Mid Essex Hospital Services NHS
NHS Trust

WOMEN'S AND CHILDREN'S DIRECTORATE CLINICAL GOVENANCE STRUCTURE POLICY (TO INCORPORATE RISK MANAGEMENT STRATEGY)	CORPORATE/STRATEGIC Registration No: 05098 Status: Public

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Document History

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1.0	Anne Smith	September 2006
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4.0	Deb Cobie	January 2010
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5.0	Meredith Deane	October 2012
5.1	Sarah Moon – clarification to sections 18.0, 19.0 and 20.0	January 2013
5.2	Meredith Deane - clarification to Appendix A	June 2013
5.3	Sarah Moon – clarification to point 10; Appendices G to N	January 2014
5.4	Sarah Moon – clarification to point 10.2; Appendices G; O and P	November 2014
6.0	Chris Berner, Lead Midwife Clinical Governance	May 2016

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1.0 Purpose

1.1 The purpose of this strategy is to outline how Women's and Children's Services aim to manage clinical and non-clinical risks in order to contribute to the Trust's overall governance and risk strategy.

1.2 It is a framework document based upon the principles set out in the Trust's overarching Risk Management Strategy and Policy (Register No: 04061); the Serious Incident Policy (Register No: 04060) and the Women's and Children's Directorate Clinical Governance Structure (Register No. 05098). The strategy will be implemented to ensure it complies with the objectives set within the document and any other external regulatory and accreditation processes.

1.3 The document also sets out the principles and strategic direction of the management of risk throughout Women's and Children's Services.

1.4 It reflects the commitment by Women's and Children's Services to improve the quality of care provided by taking proactive and positive actions to mitigate, reduce and manage the risks identified.

1.4 This policy is for the use of all staff within Women's and Children's Services

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2.0 Statement of Intent

2.1 Women's and Children's Services is committed to embedding the Trust's 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 system, which is designed to make a positive contribution towards improving the quality of patient care and the safety of its staff, patients and visitors.

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

2.4 The Trust's Risk Management Strategy and Policy will inform the Women's and Children's Directorate Clinical Governance Structure (05098) 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 Women's and Children's Services are 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 Women's and Children's Services will constantly reflect on how it works and embed a culture of continuous improvement to safeguard high standards of care.

3.3 The Women's and Children's Services will promote and embed the following:

- Quality and safety as central to the Women's and Children's Services 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 Women's and Children's Services 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 Women's and Children's Services
- 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 Women's and Children's Services has carried out risk assessments, has controls in place and recommendations for improvements for the following external bodies; Care Quality Commission (as required), 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 Women's and Children's Services are unable to resource high priority risk action plans
- Women's and Children's Services will annually review the Clinical Directorate Governance Structure (05098) to ensure it continues to reflect the objectives of the Trust Risk Management Strategy and Policy.

4.0 Targets 2015-17

4.1 Women's and Children's Services have 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 and gynaecology services'; register number 12021)
- Develop and embed a procedural framework which ensure the effective management of all risks within Women's and Children's 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 care for women and newborns
- Monitor morbidity, mortality and other significant service quality key performance indicators (KPI) using the relevant 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, i.e. Family and Friends Test, Feedback Local Survey and complaint responses are reviewed as part of the Risk Management process
- CQC assessment in June 2016
- 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 2016-2018 are set out below. These objectives will be reviewed annually and progress reported at least quarterly via the Women's and Children's 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 Women's and Children's Directorate Governance Meetings
- The sharing of the Directorate's monthly Governance Report at Women's and Children's 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 relevant 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 Women's and Children's 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 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 To investigate any 'Never Events' that occur within Women's and Children's Services, to prevent recurrence 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 60 day timescale for submission to the CCG

6.6 To ensure there are sufficient competent assessors to cover all areas for risk relevant to Women's and Children's Service including: Clinical, COSHH (control of substance hazardous to health), DSE (Display screen equipment), Health and safety to including manual handling) and Infection Prevention.

6.7 The Women's and Children's 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 and audit teams, Women's and Children's 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 mandatory training Policy'; register number 09062.

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

- National Institute of Excellence (NICE)
- Mothers and Babies Reducing Risk through Audits Confidential Enquiry
- Royal College of Midwives (RCM)
- Royal College of Obstetricians & Gynaecologists (RCOG)
- Nursing and Midwifery Council (NMC)
- NHS Litigation Agency (NHSLA)
- Kings Fund
- Maternity Matters (Department of Health)
- 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
- Kirkup Report
- Francis Report
- Keogh Report
- Berwick Report
- Saving Babies' Lives
- Cumberlege Report – Better Births 2016
- Serious Incident Framework 2015
- Perinatal Mortality Surveillance Report 2013
- MBRRACE UK 2015 Perinatal Confidential Enquiry Team
- Morecambe Bay Report
- Spotlight on Maternity 2016

6.14 To promote a proactive approach to statutory supervision of midwives to ensure that by 2016 there is a 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 Datix 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 and Nursing Managers
- Education and training available via e learning, Trust Learning and Development programmes and Mandatory Training
- Provision of expert accessible advice in risk issues
- Recommendations and outcomes publicised in the Women's and Children's Newsletter

- Distribution via risk notice board and Hot Topic to disseminate learning
- Copies of the Women's and Children's Clinical Governance Structure (05098) will be available in clinical areas throughout Women's and Children's Services; in the risk management and guideline information notice boards
- All new staff, midwifery and obstetric will meet with the Lead Midwife for Clinical Governance 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. They will ensure 100% of staff are allocated to, and at least 85% of all midwives, nurses, 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 (TNA) 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 aware of the management of risks inherent in their daily work will be identified through the training needs analysis and induction. 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 dependent 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 basic life support 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 Lead Midwife for Clinical Governance and when possible the Head of Midwifery to discuss governance and risk management processes

- All newly qualified midwives receive a written programme of preceptorship for the first 12 months of employment and nurses?
- 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 training 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 Training sessions will be available as required 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. This updated yearly.

9.0 Women's and Children's Services Clinical Governance 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 Speak up Policy (previously known as 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 Women's and Children's Services' Groups
(Refer to Appendices G to U)

10.2 Women's and Children's Services' liaise with committees/groups and forums with a responsibility for risk management:
(Refer to Appendices H, I and V)

Women's and Children's Services' Groups Terms of Reference

- Women's and Children's Directorate Governance Meeting
(Refer to Appendix G)
- Women's and Children's Clinical Audit Group Meetings
(Refer to Appendix L)

- Obstetrics and Gynaecology Consultants' Group
(Refer to Appendix J)
- Multidisciplinary Risk Management Group (MRMG) - Maternity Services
(Refer to Appendix H)

- Labour Ward Forum
  (Refer to Appendix M)
- Quality Steering Group
  (Refer to Appendix N)
- Maternity Staff Council Group
  (Refer to Appendix P)
- Maternity Manager's Group Meeting
  (Refer to Appendix R)
- Antenatal and Newborn Screening Steering Group
  (Refer to Appendix S)
- Infectious Diseases in Pregnancy Group
  (Refer to Appendix T)
- Maternity Service Liaison Committee (MSLC)
- Supervision of Midwives Group

- Children's Urgent and Emergency Care Group
  (Refer to Appendix Q)
- Paediatric Multi-disciplinary Departmental Meeting Group
  (Refer to Appendix I)
- Children's and Young People Staff Council Group
  (Refer to Appendix O)
- SAFE Paediatric Surgery Group (Wizard)
  (Refer to Appendix U)
- Paediatric Risk Management Group Meeting (CQRP Report)
  (Refer to Appendix V)

10.3 In addition, there are committees/groups within the Trust which have a level of responsibility for risk management within Women's and Children's Services 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 Women's and Children's Services review and monitor their risks as part of a wider governance agenda. The following will be discussed:

- Directorate Governance Report
- RAF Register
- Non-compliance with national recommendations e.g. NICE, CMACE
- Practice issues and changes required from learning and guidance/action plans from Audit and Risk management
- Serious Incidents
- Health and Safety alerts and issues
- Risk assessments
- Educational and clinical updates
- MCADD alerts
- Rapid response alerts
- HR updates on sickness and appraisals
- Compliance with training needs
- Infection prevention audits
- Incidents, complaints and claims (bi-monthly)

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 Lead Midwife for Clinical Governance will ensure the agenda reflects the priorities of Women's and Children's Services.

11.4 The minutes will be distributed to staff within Women's and Children's Services 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, Gynaecology and Paediatric Risk Management Group

12.1 It is the key service group in relation to local Risk Management issues; it also reviews the Risk Assurance Framework (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 Women's and Children's newsletter.

12.3 This group is accountable to the Women's and Children's Directorate Governance Meeting and feeds into the Trust Patient Safety Group via the Lead Midwife for Clinical Governance.

12.4 It meets monthly to review concise 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 Chief Executive Officer.

12.6 The Chair will notify the Head of Midwifery/Nursing to update the Women's and Children's Directorate RAF Register.

13.0 Labour Ward Forum

13.1 Meets quarterly 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
- Departmental Meetings
- Managers' Meetings
- Community Midwives Meetings
- Ward Meetings
- Supervision of Midwives Meeting
- MSLC
- Directorate Safety Huddles

15.0 Risk Management Organisation, Accountabilities, Roles and 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 Women's and Children's Services 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 is the designated Lead for Maternity Services and represents Women's and Children's Services at Board Level. The Executive Director obtains assurance from Women's and Children's Services on risk issues through:

- The daily Quality and Safety meeting (huddle) which is attended by the Head of Midwifery and Nursing and the Directorate Leads and Nurses
- One to one meetings monthly with the Head of Midwifery/Nursing to discuss and resolve risk issues that have not been addressed 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
- Daily Safety huddle
- Monthly Directorate Governance Report
- Quarterly Clinical Quality Risk Group (CQRG)
- 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 Women's and Children's Services

17.1 **Clinical Director for Women's and Children's Services -** The Clinical Directors are 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 Women's and Children's Services
- 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/Head of Nursing arising within the Maternity, Gynaecology and Children's Services to the Board. The responsibilities involve the following:

- Where risks arise outside the normal risk management process, the Executive Lead and the Chief Nurse, will be alerted to contact any 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/ Nursing, even out of hours
- Communication regarding these high level risks i.e. 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 Chief Executive Officer 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 Women's and Children's Directorate, and is the professional lead for midwifery and nursing within Women's and Children's 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
- Responsible for supporting and embedding the implementation of the Risk Management process within Women's and Children's 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 Women's and Children's 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 Women's and Children's 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. Represent the Women's and Children's Services at the Patient Safety and Quality Committee bi-monthly meetings.
viii. Act as the link between the Directorate and corporate functions on Risk Management issues
ix. Responsible for the management of the Risk Assurance Framework Register
x. Ensure that Midwifery and support staffing levels and skill mix are reflective of service requirements
xi. Allocate an Investigating Officer who is responsible for ensuring that the Duty of Candour is addressed and completed within the agreed timescales

17.4 **Specialist Midwife for Audit, Guidelines, Patient Information Leaflets and CQC Lead for Women's and Children's Services**- has responsibility for developing key relationships with clinicians and risk and governance leads within the Trust to ensure the Women's and Children's Services agenda for audit, guidelines/policies and patient information development; and CQC requirements reflect the Trust wide objectives in these key areas of service provision and strategy. The responsibilities involve the following:

- Responsible for overseeing the CQC re-visit in April 2016

- The management and co-ordination of clinical guideline development within Maternity, Gynaecology and Paediatric Services
- Communication of information concerning clinical guidelines, including electronically and in hard copy to encompass Women's and Children's Services
- Clinical guideline archivist
- To represent MEHT 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 Standard's processes
- 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
- Ensure that recommendations from National policy are embedded in practice through guidelines and that non-compliances are escalated to Board level through the RAF
- 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

17.5 **Clinical Leads for Women's and Children's Services**

Clinical Lead: Gynaecology Consultant for Risk Management
Clinical Lead: Obstetric Consultant for Risk Management
Clinical Lead: Anaesthetic Consultant for Risk Management
Clinical Lead: Paediatric/ Neonatal Consultant for Risk Management

17.5.1 They have senior clinical responsibility for Risk Management within Women's and Children's Services. The responsibilities involve the following:

- They play a key role in the implementation of this strategy with the support and collaboration of the Clinical Leads and the Head of Midwifery/Nursing.
- The Clinical Leads for Risk Management will ensure systems are in place to reduce and eliminate clinical risk throughout Women's & Children's Services everyone within his/her area with dedicated time within his/her job plan for risk management:
- They are accountable to the Clinical Director for Women's & Children's Services and will meet at least weekly with the Lead Midwife /Lead Paediatric/Neonatal Nurse for Clinical Governance to review risk events and ensure the processes for investigation and learning are complete
- It is the Clinical Lead for Risk's responsibility to:

i. Provide medical opinion on clinical risk issues and to give expert clinical advice within the Directorate on Risk Management issues
ii. To work closely with the Lead Midwife/Lead Paediatric/Neonatal Nurse for Clinical Governance
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 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. Clinical Lead with the Lead Midwife for Clinical Governance at the monthly Multi-disciplinary Risk Management meetings (applicable to Leads of Gynaecology, Obstetrics and Anaesthetics)
vii. To ensure that training and updating sessions are undertaken for all staff to include CTG, skills drills, operative procedures (applicable to Leads of Gynaecology, Obstetrics and Anaesthetics)

17.5.2 **Lead Obstetric Anaesthetist -** Has overall responsibility for the anaesthetic service in Maternity and Gynaecology 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 Women's and Children's Services
- 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

17.6 **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 Women's and Children's Services
- 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 Lead for Governance, 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 inter-professional 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 Women's and Children's Services against a National Enquiry or Report

17.7 **Lead Midwife for Clinical Governance -** Is the identified individual with responsibility for coordinating and implementing clinical risk management, audit and complaints processes within Maternity and Gynaecology 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 through the daily Directorate, Quality and Safety meeting; either electronically or 1:1
- Deputises for the Head of Midwifery/Nursing at Risk Meetings where appropriate e.g. Trust Serious Incident Management Group meetings, Directorate Governance meetings SIMG
- 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 Clinical Leads 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, audit and complaints' processes 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 Women's and Children's 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 Women's and Gynaecology 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,

Women's and Children's 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 **Band 8a: Lead Midwife for 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 Lead Midwife for Clinical Governance, Lead Obstetric Consultant for Labour Ward, Lead Anaesthetist and Clinical Lead 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 weekly 1:1 with the Head of Midwifery/Nursing to formally update risk concerns and issues that are on-going and not resolved at the daily Labour Ward Handover, which the Head of Midwifery attends with the Lead Midwife for Labour Ward. In addition to attend the daily Directorate, Quality and Safety meeting
- Attend and participate in Multi-disciplinary Risk Management meetings, MSCL and Women's and Children's Directorate Governance meetings to discuss issues and provide updates on risk events within areas of responsibility, ensuring risk control plans are communicated throughout the service
- To organise and chair the quarterly Labour Ward Forum meetings
- 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 Clinical Leads for Risk Management and the Lead Obstetrician for Labour Ward

- Meet daily with the Lead Midwife for Clinical Governance to identify on-going concerns, new risks and implement findings from incident reviews and investigations
- To immediately review any incident causing serious concern with the Lead Midwife for Clinical Governance and Obstetric Consultant for Risk Management by means of a case review, leading to completion of a 24 hour concise 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
- Review KPIs and the dashboard and implement necessary mechanisms to ensure improvements in morbidity and mortality
- 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 Community Services and Standalone Midwifery Units** 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. This role is combined with the designated Named Midwife for Safeguarding within the Maternity Service. The responsibilities involve the following:

- Work closely with the Head of Midwifery/Nursing and the Lead Midwife for Clinical Governance to ensure that risks are identified and reports are submitted in a timely manner via DATIX
- Will represent the Women's and Children's 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 Women's and Children's Directorate Governance meetings to discuss 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
- To assist in benchmarking National Recommendations

17.10 **Band 7 and Specialist Midwives -** As senior midwives within Women's and Children's 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, Diabetes, Audit, Guidelines, patient information and CQC; Practice Development, infant feeding, perineal trauma?
- 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. 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 Lead Midwife for Clinical Governance 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

17.11 **Band 8a: Lead Nurse/ Matron for Gynaecology, Neonatal, Paediatric Services**
Is Responsible for the overall professional performance and operational management of Gynaecology Outpatients, Early Pregnancy Unit, Gynaecology Oncology Service and Acute Inpatient areas. The responsibilities involve the following:

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 through the daily Directorate, Quality and Safety meeting; either electronically or 1:1
- Deputises for the Head of Midwifery/Nursing at Risk Meetings where appropriate e.g. Trust Serious Incident Management Group meetings, Directorate Governance meetings SIMG
- 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:

- Support the nominated Clinical Leads for Risk Management for Gynaecology/ Paediatric and Neonatal Unit in the review and investigation of clinical risk events

i. In the absence of the Head of Midwifery/Nursing escalate risk concerns to the Head of Governance and the Chief Nurse
ii. To provide visible clinical leadership and advice on risk management, audit and complaints' processes to all staff within the Gynaecology and Children's Services
iii. To be a source of expertise in root cause analysis techniques
iv. Provides guidance for those undertaking risk assessments and other local Risk Management functions
v. Ensure the timely investigation of appropriate incidents and monitoring of the implementation of associated action plans
vi. 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, Women's and Children's Newsletter, Forum, memorandums, Risk notice boards
vii. In conjunction with the Head of Midwifery/Nursing assist in the development of risk mitigation plans related to the Directorate Risk Assurance Framework Register
viii. Ensuring compliance of the Trust Serious Incident Reporting Policy
ix. Advise on current risks and ensure controls are in place
x. 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
xi. Will have received basic health and safety risk awareness, to support the pro-active identification of hazards and risk
xii. Manage and co-ordinate the implementation of recommendations in Rapid Response Alerts, Central Alert System

- To identify areas of concern in clinical practice following incident reporting and develop action plans to mitigate against recurrence,
- To escalate any concerns regarding clinical issues, care provision or individual practice to the Head of Midwifery/Nursing
- To develop processes to ensure safe nursing and medical practice; and service provision for Gosfield Ward, Early Pregnancy Unit and GynaeOncology, Phoenix Ward, Neonatal Unit and Children's Outpatients
- To liaise closely with the Head of Midwifery/Nursing about nursing and support staff practice issues and identified risks within the Inpatient and Outpatient environment and ensure that safe staffing levels are maintained with adequate skill mix
- Ensuring mechanisms are in place for identifying and reporting clinical risks through DATIX
- Enable staff to raise concerns on an individual basis
- Providing senior nursing leadership and expert advice to nursing and support staff
- Promote normality at every opportunity and provide advice on the care of women and children with complex needs
- Maintain the focus on safeguarding in the acute environment
- Forward the Infection Prevention Agenda
- Review KPIs and the dashboard and implement necessary mechanisms to ensure improvements in morbidity and mortality
- Undertake investigations into complaints and serious incidents as required, ensuring learning outcomes are embedded as a result of the investigation

17.12 **Women's and Children's Governance Facilitator**

- Support the Directorate by promoting and facilitating the development of effective governance, risk and assurance
- Providing advice and contributing to solutions in relation to the clinical effectiveness agenda and acting as the Directorate lead and point of contact for the DATIX system, providing expertise to ensure the administrative requirements of the incident management process are met
- To liaise with the corporate governance team to ensure a robust cohesive service

17.13 **Individual Employees to include: Midwives (all bands), Nurses, 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 Women's and Children's 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 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

20.0 Risk Assessments and Risk Assurance Framework

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

20.1 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 Women's and Children's Directorate RAF is updated 2 monthly as a minimum and reviewed at each Directorate Governance meeting

20.2 All risks identified on the Risk Assurance Framework are assessed using the standard risk matrix.
(Refer to the Trust Risk Management Strategy & Policy; register number 04061)

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

20.4 A risk rating 15 or above, will be placed on the Corporate Risk Assurance Framework and Board Assurance Framework, in accordance with the Trust Risk Management Strategy and Policy; register number 04061.

20.5 The RAF is reviewed directly by the Board at each meeting

21.0 Board Assurance from Women's and Children's Services

21.1 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 Women's and Children's Services Risk processes and performance The Executive Lead for Women's and Children's Services and the Chief Nurse will 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.

21.2 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.

21.3 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, Gynaecology and Children's Services and therefore the Trust, identified through Risk Management processes.

22.0 Escalation of Risk Management to the Board

22.1 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 Women's and Children's Services and are discussed at the various forums within Women's and Children's Services :

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

22.2 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 Women's and Children's Services; they in turn will escalate risks to the Executive Directors and Trust Board.

22.3 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.

22.4 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 diary. Once immediate concerns are addressed, normal risk management processes will be implemented.

22.5 The monthly Women's and Children's 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, Head of Midwifery/Nursing, and Head of Governance

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

22.7 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.

22.8 The Head of Midwifery/Nursing represents Women's and Children's Services at the Patient Safety and Quality Committee as required 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.

22.9 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.

22.10 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.

23.0 Management of Risk Events (Incidents)

23.1 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.

24.0 Equipment Failures

24.1 The Lead Midwife for Clinical Governance and the Practice Development Midwife will act on equipment failures ensuring reported to MDA and will act on MDA notices.

24.2 Neonatal, Paediatrics and Gosfield Ward Staff will report all equipment failures to Biomedical Engineering. The Matron will disseminate all MDA notices as appropriate to nursing staff.

25.0 Staff Appraisal

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

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

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

26.0 Safeguarding, Vulnerable and Mental Health

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

26.2 Staff are 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.

26.3 Neonatal Unit, Paediatrics and Gosfield staff are required to undertake Level 2 and level 3 Safeguarding training will be identified by ward sister and Matron. Training will be allocated dependent on their role.

26.4 Nurses training compliances are discussed at the monthly Directorate Governance meetings. Mandatory safeguarding adult MCA and DoLs now in place.

27.0 Audit, Review and Monitoring

27.1 Risk Management processes are continually evolving, in order to respond to this the Women's and Children's Services Directorate Governance Structure (05098) will be reviewed annually and when the Trust Risk Management Strategy/Policy is amended following external review e.g. from the CQC

27.2 Audit of compliance with this guideline will be considered on an annual audit basis in accordance with the Clinical Audit Strategy and Policy and the Women's and Children's annual audit work plan. The Women's and Children's Clinical Audit Group will identify a lead for the audit.

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

- Women's and Children's 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 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 Women's and Children's Services Directorate, which must include the following:
    - i. Lead Executive at board level
    - ii. Professional Lead(s)
    - iii. Clinical Governance Lead
    - 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

27.4 The findings of the audit will be reported to and approved by the Women's and Children's Clinical Audit Group 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.

27.5 The findings of the Women's and Children's Clinical Audit Group will be reported to the Women's and Children's Directorate Governance Meeting and significant concerns relating to compliance will be entered on the local Risk Assurance Framework.

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

27.7 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

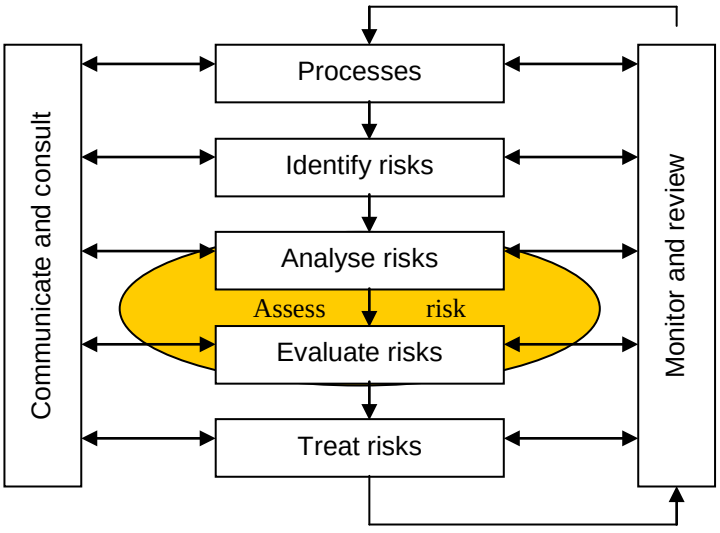
27.8 The Trust will monitor and review its performance in relation to the Management of Risk and the effectiveness of its processes.

27.9 The Head of Governance will provide a monthly 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.

27.10 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

27.11 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.

27.12 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:



28.0 References

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

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,

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

Minimum Set of Reportable Maternity Serious Incidents via Datix

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	
• Unanticipated 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 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	

Revised May 2016

Appendix B

Maternity Services 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 prisoner
- 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 postpartum haemorrhage after elective caesarean section

Revised 7th December 2015

Appendix C

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 D

Mid Essex Hospitals NHS Trust
Directorate of Women's and Children's Services

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)
- Mothers and Babies: Reducing risk through audit and Confidential Enquiry across the UK
- 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
- Kirkup: The Report of the Morecombe Bay Investigation (2015)

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

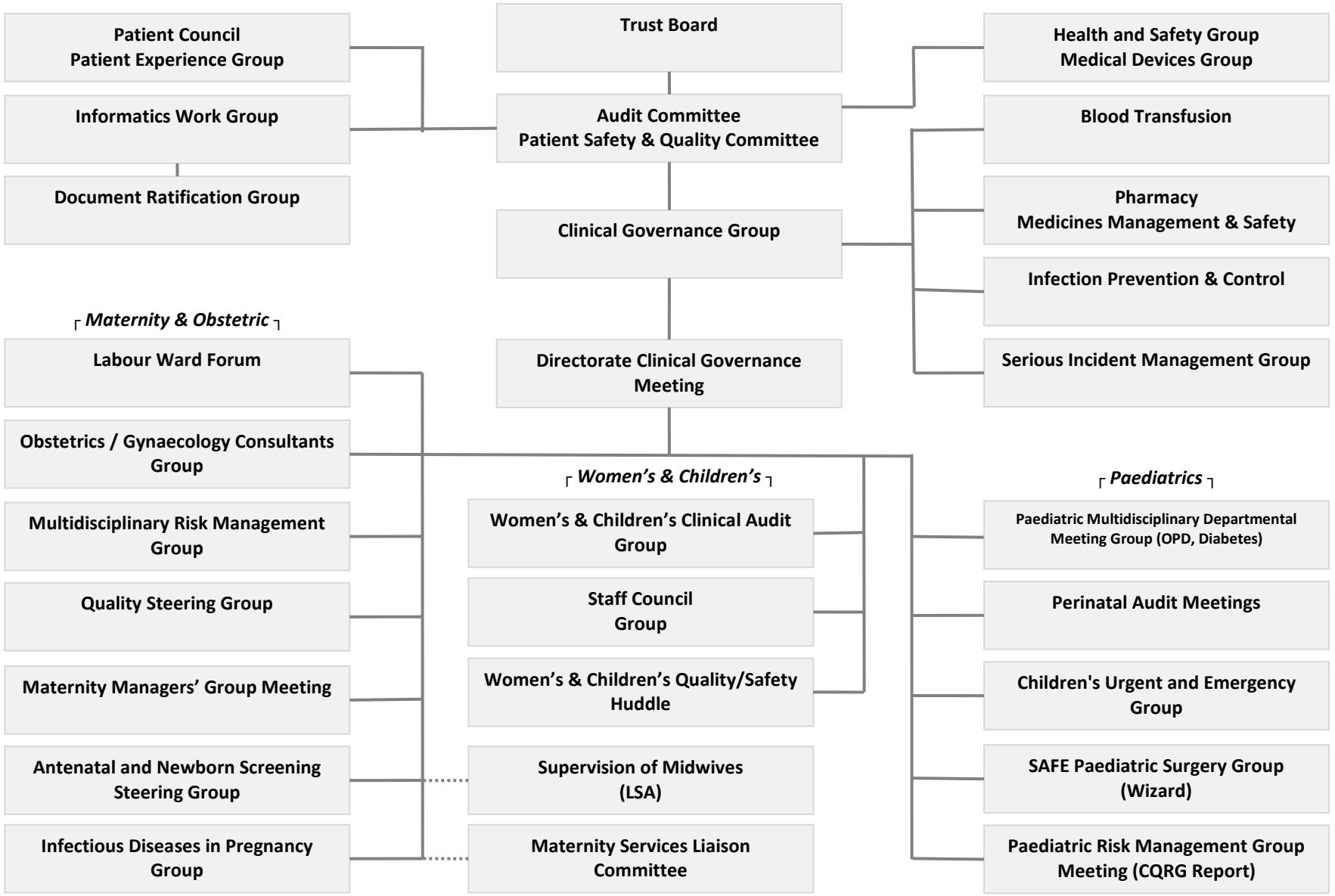
This will be escalated to the Directorate Senior Management Team who will decide if a risk assessment should be completed

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 E

Women's and Children's Services Directorate
Women's and Children's Governance Escalation Structure



Mid Essex Hospital Services NHS Trust

Women's and Children's Directorate Governance Meetings

TERMS OF REFERENCE 2016

1 MEMBERSHIP

Clinical Director (Chair)

Lead Obstetrician for Risk Management (Maternity)

Lead Midwife for Clinical Governance

Lead Obstetrician for Risk Management (Gynaecology)

Lead Nurse for Gynaecology

Lead Paediatrician for Risk Neonatal Services

Lead Nurse for Neonatal Services

Lead Nurse for Paediatric Services

Lead Obstetrician and Gynaecologist for Audit

Lead Paediatrician for Audit

Specialist Midwife for Guidelines and Audit

Lead Anaesthetist for Obstetrics

Lead Midwife for Acute Inpatient Services

Lead Midwife for Community, Midwife-led Units, Named Midwife for Safeguarding

Practice Development Midwife

Supervisor of Midwives

Governance Representatives:

Health and Safety Manager

Lead for Learning and Development

Link for Human Resources

Lead for Infection Prevention and Control

In addition to the membership detailed above, any other individual may be invited to attend at discretion of the Chair. A substitution should be assigned if a member is unable to attend.

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 Patient Safety and Quality Group 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 on-going 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

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 Women's and Children's Clinical Governance Structure (to incorporate Risk Management Strategy); register number 05098).

Terms of Reference Agreed: January 2016

Endorsed by: Multidisciplinary Risk Management Group

Implemented: Clinical Directors of Women's and Children's

Appendix G

Multidisciplinary Risk Management Group

TERMS OF REFERENCE 2016

1.0 Membership

Core Membership

Clinical Director for Women's and Children's Services
Head of Midwifery
Lead Consultant Obstetrician for Risk Management in Maternity
Lead Consultant Obstetrician for Labour Ward and Day Assessment Unit
Lead Consultant Anaesthetic for Obstetrics
Lead Midwife for Clinical Governance
Lead Midwife for Acute Inpatient Services
Lead Midwife for Community, Midwife-Led Units
Named Midwife for Safeguarding

Additional Members

Practice Development Midwife
Supervisor of Midwives
Specialist Midwife for Guidelines and Audit

Specialist Midwives

Midwifery team leader of Day Assessment Unit and Antenatal Ward
Midwifery Team Leader of Postnatal Ward
Midwifery Team Leader of Birthing Units & Co-located Birthing Unit
Obstetric Registrars
Midwives and Student Midwives

1.0 Purpose

- To raise awareness of clinical errors and near misses to facilitate a learning environment
- 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 to support maternity Health Professionals.
- To establish a forum to discuss identified cases

- To actively promote clinical risk management within the Directorate by producing regular feedback summaries of cases reviewed.
- To recommend change in the light of best practice and available evidence e.g. confidential enquiries CMACE and NICE clinical guidelines.
- To review and analyse statistical data which reflects performance and risk assess projected activity.
- 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 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.

2.0 Quorum

No business shall be transacted at a meeting unless at least four members are present including a consultant obstetrician and the specialist Midwife for Risk Management.

3.0 Accountability

The multidisciplinary group is accountable to the clinical director and will oversee all aspects of risk management with a direct line of communication to the Maternity Directorate Governance meeting.

4.0 Duties

To review and monitor risk management issues.
This will include review of:

- Departmental Risk Assurance Framework;
- Maternity Dashboard;
- Incidents both clinical and non-clinical and Serious Incidents;
- Health and Safety Incidents;
- Complaints and litigation claims;
- Clinical guidelines and audit;
- Mandatory training issues;
- Supervision of Midwives in relation to risk management of incidents;
- Feedback from,
    i. Quality Steering Group
    ii. Labour Ward Forum

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

5.0 Frequency

The group will meet monthly. All core members should arrange for a deputy in the event that they are unable to attend.

6.0 REVIEW

The Specialist Midwife for Risk Management will review the Risk Management Group's compliance with their terms of reference on an annual basis in accordance with the Maternity Risk Management Strategy (05098)

Terms of Reference Agreed: January 2016

Endorsed by: Perinatal Multidisciplinary Meeting Group

Implemented: Lead Neonatal Consultant

Appendix H

Perinatal Multidisciplinary Meeting Group

TERMS OF REFERENCE
2016

1.0 Membership

Neonatal Lead Consultant: Chair
Lead consultant for Labour ward
Lead consultant for Foetal medicine
Lead obstetrician for Risk management
Lead Nurse: Neonatal Unit
Lead Midwife for Labour Ward, Birthing Unit and Acute Inpatient Services
Antenatal Screening Midwife
Specialist Midwife for Clinical Risk Management
Named Midwife for Safeguarding
Mental Health Midwife
Practice development midwife
Specialist midwife for infant feeding
Post-natal Team leader
Lead midwife for community, midwifery led birthing units
Representatives from junior medical and midwifery staff

Additional Membership

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

2.0 Purpose

2.1 The Perinatal Multidisciplinary Team group meeting (PMDT) is a forum whose aim is to meet regularly and establish a communication channel between the obstetrics & neonatal teams to share information and have opportunity of multidisciplinary discussion about perinatal care, including high risk pregnancies.

2.2 The meeting will aim to develop key rolling agenda topics that focus on the antenatal and perinatal issues and the interface with Neonatal services with ultimate aim of providing safe, effective and seamless clinical care for mothers and babies.

3.0 Quorum

3.1 The meeting will be quorate if 4 members of the group are present. This must include the chair and one member of the obstetric team, and one member of the midwifery team.

3.2 All representatives should arrange for a deputy, if practical, in the event that they are unable to attend

4.0 Accountability

This Perinatal Multidisciplinary Group Meeting is accountable to the Clinical and Medical Directors.

5.0 INDIVIDUAL AND GROUP RESPONSIBILITIES

5.1 The group members are responsible for:

- Promoting a team approach in the management and provision of perinatal care.
- Developing key agenda topics that focus on safe, effective, compassionate and high quality care as a priority
- Providing a forum where members of a multidisciplinary team can meet to discuss, review and influence practice
- Discussing and incorporating evidence-based practice through the provision of multidisciplinary based guidelines. Monitoring current guidelines, audit and patient information incorporating obstetrics governance themes and local/national priorities
- Ensuring effective communications regarding antenatal and neonatal screening issues, high risk pregnancies, and pregnancies where safeguarding concern is likely.
- Identifying and discussing the care of vulnerable women and families.
- Facilitating the provision of an environment that promotes open discussion, a learning environment and a blame free culture
- Reviewing clinical incidents, identifying any emerging trends and to make recommendations for changes in practice within a risk management structure, including provisions of service to prevent/minimise avoidable admissions to the neonatal unit.
- Cascading action plans into midwifery meetings, Consultant Meetings and Departmental Meetings

5.2 Communication

Following each monthly meeting the Lead Neonatal consultant will:

- Approve Completed minutes and send to the Maternity Risk Manager in order to embed in the forthcoming MRMG and DGM agenda
- Ensure minutes are included in the forthcoming Paediatric Department meeting Agenda.
- Ensure minutes are circulated to core members

6.0 REPORTING ARRANGEMENTS

6.1 The Group will ensure that the Paediatric Department monthly meeting receive minutes of the monthly meetings.

6.3 Minutes and action plans to be communicated to the labour ward forum.

6.2 The minutes will be embedded into the agenda and minutes of MRMG and the Maternity Directorate Governance meeting.

7.0 FREQUENCY

7.1 Meetings will be held monthly.

7.2 Core members should attend 75% of meetings annually to ensure the effectiveness of the group

8.0 REVIEW

8.1 The chair/deputy chair will review Perinatal Multidisciplinary Meeting Group's compliance with their terms of reference on an annual basis in accordance with the Maternity Risk Management Strategy (05098)

8.2 Terms of Reference to be reviewed annually.

Terms of Reference Agreed: January 2016

Endorsed by: Perinatal Multidisciplinary Meeting Group

Implemented: Lead Neonatal Consultant

Appendix I

Obstetrics and Gynaecology Consultant Group

TERMS OF REFERENCE
2016

1.0 MEMBERSHIP

Core Members
Consultant Obstetrician/Clinical Directors (Chair)
Head of Midwifery/ Clinical Director (Deputy Chair)
Consultant Obstetrician/ Gynaecologist

Additional members
Gosfield Ward Sisters
Gynaecology Outpatients' Sisters
Maternity Secretary
Specialist Midwife for Guidelines and Audit
Lead Midwife Labour ward and Acute In-patient Services
Finance department representative
MEHT Commissioning Group representative

2.0 PURPOSE

2.1 The Obstetrics and Gynaecology Consultants Group meeting members discuss the day to day activities in the Maternity and Gynaecological Services. In addition, agenda items include junior doctors training programmes, implementation of guidelines and policies to comply with RCOG and NICE guidance.

3.0 QUORUM

3.1 No business shall be transacted at a meeting unless as a minimum 4 core members are present, to include the Chair/Deputy Chair

4.0 ACCOUNTABILITY

4.1 This multi-professional group is accountable to the Clinical and Medical Directors and will oversee all aspects of safety and quality measures with a direct line of communication to the Maternity Directorate Governance meeting via the Multi-disciplinary Risk Management Group

4.2 The Obstetrics and Gynaecology Consultants group will report issues by exception to the Multi-disciplinary Risk Management Group.

5.0 INDIVIDUAL AND GROUP RESPONSIBILITIES

5.1 **The Obstetrics and Gynaecology Consultants group members are responsible for:**

- Developing key agenda topics that focus on safe, effective, compassionate and high quality care as a priority
- Monitor quality and consistency in terms of the assurance that the documented processes are in place and effectively implemented
- Monitoring current guidelines, audit and patient information incorporating Obstetrics and Gynaecological Services' governance themes and local/national priorities i.e. NHSLA; to identify quality measures and areas for improvement
- Obstetrics and Gynaecology Consultants group should review the effectiveness of meetings and its function as a forum continually throughout the year
- Lead management will review the aims of the Obstetrics and Gynaecology Consultants group on an annual basis.

5.2 **Communication**

Following each weekly Obstetrics and Gynaecology Consultants group meeting the members will:

- Complete any agreed actions outstanding

Following each weekly Obstetrics and Gynaecology Consultants group meeting the maternity secretaries will:

- Complete the Obstetrics and Gynaecology Consultants group minutes and send to the Maternity Risk Manager in order to embed in the forthcoming MRMG agenda
- Maternity Risk Manager to embed the Obstetrics and Gynaecology Consultants group minutes into the MRMG agenda and minutes; these minutes should then be escalated to the Maternity Directorate Governance meetings

6.0 REPORTING ARRANGEMENTS

6.1 The Obstetrics and Gynaecology Consultants group will ensure that the Multi-disciplinary Risk Management Group Meeting receive minutes of the monthly meetings.

6.2 The Obstetrics and Gynaecology Consultants group minutes will then be embedded into the minutes of the Multi-disciplinary Risk Management Group Meeting; which will then be embedded into the agenda and minutes of the Maternity Directorate Governance meeting.

7.0 FREQUENCY

7.1 Meetings will be held weekly.

7.2 Core members should attend 75% of meetings annually the time to ensure the effectiveness of the group.

8.0 REVIEW

8.1 The Chair/ deputy chair will review the Obstetrics and Gynaecology Consultants group compliance with their terms of reference on an annual basis in accordance with the Maternity Risk Management Strategy (05098)

8.2 Terms of Reference to be reviewed annually.

Terms of Reference Agreed: January 2016

Endorsed by: The Obstetrics and Gynaecology Consultants Group

Implemented: Clinical Directors for Women's and Children's

Appendix J

Paediatric Multidisciplinary Departmental Meeting Group

TERMS OF REFERENCE
2016

1.0 Membership

Lead Paediatric Consultant: Chair
Lead Nurse for Neonatal Services
Lead Nurse for Children and Young People

Clinical Director for Women and Children's Services
Head of Nursing for Women and Children's Services
Directorate Finance Manager
Lead Neonatal Consultant
Named Consultant for Safeguarding
Paediatric Consultants
Neonatal Nurse Practitioners
Senior Sister Neonatal Unit
Senior Sister: Children's Outpatients
Senior Sister for Phoenix Ward
Senior Sister for Children's Critical Care
Epilepsy Specialist Nurse
Paediatric Pharmacist
Representatives from Junior Paediatric Medical Staff
Patient Council Representative

Additional Membership

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

2.0 Purpose

2.1 The Paediatric Departmental Multidisciplinary Team group meeting (PDMT) is a forum whose aim is to meet regularly to discuss, plan and review performance of children's services at MEHT. The forum is an excellent communication channel to share information and have the opportunity of multidisciplinary discussion about children's care.

2.2 The meeting will aim to develop key rolling agenda topics with the ultimate aim of providing safe, effective and seamless clinical care for children and their families.

3.0 Quorum

3.1 The meeting will be quorate if 5 members of the group are present. This must include the chair, a senior member of staff from Phoenix ward and the Neonatal unit

3.2 All representatives should arrange for a deputy, if practical, in the event that they are unable to attend

4.0 Accountability

4.1 This Paediatric Departmental Multidisciplinary Team group meeting is accountable to the Clinical and Medical Directors.

5.0 INDIVIDUAL AND GROUP RESPONSIBILITIES

5.1 **The group members are responsible for:**

- Promoting a team approach in the management and provision of children's care.
- Developing key agenda topics that focus on safe, effective, compassionate and high quality care as a priority
- Providing a forum where members of a multidisciplinary team can meet to discuss, review and influence practice
- Discussing and incorporating evidence-based practice through the provision of multidisciplinary based guidelines. Monitoring current guidelines, audit and patient information incorporating paediatric governance themes and local/national priorities
- Ensuring effective communications where safeguarding concern is likely.
- Identifying and discussing the care of vulnerable children and families.
- Facilitating the provision of an environment that promotes open discussion, a learning environment and a blame free culture
- Reviewing clinical incidents, identifying any emerging trends and to make recommendations for changes in practice within a risk management structure, including provisions of service to prevent/minimise avoidable admissions or delayed discharges.
- Cascading action plans into Children's Nursing meetings, Consultant Meetings and Departmental Meetings

5.2 Communication

Following each monthly meeting the Lead Paediatric Consultant will:

- Approve completed minutes and send to the Maternity Risk Manager in order to embed in the forthcoming Maternity Directorate Governance Meeting agenda
- Ensure minutes are circulated to core members
- For clinical governance purposes reports should go to the Trust's Clinical Governance

6.0 REPORTING ARRANGEMENTS

6.1 Minutes and action plans to be communicated to the Phoenix Ward meeting, Neonatal Ward meeting and Children's Outpatient meeting.

6.2 The minutes will be embedded into the agenda of the Women's and Children's Directorate Governance meeting.

6.3 Unresolved clinical governance issues would be reported to the Trust's Clinical Governance Group.

7.0 FREQUENCY

7.1 Meetings will be held on 3rd Monday of the month, except in August (Summer Holidays) unless previously decided to hold the meeting to discuss urgent issues..

7.2 Core members should attend 75% of meetings annually to ensure the effectiveness of the group

8.0 REVIEW

8.1 The chair/deputy chair will review Paediatric Departmental Multidisciplinary Team group meeting compliance with their terms of reference on an annual basis in accordance with the Maternity Risk Management Strategy (05098)

8.2 Terms of Reference to be reviewed annually.

Terms of Reference Agreed: January 2016

Endorsed by: Paediatric Departmental Multidisciplinary Team group meeting

Implemented: Lead Paediatric Consultant.

Appendix K

Women's and Children's Clinical Audit Group

TERMS OF REFERENCE
2016

1.0 MEMBERSHIP

Core Members

Consultant Audit Lead for Obstetrics and Gynaecology (Chair)
Specialist Midwife for Guidelines and Audit (Deputy Chair)
Lead Midwife for Clinical Governance
Practice Development Midwife
Trust Clinical Audit Lead
Consultant Audit Lead for Paediatrics
Lead for Children's and Young People
Supervisor of Midwives
Clinical Governance Facilitator

Additional members

Invitees

2.0 PURPOSE

2.1 This multi-disciplinary Women's and Children's Clinical Audit Group meeting is chaired by the Consultant Audit Lead for Obstetrics and Gynaecology or the Specialist Midwife for Guidelines and Audit in the Chair's absence. The Chair directs the discussion and review of clinical audit to ensure that the Women's and Children's Clinical Audit agenda has been addressed and revised on an annual basis.

2.2 The annual audit agenda will be comprised of the following:

- Obstetrics and Gynaecology audit
- Children's and Young People audit
- Auditable Themes via Risk and Complaints; Safety and Quality
- National Guidance
- Clinician Interest

3.0 QUORUM

3.1 No business shall be transacted at a meeting unless a minimum of 3 core members are present to include representatives from Obstetrics, Gynaecology Paediatrics and Midwifery

3.2 All core members should arrange for a deputy, if practical, in the event that they are unable to attend.

4.0 ACCOUNTABILITY

4.1 This multi-professional group is accountable to the Clinical Directors for Women's and Children's Directorate and will oversee all aspects of quality and safety measures with a direct line of communication to the Maternity Directorate Governance meeting.

4.2 The Women's and Children's Audit Group will report issues by exception to the Maternity Directorate Governance meeting.

5.0 INDIVIDUAL AND GROUP RESPONSIBILITIES

5.1 **The Women's and Children's Clinical Audit Group members are responsible for:**

Developing key agenda topics that focus on:

- Monitoring quality and consistency in terms of the assurance that the audit processes are in place and that action plans are effectively implemented through 'audit cycle'.
- Monitoring current audit and incorporating Directorate governance themes and local/national priorities to identify quality measures and areas for improvement and subsequent audit
- Ensuring that National Guidance is benchmarked and communicated as required
- A supportive role in terms of the understanding and clarity of the key aspects of the audit process
- The Women's and Children's Clinical Audit Group should review the effectiveness of meetings and its function as a forum continually throughout the year

The Women's and Children's Clinical Audit Group will review the aims of the Women's and Children's Audit Group on an annual basis.

5.3 Communication

Following each quarterly Women's and Children's Clinical Audit Group meeting the Specialist Midwife for Guidelines and Audit will:

- Complete any agreed actions outstanding

- Complete Women's and Children's Audit Group minutes and send to the Maternity Secretaries in order to embed in the forthcoming agenda for the Directorate Governance meeting

  Following each quarterly Women's and Children's Audit Group meeting, in the absence of the Specialist Midwife for Guidelines and Audit, the elected Women's and Children's Audit Group member will:

- Complete any agreed actions outstanding
- Feedback to the Specialist Midwife for Guidelines and Audit in order to update the master copy Women's and Children's Clinical Audit Group action plan
- Nominate a deputy to attend the Women's and Children's Clinical Audit Group if they are unable to attend
- Maternity Secretaries should embed the Women's and Children's Clinical Audit Group minutes into the Directorate Governance meeting agenda and minutes; these minutes should then be escalated to the Clinical Governance Group meetings

6.0 REPORTING ARRANGEMENTS

6.1 The Women's and Children's Clinical Audit Group will ensure that the Directorate Governance Meeting receive minutes of the quarterly meetings.

6.2 The Women's and Children's Clinical Audit Group minutes will then be embedded into the minutes of the Directorate Governance Group Meeting; which will then be embedded into the agenda and minutes of the Clinical Governance Group meeting.

7.0 FREQUENCY

7.1 Meetings will be held quarterly.

7.2 Core members should attend 75% of meetings annually the time to ensure the effectiveness of the group.

8.0 REVIEW

8.1 The Women's and Children's Clinical Audit Group will review the Women's and Children's Audit Group compliance with their terms of reference on an annual basis in accordance with the Women and Children's Clinical Governance Strategy (05098)

8.2 Terms of Reference to be reviewed annually.

Terms of Reference Agreed: January 2016

Endorsed by: The Women's and Children's Clinical Audit Group

Implemented: Clinical Directors for Women's and Children's

Appendix L

Labour Ward Forum

TERMS OF REFERENCE
2016

1.0 Membership

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

Additional Membership

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

2.0 Purpose

2.1 The Labour ward forum should formalise an explicit system which ensures women receive the care appropriate to their needs. Thus midwives will be responsible for women in normal labour whilst women with complicated labours or with complex obstetric problems will be looked after by a combination of midwives and medical staff. (Towards Safer Childbirth: Minimum Standards of the Organisation of Labour Wards)

2.2 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 chaired by the Lead Obstetric Consultant for Labour Ward.

2.3 The Labour Forum will aim to develop key agenda topics that focus on safe, effective, and compassionate and high quality intrapartum care as a priority based on local and national guidance.

3.0 Quorum

3.1 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.

3.2 All representatives should arrange for a deputy, if practical, in the event that they are unable to attend

4.0 Accountability

This Labour Ward Forum is accountable to the Clinical and Medical Directors and will oversee all aspects safety and quality measures with a direct line of communication to the Maternity Directorate Governance meeting via the Multi-disciplinary Risk management Group.

The Labour Ward Forum will report issues by exception to the Multi-disciplinary Risk Management Group.

5.0 INDIVIDUAL AND GROUP RESPONSIBILITIES

5.1 The group members are responsible for:

- Promoting a team approach in the management and provision of maternity services
- Developing key agenda topics that focus on safe, effective, compassionate and high quality care as a priority
- Providing a forum where members of a multidisciplinary team can meet to discuss, review and influence practice
- Discussing and incorporating evidence-based practice through the provision of multidisciplinary based guidelines. Monitoring current guidelines, audit and patient information incorporating obstetrics governance themes and local/national priorities
- Ensuring a comprehensive system for management and communication throughout the key stages of intrapartum care
- Reviewing all aspects of labour ward activity through quantitative data, i.e. professional, educational and organizational
- Facilitating the provision of an environment that promotes open discussion, a learning environment and a blame free culture
- Reviewing clinical incidents, identifying any emerging trends and to make recommendations for changes in practice within a risk management structure
- Cascading action plans into midwifery meetings, Consultant Meetings and Departmental Meetings
- Ensuring that the Multi-disciplinary Risk Management Group and Directorate receive minutes of the quarterly meetings.

5.2 Communication

Following each quarterly meeting the Lead Obstetric consultant for labour ward will:

- Complete any agreed actions outstanding

- Complete minutes and send to the Maternity Risk Manager in order to embed in the forthcoming MRMG and DGM agenda
- Ensure circulated to core members

6.0 REPORTING ARRANGEMENTS

6.1 The Group will ensure that the Multi-disciplinary Risk Management Group Meeting receive minutes of the monthly meetings.

6.2 The minutes will then be embedded into the minutes of the Multi-disciplinary Risk Management Group Meeting; which will then be embedded into the agenda and minutes of the Maternity Directorate Governance meeting.

7.0 FREQUENCY

7.1 Meetings will be held quarterly

7.2 Core members should attend 75% of meetings annually to ensure the effectiveness of the group

8.0 REVIEW

8.1 The chair/deputy chair will review the Labour Ward Forum Group's compliance with their terms of reference on an annual basis in accordance with the Maternity Risk Management Strategy (05098)

8.2 Terms of Reference to be reviewed annually.

Terms of Reference Agreed: January 2016

Endorsed by: The Labour Ward Forum Group

Implemented: Lead Obstetric Consultant for Labour Ward

Appendix M

Quality Steering Group

TERMS OF REFERENCE
2016

3.0 MEMBERSHIP

Core Members
Specialist Midwife for Guidelines and Audit (Chair)
Head of Midwifery (Deputy Chair)
Lead Midwife Labour Ward and Acute Inpatient Services Manager
Lead Midwife Community Services; Named Midwife Safeguarding
Consultant Obstetrician
Consultant Anaesthetist
Maternity Risk Management Lead

Additional members
Practice Development Midwife
Labour Ward Team Leader
Specialist Midwives in Maternity
Student Supervisor of Midwives

2.0 PURPOSE

2.1 This multidisciplinary Quality Steering Group (QSG) chaired by the Specialist Midwife for Guidelines and Audit, directs the discussion and review of practices to ensure that they are safe for staff and patients. In addition, the QSG will aim to develop key agenda topics that focus on safe, effective, compassionate and high quality care as a priority. Furthermore, the QSG's core members are key stakeholders in an effective governance structure to assess and implement ever increasing quality measures within Maternity Services.

3.0 QUORUM

3.1 No business shall be transacted at a meeting unless as a minimum the core members are present.

3.2 All core members should arrange for a deputy, if practical, in the event that they are unable to attend.

4.0 ACCOUNTABILITY

4.1 This multi-professional group is accountable to the Head of Midwifery and will oversee all aspects of quality measures with a direct line of communication to the Maternity Directorate Governance meeting via the Multi-disciplinary Risk management Group.

4.2 The QSG will report issues by exception to the Multi-disciplinary Risk Management Group.

5.0 INDIVIDUAL AND GROUP RESPONSIBILITIES

5.1 The QSG members are responsible for:

- Developing key agenda topics that focus on safe, effective, compassionate and high quality care as a priority

- Monitor quality and consistency in terms of the assurance that the documented processes are in place and effectively implemented

- Monitoring current guidelines, audit and patient information incorporating Maternity Services' governance themes and local/national priorities i.e. NHSLA; to identify quality measures and areas for improvement

- QSG should review the effectiveness of meetings and its function as a forum continually throughout the year

- Lead management will review the aims of the QSG on an annual basis.

5.3 Communication

Following each monthly QSG meeting the Specialist Midwife for Guidelines and Audit will:

- Complete any agreed actions outstanding
- Complete QSG minutes and send to the Maternity Risk Manager in order to embed in the forthcoming MRMG agenda

Following each monthly QSG meeting the elected QSG member will:

- Complete any agreed actions outstanding
- Feedback to the Specialist Midwife for Guidelines and Audit in order to update the master QSG action plan
- Nominate a deputy to attend the QSG if they are unable to attend
- Maternity Risk Manager to embed the QSG minutes into the MRMG agenda and minutes; these minutes should then be escalated to the Maternity Directorate Governance meetings

6.0 REPORTING ARRANGEMENTS

6.1 The Quality Steering Group will ensure that the Multi-disciplinary Risk Management Group Meeting receive minutes of the monthly meetings.

6.2 The QSG minutes will then be embedded into the minutes of the Multi-disciplinary Risk Management Group Meeting; which will then be embedded into the agenda and minutes of the Maternity Directorate Governance meeting.

7.0 FREQUENCY

7.1 Meetings will be held monthly.

7.2 Core members should attend 75% of meetings annually the time to ensure the effectiveness of the group.

8.0 REVIEW

8.1 The Specialist Midwife for Guidelines and Audit will review the Quality Steering Group's compliance with their terms of reference on an annual basis in accordance with the Maternity Risk Management Strategy (05098)

8.2 Terms of Reference to be reviewed annually.

Terms of Reference Agreed: January 2016

Endorsed by: The Quality Steering Group

Implemented: Head of Midwifery/Nursing

Appendix N

Children and Young People Staff Council Group

TERMS OF REFERENCE
2016

4.0 MEMBERSHIP

Core Members

Elected members:

Registered Nurse:
Band 6 Nurse (Chair)
Band 5 Nurse (Deputy Chair)

Unregistered Nurse:
Health Care Assistant

Additional members
Invitees

5.0 PURPOSE

2.1 The purpose of the Children's and Young People Staff Council Group is to drive the ethos of shared governance fostering culture of staff engagement and empowerment to improve both quality and safety of patient care and staff morale.

2.2 The purpose is to have a peer elected council. The role of the peer elected members is to proactively represent the professional interest and views of the team to drive up quality and safety within the ward or department.

2.3 The Children and Young People Staff Council Group is not in this instance a council in the traditional sense and will not have scope for discussion or tackling of HR and wider employee related issues. The forum for which is already in existence.

2.4 This Children and Young People Staff Council Group meeting is chaired by the Band 6 CYP Nurse or the Band 5 CYP Nurse in the Chair's absence. The Chair directs the discussion to ensure that the Children and Young People Staff Council Group agenda has been addressed and revised on an annual basis.

6.0 AIMS AND OBJECTIVES

3.1 The aim of the Children and Young People Staff Council Group is to provide the link between the central organisational vision and objectives with local vision and objectives to ensure staff locally are informed and empowered to both the local agenda and corporate agenda

3.2 To ensure that agreed best practice and procedures are applied across the ward/ department as a whole.

3.3 To promote a culture within the ward/ department where the delivery of the highest possible standards of patient care, staff engagement, well-being and effective working are understood to be the responsibility of everyone working within the practice and is built upon partnership and collaboration.

3.4 The Children and Young People Staff Council Group agenda will be comprised of the following:

- Ward Environment
- Uniform
- Security
- Reporting
- Health and Safety
- Women's and Children's Newsletter
- Effective Care Posters
- Safety Ward Dashboards
- Incidents and Complaints
- Performance Data
- Policies, guidelines and patient information leaflets
- Patient Feedback

4.0 QUORUM

4.1 No business shall be transacted at a meeting unless a minimum of 2 core members are present to include representatives from Children's and Young People; and the Neonatal Unit.

5.0 ACCOUNTABILITY

5.1 This Children and Young People Staff Council Group is accountable to the Clinical Directors for Women's and Children's Directorate and will oversee all aspects of quality and safety measures with a direct line of communication to the Maternity Directorate Governance meeting.

5.2 The Children and Young People Staff Council Group will report issues by exception to the Women's and Children's Directorate Governance meeting.

6.0 INDIVIDUAL AND GROUP RESPONSIBILITIES

6.1 The Children and Young People Staff Council Group members are responsible for:

Developing key agenda topics that focus on:

- Monitoring quality and consistency in terms of the assurance that issue are identified and that action plans are effectively implemented.
- Monitoring and incorporating Directorate governance themes to identify quality measures and areas for improvement
- Developing action plans in response to issue identified at Children and Young People Staff Council Group
- Providing staff with an opportunity/ 'voice' to raise key issues regarding their clinical environment
- The Children and Young People Staff Council Group should review the effectiveness of meetings and its function as a forum continually throughout the year
- The Children and Young People Staff Council Group will review the aims of the Children and Young People Staff Council on an annual basis.

6.2 Communication

Following each monthly Children and Young People Staff Council Group meeting the elected member will:

- Complete any agreed actions outstanding
- Complete the Children and Young People Staff Council Group minutes and send to the Maternity Secretaries in order to embed in the agenda for the Directorate Governance meeting on a quarterly basis.

7.0 REPORTING ARRANGEMENTS

7.1 The Children and Young People Staff Council Group will formally record the minutes of their meetings and these minutes should be submitted to the Directorate Governance Meeting on a quarterly basis.

7.2 The Chair of the Children and Young People Staff Council Group will be invited to attend the Managers' meeting on a monthly basis to discuss progress and ensure support is enlisted to drive change and improvement projects

7.2 The Children and Young People Staff Council Group minutes will then be embedded into the minutes of the Directorate Governance Group Meeting; which will then be embedded into the agenda and minutes of the Clinical Governance Group meeting.

8.0 FREQUENCY

8.1 Meetings will be held monthly.

8.2 Core members should attend 75% of meetings annually the time to ensure the effectiveness of the group.

9.0 MEMBERSHIP

9.1 Each council should have a minimum of one registered nurse and one unregistered nurse.

10.0 PERIOD OF NOTICE

10.1 Each member will be elected to the Children and Young People Staff Council Group for a period of one year

10.2 The maximum number of times that a member can be elected is two (should no other candidates come forward this can be renegociated)

10.3 Should members wish to step down they must submit a four week notice period, to enable election of a replacement.

11.0 EXCLUSION CRITERIA

11.1 The ward or unit manager is not eligible to be elected to the council.

9.0 REVIEW

9.1 The Children and Young People Staff Council Group will review the Children and Young People Staff Council Group compliance with their terms of reference on an annual basis in accordance with the Women and Children's Clinical Governance Strategy (05098)

9.2 Terms of Reference to be reviewed annually.

Terms of Reference Agreed: January 2016

Endorsed by: The Children and Young People Staff Council Group

Implemented: Clinical Directors for Women's and Children's

Appendix O

Maternity Staff Council Group

TERMS OF REFERENCE
2016

7.0 MEMBERSHIP

Core Members

Elected members:

Registered Midwife:
Band 7 Midwife (Chair)
Band 6 Midwife

Registered Nurse:
Band 6 Nurse (Deputy Chair)

Unregistered Nurse:
Health Care Assistant
Ward Clerk

Additional members
Invitees

8.0 PURPOSE

2.1 The purpose of the Maternity Staff Council Group is to drive the ethos of shared governance fostering culture of staff engagement and empowerment to improve both quality and safety of patient care and staff morale.

2.2 The purpose is to have a peer elected council. The role of the peer elected members is to proactively represent the professional interest and views of the team to drive up quality and safety within the ward or department.

2.3 The Maternity Staff Council Group is not in this instance a council in the traditional sense and will not have scope for discussion or tackling of HR and wider employee related issues. The forum for which is already in existence.

2.4 This Maternity Staff Council Group meeting is chaired by the Band 6 Midwife or the Band 5 Midwife in the Chair's absence. The Chair directs the discussion to ensure that the

Maternity Staff Council Group agenda has been addressed and revised on an annual basis.

9.0 AIMS AND OBJECTIVES

3.1 The aim of the Maternity Staff Council Group is to provide the link between the central organisational vision and objectives with local vision and objectives to ensure staff locally are informed and empowered to both the local agenda and corporate agenda

3.2 To ensure that agreed best practice and procedures are applied across the ward/ department as a whole.

3.3 To promote a culture within the ward/ department where the delivery of the highest possible standards of patient care, staff engagement, well-being and effective working are understood to be the responsibility of everyone working within the practice and is built upon partnership and collaboration.

3.4 The Maternity Staff Council Group agenda will be comprised of the following:

- Ward Environment
- Uniform
- Security
- Reporting
- Health and Safety
- Women's and Children's Newsletter
- Effective Care Posters
- Safety Ward Dashboards
- Incidents and Complaints
- Performance Data
- Policies, guidelines and patient information leaflets
- Patient Feedback

4.0 QUORUM

4.1 No business shall be transacted at a meeting unless a minimum of 2 core members are present to include representatives from Maternity and Gynaecology Services

5.0 ACCOUNTABILITY

5.1 This Maternity Staff Council Group is accountable to the Clinical Directors for Women's and Children's Directorate and will oversee all aspects of quality and safety measures with a direct line of communication to the Maternity Directorate Governance meeting.

5.2 The Maternity Staff Council Group will report issues by exception to the Women's and Children's Directorate Governance meeting.

6.0 INDIVIDUAL AND GROUP RESPONSIBILITIES

6.1 The Maternity Staff Council Group members are responsible for:

Developing key agenda topics that focus on:

- Monitoring quality and consistency in terms of the assurance that issue are identified and that action plans are effectively implemented.
- Monitoring and incorporating Directorate governance themes to identify quality measures and areas for improvement
- Developing action plans in response to issue identified at Maternity Staff Council Group
- Providing staff with an opportunity/ 'voice' to raise key issues regarding their clinical environment
- The Maternity Staff Council Group should review the effectiveness of meetings and its function as a forum continually throughout the year
- The Maternity Staff Council Group will review the aims of the Women's and Children's Audit Group on an annual basis.

6.2 Communication

Following each monthly Maternity Group meeting the elected member will:

- Complete any agreed actions outstanding
- Complete the Maternity Staff Council Group minutes and send to the Maternity Secretaries in order to embed in the agenda for the Directorate Governance meeting on a quarterly basis.

7.0 REPORTING ARRANGEMENTS

7.1 The Maternity Staff Council Group will formally record the minutes of their meetings and these minutes should be submitted to the Directorate Governance Meeting on a quarterly basis.

7.2 The Chair of the Maternity Staff Council Group will be invited to attend the Managers' meeting on a monthly basis to discuss progress and ensure support is enlisted to drive change and improvement projects

7.2 The Maternity Staff Council Group minutes will then be embedded into the minutes of the Directorate Governance Group Meeting; which will then be embedded into the agenda and minutes of the Clinical Governance Group meeting.

8.0 FREQUENCY

8.1 Meetings will be held monthly.

8.2 Core members should attend 75% of meetings annually the time to ensure the effectiveness of the group.

9.0 MEMBERSHIP

9.1 Each council should have a minimum of one registered nurse and one unregistered nurse.

10.0 PERIOD OF NOTICE

10.1 Each member will be elected to the Maternity Staff Council Group for a period of one year

10.2 The maximum number of times that a member can be elected is two (should no other candidates come forward this can be renegociated)

10.3 Should members wish to step down they must submit a four week notice period, to enable election of a replacement.

11.0 EXCLUSION CRITERIA

11.1 The ward or unit manager is not eligible to be elected to the council.

9.0 REVIEW

9.1 The Maternity Staff Council Group will review the Maternity Staff Council Group compliance with their terms of reference on an annual basis in accordance with the Women and Children's Clinical Governance Strategy (05098)

9.2 Terms of Reference to be reviewed annually.

Terms of Reference Agreed: January 2016

Endorsed by: The Maternity Staff Council Group

Implemented: Clinical Directors for Women's and Children's

Children's Urgent & Emergency Care Group

TERMS OF REFERENCE
2016

1. MEMBERSHIP

Lead for Children's Acute Care
Lead Nurse CYP
Consultant Paediatrician
Consultant Emergency Medicine
Lead A&E Children's Nurse
Surgical representative
Consultant Anaesthetist
Lead Burns Children's Nurse
Governance Representative
Trust Management Representative
Patient Council Representative

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

2. QUORUM

2.1 The meeting will be quorate if 4 members of the group are present. This must include the Chair or Deputy Chair, Consultant Paediatrician and representation from A&E dept.

3. ACCOUNTABILITY

3.1 The group is accountable to the Clinical Governance Group

4. DUTIES

4.1 The Children's Urgent & Emergency Care Group specific duties include:

4.2 To ensure that the trust is meeting the standards as described in nationally developed documents and to make recommendations for implementation where standards are not being met. These include:

- The paediatric intensive care society standards for the care of critically ill children June 2010
- East of England children & young people assessment service standards June 2011
- Standards for children and young people in emergency care settings June 2012

4.3 To monitor the above standards via an agreed audit programme

4.4 To present findings from observation audit, transfer audit and critical care audit.

4.5 To present findings from incidents for the purpose of identifying key trends to ensure that there are appropriate actions in place to prevent recurrence of a particular problem or adhere to best practice.

4.6 Where a 'learning point' has trust wide applicability, to ensure the dissemination of this point throughout all the relevant parts of the organisation.

4.7 To ensure the organisation is made aware of changes / developments from outside sources relating to children including PIC network, Retrieval service, Essex critical care network and East of England. Regularly report verbally feedback from outside networks

4.8 To review training needs of clinical staff specific to care of children with high dependency / critical care needs and to ensure that the appropriate training / skills development is made available to meet these requirements. Regularly report verbally on training

4.9 Regularly report verbally feedback from surgical group.

4.10 Regularly report verbally feedback from audits

5. Reporting Arrangements

5.1 The Children's Urgent & Emergency Care Group will report to the Clinical Governance Group on a quarterly basis.

6. FREQUENCY

6.1 Meetings will be held quarterly.

6.2 Members should attend a minimum of two meetings per year.

7. REVIEW

7.1 The Trust Secretary will review the Children's Urgent & Emergency Care Group compliance with their terms of reference on an annual basis in accordance with the Risk Management Strategy and Policy.

7.2 The Clinical Governance Group will review the performance of all groups reporting to it on a quarterly basis.

Terms of Reference Agreed: January 2016

Endorsed by: Children's Urgent & Emergency Care Group

Implemented: Lead Neonatal Consultant.

Appendix Q

Maternity Management Group

TERMS OF REFERENCE
2016

2.0 Membership

Head of Midwifery (Chair)
Lead Midwife for Acute Inpatient Services (Deputy Chair)
Lead Midwife for Community Services
Lead Midwife for Clinical Governance
Senior Midwives
Specialist Midwives

Additional Membership

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

2.0 Purpose

2.1 The Maternity Management Group meeting is a forum whose aim is to meet regularly to discuss, plan and review performance of Maternity Services at MEHT. The forum is an excellent communication channel to share information and have the opportunity of multidisciplinary discussion about the care and services provided

2.2 The meeting will aim to develop key rolling agenda topics with the ultimate aim of providing safe, effective and seamless clinical care for children and their families.

3.0 Quorum

3.1 The meeting will be quorate if 5 members of the group are present. This must include the Chair and or Deputy Chair, a lead midwife, Specialist Midwife and/or Senior Midwife

3.2 All representatives should arrange for a deputy, if practical, in the event that they are unable to attend

4.0 Accountability

4.1 This Paediatric Departmental Multidisciplinary Team group meeting is accountable to the Clinical and Medical Directors.

5.0 INDIVIDUAL AND GROUP RESPONSIBILITIES

5.1 **The group members are responsible for:**

- Promoting a team approach in the management and provision of women's and babies' care.

- Developing key agenda topics that focus on safe, effective, compassionate and high quality care as a priority

- Providing a forum where members of a multidisciplinary team can meet to discuss, review and influence practice

- Discussing and incorporating evidence-based practice through the provision of multidisciplinary based guidelines. Monitoring current guidelines, audit and patient information incorporating paediatric governance themes and local/national priorities

- Ensuring effective communications where safeguarding concern is likely.

- Identifying and discussing the care of vulnerable women and families.

- Facilitating the provision of an environment that promotes open discussion, a learning environment and a blame free culture

- Reviewing clinical incidents, identifying any emerging trends and to make recommendations for changes in practice within a risk management structure, including provisions of service to prevent/minimise avoidable admissions or delayed discharges.

- Cascading action plans into ward meetings, Consultant Meetings and Departmental Meetings

6.0 REPORTING ARRANGEMENTS

6.1 The Maternity Management Group will ensure that the Women's and Children's Directorate Governance Meeting receive minutes on a quarterly basis.

6.2 The Maternity Management Group minutes will then be embedded into the minutes of the Women's and Children's Directorate Governance Meeting.

7.0 FREQUENCY

7.1 Meetings will be held bi-monthly.

7.2 Core members should attend 75% of meetings annually the time to ensure the effectiveness of the group.

8.0 REVIEW

8.1 The Maternity Management Group will review their compliance with their terms of reference on an annual basis in accordance with the Women's and Children's Clinical Governance Structure (to incorporate Risk Management Strategy); register number 05098.

5.2 Communication

Following each monthly meeting the Lead Paediatric Consultant will:

- Approve completed minutes and send to the Maternity Risk Manager in order to embed in the forthcoming Maternity Directorate Governance Meeting agenda
- Ensure minutes are circulated to core members
- For clinical governance purposes reports should go to the Trust's Clinical Governance

6.0 REPORTING ARRANGEMENTS

6.1 Minutes and action plans to be communicated to the Phoenix Ward meeting, Neonatal Ward meeting and Children's Outpatient meeting.

6.2 The minutes will be embedded into the agenda of the Women's and Children's Directorate Governance meeting.

6.3 Unresolved clinical governance issues would be reported to the Trust's Clinical Governance Group.

7.0 FREQUENCY

7.1 Meetings will be held on 3rd Monday of the month, except in August (Summer Holidays) unless previously decided to hold the meeting to discuss urgent issues..

7.2 Core members should attend 75% of meetings annually to ensure the effectiveness of the group

8.0 REVIEW

8.1 The chair/deputy chair will review Paediatric Departmental Multidisciplinary Team group meeting compliance with their terms of reference on an annual basis in accordance with the Maternity Risk Management Strategy (05098)

8.2 Terms of Reference to be reviewed annually.

Terms of Reference Agreed: January 2016

Endorsed by: Maternity Management Group

Implemented: Head of Midwifery

Appendix R

Antenatal and Newborn Screening Steering Group

TERMS OF REFERENCE
2015

Membership

Obstetric Consultant - Consultant Lead for Infectious Diseases
Obstetric Consultant - Fetal Medicine Consultant
Head of Midwifery / Clinical Director
Acting Lead Midwife Inpatient Services
Lead Midwife Community Services
Lead BMS Haematology and Blood Transfusion
Principal Clinical Scientist
Senior Advanced Specialist Biomedical Scientist
Senior Regional QA Advisor Antenatal & Newborn, Midlands and East Region
Screening and Imms Manager PHE/NHS England (Essex Area Team)
Specialist Midwife Risk Management
Practice Educator ARU Link Midwife
Practice Development Midwife
Team Leader WJC
Team Leader St Peters
Team Leader Chelmsford Community
Senior Sonographer - Sonographer always invited, but not 1 named person
Lead Postnatal Ward
Newborn Hearing Screening Manager
Failsafe Officer
Neonatal Unit Nurse
NIPE Lead
Advanced Specialist Practitioner Essex Sickle Cell and Thalassaemia Service
ANNB Screening Co-ordinator - Chair

Meetings will only take place with the agreed attendance from a core group of staff:

- Member of the sub regional team
- Maternity representation
- All laboratory representation

Role of the Group

To assess the current provision of antenatal and newborn screening in Mid Essex and work towards the provision of an evidence based service, which is both equitable and acceptable for woman and their partners, in line with national recommendations.
Its multidisciplinary membership will aid systematic communication and dissemination of information to all stakeholders.

Objectives

- To develop/update locally agreed written screening policy that sets out the aim and standards for local programmes and in line with national recommendation and regional policy.

- To develop/update a clearly defined antenatal and newborn screening policy to include information and support for woman and their partners, informing them of their results and subsequent referral pathways.

- To develop plans for the implementation of the national standards pertaining to antenatal and newborn screening recommendations/ programmes, including the development of robust failsafe systems.

- To inform the development of evidence-based continuing education programmes for all members of the multidisciplinary team involved in screening, specific to roles and responsibilities.

- To review aspects of the service through data collection, audit and quality assurance mechanisms and to make recommendation for change, as appropriate, to improve the quality of the screening programmes.

- To inform and support Mid Essex Hospital Services NHS Trust in the commissioning of programmes by the Essex Area Team, NHS England / Public Health England.

- To identify and manage service risks, working with Public Health England / NHS England and the Quality Assurance Team.

6.0 REPORTING ARRANGEMENTS

6.1 The Antenatal and Newborn Screening Group will ensure that the Women's and Children's Directorate Governance Meeting receive minutes of the quarterly meetings.

6.2 The Antenatal and Newborn Screening Group minutes will then be embedded into the agenda of the Women's and Children's Directorate Governance Meeting.

Review

The group will annually review its:

- Terms of reference
- Membership
- The relevance and value of its work

This review will take place in the first meeting of the year

Frequency of Meeting

This meeting will be held quarterly

Confidentiality

All meetings will protect personal identity by ensuring that data in anonymised and abide by the data protection and Caldicott principles**,** as documented in the Mid Essex Hospital Services NHS Trust Confidentiality and Data Protection Policy Register No 07011.

Terms of Reference Agreed: January 2016

Endorsed by: The Antenatal and Newborn Screening Group

Implemented: Clinical Directors for Women's, Children's

Appendix S

Infectious Diseases in Pregnancy Group

TERMS OF REFERENCE
2016

Membership

GUM Consultant
Consultant Hepatologist
HIV Specialist Nurse
Consultant Obstetrician
Consultant Paediatrician
Antenatal Screening Coordinator
Senior Advanced Specialist Medical Scientist / Representative
CHRD Manager/Representative
Senior Midwife
Failsafe Officer

Role of the Group

To assess the current provision of antenatal, labour and postnatal care in Mid Essex and work towards the provision of an evidence based service, which is both equitable and acceptable for woman and their partners, in line with national recommendations for the Infectious Diseases in pregnancy screening programme. Its multidisciplinary membership will aid systematic communication and dissemination of information to all stakeholders.

Quorum

Meetings will only take place with the agreed attendance from a core group of staff:

- Specialist Consultant or Nurse for infectious diseases
- Maternity representation
- Laboratory representation

Objectives

- To develop/update locally agreed written screening policy that sets out the aim and standards for local programmes and in line with national recommendation and regional policy.

- To develop/update a clearly defined antenatal and newborn screening policy to include information and support for woman and their partners, informing them of their results and subsequent referral pathways.

- To develop plans for the implementation of the national standards pertaining to antenatal and newborn screening recommendations/ programme.

- To inform the development of evidence-based continuing education programmes for all members of the multidisciplinary team involved in screening, specific to roles and responsibilities.

- To review aspects of the service through audit and quality assurance mechanisms and to make recommendation for change, as appropriate, to improve the quality of the screening programme.

- To inform and support Mid Essex Hospital Services NHS Trust in the commissioning of programmes.

- To liaise with Public Health England (PHE) / NHS England and provide agreed data in line with programme standards, as required by PHE / NHS England and the Clinical Commissioning Group for screening pathways.

- To ensure attendance at Public Health England / NHS England Regional meetings, to liaise with regional coordinators.

6.0 REPORTING ARRANGEMENTS

6.1 The Infectious Diseases in Pregnancy Group will ensure that the Women's and Children's Directorate Governance Meeting receive minutes of the quarterly meetings.

6.2 The Infectious Diseases in Pregnancy Group minutes will then be embedded into the agenda of the Women's and Children's Directorate Governance Meeting.

Review

The group will annually review its:
- Terms of reference
- Membership
- The relevance and value of its work

This review will take place in the first meeting of the year

Frequency of Meeting

This meeting will be held quarterly

Confidentiality

All meetings will protect personal identity by ensuring that data in anonymised and abide by the data protection and Caldicott principles**,** as documented in the Mid Essex Hospital Services NHS Trust Confidentiality and Data Protection Policy Register No 07011.

Terms of Reference Agreed: January 2016

Endorsed by: The Infectious Diseases in Pregnancy Group

Implemented: Clinical Directors for Women's, Children's

SAFE Paediatric Surgery Group

TERMS OF REFERENCE
2016

1.0 Membership

Consultant ENT Surgeon (Chair)
Consultant General Surgeon
Consultant Orthopaedic Surgeon
Consultant Ophthalmologist
Consultant Plastic Surgeon
Consultant Urologist
Consultant Anaesthetist (Deputy Chair)
Consultant Paediatrician
Lead Nurse for Paediatrics
Sister Children's Day Stay Unit
Sister Children's Inpatient ward
Safeguarding Nurse
Paediatric Lead for Theatre Recovery

Additional Membership

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

2.0 PURPOSE

2.1 To set and maintain standards for the Surgical and Anaesthetic care of children across the Trust.

3.0 QUORUM

3.1 The meeting will be quorate if 4 members of the group are present. This must include the Chair or Deputy Chair, Consultant Paediatrician and representation from A&E Department.

4.0 ACCOUNTABILITY

4.1 The group is accountable to the Clinical Governance Group.

5.0 INDIVIDUAL AND GROUP RESPONSIBILITIES

5.1 **The group members are responsible for:**

- Promoting a team approach in the management and provision of children's care.
- Developing key agenda topics that focus on safe, effective, compassionate and high quality care as a priority
- Providing a forum where members of a multidisciplinary team can meet to discuss, review and influence practice
- Discussing and incorporating evidence-based practice through the provision of multidisciplinary based guidelines. Monitoring current guidelines, audit and patient information incorporating paediatric governance themes and local/national priorities
- Ensuring effective communications where safeguarding concern is likely.
- Identifying and discussing the care of vulnerable children and families.
- Facilitating the provision of an environment that promotes open discussion, a learning environment and a blame free culture
- Reviewing clinical incidents, identifying any emerging trends and to make recommendations for changes in practice within a risk management structure, including provisions of service to prevent/minimise avoidable admissions or delayed discharges.

5.2 **Communication**

Following each monthly meeting the Lead Paediatric Consultant will:

- Approve completed minutes and send to the Maternity Risk Manager in order to embed in the forthcoming Maternity Directorate Governance Meeting agenda
- Ensure minutes are circulated to core members
- For clinical governance purposes reports should go to the Trust's Clinical Governance

6.0 LEVEL OF FINANCIAL AUTHORITY

6.1 No financial authority accorded to this committee.

7.0 REPORTS RECEIVED

7.1 National, regional and local guidelines for the care of Children in Hospital from various Professional Bodies, Government bodies and Care Quality Commission.

8.0 DECISIONS/ RECOMMENDS AUTHORITY

8.1 Guidelines issued by the Group will be recommended to the Trust.

9.0 STANDING AGENDA ITEMS

- Apologies
- Previous minutes
- Agenda
- Adverse Events

10.0 REPORTING ARRANGEMENTS

10.1 Minutes and action plans to be communicated to the Phoenix Ward meeting, Neonatal Ward meeting and Children's Outpatient meeting.

10.2 The minutes will be embedded into the agenda of the Women's and Children's Directorate Governance meeting on a quarterly basis.

11.0 FREQUENCY

11.1 Monthly

12.0 REVIEW

12.1 The chair/deputy chair will review SAFE Paediatric Surgery Group compliance with their terms of reference on an annual basis in accordance with the Maternity Risk Management Strategy (05098)

Terms of Reference Agreed: January 2016

Endorsed by: SAFE Paediatric Surgery Group

Implemented: Clinical Directors for Women's and Children's

Appendix U

Paediatric Risk Management Group

TERMS OF REFERENCE
2016

1.0 Membership

Core Membership

Lead Consultant Paediatrician for Risk Management
Matron for Children and Young People
Senior Sister for Paediatrics

Additional Members

Senior Sister for Children's Outpatients
Senior Sister for Children's Emergency Department

1.0 Purpose

- To raise awareness of clinical errors and near misses to facilitate a learning environment
- 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 to support Paediatric Health Professionals
- To establish a forum to discuss identified cases
- To actively promote clinical risk management within the Directorate by producing regular feedback summaries of cases reviewed
- To recommend change in the light of best practice and available evidence e.g. NICE clinical guidelines
- To review and analyse statistical data which reflects performance and risk assess projected activity
- 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 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.

2.0 Quorum

No business shall be transacted at a meeting unless the Lead Consultant for Risk and Matron for Children and Young Children are present.

3.0 Accountability

The multidisciplinary group is accountable to the Clinical Director and will oversee all aspects of risk management with a direct line of communication to the Women's and Children's Directorate Governance meeting.

4.0 Duties

To review and monitor risk management issues. This will include review of:

- Departmental Risk Assurance Framework;
- Paediatric Dashboard;
- Incidents both clinical and non-clinical and Serious Incidents;
- Health and Safety Incidents;
- Complaints and litigation claims;
- Clinical guidelines and audit;
- Mandatory training issues;
- Supervision of Paediatric Nurses and doctors in relation to risk management of incidents;
- Feedback from Paediatric Departmental meeting

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

5.0 Frequency

The group will meet bi-weekly. All core members should arrange for a deputy in the event that they are unable to attend.

6.0 REVIEW

The Matron for Risk Management will review the Risk Management Group's compliance with their terms of reference on an annual basis in accordance with the Women's and Children Directorate Clinical Governance Structure (to incorporate Risk Management Strategy); register number 05098.

Terms of Reference Agreed: January 2016

Endorsed by: Paediatric Risk Management Group

Implemented: Clinical Directors for Women's and Children's Directorate

Appendix V

Women's and Children's Services Directorate Pathway for the Review of National Drivers within Maternity Services