News

DonnaOckenden

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Award winning report presented by The London Maternity Clinical Network into its review of maternal deaths.

The London Maternity Clinical Network established the Maternal Morbidity and Mortality Working Group in 2015 and they have published their findings into the maternal deaths in London in their first annual report.

The outcomes were presented at an international conference in Capetown, South Africa, on behalf of the working group by Dr Anita Banerjee of Guy's & St Thomas' Hospital NHS Foundation Trust and won a commendation award in March 2017.

In summary the report covered the following:

Overview

In London, in 2015, there were 130,413 live births in a population of over 8.6 million. Across the city there are significant health inequalities and a mobile population when compared to the rest of the UK.

Problems to overcome in 2015

There was no agreed, single, London-wide process for the investigation of maternal deaths. There was variable external input into individual maternal death reviews and quality of local review. It was identified that there was no overview of London issues and potential for missing London specific problems. There are 19 healthcare organisations responsible for 29 maternity units providing maternity care (including 3 midwifery led units) plus, a perception of higher death rates in London.

Objectives

All maternal death panels are now supported by the London wide M and M group. Recommendations from maternal death reports are widely distributed across London for improved learning

Progress

The multi-disciplinary review group was set up in 2015 and review panel experts were identified across London. More than 75% of all maternal death panels in 2015 had an external review and more than 80 clinicians across over seven disciplines are on the external register. There is a minimum of one external member for all deaths reviewed from 2015, (with more depending on the complexity of the case) and themes were able to be identified. The report was disseminated across London to a wide range of colleagues and launched at an event in September 2016.

Recommendations

1. Standardisation of MEOWS charts;
2. Identification of a named clinical lead;
3. Pan-London policy for reaching out to women;
4. Communication using digital technology;
5. Continuity of care(r);
6. Closer working with London Ambulance Service;
7. Implementation of the Sepsis protocol;
8. Guidelines for identifying pulmonary embolus;
9. Improving communication.

Conclusion

This is the first known multi-disciplinary, inter-hospital collaboration to standardise the maternal death review process within England. The dissemination of London-wide themes and shared learning has the potential to improve outcomes for women and babies. In future, the aim is to link with national agencies including MBRRACE and identify any potential differences for London, taking into account the complexity of care provided to many women across London.

Notes

The Maternal Morbidity and Mortality Working Group is chaired by Donna Ockenden (Co Clinical Director, London Maternity Clinical Network, NHS England) and in this role she works with and she is supported by the multi-disciplinary team of Caroline Moren, Senior Project Manager, London Maternity Clinical Network, NHS England, Richard Howard, Consultant Obstetrician, Barking Havering & Redbridge University Hospital NHS Trust, Julie Frohlich, Consultant Midwife, Guy's & St Thomas' Hospital NHS Foundation Trust, Penny Law, Consultant Obstetrician, The Hillingdon Hospital NHS Foundation Trust, Jess Read, LSA Midwifery Officer, NHS England (London Region), Kate Harding, Consultant Obstetrician, Guy's & St Thomas' Hospital NHS Foundation Trust and Dawn Newman-Cooper, Deputy Head of Clinical Programmes, NHS Bromley CCG.

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