Appendix 1

The North West London Hospitals NHS Trust
Women and Children's Directorate: Maternity Services,
Saving Mothers' Lives: Reviewing maternal deaths to make motherhood safer: 2006-2008 (Supplement to BJOG)

The Maternity Services National Recommendation and Guidelines Review Team	
Initials	**Clinical Specialisation**
CM	Head of Midwifery and Gynaecology
OL	Clinical Director of Obstetrics
BD	Obstetric Lead for Risk Management
GU	Public Health Development Lead
TM	Consultant Midwife
GL	Matron Inpatient Services
GN	Matron Community Midwifery Services
LS	Matron Delivery Suite
PM	Maternity Clinical Risk Manager
NR	Anaesthetic Lead for Obstetric Risk Management
RN	Neonatology Lead for Obstetric Risk Management
SP	Radiology Lead for Obstetric Risk Management

Compliance Matrix: Fully Compliant Partially Compliant Non-Compliant Non Applicable

The North West London Hospitals NHS Trust
Women and Children's Directorate: Maternity Services
Saving Mothers' Lives: Reviewing maternal deaths to make motherhood safer: 2006-2008 (Supplement to BJOG)

Recommendations	Local Provision/ Evidence of Implementation	Actions	Lead	Time Scale	Compliance
Planning Local Maternity Services					
1 Pre Pregnancy counselling 1.1 Women of childbearing age with pre-existing medical illness, including psychiatric conditions, whose conditions may require a change of medication, worsen or otherwise impact on a pregnancy should be informed of this at every opportunity. This is particularly important since 50% of pregnancies are not planned. They should be proactively offered advice about planning for pregnancy and the need to seek pre-pregnancy counselling whenever possible. Prior to pregnancy, these women should be offered specific counselling and have a prospective plan for the management of their pregnancy developed by clinicians with knowledge of how their condition and pregnancy interact . 1.2 Pre-pregnancy counselling services, starting for women with pre-existing medical illnesses, but ideally for all women planning a pregnancy, are a key part of maternity services and should be routinely commissioned as an integral part of the local maternity services network. They could be provided by the GP practice, specialist midwives or other specialist clinicians or obstetricians, all of whom should be suitably trained and informed. General practitioners should refer all relevant women to the local services if they do not provide such counselling themselves.	Develop robust pre-conception counseling services in Brent and Harrow. Locate current commissioning source for preconception care and re-direct funding to maternity services where preconception care will be well managed and established.	Working in collaboration with PCTs & GP to develop a preconception service model especially for women with pre-existing medical diseases or condition. Maternity services will work in conjunction with , PCTs and Local Authorities to ensure that: Local multi-agency health promotion arrangements are available for women in groups and communities who under-use maternity services or who are at greater risk of poor outcome (Vulnerable women) Maternity records should include section on plans for preconception care in subsequent pregnancies for women with pre-existing medical conditions Develop a preconception care strategies	CM/GU/PCT Leads	Review September 2011	**Non-Compliant**

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Planning Local Maternity Services					
2 Professional Interpretation Services Professional interpretation services should be provided for all pregnant women who do not speak English. These women require access to independent interpretation services, as they continue to be ill-served by the use of close family members or members of their own local community as interpreters. The presence of relatives, or others with whom they interact socially, inhibits the free two-way passage of crucial but sensitive information, particularly about their past medical or reproductive health history, intimate concerns and domestic abuse.	Professional interpreters available 24/7 and language	Conduct an annual language profile in maternity services to improve communication barriers for servicer users in the high priority language groups. Parent Education classes in 8 different languages	**GU**		**Fully Compliant**
	Developing maternity information DVD in 10 languages.	Complete DVD production		Review September 2011	**Partially Compliant**
3 Communications and referrals 3.1 Referrals to specialist services in pregnancy should be prioritised as urgent. In some specialities, routine referrals can take weeks or months, or even be rejected because of local commissioning rules. This is unacceptable for pregnant women. The referral must clearly state that the woman is pregnant, and its progress must be followed up. Trainee doctors and midwives should have a low threshold for referral "upwards" and just receive an immediate response. Referral between specialities should be at a senior level. When rapid referral is required, the senior doctor should use the telephone. 3.2 Good communication among professionals is essential. This must be recognised by all members of the team looking after a pregnant woman, whether she is "low risk" or "high risk". Her GP must be told that she is pregnant. If information is required from another member of the team, it is not enough to send a routine request and hope for a reply. The recipient must respond promptly, and if not, the sender must follow it up. With a wide variety of communication methods now available, including e-mail, texting and fax, teams should be reminded that the telephone is not an obsolete instrument.	Guideline is in place and Implemented. Implementation a new inter-professional communication tool (SBAR) used during handover and referral process. A standard letter is sent to the GP when a woman is high risk				**Fully Compliant**

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Planning Local Maternity Services					
4 Women with potentially serious medical conditions require immediate and appropriate multidisciplinary specialist care Women with pre-existing disease at the start of pregnancy: 4.1 Women whose pregnancies are likely to be complicated by potentially serious underlying pre-existing medical or mental health conditions should be immediately referred to appropriate specialist centres of expertise where both care for their medical condition and their obstetric care can be optimized. Providers and commissioners should consider developing protocols to specify which medical conditions mandate at least a consultant review in early pregnancy. This agreement should take place via local maternity networks. Pregnant women who develop potential complications: 4.2 Women whose pregnancies become complicated by potentially serious medical or mental health conditions should have an immediate referral to the appropriate specialist centres of expertise as soon as their symptoms develop. 4.3 In such urgent cases, referral can take place by telephone contact with the consultant or their secretary (to make sure they are available or identify an alternative consultant if not), followed up by a fax if necessary. 4.4 Midwives and GPs should be able to refer women directly to both an obstetrician and a non-obstetric specialist – but must inform the obstetrician. The midwife should, wherever possible, discuss this with, or alert, the woman's GP.	Conjoint Diabetic and Medical High Risk, FGM, Fetal medicine, Guideline in place. Haematology, Obesity and HIV clinics in place, with specialist input from Anesthetist, Neurologist and other patient specific consultant input. Specialist Midwives are in place to support: Infectious diseases (HIV), Diabetes, FGM, Haemoglobinopathies, Safeguarding, Teenage pregnancy, antenatal & newborn screening and pregnancy loss. New perinatal mental health midwife recruited due to start in September 2011	Require joint perinatal mental health care provision with North West and Central Mental Health Trust.	CM/GU/PCT Leads	Review September 2011	**Partially Compliant**

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Planning Local Maternity Services					
5 Clinical skills and training 5.1 Back to basics. All clinical staff must undertake regular, written, documented and audited training for the identification and initial management of serious obstetric conditions or emerging potential emergencies, such as sepsis, which need to be distinguished from commonplace symptoms in pregnancy. 5.2 All clinical staff must also undertake regular, written, documented and audited training for: The understanding, identification, initial management and referral for serious commoner medical and mental health conditions which, although unrelated to pregnancy, may affect pregnant women or recently delivered mothers. These may include the conditions in recommendation 1, although the list is not exclusive. The early recognition and management of severely ill pregnant women and impending material collapse. The improvement of basic, immediate and advanced life support skills. A number of courses provide additional training for staff caring for pregnant women and new-born babies.	Mandatory training for doctors and midwives in recognition of deteriorating patient and care escalation process				**Fully Compliant**

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6 Specialist clinical care: identifying and managing very sick women 6.1 There remains an urgent need for the routine use of a national modified early obstetric warning score (MEOWS) chart in all pregnant or postpartum women who become unwell and require either obstetric or gynaecology services. This will help in the more timely recognition, treatment and referral of women, who have, or are developing, a critical illness during or after pregnancy. It is equally important that these charts are also used for pregnant or postpartum women who are unwell and are being cared for outside obstetric and gynaecology services e.g. Emergency Departments. Abnormal scores should not just be recorded but should also trigger an appropriate response. 6.2 The management of pregnant or postpartum women who present with an acute severe illness, e.g. sepsis with circulatory failure, pre-eclampsia/eclampsia with severe arterial hypertension and major haemorrhage, requires a team approach. Trainees in obstetrics and/or gynaecology must request help early from senior medical staff, including advice and help from anaesthetic and critical care services. In very acute situations telephoning an experienced colleague can be very helpful. The recent RCOG guideline of the duties and responsibilities of consultant on call should be followed. 6.3 Pregnant or recently delivered women with unexplained pain severe enough to require opiate analgesia require urgent senior assessment/review.	Mandatory training for doctors and midwives in recognition of deteriorating patient and care escalation process The national modified early obstetric warning score (MEOWS) chart guideline is in place implemented.				**Fully Compliant**

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7 Systolic hypertension requires treatment 7.1 All pregnant women with pre-eclampsia and a systolic blood pressure of 150-160 mmHg or more require urgent and effective anti-hypertensive treatment in line with the recent guidelines from the National Institute for Health and Clinical Excellence (NICE) 3. Consideration should also be given to initiating treatment at lower pressures if the overall clinical picture suggests rapid deterioration and/or where the development of severe hypertension can be anticipated.	Guideline in place and implemented. Daily clinical review meetings with teaching.				**Fully Compliant**

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8 Genital tract infection/sepsis 8.1 All pregnant and recently delivered women need to be informed of the risks and signs and symptoms of genital tract infection and how to prevent its transmission. Advice to all women should include verbal and written information about its prevention, signs and symptoms and the need to seek advice early if concerned, as well as the importance of good personal hygiene. This includes avoiding contamination of the perineum by washing hands before and after using the lavatory or changing sanitary towels. It is especially necessary when the woman or her family or close contacts have a sore throat or upper respiratory tract infection. 8.2 All health care professionals who care for pregnant and recently delivered women should adhere to local infection control protocols and be aware of the signs and symptoms of sepsis in the women they care for and the need for urgent assessment and treatment. This is particularly the case for community midwives, who may be the first to pick up any potentially abnormal signs during their routine postnatal observations for all women, not just those who have had a caesarean section. If puerperal infection is suspected, the woman must be referred back to the obstetric services as soon as possible. 8.3 High dose intravenous broad-spectrum antibiotic therapy should be started as early as possible, as immediate antibiotic treatment may be lifesaving. It should be started within the first hour of recognition of septic shock and severe sepsis without septic shock, as each hour of delay in achieving administration of effective antibiotics is associated with a measurable increase in mortality. 4,5 8.4 There is an urgent need for a national clinical guideline to cover the identification and management of sepsis in pregnancy, labour and the postnatal period and beyond. This should be available to all health professionals, maternity units, Emergency Departments, GPs and Community Midwives. Until such time as a national guideline is developed, the principles for the management of acute sepsis as detailed in Chapter 16: Critical Care of this Report should be adopted. These are derived from those developed and updated by the Surviving Sepsis Campaign. 4 8.5 Consideration should be given to adopting a more rational system for classifying maternal deaths from sepsis, as suggested in Annex 7.1	Sepsis care bundle guideline in place and implemented				**Fully Compliant**

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9 Serious Incident Reporting and Maternal Deaths All maternal deaths must be subject to a high quality local review. In England and Wales the framework for such serious incidents (previously known as Serious Untoward Incidents/SUIs) is set out in the NPSA's "National Framework for Reporting and Learning from Serious Incidents Requiring Investigation" issued in March 2010. The results of such high quality reviews must be disseminated and discussed with all maternity staff and their recommendations implemented and audited at regular intervals.	Guidelines are in place. All SUI are monitored and reported appropriately. SUI and maternal deaths are critically reviewed and lesson learnt actively disseminated	Conduct a Trust specific CMACE seminar facilitated by CMACE organization			**Fully Compliant**
10 Pathology The standard of the maternal autopsy must be improved. The numbers of locations where they are performed should reduce, with specialist pathologists taking them on as part of agreed job plans. More clinical discretion over reporting maternal deaths to coroners is required, and there should be a complementary major input by clinicians into obtaining more consented hospital autopsies.	Sector wide approach adopted with the perinatal pathologist at Hammersmith hospital or recognized credited perinatal pathology				**Fully Compliant**

References

3 National Collaborating Centre for Women's and Children's Health. Hypertension in pregnancy: the management of hypertensive disorders during pregnancy. National Institute for Health and Clinical Excellence Guideline 107. London: RCOG, August 2010 (http://guidance.nice.org.uk/CG107/]. Accessed 5 October 2010
4 Dellinger RP, Levy MM, Carlet JM, Bion J, Parker MM, Carlet JM, et al. Surviving Sepsis Campaign: international guidelines for management of severe sepsis and septic shock. Crit Care Med 2008; 36:296-327.
5 Royal College of Pathologists, Guidelines on Autopsy Practice. Scenario 5: Maternal Death. London: Royal College of Pathologists: 2010.