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Maternity Risk Management Strategy

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Version History

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1.0	Oct 18	Maternity Governance Lead	Draft	Strategy Drafted
2.0	July 2022	Maternity Governance Lead	Final	Strategy reviewed and updated
2.1	Dec 2024	Maternity Governance Lead	Interim	Policy updated to reflect changes to our Governance Structure (Appendix B)

Document Location

Document Type	Location
Electronic	Frimley Health Guidelines Platform
Other	If printed, copied or otherwise transferred from Trust sites, policies and procedural documents will be considered uncontrolled copies. Staff must always consult the most up to date versions located on Trust Guidelines site.

Related Documents

Document Type	Document Name
Strategy	(Trust) Risk Management Strategy 2021 - 2025
Policy	Policy for the Management of Serious Incidents
Guideline	Risk Assessment Guidelines
Guideline	Root Cause Analysis Guidance
Policy	Duty of Candour Policy
Policy	Being Open Policy
Policy	Raising Concerns Policy

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1. Introduction

- 1.1 The directorate of midwifery, obstetrics and gynaecology is committed to achieving an integrated system of governance focussing on continuous improvements in quality of care and management of both clinical and non-clinical risks. This document outlines the framework in place to support the development of a rigorous risk management process and details the overall aims and objectives in achieving this.
- 1.2 Maternity services offer a wide range of care and services. The multi-disciplinary team are focussed on ensuring they communicate and work together in a way which puts the safety of families and clinical effectiveness at the centre of care and services provided. The maternity department strives to improve the safety and experience of all women using Frimley Health maternity services.
- 1.3 The management of risk is paramount to ensure that safe services are provided. All members of the multidisciplinary team have a responsibility for identifying and minimising risk to both patients and other members of staff. The management of risks are best undertaken in a progressive, honest and open environment where mistakes and untoward incidents are identified quickly and acted upon in a positive way reviewing how measures might prevent reoccurrence of identified issues.
- 1.4 The Maternity Risk Management Strategy must be read in conjunction with the Trust Risk Management Strategy 2021 – 2025, which can be found on 'ourplace' - Trust intranet page.
- 1.5 The Maternity Risk Management Strategy will be reviewed at least every five years by the Maternity Patient Safety and Quality Groups, the Obstetrics and the Gynaecology Clinical Governance Committees, prior to presentation to Care Governance Committee for approval. The Maternity Risk Management Strategy will be reviewed when the Trust Risk Management Strategy is updated and revised. This will usually be six months following ratification of the Trust Risk Management Strategy.
- 1.6 This strategy for the directorate has the support and approval of the Board of Directors. A proactive approach to risk management within the Directorate is supported by the Director of Midwifery and site-specific Heads of Midwifery, the Chief of Service and managers at all levels.
- 1.7 There are clearly identified links with clinical governance, audit, PALS, complaints and the legal departments via the maternity clinical governance team and maternity management team.
- 1.8 Communicating the risk management strategy to all members of the department will aid their understanding of risk management processes and how their role is vital to this process. The strategy will be distributed to all consultants, senior midwives and management leads individually, and to all staff through the local staff induction process.

2. Key principles

2.1 The key principles for successful implementation and continuation of the maternity risk management strategy are:

- To continuously review the effectiveness of the obstetrics clinical governance structures to ensure that it remains effective in the application of risk management process to clinical practices.
- To ensure that systems are designed to reduce the likelihood of human error occurring.
- To develop preventative risk management processes to be applied to the management of facilities, amenities and equipment.
- To ensure a culture of openness and honesty supporting and facilitating learning for all staff in the maternity department. This should be continually reviewed to ensure openness and honesty is always supported and facilitated within the department.
- To ensure a mechanism is in place for all incidents to be immediately reported, categorised by their potential impact and consequences and investigated to determine failures in an open and fair manner.
- To ensure that the department has plans in place for emergency preparedness, emergency response, business continuity and contingency that are available for all staff to access.

In particular, the department aims to:

- Ensure that evidence-based policies, guidelines and safe systems of work are in place.
- Ensure a safe environment for patients, clients, staff and visitors.
- Raise awareness of risk management principles with all staff groups in line with the Trust's Risk Management Strategy.
- Consider the human factors that lead to risk events and implement strategies to help minimise likelihood of occurrence such as a culture for taking breaks, a culture for asking for support and help if required, a culture of offering support and help to all members of the multidisciplinary team.

3. Purpose and Scope

3.1 The purpose of the Maternity Risk Strategy is to clearly describe the structures and strategy in place for the maternity multidisciplinary team over the next five years. It will define the risk management role and responsibilities of midwifery and obstetric staff. It will set out the reporting relationships both within the maternity department and the key committees external to it.

3.2 The maternity risk management strategy is applicable to all temporary and substantive members of staff who work within the maternity department and those teams which link into maternity services. The strategy is also applicable to all staff contracted to provide services within the midwifery and obstetric spectrum including honorary contract holders and all workers visiting the maternity department in the course of their employment or studies.

4. Structure – Lead Roles and Responsibilities

4.1 Chief of Nursing and Midwifery

Chief of Nursing and Midwifery is the executive lead with responsibility for managing the strategic development and implementation of the Trust's Quality Strategy and Trust's Corporate Assurance Framework. They are accountable for ensuring there is a robust system in place for monitoring compliance with Care Quality Commission outcomes of quality and safety. Chief of Nursing and Midwifery is responsible for managing quality, patient safety complaints, and medical negligence claims and setting the quality standards.

Chief of Nursing and Midwifery will meet monthly with the Director of Midwifery to review the maternity services including compliance with the Care Quality Commission indicators, maternity dashboard, risk register and complaints. Chief of Nursing and Midwifery will represent the maternity services at board level and will inform the board of any issues. Feedback from the board will be via the Chief of Nursing and Midwifery to the Director of Midwifery

4.2 Deputy Directors of Nursing

There are two Deputy Directors of Nursing, one leading on patient safety and quality and one leading on patient experience and workforce. The role of the Deputy Director of Nursing (patient safety and quality) is to promote patient safety and risk management activity, awareness and training throughout the Trust. They have an overarching responsibility for ensuring there is an effective incident reporting process, the effective management of risk data and information, and producing the Trust's risk register. The Deputy Nursing Director ensures that all serious risk incidents are reported to the Board of Directors, the foundation trust regulator, the CQC and the clinical commissioning groups, and are managed in line with the Serious Incident Policy. The role of the Deputy Director of Nursing (patient experience and workforce) is to promote excellence in patient experience, ensuring patient and carer concerns or complaints are fully investigated and that learning from them, and other patient experience sources are triangulated and used to improve patient outcomes.

4.3 Director of Midwifery

The Director of Midwifery encompasses the role of Risk Manager within Maternity and is responsible for managing and co-ordinating the obstetric risk management strategy and Clinical Governance Strategy of the Maternity Department. The post holder has a specific role in developing and reviewing clinical policies and procedures in midwifery and in the education of clinical staff regarding risk management issues. A cross site clinical governance lead for maternity is in post to support the Director of Midwifery and is delegated responsibility as appropriate. The Director of Midwifery ensures effective liaison and reporting between the Trust's Head of Patient Safety and the Patient Safety Department.

The Director of Midwifery has the following responsibilities:

- To be responsible for clinical governance arrangements across the directorate.
- To identify Trust-wide issues that impact on maternity services and take action as appropriate.
- To be responsible for business planning and continuity of the service and to identify resource requirements.

- To ensure consistent application of Trust-wide policies within the directorate.
- To provide support to individual practitioners following adverse incidents as per Guidelines for Supporting Staff Involved in Traumatic/Stressful Incidents, Complaints or Claims.
- To meet regularly with the Chief of Nursing and Midwifery, executive lead for maternity services.
- To work closely with the Chief of Service, Associate Director, Heads of Midwifery, senior midwives to ensure that risk management is implemented in the maternity services.

4.4 Chief of Service/ Associate Directors

Senior Managers including Managers at all levels of the organisation have a responsibility to manage risks at a local level in their respective wards and departments, and to develop an environment where staff are encouraged to identify and report risk issues proactively. All managers are expected to ensure that their staff report any near miss incidents, adverse incidents and serious incidents immediately, using the Trust incident reporting procedure.

Chiefs of Service/Associate Directors are responsible for developing local quality indicators to include clinical outcomes, patient safety and patient experience issues. They are also responsible for ensuring emergency planning is understood locally and business continuity plans are developed in line with the Trust framework.

Managers are also responsible for ensuring that staff receive appropriate feedback regarding specific incidents reported, and for ensuring that any recommendations following investigation of an incident are implemented and where appropriate audited at a later date to ensure they have been effective in reducing the likelihood of the incident happening again.

The Chief of Service shares responsibility for implementation of the Maternity Risk Management Strategy with the Director of Midwifery. The Chief of Service meets monthly with the Chief Executive to discuss maternity issues. The Chief of Service has the following responsibilities:

- To be ultimately accountable for clinical governance and clinical risk within obstetric and midwifery services of the Trust.
- To delegate responsibility for maternity risk management to a nominated consultant with experience and a special interest in risk. This delegated responsibility has an expectation for the nominated individual to access and fully discharge duties.
- To be fully informed and advised of the key risk issues through the Obstetrics and Gynaecology departmental meetings, of which all consultant clinicians are members.
- To agree and monitor the implementation and actions identified within the Maternity Risk Management Strategy, where there is a failure of compliance actively manages resolution of issues to ensure accomplishment of change.
- To ensure that recommendations/outcomes are communicated to and from the directorate Cross Site Obstetrics and Gynaecology Clinical Governance Committees and the Labour Ward Forums.
- To work closely with the Director of Midwifery, Heads of Midwifery, senior midwives and senior gynaecology nurses to ensure that risk management is implemented in the maternity services.

- To ensure that all medical staff comply with appropriate risk management processes and that during the annual clinical appraisal there is documented evidence that risk management is embraced.
- To monitor the implementation of this strategy and provide expert clinical advice as required.
- To provide support to individual practitioners following adverse incidents as per Guidelines for Supporting Staff Involved in Traumatic/Stressful Incidents, Complaints or Claims.

The Associate director has the following responsibilities:

- To be responsible for clinical governance arrangements across the directorate.
- To identify Trust-wide issues that impact on maternity services and take action as appropriate.
- To be responsible for business planning and continuity of the service and to identify resource requirements.
- To ensure consistent application of Trust-wide policies within the directorate.
- To provide support to individual practitioners following adverse incidents as per Guidelines for Supporting Staff Involved in Traumatic/Stressful Incidents, Complaints or Claims.
- To meet regularly with the Chief of Nursing and Midwifery, executive lead for maternity services.

4.5 Heads of Midwifery

The Heads of Midwifery have the following responsibilities:

- To identify Trust-wide issues that impact on maternity services and take action as appropriate.
- To be responsible for business planning and continuity of the service and to identify resource requirements.
- To ensure consistent application of Trust-wide policies within the directorate.
- To provide support to individual practitioners following adverse incidents as per Guidelines for Supporting Staff Involved in Traumatic/Stressful Incidents, Complaints or Claims.
- To work closely with the Chief of Service, Associate Director, Director of Midwifery, senior midwives and senior gynaecology nurses to ensure that risk management is implemented in the maternity services.
- To provide support to individual practitioners following adverse incidents as per Guidelines for Supporting Staff Involved in Traumatic/Stressful Incidents, Complaints or Claims.
- To support the implementation of the maternity safety improvement plan in line with national recommendations and care quality commission requirements.

4.6 Lead Consultant Obstetrician for Clinical Governance

The Lead Consultant for Clinical Governance has the following responsibilities:

- The Lead Consultant Obstetrician for Clinical Governance or nominated deputy consultant obstetrician will support the process of root cause analysis for all complex cases.
- The Lead Consultant Obstetrician for Clinical Governance (maternity) will attend bi-weekly Patients Safety and Quality meetings to review all significant incidents reported via the clinical incident reporting process.
- The Lead Consultant Obstetrician for Clinical Governance will ensure the Chief of Service is duly informed of all incidents where compliance to an action plan involving change is not achieved. To then work jointly with the Chief of Service of obstetrics and gynaecology to agree how to achieve progress to ensure a high-quality safe level of service.
- The Lead Consultant Obstetrician for Clinical Governance is expected to support the education of individuals in relation to risk throughout the Trust's maternity professions.
- To proactively update the Chief of Service of any areas of concern and high-risk issues as these occur.
- In the absence of the Chief of Service to act as appropriate.
- To provide support to individual practitioners following adverse incidents as per Guidelines for Supporting Staff Involved in Traumatic/Stressful Incidents, Complaints or Claims.
- To support the implementation of the maternity safety improvement plan in line with national recommendations and care quality commission requirements.

4.7 Consultant Obstetrician for labour ward matters (Labour Ward Lead)

The Consultant obstetrician for labour ward matters has the following responsibilities:

- To provide professional leadership to the multidisciplinary team working on the labour ward.
- To work with the Midwifery Matron for Intrapartum Care to develop, implement and monitor clinical guidelines.
- To ensure that recommendations from NICE, CQC, MBRRACE, Ockendon and the Royal Colleges are incorporated into local guidance where appropriate.
- In liaison with Director of Midwifery, Heads of Midwifery and Clinical Governance Lead for obstetrics and gynaecology to take a lead role to ensure the delivery of the governance agenda for labour ward.
- To co-chair Labour Ward Forum with intrapartum matrons in order to facilitate multidisciplinary communication and implementation of changes in clinical practice on the labour ward.
- Ensure communication between the labour ward forum, departmental meeting, consultant meeting and maternity patient safety and quality group.
- To manage poor performance of obstetricians in line with trust procedures.
- Along with the practice development team facilitate skills drills and ensures that remedial action is taken if shortcomings are identified during these drills.
- To support the implementation of the maternity safety improvement plan in line with national recommendations and care quality commission requirements.

4.8 Cross site Clinical Governance Lead for Obstetrics and Gynaecology

The Clinical Governance Lead for Obstetrics and Gynaecology has the following responsibilities:

- To undertake any tasks delegated by the Director of Midwifery or Heads of Midwifery.
- To facilitate and manage an effective process for identification of hazards and other factors that have implications for clinical standards and delivery of care to women in line with national standards and legislation.
- To ensure that individuals undertaking risk assessments are competent to do so by facilitating individuals to undertake suitable training and guidance.
- To identify any trends in incident and near miss reporting across the Directorate and communicate effectively with the Chief of Service, Lead Consultant Obstetrician for Clinical Governance, Director of Midwifery, Heads of Midwifery and the Trust Head of Patient Safety.
- To provide specialist advice and support to managers and risk assessors as required including categorisation of incidents.
- To delegate investigation of event reports to line managers/ where appropriate.
- To undertake annual monitoring and review of this strategy in conjunction with the Chief of Service, Director of Midwifery and Heads of Midwifery.
- To report to the Care Governance committee specialty risks, and share lessons learned across the organisation.
- To identify and analyse trends of all reported incidents from the Maternity Patient Safety and Quality Group and report to the labour ward forum, departmental meeting, cross site obstetrics and gynecology clinical governance committees and the Trust clinical governance committee.
- To ensure that all relevant information and feedback from reports is circulated at all relevant managerial levels within the Directorate.
- To be responsible for agreed action being implemented across the maternity service.
- To provide support to individual practitioners following adverse incidents as per Guidelines for Supporting Staff Involved in Traumatic/Stressful Incidents, Complaints or Claims.
- To link and attend the Trust Patient Safety Committee as required.

4.9 Lead Midwife Patient Safety

The Lead Midwife for Patient Safety has the following responsibilities:

- To be responsible for the risk coordination, implementation & dissemination of clinical and non-clinical risk within maternity to meet national, regional and local requirements.
- To ensure that all incidents are graded according to severity and likelihood of recurrence and forward incidents forms to the Trust risk management office.
- To identify any trends in incident and near miss reporting across maternity and communicate effectively with the Chief of Service, Lead Consultant Obstetrician for Clinical Governance, Director of Midwifery, Heads of Midwifery, Clinical Governance Lead and senior nurses/senior midwives.
- To be responsible for the coordination of investigations of critical clinical incidents ensuring all appropriate clinicians and managers are informed and appropriate action taken.
- To liaise closely with the Director of Midwifery and the Heads of Midwifery, clinical governance lead and the quality, audit and patient experience midwife to identify local requirements for clinical audit arising from risk management, to ensure that the

recommendations of risk reviews are disseminated and implemented to minimise further clinical risk.

- To participate in Trust wide clinical and non-clinical risk initiatives.
- To utilise effective methods to communicate clinical risk issues, outcomes and results of investigations, and to make recommendations for changes in practice to the multidisciplinary team.
- To provide feedback to individuals and arrange appropriate training where need is identified.
- To provide support to individual practitioners following adverse incidents as per Guidelines for Supporting Staff Involved in Traumatic/Stressful Incidents, Complaints or Claims.
- To report relevant case to national audits.
- To support the implementation of the maternity safety improvement plan in line with national recommendations and care quality commission requirements.

4.10 Responsibilities of the Matron for Intrapartum Care, Matron for Inpatient Services, Community Midwifery Matron and Neonatal Unit Matron

The designated Matrons have the following responsibilities:

- To oversee, monitor, review and report on the performance of their designated wards and areas.
- To implement risk management systems and processes in each area.
- To co-ordinate all clinical risk issues within their sphere of responsibility.
- To ensure a nominated matron provides cross cover for their clinical area during periods of annual/study leave.
- To liaise with the cross-site obstetrics and gynaecology Clinical Governance Lead and Lead Midwife for patient safety with regards to incidents in their designated area.
- To provide expert midwifery clinical advice within the Directorate cross site obstetrics and gynaecology clinical governance committee.
- To be responsible for investigation and grading of incidents/near misses as soon as possible, using the Trust risk grading matrix. Assessment will include the impact of the incident and potential future risk. This can be delegated to Band 7 practitioners with responsibility for overseeing completion being held by the delegating matron.
- To provide feedback to individuals and arrange appropriate training where need is identified.
- To provide support to individual practitioners following adverse incidents as per Guidelines for Supporting Staff Involved in Traumatic/Stressful Incidents, Complaints or Claims.
- To support the implementation of the maternity safety improvement plan in line with national recommendations and care quality commission requirements.
- To attend bi-weekly Patient Safety and Quality Meetings.

4.11 Lead Consultant Obstetric Anesthetist

The Lead Consultant Obstetric Anesthetist has the following responsibilities:

- To be responsible for the organisation and audit of the obstetric anesthetic service, for maintaining and raising standards through the provision of evidence-based guidelines.
- To provide anesthetic input to the labour wards forum and the maternity patient safety and quality group.
- To facilitate anesthetic training as required.
- To lead on maternity related anesthetic guidelines.
- To attend bi-weekly Patient Safety and Quality Meetings, when invited.

4.12 Consultant Paediatrician Link with maternity services

The Lead Consultant Paediatrician link has the following responsibilities:

- To provide paediatric input to the labour ward forum and the maternity patient safety and quality group.
- To facilitate paediatric training as required.
- To lead/ participate in maternity related neonatal guidelines.
- To attend bi-weekly Patient Safety and Quality Meetings, when invited.

4.13 Responsibilities of all staff

All members of staff have an important role to play in identifying and minimising risks and hazards as part of their everyday work within the Trust. Everyone has a responsibility for their own personal safety and for the safety of their colleagues, patients and all visitors to the Trust. The Directorate will actively encourage all staff to identify and assist in the risk management process.

All staff are expected to have an understanding of the Incident Reporting Procedure, and knowledge of the types of incidents, which must be reported. They must also have knowledge of specific directorate level incident triggers relevant to their department, which also require reporting. The specific incidents requiring reporting within maternity are included in *Appendix A*.

All staff members have the following responsibilities:

- Report near miss, serious and adverse events using the Trust incident report form. If the impact is serious immediate reporting to the senior manager on-call and named consultant will take place, including out-of-hours.
- Accept personal responsibility for maintaining a safe environment.
- Be aware of their legal duty to take reasonable care for their own safety and the safety of others who may be affected by their work.
- Provide safe clinical practice.
- Be familiar with Trust and Unit policies, protocols and guidelines.
- Attend risk management training.

5. The process of risk assessment within the maternity service and escalation of risk issues to the Trust board

The maternity department is committed to reducing harm, adverse incidents and outcomes. This is applied to the risk management process in two keyways:

1. By ensuring a proactive process is in place to identify risks and take preventative measure before an incident occurs through risk assessments. Risks are graded with documentation of current control measures and future action plans are identified to reduce risks.
2. By ensuring lessons are learnt after an incident, complaint or claim i.e., incident reporting procedures taking steps to minimise damage and to make changes in practice to prevent any future repetition of the incident.

5.1 Risk Assessment (as per Trust Risk Strategy, point 7, page 15)

The formal proactive method of identifying operational risks within the Trust is through the use of risk assessments. Clinical, non-clinical and business planning risk assessment is well established within the Trust. These risks then populate the directorate/specialist risk assurance frameworks. The Board of Directors are responsible for identifying strategic risks associated with strategic direction of the organisation.

The Trust is committed to ensuring that integrated clinical and non-clinical risk assessments in all departments are regularly updated and formally reviewed on an annual basis. All types of risk identified are graded using a common grading matrix which measures the risks in terms of both consequence and likelihood. (Refer to Trust Guidelines for conducting a Risk Assessment). Risks graded moderate, high & extremely high from a corporate perspective will be entered onto the Trust Risk Assurance Framework allowing meaningful comparison of risk priorities for the organisation and will be reported to the Board of Directors.

A risk assessment system incorporating the following elements is effectively used within the maternity Directorate:

5.2 Identify risk/hazard

This is achieved by gaining information from near miss and adverse incident reporting and from the clinical information system reports. This is in line with the formal reactive method of identifying risks within the Trust. Incident reporting is well established throughout the maternity department with all members of the multidisciplinary team completing these when required. As well as the corporate categories of risk identified in the Trust incident reporting procedure, the maternity risk management group have identified a set of clinical triggers for reporting (*Appendix A*). Important information can also be gained from analysis of patient complaints, legal claims, service user satisfaction surveys and national confidential enquiry reports.

5.3 Analyse risk / hazard

Using the Trust risk grading matrix, (tables 1, 2 and 3) existing control measures are determined, and the risk is analysed in terms of likelihood of recurrence and possible future consequences. The risk is then rated. This approach ensures that managers are aware at an early stage of any evolving trends highlighting higher risk incidents resulting in initiation of

immediate action as required. Written action plans are compiled where appropriate, and the risk entered on to the maternity risk register.

5.4 Monitor & review of risks through the maternity services risk assurance framework

The maternity risk assurance framework, also referred to as Risk Register, is reviewed monthly by the Maternity Patient Safety and Quality Group, reported to the obstetrics and gynaecology departmental and cross-site meetings where the progress against the framework is reviewed. As part of this process, risks are re-graded and added or removed on an on-going basis. The maternity risk assurance framework is maintained by the Head of Midwifery, Deputy Heads of Midwifery and the Clinical Governance Lead for obstetrics and gynaecology.

The maternity risk assurance framework is submitted monthly to the Trust risk office where they are reviewed on a monthly basis by the Trust Corporate Governance committee, where risks are graded high or extremely high, they are considered for addition to the corporate risk assurance framework and reported to the Board of Directors.

5.5 Trust grading matrix

The risk grading matrix is used by staff for both the grading of incident, complaints and claims and all annual risk assessments. Individual risk incidents are graded by the appropriate line manager and reviewed in the Risk Management Office by the Governance Manager and Head of Patient Safety. In maternity the lead manager for the area and/or the Lead Midwife Patient Safety will review the incident and apply a consequence and likelihood grading. Please see table below.

Instructions for Use

- Define the risk(s) explicitly in terms of the adverse consequence(s) that might arise from the risk
- Use Table 1 (see over) to determine the Consequence score(s) C, for the potential adverse outcome(s) relevant to the risk being evaluated
- Use Table 2 (see over) to determine the Likelihood score(s) L, for those adverse outcomes
- Table 3 shows the Grading Matrix for the calculated risk (C X L)

If possible, score the likelihood by assigning a predicted frequency of the adverse outcome occurring. If this is not possible, then assign a probability to the adverse outcome occurring within a given time frame such as the lifetime of the project or the patient care episode

Table 1 – Consequence Score (C)

	1	2	3	4	5
Descriptor	Insignificant	Minor	Moderate	Major	Catastrophic
Objectives / Projects	Insignificant cost increase/schedule slippage. Barely noticeable reduction in scope or quality	<5% over budget/schedule slippage. Minor reduction in quality/scope	5-10% over budget / schedule slippage. Reduction in scope or quality	10-25% over budget / schedule slippage. Doesn't meet secondary objectives	>25% over budget / schedule slippage. Doesn't meet primary objectives.
Patient/Staff Safety	Minor injury not requiring first aid	Minor injury or illness, first aid treatment required	RIDDOR / Agency reportable	Major injuries, or long-term incapacity / disability (loss of limb)	Death or major permanent capacity
Patient Experience	Unsatisfactory patient experience not directly related to patient care	Unsatisfactory patient experience readily resolvable	Mismanagement of patient care	Serious mismanagement of patient care	Totally unsatisfactory patient outcome or experience
Complaints / Claims	Locally resolved complaint	Potential claim Justified complaint peripheral to clinical care	Potential claim Justified complaint involving lack of appropriate care	Likely claim Multiple justified complaints	Multiple claims or single major claim
Clinical Service / Business Interruption	Local interruption with back up	Local interruption	Loss/interruption > 1hour	Loss / interruption > 8 hours	Loss / interruption > 24 hours
Staffing & Competence	Short term low staff level temporarily reduces service quality (<1day)	On-going low staffing level reduces service quality	Late delivery of key objective/service due to lack of staff. Minor error due to poor training. On-going unsafe staffing level	Uncertain delivery of key objective / service due to lack of staff. Serious error due to poor training.	Non-delivery of key objective / service due to lack of staff. Loss of key staff. Critical error due to insufficient training
Financial	Small loss	Loss >0.5% of budget	Loss >1% of budget	Loss >3% of budget	Loss >5% of budget
Inspection / Audit	Minor recommendations. Minor non-compliance with standards	Recommendations given. Non-compliance with standards	Reduce rating. Challenging recommendations. Non-compliance with core standards	Enforcement Action. Low rating. Critical report. Major non-compliance with core standards	Prosecution. Zero rating. Severely critical report
Adverse Publicity / Reputation	Rumours	Local media – short term. Minor effect on staff morale	Local media – long term. Significant effect on staff morale	National media < 3 days	National media >3 day. MP concern (Questions in House)
Information Governance	Damage to individual's reputation, possible media interest Potentially serious breach, less than 5 people affected of risk assessed as low	Damage to a team's reputation. Some local media interest may not go public Serious potential breach and risk assessed high. Up to 20 people affected	Damage to a services reputation/low key media coverage Serious breach of confidentiality, i.e. up to 100 people affected	Damage to organisation's reputation/local media coverage Serious breach with either particular sensitivity or up to 1,000 people affected	Damage to NHS reputation, national media coverage Serious breach with potential for ID theft or over 1000 people affected

Table 2 – Likelihood Score (L)

	1	2	3	4	5
Descriptor	Rare	Unlikely	Possible	Likely	Almost Certain
Frequency	Not expected to occur for years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily
Probability	<9%	10-24%	25-49%	50-74%	75-100%
	Will only occur in exceptional circumstances	Unlikely to occur	Reasonable chance of occurring	Likely to occur	More likely to occur than not

The risk matrix shown below to determine the colour banding for the risk:

Risk Matrix $R \text{ (risk)} = C \text{ (consequence)} \times L \text{ (likelihood)}$

Table 3 - Trust Grading Matrix

Likelihood	Consequence				
	1	2	3	4	5
1	1	2	3	4	5
2	2	4	6	8	10
3	3	6	9	12	15
4	4	8	12	16	20
5	5	10	15	20	25

The Matrix Graph will give a scored risk rating of either:

Extremely High	=	PURPLE
High	=	RED
Moderate	=	AMBER
Low	=	GREEN

This rating is used for both populating the Corporate/Local Risk Assurance Frameworks and for scoring all incidents, complaints and claims on the Datix Information System. This approach ensures that all risk analysis is based on the same assessment criteria and allows like for like comparison of all risks to the Trust. Training is provided for all staff that have responsibility for the categorisation grading and scoring of risks.

All high and extremely high graded incidents will require consideration for a formal root cause analysis to be carried out and where appropriate risks will be added to the Corporate Risk Register.

5.6 Levels of Authority for the management of identified risks

The maternity department uses the Trust wide management levels of authority table to determine the appropriate individual to manage identified risks within the department.

Table 4 – Management Levels of Authority

Risk Colour	Remedial Action	Decision to accept risk	Risk Register level
Green Low	Ward Manager/ Head of Department	Ward Manager/ Head of Department	Clinical Speciality
Orange Moderate	Associate Director Head of Service Head of Nursing/Clinical Matron	Clinical or Exec Director Corporate Governance Group	Trust Wide
Red High	Associate Director Head of Service Director	Executive Team	Trust Wide
Purple Extremely High	Director	Executive Team	Trust Wide

The handling of each categorisation is set out below:

GREEN INCIDENT

The person in charge of the area will discuss with the staff involved. Remedial actions will be noted on the Trust incident report form which will be given initially to the ward sister/ matron of area. Notify the matron/ Lead Midwife for Patient Safety if further action is required.

ORANGE INCIDENT

The Lead Midwife for Patient Safety/ Matron for the identified area will undertake a review of the incident and ensure the incident is reported to the Maternity patient safety and quality group (case note review). Appropriate remedial actions to be taken as required.

RED INCIDENT

Inform the Director of Midwifery/ Head of Midwifery, Clinical Governance Lead, Lead midwife for Patient Safety and the Trust patient safety team as soon as possible. The Lead Midwife for Patient safety will review the incident, discuss with “key staff”, and ensure that the incident is discussed at the Maternity patient safety and quality group. Appropriate remedial actions to be taken as required.

PURPLE INCIDENT

Serious obstetric incidents as defined in the trust Policy for the management of incidents including the management of serious incidents are reported to the senior manager on call and either the named or on-call consultant and hospital administrator-on-call at the time of the incident. The Director of Midwifery or Heads of Midwifery should also be informed as soon as possible.

The Director of Midwifery, Head of Midwifery or Clinical Governance Lead must ensure that the chief of service for obstetrics and gynaecology, director of nursing (via the Trust Patient Safety office), and associate director are notified the next working day. The Clinical Governance Lead will ensure that an investigation is carried out using the principles of root cause analysis and formulate any remedial actions by use of an action plan. This may be delegated to the Lead Midwife for Patient safety. A full investigation and report will be required and submitted to the Trust board.

6. Communication and feedback processes

This sets out the expectations for communication within the maternity department following the submission of an incident to the Datix risk management system.

- Initial risk assessment is carried out on receipt of incident forms, using the principles of root cause analysis.
- Specialist personnel are asked to advise on investigation of incidents as appropriate.
- Further risk assessment of near miss cases and selected clinical cases are discussed in the maternity patient safety and quality group. These meetings are held fortnightly. A verbal report from the maternity patient safety and quality group is presented to the labour ward forum by the Lead Midwife for Patient Safety or Clinical Governance Lead.
- Feedback to the maternity department's staff is undertaken on an individual basis by a member of the maternity patient safety and quality group or other designated individuals as required e.g. specialist midwives/consultant obstetricians. Group feedback is via departmental meetings, unit meetings, coordinator meetings and the message of the week.
- Multidisciplinary case review meetings are held following incidents that may result in litigation/complaints. This enables learning for those involved in the incident and allows more in-depth analysis of events. A clear account of events is also formulated in addition to the case notes. Where remedial actions are required, an action plan is formulated and individual and group feedback given as described above.

7. Committee Structure

Effective lines of communication exist between the committees and groups within the maternity clinical governance structure and with the wider Trust governance/risk management committee structure. These are demonstrated in Appendix B.

7.1 Obstetric and Midwifery Clinical Governance Committee

The Cross-site obstetric and midwifery clinical governance committee is accountable to the Trust Care Governance Committee, and the Trust Corporate Governance Committee. The terms of reference for the group are attached at *Appendix E*. The key priorities of this group are as follows:

- To review the directorate incident reporting profiles, including the quarterly patient safety report, serious incidents and actions identified, sharing of learning and changes in practice.
- To monitor serious incidents, including HSIB (Healthcare Safety Investigation Branch) and PMRT (Perinatal Mortality Review Tool) action plans until completion.
- To monitor outcomes of morbidity and mortality reviews.

- To review the local risk assessment frameworks and actions to address the identified safety and quality risks.
- To review local dashboards, note trends and identify actions required.
- To receive reports from and make recommendations to the following:
 - Labour ward forums
 - Maternity patient safety groups
 - Safeguarding
 - Antenatal screening
 - Clinical audit
 - Practice development
- To monitor patient experience including complaints, claims, Friends and Family and local and national surveys, highlighting actions identified, sharing of learning and audit of changes in practice.
- To monitor compliance with relevant mandatory training and how areas of non-compliance are being addressed.
- To ratify clinical guidelines and local policies and support the implementation of new and updated guidelines.
- To monitor progress on guideline development, including key leads, date for review and uploading to the Trust intranet.
- To ratify patient information and support the implementation of new and updated patient information.
- To monitor progress on patient information development, including key leads, date for review and uploading to the Trust intranet.
- To monitor the clinical audit programme, including local and national specialty audits at least quarterly.
- To monitor progress against national guidance including NICE, RCOG, MBRRACE, NHS Resolution and CQC standards and actions required to achieve compliance.

7.2 Labour Ward Forum

The labour ward forum is a forum that will ensure that there is a clear documented system for management and communication throughout the key stages of maternity care. The terms of reference are attached in *Appendix E*.

The key priorities of this group are as follows:

- To ensure that there is good inter-professional communication and teamwork across all professionals within the departments.
- To ensure that systems are in place to ensure that women and their babies receive the care appropriate to their needs throughout the antenatal, intrapartum and postnatal period.
- To review urgent clinical issues to assist in planning the way forward through effective multi-professional working.
- To provide information to and receive feedback from the Obstetric Clinical Governance Committee on clinical risk and implement actions to be taken.
- To receive summary reports from the Maternity Patient Safety and Quality groups.
- To review and provide site specific approval of clinical guidelines prior to full ratification in the cross-site obstetrics and gynaecology clinical governance committee.
- To make recommendations to the guidelines and patient information steering group for changes when appropriate.

- To support the practical implementation of agreed changes to guidelines.
- To define the priorities for projects relating to the service and assist in taking them forward.

7.3 Maternity Patient Safety and Quality Group

The Maternity patient Safety and Quality Group is responsible for the identification and management of clinical and non-clinical risk within the maternity services. The group reports to the Labour Ward Forum, the Cross-site Obstetrics and Midwifery Clinical Governance Committee and the Obstetrics departmental meetings. Terms of reference are attached at *Appendix F*. The Key priorities are as follows:

- To ensure effective communication between all staff with a responsibility for clinical risk.
- To identify urgent clinical issues which pose an immediate or significant risk to patient safety and make recommendations for remedial measures to mitigate the risk.
- To review and update the maternity Risk Assurance Framework monthly, escalating risks to the corporate governance group and feeding into the Corporate Risk Assurance Framework where appropriate
- To review the Maternity Dashboard monthly, noting trends and agreeing actions to address potential risks identified from the dashboard.
- To receive notification of all serious incidents and risks identified during the investigation.
- To monitor action plans from serious incidents until completion.
- To monitor HSIB recommendations until they have been implemented.
- To monitor action plans from PMRT until completion
- To report to, and receive feedback from, the Trust Board and executives responsible for patient safety in maternity via the maternity safety champions (the director of midwifery and the chief of service for obstetrics and gynaecology)
- To provide information to and receive feedback from, the Trust Patient Safety committees on each site.
- To review reports from the litigation department and note any trends identified from obstetric claims.
- To provide guidance on Duty of Candour and communication with families.
- To receive reports of cases reported to 'Each Baby Counts' and NHS Resolution and progress on management of the cases.
- To support the implementation of any changes required to achieve compliance with NHS Resolution CNST maternity standards.
- To review and discuss selected case notes identified from completed incident forms and from clinical triggers on the maternity information system. As a result, identify any clinical risk issues and remedial actions as required.
- To review action already taken and delegate further action as required ensuring continual improvements in quality and the control of risk.
- To monitor actions required or changes introduced as a result of incidents and near miss reporting.
- To ensure the facilitation of appropriate feedback to individuals involved when required.
- To consult with other professionals as required ensuring an effective multidisciplinary approach to managing risk.
- To influence the work of the labour ward forum in relation to safety and quality within the specialty.
- To give a verbal report monthly to labour ward forum and departmental meeting and a quarterly report to the obstetrics and gynaecology clinical governance committee.

7.4 Monthly Perinatal Morbidity and Mortality Meeting (PMMM)

The purpose of the PMMM is to review cases that have had joint care management from Obstetric and Neonatal teams. The emphasis of review is to identify learning and actions that may reduce the risk of both maternal and neonatal adverse outcomes for future practice. These meetings will be held monthly, and the following cases will be reviewed and discussed:

- All neonatal transfers from local unit.
- All neonatal deaths of 23 weeks gestation and above
- Exchange transfusions for hyperbilirubinaemia.
- Management of major congenital anomaly.
- All neonates born < 27 weeks gestation.
- All neonates born with birthweight <800g.
- Multiple pregnancies below 28 weeks gestation.
- Any neonate who requires cooling therapy.
- Any neonate who requires specialist including nitric oxide/HFOV Complex intensive care including neonates with symptoms of additional organ failure (inotropes, insulin infusion, chest drain, prostaglandin infusion).
- All ventilated babies.
- Unexpected morbidity/other cases as required identified by the Neonatal Consultant.

7.5 Local meetings / Consultant staff meetings

These meetings are held regularly, usually monthly, and used to discuss day to day running of the departments and any issues arising. In addition, all staff attending the meeting will be given the feedback following incidents, including serious incidents, patient satisfaction feedback, including complaints, and as team manage any outstanding actions plans.

7.6 Educational Half days and Audit

These are half day teaching sessions offered throughout the year for all Maternity staff. In addition, any audits undertaken during the previous month will be presented and discussed.

8. Risk Management Training

Contributing to Risk Management is the responsibility of all members of staff, and the Trust recognises the importance of providing risk education and awareness training for all grades of clinical and non-clinical staff. As a minimum, annual risk management training is mandatory for all clinical staff.

- All new staff are required to attend a Trust-wide induction. Risk management awareness and incident reporting is included as a structured part of the Trust's induction programme for new staff.
- At directorate level, all nurses, midwives and healthcare assistants undergo a period of preceptorship and receive written induction/orientation packs, which include risk management information. Medical staff have a local induction programme; this includes consent training and information on risk management. Locum medical staff receive induction together with a pack of relevant Trust information prior to commencing work.
- A mandatory annual update in risk management issues is delivered as part of the mandatory update days for all clinical staff in accordance with the training needs analysis for maternity.
- The obstetric risk management team receive ongoing training in the management of clinical incidents along with other relevant personnel in the department.
- All Patient Safety Team staff have completed or are completing Level 1 & 2 HSIB training. Senior leaders (Patient Safety Specialists) are currently undertaking Level 3 & 4.

9. Managing potential obstetric clinical negligence claims

9.1 Aim

The aim is to use the risk management process to identify and manage potential obstetric clinical negligence claims and refer appropriate cases to the NHS resolutions scheme.

9.2. Objectives

The objective is to investigate and report obstetric incidents that may lead to a clinical negligence claim, including:

- Maternal death
- Intra-partum stillbirth
- Unexpected neonatal death where low Apgar scores were recorded at delivery
- Baby shows signs of birth injury or other serious trauma
- Any other incident where circumstances suggest a claim may result (e.g. uterine rupture)

We aim to achieve this by:

- Protecting medical records and evidence
- Supporting staff and obtaining statements from key individuals at the time of the incident occurring
- Apply the 'Being Open' guidance to incidents where serious injury or death has occurred and complete appropriate duty of candour processes

- Ensure appropriate investigation, applying the principles of root cause analysis are completed
- Identifying areas of substandard care which may prove a risk to the Trust
- Ensuring that risk management issues are identified and apply recommended practice changes

9.3. Introduction

The Trust is required to report obstetric potential claims/claims to the NHS Resolution within the terms of the CNST Reporting Guidelines. This strategy should be read in conjunction with the Trusts' Policy and Procedures for Management of Legal Claims.

Obstetric claims, particularly those that involve neurologically damaged infants, often take a number of years to investigate and are generally high value in terms of potential financial compensation. It is necessary to ensure appropriate investigation and protection of documentation and equipment at incident stage to ensure that the Trust has the best possible information available to proceed with a clinical negligence claim.

Obstetric incidents are often distressing for all involved and it is hugely important that both staff and patients and their relatives are appropriately supported, and that clear factual information is shared.

9.4. Roles and Responsibilities for Managing Potential Obstetric Clinical Negligence Claims

9.4.1 Chief of Service, Obstetrics and Gynaecology

The Chief of Service has the following responsibilities:

- To work closely with the Director of Midwifery, Heads of Midwifery and Senior Midwifery team to ensure that obstetric incidents/complaints that may result in clinical negligence claims are fully investigated through the risk management processes
- To keep the medical director informed of such cases that may result in negligence claims
- To support the medical staff in preparation of statements following incidents that may result in clinical negligence claims
- To approve risk management recommendations and corrective actions arising from claims.

9.4.2 Lead Obstetrician for Risk Management

The Lead Obstetrician for Risk Management has the following responsibilities:

- To assist the Chief of Service and the Director of Midwifery/ Heads of Midwifery with any investigations and reports to the Trust risk office and litigation office
- To support midwifery and medical staff in the initial writing of statements, when required
- To assist in the implementation of change in practice identified through settled/ongoing/new claims

9.4.3 Director of Midwifery

The Director of Midwifery has the following responsibilities:

- Lead investigation of incidents that may result in clinical negligence claims and implement risk management review and practice changes arising from claims
- To keep the director of nursing and Trust risk manager informed of such cases that may result in negligence claims.
- To liaise with the litigation manager on all on going and potential cases.
- To review recommendations from previous claims and ensure changes of practice are implemented where appropriate.
- To monitor compliance with changes in practice arising from claims.

9.4.4 Heads of Midwifery

The Heads of Midwifery have the following responsibilities:

- To lead investigation of incidents that may result in clinical negligence claims and implement risk management review and practice changes arising from claims
- To keep the director of nursing and Trust risk manager informed of such cases that may result in negligence claims.
- To liaise with the litigation manager on all on going and potential cases.
- To review recommendations from previous claims and ensure changes of practice are implemented where appropriate.
- To monitor compliance with changes in practice arising from claims.

9.4.5 Clinical Governance Lead for Obstetrics and Gynaecology

The Clinical Governance Lead for Obstetrics and Gynaecology has the following responsibilities:

- Lead investigation of incidents that may result in clinical negligence claims and implement risk management review and practice changes arising from claims
- To keep the director of nursing and Trust risk manager informed of such cases that may result in negligence claims.
- To liaise with the litigation manager on all on going and potential cases.
- To review recommendations from previous claims and ensure changes of practice are implemented where appropriate.
- To monitor compliance with changes in practice arising from claims.

9.4.6 Lead Midwife Patient Safety

The Lead Midwife for Patient safety has the following responsibilities:

- To Assist the Director of Midwifery, Heads of Midwifery, Clinical Governance Lead for Obstetrics and Gynaecology or Obstetric clinician with any investigations and reports to the risk and litigation offices
- To support midwifery and medical staff in the initial writing of statements, when required.
- To assist in the implementation of change in practice identified through settled/ongoing /new claims

9.4.7 Trust wide Governance Manager and Head of Patient Safety

The Trust Wide Governance Manager and Head of Patient Safety have the following responsibilities:

- Review incidents in line with the Incident Reporting and Serious incidents requiring investigation (SIRI) Policies and report to external agencies where required. Notify the litigation manager of those incidents that are graded as potential obstetric claims

9.4.8 Litigation Manager

The Litigation Manager has the following responsibilities:

- Review reported potential obstetric claims and advise on action to be taken with respect to ongoing claim investigation in line with Trust claims policy.
- Notification to the NHS Resolution in line with CNST Reporting Guidelines.
- Provide reports regarding claims status (3 monthly Directorate reports/Annual Report)

9.5 Process

- The Incident form is completed via the RL system in conjunction with the clinical triggers (Appendix A)
- The lead manager for the area and/or the Lead Midwife for Patient Safety will review the incident and apply a severity and likelihood grading
- The Director of Midwifery/ Heads of Midwifery are informed of the incident
- The Trust risk office are informed via the RL system
- The Director of Midwifery/Heads of Midwifery is the lead for any incident investigation locally; this may be delegated as appropriate to other senior midwifery staff.
- A Chief of Service or Lead Obstetrician for Risk Management may be the lead investigator if the incident is an SI.
- Relevant equipment is identified and retained if faulty
- Initial statements are obtained from key staff
- Obstetric incidents will be copied from the risk management department to the claims department where grading has indicated a litigation risk or where it is considered that further investigation by the claims department may be appropriate
- The claims management policy is initiated as appropriate
- The obstetric department meet as a maternity patient safety and quality group fortnightly to review and take action on incidents, including claims/potential claims

9.6 Liaison between Litigation and Maternity Departments

- The Litigation manager meets with the Director of Midwifery/ Heads of Midwifery or Clinical Governance Lead on a quarterly basis to discuss ongoing management of potential and actual claims.
- Liaison via discussion and correspondence is ongoing with respect to individual case management, i.e., obtaining information and statements, updating case status, obtaining advice and attendance at case conferences.
- The litigation manager attends the maternity patient safety and quality group meetings as required.

9.7 Related Policies and Guidance – Available on the Intranet

- Incident and Serious Incidents Policy
- Claims Management Policy
- Duty of Candour Policy

10. Key Risk Management Priorities for 2022-2026

- To progress the CNST Quality Standards achieved in June 2021 and progress with changes/amendments as notified by NHS Resolution
- To increase the reported satisfaction of women scores from the 2021 care quality commission survey.
- Implement all recommendations following Ockendon Report published in December 2020.
- Annual review of Midwifery staffing levels and skill mix to meet the optimal 1:24.5 at Frimley and 1:23.3 at Wexham, birth ratio for the unit and midwives against acuity tool.
- To review maternity audit programme to ensure all audits monitor our current practice and improvements are made where indicated.
- Work with national Maternity and Neonatal Safety Collaborative to implement improvements to safe care for women and their babies
- To ensure cross site guidelines are kept in date and complete archiving or merging historic (site specific) guidelines.
- To further engage users of the service in identifying solutions and changes in practice to reduce risk

11. Implementation and Monitoring of Maternity Risk Management Strategy

Each member of staff is responsible for maintaining up-to-date awareness of existing documents, and for adhering to those documents in the course of their daily work. All new staff joining the Trust should be made aware through their line management of all current trust wide documents and directorate documents relevant to them.

An action plan setting out the key milestones for achieving this strategy will be developed and progress monitored locally at the directorate cross site clinical governance committee and corporately, at the trust clinical governance group.

Report	Where	Who	When /frequency
Monitoring report and action plan	Cross site Obstetrics and Midwifery Clinical Governance Committee	Director of Midwifery	Annual
Risk Management report	Cross site Obstetrics and Midwifery Clinical Governance Committee	Clinical Governance Lead for Obstetrics and Gynaecology	Quarterly/ Annual
Risk Register	Maternity patient safety and quality group, Labour Ward Forum	Director of Midwifery/ Heads of Midwifery/ Clinical Governance Lead for obstetrics and Gynaecology	Monthly

Maternity Dashboard	Maternity patient safety and quality group / Obstetrics departmental meetings Director of nursing quality forums Clinical Commissioning Groups	Director of Midwifery/ Heads of Midwifery / Director of Nursing	Monthly
Maternity risk management strategy 2022-2026 implementation plan	Cross site Obstetrics and Midwifery Clinical Governance Committee Appendix to risk management report reported to Trust clinical governance committee	Director of Midwifery /Clinical Governance Lead Head of Midwifery	Quarterly

12. Equality, Equity and Diversity

The Trust aims to ensure that its healthcare and facilities are not discriminatory and, wherever possible, attend to the physical, psychological, spiritual, and social and communication needs of any patient or visitor showing no discrimination on the grounds of ethnic origin or nationality, disability, gender, gender reassignment, marital status, age, sexual orientation, race, trade union activity or political or religious beliefs. Equality means ensuring that everyone has the same opportunities and receives the same treatment and support, whilst equity is about giving people what they need, in order to make things fair

The process for identifying and managing risk, and the manner in which this is undertaken, should not inadvertently discriminate against any groups in society based on their ethnic origin or nationality, race, political or religious beliefs. Any person who has concerns regarding the equality, equality & diversity impact of risk management activity within the department of Obstetrics should refer them in the first instance to the Equality & Diversity Lead, who may require equality impact assessments to be undertaken in order to determine whether any particular groups of patients are experiencing variations in practice.

Appendix A

Maternity Services - Trigger List for reporting incidents

Please note staff are encouraged to report any unexpected outcomes / near miss even if not on the following list.

Maternal incidents	
Maternal death / major collapse	Bladder/Bowel/Other injury
Convulsions/Eclampsia	Transfer to ITU/HDU
Failure to recognise/refer a high-risk pregnancy	DVT/PE (confirmed)
Malpresentation inc. Breech diagnosed in labour	Inverted uterus
Prolonged 2nd stage (>4 hours primip; >3 hours multip)	3rd/4th degree tear
Delay >30 minutes for grade 1 LSCS or >60 minutes for grade 2 LSCS	Readmission of mother
Anaesthetic complications	Admission following planned home confinement
Cord prolapse	Urinary retention requiring follow up / referral
Shoulder Dystocia	Pressure sore
Postpartum haemorrhage >1500ml	Misdiagnosis of antenatal screening tests
Transfusion required or Hb<8g/dl	Blood transfusion/Anti-D errors/problems
Return to theatre	Safeguarding issue not addressed
Ruptured uterus	Failure to arrange postnatal immunisation if indicated
Hysterectomy/Laparotomy	Significant maternal infection

Fetal / Neonatal incident	
Stillbirths > 24 weeks or 500g	Congenital anomaly detected at birth
Intrapartum death	Failure to arrange postnatal immunisation if indicated
Neonatal death	Blood spot screening issue
Low apgars <6 at 5 minutes and/or arterial pH<7.05 or venous pH<7.1	Infant abduction/baby discharged home with wrong mother
Unexpected transfer of term baby to Neonatal Unit	Readmission of baby
Birth injury	Baby does not fulfil criteria for birth in a level 2 NNU / In-utero transfer not possible
Low temperature <36.0c	

Organisational incidents	
Delay in responding to call for assistance	Serious breach of confidentiality
Unplanned homebirth/BBA/unattended by midwife	Potential/verbal complaint/possible media interest
Delivery outside planned place of birth (e.g. ward, car park, MW led unit if high risk)	Unavailability/loss of health records (including CTG)
Medication error – prescription, dispensing, administration	Violation of guidelines/protocols
Failure to act on an abnormal result	Inadequate staffing levels thought to compromise care
Retained or lost swab, clinical material or instrument	Staff accident/injury
Faulty/unavailable equipment	Security issue / Theft
Hospital-acquired infection	Fire
Conflict over case management	Closure of the unit
Communication Error	

Serious Incidents Requiring Investigation

Stillbirth >24 weeks if failures in care identified
Infants > 37 completed weeks of gestation that have a sudden and unexpected collapse following delivery or in the early postnatal period of a previously well infant requiring intensive care (positive pressure ventilator support)
Intrapartum death
Unexpected Neonatal Death
Maternal unplanned admission to ITU if failures in care identified
Maternal death
Baby abduction
Closure of the unit.

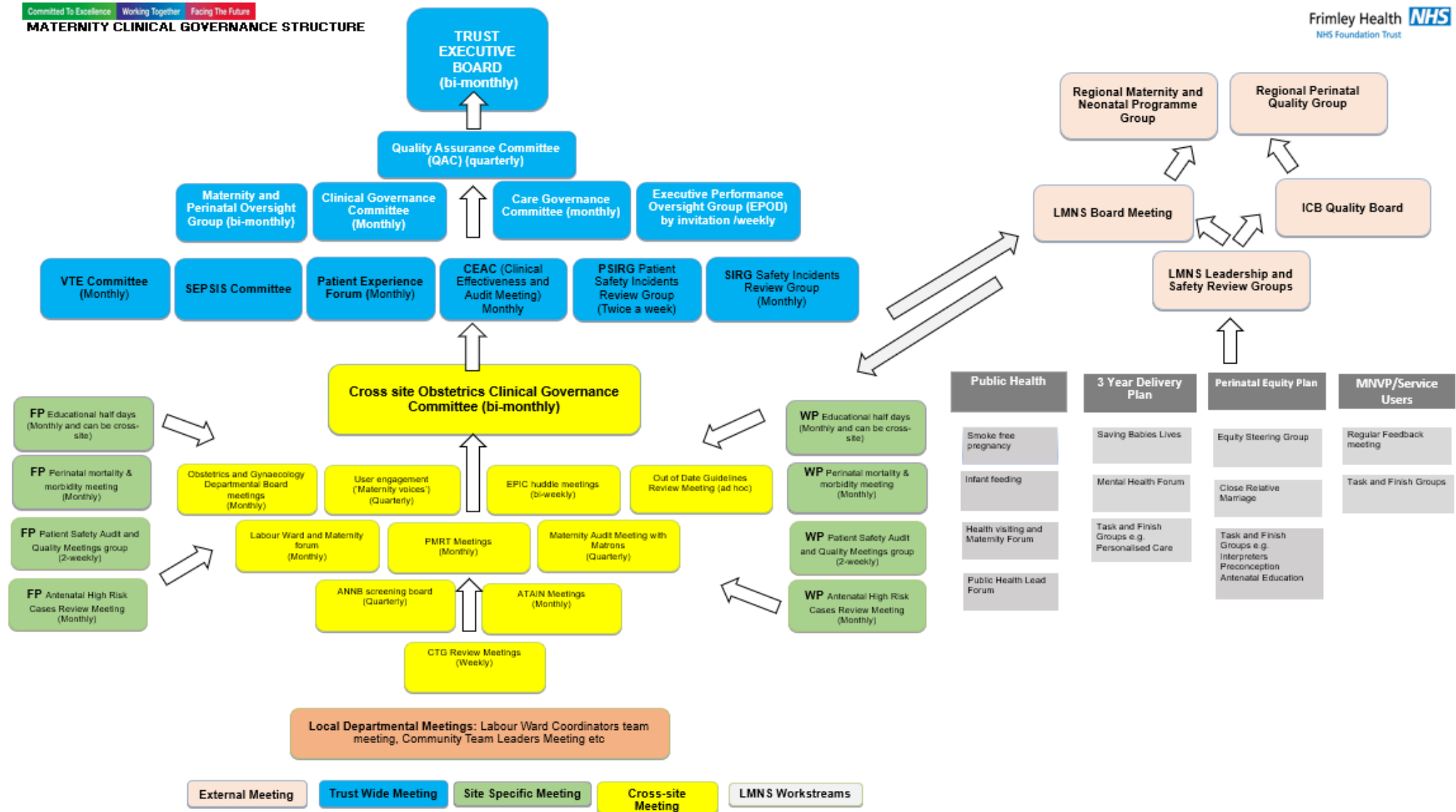
Never Events (always SIs)

Surgical	Wrong Site Surgery
	Wrong implant/prosthesis
	Retained foreign object post-procedure
Medication	Mis-selection of a strong potassium containing solution
	Wrong route administration of medication
	Overdose of Insulin due to abbreviations or incorrect device
	Overdose of methotrexate for non-cancer treatment
Mental Health	Mis-selection of high strength midazolam during conscious sedation
	Failure to install functional collapsible shower or curtain rails
General	Falls from poorly restricted windows
	Chest or neck entrapment in bedrails
	Transfusion or transplantation of ABO-incompatible blood components or organs
	Misplaced naso- or oro-gastric tubes
	Scalding of patients

**On the 16th of August 2022, the new Patient Safety incident Response Framework (PSIRF) was published. It replaces the Serious Incident Framework (SIF) (2015) and it makes no distinction between 'patient safety incidents' and 'Serious Incidents'. However, HSIB investigations will remain as well as PMRT and Never Events. The new PSIRF promotes a proportionate approach to responding to patient safety incidents by ensuring resources allocated to learning are balanced with those needed to deliver improvement. It does not prescribe what to investigate.*

From September 2022, we will be working towards implement the new framework. This means that some changes to our Risk Management Strategy may be required.

Appendix B Maternity Clinical Governance Structure



Appendix C

Department of Obstetrics and Gynaecology

Cross site Obstetrics & Midwifery Clinical Governance Committee

Terms of Reference

Purpose of the committee

The cross-site obstetrics and midwifery clinical governance committee is the overarching committee within the Directorate with responsibility for oversight and monitoring of all clinical governance activity within the maternity services.

Key objectives

- To review the directorate incident reporting profiles, including the quarterly patient safety report, serious incidents, actions identified, sharing of learning and changes in practice.
- To monitor serious incidents, HSIB and PMRT action plans until completion.
- To monitor outcomes of morbidity and mortality reviews.
- To review the local risk assessment frameworks and actions to address the identified safety and quality risks.
- To review local dashboards, note trends and identify actions required.
- To monitor compliance with and implementation of national guidelines, standards and pathways, including NICE, NHS England, RCOG and confidential enquiry recommendations.
- To receive reports in written format from and make recommendations from:
 - **Labour ward forums** – at every meeting
 - **Maternity patient safety groups** – at every meeting
 - **Safeguarding** – at every other meeting (minimum 3 times a year)
 - **Antenatal screening** - twice year
 - **Clinical audit** - at every other meeting (minimum 3 times a year)
 - **Practice development** – at every meeting
 - **Patient Experience MVP report** - twice year
- To monitor patient experience including complaints, claims, Friends and Family and local and national surveys, highlighting actions identified, sharing of learning and audit of changes in practice.
- To monitor compliance with relevant mandatory training and how areas of non-compliance are being addressed.
- To ratify clinical guidelines and local policies and support the implementation of new and updated guidelines.
- To monitor progress on guideline development, including key leads, date for review and uploading to the Trust intranet.
- To ratify patient information and support the implementation of new and updated patient information.
- To monitor progress on patient information development, including key leads, date for review and uploading to the Trust intranet.
- To monitor the clinical audit programme, including local and national specialty audits at least quarterly.
- To monitor progress against national guidance including NICE, RCOG, MBRRACE, NHS Resolution and CQC standards and actions required to achieve compliance.

Membership

- Chief of service for obstetrics and gynaecology
- Deputy chiefs of service
- Director of midwifery
- Heads of midwifery
- Lead Consultants for the labour wards
- One midwifery matron from each site
- Clinical Governance Lead
- Lead midwife for antenatal and newborn screening
- Lead midwife for practice development
- Lead midwives for patient safety from each site
- Lead midwives for quality and patient experience from each site
- IT Specialist Midwife representative
- Specialist Registrar (when invited)
- Maternity Voices Partnership representative
- Other allied healthcare professionals, obstetric, paediatric, anaesthetic & midwifery colleague attendance on ad hoc basis
- Pharmacist (when invited)

Quorum

In order for this committee to be quorate, minimum of 50% attendance will be required, one of which must be the chief of service, deputy chief of service, Director of Midwifery or Head of midwifery. There must be obstetric and midwifery representation from each site.

Frequency of meetings

The committee will meet bi-monthly.

Accountability

The directorate clinical governance committee is accountable to the Trust Care Governance group, and the Board of Directors.

Appendix D

Department of Obstetrics and Gynaecology

Labour Ward and Maternity Forum

Terms of reference

Purpose of the Group

The Labour Ward Forum is a multidisciplinary meeting that will ensure that there is a clear documented system for operational management and communication throughout the key stages of maternity care. All Labour ward forums will be cross-site meetings and the forum will consider all operational issues relevant to providing safe maternity services.

Key Objectives

- To ensure that there is good inter-professional communication and teamwork across all professionals within the departments.
- To ensure that systems are in place to ensure that women and their babies receive the care appropriate to their needs throughout the antenatal, intrapartum and postnatal period.
- To review urgent clinical issues to assist in planning the way forward through effective multi-professional working.
- To provide information to and receive feedback from the Obstetric Clinical Governance Committee on clinical risk and implement actions to be taken.
- To receive summary reports from the Maternity Patient Safety and Quality groups.
- To review and provide site specific approval of clinical guidelines prior to full ratification in the cross-site obstetrics and midwifery clinical governance committee.
- To make recommendations to the guidelines and patient information steering group for changes when appropriate.
- To support the practical implementation of agreed changes to guidelines.
- To define the priorities for projects relating to the service and assist in taking them forward.

Membership:

- **Lead Obstetrician (chair)**
- **Labour ward matron**
- Maternity ward matron
- Community and antenatal clinic matron
- Consultant obstetric anaesthetist
- Consultant neonatologist
- Neonatal unit matron
- Lead midwife patient safety

- Obstetric theatre representative
- Junior Medical staff
- Junior Midwifery staff
- Pharmacist
- Practice development representative

Quorum

For the Labour Ward and Maternity Forum to be quorate, at least one consultant obstetrician and one senior midwife (director of midwifery, head of midwifery, Clinical Governance lead or a midwifery matron) should be present and at least two other members.

Frequency and Length of Meetings

- Monthly, at least ten meetings per annum.

Minute Distribution

- To all members of the Labour Ward Forum
- To the Clinical Governance group

Accountability

The group will be accountable to the chief of service for obstetrics and gynaecology and the Director of Midwifery. Subgroups will be established and report back on proposals as required.

The chair of the group sits with the lead obstetrician for labour ward. The labour ward matron is the deputy chair.

Appendix E**Department of Obstetrics and Gynaecology****Maternity Patient Safety and Quality Group****Terms of reference****Purpose of the group**

The maternity patient safety group is part of the integrated system of clinical governance within the Directorate of Midwifery, Obstetrics & Gynaecology. These terms of reference should be read in conjunction with the Directorate Risk Management Framework and Strategy. This group will oversee and monitor patient safety within the maternity services and endeavour to facilitate the minimisation or elimination of risks wherever possible. It will also provide an open and transparent forum for improving safety and quality within the maternity service.

Key Objectives

- To ensure effective communication between all staff with a responsibility for clinical risk.
- To identify urgent clinical issues which pose an immediate or significant risk to patient safety and make recommendations for remedial measures to mitigate the risk.
- To review and update the maternity Risk Assurance Framework monthly, escalating risks to the corporate governance group and feeding into the Corporate Risk Assurance Framework where appropriate
- To review the Maternity Dashboard monthly, noting trends and agreeing actions to address potential risks identified from the dashboard.
- To receive notification of all serious incidents and risks identified during the investigation.
- To monitor action plans from serious incidents monthly.
- To report to, and receive feedback from, the Trust Board and executives responsible for patient safety in maternity via the maternity safety champions (the director of midwifery and the chief of service for obstetrics and gynaecology)
- To provide information to and receive feedback from, the Trust Corporate Governance committees.
- To review reports from the litigation department and note any trends identified from obstetric claims.
- To monitor serious incident, HSIB and PMRT action plans until completion.
- To provide guidance on Duty of Candour and communication with families.
- To receive reports of cases reported to HSIB and progress on management of the cases.
- To support the implementation of any changes required to achieve compliance with NHS Resolution CNST maternity standards.
- To review and discuss selected case notes identified from completed incident forms and from clinical triggers on the maternity information system. As a result, identify any clinical risk issues and remedial actions as required.
- To review action already taken and delegate further action as required to ensure continual improvements in quality and the control of risk.
- To monitor actions required or changes introduced because of incidents and near miss reporting.
- To ensure the facilitation of appropriate feedback to individuals involved when required.
- To consult with other professionals as required to ensure an effective multidisciplinary approach to managing risk.

- To influence the work of the labour ward forum in relation to safety and quality within the specialty.
- To give a verbal report monthly to labour ward forum and departmental meeting and a bi-monthly report to the obstetrics and midwifery clinical governance committee.

Membership

- **Consultant obstetrician clinical lead risk (chair)**
- Head of Midwifery
- Consultant obstetrician labour ward lead
- Clinical Governance Lead
- Lead midwife patient safety
- Labour ward matron
- Maternity ward matron or consultant midwife
- Neonatal unit matron
- Lead Consultant Anaesthetist for obstetrics, when invited
- Consultant Paediatrician (neonatologist), when invited
- Community Midwifery Matron
- Minutes will be circulated to the chief of service for obstetrics and gynaecology and the litigation manager
- Practice development representative

Quorum

For the maternity patient safety group to be quorate, at least one consultant obstetrician and one senior midwife (Head of midwifery, Clinical governance lead or a midwifery matron) should be present and at least two other members.

Accountability

This committee is a subgroup of the labour ward forum and will report directly to this group.

Frequency of Meetings

The group will meet every two weeks. One meeting per month will be a reports meeting attended by the multidisciplinary team where unit reports will be reviewed and cases with anaesthetic or neonatal issues will be discussed. One meeting per month will be an obstetric and midwifery case review meeting attended by obstetricians and midwives only.

Appendix F

Department of Obstetrics and Gynaecology

Monthly Perinatal Morbidity and Mortality Meeting

Terms of Reference

Purpose of the Group

The purpose of the PMMM is to review cases that have had joint care management from Obstetric and Neonatal teams. The emphasis of review is to identify learning and actions that may reduce the risk of both maternal and neonatal adverse outcomes for future practice.

It is agreed case criteria for discussion include:

- All neonatal deaths of 23 weeks gestation and above, completing ICE mortality form.
- All neonatal transfers from local unit.
- Exchange transfusions for hyperbilirubinaemia.
- Management of major congenital anomaly.
- All neonates born < 27 weeks gestation.
- All neonates born with birthweight <800g.
- Multiple pregnancies below 28 weeks gestation.
- Any neonate who requires cooling therapy.
- Any neonate who requires specialist including nitric oxide/HFOV Complex intensive care including neonates with symptoms of additional organ failure (inotropes, insulin infusion, chest drain, prostaglandin infusion).
- All ventilated babies.
- Unexpected morbidity/other cases as required identified by the Neonatal Consultant.

Key Objectives

The principal duties of the Neonatal Team

- Identify cases for discussion throughout month and complete agenda on shared drive.
- Build PowerPoint presentation to include neonatal case summary.
- Presentation to be completed prior to PMMM.
- Allocate neonatal doctors to present cases.

The principal duties of the Obstetric Team:

- Locate maternity notes of identified cases for discussion.
- Prepare joint PowerPoint presentation with all maternal details corresponding with neonatal details.
- Presentation must be completed prior to PMMM.
- Allocate Obstetric doctor to present the cases.

Joint responsibilities:

- Record of attendance must be kept of every meeting.
- Both Obstetric and Neonatal doctors are to document learning outcomes and actions at the end of each meeting on the shared drive.
- All actions to include the individual responsible to complete the task.
- At each meeting the previous meeting actions need to be concluded or stipulated as ongoing.

Membership

The meeting will be chaired jointly by the Neonatal and Obstetric Perinatal Lead Consultants. The other members of the group shall include:

- Neonatal and Obstetric medical teams.
- Neonatal and Midwifery Matrons.
- Neonatal nurses and midwives (both inpatient and community).
- Contact Supervisor of Midwives.
- Practice development Team (Paediatric and Maternity).
- Maternity Clinical Governance Team.

Quorum

The meeting requires to have a minimum attendance of:

- Two Neonatal Consultant
- Two Obstetric Consultant
- One Neonatal junior doctor
- One Obstetric junior doctor
- One midwife (Matron, Practice development or Patient Safety Midwife).
- One neonatal nurse (Matron, Senior Sister or Senior Staff Nurse).

Frequency of Meetings

The meetings will be held monthly – every second Monday of every month.

Accountability

The group will be accountable to the cross-site obstetrics and midwifery clinical governance committee and the Chief of Service Obstetrics & Gynaecology.

Appendix G

MATERNITY RISK MANAGEMENT STRATEGY Implementation Plan 2022 – 2026

Completed

In- progress

Not completed

Key Issue	Action Required	Responsible Person	Date for Completion
Maternity Risk Management Strategy needs to reflect our current practice	Review and update maternity risk management strategy, in conjunction with Trust wide Risk Management Strategy	S Pejic	September 2023
Revised Maternity Risk Management Strategy must be approved and endorsed by the whole department	Share draft Maternity Risk Management Strategy with the relevant stakeholders. Maternity Risk Management Strategy to be approved at the Labor Ward Forum and ratified by the cross-site Obstetrics and Midwifery and Gynecology committees	S Pejic	
Review of Midwifery staffing levels and skill mix to meet the optimal 1:24.5 (FP) and 1:23.3 (WP) birth ratio for the unit	Monthly monitoring of midwifery staffing Report monthly to the Director of Nursing and Chief Executive via the maternity dashboard Annual review of staff requirements Agree to work with midwifery staffing of 90/10 split.	E Luhr A Anderson D Eghobamien	September 2023
Provide Annual Report & Presentation to Trust Care Governance Committee	To present the Department's strengths & areas for improvements to the Trust Care Governance Committee, to provide information on key areas as identified by the Board of Directors.	E Luhr A Deans	December 2022