Review of MBRRACE-UK 2013 & 2014 Perinatal Mortality Individual Trust Reports

DRAFT REPORT AUGUST 2016

The 2013 individual Trust Perinatal Mortality Surveillance reports were received from each of the five Trusts in SSBCNMN and reviewed by Babu, Adam and Ruth on 10th August 2016, in addition to the 2014 individual Trust Perinatal Mortality Surveillance reports of 3 of the 5 Trusts in SSBCNMN (RWH, WMH and SaTH).

Background

The reports concerned stillbirths and neonatal deaths among the babies born within each Trust in each year (2013 & 2014), EXCLUDING births before 24 weeks gestational age and all terminations of pregnancy.

Neonatal deaths are reported by place of birth irrespective of where death occurred.

Key Findings from the review

Extended Perinatal Mortality Rates in SSBCNMN – in 2013 these varied between Trusts from being 'More than 10 % lower' (UHNM) to 'More than 10% Higher' (RWH & SaTH) compared to the average for similar Trusts & Health Boards.

Socio-economic deprivation – there were no particular surprises with both WMH and RWH having the highest proportion of women (>60%) from the most deprived areas giving birth in their hospitals, followed by DGH (around 50%), then UHNM (around 40%) and then SaTH (around 30%).

Ethnicity of baby – again there were no particular surprises, however the ethnicity of 8.5 – 10.5% of babies was recorded as unknown in the 2013 reports. The figure came down to 0.5 - 1.1% in the 2014 reports. Since the process was new in 2013 the initial high figure may just be attributable to lack of familiarity with the reporting process.

Gestational age – the percentage of babies born at 28 – 31 weeks gestation in each Trust was similar to the national average in 2013. However the percentage of babies born at 24 to 27 weeks gestation at RWH at 0.8% was higher than the national average of 0.5%, and the percentage of babies born post term (42 weeks or greater) was lower than the national average at RWH, SaTH and WMH in the 2013 report (0.7, 1.1 & 1% respectively compared to 3.2%) and the 2014 report (0.3, 1.1, 0.5% respectively compared to 2.9%).

Cause of death – The CODAC system of death classification is used. In 2013 nationally there was a large proportion of stillbirths classified as unknown (47.2%). The rate was classified as unknown was variable in our network (between 33.3% at RWH to 75% at WMH). Neonatal deaths were less often recorded as unknown both nationally (4.5%) and in our network (0 at 4 of the 5 Trusts with 7.1% at UHNM – this was only 1 baby though). In 2014 the rates of "unknowns" nationally were 46.2% for stillbirths and 5.1% for neonatal deaths. Although the rates within the network still varied from 3.7% (RWH) to 62.5% (WMH) for unknown cause of stillbirth these rates had improved from the previous year.

Post-mortem - There is variation between the units in the network in the proportion of post mortems offered:

Stillbirths 79% (UHNM) – 100% (RWH & DGH)
Neonatal deaths 55% (UHNM) – 100% (SaTH & DGH)
Deaths of unknown cause - offered a post mortem 67% (UHNM) – 100% (RWH, SaTH & DGH)
Deaths of unknown cause - consent obtained for a post mortem 14% (DGH) – 85% (SaTH)

Completeness of key data items for deaths reported by each Trust - there was some variation seen in data completeness between Trusts in our network, although overall this was reported between 97 (RWH & UHNM) – to over 99% for each Trust in 2013 report and between 92 (RWH) – over 97% in the 3 2014 reports reviewed.

Recommendations

1. Cause of death - survey demand for a workshop on CODAC classification system used in the MBRRACE-UK tool in SSBCNMN
2. Post Mortem – ask bereavement lead group to review the network findings and consider an action plan to improve the offer and uptake of post mortems across the network
3. Completeness of data – survey demand for a workshop on the MBRRACE-UK reporting tool linked to CODAC workshop in 1 above.