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Perinatal Institute comment on

MBRRACE Perinatal Mortality Surveillance - Supplementary Report to UK Trusts and Health Boards

(published 16 December 2015)

We have been asked by a number of concerned clinicians and mothers to comment on the latest MBRRACE Report, especially in relation to its RAG rating of maternity services.

While we fully support openness and benchmarking of performance, we have serious reservations about the reliability of the findings, for the following reasons:

1. Why 2013? The figures are 18 months out of date. ONS has already published the 2014 perinatal mortality rates six months ago, in July 2015.

2. The methodology for deriving 'stabilised' and 'adjusted' rates is new, untested and unproven, and misses important factors such as congenital anomalies, which have shown to be the cause of substantial variation in perinatal mortality rates across the NHS.

3. RAG rating of rare outcomes at unit level, on the basis of only 11 months of data, is not only insufficient to discern trends, but also highly unreliable due to year on year variation of small numbers.

4. RAG rating is also based on arbitrary limits which – again because of small numbers – do not result in statistically significant differences. For example, according to the published tables, most mortality rates for 'RED' units are not significantly higher than the stated average, as can be seen in the overlapping confidence intervals.

5. As a result of points above, the report will in many instances lead to inaccurate conclusions
    a. where a unit might have higher than their average rate during this short sample period: = **false alarm**, leading to unnecessary concern for mothers who have booked there, and misplaced public criticism of the unit's front line clinical staff;
    b. where a unit has a lower than their average rate during the short sample period: = **false reassurance** in suggesting that it has no problems with perinatal death rates.

6. The report's recommendation for Trusts and Health Boards to undertake case reviews only according to their RAG rating is also unhelpful, as
    a. **all units**, regardless of their baseline mortality rates, have avoidable deaths, and
    b. **all deaths** should undergo standardised clinical review, to ensure that learning points are translated into action plans for prevention.

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