The AHSN Network

NHS Improvement

The Yorkshire and Humber Neonatal Operational Delivery Network

NHS Yorkshire and the Humber Clinical Networks

Maternal and Neonatal Health Safety Collaborative – Learning System Meeting

This meeting provides an opportunity to work together with like-minded people, sharing ideas and best practice.

Wednesday 16th May 2018
1pm to 3.30pm

Venue: Hatfeild Hall, Normanton Golf Club, Wakefield, WF3 4JP
http://www.hatfeildhall.co.uk/find_us.php

PROGRAMME

13.00> Introduction

13.10 > Update from the National Collaborative
Katie De-Freitas, NHS Improvement

13.30 > The Importance of safety culture in Quality Improvement
Alison Lovatt – Improvement academy

13.50 > Learning Bite - Update on work in neonatal neurology
Dr Tony Hart – Sheffield Children's Hospital

14.20> Refreshments & opportunity to view Wave 1 site posters

14.30 > Groupwork on Culture

- **What are the barriers to a culture of safety?**
- **Sharing ideas to overcome these**

15.15 > Next Steps

FACILITATORS

Helen Brown - Operational Delivery Network Director, Y&H Neonatal & Paediatric Critical Care

Katie De-Freitas –Improvement Manager, NHS Improvement

Hilary Farrow – Quality Improvement Manager, Y&H Maternity Clinical Network

Dr Joanna Gibson – Leadership Fellow Improvement Academy

Dr Tony Hart - Consultant Paediatric Neurologist, Sheffield Children's Hospital NHS Foundation Trust

Alison Lovatt – Director of Nursing, Improvement Academy

Yorkshire & Humber AHSN Improvement Academy
Patient Safety Collaborative

To book a place, please contact:
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National Maternal and Neonatal Health Safety Collaborative

Background & Aim

The Maternal and Neonatal Health Safety Collaborative (MNHSC) is a three-year programme to support improvement in the quality and safety of maternity and neonatal services across England. The programme was announced by the Department of Health in October 2016 and supports the aims of NHS England's **Better births maternity review** and the national **maternity transformation programme.** Working alongside commissioners, providers, the patient safety collaboratives, maternal and neonatal networks and other system partners, the collaborative is led nationally by NHS Improvement.

The overarching aim of the programme is improve the safety of maternal and neonatal care provided across England along with the outcomes and experience of care received, and through this approach, address the national ambition of reducing the rates of maternal deaths, stillbirths, neonatal deaths and brain injuries that occur during or soon after birth by 20% by 2020 and 50% by 2025.

This national ambition requires all NHS trusts (plus independent providers) who provide maternity services in England to make measurable improvements in safety outcomes for women, their babies and families by exchanging ideas and best practice.

The national maternal and neonatal health safety collaborative will help all maternity care providers and commissioners to:

- improve clinical practices
- reduce unwarranted variation
- report on how they are contributing to achieving the national ambition

The programme will build local capability in quality improvement and provide structured support for local teams to assess their service and develop innovative plans for measurable improvements.

Phases of the Collaborative

2016/17 Wave 1

- Airedale NHS FT
- Bradford Teaching Hospitals NHS FT
- Leeds Teaching Hospitals
- Rotherham NHS FT

2017/18 Wave 2

- Calderdale & Huddersfield NHS FT
- Barnsley Hospital NHS FT
- Doncaster & Bassetlaw NHS FT
- Harrogate & District NHS FT
- North Lincolnshire & Goole NHS FT

2018/19 Wave 3

- York Teaching Hospitals NHS FT
- Hull & East Yorkshire Hospital NHS Trust
- Mid Yorkshire NHS Trust
- Sheffield Teaching Hospital NHS FT