MBRRACE-UK
Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK

Perinatal confidential enquiry 2018/19: multiple births

Case review panel member guidance and training

Thank you for your interest in taking part in the confidential enquiry into multiple births, specifically twin pregnancies ending in at least one late fetal loss (22-23 weeks gestation), stillbirth or neonatal death. The purpose of the enquiry is to look at quality of care, identifying aspects of both good practice and aspects where there is a need for improvement. By way of preparation for the process, this document sets out the key steps in the process and the general principles that will be applied.

Preparation for the enquiry process

The cases to be reviewed have been randomly selected from perinatal deaths reported to MBRRACE-UK for babies born during 2017. Approximately 120 pregnancies have been selected to form the basis of the confidential enquiry and have been chosen to represent a geographical spread across the UK. The case notes of the selected mothers and babies have been anonymised to safeguard the identity of the babies and families involved. A Topic Expert Group was convened to steer the enquiry (a multidisciplinary group comprising of clinical experts and parent representatives). The aim of this group was to develop a framework against which cases can be assessed.

The assessment process

Panel members will be asked whether they are able to attend an assessment panel on a particular date and once it is clear that a full multidisciplinary team can be convened (joining by telephone will not be possible) all the members of the assessment team will receive a confirmed date and venue (we will do our best to make travel arrangements as easy as possible). The meeting will last the whole day and it is essential that all the members of the panel are present for the entire meeting. Each meeting will comprise a maximum of 12 panel members of mixed specialty and will be chaired by one of the MBRRACE-UK team.

Approximately 3-4 weeks ahead of the meeting you will be given access to the notes of the cases to be discussed on that day. You will be asked to read all of the case notes and “score” the care. In addition one or perhaps two cases will be identified for which you will be asked to lead the discussion at the face-to- face consensus meeting. The number of cases reviewed at each meeting will be dependent on the complexity of the cases.

At the start of a case review panel meeting the Chair (neutral) will re-iterate the principles of the process and answer any questions prior to the start of the meeting. During the course of the case review panel meetings each case will be discussed with the aim of resolving any differences of opinion about the standard of care provided. At the end of each discussion a consensus evaluation form, based on the panel review, will be completed. The final consensual assessment of each case will be collated by the MBRRACE-UK team.

Access to case notes

All details of allocated cases (surveillance data, case notes, post-mortem report and local review) will be available for viewing ***only*** via a secure online high compliance system. Full details for accessing the anonymised notes via the case viewer will be provided to each case reviewer in an email, as well as via telephone for all new panel members. Please note: all users of the MBRRACE-UK system are required to complete and return our confidentiality statement and declaration of interest form, before access is granted to view the selected cases.

Panel members will access the case notes they have been allocated online and assess each case using the standard form. As a case review panel member you will be sent copies of the assessment forms by the MBRRACE-UK office and instructed to complete the forms for each case allocated for review. A summary score will be determined for inclusion in the final report.

For the purposes of this enquiry, we will consider the outcome for the baby and for the mother separately.

Anonymisation of cases

All cases will be available for viewing in an anonymised format and no attempt should be made by reviewers to try to identify the identity of cases.

We have developed a form to support the review process. The assessment form asks the reviewer to consider a series of steps on the care pathway which map to the various headings on the document produced by the Topic Expert Group. It comprises questions about the quality of care at each stage using a grading system, but also includes free text boxes for reviewer's opinions or other points they wish to raise, including examples of good care.

Categorisation of cases

For each aspect of care along the pathway, reviewers will be asked to grade the care into one of the following three categories separately for the outcome for the mother and the baby:

- ***Good care; no improvements identified***
- ***Improvements in care* identified which would have made no difference to outcome***
- ***Improvements in care* identified which may have made a difference to outcome***

(*Improvements in care should be interpreted to include adherence to guidelines, where these exist and have not been followed, as well as other improvements which would normally be considered part of good care, where no formal guidelines exist.)

At the end of the discussion of each case at the panel meeting, a consensus score will be agreed by the panel for the mother and for the baby for inclusion in the final report.

Please note that whilst the aim of the enquiry is to focus on quality of care HQIP (the organisation which commissions MBRRACE-UK) has specific guidance that applies in any case where any deficiencies in care are of a more serious nature:

HQIP Cause for Concern Guidance

- ***Death (child or adult) attributable to abuse or neglect, in any setting, but no indication of cross agency involvement (i.e. no mention of safeguarding, social services, police or LSCB).***

- ***Staff member displaying:***
  - ***Abusive behaviour (including allegations of sexual assault)***
  - ***Serious professional misconduct***
  - ***Dangerous lack of competency***
  - ***But not clear if incident has been reported to senior staff***

- ***Standards in care that indicate a dysfunctional or dangerous department or organisation, or grossly inadequate service provision.***

Cases felt to fulfil these criteria must be notified separately and urgently.