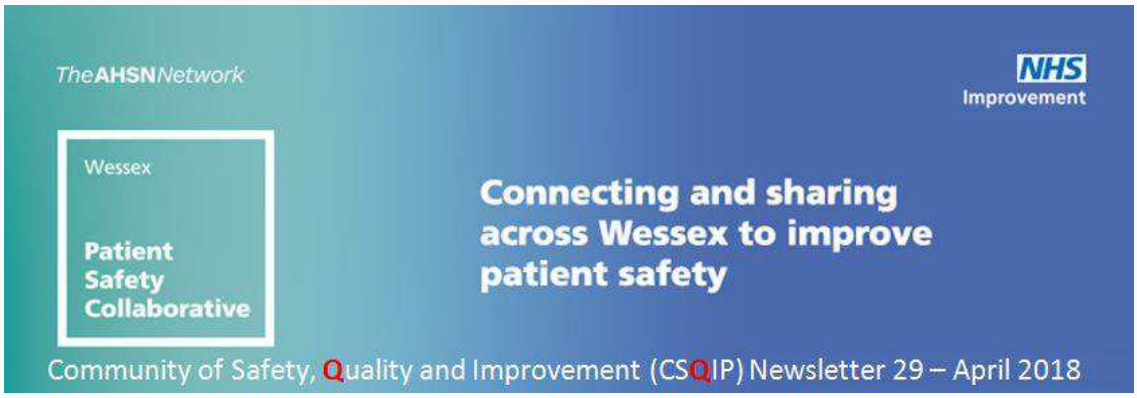
PSC Admin

From: Patient Safety Collaborative <patient.safety=wessexahsn.net@mail129.atl171.mcdlv.net> on behalf of Patient Safety Collaborative <patient.safety@wessexahsn.net>
Sent: 27 April 2018 14:18
To: PSC Admin
Subject: CSQIP NEWS - UPDATE 29: Wessex PSC - Emergency Surgery Network, Improving the Stabilisation of Preterm Babies and other regional/national news



What is CSIP? - We are a growing community that connects individuals, teams and projects across health and care in the areas of innovation, quality improvement and patient safety. We currently have over 510 members across Wessex. CSIP is supported by the Wessex Patient Safety Collaborative (PSC).

What is Wessex PSC? - We work with individuals, teams and organisations to increase capability around safety improvement. We offer engagement in a series of projects and events targeting local and national areas of safety priority. We do this in partnership with patients and we encourage networking and sharing to support the spread of good practice across Wessex.

This Newsletter also supports the Wessex **Q** community hence the recent addition of **Q**uality in the title. Two local communities linking to improve quality and patient safety.

Focus Topic

Wessex Academic Health Science Network

Wessex Patient Safety Collaborative

NHS Health Education England

The 3rd annual

Wessex CSIP Safety, Quality and Improvement Conference

Save the date:
9 October 2018
Novotel, Southampton - #CSIPwessex18

Join us to showcase and celebrate patient safety and quality improvement excellence in Wessex

Click here to view the event flyer

Wessex Emergency Surgery Network

Wessex Patient Safety Collaborative

Intense and challenging; the 2nd Wessex Emergency Surgery Network was certainly all of those things….but it was also creative, positive and thought provoking.

Multi-professional clinicians working across the pathway

Tracy Broom – Associate Director Wessex PSC, talks through the days plan

James Kirkby-Bott - Consultant General Surgeon UHS and Clinical Lead for Wessex ESN

met for a day at Chilworth to network and share ideas. We heard about and discussed Never Events, the WHO checklist, a local hernia audit, team hierarchies, an industry surgical site infection proposal and the evolution of the stress response.

We also got out the flip chart paper and pens and all practiced process mapping, a quality

improvement skill to take back to base and repeat with the whole team.

We meet every 4 months and the network is open to anyone in healthcare who works within emergency surgery in Wessex.

Tracy Broom - Wessex PSC - Associate Director
tracy.broom@wessexahsn.net

Professor Jane Reid - Clinical Consultant, Wessex PSC and Bournemouth University

Wessex News

SBAR is an easy to use, structured form of communication that enables information to be transferred accurately between individuals. SBAR was originally developed by the United States military for communication on nuclear submarines, but has been successfully used in many different healthcare settings, particularly relating to improving patient safety.

Click here to access the resource

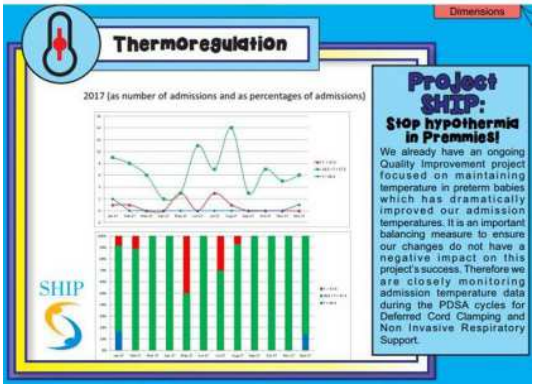
What is a Spotlight? An opportunity for local staff to highlight their Quality Improvement/Patient Safety work and share the learning.

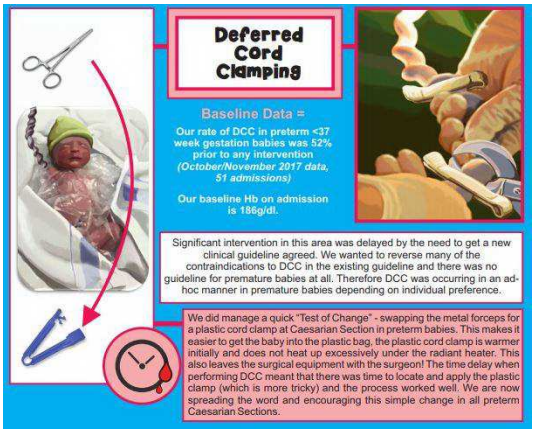
Call for Spotlight articles Email your article to us (up to 250 words) at patient.safety@wessexahsn.net and feel free to include links to further information and visuals.

Spotlight on: Improving the Stabilisation of Preterm Babies

NHS
University Hospital Southampton
NHS Foundation Trust

In 2017 the Maternity Service at University Hospital Southampton (UHS) was invited to be part of the Wave 1 launch of the Maternal and Neonatal Heath Safety Collaborative, a three year Quality Improvement (QI) programme led by NHS Improvement. The aims of the QI programme were to; develop local skills and resources in QI; create a local improvement plan; improve service quality and safety; measure improvement data to show the impact and join a local learning system.





The UHS QI team are made up of Obstetric, Midwifery and Neonatal representatives and will look to share learning from QI projects, and work collaboratively with the UHS central QI team in the QI cycles.

UHS Maternity and Neonatal have developed an improvement plan to undertake the following:

- **Create the conditions for a safety culture** – by undertaking the SCORE staff culture questionnaire to determine the safety commitment of clinicians within the maternity services. Additionally the service introduced a poster to prompt women and their families to speak up – call 'now is the time to ask'. (see poster)
- **Design and implement highly reliable and effective pathways of care** – By introducing the use of fresh eyes buddy system and SBAR to improve risk assessment in midwife-led birth centres.
- **Improve the early recognition and management of deterioration of either mother or baby during labour** - By reducing the incidence of term babies born with low Apgars, low cord Ph and/or requiring unexpected admission to the neonatal unit where lack of recognition or escalation of abnormal fetal monitoring is a contributory factor by 50% in 12 months.
- **Improving the optimisation and stabilisation of the preterm infant** - Premature babies have unique vulnerabilities after delivery and require help to stabilise and transition to extra-uterine life. The quality of care during this period is extremely important and can have a significant long term impact. Our aim is to improve the quality of care provided prior to admission to the neonatal unit with particular reference to thermoregulation, non-invasive respiratory support and deferred cord clamping. (see poster).

Project Team

Suzanne Cunningham – Director of Midwifery, Jillian Connor – Consultant Obstetrician, Donna Winderbank-Scott – Consultant Neonatologist, Marie Cann – Midwifery Quality Assurance Manager, Lisa Smith – Consultant Midwife, Anushma Sharma - Neonatal Grid Research Fellow, Alok Sharma - Consultant

Neonatologist (Project SHIP)

Vital signs and other observations used to detect deterioration in pregnant women: an analysis of vital sign charts in consultant-led UK maternity units

Click here to read the article

The next date for this training is **May 8th** at Southern House, Otterbourne, SO21 2RU.

To book please email mark.ainsworth-smith@scas.nhs.uk

Watch Ilona's incredible story

Wessex NHS Genomic Medicine Centre patient, Ilona, tells us how genome sequencing led to a diagnosis for her critical illness. From being hospitalised and in a coma, Ilona explains how a live-saving realisation by a Southampton-based geneticist has helped her to get her life back. Watch the full video here.

Hitting the headlines!

The AHSNs work to roll-out devices to help detect irregular heartbeats, and prevent strokes, was recently featured on BBC South Today. The piece includes interviews with Sharron Gordon, the AHSNs AF clinical adviser, a patient, and Dr Anthony Leung from Badgerswood surgery in Bordon.

April Newsletter

- Civility saves lives - The price of incivility - **Risky behaviour** - A way of calling out rudeness - **How incivility shuts down our brain at work** - Putting people centre stage

Click here to view the newsletter in full

Spotlight on: **Measure What Matters: an introduction to PROMs and PREMs.**
Tim Benson, R-Outcomes Ltd

Part 4 How?

The previous articles (which can be read here) outlined the need for PROMs (person-reported outcome measures) and PREMs (person-reported experience measures) to measure what matters to patients, staff and carers across health and care services, explained exactly what they are and detailed the importance/role of staff and carers.

The implementation of PROMs and PREMs can be mapped to the PDSA (Plan, Do, Study, Act) improvement cycle.

Plan: Decide what you want patients staff or carers to record. Validated questions are usually the result of much research, so don't reinvent the wheel without good cause.

Do: Be crystal clear about your aims and communicate these to the front line. Work out how best to ask people to complete the surveys and adapt the methods to local conditions as part of your routine workflow, not as an optional extra. Whatever method you choose (digital device such as a tablet, or printed forms), make sure it is quick and easy for all patients.

Study: Reporting is useful at three different levels.

1. Tailoring individual patient care to optimise outcomes (PROMs)

2. Helping local service management improve quality (PREMs)
3. Compare similar units using benchmarking (PROMs and PREMs).

People need feedback immediately – not months later – through up-to-date interactive dashboards that let users investigate the results themselves. For cohorts of patients we like to show mean scores on a 0-100 scale, where 0 means that all chose the worst option and 100 that they all chose the best option. A high score is always better than a lower score.

Act: The reason for using PROMs and PREMs is to understand better what is going on. Unexpected findings are often right and offer useful new perspectives, providing individuals and organisations with the intelligence to make changes and check that they have the impact predicted.

Tim Benson is the Founder and Director of R-Outcomes and also recently became a member of **Q.** This is the fourth of a series of articles he has written for CSQIP and he can be contacted at: tim.benson@r-outcomes.com. More information on R-Outcomes can be found on their website here.

National News

Have you got a great idea that you'd like to make happen?

Can you offer your expertise and support to help these ideas come into fruition?

Get involved with Q Exchange, a new programme that offers Q members the chance to develop project ideas and submit bids for up to £30,000 of support funding.

Click here to find out more.

Involved in mortality review?

Come to the RCPs first ever conference to share best practice and practical advice.

Whether you've been asked to take responsibility for this vital area of quality improvement for the first time, or are simply seeking a fuller understanding of mortality review, you will benefit from attending their first ever annual conference.

Click here for more information including how to book

The NIHR has just published a new highlight of research into how commissioners use research evidence and has funded six particular studies in the past five years on the use of evidence by commissioners. Click here to find out more.

NHS Improvement

The future of NHS Patient safety investigation

The Serious Incident framework (2015) describes how Serious Incidents should be reported and investigated in the NHS. NHSI are seeking views on how their guidance could be revised to support the system to respond appropriately when things go wrong. Click here for more information including how to take the survey.

Do you believe that you are doing a great job for people with diabetes and/or their families/carers?

Do you think that your team's efforts deserve recognition?

If so, put together an entry for one of the Quality in Care Diabetes 2018 categories.

Click here to find out more

The results of the NHS Staff Survey 2017 are now available. More information and the various outputs that are created as a result of the survey's publication can be found here.

Wessex PSC Events

Wessex Patient Safety Collaborative

Patient Safety Collaborative upcoming events

Date	Event	Time	Venue	Registration Information
Thursday May 3rd 2018	Wessex Emergency Department Quality Improvement Network	0930 - 1600	Conference Room 4A/B, Innovation Centre, 2 Venture Rd, Chilworth, SO16 7NP	https://www.eventbrite.co.uk/e/wessex-emergency-department-quality-improvement-network-may-2018-tickets-43321791645

Tuesday June 5th 2018	Wessex Q Connection 'UNCONFERENCE'	1300 - 1630	Grant Thornton UK, 5 Benham Road, Southton Science Park, Chilworth, SO16 7QJ	This event is for members of Q only. Please email patient.safety@wessexahsn.net for more information
Friday June 15th 2018	Wessex Maternal & Neonatal Learning System Meeting	0900 - 1400	Conference Room 4A/B, Innovation Centre, 2 Venture Rd, Chilworth, SO16 7NP	https://www.eventbrite.co.uk/e/wessex-maternal-neonatal-learning-system-2-tickets-44550763533
Wednesday June 20th 2018	Safety Culture Programme (CCGs and Primary Care)	0900 - 1600	Conference Room 4A/B, Innovation Centre, 2 Venture Rd, Chilworth, SO16 7NP	https://www.eventbrite.co.uk/e/safety-culture-programme-ccg-and-primary-care-tickets-45338822639
Thursday July 5th 2018	Deterioration/Sepsis Network Meeting	1000 - 1630	Conference Room 4A/B, Innovation Centre, 2 Venture Rd, Chilworth, SO16 7NP	Please email patient.safety@wessexahsn.net for more information
Monday July 23rd 2018	Safety Culture Programme (Community/Mental Health)	0900 - 1600	Conference Room 4A/B, Innovation Centre, 2 Venture Rd, Chilworth, SO16 7NP	https://www.eventbrite.co.uk/e/safety-culture-programme-communitymental-health-trust-tickets-45339864756
Tuesday October 9th 2018	Wessex CSIP Safety, Quality and Improvement Conference	TBC	Novotel, 1 West Quay Rd, Southampton SO15 1RA	Please email patient.safety@wessexahsn.net for more information

This email has been sent on behalf of:

Robert Payne (patient.safety@wessexahsn.net) - CSIP Project Lead, PSC
Geoff Cooper (Geoff.cooper@wessexahsn.net) - Programme Manager, PSC
Lesley Mackenzie (lesley.mackenzie@wessexahsn.net) - Programme Manager, PSC
Tracy Broom (Tracy.broom@wessexahsn.net) - Associate Director, PSC

Contact us:

@tracyPSC @wessexPSC @wessexAHSN

Come and look at the PSC projects:

wessexahsn.org.uk/programmes/21/patient-safety-collaborative

Our mailing address is:

Innovation Centre, 2 Venture Road,Chilworth, Southampton, SO16 7NP