MBRRACE-UK
Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK
SEPTEMBER 2013 NEWSLETTER 04

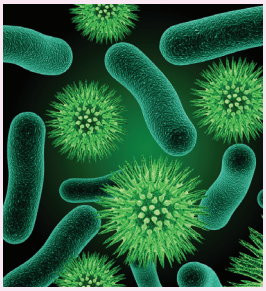
MBRRACE-UK: Delivering the UK-wide Maternal, Newborn and Infant Clinical Outcome Review Programme

Welcome to Issue 4 of the MBRRACE-UK Newsletter

Maternal Data Collection and the Confidential Enquiries

Maternal Sepsis Morbidity Confidential Enquiry – What is it and what is happening

One of the new requirements of the MBRRACE-UK work is to undertake confidential enquiries into maternal morbidities as well as maternal deaths. Maternal sepsis was chosen by the Independent Advisory Group as the topic for 2013. We have therefore selected a sample of 32 women who were critically ill with severe sepsis, and who were notified to the UKOSS severe sepsis study, to undergo confidential case review. We have contacted the MBRRACE-UK leads at the hospitals where these cases occurred to provide us with copies of the case records and details of the local clinicians involved in the care. If you haven't been contacted, then a case has not been selected from your hospital. We will shortly be contacting the local midwife, obstetrician, anaesthetist and any other relevant clinical staff involved in the case to provide their perspectives on the care of the woman concerned. If you receive a request from us, please complete the brief form as soon as possible so that we can begin the Confidential Enquiry for that case.



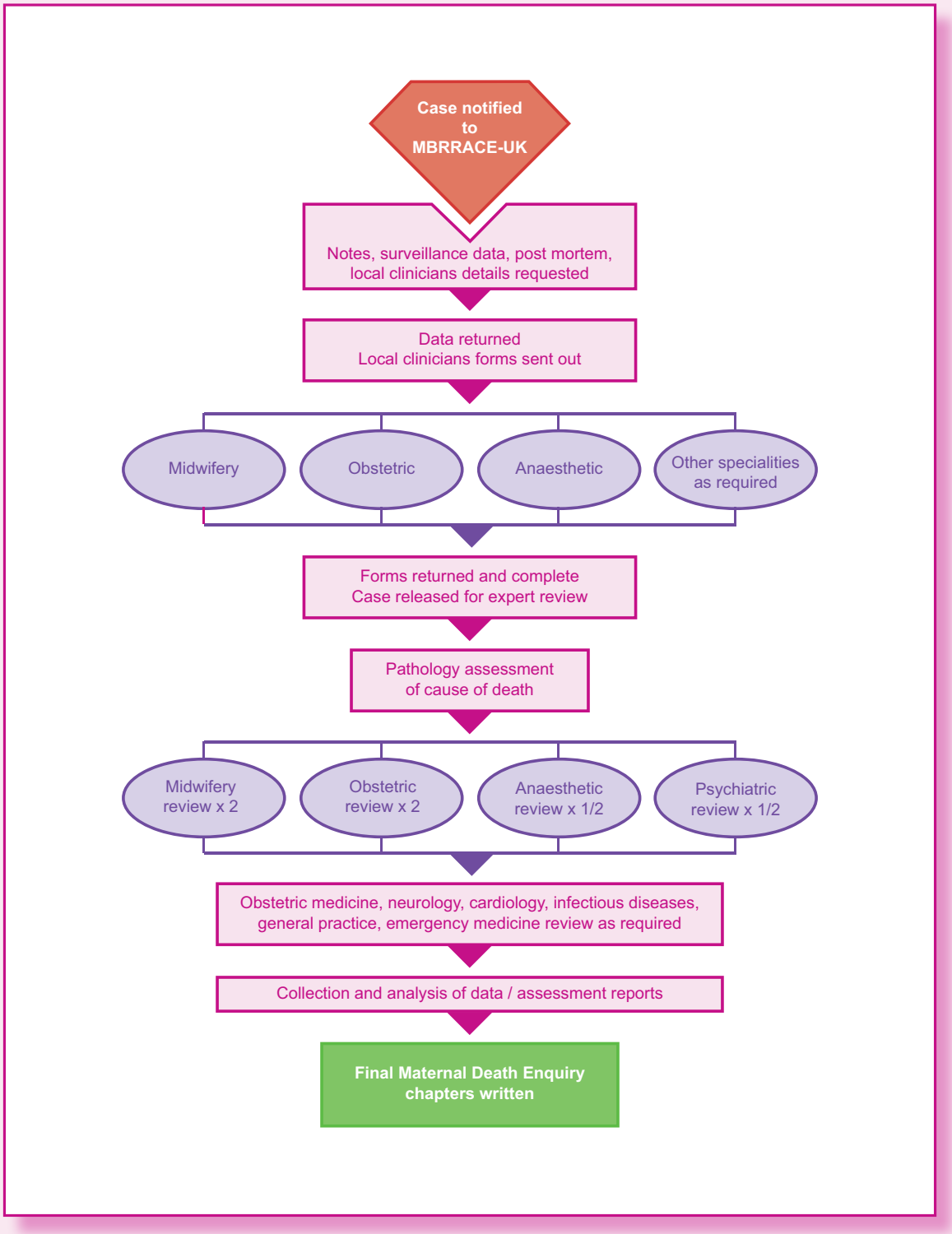
All the information received will be collated, fully anonymised, and subject to expert review using identical methodology to the Confidential Enquiry into Maternal Deaths (see overleaf). The results will be published in the 2014 report.

What happens after I notify a case of maternal death?

The flow chart overleaf illustrates what happens when you report a case of maternal death. Once we receive a notification, we request from you a full copy of the case records, together with a completed surveillance data form, and contact details for the clinicians involved in the case so that we can send them local clinicians forms for completion. We can't begin the confidential enquiry process for that case until we have all this information, so any delay in sending it to us is critical! Any delays in sending notes, surveillance data or local clinicians' reports to us may ultimately impact on the date by which we can produce the next Maternal Death Enquiry report, due in 2014. As we are sure you appreciate, we are also requesting the information for cases which occurred between 2009-12 where these data had not been collected by CMACE or where the case occurred after CMACE closed and before MBRRACE-UK was commissioned to undertake the work. Information about all these 400 cases will need to be included in the 2014 report.

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

Once we receive the information back from you it is checked by our team of midwives, and uploaded onto our secure viewing system. Each case is then reviewed by up to 16 expert assessors in pathology, midwifery, obstetrics, anaesthetics, intensive care medicine, general practice, psychiatry, obstetric medicine, neurology, cardiology, infectious diseases and emergency medicine. Each assessor produces a written report; the messages for future care identified in these reports will then be collated by each specific topic chapter writing group in order to produce the overall report and recommendations.



Perinatal Data Collection and the Confidential Enquiries

Where are we now?

At the time of publication we have:

172 - Trusts/Health Boards registered

1429 - Registered users

2421 - Cases entered and data entry complete

626 - Cases started but are incomplete

The graph below illustrates the current status of data collection and shows the predicted number of cases versus the actual data collection to date and the number of completed cases versus those still awaiting completion.

The number of incomplete cases is currently >20% of the total cases reported.

Thank you to all who have entered data.

How are we doing?

We now have 3,085 cases entered on to the data base but whilst we have made good progress, the graph illustrates that we are still well below the expected number of cases based on data from 2012. In addition to this, ONS recently reported an increase in the birth rate in England so we would anticipate a proportional increase in the number of reported cases.

So what can we do?

We know that one of the difficulties some Units are having is in accessing information when the baby has been transferred to a different hospital for neonatal care. We are planning developments with the web-based data entry system to enable the referring Unit access to the data entry form for particular case to enable missing data, for example the antenatal history, to be entered. This will enable Units to assist one another in providing information that it is otherwise difficult to obtain after transfer. Whilst waiting for this modification to the data collection system please try to get this type of information by contacting the relevant referring consultant. Even after the changes in functionality of the system, ultimate responsibility for submission of information about each case will remain with the Unit where the death occurred.

We would urge all UK units to ensure cases are entered and completed in a timely fashion. The schedule for producing the annual report on perinatal deaths means that details of cases not entered or where the information is incomplete will not be included in the report and will be shown as missing (since we will know the cases exist from death registration data). We will be sending three monthly reminders to the lead users of each Unit to try to avoid a large back-log of data entry at the end of the year. The data collection for 2013 will close in spring 2014.

Lead user identification

Pauline Hyman-Taylor and Janet Hood from the MBRRACE-UK Leicester perinatal team are currently contacting Units around the UK recruiting lead users from each Unit for maternity and neonatal data reporting. Ideally this would be a consultant obstetrician and/or midwife and a neonatal consultant and/or neonatal nurse in each Unit. If possible we would like to make local contacts based in audit depts. as well.

Lead users are essential to the MBRRACE-UK programme. They help facilitate the accuracy and completeness of the data, cascade information through their teams and facilitate their Unit's participation in the national confidential enquiries. If you have not yet nominated members of your team for this role Pauline and Janet can be contacted on 0116 252 5425 or by email: *mbrracele@npeu.ox.ac.uk*. We would love to hear from you.

Progress report on the 2013 Perinatal Confidential Enquiry

2013 Perinatal Confidential Enquiry: Congenital Diaphragmatic Hernia

What's next?

The Expert Panel met on the 9th July to agree a consensus on the key elements of care from diagnosis to discharge / death. A consensus document is being finalised and will form the basis of an assessment tool. This will be used by the confidential enquiry review panels when they convene in Autumn, to evaluate the extent to which these standards of care were achieved. The findings will be reported during 2014. We are already collecting data via case notes and your Unit may be approached in the near future and selected cases requested via the nominated lead user. Detailed instructions will be provided on the anonymisation procedure and submission of case notes for the confidential enquiry. Further information is available on request. Please contact us if you have any questions: Tel: 0116 252 5425, Email: mbrracele@npeu.ox.ac.uk

Call for topic proposals for the 'perinatal' confidential enquiry in 2015 – now open

We would like to invite topic proposals from individuals and organisations for the 'perinatal' morbidity and mortality confidential enquiry which will run during 2015. This invitation will be open from now until 31st December 2013. Any topic can be proposed provided that it is a topic suitable for investigation using the confidential enquiry methodology and it involves one OR all of the following:

- Stillbirths
- Neonatal mortality
- Neonatal morbidity
- Post-neonatal mortality
- Post-neonatal morbidity

To be considered topic proposals must be submitted by completing the topic proposal form which is available, together with more information, on the MBRRACE-UK website at:
https://www.npeu.ox.ac.uk/mbrrace-uk/topic-proposals

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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