Maternity Risk Management Strategy

V8

January 2016
# Maternity Risk Management Strategy

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1. Executive Summary

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

   2.2. 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.

   2.3. 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.

   2.4. This version supersedes any previous versions of this document.

3. Purpose / Objectives of this Strategy
   3.1. 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.

   3.2. 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.

   3.3. 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.

   3.4. 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.

   3.5. The objectives described below reflect the requirements of local and national drivers: NSF for Children and Young People, NICE guidance, Safer Childbirth, Standards for Maternity Care, Mothers and Babies: reducing risk through audits and confidential enquiries across the UK (MBRRACE-UK) and the NHSLA

   3.6. Maternity services objectives for managing risk:
• An annual Maternity Risk Management Plan which is agreed, reviewed and monitored by the Obstetric Risk Management Forum. (ORMF) (Appendix 3).
• Ensure that all risks, are identified and maintained on a ‘live’ risk register that is reviewed as per the process for maternity risk registers.
• Policies and guidelines which are audited and updated at regular intervals and monitored through agreed compliance monitoring indicators, action plans developed and monitored should any deficiencies be identified.
• 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 and changes to practice.
• 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.
• Ensure maternity staffing levels are subject to a yearly audit to establish whether they are inline with the services document governing safe staffing levels.

4. Scope
4.1. This document applies to all staff working within maternity services.

4.2. 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.

5. Ownership and Responsibilities

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.

5.2. 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.

5.3. The Nurse Executive
The 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 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. (refer to Governance Arrangements Appendix 1).
5.4. 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.

5.5. The Divisional Management Team (Women’s, Children’s and Sexual Health)
The Divisional Management Team comprising the Divisional Director, the Divisional Manager, the Divisional Nurse/Head of Midwifery are supported in the management of risk by six specialty leads for acute paediatrics, community paediatrics, neonatology, obstetrics, gynaecology and sexual health and respective matrons.

Monthly governance reports are received by the Divisional Management Board* as part of the Divisional internal assurance process. (Refer to Maternity Service Communication Map, Appendix 4). 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 Divisional Governance Report is presented at the monthly Divisional Board, this includes maternity.
*The Divisional Board comprises the Divisional Management Team, Specialty Leads, Matrons, the divisional governance lead and supporting personnel e.g. finance, HR and trust governance.

5.6. The Head of Midwifery/Divisional Nurse
The Head of Midwifery/Divisional Nurse has overall responsibility for the management of risk within the women and children’s division, which includes the maternity service. He/she is responsible for providing professional and managerial leadership for midwives, nurses, therapists and support workers within the Division. Professionally she/he reports directly to the Nurse Executive and is responsible for developing the strategic direction for midwifery, inc. 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.

5.7. The Head of Midwifery / Divisional Nurse meets on a monthly basis with the Nurse Executive, attends the Quality and Learning Group and the Women, Children’s and Sexual Health Divisional Board.

5.8. The Speciality Lead for Obstetrics
The Specialty Lead for Obstetrics is responsible for governance arrangements within the Obstetric service and meets monthly with the head of midwifery and attends the obstetric and gynaecology directorate meetings and the women and children’s divisional board. This role has responsibility for ensuring that risks associated with the objectives are identified, assessed and controlled to an acceptable level.

5.9. The Lead Consultant Obstetrician for Delivery Suite
The Lead Consultant Obstetrician for Delivery Suite provides professional guidance and leadership in this area, ensuring effective communication between obstetric, neonatal and anaesthetic colleagues and oversees the provision of safe, effective
obstetric practice. This role encompasses attendance at Clinical Incident Review Meetings, MRMF, Guideline meetings and Audit Review meetings.

5.10. The Lead Consultant Anaesthetist for Delivery Suite
The Lead Consultant Anaesthetist for Delivery Suite provides professional guidance and leadership for anaesthesia and represents the views of anaesthetic colleagues and their assistants. This role also attends Clinical Incident Review meetings, MRMF, Guideline meetings and Audit Review meetings.

5.11. 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.

5.12. The Divisional Governance Lead
The Divisional Governance lead will manage and coordinate all aspects of governance and risk across the division and provide expert advice to the Divisional Management Team, Speciality Leads and Matrons in relation to the management of risk, health and safety, CQC standards, NHSLA, integrated governance, Incidents/SI’s, claims and complaints. This role will attend the trust wide groups of Risk Committee; Complaints Review Panel, Health and Safety Committee and the Quality and Learning Group, the Divisional Board and the Maternity Services Directorate meeting, MRMF.

5.13. 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 MRMF. The midwifery matrons are responsible for escalating risk management concerns and implement changes within clinical practice. Midwifery Matrons attend the MRMF.

5.14. The Maternity Risk Manager
- Maternity Risk Manager 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.
- 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 the complaints and litigation department.
- The maternity risk manager 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 Maternity Clinical Risk Manager leads and supports members of the team undertaking Serious Incident Investigations (SI’s) and Critical Incident
investigations (CI’s) and participates in the review panel undertaking the root cause analysis (RCA).

5.15. The Practice Development Midwife
The Practice Development Midwife is responsible for the induction, updating and identification of on-going learning needs of Registered Midwives. The role is also key in the development of a programme for multidisciplinary skills/drills training. The post holder will be involved in the production and review of clinical guidelines and policies.

5.16. 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.

5.17. The Supervisors of Midwives (SOM)
The Supervisors of Midwives ensure the provision of safe, evidence based midwifery care through a robust framework of governance as defined by statute. The Supervisors of Midwives forum nominate a contact supervisor, who is responsible for maintaining communication links with the Local Supervising Authority Midwifery Officer (LSAMO). This role will rotate on an annual basis.

The supervisory team will ensure that there is a Supervisor of Midwives (SOM) attending the weekly Risk Management Meetings, on a rotational basis. The role of the attending SOM is to ensure that, where concerns have been raised about midwifery practice, a LSA decision tool is applied. (NMC 2015) To ensure a prompt and appropriate level of response to concerns raised, a SOM will be nominated to all cases that have been reported as a Serious Incident.

Each midwife will have a named SOM, who they can access for advice and support during normal working hours. An on-call SOM is available for advice, guidance and support throughout any given 24 hour period and may be called to give practical support and advice to any clinical area, at times of peak activity.

A SOM is a member of the Clinical Incident Review Group, the Maternity Guidelines Group and the MRMF.

An annual Local Supervising Authority (LSA) Report is submitted to the LSAMO. The report will be presented at the MRMF and Divisional board.

On an annual basis the LSAMO will make formal and informal visits to audit standards of supervision. Following these visits the LSAMO will feedback any actions arising. The SOM group are responsible for compliance with the action plan and will report to the MRMF and Divisional Board.

The SOMs are expected to clearly delineate their role as a SOM from their substantive role, demonstrating public protection through expert knowledge of supervision and clinical practice.
5.18. 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.

6. Benefits
6.1. 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.

7. Risks
7.1. If this strategy was not available the process of reporting and managing risks may not be communicated to all relevant staff.

8. The Strategy
8.1. 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).

- A weekly Clinical Incident Review Meeting (see Appendix 6) chaired by the Maternity Risk Manager reviews maternity clinical incidents involving women and babies 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 & Exeter Trust or Plymouth Hospital Trust) the Maternity Risk Manager will liaise with the risk manager for the neighbouring Trust.

- A ORMF (see Appendix 7) chaired by the Maternity Risk Manager 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 Clinical Audit Meeting (see Appendix 7) chaired by the Obstetric Consultant Lead for Audit, reviews the results of ongoing audits and annual re audits. Any identified deficiencies will be monitored by the ORMF who will oversee and implement any changes required. This meeting forms part of a multidisciplinary Perinatal Mortality/Morbidity Case Review Meeting.

- A monthly Maternity Guideline Group is chaired by the Practice Development Midwife (PDM) (see Appendix 9). 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.

- The multidisciplinary Perinatal Mortality/Morbidity Case Review Meeting is held at least bi monthly, this is chaired by the Lead Consultant Obstetrician for Delivery Suite. All perinatal deaths from the preceding 2 months 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. A case review form is completed.

- A weekly CTG/Caesarean Section meeting is open to any member of clinical staff. Cases are identified as an opportunity for teaching and learning. This is an informal meeting with an attendance list maintained.

- A monthly Risk Management 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, complaints and PALS with associated learning, results of audits and associated action plans, new local and national guidance, new clinical guidelines, and any other learning from experience opportunities.

8.2. Process for the Management of Maternity Services Risk Register
This should be read in conjunction with RCHT Policy and Guidance for Risk Assessment and Risk Registers.

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.

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 MRMF.

8.5. Divisional Risk Register
Any risk that scores 12 or above, or a lower risk that appears across a minimum of 2 ward/clinical areas, or a risk that cannot be reasonably managed at speciality level will be discussed at the monthly divisional board meeting where a decision will be made as to where on the risk register structure the risk should appear and an action plan will be agreed.

8.6. Corporate Risk Register
Any risks of 15 or above will be taken, by the Divisional Governance Lead, for individual discussion to the monthly Trust Risk Committee, of which the Nurse executive 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 monthly governance committee. The minutes of the Governance Committee are received by the Trust board.

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, Serious Incidents (SI’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.

![Diagram showing escalation process]

8.8. **Arrangements for the investigation of serious incidents (SI’s).**

Should be read in conjunction with RCHT Serious Incident Management Policy and procedure.

- 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 criteria for full investigation as an SI.

- Unexpected or avoidable death of one or more patients, staff, visitors or members of the public.

- Serious harm to one or more patients, staff, visitors or members of the public or where the outcome requires life saving intervention, major surgical/medical intervention, permanent harm or will shorten life expectancy or result in prolonged pain or psychological harm (this includes incidents graded under the NPSA definition of severe harm).
• A scenario that prevents or threatens to prevent a provider organisation’s ability to continue to deliver healthcare services, for example, actual or potential loss of personal/organisational information, damage to property, reputation or the environment, or IT failure.

• Allegations of abuse.

• Adverse media coverage or public concern about the organisation or the wider NHS.

• One of the core set of ‘never events’. See RCHT Serious Incident Management Policy and Procedure for List of Never Events.

• Safeguarding or incident involving a vulnerable adult.

8.9. Maternity specific Serious Incidents (SIs) in the NHS include
Acts or omissions occurring as part of NHS-funded Healthcare (including the community) that result in:

• Unexpected or avoidable death of one or more people includes suicide/self-inflicted death

• Homicide by a person in receipt of mental health care within the recent past. (See Appendix ?)

• Unexpected or avoidable injury to one or more people that has resulted in serious harm;

• Unexpected or avoidable injury to one or more people that requires further treatment by a healthcare professional in order to prevent:

  The death of a service user or Serious harm
  • Actual or alleged abuse; sexual abuse, physical or psychological ill-treatment, or acts of omission which constitute neglect, exploitation, financial or material abuse, discriminative and organisational abuse, self-neglect, domestic abuse, human trafficking and modern day slavery where:
    • Healthcare did not take appropriate action/intervention to safeguard against abuse occurring; or

  Where abuse occurred during the provision of NHS-funded care
  • This includes abuse that resulted in (or was identified through) a Serious Case Review (SCR), Safeguarding Adult Review (SAR), Safeguarding Adult Enquiry or other externally-led investigation, where delivery of NHS-funded care caused/contributed towards the incident
  • All Never Event – all Never Events are defined as serious incidents although not all Never Events necessarily result in serious harm or death. See Never Events Policy and Framework for the national definition and further information.
An incident (or series of incidents) that prevents, or threatens to prevent, an organisation’s ability to continue to deliver an acceptable quality of healthcare services, including (but not limited to) the following:

1. Failures in the security, integrity, accuracy or availability of information often described as data loss and/or information governance related issues (See Appendix ?)
2. Property damage
3. Security breach/concern
4. Incidents in population-wide healthcare activities like screening and immunisation programmes where potential for harm may extend to a large population.
5. Inappropriate enforcement/care under the Mental Health Act (1983) and the Mental Capacity Act, Deprivation of Liberty Safeguards (MCA DOLS)
6. Systematic failure to provide an acceptable standard of safe care (this may include incidents, or series of incidents, which necessitate ward/unit closure or suspension of services; or
7. Activation of Major Incident Plan (by provider, commissioner or relevant agency).

Major loss of confidence in the service, including prolonged adverse media coverage or public concern about the quality of healthcare or an organisation.

8.10. Screening Incidents

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.

Definition of a serious screening incident

- Whether a “serious incident” 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 given in the Serious Incident Framework is applicable to screening programmes.
- 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

8.10 Once a potential SI has been identified it should be escalated using point 8 of the escalation of risk flow chart.
• The responsibility for defining and verifying an adverse event as a ‘Serious Incident’ rests with the Medical Director (or a nominated deputy in their absence) during normal hours. During out of hours responsibility lies with the executive director on call.

• Once verified, the Medical Director will inform the Head of Quality, Safety and Compliance who will report the SI to the relevant external organisations.

• The Medical Director will appoint an Investigating Officer (IO) for the SI. The IO must also be trained in root cause analysis (RCA).

• The IO is responsible for the investigation, convening the RCA panel and the SI review panel, preparing the draft report with recommendations.

• The consultant in charge of the patients care is responsible for the patient and/or next of kin being kept informed regarding the investigation: see RCHT Being Open Policy.

• The IO is responsible for making sure any staff and patients involved with the incident are kept informed of the process and receive a final copy.

• Following executive sign off of the SI report the division in which the incident occurred will appoint an Action Plan Lead. For maternity services the action plan will be monitored by the MRMF and progress reported at the Divisional Board.

• The Trust will receive all SI action plans at the Divisional Quality group to ensure Trust wide shared learning takes place.

• All SI reports will be submitted to the Governance Committee as part of the confidential reporting and monitoring process.
8.11 Maternity Services Process for learning from complaints, claims and incidents.

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

- All complaints for the Division of Women and Children and Sexual Health are received by the Divisional Governance Lead who will then identify an IO.

- The Divisional Governance Lead monitors the progress of the investigation and ensures a timely response.

- For all complaints upheld, an action plan is completed and forwarded to the Trust’s Complaints Department along with the evidence that the actions have been completed to facilitate organisational learning.

- The Divisional Governance Lead produces a quarterly governance report for the MRMF and monthly exception reporting. The data is discussed, action plans monitored and lessons learnt identified, at the monthly MRMF.

- Following the monthly MRMF a newsletter is produced and distributed via email to all clinical staff within the maternity service. It is also displayed on Risk Management notice boards throughout the maternity service. This contains an overview of the incidents, complaints and PALS with identified learning points.

- The Trust’s Claims Manager is invited to attend the MRMF quarterly to report on any ongoing and new claims. Any lessons learnt are identified and distributed via the Risk Management News Letter.

- The Divisional Governance Lead will provide a report for the monthly Women, Children’s and Sexual Health Divisional Board, where learning from upheld complaints is shared across the division and any outstanding action plans are reviewed and actioned.

- The Divisional Governance Lead will provide a report for the quarterly Complaints Review Panel who report directly to the Governance Committee and is responsible for monitoring the trends in upheld complaints, and review all action plans for timely completion of the changes that need to be implemented as a result of complaints related investigations. Changes include sharing learning across multi disciplinary teams within divisions, across the trust and the wider health community where this is appropriate. The panel is chaired by the Director of Nursing, Midwifery and Allied Health Professions and includes a non-executive director and patient ambassador as part of its membership.

9.0. 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.
It will be included in the induction pack for all new obstetricians joining the maternity service and highlighted in the induction process of midwives, nurses and support workers joining the maternity services.

10.0. Monitoring compliance and effectiveness

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>Measurable objectives within the strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead</td>
<td>Maternity Risk Management Midwife</td>
</tr>
<tr>
<td>Tool</td>
<td>• A governance report, containing, risks, complaints and claims is received as per the Maternity Risk Management Forum work plan</td>
</tr>
<tr>
<td></td>
<td>• Named individuals have attended 75% of Obstetric Risk Management Forums (ORMF)</td>
</tr>
<tr>
<td></td>
<td>• LSA report has been received at the ORMF</td>
</tr>
<tr>
<td></td>
<td>• Lessons learnt from incidents, complaints and claims are included in the monthly newsletter</td>
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<tr>
<td></td>
<td>• Action plans from SIs have been monitored at the MRMF</td>
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<tr>
<td></td>
<td>• Training report is received as per the annual work plan at the MRMF</td>
</tr>
<tr>
<td></td>
<td>• An annual report from the Maternity Forum is received as per the work plan</td>
</tr>
<tr>
<td>Frequency</td>
<td>Maternity Risk Management Midwife will present an annual report to the MRMF of compliance with the above measurable objectives</td>
</tr>
<tr>
<td>Reporting arrangements</td>
<td>MRMF (see Appendix 7)</td>
</tr>
<tr>
<td>Acting on recommendations and Lead(s)</td>
<td>An action plan will be developed at the MRMF, leads will be identified, the action plan will be monitored by the MRMF</td>
</tr>
<tr>
<td>Change in practice and lessons to be shared</td>
<td>Agreed as per the action plan</td>
</tr>
</tbody>
</table>

11.0. Updating and Review

11.1 This strategy will be reviewed annually by the Maternity Risk Manager.

12.0. Equality and Diversity

12.1 All new and revised documents (excluding Human Resource documents) must acknowledge adherence to the Trust agreed equality and diversity statement by inclusion of the following:

"This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement".

12.2 All Human Resources policies must include, or refer to, the following employment statement:
"Royal Cornwall Hospitals NHS Trust is committed to a Policy of Equal Opportunities in employment. The aim of this policy is to ensure that no job applicant or employee receives less favourable treatment because of their race, colour, nationality, ethnic or national origin, or on the grounds of their age, gender, gender reassignment, marital status, domestic circumstances, disability, HIV status, sexual orientation, religion, belief, political affiliation or trade union membership, social or employment status or is disadvantaged by conditions or requirements which are not justified by the job to be done. This policy concerns all aspects of employment for existing staff and potential employees”.

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

NB: References and Associated Trust Documents
Up-to-date references, including details of supporting or associated Trust or Cornwall Health Community documents, must be listed on the Governance Coversheet.
## Appendix 1. Governance Information

<table>
<thead>
<tr>
<th>Document Title</th>
<th>Maternity Risk Management Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Issued/Approved:</td>
<td>18&lt;sup&gt;th&lt;/sup&gt; February 2016</td>
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<td>Date Valid From:</td>
<td>29&lt;sup&gt;th&lt;/sup&gt; February 2016</td>
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<tr>
<td>Date Valid To:</td>
<td>29&lt;sup&gt;th&lt;/sup&gt; February 2019</td>
</tr>
</tbody>
</table>
| Directorate / Department responsible (author/owner): | Kate Putman  
Maternity Risk Manager  
Obs and Gynae Directorate |
| Contact details:                | 01872 252270                       |
| 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 | PCT | CFT | KCCG |
|                                 | ✓    |     |     |     |
| Executive Director responsible for Policy | Medical Director |
| Date revised:                   | 18<sup>th</sup> February 2016      |
| This document replaces (exact title of previous version): | Maternity Risk Management Strategy V.6 |
| Approval route (names of committees)/consultation: | Maternity Risk Management Forum  
Maternity Guidelines Group  
Obs and Gynae Directorate  
Divisional Board for noting |
| Divisional Manager confirming approval processes | Head of Midwifery |
| Name and Post Title of additional signatories | Not Required |
| Signature of Executive Director giving approval | {Original Copy Signed} |
| Publication Location (refer to Policy on Policies – Approvals and Ratification): | Internet & Intranet | ✓ | Intranet Only |
| Document Library Folder/Sub Folder | Clinical / Midwifery and Obstetrics |
### Links to key external standards

None

### Related Documents:
- RCHT Risk Management Strategy and Policy
- RCHT Policy and Guidance for Risk Assessment and Risk Registers
- RCHT Being Open Policy.
- RCHT Serious Incident Management Policy and procedure.
- RCHT Serious Incident Management Policy and Procedure for List of Never Events.

### Training Need Identified?

No

### Version Control Table

<table>
<thead>
<tr>
<th>Date</th>
<th>Version No</th>
<th>Summary of Changes</th>
<th>Changes Made by (Name and Job Title)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dec 05</td>
<td>V1.0</td>
<td>First Maternity Risk Management Strategy</td>
<td>Jan Clarkson Maternity Risk Manager</td>
</tr>
<tr>
<td>Dec 06</td>
<td>V2.0</td>
<td>Annual review and added cross board incident management pathway</td>
<td>Jan Clarkson Maternity Risk Manager</td>
</tr>
<tr>
<td>Dec 08</td>
<td>V3.0</td>
<td>Full review &amp; consultation</td>
<td>Jan Clarkson Maternity Risk Manager</td>
</tr>
<tr>
<td>Dec 09</td>
<td>V4.0</td>
<td>Annual review and inclusion of escalation of risk and risk registers</td>
<td>Jan Clarkson Maternity Risk Manager</td>
</tr>
<tr>
<td>Dec 11</td>
<td>V5.0</td>
<td>Full review and consultation process included annual work plan and compliance monitoring process.</td>
<td>Jan Clarkson Maternity Risk Manager</td>
</tr>
<tr>
<td>December 2012</td>
<td>V6.0</td>
<td>Level at which risks are reported to divisional 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 Divisional board. Any Trust wide action points escalated to the divisional quality and learning group.</td>
<td>Jan Clarkson Maternity Risk Manager</td>
</tr>
<tr>
<td>Date</td>
<td>Version</td>
<td>Description</td>
<td>Author</td>
</tr>
<tr>
<td>--------------------</td>
<td>---------</td>
<td>-----------------------------------------------------------------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>December 2013</td>
<td>V7.0</td>
<td>Full review of document, changes to the title of the Nurse Executive and roles of Midwifery Matrons</td>
<td>Jan Clarkson Maternity Risk Manager</td>
</tr>
<tr>
<td></td>
<td></td>
<td>TOR put onto new trust template</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>TOR for Maternity Forum</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Updating of the trigger list</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Updating of the annual work plan</td>
<td></td>
</tr>
<tr>
<td>18&lt;sup&gt;th&lt;/sup&gt; February 2016</td>
<td>V8.0</td>
<td>Reviewed Sections added for Supervision of Midwifery and Screening Failsafe mechanisms</td>
<td>Jan Clarkson Maternity Risk Manager</td>
</tr>
</tbody>
</table>

**All or part of this document can be released under the Freedom of Information Act 2000**

**This document is to be retained for 10 years from the date of expiry.**

**This document is only valid on the day of printing**

**Controlled Document**

This document has been created following the Royal Cornwall Hospitals NHS Trust Policy on Document Production. It should not be altered in any way without the express permission of the author or their Line Manager.
Appendix 2. Initial Equality Impact Assessment Form

<table>
<thead>
<tr>
<th>Name of Name of the strategy / policy / proposal / service function to be assessed (hereafter referred to as policy) Maternity Risk Management Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Directorate and service area: Obs and Gynae Directorate Is this a new or existing Policy? Existing</td>
</tr>
<tr>
<td>Name of individual completing assessment: Jan Clarkson Telephone: 2270</td>
</tr>
</tbody>
</table>

1. Policy Aim*
Who is the strategy / policy / proposal / service function aimed at? This document combines both strategy and policy for 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 the outcome? As per Compliance Monitoring Tool

5. Who is intended to benefit from the policy? Users and staff of the maternity service

6a) Is consultation required with the workforce, equality groups, local interest groups etc. around this policy? N/A

b) If yes, have these *groups been consulted? N/A

<table>
<thead>
<tr>
<th></th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>C). Please list any groups who have been consulted about this procedure.</td>
<td>N/A</td>
</tr>
</tbody>
</table>

7. The Impact
Please complete the following table.

Are there concerns that the policy could have differential impact on:

<table>
<thead>
<tr>
<th>Equality Strands:</th>
<th>Yes</th>
<th>No</th>
<th>Rationale for Assessment / Existing Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Maternity Risk Management Strategy
<table>
<thead>
<tr>
<th>Category</th>
<th>X</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex</strong> (male, female, trans-gender / gender reassignment)</td>
<td></td>
</tr>
<tr>
<td><strong>Race / Ethnic communities / groups</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Disability - learning</strong></td>
<td></td>
</tr>
<tr>
<td>disability, physical disability, sensory impairment and mental health problems</td>
<td></td>
</tr>
<tr>
<td><strong>Religion / other beliefs</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Marriage and civil partnership</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Pregnancy and maternity</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian</strong></td>
<td></td>
</tr>
</tbody>
</table>

You will need to continue to a full Equality Impact Assessment if the following have been highlighted:
- You have ticked “Yes” in any column above and
- No consultation or evidence of there being consultation- this excludes any policies which have been identified as not requiring consultation. **or**
- Major service redesign or development

8. Please indicate if a full equality analysis is recommended. Yes No X

9. If you are not recommending a Full Impact assessment please explain why.

N/A

Signature of policy developer / lead manager / director Jan Clarkson

Date of completion and submission 18th February 2016

Names and signatures of members carrying out the Screening Assessment

1. Elizabeth Anderson

2.

Keep one copy and send a copy to the Human Rights, Equality and Inclusion Lead, c/o Royal Cornwall Hospitals NHS Trust, Human Resources Department, Knowledge Spa, Truro, Cornwall, TR1 3HD

A summary of the results will be published on the Trust’s web site.

Signed: Elizabeth Anderson

Date: 18th February 2016
## Appendix 3: Annual Work Plan for ORMF

<table>
<thead>
<tr>
<th>Date of meeting: Reports to be received 1 week prior to meeting date</th>
<th>Topic report</th>
<th>Person responsible for the report</th>
</tr>
</thead>
<tbody>
<tr>
<td>February</td>
<td>Annual Training Report</td>
<td>Practice Development Midwife</td>
</tr>
<tr>
<td>March</td>
<td>Complaints claims and Risk Registers</td>
<td>Divisional Governance Lead</td>
</tr>
<tr>
<td>May</td>
<td>Annual Guidelines Compliance Report</td>
<td>Practice Development Midwife</td>
</tr>
<tr>
<td>June</td>
<td>LSA report</td>
<td>Contact Supervisor of Midwives</td>
</tr>
<tr>
<td>September</td>
<td>Training Report</td>
<td>Divisional Governance Lead</td>
</tr>
<tr>
<td>October</td>
<td>Serious Incidents and Risk Registers</td>
<td>Maternity Risk Manager</td>
</tr>
<tr>
<td>November</td>
<td>Annual Staffing Reports</td>
<td>Matrons and Specialty Lead</td>
</tr>
<tr>
<td>December</td>
<td>Ratification of the Maternity Risk Management Strategy and TNA when needed</td>
<td>Maternity Risk Manager and Practice Development Midwife</td>
</tr>
</tbody>
</table>
Appendix 4. Maternity Services Communication Map

Women’s, Children’s and Sexual Health Divisional Board

Obstetric Risk Management Forum / Clinical Audit Group

Clinical Incident Review Meeting

Obstetric and Gynaecology Directorate Meeting

Clinical Audit Monitoring Group

Supervisors of Midwives Group

Midwifery Team Leaders meeting

Midwifery update day

Maternity Services Liaison Committee

Consultant meeting: Obs & Gynae

CTG / labour management

Women and newborn audit

Doctors in training

Fetontal meeting

Supervisors of Midwives Group

Midwifery Team Leaders meeting

Midwifery update day

Maternity Services Liaison Committee

Consultant meeting: Obs & Gynae

CTG / labour management

Women and newborn audit

Doctors in training

Fetontal meeting

Red=weekly
Blue=Monthly
Green=Bi-monthly
### Appendix 5:

**Maternity Services Trigger List**

**For incident and Near Miss Reporting**

<table>
<thead>
<tr>
<th>Maternal</th>
<th>Fetal / Neonatal</th>
<th>Maternity Staffing Red Flags</th>
</tr>
</thead>
<tbody>
<tr>
<td>Undiagnosed Breech at Term/In Labour</td>
<td>Misinterpretation of CTG</td>
<td>Unable to provide 1:1 care in</td>
</tr>
<tr>
<td>Blood loss &gt;1000mls</td>
<td>Significant Infections</td>
<td>established labour</td>
</tr>
<tr>
<td>Return to theatre</td>
<td>Apgars &lt;6 at 5 minutes</td>
<td>No breast feeding support</td>
</tr>
<tr>
<td>Cord prolapse</td>
<td>Abnormal Cord PH &lt;7</td>
<td>given in the 1-2hrs</td>
</tr>
<tr>
<td>Eclamptic Fit/Maternal Collapse/DIC</td>
<td>Birth injury</td>
<td>Maternal/Fetal IV Antibiotics</td>
</tr>
<tr>
<td>Surgical trauma to bladder or other organs</td>
<td>Unexpected stillbirth</td>
<td>not given within the correct</td>
</tr>
<tr>
<td>ITU Admission</td>
<td>Unexpected Fetal Abnormality</td>
<td>time frame</td>
</tr>
<tr>
<td>Resutting of Perineal Trauma</td>
<td>Neonatal Seizures</td>
<td>Missed or delayed care e.g.</td>
</tr>
<tr>
<td>APH requiring resuscitation</td>
<td>Neonatal Death</td>
<td>Delay of 60 mins or more</td>
</tr>
<tr>
<td>Anaesthetic complications</td>
<td>Unexpected admission of a baby to NNU</td>
<td>suturing</td>
</tr>
<tr>
<td>Pressure sore/skin trauma</td>
<td>Undetected Fetal Growth restriction at Term</td>
<td>Missed Medication during</td>
</tr>
<tr>
<td>Third &amp; Forth Degree Tears</td>
<td>Readmission of Baby</td>
<td>Admission</td>
</tr>
<tr>
<td>Failed assisted delivery in room</td>
<td>Missed Safeguarding Incident</td>
<td>Delay of more than 30 mins</td>
</tr>
<tr>
<td>DVT/Pulmonary Embolism</td>
<td>Inutero transfer out</td>
<td>in providing pain relief</td>
</tr>
<tr>
<td>Ruptured Uterus</td>
<td>Any undetected congenital/chromosomal abnormality</td>
<td>Delay of 30 mins or more</td>
</tr>
<tr>
<td>Shoulder Dystocia</td>
<td>that should have been detected through screening</td>
<td>between presentation and</td>
</tr>
<tr>
<td>Untreated Strep B</td>
<td>programmes</td>
<td>Triage</td>
</tr>
<tr>
<td>Septic Shock/Significant maternal Infection</td>
<td>Any avoidable repeat of a newborn blood spot</td>
<td>Full clinical examination</td>
</tr>
<tr>
<td>Maternal Death</td>
<td></td>
<td>not carried out when</td>
</tr>
<tr>
<td>Maternal Readmission</td>
<td></td>
<td>presenting in labour</td>
</tr>
<tr>
<td>Any positive results missed as a result of</td>
<td></td>
<td>Delay of 2 or more hours</td>
</tr>
<tr>
<td>failure within the Antenatal Screening</td>
<td></td>
<td>between admission for</td>
</tr>
<tr>
<td>Programme</td>
<td></td>
<td>Induction and beginning of</td>
</tr>
<tr>
<td>Community</td>
<td></td>
<td>the process</td>
</tr>
<tr>
<td>BBA</td>
<td>Verbal Complaint</td>
<td>Delayed recognition of and</td>
</tr>
<tr>
<td>Emergency transfer in from the Community</td>
<td>Drug/Medication Error</td>
<td>action on abnormal vital</td>
</tr>
<tr>
<td>Failure to refer to an Obstetrician /</td>
<td>Equipment failure / unavailability</td>
<td>signs</td>
</tr>
<tr>
<td>Anaesthetist when risk factor requires</td>
<td>Interpersonal conflict over case management</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Protocol Violation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Slips/trips and falls</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unavailability of Health Records</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Compromised staffing levels impacting on safe levels</td>
<td></td>
</tr>
<tr>
<td></td>
<td>of care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Delivery Suite staffing levels impacting on safe</td>
<td></td>
</tr>
<tr>
<td></td>
<td>levels of care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Delivery Suite Coordinator taking inappropriate</td>
<td></td>
</tr>
<tr>
<td></td>
<td>caseload</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Delay in treatment impacting on patient care</td>
<td></td>
</tr>
</tbody>
</table>

**Service / Other**

- 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

**Maternity Staffing Red Flags**

- Unable to provide 1:1 care in established labour
- No breast feeding support given in the 1-2hrs
- Maternal/Fetal IV Antibiotics not given within 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
- Unable to facilitate a Home Birth
Appendix 6: Maternity Clinical Incident Review Meeting

TERMS OF REFERENCE

1. Constitution

1.1 The maternity service has established a group known as the Clinical Incident Review Meeting; this group is accountable to the Maternity Risk Management Forum.

1.2 The Maternity Risk Management Forum has only those powers delegated in these Terms of Reference.

2. Authority

2.1 The meeting is authorised by the Head of midwifery and obstetric speciality lead to investigate any matter within these Terms of Reference. It is authorised to seek any information it requires from any employee, and all employees are directed to cooperate with any request made by the group.

3. Purpose

3.1 To provide a forum for the multidisciplinary review and identification of learning outcomes of clinical incidents reported via the electronic reporting system (datix)

3.2 Ensuring that the care provided to families within the countywide maternity services is conducted to the highest standard following evidence based guidelines, as part of the structured risk management process. Applying the principles of ‘fair’ blame in a supportive information gathering environment.

4. Membership

4.1 Core membership
- Maternity Risk Manager(Chair)
- Practice Development Midwife (Deputy)
- Consultant Obstetrician – Delivery Suite Lead
- Duty Delivery Suite Obstetric Consultant
- Consultant Anaesthetics –Delivery Suite Lead
- Midwifery Matrons
- Supervisor of Midwives
4.2 **Associate members**
- Head of Midwifery
- Neonatal representative
- Any band 7 midwife
- Antenatal and newborn screening coordinator (screening specific incident only)

4.3 Any midwife, obstetrician anaesthetist or member of the neonatal team can attend the meeting unless a particular case has been judged by the chair as being not for open discussion, in which case the chair will declare the meeting a closed meeting and non essential members will be asked to leave.

5. **In Attendance**

5.1 Anyone attending the meeting must:
- Ensure confidentiality
- Not repeat any of the discussions outside the meeting
- Refer to staff involved by their designation not by name
- Adhere to the RCHT Trust Values
- Carry out any actions designated to them and report back at the agreed time

6. **Quorum**

6.1 Chair or Deputy
   Obstetric representation
   Midwifery representation
   Supervisor of Midwives

7. **Frequency of Meetings**

7.1 1\textsuperscript{st}, 3\textsuperscript{rd} & 4\textsuperscript{th} Thursday in each month

8. **Secretariat**

8.1 Minutes by Chair

9. **Duties**

9.1 To review the notes of the clinical incidents reported, to identify if the care given was to an appropriate standard, to give feedback to individual staff or general feedback in the Maternity Risk Management Newsletter.

9.2 To make recommendations for practice changes, training requirements or audits to be discussed and implemented at the Maternity Risk Management Forum and Maternity Forum.

10. **Reporting arrangements into the Board from this group/committee**

10.1 This meeting reports into the Maternity Risk Management Forum.
10.2 The Divisional Governance Lead completes a monthly report for the Divisional Board which includes exception reporting from the Maternity Risk Management Forum.

10.3 The minutes of the Board shall be provided to the Quality & Safety Group and Governance Committee. The Chair of the board will raise any matters of significance or particular concern with the Medical Director, Head of Quality & Safety or apply them to the Divisional Risk Register.

10.4 The Board will report annually to the Quality & Safety team on its work.

11. Reporting arrangements into this group/committee(s)

11.1 Datix incident forms.

12. Other Matters

12.1 The terms of reference will be reviewed annually as part of the Maternity Risk Management Strategy.

12. Process for monitoring compliance with all of the above

12.1 Compliance monitoring as per the Maternity Risk Management Strategy.

13. Meeting Planner

13.1 The Datix's received each week will be reviewed by the Maternity Risk Manager and the health records obtained and reviewed at each meeting.

13.2 A database of attendance at the meeting, cases discussed and learning outcomes is kept by the chair of the meeting.

13.3 Feedback forms of cases discussed with individual staff are kept electronically by the chair of the meeting.

14. Corporate Statements

<table>
<thead>
<tr>
<th>Date approved by Committee/Group:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date accepted by RCHT Trust Board:</td>
</tr>
<tr>
<td>Date due for Review:</td>
</tr>
<tr>
<td>Date Reviewed:</td>
</tr>
</tbody>
</table>
### Appendix 7:

**Obstetric Risk Management Forum**

**TERMS OF REFERENCE**

<table>
<thead>
<tr>
<th>1</th>
<th>Constitution</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>The maternity service has established a group known as the Maternity Risk Management Forum; this group is accountable to the Women’s, Children’s and Sexual Health Board.</td>
</tr>
<tr>
<td>1.2</td>
<td>The Maternity Risk Management Forum has only those powers delegated in these Terms of Reference.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2</th>
<th>Authority</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1</td>
<td>The Forum is authorised by the Head of Midwifery and Obstetric Speciality Lead to investigate any matter within these Terms of Reference. It is authorised to seek any information it requires from any employee, and all employees are directed to cooperate with any request made by the Board.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1</td>
<td>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.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4</th>
<th>Membership</th>
</tr>
</thead>
</table>
| 6.1 | **Core Members: expected attendance 75%**  
Maternity Risk Manager (Chair)  
Consultant Obstetrician – Delivery Suite lead (Deputy)  
Divisional Governance Lead  
Maternity Matron  
Delivery Suite Lead Midwife  
In patient ward Managers  
Community Team Leader  
Supervisor of Midwives (SOM)  
Practice Development Midwife  
Speciality Clinical Audit Lead |
| 6.2 | **Associate Members**  
On service week Obstetrician  
Senior Paediatrician  
Senior Anaesthetist  
Complaints and Litigation Managers |
- Antenatal and newborn screening coordinator (screening specific incident only)

5 In Attendance

5.1 Any midwife, obstetrician anaesthetist or member of the neonatal team can attend the meeting unless a particular case has been judged by the chair as being not for open discussion. In which case the chair will declare the meeting a closed meeting and non essential members will be asked to leave.

6 Quorum requires 4 members

6.3 Maternity Risk Manager / Divisional Governance Lead
Consultant Obstetrician Delivery Suite lead / Service week obstetrician
Maternity Matron / Band 7 deputy
Practice Development Midwife
Supervisor of Midwives

7 Frequency of Meetings

7.1 8 times a year.

8 Secretariat

8.1 Papers to the chair 10 days before meeting
Agenda and papers distributed a week in advance
Minutes completed within a week of the meeting

9 Duties

9.1 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.

9.2 To provide advice on all matters relating to risk management within the countywide maternity services.

9.3 To oversee the service specific training and updating needs for the maternity service.

9.4 To review attendance of all staff, on a quarterly basis, at service specific training and updating sessions.

9.5 To co-ordinate the investigation of all incidents and ‘near miss’ incidents within the countywide maternity services. Receive SI reports, root cause analysis reports and monitor arising action plans.

9.6 To review upheld claims, complaints and PALS enquiries and monitor action plans.
9.7 To receive reports on the maternity risk registers, monitor action plans and escalate risks to Divisional Board as appropriate.

9.8 To ensure compliance with the Maternity Services Risk Management Strategy and Trust policies on risk.

9.9 To encourage multidisciplinary reporting of all clinical incidents within the countywide maternity services of agreed trigger factors.

9.10 To promote a pro-active approach to risk management to all disciplines within maternity services.

9.10 To ensure effective communication between maternity services and Trust communication processes.

9.11 To enable adequate support mechanisms for staff involved in adverse clinical incidents.

9.12 To receive monthly data from the clinical incident review meeting (CIRM).

9.13 To produce a monthly Maternity Risk Management Newsletter providing an overview of activity within the service, incidents reported, complaints and PALS enquiries received, well managed incidents, lessons learnt and learning opportunities. A list of new guidelines ratified and any other relevant risk management news.

9.14 To receive the results of audits and compliance monitoring reports, identify any deficiencies, develop action and monitor related action plans.

9.15 To ensure the Maternity Annual Clinical Audit Plan is developed and monitored in line with the Trusts procedure for clinical audit.

9.16 To organise and maintain the Maternity Risk Management Forum in accordance to the Terms of Reference.

9.17 Ensure that internal and external communication including recommendations and alerts from national bodies e.g. NPSA are used to improve care and enhance safety where relevant.

10 Reporting arrangements into the Board from this group / committee

10.1 The Divisional Governance Lead completes a monthly report for the Divisional Board which includes exception reporting from the Maternity Risk Management Forum.

10.3 The minutes of the Board shall be provided to the Quality & Safety Group and Governance Committee. The Chair of the Board will raise any matters of significance or particular concern with the Medical Director, Head of Quality & Safety or apply them to the Divisional Risk Register.
10.2 The Board will report annually to the Quality & Safety team on its work.

11 Reporting arrangements into this group / committee(s)

11.1 The Clinical Incident Review Meeting
11.2 The Maternity Guidelines Group

12 Other Matters

12.1 The terms of reference will be reviewed annually as part of the Maternity Risk Management Strategy.

13 Process for monitoring compliance with all of the above

13.1 Compliance monitoring as per the Maternity Risk Management Strategy.

14 Meeting Planner

3rd Friday in every month

15 Corporate Statements

| Date approved by Committee/Group: |  |
| Date accepted by RCHT Trust Board: |  |
| Date due for Review: |  |
| Date Reviewed: |  |
Appendix 8:

Appendix 9:

**Maternity Guidelines Group**

**TERMS OF REFERENCE**

1. **Constitution**

The maternity services has established a group known as the Maternity Guideline Group, this group is accountable to the Obstetric Risk Management Forum.

The Maternity Guideline Group has only those powers delegated in these Terms of Reference.

2. **Authority**

The Maternity Guideline Group has been authorised by the Head of Midwifery for the development, production and distribution of clinical guidelines to all midwives, obstetricians and allied health professionals.

3. **Purpose**

Ensuring that the care provided is conducted to the highest standard by employing a structured approach within the Acute Maternity Unit, Birth Centres and Community environments through the development, production and distribution of evidenced based clinical guidelines.

4. **Membership**

4.1 **Core Members**

- Practice Development Midwife (Chair)
- Maternity Risk Manager (Deputy)
- Midwifery Matron
- Obstetrician
- Neonatal Representative
- Anaesthetist
- Community Midwife
- Core Team Midwife
- Supervisor of Midwives

4.2 **Associate members**

Any professional who has specialist knowledge in the guideline being produced.

5. **In Attendance**
A representative from each discipline involved in maternity services will attend the meeting.

6. **Quorum 50% of core members to include:**

   Practice Development Midwife  
   Risk Management Midwife  
   Obstetrician  
   Midwifery Matron/Band 7 midwife or other core Team Midwife  
   Supervisor of Midwives

7. **Frequency of Meetings**

   Monthly

8. **Secretariat**

   Draft guidelines to the chair 10 days before meeting.  
   Agenda and papers distributed a week in advance.  
   Minutes completed within a week of the meeting.

9. **Duties**

   9.1 Ensuring that the care provided to families within the countywide maternity services is conducted to the highest standard following evidence based guidelines, as part of the process of integrated governance.

   9.2 Coordinate the review of all existing guidelines.

   9.3 Identify new guidelines when required and co-opt relevant professionals to help in the development of said guidelines. To ensure a common written format for all guidelines.

   9.4 To appraise new NICE guidance and inform the service accordingly.

   9.5 Review and benchmark the service on the recommendations from all the Confidential Enquiries. Report any non-compliance to the Trust board.

   9.6 Ensure full consultation and ratification of new guidelines, both locally and Trust wide.

   9.7 The group will be responsible for identifying training issues in relation to new guidance.

   9.8 The group will be responsible for the distribution of guidelines and ensuring the archiving of the old guidelines.

   9.9 Coordinate the review of existing patient information and develop new information as required.
9.10 To provide an annual report to the Obstetric Risk Management Forum on monitoring compliance with clinical guidelines.

10. **Reporting arrangements into the Board from this group / committee**

10.1 The Maternity Guideline Group reports into the Obstetric Risk Management Forum.

10.2 The Divisional Governance Lead completes a monthly report for the Divisional Board which includes exception reporting from the Obstetric Risk Management Forum.

10.3 The minutes of the Board shall be provided to the Quality & Safety Group and Governance Committee. The Chair of the board will raise any matters of significance or particular concern with the Medical Director, Head of Quality & Safety or apply them to the Divisional Risk Register.

10.4 The Board will report annually to the Quality & Safety Team on its work.

11. **Reporting arrangements into this group / committee(s)**

11.1 Clinical Incident Review Meeting.

12. **Other Matters**

   The terms of reference will be reviewed annually as part of the Maternity Risk Management Strategy.

13. **Process for monitoring compliance with all of the above**

   Compliance monitoring as per the Maternity Risk Management Strategy.

14. **Meeting Planner**

   First Thursday in every month

15. **Corporate Statements**

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<th>Date approved by Committee/Group:</th>
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<tr>
<td>Date accepted by RCHT Trust Board:</td>
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<td>Date due for Review:</td>
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