

News from the Eastern Patient Safety Collaborative – May 2019

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All the latest from the team

We are delighted to welcome another new starter to our team this month. Tara Marshall joins us as Deterioration – Clinical Lead. She will be supporting local teams to move beyond NEWS2 implementation and extending our work on deterioration to community providers of care. Keep an eye out for Tara's blog over the coming weeks.

Talking of NEWS2, thanks to all of you who completed the recent NEWS2 survey. An amazing 91% of organisations in the region responded, confirming the use of an early warning scoring system to assist in the recognition of a deteriorating patient – with 80% using NEWS2.

In other 'news', we really enjoyed delivering two days of quality improvement and measurement for improvement training for Health Education England. We're planning further sessions so watch this space for more details soon.

And finally, our Local Improvement Plan has been signed off by NHS Improvement, so we're happy to say we're now all systems go for delivering our workstreams for this year.

**Caroline Angel, Director – Patient Safety
Eastern Patient Safety Collaborative (PSC) Team**

News

 Making progress on the Emergency Laparotomy

Collaborative

Those involved in the Emergency Laparotomy Collaborative (ELC) will have noticed a flurry of email activity this month as our new QI Project Manager Tania Holland got her feet under the desk and geared up for the third Emergency Laparotomy Collaborative event on 17 May.

The day was a great success and had excellent feedback, with all participants agreeing that the information shared throughout the day will influence working practices within their Trust. Three Trusts are now poised to share their National Emergency Laparotomy Audit data and use the AHSN dashboard which was demonstrated at the event.

The newly agreed changes to the evidence based ELC care bundle were a key point for discussion on the day. The consensus was that the changes will help Trusts to make better use of the finite critical care resource post-operatively. No doubt this will be a hot topic discussed at the National ELC event on 25 June 2019, further updates to follow.

Spreading what works - the ED Checklist

The PSC is supporting the national adoption of the [Emergency Department Checklist \(ED checklist\)](#). The checklist is a simple time-based framework that outlines clinical tasks that need completing for each patient in the first hours of their admission to an ED. Using the checklist has been proven to improve clinical processes and reduce serious incidents from unrecognised patient deterioration, and assists any doctor, nurse, bank or agency staff who joins the department to provide the right care.

In 2018 we surveyed the 12 Trusts in our region to establish baseline information on the use of the ED checklist or equivalent in our patch. With a 50% response rate, we were able to identify that four Trusts are at various stages of implementing an ED safety checklist, with a further five sites interested in the initiative. We are now actively working with three sites to scope the value of the checklist alongside other projects that tie in to improving patient deterioration and cultural change.

Final three Eastern maternity and neonatal sites begin QI training

The [Maternal and Neonatal Health Safety Collaborative](#) is a three-year programme to support improvement in the quality and safety of maternity and neonatal units across England. Nominated improvement leads from Trusts involved build their knowledge of improvement theory by attending nine days of learning sessions. Trusts also receive intensive coaching to run one or more quality improvement projects on one of the five areas of clinical excellence to improve.

Earlier this month the final three maternity and neonatal sites from the Eastern region (North West Anglia NHS Foundation Trust, Ipswich Hospital NHS Trust and Queen Elizabeth Hospital Kings Lynn NHS Foundation Trust) joined many other colleagues from across England to begin their quality improvement training. Each site is currently identifying which of the five national clinical topics they will work on within their trusts to support the national ambition. The sites will meet again in July and November but will continue working on their projects supported by NHS England, NHS Improvement, and Eastern PSC.

Happy Birthday PReCePT

The preventing cerebral palsy in preterm labour (PReCePT) project celebrates its first birthday this month. Initially developed by the the West of England AHSN in collaboration with University Hospitals Bristol NHS Foundation Trust, the project helps to reduce cerebral palsy in preterm babies by increasing antenatal administration of magnesium sulphate (MgSO₄) to mothers in

preterm labour. It's one of seven projects selected for national adoption and spread across the AHSN network and a successful scale up of the approach across England could prevent several hundred cases of cerebral palsy per year.

PReCePT is the first perinatal programme of its kind delivered at scale across England - and we want to celebrate all of the [#PReCePTPeople](#) around the country, including in the Eastern region, who are making the programme such a success. A big thank you to everyone in maternity units playing their part to reduce cerebral palsy in preterm births.

[Find out more about PReCePT >>](#)

Resources and opportunities



▶ LISTEN: How to make patient safety easier to explain

Systems thinking and building a culture of safety are the hallmarks of improving patient safety and are second nature to improvers. However, it can be a challenge to explain this work to people outside of safety improvement circles. This podcast by the Institute for Healthcare Improvement will give you a more in-depth understanding of the messaging and terminology.

[Listen to the podcast >>](#)



▶ READ: Why Florence Nightingale's improvement lessons still matter today

Florence Nightingale is often recognised for transforming nursing from a service to a profession, and far too few recognise her as one of the first safety and quality leaders in health care. This article shows just how many of the lessons learnt from Florence Nightingale remain relevant to us today, inspiring nurses and healthcare professionals to continually improve.

[Read the article >>](#)



▶ READ: The Improvement Journey – an organisational



▶ JOIN: the Q Community and improve health and care

approach

Building an organisation-wide approach to improvement is a journey that can take several years. It requires developing staff capability and culture over the long-term, and the support, commitment and willingness of the Board to finance the skills and infrastructure needed to implement it. This new report from the Health Foundation includes case studies of three NHS trusts with outstanding CQC ratings that have implemented an organisational approach to improvement

[Read the report >>](#)

quality across the UK

Q connects people who have health and care improvement expertise across the UK. The Q community is made up of a diverse range of people including those at the front line of health and social care, patient leaders, managers, commissioners, researchers, policy makers and others. To join Q you will need to demonstrate knowledge and experience of using different approaches and methodologies to improve the quality of health and care and reflect on how you might benefit and contribute to the community.

[More information about Q >>](#)

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