Maternity SCN bulletin

NHS
London
Strategic Clinical Networks

The Maternity Strategic Clinical Network bulletin provides information and updates on the work of the network and on developments of current and new workstreams.

SPOTLIGHT: Maternal morbidity & mortality

In London numbers of women sustaining severe maternal morbidity and mortality during pregnancy and in the year following pregnancy/childbirth remain at high levels in comparison with the national average (currently 9.02 per 100,000 women MBRRACE 2015). The London rates for maternal death continue to be worse than other large cities in England with twenty-five women dying in London in 2014/2015 from direct and indirect deaths.

The London Maternity Strategic Clinical Network (SCN) has developed a London-wide process to formalise a standardised system for the review of severe maternal morbidity and maternal deaths. The intention is to ensure objective investigation, consistency and learning from these tragic events, with the overarching aim of reducing, where possible, severe harm to women and ultimately reducing London's maternal death rate.

The London Maternity SCN has set up a register of experts from London Trusts to facilitate objective investigation into these events. We ask all London Trusts to endorse this initiative, as they are likely to benefit from the support, expertise and objectivity this process brings.

The London Maternity SCN will work alongside the current reporting system of maternity serious incidents (SI) to the Patient Safety team and London Supervisory Authority at NHS England. When an SI is identified and entered onto STEIS (we would expect a 72 hour report to be produced). When this report is available, the London Maternity SCN will provide a list of appropriate specialists to assist the Trust as external expert panel members. Full contact details are provided within this list for Trusts to make direct contact with identified experts and convene the review panel locally.

The London Maternity SCN will be undertaking an annual review and thematic analysis of maternal deaths and would ask that you please forward a copy of the final SI report to assist in pulling together this report. This will support the new process and allow shared learning for all units in London.

Summary aims and objectives of the London maternal morbidity and mortality work stream:

The aims are:

- To standardise, work consistently and integrate the maternal death SI process across London to encourage learning from shared experiences and interrogation of themes that may emerge
- To centralise the requests for external panel members and share learning across London
- To provide a pool of clinical experts in relevant clinical specialties and review process experts to assist provider units with undertaking maternal deaths panel reviews within the identified timescale of 60 working days
- To encourage and improve communication flows between provider units, CCGs and coroner's office to encourage more timely reporting and conclusion of any inquests deemed necessary
- To produce an annual thematic analysis report of maternal deaths in London
- To link with national agencies including MBRRACE to promote collaborative working and avoid duplication with a London emphasis and other relevant, interested parties

Perinatal mental health

Linking in with the perinatal mental health network / national team:
On 28th January a workshop to review the pan-London perinatal mental health service specification was held. The event brought together health care experts from mental health, maternity, social care, public health, commissioners and people with lived experience from across London. The purpose was to co-produce the service specification focussing on what matters most within the perinatal mental health care pathway and achievable outcomes. The information collated at the workshop will assist in informing the service specification which will then go out for consultation during mid-February to mid-March resulting in a pan London perinatal mental health service specification to be published by the end of March 2016

Best practice toolkits

Best practice toolkits have been produced as part of the London Maternity SCN's strategy to identify areas of good practice for implementation across all maternity units in the capital, ensuring equally good outcomes for all pregnant women and their babies.

We have recently published a toolkit for ***Fetal monitoring, competency and assessment*** the aim of this document is to reduce intrapartum stillbirths and hypoxic-ischaemic encephalopathy by improving multidisciplinary competency in fetal monitoring during labour.

Click here to view our full suite of toolkits.

Whose Shoes?

The London Maternity SCN aims to improve maternity user experience and involvement across London. To support this 'Whose Shoes' workshops have been established to allow health care professionals, commissioners and users to explore local concerns, challenges and opportunities; working together to achieve shared actions, focussing on service improvement. After hosting a workshop several trusts have made changes to their services; case studies have been produced to share the learning from these sessions; to find out more ***click here.***

If you would like further information about the project or you are interested in running a workshop ***click here.***

Reports and other resources

National maternity review
- Due to be published on 23rd February 2016

MBRRACE
- Saving lives, improving mother's care report - December 2015 ***click here***
- Perinatal confidential enquiry - November 2015 ***click here***

Mental Health SCN (London)
- Perinatal Mental Health ***click here***

Contact us: If you have any questions or require further information please send an email to England.maternityscn@nhs.net

Next month's SPOTLIGHT.....

Next month's spotlight will be focusing on the DESiGN trial; a randomised control trial of the Growth Assessment Protocol (GAP) programme due to commence in 2016/17; twelve Trusts across London will be taking part. The London Maternity SCN has strongly supported the implementation of the programme to reduce the incidence of stillbirths.