



CEMACH

NEWSLETTER

Issue 3, November 2007

The Northern Ireland regional newsletter of the Confidential Enquiry into Maternal and Child Health

Welcome

Welcome to the third issue of the CEMACH newsletter.

This newsletter aims to disseminate important information about current and future CEMACH projects to health professionals who contribute to the work, and also to all those committed to improving maternal and child health through planning and delivering health services.



The CEMACH regional office is now well integrated within the Health Promotion Agency for Northern Ireland (HPA). Having produced several reports, and with more planned over the next few months, it has been a busy time for CEMACH since the last newsletter was issued.

We are pleased that the Neonatal Intensive Care, Outcomes, Research and Evaluation group (NICORE) has now joined CEMACH within the HPA. We hope that this move will consolidate the excellent work NICORE has been carrying out, supported by the goodwill of many health professionals.

Angela Bell

NICORE joins the CEMACH team within the HPA

CEMACH is pleased to welcome NICORE, which joined CEMACH in April 2007 as part of the wider Maternal and Child Health Office of the HPA.

NICORE's work is directed towards improved outcomes for newborn infants admitted to neonatal care. The group consists of a network of health professionals working together to formulate and deliver a coordinated programme of research, education and quality improvement strategies.

NICORE activities include:

- production of comprehensive reports, including details on matters such as neonatal intensive care/special care provision, outcomes in terms of mortality and morbidity, quality markers and patterns of transfer;
- facilitation of benchmarking locally, through the provision of individual unit reports, and internationally, through participation in the Vermont Oxford Network and Euroneostat;
- development and support of 'in-depth' quality improvement projects. Recent projects have included 'Reduction of nosocomial infection in infants with birth weight <1500g' and 'Timing of administration of surfactant administration'.

CEMACH hopes this partnership will be a valuable step in providing enhanced information and quality improvement work in the field of perinatal and child health.

Research midwife boosts the CEMACH team

Joanne Gluck joined the HPA as Clinical Research Midwife for CEMACH in April 2007.

Joanne assists in the planning and delivery of current CEMACH projects and she has special responsibility for supporting the maternity programme.

Joanne will be liaising directly with nurses, midwives and medical staff within trusts, assisting with quality assurance of CEMACH data and keeping staff informed of CEMACH findings and recommendations.

Joanne is also involved in auditing the uptake of perinatal autopsy in Northern Ireland. She has gained previous research experience in a variety of settings, most recently working on a multicentre worldwide study which aims to improve our understanding of abnormal levels of glucose during pregnancy.

Prior to this post she worked as a Research Nurse with the Medical Research Council at Southampton University Hospitals.



Perinatal mortality report issued

CEMACH published its annual perinatal mortality report for 2005 in April 2007.

Covering England, Wales and Northern Ireland, the report examined stillbirths, early or late fetal deaths in pregnancy and babies in the first four weeks of life.

The report shows good progress in survival rates in the very preterm babies over the past 10 years, with overall neonatal mortality reported as 3.5 per 1,000 live births. Gestation specific mortality rates for England, showed 58% of babies born at 24 weeks survived the neonatal period, increasing to 77% at 25 weeks, compared to 43% and 59% respectively a decade ago.

Concerns are raised, however, over the stillbirth rate of 5.5 per 1,000 total births, which has not improved since 1992. In greater than 50% of cases the cause of death is 'unexplained' using the current classification systems.

The regional variations are reported. Northern Ireland compares favourably with the national results. There were 227 deaths in Northern Ireland recorded by CEMACH in 2005. The Northern Ireland perinatal death rate of 8.0 per 1,000 total births was close to the 8.2 reported for England, Wales and Northern Ireland.

Maternal risk factors for perinatal death were:

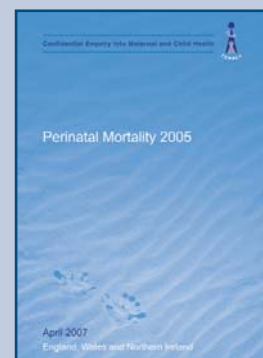
- maternal age (the highest death rates were in very young and older mothers);
- high BMI (30% of women having a stillbirth or neonatal death were obese);
- social deprivation and ethnicity.

Key areas for action include:

- development of services that target the major maternal risk factors during pregnancy such as social deprivation and ethnicity;
- greater focus on reducing the stillbirth rate through public health initiatives and research.

Copies of the report can be obtained from CEMACH central office, London, or downloaded from the CEMACH website at www.cemach.org.uk

The annual mortality surveillance report for 2006 is due to be published in January 2008.



Diabetes in pregnancy report now available

The CEMACH *Diabetes in pregnancy: caring for the baby after birth. Findings of a national enquiry* report was released on 10 October 2007.

This study has shown that, often because of routine hospital policies, a high proportion of women in England, Wales and Northern Ireland have their babies admitted to special care baby units.

Over half of all neonatal admissions were assessed as 'avoidable' by expert panels. This was mainly because of lack of any specific medical indication for admission or suboptimal thermal care on the labour ward.

The report also shows that there were a number of barriers to breastfeeding:

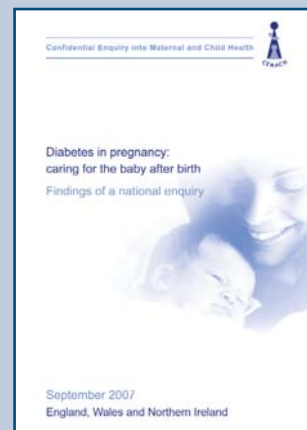
- a quarter of babies did not have early feeding on the labour ward;
- infant formula was given as first feed to two thirds of babies;
- infant formula feeding on the postnatal ward was often determined by maternal choice but babies admitted to the neonatal unit were given infant formula even when the maternal intention was to breastfeed.

The first blood glucose measurement was often performed too early, leading to unnecessary interventions and admission to a special care baby unit for some babies. The method of measurement used was often inaccurate and accompanied by insufficient documentation of management.

The report's recommendations are:

- mothers with diabetes should be informed antenatally of the beneficial effects of breastfeeding on metabolic control for their babies;
- babies should be with their mothers immediately after birth, provided there are no complications;
- mothers should be offered an opportunity for early skin to skin contact with their babies;
- staff should encourage early breastfeeding within one hour of birth;
- there should be appropriate timing of blood glucose measurement in babies of mothers with diabetes using accurate methods (eg ward based glucose electrode or laboratory analysis);
- better guidelines and training are necessary for healthcare professionals in the management of mothers with diabetes.

Copies of the report can be obtained from CEMACH central office, London, or downloaded from the CEMACH website at www.cemach.org.uk



New form to improve information quality

CEMACH is producing a new perinatal death notification form for 2008 with the aim of improving the quality of the information gathered by it.

The dataset will include a new perinatal mortality classification system to help achieve greater understanding of some of the unexplained deaths within the mortality surveillance using the current Aberdeen and Wigglesworth classifications.

The form has been piloted in three regions and has gained positive feedback. Following final revisions the form will be available for information to trusts in November.

Dr Angela Bell will be meeting with CEMACH unit coordinators from each maternity unit in Northern Ireland in November to review the form, present the findings of the pilot project and to answer any queries.

Child Health Enquiry

Child Death Review report on case ascertainment and data acquisition

CEMACH published its second interim report of the Child Death Review at the end of October to inform Local Safeguarding Children Boards (LSCBs) on the feasibility of collecting a minimum dataset of child deaths.

The Child Death Review involved collection of a core data set on all child deaths aged 29 days up to the eighteenth birthday during the 2006 calendar year in five regions (South West, West Midlands, North East, Wales and Northern Ireland).

Up to 150 of those selected from across the regions and age ranges involved in the study were subject to multidisciplinary panel review.

The short report focuses on:

- the ease of acquisition of the CEMACH dataset through the establishment and use of a network of local contacts;
- completion rates of each component of the data set.

There were 957 deaths in 2006 notified by the CEMACH Child Death Review teams compared to 461 registered deaths available from the Office of National Statistics (ONS) and the Northern Ireland Statistics and Research Agency (NISRA). In Northern Ireland there were 101 deaths notified to CEMACH compared to 71 currently registered deaths. (NISRA).

Completeness of data collection

Report	Total	Notification only		In progress		Core data set complete	
		No.	%	No.	%	No.	%
First interim report	242	86	35.5	70	28.9	86	35.5
Second report – all regions	960	17	1.7	92	9.6	851	88.6

Completion rate for the entire year of data collection was assessed when the database closed on 31 May 2007. Much higher rates of data completion were reported compared to the first interim report. This was probably because regional managers were consolidating networks and establishing local processes for obtaining information from new and diverse sources.

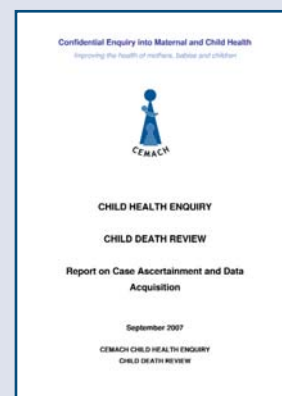
Completion rates for individual elements were summarised in the report. In general, completion rates for the variables within the data set were high. Cases which had not been signed off as complete were usually waiting for additional information from an autopsy or the coroner.

Case acquisition using the local networks was quicker than through registration data provided by ONS and NISRA, principally because registration may have been appropriately and justifiably delayed by postmortem processes, coroners' enquiries or police investigations.

However the completion of the core data set was necessarily and inevitably delayed until these other processes were complete.

The report also makes specific recommendations for a national statistical return in relation to LSCBs.

The full report on the Child Death Review will be published in April 2008.



Thank you to Child Death Review multidisciplinary panel

The final multidisciplinary review panel for the Child Death Review pilot project was held at the HPA on 3 October 2007. Eight panels were held over the past 18 months, with 30 health professionals contributing some 600 hours of work to the review panel.

CEMACH wishes to thank everyone involved in this massive undertaking and for their important contribution to the Child Death Review. We hope it will lead to improved health provision for children in the future.



The Child Death Review panel at their closing meeting.

Best wishes to Dr Claire Willis

A special word of thanks to Dr Claire Willis who moved on from her position in CEMACH in September.

Claire joined the CEMACH team in April 2006 on secondment from the Department of Health, Social Services and Public Safety as Consultant in Public Health to the HPA.



While working as Senior Medical Officer in the DHSSPS she was responsible for coordinating the Maternal Death Enquiry on behalf of the Chief Medical Officer and the Directors of Public Health. Claire continued this role within CEMACH. She brought continuity and provided leadership and guidance to the Maternal Death Enquiry but also to the wider work of CEMACH.

We wish to thank Claire for her contribution to CEMACH and wish her and her family well in the future.

New topic enquiry planned

CEMACH's next major project into maternity care will be on obesity in pregnancy.

CEMACH reports have shown that obesity is a significant risk factor in pregnancy for both maternal and perinatal death. There is also increasing evidence that obesity in pregnancy increases morbidity for both the mother and the baby.

While there are specific recommendations in some guidelines such as prevention of thromboembolism, there is no single national clinical guideline available in the UK with regard to standards of care for obesity and pregnancy.

The aim of this project will be to investigate what standards are in use in maternity units and whether they are adhered to.

The study will have three components:

- an organisational survey of services for obese pregnant women;
- development of consensus standards;
- a detailed audit of standards, using a retrospective review of case notes of women identified as obese during pregnancy.

It is expected that the survey will take place in 2008 with the more detailed work happening in 2009.

Further information will be available in the next newsletter.

Future events

CEMACH report launch

Saving Mothers' Lives: Findings of the UK confidential enquires into maternal deaths 2003–2005 (Formerly 'Why Mothers Die')

Venues

London: Tuesday 4 December, 2007 (Royal National Hotel)
Cardiff: Wednesday 5 December, 2007 (Mercure Holland House)
Manchester: Thursday 6 December, 2007 (Lancashire County Cricket Ground) with video link to Glasgow

There will be three national venues for the launch of the findings of the UK confidential enquiries into maternal deaths 2003–2005 report, which for the first time will contain 10 key recommendations.

The launch is aimed at primary and secondary health care professionals involved in caring for pregnant or recently delivered women, as well as service planners, public health professionals, commissioners of maternity services and risk managers.

The purpose of the three days is to disseminate the report's key recommendations to health professionals involved in this area of care.

The launch programmes will include the following topics:

- why mothers die: direct and indirect causes;
- key recommendations from the report;
- translating findings into practice;
- issues for midwifery care;
- a woman's perspective on maternity care.

A regional meeting and workshop on the 10 key recommendations from *Saving Mothers' Lives (2003–2005)* is also planned for spring 2008. Further details will be available soon.

For further information see the CEMACH website at www.cemach.org.uk

A word of thanks

Finally, thank you! The work of CEMACH is only possible because of the work and commitment of the many health professionals who provide data, participate, act as assessors and then implement the recommendations.

CEMACH welcomes enquiries from professionals who may wish to use the mortality data for specific projects.

Data release and data request forms are available through the CEMACH regional office or can be downloaded from the CEMACH website at www.cemach.org.uk

Contact us

Further information on the work of CEMACH can be obtained from the CEMACH (Northern Ireland) regional office.

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