THE MATERNITY & NEONATAL RISK MANAGEMENT ANNUAL REPORT

PURPOSE:

This paper covers the period 1st April 2014 to 31st March 2015 with the aim of assuring the board members that the Maternity and Neonatal Services are committed to minimising risk, and improving patient safety. This is achieved through a comprehensive, pro-active, multidisciplinary approach to risk management.

The purpose of the Maternity and Neonatal Services Risk Management Strategy is to reinforce the underlying sentiment of the Trusts Risk Management Strategy, which is: To ensure that a culture is maintained where proactive risk management and safety is everyone’s business, ensuring an open and transparent approach to reporting that promotes learning and prevents future adverse outcomes.

MAIN ISSUES:

There should be evidence that the learning arising from adverse events, root cause analysis, claims, complaints and supervisory reviews are shared throughout the Maternity and Neonatal Service and as necessary through the organisation.

Some of the recommendations, changes to practice, and learning arising from incidents.

2.5.1 Fetal surveillance and the correct plotting of fundal height on the growth chart: Continual training and reviews of fetal surveillance is ongoing to ensure the profile is constantly high.

Work continues to implement the GROW programme (Perinatal Institute’s Growth Assessment Protocol, GAP). (Training for Midwives and Obstetricians is underway but there is a shortage of Sonographers. 1 midwife will complete this training by the end of September 2015, and 2 Midwives will be trained by the end of the year. The radiology department are supporting their clinical practice hours).

2.5.2 New guidance on antenatal interpretation of CTG’s Computerised CTG’s or Dawes Redman monitors are used on all antenatal women to aid interpretation of fetal surveillance. Guidance around this analysis is to be written to enhance clinicians interpretation and understanding.

2.5.3 Telephone triage. Work has been done to improve the telephone triage proforma that is completed when women telephone the labour ward. Additional questions have been added which will prompt the question around previous telephone calls in. Staff are then encouraged to invite women in for a review if they have made contact on 2 occasions previously within a limited timeframe with the same concern.

2.5.4 3rd and 4th degree tears. Discussion continues regarding the number of reported births that have resulted in the complication of 3rd and 4th degree perineal tears. Salisbury’s current rate of 3rd and 4th degree tears (which are measured together) has decreased from 3.9% to 3.4%. A continuous review of each case is undertaken but there remains no clear contributing factors apart from women are larger today (which is a known risk factor) according to a recent local audit and report. All incidences of 3rd and 4th degree tears are reviewed individually and any practice concerns investigated and reported back to clinicians and if necessary to their line managers.

The number of 4th degree tears have decreased – 3 incidents were reported during the period of 2014/15 compared to 4 the previous year and 8 in 2012/13.
2.5.5 Commissioning arrangements for the Newborn hearing screening programme are now in place. The national recommendation that a local manager oversees this screening has now been agreed and commissioned within the Maternity tariff.

2.5.6 Investigation into the maternal death is currently under review and learnings are still to be agreed.

**Summary of 2014/15 achievements**

- Positive progress in all of the Risk Management Strategy measurable objectives
- Friends and Family testing has been consistently positive since its implementation in October 2013. Friends and Family responses have increased within Maternity services. There has been a real drive to emphasise the importance of this initiative and all staff have embraced this. It will take time for this to become truly embedded in everyday practice, but the increase in rates has been encouraging. New systems are in place within the Labour Ward to ensure all staff are aware of the need to promote the forms. In the Postnatal area, the forms are discussed and given out at the point of discharge and women and their partners are encouraged to complete the form prior to leaving. We hope to see our rates increase further over the coming months.
- The real time feedback for the Maternity Service has been consistently positive.
- The ongoing development of a rag rated clinical dashboard enabling benchmarking against other trusts in the South West.
- A huge amount of ongoing multidisciplinary teamwork with updating clinical guidelines and joint collaborative working with the quality team to improve how clinical guidelines are accessed on ICID.
- Work force review looking at activity and planning for the next 3 years alongside projected birth numbers and activity in the community has been undertaken.
- The undertaking of Birthrate plus audits to provide the specific data required to accurately measure staffing against acuity.
- Restructure of the departments PROMPT training. To incorporate CTG training and sepsis into the PROMPT day so that all doctors and midwives receive the same training.
- The leadership team to drive robust appraisals using the new SPIDA tool.
- The successful introduction and training to implement Datix web reporting of incidents within maternity and neonatal unit. This can be evidenced by an 11% increase in the reporting of incidents.
- The completion of the obstetric theatre provision.
- The uptake of staff GROW training in preparation for the implementation of customised fetal growth charts. The GROW project forms part of the Trusts ‘Sign up to safety’.
- Scanning capacity has been stretched to over capacity which has hampered the delay in implementing GROW. 3 midwife sonographers will be qualified by September 2015 which will enable this implementation to go ahead.
- A scoping exercise has been conducted looking at the capacity and demand as the current antenatal template is severely overbooked and has not been reviewed for 10 years. A further consultant clinic is to be introduced later this year.
- The number of non-labouring admissions has again marginally risen provoking a review of the antenatal DAU service.
- The implementation of Allocate for electronic off duty rosters.
- Baby steps was implemented within the public health agenda. It is an intensive programme of education delivered to vulnerable families and has a strong evidence
base suggesting that the programme directly impacts upon health and social outcomes for babies and children.

- PIMS (Positive image motivation service) is a new initiative that is supported by the Wiltshire public health team. This is a concentrated care package for women with raised BMIs to support them to manage weight gain in pregnancy and to make life changing choices that enable them to be healthier in the long term.
- Maternity is participating with the RCOG national audit ‘Each baby counts’.
- On going development with Duty of Candour to maintain open and transparent culture within the department.

**Future Plans**

- Continue to promote an open and supportive approach towards risk which continues to reflect an environment in which staff feel able to report so that reporting rates increase.
- New Midwifery-led unit is to be built to increase birth choices for women.
- A 24/7 operational Obstetric theatre.
- The recruitment and appointment of a local manager and an administrator for NHSP.
- The refurbishment of the postnatal ward.
- To include bank staff into the Allocate rostering system.
- To continue participation into the National audit Each Baby Counts the lead by RCOG’s
- Completion of the stillbirth review.
- Completion of OASIS review.
- Salisbury has signed up to be an early implementer for the NHS England ‘Reducing stillbirths care bundle’.

The maternity unit had a visit from the NMC as part of an overall audit of the LSA of the South West Region. They undertook two site visits as part of their audit and Salisbury was chosen by the LSA midwifery officer as she felt the function of supervision of midwifery is undertaken well. The audit was successful and there were no actions related to the part that Maternity played in the audit. The maternity unit received positive feedback on the day and were informed that the NMC found the Maternity Unit to be welcoming and friendly, and the environment was clean and bright. Feedback from women they spoke to on the day was very positive.

The Local Supervising Authority (LSA) carried out their annual audit of supervision of midwives in Salisbury three weeks after the NMC visit. The day began with a presentation, to an invited audience, by the supervisory team on achievements of the 2014 action plan. The LSA examined health care records, patient information, specific care plans written for women with complex care needs. They toured the unit taking note of the security of records throughout and the environment.

**ATTACHMENT AVAILABLE TO VIEW ON WEBSITE:** The Maternity and Neonatal Risk Management Annual Report (full paper).

**ACTION REQUIRED BY THE BOARD:** To note and ratify report.

**Author:** Louise Jones  
**Title:** Maternity Risk and Governance Manager  
**Date:** September 2015
SALISBURY NHS FOUNDATION TRUST

Maternity and Neonatal Risk Management Annual Report 2014/15

1. Introduction

This paper covers the period 1st April 2014 to 31st March 2015 with the aim of assuring the board members that the Maternity and Neonatal Services are committed to minimising risk, and improving patient safety. This is achieved through a comprehensive, pro-active, multidisciplinary approach to risk management.

The purpose of the Maternity and Neonatal Services Risk Management Strategy is to reinforce the underlying sentiment of the Trusts Risk Management Strategy, which is: To ensure that a culture is maintained where proactive risk management and safety is everyone’s business, ensuring an open and transparent approach to reporting that promotes learning and prevents future adverse outcomes.

To achieve this the following outcomes are set out within the Risk Management Strategy:

- A culture where risk management and patient safety is everyone’s business by ensuring clear understanding of roles and responsibilities related to risk.
- Building on the high standard of care already being provided through improvements, and the prevention, control and containment of risk.
- Maintenance of a safe environment for patients, employees and visitors.
- A robust and proactive system for reporting and analysis of adverse incidents (including near misses) with subsequent learning for all staff.
- The adoption of an open and fair approach to incident investigation which will include a culture of Being Open with patients and their families when incidents have occurred.
- Compliance with the Care Quality Commissions Essential Standards of Quality and Safety.
- Compliance with the South of England’s SI Trigger List 2014.


Achievement of the following key objectives are considered essential for the successful implementation of the Maternity and Neonatal Services Risk Management Strategy. These objectives are also steered by the Clinical Support and Family Services Directorate and recommendations from national reports.

2.1 An annual report must be produced and presented to the Trust Board to show clear direction of travel against the aims and objectives of this strategy within the Maternity and Neonatal Service. Achieved by way of this document
2.2 Incident reporting rates should continue to rise as the open reporting of incidents is encouraged within an open and fair culture.

<table>
<thead>
<tr>
<th>Year</th>
<th>Total number of incidents reported for year</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012/13</td>
<td>446</td>
</tr>
<tr>
<td>2013/14</td>
<td>477</td>
</tr>
<tr>
<td>2014/15</td>
<td>530</td>
</tr>
</tbody>
</table>

The total number of incidents reported has increased by 53 (11.11%) on the previous year. An open and supportive approach towards risk continues, which reflects an environment in which staff should feel able to report. The monthly incident report summary continues to be cascaded to all staff outlining all incidents reported, agreed outcomes thus creating an opportunity for discussion, but fundamentally for learning to be enhanced, this ensures that there is transparency surrounding activity, that there is a robust process for reviewing and investigating incidents and that the outcomes and any learning achieved can be fed back to the workplace.

All reviews/investigations are shared in full with families and staff members who have been directly involved in the care. When an incident is identified that requires a review the Maternity Risk and Governance Manager contacts the family in writing to inform them that there will be a review into their care. At that time the family are invited to ask questions they feel they would like included in the review. Families are given regular updates on the progress and a meeting is offered in person to the family to share the findings of the review when it is completed.

The Maternity Risk and Governance Manager and the Obstetric Consultant lead for risk work collaboratively to ensure all risks and incidents are considered, and that the duty of candour is extended and upheld for all moderate incidents.

The reports, with the recommendations raised from incident reviews and investigations, are cascaded and shared throughout the department and discussed in the multidisciplinary Clinical Governance Forum. A paper copy of all reviews is then kept within the clinical areas for staff to access to promote ongoing learning.

The table below shows the breakdown of incidents by severity. There has been an increase in the number of catastrophic incidents reported from 2 to 3 since previous year. The number of majors have reduced from 2 to 1 incident over the year (all subject to SII or Clinical Reviews), with a reduction in moderate and minor events and a significant increase in the number of no harm events reported.
The largest number of reported incidents 234, (43.3%), were clinical incidents within the labour and delivery stage of care (Intrapartum), this is unchanged from the previous year. The majority of these are trigger events which are known potential complications of labour that all maternity units should be reporting against. This allows us to monitor whether complication rates are rising and therefore where further investigation should be focussed.

2.3 All staff groups across Maternity and Neonatal Services must report incidents as per the Adverse Events Reporting Policy and in compliance with the Maternity and Neonatal services Trigger List (appendix 1).

The graph below demonstrates the reporting rates amongst non midwife groups. The number of midwives reporting incidents has increased however the other groups have either stayed the same or reduced. This is likely to be due to the implementation of Datix web and staff in these groups are being encouraged to sign up to the training.
Staff types reporting incidents Period: 1st April 2014 - 31st March 2015

<table>
<thead>
<tr>
<th>Staff Type</th>
<th>Incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bank/Agency/Locum</td>
<td>1</td>
</tr>
<tr>
<td>Administration/Clerical/Secretarial</td>
<td>2</td>
</tr>
<tr>
<td>Ancillary</td>
<td>4</td>
</tr>
<tr>
<td>External</td>
<td>5</td>
</tr>
<tr>
<td>Clinical Assistant</td>
<td>10</td>
</tr>
<tr>
<td>Medical</td>
<td>12</td>
</tr>
<tr>
<td>Not known</td>
<td>14</td>
</tr>
<tr>
<td>Manager</td>
<td>16</td>
</tr>
<tr>
<td>Allied Health Professional</td>
<td>21</td>
</tr>
<tr>
<td>Nursing/Midwifery</td>
<td>445</td>
</tr>
</tbody>
</table>

2.4 Where necessary incidents will be reported to other agencies, for example: NPSA, Director of Public Health, MBRACE, UKOSS, NHS Litigation Authority and Local Supervising Authority, RCOG (each baby counts).

In September 2014, the web reporting of incidents to the electronic database (Datix) was implemented in Maternity. All adverse incidents and near misses are now inputted onto the Trusts electronic database (DatixWeb).

Once inputted Datix web automatically notifies the Maternity Risk and Governance Manager, the Labour Ward Manager and the Contact Supervisor of Midwife of the incident. The Maternity risk and Governance manager considers whether there are any fitness to practice issues. This would necessitate escalation to the Head of Maternity and Neonatal services in the first instance. This may lead to a Supervisory review conducted by a Supervisor of Midwives (SOM) and inputted onto the LSA database.

Via Datix web clinical ward leads are notified of the incidents through email and are then able to investigate the incident within their area of expert knowledge and can complete the investigation. Once completed the grading is confirmed by the Maternity Risk and Governance manager and are then moved onto to the risk department for review and closure of the incident. Datix reporting system is used for the logging of all incidents which are reported and these are then monitored at the monthly Maternity Risk Management forum and the Trusts Clinical Risk Group. The Risk and Governance Manager reports all serious incident inquiries (SII's) to the head of Risk Management and they are then reported through STEISS.

Maternity services ensure that any external reporting requirements are met in collaboration with the Head of Risk.

Each Baby Counts is the RCOG’s national quality improvement programme to reduce the number of babies who die or are left severely disabled as a result of incidents occurring during term labour. The maternity and neonatal services signed up to this initiative when it launched in January 2015.
2.5 There should be evidence that the learning arising from adverse events, root cause analysis, claims, complaints and supervisory reviews are shared throughout the Maternity and Neonatal Service and as necessary through the organisation.

Feedback and learning from reviews are discussed at the department’s Clinical Governance sessions. This is a multidisciplinary forum where lessons learnt can be cascaded. All Clinical Reviews/Serious Incident Inquiries are reported to Clinical Risk Group, and Trust Board, detailing the nature of the incident, the key findings and subsequent recommendations. The Head of Risk Management also provides the Clinical Governance Committee with a quarterly report on compliance with the recommendations from the reviews. Some of the recommendations, changes to practice, and learning arising from incidents.

2.5.1 Fetal surveillance and the correct plotting of fundal height on the growth chart: Continual training and reviews of fetal surveillance is ongoing to ensure the profile is constantly high. Work continues to implement the GROW programme (Perinatal Institute’s Growth Assessment Protocol, GAP). (Training for Midwives and Obstetricians is underway but there is a shortage of Sonographers. 1 midwife will complete this training by the end of September 2015, and 2 Midwives will be trained by the end of the year. The radiology department are supporting their clinical practice hours).

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The number of 4th degree tears have decreased – 3 incidents were reported during the period of 2014/15 compared to 4 the previous year and 8 in 2012/13.

2.5.5 Commissioning arrangements for the Newborn hearing screening programme are now in place. The national recommendation that a local manager oversees this screening has now been agreed and commissioned within the Maternity tariff.
2.5.6 Investigation into the maternal death is currently under review and learnings are still to be agreed.

2.6 Maternity and Neonatal Risk Group is to meet at least 10 times annually with an attendance list and documented minutes of actions being taken

The Maternity and Neonatal Risk Management group has met on 10 occasions throughout this period. The forum is jointly chaired by the Maternity Risk and Governance Manager and the Lead Obstetric Consultant for risk. Attendance from the Head of Maternity, the Lead anaesthetic Consultant for Obstetrics and the Paediatric Consultant for risk is mandatory. This forum is supported by the Trust Lead for risk and any concerns she has are escalated to the Executive lead for risk.

The attendance at maternity risk forum is encouraged for all staff, to promote openness and for learning. All meetings are minuted, actions identified and a copy disseminated to all staff through the communication folders and a quarterly report is circulated in the form of a newsletter updating staff on key areas to raise awareness and promote learning. The minutes provide an audit trail which provides a link to the other forums when issues need to be discussed with a wider group of staff. (see appendix 1 for Terms of reference). Staff are keen to learn about outcomes of incidents that they have reported, and this continues to be acknowledged as a positive change.

2.7 The Maternity and Neonatal Risk Group must report to the Trust Clinical Risk Group as a standing agenda item.

The Maternity Risk and Governance Manager and/or the Obstetric Consultant lead for Risk and Governance have attended the Trusts Clinical Risk Group monthly where Maternity and Neonatal risk items are a standing agenda item, and the maternity dashboard is presented for scrutiny. The development of a regional dashboard is underway and the department intends to use this toll for further benchmarking by the end of 2015.

A robust review into stillbirths was undertaken and shared with the clinical risk group and with the commissioners.

2.8 There must be attendance at the Directorate Governance 3:3 by the Head of Midwifery (or nominated deputy) to ensure that maternity and neonatal incidents and risks are discussed as part of the Directorate Risk Register and Incident Report Card with the executives present and the Head of Risk Management.

The Head of Midwifery attends the Directorate 3:3s to ensure a seamless and open reporting structure of relevant information relating to risk and governance.

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

A work force review has been undertaken and was presented at the October 2014 Trust Board. There was acknowledgment that the midwife to birth ratio was not at an acceptable level. Although 1:1 care in labour is maintained this requires frequent use of the escalation process which pulls on the community teams. These discussions initiated Birth Rate Plus to be commissioned in undertaking work within the department during November 2014 to January 2015 to provide further detail around staffing and the units activity. The final report from the birth rate plus assessment was circulated and a business case put forward to the Director of Nursing and the Chief Operating Officer prior to being discussed within the project board. An immediate appointment of 5 band 6s was agreed increasing our WTE from 73 to 78. Ongoing recruitment of staff continues.
2.10 **There should be evidence that National Guidance i.e. NSF / NICE / National Confidential Enquiries have been reviewed and recommendations implemented where appropriate.**

All Trust clinical guidelines are based on relevant national guidance and are formally approved through the Trust process. Within maternity and the neonatal service new guidance that is released nationally is reviewed within the Governance forums. The findings are then presented and discussed at the Maternity/Neonatal Clinical Governance Forum. A baseline audit assessment is then undertaken by a nominated clinician to ensure that recommended quality standards are included within the local guidance as applicable. The audit results are returned to the clinical governance session for review, and adjustments to practice are made following discussion.

2.11 **Risk and patient safety awareness is everyone’s business and is included in all staff’s job description.** Achieved

2.12 **The Maternity and Neonatal Service must have a dynamic risk register which shows depth and breadth of risks identified. Risks should be reviewed as a standing agenda item (as a minimum quarterly) at the Maternity and Neonatal Risk Group meeting. As a result all risks should be in date.**

The Risk Register is maintained and discussed as a set agenda at the monthly Maternity and Neonatal Risk Management meeting within a multidisciplinary forum. All risks due for review are assessed and the risk escalated or reduced as the risk changes. A number of risks have been closed on the register due to successful capital bids such as, the Maternity call bell system – The old system was no longer able to meet the needs of the service with many points of call beyond repair. The new call bell system in the NNU was not able to link to the rest of the maternity system and in parts of the NNU the system wasn’t working at all. Money was agreed and the system was replaced.

Departmental risks are identified through adverse events/near misses, complaints, claims, clinical risk assessments, health and safety inspections and audit and incorporate all risks associated with delivery of care.

The current top 2 risks on the departmental risk register are:

**Maternity staffing** which is reviewed monthly. The complexity of this involves balancing a static number of staff with an inability to exactly predict when women will labour. National guidance is available to support midwifery staffing numbers which the department considers alongside the local skill mix review process. As previously stated in 2.9 a work force review has been undertaken which initiated the commissioning of Birth Rate Plus to review the departments staffing and acuity. This work is ongoing as part of the Maternity Services Review

Day to day a robust escalation plan is utilised to ensure 1:1 care in labour and the safety of women. This is led by the supervisors of midwives out of hours and a duty manager during office hours. There is a National Maternity review underway and this is expected to have an impact on traditional working patterns. The full review is expected to be published in early 2016

**The dedicated obstetric theatre** has been an emergency provision open between 8am to 5pm on weekdays for the last 15 years. This risk is reviewed 3 monthly on the risk register. Agreement is now in place that the theatre will function 24 hours 7 days a week. Plans are underway for this to be implemented by October 2015.
3. **Serious Incident Inquiries (SII)/Clinical Reviews.**

The department has undertaken 7 reviews during the 2014/15 period compared to 8 in 2013/14.

1 review was completed using the local review format, and 6 were reported as SII’s. (This compared to 5 SII’s that were reported during 2013/14). The number of incidents that required formal escalation within the Trust was expected to increase due to the change to the South of England reporting structure which has extended the definition of SII’s.

All reviews had engagement from staff involved in all aspects of care, and involvement with each of the families was sought. As a result of these reviews a number of recommendations were made and implemented. The recommendations are reviewed prior to implementation and are then monitored by the clinical governance committee.

The number of still births in 2011/12 had risen to 14 (0.5%) prompting a thorough, multidisciplinary review. The number of stillbirths in 2012/13 decreased to 8 (0.3%) and in the year 2014/15 that number increased to 10 (0.4%). Of these 10, 2 had known abnormalities but had chosen to continue with their pregnancies. Each case continues to be reviewed individually at the monthly Perinatal meeting and when necessary, are commissioned as a clinical review/SII. (2 of these were investigated as SII’s this year). A repeated stillbirth review (2012-2014) is underway following on from the previous years (2010-2012) investigation.

4. **User Feedback**

Overall complaints and concerns have been reduced by half from the previous year. This is partly due to the provision of face to face meetings with families providing them with an opportunity to air their concerns at the earliest opportunity. This can also be attributed to the workforce embracing the need to have robust communication.

All complaints, concerns and comments are examined for trends and themes. During this period there have been 14 complaints and 10 concerns

4.1 **Complaints**

It would seem that there was an emerging theme during this period where staff behaviour, in particular, their attitude was raised in 4 complaints. These were involving different members of staff and a variety of situations within the maternity unit. When examining each incident further, it would appear that there was some miscommunication and a feeling that the complainant’s were unhappy with the advice or management plans offered rather than the way in which these were communicated.

3 complainants identified, clinical management decision made in the intrapartum period as their main concern.

2 complaints were related to incidents which occurred several years ago. One in relation to an incorrect diagnoses of a DVT and the other regarding the management of a case were an incorrect HIV result was shared with the family.

The remainder of the complaints on analysis do not share common themes:

- The provision of Paediatric Services on the postnatal ward
• Management of ‘prolonged rupture of membranes (PROM)’, in particular Group B strep and the late onset of neonatal sepsis.
• Safeguarding issue, requiring the removal of the baby at birth, Mother felt this management was unjust.
• Information governance concern surrounding the sharing of patient’s information amongst other staff members.
• Waiting time in the Day Assessment Unit.

4.2 Concerns

2 concerns were raised regarding staff attitude. Again these were isolated incidents.

• Difficulties accessing a community midwife.
• Standard of amenity rooms. More than one family commented on the poor standards of these rooms. These have recently been upgraded during the postnatal refurbishment.
• Anomaly scan appointment time was changed and no apparent apology offered.
• During transfer to theatre, a woman’s jewellery was removed. The woman’s earrings was thought to be placed in the midwife’s scrub pocket and unfortunately was misplaced. All jewellery is given to family members for safe keeping. Community midwives encourage women not to bring in valuables with them to the hospital.
• A woman received an anomaly scan appointment when sadly she had lost her baby at 15 weeks gestation. Changes to the bereavement paperwork has been made to prevent a recurrence of this. Antenatal clinic staff are now responsible in cancelling all antenatal appointments in the event of a miscarriage.
• Lack of fetal medicine support when sadly a fetal abnormality was detected. Poor management decision following the TOP.

5. Summary of 2014/15 achievements

• Positive progress in all of the Risk Management Strategy measurable objectives.
• Friends and Family testing has been consistently positive since its implementation in October 2013. Friends and Family responses have increased within Maternity services. There has been a real drive to emphasise the importance of this initiative and all staff have embraced this. It will take time for this to become truly embedded in everyday practice, but the increase in rates has been encouraging. New systems are in place within the Labour Ward to ensure all staff are aware of the need to promote the forms. In the Postnatal area, the forms are discussed and given out at the point of discharge and women and their partners are encouraged to complete the form prior to leaving. We hope to see our rates increase further over the coming months.

• The real time feedback for the Maternity Service has been consistently positive.
• The ongoing development of a rag rated clinical dashboard enabling benchmarking against other trusts in the South West.
• A huge amount of ongoing multidisciplinary teamwork with updating clinical guidelines and joint collaborative working with the quality team to improve how clinical guidelines are accessed on ICID.
• Work force review looking at activity and planning for the next 3 years alongside projected birth numbers and activity in the community has been undertaken.
• The undertaking of Birthrate plus audits to provide the specific data required to accurately measure staffing against acuity.
• Maintaining the quarterly 'quality of midwifery supervision' meeting occurs with the Director of Nursing, Head of Midwifery, Head of Governance and the Contact Supervisor of Midwives to feedback outcome of supervisory investigation and completion of any recommendations to provide additional assurance to the Trust.

• Restructure of the departments PROMPT training. To incorporate CTG training and sepsis into the PROMPT day so that all doctors and midwives receive the same training.

• The leadership team to drive robust appraisals using the new SPIDA tool.

• The successful introduction and training to implement Datix web reporting of incidents within maternity and neonatal unit. This can be evidenced by an 11% increase in the reporting of incidents.

• The completion of the obstetric theatre provision.

• The uptake of staff GROW training in preparation for the implementation of customised fetal growth charts. The GROW project forms part of the Trusts ‘Sign up to safety’.

• Scanning capacity has been stretched to over capacity which has hampered the delay in implementing GROW. 3 midwife sonographers will be qualified by September 2015 which will enable this implementation to go ahead.

• A scoping exercise has been conducted looking at the capacity and demand as the current antenatal template is severely overbooked and has not been reviewed for 10 years. A further consultant clinic is to be introduced later this year.

• The number of non-labouring admissions has again marginally risen provoking a review of the antenatal DAU service.

• The implementation of Allocate for electronic off duty rosters.

• Baby steps was implemented within the public health agenda. It is an intensive programme of education delivered to vulnerable families and has a strong evidence base suggesting that the programme directly impacts upon health and social outcomes for babies and children.

• PIMS (Positive image motivation service) is a new initiative that is supported by the Wiltshire public health team. This is a concentrated care package for women with raised BMIs to support them to manage weight gain in pregnancy and to make life changing choices that enable them to be healthier in the long term.

• Maternity is participating with the RCOG national audit ‘Each baby counts’.

• On going development with Duty of Candour to maintain open and transparent culture within the department.

6. Future Plans

• Continue to promote an open and supportive approach towards risk which continues to reflect an environment in which staff feel able to report so that reporting rates increase.

• New Midwifery-led unit is to be built to increase birth choices for women.

• A 24/7 operational Obstetric theatre.

• The recruitment and appointment of a local manager and an administrator for NHSP.

• The refurbishment of the postnatal ward.

• To include bank staff into the Allocate rostering system.

• To continue participation into the National audit Each Baby Counts the lead by RCOG’s.

• Completion of the stillbirth review.

• Completion of OASIS review.

• Salisbury has signed up to be an early implementer for the NHS England ‘Reducing stillbirths care bundle’.
The maternity unit had a visit from the NMC as part of an overall audit of the LSA of the South West Region. They undertook two site visits as part of their audit and Salisbury was chosen by the LSA midwifery officer as she felt the function of supervision of midwifery is undertaken well. The audit was successful and there were no actions related to the part that Maternity played in the audit. The maternity unit received positive feedback on the day and were informed that the NMC found the Maternity Unit to be welcoming and friendly, and the environment was clean and bright. Feedback from women they spoke to on the day was very positive.

The Local Supervising Authority (LSA) carried out their annual audit of supervision of midwives in Salisbury three weeks after the NMC visit. The day began with a presentation, to an invited audience, by the supervisory team on achievements of the 2014 action plan. The LSA examined health care records, patient information, specific care plans written for women with complex care needs. They toured the unit taking note of the security of records throughout and the environment.
MEETINGS AND FORUMS

TERMS OF REFERENCE

Maternity and Neonatal Risk Management Form

- **AIMS.**

To ensure systems are in place so that women and their families experience safe, high quality, clinically effective care at all times. The overriding commitment of the Maternity and Neonatal Risk Management forum is to encourage safe effective clinical practice. In addition to this, the group is committed to implementing activities designed to identify and decrease the risk of patient injury associated with clinical care.

The main functions of the group are:

- To encourage safe, effective clinical practice.
- To feedback through the workforce via; communication groups, Supervisors meetings, Community midwives meetings, directly to staff involved.
- To monitor and review the departmental risk register.
- Monitor and review the maternity and Datix monthly report card
- To review monthly incidents, identify trends/themes in reporting and cascade these out to staff groups through quarterly newsletter.
- Keep minutes of meetings with recommendations and responsibility for action. These should be cascaded out to staff groups.
- Monitor clinical audit plans and ensure that lessons learned/ feedback is given to staff.
- Act as a central pool of expertise to supplement and support risk management work across the service and encourage a systematic approach to the management of clinical risk.

**MEETINGS AND AGENDAS**

- Meetings will be held monthly (a minimum of 9 meetings should take place throughout the 12 months)
- The quorum for the group is 4 members (either Maternity Risk Manager, or consultant lead to chair meeting)
- Members are expected to attend 5 out of 10 meetings annually.
- Obstetric Lead for Risk or Head Of Midwifery must be present to ensure information is disseminated fully.
- Agenda items should be notified to the chair 7 days prior to the meeting.
- An agenda should be issued 3 days prior to the meeting.
- Minutes should be available 7 days from the meeting.
- Records of Meetings will be maintained

**Membership**

Consultant Obstetrician lead for risk (Chair)
Maternity Risk and Governance Manager
Head of Maternity and Neonatal Services
Consultant Anaesthetist
Postnatal and Neonatal Services Manager
Labour ward lead
Community Manager and Named Midwife for Safeguarding children.
Consultant Paediatrician
Antenatal lead
Supervisor of Midwives
Minimum attendance being 50%
(This forum is open to all clinical staff within the Maternity and Neonatal department).