Appendix 2

The North West London Hospitals NHS Trust
Women and Children's Directorate: Maternity Services
CMACE Review of Maternal Deaths in London January 2009- June 2010 Commissioned by NHSL

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

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Recommendations	Local Provision/ Evidence of Implementation	Actions	Lead	Time Scale	Compliance
1 Serious Incident Requiring Investigation (SIRI) Reports for maternal death investigation 1.1 A standard template, such as the one provided by NPSA, should be adopted and completed in full for all maternal deaths. SIRI reports for maternal death should include substantial involvement from a senior clinician and /or senior manager external to the Trust	Maternity Services use the NPSA template for all SUI reports. External reviews are commissioned as required as part of the SUI process. Executive Director chairs the SUI panel All SUI are monitored and reported appropriately. SUI for maternal deaths are critically reviewed and lesson learnt actively disseminated		Head of Midwifery, Clinical Director, Maternity Clinical Risk Manager		**Fully Compliant**

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Recommendations	Local Provision/ Evidence of Implementation	Actions	Lead	Time Scale	Compliance
2 Senior Midwifery Support 2.1 The Labour Ward coordinator must be supernumerary. There must be an escalation process to address exceptional instances where due to low staffing or high clinical activity, this is not feasible, to ensure high quality care and best use of resources at all times.	Crewing on Delivery Suite to reflect supernumerary status of coordinator with robust escalation process in guidelines. Annual staffing and acuity audit to inform business planning process. Achieved CNST Level 1 December 2010		Head of Midwifery & Matrons		**Fully Compliant**
2.2 Early involvement of Supervisors of Midwives must be sought when the maternity service is regarded as becoming unsafe or when staff feel that need an enhanced level of support, eg when a woman is critically ill.	Supervisor of Midwives rota in place ensuring 24/7 access to on call Supervisor. SoM to midwife ratio monitored on Maternity Dashboard against NMC standard 1:15 SoM involvement in clinical risk monitored	To continue to nominate midwives to the role to achieve NMC standard as currently 1:18 To monitor calls to the SoM to ensure escalation of unsafe conditions	SoM team & Head of Midwifery		**Fully compliant**

3 Consultant Obstetricians and clinical leadership Recognising the importance of senior obstetric involvement in the care of women with medical and obstetric complications; 3.1 Each unit should have a recognized Labour Ward Lead Consultant 3.2 Consultants should be present on Labour Ward during all rostered sessions 3.3 Consultants should be proactive in leading, planning and reviewing the care of women with complicated medical, antenatal, intrapartum or postnatal care. 3.4Particular attention should be paid to continuity of care each day and throughout a woman's admission, ensuring adequate arrangements are in place for the transfer of clinical information. 3.5 Women with complex co-existent clinical conditions require continuity of care from their named obstetric consultant (or designated colleague) regardless of their place of admission	Labour Ward Lead in post with clear outline of role and responsibilities 60 hours presence only provided, non-compliant with RCOG guidelines I post vacant, 2 locum Consultants in post, shortage of manpower. Guideline in place for care plans for management of high risk women. Continuity of care not achievable due to shortage of consultants and Obs/Gynae split in job plans. Not achievable with current obstetric establishment. Consultants cover DS and wards as part of a rota	Business case to be presented to the Executive Committee to consider increase in consultant obstetrician establishment from 9 to ideally 12 to ensure 98 hour presence on DS	Clinical Director, Divisional General Manager, Head of Midwifery	September 2011	**Non compliant**

4. Training in recognition and management of the sick and/or deteriorating woman 4.1 Maternity services providers should provide training to all clinicians to ensure that they are competent and confident in the recognition and management of the sick and/or deteriorating woman. 4.2 Training should be multidisciplinary, regular and attendance should be audited 4.3Training should emphasize early involvement of anesthetists in the care of sick women 4.4 Consideration should be given to running real time drills in the clinical area	Training provided to midwives and nurses separately from doctors. Annual training for midwives and nurses and monitored and audited Compliant and Reinforced on HDU study day Currently not part of Drills and Skills	Training Needs Analysis to be updated to include this topic as mandatory for midwives, nurses and doctors. To be added to the mandatory Drills and Skills programme commence in August 2011	Head of Midwifery, RCOG Tutor and Consultant Midwife for Normal Birth& Education team	September 2011	**Partially Compliant**

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Recommendations	**Local Provision/ Evidence of Implementation**	**Actions**	**Lead**	**Time Scale**	**Compliance**
5 Additional training to address apparent deficits in knowledge. **Maternity Service Providers should implement regular training to address deficiencies in the following areas of care, highlighted within the review:** • Recognition of shock • Recognition of abnormal test results including ECG's • Management of PPH including potential side effects of treatment • The use of blood transfusion and preparedness when atypical antibodies are present • Haematological conditions • Fluid balance management • Management in delay in 2nd stage of labour • Signs of and presentation of acute neurological conditions including subarachnoid haemorrhage • Recognition of non-obstetric illness including influenza (seasonal and H1NI)	Mandatory training for doctors and midwives in recognition of deteriorating patient and care escalation process				**Fully Compliant**

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Planning Local Maternity Services					
6 Haemorrhage **When managing massive obstetric haemorrhage, clinicians should:** a) Consider the early use of blood products b) Have access to and use near patient haemoglobin testing c) Always ensure accurate measurement of revealed blood loss, acknowledge the inherent inaccuracy of estimated blood loss and recognize the possibility of concealed haemorrhage d) Formally initiate the local major obstetric haemorrhage protocol early during ongoing haemorrhage e) Consider all potential causes rather than focus solely on uterine atony. Clinicians should receive regular education about the clinical signs and symptoms of hypovolaemia (see also recommendation 5)	Mandatory training for doctors and midwives in recognition of deteriorating patient and care escalation process in place The national modified early obstetric warning score (MEOWS) chart guideline is in place implemented.				**Fully Compliant**

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Recommendations	**Local Provision/ Evidence of Implementation**	**Actions**	**Lead**	**Time Scale**	**Compliance**
7 Sepsis and Viral Infection Sepsis and acute viral infection should be considered in the differential diagnosis of all sick women during pregnancy and postpartum period. Appropriate treatments and infection control measures should be adopted where infectious illness is suspected.	Sepsis bundle implemented and monitored.		Clinical Director and Head of Midwifery		**Fully Compliant**

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8 Seasonal Influenza vaccination All pregnant women should be strongly recommended to have the seasonal 'flu vaccine. Maternity service providers should reinforce the current DOH recommendation regarding vaccination of staff.	Vaccination programme developed and implemented in primary and secondary care in conjunction with Brent & Harrow PCT with aim of 60% vaccination uptake. OH policy in place recommending vaccination of all front line staff		Consultant Midwife in Public Health , PCT PH Leads & Chief Pharmacist DoN		**Fully Compliant**

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Recommendations	**Local Provision/ Evidence of Implementation**	**Actions**	**Lead**	**Time Scale**	**Compliance**
9 Postmortem examination Postmortem examinations by a specialist pathologist should be performed following all maternal deaths. This may include asking the next of kin to consent to a post mortem if the coroner has not pursued this. When clinicians are certain of the cause of death, they should still contact a specialist pathologist for advice.	All maternal death postmortems are conducted by an accredited perinatal pathologist appointed by HM Coroner				**Fully Compliant**