Warrington and Halton Hospitals NHS
NHS Foundation Trust

Shared learning from a systematic and consistent method of multidisciplinary review of babies reported to 'Each Baby Counts' in Cheshire and Merseyside

[1]Ai-Wei Tang, [1]Rita Arya, [1]Anne Goodwin, [2]Devender Roberts

[1]Warrington and Halton NHS Foundation Trust,

[2]Liverpool Women's NHS Foundation Trust

Introduction

- Future maternity care recommends working in collaboration across different hospitals within a region
- The Special Interest Group reviewing strategies for reducing stillbirths of the **Cheshire and Merseyside Maternity, Children and Young People Strategic Clinical Network (MC&YP SCN)** has developed a process to systematically examine and perform an honest review of care provided to:
  - Intrapartum stillbirths
  - Babies with severe brain injury due to labour
  - Early neonatal deaths

Aims

- Be consistent and reduce bias in the review process
- Identify recurrent themes and risk factors
- Produce actions plans for these themes for shared learning in the region

Distribution of review panels April 2015 – March 2016

NHS Trusts and Organisations	No. Of Panels
Liverpool Women's NHS Foundation Trust	3
East Cheshire NHS Trust – Macclesfield Hospital	3
One to One Midwives	1
Southport and Ormskirk Hospital NHS Trust	1
St Helens and Knowsley Teaching Hospitals NHS Trust – Whiston Hospital	1
Warrington and Halton Hospitals NHS Foundation Trust – Warrington Hospital	2
Wirral University Teaching Hospital NHS Foundation Trust – Arrowe Park Hospital	4

MC&YP SCN Multidisciplinary Review Process

All organisations in region report to SCN babies reported to 'Each Baby Counts'

SCN centrally coordinates a review panel
- Minimum 2 external reviewers (at least 1 Obstetrician and 1 Midwife)
- Internal reviewers determined locally

Analyse care by utilising the National Patient Safety Agency (NPSA) Intrapartum Toolkit:
Proforma for review of intrapartum related perinatal deaths (v3)

Identify risk factors and areas for improvement

Disseminate 'Lessons Learnt' for shared learning in Cheshire and Merseyside

Recurrent Themes Identified

- Inappropriate documentation
- Failure to escalate events to senior members of staff
- Lack of situational awareness in labour ward
- Misinterpretation of CTG

Discussion and Conclusions

- Able to consistently and systematically review all intrapartum stillbirths, cases of severe brain injury secondary to labour and early neonatal deaths in the region
- Plan to collate recurrent themes that contribute to these adverse events, generate action points and circulate them as regional documents for shared learning
- Aim to develop more regional guidelines for standardisation of practice, and reduce variation of Obstetric care between maternity units
- Success of current process led to discussions for a similar review process for unplanned caesarean hysterectomies and maternal deaths

High Quality, Safe Healthcare
Quality People Sustainability