MBRRACE-UK perinatal mortality surveillance report: UK perinatal deaths for births in 2014

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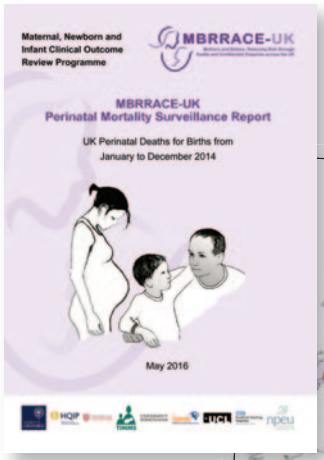

The second MBRRACE-UK national perinatal surveillance report.

The neonatal mortality map.

The second MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) national perinatal surveillance report was launched at the Royal College of Obstetrics and Gynaecologists (RCOG) in London on 17 May 2016. The report, which received wide coverage in the media, relates to births in 2014. This year there were a number of new features. Probably the most significant change is that the report contains information by both local areas and individual trusts and health boards: last year this information for births in 2013 was published in two separate reports.

This year's report includes crude mortality rates for stillbirth, neonatal mortality and extended perinatal mortality, as well as stabilised and adjusted rates. These latter rates take account of chance variation (particularly a problem where the number of births occurring at an organisation is quite low) and important population differences (eg socioeconomic deprivation levels). It is important to remember when looking at the MBRRACE-UK report that the main analyses all exclude infants born before 24 weeks of gestation and terminations of pregnancy. As a result, the figures in the report may not exactly match your own local data.

The main report is free to access and can be downloaded from www.npeu.ox.ac.uk/downloads/files/mbrrace-uk/reports/MBRRACE-UK-PMS-Report-2014.pdf. In addition, on the website there is a copy of the slide set used at the launch on 17 May that can be downloaded for teaching purposes. As well as the main report, each trust and health board can obtain an individual report based on the deaths of infants born in their hospitals. These are not on the website but can be obtained from any of the registered lead reporters for your trust or health board. The graphs in these individual reports are also available as slides for teaching purposes.

It was decided to continue to report the various mortality rates using a traffic light system. Mortality rates for commissioning organisations and local authorities are compared to the relevant national average. For trusts and health boards, comparison is against a 'peer group average' with trusts and health boards allocated to one of five groups based on their access to neonatal intensive care, neonatal surgical provision and the number of in-house births. For those organisations rated red or amber it is important that there is a local review to try to understand the possible underlying factors that could be improved. The starting point should be ensuring that the data entered are complete and accurate. In addition, for commissioners, local authorities and neonatal networks the primary focus of the review should be population factors and issues in relation to the care pathway. For trusts and health boards the focus should be on individual patient care and, in particular, identifying potentially avoidable factors.

As with last year, the information is presented as tables and maps. The key messages from the report include:

1. National data subdivided by gestation demonstrate the major influence of prematurity, not only in relation to neonatal death, but also in relation to all categories of stillbirth.
2. The information, both by commissioning organisations and by trusts and health boards, continues to show great variation across the UK.
3. The issue of variation in outcome is especially stark in relation to neonatal network data. It is the neonatal mortality map, after stabilisation and adjustment, which is perhaps the most striking, showing a very clear north-south

divide for which there is no obvious explanation.

4. Rates of reporting of infants born showing no signs of life at 22 and 23 weeks' gestation has shown improvement compared to the data for 2013 but this needs to be reviewed at a local level by all trusts and health boards to ensure there is a systematic process for reporting these deaths to MBRRACE-UK. It is anticipated that the outcomes of these infants will be reported in more detail in next year's report.
5. There is more detail about the cause of death coding system used by MBRRACE-UK (CODAC), particularly in relation to congenital anomalies. We are very keen to move to a situation where mortality rates can be presented with and without those related to a congenital anomaly. At present even some major neonatal surgical centres report very few deaths related to a congenital anomaly. This was identified as being especially unusual as some other, apparently similar, centres reported that over half of their deaths were directly caused by or associated with the presence of a major congenital anomaly. It is really important for trusts and boards to work hard at making their coding via the CODAC system as accurate as possible in order that next year's report can look at mortality rates with and without the impact of congenital anomalies.

The launch of the MBRRACE-UK report took place at the RCOG on 17 May 2016. The meeting, opened by Health Minister the Rt Hon Ben Gummer MP, was very well attended by clinical staff from across the UK.

Work is underway on the next perinatal confidential enquiry, which is focussed on intrapartum-related deaths and will be launched at the end of 2017. Requests for notes of cases to be included in the review will be sent out shortly.

On behalf of MBRRACE-UK we would like to offer a big thank you to everyone involved with the reporting of late fetal losses, stillbirths and neonatal deaths across the UK. It is only with the collaboration of trusts and health boards that we can report in detail about perinatal mortality and identify ways to reduce the number of deaths every year in order to try to achieve the lower rates seen in many countries in Europe.

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Are you interested in becoming an MBRRACE-UK review panel member?

Seek nomination from your professional body or contact MBRRACE-UK directly:

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