The Royal Wolverhampton Hospitals NHS Trust	

Trust Board Report

Meeting Date:	22 July 2013
Title:	Perinatal Mortality New Cross Hospital 2012
Executive Summary:	
Action Requested:	
Report of:	Dr Jonathan Odum – Medical Director
Author: **Contact Details:**	Dr Helen Sullivan Tel 01902 695958 Email : Jonathan.Odum@nhs.net
Resource Implications:	
Public or Private: **(with reasons if private)**	Public Session
References: **(eg from/to other committees)**	
Appendices/ **References/** **Background Reading**	
NHS Constitution: **(How it impacts on any decision-making)**	In determining this matter, the Board should have regard to the Core principles contained in the Constitution of: - Equality of treatment and access to services - High standards of excellence and professionalism - Service user preferences - Cross community working - Best Value - Accountability through local influence and scrutiny

Background Details

Perinatal Mortality New Cross Hospital 2012

Definitions

Perinatal mortality rate = stillbirths and neonatal deaths per 1000 births
Stillbirth rate = stillbirths per 1000 births
Early neonatal death rate = deaths within first seven days per 1000 births
Neonatal death rate = deaths within first 28 days per 1000 births

Uncorrected data 2012

56 deaths
25 stillbirths
31 neonatal deaths

With a total number of births of 4072

Perinatal mortality rate = 14.0/1000
Stillbirth rate = 6.1/1000
Neonatal death rate = 7.6/1000

Corrections to data 2012

The data presented by national and regional organisations is always corrected for a number of factors. Unfortunately recently these organisations have not revealed which corrections they have applied to their data. I have listed corrections that have been applied to the national mortality rates in the past. The correction least likely to be applied is in utero transfer as there is at least some opportunity for the receiving maternity unit to affect the outcome.

Ex utero transfers	Baby transferred to New Cross after birth	10 neonatal deaths
Unbooked women	Women whose first presentation to maternity service was with a dead baby or in advanced labour	5 (2 neonatal deaths and 3 stillbirths before labour)
Birth weight < 500g		2 neonatal deaths
Lethal congenital abnormalities		6 (1 stillbirth / registerable TOP and 5 neonatal deaths)
In utero transfers	Mother transferred to New Cross when concerns arise to be near neonatal cot	2 neonatal deaths

Corrected data New Cross Hospital 2012

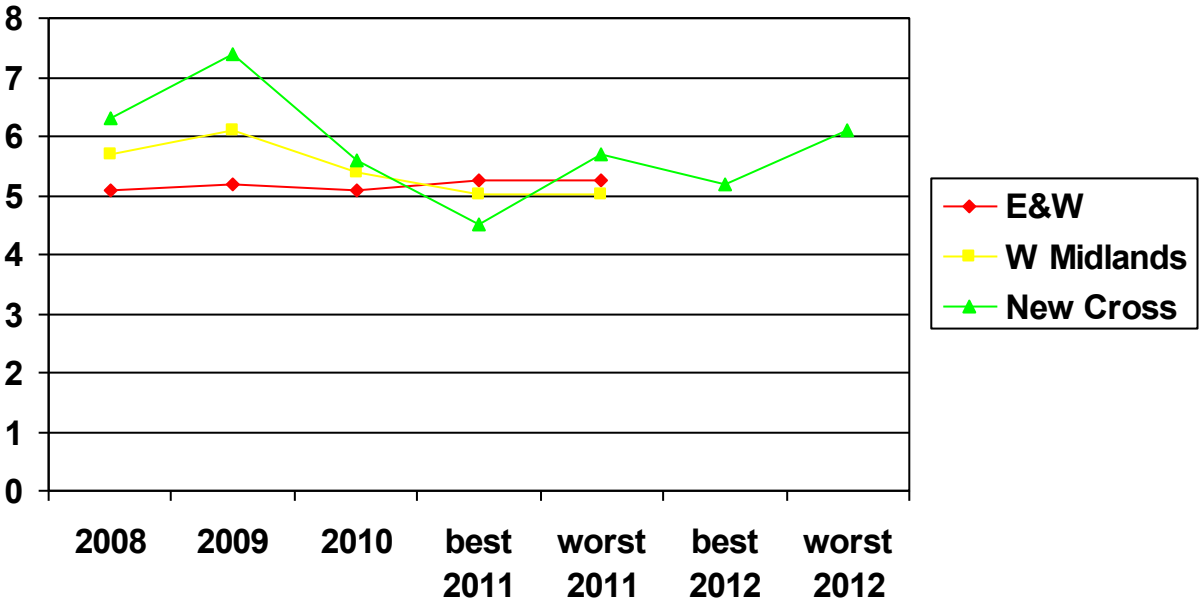
If all the corrections are applied to the mortality rates at New Cross, they are as follows:

Perinatal mortality rate	= 8.6/1000
Stillbirth rate	= 5.2/1000
Neonatal death rate	= 2.9/1000

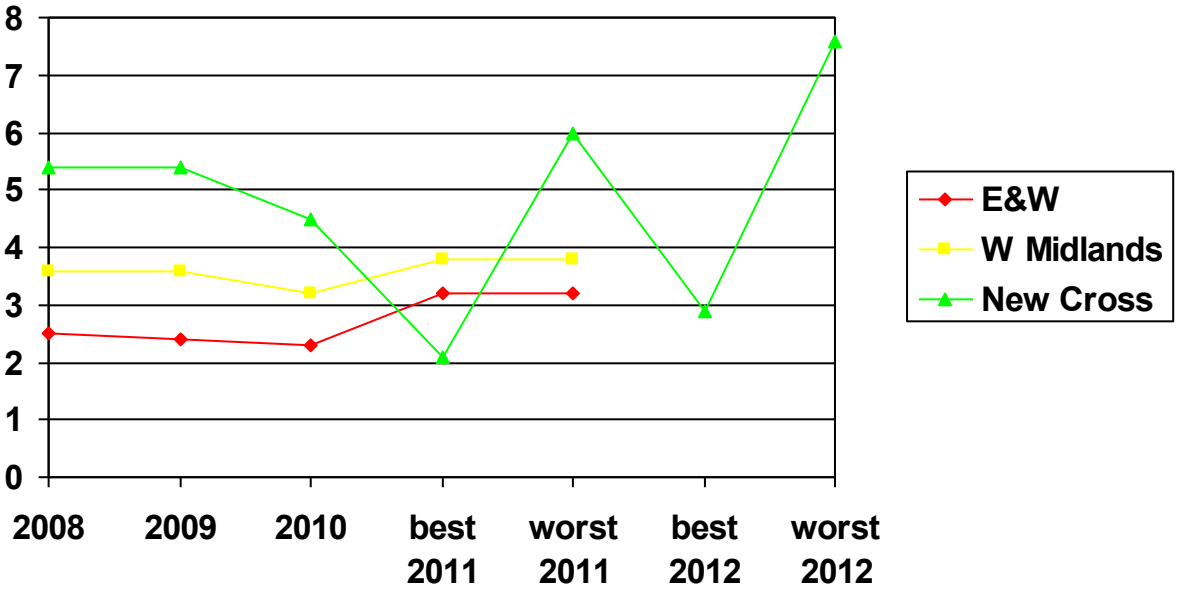
Comparison to national and regional rates

I have not identified the 2012 national and regional mortality rates to date. This is likely to be because of the reconfigurations of healthcare.

Stillbirth rates (per 1000)



Neonatal death rates (per 1000)



We report our data to regional and national organisations to try to gain comparative data. We were reporting to the West Midlands Perinatal Institute but this closed in April 2013. We are now reporting to MBRRACE-UK (Mothers and Babies Reducing Risk through Audit and Confidential Enquiries). Sometimes the data we receive back is not as useful as we would wish.

- Relates to the Wolverhampton PCT (as was) not New Cross specifically
- Presented as rolling averages
- No transparency as to the corrections applied to the crude rate.
- Only reports early neonatal deaths or includes all infant deaths

It is to be expected that the perinatal mortality rate at New Cross will be higher than the national and regional averages because of:

- Level 3 neonatal unit (able to manage the sickest babies)
- Deprivation e.g smoking rates
- Higher rates of consanguinity leading to higher rates congenital anomaly

2011 data from the West Midlands Perinatal Institute would suggest our stillbirth rates and neonatal death rates are in line with other units with Level 3 neonatal units The stillbirth rate (rolling averages) are 6.9 at New Cross, 6.9 at Birmingham Women's Hospital and 8.2 at Heartlands Hospital.

Review of stillbirths and neonatal deaths

Perinatal mortality meeting

All cases of stillbirth and neonatal (and indeed early infant deaths) are presented at the monthly Perinatal Mortality meeting which is attended by both obstetric and neonatal staff and a perinatal pathologist from Birmingham Women's Hospital. This meeting is both educational and an opportunity to review the causes of deaths. The perinatal mortality data has been presented annually for the last two years, with simple analysis by gestation and causes compared to the rates reported by CMACE 2009 (Confidential Mother and Child Enquiry – now not in existence).

Risk management

All stillbirths (other than terminations of pregnancy) are discussed at the Weekly Obstetric Risk meeting. This is attended by the risk manager, midwifery managers, bereavement midwife, supervisor of midwives, delivery suite manager, lead consultant for delivery suite and Dr Vanner. At this meeting detailed case summaries are discussed and the quality of care assessed. A CESDI (Confidential Enquiry into Stillbirths and Deaths in Infancy – now not in existence) code is assigned. This is used to assign the final categorisation according to the Trust's risk matrix.

A quarterly report is produced which is brought to the Obstetrics and Gynaecology Audit and Governance Meeting and therefore feeds into the Trust's Audit and Governance service.

A similar process is in place for neonatal services.

Risk management codes stillbirths 2012

CESDI 0	(green)	No suboptimal care	20
CESDI 1	(yellow)	Suboptimal care, different care would have made no difference to the outcome	4
CESDI 2	(amber)	Suboptimal care, different care might have made a difference to the outcome	1*
CESDI 3	(red)	Suboptimal care, different care would reasonable be expected to make a difference to the outcome	0

* failure to investigate a woman fully for a second episode of reduced fetal movements when she attended with pain.

STEIS incidents

- All stillbirths over 37 weeks gestation and
- Intrapartum stillbirths

are reported via the STEIS system. As required a RCA is prepared, as it would also be for any red incident (and for some amber incidents, especially where it is thought there are significant lessons to be learnt). The RCAs are monitored through the Obstetrics and Gynaecology Audit and Governance Committee, which feeds into the Trust Audit and Governance Service.