

News from the Eastern Patient Safety Collaborative – March 2019

[View in browser](#)



Growing team and showcasing work to be proud of

We are delighted to share the news that our team is growing. This month we welcome Richard Goorney, Human Factors Adviser, to the team. Find out more about Richard and how he will be helping us to understand the role of human factors in healthcare in next month's newsletter. We'll also be welcoming more new members to the team in April, so watch this space for more info.

In the meantime, I wanted to express a big thank you to all those who completed the NEWS2 survey this month. The results will help us gain an overall baseline for our work in deterioration from April.

To those of you attending the International Forum on Quality and Safety in Glasgow this week, please do come and say hello at the PSC stand, and check out our poster about the Community Conversations Medicines Initiative, which showcases our work on the value of informal conversations in a community setting to support people in getting the most benefit from their medicines use.

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

News

➤ Independent review praises PSC achievements

Earlier this month The King's Fund published its [independent report](#) on the progress and impact made by England's Patient Safety Collaboratives (PSCs) in their first four years.

The King's Fund interviewed leaders and experts on quality improvement as part of the review, aiming to explore what has worked best in particular circumstances, what practices might be applied more consistently across the collaboratives and what further learning is needed to increase their effectiveness.

The report's author, Ben Collins, said in his blog: "Over their first four years, the collaboratives have delivered some fantastic improvement programmes: an emergency laparotomy collaborative that delivered a 42% reduction in risk-adjusted mortality; or a falls collaborative that delivered a 60% reduction in falls."

He concludes: "From our research on this complex subject, we would advocate a continued commitment to localism in the delivery of improvement projects, realism about the resources required and the likely initial impact of projects, and a focus on creating stable, fulfilling improvement careers."

[Read Ben's blog >>](#)

▶ Local learning systems focus on improving maternity and neonatal services

Local Learning Systems (LLS) across the country and our region are identifying system wide improvement topics to strengthen the work all maternity and neonatal sites are currently doing as part of the Maternity and Neonatal Health Safety Collaborative.

The LLS is open to all working in maternity and neonatal services and involves women and families. Quality improvement tools and techniques are encouraged to improve services and enhance even further the quality of care provided to women, babies and their families.

An LLS provides:

- a forum for local improvement to thrive
- opportunities for all network partners to work collaboratively
- opportunities for system level improvement at trust level and across the system
- a sustainable solution for maternal and neonatal improvement.

For more details about where your LLS is please contact jill.houghton@eahsn.org

Resources and opportunities



▶ **LEARN:** Improvement Fundamentals minicourses



▶ **WATCH:** Dilemmas in suicide prevention

[Improvement Fundamentals](#) is a programme of free online mini courses in quality improvement (QI) for those involved in health or social care services. Launched last year by NHS England's Sustainable Improvement team, the first four courses in the programme will run again back to back from this month. Existing users can [enrol directly](#). New users should [register first on the QI Learning Platform before enrolling >>](#)

This new film, produced by Loughborough Design School [working in partnership with the PSC and other partners](#), translates research findings into an engaging and powerful film. It reveals the uncertainties and complex dilemmas that healthcare professionals face when caring for patients who are considering taking their lives. It aims to initiate discussion around whole-system improvement with various stakeholders including practitioners, managers, policy makers and media. [Watch the film >>](#)



➤ EXPLORE: Publications and resources for QI

The Health Foundation has worked in quality improvement for over 15 years, developing a wealth of valuable reports and toolkits to help inform practice and policy. Have a look at the range of resources that are available for you to download, including: *Quality Improvement Made Simple*; *Using Communications Approaches to Spread Improvement*; *Evaluation: What to Consider*, and many more. [Explore the library of QI resources >>](#)



➤ READ: Improving patient safety through collaboration

The King's Fund has published its independent report on the progress and impact made by England's Patient Safety Collaboratives (PSCs) in their first four years. *Improving patient safety through collaboration - A rapid review of the academic health science networks' patient safety collaboratives* was commissioned by the AHSN's and developed independently by the King's Fund in late 2018. [Download the discussion paper >>](#)



➤ ATTEND: Implementing the medical examiner system

Thursday 25 April, 9.30am-4.30pm, London

The recent appointment of Dr Alan Fletcher as National Medical Examiner represents an important step in establishing a medical examiner system across England and Wales. At this event, organised by the Royal College of Pathologists, you will learn about the role of the national medical examiner, hear an

update on the implementation of the system and the digital solution, and find out about the next phase of the medical examiner system.
[Book your place >>](#)

Thoughts and views

 [@LeggKerri](#)

14 March 2019

Thank u to [@TheEAHSN](#) for another brilliant LFD forum today. We were grateful for the plenary slot to share why implementing [#Learningfromdeaths](#) & [#medicalexaminers](#) in the [@MSEssex_STP](#) was so important to us & how it's making a difference across in our acute hospitals

 [@TheEAHSN](#)

14 March 2019

Don't miss mum Jennie's moving [#PReCePT](#) story about the birth of her 'miracle boys' <http://bit.ly/2VZAnRc>. Such an inspiring film.

 [@TheEAHSN](#)

27 February 2019

Interested in representing patients in your area? We will give you free training and support to run workshops to gather the views of your community on health and social care issues. Become a Patient & Public Voice Partner – find out more: <https://t.co/9pMid4RXW2>

Connect and share

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

 Website

 Twitter

 LinkedIn

 Email us

 YouTube

Copyright © 2019 EAHSN. All rights reserved.

Our mailing address is:

Unit C, Magog Court, Shelford Bottom, Cambridge, CB22 3AD

Want to change how you receive these emails?

You can [update your preferences](#) or [unsubscribe from this list](#)