Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Maternity Incidents and Investigations Overview: 25th December 2020 – 25th January 2021	**Date:** 8 February 2021	
Prepared By:	Meg Haselden Head of Governance, Penny Cole Head of Midwifery		
Approved By:	Julie Hogg Chief Nurse		
Presented By:	Julie Hogg Chief Nurse		

Purpose		
To apprise the Trust Board of all serious incidents occurring in Maternity Services in line with NHSE/I requirements following the Ockenden Review of Maternity Services at Shrewsbury and Telford Hospitals NHS Trust published in December 2020.	**Approval**	
	Assurance	**X**
	Update	X
	Consider	

Strategic Objectives				
To provide outstanding care	**To promote and support health and wellbeing**	**To maximise the potential of our workforce**	**To continuously learn and improve**	**To achieve better value**
X			**X**	

Overall Level of Assurance				
	Significant	**Sufficient**	**Limited**	**None**
		X		

Risks/Issues	
Financial	
Patient Impact	**X**
Staff Impact	**X**
Services	**X**
Reputational	

Committees/groups where this item has been presented before

N/A

Executive Summary

Between 25th December 2020 and 25th January 2021 there were 95 Maternity Service related incidents reported on Datix. Of these incidents 82 are classified as 'no harm' incidents, eleven as 'low harm' incidents and there have been two 'moderate harm' incident reported.

During this reporting period there have been no incidents reported that meet the Serious Incident Framework criteria. There has been one incident meeting HSIB reporting criteria, however following review HSIB are not investigating as it does not meet their investigation thresholds recently revised in relation to Covid restrictions.

Three incidents have been heard at the Trust scoping meeting with two going forward for local investigation and 1 requiring no further action.

There has been one final STEIS Level investigation report heard at the Trust Sign Off meeting (TSO) and signed off by the Chief Nurse and the Medical Director. This has now been submitted to the CCG of consideration of closure on STEIS and the final report has been included with this paper for the information of the Board.

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.