

Thematic review – learning from maternal deaths following termination of pregnancy provision

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Background

The 2015 national maternity ambition in England aims to halve maternal deaths by 2025. Women accessing termination of pregnancy services, particularly those provided by healthcare clinics providing NHS-funded abortion care, may be at greater risk of harm due to a lack of multidisciplinary working across the healthcare system.

The Maternity and Newborn Safety Investigations (MNSI) programme investigates patient safety events, working closely with staff, trusts and families, aiming to improve maternity safety in England.

Methods

Six maternal deaths following termination of pregnancy in healthcare clinics providing NHS-funded abortion care or in NHS providers had MNSI investigations completed between 2019 and 2023; these underwent detailed thematic review.

MNSI uses the Systems Engineering Initiative for Patient Safety (SEIPS) model (Carayon, 2006; Holden et al, 2013) to help understand why patient safety events occur. We consider the relationships and interactions between people, tasks, technology and tools, the environment, organisational factors, and national policies and professional guidance, that contribute to how patient safety events occur.

Conclusion / key messages

- Healthcare clinics providing NHS-funded abortion care may not have access to NHS patient records, meaning that clinical decisions may be made without all the relevant information. There is a need for a detailed standardised history taking tool to support safe assessment.
- Information sharing with GPs may not be possible, due to patient confidentiality. Providers must encourage women to consent for sharing of information to mitigate risk and may wish to consider an opt out approach.
- There is a need for clearer written and verbal safety netting to support after care, to include information about bleeding and signs or symptoms of sepsis.

External influences

- Private providers - screening/risk assessment
- Private providers - onus on mother to access NHS care for any follow up if concerns
- COVID-19 system changes

Technology and tools

- Access to clinical care history
- Point of care testing
- Information sharing with GPs & NHS providers

Person

- Pre-pregnancy counselling
- Medical co-morbidities
- After care
- Safety netting advice: SEPSIS & retained products of conception

Organisation of work

- Clinical oversight
- Virtual consultations
- Standardisation of records;
 - access to records from NHS (GPs, ED can't access on private notes)
 - reliant on patient descriptions

Physical environment

- Increase in virtual or telephone consultations
- Posting TOP medication to patients at home

Tasks

- Risk assessment;
 - reliance on information provided by mother
 - based on basic non standardised screening tools
- Access to full medical history for private providers - not available
- Escalation of concerns - lack of joined up care with NHS

Wanted/unwanted outcomes

System performance:

- Access to clinical information access and sharing
- Risk assessment with no access to full history

Human wellbeing:

- Understanding of risks pre-pregnancy and post pregnancy
- Clinical oversight
- MDT after care: private providers & NHS
- Providing clear safety netting advice

1. Inequalities in accessing healthcare services



31F - MTOP 7/40
8 days later - heavy vaginal bleeding
Lack of identification of sepsis

OOH GP (no access to regular notes)
Hospital delay in identifying sepsis and starting treatment (diagnostic bias of pregnancy related)

41F - alcoholic liver disease
5/40 wanted early TOP
Tel review for MTOP
4 days later unresponsive at home

No face-to-face review
No mention of PMH in consultation with reproductive choices team

2. Limited transparency between health records



- Early medical termination clinic could not see PMH
- Major haemorrhage at home

3. Limited safety-netting advice and follow up



MTOP case - not followed up when DNA

Safety netting

Puts onus on woman; difficult for vulnerable women

No follow-up for high-risk women

Do not attend

No follow up

To find out more about MNSI and our investigations or to attend a webinar discussing this topic further please scan the QR code

