The North West London Hospitals NHS NHS Trust	Agenda Item	
Brent Overview & Scrutiny Committee	Paper	
Meeting on: 20th September 2011	Attachment	2 appendices

Subject: Benchmarking against National and Pan London reports on Maternal Death July 2011

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Summary:
The purpose of this paper is to provide Brent Overview and Scrutiny Committee with assurance that recently published reports relating to National and Pan London maternal deaths have been reviewed by NWLH Trust and appropriately benchmarked for compliance against the recommendations.

The Trust Maternity Services have reviewed the following reports, all published between March to June 2011:

- Centre for Maternal and Child Enquires (CMACE) Report 'Saving Mothers' Lives 2011 (confidential maternal death enquiry 2006-8).
- CMACE 2011 A Review of Maternal Deaths in London Jan 2009-June 2010
- CMACE London Maternal Death Review Trust Specific Feedback Report Jan 2009- June 2010

These reports outline in all 19 recommendations, against which the Trust has benchmarked a positive achievement of 79% compliance. Where gaps in service are identified appropriate actions are being undertaken to address these issues.

Areas for further action to meet the recommendations are:

Two areas of non- compliance with the recommendations have been identified:

- Provision of pre-pregnancy counselling. This is primarily undertaken by the woman's General Practitioner (GP) and local community services. The Trust will work in partnership with commissioners and support community healthcare providers to work towards this recommendation.

- Consultant Obstetricians and Clinical Leadership. This recommendation reflects the Royal College of Obstetricians and Gynaecologists (RCOG) guidelines on the number of Obstetricians recommended per number of births (1:500), continuity of care by a named obstetric consultant and proposed obstetric staffing targets for consultant presence on the labour ward (98hrs). The Trust provides consultant cover to the labour wards; however it is not always possible to provide continuity of care by the same consultant due to their other responsibilities e.g. operating and out-patient clinics. Additional consultant obstetricians would be required to meet this recommendation; a business case is currently being developed for consideration.

Three areas of partial compliance have been identified:

- Women with potentially serious medical conditions require immediate and appropriate multidisciplinary specialist care. . Multidisciplinary specialist care is provided in the majority of areas e.g. diabetes, HIV, obesity, however joint perinatal mental healthcare provision needs to be strengthened.
- Training in recognition and management of the sick and/or deteriorating woman. This training is provided but not currently in a multidisciplinary format as recommended. A new multidisciplinary training programme will be commenced from August 2011 and scenarios will also be included in the mandatory simulation skills and drills programme.
- Interpretation services. Professional interpreters are available 24/7 and parent education classes in eight different languages. However following an annual language profile review a DVD has also been developed to support the provision of maternity care information in the top ten languages, this should be available in the next two months.

The report provides a summary of the National and Pan London reports and Trust position when benchmarked against the recommendations within an action plan template.

The Brent Overview & Scrutiny Committee is asked to:

- Note the Maternity Services benchmarked position August 2011 against national and pan London reports which demonstrate high levels of compliance overall - 79%
- Support the ongoing actions to improve compliance with the recommendations.

Benchmarking against National and Pan London reports on Maternal Death July 2011

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1. Purpose

The purpose of this report is to provide Brent Overview & Scrutiny Committee with assurance that all relevant recently published reports relating to maternal death have been reviewed and appropriately benchmarked for compliance against recommendations. In view of the organisational history of the Trust, in relation to maternal mortality, it is important that Brent Overview & Scrutiny Committee is given assurance that the Trust maternity services have implemented the recommendations and that processes are monitored in a robust and systematic manner. Where gaps in service are identified the Women's management team are taking action to address these issues.

The three publications relevant to this paper are:

- CMACE Report 'Saving Mothers' Lives 2011 (confidential maternal death enquiry 2006-8).
- CMACE 2011 A Review of Maternal Deaths in London Jan 2009-June 2010
- CMACE London Maternal Death Review Trust Specific Feedback Report Jan 2009- June 2010

2. Definition of a Maternal Death

A maternal death is a death occurring during pregnancy or within 42 days of delivery, miscarriage, termination of pregnancy or ectopic.

- *Direct* – as a direct result of pregnancy
- *Indirect* – as a result of pre-existing or new medical or mental health conditions aggravated by pregnancy, such as heart disease or suicide
- *Coincidental (*fortuitous) – are unrelated to pregnancy
- *Late (*between 42-365 days after delivery) – are those occurring between 6 weeks and 1 year after delivery, and can be direct, indirect or coincidental causes

3. CMACE Report ' Saving Mothers' Lives (published March 2011)

The overwhelming strength of successive CMACE {Centre for Maternal and Child Enquiries} Enquiry Reports has been the impact their findings have had on maternal and neonatal health in the UK and further afield. Over the years there have been many impressive examples of how the implementation of their recommendations and guidelines have improved policies, procedures and practice and saved the lives of more mothers and babies.

Encouraging results are given in this report, in particular the reduction of *Direc*t causes, especially thromboembolism. Another example is the increasing number of women booking for maternity care by 12 completed weeks of pregnancy, a key recommendation in earlier reports and which has been chosen to be a cornerstone of maternity-care provision in England. However, in other areas, improvements remain to be seen, and therefore some recommendations have been repeated from the last Report.

3.1 'Top Ten' recommendations:

The CMACE report states that over time, as the evidence base for clinical interventions has grown, and with the expansion of the enquiry into other professional areas, the wider social and public-health determinants of maternal health, the number of recommendations made in this Report has increased. However this has made it difficult for commissioners and service providers, in particular at Trust level, to identify those areas that require action as a top priority. Therefore this report contains a list of 'Top Ten' recommendations which all stakeholders involved in providing maternity services are advised to introduce, and audit as soon as possible.

Upon receipt of the CMACE report, Maternity services provided a report to the Patients Safety and Quality Committee in March 2011. The Top Ten recommendations have been reviewed and a benchmarked position determined with an action plan incorporated (Appendix 1). The action plan provides assurance to the Trust Board of compliance with the recommendations and will be performance managed through the Maternity Governance Board and Patients Safety and Quality Committee.

CMACE Report ' Saving Mothers' Lives

	'Top Ten' Recommendations	RAG Status
1.	Pre-pregnancy counselling	
2.	Professional interpretation services	
3.	Communications and referrals	
4.	Women with potentially serious medical conditions require immediate and appropriate multidisciplinary specialist care	
5.	Clinical skills and training	
6.	Specialist clinical care: identifying and managing very sick women	
7.	Systolic hypertension requires treatment	
8.	Genital tract infection/sepsis	
9.	Serious Incident Reporting and Maternal Deaths	
10.	Pathology	

4. CMACE 2011 Review of Maternal Deaths in London Jan 2009-June 2010

During 2010 London Local Supervising Authority (LSA) and NHS London became concerned that there was an apparent increase in the number of the maternal deaths occurring in London. CMACE was therefore commissioned by the LSA and NHSL to:

- Investigate an apparent increase in the number of maternal deaths in London during 2009 and 2010;
- Identify trends and themes associated with these maternal deaths;
- Identify learning points specific to London;
- Ensure the continuing provision of safe maternity services in London

The World Health Organisation (WHO) definition of maternal death was used for the review: " the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes".

4.1 Results

It was found that between the dates above there were 42 maternal deaths notified to CMACE meeting the case definition.

Direct	Indirect	Coincidental	Late	Unknown	Total
17	19	2	2	2	42

During this period for NHS London the maternal mortality rate (the number of maternal deaths per 100,000 maternities) was calculated as 19.3 and demonstrates a statistically significantly increased rate compared with the (provisional) national rate for this time, 8.6.

4.2 Clinical and socio- demographic factors

Haemorrhage and sepsis were the most common causes of *Direct* maternal deaths, and diseases of the central nervous system and infectious diseases were the most common cause of *Indirect* deaths.

There was an increased risk identified for younger and older women, a higher number had their ethnicity classified as 'Other', more had been born in Asia, compared with the maternal death populations for the 2006-8 Maternal Death Enquiry. The deprivation profile for this group was broadly similar to that found in the MDE report. 36 % had previous pregnancy complications with previous Caesarean Section being the most common, followed by mental health (17%), gastro-intestinal(14%), respiratory (12%), sepsis (12%).Just under half of the women (43.7%) were overweight, obese or very obese. 55% of the women booked for antenatal care by 12 weeks, 30% in second trimester and 5% in the third trimester. 31of the maternal deaths occurred in the first six weeks postpartum.

NWLH NHS Trust maternity population have a 44% high risk category.

Gestation of pregnancy at which women died:

1st trimester 0-12 weeks	12-24 weeks	25-29 weeks	30-37 weeks	>37 weeks	Total
2	5	6	12	17	42

4.3 Conclusion

The report concluded that it had highlighted several interdependent themes contributing to maternal mortality in London, some of which have featured in previous confidential enquiries into maternal death.

Specific challenges were identified in relation to the management of haemorrhage and sepsis which should be addressed along with the need to ensure training in a number of particular areas which have been identified in the report. At a systemic level, the report concludes, there are clear challenges for consultants and senior midwives in delivering their leadership role which requires attention. The need for timely recognition of serious illness was an important recurrent theme.

4.4 Recommendations

Appendix 2 contains the benchmarked position in relation to the nine recommendations and details actions to be taken to achieve compliance.

Review of Maternal Deaths in London Jan 2009-June 2010

	Recommendation	RAG Status
1.	SUI Reports for maternal deaths	
2.	Senior Midwifery Support	
3.	Consultant Obstetricians and Clinical Leadership	
4.	Training in recognition and management of the sick and/or deteriorating woman	
5.	Additional training to address apparent deficits in knowledge	
6.	Haemorrhage	
7.	Sepsis and Viral Infection	
8.	Seasonal influenza vaccination	
9.	Post-mortem examination	

5. CMACE London Maternal Death Review Trust Specific Feedback Report Jan 2009- June 2010

This report was provided to individual Trusts as part of the Pan London report commissioned by LSA and NHSL. The panel ascribed 3 maternal deaths to the Trust in this period and it has not been possible to challenge this as CMACE has ceased to function earlier in 2011. The third women referenced was booked at a neighbouring maternity unit and delivered there, being transferred to NWLH NHS Trust for ITU and St Mark's specialist care and died of her original surgical problems. The cause of death in these three cases is:

1. **Sepsis** :
   This woman had a normal vaginal delivery with third degree tear in her second pregnancy. She was discharged from hospital and then readmitted with abdominal pain and feeling unwell. Her care was complicated by late diagnosis of a ruptured caecum by the surgical team at the London hospital where she delivered.

2. **Diseases of the central nervous system**:
   This woman was in her first pregnancy at Northwick Park Hospital, low risk at booking who presented at term in a collapsed state, an Emergency Caesarean Section was performed and mother diagnosed with a subarachnoid haemorrhage, she subsequently died at a tertiary hospital. Baby was born in a poor condition and transferred to a tertiary Neonatal Unit and died.

3. **Categorised as 'other' :**
   This woman had delivered her fourth baby at Northwick Park Hospital and at 11days postnatal, self-referral to A&E having collapsed at home, complaining of right sided abdominal/groin pain followed by reduced power and numbness in her right leg and then 'blacked out'. - impression ?DVT ?Sepsis. Seen on Delivery Suite and referred for a CT, patient collapsed, surgical intervention was on-going, noted to have a right Common Iliac Artery tear/rupture 3cm below the aortic bifurcation. The iliac artery was repaired, however complete haemostasis was not achieved and patient was transferred to ITU and died subsequently.

5.1 Learning points

There were six learning points highlighted for NWLH Trust in this report and are addressed in the two appendices attached and also form part of the action plan from the last maternal death SUI action plan which is currently being implemented.

1. The Labour Ward co-ordinator should be supernumerary
2. Adherence to the 4 hour discharge target in A&E meant an inappropriate transfer to the obstetric unit. The patient should be treated at the most appropriate place regardless of targets.
3. Critically ill postpartum women who have no obstetric cause for their illness should not be treated on the Labour Ward.

4. Training is needed in the identification and treatment of a critically ill patient
5. There should be early escalation and involvement of senior staff.
6. Always reconsider differential diagnoses and review management plans if a patient remains unwell.

6. Conclusion

The CMACE national maternal death confidential enquiry 2006-8, the CMACE Pan London Maternal Death Review January 2009-June 2010 and the individualised Trust report on maternal deaths occurring in that period have been reviewed by maternity services in a timely and appropriate manner. These reports have been reviewed and benchmarked by the multidisciplinary team to assess the maternity service in terms of robust clinical governance arrangements, workforce, leadership and compliance with quality standards which optimise patient safety. Overall in 19 recommendations 79% compliance was achieved.

These reports acknowledge the challenges of providing maternity care in London which is one of the most diverse cities in the world, which has experienced a rapidly growing population, with ever increasing numbers of births. Obesity, diabetes, and the age at which women give birth and the use of fertility treatment are all increasing. These factors increase the risk of medical complications, making thorough risk assessment and early management of complications essential.

Areas of non-compliance by the Maternity services with recommendations in the reports have been assessed and RAG rated and action plans with appropriate monitoring arrangements agreed. Where appropriate these risks are recorded on the Maternity Risk register with mitigating actions.

The Brent Overview and Scrutiny Committee can be assured that the Trust has a robust clinical governance framework in place with a clear escalation process to the Trust Board. The actions contained in the benchmarked action plans will be performance managed through the Divisional Governance framework and reviewed and monitored regularly by the Trust Patient Safety and Quality Committee within agreed time scales.

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