Maternity and Neonatal Safety Improvement Network Event

North East and North Cumbria

Academic Health Science Network
North East and North Cumbria

National Patient Safety Improvement Programmes

Maternity and Neonatal

Thursday 11 March, 9am – 12pm

SPEAKERS

- **Tony Roberts**, AHSN NENC, South Tees Hospitals NHS FT, North East Quality Observatory Service (NEQOS)
- **Karen Hooper**, Network Delivery Manager (Maternity), NHS England North East and North Cumbria
- **Charlie Merrick**, Senior Improvement Manager, NHS England & Improvement
- **Julia Wood**, MatNeoSIP Lead – NENC, AHSN NENC
- **Becca Scott,** North East Local Maternity Systems Prevention Lead, North East & North Cumbria Perinatal Mental Health Clinical Network Lead
- **Sarah Wall,** Service User Voice Representative
- Northumbria, Tyne & Wear, Durham Local Maternity System
- **Kathryn Hardy,** Local Maternity System Programme Lead, Local Maternity Systems for Northern England
- **Nicola Jackson,** Local Maternity System Programme Lead, Local Maternity Systems for West, North and East Cumbria

National Patient Safety
Improvement Programmes

Maternity and Neonatal

Maternity and Neonatal Safety Improvement Programme (MatNeoSIP) for NENC

Tony Roberts

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TheAHSNNetwork
North East and North Cumbria Patient Safety Collaborative

Northern England Maternity and Perinatal Mental Health Clinical Networks

LMS Local Maternity Systems Northern England

Northern Neonatal Network

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NHS Improvement


WELCOME

Agenda

Time	Agenda item
09:00	Welcome and introduction
09:10	The Maternity and Neonatal Landscape
09:20	National and Regional Overview of MatNeoSIP
09:35	Delivery of Risk Education to reduce tobacco in pregnancy
10:00	Break
10:10	PreTerm Birth Perinatal Optimisation Care Bundle
10:20	Share and Learn: Trust updates
11:00	Break
11:10	Share and Learn continued
11:25	A Co-production Model across NENC
11:35	Regional Culture Work
11:45	Next steps
12:00	Close

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The Maternity and Neonatal Landscape

Karen Hooper
Network Delivery Manager (Maternity)
NHS England-North East and North Cumbria

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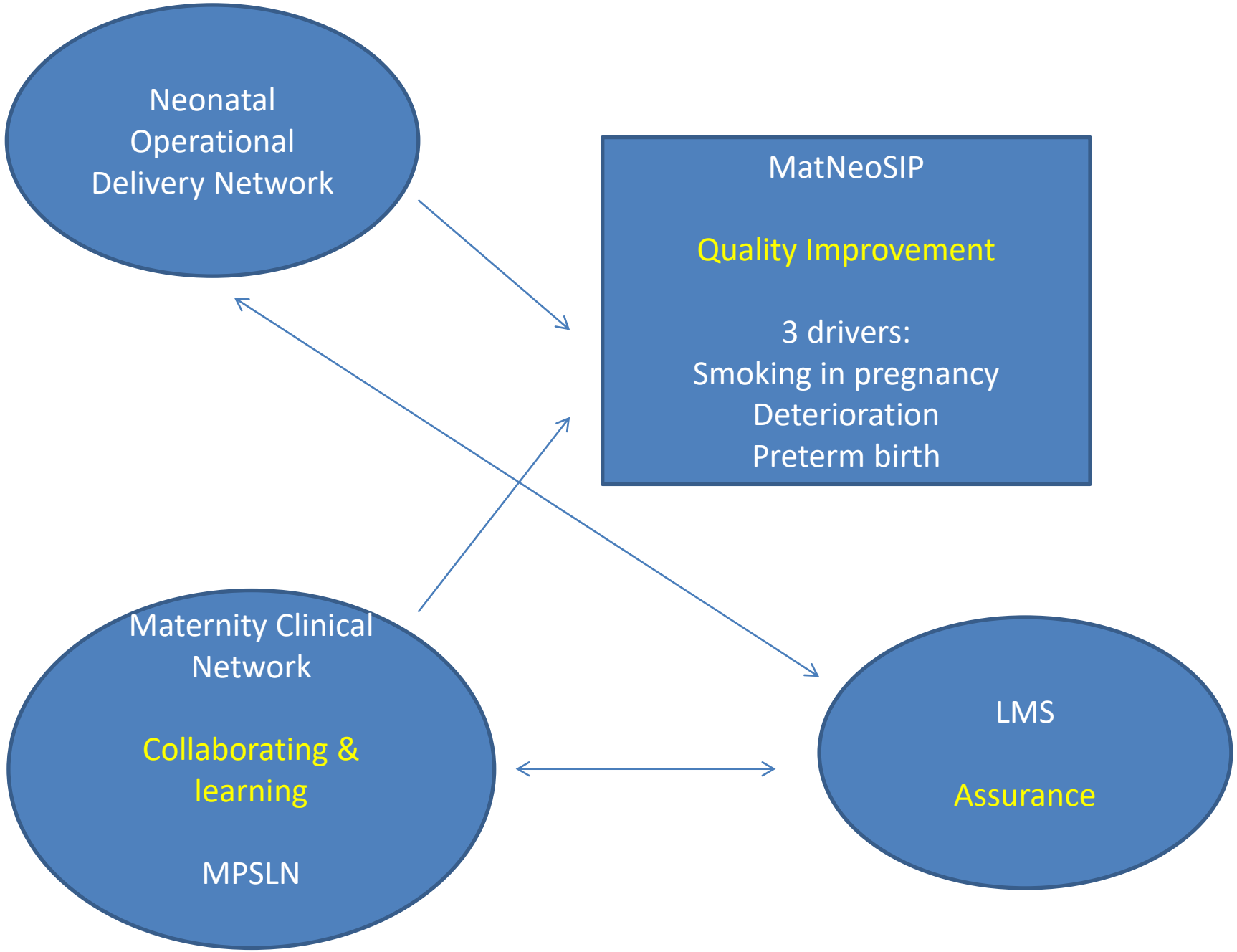
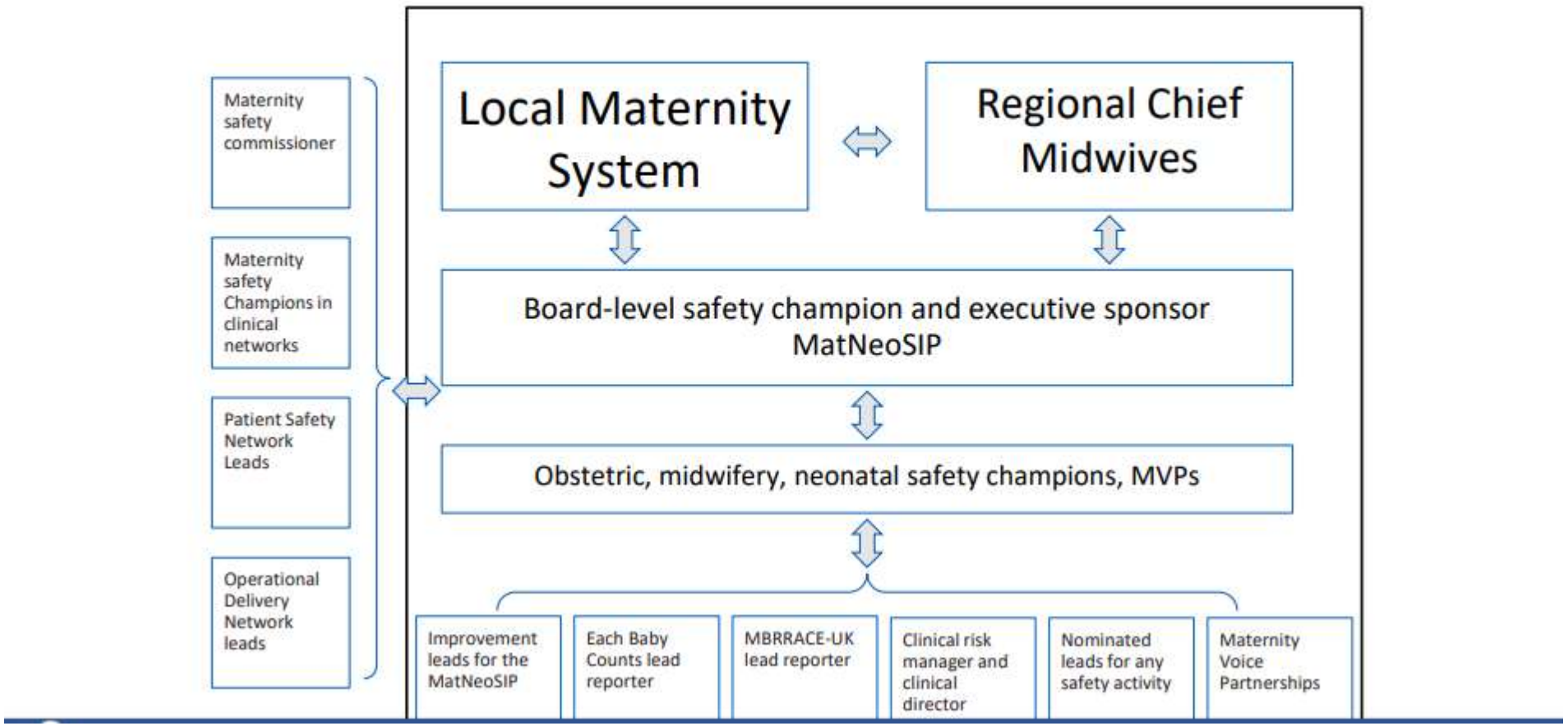

Neonatal
Operational
Delivery Network
MatNeoSIP
Quality Improvement
3 drivers:
Smoking in pregnancy
Deterioration
Preterm birth
Maternity Clinical
Network
Collaborating &
learning
MPSLN
LMS
Assurance

- MPSLN
  - sharing of incidents & learning
  - External review process
  - Learning form national reports
- MatNeoSIP
  - Quality improvement
  - 3 drivers

- Clinical Network Safety Champions
  - ➔ Maternity Voices Partnership User Chair
  - ➔ Board level maternity safety champions usually same person as MatNeoSIP executive sponsor
  - ➔ Regional Chief Midwife
  - ➔ Regional Lead obstetrician
  - ➔ Local Improvement lead for MatNeo SIP
  - ➔ Operational Delivery Network leads
  - ➔ Lead commissioner for safety in LMS
  - ➔ National Maternity Safety Champions
  - ➔ Maternity Transformation programme leads

https://www.england.nhs.uk/wp-content/uploads/2021/02/Feb-2021-Maternity-and-Neonatal-Safety-Champions-Toolkit-July-2020.pdf



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Maternity and Neonatal

National and Regional Overview of MatNeoSIP

Charlie Merrick, Senior Improvement Manager, NHS England & Improvement
Julia Wood, MatNeoSIP Lead – NENC, AHSN NENC

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National Overview

3 main workstreams

> Optimisation and stabilisation of preterm infant

> Early recognition and management of deterioration of women and babies

> Smoke free pregnancy

Additional work

> Local Improvement Plans

> Responding to Covid-19

> Safety Culture

> Addressing Inequalities

Aim

To reduce the national rate of preterm births from 8% to 6% and reduce the rate of stillbirths, neonatal death and brain injuries occurring during or soon after birth by 50% by 2025

Primary Drivers

- Provide safe **antenatal** care
- Provide safe **peripartum** care
- Provide safe **postnatal and neonatal** care

Secondary Drivers

Provide safe antenatal care

- Access and referral to specialist smoking cessation services
- Brief intervention training for maternity and neonatal staff
- CO monitoring offered to all pregnant women
- Develop system-wide pathways to achieve a smoke-free pregnancy
- Utilise the PIER framework to identify and respond to deterioration throughout the entire pathway of care
- Antenatal corticosteroids offered to women in threatened preterm labour
- Intrapartum antibiotic prophylaxis offered to all women in established preterm labour
- Magnesium sulphate offered to women where preterm birth is imminent or planned
- All babies born in appropriate care setting for gestation (place of birth)

Provide safe peripartum care

- Effective use of Maternity Early Warning Score (MEWS) to identify and respond to maternal deterioration
- Optimal cord management received by all babies less than 34 weeks gestation

Provide safe postnatal and neonatal care

- Continuation of the care pathway to ensure babies are discharged to a smoke-free home
- Effective use of MEWS and Neonatal Early Warning Trigger and Track (NEWTT) to identify and respond to both maternal and neonatal deterioration
- Optimal normothermic range for all babies less than 34 weeks gestation
- Maternal breast milk received within 6 hours of birth by all babies less than 34 week gestation

Workstream Key

- Smoke-free pregnancies
- Early recognition and management of deterioration of women and babies
- Optimisation and stabilisation of the preterm infant

Key enablers

1. **Addressing inequalities –** understand local health inequalities to ensure selected interventions improve the lives of those with the worst health outcomes fastest
2. **Patient and carer co-design –** employ a co-production approach with patients, carers and service users who represent the diversity of the population served
3. **Safety culture –** use safety culture insights to inform quality improvement approaches
4. **Patient safety networks –** co-ordinate and facilitate patient safety networks to provide the sub-regional delivery architecture for improvement
5. **Improvement leadership –** identify and nurture leadership, including clinical leaders, to lead improvement through the networks
6. **Building QI capacity and capability –** use a dosing approach to build quality improvement capacity and capability
7. **Measurement –** develop a robust measurement plan including relevant process, balancing and outcomes metrics
8. **Improvement and innovation pipeline –** undertake horizon scanning and prioritisation to inform future national workstreams

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Regional view

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Optimisation and stabilisation of the preterm infant

> Test site for the Preterm Perinatal Optimisation Pathway – more information later

> **Place of birth:** NENC achieved the highest percent across England in both 2018 and 2019 (2019, NNAP)

> **Antenatal steroids:** NENC was very slightly above the national average by 0.3% (2019, NNAP)

> **Magnesium sulphate**: NENC was above the national average by 0.9% in 2019 (2019, NNAP)

> **Intrapartum antibiotics:** Need to understand baseline

> **Optimal cord management:** Is there a recording issue?

Establishing a mini-collaborative to focus on this from Q1 2021/22

> **Normothermia:** Second lowest performing region in 2019 (2019, NNAP).

Looking to establish a mini-collaborative end of 2021

> **Maternal breast milk:** Lowest performing region in 2019.

Work ongoing as part of UNICEF BFI (Baby Friendly Initiative)

Smoke-free pregnancies

- Initial focus is going to be on risk education – Becca Scott
- From January 2022 we will look at what other projects we can work on in line with the driver diagram

Early recognition and management of deterioration of women and babies

MEWS:

> Rollout of nationally developed MEWS (2022)

> Understand use/challenges/where it works well

NEWTT:

> Understand use/challenges/where it works well

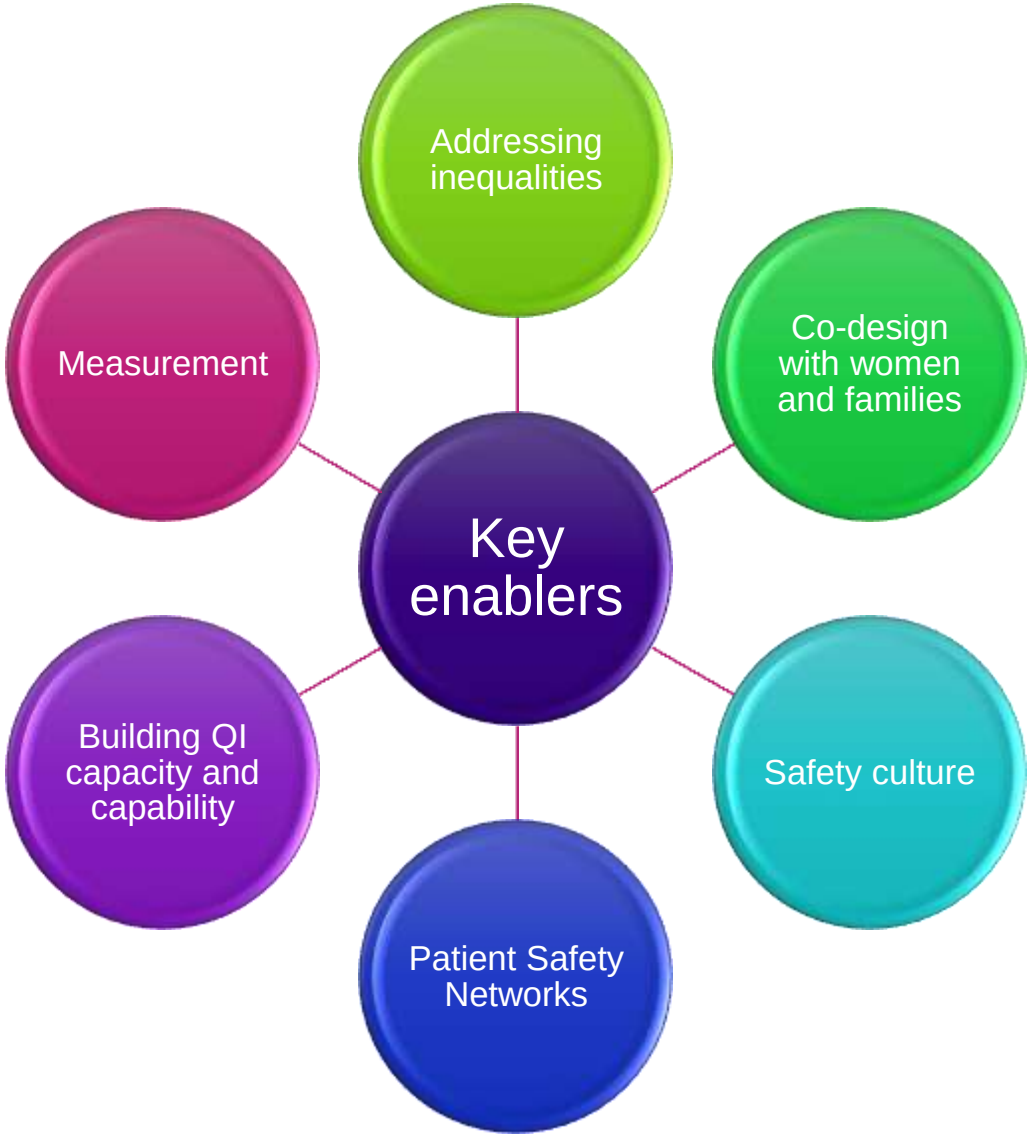
PIER Framework:

> **P**lan / **P**repare / **P**revent

> **I**dentification

> **E**scalation

> **R**esponse


Addressing inequalities
Measurement
Co-design with women and families
Key enablers
Building QI capacity and capability
Safety culture
Patient Safety Networks

Support: Trusts/Groups

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Maternity and Neonatal

Delivery of Risk Education to reduce tobacco in pregnancy

Becca Scott, North East Local Maternity Systems Prevention Lead
North East & North Cumbria Perinatal Mental Health Clinical Network Lead

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Delivery of Risk Education to reduce tobacco use in pregnancy

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Northumberland, Tyne and Wear and Durham
Local Maternity Systems

Becca Scott
NE LMS Prevention Lead

NE Smoking at time of delivery: 2017/18 16.3% (England 10.8%), 2019/20 15.2% (England 10.4%)

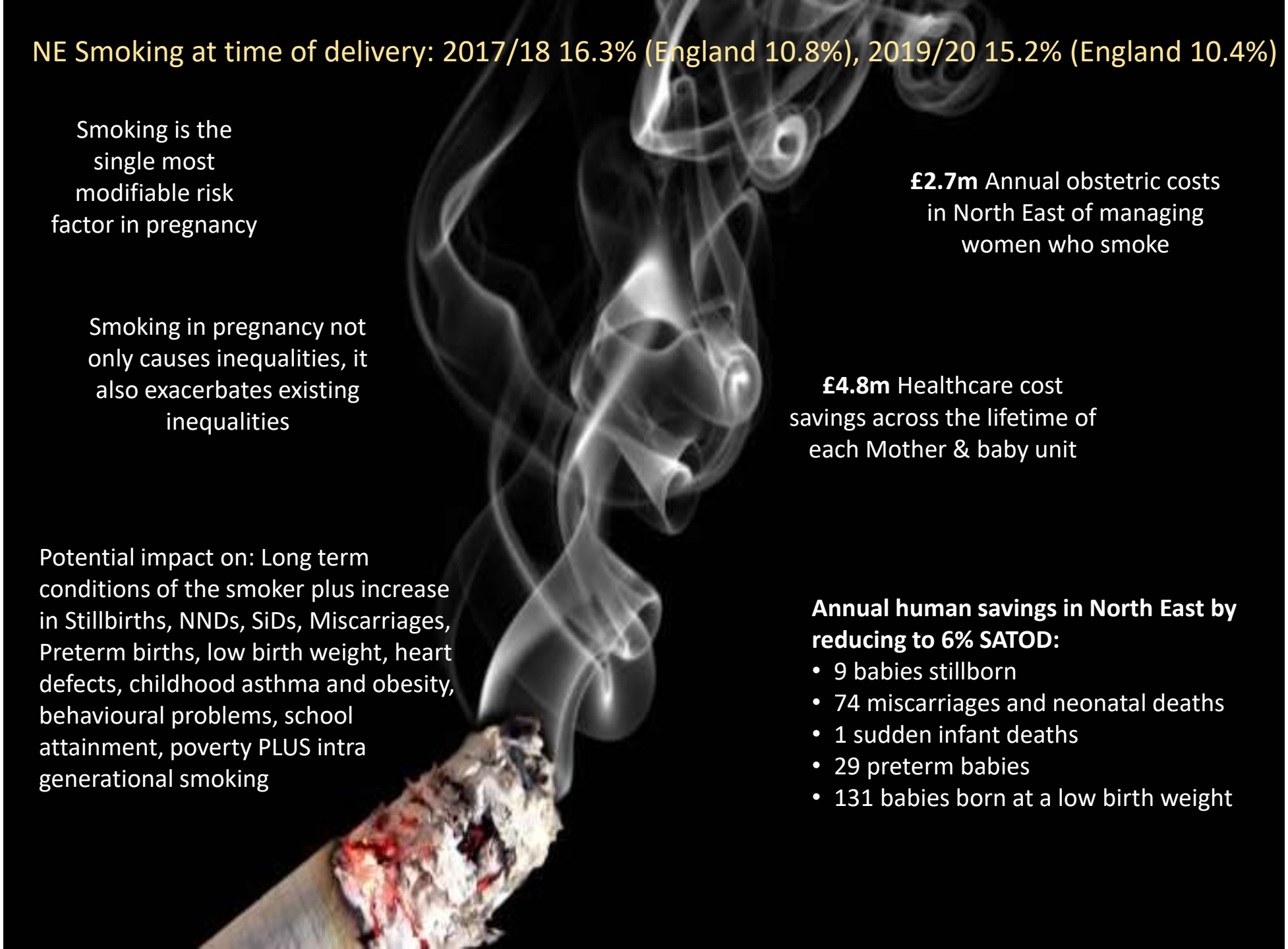
Smoking is the single most modifiable risk factor in pregnancy

£2.7m Annual obstetric costs in North East of managing women who smoke

Smoking in pregnancy not only causes inequalities, it also exacerbates existing inequalities

£4.8m Healthcare cost savings across the lifetime of each Mother & baby unit

Potential impact on: Long term conditions of the smoker plus increase in Stillbirths, NNDs, SiDs, Miscarriages, Preterm births, low birth weight, heart defects, childhood asthma and obesity, behavioural problems, school attainment, poverty PLUS intra generational smoking



Annual human savings in North East by reducing to 6% SATOD:

- 9 babies stillborn
- 74 miscarriages and neonatal deaths
- 1 sudden infant deaths
- 29 preterm babies
- 131 babies born at a low birth weight

Workplan

- Deep Dive audit - May 2021
- Implementation of the NHS Long Term Plan 2021-24
  - ➢Regional approach
  - ➢Embed pathway
  - ➢Acute settings - Bedside support and treatment
  - ➢Development of regional NRT provision system
  - ➢Maternity Support Worker role and holistic family approach is pivotal
- Relapse Prevention
- Social and emotional/mental health support
- Risk Education Intervention

The babyClear© Risk Perception approach

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Local Maternity Systems

- This intervention is aimed at targeting women who initially decline support.
- The intervention takes places at the dating scan.
- The intervention is designed to clearly highlight the risks of smoking.
- The woman undertakes the CO monitoring with the device plugged into a computer. On the screen there is an image of a baby along with the percentage of carbon monoxide concentration in the blood for both the mother (COhb) and fetus (FCOhb).
- A demonstration using a doll and placenta is undertaken to highlight how smoking directly impacts the placenta and in turn how this effects the baby.

Risk Perception service scope (March 2020)

- 3 out of the 7 NE FT's offer some form of Risk Perception
- 1 out of the 7 NE FT's deliver Risk Perception as it is trained

Barriers to delivering Risk Perception include;

- Time to deliver intervention
- Delivery by Midwife only
- Cost and time to train in RP

Key enablers to delivering RP:

- Quicker time to deliver
- Visual tools that are underpinned with facts
- Being delivered by other professionals (SSA, Sonographers, HV's, Obstetricians)
- Offering at/during scans and with baby present

Risk Education Intervention Recommendations

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- **Intervention "Enhanced Visual Risk Education Intervention"**

A three-stage approach

  – 12 week
  – 20 weeks
  – Newborn

- **Training**

Training on delivery of the interventions should be undertaken by Midwives, Sonographers, MCAs and Health Visitors based on a train the trainer approach.

- **Evaluation**

There is a clear need for such an intervention to be evaluated, as practice anecdotes suggest such method of intervention is appropriate and effective. Yet searching the literature, it seems to suggest education regarding risk is not effective. Therefore, this intervention should be evaluated within each of the trust areas in terms of quit rates.

How to move the workplan forward?

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- Questions for discussion in breakout rooms…

- Group 1 - Risk Education Intervention
- Group 2 – Social and emotional/mental health support
- Group 3 – Relapse prevention

How to move the workplan forward?

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Northumberland, Tyne and Wear and Durham
Local Maternity Systems

Feedback

- Group 1 - Risk Education Intervention
- Group 2 – Social and emotional/mental health support
- Group 3 – Relapse prevention

Questions

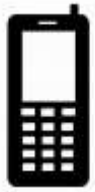
LMS
Darlington, Tees, Hambleton, Richmondshire and Whitby
Northumberland, Tyne and Wear and Durham
Local Maternity Systems

CONTACT DETAILS:

BECCA SCOTT
Regional Local Maternity Systems Prevention Lead


@Sparkle_Becca


Rebecca.Scott@durham.gov.uk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PreTerm Birth Perinatal Optimisation Care Bundle

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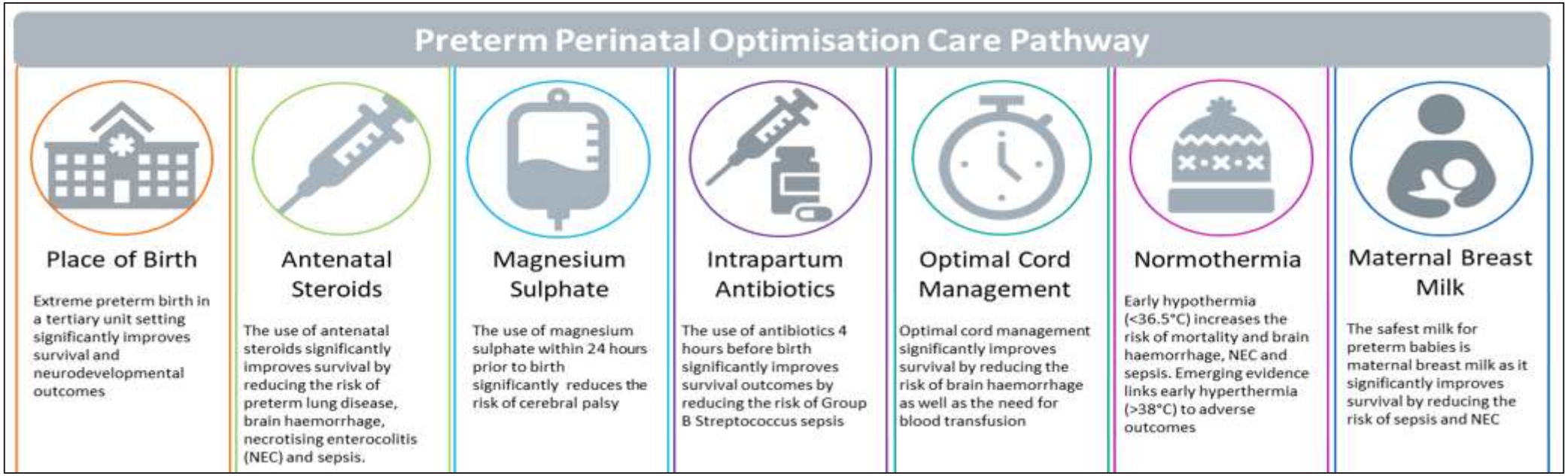
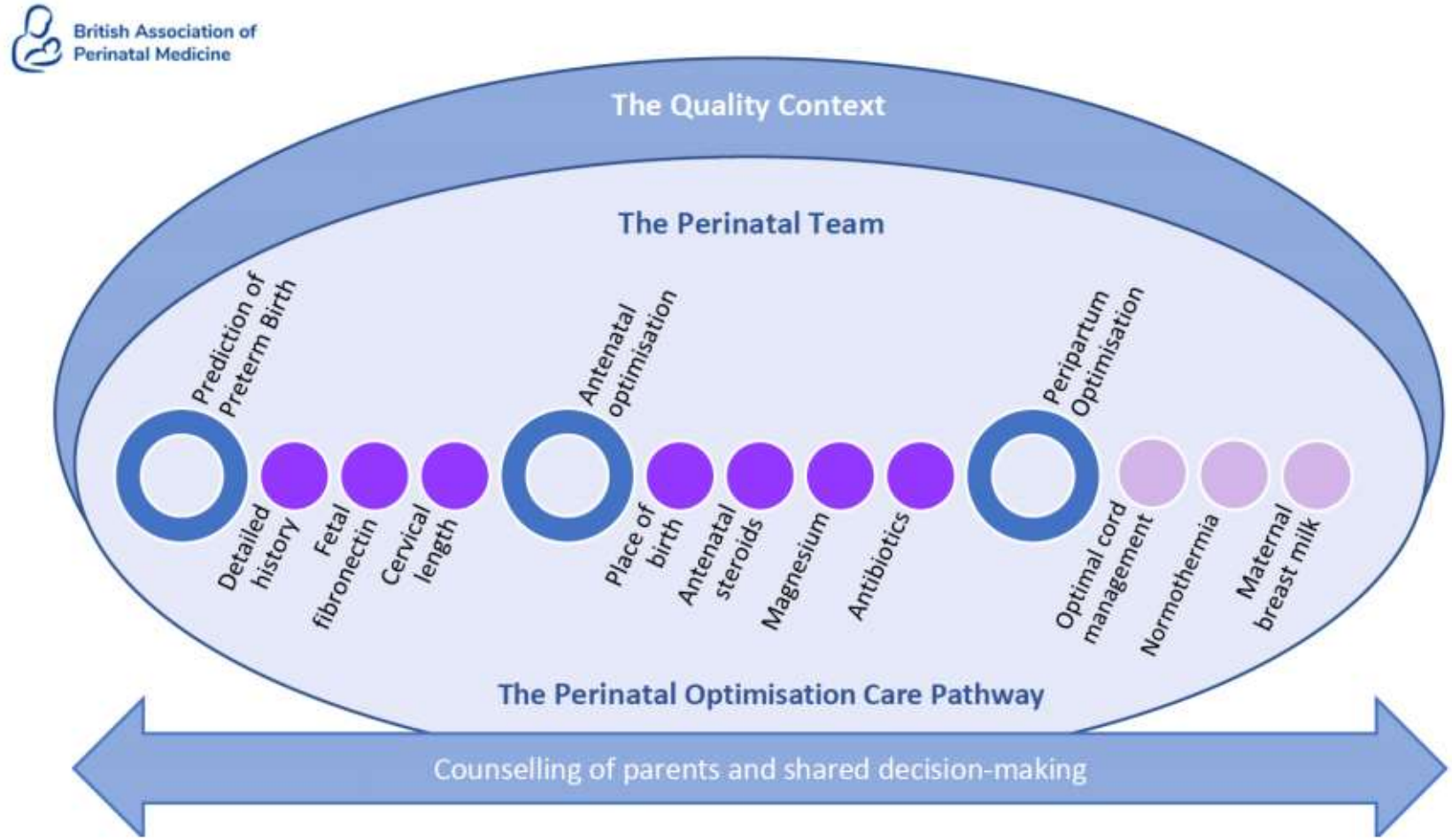
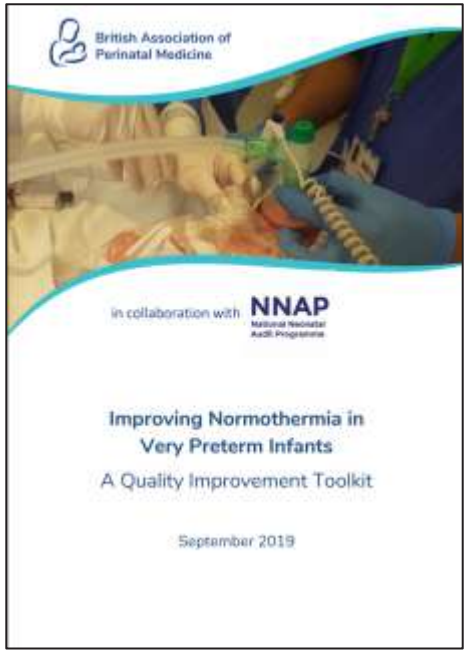
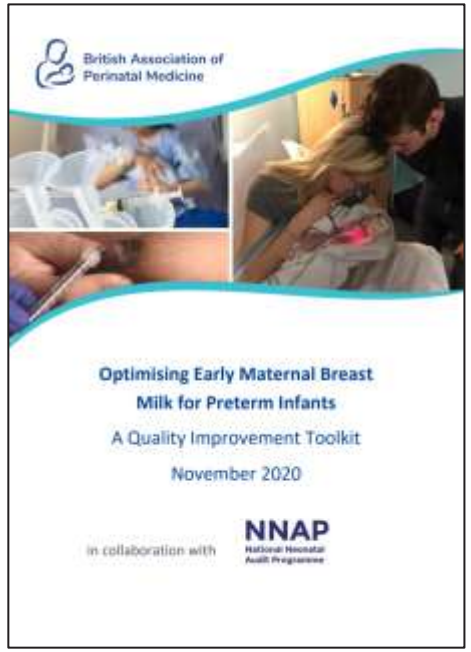

Preterm Perinatal Optimisation Care Pathway
Place of Birth
Extreme preterm birth in a tertiary unit setting significantly improves survival and neurodevelopmental outcomes
Antenatal Steroids
The use of antenatal steroids significantly improves survival by reducing the risk of preterm lung disease, brain haemorrhage, necrotising enterocolitis (NEC) and sepsis.
Magnesium Sulphate
The use of magnesium sulphate within 24 hours prior to birth significantly reduces the risk of cerebral palsy
Intrapartum Antibiotics
The use of antibiotics 4 hours before birth significantly improves survival outcomes by reducing the risk of Group B Streptococcus sepsis
Optimal Cord Management
Optimal cord management significantly improves survival by reducing the risk of brain haemorrhage as well as the need for blood transfusion
Normothermia
Early hypothermia (<36.5°C) increases the risk of mortality and brain haemorrhage, NEC and sepsis. Emerging evidence links early hyperthermia (>38°C) to adverse outcomes
Maternal Breast Milk
The safest milk for preterm babies is maternal breast milk as it significantly improves survival by reducing the risk of sepsis and NEC


British Association of Perinatal Medicine
The Quality Context
The Perinatal Team
Prediction of Preterm Birth
Detailed history
Fetal fibronectin
Cervical length
Antenatal optimisation
Place of birth
Antenatal steroids
Magnesium
Antibiotics
Peripartum Optimisation
Optimal cord management
Normothermia
Maternal breast milk
The Perinatal Optimisation Care Pathway
Counselling of parents and shared decision-making


British Association of Perinatal Medicine
STAMPED
Antenatal Optimisation
Antenatal Optimisation
for Preterm Infants less than 34 weeks
A Quality Improvement Toolkit
October 2020
in collaboration with
NNAP


British Association of Perinatal Medicine
Optimal Cord Management in Preterm Babies
A Quality Improvement Toolkit
December 2020
in collaboration with
NNAP


British Association of Perinatal Medicine
in collaboration with
NNAP
Improving Normothermia in Very Preterm Infants
A Quality Improvement Toolkit
September 2019


British Association of Perinatal Medicine
Optimising Early Maternal Breast Milk for Preterm Infants
A Quality Improvement Toolkit
November 2020
in collaboration with
NNAP

Next steps

Mapping of each intervention:

> What are the key steps and decision making processes within each Unit

> What are the processes between Units within each Trust

> What are the processes between organisations and the handover of care between professionals

> For all, what does ‘good’ look like

> For all, what are the barriers to achieving ‘good’

Conversations with each Trust:

> Who should be involved?

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Maternity and Neonatal

A Co-production Model across NENC

Sarah Wall, Service User Voice Representative
Northumbria, Tyne & Wear, Durham Local Maternity System

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Coproduction with Service Users

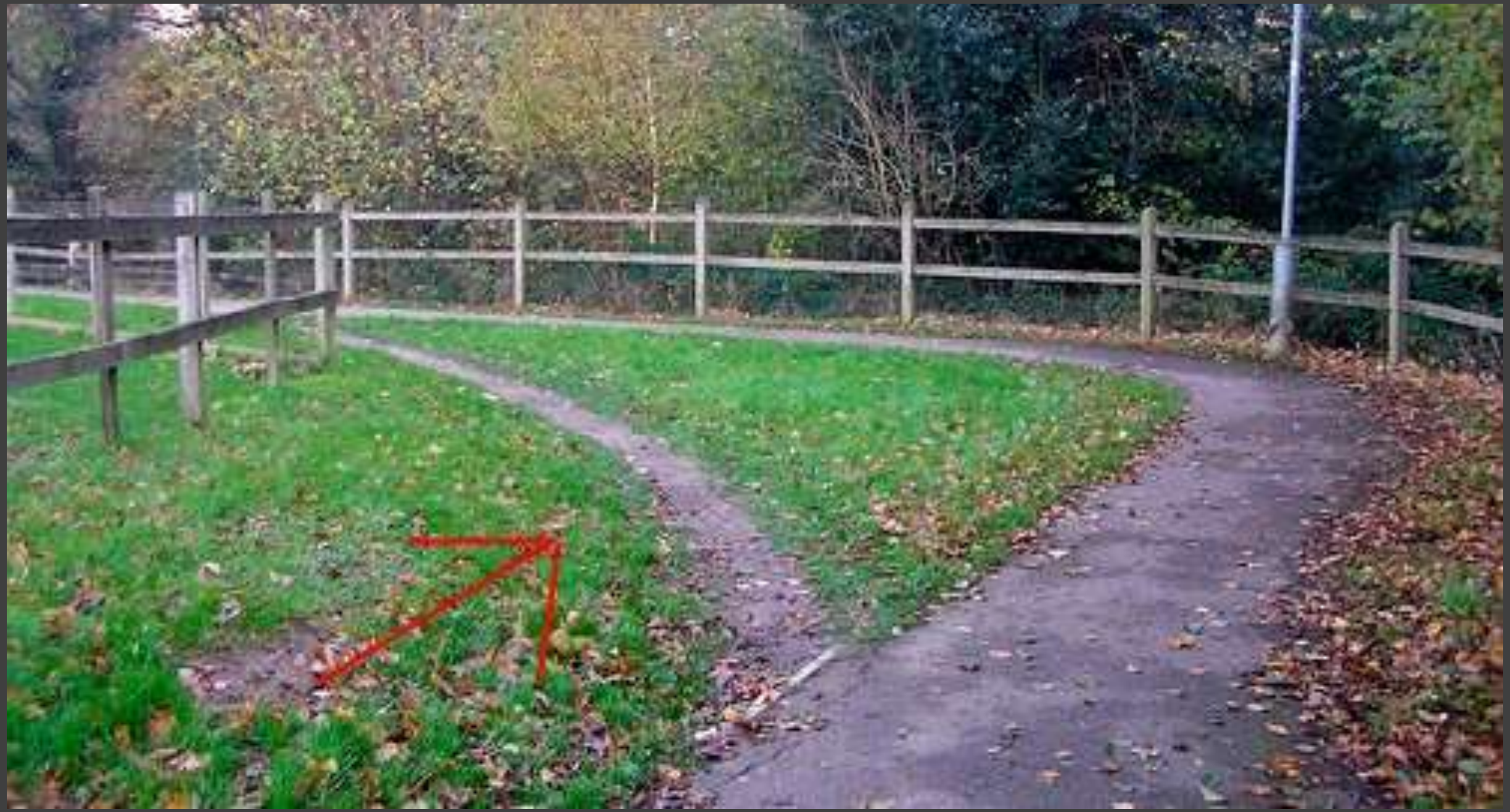
Sarah Wall

Service User Voice Representative

NTWD Local Maternity System

NE & Yorkshire Maternity Transformation Program

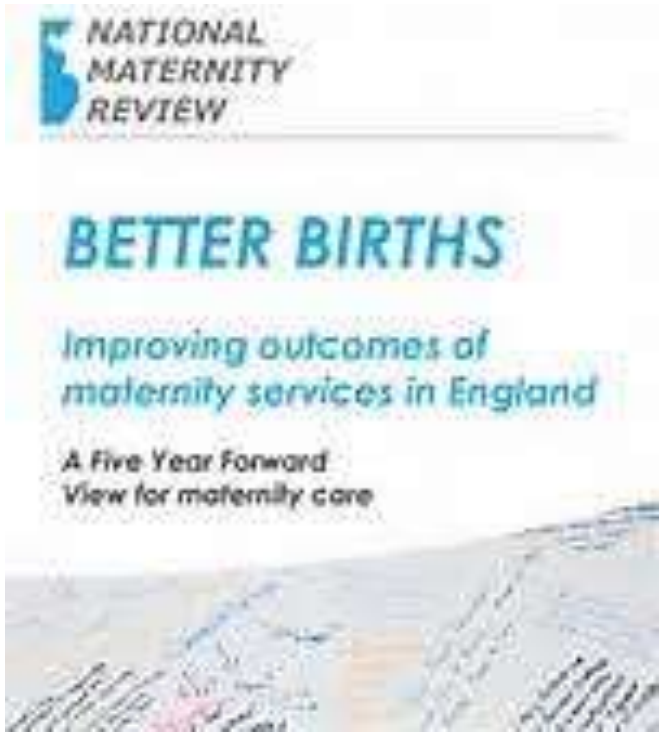
sarahlwall@hotmail.com



Service User Voice… why listen?

Co-production acknowledges that people with ‘lived experience’ are best placed to advise on what support and services will make a positive difference to their lives. Done well, co-production helps to ground discussions in reality, and to maintain a person-centred perspective.


Co-production
Co-design
Engagement
Consultation
Informing
Educating
Coercion
Doing with
in an equal and reciprocal partnership
Doing for
engaging and involving people
Doing to
trying to fix people who are passive recipients of service



"Local maternity systems should be responsible for ensuring that they co-design services with service users and local communities."

Clinical Negligence Scheme for Trusts - Safety Action Point 7, MVPs

'Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?

- Terms of Reference for your MVP
- Minutes of MVP meetings demonstrating explicitly how feedback is obtained and the consistent involvement of Trust staff in coproducing service developments based on this feedback
- Evidence of service developments resulting from coproduction with service users
- Written confirmation from the service user chair that they are being remunerated for their work and that they and other service user members of the Committee are able to claim out of pocket expenses
- Evidence that the MVP is prioritising hearing the voices of women from Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation, as a result of UKOSS 2020 coronavirus data.

2) **Listening to Women and their Families**
   a) Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services

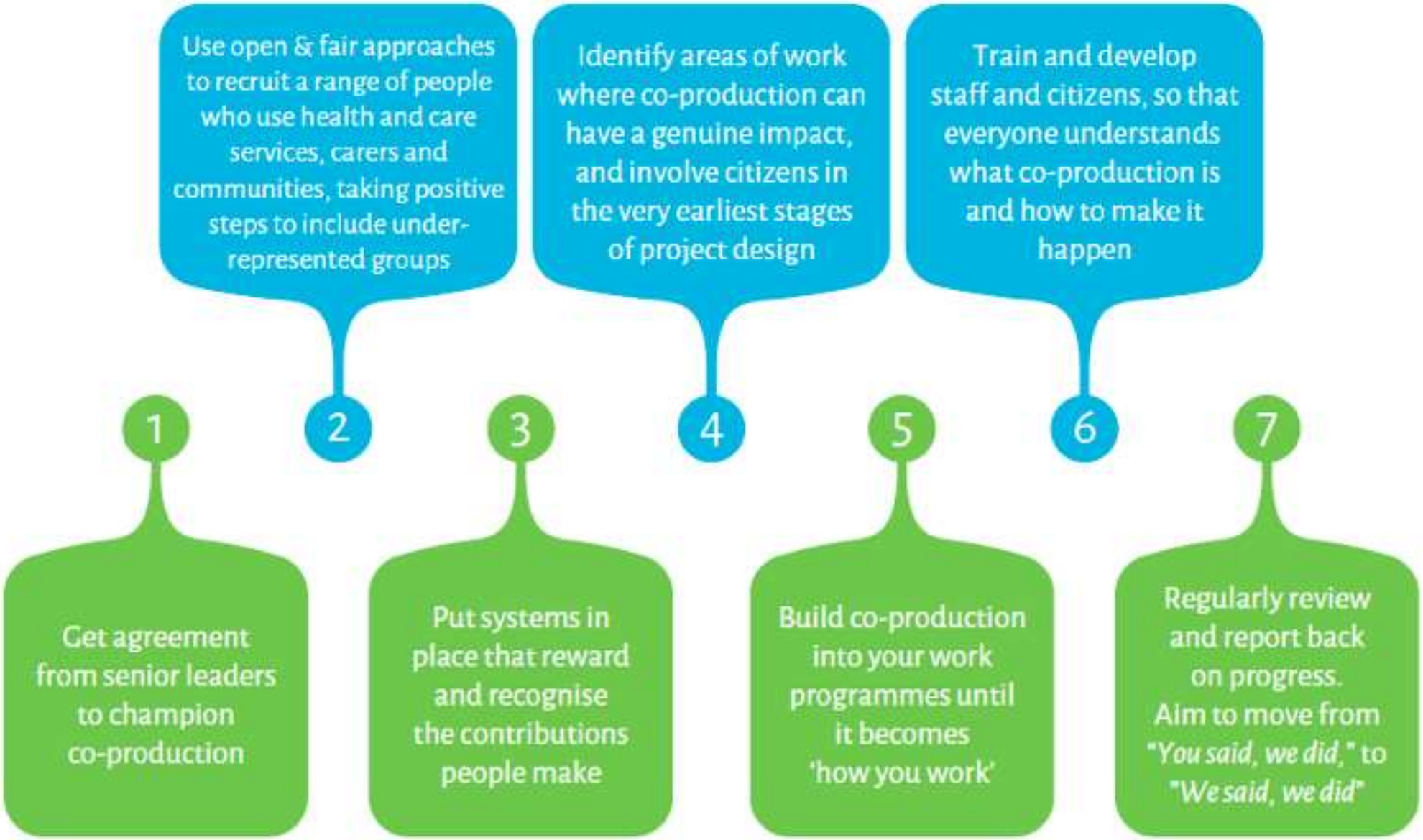
Ownership, understanding and support of co-production by all

A culture of openness and honesty

A commitment to sharing power and decisions with citizens

Clear communication in plain English

A culture in which people are valued and respected


Use open & fair approaches to recruit a range of people who use health and care services, carers and communities, taking positive steps to include under-represented groups
Identify areas of work where co-production can have a genuine impact, and involve citizens in the very earliest stages of project design
Train and develop staff and citizens, so that everyone understands what co-production is and how to make it happen
1
2
3
4
5
6
7
Get agreement from senior leaders to champion co-production
Put systems in place that reward and recognise the contributions people make
Build co-production into your work programmes until it becomes 'how you work'
Regularly review and report back on progress. Aim to move from "You said, we did," to "We said, we did"

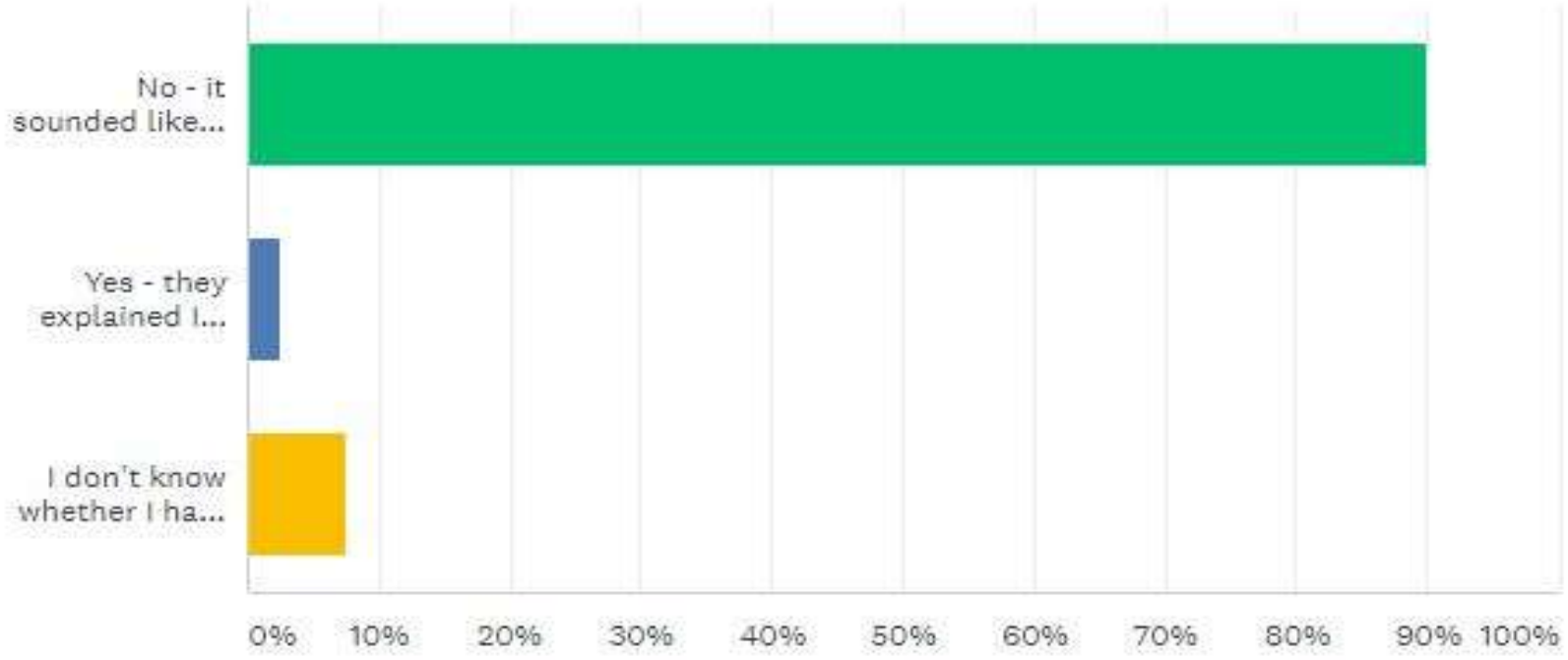
“In a maternity context, the best way of instituting service user co-production is through a Maternity Voices Partnership.” – Better Births

MVP Example

- **<u>Are Covid tests compulsory when you go in to have your baby?</u>**
  - Access to senior staff to find out
- Isolated incidents or more generalised issue?
  - Ask more service users
  - Ask some detailed questions
- Signposting individual service users
  - 24h Maternity Advice Line
  - Care giving Midwife
  - Professional Midwifery Advocates

Did you know that you didn't have to have the Covid test?

Answered: 40 Skipped: 0



ANSWER CHOICES	RESPONSES	
No - it sounded like I had to have it	90.00%	36
Yes - they explained I didn't have to have it	2.50%	1
I don't know whether I had to have it or not	7.50%	3
TOTAL		40

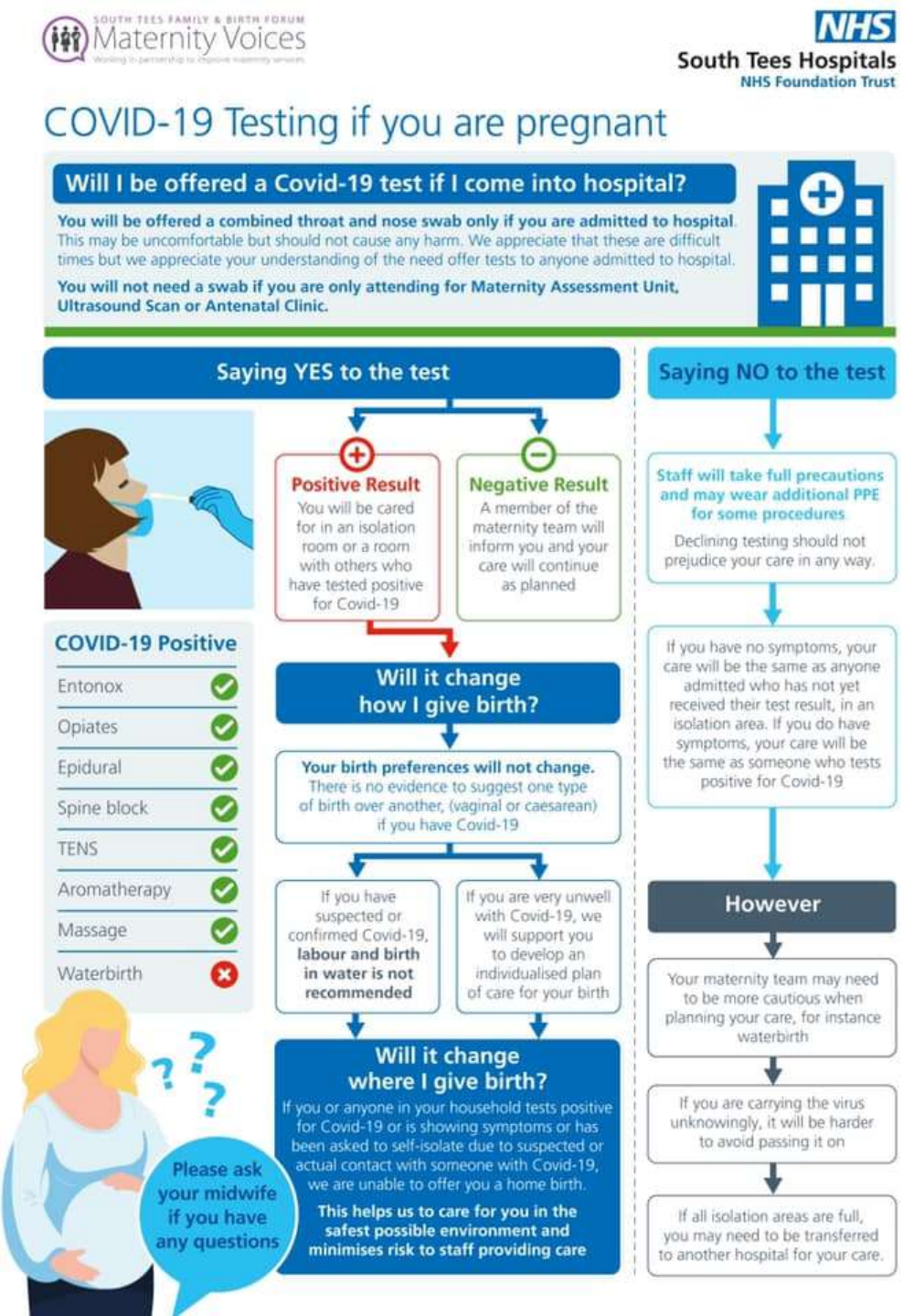
Did you feel that saying "no" to a Covid test was an option?

Answered: 40 Skipped: 0

ANSWER CHOICES	RESPONSES	
Yes - it was totally clear that I could decline the test and I knew what would happen if I did	2.50%	1
Yes - but I didn't know what would happen if I didn't have the test	0.00%	0
Maybe - I thought I could have said "no" if I felt strongly about it	5.00%	2
Not really - there was an assumption that I wouldn't say "no"	30.00%	12
No - I could have declined but it would have prevented my care from going ahead	12.50%	5
No - it was totally clear that I had to have the test	50.00%	20
TOTAL		40

- Bring the issue to the MVP group/meeting
  - Discuss with clinical and service user members to raise awareness of the issue

- Coproduction of clear information
  - Draft shared to MVP group for comments
  - Changes made to improve accessibility
  - Infographic signed off
  - Infographic shared via MVP and Trust social media



Is it...

- Informative?
- Accurate?
- Clear?
- Kind?
- Comprehensive?
- Reassuring?
- Neutral?
- Respectful of choice?
- Honest?
- Inclusive?
- Accessible?


VK.COM/PITERSKII_PUNK_WALL
I love it!
Me too!

Many Thanks

sarahlwall@Hotmail.com

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Maternity and Neonatal

Regional Culture Work

Kathryn Hardy, Local Maternity System Programme Lead, Local Maternity Systems for Northern England
Nicola Jackson, Local Maternity System Programme Lead, Local Maternity Systems for West, North and East Cumbria

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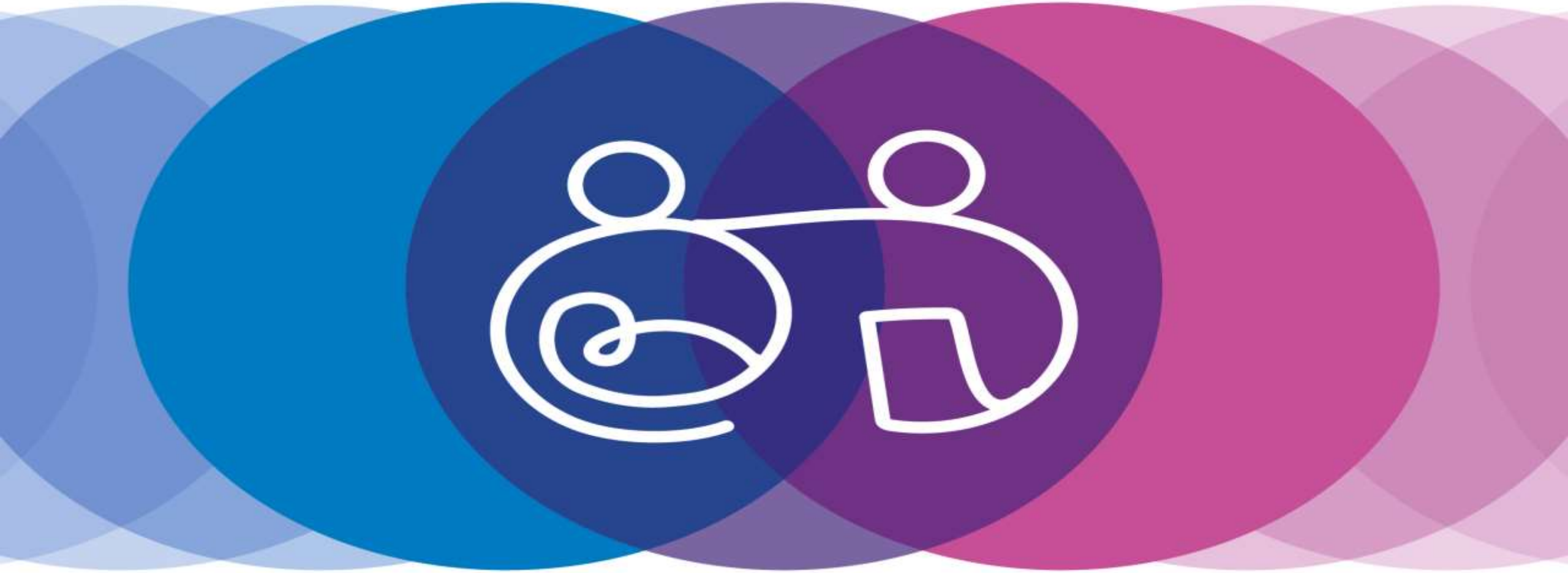
Northern England & North Cumbria Local Maternity Systems

LMS
Local Maternity Systems
Northern England



CULTURE WORK ACROSS THE LMS

BAME WORK

- Increase support for at-risk pregnant women – Refugee & asylum Seekers, videos 8 Languages
- Reach out and reassure pregnant Black, Asian and minority ethnic women with tailored communications – Spice FM, Recite-me, HAREF, NEAS, MVPs
- Minimise the risk of Vitamin D insufficiency – WRVS shop supplies Vitamin D
- Gather the correct data – SI Reports how can we address risk and structure training if we don't know demographics
- Cultural awareness training

Culture work

- SCORE survey regional work continues – working with PMAs, HOM, Julia Wood
- Leadership opportunities – How do we develop our future midwifery leaders?
- Review support available for the team. What is needed?
- Steve Head - *Taking care of yourself and your future – 27/04/2021* The aim is that by the end of this session you will feel uplifted and have practical tools, tips and strategies to help you with your mental wellbeing and resilience during these challenging times.

National Patient Safety
Improvement Programmes

Maternity and Neonatal

Next Steps

Julia Wood, MatNeoSIP Lead – NENC, AHSN NENC

@NatPatSIP / @MatNeoSIP

www.improvement.nhs.uk

Delivered by:

The AHSN Network
North East and North Cumbria Patient Safety Collaborative

Northern England Maternity and Perinatal Mental Health Clinical Networks

LMS Local Maternity Systems Northern England

Northern Neonatal Network

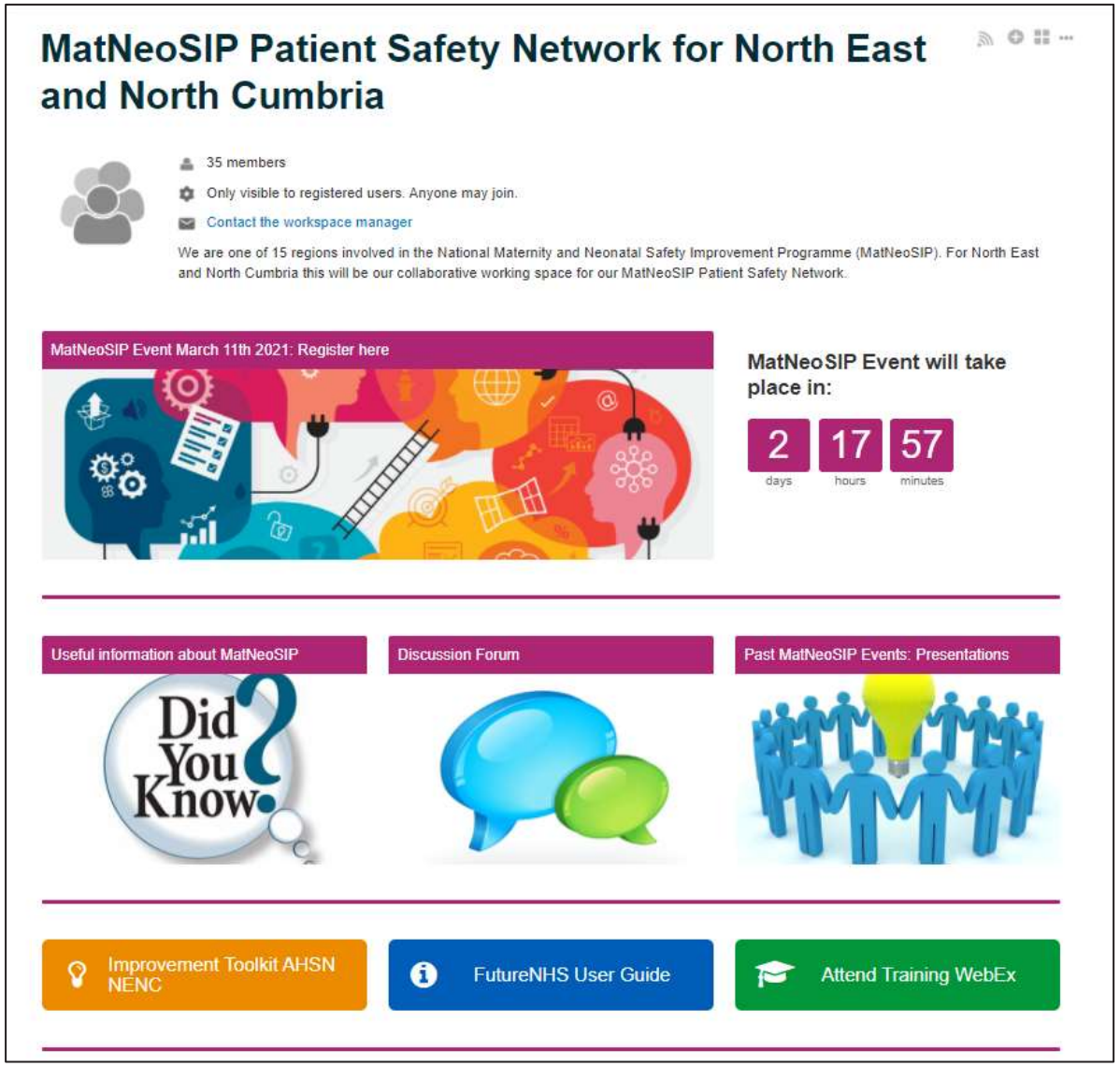
Led by:
NHS England
NHS Improvement

FutureNHS online platform

> The FutreNHS Collaboration Platform is a web based tool which supports people from across the health and social care sector to work together more effectively.

> The Platform enables people to share, learn and connect with others, to deliver high quality integrated health and care services for patients and service users.

> [MatNeoSIP Patient Safety Network for North East and North Cumbria - FutureNHS Collaboration Platform]



Help with Quality Improvement

[PowerPoint Presentation (ahsn-nenc.org.uk)]

Future MatNeoSIP Provisional Dates

- 14th June pm
- 20th September pm
- 13th December pm

Next steps

> Identify who should be the best people to speak to regarding the PreTerm Birth Perinatal Optimisation Care Bundle
> Become a member of the Regional MatNeoSIP Hub
> Use the QI Toolkit
> Ask for help
> Add potential dates to your diaries

National Patient Safety
Improvement Programmes

Maternity and Neonatal

Dr Stephen Sturgiss is retiring

@NatPatSIP / @MatNeoSIP

www.improvement.nhs.uk

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Dr Stephen Sturgiss

- What three words spring to mind when you think of Stephen?
- What impact has Stephen had across the region?


Considered
Knowledgeable
Focused
Informed
Balanced
Measured
Inclusive
Cool
Supportive
Caring
Fair
Gentle
builder
Reliable
Patient
Calm
Diplomatic
listener
Kind
Consensus
Open-minded
Leader
Respectful
Listens
Wise
Subtle
Good
Reasoned
Dedicated
Thoughtful
Collaborative

Excellent inclusive leadership

Outstanding maternity leader

Supported an **open and transparent patient safety learning culture**

Enabled **closer working** with the neonatal and maternity networks

Collaborative visionary leader

Sharing knowledge widely

Collaborative learning and improvement

Respected, focused and **passionate**

Connection, partnership, **patient centred**

Sharing of expert knowledge

Leadership, consistency and **innovation**

Absolutely **ALWAYS put mums and babies at the centre of our thinking**

Great leader and very approachable personality

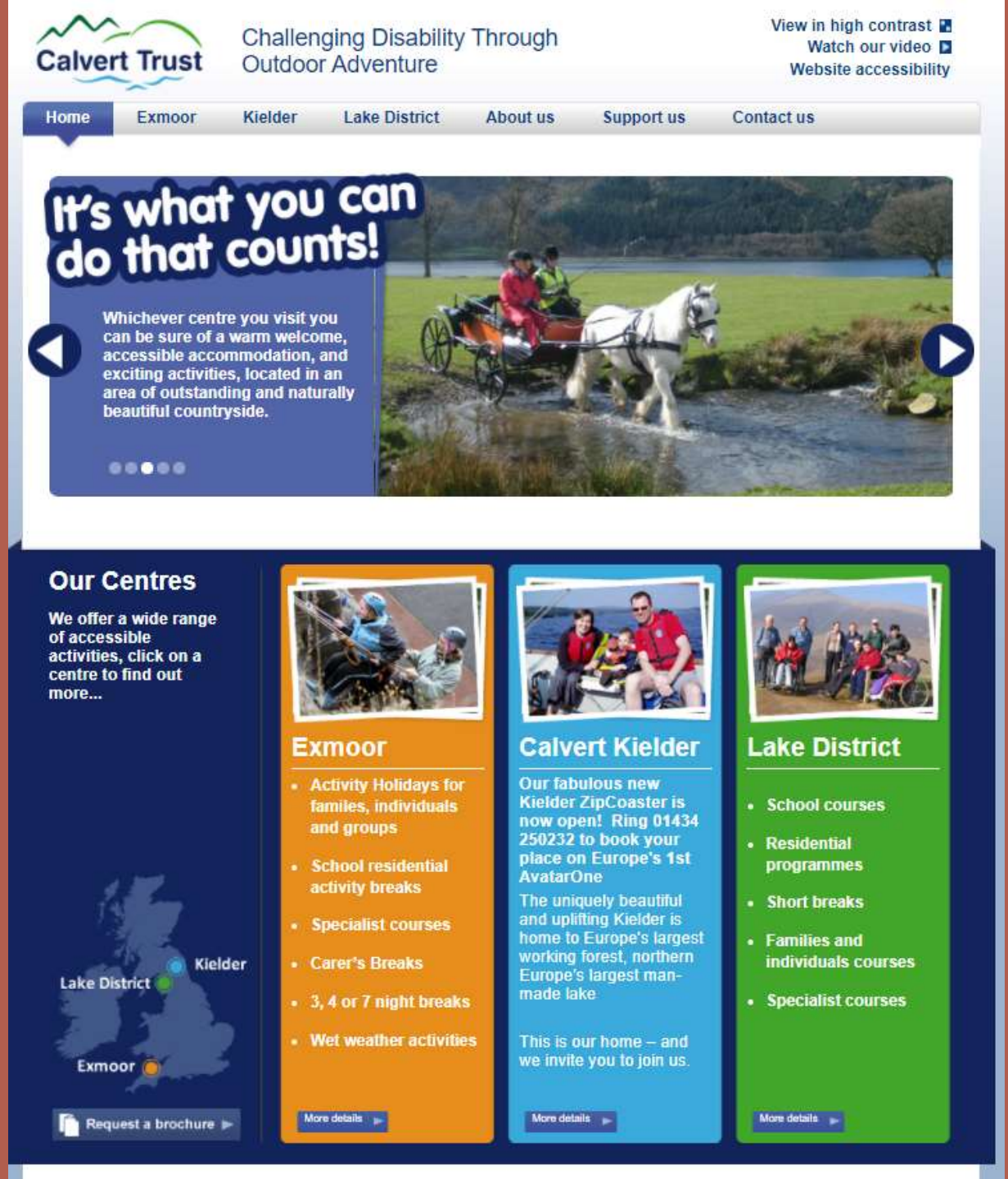
Far reaching, productive, excellent clinical support

Developed a well functioning maternity network

Excellent **communicator** who has enabled many teams to come together

Brought the region together to make wide ranging improvements to maternal and neonatal care

Delivers, drives and reasons



[Dr Sturgiss is retiring: Collecting for the Calvert Trust (paypal.com)]


THANK YOU