AIMS For a better birth...

Future Mothers 2014

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MBRRACE UK conference on the Confidential Enquiry into Maternal Deaths and Morbidity

The day1 was opened by Maureen Watt, Scottish Minister for Public Health. Other speakers included the many people who have worked directly on the report. The 120 page report, Saving Lives, Improving Mothers' Care: Lessons learned to inform future maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-20122 is produced by the National Perinatal Epidemiology Unit in Oxford and available to the public.

This was a sombre day - 321 women died, 581 children were left motherless and for each mother who died, 100 women had severe complications. Avoidable or not, the human cost is profound.

Marian Knight told delegates about the Confidential Enquiry process: the report will now be annual, include Ireland and will focus on specific morbidities (any one of us can propose a topic for this). Collecting information for this enquiry was particularly challenging, due to a 14 month gap in data collection. The team had to go to coroners (not all maternal deaths are reviewed by a coroner), Local Supervising Authorities and others. It also covers four years rather than the usual three. The maternal mortality rate in the UK of 10 women in every 100,000 is apparently comparable to many other European countries, despite media criticisms. Marion suggested that in half of the maternal deaths, better care might have made a difference. Numbers of speakers expressed concerns about how reviews of maternal deaths are conducted: not all staff are involved and not all are rigorous. For example, Sara Kenyon told us that 47% of maternal deaths due to sepsis were not critically reviewed and only 5% were externally reviewed.

Numbers of speakers stated that having a flu vaccine, greater awareness of sepsis and better care for women with epilepsy (currently there is a lack of consensus about good care) would have saved some mothers' lives, and that many women who died were older, poorer, from ethnic minority groups, born in other countries, overweight, had pre-existing medical problems, and/or mental health problems.

Speakers urged practitioners to improve basic clinical skills such as: history taking and observations (as was highlighted in the last Confidential Enquiry), engaging women (especially those with social and/or medical complications), developing better ways of team working, creating individual and flexible care plans, and contacting senior clinicians with any concerns.

Many speakers emphasised the need to observe and listen to women; carrying out full assessments and approaching a developing crisis in a structured and systematic way, with the right senior staff, based on

best available evidence, making sure that a plan is in place and that decisions are carried out. Sepsis was one of the topics focused on by this Confidential Enquiry and numbers of talks covered it in detail: it is apparently the most common cause of death worldwide, the incidence is higher following forceps and caesarean births and it is more common among women postnatally than the general population.

Alison Rodger pointed out that repeated self-referral should be a 'red flag' to practitioners and should trigger investigation (as should reports of abdominal pain). Kevin Rooney described how he contributed to a collaborative approach to reduce sepsis mortality rates in Scotland.3 Craig Stobo gave a personal account of the tragic death of his wife and unborn child through sepsis and provided information about the Trust that has been set up to increase awareness and knowledge about sepsis in her memory (www.featuk.org.uk).

Other topics included:

The rise and treatment of severe haemorrhage The key messages were to anticipate, recognise, observe, record, communicate, act quickly with the correct treatments and make sure someone continues to take responsibility.

Amniotic fluid embolism The main message here was that we have good guidelines - implement them. Neurology Adrian Wills suggested that while not many women could have survived, there is insufficient access to neurologists who can diagnose serious from non urgent cases and that this is a complicated area requiring much discussion. Anaesthesia Deaths from anaesthesia have been reduced, but prompt, correct responses and follow up are vital. Whatever was discussed, the same themes were repeated:

- good team working and communication
- fast recognition and treatment of serious problems
- getting senior staff involved
- regular observations and recording these
- good resuscitation skills

These are not dissimilar to the recommendations of the previous Confidential Enquiry. But, where resources are stretched to their limits, it is not difficult to see why some women may not receive the prompt and correct treatment they need in an emergency.

The new NICE Guideline on Intrapartum Care which recommends that practitioners should inform healthy women that out of hospital settings are safe for them and their babies and that they reduce intervention rates are a welcome addition to the creation of safety for women and babies. Implementing these recommendations would leave more time and resources for obstetricians to look after the women who need their care.

One final issue that has not to my knowledge arisen in previous Confidential Enquiries is that of changing financial arrangements for health care which can lead to delays in treatment. This played a part in the care of at least one of the woman who died. If the relentless privatisation of the NHS in England is to

continue, this will surely feature more prominently in maternal and other deaths.

Nadine Edwards

References

1. Future Mothers 2014: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiry into Maternal Deaths and Morbidity 2009-2012. MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK. December 2014, Edinburgh.
2. www.npeu.ox.ac.uk/downloads/files/mbrrace-uk/reports/Saving%20Lives%20 Improving%20Mothers%20Care%20report%202014%20Full.pdf.