Sherwood Forest Hospitals
NHS Foundation Trust

Meeting:	Board Of Directors
Date of meeting:	7 January 2021
Title of paper:	Maternity Incidents and Investigations Overview 1st September 2020 - 30th December 2020

Executive Summary:

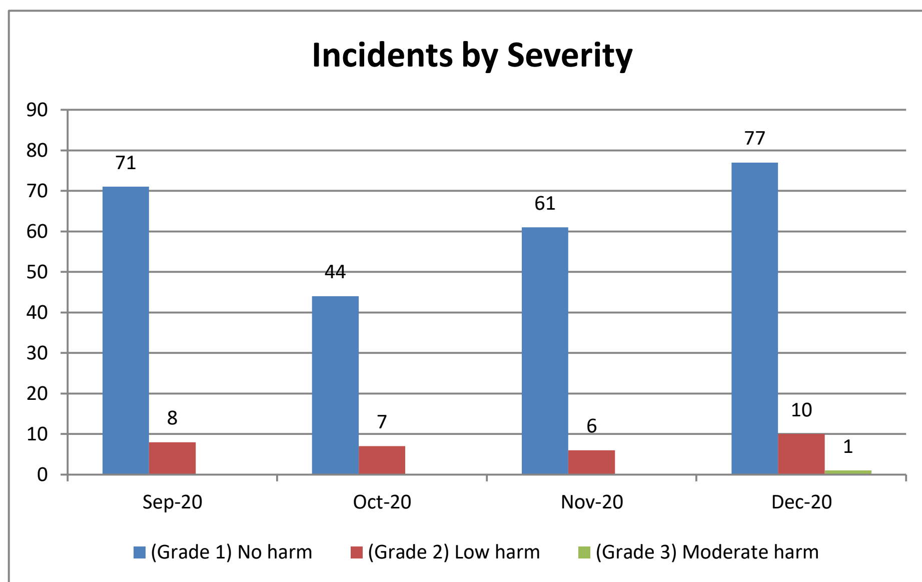
Following the publication of the Ockenden Review of Maternity Services at Shrewsbury and Telford Hospitals NHS Trust in December 2020, NHSE/I have issued a series of steps to be taken by all NHS Trusts providing maternity services. One of these requirements is that all maternity Serious Incidents (SI's) are shared with Trust Board on a monthly basis.

As the first of these reports to Trust Board, this report will detail incidents from 1st September – 30th December 2020. Going forward Trust Board will be updated on incidents occurring during the previous month.

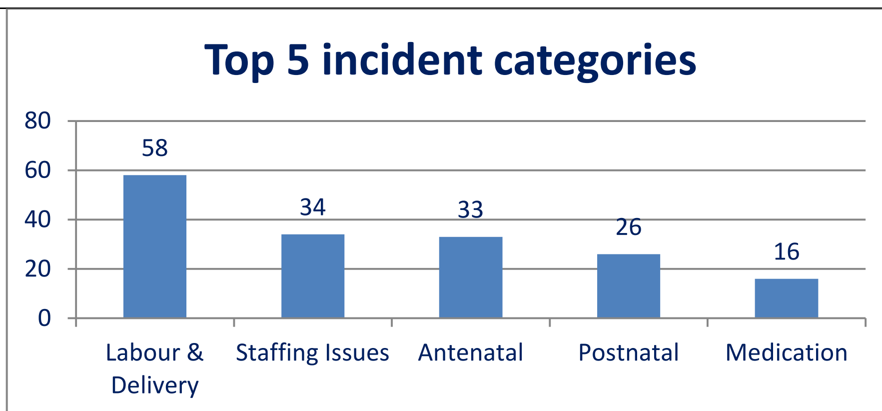
Maternity Incidents 1st September – 30th December 2020 Overview

Between 1st September 2020 and 30th December 2020 there were 286 Maternity Service related incidents reported on Datix. The full listing report can be seen at appendix 1. Of these incidents 254 are classified as 'no harm' incidents, 31 as 'low harm' incidents and there has been 1 'moderate harm' incident reported.

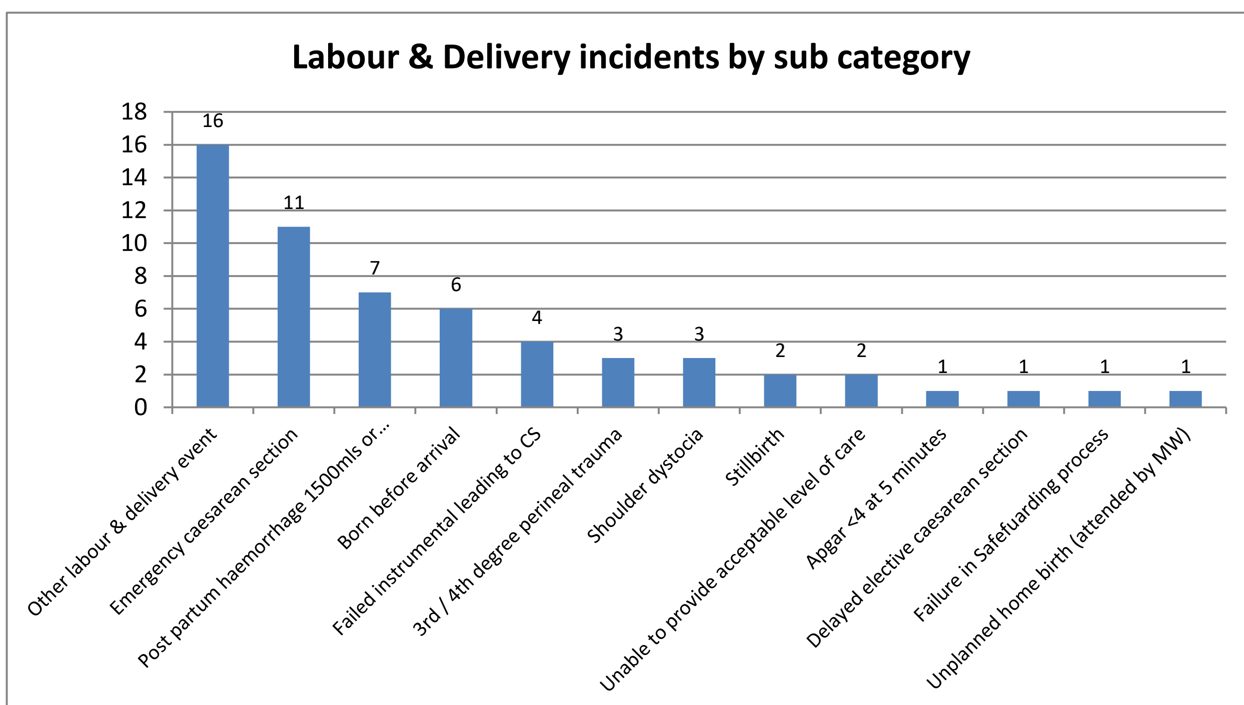
The incidents are broken down by grade and by month in the graph below:



The top 5 occurring reporting categories are detailed in the following graph:



As can be seen the most commonly reported incidents are in regard to labour and delivery. This category is further broken down in the graph below:



Serious Incidents

During this time period there have been no incidents reported that meet the Serious Incident Framework criteria.

There has been 1 no trust attributable harm incident, an intrapartum stillbirth that fell within the criteria for an HSIB investigation. Initial scoping for this incident did not identify any lapses in care.

Investigation Reports Signed Off and Investigations Commissioned

From 1st September to date there have been four final investigation reports heard at the Trust Sign Off meeting (TSO) and signed off by the Chief Nurse and the Medical Director. There have been a further four incidents heard at the Trust Scoping meeting that have had investigations commissioned.

Of the four signed off reports two were investigated by HSIB, one was STEIS reportable and one met

both HSIB and STEIS criteria. This one is still under investigation by HSIB and so is held 'frozen' on STEIS, however a report detailing issues identified during the initial fact finding post incident have been presented to Trust Sign Off Group along with a corresponding action plan. This interim report has been signed off and the actions are underway while the final HSIB report and conclusions are awaited.

Themes

Within these eight incidents there have been two maternal deaths; both maternal deaths appear to be of the same cause and there are no common themes identified between them at this time, however the final investigation report needs to be finalised before confirming this. This incident met the criteria for reporting to HSIB, but HSIB were unable to gain the required consent hence the STEIS level investigation currently underway.

The final reports and initial fact finding for the still birth and intrapartum death incidents have not revealed any common themes other than very broadly, communication issues is a feature in three of them.

The fourth case has highlighted issues with CTG monitoring and training and in the fifth case no lapses in care have been identified.

There has been one near miss incident reported with regard to a potential wrong route infusion. The midwife involved in the incident was commended for coming forward and reporting it. The reporting of the incident has led to important learning and changes in practice being shared across the Division to improve safety.

Next steps:

All maternity related incidents reported will continue to be reviewed and escalated accordingly in line with the Trust Incident Reporting Policy and Procedures, MBRACE and HSIB reporting criteria.
Trust Board will receive a monthly update to include all incidents meeting the SI framework criteria as required by NHSE/I in response to the Ockenden Report 2020 findings and recommendations. The Ockenden Report can be seen at appendix 1.

Submitting Author:	Julie Hogg Chief Nurse
Action required:	For information and discussion.