Northern England
Clinical Networks

Development of a system-wide process for implementing the recommendations for independent external presence at maternity case reviews

Overview

Recent national maternity safety-related initiatives/reports recommend that local teams investigating serious clinical incidents have an external clinician present aiming to enhance quality of investigations, share the lessons learnt more widely, breaking down barriers between healthcare organisations and assisting in the promotion of good practice.

The Northern England Clinical Network (NECN) via the development of a Maternity Patient Safety Learning Network (MPSLN) has facilitated this process on an informal voluntary basis.

Objectives

To report on the growth, development and outcomes of this system-wide process for the facilitation of external clinician presence at serious case reviews in the North East of England.

Methods

Provider trusts contact the NECN, who coordinate volunteers from within the MPSLN to attend.

Results

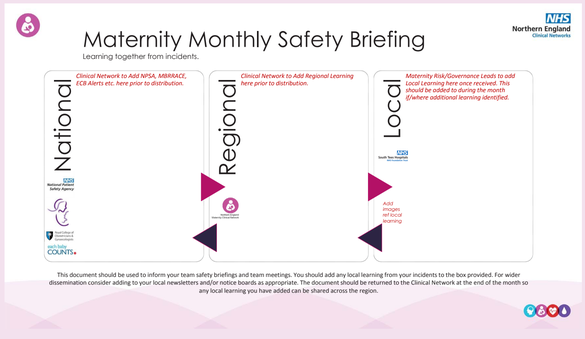
This process has grown and developed and all of the 9 acute provider Trusts in the region have recognised the merits of the approach, each becoming involved in requesting and providing external panel members.

More than 40 clinicians have attended case reviews and have brought numerous lessons learnt back to the MPSLN meetings for further sharing across the network area. In some cases where external members have not been available, we have been able to provide a paper external review of notes and accompanying review reports.

The success of this process have led to a steady increase in requests for volunteers, which has meant that there has been a need to develop a more robust, formal terms of reference (TOR), administrative support and monitoring and a plea for increased numbers of experienced clinicians to join the review team pool.

The new TOR were approved by all three LMS boards and the Clinical Advisory group, Heads of Midwifery and Maternity Patient Safety Learning Network. They were formally presented at the regional patient safety event with accompanying case reviews and learning shared.

We have linked closely with similar work on-going in other Clinical Networks to share best practice ideas and have open attendance at learning events to discuss cases and share safety messages and examples of excellent care widely.


Maternity Monthly Safety Briefing

Learning together from incidents.

Northern England Clinical Networks

National

Clinical Network to Add NPSA, MBRRACE, ECB Alerts etc. here prior to distribution.

Regional

Clinical Network to Add Regional Learning here prior to distribution.

Local

Maternity Risk/Governance Leads to add local Learning here once received. This should be added to during the month if/where additional learning identified.

Add images ref local learning

This document should be used to inform your team safety briefings and team meetings. You should add any local learning from your incidents to the box provided. For wider dissemination consider adding to your local newsletters and/or notice boards as appropriate. The document should be returned to the Clinical Network at the end of the month so any local learning you have added can be shared across the region.

Positive outcomes from this developing process are; (a) improved networking, collaboration and relationships between neighbouring organisations, (b) value added by independent voices at identified case reviews leading to improvement and standardisation of the review process across the region, (c) identification of incident themes for further review on a region-wide basis and wider sharing of lessons learnt and good practice via the MPSLN meetings, (d) the MatNeo collaborative work including links to the neonatal network, and (e) production of regular region-wide patient safety events to share messages.


Northern England Thematic Review of Shoulder Dystocia Cases 2016-17

Maternity Patient Safety Learning Network – November 2017

Conclusion

A region-wide system to facilitate external clinician presence at serious case reviews can be implemented very successfully, and with high levels of participation from all maternity providers in the area.

Next steps

Expansion of pool of external clinicians to enable better matching of skills and knowledge to case under review.

Link to Healthcare Safety Investigation Branch (HSIB) and Perinatal Mortality Review Tool (PMRT).

Communications support to better share messages, including; patient safety learning events and regular bulletins.

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