MATERNITY SERVICES NORTH CUMBRIA

MATERNITY SERVICES RISK MANAGEMENT STRATEGY 2011-13

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Related Policies

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1. INTRODUCTION

The Trust is committed to providing high quality maternity services and to manage and minimise risk in a systematic and structured way within this service. The Trust is committed to providing an integrated approach to risk management in maternity care, with the aim of reducing and learning from untoward incidents, near misses, complaints and claims thereby increasing patient satisfaction and promoting beneficial outcomes and high quality care.

This document reflects principles in the North Cumbria University Hospitals NHS Trust (NCUHT) Governance, Risk Management & Quality Strategy and must be read in conjunction with the NCUHT Governance, Risk Management & Quality Strategy.

The Maternity Service in North Cumbria will provide assurance to the Family Services and Clinical Support Divisional Board and the Trust Governance and Quality Committee that:

- untoward incidents and near misses are reported by all areas, including Community Midwifery, and staff groups
- untoward incidents and near misses are investigated appropriately
- all risks are adequately identified and entered onto the maternity department Risk Register, which forms part of the Family Services and Clinical Support Divisional risk register
- all Risk Registers are reviewed, updated and monitored
- This process is carried out within agreed timescales

The Family Services and Clinical Support Division are required to report and provide assurance to the Governance and Quality Committee that:

- An integrated approach to managing risk which aims to either eliminate or control is in place, including Clinical, Organisational, Health & Safety or Financial
- The Family Services and Clinical Support Divisional Risk Register is regularly reviewed, updated and effectively managed
- Local arrangements are established and implemented in accordance with the principles and objectives set out in this Strategy, ensuring that the maternity services has a local Risk Register
- Incidents and near misses are reported and investigated
- All Serious Untoward Incidents (SUIs) are appropriately escalated and conducted according to the Trust’s Incident Management Policy and agreed protocol required by NHS Cumbria
Local aggregated analysis takes place relating to data provided from incident, complaints and claims reports, and that action is planned and implemented as appropriate.

All executive directors, directors, members of the Family Services and Clinical Support Services Divisional Board and all staff with a managerial and supervisory responsibility, will have risk management responsibilities defined in their job descriptions.

Each division has a named Governance Facilitator who has the responsibility to facilitate the co-ordination of risk management and risk education within the division. Each divisional Governance Facilitator will contribute rotationally to corporate risk management activities and training.

All managers in the Maternity Services have a responsibility to encourage staff to identify risks and to ensure that they are familiar with this strategy along with the Trust Risk Management Strategy, and the latest risk management policies, guidance and controls.

SUls are identified through the risk process and actions arising from investigations are completed within the required timescales.

1.1 Objectives for Managing Risk in maternity services

- To ensure policies and systems are in place to minimise risks and promote high quality, safe care to women, babies and their families
- To ensure effective coordination of clinical risk management within the maternity service through an agreed reporting and committee structure, with formal links to Trust management and the Trust Board
- To develop and use local risk processes to ensure actions, outcomes, changes in practice and lessons learnt are effectively disseminated throughout the service and the organisation.
- To ensure all operational guidelines are kept up to date with best practice in line with advice from National Institute for Clinical Excellence (NICE), Royal College of Obstetricians (RCOG), Royal College of Midwives (RCM), Local Supervising Authority (LSA), Confidential Enquiry Into Maternal and Child Enquiries (CEMACE) recommendations and other external bodies.
- To ensure that the staffing structure and staffing levels in maternity are fit for purpose and meet national guidelines. They must be coordinated and monitored with annual audit in line with the local standards on staffing levels for midwifery and nursing staff, obstetricians and anaesthetists and anaesthetic assistants.
• To ensure staff are aware of their responsibilities for clinical governance and risk management and compliance with key regulatory bodies.

• To develop and use the integrated Risk Register and assurance framework, ensuring strategic risks are escalated to the Trust Board.

• To respond to external recommendations for improvement in maternity services (e.g. Care Quality Commission (CQC) reviews of maternity services) and other national directives.

• Secure highest possible standard of risk management for external validation including, NHSLA, CNST maternity standards

2. PURPOSE OF DOCUMENT

The purpose of the Strategy is to minimise risks to pre and post natal women and the newborn through the implementation of a risk management framework which:

• Identifies the principal risks to the achievement of the Trust’s objectives for maternity services.
• Evaluates the nature and extent of the risks.
• Manages risk efficiently, economically and effectively to ultimately reduce or avoid risks in future.

3. SCOPE

This strategy applies to all staff, trainees, agency and volunteer staff contracted to work within any part of the Trust’s maternity services which comprises:

In patient units including the full range of maternity services at West Cumberland Hospital and Cumberland Infirmary.
• Delivery Suites
• Ante Natal Care (OPD / In-patient)
• Post Natal (In-patient / OPD)
• Special Care Baby Units
• Ultrasound
• Community Midwifery North Cumbria-wide, providing antenatal care, home birth and postnatal care
• Penrith Birthing Centre. This is a community-based midwifery service providing 24-hour intrapartum care to low risk women. This unit is linked to the in-patient unit in Carlisle for situations where clinical complications develop, enabling transfer to obstetric care

4. DEFINITIONS
The following definitions are used in this Strategy; further details and a comprehensive glossary are included in the Governance, Risk Management & Quality Strategy.

- **Risk** is the probability of something happening that will impact on the organisation’s ability to achieve its objectives (e.g. loss, injury or other adverse consequence)

- **Untoward Incident (Sometimes called Adverse Events).** Any incident/near miss event or circumstance arising during NHS service provision that could have or did lead to unexpected harm, loss or damage. Untoward Incidents can range from no harm untoward incidents to Serious Untoward Incidents.

- **Near Miss.** Where no harm, loss or damage is caused but could have resulted in harm, loss or damage in other circumstances.

- **Harm, in the context of Patients, is defined as injury (physical or psychological), disease, suffering, disability or death.** In most cases harm can be considered to be unexpected if it is not related to the natural cause of the patient’s illness or underlying condition.

- **Acceptable Risk (Sometimes called Tolerable Risk).** A risk that is allowed to exist so that certain benefits can be gained, whilst there is an acceptable level of confidence that the risk is under control and that the risk has been reduced to the lowest practicable level.

5. OUR ORGANISATIONAL VALUES

As an organisation, we recognised that our values and behaviours are central to how we embed governance, risk management and quality in all our activities and day to day responsibilities.

Our values are to:

**Embed quality and safety at the heart of everything we do**

*To achieve this we will;*

- Treat our patients the public and each other with honesty and openness
- Promote and protect each individual’s right to be treated with dignity and respect
- Measure and continuously improve the standards of safety and quality delivered to our patients
- Provide a safe and clean environment that promotes patients' comfort and well-being
- Support and develop our staff to deliver and achieve the best possible standards of care
- Measure and improve the experience of our patients and our staff
- Be polite, courteous and non-judgemental in our communication and engagement with each other
- Be caring, compassionate and kind to others
Deliver excellence at every turn

To achieve this we will:

- Ensure we use our resources in the most efficient way
- Strive to get the basics right, first time, every time
- Practice efficient and effective team working by committing to achieving common goals in every team and department
- Encourage involvement and ownership
- Use evidence, best practice and innovation to develop our services for the future
- Learn from our mistakes
- Celebrate and encourage excellence across our organisation and build pride in our reputation
- Be responsible and accountable for our own and collective actions

6. QUALITY OF CARE

The Care Quality Commission (CQC) is the independent regulator of health and adult social care services in England. All providers have to be registered for the services they provide and therefore licensed in meeting essential standards of quality and safety which the CQC monitors on a regular basis.

The Trust applied for registration with the CQC and was granted full registration without conditions from 1 April 2010. In order to maintain this registration the Trust has developed steering group to monitor the ongoing collection of evidence to maintain that registration.

The Director of Governance & Company Secretary chairs this group and reports to Governance & Quality Committee on progress and by exception as required.

The Trust Board also receive a quarterly report on compliance with the CQC regulations and outcomes.

Care Quality Commission Essential Standards of Quality and Safety

1. You can expect to be involved and told what’s happening at every stage of your care
   - You will always be involved in discussions about your care and treatment, and your privacy and dignity will be respected by all staff.
   - You will be given opportunities, encouragement and support to promote your independence.
   - You will be able to agree or reject any type of examination, care, treatment or support before you receive it.
2. **You can expect care, treatment and support that meets your needs**  
- Your personal needs will be assessed to make sure you get care that is safe and supports your rights.  
- You will get the food and drink you need to meet your dietary needs.  
- You will get safe and co-ordinated care where more than one care provider is involved or if you are moved between services.

3. **You can expect to be safe**  
- You will be protected from abuse or the risk of abuse, and staff will respect your human rights.  
- You will be cared for in a clean environment where you are protected from infection.  
- You will get the medicines you need, when you need them, and in a safe way.  
- You will be cared for in a safe and accessible place that will help you as you recover.  
- You will not be harmed by unsafe or unsuitable equipment.

4. **You can expect to be cared for by qualified staff**  
- Your health and welfare needs are met by staff who are properly qualified.  
- There will always be enough members of staff available to keep you safe and meet your health and welfare needs.  
- You will be looked after by staff who are well managed and have the chance to develop and improve their skills.

5. **You can expect your care provider to constantly check the quality of its services**  
- Your care provider will continuously monitor the quality of its services to make sure you are safe.  
- If you or someone acting on your behalf makes a complaint, you will be listened to and it will be acted upon properly.  
- Your personal records, including medical records, will be accurate and kept safe and confidential.

The services, treatment and care provided to the population of North Cumbria must be safe, effective and sustainable. Treatment and care is based on the best available evidence of interventions that work and is delivered by competent and qualified staff.

7. **ROLES AND RESPONSIBILITIES**

See Maternity Services Management Structure in Appendix 1
The Roles & Responsibilities for the management of Maternity Services are described in this strategy. It is important that the wider Trust responsibilities for Governance and Risk Management are read and understood in conjunction with this section (please see NCUHT Governance, Risk Management & Quality Strategy).

All professionals: midwives, obstetricians, anaesthetists and paediatricians, must work together to agreed protocols to optimise the outcome for both the mother and her baby, especially in complicated pregnancies.

7.1 Chief Executive and the Trust Board

The Trust Board is responsible and accountable for ensuring that effective governance and risk management systems are in place to support the safe delivery of care to patients as well as ensuring a safe working environment for all staff.

The Chief Executive has on behalf of the Trust Board, responsibility for maintaining a sound system of internal control. This requires the organisation to have in place the necessary controls to manage its risk exposure. Through the Trust Board, Audit Committee, Governance & Quality Committee and Divisional Boards, the Chief Executive is assured that effective leadership for Governance and Risk Management is provided and that the strategic objectives are met.

Each Executive Director and Director is responsible for ensuring that their individual obligations for effective governance and risk management are achieved and implemented within their areas of responsibility. This includes leading the reinforcement of the organisational values and goals that determine our culture.

The Trust Board is responsible for ensuring that effective information and reporting structures exist to ensure scrutiny on key governance and risk issues, which contribute to the standards of safety and quality across the organisation.

This includes receiving:

- Monthly exception report on key governance issues, incorporating on a quarterly basis the key issues arising from the Divisional Governance Reports for that quarter
- Quarterly report on Integrated Strategic Risk Register and Assurance Framework
- Six monthly review of the status of the Trust's objectives
- Formal minutes from the key committees of the Board as detailed in Appendix 6.
- Report on compliance with Care Quality Commission Registration
• Internal Audit Review of the Trust’s Governance and Risk arrangements as part of the Statement of Internal Control.

Responsibility for the day-to-day management of risk is devolved locally to the Business Units, Divisions and Corporate Departments, which are tasked with the responsibility to lead the co-ordination, integration, oversight and support of the risk management agenda through the Trust’s Governance Structure.

7.2 Medical Director

- Recognised Responsible Officer (RO) for the Trust.
- Responsibility for ensuring effective systems and processes are in place to support the delivery of safe quality care (jointly with DoN).
- Responsibility for ensuring effective clinical governance arrangements are in place (jointly with the DoN).
- Responsibility for ensuring that necessary arrangements are in place for the Caldicott Guardian role for the Trust.
- Responsibility for ensuring the pillars of governance are embraced and implemented across the organisation (jointly with DoN).
- Advise the Trust Board on any issues relating to clinical governance.

7.3 Clinical Director

The Clinical Director has joint responsibility with the Head of Midwifery for overseeing clinical risk management throughout the maternity service. The Clinical Director is accountable to Associate Medical Director.

In addition to the above duties they also have the following responsibilities:
- Receiving information in relation to all significant risk issues
- Being a professional lead within the divisional structure
- Monitoring and review of the Risk Register at divisional meetings.
- Raising clinical risk issues with the Associate Medical Director monthly at divisional meetings
- Chair the North Cumbria Maternity Services Risk Management Meeting
- Support effective team-working in conjunction with the Head of Midwifery, Clinical Midwifery Managers, Risk Midwives and Lead Obstetricians for Delivery Suite to manage risk within the service
- Ensure medical elements of the NHSLA maternity services Clinical Risk Management Standards agenda are met.
- Ensuring that there is thorough incident investigation and learning from incidents, complaints and claims
- Providing medical staff with appropriate feedback and support during and following SUI investigations.
- Provide medical staff with appropriate support and feedback both during and following investigations.
- Undertaking an annual audit of medical staffing levels to ensure that levels are appropriate to deliver high quality care
7.4 **Director of Nursing and Quality**

The Director of Nursing and Quality is the Executive Lead at Trust Board level with responsibility for Maternity Services. This person communicates with the Head of Midwifery through the weekly Governance Delivery Group, weekly Senior Nurse/Midwifery Group and monthly on a one to one basis.

The Director of Nursing has specific responsibility to:

- Be the executive director with responsibility for governance including risk management for acute and maternity services.
- Ensure that serious untoward incidents are managed and investigated by attendance at weekly Governance Delivery Group.
- Ensure the provision of risk related reports to the Trust Board
- Report to the Board on all relevant Risk Management Standards
- Ensure risks are monitored on the Integrated Risk Register and Assurance Framework in conjunction with the Director of Governance.
- Be the delegated named “submitter” for the Care Quality Commission registration requirements

7.5 **Head of Midwifery**

The Head of Midwifery has joint responsibility with the Clinical Director for overseeing clinical risk management throughout the maternity service. The Head of Midwifery is accountable to the Director of Nursing and Quality and is a member of the Trust's Governance and Quality Committee.

In addition to the above duties they also have the following responsibilities:

- Development and maintenance of local risk management policies and procedures
- Being a professional lead with the divisional structure
- Raising clinical risk issues with the Director of Nursing and Quality at monthly one-to-one meetings and attendance at Governance and Quality Committee
- Ensuring that there is thorough incident investigation and learning from incidents, complaints and claims
- Providing midwifery/nursing staff with appropriate feedback and support during and following SUI investigations.
- Monitoring and review of the Risk Register at divisional meetings.
- Ensuring that the midwifery elements of the NHSLA maternity services Clinical Risk Management Standards agenda are met.
- Undertaking an annual audit of midwifery staffing levels to ensure that levels are appropriate to deliver high quality care
7.6 Clinical Midwife Managers (One at CIC and One at WCH) and Community Midwife Manager

Midwifery managers have a crucial role in the smooth and efficient management of the maternity services in particular for Clinical Midwife Managers, the labour ward. They must provide advice, support and guidance. They must ensure there is a supportive, positive environment that encourages learning and development of all staff. They must also ensure a quality service through evidence-based guidelines, safe and effective resourcing of equipment and support systems for mentoring new and junior midwives and students.

Clinical Midwife Managers and the Community Midwife Manager are specifically responsible for managing risk at a local level and must:

- Actively implement this Risk Management Strategy in their areas of responsibility and raise risk awareness in the department
- Ensure midwifery standards for the NHSLA maternity services Clinical Risk Management Standards agenda are met.
- Ensure that all staff attend annual mandatory training or that they complete the work book, as determined by the training needs analysis.
- Ensure that risk management is an integral part of appraisal.
- Encourage identification of potential risks within the work area.
- Seek risk and safety advice as appropriate.
- Ensure risk assessment is carried out within the service and action plans are developed, monitored and implemented.
- Carry out investigations and provide staff with appropriate feedback and support i.e. time, during and following investigations.
- Ensure incidents are reported and investigated and ensure that lessons learnt are shared through staff meetings monthly NC Newsletter.
- Deal with complaints and claims and disseminate lessons learned.
- Escalate risks that cannot be managed locally to the Directorate / Divisional meetings and inform North Cumbria Risk Meetings
- Ensure recommendations from NICE, CEMACE are implemented in conjunction with the multi-disciplinary team
- Develop Guidelines

7.7 Clinical Risk Coordinator

The Clinical Risk Coordinator is responsible, in conjunction with the Head of Midwifery and Clinical Director, for co-ordinating and developing an effective risk management process within the maternity services.

This person has specific responsibility to:
- Facilitate the implementation of maternity standards for the NHSLA Maternity Services Clinical Risk Management Standards.
- Maintain, develop and co-ordinate an effective risk process within maternity services which contributes to the Trust clinical governance agenda.
- Co-ordinate risk identification and analysis through the collation and review of all incidents
- Discuss with the Midwifery Managers, Lead Obstetricians and Supervisors of Midwives, any practice issues identified through incidents
- Work with the Lead Obstetricians and Midwifery Managers, to coordinate the clinical guideline audits. Ensure that lessons learnt from audits and actions plans implemented are reported to North Cumbria Risk meeting
- Support the Midwifery Managers and Clinical Director in ensuring incidents and appropriate actions are taken in a timely manner
- Review the Risk Management Strategy with the Head of Midwifery and Clinical Director on an annual basis.

### 7.8 Supervisors of Midwives

The Supervisor of Midwives have a key role in risk reduction through the promotion of evidence-based practice including guideline development, policy and procedures. Statutory supervision of midwives is an integral part of the clinical governance framework.

- Supervisors of Midwives are represented at all local maternity communication forums such as the Maternity Service Liaison Committee, Maternity Risk Management Meetings, perinatal audit meetings and the Labour Ward Forum
- A supervisor of midwives is available 24 hours a day and may be contacted by any member of the public or maternity team for support and advice.
- Provide individual support and guidance to individual midwives allocated to them as well as be accessible to all midwives in the department.
- Assume a vital role within the Maternity Service Escalation Policy and raise the issue of over-capacity and serious incidents

The North Cumbria Supervisors of Midwives are specifically responsible to:
- Conduct Annual Supervisory reviews to ensure midwives are fit to practice and identify training or personal development needs. Make recommendations to the Practice Development Coordinator to incorporate into the Training Needs Analysis for midwives.
- Work in partnership with the nominated Lead Midwife to provide preceptorship for new qualified / newly appointed midwives.
- Proactively support staff through training and development issues arising out of adverse incidents that are identified at risk management meetings
- Participate in all aspects of risk assessment and risk management whether formal or informal
- Participate in case reviews and SUI investigations by either supporting the midwives or being part of the investigation.
- Receive and review the Local Supervising Midwifery Officers Annual Audit Report / Action Plan. Produce a local action plan in response, which will
be reported to the North Cumbria Maternity Risk and copied to the Director of Nursing Quality and Governance.

7.9 Lead Consultant Obstetrician for Labour Ward (One at CIC and One at WCH)

This person, together with the clinical midwife manager has overall responsibility for the organisation, standard setting, risk management and audit on the labour ward.

The lead obstetrician has a crucial role in the smooth and efficient management of the labour ward and in providing advice, support and guidance. This includes ensuring there is:
- a supportive, positive environment that encourages learning and development of all staff
- a quality service through evidence-based guidelines
- a robust risk management framework
- support systems for mentoring new and junior medical staff.

The lead obstetrician is also specifically responsible for:
- Maintaining and developing an effective risk process within maternity services which contributes to the Trust clinical governance agenda.
- Ensuring medical standards for the NHSLA maternity services Clinical Risk Management Standards agenda are met.
- Encouraging identification of potential risks within the work area.
- Ensuring medical staff attendance at Trust induction, and mandatory training / skill drills events as determined by the trust Training Needs Analysis.
- Carrying out investigations and provide medical staff with appropriate feedback and support during and following investigations.
- Dealing with complaints and claims and disseminating lessons learned.

7.10 Lead Obstetric Anaesthetist (One at CIC and One at WCH)

The Lead Obstetric Anaesthetists are an integral part of the obstetric team and in the management of women who become seriously ill. Anaesthetists provide 24 hour availability. There is a designated lead anaesthetist for each labour ward who works with the maternity team communicating with the Lead Obstetrician.

The Lead Obstetric Anaesthetist also has specific responsibility for:
- Participation in guideline development relating to anaesthetic provision within Maternity Services
- Attendance at site-based and North Cumbria risk meetings
- Participate in relevant Obstetric Anaesthetic Audit
- Report to Anaesthetic Directorate about Anaesthetic delivery issues within maternity services
7.11 Site Based Clinical Risk Midwives (WCH, CIC and Community)

Have specific responsibility to:
- Co-ordinate incident reporting, risk identification and analysis.
- Escalate incidents and complaints as necessary.
- Undertake and support others in completing risk assessments.
- Contribute to and maintain their site-based Risk Register on Ulysses.
- Provide summary and trend analysis of risk activity to local and North Cumbria risk.
- Work with the multi-disciplinary to team to ensure midwifery standards are met for the NHSLA maternity services Clinical Risk Management Standards.
- Work with Family Services Governance Facilitator.
- Contribute to the review of the Maternity Services Risk Management Strategy.

7.12 Lead Midwives

Delivery Suite on both CIC and WCH sites have a rota of experienced clinical senior midwives who provide clinical leadership and operational management.

Lead midwives have a responsibility to:
- Work in partnership with Clinical Midwife Manager, site based Risk Midwives and Head of Midwifery to ensure that Maternity Services incident reporting process is adhered to.
- Ensure Risk Assessment process is adhered to by raising concerns as appropriate.
- Provide expert clinical advice at local risk meetings, in-house training and development of guidelines.
- Provide leadership in implementation of change and service development.
- Work in partnership with the nominated Supervisor of Midwives to provide preceptorship for new qualified / newly appointed midwives.
- Communicating and liaising with other members of the multi-disciplinary team to ensure the highest possible standard of care is maintained through continued monitoring of service provision.

7.13 Practice Development Coordinator

Working with the Education and Training Manager to monitor and provide training for staff in line with Trust mandatory training needs.

Specific responsibility to:
- Develop and maintain the Training Needs Analysis (TNA) for Maternity Services
- Monitoring that all staff attend and complete the relevant training programmes in accordance with the TNA, including non-attenders
- Provide a report and attend the North Cumbria Risk meeting regarding staff attendance at all mandatory training
- Maintain training records / database along with the Education & Training Manager
- Develop training needs specifically identified through audit, incident reports, annual appraisal and midwifery supervision annual reviews

7.14 Governance Facilitator for Family Services and Clinical Support Division

Has specific responsibility to:
- Ensure the development of clinical governance and risk management within maternity services is developed in conjunction with the Trust’s objectives.
- Provide support for the development, implementation and monitoring of risk management within maternity services.
- Work with the maternity risk team facilitate the process for the management of incidents
- Provide support to all members of the divisional team with regard to management of risk, incidents, complaints, and claims
- Develop and maintain the divisional Risk Register in conjunction with the maternity risk team
- Work together with the Head Of Midwifery and Clinical Director ensure the key issues from the Maternity Service, in relation to the 6 Core Pillars of Governance (8.1) will form part of the Family Services & Clinical Support Divisional Governance Report

7.15 All Staff

All staff working in maternity services across the Trust (medical staff, midwives, nurses, assistant practitioners, maternity care assistants and non clinical staff) are responsible for maintaining an awareness of best practice in their own area of work and familiarity with equipment provided for their own and patient use. This includes:

- Maintaining an awareness of emergency procedures e.g. resuscitation, evacuation and fire precaution procedures.
- Complying with relevant policies, procedures and guidelines, incident reporting and risk assessment requirements and ensuring attendance at risk induction and mandatory refresher training.
- Reporting incidents and potential risks including actions taken at the time of incident.
- Reporting all incidents that are included in the maternity services Trigger List.
- Participating in continuous risk assessment activity.
- Providing statements as requested.
- Participating in annual appraisal process.
8. HOW OUR ORGANISATION IS GOVERNED

8.1 Our Organisation has six Core Pillars of Governance:

**Governance, Risk and Quality**

- Compliance & Regulation
- Standards, Safety & Experience
- Risk Management
- Workforce Governance
- Information Governance
- Financial Governance

8.1.1 Compliance and Regulation

This is the conforming to agreed standards through the various regulatory bodies that all NHS organisations have to comply with for example NHSLA, CQC, CNST, HSE. The outcomes from external agency visits as well as meeting the required national and local performance indicators is also included in our compliance with key standards and regulations.

8.1.2 Standards, Safety & Experience

These are the three core strands for how we measure quality within our organisation:

- The **Standards** of care we set for our patients and staff and how we monitor and benchmark against best practice and other organisations.
- The **Safety** of the care we provide to our patients and the Safety of the environment we provide for our staff to work in.
- The **Experience’s** our patients have from the care we give and the Experience’s our staff have in their day to day working environment.

8.1.3 Risk Management

This is the process within the organisation for the management of all clinical and non clinical risks. This includes the management of incidents, near misses, and ongoing assessment of risks in clinical and non clinical areas across the organisation.

8.1.4 Workforce Governance

This is the system to ensure all staff are safe and supported to deliver quality patient care. This includes the collective accountability to ensure fair and effective management arrangements exist for all staff as well as how we develop our staff to meet the objectives of our organisation.
8.1.5 **Information Governance**

This ensures necessary safeguards for, and appropriate use of, patient and personal information.

8.1.6 **Financial Governance**

*Standards, safety and experience*

This is the process by which the finances and our financial plans for the organisation are monitored and reviewed. A key component of this is ensuring all staff follow the Trust's Standing Financial Instructions and Scheme of Delegation.

8.2 **Reporting and monitoring framework**

The Trust has in place a committee structure which supports the effective governance and risk management of the organisation. The key committees of the organisation have an agreed annual programme of work to ensure the delivery of their terms of reference. The divisional reporting structure is a key strand of our reporting and monitoring framework from 'Ward to Board'.

This strategy describes how the key groups within maternity services link into the reporting and monitoring framework of the Trust.

9. **GOVERNANCE AND RISK IN PRACTICE IN MATERNITY SERVICES**

In addition to the Trust’s committee structure, there is a specific structure within maternity services, which joins the two systems together to ensure robust governance arrangements across maternity services and the wider organisation.

Figure 1 outlines how incidents are escalated and integrated into the Trust’s systems but also how these are monitored and reviewed within maternity services.
Figure 1: Maternity Risk Management Structure

Live Incident Management & Declaration of SUI Process

Core Risk Team Site Specific (Clinical Midwife Mgr, Lead Obstetrician, Risk Midwife) (A)

Governance Delivery Group (Head of Midwifery & Risk Midwife) *

Scrutiny Group *

Executive Directors

Trust Board

Monthly Site Based Maternity Risk Group (C)

Labour Ward Peer Review (B)

O&G Directorate (E)

North Cumbria Maternity Risk Meeting (D)

Family Services Divisional Board (G)

Governance Committee *

Trust Board

Governance reporting, review & monitoring

North Cumbria Peer Review Meeting (F)

Detailed terms of reference can be found at Appendix 3 for A, B, C, D, E, F and G.

* All other meetings on here can be found in the general strategy for the Trust.
9.1 **Maternity Core Risk Team Site-based Weekly Meetings**

The Site-based Weekly Maternity Risk Meetings consist of:

- Clinical Midwife Manager
- Lead Obstetrician
- Risk Midwife

The purpose of this group is to review all Ulysses incident reports and submit a summary to the weekly Governance Delivery Group. Investigations into any incidents that require immediate action are included in the report to the Governance Delivery Group. The Maternity Core Risk Team also identify cases for the labour ward peer review meeting. The Core Risk Team also identify incidents that could be a Serious Untoward Incident. (See Appendix 3 for Terms of Reference).

9.2 **Labour Ward Peer Review Meeting**

To ensure weekly multi-disciplinary review of cases and incidents. The meeting consists of:

- Lead Obstetrician
- Lead Risk Midwife
- Clinical Midwife Manager
- Midwives
- Consultants and other medical staff

The purpose of the group is to review incidents and specific cases from the previous week, identify opportunities for learning lessons and identify and inform educational and audit needs. This group links closely to the site based Core Risk Team. (See Appendix 3 for Terms of Reference).

9.3 **Monthly Maternity Risk Management Meeting (site based)**

This committee will report to the North Cumbria Maternity Risk Management meeting. The meeting consists of:

On each site CIC and WCH:

- Lead Obstetrician
- Clinical Risk Midwife
- Clinical Midwife Manager
- Consultant Obstetrician
- Open to all maternity staff, medical and midwifery
- Multi-disciplinary staff e.g. paediatrician, anaesthetist, theatre staff
The purpose of the group to provide feedback to maternity staff on the key site based risk management issues and provide regular monitoring and review of risk management issues.

This monthly meeting will formally report to the North Cumbria Maternity Risk Management meeting. The meeting will also ensure the directorate meetings on each site are informed of the key risk and incident issues. (See Appendix 3 for Terms of Reference).

9.4 North Cumbria Maternity Risk Management meeting

The North Cumbria Maternity Risk Management Meeting is accountable to the Family and Clinical Support Services Divisional Board for the management of risk within the maternity service.

The membership of this group consists of:

- Clinical Director
- Lead Obstetricians CIC and WCH
- Head of Midwifery
- Obstetricians from each site
- Clinical Midwife Managers, CIC & WCH
- Community Midwife Manager
- Risk Midwives, CIC / WCH & Community
- Other appropriate Health Care professionals, e.g. Paediatricians, Anaesthetists or deputies as appropriate.
- All members of the maternity team are invited to attend.

The purpose of this group is to review all risk management issues and incidents across North Cumbria to ensure consistency of clinical practice and standards of maternity care to patients. This includes receipt of the annual audit of staffing levels for midwives, obstetricians, anaesthetists and theatre staff.

The North Cumbria meeting will inform the Family and Clinical Support Services Divisional Board of the key risk management issues within the maternity service. (See Appendix 3 for Terms of Reference).

9.5 North Cumbria Obstetric & Gynaecology Directorate Site Meetings

The purpose of this meeting is to ensure the effective operational management of the Obstetrics and Gynaecology (O&G) directorate.

The O&G Directorate meetings are accountable to the Family Services and Clinical Support Divisional Board.

The membership of this group consists of:
• Chair  Clinical Director
• Business Manager
• Finance Representative
• Human Resources Representative
• Governance Representative
• Head of Midwifery
• Consultant Obstetricians / Gynaecologists
• Matrons / Sister from Gynaecology
• Clinical Midwife Managers
• Supervisor of Midwives representative
• Community Midwifery Manager

The minutes will be accessible to everyone in the department. The directorate meeting will escalate key issues to the Divisional Board.

Members of the departmental meeting are responsible for ensuring approved decisions are applied and effective in their respective areas of responsibility and staffs are informed of important developments as appropriate. (See Appendix 3 for Terms of Reference).

9.6   North Cumbria Peer Review Meeting

The membership of the group consists of:

• Clinical Director
• Consultant Obstetrician from each site
• Clinical Midwife Managers from both sites.
• Community Midwife Manger
• Lead Coordinator for Risk
• Risk Midwives
• Head of Midwifery
• Supervisor of Midwives

The purpose of the Peer Group is to enable an in-depth discussion of high level incidents arising on each site. Service delivery issues will be identified and any further actions will be determined. The group will provide peer review on outcomes of incidents to ensure all necessary actions and lessons are fully captured, thus ensuring improvements in practice across the maternity service. (See Appendix 3 for Terms of Reference)

The group will inform the Monthly Site-Based Risk Meetings

9.7   Governance Delivery Group

The Governance Delivery Group consists of:

• The Director of Nursing and Quality
• The Medical Director
• Director of Governance and Company Secretary
• The Head of Patient Safety and Clinical Governance
• The Head of Midwifery and risk midwife as necessary
• The Heads of Nursing
• The Governance Facilitators
• The Information Governance Officer

The main remit of this group is to ensure the operational issues identified within the clinical Divisions (including maternity) are reviewed on a weekly basis to ensure appropriate action and escalation is in place.

This group is also responsible for reviewing the preliminary information regarding critical incidents and making recommendations to the Chief Executive regarding the declaration of a serious untoward incident. In addition, this group also reviews new complaints and monitors action plans to ensure lessons are learned across the organisation.

This group also monitors and authorises the closure of critical incidents, following investigation to ensure improvements are made and lessons are learnt.

The Head of Midwifery ensures that incidents within the Maternity Service are joined up to the Trust’s overarching Risk Management system by ensuring that maternity issues also feed into the weekly Governance Delivery Group. The Governance Facilitator for Family Services and Clinical Support also ensures that there is a feedback mechanism in place between this group and the Maternity Risk Management System.

9.8 Governance Scrutiny Group

The Governance Scrutiny Group consists of the Director of Nursing & Quality Medical Director, Director of Governance & Company Secretary and Head of Patient Safety and Clinical Governance. The main remit of this group is to scrutinise on a weekly basis the key outputs from the Governance Delivery Group as well as discussing any other significant governance issues that arise within the organisation.

This group also reviews and makes recommendations to the Chief Executive regarding the declaration of Serious Untoward Incidents.

Any key issues are reported from this group into the Executive Management Team (EMT) and Senior Management Team (SMT) where appropriate on a weekly basis.

The outputs of the Governance Scrutiny Group in relation to declaring an SUI are reported to the Trust Board on a monthly basis.
The Governance Scrutiny Group also invites representatives to the meeting before closure of high level incidents or to discuss issues in greater detail, where necessary.

9.9 Family and Clinical Support Services Divisional Boards

Each division has in place a Divisional Board, which reviews the ‘six core pillars’ of governance at each meeting. This ensures that the core components of governance are joined up and aligned to this strategy. Each quarter the Family and Clinical Support Services Divisional Board will report issues relating to the core pillars of Governance via a reporting template to the Governance and Quality Committee. This includes the annual audit of staffing levels for midwives, obstetricians, anaesthetists and theatre staff.

9.11 The Governance and Quality Committee

This is the Committee of the Trust Board with the responsibility for gaining assurance in relation to risk controls for clinical and non-clinical risks, governance and quality. This is the main committee through which the organisation is assured that risks are mitigated. Appropriate control mechanisms and adequate assurance is provided that the Trust is running an effective and safe business. The Governance and Quality Committee review specific divisional issues as well as join up any common themes on the risk, quality or governance across the organisation. Following the quarterly reports from the Division the key issues are reported to the Trust Board each quarter in the monthly governance report.

10. RISK MANAGEMENT PROCESS IN MATERNITY SERVICES

Figure 1 outlines the specific structural and organisational arrangements that apply to Maternity Services and how this links into the Trust’s Risk Management structure.

There are three sites within North Cumbria delivering maternity services, West Cumberland Hospital, Cumberland Infirmary and Penrith Birthing Centre. For the management of risk, the Penrith Birthing Centre is included within the Cumberland Infirmary site based risk meetings.

The management structure for maternity services is shown in Appendix 1; this includes risk management roles as detailed in Roles and Responsibility section above.

This section describes the levels of incident reporting and escalation within maternity services.

10.1 Incident Reporting and Escalation
The Maternity Services records all incidents in line with Safer Childbirth Recommendations, this is to ensure that clinical practice within maternity can be monitored in terms of trends, as well as identifying critical or serious untoward incidents.

10.1.1 Process for immediately escalating risk management issues from the maternity service to board level

Any risk management issues that require immediate action will be escalated by the Clinical Midwife Manager/Community Midwife Manager/ lead obstetrician to the Clinical Director/ Head of Midwifery. The Clinical Director/Head of Midwifery will notify the Director of Nursing and Quality for escalation to the Trust Board and Chief Executive.

10.1.2 All incidents (Level 1)

The department has an agreed ‘trigger list’ (see appendix 4) of incidents for which an incident form must be completed. However this list is not exhaustive and any incident or near miss must be reported via the online Ulysses system. Incidents are sent initially to the site based risk midwives.

The site based risk midwives check the incident form for completeness and clarify whether any further action or escalation is required. The incident will then be graded according to the NPSA 5 x 5 matrix (appendix 2).

The site based core risk team will review all Ulysses incident reports that are categorised as level 2/3 by the risk midwife.

The decision to take an incident to High Level (Level 2) is made by the Core Risk Team and are then reported to the weekly Governance Delivery meeting. This will ensure timely assessment and review by the Medical Director and Director of Nursing with input from maternity team.

All incidents and trend analysis are reviewed monthly at the site-based Maternity Risk meetings, a summary of these are reported to the North Cumbria Maternity Risk meetings bi-monthly.

10.1.3 Trend Analysis

The site based risk midwives produce trend analysis reports detailing reported incidents, complaints and claims and summarising actions taken. These quarterly summaries identify trends or clusters. The reports are initially reviewed at the site specific Maternity Risk Management Meeting. The action required is then determined. A combined report is produced from the site based reports by the Lead Coordinator for Risk. This combined report which is a summary of all incidents complaints and claims for the whole maternity
service is reviewed at the North Cumbria Risk Management Meeting. It is also disseminated throughout each base in the maternity services. This report forms part of the data set for a quarterly report for the Governance and Quality Committee by the DGM / AMD.

Outcomes from incidents, complaints or claims that identify risks to the maternity service are assessed by the site specific risk midwife. Where controls are required to mitigate the risk, a risk assessment will be completed and escalated as necessary according to the level of risk and controls required.

10.1.4 High Level Incidents (Level 2)

Any incident categorised as level 2 by the risk midwives or any incident that falls into any of the following categories automatically triggers a case review at the labour ward peer review meeting. This review will take place as part of the site specific management of risk and will be organised by the risk midwife/ lead obstetrician. This review group must include three people which of which one must be an obstetrician and a senior midwife.

- perinatal death,
- severe maternal morbidity including ITU admission
- blood transfusion of 6 units or more,
- hysterectomy,
- severe neo-natal morbidity including apgar 4 or less at 5 minutes,
- cord pH of 7.05 or less (venous or arterial)
- any other case that causes serious concern and a majority of the members of the site base Maternity Risk Management Meeting considers it to be a suitable subject for review.

Following this local review, recommendations regarding departmental management will be made and implemented by the appropriate clinical lead.

All level 2 incidents are reported to the Governance Delivery Group.

10.1.5 Serious Untoward incidents (Level 3)

Any incident which triggers the criteria set out in Appendix 4 must be reported immediately to the Medical Director, Director of Nursing & Quality and Director of Governance who will assess any ongoing or other immediate patient safety risks following the incident with the Lead Obstetrician and Midwifery Manager. This includes an immediate assessment and timeline of facts in order to inform the declaration of an SUI. Any risk management issues that require immediate action will be escalated by the Clinical Midwife Manager/Community Midwife Manager to the Head of Midwifery. The Head of Midwifery will notify the Director of Nursing and Quality for escalation to the Trust Board and Chief Executive.

The incident will then be formally reported by the Core Risk Team (site specific) to the next Governance Delivery Group. If it is decided by the
Governance Scrutiny Group that the incident does not trigger an SUI, this is reported back to the Core Risk Group who will review the incident as either a high level or general incident.

See appendix 5 Flow Chart for Potential Serious Untoward Incidents (SUI’s) in Maternity Services.

10.1.6 Peer review and multi-disciplinary review

It is necessary to review incidents at all levels within the multi-disciplinary team to ensure appropriate peer review, both site specifically and across site.

Each site has a Labour Ward Peer Review Meeting, which takes place weekly. The Core Risk Group determine the cases which will be reviewed (see 10.1.4).

The key function of this meeting is to review cases from a multi-disciplinary perspective and identify any lessons to be learned. This information will then be used to feedback to staff directly involved in the case, disseminate throughout the maternity team the lessons learned and inform future education and audit programmes as appropriate.

The North Cumbria Peer Review Meeting provides the opportunity for cross site peer review and sharing of lessons learned. This will promote consistency of clinical practice and standards. Cases based on the following criteria must be reviewed. Other cases may be reviewed here as determined by the risk midwife, Clinical Midwife Manager and/or lead obstetrician:

- Concerns over management/substandard care
- potential/actual SUI
- Educational value
- interest

10.2 Complaints and Claims

Complaints and claims are dealt with individually in accordance with the Maternity Services policy on Incidents, Complaints and Claims.

Each complaint and claim is reviewed at the site based risk management meeting. The outcome, including lessons learned are disseminated to the individuals involved and where relevant to the Maternity Service as a whole, via the North Cumbria Maternity Newsletter. The manager leading on the investigation into the complaint or claim is responsible for this.

10.3 Risk Assessment, Identification and Evaluation

In addition to the reporting and grading of incidents the assessment and monitoring of risk within maternity services is described below:
10.3.1 Risk Assessment and Identification

All members of staff within the maternity unit have the responsibility to identify and complete a risk assessment within their area, including those which may arise from an incident, complaint, claim or near miss. Each Maternity Unit has a site based risk midwife who review all risks to ensure they are graded and escalated appropriately.

The Trust has a number of mechanisms where risk assessment and identification of risk takes place. These include:

- External scrutiny and inspections e.g. internal/external audit reports, CQC, NHSLA and CNST
- Occurrences such as incident reporting, claims, complaints
- Internal assessments e.g. SABS, EIA of policies
- Business Planning including business cases
- Project implementation
- Operational assessment of risk at ward and departmental level

The Trust Risk Scoring Matrix is shown in appendix 2.

10.3.2 Risk Analysis and Control

All risk assessments pertaining to maternity are scrutinised monthly by the individual site-based directorate meetings and reported to their Divisional Board. The Divisional Management Board will consider the status of the risks
and is empowered to re-grade and challenge the action plans to mitigate the risk and ensure the adequacy of the controls in place. This includes the required escalation to the Strategic Risk Register due to their impact on the organisations principal objectives.

The Trust uses the 5 x 5 matrix as recommended by the National Patient Safety Agency and this is detailed in Appendix 2. This is a generic matrix, which is used to assess the full range of risks i.e. clinical, non-clinical, operational, strategic and financial. The 5 x 5 matrix identifies a risk score by reviewing the likelihood of the risk occurring and the consequence this will have as a result.

Staff guidance has been developed to support the use of the Risk Assessment, Identification and Evaluation Framework and can be found in the Trust’s Risk Assessment Policy.

Where a risk has been identified appropriate controls have been put in place to mitigate or control the risk to an acceptable level. All identified risks must have a treatment plan. There are four treatment plan options called the 4 “Ts”.

**Tolerate**  Accept the risk at its current level (with adequate controls in place)

**Transfer**  Transfer the risk to another party where further controls or actions are required in order to adequately mitigate the risk. The consequences of this action will need risk assessing to ensure the risk is controlled as far as possible within the Trust’s accountability.

**Terminate**  Stop the activity that presents the risk. The consequences of this action will need risk assessing in terms of the impact on the provision of the Trust’s services and local population.

**Treat**  Take action to reduce or mitigate the risk, in terms of reducing the likelihood or its occurrence or reducing the severity of impact if it does occur.

**10.3.3 Risk Monitoring**

The Trust has in place a specific process for the monitoring of risks across the organisation that categorises risks as either operational or strategic. Operational risks are those that can be managed and controlled within the clinical division. Strategic risks are risks which directly impact on the delivery of the organisations principal objectives. The combined divisional risk registers and strategic risk register provides the Trust wide integrated risk register and assurance framework which consists of operational and strategic risks.
To ensure risks are managed through one system (Ulysses) any risk in the organisation must have an assurance section also completed that outlines:

- Controls against the risk
- Assurances/evidence that the controls are working
- Risk grading
- Assurance sources (types)
- Gaps in control
- Gaps in assurance

Diagram 10.3.4 illustrates how the risk assessment and escalation process operates across the Trust, including how this is monitored and reviewed.

10.3.4 Process for the Management of the Maternity Services Risk Register. –

- Risk identified within the department.
- Risk assessment completed by the risk midwife.
- Added to the local site based Risk Register by the Risk Midwife
- Local review and update of the Risk Register is monthly by site specific core risk team and any actions are identified.
- Any risks identified but not resolved with the department and therefore remaining on the Risk Register are reviewed at the Directorate meeting. Further actions are identified and monitored.
- If any risk identified is still not resolved it is then escalated to Family and Clinical Support Services Divisional Board by the Head of Midwifery /Clinical Director. Further actions are identified and monitored.
- The level of risk, controls and timescales are scrutinised by the Family and Clinical Support Services Divisional Board. It considers and recommends whether the risk remains operational (division) or strategic (Trust Board). The local divisional register is then updated.
- The integrated operational risk register and assurance framework is reported to and monitored by the Governance and Quality Committee on a quarterly basis through the Divisional Report.

The Divisional General Manager and Associate Medical Director will inform the relevant Director where the Divisional Management Board considers a risk to be escalated as strategic.

Strategic risks are then reviewed by the EMT/SMT on a monthly basis as part of updating the Integrated Risk register Assurance Framework prior to review and scrutiny by the Trust Board each quarter. The Governance Quality Committee will highlight any specific issues in relation to risk management as part of their reporting to the Trust Board.

The Head of Midwifery who is an attendee at the weekly Governance Delivery Group will inform and provide assurance to the Director of Nursing and Quality (Trust Board Lead Executive for Maternity Services).
10.3.4 Risk Assessment and Escalation Process - Maternity

**Ward or department**

1. Risk identified or reviewed
2. Risk assessment completed
3. Add to risk register via Nominated Lead & Risk Midwife *
   - Independent Review
4. Local review by site-based risk management meetings within the month
5. Controls, actions, timescales and lead personnel assigned and feedback to ward/department
6. Risk register updated
7. Level of risk, controls and timescales scrutinised by Divisional Management Board
8. Consideration and recommendation given as to whether the risk remains operational (Division) or Strategic (Trust Board)
9. Local divisional register (Ulysses) updated and reviewed by maternity risk team monthly
10. Integrated Operational Risk Register and Assurance Framework reported to Governance and Quality Committee Quarterly through the Divisional Report

**Governance Review**

1. Governance Delivery Group review all new risks added to Ulysses monthly to independently check impact of new risks being added to the system
2. Further information and updates requested from division or directorate if required
3. Governance Delivery Group identify any potential strategic risk

**Strategic Review**

1. Potential strategic risk discussed with relevant Director
2. EMT and SMT review new strategic risks prior to approval
3. Strategic risks reviewed by Executive Management Team Quarterly
4. Integrated Strategic Risk Register and Assurance Framework reported to Trust Board quarterly

**Operational Risk**

1. Trust wide risk register on Ulysses
2. Risk continuously reviewed for grading, adequacy of controls and actions, including movement to Residual Risk Register or no longer a risk

**Feedback to ward and department on status of risk**
11. IMPLEMENTATION OF STRATEGY

This strategy and related policies and procedures will be made available on the Trust intranet, and promoted though the risk management system in maternity.

12. RISK MANAGEMENT TRAINING IN MATERNITY SERVICES

The department have conducted a training needs analysis for risk management training and awareness in maternity services and details of the current requirements by staff group are contained in the Trust's Staff Training Programme and Training Needs Analysis (TNA) Matrix.

In summary all staff require

i. Trust-wide Induction on commencing in post
ii. Local induction on commencing in the post
iii. Annual update training on Risk Management, Health and Safety or by completing the annual H&S workbook.

A record of staff attendance will be held and staff will be reminded of their need to attend the above training.

All clinical midwifery staff are subject to the requirements of statutory supervision with a Supervisor of Midwives and must attend an annual supervisor of midwives review.

13. MONITORING COMPLIANCE WITH STRATEGY AND LEADERSHIP ARRANGEMENTS

The Trust will monitor compliance with the Maternity Services Risk Management Strategy and Leadership structure in the following ways:

13.1 Assurance within maternity services

The North Cumbria Maternity Risk Management Meeting will be responsible for assuring compliance with this strategy and associated policies and will undertake this by:

(i) Receiving a quarterly trend analysis report on incidents, complaints and claims arising from maternity services from all sites, and evidence of lessons learned.
(ii) Receiving minutes from site based Maternity Risk Management Meetings and the North Cumbria Peer Review meeting detailing discussions and actions taken.
(iii) Monitoring the progress of agreed action plans on incidents, complaints and claims.
(iv) Receiving reports on levels of mandatory training within the service and the actions taken to achieve standard set within the TNA.
(v) Reviewing the maternity services Risk Register.
(vi) The local Supervising authority ensures Supervisors of Midwives are up to date and practice within their remit to fulfil the functions of the LSA. The contact supervisor of midwives coordinates this.
(vii) Roles and responsibilities will be monitored through the staff appraisal system
(viii) Vacancies in any key roles will be monitored by the site based risk management meeting and escalated following risk assessment by the site based risk midwife

13.2 Assurance to the Trust Board and Stakeholders

The Trust Board and Stakeholders will receive assurance in the following ways:

- The Head of Midwifery is responsible for providing assurances on compliance with this strategy and associated policies and procedures.
- The North Cumbria Maternity Risk Management Meeting will report to the Family Services & Clinical Support Services Divisional Board via the Governance Facilitator’s report quarterly.
- The Maternity Service will escalate risks that have a strategic impact through the Divisional Board when mitigation is outside their control and/or the risk grading requires escalation as a potential strategic risk.

13.3 Assurance of the Leadership arrangements

The Board has nominated a member of the Trust Board with responsibility of maternity services. The Director of Governance and Company Secretary will alert the Chief Executive if there are any occasions when maternity matters may be discussed in the absence of the named Board Lead (e.g. due to planned absence) and the CEO will nominate an alternate to be agreed with the Trust Chairman.

The Clinical Director and the Head of Midwifery will ensure that all key posts within the maternity department remained filled. If there are a change of personnel then the Clinical Director or Head of Midwifery will ensure that appropriate acting up arrangements are in place to cover any gaps.

The contact Supervisor of Midwives will undertake an annual audit to ensure:

- The midwife to Supervisor of Midwives ratio is never more than 15:1
- All midwives have had an annual review with a supervisor of midwives
- 24 hour on call cover by Supervisors of Midwives has been achieved
- Supervisors of midwives have been represented at
  - Maternity Service Liaison Committee
  - Site Based Maternity Risk Management Meeting
  - North Cumbria Maternity Risk Management Meeting
This audit will be reported to the North Cumbria Supervisor of Midwives monthly meeting. An action plan will be agreed if any standards have not been met. Any actions that cannot be addressed locally will be escalated to the LSA.

14. REFERENCES

APPENDIX 1 – MATERNITY MANAGEMENT STRUCTURE - SEE CHANGES

SUPERVISION OF MIDWIVES

Director of Nursing & Quality

Director of Governance & Co Secretary

Medical Director

Director of Operations

Divisional General Manager

Business Manager

Governance Facilitator

Lead Obstetrician & Clinical Midwife Manager CIC Community Mgr

Site based Risk Midwife

Community Midwife Manager for Penrith

Risk Midwife for Penrith & Community

Lead Obstetrician & Clinical Midwife Manager WCH Community Mgr

Site based Risk Midwife

Clinical Director Obstetrics / Lead Co-ordinator for Risk

Associate Medical Director

Head of Midwifery

Director of Governance & Co Secretary
### APPENDIX 2 - RISK SCORING MATRIX

FOR THE FULL RISK MATRIX FOR RISK MANAGERS, GO TO WWW.NPSA.NHS.UK

<table>
<thead>
<tr>
<th>Domains</th>
<th>1 Negligible</th>
<th>2 Minor</th>
<th>3 Moderate</th>
<th>4 Major</th>
<th>5 Catastrophic</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Impact on the safety of patients, staff or public (physical/psychological harm)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Minimal injury requiring no/minimal intervention or treatment</td>
<td>• Minor injury or illness, requiring minor intervention</td>
<td>• Moderate injury requiring professional intervention</td>
<td>• Major injury leading to long-term incapacity/disability</td>
<td>• Incident leading to death</td>
<td></td>
</tr>
<tr>
<td>• No time off work</td>
<td>• Requiring time off work for &gt;3 days.</td>
<td>• Requiring time off work for 4-14 days</td>
<td>• Requiring time off work for &gt;14 days</td>
<td>• Multiple permanent injuries or irreversible health effects</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Increase in length of hospital stay by 1-3 days.</td>
<td>• Increase in length of hospital stay by 4-15 days</td>
<td>• Increase in length of hospital stay by &gt;15 days</td>
<td>• An event which impacts on a large number of patients</td>
<td></td>
</tr>
<tr>
<td><strong>Quality/Complaints/ Audit</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Peripheral element of treatment or service suboptimal</td>
<td>• Overall treatment or service suboptimal</td>
<td>• Treatment or service has significantly reduced effectiveness</td>
<td>• Non-compliance with national standards with significant risk to patients if unresolved</td>
<td>• Totally unacceptable level or quality of treatment/service</td>
<td></td>
</tr>
<tr>
<td>• Informal complaint/inquiry</td>
<td>• Formal complaint (stage 1)</td>
<td>• Formal complaint (stage 2) complaint</td>
<td>• Multiple complaints/ independent review</td>
<td>• Gross failure of patient safety if findings not acted on</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Local resolution</td>
<td>• Local resolution (with potential to go to independent review)</td>
<td>• Low performance rating</td>
<td>• Inquest/ombudsman inquiry</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Single failure to meet internal standards</td>
<td>• Repeated failure to meet internal standards</td>
<td>• Critical report</td>
<td>• Gross failure to meet national standards</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Minor implications for patient safety if unresolved</td>
<td>• Major patient safety implications if findings are not acted on</td>
<td>• Non-compliance with national standards with significant risk to patients if unresolved</td>
<td>• Multiple complaints/ independent review</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Reduced performance rating if unresolved</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Human Resources/Organisational Development/Staffing/Competence</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Short-term low staffing level that temporarily reduces service quality (&lt;1 day)</td>
<td>• Low staffing level that reduces the service quality</td>
<td>• Late delivery of key objective/service due to lack of staff</td>
<td>• Uncertain delivery of key objective/service due to lack of staff</td>
<td>• Non-delivery of key objective/service due to lack of staff</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Unsafe staffing level or competence (&gt;1 day)</td>
<td>• Unsafe staffing level or competence (&gt;5 days)</td>
<td>• Ongoing unsafe staffing levels or competence</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Low staff morale</td>
<td>• Loss of key staff</td>
<td>• Loss of several key staff</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Poor staff attendance for mandatory/key training</td>
<td>• Very low staff morale</td>
<td>• No staff attending mandatory/key training</td>
<td></td>
</tr>
<tr>
<td><strong>Statutory Duty/Inspections</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• No or minimal impact or breach of guidance/statutory duty</td>
<td>• Breach of statutory legislation</td>
<td>• Single breach in statutory duty</td>
<td>• Enforcement action</td>
<td>• Multiple breaches in statutory duty</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Reduced performance rating if unresolved</td>
<td>• Challenging external recommendations/improvement notice</td>
<td></td>
<td>• Improvement notices</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Low performance notices</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Critical report</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Maternity Services Risk Management Strategy 2011-2013 Page 38 of 58
<table>
<thead>
<tr>
<th>Adverse Publicity/Reputation</th>
<th>Business Objectives/Projects</th>
<th>Finance including Claims</th>
<th>Service/Business Interruption Environmental Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Rumours</td>
<td>• Insignificant cost increase/ schedule slippage</td>
<td>• Small loss Risk of claim remote</td>
<td>• Loss/interruption of &gt;1 hour</td>
</tr>
<tr>
<td>• Potential for public concern</td>
<td></td>
<td></td>
<td>• Minimal or no impact on the environment</td>
</tr>
<tr>
<td></td>
<td>• Local media coverage - short-term reduction in public confidence</td>
<td>• &lt;5 percent over project budget</td>
<td>• Loss/interruption of &gt;8 hours</td>
</tr>
<tr>
<td></td>
<td>• Elements of public expectation not being met</td>
<td>• Schedule slippage</td>
<td>• Minor impact on environment</td>
</tr>
<tr>
<td></td>
<td>• Local media coverage - long-term reduction in public confidence</td>
<td>• 5-10 percent over project budget</td>
<td>• Loss/interruption of &gt;1 day</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Schedule slippage</td>
<td>• Moderate impact on environment</td>
</tr>
<tr>
<td></td>
<td>• National media coverage with &lt;3 days service well below reasonable public expectation</td>
<td>• Non-compliance with national 10-25 percent over project budget</td>
<td>• Loss/interruption of &gt;1 week</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Key objectives not met</td>
<td>• Major impact on environment</td>
</tr>
<tr>
<td></td>
<td>• National media coverage with &gt;3 days service well below reasonable public expectation MP concerned (questions in the House)</td>
<td>• Key objectives not met</td>
<td>• Permanent loss of service or facility</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Total loss of public confidence</td>
</tr>
<tr>
<td></td>
<td>• Total loss of public confidence</td>
<td></td>
<td>• Catastrophic impact on environment</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- 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
- Insignificant cost increase/ schedule slippage
- <5 percent over project budget
- Schedule slippage
- 5-10 percent over project budget
- Schedule slippage
- Non-compliance with national 10-25 percent over project budget
- Schedule slippage
- Key objectives not met
- Incident leading >25 percent over project budget
- Schedule slippage
- Key objectives not met
- Small loss Risk of claim remote
- Loss of 0.1-0.25 percent of budget
- Claim less than £10,000
- Loss of 0.25-0.5 percent of budget
- Claim(s) between £10,000 and £100,000
- Loss of 0.5-1.0 percent of budget
- Claim(s) between £100,000 and £1million
- Uncertain delivery of key objective/Loss of >1 percent of budget
- Claim(s) >£1million
- Failure to meet specification/ slippage
- Loss of contract/payment by results
- Non-delivery of key objective/Loss of >1 percent of budget
- Claim(s) >£1million
- Permanent loss of service or facility
- Catastrophic impact on environment
- 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.

<table>
<thead>
<tr>
<th>Likelihood score</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Descriptor</td>
<td>Rare</td>
<td>Unlikely</td>
<td>Possible</td>
<td>Likely</td>
<td>Almost certain</td>
</tr>
<tr>
<td>Frequency</td>
<td>This will probably never happen/recur</td>
<td>Do not expect it to happen/recur but it is possible it may do so</td>
<td>Might happen or recur occasionally</td>
<td>Will probably happen/recur but it is not a persisting issue</td>
<td>Will undoubtedly happen/recur, possibly frequently</td>
</tr>
</tbody>
</table>

Note: the above table can be tailored to meet the needs of the individual organisation.

Some organisations may want to use probability for scoring likelihood, especially for specific areas of risk which are time limited. For a detailed discussion about frequency and probability see the guidance notes.

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

<table>
<thead>
<tr>
<th>Likelihood score</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Likelihood</td>
<td>Rare</td>
<td>Unlikely</td>
<td>Possible</td>
<td>Likely</td>
<td>Almost certain</td>
</tr>
<tr>
<td>5 Catastrophic</td>
<td>5</td>
<td>10</td>
<td>15</td>
<td>20</td>
<td>25</td>
</tr>
<tr>
<td>4 Major</td>
<td>4</td>
<td>8</td>
<td>12</td>
<td>16</td>
<td>20</td>
</tr>
<tr>
<td>3 Moderate</td>
<td>3</td>
<td>6</td>
<td>9</td>
<td>12</td>
<td>15</td>
</tr>
<tr>
<td>2 Minor</td>
<td>2</td>
<td>4</td>
<td>6</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>1 Negligible</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Note: the above table can be adapted to meet the needs of the individual trust.

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. Define the risk(s) explicitly in terms of the adverse consequence(s) that might arise from the risk.

2. Use table 1 (page 13) to determine the consequence score(s) (C) for the potential adverse outcome(s) relevant to the risk being evaluated.

3. Use table 2 (above) 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.

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

5. Identify the level at which the risk will be managed in the organisation, assign priorities for remedial action, and determine whether risks are to be accepted on the basis of the colour bandings and risk ratings, and the organisation’s risk management system. Include the risk in the organisation risk register at the appropriate level.
## Core Risk Team (Site Based) Terms of Reference (Ref A)

### 1. Accountability
The Core Risk Teams are site based with the accountability for the day to day management and escalation of risk within maternity services.

The Core Risk Team is ultimately accountable to the Medical Director and Director of Nursing and Quality.

### 2. Purpose
The Purpose of the Core Risk Team is to ensure each site has daily systems of escalation in place with a formal weekly review of all incidents.

### 3. Membership
- Lead Obstetrician (or lead Consultant)
- Lead Risk Midwife
- Clinical Midwife Manager

Quorum – any two members of the group.

### 4. Connectivity
The Core Risk Group reports weekly to the Governance Delivery Group and monthly to the site based maternity risk management meeting.

### 5. Frequency of Meetings
Weekly or daily if required.

### 6. Duties and Responsibilities
- Review immediate patient safety incidents and ensure immediate controls and escalation is in place for the management of individual cases.
- Ensure incidents are reported, reviewed and graded correctly on Ulysses.
- Escalate and provide a summary of incidents to be reported to the Governance Delivery Group.
7. OTHER MATTERS

If the Lead Obstetrician is not available the representative consultant will form part of the Core Risk Group.

| ISSUE DATE | January 2012 |
| REVIEW DATE | January 2013 |

- Immediate escalation of SUIs as per appendix 5.
- Co-ordinate the report for the site based maternity risk management meetings and the north Cumbria maternity risk meeting.
## 1. ACCOUNTABILITY

This group reports to the monthly site based maternity risk management meeting on any lessons learned or changes in practice/guidelines.

## 2. PURPOSE

To ensure multi-disciplinary review of cases and incidents.

## 3. MEMBERSHIP

- Lead Obstetrician
- Risk Midwife
- Clinical Midwife Manager
- Midwives
- Consultants and other medical staff

Quorum: one obstetrician and one senior midwife.

## 4. CONNECTIVITY

Links closely to the site base Core Risk Team.

## 5. FREQUENCY OF MEETINGS

Weekly.

## 6. DUTIES AND RESPONSIBILITIES

- Review incidents and specific cases.
- Identify opportunities for learning lessons.
- Identify and inform educational and audit needs.

## 7. OTHER MATTERS

ISSUE DATE January 2012
1. **ACCOUNTABILITY**

The committee will report to the North Cumbria Maternity Risk Management meeting.

2. **PURPOSE**

- Co-ordinate the key site based risk management issues on a monthly basis and feedback to maternity staff.

3. **MEMBERSHIP**

<table>
<thead>
<tr>
<th>Chair</th>
<th>Lead Obstetrician</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vice Chair</td>
<td>Clinical Risk Midwife</td>
</tr>
</tbody>
</table>

On each site CIC and WCH:

Lead Obstetrician  
Clinical Risk Midwife  
Clinical Midwife Manager  
Consultant Obstetricians  
Open to all maternity staff, medical and midwifery, and the multi-disciplinary team e.g. paediatrician, anaesthetist

Quorum: Obstetrician and Senior Midwife

4. **CONNECTIVITY**

The site based Core Risk Team will use the information provided to the Site Based Maternity Risk Group to inform the report to the North Cumbria Maternity Risk Management meeting.

5. **FREQUENCY OF MEETINGS**

Monthly.
6. DUTIES AND RESPONSIBILITIES

- Consider the site based trend analysis report.
- Provide feedback to maternity staff on the key site based risk management issues.
- Provide regular monitoring and review of risk management issues.

7. OTHER MATTERS

<table>
<thead>
<tr>
<th>ISSUE DATE</th>
<th>January 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>REVIEW DATE</td>
<td>January 2013</td>
</tr>
</tbody>
</table>
1. ACCOUNTABILITY

The North Cumbria Maternity Risk Management Meeting is accountable to the Family and Clinical Support Services Divisional Board for the management of risk within the maternity service.

2. PURPOSE

Review all risk management issues and incidents across North Cumbria to ensure consistency of clinical practice and standards of maternity care to patients.

3. MEMBERSHIP

<table>
<thead>
<tr>
<th>Chair</th>
<th>Clinical Director</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vice Chair</td>
<td>Head of Midwifery</td>
</tr>
<tr>
<td>Lead Obstetricians CIC and WCH</td>
<td></td>
</tr>
<tr>
<td>Obstetricians from each site</td>
<td></td>
</tr>
<tr>
<td>Clinical Midwife Manager, CIC &amp; WCH</td>
<td></td>
</tr>
<tr>
<td>Community Midwife Manager</td>
<td></td>
</tr>
<tr>
<td>Clinical Risk Coordinator</td>
<td></td>
</tr>
<tr>
<td>Risk Midwives, CIC / WCH &amp; Community</td>
<td></td>
</tr>
<tr>
<td>Members of Maternity Team</td>
<td></td>
</tr>
<tr>
<td>Other appropriate Health Care professionals, e.g. Paediatricians, Anaesthetists or deputies as appropriate</td>
<td></td>
</tr>
<tr>
<td>Quorum: obstetrician and senior midwife from each site.</td>
<td></td>
</tr>
</tbody>
</table>

4. CONNECTIVITY

The meeting will inform the Family and Clinical Support Services Divisional Board of the key risk management issues within the maternity service.

5. FREQUENCY OF MEETINGS

Bi-monthly
6. DUTIES AND RESPONSIBILITIES

To have bi-monthly meetings to:

- Respond to and advise on issues reported in the site based risk management reports and where appropriate recommend actions with timescales for reporting back.
- Receive, consider and compare the site based trend analysis reports (incorporating Penrith Hospital within the CIC report).
- Receive the annual audit of staffing levels for midwives, obstetricians, anaesthetists and theatre staff.
- Recommend changes in practice in response to audit, incidents complaint and claims investigations.
- Recommend changes in practice in response to RCOG guidelines, CEMACH national office confidential enquires / reports and NICE guidelines.
- Review the maternity Risk Register and recommend risk assessments where appropriate.
- Make recommendations to the site based Maternity Risk Management Groups.
- Make quarterly reports to the Family and Clinical Support Services Divisional Board.
- Ensure compliance with the requirements of the Clinical Negligence Scheme for Trusts Maternity Clinical Risk Management Standards.
<table>
<thead>
<tr>
<th>OTHER MATTERS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>REVIEW DATE</td>
<td></td>
</tr>
<tr>
<td></td>
<td>January 2012</td>
</tr>
<tr>
<td></td>
<td>January 2013</td>
</tr>
</tbody>
</table>
1. **ACCOUNTABILITY**

The O&G Directorate meetings are accountable to the Family Services and Clinical Support Divisional Board.

2. **PURPOSE**

To ensure the effective operational management of the directorate of Obstetrics and Gynaecology.

3. **MEMBERSHIP**

<table>
<thead>
<tr>
<th>Chair</th>
<th>Clinical Director</th>
</tr>
</thead>
<tbody>
<tr>
<td>Management Lead</td>
<td>Business Manager</td>
</tr>
<tr>
<td>Head of Midwifery</td>
<td></td>
</tr>
<tr>
<td>Consultant Obstetricians / Gynaecologists</td>
<td></td>
</tr>
<tr>
<td>Matrons / Sister from Gynaecology</td>
<td></td>
</tr>
<tr>
<td>Clinical Midwife Managers</td>
<td></td>
</tr>
<tr>
<td>Supervisor of Midwives representative</td>
<td></td>
</tr>
<tr>
<td>Community Midwifery Manager</td>
<td></td>
</tr>
<tr>
<td>Clinical Risk Coordinator</td>
<td></td>
</tr>
<tr>
<td>Finance Representative</td>
<td></td>
</tr>
<tr>
<td>Human Resources Representative</td>
<td></td>
</tr>
<tr>
<td>Governance Representative</td>
<td></td>
</tr>
</tbody>
</table>

Quorum: one obstetrician and one senior midwife from each site.

4. **CONNECTIVITY**

The minutes will be accessible to everyone in the department. The directorate meeting will escalate key issues to the Divisional Board.

5. **FREQUENCY OF MEETINGS**

Monthly via videoconferencing
The CD is responsible for the agenda, minutes and action list which will be circulated by email by the departmental secretary before the next meeting.
6. DUTIES AND RESPONSIBILITIES

- To provide management and leadership for the department of Obstetrics and Gynaecology.
- The members of the Directorate Meeting are collectively responsible for the implementation of strategy on behalf of the division.
- The committee should manage, monitor and evaluate the department’s performance and progress. This will include maintaining financial control and monitoring HR and KPI.
- Performance manage the statutory and mandatory training in the department.
- Facilitate clinical and corporate governance and risk management by support for and actions generated by the departmental risk systems in obstetrics and gynaecology.
- To monitor the progress against CNST standards.
- To support the implementation of action plans developed from clinical audits undertaken in the department.

7. OTHER MATTERS

Members of the departmental meeting are responsible for ensuring approved decisions are applied and effective in their respective areas of responsibility and staffs are informed of important developments as appropriate.

<table>
<thead>
<tr>
<th>ISSUE DATE</th>
<th>January 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>REVIEW DATE</td>
<td>January 2013</td>
</tr>
</tbody>
</table>
1. **ACCOUNTABILITY**

   The committee will report to the site based core team on lessons learned or changes in practice/guideline.

2. **PURPOSE**

   To provide cross site peer review of cases.

3. **MEMBERSHIP**

<table>
<thead>
<tr>
<th>Chair</th>
<th>Clinical Director</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vice Chair</td>
<td>Lead Obstetricians CIC and WCH</td>
</tr>
<tr>
<td>Consultant Obstetricians from each site</td>
<td></td>
</tr>
<tr>
<td>Clinical Midwife Managers from both sites</td>
<td></td>
</tr>
<tr>
<td>Community Midwife Managers</td>
<td></td>
</tr>
<tr>
<td>Clinical Risk Coordinator</td>
<td></td>
</tr>
<tr>
<td>Risk Midwives</td>
<td></td>
</tr>
<tr>
<td>Head of Midwifery</td>
<td></td>
</tr>
<tr>
<td>Supervisor of Midwives</td>
<td></td>
</tr>
<tr>
<td>Governance Facilitator</td>
<td></td>
</tr>
<tr>
<td>Family Services</td>
<td></td>
</tr>
</tbody>
</table>

4. **CONNECTIVITY**

   The group will inform the site based core team.

5. **FREQUENCY OF MEETINGS**

   Bi Monthly

6. **DUTIES AND RESPONSIBILITIES**

   - Peer Group Review on cases from each site.
   - Determine further actions required.
   - Identify lessons to be learned and how to disseminate.

7. **OTHER MATTERS**
The outputs from the peer review will also inform future education and audit priorities.

<table>
<thead>
<tr>
<th>ISSUE DATE</th>
<th>January 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>REVIEW DATE</td>
<td>July 2012</td>
</tr>
</tbody>
</table>
APPENDIX 4 - TRIGGER LIST FOR INCIDENT REPORTING MATERNITY SERVICES

Trigger list - for incident reporting - reported though on-line Ulysses reporting. Please report ANY incident you think appropriate. All parts of the form need to be completed. Information needs to be clear, factual and not your opinion.

<table>
<thead>
<tr>
<th>MATERNAL INCIDENTS</th>
<th>FETAL / NEONATAL INCIDENTS</th>
<th>ORGANISATIONAL INCIDENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Anaesthetic complications</td>
<td>• Undiagnosed fetal anomaly</td>
<td>• Medication errors</td>
</tr>
<tr>
<td>• Delay in grade 1 c/s &gt; 30 minutes</td>
<td>• Misinterpretation of A/N screening tests</td>
<td>• Equipment failure – Batch numbers and / or equipment to be kept for reference / further investigation</td>
</tr>
<tr>
<td>• Delay in grade 2 &gt; 60 mins</td>
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<tr>
<td>• Eclampsia / convulsions</td>
<td>• Stillbirth</td>
<td>• Unavailability of health records</td>
</tr>
<tr>
<td>• Laparotomy /hysterectomy</td>
<td>• Neonatal death</td>
<td>• Unavailability of equipment</td>
</tr>
<tr>
<td>• Return to theatre</td>
<td>• Term baby admitted to SCBU</td>
<td>• Retained swab or instrument</td>
</tr>
<tr>
<td>• C/s after attempted instrumental delivery</td>
<td>• Birth trauma</td>
<td>• Delay in responding to a call for assistance</td>
</tr>
<tr>
<td>• PPH - Hb &lt; 8 mgs or a blood transfusion of 4 units or more.</td>
<td>• Neonatal seizures</td>
<td>• Staffing levels</td>
</tr>
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<td></td>
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<tr>
<td>• ITU admissions / Maternal Death</td>
<td>• Apgar &lt;7 @ 5 mins</td>
<td>• Assaults / Verbal aggression towards staff</td>
</tr>
<tr>
<td>• Third and fourth degree tears</td>
<td>• Cord PH &lt; 7.05 Arterial &lt; 7.10 Venous</td>
<td>• Hospital acquired infection</td>
</tr>
<tr>
<td>• Shoulder dystocia / Difficulty with shoulders Complete a “shoulder dystocia” form and file in patients notes</td>
<td>• Fetal laceration @ C/S</td>
<td>• Unplanned home birth /BBA</td>
</tr>
<tr>
<td>• Undiagnosed breech in labour</td>
<td>• Readmission of baby</td>
<td>• Clerical errors e.g. misfiling</td>
</tr>
<tr>
<td>• Pulmonary embolism</td>
<td></td>
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<tr>
<td>• Venous thromboembolism</td>
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<tr>
<td>• Uterine rupture</td>
<td></td>
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<tr>
<td>• Readmission of mother</td>
<td></td>
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<tr>
<td>• Significant infections</td>
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<tr>
<td>• Cord prolapse</td>
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<tr>
<td>• Trauma to bladder</td>
<td></td>
<td></td>
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<tr>
<td>• Undiagnosed S.G.A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Misinterpretation of a CTG</td>
<td></td>
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</tr>
</tbody>
</table>

INCIDENTS WILL BE ESCALATED ACCORDING TO THE LEVELS OUTLINED IN THE MATERNITY RISK MANAGEMENT STRATEGY:

LEVEL ONE – GENERAL INCIDENTS
LEVEL TWO – HIGH LEVEL INCIDENTS
LEVEL THREE – SERIOUS UNTOWARD INCIDENTS
APPENDIX 5 - FLOW CHART FOR POTENTIAL SERIOUS UNTOWARD INCIDENTS (SUI'S) IN MATERNITY SERVICES

Easily identifiable SUI

Urgent case review by:
- Core Risk Team and
- Consultant Obstetrician involved in case
- Head of Midwifery

cc. into documentation:
- Clinical Director – Obstetrics
- Governance Facilitator
- Produce summary of the key points

Case review documented &
Initial timeline established

Governance Scrutiny Group
Review outputs from case review and initial timeline.

Case meets SUI Criteria
- SUI NO
- SUI YES

Case referred back Core Risk Team to be considered as level 1 or 2.

SUI to be declared by Chief Executive
Governance Facilitator will co-ordinate the Trust investigation process

Governance Facilitator alerted ASAP
MD, DoN, DoG informed ASAP
APPENDIX 6 – TRUST COMMITTEE STRUCTURE 2010/2011

Trust Board

Audit Committee
Remuneration Committee
Charitable Funds Committee

Governance & Quality Committee

See Supporting Structure

Finance, Performance and Workforce Committee
Senior Management Team
New Hospital Project Board

STATUTORY GOVERNANCE, RISK & QUALITY STRATEGY AND OPERATIONAL DELIVERY
North Cumbria University Hospitals NHS Trust
Governance, Risk Management & Quality Strategy
Publication Date: Draft Version 0.10

GOVERNANCE AND QUALITY COMMITTEE
SUPPORTING COMMITTEES/GROUPS

Divisions

Governance & Quality Committee

Health and Safety Committee

Safeguarding Board

Information Governance Steering Group

Trust Policy Group

Clinical Standards Sub Committee

Education, Training and Research Committee

Healthcare Records Committee

Emergency Planning Committee

Infection, Prevention and Control Committee

Drugs and Therapeutics Committee