NHS Improvement

National maternal and neonatal health safety collaborative

Autumn update

Introduction

It's hard to believe that we are almost half way through our year working with Wave2 trusts, but, having said that, the recent learning set in London did show what an incredibly long way those teams have come already on their improvement journeys. The amount of activity underway both with Wave2 trusts and through the Local Learning Systems across the country is phenomenal and fantastic to see.

The Maternal and Neonatal Health Safety Collaborative (MNHSC) was created to build capability for quality improvement and to provide a mechanism for learning and good practice to be shared across the maternity and neonatal system. It is a privilege and tremendously exciting to see that staff across professions and organisations are starting to work together, sharing their knowledge and supporting each other to improve services. It truly does feel like the beginnings of a movement of learning and continuous improvement and a fabulous opportunity to make services safer for women and families.

Find out more below about what the collaborative has been up to over the past three months and about our future plans.

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Head of Improvement Programmes (Patient Safety)

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Clinical Lead MNHSC

News

National context – Maternity Transformation Programme

The Maternal and Neonatal Health Safety Collaborative (MNHSC) contributes to the aim of the NHS's Maternity Transformation Programme (MTP), to reduce the rate of stillbirths, neonatal death and brain injuries occurring during or soon after birth by 20% by 2020.

The MTP leads on a wide range of activities and initiatives to improve the quality of care women and their babies receive. This has created a once in a lifetime opportunity for the MNHSC to support those working in maternal and neonatal services to improve the safety of care, and experiences and outcomes for women, families and their babies.

Safety is the golden thread that aligns the various initiatives and nine workstreams of the MTP, driven largely by this national ambition, and the recommendations from *Better Births*. The MNHSC primarily contributes to workstream two: Promoting good practice for safer care but has alignment and interdependencies with several other workstreams.

As part of the MTP NHS England has developed a Maternity Choice Framework with resources to enable local maternity systems to ensure choice and personalisation is offered to women in their areas. This is now available on the LMS Hub or through NHS England's website: https://www.england.nhs.uk/mat-transformation/mat-pioneers/.

Findings from culture survey – executive report

Since April this year the MNHSC has worked with Wave1 and Wave2 trusts to assess the safety culture of their departments and teams. We have had a great response rate from teams and in all around 18,000 people in 89 trusts have completed the SCORE survey.

The real value of this exercise is that improvement teams can use the cultural insights from the surveys to inform and support the quality improvement work within trusts. Debriefing teams after the survey is one way to start conversations about culture. It provides an opportunity to learn from areas of success, explore opportunities for improvement, and identify ways that teams can work together to develop and nurture a safety culture. Creating the right environment for a safety culture to flourish, will in turn support improvement work and lead to safer care for women and babies.

As a national programme we have found the insight from the safety culture surveys fascinating and are preparing an executive summary report to share some of the themes and trends shown across the surveys. The report will also signpost interventions that we know can support improvements to culture and describe the behaviour and actions for healthcare workers to support teams to develop and nurture a safety culture. The data is all anonymised and shows the results at a national level only.

We will circulate this executive summary to you by the end of the year.

Local Learning System meetings

The MNHSC Local Learning Systems (LLSs) bring together all those involved in maternal and neonatal care across Local Maternity Systems (LMS), Maternity Clinical networks (MCNs), Neonatal Operational Delivery Networks (ODNs), NHS Improvement, Patient Safety Collaboratives (PSCs) and others to share learning from the MNHSC and make links to the national Maternity Transformation Programme (MTP). They are open to multi-professional staff working in maternity and neonatal care across provider and commissioning organisations, regardless of which wave of the MNHSC they are in. The LLSs aim to create environments where collaboration can prosper to tackle improvements at both organisations and system level. The LLS is a forum to share learning from improvement work but also to

build capability for improvement and work on system-level challenges aligned to the national driver diagram.

There are now 20 LLSs around the country, although this number may change as groups reach maturity. Most LLSs have had at least two meetings to date and are starting to focus on system-level topics. The LLSs will work on topics relating to the national driver diagram and the primary drivers: reducing smoking in pregnancy, reconition and management of deterioration of mother and baby, stablisation and optimisation of the very perterm infant, and detection and management of diabetes in pregnancy and neonatal hypoglycaemia. For example, the north west LLS is working collectively on the stabilisation and optimisation of the very preterm infant and the south west LLS is looking at reducing smoking in pregnancy.

PSCs across England are supporting the MNHSC by facilitating LLS meetings. Please contact your local PSC to find out when LLS events are taking place in your area: https://improvement.nhs.uk/resources/patient-safety-collaboratives/

Wave2 news

Learning set

We welcomed Wave2 trusts to Wembley this month for the second learning set and were delighted that around 140 improvement leads and 17 executive sponsors were able to join us from the 43 trusts. It was a fantastic three-days, exhausting, exhilarating and inspiring. Improvement leads heard presentations on measurement for improvement, human dimensions, PDSA cycles, and were then invited to use the theory to refine their own improvement and measurement plans. We also were treated to speakers talking about quality improvements projects relating to the five primary drivers (reducing smoking in pregnancy, deterioration of mother and baby, stablisation and optimisation of the very perterm infant, detection and management of diabetes in pregnancy and neonatal hypoglycaemia), some of them improvement teams from Wave1 trusts.

It was great to see Wave2 improvement teams sharing their change ideas, challenges and solutions with each other. We were very pleased to welcome 17 executive sponsors on day 3 who attended to support their teams and hear more about their improvement projects.

Entering the test phase

Following a thorough diagnostic phase, our Wave2 trusts have now all selected the quality improvement projects that they will be working on over this year and have created an improvement plan for each project. This month most trusts will be starting to carry out small tests of change by running PDSA (plan, do, study, act) cycles.

Over the coming months teams will be refining and testing, with different colleagues, in different settings and under different conditions, and eventually the results of these PDSA cycles informed by measurement will inform whether the change ideas need to be adopted, adapted or abandoned. By the end of the test phase the idea is that each team will have some successful change ideas that can be refined and scaled-up across their services.

Learning Set 3 – Wave2 trusts

The final learning set for Wave2 trusts has been scheduled for **16-18 January 2019** and will take place in Bristol. As previously, we will be inviting executive sponsors to attend the final day, **18 January**, so please put this in your diary if you are the board level executive for a Wave2 trust.

Resources

Case studies

We are currently developing a series of case studies from Wave1 trusts and will be sharing these through the NHS Improvement Hub shortly. Watch this space for more!

Patient safety collaboratives – support and coaching

PSCs are providing a range of support to trusts to help them with their improvement plans and progress towards meeting the aims of the MNHSC. This includes quality improvement coaching and support with using the LifeQI system; in addition to supporting trusts with their culture surveys and debriefing. Please contact your local PSC to find out more about how they can support you: https://improvement.nhs.uk/resources/patient-safety-collaboratives/

IHI Open School – free subscriptions on offer

Part of MNHSC's support offer to staff within trusts is free access to a subscription with IHI's Open School. These subscriptions are open to all nominated improvement leads from trusts in Waves 1, 2 and 3. This is a great opportunity for supplementing the quality improvement

knowledge within maternity and neonatal teams, particularly if you have had a change of improvement leads or if you want to get your 'home' team up to speed.

We would really encourage all trusts to take up this offer. The courses are generally divided into 20 minutes of online learning, so it doesn't have to be a huge time commitment.

Open schools is a global learning community and provides support including online learning, project-based learning and access to communities and networks with other healthcare professionals across the world. This is a fantastic opportunity to benefit from great resources helping to build your core skills in improvement, safety, system design and leadership.

To register go to www.IHI.org/registerfull and then visit www.ihi.org/enterpasscode. You will need to quote: **13B27FDC** to get your free subscription.

For action

MatNeo Portal – monthly highlight reports

Our new MatNeo improvement portal is now up and running and we will be asking improvement leads to submit their highlight reports through the portal from this month. If you are in Wave2 please input your programme data by the **third Friday of the month**. The first submission date will be Friday 21 September. You will be receive an email from the PSMU with instructions on how enter your metrics into the portal.

For Wave1 trusts, we would like you to still submit your highlight reports on a quarterly basis. The next date for submission is **Friday 19 October**.

When you visit to enter your measures you will see that we have now updated an agreed set of operation definitiions for the measures for smoking in pregnancy and optimisation and stabilisation of preterm infant. The updated definitions are as below:

Proportion of women who smoke at booking	Number of pregnant women who are known to be smokers at the time of booking appointment	All pregnant women attending a booking appointment
Proportion of women who smoke at time of delivery	Numerator: Number of women known to be smokers at the time of delivery	Denominator: Number of maternities
Proportion of babies admitted to NNU with hypothermia (temperature <36.5oC)* less than 32 weeks gestation	Numerator: Number of babies admitted to a neonatal unit with a recorded diagnosis of hypothermia less than 32 weeks gestation	Denominator: number of babies admitted to neonatal unit at less than 32 weeks gestation

Life QI

Please join the MNHSC group for your wave on Life QI, this is a great resource for sharing learning across the different teams. It would be helpful if you could identify which of the waves you are in and which of the five primary drivers you are working on when you enter your project details to allow others to search and find where there are other teams working on the same topic.

You can also link your project to the MNHSC programmes by choosing which wave you are in and by joining the group linked to your primary driver. To do this:

- Select programmes and request to join: 'National Maternal and Neonatal Health Safety Collaborative: Wave 1, 2 or 3'
- Select groups and request to join 'Clinical Driver – smoking, deterioration, optimisation, diabetes or hypoglycaemia' (you can join more than one group if you are working on more than one primary driver)

If you make a request to join, a member of the central programme team will accept you request.

Follow us on Twitter

Follow us on twitter at **@MatNeoQI** and we'd love to hear about what you are doing on your local improvement projects or as part of your local learning system so please share your stories using the hashtag **#MatNeoQI**.

We would like to hear from you!

Have you got a good story to tell us? Have you seen improvements to safety, quality or outcomes through your improvement projects? Have you led successful partnerships with women and families? How have you led and applied learning from the culture surveys and de-briefing to inform your improvement plans? How have you shared the outcomes of your work, engaged your team or helped to build QI capability. We would like to hear from you, please email nhsi.maternalandneonatalsafety@nhs.net

Upcoming events

The next MNHSC National Learning Event will take place in **London on Monday 18 March** 2019. Improvement leads from all waves, executives sponsors, faculty members, and partners such as colleagues from across the MTP, Royal Colleges, ODNs, MCNs, third sector, MVPs and LMSs will be invited to attend and share their quality improvement learning and hear the progress of the MNHSC.

Learning Set 3 for Wave2 trusts will take place on **16-18 January 2019** in Bristol.

NHS Improvement

RCM Conference

MNHSC will be attending the annual Royal College of Midwives conference in Manchester on 4 and 5 October. Come along to the NHS Improvement exhibition stand to find out more about the collaborative and how we can support your quality improvement work.

Webex sessions

We run regular webex sessions aimed primarily for trusts in the active wave, currently Wave 2, but if you are in Wave 1 or 3 you are welcome to join these sessions, if you are interested in a particular topic. Please email nhsi.maternalandneonatalsafety@nhs.net for details of how to join the session. The next webex sessions will take place on:

Video conferences	**Date**	**Time**
Workstream 'drop in' webex: Smoke free pregnancy	Monday 8th October	15.00-16.00
Workstream 'drop in' webex: Diabetes in pregnancy	Monday 15 October	15.00-16.00
Workstream 'drop in' webex: Neonatal hypoglycaemia	Monday 22 October	15.00-16.00
Workstream 'drop in' webex: Optimisation of very preterm infant	Monday 29 October	15.00-16.00
Workstream 'drop in' webex: Deterioration	Monday 5 November	15.00-16.00

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