

NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST

DIRECTORATE OF WOMEN'S SERVICES

MATERNITY CLINICAL RISK MANAGEMENT STRATEGY

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1. Introduction

This strategy document sets out the Maternity Services philosophy for managing clinical risk and outlines aims and objectives to manage risk effectively.

Maternity Services at the RVI aim to provide a robust patient safety culture and environment committed to Risk Management control and recognition.

All staff are expected to:

- Be aware of the principles of risk management
- Adopt appropriate practice to reduce risk.

This strategy document should also be read in conjunction with the Trust Risk Management Strategy which can be found on the Trust Policy and Procedures Intranet site.

2. Statement of Philosophy for Managing Clinical Risk

Risk Management is an important component of Clinical Governance. Its purpose is:

- To protect patients from avoidable harm (physical and psychological)
- To ensure that the patient and family are informed and supported when an adverse event occurs
- To protect staff and the Trust when an adverse outcome occurs.

Key elements are:

- Safe, evidence-based practice
- Risk assessment
- High quality record keeping and documentation
- Appropriate clinical policies, procedures and guidelines
- An emphasis on learning, not blame, from formal case reviews
- Appropriate responses to complaints and discontent.

The Maternity Service actively supports the promotion of a positive and non-punitive approach to incident reporting.

In order to manage risk effectively and to meet our statutory obligations, it is necessary to ensure that a rigorous system is in place to identify and report all incidents and near misses within Maternity Services. All staff, irrespective of grade and discipline, are encouraged to report incidents and near misses promptly.

Errors, incidents, accidents and near misses in all areas of clinical and non-clinical activity can result in serious harm to patients, staff and other personnel as well as to Trust property and reputation. It is therefore essential to ensure that all possible steps are taken to minimise the risk of initial incident occurrence and subsequent recurrence. All staff must adhere to the principles of risk management as an integral part of best clinical practice with the focus upon patient safety and prevention of avoidable harm.

The promotion and development of a positive and non-blaming incident reporting culture is pivotal to effective risk management within the Maternity Services and will provide information, which will enable us to learn from adverse events and facilitate action to prevent recurrence.

3. Maternity Risk Management Strategy Objectives

The principal objective of the Risk Management Strategy is to provide the Trust Board of Directors with sufficient assurance that appropriate structures and processes are in place to minimise risks. The strategy will seek to:

- Ensure that risk management processes are integral to Maternity Services working practices and culture
- Ensure urgent and emerging issues are communicated to the Trust Board through the Executive Director
- Encourage the reporting of mistakes, ensuring that lessons are learned and preventative measures introduced in a non-blame culture
- Ensure that through the strengthening of risk management arrangements there are continual improvements to patient safety
- Minimise claims for accident or injury against Maternity Services
- Support systems which eliminate, transfer or reduce risks to as acceptable a level as possible
- Secure the highest possible standards of risk management in terms of external validation, including the NHS Litigation Authority (NHSLA) Clinical Negligence Scheme for Trusts (CNST) Risk Management Standards
- To maintain a direct line of communication between the Maternity Services and the Trust Board by maintaining a risk register which is reviewed in detail every three months at the Clinical Improvement and Risk Group (CIRG)
- Ensure that staff are trained effectively in essential clinical skills.

Review and distribution

The Maternity Risk Management Strategy is reviewed every two years by the Clinical Improvement and Risk Group (CIRG). Any changes to the Strategy which are needed before then are distributed to all staff by updated information in the Directorate newsletter. All ward areas have a copy of the Maternity Risk Management Strategy in their yellow 'Risk Management' files and the master copy is kept on the Intranet Policies database. All staff are informed about the Risk Management process and strategy document as part of their induction program.

4. Assurance Framework

Effective risk management requires commitment and active involvement of all employees and it is therefore vital that the risk management process is communicated and embedded throughout Maternity Services and the whole organisation. There is also a need for robust mechanisms to

monitor risk management performance. The audit and scrutiny functions will play an important role in testing the effectiveness and embedding of risk management throughout the Trust.

Assurance Framework

The Assurance Framework provides the Trust Board, through the Executive Director and the Trust Clinical Governance structure, with assurance that the risks to Maternity Services are being managed appropriately. This is achieved by close working links between the Directorate Management team and the Trust Directors and by consideration of minutes of the Directorate Clinical Improvement and Risk Group by the Trust Clinical Governance and Risk Department.

The Maternity Service will ensure that the following arrangements are established:

- The Strategy is effectively communicated to all staff working within the Maternity Service
- All Maternity Service staff are required to implement the strategy
- An annual Risk Management Report is produced and reviewed by the Corporate Governance Committee.
- An accurate register of all risks within Maternity Services is monitored both at department level and by the Governance lead, the Directorate Manager and the Clinical Director
- Risk Management / Clinical Governance issues are discussed at regular Directorate Performance Management Reviews – held every 3 months and chaired by one of the Trust Executives
- Annual attendance at the Clinical Practice and Standards Review chaired by the Medical Director
- A standing committee (CIRG) monitors the risk management and clinical governance processes on behalf of the Directorate.

5. Leadership and Accountability within Maternity Services

Operational lead responsibilities are as outlined in the overall Trust Risk Management Strategy. Maternity specific leadership and accountability responsibilities are as below:

Clinical Director

The Clinical Director has joint responsibility with the Directorate Manager/ Head of Midwifery for overseeing clinical risk management throughout the maternity service. The Clinical Director is accountable to the Medical Director. Their role is to ensure effective clinical governance arrangements are in place by:

- Receiving information in relation to all significant risk issues
- Being a professional lead within the Directorate structure
- Raising clinical risk issues with the Medical Director as required
- Ensuring the Risk Management Strategy is disseminated and that all staff are aware of their responsibilities in respect of the Strategy
- Managing Clinical Performance issues
- Supporting effective team working in conjunction with the Directorate Manager/ Head of Midwifery, Director of Quality and Effectiveness, Chair of CIRG, Risk Management Midwife, and Obstetric Leads to manage risk within the service
- Ensuring that all clinical and non-clinical risks are reported on the Risk Register, with appropriate controls, action plan and regular review
- Providing the lead in serious untoward incident investigations

- Giving expert clinical leadership and advice
- Undertaking an annual audit of medical staffing levels to ensure that levels are appropriate to delivering high quality care.
- Liaising with the Directorate Manager to develop business and contingency plans to address any staffing shortfalls identified
- Maintaining direct communication with the Trust Medical Director by representing Maternity Services at the Clinical Policy Group meeting, as well as at Clinical Standards and Practice Review meetings.

Head of Midwifery / Directorate Manager

The Head of Midwifery (HoM)/ Directorate Manager (DM) has joint responsibility with the Clinical Director for overseeing clinical risk management throughout the maternity service. The HoM/ DM is accountable to the Director of Nursing and Patient Services. In addition to the above duties they also have the following responsibilities:

- Development and maintenance of local risk management policies and procedures
- Being a professional lead within the Directorate structure
- Raising clinical risk issues with the Nursing and Patient Services Director as required
- Identification of risk management training needs to ensure that staff and volunteers are able to work safely and comply with Trust procedures
- Ensuring that incidents, claims and complaints are thoroughly investigated and that learning from incidents, complaints, claims and audit is implemented effectively
- Maintaining robust reporting systems within the maternity service
- Ongoing monitoring and review of the risk register
- To performance manage the complaints process within the Directorate in line with local and national standards
- Undertaking an annual audit of midwifery staffing levels to ensure that levels are appropriate to deliver high quality care
- Liaising with the Clinical Director to develop business and contingency plans to address any identified staffing shortfalls.

Executive Lead at Board Level – Director of Nursing and Patient Services

The Director of Nursing and Patient Services as the Executive Lead communicates closely with the Directorate Manager both formally and informally.

Urgent escalation of issues will be raised as outlined in section 7.

Ongoing assurance is provided to the Executive Lead as outlined in section 4.

Regular planned communication is maintained by:

- One to one meetings at least every 2 months
- Lead executive in performance reviews 3 times per year

Director of Quality and Effectiveness

The Director of Quality and Effectiveness will support the Directors of the Trust with implementation and development of the Trust Risk Management Strategy. They will also be responsible for integration of corporate governance departments and systems, with the aim of developing and improving reporting, analysis and learning on all aspects of clinical governance and risk including health and safety, litigation and claims, complaints, fire, and security.

Within Maternity Services the Director of Quality and Effectiveness will be represented at the monthly Clinical Improvement and Risk Group. Minutes of the meetings are forwarded to the Clinical Governance and Risk Department.

The Risk Management midwives will liaise with the Director of Quality and Effectiveness for advice regarding a risk management situation or to inform her directly of an adverse event, if appropriate. In the event of a Serious Untoward Incidents (SUIs) the Director will arrange external input to the investigation when necessary.

- The Director of Quality and Effectiveness will ensure and facilitate the production of the Annual Assurance Report to be reviewed by CIRG and the Corporate Governance Committee.

Chair of the Clinical Improvement and Risk Group (CIRG)

Responsibilities include:

- Ensuring that the Directorate Clinical Improvement and Risk Group is held on a regular basis (at least ten times a year)
- Ensuring appropriate representation at the meeting
- Ensuring that the agenda addresses relevant issues, with standing items that facilitate monitoring of the group's work plan, NHSLA/CNST issues, Baby Friendly initiative, formal case reviews (including child deaths reviews), aggregated adverse event reports, complaints, safeguarding issues, the risk register, infection control, findings from audits, minutes of the Delivery Suite Executive group, SUIs, staffing, external guidance (NICE, CMACE, Royal Colleges etc.), safety alerts (NPSA, HPA, Medical Devices etc.), Training Needs Analysis and Annual Assurance Report.

Risk Management Midwives

The Lead Risk Management Midwife and the Risk management Midwife have responsibility for the co-ordination of clinical risk activities within the Maternity Service. Those responsibilities include:

- Co-ordinate risk identification and analysis through the collation and review of all incidents
- Raise awareness of risk management issues among staff throughout the Maternity Service
- Working with the Matrons, Consultants, Clinical Director and Head of Midwifery to ensure risk is minimised
- Discuss with the Supervisors of Midwives any practice issues identified through incidents
- Support staff during investigation and analysis of incidents
- Devise a programme for monitoring performance and implementation of CNST standards and report results across the various departments
- Provide reports on progress to the Clinical Director/ Directorate Manager and Director of Quality and Effectiveness
- Co-ordinate annual review of the Risk Management Strategy

- Ensure there is appropriate feedback to staff within the Maternity Services regarding lessons learned, actions taken from incidents and identification of risks
- Ensuring that lessons learnt from audits are fed back to the relevant people so that an action plan can be formulated to ensure completion of the audit cycle
- Contributes to the Training and Education Program of midwives and medical staff and monitors attendance.

Other responsibilities include:

- Ensuring incidents are investigated promptly and action plans are completed
- Review of incident analysis, reporting trends and /or issues of concern to CIRG
- Co-ordination of the monthly Directorate audit meeting
- Monitoring the progress of audits ensuring that they are registered with the Trust
- Providing a summary of audits presented to the monthly Obstetric Group meeting
- Updating staff on risk management issues through regular communication via the directorate newsletter
- Ensuring the Risk Management Strategy is available for all staff to access via the Intranet and yellow risk management files in all areas
- Meeting all new staff to introduce them to risk management during their induction
- Identifying areas of risk that need to go onto the Risk Register.

Lead Consultant Obstetrician for Delivery Suite

The Lead Consultant has a responsibility to ensure that any risks identified on Delivery Suite are managed appropriately through incident reporting and investigation.

Other responsibilities include:

- Regular attendance at the risk management morning meetings
- Ensuring lessons learnt through incident investigation are shared either formally or informally
- Organising and Chairing the Delivery Suite Executive meeting which meets at least ten times a year
- Contributing widely to the monitoring and audit of CNST standards that impact on Delivery Suite
- Identifying areas of risk that need to go onto the Risk Register
- Organising live drills sessions on Delivery Suite and the wards
- Facilitating on the Clinical Skills Drills training day
- Contributing to the Directorate Education and Training Programme.

Lead Clinical Midwife Manager for Delivery Suite

The Lead Midwife has a responsibility to ensure that any risks identified on Delivery Suite are managed appropriately through incident reporting and investigation.

Other responsibilities include:

- Regular attendance at the risk management morning meetings

- Ensuring lessons learnt through incident investigation are shared either formally or informally
- Attending the Delivery Suite Executive meeting which meets at least ten times a year.
- Contributing widely to the monitoring and audit of CNST standards that impact on Delivery Suite
- Identifying areas of risk that need to go onto the Risk Register
- Contributing to the Directorate Education and Training Programme.

Lead Obstetric Anaesthetist

There is a dedicated lead anaesthetist who works closely with the maternity team and has direct communication links with the Delivery Suite Leads and the Clinical Director. They have responsibility for:

- Providing advice and guidance on relevant training standards and best practice standards
- Providing guidance on National Patient Safety Agency (NPSA) alerts pertaining to anaesthetics
- Escalating risks and monitoring trends in relation to maternity high dependency care, theatre management, recovery and operative case management
- Undertaking an annual audit of medical staffing levels to ensure that levels are appropriate to delivering high quality care.
- Liaising with the Clinical Director to develop business and contingency plans to address any staffing shortfalls identified
- Identify areas of risk that need to go onto the Risk Register
- Regular attendance at the CIRG
- Ensuring regular attendance by one of the Consultant Anaesthetists at the Delivery Suite Executive meeting.

Supervisor of Midwives

There are 19 Supervisors of Midwives (SoM) and they have the following responsibilities:

- Undertake annual review of all midwives
- Participate in all aspects of risk assessment and risk management whether formal or informal
- To proactively support staff through training and development issues arising out of adverse incidents that are identified at risk management meetings
- To investigate incidents when required to do so
- To be actively involved in developing and updating maternity policies, documentation and guidelines through membership of various groups
- Advise on issues relating to individual practice of midwives ensuring safety of mothers and babies
- Ensuring that there is an appropriate communication framework in place for the reporting of risks and the dissemination of lessons learnt
- Participation in formal case reviews and SUI reviews.

6. THE RISK REGISTER

(Also refer to the Risk Register- Policy for Management and Use)

The Risk Register is managed by the Governance Lead, Directorate Manager and Clinical Director.

The Risk Register is reviewed at department meetings, where it is expected that it will be used as a tool to continually review and mitigate risks identified close to the patient; supervision of this process, and monitoring of risks that cut across department boundaries, are reviewed at CIRG.

New risk issues that are identified should be brought to the attention of any senior member of staff – this includes the Directorate Manager, Clinical Director, Matrons, Consultants or Risk Management Midwives. The risk issue of concern should then be discussed at the next appropriate meeting (if it hasn't been discussed already) i.e. departmental, Obstetric Group, Delivery Suite Executive whereby the 'risk' should be discussed in more detail. If the 'risk' then needs to go onto the Risk Register it should be entered by a member of senior staff and final authorisation is given by the Directorate Manager/ Clinical Director / Governance Lead prior to going onto the 'live' register..

All senior staff should have had training on the use of the Risk Register and further training is available if required.

The Risk Register is a standing agenda item for CIRG. New risk issues are discussed at each meeting. The Directorate Manager and Clinical Director review the appropriateness of risk every three months.

The Trust Board is responsible for identifying significant strategic risks and for ensuring that they are managed through the Assessment Framework process and the Trust Risk Management Strategy. Duties for monitoring the high risks will be delegated by the Trust Board to the Corporate Governance Committee and the Audit Committee.

The Maternity Risk Register is reviewed three times a year at the Directorate Performance Review meetings which are chaired by an Executive Director of the Trust. It is also discussed at the annual Clinical Standards and Practice Review meeting.

7. ESCALATION OF RISK MANAGEMENT ISSUES TO THE TRUST BOARD

Urgent and immediate escalation of risk management issues should be via the Directorate Manager and /or Clinical Director to the Director of Nursing and Patient Services and/or the Medical Director or to the Director of Quality and Effectiveness if an SUI is suspected. This is usually via a telephone call in the first instance with a follow-up with an e-mail later to clarify details and meetings and further discussion as required.

In the absence of the above Management Team a deputy will take on this responsibility together with the Risk Management Midwife who will contact the Director for Quality and Effectiveness or the Clinical Governance and Risk Department and request advice and/or support.

In an acute event the risk management issue may have resolved as quickly as it was generated and need no further investigation. Any outstanding issues will be discussed with the appropriate Head of Department and the Clinical Director and Directorate Manager informed.

Any issues that warranted 'urgent escalation to the Trust Board should be raised by the Clinical Director or Head of Midwifery.

8. THE RISK MANAGEMENT STRUCTURE

Groups and Committees with responsibility for Risk

Group/ Committee	Key responsibilities	Frequency
TRUST LEVEL		
Corporate Governance Committee	Provides a forum that develops and advises the Trust on strategy, policy, priorities and implementation of non-clinical risk management. Receives the Annual Assurance report from the Directorate	Annually
Audit Committee	Provides the board with an independent and objective review of financial and organisational controls and risk management systems and practice. Receives a report on high level risks.	Minimum of quarterly
Clinical Governance and Quality Committee	Standing Committee of the Trust to ensure that there is in place proper processes for continuously monitoring and improving clinical quality.	Bi-monthly
Clinical Policy Group	Advises the Trust on matters of clinical policy.	Monthly
Clinical Risk Group	Ensures an integrated approach to clinical and non-clinical risk management across the Trust.	Quarterly
MATERNITY SERVICE LEVEL		
Clinical Improvement and Risk Group	This groups overriding commitment is to encourage safe effective clinical practice within the Directorate. Some responsibilities include: review of incident trends, review of complaints and claims highlighting key issues to the appropriate group, ensure that guidelines have been ratified appropriately, ensuring the risk register is regularly reviewed, ensuring 'alerts' have been auctioned, that NICE guidance has been reviewed and an overview of the TNA delivery.	Monthly – at least ten times a year
Obstetric Group	Chaired by the Clinical Director in attendance with all Obstetric Matrons/ Consultants and Risk Management Midwife. Discuss and monitor operational issues, guidelines, staffing levels, research proposals, risk and governance issues.	Monthly – at least ten times a year
Directorate Management Team meetings	Chaired by Directorate Manager in attendance with Matrons/ Managers. Discuss and monitor finance, activity, operational issues, staffing levels, any issues related to risk and governance.	Weekly
Delivery Suite Executive	Discussion of any issues specifically related	Monthly – at

	to delivery suite. Anaesthetics and neonatal issues are also addressed.	least ten times a year
Supervisor of Midwives Group	Provide leadership and guidance to midwives. Involvement with incidents that identify practice issues. All Supervisors have a responsibility to ensure competent practice of Midwives and effective standards of care for mothers, babies and staff and therefore play a key role in the risk management strategy.	Monthly

Terms of Reference for the Maternity Service Level Groups can be found in Appendix 1

Terms of Reference for the Trust Level Groups are within the Trust Risk Management Strategy

9. RISK MANAGEMENT POLICY AND PROCEDURES

9.1 Incident Reporting

(Also refer to Trust Policy on Management and Reporting of Accidents and Incidents)

Incidents and adverse events that occur within maternity services need to be reported onto the DatixWeb electronic reporting system. There is a maternity specific data set for incident reporting (trigger lists) in each area which prompt reporting, these lists are neither exhaustive nor exclusive (see Appendix 2). If in doubt whether an incident should be reported, it should be discussed with the line manager and/or consultant as appropriate. In line with the Being Open Policy the patient (or parents) should be made aware of the event at the earliest opportunity. They should also be informed that this event/incident will be reviewed and discussed in more detail by more senior personnel. It is good practice to document in the notes that a Datix form has been completed.

Co-ordination of Incident Reporting

The frequency of meetings to analyse adverse events and share lessons to be learnt varies between departments and clinical areas.

Delivery Suite every weekday at 08.15

Predominantly incidents related to Delivery Suite and Maternity Assessment Unit (MAU) are discussed at this meeting. The Consultant on-call for the wards will chair the meeting assisted by the Risk Management Midwife. Also in attendance will be one of the Midwifery Managers. This meeting is multidisciplinary and multiprofessional – SpR's, SHO's, Midwives and Anaesthetic representation, if required.

Antenatal clinic /Fetal Medicine Unit

These are discussed on a monthly basis at team meetings. If required, incidents will be discussed first with the Matron and Risk Management Midwife.

Community

Incidents relating to community care are discussed at the monthly community meeting with the Community Manager and attending community staff. If required, incidents will be discussed first with the Matron and Risk Management Midwife.

Postnatal

Incidents relating to the postnatal ward will be reviewed by the ward leader and if appropriate discussed at the monthly core team meeting. Specific incidents will also be discussed at the postnatal grand round which is held once a week. Often postnatal incident forms will also be discussed with the neonatal unit if the incident involves management of a baby.

Antenatal ward

Incidents relating to the Antenatal ward will be reviewed by the Ward Sister and if appropriate discussed at the Antenatal Grand Round once a week. A Risk Management Midwife will be in attendance.

Once a Datix form has been completed either the Matron/Risk Management Midwife/ Midwifery Manager/ Consultant in charge will:

- Review the case notes
- Consider and, if necessary, debrief the individual staff involved
- Identify whether or not statements are needed, and supervise their production
- Ensure that the patient or parent, and their family are kept informed.

The majority of adverse events will require minor (i.e. a retrospective entry to the notes) or 'no further action'. Some events will require further meetings with the staff involved. This will depend on the type of incident but may involve:

- 1) a debriefing session only
- 2) debriefing and formal case review or
- 3) root cause analysis investigation following initial review.

Reporting incidents of concern

Depending upon the seriousness of the issue, it may be necessary to discuss the incident with the Clinical Director/ Head of Midwifery or the Director of Quality and Effectiveness. It may be appropriate to contact a junior doctor's educational supervisor or a Supervisor of Midwives if there are issues concerning medical / midwifery competence.

Formal Case Review/ Root Cause Analysis

When a serious adverse event occurs within the Maternity Services it is absolutely necessary that we examine it in detail in order to learn from it. A debriefing meeting is ideally held within 72 hours. It may not be practical to get everybody together that was involved in the incident within 72 hours therefore in some cases staff may need to be spoken to on an individual basis by their Manager/Consultant/Risk Management Midwife. A Formal Case Review or Root Cause Analysis (RCA) will then be organised ideally to take place within four weeks.

The analysis inherent in this process is the reflective practice generated by studying a particular event in great detail. The aims of a Formal Case Review are to:

- Give the opportunity to analyse and discuss the incident

- Review organisational processes that may have contributed to the events (Root Cause Analysis will be undertaken if relevant to the case)
- Suggest ways in which practice or training may be improved
- Encourage reflection and learning through experience
- Manage effectively incidents that may lead to a claim.

Case review meetings have to be multi-disciplinary if they are to be useful to participants, effective in improving practice and capable of creating organisational change. They must therefore include all medical, midwifery, nursing and support staff who were involved in the incident.

Intrapartum events

The Matron for Delivery Suite and Lead Obstetrician will consider a Formal Case Review in the following circumstances in collaboration with the Risk Management Midwife:

Maternal

- Death (compulsory)
- Unexpected transfer to ITU
- Eclampsia
- Uterine rupture with poor outcome for the infant
- Major Obstetric Haemorrhage
- Clinical situations requiring maternal resuscitation
- Retained swab

Fetal / neonatal

- Neonatal seizures
- Unexpected severe illness or death in a baby of > 32 weeks
- Bone fracture, nerve palsy or subaponeurotic haemorrhage
- Intrapartum fetal death (compulsory)

Any member of staff wishing to discuss other serious adverse events not included in this list can also suggest a review meeting. This list is necessarily much smaller than that for generating adverse event forms: only the most serious adverse events, or near misses, justify the organisation of a Formal Case Review.

The Matron/Midwife Manager and/or Head of Department will individually assess adverse events occurring within other clinical areas and arrange that a review be conducted if appropriate. Where there is clear **evidence of sub-standard care** – a formal case review will be held.

The Head of Midwifery and Clinical Director should be notified when a formal case review is to take place and they should receive the minutes of the review meeting.

Attendance

Those persons requested to attend will include all the members of staff involved in the incident, the Risk Management Midwife, the Matron and the Head of Department for the area concerned. The review will not be open to other parties except by special arrangement.

Confidentiality

The oral discussions will remain confidential to the participants.

Chair

The facilitator (chair) will usually be the Risk Management Midwife.

Structure of the meeting

- The case will be presented briefly, usually involving a time line displayed for everyone to see and a summary given for all staff to read.
- Each individual participant in the meeting will then have the opportunity to highlight the issues from their perspective.
- An analysis of these issues will then be conducted using Root Cause Analysis if appropriate.
- Action points for reducing the risk of a recurrence of the incident will be agreed.

Sub-standard Care

When there is evidence of sub-standard care, the Risk Management Midwife/ Lead person in charge of the review – will inform the Clinical Director and Head of Midwifery. Statements should be collected from the persons involved and individual meetings will be organised with either their educational supervisor or Supervisor of Midwives and Manager.

All documentation arising from any element of the risk management process may be disclosed to the Trust Solicitors in the event of litigation.

9.2 Serious Untoward Incident (SUI)

(This section must be read in conjunction with the Trust 'Serious Untoward Incidents (SUIs) Reporting and Management Policy available on the Intranet.)

If a case is considered to be a SUI then it must be discussed with the Head of Midwifery/Directorate manager and Clinical Director as soon as possible after the event has occurred. If between them they think the incident is a possible SUI the Director for Quality and Effectiveness should be informed. All SUI's will be reported to Commissioners of Newcastle upon Tyne Primary Care Trust (PCT) –by the Trust Patient Safety Advisor. The Local Supervisory Authority Midwifery Officer (LSAMO) should also be notified by the Risk Management Midwife.

SUI cases include:

- Maternal Death
- Intrapartum Stillbirth
- Serious birth trauma to a baby for example: Skull Fracture
- Baby Abduction.

All SUIs will require a Root Cause Analysis (RCA) which must be attended by an appropriate person, who is external to the Directorate and can offer unbiased and impartial input into the investigation. The Trust Patient Safety Advisor must also be kept informed of the progress of a SUI investigation and minutes of the meeting must be sent to the Director of Quality and Effectiveness.

The SUI investigation will be organised by the Risk Management Midwives and all staff involved in the case will be invited to attend. Ideally the meeting should take place within four weeks of the incident, however it must be recognised that there may be a delay in organising the RCA if key people are unavailable within the desired timescale. Statements should be obtained before the RCA meeting.

9.3 Complaints and Claims

(This section must be read in conjunction with the Trust Concerns and Complaints Policy and the Claims Management Policy available on the Intranet.)

Any complaints or potential claims are sent directly to the Directorate Manager who will review the notes and request statements. A response is drafted and a formal reply is made from the Chief Executive (CE).

Complaints and responses are monitored and discussed at the Complaints Panel which is held monthly. Women's Services, as all other Directorates, present on a rolling basis to this group advising of any trends or specific issues and what has been done to address these. An overview of complaints is given each month by the HoM/DM to the CIRG group. Individual staff members are counselled as appropriate.

Managing Incidents Effectively That May Lead To A Claim

Despite good management and compliance with guidelines some incidents will not have a good outcome and will inevitably lead to a claim. When such an incident occurs it is imperative that all valuable information is collected as soon as possible after the incident. Although it is difficult to know which incidents will lead to a claim there are some incidents listed on the trigger list which you should familiarise yourself with that may lead to a claim.

The following section will consider some of these incidents and list recommended actions to be undertaken so that the relevant information is available and collated appropriately.

Cord Ph < 7.0 – baby unwell and transferred to SCBU

Ensure paired cord sample results are obtained and results written on the partogram and filed in the appropriate envelope.

Check CTG has been archived and print off copy of the CTG (this copy should be filed in the hospital notes). Ensure original CTG is stored in the Trust approved resealable CTG envelope. Placenta should be sent for histopathology.

Ensure any retrospective entries to notes are written as soon as possible.

Statements are started as soon as possible by all key staff involved in the care and resuscitation of the baby (before the end of the shift).

Intrapartum fetal death

Check CTG has been archived and print off copy of the CTG (this copy should be filed in the hospital notes). Ensure original CTG is stored in the Trust approved resealable CTG envelope. Ensure documentation in notes prior to event occurring is thorough and includes who attended when help requested.

The placenta should be sent for histopathology.

Ensure accurate documentation in the notes regarding examination of placenta and cord i.e. true knot evident, cord entanglement.

Statements should be written as soon as possible by all key staff involved (before the end of the shift).

Bone fracture / nerve palsy

Ensure documentation is good regarding the actual delivery.

If shoulder dystocia occurred HELPERR mnemonic form to be completed.

The X-ray of the fracture should be saved / archived appropriately.

Consider photographing the injury if appropriate.

Statements should be written as soon as possible by all key staff involved in the care (before the end of the shift).

Cut and/ or excessive bruising to face/ head following instrumental delivery or Caesarean section

Document the discussion with the parents.

Consider photographing the injury.

Ensure that a clear explanation is in the notes as to how the injury was sustained.

If a cut to the face occurs which warrants suturing (including steri strips) ensure referral to plastics on-call SpR.

Ensure clear documentation regarding sutures used and subsequent care plan – copies to be filed in both maternal and baby notes.

Statements should be written as soon as possible by all key staff involved (before the end of the shift).

Severe shoulder dystocia / symphysiotomy

Ensure paired cord sample results are written on the partogram and filed in the appropriate envelope.

The HELPERR mnemonic form should be fully completed with accurate timing of manoeuvres required.

Ensure any retrospective entries to the notes are written as soon as possible.

The Operative delivery record should be as descriptive as possible including assistance requested.

An early referral should be made to an uro-gynae consultant (if symphysiotomy performed).

Statements should be written as soon as possible by all key staff involved (before the end of the shift).

Uterine rupture

The Operative delivery record should be as descriptive as possible including assistance requested.

Ensure the partogram has thorough documentation of events leading up to the rupture.

Check CTG has been archived and print off copy of the CTG (this copy should be filed in the hospital notes).

Ensure paired cord sample results are written on the partogram and filed in the appropriate envelope.

Statements should be written as soon as possible by all key staff involved (before the end of the shift).

Bladder damage with voiding complications

Ensure partogram has thorough documentation including bladder care given in labour (retrospective entry to notes may be required).

If operative procedure undertaken ensure thorough documentation of any complications.

Ensure documentation regarding postnatal voiding and management is clearly documented.
File safely fluid balance charts and any bladder scan reports.
Involve early input from an Uro-gynae nurse specialist / physiotherapist.
Statements should be written as soon as possible by all key staff involved (before the end of the shift).

Drug error leading to maternal and or fetal /baby compromise

Statements should be written as soon as possible by all key staff involved (before the end of the shift).
Be 'honest and open' and discuss the incident with the patient / family.
Photocopy the prescription chart.
Ensure subsequent care of the patient is well documented.

Health and safety incident i.e. slipped on wet floor, cut sustained from sharp object/ broken glass, personal injury to staff/ patient or visitor

Ensure the person injured is reviewed by appropriate medical staff and assessment obtained.
Consider photographing anything relevant.
A statement should be written by the person whom the incident was first reported to and the person who witnessed the damage caused.
If the incident involved a staff member then they should write a statement explaining how the incident occurred.

All statements must be forwarded to the Risk Management Midwives.

There will also be 'unusual rare incidents' that occur that cannot be listed above. If you are involved with such an incident – pause and think about the consequences of such an event. Could this be an incident that leads to a successful clinical negligence claim or attention from the media? Has unintentional harm occurred to a patient?
If in doubt collect as much information as possible about the event as soon as it occurs and please inform the senior midwife on duty and the Supervisor of Midwives on-call. They can advise you more about the incident and may suggest some of the above actions.

9.4 Providing Staff Support

(This section must be read in conjunction with the Trust Supporting Staff involved in a traumatic/stressful Incident, Complaint or Claim Policy available on the Intranet.)

Guidance for Line Managers, Supervisors of Midwives, Departmental Heads and Supervising Consultants

Introduction

Whether or not a member of staff feels personally culpable for any events surrounding an adverse incident, the possibility of blame or criticism, whether public or private, is extremely stressful. Even without such a possibility, involvement at any level in an adverse incident gives rise to substantial anxiety.

Anxious or stressed members of staff seldom perform at their best while matters remain unresolved and it is therefore in the interests of patients, staff and line managers to provide close support for individuals who have been involved in a serious adverse incident.

The Guidance deals with the roles of line manager, supervising consultants, departmental heads, and the individual staff concerned in managing the situation. The purpose is:

- To give line managers practical suggestions for support for the staff for whom they are responsible
- To give everyone in the Directorate the expectation that in such circumstances there is a culture of care and support, not victimisation and recrimination.

The guidance relates only to providing staff support, and does not replace, supersede or involve personnel guidelines, professional responsibilities, circumstances in which there may be disciplinary action, issues relating to patient protection, or internal enquiries.

Immediate Debriefing

One of the most important functions of middle grade or senior members of staff, whether Medical, Nursing or Midwifery, is to give close support in the immediate aftermath of an adverse incident. This may mean sitting down in a private room over a cup of coffee and just listening to what happened. This is the most important investment of the time that can be made, but is an opportunity that is all too seldom taken.

Assistance with preparing Statements or Reports

It is helpful to identify the person with whom the individual concerned should liaise, for assistance with checking the content of statements or reports.

Group debriefings

These are sometimes useful when there are individuals who would value such a discussion, but a formal case review (which performs much the same function) has not been thought necessary. Such a session requires strong chairmanship to avoid an atmosphere of recrimination or blame. It can usefully be based around a presentation of the case and a reappraisal of the options, judgements and decisions that were made or could have been made. It must have a primarily education focus. It is particularly helpful that it should take place before the incident is discussed in a broader forum such as a perinatal morbidity & mortality meeting. Group debriefings in no way substitute for the need of individual care for the parties concerned.

Inquests

Where an inquest is scheduled, the prospect of having to give evidence in a Coroner's Court can be extremely daunting. The Trust Legal Department is available to advise and support persons who are summoned to give evidence at an inquest. A pre-inquest meeting for all those giving evidence can be extremely useful.

It may be helpful to arrange a visit to the Coroner's Court. It may also be helpful to identify people within the Directorate who have personal experience of the Coroner's Court. They can relate their own experiences to those faced with prospect of attending the court for the first time.

Statement writing

The Trust has a guideline on how to write a statement the correct way (available on the intranet). Please refer to this if you do need to write a statement.

10. Local and Organisational Learning

It is essential that the Maternity service proactively uses the lessons learnt from audits of practice, incidents, complaints, claims and other information sources to improve clinical care and that staff are trained appropriately in response to these lessons.

To achieve this, the following systems are in operation within the Directorate and will be monitored as part of this Risk Management Strategy.

Locally, CIRG has a responsibility to ensure that lessons learnt from all formal case reviews, incidents and SUIs are implemented and monitored as appropriate.

a. Incidents

- Interesting issues where lessons can be learnt will be shared via the monthly Directorate Newsletter.
- The Datix form requires completion of a section on 'lessons learnt' which can be included in reports as required.

b. SUI

- Lessons learnt from SUIs will be minuted and an action plan written. The Trust Patient Safety Advisor will communicate on a frequent basis with the Risk Management Midwife to ensure that lessons learnt are implemented and monitored. The SUI will not be closed by the PCT until they are assured that action plans have been completed.
- On occasions it may be appropriate to e-mail all midwives and medical staff and inform them of the outcome of such an incident. A copy of the e-mail will be kept in the communication file.
- The SUI report will be written by the Clinical Director or other nominated senior clinician and sent to the Medical Director to provide board assurance that lessons learnt are implemented and monitored.

c. Formal Case Review

- Following the meeting the Risk Management Midwife will compile a written summary of the review for distribution to the participants of the meeting. The minutes will include any recommendations with timescales and state who the responsible person for the action plan will be. The report is private and confidential to the participants.
- A summary of the formal case review will be presented to the Obstetric group meeting and the CIRG. In some circumstances the reviews will also be discussed at the Supervisor of Midwives monthly meeting, Delivery Suite Executive meeting and Heads of Department meeting if relevant.

- Incidents that have required a formal case review will have written minutes. These are only shared by the participants of the case but if there are learning issues for all staff the outcome of the case review may be summarised briefly highlighting the lessons learnt/ change to practice.
- A master copy of the report will be held by the risk management midwife (paper and electronic).

d. Complaints and Claims

- CIRG has a responsibility to ensure that lessons learnt from all complaints and claims are implemented and monitored as appropriate following discussion at each meeting.
- In addition lessons learnt from complaints and claims which are applicable to all staff within Women’s Services are disseminated through the Directorate Newsletter.
- Where there are specific changes in practice required as the result of a complaint these are actioned and detailed on Procedure change notes which are reported to and monitored by the Complaints Panel.

e. Audits

Results of audits which have been undertaken in the Directorate are presented to the appropriate monthly departmental audit meeting in the first instance and then the main learning points are reported to and reviewed by CIRG. Learning points which need further dissemination will be included in the Departmental newsletter.

11. Training

The main training requirements for the Directorate are outlined in the “Training Needs Analysis: for staff that care for women and the newborn” document. The delivery of the Training Needs Analysis (TNA) is monitored by CIRG six monthly to ensure that training rates and follow up of non attendance at identified training sessions are maintained at acceptable levels. Where CIRG identifies that there are Directorate training needs as a result of their review of incidents, claims, complaints and audits these will be considered and incorporated annually by the TNA Lead.

12. Monitoring

Monitoring of the requirements of the Maternity Clinical Risk Management Strategy will occur as follows:

Requirements	Person responsible	Frequency	Reported to and reviewed by
Risk register report	Risk Manager	Quarterly	Corporate Governance Committee and Directorate Performance Review
Risk register report	Directorate Management team	Monthly	CIRG
Annual Assurance	Directorate	Annual	CIRG and Corporate

Report	Management team		Governance Committee
<p>To include:</p> <ul style="list-style-type: none">Board assurance processEscalation of risk management issues to BoardRoles and responsibilities of lead professionalsGovernance arrangements of SUIs, Incidents, Complaints and ClaimsDissemination of lessons learntOverview of the delivery of the “Training Needs Analysis; for staff that care for women and the newborn”			

Appendix 1 Terms of reference for Maternity Service Level Groups

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Women's Services Clinical Improvement and Risk Group

Constitution and Terms of Reference

Members:

Clinical Governance lead – Chairman
Clinical Director
Directorate Manager/Head of Midwifery
Representative from the Trust Clinical Governance and Risk Department
Risk Management Midwife(s)
Consultant Anaesthetist
Consultant Gynaecologist
Consultant Neonatologist
Consultant Obstetrician (Head of Obstetrics)
Lead Obstetrician for delivery suite
Nurse/Midwife Manager – Antenatal/Intrapartum
Nurse/Midwife Manager – Gynaecology
Nursing/Midwife Manager – Neonatal/Postnatal
Nursing/Midwife Manager – Reproductive Medicine
Nursing/Midwife Manager – Community

By invitation or co-opting:

Other individuals may be invited ad hoc, or regularly, or for specific agenda items, as the group may require for the discharge of its responsibilities.

Quorum:

The Chair, or the Chair's nominated deputy, plus at least four members.

Frequency:

The group meets at least six times a year.

Overall purpose:

To support and promote clinical excellence in Women's Services by:

- Embedding a culture of risk assessment, risk management and patient safety at all levels and among all staff groups
- Promoting and coordinating audit to monitor clinical practice against agreed standards, and in response to incidents and complaints
- Addressing external guidance that may be implemented in the Directorate.

Terms of Reference

- The Clinical Improvement and Risk Group is responsible for ensuring that:
- The Women's Services Risk Management Strategy is approved and implemented within the Directorate
- External guidance on best practice is considered, and implemented as appropriate
- Policies and systems for maintaining standards of staff training and clinical competency are in place and feedback is given to CIRG six monthly regarding training attendance

- Any training issues identified through incidents, audits, complaints or claims are addressed.
- The decentralised framework for ascertainment of risk, incident reporting and incident review operates efficiently and effectively
- Trends in risk within the Directorate are identified and corrective measures implemented
- The Directorate risk register is regularly scrutinised and updated
- System or organisational changes are initiated in response to audits, the analysis of adverse events and near misses, and formal case reviews
- All formal case reviews are briefly presented to CIRG
- The Directorate retains its Level 3 accreditation with respect to the Clinical Negligence Scheme for Trusts
- Audits required for CNST should be presented to an appropriate group i.e. Obstetric Group, DMT or CIRG
- The requirements of the NHSLA Acute Standards are effective within the Directorate and subsequently contribute to the Acute Standards assessment
- Policies and guidelines are widely available and regularly updated
- Systems are in place for departments within the directorate to create and review their guidelines. Some guidelines will come to CIRG for final approval
- Escalation of risk issues occurs as appropriate through the reporting mechanisms outlined below.

Organisational Relationships

The Chief Executive has the ultimate responsibility for assuring the quality of services provided by the Trust.

The Chair is formally accountable to the Clinical Director through the Heads of Department meeting, and the Clinical Director and Directorate Manager are members of the Group.

- Links outside the Directorate will include:
- Confidential Enquiry into Maternal and Child Health (CEMACH)
- Regional Maternity Survey Office
- National Confidential Enquiry into Perioperative Deaths
- The Medicines and Healthcare products Regulatory Agency (MHRA)
- Clinical Negligence Scheme for Trusts/NHS Litigation Authority (CNST/NHSLA)
- Human Fertilisation & Embryology Authority (HFEA)
- National Patient Safety Agency (NPSA)
- Trust Safeguarding group
- Child Death Overview Panel for North of Tyne

Reporting Mechanisms

The CIRG will normally report annually to the Trust Clinical Governance Committee. Major risks will be reported immediately via that committee, or to the Medical Director through the Clinical Director, choosing the appropriate pathway. Serious Untoward Incidents will be reported as specified in the SUI policy.

Circulation of minutes

Minutes will be circulated to the membership.

Appointment of Chair

The Chair of the group will be appointed by the Clinical Director.

Modification of the terms of reference

Any modification to the terms of reference will be approved by the group; final approval will be with the Clinical Director, and amendments will be ratified by the Trust Clinical Governance and Quality committee.

Implementation and review

These terms of reference will be effective from the date at the end of this document, and will be reviewed annually.

Dr MP Ward Platt
Chair, Clinical Improvement and Risk Group
January 2010

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Women's Services Directorate Management Team (DMT)

Constitution and Terms of Reference

Membership

- Head of Midwifery/Directorate Manager
- Manager Delivery suite MAU and 34
- Manager Ante Natal Clinic, Fetal Medicine and Ultrasound services
- Manager for ward 35 and Post Natal services
- Manager for Gynaecology services
- Manager for Community Services and Specialist Midwives
- Manager for Administration
- Other personnel as invited

Meetings

The meetings take place at weekly intervals and will last 2-3 hours as planned. All managers are expected to attend.

Aims of the DMT Meetings

1. To facilitate open and direct discussion between managers on issues relating to and affecting the Directorate.
2. To provide a supportive network for managers within the directorate
3. To share ideas and to put forward creative ways of dealing with problems.
4. To provide representation at Departmental meetings, good communication and a two-way flow of information, between the management and the various meetings held in the directorate and Trust.
5. To provide appropriate liaison with other agencies as required.
6. To discuss Risk Management issues including results of certain audits including attendance at training and provision of information. Other relevant audit results will be brought to the meeting by the Risk Management Midwife for further discussion
7. To review ongoing training needs within the Directorate and develop action plans as necessary.
8. To monitor staff sickness levels and makes referrals as appropriate in liaison with Human Resources.
9. To review, revise and update the documentation used by the managers as and when required.

10. To consider the levels of activity and workload within the directorate and discuss relevant actions or solutions.
11. To ensure the provision of a Safeguarding Rota, which provides cover until 17.00 hours on weekdays.
12. To allocate a manager to provide review of new staff members during probationary period.
13. To allocate directorate issues to the most appropriate manager.

Notes of the meetings

Minutes of the meetings are available to all managers on the shared drive. This includes an action column.

Nov 2009

Revision Date: Nov 2011

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Women's Services Directorate Delivery Suite Executive Group

Constitution and Terms of Reference

Attendance at meetings of the Delivery Suite Executive Group – Delivery Suite Forum is open to anyone with an interest in the running of the Delivery Suite. Meetings take place in the Maternity Department of the RVI at 10.30 hours on the third Friday of each month. All meetings will be chaired by the delivery suite lead obstetrician or the delivery suite manager. The following should endeavour to attend the meeting whenever possible.

- Consultant Anaesthetist
- Anaesthetic Nurse / ODA
- Obstetric Theatres Lead Nurse
- Consultant Neonatal Paediatrician
- The Clinical Director
- The Head of Midwifery
- Obstetric Consultant representing Maternal Medicine
- Obstetric Consultant representing Fetal Medicine
- Co-ordinating Midwife from Delivery Suite
- Practice Support Midwife
- Risk Manager
- Trainees in obstetrics & gynaecology

The remit of the group is to ensure that the principles of clinical governance are met in the delivery of intrapartum care. To achieve this, the group will:

- oversee all activity on the Delivery Suite
- determine clinical medical (obstetric, anaesthetic and neonatal paediatric) policy on the Delivery Suite, liaising with the Consultant body
- determine midwifery policy on the Delivery Suite, liaising with the Midwifery Managerial body
- act as a point of liaison between professional and lay groups that hold an interest in the functioning of the Delivery Suite
- record policy in annually updated, multidisciplinary Delivery Suite Guidelines
- verify and ratify such guidelines
- audit areas of clinical practice on the Delivery Suite systematically and in response to or in anticipation of locally and nationally determined priorities. Key areas for audit include PPH, shoulder dystocia, perineal repair, vaginal operative delivery and emergency caesarean sections

- modify practice and implement training in the light of audit findings
- ensure that a programme of multidisciplinary training is promoted, dealing with issues relating to the provision of intrapartum care
- ensure that mechanisms are in place to monitor the ongoing training of staff active in the clinical arena
- promote an active, inclusive risk management policy on the Delivery Suite
- ensure that mechanisms are in place to respond to issues raised at risk management meetings on the Delivery Suite
- monitor research activities on the Delivery Suite and liaise with the Consultant body if issues of concern or potential benefit are raised
- devise strategy for the development and delivery of intrapartum care.

The Newcastle upon Tyne Hospitals NHS Foundation Trust
Women's Services Directorate Local Supervisor of Midwives Forum

Constitution and Terms of Reference

Membership

- Chair of Local SOM Forum
- Contact Supervisor
- All appointed Supervisors
- Student Supervisors undertaking the Preparation of Supervisor's Course
- Local Supervising Authority Midwifery Officer (LSAMO) when available/if required
- Others may be invited to join the group as required

Meetings

The Supervisors meet monthly. The meetings will last 2-4 hours as planned.

For the purposes of being quorate each meeting must have a minimum of six members present for actions to be considered and sanctioned.

Access to meetings

Any midwife may raise an issue with the supervisors, either attending a meeting following invitation, sending a letter, or asking a supervisor to present their idea.

Aims of the Supervisors Meetings

1. To facilitate open and direct discussion between supervisors on issues related to supervision and the safety of mothers and babies receiving care in our maternity service.
2. To further develop a supportive supervisory framework within which midwives feel comfortable to ask for help and guidance.
3. To support individuals in their practice as supervisors, share ideas and to put forward creative ways of dealing with problems.
4. To provide representation at the Delivery Suite Executive Group, good communication and a two-way flow of information, between the management of the maternity services and supervision.
5. To provide appropriate liaison with other agencies, i.e. NHS Trust user groups, social services etc.
6. To attend Risk Management meetings when required, providing support to midwives with Risk Management and Clinical Governance issues.
7. To ensure that a SOM attends any SUI root cause analysis meeting.

8. To undertake supervisory audits as required by the LSA.
9. To assist the contact supervisor in production of the annual supervisors report to the LSA.
10. To ensure that all midwives are given the opportunity to attend an annual supervisory review with a supervisor.
11. To review, revise and update the documentation used by the supervisors as and when required.
12. To consider succession planning for the supervisory team, arranging for information to enable midwives to nominate a colleague for training as a supervisor.
13. To ensure that all midwives have a choice of supervisor, and that new midwives to the service are provided with information about supervision and the individual supervisors.
14. To ensure the provision of a 24 hour on call rota of supervisors.
15. To plan how supervisors can develop a stronger presence of supervision within the services, having more influence and impact on midwives in the future.
16. To allocate a supervisor for investigation and assessment of cases when necessary.
17. To review and comment on appropriate draft guidelines.
18. To be kept informed of audit outcomes, training issues, incident investigations that may affect midwifery practice. This will be done by regular feedback of events by the Risk Management midwife.

Notes of the meetings

Minutes of the meetings are available to all supervisors on shared drive/ community midwives hard copy.

A copy of all meetings are circulated to the LSAMO

Reviewed and amended: May 2009

Revision Date: May 2012

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Women's Services Directorate Obstetric Group

Constitution and Terms of Reference

Purpose of Group

The purpose of the multidisciplinary group is to maintain and develop high quality obstetric services, ensuring the delivery of safe, sustainable, clinically effective and continuously improving maternity care before, during and after pregnancy.

Remit

All aspects of services imparting on women and their families as well as staff working within the maternity department.

Chair

The Head of Obstetrics

Frequency of Meetings

Monthly

Responsibilities

The group is responsible for ensuring that:

- All maternity staff provide high quality, accountable maternity care in accordance with local guidelines and nationally acceptable care standards.
- There is development and implementation of Obstetrics and Midwifery Strategy.
- All maternity staff are appropriately trained to carry out their designated roles.
- Referenced, authored guidelines are produced and updated for all aspects of antenatal, intrapartum and postnatal care. All guidelines relevant to maternity services will be approved by the group prior to implementation.
- National recommendations/guidelines are assessed and once agreed there is a plan for implementation and outgoing assessment of compliance.
- There are effective mechanisms for proactive ascertainment of risk/incident reporting and review.
- A widespread audit programme is supported in conjunction with the Directorate audit lead. The programme must ensure assessment of the clinical performance of the Unit as well as compliance with National Guidelines and Directives. There will be regular discussion of recommendations from all audit projects relevant to maternity services.

- Satisfactory mechanisms are in place for the collection of accurate information about unit activity, staffing levels and clinical performance.

Opportunities are provided, wherever possible, to meet the educational needs of midwives, medical staff/students and other care providers contributing to the delivery of maternity care.

Research

- Research is facilitated and encouraged wherever possible.

Finance

- Maternity care is provided within a responsible sustainable financial framework. The group will also ensure that deficiencies in funding, where impacting of delivery of care are brought to the attention of the Trust.

Accountability and relationship with Obstetric subgroups

- The Obstetric Department Group is accountable to the Directorate through the Clinical Director and Head of Midwifery.

Links

- Heads of Department
- Antenatal Services Group
- Delivery Suite Executive
- Clinical Improvement Group (CIRG)
- Community Midwifery
- Postnatal Group
- Consultant's group

It is envisaged that much of the administrative work will be undertaken/supervised by the obstetric subgroups. All significant decision (i.e. alteration to clinical policies, service developments, realignment or allocation of new roles, issues with funding implications) will be taken by the Obstetric Group – usually after discussion at the monthly meeting.

Obstetric Group Standing Monthly Agenda Items

- Activity / staffing levels – obstetricians, midwives and anaesthetists
- Feedback from
 - Heads of Dept Meeting
 - Delivery Suite Executive
 - Fetal Medicine
- Clinical improvement and risk group
 - Resume of audits
 - Clinical Incident reviews / Risk Management issues
 - Risk Register
- Guidelines
- Research
- Infection Control
- eRecord

Modification of Terms of Reference

Any proposed modification to the terms of Reference must have the approval of the Group and be approved by the Clinical Director and Head of Midwifery.

Revised: January, 2010

Review date: January 2012

Appendix 2

Obstetrics and Neonatal Adverse Events Data Set Trigger List

Please note staff are encouraged to report any unexpected outcomes even if not on the following list:

<p>All specialities</p> <ul style="list-style-type: none"> • Communication error • Miscellaneous • Drug error – prescription, dispensing, administration • Equipment failure • Unavailability of equipment • Unavailability of health records • Lost instruments/ swabs • Failure to act on an abnormal result • Conflict over case management • MRSA infection <p>Maternal events</p> <ul style="list-style-type: none"> • Death • Convulsions/ Eclampsia • Transfer to ITU • Clinical situation requiring maternal resuscitation • DVT/PE (Confirmed) • Bleeding requiring transfusion 3 or more 	<p>Intrapartum</p> <ul style="list-style-type: none"> • Unplanned homebirth / BBA • Unattended delivery by midwife • Intrapartum fetal death • Deviation from 2nd stage guidelines • Undiagnosed malpresentation • Excessive blood sampling (> 5 occasions) • Failure of blood gas analyser to give results • Failure to respond to a pathological CTG • Misinterpretation of a CTG • Loss of CTG record (paper copy) • Ruptured uterus • Trauma to bladder • Delay >30 minutes between decision and implementation of emergency caesarean section for <u>fetal compromise</u> • Undue or avoidable delay in performing CS for reasons other than fetal distress • Adverse maternal or neonatal outcome when more than one instrument used to attempt vaginal delivery • 3rd and 4th degree lacerations • Cord blood pH <7.1 • Apgar <6 at 5 mins • Shoulder dystocia • Return to theatre • Pressure Sore • Significant delay in treatment/ management due to excessive workload/ staffing issues (not IOL) • Blood loss > 1500mls • Hysterectomy/Laparotomy • Cord prolapse
<p>Antenatal</p> <ul style="list-style-type: none"> • Failure to refer high risk pregnancy to a specialised clinic • Failure to give antenatal anti-D when indicated • High risk delivery other than on delivery suite <p>Community</p> <ul style="list-style-type: none"> • Intrapartum transfer of a booked home birth • Postpartum transfer following home birth • Safeguarding children plan not up-to-date <p>MAU</p> <ul style="list-style-type: none"> • Stillbirths > 24 weeks • Inability to transfer to D/S due to workload/ staff resulting in compromised care • High risk delivery other than on delivery suite 	

<p>Prenatal and fetal medicine</p> <ul style="list-style-type: none"> • Misdiagnosis antenatal test • Undiagnosed fetal abnormality • Undiagnosed SGA • Complications (including fetal death) following an invasive procedure • Failure to obtain a sample during an invasive procedure • Failure to achieve embryo reduction or fetocide • Unexpected fetal death • Incomplete/inaccurate data for screening tests 	<p>Neonatal</p> <ul style="list-style-type: none"> • Bone fracture • Skin injury (e.g. cut at caesarean delivery) • Nerve palsy (VII nerve, brachial) • Injury, whether traumatic or due to tissue ischemia • Collapse of baby on postnatal ward • Failure to perform 'Guthrie' Test • Seizures in an inborn baby >32 weeks • Neonatal death >32 weeks • Unexpected transfer of term baby to Special Care • Excessive bruising following assisted delivery • Transfer of hypothermic baby from D/S to ward • Baby fall • Baby with absent identification bands
<p>Anaesthetic</p> <ul style="list-style-type: none"> • Failure to refer (Antenatally) for anaesthetic review • Failure of intubation • Awareness during general anaesthesia • Severe hypertension or hypotension • Excessive spinal or epidural analgesia • Severe drug reaction • Dural tap • Inadequate analgesia or anaesthesia • Neurological complications • Delayed anaesthetic consultation leading to increased fetal or maternal morbidity 	<p>Postnatal</p> <ul style="list-style-type: none"> • Failure to arrange rubella immunisation if indicated • Failure to give anti-D when indicated • Failure to give heparin • Urinary complications (e.g. chronic retention, suprapubic catheter) • Perineal wound breakdown • Return to theatre • Readmission of mother with perineal problems • Readmission of mother- other • Readmission of baby with feeding problems • Readmission of baby - other • Discharged home with urinary follow up appointment • Absence of baby ID bands • Failure to notify discharge to community • Pressure sore • Baby fall