21.	**Reports Received** - **W&C Building Power Outage** Final Report received –demonstrates some good process in place. Actions are being progressed via the EPRR Managers asked to ensure back up phones in areas & staff aware of use. - **Infant Feeding 6 monthly Report** Report shows compliance with readmissions of babies with >12% weight loss within the first 28days of life During the audit period September 2015 – February 2016 a total number of 30 babies were readmitted to hospital with feeding problems during the first 28 days of life. A total of 13 were readmitted with > 12% weight loss, of these 13 cases **9** were identified as non-compliant using the essential feeding support criteria • 6 - Feed charts did not reflect effective milk transfer - • BNO for 36 hrs – discharged home. • MEC on day 3 – not weighed. • BNO on day of discharge. • NPU on day discharge Changes in practice • From January 2016 all babies who remain in - patients on day 3 are to be weighed. • A new feed chart has been produced. A Breast feeding assessment tool is now incorporated in the chart - this will need to be completed prior to discharge. This should help staff to identify any baby not effectively transferring milk prior to discharge. • Changed Audit criteria from December 2016 to look at any identifiable risk factors or gaps in care that may contribute to excessive weight loss re-admissions - **RCOG Each baby Counts** Since January 2015, the Each Baby Counts programme has been collecting and pooling the results of local risk management reviews to gain a national picture to better understand of stillbirths and babies that suffer a severe brain injury because of complications during labour Each Baby Counts' Aims and Objectives To achieve a 50% reduction by 2020 in incidents during term labour that lead to stillbirth, early neonatal death or severe brain injury. 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** Midwifery managers requested to review and updated BC plans in light of power outage. Completed for CLS