

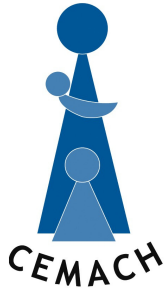
Confidential Enquiry into Maternal and Child Health

Improving the health of mothers, babies and children

CEMACH OVERVIEW

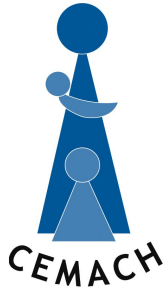
Rosie Houston

Research Fellow (Child Health)



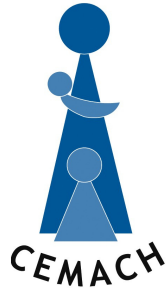
Scope and Methodologies

- Children to 18 years
- Maternal (including stillbirths)
- Organisational survey
- Analysis of study population
- Retrospective casenote review
- Assess care against standards
- Identify and aggregate avoidable factors



Reporting and outputs

- National reports
- Trust-specific reports and feedback
- Interactive workshops – closing the loop
- Post project reviews



NPSA Funded Work

Ongoing

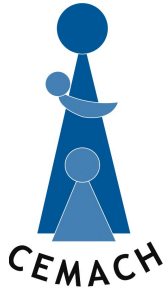
- Perinatal Mortality Surveillance
- Maternal Death Enquiry

Maternal and Perinatal Projects

- Diabetes in Pregnancy (completed)
- Obesity in Pregnancy (current)
- Intrapartum Mortality/Neonatal Encephalopathy (under development)

Child Health Projects

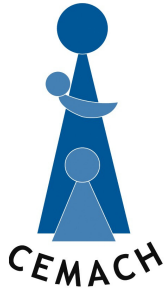
- Child Death Review (completed)
- Head Injury (about to start)



Perinatal Mortality Surveillance

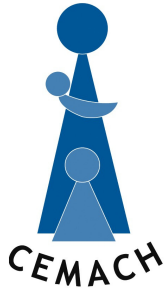
- Around 1 in 200 pregnancies end in stillbirth
- Around 1 in 300 babies die in the first four weeks of life
- Since 2000 the neonatal mortality rate has declined significantly (from 3.9 to 3.3 per 1000 live births)
- Maternal age, obesity, social deprivation remain important factors for perinatal mortality
- Post mortem examination uptake has continued to decline from 48% of all deaths in 2000 to 30% in 2006.

Not all preventable but surveillance is important



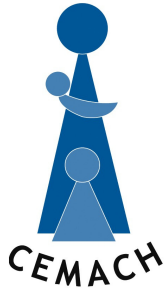
Child Death Review: Aims

- To identify all child deaths aged 28 days to 18 years in the selected regions during the calendar year 2006.
- To collect “core” data on all those deaths.
- To conduct a detailed review of a subset of the deaths with a focus on identifying avoidable factors.
- To inform the feasibility of conducting national confidential enquiry work into child deaths.
- To confirm (or otherwise) the cause of death given at registration and to assess the scope for identifying factors over and above that available from registration.



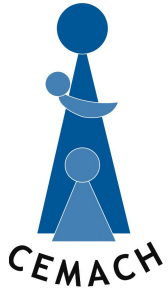
Child Death Review: Methods

- Notification to regional office
- Completion of 'core dataset' (957 cases)
- Subset of cases (126) selected for multidisciplinary panel review in a different region
- Multidisciplinary panel complete enquiry proforma



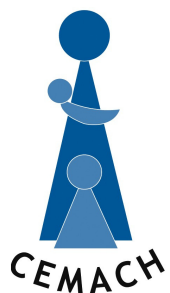
Child Death Review: Key findings & Recommendations (1)

- Feasibility of confidential enquiries in children
- Need for further epidemiological studies
- Many examples of good practice
- Failure to recognise severe illness e.g. in primary care and issues for training of professionals



Child Death Review: Key findings & Recommendations (2)

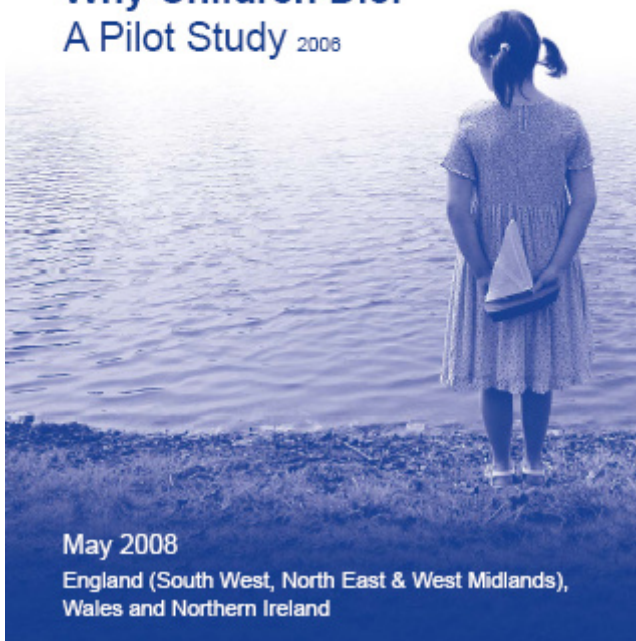
- Missed clinic appointments
- Poor coordination of care/communication
- High prevalence of pre-existing disease in the children who died
- Life limiting illness & place of end of care



Confidential Enquiry into Maternal and Child Health



Why Children Die: A Pilot Study 2008



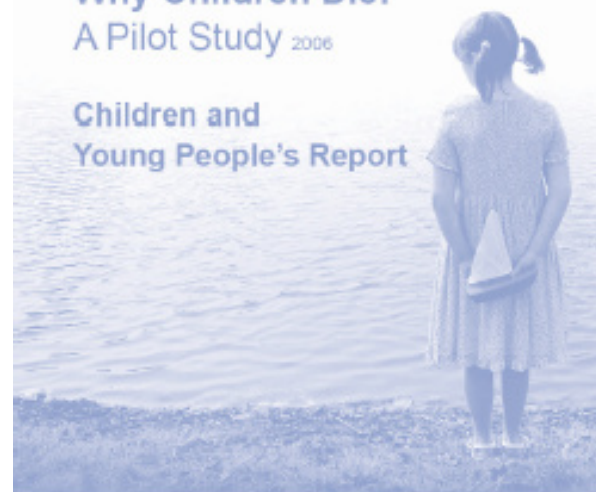
May 2008
England (South West, North East & West Midlands),
Wales and Northern Ireland

Confidential Enquiry into Maternal and Child Health



Why Children Die: A Pilot Study 2008

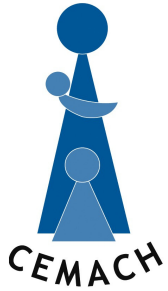
Children and Young People's Report



May 2008



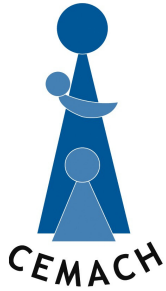
www.cemach.org.uk



‘Working Together’ How CEMACH can support LSCBs

Child Deaths (>28 days)

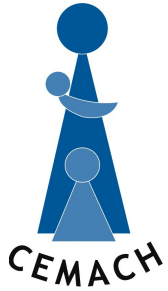
- Receive notification of deaths
- Collect core data
- Copies of data forms provided prior to CDOP meetings
- Data entry into web-based, secure database designed by CEMACH
- Periodic reports of number of deaths and completion of data forms
- Annual report on all deaths



‘Working Together’ How CEMACH can support LSCBs

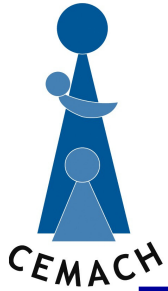
Neonatal deaths

- Receive notification of deaths
- Collect core data (CEMACH PDN plus supplementary variables)
- Copies of data forms provided prior to CDOP meetings
- Data entry into web-based, secure database designed by CEMACH
- Periodic reports of number of deaths and completion of data forms
- Annual report of neonatal data including rates, socio-demographic analysis, and comparison to other LSCBs



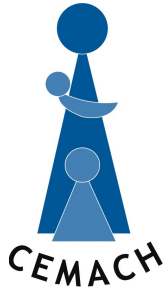
What CEMACH will produce for LSCBs

- Protocol for data collection, analysis, and reporting system
- Professionally formatted data collection forms
- Completed forms for individual infants and children
- Data will be entered into a web-based database that meets all data security and information governance requirements
- Periodic and annual reports on child deaths



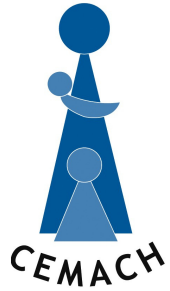
Head injury in Children

- Traumatic head injury is the most common cause of death and disability in children (*Hawley et al, 2003*)
 - 30% of deaths due to external causes of injury in 1-14 year olds
- Leading cause of emergency hospital admissions (*HES, 2007*)
- Potentially avoidable factors contributing to death of children with head injury identified by previous studies:
 - Delayed diagnosis of a moderate to severe head injury
 - Inadequate airway management
 - Insufficient management of hypotension
 - Poor management of transfers between hospitals
 - Delay of admission or transfer to a PICU or neurosurgical centre



What do we want to find out?

- How local services organised and whether clinical guidelines and protocols are available
- Prevalence of hospital admission of children aged between 0 and 15 years (14 years and 364 days) with an isolated head injury
- Extent of variation in the early management (first 72 hours) of head injury
- Whether adherence to standards makes a difference to outcome



Methods

- National survey of all ambulance service NHS trusts acute NHS trusts
- Minimum core data set completed for all children up to 15 years *admitted* to hospital due to head injury between July and December 2009
- Follow up after three or six months post admission
- Multidisciplinary Confidential Enquiry Panels