



REVIEW OF THE MATERNAL DEATH ENQUIRY

TERMS OF REFERENCE

1. Purpose of review

The purpose of the review will be to advise the Board on how it should seek to undertake the maternal death enquiry (MDE) as part of the CEMACH programme, for which the NPSA is lead commissioner, following completion of the current triennium (2009-2011), i.e. in respect of maternal deaths from 1 January 2012.

2. Current position

The MDE commenced in 1952. It is a long-established and successful programme. Its contribution to improving the safety of maternity care is recognised and valued by bodies such as the RCOG and RCM in addition to national health departments across the UK and the Republic of Ireland. Maternal mortality directly attributable to obstetric complications has fallen some 90% during the period of the enquiry.

The work is based on the collection of a common dataset and multidisciplinary case note peer review on all direct and indirect maternal deaths occurring during pregnancy and up to 42 days after delivery (6 months where suicide or cardiomyopathy is involved).

Use is made of local reviews undertaken by the healthcare provider or other local agency to fulfil local clinical governance responsibilities. In addition, all cases are subject to a full assessment through a number of stages involving the regional assessors, clinical director and central assessors.

A triennial report known as "Saving Mothers' Lives" is produced.

3. Reasons for the Review

The CMACE board is committed to the ongoing development and enhancement of the MDE. Its vision for the maternal death enquiry is as a programme for the continuous improvement of maternal safety. This will include the major national triennial report focusing on the results of case reviews of maternal deaths along with the development of other outputs from the enquiry.

Work on the development of this vision has already led to the introduction, for example, of the provision of basic notification data to the Care Quality Commission (CQC) and Healthcare Inspectorate Wales (HIW) to assist them in the identification of maternity providers with high mortality levels and the development of a continuing interactive workshop programme to promote the enquiry's findings at a local level.

Further outputs with a view to ensuring continuous improvement in maternal safety might include, for example, annual maternal mortality surveillance reports, peer review papers, regional cause for concern reports and rapid national alerts.

The current system has been designed with a view to delivering the triennial report and whilst some wider outputs are possible in this context, this can also lead to complications.

The environment in which the MDE has been conducted has changed greatly in recent times, for example:

- The introduction of clinical governance at local level has led to an increase in serious untoward incident review activity, including maternal mortality, although the reviews can be of variable quality.
- New bodies have been set up at national level with responsibilities for clinical standards and patient safety (e.g. NPSA, NICE, CQC, NHSLA/CNST and HIW) which impact on the maternity sector.
- Development work in relation to the maternity dataset.
- Expectations in respect of methodological robustness for health care studies have increased requiring explicit documentation on the processes by which conclusions are reached.
- Expectations in respect of a robust audit trail for database information used for peer review papers have increased.
- There is a greater expectation of an early response where problems are identified (e.g. cause for concern reporting and national alerts).
- CMACE has to demonstrate that its work is compliant with its charitable objects, for which independently published peer review articles are required.

With a view to delivering its broad vision for a maternal death enquiry contributing continuously to the improvement of maternal safety and in the context of the changing context described above, the CMACE Board wishes to receive advice on how to take forward the approach and methodology for the MDE for the period after 1 January 2012.

4. Specific areas in which advice is sought

The Board has a responsibility for ensuring that it can demonstrate to stakeholders and funding bodies that the MDE is making the maximum possible impact within a changing environment for improving the safety of maternity care. The Board wishes to receive advice on any matters in respect of the MDE relevant to this overall aim. In addition there are a number of specific questions that are indicated:

- What unique role and contribution should be played by each of the review/enquiry levels (i.e. local, regional and national) and how should they relate to each other?
- An explicit balance is required for the MDE between the need to ensure prompt reporting where there are specific problems and/or that information is imparted at the earliest stage possible, whilst at the same time ensuring that there is robust evidence for deriving overall conclusions. What should the approach be to the type, frequency and timeliness of reporting of the different reports needed from the MDE programme?
- How should the MDE ensure optimal links, paying due regard to the need to retain confidentiality, to other national bodies and functions with related patient safety and clinical standards roles?
- What would be the issues, including pros and cons, of the introduction of maternal mortality surveillance reporting and/or “near miss” enquiries?
- How can peer review publication of results of MDE work be augmented? Are there obstacles to this, such as risks to confidentiality, and how might these be addressed?
- Are any opportunities seen for greater integration of the MDE into the wider GEMACH programme for which the NPSA is the lead commissioner and CMACE the provider?

5. Modus operandi for the review

An independent Chair will be appointed by the CMACE Board. The person will be of appropriate standing but without previous involvement in the national enquiry. An honorarium will be offered. A review board will be established to include lay involvement. The review board will not include any parties currently involved in writing maternal death enquiry reports. Key stakeholders, e.g. RCOG, RCM, DH, NPSA, NHSLA, CQC and representatives of the other nations which fund the enquiry will be invited to provide input on how they wish to see the work move forward. This may be in the form of a written submission or by attending a session of the review board. Academic input will also be sought. A Project Manager from the CMACE staff will be identified to support the Chair and review board. The Chair would have responsibility for delivering the report to the CMACE Board.

6. Stakeholders and consultation

The MDE review will be carried out in a consultative manner to ensure that decisions are only made in the light of the views of stakeholders, who will include:

- The departments of health of the participating nations in the UK and Ireland
- National bodies with a remit for improving maternity outcomes
- Relevant academic departments
- Relevant royal colleges
- NHS organisations and maternity care providers
- Charities and independent bodies with an interest in maternal outcomes.

Although it will not be practical to contact every professional with an interest in maternity care, there will be opportunities, via the CMACE website, for participation in the consultation for any bodies or individuals not identified above.

7. Reporting

The draft report will be presented to the CMACE Board to enable it to make comments prior to a final draft being submitted. The report will cover, inter alia, a description of how the review was undertaken, the views of stakeholders, an analysis of the key issues and recommendations for the future conduct of the maternal death enquiry.

8. Timescale for the review

The triennial cycle for the MDE sets the parameters for the timing of any review. In order to be implemented from 1 January 2012, there needs to be a substantial lead-in time from the approval of any review recommendations by the CMACE Board. This is required to provide time to design, print and distribute any new operating procedures and enquiry documents and work with those involved both locally and nationally with the process to ensure that all involved know their role in a revised system. This will require the Board to have approved the recommendations of any review by March 2011.

30 March 2010