FW: Maternity and newborn, children and young people newsletter

Moore Ruth (UNIVERSITY HOSPITAL OF NORTH STAFFORDSHIRE NHS TRUST)

Sent: 28 August 2014 10:43

To: adam.gornall@sath.nhs.uk; Kumararatne Babu (THE ROYAL WOLVERHAMPTON NHS TRUST); Moore, Alison [alison.moore2@uhns.nhs.uk]; Sutcliffe Melanie (THE ROYAL WOLVERHAMPTON NHS TRUST); Carnwell Sarah (UNIVERSITY HOSPITAL OF NORTH STAFFORDSHIRE NHS TRUST)

Dear All

Please see email below with the first edition of a newsletter from the Maternity and newborn, children and young people patient safety newsletter.

How would you like this cascading to neonatal and maternity colleagues in the network, Maternity Network Meeting, QIPP Meeting, Board Meeting or general email circulation?

Kind regards
Ruth

Ruth Moore
Network Manager/Lead Nurse

Staffordshire, Shropshire & Black Country Newborn & Maternity Network

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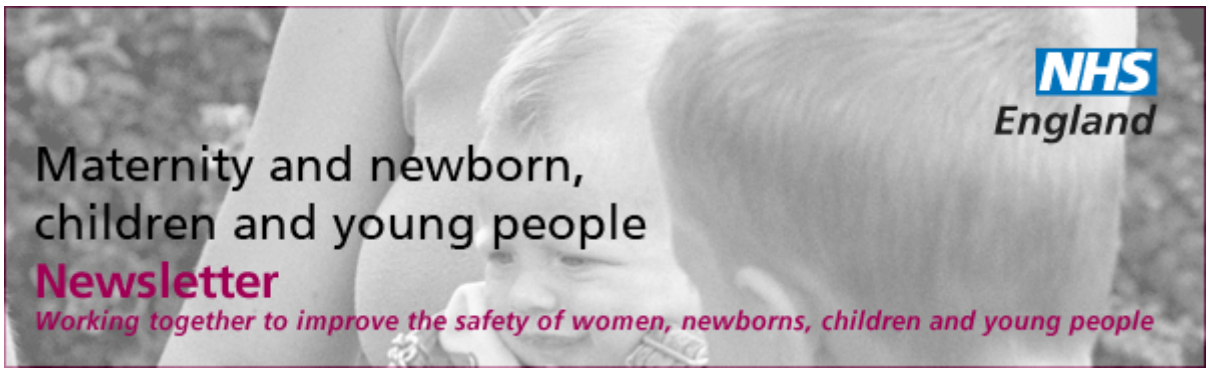
From: Patient Safety Domain [domain5@patientsafetyfirst.gv-c.com]
Sent: 28 August 2014 09:16
To: Moore Ruth (UNIVERSITY HOSPITAL OF NORTH STAFFORDSHIRE NHS TRUST)
Subject: Maternity and newborn, children and young people newsletter

If you cannot read this email, please click here



Dear Ruth

Welcome to the first edition of the Maternity and Newborn Children and Young People patient safety newsletter. This is a bi-monthly publication, keeping you up to date on the maternity, newborn, children and young people's work programmes.

Facts

There are more than 11 million children living in England and almost 700,000 babies born in England and Wales each year.

Last year the National Reporting and Learning System received over a million patient safety incident reports. Of these, 14% were reported from maternity or community settings, approximately 2% related to neonates and 5% were reports of children and young people under 18!

The maternity and newborn programme and the children and young people patient safety programme this year are aimed at building and bringing together the resources, intelligence and communities being created or developing across the country.

The programmes are strengthened by the advice and support of the Patient Safety Expert Groups for Women's Health and Infant, Children and Young People.

Please **email us** let us know if you'd like to get involved or would like to share resources' ideas, projects or words of encouragement. Use the link below to contact us: england.deterioration@nhs.net

Children & Young People programme

The Children and Young People work programme

The patient safety work programme for children and young people this year is focussed on the NHS Outcomes Framework 5.6.

The aims of this work are to reduce the incidence of failure to monitor children in acute settings; so to improve the recognition and response to deterioration.

However we would like to extend this across the pathway and in all settings where infants, children and young people are seen.

The Maternity and Newborn work programme

The patient safety work relating to Maternity and Newborns is

update

Deterioration

The deterioration in children advisory group has been set up to provide expertise on the programme, which has the following main elements.

- The creation and development of a Deterioration Platform on the Patient Safety First website, including a Community of Interest, tools and resources for use by clinicians and commissioners, sharing and showcasing exemplar organisations, patient and parent stories and improvements in patient safety including an opportunity for others to learn from and connect with them.
- Mapping the work completed or currently underway on any aspect of improving care for the deteriorating child and highlighting the gaps that will create further opportunities, including a focus on Paediatric Early Warning Scores (PEWS) to improve understanding, reliability and improved outcomes.
- An aggregate review of a small number of investigations and a 'deep dive' exercise using experts in the field of investigations and clinical practice as well as evidence and research. This may also draw together wider evidence of good practice examples and provide a plan for deterioration Investigations in the future.
- The creation of film resources and accompanying material with and for parents, children and young people focussed on patient safety concerns, participation and partnership for safer care.
- The development, roll out and evaluation of the paediatric patient safety thermometer also links with this programme; it is commissioned and supported by NHS England and led by Haelo.

Sepsis

The deterioration in children advisory group has been set up to provide expertise on the programme, which has the following main elements.

- A series of all-age workshops (including commissioners, clinicians and experts to drive

focused on the NHS Outcomes Framework indicator 5.5.

The aims of this work are to reduce the number of avoidable full term admissions to neonatal units.

In addition, we have ambitious projects focusing on the reduction of stillbirth, intrapartum hypoxia and early neonatal death, Never Events relating to retained swabs and management of jaundice.

If you have any ideas or resources to share or would like to get involved in any of this work please email us or contact one of the team:

Jayne Wheway
Head of Patient Safety for Children and Young People
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Michele Upton
Patient Safety Lead for Maternity and Newborns
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the agenda forward locally) and master classes (groups of clinicians from a single organisation/ pathway), working with the UK Sepsis Trust.
- Issuing a stage two Patient Safety Alert, in September in recognition of World Sepsis Day to highlight a range of tools and resources; sharing good practice, guidance and the launching the Community of Interest on the deteriorating platform with an area for sepsis.
- For children specifically, colleagues in the South West are developing a pathway tool for the recognition and treatment of sepsis in children using the NICE feverish illness in children guidelines and leading to the Paediatric Early Warning Score and the Paediatric Sepsis Six bundle. They are due to pilot in late summer. We are working with them to try to create a training and implementation package to be offered as a national resource.
- A sepsis in children summit in October as a round table facilitated discussion on the way forward with experts in the field and a separate piece of work to look at the various local CQUINs and other drivers for this issue.
- Dr Ron Daniels will be hosting a webinar entitled 'Sepsis - a call to action' on 10th September 9:00 to 10:00. To register for the session click here.

Maternity and Newborn programme update

Reducing term admissions to NNU

- 2 - 3 months of prospective, locally led audits of reasons for term admissions.
- ONS data to clarify whether the known increase in term admissions is proportionate to the number of live births - October 2014!
- Matching maternal and infant variables to understand whether respiratory admissions are as a result of elective C/S prior to 39 weeks as suggested by previous studies and local audit.
- Including hypoxic ischaemic encephalopathy prevention in our work on stillbirth and early neonatal death prevention. This will be undertaken as a care bundle through maternity teams.
- A series of workshops in early 2015 to share

Laura Johnson
Project Manager,
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Forward this Email

good practice, learn from incidents by standing in the shoes of parents and accessing resources from both industry and healthcare.
- Expert focus groups leading on prevention of term admissions relating to hypoglycaemia and infection.
- Have something to share and want to get involved? Email us

Patients' and parents' stories

Talking with parents, children and young people who have been harmed by our care is very challenging but often a significant driver for change.

"We experienced what could only be described as overnight shock and heartbreak. Vasili showed early signs of newborn baby jaundice after he was born, and due to an inexperienced midwife his condition was noted but not acted on until it was too late.

Now we are faced with bringing up our little boy who has been damaged by a rare condition called kernicterus. Kernicterus has caused Vasili to suffer sight and hearing loss, spastic cerebral palsy and damage to the brain. The reality is kernicterus could have easily been detected and cured or even reversed if caught early on.

We are planning to work with NHS England to improve the recognition and action on jaundice to stop kernicterus happening to another baby and another family.

We would urge you to become involved."

Michael and Elena Kalisperas