Mothers and Babies-Reducing Risk through Audits and Confidential Enquiries

Abstract:

The Confidential Enquiries into Maternal Deaths (CEMD) is being disbanded and will be incorporated into a new structure called MBRRACE-UK. Mothers and Babies-Reducing Risk through Audits and Confidential Enquiries throughout the UK. The CEMD, which has been in existence since 1952, was highly valued by clinicians. It had an unbroken 60 year history in existence. It set the bar for higher obstetric standards. It monitored the causes of maternal death and improved safety. It operated through a system of anonymised case records of obstetric deaths. A group of regional and national assessors examined the circumstances around each case. The assessors then made recommendations on the lessons to be learned. The Enquiry had widespread support among obstetricians and was an important voice in advocating better maternal care. It constantly stressed the important of clinical vigilance. It emphasized that old messages need to be frequently repeated and that there is no room for inertia. Its strength was its ability to identify avoidable causes of maternal death in a no-blame culture. This resulted in an almost total buy-in. After preparation of the report and before its publication all maternal death forms, relevant documents and files related to the period of the report are destroyed and all electronic data is irreversibly destroyed.

The triennium report 2006-2008, published in March 2011, recorded an overall maternal mortality rate of 11.1 per 100,000. It identified substandard care in 70% of direct deaths and 15% of indirect deaths. Shennan and Bewley, state that some deaths are inevitable, but avoidable ones are unacceptable. The Enquiry was truly owned by the professionals who were happy to participate in the reviews of the worst clinical outcomes. The new report set out a top 10 recommendations list. These are designed to optimise the importance of perinatal health and reducing adverse outcomes. Concerns were expressed about the emergence of community-acquired Group A streptococcal disease. All women who died with Group A streptococcal infection had either worked with or were the mother of young children. It underlines the national pathology services and continued high quality local review of maternal deaths. The number of locations where pathology is undertaken should reduce and specialist pathologists taking on perinatal pathology as part of an agreed service. Ireland joined the Enquiry in Jan 2009 at the commencement of the 2009-11 triennium and its contribution will be included in the next Report. The Irish office is located at the Irish National Perinatal Epidemiology Unit in Cork.

Despite its wide reputation and influence, CEMD has increasingly been criticised by a number of groups and individuals. It is perceived as being too anecdotal. It is described as providing opinion rather than peer review. Meanwhile its supporters pointed out the contributions from many supporters. Following a period of intense debate it was decided to incorporate the CEMD into the new structure MBRRACE-UK.

MBRRACE-UK is a collaboration of the National Perinatal Epidemiology Unit (NPEU), Oxford and many hospitals, trusts, charities and organisations. The lead in Jenny Horrocks at the NPEU. The new system will incorporate TIMMS- The Infant Mortality and Morbidity Studies. TIMMS is a collaborative programme of national and regional research projects. It will investigate the causes, consequences and management of morbidity and mortality of the fetus and infant. The new system will develop for greater visibility in Neonatal care. In 2003 Neonatal networks were set up in the UK. Subsequently the Neonatal taskforce, Neonatal toolkit, Neonatal quality improvement programmes and the Neonatal audit programme were established. The objective is that data should be captured once and should be of high quality. There was a need for greater visibility in Neonatal care. The Neonatal networks were set up in the UK. Subsequently the Neonatal taskforce, Neonatal toolkit, Neonatal quality improvement programmes and the Neonatal audit programme were established. The objective is that data should be captured once and should be of high quality. The Neonatal networks were set up in the UK. Subsequently the Neonatal taskforce, Neonatal toolkit, Neonatal quality improvement programmes and the Neonatal audit programme were established.

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