3	**Matters Arising (not on agenda)**	
action		
4.	**Incidents Review** **SBAR** – Missing Biopsy specimen – Patient who had biopsy taken at Colposcopy Clinic – sample hadn't been sent to Lab, so when the patient rang for results there weren't any logged for this lady. Reviewed by SI panel – immediate action taken was to put a box in each of the treatment rooms and specimens are to be put into these, for collection later in the day. SOP has been revised to include how to take a specimen At the end of each clinic there will be a check to ensure all specimens taken at that clinic have been logged and sent to the Lab. SI panel are happy that actions have been taken to reduce recurrence of incident. Dept. have apologised to patient and arrangements made for her to return to clinic for more biopsy's to be taken.	
Action		
5.	**Research -** Update not due this month	
Action		
6.	**NPSA level 1 Reviews/Action Plans** **New -** None **Ongoing** • I&S EPAU incidents Action Plan – - nearly completed – update next month by JVR • Infant Death Action Plan – Drills/simulation and staff training, JG running on monthly basis on wards. Standardisation of trolleys – ongoing waiting for anaesthetist to inform what needs to be on them. Unsure if discussions have taken place with regard to transferring deceased to mortuary	
Action	**JVR update on 124976** **DP follow up transfer to mortuary**	**JVR** **DP**
7.	**NPSA Level 2 Review/Action Plans** **New** – **Datix** I&S Still Birth - waiting to find out how will be taken forward in relation to an investigation - OSR completed and it highlighted issues with care provided/decision making. In ethos of transparency external reviewer to analyse this case as no one in the Trust outside of the Division with expertise to review the case. Datix I&S Formally receiving transfer SBAR sheet today in relation to level 2 incident from 31st March 2015 - level 2 report outstanding – Jackie Hughes currently producing. Following OSR in April Midwifery have implemented SBAR whenever a lady is transferred from the birthing suite to the delivery suite & lady will be reviewed by the shift leader and Doctor. **Ongoing** • I&S – action plan -closed	

Action		
8.	**Obstetric Secondary Review Action Plans** • **Datix** Child A JCF and JMc reviewed 31wk twin death of 1 twin, complex case where mother had Irrelevant & Sensitive – documentation was excellent, multi-disciplinary working was excellent, clear reviews, precise management plans, and excellent escalation from midwifery to medical staff when there were concerns. No issues with any element of care provided. Will be subject to Neonatal review and will be discussed at Perinatal mortality review meeting. Appropriate Obstetrically and well managed case. • **Datix** I&S JF, KG and SB completed OSR for still birth in labour– from that recommendations have been made – currently awaiting commission of level 2 investigation as above	
Action		
9.	**Systems Reviews/Other Action Plans** • Anti D action plan – audit action plan – updated and complete • Action Plan CQC Outlier Puerperal Sepsis – final action plan received and all actions now embedded in practice. KG informs there will be 10 sets of notes audited per month and codes checked – this will be an ongoing process. Will be revisited on RHD as an update.	
Action		
10.	**Claims and Complaints/ PALS** • Not due – reports to be quarterly.	
Action		
11.	**Audit** • None	
Action		
12.	**NICE Guidelines** • None	
Action		
13.	**NCEPOD** New Received – None Ongoing – None Closed – None	
Action	**DP to follow up as none received in the past few months**	**DP**
14.	**W&C Safety & Quality** • JD provided update – summary from May meeting as June's meeting cancelled. Main focus of the group being the quality and Care Metrics. How we learn from complaints, claims and incidents. Aggregated report is very useful clinically but needs to be more specific to Women & Children's and include more detailed clinical learning. • The quarterly incident trend analysis report provides notification of near misses and trends in no/low	