Women's Services Quality Safety and Governance Policy

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1.0 Introduction

The Women's Services Quality Safety and Governance Policy has been developed to comply with legal and statutory requirements to continually improve the safety, experience and quality of patient care.

This policy is to be used in conjunction with the Trusts Quality Strategy and Incident management policy.

http://systems/pt/Policy%20One/Trust%20Strategies/Quality%20Strategy.pdf

https://portal.bdgh-tr.trent.nhs.uk/SiteDirectory/TrustApprovedDocuments/TAD/Incident%20management%20V6

2.0 Objective

This policy describes the framework for identifying, managing and reducing the risks (actual or potential) which exist within the Maternity and Neonatal Service and its environment. This applies to all staff working with Maternity and Neonatal Services in all settings and describes the arrangements for ensuring that lessons learnt and embedded from all incidents, complaints and claims are actively disseminated to all staff.

See Appendix 3: for Maternity Services Measurable Objectives and Compliance.

3.0 Scope

The intention of this policy is so that any member of staff and contractor within the Trust whom identifies an incident can confidently and efficiently report an incident, and openly investigate via the correct process depending on the level of harm and statutory requirements.

4.0 What is an incident

Wherever possible we align with the Local Maternity and Neonatal System (LMNS) and wider Trust system however due to maternity legislation and reports some specific circumstances differ from the Trust process.

Alongside this document please refer to:
https://portal.bdghtr.trent.nhs.uk/SiteDirectory/TrustApprovedDocuments/TAD/Incident%20management%20V6
Trigger list grading of harm and case review.pdf

4.1 Datix® reporting

http://svsharepoint/clinical/Riskman/Risk%20Management/Incident%20Reporting%20Procedures/Incident_Reporting%20Procedure%20-%20Jan%202012.pdf

Appendix 1 and 2 of the trust incident management (linked above) policy contains a user guide for Datix®

An E-mail is sent in real time by the Datix® system to the Lead Midwives/Nurses/Governance team and relevant specialist departments informing them of the incident. They will review the incident on the Datix® system and complete a case review per the LMNS criteria.

Specific incidents also require external reporting as per the policy above. Within maternity services antenatal screening incidents will be investigated by the Antenatal Screening Co-ordinator who will determine if the incident is a local isolated incident or likely to affect other antenatal screening services. They will escalate to the Screening Quality Assurance Service (SQAS) as appropriate – for further information see link below
https://www.gov.uk/government/publications/managing-safety-incidents-in-nhs-screening-programmes

4.1.1 Grading of Harm

Harm will be graded based on the LMNS criteria. This list is not exhaustive and any issues with grading of harm will be discussed as an MDT during the Weekly Incident Review Meeting.

4.2 Case reviews

Case reviews should be completed within 72 hours as per the LMNS agreed criteria on the LMNS template:
https://teamsites.bdgh-tr.trent.nhs.uk/CBU3/MaternityDocuments/LMNS%20documents/LMNS%20Case%20review%20Template%20New%200622.docx

This is completed by the Datix® lead handler or allocated individual alongside the on call Obstetric Consultant. All reviews must be MDT (where expert opinion is required Specialist services should be invited e.g. specialist diabetes or the bereavement midwife). Therefore, daily huddles are to take place at 10:30am and/or 13:30 Monday to Friday in the Barnsley Birthing Centre (BBC) leads office. The timings are flexible according to the schedule of the investigators involved.

Once completed this must be emailed to the Maternity Governance team via bdg-tr.maternitygovernance@nhs.net who will add the case review to the Weekly Incident Review meeting agenda for discussion.

4.3 Duty of Candour

The maternity and neonatal services will adhere to national and legal processes outlined in the Trust guidance and the compliance to this will be monitored via the women's Business and Governance monthly meeting.

Duty of Candour is a statutory obligation to be open and honest in the event of an incident where patient harm has occurred.

Please refer to trust guideline on being open and honest;
http://sv-sharepoint/clinical/Riskman/Duty%20of%20Candour/Forms/AllItems.aspx

https://portal.bdgh-tr.trent.nhs.uk/SiteDirectory/TrustApprovedDocuments/TAD/Duty%20of%20Candour%20V1.3

4.4 Investigation process

See appendix 4 for the Maternity Incident Flow Chart

4.4.1 Weekly Incident Review Meeting

Weekly Datix's® and case reviews are discussed at the weekly meeting see linked term of reference
The TOR are currently under review. Please contact bdg-tr.maternitygovernance@nhs.net if you require these

4.4.2 Criteria for escalation to a Serious Incident (SI)
Every incident must be considered on a case-by-case basis using the description below. Within Maternity services any incidents investigated by Maternity and Newborn Safety Investigations (MNSI) are logged and managed as per the Serious incidents Policy – https://portal.bdgh-tr.trent.nhs.uk/SiteDirectory/TrustApprovedDocuments/TAD/Serious%20Incident%20Policy

Internally investigated SI's are discussed with the LMNS as per the TOR https://teamsites.bdgh-tr.trent.nhs.uk/CBU3/MaternityDocuments/LMNS%20documents/LMNS%20peer%20review%20SOP.doc

4.4.2 Criteria for escalation to a High Level Review (HLR)
Please refer to https://portal.bdgh-tr.trent.nhs.uk/SiteDirectory/TrustApprovedDocuments/TADDocs/Escalation%20and%20investigation%20of%20high%20level%20reviews%20V2.pdf

4.4.3 Criteria for escalation to a NHS Resolution (NHSR)
The Trust Legal Team will report all qualifying cases to the Early Notification (EN) scheme as per CNST safety action 10.

MIS-year-4-relaunch-October-2022-v5-Final-HV-approved-1.docx (live.com)

4.4.4 Criteria for escalation to the Maternity and Newborn Safety Investigations (MNSI) (previously known as Healthcare Safety Investigation Branch, HSIB)
The criteria for referral is found at https://www.hsib.org.uk/what-we-do/maternity-investigations/what-we-investigate/

All HSIB referrals will be logged as SI's as per Trust policy. HSIB investigations have replaced the trusts maternity SI investigations (HSIB, 2020). However, following the 72 hour case review any immediate learning will be actioned.

The Maternity Governance Team will provide all families with information relating to the process and verbal consent for referral.

The Maternity Governance Team will notify HSIB of the referral via the online portal Select form type | HSIB Portal.

HSIB will contact The Governance Team to discuss the case and accept the referral. Once HSIB receive consent from the family they will notify the Governance Team who will upload all required documentation to the portal.

4.5 Mothers and Babies; Reducing Risk through Audit and Confidential Enquires across the United Kingdom (MBRRACE-UK) Surveillance system

4.5.1 Maternal Death
Maternal Death.pdf (trent.nhs.uk)
Notification to MBRRACE-UK is required for all mothers who die during pregnancy or up to 12 months after giving birth.

4.5.1 Fetal loss and Neonatal Death

Please refer to https://www.npeu.ox.ac.uk/mbrrace-uk/data-collection for the cases which require notification to MBRRACE-UK and review via Perinatal Mortality Review Tool (PMRT):
https://teamsites.bdgh-tr.trent.nhs.uk/CBU3/MaternityDocuments/Terms%20of%20Reference/Perinatal%20Mortality%20Review%20Tool%20and%20External%20Peer%20Review%20Process.doc

This is completed in accordance with CNST requirements Safety action one https://resolution.nhs.uk/wp-content/uploads/2022/10/MIS-year-4-relaunch-October-2022-v5-Final-HV-approved-1.docx

The Bereavement Midwife and Governance Team ensure parental involvement as per the LMNS Parental Engagement SOP https://portal.bdgh-tr.trent.nhs.uk/SiteDirectory/TrustApprovedDocuments/TADDocs/PMRT%20parental%20engagement.pdf

4.6 Criteria for referral to Child Death Overview Panel (CDOP)

For further information on the CDOP process please see Child Death Overview.pdf (trent.nhs.uk)

4.7 Shared Learning and Feedback

- The Governance Team collaboratively produce a weekly safety brief following the weekly incident review meeting. This is distributed to all staff via email, Connect® handover, SharePoint and Wardbook (closed Facebook group for staff) and discussed at daily handovers.
- The full Reports from MNSI, SI's and HLR's are shared with all staff via the Trust's Governance Processes,
- Learning cases will be presented at the relevant meetings; Perinatal Mortality Meeting and Women's Safety Forum and incorporated in the yearly training.
- The Governance Team produce a monthly newsletter for Women's services to share learning from cases investigated and National reports e.g. HSIB learning reports. This is shared via via email, Connect® handover, SharePoint and Wardbook (closed Facebook group for staff)

4.7 Supporting staff

4.7.1 Writing a statement

There are occasions when staff maybe be asked to write a statement or be interviewed following an incident, a complaint, a claim, an inquest or for evidence during legal proceedings.

4.7.2 Guidance on Preparation of Statements

The Governance and Legal Team will support staff if statements are required.

Statements must be factual, avoid opinion, assumptions or speculation. It is important to carefully consider the contents and make sure the information contained is accurate.

Format of a statement;

- Typed,
- In the footer have page number e.g. Page 1 of 5 and name and space to sign each page,
- Write the statement in the first person,
- Include clear dates and times,

- Set out the statement in chronological order; and
- Explain terminology and abbreviations and test/ observation results and normal parameters,
- State your Name, address, qualification e.g. Registered Midwife, professional registration number and your job title i.e. designated midwife, Obstetric Registrar on call.
- Statements should be verified by a statement of truth – 'I believe the facts contained in this witness statement are true.'
- Clarify if you have had direct involvement with the patient or if you are relying solely on the medical records to provide an overview,
- State what time you came on duty and what information you were given on handover.
- Refer to the patient by their title and surname. Never refer to them as 'the patient' of 'the deceased',
- Refer to colleagues by their full names and titles,

If you need any assistance in writing or preparing a statement please contact the Legal Services Department on 1656/1479 or by email bdg-tr.legalservices@nhs.net or the Governance Team via bdg-tr.maternitygovernance@nhs.net Ext 3180/2194.

4.7.3 Debrief

Following clinical incidents staff will have the opportunity for debriefing as per the Trust policy https://portal.bdgh-tr.trent.nhs.uk/SiteDirectory/TrustApprovedDocuments/TADDocs/Supporting%20staff%20involved%20in%20an%20incident,%20inquest,%20complaint%20or%20claim.pdf .

4.8 Process for Complaints

For more information

http://departments/PatientExperience/Complaints%20Resources/Forms/AllItems.aspx

4.9 Process for responding to complaints

Please refer to the Trust Claims Policy for further information - see link below.
https://portal.bdgh-tr.trent.nhs.uk/SiteDirectory/TrustApprovedDocuments/TAD/Claims

4.10 Responding to Independent Reviews of other Maternity Units

Following publication of reports from independent reviews e.g. Kirkup, Ockenden and Care Quality Commission (CQC) reports on other Maternity Units:

- The unit will review recommendations from the reports and hold a Multidisciplinary Team meeting to benchmark Barnsley Hospital Maternity Services against them.
- The unit will identify any actions required to improve the care provided and maintain patient safety.
- The actions required and learning will be shared via the Women's Services Business and Governance meeting, at labour ward forum, Women's safety Forum and in the monthly Governance newsletters.
- The actions will be added and monitored via the Maternity Services Improvement plan.

4.11 Risk registers

Please see https://portal.bdghtr.trent.nhs.uk/SiteDirectory/TrustApprovedDocuments/TAD/Risk%20Management%20Policy%20and%20Procedure%20v%201.0 for more information.

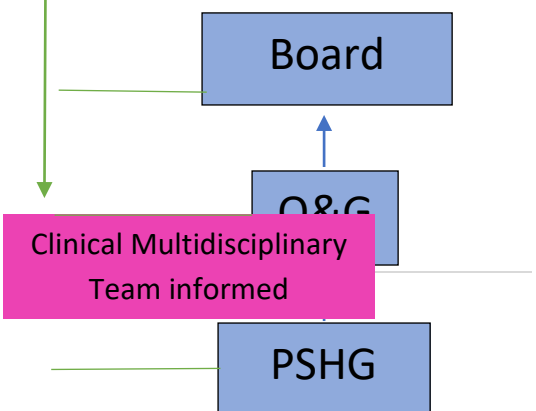
5.0 Assurance to Trust Executives

The trust structure can be found at http://intranet.bdgh-tr.trent.nhs.uk/about-the-trust/organisational-structure-charts/

The Provider Board Measures paper is produced by the Governance Team with Deputy Head and Head of Midwifery oversight. Following recommendations from the Ockendon 2022 report it is presented monthly by the Board Level Safety Champion. Board reports can be found at Corporate Documents - Corporate Documents (barnsleyhospital.nhs.uk).

5.1 Governance and Safety Meetings within the Maternity and Neonatal Services with a focus on Risk Reduction

Please see the flow chart below detailing how safety information is shared from Ward to board and back again.



Governance Ward to Board flow chart

Key	
	Meetings
	Clinical staff
	Escalation
Green arrow	Feedback to ward level
Blue arrow	Escalation

Escalation needed

Escalation needed

6.0 Roles and responsibilities

For organisational roles and responsibilities (including CBU Directors, / Associate Directors of Nursing / Midwifery) please refer to the Trust Risk Management Policy – *see link below.*
https://portal.bdghtr.trent.nhs.uk/SiteDirectory/TrustApprovedDocuments/TAD/Risk%20Management%20Strategy

Role	Responsibility
Consultant for Governance Lead	• Will deputise as chair of the Weekly Incident Review Meeting and the Women's Services Business & Governance Meeting. • Will report to the Obstetric Clinical Lead any significant risk issues, recommendations, action plans and changes in practice via the consultant meeting. • Will provide expert medical opinion for any investigations • Will attend the litigation group when invited to provide medical expertise on all maternity claims / disclosures. • Will be involved in the development of guidelines.
Maternity and Neonatal Safety Champion The TOR are currently under review. Please contact bdg-tr.maternitygovernance@nhs.net if you require these Link to the poster	• Maintain effective communication with local clinical maternity networks and collaborations within the region. • Work with the Obstetric and Midwifery Safety leads to ensure that maternity issues are communicated and championed at board level. • Monitor safety and outcomes in maternity and Neonatal services in accordance with the CNST requirements MIS-year-4-relaunch-October-2022-v5-Final-HV-approved-1.docx (live.com) • Contribute to the locally developed quality improvement plan. • Attend Perinatal Safety Champion meetings with the Director of Nursing. • Working in accordance with https://www.england.nhs.uk/wp-content/uploads/2020/12/transforming-perinatal-safety-resource-pack.pdf
Quality Safety and Governance Lead midwife	• Work in accordance with national and local polices • Have oversight of the Governance Team daily work • Produce the monthly Provider Board Measure Paper • Work with the Lead Obstetric

	Consultant and DHoM to coordinate and have oversight of clinical audits. • Attend and deputise when required at the Weekly incident Meeting • Attend required internal and external trust meetings • Monitor and maintain Trust action plans in relation to national reports • Ensure training issues identified to the Maternity Practice Education Team are actioned.
Governance Lead Midwife	• Work in accordance with national and local polices • Will chair the weekly Incident Review meeting • Attends the Trust Governance meetings to maintain two-way communication, and inform the Women's Services of potential organisational risks and changes in policy or practice. • Will ensure Governance policies, procedures and processes are in place and complied with in all areas. • Will escalate training issues identified to the Maternity Practice Education Team ensuring that appropriate training is provided for staff. • Will collate clinical incidents to inform the Women's Services Business & Governance Meeting of significant risks or evolving trends and actions. • Will ensure that local investigation action plans are discussed at the Women's Services Business & Governance Meeting to monitor and ensure completion. • Will have an awareness and be involved in clinical audits. • Contribute to the monthly Provider Board Measure Paper • Monitor and update monthly the Women's Risk Register
Lead Consultant for Obstetrics and Lead Consultant for Birthing Centre	• Will attend the Labour Ward Forum and provide medical expertise on all Birthing Centre issues • Will provide expert medical opinion for any investigations • Will attend the litigation group when invited to provide medical expertise on all maternity claims / disclosures. • Will be involved in the development of guidelines.

Ward Leads and Community Team Leaders for Maternity Services	• Will manage incidents within their clinical area, escalating any concerns via the governance process. • Will investigate incidents in line with Trust policy. • Will attend the Weekly Incident Review Meeting and the monthly Women's Services Business & Governance meeting and provide updates on clinical incidents, accuity and escalate any concerns. • Participate in the production of the weekly safety brief. • Individual feedback following investigations regarding lessons learned to staff. • Will be involved with the development of guidelines. In addition the BBC lead will chair the Labour Ward Forum in accordance with the TOR.
Lead Anaesthetists Consultant for Obstetrics	• Will attend the Labour Ward Forum, and Women's Services Business & Governance Meetings and provide an anaesthetic opinion on any risk issues that arise. • Will promote Obstetric Anaesthetic services and maintain safe clinical practice. • Will be involved in the development of anaesthetic based guidelines. • Will be involved with training for all grades of staff as per the Training Needs Analysis (TNA)
Lead Consultant Paediatrician for Neonatal	• Will attend the Labour Ward Forum and ATAIN meetings and provide expert advice where appropriate. • Will provide expert opinions for investigations. • Will be involved in the development of paediatric based guidelines
Matron	• Will work in accordance with https://www.england.nhs.uk/mat-transformation/matrons-handbook/ • Will work with the CBU management team and Governance Team to promote good governance practice across the service. • Will work with teams to provide the highest standard of clinical care and monitor quality and patient safety within

	the CBU. • Will participate in incident investigation. • Will attend the stipulated meetings both internally and externally
Practice Educator Midwives	• Will co-ordinate education and training for the multidisciplinary maternity team in accordance with the TNA • Will monitor the Trust training database and cross reference with attendance at Maternity Training to ensure compliance. • Will liaise with the Deputy Head of Midwifery and Governance Team to review changes to guidelines in response to trends, themes and complaints • Will co-ordinate guideline development, review, implementation, dissemination and archive
All staff	• Work in accordance to the Governance trust policies • Will work with the Governance Team, Maternity Leads and the Matrons in the implementation, development and delivery of the Governance Strategy
Service Users	• Will attend the Maternity Voices Partnership Group on a monthly basis. • Attend Women's Services Business & Governance meetings to be involved in the incidents and complaints processes. • Will be involved in development of guidelines and leaflets.
LMNS	• Will share the learning across the LMNS via Monthly meetings and posters, • Providing support and participate in peer review process of SIs, and off pathway births • Organise the PMRT external review presence • ATAIN oversight of monthly trends and themes

7.0 Associated documents and references

Healthcare Safety Investigation Branch (HSIB) Maternity Investigations
https://www.hsib.org.uk/maternity/
Health & Safety Executive - RIDDOR reportable incidents
https://www.hse.gov.uk/riddor/reportable-incidents.htm
HM Government Child Death Review Statutory and Operational Guidance England October 2018
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/859302/child-death-review-statutory-and-operational-guidance-england.pdf
Kirkup 2015
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/408480/47487_MBI_Accessible_v0.1.pdf
NHS Resolution Early Notification Guidance https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/early-notification-scheme/
NHS Improvement Never Events List January 2018
https://improvement.nhs.uk/documents/2899/Never_Events_list_2018_FINAL_v7.pdf .
NHS England Managing Safety Incidents in NHS Screening programmes Aug 2017
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/672737/Managing_safety_incidents_in_National_screening_programmes.pd
NHS England Patient Safety Strategy July 2019 https://www.england.nhs.uk/wp-content/uploads/2020/08/190708_Patient_Safety_Strategy_for_website_v4.pdf
NHS England Serious incident Framework https://www.england.nhs.uk/wp-content/uploads/2020/08/serious-incidnt-framwrk.pdf
NHS England Matrons handbook – Governance NHS England » Governance, patient safety and quality
Ockenden 2020 https://www.ockendenmaternityreview.org.uk/july-2021/
Ockenden 2022 https://www.ockendenmaternityreview.org.uk/wp-content/uploads/2022/03/FINAL_INDEPENDENT_MATERNITY_REVIEW_OF_MATERNITY_SERVICES_REPORT.pdf
PMRT Guidance for Trusts and Health Boards July 2018 Version !.2
https://www.npeu.ox.ac.uk/assets/downloads/pmrt/3b_Guidance%20for%20using%20the%20PMRT%20July%202018%20v6.pdf
Royal College of Obstetricians (RCOG) Each Baby Counts National Quality Improvement Programme. https://www.rcog.org.uk/en/guidelines-research-services/audit-quality-improvement/each-baby-counts/information-for-trusts-health-boards/frequently-asked-questions/
Royal College of Obstetricians (RCOG) Clinical Governance Advice No 2. Improving patient safety: Risk management for Maternity & Gynaecology. September 2009.
https://www.rcog.org.uk/globalassets/documents/guidelines/clinical-governance-advice/cga2improvingpatientsafety2009.pdf
Screening incidents reporting https://www.gov.uk/government/publications/managing-safety-incidents-in-nhs-screening-programmes

8.0 Training and resources

All staff will be made aware at local induction of the governance and Quality strategies and polices. Staff will undertake once only training on duty of candour and have updates on governance issues as per the TNA.

Ad-hoc advice and training can also be provided by the Governance Team or Health and Safety Team upon request on a one to one basis or as a group session. This can be tailored to what is required e.g. incident reporting, incident investigation or incident report generation.

8.0 Monitoring and audit

Minimum	Process for	Responsible	Frequency	Responsible	Responsible	Responsible

requirement to be monitored	monitoring e.g. audit	individual/ group/ committee	of monitoring	individual/ group/ committee for review of results	individual/ group/ committee for development of action plan	individual/group/ committee for monitoring of action plan and Implementation
Weekly incident Meetings are held and quorate	Review minutes and attendance.	Governance Midwife	Yearly	Women's Services Business & Governance Meeting	Governance Midwife	Women's Services Business & Governance Meeting
Monthly Women's Business & Governance Meetings are held and Quorate	Review minutes and attendance	Deputy Head of Midwifery	Yearly	CBU 3 Business & Governance Meeting	Deputy Head of Midwifery	CBU 3 Business & Governance Meeting

9.0 Equality and Diversity

This section is mandatory for all Trust Approved Documents and must include the statement below:

The Trust is committed to an environment that promotes equality and embraces diversity in its performance as an employer and service provider. It will adhere to legal and performance requirements and will mainstream equality, diversity and inclusion principles through its policies, procedures and processes. This policy should be implemented with due regard to this commitment.

To ensure that the implementation of this policy does not have an adverse impact in response to the requirements of the Equality Act 2010 this policy has been screened for relevance during the policy development process and a full equality impact assessment is conducted where necessary prior to consultation. The Trust will take remedial action when necessary to address any unexpected or unwarranted disparities and monitor practice to ensure that this policy is fairly implemented.

This policy can be made available in alternative formats on request including large print, Braille, moon, audio, and different languages. To arrange this please refer to the Trust translation and interpretation policy in the first instance.

The Trust will endeavor to make reasonable adjustments to accommodate any employee/patient with particular equality, diversity and inclusion requirements in implementing this policy. This may include accessibility of meeting/appointment venues, providing translation, arranging an interpreter to attend appointments/meetings, extending policy timeframes to enable translation to be undertaken, or assistance with formulating any written statements.

9.1 Recording and Monitoring of Equality & Diversity

This section is mandatory for all Trust Approved Documents and must include the statement below:

The Trust understands the business case for equality, diversity and inclusion and will make sure that this is translated into practice. Accordingly, all policies will be monitored to ensure their effectiveness.

Monitoring information will be collated, analysed and published on an annual basis as part of Equality Delivery System. The monitoring will cover the nine protected characteristics and will meet statutory employment duties under the Equality Act 2010. Where adverse impact is identified through the monitoring process the Trust will investigate and take corrective action to mitigate and prevent any negative impact.

Appendix 1
Glossary of terms

ATAIN – Avoidance of Term Admissions in Neonatal unit.
CQC – Care Quality Commission.
CNST – Clinical Negligence Scheme for Trusts
HSIB – Healthcare Safety investigation Branch
MNSI -Maternity Neonatal Safety Investigations
LMNS- Local Maternal and Neonatal System
NHSR – NHS Resolution
NICE – National Institute for Health and Care Excellence
PMRT- Perinatal mortality Review Tool
RCOG – Royal College Obstetricians & Gynaecologists
TNA – Training Needs Analysis.

Appendix 2: Maternity Services Measurable Objectives and Compliance

Strategy Statement	Actions to be Taken	Evidence	Lead Responsibility
1. The Datix trigger list will be available to all staff on the Trusts approved document site (TAD).	Maintain an up-to-date trigger list and guideline	Trigger list	Maternity Governance Team
2. The effective and timely investigation of Datix®, complaints or claims, highlighting any issues that need addressing within service.	Appropriate lead investigator is identified and an investigation commenced within a week of incident identification. Any local Maternity investigation initiated should be performed alongside an obstetric/paediatric consultant (where necessary).	Datix® - Lead investigator identified & dated online. Complaints – Lead responder identified & dated on proforma. Claims – Claims Dept identify lead & record on proforma.	Matrons for Maternity, Midwifery Leads, Maternity Governance Team Complaints Department
3. Lessons learnt from investigations are disseminated, action plans agreed and embedded in practice. This is achieved by: a) Individual feed-back b) Up to date Governance Boards within the clinical area c) Weekly Safety Brief d) Monthly Governance newsletter	Document verbal feedback on Datix reporting system or via email, Evidence in the weekly incident review agenda action tracker.	Documented evidence of verbal feedback on Datix® and the weekly incident review action tracker.	Midwifery Leads and Maternity Governance Team
	Monthly Governance newsletter	Monthly Governance newsletter shared with all staff via email, Connect handover, Wardbook and SharePoint	Maternity Governance Team

Strategy Statement	Actions to be Taken	Evidence	Lead Responsibility
4. Review events / incidents during multi-disciplinary case discussions	Case discussions held at: • Morning Handover on Labour Ward and/or 10:30 huddle • Regular case discussions led by the consultant on call • Monthly Perinatal Mortality meetings and 6 monthly safety summits • Monthly Safety forum • LMNS meetings • Extra multidisciplinary case discussions as required	Documented attendance and discussion at: • Morning Handover on Labour Ward • Weekly incident review Meetings • Monthly Perinatal Mortality meetings • LMNS meetings • Extra multidisciplinary case discussions as required	Midwifery Leads Lead Obstetric Consultant for Governance Labour Ward Lead Consultant Maternity Governance Team LMNS
5. Managing the Maternity Risk Register to highlight issues according to the risk they pose using the Trust Risk Matrix and then highlighted to the Directorate Manager and documented on the Directorate Risk Register	Add and maintain the Maternity Risk Register.	The presence of all Obstetric Risks identified on the Trust Intranet with Risk Ratings	Directorate Manager Deputy Head of Midwifery Maternity Governance Team
6. Review and where appropriate implement national guidance	Review of national guidance & reports go to; Labour Ward Forum Clinical Audit meeting Women Business and Governance	Minutes of Labour Ward Forum and Women's Business and Governance Agenda of the Clinical Audit meeting	Clinical Director HoM/Deputy HoM Obstetric Consultant Leads Maternity Governance Team Clinical Audit Department BBC Lead Midwife

Strategy Statement	Actions to be Taken	Evidence	Lead Responsibility
7. Inform practice as recommended by local audits.	Review of clinical audit & reports go to; Audit meeting inform practice / training by dissemination of audit results. CBU3 Business and Governance	Minutes of CBU3Business and Governance Newsletter / emails for dissemination of recommendations	Clinical Director Obstetric Consultant Leads Maternity Governance Team Clinical Audit Department BBC Lead Midwife
8. Process for escalating Governance issues from the Maternity service to Board level.	Follow the Ward to Board flowchart process	See	All staff
9. Process by which the board lead executive communicates with and obtains assurance from the Maternity Service	The Chief Nurse is the named lead executive at Board level and Maternity Safety Champion who has responsibility for Maternity Services. The Chief Nurse role is to ensure that the Board is aware of any safety concerns and assured of the processes and practices in place to keep patients safe. They have a key communication role between Maternity Services and the Board and fulfils this by: • Monthly 1:1 meeting with Head of Midwifery • Maternity reports form part of the chief nurse report to Trust Board. • Escalating Risk Management issues to Board level from the Patient Safety and Harm Group. • Receive issues needing immediate escalation via the Head of Midwifery	Notes / Diary for weekly meeting with HoM / Chief Nurse or Director of Nursing ToR and minutes of the meetings Monthly Provider Board Measure Paper Emails regarding immediate escalation	HoM Maternity safety champions Quality Safety and governance Lead Maternity Governance Team

PROUD to care

NHS Barnsley Hospital Trust

Appendix 3 Incident Flow Chart

Incident Logged on Datix.
Labour ward lead / Governance midwife screen incidents for any that may require higher escalation.
Ensure that Datix are closed within 14 days unless the incident is logged as an SI / RCA

Lead midwives in each area will screen incidents daily: moderate/ serious harms will require a case review within 1-2 working days. (Appendix 1). The lead for the area will complete. **These cases will be reviewed by the MDT weekly risk meeting. Level of harm will be agreed at this meeting/area for learning to be shared.**

If the panel determine that a higher level investigation is required the case should be referred to the weekly patient safety panel for discussion of the incident and proposal re RCA or SI. (see flow chart for PMRT, SI, and HSIB)

PMRT Cases
IUFD from 22 – 40 weeks, Intrapartum Stillbirth and Early neonatal death within 28 Days.

- The case will be reviewed within 24 hours by the lead midwife on BBC / Consultant on call
- Bereavement midwife / Governance midwife will data input patient details onto MBRRACE within one week of the incident.

PMRT Lead allocated via rota.

PMRT Lead
- Liaise with Bereavement midwife to obtain parental concerns and she will undertake duty of candour as required.
- Data input initial review onto PMRT tool.
- Liaise with Governance midwife for date to complete review within **4 WEEKS of the incident.**
- Ensure that appropriate people attend the PMRT panel meeting.
- Publish the report when the PM and histology results are obtained and distribute.

Serious Incidents
Maternal Deaths, Intrapartum Stillbirths, Never events.
Any case where there has been significant harm caused.
Please refer to guideline for management of incidents, complaints and claims.
Inform Governance Midwife / HOM of cases.

Governance Midwife / Lead midwives to present case to patient safety panel for confirmation of escalation as an SI.
Complete an escalation form as required (Never Events)

NHSR and HSIB
- Intrapartum Stillbirths, Early neonatal deaths at term within 6 days of delivery.
- Babies >37 weeks gestation following labour diagnosed with: HIE Grade 3, actively therapeutically cooled; or have a combination of the following signs: decreased central tone, comatosed, seizures of any kind.

ALL the above cases need referral to BOTH agencies.

HSIB
Escalate cases to the lead midwives who are the links for HSIB: Governance Midwife, Maternity Matron and HOM. They will escalate to HSIB using the MIDAS electronic system within **10 DAYS of the incident.**

NHSR
Escalate cases to the Governance Midwife / Lead midwives on BBC. They will complete the template for NHSR referral and send to legal services within **10 DAYS of the incident occurring.**

N.B. Some cases may need to be escalated as an SI and referred to more than one agency - PMRT, NHSR and HSIB.

N.B. Ensure that Trust Duty of Candour policy is implemented for all cases causing moderate harm and above.

Appendix 4 (must always be the last appendix)
Maintain a record of the document history, reviews and key changes made (including versions and dates)

Version	Date	Comments	Author

Review Process Prior to Ratification:

Name of Group/Department/Committee	Date
Reviewed by Maternity Guideline Group	
Reviewed at Women's Business and Governance meeting	
Approved by CBU 3 Overarching Governance Meeting	
Approved at Trust Clinical Guidelines Group	
Approved at Medicines Management Committee (if document relates to medicines)	N/A

Trust Approved Documents (policies, clinical guidelines and procedures)

Approval Form

Please complete the following information and attach to your document when submitting a policy, clinical guideline or procedure for approval.

Document type (policy, clinical guideline or procedure)	Policy
Document title	Women's Services Quality Safety and Governance Policy
Document author (Job title and team)	Quality, Safety and Governance Lead
New or reviewed document	Reviewed
List staff groups/departments consulted with during document development	Midwifery Obstetric Clinical Governance
Approval recommended by (meeting and dates):	**CBU3 overarching governance meeting**
Date of next review (maximum 3 years)	22/02/2026
Key words for search criteria on intranet (max 10 words)	Datix Grading of harm Case reviews Duty of candour Investigation Serious Incident (SI) High Level Review (HLR) PMRT CDOP Learning
Key messages for staff (consider changes from previous versions and any impact on patient safety)	

I confirm that this is the <u>FINAL</u> version of this document	**Name: Jade Carritt** **Designation: Governance Midwife**

FOR COMPLETION BY THE CLINICAL GOVERNANCE TEAM

Approved by (group/committee): **Date approved:** **Date Clinical Governance Administrator informed of approval:** **Date uploaded to Trust Approved Documents page:**