MBRRACE-UK
Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK
JULY 2015 NEWSLETTER 09

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

Forthcoming Launches

In November we will launch the report of the findings from the Confidential Enquiry into Term Antepartum Stillbirths:

Thursday 19th November 2015, Royal College of Obstetricians and Gynaecologists, London NW1 4RG
Cost: £120.00 per delegate

In December we will launch the report of the findings of the Confidential Enquiry into Maternal Deaths for 2011-13

Tuesday 8th December 2015, Royal College of Obstetricians and Gynaecologists, London NW1 4RG
Cost: £120.00 per delegate

In December we will also hold a meeting in Edinburgh where we will present the findings from both reports, the Confidential Enquiry into Term Antepartum Stillbirths AND the Confidential Enquiry into Maternal Deaths for 2011-13:

Thursday 10th December 2015, Royal College of Physicians Edinburgh, EH2 1JQ
Cost: £120.00 per delegate

In January we will also hold a meeting at Lagan Valley, Belfast where we will present the findings from both reports, the Confidential Enquiry into Term Antepartum Stillbirths AND the Confidential Enquiry into Maternal Deaths for 2011-13:

Wednesday 13th January 2016, Lagan Valley Island Conference, Lisburn, BT27 4RL
Cost: £120.00 per delegate

To book for these events go to: ***www.npeu.ox.ac.uk/mbrrace-uk/bookings***

National Perinatal Mortality Surveillance Report

Following the successful launch in June of the National Perinatal Mortality Surveillance Report for 2013:

The full report, the executive summary, infographic and lay summary are available to download at:
www.npeu.ox.ac.uk/mbrrace-uk/reports

You can view short podcasts which explain specific elements of the report at:
www.npeu.ox.ac.uk/mbrrace-uk/presentations

You can download slide presentations to share with colleagues at:
www.npeu.ox.ac.uk/mbrrace-uk/presentations

You can buy a printed copy of the report for £10 plus postage and packing from:
www.npeu.ox.ac.uk/mbrrace-uk/reports

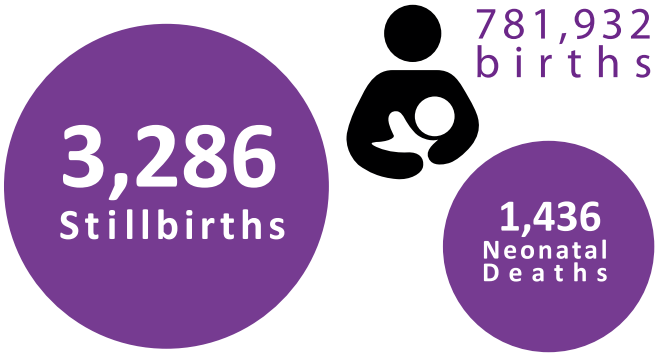
Copies of the report of the Confidential Enquiry into Maternal Deaths 2009-2012 published in December 2014 can also be downloaded from the MBRRACE-UK website: **www.npeu.ox.ac.uk/mbrrace-uk/reports** where you can also buy a printed copy of this report for £10 plus postage and packing.

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

The Kirkup Report

The recent UK independent investigation of the care provided by the maternity and neonatal services at the *University Hospitals of Morecambe Bay NHS Foundation Trust* made recommendations for the systematic recording and tracking of perinatal mortality data at local level. This included the transfer of care between hospitals, and suggested NHS England build on the MBRRACE-UK programme of national audits. It also recommended *"the mandatory reporting and investigation as serious incidents of maternal, deaths, late and intra-partum stillbirths and unexpected neonatal deaths."* [1]

MBRRACE-UK Perinatal Mortality Surveillance Report (June 2015)



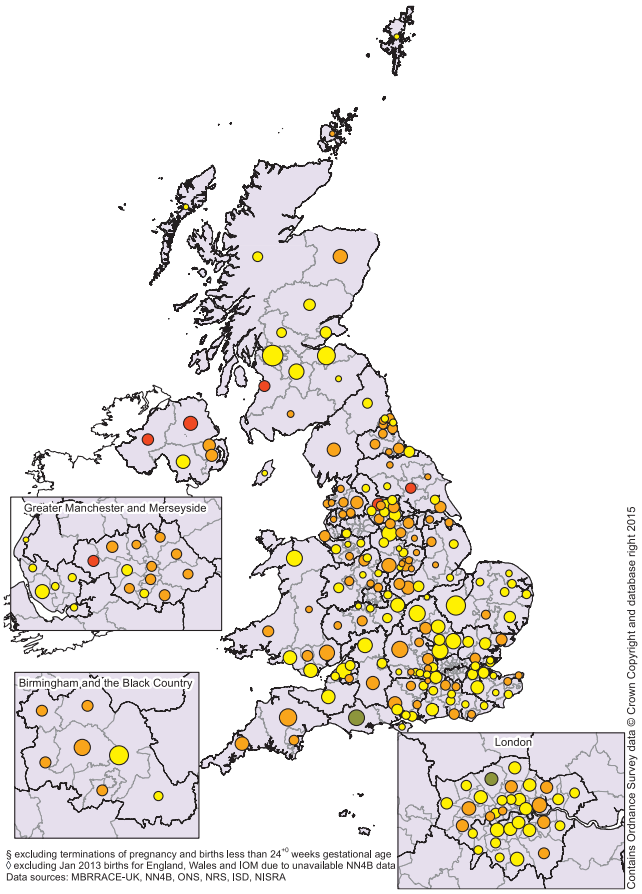
The MBRRACE-UK Perinatal Mortality Surveillance Report (*www.npeu.ox.ac.uk/mbrrace-uk/reports*), of UK perinatal deaths for births from January to December 2013, was launched at the Royal College of Obstetricians and Gynaecologists in London, on Wednesday 10th June. The number of UK stillbirths and neonatal deaths has decreased over the last 10 years. The report highlighted the variation in mortality rates for health organisations across the UK even after taking into account differences in the ethnicity of the babies, and the age and the level of socioeconomic deprivation of the mothers.

Which babies are most at risk?

[1] *Kirkup B. The Report of the Morecambe Bay Investigation. London: The Stationery Office. 2015*

https://www.gov.uk/government/publications/morecambe-bay-investigation-report

Extended perinatal mortality by Clinical Commissioning Group, Health Board and Local Commissioning Group, 2013



How to read the map:

The colours represent:

- more than 10% lower than the UK average
- up to 10% lower than the UK average
- up to 10% higher than the UK average
- more than 10% higher than the UK average

The report has introduced a new way of analysing the data collected by clinical teams from across the UK. Perinatal mortality rates are reported using maps and tables to display the local rate compared to the UK average by organisations responsible for commissioning care, (see map above), delivering care and local public health. Crude mortality rates are reported together with stabilised & adjusted rates which allow for factors such as the number of babies delivered and the number of high risk pregnancies cared for.

For further information the full report, the lay summary and an information sheet are all available to download free of charge via *www.npeu.ox.ac.uk/mbrrace-uk/reports*

Timely Data Entry

Improving the accuracy and completeness of the data collected will enable MBRRACE-UK to provide useful information to clinicians and reflect a true picture of the differences in care across the country in the annual report. Health providers can then understand where and how to target improvements in quality of care to save babies' lives in the future. Ideally this would be achieved by completing data entries within three months of a death occurring and we would encourage this as far as possible at all UK hospitals.

Reporting Late Fetal Losses

We would like to remind all registered reporters of the need to report late fetal losses, babies born showing no signs of life at 22 and 23 weeks gestation, via the MBRRACE-UK surveillance system. This will provide a more accurate picture of UK perinatal mortality rates. In the 2013 report, there were clearly Trusts who did not ensure data collection was complete for this group of babies.

Assigned Cases Facility

One of the reasons often given for delays in data entry is the difficulty in obtaining the mother's demographic details, her medical and obstetric history and details of labour and delivery once her baby has been transferred to the care of the neonatal team. The assigned cases facility allows temporary access to the form by the obstetric team in another Trust who can provide these details. We would encourage all UK clinical teams to use this facility. For further details contact MBRRACE-UK via email:

mbrrace-uk@npeu.ox.ac.uk
or telephone: **0116 252 5425**

Reporting Deaths of Babies From a Multiple Pregnancy

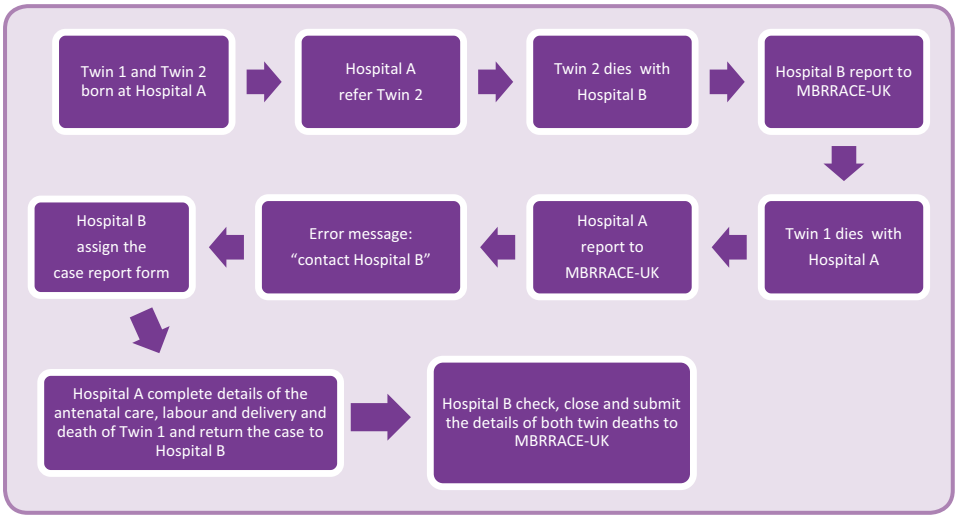
Reporting the death of a baby born as a result of a multiple birth, who then dies under the care of another Trust or Health Board, has also proved to be problematic in some cases. The suggested solution to this, is for the clinical teams in each hospital, to liaise and use a single case report form. MBRRACE-UK are happy to put teams in contact with one another to facilitate this. For example:

*A mother received her antenatal care and was booked to deliver her twin babies in **Hospital A**. **Twin 1** was delivered alive and remained with the obstetric team. **Twin 2** required a referral to the neonatal team in the neighbouring Trust (**Hospital B**) and was transferred into their care.*

*Unfortunately **Twin 2 died** on the neonatal unit shortly afterwards and the neonatal team reported the case to MBRRACE-UK.*

*Several days later **Twin 1** died under the care of the team at **Hospital A**. The team there tried to report the case to MBRRACE-UK and received an error message which highlighted that the mother's details were already recorded on the system and suggested the reporter contact the team at **Hospital B**.*

*The lead reporter at **Hospital B assigned** the existing case report form to the reporter at **Hospital A**, who completed both the details of the mother's antenatal care, labour and delivery and the details of the death of **Twin 1**, then returned the case to **Hospital B** who checked, closed and submitted the case to the MBRRACE-UK team.*



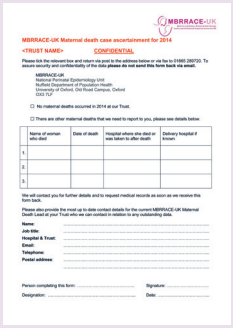
Eligibility reminder for reporting maternal deaths

Maternal deaths eligible for notification to MBRRACE-UK are:

All deaths of pregnant women and women **up to one year following the end of the pregnancy (delivery, miscarriage, TOP)** regardless of the place and circumstances of the death. This includes early pregnancy deaths, indirect maternal deaths and coincidental maternal deaths.

Anyone can report a maternal death so if you have heard about a case and you want to ensure it has been reported, please ring the Oxford MBRRACE-UK office on 01865 289715.

Case ascertainment for 2014 and late cases



In the last week of June, we contacted all NHS Trusts and Health Boards with maternity units across the UK to ensure that all maternal deaths for the 2014 period are reported to us.

A letter with a response form was sent electronically to the Maternal Death Lead at each Trust/Health Board and Clinical Audit Staff were also copied in where possible. This gives the opportunity to report any additional maternal deaths from 2014 that you have become aware of in addition to those already reported to us. We understand the difficulty in identifying all cases, especially deaths associated with miscarriages and terminations which may occur elsewhere in the hospital.

We also appreciate that deaths which occur some months after discharge (late deaths) are difficult for you to identify and we do not expect you to do this, although if you happen to identify any such deaths we would be grateful if you would notify them to us.

So far, we have received over 50% of the responses back and would like to thank everyone who has done so for sending their confirmations.

Please may we ask those who have not returned the form yet, to complete it to the best of your knowledge and return to the Oxford MBRRACE-UK office through the post. This form is also an opportunity to inform us of any changes in contact details for Maternal Death Leads at your Trust/Health Board.

Maternal data collection update

With your help we have completed the data collection for cases which will be included in the report due for publication in December 2015. We continue requesting documentation required for the next topics for the confidential enquiries and appreciate your ongoing commitment and contributions.

For the cases we know about from 2014, we have so far received complete documentation for 76% of the cases and we continue to chase outstanding surveillance forms and patient notes. May we request that you send us the required documentation at your earliest convenience to allow enough time for us to carry out the confidential enquiries.

MBRRACE-UK team

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

T: 01865 289715 (Maternal Team, Oxford)

T: 0116 252 5425 (Perinatal Team, Leicester)

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

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