One + all | we care

Royal Cornwall Hospitals NHS Trust

Maternity Risk Strategy Management Clinical Guideline

V10.0

December 2022

1. Aim/Purpose of this Guideline

1.1 The maternity service recognises that the principles of good governance must be supported by an effective risk management system that is designed to deliver improvements in patient safety and quality of care as well as the safety of its staff and visitors.

1.2 It is important to remember that the maternity service cannot operate in isolation from the rest of RCHT, sharing many systems and procedures, therefore this strategy should be read in conjunction with the RCHT Risk Management Strategy and Policy, and applies to all employees within the maternity service whether substantive or honorary.

1.3 This version supersedes any previous versions of this document.

Data Protection Act 2018 (General Data Protection Regulation – GDPR) Legislation

The Trust has a duty under the Data Protection Act 2018 and General Data Protection Regulations 2016/679 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed, and documented. We cannot rely on opt out, it must be opt in.

Data Protection Act 2018 and General Data Protection Regulations 2016/679 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the Data Protection Act 2018 and General Data Protection Regulations 2016/679 please see the Information Use Framework Policy or contact the Information Governance Team

Royal Cornwall Hospital Trust rch-tr.infogov@nhs.net

2. The Guidance

2.1 Context/Background

2.1.1 This document combines both strategy and policy for the management of risk within the Royal Cornwall Hospitals NHS Trust (RCHT) maternity services.

2.1.2 This guideline makes recommendations for women and people who are pregnant. For simplicity of language the guideline uses the term women throughout, but this should be taken to also include people who do not identify as women but who are pregnant, in labour and in the postnatal period. When discussing with a person who does not identify as a woman please ask them their preferred pronouns and then ensure this is clearly documented in their notes to inform all health care professionals.

2.2 Purpose / Objectives of this Strategy

2.2.1 The Maternity Service recognises that the provision of maternity care, and related activities, is inherently 'risky' and will therefore take every measure (reasonably practicable) to ensure the safety of women, their infants, staff and the public through the provision of high-quality care, to an agreed minimum standard, by competent, well-trained staff within suitable, well-maintained environments.

2.2.2 The service recognises that whilst accidents and mistakes may happen through human error, systems failures and other factors may also play a part. When things go wrong it is therefore important that under the Duty of Candour, staff are open and honest. A willingness to learn is a driver in reducing and eliminating future risks, accidents and mistakes.

2.2.3 The service will achieve this through the proactive identification, assessment, management and reduction of risk through a planned programme of risk management which is subject to regular monitoring.

2.2.4 The overall aim of the Maternity Risk Management Strategy is to ensure that robust risk management processes are in place leading to improved quality of care and the maintenance of a safe environment for patients, women and their infants, the public and Trust employees. In this way the Trust's reputation and assets remain intact.

2.2.5 The objectives described below reflect the requirements of local and national drivers such as:

- NSF for Children and Young People,
- NICE guidance, Saving Babies Lives Care Bundle,
- Safer Maternity Staffing,
- Local maternity Systems Implementations,
- Better Births,
- Royal College of Obstetrics and Gynaecology guidelines,
- MBRRACE,
- Perinatal Mortality Tool,
- National Bereavement Pathway
- Plus all other local and national drivers that come to fruition during the lifetime of this guideline.

2.2.6 Maternity services objectives for managing risk:

- At minimum there will be monthly Patient Safety Meeting, please refer to Terms of Reference Appendix 5

- Support risk owners to review risks and any issues to the monthly governance meeting.

- Policies and guidelines which are audited and updated at regular intervals and monitored through the audit team. The audit action plans are developed and then monitored for compliance at the monthly.

- Maternity Governance Meeting.

- Ensure that lessons are learnt, and patient care improved through the analysis and review of adverse incidents, near misses, complaints and claims as evidenced through completed action plans as devised by the care group following the recommendations from both external, and

- internal safety investigations. These action plans are reviewed at the monthly Maternity Governance meeting.

- Ensure all relevant maternity staff receives induction and relevant training and education to undertake their roles in order to meet the needs of the service and their professional bodies where relevant. The responsibility sits with the clinical director of obstetrics, practice development midwife, clinical skills facilitators, team leaders and patient safety midwife.

- Ensure maternity staffing levels are subject to a yearly review to establish whether they are in line with the document governing safe staffing levels.

2.3 Scope

2.3.1 This document applies to all staff working with in maternity services.

2.3.2 Governance and Risk management is the responsibility of all staff, although managers at all levels are expected to take an active lead to ensure that risk and governance is a fundamental part of their operational area.

2.4 Definitions / Glossary

- CQC Care Quality Commission
- DPA Date Protection Act
- IO Investigating Officer
- MBRRACE Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries in the UK
- NHSR National Health Service Resolutions
- NSF National Service Framework

- NICE National Institute of Clinical Excellence
- PDM Practice Development Midwife
- QA Quality Assessment
- RCA Root Cause Analysis
- RCHT Royal Cornwall Hospitals Trust
- PSIRF Patient Safety Investigation Review Form
- PSR Patient Safety Review
- PSII Patient Safety Incident Investigation
- HSIB Healthcare Safety Investigation Branch

2.5 Ownership and Responsibilities

2.5.1 The Chief Executive and the Trust Board

The Chief Executive, on behalf of the Trust Board, is the accountable officer with overall responsibility for risk management including Health and Safety. This imposes a requirement for trusts to be in a position to provide an assurance statement in their annual report that the organisation has the necessary controls in place to manage its exposure to risk.

In order to make such a statement, the Chief Executive and Trust Board will need to have evidence that the Maternity Risk management Strategy is being actively implemented, systems/procedures are being regularly reviewed, and where required, developments and improvements are being made.

2.5.2 The Chief Nurse

The Chief Nurse Executive reporting to the Chief Executive has delegated responsibility from the Chief Executive for the coordination of all elements of risk management, to include staff and patient safety. This includes responsibility for ensuring that the required structures and resources are in place to enable effective risk management to take place. The Chief Nurse Executive is the named lead executive at Trust board level with responsibility for maternity services and is a member of the Governance Committee, the Quality and Learning Group, the Risk Committee and the Complaints Review Panel.

2.5.3 The Medical Director

The Medical Director reporting to the Chief Executive is responsible for the management of risk associated with the confidentiality of patient information to include the role of the Trust's Caldicott Guardian.

2.5.4 The Care Group Management Team (Women's, Children's and HIV).

The Care Group Care Group Management Team comprising the Care Group Manager, the Care Group Head of Nursing/Head of Midwifery are supported in the management of risk by six specialty leads for acute paediatrics, community paediatrics, neonatology, obstetrics, gynaecology and HIV and respective matrons.

Monthly governance reports are received by the Care Group Management Board* as part of the Care Group internal assurance process. They are responsible for ensuring compliance with standards and overall risk management systems and processes as laid down in both the Trust wide Risk Management Strategy and the Maternity Risk Management Strategy. A monthly Care Group Governance Report is presented at the monthly Care Group Board, this includes maternity.

The Care Group Board comprises the Care Group Management Team, Specialty Leads, Matrons, the Care Group governance lead and supporting personnel e.g. finance, HR and trust governance.

2.5.5 The Director of Midwifery/Head of Nursing

The Head of Midwifery/Care Group Head of Nursing has overall responsibility for the management of risk within the women and children's Care Group, which includes the maternity service. They are responsible for providing professional and managerial leadership for midwives, nurses, therapists, and support workers within the Care Group. Professionally they report directly to the Chief Nurse Executive. The Director of Midwifery is responsible for developing the strategic direction for midwifery, including ensuring risk management policies and procedures are in place within maternity services and all staff understand and are aware of their role in minimising clinical and non-clinical risks.

The Directory of Midwifery/Head of Nursing meets on a monthly basis with the Chief Nurse, attends the Quality and Learning Group and the Women's, Children's and HIV Care Group Board.

2.5.6 The Clinical Directors

The Clinical Directors for obstetrics are responsible for governance arrangements within the obstetric service and meet monthly. They attend the Obstetrics and Gynaecology Directorate meetings and the Women and Children's Care Group board. This role has responsibility for ensuring that risks are associated with the objectives are identified, assessed and controlled to an acceptable level.

2.5.7 The Lead Consultant Obstetrician for Patient Safety

The Lead Consultant Obstetrician provides professional guidance and leadership in this area, ensuring effective communication between midwifery, obstetric, neonatal and anaesthetic colleagues and oversees the provision of safe, effective obstetric practice. This role

encompasses attendance at Patient Safety Clinical Incident Review Meetings, Maternity Forum, Maternity Governance, Guideline meetings and Perinatal Audit Review meetings.

2.5.8 The Lead Consultant Anaesthetist for Patient Safety

The Lead Consultant Anaesthetist provides professional guidance and leadership for anaesthesia and represents the views of anaesthetic colleagues and their assistants. This role also attends Patient Safety, Maternity Forum and Maternity Governance Guideline meetings.

2.5.9 The Lead Consultant Neonatologist for Delivery Suite

The Lead Consultant Neonatologist for Delivery Suite provides professional guidance and leadership for neonatology and represents the views of paediatric colleagues and their assistants.

2.5.10 The Care Group Care Group Governance Lead

The Care Group Governance lead will manage and coordinate aspects of governance and risk across the Care Group and provide advice to the Care Group Management Team, Speciality Leads and Matrons in relation to the management of risk, health and safety, CQC standards, integrated governance, Incidents/ PSR/PSII, claims and complaints. This role will attend the trust wide groups of Health and Safety Committee and the Incident Review and Learning Group, the Care Group Board and the Maternity Services Directorate meeting, Maternity Governance (MRMF).

2.5.11 The Midwifery Matrons

The roles of the Midwifery Matrons provide professional and managerial leadership for midwives, nurses and support workers within the Directorate. These roles will include risk assessment, incident investigation, maintenance of safe staffing levels and the escalation processes.

These roles will also receive all incidents, relating to their clinical areas within maternity services, reported via the Trust electronic reporting system (DATIX).

The Midwifery Matrons will provide expert midwifery advice within the maternity service and also to the Maternity Forum.

The midwifery matrons are responsible for escalating risk / maintaining risk registers for clinical areas management concerns via the Maternity Governance meeting and implement changes within clinical practice.

Midwifery Matrons attend the Maternity Forum and Maternity Governance.

Midwifery Matrons are responsible alongside the Head of Midwifery for monitoring compliance with the Clinical Negligence Scheme for Trusts (CNST) standards.

2.5.12 The Patient Safety Midwife

The Patient Safety Midwife is responsible for coordinating clinical risk activities within the maternity service including the day to day operational management of clinical risk and related issues within the service which includes promoting safe practice, disseminating learning related to adverse incidents and complaints and the production and review of clinical policies and guidelines.

The Patient Safety Midwife lead will manage and coordinate all aspects of governance and risk across the Speciality and provide expert advice to the Care Group Management Team, Speciality Leads and Matrons in relation to the management of risk, health and safety, CQC standards, NHSR, integrated governance, Incidents/PSR/PSII's, claims.

This role also provides a link with the Trust Risk Management Team and ensures effective communication on risk management issues amongst medical and midwifery staff and litigation department.

The Patient Safety Midwife receives all incidents, relating to maternity services, reported via the Trust electronic reporting system (DATIX) and performs an initial assessment of the level of the incident and takes action accordingly.

The Patient Safety Midwife leads and supports members of the team undertaking Patient Safety Reviews and Patient Safety Incident Investigations.

The Patient Safety Midwife coordinates with all external monitoring agencies e.g. HSIB, MBRRACE, NHSR and supports staff involved in these processes**.** When incidents occur that require referral to HSIB, the governance process in appendix 8 should be followed.

The Patient Safety Midwife formulates the Maternity Dashboard and highlights any trends or learning. An assurance report is also provided monthly to the Maternity Governance meeting.

The Patient Safety Midwife leads the Patient Safety Meetings and provides an assurance report on risks in maternity to the Maternity Governance meeting on a monthly basis.

The Patient Safety Midwife leads on the monthly Maternity Forum meeting and provides an assurance report monthly to the Maternity Governance meeting.

2.5.13 The Practice Development Midwife

The Practice Development Midwife is responsible for the induction, updating and identification of on-going learning needs of Registered Midwives and creates programme for multidisciplinary skills/drills training. The Please refer to the Training Needs Analysis for the full role of the PDM.

2.5.14 The Delivery Suite Co-ordinators

The Delivery Suite Co-ordinators will lead, manage and co-ordinate every shift on Delivery Suite. The role of co-ordinator is key in ensuring that effective communication channels exist between all disciplines working on the Delivery Suite and that all midwives are delivering safe, high quality care within agreed protocols and guidelines. The Delivery Suite Co-ordinators are responsible for completing Datix's as per the Trust risk management strategy.

2.5.15 Maternity Staff

All employees, including locum and agency staff working within the service will comply with Trust policies, report incidents promptly, take responsibility for their own professional development, maintain a safe working environment and take immediate action if concerns arise and communicate effectively within the team environment.

2.6 Benefits

The benefits of this strategy is to ensure that all staff within maternity are aware of their responsibility in relation to reducing risk and to ensure staff are aware of the processes and communication channels within the service.

2.7 Risks

This risk strategy needs to be available to support and guide staff to deal with risks and enable staff to understand who is responsible when an incident occurs.

2.8 The Strategy

2.8.1 Patient Safety

Clinical Risk Management in practice within the Royal Cornwall Hospitals Trust Maternity Service, including learning from experience processes

All clinical and ward based clerical staff will receive instruction during their Trust Induction on the electronic incident reporting system (Datix) and advice on what to report and where to access the incident reporting trigger list (Refer Maternity Services Trigger List, Appendix 5), this list is not exhaustive, and staff are encouraged to report adverse clinical incidents. Datix should not be used to identify individuals or apportion blame.

The Patient Safety Meeting (see Appendix 5) chaired by the Patient Safety Midwife reviews maternity clinical incidents involving women and neonates who have received care by the maternity service of Royal Cornwall Hospitals Trust. The incidents are reviewed by the group and a decision made about the ongoing management or closure of the incident.

Where incidents involve employees from a neighbouring Trust (Northern Devon Healthcare Trust, Royal Devon and Exeter Trust or Plymouth Hospital Trust) the Patient Safety Meeting will liaise with the risk manager for the neighbouring Trust.

The Maternity Forum (see Appendix 6) chaired by the Patient Safety Meeting reviews all areas of risk: trends, action plans arising from incidents and SIs, agrees and disseminates lessons learnt from incidents/claims and complaints, reviews risk registers, monitors induction and training process and attendance.

A Perinatal Audit Meeting chaired by the Obstetric Consultant Lead for Perinatal Audit, reviews the results of ongoing audits and annual re audits. Any identified deficiencies will be monitored by the Maternity Governance who oversee and implement any changes required. This meeting forms part of a multidisciplinary Perinatal Mortality/Morbidity Case Review Meeting. All perinatal deaths from the preceding month are presented to a multidisciplinary audience, followed by a discussion/debate around possible contributing factors, lessons learnt and management of any future pregnancies. Cases of morbidity, with possible learning opportunities are discussed. The PMRT review process is completed and forms an action plan which is monitored at Maternity Governance.

A monthly Maternity Guideline Group is chaired by the Practice Development Midwife (PDM) (see Appendix 7). This is a multidisciplinary group which identifies and produces new guidelines, in light of new evidence. Responsibilities include review of existing guidelines within a 3 year time scale and identification of training requirements arising from a new guideline.

A Patient Safety Newsletter is distributed to all staff via email and displayed on the Risk Management notice boards. This contains an overview of all incidents reported with associated learning, an overview of all claims and any other learning from experience opportunities.

2.8.2 Process for the Management of Maternity Services Risk Register.

This should be read in conjunction with RCHT Risk Assessment and Management Strategy and Policy

2.8.3 Clinical area/ward risk register

Each ward/clinical area will have an effective risk register in place which clearly outlines any risks that threaten the safety and efficiency of the maternity service. Each risk must have an action plan, with an appropriate review date until the risk is managed/reduced or eliminated. This should be reflected on the risk register.

2.8.4 Maternity Risk Register

If the risk is not manageable at ward/clinical area level, then ward managers and team leaders will inform the relevant midwifery matron to discuss whether the risk should be escalated to the maternity risk register with an appropriate action plan. It will then become the responsibility of the midwifery matron, to manage the risk. The risk will be reviewed at the Maternity Governance.

2.8.5 Care Group Risk Register

Any risk that scores 10 or above, or a risk that cannot be reasonably managed at speciality level will be escalated to the monthly Care Group board meeting in order to ensure the risk is managed by the appropriate Specialty and to facilitate Care Group approval for those risks scoring 10 or more.

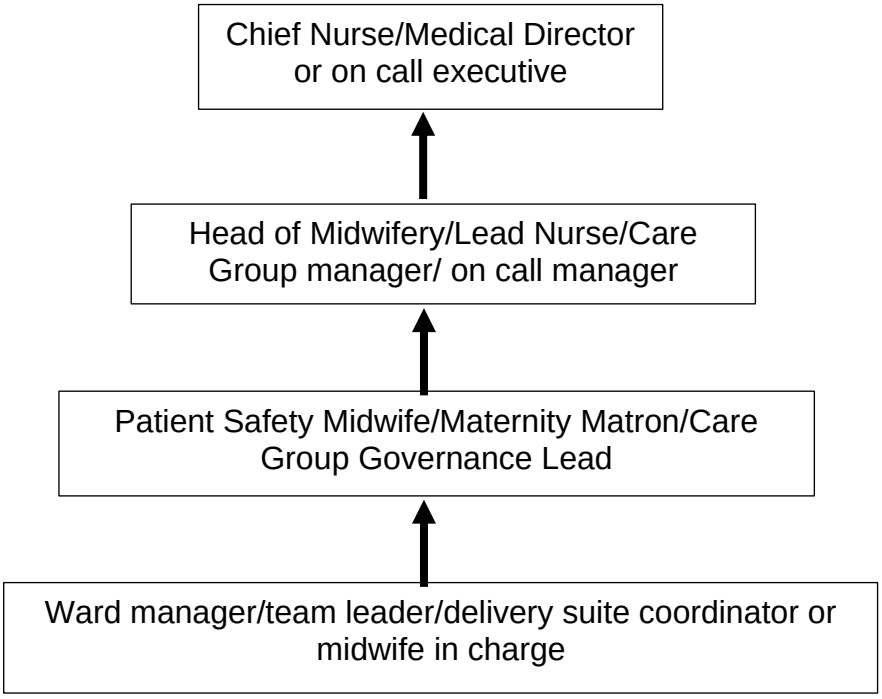
A lower risk that appears across a minimum of 2 ward/clinical areas will be discussed within all Specialties affected, and at Care Group Board should it score 10 or above.

2.8.6 Corporate Risk Register

Any risks of 15 or above will be taken, with a report from the risk owner, by the Trimuverate, for individual discussion to the monthly Trust Risk Committee, of which the Chief Nurse is a member. The decision will be made at this group whether to add the risk to the corporate risk register. The corporate risk register is discussed at the Quality Governance Group. The minutes of the Governance Committee are received by the Trust board.

2.8.7 Process for immediate escalation of risk from maternity service to board level.

Should a risk arise that needs urgent escalation such as media exposure, Never Event, PSII's , unresolved operational issues and risks impacting on strategic objectives, where time does not allow governance processes to be followed, the following verbal process should be followed, following the verbal escalation of the risk, an electronic incident reporting form (DATIX) must be completed detailing the risk and the escalation process followed and the risk must be added to the risk register.



2.8.8 Arrangements for Patient Safety Incident Investigation

(Should be read in conjunction with RCHT Incident Management Policy)

Royal Cornwall Hospitals NHS Trust has an obligation to investigate certain circumstances where patients may have been harmed as a consequence of acts of omission or commission during their treatment. In order to meet this requirement certain events must be formally reported so that an assessment can be made as to whether they meet the national criteria for PSII or if a patient safety review is indicated.

2.8.9 Screening Incidents

2.8.9.1. A screening incident is any unintended or unexpected incident(s) that could have or did lead to harm to one or more persons who are eligible for NHS screening; or to staff working in the screening programme. A screening incident can affect populations as well as individuals. It is an actual or possible failure in the screening pathway and at the interface between screening and the next stage of care. Although the level of risk to an individual in an incident may be low, because of the large numbers of people offered screening, this may equate to a high corporate risk.

2.8.9.2. Definition of a serious screening incident

Whether a “serious incident”/PSII should be declared is a matter of professional judgement on a case by case basis. It should be a joint decision by the risk management forum, informed by QA advice.

In distinguishing between a screening incident and a serious screening incident, consideration should be given to whether individuals, the public or staff would suffer avoidable severe (i.e. permanent) harm or death if the problem is unresolved.

The definition of serious incidents/PSII given in the Serious Incident Framework is applicable to screening programmes.

2.8.9.3. Accountability for managing Screening Incidents:

RCHT is accountable for ensuring safe and coherent screening for the population screened, according to service specifications

RCHT is accountable for the safe and coherent delivery of the screening pathway

RCHT is accountable for ensuring that screening incidents are reported, investigated and managed in accordance with national guidance and regulations.

From the outset, RCHT will work closely with its commissioner and be advised by the regional QA director/lead. A Screening Incident Assessment Form (SIAF) should be completed and forwarded to Public health screening quality assurance service.

RCHT will provide communications support in a screening incident, with this depending on its severity and provider size/capacity

2.8.10 Once a potential PSII has been identified The Trusts Incident Management Policy (March 2022) should be followed.

2.8.11 Maternity Services Process for learning from complaints, claims and incidents.

2.8.11.1. The maternity service will ensure that both local and organisational learning occurs following all grades of incidents, complaints (formal and informal) and claims.

2.8.11.2. All complaints for the Women, Children and HIV Care Group are received by the Care Group Governance Lead who will then request that the Specialty to identify an IO.

2.8.11.3. The Care Group Governance Lead monitors the progress of the investigation and liaises with the Specialty to ensure a timely response.

2.8.11.4. For all complaints upheld, an action plan is completed and forwarded to the Trust's Patient Experience Team along with the evidence that the actions have been completed to facilitate organisational learning.

2.8.11.5. The Care Group Governance Lead produces a monthly governance report for the Specialty meeting, which is also shared at the Maternity Governance meeting. The data is discussed, action plans monitored, and lessons learnt identified.

2.8.11.6. The Care Group Governance Lead will provide a report for the monthly Women, Children's and Sexual Health Care Group Board, where learning is shared across the Care Group and any outstanding action plans are reviewed and actioned.

2.9 Implementation and Action Plan

This policy will be submitted to the document library for inclusion, it will be emailed out to all maternity staff and it will be displayed on the risk management notice boards.

3. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	Measurable objectives within the strategy
Lead	Patient Safety Midwife
Tool	• A governance report, containing, risks, complaints and claims is received as per the Maternity Risk Management Forum work plan • Lessons learnt from incidents, are included in the Patient Safety newsletter • Action plans from SIs have been monitored at the Maternity Governance meeting • Training report is received as per the annual work plan at the Maternity Governance meeting
Frequency	Patient Safety Midwife will present a monthly report to the Maternity Governance of compliance with the above measurable objectives
Reporting arrangements	Maternity Governance
Acting on recommendations and Lead(s)	An action plan will be developed at the Patient Safety Meeting and leads will be identified, the action plan will be monitored at Maternity Governance
Change in practice and lessons to be shared	Agreed as per the action plan

4. Equality and Diversity

4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the 'Equality, Inclusion and Human Rights Policy' or the Equality and Diversity website.

4.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Maternity Risk Strategy Management Clinical Guideline V10.0
This document replaces (exact title of previous version):	Risk Management Strategy V9.0
Date Issued/Approved:	June 2022
Date Valid From:	December 2022
Date Valid To:	December 2025
Directorate / Department responsible (author/owner):	Clare Sizer, Patient Safety Midwife
Contact details:	01872 255019
Brief summary of contents:	This document combines both strategy and policy for the management of risk within the RCHT maternity services.
Suggested Keywords:	Maternity, risk management, strategy, risk, guideline, forum, RCHT, MRMF, risk register
Target Audience:	RCHT: Yes CFT: No CIOS ICB: No
Executive Director responsible for Policy:	Chief Medical Officer
Approval route for consultation and ratification:	Maternity Risk Management Forum Maternity Guidelines Group Obs and Gynae Directorate Care Group Board for noting
General Manager confirming approval processes:	Caroline Chappell
Name of Governance Lead confirming approval by specialty and care group management meetings:	Caroline Amukusana
Links to key external standards:	None
Related Documents:	• RCHT Risk Management Strategy and Policy • RCHT Policy and Guidance for Risk Assessment and Risk Registers

Information Category	Detailed Information
	• RCHT Being Open Policy. • RCHT Serious Incident Management Policy and procedure. • RCHT Serious Incident Management Policy and Procedure for List of Never Events. RCHT Incident Management Policy (Including the Patient Safety Incident Response Framework) March 2022
Training Need Identified?	No
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
Document Library Folder/Sub Folder:	Clinical / Midwifery and Obstetrics

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
Dec 05	V1.0	First Maternity Risk Management Strategy	Jan Clarkson Maternity Risk Manager
Dec 06	V2.0	Annual review and added cross board incident management pathway	Jan Clarkson Maternity Risk Manager
Dec 08	V3.0	Full review and consultation	Jan Clarkson Maternity Risk Manager
Dec 09	V4.0	Annual review and inclusion of escalation of risk and risk registers	Jan Clarkson Maternity Risk Manager
Dec 11	V5.0	Full review and consultation process included annual work plan and compliance monitoring process.	Jan Clarkson Maternity Risk Manager

Date	Version Number	Summary of Changes	Changes Made by
December 2012	V6.0	Level at which risks are reported to Care Group board has changed from 9 to 12, in line with the RCHT 'Policy and guidance for risk assessment and risk registers', May 2012. Updating of the annual work plan The LSA report has been received at MRMF and Care Group board. Any Trust wide action points escalated to the Care Group quality and learning group.	Jan Clarkson Maternity Risk Manager
December 2013	V7.0	Full review of document, changes to the title of the Nurse Executive and roles of Midwifery Matrons TOR put onto new trust template TOR for Maternity Forum Updating of the trigger list Updating of the annual work plan	Jan Clarkson Maternity Risk Manager
18th February 2016	V8.0	Reviewed Sections added for Supervision of Midwifery and Screening Failsafe mechanisms	Jan Clarkson Maternity Risk Manager
2nd May 2019	V9.0	Full review and removal of Supervisor of Midwives role as this no longer exists.	Clare Sizer, Patient Safety Midwife and Trudie Roberts Community Matron
May 2022	V10.0	Full review- removal of SI and addition of PSIR framework Updated Maternity Datix Trigger List Updated Maternity Patient Safety ToR Update Materntiy Forum ToR	Tamara Thirlby Patient Safety Midwife

Appendix 2. Equality Impact Assessment

Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the Trust to identify where a policy or service may have a negative impact on an individual or particular group of people.

For guidance please refer to the Equality Impact Assessment Policy (available from the document library) or contact the Equality, Diversity and Inclusion Team rcht.inclusion@nhs.net

Information Category	Detailed Information
Name of the strategy / policy / proposal / service function to be assessed:	Maternity Risk Strategy Management Clinical Guideline V10.0
Directorate and service area:	Obstetrics and Gynaecology Directorate
Is this a new or existing Policy?	Existing
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Leann Morris Practice Development Midwife
Contact details:	01872 255019

Information Category	Detailed Information
1. Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)	This document combines both strategy and policy fir the management of risk within the RCHT maternity services
2. Policy Objectives	Ensuring that the care provided is conducted to the highest standard by employing a structured Risk Management process within the Acute Maternity Unit, Birth Centre and Community environments.
3. Policy Intended Outcomes	Ensuring that the care provided is conducted to the highest standard by employing a structured Risk Management process within the Acute Maternity Unit, Birth Centre and Community environments.
4. How will you measure each outcome?	As per Compliance Monitoring Tool
5. Who is intended to benefit from the policy?	Users and staff of the maternity service

Information Category	Detailed Information
6a. Who did you consult with? (Please select Yes or No for each category)	• Workforce: Yes • Patients/ visitors: No • Local groups/ system partners: No • External organisations: No • Other: No
6b. Please list the individuals/groups who have been consulted about this policy.	**Please record specific names of individuals/ groups:** Midwifery Guidelines Group Obstetrics and Gynaecology Directorate
6c. What was the outcome of the consultation?	Strategy agreed
6d. Have you used any of the following to assist your assessment?	**National or local statistics, audits, activity reports, process maps, complaints, staff or patient surveys:** No

7. The Impact

Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

Protected Characteristic	(Yes or No)	Rationale
Age	No	
Sex (male or female)	No	
Gender reassignment (Transgender, non-binary, gender fluid etc.)	No	
Race	No	
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	No	
Religion or belief	No	

Protected Characteristic	(Yes or No)	Rationale
Marriage and civil partnership	No	
Pregnancy and maternity	No	
Sexual orientation (e.g. gay, straight, bisexual, lesbian etc.)	No	

A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment: Clare Sizer

If a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here:
Section 2. Full Equality Analysis

Appendix 3: Annual Work Plan for Maternity Governance

Date of meeting: Reports to be received 1 week prior to meeting date	Topic report	Person responsible for the report
February	Annual Training Report	Practice Development Midwife
March	Complaints claims and Risk Registers	Care Group Governance Lead
May	Annual Guidelines Compliance Report	Practice Development Midwife
June		
September		
October	Serious Incidents and Risk Registers	Patient Safety Midwife
November	Annual Staffing Reports	Matrons and Specialty Lead
December	Ratification of the Maternity Risk Management Strategy and TNA when needed	Maternity Risk Manager and Practice Development Midwife

Appendix 4: Maternity Services Trigger List For incident and Near Miss Reporting

Maternal

· Undiagnosed Breech at Term/ In Labour
· Prolonged second stage: >3hrs for a primip
>2 hrs for a multip
· Blood loss >1000mls
· Unsuccessful instrumental delivery
· Use of two different instruments for delivery
· Return to theatre
· Cord prolapse
· Category 1 LSCS
· Eclamptic Fit/ Maternal Collapse /DIC
· Surgical trauma to bladder or other organs
· ITU Admission
· Re-suturing of Perineal Trauma
· APH requiring resuscitation
· Anaesthetic complications
· Pressure sore/skin trauma
· Third and Forth Degree Tears
· Failed assisted delivery in room
· DVT/ Pulmonary Embolism
· Ruptured Uterus
· Shoulder Dystocia
· Untreated Strep B
· Septic Shock/ Significant maternal Infection
· Maternal Death
· Maternal Readmission
· Any positive results missed as a result of failure within the Antenatal Screening Programme
· Covid +ve outliers receiving care outside of maternity guidelines
· Infection control requiring isolation that did not take place

Fetal / Neonatal

· Misinterpretation of CTG
· Significant Infections
· Apgars <6 at 5 minutes
· Abnormal Cord PH <7 BE ≥ -16
· Birth injury
· Unexpected stillbirth
· Unexpected Fetal Abnormality
· Neonatal Seizures
· Neonatal Death
· Unexpected admission of a baby to NNU
· Fetal Growth Restriction at Term 10th centile
· Readmission of Baby
· Missed Safeguarding Incident
· Concealed Pregnancy
· Inutero transfer out
· Any undetected congenital/ chromosomal abnormality that should have been detected through screening programmes
· Any avoidable repeat of a newborn blood spot
· Baby born outside of recommended NICU criteria (<27/40 singleton <28/40 multiple birthweight <800g)

Service / Other

· Verbal Complaint
· Drug/ Medication Error
· Equipment failure / unavailability
· Interpersonal conflict over case management
· Protocol Violation
· Slips/trips and falls
· Compromised staffing levels impacting on safe levels of care
· Delay in opening 2nd theatre
· Delivery Suite Coordinator being non-supernumerary
· Delay in treatment impacting on patient care
· Any delay in a test arriving in the lab that has an impact on patient care
· Lack of capacity impacting upon patient care
· Escalation Policy Evoked
· Infant at risk of abduction
· Unavailability of Health Records

Maternity Staffing Red Flags

· Unable to provide 1:1 care in established labour
· No breast feeding support given in the 1-2hrs following birth
· Maternal/ Fetal IV Antibiotics not given with in the correct time frame
· Missed or delayed care e.g. delay of 60 mins or more suturing
· Missed Medication during admission
· Delay of more than 30 mins in providing pain relief
· Delay of 30 mins or more between presentation and Triage
· Full clinical examination not carried out when presenting in labour
· Delay of 2 or more hours between admission for Induction and beginning of the process
· Delayed recognition of and action on abnormal vital signs
· No staff breaks

Community

· BBA Born before arrival
· Emergency transfer in from the Community
· Failure to refer to an Obstetrician/ Anaesthetist when risk factor present.

Appendix 5

Women, Children's and HIV Patient Safety Meeting

Terms of Reference

1. Constitution

The purpose of this meeting is to monitor and review all aspects of the Maternity units performance in relation to:-

1.1 Review clinical incidents as identified by the Patient Safety midwife

1.2 Discuss any other business relating to patient safety

1.3 To share patient safety reports/incident reviews/findings from PSII's and clinical incident reviews

1.4 To discuss complaints in relation to safety concerns

1.5 To review unusual high risk antenatal patients identified by individual practitioners.

2. Conduct of business

The group will meet 3 times a month to carry out its responsibilities. These meetings will be held on the first, second and third Friday mornings of each month.

The Chair of the meeting may call for additional meetings should the need arise.

The chair shall be supported by Committee Secretary who will agree the agenda with the Chair and share all necessary papers, attend meetings to take minutes, keep a record of matters arising and action plans and generally provide support to the Chair and members of the Committee.

3. Membership and attendance

3.1 The Committee's membership shall be comprised of:

1. Committee Chair – Patient Safety Midwife
2. Deputy Chair
3. Named risk management obstetric consultant lead
4. Named risk management obstetric consultant anaesthetist lead
5. Matrons
6. Area Patient Safety Champions
7. Head/Director of Midwifery
8. Audit Midwife
9. Practice Development Midwife
10. IT midwife

11. Committee Secretary

12. Open invitation to clinical staff

3.2 The meeting will be quorate if five members are present, including-

- a member of the senior management team
- Named risk management obstetric consultant lead or equivalent
- Named risk management obstetric consultant anaesthetist lead or equivalent

4. Duties

4.1 Strategic and Policy

- The group will consider all aspects of patient safety in relation to the Maternity Risk Management Strategy (RCHT, 2022)

4.2 Implementation

- The group provides a forum for a multidisciplinary approach to the review of incidents that happen within the maternity care group. The group will decide if an incident requires further investigation via the Patient Safety Incident Response Framework (PSIRF). If a Patient Safety Review section one (24 hour report) is required, the panel will nominate a group member to complete the form which must be approved by Care Group (not a staff member directly involved in the incident) and submitted to central governance. If a senior member of staff is involved in an incident, they will not be involved in any part of the investigation or sign off process.

4.3 Performance monitoring

- Escalation of issues raised at the Patient Safety Meeting to the Trust Board will occur via the following channels-
    - Head of Midwifery/Nursing direct line reporting to the Executive Lead, Chief Nurse and CEO
    - Patient Safety and Quality Committee
    - Via Care Group Clinical Director in the executive operational group

4.4 Review and Compliance

- The committee secretary will keep an action log embedded within the minutes of the meeting, which will be reviewed monthly

4.5 Learning Lessons

- The group will ensure appropriate implementation of actions brought forward from review of patient safety incidents
- The action log will be reviewed as part of every meeting agenda, to provide reassurance that actions are completed

- Learning will be shared to all staff via a multitude of avenues including ‘top-tips’, newsletters, emails, and team leader feedback.

5. Accountability and reporting arrangements

- The minutes will be shared to staff within Women’s and Children’s Services and the Clinical Director, Speciality lead, Head of Governance, Chief Nurse

- The patient safety midwife will provide assurance to the monthly Maternity Governance meeting via the Patient Safety Exception Report.

- If concerns are raised around an individual member of staff, the line manager and matron of that staff member will be informed and asked to create a timeline of any previous incidents that the staff member may have been involved in. Any further action will be decided by the matron.

6. Review arrangements

- The Committee Terms of Reference and performance will be reviewed bi-annually by the members.

Date for review-

March 2024

Appendix 6 Maternity Forum

1. Constitution

The Maternity Forum Meeting is responsible for ensuring that Maternity national drivers are embedded within the Maternity Service and that it operates within the law, complies with its regulators and delivers safe, high quality and effective care and that legislation and all standards are met. It will provide evidence to the Maternity Governance meeting that the Maternity Service has effective systems of internal control in relation to National drivers and learning.

The group has delegated responsibility and authority to report to the maternity Governance meeting.

2. Conduct of business

The group will meet once a month to carry out its responsibilities. These meetings will be held on the 3rd week of the month.

The Chair of the Group may call for additional meetings should the need arise.

The Group shall be supported by an administrator who will agree the agenda with the Chair and produce all necessary papers, attend meetings to take minutes, keep a record of matters arising and action plans and generally provide support to the Chair and members of the group.

3. Membership and attendance

3.1 The Group's membership shall be comprised of:

1. Group Chair – Patient Safety Midwife
2. Deputy Chair – Clinical Matron/HOM
3. Clinical leads
4. Labour ward Lead/manager
5. Anaesthetic lead
6. Area risk champions
7. LMS chair
8. Maternity voices partnership chair
9. Audit Midwife
10. Matrons
11. Practice Development Midwife
12. IT Midwife
13. Neonatal Attendance
14. Open invitation to clinical staff

The meeting will be quorate if five members are present, of whom one must be a member of the Senior Management Team and at least one medical representative.

4. Duties

4.1 Strategic and Policy

- The group will consider all aspects of patient safety in relation to the Maternity Risk Management Strategy (RCHT, 2022)

4.2 Implementation

The purpose of this Maternity Forum Meeting is to monitor and review all aspects of the Maternity Service incidents in relation to:-

- National papers and new Maternity drivers
- Local maternity System updates
- Maternity voices themes
- Sharing of excellence- celebrating success
- Themes from complaints
- Learning from SI's
- Exception reports from clinical dashboard

The Committee has delegated responsibility and authority to report to the Directorate governance meeting.

4.3 Performance monitoring

- Escalation to the Maternity Service Governance meeting of issues raised via an exception report
- Care Group Governance Board reports to the Trust Management Committee (Executive)
- The Trust Management Committee reports to the Quality Assurance Committee which in turn reports to the Trust Board

In exceptional circumstances there is a direct route to the Executive Lead, Chief Nurse and CEO from the Head of Midwifery and Speciality Obstetric Lead

4.4 Review and Compliance

- The Meeting administrator will keep an action log to be reviewed monthly.
- The Patient Safety Midwife, Matrons Obstetric Lead Consultant will work together and be responsible for coordinating and administrating the agendas, minutes and any other matters concerning the administration of the group.
- Agendas, papers, minutes and a schedule of meetings will be maintained on the Care Group drive.

- A copy of all agendas, minutes and papers will be sent to the Meeting Secretary for archiving on the Care Group's central shared drive.

- Any member of staff may raise an issue with the Chair, this will be discussed with the staff member and the most appropriate meeting forum will be jointly agreed.

- An Exception report will be compiled by the Chair and reported to the Maternity Service Governance meeting.

The Group administrator will keep an action log to be reviewed monthly. The administrative support to this meeting will take minutes and distribute to the members of the group.

4.5 Learning Lessons

- Identified learning, from all reporters is shared via patient safety /Head of Midwifery / practice development newsletters

4.6 Risk Management

- Review and bench mark national guidelines against local practices.

5. Accountability and reporting arrangements

- The minutes will be distributed to staff within Maternity and Neonatal Services and the Clinical Director, Speciality Leads, Head of Governance, Chief Nurse on a monthly basis

6. Review arrangements

- The Committee Terms of Reference and performance will be reviewed bi-annually by the members.

7. Sub Committee Arrangements

The Committee will periodically review the composition and performance of its performance and receive regular reports from the following sources:

- NICE
- RCOG
- Maternity voices partnership
- LMS
- Guideline meetings
- Clinical dashboard

Date for review

March 2024

Appendix 7: Maternity Guidelines Group Terms of Reference

1. Constitution

1.1. The Maternity Guidelines Meeting is responsible for ensuring that Maternity guidelines are embedded within the Maternity Service. That it operates within the law, complies with its regulators and delivers safe, high quality and effective care and that legislation and all standards are met. It will provide evidence to the Maternity and Obstetric Business and Governance meeting that the Maternity Service has effective systems of internal control in relation to guideline management.

1.2. The Committee has delegated responsibility and authority to report to the Maternity and Obstetric Business and Governance meeting.

2. Conduct of Business

2.1. The Committee will meet once a month to carry out its responsibilities. These meetings will be held on the 1st Thursday afternoon of the month, unless stated otherwise. The Chair of the Committee may call for additional meetings should the need arise.

3. Membership

3.1. The Committee's membership shall be comprised of-

- Committee Chair –
- Deputy Chair if chair not available
- Practice Development Midwife
- Obstetric Lead for Guidelines
- Audit Midwife
- Members of the Senior Midwifery Team, including Director of Midwifery, Deputy Director of Midwifery, Consultant Midwife and Maternity Matrons
- Patient Safety Midwife, Governance Support Midwife or Fetal Well Being Lead

4. Duties

4.1. The group will consider all aspects above in relation to the Maternity national drivers e.g. NICE and RCOG guidelines

4.2. The group will review and approve guidelines which are brought to the meeting, including full updates and changes made for other reason- e.g. patient safety incidents and learning

4.3. The Group will review the Guidelines Schedule and escalate guidelines which are expired or due to expire

4.4. The group will read and comment on the guidelines prior to the meeting where possible

5. Quorum

5.1. The quorum necessary for the transaction of business shall be if four members are present, of whom one must be a member of the Senior Midwifery Team, a Consultant Obstetrician and an Obstetric Consultant Anaesthetist

6. Minutes and reporting

6.1. The minutes of all meetings of the Group shall be formally recorded and reported monthly to all Group members

7. Performance and evaluation

The Committee shall review its collective performance and that of its individual members on a regular basis

7.1. Escalation to the board of issues raised at this meeting will occur via the Maternity Governance Meeting

8. Review

8.1. The Committee's terms of reference shall be reviewed at least biennially by the members

9. Sub Committee Arrangements

9.1. The Maternity Governance Meeting will receive regular reports from guidelines exception report

Date for review

November 2024