THE MATERNITY & NEONATAL RISK MANAGEMENT ANNUAL REPORT

PURPOSE:

This report covers the period 1st April 2012 to 31st March 2013 with the aim of assuring the Board members that the Maternity and Neonatal Services are committed to the challenge of minimising risk and improving patient safety. This is done through a comprehensive, pro-active, multi-disciplinary approach to risk management.

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

This paper demonstrates the maternity and neonatal service’s commitment to Risk Management and outlines the achievements of the past year.

MAIN ISSUES:

Complaints

All complaints, incidences and concerns are examined for trends and themes. Communication continues to be identified as a theme within complaints. Better communication has become a priority, more emphasis is placed upon communication on induction programmes, mandatory training and challenging individuals who can be supported to improve their personal style of communication. This has been applied to all staff disciplines. Issues surrounding communication was the highest cause of complaints and included:

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  - Communications and information provided by staff members that includes communication between other service providers.
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  - Management of care, particularly in labour.
  - Triaging of patients.
  - Issues surrounding consent for a procedure.
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- Other complaints focus on:
  - Data protection issues.
  - Accessing TWOC service.
  - Out of hours early pregnancy complications/management.
  - Associated charges for amenity rooms and car parking.
  - Issue surrounding the administration of diamorphine in labour.
  - Service delivery issue relating to the transfer of a neonate form several neonatal services.
  - Hygiene of the wards during the emergency relocation of the labour ward.
  - The use of IV antibiotics for the prophylactic cover in labour for GB strep.
Summary of 2012/13 Achievements

- The Neonatal Unit Project work has been completed. The Unit now provides accommodation for parents to be with their sick newborn baby.
- A new Bereavement Suite Project has been completed and opened. A Bereavement and Palliative care team has been developed and offers consistency of information for parents alongside continuity of care.
- Due to a successful bid for Government money, the labour ward refurbishment is underway, providing an enhanced environment for birth. The aim is to have completed the work by the end of 2013.
- A change in the agreed local delivery times for women requiring an emergency caesarean section.
- Two full CTG study days held for all staff and for neighbouring Trusts.
- A new format for maternity hand held notes.
- A new pathway has been developed for women requesting an elective caesarean section.
- A development of the Maternity dashboard.
- The real time feedback for the Maternity Service has been consistently positive.

Future Plans

- A Workforce Review to benchmark staffing and activity, and plan for the next 3 years alongside projected birth numbers and local activity in the community.
- An improved format for clinical guidelines and how they are accessed on ICID.
- Improvement with complex care planning as there is a constant increase in the number of women becoming pregnant who have more complexities than seen previously. The Maternity Service has seen a greater proportion of women over 40 having a first baby, the average BMI of women is now over 30 and complex health issues are becoming more prevalent such as cystic fibrosis, HIV and mental health issues. All these require greater input from Midwives, Obstetricians, primary and secondary care.
- To develop the dashboard further to enable benchmarking against other Trusts.
- Continue to promote an open and supportive approach towards risk which continues, to reflect an environment in which staff feel able to report.
- To enhance fetal surveillance by adopting customised fetal growth charts.
- Recruitment of a Named Midwife for Safeguarding Children.
- Adjustments to be made to incident reporting in line with the change to the South of England reporting structure. It is expected that there will be an increase in the number of incidences that will require formal escalation within the Trust.
- Friends and Family testing is to be rolled out in Maternity in October 2013.

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: Fiona Coker
Title: Head of Maternity & Neonatal Services
Date: September 2013
Maternity and Neonatal Risk Management Annual Report 2012/13

Introduction

This report covers the period 1st April 2012 to 31st March 2013 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, multi-disciplinary approach to risk management.

This paper demonstrates the maternity and neonatal service’s commitment to risk management and outlines the achievements of the past year. The following outlines achievement and progress against the strategic goals:

- 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. 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.

- The purpose of the Maternity and Neonatal Services Risk Management Strategy is to reinforce the underlying principles of the Trust’s 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

Maintenance of a Safe Environment for Patients, Employees and Visitors

- The service has been consistent in achieving over 95% harm free care as measured by the NHS Safety Thermometer.
- Infection control audits have demonstrated good compliance with hand hygiene.
- VTE audits have demonstrated 100% compliance assuring that all women are risk assessed on all admission.

A robust and proactive system for reporting and analysis of adverse incidents 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.

An open and supportive approach towards risk continues, which reflects an environment in which staff feel able to report. This ensures that there is transparency surrounding activity, that there is a robust process for reviewing and investigating incidences and that the outcomes and any learning achieved can be fed back to the workplace.

- Incident forms as they originate, are reviewed by the Risk and Governance Manager to firstly ensure there are no Fitness to Practise 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).
• Relevant Incident forms are disseminated to the clinical ward leads who are able to respond with their area of expert knowledge and can complete the sheet 2. These are then returned to the Risk Manager for grading to be confirmed and then sent to risk to be inputted onto the Trusts Datix reporting system.
• The Trust's Datix reporting system is used for the logging of all incidents which are reported on and then monitored at the monthly Maternity Risk Management Forum and the Trust’s Clinical Risk Group.
• The monthly incident report summary continues to be cascaded to all staff outlining all incidents reported and agreed outcomes thus creating an opportunity for discussion, but fundamentally for learning to be enhanced.
• The Maternity Risk and Governance Manager, the Labour Ward Lead Consultant Obstetrician and the Lead Consultant Anaesthetist for Obstetrics are responsible for scrutinising incidences on a weekly basis to highlight any incidents relating to their area of expertise. This ensures a timely response and actions put in place to reduce the likelihood of recurrence.
• Risk and governance continues as an agenda item at the monthly Community Midwives Forum with an overview of recent incidents and reviews. Staff are given the opportunity to raise concerns relating to community working but also to be kept up-to-date with any themes of incidents occurring within the unit.
• The clinical leads for Postnatal, NICU, Antenatal services and Labour Ward are updated monthly at the clinical Leads Forum, highlighting areas of concerns and any outstanding actions which need addressing.

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 recommendations from national reports.

• Maternity and Neonatal Risk Group meet a minimum 10 times annually with an attendance list and documented minutes of actions being taken.

• The Maternity and Neonatal Risk Management Group have met on 12 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 they have are escalated to the Executive Lead for Risk.

• The attendance at the Maternity Risk Forums encourage all staff to promote openness and for learning. All meetings are minuted and actions identified, and distributed to all staff through the communication folders. 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.
• All reviews/investigations are shared with families and staff members who have been directly involved in the care. The reports, with the recommendations raised from such reviews and investigations, are cascaded and shared throughout the department.

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.

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 the Obstetric Consultant Lead for Risk and Governance attend the Trust’s Clinical Risk Group meetings on a monthly basis where Maternity and Neonatal risk items are on the agenda and the maternity dashboard is presented for scrutiny.

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 3:3 to ensure a seamless and open reporting structure of relevant information relating to risk and governance.

All staff groups across the Maternity and Neonatal Services must report incidents as per the Adverse Events Reporting Policy and in compliance with the Maternity and Neonatal Service Trigger List.

<table>
<thead>
<tr>
<th>Year</th>
<th>Intrapartum Incidents</th>
<th>Treatment/Procedure Incidents</th>
<th>Drug Errors</th>
<th>Total of Incidents Reported for Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>228</td>
<td>42</td>
<td>30</td>
<td>519</td>
</tr>
<tr>
<td>2012</td>
<td>183</td>
<td>17</td>
<td>17</td>
<td>444</td>
</tr>
</tbody>
</table>

The table above demonstrates areas of improvement in incidents. In addition, there has been a decrease in the number of babies readmitted with weight loss due to feeding problems as the most vulnerable babies are now being identified prior to being discharged home postnatally with the implementation of a change in the management of high risk babies.
The largest number of reported incidents 183 (45.7%) were clinical incidents within the labour and delivery stage of care. The majority of these are trigger events. This continues to reflect the activity from the previous year also in all stages of care where incidents occurred.

There should be evidence that the learning arising from Adverse Events, Claims and complaints are shared throughout the Maternity and Neonatal Service

- Salisbury's current rate of 3rd and 4th degree tears is 3.1%, (compared to 5% nationally). This is a slight increase from the previous year where it was reported as 2.9%. This was due to an increase in the number of 4th degree tears (8 in total for the year) which occurred between October 2012 and January 2013. 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. A robust database is collated to monitor any themes.

- The RCOG recently published an individualised audit report. This benchmarking exercise enabled us to establish that as a department we do well against the national average with induction of labour, elective caesarean section, emergency caesarean section and the percentage of babies delivered by Ventouse. The audit also shows us where improvement is needed against the national averages, the areas highlighted are 3rd degree tears in spontaneous vaginal deliveries, and the instrumental delivery rate, particularly forceps is much higher than the national average. This has led to audits being implemented to look into second stage of labour practice and a separate audit reviewing our instrumental deliveries. These audits (amongst others) are then shared at the Clinical Governance sessions held throughout the year.

- The multi-disciplinary team training PROMPT ensures consistency with training and in emergency situations, and ensuring that staff are working to the same guidance. The Post Partum Haemorrhage Guidance now links in with the Trust’s massive transfusion protocol. The consistent approach to obstetric emergencies has impacted on the consistency of care in emergency situations which in turn accounts for the increase in the number of incident grading outcomes of ‘no harm.’
There should be evidence that National Guidance i.e. NICE/National Confidential Enquiries have been reviewed and recommendations implemented where appropriate.

- All clinical guidance is based on relevant national guidance and formally approved through the Trust process.

- Within maternity and neonatalology, new guidance is released nationally and is reviewed within the Governance forum and local guidance written accordingly. A baseline audit assessment of latest recommendations are discussed within this multi-disciplinary forum to ensure robust and evidence based guidelines are implemented. The audit results are returned to the Clinical Governance session for review and adjustments to practice are made following discussion.

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

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

The current top 2 risks on the Departmental Risk Register are:

- **Maternity Staffing** - This is reviewed regularly. The complexity of this involves balancing a static number of staff with an inability to exactly predict when women will labour. We have good data that predicts the number of expected births for any given month, but we cannot predict that 20 of them may birth on the same day. Recruitment has recently been identified as a challenge that the Trust is supporting the service with.

- **Provision of 1:1 Care for Women in Active Labour and High Risk Cases** - There is clear evidence base (RCOG 2008) that states women in active labour have improved outcomes when they have 1:1 care from a midwife. This is managed with a robust escalation policy. The labour ward leads are reviewing activity, dependency and capacity on a shift by shift basis and the on call supervisor will support the escalation when the activity outstrips staffing on any particular shift.

Serious Incident Inquiries/Clinical Reviews.

- The department has undertaken 8 reviews during the 2012/13 period - 4 were completed using the local review format, 2 for the clinical review process and 2 were reported as SII’s. All reviews had engagement from staff involved in all aspects of care, and where appropriate, involvement with the family 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, multi-disciplinary review. The number of stillbirths in 2012/13 has decreased to 8 (0.3%). Each case continues to be reviewed individually at the monthly Perinatal meeting and when necessary, are commissioned as a review. Between April 2012 and March 2013 no links or trends have been identified.
• Uptake of post mortem examinations has previously been low and the length of time taken for the reports to be received was taking a minimum of 18 weeks. This was prolonging the distress for families and was also becoming a theme within complaints. There has been a drive to ensure all discussions with parents about post mortems are carried out by a senior Obstetrician and these discussions are documented clearly in the notes. Along with new service provision which has improved the timeliness of these examinations, an audit indicator has been implemented which feeds into the overall findings of each case.

Complaints

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Fiona Coker
Head of Maternity & Neonatal Services
September 2013
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 and community midwives meetings, directly to staff involved.
- To monitor and review the departmental risk register.
- 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 the 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 Neonatal Department).