Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Maternity Services Risk Managements Strategy

This procedural document supersedes: Maternity Services Risk Management Strategy - CORP/RISK 16 v.8 published 27 June 2016

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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 9	17 March 2021	Major Changes Please Read in Full	Lois Mellor Emma Merkuschev Denise Morgan
Version 8	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	• 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	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** • Re-organisation 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.	Sharon E Smithson Carol Lee Claire Keegan

		• 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	

Contents

Page No.

1 INTRODUCTION

- All services and clinical care within healthcare are not risk free. It is important however, to minimise risks and to ensure that when making decisions, those doing so are deliberately choosing to make judgements from a range of fully detailed and understood options.
- Adverse incidents are in most cases a result of a lack of clear procedures and policies or non-compliance with both, poor working practices and/or training, inadequate communications, environmental hazards or staff working beyond their competence.
- The Maternity service aims to reduce the potential for incidents in the proactive management of risk. All staff have a role in managing risk through compliance with Trust Policies and procedures, maintaining competence, identifying and responding to hazards and reporting incidents. This Strategy sets out how the Maternity Services aims to manage its risks.
- Where organisational systems or genuine human errors occur the Maternity Service is committed to ensure that the patient and or families are told openly and honestly when errors occur which cause harm to a mother or the baby

2 PURPOSE

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

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. 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 Identification, Assessment and Management Policy CORP/RISK 30):

- **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).

- **Risk Management**

  Described as a five stage process namely:

  - The identification of all risks which have potentially adversely effects the Trust's business and the safety of patients, staff and visitors, together with the quality of service.
  - The assessment and evaluation, elimination and reduction of the risks identified.

- The creation of a system for the protection of assets and income combined with a cost effective service.
- 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.
- 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.

- **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".

- **Incidents**

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

- **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.

- **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

- **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.

- **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 Specialty 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.

5 MATERNITY RISK MANAGEMENT OBJECTIVES

- To ensure all serious incidents are reported and managed in accordance with the Serious Incident (SI) Policy – Reporting, Investigating and Learning from Serious incidents CORP/RISK 15
- Ensure compliance in reporting cases to the relevant agencies within set timescales
- To ensure adequate and appropriate staffing levels to provide safe care to women and babies at all times through timely and effective recruitment and retention of staff in all specialities working in maternity.
- To ensure mandatory training is completed and monitored to comply with the requirement of the Trust and the Maternity Incentive Scheme
- Demonstrate the process for identifying risks both clinical and non-clinical and how they are managed within a maternity clinical governance framework, which includes the risk management process. Analyse trends in adverse incidents/near misses/complaints to ensure a system of continuous improvement.
- Provide effective communication to all maternity staff through minutes of meetings/memos/emails/blogs and Newsletters
- Ensure that staff work within written guidelines, policies and protocols, which are easily available and regularly reviewed through audit
- Ensure compliance with national guidance and legislation demands on the Trust are implemented within one year of publication.
- Ensure compliance with relevant national reporting systems in the event of an adverse outcome meeting the set criteria; Each Baby Counts (EBC), NHS Early Resolution Scheme (ERS), Perinatal Mortality Review Tool (PMRT), MBRRACE.
- Ensure cases meeting the set criteria are reported and investigated by the Healthcare Safety Investigation Branch (HSIB)
- Suspected safety or serious screening Incidents within the screening programme will be notified by the Screening Midwives to the QA team and the screening and immunization team at PHE via the Screening incident assessment Form (SIAF).

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 Identification, Assessment and Management Policy [CORP/RISK 30]:

6.1 All Employees

- 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.

- 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.
- All staff are accountable for achievement against agreed personal objectives, which contribute to organisational objectives.
- 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 Identification Assessment and Management Policy (CORP/RISK 30).

6.3 Divisional Roles and responsibilities

Director of Midwifery

The Director of Midwifery oversees the effective implementation and application of all midwifery related Trust policies, procedures and standards within the Directorate with professional responsibility for ensuring compliance with the letter and spirit of such policies. This includes proactively implementing and evaluating the Risk Management and Quality Assurance policies to ensure the Trusts Clinical Governance agenda is adhered to and that strategies are implemented to promote clinical effectiveness, quality care delivery and a safe and healthy work place.

The Director of Midwifery supports the embedding of a governance culture within the midwifery team through communication and monitoring.

This includes facilitating the implementation of an effective Risk Management Strategy for Maternity Services and that relevant training and mandatory updates are provided for all staff.

In conjunction with the matrons, they identify risks to be entered onto the directorate risk register and prioritise risks and develop risk action plans. The Director of Midwifery also advises on risks that may require escalation onto the Trust Corporate risk register and to providing advice on actions required to mitigate those risks.

The Director of Midwifery supports the Divisional Director in ensuring that Serious Incidents are managed in accordance with the agreed approach. They also review clinical incidents, safety reports and Serious Incidents and advise on actions as appropriate.
Together with the Lead Obstetrician for Governance, Governance Midwife form the Quality and Safety Team
The Director of Midwifery and Group Director attend the Quality Assurance and Learning committee and prepare a Maternity Quality and Safety report which includes Directorate Clinical Governance issues for presentation at this committee.

Divisional Director
The Divisional Director works closely with the directorate clinical and administrative teams to assist them with collating the evidence of their areas compliance against clinical governance standards.
The Divisional Director facilitates the compilation of the directorate risk register, noting that ownership of each risk is the responsibility of those who it has been agreed and allocated to, and ensures that risks are raised to Trust Clinical Governance Committee. They advise the Maternity Clinical Governance Committee on compliance with corporate governance systems and processes including policy matters.

Matrons for Hospital and Community Maternity Services
The Matrons lead the embedding of a governance culture within the midwifery care teams, ensuring all staff understands their responsibility for service quality and patient safety and that mechanism are in place to monitor patient safety and for measuring clinical outcomes and other quality measures.
The Matrons are accountable for compliance with clinical governance standards, including NHSR & CQC for midwifery care within the directorate and for ensuring that the teams maintain and provide evidence of compliance against the standards required.
In conjunction with the Director of Midwifery, Clinical Lead & Directorate Manager they identify risks to be entered on to directorate risk register, prioritise risks & develop risk action plans and are responsible for monitoring implementation of actions to reduce risk.
The matrons oversee the effective management of clinical incidents and safety reports and take action as appropriate by ensuring, patient risk assessments, audits and root cause analysis/investigations and ensure remedial actions are taken & records maintained.

Obstetric Governance Lead
The Maternity Clinical Governance Lead has overall accountability for applying clinical governance principles to the delivery of maternity services responsible for ensuring a mechanism is in place to monitor patient safety and measuring clinical outcomes. This includes the use of standard operating procedures, guidelines and protocols pertinent to maternity services; the recording of, reporting of and learning from adverse incidents;

ensuring participation in continuing professional development and the delivery of clinical audit across the department.
The Clinical Governance Lead will ensure that: Maternity services comply with the clinical governance principles, ensuring safe, evidence-based practice, which meets local and national standards.
The Obstetrics and Gynaecology Clinical Lead is. The role is also. This includes.
Principle Responsibilities & Tasks

- accountable for compliance with clinical governance standards including NHSR, for the directorate
- In conjunction with the Director of Midwifery, Medical Leads, the Directorate Manager and the Matrons, the Consultants identify risks to be entered onto the directorate risk register, for prioritising risks and developing risk action plans as appropriate.
- ensuring that the teams maintain and provide evidence of compliance against the standards required
- Prepare agenda and chair monthly Maternity Clinical Governance Committee Meeting
- Collation and distribution of relevant risk management data to staff within maternity services and Trust Clinical Governance Committee where required.
- Advise the Clinical Director and Director of Midwifery of all serious adverse clinical incidents
- To lead and coordinate the department's participation in any internal or external reviews, audits or inspections and prepare follow-up action plans.
- Responsible for completing any relevant clinical governance documentation and be available during any external inspections and make available any such documentation required by the assessors to monitor clinical practice and risk management compliance.

Reports to

The Divisional Clinical Governance lead who will report to the Divisional Director, Director of Midwifery and the Trust Clinical Governance Committee.

Lead Obstetrician for Delivery Suite

Principle Role and responsibilities:

- The lead obstetrician must provide strong professional leadership and support for all disciplines. Working together with the delivery suite manager and lead obstetric anaesthetist, they will ensure that clinical and professional leadership is available to all staff within the delivery suite. In order to do this effectively the lead obstetrician

should maintain a regular presence on delivery suite, by undertaking regular clinical sessions.

- It is important that the lead obstetrician maintains an overview of all adverse incidents that occur on delivery suite and undertakes a rapid response by ensuring that supportive and non-judgemental information gathering meetings are held with the obstetric staff involved as soon as is possible following such an incident. They should play an active role in the rapid instigation of safety measures as and when a risk requiring such measures is brought to light.
- Communicate openly and consult extensively with clinicians and midwives, to manage the performance of the delivery suite in terms of efficient and effective use of all resources, together with the development and maintenance of the highest standards for delivery of patient care.
- They should promote the practice of evidence based medicine, continuous learning, innovation and development. They should encourage and support involvement in research, audit, education and training.
- They should attend the maternity clinical governance meetings and ensure that decisions taken by this committee are translated into clinical practice on the delivery suite by ensuring teaching, training and communicating changes in policy.
- The lead obstetrician should facilitate the collection and availability of perinatal statistics through local reporting and the mechanisms put in place by MBRRACE.
- The Lead co-ordinates the CDS/ Labour Ward forum in conjunction with the Delivery Suite Manager and Matron.
- Responsible to ensure that Caesarean section rate, PPH rate, stillbirth. Off pathway preterm delivery and instrumental delivery rate are within national targets. To achieve this by working together with clinical director, college tutor, intrapartum matron and CDS/LW manager.
- Regularly update oneself with maternity dashboard and quality parameters. Work collaboratively with various leads to improve dashboard performance.
- Ensure maternity guidelines are up to date.
- Provide clinical leadership and organisation for the medical staffs working within labour ward by visible, clinical presence and input in the multidisciplinary teaching sessions which includes case reviews within a supportive and learning environment.
- To support governance team in any labour ward related complaints and investigations into serious incidents.

Lead Paediatrician for Neonatal Care

The lead paediatrician for neonatal care is responsible for setting the standards for neonatal care, which includes neonatal resuscitation training and equipment in all areas where neonatal resuscitation is performed.

The lead neonatologist or deputy attends the Maternity Governance meetings, and is responsible for providing feedback on outcomes for all cases of neonatal morbidity. The lead neonatologist also attends the Perinatal Morbidity and Mortality meeting The lead neonatologist (or deputy) is responsible for liaising with the obstetric department for all matters relating to neonatal care, which includes the provision of clinical guidelines and policies.

Lead Obstetric Anaesthetist

The lead obstetric anaesthetist has overall accountability for applying clinical governance principles to the delivery of maternity anaesthetic services. This includes the use of standard anaesthetic procedures, guidelines and protocols pertinent to anaesthetic services; the recording of, reporting of and learning from adverse incidents; patient information; ensuring participation in continuing professional development and the delivery of clinical audit across the department. Attend monthly maternity clinical governance meetings and report back to the anaesthetic workforce. An annual joint obstetric and anaesthetic meeting is held to discuss and ensure lessons are learnt from adverse outcomes.

The lead in obstetric anaesthesia ensures that:

- An antenatal assessment service is provided to high-risk women with existing co-morbidities.
- 24 hour cover by dedicated delivery suite anaesthetist and nominated "out of hours" consultant to provide analgesia in labour, anaesthetic interventions and care for the critically ill woman
- A full "working hours" consultant-led cover to optimise training of junior staff with high turnover.
- Supervision of junior anaesthetists training according to Royal College of Anaesthetists standards and ensure basic competency is achieved before on call commitments undertaken.
- Monitoring of adverse incidents involving anaesthetic staff and either discuss with individuals concerned or their educational supervisors.
- Investigate, monitor and review all anaesthetic incidents and complaints.
- Perform root cause analysis when required and publish and distribute findings.
- Short term and long term workforce management
- Participate in multidisciplinary training of epidural management and high dependency care of sick patients

Clinical Governance Midwife

The role of the Maternity Clinical Risk Manager is to coordinate clinical risk activities and risk management across maternity services, together with the Lead Obstetrician responsible for

clinical risk, Director of Midwifery & the Quality Improvement and Audit Midwife form the Maternity Quality and Safety Team.

The main responsibilities of the Maternity Clinical Risk Manager are:

- To investigate, monitor and review all Maternity incidents to ensure an appropriate level of investigation is undertaken and actions put in place to reduce or eliminate risk and that learning is shared with all staff.
- To ensure that cases meeting a set criteria are entered onto appropriate national reporting systems StEIS, EBC, NHS ENS and PMRT
- To report all cases meeting the criteria to the Healthcare Safety Investigation Branch (HSIB) and support the investigation process working with the investigators to upload health records and arrange interviews with staff
- To undertake responsibility for initiating the process and monitoring progress of internal investigations and ensuring sign-off within set timescales.
- To meet with the Urgent Divisional Director to update on the progress of all maternity investigations
- To undertake the role of investigating officer for all maternity complaints. To monitor the learning from complaints and implementation of action plans through minutes of meetings, reports and professional development
- Ensure lessons are learned from incidents, complaints and claims through teaching, professional development and written reports
- To assist in the preparations for external assessments such as Care Quality Commission and other external agencies
- To represent maternity on the Patient Safety Committee ensuring matters relating to maternity are discussed and actions from the meetings are disseminated through the clinical Maternity Clinical Governance Committee.
- Support the Director of Midwifery and Head of Legal Services regarding potential and on-going claims relating to maternity care
- To coordinate the Health & Safety activities within maternity
- Prepare and present monthly complaints and incident reports to Maternity Clinical Governance Committee and Midwifery Services Committee.
- Contribute to the annual maternity quality and safety update report for the Board.

CDS/ Labour Ward Manager

The CDS/ Labour Ward Manager is responsible for providing professional leadership and clinical expertise on the CDS/ Labour Ward. The CDS/ Labour Ward Manager will:

- Ensure that services are delivered safely and effectively and support improved patient experience and clinical outcomes delivering high quality, women focussed care.

- Ensure adequate staffing levels at all times to ensure women receive safe and effective care in labour and women who are seriously ill requiring high dependency care.
- The CDS/ Labour Ward Manager will work closely with the Lead Obstetrician for CDS/ Labour Ward to develop common guidelines, education and high clinical standards
- Promote multidisciplinary team working.
- Actively contribute to the implementation of local and national policies and National Service Frameworks.
- Attend Maternity Clinical Governance Committee and sub-committee meetings to provide expert opinion and to ensure recommendations and action plans are implemented.
- Monitor the quality of the environmental standards within CDS/ Labour Ward. Manage any shortfall in service provision.
- Provide effective feedback to staff.
- The CDS/ Labour Ward Manager will ensure all necessary medical equipment is available, in good working order and regularly serviced

Professional Midwifery Advocates (PMA)

Professional midwifery Advocates fulfil the requirements of the A-EQUIP model of clinical midwifery supervision which has been introduced by the Department of Health to replace midwifery supervision which was removed from statute in 2017

Delivery of the A-EQUIP model is mandated within the NHS Standard Contract (NHS England 2017/18) and the model is based upon CQC standards.

The team of PMAs support midwives to learn and reflect from clinical events using restorative clinical supervision. There is close liaison between the PMAs and the senior management team to identify those who would benefit from this support however it can be accessed by any midwife. In addition to this the PMA's have a role in teaching, facilitating and leading service improvement and supporting all midwives to give individual care to women who may require complex care planning.

Education Team

The Education Team is responsible for organising multi-professional training and updating of staff working in maternity. Training is based upon requirements from national guidance and as a result of incidents, complaints and claims.

Education Leads for Maternity

The Education lead is responsible for identifying and addressing the training needs of the multi-disciplinary team which includes doctors, midwives, nurses, recovery nurses, nursery

nurses and maternity care assistants. Training is delivered through structured teaching, support in practice, information sharing and e-learning. All training is captured on a specific database that logs individual's engagement and progress with professional development and skill maintenance. Failure to comply with the required Mandatory Training is addressed as per the Trust Maternity Training Needs Analysis (CG065).

The Education lead also works closely with the Director of Midwifery to identify Professional Development Needs based on the Strategic Plan of the Trust and Succession Planning requirements.

The Education lead is also responsible for the Preceptorship programme that enables a newly qualified midwife to make the transition from Student Midwife to Practicing Midwife a safe yet positive experience.

Maternity Ward/Departmental Managers

All Ward and Departmental Managers are responsible for implementing the clinical risk strategy in the workplace by ensuring:

- All staff know how to report incidents and to escalate serious concerns or serious incidents in a timely manner.
- All incidents and complaints are investigated in accordance with the Trust policies and action plans implemented to avoid recurrence. All complaints relevant to the ward area are discussed at monthly meetings which is evidenced in minutes of ward meetings
- All staff attend mandatory training as outlined in the Maternity TNA.
- All staff are aware of the Trust guidelines/policies/protocols
- Risk assessments are completed and reviewed annually for their area of responsibility. A Risk Register is maintained and reviewed the departmental risk register is populated with red and amber incidents which are escalated to the Matron.

Supporting personnel

The Maternity Services work closely with the Patient Safety and Legal teams.

6.4 Monitoring Compliance of Leadership Arrangements

The Division will monitor compliance by undertaking annual review of the key aspects of the role of the Leaders for risk mentioned above.

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 Maternity Structure

Children's and Families Board
This meeting is chaired by the Divisional Director with the Board Level safety champion as deputy. The Board consists of senior managers from paediatrics, gynae and maternity in the division, CCG representation and the Board Level safety Champion.
The board seeks assurance from the Divisional Clinical Governance Meeting, and report directly to the Trust Clinical Governance and Quality Committee. The Board escalated concerns that cannot be addressed in the Division.

Divisional Clinical Governance Meeting
This meeting is chaired by the Divisional Governance Lead with the Maternity Governance Lead / Clinical Governance Midwife as deputy chair. The meeting has senior representation from all the specialities. The meeting monitors the services and seeks assurance from the speciality governance meetings for paediatric, maternity, gynae and Tri Health.
The meeting provides assurance to the Children's and families Board and / or escalates concerns that cannot be addressed within the Directorates.

Maternity & Gynae Clinical Governance Meeting (Speciality Governance)
This meeting is chaired by the Lead Obstetrician for governance in maternity and the Clinical Governance Midwife (deputy Chair). The Maternity & Gynae Clinical Governance Meeting is established to address all matters relating to governance and clinical and non-clinical risk to build upon and improve the quality of gynaecological and maternity service provision. The committee meets monthly with the exception of. The Committee has multi-professional representation including a lay representative from the Maternity Voices Partnership.
Matters arising from the Trust Quality metrics and speciality groups are discussed as a regular agenda item. The minutes from the Trust Senior Team Management meetings are circulated to the Clinical Governance Leads. The Director of Midwifery reports back discussions from the meeting.
A monthly Trust Risk Management report is produced and presented by the Maternity Clinical Governance Midwife detailing the previous months serious incidents and identifies trends from incident reporting. A summary of complaints is provided.
Red and amber risks on the Maternity Risk Register are reviewed, updated with actions required.

Perinatal Mortality and Morbidity Meeting
The meeting is chaired by the Labour ward/ Central delivery Suit Leads. The Perinatal Mortality and Morbidity Group meets monthly to review incidents within the previous

month where mortality or morbidity has been highlighted. Also within the Perinatal Mortality and Morbidity Meeting PMRT discussions are also undertaken. This is a multidisciplinary meeting with medical, midwifery and neonatal representation. It is responsible for identify risks and themes, learning from incidents related to the maternity and neonatal services and to discuss the maternity dashboard. It escalates risks and concerns to the Maternity and Gynaecology Clinical Governance Meeting.

Perinatal Mortality Review Group
The Perinatal Mortality Review Group meets monthly to review all perinatal deaths and to complete the Perinatal Mortality Review Tool. The aim of the Perinatal Mortality Review Tool (PMRT) is to support standardised perinatal mortality reviews across NHS maternity and neonatal units in England, Scotland and Wales. The tool supports: Systematic, multidisciplinary, high quality reviews of the circumstances and care leading up to and surrounding each stillbirth and neonatal death, and the deaths of babies who die in the post-neonatal period having received neonatal care.
The review tool generates reports which identify learning and actions to be taken and can be shared with the parents.

Maternity Clinical Audit meeting
The group meets a minimum of monthly and is chaired by The Lead of Audit The group reviews local and National standards for maternity services and develops the annual audit programme ensuring its implementation. The group also ensures that the audit results are disseminated to all relevant staff and that changes occur in clinical practice as a result of audits
Additionally a summary of audit reports are posted on the Maternity intranet site and summaries published in the Maternity newsletter, minutes, memos and via email.

Screening Operational meeting
This meeting is chaired by the Director of Midwifery with her deputy as Vice Chair. The group is responsible for the monitoring and delivery of all screening in the Maternity Service. It is a multidisciplinary group from the maternity service, ultrasonography and the laboratories. The group meets quarterly and escalates concerns to the Maternity and Gynae clinical governance meeting.
All screening incidents are signed off by the Director of Midwifery prior to being reported externally to the SIT/QA monitoring for sign off.

Obstetric Case Review meeting / Intrapartum Forum
This group meets weekly and is chaired by the Labour Ward / CDS Lead, this multidisciplinary meeting with medical and midwifery representation. It is responsible for identify risks, learning from incident related to the maternity service. It escalates risks and concerns to the Maternity and Gynae Clinical Governance Meeting.

Senior Midwifery Team Meeting
The Midwifery leaders meet monthly, and is chaired by the Director of Midwifery or deputy to discuss all matters related to Midwifery management and practise. All midwifery managers attend the meetings

Monthly presentations of the mandatory training compliance are presented and actions agreed where levels fall below 80%.
Information is disseminated to staff by ward/departmental managers at meetings and in weekly blogs and is evidenced in the minutes of meetings. The maternity newsletter also covers information from the meeting.

Maternity Clinical Guidelines Group
The Maternity Clinical Guidelines group meets monthly and is chaired by the Consultant Lead for Guidelines and the Clinical governance Midwife as deputy. All policies and operational, clinical/non-clinical guidelines are produced using the Trust 'Procedural Documents Policy (CG001)' template and are approved by the Guidelines Group with the exception of policies which are approved by the Divisional Clinical Governance Committee. Once approved they are posted on the Trust Website
The Clinical Governance Admin and Clinical Governance Lead Consultant co-ordinates the review and posting of all operational policies and clinical/non-clinical guidelines. All reviewed/amended guidelines/policies/protocols/patient information leaflets are archived.

The LMS Steering Group.
This meeting is chaired by the Director of Midwifery with her deputy as vice chair. There is representation for all the work streams related to delivering the LMS agenda, the LMS, CCG's and MVP's. The group is responsible for overseeing the delivery of the Maternity Transformation Programme and escalates concerns to the senior management Team Meeting.

Maternity Voices Partnership Meetings
Maternity Voices Partnership is a team of service users, service user representatives, midwives, doctors and commissioners. The committee work together to review and contribute to the development of local maternity services and to ensure quality standards including clinical risk are paramount. The committee meets quarterly to ensure that women's views are considered in any decisions made about changes in local maternity service. Action plans from complaints and clinical incidents are standing agenda items at this meeting. The MVP's representative has a seat on the LMS steering Group

7.2 Staffing

Midwifery and Support Staffing
The Maternity service has an agreed funded establishment for midwives and support staff to provide minimum staffing levels to ensure safe delivery of care to the women and babies. A bi-annual Birth rate plus table top review is completed and the results presented to the Board as part of the Trust skill mix review.
On a daily basis a unit coordinator monitors staffing levels across the service using the birth rate plus app, redeploying staff where necessary. A Maternity Escalation Plan exists to advise staff on managing situations where staffing falls below an acceptable minimum or the workload exceeds safe working.

The birth rate + App is used to monitor midwifery staffing in Intrapartum and ante natal / post-natal areas on a four hourly basis. Some of these results are reported in the dashboard which is distributed monthly.
The midwifery and support staffing establishment is monitored monthly by the Maternity Clinical Governance Committee and reported using the data from the birth rate plus app.

Obstetric Staffing
The minimum level of medical staffing to provide adequate cover for the CS/LW is defined within the obstetric staffing workforce plan. Short-term sickness is managed by internal cover. Consultant obstetricians are based within the CDS/LW providing easy access and aim to provide 40 hours cover at BDGH and 60 hours at DRI per week on each site with no other clinical commitments. Against this standard is reported to the Maternity & Clinical Governance Group on the maternity dashboard. Cover in the event of sickness will be organised by the duty consultant according the flow chart within the obstetric workforce plan.

Anaesthetic Staffing
The Duty Anaesthetist denotes a trainee Anaesthetist who has been assessed as competent to undertake duties on the Delivery Suite under a specified degree of supervision in accordance with the RCoA curriculum 2010.
The Duty Anaesthetist is immediately available for emergency work on the obstetric unit 24 hours per day. They bare have responsibility for elective obstetric work or the Intensive Care Unit, general theatres and do not carry the “crash bleep” for the general hospital.
The Duty Anaesthetist works in conjunction with a trained Operating Department Practitioner (ODP). This ODP is dedicated to maternity services and has no other service commitments in the hospital at this time. In the event of sickness the theatre team co-ordinator will organise cover from the multi-skilled theatre team as detailed on the flow chart within the Anaesthetic Workforce Plan.
The Duty Anaesthetist is supported by a Consultant Anaesthetist, resident on the Delivery Suite Monday to Friday 8am - 8.30pm. Outside these hours the Consultant Anaesthetist is contacted via switchboard. Out of hours there is a further resident Anaesthetist who is fully trained in obstetric anaesthesia. This Anaesthetist will have other commitments in the hospital at this time. Anaesthetic cover is monitored monthly on the maternity at the MCGMC. In the event of sickness the duty consultant will be responsible for organising cover from within the Anaesthetic department.

Neonatal Staffing
There is a Level 1 unit at BDGH and a Level 2 unit at DRI. These are staffed by neonatal nurses and in accordance with the BAPM guidelines. There is a Consultant Paediatrician, Speciality Trainee and Foundation year doctor covering both units 24/7.
Staff Training.
Risk management training is not only essential to the operation of the system, strategy and Trust culture; it is also required by law under the Health & Safety at Work Act 1974. All maternity staff receive clinical and non-clinical risk awareness training at the core induction further supported by specific risk training provided through e-learning or face to face teaching in accordance with the Trust Mandatory Training Policy and the Maternity Specific Training Needs Analysis.

7.3 Maternity Risk Management Processes

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
- Monthly Risk management Report
- Dissemination of lessons learnt to all staff

7.4 Adverse Incident Reporting

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

- Risk Identification, Assessment and Management Policy CORP/RISK 30
- Being Open, Saying Sorry and Duty of Candour CORP/RISK 14
- Serious Incident (SI) Policy CORP/RISK 15

Specific obstetric trigger incidents are outlined in Appendix 6.

7.5 Risk Assessments, Analysis and Evaluation

Risk assessments will occur in accordance with the Policy for the Risk Identification, Assessment and Management Policy CORP/RISK 30.

7.6 Risk Register

The Maternity service is responsible for maintaining the Maternity and Gynaecology Divisional 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.

7.7 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 Divisional Governance Lead.
- The Maternity and Gynaecology Risk Register is a standing agenda item on the Maternity and Gynae Clinical Governance group and the Divisional Governance Group

- The Maternity and Gynaecology Risk Register, is a standing agenda item at the Divisional Senior Management Team Meeting.
- Any risk identified as "Extreme" (15 or above) that cannot be controlled and managed within the Division 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 Maternity and Gynae Clinical Governance group review all clinical risks and actions taken/planned on a monthly basis, and will monitor progress against action plans.
- The Divisional Senior Management Team Meeting will review all changes to the Specialty Risk Register.

8 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.

9 EQUALITY IMPACT ASSESSMENT

The Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are disadvantaged over others. Our objectives and responsibilities relating to equality and diversity are outlined within our equality schemes. When considering the needs and assessing the impact of a procedural document any discriminatory factors must be identified.

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 1.

10 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.

11 DATA PROTECTION

Any personal data processing associated with this policy will be carried out under 'Current data protection legislation' as in the Data Protection Act 2018 and the UK General Data Protection Regulation (GDPR) 2021.

For further information on data processing carried out by the trust, please refer to our Privacy Notices and other information which you can find on the trust website: https://www.dbth.nhs.uk/about-us/our-publications/information-governance/

12 TRUST POLICIES LINKED TO THIS STRATEGY

- Risk Identification, Assessment and Management Policy - CORP/RISK 30
- Being Open, Saying Sorry and Duty of Candour Policy CORP/RISK 14
- Serious Incidents (SI) Policy - CORP/RISK 15
- Incident Management Policy CORP/RISK 33

13 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

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National Health Service litigation authority is now NHS resolutions https://resolution.nhs.uk/

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

APPENDIX 1 - EQUALITY IMPACT ASSESSMENT PART 1 INITIAL SCREENING

Service/Function/Policy/Project/ Strategy	Division	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
Policy	Children and Families Division	Lois Mellor	Existing Policy	November 2020

1) Who is responsible for this policy? Name of Division/Directorate: Children and Families Division

2) Describe the purpose of the service / function / policy / project/ strategy? Who is it intended to benefit? What are the intended outcomes? All Staff relating to maternity services

3) Are there any associated objectives? Legislation, targets national expectation, standards: National requirements for maternity risk assessment policy

4) What factors contribute or detract from achieving intended outcomes? – None

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? Details: [see Equality Impact Assessment Guidance] – No

- **If yes, please describe current or planned activities to address the impact** [e.g. Monitoring, consultation] –

6) Is there any scope for new measures which would promote equality? [any actions to be taken]

7) Are any of the following groups adversely affected by the policy?

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

8) Provide the Equality Rating of the service / function /policy / project / strategy – tick (✓) outcome box

Outcome 1 √	Outcome 2	Outcome 3	Outcome 4

If you have rated the policy as having an outcome of 2, 3 or 4, it is necessary to carry out a detailed assessment and complete a* **Detailed Equality Analysis form – see CORP/EMP 27.

Date for next review: November 2023

Checked by: Emma Merkuschev **Date: 23rd November 2020**