Managing Incidents and Review of Care in Maternity Standard Operating Procedure and Terms of Reference

1. Scope and Expectations

Setting	
Activities	

2. SOP Governance

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3. Objective

The purpose of this document is to ensure that there is a consistent and robust approach to incident managing (review, investigation, Duty of Candour and learning) for all clinical incidents, reported via the DATIX IQ system or otherwise identified and is in line with relevant policies and procedures.

This procedure describes the management arrangements for consistent review and investigation of incidents and the subsequent dissemination of local and organisational learning and improvement.

This document must be read in conjunction with the relevant Trust policies and procedures e.g.: Incident Management Procedure, Being Open and Duty of Candour Policy. The Document Leads must ensure the document is updated, if required, when the above Trust Policies/procedures are updated.

The key objectives of this procedure are:

- To ensure that every incident is reviewed and/or investigated within Trust approved timescales.

- To ensure that governance arrangements involve representation from the whole multi professional team
- To initiate a systematic process for the review and/or investigation for all clinical incidents, reported via the Datix incident reporting system.
- To support the communication of lessons learned from incident investigations to all staff
- To ensure that the response to each incident will be proportionate to the scale, scope and complexity of the incident and will support a 'Just Culture' approach.
- To ensure that we are robust and consistent in external reporting requirement

4. The Procedure

Reviewing Clinical Incidents

The expectation of the directorate is that all incidents are reviewed within 7 days to ascertain the level of grading and confirm the correct handler. The Senior Midwifery Management team should be proactively reviewing new incidents in their respective clinical areas each day.

The level of action required following an incident is dependent on the severity of grading given. Incidents graded as no harm, low harm or a near miss will be reviewed, investigated and managed by Senior Midwifery Clinical Managers of the clinical area where the incident originated.

Any associated learning should be effectively communicated to the wider team. Near misses with the potential to cause serious harm may require review by the Maternity Risk and Governance Team.

The following incidents will require review by the Maternity Risk and Governance Team within 72 working hours, incidents graded:

- Moderate, Severe, or Catastrophic
- A serious near miss
- A never event
- Any other incident identified as requiring further review

Incident Review Proformas (IRP) will be completed for the Virtual Incident Review Panel (VIRP) for incidents that are moderate. These will be reviewed twice weekly through VIRP by a multi-professional team. This team will be made up of but not limited to:

- Risk and Governance Midwifery Team
- Practice development midwives/ practice educators
- Professional Midwifery / Nurse Advocates
- Specialist Midwives
- Therapy staff
- Theatre Staff
- Anaesthetic Staff
- Bereavement staff
- Clinical ward managers
- Matrons
- Clinicians involved in the incident if appropriate
- Other specialities/ stakeholders e.g., anaesthetics, surgery (where possible they should be asked to attend or be consulted)
- Consultant Clinical Lead for Governance

In order to be quorate, the following impartial staff need to be present:

- Risk and Governance Midwife (1)
- Consultant Obstetrician (1)
- Neonatologist (1) - If neonatal involvement
- Anaesthetics (1) - if anaesthetic involvement
- Matron (1)
- Senior midwifery staff

The purpose of VIRP is to identify any issues that need to be addressed, identify any immediate actions or any learning that can take place, to ascertain whether Statutory Duty of Candour is required and to assign a level of investigation to cases as an MDT panel. This meeting takes place via teams or in person. VIRP is co-chaired by a Consultant Obstetrician (usually the Consultant Clinical Lead for Governance, however this can be deputised) and by a Risk and Governance Midwife. The cases are shared on screen and verbally presented. Multi-professional discussion is encouraged and the incident review proforma should contain the following information to enable review:

- A synopsis of what has happened/ suspected to have happened
- The incident description as per Datix IQ
- Any context that is pertinent to the case
- What the actual/suspected level of harm is
- Proposed level of investigation
- Any commendable practice identified
- Any areas of concern

Any immediate safety concerns identified through VIRP should be escalated to the Governance and Quality Lead Midwife for further review and/or discussion through the Senior Leadership Team. Once the VIRP meeting has concluded and met consensus, the IRP document and the corresponding datix will be completed to reflect the discussions.

Cases that meet the threshold for investigation should be promptly reported to the Corporate Governance team:

dhft.incidentinvestigations@nhs.net siting the level of proposed investigation and a rationale for such.

- Duty of Candour letter should be commenced and sent within 10 working days.
- This should be uploaded to Datix IQ.
- Incidents should remain open on Datix until the final Duty of Candour Letter has been sent.

Incidents Requiring a 72 Hour Rapid Review

Maternity incidents will require a 72 hour rapid review in the following instances:

- Maternal Death
- Maternal Admission to ITU
- Cases meeting the MNSI threshold of reporting
- Cases that will be escalated for PMRT
- Any other incident deemed to require additional review

Within 72 hours a rapid review report will be commenced. The purpose of this is to collate and review key information surrounding the incident to identify what issues need to be addressed, and any actions required to address any immediate safety concerns. The maternity governance team will require access to the patient records, both paper and digital.

The rapid review report should be conducted by the Risk and Governance Midwife with relevant leads from the list below (this list is not exhaustive):

Depending on the nature of the incident, relevant leads from the list below will be included in the initial review of the incident (this list is not exhaustive):

- Practice development midwives/ practice educators
- Professional Midwifery / Nurse Advocates
- Therapy staff
- Clinical ward managers
- Matrons
- Clinicians involved in the incident if appropriate
- Other specialities/ stakeholders e.g., anaesthetics, surgery (where possible they should be asked to attend or be consulted)
- Consultant Clinical Lead for Governance
- Specialist Midwives

Senior Governance Oversight Panel

The 72-hour rapid reviews will be taken through the Senior Governance Panel once they have been reviewed through VIRP. This meeting occurs once weekly, for oversight from the Senior Leadership Team, and recommendations for level of investigation will be discussed. Please see full terms of reference for this panel for further information.

The Senior Governance Overview Panel should be attended by:

- DOM
- HOM or ADOM
- Deputy HOM's
- Governance and Quality Lead Midwife (Chair)
- Risk and Governance Midwife
- ACD for Neonatology (or Deputised)
- Consultant Obstetric Lead for Governance (or Deputised)
- Consultant Anaesthetic Lead for Governance (or Deputised)
- Matrons

The panel is deemed quorate if there is representation from:

- One matron
- One member of the governance team
- Obstetric representation
- Anaesthetic representation
- Neonatology representation - as required
- A midwife of deputy HOM status or above

72-hour rapid reviews are subsequently discussed at the Weekly 72-hour review meeting which is held corporately, for finalisation of level of investigation and Trust Wide oversight.

Cases that meet External Reporting Requirements

Some cases will require an external review (as outlined in the table below). Where an external referral is required, it is important that this is done at the earliest opportunity. Duty of candour will still be completed within 10 days of the incident being identified.

External Body	Reporting Requirement
MBRRACE	• Maternal Deaths (direct or indirect up to 365 days after pregnancy)
MBRRACE PMRT: Perinatal Mortality Review Tool	• Stillbirths (when a baby has died after 22 completed weeks of pregnancy) • Neonatal Death (of a baby who is less than 28 days of age) • The deaths of babies who died in the post-neonatal period who have received neonatal care
MNSI	• All cases of early Neonatal Death (within 7 days of birth) • All direct maternal deaths • Cases of intrapartum stillbirth • Cases of HIE grade 3

5. Process

Incidents that are Formally Declared as Requiring Investigation

For incidents that meet the threshold for investigation, under the PSIRF framework the approved methodology should be used. Presently these are;

- Swarm
- After Action Review (AAR)
- Patient Safety Incident Investigation (PSII)
- Multidisciplinary Thematic Review

In order to fully investigate, we must engage families in line with PSIRF principles and Duty of Candour. The expectation is that families are sensitively informed, initially through verbal duty of candour and subsequently through written duty of candour that an investigation or review is taking place. The family must have opportunity to ask questions to inform the Terms of Reference for the investigation.

The staff involved in the incident should also be informed that a review into care is being conducted.

Incident Review Meetings (IRM)

Once the investigation is declared, an incident review meeting should be conducted. This should involve a multidisciplinary panel of staff members, some of which are impartial to the incident (but of relevant speciality) and the staff involved in the care should be invited to the panel. The panel uses terms of reference which aim to

underpin the investigation. Models such as the SEIPs model (PSIRF) should be made available to ensure that the principles of the investigation remain systems and processes focused.

The Terms of Reference should be circulated ahead of the meeting, to ensure that all parties in attendance understand the objective of the IRM. Any timelines or additional papers should also be circulated ahead of time to allow for preparation.

Staff members who are coming to the meeting are welcomed to bring support, in the form of a line manager, colleague, Professional Advocate or union representative. Advanced warning of meeting dates and times is expected to ensure adequate support can be secured. If staff members are unable to attend the meeting, it is acceptable for a recollection of events document to be submitted and tabled at the meeting. Personal recollections should not form part of the pre-reading papers.

During the incident review meeting, the timeline of care is reviewed, and the Terms of Reference are answered by the multidisciplinary panel. Once consensus is reached, the panel should make recommendations for learning and actions to be undertaken, to reduce the risk of similar incidents happening again.

Incident review meetings should be recorded or have minutes taken to record the content of MDT discussions.

Report Writing

Following the incident review meeting, the report should be written on the template which corresponds to the investigation type. The most up to date versions of these templates are available on the Trust Intranet (Net-i) under the PSIRF framework tab.

The report should be completed factually, and to a standard that can be shared with families, if required.

Once completed in draft, the report should be circulated to the attendees, and opportunity for factual accuracy provided. Once all of the panel members are satisfied that the content of the report is representative, the report should be approved divisionally.

PSII reports will also require corporate level sign off which can be obtained through dhft.incidentinvestigations@nhs.net

All information should be saved in an electronic file, that is titled with the patient's surname and Datix number as a minimum. The investigation files are saved by year and investigation type to ensure ease of access.

6. Information Governance

It is imperative that all relevant records into investigations are saved within the Shared Drives. Information regarding patient investigations should not be saved onto personal drives.

7. Export/ use of data

Detail where/ how the information is to be used/ shared/ uploaded or exported. Include any specific considerations such as the format and whether there is a need for password protection