MBRRACE-UK
Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK
MARCH 2014 NEWSLETTER 05

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

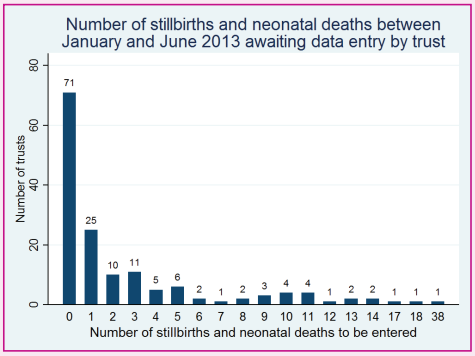
Welcome to Issue 5 of the MBRRACE-UK Newsletter

Perinatal Data Collection

Where are we now?

All NHS Trusts in England and Health Boards in Wales that had a stillbirth or neonatal death in the first 6 months of 2013 have now received a report from us highlighting any deaths checked against Office for National Statistics (ONS) death registrations that we could not identify on the MBRRACE-UK system.

The graph below shows that nearly half of all trusts (71 out of 152) had entered all of these cases but 16 trusts still have 10 or more cases to enter. If you have cases still outstanding please let us know if there is anything we can do to help.



We plan to send similar reports to the NHS Boards in Scotland soon.

Late fetal losses at 22 and 23 weeks gestation

Just a reminder that we are also collecting information for all deaths at 22 and 23 weeks gestational age whether the baby showed signs of life or not. This will help improve the reporting of death rates and allow comparison with other countries. Please ensure that you enter all such deaths into the MBRRACE-UK system. Unfortunately, we are unable to help you by identifying missing cases at this gestation where there were no signs of live at birth (late fetal losses) as these babies are not registered with ONS or National Records for Scotland.

Cases not closed

Of the 6006 cases entered so far, 1089 have not been closed. Although we understand that there are different reasons for this, many incomplete case have been outstanding for over 6 months. Please would you check your cases and see if they can now be closed. Please contact us to have any cases entered in error that need to be deleted from the system.

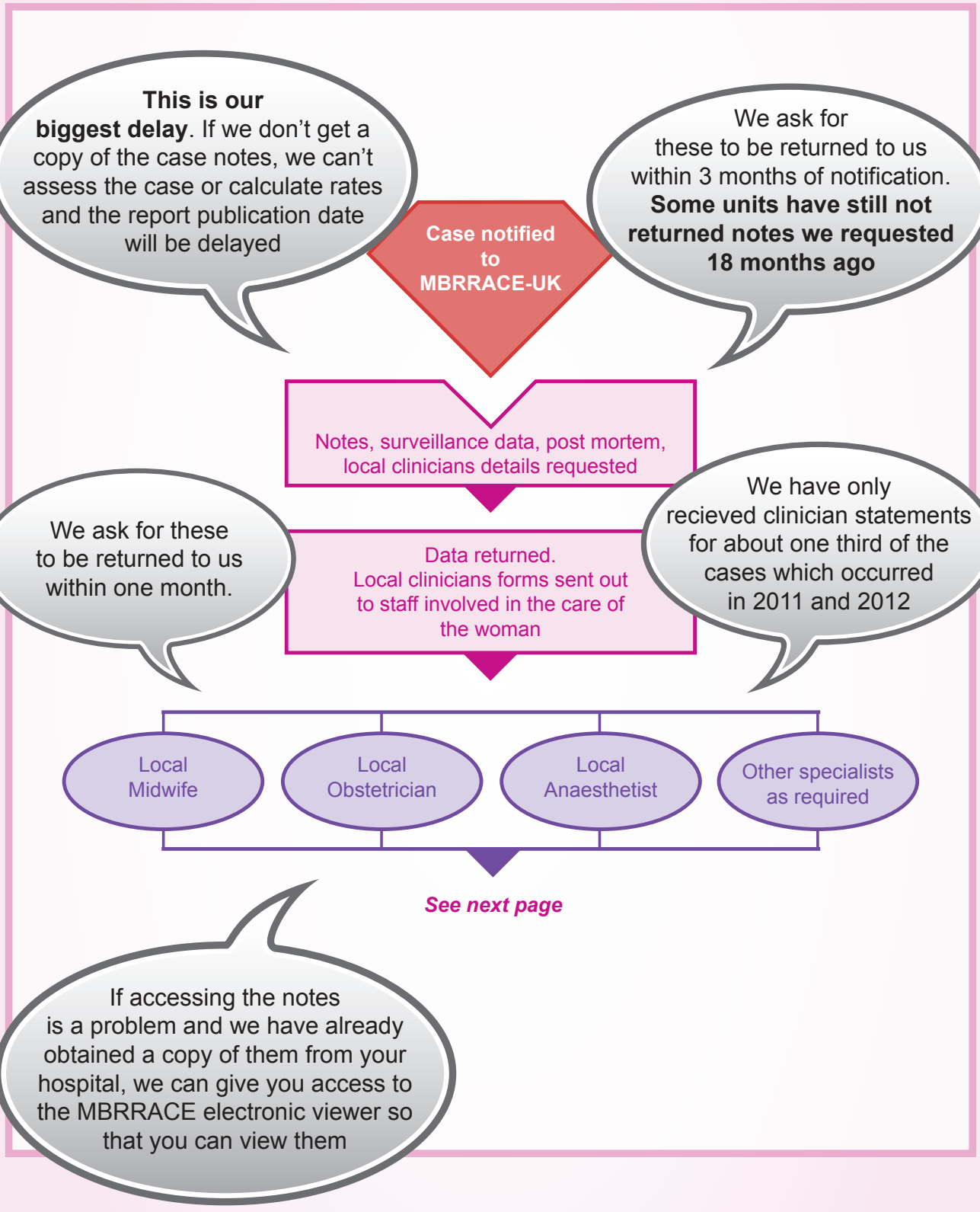
We recognise the difficulties in collecting data for cases that have transferred between Trusts/Health Boards. Soon you will be able to share access with users in other Trusts/Health Boards to assist one another with missing data. Nevertheless, ultimate responsibility for submission of cases remains with the Unit where the death occurred.

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

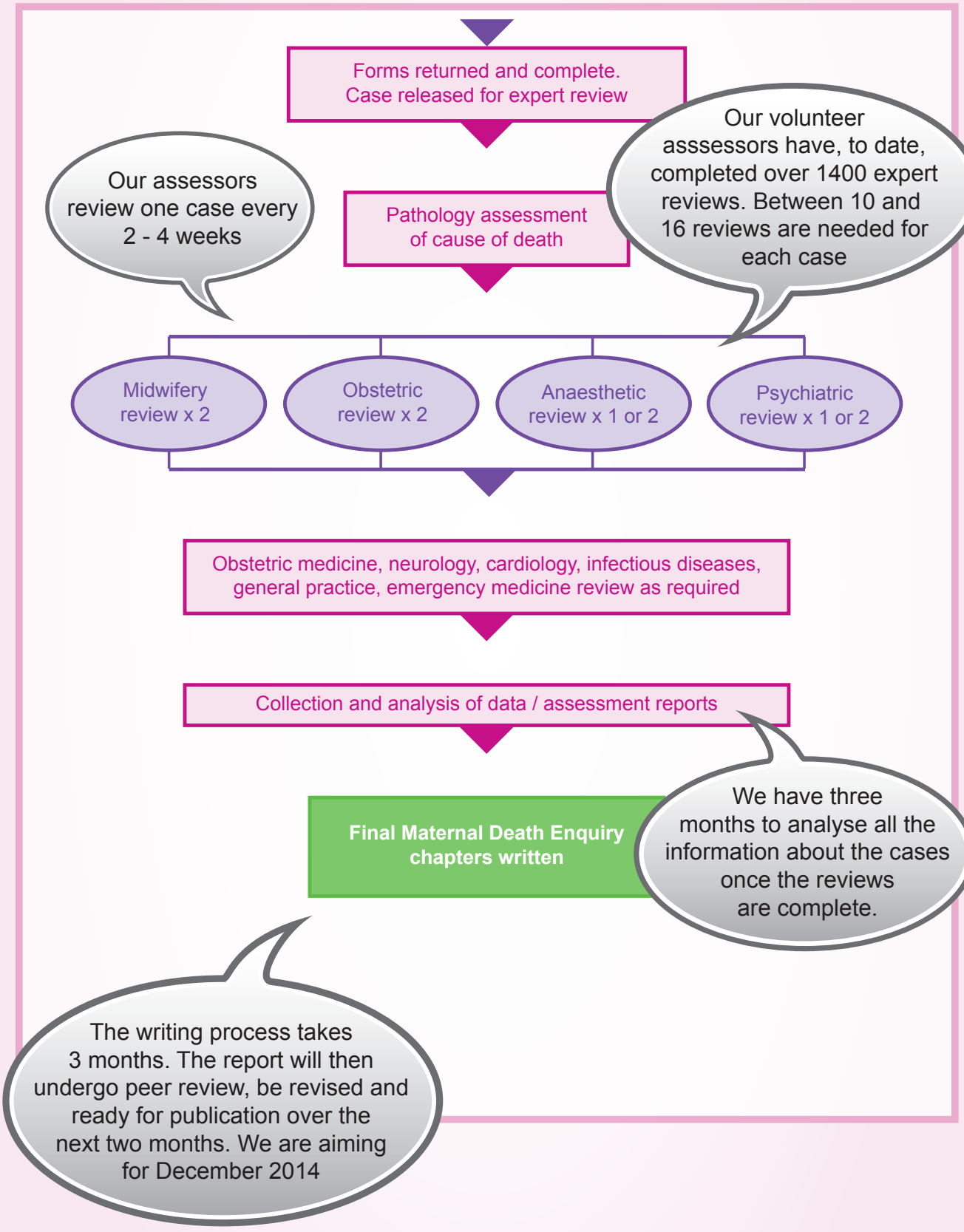
Thank you also to all of the clinicians who have adopted the role of MBRRACE-UK lead user.

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

Producing the Maternal Confidential Enquiry Report -



Your help is needed to allow the Confidential Enquiry to be published this year.



Progress report on the Perinatal Confidential Enquiries

Progress report on the 2013 Perinatal Confidential Enquiry: Congenital Diaphragmatic Hernia

What's next?

The first two case review panels met in February and further panel meetings are planned for April/May/June. However this will depend on two things:

- The timely return of case notes requested for review. Following recent approval from the Confidentiality Advisory Group (CAG) (ECC5-05(f)/2012), ***case notes no longer need to be anonymised by the clinical staff in the Trusts selected to participate in the enquiry***. We now have approval to anonymise identifiable data in-house. Please forward photocopies of the case notes of selected cases as soon as possible.
- We would welcome additional reviewers from the following disciplines to participate in the case review process:
    - ***Midwifery***
    - ***Obstetrics***
    - ***Neonatal Nursing***
    - ***Anaesthetics***
    - ***Paediatric Surgery***

If you or your colleagues are interested please contact us:

Tel: 0116 252 5425, Email: mbrracele@npeu.ox.ac.uk

The findings of the enquiry will be reported at the launch meeting planned for December 2014.

2014 Perinatal Confidential Enquiry:

Normally-formed antepartum term stillbirth

We will shortly be setting up a Topic Expert Group with responsibility for agreeing the care pathway standards to be used in the review process for these cases. We will be contacting the relevant professional organisations to put out a call for interested individuals very soon.

We will also be seeking an experienced midwife to work with us part-time to assist in the identification and retrieval of cases for the enquiry, which will be sampled from the stillbirths reported via the MBRRACE-UK surveillance system.

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)

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