# Agenda Item: 18

## TRUST BOARD – 22 September 2010

### Maternity Risk Management Strategy 2010

<table>
<thead>
<tr>
<th><strong>PURPOSE:</strong></th>
<th>To present to the Trust Board the revised Trust Maternity Risk Management Strategy for consideration and approval.</th>
</tr>
</thead>
</table>
| **PREVIOUSLY CONSIDERED BY:** | Divisional Board  
Director of Nursing & Deputy Director of Governance |

### IMPLICATIONS:

| **Objective(s) to which issue relates:** | Objective 1. To consolidate acute services for complex or serious conditions onto a single site.  
Objective 4. To improve the quality of all aspects of our services. |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Risk Issues:</strong></td>
<td>Core to the governance, risk management and assurance processes within the Women’s and Children’s Division.</td>
</tr>
<tr>
<td><strong>Financial:</strong></td>
<td>Potential if CNST level 2 is not maintained</td>
</tr>
<tr>
<td><strong>HR:</strong></td>
<td>None identified</td>
</tr>
<tr>
<td><strong>Healthcare/National Policy:</strong></td>
<td>Healthcare Regulation through the Care Quality Commission and Maternity Clinical Risk Management Standards (CNST)</td>
</tr>
<tr>
<td><strong>Legal Issues:</strong></td>
<td>Potential</td>
</tr>
<tr>
<td><strong>Equality Issues:</strong></td>
<td>None identified</td>
</tr>
</tbody>
</table>

### RECOMMENDATIONS:

The Trust Board is asked to consider and approve the revised Trust Maternity Risk Management Strategy 2010. This Strategy is fundamental to meeting the requirements for CNST and is in line with the Trust Risk Management Strategy.

**DIRECTOR:** Director of Nursing  
**PRESENTED BY:** Deputy Director of Governance  
**AUTHOR:** Head of Midwifery & Gynaecology /Clinical Governance Coordinator Women’s Services  
**DATE:** September 2010
WOMEN’S AND CHILDREN’S SERVICE
OBSTETRICS & GYNAECOLOGY
MATERNITY RISK MANAGEMENT STRATEGY

Produced by: Rami Atalla – Divisional Chair for Women’s Services
Bernadette Herbert – Divisional Director for Women’s and Children’s Services
Christine Nixon – Head of Midwifery & Gynaecology
Mary Pollen – Clinical Governance Co-ordinator for Women’s Services

Date updated: August 2010

Ratified by: Mr. D Salvesen – Clinical Director for Women’s Services
Christine Nixon – Head of Midwifery

Policy to be reviewed: April 2011
Policy to be reviewed by: Clinical Governance Group
Policy to be used in conjunction with: Trust Risk Management Strategy
Trust Policy for Adverse Incident Reporting & Investigation
Infection Control Policy File
Health & Safety Policy File

Issue number: 5
1.0 INTRODUCTION

1.1 This Maternity Risk Management Strategy sets out the principles, processes and strategic direction of Clinical Risk Management for Maternity Services within the Division of Women’s & Children’s Services. The document is devised for the use of all the members of the multidisciplinary team who are involved in the delivery of maternity care to women and their families. It also sets out the maternity services plan for the identification, prevention and management of risk throughout the unit. This document should be used in conjunction with the Trust Risk Management Strategy and any local or national documents and guidelines relating to risk within the organisation. It reflects the commitment of the maternity services to improving the quality of care by taking positive action to eliminate, reduce and manage clinical risk's identified. The service recognises that risk management must be imbedded in order for the service to function safely and effectively. All staff have a responsibility to be familiar with the Maternity Risk Management Strategy, follow policies and guidelines and take the necessary actions required to reduce risk.

1.2 Definition

Risk management is a systematic process of risk identification, analysis and evaluation and correction of potential and actual risks to a patient, visitor or member of staff.

Although the retrospective review of adverse events provides important information on how systems and procedures can be improved, there must also be ongoing examination of services to predict where latent risk exists.

2.0 STATEMENT OF PHILOSOPHY

2.1 The Maternity Service will engage in proactive risk management as part of a systemic approach to risk assessment and in line with the clinical governance agenda by utilising and fostering:

- An open transparent culture (National Patient Safety Agency 2003)
- Statutory Supervision of Midwives (Midwives rules and standards 2004)
- Evidence based practice and guidelines
- Practice development
- Continuous professional education and learning.
3.0 Risk Funding

The Trust obtains cover through the Clinical Negligence Scheme for Trusts and the Non Clinical Risk Pooling Scheme operated by the NHS Litigation Authority. Both of these schemes have excess levels where the Trust is prepared to underwrite some of its own losses.

4.0 AIM OF THIS STRATEGY

4.1 To describe the process of risk management within the maternity services.
4.2 To demonstrate how the maternity risk management strategy is integrated within the overall Trust Board Assurance Framework.
4.3 To provide a framework within the Maternity Services through which risk is identified and acted upon to minimise adverse outcomes for service users and staff.
4.4 To provide an open culture and proactive approach to risk management to enable practitioners to learn and develop their practice in order to provide high quality care.

5.0 MATERNITY SERVICES OBJECTIVES

5.1 2010/11 objectives
5.1.1 Ensure systems and processes in place for consideration and application of national confidential enquiries continues to operate in a structured and cohesive manner
5.1.2 Maintain the arrangements put in place to provide the level of medical leadership and experience required to comply with the NHSLA Risk Management Standards.
5.1.3 Recovery training for midwives to be detailed in guideline

5.2 On-going objectives
5.2.1 Maintain and continually seek to improve the quality of maternity care provided by the service through the identification, control and minimization of risk and the provision of a safe environment for patients, staff and visitors.
5.2.2 Through the process of statutory supervision of midwives, promote excellence in midwifery and thereby a culture of safe, effective care.
5.2.3 Promote active risk management and the reporting of adverse/serious untoward incidents with all staff by providing support which encourages reflective review, a positive learning experience and improvements or changes in practice via the application of lessons learned from incidents within the department/division, the Trust and nationally.
5.2.4 Encourage a culture of accountability and openness in a safe, fair and supported environment
5.2.5 Ensure risk management systems and processes are clear and understood by all staff and that risk assessments are carried out in accordance with the Trust’s risk management process.

5.2.6 Review and where appropriate implement recommendations from national guidance e.g. NICE (National Institute of Clinical Excellence), CMACE, Maternity Matters.

6.0 RISK MANAGEMENT STRUCTURE AND PROCEDURE FOR MATERNITY SERVICES

6.1 East and North Herts NHS Trust Maternity Services risk management structure follows the Trust policies and procedures for management of clinical and non-clinical risk.

6.2 All adverse/serious incidents must be reported by a member of staff by the completion of the trust Adverse Incident/Near Miss Reporting Form and follow Serious Untoward reporting procedure (see appendix 2 Maternity Trigger List and Trust policies which can be found in the Policy & Procedure Risk Management file in all clinical areas). It is the responsibility of the person reporting the incident to ensure immediate action is taken or instigated, if required, to ensure user/patient or staff safety.

The Trust and maternity service operate a 24-hour on call rota in the event that a member of staff needs to escalate an incident or obtain advice from a manager, Supervisor of Midwives or executive.

6.3 Completed incident forms are forwarded to the Midwifery Manager responsible for the clinical area within 24 hours. Incidents will be graded using the Trust grading matrix (see Appendix 1). The most appropriate personnel, e.g. the Midwifery Manager, Consultant Obstetrician or Clinical Governance Coordinator will ensure appropriate action is taken to remedy the situation and address any identified risks in the clinical area. They will involve the relevant personnel in this process. They will initiate investigations, obtaining statements from staff involved in clinical incidents. They will liaise with the Head of Midwifery, Clinical Director and Clinical Governance Co-ordinator to ensure appropriate clinical investigations of adverse incidents, near misses or serious untoward incidents are initiated and undertaken. It is expected that an initial assessment of the incident will be completed within 24 hours.

Once grading has been completed and initial action taken to address the incident the completed form is forwarded to the Clinical Governance Co-ordinator for Women’s Services and the Trust Clinical Risk Manager; it is expected that this will be completed within 48 hours of the incident.

6.4 The Clinical Governance Co-ordinator receives the completed incident reporting forms. She/he will ensure that the form has been completed appropriately and follow up with Midwifery Managers or Consultants to ensure the appropriate investigation has been initiated, ensuring that statements are obtained from and/or interviews are conducted with staff involved in an incident.

He/she will ensure that incident forms are sent to the Trust Risk Manager for inclusion in the clinical incident database. Following Trust procedures he/she will ensure that moderate and high-risk rating incidents are included in the risk register for the Division.
The Clinical Governance Co-ordinator will support the Midwifery Managers and Consultants to undertake investigations of clinical incidents and will assist in identifying and developing action plans and recommendations to address risks within the Division.

She/he will co-ordinate, analyse and collate risk management information and incident reports and will provide reports for the risk management group, clinical governance group and Divisional Board.

6.5 Staff involved in an investigation of an adverse or serious untoward incident will be offered support from a senior professional of their choice. In the case for junior medical staff this support will be offered by a Supervisory Consultant, for Associate Specialists or Consultants appropriate support would be agreed with the Divisional Chair or Medical Director. For midwives, support would normally be provided by the named Supervisor of Midwives. If this is not considered appropriate, alternative support would be offered from another Supervisor of Midwives.

6.6 **Women’s Services Specialty Risk Management Group**
The Women’s Services Specialty Risk Management Group will meet every month on each site. It is a multi-disciplinary group to review incidents reported since the previous meeting. The group will identify actions required as a result of the incident investigation to minimise clinical risk and prevent or reduce recurrence. The group will analyse trends from incidents and identify practice development or training requirements to address identified risks.

The Risk Management group will report to the Women’s Services Specialty Clinical Governance Group. (See appendix 3 Terms of Reference and membership.)

6.7 **Women’s Services Specialty Clinical Governance Group**
- The group will meet every 3 months.
- Monitor progress of action plans and recommendations arising from Risk Management Group.
- Analysis of adverse incidents and complaints trends
- Updating progress on clinical claims and changes in practice identified through clinical claims
- Monitor implementation of staff training and development programme identified from risk management issues
- To develop, monitor, review and update as appropriate the Local Maternity Services Risk Register and escalated risks for inclusion into the Corporate Risk Register (see appendix 4 Terms of Reference).

7.0 **ROLE AND RESPONSIBILITY FOR RISK MANAGEMENT**

7.1 **Trust Wide**
The Chief Executive has overall accountability and responsibility for risk management within the Trust, and following the implementation of a system of Director line-accountability in 2007, he has delegated responsibility for providing assurance on all areas of risk to individual Executive Directors. Responsibility for maintaining the Trust’s risk management arrangements has been delegated by the Chief Executive to the Director of Finance.

The Executive Directors are held to account for progress with mitigating identified risks by the Risk and Quality Committee, while the Trust’s Audit Committee
provides assurance to the Board on the overall process for identification, assessment and management of risk.

The key areas and standards that each Executive Director has accountability for all are defined on the Trust Corporate and Governance Assurance Maps. Each Director has clear assurance systems and structures in place to support the delivery of their areas of responsibility which includes line management structures and supporting committees. The Executive Team and each Director is accountable to the Board through the Board committee structure. Each Division will be accountable through the Divisional Performance Structures and to the Executive Directors.

Commitment to risk management is a non-negotiable requirement at all levels of the organisation. All staff throughout the Trust, including contractors and temporary staff, are expected to participate in risk management processes. Specific duties and responsibilities are outlined in the Trust Risk Management Strategy.

The designated Assurance Committees of the Trust Board are the Risk and Quality Committee and the Audit Committee. They are supported by the Finance and Performance and Executive Committees. The Terms of reference for these Board Committees are provided in the Trust Risk Management Strategy.

7.2 Responsibilities of all staff
All staff, including locums, agency and honorary contracted staff have a personal and professional responsibility to be familiar with the Risk Management Strategy, follow policies and guidelines and take the necessary actions required to reduce risk (see Trust Adverse Incident Reporting and Investigation Policy).

7.3 All clinicians and midwives
Medical, Midwifery, Nursing and Allied Health Professional staff have responsibility to assess the risks of the clinical services they offer. They must follow Trust policies and procedures; ensure that identified risks and incidents are dealt with swiftly and effectively; report all incidents and near misses to the Risk Management Department; and undertake mandatory training.

They must inform patients of all common or serious risks relevant to the treatment offered and ensure appropriate consent is sought.

Permission must be sought for the introduction of all new interventional procedures, they must be assessed for risks and appropriate training must be undertaken by the operator before they are commissioned.

7.4 Divisional Chair and Divisional Director
The Divisional Chair and Director are responsible for ensuring that effective risk management processes, as described within the Trust's Risk Management Strategy, are in place and implemented within the Division. The Divisional Chair is responsible for leading and monitoring clinical governance issues with relevant staff.

7.5 The Head of Midwifery
The Head of Midwifery is responsible for providing professional and managerial leadership for midwives and nurses within the Specialty. Professionally she/he reports directly to the Director of Nursing on all matters relating to midwifery practice within the Trust and is responsible for developing the strategic direction for midwifery and gynaecological nursing. She/he is responsible for operational management and leadership for Maternity and Gynaecology Services and one of
the responsibilities is to ensure risk management policies and procedures are in place within Women’s services and that all staff understand and are aware of their role in minimising clinical and non-clinical risks.

7.6 **Clinical Directors**
The Clinical Directors are accountable for clinical governance performance of the specialty and in conjunction with the Head of Midwifery and Gynaecology for the implementation of policies and procedures for risk management in their specialty area; that is Women’s services. They must ensure that risk assessments are undertaken and preventative action is carried out when necessary.

7.7 **Lead Obstetrician for Labour Ward**
The Lead Obstetrician for Labour Ward matters is responsible for providing clinical leadership and organisation for all medical staff working in the labour ward. In conjunction with the Midwifery Manager for Labour Ward and the Training and Skills Development Midwife he/she is responsible for organising multidisciplinary training and standard setting and ensuring good inter-professional relationships are maintained.

7.8 **Clinical Governance Co-ordinator**
The Clinical Governance Coordinator for Women’s Services supports the Clinical Directors and Head of Midwifery in the implementation of the Trust Governance and Risk Management agenda. She/he co-ordinates risk management activities within the maternity department. This role also provides a link with the Trust Risk Management team and ensures effective communication on risk management issues amongst medical and midwifery staff and the complaints and litigation department. The Clinical Governance Coordinator is responsible for the coordination of the clinical incident reporting system and, where appropriate, undertakes the lead investigator role when dealing with incidents or litigation claims. He/she communicates the recommendations and action plans of adverse and serious incidents to the Specialty Clinical Governance Group and the Clinical Incident Review Committee.

7.9 **Midwifery Managers**
The Midwifery Managers are responsible for providing clinical leadership and operational management of defined clinical areas within the maternity and gynaecology service, this includes ensuring risk management procedures and policies are implemented, monitored and adjusted to ensure clinical and non-clinical risk is minimised within the service. They, in conjunction with the Head of Midwifery, Clinical Directors or the Clinical Governance Co-ordinator, are responsible for organising and undertaking investigations of all incidents within the clinical areas, following Trust procedures and policies. This will include implementation and monitoring of agreed action plans and recommendations for change in midwifery or gynaecology nursing practice. They will provide regular progress reports on achievement against action plans to the Head of Midwifery through the Divisional risk management structure. They will ensure appropriate communication is maintained, involving the relevant personnel in the event of a serious or adverse untoward incident. The operational managers are responsible for undertaking assessments of clinical and non-clinical risk within maternity and gynaecology services.

7.10 **Midwifery Manager for Labour Ward**
The Midwifery Manager for Labour Ward is responsible for providing clinical leadership and organisation of all labour ward staff. She supports the lead
obstetrician in ensuring good inter-professional relationships and with the Training & Skills Development midwife provides support in the organization of multidisciplinary training and standard setting for Labour Ward.

7.11 **Consultant Obstetric Anaesthetist**
The Consultant Obstetric Anaesthetist is responsible for providing expert clinical leadership and advice to the obstetric anaesthetic team, implementing any recommended changes to clinical practice, escalating risk management issues to the appropriate group or committee and providing feedback to members of their team.

7.12 **Supervisor of Midwives**
Supervisors of Midwives (SoM) promote excellence in midwifery practice to ensure the safe and effective care of mothers and babies. The team of SoM at East and North Herts provide 24-hour on call SoM cover. Every midwife employed within the trust has a named SoM and many independent midwives working locally have named SoM from the East and North Herts Team.
The SoM Team meets monthly. The agenda is based on the 5 SoM standards.
Standard 1: Women focused maternity services
Standard 2: Supervisory Systems
Standard 3: Leadership
Standard 4: Equity of access
Standard 5: Midwifery Practice
The SoM team offer monthly Reflective sessions for midwives and student midwives across both trust sites.
SoM undertake supervisory investigations of critical incidents. The supervisory investigation must be open, transparent and fair providing an opportunity for a midwife to be involved and present her side of events. The investigation follows a format devised by the Local Supervising Authority (LSA) which has to be completed within 20 days of declaring the investigation. The SoM are allocated in turn to complete an investigation. The named SoM for the individual and or any managers involved in the investigation would not be asked to complete the SoM investigation. 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.
The SoM team provides an Annual Report to the LSA and has a written Supervision of Midwifery Strategy.
Recommendations from NICE, CEMACH and Government reports are incorporated into supervisory activities.

7.13 **Relationships between Assurance Standards, Incidents, Complaints, Claims and Clinical Governance.**
The Maternity Services Risk Management Structure reflects and supports the Trust’s holistic and integrated approach to managing all risks.

7.14 **Safety and Security**
The arrangements for safety and security within the Division reflect the arrangements in the Trust Risk Management Strategy.

7.15 **Reporting arrangements and Communication**
- Every 2 months the Clinical Governance Co-ordinator reports to Trust’s Clinical Incident Review Committee the progress of action plans from all Serious Untoward Incidents. She/he will report back to Clinical Governance Group.
• The Divisional Chair and Director attend the Clinical Governance Strategy Committee which is held monthly chaired by the Medical Director. This committee reports to the Risk and Quality Committee which reports directly to Trust Board. The Head of Midwifery also represents nursing and midwifery for the Division on the Clinical Governance Strategy Committee.

• Women’s services provide a monthly report including clinical governance issues to the Divisional Board.

• Women’s services also report clinical governance or patient quality issues through the Divisional Performance meetings held every two months with the executive team.

7.16 Feedback to staff

Feedback to staff is achieved through a standing item on each staff meeting agenda, Clinical Governance notice board and the Clinical Governance Newsletter. The newsletter will be distributed to all medical, midwifery, ancillary and clerical staff. Individual feedback will be given to those clinicians who have reported incidents via the incident reporting system.

8.0 IMPLEMENTATION OF THE RISK MANAGEMENT PROCESS

8.1 Risk identification

Risks can be identified following the reporting of an adverse incident or through a proactive approach by undertaking risk assessments. Risks may be identified by comparing practice against standards and guidance on best practice. Incident reporting is encouraged from all levels of staff and is assisted by the development of a trigger list (see appendix 2). (Ref. CNST standard 1.8)

8.2 Incident Reporting System

• Incident forms are available in all clinical areas and in community team offices. A Risk Management Policy folder containing the Maternity Risk Management Strategy, the Trust’s Risk Management Strategy and the Trust’s Adverse Incident Reporting and Investigation Policy is located in all key areas.

• The top copy of completed adverse incident/near miss reporting forms should be sent to the Trust Clinical Risk Management Department. The second copy should be sent to the Clinical Governance Coordinator for Women’s Services as soon as possible. The bottom copy is retained in a file in the clinical area.

8.3 Risk assessment

The Maternity Services will undertake a planned and systematic approach to managing and minimising risk. The specialty will identify and measure hazards and a valued judgment based on objective criteria as to whether suitable control measures are in place will be reviewed and revised where appropriate. The specialty will maintain a local Risk Register and issues that remain unresolved and those of high risk will be incorporated within the Trust’s Risk Register. The active Risk Register will be communicated to the Trust Clinical Risk Management Department. (Ref. CNST standard 1.1)

8.4 Clinical Audits

The audit leads identify audit topics:
• Identify recommendations made in the national confidential enquiries, including CEMACH, CEMD, CESDI, NCEPOD and CISH.
• Mandatory audit topics from the Trust Audit Department
• Reported adverse incidents
• Complaints and litigation
• Risk Assessments
• National Service Frameworks
• Clinical Guidelines
• Weekly caesarean section discussion meetings
• Perinatal discussion meetings.

8.5 Midwifery Supervision
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. CNST standard 1.2)

9.0 TRAINING

9.1 Risk Management
All staff have access to the Risk Management Policies folder in clinical areas and via the intranet. Risk management awareness sessions are included in the in-service training programme and the orientation programme for new staff.

9.2 Trust mandatory training
All medical and midwifery staff are required to attend annual updates on adult life support, fire, moving and handling, infection control and blood transfusion organised by the Trust. Midwives are also required to attend annual neonatal life support training.

9.3 Skills & Drills
All medical and midwifery staff are required to attend the multidisciplinary skills and drills on labour ward emergencies annually. (Ref. CNST Standard 1.10)

9.4 Fetal monitoring
All obstetric and midwifery staff should undertake six monthly multi-disciplinary education / training sessions, on the management of labour, fetal heart rate auscultation and CTG interpretation (Ref. CNST Standard .3). This can be achieved by:

• Attending the in-service training programme.
• Accessing and complete 25% the K2 teaching package or 5 simulator cases annually.
• Attending the weekly meeting to discuss caesarean sections of previous week or any forum that a structured discussion of the interpretation of CTG is taking place.
10.0 Confidential Enquiries of Maternal Death and Stillbirth, NICE Guidance, National Service Frameworks and Maternity Matters

Documents pertinent to Maternity Services are discussed at the Clinical Governance Rolling Half Day Audit meetings and Supervisor of Midwives meetings. Actions plans to fulfill recommendations are put in place. Feedback on progress and outstanding issues are monitored in the Clinical Governance Group.

11.0 Strategy Review

The Maternity Risk Management Strategy is a working document. It will be reviewed annually by the maternity Clinical Governance group and ratified by the Trust Board. (Ref. CNST Standard 1.1.1)

12.0 Reference:

Appendix 1: Guidance and Risk Matrix

This incident/near miss reporting helps the Trust to make sure that appropriate actions have been taken following an adverse incident. Any member of staff observing an adverse incident or near miss must ensure that this form is completed. If necessary, please continue on a separate sheet of paper, photocopy and attach to the reporting form. Completion of the form does not constitute an admission of liability of any kind, either by the person making the report or any other person. However, forms completed for incidents may be available to all parties in the event of legal proceedings, and it is therefore essential that they are completed accurately and factually. This form should be completed with reference to the Adverse Incident Policy and Procedure and the Risk Management Strategy.

To report an adverse incident / near miss, please complete Sections A – E of the form.

REPORT SERIOUS INCIDENTS IMMEDIATELY TO RISK MANAGER / DIRECTOR OF NURSING IN LINE WITH SUI POLICY

No abbreviations or shorthand should be used. RECORD ONLY FACTS AND NOT OPINIONS

The forms apply to ALL incidents and near misses including: Patient, Staff, Contractor, Agency/Locum and Visitor accidents or incidents, Fire incidents and Security incidents.

Adverse Incident is defined as ‘any event or circumstances arising during the NHS care of a patient that led to unintended or unexpected harm, loss or damage.’

Examples of adverse incident types: Communication problems, Falls, Violence & Aggression, Medication Errors, Security incidents, Equipment failure or misuse, Radiation, Fatalities or SUIs etc.

A Near Miss are those incidents or accidents which did not lead to harm or property damage, but could have.

In ALL cases the Adverse Incident / Near Miss Reporting Form must be forwarded to your line manager / head of service for completion within 8 hours. A copy of the Adverse Incident Form must be filed in the Ward / Department Incident file, and NOT IN THE PATIENTS RECORDS.

Guidance for Managers / Heads of Service

Manager / Head of Service refers to person in charge of ward / department at the time of incident and should be more senior than individual completing the form.

Upon receipt of the forms completed by members of staff, please complete section F

For Level 1 and 2 (Green & Yellow) Adverse incidents action should be taken on the ward / department as appropriate and a copy of the completed form forwarded to the Risk Manager (Postal Code L57).

For Level 3 and 4 (Orange and Red) Adverse Incidents take any immediate action required and notify immediately the relevant General Manager / Risk Manager / Director of Nursing. For Out of Hours incidents notify the Senior Manager On Call via switchboard. (Please refer to Adverse Incident Policy & Procedure)

Section F should be completed with reference to the following risk assessment grid:

<table>
<thead>
<tr>
<th>Consequence / Impact</th>
<th>Frequency / Likelihood</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>Description</td>
</tr>
<tr>
<td>1 None / Insignificant</td>
<td>No treatment, first aid, low financial loss. Some loss of reputation</td>
</tr>
<tr>
<td>2 Minor</td>
<td>Medical treatment required. Moderate environmental implications. Moderate financial loss</td>
</tr>
<tr>
<td>3 Moderate</td>
<td>Serious injuries to 1 or more persons. Serious environmental implications. Serious financial loss</td>
</tr>
<tr>
<td>4 Major</td>
<td>Excessive injuries. Major environmental implications. Major financial loss, business interruption</td>
</tr>
<tr>
<td>5 Catastrophic</td>
<td>Death of persons. Closure of Trust</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Level</th>
<th>Descriptor</th>
<th>1 Rare</th>
<th>2 Unlikely</th>
<th>3 Possible</th>
<th>4 Likely</th>
<th>5 Almost Certain</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Rare</td>
<td>Yellow: low 5</td>
<td>Yellow: low 10</td>
<td>Orange: moderate 15</td>
<td>Red: high 20</td>
<td>Red: high 25</td>
<td></td>
</tr>
<tr>
<td>4 Likely</td>
<td>Yellow: low 4</td>
<td>Yellow: low 8</td>
<td>Orange: moderate 12</td>
<td>Red: high 16</td>
<td>Red: high 20</td>
<td></td>
</tr>
<tr>
<td>3 Possible</td>
<td>Green: very low 3</td>
<td>Yellow: low 6</td>
<td>Orange: moderate 9</td>
<td>Red: high 12</td>
<td>Red: high 15</td>
<td></td>
</tr>
<tr>
<td>2 Unlikely</td>
<td>Green very low 2</td>
<td>Green: very low 4</td>
<td>Yellow: low 6</td>
<td>Orange: moderate 8</td>
<td>Red: high 10</td>
<td></td>
</tr>
<tr>
<td>1 Rare</td>
<td>Green: very low 1</td>
<td>Green: very low 2</td>
<td>Yellow: low 3</td>
<td>Orange: moderate 4</td>
<td>Red: high 5</td>
<td></td>
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</tbody>
</table>
## Appendix 2
### MATERNITY
#### INCIDENT REPORT INDICATORS/TRIGGERS

<table>
<thead>
<tr>
<th>Maternal death</th>
<th>Birth trauma</th>
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</thead>
<tbody>
<tr>
<td>Undiagnosed breech</td>
<td>Fetal laceration at caesarean section</td>
</tr>
<tr>
<td>Shoulder dystocia</td>
<td>Cord pH &lt; 7.05 arterial or &lt; 7.1 venous</td>
</tr>
<tr>
<td>Blood loss &gt; 1500mls</td>
<td>Neonatal seizures</td>
</tr>
<tr>
<td>Return to theatre</td>
<td>Term baby admitted to neonatal unit</td>
</tr>
<tr>
<td>Eclampsia</td>
<td>Undiagnosed fetal anomaly</td>
</tr>
<tr>
<td>Hysterectomy/laparotomy</td>
<td>European Congenital Anomalies and twins (Eurocat)</td>
</tr>
<tr>
<td>Anaesthetic complications</td>
<td>Unavailability of health record</td>
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<tr>
<td>Intensive care admission</td>
<td>Delay in responding to call for assistance</td>
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<tr>
<td>Venous thromboembolism</td>
<td>Unplanned home birth</td>
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<tr>
<td>Pulmonary embolism</td>
<td>Faulty equipment</td>
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<tr>
<td>3rd &amp; 4th degree tears</td>
<td>Conflict over case management</td>
</tr>
<tr>
<td>Unsuccessful forceps or ventouse</td>
<td>Potential service user complaint</td>
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<tr>
<td>Uterine rupture</td>
<td>Medication error</td>
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<tr>
<td>Readmission of mother</td>
<td>Retained swab or instrument</td>
</tr>
<tr>
<td>Stillbirth &gt; 500g</td>
<td>Health care acquired infection</td>
</tr>
<tr>
<td>Neonatal death</td>
<td>Violation of local protocol</td>
</tr>
<tr>
<td>Apgar &lt; 7 at 5 minutes</td>
<td></td>
</tr>
</tbody>
</table>

Ref RCOG 2009

This list is not exhaustive. Any other incident considered by staff as serious regardless of eventual outcome (near miss) should be reported.
## Appendix 3

**GYNAECOLOGY**

**INCIDENT REPORT INDICATORS/TRIGGERS**

<table>
<thead>
<tr>
<th>Event Description</th>
<th>Trigger/Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Damage to structures (e.g. ureter, bowel, vessel)</td>
<td>Unplanned return to theatre</td>
</tr>
<tr>
<td>Delayed or missed diagnosis (e.g. ectopic pregnancy)</td>
<td>Unplanned return to hospital within 30 days</td>
</tr>
<tr>
<td>Anaesthetic complications</td>
<td>Delay following a call for assistance</td>
</tr>
<tr>
<td>Venous thromboembolism</td>
<td>Faulty equipment</td>
</tr>
<tr>
<td>Failed procedures (e.g. termination of pregnancy, sterilisation)</td>
<td>Conflict over case management</td>
</tr>
<tr>
<td>Unplanned intensive care admission</td>
<td>Potential service user complaint</td>
</tr>
<tr>
<td>Omission of planned procedures (failure to insert IUCD after a hysteroscopy)</td>
<td>Medication error</td>
</tr>
<tr>
<td>Unexpected operative blood loss &gt; 500ml</td>
<td>Retained swab or instrument</td>
</tr>
<tr>
<td>Moderate/severe ovarian hyperstimulation (assisted conception)</td>
<td>Violation of local protocol</td>
</tr>
<tr>
<td>Procedure performed without consent (e.g. removal of ovaries at hysterectomy)</td>
<td></td>
</tr>
</tbody>
</table>

Ref RCOG 2009

This list is not exhaustive. Any other incident considered by staff as serious regardless of eventual outcome (near miss) should be reported.
Appendix 4

WOMEN’S SERVICES SPECIALTY
RISK MANAGEMENT GROUP
TERMS OF REFERENCE

Aims and objectives

- Review of incidents reported since the last meeting
- To recommend further actions or investigations for specific incidents
- Review outstanding actions from specific incidents identified during the previous month’s meeting
- Review reports of actions recommended from previous meeting and investigations
- Identify trends in clinical incidents
- Ensure learning from these incidents or near misses is implemented within the service
- Report to Obstetrics & Gynaecology Clinical Governance Group 4 times a year

Membership

- Clinical Director and/or Divisional Chair (chairperson)
- Consultant Lead for Delivery Suite
- Consultant Anaesthetist for Obstetrics
- Neonatologist or neonatal nurse
- Clinical Governance Coordinator
- Clinical Midwifery Manager or Senior Midwife Manager for Delivery Suite, In-patients and Community/Antenatal Clinic
- Senior sister of gynaecology ward
- Supervisor of Midwives
- Other individuals will be co-opted as appropriate
Working arrangement

- The meeting will be held monthly on each hospital site.
- Incident summary from previous month will be provided by the Clinical Risk Department / Clinical Governance Coordinator for discussion.
- Specific incidents will be analysed and action plan will be decided as appropriate
- Recommendations and action plans will be reported to the Clinical Governance Group.
- Actions and recommendations identified from the meeting will inform practice and may initiate audit and/or review of protocols and guidelines
- Actions and recommendations from the meeting will be disseminated to staff via staff meetings, memos, clinical governance newsletter and clinical governance notice board.

- Responsibility of action for meeting
  - Keep action notes
  - Midwifery Managers, the senior neonatal nurse and consultants are responsible for the assessment and action following through of the incidents that occurred in their area
  - Midwifery Managers, the senior neonatal nurse and the consultants are responsible for reporting to the meeting the actions that were taken
Appendix 5

WOMEN’S AND CHILDREN’S SERVICES DIVISION

WOMEN’S SERVICES SPECIALITY

CLINICAL GOVERNANCE GROUP

TERMS OF REFERENCE

Aim

- Provide a forum for developing strategy for the Specialty as a result of incidents reported through risk management, complaints or litigation claims
- Monitor trends identified through risk management reports, monitor implementation of action plans and ensure the Specialty is taking appropriate action to minimize risk to service users and staff to prevent reoccurrence
- Identify practice development required to improve service delivery and clinical quality
- Identify and monitor the actions required to achieve the above.

Membership

- Divisional Chair for Women’s Services (chairperson)
- Clinical Directors for obstetrics and gynaecology
- Infection Control Lead for the Specialty
- Head of Midwifery
- Neonatologist and Lead Nurse for neonatal services
- One Consultant Anaesthetist for Obstetrics
- Divisional Director for Women’s and Children’s Services
- Deputy General Manager
- Trust Senior Clinical Risk Management Advisor
- Trust Legal Services Manager
- Clinical Governance Coordinator for Women’s Services
- Senior Midwife Manager/Clinical Midwifery Manager for In-patients and for Strategic Development from QEII and Lister maternity units
- Supervisor of Midwives
- Gynaecology Matron
- Other individuals will be co-opted as appropriate
- If any individual unable to attend, a nominated deputy should take his/her place
**Working arrangement**
- The group will meet 3 monthly, alternating sites
- Review action points from previous meeting
- Receive summary reports of clinical and non-clinical incidents occurring in the Specialty in the previous quarter – identifying trends in incidents and actions taken to minimize risk or prevent recurrence from Women’s Specialty Risk Management Group.
- Report from the Trust Senior Clinical Risk Management Advisor/Clinical Governance Coordinator of trends and analysis of adverse incidents, SUI & SAI cases, learning from incidents across the Trust and any good practice that has been adopted by the Trust or other Divisions
- Review and update the Specialty risk assessments and risk register
- Report from Legal Services Manager updating progress on clinical claims and changes in practice identified through clinical claims
- Monitor implementation of staff training and development programme identified from risk management issues
- Receive update on Specialty position with regard to infection control policy adherence

**Communication**
- Unresolved risks which have been entered onto the specialty and corporate risk registers will have action plans formulated and will be escalated to the Divisional Board by the Clinical Director/Head of Midwifery. The responsibility for resolution still lies within the Division.
- Ongoing reports to Specialty meeting
- Women’s Specialty Risk Management Group
- Labour Ward Forums
- Supervisor of Midwives meetings
- Senior Midwifery Managers meetings
- Staff meetings
- Clinical Governance notice board

**Quorum**
Four members will be deemed quorate:
Clinical Chair/Clinical Director
Clinical Governance representative
Head of Midwifery/Midwife Manager
Neonatology representative
Administration
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

TOR approved September 2009
For review September 2010
Appendix 6

An overview of the assurance process is illustrated below.

![Diagram showing the assurance process]

- Local & Corporate Risks
  - Lead Executive Director
  - Clinical Divisions & Corporate Directorates

- Risk Register
- Assurance Framework
- Challenge & Review
- Audit Committee
- RAQC
- Executive Committee
- BOARD
## Appendix 7  Maternity Risk Management Strategy
### Action Plan 2010

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Planned Action</th>
<th>Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>5.1.1</strong></td>
<td>Ensure systems and processes in place for consideration and application of national confidential enquiries continues to operate in a structured and cohesive manner</td>
<td>Gap analysis to be presented at the Women’s Specialty meetings monthly and unresolved actions considered for inclusion on the risk register</td>
</tr>
<tr>
<td><strong>5.1.2</strong></td>
<td>Maintain the arrangements put in place to provide the level of medical leadership and experience required to comply with the NHSLA Risk Management Standards</td>
<td>Fourth Consultant labour ward lead appointed Jan 2008 Locum cover for fifth consultant post continuously advertised Funding for substantive posts in business plan</td>
</tr>
<tr>
<td><strong>5.1.3</strong></td>
<td>Recovery training for midwives to be detailed in guideline</td>
<td>Guideline to be updated</td>
</tr>
<tr>
<td><strong>Ongoing objectives</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>5.2.1</strong></td>
<td>Maintain and continually seek to improve the quality of maternity care provided by the service through the identification, control and minimization of risk and the provision of a safe environment for patients, staff and visitors.</td>
<td>Promote staff awareness and understanding of risk management and incident reporting through local induction and compliance with the maternity training needs analysis.</td>
</tr>
<tr>
<td><strong>5.2.2</strong></td>
<td>Through the process of statutory supervision of midwives, promote excellence in midwifery and thereby, a</td>
<td>Supervisor annual review Continue reflective sessions for staff and encourage attendance</td>
</tr>
<tr>
<td>5.2.3</td>
<td>Promote active risk management and the reporting of adverse/serious untoward incidents with all staff by providing support which encourages reflective review, a positive learning experience and improvements or changes in practice via the application of lessons learned from incidents within the department/division, the Trust and nationally.</td>
<td>Continue risk management awareness training session in the monthly In-service midwives mandatory training and in the orientation programme for all new staff. Debriefing following incidents Support from named supervisor of midwives Reflective review sessions</td>
</tr>
<tr>
<td>---</td>
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</tr>
<tr>
<td>5.2.4</td>
<td>Encourage a culture of accountability and openness in a safe, fair and supported environment</td>
<td>Monthly Perinatal meeting Risk management awareness during in-service training and orientation programme. Clinical governance newsletter Incident, complaints and claims trends and summary discussed at Clinical Governance Group meeting and displayed on clinical governance board.</td>
</tr>
<tr>
<td>5.2.5</td>
<td>Ensure risk management systems and processes are clear and understood by all staff and that risk assessments are carried out in accordance with the Trust’s risk management process.</td>
<td>Continue risk management awareness training session in the monthly In-service midwives mandatory training and in the orientation programme for all new staff.</td>
</tr>
<tr>
<td>5.2.6</td>
<td>Review and where appropriate implement recommendations from national guidance e.g. NICE (National Institute of Clinical Excellence), CMACE (Centre for Maternal and Child Enquiries), Maternity Matters.</td>
<td>Compliance with Maternity Key Guideline 11.4 “Implementing National Confidential Enquiries”.</td>
</tr>
</tbody>
</table>
## Appendix 8

### Maternity Risk Management Strategy

#### Action Plan Update September 2009 - September 2010

<table>
<thead>
<tr>
<th>Planned Action</th>
<th>Action Undertaken</th>
<th>Achievement</th>
</tr>
</thead>
</table>
| Ensure the process for induction of maternity staff is clear within the written guidance. | • Update “Welcome to East & North Herts NHS Trust” orientation pack for staff.  
• Training Needs Analysis to be written and include mandatory sessions to be included in induction. | Achieved |
| Maintain an effective database to facilitate the demonstration of attendance of staff at training sessions as detailed in the training needs analysis via an audit at future CNST assessments. | • Database is in place and currently maintained by the Training & Skills Development Midwife and reviewed via the Maternity Dashboard which is presented at the labour ward forum and clinical governance group meeting. | Achieved |
| Develop a patient information database and monitor this to ensure information is reviewed, up to date and that ownership is detailed. | • Re-instigate service user information group and adhere to review dates | Not achieved |
Maternity Risk Strategy – August 2010

Distribution list:

Divisional staff
Nick Carver – Chief Executive
Mr. Rami Atalla and Dr Andy Raffles – Co- Divisional Chair for Women’s & Children’s Services
Bernadette Herbert – Divisional Director, Women’s & Children’s Services
Emma Costin - Deputy General Manager
Mr Douglas Salvesen, Clinical Director Obstetrics
Mr Alasdair Drake, Clinical Director Gynaecology
All Obstetrics & Gynaecology Consultants
Christine Nixon - Head of Midwifery & Gynaecology
Midwifery Managers
Joy Kirby - LSA Officer, Eastern Region West
Supervisors of Midwives
James Quinn – Medical Director, Chairperson of Clinical Governance Strategy Committee
Sue Greenslade – Director of Nursing and Infection Control
Andrew Hood – Chief Pharmacist
Lead Consultant Microbiologist
Dr Mike Chilvers – Clinical Director Anaesthetics, Theatres & ICU
CD for Pathology services
Dr Kavita Chawla – Clinical Director Acute Paediatrics
Dr Jonathan Kefas – Clinical Director Neonatal services
Jacinta Dulnlea – Matron Children’s services
Lesley Dustagheer – Matron Children’s services
Del Brown – Lead Nurse, Neonatal Services
Jacqui Evans – Clinical Governance Manager
Mary Emson – Named Nurse for Child Protection
Philomena James – Senior Clinical Risk Management Advisor
Jackie Martin – Legal Services, Complaints and PALs Manager
Chris Boseley – Safety & Security Manager
Tracey Westley – Clinical Governance Manager, East & North Herts PCT
Jane Barker – Chairperson of Maternity Services Liaison Committee
Sandra Betterton – Clinical Governance Facilitator, East of England Strategic Health Authority
Natalie Mudge – Clinical Standard Advisor, East of England Ambulance & Paramedic Service NHS Trust
Julie Juliff – Commissioning Manager for Acute Children’s, Maternity and Women’s Services