West Hertfordshire Hospitals NHS
NHS Trust

Agenda item 110/08

Women's and Children's Services Division
Maternity Services
Risk Management Strategy

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The Trust is committed to promoting an environment that values diversity. All staff are responsible for ensuring that all patients and their carers are treated equally and fairly and not discriminated against on the grounds of race, sex, disability, religion, age, sexual orientation or any other unjustifiable reason in the application of this policy, and recognising the need to work in partnership with and seek guidance from other agencies and services to ensure that special needs are met.

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1.0 Introduction

This document is an appendix to the Trust Risk Management Strategy. The purpose of this strategy is to identify the specific Risk Management Strategy for Women's and Children's Maternity Services (WACS), however it should be read in conjunction with the Trust Risk Management Strategy and all other supporting policies and procedures. The aim of the Strategy is to minimise risks to the mothers and babies through the implementation of a risk management framework which:

- Identifies the principal risks to the achievement of the Trusts objectives for Maternity Services
- Evaluates the nature and extent of the risks
- Manages them efficiently, economically and effectively.

2.0 Statement of Philosophy

This strategy has been developed as a clear statement of the maternity unit's continual commitment to delivering improved maternity service and minimising the risk to mother's and their babies through a proactive approach to reducing and preventing adverse outcomes.

It provides an integrated approach to care with the aim of reducing adverse events, increasing patient satisfaction and promoting beneficial outcomes.

The maternity services support an open, honest and participative culture, which focuses on improving systems of care.

This strategy applies to all groups of maternity staff, trainees, agency staff, volunteers and any other NHS professionals contracted for employment within the Trust maternity services.

3.0 Local Objectives

The objectives of this Maternity services strategy are to:

- Identify, analyse and control risks via adverse events and near misses reporting
- Foster an open culture of fairness, learning and support
- Develop a clear accountability framework encompassing leadership, risk groups, reporting arrangements, strategies and policies
- Progressively reduce the severity and future risk of adverse events
- Maintain a Divisional Risk Register, which will enable risks to be escalated as appropriate.
- Achieve compliance with all risk management standards and recommendations from external sources such as CNST, Standards for Better Health, the Health Care Commission, and the relevant confidential

enquiries. In addition any other relevant statutory, mandatory and professional requirements

- Ensure compliance with all relevant **NICE** guidance, including entry on to the risk register where there is non-compliance

- **Work to achieve KPI's and Objectives as agreed by the Divisional Board and CSE, these include:**
- Working towards reducing the caesarean section rate to bring in line with national average, through the actions agreed at CSE and the HCC action plan.
- Review the management of all postpartum haemorrhages over 2500mls and discuss at Risk meetings
- Review all 3rd/4th degree tears to ensure that compliance with suturing within 1 hour is being achieved whenever possible, and to investigate cases when this is not occurring.

4.0 Definitions

Risk

Risk is the chance that an event will occur and impact upon the Division's service objectives. It is measured in terms of likelihood and consequence

Risk Assessment

Risk assessment is the process used to determine risk management priorities by evaluating and comparing the level of risk against predetermined acceptable levels of risk.

Risk Management

Risk management is the systematic application of management policies, procedures and practices to the tasks of identifying, analysing, assessing, treating and monitoring risk.

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. The Trust will ensure that risk management is supported by the development of formal mechanisms to assess risk and to measure the effectiveness of risk management strategies, plans and processes. In particular:

- Risk management will be supported by accurate, timely and effective incident reporting, including categorising the consequences of risk and investigating system failures
- Preventative risk management processes will be applied to the management of facilities, amenities, equipment and clinical practice

- Safe systems of work will be in place to protect patients, visitors and staff
- Risk Registers will be in place across the Trust

5.0 Roles and Responsibilities

This section describes the responsibilities of senior Trust staff and specifically staff within Women's and Children's Services (WACS).

Chief Executive

The Chief Executive is responsible for ensuring that a risk management system is established, implemented and maintained in accordance with this strategy. This includes ensuring the Trust meets relevant statutory requirements and that it complies with best practice as described by the Department of Health. Assignment of responsibilities in relation to risk management is the prerogative of the Chief Executive. The Chief Executive ensures that so far as it is reasonably practical resources are available to manage risk.

Executive Directors

Executive Directors have overall responsibility for the implementation of the Risk Management Strategy. They are responsible for the oversight of the processes for identifying and assessing risk, and for advising the Chief Executive as necessary. They must ensure that so far as it is reasonably practical, resources are available in order to manage risk. They are responsible for establishing and maintaining a forum within their directorate for the open discussion of risk management incidence and topics. Further specific responsibilities are outlined below.

The Director for Patient Safety and Medical Director supports the Chief Executive in the day-to-day management of organisational / strategic risk and ensure that all over-arching risk management standards are complied with e.g. The Director for Patient Safety is charged with the strategic management of the Department of Health's Standards for Better Health ensuring continual improvements in compliance for all Standards. The Director of Patient Safety is also charged with the responsibility for risk throughout the Trust that has a direct impact upon patient care and safety. Where appropriate, Health & Safety issues may be referred to and become the responsibility of the ***Director of Human Resources*****.**

The Director of Human Resources on behalf of the Chief Executive is charged with the responsibility for risk management relating to staff and for Health & Safety throughout the Trust.

The Director of Estates and Facilities, on behalf of the Chief Executive, is responsible for Environmental Risk Management and operational Estates and Facilities Management issues.

All Directors are expected to liaise effectively so that areas of overlap are not confused or omitted. All staff are expected to notify the ***Medical Director*** or their risk management team of any new legal or statutory obligations or any new guidance that they may encounter. The Associate Director of Integrated Governance must then ensure that appropriate arrangements are being set in train by the relevant mangers/staff.

Assistant Director of Clinical Governance , Quality and Risk

The Assistant Director of Clinical Governance, Quality & Risk is accountable to the Medical Director and will:

- Ensure that the Trust is aware of all legal and statutory responsibilities and guidance and that appropriate action is underway to enable compliance.
- Ensure implementation, co-ordination and monitoring of risk management activity within the Trust, ensuring that systems and processes are in place for the continuous effective management of risk in line with this strategy and National Health Service Litigation Authority (NHSLA) Risk Management Standards.
- Have overall responsibility for reviewing risk management performance through the interrogation and trend analysis of incident reporting, PALS, Complaints and Claims data held in the Trust Risk Management Database. The analysis of this data will form part of a quarterly aggregated governance report to the Trust Board.
- Have responsibility for implementing and monitoring Quality Key Performance Indicators ensuring a continual improvement in performance.
- Will operationally manage Standards for Better Health, ensuring Action Plans are completed and evidence populated on to the Trust Risk Management Database. Any areas of non-compliance will be added to the Trust's Risk Register. The Head of Clinical Governance and Risk will also be responsible coordinating and submitting the Trusts Annual Self Assessment.

Risk Manager

The Risk Manager will be responsible to the Assistant Director of Clinical Governance and Risk.

The Risk Manager will:

- Act as a Trust wide point of resource for risk related issues and responsible for supporting the Divisional Risk Leads including the **WACS Risk Lead**.
- Ensure smooth functioning of the incident reporting system

- Be responsible for the day-to-day management of the Trust's Risk Management Database and operational Risk Management activity.
- Maintain and develop appropriate policies and procedures in light of current legislation knowledge and invention.
- Co-ordinate the Annual risk management report which will include aggregated analysis of Datix in relation to Incidents, Complaints & Claims and the performance of the Risk Management System providing assurance of the Trusts overall system of internal control. This will be presented annually to the Complaints, Incidents & Near Misses Review Group, Audit Committee and the Trust Board

5.1 WACS Divisional Manager and Divisional Clinical Director

The Divisional manager and Divisional Clinical Director are responsible to their respective executive director and ultimately the Chief Executive for the implementation of this policy within their areas of responsibility. They are responsible for:

- Managing strategic risk and ensuring risk assessment systems are functioning across the division
- Ensuring medical staff contribute to the clinical governance agenda.
- Identifying risk and prioritising for corrective action.
- Contributing to the risk register.
- Carrying out investigations and supporting the Divisional Risk Lead in investigating as appropriate.
- Provide medical staff with appropriate support and feedback both during and following investigations.

5.2 The Risk leads for Obstetrics and Gynaecology

The Risk Leads for Obstetrics and Gynaecology are the joint leads for Risk Management within their speciliaties; this responsibility is shared with the Divisional Risk Lead.

Specifically the Risk Leads for Obstetrics and Gynaecology are responsible for –

- Ensuring medical staff contributes to the clinical governance agenda.
- Identifying risk and prioritising for corrective action.
- Chairing the relevant Risk Management meetings within their specialties and contribute to the Divisional Clinical Governance agendas and meetings
- Carrying out investigations and supporting the Divisional Risk Lead in investigations as appropriate.
- Providing medical staff with appropriate support and feedback both during and following investigations.

5.3 The Divisional Risk Lead for WACS

In conjunction with the senior management team the Risk Lead for the Division has responsibility for establishing and maintaining an effective risk management system within the unit, for ensuring compliance with all statutory requirements and for adhering to guidance issued by the Department of Health in respect of Governance. Specifically the Lead is responsible for –

- Co-ordinating all Directorate risk management activity.
- Ensuring risk assessments are completed, risk action plans formulated, implemented and monitored and directorate risk registers maintained.
- Keeping abreast of risk performance issues and acting as a source of professional advice to Directorate staff.
- Assess the evidence required for CNST, HCC, and Standards for Better Health activity, ensure that relevant action plans are implemented and required evidence assimilated.
- Ensure that recommendations from confidential enquiries and other external reports are discussed at the appropriate forums within the Division.
- Facilitate the Divisional Clinical Governance meetings.
- Providing reports and analysis of risk activity to Directorate Governance Groups.
- Carrying out and facilitating major investigations.
- Providing staff support and debriefing as appropriate.
- Facilitating risk management training and education.
- Liaising with –
    - Health & Safety
    - Control of Infection
    - Audit
    - Guidelines Group
    - Midwifery Supervision
    - Trust Risk Manager

- Providing quarterly reports with analysis of the data identifying any trends of coded incidents to the Risk Management Group the Divisional Board and Labour Ward Forum.
- Feedback clinical risk issues and investigation findings to senior midwife and Supervisor of Midwives meetings.

5.4 The Head of Midwifery has overall responsibility for:

- The implementation of the Women's and Children's Division's Risk Management Strategy and Policy within maternity.
- Overseeing the processes for identifying and assessing risk, and advising as necessary.
- S/he must ensure that so far as is reasonably practical resources are available in order to manage risk. They are responsible for establishing and maintaining forums within their Division for the open discussion of risk management incidence and topics.

- The Head of Midwifery will ensure that all staff working within maternity are aware of all legal and statutory responsibilities in relation to risk and that appropriate action is undertaken to enable compliance.

5.5 Supervisors of Midwives are responsible for –

- Protecting the public from poor clinical practice.
- Supporting women in their choices.
- Supporting Midwives in their practice.
- Supporting risk management activity by involvement in reporting and analysis of incidents and near misses.
- Supporting staff through the investigation process.

5.6 Consultant Midwife is responsible for-

- Works closely with head of Midwifery, Divisional Manager for Maternity, Supervisors of Midwives, labour ward leads, Lead Obstetrician for risk and Risk Lead in promoting clinical effectiveness.
- Responsible for public health issues.
- Assists in formulating guidelines based on new evidence.

5.7 Consultant Anaesthetists are responsible for_

- Ensuring that all anaesthetic staff contribute to the obstetric clinical governance agenda including reporting of incidents.

- Identify which anaesthetic related triggers should be reported by the obstetric anaesthetic staff and update this list as appropriate

- Identify anaesthetic risks within the maternity unit and prioritise for corrective action, including relevant risks, which should go onto the risk register.

- Carry out investigations and support the Divisional Risk lead with investigations and be involved in multidisciplinary investigations if appropriate, including the Critical Incident Review Group.

- Provide anaesthetic staff with support both during and following investigations.

- Ensure that obstetric anaesthetic staff are updated with the relevant training and skills

- Contribute to the multidisciplinary training programme including ‘skills and drills’, high dependency care and patients undergoing anaesthesia.

- Lead on relevant audits.

5.8 Matrons within the Division are responsible for –

- Ensuring staff contributes to the clinical governance agenda.
- Managing risk and ensuring risk assessment systems are functioning at ward level.
- Identifying risk issues and prioritising for corrective action.
- Contributing to the risk register.
- Carrying out investigations and assisting the Divisional Manager/Clinical Director/Directorate with the investigation process as appropriate.
- Providing clinical staff with appropriate support and feedback during and following investigations.

5.9 Ward Managers/Core Midwives are responsible for –

- Ensuring appropriate training is provided in the handling and safe use of new equipment to the ward/department.
- Ensuring risk assessment is carried out within the ward/department area and action plans are developed and appropriately actioned.
- Ensuring compliance with the Incident Procedure and ensuring that staff receives support during and feedback following investigation of incidents.
- Encouraging the identification of potential risks within their work area.
- Ensuring staff attendance at risk induction and mandatory training sessions.
- Completing incident forms, undertaking and participating in the investigation process as required.
- Providing staff with appropriate support and advice.

5.10 All staff (medical staff, midwives, nurses and non-clinical staff) are responsible for –

- Reporting incidents and potential risks to the ward/department manager.
- Recording incident details and assisting in investigation as required.
- Participating in continuous risk assessment activity.
- Maintaining an awareness of best practice in their own area of work, and familiarity with equipment provided for their own and patient use.
- Maintaining an awareness of emergency procedures e.g. resuscitation, evacuation and fire precaution procedures.
- Being familiar with relevant policies, procedures and guidelines, incident reporting and risk assessment requirements, and ensuring attendance at risk induction and mandatory refresher training.

In addition all clinical staff must

- Practice within the standards of their professional bodies, other national standards, and any locally determined clinical policies and guidelines to ensure their practice is as risk free as possible

6.0 Relevant Committees with responsibility for Risk Management

- WACS Clinical Standards Executive
- Maternity and Neonatal Risk Management Group

- Women's and Children's Services Clinical Governance and Audit Meeting
- Labour Ward Forum
- Critical Incidents Review Group

All these meetings are listed in the appendices including their aims and membership.

Other groups, which support risk management activity, are :

- The multi-disciplinary Clinical guidelines group, who have a responsibility to ensure that all guidelines, protocols, practices and policies are current and support the ethos of safe practice and are evidence based.

  All guidelines must adhere to the Trust 'Policy Development Framework' and be ratified through the correct channels as laid down in the framework document.

- Supervisor of Midwives monthly meetings, responsibility for protecting mothers and babies through promoting best clinical practice by midwives.

- Core midwife meetings, where risk management will be a standing item on the agenda.

- Perinatal meetings which are led by the Labour Ward Consultant and involve case presentations by junior doctors to discuss various cases particularly where there has been a poor outcome

The maternity services recognise that in assuring effective and comprehensive risk management: there must be links between risk management and the systems for legal claims, complaints management, clinical audit and clinical guideline development and midwifery supervision.

7.0 Implementation and Training

All staff are required to attend risk management awareness training as part of the Trust Induction programme. This will include risk management, health and safety and incident reporting. The training department operate a system to record attendance and will address and rectify inadequate attendance. The Divisional management team is expected to address poor attendance at mandatory training sessions.

Risk management training is also provided at local induction for clinical staff and preceptorship for new midwives. Evidence of training will be entered onto the maternity training database.

The Divisional Risk Management Strategy is posted on the Divisional Intranet page; in addition a copy of the strategy is available in all clinical areas. A copy of the strategy is given to all clinical staff during their period of induction. All staff will be made aware of any changes to the strategy through such means

as the Divisional risk newsletter and information posted on the clinical governance boards in each clinical area.

8.0 Risk Management Process

The purpose of risk management in health care is to reduce risks to patients and staff in order to improve the safety and quality of care provided. It is also used to evaluate the delivery of clinical care, the environment in which it is delivered and the financial resources available. It is an approach that is common to Corporate and Clinical Governance.

Risk Management is about managing uncertainty. It is dependent upon a number of factors, some of which may be out of our control, e.g. social and political pressures and others which we can influence, e.g. human behaviour and performance and working practices.

The Trust's Maternity Risk Management Strategy is designed to assist individuals in identifying and determining risk activities so that resources can be targeted to reduce risks.

The types of risks that might be encountered in WACS include:

- Clinical Risk (associated with the diagnosis and treatment of patients)
- Legal Risk (risks arising through non-compliance with existing legislation e.g. occupational health and safety legislation)
- Organisational Risk (risks arising from ineffective implementation of policies and procedures, poor communication, poor staffing and management structures).
- Environmental Risk (risks arising from the failure to provide a safe and suitable environment for work contractors, patients and visitors)

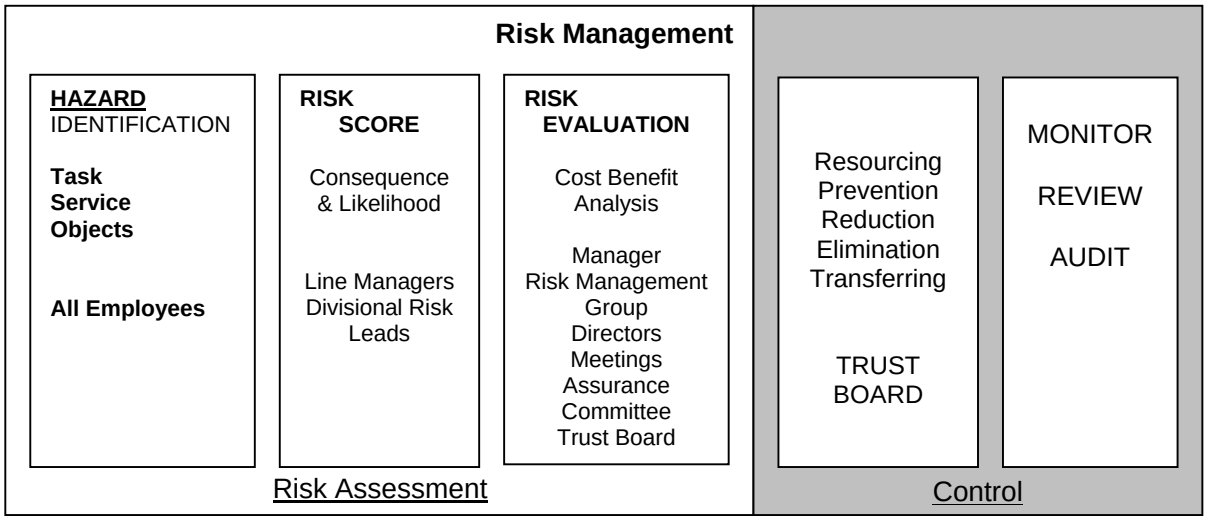
Examples of risks might include:

- Patients who may or were injured as a result of interventions, procedures, treatment or care
- Employees who may suffer physical or emotional damage as a consequence of their work
- Injury to a member of the public
- Theft or fraud
- Damage to the physical assets of the Trust
- Damage to the reputation of the Trust

Risks are identified within the Women's and Children's Services through:

- Incident reporting (including RIDDOR) (I suggest that you include your trigger list in the appendix)
- Complaints
- Claims
- External Assurance (such as CNST, Standards for better Health)
- Proactive risk assessment
- Results of learning from quarterly trend analysis
- Measuring achievement against set KPIs or non-achievement
- Learning from the national confidential enquiries such as CEMACH and from individual case reviews

The risk management process will be as shown in the diagram set out below:



9.0 Risk Analysis Tools

As required by the Trust the Division has adopted a standard Risk Scoring Matrix see appendix for identifying and measuring risks both proactively and retrospectively. This methodology assesses the likelihood and consequences of risk events and issues.

Trust management must ensure that any risks which fall above the tolerance lines are reported to the Divisional Risk Lead, Risk Manager or Head of Clinical Governance & Risk, the Executive Director and in the case of clinical risk, the Lead Consultant or Clinical Director immediately, who will take appropriate action. They will then inform the relevant committee, as soon as is practically possible.

Initially, it is the responsibility of the Divisional Risk Leads to ensure all risks identified within their division are included on their divisional risk registers. Risks scoring less than 15 will be the responsibility of the division to manage and reduce their potential impact on the Trust. All organisational risks and risks scoring greater than 15 will be included on a high level Risk Register where they will be regularly considered by relevant committees.

The Trust uses Datix, an electronic risk management system for the management of all risks, claims, complaints, PALS and incident reporting data. This programme will be accessible by the Risk Leads and other key staff throughout the Trust for appropriate interrogation and reporting thereby additionally identifying risk issues and themes for attention.

Root cause analysis (RCA) will be considered on all incidents scoring over 9. Further risks identified from analysis will be placed on the Risk Register and passed to the relevant individuals/committees for action. Further detailed information on RCA is available from the Trust Incident & Investigation Policy.

10.0 Monitoring, Audit and Review

Implementation of the strategy and associated procedures is subject to ongoing monitoring and review by the Divisional Risk Management Group:

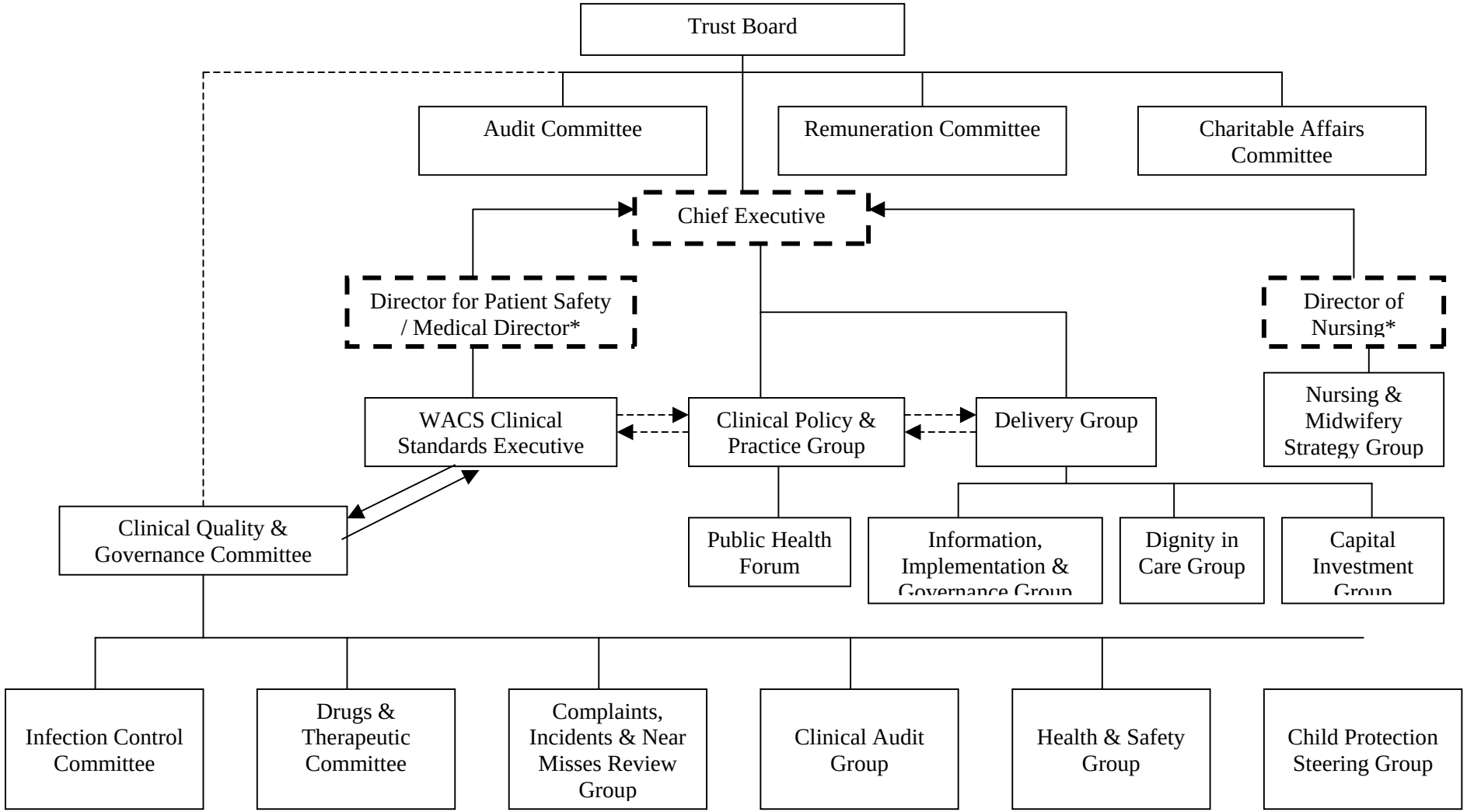
- Monitoring progress made against any risk management plans
- Analysis of trends from integrated incident reporting and identifying areas of high risk for escalation to the Divisional board and above.
- Audit of incident reporting and investigation
- Ensuring compliance with external bodies such as CNST and Standards for Better Health

The Trust Board is ultimately accountable for ensuring that the Trust is doing its 'reasonable best' to achieve the requirements of the corporate assurance programme. The 'open and transparent' culture of the Trust in terms of the way it conducts its business and affairs enhances this, as does the Trust's desire to be a learning organisation

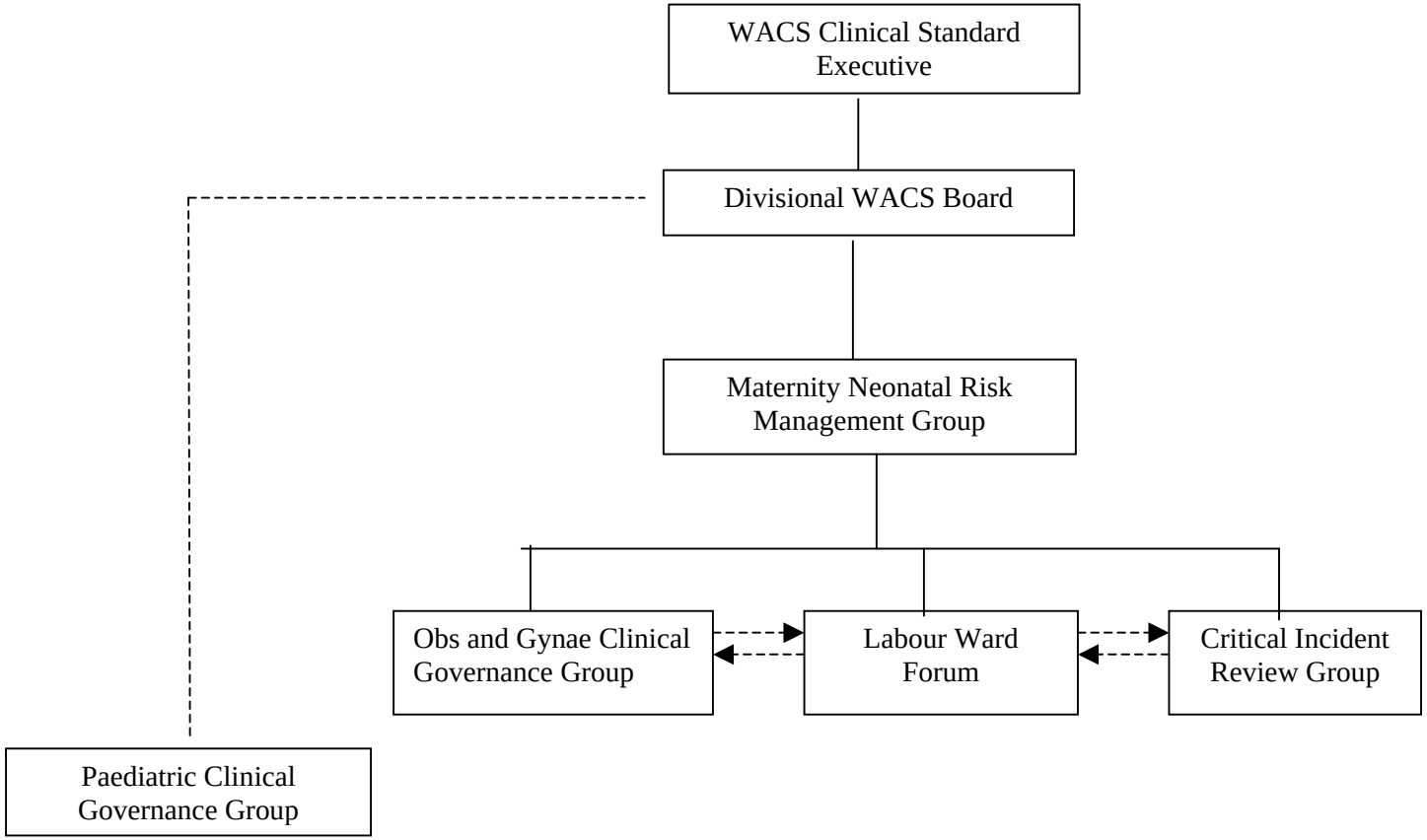
11.0 Review Date

This strategy is subject to annual Board review.

Appendix 1 Divisional Risk Structure



Appendix 2 WACS Divisional Risk Structure



Appendix 3

Clinical, Quality & Governance Committee

The Clinical, Quality & Governance Committee is not a formal sub committee of the Board. However, it will have direct access to the Board should it feel there are issues that need to be reported to them. Its primary focus will be matters of patient safety and it will have a number of executive level groups reporting to it, all of which will have responsibility for a specific aspect of patient safety. It will have a broad membership with substantial clinical involvement. It will be chaired by the Director of Patient Safety / Medical Director, or other senior clinician and will also have a Non Executive Director within its membership. Refer to Appendix 3 for the Trust Board Sub Committees and Executive Groups Reporting Structure.

NB: *(This section of the Risk Management Strategy will be updated following ratification and drawing up of formal Terms of Reference).*

Appendix 4

WACS Clinical Standards Executive Committee

Clinical Standards Executive will be the Executive arm of the Clinical Quality and Governance Committee from whom it will seek advice, though its accountability as an Executive Group will be through the Executive line. The Director of Patient Services / Medical Director will chair the CSE. It will be responsible for providing a day-to-day focus on the achievement of high quality clinical services, which will entail:

CSE Status:	Sub-committee of the Trust Board
Chair:	Associate Director for Clinical Governance
Membership:	Chief Executive Officer (Deputy Chair) Non-executive Director Chief Nurse/Director of Patient Services Clinical Lead for Clinical Audit Head of Clinical Governance, Quality & Risk Clinical Governance Manager
WACS Membership	WACS Maternity Risk Lead Divisional Manager Head of Midwifery Head of Paediatric Nursing Clinical Director Paediatrics/NICU Consultant Obstetrician Risk Lead Clinical Directors for Obstetrics and Gynaecology
Frequency of Attendance:	Six times a year.

1. Remit

1.1 The purpose of the CSE is to seek assurance that the Trust's clinical services are continually developed and improved through the implementation of robust systems and processes whilst fully supporting the objectives of clinical, corporate and research governance.

1.2 In order to achieve the above, the CSE will coordinate a clinical divisional review programme whose remit is illustrated in the diagram below:

The Divisional Director, Divisional Manager, Clinical Directors and Head Nurse from each Division will be required to attend their relevant CSE meeting

The programme will comprise the following elements:

- The clinical audit programme
- Key clinical issues and risks for the division. Incident and near incident analysis.
- Identification and monitoring of clinical performance indicators (Kpi's)
- Implementation of national recommendations and noting changes in practice
- Reporting and progressing serious clinical incidents
- Monitoring compliance with clinical policies
- Public Health
- Complaints
- Scrutiny of agendas and minutes of Clinical Governance days.

2. Accountability

2.1 The CSE will report directly to the Trust Board. It will regularly submit formally recorded minutes of the CSE accordingly.

3. Organisational Relationships

3.1.1 The Chair of the CSE will be a member of the Governance Committee and will maintain a direct link from the CSE to the Assurance Committee thereby providing assurance of effectiveness of the clinical governance programme within the Trust.

4. Responsibilities

4.1 To ensure there are adequate corporate resources and processes within the Trust for the effective management of clinical governance.

4.2 To ensure that clinical governance is a fundamental component of divisional management, which is incorporated into their annual business plans. To ensure that this is executed effectively through robust systems and processes, which provide assurance on the quality and provision of clinical services.

4.3 To seek assurance of the Trust's strategy to manage the Standards for Better Health, to receive compliance progress reports and to specifically discuss and address obstacles to compliance.

4.4 To receive assurance that a patient safety culture is being developed within the Trust and thereby ensuring developmental progress against Standards for Better Health Developmental Standard D1.

4.5 To implement and monitor clinical performance indicators within the clinical divisions and to ensure improvements in the performance in relation to the provision of clinical care.

4.6 To review and ratify relevant corporate level clinical policies, procedures and guidance.

4.7 Review compliance against relevant Standards for Better Health and NHSLA Risk Management Standards.

4.8 To investigate and ensure address of serious clinical deficiencies, notified through divisions and Serious Untoward Incident and exception reporting, ensuring that specialist advice is made available as necessary.

4.9 To positively support the development of professional and personal standards of conduct and practice in all clinical divisions.

4.10 To ensure a rolling Clinical Governance Day programme is in place within the Divisions and to provide guidance on the generic content of their agenda.

4.11 To review and monitor the process for the dissemination of NICE Guidance, NSF, Priorities Forum Guidance and other relevant clinical guidance across the Trust and to seek assurance of compliance and/or obstacles to compliance.

5. Reporting Arrangements

The CSE will ensure that the Governance Committee is provided with an annual programme in place to manage clinical governance. Issues identified from individual divisional clinical reviews will influence the programme. These reviews will also be formally recorded. The CSE will also provide an annual report providing an overview of the year's activity. The CSE will maintain effective liaison arrangements with the Assurance Committee.

Appendix 5

Women's & Children's Services

Maternity and Neonatal Risk Management Group Terms of Reference

Aims of Group

- The aims of the group are to:
- Examine practice in Antenatal, intrapartum, postnatal and neonatal care.
- Discuss adverse events and near misses, identifying any trends.
- Review systems, lesson learning, action planning and proactive risk assessment.
- Identify Divisional risks, which require entry onto the risk register and cascading to the Trust Risk management Committee or Clinical Standards Executive.
- Review risk register re-evaluate and re-assess entries on a regular basis.

Membership

3 Consultant Obstetricians, 1 Consultant Neonatologist, 1 Anaesthetist, Head of Midwifery, Divisional Risk Lead, Senior representation from ALL departments, Supervisor of Midwives.

Current List

Consultant Obstetrician & Gynaecologist, Risk Lead for Obstetrics

Divisional Risk Lead

Supervisor of Midwives

Consultant Obstetrician, Labour Ward Lead

Consultant Obstetrician

Lead for Ultrasound

Consultant Anaesthetist

Consultant Neonatologist

Head of Midwifery

Consultant Midwife

Matron for Community and outpatient clinics

Matron Inpatient & Antenatal Services

Matron for Delivery Suite and ABC

Trust Fetal Screening Coordinator

Matron for SCBU

Senior Registrar

Nominated Deputies

Consultant Obstetrician and College Trainer

Consultant Obstetrician & Gynaecologist, Research Lead

Consultant Anaesthetist

Ward Manager Katherine & Knutsford

Ward Manager Victoria Ward

Ward Manager ABC

Registrar Obstetrics & Gynaecology

Neonatal Nurse Practitioner

Acting Matron SCBU

Supervisor of Midwives

All deputies will be recorded in minutes and Chair advised of representation. It is the responsibility of the Risk Management Group member to ensure nominated deputy is arranged prior to the meeting and Carol Hiscock informed.

Terms of Reference

Administration Support

Carol Hiscock Secretary to Mr Boret – minute meetings and circulate dates and agenda.

Chairing of the Group

Closed Forum led by Lead Obstetrician for Risk and the Divisional Risk lead.

Objectives of the Group

- Make recommendations on practice, guidelines, service provision for antenatal, intrapartum, postnatal and neonatal care.
- Review and action plan the CNST requirements
- Identify and recommended new evidence into practice soon as practicable. Including recommendations from NICE and Royal Colleges.
- Review recommendations of Confidential Enquiries, benchmark present practise, Action and audit compliance. To include CEMACH, NCEPOD and NCISH (safety first).
- Encourage safe evidence-based practices through the provision of comprehensive multidisciplinary guideline. This will include recommending to the guidelines group where a new guideline may need developing or review of an existing one.
- Review trends in incident reporting system and recommend clinical audits.
- Review and action as required all Serious Untoward Incidents.
- Feed into open multidisciplinary clinical governance meetings with all learning points from anonymised cases.
- Feed to ward meetings and send alert memos as required.
- Feed into Senior Midwives meeting, Consultant Meetings and Departmental Meetings with regards to staffing levels and Training issues. Recommendations and action plans to be supplied.
- Minutes to be fed into the Labour Ward Forum by the Divisional Risk Lead
- Report minutes to the to the Divisional Management Board so that they can be escalated for review and acknowledgement by the relevant Trust board

Meetings

12 meetings per year with dates sent out in advance by Carol Hiscock, Administration support.

Appendix 6

Women's and Children's Services Maternity Clinical Governance and Audit Meeting Terms of Reference

Lead

Facilitated by Divisional Risk Lead

Aims

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

Membership

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

Objectives of the Group

- To present anonymised cases including serious untoward incidents identifying lessons that have been learnt and need to be shared including any action plans to be implemented. These should include joint presentations with the multi-disciplinary team i.e Neonatologist or Anaesthetists etc.
- Present audit that has been undertaken within the maternity and gynaecological services and discuss implications of the findings and agree further actions and audit if required.
- Present findings and recommendations form all relevant confidential enquiries such as CEMACH, NICE and any other directives form such organisations as NPSA, HCC and CNST.
- Discuss policy decisions and changes.
- Include as standing agenda items such as infection control and feedback on any directives from the Trust.

Meetings

Approximately 10 meetings per year (Trust sets the dates), of which at least 2 will have joint case presentations with the Neonatal Department.

Administration Support

CNST/Datix clerk to assist with preparation for the day and taking of minutes

Minutes will be circulated to all clinical areas and will include any presentations that have been made.

Appendix 7

Labour Ward Forum Terms of Reference

Aims of Group

The aims of the group are to:

- To look at professional and organisational issues for labour ward.
- Review Labour Ward Activity
- Review policies and guidelines with reference to the guidelines group
- Review current research, Government reports and Confidential Enquiries as apply to labour ward
- Discuss adverse events and near misses, and review trends as identified by the Risk Management Group.
- Take forward, lesson learning and planned action as recommended by the Clinical Governance group or Risk Management Group.
- Review staff training issues, Consultant/Registrar cover and labour ward staffing levels

Membership

2 Consultant Obstetricians, 1 Consultant Neonatologist, 1 Anaesthetist, Head of Midwifery/Consultant Midwife, Divisional Risk Lead, Labour Ward Co-coordinator/Matron, Senior Registrar, Junior Midwife and Junior Medical (on Labour Ward rotation) Supervisor of Midwives, Consumer Representation, NICU Matron.

Current List

Consultant O&G Research Lead

Consultant O&G Labour Ward Lead (Joint Chair)

Consultant Anaesthetist

Consultant Neonatologist

Divisional Risk Lead

Consultant Midwife

Labour Ward Matron (Joint Chair)

Head of Midwifery

Supervisor of Midwives

NICU Matron

Core Midwife

Labour Ward Midwifery Representative

Registrar, Junior Medical Representative

NCT/MSLC User Representatives

Clinical Facilitator

If unable to attend a suitable substitute must be agreed and notified to the Administration support in advance of the meeting

Administration Support

Datix administration Clerk

Chairing of the Group

Forum led by Labour Ward Lead Clinical Obstetrician and the Labour Ward Matron.

Objectives of the Group

- Review and action plan the CNST requirements
- Identify and recommended new evidence into practice soon as practicable
- Encourage safe evidence-based practices through the provision of comprehensive multidisciplinary guidelines
- Review trends in incident reporting system as presented by the Risk Management Group and recommend/support clinical audits.
- Review and action as required all Serious Untoward Incidents relevant to Labour Ward.
- Feed into open multi-disciplinary risk management meetings. Feed to ward meetings and send alert memos as required.
- Feed into Senior Midwives meeting, Consultant Meetings and Departmental Meetings with regards to staffing levels and Training issues. Recommendations and action plans to be supplied.
- Minutes to be fed into Risk Management Group by Chair for noting
- Report to Divisional Board and Clinical Standards Executive Group

Meetings

A minimum of 4 per year, dates sent out in advance by Administration support.

Appendix 8

Critical Incidents Review Group

Immediately following an adverse event, near miss or clinical trigger, the staff member reports
the event via the Trust incident reporting procedure and will complete an incident form, the Ward Manager/Core Midwife or area Matrons should then grade these, with serious incidents being reported directly to the Risk Lead, in order for an initial review of the case to be undertaken.

All potential serious untoward incidents should be reviewed by the **Critical Incidents Review Group**, which will meet within 48 hours of a serious incident. The Division follows the Trust policy for the reporting and escalation of actual or potential serious untoward incidents as laid out in the Trust **Incident Reporting Policy.**

Its membership comprises-

- Obstetric Consultant
- Labour Ward Matron or Matron for the relevant area
- Divisional Risk lead
- Head of Midwifery
- Supervisor of Midwives
- Relevant medical personnel as required

Key agenda items

- To examine the facts and circumstances in detail
- To decide on the next steps necessary to address the essential issues
- To appoint an investigating officer to conduct an investigation
- Initiate statement collection from staff involved in the incident.
- To identify the failings and strengths and formulate an action plan with conclusions
- To take the necessary actions in relation to findings
- To act as a support mechanism for all those affected by the incident
- To report back to other groups which link with risk management

Appendix 9 – Risk Analysis Tools

Table 1 Consequence scores

Choose the most appropriate domain for the identified risk from the left hand side of the table Then work along the columns in same row to assess the severity of the risk on the scale of 1 to 5 to determine the consequence score, which is the number given at the top of the column.

	Consequence score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards

Human resources/ organisational development/ staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Table 2 Likelihood score (L)

What is the likelihood of the consequence occurring?

The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency.

Likelihood score	1	2	3	4	5
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur,possibly frequently

Table 3 Risk scoring = consequence x likelihood (C x L)

	Likelihood				
Likelihood score	**1**	**2**	**3**	**4**	**5**
	Rare	**Unlikely**	**Possible**	**Likely**	**Almost certain**
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

For grading risk, the scores obtained from the risk matrix are assigned grades as follows

	1 - 3	Low Risk
	4 - 6	Moderate Risk
	8 - 12	High Risk
	15 - 25	Extreme Risk

Instructions for use

1. Use table 1 to determine the consequence score(s) (C) for the potential adverse outcome(s) relevant to the risk being evaluated.
2. Use table 2 to determine the likelihood score(s) (L) for those adverse outcomes. If possible, score the likelihood by assigning a predicted frequency of occurrence of the adverse outcome. If this is not possible, assign a probability to the adverse outcome occurring within a given time frame, such as the lifetime of a project or a patient care episode. If it is not possible to determine a numerical probability then use the probability descriptions to determine the most appropriate score.

Calculate the risk score the risk multiplying the consequence by the likelihood:
C (consequence) x L (likelihood) = R (risk score)

Appendix 10

Maternity Incident Criteria List

1. Anaesthetic complications
2. Apgar score 7 or less at 5 mins or cord PH <7.10
3. BBA
4. Crash caesarean section
5. Death - maternal
6. Death - neonatal
7. Delay |>30 mins performing C/S after decision to proceed
8. Eclamptic fit
9. Equipment unavailable or malfunctioning
10. Ventouse/ forceps delivery- unexpectedly difficult or failed
11. Help -difficulty or unable to contact
    Obstetric, Paed, Anaesthetic, ODA, Other
12. Hysterectomy - at C/S or post-partum.
13. ITU/CCU -mother
14. Term admission to NICU
15. IVI complication
16. Infant injury e.g. Fractured skull/limb, nerve damage
17. All IUDs over 24 weeks gestation
18. Third and fourth degree tears
19. Shock (maternal) requiring resuscitation e.g. PE, amniotic fluid embolus
20. Unplanned return to theatre - maternal
21. PPH >1000mls **OR** patient a requiring a blood transfusion postnatal
22. Cord prolapse
23. Retained swab
24. Ruptured uterus
25. Second stage of labour lasting >3 hours
26. Shoulder Dystocia
27. Transfusion error/reaction including anti-d problems
28. Undiagnosed breech in labour
29. Unit closure
30. Uterine inversion
31. High dependency care requiring ‘specialising’ on D/S - i.e. PIH, diabetic mother
32. Miscellaneous

Appendix 11

References

- West Herts NHS Trust Risk Management Strategy (March 2008)
- Incident and Investigation Policy (including Management of SUIs) (December 2007)