Doncaster and Bassetlaw Hospitals NHS
NHS Foundation Trust

Maternity Services Risk Management Strategy

This procedural document supersedes: Maternity Services Risk Management Strategy - CORP/RISK 16 v.7 published January 2013

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Amendment Form

Please record brief details of the changes made alongside the next version number. If the procedural document has been reviewed **without change**, this information will still need to be recorded although the version number will remain the same.

Version	Date Issued	Brief Summary of Changes	Author
Version 8	27 June 2016	• Minor changes due to the restructure of the CSUs into CARE groups and the new versions of Trust policies and the new Trust committees • CORP/RISK 30 • CORP/RISK 15 • CORP/RISK 13	Mounir Hanna
Version 7	July 2012	**Amendments** ➢ Amended Risk management Process – Appendix 7 ➢ Compliance Monitoring for Lead Professionals ➢ LSAMO Annual Report ➢ Amended Immediate Escalation to Trust Board ➢ New style Trust format (7 January 2013)	Andrea Squires Claire Keegan
Version 6	March 2012	**Amendments** ➢ Introduction ➢ Scope ➢ Maternity Risk Management Objectives ➢ Maternity Structure ➢ Maternity Risk Register escalation process ➢ Reporting, monitoring and learning ➢ Obstetric triggers	Carol Lee Claire Keegan
Version 5	August 2010	**Amendments** ➢ Reorganisation of introduction section ➢ Minor change to purpose section ➢ Changes to maternity risk management objectives to ensure they are measurable ➢ Risk management roles and responsibilities and risk management structures amended in accordance with changes made to Trust Risk Management Strategy. ➢ Monitoring of compliance-in accordance with Maternity Service clinical Governance monitoring Document. Specifics removed from this document ➢ Removed maternity committees link chart as covered in appendix x1- maternity Clinical Governance structures **New Additions** ➢ Addition of immediate escalation process to Trust Board - section 8 Flow chart detailing risk escalation process	Sharon E Smithson Carol Lee Claire Keegan

Contents

1. INTRODUCTION

1.1 The Maternity Service Risk Management Strategy is written in accordance with the Trust Risk Management Strategy and related documents. The Maternity Risk Management Strategy will be amended following publication of a revised Trust Risk Management Strategy which will reflect recent changes to trust structures.

1.2 This Risk Management Strategy sets out the principles, processes and strategic direction of Risk Management for Maternity Services within the Children and Families Governance Group. The framework in place to support the implementation of a rigorous risk management process is outlined along with the overall objectives.

1.3 The Maternity Service is committed to achieving an integrated system of governance focusing on continuous improvements in quality and in the control and reduction of risk.

1.4 The Maternity Service within Doncaster and Bassetlaw Hospitals Foundation Trust (DBHFT) is committed to providing high quality women focused care, by seeking to ensure appropriate standards of professional competence, confidence and clinically effective delivery of safe services.

1.5 This strategy will be reviewed and approved through the Maternity and Gynaecology Clinical Governance Group (MGCGG) and presented to the Care Group Clinical Governance Group following review.

1.6 The Trust will comply with the UKNSC guidance on managing screening incidents. All providers contributing to a screening pathway have a joint accountability to ensure safe and coherent screening for the population screened in accordance with national service specifications. Each provider is accountable for the safe and coherent delivery of their part of the screening pathway and has joint accountability at the interface with another provider. Providers of screening services have a responsibility to operate within this guidance.

2. PURPOSE

2.1 The purpose of this document is to define the Maternity Service Risk management systems and processes and their relation to Trust wide risk management.

3. SCOPE

3.1 This document describes the framework that the Maternity Service uses to identify, manage and reduce the risks (actual or potential) which exist within the Maternity Service and its environment.

3.2 This document provides the framework for Risk Management within Maternity Services. This applies to all staff working with Maternity Services in all settings and describes the arrangements for ensuring that lessons learnt from all incidents, complaints and claims are actively disseminated to all staff.

4. DEFINITIONS

These definitions are in accordance with those in the Trust Risk Management Strategy (CORP/RISK 30):

4.1 Risk

Defined by the government in 'An organisation with a Memory' as "the likelihood, high or low, that somebody or something will be harmed by a hazard, multiplied by the severity of the potential harm" (2000).

4.2 Risk Management

Described as a five stage process namely:

1. The identification of all risks which have potentially adverse affects on the Trust's business and the safety of patients, staff and visitors, together with the quality of service.
2. The assessment and evaluation, elimination and reduction of the risks identified.
3. The creation of a system for the protection of assets and income combined with a cost effective service.
4. The creation of a management environment in which pro-active and positive action is taken to eliminate or reduce risks and ineffective or inappropriate working practices.
5. The creation of an environment in which staff are encouraged and supported to report errors, near misses and untoward incidents so that learning and improvement is the outcome.

4.3 Clinical Governance

Defined by the Government in "A First Class Service: Quality in the New NHS" as "a framework through which NHS organisations are accountable for continuously improving the quality of their services and safe-guarding high standards of care by creating an environment in which excellence in clinical care will flourish".

4.4 Incidents

In this strategy an untoward incident includes any occurrence which was not as expected and includes accidents, complaints and claims.

4.5 Serious Incidents

Serious Incidents (SI) are those incidents reported as per the trust policy on the management of serious incidents and which are investigated using a root cause analysis methodology

4.6 Acceptable Risk

The Trust recognises that eliminating all risk is not possible and that systems of control must not be so rigid that they stifle innovation, creativity and the imaginative use of resources. In this context, the Board of Directors defines "acceptable" as follows: An acceptable risk is one which has been accepted after proper evaluation and is one where proper controls have been implemented. The acceptance of a risk should represent an informed decision to accept the likelihood of that risk. It must be:

- Identified and entered on the Risk Register
- Quantified (Consequences and Likelihood)
- Reviewed and have been deemed acceptable by the Board of Directors
- Controlled and kept under review

4.7 Dashboard

The dashboard is the reporting tool which senior managers and the Board of Directors use to monitor performance. The dashboard contains a range of performance measures which are colour coded green, amber and red depending on progress made against the target.

4.8 Risk Register

The Trust' corporate Risk Register is a register of all of the extreme risks which are recorded in the Trust. It includes action plans to mitigate the risks and progress against these plans.

The Risk Register identifies which staff member is leading on the mitigation of the list and the initial and residual risk score. The Risk Register is reviewed and updated monthly.

The Maternity and Gynaecology Risk Register forms part of the Speciality Clinical Governance Group. The Risk Register is reviewed and updated monthly at the Maternity and Gynaecology Clinical Governance Forum. Further detail is found in section 8.8.

5. MATERNITY RISK MANAGEMENT OBJECTIVES

5. 1 The Children and Families Care Group is committed to reducing healthcare risks and to implementing risk management at all levels throughout the Maternity Service this will be achieved through the following:

- Ensuring risk and patient safety awareness is an integral part of everyone's role within Maternity Services and that all grades and disciplines of staff report incidents, potential risks and near misses. All staff groups complete adverse incident forms.

- All staff receive appropriate training in risk management as set out in the Maternity Service Training Needs Analysis and Trust SET Statutory & Essential Training.

- All staff will undertake appropriate training to enhance safe practice. Training will be specific to their role and skill level as set out in the Maternity Service Training Needs Analysis. Examples include Obstetric emergency skills and drills, electronic fetal monitoring interpretation and neonatal resuscitation.

- All staff have access to the Maternity Service Risk Management Strategy and Maternity Quarterly Risk Management Report.

- Systematic review and analysis of all Serious Incidents, incident trends, emergent themes from adverse incident reporting, and clinical claims will identify opportunities to improve patient care, and changes required to clinical practice / policy formation.

- Where appropriate, incidents will be reported to other agencies e.g. PCT, the NPSA, the Director of Public health, MBRRACE, NHS Litigation Authority and Local Supervising Authority.

- The Care Group Risk Register will be proactively maintained to ensure risks are identified, managed and where appropriate escalated to Trust level via the care group

- Staff will receive feedback concerning risk management, governance issues via:
    - The Quarterly Risk Management Report
    - Patient Safety Bulletin and Boards
    - Ward handover briefs
    - Audit meetings, Perinatal mortality
    - DatixWeb.

- Learning outcomes from incidents, near miss events, case reviews, Root Cause Analysis, complaints and clinical claims will be disseminated to all appropriate staff and the organisation. Dissemination will be via the Patient Safety Boards and Quarterly Risk Management Report.

- To monitor and review the implementation of policy/ guideline/ practice change from lessons learned and trends analysis.

- To ensure the MGCGG Monitoring Document is utilised and continually developed.

- Annually review staffing of clinical areas and review skill mix to ensure leadership and safe clinical practice is maintained, for all disciplines of staff.

- All midwives will have an annual supervisory review undertaken by their allocated Supervisors of Midwives.

6. RISK MANAGEMENT ROLES AND RESPONSIBILITIES/LEADERSHIP

The roles and responsibilities in relation to risk management are set out within this strategy and the Trust Risk Management strategy [CORP/RISK 30]:

6.1 All Employees

6.1.1 All employees of the Trust, including contractors and temporary/agency staff are responsible for assisting in the implementation of this policy and highlighting any areas of risk in line with this policy.

6.1.2 All staff employed by, or working within the Trust have an individual responsibility to report all adverse incidents they are involved in or may witness. They should be familiar and comply with the Risk Management Strategy including filling online DATIX forms and with other appropriate policies and procedures. All staff should attend mandatory training as required.

6.1.3 All staff are accountable for achievement against agreed personal objectives, which contribute to organisational objectives.

6.1.4 The Maternity Services support an open, honest and participative culture where clinical incidents are reported, lessons are learned and, where appropriate, systems of care are improved as a result.

6.2 Trust Level

The Trust level risk management structures are taken from the Trust Risk Management Strategy (CORP/RISK 30) and can be found on the organisational chart in Appendix 1.

6.2.1 Board of Directors

6.2.1.1 The Board of Directors are responsible for reviewing the effectiveness of Internal Controls – financial, organisational and clinical. The Board is required to produce statements of assurance, which demonstrate that it is doing its 'reasonable best' to ensure that the Trust meets its objective and protects patients, staff, the public and stakeholders against risk of all kinds.

6.2.1.2 To inform the annual Statement on Internal Control (SIC) made by the Chief Executive in the annual accounts, the Board of Directors must be able to demonstrate that they have been informed, through the assurance

framework about all significant risks and that they have arrived at their conclusions on the totality of risk, based on the evidence presented to them.

6.2.2 Chief Executive

The Chief Executive is responsible for risk management as the accountable officer within the DBHFT. The Chief Executive is responsible for ensuring that a risk management system is established, implemented and maintained in accordance with this policy. The Chief Executive ensures that, so far as it is reasonably practical, resources are available to manage risk.

6.2.3 Executive Directors

Executive Directors have overall responsibility for the implementation of the risk management strategy. They are responsible for the oversight of the processes for identifying and assessing risk, and for advising the Chief Executive as necessary. They must ensure that so far as it is reasonably practical resources are available in order to manage risk. They are responsible for establishing and maintaining a forum within their divisions for the open discussion of risk management incidence and topics. Further specific responsibilities are outlined below.

6.2.4 Medical Director/Director of Nursing, midwifery and quality

6.2.4.1 The Medical Director and Director of Nursing midwifery and quality support the Chief Executive in the day-to-day management of organisational/strategic risk and will ensure that all over-arching risk management standards are complied.

The Medical Director and the Director of Nursing, midwifery and quality, on behalf of the Chief Executive, have overall responsibility for risk throughout the Trust that has a direct impact upon patient care and safety.

6.2.4.2 The Medical Director is responsible for:

- Clinical Governance,
- Care Quality Commission registration requirements,
- Accountability for practice,
- Clinical and professional leadership and development,
- Clinical research and supervision,
- Contribution to the commissioning of education,
- Clinical audit and outcome measures,
- Professional leadership and development,
- Implementation of training and development policies,
- Caldicott Standards and Information Governance Initiatives and processes,
- Human Tissue Act,
- Maternity Executive Lead (see Maternity Structures).

6.2.4.3 The Director of Nursing, midwifery and Quality is responsible for:

- Clinical Governance,
- Care Quality Commission registration requirements,
- Accountability for practice,
- Clinical and professional leadership and development,
- Clinical research and supervision,
- Contribution to the commissioning of education,
- Clinical audit and outcome measures,
- Professional leadership and development,
- Implementation of training and development policies,
- Healthcare Associated Infections (HCAI),
- Safeguarding Vulnerable Adults,
- Safeguarding Children.

6.2.5 Care Group Managers

Care Group Managers will ensure that it has, within its managerial structure, a lead for:

- The development of a Care Group Risk Register.
- The implementation of risk management systems and processes, both clinical and non-clinical, in each ward or department concerned.
- Compliance with Care Quality Commission registration requirements.
- Ensuring attendance of staff at appropriate education and training sessions.
- Implementing specific policies and procedures.
- Raising risk awareness among all staff at operational level.

6.2.6 Head of Patient Safety and Experience

The Head of Patient Safety and Experience will be responsible to the Director of Nursing, Midwifery and Quality and is responsible for:

- Implementation, Co-ordination and monitoring of risk management activity within the Trust, ensuring that systems and processes are in place for the continuous effective management of risk in line with this policy and National Health Service Litigation Authority.
- The review of risk management performance through the interrogation and trend analysis of incident reporting, PALS, Complaints and Claims data held in the Trust Risk Management Database. (DATIX) The analysis of this data will form part of a quarterly aggregated governance report to the Patient Safety Review Group and by way of an executive summary to the Clinical Governance Quality Committee.

- Ensuring smooth functioning of the incident reporting system and be responsible for the day-to-day management of the Trust's Risk Management Database (DATIX) and operational Risk Management activity, including the management of serious incidents.

6.2.7 Care Groups

6.2.7.1 Will be responsible to their Care Group Director and manager and ultimately the Chief Executive for the implementation of the Trust Risk Management Strategy within their respective areas of responsibility. Specifically they will:

- Develop a Care Group Risk Register, and action plans for the management of risk in their area.
- Ensuring that all identified risks are added to the Care Group Risk Register and treated locally where the score is less than 8 and where control measures are within delegated financial limits. Risk over 8 and less than 15 to be escalated to the Care Group Governance forum.
- Establishing and maintaining a forum within their Department/Care group for the open discussion of risk management incident and topics.
- Ensuring care group compliance with the various external assurance assessments, e.g. NHSLA Acute and Maternity Risk Management Standards.

6.2.7.2 The responsibility of the following can be found in the Trust Risk Management Strategy (CORP/RISK 30):

- Director of people and Organisational Development.
- Director of Finance.
- Director of Facilities and Commercial Development.
- Director of Performance.
- Director of Strategy and Improvement.
- Head of Information Governance and Registration Authority Manager.
- Occupational Health Manager.
- Health and Safety Manager.
- Legal Services Manager.
- Fire Officer.
- Manual Handling Manager/ Coordinator (clinical and non-clinical).
- Radiation Protection Committee.
- Infection Prevention and Control Team.
- Local Security Management Specialist.
- Local Counter Fraud Specialist.
- Director of Education.
- Divisional and Business Unit Teams.

6.3 Duties of named individuals responsible for Risk within the Maternity Service

The Maternity Services Risk Management Structure is detailed in Appendix 2.

6.3.1 Lead Executive at Board Level

6.3.1.1 The Medical Director is the named Lead Executive at Trust board with specific responsibility for Maternity Services.

6.3.1.2 He/she will gain assurance from the maternity service by:

- Receiving the Maternity Quarterly Risk Management Report and monthly copies of the Maternity and Gynaecology Clinical Governance Group minutes.
- Attendance at Clinical Governance Quality Committee, Patient Safety Review Group and attending the Maternity and Gynaecology Clinical Governance Group on an annual basis.

6.3.2 Maternity and Gynaecology Clinical Governance Leads

The individual leads for Doncaster and Bassetlaw have overall operational responsibility for the management of clinical governance delegated by the Care Group Governance Lead, including risk management within Maternity and Gynaecology. Specific responsibilities are outlined in the Trust Clinical Governance Strategy 2008 -2011.

6.3.3 Clinical Risk Coordinator

The Maternity and Gynaecology Matron coordinates and ensures risk management is effective in all clinical areas and supports the role of the Maternity and Gynaecology Clinical Governance Lead.

6.3.4 Head of Midwifery/General Manager

Children and Families Care Group Head of Midwifery/General Manager support the Clinical Governance Lead in executing their duties, ensuring risk management processes and frameworks are in place within maternity services and across the Care Group on both sites.

6.3.5 Care Group Director

The Care Group Director supports the Care Group Governance Lead and Speciality Governance Lead in executing their duties, ensuring risk management processes and frameworks are in place within maternity services and across the Care Group on both sites.

6.3.6 Lead Obstetricians for CDS/ Labour Ward

There is an individual lead for CDS/ Labour Ward matters on each site. They are responsible for providing clinical leadership and organisation for all medical staff working in the labour ward. In conjunction with the labour ward lead midwives

they will ensure good inter-professional relationships are maintained and ensures that outcomes/ recommendations are implemented and monitored through the framework of clinical governance.

6.3.7 CDS/Labour Ward Lead Midwives

There is an individual lead on each site. They are responsible for the clinical leadership of midwives and support workers working on the labour wards. They will work closely with the labour ward lead obstetricians and anaesthetists to ensure effective inter-professional relationships. They will ensure that risk management processes are effective within the clinical area and address policy and practice changes effectively.

6.3.8 Lead Obstetric Anaesthetist

There is an individual lead on each site. They are responsible for the clinical leadership of anaesthetists providing care on the labour ward and are involved in the management of complex cases. They are actively involved in the development of policy development and implementation of changes following incidents or where risk issues are identified.

6.3.9 Ward and Departmental Managers

The manager of each clinical area supports the risk management processes at local level. They are responsible for the clinical leadership of midwives and midwifery support workers working on the individual clinical area. They will ensure that risk management processes are effective within the clinical area and address policy and practice changes effectively.

6.3.10 Supervisor of Midwives

6.3.10.1 All supervisors of midwives provide cross-site cover on the 24/7 on call rota. All are actively involved in escalation of identified risks through the clinical governance framework.

6.3.10.2 Incidents occurring which involve midwifery practice issues will also require a supervisory investigation. This occurs in collaboration with the LSA and following national Supervisory Guidelines.

6.3.10.3 A supervisor of midwives will be involved in the investigation of all Serious Incidents (SI). All Serious Incidents will be reported to the Local Supervising Authority (LSA).

6.3.10.4 Supervisors of midwives will support the implementation and monitoring of any action plans and lessons learned from any internal or external incidents/risk issues.

6.4 Monitoring Compliance of Leadership Arrangements

The Care Group will monitor compliance by undertaking annual review of the key aspects of the role of the Leaders for risk mentioned above, using a pro forma (Appendix 8).

The key aspects to be reviewed are:

- Attendance at key meetings.
- Participation in investigations relating to patient incidents.

Findings from the review will the discussed at the MGCGG. Action plans will be devised and monitored by this group on a monthly basis. The Maternity Risk Coordinator will be responsible for ensuring actions are implemented in a timely manner.

7. RISK MANAGEMENT COMMITTEE STRUCTURES

7.1. Trust Risk Management Committee Structures

The Trusts Governance Structures can be found in Appendix 1 of the Trust Risk Management Strategy (CORP/RISK 30).

All committees/groups within the structure have a responsibility for escalating risk issues discussed at the committee in line with the trust escalation process: however the following groups have specific functions pertaining to risk management:

- Audit and Non Clinical Risk Sub Committee (ASC).
- Clinical Governance Quality Committee.

Terms of Reference for each group are set out in the Trust Risk Management Strategy [CORP/RISK 30].

7.1.1 Audit and Non-clinical Risk Committee (ANCRC) and Clinical Governance Oversight Committee (CGOC)

The ANCRC and CGOC are established as governance sub-committees of the Board of Directors. The committees' primary role in respect of risk management is to seek assurance on behalf of the board that internal control and risk management systems are sufficiently robust to ensure delivery of organisational objectives. Where there are significant concerns or gaps in assurance or control, the committees escalate these to the board.

The ANCRC focuses on non-clinical risk areas, while the CGOC focuses on clinical risk and governance. Both committees review the assurance framework and receive the Corporate Risk Register.

The ANCRC also monitors the integrity of the financial statements of the Trust, while the CGOC monitors clinical governance standards.

7.1.2 Clinical Governance Quality Committee (CGQC)

This is a sub-committee of the Board of Directors and is responsible for the development of a strategic approach to clinical governance across the organisation.

7.2 Maternity Structure

7.2.1 Maternity and Gynaecology Clinical Governance Group (MGCGG)

The terms of reference are in Appendix 3.

7.2.1.1 This is the group for overseeing and steering effective management of all risks associated with maternity services.

7.2.1.2 There is a single Maternity and Gynaecology Clinical Governance Group, which incorporates both Doncaster and Bassetlaw Sites.

7.2.1.3 The Maternity and Gynaecology Clinical Governance Lead chairs the meetings. They are supported in this role by the Matron who is the vice chair.

7.2.1.4 The group meets monthly as part of the governance agenda and undertakes the following:-

- Receives monthly trend analysis from each area, and reviews risk issues including trends from all clinical areas.
- Reviews complaints and claims.
- Encourage appropriate incident reporting within the Specialty.
- Review all adverse events to identify significant risks to facilitate improvement of patient safety, and to influence audit.
- The MGCGG monitors and reviews the Maternity and Gynaecology Risk Register as part of the Care Group Risk Register.
- The Maternity Services Quarterly Risk Management Report is received and discussed at the MGCGG. The meeting will identify appropriate actions required in response to the report. This report is received by the Trust Board and the Maternity Executive Lead. The executive summary is presented to the CGSC.
- To ensure all serious and dangerous incidents are reported to the Medical Director within the required time scale, using the standard reporting form.

- Recommend and facilitate all investigations of adverse incidents and complaints, including root cause analysis, and to ensure shared learning throughout the Specialty and Trust-wide, as appropriate.

- Assist the Trust in NHSLA Risk Management Assessment compliance.

- Assist the Trust in compliance with the Standards for Better Health.

- Ratify local Policies and Procedures, and Maternity Service Guidelines and initiate identified training requirements.

- Discuss any relevant Care Group and Clinical Governance Quality Committee and Patient Safety Review Group issues, pertinent to the Specialty and to minute those discussions in the group meeting.

- Review and implement the findings and recommendations of National Confidential Enquiry Reports pertinent to the Specialty.

- Review and implement the findings and recommendations of any High Level Enquiries pertinent to the Specialty.

- Review and implement the National Institute of Clinical Excellence (NICE) Guidance, as appropriate and take into account nationally agreed guidance when planning and delivering treatment and care.

- Monitor infection prevention and control issues and ensure compliance with policies.

- On receipt of the annual LSA report Supervision of midwives will produce and action plan which along with the report will be presented and reviewed at Maternity and Gynaecology Clinical Governance Group.

- Ratifies final draft Maternity and Gynaecology Guidelines and Policies.

7.2.1.5 Minutes are received by the care group forum and the Trust Clinical Governance and Quality Committee and the Maternity Executive Lead.

7.2.2 CDS / Labour Ward Forum

7.2.2.1 This multi-disciplinary cross-site forum meets on alternate months and is chaired by the Labour Ward Lead obstetrician with the support of the Labour Ward lead midwives and the Guideline Pathway Coordinator.

7.2.2.2 Minutes are received from MGCGG in order to implement policy / practice changes from identified risks.

7.2.2.3 The group also receives and implements recommendations from National directives including, NICE, NSF, MBRRACE and the Care Quality Commission.

7.2.2.4 Minutes are disseminated to the MGCGG for action of any potential or identified risk issues.

Terms of Reference can be found in Appendix 4.

7.2.3 Audit Meeting

7.2.3.1 Audit meetings are held monthly, minutes and action points are disseminated to MGCGG and CDS/Labour Ward Forum.

7.2.3.2 Any identified risk management issues are used to inform the audit activity plan. Clinical Governance and Adverse Incidents are standing agenda items.

Appendix 1 highlights the communication links between the above groups.

8. RISK MANAGEMENT PROCESSES

8.1 There is a need to ensure a common approach for the management of risk across the Trust that supports the assurance and business requirements of the board.

Risk is identified proactively at a local or corporate level in response to a potential or known problem which has not resulted in a known incident, or reactively once an incident has occurred.

8.2 Risk management is a systematic process of:

- Identification
- Analysis and evaluation
- Control
- Review

Trust processes for proactive and active risk identification can be found in the Trust Risk Management Strategy (CORP/RISK 30).

8.3 Proactive Risk Identification

- Annual Trust Wide risk assessment
- Ad hoc risk assessment
- Assurance framework

For further detail please see Trust Risk Management Strategy (CORP/RISK 30).

8.4 Reactive Risk Identification

- Adverse incident and near miss reporting
- Complaint reporting

- Claims
- External assessments from reviews
- Risk Register

For further detail please see Trust Risk Management Strategy (CORP/RISK30).

8.5 Maternity Risk Management Processes

8.5.1 Risk Management Processes within the Maternity Services include (see Appendix 7):-

- Adverse Incident and Near Miss Reporting
- Maternity and Gynaecology Risk Register
- Multi-Disciplinary Team meetings,
- Case note review
- Review of incidents, claims and complaints
- Root Cause Analysis meetings
- Quarterly Risk management Report
- Dissemination of lessons learnt to all staff

8.6 Adverse Incident Reporting

8.6.1 The reporting of adverse incidents, near misses and serious incidents must be carried out using the guidance of the following policies:-

- Adverse Incident Reporting CORP/RISK 13
- Serious Untoward Incident CORP/RISK 13

8.6.2 Trust guidance includes the use of the RCA process for all SI's including the involvement of an appropriate unbiased external individual.

8.6.3 Specific obstetric trigger incidents are outlined in Appendix 6.

8.7 Risk Assessments, Analysis and Evaluation

8.7.1 Risk assessments will occur in accordance with the Policy for the Reporting and Management of Incidents and Near Misses CORP/RISK 13.

8.7.2 Identified an analysis of the risks will be undertaken using the Trust's Risk Scoring Matrix **(Appendix 7).** This involves making an estimate of the probability and frequency of the risk occurring; its impact, consequence and a consideration of all action required. All assessed risks will be recorded on the appropriate Risk Register.

8.8 Control, Action and Review Guidance

The assessed level (grade) of the risk will determine what action is to be taken. This is detailed in the Risk Register and Risk Assessment Procedures.

8.9 Risk Register

The Maternity service is responsible for maintaining the Maternity and Gynaecology Care Group Risk Register to ensure that risks are systematically identified and addressed at the appropriate level in the organisation.

The Risk Registers will be populated as a result of risk assessments, incidents, complaints and claims (Appendix 7). Risks will be scored using the matrix presented in Appendix 6.

8.10 Escalation Process

- The escalation process is shown in Appendix 7.

- Risk Assessments undertaken and scoring below nine are maintained on local ward and department Risk Registers.

- Risk assessments scoring 8 or above or where wards and departments cannot manage the risk, are escalated for discussion and review at the monthly MGCGG for inclusion on the Maternity and Gynaecology Risk Register and escalated to the Care Group Governance Lead.

- The Maternity and Gynaecology Risk Register is a standing agenda item on the MGCGG.

- The Maternity and Gynaecology Risk Register, comprising Maternity and Gynaecology and is a standing agenda item at the Care Group Senior Management Team Meeting.

- Any risk identified as “Extreme” (15 or above) that cannot be controlled and managed within the Care Group will be escalated to the Corporate Risk Register for consideration by the Executive Team via the MGCGG/SMT minutes.

- Action Plans must accompany all risk assessments and be maintained at the level of the appropriate Risk Register. Local action plans will be reviewed quarterly by the ward /department Manager.

- The MGCGG review all clinical risks and actions taken/planned on a monthly basis, and will monitor progress against action plans.

- The Care Group Senior Management Team Meeting will review all changes to the Speciality Risk Register.

8.10.1 Immediate Escalation of Risks to Trust Board

Where issues are such that immediate escalation to Trust Board is required e.g. maternal death the following process is initiated:-

Action	Recipient	Documentation
Immediate Phone Call	In hours: Head of Midwifery/Deputy to the Trust Director of Nursing Services and the Medical Secretary	On the appropriate Pro Forma/Checklist i.e. Maternal Death Checklist, Suspension of Admissions Checklist (Pro Forma/Checklist can be found in the Appendix of the relevant Guideline/Policy)
	Out of hours: Senior Midwife/Supervisor of Midwives on call and on call Trust Executive	
Confirmation Email within 24 hours	Trust Director of Nursing, Medical Director and Head of Midwifery	Copy to be filed with Adverse incident Form
Completion of Adverse Incident Form	In accordance with Trust Serious Incident Policy (CORP/RISK15)	

9 REPORTING, MONITORING AND LEARNING

9.1 Learning from risks, incidents and other such events is key to developing a culture in the Care Group that welcomes knowledge of such events as an opportunity to improve patient care, the services offered within the Care Group and the working environment and safety of staff.

9.2 All reported incidents, complaints and legal claims are entered on the Trust Datix risk management database and information retrieved is used to inform the MGCGG of incidents, claims, and complaints activity, trends and analysis. The MGCGG will receive the following reports on a monthly basis for review and discussion:

- Monthly clinical incident report from each ward and department with a synopsis of trends.
- Quarterly Risk Management Report.
- Complaints and claims are discussed within the Quarterly Risk Management Report and a verbal report is given at each meeting.
- Quarterly Training Report

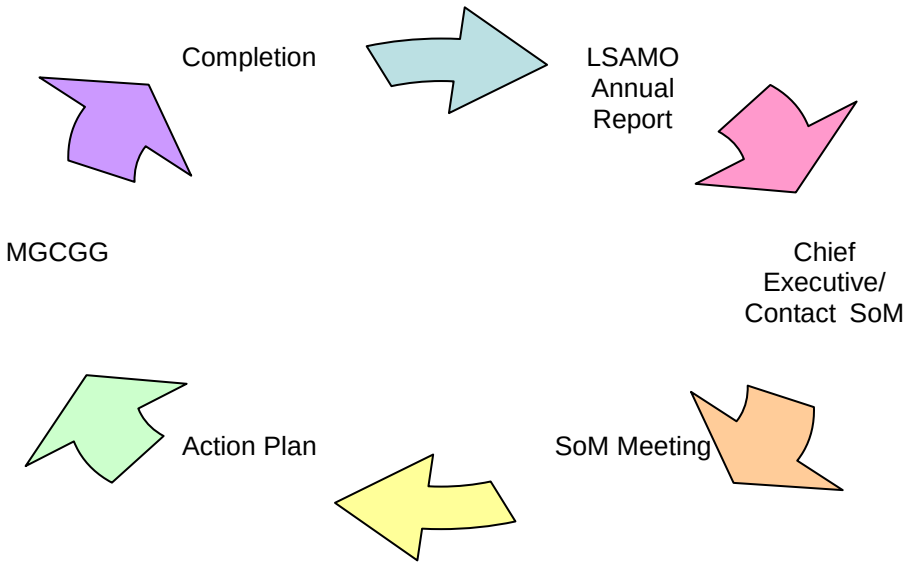
9.3 Any actions which are identified during discussion of the above reports will be entered onto an MGCGG action plan and monitored monthly at MGCGG.

9.4 Communicating the 'learnt lessons' from internal incidents, claims, and complaints is an important factor in the Care Group approach to managing risk:

- Display of the Quarterly Risk Management Report.
- Action plans resulting from Serious Incidents, case reviews, internal incidents, complaints and claims will be displayed on all Ward and Department Patient Safety Boards.
- Learning will be identified and disseminated through a number of forums including Audit, Perinatal Mortality and CDS forum where practice change will be implemented.
- Discussion at handover brief and Patient Safety Bulletin.

10. LOCAL SUPERVISING MIDWIFERY OFFICERS' ANNUAL REPORT

The LSAMO provides an annual report to the Chief Executive and the Contact Supervisor. Any issues that are identified will be subject to the formulation of an action plan by the Supervisors of Midwives Team at the Supervisor of Midwives Team Meeting within two months of the report being received, and included in the annual work plan. The action plan will be continuously reviewed by Supervisor of Midwives Team and reported to the MGCGG until completion has occurred.



11. RISK MANAGEMENT AWARENESS TRAINING

Risk management awareness training will be delivered in accordance with the Risk Management Strategy [CORP/RISK 30] and the Maternity Services Training Needs Analysis.

12. MONITORING COMPLIANCE

Compliance will be monitored in accordance with the Maternity Clinical Governance Monitoring Document. The MGCGG will have overall responsibility for monitoring this Strategy and the key objectives within it. Where deficiencies are identified an action plan will be developed and actioned via this group.

13. EQUALITY IMPACT ASSESSMENT

An Equality Impact Assessment (EIA) has been conducted on this procedural document in line with the principles of the Equality Analysis Policy (CORP/EMP 27) and the Fair Treatment for All Policy (CORP/EMP 4).

The purpose of the EIA is to minimise and if possible remove any disproportionate impact on employees on the grounds of race, sex, disability, age, sexual orientation or religious belief. No detriment was identified. See Appendix 9.

14. REVIEW OF STRATEGY

The MGCGG will formally review the strategy at least every three years and approve any amendments.

The Trust will formally approve the strategy through the Clinical Governance Quality Committee.

15. TRUST POLICIES LINKED TO THIS STRATEGY

- Risk Identification, Assessment and Management Policy - CORP/RISK 30
- Policy for the Reporting and Management of Incidents and Near misses - CORP/RISK 13
- Being Open and Duty of Candour Policy CORP/RISK 14
- Serious Incidents (SI) Policy - CORP/RISK 15

16. REFERENCES

Department of Health (2007) *Maternity matters: choice, access and continuity of care in a safe service.* London: COI. www.dh.gov.uk

Department of Health (2000) *an organisation with a memory. London, DH*

Healthcare Commission (2006) *Learning From investigations: London: Commission for health Care Audit and Inspection* www.healthcarecommisons.org.uk

National Patient Safety Agency (November 2009) *Patient Safety Notice 2009/PSA003* November 2009

National Patient Safety Agency (November 2009) *Being Open Policy- Communicating Patient Safety Incidents with patients and their carers,*

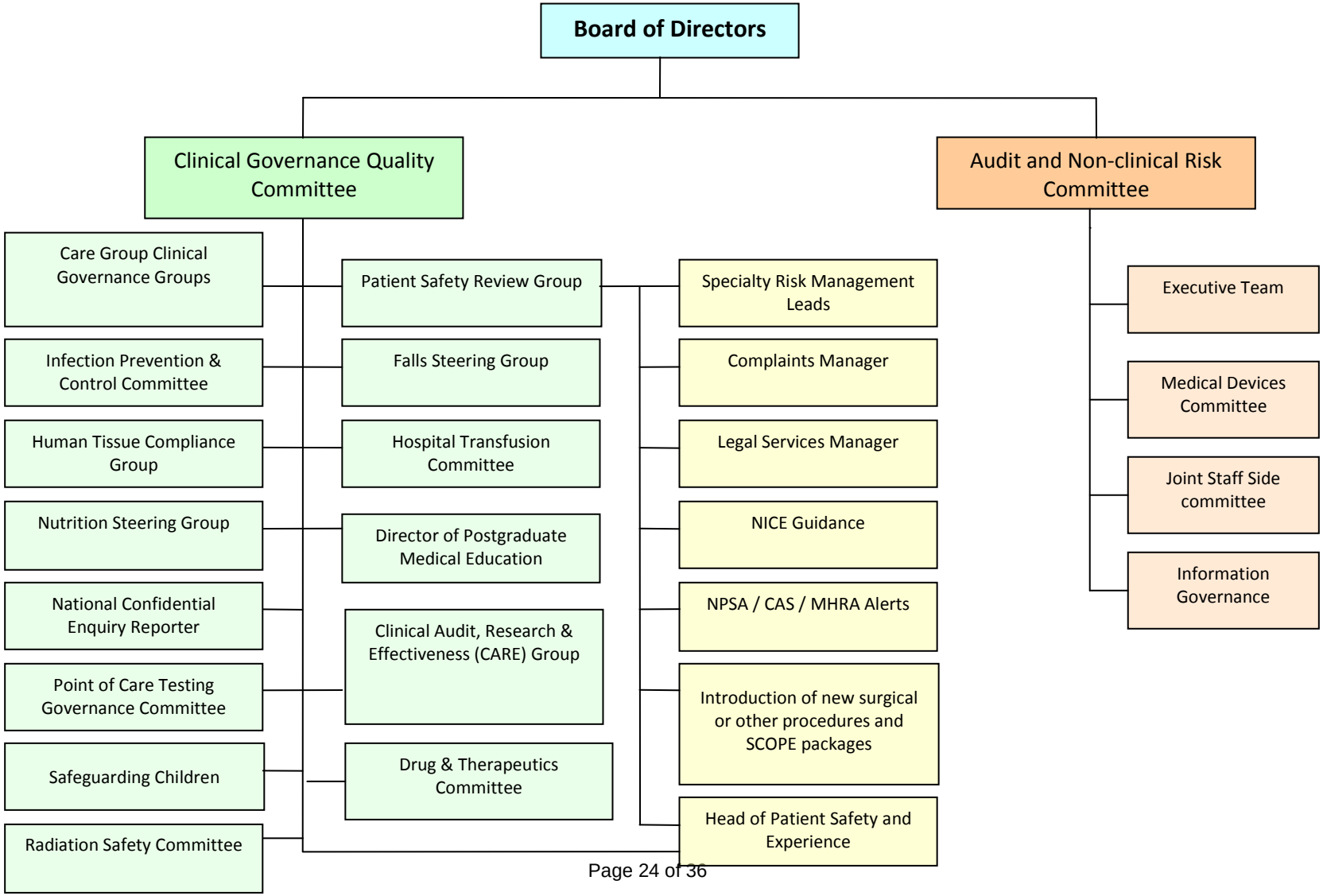
National Patient Safety Agency (April 2004), *Seven Steps to Patient Safety*

National Health Service Litigation Authority (January 2010) *Risk Management Standards*

National Health Service Litigation Authority (May 2009) *Apologies and Explanations.* Letter to chief executives and finance directors

Royal College of Anaesthetists, Royal College of Midwives, Royal College of Obstetricians and Gynaecologists, Royal College of Paediatrics and Child Health. *(2007). Safer Childbirth: Minimum Standards for the organisation and delivery of Carte in labour. London, RCOG. Press. www.rcog*

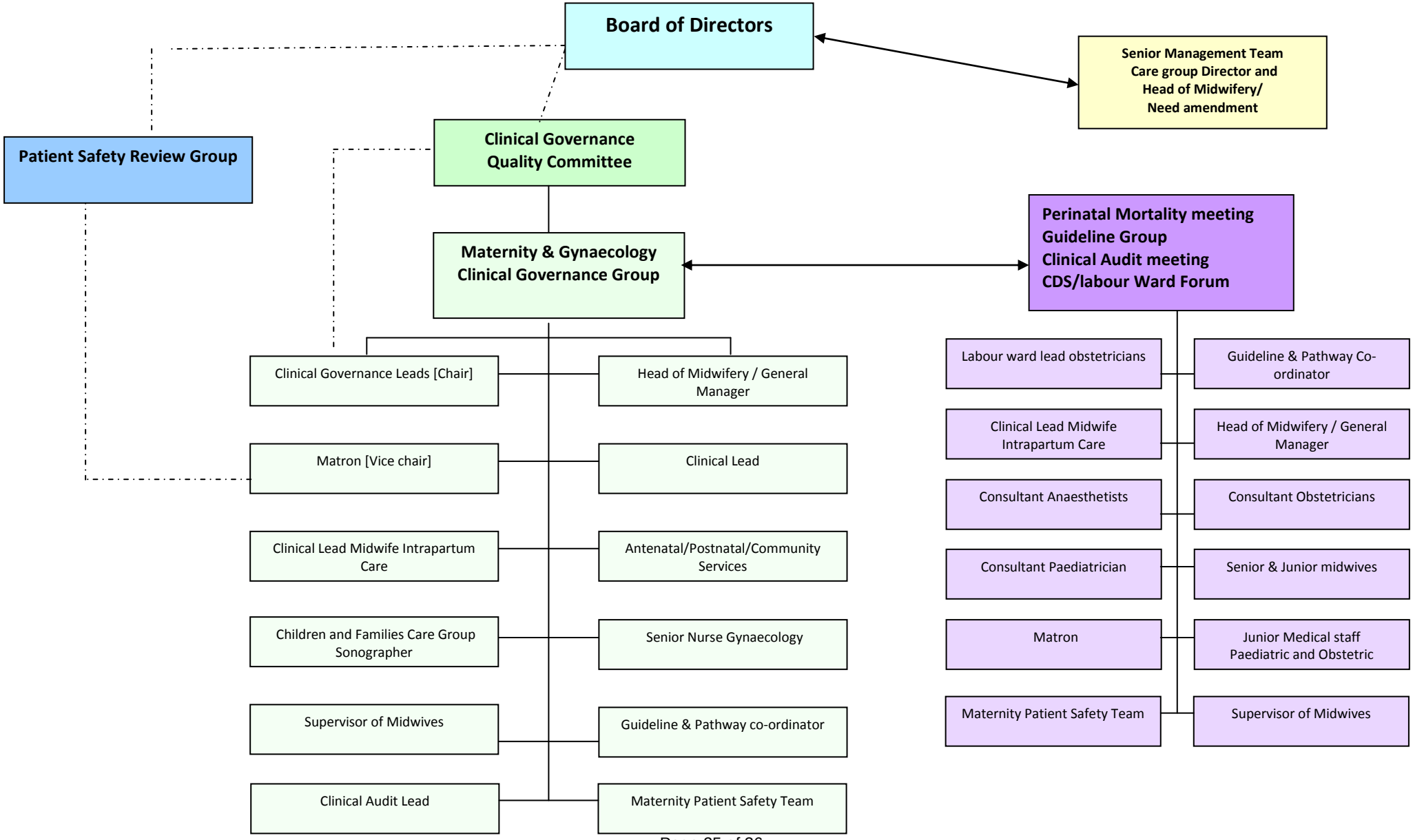
Trust Risk Management Structure



Maternity Risk Management Structure

Appendix 2

CORP/RISK 16 v.8



APPENDIX 3 – SPECIALTY CLINICAL GOVERNANCE GROUP

DONCASTER & BASSETLAW HOSPITALS
NHS FOUNDATION TRUST

Specialty Clinical Governance Group

Terms of Reference

1. The Specialty Clinical Governance Group is a sub-committee of the Care group Governance. The Specialty Clinical Governance Group meets monthly and the minutes are circulated to :

   - Clinical Governance Quality Committee
   - Senior Management Team
   - Maternity Lead Executive

   The minutes of the Specialty Clinical Governance Group will include the names and designations of attendees.

2. The Specialty Clinical Governance Group will have the following multi-membership :

   - Specialty Clinical Governance Lead (Chair)
   - Matron or individuals of a similar status (Vice Chair)
   - Clinical Lead
   - Multi-disciplinary and multi-site representatives from Specialty
   - Supervisor of Midwives.

3. The Specialty Clinical Governance Group will only be deemed quorate if the following requirements are met:

   - The Chair and/or Vice Chair is present
   - There must be at least half of the members in attendance, including the Chair and/or Vice Chair, one of which must hold Consultant status within the Specialty.
   - In the event of the group being non-quorate, the meeting may continue on an 'information exchange' basis at the discretion of the chair.

4. The Specialty Clinical Governance Group's objectives are to:

   - Receives monthly trend analysis from each area, and reviews risk issues including trends from all clinical areas.
   - Review complaints and claims.

- Encourage appropriate incident reporting within the Specialty.
- Review all adverse events to identify significant risks to facilitate improvement of patient safety, and to influence audit.
- The MGCGG monitors and reviews the Maternity and Gynaecology Risk Register as part of the Care Group Risk Register.
- The Maternity Services Quarterly Risk Management Report is received and discussed at the MGCGG. The meeting will identify appropriate actions required in response to the report. This report is received by the Trust Board and the Maternity Executive Lead. The executive summary is presented to the CGSC.
- To ensure all serious and dangerous incidents are reported to the Medical Director within the required time scale, using the standard reporting form.
- Recommend and facilitate all investigations of adverse incidents and complaints, including root cause analysis, and to ensure shared learning throughout the Specialty and Trust-wide, as appropriate.
- Assist the Trust in NHSLA Risk Management Assessment compliance.
- Assist the Trust in compliance with the Standards for Better Health.
- Ratify local Policies and Procedures, and Maternity Service Guidelines and initiate identified training requirements.
- Discuss any relevant Clinical Governance Quality Committee and Patient Safety Review Group issues, pertinent to the Specialty and to minute those discussions in the group meeting.
- Review and implement the findings and recommendations of National Confidential Enquiry Reports pertinent to the Specialty.
- Review and implement the findings and recommendations of any High Level Enquiries pertinent to the Specialty.
- Review and implement the National Institute of Clinical Excellence (NICE) Guidance, as appropriate and to take into account nationally agreed guidance when planning and delivery treatment and care.
- Monitor infection prevention and control issues and ensure compliance with policies.
- On receipt of the annual LSA report Supervision of midwives will produce and action plan which along with the report will be presented and reviewed at Maternity and Gynaecology Clinical Governance Group.
- Ratifies final draft Maternity and Gynaecology Guidelines and Policies.

5. The Specialty Clinical Governance Group Agenda will follow the standard pro-forma. Further items for inclusion on to the agenda will be given to the Chair or Vice Chair one week in advance of the meeting date and an Agenda will be prepared and distributed to members in advance of each meeting.

6. In addition to presenting the minutes of its meetings, the speciality clinical governance group will report to the Care Group Clinical Governance monthly. The report will include the specialities action plan which will outline the key

actions/objectives the speciality will undertake to develop clinical governance and improve the quality of care to patients within the next 12 months.

7. The Specialty Clinical Governance Group will report to the Patient Safety Review Group on a quarterly basis. The report will include detailed analysis (with actions and/or recommendations) of the following:

- Complaints
- Claims
- Adverse Incident Report.

APPENDIX 4 – CENTRAL DELIVERY SUITE [CDS]/LABOUR WARD FORUM - TERMS OF REFERENCE

DONCASTER AND BASSETLAW HOSPITALS NHS FOUNDATION TRUST
CHILDREN AND FAMILIES CARE GROUP

CENTRAL DELIVERY SUITE [CDS]/LABOUR WARD FORUM

TERMS OF REFERENCE

1 The forum multidisciplinary and meets bi-monthly. Minutes are circulated to:
- Maternity and Gynaecology Clinical Governance Group
- Maternity and Gynaecology Guideline Group

2. Membership includes:
- Labour ward lead obstetrician (both sites)
- Labour ward lead midwives (both sites)
- Clinical guideline and Pathway coordinator
- Consultant Anaesthetist
- Consultant Paediatrician
- Junior midwifery and obstetric staff
- Supervisor of Midwives

Attendance is essential to ensure an effective meeting.

A record of attendance and notes/action log of each meeting will be produced.

Where members are unable to attend a meeting it is their responsibility to send a deputy wherever possible.

3. The Forum will be deemed quorate if a Consultant Obstetrician is present and three other members.

Where the meeting is not quorate the meeting may continue in an information exchange basis.

Objectives

- To ensure the intrapartum care provided is safe, evidence based, responsive to the needs of the women and of a high standard.

- To ensure intrapartum care is subject to ongoing audit, and the results are considered, any change implemented and re-audit planned.

- The forum will review labour ward activity and identify issues for action, ensuring liaison with the Obstetric and Gynaecology Clinical Governance Group where

issues of concern are highlighted.

- Identify areas suitable for audit and liaise with the audit lead to ensure the subjects are included in the audit calendar.

- Review intrapartum equipment requirements.

- Review training needs in accordance with the Maternity Training Plan in relation to the provision of intrapartum care.

APPENDIX 5 – OBSTETRIC INCIDENT TRIGGERS

Obstetric Incident Triggers

Obstetric specific incidents that require reporting:

- Apgar – less than 6 at 5 minutes
- BBA
- Cord Ph - <7.1
- Misinterpretation of CTG
- Delay – over 30 minutes for emergency LSCS
- Duration of labour > 18hrs
- Eclampsia
- Fetal laceration at LSCS
- Maternal death
- Maternal Emergency – Blood loss > 1500mls
- Obstetric Emergency – Cord prolapse
- Extensive perineal trauma (3rd and 4th degree tears)
- Re-admission post partum
- Stillbirth
- Shoulder dystocia +/- suspected brachial plexus injury
- Undiagnosed breech
- Suspension of Maternity Services
- Postpartum urinary retention 1000mls or more
- Unexpected admission to NNU

APPENDIX 6

Qualitative Measures of Consequences (Actual / Potential) –
select the descriptors which best fit the risk you have identified

PART 1

Descriptor	Insignificant 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
Injury (Physical/ Psychological)	►Adverse event requiring no/minimal intervention or treatment.	►Minor injury or illness – first aid treatment needed ►Health associated infection which may/did result in semi permanent harm ►Affects 1-2 people	►Moderate injury or illness requiring professional intervention ►No staff attending mandatory / key training ►RIDDOR / Agency reportable incident (4-14 days lost) ►Adverse event which impacts on a small number of patients ►Affects 3-15 people	►Major injury / long term incapacity / disability (e.g. loss of limb) ►>14 days off work ►Affects 16 – 50 people	►Fatalities ►Multiple permanent injuries or irreversible health effects ►An event affecting >50 people
Patient Experience	►Reduced level of patient experience which is not due to delivery of clinical care	►Unsatisfactory patient experience directly due to clinical care – readily resolvable ►Increase in length of hospital stay by 1-3 days	►Unsatisfactory management of patient care – local resolution (with potential to go to independent review) ►Increased length of hospital stay by 4 – 15 days	►Unsatisfactory management of patient care with long term effects ►increased length of hospital stay >15 days ►Misdiagnosis	►Incident leading to death ►Totally unsatisfactory level or quality of treatment / service
Environmental Impact	►Onsite release of substance averted	►Onsite release of substance contained ►Minor damage to Trust property – easily remedied <£10K	►On site release no detrimental effect ►Moderate damage to Trust property – remedied by Trust staff / replacement of items required £10K - £50K	►Offsite release with no detrimental effect / on-site release with potential for detrimental effect ►Major damage to Trust property – external organisations required to remedy - associated costs >£50K	►Onsite /offsite release with realised detrimental / catastrophic effects ►Loss of building / major piece of equipment vital to the Trusts business continuity
Staffing & Competence	►Short term low staffing level (<1 day) – temporary disruption to patient care ►Minor competency related failure reduces service quality <1 day ►Low staff morale affecting one person	►On-going low staffing level - minor reduction in quality of patient care ►Unresolved trend relating to competency reducing service quality ►75% - 95% staff attendance at mandatory / key training ►Low staff morale (1% - 25% of staff)	►Late delivery of key objective / service due to lack of staff ►50% - 75% staff attendance at mandatory / key training ►Unsafe staffing level ►Error due to ineffective training / competency we removed ►Low staff morale (25% - 50% of staff)	►Uncertain delivery of key objective / service due to lack of staff ►25%-50% staff attendance at mandatory / key training ►Unsafe staffing level >5days ►Serious error due to ineffective training and / or competency ►Very low staff morale (50% – 75% of staff)	►Non-delivery of key objective / service due to lack of staff ►Ongoing unsafe staffing levels ►Loss of several key staff ►Critical error due to lack of staff or insufficient training and / or competency ►Less than 25% attendance at mandatory / key training on an on-going basis ►Very low staff morale (>75%)
Complaints/ Claims	►Informal / locally resolved complaint ►Potential for settlement / litigation <£500	►Overall treatment / service substandard ►Formal justified complaint (Stage 1) ►Minor implications for patient safety if unresolved ►Claim <£10K	►Justified complaint (Stage 2) involving lack of appropriate care ►Claim(s) between £10K - £100K ►Major implications for patient safety if unresolved	►Multiple justified complaints ►Independent review ►Claim(s) between £100K - £1M ►Non-compliance with national standards with significant risk to patients if unresolved	►Multiple justified complaints ►Single major claim ►Inquest / ombudsman inquiry ►Claims >£1M
Financial	►Small loss ►Theft or damage of personal property <£50	►Loss <£50K ►Loss of 0.1 - 0.25% of budget ►Theft or loss of personal property <£750	►Loss of £50K - £500K ►Loss of 0.25 – 0.5% of budget ►Theft or loss or personal property >£750	►Loss of £500K - £1M or loss of 0.5 – 1% of budget ► Purchasers failing to pay on time	►Loss > £1M or loss >1% of budget ►Loss of contract / payment by results

Appendix 6

Part 2 Consider how likely the outcomes (descriptors) are to happen

Qualitative Measures of Likelihood

Level	Descriptor	Example
1	Rare	Difficult to believe that this will ever happen / happen again
2	Unlikely	Do not expect it to happen / happen again, but it may
3	Possible	It is possible that it may occur / recur
4	Likely	It is likely to occur / recur, but it is not a persistent issue.
5	Almost certain	Will almost certainly occur / recur, and could be a persistent issue

3 Using the Risk Rating Matrix determine the Severity (Extreme / High / Moderate / Low)

Risk Rating Matrix

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

E = Extreme Risk – Immediate action required (stop the activity)

H = High Risk – Senior Management attention needed

M = Moderate Risk – Management responsibility must be ascertained.

L = Low Risk – Manage by routine procedures

Appendix 7

Maternity Risk Management Process

Removal of Risk from Register

Action	Forum
Action plan completed	Agreed at MGCGG
Down grade risk to Level 1	Agreed at MGCGG
Remains at Level 1 for at least 1 month	Agreed at MGCGG
Remove from Risk Register	Agreed at MGCGG

Risk identified via risk assessment, incident, claim, complaint and other patient experience

Risk assessment completed by appropriate member of staff e.g. departmental head

Grade the risk to determine the route for management

Immediate Escalation to Trust Board

Action	Recipient
Immediate Phone Call	In hours: Head of Midwifery/Deputy to the Trust Director of Nursing Services and the Medical Secretary
	Out of hours: Senior Midwife/Supervisor of Midwives on call and on call Trust Executive
Confirmation Email within 24 hours	Trust Director of Nursing, Medical Director and Head of Midwifery
Completion of Adverse Incident Form	

0 – 8 (Low/Moderate)
Identified risks monitored at ward/department level

Entered onto Ward/Department Risk Register and monitored monthly by Manager and MGCGG

9 -14 (High)
Identified risks monitored at ward/department level and Care Group level

Entered onto Care Group Risk Register and monitored monthly by MGCGG

15 > (Extreme)
Identified risks monitored at Care Group level and corporate level via minutes for consideration and further action

Entered onto Care Group Risk Register and Corporate Register considered, monitored monthly by MGCGG and CGSC

Risks entered onto the Corporate Risk Register will be reported to Management Board via the Head of Corporate Affairs for monthly review, and to the Audit and Non-clinical Risk Committee for quarterly review

Appendix 8

Monitoring Compliance with Lead Professional								
	Attendance at MGCGG	Attendance at CDS Forum	Attendance at SMT Meeting	Investigation	Minutes of Meeting	Communication/ Correspondence	% Compliance	Action
Director of Nursing								
Clinical Governance Lead								
Clinical Risk Coordinator								
Professional Leads								
Lead Obstetricians for CDS/LW								
Lead Midwives for CDS/LW								
Lead Obstetric Anaesthetist								
Ward/Dept Managers								
Supervisor of Midwives								

APPENDIX 9 – EQUALITY IMPACT ASSESSMENT PART 1 INITIAL SCREENING

Policy	Care Group/Executive Directorate and Department	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
Maternity Services Risk Management Strategy	Children and Families Care Group Director	Mounir Hanna	Revised Strategy	March 2016

1. Who is responsible for this policy? Children and Families Care Group Director

2. Describe the purpose of the policy? To define the Maternity Service Risk management systems and processes and their relation to Trust wide risk management.

3. Are there any associated objectives? The Children and Family Care Group is committed to reducing healthcare risks and to implementing risk management at all levels throughout the Maternity Service

4. What factors contribute or detract from achieving intended outcomes? Compliance with the policy

5. Does the policy have an impact in terms of age, race, disability, gender, gender reassignment, sexual orientation, marriage/civil partnership, maternity/pregnancy and religion/belief? No

6. If yes, please describe current or planned activities to address the impact N/A

7. Is there any scope for new measures which would promote equality? N/A

8. Are any of the following groups adversely affected by the policy?

a. Protected Characteristics	Affected?	Impact
b. Age	No	
c. Disability	No	
d. Gender	No	
e. Gender Reassignment	No	
f. Marriage/Civil Partnership	No	
g. Maternity/Pregnancy	No	
h. Race	No	
i. Religion/Belief	No	
j. Sexual Orientation	No	

9. Provide the Equality Rating of the service/ function/policy /project / strategy

Outcome 1 ✓	Outcome 2	Outcome 3	Outcome 4

10. Date for next review: **January 2019**

Checked by: Mounir Hanna **Date:** 21 March 2016