

OXFORD AHSN
Patient Safety Collaborative

OCTOBER 2014

Foreword

“Place the quality of patient care, especially patient safety, above all other aims”

FROM: *A promise to learn – a commitment to act: Improving the safety of patients in England* by the National Advisory Group on the safety of patients in England (the Berwick Review), August 2013.

Patient safety is a priority for the Oxford Academic Health Science Network and for all our partner organisations. This document showcases some of the good work to enhance safety already established in our region based on priorities determined by patients, families and NHS staff. Our new *Patient Safety Collaborative* has a vital role to play in developing new programmes, coordinating patient safety initiatives and evaluating their impact across the region to make sure that patients receive safe, high quality care wherever they are seen and whatever treatment they receive.



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Executive Summary

Achieving safe healthcare has the potential to bring very great benefits to patients, families and all involved in the delivery of care. The impact of even small improvements in patient safety is massive, both in terms of reducing the disease burden and in the huge economic benefits of safer healthcare. Many safety initiatives are in progress in the Oxford AHSN region in acute NHS hospitals, community and mental health settings, independent providers and in the patient's home. The bodies involved in this work include NHS trusts, care homes, social care bodies within local authorities, care commissioning groups, universities and preexisting collaboratives and federations.

The Oxford Academic Health Science Network Patient Safety Collaborative (PSC) will focus initially on a small number of clinical programmes but also act as an umbrella and coordinating centre for the many important patient safety initiatives – both practice and research – within Berkshire, Buckinghamshire, Bedfordshire and Oxfordshire. The principal aims of the PSC will be to:

- Develop safety from its present narrow focus on hospital medicine to embrace the entire patient pathway
- Develop and sustain clinical safety improvement programmes within the Oxford AHSN
- Develop initiatives to build safer clinical systems across the Oxford AHSN
- Collaborate and support sister safety programmes both nationally and internationally.

Early priorities are:

- The active engagement of patients and carers
- The development of a safety information system for the PSC
- Establishment and support of programmes on acute kidney injury, medication safety, pressure ulcers and safety in mental health
- Developing capacity and capability in leadership for safety improvement.

The PSC has chosen to focus on a small number of core areas in the first instance. We are conscious that further consultation needs to take place with a wide range of partners and that the full programme of work will only emerge gradually. The programmes set out here should be seen as a starting point and not a definitive account.

In time we hope to develop programmes which will address risks and vulnerabilities across the system and which are oriented towards building a safer healthcare system. Our longer term aim must be to design safe systems of care rather than address individual safety and quality issues.

Evolution and progress of patient safety

Twenty years ago the field of patient safety, apart from a number of early pioneers, did not exist and the lack of research and attention to medical accidents could reasonably be described as negligent¹. Major progress has now been made in assessing the nature and scale of harm in many countries. The findings of the major record review studies are widely accepted and numerous other studies have catalogued the nature and extent of surgical adverse events, infection, adverse drug events and other safety issues^(2,3). Analyses of incidents are now routinely performed, albeit often in a framework of accountability rather than in the spirit of reflection and learning.

Substantial progress has been made in many clinical areas in understanding the causes of error and harm. Surgery, for instance, was long ago identified as the source of a high proportion of preventable adverse events. A decade ago most of these would have been considered unavoidable or ascribed, generally incorrectly, as due to poor individual practice. Studies of process failures, communication, teamwork, interruptions and distractions have now identified multiple vulnerabilities in systems of surgical care⁽⁴⁻⁶⁾. Many groups are now moving beyond the undoubted gains of checklists to consider the wider surgical systems and the need for a more sophisticated understanding of surgical teamwork in both the operating theatre and the wider healthcare system⁷.

A considerable number of interventions of different kinds have shown that errors can be reduced and processes made more reliable. Interventions such as computer order entry, standardisation and simplification of processes and systematic handover have all been shown to improve reliability, and in some cases reduce harm, in specific contexts^(3,8-10). We have, however, relatively few examples of large scale interventions which have made a demonstrable impact on patient safety; the two most notable exceptions being the reduction of central line infections in Michigan and the introduction of the *World Health Organisation* (WHO) surgical safety checklist^(11,12).

Safety improvements at system level, the aim of the current collaborative programme, have been much harder to achieve. The UK Safer Patients Initiative, which engaged some of the acknowledged leaders in the field, was successful in engaging and energising staff and producing pockets of improvement. However, it failed to show any large-scale change on a variety of measures of culture, process and outcomes⁽¹³⁻¹⁴⁾. Longitudinal record review studies in the United States, France, the United Kingdom and the Netherlands have shown little change at a national level⁽¹⁵⁻¹⁷⁾. We do not therefore have clear evidence of wide sustained change or widespread improvements in the safety of healthcare systems.

Current patient safety landscape in the NHS

Clinical risk management emerged as an organisational priority in the NHS in the mid-1990s. Patient safety began to escape its medico-legal origins in 2000 with the publication of Sir Liam Donaldson's influential report 'An Organisation with a Memory (OWAM)¹⁸. The publication of OWAM led to the establishment of the National Patient Safety Agency (NPSA) and the national reporting system for patient safety incidents (NRLS). The agency was primarily focused on managing the reporting system with comparatively little attention given to safety improvement programmes which, at that time, were still to emerge as an international priority.

Safety, with outcome and patient experience, was established as one of the three cardinal objectives for the NHS in 'High Quality Care for All'¹⁹. This report led to the introduction of a range of indicators measuring mortality, complications and survival rates and patient perceptions of care to enable clinicians to benchmark and improve their performance. The introduction of a list of reportable 'Never Events' was also important in signalling that Trusts must implement relevant national guidance such as site marking and the WHO surgical checklist.

The NHS Outcomes Framework now forms the basis of the quality criteria set by commissioners. Safety is most strongly associated with Domain 5 which places a requirement on the NHS to treat and care for people in a safe environment and protect them from avoidable harm. Each domain has an overarching set of indicators to measure progress but the safety domain is less well developed than others. The development of the 'Safety Thermometer' marks the development of a more sophisticated system of measurement²⁰. The four types of harm measured are pressure ulcers, falls with harm, urinary tract infection in patients with a catheter and risk assessment for venous thromboembolism.

In summary, there has been increasing government focus on measuring and monitoring patient safety over the past ten years, as respective governments responded to the latest crisis and sought to assure themselves and the public that healthcare is safe. However, the overriding approach to safety has been that of regulation, judgement control and performance management with comparatively little focus on safety improvement^(21,22).

The recent report by Don Berwick²³ marks a radical change in the approach to safety taken within the NHS in that it treats safety as a positive aspiration and places emphasis on action at all levels of the system. The report succinctly summarises the challenges faced by the NHS in seeking to improve the delivery of care. These include the need for enhanced clinical and board leadership in safety and quality, a greater capacity for listening to the patient voice, a wider programme of training in safety and quality improvement, and the development of effective information systems.

Patient Safety Collaboratives 2014: *the new vision*

The aim of the Patient Safety Collaboratives programme is to create a comprehensive, effective, and sustainable improvement system with a culture of continual learning and improvement in patient safety. This will contribute to the NHS Outcomes Framework aims of treating and caring for people in a safe environment and protecting patients from avoidable harm and will also respond to the recommendations in the Francis and Berwick reports. NHS Improving Quality (NHS IQ) has aligned the PSCs to the 15 already established Academic Health Science Networks (AHSNs).

The 15 Collaboratives and the programme as a whole will focus on a number of discrete clinical areas with an additional remit to improve the safety of vulnerable patient groups. The programme aims to provide evidence of long-term safety improvement, an ambition that has largely eluded previous major safety programmes, both nationally and internationally. The collaborative programme also aims to deliver a significant increase in the patient safety improvement capability of the NHS by ensuring NHS staff from 'board to ward' and beyond have access to advice, support, resources and programmes of learning about safety.

The Oxford AHSN has taken the view that senior leadership and endorsement is critical to the success of the Collaborative. For this reason we have chosen to incorporate the PSC within the well-established AHSN structure, which draws on the leadership of all the main bodies within the AHSN region. Oxford AHSN has already created an Informatics theme and placed measurement at the heart of the Collaborative.

We have already embarked, through our Patient Safety Academy, on a programme of NHS organisational board engagement to collect and understand the safety concerns and priorities across the Oxford AHSN region. We have identified key personnel within each board who will act as champions for patient safety, learning, and for mastering and applying modern methods for quality control, quality improvement and quality planning.

Patient safety in the Oxford AHSN

The Oxford AHSN has carried out an extensive mapping process to draw together the patient safety initiatives currently underway across its geography. We have found that extensive work on safety is being carried out by our partners. These initiatives are being carried out in a variety of settings, from acute NHS hospitals, through community and mental health hospitals, or in the patient's home or care home. The bodies involved in this work include NHS acute trusts, NHS community trusts, NHS mental health trusts, social care bodies within county councils, care commissioning groups, universities and pre-existing collaboratives and federations.

Although we cannot describe all these initiatives in this document, examples are provided on pages 6 and 7 to illustrate the range of this work by describing some of the main current programmes and providing some additional illustration of specific programmes (See *Figures. 1 and 2*).

FIGURE 1: Illustration of specific Programmes

Illustrative clinical safety programmes within the Oxford AHSN

- **Safer medications/prescribing** (*Patient Safety Federation, Oxford Health, Oxford University Hospitals, Best Care Medicines Optimisation Clinical Network, Oxford Brookes University, South of England Mental Health Collaborative*)
- **Suicide prevention** (*Oxford Health, South of England Mental Health Collaborative*)
- **Tissue viability** (*Health Education Thames Valley, Oxford Health, Patient Safety Federation*)
- **Reducing sepsis & infection** (*Patient Safety Federation, University of West London*)
- **Malnutrition** (*Patient Safety Federation, University of West London*)
- **Falls prevention** (*Mental Health Patient Safety Collaborative, Patient Safety Federation*)
- **Handovers** (*Bucks New University; Oxford University Hospitals*)
- **Electronic blood transfusion** (*NHS Blood Transfusion Service, Oxford University Hospitals, Oxford AHSN Clinical Innovation Adoption [CIA] Programme*)
- **Reducing the risk of embolism using intermittent pneumatic compression** (*Oxford AHSN CIA Programme, Thames Valley Cardiovascular Strategic Clinical Network*)
- **Bladder scanner for improved catheter management** (*Oxford AHSN CIA programme and all acute trusts*)
- **Intraoperative fluid management** (*Oxford AHSN CIA Programme and all acute trusts*)
- **Gestational diabetes** (*Oxford AHSN CIA Programme and Diabetes Clinical Network*)
- **Reduction of pre-term births outside a Tier 3 hospital environment** (*Maternity Clinical Network*)
- **Referral of vulnerable patients to community pharmacist for medicines use review on hospital discharge** (*Medicines Optimisation Clinical Network*)
- **Introduction of Vaccine Knowledge website and the increase of flu vaccine uptake for 2- and 3-year-old children** (*Children's Clinical Network*)
- **Increasing the use of anticoagulants in patients with atrial fibrillation** (*Oxford AHSN CIA Programme and Medicines Optimisation Clinical Network*)
- **Redesign of 24/7 care and handover at OUH Trust** (*PSA and OUH Trust*)
- **SEND Programme to develop electronic monitoring of vital signs** (*Oxford University Dept of Clinical Engineering, OUH Trust and PSA*)
- **Urgent specialist care referral reform programme** (*QRSTU and OUH*)

FIGURE 2: Examples of Patient Safety Initiatives

Reducing violence and aggression

Oxford Health NHS Foundation Trust is developing improved approaches to restrictive practices to reduce the use of prone positioning and techniques that restrict patient movement. This work includes a new programme to train staff to use more preventative measures to reduce the levels of violence and aggression. A pilot project underway in an adolescent ward has achieved a 50% reduction in the use of physical restraint in the first year of the project by focusing upon assessment, care planning and de-briefing.

Reducing risk to mothers and babies

The newly developed Oxford Gestational Diabetes health management system incorporates real-time management of blood glucose control and the ability to communicate with the patient through a web-based application. Healthcare providers can view blood glucose measurements on a secure website as they are taken, and act more quickly to adjust medication rather than waiting until the next hospital clinic visit.

Pressure Ulcer Prevention

Buckinghamshire Healthcare NHS Trust has developed a strategy to reduce the numbers of avoidable pressure ulcers in both hospital and the community. Wards and community teams now have a pressure ulcer prevention 'champion' to share knowledge and support new ways of working and over 500 staff have received training and support from tissue viability clinical nurse specialists. This has led to a major reduction in the incidence of pressure ulcers with some wards not having a single pressure ulcer in the last year.

Improving safety and efficiency of blood services

The blood transfusion service at Oxford University Hospitals NHS Trust (OUH) has introduced a series of innovations in the last ten years to improve the safety of the transfusion process. The electronic transfusion system uses two-dimensional barcodes on patient wristbands, blood samples and blood units, within which is encoded the patient core identify data. These changes have led to a large reduction in transfusion errors, more rapid availability of blood for urgent cases, less blood wastage and reduced usage of blood.

The OUH transfusion team is working with Buckinghamshire Healthcare NHS Trust to implement and evaluate the electronic transfusion process across the Oxford AHSN region.

Reducing pre-term births outside a Tier 3 critical care environment

Recent research suggests that extremely pre-term babies (those born between 22 and 26 weeks gestation) are more likely to survive if they are born in a Level 3 neonatal unit. The Oxford AHSN Maternity Clinical Network is identifying barriers to transfer and designing a system to improve the timely transfer of the pregnant mother to appropriate neonatal facilities. This should lead to significant improvement in the survival rate of extremely pre-term babies within the Oxford AHSN region.

Improving the surgical management of suspected appendicitis

Surgeons and Trusts across the Oxford AHSN region are working with the Patient Safety Academy to improve the speed and accuracy of decision-making and treatment planning for patients with symptoms of appendicitis presenting to surgical emergency services. This will ensure that all patients needing surgical exploration for suspected appendicitis receive surgery within the Royal College of Surgeons' recommended timeframe.

Capability and capacity for improvement

The Royal Berkshire NHS Foundation Trust has developed, piloted and now embedded Making Every Moment Count. This is an initiative for trainees of every specialty and grade to acquire quality improvement skills and put them into action to improve patient care. For example, the 'FEED ME UP' campaign was implemented to prevent aspiration pneumonia in enterally-fed patients. The introduction of simple but effective measures has reduced the rate of aspiration pneumonia in tube-fed patients from 60% to zero. This work has been adopted regionally, nationally and internationally.

Patient safety units and networks in the Oxford AHSN

In addition to specific clinical programmes, the Oxford AHSN is home to a number of groups and networks working to improve patient safety across settings. These include:

OxSTaR (*Oxford Simulation, Teaching and Research*)

OxSTaR is based at the John Radcliffe Hospital, Oxford. The centre provides a state-of-the-art environment where medical students and multidisciplinary teams can use both adult and paediatric patient simulators to rehearse a wide variety of medical scenarios. OxSTaR provides healthcare professionals with a realistic simulated environment to enhance their ability to cope with medical emergencies without fear of harming patient either in or out of hospital.

Patient Safety Federation (PSF)

The PSF comprises healthcare organisations of Buckinghamshire, Berkshire, Oxfordshire, Hampshire and the Isle of Wight. The PSF programme includes: reducing sepsis mortality, developing safer medicines pathways, control of infection in both hospitals and community and developing an understanding of safety issues in mental health and community settings. Each workstream is headed by a senior member of an NHS trust and draws its membership from practitioners and academic experts across the organisations. This has led to credible, practical solutions which have improved the safety of patients across the region.

Quality, Reliability, Safety and Teamwork Unit (QRSTU)

The QRSTU analyses the safety and quality of surgery, and concentrates particularly on developing and evaluating interventions to improve systems of work. Previous studies have included the first detailed scientific study of the impact of an aviation-style Crew Resource Management teamwork training programme on technical error rates in operating theatres, and a major study of the effect of applying the Lean quality improvement system on safety in a surgical ward. They have recently completed a suite of studies demonstrating the synergistic effects of combining interventions focused on staff culture and those based on systems improvement. QRSTU also support the Clinical Human Factors Group in their work to improve surgical safety in the UK.

South of England Improving Safety in Mental Health Collaborative

The aim of the South of England Improving Safety in Mental Health Collaborative is to develop senior leadership for safety, enhance the safety and reliability of mental healthcare, medication safety and improve physical care of mental health patients. The Collaborative began in the South West in 2011 and was spread across the South of England in 2013. Multidisciplinary teams attend regular learning sessions based on the Institute for Healthcare Improvement's approach to improvement and collaboratives. Participating organisations have shown significant reduction in harm and sustainable change in practice across a number of clinical areas including suicide reduction and failure to return from leave. Further work on pressure ulcers, falls and medication omissions is in progress.

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- Collaborate and support sister safety programmes both nationally and internationally.

The PSC will support and coordinate the wide range of existing safety and quality improvement programmes within the Oxford AHSN region, acting as a bridge between diverse clinical settings to provide a critical mass of improvement expertise. Through the Oxford AHSN the PSC would utilise existing clinical networks, create clinical communities if necessary, identify clinical champions and engage managers and organisations. The information unit (see below) will provide the necessary informatics support to enable a coordinated approach, both within organisations and across the Oxford AHSN region.

Patients and patient safety

Healthcare depends on people being actively engaged in maintaining their health and in managing the illnesses that affect them. There is increasing evidence to suggest that person-centred care, or measures of positive patient experience, is linked to clinical outcomes; for example, reductions in mortality, rates of hospital-acquired infection or surgical complications, high quality clinical care or best practice and improved patient functioning.

Patient safety has sought to engage patients in a variety of ways, but has been primarily focused on hospital settings in which patients have distinct but limited scope to improve safety. In the community and home, however, patients and carers are in charge of healthcare. We believe that the healthcare of the future, with much more care being delivered in the home under the patient's direct control, will require a new vision of patient safety necessarily focused on the patient and their environment, more than on the professionals and the hospital environment.

The Oxford AHSN Patient and Public Involvement, Engagement and Experience theme is working to embed partnership with patients and the public across the Oxford AHSN's work programmes through:

- Involvement: working with patients, carers and the public to improve care delivery
- Engagement: working with patients and their families to improve their own care
- Experience: listening to and acting on what patients, carers and the public say.

This three-tiered approach to public and patient involvement will be the foundation of our approach to patient safety. Our strategy embraces patients and members of the public who wish to be kept informed and involved in their care, those who will be actively involved in specific projects and those who will be involved in ongoing strategic planning.

We also wish to develop a further programme of work aiming to support patients, families and staff in the aftermath of serious incidents. When a patient is harmed in healthcare, the associated trauma can be considerable. The patient may suffer both physical harm and psychological trauma, which may extend to their family. Staff involved may also be seriously affected. The NHS has very limited services for supporting patients, families and staff in the aftermath of serious incidents. The PSC would seek to bring a shared commitment from partner organisations to provide support to those affected by serious incidents and to those who raise safety concerns within organisations.

The Patient Safety Academy – leadership for improvement

The Oxford AHSN's Patient Safety Academy is a new organisation funded by Health Education Thames Valley, which uses the expertise accumulated in the QRSTU and OxStar (see above) to provide training and support for patient safety initiatives. The areas of strategic focus include surgery, mental health and primary care as well as senior management in acute trusts. The programmes aim to build capacity in safety improvement by identifying and training groups of clinical champions in each Trust or area, and supporting them in developing and delivering improvement projects. The champions form a multidisciplinary group of key leaders, who influence, educate and persuade their colleagues to become involved in safety improvement and system redesign. We believe that this approach will be particularly effective in taking evidence-based safety interventions and implementing them at scale.

The senior leaders seminar series within the Academy will engage board members in developing new approaches to managing risk and enhancing safety. The Academy is holding intensive meetings with a selected group of key board members in each Trust to discuss a proposed agenda for change, which includes three elements:

1. Reform of systems for detecting and analysing problems
2. Building capacity for systems redesign and improvement
3. Developing a coherent safety leadership strategy.

Each of these themes involves practical initiatives such as a peer-to-peer system of expert analysis of serious incidents. Over a two-year period the Academy will facilitate and monitor progress in organisational safety by assessing processes such as Serious Incidents Requiring Investigation (SIRI) and mortality and morbidity audits, and outcomes such as complication rates for surgery.

Safety measurement and information systems

The Oxford AHSN Informatics theme provides a service to the Oxford AHSN Best Care clinical networks and other programmes and themes combining engagement, data management and the support and mobilisation of partners to improve local informatics systems. The fundamental strategic aims for the Informatics theme include:

- Mapping informatics requirements and establishing a common information sharing agreement
- Supporting the extension of research databases across primary, community and acute services
- Utilising informatics to support patient empowerment in care delivery
- Facilitating patient recruitment to research studies and clinical trials.

Informatics and data will be pivotal to the work of the PSC. Data will firstly be required to develop an overview of the Oxford AHSN region in terms of patient safety. This will be visualised as a suite of reports or in a geospatial map. From this initial exercise it will be possible to identify areas of significant variation in performance against national patient safety priorities as well as areas of high risk to patients. This data will provide direction for the PSC when developing its strategic programme and in the selection of specific projects. Informatics and data will be necessary to develop a baseline of performance on selective metrics prior to the initiation of the project and for monitoring change over time.

The Oxford AHSN Informatics theme will engage with the PSC to ensure that the relevant partners have the capacity to map the landscape, develop baselines and monitor progress. We will draw on the recently published framework for safety measurement and monitoring recommended by NHS England²⁴. The informatics service will also provide data analysis expertise to develop patient safety data metrics such as:

- **Infection rates** – such as catheter acquired urinary infections
- **Incidence and severity of pressure ulcers**
- **Delayed discharges** – including A&E-to-admission delays
- **Medicines Management** – such as medication reconciliation, allergy status.

This expertise also extends to the acquisition of data from both national sources (such as the Safety Thermometer) and locally developed sources including those hosted at Clinical Commissioning Group or Commissioning Support Unit level.

Clinical safety programmes

The PSC has chosen to focus on a small number of core areas in the first months. We are conscious that further consultation needs to take place with a wide range of partners and that the full programme of work will only emerge gradually. The programmes set out here should be seen as a starting point, and not as a definitive account of the PSC.

PROGRAMME 1: Reducing the incidence of acute kidney injury

Acute kidney injury (AKI) is a common and potentially life-threatening condition that frequently occurs in acutely unwell patients in both hospital and community settings. AKI in hospitalised patients often leads to chronic end stage renal disease and is associated with high mortality rates. The cost of renal disease in the NHS was estimated at £1.64bn in 2009/10 and much was due to AKI²⁵. Studies have highlighted severe deficiencies in the recognition and management of AKI in hospitalised patients, many of which may have actively contributed to patient death. Patients in the community also develop AKI and, while there is less research in this area, recent studies suggest that AKI may go unrecognised in the community for some time and that the diagnosis of AKI is as commonly missed as cancer in primary care²⁶.

A number of projects are ongoing to improve the detection of AKI in the community. These include the NHS England Acute Kidney Injury Programme that has developed, and now implemented, an electronic clinical alerting system. Educational initiatives in primary care and the identification of at-risk patients through an integrated electronic prompt should also improve identification of cases. Innovations such as point of care creatinine testing may also have an important role in the future diagnosis of AKI²⁷.

The Patient Safety Federation has led an innovative intervention combining three approaches for the management of AKI. Information design, human factors and quality improvement methodology have been combined to develop a tool to support detailed implementation of guidelines. A newly designed fluid balance assessment has been introduced alongside a ward-based simulation training programme to improve staff skills and knowledge of AKI prevention and management. We anticipate building on this work to develop a collaboration across the Oxford AHSN region and other areas. This will be a partnership between the Patient Safety Federation, the Oxford AHSN Out of Hospital Clinical Network and other groups. Combined hospital and community interventions will be developed to monitor AKI across the Oxford AHSN region.

PROGRAMME 2: Improving medication safety

The NHS spends in excess of £12bn pounds on medicines annually – 70% in primary care and 30% in secondary care. Medicines are the most common NHS intervention:

- 16.4 prescriptions are dispensed in England per head of population per year in primary care
- An estimated 1.6 million people visit a community pharmacy every day
- 97% of hospital patients are taking medicines with 82% taking four or more.

Medication related incidents are the third most common event reported to the National Reporting and Learning System and 11.8% of prescriptions in primary care contain an error. Prescribing errors occur in 4% of all prescriptions, most commonly as incorrect dose or frequency; 7% of prescriptions are sub-optimal because of under-treatment or failure to titrate dose. Formal trials of pharmacist-led IT systems have demonstrated reductions in these errors, particularly those that could lead to hospital admission²⁸.

The PSC will work closely with the Oxford AHSN Medicines Optimisation Clinical Network to develop a shared programme on medicines safety across primary, secondary, tertiary, mental health and community sectors. This group will aim to improve medication safety reporting and use learning to drive specific projects to reduce medication safety errors and risk. In the first instance, they will aim to improve medication reconciliation rates between home and hospital settings, as this is a known area of risk to patients.

PROGRAMME 3: Reducing pressure ulcers

Pressure ulcers are painful, limiting and can be life-threatening. Evidence suggests that 10-12% of all patients suffer from pressure ulcers. A substantial proportion of these can be avoided with simple, effective nursing interventions^(29,30).

Buckinghamshire New University has developed a learning network and educational package which incorporates evidenced and standardised guidance for the prevention and management of pressure ulcers for use by all NHS partners, patients, unpaid carers, domiciliary care and nursing homes. The pressure ulcers team is working with service users, clinical experts and sports scientists to co-design talking heads videos, which provide practical demonstrations of how to relieve pressure when immobilised and self-caring or in receipt of home care. A partnership is being established to extend this work with others in the Oxford AHSN region including patient and carer groups, Health Education Thames Valley, Mental Health Collaborative, South Central Ambulance Service and others.

The aims of this partnership are:

- Reduction in number and severity of pressure ulcers
- Reduction in pressure ulcers at grades 3&4
- Reduction in number of hospital readmissions for pressure ulcers.

PROGRAMME 4: Safety in mental health

This programme will initially focus on the Failure to Return to the Ward project being developed and tested by Oxford Health NHS Foundation Trust and the South of England Mental Health Collaborative. Further projects will be initiated following consultation with community and mental health partners across the Oxford AHSN region.

The Failure to Return to the Ward project focuses on both detained and informal patients to ensure their safe, timely return to acute mental health wards following a period of leave and to reduce the number of absconding incidents. The programme tests a range of interventions to change ward culture and processes associated with leave arrangements on acute wards. This includes clear leave planning with patients and the therapeutic aims of the leave and travel arrangements. Patients are provided with a card detailing ward contact numbers and their agreed time of return. In the first year the programme demonstrated sustained improvement with the proportion of patients returning on time rising from 30% to 76%. The project is entering a second phase and six wards are now refining these interventions. The aim is for all Oxford Health acute mental health wards to demonstrate a 50% reduction by 1 April 2015 and to disseminate this work across the Oxford AHSN region.

Integration and governance

The Oxford AHSN is hosted by Oxford University Hospitals NHS Trust and is governed by the Oxford AHSN Board which oversees the Oxford AHSN's strategy and signs off its Business Plan. The Oxford AHSN Partnership Board has representation from all NHS providers and commissioners, universities, Local Enterprise Partnerships and life science industry within the Oxford AHSN region. The Oxford AHSN Board consists of the Chairman, Deputy Chairman and Chief Executive of the Oxford University Hospitals NHS Trust, the host Trust, the Chief Operating Officer and the Chairs of our six Programme and Theme Oversight Groups.

The Oxford AHSN has four programmes and two themes. The Best Care programme consists of ten Clinical Networks, two Continuous Learning strands and a Sustainability theme. A new safety strand has been created in Best Care to accommodate the PSC. The Best Care Programme has its own board which provides internal governance and is accountable to the Oxford AHSN Board for the strategy and delivery of the Best Care programme. The Best Care Programme Board is supported by the Best Care Oversight Group, which acts as a critical friend to the programme. The Lead of the PSC is a member of the Best Care Programme Board.

The PSC will have its own steering group which will make decisions on direction, resource allocation, priorities and work plans. The steering group and associated governance structures will embrace the NHS England guidance for locally-led, nationally relevant programmes of work. The steering group membership covers social, primary, community and acute care and the universities, and will engage the public, patients, carers and national and international safety experts.

The PSC steering group will meet monthly initially to agree detailed priorities and allocate resources. Any major decisions regarding budget and priorities will be ratified through the governance structure outlined above. Terms of Reference for the steering group will also be created and refined, but are likely to include the review of purpose, membership and leadership on a biennial basis.

Building a safer system

Enhancing safety across the Oxford AHSN region requires a variety of interlinked activities. Patients are vulnerable to harm both because of specific failures in the processes of care (addressed by the clinical programmes) and because of wider systemic problems such as poor equipment design, inadequate handover and lack of standardisation of core processes. Some safety issues will be resolved by new designs and technology. We therefore need to focus both on specific clinical issues and on fundamental issues that undermine the work of staff and the care they provide to patients. Major known issues include:

- The plethora of policies, guidelines and procedures that confuse rather than support the work of clinical staff
- Poor reliability of basic processes in many settings, for instance equipment availability in the operating theatre
- Unnecessary and confusing variability in practice across the Oxford AHSN region in, for instance, junior doctors' induction
- Inadequate processes for handover and communication at discharge.

We regard improvements to healthcare systems as fundamental to safety and a critical underpinning to programmes of work on specific clinical topics. Looking further ahead we need to move beyond single projects and interventions to a more integrated, proactive design-centred approach. The timescale for work of this nature is longer and will require collaboration with a wide variety of other groups within the Oxford AHSN region. Our ultimate longer term aim must be to design and build safe systems of care.



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