The AHSN Network

NHS Improvement

Maternity and Neonatal Learning System

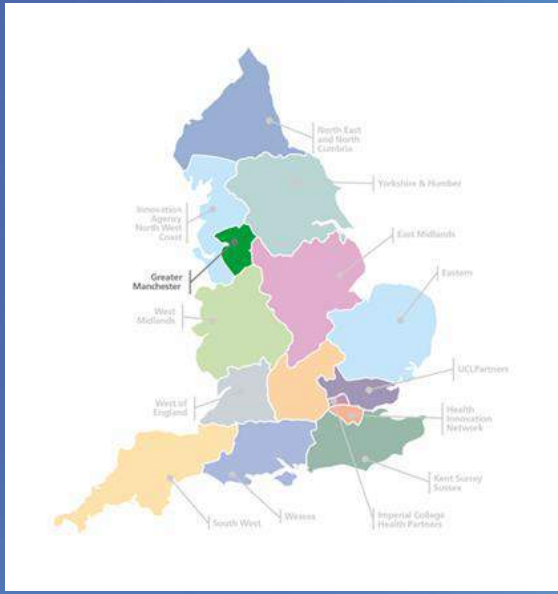
12th of March 2018

Greater Manchester

Patient Safety Collaborative

The AHSN Network

NHS Improvement



Welcome

Amanda Risino

Managing Director Health Innovation Manchester

Patient Safety Collaborative Steering Group (Chair)

Greater Manchester

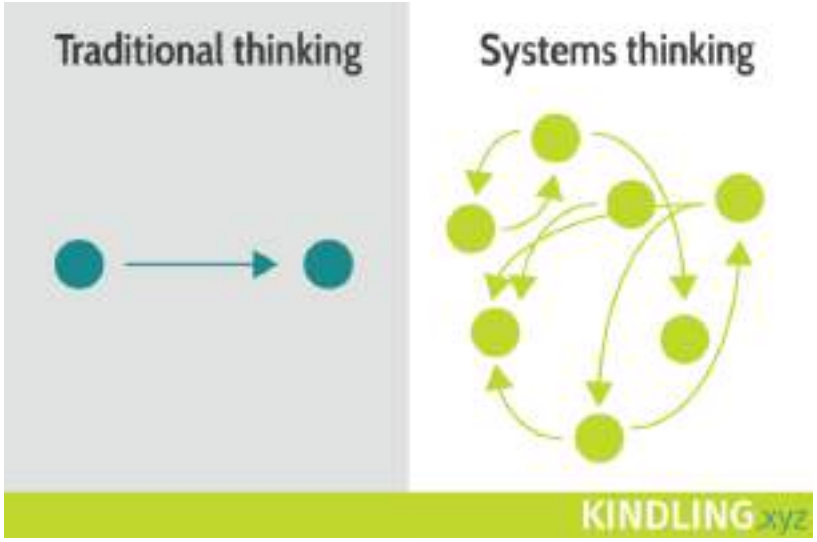
Patient Safety Collaborative

Health Innovation Manchester (HInM)

- GM is the first region in the country to take control of its combined health & social care budgets, with a budget of more than six billion pounds

- GM health devolution has enabled the formation of an Academic Health Science System facilitating the acceleration of clinical research into clinical practice

Health Innovation Manchester (HInM)



- HInM supports a 'One Manchester Team' to tackle GM health & care challenges and delivers the GM Patient Safety Collaborative with a mandate to create a culture of continuous learning and improvement in the NHS
- Promoting a system thinking approach to patient safety and population health across Greater Manchester

Patient Safety Collaborative National Context

The national PSC is the largest safety initiative in the history of the NHS, supporting and encouraging a culture of safety, continuous learning and improvement, across the health and care system.

For further information on Health Innovation Manchester Patient Safety Collaborative

Amanda Risino

Managing Director Health Innovation Manchester

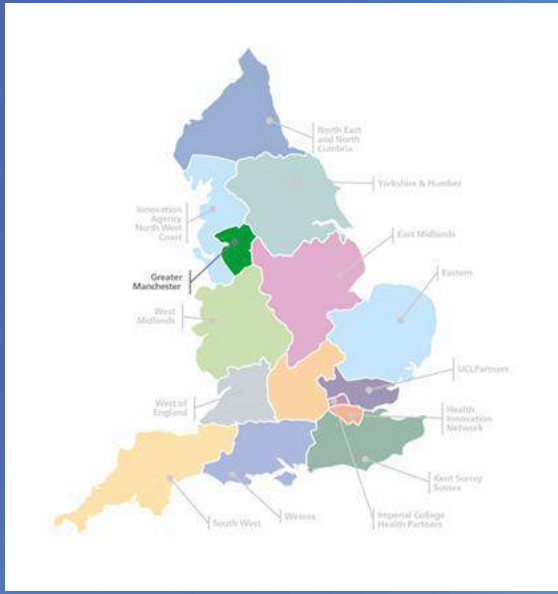
@healthinnovmcr

Tel: 0161 206 7979

HInM, Suite C, Third Floor, Citylabs, Nelson St, Manchester , M13 9NQ

The AHSN Network

NHS Improvement



Patient Safety collaborative overview

Jay Hamilton

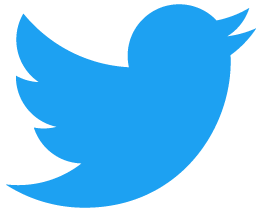
Associate Director Patient Safety Collaborative

Patient Safety Collaborative Steering Group (vice Chair)

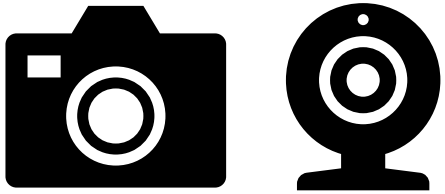
Greater Manchester

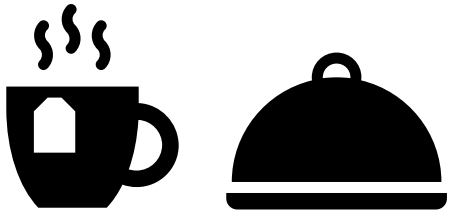
Patient Safety Collaborative

Housekeeping



@GM_PSC





Health Innovation Manchester

AGENDA – 12 March 2018

Conference Room 1, Ground Floor, Citylabs, Nelson Street, Manchester, M13 9NQ

Sharing Local Innovations

Time	Title	Presenter
9:00	**Arrival Tea/Coffee**	
9:30	**Welcome and Introductions**	**Amanda Risino** - Managing Director, Heath Innovation Manchester
9:40	**Patient Safety Collaborative Overview**	**Jay Hamilton** - Associate Director, Lead for GM Patient Safety Collaborative, Heath Innovation Manchester
9:50	**GM Local Maternity System**	**Jen Sager** - Senior Project Manager, Local Maternity System
10:00	**Interactive Health Innovation Quiz**	**Bob Diepeveen** - Patient Safety Collaborative GM Improvement Advisor, Health Innovation Manchester
10:15	**Getting Innovation to the Frontline: Episcissors**	**Cara Afzal** - Senior Programme Development Lead, Health and Implementation, Health Innovation Manchester **Alexander J. Fisher –** Director, Advanced Global Health
10:30	**Women's Experience**	**Victoria Ashcroft**
10:45	**Break**	
11:00	**Getting Innovation to the Frontline:** ▪ **Rainbow Clinic** ▪ **Table discussion**	**Prof. Alex Heazell** - Senior Clinical Lecturer in Obstetrics and Clinical Director of the Tommy's Stillbirth Research Centre, University of Manchester **Louise Stephens** – Specialist Midwife

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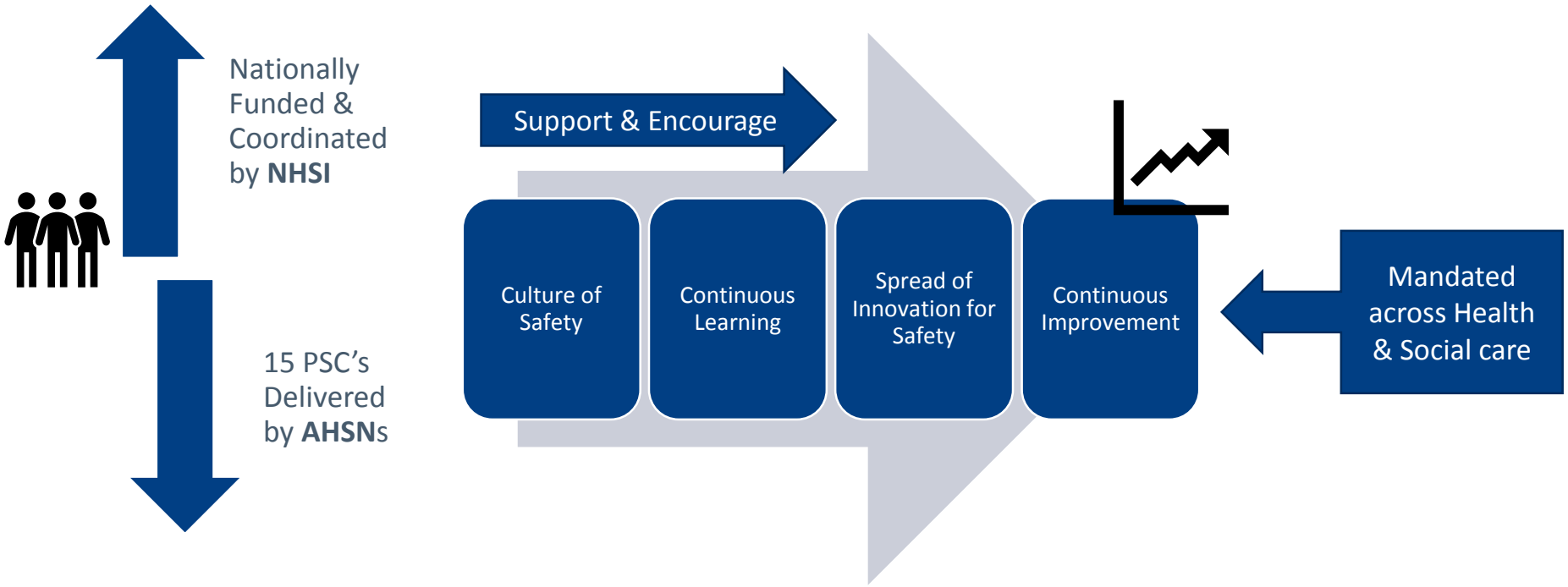
Maternity and Neonatal Learning System Launch Event

Time	Title	Presenter
11:30	**National Maternity and Neonatal Collaborative – role of PSC**	**Debby Gould** – Clinical Lead, Maternity and Neonatal, GM Patient Safety Collaborative, Health Innovation Manchester
11:40	**Learning from Wave 1 / The Journey So Far**	**Jen McCartney -** Divisional Support Manager, Women and Children's Division, The Pennine Acute Hospitals NHS Trust **Lewis Stott** - Assistant Directorate Manager Obstetrics, Pennine Acute
11:50	**Big 5 Introduction**	**Julie McCabe** – Network Director, North West Neonatal Operational Delivery Network
12:00	**Big 5 Efforts in GM**	**All**
12:30	**Lunch (afternoon drinks)**	
13:15	**Learning Systems – how do we work together?**	**Tazeem Shah** – Project Manager, GM Patient Safety Collaborative, Health Innovation Manchester
14:30	**Use of Quality Improvement in PSC**	**Bob Diepeveen** - Patient Safety Collaborative GM Improvement Advisor, Health Innovation Manchester
15:30	**Plan next period**	**All**
15:50	**Summary and Next Steps**	**Jay Hamilton** - Associate Director, Lead for GM Patient Safety Collaborative, Health Innovation Manchester

National Patient Safety Collaboratives



PSC workstream

Workstream 1: Deteriorating Patient

- *To reduce avoidable harm & enhance the outcomes & experience of patients who are deteriorating*

Workstream 2: Culture & Leadership

- *To help create the conditions that will enable healthcare organisations to nurture & develop a culture of safety by 31st March 2019*

Workstream 3: Maternity & Neonatal

- *To improve maternity & neonatal care, specifically reducing the rate of stillbirth, neonatal death & brain injuries occurring during or soon after birth by 20% by 2020*

For further information on Health Innovation Manchester Patient Safety Collaborative

Jay Hamilton

Managing Director Health Innovation Manchester

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GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS

Greater Manchester and Eastern Cheshire
Strategic Clinical Networks

Local Maternity System (LMS)

Greater Manchester Health and Social Care Partnership

What is a Local Maternity System?

Role of the LMS is to:

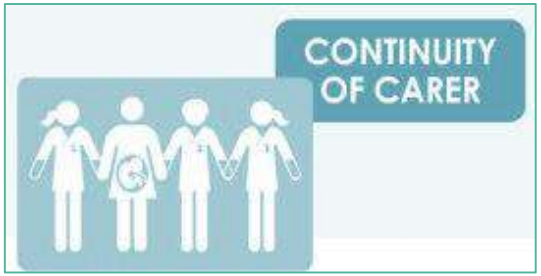
- Bring together providers involved in maternity and neonatal care including ambulance service and primary care services
- Co-produce services with women, their partners and communities
- Put in place the infrastructure needed to support services working together
- Develop new approaches to commissioning services that span organisational and service boundaries
- Commission maternity services to support personalisation, safety and choice

LMS's will:

- Provide the opportunity to do something different
- Work closely with NHS England Clinical Networks
- Have in place robust governance, structure and leadership for transformation
- Oversee the implementation of a local Maternity Strategy

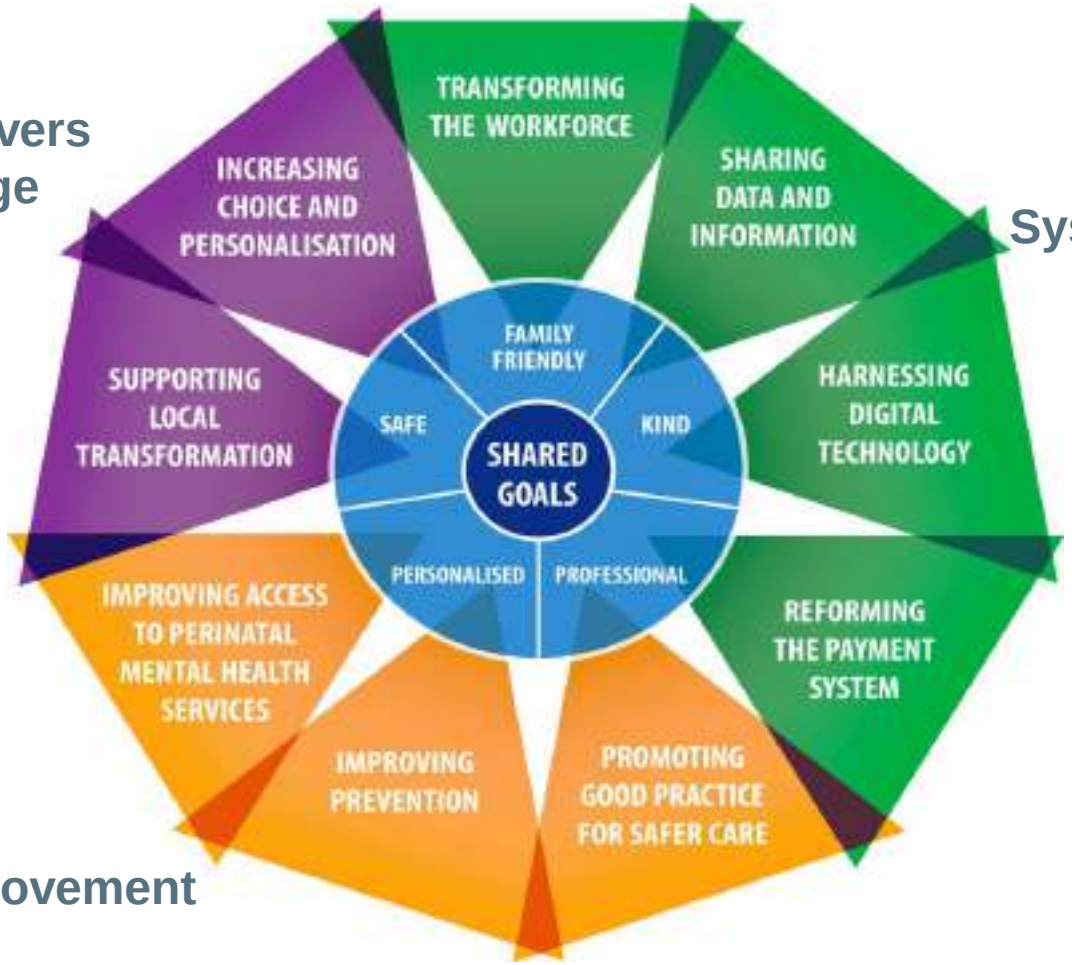
Who are the Local Maternity System?

7 themes of Better Births



9 National MTP work streams

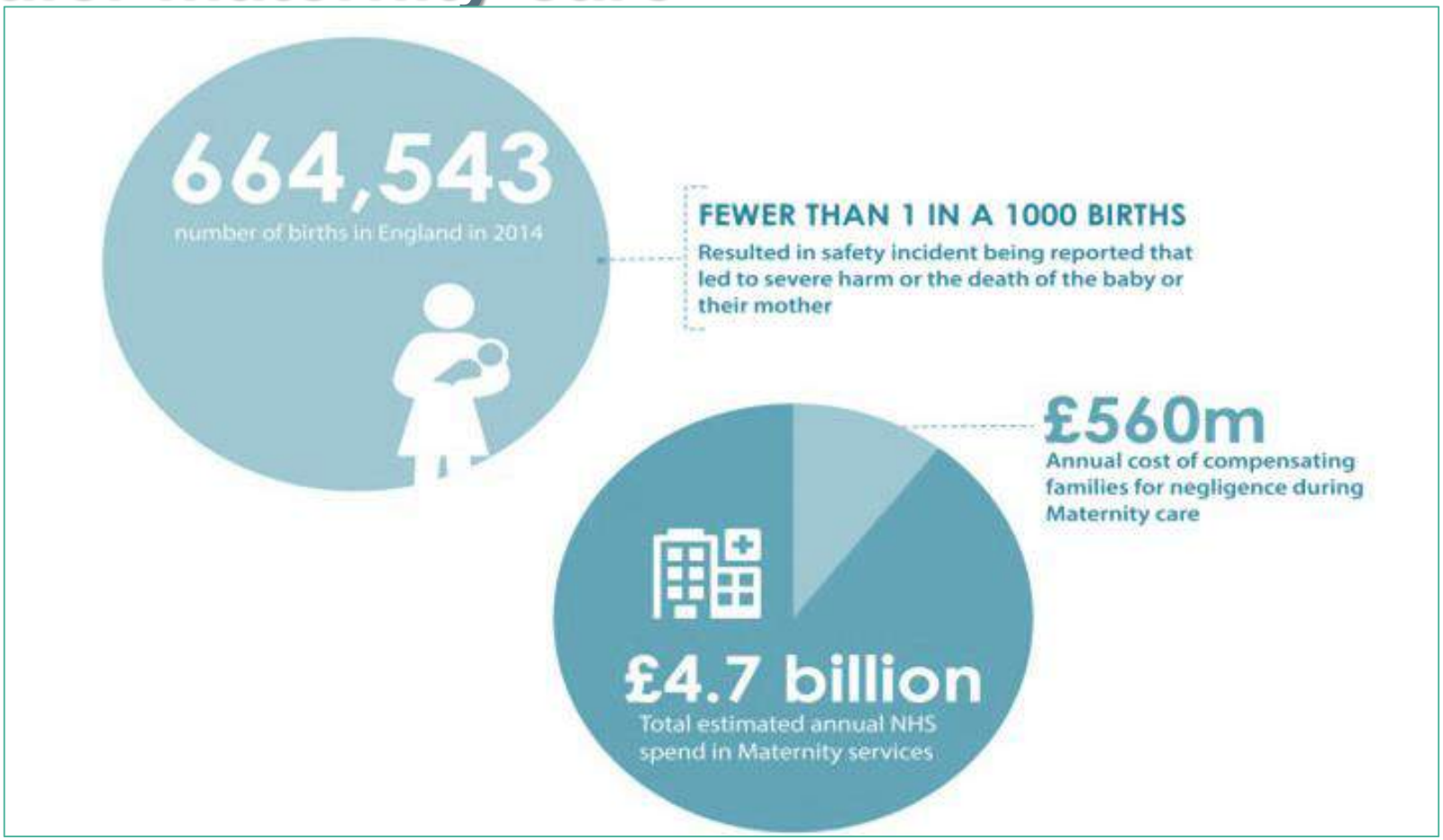
Local drivers for change



System enablers

Service improvement

Safer maternity care



The Secretary of State's ambition is reduce the rate of stillbirths, neonatal and maternal deaths and brain injuries by 50% by 2025.

GM&EC Maternity Transformation

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End of March 2018 Maternity and Neonatal Transformation Strategy to be made available publicly

What we know about GM&EC

12.9% of women smoke at time of delivery

(Data collected from ONS Sept 16 to Aug 17)

29% of mothers giving birth in Greater Manchester and Eastern Cheshire are from Black and Minority Ethnic (BME) communities

(Data collected 2015/2016 PHE Fingertips)

19.75% of women who become pregnant are overweight (BMI >30)

(Data collected 2016/17 NHS maternity statistics)

Around 37 full term babies per 1000 are admitted to the neonatal unit

(Local Maternity Dashboard)

21 mothers per 1000 were readmitted to hospital within 30 days after giving birth

(Local Maternity Dashboard)

What we know about GM&EC

Around 30 women per 1000 experience a 3rd or 4th degree tear

(Nov 16 –Oct 2017 local Maternity Dashboard)

4.54% of women have an obstetric hemorrhage

(Nov 16 –Oct 2017 local Maternity Dashboard)

10.9% of babies are born before 37 weeks

(NHS Maternity Statistics 2017,Sept 16 – Aug 2017 Local Maternity Dashboard)

Currently around 65% of women initiate breastfeeding, and 40% continue to breastfeed at weeks

(NHS England Statistical Release on Breastfeeding Oct 2017, Nov 16 – Oct 17 Local Maternity Dashboard, 16/17 PHE Fingertips)

What we know about GM&EC

4.6 of stillbirths per 1000
(Local Maternity Dashboard Local Data Jan -Dec 16)

2.74 of Neonatal Deaths per 1000
(ONS GM&EC Data 2013-2015)

1.26 Intrapartum Brain Injuries per 1000
(Local Maternity Dashboard 2016)

10.5 Maternal mortality per 100,000

(Local Maternity Dashboard 2016)

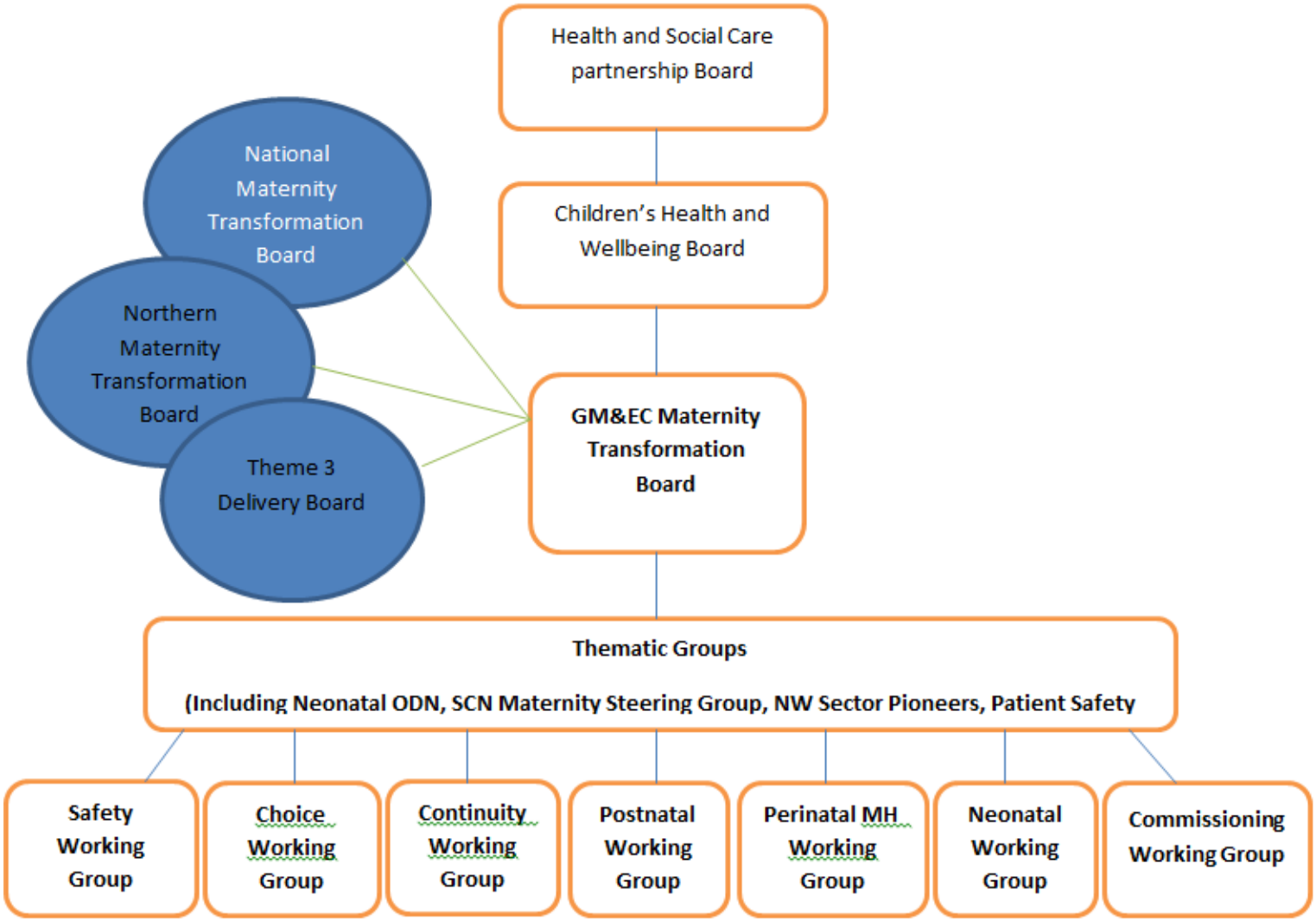
What we know about GM&EC

- Greater Manchester and Eastern Cheshire supported over 38,000 women to birth their babies in 2017.
- We cover a geographical area of over 993 Square Miles, which is a variety of urban and rural areas.
- Within this area there are areas of significant deprivation and health inequality
- We have 7 maternity providers, with 9 maternity sites (soon to be 10 with the opening of Ingleside (FMU in Salford, run by Bolton FT) and 11 CCG's.
- We have 1 maternity Pioneer looking at Choice and Personalisation as part of the Maternity Transformation programme (Salford CCG, Bolton CCG and Wigan CCG)

Our Vision

Maternity services in Greater Manchester and Eastern Cheshire should work with women and their families to meet their wishes and needs, producing outcomes for them and their babies that are comparable to the best in the world.

Greater Manchester and Eastern Cheshire LMS



Greater Manchester and Eastern Cheshire LMS

Developments to date

- Stakeholder Analysis
- Workstreams established with clinical representation from across Greater Manchester and Eastern Cheshire
- Service Users at the heart of the plan
  - ➢ Maternity Voices Partnership Network set up
  - ➢ Co-produced the Maternity Transformation LMS vision and plan, and co-leading on Choice and personalisation working groups

– Development of a communication strategy and implementation plan
– Data sources identified, baseline figures updated with proposed trajectories
– Working in partnership with GM Strategic Clinical Network (SCN) and Patient Safety Collaborative
– Setting up of working groups within Maternity transformation plan

For more information contact:

Alison McGovern– GM&EC LMS Programme Lead
Jennifer Sager – GM&EC LMS Senior Project Manager

✉: gmec-cmpc@nhs.uk
: www.gmecscn.nhs.uk
@GMEC_SCN or tag us **#MaternityGM**
📖Our Maternity Transformation Strategy Summary (will be released end of March)

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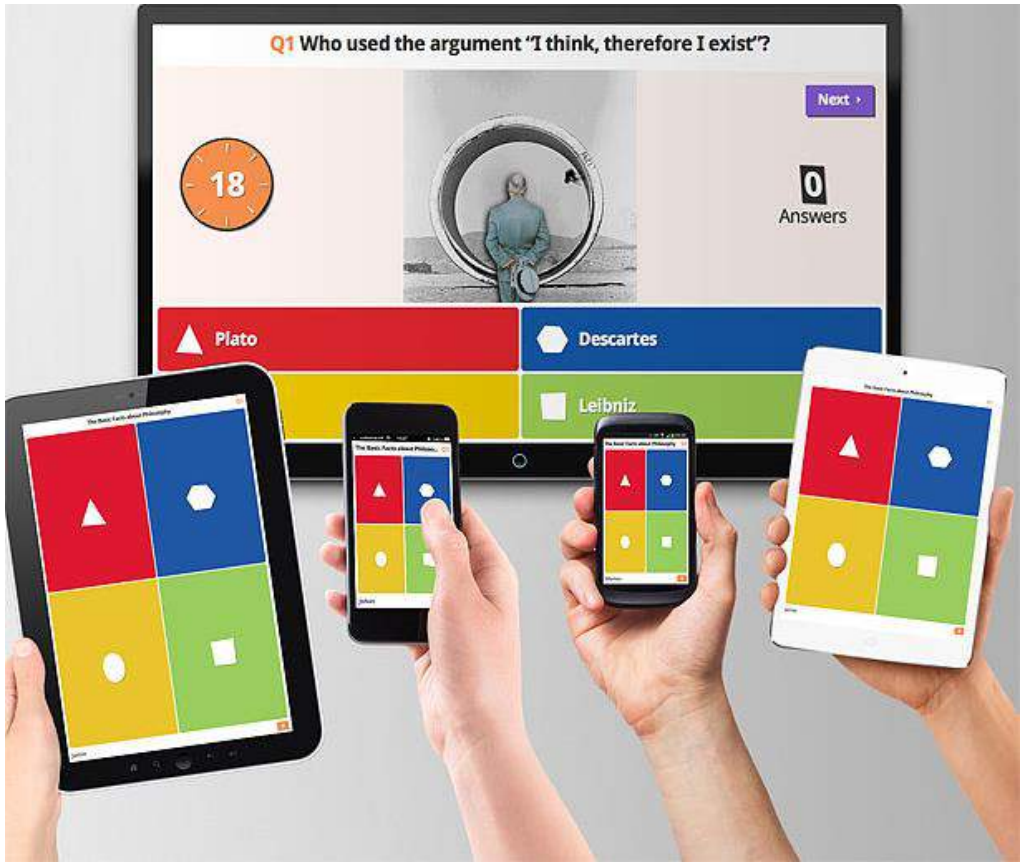
Interactive Health Innovation Quiz

Greater Manchester

Patient Safety Collaborative

What do you already know about today?



Health Innovation Manchester

National Innovation Accelerators - getting innovations to the frontline!

Example of : Episcissors-60 roll out and new innovation - the Hampton App

Cara Afzal, Senior Programme Development Lead, Health and Implementation

Alexander J. Fisher
Director, Advanced Global Health

12 March 2018

Discovering Developing Delivering

The NHS Innovation Accelerators

- NHS England initiative delivered in partnership with the 15 Academic Health Science Network, hosted by UCL Partners
- Supporting delivery of FYFV by accelerating uptake of high impact, evidence-based innovations for patient, population and NHS staff benefit
- 469 additional NHS commissioners and providers now using NIA innovations; £28.6m in external funds secured; 14awards won; 10 selling internationally
- Impact data demonstrates earlier intervention, reductions in complications and emergency admissions, cost savings
- ITT incentivising the adoption and spread of transformation innovation.

The Innovation Technology Tariff (ITT) – costing models

Theme	Example product	How will it operate
1) Guided mediolateral episiotomy to minimise the risk of obstetric anal sphincter injury	Episcissors-60	Incentive based on activity. The price 16.00 per use.
2) Reduction of bacterial contamination and accidental administration of medication	Non-injectable arterial connector (NIC)	Provided under the zero cost model. The value of this device per patient is £2.
3) Prevention of ventilated associated pneumonia in critically ill patients	Pnuex	Provided under the zero cost model. NHS England is covering the cost of the tubes valued at £150 each.
4) Applications for the self-management of Chronic Obstructive Pulmonary Disease	myCOPD	Provided under the zero cost model. NHS England is covering the cost of licences valued at £20.00 per patient.
5) Frozen Faecal microbiota transplantation (FMT) for recurrent Clostridium difficile infection rates	Frozen Faecal Microbiota Transplants for Treating C.difficile Infections	Provided under the zero cost model. NHS England is covering the cost of FMT aliquots valued at £95.00 per patient.
6) Management of Benign prostatic hyperplasia as a day case	Urolift	Re-imbursement automated via tariff recoded under a new OPCS code.

FMT Awaiting MHRA approval

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The AHSN *Network*

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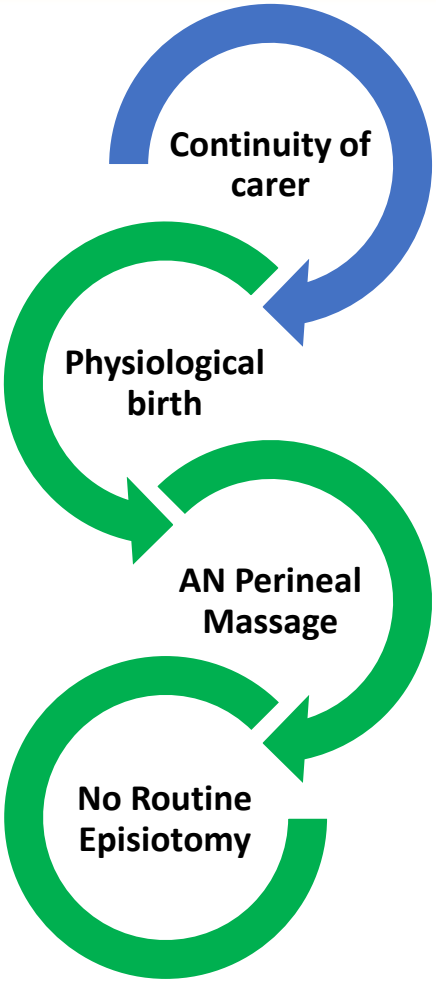
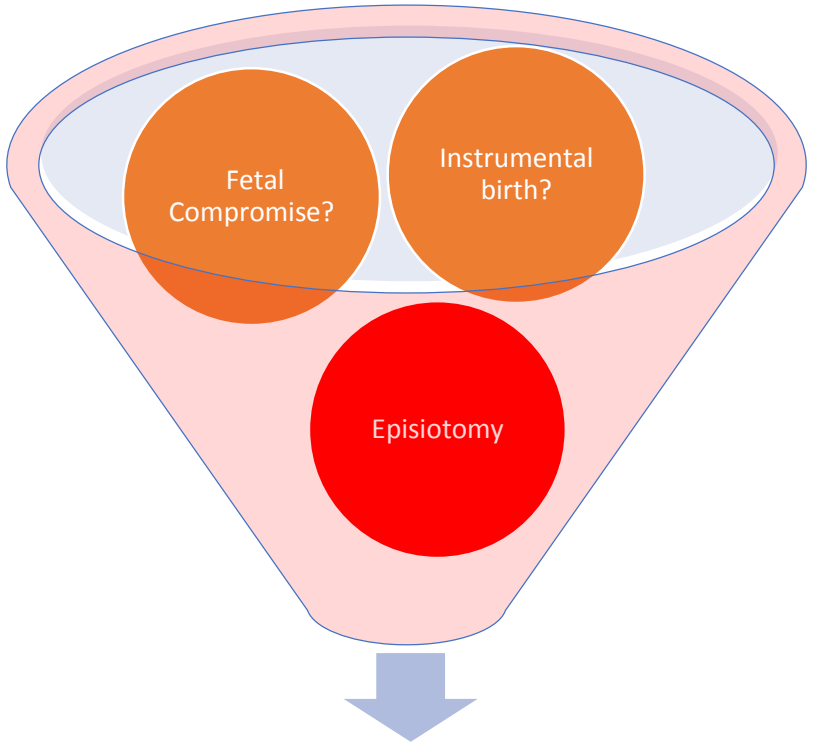
Introducing NHS England's Innovation Technology Tariff

- Accessing the zero cost NHS ITT
- ITT introduced to incentivise the adoption and spread of transformational innovations in the NHS
- Aims to remove need for multiple local price negotiations and guarantee automatics reimbursement when an approved innovation is used
- The ITT allows NHS E to optimise it's purchasing power and negotiate "bulk buy" price discounts where applicable on behalf of the NHS
- 2017-19 first years pathfinder

Preventing Avoidable Harm From Severe Perineal Trauma





EPISCISSORS

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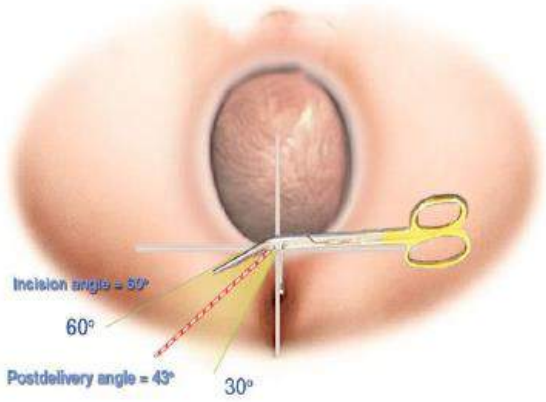
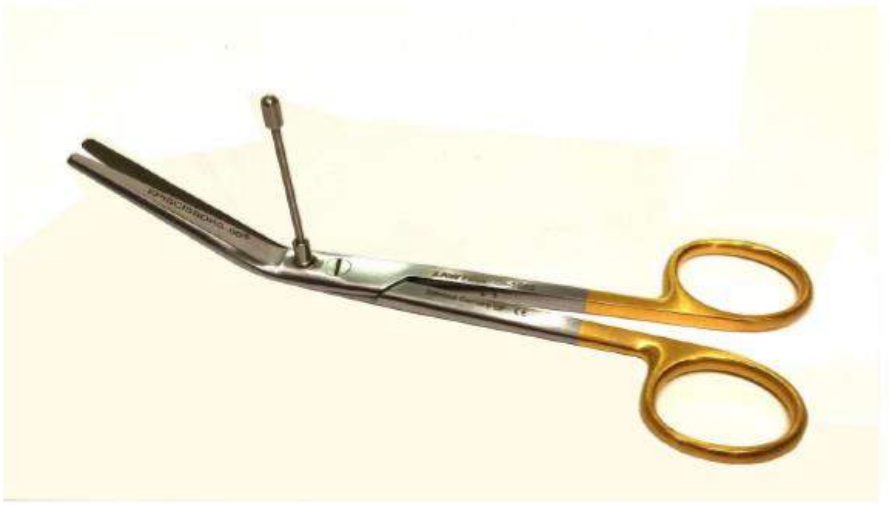
Achieving Innovation at scale in the NHS: EPISCISSORS-60

Dr Dharmesh Kapoor, NIA Fellow – inventor of the Episcissors-60

EPISCISSORS-60

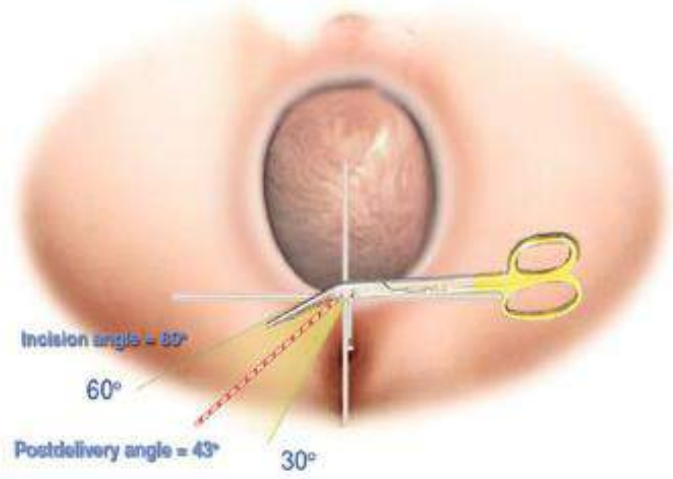
FIRST SCISSORS DESIGNED TO GIVE AN ACCURATE MEDIOLATERAL EPISIOTOMY; PATENT OWNED BY PLYMOUTH HOSPITALS NHS TRUST





Ref: Kapoor , 2017

"SPECIAL SCISSORS DESIGNED TO ENSURE AN INCISION ANGLE OF 60 DEGREES HAVE BEEN SHOWN TO BE EFFECTIVE IN ACHIEVING THE CORRECT ANGLE[29,30]. EVIDENCE LEVEL 3"



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"WHERE EPISIOTOMY IS INDICATED, THE MEDIOLATERAL TECHNIQUE IS RECOMMENDED, WITH CAREFUL ATTENTION TO ENSURE THE ANGLE IS 60 DEGREES AWAY FROM THE MIDLINE WHEN THE PREINEUM IS DISTENDED. (D)"

Royal College of Obstetricians and Gynaecologists

Bringing to life the best in women's health care

Health Innovation Manchester

Obstetric Anal Sphincter Injuries (OASIS)

Incidence

- 30,000 new cases each year
- 6% in first vaginal births
- Leading cause of anal incontinence in women (9:1 F:M)

Direct Costs

- £1625 per case for repair + post operative care
- £48.75 million each year

Indirect Costs

- 25% of Women choose elective caesarean delivery (extra £1100 per birth, £4.9 million each year)
- £2500 per year/person for fecal incontinence

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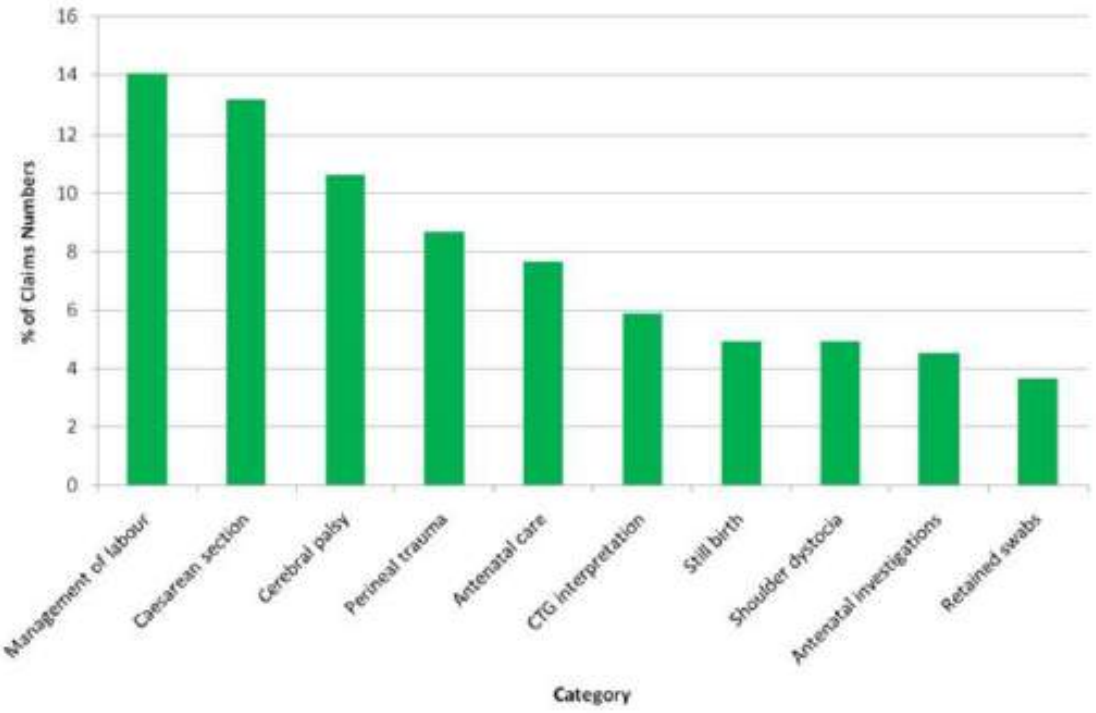
Litigation costs

- Perineal trauma is the 4th highest reason for claims made in obstetrics over 10 years
- £31 million in legal pay-outs alone
- OASIS being mooted as a patient safety indicator
- £1.6 million damages for OASIS due to an acutely angled Episiotomy



Episcissors-60 - in Greater Manchester

Approximately 15% of births require an episiotomies nationally each year, resulting in over 30,000 Obstetric anal sphincter injuries (OASIS) with approximately 12,000 women suffering bowel incontinence.

Based on a GM 2.8 m population estimate:

- #women requiring a episiotomy per year (15% of all births) = 5,160
- Estimated # of OASIS cases per year 1,290 in GM
- Combined savings for prevented OASIS and secondary repair, is estimated at £1,380,796
- Annual avoided litigation costs if 50% of OASIS cases averted = **£80, 846**

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Results from UK Hospitals, where they have replaced old episiotomy scissors with Episcissors-60

- 20% reduction in childbirth anal sphincter injuries (OASIS) at Poole and Hinchingbrook hospitals (Van Roon et al;2015)
- 40-50% reduction at Croydon University Hospital (Lou, 2016)
- 40-50% reduction at Royal Free and Barnet Hospitals (Myers, 2016, Unpublished audit)

Progress made in GM adoption

All hospitals in the region other than Warrington, East Cheshire and Uni Hospital of South Manchester (now MFT) have adopted, we are just checking in with sites to make sure!

Some of the barriers to adoption

Reason for not adopting	Some solutions
Difficulty making cogent Business case	ITT provides the fund for the scissors Make CCGs aware of the cost implications of continued high rates of OASIS (detailed in NHS E Guidance)
If injury rates go down Trust loses income	Make CCGs aware of the cost implications for continued high rates of OASIS
Single use instrumentation	One third of English Trusts use single use birth packs Have off site sterilisation facilities
Clinical apathy	Clinical engagement, provision of support , use any other validated means to perform the 60 degree angle episiotomies

What have we done so far - our approach to adoption

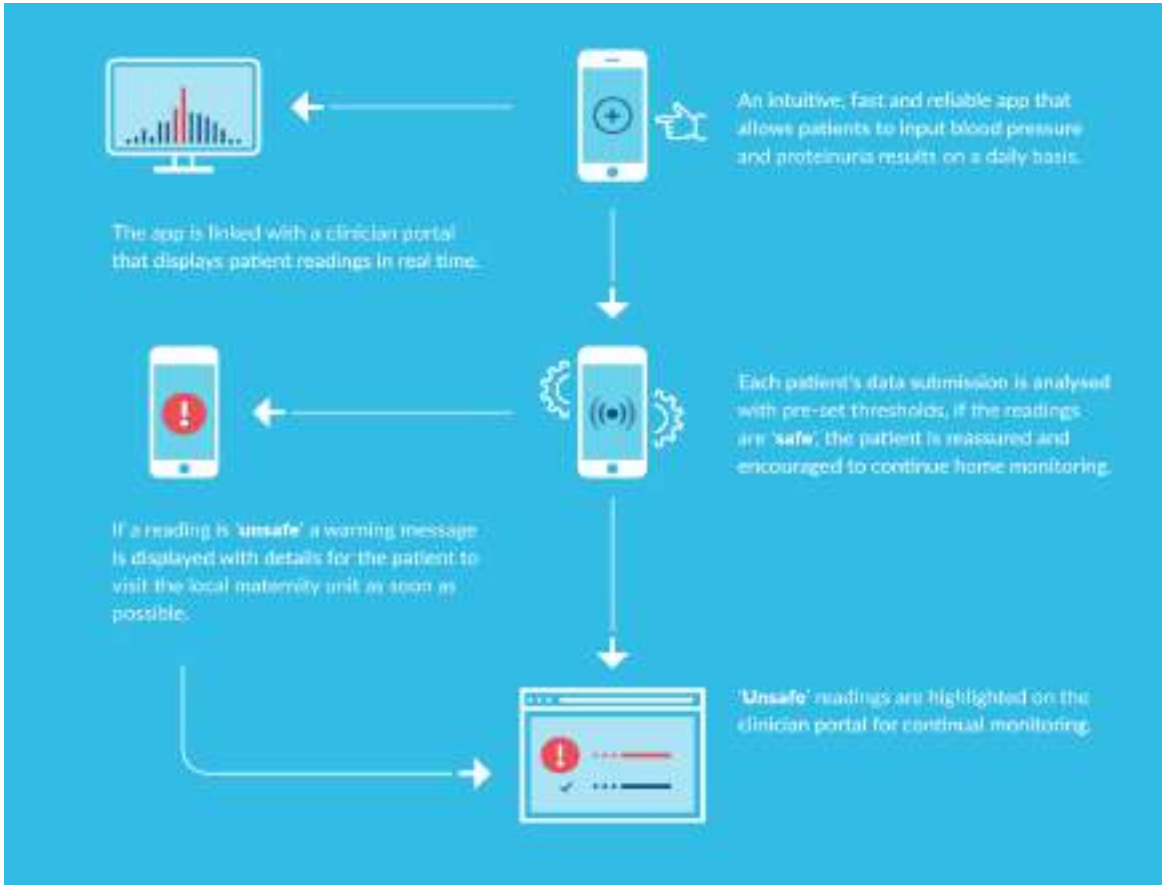
- Sourcing and sharing information;
  - on the Tariff attached to the products and summarising how it works
  - A gathering of Implementation Toolkits and meetings with NIA fellows and companies involved in product development
  - Information gathering from other AHSNs on the strategies employed for deployment
  - A baseline assessment of the number of products spread - by sourcing information from the NIA Clinical Fellows and the developers, on which sites they had successfully engaged with.

What have we done - approach to adoption continued…

- **Engagement with Procurement leads**, sharing the details of the products, the Tariff information
- Contact with **Innovation leads at Trusts**, where information has been available.
- Presentation and relevant NIA ITT Product information shared with all **GM Procurement Leads**
- Presentation **at Medical Directors**, including sharing of detailed information packs on all products. With a follow, up meeting, with MD leads which took place on the 18th December 2017
- Production of a **NIA summary slides pack** for GM HSCP and sharing of products with LCO leads
- Working through the Medical Directors and the Innovation, **Prioritisation and Monitoring committee (IPMC).**

The Hampton App – This year's National Innovation Accelerator Maternity Product

- Up to 10% of patients are hypertensive and therefore at risk of pre-eclampsia.
- Standard pathway for hypertensives is to visit hospital 2/3 times per week for BP and proteinuria assessments.
- 90% of these patients have safe readings.
- The Hampton App is home BP and proteinuria app.
- Mothers input daily BP results and proteinuria (optional). The app has an inbuilt algorithm – if an unsafe reading is provided the mother and hospital are immediately informed.
- With a safe reading the mother is reassured and continues home monitoring.
- Information is shared real time with clinician web portal, allowing clinicians to review data any time and track 'unsafe' patients.



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Hampton App - Benefits

- 53% reduction in BP MAU/Triage visits
- >90% of women feel empowered and have reduced anxiety
- Average BP appointment time reduces from 116 to 44 mins

Cost of Home Monitoring via Hampton App:

$_{\text{1 DAU visits/ 2 week}}$ = 0.5 x [(Midwife compensation) + (Doctor compensation) + (Blood tests' cost) + (Fetal CTG cost)]$= 0.5\ x\ \left[\left(\frac{44\ x\ 40\ min}{60\ min}\right) + \left(\frac{103.33\ x\ 20min}{60min}\right) + (2.65 + 2.78 + 2.12) + 27\right] = £\ \mathbf{49.16}$

Cost of Standard Pathway:

Cost per week $_{\text{3 DAU visits/week}}$ = 3 x [(Midwife compensation for 40min) + (Doctor compensation for 20min) + (Blood tests' cost+ (Fetal CTG cost)] $= 3\ x\ \left[\left(\frac{44\ x\ 40\ min}{60\ min}\right) + \left(\frac{103.33\ x\ 20min}{60min}\right) + (2.65 + 2.78 + 2.12) + 27\right] = £\ \mathbf{294.96}$

- Weekly saving per patient of £245.80
- Greater Manchester Region has c3,400 hypertensive patients, this could lead to £835,720/week
- Hampton app costs £24/patient and lasts 12 months – current users provide antenatal and 6 week post natal monitoring.

Health Innovation Manchester

Thank you

For more information about the innovations showcased contact:

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Alexander J. Fisher, Director, Advanced Global Health
Email: alex.fisher@aghealth.co.uk
Tel: 0207 0788 867

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Discovering Developing Delivering

The AHSN Network

NHS Improvement

Women's Experience

Victoria Ashcroft

Greater Manchester

Patient Safety Collaborative

The AHSN Network

NHS Improvement

Break

Greater Manchester

Patient Safety Collaborative

Improving Care in Pregnancy after Stillbirth

Louise Stephens
Specialist Midwife
Manchester Rainbow Clinic

MANCHESTER 1824

The University of Manchester

NHS Manchester University NHS Foundation Trust

St Mary's Hospital

Tommy's

St Mary's Rainbow Clinic

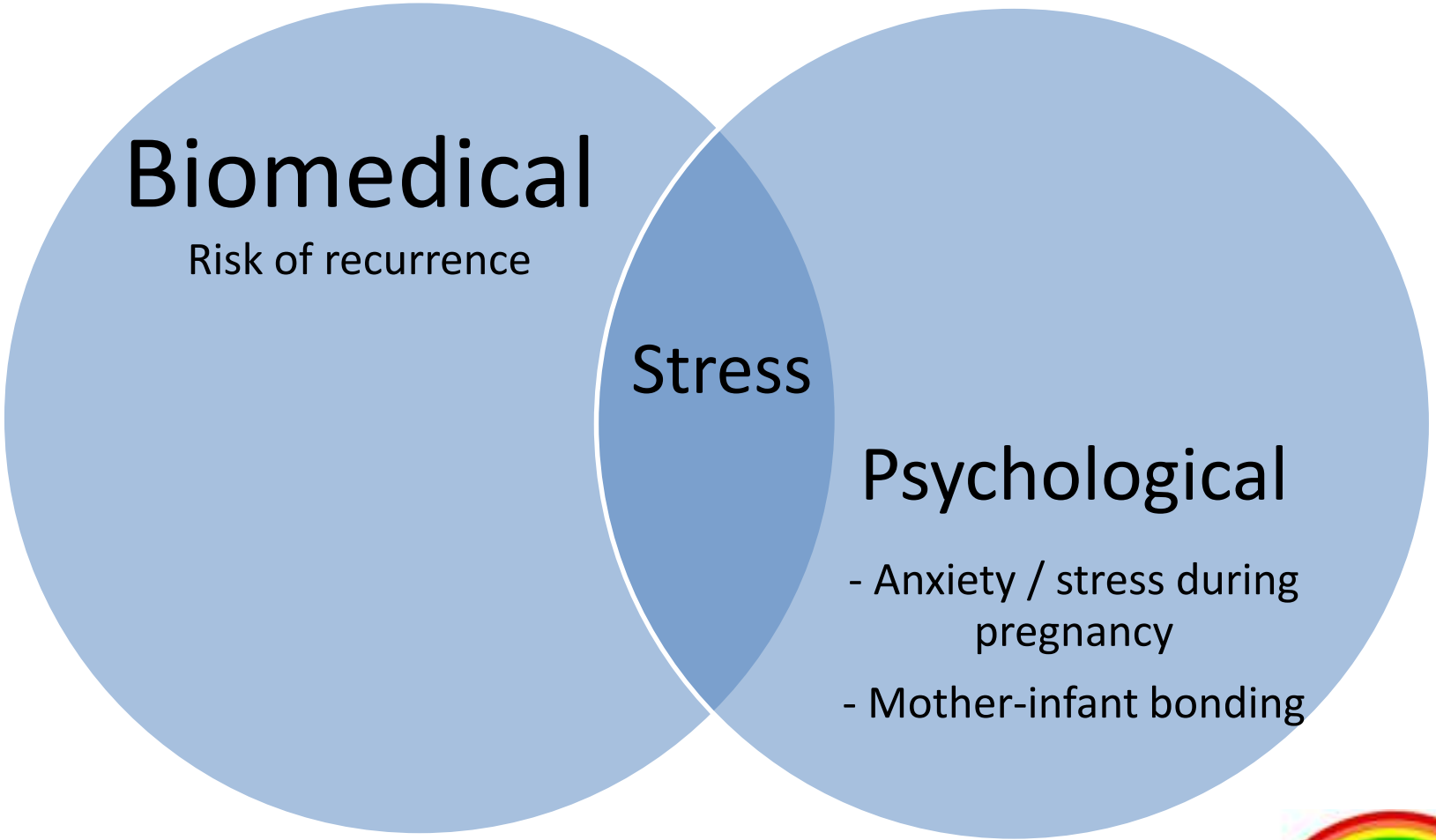
Risk factors and Stillbirth

The majority of stillbirths occur in women with no apparent risk factors (81%)

- Majority confer moderately increased risk

Salihu et al. J Obs Gyn Res 2008, Reddy et al. Obstet Gynecol 2010, Heazell and Froen, J Obs Gyn 2005, Kesmodel et al. Am J Epidemiol 2002, McCowan et al. ANZJOG 2007, Gardosi et al. BMJ ,2013. Lamont et al. BMJ 2015

Why is previous stillbirth important?



What are women's experiences in subsequent pregnancies?

DOI: 10.1111/1471-0528.12656
www.bjog.org

Systematic review

Parents' experiences and expectations of care in pregnancy after stillbirth or neonatal death: a metasynthesis

TA Mills,[a] C Ricklesford,[b] A Cooke,[a] AEP Heazell,[b,c] M Whitworth,[b,c] T Lavender[a]

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Accepted 6 December 2013. Published Online 4 March 2014.

Background Pregnancy after perinatal death is characterised by

Main results Fourteen studies were included in the synthesis,

What is Rainbow Clinic?

- Multidisciplinary Specialist Clinic
- Consultant Led
  - Additional midwifery Support
  - Continuity of Care/Carers
  - Directed investigations
- Placental profile at 23 weeks
- Shared care with relevant services
  - Diabetes / Hypertension Clinic

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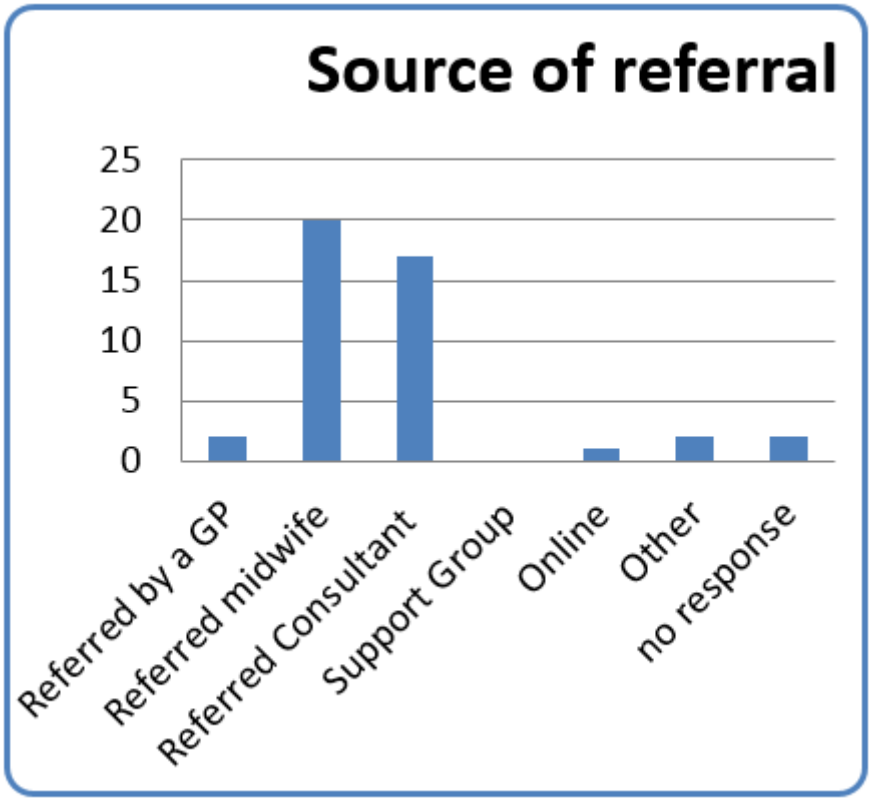
Referral Criteria

- Previous stillbirth after 24 weeks
- More than one previous stillbirth after 24 weeks
- Previous fetal death in utero between 20-24 weeks
- Previous neonatal death due to placental cause

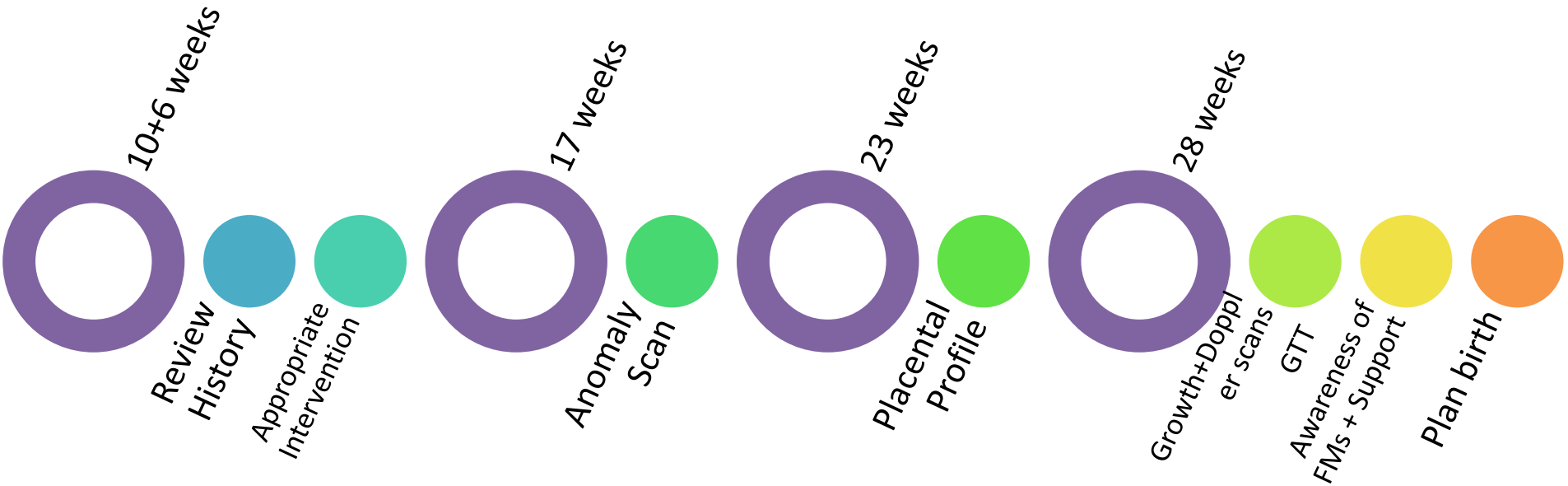


Clinical Care After Stillbirth

Continuous Pathway

- Diagnosis
- Induction of Labour
- Complications during birth
- Investigations
- Bereavement Support
- Preconception Care
- Care in Subsequent Pregnancy

Care in Subsequent Pregnancy



Interventions in Subsequent Pregnancy

- Stop cigarette smoking [B]
  - Räisänen S et al. 2013 – Smoking cessation in first trimester reduced risk of stillbirth to same as non-smokers
  - Cnattingius et al. 2006 – smoking in next pregnancy reduced in women had experienced a stillbirth (OR 0.76) compared to non-fatal outcomes
- Aspirin [A]
  - Roberge et al. 2013 - 75-150mg Aspirin <16/40 has greater effect in reducing perinatal death (RR = 0.41 vs. 0.93)
- Low molecular weight heparin [B-]
  - Kupferminic et al.2011 – LMWH in women with inherited thrombophilia 0% recurrence vs. 7% untreated
  - Kupferminic et al. 2011b – LMWH in women with placental findings without thrombophilia 6% treated vs 22% in untreate

MANCHESTER 1824

The University of Manchester

NHS Manchester University NHS Foundation Trust

Compassionate Care

Tommy's

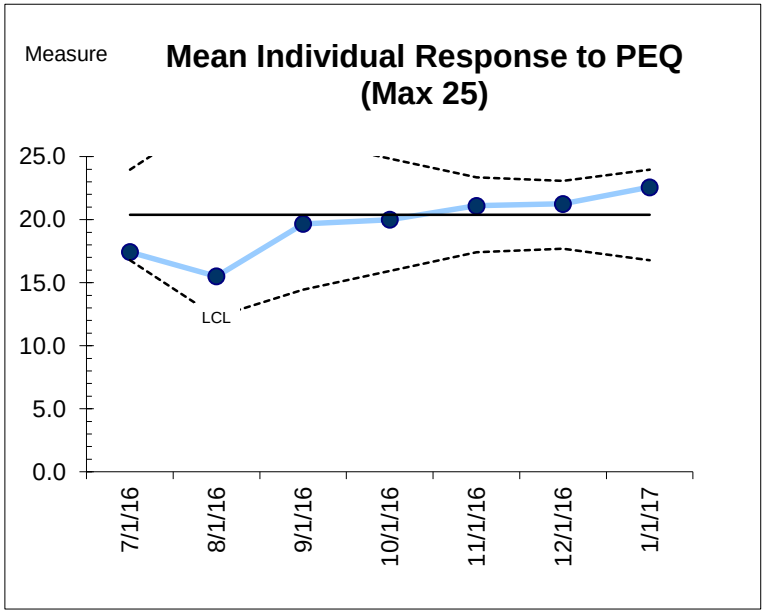
St Mary's Rainbow Clinic

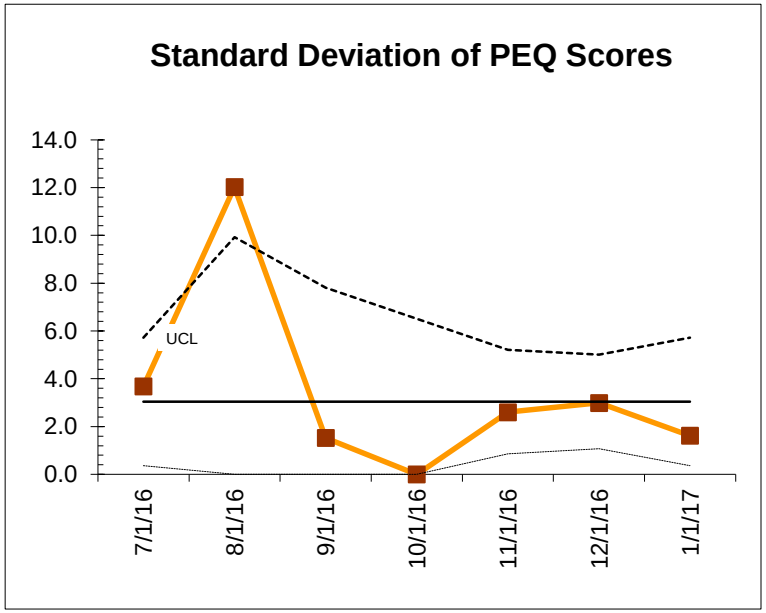
Outcome Data

- Preterm birth rate has remained lower than before Rainbow Clinic (6.5% vs. 21%)
- High Caesarean section rate (dependent on previous IPSB)
- NICU admission reducing in frequency

Year	Period	Births <37w (%)	IOL (%)	El CS (%)	Em CS (%)	SVD (%)	Instrumental Delivery (%)	NICU (%)
2016	Q1	0	41.7	20.7	37.9	37.9	3.4	17.2
	Q2	18.8	68.4	18.8	12.5	65.6	3.1	12.5
	Q3	22.2	79.2	24.4	24.4	44.4	6.7	17.7
	Q4	5.71	22.8	37.1	11.4	45.7	5.71	8.5
2017		6.5	38.6	24.4	9	50	7.95	12.5

Patient Experience Questionnaire





- Median score increased to be consistently >20
- 6 points of consecutive improvement since September 2016

Qualitative Data - Experience

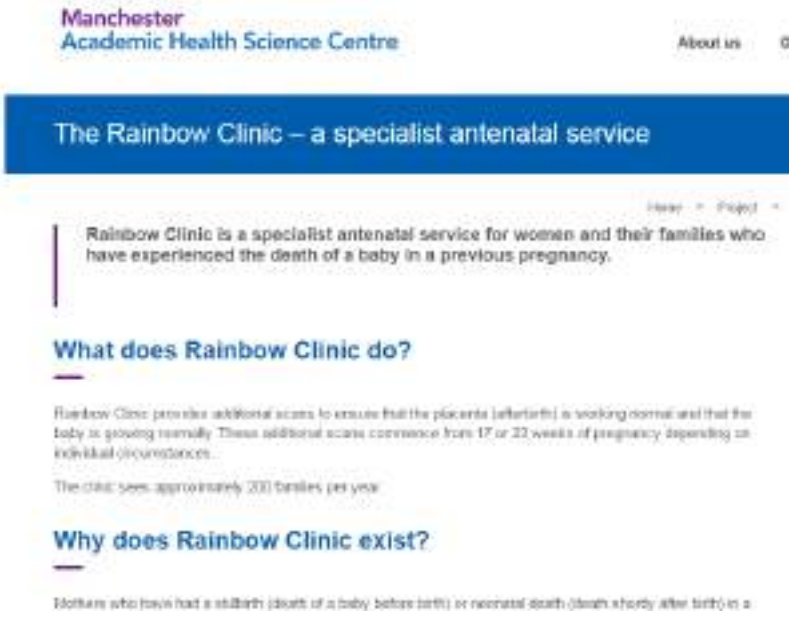
"I would recommend the Rainbow Clinic without any hesitation. This pregnancy has been tough but it would have been so much more difficult without the support and expertise of the Rainbow Clinic."

"I would recommend the Rainbow Clinic to another family. The midwife and doc have been lovely and help me after the loss of our little boy."

"Feels like there should be one in every hospital."

Rainbow Clinic Website

http://www.mahsc.ac.uk/projects/rainbowclinic/



Follow Us on Twitter

@MRainbowclinic
@MCR_SB_Research
@louloustevo

The AHSN Network

NHS Improvement

Table discussion

Greater Manchester

Patient Safety Collaborative

Table discussion

- Half of the tables starts with Episcissors
- Other half starts with Rainbow clinic
- On your tables answer the following questions:

1. What is your current practice?
2. What do you need to get it working in your system?
3. What are some of the barriers
4. Who might be the champions who could help you unblock these barriers

10 minutes

The AHSN Network

NHS Improvement

National Maternity and Neonatal collaborative – role of the Patient Safety Collaborative

Debby Gould

Clinical lead maternity and neonatal GM Patient safety Collaborative, Health Innovation Manchester

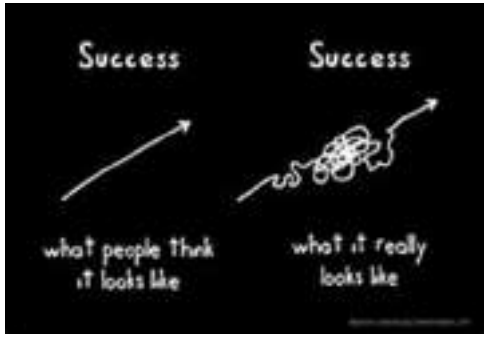
Greater Manchester

Patient Safety Collaborative

What is the ambition of the maternity and neonatal collaborative?

By 2020 each Trust, local maternity system and network should have:

- significant capability (& capacity) for **improvement**
- detailed knowledge of local cultural issues
- developed a locally sensitive **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**



Safety Improvement Innovation

Wave 1

NHS The Pennine Acute Hospitals NHS Trust

Wave 2

NHS Bolton NHS Foundation Trust

East Cheshire NHS Trust

Wave 3

NHS Wrightington, Wigan and Leigh NHS Foundation Trust

Stockport NHS Foundation Trust

NHS Tameside and Glossop Integrated Care NHS Foundation Trust

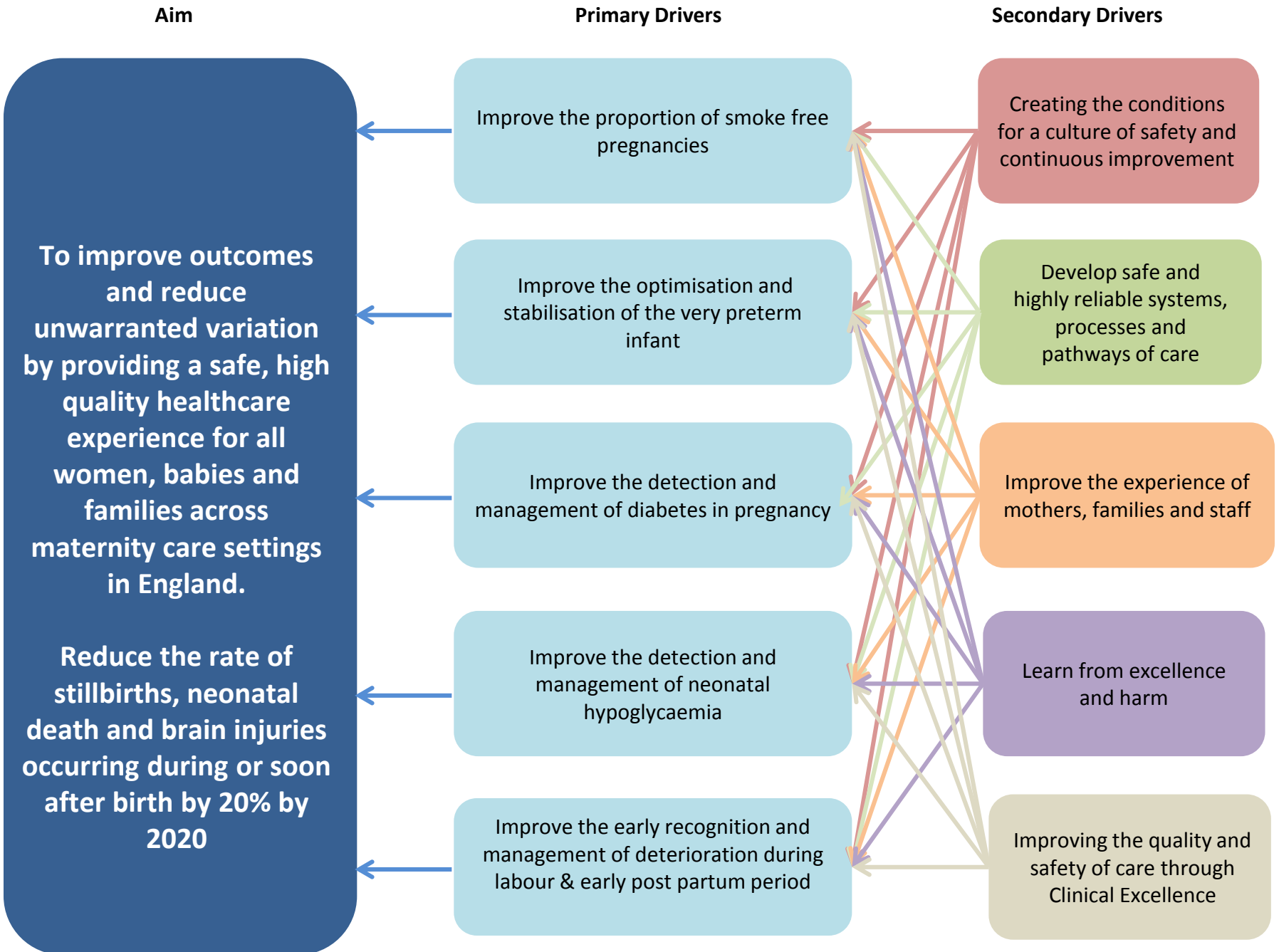
NHS Manchester University NHS Foundation Trust

NHS Wrightington, Wigan and Leigh NHS Foundation Trust

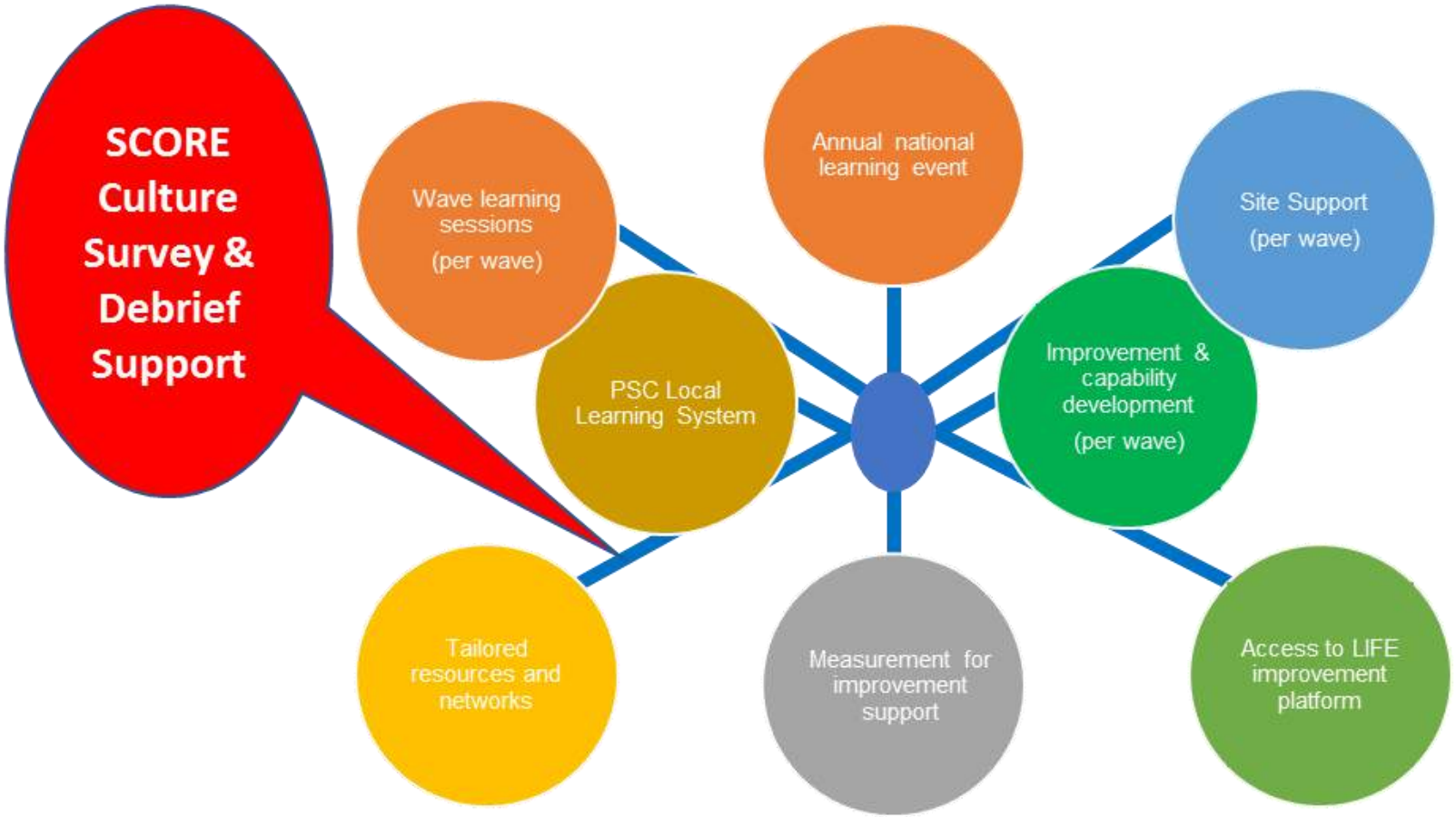
TheAHSNNetwork

National Driver Diagram - Version 6 Jan 2018

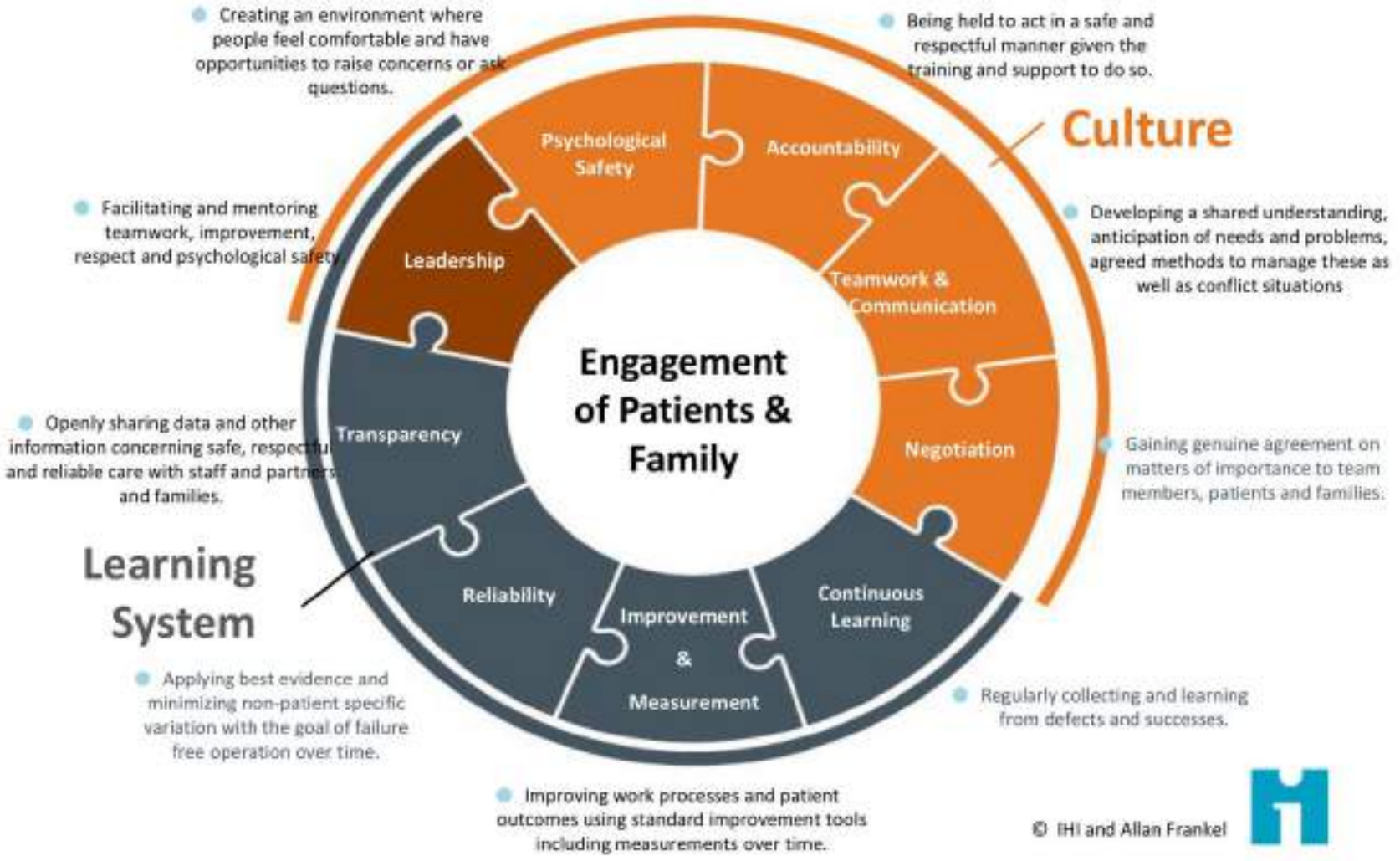
NHS Improvement



What additional support do organisations in the national learning set receive?



Framework for Safe, Reliable and Effective Care



Psychological Safety

South West Academic Health Science Network

We are our own image consultants and best image protectors

To protect one's image, if you don't want to look:

STUPID	Don't ask questions
INCOMPETENT	Don't ask for feedback
NEGATIVE	Don't be doubtful or criticize
DISRUPTIVE	Don't suggest anything innovative

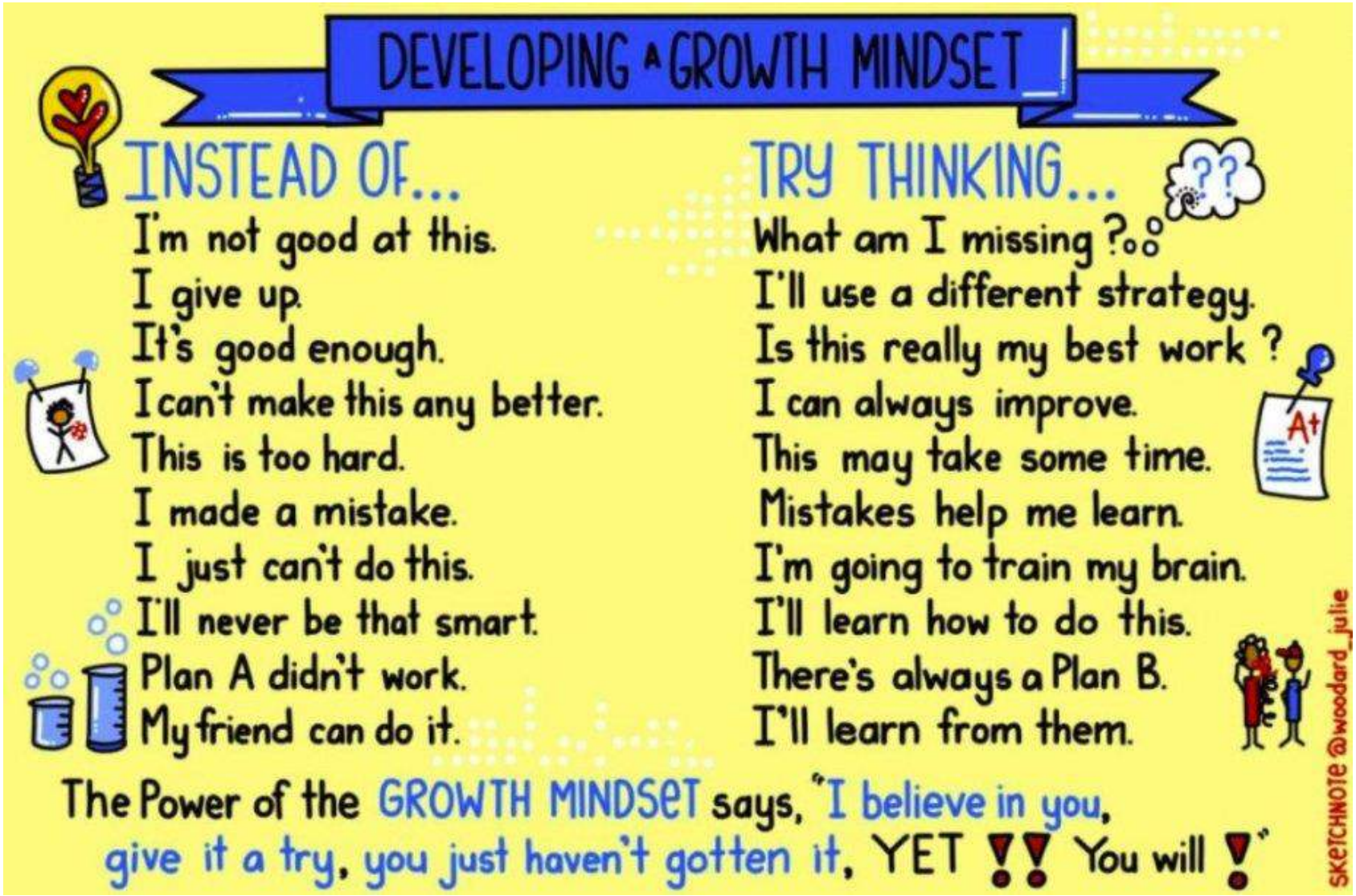
Source: Amy Edmondson

What is Safety Culture?

South West Academic Health Science Network

- Shared basic assumptions
- Discovery, creation or development of those assumptions by a defined group
- Group learning of how to cope with its problem of external adaptation and internal integration
- Identification of ways that have worked well enough to be considered valid
- Teaching new members of the group the correct way to perceive, think and feel in relation to any problems

Weick K and Sutcliffe KM. Managing the unexpected. Assuring high performance in an age of complexity. Josey Boss, San Francisco, 2001


DEVELOPING A GROWTH MINDSET
INSTEAD OF...
I'm not good at this.
I give up.
It's good enough.
I can't make this any better.
This is too hard.
I made a mistake.
I just can't do this.
I'll never be that smart.
Plan A didn't work.
My friend can do it.
TRY THINKING...
What am I missing ?
I'll use a different strategy.
Is this really my best work ?
I can always improve.
This may take some time.
Mistakes help me learn.
I'm going to train my brain.
I'll learn how to do this.
There's always a Plan B.
I'll learn from them.
The Power of the GROWTH MINDSET says, "I believe in you, give it a try, you just haven't gotten it, YET !! You will !"
SKETCHNOTE @woodard_julie

For further information on Health Innovation Manchester Patient Safety Collaborative

Debby Gould

Clinical Lead Maternity Neonatal Collaborative

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@healthinnovmcr

Tel: 0161 206 7979

HInM, Suite C, Third Floor, Citylabs, Nelson St, Manchester , M13 9NQ

NHS Improvement

Pennine Acute NHS Trust

Our Journey So Far ..

National maternal and neonatal health safety collaborative

Meet the team

Penny Martin – Divisional Managing Director

Jen McCartney – Divisional Support Manager

Lewis Stott – Assistant Directorate Manager

@MatNeoQI
improvement.nhs.uk

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CQC 2016…….

Inadequate

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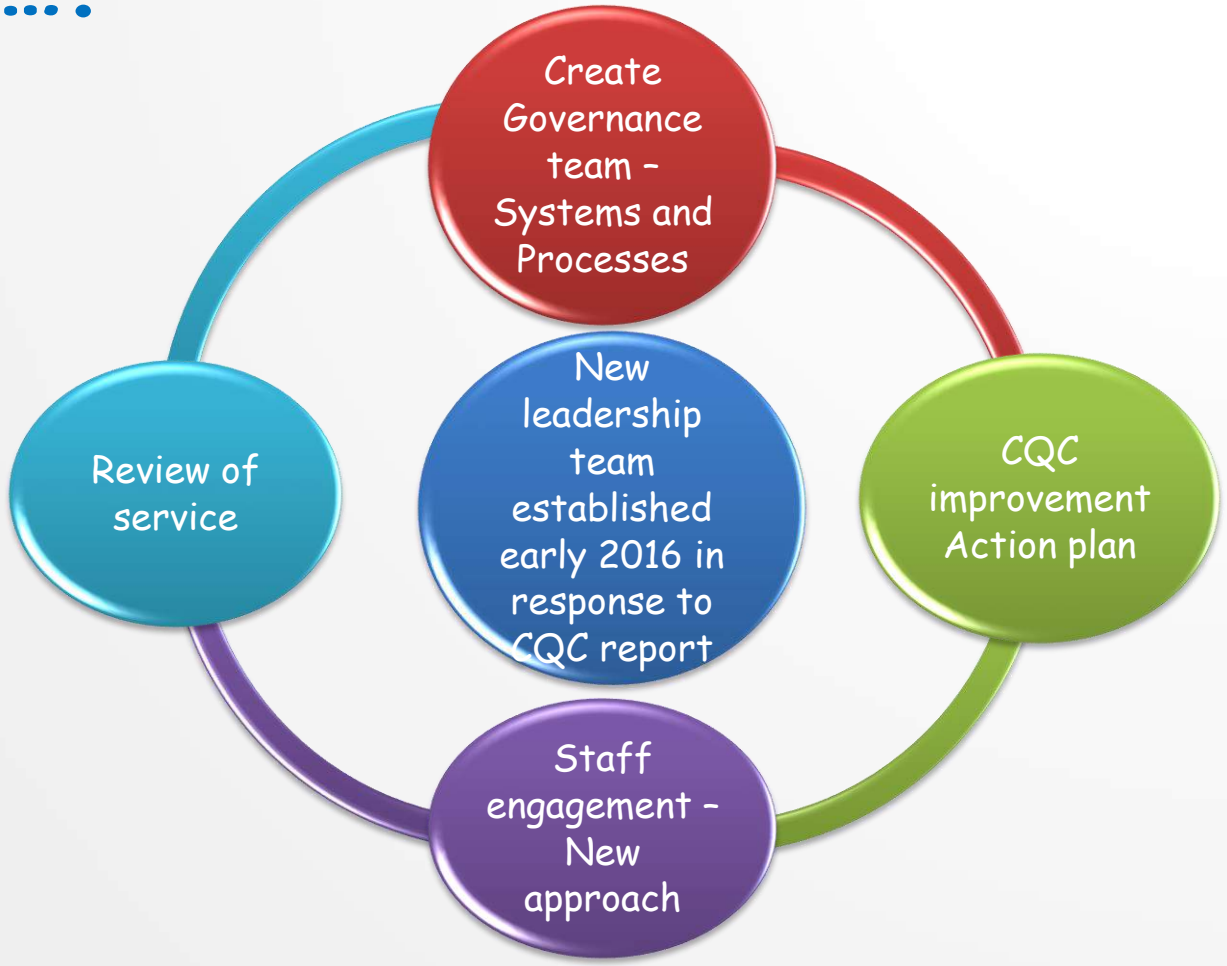
Staff felt……

Led to…….


Create Governance team – Systems and Processes
CQC improvement Action plan
Staff engagement – New approach
Review of service
New leadership team established early 2016 in response to CQC report

Saving lives, Improving lives

NHS
Oldham Care Organisation
Northern Care Alliance NHS Group

What happened next…

May 2017 successful application to join wave 1 of the NHSI Maternity & Neonatal Safety Collaborative

Our Approach

Focus on

- "Saving babies" A framework for improvement
- Improving the identification and management of sepsis in babies
- Improving the reliability of fetal monitoring and neonatal resuscitation
- Human Factors – Break the Rules for Better Care

Our Challenges

- Time
- Staff engagement
- Focus

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Our focus today?

Break the Rules for Better Care

‘Break The Rules For Great Care’

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4.a) Work with Mothers and families to improve their experience of safer care. - Run the ‘ **Break the Rules for great care programme’ to collate minimum 500 responses from women and families and staff and report findings by 31st January 2018.**

Stakeholder Engagement	Patient experience midwife role links with careopinion /Healthwatch engagement events ie @whose shoes MLAG members and representatives to be involved in work streams of their choice
TED (Time; Escalation; Decision) Teaching resource to be used to lead improvement	Interactive workshop using TED at ‘Saving babies’ launch 18th October 2017 Develop TED cascade training for all staff
Implement ‘Listen to me’ programme	Develop guideline using the ‘Listen to me’ resource Launch & cascade teach ‘Listen to me’ Embed ‘Listen to me’ in mandatory training
Run ‘Break the rules for great care programme’	5 day event aiming for 500 responses from staff/women/ families Collate, respond and disseminate findings

Measures:

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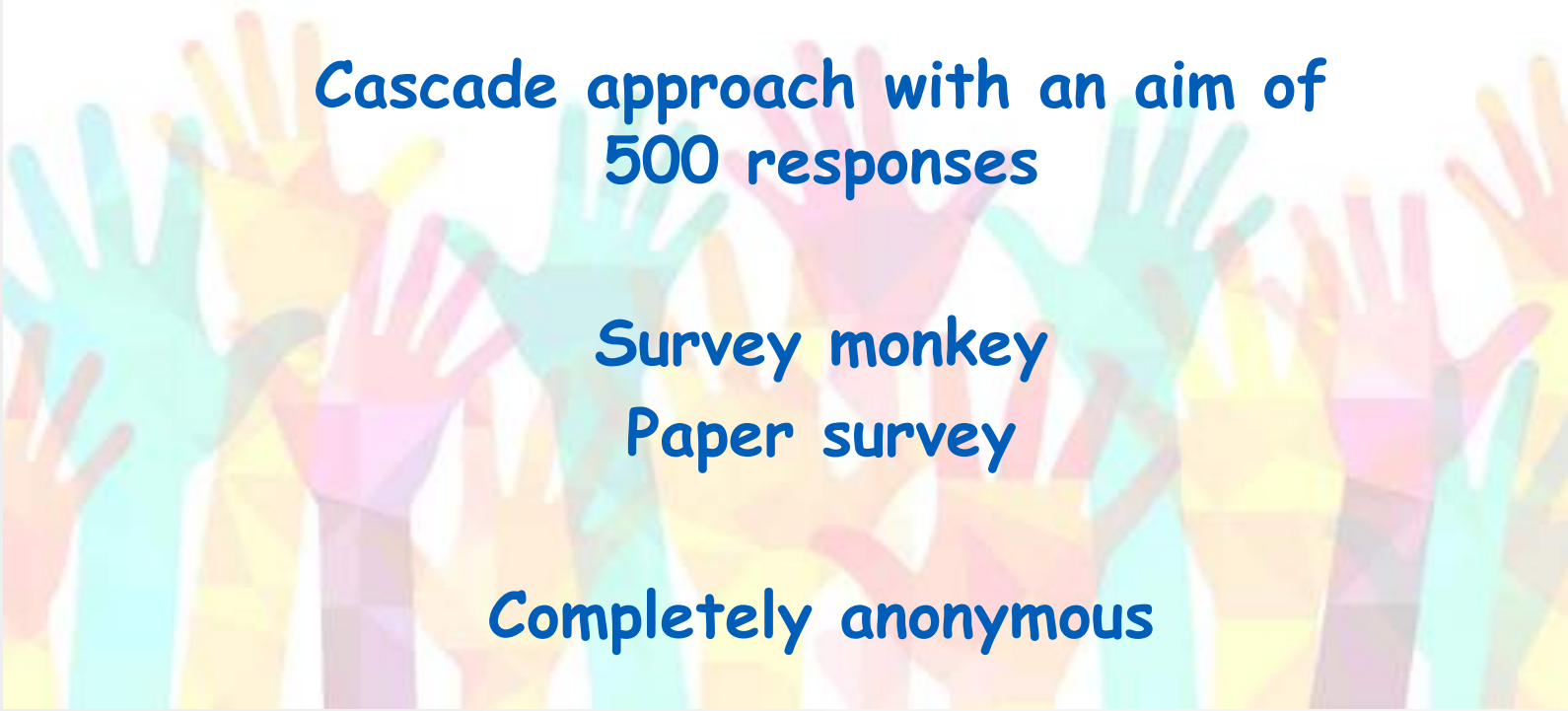
How to get involved



Cascade approach with an aim of 500 responses

Survey monkey

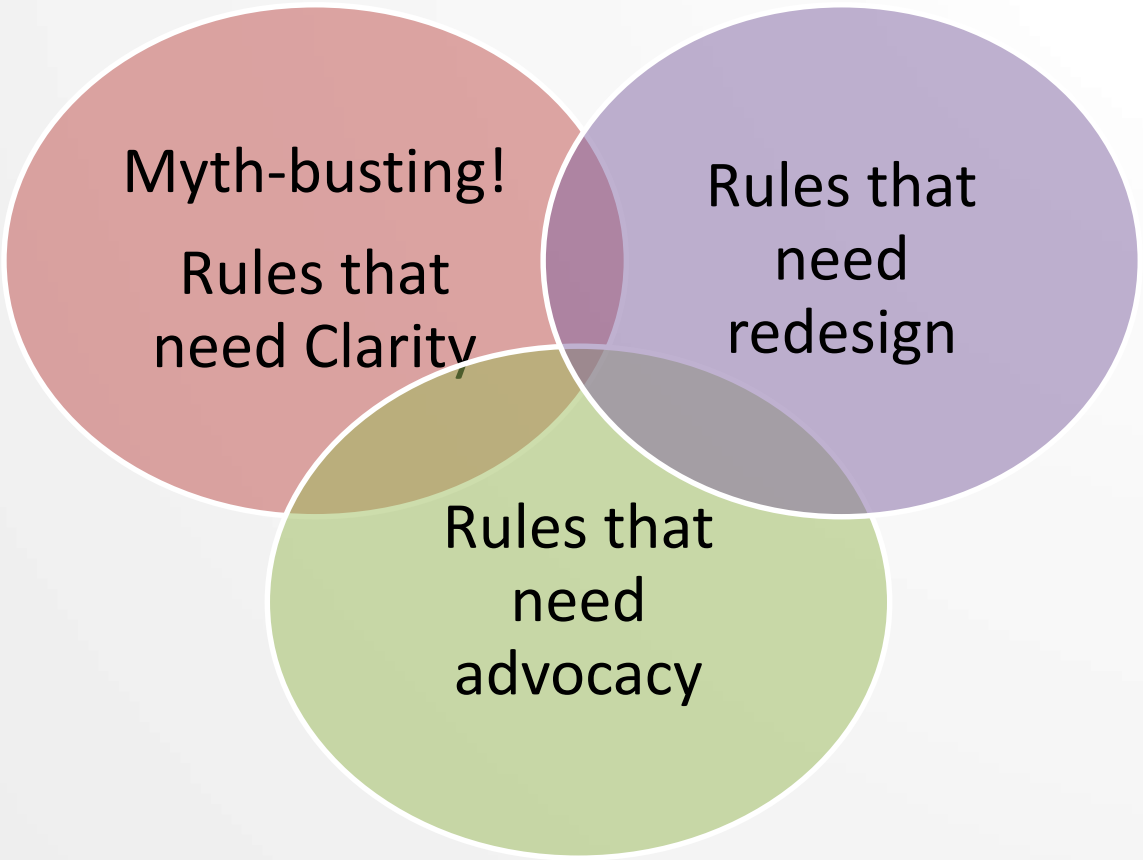
Paper survey

Completely anonymous

"If you could **break one rule** for better care what would it be and why?"

"If you could **change one aspect** of your care what would it be and why?"

Categories…


Myth-busting!
Rules that need Clarity
Rules that need redesign
Rules that need advocacy

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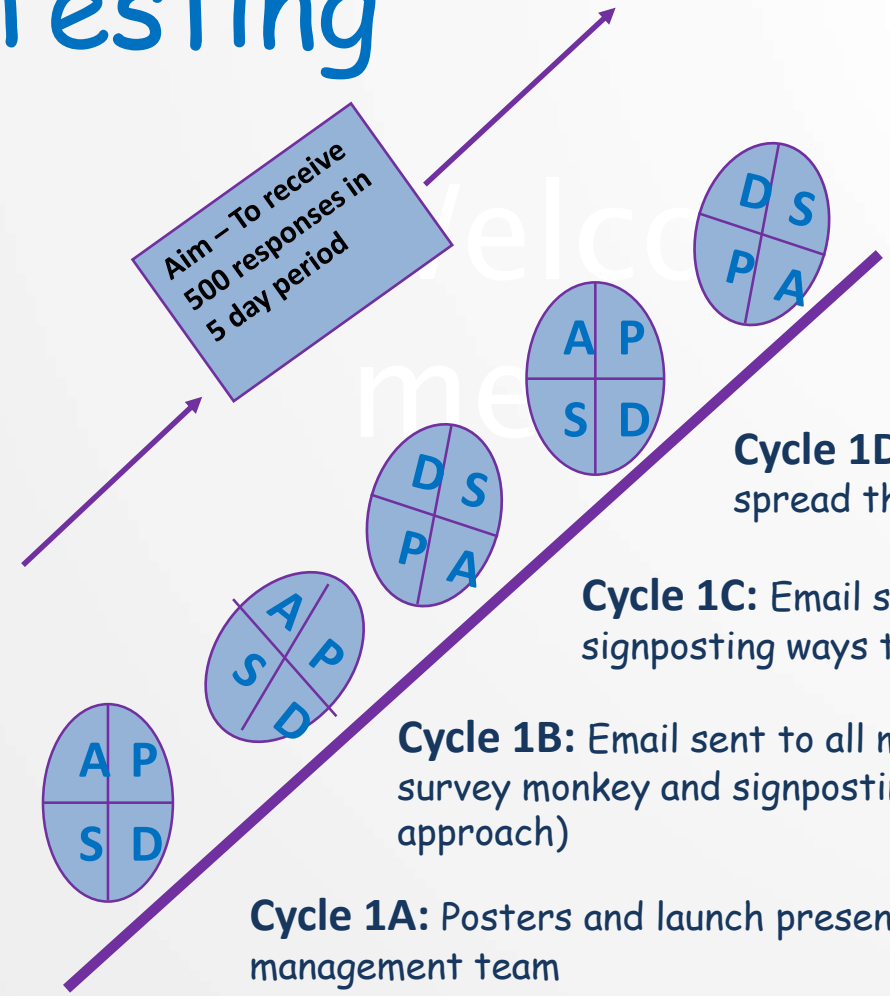
PDSA Testing



1E: Collate information review PDSA – 495 responses received

Cycle 1D: Small team floor walking to spread the word

Cycle 1C: Email sent to all staff signposting ways to respond

Cycle 1B: Email sent to all managers with links to survey monkey and signposting paper survey (cascade approach)

Cycle 1A: Posters and launch presentation to management team

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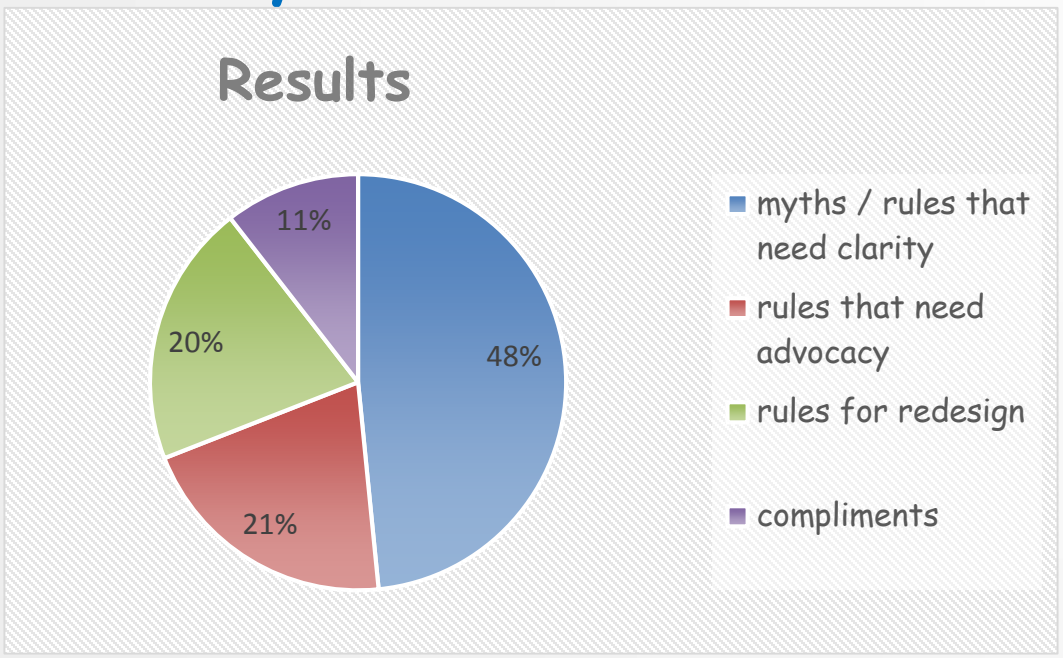
Analysis and themes



Themes

- Medication processes
- Agency staff capability
- IT systems
- Lumber puncture process
- Birth companions
- Paperwork
- Pain relief

Myth / clarity fact sheet to go out to all staff

Break the rules compliment board to display all the positive comments for our service

Rules that need redesign / clarity will be themed and established as workstreams

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Women and Families at the heart of everything

Care Opinion

Maternity Quality Improvement Forum

Whose Shoes

Patient Experience Midwife

Maternity Voices

Lessons Learned

- Recognition of slow start
- Strengthen relationship and utilise support from Health Innovation and AQUA
- Build on engagement from Break the Rules to continuously improve services in conjunction with staff and patients
- Using Life system share knowledge and learn from other Trusts
- Celebrate success of Break the Rules Campaign with teams and share compliments received during the campaign to continuously boost morale

And our advice to you …

Start small

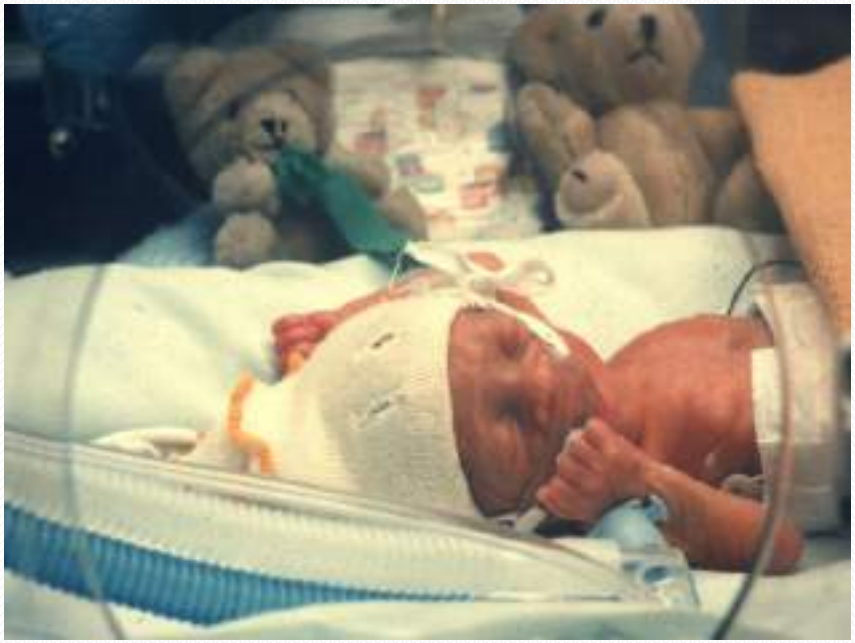
Go where the energy is ..

Use your data!

Any Questions

Maternity and Neonatal Safety Collaborative

Safety is the state of being "safe", the condition of being protected from harm or other non-desirable outcomes



Julie McCabe
Network Director
RGN RM BA MSc

Neonatal Work Programme

Better Health
Improving Outcomes

- Family integrated care
- Reducing the number of babies separated from their mothers
- Optimising Place of delivery
- Network approach to the reduction in neonatal mortality
- Workforce development

Better care
Improving Quality

- Cardiac pathway
- Integrated palliative care
- Surgical pathway
- Single surgical service
- Neonatal outreach CQUIN
- Network education and training
- Workforce development

Better value
Right care, right place, right professional

- Activity Capacity Demand review
- Central capacity cot/bed management system
- Network procurement
- New Pricing and contracting models
- Workforce planning

Quality Improvements

- NWNODN quality improvement programme
- Maternity and Neonatal Transformation – local Maternity Systems
  - Better births implementation plan
- Maternity and Neonatal Health Safety collaborative
  - Support maternal and neonatal care services to provide a safe, reliable and quality healthcare experience to all women, babies and families across maternity care settings in England
  - Create the conditions for continuous improvement, a safety culture and a national maternal and neonatal learning system.
  - Contribute to the national ambition of reducing the rates of maternal and neonatal deaths, stillbirths, and brain injuries that occur during or soon after birth by 20% by 2020.

Neonatal Mortality EMBRRACE 2017

	Births	Code
Cheshire and Merseyside Neonatal Network	28,573	●
Lancashire and South Cumbria Neonatal Network	16,986	●
Greater Manchester Neonatal Network	37,215	●

- ● up to 10% higher than the average for the comparator group
- ● more than 10% higher than the average for the comparator group

NHS Improvement

Maternal and neonatal health safety collaborative: national learning event

Thursday 1 March 2018

collaboration trust respect innovation courage compassion

5 key Clinical Interventions

1. Improve the proportion of smoke free pregnancies
2. Improve the optimisation and stabilisation of the very preterm infant
3. Improve the detection and management of diabetes and management of diabetes in pregnancy
4. Improve the detection and management of neonatal hypoglycaemia
5. Improve the early recognition and management of deterioration of either mother or baby during or soon after birth

Public Health England

Child Health Profile

March 2017

Manchester

This profile provides a snapshot of child health in this area. It is designed to help local government and health services improve the health and wellbeing of children and tackle health inequalities.

The child population in this area

		Local	Region	England
Live births (2015)		8,051	85,838	664,399
Children aged 0 to 4 years (2015)		38,700 7.3%	443,200 6.2%	3,434,700 6.3%
Children aged 0 to 19 years (2015)		135,500 25.6%	1,698,900 23.7%	13,005,700 23.7%
Children aged 0 to 19 years in 2025 (projected)		150,400 26.2%	1,767,000 23.8%	14,002,600 23.8%
School children from minority ethnic groups (2016)		39,424 60.9%	191,921 21.2%	2,032,064 30.0%
Children living in poverty aged under 16 years (2014)		35.6%	22.8%	20.1%
Life expectancy at birth (2013-2015)	Boys	75.6	78.1	79.5
	Girls	79.8	81.8	83.1

Children living in poverty

Map of the North West, with Manchester outlined, showing the relative levels of children living in poverty.

Key findings

Children and young people under the age of 20 years make up 25.6% of the population of Manchester. 60.9% of school children are from a minority ethnic group.

The health and wellbeing of children in Manchester is generally worse than the England average. The infant mortality rate is worse than the England average. The child mortality rate is similar to the England average.

The level of child poverty is worse than the England average with 35.6% of children aged under 16 years living in poverty. The rate of family homelessness is worse than the England average.

Children in Manchester have worse than average levels of obesity: 11.4% of children aged 4-5 years and 25.1% of children aged 10-11 years are classified as obese.

In 2015/16, children were admitted for mental health conditions at a similar rate to that in England as a whole. The rate of inpatient admissions during the same period because of self-harm was lower than the England average.

In 2015/16, there were 31,975 A&E attendances by children aged four years and under. This gives a rate which is higher than the England average. The hospital admission rate for injury in children is higher than the England average, and the admission rate for injury in young people is lower than the England average.

Improve the optimisation and stabilisation of the very preterm infant

<27 Week First Admissions Apr 16 – Mar 17

Locality/Unit	<27 weeks first admissions
Greater Manchester	127
A (NICU)	50
B	3
C	1
D (NICU)	35
E (NICU)	28
F	5
G	0
H	5
Cheshire & Merseyside	69
Lancashire and South Cumbria	52
Grand Total	248

	IC %	
NICUs	2015/16	2016/17
Greater Manchester	89%	90%
Cheshire & Merseyside	73%	83%
Lancashire & South Cumbria	89%	91%

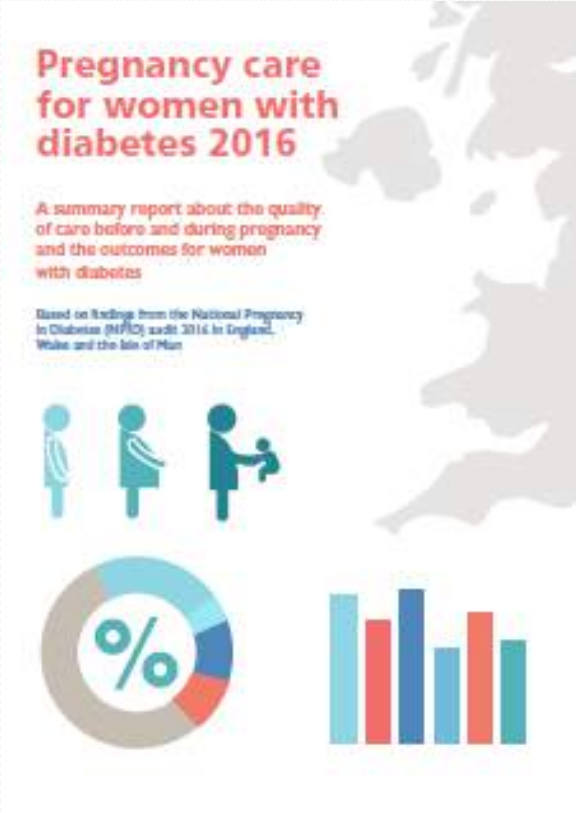
Optimising Outcomes

Administration of steroids 24- 34/40 2015-2017				
	Eligible Mothers	Steroids given (%) (N: National %)	Not given	Missing/Unknown
2015	2439	2098 (84%) (N: 85%)	330	9
2016	2353	2011 (85%) (N: 85%)	299	43
2017	2318	2017 (87%) (N: 82.6)	223	78

PReCePT: Reducing cerebral palsy through improving uptake of magnesium sulphate in preterm deliveries

Administration of Magnesium Sulphate < 30/40 2016 -2017				
	Eligible Mothers	Magnesium Sulphate Given(%) (N: National %)	Not given	Missing/Unknown
2016	586	205 (35%) (N: 39%)	188	193
2017	532	321 (60%) (N: 57.4%)	140	71

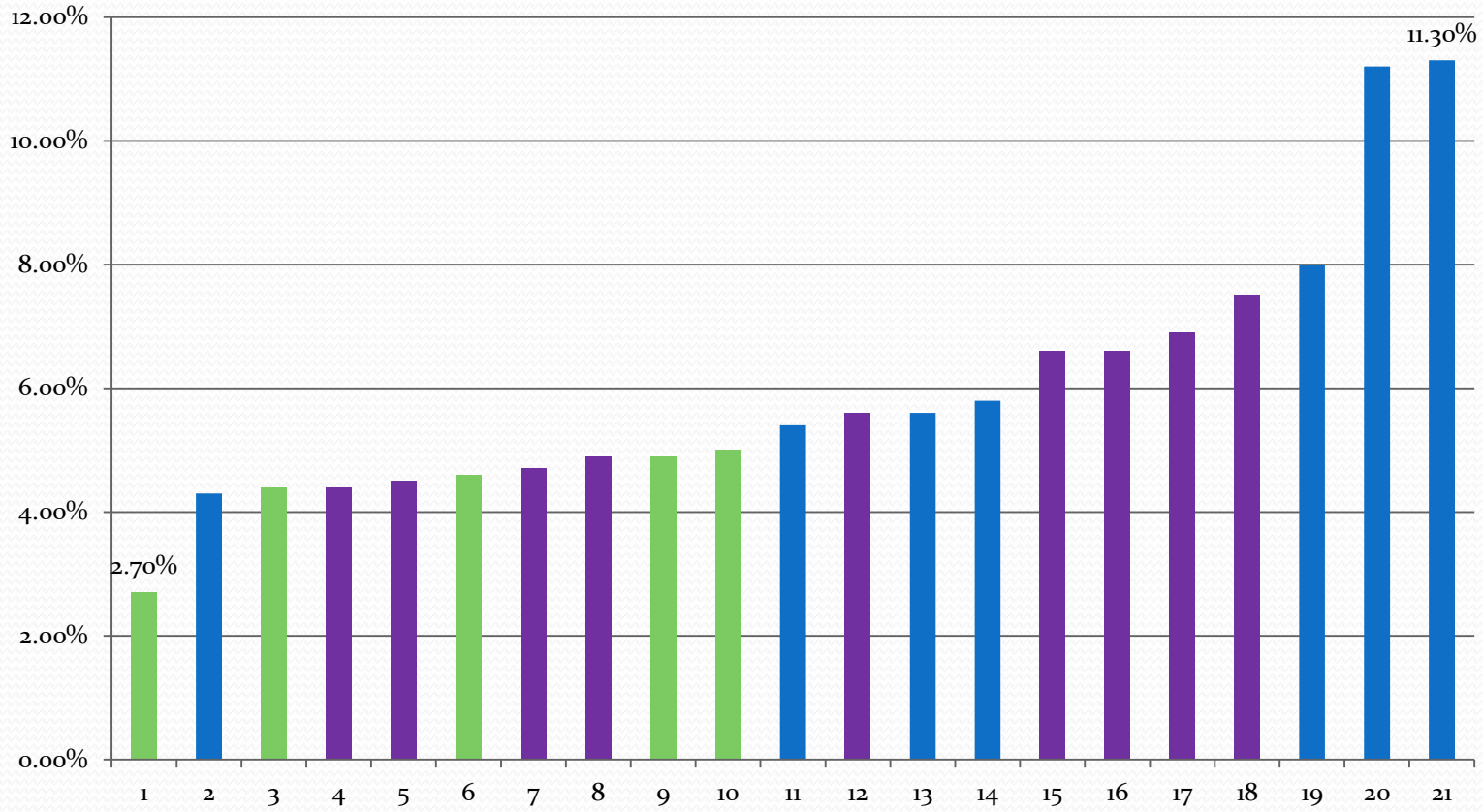
Improve the detection and management of diabetes in pregnancy



Improve the detection and management of neonatal hypoglycaemia

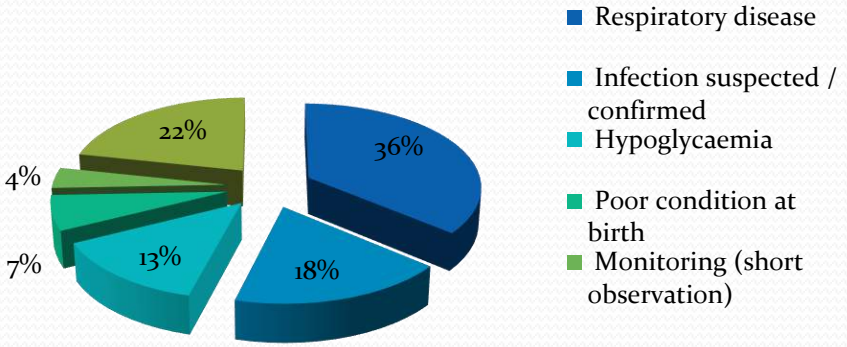
Term admissions by unit as % of total births

L&SC
GM&EC
C&M

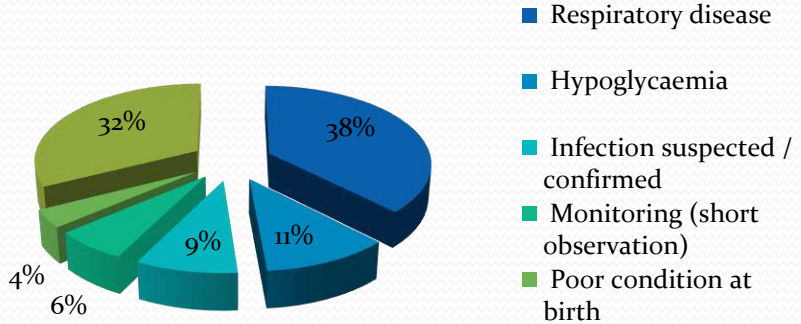


Top 5 reasons for Admission

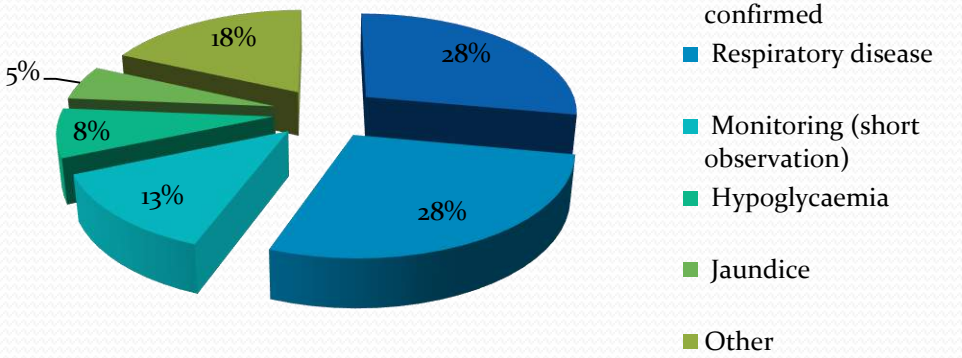
Lancashire and South Cumbria



Greater Manchester & East Cheshire



Cheshire & Merseyside



Improve the early recognition and management of deterioration of either mother or baby during or soon after birth

Surveillance, Benchmarking, Learning

NWNODN Dashboard - Activity and Transfers

NHS North West Neonatal Operational Delivery Netw

Working together to provide the highest standard of care for babies and families

CRITERIA	QUERY	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Average
TERM ADMISSIONS	NUMBER OF TERM ADMISSIONS	332	352	328	373	336	363	319	356	364	380	365	336	350
	% OF TOTAL LIVE BIRTHS	4.7%	5.2%	4.8%	5.4%	5.5%	5.3%	4.8%	5.1%	5.6%	5.3%	5.2%	4.8%	5.1%
	% OF NNU ADMISSIONS	56%	52%	55%	49%	49%	48%	55%	52%	52%	48%	50%	52%	52%
	% of TERM BIRTHS (37+ weeks)	48.5%	49.2%	48.1%	54.5%	52.3%	51.9%	48.0%	50.6%	52.0%	52.1%	49.5%	50.0%	50.6%
<27 WEEKS IN LNU	TOTAL <27 WEEKS BORN IN LNU	3	2	1	5	2	1	6	0	4	4	3	4	2.9
	TOTAL <27 WEEKS STILL IN LNU AFTER 24 HRS	0	0	0	0	0	0	0	0	0	0	0	0	0.0
<32 WEEKS IN SCBU (FURNESS GENERAL HOSPITAL)	TOTAL <32 WEEKS BORN IN SCBU	0	0	0	0	1	0	0	0	1	0	0	0	0.2
	TOTAL <32 WEEKS STILL IN SCBU AFTER 24 HRS	0	0	0	0	0	0	0	0	0	0	0	0	0.0
% NETWORK IC ACTIVITY IN NICUs	NWNODN	87%	91%	91%	88%	87%	92%	89%	91%	89%	88%	86%	88%	89%
	CHESHIRE & MERSEYSIDE	86%	88%	86%	82%	83%	87%	79%	89%	85%	84%	84%	84%	85%
	GREATER MANCHESTER	88%	94%	93%	94%	88%	95%	96%	91%	93%	90%	87%	89%	91%
	LANCASHIRE & SOUTH CUMBRIA	87%	94%	89%	80%	91%	95%	87%	92%	90%	88%	88%	93%	90%
INAPPROPRIATE TRANSFERS OUT OF NWNODN (TARGET <5%)	% TRANSFERS OUT OF NWNODN	0.00%	0.28%	0.00%	0.00%	0.16%	0.14%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.05%
	CHESHIRE & MERSEYSIDE	0.00%	0.78%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.06%
	GREATER MANCHESTER	0.00%	0.00%	0.00%	0.00%	0.00%	0.30%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.03%
	LANCASHIRE & SOUTH CUMBRIA	0.00%	0.00%	0.00%	0.00%	0.76%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.06%

Activity | Transfers | Clinical | Outcomes | Nurse Staffing

Strategy for Success

- Focus on patient
- Focus on quality improvement
- Quality improvements that will make a difference
- Identify priorities
- Evidence and Data to inform change and evaluation of impact
- Working at different levels, local teams network wide, ODN wide and Nationally
- Articulate what good looks like
- Share good practice
- Link and build relationships with people that can make change happen and ensure it is sustainable
- Robust Governance

Thank You

Julie.mccabe@alderhey.nhs.uk

07725515999

Greater Manchester Patient Safety Collaborative

TheAHSNNetwork

NHS Improvement

Health Innovation Manchester

Big 5 Barometer

Organisation:

Mark where you think your organisation is on the improvement journey for the following topics

	Don't know	Getting started	Solved it
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			

The AHSN Network

NHS Improvement

Lunch

Greater Manchester

Patient Safety Collaborative

The AHSN Network

NHS Improvement

Learning Systems – how do we work together?

Greater Manchester

Patient Safety Collaborative

Facilitators all set?

Facilitator Name	Table Number	Colour
Debby Gould	1	Grey
Tazeem Shah	2	White
Joanna Casby	3	Yellow
Hakeel Qureshi	4	Brown
Bob Diepeveen	5	Light pink
Eva Bedford	6	Purple
Krishna Agravat	7	Red
Farah Irfan-Khan	8	Bright pink

Discussion – What is a Local Learning System?

Take 5 minutes to discuss how you would define a maternity/neonatal learning system across GM?

What is a Local Learning System?

- Local Learning Systems will be the Improvement community aligned to support each LMS
- Waves and stakeholders will share and learn from each other
- groups to meet **four** times per year
- All providers and other key stakeholders to be included from the outset
- Opportunity for system level improvement / scale up within each LMS
- Operating model needs to be sensitive to current local activity and network / LMS maturity

What should a local learning system provide?

- A forum for local improvement to thrive
- An opportunity for all network partners to work collaboratively
- Effective collaboration between local partners
- Opportunities for system level improvement
- An opportunity for increasing local improvement capability
- A sustainability solution for maternal and neonatal improvement

Pre-Mortem / TRIZ

- Make a list of all you can do to:

make the Maternity and Neonatal Learning System fail

- First take about 2 minutes to create your individual list
- After that share your ideas on your table and capture them on flipchart

10 minutes

Pre-Mortem / TRIZ
Step 2:

- Have you ever experienced any of the items on your list, Please circle these items.
- Have a discussion per circled item and share your experiences.

10 minutes

Pre-Mortem / TRIZ
Step 3:

- How can these circled items be turned into ideas for our network?
  - What can I / We (Learning System) / Patient Safety Collaborative / Others contribute to stop this from happening?
  - Capture your output in a table like this:

List Barrier/Issue	I	We (Learning System)	GMPSC	Others

15 minutes

The AHSN Network

NHS Improvement

Use of Quality improvement in the Patient Safety Collaborative

Bob Diepeveen
Improvement Advisor
@diepbob

Greater Manchester

Patient Safety Collaborative

Quality Improvement knowledge

- Please fill out this short questionnaire :

https://www.surveymonkey.co.uk/r/BNLBVLR

Please rate yourself for each of the following theories, methodologies or skills of Quality Improvement using the scoring below:

Level 0	I have no knowledge of this.
Level 1	I have some awareness of this but I do not know how to apply it.
Level 2	I am able to apply this in limited scenarios with some assistance.
Level 3	I know when, where and how to apply this and am able to do so on my own.
Level 4	I have good experience of using this and am able to adapt to use in a multitude of situations.
Level 5	I can teach this theory, methodology or skill to others.

My first improvement project

- What is the problem?

- (Video not included on the website)

What are you trying to accomplish?

Criteria for a good aim

- Specific
- Measurable
- Timely

Example

- Reduce the number of Grade 4 Pressure Ulcers in Greater Manchester by 25% by 31st of December 2018

AIM

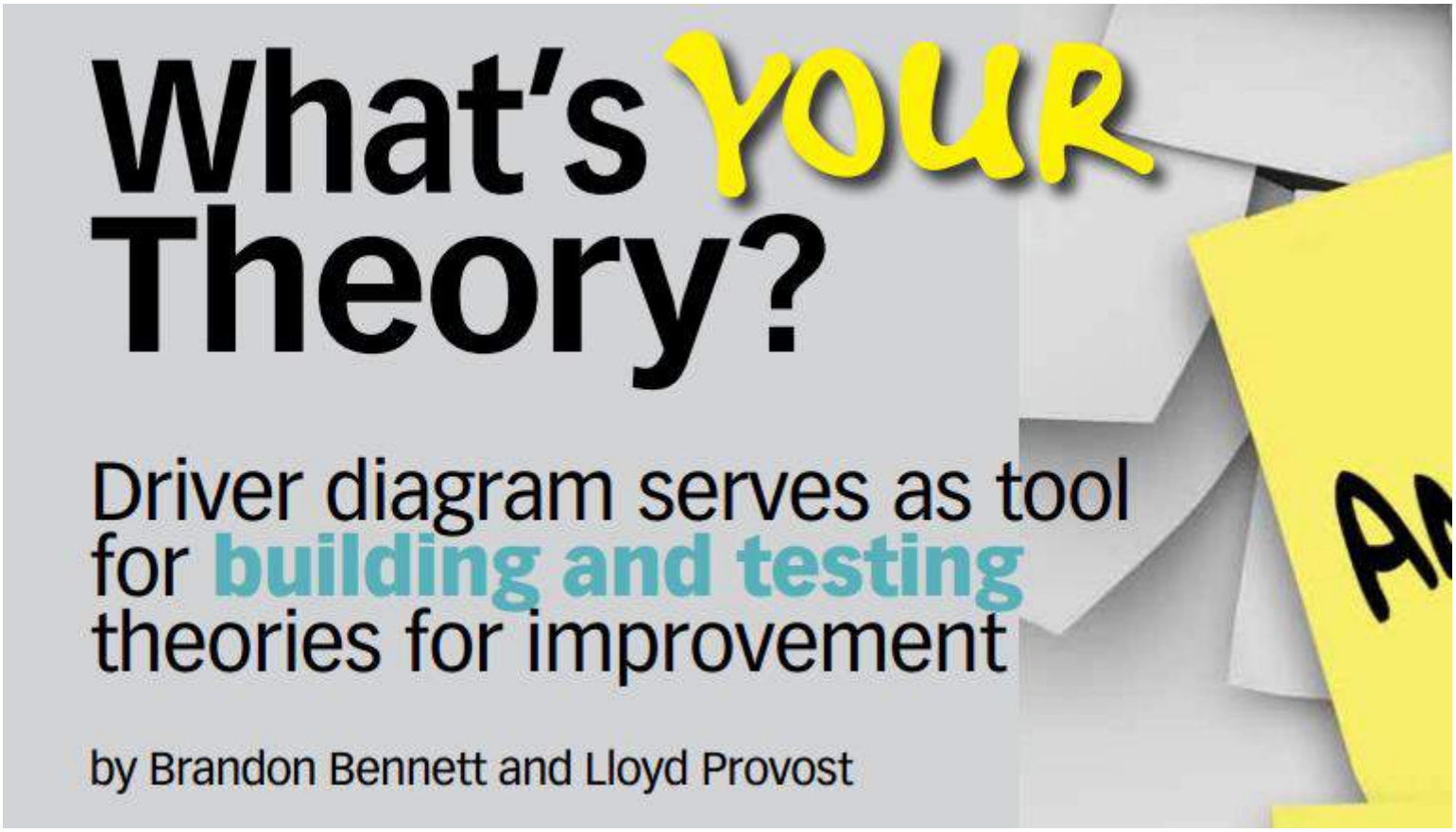
- What's an aim for my first improvement project

How do we know that a change is an improvement?

Operational definition

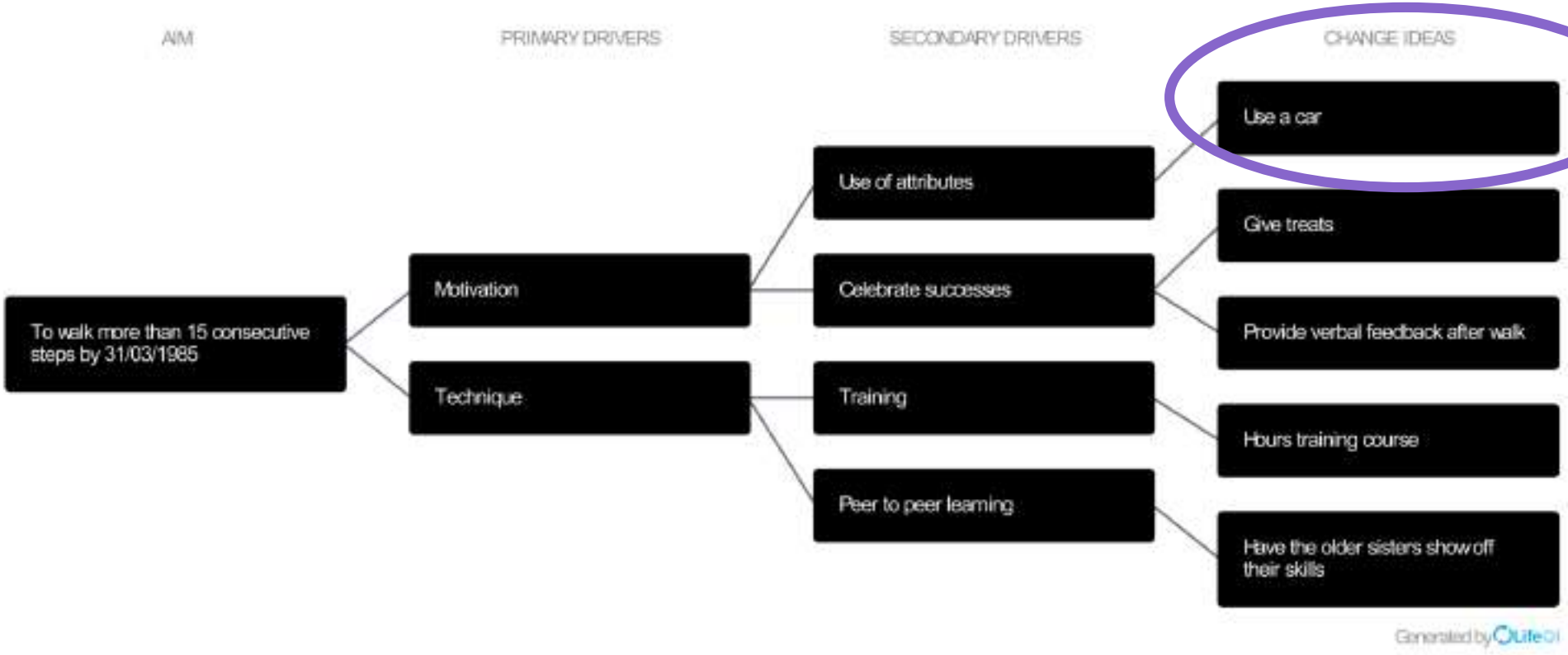
- (Video not included on the website)

What changes can we make that will result in improvement?



Bennet B, Provost L. What's your theory, QP, 2015-07:36-43

What change can we make that will result in improvement?

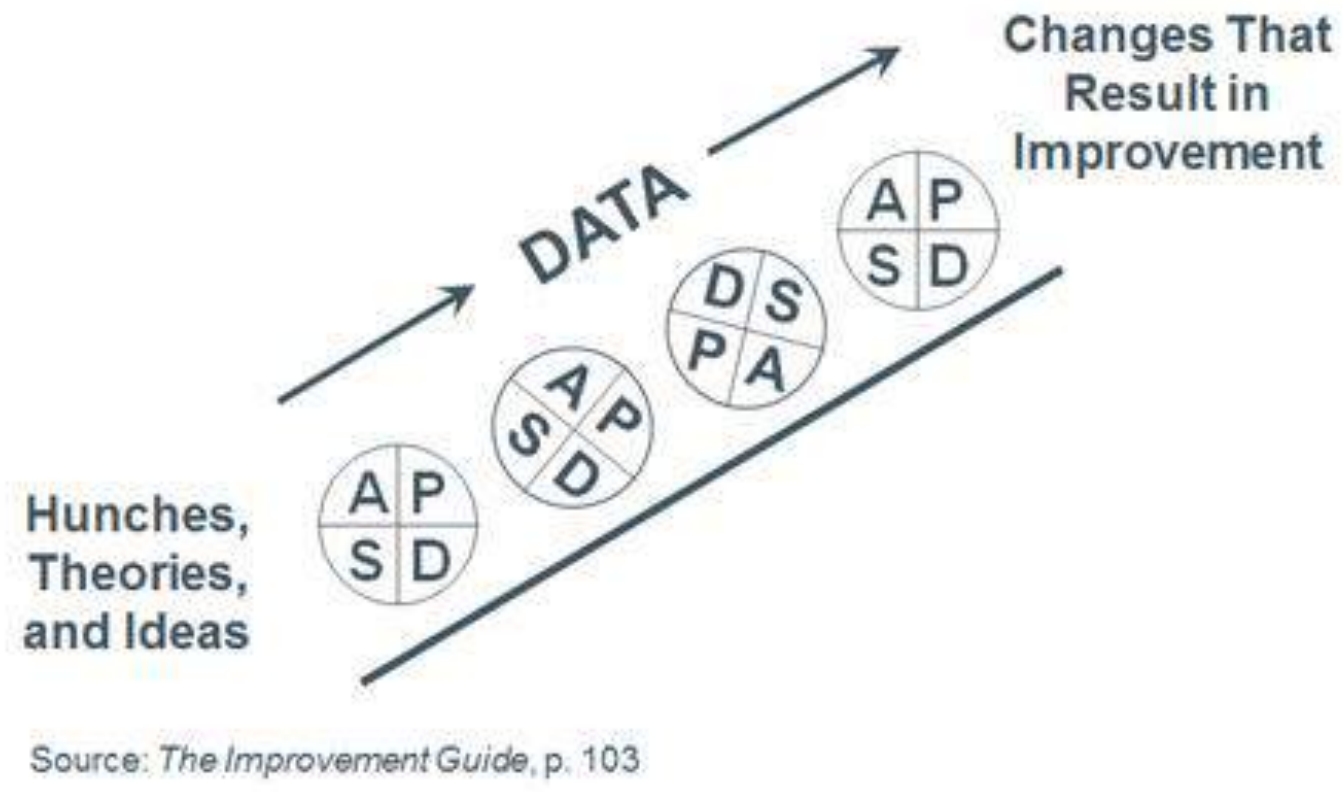


PDSA 1

- (Video not included on the website)

Is this an improvement?

Plan Do Study Act



Langley G, Nolan K, Nolan T, Norman C, Provost L, editors. The improvement guide. San Francisco: Josey-Bass; 1996.

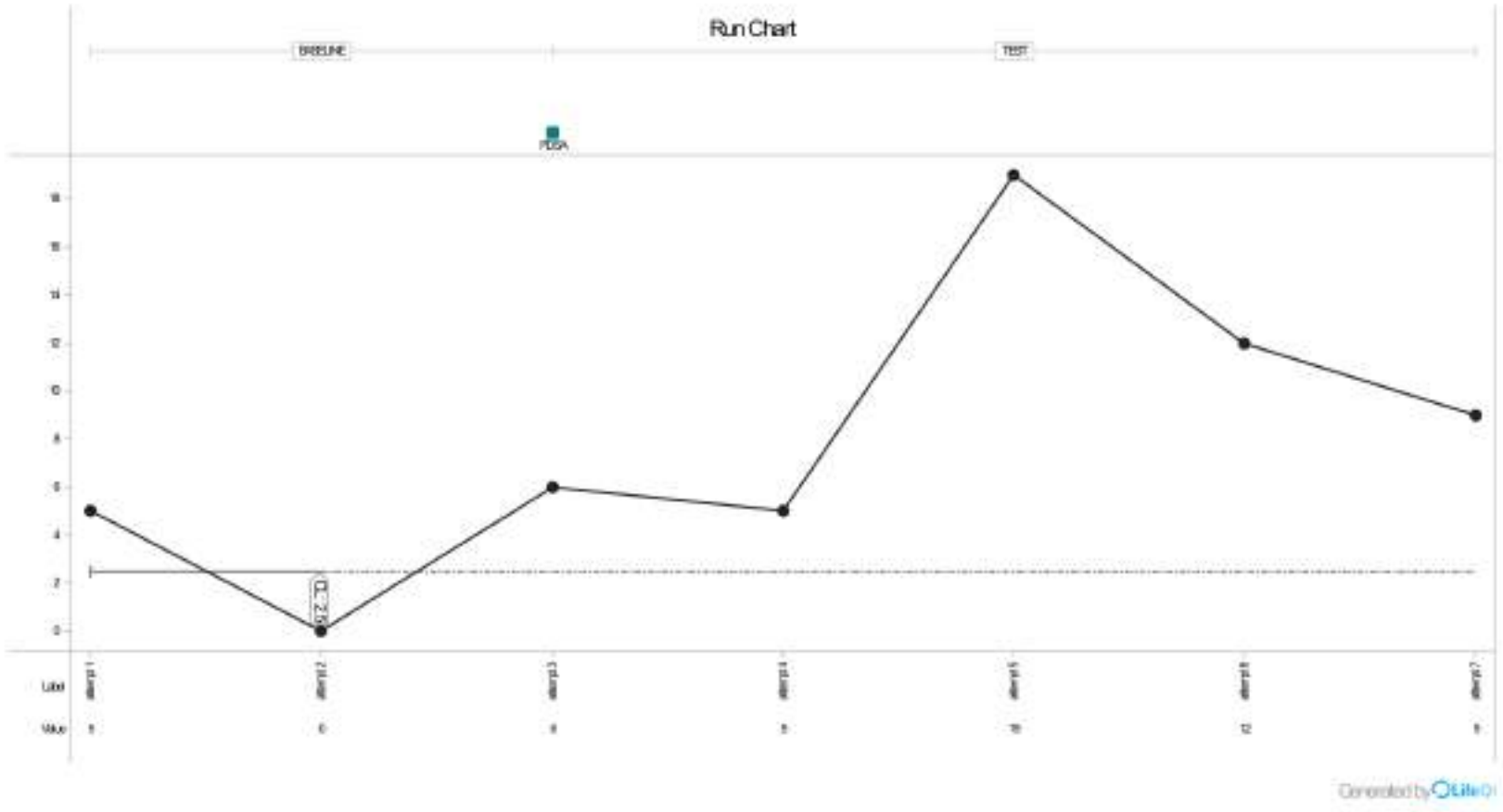
Next PDSA

- (Video not included on the website)

Unexpected observations

- (Video not included on the website)

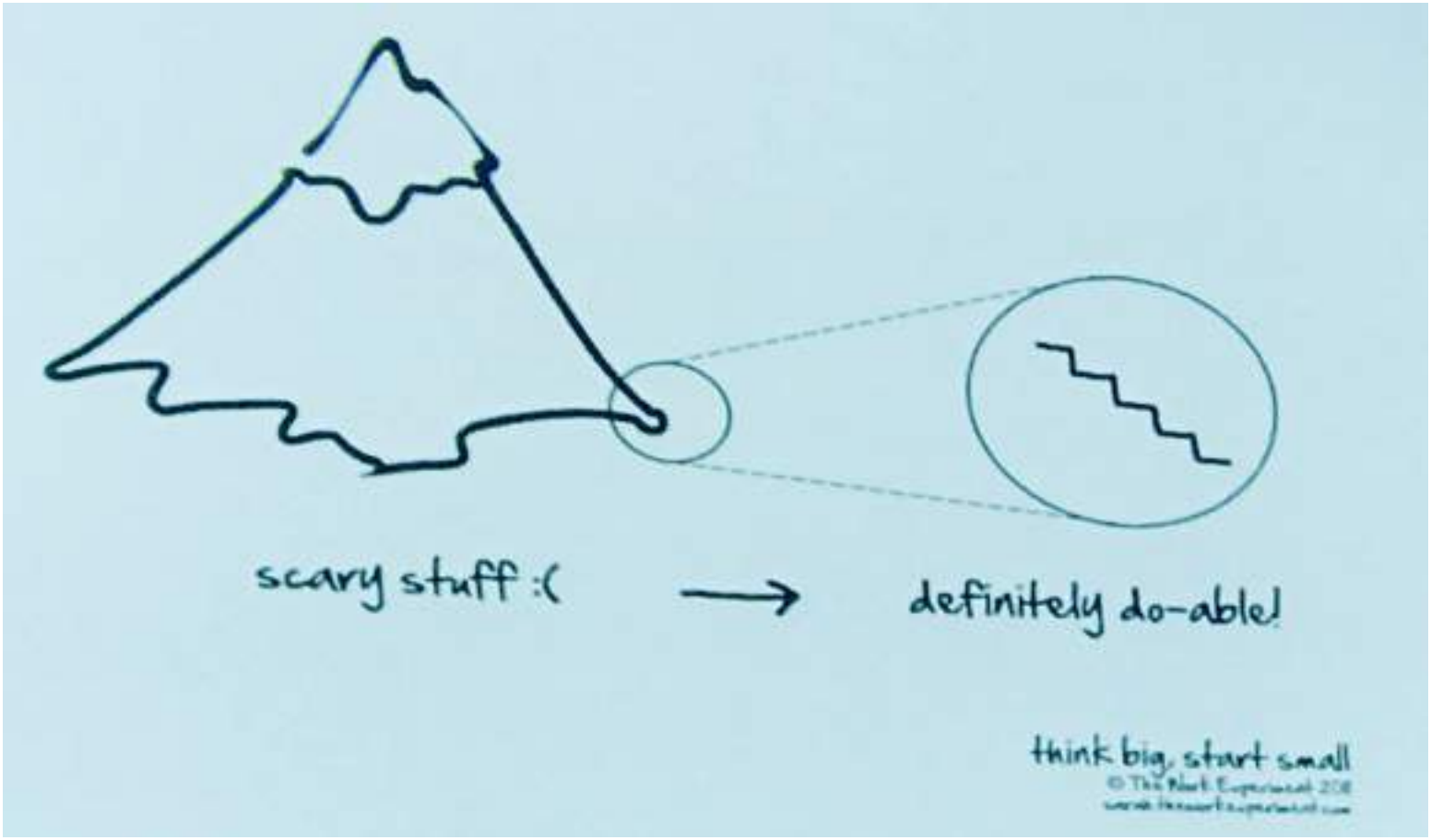
What did we learn?



Stretching your goal

My highest point

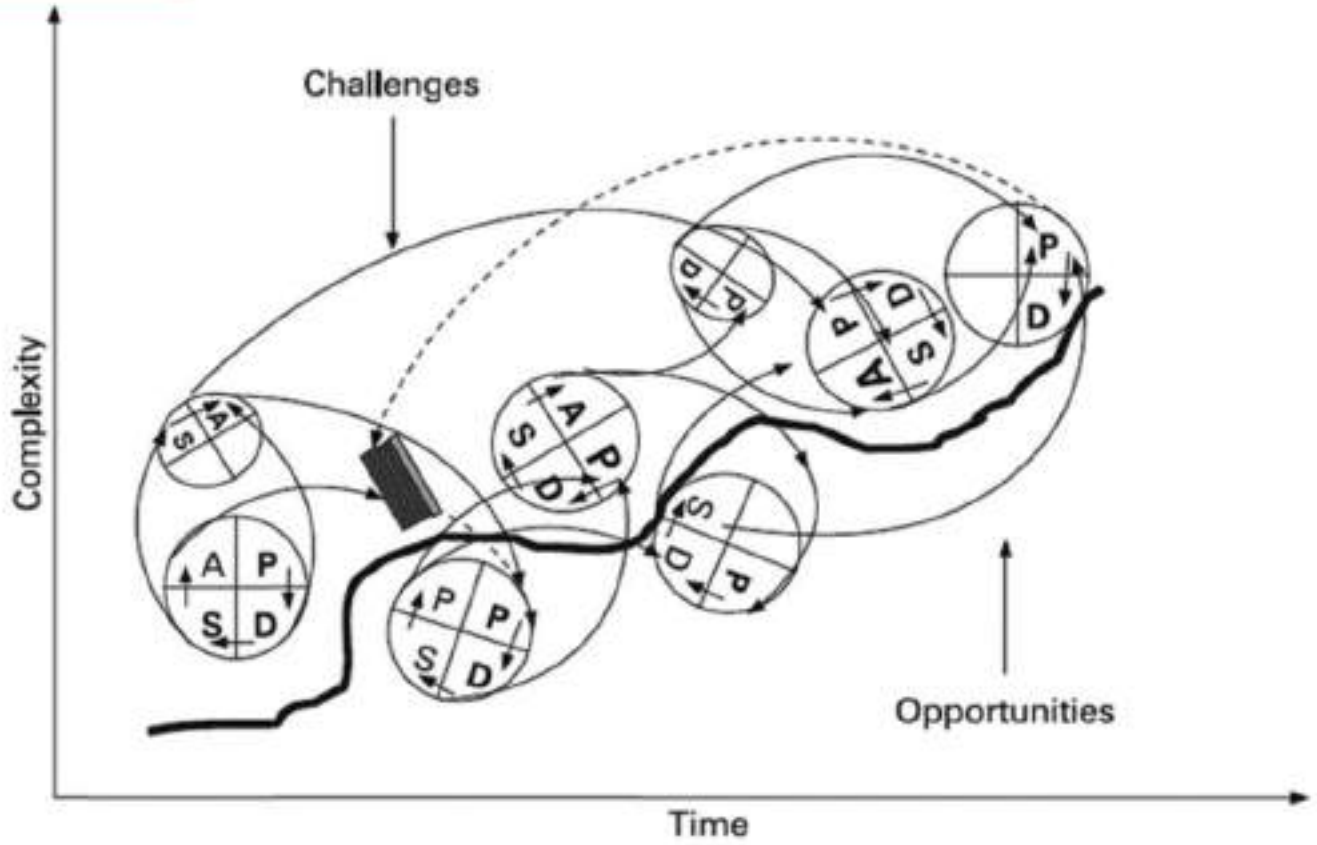
Start Small



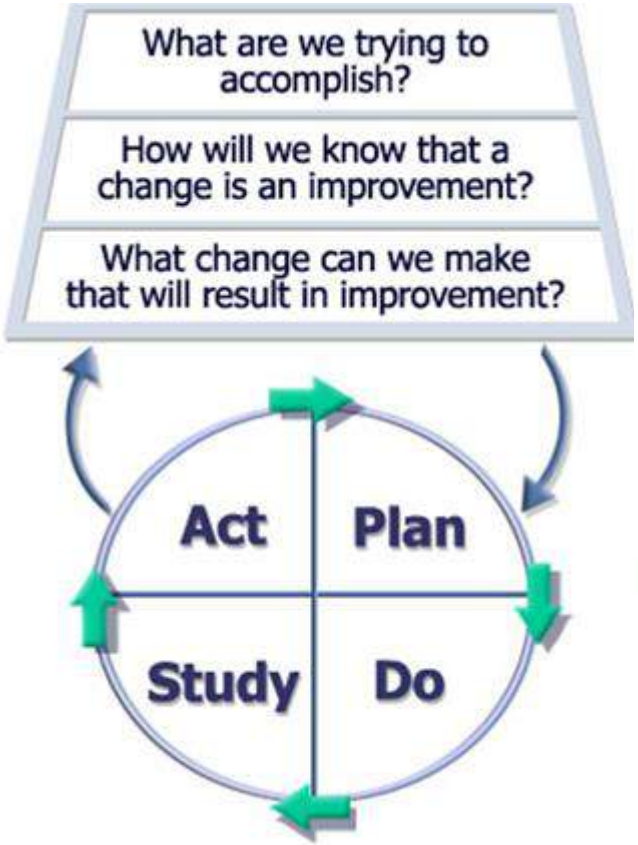
BMJ Quality & Safety

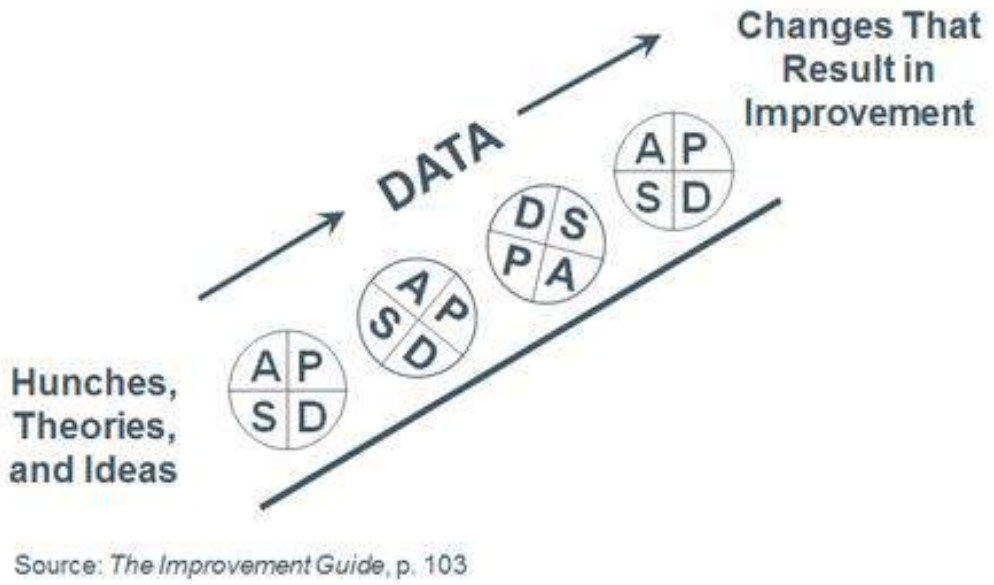
Building knowledge, asking questions

Greg Ogrinc and Kaveh G Shojania *BMJ Qual Saf* 2013;0:1–3.



Model for Improvement





Langley G, Nolan K, Nolan T, Norman C, Provost L, editors. The improvement guide. San Francisco: Josey-Bass; 1996.

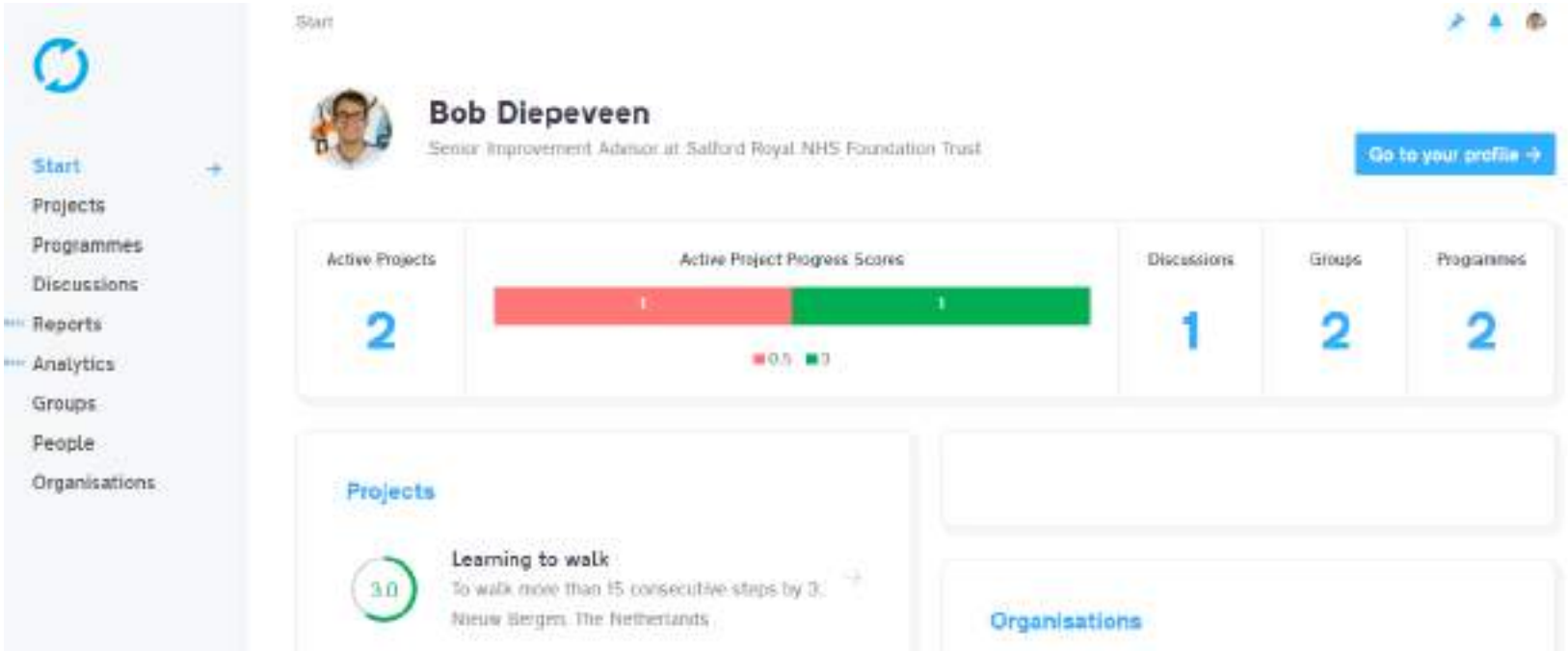
Simple, sound solutions

Team roles

- Clinical Leader
- Day to day leader
- Technical expert (data analyst / improvement advisor / LifeQI)
- Subject matter expert
- Patient representative
- Project Sponsor

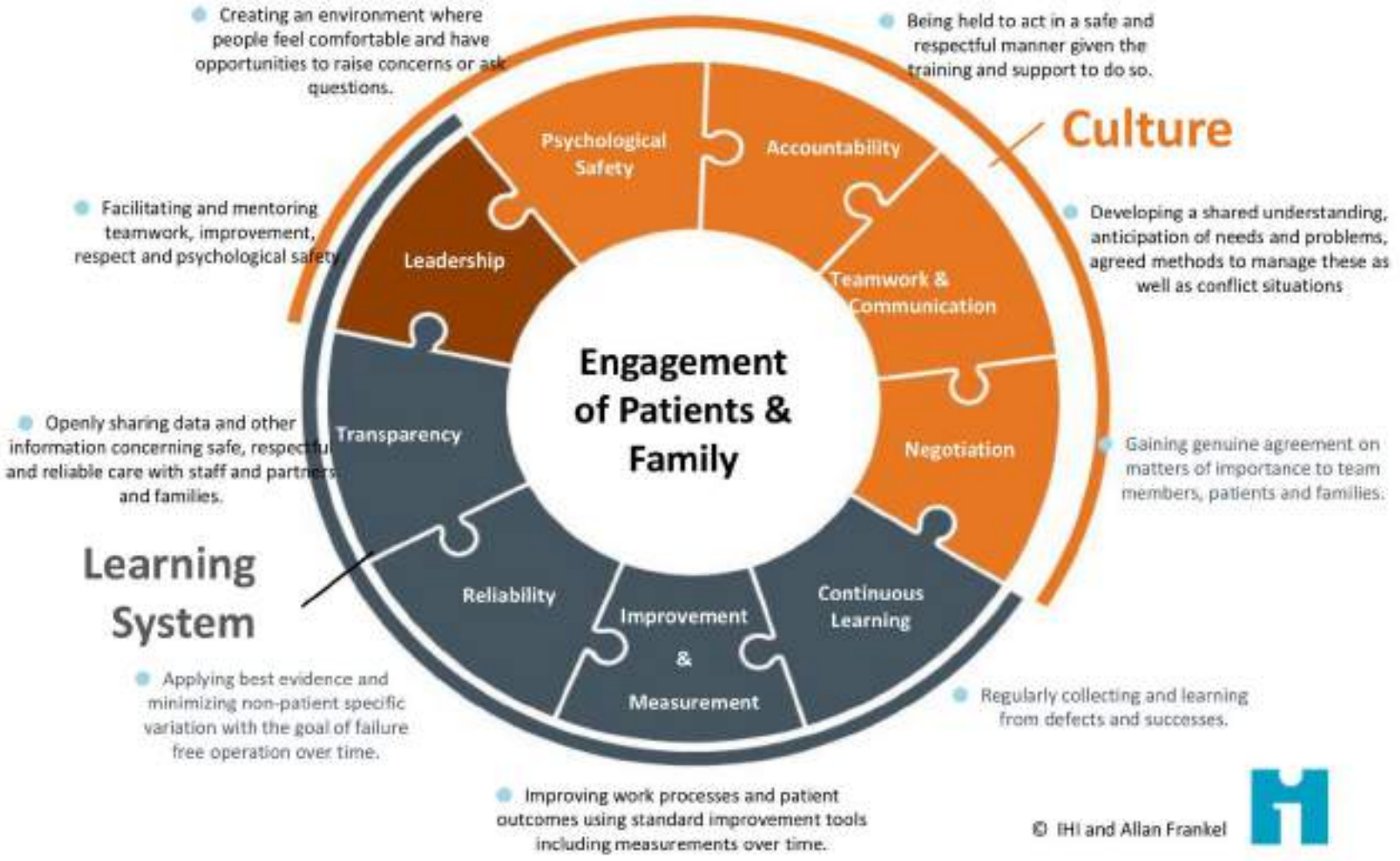
http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementFormingtheTeam.aspx

Life QI platform



https://uk.lifeqisystem.com/

Framework for Safe, Reliable and Effective Care

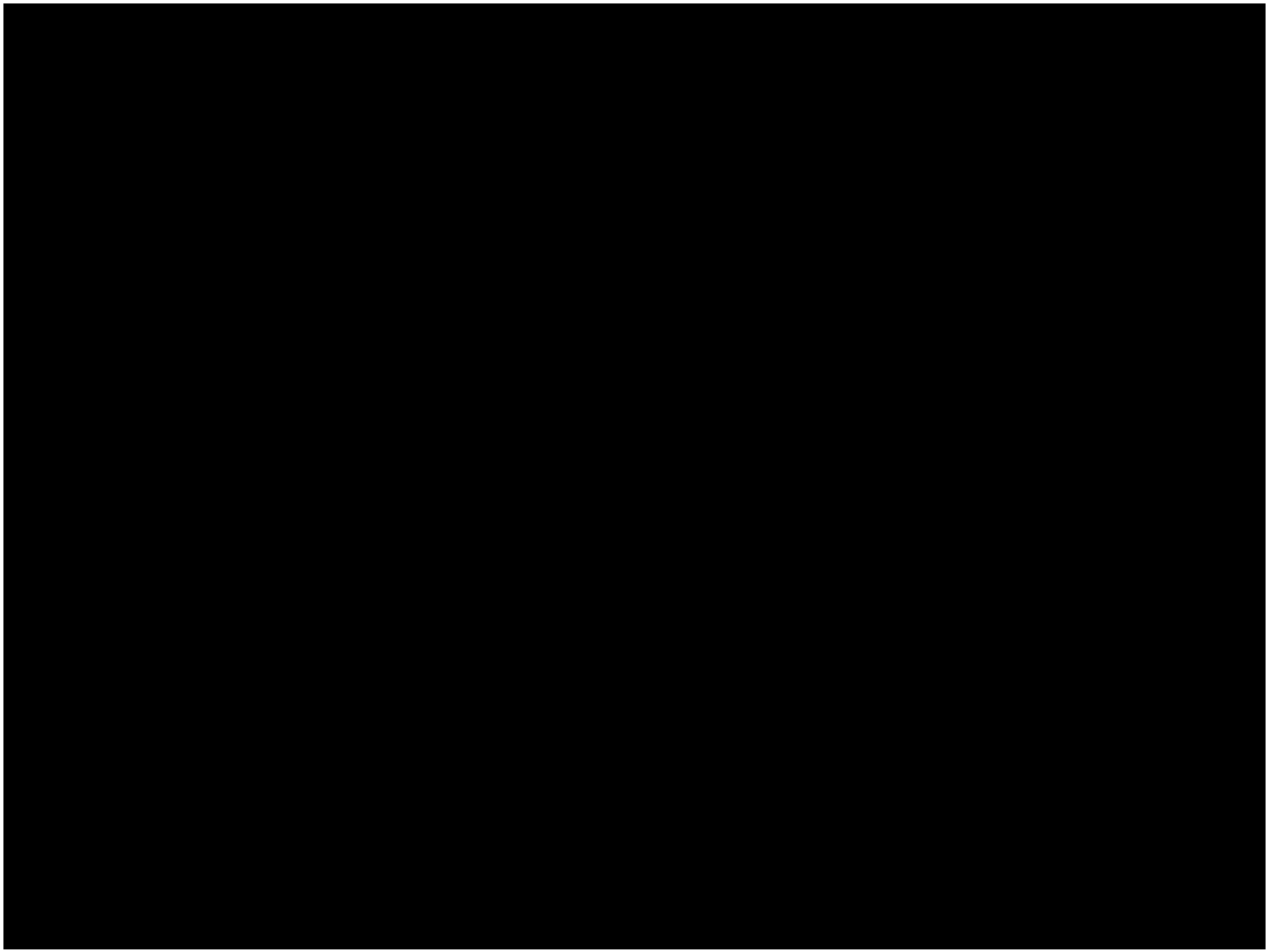


"If one can figure out how to effectively reuse rockets just like airplanes, the cost of access to space will be reduced by as much as a factor of a hundred. A fully reusable vehicle has never been done before. That really is the fundamental breakthrough needed to revolutionize access to space."

Elon Musk

https://www.youtube.com/watch?v=bvim4rsNHkQ

How not to launch a rocket



For further information on Health Innovation Manchester Patient Safety Collaborative QI

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The AHSN Network

NHS Improvement

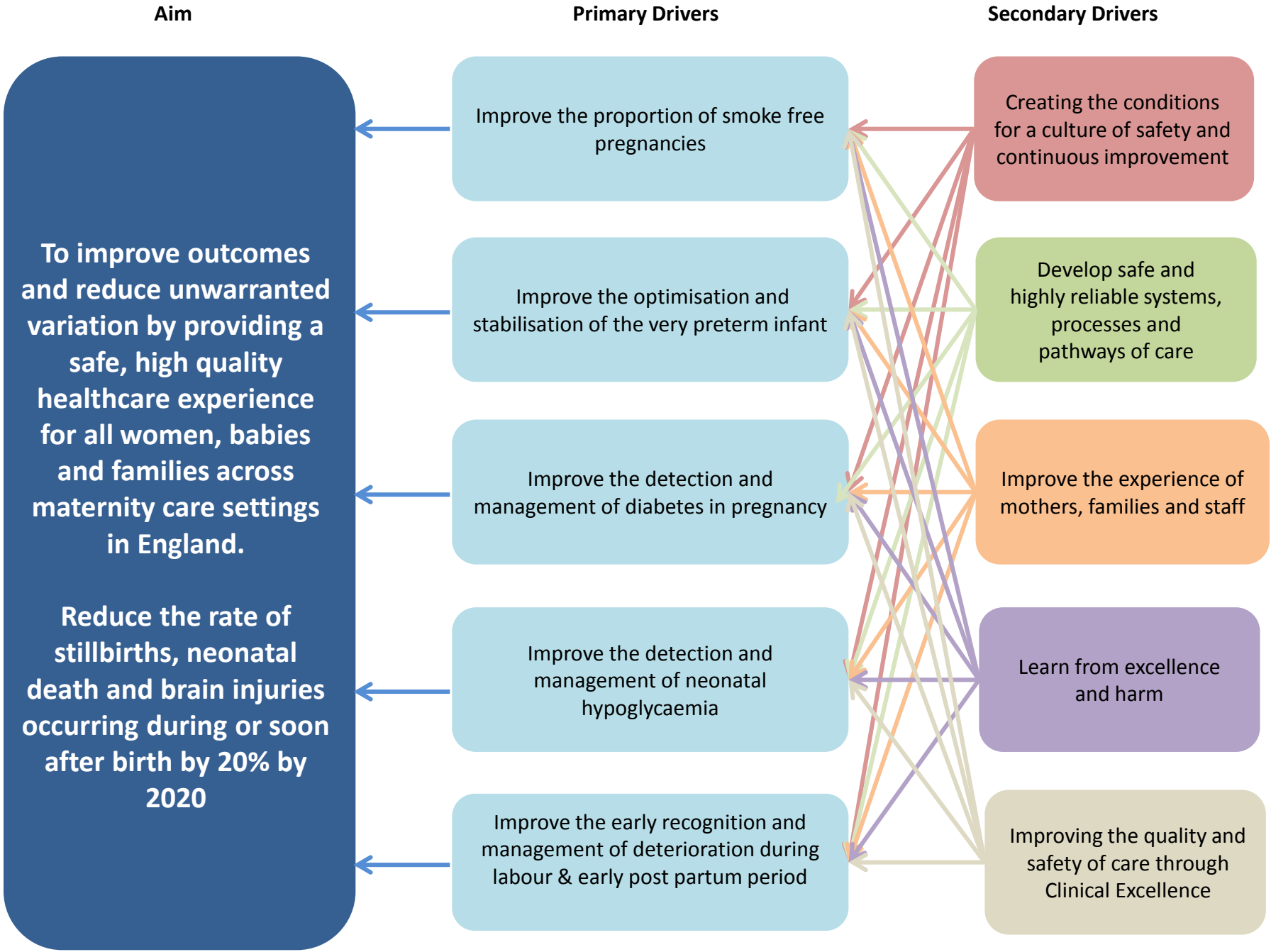
Plan next period

Bob Diepeveen

Improvement Advisor

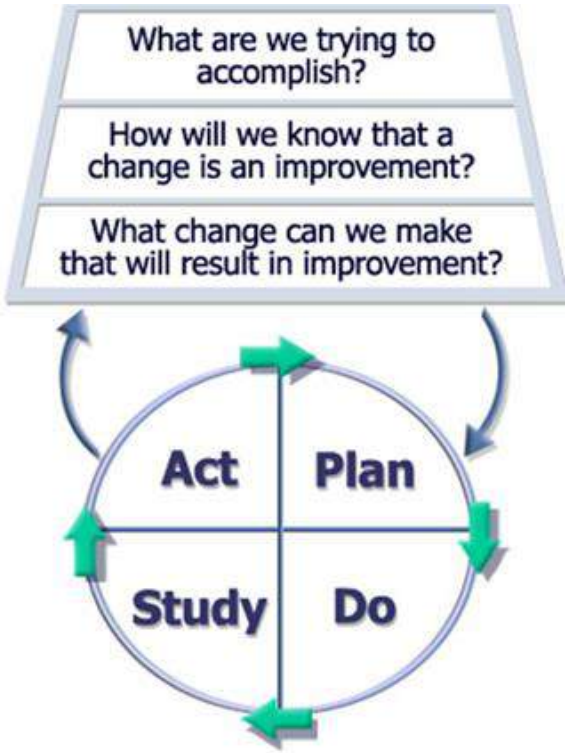
Greater Manchester

Patient Safety Collaborative


Aim
Primary Drivers
Secondary Drivers
To improve outcomes and reduce unwarranted variation by providing a safe, high quality healthcare experience for all women, babies and families across maternity care settings in England.
Reduce the rate of stillbirths, neonatal death and brain injuries occurring during or soon after birth by 20% by 2020
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

Start your plan

- What is your problem?
- What is the size of your problem?
- Understand your system?
- What is your priority
- Who should be part of your team?



Share your details

- Write on the sheet for HInM:
  - Organisation
  - Who is your champion + email
  - What can we help you with?

The AHSN Network

NHS Improvement

Summary and next steps

Jay Hamilton

Associate Director, Lead for GM Patient Safety Collaborative, Heath Innovation Manchester

Greater Manchester

Patient Safety Collaborative

Evaluation

https://www.surveymonkey.co.uk/r/KDVJ5ML

Resources

- Website
- National documents
- etc

Next Steps and Dates for your diary

- **GMPSC Learning Systems Next Event 5th June 2018 CityLabs**
- SCORE survey Wave 1 Trust March 2018; Wave 2 April 2018
- WebEx TBC
- National Sessions
- Second Wave Learning sets dates (Bolton Foundation Trust and East Cheshire)
  - May 9/10/11
  - Sept 11/12/13
  - Jan 16/17/18

The AHSN Network

NHS Improvement

Thank you

Greater Manchester

Patient Safety Collaborative