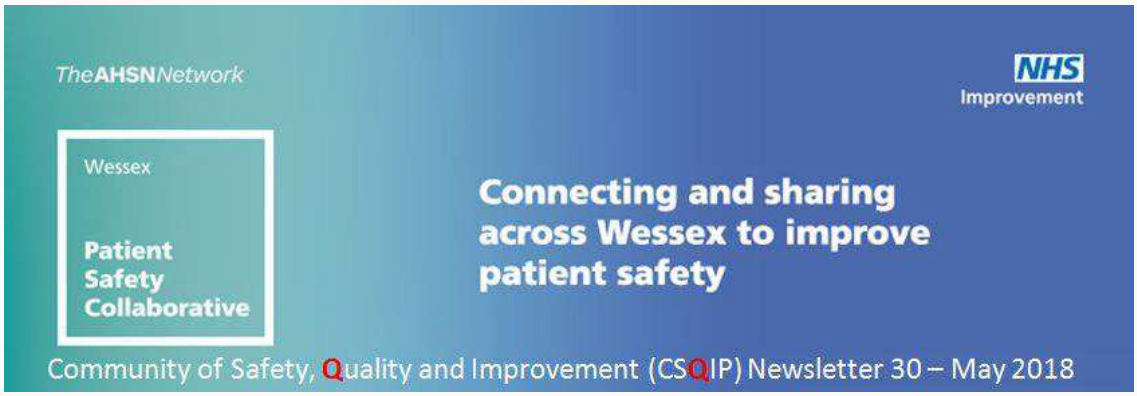
PSC Admin

From: Patient Safety Collaborative <patient.safety=wessexahsn.net@mail218.atl171.mcdlv.net> on behalf of Patient Safety Collaborative <patient.safety@wessexahsn.net>
Sent: 24 May 2018 13:01
To: PSC Admin
Subject: CSQIP NEWS - UPDATE 30: Wessex PSC - Emergency Department Network, Safety Culture Programme 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 530 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 PSC – Emergency Department Network

Emergency Department Network meeting 3rd May 2018

Lively and informative, ED Network members and guest speakers contributed to another successful meeting with members pledging to use Quality Improvement (QI) methodology for future projects and introducing Favourable Event Reporting Form (FERF) to improve staff experience.

Tracy Broom (Associate Director Wessex PSC) presenting at the Emergency Department Network

The day came at the end of a year where a number of Wessex ED departments hosted the Network, sharing their improvement work with an emphasis on patient safety and the success and challenges of using QI methodology. Having space to share their experience of making a change to practice we have witnessed the successful adoption of the ED Checklist in many of the Wessex Trusts.

Rachel Clare talks about the Favourable Event Reporting Form (FERF)

Specialist Nurse Rachel Clare shared her experience of Appreciative Inquiry and FERF which is used at UHS. The recognition and re-enforcement of successful events and behaviours, which helps to improve patient safety culture was welcomed by all ED network members.

Led by the WPSC Clinical Leads, Dr Matt Inada Kim (Deterioration Network Lead), Dr Usha Couderc and Dr Sarah Grimwood there was an enthusiastic debate on how best to manage the deterioration of patients as they move across the patient pathway, from general practice to acute hospital, via ED.

Dr Matt Inada-Kim talking NEWS2 and Emergency Medicine

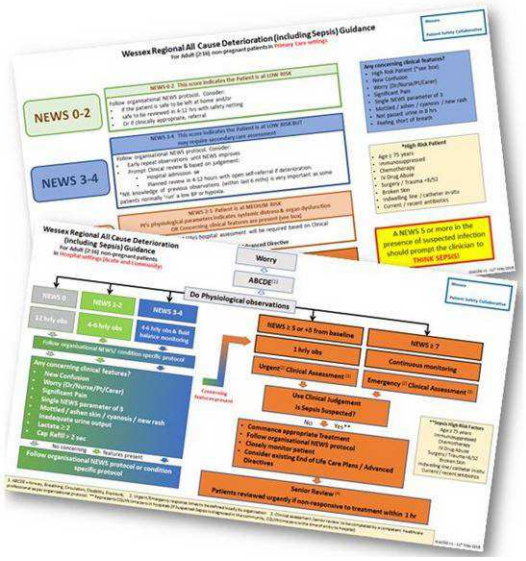
The next ED Network meeting is on the 5th December 2018 at Chilworth, SO16 7NP. More details to follow in CSQIP

Lesley Mackenzie - Programme Manager - Wessex PSC lesley.mackenzie@wessexahsn.net

Wessex News

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.



Launch of the NEW Wessex All Cause Deterioration Guidance (WACDG)

Wessex PSC are delighted to be able to announce the launch of the Wessex All Cause Deterioration Guidance which is a significant piece of work co-designed by the Wessex PSC Deterioration Network.

Our aim in producing this guidance is to encourage the development of a consistent language and approach to the management of physical deterioration across Wessex and to help ensure that escalation pathways within and between healthcare organisations are aligned to a common understanding and set of thresholds.

We believe the WACDG is going to make a huge contribution to shaping a consistent approach to Deterioration and the use of NEWS2 across Wessex and thereby, most importantly, improving patient outcomes.

Further information about the WACDG can be found on the WPSC website here.

Spotlight on: Wessex PSC – Safety Culture Programme

A safety culture in healthcare is one where staff have a positive experience of psychological safety, teamwork and leadership, and feel comfortable discussing when things don't go as planned.

Safety Culture expert Professor Jane Reid at a recent Patient Safety Collaborative event

Each workshop will be delivered by the WPSC Team and a regional speaker who will be presenting on one of the following: Tribalism, favourable event reporting, Schwartz rounds, humanising healthcare and patient centred care.

Click here to view the event flyer with dates and booking information

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Guest Editorial

JOURNAL OF Perioperative Practice

AfPP PROGRESSING SAFER SURGERY

The notion of quality

In the course of our perioperative work, we are all engaged in the pursuit of quality health care for those we serve. This is often framed in terms of assuring good clinical outcomes, lives saved, reductions in avoidable harm, optimizing 'QALYs' (quality adjusted life years) and for our bean counter colleagues, the efficiencies and effectiveness achieved; relative to each pound of public money invested in service provision.

The notion of quality is relative and sits in a spectrum; it is subject to interpretation, perception and further framed by assumption and presumption.....

Click here to read the article in full

Professor Jane Reid - Former President AfPP and IFPN - Clinical Consultant Wessex Patient Safety Collaborative/AHSN - NED Salisbury NHS Foundation Trust - janehreid@googlemail.com

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Now we're in the run-up to the NHS 70th birthday celebrations on Thursday 5 July, the AHSN Network has teamed-up with NHS Digital to showcase some of the latest healthcare innovations via an online countdown calendar. Behind every door is an innovation that showcases some of the latest healthcare innovations that are making a positive difference to patients, carers, staff and NHS organisations.

The #NHS70Innovations campaign started on 25 April, which marked 70 days until the NHS turns 70 years old. The campaign is shining a spotlight on the diverse range of innovations both existing and coming into the NHS, with a new innovation revealed every day.

Explore the countdown calendar at nhs70innovations.org.uk and follow the #NHS70Innovations hashtag on social media.

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

Part 5 Common Features

The previous articles (which can be read here along with the final ones in the series 6 and 7) 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 and the implementation process.

R-Outcomes PROMs and PREMs are an example of a modern suite of tools, with a common look and feel. Modules are mixed and matched to make up short surveys for completion by patients, staff or carers.
Each module addresses a separate domain, but is suitable for all types of patient, irrespective of their condition or mode of treatment. This generic property is useful when patients are heterogeneous or have several conditions.
Each module comprises four question items with four response options each. The options are displayed with the best on the left and the worst on the right, colour coded (green, yellow orange and red) with a smiley-face emoji. NB use of colour and emoji are not core requirements. Responses are optional.
The scoring scheme for individual items is 0 for the worst option and 3 for the best option, with 1 and 2 for intermediate options. The item scores in a module can be added, giving a summary score with a range from 0 (all worst) to 12 (all best).
The number of words in any module is less than 50 and the reading age less than 10, making it quick and easy to understand. When using paper forms, we try to keep all of the questions on one side of a sheet of A4 paper. A free text comment box is provided and we encourage its use. Typical demographic data collected includes gender, age in deciles and number of medications, as a proxy for multiple conditions.

Click here to read the full series of 7 articles

Tim Benson is the Founder and Director of R-Outcomes and also recently became a member of **Q.** This is the fifth of a series of articles he has written for CS**Q**IP 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

NHS Improvement **Patient safety alerts**

Resources to support the safe adoption of the revised National Early Warning Score (NEWS2)

A resource alert has been issued to support providers to adopt the revised National Early Warning Score (NEWS2) to detect deterioration in adult patients. Click here to find out more.

Risk of death or severe harm from inadvertent intravenous administration of solid organ perfusion fluids

A warning alert has been issued on the risk of inadvertent intravenous administration of solid organ perfusion fluids. Click here for more information.

HSIB HEALTHCARE SAFETY INVESTIGATION BRANCH

Health Care Safety Investigation Branch

The HSB have released the first interim bulletin relating to their investigation into the design and safe use of portable oxygen systems - find the full details here

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Think Sepsis

A film for all healthcare workers involved in the care of sick children. This awareness-raising teaching aid has been developed to help health care professionals spot and respond to the warning signs of sepsis in children.

Dr Aidan Fowler appointed as NHSI National Director of Patient Safety

Dr Aidan Fowler is to join NHS Improvement as NHS National Director of Patient Safety in July 2018. Reflecting the system-wide nature of the role, Dr Fowler will also be appointed as a Deputy Chief Medical Officer by the Chief Medical Officer and Department of Health and Social Care. Click here for more information.

The AHSN Network NHS England
NHS Innovation Accelerator

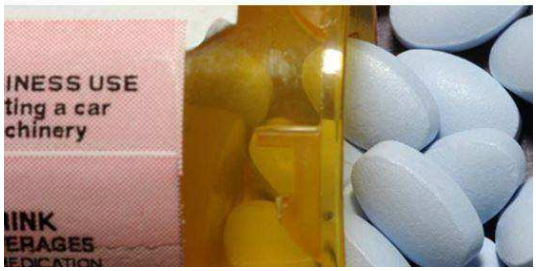
The NHS Innovation Accelerator (NIA) supports delivery of the Five Year Forward View by accelerating uptake of high-impact innovations for patient, population and NHS staff benefit. It also provides real-time practical insights on spread to inform national strategy.

OVIVA | DIABETES SUPPORT

One example is a fully remote, technology-enabled programme of type 2 diabetes structured education and behaviour change, combining one-to-one support from a registered dietitian with evidence-based online educational materials and use of the Oviva app. More information can be found here or on the Oviva website.

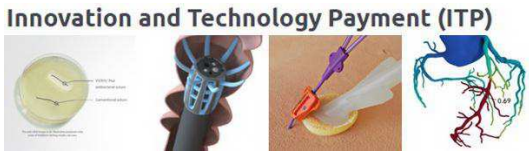
Dissemination Centre
Discover Portal

NHS National Institute for Health Research 70 YEARS OF THE NHS 1948 - 2018



Adding the extra antibiotic rifampicin did not improve cure rates after sepsis

A trial funded by NIHR found that adding the antibiotic rifampicin did not improve cure rates or reduce deaths for people with bacterial blood infections caused by *Staphylococcus aureus*. It increased the risk of adverse reactions requiring a change in treatment and the chances of drug interactions. Click here to find out more.



The NHS Innovation and Technology Payment (ITP) programme went live on 1 April 2018, in follow up to the Innovation and Technology Tariff (ITT) launched last year. Find out more here

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What's new on Atlas?

Our *Atlas of Solutions in Healthcare* brings together proven innovations and improvements from the AHSNs and Patient Safety Collaboratives that are making a positive difference to people's lives and saving money for the NHS.

We are continually adding new case studies to Atlas and the latest are:

Safer Culture, Better Care – the 'SCORE' assessment tool: click here
Reducing urinary tract infections in care homes: click here
LPZ – improving quality and safety in care homes: click here
Managing urgent care flow with Healthcab: click here
Improving operational efficiency for patients with Medic Bleep: click here
iSpace – dementia-friendly GP surgeries: click here
Improving patient involvement in diabetes management: click here
Safer Provision and Caring Excellence – the impact of SPACE: click here
We share the NEWS – National Early Warning Score: click here
Limiting patient harm due to Acute Kidney Injury: click here
Reducing acute kidney injury and sepsis mortality: click here
The Tookie Vest: click here

Sustainable Improvement Change Model

NHS England's Sustainable Improvement team has published an updated and enhanced version of the Change Model. The model, originally developed in 2012, is a framework for any project or programme seeking to achieve transformational, sustainable change. The refreshed 2018 version includes a PDF guide and a series of supporting diagnostic tools.

Pharmacists for care homes

NHS England has announced plans to deploy pharmacists into care homes to help reduce overmedication and cut unnecessary hospital stays.

National lung 'task force' established

National partners have convened the country's first taskforce for lung health. Made up of patients, professionals and charities with input from industry, it will consider the best available evidence and set out a new, five year strategy to improve the nation's lung health.

More information: read this interview with British Lung Foundation CEO Penny Woods

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Can you speak human? Why we underestimate the 'power of simple'

Discover the power of 'speaking human' in this blog from Louise Thompson, director of communications at Burton Hospitals NHS Foundation Trust, as she explains the importance of using accessible and clear language.

Wessex PSC Events

Wessex Patient Safety Collaborative

Patient Safety Collaborative upcoming events

Date	Event	Time	Venue	Registration Information
Tuesday June 5th 2018	Wessex Q Connection 'UNCONFERENCE'	1300 - 1630	Grant Thornton UK, 5 Benham Road, Southton Science Park, Chilworth, SO16 7QJ	https://www.eventbrite.co.uk/e/q-networking-event-unconference-tickets-44366540517
Friday June 15th 2018	Wessex Maternal & Neonatal Learning System Meeting	0830 - 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 12th 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
Thursday September 13th 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
Friday September 21st 2018	Emergency Surgery Network Meeting	1000 - 1600	Conference Room 4A/B, Innovation Centre, 2 Venture Rd, Chilworth, SO16 7NP	Please email patient.safety@wessexahsn.net for more information
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
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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