



Wessex Maternity and Perinatal Mental Health Strategic Clinical Network

Wessex CO Monitoring Pathway

30th October 2019

Gail Thomas
Quality Improvement Lead



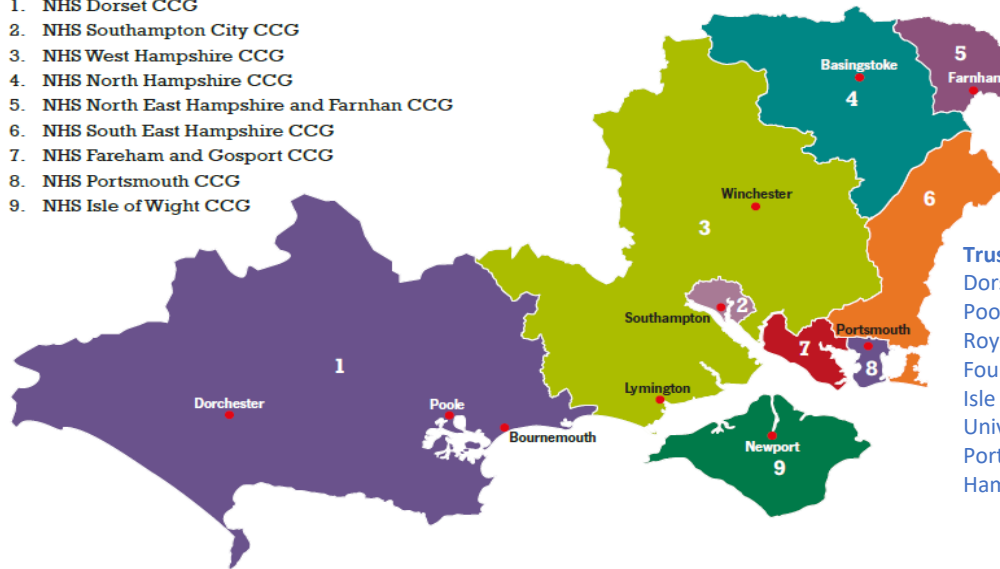
NHS England and NHS Improvement





Wessex Clinical Network

1. NHS Dorset CCG
2. NHS Southampton City CCG
3. NHS West Hampshire CCG
4. NHS North Hampshire CCG
5. NHS North East Hampshire and Farnham CCG
6. NHS South East Hampshire CCG
7. NHS Fareham and Gosport CCG
8. NHS Portsmouth CCG
9. NHS Isle of Wight CCG



Trusts

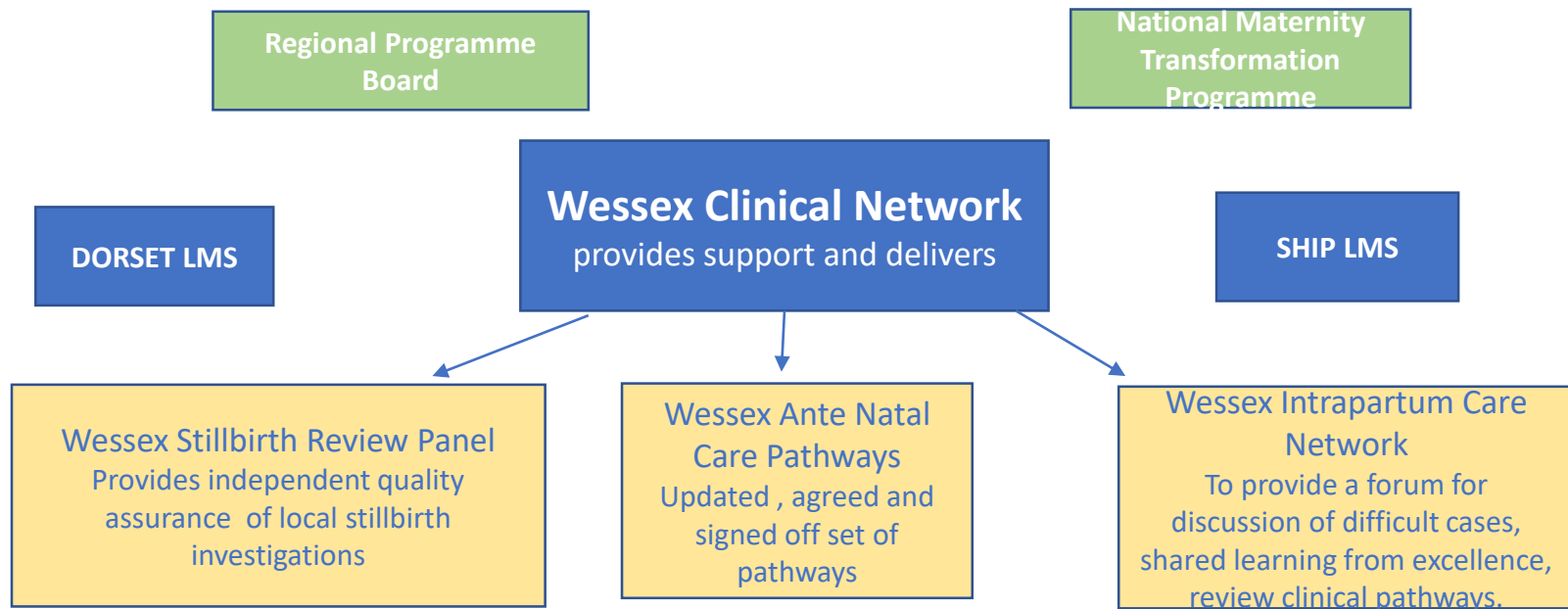
- Dorset County Hospital NHS Foundation Trust
- Poole Hospital NHS Foundation Trust
- Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust
- Isle of Wight NHS Trust
- University Hospital Southampton NHS FT
- Portsmouth Hospitals NHS Trust
- Hampshire Hospitals NHS Foundation Trust

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Wessex Clinical Network



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Actual Case history

Stillbirth Case presented to the Wessex Stillbirth Review Panel for quality assurance purposes

One of the key findings from the review :

'As part of the ante natal appointments the women was tested and identified as having a VERY HIGH CO reading, but no evidence of follow up action was recorded.

Further discussion between the trust members identified :

- * No clear pathway for CO Monitoring in some trusts
- * Variation in pathways – some pathways still under development
- * Results and actions not always recorded
- * Lack of evidence regarding referral to smoking cessation services

Recommendation from the panel

A standardised Wessex Ante Natal Care Pathway for CO Monitoring





Wessex Ante Natal Care Pathways

CO Monitoring Pathway

Developed as a regional pathway to provide standardised care across Wessex

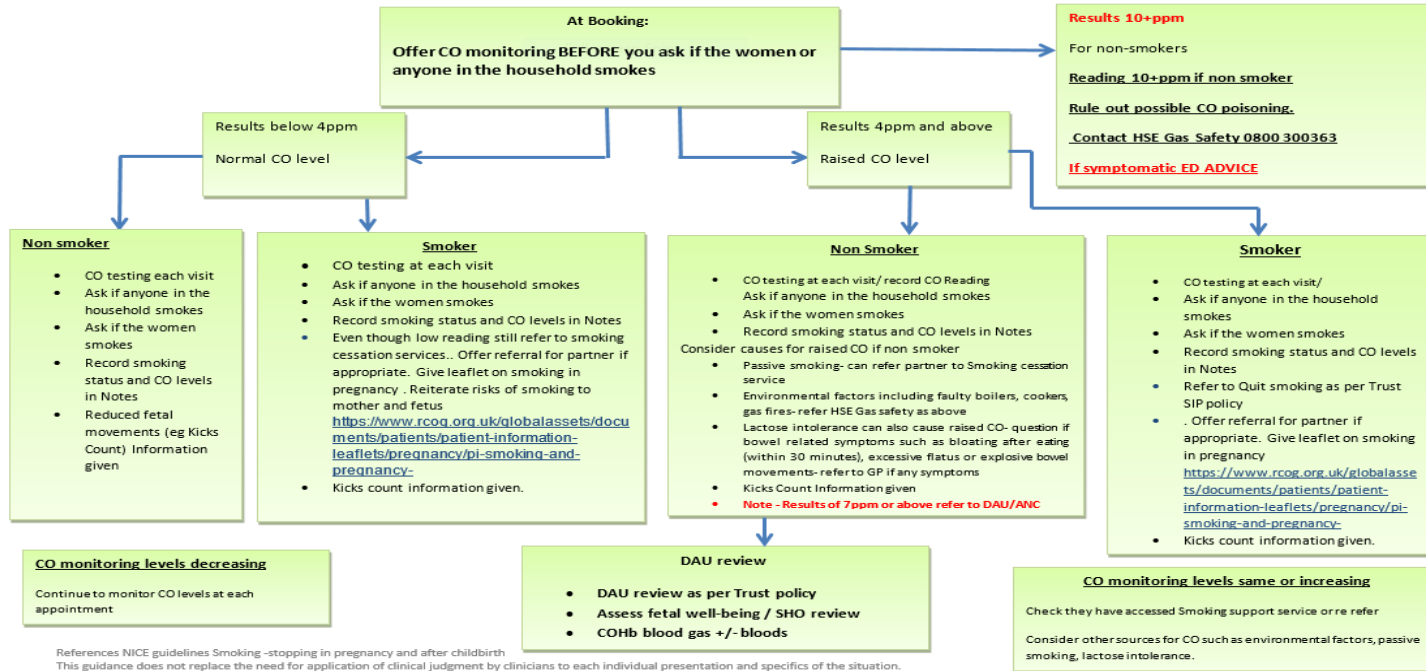
Recommendations from the group

1. CO Monitoring is carried out for **all women**
2. At booking and at **all** ante natal appointments
3. Kicks Count Leaflet information given out and conversations had at each appointment





No18 COMMUNITY AND SECONDARY CARE PATHWAY FOR CO TESTING IN PREGNANCY



References NICE guidelines Smoking -stopping in pregnancy and after childbirth
This guidance does not replace the need for application of clinical judgment by clinicians to each individual presentation and specifics of the situation.
Pathways current at time of Publication.





Challenges to Implementation

Support for midwives – a different approach to the smoking conversation

Co Monitors – working effectively and readily available

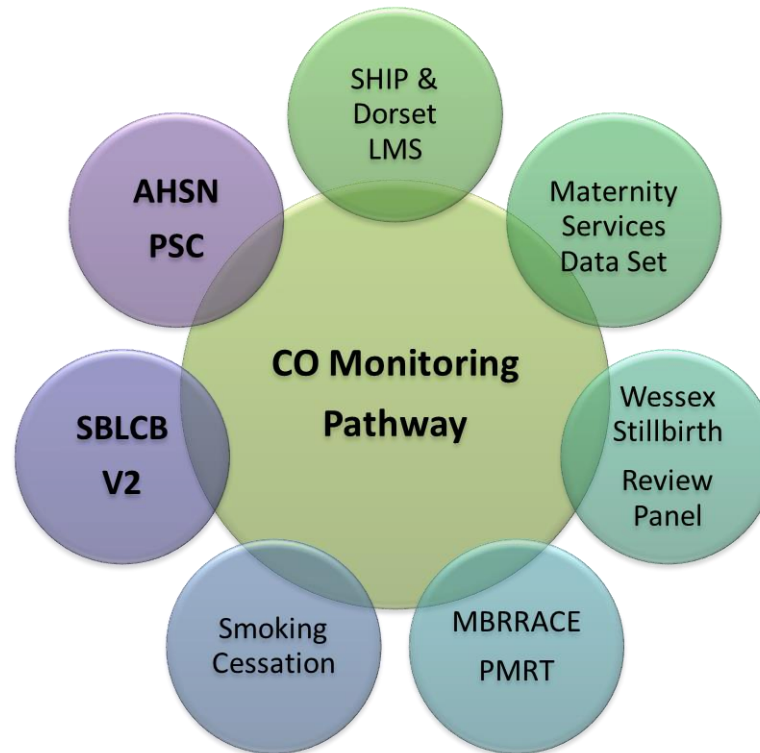
Smoking cessation services – what's in place

Data Collection - what and how – to feed into the MSDS





How we link it all together



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Thankyou

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Wessex Maternity & Neonatal Local Learning System

Supporting the National Maternity & Neonatal Safety Improvement Programme

Lesley Mackenzie
Patient Safety Programme Manager

Wessex

**Patient
Safety
Collaborative**

October 30th 2019

Maternity and Neonatal Safety Improvement Programme

A national ambition to reduce the rate of maternal and neonatal deaths, stillbirths, and brain injuries that occur during or soon after birth by 20% by 2020

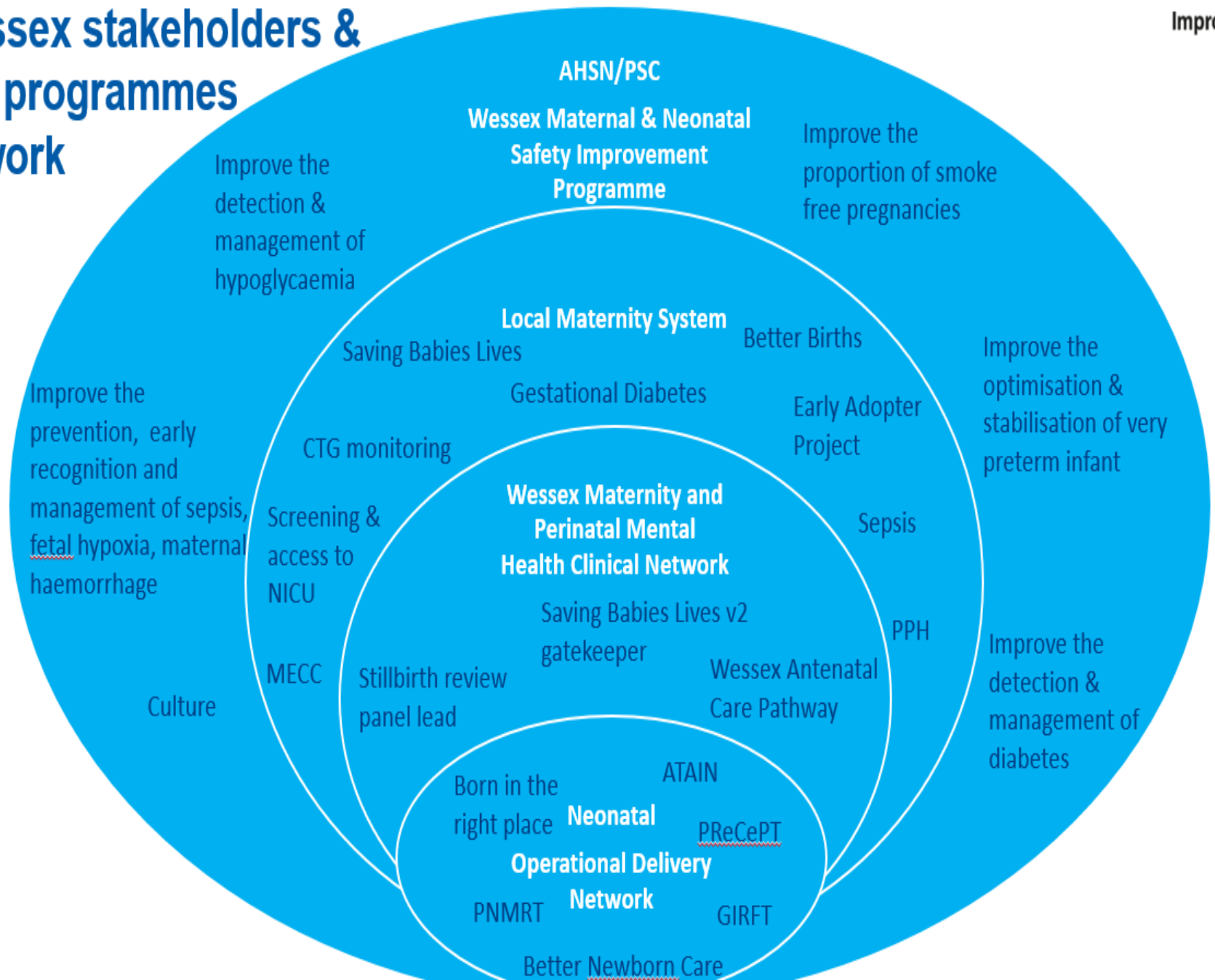
- There are 5 clinical priority areas that trusts are focusing on:

- Improve the proportion of smoke free pregnancies
- Improve the optimisation and stabilisation of the very pre-term infant
- Improve the detection and management of diabetes in pregnancy
- Improve the detection and management of neonatal hypoglycaemia
- Improve the early recognition and management of deterioration during labour & early post-partum period

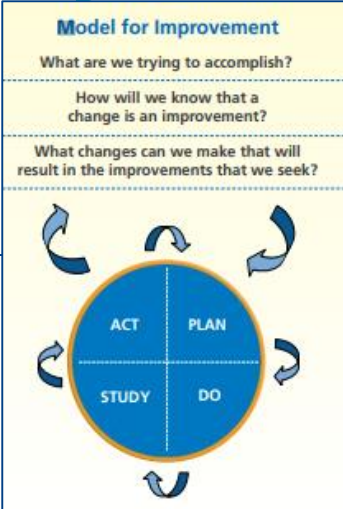
- There are 5 outcomes that are considered key to deliver the desired outcome:

- Creating conditions for a culture of safety and continuous improvement
- Develop safe and highly reliable systems, processes and pathways of care
- Improve the experience of women, families and staff
- Learn from excellence and error or incidents
- Improving the quality and safety of care through clinical excellence

Wessex stakeholders & key programmes of work



Wessex Maternal & Neonatal Learning System

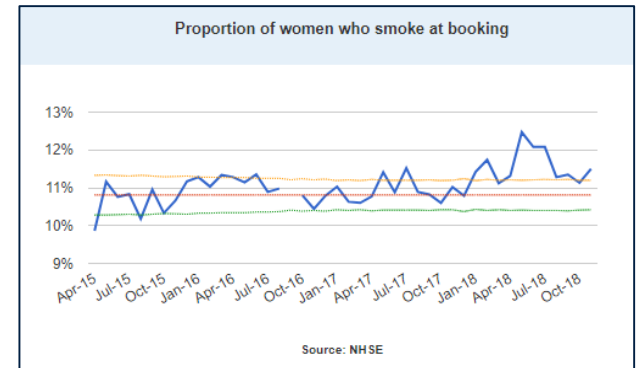
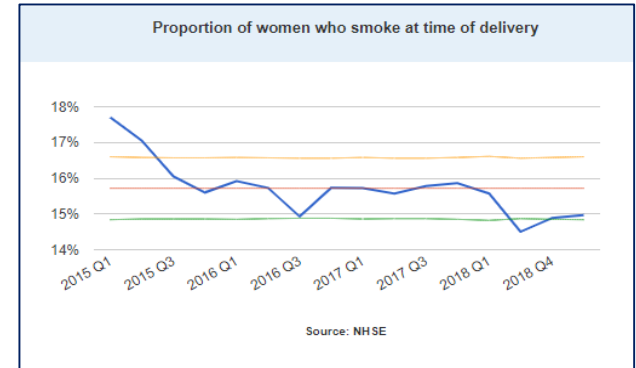
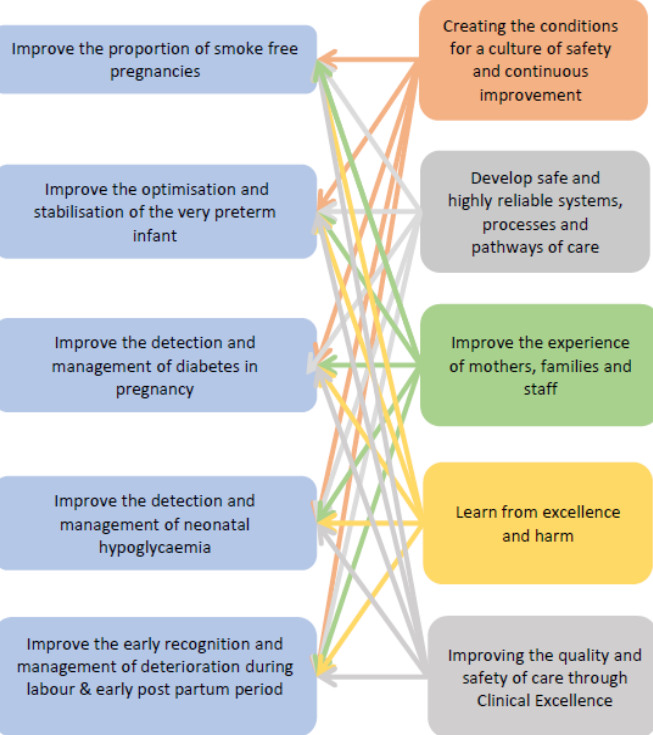


unwarranted variation by providing a safe, high quality healthcare experience for all women, babies and families across maternity care settings in England.

Reduce the rate of stillbirths, neonatal death and brain injuries occurring during or soon after birth by 20% by 2020

Primary Drivers

Secondary Drivers



What next?

- The **Wessex System Level Improvement Lead** will meet regularly with the Smoking in Pregnancy (SiP) Leads to review progress and **offer support with implementation**, using the Quality Improvement (QI) methodology
- At the Wessex Local Learning System (LLS) we will encourage the **SiP Leads to share their learning**; successes and challenges of embedding the Wessex CO monitoring pathway
- **SiP Leads** will be encouraged to **celebrate the success** of embedding the pathway in practice at every opportunity