives who have agreed to help. Their remit will be to provide input and suggestions for training for registered reporters to help them negotiate the CODAC system for the categorisation of perinatal deaths, provide coding examples and to contribute to the content of a 'CODAC users handbook'.

Missing cases for 2014

We have recently sent the first report for Trusts/Health Boards listing deaths in 2014 registered by parents that we could not identify as reported on the MBRRACE-UK system. To help reporters we have started these cases in the MBRRACE-UK system with the basic information we have from national death registration data. If you have received a report:

- Please complete the remaining data for the case we have started for you
- Cases will then be automatically removed from your list of missing cases
- Starting a completely new case will mean a delay before it is removed from the list of missing cases

We know that many of you will currently be working very hard to enter the outstanding cases for 2014. Thank you to those of you in the hospitals below who, when we sent our regular report in early January 2015, had entered all their cases for the first 6 months of 2014 in England and Wales and for the first 9 months in Scotland:

Airedale General Hospital
Alexandra Hospital, Worcestershire
Barnet Hospital
Barnsley Hospital
Basildon University Hospital
Bassetlaw Hospital
Bedford Hospital
Birmingham Children's Hospital
Birmingham Women's Hospital
Blackpool Victoria Hospital
Bronglais General Hospital
Calderdale Royal Hospital
Chesterfield Royal Hospital
City Hospital, Birmingham
Colchester General Hospital
Conquest Hospital
Countess of Chester Hospital
Croydon University Hospital
Darent Valley Hospital
Darlington Memorial Hospital
Diana Princess of Wales Hospital, Grimsby
Doncaster Royal Infirmary
Eastbourne District General Hospital
Edith Cavell Campus, Peterborough
Epsom General Hospital
Evelina Children's Hospital
Friarage Hospital
Frimley Park Hospital
Furness General Hospital
George Eliot Hospital
Glan Clwyd Hospital
Good Hope Hospital
Harrogate District Hospital
Hillingdon Hospital
Hinchingbrooke Hospital
Homerton Hospital
Horton General Hospital
Ipswich Hospital
Jessop Wing, Sheffield
Kettering General Hospital
King's College Hospital
Leeds General Infirmary
Leicester General Hospital
Leicester Royal Infirmary
Leighton Hospital
Lincoln County Hospital
Macclesfield District General Hospital
Mid Staffordshire Foundation Hospital
Milton Keynes Hospital
Morriston Hospital
Musgrove Park Hospital
Nevill Hall Hospital
North Devon District Hospital
North Manchester General Hospital
North Middlesex University Hospital
Northampton General Hospital
Ormskirk District General Hospital
Pilgrim Hospital
Pinderfields General Hospital
Princess Alexandra Hospital, Harlow
Princess of Wales Hospital, Bridgend
Princess Royal Hospital, Haywards Heath
Queen Charlottes & Chelsea Hospital
Queen Elizabeth Hospital, Gateshead
Queen's Hospital, Romford
Rotherham General Hospital
Royal Albert Edward Infirmary
Royal Alexandra Hospital, Paisley
Royal Berkshire Hospital
Royal Bolton Hospital
Royal Derby Hospital
Royal Free Hospital
Royal Gwent Hospital
Royal Preston Hospital
Royal Shrewsbury Hospital
Royal Surrey County Hospital
Royal Victoria Infirmary, Newcastle upon Tyne
Scarborough General Hospital
Scunthorpe General Hospital
South Tyneside District Hospital
St Helier Hospital, Carshalton
St James's University Hospital, Leeds
St Mary's Hospital, Isle of Wight
St Peter's Hospital, Chertsey
St Richards Hospital, Chichester
Stepping Hill Hospital
Sunderland Royal Hospital
Tameside General Hospital
The Great Western Hospital
The Princess Royal University Hospital, Orpington
The Royal Oldham Hospital
Tunbridge Wells Hospital
University College Hospital, London
University Hospital North Durham
University Hospital of North Tees
Wansbeck General Hospital
Warrington Hospital
Warwick Hospital
Watford General Hospital
West Cumberland Hospital
West Suffolk Hospital
Wexham Park Hospital
Whipps Cross University Hospital
Whiston Hospital
William Harvey Hospital
Worcestershire Royal Hospital
Worthing Hospital
Wrexham Maelor Hospital
Wythenshawe Hospital
York Hospital

About the MBRRACE-UK Confidential Enquiry into Maternal Deaths Annual Reports

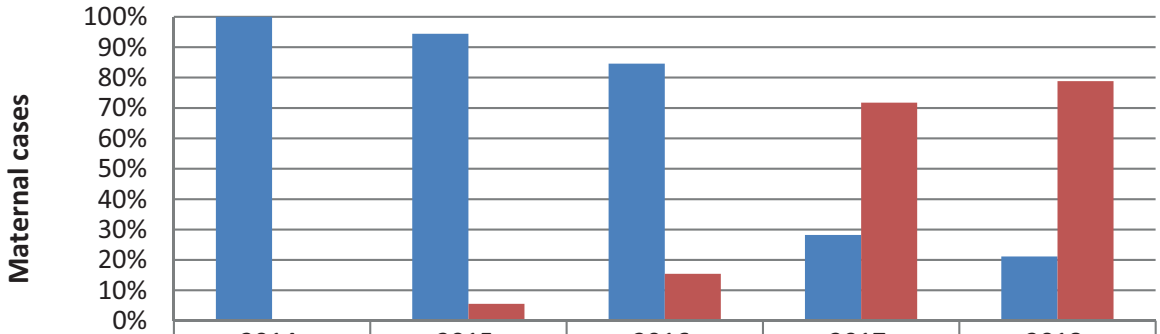
In the past the maternal mortality reports were published on a triennial basis. This is because the number of maternal deaths from individual causes is small, and thus three years' worth of data are required to identify consistent lessons learned for future care and to maintain anonymity and confidentiality. We are now required to report on an annual basis. However, the need to undertake annual reporting does not change the requirement for three years' worth of data, therefore, each cause-specific chapter which appeared in the previous triennial reports will now appear in an annual report once every three years on a cyclical basis, alongside a surveillance chapter reporting three years of statistical data. The topics for inclusion in the 2014–16 reports are as follows:

2014 Report (published):	**2015 Report**	**2016 Report**
*Surveillance data on maternal deaths from 2009–12. *Confidential Enquiry reports on: - severe morbidity from sepsis - deaths due to: haemorrhage amniotic fluid embolism anaesthesia neurological and other indirect causes (excluding cardiac and malignant causes)	*Surveillance data on maternal deaths from 2011-13. *Confidential Enquiry reports on: - deaths due to: psychiatric causes thrombosis & thromboembolism malignancy late and coincidental causes	*Surveillance data on maternal deaths from 2012-14. *Confidential Enquiry reports on: - severe morbidity from cardiac and psychiatric causes - deaths due to: cardiac causes pre-eclampsia, eclampsia & related causes deaths in early pregnancy

Update on Maternal Data Collection

Thank you to everyone who has returned notes for their cases to the MBRRACE-UK office in Oxford.

Completeness of maternal data collection (2009-2014 cases) for inclusion in CEMD reports



	2014 Report	2015 Report	2016 Report	2017 Report	2018 Report
Notes Complete	100.00%	94.43%	84.57%	28.24%	21.15%
Data Outstanding	0.00%	5.57%	15.43%	71.76%	78.85%

updated 11 February 2015

Completeness of case notes for Confidential Enquiry Reports

The MBRRACE-UK team in Oxford has been collecting surveillance forms and copies of case notes for maternal deaths that will be included in the upcoming annual maternal reports. In the chart on the previous page you can see our progress. With your help so far, we have achieved 94% data completion for cases to be reviewed for inclusion in the 2015 report and 84% for the 2016 report. Thank you for your on-going commitment.

However, we continue to request and chase documentation at NHS Trusts/Health Boards, Coroners'/ Procurator Fiscals' offices and GP practices. All Units that have outstanding data collection for cases which will be included in 2015 report have been contacted and we would request that you send us the required documentation and information as a matter of urgency.

Looking Ahead

Maternal Morbidity Confidential Enquiry 2016 - Artificial heart valves in pregnancy

One of the new aspects of the MBRRACE-UK work is to undertake confidential enquiries into maternal morbidities. 'Women with artificial heart valves' was the topic chosen by the Independent Advisory Group for inclusion in the 2016 report. We have therefore selected a sample of 35 women, who were notified to the on-going UKOSS study, to undergo confidential case review.

Anne Smith in Oxford has started contacting MBRRACE-UK Maternal Leads at the hospitals where these cases occurred asking them to provide us with copies of the case records and details of the local clinicians involved in the care. If you are not contacted within the next three months then a case has not been selected from your hospital.

All the information received will be collated, fully anonymised, and subject to expert review using the same methodology as for the confidential enquiry into maternal deaths. The results will be published in the 2016 report.

Case ascertainment for 2014

In spring 2015, the Oxford team will start contacting all Trusts/Health Boards to ascertain maternal deaths that occurred in 2014 across the UK. We urge all Units that have had a death not yet notified to contact the Oxford MBRRACE-UK office on 01865 289715 to report the death. Please remember to report every maternal death within 7 days from the incident and to return the surveillance form and copies of all the case notes within 21 days from notification.

MBRRACE-UK team

E: mbrrace-uk@npeu.ox.ac.uk

T: 01865 289715 (Maternal Team, Oxford)

T: 0116 252 5425 (Perinatal Team, 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