THE JOURNAL

Written by healthcare professionals for healthcare professionals

LESSONS LEARNED
Improving our practice
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Vol.1 Issue 1 Spring 2014

Compassion in Leadership

In the first in a series of articles that explore our core values, we look at how compassion can be translated into behaviours which are role-modelled from the 'top down'.

By Michelle Russell
GE Healthcare Finnamore

I'm with the NHS Leadership Academy in Leeds this week, where I'm Faculty to a cohort of Top Leaders - intelligent, experienced, passionate, inspiring women and men from all across the NHS, who are committed to making the NHS the best it can be. Who above all else, think about, talk about and care about the patient. We've listened to Julie Bailey tell about the horrors of Mid Staffs. We've explored problems and messy solutions; wrestled with how you create sustainable, system change.

And inevitably, the conversation always returns to a few key themes: character, values, passion and compassion. You know compassion when you see it, but describing it with words can sometimes be a bit like pinning down a cloud; fluffy and elusive. That said, we must find a way to use words and stories to articulate what compassion looks like in practice, so people can have meaningful conversations about it, hold up those who model it and challenge those who don't. I've spent the last several months working with your Trust to translate its own values of Dignity & Respect, One Team, Quality & Safety, and (yes) Compassion, into behaviours, so people can have a common frame of reference for confronting those who flout the values and for holding up as role models those who embody them.

I heard the story of Mary, a matron who everyone acknowledged as the paragon of compassion. She was mindful and sensing of the subtle shifts in the environment and people. She seemed to know instinctively when patients, their families, and her colleagues were struggling, having an especially bad day. What was her magnanimous act of compassion? A cup of tea to those in trouble - you could have said a cup of kindness. The perfect example of how the mundane, consistently and authentically lived, is really quite extraordinary.

But compassion starts with you. You create the environment, and you consciously, or unconsciously, determine with every small word and deed whether compassion

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WELCOME TO THE JOURNAL

The Journal is published quarterly by Surrey and Sussex Healthcare NHS Trust (SASH). It is written and edited by healthcare professionals for healthcare professionals and aims to improve interprofessional engagement, collaborative practice and knowledge-sharing across the Trust, whilst helping to embed a culture of continual learning and quality improvement.

Editor
Maxine May
Tel: 01737 768511 x 2633
Email: Maxine.may@sash.nhs.uk

Articles should be submitted to TheJournal@sash.nhs.uk and referenced Harvard style (maximum of three references per article).

Continued from page 1
thrives or withers within SASH.

If you sometimes struggle to demonstrate compassion in every interaction of your very busy, harried day, then you're normal. But at least you're thinking about it, being mindful. And if you wonder if others would call you a compassionate leader, there's a quick acid test. Ask yourself: how do I make people feel? Even before you look in the mirror, your heart will have fed you back your answer.

About the author
Michelle is on the faculty of the NHS leadership Academy and is currently Practice Leader for Culture and Leadership/Director - GE Healthcare Finnamore.

"Comment"

AN OPPORTUNITY TO ENGAGE AND LEARN

Time slips by quickly when we work day after day to help patients, their families and each other. Having been away for seven weeks my mum cannot believe the growth in my daughter, and I cannot believe so much has happened at SASH. Very visibly on our journey towards being a foundation trust (FT) we have had the mock CQC inspection, and the date of our Chief Inspector of Hospitals inspection has been announced. The inspection found fantastic engagement with all grades of staff, many examples of good practice, effective leadership and a focus on understanding patient experience. This is a strong foundation on which to plan and deliver services that fit our current CQC ranking (Band 6 – lowest concern) and be a successful FT. As inspections approach you will know everyone is much more willing to listen. Use this opportunity to its fullest extent. Read *The Journal*. Let us know what it would be useful to feature. We want it to be interesting, readable and relevant to you.

> "The inspection found fantastic engagement with all grades of staff"

Dr Des Holden
Medical Director

THE 6Cs ONE YEAR ON...

When the 6Cs - Care, Compassion, Competence, Communication, Courage, and Commitment - were launched a year ago as part of the Compassion in Practice strategy, they were values and behaviours that patients identified as important and that nurses, midwives and care staff considered integral to being a professional.[1]

We are using our Nursing and Recruitment strategy to implement the 6C's here at SASH. We have introduced intentional rounding and incorporated them into the SKIN Bundle to reduce paperwork and improve patient outcomes.

In response to the Cavendish Review[2] and Francis Report[3], we have recently changed the title of our healthcare assistants to nursing assistants. This provides them with the recognition they deserve and highlights the important role they play in delivering high quality care; a conversation that we recently had with the Secretary of State for Health, Jeremy Hunt, when he visited us in March (above). He was 'hands-on' during his visit, spending time on the wards as a nursing assistant and helping with patient lunches. He said our hospital is 'fantastically patient-centred' and I am proud to say that much of this is accredited to our nursing staff, midwives and nursing assistants who work tirelessly, sometimes under very difficult circumstances, to provide high quality, compassionate care.

By Fiona Allsop
Chief Nurse

Footnotes:
1/ NHS England (2014) Compassion in practice: One year on [Online]. Available at: http://www.6cs.england.nhs.uk (Accessed: 08/04/14)
2/ Great Britain: Department of Health (2013) The Cavendish review: an independent review into healthcare assistants and support workers in the NHS and social care settings [Online]. Available at: https://www.gov.uk (Accessed: 08/04/14)
3/ Report of the Mid Staffordshire NHS Foundation Trust public inquiry executive summary (2013) [Online]. Available at: http://www.midstaffspublicinquiry.com (Accessed: 08/04/14)

Under the spotlight...

Sinead McGuinness
Staff nurse

"Keeping up-to-date with current evidence to provide the best care possible and being able to communicate effectively and work collaboratively"

Annette Quinlan
Sister

"Respecting individuality by focusing on the person and not the condition and being able to gain a patient's trust so they feel able to discuss their worries and concerns"

Sarah Hutson
Senior Radiographer

"Taking the initiative to improve and expand ones knowledge to better the care you provide. Subsequently having the knowledge and skills to modify practice to suit patients' needs"

...Professionalism and what it means to you

In future issues we explore professionalism in terms of safety and ethical considerations. We start by asking what professionalism means to you

By Selina Chandler
Ward Manager

What does professionalism mean to me? I have been a nurse for over 32 years and I feel that professionalism is not only about the NMC Code of Conduct but is about the person themselves. It is about being kind and compassionate and about putting yourself 'in the shoes' of the people that you care for and their relatives. I feel sad when politicians are suggesting that nurses need to go on a course to learn how to care, caring is not a skill that can be learnt, it is something that comes from within; it's about having general empathy and a connection with people.

I would never consider employing anyone into my team who did not express the desire to care for people and have a genuine interest in older people. Other skills can be learnt.

It's about wanting to be open and honest and people seeing in your face that you are there to help them. It's about being approachable and available and knowing when to approach people and when to give them space for thought.
Being professional is about looking after the team, understanding their needs, being friendly and supportive to each other and recognising each others'strengths and weaknesses'and embracing what each and every one brings to the team We must all look after each other and take pride in each other and what we do, without a happy well looked after team we will not have happy well looked after patients.

Do you have different views? Visit *The Journal* online and post your comments.

EXPERT OPINION

Leading by example

You might not believe me, but patients really don't want to complain. Partly, that's because they see how hard you are working already but also it's because, often, they feel too scared to say what they really think.

That's a shame, because there are lots of things you could learn about – and fix – from knowing what patients and relatives really think. That's what Patient Opinion is for: a safe and simple way for patients to tell you what's good or could be better, and for you to tell them (and everyone else) what you're doing about it.

Doing feedback like this – online, in public, in real-time – can be scary for staff too, but many at Surrey & Sussex Trust have already taken the plunge and are showing the rest of the NHS how to do it. Stories about Trust services on Patient Opinion have been viewed over 400,000 times so far. But more importantly, these stories are leading to changes that make care better for everyone.

The changes you at the Trust are creating, through your transparent approach, are not just practical – important though those are. In showing everyone how you listen to, and act on patient feedback, you're changing the culture of the organisation as a whole. More than that, you're giving the rest of the NHS a glimpse of a different future for healthcare – one in which the best care comes from patients and staff working together. So keep at it: you're inspiring thousands of people you've never met.

By James Munro,
Chief Executive,
Patient Opinion

MaPPs: Improving patient understanding

By David Heller
Chief Pharmacist

One factor as to why a patient's condition doesn't improve, or even deteriorates, is that they might not understand their medicines. Patient surveys in past years have informed us that we have not been good at explaining the purpose, or the main side effects, of medicines to patients before they go home. Some people may not remember the conversation because all they have to take away is the box of medicine and the leaflet inside that is written in tiny print.

Last summer, the pharmacy team introduced MaPPs (Medicines: A Patient Profile Summary). These leaflets are produced using the MaPPs website and they provide a short summary of important information about each medicine that the patient is taking. At present, we are using them for any new medicines prescribed for inpatients before they are discharged but in the future we are aiming for leaflets to be produced automatically at the same time as discharge letters. It is important that at discharge, nursing staff go through the leaflet with the patient before they leave the hospital, so our patients have a good understanding of the medicines that they have been given.

The information in the leaflets is in plain English and explains what the medicine is for; the most common side effects; any special measures the patient needs to be aware of e.g. avoiding iron tablets, or any other factors that need to be considered.

> "We have not been good at explaining the purpose, or the main side effects, of medicines to patients"

To visit the MaPPs site, click on the link from the front page of the electronic patient tracking and discharge system. No log-in is required. If you have any queries relating to either leaflet content, or production, please contact your pharmacist.

Trained dementia champions Sister Liz Tresadern and Ward manager Tapuwa Matinya

CREATING A MORE 'DEMENTIA FRIENDLY' ENVIRONMENT

By Steve Adams
Consultant Nurse
Dementia and Older People

Dementia is a huge issue for health and social care in the UK. Around 820,000 people in the UK have dementia; more than double the number of people affected by cancer, heart disease and stroke combined. It costs this country £23 billion pounds a year, which is double the cost of cancer care, triple the cost of heart disease care and quadruple the cost of stroke care. We know that nationally between 25-30% of our beds at any one time are occupied by someone with dementia[1]. Being in hospital can be incredibly distressing for someone with dementia and their family but in the past hospitals have not always recognised that patients with dementia are a 'core' part of our work.

> "Patients with dementia are a 'core' part of our work"

It is my vision that this will change and that we will develop compassionate person-centred care for dementia patients regardless of where they are in the hospital and that all staff are involved in this. To support this, we are looking at ways to improve the environment to make it more 'dementia friendly'. We have introduced dementia training as mandatory for all nurses, nursing assistants and therapies' staff. We will be doing the same for doctors, midwifery and non-clinical staff in coming months. There is also a rolling eight week programme of enhanced modules for all staff *.

We have also started to use the 'This is me' passport for people with dementia. It is filled out either by the person affected, or someone who knows them well, and provides us with useful information to help provide compassionate care for them. We are using it on Capel, Meadvale, Abinger, Nutfield, Leigh and Newdigate wards and will be rolling it out to other areas later this year.

Footnote:

*Please contact Steven.adams@sash.nhs.uk for training course details.

1/ Alzheimer's Society (2014) Statistics. Available at: http://www.alzheimers.org.uk (Accessed: 03/04/14)

Holistic Care in Practice

In the first of a series of articles that focus on 'patient-centred care', Macmillan Senior Breast Care Nurse, Liz Darragh (pictured on the right) explains the importance of Holistic Needs Assessments (HNAs) in promoting patient well-being.

The National Cancer Survivorship Initiative recognises that people are now living longer following treatment[1] and through my experience working as a Macmillan nurse, I have learned that to improve a patient's overall pathway and to promote their well-being, holistic care is paramount.

To support patients post-treatment, our breast care nurses have initiated a new nurse-led 'Holistic Needs Assessment (HNA) Support and Wellbeing' clinic. Patients have the opportunity to discuss concerns, engage and reflect on the enormity of what they – and their families - have been through. When they come to our clinic, they are not only living with the after effects of the disease and associated treatment regimens, but are frequently having to deal with the acute and potential long-term side-effects; it is our role to offer support and show them strategies to help them cope with both physical and psychosocial concerns.

Having established a rapport with the patient from the onset of diagnosis, and having been there for them through treatment, it is rewarding to be able to support them after treatment has finished to help them regain some control in their daily living.

Use of Holistic Care Tools

A Holistic Needs Assessment (HNA) used at key points in the patient pathway, from diagnosis to end-of-life can help identify areas of individual concern[2] and enable us to advise and signpost as necessary. The patient is at the heart of our assessment and every care plan is tailored to meet their needs. Assessments are 'concerns led' and patients are encouraged to assess their own needs.

We have adopted the Macmillan Cancer Support HNA tool[2] - a practical assessment with a focus on the following concerns and needs:

- Physical;
- Emotional;
- Practical;
- Family Relationships;
- Lifestyle /Information;
- Spiritual /Religious

We help normalise concerns where possible and seek further levels of intervention with the patient's consent, to aid recovery and rehabilitation.

> "I have learned that to improve a patient's overall pathway and to promote their well-being, holistic care is paramount"

What are the benefits of HNA?

Evidence suggests that an HNA and care planning helps patients feel in control; cared for; less anxious; more confident and feeling that they know what to expect[3].

We provide each patient with a copy of their care plan and notify their GP, enabling appropriate interventions, such as additional support and information, signposting, or referral to other services if required.

Feedback from patients about our clinics has been insightful. Comments such as "seeing it in black and white makes it very real" and "feels good to have it all on paper so I am not carrying it around in my mind", serve to underline the importance of the HNA. We aim to keep improving the support we offer patients and as part of this, we are looking to audit clinic attendances, outcomes and patient feedback later this year.

By Liz Darragh

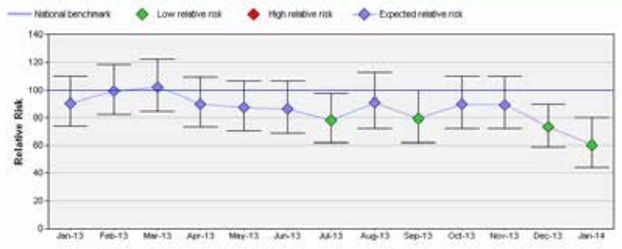
Footnote:

1/ National Cancer Survivorship Initiative (2014) National Cancer Survivorship Initiative. Assessment and Care Planning (2012). Available at: http://www.ncsi.org.uk (Accessed: 09/04/14)

2/ National Cancer Action Team NCAT (2010) Holistic Needs Assessment for people with cancer: A practical guide for healthcare professionals. Available at: http://www.ncsi.org.uk (Accessed: 09/04/14)

3/ National Institute for Health and Care Excellence (2011) Guidance on Cancer Services: Improving Supportive and Palliative Care for Adults with Cancer (2004). http://www.nice.org.uk (Accessed: 09/04/14)

Clinical effectiveness
Audit
Research & development
Education & training



Real-time tracking of mortality online

By Dr Anna Austin
Core Medical Trainee

Despite significantly high adjusted mortality rates, the abundant warnings of sub optimal care came too late for Mid Staffordshire NHS Trust[1]. Inpatient mortality statistics cannot necessarily be elucidated by haphazardly structured local mortality meetings and standardised indices alone. Alternative methods of data collection and analysis are needed.

In 2013 we developed an electronic mortality review system. Each in hospital death now undergoes a medical review to determine whether the death was unexpected. Such deaths are then subject to more detailed clinical peer review. We have recently analysed six months of data for medicine.

In this time there were 603 deaths for which 483 had mortality reviews completed. Data can be analysed by various criteria. For example, mortality was higher as one might expect for ≥75yrs and for those in hospital for more than eight days. No significant variation was seen however in the numbers of patient dying on weekdays (14.0%) compared to weekends (14.4%) nor in hours (56%) versus out of hours (44%). MDT recommendations create a permanent online record of key recommendations for example, clear documentation of the frequency of physiological observations and adherence to surviving sepsis proformas being two examples.

The database is allowing us real time tracking of mortality to find out why patients die in hospital and promote both clinician and organisational learning for the benefit of patient care.

Footnote:

1/ Francis, R (2013) Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry [Online]. Available at: http://www.midstaffspublicinquiry.com (Accessed: 23/03/14)

NICE guidance – help is at hand

The last 12 months have seen more changes at the National Institute for Health and Care Excellence (NICE) than any since we were created 14 years ago. From April 2013 our role was expanded to provide evidence based guidance and standards to social care as well. This puts us in a really good position to make a very important contribution to work on integration between health and social care.

Our quality standards programme for health is progressing well and we have now published over 50. Each standard contains evidence based statements of what really high quality care looks like in that particular area and also provides metrics to enable you to assess your performance against the statement.

We continue to produce advice on new medicines and treatments and this programme has recently been expanded to cover highly specialised technologies treating rare conditions for relatively small patient populations. The first piece of this guidance will be available in July.

Some of you may have seen the new NICE Pathways. These are a more intuitive, interactive presentation of guidance that brings together all the recommendations that NICE has made around a particular condition in one place. We now have 90% of our guidance covered by Pathways and they have proven really popular with clinical teams.

My job involves helping hospitals, CCGs, GPs and local authorities take NICE guidance and put it into practice to enable them to deliver really great services for patients and service users. People are often unaware of some of the new areas that NICE is working on and I can also help show them all the support products we develop to make it easier to put guidance into practice. A really important part of my job is to give feedback to NICE on what people think of our work. If you've got something to tell me or think I can help with please get in touch at Steve.sparks@nice.org.uk

By Steve Sparks
Associate Director Field Team & Implementation Consultant NICE (South East)

Getting the most out of clinical audit

By Jonathan Parr
Clinical Governance Compliance Manager

Clinical Audit is vitally important in answering the question: 'Are we actually doing the right thing, and in the right way?' This question is sometimes framed at national level, but increasingly can relate to an issue arising from a complaint or clinical incident.

With over 200 audits conducted each year, providing support for clinicians is vital. Each Division employs their own Clinical Audit Facilitator who provides support to managers and clinicians undertaking registered clinical audit projects. This includes advising and supporting staff with any aspect of their clinical audit project, from initial design to final presentation. They also work in conjunction with the specialty audit leads in monitoring the audit programmes and ensuring that the findings of audits are actioned for the benefit of our patients and service users.

In line with our Clinical Effectiveness Strategy, your audit project MUST BE REGISTERED with the Audit Facilitator before starting, using the audit proposal form. This can be accessed on the intranet. Without a valid registration number you will be unable to request medical records for audit, nor will you be able to request patient lists from the Information team for audit purposes. This not only makes sure that all audit activity takes place under strict governance arrangements, but also ensures that you receive the best advice from your audit facilitator so that your time is effectively spent carrying out an audit that will directly impact on helping us maintain and improve the quality of care.

Your Divisional Audit Facilitators:
Surgery: Dr Delvene Thompson (Ext 6568)
Medicine: Eman Jawad (Ext 6220)
WaCH: Sara Cuming (Ext 6209)

Footnote:

To find out more about conducting an audit visit: The Journal at http://intranet.sash.nhs.uk/

Clinical Audit Cycle

CLINICAL TRIALS: EVERYONE'S RESPONSIBILITY?

Dr Ben Mearns speaks about his involvement in research and encourages more consultants to follow suit.

I am sure that like me, some think a PI. is a private detective, but in research this stands for Principal Investigator. We all know that our day jobs can be busy enough and it can be a challenge to fit more in. So if a doctor or consultant wants to become involved in research, how can it be done?

Dr Ben Mearns – Clinical Lead for Acute & Elderly Medicine

The first trial where I acted as PI at SASH, was on the Stroke SOS trial. At first, I was unsure what to expect and it was a little anxiety-provoking. The good news is that the R&D department are very supportive. They guide you through GCP training which you must do as a PI and also explain how a PI can delegate tasks. Our specialist research nurses help with administrative tasks and keep the trial on track.

Being a PI does not mean that you are solely in charge of the trial, just that you are accountable for our Trust's participation in it. There is collaborative working with the main trial team.

I have since signed up the Acute Medical Unit to two trials this year, ENCEPH-UK and PREFER VTE - both are quite different, but both fit in entirely with the way that we work and I think that is key. They are educational and clinically-focussed on things that we do already. We have involved all of the consultants and some of the juniors and our team are excited and energized about the work. It not only helps bring money into the trust but it is great for our reputation.
It is amazing how quickly you can add research to your department and I would encourage other consultants with an interest to do the same.

WARD ROUND SIMULATION TRAINING

In January 2014, the SASH ward round simulation training led by Dr Chris Bruce was awarded £40, 000 of Technology Enhanced Learning Initiative monies to develop the training. Dr Bruce and Dr Natalie Powell will be working with Simulation leads from South West Thames Foundation School and the Brighton and Sussex Medical School to develop the training to become a regional programme for all medical students and foundation doctors.

The big step to FY1

By Dr Andy Kermode
FY1 Doctor

The transition from being a medical student to fulfilling the role of a FY1 doctor was a journey that I nervously anticipated. The joy of graduating after five years of study is quickly forgotten as the fear of the first day on- call becomes a reality.

Our induction was suitably swift, allowing time to get to grips with the orientation and standard procedures of our proving ground. It was when I was unleashed on the ward, as I flailed around trying to organise the daily generated jobs, that my first interactions with other members of staff occurred. Fleeting, but friendly, these brief encounters became regular conversations, catch ups, and eventually good humour between colleagues.

My focus in the first few weeks was entirely around 'getting the job done'. I was slow at everything; from taking and sending bloods, to organising a CT scan. However, as I became more familiar with hospital process, I started to move a bit quicker.

I started FY1 on a vascular surgical rotation, which required more organisational skills than I had needed on student placements. I must confess, at first, hospital organisation and administration was one area I knew little about. A 'post take ward round' was not something I knew about, nor how to book a patient into theatre, yet I was expected to organise these tasks regularly. However, my Registrars and Senior House Officers (SHOs) were supportive in teaching me the basics and getting me up to speed; a life saver for a weekend on-call.

Four months in and over the Christmas period, I experienced a nightshift; teamwork and efficiency were the name of the game. If you didn't personally know the team on-call, it didn't matter – you had a job to do and communicating to your peers was an essential part of that. It was tiring, but a most rewarding experience; a vital part of my FY1 year. The team were united by Christmas cheer and visiting the wards was a pleasure. Christmas cake provided the glue that held my motivation between complex cases as I experienced the highs and lows of being a doctor. Following the death of one particular patient, I spent the next two nights reflecting on his management and considering if I could have done anything to prevent it. It was only after talking through what happened with my team, that I understood that they too experience this anguish; I now realise that it may be the first time, but not the last time, I feel that way.

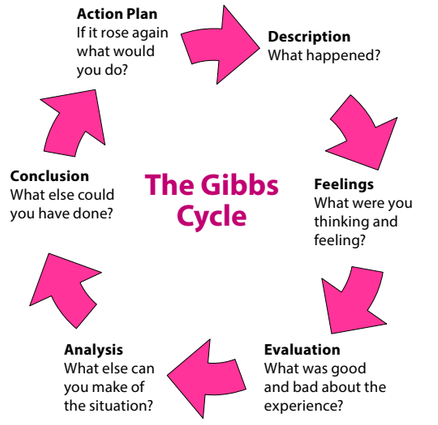
The hospital you work for moulds you from a fresh faced medical student into a (largely) capable and useful team member. Although I'm unsure into which speciality to delve, I have gained breadth of experience and for the future this has given me a secure footing from which to move forward.

WHAT IS REFLECTION?

When we reflect we are consciously evaluating our experiences, our feelings and our actions or responses and then analysing and making sense of them in order to learn from them. It is one way that an individual can start to understand themselves better, build on their strengths and make conscious decisions about future actions.

Reflective practice should be familiar to all healthcare professionals, yet it is a valuable exercise for anyone - clinical or non-clinical. In the same way that reflective practitioners are more likely to deliver better, more compassionate care, reflective managers are more likely to make better decisions and provide better support.

Reflective practice across an organisation may lead to continual questioning of assumptions and challenge the accepted way of doing things. Embedding a reflective culture leads to a cycle of service improvements, transformations and facilitates a true 'learning organisation'.



Some suggestions to help you get started:

Make a note of experiences soon after they occur;
Ask yourself 'what have I learnt today'?
Promote an open culture by asking for feedback from colleagues ; Look for patterns and connections in experiences – a key to reflection is spotting repetitive patterns and learning from them.

By Jill Dyer
Learning and Development Manager

Footnote:
Gibbs Reflective Cycle (no date) Available at: http://www.brookes.ac.uk/ (Accessed: 22/04/14)

Consultants Thayalan Kandiah and Kofi Nimako leading the PROMs development team.

A new approach to PROMS

Dr Thayalan Kandiah
Consultant Paediatric Dentist

and Dr Kofi Nimako
Consultant Chest Physician

Patient experience of health services and the care that they receive has become an integral part of health policy, regulation and service improvement. At SASH, we have been measuring patient experience for a number of years through the Your Care Matters survey. However, to improve the quality of care that we provide there has to be a focus also on clinical outcomes. Clinicians tend to focus on outcomes, which they consider important such as lung function and ECG's. However, in many cases, these outcomes are different from those deemed to be important by patients.

Patient reported outcome measures (PROMS) are structured questionnaires that measure the patients' perception of their health status; functional health and their health-related quality of life (HRQOL). They complement other outcome measures in order to gain a more rounded picture of the patients' views on both the process and the outcome of care. PROMS are either generic questionnaires, which are validated for a number of conditions, or condition specific. Collaboration with the patient will enable clinicians to understand clinical outcomes from their perspective, which is fundamentally important and will ultimately improve quality of care.

> "We are developing a new approach to PROMS by incorporating it into daily clinical practice"

PROM data is already collected for some elective surgical procedures. However, at SASH we are developing a new approach to PROMS by incorporating it into daily clinical practice. This we believe will ultimately lead to both patients and clinicians working together to improve patient care.

Initially, we intend to pilot generic PROMS utilising the existing Your Care Matters platform. The pilot will take place within the Respiratory wards (Tilgate and Tandridge) and the Dental & Maxillofacial department. Following on from this we will expand the use of generic PROMS to other departments. Alongside this, we will be encouraging the use of condition specific PROMS within each speciality. This has been underway in some specialities already. The benefits of this are that it will engage patients in their care, give real time feedback, allow for shared decision-making and ultimately seek to enhance the quality as well as the outcome of care given. Using PROMS will put SASH in a unique position whereby as a Trust, we are actively engaging our patients as well as our clinical staff in order to deliver safe, effective and quality care.

Footnote:
ANAND, P.S., ABDULLATIF, M.A., ASHLEY, P. and KANDIAH, T. (2014) 'Patient reported outcome measures (PROMs) of patients/carers attending for dental procedures under general anaesthesia in a paediatric dental department', International Journal of Paediatric Dentistry, 23 (Suppl. 1), 53–234 (abstract)

IMPROVING SERVICES COLLABORATIVELY

Since the earliest days of negotiation to bring in a community pharmacy to dispense outpatient prescriptions, I had a vision that included much wider support for patients, service-users and staff. That vision is now coming to fruition with new on-site services, giving staff and visitors access to free NHS Health Checks and we are one of only two Trusts in the country to offer this service. Over 70 staff have booked, or have completed a Health Check so far, at no cost to them or the Trust. Hinal Patel, Boots store manager, says that she is delighted to offer this service which has resulted in several people being advised to see their GP for specific problems that were not previously identified.

Staff are also able to get help from Boots to stop smoking and now this same service is also available for hospital patients referred to Boots by Trust doctors. The partnership we have with Boots is synergistic and we are looking forward to yet more developments over time in the hope of widening the range of services that we are able to offer to local people.

By David Heller
Chief Pharmacist

REDUCING EMERGENCY ADMISSIONS FROM CARE HOMES


Rachel Cooke (left) with Susan Merner (centre) and Alison Owen (right) who carried out the literature review

By Rachel Cooke
Head of Library and Knowledge Management

Last September SASH's Library and Knowledge Services team was invited to carry out a detailed review of the evidence on the topic of reducing emergency admissions from care homes, for the EQR (Enhanced Quality and Recovery) team of the KSS Academic Health Science Network.

The purpose of the review was to provide the evidence on which the EQR team could base a new piece of work on reducing emergency admissions from care homes. The EQR team use an established Enhancing Quality methodology. From the literature review, the EQR team aim to identify five to ten top interventions that care homes can carry out that will reduce the likelihood of emergency admissions. These interventions will be shared with the care homes to enable them to improve their practices. A set of measures will be developed to enable the care homes to record and assess their progress in improving their practices to bring about the needed changes. The EQR team work in a collaborative way, twice a year they bring together clinicians, practitioners and others (e.g. care homes) working to improve practice in a particular area to share: how they are doing, and their good practice.

Whilst there is a rich evidence base relating to primary, community and secondary care, there is much less written about care homes, this meant the search for sound evidence needed to be wide. The review was carried out by Alison Owen, Knowledge Skills and Systems Librarian and Susan Merner, Deputy Head of Library Services. Alison created the resulting 40 page synthesised review of the evidence, this covered:

- Baseline data to measure improvement
- Reasons for hospital admissions from care homes
- Best practice evidence/outcomes relating to reducing admissions from care homes

On the strength of this work the library team has been commissioned to work with the KSS AHSN on an on-going basis (one day a week), with Alison embedded in the EQR team in the role of clinical librarian. The results of this work will also help inform the developing services within community Geriatrics across Surrey and Sussex, who outreach to nursing homes in the SASH catchment area.

To access the review, please contact Rachel.cooke@sash.nhs.uk

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By Susan Merner and Alison Owen

PATIENT SAFETY IN SURGERY AND 'NEVER EVENTS'

By Miss Shamaela Waheed
Consultant Oncoplastic Breast Surgeon

What are we doing in Surgery to make it safe? We are all probably aware of the WHO Checklist[1] - but why is this so important? A key Trust priority is to ensure patient safety.

In response to a 'Never Event' in the past year where the wrong operation was performed, the Trust has put forward the 6 safer steps for Surgery. "Never events" are serious, preventable patient safety incidents that should never have happened. Trusts have to report them annually and the CQC uses them as a measure to assess quality.

They include: wrong site surgery; wrong operation; retained instrument or swab post operatively; misplaced nasogastric/orogastric tube; intravenous administration of KCL; inpatient maternal death from post-partum haemorrhage after elective c-section.

The whole surgical directorate follows a theatre 'code of conduct' introduced to prevent 'never events', highlighting the need for punctuality, respect for all team members; minimising noise in theatre; avoiding feeling under pressure to hurry if there are time issues and a calm atmosphere being of utmost importance.

If an untoward incident occurs, it is important to tell the patient what went wrong, openly and honestly. Communication with the team and theatre staff is important to ensure that it does not happen again.

We must all learn from the incident and be more mindful in our own practice. Mistakes do happen, but if we have important systems in place, we can minimise them and make our Trust safer.

Issue 2 of *The Journal* is due out in the summer. If you have an idea for an article that you would like to discuss, contact Maxine.may@sash.nhs.uk

Footnote:
World Health Organisation (WHO) (2014) *WHO Surgical Safety Checklist and Implementation Manual* [Online]. Available at: www.who.int (Accessed: 16/04/14).

> "Reflecting and learning from our mistakes and sharing this knowledge to make our hospital a safer place"

Lessons learned

Edited by Dr Ben Mearns
Clinical Lead for Acute & Elderly Medicine

Whether it be from complaints, incidents, near misses, audits, patient feedback or sadly, patient deaths, as practitioners we all need to learn from our mistakes to continually improve the care we offer.

Time matters to survive sepsis

Upon arrival, a patient was rapidly diagnosed with severe sepsis. Upon review of the notes it was clear that there had been a significant delay from the point of prescribing the antibiotics up until when they were given. Whilst there was no obvious harm to the patient on this occasion, evidence suggests that patient survival is positively correlated to the speed at which antibiotics are given.

Lesson to learn: If a drug is to be given urgently the doctor must inform the nurse looking after the patient and take responsibility for ensuring this has been done.

Listen to our patients

A patient had been admitted with a straightforward medical problem but had a chronic and more complex rare underlying diagnosis. She asked us to contact her specialist team to ensure they agreed with her treatment but this contact never happened. She subsequently experienced a complication and felt this would not have happened had we listened to her. We have since created a Patient-Led Guideline for the Medical Division with the expectation that we will contact external specialists if a patient asks, if they are on a clinical trial, or for any other clinical information.

Lesson to learn: Even if we feel that specialist advice is not required, we should seek it if the patient requests that we do.

Sharps awareness

There have been a number of sharps incidents when taking blood gas samples in emergency situations. Following a health and safety review, we are now to roll-out a safer alternative to our current ABG syringe and needle.

Lesson to learn: All staff need to follow the sharps protocol at all times and ensure that they do everything possible to protect themselves. All clinical staff need to familiarise themselves with the new safety ABG system via ward training.

Events round up

PHYSICIANS ASSOCIATES CPD EVENT

Consultant in Acute and Geriatric medicine and editorial committee member at *The Journal*, Dr Natalie Powell (above left), with Physicians Assistant (AMU), Rachel Forbes-Pyman, who hosted a successful CPD event for Physicians Associates (PAs) in March. The event , which will become an annual event, was well-attended, attracting PAs from across the country. Talks were given by Drs Powell, Mearns, Sneddon, Cetti, Mackenzie and Field and workshops were run by junior doctors, Martin Dachsel, Alice Davies and Charlotte Kelly.

ANNUAL BREASTFEEDING CONFERENCE

Surrey and Sussex Breastfeeding Working Group hosted another successful annual Breastfeeding Conference at East Surrey Hospital. The keynote speech on 'Biological nurturing' was delivered by Dr Suzanne Colson, Honorary Senior Midwifery Lecturer at Canterbury Christ Church University, who was making a return visit to East Surrey almost ten years after delivering her initial PhD research findings here. Current research on co-sleeping was presented by Dr Charlotte Russell from ISIS (Infant Sleep Information Service). The event was organised by Infant Feeding Co-ordinator, Min Chadd.

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We want to make *The Journal* relevant and useful to you. In support of this we have compiled a suggested reading list to accompany some of the features and topics featured in this issue. Visit The Journal at:
http://intranet.sash.nhs.uk/

We welcome your feedback. Complete our online survey, or pledge your support/join us on Twitter @ sashnhs #SASHTheJournal.

Achievements and Professional Recognition

Congratulations to…

…Drs Dachsel, Davies, Bruce, and Austin on acceptance to the Society for Acute Medicine Spring conference for their work on meeting the cost of funding Core medical and high specialist medical training. This was also published in the most recent edition of the RCP Journal, Commentary. Dr Austin also has a poster presenting her work on mortality reviews.

… to Dr Ming (right) and Dr Zhang whose case presentation has been accepted for the SAM conference and also the Association of British Neurologists.

… Chris Turner, CNS for breast cancer, who has been awarded a first-class BSc (Hons) Clinical Practice (Cancer Care) from the University of Surrey.

…to Dr Sam Trowbridge whose abstract on the use of the ward safety checklist in surgery has been accepted for the UK patient safety congress 2014.

…Susan Pirie (below right), Practice Educator for Theatres with Dr Peter Carter (below left) Chief Executive and General Secretary of the Royal College of Nursing (RCN). Susan recently took her place on the RCN Perioperative Forum Steering Committee participating in activities pertinent to perioperative practice, such as the NHS England Surgical Safety Board, the Perioperative Care Collaborative and 'Shaping the future direction of the enhanced recovery care pathway seven days a week'.