Document Title:	**LEARNING FROM INCIDENTS, COMPLAINTS AND CLAIMS IN MATERNITY AND GYNAECOLOGY SERVICES**		
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Author/Contact: (Asset Administrator)	Christine Berner, Lead Midwife for Clinical Governance		
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Consulted With:	Post/ Approval Committee/ Group:	Date:
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Related Trust Policies (to be read in conjunction with)	04061 Risk Management Policy and Procedures 11025 Serious Incident Policy 04082 Complaints Handling Policy 06028 Management of Maternal Death 10088 Learning from Experience Policy 09062 Mandatory Training Policy for Maternity Services (incorporating Training Needs Analysis)09100 Incident Policy East of England Serious Untoward Incident policy 05098 Women's and Children's Directorate Clinical Governance Structure Policy (to incorporate Risk Management Policy)

Document Review History:			
Version No:	**Authored/Reviewer:**	**Summary of amendments/ Record documents superseded by:**	**Issue Date:**
1.0	Meredith Deane		October 2012
1.1	Meredith Deane	Clarification to 3.0	November 2012
2.0	Christine Berner		10 May 2016
3.0	Christine Berner	Full Review	18th June 2019

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1.0 Purpose

1.1 The purpose of this guideline is to set out and demonstrate how the Maternity and Gynaecology Services will ensure that learning occurs from all kinds of incidents, serious incidents, near misses, complaints and claims. This will include all those investigated in relation to patients, staff or visitors. It will ensure that all sources of learning are identified and utilised and that these are shared across the Maternity Service the organisation as a whole, when appropriate.

1.2 The Maternity and Gynaecology Services will promote a fair blame culture. The findings of investigations are not intended to blame individuals but to identify the casual factors and prevent recurrence. This guideline is therefore designed to support a learning culture and to ensure that changes in practice or system design occur where required.

1.3 Refer to:

- Women's and Children's Directorate Clinical Governance Structure; register number 05098;
- Risk Management Policy and Procedures; register number 04061;
- Serious Incident Policy; register number 11025;
- Learning from Experience; register number 10088;
- Complaints Handling Policy; register number 04082;
- Incident Policy; register number 09100;
- Being Open and Duty of Candour policy; register number 08063
- Claims Handling Policy and Procedure; register number 04081.

2.0 Objectives

2.1 The key objectives of this guideline are:

- To ensure that every incident, serious incident, complaint or claim is investigated within the set timescales.
- To initiate a systematic process for aggregating analysis of incidents, complaints and claims.
- To ensure that all serious incidents undergo a root cause analysis investigation, involving, as appropriate unbiased input as set out in the Serious Incident Policy; register number 11025
- To communicate lessons learned from all incident investigations to all staff across the service and that action plans are monitored and reported via the monthly Divisional Governance and Board meeting
- To ensure action plans are centralised on a database and monitored at least monthly, with non-compliance escalated to the Head of Midwifery/Nursing. The database will be the responsibility of the Lead Midwife for Clinical Governance. Actions are monitored through Datix, and all evidence of actions are attached to the Datix.
- To discuss learning from analyses, trends and themes at divisional Governance and Board Meetings, multidisciplinary perinatal mortality meeting, monthly audit meetings, quarterly audit meetings, manager's meetings, monthly risk management meetings, Professional Midwifery Advocates meetings, (Refer to the policy 'Women's and Children's Division's Clinical Governance Structure'; register number 05098).

- To measure the effectiveness of the changes to practice by reduction in similar incidents and improved outcomes divisionally.
- To build on the culture of reducing error rates by targeting underlying systems failures.
- For all staff to be able to identify clinical and non clinical risks and report incidents via DATIX, using the triggers for incident reporting and when it is believed that harm has been caused.
- To ensure Maternity and Gynaecology Services complaints and claims are monitored via the central DATIX system, which allows an aggregation of themes.
- The level of risk associated with incidents, complaints and claims will be assessed utilising the process set out in the "Women's and Children's Division's Clinical Governance Structure"; register number 05098 and will trigger addition to the Divisional Risk Assurance Framework (RAF) Registers when mitigation is not possible.

3.0 Integration of Information

3.1 The DATIX electronic Risk Management reporting system allows the linking of data on incidents, complaints, PALS enquiries and claims.

3.2 The Divisional Governance Report, provided by the Women's and Children's Clinical Governance Facilitator and Head of Governance will include a quantitative and qualitative analysis of complaints and incidents identifying any trends.. The Complaints and PALS team also submit a separate report regarding complaints, which is reviewed at the Divisional Governance and Board meeting.

3.3 The Divisional claims and complaints reports are reviewed at the Divisional Governance and Board Meeting and the Maternity Service Risk Management Group meeting. Any formal concern which has been raised by a patient with an alleged degree of harm will be discussed at the Directorate Review Group to decide if the response should be answered by the complaints process or the clinical incident investigation process.

3.4 The Trust's Governance department will also monitor how effectively recommendations are implemented within Maternity and Gynaecology. Exception reports will be presented monthly to the Divisional Board and Governance meeting. The number of open electronic incidents are discussed weekly at the Divisional Safety Huddle, monthly at the Divisional Board and Governance meeting as well as the Trust's monthly Risk and Compliance meeting. Unresolved risks are collated on the Risk Assurance Framework, new and high scoring risks are presented at the Divisional Board and Governance meeting and the monthly Accountability and Performance meeting for discussion and on-going monitoring.
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3.5 Information will be communicated out to all staff via staff memos, newsletters and notice board updates.

3.6 Where specific trends are identified, a trend analysis, benchmarking or audit process will be undertaken.

4.0 Dissemination of Information

4.1 The monthly reports will be an agenda item on the following groups: Divisional Governance and board Meeting, Maternity Service Risk Management meetings.

4.2 In addition, the Lead Midwife for Clinical Governance will ensure that a summary of the Serious Incident reports will be circulated to all staff, as well as any learning from clinical and non-clinical incidents, complaints and legal cases are shared through the divisional newsletter, and secure media sites, as well as being incorporated into practice through ward handovers, guideline and notes updates and mandatory training.

5.0 Maternity Service and Organisational Learning

5.1 All complaints, claims and incidents, which are subject to a management investigation, must include an action plan. The recommended actions will be disseminated and monitored via the Datix system.

5.2 The Divisional Governance and Board Meeting and Risk Management Group will monitor the implementation of the actions and learning arising from Serious Incidents, claims and complaints. The Trust's monthly Risk and Compliance Group meeting and the Accountability and Performance meeting will be provided with assurance that unresolved risks are monitored via the RAF.

6.0 Meetings, Groups and Forum

6.1 The local Clinical Governance arrangements within the Maternity and Gynaecology Services will provide the framework by which lessons learned from all risk events, incidents, complaints and claims are actively disseminated.

6.2 Refer to the Women's and Children's Directorate Clinical Governance Structure; register number 05098 for all meetings and forums and roles and responsibilities of individuals within Maternity services which relate to this policy.

7.0 Risk Event Reporting (DATIX)

7.1 All incidents must be reported on DATIX in accordance with the Incident Policy (09100). Information relating to Director Review Group meetings, timelines and the decisions made are filed electronically on the Governance database for management of serious incidents. Incidents will normally be reported on Datix within 24 working hours.

7.2 Guidance on how to complete a DATIX form is available on the intranet.

7.3 Incidents, risks and near misses (clinical and non-clinical) should be reported in accordance with the Incident Policy (09100) to ensure a timely response and immediate mitigation).

7.4 The reporting of datixes allows the Trust to manage risks that will lead to improved safety, reduced risk and the provision of a high quality maternity service.

7.5 DATIX will be used to report on medical equipment problems and medication events/ errors as well as health and safety issues.

7.6 All risk events should be investigated with appropriate remedial action implemented.

7.7 For any incident which may meet the criteria for a Serious Incident (see "Serious Incident Policy", register number 11025) a 24 hour report will be written, and presented to the Director's Review Group who will determine if the incidents warrants declaring as a Serious Incident. The decision to declare an incident as a Serious Incident is taken by the Director's Review Group.

7.8 Completed and approved comprehensive reports are circulated to all staff after individual feedback is given; thematic learning is presented at divisional formal meetings and embedded in practice.

8.0 Management of Risk Event Reporting

8.1 Incident forms do not form part of the patient records and therefore should not be retained in the patient's records. Completion of an incident form does not constitute an admission of liability.

8.2 Datix reported risk events will be forwarded electronically to the Lead Midwife for Clinical Governance, the Head of Midwifery/Nursing and relevant midwifery managers and team leaders.

8.3 An immediate review of the health care records will occur if any incident raises risk concerns which may require an immediate action. This will be undertaken by the Specialist Midwife for Risk Management, Clinical Lead for Risk Management, Head of Midwifery/Nursing to determine if further investigation is required and remedial action necessary.

8.4 A Datix will be completed by a member of staff who is aware of the details of the incident. Where immediate actions have been undertaken, this should be included in the Datix.

8.5 The daily Divisional Safety Huddle meeting reviews incident reports submitted over the previous 24 hours. The management of these incidents is decided at this meeting and the investigating officer is assigned. The meeting is chaired by the Head of Midwifery/ Head of Nursing/ Clinical Director. The meeting is attended by the lead midwives and nurses. Significant incidents should be identified to the governance team for review at the Director's Review Group meeting, which is jointly chaired by nursing medical and governance representatives.

8.6 The Specialist Midwife for Risk Management is responsible for the follow up of all reported maternity risk events and the daily dialogue with the Head of Midwifery/Nursing regarding incidents reported.

8.7 The Specialist Midwife for Risk Management with the Clinical Governance Facilitator will provide a trend analysis report for the Divisional Governance and Board Meetings to identify commonalities and on-going mitigation.

8.8 The Specialist Midwife for Risk Management will meet at least weekly with the Lead Obstetric Consultant for Risk Management.

9.0 Serious Incidents (SI)

(Refer to the Serious Incident Policy; register number 11025)
(Refer to Appendix B)

9.1 The framework for reporting and investigating serious incidents supports openness and learning.

9.2 The response to each incident will be proportionate to the scale, scope and complexity of the incident and will support a 'Just Culture' approach.

9.3 A serious incident requiring investigation is defined as an incident that occurred in relation to NHS-funded services and care resulting in death, serious harm, allegations of abuse, adverse media coverage or a never event.

9.4 For incidents which may meet the criteria for declaring as a 'Serious Incidents, (see Serious Incident policy 11025) the Head of Midwifery/Nursing will be informed immediately by telephone/email, the incident will be escalated as appropriate the next working day to the Director of Nursing, and Clinical Director.

9.5 A maternal death will be escalated immediately to the on-call Executive Director via the Head of Midwifery/Nursing.

9.6 A serious incident which meets the criteria for reporting to the Healthcare Safety Investigation Branch (HSIB) will be notified promptly after the incident. Recommendations from the report will be shared.

9.7 Incidents which meet the criteria for reporting to NHS Resolution's Early Notification scheme, will be notified through the Trust's Legal Department within 30 days.

10.0 Investigation and management of Serious Incidents (SI) and Never Events

10.1 When a SI has been identified, the following process must be followed in line with the Trust Serious Incident Policy, in or out of hours.

10.2 The table below outlines the reporting structure for potential serious incidents.

Who	**Reports to: in normal office hours**	**Reports to: out of hours**
Staff member who identifies possible serious incident	Midwifery Manager, specialist Midwife for risk Management, Lead Midwife for Clinical Governance, Head of Midwifery/Nursing Completes a Datix	Midwifery Manager on call Who informs the Head of Midwifery/Nursing
Unit leader or site Manager /Midwifery manager on call	Head of Midwifery/Nursing Executive Lead If a **serious criminal act** is suspected, the **police** should also be informed **immediately**	Executive On call
Head of Governance Chief Nurse	Director of Nursing, Managing Director and Medical Director	

10.3 The SI management process will then follow the 'High Level SO Process' as outlined in appendix 2 and appendix 5 of the Serious Incident Policy (11025).

10.4 **The Head of Midwifery** will allocate an Investigating Officer (IO).

10.5 **The Investigating Officer** will establish an event log as a contemporaneous record of what actions are taken, to include the following:

- Notify the consultant in charge of the patient's care that the incident is a SI;
- Communicate with and update the patient and their relatives;
- Offer support and maintain a dialogue as the investigation progresses;
- Arrange for the release of staff who were present at the time of the incident to a) draft a statement and b) and assess the impact of the incident on them;
- Assess the need for counselling for the staff involved;
- Explain to staff on duty what has happened and keep them briefed;
- Assess the potential for press interest and advise Head of Midwifery/Nursing who will liaise with the Director of Communications where appropriate;
- Reinforce the need for staff to maintain confidentiality;
- Assess the requirement to liaise with the police/security team and making arrangements to do so when appropriate;
- Liaising with the legal team, Head of PALS and Complaints about any potential coroner's case;
- Confirm the senior midwife on duty has ensured that a Datix form is completed by staff involved in the incident prior to leaving duty.

10.6 All investigation notes and photocopies of maternity records (including CTGs) should be archived within the maternity services: the electronic record of the investigation will be stored in the designated file on the m-drive, the hard copies of the risk event form, maternity records and investigation, including interviews and statements will be stored by the Maternity Clinical Governance team as well as being attached to the Datix.

10.7 Where a helpdesk process is required, this will be managed by the Head of Midwifery and the Director for Communications.

10.8 The midwife in charge has responsibility for ensuring that all related records are kept secure until such time as they are handed over to the Divisional governance Team.

10.9 Other notifications will be undertaken by appropriate staff, e.g. infection prevention team will inform the Health Protection Agency.

10.10 The Investigating Officer will appoint a case panel as part of the investigation team.

10.11 The Investigating Officer will be a senior clinician or midwife, expert in the relevant field, but not involved with the incident, and will be conversant with the SI process.

10.12 They will complete a 24 hour concise report to determine the main facts and identify any significant risks, which require immediate action.

10.13 The 24 hour report will be forwarded to the Head of Midwifery/Nursing for presentation at the next day's DRG meeting.

10.14 The SI may be de-escalated by the DRG following receipt of the concise report.

10.15 **Level 2 comprehensive reporting within 30 days**

10.16 The IO will be familiar with the requirements for Serious Case Reviews for child protection issues where these are relevant to the Trust investigation process.

10.17 The Level 2 investigation will use Root Cause Analysis to determine the root cause of the incident. Where deemed beneficial through the investigation process, an external agency will be involved to provide an unbiased input. The terms of reference for the investigation will be determined at the daily Quality and Safety Meeting.

10.18 The IO **will** undertake the following:

- Using the Trust's formal template (see Serious Incident Policy, 11025) request statements and when required arrange to interview staff involved in the incident;
- Ensure that copies of the notes, incident forms, and other relevant documentation are available for staff asked to interview or for statements;
- Determine the terms of reference and arrange a panel review within the target timescale of 45 days for reporting to the Clinical Commissioning Group. Extensions may be agreed with the Clinical Commissioning Group. to enable an effective comprehensive investigation;
- The management of support for staff directly involved in the investigation will be discussed at the daily Safety Huddle Meeting. It may be determined, from the nature of the incident, that consideration needs to be given to whether the individual (s) involved, restrict their duties or be suspended, either for their own safety or well being or that of others, including patients. Consideration should be given to the individual to relocate their workplace as a supportive measure;
- Fitness to practice/purpose concerns should be raised by the IO to the Head of Midwifery.

10.19 A Panel Review Group will be arranged to review the findings of the IO, all evidence at this meeting will be anonymised to ensure objectivity. Panel members will be experts in the realm of the incident; but also must not be involved in the incident to maintain objectivity.

10.20 The purpose of the Panel Review Group is to identify: contributory factors, care and service delivery problems, root causes and recommendations for learning.

11.0 Monitoring Effectiveness of Risk Reduction Measures

11.1 This will be the primary responsibility of the Lead Midwife for Clinical Governance, Head of Midwifery, Clinical Director and Executive Lead for Maternity Services. The clinical governance structures within the Trust will support the reduction and management of risks within Maternity Services.

11.2 Where high level risks have been identified, the implementation and effectiveness of mitigation plans will be monitored by the Patient Safety and Quality committee and the Governance Team through the process outlined in the Risk Management Strategy.

11.3 The RAF will be reviewed bi-monthly at Divisional Governance and Board Meetings and at least quarterly at the Patient Safety and Quality Committee.

12.0 ANNB Screening Incidents

(Refer to "Women's and Children's Directorate Clinical Governance Structure Policy (to incorporate Risk Management Policy)"; register number 05098 and the "Incident policy"; register number 09100)

13.0 Management of Incidents, Complaints and Claims

13.1 Incidents, complaints and claims will be assessed on an individual basis and undergo a root cause analysis as appropriate in accordance with the guidance of the Incident Policy; registration number 09100.

13.2 Review and discussion of incidents, complaints and claims will be an agenda item at the following forums/meetings:

- Multidisciplinary Risk Management Group;
- Divisional Governance and Board Meeting;
- Labour Ward Forum;
- Manager's Meetings.

Please refer to the "Learning from Experience Policy"; Register No 10088, or full details of the organisation wide approach to investigation, analysis and learning from incidents, complaints and claims.

13.4 The Trust guidance (refer to "Incident Policy"; Register number 09100) applies to all types of incidents, whether clinical or non-clinical, including those giving rise to complaints or claims.

13.5 All Maternity Services complaints are forwarded to the Head of Midwifery/Nursing for allocation of an Investigating Officer.

13.6 The completed investigation with recommendations and learning will be forwarded to the Head of Midwifery/Nursing for approval and agreement of Action Plans with a strategy for sharing learning evident in the response.

13.7 The Head of Midwifery/Nursing will forward the investigation template and response to Complaints and PALs.

13.8 All complaints will be responded to in line with the "Complaints Handling Policy"; register number 04082.

13.9 All complaints are logged centrally on the DATIX system by the PALS Department.

14.0 Learning from Incidents, Complaints and Claims

14.1 This should be read in conjunction with the “Serious Incident Policy”; register number 11025 and “Learning from Experience”; register number 10088.

14.2 Implementing recommendations from incident investigations will demonstrate that the maternity service is learning from risk events/incidents, complaints and claims. Learning will contribute to improved safety and quality of the patient experience.

14.3 Outcomes will be at shared at departmental level through established communication systems.
(Refer to Women’s and Children’s Directorate Clinical Governance Structure; register number 05098)

14.4 Learning outcomes will be shared to ensure minimising risks of recurrence; these will be through formal feedback to the maternity service and support and implementation of training and updates for individuals involved in the incident.

14.5 Learning outcomes from incidents, complaint and claims will be disseminated through a variety of forum:

- Clinical data is incorporated into the monthly maternity dashboard. This is displayed in the clinical areas and circulated to the Head of Midwifery, the Chief Nursing Officer and the Director of Nursing;
- Red areas identify risks which are outside of acceptable parameters. These are discussed at the monthly audit meeting with the relevant actions to be taken;
- Outlying risks are discussed at the monthly divisional Governance and Board Meeting to identify emerging trends. The dashboard and statistics are discussed at the monthly Risk Management meeting as an agenda item;
- The maternity dashboard is displayed in clinical areas;
- Professional Midwifery Advocates monthly meeting as an agenda item;
- Learning is disseminated through mandatory training (particularly human factors training);
- Presentation of admissions to the neonatal unit, both planned and unplanned at the monthly perinatal mortality and obstetric audit meeting;
- Learning from incidents is feedback on a monthly basis prior to the perinatal mortality and obstetric audit meeting;
- The maternity services liaison committee – complaints and risk events;
- The bi monthly midwives team leaders meeting;
- The investigation report is circulated to all staff;
- Individual feedback;
- Guideline and policy changes;
- Quarterly divisional newsletter which contains the top risks and incidents are circulated to all staff;
- Formal ward handovers on a daily basis;
- Safe, effective care updates.

15.0 Monitoring of Action Plans

15.1 The Specialist Midwife for Risk Management will ensure that the recommendations and Action Plans from each Serious Incident Investigation; these will be monitored ensure actions are completed within set timescales.

16.0 Staffing and Training

16.1 All midwifery and obstetric staff must attend yearly mandatory training which includes learning from incidents, complaints and claims. Training is delivered by the Specialist Midwife for Risk Management or the Lead Midwife for Clinical Governance.
(Refer to 'Mandatory training policy for Maternity Services (incorporating training needs analysis); Register number 09062)

16.2 All midwifery and obstetric staff are to ensure that their knowledge and skills are up-to-date in order to complete their portfolio for appraisal and revalidation.

17.0 Equality Impact Assessment

17.1 Mid Essex Hospital Services NHS Trust is committed to the provision of a service that is fair, accessible and meets the needs of all individuals.
(Refer to Appendix D)

18.0 References

Knight, M et al (eds) on bealf of MBRRACE-UK (2018) Saving Lives, Improving Mothers' Care: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2014–16. Oxford: National Perinatal Epidemiology Unit. Available at: https://www.npeu.ox.ac.uk/mbrrace-uk/reports

NHS Resolution (2019) Early Notification Scheme. [online] https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/early-notification-scheme/ (Accessed 10/06/2019)

Healthcare Safety Investigation Branch. Maternity Investigations [online] https://www.hsib.org.uk/maternity/ (accessed 10/06/2019)

National Institute for Health and Care Excellence (2015) Safe Midwifery Staffing for Maternity Settings. NICE Guideline (NG 4) London: NICE Available online at: https://www.nice.org.uk/guidance/ng4

Care Quality Commission (2010)Guidance about compliance: Essential standards of quality and safety. What providers should do to comply with the section 20 regulations of the health and social care act 2008. London: Care Quality Commission

Royal College of Obstetricians and Gynaecologists, Royal College of Midwives, Royal College of Anaesthetists, Royal College of Paediatrics and Child Health (2007) Safer

Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour. London: RCOG.

NHS England Patient Safety Domain (2015) Serious Incident Framework: Supporting Learning to Prevent Reoccurrence. London: NHS England Available at: https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf

2018 edition available:
NHS Improvement (2019) Never Events List 2018. London: NHS Improvement Available at: https://improvement.nhs.uk/documents/2266/Never_Events_list_2018_FINAL_v5.pdf

UK National Screening Committee. (2017) Managing Safety Incidents in NHS Screening Programmes. London: Public Health England Available online at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/672737/Managing_safety_incidents_in_National_screening_programmes.pdf

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 5 hours)
Rupture of uterus (fetal parts in the abdomen)
Difficult intubation
Failed forceps or ventouse
Failed instrumental delivery/2nd stage Caesarean section
Maternal injury during delivery (bladder/bowel)
Third degree tear
Fourth degree tear
PPH > 500mls or symptomatic vaginal birth
PPH > 1000ml caesarean section
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 (>22 weeks)/unbooked woman
Severe APH
Severe PET/Eclamptic fit
Maternal collapse
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

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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
Closure of standalone birthing units
Pressure Ulcers
Unplanned admission to ITU
DVT/pulmonary embolism

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

Appendix B

Minimum Set of Reportable Maternity which may be potential Serious Incidents (level of harm to be assessed)

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 at 5 minutes where there are also neonatal seizures or cord pH of less than 7.1	
Organisational	
• Closure of the acute Maternity Unit which impacted upon patient care. • Any other incidents where circumstances suggest a claim may result	

Appendix C

A Serious incident requiring investigation is defined as an incident that occurred in relation to NHS-funded services and care resulting in one of the following:

- Unexpected or avoidable death
- Serious harm where the outcome requires life saving intervention, major surgical/medical intervention, permanent harm or will shorten life expectancy or result in prolonged pain or psychological harm
- Scenario that prevents a provider organisations ability to continue to deliver healthcare services
- Allegations of abuse
- Adverse media coverage or public concern about the organisation
- Core ‘Never Events’ – wrong site surgery, retained instrument, in-hospital maternal death from postpartum haemorrhage after elective caesarean section.

NHS England (2015)

Appendix D: Preliminary Equality Analysis

This assessment relates to: 12021 Learning From Incidents, Complaints and Claims in Maternity and Gynaecology Services

A change in a service to patients		A change to an existing policy	**X**	A change to the way staff work	
A new policy		Something else (please give details)			

Questions	**Answers**
1. What are you proposing to change?	Full Review
2. Why are you making this change? **(What will the change achieve?)**	3 year review
3. Who benefits from this change and how?	Patients and clinicians
4. **Is anyone likely to suffer any negative impact as a result of this change?** If **no**, please record reasons here and sign and date this assessment. If **yes**, please complete a full EIA.	No
5. a) Will you be undertaking any consultation as part of this change? **b) If so, with whom?**	Refer to pages 1 and 2

Preliminary analysis completed by:

Name	Chris Berner	**Job Title**	Lead Midwife Clinical Governance	**Date**	April 2019