NWLHT MATERNITY REPORT

For the Harrow Performance & Finance Scrutiny Sub-Committee

Meeting to be held on 15 July 2008

1. Purpose

NWLHT has been asked to present a written report to the Committee in relation to an item on 'Northwick Park Hospital Maternal Deaths'. The Trust has specifically been asked for information from the last three years in terms of the number of maternal deaths vs number of births, compared to the national average for maternity deaths

2. National Maternal Mortality Rate

The international definition of the maternal mortality ratio is the number of *Direct* and *Indirect* deaths per 100,000 live births.

As described in "Saving Mother's Lives", December 2007, the current national maternal mortality rate identified was 14 deaths per 100,000 maternities.

3. NWLHT Maternal Deaths 2005 – 2008.

The figures for North West London Hospitals Trust over the past three years are as follows:

	2005/06	**2006/07**	**2007/08**
Maternal Death	0	0	3 (2 in 2007, 1 in 2008)
Births	4704	4884	5240

Based on the national maternal mortality rate the Trust could expect to see in the region of 3 deaths every 4 years, However, this rate does not reflect the high risk nature of the unit base and the complexity of case mix presenting at the Trust. 60% of our local population are perceived to be high risk.

4. Maternal Incident Review Process

The three deaths have all been reviewed as part of the Maternity Risk Management process which involves a multidisciplinary case review. In addition, given the occurence of the three deaths over a 10 month period, the Trust has instigated a further Review to assure itself that there are no underlying trends linking the three maternal deaths in 2007/08. At this point there is no reason to believe these three deaths are linked in terms of causative factors.

The review is being chaired by a non-executive Director from Harrow PCT and has 3 expert independent clinicians on the panel. Its report should be available in August 2008.

5. Clinical Scorecard

The Maternity Unit has a detailed Clinical Scorecard that is used to monitor key clinical indicators within the unit. This is reviewed on a weekly basis by the Maternity Management Team, and is reviewed on a monthly basis by the Trust Board and shared with the local Primary Care Trusts. Key indicators include ceasarean section rates, numbers of women admitted to ICU and the number of women who have experienced a bleed post delivery. This scorecard has now been adopted as national best practice, and it allows the Trust Board to carefully monitor clinical and activity performance and take supportive corrective actions where required.

6. Conclusion

The occurance of three maternal deaths within one financial year has been taken extremely seriously by the Trust. The Review that has been instigated will ensure the Trust is able to assure itself of the safety of the service and take any action should it be required.

Fiona Wise
Chief Executive
30 June 2008