Women & Children's Care Governance Board
PLANNED & URGENT CARE
16th June 2016
2pm Conference room A
Minutes

Members	Attendance	Representative
Planned Care		
Jim McCormack (JMcC) - Consultant O&G/Risk Lead for Gynae (Chair)	Apologies	
Sara Brigham (SB) – Consultant O&G/Risk Lead for Obstetrics	Apologies	
Julie Fogarty (JCF) - Head of Midwifery (Deputy Chair)	Present	
Kathie Grimes – CLS Manager/Deputy Head of Midwifery	Apologies	
Carmel Healey (CH) - Pathway Manager /Head of Nursing Planned Care	Apologies	
Jo Davies (JD) – Consultant O&G	Present	
Lorraine Dinardo (LD) – Consultant O&G	Present	
Sarah Harper-Lea - Head of Legal Services	Apologies	
Gwenda Jones – Supervisor of Midwives	Present	
Jean Fisher – ANC Manager	Apologies	
Nicola Kearsley- O&G Research	Apologies	
Annemarie Lawrence – Risk Midwife (AL)	Present	
Urgent Care		
Ravi Jayaram (RJ) – Consultant Paediatrician/Lead Clinician for Children's Services	Present	
Ann Martyn –(AMa) Acting Lead Nurse for Children's Services	Present	
Caroline Burchett – Paediatric Research	Apologies	
Habeeb Braimo - BPM	Apologies	
Anne Murphy – Lead Nurse	Apologies	
Jackie Hughes – HMB Strategy Manager	Apologies	
Alison Kelly - Director of Nursing, Quality and Environment	Receives minutes for escalating to Trust Boards	
Minutes taken by: Annemarie Lawrence		

Item	*Key points & actions*	*Owner*
1.	**Welcome and Apologies** Jim McCormack, Sara Brigham, Carmel Healey, Sarah Harper-Lea, Jean Fisher, Anne Murphy.	
2.	**Previous Minutes/Follow up Actions** Previous minutes agreed as accurate.	

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21. **Reports Received**

Irrelevant & Sensitive

Report to be discussed at the next Safety & Quality Meeting

- **NNU Thematic Review-8th February 2016**

There was a higher than expected mortality rate on NNU in 2015. Cases have been reviewed at NNIRG, perinatal mortality review or neonatal review meetings and action plans have been made. An obstetric thematic review did not identify any common themes or identifiers that might be responsible for the rise in mortality in 2015. The aim of the neonatal meeting was to review the cases again as a multidisciplinary team with an external reviewer and tertiary level neonatologist to assess:

- Were all action points completed
- Any new areas of care improvement
- Any possible common themes
- Discuss if further action is required

There was no common theme identified in all the cases

Action

22 **Business Continuity Update**

Irrelevant & Sensitive