MATERNITY RISK MANAGEMENT STRATEGY 2015/16

PURPOSE:

To present the Trust Board with the revised Maternity Risk Management Strategy for approval.

MAIN ISSUES:

The overall objective of the Risk Management Strategy is to ensure that robust risk management processes are in place within the Maternity and Neonatal unit which will assure the Trust Board.

Key items to note:

Additional text has been added to section 8.2.6 detailing the role of Antenatal Manger

Appendix 2: Updated departmental structure.

ACTION REQUIRED BY THE BOARD:

The Trust Board is asked to consider and approve the revised Maternity and Neonatal Risk Management Strategy 2015.

ATTACHMENT/S AVAILABLE TO VIEW ON WEBSITE:


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TITLE: Maternity Risk and Governance Manager
MATERNITY AND NEONATAL SERVICES
RISK MANAGEMENT STRATEGY

Post holder responsible for Policy: Midwife Risk and Governance Manager

Directorate responsible for Policy: Clinical Support and Family Services

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SDH

Date written: September 2010

Approved by: Maternity and Neonatal Risk Management Group

Date approved:

Ratified by: Trust Board

Date Ratified: October 2015

Next due for revision: October 2016

Date policy becomes live: October 2015

VERSION INFORMATION

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| 4.0     | Midwife Risk and Governance Manager | October 2013 | 8.2.2 Additional text  
|         |                |            | 8.2.7 Change to labour ward manager.  
|         |                |            | 8.2.10 Added role of duty manager.  
|         |                |            | 8.2.11 added text to Supervisors of Midwives  
|         |                |            | 8.2.12 Added role of contact Supervisor.  
|         |                |            | 11.1.2 added text  
|         |                |            | 11.1.3 added text  
|         |                |            | Appendix 3 Maternity Governance Monitoring structure |
| 5.0     | Midwife Risk and Governance Manager | October 2014 | 8.2.6 Added role of Community and Safeguarding Managers  
|         |                |            | 12: Additional text re Datix web  
|         |                |            | Appendix 11: SOM Trusts Assurance meetings. |
| 6.0     | Midwife Risk and Governance Manager | September 2015 | Appendix 2: Updated departmental structure.  
<p>|         |                |            | 8.2.6 Added role of Antenatal Services Manager |</p>
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1. INTRODUCTION

The purpose of the Maternity and Neonatal Services Risk Management Strategy is to underpin and support the Trust’s Risk Management Strategy by setting out the systems and processes to be used to manage risk within the Maternity and Neonatal Services. This Risk Management Strategy should be read in conjunction with the Trust’s Risk Management Strategy.

Risk management is a systematic method of identifying, analysing and evaluating risk associated with service activity. Risks have to be analysed, treated and monitored. In one sense, incident reporting is on the reactive side of risk management. More emphasis needs to be placed on the proactive side, as risk management is more effective when resources are used to minimise the occurrence of patient safety incidents instead of responding when things have gone wrong.

The Maternity and Neonatal Services at Salisbury NHS Foundation Trust are committed to providing a high standard of woman and infant centered care. The complex nature of healthcare provided by the service and the high cost in terms of personal, financial, and reputational loss if unexpected outcomes occur is well recognised.

The Trust is committed to providing a Maternity and Neonatal Service that is focused on patient safety, professional and public accountability, whilst acting responsibly within the financial and resource constraints imposed upon it. The service accepts that ‘honest failures’ will occur and believes that risk management can and will inform and improve practice. When things go wrong it is important that the response is one of openness and learning with a drive to reduce future risk for patients, as well as supporting patients, staff, and anyone who may suffer as a consequence. Every incident reported presents a learning opportunity enabling improved delivery of future services.

The Maternity and Neonatal Service is thus committed to the challenge of minimising risk and improving patient safety through a comprehensive, pro-active, multidisciplinary approach to risk management.

This Maternity and Neonatal Services Risk Management Strategy details the risk structures and processes within the Maternity and Neonatal Services and how these feed into Salisbury NHS Foundation Trust’s risk framework. This strategy should be read in conjunction with the following Risk Management Policies which are all available on the intranet:

- Risk Management Policy and Procedure
- Adverse Events Reporting Policy
- Serious Incidents Requiring Investigation Policy
- Duty of Candour and Being Open Policy

2. DEFINITIONS

Throughout this Strategy the term ‘Maternity and Neonatal Service’ is used. This term includes the following services, whether provided in an acute, primary or community setting by Trust staff:

- Antenatal Services – The provision of healthcare monitoring during pregnancy for example screening, which assist in the assessment and monitoring of the current state of the pregnancy and its possible ongoing pregnancy effects on the woman.
- Intrapartum Services - The provision of healthcare from the onset of labour to the end of the third stage of labour.
• Postnatal Services - The provision of health care provided to a woman and her baby following the birth.
• Midwifery led care - Midwife led model of care based on the premise that pregnancy and birth are normal life events.
• Neonatal unit - The Neonatal Unit provides care for premature or sick newborn infants.
• Obstetric anaesthetics - The provision of anaesthetic services specifically for pregnant women.
• Obstetric theatre services - The provision of theatre services specifically for pregnant women.

3. Aim of the Maternity and Neonatal Services Risk Management Strategy

The aim of the Maternity and Neonatal Services Risk Management Strategy is to ensure that women and their families experience safe, high quality, clinically effective care at all times, to ensure a positive birth experience and a healthy outcome for mother and baby. Through a proactive approach to risk management, systems of care can be improved as deemed necessary to maintain high standards of care. Poor management of care is identified and immediately escalated.

The Maternity and Neonatal Services Risk Management strategy and the Trusts Risk Management Strategy, aim to achieve a culture where proactive risk management and safety is everyone's business, there is an open and honest reporting of incidents, a culture which encourages organisational learning, and risks are continuously identified, assessed and minimised. This is achieved through robust risk management processes within the department which will assure the Trust Board that it is discharging its responsibilities in relation to the management of risk in Maternity and Neonatal services.

4. Scope

This policy applies to all employees (including temporary staff and contractors) within the Maternity and Neonatal Service and requires an active lead from managers at all levels.

5. Outcomes

By putting the strategy into operation the Maternity and Neonatal Services aim to achieve:

• 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 NHS England’s (South) SI Trigger List.

6. Measurable Objectives For Managing Risk via the Maternity and Neonatal Services Risk Management Strategy

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 the recommendations
• 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.
• Incident reporting rates should continue to rise as the open reporting of incidents is encouraged within an open and fair culture.
• 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).
• 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.
• There should be evidence that the learning arising from adverse events, root cause analysis, claims, complaints and supervisory reviews is acted on and shared throughout the Maternity and Neonatal Service, and as necessary through the organisation.
• Maternity and Neonatal Risk Group is to meet as a minimum 10 times annually with an attendance list and documented minutes of actions being taken.
• The Maternity and Neonatal Risk Group must report to the Trust Clinical Risk Group as a standing agenda item.
• There must be attendance at the Directorate Governance performance meetings 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.
• 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.
• There should be evidence that National Guidance i.e. NSF / NICE / National Confidential Enquiries have been reviewed and recommendations implemented where appropriate.
• Ensure risk and patient safety awareness is an integral part of everyone’s role within Maternity and Neonatal Services.
• 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 at the Maternity and Neonatal Risk Group meeting. As a result there should be evidence that all risks are appropriate, in date, and subject to review.

7. Maternity and Neonatal Services Risk Management Structure
See appendix 2 for diagram showing all committees/sub committees/groups which have responsibility for risk.

8 Roles and Responsibilities:
8.1 Trust Level
8.1.1 The Chief Executive has the overall responsibility for risk management within Salisbury NHS Foundation Trust. This responsibility has been delegated to the Director of Nursing who is the Executive Lead for Risk.
8.1.2 The Director of Nursing has responsibility for the strategic management of risk across the whole Trust including Maternity and Neonatal services. The Director of Nursing has a lead role in liaising with the executive team to ensure risk has a high profile at Trust Board level and ensuring that there is a robust risk management framework in place across
the organisation resulting in the achievement of the objectives within the Trust Risk Management Strategy.

Specific duties include:

- Presenting the annual Risk Management Report to the Trust Board.
- Coordinating an annual Trust Board workshop along with the Head of Risk Management for both executive and non executive directors.
- Attending Trust Board meetings in capacity as Executive Lead for Risk (or nominated deputy).
- Attending Clinical Risk Group as Executive Lead for Risk (or nominated deputy).
- Commissioning of Serious Incident Inquiries and Clinical Reviews.
- Attending the Directorate performance meetings where risk registers and incident report cards are reviewed at Directorate level
- Monthly 1:1s with the Head of Maternity and Neonatal Service.

The Board Lead executive (Director of Nursing) communicates with and obtains assurance from the Maternity and Neonatal Service through:

- Attendance of both the Executive Lead (or nominated deputy) and Head of Maternity and Neonatal Services (or nominated deputy) at the Directorate performance meetings where risk issues are discussed through presentation of the Directorate Risk Register and Incident Report Card.
- Monthly 1:1s with the Head of Maternity and Neonatal Service.
- Attendance at the Clinical Risk Group (or nominated deputy) where maternity is a standing agenda item with reporting from the Maternity and Neonatal Risk Management Group.

8.1.3 Head of Risk Management

- The Head of Risk Management is responsible for maintaining and updating appropriate and compliant Risk Management Policies and procedures.
- The Head of Risk Management is responsible for co-ordinating and updating the Assurance Framework as well as presenting the document at the Assurance Committees.
- The Head of Risk Management is responsible for ensuring the Trust has a comprehensive and dynamic Risk Register and working with Directorate Management Teams to ensure that they understand their accountability and responsibilities for managing risks in their areas.
- The Head of Risk Management is responsible for ensuring information is provided on incident data to Directorate Management Teams, the Clinical Governance Committee, and Trust Board.

8.1.4 Directorate Management Team:

Directorate Management Teams are accountable and have authority to ensure appropriate risk management processes are implemented within their respective directorates and areas of authority. Each Directorate Management Team is required to:

- Work proactively to achieve the Trusts Key Performance Indicators for Risk Management.
• Understand and implement the Trust’s Risk Management Strategy and related policies.
• Ensure that appropriate and effective Risk Management processes are in place within their delegated areas.
• Ensure Directorate activity is compliant with national risk management standards and safe practices, alerts etc
• Develop specific objectives within their service plans which reflect their own risk profile and the management of risk.
• Risk assess all business plans/service developments including changes to service delivery.
• Ensure that risk assessments, both clinical and non-clinical, are undertaken throughout their areas of responsibility. The risks identified will be prioritized and action plans formulated. These action plans will be monitored through the 3:3 meetings.
• Maintain a directorate risk register (clinical, non-clinical and financial). Formally reporting high and extreme risks via the 3:3.
• Report all incidents in accordance with the Adverse Events and Near Misses Policy and identify action taken to reduce or eliminate further incidents.
• Undertake investigation into all serious incidents, in accordance with the Adverse Event Reporting Policy providing evidence of local resolution and learning.
• Disseminate learning and recommendations made as a result of incident investigations, clinical reviews, and serious incident inquiries within their areas of responsibility.
• Monitor and report on the implementation and progress of any recommendations made which fall within their area of responsibility i.e. within the Directorate.
• Ensure that all staff are made aware of risks within their working environment and their personal responsibilities within the risk management framework.
• Identify own training needs to fulfill the function of managing risk as a senior manager. As a minimum ‘Risk’ updates will be provided via the Directorate 3:3s. Further training can be accessed via the Risk Department.

8.2 Maternity and Neonatal Service Level

8.2.1 The Head of Midwifery and Neonatal Services is responsible for providing professional and managerial leadership for Midwives and Nurses within the service and is responsible for developing the strategic direction for the Maternity and Neonatal Services. The Head of Midwifery and Neonatal Services has overall responsibility for ensuring Risk Management Policies and procedures are in place within the Maternity and Neonatal Service. The Maternity Risk Manager is responsible for the day to day management of risk related activity and reports directly to the HOM.

Specific risk related duties include:

• Attending the Maternity and Neonatal Risk Management Group (or nominated deputy)

• Attending regular (at least quarterly) 1:1s with the Executive lead for Risk - the Director of Nursing at least quarterly.

• Attending Directorate 3:3s (or nominated deputy) where the Directorate Risk Register and Incident report card are discussed to ensure that the Maternity and Neonatal Service risks are discussed with the executive team.
8.2.2 Maternity Risk and Governance Manager

Operationally, the Maternity Risk and Governance Manager works collaboratively with the Head of Risk Management and the Head of Maternity and Neonatal Services. The Maternity Risk and Governance Manager works with the lead Obstetrician for Clinical Risk. Lead Obstetric Anaesthetist, lead Paediatrician, Labour ward Managers, Antenatal Manager and Community Manager to coordinate Risk management issues for the Maternity, Neonatal and Community setting.

Specific duties include:

- Co Chair of the Maternity and Neonatal Risk Management Group.
- Coordination of the Maternity and Neonatal Services Risk Register.
- Coordination of incident reporting processes within the department to ensure that all incidents are investigated to an appropriate level presenting findings from individual incidents or themes/trends across incident groups to the Maternity and Neonatal Risk Management Group.
- Share learning across the department as a result of incident investigations.
- Attend the Clinical Risk Group (or nominated deputy) to report on Maternity and Neonatal Risk activity on behalf of the Department and to report back any Trust issues at the Maternity and Neonatal Risk Management Group.
- Author of the Maternity and Neonatal Services Annual Report to the Trust Board.
- Act as a panel member on any Serious Incident Inquiries as nominated by the Executive Lead for Risk.
- Lead Midwife for Clinical Governance. Coordinates the audit programme and ensures learning from risk reviews are cascaded to all maternity and neonatal staff are incorporated into clinical policies and practices.

8.2.3 Consultant Lead for Labour Ward and Obstetric Risk Management

works with the Midwife Risk Manager to ensure implementation of the Risk Management Strategy and framework. Specific duties include:

- Co chairs the Maternity and Neonatal Risk Management Group.
- Attend the Clinical Risk Group (or nominated deputy) to report on Maternity and Neonatal Risk activity on behalf of the Department and to report back any Trust issues at the Maternity and Neonatal Risk Management Group.
- Act as a panel member on any Serious Incident Inquiries as nominated by the Executive Lead for Risk.
- Is responsible for providing clinical leadership for all medical staff working in the labour ward and ensures good inter-professional relationships are maintained. Specific duties include:
  - Involved in incident investigations and recommendations for improving practice.
  - Involved in Obstetric investigations and recommendations for improving practice as nominated.
  - Raises obstetric issues within the Maternity and Neonatal Risk Management Meeting and provides feedback on Risk Management issues to obstetric staff as appropriate.

8.2.4 Consultant Lead Obstetric Anaesthetist

is responsible for providing clinical leadership and organisation for all anaesthetic medical staff working in the unit and ensures good inter-professional relationships are maintained. Specific duties include:

- Involved in incident investigations and recommendations for improving practice.
- Attends the Maternity and Neonatal Risk Management Group (or nominated deputy).
- Raises anaesthetic issues within the Maternity and Neonatal Risk Management Meeting and provides feedback on Risk Management issues to anaesthetic staff as appropriate.
8.2.5 Consultant Lead for Neonatology is responsible for providing clinical leadership for all paediatric medical staff working in the unit and ensures good inter-professional relationships are maintained. Specific duties include:

- Involved in incident investigations and recommendations for improving practice.
- Attends the Maternity and Neonatal Risk Management Group (or nominated deputy).
- Involved in Obstetric/paediatric panel investigations and recommendations as nominated.
- Raises paediatric issues within the Maternity and Neonatal Risk Management Meeting and provides feedback on Risk Management issues to paediatric staff as appropriate.

8.2.6 Antenatal Services Manager

- Involved in incident investigations and recommendations for improving practice.
- Attends the Maternity and Neonatal Risk Management Group (or nominated deputy).
- Provides feedback to Antenatal Unit staff on any recommended changes to clinical practice arising out of incidents, complaints and claims.
- Work collaboratively with risk management team to ensure co-ordination, monitoring, investigation and learning from adverse events is managed appropriately.

8.2.7 Community Services Manager and Named Midwife for safeguarding children

- Ability to make judgements on a range of complex midwifery problems which require investigation, analysis and assessment
- Involved in incident investigations and recommendations for improving practice.
- Provides feedback to individuals and implement any recommended changes to clinical practice arising out of incidents, complaints and claims.
- Attends the Maternity and Neonatal Risk Management Group
- Working in partnership with Head of Maternity and Neonatal Services the post holder will lead and participate in the implementation of the Maternity Services Risk Management Strategy with a focus on the achievement of NHSLA Standards, NSF for Maternity Services, CQC expectations within safeguarding and ensuring compliance with appropriate Governance frameworks
- Work collaboratively with risk management team to ensure co-ordination, monitoring, investigation and learning from adverse events is managed appropriately.
- Development and delivery of safeguarding systems whilst ensuring the quality of safeguarding practices within maternity and neonatal services will be a priority.

8.2.8 Labour Ward Manager

- Involved in incident investigations and recommendations for improving practice.
- Attends the Maternity and Neonatal Risk Management Group (or nominated deputy).
- Provides feedback to individuals and implements any recommended changes to clinical practice as a result of incidents, complaints and claims.
- Work collaboratively with risk management team to ensure co-ordination, monitoring, investigation and learning from adverse events is managed appropriately.

8.2.9 Neonatal and Postnatal Services Manager

- Involved in incident investigations and recommendations for improving practice.
- Attends the Maternity and Neonatal Risk Management Group (or nominated deputy).
- Provides feedback to Postnatal and Neonatal Unit staff on any recommended changes to clinical practice arising out of incidents, complaints and claims.
- Involved in the coordination and running of Perinatal Morbidity and Mortality Forum.
8.2.10 Practice Development Midwife
- Attends the Maternity and Neonatal Risk Management Group (or nominated deputy).
- Co-ordinates and implements any recommended training schedules or changes to current training (TNA).
- Provides expert midwifery advice especially concerning training issues.
- Ensures the clinical guidelines used by the service are current and evidence based, where the evidence exists, to reflect best practice.

8.2.11 Duty Manager
- A senior midwife is rostered daily Monday to Friday to take the role of Duty manager.
- Management of off duty to ensure staffing levels and skill mix meet the needs of the service on a day to day basis.
- Assess the unit capacity, bed occupancy and anticipated requirements on the day shift and consider the need in the community if issues have been escalated from there.
- Co-ordinate unit breaks. Arrange with leads in each area that breaks are arranged early in the shift and taken.
- Co-ordinate escalation for increasing activity as required.
- Co-ordinate bed management and increasing capacity.

8.2.12 Supervisors of Midwives
Supervision is a statutory responsibility which provides a mechanism for support and guidance to every midwife. The purpose of supervision of midwives is to protect women and babies by actively promoting a safe standard of midwifery practice.
Supervision is a means of promoting excellence in midwifery care, by supporting midwives to practise with confidence, therefore preventing poor practice. (NMC 2009). Supervision of midwives sit externally to the Trust and are appointed by the local supervising authority midwifery officer.

- Supervisors utilise NMC rules/standard/code when contributing to risk management reports.
- A Supervisor of Midwives (SoM) attends all risk and governance forums to ensure that the statutory rules and standards relating to supervision of midwives and midwifery practice are met. (NMC 2009).
- A supervisor of midwives must be present on all risk review panels to provide assurance of the safety of women and babies. The SOM then acts as a link between risk management and the SOMs forum.
- Supervisors investigate any complaints or incidents involving midwifery practice. These reports are given directly to the LSAMO who makes the decision regarding the midwife’s fitness to practice. (This could be a local action plan, an LSA action plan or a referral to the NMC).
- The recommendations of the Supervisor of Midwives investigation may form part of the action plan for the Maternity Service in terms of practice development for the service or individual practitioners.
- Every midwife employed within the trust has a named SoM
- All midwives will have an annual supervisory review undertaken by their allocated supervisor of Midwives. On receipt of the annual LSA report
- Supervisors of midwives (SoM) will produce an action plan which along with the report will be presented and reviewed at the Maternity Clinical Governance Forum.
- All supervisors of midwives ensure that all practicing midwives submit their intention to practice annually by the 1st April and that this is entered onto both the LSA and NMC database to enable midwives to continue on the register.
• The team of supervisors of midwives at Salisbury Foundation Trust provide 24-hour on call cover for any practice issues or complex care planning. They are available for women, their families and midwives.
• The LSA Officer carries out an annual audit of supervisory activity within the unit and produces a report and a work plan which is sent to all supervisors of midwives, Head of Midwifery and the Director of Nursing.

8.2.12 Contact Supervisor of Midwives
• This is a named supervisor of midwives who is nominated by her peers to act as a conduit between the LSA and the supervisors of midwives and also between the supervisors, the head of midwifery and the wider Trust.
• Meets quarterly with all other contact supervisors of midwives and the LSAMO to discuss practice issues across the South West LSA region.
• Coordinates supervisory activity within the unit.
• Oversees all supervisor of midwives investigations locally.
• Provides a quarterly briefing paper and meets quarterly with the HOM and the DON to discuss supervisory activity including themes and feedback of any learning to the department. Provides assurance that midwives are safe to practice and any that concerns are investigated.
• To monitor completion of any LSA or local action plans for midwives.
• To monitor progress against the annual work plan.

8.2.13 All Maternity and Neonatal Services Staff
For risk management to be effective it must actively involve staff at all levels within the organisation (i.e. ‘Board to Ward’), it must be seen as everyone’s responsibility and not just that of any one individual or department.

All Staff are required to:
• Be conversant with the Maternity and Neonatal Services Risk Management Strategy and have a working knowledge of all related risk polices.
• Comply with Trust policies, procedures and guidelines to protect the health, safety, and welfare of any individuals affected by Trust activity.
• Acknowledge that risk management is integral to their working practice within the Trust.
• Report all incidents, near misses and be familiar with the reporting of trigger list, in accordance with the Adverse Events Policy and take action to reduce or eliminate further incidents.
• Report any risk issues to their line manager.
• Participate in the investigation of any adverse events as requested.
• Attend mandatory training appropriate to role.
• Staff must comply with professional guidelines (as applicable to their role and profession) and act in accordance with such guidelines and codes of practice.

9. Maternity and Neonatal Services Risk Register
The Maternity and Neonatal Risk Register is developed and managed in accordance with the Trust’s Risk Management Policy and Procedure.

9.1 Departmental Level
Departmental risks are identified through adverse events/near misses, complaints, claims, clinical risk assessments, health and safety inspections and audit and should incorporate all risks associated with delivery of care.
Risk assessments carried out within the Maternity and Neonatal Unit must utilise the format as set out in the Risk Management Policy and Procedure (available on the intranet). This process for submission and review must be adhered to.

The risk assessment proforma and risk rating matrix must be applied to all risk assessments.

Once a risk assessment is completed it must be submitted to the Maternity Risk and Governance Manager who will ensure its input onto Datix (risk software used across the Trust). This then provides the departmental risk register.

The Maternity Risk and Governance Manager will present any new, rising risks, or those requiring review at the monthly Maternity and Neonatal Risk Management Group meeting. The risk register should be seen as a dynamic process as ranking/prioritisation of risks will change as risk reduction practices take place.

### 9.2 Directorate Level

Each Directorate will continue to maintain a comprehensive risk register, which will be formally reviewed at four monthly intervals through the Directorate Performance Meetings. At these meetings the directorates will be expected to report on their risk register (risks scoring 12 or above), highlight any new or emerging risks to service delivery and present action plans for minimising and managing these risks. The performance meeting should identify those departmental risks which also pose a corporate threat and so require inclusion on the Trust Risk Register. The risk register should be seen as a dynamic process as ranking/prioritisation of risks will change as risk reduction practices take place. The DMT has responsibility for ensuring that all risks within the Directorate are appropriately graded and have sufficient actions in plan to mitigate/reduce the risk.

### 9.3 Trust Risk Register

The Trust Risk Register is a combination of risks identified at corporate level and those at departmental and Directorate level which have followed the process as set out above. On a quarterly basis the Head of Risk Management presents the Trust Risk Register to the Assurance Committees (Clinical Governance Committee - clinical risks; Joint Board of Directors - organisational, HR, IT risks; Finance Committee – financial risks) along with the Assurance Framework.

The Assurance Committee Chairs provide an exception report and minutes to the Trust Board following these quarterly reviews. The appropriate Assurance Committee or the Trust Board can recommend whether an extreme risk should be transferred onto the Assurance Framework.

### 10. Immediate Escalation Of Risk Management Issues To Trust Board Level

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

The Head of Midwifery and Neonatal Services or Midwife Risk Manager will inform the Executive Lead for Risk (Director of Nursing), the Head of Risk Management, and also a Directorate Management team member.

In normal working hours a phone call between the Head of Midwifery/Head of Risk/ Director (or her deputy) of Nursing to inform them of the incident that has occurred.

Out of hours this phone call will be between a senior midwife/ supervisor of midwives on call, to the on call Trust Director.

The phone call is then followed up with an email of confirmation to the Head of Risk/ Director (or her deputy) of Nursing. E-mails will also be sent to the Head of Midwifery/ Deputy.
The incident should be inputted onto datixweb, where appropriate. Serious incidents are managed in accordance with the Trust Serious Incident Policy (available on the intranet).

11. Learning as a Result of Incidents, Complaints, and Claims

11.1 Incidents
All reported incidents are reviewed by the Midwife Risk Manager and where necessary delegated to appropriate clinical experts to review further. When serious concerns are identified, these concerns are highlighted and acted upon immediately.

All staff should be aware of the Trust Adverse Event Reporting Policy (available on the intranet) and the requirements for the immediate reporting of serious events as set out in the Serious Incident Policy. (available on the intranet). All incidents should be reported onto datix web. (refer to how to report an incident appendix A, on the intranet). The Maternity and Neonatal Services have an established trigger list (appendix 1) which informs staff on the types of clinical events which must be reported via this route, although this is not exhaustive.

The level of investigation required is informed by the grading of the incident. All incidents are reported monthly at the Maternity and Neonatal Risk Management Meeting where trends and themes are identified across the incident categories. Any event graded as major or catastrophic is discussed individually and a full investigation commissioned with resulting findings and recommendations reported back into the group.

The maternity and neonatal incidents are also reported monthly at the Trust’s Clinical Risk Group as a standing agenda item. The Head of Risk Management produces a monthly report card which covers themes and trends across incident categories but also identifies any major or catastrophic events individually with narrative, this would also include any Maternity and Neonatal Services incidents of this severity. These individual incidents are discussed and the level of investigation agreed. Any Serious Incident Investigations should have been escalated immediately to the Head of Risk Management and Executive Lead for Risk as per the Serious Incident Policy and full investigation commissioned as a result of this. The Clinical Risk Group acts as a safety net and reflective forum to ensure that all serious events have been communicated and the appropriate level of investigation commenced.

11.1.2 Serious Incident Inquiries/Clinical Reviews
As a minimum any serious incident requiring Serious Incident Investigation or Clinical Review must undergo full investigation utilising root cause analysis methodology. Serious Incident Inquiries and Clinical Reviews are commissioned by the Executive Lead for Risk and coordinated by the Risk Management Department. A panel appropriate for the investigation will be nominated, this may include where required external panel membership. In all cases where a review has been commissioned a supervisory review is undertaken by 2 SOMs to assess if there are any practice issues relating to an individual midwife. If this is found to be the case the LSA midwifery Officer is informed and a supervisory investigation may be recommended and be conducted alongside the risk investigation. All SII should be uploaded onto the LSA database.

The final report and recommendations of any Clinical Review or Serious Incident Inquiry will be presented at the Clinical Risk Group for ratification to ensure that appropriate methodology has been used and the recommendations are valid. The final report is then signed off by the Chief Executive before being shared with the family.

11.1.3 Recommendations and Learning
Recommendations and learning from incidents are disseminated via the Clinical Governance...
Meetings, Maternity and Neonatal Risk Management Group meetings, Perinatal meetings and/or Maternity Governance Forum and Supervisors Forum. Maternity and neonatal incidents will be shared with all staff and changes/recommendations fed back through notice boards, emails, various forums and the minutes of these shared to reach the wider workforce staff.

11.1.4 Trust Board Assurance

The Trust Board are made aware of all commissioned clinical reviews and Serious Incident Inquiries through a report produced by the Head of Risk Management which is presented to the Trust Board as a minimum three times per year. This report can be requested more frequently by the Trust Board if there are particular issues arising.

The Head of Risk Management monitors progress against recommendations from all Clinical Reviews and Serious Incident Inquiries. Assurance is provided through a quarterly report produced for the Clinical Management Board which is also presented to the Clinical Governance Committee on an annual basis. The Annual Risk Management Report and Annual Maternity and Neonatal Risk Management Report also discuss changes to practice as a result of serious incidents.

11.1.5 Learning from Experience – Case Reviews

The Maternity and Neonatal Services are also committed to learning via the use of case reviews which are prepared and presented at the Perinatal Meetings.

11.1.6 Comments, Concerns and Complaints.

Comments, Concerns and complaints are coordinated by the Customer Care Department and managed within the Maternity and Neonatal Services as per the Customer Care Policy. Comments, concerns, and complaints data is recorded using Datixweb Risk Management software.

Comments and concerns raised with senior staff within the Maternity and Neonatal Services are addressed immediately, taking corrective action where appropriate. The Trust Customer Care Department can be called upon to assist staff in the resolution of issues in real time.

Complaints may be made in writing, via e-mail or verbally. Where practice issues or concerns relating to an individual midwife, the complainant will be offered an early face-to-face meeting to discuss their concerns with a Supervisor of Midwives. On these occasions, the minutes / outcome of the meeting will often be used to formulate a follow-up formal written response.

A report of new complaints received, response times for closed complaints and lessons learnt is presented at the Directorate 3:3 meeting quarterly. Patient surveys and PPI project results will also be received and analysed at this forum.

11.1.7 Unexpected admission to Neonatal Unit (see appendix 9)

All babies over 37 weeks gestation that are admitted to the neonatal unit, will have an incident form generated and case reviewed by an obstetrician, if the admission is straight from labour ward, or a paediatrician if the admission is via the postnatal ward. All cases will be entered onto the unexpected admissions to neonatal unit database and graded once the management of care has been reviewed. Lessons learnt will be circulated through direct feedback to individuals involved, communication groups, SOM meetings and community meetings.
11.2 Claims
The Maternity and Neonatal Service liaises closely with the legal department to deal with claims and potential claims arising out of complaints and incidents promptly and transparently.

12. Dissemination Of Lessons Learnt Within Maternity and Neonatal Services
Communicating the learning and recommendations from internal incidents, claims, and complaints is an important factor in the Maternity and Neonatal units approach to managing risk. Learning will be identified and disseminated through the Clinical Governance, Perinatal Mortality and maternity and neonatal Risk forums where practice change will be implemented.

Action plans resulting from Serious Incidents, case reviews, internal incidents, complaints and claims will be cascaded via
- communication groups.
- Notice Boards with information on current audits results and topics.
- Theme of the month
- File with all SII reports in clinical areas for clinicians to read.

13. Monitoring
The Maternity and Neonatal Services Risk Management Group will undertake an annual audit to ensure that the spirit of the Maternity and Neonatal Risk Management Strategy is met. This will be reported to the Maternity and Neonatal Risk Forum with an action plan if required.

Auditable standards:

<table>
<thead>
<tr>
<th>Standard</th>
<th>Evidence</th>
<th>Review/monitoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>M&amp;NRM meeting</td>
<td>9 out of 12 meetings take place</td>
<td>Maternity Risk Annual audit</td>
</tr>
<tr>
<td>M&amp;NRM meeting</td>
<td>Meetings are quorate</td>
<td>Maternity Risk Annual audit</td>
</tr>
<tr>
<td>Departmental Risk Register</td>
<td>Risks are reviewed quarterly unless “ongoing” which may be annually</td>
<td>M&amp;NRM minutes, 3:3 minutes</td>
</tr>
<tr>
<td>Departmental Risk Register</td>
<td>All risk are logged on Datix</td>
<td>Datix audit annually</td>
</tr>
<tr>
<td>Complaints/claims</td>
<td>All complaints are logged on Datix</td>
<td>Datix audit annually</td>
</tr>
<tr>
<td>Dissemination of lessons learnt</td>
<td>Relevant clinical changes/actions will be cascaded to staff groups as appropriate</td>
<td>Theme of the month board. Minutes of meeting. Daily safety briefings.</td>
</tr>
<tr>
<td>Staffing levels review</td>
<td>Staffing levels for midwives, obstetricians &amp; anaesthetists are</td>
<td>Annual audit Quarterly dashboard review</td>
</tr>
<tr>
<td>Reviewed</td>
<td>At M&amp;NRM</td>
<td></td>
</tr>
<tr>
<td>-------------</td>
<td>-----------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>TNA review</td>
<td>All staff groups will be complaint with their training needs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Quarterly database review/report</td>
<td></td>
</tr>
<tr>
<td></td>
<td>M&amp;NRM group - action plan if required</td>
<td></td>
</tr>
<tr>
<td>Maternal incident / near miss</td>
<td>Fetal / neonatal incident / near miss</td>
<td></td>
</tr>
<tr>
<td>------------------------------</td>
<td>--------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Maternal death</td>
<td>Stillbirth &gt; 500g</td>
<td></td>
</tr>
<tr>
<td>Maternal resuscitation</td>
<td>Neonatal death</td>
<td></td>
</tr>
<tr>
<td>Unexplained maternal collapse</td>
<td>Apgar score &lt; 7 at 5 minutes</td>
<td></td>
</tr>
<tr>
<td>Undiagnosed breech</td>
<td>Birth trauma</td>
<td></td>
</tr>
<tr>
<td>Shoulder dystocia</td>
<td>Erbs Palsy/Brachial plexus injury</td>
<td></td>
</tr>
<tr>
<td>Blood loss &gt;1000mls</td>
<td>Fetal laceration at LSCS</td>
<td></td>
</tr>
<tr>
<td>Return to theatre</td>
<td>Cord pH &lt; 7.05 arterial or &lt; 7.1 venous</td>
<td></td>
</tr>
<tr>
<td>Eclampsia</td>
<td>Neonatal seizures</td>
<td></td>
</tr>
<tr>
<td>Hysterectomy/Laparotomy</td>
<td>Undiagnosed fetal anomaly</td>
<td></td>
</tr>
<tr>
<td>Venous thromboembolism</td>
<td>Incorrect plotting of SBR or SBR above transfusion threshold</td>
<td></td>
</tr>
<tr>
<td>Pulmonary embolism</td>
<td>Significant infection</td>
<td></td>
</tr>
<tr>
<td>3rd and 4th degree tear</td>
<td>Pressure necrosis/NCAP related incidents</td>
<td></td>
</tr>
<tr>
<td>Uterine rupture</td>
<td>Readmission of baby</td>
<td></td>
</tr>
<tr>
<td>Readmission of mother</td>
<td>Hypoxic ischemic encephalopathy (HIE)</td>
<td></td>
</tr>
<tr>
<td>2222 LSCS - failure to meet time standard</td>
<td>Necrotising enterocolitis (NEC)</td>
<td></td>
</tr>
<tr>
<td>Cord prolapse</td>
<td>Gestation less than 28 weeks (or 30 week twins)</td>
<td></td>
</tr>
<tr>
<td>Trauma to bladder or other organs</td>
<td>Hypothermia</td>
<td></td>
</tr>
<tr>
<td>Blood transfusion reaction</td>
<td>Transported without heated cot or transport incubator</td>
<td></td>
</tr>
<tr>
<td>Loss of clinical materials i.e. swabs</td>
<td>Neonatal abstinence requiring admission</td>
<td></td>
</tr>
<tr>
<td>Significant infection</td>
<td>Procedure / intervention complication (e.g. extravasation injury)</td>
<td></td>
</tr>
<tr>
<td>Pressure ulcer (also report to hotline 4062)</td>
<td>Any child transferred for tertiary care</td>
<td></td>
</tr>
<tr>
<td>CCOT involvement in care</td>
<td>Ventilation &gt; 24 hours</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pneumothorax</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Anaesthetic incident / near miss</th>
<th>Organisational incident / near miss</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dural tap</td>
<td>Unavailability of health record</td>
</tr>
<tr>
<td>Failed intubation</td>
<td>Unplanned home birth or transfer in from home birth</td>
</tr>
<tr>
<td>Anaphylaxis</td>
<td>Issues related to equipment</td>
</tr>
<tr>
<td>(medication error and needlestick injury as per organisational incident list)</td>
<td>Issues related to staffing</td>
</tr>
<tr>
<td>Unplanned admission to Intensive Care</td>
<td>Medication error or adverse drug reaction</td>
</tr>
<tr>
<td>Neuropraxia</td>
<td>Needlestick injury</td>
</tr>
<tr>
<td></td>
<td>Unavailability of facility or equipment failure</td>
</tr>
<tr>
<td></td>
<td>Incidents relating to data protection/security</td>
</tr>
<tr>
<td></td>
<td>Unavailability of bed/ neonatal cot</td>
</tr>
<tr>
<td></td>
<td>Child protection</td>
</tr>
<tr>
<td></td>
<td>Injury to staff, patient or visitor</td>
</tr>
<tr>
<td></td>
<td>Communication issues</td>
</tr>
<tr>
<td></td>
<td>Violence and aggression</td>
</tr>
<tr>
<td></td>
<td>Miscellaneous</td>
</tr>
</tbody>
</table>
Reporting structure: Band 2 - to Head of Midwifery

Departmental Structure – Maternity and Neonatal Services

- Head of Maternity and Neonatal Services
  - Risk & Governance Lead
  - Postnatal & Neonatal Services Manager
  - Antenatal Services Manager
  - Community Services Manager
  - Clinical services Managers
  - Labour Ward Managers
  - Practice Development Lead
  - Audit / Complaints lead MW
  - Neonatal Nurses
  - Postnatal Screening coordinator
  - Antenatal Screening coordinator
  - Community Midwives & MAs
  - Midwives
  - System Administrator
  - Maternity Care Assistants Manager
  - PA / Office Administrator
  - Screening Administrator
  - Maternity Receptionists & Clerical Assistants
  - Maternity Care Assistants
Governance Monitoring Structure - Maternity

Guidelines developed by clinical staff using input from NICE, RCOG, NHSLA or updated through review process

Guideline implemented

Guideline monitored through audit

Incidents arising with compliance

Individual Practice – reviewed by SOM or Line Manager
Service Delivery – investigated by Maternity Risk Mgr

Review by Maternity Governance Forum

Trust CMB - Guidelines reviewed and approved

Maternity Clinical Governance - Proposed improvements to Guidelines

Clinical Leads Forum
Supervisor of Midwives Forum

Trust Board

Trust Clinical Governance Committee

Trust Clinical Risk Group - Approve reports, actions and recommendations

Maternity Risk Management Forum - Review of compliance, incidents, reviews and risk register

Panel established and review undertaken

Head of Risk & Exec Risk Lead commission reviews
Maternity and Neonatal Risk Management Forum

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
Maternity Risk and Governance Manager (Chair)
Head of Maternity and Neonatal Services
Consultant Anaesthetist
Postnatal and Neonatal Services Manager
Labour ward lead
Consultant Paediatrician
Antenatal lead
Supervisor of Midwives
Minimum attendance being 50%

(This forum is open to all clinical staff within the maternity and Gynaecology department).
TERMS OF REFERENCE

Maternity Governance Forum

Aim:

- The Maternity Governance Forum will meet every two months to ensure that there is a clearly documented system and process for management and communication throughout the key stages of maternity care.

- It is imperative that there is good inter-professional communication and teamwork, especially during the intra-partum period. This is considered by the NHS Litigation Authority to be best achieved by having a multi-disciplinary forum comprising:

1. **Membership**

   Lead Obstetrician*
   Midwifery lead in risk management*
   Clinical Midwife Manager*
   Obstetric Anaesthetist*
   Neonatal Paediatrician*
   Consultant Obstetricians
   Obstetric SpR*
   Supervisor of Midwives*
   Obstetric and Paediatric SHO
   Midwifery Staff
   Consumer Representative

   There will be a quorum of 6

   *If the nominated person is unable to attend a representative should attend in their place

2. **The purpose of the group:**

   - To meet to review all aspects of maternity services activity including:
   - To review professional (clinical) issues.
   - To review organisational issues.
   - To review broader subjects which incorporate staffing and skill mix; education and training; monitoring of the environment in relation to the safety of mothers and babies.
   - To review any issues related to other areas within maternity and neonatal services.
   - Evidence based guideline development, encompassing all areas of the maternity services.
   - To follow the guiding principles within the document ‘Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour.’ (RCOG, October 2007)
   - To ensure that the Maternity Governance Forum develops and participates in the monitoring of standards as outlined in the above document.
   - Any issues raised at the Maternity Risk Group meetings that are relevant to the Maternity Governance Forum will be raised by the Midwifery Risk Manager.

3. **Frequency of meetings**

   Meetings are held every two months
There will be a published agenda, detailed minutes and a register maintained of membership, grade and role.

The dates of the Maternity Governance Forum will be published 12 months in advance.

Distribution of the Maternity Governance Forum minutes will include:
Forum Membership
Clinical areas on e-mail

4. Reporting Structure

The Maternity Governance Forum will report to the Maternity Services Risk Management Group. Information will then be escalated as required via the Trust Risk Management Group. The Maternity Governance Forum will report within maternity services through the Midwifery Group Practices and clinical areas and Supervisors of Midwives meetings.
Supervisor of Midwives Forum

Midwifery supervision is a statutory function for maternity services. It is proactive and facilitates good standards of practice and individual development of midwives. Every practicing midwife will have a named Supervisor of Midwives. Midwifery supervision is responsible for safeguarding the safety of mothers and babies and is therefore an integral part of the Clinical Governance and the risk management process (Ref. NHSLA standard 1.2)

The main functions of the group are:

Specific duties:

- Represented at the Maternity and Neonatal Risk Management Group, Clinical Governance forum, Maternity Governance and Perinatal forum.
- Assist in incident and complaint investigations as appropriate.
- A supervisor of midwives will be involved in the investigation of all Serious Incidents (SI). All Serious Incidents will be reported to the Local Supervising Authority (LSA). This occurs in collaboration with the LSA and following national Supervisory Guidelines.
- Incidents occurring which involve midwifery practice issues will also require a supervisory investigation.
- Supervisors of midwives will support the implementation and monitoring of any action plans and lessons learned from any internal or external incidents/risk issues.
- Provide professional advice to other midwives on a 24 hour basis through an on call system.
- The SoM team provides an Annual Report to the LSA and has a written Supervision of Midwifery Strategy.
- Recommendations from NICE, MBRACE and Government reports are incorporated into supervisory activities.
- The SoM Team meets monthly.
- The minutes of the meeting will be circulated to all members within 2 weeks of the meeting.
- The agenda will be circulated 7-10 days before the meeting.
- Agenda items should be forwarded to the chair at least 14 days before the meeting.
- On receipt of the annual LSA report Supervision of midwives will produce and action plan which along with the report will be presented and reviewed at Maternity and Gynaecology Clinical Governance Group.

Membership

- All Supervisors of midwives
- All student supervisors of midwives
Perinatal Mortality & Morbidity Meeting

The Maternity and Neonatal Services recognise the need to review any cases that have resulted in poor or unexpected outcomes for either mother or baby related to the antenatal period and through the postnatal / neonatal period.

It requires close co-ordination between midwives, obstetricians, neonatologists, neonatal nurses and ultrasonographers.

This is achieved through regular multi-disciplinary review meetings to discuss Perinatal morbidity and pathology.

Aims

- To review recent cases focusing on those, which resulted in Perinatal mortality or morbidity including near misses (see Maternity Risk Management Reporting Trigger List)
- To provide a forum for multi-disciplinary discussion and learning
- To provide a forum to discuss the recommendations of MBRACE, other National Confidential Enquiries and relevant national or local documents.
- To develop an increased knowledge and understanding of high risk obstetric and neonatal complications.
- To provide a forum to recognise the need for changes to practice and to forward learning points to the relevant maternity and Neonatal Governance groups for action.
- To serve as the forum to inform completion of both Stillbirth (MBRACE) and RCOG ‘Each baby counts’ and Child Death (CPOD) review paperwork.

Membership

Meetings are multi-disciplinary and open to all interested health care professionals. The meetings will uphold an environment of mutual respect for personal and professional opinions expressed with the aim of interprofessional learning. They are held monthly and representatives from the following disciplines are expected at every meeting.

- Obstetricians
- Paediatricians
- Midwives
- Neonatal Nurses
- Ultra-sonographers (as appropriate to the individual cases)
• Anaesthetists (as appropriate to the individual cases)

A record of attendance will be kept and members will be required to sign the attendance sheet at each meeting.

The meeting will be jointly chaired by a Consultant for both Obstetrics and Paediatrics. The meeting will be considered Quorate when a minimum of 2 consultant obstetricians and 2 Consultant Paediatricians are present.

It is expected that the consultants will send apologies direct to the chair person when they are unable to attend the meeting.

Meeting format
Meetings will consist of:

(1) Case Reviews
(2) Informal Discussions
(3) Presentations of topics related to Perinatal mortality and/or morbidity
(4) Guest presentations as appropriate
(5) Follow up of cases from previous meetings subsequent to Paediatric or obstetric reviews and assessments

An anonymised record of cases presented and multiprofessional discussions will be kept along with any relevant presentations. Recommendations for changes in practice or guidelines may be presented to the Maternity Governance Forum for ratification.

Unresolved cases
In the rare case where those present cannot reach a clear agreement of appropriateness of care delivery, the case will be reviewed outside the meeting by a panel that includes as a minimum:
Consultant Paediatrician - lead for neonates
Consultant Obstetrician - labour ward lead
PN and neonatal services manager
Labour ward co-coordinator
Maternity Risk and Governance Manager

This panel will again review the presentations of the case, if at this stage they cannot agree the appropriateness of care then escalation to the Trusts Risk Manager and the Executive Lead for Risk should be undertaken by the Head of Midwifery or the Maternity Risk Manager.

References

1. RCOG – Green top Guideline Late intra uterine deaths and still birth October 2010
2. Working together to safeguard children” document march 2010 - chapter 7
Maternity and Gynaecology Clinical Governance

The Maternity and Gynaecology Clinical Governance meeting is 6 times per year. These sessions are split throughout the year so that Maternity Clinical Governance is the main focus for 3 of the sessions and Gynaecology for the other 3 sessions. This forum provides an opportunity to: discuss lessons learnt following serious incidents, to feedback themes from complaints, to present any audits undertaken within the service and discuss the findings in relation to changes required to practice. All grades of staff are encouraged to attend this meeting.

Aims

- To encourage multidisciplinary review and analysis of critical incidents (including serious untoward) and risks
- Encourage multidisciplinary participation in clinical audit across the Division, present and discuss findings and make recommendations for further audit.
- Dissemination and review of current research, Government reports and Confidential Enquiries.
- Disseminate any information as required by the Trust.

Membership

Open to all clinical staff within the maternity and Gynaecology department and where necessary to include members of relevant multi-disciplinary teams from outside the department.

Objectives of the Group

- To present anonymised cases including serious untoward incidents identifying lessons that have been learnt and need to be shared including any action plans to be implemented.
- Present audit that has been undertaken within the Maternity and Gynaecological services and discuss implications of the findings and agree further actions and audit if required.
- Present findings and recommendations form all relevant confidential enquiries such as MBRACE, NICE and any other directives form such organisations as NPSA, HCC and NHSLA.
- Discuss policy decisions and changes.
- Include as standing agenda items such as infection control and feedback on any directives from the Trust.
APPENDIX 9

Unexpected admissions to Neonatal Unit (37+ gestation)

Database collated for all unexpected admissions to NNU

Babies admitted from postnatal ward should be reviewed by a paediatrician and Neonatal Nurse and graded for degree of risk.

Babies admitted from labour ward/theatre should be reviewed by an obstetrician, risk manager and Supervisor of Midwives and graded for degree of risk.

Any cases that need further review with be put on agenda for Perinatal the following month.

Lessons learnt will be circulated through; direct feedback to individuals involved. Communication groups, SOM meetings, community meetings
Purpose

To provide assurance to the Executive team that the quality and safety of care for mothers and babies is consistent with expected standards of care.

To report on statutory activities of Supervisors of Midwives.

To report on findings from audits, investigations and reviews to the Clinical Governance Committee.

To ensure progress against the annual work plan and statutory activity is completed.

To raise the profile of the statutory Supervision of Midwives within the Trust.

Membership

Director of Nursing, Midwifery and Allied Health Professionals - Chair
Deputy Director of Nursing, Midwifery and Allied Health Professionals – Deputy Chair
Head of Midwifery
Contact Supervisor of Midwives
Head of Clinical Effectiveness
Non-Executive Director

Frequency of attendance

The members are expected to attend all meetings or send a nominated deputy in their absence. Attendance will be monitored and managed where appropriate.

Quorum

The Chair or Deputy Chair must be in attendance with the Head of Midwifery or Deputy Head of Midwifery and the Contact Supervisor of Midwives or another Supervisor of Midwives.

Frequency of meetings

The group will meet at the end of each quarter in July, October, January and April.

Accountability/reporting arrangements

The minutes of each meeting will be presented to the Clinical Governance Committee.

Monitoring Arrangements

The terms of reference, reporting process, membership and attendance will be reviewed annually and amended accordingly.
References


11. **LSA Standards for the Statutory Supervision of Midwives** (2007) LSA Midwifery Officers, Orbital design, Lancashire
