University Hospitals Dorset
NHS Foundation Trust

# Perinatal Quality Oversight

## Maternity and Neonatal Quality and Safety Report

Director of Maternity and Neonatal services – Amy Stubbs
Head of Midwifery and Neonatal services – Kerry Taylor

September data 2026

We are
caring
one team
listening to understand
open and honest
always improving
inclusive

# Perinatal Quality Surveillance

## Regional Maternity Heatmap

**Data refreshed:** 23/09/2026 11:01:35

## Scoring

Region: South West

NHS England

Heatmap month: September 2026

| Provider | Overall score | CQC Mat overall rating | Stake holder concerns | CQC S29a | CQC s31 | Ext. ind. review | Coroner reg 28 | Mat Oversight | MIS | CNST repay ment | Eth. DQ | CQC Mat Survey | SBL | Midw ives vac. | MSW vac. | Obs vac. | Unfilled roles | Snr L'ship not in post | Safety champs | Birthrate + (last 3 yrs) | Neonatal death rate | Perinatal death rate | Stillbirth rate |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST | 37.0 | 2.0 | 1 | 0 | 5 | 5 | 0 | 5 | 3 | 0 | 0 | 2 | 4 | 1 | 2 | | 0 | 0 | 0 | 0 | 1 | 3 | 3 |
| SOMERSET NHS FOUNDATION TRUST | 34.0 | 5.0 | 1 | 0 | 0 | 0 | 0 | 5 | 0 | 0 | 0 | 2 | 4 | 1 | 1 | | 3 | 0 | 0 | 1 | 5 | 3 | 3 |
| ROYAL DEVON UNIVERSITY HEALTHCARE NHS FOUNDATION TRUST | 32.0 | 3.0 | 3 | 0 | 0 | 0 | 0 | 2 | 0 | 0 | 0 | 1 | 4 | 1 | 4 | | 1 | 0 | 0 | 0 | 5 | 5 | 3 |
| TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST | 25.0 | 3.0 | 0 | 0 | 0 | 0 | 0 | 2 | 0 | 0 | 0 | 1 | 4 | 2 | 1 | | 1 | 0 | 0 | 0 | 5 | 3 | 3 |
| GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST | 24.0 | 3.0 | 1 | 0 | 0 | 0 | 4 | 0 | 0 | 0 | 0 | 2 | 4 | 0 | 0 | | 1 | 0 | 0 | 0 | 3 | 3 | 3 |
| UNIVERSITY HOSPITALS PLYMOUTH NHS TRUST | 23.0 | 3.0 | 0 | 0 | 0 | 0 | 0 | 2 | 0 | 0 | 0 | 2 | 4 | 1 | 2 | | 0 | 0 | 0 | 0 | 3 | 3 | 3 |
| ROYAL CORNWALL HOSPITALS NHS TRUST | 20.0 | 1.0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 2 | 0 | 4 | | 0 | 0 | 0 | 0 | 5 | 3 | 3 |
| UNIVERSITY HOSPITALS BRISTOL AND WESTON NHS FOUNDATION TRUST | 20.0 | 1.0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 4 | | | | 1 | 0 | 0 | 0 | 5 | 5 | 3 |
| UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST | 20.0 | 3.0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 2 | 1 | 4 | | 1 | 0 | 0 | 0 | 1 | 3 | 3 |
| SALISBURY NHS FOUNDATION TRUST | 19.0 | 1.0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3 | 1 | 2 | 2 | 2 | | 1 | 0 | 0 | 0 | 1 | 3 | 3 |
| DORSET COUNTY HOSPITAL NHS FOUNDATION TRUST | 14.0 | 1.0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 1 | | 1 | 0 | 0 | 0 | 3 | 3 | 3 |
| ROYAL UNITED HOSPITALS BATH NHS FOUNDATION TRUST | 13.0 | 0.0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 1 | | 1 | 0 | 0 | 0 | 3 | 3 | 3 |
| NORTH BRISTOL NHS TRUST | 12.0 | 1.0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3 | 2 | | | | 1 | 0 | 0 | 0 | 1 | 1 | 3 |

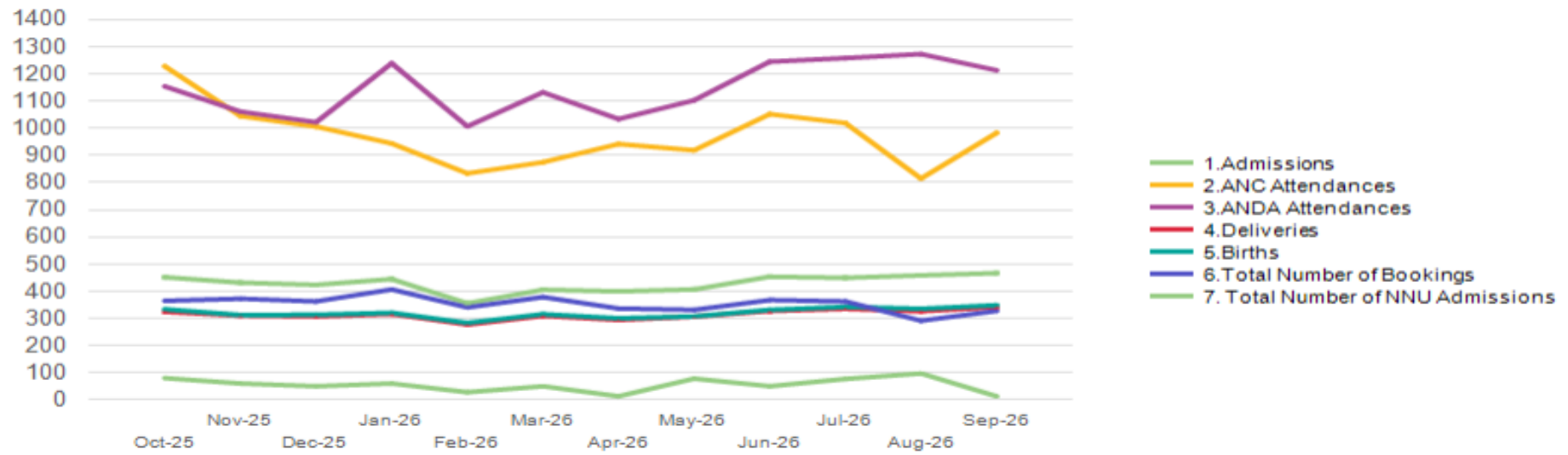
We are caring one team listening to understand open and honest always improving inclusive

# Perinatal Quality Surveillance

**Executive Summary**

This report sets out to the Trust Quality Committee the quality and safety activity covering the month of September 2026 .This is to provide assurance of maternity quality and safety and effectiveness of patient care to the Trust Board

Monthly UHD Activity




Data Discrepancy Meetings with BI & Digital MWs are in progress, the next one is scheduled for 17 November.

| Metric | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | Mar-26 | Apr-26 | May-26 | Jun-26 | Jul-26 | Aug-26 | Sep-26 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1.Admissions | 452 | 432 | 424 | 445 | 356 | 406 | 400 | 407 | 454 | 450 | 459 | 467 |
| 2.ANC Attendances | 1228 | 1045 | 1006 | 944 | 834 | 875 | 942 | 919 | 1052 | 1019 | 815 | 983 |
| 3.ANDA Attendances | 1154 | 1061 | 1022 | 1239 | 1007 | 1132 | 1034 | 1103 | 1245 | 1258 | 1273 | 1213 |
| 4.Deliveries | 325 | 311 | 308 | 317 | 278 | 310 | 295 | 307 | 328 | 336 | 327 | 342 |
| 5.Births | 334 | 313 | 314 | 321 | 284 | 316 | 301 | 308 | 332 | 343 | 336 | 349 |
| 6.Total Number of Bookings | 365 | 373 | 363 | 407 | 341 | 379 | 337 | 332 | 368 | 363 | 292 | 328 |
| 7. Total Number of NNU Admissions | 81 | 61 | 51 | 61 | 29 | 51 | 14 | 79 | 51 | 78 | 98 | 14 |

# Perinatal Quality Surveillance

## Summary of maternity & neonatal metrics

DiiS
Dorset Intelligence & Insight Service

| Group | Metric Id | MetricName | Provider Latest Date | UHD Value | UHD Target | UHD Variation | UHD Assurance |
|---|---|---|---|---|---|---|---|
| Birth | 1 | No. of women delivered (all births) | Sep 26 | 341 | | | |
| | 2 | No. women delivered (unregistrable baby/babies only) | Sep 26 | 6 | | | |
| | 3 | Number of women delivered (multiple births where at least one unregistrable and one registrable) | Sep 26 | 1 | | | |
| | 6 | Number of babies born | Sep 26 | 348 | | | |
| | 7 | No. of registrable babies born | Sep 26 | 341 | | | |
| Booking | 15 | Total number of bookings | Sep 26 | 315 | | | |
| | 16 | % bookings completed <10 weeks gestation | Sep 26 | 79.7% | 65% | | |
| Continuity of Carer | 17 | % of women on continuity of carer pathway by 29 weeks' gestation | Sep 26 | 6.53% | | | |
| | 18 | % of Black and Asian women on continuity of carer pathway by 28 weeks' gestation | Sep 26 | 86.4% | | | |
| | 19 | % of women (IMD-1) placed on a continuity of carer pathway | Sep 26 | 0% | | | |
| Infant Feeding | 35 | % of babies receiving breast milk at first feed | Sep 26 | 79.4% | 72% | | |
| | 36 | % babies receiving breast milk at discharge from midwifery care to HV/GP (10 - 28 days PN) | Sep 26 | 73.3% | | | |
| Maternal Morbidity & Mortality | 13 | Rate per 1,000 Women with >= PPH 1500ml(previous 3 months aggregated) | Sep 26 | 33.1 | 30 | | |
| | 14 | Rate per 1,000 women with 3rd/4th degree tears (current three months aggregated) | Sep 26 | 19.3 | 28 | | |

# Perinatal Quality Surveillance

## Summary of maternity & neonatal metrics

| Group | Metric Id | MetricName | Provider Latest Date | UHD Value | UHD Target | UHD Variation | UHD Assurance |
|---|---|---|---|---|---|---|---|
| Maternal Morbidity & Mortality | 26 | Maternal death - number of deaths of women during or up to 1 year following the end of pregnancy (irrespective of place/circumstances of death) | Sep 26 | 0 | | | |
| | 27 | Number of women admitted to ITU associated with birth up to 28 days post-natal (any birth, not including any other trust birth) | Sep 26 | 0 | | | |
| Perinatal Morbidity | 8 | % of term babies admitted to NNU | Sep 26 | 3.16% | 5% | | |
| | 22 | % of babies <3rd birthweight centile, born >37+6 weeks | Sep 26 | 0% | | | |
| | 62 | Rate per 1,000 babies born at term with an Apgar score <7 at 5 minutes (CQIMApgar) | Sep 26 | 12.3 | 13 | | |
| Perinatal Mortality | 11 | No. of still births per month | Sep 26 | 1 | | | |
| | 12 | No. of neonatal deaths < 28 Days | Sep 26 | 0 | | | |
| | 20 | Annual rate of stillbirths per 1,000 births - rolling 12mths | Sep 26 | 2.60 | 2.5 | | |
| | 41 | Rate per 1,000 of live birth babies who died within 28 days of birth - rolling 12mths | Sep 26 | 1.83 | | | |
| Preterm Birth Data | 23 | No. of singleton babies born <27 weeks' or multiples born <28 weeks' gestation or birthweight <800g | Sep 26 | 0 | | | |
| | 33 | Rate per 1,000 births which are preterm ( < 37 week's gestation) | Sep 26 | 73.3 | 60 | | |
| Treating Tobacco Dependency | 9 | % of women smoking at booking | Sep 26 | 9.21% | | | |
| | 10 | % of women smoking at delivery (previous month) | Sep 26 | 6.12% | 6% | | |
| | 37 | % of women with a CO measurement at time of booking | Sep 26 | 93.3% | 95% | | |
| | 38 | % of women with a CO measurement at time of 36 weeks' gestation | Sep 26 | 83.8% | 95% | | |

# Perinatal Quality Surveillance

## Full Countermeasures Summaries

## DiiS Dashboard Escalations

| | |
|---|---|
| PS | |
| P | • Neonatal Nurses sickness |
| PE | |
| QOS | • Post partum Haemorrhage (PPH) >1500mls |
| SS | |

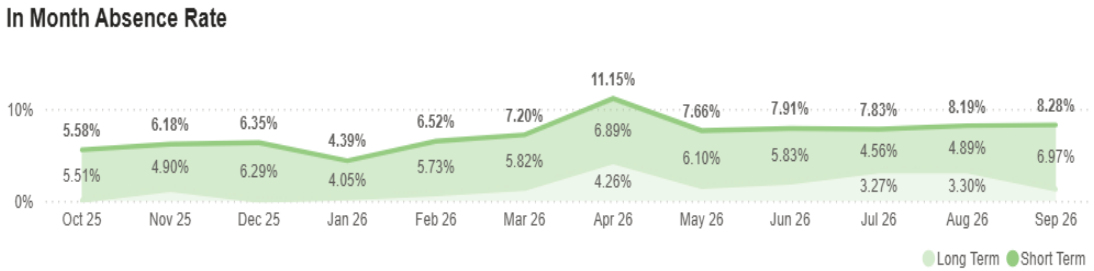
# Perinatal Quality Surveillance - Ongoing QI

## Countermeasure Summary

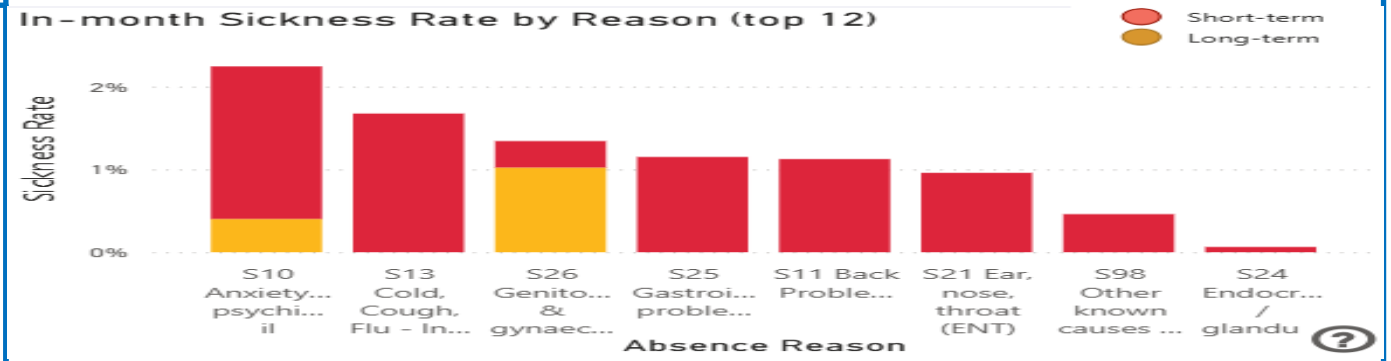
**Project / Metric Name – Neonatal sickness rates**

**Owner:** Kerry Taylor HOM and Karen Dent NICU Matron
**Metric:** <4 % Trust Target
**Desired Trend:** Downward trend

### 1. Historic Trend Data - Cosmos –12/10/26




### 2. Stratified Data: Cosmos 12/10/26




### 3. Top Contributors

- Sickness above 8%. Long term sickness more prevalent since March '26
- Anxiety and Stress main reasons for sickness
- Absence management aligning with Care Group and Maternity and is following policy.
- Monthly unit sickness review meeting in place. Sickness management spreadsheet in place

### 4. Action Plan and impact

| Contributor | Potential Root Cause | Countermeasure/Actions | Owner | Due by? | Outcome |
|---|---|---|---|---|---|
| Supporting staff in managing sickness | Supporting staff through stressful situations | HoM to work with team and HR to introduce supportive action plan as per maternity actions plan –<br>• Sickness reviews<br>• Managing and supporting staff with Bradford score above 350 | KT/KD | Sept 26 | To support staff in managing and staff returning to work support. |
| High sickness amongst staff who work bank shifts | Minimal bank cover | • Bank advert June, July and August then quarterly until pool of staff able to support. | KD | Nov 26 | Increased neonatal nurse bank pool. Recently recruited 3. 4 more in progress. |
| Anxiety and Stress main reason for sickness | Predominantly related to home life | • Referrals to occupational health, supportive meetings and reasonable adjustments made | KD | Sept 26 | To ensure support can be put in place for staff struggling with stress and anxiety. |
| 21 days sickness to cold, cough and flu. | Ensure flu vaccinations offered to team. | • Senior midwifery team to offer daily vaccinations on ward – aim for 60% vaccination rate. | KT | Dec 26 | Reduced levels of coughs, colds, flu. |

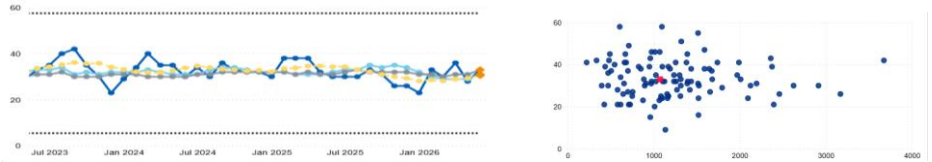
# Perinatal Quality Surveillance - Ongoing QI

## Countermeasure Summary

**Project / Metric Name –** Postpartum Haemorrhage (PPH) >1500mls

**Owner:** Bernadette Chubb – Consultant midwife
**Metric**: <30 per 1000
**Desired Trend**: downward

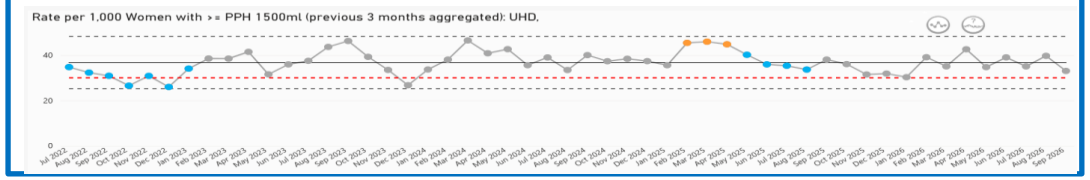
### 1. Historic Trend Data – National dashboard June 2026 14/9







**Diss Dashboard Aggregated 3 months 11/9/26**




### 2. Stratified Data:

In September, there were 8 incidences of a PPH ≥1500mls, 23 per 1000 (33.1 per 1000 DiiS 3 months aggregated)

The causes for blood loss include:

- Trauma
- Tone

2 woman lost greater than 2000mls (2119mls and 2820mls). In line with Maternity Care Bundle, all cases where blood loss ≥2000mls undergo a full MDT review.

### 3. Top Contributors

- Delay in escalation of PPH when blood loss reaches 500mls.
- Delay in transfer to theatre
- Delay in informing consultants

### 4. Action Plan and impact

| Contributor | Potential Root Cause | Countermeasure/Actions | Owner | Due by? | Outcome |
|---|---|---|---|---|---|
| Delay in transferring to theatre and informing consultants | Lack of a second emergency theatre, lack of awareness of when to call the consultants | Ongoing work on theatre utilization and escalation to highlight further resource requirement.<br>Laminates and staff education underway to reinforce when to call a consultant. | KLG/GG | Nov 26 | Improved escalation |
| Delay in escalation at 500ml blood loss | Lack of recognition of escalation threshold and PPH trigger points | LWCs to reinforce this key safety message during the daily safety huddle and handover, highlighting the importance of early recognition of PPH trigger points and timely escalation in accordance with the local PPH guideline.<br>PPH guideline and tools are under continuous review, LW skills and drills continue | BC | Sept 26 | Improved compliance |

# Perinatal Quality Surveillance

## Watch metrics

# Perinatal Quality Surveillance

## Watch Metric
## QI Projects

| | |
|---|---|
| PS | |
| P | • Midwifery sickness<br>• Midwifery turnover |
| PE | |
| QOS | • % of babies who had their umbilical cord clamped on or after one minute after birth<br>• Babies readmitted to hospital who were under 30 days<br>• Rate per 1000 babies born at term with an APGAR score <7 at 5 minutes<br>• Rate per 1000 with 3rd /4th degree tears |
| SS | |

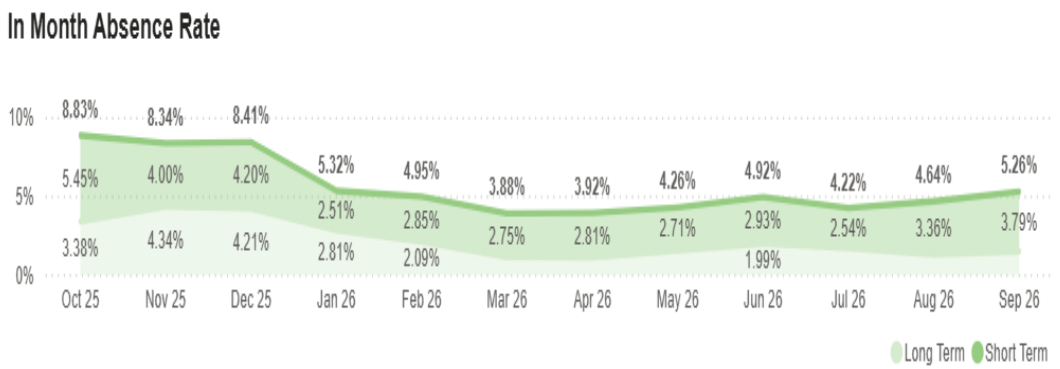
# Perinatal Quality Surveillance - Ongoing QI

## Watch - Countermeasure Summary

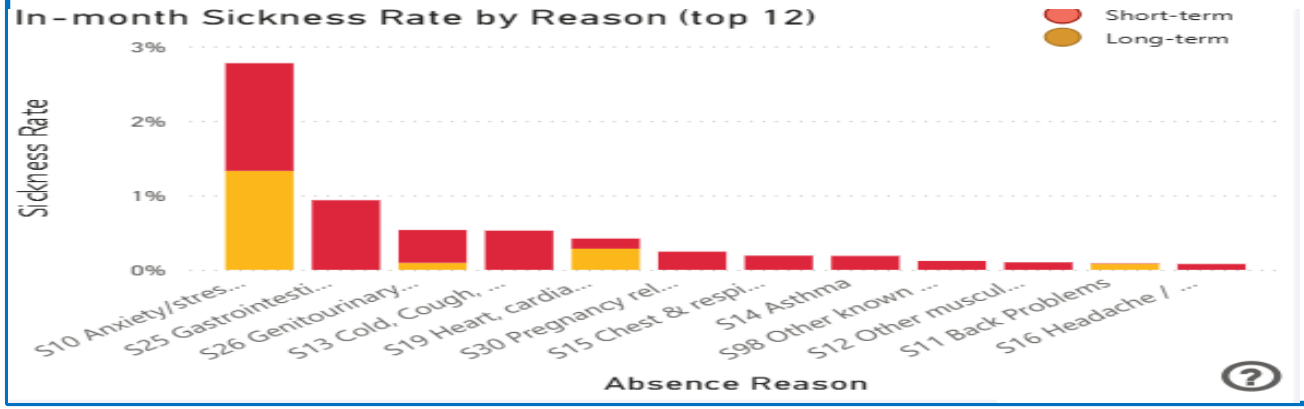
**Project / Metric Name –** Midwifery Sickness Rates

**Owner:** Amy Stubbs DOM & Kerry Taylor HOM
**Metric**: <4%Trust target
**Desired Trend**: downward

### 1. Historic Trend Data – Cosmos 12/10/2026




### 2. Stratified Data: Cosmos 12/10/2026




### 3. Top Contributors

- Anxiety and stress remains as main reason for sickness.
- Return to work interviews were not consistent but have improved.
- HR support required with managing staff members with really high Bradford scores.

### 4. Action Plan and impact

| Contributor | Potential root cause | Countermeasure/ Actions | Owner | Date by? | outcome |
|---|---|---|---|---|---|
| Managing absence | Return to work interviews managing Bradfords scores over 250 not consistent | Process in place for RTW oversight – closer monitoring of compliance required by band 8 team. | KT | Completed but monitoring ongoing. | Staff will feel that organisation cares for their wellbeing |
| Sickness for flu, colds and coughs has been high in previous years. | Low staff vaccination rates, 19% in 2024 and 48% in 2025 | Senior midwifery team to support vaccination service and aim for 60% staff vaccination rate. | KT | Dec 2026 | Minimal flu related sickness. |
| Managing absence when sickness levels really high. | Policy indicates managers discretion when making decisions about proceeding to final hearing. | Consistent approach required for managing cases and to ensure policy followed with HR support. | KT / HR | Jan 2027 | Improved staff sickness. |

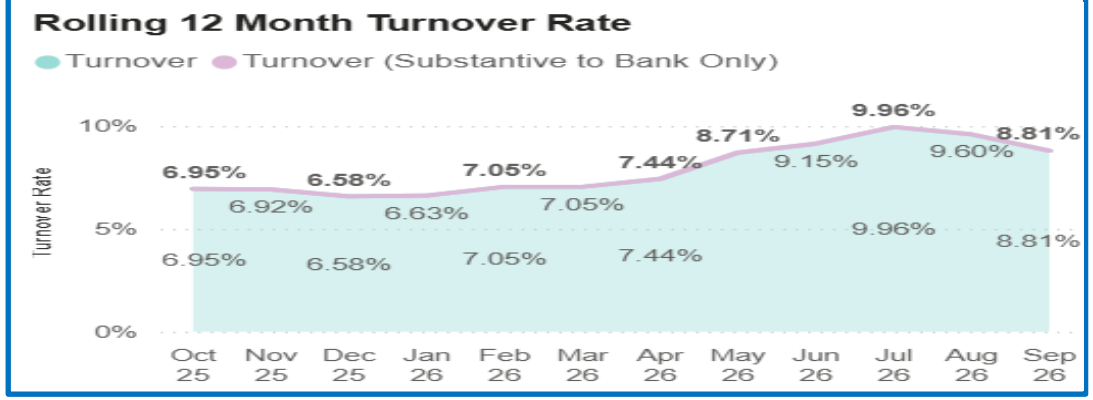
# Perinatal Quality Surveillance - Ongoing QI

## Watch - Countermeasure Summary

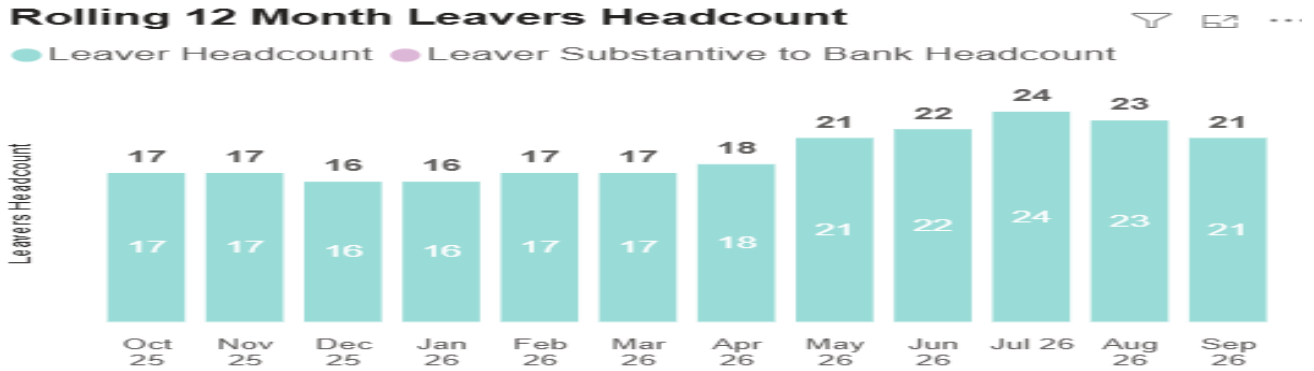
**Project / Metric Name –** Midwifery Turnover Rates

**Owner:** Amy Stubbs DOM & Kerry Taylor HOM
**Metric**: <6.2%
**Desired Trend**: downward

### 1. Historic Trend Data – Cosmos 8/10/2026




### 2. Historical Trend Data – Cosmos 8/102026




### 3. Top Contributors

- 0.61 wte midwives planned to leave between now and end Nov 2026.
- Exit interview process needs relaunch.
- Onboarding SOP being developed which will include off boarding process.

### 4. Action Plan and impact

| Contributor | Potential Root Cause | Countermeasure/Actions | Owner | Due By? | Outcome |
|---|---|---|---|---|---|
| Supporting staff in exit interviews | Understanding if some staff would consider retire and return | To remind clinical leaders of process when resignation submitted – new roster manager to ensure process followed and exit interview offered. | KT | Nov 2026 | Evidence of reasons for leaving well recorded and all options explored to retain experienced staff. |
| Turnover slightly higher than national average for maternity. | To offer support prior to resignations. | PMA daily walking the floor to support staff and detect early concerns for staff wanting to leave. Staff supported to rotate between areas to improve job satisfaction. Monthly touchpoint RCM and HOM. Star of the month introduced to show staff appreciation. | KT | Nov 2026 | Reduction in turnover rate. |

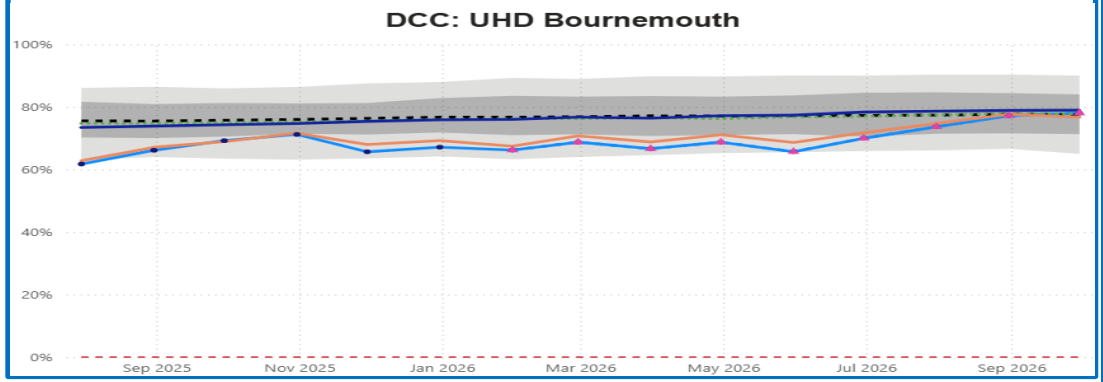
# Perinatal Quality Surveillance - Ongoing QI

## Watch - Countermeasure Summary

**Owner:** Marie Lindsay Sutherland ANNP and Karen Dent NICU Matron
**Metric**: 90 % SBL target
**Desired Trend**: upward trend

Project name/Metric name % of babies preterm who had their umbilical cord clamped after 1 minute of birth

### 1. Historic Trend Data




### 2. Stratified Data

7 babies in September
**86 % got DCC – 1 baby got 30 seconds as clinically needed a 2-person jaw thrust – also GA/ mum haemorrhaging.**

**Quarter 2= 96%**

Life start machine used successfully

Trend Data Key: light blue line – UHD (not including Q2), Navy blue line-Network, Orange line-ICB

### 3. Top Contributors

- Work is continuing embedding use of Life start machine including early preparation
- Purchased a long PEEP circuit to assist transition at birth. Linked with theatres about performing DCC when life start not ready- plan in place
- Ensuring all data input into correct field on Badger Net as NNAP data does not match our recorded data

### 4. Action Plan and impact

| Contributor | Potential Root Cause | Countermeasure/ actions | Owner | Due By? | Outcome |
|---|---|---|---|---|---|
| Ensuring all data input into correct field on Badger Net | Multiple data fields in multiple places on Badger Net | Badger Net data is checked monthly to amend and cleanse for NNAP dashboard | KK<br>MLS | In place- continuous | Reliable data |
| Checking the Life start is ready for use | High workload for ANNP/clinical fellow team. Reduced time for equipment checks daily | Checklist added to Life start machine for nursing staff to check. Picture user to aid recognition of equipment. | FM | In place | System checking to provide assurance of workable life start machine when needed |
| Preparing Life start for expected delivery in advance | Lack of time<br>Lack of alternative to the Life start | Encouraging preparation in advance at the earliest available opportunity. Devising a method of assisting transition from birth and delivering DCC without the Life start | MLS<br>KD<br>GF | Completed | Less reliance on one system |
| | | Link with theatre staff to determine a way of delivering DCC when life start is not ready. | KD<br>MLS | June 2026 | new pipes applied end of September |
| | | Saving Babies Lives V3 Element 5 monthly meeting. Deep dive into preterm optimization of each prem birth | MLS<br>KD<br>BC | In place continuous assessment | Continuous monitoring |

# Perinatal Quality Surveillance - Ongoing QI - Watch metric

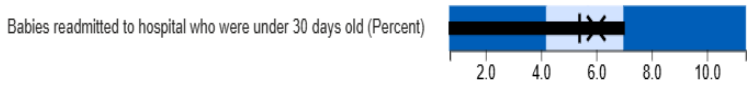
## Watch - Countermeasure Summary

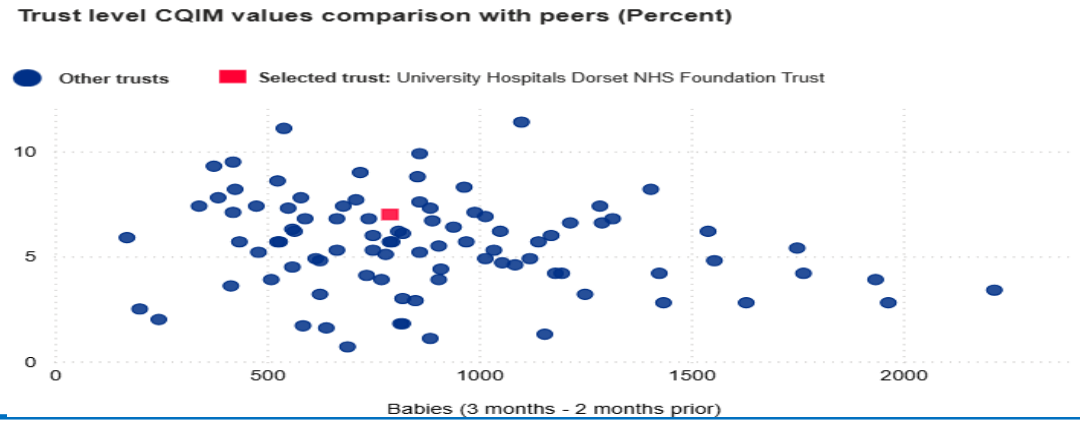
**Project / Metric Name –**

Reduction in babies re admitted to hospital 30 days post birth

**Owner:** Akeisha Robinson (Senior Outpatient Matron)/ Karen Fernley (Matron child health)
**Metric:** Reduce admissions
**Desired Trend:** Down -ward trend

**1. Historic Data –**
**Maternity National dashboard**
**June 2026 data extracted 9/9**




## 2. Stratified Data

Current trends suggest that Coding errors appear to be the main reason for the high rates of readmission

Well baby clinic has reduced coding errors within Maternity

**In September there were 43 readmissions**

- 33 readmissions were to pediatrics **(9 true readmissions)** coding errors remains a main contributor for high numbers
- 10 readmissions to maternity/ NNU (**9 true readmissions**)
  - 7 readmitted to Postnatal Ward (2 for weight loss, 4 with jaundice and 1 with poor feeding)
  - 2 readmitted to NICU (1 of which was a repat from UHS)

1 well baby was readmitted with an unwell mother (coded correctly)

In August SSG agreed to the SBAR regarding changing the way readmission are recorded. This will support with the errors in coding. Meeting in October to review progress.

## 3. Top Contributors

- Weight loss
- Jaundice needing treatment
- Coding errors

## 4. Action Plan and impact

| Contributor | Potential Root Cause | Countermeasure/actions | Owner | Due by | Outcome |
|---|---|---|---|---|---|
| Poor weight gain | Babies readmitted due to poor weight gain and discharged from unit with no management plan | New postnatal pathway aiming to give earlier feeding support | JT/AR/CB | Completed | Additional feeding support to prevent weight loss |
| Jaundice | Babies admitted with abnormal TBR for SBR with no other concerns | Well baby clinic commenced in Nov This initially triages babies that need SBR's to reduce babies of normal results being admitted. This service has also provided infant feeding for weight loss. | JT/AR/CB | Completed | Reduce avoidable readmissions |
| Coding | Coding errors | Working group set up to address coding issues – SBAR completed | KF/ANNP | October 2026 | Address coding concerns |

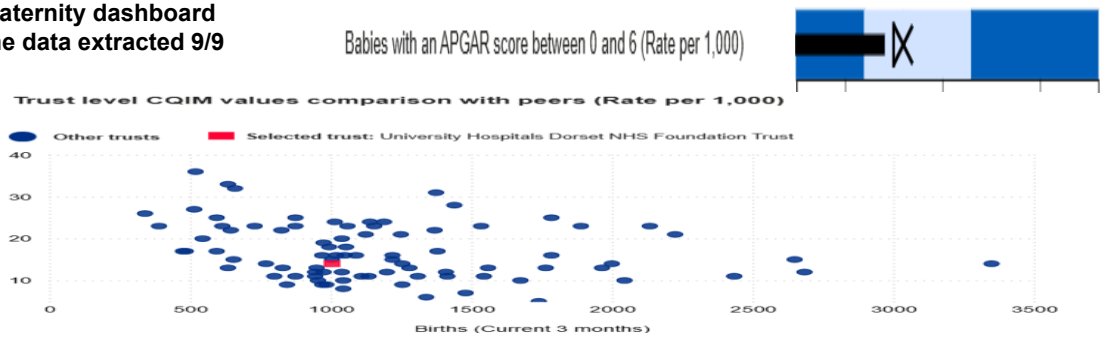
# Perinatal Quality Surveillance - Ongoing QI

## Watch - Countermeasure Summary

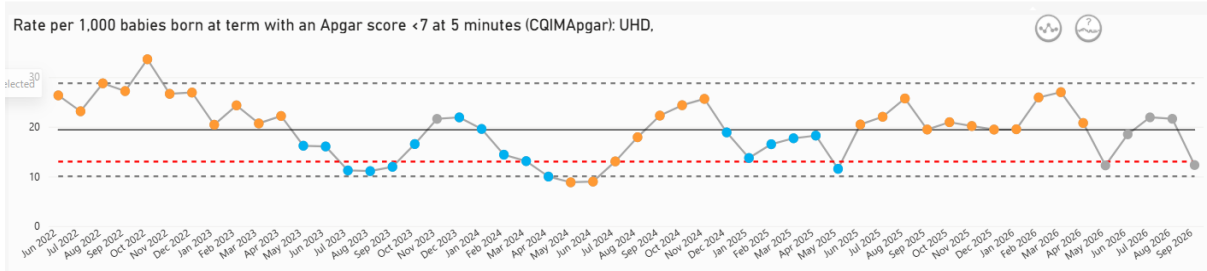
**Project / Metric Name –**
Rate per 1000 babies born at term with an APGAR score <7 at 5 minutes

**Owner:** Gabby Garbett, Labour Ward Matron and Geedi Farah, NN Consultant
**Metric:** <20 per 1000
**Desired Trend:** Downward trend
**Stratified Data:** 3 per 1000 (1)

### 1. Historic Trend Data
**Maternity dashboard**
**June data extracted 9/9**




### 2. Stratified Data DiiS 11/9/26




### 3. Top Contributors

1. APGAR Documentation and Scoring Inconsistency

2. Delayed or Inconsistent Neonatal Escalation Processes

### 4. Action Plan and impact

| Contributor | Potential Root Cause | Countermeasure/Actions | Owner | Due by? | Outcome |
|---|---|---|---|---|---|
| APGAR Documentation and Scoring Inconsistency | Variation in APGAR assessment and lack of a standardized documentation process during neonatal resuscitation | Introduce on the ward mini educations sessions to teach APGAR scoring. Produce a proforma to aid at delivery | GG/ES | completed | Improved consistency and reliability of APGAR scoring, documentation, audit data and communication between teams. |
| Delayed or Inconsistent Neonatal Escalation Processes | Inconsistent use of escalation pathways and communication regarding neonatal attendance requirements. | Reinforce neonatal escalation policy, including clear triggers for 2222 calls and ANNP attendance. Share learning through multidisciplinary education and simulation training. | GG/KB | completed | Earlier neonatal team involvement, reduced delays in advanced resuscitation and improved safety for compromised newborns. |
| Data reassuring nationally | Need to consider wider data collection | Report produced and has been shared at CGB SDR and Exec oversight – next to present at Safety Champions in December 2026 | GF | Dec 2026 | Determine if further monitoring required. |

# Perinatal Quality Surveillance - Ongoing QI

## Watch - Countermeasure Summary

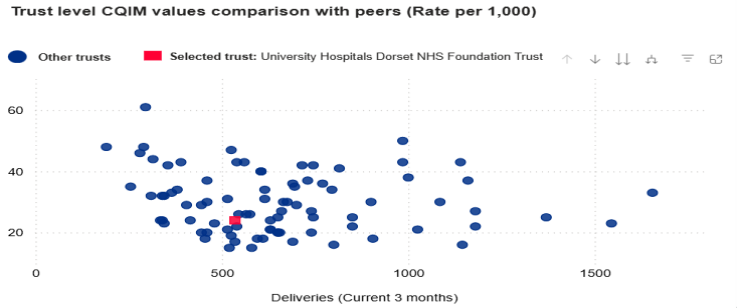
**Metric Name/Problem statement:**

OASI rate per 1,000 women/birthing people giving birth at UHD

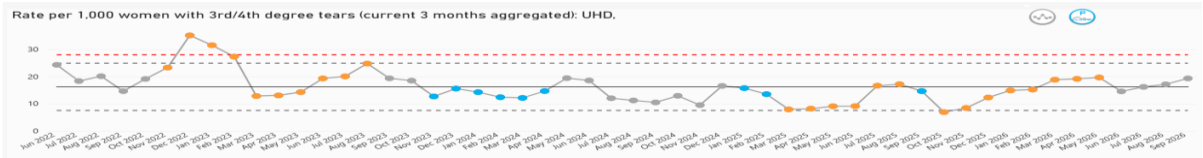
**Owner:** Bea Chubb, Consultant Midwife
**Metric**: <30 per 1000
**Desired Trend:** below national average of 30 per 1,000

### 1. Historic Trend Data - National maternity dashboard June 2026 Extracted 9/9




### 2. Stratified or segmented data- DiSS aggregated 3 months 11/9/26)




In September, there were 5 x OASI (Obstetric Anal Sphincter Injury) incidents.

2 x 3A tears both following SVB (Spontaneous Vaginal Births)
3 x 3B tears - 2 x SVB, 1 x Forceps birth

Based on vaginal births (176) rate is 28 per 1000
Based on all births (342) rate is 14 per 1000

### 3. Top Contributors

- Instrumental births carry an increased risk of OASI injury
- Potential for new midwives to trust, midwives on rotation to not have had previous OASI care bundle training

### 4a. Action Plan

| Contributor | Potential Root Cause (ask Why?) | Countermeasure | Owner | Due by date | Estimated Impact (Quantified) |
|---|---|---|---|---|---|
| Instrumental births carry an increased risk of OASI injury | High-risk intervention | Obstetric team have dedicated one of their training session to OASI prevention in line with the OASI care bundle<br>New resident | KG | Nov 2026 | Increased education, reduced rates |
| Potential for new midwives to trust, midwives on rotation to not have had previous OASI care bundle training | Midwives who are not trained/have not had updates may not practice in line with guidance | Refresher training for staff, increased awareness through local communications, liaise with PD team for new starters.<br>Oasi week to be planned for November 2026. | BC | Nov 2026 | Increased education, reduced rates |

# Summary of maternity & neonatal metrics

Dorset Intelligence & Insight Service

## Sustained Improvements

| | |
|---|---|
| PS | • **Bookings** at <10 weeks – sustained |
| P | |
| PE | |
| QOS | • **ATAIN** Avoidable term admissions to Neonatal Unit –sustained <5% |
| SS | |

# Perinatal Quality Surveillance - Ongoing QI - Sustained

**Sustained QI**

**Project / Metric Name –**

Booking <10 weeks

**Owner:** Akeisha Robinson, Senior Matron Outpatient Services
**Metric**: 65% of bookings <10 weeks
**Desired Trend:** upward trend

**1. Historic Trend Data- DiiS 17/9/26**




**2. Stratified Data**

Bookings at <10 weeks – September 79.5 %
Late booking main contributors:
- 6.9% - EDD change after scan
- 5.2% referred after 9 weeks
- 3.1% rebooked or DNA (this was 18% in May, 5% June, 4% July and August 3%)

Current workstream Metric – reviewing the reasons for patients referring after 9 weeks- early indication theme being unknown LMP's

**3. Top Contributors**

- Change of EDD following 1st scan
- Late referrals after 9 weeks
- Rebooked/DNA Appointments

**4. Action Plan and impact**

| Contributor | Potential Root Cause | Countermeasure/actions | Owner | Due by | Outcome |
|---|---|---|---|---|---|
| Change of EDD from scan appointment | Appointments sent based on LMP however after 1st scan the EDD might change for some patients so not within correct timeframe . | • To mitigate EDD changes Admin to send booking appointment for 9 weeks to reduce error in timings. No impact on earlier bookings to care requirements<br>• Long term digital solution required moving to Epic in 2028 until then manual adjustment. | CW | Completed | System improvement through digital update |
| Rebooked/DNA Appointments | Patients not aware of the importance of booking appointment | • Booking appointment letter reworded to emphasis the importance of screening | MB/JT | Completed | Reduction in rebooked/DNA Appointments |
| Late referral after 9 weeks | Change to Healthier Together Website | • Reduction in late referrals this month after changes made to Healthier Together Website making the link to referring pregnancy more prominent. | DJ | Completed | Reduction in the number of late referrals |
| | | • Increase in late refers based on known LMP's. Review into reasons for referring late | JT | December 26 | |

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# Perinatal Quality Surveillance - Ongoing QI - Sustained

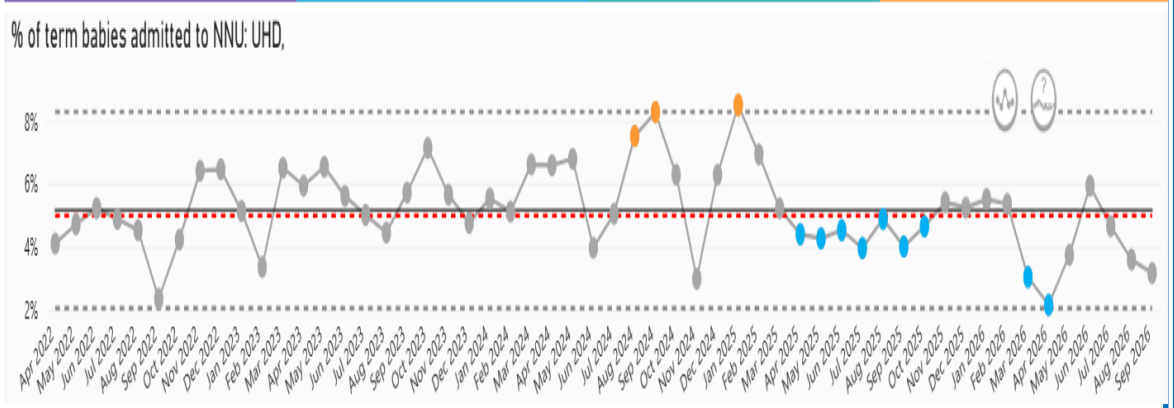
**Project / Metric Name** Neonatal Term Admissions to NICU

**Owner:** Christine Smith Inpatient Matron / Karen Dent NICU Matron
**Metric:** <5% regional target <6% national target
**Desired Trend:** downward

Avoiding Term Admissions into the Neonatal Unit (ATAIN) was introduced by NHS England in Feb 2017, with the aim of reducing harm leading to avoidable admissions to NICU for babies born ≥37 weeks' gestation.

QI projects for 2026 will focus on physiological support to aid transition and reduce admissions for hypoglycemia and hypothermia, along with evidence-based methods for delivery of bedside CPAP. The 'Red Hat' initiative was launched in early 2026.

## 1. Historic Trend Data- DiiS 17/9/26




## 2. Stratified Data

In September there were 9 term babies admitted to the Neonatal Unit.
In line with ODN, calculated on all registerable births - 2.58% of all babies born. This remains both below National (6%) and Regional (5%) target (for 18months consistently).

22% of September's admissions to NICU followed a spontaneous vaginal birth
33% followed a Cat 2 Emergency caesarean (EMCS)
22% followed a Cat 4 Elective caesarean section (ELCS)
22% followed a Forceps birth

77% of babies were White British ethnicity, 11% Other and 11 % Black Caribbean

**IMD (Index of Multiple Deprivation)** quintile 1-5, the higher the quintile = areas of less deprivation:
1= bottom 20% most deprived neighborhoods in England.

IMD 1 – 0 % admissions
IMD 2 – 44 % admissions
IMD 3 – 22 % admissions
IMD 4 – 22 % admissions
IMD 5 – 11 % admissions

The main reason for admission remains as respiratory issues.

## 3. Learning from August case reviews in September's meeting: September cases to be reviewed 14th October.

No avoidable admission in Augusts 13 term babies admitted to NICU.

- At busy times, it is even more important that normal escalation pathways are followed
- Several cases reviewed showed inconsistent actions and escalations were made in response to the unit being very busy.
- Abnormal antenatal CTG did not lead to transfer from Aspen to Woodlands. Earlier transfer may have led to an earlier delivery.
- Alertive used to escalate neonatal concerns, this should be 2222 and/or emergency bell.
- PV bleeding for patients on Haven require transfer to continuous monitoring and transfer to Labour ward.
- Important to ensure there is clear documentation of evidence/discussion around reasons for when there is a delay in transferring to theatre.



# Workforce

# Mat Neo Red Flags from Birthrate+ Acuity Tool and Safe care. September 2026

Clinical Red Flag reporting moved from locally determined clinical red flags to alignment with NICE (NICE,2015) and the Birthrate+ Acuity Tool.
Aspen Antenatal Ward and Woodlands Labour ward report red flags.
Due to the change in reporting, ongoing education is provided to staff to ensure accuracy of data. Some red flags are captured below from LERN submissions.
Red flags are a trigger that patient safety or experience is being impacted, and you need to consider if redeploying staff will resolve the issue. Other reasons for redeployment could include periods of increased activity, staff sickness, additional clinics/operating lists.

| NICE Red Flag | Woodlands Labour Ward | Reasons Recorded | Aspen Antenatal Ward | Reasons recorded |
|---|---|---|---|---|
| Delayed or cancelled time-critical activity. (Cat 1,2 caesarean birth) | 3 | Cat 2 delay<br>ARM delay | 0 | |
| Missed or delayed care. (e.g Delay of 60 mins or more for suturing, TWOC, washing) | 0 | | 0 | |
| Missed medication during admission. (e.g diabetes medication, IV antibiotics) | 0 | | 0 | |
| Delay of more than 30 mins in providing pain relief. | 0 | | 0 | |
| Delay of 30 mins or more between presentation and triage. | 0 | | | |
| Full clinical examination not carried out when presenting in labour. | 0 | | | |
| Delay of 2 hours or more between admission for induction and beginning of process. | 0 | | 1 | |
| Delayed recognition of and action and action on abnormal vital signs. (e.g sepsis/urine output) | 0 | | 0 | |
| Any occasion when 1 midwife is not able to provide continuous 1:1 care to a woman in labour. | 2 | High activity, staff redeployed from mgt and training to resolve. | | |
| Coordinator unable to maintain supernumerary status – NOT providing 1:1 care. | 1 | No reason recorded | | |
| NICU. Pre shift <2 QIS nurses on shift. | 2 | Sickness. Bank & staff redeployed from mgt to safely manage. | | |
| NICU. Pre shift <6 nurses on duty. | 9 | Sickness. Bank & staff redeployed from mgt to safely manage. | | |
| NICU. On shift >21 babies admitted to the unit. | 0 | | | |

# Obstetrics and Gynecology Medical Staffing

**Risk register to be approved at 15**

- Consultant rota - Resident labour ward presence 70 hours per week, achieving minimum of 2 ward rounds per day. Consultant rota fully staffed in September after the recruitment of 2 new consultants who commenced in post in June & September.
- One Obstetric vacancy will arise in late October and one gynaecology vacancy in December.
- Substantive posts have gone out for advert. Interim locum posts awaiting approval
- Middle Grade rota – Improved staffing from October – 14.5 WTE on 16 person rota. Will increase to 17 WTE in January
- Care group finance directors reviewing medical budget – annual process, now complete.

**MIS**

- 'Obstetric Emergencies and When a Consultant Must Attend' March – May Audit showed 50% compliance
- Period of education and awareness raising
- Re-audit in September – 88& compliance
- Opportunity for improvement – MOH

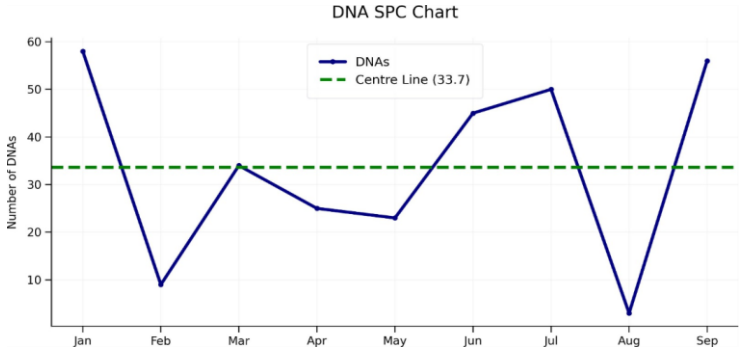
# Training and Education

## Countermeasure Summary Template

**Metric Name/Problem statement:**
All professionals must train together in key areas; NLS, PROMPT, FM and associated CCFV2

**Owner:** Rebecca Savage, Emma Barton and Lucy Hyde
**Matric:**
**Desired Trend:** national target MIS safety action b 90% target for compliance across all professional staff and training modules

### 1. Historic Trend Data – see slide 24 and 25




### 2. Stratified or segmented data

Module 1, 4&5 (SBL) – Compliance remains over 90% with no foreseen issues. Looking at ways to deliver this next year, potentially with a hybrid module.
Module 2 (Fetal Monitoring)- Fetal monitoring compliance continues to remain consistently above 90% overall. Compliance was projected to remain >90% for all staff groups for remainder of 2026. The new rotation of obstetric staff have not had FM training allocated on rota, this has been escalated and needs to be addressed urgently.
Module 3 (PROMPT) - All obstetric doctors booked to attend PROMPT by November, currently 100% compliant for these staff groups. Anaesthetic consultants are currently 100% compliant with 4 to attend in October and November to maintain this. Anaesthetic rotational doctors are currently 84.61% with a projected compliance of 97.82% in October.
Module 6 (NBLS) - Compliance remains over 90% for NBLS.

### 3. Top Contributors

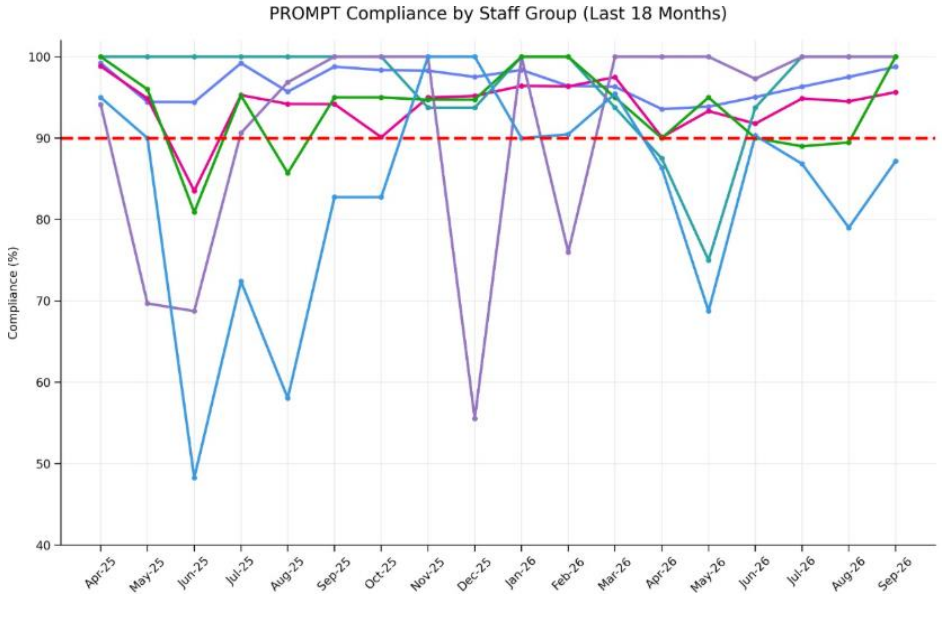
Anaesthetic rotational doctors PROMPT compliance, which will resolve in October

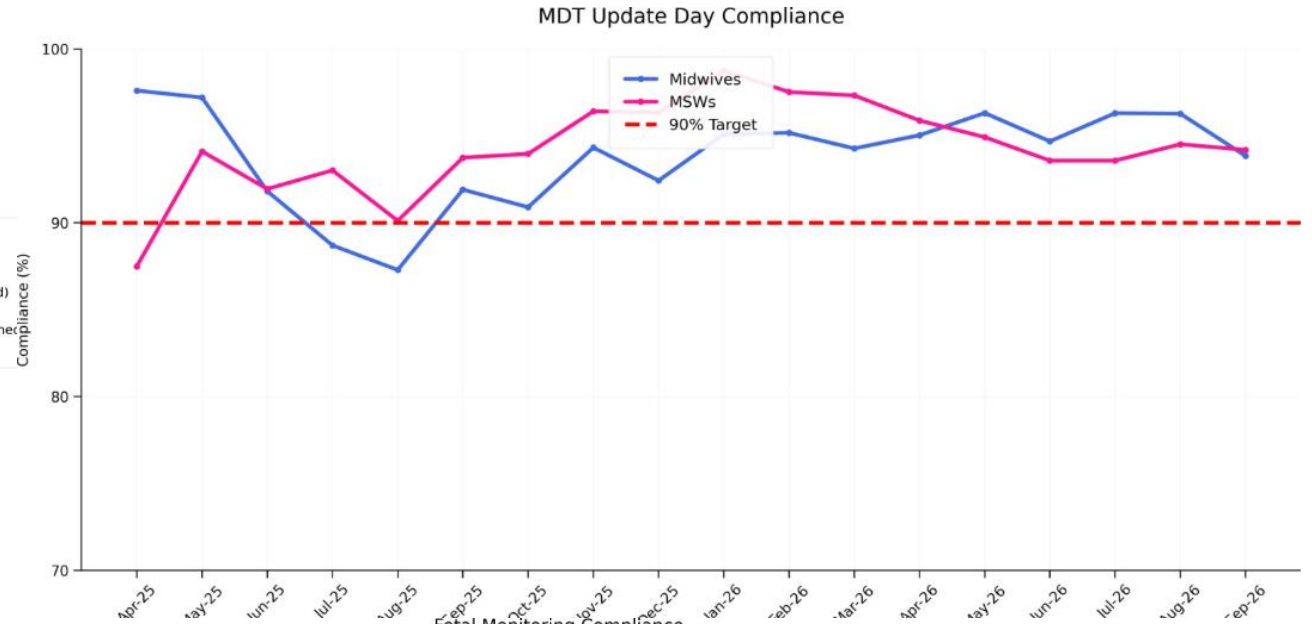
New rotating SpRs not had FM training added to rota for Oct and Nov

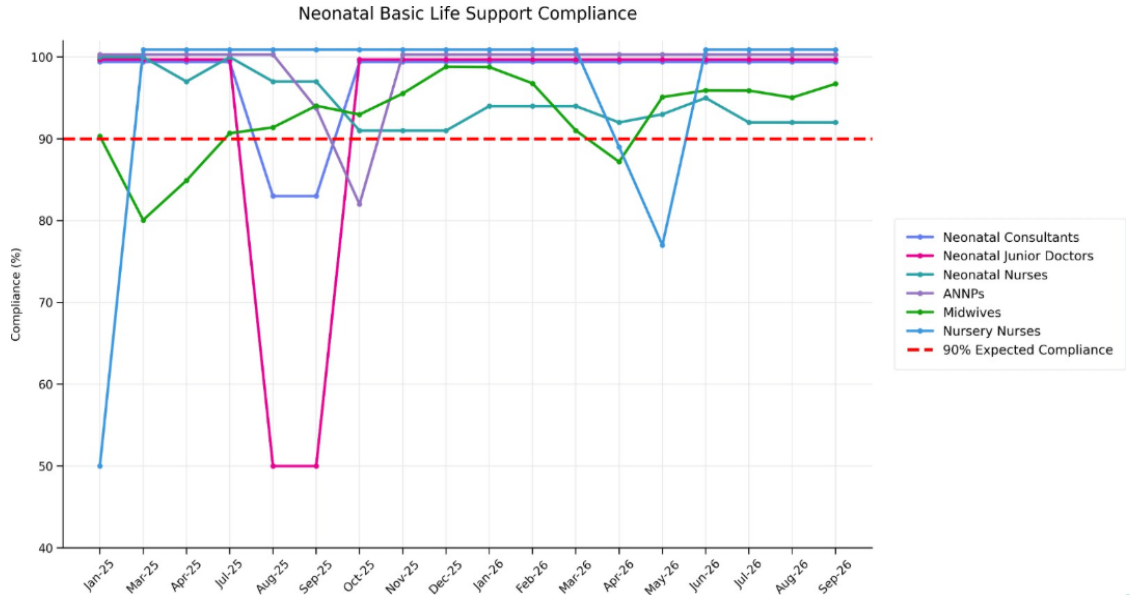
### 4a. Action Plan

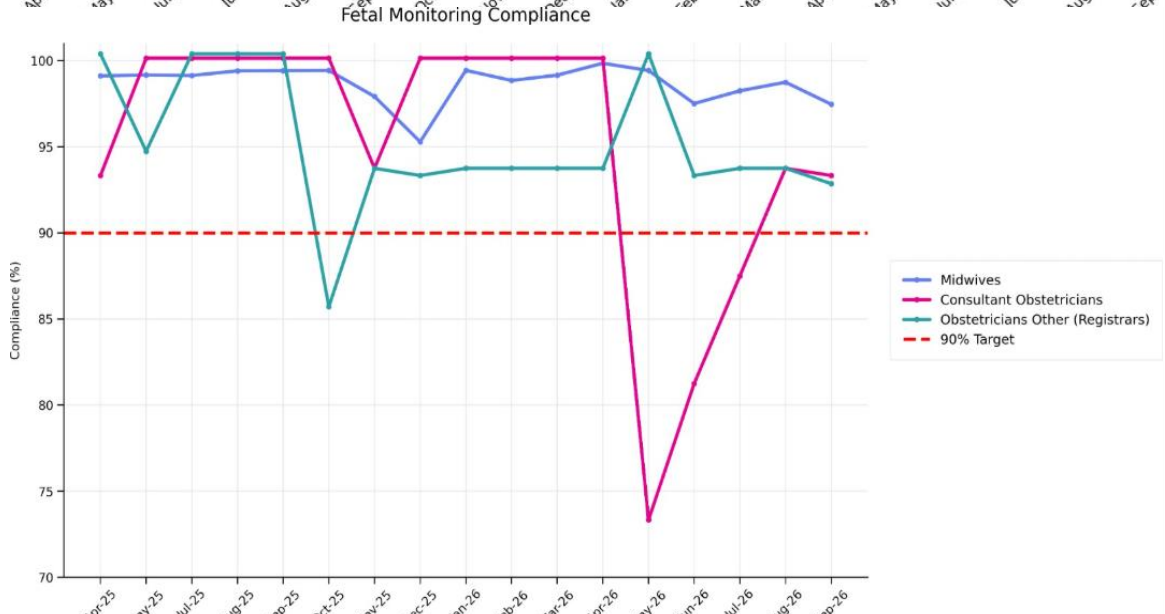
| Contributor | Potential Root Cause (ask Why?) | Countermeasure | Owner | Due by date | Estimated Impact (Quantified) |
|---|---|---|---|---|---|
| Anesthetic compliance | Multiple rotations throughout the year, difficult to keep on top of bookings. | PROMPT lead anaesthetist allocated, escalated to clinical director. | Sophie Ellis/Joe Kinselal | Oct | Continued booking processes and oversight from anesthetic teams with improved compliance |
| Training facilitation to include anesthetic lead | X2 anesthetist have asked to be involved in PROMPT training. | Dates given to volunteers<br>Joe Kinsella to be part of planning for next years PROMPT | Joe Kinsella<br>Lucy Hyde | November | Improved MDT faculty to improve training quality |
| NBLS compliance gap | Reduced training provision during unexpected absence highlighting low resilience in faculty | Identify more Midwifery staff to complete GIC to provide training<br>Existing midwifery RC trained instructors to maintain compliance | Marianne Spicer<br>Senior team | Ongoing | Increased ability to provide training and retain compliance |
| Fetal Monitoring - New SpR training compliance | Not added to rota by Obstetric Rota team. | Escalated as a concern and immediate action required | Sarah Kennedy/Obs Rota | Urgent Oct | None compliance of Obs Registrars / Patient Safety |

# Training Compliance




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# HOME BIRTH SIMULATION 2026

Debrief summary • 9 September 2026 • 09:00–13:00

## SCENARIO SYNOPSIS

Hailey Sims, 37 years, P1 at 39+4, was taking over care from the night midwives for a planned home birth. She had a fixed birth plan, a doula present and initially did not wish to have fetal monitoring. Her background included a previous forceps birth with a 700 mL PPH and an antenatal Hb of 104 g/L. She had declined vaginal examinations and was well on initial observations.
During labour, Hailey experienced SROM with meconium-stained liquor. The team needed to recognise and communicate the change in risk, discuss options with Hailey and her doula, and escalate appropriately. Following explanation, she accepted intermittent auscultation. In second stage, concerns arose regarding the fetal heart rate, requiring communication, escalation and decision-making. The baby was then born requiring a small amount of neonatal resuscitation. Once the baby was stable, Hailey developed a PPH. The team were expected to manage the PPH, arrange ambulance transfer as she became increasingly unstable, and provide an SBAR handover on arrival to Woodland Delivery Suite.

## KEY LEARNING POINTS FROM THE DEBRIEF

### TOOLS

- Bring the birth plan into the discussion early; consider a consistent UHD birth-plan template.
- The birthing bag felt chaotic — review organisation and layout.
- Further feedback on PPH management performance was requested.
- PPH algorithm was difficult to follow in the home-birth context — consider a larger, clearer A3 version.
- Explore drug communication and shared learning between paramedic and midwifery teams.

### TASKS

- Communicate any changes in PPH medication management to all relevant staff.

### PERSON

- Clarify whether/when the OPCO should update the Duty Lead.
- Agree expectations for communication with ambulance crews.
- Consider the paramedic role during neonatal resuscitation, including whether they undertake NLS while the midwife concentrates on the mother; recognise this may be paramedic-specific/dependent.
- Consider human factors during the NLS scenario.
- Use shared decision-making and clear communication with paramedics.

### PERSON

- Plan a clear handover between paramedics and midwives, including timing of interventions before leaving for hospital.
- Encourage collaboration between paramedics and midwives during emergencies.
- Provide a detailed early handover to ambulance crews so others can be informed if additional resources are needed, e.g. HEMS.

### ORGANISATION

- Review the ambulance category clarification relevant to home-birth transfer.
- Clarify the process for professional 999 / IFT and how the ambulance service shares its PPH algorithm with UHD.

### TECHNOLOGY

- Explore use of red phones on the labour ward for PPH/MOH communication.
- Review BadgerNet usability in an emergency/home-birth context.
- Paramedics reported excellent technology for baby monitoring; consider whether midwives can access/use the same capability where appropriate.

# Staff Feedback – Safety Champion Walkaround
# ANC & RBH Community Hub 23/09/2026
# S Herbert (CNO), A Stubbs (DOM) and A Eaton (Matron)

| YOU SAID | WE DID |
|---|---|
| • Connectivity issues in the community. | • Escalated to deputy director of IT for support – meeting planned for October 2026. |
| • Challenges with high call in to unit due to poor coverage of hospital on-call – creating difficulties with staffing community work the following day. | • 75% of hospital on-calls currently covered, with immediate effect no removal of hospital on-call shift without agreement from DOM or HOM. We are confident this action will improve the position moving forward. |
| • ANC: Concerns raised around hot-desks being used in break room. | • New ANC lead to promote ground rules for use of hot desks in this space – teams meetings and phone calls to not be conducted while others using the room for a break and share alternative break spaces across the Trust if preferred. |

# Culture of Learning, Safety and Support



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# Perinatal Quality Surveillance

## Maternity Outcomes Signal System (MOSS) - Summary

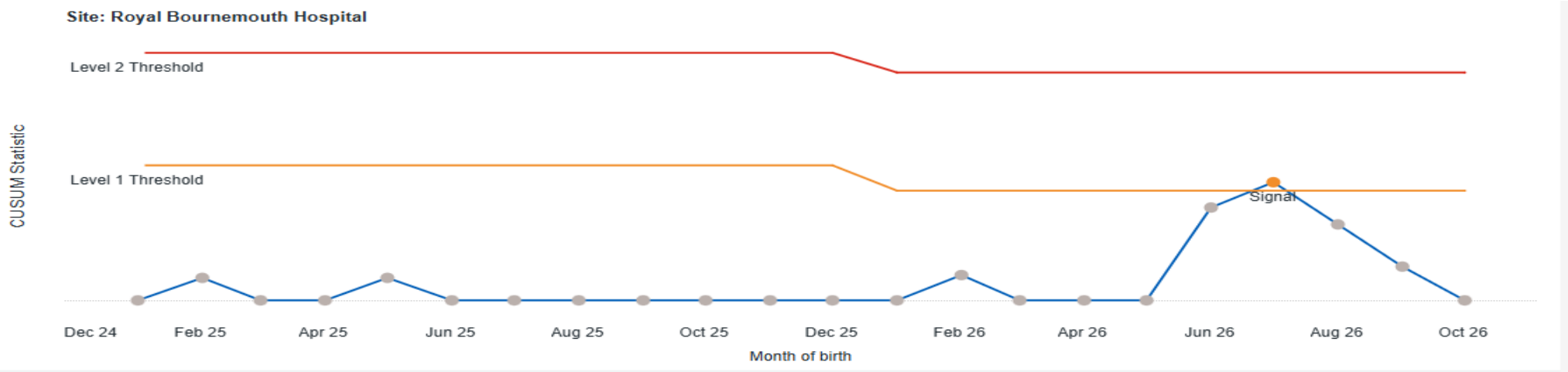
Latest Event: **25 Jul 26**
Refreshed: **07 Oct 26**

NHS

**Region**: South West | **ICB**: NHS Dorset ICB | **Trust**: University Hospitals Dorset NH... | Reset filters

### Signal summary table

| Signals over last 6 months | | Signals over last 12 months | |
|---|---|---|---|
| Level 1 | Level 2 | Level 1 | Level 2 |
| 1 | 0 | 1 | 0 |




We are caring | one team | listening to understand | open and honest | always improving | inclusive

# Thirlwall Inquiry Report and Recommendations

Report and Immediate Actions received by the Trust and Neonatal Team September 2026. The Matron has held an initial listening event with staff to process the contents and plans made with the Clinical Director and Director of Maternity and Neonatal Services to establish a working party in October 2026 to monitor implementation of recommendations

**Immediate actions**

| Action | Owner | Completion status |
|---|---|---|
| Review of Thirlwall Report and recommendations at Trust Board | CNO/DOM | November 2026 – on track |
| Ensure all staff are aware of SUDIC protocol and that this applies to all Neonatal Deaths which is unexpected or where there is no medical cause. | WCSS Medical Director | 28 September 2026 -Complete |
| Continue to implement the National Bereavement Care Pathway for stillbirth and Neonatal Death | Maternity matron/ Neonatal Matron | March 2027- On track |
| Implement CCTV monitoring in Neonatal Unit Insulin storge fridges | Maternity and Neonatal Service Manager | 30 November 2026 –On track |
| Ensure unit compliant with GIRFT Neonatology guide to safe insulin use | Clinical Director Neonatal Service | 31st March 2027- On track |
| Trust to assure that all staff members are complaint with safeguarding training requirements to the level required for their role | Corporate Safeguarding lead | March 2027 – on track |

# Triage

| Metric | September |
|---|---|
| **1. Proportion of women for whom expected timeframes are met for initial assessment and for clinical review, based on their category of urgency.** | Achieved 79% for Initial Triage within 15 minutes of arrival (against local target of 80%)<br>Category of Urgency<br>Green (review within 4 hours) 81.2%<br>Yellow (review within 1 hour) 69%<br>Orange (review within 15 minutes) 66.2% |
| **2. a) Proportion of women who experience a delay in assessment, review or onward care**<br>**b) proportion of these where there is an outcome recorded.** | 21% delay in initial triage assessment of 15 minutes<br>34% delay in onward care<br>Outcome- recorded for all women who attended |
| **3. Number of improvement actions implemented where issues are identified, including through service user feedback, performance data, incidents, audits, complaints or staff feedback** | 1 Improvement action implemented following patient feedback about not knowing wait times for review. Review Timecards now given and staff share review times after initial Triage |
| **4. Frequency of staff being redeployed to other maternity care areas within the unit from maternity triage:**<br>**% of shifts affected by re-deployment** | 6 staff members (4% of shifts) were redeployed to other care areas for part of/ all of shift. 2 staff members moved to provide break relief. (In each case the department was risk assessed to ensure reduced activity and low impact before redeployment). |

| Improvement actions | Progress | Impact | Responsible |
|---|---|---|---|
| Reduce the number of labour assessment carried out in Maternity Triage | Launched with team and communications shared with all staff in September.<br>Plan now to monitor for reduction | Reduction in the number of assessments seen in maternity Triage which will increase the team's capacity to carry out Initial triage within 15 minutes and raise compliance | Triage Lead<br>Senior Outpatient Matron |
| Implementation of the Healthier together App | April – August –development of App and testing<br>October – November - Launch | Reduction in the number of calls to the MAL which should be directed to other services, therefore reduction in call wait times | ICB |

# Perinatal Quality Surveillance - Mortality PMRT

## True North: Quality

**Perinatal Surveillance Tool Data September 2026 –**
Mortality MBRRACE (Mothers and Babies Reducing Risk through Audit & Confidential Enquiries) reportable cases for PMRT (Perinatal Mortality Review Tool)

**Ambition:** To ensure robust, transparent, multidisciplinary and patient-centered review of all perinatal losses with external oversight.

**Goal:** To ensure all eligible perinatal losses are reported to the required standard.

## MBRRACE reportable cases for PMRT review:

| | Late Fetal Loss | Stillbirth | Neonatal Death |
|---|---|---|---|
| **September 2026** | 0 | 1 | 0 |

| PMRT Review Status | Number |
|---|---|
| Number of UHD cases pending initial review at PMRT panel –arranged for 14th October 2026 | **4** |
| Number of cases awaiting pending PM/final and/or review/report closure | **5** |
| Number of cases reported by external Trusts, requiring joint review | **0** |
| **TOTAL cases requiring review completion** | **9** |

All cases are reviewed through PMRT meetings with neighbouring Trust DCH where care is discussed and graded. Family feedback is sought for all PMRT cases in the appropriate first language, within the recommended timeframe. Feedback is valued and a central part of the review process. A QR code for feedback is in use, to encourage a greater uptake in parental feedback.

- **Reportable cases to MBRRACE requiring PMRT review in September 2026 from UHD = 1.**
  MAT 005-194, L181460: 33+3 Antenatal Stillbirth diagnosed when attending with absent fetal movements since the previous day. Reviewed at MatNeo Risk MDT findings - Excellent practice in offering interpreter services through pregnancy. Learning – Need for clear escalation pathway (underway). Further discussion to take place around maternal request ELCS when SB. For review through PMRT.

**All MBRRACE cases are reported through the NHSE Submit a Perinatal Event Notification (SPEN) portal within the appropriate time frame.**

*Refer to Appendix 1 Q2 PMRT Board Report*

# Perinatal Quality Surveillance - Mortality

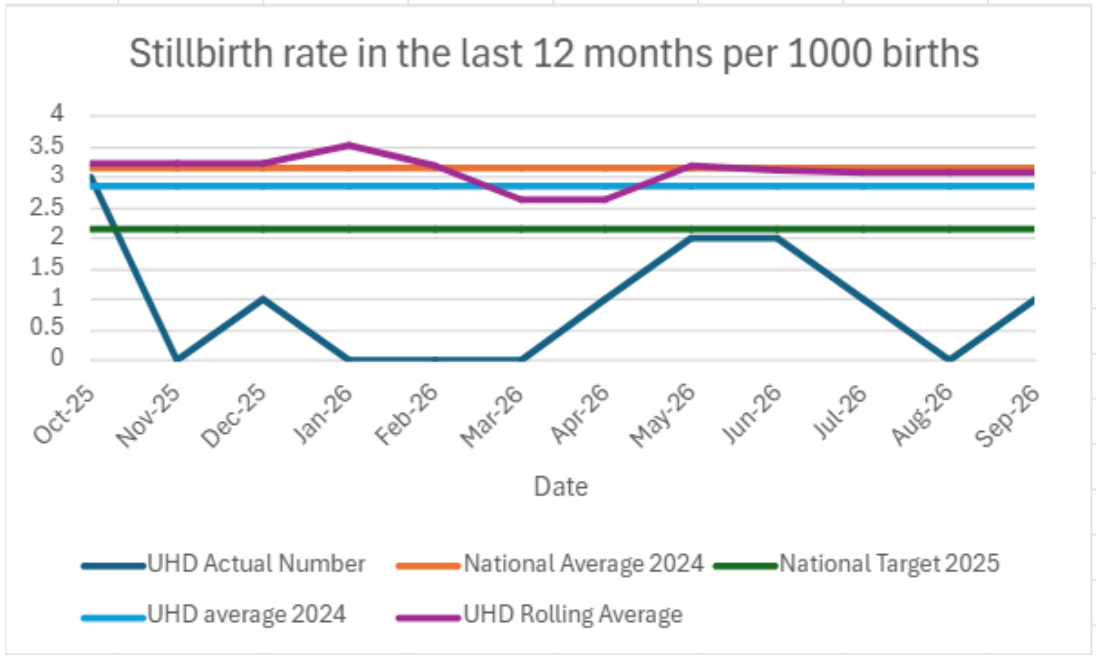
**Due to unexpected circumstances and high operational demand, September's PMRT meeting was cancelled.**
**Three cases due to be reviewed in September (all first reviews), will be reviewed in October:**

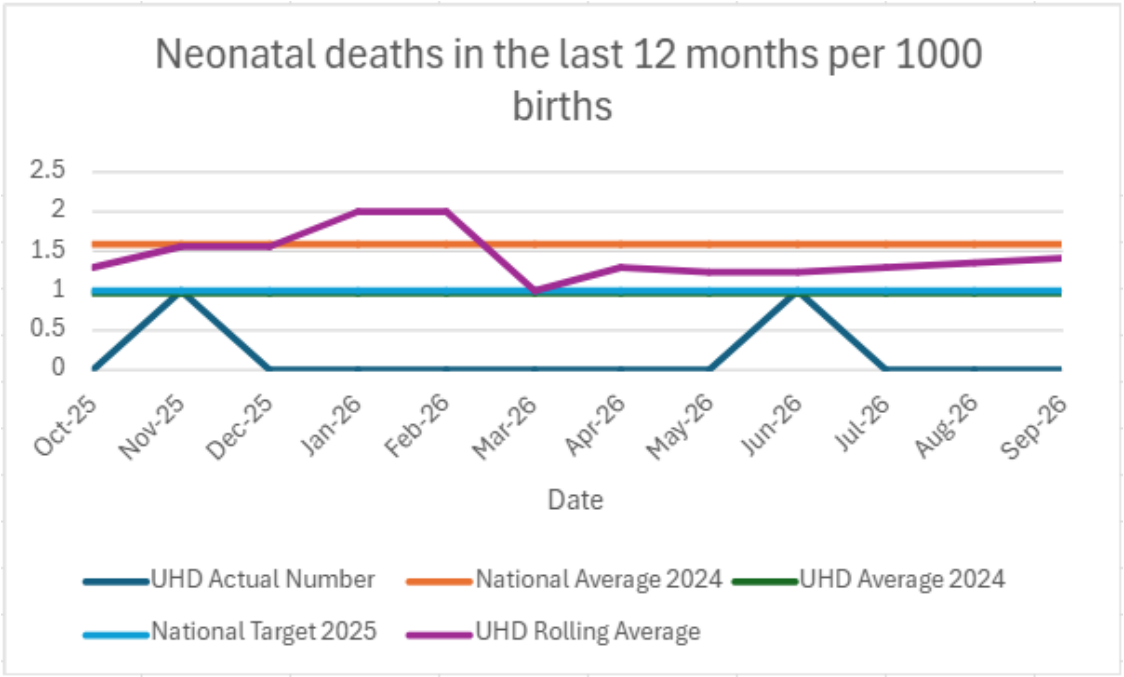
- **MBRRACE ID 104446: Neonatal Death, Day 0, 38+3, June 2026.**
  Cat 1 EMCS when mother presented bleeding. Family feedback received. Family consented to MNSI investigation.

- **MBRRACE ID 104909. Antenatal Stillbirth, 37+2, July 2026.**
  Loss diagnosed during routine serial USS. No family feedback received to date

- **MBRRACE ID 104536. Antenatal Stillbirth, 37+5, June 2026**.
  Presented with history of RFM for 2 days whilst out of area. Family feedback received. Mother's home Trust contributing to PMRT review.

*See Appendix 2 PMRT Grading of care*



# Perinatal Quality Surveillance- MNSI

## True North: Quality MNSI

**Perinatal Surveillance Tool Data – Maternity and Newborn Safety Investigations , MNSI**

**Ambition:** To ensure robust, transparent, multidisciplinary and patient-centered review with external oversight.
**Goal:** To ensure all eligible cases are referred within the appropriate timeframe, reviewed thoroughly and learning implemented.

**MNSI new cases:**

There were no new cases referred to MNSI and NHSR in September.

The case below occurred in September 2026 and was referred to MBRRACE via SPEN and will be referred to MNSI for consideration in October 2026:

MAT 005-025 L181350: Maternal death in pregnancy at unknown gestation of a type 1 diabetic, poorly controlled. Cause of death unknown at present. Case referred to the coroner and submitted to MBRRACE via SPEN portal. Advice has been sought from MNSI – awaiting confirmation whether this case meets criteria for referral.

**MNSI ongoing cases:**

- MAT 003-898 L175981 Neonatal death following significant antepartum hemorrhage at home- Category 1 caesarean section. Baby born in poor condition and died soon after delivery.
- MAT 004-25 L177520 40+1 abnormal CTG – Category 1 caesarean section. Baby born in poor condition –ventilated and transferred to tertiary canter for cooling.

**All MNSI cases were reported through the NHSE Submit a Perinatal Event Notification (SPEN) portal within the appropriate time frame.**

# Perinatal Quality Surveillance-PSIRF

## True North: Quality

**Perinatal Surveillance Tool Data September 2026 – The Serious Incident framework has been migrated to the Patient Safety Incident Response Framework (PSIRF), and some cases continue to be STEIS reportable at present.**

**Ambition:** To ensure robust, transparent, multidisciplinary, and patient-centered review of all PSIRF incidents

**Goal:** To ensure all eligible cases, systems and process are reviewed thoroughly and learning implemented to improve patient safety

**Incidents requiring escalation through PSIRF:**

All incidents are triaged following an initial review. Those graded as amber and above are reviewed in the weekly risk MDT meetings. Any additional learning responses identified or cases requiring escalation are then discussed at care group weekly PSIRF Rapid review meetings.

**There were 6 Mat Neo incidents which required escalation for discussion at care group PSIRF Rapid review meetings in September:**

- **L180501 –** Unaccounted for swab following birth, delay in performing count. X-ray performed – NAD. **Learning response –** PSIRF timeline review and Audit of newly introduced LOCCSIP forms and personal reflection.
- **L180686 –** Delay in re-siting a cannula mid IV antibiotic administration for a patient readmitted following the birth of her baby with pyelonephritis. **Learning response –** PSIRF case review, escalation poster to be created, linking in with CST for additional support when medical team busy.
- **L181111 –** 35+6 woman attended triage in pain with absent fetal movements, fetal bradycardia noted, Category 1 cesarean section performed within 29 minutes of arrival. Signs of placental abruption noted at delivery. Baby born in poor condition, intubated and cooled. Transferred to tertiary centre for ongoing care. **Learning response –** TRIM brief for staff, PSIRF timeline review of care. Excellent team working noted with a swift response, in an emergency situation.
- **L181201, L181305 –** 2 x Incorrectly labelled group and save samples**. Learning response –** Personal reflections. Quality improvement work underway with team on correct processes for completion of blood cross matching.
- **L181665 –** Impacted fetal head requiring T incision to uterus, manual dis impaction and breech extraction. **Learning response –** Case review.

**Ongoing PSIRF investigations:**

**Patient Safety Incident Investigation (PSII):**

- (L159852) 6.2L Major Obstetric Hemorrhage (MOH) following a Category 2 emergency caesarean section (EMCS) and Hysterectomy in theatre, then transfer to ITU. Immediate learning identified and actions assigned. Awaiting draft report and action planning meeting.

**After Action Review (AAR):**

- (L175515) 8.5L Major Obstetric Hemorrhage (MOH) following placenta praevia and Category 1 emergency caesarean section (EMCS) , ITU admission and hysterectomy. AAR meeting took place. Synopsis created and will go through Governance process in October for final sign off.

**Final reports received:**

- No final reports were received in September.

# Perinatal Quality Surveillance-PSIRF

## True North: Quality

### Table of open Maternity/Neonatal Incidents – updates and referrals September 2026:

| Datix/LERN Ref Description | STEIS | Incident Date | Progress | Investigation / Review |
|---|---|---|---|---|
| **L159852** 6.2L Major Obstetric Hemorrhage (MOH), Hysterectomy, ITU admission | Yes 2025/6703 | Oct '25 | Delays due to changes in lead investigators.<br>A draft report is awaiting dissemination, and an Action Planning Meeting is scheduled for Nov. | PSII<br>STEIS reportable |
| **L175515** 8.5L Major Obstetric Hemorrhage (MOH), Hysterectomy, ITU admission | No | June '26 | After Action Review meeting held 18/08/26.<br>Draft report completed.<br>Synopsis created and will go through Governance process with AAR in October for final sign off. | AAR |
| **L175981** Neonatal death at 38+3 following a significant antepartum haemorrhage at home. | Yes 2026/2907 | June '26 | MNSI review ongoing.<br>Staff interviews have taken place.<br>Awaiting draft report. | MNSI<br>STEIS reportable |
| **L177520** Term baby transferred to a Tertiary centre for therapeutic cooling . | No | July '26 | MNSI have held their ToR meeting, UHD awaiting response.<br>Claim rejected by NHSR as does not meet the scheme reporting criteria | MNSI<br>Not STEIS reportable (confirmed by LMNS) |
| **L179070** Patient with positive blood cultures. Poor documentation of cannula/catheters insertion and subsequent VIP scoring. | No | August '26 | AAR originally planned for Sept, postponed. New date TBC | AAR |

# Risk Register

| | APPROVED RISK SUMMARY | IN HOLDING |
|---|---|---|
| TOTAL | 9 | |
| 15 + High | 1 | |
| 12 + Moderate | 2 | |
| 8 – 10 Moderate | 2 | |
| 4 – 6 Low | 4 | |
| 0 – 3 Very Low | 0 | |

**Risks in holding in Sept 2026**

| Risk ref | Risk rating | Risk description |
|---|---|---|
| N/A | | |

**New Risks – Sept 2026**

| Risk ref | Risk rating | Risk description |
|---|---|---|
| N/A | | |

**Removed risks – Sept 2026**

| Risk ref | Risk rating | Risk description |
|---|---|---|
| 1648 | 2 | Neonatal Consultant Rota – met target risk grading of 2. 7th Consultant started in early September |

**Horizon scanning risks**

**Gaps in Neonatal medical staffing -**The current establishment is 14.5 WTE (10% below the recommended minimum).

**Connectivity in community /iPads 5G required to work online –** Community midwives currently working offline outside of the unit. Meaning document is not completed in real time. Live information is not available until back in the unit.

# Risk Register (at a glance)

| Date opened | ID | Title | Risk level (current) | Rating (current) | Increase / decrease | Review by |
|---|---|---|---|---|---|---|
| 20/07/2026 | 1202 | Medical staffing women's health | High 15-25 | 15 | ⟺ | 21/10/2026 |
| 16/11/2023 | 1995 | Baby Abduction systems and processes | Moderate 8 - 12 | 12 | ⟺ | 21/10/2026 |
| 29/04/2026 | 2328 | Maternity Patient Prescribing in Primary Care | Moderate 8 - 12 | 12 | ⟺ | 30/10/2026 |
| 14/09/2025 | 2246 | Access to a second emergency obstetric theatre team | Moderate 8 - 12 | 10 | ⟺ | 23/11/2026 |
| 02/06/2026 | 2336 | Reliability of 'Hugs' baby tag system in MatNeo | Moderate 8 - 12 | 8 | ⟺ | 13/10/2026 |
| 15/01/2024 | 2018 | Ventilator on Portable Incubator | Low 4 - 6 | 6 | ⟺ | 29/10/2026 |
| 01/08/2024 | 2098 | Elective caesarean capacity | Low 4 - 6 | 6 | ⟺ | 23/10/2026 |
| 06/05/2026 | 2330 | Safeguarding Children Level 3 compliance in Maternity | Low 4 - 6 | 4 | ⟺ | 19/10/2026 |
| 29/04/2026 | 2327 | Service design of the Maternity Advice Line | Low 4 - 6 | 4 | ⟺ | 30/11/2026 |

⟺ No change in risk grading.

# Risk Register

| Risk ref | Risk rating | Risk description | Opened | Breaching tolerance Y/N | Current mitigation(s) | Additional actions agreed at SDR/ Updates |
|---|---|---|---|---|---|---|
| 1202 | 15 | Medical staffing women's health | 20/07/2017 | N (9-15) | Safe staffing standards<br>Rota management<br>-Locum shifts procedures<br>2WW compliance<br>RTT compliance<br>Theatre utilization standards<br>LMNS<br>CQC,RCOG standards | **29/7/26**: The risk was approved at 15 by the Oversight Group, with the following actions to be reviewed/ added to the risk register.<br>Local and national reputation risk. Impact on the Senior midwifery team re: OPEL 4 actions whilst on-call, SOP for escalation process to medical staffing- decision re: to add a meeting with DOM/ CD and ?exec re: declaring OPEL 4.This risk will be escalated to Trust Board.<br>**21/8/26**: Grading to remain the same. New National Opel escalation policy has been introduced- yet to go through MatNeo Governance process. This escalation does not trigger opel 4 status for gaps in medical staffing. August has not been as challenging as predicted, with good uptake from UHD staff for cover of additional shifts.<br>**21/9/26**: Middle grade staffing numbers has marginally improved, with the recruitment of 2 clinical fellow, however they are currently in their induction period and therefore there are still multiple unfilled OOH shifts and difficulty supporting daytime clinical activity. risk rating to remain the same. We expect improvement in staffing from October 2026. |
| 1995 | 12 | Baby Abduction Systems and processes | 16/11/2023 | Y (4-6) | -Locked Card reader doors plus intercom systems in all ward areas.<br>-Additional card reader access added to internal double doors within Maternity front entrance<br>-Baby tag system in use in MatNeo<br>- Lockdown function on doors in MatNeo BEACH building<br>-Plans for annual baby abduction drill | **23/06/26** -Discussed with DoM, and risk grading increased to '12', therefore moved into holding pending approval.<br>**14/07/2026** Risk reviewed and discussed at MatNeo Governance and Education meeting: Risk rating agreed, for approval at Care Group Board due to proposed risk rating of 12.<br>**24/07/2026** - Risk reviewed at the WCCSS CGB, all present in agreement with risk and rating (minutes available on request) moved to approved risk status.<br>**30/07/2026** - Risk reviewed with Senior Inpatient Matron. Grading to remain the same as issues with Card reader doors and green 'break glass' remain unresolved. Weekly Task and Finish group with relevant teams continues.<br>**21/08/2026:** Baby tagging task and finish group in progress with representatives across Estates, Emergency Planning, Maternity and Security- multiple work streams within this group cover all issues addressed in this risk. Action trackers are in place for this task and finish group which meet weekly. Security personnel will remain in situ on floors 2&3 until assurance has been provide by this group.<br>**21/09/2026**: Task and finish group ongoing with action trackers, security remain on L2 and 3. |
| **2328** | 12 | Maternity Patient Prescribing in Primary Care | 29/04/26 | **Y (4-6)** | • National PGD utilised to support the distribution of medication within the acute and community setting<br>• Medication/prescriptions being currently supplied from within the Antenatal clinic setting<br>• GP Alliance supportive of continuing to prescribe while maternity services transitions and develops pathways to support this change in prescribing practice<br>• Process in place to support the supply of Ferrous Sulphate (under midwife exemption)<br>• GP to continue to treat MSU and wound infection if originated from within the community setting<br>• Temporary measure in place of patients of patients being issued with a Boots prescription if identified as needing Folic Acid 5mg. | **19/06/2026** Risk approved at Care Group Board<br>**23/06/2026** Process now in place to support the distribution of Aspirin (under PGD) for at risk patients from within the ANC following a patients 12- week (3 months given) and 20 week ultrasound (final 3 months supply given) scan, to take patient up to 36 weeks of pregnancy. Working through a process to have access to 'Cleo System' to support electronic prescribing<br>**26/07/26** Reviewed and no update to change in process outlined below. Awaiting decision regarding access to CLEO system which may allow prescriptions to be sent to patient's local pharmacy.<br>**28/08/26:** 28/08/2026 - Exploring which local community services can support with access to medication for patients within their community<br>**21/9/2026**: After exploring community outreach, only viable support remains through electronic prescribing. Awaiting update regarding access to CLEO system. Patients continue to access Aspirin and ferrous sulphate from within the Antenatal Clinic department. Supply of aspirin not able to meet the demand and have utilised Boots supply in the interim.<br>**29/10/26**: Presented and discussed at risk oversight committee. |

# Risk Register

| Risk ref | Risk rating | Risk description | Opened | Breaching tolerance Y/N | Current mitigation(s) | Additional actions agreed at SDR/ Updates |
|---|---|---|---|---|---|---|
| **2246** | 10 | Inability to access a second obstetric theatre | 14/09/25 | N (6-10) | •Triaging potential emergency cases<br>•Ongoing monitoring of patient whilst awaiting theatre<br>•Alerting elective surgical teams to consider where lists can be paused during core working hours<br>•Flow chart from Protocol to risk assess and summon a second emergency obstetric team to theatres is in place and agreed by maternity, obstetrics, theatres and anaesthetics (displayed in Labour ward/ maternity theatres/fishbowl)<br>•An additional emergency team to be compiled from CEPOD and existing obstetric theatre team where available<br>•Staff training, skills and drills<br>•Consider moving patient to main theatre if both maternity theatres are occupied<br>•Escalation to Clinical Site Team | **8/6/26:** Risk to remain at 10 - awaiting temporary staffing to be made substantive in theatres<br>**26/06/26** Theatres are currently going through the process to recruit current bank staff members of the CEPOD team into substantive posts. Once this process has been completed, this risk will be reviewed with the view to close it.<br>**21/9/2026:** Audit to assess compliance with emergency access to theatre has shown that the department is 57% compliant with cat 2 delivery times, ie 43% are not delivered within the 75minutes target delivery time. a large proportion of those non compliant were due to no availability of a second emergency obstetric theatre and team. Other themes were also identified but are a smaller percentage reason. A working group is being set up to action this. |
| **2336** | 8 | Reliability of Hugs baby tag system in MatNeo | 02/06/26 | **Y (4-6)** | •ID card reader doors to wards where babies reside<br>•Newborn security policy<br>•Baby tag SoP<br>•Tailgating signs on doors<br>•Tailgating audits<br>•Transmission of baby tag alarms to handheld Myko devices<br>•24/7 security presence on floor 3 when lockdown not initiated<br>•Reinforced staff vigilance and staff escort protocols<br>•Continued use of baby tags where possible<br>•Datix/ LERN forms | **19/06/26** Risk presented, discussed and approved at MatNeo Governance and Education meeting. Linked to Risk 1995 baby abduction.<br>**13/08/26:** Risk reviewed and updated with DoM. Further training from Ascom with the postnatal teams has taken place, which will continue with staff on other ward areas. Risk to remain the same, pending update from Task and Finish Group. |
| **2098** | 6 | Elective caesarean capacity | 01/08/25 | N (9-15) | •Ad hoc operating lists being organised at short notice.<br>•Emergency team providing elective work. | **5/5/26:** Series of meeting with all stakeholders commenced to action the approved business case. Aiming to start to providing 8 lists per week from 1/7/26. Currently at 7 lists. risk reviewed and grading to remain the same until July 2026 and then reviewed.<br>**24/07/26:** Risk reviewed with Obstetric Consultant lead. Risk grading reduced from 10 to 6 (3,2) in view of implementation of 8 lists per week since 13th July 26. However, to implement the full business plan, midwifery team and Anaesthetic team recruitment still needs to occur. Currently, the emergency anaesthetic staff are performing 21 pre-op assessments per week in addition to their emergency work load. The aim is for this work to go into a Clinic setting. |
| **2018** | 6 | Ventilator on Portable Incubator | 15/01/24 | N (9-15) | •The control would be that if it was defective that we would need to use the Resuscitaire to move a patient from delivery suite to NICU. This is inadequate, as although it can be pressure controlled, it is a manual form of delivering resuscitation. However, this could not be used to take babies to MRI and Xray department for contrast studies or ultrasounds etc.<br>•9/5/25-We have a Hamilton T1 and MR1 available from critical care if required to use for procedures within the hospital as on same site as radiology now (contrast/scans etc) External transfers done by SONET team | **14/05/2026:** Risk reviewed with GM for women and children: Hamillton portable ventilator has been received and training is in progress. Consumables in MD1 process. Ventilator needs to be secured on to the transport rig- plan being produced to achieve this.<br>**29/07/2026:** Risk reviewed and updated with General Manager for Women and Children. Risk grading to remain the same at present. MD1 process complete. Order placed this week. Training for equipment has already been completed. |

# Risk Register

| Risk ref | Risk rating | Risk description | Opened | Breaching tolerance Y/N | Current mitigation(s) | Additional actions agreed at SDR/ Updates |
|---|---|---|---|---|---|---|
| **2330** | 4 | Safeguarding Children Level 3 compliance in Maternity | 06/05/26 | N (9-15) | • For midwives it has been agreed that the short blended face to face session that is required can now be achieved by attending the safeguarding session on the annual mandatory midwifery update day.<br>• Support secretary reminds midwives when their competency for Safeguarding Level 3 is due to expire and advises that they need to complete the online session prior to attending the Midwifery update day.<br>• Compliance figures are reported at the MatNeo Safety & Quality meeting, clinical leaders, Safeguarding steering group and Safeguarding Trust quarterly meeting.<br>• The Clinical Director and rota co-ordinator and admin manager have been advised of the Obstetric compliance levels, giving names of staff members not compliant and compliance levels. | **14/05/26** Risk discussed at MatNeo Governance and Education meeting, approved at a low 4.<br>**19/08/26:** Risk reviewed with Named Midwife for Safeguarding- grading to remain the same. Mitigations and actions are ongoing |
| **2327** | 4 | Service design of the Maternity Advice Line | 29/04/26 | N (6-10) | • Monthly monitoring of the number of calls<br>• Monthly monitoring of the call answer rate<br>• Admin Line in place (Monday - Friday (0800 - 1600) to reduce the number of admin related calls, freeing the midwife to respond to clinical calls.<br>• Staff on MAL can book patients into the electronic triage diary, allowing for efficient handover and speed of answering other calls.<br>• Calls queue and staff will return patient calls if they drop off. | **14/05/26**: Risk discussed at MatNeo Governance and Education meeting, approved at a low 4<br>**23/06/26** Development of Healthier Together App has commenced<br>- SBARN in progress to recruit a Band 7 Lead (0.5 wte) to support the transformation, development and service redesign of the MAL<br>- Access gained to DCH online diary to allow for swifter communication between MAL staff and DCH<br>**21/9/2026:** Planned go live date for Healthier Together App in October Meeting in place to discuss auditable standards and escalation with DCH Head of Midwifery |

# LERN - Risk: Supporting data
# Health and Safety

**There was 1 Health and Safety (H&S) incidents in September**

| Incident | Apr | May | June | Jul | Aug | Sep |
|---|---|---|---|---|---|---|
| Contact/Collision with Objects/animal | 1 | 0 | 0 | 0 | 0 | 0 |
| Staff accident / fall | 0 | 1 | 0 | 1 | 0 | 0 |
| Patient accident / fall | 0 | 0 | 0 | 0 | 1 | 1 |
| Needlestick (contact with sharps) | 1 | 0 | 0 | 2 | 2 | 0 |
| Splash (blood or body fluids) | 0 | 0 | 0 | 1 | 1 | 0 |
| TOTAL | 2 | 1 | 0 | 4 | 4 | 1 |

**Severity of Incidents for non LFPSE LERNS:**

| | |
|---|---|
| No Harm/Near Miss | 33 |
| Minor | 4 |
| Moderate | 0 |
| Severe | 0 |
| Death | 37 |

**Health and Safety incidents:**

**LFPSE:**

- **L181864** Baby born onto birthing mat on the floor following a rapid birth in a part seated/ part standing position. Midwife delivered baby who slipped a short distance from the midwife's hands to the birthing mat. Duty of candour applied immediately to parents. Baby reviewed promptly by ANNP, dropped baby policy followed and CT scan of baby's head was NAD. Baby and mum were then discharged home.

# LERN : supporting data- reported incidents

**Mat Neo Top 10 reported Incidents:**

| Top Incidents LFPSE related | Apr | May | Jun | Jul | Aug | Sep |
|---|---|---|---|---|---|---|
| Readmission of mother | 5 | 3 | 12 | 10 | 15 | 10 |
| Term baby admitted to neonatal unit | 6 | 11 | 18 | 15 | 13 | 9 |
| Post partum haemorrhage ≥1500ml | 9 | 16 | 16 | 19 | 9 | 8 |
| Readmission of baby | 9 | 7 | 2 | 2 | 2 | 7 |
| Treatment/procedure delayed | 2 | 1 | 3 | 5 | 5 | 6 |
| Failure/insufficient/incomplete monitoring | 9 | 7 | 6 | 8 | 6 | 5 |
| Third/fourth degree tears | 4 | 6 | 3 | 6 | 6 | 5 |
| Failure to administer | 3 | 1 | 1 | | 2 | 5 |
| Incorrect/insufficient handover | 7 | 7 | | | 7 | 4 |
| Transferred for tertiary care | | | 1 | 2 | 1 | 3 |
| Shoulder dystocia | 4 | 7 | 4 | 2 | 3 | 3 |
| Insufficient numbers of healthcare professionals | 1 | 4 | | 4 | 7 | 3 |
| Ambiguous/incorrect/incomplete | 3 | 2 | | | 5 | 3 |

**Maternity Services - Incident Status – Last Six Months:**

| Datix/ LERN forms | Apr | May | June | Jul | Aug | Sep |
|---|---|---|---|---|---|---|
| In the holding area, awaiting review | 0 | 0 | 0 | 0 | 0 | 0 |
| Being reviewed | 69 | 80 | 81 | 88 | 112 | 89 |
| Finally approved | 56 | 64 | 39 | 50 | 51 | 42 |
| **Total number of Datix submissions** | **125** | **145** | **120** | **138** | **163** | **131** |
| New PSII | 0 | 0 | 0 | 0 | 0 | 0 |
| New AAR | 0 | 0 | 1 | 0 | 1 | 0 |
| Action planning meeting | 1 | 0 | 0 | 0 | 0 | 0 |
| Ongoing investigations | 2 | 2 | 2 | 2 | 2 | 2 |
| **Total number of PSIRF investigations** | **2** | **2** | **3** | **2** | **3** | **3** |

**Mat Neo Top 3 reported incidents for September:**

1. Readmission of mother = 10 (Hypertension x4, Sepsis with unknown origin x2, mastitis x1, cellulitis x1, mental health support x1, blood patch x1) - Postnatal rapid access clinics launched on 21st Sept 26. These run twice a week.
2. Term baby admitted to neonatal unit = 9 (see slide 19)
3. Post partum hemorrhage >1500mls = 8 (see slide 8)

# LERN - Risk: Mat Neo Medication Incidents

| | Apr | May | June | July | August | Sept |
|---|---|---|---|---|---|---|
| Administration to Patient | 8 | 9 | 2 | 3 | 4 | 9 |
| Delivery Processes | 0 | 0 | 0 | 0 | 0 | 0 |
| Storage Processes (in pharmacy or on unit) | 1 | 0 | 0 | 0 | 0 | 2 |
| Other | 0 | 0 | 0 | 1 | 0 | 1 |
| Prescribing Processes | 2 | 1 | 1 | 0 | 3 | 1 |
| Procurement/Supplier Processes | 0 | 0 | 0 | 0 | 0 | 0 |
| Dispensing Processes | 0 | 0 | 0 | 1 | 0 | 0 |
| Medication advice | 0 | 0 | 0 | 0 | 0 | 0 |
| Preparation / Formulation Processes | 0 | 0 | 0 | 0 | 0 | 0 |
| Post Admin Patient Monitoring | 0 | 0 | 0 | 0 | 0 | 0 |
| Total | 11 | 10 | 3 | 5 | 7 | 13 |

**There have been 13 MatNeo medication incidents in September.**
**Resulting in: No harm/near miss x7, Delay in care/treatment - no harm x 3, Delay in care/treatment x3**

**9 – Administration errors to Patient (7 NICU, 1 Mulberry PNW):**
L180686 – Delayed Vancomycin dose to a woman with presumed sepsis due to delayed IV access on Mulberry (delay in care/treatment)
L181482 – Missed administration of Caffeine on NICU (delay in care/treatment)
L181413 – Missed administration of Caffeine on NICU (delay in care/treatment)
L182091 – AN enoxaparin not prescribed and administered when indicated from ANC
L181613 – IV fluids administered over a long period: fluids found to have been 5 hours out of date administered to a baby on NICU
L181148 – 1 dose of Gentamycin missed due to ongoing emergency in NICU
L180592 – 1 dose of Vancomycin delayed 2 hours due to missing drug cupboard keys on NICU
L180558 – Too little Acyclovir given through an IV line on NICU
L180390 – Nebuliser not administered to a baby as prescribed on NICU
**2 – Storage process**
L181945 – Milk room door jammed, room and freezer insecure and door propped open.
L180523 – Milk fridge switched off at wall
**1– Prescribing process**
L181887 – Folic acid prescribed as 50mg instead of mcg.
**1 – Other**
L181845 – Incorrect giving set used for TPN and lipids while on NICU

# Learning & Key Safety Messages

## Safety Messages & Learning

Please familiarise yourselves with July's updates to policies which are now live on the intranet:

Management of neonatal head trauma related to birth
Neonatal infant and orthopaedic care SOP
Telephone and triage SOP
Maternity triage SOP
Supporting lactation in the neonatal unit
Tongue tie
Infant feeding policy
Accidental dural puncture
PPH
Weighing neonates
Jaundice in the newborn

### Learning from recent maternity incidents:

Please refer to the below from the 'perinatal investigation of the placenta' policy which details;
Placenta's to keep for 24 hours (in the fridge on Labour Ward) and placentas that require sending to histology.

Placentas to be kept for 24 hours

- Clinical features of maternal and neonatal sepsis
- Unexpected admissions to NICU

Placentas that need to be sent to histology

- Fetal or perinatal death
- Miscarriage (14+0-23+6 weeks gestation)
- Termination of pregnancy for fetal abnormality – if requested by fetal medicine team.

For the above placenta please follow childbearing loss guideline. keep with the baby in the SPRING fridge and then sending with baby.

- Preterm birth <32 weeks
- Fetal growth restriction (birthweight <3rd centile or drop on growth velocity >2 quartiles or >50 percentiles).
- Fetal hydrops
- Either cord pH of <7.0
- Clinical features of maternal or neonatal sepsis
- Massive placental abruption
- Monochorionic twins with TTTS
- Prenatally diagnosed or macroscopically identified placental abnormality or umbilical cord anomalies

Please auscultate the fetal heart with a sonicaid or pinard prior to commencing *ALL* CTGs, this is in line with NICE guidance.

Please submit a LERN for all impacted fetal head emergencies as this is now a maternity trigger.

ICE must be used for all blood tests requests and PDA for group and saves, if you do not have access, please refer to recent email communication sent regarding this.

We now have evacuation cribs located in the fire exit stair wells, please scan this QR code to view a step-by-step video on how to use them.

Please treat high CO readings in the same way as you would a high BP. If a woman reports, she is a non-smoker and blows a CO of 4 or more this triggers a referral or re-referral to the SIP team.
Consent does not require to be sought for this.

MOH co-ordinator

- Please do not take on any other responsibility during an active MOH when you are allocated the role of the MOH co-ordinator until the emergency has been stepped down.
- Remember to follow the protocol of;
- 2222 to initiate the MOH emergency
- 5555 to alert transfusion
- 2222 to inform the porter where to attend (eg theatre to collect blood samples or transfusion to collect blood products)

Continue to use the MOH proforma as a visual prompt during an ongoing MOH.

Referrals for mental health support will now be through the new LOTUS maternal wellbeing clinic being run jointly with Juneida Khodabocus and Emily Seddon.

## What we did well

We often see outstanding care during reviews and feed these back to indivdual staff via the trusts 'thank you' cards.

Congratulations to Rachael Cole who has been successfully appointed to Antenatal Clinic Lead.

Congratultions to Lauren Govier for starting her commencing her ACP role.

Warm welcome to Amy Stubbs our new Director of Midwifery who has commenced a handover period in September.

Congratulations to the neonatal team who have been recognised as a national high performer for parental involvement on ward rounds.

Bookings by 10 weeks at 74% national target is 65%, well done community.

*All these safety messages have come from learning from LERN incidents reported and reviewed by maternity staff, including Serious Incidents, External Investigations and Perinatal Mortality Reviews.*

Communicate - Say it, hear it, do it! Improve - Change it! Teamwork - Share it! Pride - Show it!

We are caring one team listening to understand open and honest always improving inclusive

# Perinatal Quality Surveillance - Neonatal

## True North: Quality

## Babies born <27/40

### Background:

UHD Maternity has a Level 2 Neonatal intensive care unit (NICU).

Therefore, UHD are not equipped to care for babies that are ≤27 weeks' gestation (singleton), <28 weeks (multiple pregnancy)/ ≤800g at any gestation. These babies should be cared for in a Tertiary (level 3) centre.

The Trust reviews and sends an Exception reports to the Neonatal Operational Delivery Network for any babies meeting this criteria that are born in UHD, as this is identified as not being in the optimum place to birth.

### September 2026:

There were 0 births <27 weeks' gestation in September 2026.

Pre-term optimisation review group (PORG) meeting continues to meet monthly  to review all pre-term births. Learning from these reviews are being shared to all staff. With actions being assigned.

# Antenatal Screening

## Antenatal Screening

We had no serious antenatal screening incidents in September.

**SCT Programme**
We offered testing of another biological parent to 12 families this month. We had two high chance women where the other biological parent was not available to screen. Both women declined an invasive procedure and a high risk family form was completed for the screening lab in Portsmouth

**IDSP**
We had just one known positive screen for Hepatitis B in September. We had two women decline infectious disease screening who will be formally reoffered it at their anomaly scans as per the pathway.

**FASP**
We had nine higher chance first trimester screens in September. Four have had lower chance NIPT results, two has declined any further testing, two opted for an invasive test one of which was negative and one is awaiting the result, and one made the difficult decision to interrupt the pregnancy after abnormalities were seen on scan.

**ADVISE**
Current vacancy for a Fail Safe Officer. Interviews are on 14th October and the work is being undertaken by the Screening Coordinators and teams in the meantime.

# Newborn Screening

## Newborn Screening

There were no serious Postnatal Screening incidents in September 2026.

## NIPE  (Newborn Infant Physical Examination)

There were no NIPE screening incidents in September.

## NBS (Newborn Blood Spot Sampling)

There were no NBS incidents in September.  There were 5 NBS avoidable repeats, however, 2 of them had been taken in another unit.

## Infectious Diseases Pathway

There were no Infectious diseases reportable incidents in September.  2 babies were born to a Hep B positive mothers, and the correct pathways were followed.

## Newborn Hearing Screening

There were no newborn hearing screening incidents to report for September 2026.

# Listening to Women and Families



We are caring one team listening to understand open and honest always improving inclusive

# Service User Feedback

| 2026 CQC Maternity Survey Main Areas of Focus: |
| --- |
| Midwives to provide relevant information about feeding the baby during pregnancy. |
| To ensure during labour and birth, service users are involved in decisions about their care. |
| To ensure birth supporters are involved in care during labour and birth, as much as they want to be. |
| To ensure advice about feeding baby is available during evenings, nights and weekends once service users have been discharged home. |
| To ensure service users receive the help and advice from a midwife about feeding their baby, in the 4 weeks after birth, once at home. |
| To give enough information to service users on the physical recovery after birth, once at home. |
| Midwives to give enough support and advice on feeding the baby postnatally. |
| At the postnatal check-up (around 6-8 weeks after the birth), GP's to spend enough time talking about service users own physical health. |
| To ensure service users are able to get a member of staff to help when needed postnatally. |
| To ensure service users are given information about any changes they might experience to their mental health after having a baby. |
| To ensure service users are given the information or explanations needed while on the postnatal ward. |

Survey results and action plan to be shared at Clinical Leaders and Education and Governance in October.

Monthly meetings with staff and MNVP to progress action plan.

# Complaints September 2026

| New Complaints Received | Themes |
|---|---|
| 6 | • Challenges with booking of elective caesarean section.<br>• Cleft palate missed<br>• Concerns about position of baby identified at scan<br>• Concerned that medical notes were falsified<br>• IOL, ANW and PNW – communication challenges and concerns about IPC X2 |
| **Concerns/PALs 5** | Patient contacted PALS as elective caesarean not yet booked.<br>Patient admitted to ANW requesting information re delay in transfer to Woodlands for ARM.<br>Query whether placenta had been sent for testing.<br>Patient requesting Birth Afterthoughts appointment.<br>Patient requesting medical certificate regarding clinical advice not to fly. |

**2 Complaints closed in September:**

- Concerns regarding gynaecological referrals for a fibroid – care was appropriate.
- Concerns about call bell not working on labour ward, staff on PNW not kind, feeding support minimal and food trays and bloodied sheets left on the bed.

**Currently 13 open complaints:**

Maternity matron's attend a monthly maternity specific complaints meeting and monthly care group complaints meeting to monitor progress and timeframes. HOM attends trust patient experience group.

# Litigation

## Litigation and Inquests:

### Claims and Inquests Activity Summary for Sept 2026

**Current Position**
34 open claims
1 open linked claim (primary specialty Radiology)
6 open ENS
3 open inquest files

**Activity in September**
0 new claims received
0 claims damages agreed
0 claim closed
1 new ENS (reopened)
0 ENS damages agreed
0 ENS closed
0 Inquest opened

**Claims activity**
There were no new or closed claims in September

*See Appendix 3 Q2 MatNeo Claims and Inquests Report*

# Litigation

## Litigation and Inquests:

**Claims and Inquests Activity Summary for September 2026 continued.**

**3 x open Inquest files:**

**INQ2425/102P** – High risk mother moved to Birth Centre where continuous monitoring was discontinued. Delay in identifying abnormal heartrate and delay in delivery. Baby admitted to NICU but passed away at 3 days of age. Linked to incident L135383. Inquest to be heard over 5 days from 2 – 6 November. Midwifery and obstetric staff have been called. External legal representation has been commissioned.

**INQ2526/074B** - a Neonatal death following a court order for the withdrawal of treatment. The baby had been delivered in ED via perimortem Caesarean Section at 32+5 weeks following the mother suffering a cardiac arrest. An inquest has now been formally opened, and statements are about to be requested from key staff. A Pre-Inquest Review Hearing has been listed for April 2027.

**INQ2526/159P** - a Neonatal death at 10 days of age in the community. Linked LERN L147599. The inquest is due to be heard on 26 January 2027.

# Service User Feedback

NHS
University Hospitals Dorset
NHS Foundation Trust

## The Friends and Family Test

**C24L**

Thinking about your recent visit to our hospital, overall, how was your experience of our service?

| Month | Number of responses | Experience 'Good' |
|---|---|---|
| September 2026 | 113 | 79.6% |




| | |
|---|---|
| Very good | 69.0% |
| Good | 10.6% |
| Neither good nor poor | 7.1% |
| Poor | 4.4% |
| Very poor | 8.8% |
| Don't know | 0.0% |

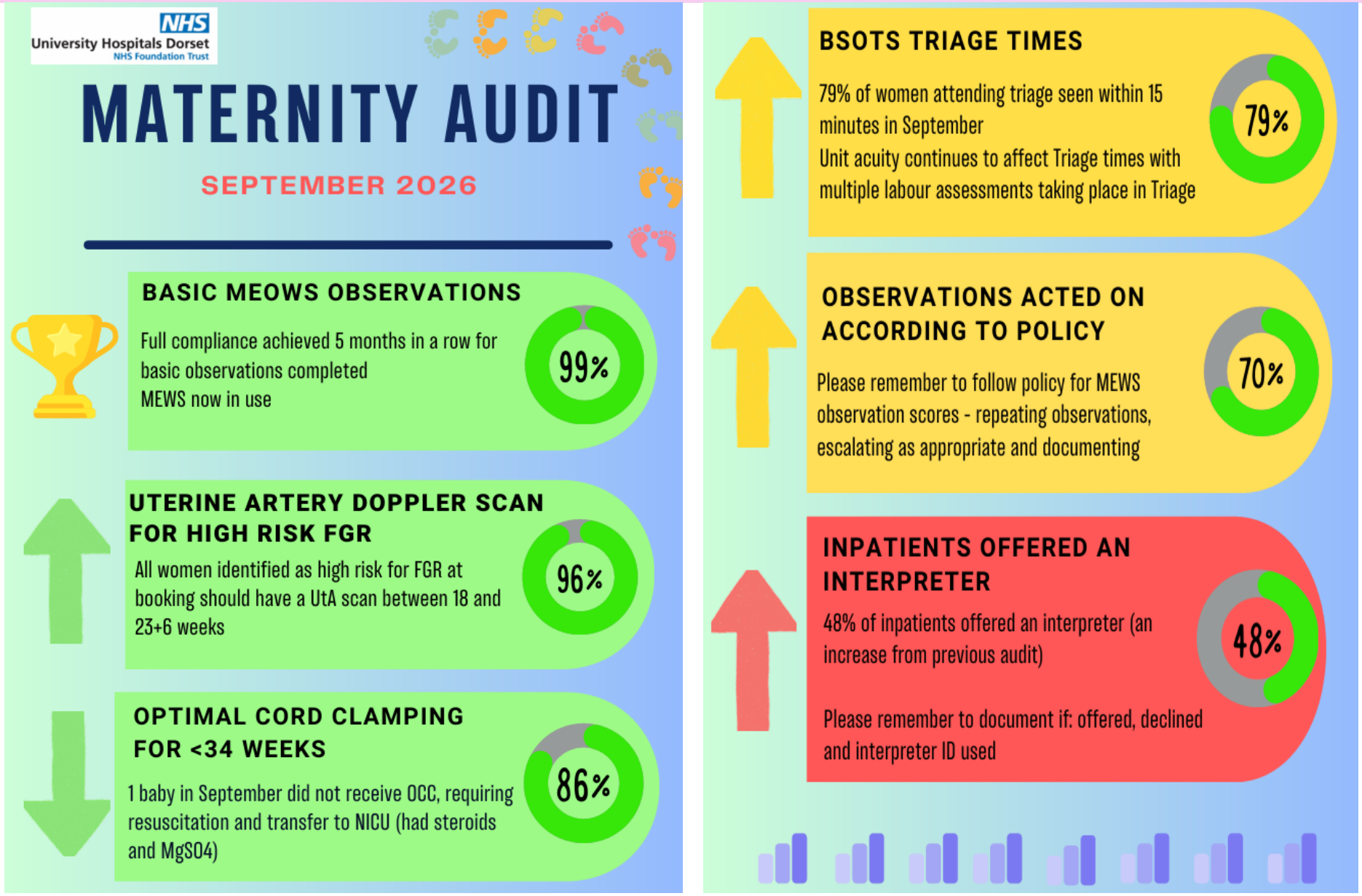
Friends and Family "Good" rating has reduced monthly:

May 90.9%
June 87.6%
July 86.5%
August 84.7%
September 79.6%

Plan to review last 3 months data in detail for concerning themes and share with clinical leaders in October and add actions to patient experience action plan.

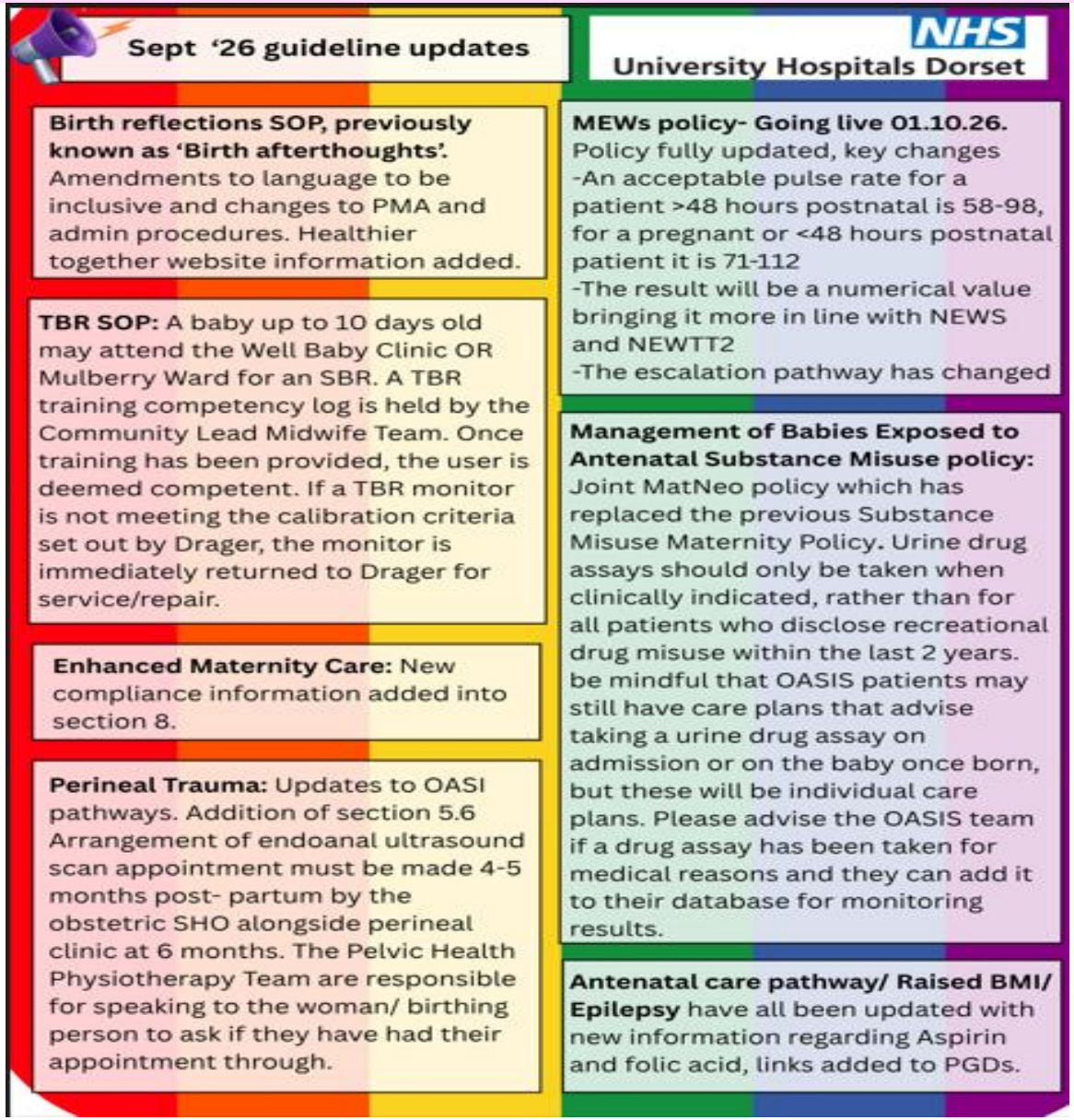
| Feedback comments |
|---|
| Absolutely amazing, including the c section, staff and room we stayed in, the staff were all amazing and the c section they made me feel at ease and the room was brilliant, couldn't fault anything |
| After a worry about baby movements the team were able to answer my call quickly with kindness, booked me an immed[illegible]tment and see me within an hour of my initial call. The lovely ladies on the ward treated me with such kindness and understanding and they were able to reassure me and answer all of my questions. I couldn't thank them enough for the reassurance and the way they made me feel that morning. |
| Felt like my induction wasn't great and I got left waiting around for ages before actually being able to move to the labour ward. I stayed 2 nights prior to moving to the labour ward and didn't really get given much update as to what was going on. |
| From going into labour and delivery and having my c section to leaving all of the staff were amazing. They were all so kind and reassuring. They were all polite and reallly helpful. Both the labour and delivery and the room in acorn ward were very clean and comfortable |
| I ended up having a second emergency c-section which I was really upset about but the team were fantastic. Told me I'd done everything possible to get my baby out naturally but it was now a matter of urgency. After the operation I was moved to a private room where me and my husband were able to stay and I was well tended to and looked after by a fabulous team. |
| The appointment was very delayed but when I was seen the consultation was patient centred. |

# Quality – Audit




Interpreter Audit results being shared at Education and Governance meeting on 15th October 2026 for wider discussion and creation of action plan. Immediate reminder to staff via risky business and QUAD messages.

# Guideline Updates – September 2026



# Quality - Infection Prevention Sep 26
# Hand Hygiene

| Area % | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ANC | 96.6 | 100 | 100 | 100 | 100 | NS | NS | 100 | 100 | 100 | 100 | NS | 100 |
| Triage | 100 | 100 | 100 | 75.9 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 |
| Aspen | NS | 96.7 | 96.6 | 96.6 | 100 | NS | 96.7 | 100 | 100 | 100 | 100 | NS | NS |
| Woodland | 95.2 | 93.1 | 82.4 | 93.3 | 100 | 96.4 | NS | 95 | 95 | 95 | 95 | 100 | 95 |
| Haven | 90.9 | 89.5 | 90 | 94.3 | 87.5 | 71.4 | 93.3 | 100 | 100 | 95 | 100 | 100 | 100 |
| Mulberry/ Acorn | 100 | 100 | 100 | 80 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | NS | 100 |
| Comm Hub | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 |
| NICU | 95 | NS | 100 | 100 | 100 | 93.3 | 93.3 | 100 | NS | NS | 85 | 85 | 90 |

Non submission and data quality to be discussed at clinical leaders in October.

# Quality public health - Infant Feeding

## Breastfeeding Initiation (Counts of babies) data for last 6 months:

| Month | Number of livebirths | Number of babies with BF initiated within 48 hours | % of babies with BF initiated within 48 hours | Number of babies with BF initiated | % of babies with BF initiated | Number of babies with BF not initiated | Number of babies who tried to feed when BF was not initiated | Number of babies with no BF initiation questions answered |
|---|---|---|---|---|---|---|---|---|
| Apr-26 | 300 | 257 | 85.7 | 266 | 88.7 | 27 | 0 | 7 |
| May-26 | 306 | 260 | 85 | 271 | 88.6 | 32 | 2 | 3 |
| Jun-26 | 330 | 272 | 82.4 | 286 | 86.7 | 37 | 0 | 7 |
| Jul-26 | 342 | 292 | 85.4 | 301 | 88 | 33 | 3 | 8 |
| Aug-26 | 335 | 269 | 80.3 | 283 | 85.7 | 38 | 0 | 12 |
| Sep-26 | 348 | 283 | 81.3 | 291 | 83.6 | 40 | 2 | 17 |
| **Total** | **1961** | **1633** | **83.3** | **1703** | **86.8** | **205** | **7** | **51** |

## Women breastfeeding at UNICEF checkpoints – September 2026:

| UNICEF checkpoint | Number with applicable note type | Had a full feeding assessment | Breastfeeding at checkpoint | % Breastfeeding at checkpoint | % Having assessment and breastfeeding at checkpoint |
|---|---|---|---|---|---|
| Transfer to Community | 331 | 252 | 263 | 79.46 | 79.76 |
| Transfer to Health Visitor | 208 | 81 | 152 | 73.08 | 75.31 |
| Feeding on Day 10 | 189 | NA | 125 | 66.14 | 0 |

# Quality public health - Infant Feeding

UNICEF BFI updates:

- Proposed Stage 2 assessment Spring of 2027 (date not yet agreed)
- Staff Trained to date:
  - Midwives - 49%
  - MSW: 65%
- Medical staff training planning in progress
- Concerns regarding meeting auditing targets for stage 2 – senior team aware
- 3 feeding champions undertaking UNICEF auditing training
- Specialist infant feeding clinic underway
- New Ferndown feeding classes have had significant uptake



Infant feeding general progress:

- New feeding charts created and approved by patient information team. Awaiting equipment for PNW rooms.
- Breast pump trial underway until end of October 2026
- BfN peer supporter has started – positive feedback from staff and families.
- BEAT/Green-brain infant feeding e-learning delayed due to pressures within BEAT team
- In response to CQC infant feeding results, we are working on an AN feeding conversations schedule and improved advertising of feeding classes

# Quality - Smoking in Pregnancy

| | Target Percentage | Sep-26 | Aug-26 | Jul-26 | Jun-26 | May-26 | Apr-26 | Mar-26 | Feb-26 | Jan-26 | Dec-25 | Nov-25 | Oct-25 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 5.79 | 4.45 | 3.03 | 6.79 | 6.40% | 5.10% | 6.87% | 7.90 | 3.93 | 6.92% | 6.66% | 7.37% |
| CO measurement at booking appointment | min 90- stretch 95% | 93.60% | 99.00% | 95.90% | 92.90% | 93.30% | 91% | 78.80% | 83.30 | 92.1 | 96.70% | 96.50% | 96.20% |
| CO measurement at 36-week appointment | min 80- stretch 95% | 95.80% | 97.80% | 94.60% | 96.10% | 95.20% | 94% | 87.40% | 92.80 | 94.9 | 99.00% | 98.00% | 96.90% |
| Smoking status** at booking appointment | min 80- stretch 95% | 100.00% | 100.00% | 100.00% | 99.70% | 100.00% | 100% | 100.00% | 100.00 | 99.8 | 100.00% | 99.70% | 99.70% |
| Smoking status** at 36-week appointment | min 80- stretch 95% | 100.00% | 100.00% | 91.30% | | 100.00% | 100% | 100.00% | 100.00 | 95.45 | 100.00% | 100.00% | 95.63% |
| Smokers* that have an opt out referral at booking to an in-house/in reach tobacco dependence treatment service. | min 90- stretch 95% | 94.70% | 100.00% | 100.00% | 88.00% | 84.20% | 94% | 84.60% | 96.30 | 93.3 | 96.00% | 95.80% | 96.15% |
| Smokers* that are referred for tobacco dependence treatment who set a quit date. | min n/a- stretch 60% | 68.18% | 52.94% | 56.52% | 64.71% | 62.50% | 46% | 65.00% | 68.75 | 60 | 70.00% | 63.63% | 74.07% |
| Smokers* at antenatal booking who are identified as CO verified non-smokers at 36 weeks. | 30% | 54.55% | 23.53% | 78.26% | 94.74% | 46.67% | 47% | 58.60% | 60.00 | 41 | 54.55% | 63.34% | 58.30% |
| Smokers* that set a quit date and are identified as CO verified non-smokers at 4 weeks | min 50- stretch 60% | 86.67% | 37.40% | 84.62% | 72.73% | 70.00% | 83% | 82.00% | 72.73 | 66.7 | 92.86% | 71.42% | 60.00% |
| Women who have documented evidence of immediate feedback to their named maternity healthcare professional when a woman does not book or attend appointments with in house tobacco dependence treatment service. | 85% | 85.71% | 86.67% | 90.00% | 80.00% | 100.00% | 89% | 92.00% | 100.00 | 100 | 93.75% | 100.00% | 86.95% |
| Percentage of staff with in-date training compliance on the use of CO testing and discussion of results. | min 90- stretch 95% | | 95.35% | | | 95.60% | | >90% | 93.22 | >90 | 92.43% | 94.96% | 92.44% |
| Percentage of maternity staff with annual in date training compliance on the delivery of VBA making an opt out referral and maternity pathway processes. | min 90- stretch 95% | | 95.35% | | | 95.60% | | >90% | 93.22 | >90 | 96.35% | 94.96% | 92.44% |
| Individuals delivering tobacco dependence treatment interventions who are fully trained to NCSCT standards | min 90- stretch 100% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100% | 100.00% | 100.00 | 100 | 100.00% | 100.00% | 100.00% |
| Pregnant people not smoking at delivery | 94% | 96.84% | 96.30% | 97.98% | 97.73% | 94.15% | 96.99% | 97.45% | 97.15 | 94.73 | 96.88% | 97.14% | 95.50% |
| Pregnant people smoking at delivery | 6% | 3.16% | 3.97% | 2.06% | 2.47% | 3.85% | 3.01% | 2.55% | 2.85 | 5.27 | 3.22% | 2.86% | 4.50% |

**Alert:** We have noted a drop off in smokers being streamed in to the risk perception clinic. Number of smokers we would expect vs numbers seen in clinic doesn't correlate. Admin have reported that there was low awareness of this and therefore will now take this as an action going forward.

**Advise:** Poor compliance last month appears to have been erroneous, when reviewing results from same period last year also an erroneous period where targets not met. Need to look at potential reasons why timing in year is an issue, would correlate with Post- New year as data collected at delivery. To discuss with team how to prevent this happening next year, as otherwise meeting targets fairly consistently.

**Assure:** UHD to take up Significant Offer bolt on of NSPIS scheme, enabling us to provide the incentives programme to partners of smokers. This has been noted to increase quit uptake and success. Discussions to provide basic SiP training with staff member in Aspen, to facilitate provision of wider NRT products to smokers and to improve awareness of smoking and vaping for inpatient staff.

# Key Dates

**September 2026**

- Tuesday 1 September – Quality Committee
- Thursday 3 September – Staff Listening Event (PROMPT)
- Friday 4 September – Amy Stubbs onsite for second shadow day with Lorraine Tonge
- Monday 7 September – People & Culture Committee
- Tuesday 8 September – MIS Auditor onsite, Mark Stabb
- Wednesday 9 September – Board of Directors
- Thursday 10 September – Staff Listening Event (Midwife Update Day)
- Wednesday 16 September – Mat Neo Clinical Leaders Meeting
- Monday 21 September – Amy Stubbs first day (Director of Maternity and Neonatal Services)
- Tuesday 22 September – CQC/BCP Safeguarding Visit to RBH
- Wednesday 23 September – Safety Champions Walkaround – ANC & RBH Community
- Friday 25 September – Deadline for Submission A Evidence for Amos & Ockenden 10 Point Plan
- Monday 28 September – Regional D/HoMs Meeting, Taunton
- Wednesday 30 September – Lorraine Tonge's last day & Goodbye Event

**October 2026**

- Tuesday 6 October – Quality Committee
- Tuesday 13 & Thursday 15 October – Birthrate Plus Acuity App refresh training
- Wednesday 14 October – SW Perinatal Conference, Taunton
- Thursday 15 October - Safety Champions Walkaround – Triage & ANW
- Wednesday 21 October – Mat Neo Clinical Leaders Meeting

# Maternity and Neonatal Escalation Report

NHS University Hospitals Dorset NHS Foundation Trust

## ALERT

1. Significant concerns re access to a second emergency obstetric theatre. This is causing a delay to Cat 2 caesarean sections and was raised as a concern from the obstetric team, anaesthetists and theatre leads – A3 currently being produced and to be further escalated to Lorraine Tonge and James Balmforth for oversite.
2. Upcoming BEACH generator work and impact on safe service provision. Lorraine Tonge has escalated already through care group and to execs for support with further decisions.
3. Reaudit of consultant attendance out of hours as compliance less than 80% - achieving this target is a MIS requirement.

## ADVISE

1. Theatres have introduced raspberry ,coloured scrubs for birth supporters – making non-clinical people easy to identify.
2. Apgar Scores less than 7 – Peter McEwen to lead on this piece of work but acknowledged that obstetric as well as midwifery input required. Action plan to be shared at CGB in September.
3. Planned training with Fetal Medicine team on Vasa Praevia awareness for all Sonographers.
4. Adapting PPH Proforma further with stakeholder support -

## ASSURE

1. MOH numbers above 2 litres are reducing – indicating that the training provided has resulted in reducing the amount of blood loss experienced.
2. Community Midwives – bookings before 9 weeks for August 80.5 which is the highest figures compliance to date – this data is outstanding.

# Celebrations



We have welcomed Amy Stubbs as our new Director of Maternity and Neonatal Services.



Helen Preece has taken over as our new Obstetric Lead Consultant and is now a vital member of the QUAD.

*Congratulations to our Research Team:*

*Following the launch of the NHS evaluation programme on 1 October 2026, over the next year babies born across England will begin to receive screening for spinal muscular atrophy (SMA) as part of the routine newborn blood spot test (heal prick test). SMA is a genetic disease that destroys the nerve cells in the brain and spinal cord which control movement.*

*The research midwives at University Hospitals Dorset played an important role in helping to advance this. Working with Oxford University and the Newborn Screening Laboratory at Queen Alexandra Hospital, Portsmouth, they recruited more than 2750 local families to the SMA-NBS study over a 14 month period. This showed SMA screening can be successfully included in the routine NHS newborn blood spot test and provided valuable evidence on how babies can be diagnosed before symptoms appear, giving them access to life-changing treatment at the earliest possible opportunity.*

*The SMA-NBS study helped inform the work of the UK National Screening Committee, contributing important data on screening accuracy, laboratory processes, referral pathways and family support services. The importance of this extra test has been further publicised by the singer Jesy Nelson whose children both have SMA.*



Two amazing celebrations captured in one photograph – the start and end of a midwifery career.

Lorraine Tonge our Director of Midwifery and Neonatal Services retired after 29 years of NHS service.

Our 3rd year student midwives have celebrated completing their training with many of them securing jobs at UHD.

# Celebrations



September
MatNeo
Stars of the
month.



***Jess McNally*** **is one of our Maternity Support Workers, mainly working on Woodlands Labour ward and Aspen Antenatal ward. She was nominated by her colleagues as she is always hard working and helpful. She is a good leader supporting other staff and uses her initiative on shift. Her colleagues describe her as friendly, funny and caring. She is often the first to offer help, which is appreciated and noted by the team. Jess is "amazing" and the team feel they would be lost without her. Jess's colleagues appreciate how pleasant it is to work with her and that she is always proactive with her work.**

***Cherie Wells*** **is our Obstetric Administration Manager in Mat Neo. Her colleagues nominated her because they felt she goes above and beyond to ensure tasks are completed, with nothing ever being too much trouble. She has been recognised for the extra work she has taken on board during staff shortages and the clerical team moving to the new Tringham building, achieving the demands of these roles alongside her own work responsibilities. Her colleagues want to thank her as they feel they would be completely lost without her. Her colleagues felt that Cherie consistently puts the needs of the team first and is a huge support, especially during the recent busy months and during a significant period of change. Cherie was nominated because when the team need her, she is there getting involved, working additional shifts to cover gaps in the service and giving up her own time to make sure staff feel supported. The team felt that Cherie genuinely cares about her colleagues and the wider Mat Neo team and service and is approachable and reliable, like the star she is!**

# Appendices

Appendix 1: Q2 PMRT Board Report

Q2 PMRT Board Report

Appendix 2: PMRT grading of care

PMRT Grading of Care

Appendix 3: Q2 MatNeo Claims and Inquests Report

Q2 MatNeo ms and Inquest Re

# Glossary

ANC – antenatal clinic
ANDA – antenatal day assessment
ATAIN – avoidable term admissions in NICU

BBV – blood born viruses
BNFC – British national formulary for children

CCU – critical care unit
CO – carbon oxide
CPCP – continuous positive airway pressure
CS – caesarean section - ELCS (elective caesarean section)

Diis – Dorset intelligence & insight survey

FTE- full time equivalent

HV/GP – health visitor/general practitioner

IOL – induction of labour

IMD – indices of multiple deprivation
ITU – intensive therapy unit

LMNS – local maternity and neonatal system
LW – labour ward

MAL – maternity advice line
MEOWS – modified early obstetric warning score
MNVP – Maternity and neonatal voices partnership

NICU – neonatal intensive care unit
NIPT – non evasive prenatal testing
NNST – newborn blood spot screening test
NNU – neonatal unit

OASI – obstetric anal sphincter injury
OPD – outpatients department

PEEP – positive end expiratory pressure
PMA – professional midwifery advocate
PMRT – perinatal mortality review tool
PPH – postpartum haemorrhage
PRMPT – practical obstetric muti professional training
PSII – patient safety incident investigation
PSIRF – patient safety incident response fame work
PUPPS – polymorphic eruption of pregnancy

RDS – respiratory distress syndrome

SBR – total bilirubin
SBAR – situation, background, assessment and recommendation
SBL – saving babies lives
SIAF – screening incident assessment form
STEIS – strategic executive information system

TCU – transitional care unit
TRIM – trauma risk management
TTN – transient tachypnea of the newborn

# YOU MAY SEE OUR BOARD SAFETY CHAMPIONS ON THEIR WALKABOUTS TO MEET STAFF



Michael Marsh

Non-Executive Director



Sarah Herbert
Chief Nursing Officer



Dr Peter Wilson
Chief Medical Officer

## Board safety champions

