Editorial

From CEMD to CEMACH to CMACE to…? Where now for the Confidential Enquiries into Maternal Deaths?

In Doctor Who, the world’s longest-running science fiction television series [1], the Doctor ‘regenerates’ at intervals from one external form to another, represented on screen as the transition from one actor to another. Inside, however, it’s really the same old Doctor, fighting for good in a violent and unpredictable universe.

The Confidential Enquiries into Maternal Deaths (hereafter ‘the Enquiry’), the world’s longest-running clinical audit, has also gone through various transitions throughout its long history, whilst inside it’s the same vital tool, part of our collective battle to monitor and reduce maternal deaths and improve the safety of childbirth. Those same anaesthetists who, as children, cowered behind the sofa in horror as Doctor Who’s latest dreadful enemy threatened mankind on their television screens also remember with horror the vignettes describing disaster after avoidable disaster when anaesthesia was the third most common cause of direct maternal death, after hypertensive disease and thromboembolism [2]. The reduction in maternal deaths due to anaesthesia, whilst no cause for complacency, is rightly celebrated as one of the major achievements of our specialty [3].

Regeneration was always a tricky time for the Doctor, whose cognitive function could be a little unstable afterwards (as could many of his fans’). For the last few years, we seem to have been witnessing a prolonged regenerative process affecting the Enquiry, with multiple changes in a relatively short time. This has led to considerable confusion amongst its followers, and – more importantly – a great deal of uncertainty, with the apparent suspension of the Enquiry for the past several months. With the recent publication of a report into the whole process [4], and the prospect of some much-needed stability in the offering, it seems that a summary of the storyline so far, and what the future might bring, is appropriate.

The Enquiry began as local audits (though the modern concept of clinical audit didn’t arise until some 70 years later) in the 1920s, becoming the Confidential Enquiries into Maternal Deaths in 1952, under the auspices of the Department of Health. Initially restricted to England and Wales, it was extended in 1985 to the whole of the UK. In 1999, it was administered from within the then National Institute of Clinical Excellence (NICE; this always struck me as a strange home, given that NICE was set up primarily to determine which treatments were effective) and, in 2003, as the Confidential Enquiries into Maternal and Child Health (CEMACH), a unit residing within the Royal College of Obstetricians & Gynaecologists. A review of the Department of Health’s ‘arm’s length bodies’ in 2008 [5] led in 2009 to CEMACH’s becoming an independent charity, the Centre for Maternal and Child Enquiries (CMACE), with the programme commissioned mainly by the National Patient Safety Agency (NPSA). In 2010, the National Confidential Enquiries went out to competitive tender and the bid for the maternal death enquiry was won by the rather heftily named Mothers and Babies: Reducing the Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK), a new consortium involving the universities of Leicester, Liverpool and Birmingham, and Imperial College London, amongst others. MBRRACE-UK was to be based at Oxford University’s National Perinatal Epidemiology Unit (NPEU), which also runs the UK Obstetric Surveillance System (UKOSS). It was due to take over the Enquiry from 1st April 2011 (the child health programme contract was awarded to the Royal College of Paediatrics and Child Health) but in March 2011, the NPSA and the UK Departments of Health announced a halt to the takeover, pending further review. It is the outcome of this review that has just been published [4].

The Maternal and Newborn Clinical Outcome Review Panel was chaired by Dr Sheila Shribman, National Clinical Director for Children, Young People and Maternity Services at the Department of Health. The other seven panel members include three obstetricians, a midwife but no anaesthetist [4]. That the Panel was able to produce its report within two months of confirmation of its membership is impressive. The headline message is that funding of the Enquiry (hereafter ‘Programme’) will continue, although the requirement for the new provider to make ‘major improvements’ to the current ‘time consuming and costly’ data collection process suggests that the amount of funding available, already reduced over successive years, will be lower than before. The timeliness of reporting should be ‘drastically improved’, and the new process must include early establishment of the cause of death and involve multidisciplinary case assessment. Inclusion of morbidity in some form is also specified. The body responsible for commissioning the Programme, taking over from the NPSA as the latter itself succumbs, will be the Healthcare Quality Improvement Partnership (HQIP).
The Report categorically states that a new service provider ‘should be in place by 01 April 2012’, and that the ‘interim data’ (deaths occurring since the period covered by the most recent triennial report – i.e. since 2008), must not be lost, nor their value wasted. This last point should offer some reassurance to anaesthetists and others who have felt left somewhat in limbo for the past several months, and the firm commitment to the Programme’s continuation should make up, to some degree, for the rather jumbled (some might say chaotic) sequence of events earlier this year.

So what does this all mean for obstetric anaesthetists? The good news is that there should continue to be some sort of ongoing review and reporting of maternal deaths in the UK, and that we can continue to draw upon this resource to support our ever-important efforts to improve maternal safety. Many of the recommendations (timelier reporting, multidisciplinary assessment, inclusion of morbidity) were planned for the Programme anyway after the last round of tendering, and there had already been meetings of the CMACE assessors to discuss how to achieve these changes, before the publication of this Report. However, the lack of anaesthetic input, that will be so familiar to anaesthetists, is disturbing. The Report states that the Panel consulted with obstetric, paediatric and midwifery professional bodies, including their Royal Colleges, but no anaesthetic body is listed. In addition, comments were received (implying they were not sought) from the Royal Colleges of Physicians, Psychiatrists and Pathologists – and the Obstetric Anaesthetists’ Association is listed here, at least. (The Presidents of both the Royal College of Anaesthetists and the Association of Anaesthetists of Great Britain & Ireland wrote to the Chief Medical Officer when the review was announced, but neither body was invited to comment (Drs P. Nightingale and I. Wilson, personal communication)). ‘Independent Advisory Groups’ are mentioned a number of times, but it’s not clear what these are or how they will feed into the process – and even whether there’ll be more than one (the final mention states ‘An Independent Advisory Group will be established to provide independent clinical and professional advice’. Although the Report does at least mention anaesthesia in the context of specialty-based reports (alongside midwifery and general practice), these are distinct from ‘specialist medical reports’ that include cardiology, neurology, pathology and psychiatry, for which anaesthesia presumably is not felt to qualify. And of course, the possibility of squeezing more out of less must remain a continuing concern.

The next steps are a repeat of last year’s tendering process, and formation of a working group to assist HQIP with producing a detailed specification, with another group to deal with the interim data, including monitoring them for any emerging trends until the new provider is appointed. Whether there will be any input to these groups from our specialty remains to be seen. It is also unclear whether and how the existing network of anaesthetic assessors might fit into the new programme. Meanwhile, any readers who are involved in, or become aware of, a maternal death in the UK should ensure it is reported via the temporary logging system at http://www.mpmn.nhs.uk.

The thrill of watching heroes like Doctor Who is always against the background of knowing that somehow, he (and so far it’s always been a ‘he’), though the concept of a female Doctor isn’t a new one [6]) will always come through in the end. In real life, though, nothing is certain, so it is with some relief that we can take an overall positive view of the Review Panel’s report. In both real life and fiction, however, anaesthesia is often under-represented, and it would appear that this has been the case with the above review process too. If only Doctor Who were to regenerate as a female, become pregnant, develop a major complication and be saved by a plucky obstetric anaesthetist.

Competing interests
I am Central Anaesthetic Assessor of the Maternal Death Enquiry, or at least I was until CMACE’s demise.

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References


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