



Patient Safety Collaboratives

Making care
safer for all

Patient Safety Collaboratives
The AHSN Network

NHS
Improvement

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Foreword

It is now almost three years since Professor Don Berwick published his report *A promise to learn – a commitment to act*, about improving the safety of patients in England.

The Patient Safety Collaboratives (PSCs), founded in response to one of his key recommendations, have played a critical role in delivering his vision of change in the culture of patient safety, across the NHS.

The 15 collaboratives, funded by NHS Improvement and owned by local patients and NHS staff, are the largest patient initiative in the history of the NHS. They are now well established, delivering approaches to continual learning and safety improvement to every part of our healthcare system.

They have provided local learning and created improvement hubs, bringing together clinicians, managers, academics and patients to develop and test solutions to meet local priority safety issues.

As shown in the pages that follow, the collaboratives are providing a basis for the most successful innovations to be shared on a national scale, so that proven best practice can be adopted across the country.

A key aim of the collaboratives is to ensure that continual patient safety learning sits at the heart of healthcare in England. Quality improvement and patient safety becomes increasingly important when pressure in the system increases as the NHS responds to the needs of our growing population.

Our ability to respond to the safety needs of our patients impacts hugely on the morale of frontline staff. They deserve our constant attention. We must create conditions that make the best use of our resources, both human and financial. The collaboratives are about doing the right thing, first time, and every time.

Patient safety is now a mainstream concern, embedded in every hospital ward, GP's surgery and community service. It requires commitment from all of us who work in the NHS, as well as from those who use it, to work together to make it the safest healthcare system in the world.

I look forward to the PSCs continuing to play a lead role in this journey of continuous improvement on which we have all embarked.



Dr Mike Durkin

NHS National Director of Patient Safety, NHS Improvement
June 2016

Patient Safety Collaboratives: who we are and what we do

The Patient Safety Collaboratives (PSCs) play an essential role in identifying and spreading safer care initiatives from within the NHS, as well as drawing on the best ideas from industry, ensuring these are shared and implemented throughout the system.

We seek to add value to existing organisationally based patient safety programmes by working across the whole healthcare system and by bringing organisations together to learn from each other. Each Patient Safety Collaborative is based in one of 15 Academic Health Science Networks (AHSNs) located throughout England. AHSNs bring together the talents of the NHS, universities and healthcare industries from within their regional footprints.

We lead selected patient safety initiatives nominated by local NHS organisations, and collectively, we are part of NHS Improvement's national patient safety programme with a mandate to create a culture of continuous learning and improvement in the NHS.

Making a difference

We are focused on delivering measurable and sustainable improvements in specific patient safety areas during the course of our current five-year term.

Working across organisational boundaries, locally led safety initiatives have resulted in a broad range of outcomes including:

- Care bundles that reduced mortality after emergency laparotomies by 42 per cent.
- Clearer clinician-produced guidance that improves discharge information on acute kidney injury.
- A 50 per cent increase in service users returning to mental health wards on time.
- Reductions in inpatient medication errors.
- Safety huddles that led to a reduction of 60 per cent in patient falls.

We support organisations, individuals and teams in building skills in, and knowledge of, patient safety. We address the challenges of quality improvement, and provide opportunities for sharing best practice.

Working with teams in our local health economies, we identify opportunities for safety improvement, and enable spread and adoption of solutions, so that each PSC sets its own priorities in line with local needs.

Focusing on the fundamental principles of culture and behaviour, NHS England established the Patient Safety Collaboratives to identify and spread safety improvement approaches across the system that would:

- Place the quality of patient care, especially patient safety, above all other aims.
- Engage, empower and hear patients and carers at all times.
- Foster the growth and development of all staff, including their ability to improve the processes which they are part of.
- Embrace transparency, unequivocally and everywhere, in the service of accountability, trust, and the growth of knowledge.



Image supplied by Health Innovation Network

Working in partnership

The Patient Safety Collaboratives are working in partnership with the national Sign up to Safety initiative.

Organisations who join the initiative, agree to strengthen patient safety by committing to its five Sign up to Safety pledges:

- 1 Put safety first** Commit to reduce avoidable harm in the NHS by half, and make public its locally developed goals and plans.
- 2 Continually learn** Make the organisation more resilient to risk, by acting on the feedback from patients and staff, and by constantly measuring and monitoring how safe our services are.
- 3 Be honest** Be transparent with people about its progress in tackling patient safety issues, and support staff in being candid with patients and their families if something goes wrong.
- 4 Collaborate** Take a leading role in supporting local collaborative learning, so that improvements are made across all the local services that patients use.
- 5 Be supportive** Help people to understand why things go wrong, and how to put them right. Give staff the time and support to improve, and celebrate success.

Our leadership role

The Patient Safety Collaboratives' vision is to improve patient safety across England. Our goal is to create a comprehensive, effective and sustainable system, which will support the development of a culture of continual learning.

The PSCs play a key leadership role in patient safety both at national and regional level. We collaborate and coordinate initiatives that cross organisational, sectoral and geographical boundaries. We work in all care settings including maternity care, mental health, GP practices, acute hospitals, community health services and nursing homes. We also work with people who manage their own conditions at home, as well as frail older people, and those admitted to hospitals.

To deliver our vision at scale and pace, we have established clusters; groups of PSCs coming together and working with healthcare organisations to address key healthcare themes. More information on the role of the clusters can be found on p14.

Patient safety in action

Yorkshire & Humber Patient Safety Collaborative is working in partnership with the Royal College of Physicians to deliver the national Mortality Case Record Review over the next three years. This pioneering programme will develop and implement a standardised way of reviewing the case records of adults who have died in acute hospitals. Its objective is to improve our understanding of problems that may have arisen during care and contributed to a person's death.



Image supplied by Imperial College Health Partners



Led by Kent, Surrey and Sussex, a cluster of nine Patient Safety Collaboratives are working together to create a common process an outcome measurement with acute kidney injury. They will be reported by the UK Renal Registry and used locally by PSCs, strategic clinical networks, acute trusts and commissioners to improve the safety and quality of care for people with the condition.

Twelve Patient Safety Collaboratives, led by the Innovation Agency, are working with the National Board for Sepsis on earlier identification and treatment of people with sepsis, and the deterioration that sometimes arises as a result of the condition.

Under the leadership of East Midlands, six Patient Safety Collaboratives are working together on safer discharge of patients and transfer of care.

Ten Patient Safety Collaboratives have adopted a web-based platform, which provides the tools needed for quality improvement projects, including sharing data, and plotting results in run charts. Developed by South West AHSN with the digital company seeDATA, this new system will allow teams from across England to share results and work together. Since its launch in January 2016, there are now 220 projects on the platform and more than 500 users.

In 2016, Patient Safety Collaboratives will continue to develop plans for the adoption and spread of other successful schemes, as well as sharing our learning nationally and continuing to build capability for improvement and leadership in patient safety in our local NHS.

KENT, SURREY AND SUSSEX AHSN WITH WEST OF ENGLAND AND WESSEX PSCs

Care bundles reduce mortality after surgery by 42 per cent

The issue

Each year, approximately 30,000 patients in England undergo an emergency laparotomy, a surgical procedure involving an incision to gain access to the abdominal cavity. It is a high risk operation and often entails prolonged lengths of hospital stay, and high mortality rates, particularly among the elderly.



What we did

The Emergency Laparotomy Collaborative (ELC) is a two-year improvement project that aims to improve standards of care and outcomes for patients undergoing emergency laparotomy. It is run in collaboration with three AHSNs, working across 28 hospitals.

The ELC enables the adoption and spread of the Emergency Laparotomy Pathway Quality Improvement Care (ELPQuIC) bundle, which aims to improve standards of care for patients undergoing emergency laparotomies, to help reduce mortality rates, complications, and length of stay in hospital.

It consists of an initial assessment with early warning scores, early use of antibiotics, intervals of less than six hours between decision and operation, goal-directed fluid therapy and post-operative intensive care.

The programme uses:

- Early Warning Score (EWS) to identify patients most at risk of deterioration, and deliver prompt resuscitation if necessary.
- Treatment with Sepsis Six, a bundle of medical therapies designed to reduce mortality levels among patients with sepsis.
- Definitive surgery within six hours of the decision to operate, for patients at greatest risk.
- Appropriate dynamic fluid resuscitation and optimisation using goal-directed fluid therapy. This involves the administration of intravenous fluids to optimise patients' tissue perfusion, which has been shown to reduce complications and hospital length of stay, following major surgery.
- Post-operative critical care (level two or three) for all patients.

The implementation of ELPQuIC achieved a 42 per cent reduction in risk-adjusted mortality over an eight-month period. Our ambition is to scale up this improvement by implementing the bundle across 28 hospitals. The ELC will finish in summer 2017.



Image supplied by Nottingham University Hospitals NHS Trust, courtesy of East Midlands AHSN

“Structured audit in quality improvement is the way ahead for so many of the problems that patients are suffering in the NHS and in medicine in general today. We have to be multidisciplinary, we have to be multi-specialty, and it’s the very fact that we have to bring people together that can make such a huge difference for mortality and morbidity for an incredibly high-risk group of patients.”

Dr William Harrop-Griffiths, Consultant Anaesthetist, Royal College of Anaesthetists

“This project is about bringing teams of hospitals together within their Academic Health Science Networks to improve outcomes for patients undergoing emergency general surgery. People are beginning to understand the value of quality improvement for this type of complex project, which is not served very well by randomised control trials, and this offers something that hospitals can really work with to try to improve emergency surgical outcomes.”

Professor Carol Peden, Professor of Anaesthesia, and Health Foundation and IHI QI Fellow

PSC AT YORKSHIRE & HUMBER AHSN

Safety huddles reduce falls by as much as 60 per cent

The issue

Falls in hospitals are a frequent occurrence, causing pain, injury, increased length of stay, and in a significant number of cases, death. They are estimated to cost the NHS more than £2.3 billion a year. About 30 per cent of people aged 65 or older have a fall each year, increasing to 50 per cent in people 80 or older.

What we did

We worked with more than 66 frontline teams across 18 organisations in Yorkshire and Humber, including two private nursing care homes, and two general practice teams.

We supported and coached frontline teams as part of the Huddles for Safer Healthcare (HUSH) programme, which included:

- Facilitation of safety culture surveys, and feedback to staffing teams to encourage discussion of barriers and solutions.
- Support to start safety huddles, designed in conjunction with the teams to fit in with their processes.
- Planned and structured implementation of key principles using a 'stages of implementation' checklist.

The teams we worked with achieved a significant reduction of inpatient falls. Four wards reduced the combined average number of falls per week by 60 per cent.

One ward has moved from an average of one fall a week to repeatedly achieving between 30 and 60 fall-free days.



“The whole ward team has really embraced the safety huddle concept. Today we have reached the milestone of 30 days without a fall, which, given the history of falls on this ward, is really significant.”

Dr Alan Hart-Thomas, Clinical Director,
Calderdale & Huddersfield NHS Trust

PSC AT IMPERIAL COLLEGE HEALTH PARTNERS AHSN

Simple changes lead to a reduction in inpatient medication errors

The issue

The majority of patients receive and take their prescribed medication without any adverse incident. However, prescribing errors occur in one to 15 per cent of inpatient medication orders, causing a reduction in the probability of the treatment being timely and effective, or resulting in patient harm in one to two per cent of cases. One study found that 124,260 prescriptions made by foundation year doctors, across 19 hospitals over seven days, contained 11,077 errors.



What we did

Working with ten organisations across six NHS trusts in North West London, we created a prescribing improvement model to reduce the occurrence of these incidents by ensuring personalised feedback to prescribers, and improving the quality, consistency, and frequency of feedback provided by hospital pharmacists.

The steps that were taken to implement the new model included:

- Issuing attitudinal surveys providing information on perceptions pre- and post-implementation, for both prescribers and pharmacists.
- Creating an enhanced drug chart with a printed name to improve prescriber identification, where needed, locally.
- Issuing a personal name stamp for prescribers.
- Bi-annual coaching for pharmacists and annual awareness sessions for junior doctors' as part of their induction.
- Fortnightly emails to prescribers entitled Good Prescribing Tips.

We facilitated shared learning from common and/or serious medication errors. By embedding the feedback system into 'business as usual' practice across the trust, it also ensured ongoing learning across the junior doctor population rotating between NHS trusts across North West London.

Data we have gathered indicates that there has been a reduction in the prescribing error rate from 11 per cent to nine per cent across six NHS trusts.

All AHSNs work together in a medicines optimisation network, which includes medicines safety.

PSC AT OXFORD AHSN

Simple improvements lead to a 50 per cent increase in mental health service users returning to wards on time

The issue

Service users absconding from acute psychiatric wards is a significant safety issue that can have a range of negative consequences for them, their relatives, and staff.

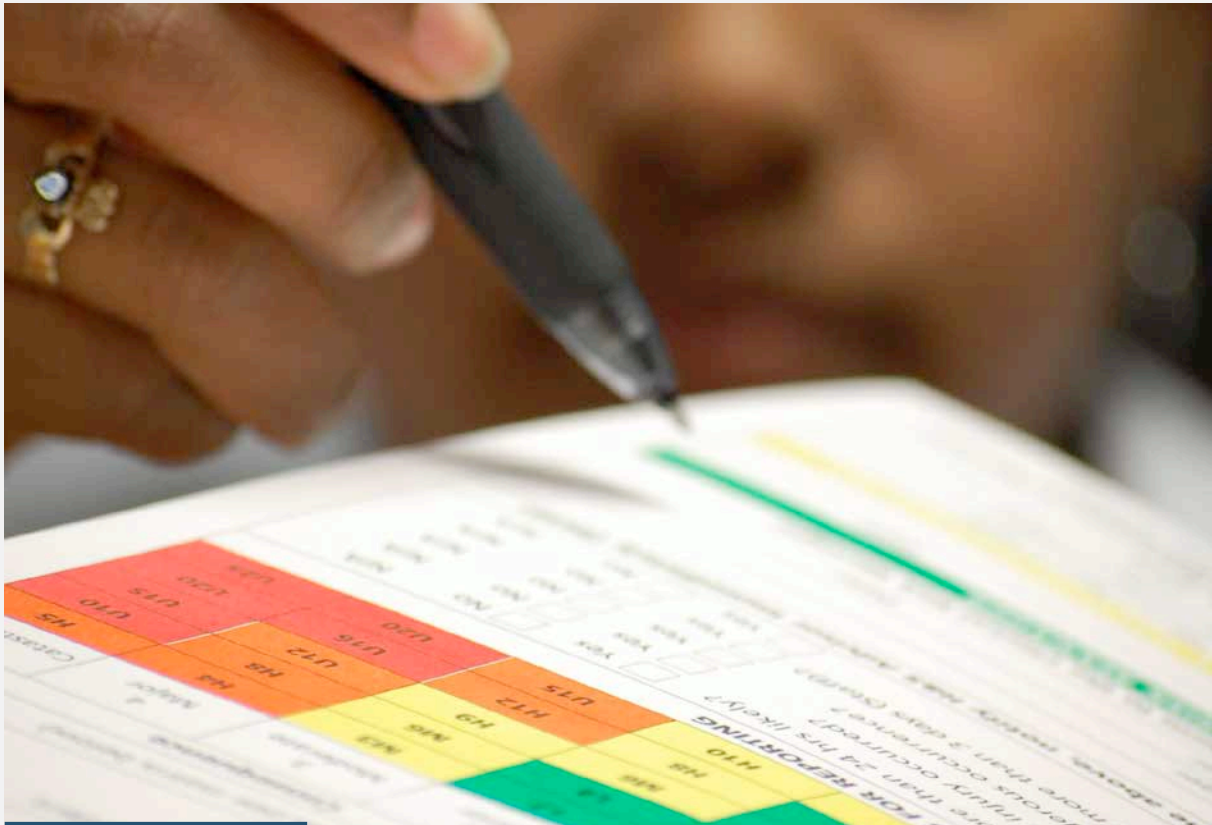
Between 2003 and 2013, 22 per cent of suicides in England occurred when a service user absconded from a mental health ward.

Service users are at greater risk of self-harm, self-neglect, missed medication and interruptions to treatment plans. Absconding incidents can also cause relatives and staff distress and anxiety, and can lead to deterioration in the relationship between staff and service users' relatives.

What we did

We set out to improve the rates of safe return of both detained and informal service users who were taking planned leave, or time away, from acute psychiatric wards. We engaged three NHS trusts within Oxford AHSN, which are all providers of both mental health and community services across large, dispersed populations.

On the lead ward, baseline data was collected over 17 weeks, and the mean rate for service users returning on time was just over half of the total number of service users returning to the ward.





We worked with ward staff to develop four tests of change, using Plan, Do, Study, Act cycles including:

- PDSA cycle 1: establishment of a signing in and out book
- PDSA cycle 2: ward phone card
- PDSA cycle 3: service user information leaflets
- PDSA cycle 4: introduction of a pre-leave form

After implementing the improvement cycles, the number of service users who returned to the ward on time increased to 87 per cent. This is an improvement of 56 per cent.

A further five wards in the Oxford Health NHS Foundation Trust achieved mean return-on-time rates of above 85 per cent.

Berkshire Healthcare NHS Foundation Trust achieved a mean of 91 per cent return-on-time rate, on its lead ward, after implementing the improvement cycles.

Central and North West London NHS Foundation Trusts are now commencing their diagnostic phase prior to implementing the improvement cycle.

This work is being shared through the mental health cluster.

“Through its understanding and passion for patient care and safety, and its drive and support for our teams, Oxford AHSN Patient Safety Collaborative has enabled the wards to achieve excellent success in implementing, maintaining and sustaining the safe return of mental health patients from leave using quality improvement methodology.”

Nokuthula Ndimande, Matron, Oxford Health NHS Foundation Trust

Shared priorities for 2016/17

PSCs have created clusters around specific themes and health issues to facilitate learning and adoption of innovation. The current priority areas include deterioration and sepsis, safer discharge, acute kidney injury, medicines optimisation and mental health.

The clusters develop local improvement metrics and expertise, build on the existing evidence base, and share the outputs of their work with the wider NHS in these key areas by:

- Creating a learning network of individuals in improvement organisations working on specific themes or health issues.
- Mapping areas of current work and creating sub-networks of common interest.
- Identifying current measurement strategies and identifying areas where a common approach would be helpful.
- Creating mutually beneficial relationships with national programmes and bodies working on specific themes or issues.
- Agreeing ways of working, such as face-to-face meetings, webinars, collaborative learning and document sharing.
- Agreeing ways of documenting learning and sharing other clusters.

National patient safety clusters

PSC	Acute kidney injury	Medicines optimisation	Sepsis and deterioration	Mental health	Discharge/transfers of care
Eastern		●	●		●
East Midlands		●		●	●
Greater Manchester		●		●	●
Health Innovation Network		●	●		
Imperial College Health Partners		●			●
Innovation Agency	●	●	●		●
Kent, Surrey & Sussex	●	●	●	●	●
North East & North Cumbria	●	●	●		
Oxford	●	●	●	●	●
South West	●	●	●	●	●
UCLPartners	●		●		
Wessex		●	●	●	●
West Midlands	●	●	●	●	
West of England		●	●	●	
Yorkshire & Humber	●	●	●	●	

● PSC priority ● Denotes lead PSC

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