



CEMACH

NEWSLETTER

Issue 2, December 2006

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

Welcome

Welcome to the second issue of the CEMACH regional office newsletter, produced to disseminate information about current and future planned CEMACH projects to all health professionals who contribute to the work.

It has been a time of change for the CEMACH regional office since production of the last newsletter, with a new location and also the appointment of a new regional coordinator following the retirement of Dr Maureen Scott, who established the enquiry in Northern Ireland.

The CEMACH regional office moved to the Health Promotion Agency for Northern Ireland (HPA) in December 2005. Although the work is now commissioned by the Department of Health, Social Services and Public Safety (DHSSPS) through the HPA, the work continues to be overseen by a multidisciplinary steering group, chaired by the Chief Medical Officer.

Dr Angela Bell took on the role of CEMACH Regional Coordinator in January 2006 following Dr Scott's retirement at the end of 2005. Despite the major changes in CEMACH over the past year, the transition has been very smooth due to the support and continuity brought by Terry Falconer and the support from the HPA.

Angela Bell

HPA welcomes CEMACH

As Chief Executive of the Health Promotion Agency (HPA) I was delighted to formally welcome CEMACH (Northern Ireland) into the organisation almost a year ago in January 2006.

We welcomed this new area of work in the knowledge that it would complement the wider public health remit of the HPA extremely well – and this has indeed been the case.

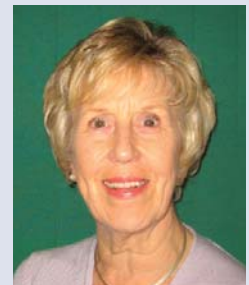
The integration of CEMACH into the HPA has resulted in the development of new processes and procedures that will ensure the important role of the enquiry is maintained and developed in partnership with other Health and Personal Social Services bodies.

We are committed to providing support for the ongoing and developing work of CEMACH and to enhancing its work by integrating recommendations and lessons learnt from enquiries such as CEMACH into wider public health practice.

Brian Gaffney

Best wishes to Dr Scott on her retirement

Dr Maureen Scott was appointed Regional Coordinator for the Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI) in Northern Ireland at its inception in 1993.



She developed a prompt and reliable reporting system for perinatal deaths at a time when no surveys or enquiries into fetal and infant loss were being conducted at a regional level.

Dr Scott left a well established enquiry, having built up strong links and support over the years with all health professionals who contribute to maternity services in Northern Ireland.

We would like to wish Dr Scott a very happy and healthy retirement and thank her for the major contribution she provided to maternal and perinatal health in Northern Ireland.

Meet the current staff



Dr Angela Bell

Angela took on the role of CEMACH Regional Coordinator in January 2006 following her appointment to the HPA as Director of Maternal and Child Health.

She worked as a consultant paediatrician with an interest in the newborn for 15 years at the Ulster Hospital, where she was also Clinical Director for Maternal and Child Health.



Dr Claire Willis

Claire joined the CEMACH team in May 2006 following her appointment to the HPA as a consultant in public health, on secondment from the DHSSPS.

Previously, she was a Senior Medical Officer in the DPSSPS, working in the area of health information and maternal and child health.



Ms Terry Falconer

Terry is well known to many of you, having worked with CEMACH since 1995.

She was appointed to the HPA as Project Manager for CEMACH, on secondment from Queen's University, Belfast, where she holds the position of Research Fellow.



Ms Ann Marie McCann Ms Stephanie Hamilton

Completing the team and providing essential administrative and database support are Ann Marie, top, and Stephanie who are both employed by the HPA.

Future events

Diabetes and pregnancy: are we providing the best care?

There will be three national launches for the final report of the CEMACH 'Diabetes in pregnancy' programme.

Choice of venues

- Sheffield, 26 February 2007 (Sheffield United Football Stadium)
- Birmingham, 27 February 2007 (Birmingham Bescot Stadium)
- London, 1 March 2007 (The Barbican)

The programme began in 2001 to provide a national overview of the epidemiological, organisational and clinical issues associated with diabetes in pregnancy.

The launches are for all primary and secondary care providers who may be involved in the care of women of reproductive age with Type 1 or Type 2 diabetes.

The programme will include:

- findings and recommendations from the report;
- updates on recent research initiatives into diabetes and pregnancy;
- other European centres' experiences of diabetes and pregnancy.

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

CEMACH regional conference on diabetes in pregnancy

In May, the CEMACH regional office held a conference on diabetes in pregnancy. The aim of the event was to present the findings from the second module of the CEMACH diabetes enquiry, the cohort report on pregnancy in women with Type 1 and Type 2 diabetes, and also to discuss how the findings could be taken forward in Northern Ireland.

The event was attended by almost 100 delegates from a wide range of professions.

Staff from the CEMACH central office in London contributed to the event, setting the scene for the day by giving the background to the diabetes cohort report and outlining the main results.

Guest speakers from England included Mr Steve Walkinshaw, a consultant obstetrician who gave a lively delivery of key messages for maternity staff, and Dr Gillian Hawthorne, a consultant physician from Newcastle who presented key messages for the diabetic team.

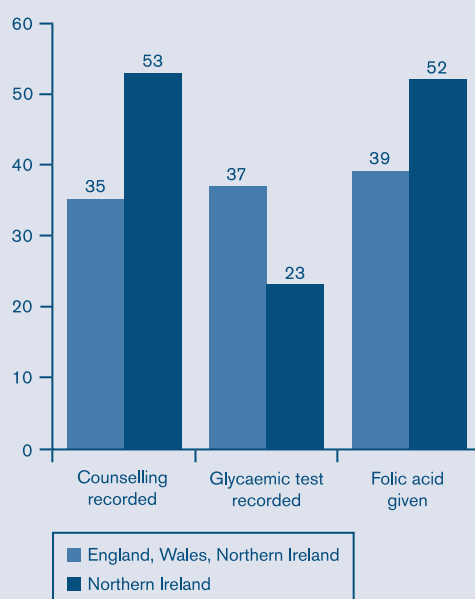
A local perspective was given by Dr Sanjeev Bali, a consultant neonatologist, and Dr David McCance, a consultant physician.

Key messages from the conference:

- Type 2 diabetes is becoming more common in pregnancy and has the same adverse outcome for the baby as Type 1 diabetes if poorly controlled;
- there is poor pre-pregnancy planning for women with diabetes, with few receiving counselling, many not taking folic acid and many having poor glycaemic control before embarking on pregnancy;
- there is a need for multidisciplinary clinics for management of women with diabetes during pregnancy.

The event finished with a workshop in the afternoon, where the participants considered the report in relation to the service provided in Northern Ireland. Groups considered six different questions, which produced a wealth of ideas. Similar messages came out of all the groups in relation to pre-pregnancy planning clinics and education of the public and health professionals.

Preparation for pregnancy in women with diabetes – Northern Ireland alone, compared to England, Wales and Northern Ireland combined



It is hoped that lessons learned on the day will help health professionals provide an improved service to women with diabetes and contribute to better outcomes for the women and their babies.



Pictured at the Diabetes in Pregnancy conference are, from left, speakers Dr David McCance, Consultant Physician, Regional Centre for Endocrinology and Diabetes, Royal Victoria Hospital, Belfast; Dr Gillian Hawthorne, Consultant Physician, Newcastle Diabetes Centre, Newcastle; and Chairperson, Dr Catherine Ritchie, Consultant Physician, Craigavon Area Hospital.

Maternal enquiry: Why mothers die

The aim of the maternal health enquiry is to help ensure that all pregnant and recently delivered women receive the best possible care in appropriate settings that take account of their individual needs.

The maternal enquiry programme is currently based on a triennial report that covers all causes of maternal deaths. This has been the approach since 1952 and much has been achieved since then. Deaths from direct obstetric causes have fallen by over 90% since the 1950s and fewer than 120 are now expected in each triennium.

There are, however, issues related to maternal mortality and morbidity where there is no evidence of improvement and where matters appear to be getting worse. Causes of death indirectly related to pregnancy, eg suicide or heart disease, are now more common than those directly related to it. Public health issues, such as obesity, have been identified as increasingly important in understanding maternal mortality.

It is a government requirement that all maternal deaths should be subject to confidential enquiry. The scope of the enquiry includes late maternal deaths, ie any death that occurs during or within one year of pregnancy, childbirth or abortion.

Definitions of maternal deaths¹

– Maternal deaths*

Deaths of women while pregnant or within 42 days of the end of the pregnancy, from any cause related to, or aggravated by, the pregnancy or its management, but not from accidental or incidental causes.

– Direct*

Deaths resulting from obstetric complications of the pregnant state (pregnancy, labour and puerperium), from interventions, omissions, incorrect treatment or from a chain of events resulting from any of the above.

– Indirect*

Deaths resulting from previous existing disease or disease that developed during pregnancy and which was not due to direct obstetric causes, but which was aggravated by the physiologic effects of pregnancy.

– Late***

Deaths occurring between 42 days and 1 year after abortion, miscarriage or delivery that are due to *Direct* or *Indirect* maternal causes.

– Coincidental (Fortuitous)**

Deaths from unrelated causes which happen to occur in pregnancy or the puerperium.

* World Health Organization. ICD 9. Geneva: WHO, 1977.

** ICD 9/10 classifies these deaths as *Fortuitous* but the enquiry prefers to use the term *Coincidental* as it is a more accurate description. The enquiry also considers deaths from *Late Coincidental* causes.

*** World Health Organization. ICD 10. Geneva: WHO, 1992.

Notifications are made to the relevant Director of Public Health for the woman's Board area. The CEMACH regional office then arranges for the enquiry form to be completed by the health professionals involved in the case and obtains copies of the relevant case notes, which are anonymised prior to multidisciplinary review of the death. Local professional input to the multidisciplinary review panel is provided by Dr Ann Harper, as obstetric lead, along with sub-specialty input from anaesthetics, midwifery, pathology and psychiatry.

Future plans

From 2006, CEMACH is developing a new approach to the maternal enquiry. Continuous monitoring of trends in maternal mortality will be performed with regular analysis and reporting of maternal mortality annually along with stillbirths and neonatal deaths to ensure that any worrying fluctuations are picked up quickly. A full report on deaths, *Why mothers die*, will be published every four years, rather than the current three. This will be supplemented by in-depth topic-based enquiries to explore and make a contribution to understanding those causes of maternal mortality and morbidity that are now proving difficult to reduce.

¹ Confidential Enquiry into Maternal and Child Health. *Why mothers die 1997–1999*. The sixth report of the confidential enquiries into maternal deaths in the United Kingdom. London: CEMACH, 2004.

Child health enquiry programme

In 2004, CEMACH established a new child health enquiry programme to complement the organisation's long standing work in maternal and perinatal health. Following an open invitation/selection process, two projects were taken forward to explore the feasibility of conducting confidential enquiry work in child health on a national basis. The first project is a review of all children's deaths and the second will focus on head injury in children, which will review morbidity as well as mortality.

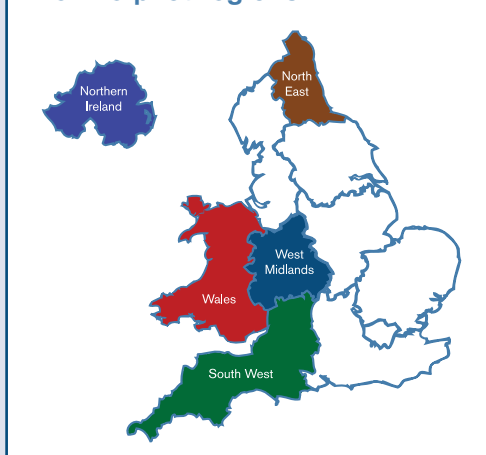
The child death review project

Northern Ireland is one of five UK regions contributing to *The child death review*. The aim of the project is to obtain an overview of all child deaths and identify preventable and avoidable factors.

The objectives are to:

- identify all the deaths of children aged between 28 days and 18 years in the five pilot regions (see map opposite);
- collect 'core' data on all those deaths;
- conduct a detailed review of a subset of deaths to identify preventable and avoidable factors;
- assess the feasibility of conducting national confidential enquiry work into child deaths.

The five pilot regions



This work is being carried out in association with the Department for Education and Skills' Local Safeguarding Children's Boards in England with the aim of informing future data collection methods of all child deaths.

The project is reviewing the deaths of children aged between 28 days and 18 years in the five UK regions detailed in the map. The five regions together will contribute approximately 33% of national childhood deaths, with an expected annual total of 995 cases, 120 of these in Northern Ireland.²

Core dataset

The core data on each child death are captured on a standardised form. It includes demographic and death certificate information, previous medical and developmental history, social circumstances of the child, and circumstances of non-natural deaths. It does not include opinions of care or value judgments. Official data collection for the child death review commenced on 1 January 2006 and will continue on all deaths that occur by 31 December 2006. Notifications and core dataset collection on all deaths are progressing satisfactorily, with a total of 94 cases notified in Northern Ireland by the end of October 2006.

Multidisciplinary case reviews

Multidisciplinary reviews are conducted on a randomly selected subset of cases using a structured pro forma. The aim of the case reviews is to identify preventable and avoidable factors. The reviews are conducted on anonymised notes from cases selected from 'out of region'.

The multidisciplinary panels in Northern Ireland are chaired by Dr Moira Stewart, Consultant Paediatrician and Senior Lecturer in Child Health, Queen's University, Belfast. The panel comprises a wide range of local health professionals – health visitors, paediatric nurses, paediatricians, social workers, paediatric pathologists, anaesthetists, police, paramedics and lay members. Additional members from sub-specialties are invited to join the panel depending on the type of cases selected for review. The first panel met in Belfast in September 2006, with a further five panels planned.

Conclusion

The final report of this review will be published in early 2008. It will provide valuable information on why and where children are dying, whether any of the deaths could be prevented, and how quality of care could be improved.

² The Office for National Statistics and Northern Ireland Statistics and Research Agency, 2004

Further development of the CEMACH newsletter

From 2007 the *CEMACH newsletter* will be produced biannually. We aim to present a good balance of current work being undertaken by the CEMACH regional office for Northern Ireland, other work throughout the United Kingdom and advance notice of upcoming work and events. We hope that you find the publication both informative and useful.

In our efforts to improve our communications with you and ensure we are sending you the right information at the right time, we would welcome any suggestions regarding future content. You can contact our editorial office either by telephone or email at the address below.

During 2007 we hope to conduct a survey through the newsletter on the content and target audience. More information will be available in the next issue.

If you are currently not on the mailing list to receive the *CEMACH newsletter* or know of any colleagues who would like to be included on the mailing list to receive future issues, please contact us at the address below.

A word of thanks

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

A special thank you to several people who have made a significant contribution to CESDI and CEMACH, and who have recently retired:

- Ms Maureen Beattie, CEMACH Area Coordinator for perinatal death notifications for the Western Board;
- Mrs Ester Miller, Midwifery Manager, Erne Hospital, and midwifery assessor for the maternal death enquiry;
- Dr Inder Bali, Consultant Anaesthetist, Antrim Area Hospital, and anaesthetic assessor for the maternal death enquiry;
- Dr Murray Quinn, Consultant Paediatrician, Altnagelvin Hospital, and unit contact for child health and perinatal work.

CEMACH welcomes enquiries from professionals who may wish to use the mortality data for specific projects. Data release policy 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. To view issue one of the *CEMACH newsletter* go to www.cemach.org.uk/publications/CEMACH_Newsletter2004.doc

Address: CEMACH (Northern Ireland) regional office,
Health Promotion Agency for Northern Ireland,
18 Ormeau Avenue,
Belfast
BT2 8HS

Tel: 028 9031 1611
Fax: 028 9031 1711
Email: northern.ireland@cemach.org.uk
Web: www.cemach.org.uk/northernireland.htm

