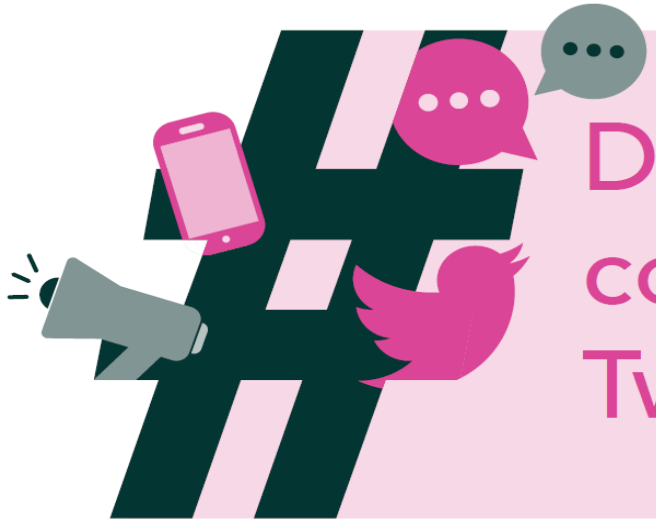

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C2 #qfc2

Institute *for* Healthcare Improvement

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TheAHSNNetwork

NHS Improvement

Building a national patient safety programme

Part A: Beyond Berwick: the Development of the Patient Safety Collaboratives in England

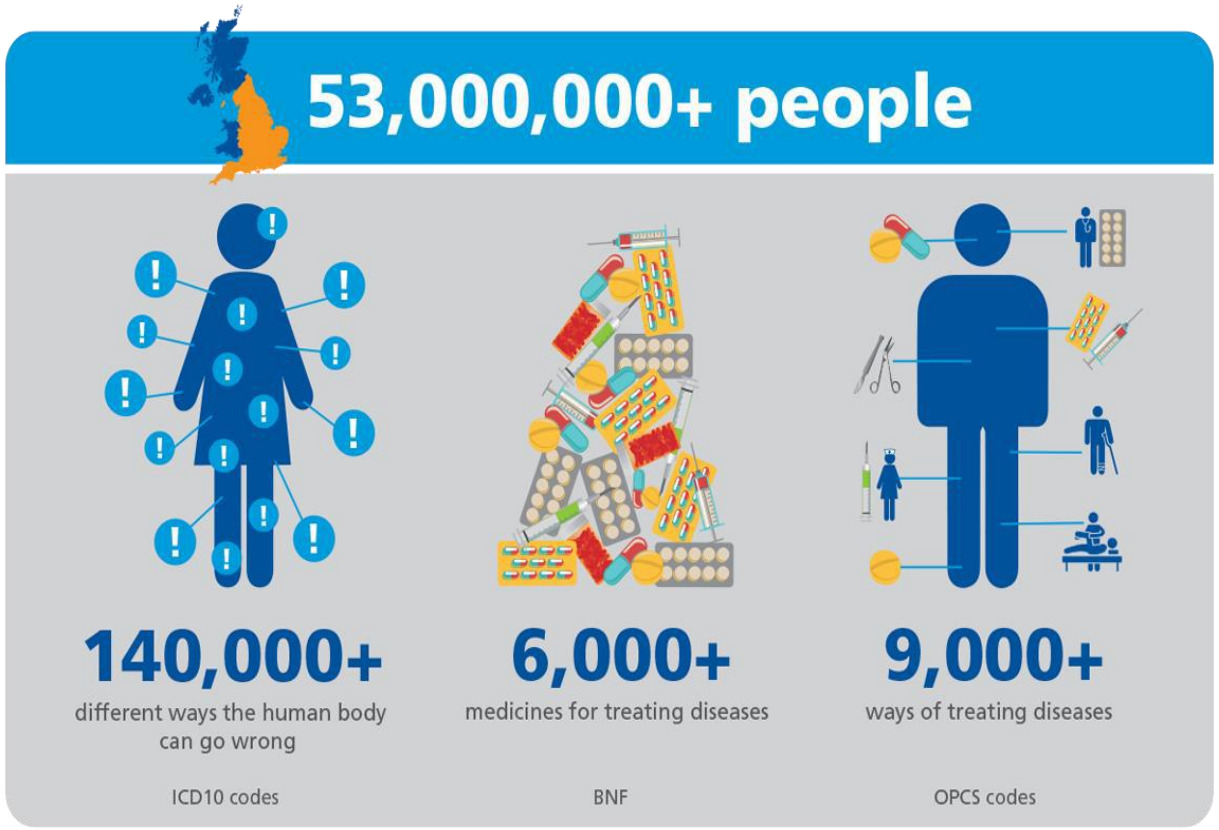
Cheryl Crocker, Chair for the Patient Safety Leads, Academic Health Science Network

Aidan Fowler, National Director of Patient safety, NHS Improvement

Great potential for error – the NHS in England

In England:

- 135 acute non-specialist trusts
- 17 acute specialist trusts
- 54 mental health trusts
- 35 community providers
- 10 ambulance trusts
- 7,454 GP practices
- 853 for-profit and not-for-profit independent sector organisations, providing NHS care



Created in response to Francis and Berwick

"*The most important single change in the NHS in response to this report would be for it to become, more than ever before, a system devoted to continual learning and improvement of patient care, top to bottom and end to end*."

Berwick Report, August 2013

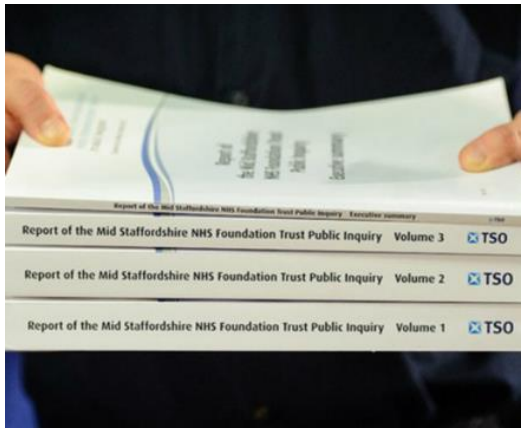
Picture: POSED BY MODELS

BERWICK'S TEN KEY STEPS TO HEAL NHS

- New criminal offences should be created to punish recklessness, wilful neglect or mistreatment by organisations or individuals
- Health bodies that withhold or obstruct relevant information should be subject to criminal sanctions
- A review of 'correct' staffing levels should be held by the National Institute for Health and Care Excellence, but adequate levels determined locally
- Over-complex regulatory system should be simplified, with an independent review of agencies completed by 2017
- Complaints system should be improved, possibly reinstating Community Health Councils
- No duty of candour imposed on individual healthcare workers
- Patient voices must be heeded at all times
- NHS must adopt a culture of learning and improvement by all staff
- Targets must not overtake interests of patients
- All leaders in NHS must put patient safety at top of their priorities

Created in response to Francis and Berwick

"Following Don Berwick's recommendation, NHS England will establish a ***new Patient Safety Collaborative Programme*** *across England to spread best practice, build skills and capabilities in patient safety and improvement science, and to focus on actions that can make the biggest difference to patients in every part of the country. They will be supported to systematically tackle the leading causes of harm to patients. The programme will start in April 2014."*

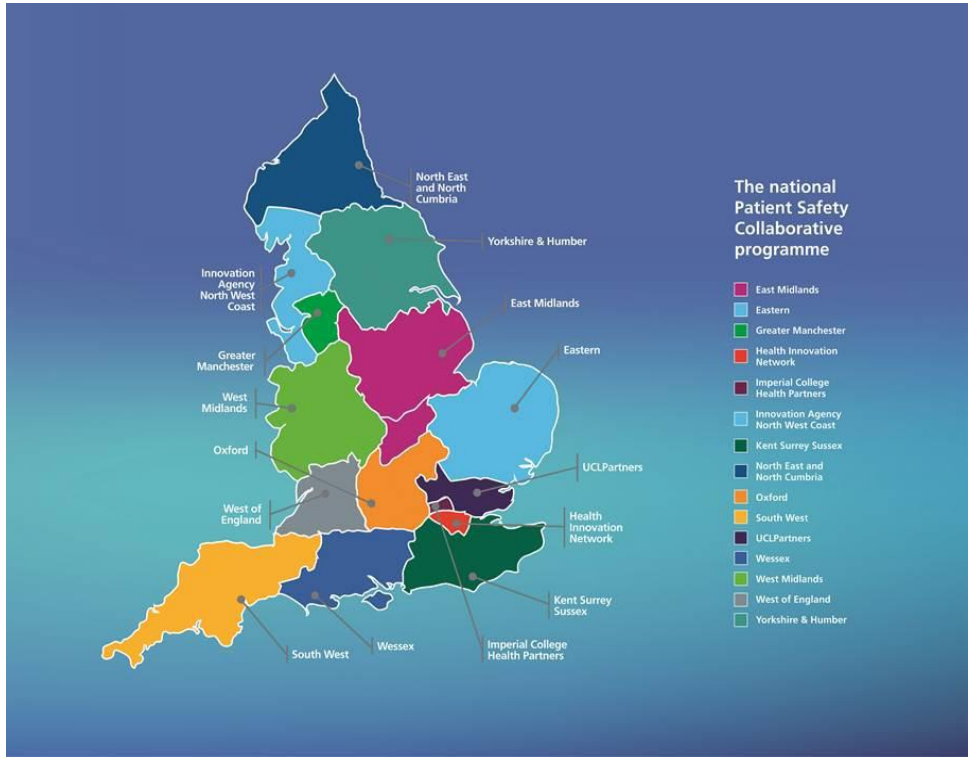


The UK government's response to Francis, November 2013

Introduction to the National patient safety collaborative programme

- A network of 15 locally owned and run patient safety collaboratives across England
- Programme created through collaborative design days rather than top down
- Measure and tackle the leading causes of harm to patients using their own innovation, as well as supported centrally with tools and guidance
- Offer staff, users, carers and patients the opportunity to work together locally to tackle specific patient safety problems
- Build patient safety improvement capability using evidence-based improvement methodologies
- The largest and most comprehensive collaborative improvement initiative in the world

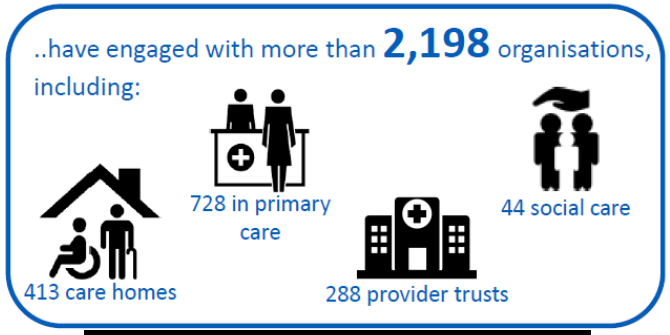
National patient safety collaborative programme structure



- Follows the established AHSN footprint
- 2-5m population served by each collaborative
- National funding and coordination by NHS Improvement
- National support for:
  - change packages/ interventions
  - knowledge sharing
  - consistent measurement
  - networks/communities

How the programme works locally

- Systematic approach to quality improvement
- Primary focus on clinical safety, culture, leadership and measurement
- Local engagement across all care settings
- Support quality improvement capability linked to improvement work
- Harness talents - staff, patients, academia and industry

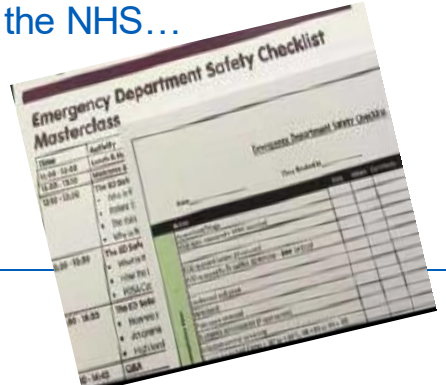


Sharing improvement nationally

- Mechanism for spread and adoption of improvement and innovation
- Share approaches for implementing national policy – NEWS2
- Developing interventions with national application – ED Checklist
- Using expertise to develop tools and guidance – Suspicion of Sepsis Dashboard
- Patient Safety Measurement Unit – develop strategies for and increase capability in measurement for improvement

.. ED checklist

developed in West of England to improve recognition and treatment of serious illness such as stroke, heart attack and sepsis. Now recommended for national use across the NHS…



Emergency Laparotomy Collaborative

What?

Emergency laparotomy is a common high-risk surgical procedure, with 30,000-50,000 performed annually in the UK.

Why?

14.9% of emergency laparotomy patients are reported to die within 30 days of surgery, rising to 24.4% for those over the age of 80 years.

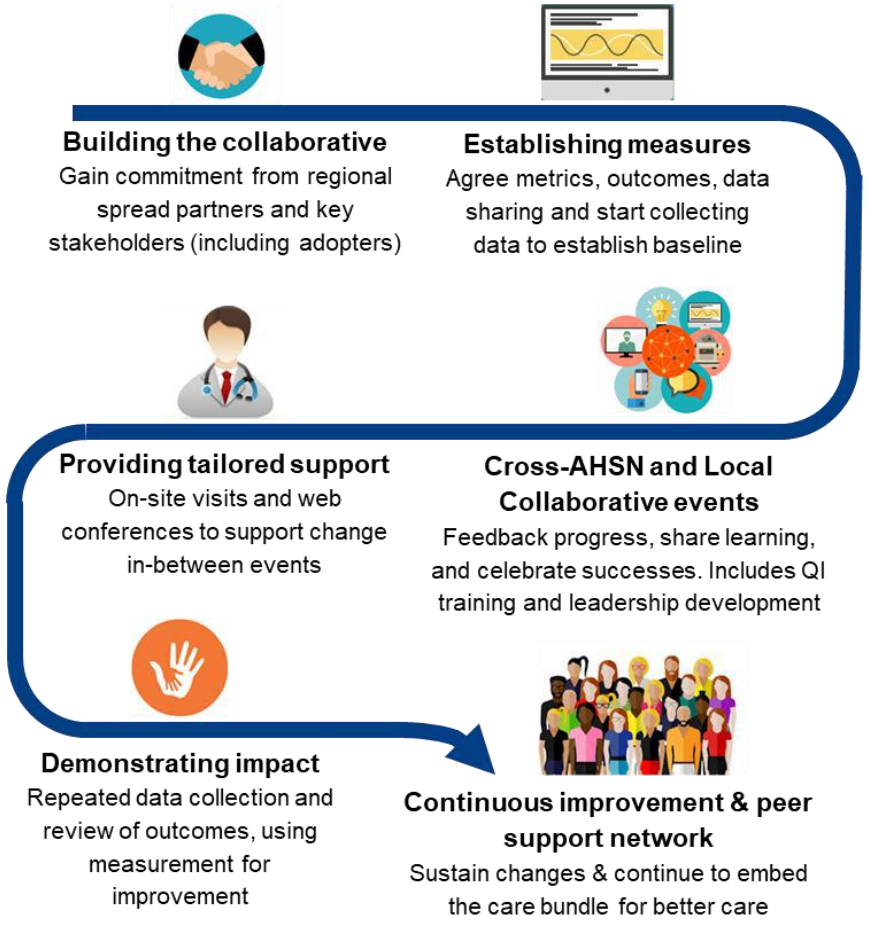
How?

- An evidence-based care bundle was developed by the Royal Surrey County Hospital NHS Foundation Trust.
- After implementing the care bundle in four UK hospitals (the ELPQuiC project), data was collected over an eight-month period.
- With the support of the Health Foundation the care bundle has been implemented in 28 hospitals.

Emergency Laparotomy Collaborative

Outcomes

- Of the 5,793 patients at participating hospitals between 1st October 2015 and 31st December 2016, **over 98%** received at least one aspect of the care bundle.
- Initial results across 28 hospitals show reduced average length of stay by **1.3 days** and reduced crude in-hospital 30-day mortality rate by 11%.
- An **estimated 79 lives** saved in one year, in one region alone.



Deteriorating patient

What?

Patient deterioration is an evolving, predictable and symptomatic process of worsening physiology towards critical illness.

Why?

For example, sepsis is a serious complication of an infection. Although treatable, sepsis kills 37,000 people a year in the UK.

How?

- The Suspicion of Sepsis dashboard can identify deterioration from routine administrative data.
- NEWS2 provides an early warning scoring system for acute and community settings to recognise, track and respond at all stages of a patient's journey, including at points of handover of care.

Sample Charts from SOS Insights Dashboard showing Wessex AHSN* Data

(* Dashboard can filter data to show, amongst others, National, AHSN or Trust level activity)

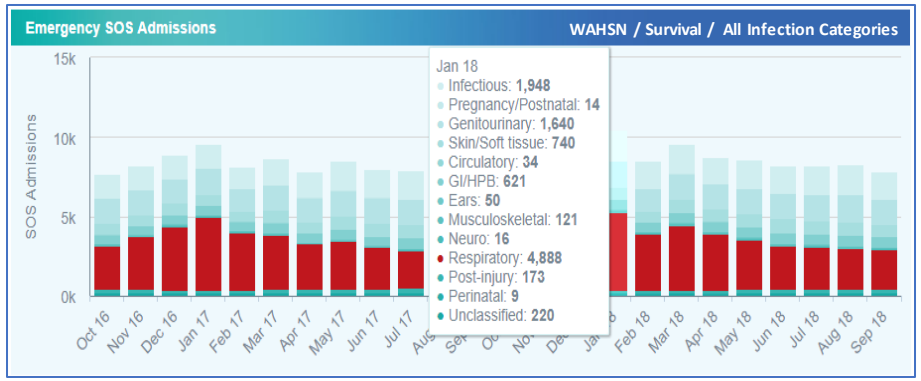


Chart A Breakdown of SOS Admissions by Infection Category showing impact of each category according to filters set. Within Wessex, at AHSN level, Respiratory, Infectious & Genitourinary are top three categories accounting for 80% of cases by Pareto Analysis.

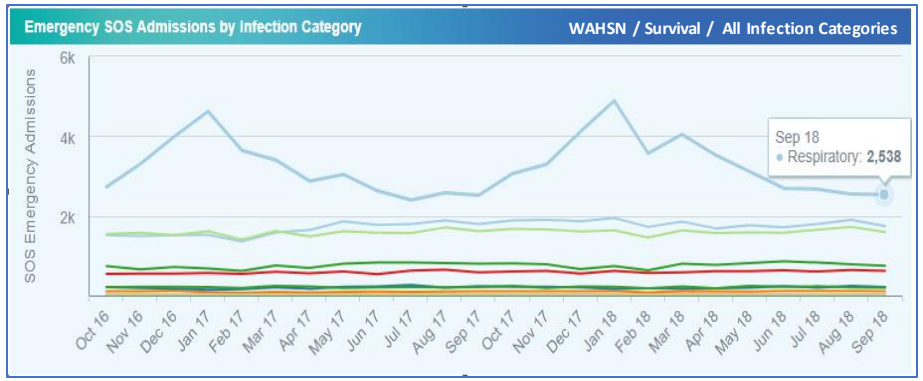


Chart B Most significant (numerically) SOS Admissions over time, showing seasonal trends by Infection Category. Wessex data demonstrates seasonal pattern in top category (Respiratory) of SOS cases (see Chart C for operational impact).

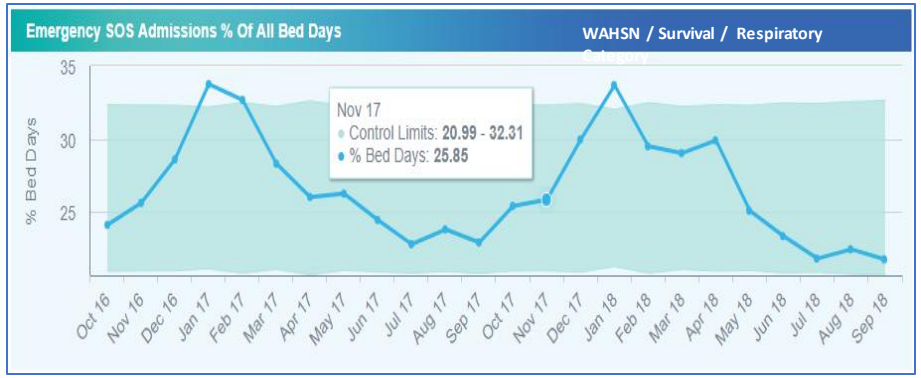


Chart C SPC chart showing the impact that the seasonal fluctuations in Respiratory SOS cases (Chart B) are having on operational activity (admissions) with significant variation including Special Cause Variations seen in patterns of Emergency Admissions.

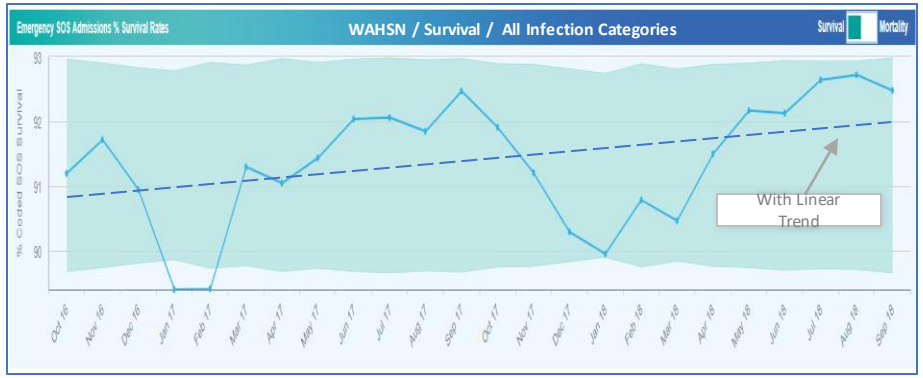
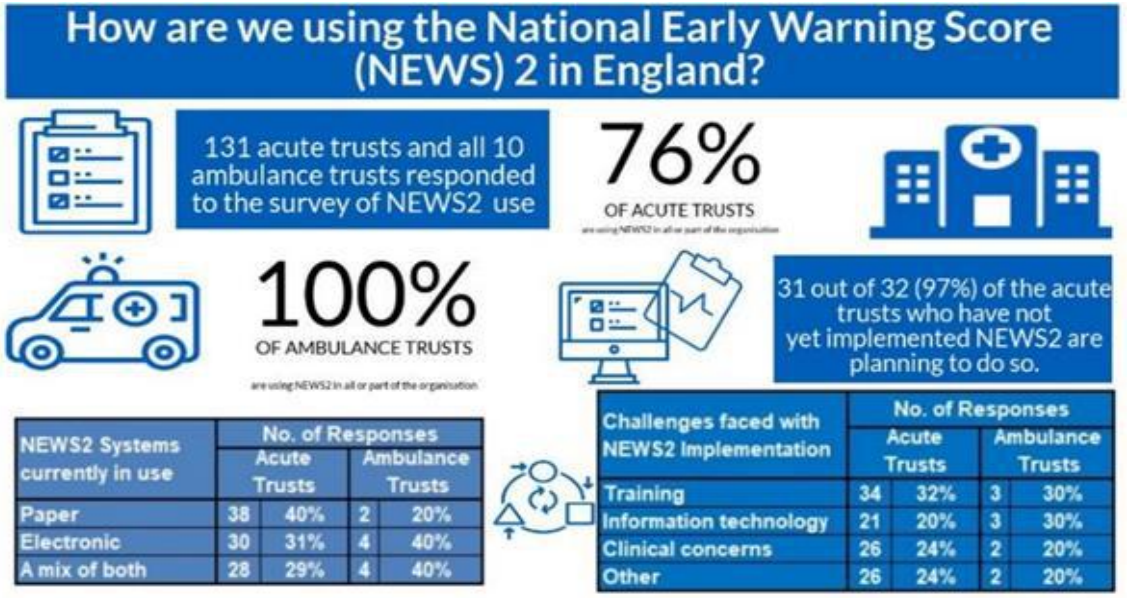


Chart D SPC chart showing seasonal trends in Survival rates over last 2 years. Linear Trend line indicates improvement in survival outcomes (reducing mortality) over this period which are potentially linked to the PSC Deteriorating Patient Workstream interventions.

Deteriorating patient

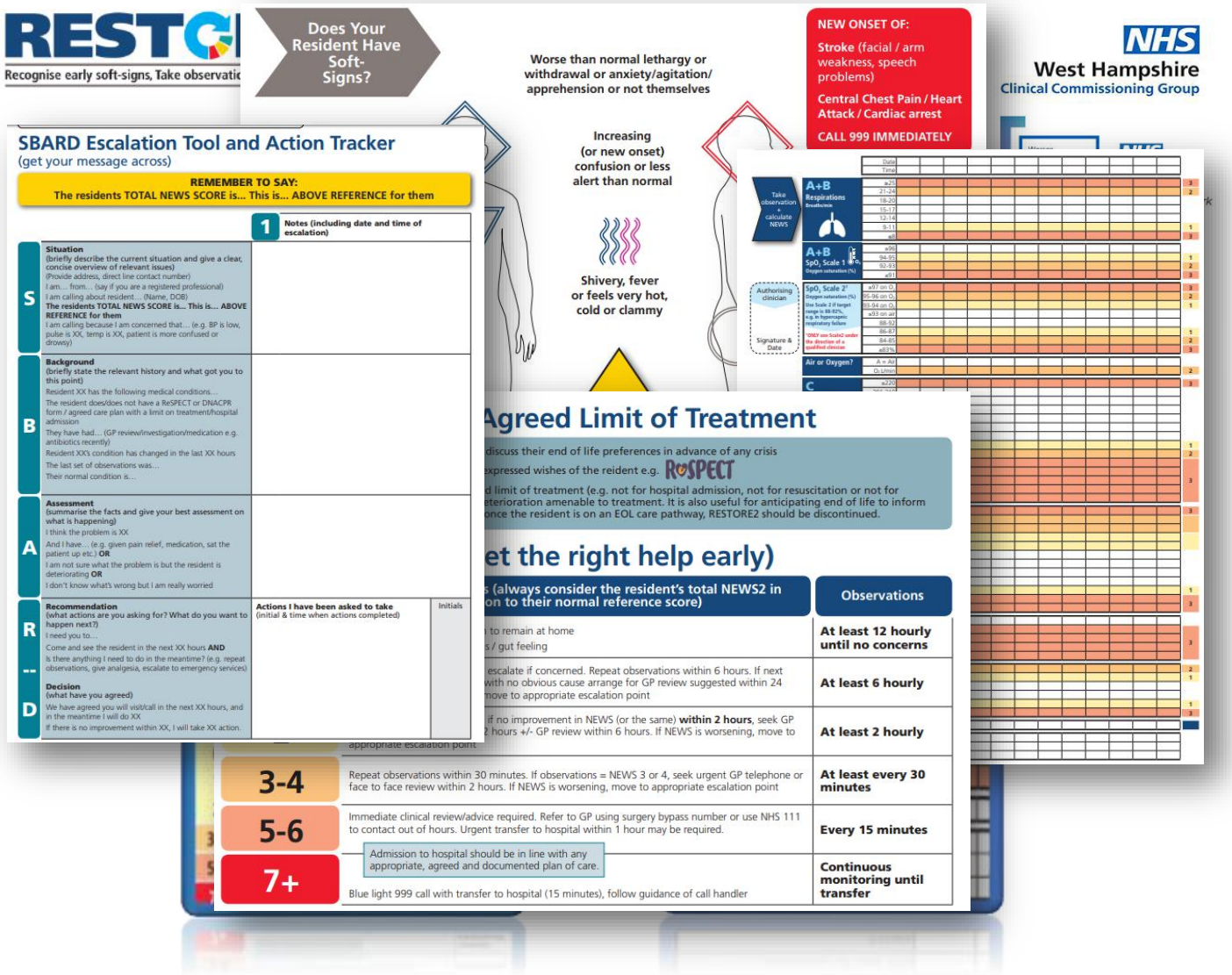


NEWS2 Systems currently in use	No. of Responses			
	Acute Trusts		Ambulance Trusts	
Paper	38	40%	2	20%
Electronic	30	31%	4	40%
A mix of both	28	29%	4	40%

Challenges faced with NEWS2 Implementation	No. of Responses			
	Acute Trusts		Ambulance Trusts	
Training	34	32%	3	30%
Information technology	21	20%	3	30%
Clinical concerns	26	24%	2	20%
Other	26	24%	2	20%

Outcomes

- **95%** of acute trusts and **all** ambulance trusts are using the National Early Warning Score
- NHS England's National Quality Board has supported its adoption across **all acute care,** incentivized through a national CQUIN scheme


RESTO
Recognise early soft-signs, Take observatio
Does Your Resident Have Soft-Signs?
Worse than normal lethargy or withdrawal or anxiety/agitation/ apprehension or not themselves
Increasing (or new onset) confusion or less alert than normal
Shivery, fever or feels very hot, cold or clammy
NEW ONSET OF:
Stroke (facial / arm weakness, speech problems)
Central Chest Pain / Heart Attack / Cardiac arrest
CALL 999 IMMEDIATELY
NHS
West Hampshire
Clinical Commissioning Group
SBARD Escalation Tool and Action Tracker
(get your message across)
REMEMBER TO SAY:
The residents TOTAL NEWS SCORE is... This is... ABOVE REFERENCE for them
1
Notes (including date and time of escalation)
S
Situation
(briefly describe the current situation and give a clear, concise overview of relevant issues)
(Provide address, direct line contact number)
I am... from... (say if you are a registered professional)
I am calling about resident... (Name, DOB)
The residents TOTAL NEWS SCORE is... This is... ABOVE REFERENCE for them
I am calling because I am concerned that... (e.g. BP is low, pulse is XX, temp is XX, patient is more confused or drowsy)
B
Background
(briefly state the relevant history and what got you to this point)
Resident XX has the following medical conditions...
The resident does/does not have a ReSPECT or DNACPR form / agreed care plan with a limit on treatment/hospital admission
They have had... (GP review/investigation/medication e.g. antibiotics recently)
Resident XX's condition has changed in the last XX hours
The last set of observations was...
Their normal condition is...
A
Assessment
(summarise the facts and give your best assessment on what is happening)
I think the problem is XX
And I have... (e.g. given pain relief, medication, sat the patient up etc.) OR
I am not sure what the problem is but the resident is deteriorating OR
I don't know what's wrong but I am really worried
R
Recommendation
(what actions are you asking for? What do you want to happen next?)
I need you to...
Come and see the resident in the next XX hours AND
Is there anything I need to do in the meantime? (e.g. repeat observations, give analgesia, escalate to emergency services)
D
Decision
(what have you agreed)
We have agreed you will visit/call in the next XX hours, and in the meantime I will do XX
If there is no improvement within XX, I will take XX action.
Actions I have been asked to take
(initial & time when actions completed)
Initials
Agreed Limit of Treatment
discuss their end of life preferences in advance of any crisis
expressed wishes of the reident e.g. ReSPECT
d limit of treatment (e.g. not for hospital admission, not for resuscitation or not for
eterioration amenable to treatment. It is also useful for anticipating end of life to inform
once the resident is on an EOL care pathway, RESTORE2 should be discontinued.
et the right help early)
(always consider the resident's total NEWS2 in on to their normal reference score)
Observations
to remain at home
/ gut feeling
At least 12 hourly until no concerns
escalate if concerned. Repeat observations within 6 hours. If next with no obvious cause arrange for GP review suggested within 24 move to appropriate escalation point
At least 6 hourly
if no improvement in NEWS (or the same) within 2 hours, seek GP 2 hours +/- GP review within 6 hours. If NEWS is worsening, move to
At least 2 hourly
3-4
Repeat observations within 30 minutes. If observations = NEWS 3 or 4, seek urgent GP telephone or face to face review within 2 hours. If NEWS is worsening, move to appropriate escalation point
At least every 30 minutes
5-6
Immediate clinical review/advice required. Refer to GP using surgery bypass number or use NHS 111 to contact out of hours. Urgent transfer to hospital within 1 hour may be required.
Every 15 minutes
Admission to hospital should be in line with any appropriate, agreed and documented plan of care.
7+
Blue light 999 call with transfer to hospital (15 minutes), follow guidance of call handler
Continuous monitoring until transfer
A+B
Respirations
Breaths/min
A+B
SpO2 Scale 1
Oxygen saturation (%)
SpO2 Scale 2
Oxygen saturation (%)
Air or Oxygen?
C
Take observation + calculate NEWS
Authorising clinician
Signature & Date

PReCePT

What?

- Antenatal magnesium sulphate given prior to birth reduces the risk of a pre-term baby developing cerebral palsy by 50%.

Why?

In the UK, 1% of births are up to 10 weeks premature. Of these, 10% develop cerebral palsy.

How?

- Selected by NHS England as one of The AHSN Network's seven national adoption and spread programmes for 2018-2020.
- PReCePT is the first ever perinatal programme delivered at scale across England.
- Aiming for at least 85% of all eligible mothers across England to receive magnesium sulphate by 2020.

PReCePT

Antenatal magnesium sulphate given prior to birth reduces the risk of a pre-term baby developing cerebral palsy by **50%**.

In the UK, **1% of births** are up to 10 weeks premature. Of these, **10% develop cerebral palsy**.

Impact

- We will treat a MINIMUM of **1048 additional babies** across all **152 units** in England.
- We will increase our baseline in 2017 (NNAP data) of

  - 60% uptake to 85% uptake
- Potential life time **savings of £5.1 million per baby**

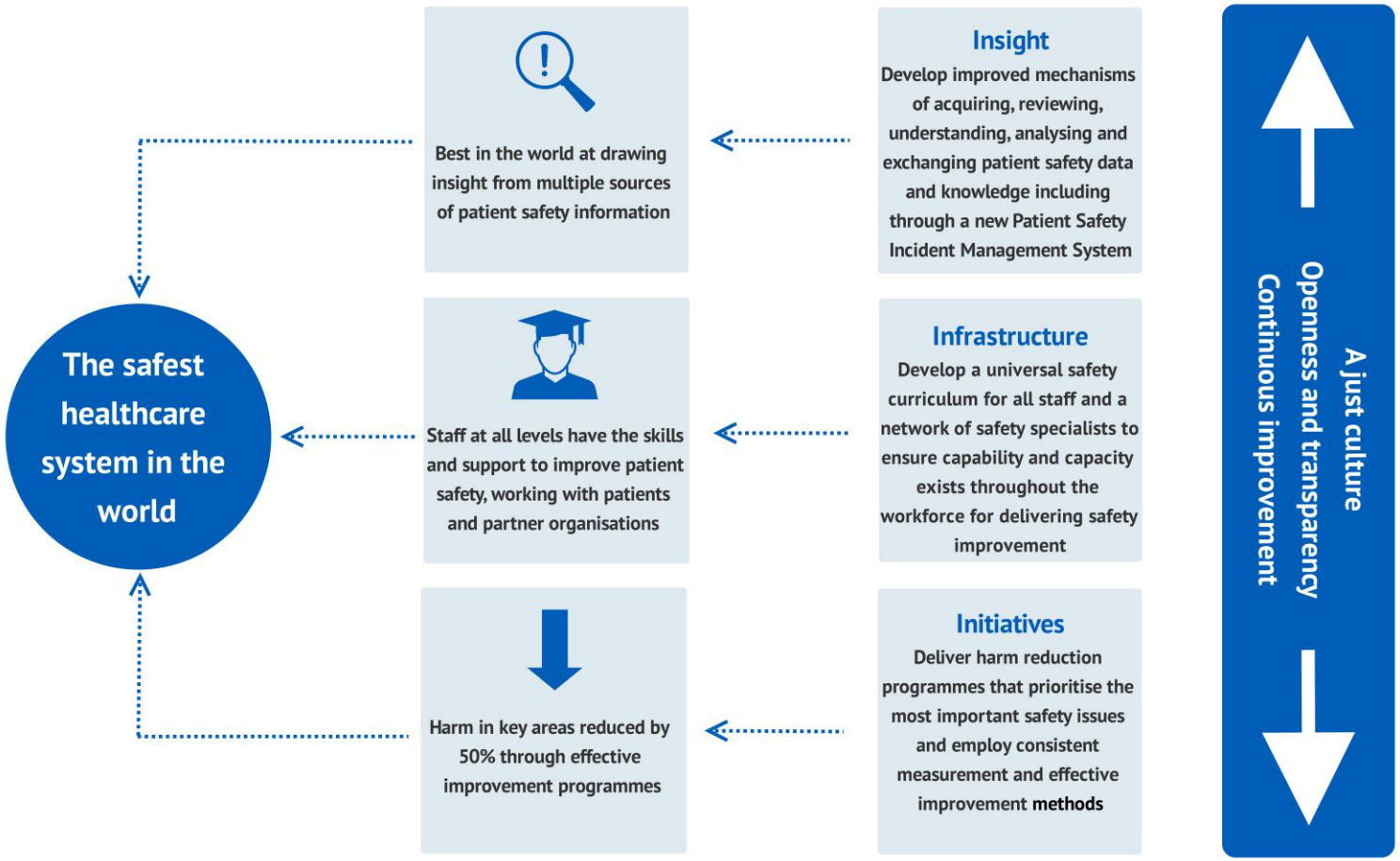
2017 AHSN Network PSC Review: Key learning themes

1. **Creating a national learning system**
2. **Partnerships accelerate innovation**
3. **Acting locally, impacting system-wide**
4. **Building on the foundations**

Findings from 2019 NHS Improvement commissioned PSC retrospective review

- Good foundations, but variety across the country
- Some achievement, success and good practice
- Not gone 'as far or as fast' as intended
- Recommendations:
  - A clearly defined role aligned to the National Patient Safety Strategy
  - More collaboration and engagement with other national bodies and regional structure
  - Priorities aligned to national initiatives and based on robust data
  - Local improvement plans with measurable outcomes
  - Systematic approach to spread and adoption

Developing a Patient Safety Strategy for the NHS



Our patient safety initiatives

Harm in key areas reduced by 50% through effective improvement programmes

Initiatives now - starting point is to build on work already planned or underway

Patient Safety Collaboratives

The Patient Safety Measurement Unit

Maternity and Neonatal Safety Collaborative

Intention to deliver **WHO 'medication without harm' challenge** and **Mental health PS programme**

Clear ROI for some focused projects eg **stillbirth care bundle**, **NEWS** work impacting on **sepsis mortality**, **Emergency Laparotomy**, **PReCePT**

Proposed initiatives of the future - based on PSC programme and development of national QI work

Recommissioned **Patient Safety Collaborative programme**

Build on partnership work on **deterioration**

Whole system **falls and fracture prevention**

Building on **maternity and neonatal safety**

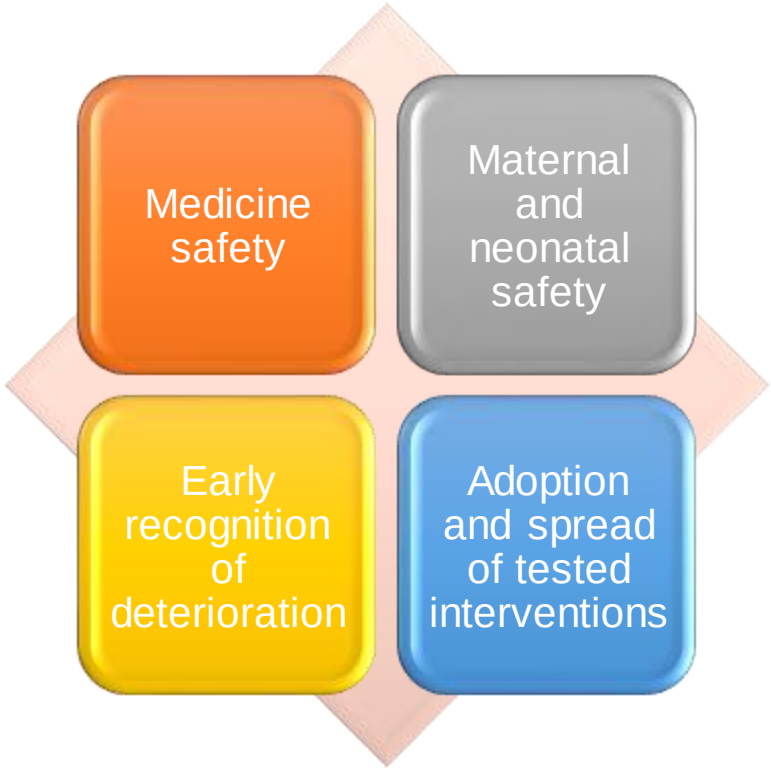
Medicines safety and **Mental health safety** programmes

Whole system approach to reducing **Never Events**

Pressure ulcer/ Infection Prevention and Control improvement work

Future commission:

- Four workstreams – collective focus accelerating pace of learning and improvement
- Underpinning principles of:
  - Creating a just safety culture
  - Building improvement capability
  - Working with patients, carers, women and families
  - Leadership for patient safety
  - Specific workstream interventions



Test and refine local interventions: creating an adoption and spread pipeline

Thank you

@ptSafetyNHS @PSCollaborative

improvement.nhs.uk/improvement-hub/patient-safety/

Healthcare Improvement Scotland

EVERY PERSON EVERY TIME SCOTTISH PATIENT SAFETY PROGRAMME

PS!
Dansk Selskab for PatientS!kkerhed
Danish Society for Patient Safety

Patient Safety

The Scottish and Danish Approach

Collaboration

Welcome

Share the **key factors** and **conditions** that are required to achieve and sustain improvements in safety at scale

Consider the learning from our national safety programmes within the **design of change ideas** for **your context**

Understand how **improving safety impacts** the **broader quality** domains

Vibeke Rischel
Head of Healthcare Improvement
Danish Society Patient Safety
@vibekerischel

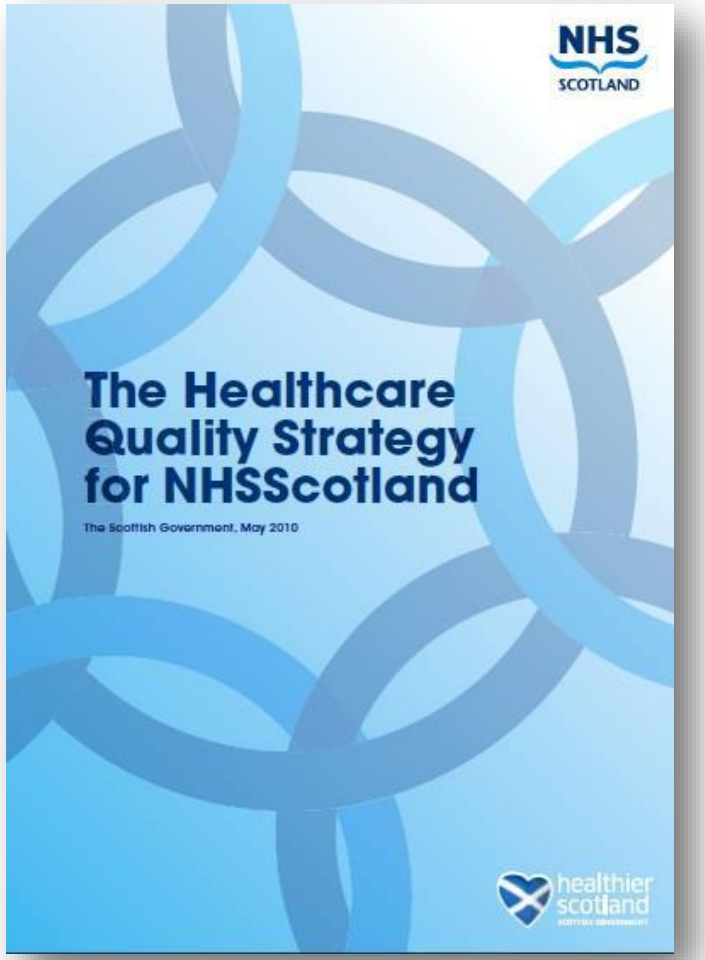
Joanne Matthews
Head of Improvement & Safety
Healthcare Improvement Scotland
@joanne37m

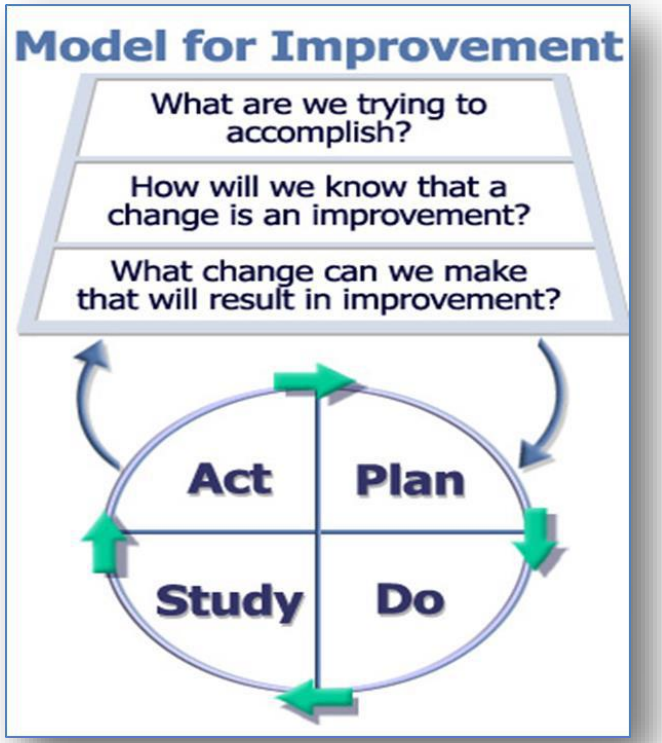
Why Safety Matters to You


EVERY PERSON
EVERY TIME
SCOTTISH
PATIENT
SAFETY
PROGRAMME

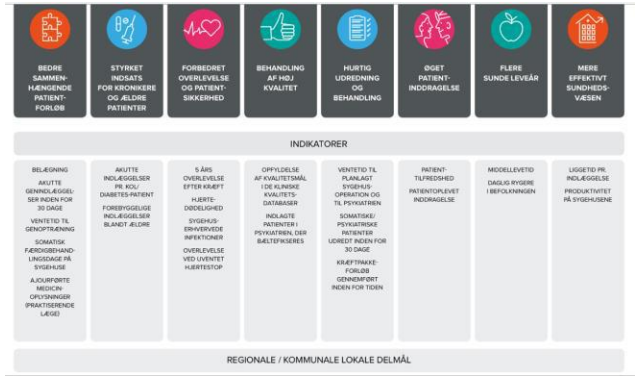

PS!
Dansk Selskab for
PatientS!kkerhed
Danish Society for Patient Safety

Courage


NHS
SCOTLAND
The Healthcare Quality Strategy for NHSScotland
The Scottish Government, May 2010
healthier scotland


Model for Improvement
What are we trying to accomplish?
How will we know that a change is an improvement?
What change can we make that will result in improvement?
Act
Plan
Study
Do

From Quality control to Quality Improvement in Denmark.



Acceleration af sundhedsvæsenets forbedringsarbejde

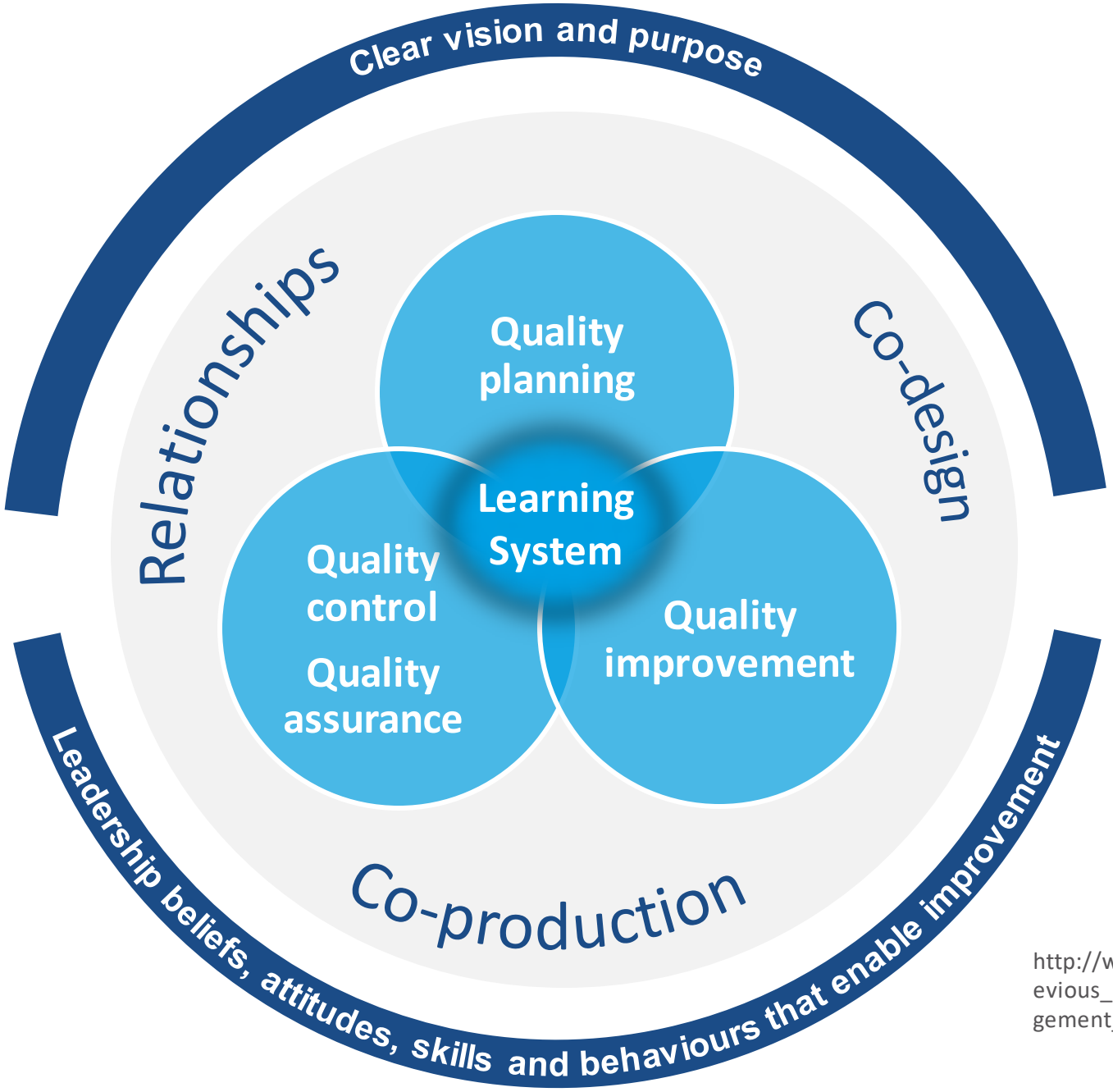
Dansk Selskab for Patientsikkerhed

Patientsikkert Sygehus

Et kvalitetsprogram

Fra Patientsikkert Sygehus til forbedringsarbejde på sundhedsområdet

Creating the Conditions



Healthcare Improvement Scotland

http://www.healthcareimprovementscotland.org/previous_resources/policy_and_strategy/quality_management_system.aspx

At your table

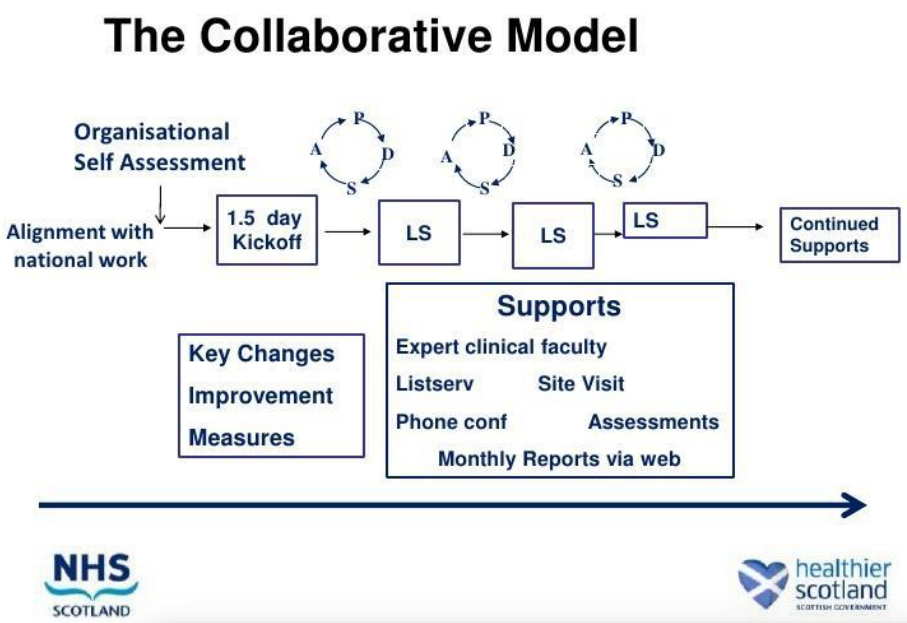
How is your organisation creating the conditions to build a culture of safety?

Collaboration

"Men wanted for hazardous journey. Small wages, bitter cold, long months of complete darkness, constant danger. Safe return doubtful. Honour and recognition in case of success."

Quoted in Shackleton's Way: Margot Morrell and Stephanie Capparell.

Collaboration




EVERY PERSON
EVERY TIME
SCOTTISH
PATIENT
SAFETY
PROGRAMME


Institute for
Healthcare
Improvement


cpsi icsp
Canadian
Patient
Safety
Institute
Institut
canadien
pour la sécurité
des patients


Patient Safety First
Working together for quality services


PS!
Dansk Selskab for
PatientS!kkerhed
Danish Society for Patient Safety

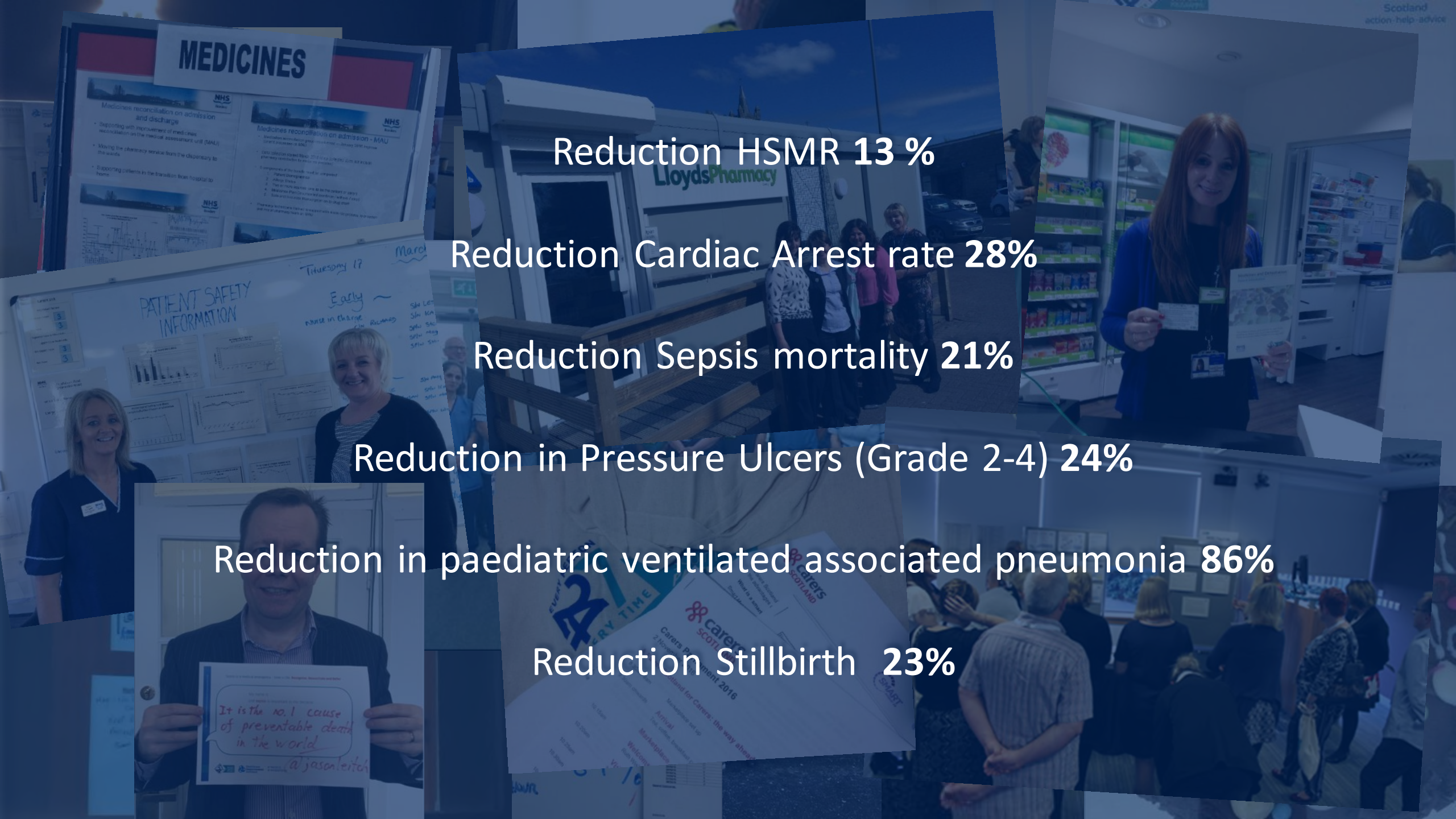

HSC
Public Health
Agency
Safety Forum


In Safe Hands
pasientsikkerhetsprogrammet.no
24
7

At your table

How is your board collaborating to improve?


COMMITMENT



Reduction HSMR **13 %**

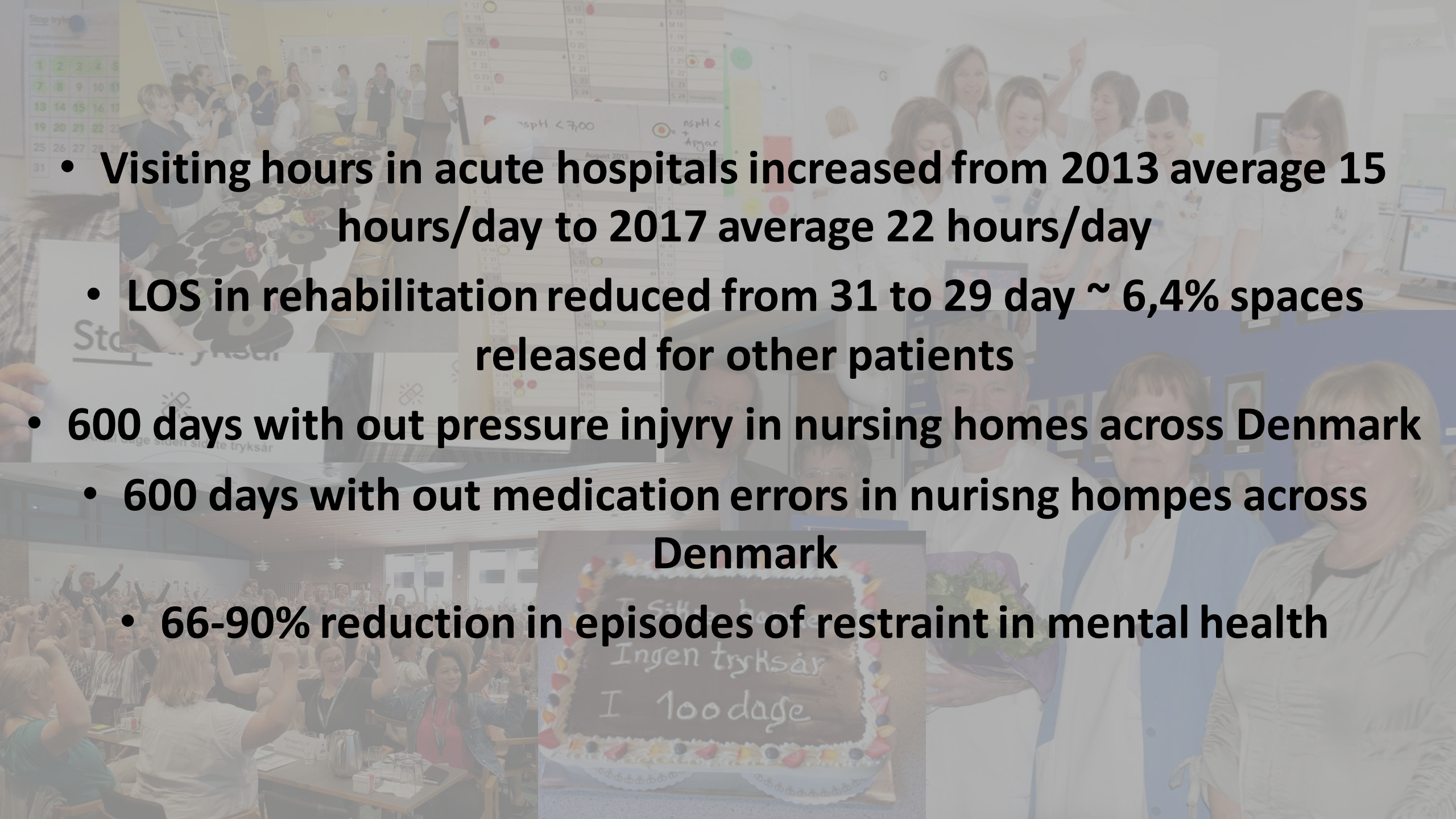
Reduction Cardiac Arrest rate **28%**

Reduction Sepsis mortality **21%**

Reduction in Pressure Ulcers (Grade 2-4) **24%**

Reduction in paediatric ventilated associated pneumonia **86%**

Reduction Stillbirth **23%**



- Visiting hours in acute hospitals increased from 2013 average 15 hours/day to 2017 average 22 hours/day
- LOS in rehabilitation reduced from 31 to 29 day ~ 6,4% spaces released for other patients
- 600 days with out pressure injyry in nursing homes across Denmark
- 600 days with out medication errors in nurisng hompes across Denmark
- 66-90% reduction in episodes of restraint in mental health

Commitment

“Reducing harm results in not only better outcomes for patients but the system too”

Professor Chris Ham
Kings Fund
NHS Scotland Event 2016

Pressure Ulcers - across Scotland we've achieved an average reduction of grade 2-4 pressure ulcers of 44 a month

Impact on patients

Reduced length of stay in an acute hospital of on average 5 – 8 days per pressure ulcer avoided

Impact on resources

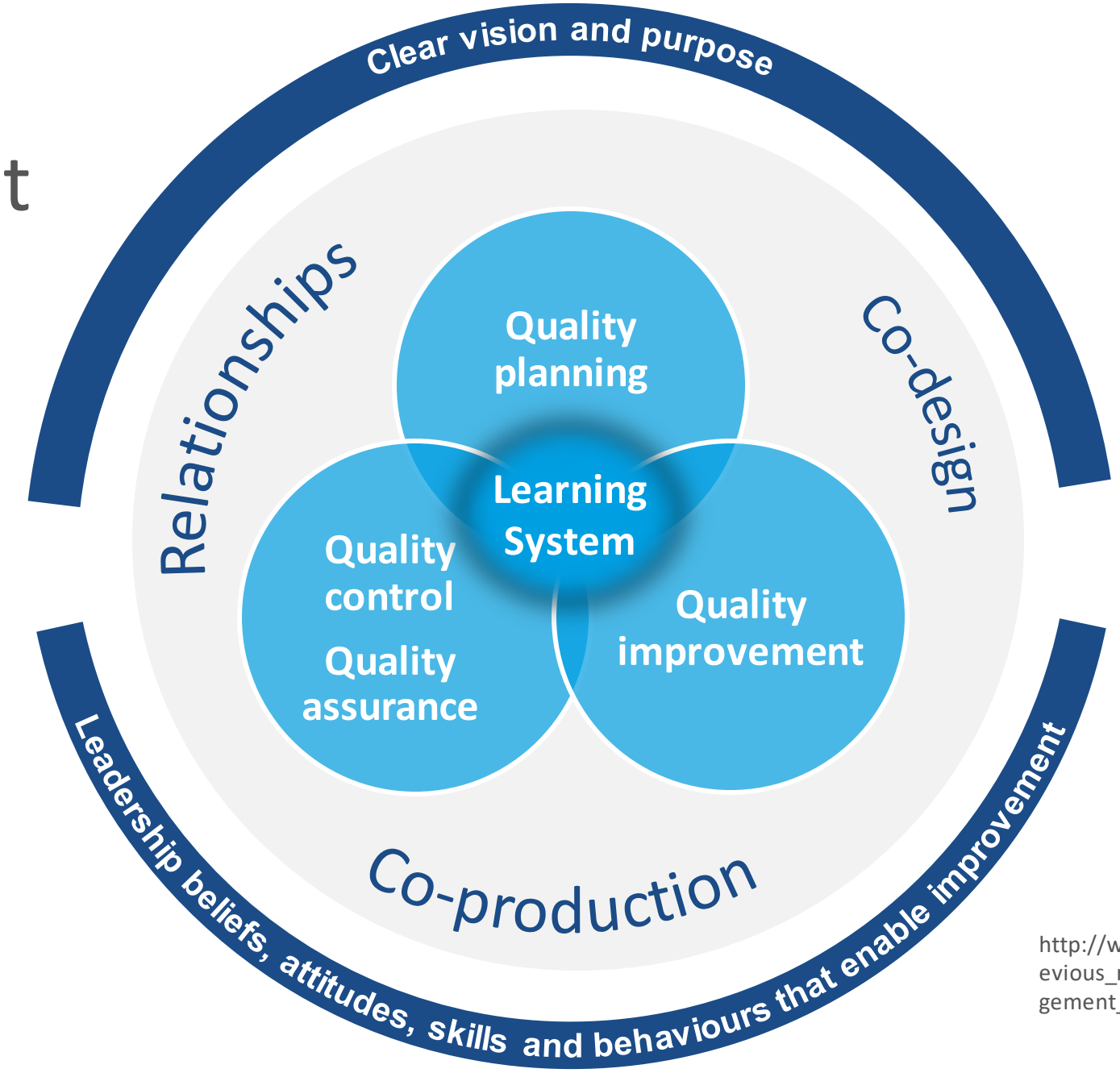
Total efficiency savings of between £184k (if all grade 2) and £460k a month (if all grade 4)

Is the Pressure Ulcer Bundle (PUB) tested and implemented in a collaborative cost effectiv?

- Sønderborg municipality 75.264 inhabitants 25% +65 participated in the In safe hands collaborative.
- The PUB caused a 63% reduction in the incidence of pressure ulcers in the population receiving care at home or in residential homes (from 12,5% to 4,7%).
- The saving is 8153 DKK ~936£ ~1092€ for each pressure ulcer prevented. This included the investment in new equipment, salaries to staff during training etc.

http://www.xn--isikrehnder-g9a.dk/media/2457/raunbak-jensen-friis-hoffmann-justesen-cost-effectivness-analysis-of-the-pressure-ulcer-bundle-in-the-municipalty-of-soenderborg.pdf

Our Future Commitment



Healthcare Improvement Scotland

http://www.healthcareimprovementscotland.org/previous_resources/policy_and_strategy/quality_management_system.aspx

Today’s Context

Collaboration

Thank you


Healthcare
Improvement
Scotland
EVERY PERSON
EVERY TIME
SCOTTISH
PATIENT
SAFETY
PROGRAMME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Dansk Selskab for
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