# Maternity Risk Management Strategy (CG347)

## Approval and Authorisation

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## Change History

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Other relevant corporate and procedural documents

- Risk Management Policy and Procedure (2017) CG027
- Incident Reporting Investigation and Learning Policy (2017) CG553
- Complaints Policy (2016) CG009
- Raising Concerns at Work (Whistle Blowing) Policy (2017) CG055
- Claims Management Policy (2016) CG089
- Trust Mandatory Training Policy (2017) CG065
- Maternity Specific Mandatory Training Policy (2017) CG360
- Information Governance Strategy & Policy (2016) CG004
- Procedural Documents Policy (2018) CG001
- Maternity Escalation & Diversion protocol (2017) CG483
- Duty of Candour Being Open Policy (2017) CG605
- Terms of Reference for the following Committees:
  i. Maternity Clinical Governance Committee
  ii. Maternity Quality & Safety Committee
  iii. Morning operational Meeting
  iv. Weekly Safety and Quality Team Meeting
  v. Perinatal Mortality and Morbidity Committee
  vi. Perinatal Mortality Review Group
  vii. Maternity Audit Committee
  viii. Midwifery Services Committee
  ix. Maternity Clinical Guidelines Committee
  x. Maternity Information Committee
1.0 Introduction

All services and clinical care within healthcare are not risk free. It is important however, to minimise risks and to ensure that when making decisions, those doing so are deliberately choosing to make judgements from a range of fully detailed and understood options.

Adverse incidents are in most cases a result of a lack of clear procedures and policies or non-compliance with both, poor working practices and/or training, inadequate communications, environmental hazards or staff working beyond their competence.

The Maternity service aims to reduce the potential for incidents in the proactive management of risk. All staff have a role in managing risk through compliance with Trust Policies and procedures, maintaining competence, identifying and responding to hazards and reporting incidents. This Strategy sets out how the Maternity Services aims to manage its risks.

Where organisational systems or genuine human errors occur the Maternity Service is committed to ensure that the patient and or families are told openly and honestly when errors occur which cause harm to a mother or the baby.

2.0 Scope

The Maternity Risk Management Strategy (MRMS) integrates with and is complementary to the Risk Management Policy and Procedure (CG027), which aims to ensure safety of patients, staff and the public and in supporting the delivery of affordable quality maternity care that achieves excellent results.

The strategy is available to all maternity staff on the Trust Intranet website under Maternity Policies and Protocols.

3.0 Purpose

The purpose of this Strategy is to ensure that all maternity staff are aware of the process for managing risk within the maternity services and the responsibilities and mechanisms for doing so. The strategy ensures the management of risk in maternity is consistent with and supports the achievement of the Maternity Services and Trust strategic and corporate objectives;

In line with the Trusts strategic aim, the maternity services will provide:

- A consistent and effective risk management processes at all levels within maternity
- The development of a learning culture to support improvements to the safety of the maternity services
- Integration of risk management into the objective setting process
• A culture of openness and honesty

A robust ward to Board risk process ensuring a clear understanding at Board level of the key risks facing the maternity services.

Objectives:

• To ensure all serious incidents are reported and managed in accordance with the Incident Reporting, Investigation and Learning Policy (CG039).

• Ensure compliance in reporting cases to the relevant agencies within set timescales

• To ensure adequate and appropriate staffing levels to provide safe care to women and babies at all times through timely and effective recruitment and retention of staff in all specialties working in maternity.

• To ensure mandatory training is completed and monitored to comply with the Trust Mandatory Training Policy (CG065) and Maternity Specific Training Needs Analysis (CG360).

• Demonstrate the process for identifying risks both clinical and non-clinical and how they are managed within a maternity clinical governance framework, which includes the risk management process. Analyse trends in adverse incidents/near misses/complaints to ensure a system of continuous improvement.

• Provide effective communication to all maternity staff through minutes of meetings/memos/emails/blogs and the monthly Maternity Newsletter

• Ensure that staff work within written guidelines, policies and protocols, which are easily available and regularly reviewed through audit

• Ensure compliance with national guidance and legislation demands on the Trust are implemented within one year of publication.

• Ensure compliance with relevant national reporting systems in the event of an adverse outcome meeting the set criteria; Each Baby Counts (EBC), NHS Early Resolution Scheme (ERS), Perinatal Mortality Review Tool (PMRT), MBRRACE.

• Ensure cases meeting the set criteria are reported and investigated by the Healthcare Safety Investigation Branch (HSIB)

• Suspected safety or serious screening Incidents within the screening programme will be notified by the Screening Midwives to the QA team and the screening and immunization team at PHE via the Screening incident assessment Form (SIAF).
4.0 Duties and Responsibilities

The corporate roles and responsibilities are outlined in the Trust Risk Management Policy and Framework.

4.1 Care Group Roles and responsibilities

4.1.1 Director of Midwifery

The Director of Midwifery oversees the effective implementation and application of all midwifery related Trust policies, procedures and standards within the Directorate with professional responsibility for ensuring compliance with the letter and spirit of such policies. This includes proactively implementing and evaluating the Risk Management and Quality Assurance policies to ensure the Trusts Clinical Governance agenda is adhered to and that strategies are implemented to promote clinical effectiveness, quality care delivery and a safe and healthy work place.

The Director of Midwifery supports the embedding of a governance culture within the midwifery team through communication and monitoring.

This includes facilitating the implementation of an effective Risk Management Strategy for Maternity Services and that relevant training and mandatory updates are provided for all staff.

In conjunction with the matrons, they identify risks to be entered onto the directorate risk register and prioritise risks and develop risk action plans. The Director of Midwifery also advises on risks that may require escalation onto the Trust Corporate risk register and to providing advice on actions required to mitigate those risks.

The Director of Midwifery supports the Group Director in ensuring that Serious Incidents are managed in accordance with the agreed approach. They also review clinical incidents, safety reports and Serious Incidents and advise on actions as appropriate.

Together with the Lead Obstetrician for Risk, the Maternity Clinical Risk Manager, and the Quality Improvement and Audit Midwife form the Quality and Safety Team

The Director of Midwifery and Group Director attend the Quality Assurance and Learning committee and prepare a Maternity Quality and Safety report which includes Directorate Clinical Governance issues for presentation at this committee.

4.1.3 Obstetric and Gynaecology Clinical Lead

The Obstetric and Gynaecology Clinical Lead is responsible for ensuring a mechanism is in place to monitor patient safety and measuring clinical outcomes. The role is also accountable for compliance with clinical governance standards including NHSLA, for the directorate. This includes ensuring that the teams
maintain and provide evidence of compliance against the standards required. In conjunction with the Director of Midwifery, Medical Leads, the Directorate Manager and the matrons, the Clinical Director identifies risks to be entered onto the directorate risk register, for prioritising risks and developing risk action plans as appropriate.

4.1.4 **Directorate Manager Maternity and Children’s services**

The Directorate manager works closely with the directorate clinical and administrative teams to assist them with collating the evidence of their areas compliance against clinical governance standards.

The Directorate Manager facilitates the compilation of the directorate risk register, noting that ownership of each risk is the responsibility of those who it has been agreed and allocated to, and ensures that risks are raised to the Urgent Care Board for placement onto the UCG risk register as appropriate.

They advise the Maternity Clinical Governance Committee on compliance with corporate governance systems and processes including policy matters.

4.1.5 **Matrons for Hospital and Community Maternity Services**

The Matrons lead the embedding of a governance culture within the midwifery care teams, ensuring all staff understand their responsibility for service quality and patient safety and that mechanism are in place to monitor patient safety and for measuring clinical outcomes and other quality measures.

The Matrons are accountable for compliance with clinical governance standards, including NHSLA & CQC for midwifery care within the directorate and for ensuring that the teams maintain and provide evidence of compliance against the standards required.

In conjunction with the Director of Midwifery, Clinical Lead & Directorate Manager they identify risks to be entered on to directorate risk register, prioritise risks & develop risk action plans and are responsible for monitoring implementation of actions to reduce risk.

The matrons oversee the effective management of clinical incidents and safety reports and take action as appropriate by ensuring, patient risk assessments, audits and root cause analysis/investigations and ensure remedial actions are taken & records maintained.

4.1.6 **Lead Obstetrician for Maternity Clinical Governance**

The Maternity Clinical Governance Lead has overall accountability for applying clinical governance principles to the delivery of maternity services. This includes the use of standard operating procedures, guidelines and protocols pertinent to maternity services; the recording of, reporting of and learning from adverse incidents; ensuring participation in continuing professional development and the delivery of clinical audit across the department.

The Clinical Governance Lead will ensure that:
• Maternity services comply with the clinical governance principles, ensuring safe, evidence-based practice, which meets local and national standards.

• A culture of continuous quality improvement is encouraged at all levels in the department to maintain high standards, thus creating an environment in which excellence in clinical care will flourish.

**Principle Responsibilities & Tasks**

Prepare agenda and chair monthly Maternity Clinical Governance Committee Meeting

Collation and distribution of relevant risk management data to staff within maternity services and Trust Clinical Governance Committee where required.

Advise the Clinical Director and Director of Midwifery of all serious adverse clinical incidents

To lead and coordinate the department’s participation in any internal or external reviews, audits or inspections and prepare follow-up action plans.

Responsible for completing any relevant clinical governance documentation and be available during any external inspections and make available any such documentation required by the assessors to monitor clinical practice and risk management compliance.

**Reports to**

The Clinical Governance lead will report to the Urgent Care Group Director with the Trust Clinical Governance Manager.

4.1.7 **Lead Obstetrician for Maternity Clinical Risk**

• The responsibility of the lead obstetrician for maternity clinical risk is to monitor maternity adverse incidents; to report serious incidents in accordance with the *Incident Reporting, Investigation and Learning Policy (2017)* (CG553). Together with the Director of Midwifery, Maternity Clinical Risk Manager, and the Quality Improvement and Audit Midwife form the Maternity Quality and Safety Team

Additional responsibilities include:

• Collate cases for discussion and prepare summaries for the Maternity Quality and Safety Committee. To review minutes and monitor the implementation of actions.

• Monitor and act on adverse incidents involving medical staff and if necessary, discuss with individuals concerned and/or their educational supervisors

• Work with the Director of Midwifery and the Maternity Clinical Risk Manager to identify cases that require further investigation

• Serious incidents that have undergone root cause analysis are discussed once the investigation is completed. The recommendations, learning outcomes and the action plan are circulated to the members of the Quality
and Safety Committee and to the chair of the Maternity Clinical Governance Committee and the Trust Head of Patient Safety.

- Participate in the Perinatal Mortality Review group as a core member
- Report cases to Each Baby Counts as per criteria.
- Lead for Maternity Academic Half Day scheduling arranging speakers, topics and recording attendance
- Where training need is identified through the maternity clinical governance process this is added to the mandatory training days or ‘topics of the month’.

### 4.1.8 Lead Obstetrician for Delivery Suite: Role and responsibilities

- The lead obstetrician must provide strong professional leadership and support for all disciplines. Working together with the delivery suite manager and lead obstetric anaesthetist, they will ensure that clinical and professional leadership is available to all staff within the delivery suite. In order to do this effectively the lead obstetrician should maintain a regular presence on delivery suite, both by undertaking regular clinical sessions and also by daily input in a non-clinical capacity (when not on leave). They should be available to assist in and support the process of de-briefing staff following difficult and/or traumatic incidents.

- It is important that the lead obstetrician maintains an overview of all adverse incidents that occur on delivery suite and undertakes a rapid response by ensuring that supportive and non-judgemental information gathering meetings are held with the obstetric staff involved as soon as is possible following such an incident. They should play an active role in the rapid instigation of safety measures as and when a risk requiring such measures is brought to light.

- Working with the delivery suite manager, consultant midwife and lead obstetric anaesthetist, in consultation with all staff, they should ensure that common guidelines, education and standards relevant to delivery suite care are developed, updated, maintained and communicated. It is recommended that the lead attends the daily Maternity Operational Meeting at 09.00.

- Communicate openly and consult extensively with clinicians and midwives, to manage the performance of the delivery suite in terms of efficient and effective use of all resources, together with the development and maintenance of the highest standards for delivery of patient care.

- They should promote the practice of evidence based medicine, continuous learning, innovation and development. They should encourage and support involvement in research, audit, education and training.

- They should attend the maternity clinical governance meetings and ensure that decisions taken by this committee are translated into clinical practice on the delivery suite by ensuring teaching, training and communicating changes in policy.
• The lead must ensure that recommendations from MBRRACE, NICE, the Healthcare Commission and the Royal Colleges are incorporated into local guidance where appropriate.

• The lead obstetrician should facilitate the collection and availability of perinatal statistics through local reporting and the mechanisms put in place by MBRRACE.

• The Lead co-ordinates the Intrapartum forum in conjunction with the Delivery Suite Manager and the MLU manager.

4.1.9 Lead Paediatrician for Neonatal Care

The lead paediatrician for neonatal care is responsible for setting the standards for neonatal care, which includes neonatal resuscitation training and equipment in all areas where neonatal resuscitation is performed.

The lead neonatologist or deputy attends the Maternity Quality and Safety Committee meetings and is responsible for providing feedback on outcomes for all cases of neonatal morbidity. The lead neonatologist also attends the Perinatal Morbidity and Mortality meeting.

The lead neonatologist (or deputy) is responsible for liaising with the obstetric department for all matters relating to neonatal care, which includes the provision of clinical guidelines and policies.

4.1.10 Lead Obstetric Anaesthetist

The lead obstetric anaesthetist has overall accountability for applying clinical governance principles to the delivery of maternity anaesthetic services. This includes the use of standard anaesthetic procedures, guidelines and protocols pertinent to anaesthetic services; the recording of, reporting of and learning from adverse incidents; patient information; ensuring participation in continuing professional development and the delivery of clinical audit across the department.

Attend monthly maternity clinical governance/risk committee meetings and report back to the anaesthetic workforce. An annual joint obstetric and anaesthetic meeting is held to discuss and ensure lessons are learnt from adverse outcomes.

The lead in obstetric anaesthesia ensures that:

• An antenatal assessment service is provided to high-risk women with existing co-morbidities.

• 24 hour cover by dedicated delivery suite anaesthetist and nominated "out of hours" consultant to provide analgesia in labour, anaesthetic interventions and care for the critically ill woman.

• A full "working hours" consultant-led cover to optimise training of junior staff with high turnover.

• Supervision of junior anaesthetists training according to Royal College of Anaesthetists standards and ensure basic competency is achieved before on call commitments undertaken.
• Monitoring of adverse incidents involving anaesthetic staff and either
discuss with individuals concerned or their educational supervisors.
• Investigate, monitor and review all anaesthetic incidents and complaints.
• Perform root cause analysis when required and publish and distribute
findings.
• short term and long term workforce management
• participate in multidisciplinary training of epidural management and high
dependency care of sick patients

4.1.11 Consultant Midwives
There are two Consultant Midwives employed within the maternity services.

Consultant Midwife 1:
Whose role is to lead on initiatives to promote normal child birth.

• Facilitates practitioners to improve their evidence based practice and
  maintain competence
• Leads on the development and monitoring of practice that enhance the
  physiological process of labour and birth
• Facilitates birth experiences for women with complex needs or additional
  risk factors to ensure they experience processes supporting normality
• Provides expert advice to midwives, doctors and commissioners
• Supports and guides the midwifery led unit team
• Actively contributes to strategic planning of services
• Plans and implements models of care
• Leads on the implementation of midwifery research
• Actively participates in clinical audit and the development of evidence-
  based clinical standards of care
• Audits practice and service; evaluates maternity care and service provision
• Acts as a resource both internally and externally to the Trust within health
  and social care.

Consultant Midwife 2:
Leads the development and implementation of quality initiatives and health
programmes to reduce health inequalities, increase normality and improve
outcomes for mothers and babies and shares this knowledge locally, regionally
and nationally. Provides clinical leadership; advice and support to all colleagues
providing midwifery care in primary and secondary care settings.

• Develops midwifery care to promote maternal health and wellbeing and
  hence further women centred care, improving women’s experiences of
  pregnancy, birth and early parenting.
• Actively promotes and develops care pathways for public health issues
  that promote normal birth. Provides expert clinical advice to all medical
and midwifery staff to ensure best practice standards are met that will improve outcomes for women and influence a reduction in interventions

- Leads service redesign and empowering midwives to meet the health and social needs of the local populations in line with key objectives outlined in local and national policy documents.
- Actively contributes to the Strategic planning of the service
- Leads the implementation of midwifery research to enhance the body of midwifery knowledge
- Empowers, educates and trains midwives to care for women and her family from a holistic perspective.
- Ensures that all midwifery practice is evidence based and that all staff are competent and capable as required for their role in promoting normality wherever possible and ensuring maternal health and wellbeing.
- Shares expertise and acts as a resource for public health and midwifery, sharing expertise both internally and externally to the Trust
- Provides clinical midwifery leadership to the Community Midwives and Practice Development Midwifery Team
- Works in collaboration with Public Health Teams within the Local Authorities.
- Works with the Director of Midwifery to ensure all local and national policy is assessed, benchmarked and implemented locally.

4.1.12 Maternity Clinical Risk Manager

The role of the Maternity Clinical Risk Manager is to coordinate clinical risk activities and risk management across maternity services, together with the Lead Obstetrician responsible for clinical risk, Director of Midwifery & the Quality Improvement and Audit Midwife form the Maternity Quality and Safety Team.

The main responsibilities of the Maternity Clinical Risk Manager are:

- To investigate, monitor and review all Maternity incidents to ensure an appropriate level of investigation is undertaken and actions put in place to reduce or eliminate risk and that learning is shared with all staff.
- To ensure that cases meeting a set criteria are entered onto appropriate national reporting systems STEIS, EBC, NHS ENS and PMRT
- To report all cases meeting the criteria to the Healthcare Safety Investigation Branch (HSIB) and support the investigation process working with the investigators to upload health records and arrange interviews with staff
- To undertake responsibility for initiating the process and monitoring progress of internal investigations and ensuring sign-off within set timescales.
- To meet with the Urgent Care Group Director to update on the progress of all maternity investigations
• To undertake the role of investigating officer for all maternity complaints. To monitor the learning from complaints and implementation of action plans through minutes of meetings, reports and professional development.
• Ensure lessons are learned from incidents, complaints and claims through teaching, professional development and written reports.
• To assist in the preparations for external assessments such as Care Quality Commission and other external agencies.
• To represent maternity on the Patient Safety Committee ensuring matters relating to maternity are discussed and actions from the meetings are disseminated through the clinical Maternity Clinical Governance Committee.
• Support the Director of Midwifery and Head of Legal Services regarding potential and on-going claims relating to maternity care.
• To coordinate the Health & Safety activities within maternity.
• Prepare and present monthly complaints and incident reports to Maternity Clinical Governance Committee and Midwifery Services Committee.
• Contribute to the annual maternity quality and safety update report for the Board.

4.1.13 Delivery Suite Manager

The Delivery Suite Manager is responsible for providing professional leadership and clinical expertise on the Delivery Suite. The Delivery Suite Manager will:

• Ensure that services are delivered safely and effectively and support improved patient experience and clinical outcomes delivering high quality, women focussed care.
• Ensure adequate staffing levels at all times to ensure women receive safe and effective care in labour and women who are seriously ill requiring high dependency care.
• The Delivery Suite Manager will work closely with the Lead Obstetrician for Delivery Suite and Consultant Midwives to develop common guidelines, education and high clinical standards.
• Promote multidisciplinary team working.
• Actively contribute to the implementation of local and national policies and National Service Frameworks.
• Attend Maternity Clinical Governance Committee and sub-committee meetings to provide expert opinion and to ensure recommendations and action plans are implemented.
• Monitor the quality of the environmental standards within the Delivery Suite. Manage any shortfall in service provision.
• In collaboration with the Maternity Clinical Risk Manager co-ordinate the investigation and response to informal and formal complaints received.
from women and their families. Monitor the implementation of agreed action plans and to ensure learning

- Provide effective feedback to staff.
- The Delivery Suite Manager will ensure all necessary medical equipment is available, in good working order and regularly serviced

4.1.14 **Professional Midwifery Advocates (PMA)**

Professional midwifery Advocates fulfil the requirements of the A-EQUIP model of clinical midwifery supervision which has been introduced by the Department of Health to replace midwifery supervision which was removed from statute in 2017. Delivery of the A-EQUIP model is mandated within the NHS Standard Contract (NHS England 2017/18) and the model is based upon CQC standards.

The team of PMAs support midwives to learn and reflect from clinical events using restorative clinical supervision. There is close liaison between the PMAs and the senior management team to identify those who would benefit from this support however it can be accessed by any midwife. In addition to this the PMA’s have a role in teaching, facilitating and leading service improvement and supporting all midwives to give individual care to women who may require complex care planning.

4.1.15 **Practice Development Team**

The Practice Development Team is responsible for organising multi-professional training and updating of staff working in maternity.

Training is based upon requirements from national guidance and as a result of incidents, complaints and claims

4.1.15.1 **Practice Development Midwife**

The Practice Development Midwife is responsible for identifying and addressing the training needs of the multi-disciplinary team which includes doctors, midwives, nurses, recovery nurses, nursery nurses and maternity care assistants. Training is delivered through structured teaching, support in practice, information sharing and e-learning. All training is captured on a specific database that logs individual’s engagement and progress with professional development and skill maintenance. Failure to comply with the required Mandatory Training is addressed as per the Trust Maternity Training Needs Analysis (CG065).

The Practice Development Midwife also works closely with the Director of Midwifery to identify Professional Development Needs based on the Strategic Plan of the Trust and Succession Planning requirements.

The Practice Development Midwife is also responsible for the Preceptorship programme that enables a newly qualified midwife to make the transition from Student Midwife to Practicing Midwife a safe yet positive experience.
4.1.15.2 Clinical Skills Trainer
The Clinical Skills Trainer for Maternity offers training and practical support to the multi-disciplinary team. This includes facilitating the development of the extended skills for midwives, maternity care assistants and nursery nurses, through structured teaching and support in practice. The recovery nurses are offered an annual update on obstetric emergencies relevant to their role taught in small groups. A database is maintained for skills and equipment training. Teaching sessions are also provided to the obstetric team on relevant issues such as neonatal resuscitation, use of equipment on Delivery Suite and basic obstetric skills for Foundation Year doctors.

4.1.15.3 Practice Educators
The Practice educator role is divided into two parts
- 40% of the role has a responsibility for learning and development for pre and post registration student midwives in training, linking with the University of West London. This links to ensuring that qualified midwives are developed and are given the opportunity to become sign off mentors. The practice educator role is to maintain a sign off mentor register ensuring the Maternity unit has adequate sign off mentors and co-mentors to accommodate the number of student midwives in training.
- 60% of the Practice Educator role is to ensure the learning and development of post registration midwives, working closely with the Practice Development and Clinical Skills midwives to deliver learning and development of qualified staff both hospital and community based.

4.1.16 Quality Improvement and Audit Midwife
The quality improvement and audit midwife is responsible for:
- Coordinating the implementation and dissemination of a rolling programme of quality improvement and audit to meet national, regional and local standards
- Links with the Trust Quality Assurance team to maintain standards and share findings (or outcomes) across the Trust
- Supporting staff undertaking audits and ensuring accuracy of data collection, report writing and dissemination of audit results.
- Ensuring recommendations are agreed and action plans from risk and audit are completed in a timely manner.
- Producing Monthly Maternity Newsletter, which is distributed to all maternity clinical areas including community. This contains summaries of audit results, risk management issues and general information on clinical practice and departmental chat.
- Links with Maternity service guideline leads to update Trust guidelines in accordance with new national standards and action plan recommendations.
• Together with the Director of Midwifery, Lead Obstetrician for Risk and the Maternity Clinical Risk Manager to form the Risk Team

4.1.17 Maternity Information Manager
The Maternity Information Manager is responsible for managing all maternity clinical guidelines/policies/protocols and maternity information posted on the Trust Intranet via the Policy Hub for accessibility by staff internally and on the Trust website for public access.

The Maternity Information Manager is a member of the Clinical Guidelines Committee and the Maternity Clinical Governance Committee.

All document review, posting, messaging and archiving is managed by the maternity information officer. A monitoring tool is used to identify when documents are due for review and to plot the progress of the review process. The Maternity Information Manager is also responsible for updating the tracker which shows Procedural document compliancy by percentage which is presented by the Director of Midwifery to the Urgent Care Committee in the Monthly performance report.

4.1.18 Maternity Ward/Departmental Managers
All Ward and Departmental Managers are responsible for implementing the clinical risk strategy in the workplace by ensuring:

• All staff know how to report incidents and to escalate serious concerns or serious incidents in a timely manner.
• All incidents and complaints are investigated in accordance with the Complaints Policy (CG009) and action plans implemented to avoid recurrence. All complaints relevant to the ward area are discussed at monthly meetings which is evidenced in minutes of ward meetings.
• All staff attend mandatory training as outlined in the Maternity TNA.
• All staff are aware of the Trust guidelines/policies/protocols.
• Risk assessments are completed and reviewed annually for their area of responsibility. A Risk Register is maintained and reviewed. The departmental risk register is populated with red and amber incidents which are escalated to the Matron.

4.1.19 Supporting personnel
The Maternity Services work closely with the Patient Safety and Legal teams.
An organisational flow chart demonstrates organisational structure and reporting mechanism for governance and risk in maternity. See appendices 2 & 3.

5.0 Maternity Governance and Quality and Safety Arrangements
The maternity service has a well-established clinical governance structure which ensures clear communication between the committees and subcommittees which
report to The Urgent Care committee and Quality Performance and Learning Committee.

5.1 **Maternity Clinical Governance Committee**

The Maternity Clinical Governance Committee (MCGC) is established to address all matters relating to governance and clinical and non-clinical risk to build upon and improve the quality of maternity service provision. The committee meets monthly with the exception of August and is chaired by the lead obstetrician for maternity clinical governance or deputy. The Committee has multi-professional representation including a lay representative from the Maternity Forum.

Matters arising from the Trust Quarterly Performance and Learning Committee are discussed as a regular agenda item. The minutes from the Trust Senior Team Management meetings are circulated to the Clinical Governance Leads. The Director of Midwifery reports back discussions from the meeting.

A monthly Maternity Incident and Complaints report is produced and presented by the Maternity Clinical Risk Manager detailing the previous months serious incidents and identifies trends from incident reporting. A summary of complaints is provided.

Red and amber risks on the Maternity Risk Register are reviewed, updated with actions required

The Clinical Director and the Director of Midwifery provide reports to the Urgent Care committee and Trust Quality Assurance and Learning Committee.

Minutes of the MCGC sub-committees are monitored and matters arising are discussed.

5.2 **Maternity Quality and Safety Committee**

The Maternity Quality and Safety Committee (MQ&SC) is a sub-committee of the MCGC. The obstetric lead for clinical risk or an appointed deputy chairs the Committee. The Committee meets monthly except in the month of August. to review cases identified through incident reporting or at the Morning Operations Meeting. Feedback from Recommendations and actions from Root Cause Analyses are presented and discussed to ensure effective communication and learning from serious incidents.

The Trust Legal Department is made aware of all cases that meet the criteria for the NHS ENS within the set timescales or any other case that may potentially lead to a claim at the earliest opportunity.

5.3 **Maternity Operational Morning Meeting**

The morning operational meeting is held weekday mornings with the exception of public holidays. The team responsible for the maternity services on the day discuss staffing and capacity for the following 24 hours, weekends and public holidays. In addition capacity and an overview of current inpatients, including outliers and activity are discussed to identify care needs and priorities.
Incidents for the previous 24 hours or over a weekend/public holiday are reviewed. All incidents are recorded in a diary so that actions can be followed up the next day.

In the event of a serious incident or unexpected poor outcome a timeline is undertaken by the unit coordinator of the day. The timeline is emailed to the Risk Team to determine whether a scoping meeting is required. If any practice related issues are identified they are escalated to the ward or department manager or educational supervisor to address.

5.4 **Weekly Quality and Safety Team Meeting**

The Quality and Safety Team meet on a Friday morning immediately following the Morning Operational Meeting. The purpose of the meeting is to monitor the progress of root cause analyses investigations in compliance with the Incident Reporting Investigation and Learning Policy - v1.0 - CG553

All cases of term admissions to the Neonatal Unit are reviewed to ensure that cases requiring investigation or reporting to external agencies are not missed.

Issues relating to clinical risk management are discussed and actions taken. A record of cases discussed is held in the incident diary.

The Head of Patient Safety is invited to attend these meetings.

5.5 **Perinatal Mortality and Morbidity Committee**

Perinatal Mortality and Morbidity Committee meetings are held monthly and are attended by obstetricians, neonatologists and midwives to discuss mortality and morbidity cases. These meetings provide an opportunity for learning and attendance by all grades of staff is encouraged. A review of all unexpected admissions to the neonatal unit and the annual audit of babies readmitted with feeding related issues is presented at this committee.

Summaries of all case discussions are made and learning identified. Cases may be referred to the Quality and Safety Committee for more in depth consideration as determined by the senior clinicians present.

5.6 **Perinatal Mortality Review Group**

The Perinatal Mortality Review Group meets monthly to review all perinatal deaths and to complete the Perinatal Mortality Review Tool. The aim of the Perinatal Mortality Review Tool (PMRT) is to support standardised perinatal mortality reviews across NHS maternity and neonatal units in England, Scotland and Wales. The tool supports: Systematic, multidisciplinary, high quality reviews of the circumstances and care leading up to and surrounding each stillbirth and neonatal death, and the deaths of babies who die in the post-neonatal period having received neonatal care.

The review tool generates reports which identify learning and actions to be taken and can be shared with the parents.
5.7 **Maternity Quality Improvement and Audit Committee**

The Maternity Quality Improvement and Audit Committee meets a minimum of quarterly and is chaired by the Quality Improvement and Audit Midwife. The Committee reviews local and National standards for maternity services and develops the annual audit programme ensuring its implementation. The committee also ensures that the audit results are disseminated to all relevant staff and that changes occur in clinical practice as a result of audits.

Additionally a summary of audit reports are posted on the Maternity intranet site and summaries published in the Maternity newsletter.

5.8 **Midwifery Services Committee**

The Midwifery services committee meets monthly and is chaired by the Director of Midwifery or deputy to discuss all matters related to Midwifery management and practise. All midwifery managers and specialist midwives attend the meetings.

Monthly presentations of the mandatory training compliance are presented and actions agreed where levels fall below 80%.

Information is disseminated to staff by ward/departmental managers at meetings and in weekly blogs and is evidenced in the minutes of meetings. The maternity newsletter also covers information from the meeting.

5.9 **Maternity Clinical Guidelines Committee**

The Maternity Clinical Guidelines Committee meets quarterly and is chaired by the Director of Midwifery or deputy. All policies and operational, clinical/non-clinical guidelines are produced using the Trust ‘Procedural Documents Policy (CG001)’ template and are approved by the Maternity Clinical Governance Committee with the exception of policies which are approved by the Trust Clinical Governance Committee. Once approved they are posted on the Trust Website.

The Maternity Information Officer co-ordinates the review and posting of all operational policies and clinical/non-clinical guidelines. All reviewed/amended guidelines/policies/protocols/patient information leaflets are archived.

5.10 **Maternity Information Group**

All maternity information leaflets are reviewed biannually and in accordance with the Trust standards for patient information. Where possible they are translated in the main foreign languages. Midwives, GP’s and service users can access patient information leaflets via the Trust website which are managed by the Maternity Information Officer. Maternity information leaflets can be accessed by patients via the Trust website under Maternity leaflets.

5.11 **Maternity Voices Partnership (Formerly the Maternity Services Liaison Committee - MSLC)**

Maternity Voices Partnership a Maternity Services Liaison Committee is a team of service users, service user representatives, midwives, doctors and
commissioners. The committee work together to review and contribute to the development of local maternity services and to ensure quality standards including clinical risk are paramount. The committee meets quarterly to ensure that women’s views are considered in any decisions made about changes in local maternity service. Action plans from complaints and clinical incidents are standing agenda items at this meeting. The Chair of the Maternity Forum is a member of the Maternity Services Clinical Governance Committee and has an agenda item. The committee's Terms of Reference and Annual Reports can be found here: https://westberksmslc.wordpress.com/annual-reports/.

6.0 Staffing

6.1 Midwifery and Support Staffing

The Maternity service has an agreed funded establishment for midwives and support staff to provide minimum staffing levels to ensure safe delivery of care to the women and babies. An annual BirthratePlus table top review is completed and the results presented to the Board as part of the Trust skill mix review.

On a daily basis a unit coordinator monitors staffing levels across the service redeploying staff where necessary. An Escalation and Unit Diversion protocol (CG483) exists to advise staff on managing situations where staffing falls below an acceptable minimum or the workload exceeds safe working.

The National Patient Safety Agency scorecard is used to monitor midwifery staffing on Delivery Suite on a four hourly basis. Some of these results are reported in the dashboard which is distributed monthly.

The midwifery and support staffing establishment is monitored monthly by the Maternity Clinical Governance Committee and reported on the maternity dashboard.

6.2 Obstetric Staffing

The minimum level of medical staffing to provide adequate cover for the Delivery Suite is defined within the obstetric staffing workforce plan. Short-term sickness is managed by internal cover as detailed in the flow chart within the obstetric workforce plan. Consultant obstetricians are based within the Delivery Suite providing easy access and aim to provide 168 hours cover per week with no other clinical commitments. Against this standard is reported to the Maternity Clinical Governance Committee on the maternity dashboard. Cover in the event of sickness will be organised by the duty consultant according the flow chart within the obstetric workforce plan.

6.3 Anaesthetic Staffing

The Duty Anaesthetist denotes a trainee Anaesthetist who has been assessed as competent to undertake duties on the Delivery Suite under a specified degree of supervision in accordance with the RCoA curriculum 2010.

The Duty Anaesthetist is immediately available for emergency work on the obstetric unit 24 hours per day in a 13-hour shift pattern. This allows formal
handover between shifts. They bare no responsibility for elective obstetric work. They also bare no responsibility for the Intensive Care Unit, general theatres and do not carry the “crash bleep” for the general hospital.

The Duty Anaesthetist works in conjunction with a trained Operating Department Practitioner (ODP). This ODP is dedicated to maternity services and has no other service commitments in the hospital at this time. In the event of sickness the theatre team co-ordinator will organise cover from the multi-skilled theatre team as detailed on the flow chart within the Anaesthetic Workforce Plan.

The Duty Anaesthetist is supported by a Consultant Anaesthetist, resident on the Delivery Suite Monday to Friday 8am - 8.30pm. Outside these hours the Consultant Anaesthetist is contacted via switchboard. Out of hours there is a further resident Anaesthetist who is fully trained in obstetric anaesthesia. This Anaesthetist will have other commitments in the hospital at this time. Anaesthetic cover is monitored monthly on the maternity at the MCGMC. In the event of sickness the duty consultant will be responsible for organising cover from within the Anaesthetic department.

6.4 Neonatal Staffing

There are 7 Consultant Paediatricians with a neonatal interest providing dedicated daytime cover on the neonatal unit. Out of hours cover is provided by the above, as well as three further paediatricians. Out of hours consultant cover is combined with the general paediatric cover Monday – Thursday and dedicated Neonatal cover Friday, Saturday and Sunday.

There are 10 ST 4-8 trainees providing out of hours middle grade cover, which is combined with paediatrics. During daytime hours there is 1 middle-grade trainee with neonatal only duties. There are 5 advanced Neonatal Nurse Practitioners who together with 4 ST 1-3 trainees and one foundation year 2 doctor provide dedicated 24 hour cover to the neonatal unit. The establishment provides 8 nurses on per shift and 1:1 care for intensive care patients is attempted, although a single nurse may need to look after another patient of lower dependency in addition to an intensive care patient.

7.0 Staff Training

Risk management training is not only essential to the operation of the system, strategy and Trust culture; it is also required by law under the Health & Safety at Work Act 1974. All maternity staff receive clinical and non-clinical risk awareness training at the core induction further supported by specific risk training provided through e-learning or face to face teaching in accordance with the Trust Mandatory Training Policy and the Maternity Specific Training Needs Analysis.

The Practice Development Midwife and the Lead Obstetrician for Clinical Risk coordinate and monitor Trust and maternity specific training for all clinical staff. A monthly report is provided to the MCGC and the Midwifery Services Committee.
on a quarterly basis to ensure the required compliance is maintained in adult and neonatal resuscitation and CTG interpretation.

The Maternity Specific Training Needs Analysis (CG360) details the specific training requirements for all maternity staff. Where applicable training is multidisciplinary. All training is recorded and reported as described in the risk management process. Follow up on non-attendees is detailed within the Maternity TNA and is managed by the Practice Development team and the Lead Obstetrician for Clinical Risk. Training is provided by midwifery and medical specialities as required with the support from Trust specialist staff. PROMPT multidisciplinary Skills drills are carried out in clinical areas and in the Trust Simulation Centre.

7.1 **Academic Half Days**

The maternity service recognises the importance of learning lessons from incidents, complaints and claims. Academic half days are held quarterly and a multidisciplinary attendance is encouraged.

The aim of the academic half days is to share the lessons from serious incidents and where a training need has been identified the department ensures that this is included either within the mandatory study days or presentation at the academic half days to which all staff are invited.

Recommendations and action plans from Serious Incidents investigations are discussed.

8.0 **Risk Management Process**

8.1 **Adverse Incidents**

The Maternity Services recognise that adverse incident reporting is an important measure of risk management failings. The Trust uses the Datix Incident Reporting System to report incidents both clinical and non-clinical and near misses.

All maternity incidents are managed in accordance with the Trust Adverse Incident Reporting Policy (CG038) by the Maternity Clinical Risk Manager who maintains a database so that trends can be identified. A monthly Incidents and Complaints Report is presented at the MCGC. Staff are encouraged to report all incidents regardless of severity and to prompt this trigger lists are available for all clinical areas on the maternity intranet site.

All maternity incidents are discussed at the Morning Operational Meeting and follow up allocated to the most relevant person. A diary is maintained to record those responsible for actions and follow-up on incidents.

The Lead Obstetrician, the Quality Improvement and Audit Midwife and the Maternity Clinical Risk Manager meet Friday mornings to discuss incidents for the preceding week to identify learning and how best to ensure all staff are aware of the learning.
Staff feedback is generated automatically by email detailing actions taken to avoid recurrence. Individualised feedback is provided by ward/department managers or the maternity clinical risk manager.

8.2 Serious Incidents
Notification of serious incidents in maternity are managed as follows:

Immediate action
In the event of a serious incident/risk issue this will be reported immediately to the appropriate senior member of staff/line manager. The senior member of staff/line manager will request a timeline and notify the Director of Midwifery and/or duty obstetrician.

The Director of Midwifery/Duty Obstetrician will decide whether to notify the incident to the UCG Director, CMO, CN and Head of Patient Safety. If practice issues are evident they will be escalated to the relevant manager or educational supervisor for appropriate action.

Where serious harm has occurred the Quality and Safety Team will review the timeline and decide whether a scoping meeting is required. The maternity clinical risk manager will schedule a scoping meeting as soon as possible.

Where an investigation is required the maternity risk manager will undertake the duty of candour by contacting the patient/parent directly which will be followed up in writing in a letter sent by the Chief Executive or deputy. In cases involving a baby the lead neonatal consultant will be invited to attend the scoping meeting. On completion of an investigation the RCA report and file and action plan are held on the Trust audit and Maternity shared drives with statements and other relevant material such as evidence of shared learning.

Further information on the Serious Incident process is available in the Incident Reporting, Investigation and Learning Policy (CG553)

8.3 Serious Incident Reporting for antenatal and newborn screening incidents.
Suspected safety or serious screening Incidents within the screening programme will be notified by the Screening Midwives to the Quality Assurance Team and the screening and immunization team at Public Health England via the Screening Incident Assessment Form (SIAF).

8.4 Complaints
Maternity complaints are managed in accordance with the Trust Complaints Policy (CG009), which is coordinated by the Maternity Clinical Risk Manager. Responses to complaints are accompanied by an action plan and case file consisting of statements and supporting information. Maternity complaints are summarised and reported in the monthly Maternity Complaints and Incident
Report which presented at the MCGC and the Midwifery Services Committee meetings.

Maternity complaints are discussed at ward meetings to ensure learning from complaints, which can be evidenced within the ward/departmental blogs. Where a training need is identified the Practice Development Team will incorporate training within the mandatory study days.

8.5 Maternity Risk Register

Datix Risk Register is used to complete risk assessments which automatically populate the Maternity Risk Register. Each ward and department in maternity has a nominated risk officer who maintains the risk register following the identification of risks through the risk assessment process as described in the Trust Risk Management Policy and Procedure (CG027).

Maternity matrons and department managers are responsible for managing risks, implementing and monitoring appropriate risk management control measures within their designated areas and scope of responsibility. The risk officers are responsible for updating the risk assessments at least annually.

Where significant risks have been identified and where local control measures are considered to be potentially inadequate, these risks should be raised at the Urgent Care Group and the Quality Assurance and Learning Committee and escalated onto the Trust’s Corporate Risk Register.

The Directorate manager is responsible for overseeing the Maternity risk register and for reporting progress on eliminating risks at the Maternity Clinical Governance Meeting.

8.5 Claims Management

Maternity services continue to see an increase in the number of claims made against NHS Trusts. It is essential that there is a close working relationship between the Maternity service and the Legal Services Department to ensure that where there is potential for a claim against the Trust the Head of Legal Services is made aware at an early stage.

The maternity clinical risk manager/lead obstetrician for risk or the Director of Midwifery will inform the Trust legal services department within 14 working days of the incident that a notifiable severe brain injury incident under the NHS Early Notification Scheme has occurred using the Early Notification report form.

Maternity services work collaboratively with the Head of Legal Services and is compliant with the Clinical Negligence Claims Management Policy (CG089).

The Head of Legal Services is responsible for presenting a bi-monthly claims report, which includes maternity cases to the Trust Patient Safety Committee. The report contains a breakdown of claims by Care Group.
9.0 Consultation Undertaken
Prior to ratification of the Maternity Clinical Risk Strategy it will be circulated to all members of the MCGC for review and signed off by the Maternity Clinical Governance Committee.

10.0 Dissemination/Circulation/Archiving
Once ratified the Maternity Risk Strategy will be brought to the attention of all maternity staff through the Maternity Newsletter and is accessible on the Trust intranet site.

The Maternity Information Manager is responsible for archiving all previous versions and supporting evidence of approval for this strategy.

11.0 Document Review
The Maternity Clinical Risk Manager will review the Maternity Clinical Risk Management Strategy every two years.

12.0 Implementation
The Maternity Clinical Governance Committee is charged with ensuring that the strategy is effectively embedded within the maternity services.

13.0 Monitoring Compliance and Effectiveness
The maternity clinical governance activity will be monitored on an on-going basis. The responsibility for monitoring the process is that of the Lead Obstetrician for Maternity Clinical Governance.

Further monitoring requirements are shown in the following table:

<table>
<thead>
<tr>
<th>Aspect of compliance or effectiveness being monitored</th>
<th>Monitoring method</th>
<th>Individual or department responsible for the monitoring</th>
<th>Frequency of monitoring activity</th>
<th>Group / committee which will receive the findings / monitoring report</th>
<th>Committee / individual responsible for ensuring that the actions are completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>The duties of individuals responsible for governance/risk in maternity</td>
<td>To be addressed by the monitoring activities below</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monitoring frequency, attendance (quorate) and actions from Clinical Governance and Sub-committees</td>
<td>Review minutes of MCGC &amp; sub-committees / Maternity dashboard</td>
<td>Maternity Clinical Governance lead</td>
<td>Monthly</td>
<td>Trust Clinical Governance Committee</td>
<td>MCGC</td>
</tr>
</tbody>
</table>
### Table 2: Monitoring table

**Note:** The monitoring requirements may be amended in order to meet the changing requirements of the organisation.

#### 14.0 Supporting Documentation and References


4. Heathcare Safety Investigation Branch: [https://www.hsib.org.uk/maternity/](https://www.hsib.org.uk/maternity/)


8. NHS Litigation Authority, Maternity Clinical Risk Management Standards 2011-2012


11. National Health Service Litigation Authority. (201) Duty of Candour Building a Culture of Candour


14. MBRRACE-UK. [https://www.npeu.ox.ac.uk/mbrrace-uk](https://www.npeu.ox.ac.uk/mbrrace-uk)


Appendices 1 – 7 follow
Appendix 2 – Quality Governance Committee structure

Quality Governance Committee Structure
May 2018 (V14.1)
Appendix 3 – Maternity Clinical Governance Structure

Maternity Clinical Governance Structure and Reporting Mechanism

- Trust Board
- Quality Committee
- Trust Audit and Clinical Risk Committee
- Executive Management Committee (EMC)
- Executive Quality Assurance & Learning Committee
- Urgent Care Group
- Maternity Clinical Governance Committee
- Maternity Directorate Team Meeting
- Maternity Morning Operational Meeting/Maternity Risk Team meeting
- Labour Ward Forum
- Maternity Quality & Safety Committee
- Maternity Voices Partnership
- Perinatal Mortality & Morbidity Committee
- Maternity Quality Improvement and Audit Committee
- Midwifery Services Committee
- Maternity Clinical Guidelines Committee
- Perinatal Mortality Review Group
- Maternity Patient Information Group

NB (Sept 2018)
Appendix 4 – Maternity Clinical Governance Team (flowchart)

Maternity Clinical Governance Team

Clinical Lead Obstetrician

Lead Obstetric Anaesthetist
Lead Obstetrician Governance
Lead Obstetrician Delivery Suite
Lead Obstetrician Clinical Risk
Lead for Feto-Maternal Medicine
Consultant Midwives
Maternity Matrons
Maternity Clinical Risk Manager
Practice Development Team
Delivery Suite Manager
Ward Managers/Team Leads
Quality Improvement & Audit Midwife
Research Midwife
Maternity Information Officer
Maternity Voices Partnership
Junior Obstetric Doctors
Midwives
Mat & Gynae Theatre Manager
Maternity Pharmacist

NB (May 2018)
Appendix 5 – Maternity Risk Assessment and Risk Register

Maternity Risk Assessment and Risk Register Process

High & Medium Risk
Directorate Risk Register
Approved at Directorate Meeting
Reviewed Monthly at Mat & Gynae Risk Register Review Meeting & Maternity Clinical Governance Committee

High Risk
Urgent Care Group Board Risk Register
Reviewed monthly

High Risk
Trust Risk Register
Reviewed Monthly

Low Risk
Local Risk Register
Reviewed annually by Ward Managers/Risk Officers/Matrons

NB (Mar 2019)

This document is valid only on date last printed
Appendix 6 – Maternity Incident Trigger List

As a minimum the following types of adverse incident should be reported electronically

Maternal

- Maternal death – see Maternal Death Policy (CG496)
- Maternal resuscitation
- Concerns about management of labour
- Postpartum haemorrhage >1500 mls *Complete MOH proforma for loss over 1500mls*
- Third/fourth degree tear
- Manual removal of placenta
- Trauma to bladder or other organs
- Shoulder dystocia – *document procedures, baby’s condition and any injury – complete Shoulder Dystocia proforma*
- Significant infections
- Seriously ill patients / eclampsia
- Unplanned home birth (BBA)
- Maternal transfer – from home to unit/ICU or other ward in hospital
- Postnatal readmission of mother/baby
- Return to unit with infected wound/perineum/urinary problems
- Return to theatre – *at any time*
- Loss/retention of clinical materials/swabs
- Misdiagnosis of antenatal screening tests
- Transfer to ITU
Neonatal

- Undiagnosed IUGR
- Undiagnosed Breech
- Cord prolapse
- Stillbirth/neonatal death
- Low apgar scores - <6 at 5 minutes or Cord pH <.7.0 and BE >10
- Unexpected transfer to neonatal unit (term only) – including neonatal seizures
- In-utero transfers in/out of mother/baby – use information folder on Delivery Suite
- Birth injury – please complete diagram proforma for injury to baby in Stationery/Neonatal folder

Miscellaneous

- Inadequate staffing levels for workload – use Del Suite Log proforma under Stationery/Del Suite
- Drug errors – report to Maternity Clinical Risk Manager ASAP
- Delay in carrying out emergency caesarean section/disruption caused to other theatre lists. Opening second theatre
- Unavailable health record/ incorrect entry
- Communication breakdown
- Unavailability/failure of equipment/facility
- Closure of unit – see Escalation & Diversion protocol (CG483)
- Incidents of abuse/aggression
- Health and Safety issues: slips/trips/falls/needle-stick injury/other
- Breach of security/theft

This list is merely a guide and is not exhaustive. Staff should feel comfortable to report any incident that harms or has the potential to harm.

Record the Adverse Incident number in the patient's health record where appropriate, with signature of person completing form

Author: Nicky Benns
Date: February 2019
Job Title: Maternity Clinical Risk Manager
Review Date: May 2020
Policy Lead: Group Director Urgent Care
Version: V9.1 Feb 2019
V9.0 ratified 4/5/18
Location: Policy hub/ Clinical / Maternity/ Professional guidelines & protocols (CG347)