# Process for cascading learning within maternity

Trust ref:C37/2022

## 1. Introduction, background and scope

It has been highlighted in numerous reports (CQC 2020, Kirkup 2015, Ockenden 2022, RCOG 2020) that NHS organisations should improve the way in which they cascade learning following incidents and adverse events within the maternity service. Services rated as outstanding by the CQC have cultures which encourage openness and continuous learning, with effective incident reporting, investigations and learning processes in place.

As well as adopting a culture of reporting patient safety incidents, learning when care is not provided as planned or when clinical outcomes are poor is imperative to improving maternity care. Maternity services need to prioritise learning to ensure staff have the correct skills, knowledge, experience and resources to undertake their role.

This Standard Operating Procedure (SOP) should be used in conjunction with the Incident and Accident Reporting UHL Policy (Trust ref: A10/2002)

This SOP describes the process of cascading learning points for all staff working in or with Leicester Maternity.

**Related documents:**

- Being Open (Duty of Candour) UHL Policy (Trust ref: B42/2010)
- Freedom to Speak Up, Raising Concerns UHL Policy (Trust ref: A15/2001)

## 2. Process

The table below outlines the process for cascading learning (the list is not exhaustive)

The process is divided into 3 sections:

**Source:** where the information for learning is generated from

**Information:** what information is being shared

**How:** how the information is being shared

Table 1: Cascading learning

| Source | Information | How |
|---|---|---|
| **Internal:**<br>• Datix reporting themes<br>• Serious incident reviews<br>• Perinatal risk group (PRG)<br>• Perinatal mortality review panel (PMRP)<br>• CTG seminars<br>• Clinical audit<br>**External:**<br>• MNSI & MBRRACE<br>• National patient safety alerts (NPSA) | • Serious incident learning bulletins<br>• Quality, Improvement & Learning bulletin (QUAIL)<br>• Maternity newsletter<br>• MNSI reports<br>• Safety bulletins | • Education programs<br>• Presentations (e.g. audit meetings)<br>• E-mails<br>• Facebook – written information & Facebook Live<br>• Local team meetings<br>• Staff forums<br>• Safety huddles<br>• Quality & safety half day learning<br>• Notice boards in clinical areas |

**Evaluation:**

Whilst it is acknowledged that there are difficulties in measuring staff engagement in learning from incidents and adverse events, increasing the accessibility of the information through a variety of tools to support dissemination can provide opportunities for evaluation. This evaluation through feedback and audit can provide evidence to support ongoing strategies to enhance the development of current and future learning from incidents.

## 3. Education and training

No specific training requirements

## 4. Monitoring Compliance

| What will be measured to monitor compliance | How will compliance be monitored | Monitoring Lead | Frequency | Reporting arrangements |
|---|---|---|---|---|
| Is learning from incidents reaching clinical teams effectively? | Spot checks to monitor learning is being shared and to discuss with teams new ways to share information more effectively | Audit midwife | Annually | Quality Board |

## 5. Supporting References

CQC (2020) Getting Safer Faster: Key areas for improvement in maternity services

Kirkup (2015) The Report of the Morecombe Bay Investigation

Ockenden (2022) Independent Review of Maternity Services, Shrewsbury and Telford Hospitals NHS Trust

RCOG (2020) Each Baby Counts. Final report

## 6. Key Words

Shared learning, learning from incidents

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**The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.**
**As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.**

| CONTACT AND REVIEW DETAILS | | | |
|---|---|---|---|
| **Document Lead (Name and Title)**<br>N Cammiss – Quality & Safety Manager | | | **Executive Lead**<br>Chief Nurse |
| **Details of Changes made during review:** | | | |
| **Date** | **Issue Number** | **Reviewed By** | **Description Of Changes (If Any)** |
| **June 2022** | **1** | | |
| **December 2024** | **2** | **N Cammiss** | **Changed HSIB to MNSI** |