

HSIB escalation of emerging concerns- MI-006358 Action Plan May 2022

Concern	Action	Lead	Date	Progress	Outcome
<b>Supporting mothers whose first language is not English</b>					
<b>Insufficient provision / usage of interpreting services for antenatal appointments.</b>	Purchase of language line I-pads to enable easy access video interpreting.	Kay Pagan	06/22	Devices currently in medical electronics and anticipated to be in use by June 2022	In progress
	Consider how we can improve the initial identification of women who need an interpreter as women do not always volunteer this information prior to the Booking appointment. This is included on the electronic booking form but is frequently not answered or completed incorrectly	Jo Beer/ Community Managers/MVP	08/22		
	Following the recent roll-out of Cerner Maternity EPR there needs to be further education and improvement in the documentation of both the offer and any decline of use of an interpreter, and clarification of when an interpreter is used				
	Repeat the interpreting	Audit Lead	01/23	I-pads expected to be in use by	

	audit no earlier than 6 months after the roll out of the video devices to assess if this has had the impact expected			June 2022. Audit provisionally to be repeated in January 2023	
	Roll out of common procedures leaflets in different languages, e.g. caesarean section, induction of labour	OMS team/MVP	08/22		
<b>Family members being used to interpret information for the mother</b>	Improved documentation specifically recording that interpreting services have been offered but declined in preference of a family member	Quality and safety Team/ Digital Midwife/Data Quality Midwives	08/22		
	Improved documentation of when interpreting services have been accepted but have not been used. For example: Interpreter did not attend appointment, devices unavailable, clinical emergency requiring immediate communication	Quality and safety Team/ Digital Midwife/Data Quality Midwives	08/22		
<b>Fetal growth surveillance</b>					
<b>Opportunities for growth ultrasound scans to being undertaken following a slowing growth trajectory on</b>	Lessons Learned to be circulated to all staff, with focus on Maternity Assessment Centre	Quality and Safety Team	05/22	Lessons Learned will be circulated by 20/05/22	In progress

<b>symphysis-fundal height measurements.</b>	staff, reminding that if a woman is referred with a slowing growth trajectory on SFH and is re-measured by a different clinician and a measurement discrepancy is identified, the smaller measurement should still generate a growth scan referral to avoid false reassurance.				
<b>Trust audit for missed small or gestational age (SGA) babies</b>					
<b>No audits completed after September 2021.</b>	Re-instatement of monthly FGR MDT meetings from 1 June 2022	Safer Maternity Care Midwife/ Fetal Medicine Consultant	06/22	Next meeting planned 01/06/22	
	Retrospective MDT review of the January to May 2022 cases, including collation of any themes and trends to then be included into an overarching annual report of the 12 months May 2021 to May 2022	Safer Maternity Care Midwife/ Fetal Medicine Consultant	08/22		
	Quality and Safety lead midwife to review what data is collected for the rolling dashboard to ensure that the methodology is still relevant following the change of EPR	Quality and Safety Lead Midwife	06/22		

	systems				
<b>Uncertainty about the validity and reliability of data provided to the investigation, in relation to missed SGA audits from March 2020 to September 2021</b>	Following the change from Medway to Cerner EPR, the Maternity Service is working closely with Business Intelligence to ensure that we meet the MSDS reporting elements of the Saving Babies' Lives Care Bundle. Medway did not support the submission of this data previously.	Quality and Safety Lead Midwife/Business Intelligence team	07/22		