Mid Essex Hospital Services NHS
NHS Trust

MATERNITY RISK MANAGEMENT STRATEGY 2012-15	CORPORATE/STRATEGIC Registration No: 05098 Status: Public

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1.0	Anne Smith	September 2006
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5.1	Sarah Moon – clarification to sections 18.0, 19.0 and 20.0	January 2013

It is the staff responsibility to ensure that they are accessing the most up to date version of this document which will always be the version on the intranet.

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1.0 Purpose of the Strategy

1.1 The purpose of this strategy is to outline how the Maternity Service aims to manage clinical and non-clinical risks to contribute to the Trusts overall governance and risk strategy. It is a framework document based upon the principles set out in the Trust's overarching Risk Management Strategy + Policy 2011 (Register No. 04061) and the Serious Incident Policy (Register No. 04060). The strategy will be implemented to ensure it complies with the objectives set within the document and any other external regulatory and accreditation processes.

1.2 The document also sets out the principles and strategic direction of the management of risk through out the 3 maternity units and community environments within the Maternity Service.

1.3 It reflects the commitment by the maternity service to improve the quality of care provided by taking proactive and positive actions to mitigate, reduce and manage the risks identified.

1.4 This strategy is for the use of all staff within the maternity services.

2.0 Statement of Intent

2.1 The Maternity Service at Mid Essex Hospital is committed to embedding the Organisational Objectives within its governance agenda and delivering a high quality, safe and patient-centred service which will improve outcomes and ensure the best possible use of public resources.

2.2 The service will provide a Risk Management programme, which is designed to make a positive contribution towards improving the quality of patient care and the safety of its staff, patients and visitors. I

2.3 This strategy will outline the arrangements by which risks of all kinds will be managed within Maternity Services and how this aligns with the Trust Risk Management Framework. It represents a holistic approach to the Management of Risk (clinical, financial, business, environmental and organisational = integrated) and will ensure that integrated risk management is addressed in a systematic way, ensuring minimising loss of resources and protecting the reputation of the Maternity Service

2.4 The Trust's Risk Management Strategy and Policy will inform the Maternity Services Risk Management Strategy to ensure it complies with the overarching process for the Trust Management of Risks and communicates in an appropriate and timely way through the key duties assigned to individuals and through the lines of reporting to Board level.

2.5 The roles and responsibilities of staff and committees and the framework for the management of risks and incidents, dissemination of learning and escalation to the Trust Board will be outlined in this strategy.

3.0 Philosophy

3.1 The Maternity Service is committed to the principles of clinical governance to ensure safe, high quality and effective care within an environment which promotes the well being and satisfaction of women, their babies and families, staff and the public.

3.2 The Maternity Service will constantly reflect on how it works and embed a culture of continuous improvement to safeguard high standards of care.

3.3 The Maternity Service will promote and embed the following:

- Quality and safety as central to the Maternity Service that aligns with the Trust's overarching organisational strategy and integrated learning agenda

- An open, fair blame culture that encourages all staff to report all risks, hazards, near misses and risk events without the fear of recrimination

- The use of **root cause analysis (RCA)** when investigating incidents and complaints that does not to single out an individual for blame, but to look at the context in which the incident occurred.

- The Maternity Service will ensure that when required appropriate unbiased external input will be sought and used with the investigation process, this will either be in the form of external experts on the panel review team or an external investigating officer will be appointed

- Encourage all service users and their relatives to report concerns and risk related issues to healthcare professionals or the PALs/Complaints department.

- Excellence in clinical practice by ensuring processes for managing risk reduce and minimise poor outcomes and adverse events

- That Risk Management processes are supported by the Local Supervising Authority (LSA) statutory framework for supervision of midwives

- To monitor and manage financial and business risks within the Maternity Service

- To develop benchmarked objectives that link to the Trust strategic objectives and to the key performance indicators for quality improvements

- Where issues are identified that require stronger control measures and escalation they will be added to the Directorate Risk Assurance Framework Register.

- Provide evidence that the Maternity Service has carried out risk assessments, has controls in place and recommendations for improvements for the following external bodies; Care Quality Commission (as required), Clinical Negligence Scheme for Trusts (CNST,) Health and Safety Executive, Clinical Commissioning Groups (CCG), NHS Trust Development Authority for Midlands and East and the East of England Local Supervisor Authority (LSA)

- To escalate to the Board via established communication channels when the Maternity Service is unable to resource high priority risk action plans

- The Maternity Service will annually review the Risk Management Strategy to ensure it continues to reflect the objectives of the Trust Risk Management Strategy and Policy.

4.0 Targets 2012-2014

4.1 The Maternity Service has agreed the following performance outcomes with a 3 year plan for achievement:

- The identification and analysis of trends and themes and mitigation of identified, actual and potential risks
- Regular audit, which becomes part of everyday culture and focuses on improvements
- The communication of lessons learned from incidents, complaints and claim reports that continue to inform and contribute to improvement in the quality of care (Refer to Learning from Incidences, complaints and claims in maternity Register No. 12021)
- Develop and embed a procedural framework which ensure the effective management of all risks within Maternity Services
- National confidential enquiries and government reports relevant to Maternity Services are reviewed and an action plan formulated within 6 months of publishing, non-compliance will trigger inclusion on Risk Assurance Framework Register
- The competencies set out in the Training Needs Analysis for Maternity Services are fit for purpose for all staff that cares for women and newborns
- Monitor morbidity, mortality and other significant service quality key performance indicators (KPI) using the Maternity Dashboard, this will be monitored at the monthly Directorate Clinical Governance Meetings and reported on at the Patient Safety and Quality Committee at least annually
- Ensure that reports reflecting the patient experience, ie Net Promoter Score, Women's Survey and compliant responses are reviewed as part of the Risk Management process
- Achieve Clinical Negligence Schemes for Trusts (CNST) Level 2 February 2013
- All guidelines will be reviewed on a 3 yearly cycle or more frequently where indicated by local or national recommendations. This will include feedback through the systematic review of incidents, complaints and claims

5.0 Measurable Objectives

5.1 Specific measurable objectives for 2012-2014 are set out below. These objectives will be reviewed annually and progress reported at least quarterly via the Directorate Governance Reports;

- An increase in DATIX reporting
- Increased staff awareness of the process for managing clinical and non-clinical risks
- Identified staff learning from Serious Incidents through established communication mechanisms
- Increased attendance from all grades of staff at Risk Meetings and Directorate Governance Meetings
- The sharing of the Integrated Learning Report at Directorate Governance Meetings
- Discussion at Manager's Meetings and dissemination at ward level of themes and trends of incidents and serious incidents and learning from recommendations
- Year on improvements in outcomes for women and babies identified through the Maternity Dashboard and CQUIN targets, overall reduction in morbidity and mortality
- Improvements in actual numbers of health and safety incidents through attendance at Mandatory training updates and e-learning
- Achievement of >85% at Mandatory Training for all grades of staff within Maternity Services and the achievement of multidisciplinary skills and drills training

6.0 Current Objectives

6.1 The strategic objectives will ensure the provision of safe and effective maternity care by identification of risks that may adversely affect the service, while seeking to minimise or prevent occurrence.

6.2 All managerial staff have the skills to undertake a risk assessment and are able to grade a risk, identify control measures and the actions required to mitigate

6.3 Reduce the severity and harm occurring to women and their baby's as a result of incidents by 2 % in the next 3 years, this includes all incidents involving morbidity, mortality and patient experience events (complaints)

6.4 To investigate any 'Never Events' that occur within Maternity Services, to prevent re currence by implementing immediate actions to mitigate harm and ensure learning

6.5 All Serious Incident (SI) investigations are completed and signed off by the Trust Serious Incident Management Group (SIMG) within the 45 day timescale for submission to the PCT

6.6 To ensure there are sufficient competent assessors to cover all areas for risk relevant to the Maternity Service including: Clinical, COSHH (control of substance hazardous to health), DSE (Display screen equipment), H+S (Health and safety including manual handling), Infection Prevention

6.7 The Maternity Service will produce suitable and sufficient risk mitigation plans for all extreme/high level risks and where appropriate a business case will be developed.

6.8 The multidisciplinary audit programme will meet local and national requirements, including risk issues highlighted through incidents, complaints, legal claims and patient surveys

6.9 The implementation of action plans arising from incidents, complaints, claims, alerts and audits are monitored through the Risk Management Group, Directorate Governance Meeting and Ward meetings

6.10 To ensure that staff are aware of their responsibility to contribute to the identification and assessment of risks and to take positive action to manage them appropriately

6.11 To provide a supportive environment with effective communication systems to ensure learning of lessons identified from incidents, complaints and claims

6.12 Provide training for all staff to become competent in managing risks inherent in their daily work: on local induction and annually thereafter at mandatory training to ensure that medical, midwifery and allied professionals have maintained agreed levels of competencies as outlined in the Maternity Training Needs Analysis (Register No.)

6.13 To facilitate best practice that is evidence based, benchmarked and incorporates recommendations of:

- National Institute of Excellence (NICE)
- Centre for Maternal and Child Enquiries (CMACE)
- Royal College of Midwives (RCM)

- Royal College of Obstetricians & Gynaecologists (RCOG)
- Nursing and Midwifery Council (NMC)
- NHS Litigation Agency (NHSLA) and Clinical Negligence Schemes for Trusts (CNST)
- Kings Fund
- Maternity Matters
- Equity and Excellence in the NHS: Liberating the NHS
- NHS Outcomes Framework
- NHS Operating Framework
- National Service Framework for Children, Young People and Maternity Service (DH)

6.14 To promote a proactive approach to statutory supervision of midwives and ensure by 2014 that there is a yearly review of the Local Supervising Midwifery Officers' annual audit and a local action plan is developed in a response to this, which is discussed and monitored at the monthly supervisory and Multidisciplinary Risk Management Meetings.

6.15 Maternity Trigger Lists will be available in each clinical area; all incidents are reported electronically via DATIX and are logged on a central system.
(Refer to Serious Incident Requiring Investigation Policy; register number 11025)

7.0 Communication

7.1 The effective implementation of this strategy is supported by a communication strategy for all staff, this includes:

- Copy of strategy available on Trust Intranet: accessible to all staff
- Strategy circulated to all staff via email
- All policies and guidelines available on Trust Intranet
- Strategy discussed at Manager Meetings and disseminated at ward meetings, via Midwifery Managers
- Education and training available via e learning, Trust Learning and Development programmes and Maternity Mandatory Training
- Provision of expert accessible advice in risk issues
- Recommendations and outcomes publicised in the Maternity Newsletter
- Distribution via risk notice board and Hot Topic to disseminate learning
- Copies of the maternity Risk Management Strategy will be available in clinical areas throughout the service in the risk management and guideline information folders
- All new staff, midwifery and obstetric will meet with the Risk Management Midwife during their induction programme and receive risk management information

8.0 Training and Development

8.1 The Practice Development Midwife and the Trust Lead for Professional Development have joint responsibility for the regular review of mandatory training within Maternity Services. They will ensure 100% of staff are allocated to, and at least 85% of all midwives, doctors and support staff attend Mandatory Training on an annual basis
(Refer to Maternity Services Mandatory Training Policy; register number 09062)

8.2 The Training Needs Analysis supports the competencies required of the Mandatory Training Days, the TNA is reviewed at least annually.

8.3 Appropriate training programmes for all staff to become competent in managing risks inherent in their daily work will be identified through the TNA. This will include:

- The risk event triggers and near misses
- Health and safety triggers
- Incidents, serious incidents and near misses
- Themes and trends from incidents
- Information on how to complete a risk event form via DATIX web reporting
- The responsibility of sharing learning at ward level of incidents and ongoing mitigation
- The process for analysis of the risk event reports and managers reports
- Root cause analysis methodology for investigating complaints, incidents and serious incidents
- The fair blame culture and transparency of reporting that is required for learning to occur and risks to be reduced

8.4 The training of staff will have a positive contribution towards improving the quality of patient care and the safety of its staff, patients and visitors.

8.5 All senior staff will be given the opportunity to undertake training in Root Cause Analysis and incident and complaint investigations, this will be dependant on level of experience and current role within the service.

- All new staff to the service will attend a Trust Wide induction programme on the day of starting employment which includes training in Risk and Safety Management
- All new staff within the service both qualified and support staff will have a period of, induction of no less than 2 weeks, this includes medical devices training
- All new staff will receive written orientation packs which includes Risk Management information
- All new staff to the service within their orientation meet with the Risk Management Midwife and when possible the Head of Midwifery to discuss governance and risk management processes
- All newly qualified midwives receive a written programme of preceptor ship for the first 6 months of employment
- All staff have an annual appraisal whereby training and updating in risk management process is discussed and facilitated
- All staff will be allocated to annual mandatory training
- Medical staff receive Corporate and local Induction, including consent trainings and Risk Management

8.6 Staff attendance at Mandatory Training will be recorded and monitored by the Practice Development Midwife; this will be reported to the Head of Midwifery/Nursing and Lead for Professional Development within the Trust and recorded on the trust wide training database for all staff.
(Refer to Guideline Maternity Services Mandatory Training Policy; register number 09062)

8.7 All relevant staff will receive training in the use of diagnostic and therapeutic equipment. Staff will complete an assessment equipment competency tool to identify learning requirements for safe use of equipment

8.8 Monthly training sessions will be available to facilitate training in the handling of equipment following standard operating procedures at point of care testing. A central log will be maintained for all staff competencies related to the use of equipment within the Maternity Service.

9.0 Maternity Services Risk Management Structure

9.1 The management of risk forms part of the Trust's overall approach to Integrated Governance.
(Refer to Appendix G)

9.2 The Whistle Blowing Policy will be used for those situations where staff have concerns about standards that may not be addressed through normal channels.

10.0 Terms of Reference

10.1 The Terms of Reference for Maternity Services Groups
(Refer to Appendices I and M)

10.2 The maternity service has or liaises with committees/groups and forums with a responsibility for risk management: (Refer to Appendices H, I and M)

Maternity Services Groups and Forums

- Directorate Clinical Governance Meeting
- Multidisciplinary Risk Management Group (MRMG) - maternity services
- Labour Ward Forum
- Perinatal Multidisciplinary and Audit Meeting
- Maternity Service Liaison Committee (MSLC)
- Patient Council
- Supervision of Midwives Team
- Multidisciplinary Risk Management Group
- Directorate Governance Meetings
- Perinatal Mortality Paediatric and Obstetric Audit Meeting
- Labour Ward Forum
- Clinical Practice Group Meetings

10.3 In addition, there are committees/groups within the Trust which have a level of responsibility for risk management within maternity which is not their primary function.
(Refer to Trust Risk Management Strategy; register number 04061)

11.0 Directorate Governance Meetings

11.1 This is a Directorate-wide meeting whereby Maternity Services review and monitor their risks as part of a wider governance agenda. The following will be discussed monthly:

- Directorate Governance Report
- Quarterly Integrated Learning Report (quarterly)
- Incidents, complaints and claims
- RAF Register (bi-monthly)
- Non-compliance with national recommendations e.g. NICE, CMACE (bi-monthly)
- Practice issues and changes required from learning and guidance
- Serious Incidents
- Health and Safety alerts and issues
- Risk assessments
- Educational and clinical updates
- MCADD alerts

- Rapid response alerts

11.2 This meeting provides the forum for discussion of local Risk Management issues

11.3 The Head of Midwifery/Nursing, Clinical Director and the Risk Management Midwife will ensure the agenda reflects the priorities of the Maternity Service

11.4 The minutes will be distributed to staff within the Maternity Service and the Chief Executive, Executive Lead, Clinical Director, Head of Governance, Chief Nurse

11.5 A summary of key points raised will also be made available to all staff via the Head of Midwifery/Nursing Staff Updates Memo, where they have not been addressed via the Hot Topic updates.

11.6 Escalation to the board of issues raised at this meeting will occur via the following mechanisms**:**

- Head of Midwifery/Nursing direct line reporting to the Executive Lead, Chief Nurse and CEO
- Patient Safety and Quality Committee
- Via Head of Governance meetings with Head of Midwifery/Nursing
- Via daily Serious Incident Management Group Meetings (SIMG)

12.0 Maternity Risk Management Group

12.1 It is the key service group in relation to local Risk Management issues; it also reviews the RAF Register and supports the implementation of actions identified.

12.2 This group provides a forum for a multidisciplinary approach to incidents, complaints and risk assessments, findings are discussed and service-wide learning occurs through Risk Management newsletter

12.3 This group is accountable to the Directorate Clinical Governance Meeting and feeds into the Trust Patient Safety Group via the Risk Management Midwife.

12.4 It meets monthly to review Level 1 Incidents and practice issues which occur locally, that have either resulted in a near miss, poor outcomes or had the potential for litigation or complaint.

12.5 The group will analyse moderate to severe trends following investigation of a Serious Incident to identify concerns and implement remedial action, these will be communicated to the Head of Midwifery/Nursing who will escalate appropriately to the Chief Nurse, Executive Lead or CEO.

12.6 The Chair will notify the Head of Midwifery/Nursing to update the Directorate RAF Register.

13.0 Labour Ward Forum

13.1 Meets monthly and has multidisciplinary attendance from across the Maternity Service. It will ensure the implementation of findings from incident investigations related specifically to the Labour Ward, Obstetric Theatres and acute antenatal inpatients.

14.0 Other relevant forums for the dissemination for Risk Management

- Consultant Meetings weekly
- Community MW Meetings
- Ward Meetings
- Managers Meetings
- Band 7 Meetings
- Mandatory Training
- MSLC
- SoM Meeting

15.0 Risk Management Organisation, Accountabilities, Roles + Responsibilities

(Refer to Trust Risk Management Strategy and Policy; register number 04061)

15.1 The nominated professional leads with responsibility for overseeing Risk Management for the Maternity Service are the **Clinical Director and the Head of Midwifery/Nursing for Women's and Children's Services. This responsibility is designated by the Chief Nurse and Medical Director**

16.0 The Chief Nurse

16.1 The Executive Director of Nursing (**Chief Nurse)** is the 'Designated Lead' for Maternity Services and represents Maternity Services at Board Level. The Chief Nurse obtains assurance from the Maternity Service on risk issues through:

- The daily Serious Incident Management Group (SIMG) with the Head of Governance, Heads of Nursing and Midwifery or nominated deputy
- One to one meetings monthly with the Head of Midwifery/Nursing to discuss and resolve risk issues that have not been addressed via SIMG or require longer term resolution
- Where risk issues remain unresolved they will be escalated to the Executive Team via the Executive Lead and/or the Chief Nurse
- Weekly Heads of Nursing/Midwifery meetings where Maternity risks and complaints are monitored
- Monthly Directorate Governance Report
- Quarterly Integrated Learning Report
- As a key member of the Patient Safety and Quality committee
- Escalation through the Chief Medical Officer where risks are identified related to medical professionals involved in clinical incidents, complaints and claims that cannot be resolved locally by the Clinical Director

17.0 Leadership Arrangements for Risk within Maternity Services

17.1 **Clinical Director for Women's and Children's Services -** The Clinical Director is jointly accountable for managing the integrated risk agenda and governance within the Directorate. The role sits within the triumvirate of Senior Management responsibility with the Head of Midwifery /Nursing and Executive Lead for Women's and Children's Services. This includes ensuring:

- Processes are in place to identify, assess and manage risks through implementation and review of the Risk Assurance Framework (RAF) Register
- Effective systems are employed for reporting, recording and investigation of all adverse events, such as Serious Incidents, risk events, near misses, complaints and claims

- The Clinical Director is also the joint chair with the Head of Midwifery/Nursing of the Directorate Governance Meetings which brings together a multidisciplinary review and learning agenda.

- Responsible for maintaining communication with the Head of Midwifery/Nursing and Clinical Lead who have senior responsibility for risk management within the Maternity Service.

- Ensures medical staff in the maternity service understand their part in the management of risk and that adequate communication systems are in place to reach staff at every level

- Identify the steps to reduce risks and record these measures appropriately

17.2 **Executive Lead for Directorate of Women's and Children's Services -** the Executive Lead is responsible for monitoring the Directorate Risk Assurance Framework Register and escalating risks identified by the Head of Midwifery arising within the Maternity Service to the Board. The responsibilities involve the following:

- Where risks arise outside the normal risk management process, the Head of Midwifery/Nursing should alert the Executive Lead and the Chief Nurse, who will directly report unresolved and residual risks to the Board

- Clinical practice issues that require immediate escalation to the Chief Nurse will include Maternal Death, serious breaches of NMC Code of Conduct and Midwives Rules that would require immediate suspension of an individual

- Operational issues that require immediate escalation to the Executive Lead will include Unit Closure, serious breaches of security and/or damage to the reputation from negative publicity. In these instances the Chief Executive, Chief Nurse, Director of Communications' and Executive Director on call will be contacted immediately by the Head of Midwifery, even out of hours

- Communication regarding these high level risks ie 15 and above that will negatively impact on service provision, organisational reputation and the safety of the service will be via telephone and face-to-face communication, not via email due to the sensitivity of the subject matter

- Where necessary, the Executive Lead will escalate risks to the Trust Board and CEO immediately that have been raised by the Head of Midwifery/Nursing

17.3 **The Head of Midwifery and Nursing -** responsible for the operational management of the Directorate, and is the professional lead for midwifery and nursing within the Maternity Services. The responsibilities involve the following:

- The Head of Midwifery/Nursing is the most senior midwife in the Trust and works closely with the Clinical Director and Executive Lead to meet the Trust identified strategic objectives

- Is accountable for Risk Management and Governance arrangements within the Directorate, supported by the Clinical Director and Executive Lead

- Accountable to the Chief Nurse and the Executive Lead to bring to the attention of the Directors and the Board any significant operational risks

- The Head of Midwifery/Nursing is a member of the Serious Incident Management Group, led by the Chief Nurse

- Responsible for supporting and embedding the implementation of the Risk Management process within Maternity Services and ensures the recommendations from incidents, complaints and claims are implemented , themes are monitored, risk assessments are carried out, claims and complaints are reviewed and reports submitted within set timescales to relevant committees

- Oversees the management and processes related to the investigation of risk events, communication with families, responses to complaints, actions and learning from incidents (risk events), complaints and claims

- In addition the Head of Midwifery/Nursing will:

i. Ensure expert advice is available for Risk Management within Maternity Services
ii. Ensure that the Directorate policies, procedures and guidelines support the development of risk management strategies for the Trust
iii. Ensure appropriate personnel carry out the investigation of incidents, complaints and claims
iv. Identify significant clinical and non-clinical risks within the Maternity Services and monitor the controls in place
v. Progress the management of identified risks through the Trust Risk Management Strategy and Policy
vi. Advise the Chief Nurse, Executive Lead, and Chief Medical Officer as required, of any incidents or risks which cannot be adequately controlled
vii. Meet with the Chief Nurse daily via the Serious Incident Management Group (SIMG) to discuss, raise and resolve immediate professional, clinical and non-clinical risk issues/concerns.
viii. Represent the Maternity Services at the Patient Safety and Quality Committee bi monthly meetings.
ix. Act as the link between the Directorate and corporate functions on Risk Management issues
x. Responsible for the management of the Risk Assurance Framework Register
xi. Ensure that Midwifery and support staffing levels and skill mix are reflective of service requirements

17.4 **Clinical Lead: Obstetric Consultant for Risk Management -** The Lead Consultant for Risk Management is also the Clinical Lead for Obstetrics and Gynaecology. They have senior clinical responsibility for Risk Management within the Maternity Service. The responsibilities involve the following:

- They play a key role in the implementation of this strategy with the support and collaboration of the Consultant Obstetricians and the Head of Midwifery/Nursing.

- The Lead Consultant for Risk Management will ensure systems are in place to reduce and eliminate clinical risk throughout the service with dedicated time within his/her job plan for risk management:

- They are accountable to the Clinical Director for Obstetrics and Gynaecology and will meet at least weekly with the Risk Management Midwife to review risk events and ensure the processes for investigation and learning are complete

- It is the Obstetric Consultant for Risk Management responsibility to:

i. Provide medical opinion on clinical risk issues and to give expert clinical advice within the Directorate on maternity Risk Management issues
ii. To work closely with the Risk Management Midwife
iii. Participate and contribute to clinical risk identification analysis and management through involvement in Risk Management Meetings, Case Reviews, Directorate Governance Meetings and audit
iv. To provide visible clinical advice within the Maternity Unit on clinical risk issues to ensure immediate mitigation and prevention of incidents
v. To participate in the review of incidents and serious incidents within the department
vi. To undertake training and updating sessions for all staff to include CTG, skills drills, operative procedures

17.5 **Lead Obstetrician for the Labour Ward -** Ensure the effective and efficient running of the Labour Ward and Obstetric Theatres, ensuring safe practice, medical skill mix and staffing levels reflect the needs of the service. The responsibilities involve the following:

- Liaises closely on a daily basis with the multidisciplinary team to ensure all aspects of patient safety reflect national recommendations and local need. Escalates concerns to the Clinical Lead, Clinical Director and Head of Midwifery when risks are identified and immediate mitigation cannot resolve the issue.

- Is responsible for patient safety by ensuring a thorough understanding of clinical governance, including the process of risk management, clinical incident reporting and investigation, and of the litigation process. That this is communicated to medical staff within the Maternity Service

- In addition the Lead Obstetrician for Labour Ward will:

i. Have an understanding of the staffing structures and requirement for all staff groups on the Labour Ward and within Obstetric Theatres
ii. Liaise with the Obstetric Consultant for Risk Management and midwife for clinical risk management, and the Labour Ward Manager to discuss and act upon identified risk issues
iii. Provide clinical leadership and organisation for the medical staff working within the Labour Ward by visible, clinical presence and input in the management of high dependency care on the Labour Ward, and in the transfer of patients' to and from HDU/ITU
iv. Have a thorough understanding of neonatal resuscitation and intensive care
v. Actively support and promote normal labour and birth
vi. Participate in the multidisciplinary Labour Ward weekly case review within a supportive and learning environment
vii. Maintain good interprofessional communication and relationships
viii. Lead on the quarterly Labour Ward Forum in conjunction with the Labour Ward Manager
ix. Supervise, teach, appraise and assess junior medical and midwifery staff on the Labour Ward
x. Undertake and embed findings from clinical audit

xi. Be involved in the review and updating of evidence based guidelines
xii. Participate in the risk assessment of the maternity service against a National Enquiry or Report

17.6 **Lead Obstetric Anaesthetist -** Has overall responsibility for the anaesthetic service in Maternity Services, incorporating the Labour Ward and Obstetric Theatres, and liaising closely with the obstetric and midwifery staff, in particular the Obstetric Consultant for Risk Management, the Lead Obstetrician for Labour Ward and Head of Midwifery/ Nursing. The responsibilities involve the following:

- Ensures the anaesthetic service is delivered in accordance with national recommendations and provides specialist clinical leadership in Anaesthetic management

- Contributes to the reporting and review of risk issues within the service- both actual and potential

- Is involved in the management of issues raised in relation to patient safety, in particular high risk patients and provides clinical expertise on all aspects of anaesthetic care to women within the Maternity Service

- Facilitates and promotes effective communication ensuring a positive learning environment for the multidisciplinary team

- Attends the Labour Ward Forum and Multidisciplinary Risk Management group meetings and ensures anaesthetic representation at relevant forums/meetings in their absence

- Provides clinical leadership and organisation for the anaesthetists working within the Labour Ward by working with and supporting anaesthetists to ensure changes in practice and compliance with national recommendations and guidelines

17.7 **Specialist Midwife Risk Management -** Is the identified individual with responsibility for coordinating and implementing clinical risk management activities within Maternity Services. The responsibilities involve the following:

- Is accountable to and reports to the Head of Midwifery/Nursing, with whom she discusses both potential and reported risk events with on a daily basis, either electronically or 1:1

- Deputises for the Head of Midwifery/Nursing at Risk Meetings where appropriate e.g. SIMG and represents the Maternity Service at the Patient Safety Group.

- Identify significant risks and Serious Incidents, ensuring they are communicated to the Head of Midwifery/Nursing, Lead Consultant for Risk Management and the Clinical Director, who will in turn escalate these to the Chief Nurse, Executive Lead, Clinical Director and Head of Governance

- In addition they will also:

  i. Support the nominated Obstetric Consultant for Risk Management and Lead Obstetrician for Labour Ward in the review and investigation of clinical risk events
  ii. In the absence of the Head of Midwifery/Nursing Escalate risk concerns to the Head of Governance and the Chief Nurse

iii. To provide visible clinical leadership and advice on Risk Management process to all staff within the Maternity Service including midwifery managers
iv. To be a source of expertise in root cause analysis techniques
v. Provides guidance for those undertaking risk assessments and other local Risk Management functions
vi. Develop and participate in Risk Management Training programmes within Maternity Services
vii. Ensure the timely investigation of appropriate incidents and monitoring of the implementation of associated action plans
viii. Analyse trends and themes obtained from incidents, complaints and claims, providing information and recommendations to Senior Management within Maternity Services
ix. Develop a system of communication, to ensure feedback and learning from risk events, complaints, claims and analysis of trends to all staff via monthly Directorate Governance Meetings, Risk Management Meetings, Hot Topic, Risk Management Newsletter, Labour Ward Forum, memorandums, Risk notice boards
x. In conjunction with the Head of Midwifery/Nursing assist in the development of risk mitigation plans related to the Directorate Risk Assurance Framework Register
xi. Ensure full and effective utilisation of the risk event reporting system (DATIX)
xii. Ensuring compliance of the Trust Serious Incident Reporting Policy
xiii. Advise on current risks and ensure controls are in place
xiv. Be responsible for the centralised monitoring of action plans and implementation of recommendations following risk assessments, reporting of incidents and investigation of Serious Incidents to ensure dissemination of learning
xv. Leading the Multidisciplinary Risk Management Group (MRMG) providing feedback to staff on analysis and trends and interface with the Labour Ward Forum to ensure lessons learned are shared between clinical areas
xvi. Is responsible for the management of the Directorate Governance Meeting.
xvii. Will have received basic health and safety risk awareness, to support the pro-active identification of hazards and risk
xviii. Manage and co-ordinate the implementation of recommendations in Rapid Response Alerts, Central Alert System

17.8 **Specialist Midwife for Audit, Guideline Development and CNST** - has responsibility for developing key relationships with clinicians and risk and governance leads within the Trust to ensure the Maternity Services agenda for audit, guideline development and NHLSA/CNST requirements reflect the Trust wide objectives in these key areas of service provision and strategy. The responsibilities involve the following:

- They will be responsible for overseeing the CNST Project work for Level 2 assessment in February 2013
- The management and co-ordination of clinical guideline development within Maternity Services
- Communication of information concerning clinical guidelines, including electronically and in hard copy, both within and without Maternity Services
- Clinical guideline archivist
- To represent Maternity Services on the Patient Information Group (PIG) and Document Ratification Group (DRAG)
- To progress the work for implementation of patient information through the information standards work

- Develop and participate in multidisciplinary Audit programmes relating to clinical guidelines and midwifery practice
- Liaise with the Lead Consultant Obstetrician with responsibility for clinical audit to ensure a timely and effective programme of audit is evident within the Maternity Service
- To ensure that audit is multidisciplinary in approach and is equally balanced in approach of proactive and reactive to ensure safe and high quality practice is underpinned by research based evidence and driven by national recommendations
- Undertake investigations into complaints and serious incidents as required, ensuring learning outcomes are embedded as a result of the investigation

17.9 **Band 8a: Lead Midwife Labour Ward, Birthing Unit and Acute Inpatient Services -** Responsible for the overall professional performance and operational management of midwifery and support staff on the Labour Ward, Birthing Unit, Obstetric Theatre and in acute inpatient areas. The responsibilities involve the following:

- To identify areas of concern in clinical practice following incident reporting and develop action plans to mitigate against recurrence, working closely with the Risk Management Midwife, Lead Obstetric Consultant for Labour Ward, Lead Anaesthetist and Consultant Obstetrician for Risk Management

- To escalate any concerns regarding clinical issues, care provision or individual practice to the Head of Midwifery/Nursing and the Lead Obstetric Consultant to ensure an immediate review and mitigation of the situation

- To develop processes to ensure safe midwifery and medical practice and service provision in the Labour Ward, Birthing and Obstetric Theatre.

- To liaise closely with the Head of Midwifery/Nursing about midwifery and support staff practice issues and identified risks within the Labour Ward environment and ensure that safe staffing levels are maintained with adequate skill mix.

- Attend bi-weekly 1:1 with the Head of Midwifery/Nursing to formally update risk concerns and issues that are ongoing and not resolved at the daily Labour Ward Handover, which the Head of Midwifery attends with the Lead Midwife for Labour Ward

- Ensuring mechanisms are in place for identifying and reporting clinical risks through DATIX
- Enable staff to raise concerns on an individual basis
- Working in close partnership with Obstetric Consultant for Risk Management and the Lead Obstetrician for Labour Ward
- Meet at least weekly with the Risk Management Midwife to identify ongoing concerns, new risks and implement findings from incident reviews and investigations
- To immediately review any incident causing serious concern with the Risk Management Midwife and Obstetric Consultant for Risk Management by means of a case review, leading to completion of a 24 hour level 1 report this will then be sent for approval to the Head of Midwifery who will present at the daily SIMG meeting
- Providing feedback daily at the Labour Ward Handover on risks identified, mitigation and practice changes
- Providing senior midwifery leadership and expert advice to midwifery and support staff
- Promote normality at every opportunity and provide advice on the care of women with complex needs
- Maintain the focus on safeguarding in the acute environment
- Forward the Infection Prevention Agenda

- Work in partnership with Emergency Care for the smooth and effective running of the Obstetric Theatre, ensuring joint communication regarding practice issues and risk events
- To benchmark National Recommendations e.g. King's Fund with local care provision to assess gaps and escalate concerns to the Head of Midwifery
- Review KPIs and the Maternity Dashboard and implement necessary mechanisms to ensure improvements in morbidity and mortality
- Attend and participate in Labour Ward Forum, MSLC and Directorate Governance issues and provide updates on risk events within areas of responsibility, ensuring risk control plans are communicated throughout the service
- Undertake investigations into complaints and serious incidents as required, ensuring learning outcomes are embedded as a result of the investigation

17.10 **Band 8a: Lead Midwife Community Services, Standalones, Antenatal Clinic** responsible for the overall professional performance and operational management of midwifery and support staff in community services, standalone maternity units and Antenatal Clinic at the acute site. They are also the designated Name Midwife for Safeguarding within the Maternity Service. The responsibilities involve the following:

- Work closely with the Head of Midwifery/Nursing and the Risk Management Midwife to ensure that risks are identified and manager's reports are submitted in a timely manner via DATIX

- Will represent the Maternity Service in contributing to clinical governance and risk assurance arrangements within the Directorate in relation to their area of Operational Responsibility

- Will ensure that risk arrangements are in place at the standalone Maternity Units and these align with all processes set out for the management of risk, including early identification, controls and mitigation

- Review KPI's and the Maternity Dashboard and implement necessary mechanisms to ensure improvements in morbidity and mortality

- Attend and participate in Labour Ward Forum, MSLC and Directorate Governance issues and provide updates on risk events within areas of responsibility, ensuring risk control plans are communicated throughout the service

- Promote normality and safe clinical midwifery practice within midwifery-led services, embedding a culture of clinical risk assessment to ensure appropriate responses to developing risks in community settings

- Undertake investigations into complaints and serious incidents as required, ensuring learning outcomes are embedded as a result of the investigation

17.11 **Band 7 and Specialist Midwives -** As senior midwives within the Maternity Service they are accountable and professionally responsible to the Head of Midwifery and the Chief Nurse. They will direct line report to the senior Midwifery Manager or Head of Midwifery/Nursing for their clinical area of work or expertise. The responsibilities involve the following:

- They have and are expected to develop close working relationships with each other and the Risk Management Midwife for all concerns and issues regarding Risk Management within their areas of responsibility.

- There is an identified **Team Leader** for the following clinical areas within the Maternity Service: Day Assessment Unit, Triage and Antenatal Inpatients, Antenatal Clinic, Postnatal Ward, St Peters Maternity Unit, WJC Maternity Unit, Chelmsford Community, Labour Ward

- There are **Specialist Midwives** for the following areas: Antenatal and Newborn Screening, Infant Feeding, Safeguarding, Perinatal Mental Health, Vulnerable, Risk Management, Audit, Guidelines + CNST, Maternity IT, Practice Development

- The ANNB Screening Co-ordinator is responsible for the investigation and reporting of all Screening incidents to the Screening Committee and Head of Midwifery/Nursing and governance team. All Screening incidents will be reported via DATIX.

- The Band 7 and 8a Midwives (in addition to defined responsibilities) have:

i. Have investigating officer training in risk assessment and serious incident / complaint management
ii. Have responsibility for health and safety in their clinical area of management
iii. Have a responsibility to support the Senior Management Team and Midwifery Managers and to introduce and maintain changes in practice and monitor the quality and standard of clinical care
iv. To identify, co-ordinate and communicate clinical and non-clinical risks to inform the service wide risk assessment framework
v. To undertake risks assessments with the assistance of the Risk Management Midwife within their sphere of practice
vi. Responsible for cascading information from the monthly Directorate Governance Meetings, weekly Manager's Meetings and the Multidisciplinary Risk Management Group to their individual Teams
vii. Have a remit to ensure that all measures related to patient safety such as High Impact Interventions, Infection Prevention and safeguarding are disseminated and embedded in clinical practice

17.12 **Individual Employees to include: Midwives (all bands), Medical staff, Support Workers, Administration and Clerical staff:**

- All are responsible within their particular area of activity for their own health and safety and that of their co-workers and others that may be affected by their actions or inaction
- All have a responsibility to be aware and gain an understanding of Trust Policy, Directorate Policy and Maternity Services clinical and operational standards, guidelines and procedures
- All staff will report via DATIX, clinical and health and safety incidents and near misses and report directly to the Risk Management Midwife or the Trust Health and Safety as appropriate
- Midwives have a statutory professional duty to practice within the rules and codes of the NMC and to maintain professional development in line with PREP (post registration education preparation)
- Midwives have a statutory duty to notify their intention to practice to the Local Supervising Authority in which they are practising

- Medical staff must maintain professional accountability according to their registration code of conduct
- Identify risks at local level and inform their line manager
- Work with their managers to develop and implement risk controls as part of normal service delivery
- Take steps to avoid harm to patients, staff, visitors, property and themselves
- Participate in as required the investigation of complaints and incidents within the Maternity Service
- Take responsibility for attendance at Directorate Governance Meetings, Risk Management Group and Clinical Practice Group
- Ensure that learning shared via Risk management processes at an individual and group level is embedded in their clinical practice
- Take responsibility for updating skills and knowledge to ensure they are safe and effective practitioners by attendance at annual Mandatory Training

18.0 Supervisors of Midwives

18.1 Risk Management is an integral part of the role of the Supervisor of Midwives (SoM), protecting the public and ensuring a fit for practice workforce.

18.2 In addition the Supervisor of Midwives will:

- Provide a proactive and visible approach to identifying risks in clinical practice
- Providing clinical expertise within the Maternity Service
- Safeguard and enhance the quality of care for the women and babies using the Maternity Service
- Be a source of sound professional advice on all midwifery matters
- Promote normality for women and babies
- Ensure requests for care provision by service-users that may involve increased risk to the woman and/or baby involve plans of care that are communicated to the wider maternity service staff
- Be involved in the development of guidelines and policies, embedding practice changes in clinical areas
- Support staff involved in incidents and when outcomes find poor practice standards
- Promote proactive Risk Management and a fair blame culture
- Teach on Mandatory Training
- Provide expert advice at Serious Incident reviews
- Report maternity related Serious Incidents to the LSAMO where there are concerns regarding midwifery practice
- Reporting serious cases involving professional misconduct where the Nursing Midwifery Council (NMC) Rules and Codes of Professional Conduct have been contravened
- Participate in the response to complaints
- Participate in Risk Management Meetings, Maternity Service Liaison Committee, Directorate Governance Meetings in their capacity as Supervisor of Midwives
- Provide guidance on maintenance of registration and identifying opportunities in relation to statutory requirements
- Investigate as appropriate using Root Cause Analysis methodology any issues related to midwifery practice that may result in poor outcomes for women and or babies
- Monitoring the standards of midwifery practice through audit. The LSA will undertake a bi-annual audit. The audit report will be presented by the LSA Officer at the monthly MEHT SOM meeting. An action plan will be developed and monitored by the SOM team at MEHT.

19.0 Risk Assessments and Risk Assurance Framework

(Refer to the Trust Risk Management Strategy and Policy; register number 04061; point 7.0)

19.1 Outstanding or unresolved risks will be placed on the Directorate Risk Assurance Framework Register by the Head of Midwifery/Nursing and Risk Management Midwife and approved by the Executive Lead and Clinical Director. The Directorate RAF is updated 2 monthly as a minimum and reviewed at each Directorate Governance meeting

19.2 All risks identified on the Risk Assurance Framework Register are assessed using the standard risk matrix.
(Refer to the Trust Risk Management Strategy & Policy Register number 04061 point 6.3)

19.3 The Directorate Risk Assurance Framework is reviewed by the Patient Safety and Quality Committee on an annual basis.

19.4 A risk rating 15 or above, will be placed on the Corporate/Trust Risk Assurance Framework, in accordance with the Trust Risk Management Strategy and Policy; register number 04061. The RAF is reviewed directly by the Board at each meeting

20.0 Board Assurance from the Maternity Service

20.1 The Executive Lead will be present (or receive the minutes) but not chair the Directorate Governance Meeting this will ensure Board to floor review of Maternity Services Risk processes and performance The Executive Lead for Women's and Children's Services and the Chief Nurse communicate directly with the Board and the other Executive Directors regarding risks identified and communicated by the Head of Midwifery/Nursing. This will be at either Patient Safety and Quality Committee or weekly Executive Director Meetings as required.

20.2 The Executive Lead will work in partnership with the Head of Midwifery/Nursing and Clinical Director to ensure that risk issues of all kinds are discussed in a timely manner and resolved appropriately to mitigate against recurrence and identify residual risks.

20.3 The Head of Midwifery/Nursing is responsible for bringing to the attention of the Executive Lead, Chief Nurse and through direct reporting lines to the CEO, any significant risks to the Maternity Service and therefore the Trust, identified through Risk Management processes.

21.0 Escalation of Risk Management to the Board

21.1 Risk management issues are identified from staff, the public and the reporting of incidents, complaints, claims, risk assessments proactively identify clinical and non-clinical risks within the Maternity Service and are discussed at the various forums within the Maternity Services:

- Directorate Governance Meeting
- Multidisciplinary Risk Management group
- Labour Ward forum
- Perinatal Mortality and Obstetric Audit group
- Supervisor of Midwives meetings
- Clinical Practices Group

21.2 Once identified, risk management issues are escalated to the Head of Midwifery/Nursing who will escalate to the Chief Nurse and Executive Lead for the Maternity Services; they in turn will escalate risks to the Executive Directors and Trust board.

21.3 The Head of Midwifery/Nursing is also able to report directly concerns relating to risk and governance to the CEO, in the absence of the Executive Lead. This may be done at the weekly Executive Directors Meetings or through appointment.

21.3 The Head of Midwifery/Nursing will bring to the attention of the Executive Lead and / or the Chief Nurse and through direct reporting lines to the CEO, any immediate, significant risks to the Maternity Service and therefore the Trust, identified through Risk Management processes. The Head of Midwifery/Nursing will contact the Executive Lead, the Chief Nurse and / or the CEO via telephone or face to face. This correspondence will be documented in the Head of Midwifery/Nursing's log book. Once immediate concerns are addressed, normal risk management processes will be implemented.

21.4 The monthly Directorate Governance Meetings are attended by the following key people, who report directly either to the CEO and/or the Board governance and risk concerns: Clinical Director, Executive Lead, Head of Midwifery/Nursing, and Head of Governance

21.5 This will ensure that the risks identified are escalated to the Board via this formal mechanism.

21.6 Minutes of these meetings can be disseminated to the Board via the Head of Governance, the Executive Lead and the CEO, who all receive a copy.

21.7 The Head of Midwifery/Nursing represents Maternity Services at the Patient Safety and Quality Committee at bi monthly but more frequently when unresolved risks present a moderate/extreme residual rating and there are concerns regarding resolution. The minutes of this committee meeting are forwarded to the Trust Board via the Trust Secretary.

21.8 Further Trust Board assurance is achieved through the Head of Governance and Chief Nurse who will escalate concerns raised at the daily SIMG meeting via attendance at the Directors and Board meetings.

21.9 The submission to the Board of the Integrated Learning and Governance reports including Maternity Service risk events and mitigation will provide further assurance of the Risk Management process within the Directorate.

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22.0 Management of Risk Events (Incidents)

22.1 Refer to Maternity Services Incidents, complaints and claims; register number 12021
Refer to Trust Management of Serious Incidents Policy; register number 04060.
Refer to Learning from experience Policy; register number 10088.

23.0 Equipment Failures

23.1 The Risk Management Midwife and Practice Development Midwife will act on equipment failures ensuring reported to MDA and will act on MDA notices.

24.0 Staff Appraisal

24.1 All staff working within the Directorate will have an annual appraisal and develop their Personal Professional Development Plan.

24.2 Midwives will have an annual Supervisory Review with their named Supervisor of Midwives.

24.3 Outcomes of these will be used to inform the education and training analysis for the Directorate.

25.0 Safeguarding, Vulnerable and Mental Health

25.1 All staff will be trained to the appropriate level in safeguarding, and mental health as part of the annual mandatory training.

25.2 Staff required to undertake Level 2 and Level 3 Safeguarding Training will be identified by the Lead Midwife for Safeguarding and allocated to training relevant to Trust requirements for their role.

26.0 Audit, Review and Monitoring

26.1 Risk Management processes are continually evolving, in order to respond to this the Maternity Risk Management Strategy will be reviewed annually and when the Trust Risk Management Strategy/Policy is amended following NHSLA recommendations or following external review e.g. from the CQC

26.2 Audit of compliance with this guideline will be considered on an annual audit basis in accordance with the Clinical Audit Strategy and Policy, the Maternity annual audit work plan and the NHSLA/CNST requirements. The Audit Lead in liaison with the Risk Management Group will identify a lead for the audit.

26.3 As a minimum the following specific requirements will be monitored:

- Maternity service's measurable objectives for managing risk
- Process for managing the maternity service's risk register
- Maternity service's risk management structure, detailing all the committees/ groups within the organisation (not just the maternity service), which have some responsibility for risk within the maternity service
- Process for receipt and review of the Local Supervising Midwifery Officers' annual audit and action plan
- Process for immediately escalating risk management issues at any time, from the maternity service to board level
- Leadership arrangements, detailing all those individuals within the organisation (not just the maternity service) who have management responsibility for risk within the maternity service
- Process by which the board lead executive communicates with and obtains assurance from the maternity service

- Description of the duties of the named individuals with responsibility for risk within the maternity service, which must include the following:
    i. Lead executive at board level
    ii. Professional lead(s)
    iii. Clinical risk coordinator
    iv. Lead consultant obstetrician for labour ward matters
    v. Clinical midwife manager for labour ward matters
    vi. Lead obstetric anaesthetist for anaesthetic services
    vii. Supervisors of midwives

26.4 The findings of the audit will be reported to and approved by the Multi-disciplinary Risk Management Group (MRMG) and an action plan with named leads and timescales will be developed to address any identified deficiencies. Performance against the action plan will be monitored by this group at subsequent meetings.

26.5 The audit report will be reported to the Maternity Directorate Governance Meeting (MDGM) and significant concerns relating to compliance will be entered on the local Risk Assurance Framework.

26.6 Key findings and learning points from the audit will be submitted to the Patient Safety Group within the integrated learning report.

26.7 The Head of Midwifery/Nursing, Clinical Director and Executive Lead via the Directorate Governance Meetings and Patient Safety and Quality Committee will oversee the effective implementation of this strategy by:

- Addressing progress on the objectives outlined
- Review the RAF Register monthly
- Assess and confirm compliance with external accreditation and the regulator

26.8 The trust will monitor and review its performance in relation to the Management of Risk and the effectiveness of its processes.

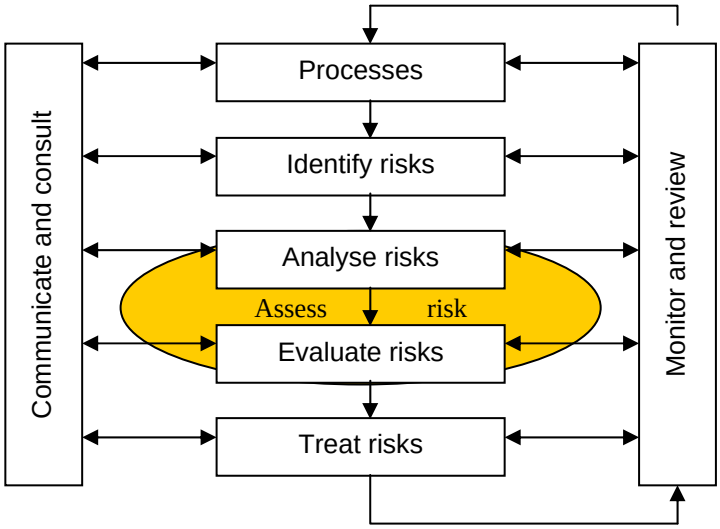
26.9 The Head of Governance will provide a quarterly Integrated Learning Report. This will include analysis of incidents, complaints and claims as a minimum that will inform the forward projections for Governance and Risk within Maternity Services.

26.10 Compliance with the measurable objectives will be undertaken by the senior Management Team on an annual basis and inform the Maternity Services aspect of the Integrated Learning Report

26.11 The effectiveness of the implementation of this strategy will be monitored in line with the Trust Risk Management Strategy and Policy; register number 04061 and Incident Policy; register number 09100.

26.12 Whistle blowing trends will also be included

26.13 Ensuring that the Trust's Risk Management systems form a key part of the annual clinical audit cycle, which are also reflective of external assessment such as the CQC:



27.0 References

Clinical Negligence Scheme for Trusts Maternity Clinical Risk Management Standards: 2012/2012

Care Quality commission (2009), Essential standards of quality and safety: compliance with section 20 of the health and social care act 2008

Department of Health (2004) NHS England: Directions to New NHS Bodies on Security Management Measures. DOH: London

Department of Health (2000) An Organisation with a memory

NHSLA (2009) Serious Incident reporting policy including the procedure to be followed for safeguarding children

NPSA (2010) National framework for reporting and learning from serious incidents requiring investigation,

NPSA (2001) Doing less harm

NPSA (2004) Seven steps to patient safety

Institute for Healthcare Innovation (2009) 2nd edition global trigger tool for measuring adverse events

Royal College of Obstetricians and Gynaecology (2007) Towards Safer Childbirth, London.

Appendix A

Trigger List for Maternity Incident Reporting

<table>
<tr><th colspan="2">Labour Ward/Midwifery-led Units/Community</th></tr>
<tr><td>

Unplanned homebirth/BBA
severe infection
Severe PET/Eclamptic fit
Prolonged 2nd stage (over 3 hours)
Rupture of uterus or scar dehiscence
Anaesthetic problem
Failed forceps or ventouse
2nd stage Caesarean section following failed instrumental delivery
Maternal injury during delivery (bladder/vaginal)
Third/fourth degree tear
PPH > 500mls or symptomatic
Woman requiring blood transfusion
Return to theatre
Retained swab/instrument
Maternal death

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Undiagnosed breech
Misdiagnosis of antenatal screening tests
failure to recognise fetal compromise
Cord prolapse
Shoulder dystocia
Delay in delivery of 2nd twin leading to adverse outcome
Low Apgars < 6 at 5 minutes
Arterial cord pH of 7.1 or below
Difficult resuscitation due to equipment/inexperience
Birth trauma to baby
Unexpected fetal abnormality
Unexpected admission to NNU at term
Seizure within 24 hours of birth
Stillbirth, Intrapartum Death, Neonatal Death
Hysterectomy

</td></tr>
<tr><th>Antenatal/Postnatal</th><th>General/Organisational</th></tr>
<tr><td>

Missed screening follow up: maternal/neonatal
Late booker/unbooked woman
Severe APH
Severe PET/Eclamptic fit
Maternal collapse
Transfer back to Labour Ward
Secondary PPH
Severe infection/wound breakdown
Faecal or urinary incontinence
Postnatal readmission of woman/baby
Puerperal psychosis
Congenital abnormality
Admission to NNU of term baby
Neonatal septicaemia
Neonatal seizures within first 24 hours
Neonatal Fractures

</td><td>

Misidentification of patients
Failure to gain consent
Wrong procedure carried out
Breach of confidentiality
Abnormal results not recognised
Medication errors
Unavailability of health records
Unavailability/failure of facilities or equipment
Failure to escalate concerns
Staffing levels
Delays to patient care due to capacity
Any other adverse event
Complaints by patients/visitors against staff
Closure of NNU due to capacity
Pressure Ulcers
Unplanned admission to ITU
DVT/pulmonary embolism

</td></tr>
</table>

Appendix B

Minimum Set of Reportable Maternity Serious Incidents

Maternal	
• Maternal Death • Maternal unplanned admission to ITU • Peripartum hysterectomy • Significant postpartum haemorrhage where care or service delivery problems contributed to the outcome • Unidentified retained swab or instrument	
Neonatal	
• Intrapartum Death • Antenatal Intrauterine Death where there were identified care or service delivery problems • Unexpected neonatal death where the death was not anticipated as a significant possibility 24 hours before the death nor was a result of extreme prematurity • Unexpected admission to NNU in infants over 37 completed weeks of gestation that have persistent low Apgar scores of less than 6@5 minutes where there is also neonatal seizures or cord pH of less than 7.1	
Organisational	
• Closure of the acute Maternity Unit • Any other incidents where circumstances suggest a claim may result	

Appendix C

Maternity Service Never Events

- Wrong Site Surgery
- Wrong Implant/Prosthesis
- Retained foreign object post operation
- Wrongly prepared high-risk injectable medication
- Maladministration of potassium-containing solutions
- Wrong route administration of chemotherapy
- Wrong route administration of oral/enteral treatment
- Intravenous administration of epidural medication
- Maladministration of Insulin
- Overdose of midazolam during conscious sedation
- Opioid overdose of an opioid-naïve patient
- Inappropriate administration of daily oral methotrexate
- Suicide using non-collapsible rails
- Escape of a transferred prisioner
- Falls from unrestricted windows
- Entrapment in bedrails
- Transfusion of ABO-incompatible blood components
- Transplantation of ABO-incompatible organs as a result of error
- Misplaced naso – or oro-gastric tubes
- Wrong gas administered
- Failure to monitor and respond to oxygen saturation
- Air embolism
- Misidentification of patients
- Severe scalding of patients
- Maternal death due to post partum haemorrhage after elective caesarean section

Appendix D

Maternity Services ANNB Screening Serious Incidents

Serious Incidents in screening programmes

For screening programmes this definition can be clarified further as follows:

- An actual or possible failure at any stage in the pathway of the screening service, which exposes the programme to unknown levels of risk that screening, assessment or treatment have been inadequate, and hence there are possible serious consequences for the clinical management of patients
- The level of risk to an individual may be low, but because of the large numbers involved the corporate risk may be very high
- Complex screening pathways often involve multidisciplinary teams working across several NHS organisations in both primary and secondary care, and inappropriate actions within one area, or communication failures between providers, can result in serious incidents.

Appendix E

Mid Essex Hospitals NHS Trust
Directorate of Women, Children & Sexual Health

The Process for the Review, Benchmarking and Action Planning of Published Professional Reports within Maternity Services

There are many reports published which impact on the safe practice standards, Quality of Care provision and the safety of women, babies and families using Maternity Services.

Below are listed the reports pertinent to Maternity Services, this list is not definitive and all published reports should be considered:

- National Institute of Clinical Excellence (NICE)
- Confidential Enquiry Maternal and Child Health (CEMACH)
- Confidential Enquiry into Homicide and Suicide by people with mental illness (CISH)
- National Confidential Enquiry into Perioperative Death (NCPOD)
- Royal College of Obstetricians & Gynaecologists (RCOG)
- Association of Anaesthetists (AOA)
- Obstetric Anaesthetists Association (OAA)
- Nursing and Midwifery Council (NMC)
- Department of Health (DH)
- Royal College of Midwives (RCM)
- Kings Fund
- National Service Framework

Maternity Services has an agreed process to benchmark the recommendations of these professional reports and any others relevant to obstetric and midwifery care against current practice and review that practice against the best evidence available.

Agreed Pathway

Reports come into the Trust usually via the Chief Executive or the Director of Nursing. Other contact points may be:

- The Medical Director
- The Clinical Director
- Obstetric Anaesthetic Lead Consultant
- Primary Care Organisations
- Local Supervising Authority Responsible Midwifery Officer
- Head of Governance

The Head of Midwifery/Nursing is the recognised Professional Lead for Midwifery and will be a central point of contact for cascade.

The Process

Published Reports are disseminated to the Head of Midwifery/Nursing.

The Head of Midwifery/Nursing will review the report and disseminate to the Clinical Director, Consultant Obstetricians, Anaesthetic Lead, Risk Management Midwife and relevant specialist Leads within the Senior Midwifery Management Team.

The report will be discussed a the Directorate Governance Meeting, the Risk Management Midwife will then co-ordinate the review and benchmarking at local level and provide a response to the central Audit Department.

Following a Gap Analysis and benchmarking review, any deficits will be escalated to the Head of Midwifery/Nursing for inclusion on the Directorate Risk Assurance Framework Register.
The local forum for the Midwifery, Obstetric Team and anaesthetic team to review and benchmark current practice against the recommendations and identify whether there is compliance with recommendations is the MRMG.

The outcome will be reported to the Head of Midwifery/Nursing.

Compliance

Good practice can be disseminated and shared throughout the service and across the Trust.

Non-Compliance

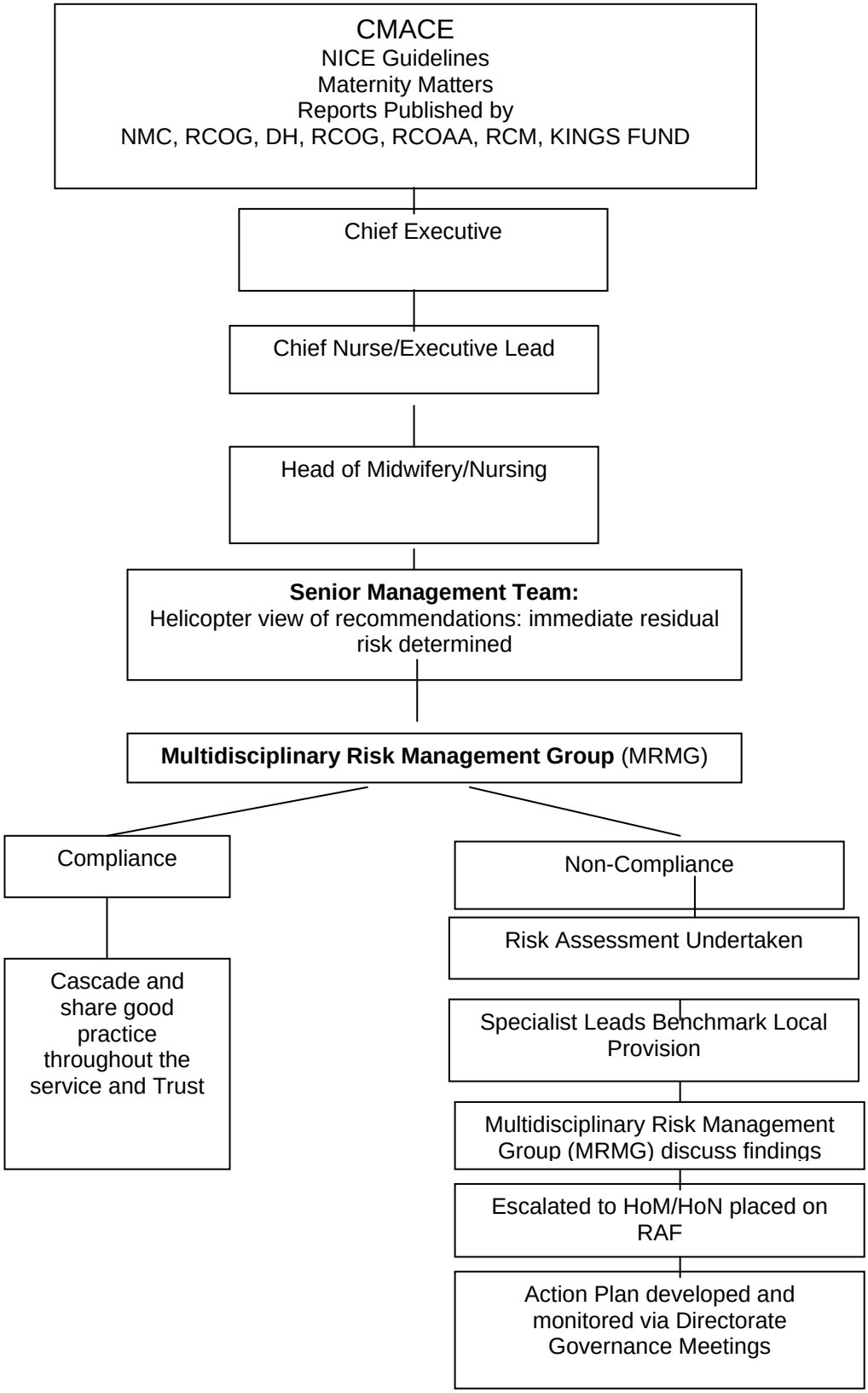
This will be escalated to the Directorate Senior Management Team who will decide if a risk assessment should be completed

The risk assessment is analysed at the Multidisciplinary Risk Management Group for review to clearly identify where measures cannot be put in place to minimise the risk. The risk can be escalated to the Executive Lead and Chief Nurse for consideration and reporting to the Trust Board via the Patient Safety and Quality Committee as appropriate.

The response from the Committee to the identified risk will be fed back directly to the Executive Lead and Head of Midwifery.

Appendix F

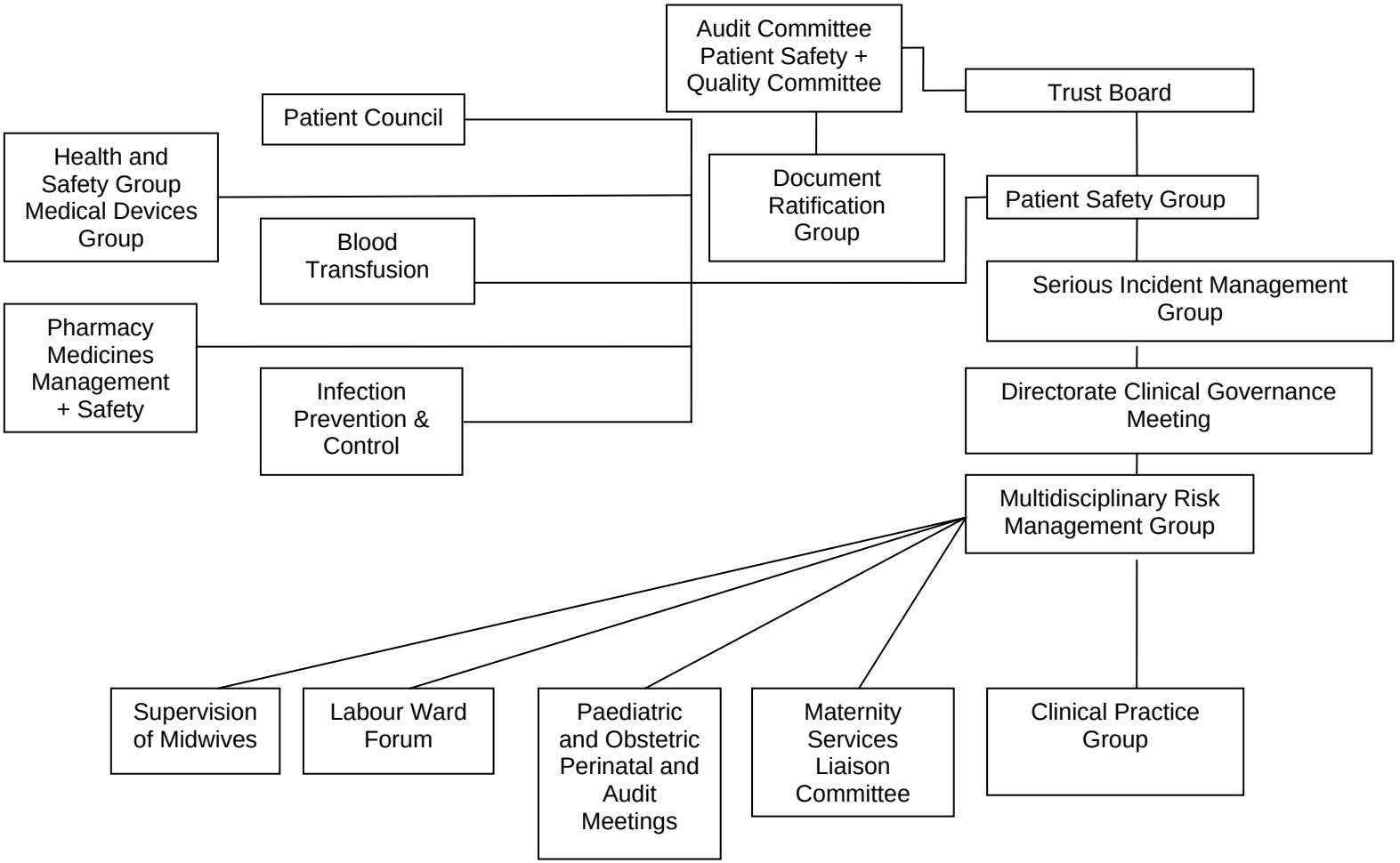
Women's, Children's & Sexual Health Directorate Pathway for the Review of National Drivers within Maternity Services



Appendix G

Women's, Children's & Sexual Health Directorate

Maternity Services Risk Management + Escalation Structure



Appendix H

MID ESSEX HOSPITAL SERVICES NHS TRUST
Women's, Children's and Sexual Health Directorate

Multidisciplinary Risk Management Group Meetings

Terms of Reference:

- To review risk and incident reporting trends reported through Datix web and ensure appropriate action is identified and implemented
- To identify and implement staff training and development needs including midwives who require support through the statutory supervision framework.
- To recommend change in the light of best practice and available evidence e.g. confidential enquiries CMACE and NICE clinical guidelines.
- To identify and produce risk assessments when recommendations cannot be followed due to financial or resource deficiencies and escalating this to the Head of Governance and patient Safety and Quality Committee
- To review and feedback serious incidents, identifying trends/actions to be taken and recommend changes in practice.
- To actively promote clinical risk management within the Directorate by producing regular feedback summaries of cases reviewed.
- To establish a forum to discuss identified cases
- To raise awareness of clinical errors and near misses to facilitate a learning environment
- To promote a fair blame culture within the division where reporting incidents and near misses inform learning and a reduction in risks of reoccurrence, clearly demonstrating learning

Core Membership:

Lead Consultant- Clinical Risk Management Obstetric
Lead Midwife- Clinical Risk Management
Consultant Anaesthetist
Consultant Paediatrician
Head of Midwifery
Supervisor of Midwives
Labour Ward Manager
Acute Midwifery Services manager
Community Midwifery Services Manager

Adhoc Membership:

Lead Obstetric Consultant – labour ward
Lead (specialist) Midwives
Senior Midwife DAU & Antenatal Assessment Unit
Senior Midwife Postnatal & Antenatal Ward STJ
Senior Midwives – birthing units & co located unit
Ultrasonographer
Obstetric registrar
Midwife

Appendix I

MID ESSEX HOSPITAL SERVICES NHS TRUST
Women's Children's and Sexual Health Directorate

Labour Ward Forum

Terms of Reference 2013

Definition

The Labour Ward Forum is a multidisciplinary forum whose aim is to meet regularly to develop and improve clinical aspects of intrapartum care based upon local and national guidance.

Terms of Reference

- To promote a team approach in the management and provision of maternity services.
- To provide a forum where members of a multidisciplinary team can meet to discuss, review and influence practice
- To discuss and incorporate evidence-based practice through the provision of multidisciplinary based guidelines
- To ensure a comprehensive system for management and communication throughout the key stages of intrapartum care
- To review all aspects of labour ward activity through quantitative data, i.e. professional, educational and organizational
- To facilitate the provision of an environment that promotes open discussion, a learning environment and a blame free culture
- To review clinical incidents, identifying any emerging trends and to make recommendations for changes in practice within a risk management structure
- To cascade action plans into midwifery meetings, Consultant Meetings and Departmental Meetings.
- The Labour Ward Forum will ensure that the Multi-disciplinary Risk Management Group and Directorate receive minutes of the quarterly meetings.
- To review the Terms of Reference annually to ensure compliance in accordance with Risk Management Strategy and Policy.

Core Membership

Chair: Lead Obstetric Consultant for Labour Ward
Head of Midwifery
Lead Obstetric Anaesthetist Labour Ward
Lead Midwife for Labour Ward, Birthing Unit and Acute Inpatient Services
Lay person representatives
Consultant Neonatologist
Neonatal Clinical Nurse Specialist
Specialist Midwife for Clinical Risk Management
Supervisor of Midwives
Obstetric Theatre Lead
Mid Essex PCT Lead
Representatives from junior medical and midwifery staff

Adhoc Membership

Any other individual may be invited to attend at the discretion of the chair.

Quorum

- Meetings will be held quarterly
- Members should attend a minimum of two meetings per year.
- The meeting will be quorate if 4 members of the group are present. This must include the chair and one member of the obstetric, anaesthetic and midwifery team.
- All representatives should arrange for a deputy, if practical, in the event that they are unable to attend

MID ESSEX HOSPITAL SERVICES NHS TRUST

Concise Root Cause Analysis Report

Mid Essex Hospital Services NHS
NHS Trust

Concise Root Cause Analysis Report

Incident Reference Number (Datix) *Datix to be completed for all incidents and sent to Governance dept upon completion*	
Date of incident	
Time of incident	
Type of incident	Please select from the following list If 'other' please indicate here
Description of incident	
Healthcare speciality involved	
Name of principal person involved	
Principal person's date of birth	
Consultant	
Summary of diagnosis	
Date of admission (if inpatient)	
Reason for admission (or referral if outpatient)	
Named Nurse / Midwife or Keyworker	
Effect on principle person = Level of harm / severity	Please select from the following list

Potential severity (1-5)	Likelihood of recurrence at that severity (1-5)	Risk rating (C= A x B)	Information Governance Risk rating ONLY
A	**B**	**C**	**(0 – 5)**

(B) Likelihood		(A) SEVERITY (for risk rating guidance follow link http://meht-intranet/EasysiteWeb/getresource.axd?AssetID=9981&type=full&servicetype=Attachment)					ACTION
		1 Insignificant	2 Minor	3 Moderate	4 Major	5 Catastrophic	
	1 – Rare	Low 1	Low 2	Low 3	Low 4	Low 5	No action this 12 months
	2 – Unlikely	Low 2	Low 4	Low 6	Med 8	Med 10	Action within 6-12 months
	3 – Mod	Low 3	Low 6	Med 9	Med 12	High 15	
	4 – Likely	Low 4	Med 8	Med 12	High 16	High 20	UrgentAction
	5 – Almost Certain	Low 5	Med 10	High 15	High 20	High 25	

Chronology (timeline) of events (in brief)

Date & Time	Event

Level 1 Incident Report Form – Concise, Version 2.0, May 2010

Page 1 of 2

Detection of incident *Eg: When the error in patient's treatment was identified.*	Please select from the following list		
Care and service delivery problems *This should cover **key problem** points e.g. Nurses on ward regularly did not fully complete patients notes with regard to known allergies*			
Contributory factors *Other factors/issues which have contributed to the problem*			
Root causes *Most fundamental underlying factors contributing to the incident that can be addressed.*			
Lessons learned *Identified key safety and practice issues which may not have contributed to the incident, but from which others can learn*	1		
	2		
	3		
	4		
	5		
Recommendations *To be numbered and linked to learning and root causes.* **Recommendations will be progressed by Governance and via Divisional Governance Meetings on a bi-monthly basis for evidence of implementation.**	1		Time scale
	2		Time scale
	3		Time scale
	4		Time scale
	5		Time scale
Arrangements for shared learning *Description of how learning will be disseminated to immediate team and further Trust wide.*			
Communication with patient(s) / relatives? ***Was the patient harmed? If so was the patient/carer informed?***	Please select from the following list		
Support provided for staff ***Did the staff member require support?***	Please select from the following list		
How likely is there to be any media interest	Please select from the following list		
Do you recommend that a comprehensive investigation takes place?	Please select from the following list		
Reason why (please provide rationale)			
Name of person completing report			
Job title			
Date			
Signature			

**** 'Being Open' and 'Supporting Staff' documentation can be found on the Incident and Risk page of the intranet***

Please complete and copy to relevant manager, Director of Nursing, Risk and Compliance Manager

Appendix K

Serious Incident Worksheet

SERIOUS INCIDENT WORKSHEET

NAME:		
HOSPITAL NUMBER:		
INCIDENT DATE:		
INCIDENT NUMBER:		
TYPE OF INCIDENT:		
PLACE OF INCIDENT:		
RM INVESTIGATION COMMENCED		
Scope of investigation decided with Lead Inv		
LEVEL OF INVESTIGATION:		
STEIS NUMBER:		
DUE DATE FOR SHA:		
HEAD OF MIDWIFERY INFORMED:		
CLINICAL GOVERNANCE INFORMED:		
CHIEF NURSE INFORMED:		
INFORMED:		
INFORMED:		
INFORMED:		
INFORMED:		
WOMAN'S NAMED CONSULTANT INFORMED:		
Woman and Partner informed that SI		
SOM ON CALL ASKED TO INVESTIGATE:	NAME:	DATE:
LINE MANAGER INFORMED:		
ADDED TO SI DATABASE:		
OBSTETRIC NOTES PHOTOCOPIED:		
INVESTIGATION PROFORMAS ATTACHED:		
Multidisciplinary Team PreMeet Arranged		
TIMELINE COMMENCED:		
MINUTES TYPED AND CIRCULATED:		
DATES OF REPORT VERSIONS: Daily Sheets: Admission Book: Theatre Book: Date Final Version sent to NHSL:	VERSION 1: VERSION 2: VERSION 3: VERSION 4: VERSION 5: Date sent to FW, SM + AD:	

CLM 0910 V5

SERIOUS INCIDENT WORKSHEET

NAME:
STEIS NUMBER:
PAGE NUMBER:

NAME OF STAFF INVOLVED	TITLE	TIMELINE CODE	PERSONAL SOM OR EDUCATIONAL SUPERVISOR	PERSONAL SOM OR ED. SUP. INFORMED (Y/N)	DATE STATEMENT REQUESTED	DATE STATEMENT RECEIVED

6 Week PN Appointment made with Consultant	Date Requested:	Date of Appt:
Name of Consultant for 6/52 appointment		
Serious Incident discussed with parents at 6/52 appointment		
MEETING ARRANGED for PARENTS TO DISCUSS FINAL REPORT with Consultant:		
FINAL COPY OF REPORT SENT TO STAFF involved in incident		
FINAL COPY OF REPORT SENT TO CONSULTANT		
ACTION PLANS LOGGED ONTO DATABASE		
ACTION PLANS COMPLETED:		

CLM 0910 V5

SERIOUS INCIDENT WORKSHEET

NAME:
STEIS NUMBER:
PAGE NUMBER:

DATE OF INITIAL RM MEETING: LIST STAFF PRESENT:		
DATES OF SUBSEQUENT MEETINGS TO DISCUSS REVIEW AND UPDATE REPORT: LIST STAFF PRESENT:		

CLM 0910 V5

SERIOUS INCIDENT WORKSHEET

NAME:
STEIS NUMBER:
PAGE NUMBER:

NAME OF STAFF INTERVIEWED	DATE OF INTERVIEW	RELEVANT INFORMATION FROM INTERVIEW

Appendix L

Mid Essex Hospital Services NHS
NHS Trust

Directorate / Corporate Governance Meetings

TERMS OF REFERENCE

1 MEMBERSHIP

MEMBERS
Clinical Director (Chair)
Executive Lead
Head of Nursing/ Head of Midwifery (Deputy Chair)
Lead Nurse(s)
Governance Representative(s)
Clinical Audit Representative
HR Representative
Infection Prevention & Control

In addition to the membership detailed above, any other individual may be invited to attend at the discretion of the Chair.

2 PURPOSE

2.1 The purpose of the group is to provide a forum to review performance in all areas of directorate governance and to monitor the implementation of recommendations to address any identified deficiencies.

3 QUORUM

3.1 No business shall be transacted at a meeting unless at least four members are present including either the Chair or Deputy Chair.

4 ACCOUNTABILITY

4.1 The Group is accountable to the Executive Group Meeting through ensuring the routine review and follow up of Governance issues and recommendations.

5 DUTIES

5.1 To review and monitor any and all governance performance issues.

5.2 This will include review of:

- Directorate / Departmental Risk Assurance Framework;
- Incidents both clinical and non clinical and Serious Incidents
- Health and Safety Incidents
- Complaints
- Claims
- CQC Compliance

- NICE / NCE guidance compliance
- Clinical Audit reports and implementation of appropriate actions
- Mandatory Training attendance including Blood Transfusion Competencies / Equipment Competencies and other bespoke training as relevant to the Directorate; and
- Human Resources./ Appraisal /Sickness /recruitment

5.3 Where deficiencies in performance are identified, actions will be reviewed or developed by the group and progress monitored at each meeting.

5.4 In addition, all Directorates, including the Directorate of Women's and Children's Services will discuss the Integrated Learning Report, provide educational and clinical updates as identified through National Drivers and outcomes of investigations.

5.5 The Maternity Service will ensure that the Maternity Dashboard is discussed monthly and practice issues are discussed in relation to the outcome measures. The group will agree the methods of ongoing monitoring and improvement measures where required.

6 REPORTING ARRANGEMENTS

6.1 The Group will receive reports on key work-streams from the Governance Team, IP&C, HR and Training & Development

6.2 The group will report to the Executive Group Meeting

7 FREQUENCY

7.1 Monthly / Bimonthly.

8 REVIEW

8.1 Directorate Governance Groups should review the effectiveness of meetings and their function as a forum continually throughout the year with a formal review undertaken once yearly.

8.2 The Trust Secretary will review Directorate / Department Governance Meeting compliance with these terms of reference on an annual basis in accordance with the Risk Management Strategy and Policy.

September 2012

Appendix M

Management of the Directorate Risk Assurance Framework Register
Introduction

A Risk Register is a tool that enables an organisation to understand its comprehensive risk profile; it is a repository for clinical and non-clinical risk information that poses a threat to the objectives of the Directorate in ensuring a high quality and safe service to women and babies.

A Risk Register should be an active tool populated through a risk assessment and evaluation process. This enables risk to be quantified and ranked. It provides a structure for collating information about risks that helps both in the analyses of risks and in decision about whether or how those risks should be treated.

Within the Trust there are 2 Risk Assurance Framework Register levels:

- Directorate
- Corporate

The Corporate Risk Register is built from the Directorate RAF Registers and also includes organisation wide and strategic risks, this includes all risks rated 15 and above.

Once a risk has been identified it is discussed locally within the Directorate, and if significant in nature, at the Directorate Governance Meeting and escalated to the Patient Safety and Quality Committee. A robust action plan must then be developed and a lead identified for its implementation and conclusion. The responsibility for the appropriate management of a risk will remain within the Maternity Service and with the Manager who has been given the lead responsibility for the action plan.

Appendix N

Management responsibility for different levels of risk within the Organisation

Risk Rating	Management Responsibilities
Low 1-3 (Green)	The risk of injury or damage is minor and unlikely to happen again All Staff via DATIX **Manager to agree mitigation plan if required**
Moderate 4-6 (Yellow)	These risks may result in the need for additional medical treatment and/or have a marginal financial impact, which can be readily controlled and managed by the organisation. **Manager to agree mitigation plan**
High 8-12 (Orange)	These risks could impact on the Trust and threaten objectives with severe financial loss **The Head of Midwifery/Nursing, Chief Nurse, Executive Lead must be notified of these risks to ensure appropriate escalation to the Board** **To be added to the Directorate RAF Register** **Mitigation plans must be monitored and reviewed at the Directorate Clinical Governance Meetings**
Extreme 15-25 (Red)	These risks will pose a threat of excessive injury or fatality and include those which could occur on a frequent basis. They may also cause severe financial or reputational loss **The Head of Midwifery/Nursing , Executive Lead and Chief Nurse must be made aware immediately if an extreme risk is identified, the mitigation plan must be agreed and monitored at Board level** **To be added to the Directorate RAF Register** **To be added to the Trust Risk Assurance Framework Register and reviewed at Board level and monitored through the PS+Q Committee** **All high risk and extreme risks will be communicated to the Chief Executive/Board by the HoM or Executive Lead** **All risks graded 15 and over will be added to the Corporate RAF Register**

Risk Management Responsibilities

1. All Staff	Risks/hazards/complaints reported in line with policy – DATIX, to Head of Midwifery/Clinical Director, Executive Lead
2. Risk Assessors	Undertake risk assessments and report findings in accordance with Trust Wide Risk Assessment process
3. Head of Midwifery/Nursing	Ensure risk assessments that trigger moderate/high rating are included on the Directorate RAF register Instigate treatment/action plans and monitor Review Directorate RAF Register Escalate risks to Chief Nurse/CEO/Board when rated severe
5. Executive Lead for WCS	Escalate risks to Board as required via

	Decision/discussion/information process Monitor Directorate Risks on Corporate RAF register
6. Chief Nurse Chief Medical Officer	Escalate clinical risks identified at SIMG immediately to CEO Ensure strategic mitigation of organisational risks Provide clinical executive link between department and board committee reporting and monitoring
5. Head of Governance	Monitors all risks daily Escalates strategically Supports mitigation against organisational risks
7. Serious Incident Management Group (SIMG)	Daily monitoring and escalation of all incidents and incidents and risks Organisational focus and cross – discipline mitigation
8. Patient Safety + Quality Committee	Reviews the Corporate Risk Register quarterly Reviews reports on issues that cannot be managed and or funded locally Monitors treatment/actions plans that are rated severe Reviews Directorate Risk Registers annually Considers clinical and non-clinical risks that have been identified by groups and leads that report into the committee
9. Trust Board	Reviews Corporate Risk Register and Integrated Learning Report at least quarterly Reviews system of Risk management + Governance Seek assurance that processes are robust to respond to SIs

Definitions

Risk can mean different things in different contexts. For the benefit of this strategy the risks faced by the Maternity Services can be refined into 6 categories. Boundaries between the categories may not always be clear and some risks may fall into more than one category: -

Clinical Safety	Patient safety and experience Serious Incidents, clinical outcomes and the delivery of high quality care National Drivers and Standards for care such as NICE, CMACE
Health + Safety	Employee safety, safety of visitors to the Trusts premises Trust Infrastructure
Strategic	Long term strategic objectives of the Trust May be affected by legal and regulatory changes Changes within the Business environment and market forces
Compliance	Meeting statutory and non statutory standards set by the Care Quality commission, Health and Safety Executive, NHS Litigation Authority and other regulatory or enforcement bodies such s the Information Commissioner and local Fire Authority
Financial	Income, expenditure, fulfilment of contracts, commissioning arrangements Correct application of Standing Orders, Standing Financial Instructions and the Scheme of Delegation
Reputational	Recognises the impact of public opinion and events which may damage the credibility or good name of the Trust