The AHSN Network

NHS

Patient safety in partnership

Our plan for a safer future 2019-2025: Progress report

June 2022

Contents

The Academic Health Science Network's (AHSN Network) plan for patient safety was published in September 2019 in response to the *NHS Patient Safety Strategy: Safer culture, safer systems, safer patients*, 2019 (www.england.nhs.uk/patient-safety/the-nhs-patient-safety-strategy).

The strategy acknowledges the work of Patient Safety Collaboratives (PSCs) – commissioned through and hosted by England's 15 Academic Health Science Networks (AHSNs) – as a key improvement and delivery arm for the National Patient Safety Improvement Programmes (NatPatSIP).

Introduction

Creating the conditions for a positive culture of improvement has always been a challenge, and not just for the healthcare sector. Add in two years' disruption from the Covid pandemic and the systemic problems it has highlighted, and it can be hard to see where progress may be made.

Coupled with continued headlines about historic failures in people's care, patient safety quite rightly remains high on the agenda.

However, as we learn to live with and move on from Covid, there is also an opportunity to consider how to make our healthcare systems more robust and sustainable, and make quality improvement practices the norm.

The AHSN Network patient safety plan originally set out our commitment to contribute to the objectives of the NHS Patient Safety Strategy. Three years later it is time for a refresh.

At the same time, the network has been reviewing how it can work better together to maximise its collective impact. We have been considering our strategic purpose and ambition, so it is only right that we revisit and restate our vision and aims in the patient safety plan to align with these shared priorities.

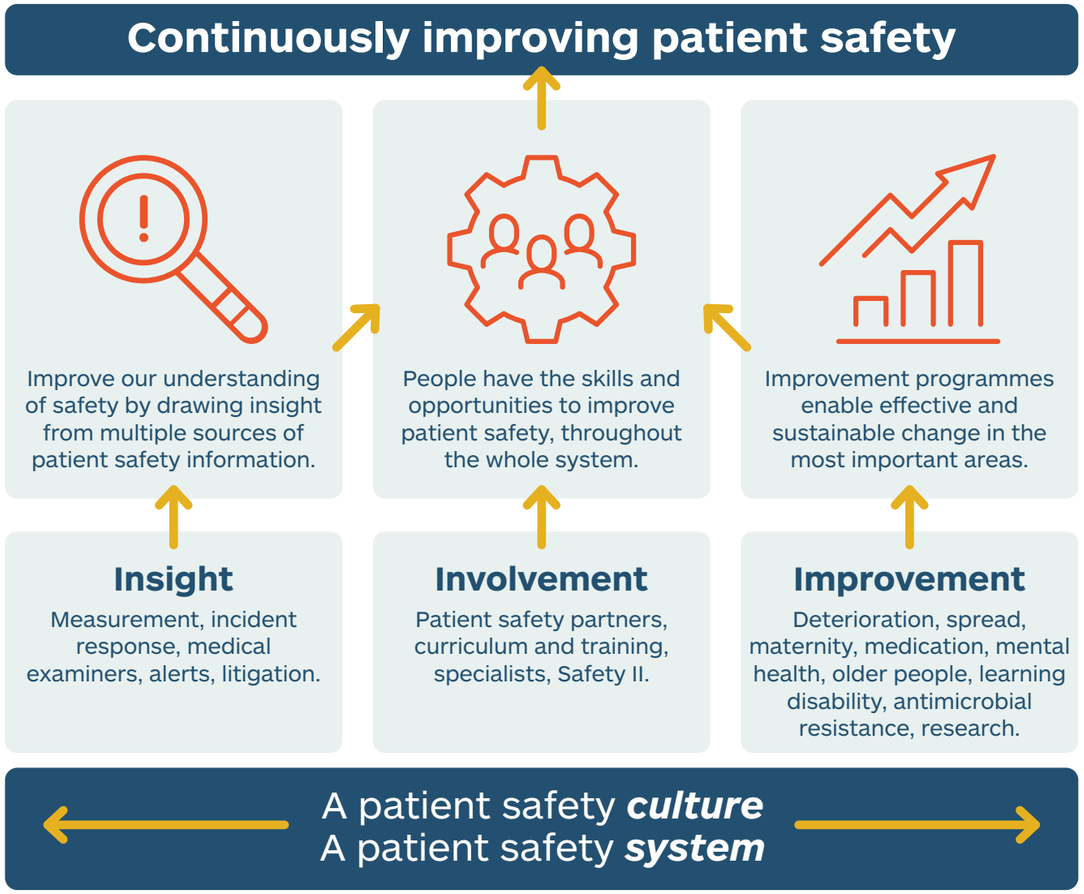
Patient safety is a cross-cutting theme of the AHSN Network strategy. In addition, each AHSN hosts a Patient Safety Collaborative, which works in its area to support teams to deliver five national safety improvement programmes, commissioned by NHS England and NHS Improvement (NHSEI).

In 2021/22, we were able to get back on track, post-Covid, to moving forward these quality improvement initiatives. In the current year, the programmes are:

- Managing deterioration in care home residents
- Maternal and neonatal safety
- Mental health safety for in-patients
- Medicines safety
- Systems safety, including a new patient safety incident response framework

Some of our successes include our work with care homes, where 58% are now reporting testing or implementing tools to help the management of deterioration; 146 mental health wards are engaged with projects to reduce restrictive practice; and 91% of hospital trusts are working on ensuring that births take place in the most appropriate setting. →

"The AHSN Network patient safety plan originally set out our commitment to contribute to the objectives of the NHS Patient Safety Strategy. Three years later it is time for a refresh."



A summary of the NHS Patient Safety Strategy (page 18)

To do this successfully we must actively involve patients, carers and the public in all aspects of patient safety work and ensure we address health inequalities. Over the last year, PSCs have set up Safety Networks, which bring together key stakeholders, including people with lived experience, to share and learn together.

Patient safety work is never finished. There is always more we can do, and developing this culture of improvement remains at the heart of the NHS strategy and our patient safety plan. We believe AHSNs are best-placed to help embed patient safety in all we do across our inter-connected landscape, and improve the safety of healthcare services for everyone.

Natasha Swinscoe
National patient safety lead for the AHSN Network

Professor Gary Ford
Chair of the AHSN Network

> To do this successfully we must actively involve patients, carers and the public in all aspects of patient safety work.

Our vision

Our ambition remains to support the delivery of the NHS Patient Safety Strategy and therefore our vision is aligned to the national strategy: **'for the NHS to continuously improve patient safety.'**

In line with the AHSN Network strategy, we will achieve this by seeking to achieve: **'a substantial increase in the adoption and spread of innovation across health and care systems.'**

The national strategy does not set a target, but looks for opportunities to be safer. It estimates that there is potential for a minimum of 928 extra lives saved and £98.5 million in treatment costs saved.

The NHS Patient Safety Strategy aims to save

1,000 extra lives

and £100 million

every year from 2023/24 excluding litigation costs

The AHSN Network is already making a significant contribution.

What have we achieved?

8,761

of 15,080 (58%) of care homes testing or implementing a deterioration management tool

146

mental health and learning disability wards actively involved with the reducing restrictive practice improvement work

7,500

carers trained on deterioration tools through our LeDeR learning disability programme

750,000+

views of our deterioration management training films for care home staff on YouTube

89%

of trusts adopting elements of the chronic obstructive pulmonary disease (COPD) care bundle

120

medicines safety champions recruited in care homes

COVID-19 outcomes

92%

of trusts implemented all three interventions of our tracheostomy programme by March 2021

100%

of CCGs in England had launched the national Covid Oximetry @home model by December 2020

96%

of acute trusts set up virtual ward pathways by March 2021

Health inequalities

The differences people face in their health and wellbeing are affected by many factors – geography, income, ethnicity, or social inclusion – and are compounded by 'unwarranted variation': disparity in healthcare services depending on where you live.

As well as access to care, there are also differences in the way patient safety incidents are experienced by patients, as explored in a paper by clinical fellow Dr Cian Wade, Action on patient safety can reduce health inequalities (BMJ, 2022).

The key observations made by Dr Wade include:

- Patient safety incidents experienced disproportionately by marginalised patient groups exacerbate health inequalities.
- Biases embedded in the healthcare system, its workforce, and medical practice drive differences in the risk of harm and can be used as an entry point for solutions to these issues.
- Viewing health inequalities through the lens of patient safety identifies an additional line of action for which healthcare professionals and systems have a clear responsibility.

Through the AHSN Network strategy's aim to 'increase the adoption and spread of innovation across health and care systems', we will increasingly focus work on those areas where there are drivers of health inequalities, as well as considering patient safety inequalities.

Delivering safer care

The AHSN Network has been working towards a unified strategy that will guide all fifteen AHSNs and their Patient Safety Collaboratives, with a common purpose, ambition and priorities.

As well as specific programmes of delivery, patient safety is a cross-cutting theme throughout the strategy. Over the following sections, this patient safety plan reflects on how our work is focused by the three strategic aims set out in the diagram below, to make a positive contribution to the aims of the NHS Patient Safety Strategy.

> "Patient safety remains a central priority and guiding principle for all AHSNs."

Our purpose

Transforming lives through health innovation.

Our ambition for 2021-26

To achieve a substantial increase in adoption and spread of innovation across health and care systems.

Our strategic aims for 2021-26

- **Multiply our scale and depth of impact through outcomes-led programmes.**
- **Building a high-impact national innovation pipeline.**
- **Establishing the AHSNs as a national authoritative voice on transforming health through the spread of innovation.**

Innovation in patient safety supports each of the aims of the AHSN Network strategy.

Strategic Aim 1

Multiply our scale and depth of and impact through outcomes-led programmes.

- **We will deliver patient safety programmes that align with Integrated Care System (ICS) priorities based on national and local drivers.**
- **We will deliver outcomes supported by a comprehensive measurement strategy that will maximise our impact across the health and care system.**

Current AHSN programmes

These three national programmes have specific patient safety outcomes. AHSNs have been working over the last two years on increasing their spread and adoption:

Focus ADHD

- Reduction in time for assessment and decision-making.
- Improved clinician satisfaction and confidence in diagnosing or excluding Attention Deficit Hyperactivity Disorder (ADHD).

Cardiovascular disease (CVD) approaches

- **Blood Pressure @home** – aiming to prevent heart attacks, strokes, and vascular dementia in patients with hypertension.
- **Lipid Management and Familial Hypercholesterolaemia (FH)** – aiming to increase detection, improve management and optimise the use of all medicines for patients on the cholesterol management pathway.

Early Intervention Eating Disorders in young people

- Reduction in the length of time young people have untreated eating disorders.
- Reduction in waiting times, day/in-patient admissions and bed days.

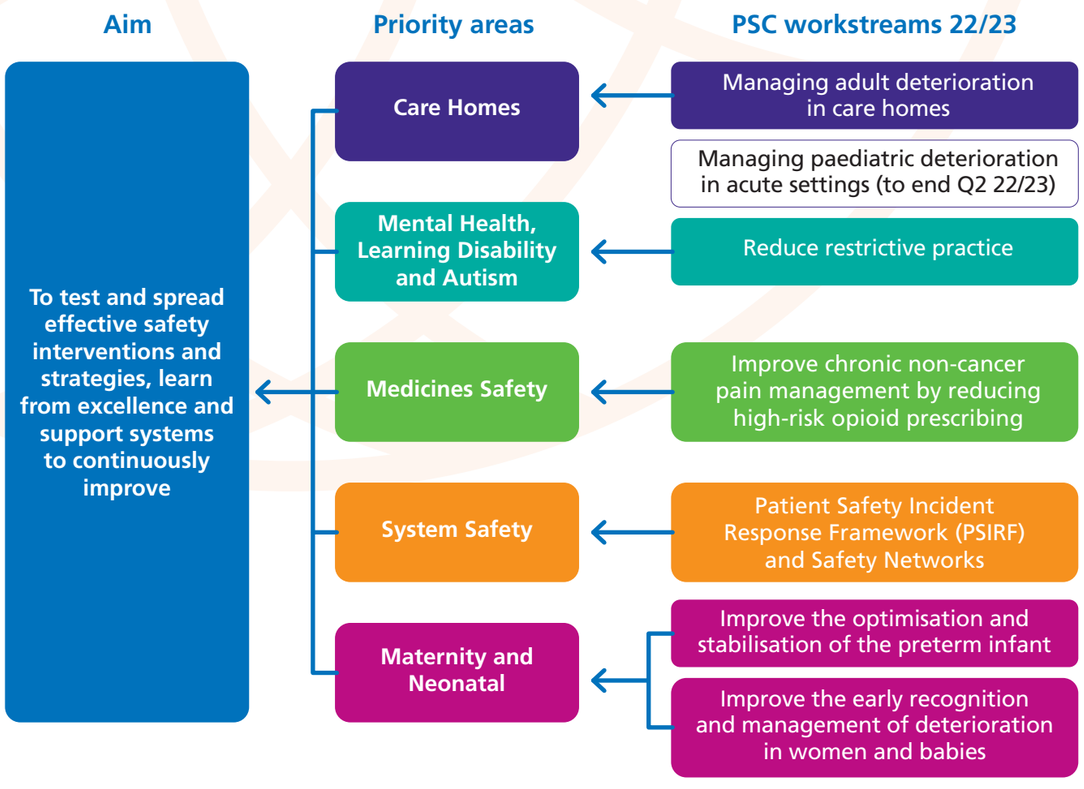
National Safety Improvement Programmes

Through the programmes commissioned by NHS England and NHS Improvement, and with development of further national quality improvement work, the AHSN Network is well-placed to make a direct and significant contribution to the NHS Patient Safety Strategy.

Our approach is that patient safety should be woven throughout our wider improvement and innovation agenda. Full integration with the AHSN Network programmes, supported by good quality improvement methodology, research and evaluation, can be sustained under the right conditions:

cultural readiness, effective leadership and building quality improvement capability.

The current programmes which Patient Safety Collaboratives are delivering in their respective AHSNs for 2022/23 are shown in the 'driver diagram' below.



Impact of the national programmes

Managing Deterioration SIP

The number of care homes that have adopted a deterioration management tool (rounded to nearest 500 homes):

Q4 2020/21 = 2,500
Q1 2021/22 = 4,500
Q2 2021/22 = 6,000
Q3 2021/22 = 8,000
Q4 2021/22 = 7,500*
Q4 2021/22 target = 9,000
CQC registered care homes = 15,000

*Q4 21/22 had fewer care homes adopted, compared to Q3

Care home staff described how the tool led to better decision-making and improved relationships with their multidisciplinary teams (MDTs) as automated data sets provided evidence of deterioration.

Maternity and Neonatal SIP

Q1 **42%** of trusts

Q4 **91%** of trusts have adopted **Place of Birth**

This improvement leads to:

1 more baby surviving for every **20** women transferred to the appropriate setting

Medicines Safety SIP

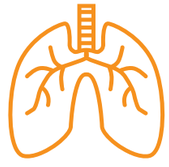
'This programme has enabled me lead our team towards a culture which prioritises safety, quality and teamwork.'

Mental Health SIP

36% of mental health and learning disability wards engaged with the reducing restrictive practice (RRP) are testing and implementing the improvement change package

Adoption and Spread SIP

COPD



89% of trusts have adopted elements of the COPD care bundle.

79% of sites reported to have adopted all elements of the COPD care bundle.

Asthma

60% of trusts have adopted the asthma care bundle.

Maternity and neonatal optimisation of the pre-term infant

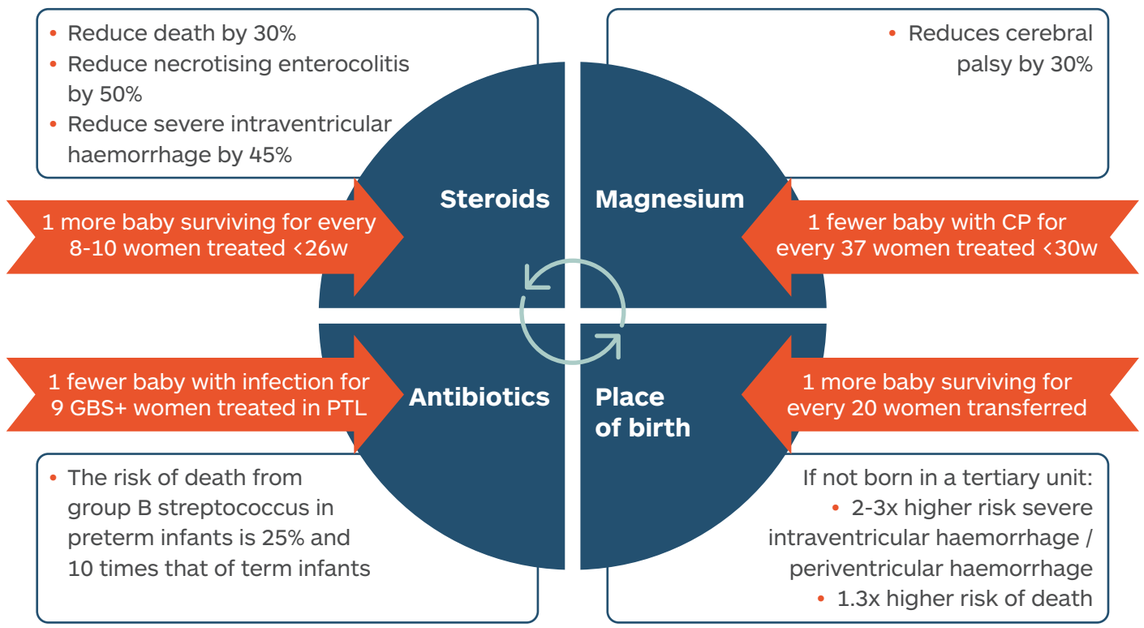
Maternity is a clinical theme within the AHSN Network strategy, and with the recent reviews of maternity services in England, this has focused the need for improvements for the care of women from conception to birth.

Inequalities in maternal and neonatal health persist. In 2018, more than one in four of all live births in England and Wales were to mothers born outside the UK, and 13% of all babies born in 2013 to 2017 belonged to a black, Asian or minority ethnic group.

Although it is important to recognise that even in these groups, maternal and neonatal death is rare, the differences are significant, with black women five times more likely to die during pregnancy, and Asian or Asian British babies having a 73% increased risk of neonatal death compared to white babies. Mortality figures are the 'tip of the iceberg', indicating a higher level of morbidity according to data from the latest MBRRACE-UK report, *Saving Lives, Improving Mothers' Care*.

Disproportionate outcomes in preterm birth, perinatal mental health, and hospitalisation from COVID-19 have all been found. The causes of poorer outcomes for women and babies from certain communities are multifactorial, and more research is needed to better understand the contributory factors.

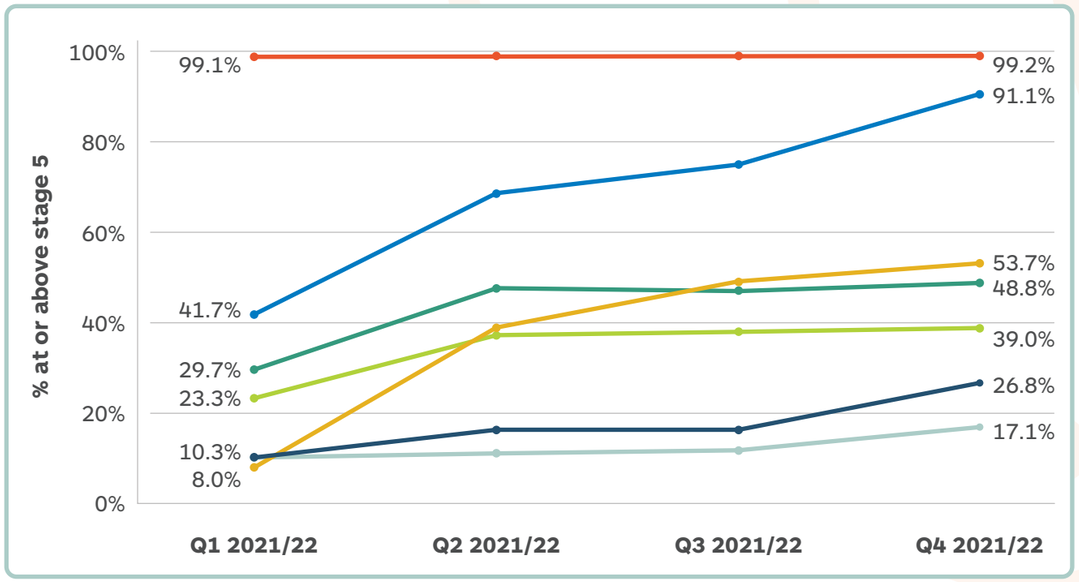
Core20PLUS5 is a national NHS England and NHS Improvement approach to support the reduction of health inequalities at both national and system level. The approach defines a target population cohort – the Core20PLUS5 – and identifies five key clinical areas requiring accelerated improvement. Improving continuity of care for mothers in black, Asian and minority ethnic communities is one of the five clinical areas.



Babies who are born preterm (especially those born before 34 weeks), contribute significantly to the overall neonatal death and brain injury rates in England.

The Maternity Transformation Programme (MTP) is supporting a national ambition to reduce these significant harms alongside reductions in stillbirth rates, maternal mortality and preterm birth.

The MatNeoSIP has developed a seven-element care pathway in partnership with the British Association of Perinatal Medicine, The Royal College of Obstetricians and Gynaecologists, The Royal College of Midwives and others. The diagram below shows how Patient Safety Collaboratives have been helping increase their uptake over the last year.



- Magnesium sulphate
- Place of birth
- Corticosteroids
- Normothermia
- Optimal cord management
- Antibiotics
- Maternal breast milk

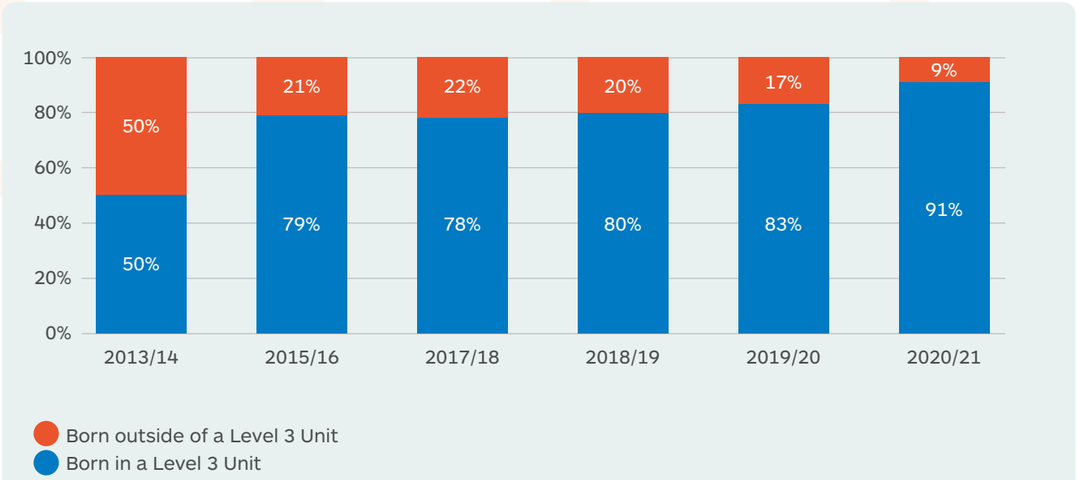
- With the uptake of magnesium sulphate at 99%, the next highest is Place of Birth, which increased the number of trusts achieving the highest stage of adoption (stage 5) from 41.7% in Q2 21/22 to 91.1% in Q4 21/22.
- Another significant increase in adoption was the use of corticosteroids, which increased to 53.7% of sites.
- Maternal breast milk and antibiotics are the least mature, with 17.1% and 26.8% of trusts at adoption stage 5 or above respectively.

Maternity and neonatal optimisation in practice

The Oxford AHSN Maternity Network brought together stakeholders from across the region to work together so that more extremely premature babies are born in a Level 3 unit, with a region-wide package of improvements put in place.

This required a significant shift in working practices, from making decisions based on availability of beds/staff, to focus on the risks for the mother and baby.

The initiative led to an increase in extremely preterm babies born in a Level 3 unit from 50% to 91%. It is estimated that the lives of four more extremely premature babies are being saved every year, a 5% increase.



PERIPrem care bundle

National child mortality data show that 69% of infants who died under a year old were born preterm. Maternity and neonatal professionals are working to cut instances of mortality and serious brain injury in half by 2025, in line with the NHS long-term plan.

PERIPrem is a care bundle of eleven interventions, which range from optimal cord clamping to offering mothers magnesium sulphate, which reduces the risk of the baby developing cerebral palsy later in life.

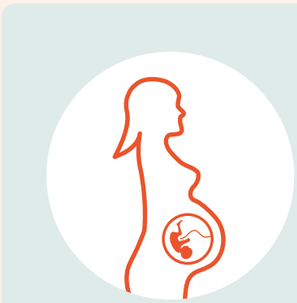
The bundle was developed by the West of England and South West Academic Health Science Networks. In partnership with the South West Neonatal Network, every maternity and neonatal unit in the region, along with parent groups, has helped design and test the care bundle.

The PERIPrem bundle has four additional elements to the optimisation bundle focusing on neonates. This extended bundle is being trialled in the South and West of England as a pipeline programme for the AHSN Network.

Examples of AHSN pipeline projects which became a national programme of work include:

- **Place of birth** – originated as a local innovation, which has now spread to 75% of trusts and become part of the national pre-term optimisation bundle.
- **PReCePT (Prevention of Cerebral Palsy in PreTerm Labour)** – has been sustained after 12 months, woven into policy and NICE guidance.

Find out more about the PERIPrem care bundle.



22%

reduction in mortality, which if scaled up nationally would mean **220** fewer preterm babies dying per year.

Enhanced Health in Care Homes

The primary aim of this commission from NHS England and NHS Improvement was to support care home staff at scale, to identify early soft signs of deterioration in residents and enable them to communicate with multi-disciplinary teams and take early action.

Enhanced Health in Care Homes (EHCH) is an implementation framework through which NHS services work in partnership with care home providers and local authority services to develop new models of care and support for older people.

Since Q4 2020/21, ManDetSIP work has resulted in a

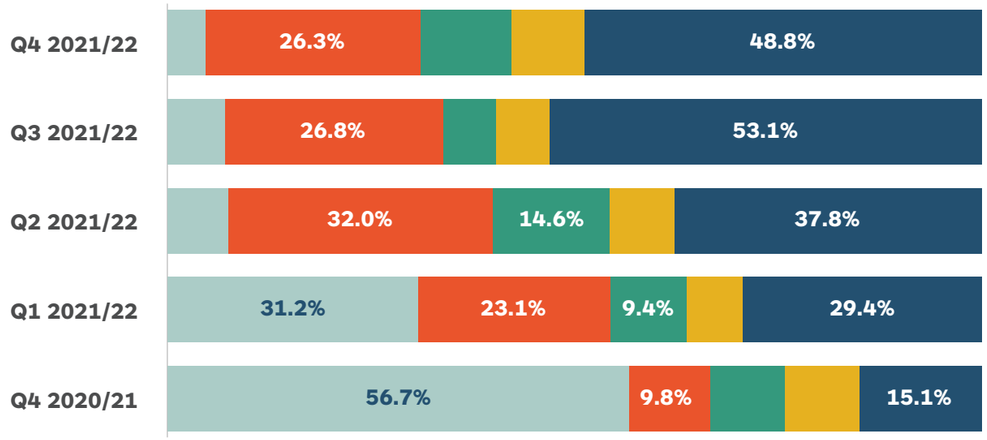
216%

increase of care homes using a deterioration management tool.

8,761

of 15,080 (58%) of care homes in England were at the testing or implementation stage or above for tools including RESTORE2, RESTORE2*mini*, NEWS2, SBAR(D) and soft signs.

Bar chart showing change in stage of adoption



- Stage 0: No Contact
- Stage 1 & Stage 2
- Stage 3: Decision
- Stage 4: Testing and implementation
- Stage 5 and above

An evaluation of one of the tools used in care homes, RESTORE2*mini*, showed that care home staff:

- Loved receiving teaching.
- Appreciated being able to share experiences with colleagues.
- Found that the training validated concepts that they had developed for themselves.
- Believe the training will give them confidence to 'speak up'.
- Found the training started to give them a professional language for talking to health professionals.
- Thought that RESTORE2*mini* would be useful.

RESTORE2
Recognise early soft-signs, Take observations, Respond, Escalate

EHCH in practice – West Midlands

West Midlands Patient Safety Collaborative (WMPSC) designed and delivered an improvement programme to upskill and empower the care home workforce to recognise and respond more effectively to residents showing signs of deterioration.

In 2021/2022, WMPSC scaled up a successful managing deterioration support programme to over 1,257 homes with over 37,700 residents – 76% of the region's total. The care homes engaged are now implementing or have adopted deterioration management tools within their care home settings.

Outcomes

- Deterioration networks established in all six of the region's ICSs.
- 636 GP practices trained in the use of deterioration management tools across four ICSs, with 331 GP practices actively testing deterioration management tools.
- 100% of community trusts and mental health trusts are now using deterioration management tools in the West Midlands.

Supporting carers of people with a learning disability

The 2020 LeDeR report (Learning from Deaths of people with learning disability Report), showed that people with learning disabilities are six times more likely to die from COVID-19. AHSNs have been working in their areas to build the capability of care staff to spot when the health of people with a learning disability may be deteriorating.

- **Wessex** and **West of England AHSNs** were commissioned by NHSEI to design a tool, training package and tailored videos to support deterioration management in care homes.
- Building on their existing Learning Disability Collaborative, which has over 300 members, **West of England AHSN** delivered RESTORE2, RESTORE2*mini* and 'train-the-trainer' sessions remotely to care homes during the pandemic. Co-created with supporting organisations, carers, and people with lived experience of a learning disability, the result was 7,500 carers trained and 105 care providers receiving training care for people with a learning disability.
- The **East Midlands** and **West Midlands AHSNs** are working with local authorities and health colleagues in four pilot sites, with people with learning disabilities and their families, to test and trial new tools, tech and processes. The pilot will provide evidence to help improve care and outcomes for people with learning disabilities who reside in supported living environments. At the end of the pilot, the aim is to recommend an existing, evidence-based product, methodology or tool that can be scaled up and rolled out nationally.

COPD and asthma

Through the national Adoption and Spread Safety Improvement Programme, Patient Safety Collaboratives worked to spread evidence-based practice, including discharge care bundles for asthma and chronic obstructive pulmonary disease (COPD). The programme ended in March 2022 and achieved the following impact:

COPD

- Percentage of admissions receiving all elements of the discharge care bundle increased from 9% at the end of 2018/19 to 24% at the end of 2021/22.
- The number of additional admissions benefitting was over 1,000 (for the entire bundle), since the programme began in Q1 2019/20.

Asthma

- Percentage of admissions benefitting increased from 37% in 2019/20 to 50% in Q4 2021/22, with an average of 47% across the 15 AHSNs for 2021/22 YTD.
- Over 600 admissions received the entire bundle over baseline, since the improvement programme began in Q1 2020/21.

Outcomes

South West AHSN supported Royal Cornwall Hospitals NHS Trust with bespoke quality improvement support and coaching, increasing their implementation of all elements of the COPD care bundle from zero to 46%, despite the pandemic.

In the Kent Surrey Sussex area, improved outcomes were recorded from 2014/15 to 2018/19, during which COPD care bundle compliance:

- Reduced average length of stay from 5.7 days to 4.8 days
- Reduced regional in-patient mortality from 4.49% to 3.67%

Strategic Aim 2

Building a high-impact innovation pipeline to support economic growth.

- **We will work with our partners to identify and develop local innovations that improve safety.**
- **We will test, evaluate and spread innovations that have the potential to reduce harm and improve safety.**

Our connections to academia include Patient Safety Research Centres (PSRCs) and the Applied Research Collaboratives (ARCs), with whom we have a joint AHSN/ARC post. They help to both identify the evidence and research that can lead to new programmes of work for piloting and testing, and also to evaluate those programmes in small 'test of change' areas before they are ready for wider adoption.

New AHSN programmes

These two new, national programmes have specific patient safety outcomes, and are underway with the aim of increasing their spread and adoption:

Polypharmacy

- Increasing use of Polypharmacy Prescribing Comparators to identify and prioritise patients for a shared decision-making Structured Medication Review.
- Increasing confidence amongst the primary care prescribing workforce to safely stop medicines identified to be inappropriate or unnecessary.

Lower limb wound care

- In five years, we can expect 30% reduced leg ulcer prevalence each year.
- Reduced admission to hospital.

In addition, there are

189

local initiatives which have been logged by individual AHSNs which have a patient safety and quality improvement priority – this is the largest group in our local impact tracker.

HSJ Award winner

COVID Oximetry @home and virtual wards: AHSN Network (2021)

HSJ Patient Safety Award winners

Primary care and COVID Oximetry @home: North East and North Cumbria AHSN (2021)

PreciSSIon (surgical site infection): West of England AHSN (2021)

PERIPrem (maternity and neonatal): West of England AHSN and South West AHSN (highly commended, 2021)

PReCePT (maternity and neonatal): ICHP (2020), West of England AHSN (2019)

RESTORE2 (managing deterioration): Wessex AHSN (2020)

BSOTS (maternity and neonatal): West Midlands AHSN (2020)

Maternity services: Oxford AHSN (2020)

LPZ (care homes): East Midlands AHSN (2019)

SoS Insights Dashboard (managing deterioration): Imperial College Health Partners (2019)

Maternity triage

Unlike mainstream emergency medicine, there is currently no standardised triage system within maternity for unscheduled appointments.

The Birmingham Symptom-specific Obstetric Triage System (BSOTS) was co-produced in 2013 by midwives and obstetricians from Birmingham Women's and Children's NHS Foundation Trust and the National Institute of Health Research Applied Research Collaboration.

Through BSOTS, the number of women seeing a midwife within 15 minutes of arrival increased from 39% to 54%. Over 40 maternity units have implemented BSOTS and a further 25 have been trained.

It's estimated that if BSOTS was implemented in all the maternity units in the UK, over two million women may be seen sooner and assessed in a standardised way.

2 million

women could benefit

7

PSCs are now working on spreading BSOTS

B	Birmingham
S	Symptom-specific
O	Obstetric
T	Triage
S	System

Evaluation by NIHR CLAHRC West Midlands demonstrated that BSOTS:

- Significantly improved number of women assessed with 15 minutes of arrival (particularly red/amber)
- Is likely to improve safety for women and babies
- The system has strong inter-rater reliability suggesting it offers a reliable method of triaging women
- All the midwives reported that BSOTS training had improved their knowledge and confidence

This maternity triage system has now spread from the West Midlands to other AHSNs demonstrating the potential to scale up evidence-based innovations through our networks.

Reducing restrictive practice

Restrictive interventions may be used with in-patients of mental health and learning disability services, where there is a need to take immediate control of a dangerous situation, or a risk of harm to the person or others if no action is taken.

The Mental Health Safety Improvement Programme has been working with wards to help them reduce how often they use restrictive practice, and will increase its focus on this over the next year. The programme is working with the National Collaborating Centre for Mental Health (NCCMH) and Patient Safety Collaboratives, which have created Safety Networks to support improvements, often with the insight of people with lived experience.

Expected outcomes:

- Reduce incidents of restrictive practice.
- Reduce number of rapid tranquilisations.
- Reduce length of stay in seclusion.
- Reduced staff injury.

Expected impact:

- Improved service user experience.
- Improved staff morale/ experience.
- Better utilisation of services.
- Reduced self-harm/ suicide rates.

So far, the programme has engaged with 92 mental health wards and 19 learning disability wards.

146

out of 252 (58%) mental health and learning disability wards have engaged with the programme so far.

97

wards are testing or implementing the quality improvement methodology.

Opioid use for non-cancer pain

Over half a million people in England are prescribed opioid analgesia for longer than three months, the majority having chronic pain that is not associated with cancer. Opioids are highly effective and, when used judiciously, are of great benefit to many people living with pain. However, in the case of 'chronic non-cancer pain', when the source of long-term pain does not have a cause that can be treated, opioids can do more harm than good, particularly when used at higher doses.

At the end of 2021/22, a real-world intelligence gathering exercise was undertaken by PSCs, which analysed 112 case studies across England. These resulted in the pathway shown below, which gives the strength of evidence for interventions at each of the five stages.

Outcomes

- Kernow CCG in Cornwall, as part of their system-wide programme, achieved an 18% reduction in total oral morphine equivalent prescribing over three years (with a 28% reduction in high-dose patients), leading to a reduction on their £3.3m annual spend of £594,000 per annum.
- Gloucestershire's system-wide 'Living Well with Pain' programme, which included a primary care 'risk mitigation programme', resulted in 308 out of 762 high-risk patients (40%) supported to reduce or stop their pain medication.

Prevent Initiation	De-escalate	Find chronic use	Treat (taper & support)	Sustain
Moderate evidence found	Minimal evidence found	Significant evidence found	Significant evidence found	Moderate evidence found

The pathway that emerged from the analysis identified five stages

Remote monitoring technology for care homes

New technology is helping to gather and communicate information about care home residents, when their condition deteriorates. Solutions like Whzan Blue Box help care home staff monitor residents' health and mobility by measuring vital signs, recording photos, performing assessments and using questionnaires. These provide a National Early Warning Score (NEWS2), which can be shared with health professionals to help determine next steps.

- Supported by UCLPartners, five integrated care systems in London joined forces to expand the use of remote monitoring technologies in care homes, in partnership with six different technology providers. As of June 2021, 4,500 residents and over 600 care homes have benefited.
- Eastern AHSN is running an Innovate UK pilot across the region, connecting care homes using Whzan Blue Box. They have reached 148 homes including those providing learning disability care. They designed a dashboard to monitor usage, and have created a community of practice to capture system learning and return on investment.

Feedback has shown that time delays have been reduced due to the training and usage of the tools and equipment in homes and part of the wider MDT, and overall staffing costs reduced. Staff feel empowered to escalate concerns and more confident when residents feel unwell.

A recent independent study by NENC AHSN showed eight care homes saved more than

£756,000

in emergency services costs over one year by using Whzan Blue Box, including:

22% reduction in 999 ambulance requests

35% reduction in unplanned GP visits

50% reduction in 111 calls

Identifying common care issues

Landelijke Prevalentiemeting Zorgkwaliteit or LPZ (National Prevalence Measurement of Quality of Care) originated in The Netherlands and is an internationally renowned annual independent audit for the measurement of care quality.

LPZ uses an audit tool to help care homes measure the prevalence of common care issues (such as deterioration, pressure ulcers, continence, nutrition, falls, restraint and pain).

East Midlands PSC supported participating care homes to interpret the results and use the findings to put quality improvement measures in place and enable them to track their progress year-on-year.

A recent paper from Adam Gordon, Professor of the Care of Older People, University of Nottingham, shows that LPZ is associated with a fall in incidence of pressure ulcers, such that related savings to the NHS would be in the region of £207.56 per resident, equating to £87.2m across the 420,000 care home residents in England with respect to this condition alone.

Safe Steps

205
Health and care organisations

36,552
Risk screenings

28%
Falls reduction

20%
Fewer falls-related ambulance callouts

Our partnership working with care homes has helped us to make progress in reducing and preventing falls. There is significant potential for us to capitalise on this nationally by aligning activity and resources with the wider AHSN Network and the frailty programmes AHSNs are invested in.

One example is Safe Steps, a digital health app designed to help reduce falls for older people living in care homes. Safe Steps is currently live in over 200 care homes in and around the North West. It has also been trialled at a 95-bed intermediate care unit in Tameside where it was used almost 3,000 times by 46 members of staff to prevent falls on the unit.

The tool measures 12 key risk factors based on NICE guidelines and provides a personalised action plan with evidence-based recommendations to reduce falls risks. Initial evaluations over 12 months indicated a 21% reduction in falls and a 20% reduction in ambulance service call-outs.

In response to COVID-19, health and care professionals from Greater Manchester have worked with Safe Steps to develop a UK-first digital innovation that helps care homes to track the disease. The tool allows care home staff to input information about a resident's COVID-19 related symptoms into a tracker, which can be shared directly with the resident's GP and NHS community response team, to ensure that a swift assessment and response can be put in place.

Find out more about Safe Steps.

SAFE STEPS
PREVENTING FALLS • IMPROVING LIVES

Strategic Aim 3

Establishing the AHSNs as an authoritative voice on transforming health through the spread of innovation.

- **We will continue to develop partnerships in the safety domain where we can influence, offer expertise and share our work.**
- **We will strengthen our place in the system as recognised patient safety experts.**

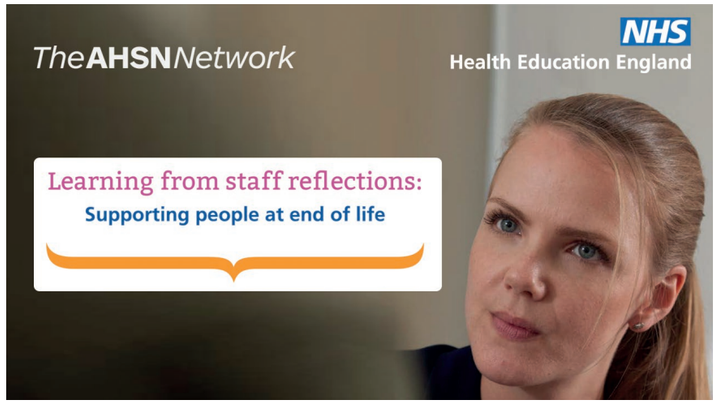
We work proactively with a wide range of stakeholders to help influence the patient safety agenda, shown in the diagram below. AHSNs also work closely with their local health and care systems at a strategic level, and Patient Safety Collaboratives convene Safety Networks to work together on the delivery of the national safety improvement programmes.

Supporting people at the end of life

Learning from staff reflections: supporting people at end of life is the result of a project commissioned by Health Education England, which was delivered by the AHSN Network.

It explores how patients and families are supported around the time of death, and examples of good practice from healthcare organisations across England.

The project took a novel approach by employing two Patient Safety Fellows to gather evidence and learning. They engaged with over 200 staff from over 40 healthcare organisations to understand what was working well, and where there were gaps in bereavement support.



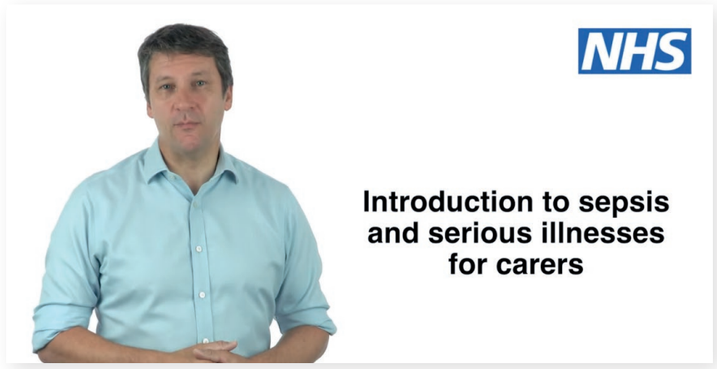
Professor Bee Wee, National Clinical Director for Palliative and End of Life Care, wrote this blog supporting the findings of the report.

> Open and honest communication is essential for patient safety.

Training for care home staff

We created a training programme for care home staff, including a series of 21 training videos aimed at those who care for residents at risk of deterioration, with seven videos specific to learning disability services.

The films are around three minutes each and describe how to take measurements from residents correctly (such as blood pressure and oxygen saturation), how to spot the soft signs of deterioration, and prevent the spread of infection.



The videos have so far collectively received over 750,000 views.

They were produced in 2020 as a collaboration between Wessex and the West of England AHSNs and Hampshire, Southampton and Isle of Wight CCG, and funded by Health Education England.

Meeting the workforce challenge

The NHS workforce in England is in crisis: urgent action is required to tackle a cycle of shortages and increased pressures on staff, which has been exacerbated by the COVID-19 pandemic.

The AHSN National Workforce Programme focuses on workforce productivity through projects centred on one or both of the following:

- pathway redesign; and/or
- innovation including digital, technology or artificial intelligence.

AHSNs are well-positioned as a part of the NHS response to this challenge, by demonstrating how innovation can drive efficiencies and improvements in ways of working, resulting in an upskilled workforce, and giving back more time for care.

Improved patient safety outcomes form part of this approach, such as:

- COVID Oximetry @home: using pulse oximetry to help people at risk from Covid to monitor their health safely at home.
- Whzan: tools to allow care homes to collect and share information about the health of their residents (see page 26).
- Digital care for care homes: testing approaches to implement a digital care record for residents.
- SPACE: strengthening safety culture in care homes, through training and workshops (see below).

Moving forward, we will recognise workforce considerations in everything we do, and take the opportunity to identify, classify and measure workforce impacts for all existing and pipeline projects across the network, including patient safety.

SPACE quality improvement training

SPACE (Safer Provision and Care Excellence) was originally a two-year large-scale quality improvement (QI) pilot programme in 35 care homes across the West Midlands sponsored by the West Midlands Patient Safety Collaborative.

It aimed to upskill care home staff through training them in basic QI techniques and methodologies which empower staff to identify solutions to common problems within their care settings.

Improvements following the SPACE programme included:

- A downward trend in recorded falls.
- A reduction in the number of more severe pressure ulcers.
- Significant improvement in safety culture and in uptake of quality improvement methods.
- Significant uptake of staff led initiatives.

Initially 105 of the region's care homes took part in the training.

It has now been taken forward as part of the PSC's managing deterioration work, and they have trained 718 care homes in deterioration management tools, drawing on the quality improvement principles of the SPACE programme.

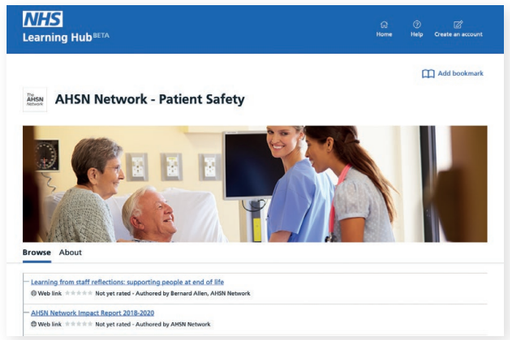
Find out more about SPACE.

Learning Hub

As well as formal training modules on Health Education England's e-learning for healthcare portal, we have launched a channel of patient safety resources on their new Learning Hub.

This digital platform provides easy access to a wide range of education and training resources for the health and care workforce, and is designed to be the place to find, share, discuss, review and collaborate on education, training and learning resources across sectors.

Users can contribute digital resources (including e-learning, video, audio, images, documents, web links, articles) and search, access and rate the learning resources that have been contributed by stakeholders and the health and care workforce.



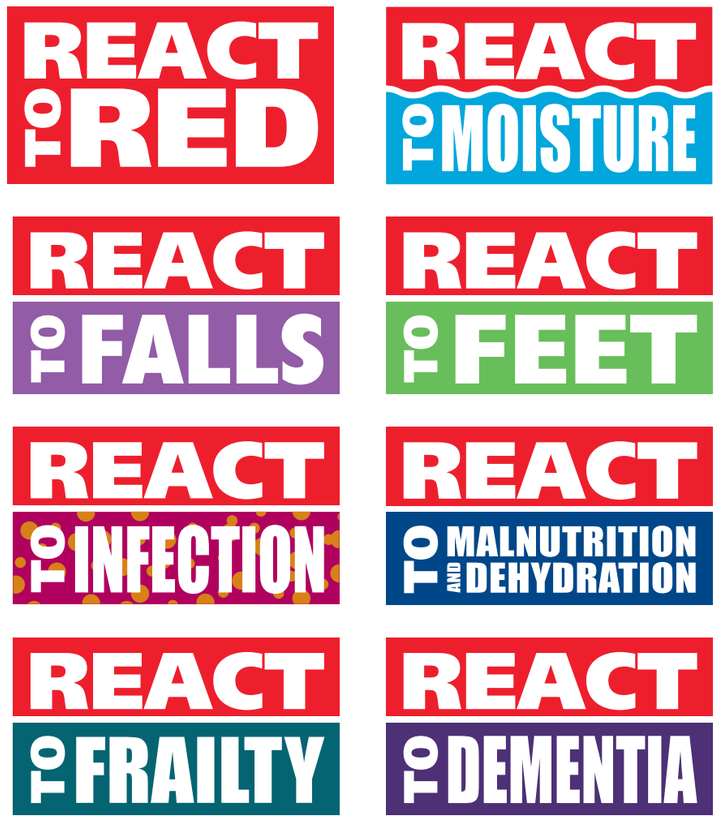
View the catalogue of resources on the Learning Hub.

REACT TO

AHSNs have developed a number of resources and products which support multi-disciplinary training such as The REACT TO series of training resources for care homes. These are available free of charge on the REACT TO website.

East Midlands AHSN, with funding from the Health Foundation, has been working with a small group of care homes from across the region to develop a React to Quality Improvement resource, which will be launched in October 2022.

The React To series has also been translated and used with international partners through the East Midlands AHSN's LPZ care home project (see page 26).



Conclusion

Delivering patient safety together

Patient safety must continue to lead the agenda in these changing times. As we have shown in this update, the extraordinary range of AHSN Network projects happening all over the country is not only making care safer, but is also having a positive impact on the recovery from coronavirus, and helping to reduce demand on services in general practice and acute trusts.

While patient safety requires a specific set of skills and capabilities – which Patient Safety Collaboratives work to spread in their areas – the real power of this methodology is in bringing teams and organisations together to work on shared challenges.

Its principles of quality improvement, developing a positive safety culture, building capacity and capability, and addressing inequalities provide a framework where continual improvement becomes the norm, keeping patients' needs at its core and involving them in meaningful ways.

AHSNs have always been the 'connectors' in their areas as trusted system partners. We bridge the national and regional with the local, and help make sense of the innovation landscape. Increasingly, we are shaping our priorities around those of Integrated Care Systems and the new Integrated Care Boards, and strengthening our relationships with wider system partners, such as local authorities, care providers and Primary Care Networks.

PSCs remain a major delivery partner for the NHS Patient Safety Strategy. This constantly evolving and dynamic relationship will see us work on a new systems safety programme over the coming year, and move towards a new operating model for 2023/24 onwards.

Meanwhile, AHSNs continue to develop a pipeline of innovations that have the potential to positively impact patient safety. Our ambition is for the AHSN Network strategy to build on the progress we have made so far and increase the patient safety benefits of our collective work.

There is always more to be done, particularly to refocus on safety culture despite the many challenges of the last two years of the pandemic. However, we know there is a huge amount of enthusiasm and dedication among the many health and care professionals we support, and through this patient safety plan we look forward to working with our partners to make a difference.

To find out more and get involved, contact your local Academic Health Science Network.

Acknowledgements

This plan was created in 2019 and has been updated in consultation with many internal and external stakeholders. It represents the ambition of all 15 AHSNs as a national AHSN Network. We would like to thank everyone who has contributed and shared their work for this update.

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