News from the Eastern Patient Safety Collaborative – Dec 2019
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**Oops! Sorry - there was a broken link in the December newsletter we sent you this morning. Here it is with the correct link...**


## Wishing you all a very happy Christmas

As is traditional at this time of year, I've been looking back and reflecting on what we've achieved in 2019, while also making plans for a fresh year ahead.

It's been an exciting year for the Eastern PSC team, one that's seen us working across the region delivering our national workstreams: Deterioration, Maternity and Neonatal Safety Improvement programmes and the Adoption and Spread projects, as well as our ongoing work to maximise improvement capacity and capability. We've delivered many workshops in partnership with Health Education England, training over 200 frontline and operational staff.

Most recently, we were also very happy to welcome Jodie White to the team (more on this below).

We're all now excited about the upcoming work that we have planned, and are looking forward to working with you in 2020. Wherever you are and whatever you're doing over the festive period, especially anyone working during this time, I wish you all a very happy Christmas.

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

# News

## Maternity and Neonatal Safety Improvement Programme update

On the 14 - 15 November the final National Learning Set for wave 3 of the Maternity and Neonatal Safety Improvement Programme (MatNeoSIP) was held in Harrogate. The two days were packed with learning and sharing, as well as opportunities to develop quality improvement skills.

Norfolk and Waveney Local Learning System (LLS) leaders gave a presentation about how their LLS operates and their achievements to date on the system-wide project 'Right Place of Birth' for babies born under 27 weeks. The presentation was well received and the team were congratulated for their hard work and effective engagement. Well done to the team.

The Clinical Improvement Leaders Group (CILG) has been launched by NHS England/Improvement under the auspices of MatNeoSIP. The CILG is a national group of multi-professional clinical leaders from across maternity and neonatal care who have interest and skill in leadership, improvement and safety. The CILG will support the ambitions and aims of the MatNeoSIP and:

- Develop a local network of clinical improvement leaders within each LLS
- Support individuals to 'lead' work within individual LLSs
- Influence and help drive local improvement
- Coach colleagues in quality improvement approaches and improvement
- Provide content expertise and advice to the national programme

A stock-take of members to ensure there is the right mix of neonatal and maternity clinicians is underway to ensure sufficient coverage across the 18 LLSs nationally. We look forward to updating you on how this progresses next year.

## Welcome to our newest team member

We'd like to extend a warm welcome to our newest team member - Jodie White.

Jodie is joining us on secondment from East and North Hertfordshire CCG and will be leading the scoping phase of the Medicines Safety Improvement Programme (MedSIP).

Welcome to the team, Jodie!

## Blog: Patient safety in ambulance services

*Richard Smith is a Paramedic who has recently completed his MSc in Simulation and Patient*

*Safety. Following is an edited version of a blog he wrote for us about his research project...*

When I qualified as a Paramedic in 2013, I was not aware of the amount of work that occurs behind the frontline to keep patients and staff safe.

Whilst working for East of England Ambulance Service NHS Trust (EEAST), I was given the opportunity to join and work with the patient safety team. This gave me valuable exposure to how the NHS manages patient safety, both reactively and proactively, and led to an interest in improving patient and staff safety.  So, in 2015, when I began an MSc in Simulation and Patient Safety at the University of Plymouth, I chose to focus on attitudes towards incident reporting within ambulance services for my research dissertation.

Effective incident reporting in ambulance services is essential to identify risk and learn when things go wrong to prevent re-occurrence. Examination of 'near misses' can also prevent future incidents, therefore keeping both staff and patients safe. However, for incident reporting to be effective, it relies on an established safety culture within an organisation so individuals feel empowered and safe to report. The aim of my research was to understand attitudes towards incident reporting, thereby enabling effective reporting and improved patient safety.

Eastern PSC provided me with support in a number of ways to develop and undertake my research project. The research used semi-structured interviews for the qualitative component and the SCORE safety culture survey for the quantitative element. Eastern PSC provided access to the SCORE survey, funding for part of the cost of the MSc and a wealth of advice and guidance in relation to patient safety, which I would like to thank them for.

There is, unfortunately, a paucity of research on ambulance service incident reporting - as far as I am aware, this research was the first to investigate the process within an ambulance service in England.

I hope to publish the full research in an academic journal within the near future. The results have provided insight into how incident reporting is used and perceived within an ambulance service, which has led to a number of recommendations on how incident reporting can be enhanced to reduce harm.

I hope that the conclusions will be useful to many, and indeed, the recommendations are already being taken forward at EEAST. So watch this space for more information when the research is published!

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## Resources and opportunities

## READ: The Measurement Maze

Measurement in the NHS should contribute to driving improvement in quality of care, however, little insight from these measures is making its way to local clinical teams.

Given the volume of national indicators across multiple sources, and multiple national bodies sponsoring and using the data, there is a case for reviewing national quality measurements to make them more streamlined and simpler. A more coherent national framework might need to articulate and differentiate more clearly between the audiences, with a focus on clinical teams.

The Health Foundation's latest briefing on this topic takes a snapshot of national quality measures in three clinical areas with differing levels of national scrutiny – breast cancer, children and young people's mental health (CYMPH), and renal care.

Read it here >>

## OPPORTUNITY: Older patients - an emerging challenge in surgery

East Suffolk and North Essex NHS Foundation Trust are running a one-day course 'Older Patients – an Emerging Challenge in Surgery' on 18 March 2020.

The course is aimed at understanding the importance of provision of older patients' services for emergency surgical patients and to improve the awareness of complex needs of elderly patients when they are admitted with emergencies under acute surgical teams. The course is accredited by the Royal College of Surgeons of England.

Find out more and register here >>


## FINALLY: Happy 2020!

As we say a final goodbye to 2019, we'll leave you by saying we wish you all the best for a happy and successful new year.

We have lots more exciting projects planned for 2020 and we look forward to working with you on many more collaborations throughout the year.

## Connect and share

If you would like to suggest a story for the next newsletter or provide feedback please contact improvement@eahsn.org.

**Our mailing address is:**
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