Countess of Chester Hospital NHS
NHS Foundation Trust

Women & Children's Care Governance Board
PLANNED & URGENT CARE
Thursday 21st July 2016
2pm Conference room A
Minutes

Members	Attendance	Representative
Planned Care		
Jim McCormack (JMcC) - Consultant O&G/Risk Lead for Gynae (Chair)	Present	
Sara Brigham (SB) – Consultant O&G/Risk Lead for Obstetrics	Present	
Julie Fogarty (JCF) - Head of Midwifery (Deputy Chair)	Present	
Kathie Grimes – CLS Manager/Deputy Head of Midwifery	Apologies	
Carmel Healey (CH) - Head of Nursing Planned Care	Apologies	
Jo Davies (JD) – Consultant O&G	Apologies	
Lorraine Dinardo (LD) – Consultant O&G	Apologies	
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) Ward Manager Children's Unit	Apologies	
Caroline Burchett – Paediatric Research	Apologies	
Habeeb Braimo - BPM	Apologies	
Anne Murphy – Lead Nurse (AMu)	Present	
Jackie Hughes – HMB Strategy Manager	Apologies	
Janet McMahon (JMcM) – temporary Risk and Patient Safety Lead	Present	
Alison Kelly - Director of Nursing, Quality and Environment	Receives minutes for escalating to Trust Boards	
Minutes taken by: Anne Mason (AM)		

Item	
1.	**Welcome and Apologies** Jean Fisher, Jo Davies, Steve Brearey, Lorraine Dinardo

	JD's report received & reviewed in April 2016 **CAS Alerts** 27 alerts in total for month of June - no action required **Policies** **The following policies have been subject to peer review prior to formal ratification by this Board:-** Management of urine test in pregnancy Perinatal Loss Postnatal Hypertension **Risks** **New Risks for Escalation in Month** :- ID I&S Potential damage to reputation of Neonatal Service and wider Trust due to apparent increased mortality within neonatal Unit – Residual grading 20. ID I&S Apparent increased Mortality within Neonatal Unit – Residual grading 15. ID I&S – Vacancies within Paediatric community care packages – Residual grading 9. ID I&S – 16/17 Block contracts V's SLA. Children's community care packages – Residual grading 12. ID I&S Doctor shortage on NNU – Residual grading 20. ID I&S Additional capacity on NNU, requiring to support babies on IV therapies – Residual grading 12 ID I&S – Lack of Consultant Ophthalmology cover for absence on NNU – Residual grading 9 ID I&S – North Wales COTS – Unpredictable acuity of babies. NNU – Residual Grading 9 • Datix I&S missing from Quality and Safety Assurance Report – to be added • OSR that are not SBAR's to be added to report in relation to Datix I&S – Admission to NNU • PALS issues need to be added to Q&S Assurance report	
action	**Meeting to be arranged to discuss impact of Q&S Assurance Report review processes and agenda for W&CGB** **AL to amend SI I&S & I&S to show Neonatal Incident not Obstetric/Maternity** **AM to email Laura Bennett re outstanding actions for I&S**	**Group** **AL** **AM**
5.	**Research** No update due this month	
action		
6.	**North West Human Milk Bank (Quarterly)** Update due August 2016 Letter from L. Coulter to be discussed at this meeting.	

7.	**Minutes to receive** Paediatric Specialty Meeting Human Milk Bank – Delayed until August Antenatal Screening Board Minutes (quarterly)
8.	**These minutes to be received by** • Director of Nursing • Urgent and Planned Care Divisional Boards
9.	**Reports received** • **CQC Briefing June 2016 Learning from serious incidents in NHS acute hospitals** Conclusion:- Provider organisations have primary responsibility for making sure that their staff have the skills, capacity and support they need to carry out good quality investigations. They should have access to external expertise when needed, and opportunities to contribute to wider improvement initiatives when incidents may not warrant a formal investigation but where learning and solutions are needed to reduce the risk of them happening again. Trust boards must ask themselves if their investigations are making a difference and leading to improvement. • **ANSB Report** No issues with compliance • **Midwifery PALS report Jan-June 2016** The 11 Contacts had different themes. The reasons for contacting PALS:- • Waiting time in ANC x1 • Feedback re excellent care x 5. • Discharge communication and management of wound infection x 1 • Midwife attitude in ANC X 1 • Community midwife attitude x 1 • Midwife attitude in CLS X 1 • Doctor attitude x 1 • Paediatric Doctor delay- Reg was at an emergency X1 (care excellent) The Contacts that required investigation received scrutiny of the issue by the relevant manager with the individual staff members being spoken to when required. The Head of Midwifery also offered a face to face meeting when appropriate. Issues were fed back to safe via safety brief & emails were appropriate. As a result of the PALS contact there were no guidelines that required review To date none of the PALS contacts has become a formal complaint. **Trust CQC Quality Report** – Following scheduled Inspection February 2016 • Maternity & Gynaecology section formally received • Demonstrated a rating of GOOD for all 5 KLOE's • Action plan for Maternity produced & has been signed off by DoN • CQC Action plan is an ongoing document & will be reviewed at W&CGB each month until signed off. **Midwifery ICC Assurance Report July 2016** Midwifery Assurance report presented to July Trust ICC Committee with no areas of concern or poor practice identified. All areas of Midwifery are compliant. **Action** AMu to bring Children's CQC report & Action Plan to next meeting
	Any Other Business • JCF confirmed CLS business continuity plans updated following power outage on 15th April 2016.
	Items to report to QSPEC • No items to escalate this month