



Maternal and Neonatal Health Safety Collaborative

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North West Coast Patient Safety Collaborative

What is the aim?

To improve the safety and outcomes of maternal and neonatal care by reducing unwarranted variation and provide a high quality healthcare experience for all women, babies and families across England

What is the ambition of the collaborative?

By 2020 each trust and local maternity system should have:

- significant capability (and capacity) for improvement
- detailed knowledge of local cultural issues
- developed a local improvement plan
- made significant improvement to local service quality and safety
- data to share with their board, staff and commissioners that reflect these improvements

...to create the conditions for a safety culture and a national maternal and neonatal learning system

Aim

Primary Drivers

Secondary Drivers

To improve the safety and outcomes of maternal and neonatal care by reducing unwarranted variation and provide a high quality healthcare experience for all women, babies and families across maternity and neonatal care settings in England

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

Improve the proportion of smoke free pregnancies

Improve the optimisation and stabilisation of the very preterm infant

Improve the detection and management of diabetes in pregnancy

Improve the detection and management of neonatal hypoglycaemia

Improve the early recognition and management of deterioration during labour & early post partum period

Creating the conditions for a culture of safety and continuous improvement

Develop safe and highly reliable systems, processes and pathways of care

Improve the experience of mothers, families and staff

Learn from excellence and harm

Improving the quality and safety of care through Clinical Excellence

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How are the waves structured?

Wave 1

April 2017 – March 2018

- 44 Trusts to form first national learning set
- Supported at national level to enable local delivery
- Wave 1 organisations provide improvement leadership within local learning systems (LLS) with Wave 2 and 3

Wave 2

April 2018 – March 2019

- Further 43 Trusts across England to form second national learning set
- Supported at national and local level
- Wave 1 and 2 organisations to provide improvement leadership within LLS with wave 3

Wave 3

April 2019 – March 2020

- Remaining 46 Trusts to form third national learning set
- Supported at national and local level
- LLSs continue to mature and:
 - sustain improvements
 - build QI capability
 - explore new priorities

How are the meetings structured?

National Learning Event

- Annual progress and learning shared from active wave organisations – scale up

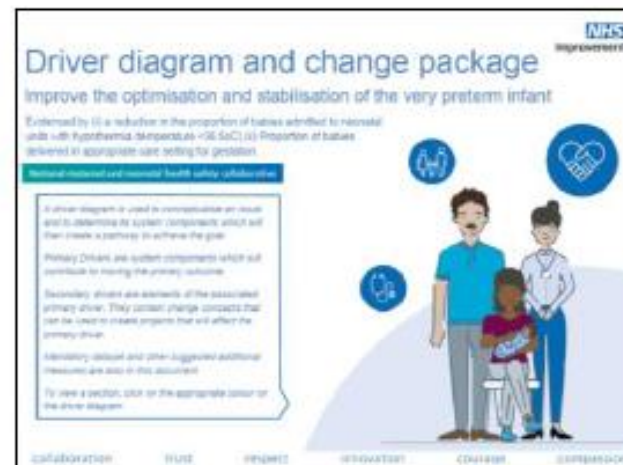
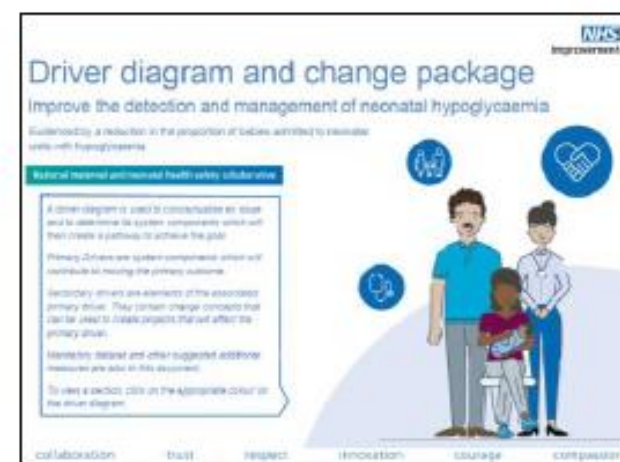
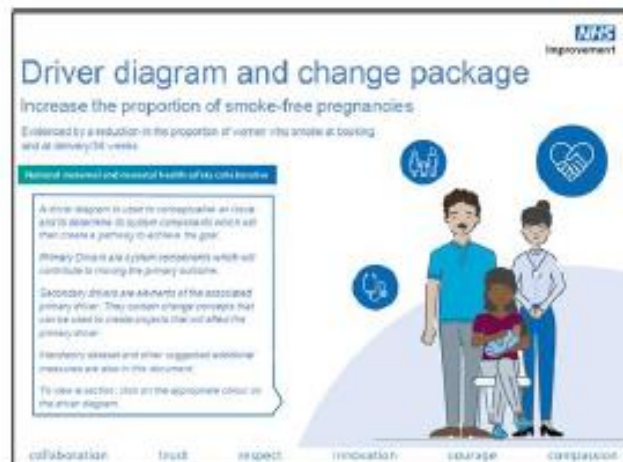
National Learning Set

- Three x 3-day training and support meetings for Trust based local improvement leads
- Engagement with board level safety champions (executive sponsors)
- Tailored unit level support by central programme team

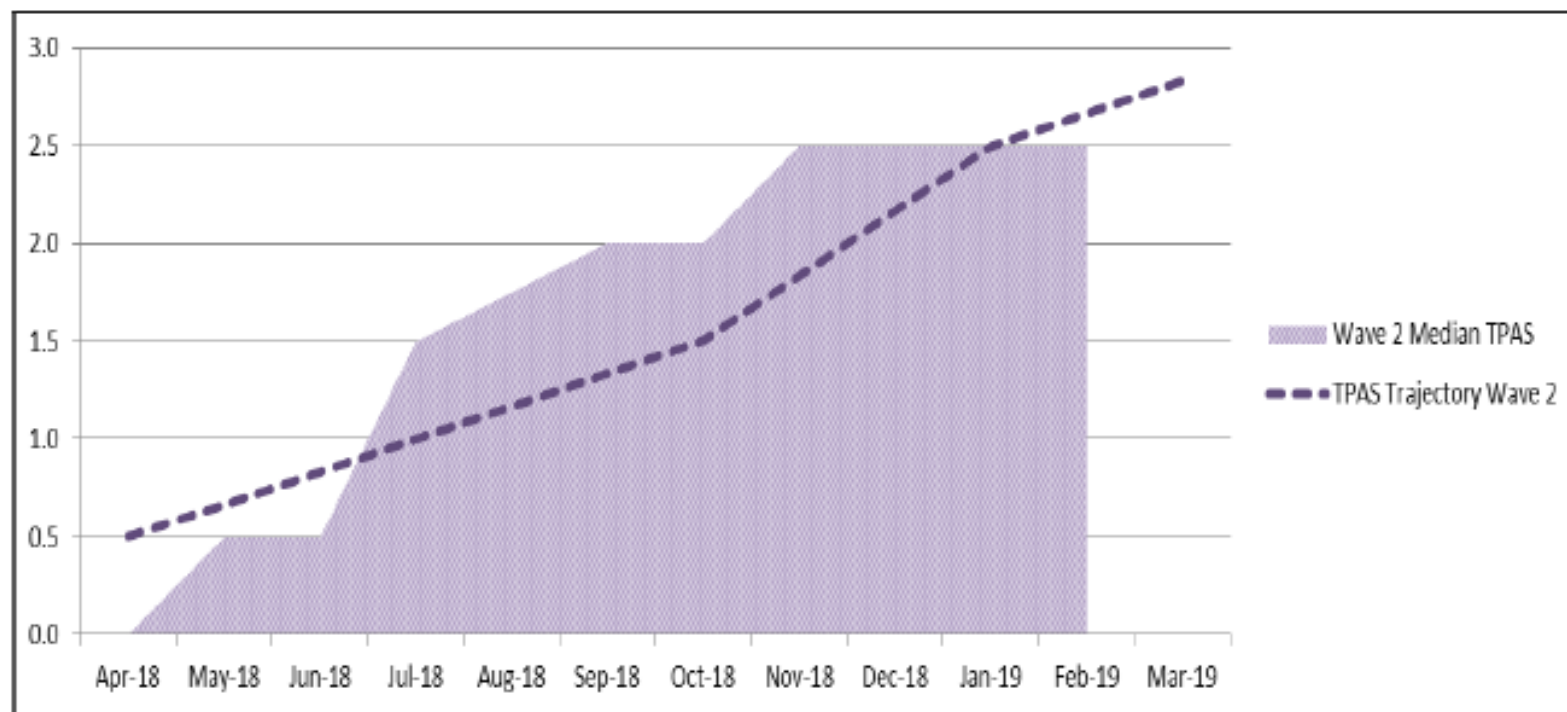
Local Learning Systems

- Quarterly meetings
- Facilitated by the Patient Safety Collaboratives
- Supported by all stakeholders
- Bring together all organisations and professional groups including commissioners and parents/families

Change Packages and Measures



Wave 2 Trust Progression Assessment Scores (TPAS)

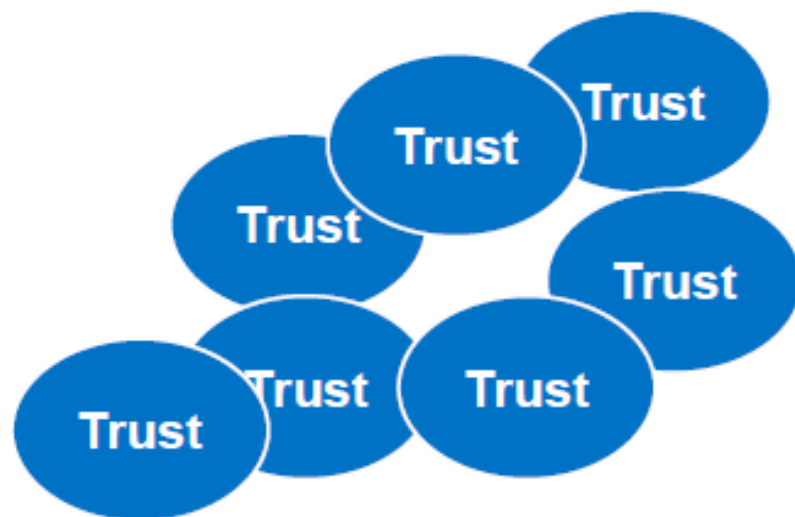


Reporting Table

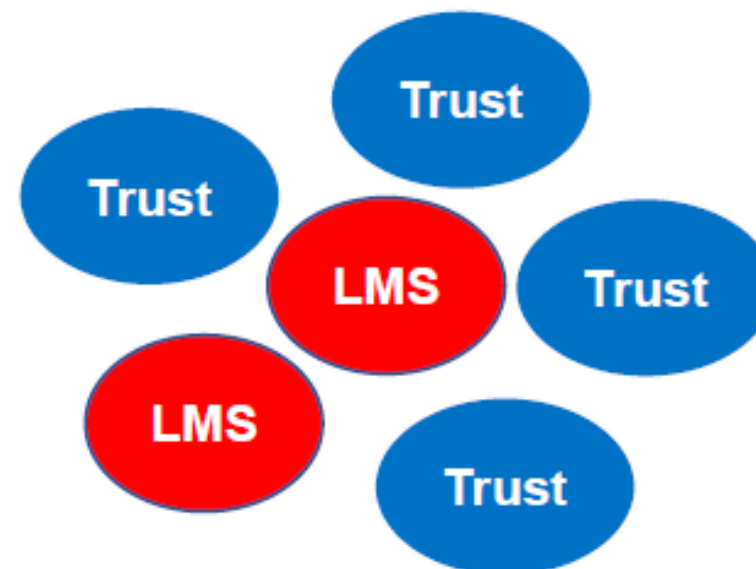
Score	Description
0.5	Intent to Participate
1.0	Charter and team established
1.5	Planning for the project has begun
2.0	Activity, but no changes
2.5	Changes tested, but no improvement
3.0	Modest improvement
3.5	Improvement
4.0	Significant improvement
4.5	Sustainable improvement
5.0	Outstanding sustainable results

Improvement at multiple levels

National Learning Set (Trust Improvement)

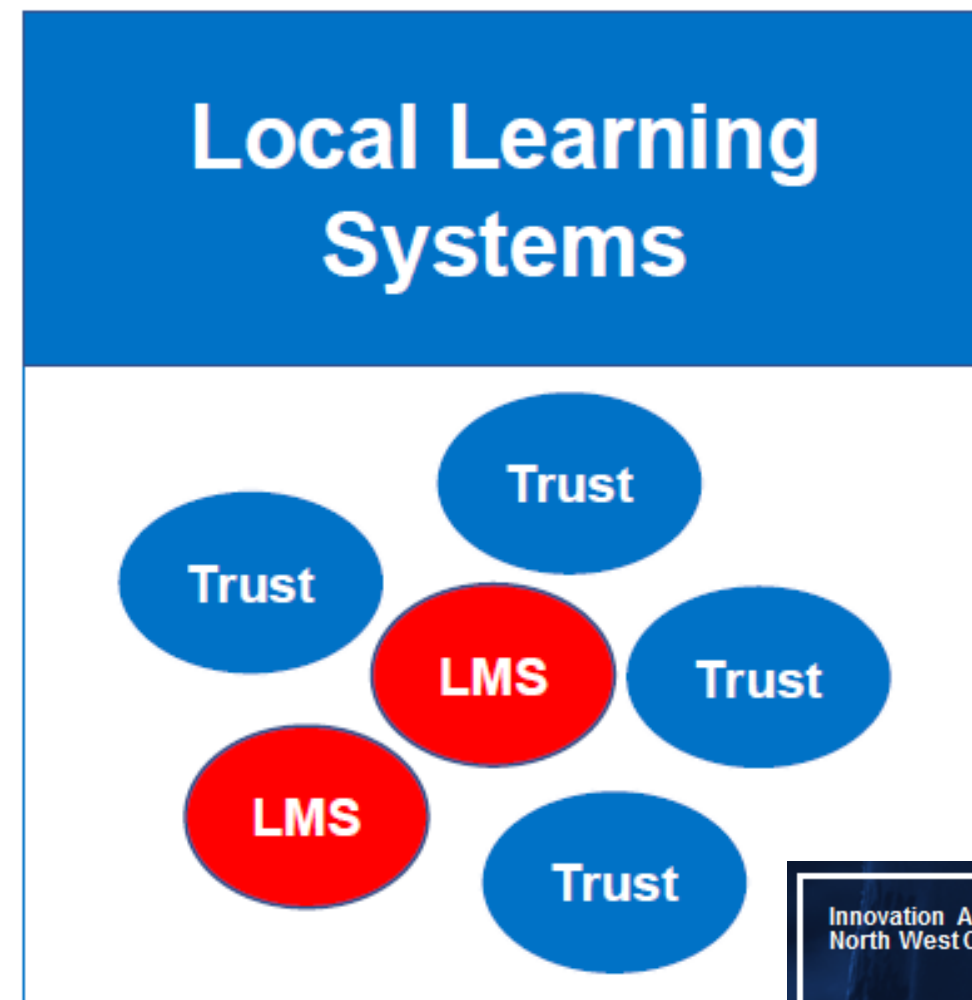


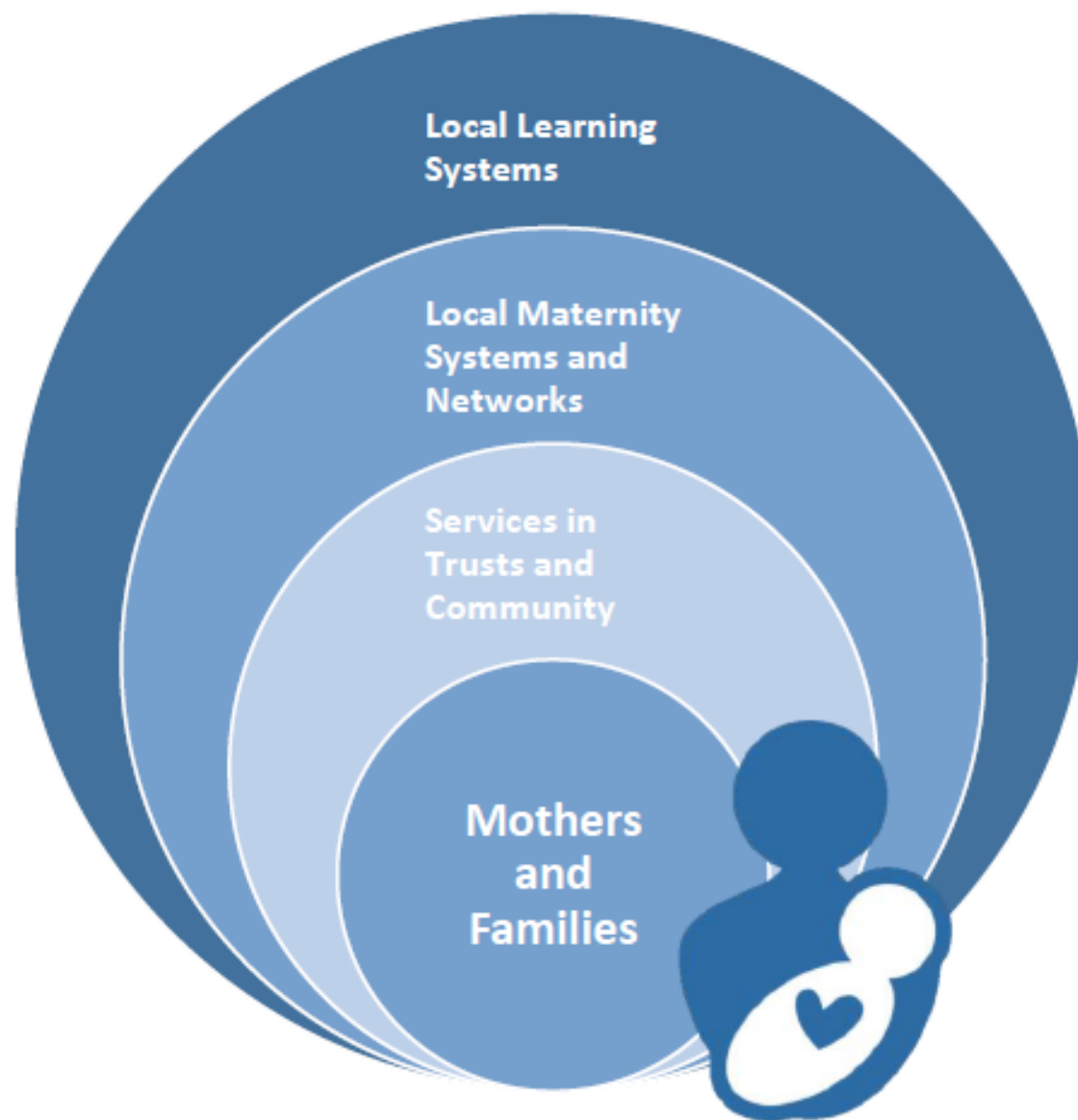
Local Learning Systems (System Improvement)



Learning together

- The collaborative learning systems are the local improvement communities that support the national driver diagram with system level improvement
- All trusts (waves 1-3) and key stakeholders share and learn from each other
- System groups will meet up to **four** times per year
- All providers and key stakeholders will be included from the outset

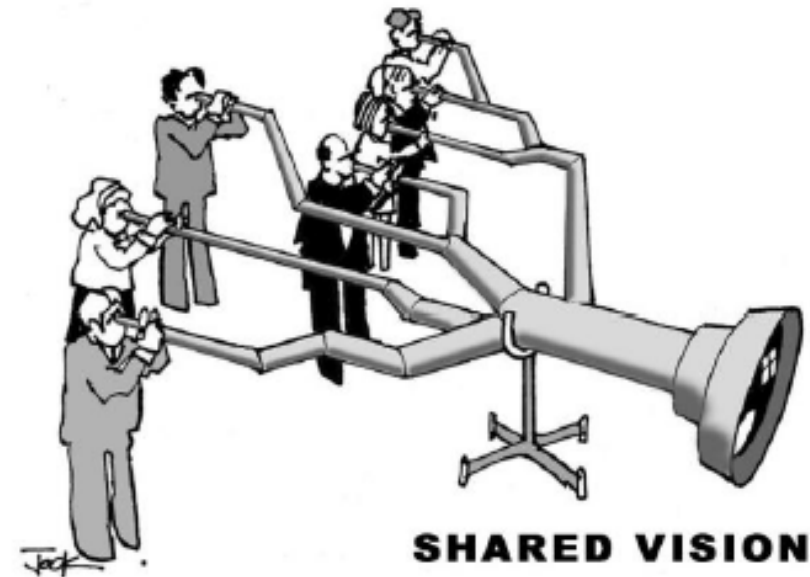




What should a local learning system provide?

There are 19 Local Learning Systems developing across England:

- A forum for quality improvement to be shared and to thrive
- An opportunity for all stakeholders to work collaboratively
- An opportunity to build local improvement capability
- New insights and learning from excellence
- Support for Local Maternity Systems
- Opportunities for system level improvement / scale-up within each learning system



What support will trusts in the national learning set receive?



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Activity of an individual unit

Diagnostic Phase

- Establish service baseline (data)
- Map care pathway
- Identify good practice
- Undertake culture surveys
- Determine local priorities and areas for improvement
- Choose 1+ primary drivers from national driver diagram
- Identify project teams and engage leaders
- Develop local improvement plan



Testing Phase

- Develop the aim of each project
- Set up and engage project team
- Use the national change package to test ideas within team
- Commence PDSA cycles
- Collect measures and continue to test
- Communicate learning



Refine and Scale-up Phase

- Continue PDSA cycles
- Share learning with team, other waves and learning system
- Continue to monitor changes
- Communicate success
- Scale-up and sustain improvement

So what does this all mean?

Improvement teams will need to:

- Find time and support to undertake this
- Understand the service user perspective
- Define the ambition and aim(s) of the team
- Understand the current service (the baseline) – to learn from its strengths and identify its weaknesses
- Engage the wider maternity and neonatal team – there is an improvement role for everyone
- Work with the clinical evidence (the 'what') but try to understand 'how' to implement reliably
- Start small and undertake improvement through small tests of change
- Report on progress monthly – others will be interested in your learning
- Realise that while there are quick wins, there may be no improvement solutions until the solutions have been tested, measured and refined



Where to go for help

- Your local patient safety collaborative
- NHS Improvement central team

<https://improvement.nhs.uk/resources/maternal-and-neonatal-safety-collaborative/>

- In Wales talk to 1000 Lives
- In Scotland talk to Health Improvement Scotland
- Get involved in your Local Learning system



Thank you & questions

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