National Patient Safety
Improvement Programmes

National
Programmes

National Patient Safety Improvement Programme

Q4 2022/2023

Progress Report

@NatPatSIP / @MatNeoSIP

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Delivered by:
The AHSN Network

Led by:
NHS England

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Executive Summary

Managing Deterioration Safety Improvement Programme

The adoption of tools by care homes to support their management of residents when they deteriorate continues to take place across complex healthcare systems. In this quarter Patient Safety Collaboratives (PSCs) have reported further increases in decision, adoption and sustainability of deterioration management tools in care homes across England. This includes:

- 77.6% of care homes having committed to and/or actively training in the use of a deterioration management tool – totalling 11,621 homes.
- 61.2% of care homes in England are reported to have adopted a deterioration management tool – meaning regular use whilst building to full scale spread and sustained use across all parts of the organisation. That equates to 9,164 care homes in England.
- 19.9% of care homes are reported to have sustained the use of tools across their organisations for 12 months or more. This reflects sustainability in 2,984 care homes.

This quarter has seen continued engagement. PSCs have facilitated deterioration focused network events and have collaborated with key system stakeholders to align interdependencies and accelerate the pace of change. Focused work is taking place to develop sustainability plans for the ongoing training and adoption of deterioration management tools. Whilst some PSCs have identified a process for transition and handover of work to ICS, this has not yet been possible in some areas where ICS are still establishing and recruiting to roles. PSCs are continuing to map and validate deterioration escalation pathways and work with teams to agree new ways of working.

Analysis and modelling based on data provided by the West Midlands PSC and Q4 submissions has further demonstrated the potential impact of care homes adopting deterioration management tools could have on key outcome measures.

Maternity and Neonatal Safety Improvement Programme

Optimisation and stabilisation of the preterm infant: Significant improvement continues to be made in all seven interventions on the pathway. This can be demonstrated by local/regional data analysis, illustrating improvement over time as per figure (5, 6, 9, 10, 11, 12). We can see a correlation in improvements in adoption and spread (A&S), to process level data and outcomes.

Preterm Optimisation – Improvement was seen in the adoption and spread (A&S) of each intervention moving from stage 4 of implementation to stage 5 adoption in all Trusts. Nationally, each individual metric has achieved this ambition of over 65% achieving stage 5, (figure 5). However, the overall ambition for Q4 did not reach the national ambition of 65% since some Trusts were at an A&S stage of 4.

Biggest Improvements seen in adoption and spread

- Antenatal Corticosteroids from 41% in Q2 21/22 to 93% at end of Q4 22/23
- Maternal Breast Milk from 12% in Q2 21/22 to 74% at end of Q4 22/23
- Intrapartum antibiotics from 17% in Q2 21/22 to 75% at end of Q4 22/23

To note of this increase maybe due to some AHSNs previously under reporting.

Data taken from Clevermed shows national improvement with Optimal Cord Management from a baseline of April 2020, 33% improved to 61% March 2023. **These data cover 83% of the country*

Early recognition and management of deterioration of women and babies:

- NEWTT2 was published by BAPM in January 2023 following agreement by the representative stakeholder group.
- MEWS Phase Two, Part Two completed. This had focussed on higher acuity areas such as labour ward and triage.
- PSCs have continued to support further testing and implementation of the Each Baby Count Learn and Support toolkits to align with the PIER framework.
- Organisations identified to commence implementation in Q1 2023/24.

Medicines Safety Improvement Programme

- 19 ICBs/ ICSs were working with Patient Safety Collaboratives (PSCs) through Quality Improvement in Q4. Of these, 10 are in Phase 6 – Action.
- We await the end of year data from NHSBSA (expected early June 2023) that will provide national outcome data up to end of March 2023. This update will correct any boundary changes as well as include updates such as the second national outcome metric (High Dose).

Mental Health Safety Improvement Programme

The MHSIP now has 98% of all eligible NHS MHLDA Trusts involved with the programme, either supported directly by PSCs or involved through the mental health patient safety networks.

261 wards across England are actively engaged in the MHSIP RRP work, including wards across NHS MHLDA Trusts, as well as all of the major private providers of NHS-funded mental health inpatient services.

Nationally, the programme is directly supporting 13% of all wards in MHLDA NHS Trusts in England to utilise the RRP change package. The programme is already exceeding the 22/23 commission target of 10%.

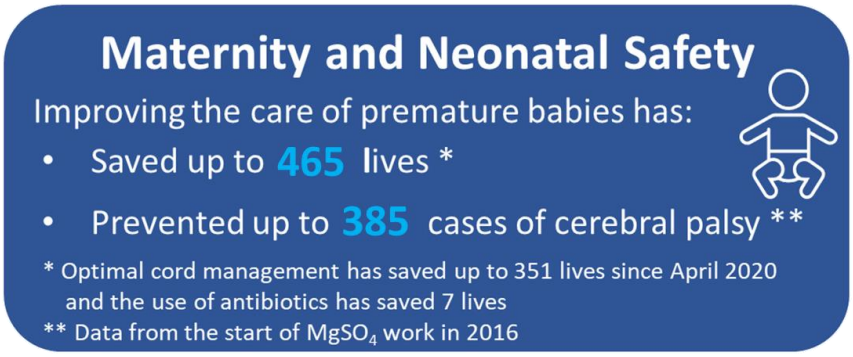
Systems Safety

- In In Q4, all 15 PSC teams continued their engagement with the ICSs and providers in their area especially the Quality and safety leads, Chief Nurses, Patient Safety Specialists, amongst other stakeholders to support the System Safety workstream deliverables over Q4.
- PSCs have engaged with all 42 ICSs in England to support the System Safety work via learning events, webinars and resource sharing. There is variation in terms of the level of engagement and PSIRF phase completion depending on local pressures and priorities. No quantitative data (phases completed by Trusts) is being collected via the QART dashboard mainly to enable systems to progress at their pace, but with a vision for all NHS provider Trusts to transition to PSIRF by Autumn 2023.
- System safety co-ordinators from the PSCs contributed to and participated in the NHS England led PSIRF Regional Implementation group meetings. PSC representatives also joined the NHS England led webinars in Q4.

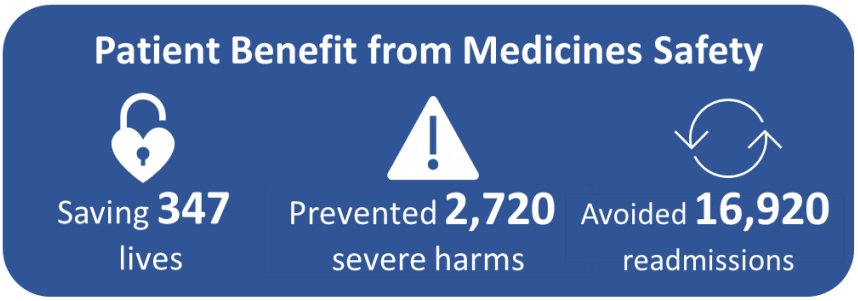
Key Infographics

Managing Deterioration Safety Improvement Programme

Maternity and Neonatal Safety Improvement Programme



Medicines Safety Improvement Programme



Mental Health Safety Improvement Programme

Systems Safety

National Patient Safety Improvement Programmes

Managing Deterioration

Summary of Q4 2022/2023 Progress

Programme Expected Outcomes

The Managing Deterioration Safety Improvement Programme's delivery of optimised acute deterioration management of residents in care homes is expected, along with many other national, regional and local programmes, to improve not only the quality of care for residents, but to increase care that is delivered at the right time and in the right place. This means we expect more residents to receive care in their homes or access primary and social care and only those most in need attending hospital. We have therefore set out the following key urgent and emergency care and response activity measures that might potentially be influenced by increased use of deterioration management tools and a whole system approach to managing escalation and response when care homes identify deterioration in a resident:

- The number of calls to 999
- The number of residents conveyed to hospital
- The average length of stay of a care home resident following hospital admission

Programme Deliverables

The Patient Safety Collaboratives (PSCs) were commissioned this year to work towards the following ambitions:

- Training in the use and application of RESTORE2/RESTORE2 mini or equivalent tools (Level 3 or greater in our programme adoption scale) delivered to 95% of care homes by the end of March 2023
- Adoption of RESTORE2/RESTORE2 mini or equivalent tools within an embedded care home PIER pathway (Level 5 or greater in our programme adoption scale) in 85% of care homes by the end of March 2023
- Sustainable adoption of RESTORE2/RESTORE2 mini or equivalent tools (identified reliable application for at least 1 year, and reported as Level 7 in our programme adoption scale) in 40% of care homes by the end of March 2023
- Development and delivery of local data sets that ensure regular reporting and review of resident related outcomes that might be impacted by improved management of acute physical deterioration.

Progress and contribution to NatPatSIP ambitions 22/23

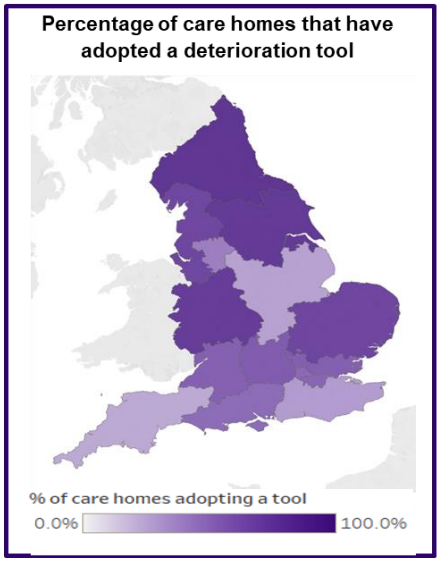


Figure 1 shows the percentage of care homes that have adopted a deterioration tool (NEWS2 and/or Soft Signs). Variation in percentage of adoption can in part be explained by substantial difference in the number of care homes per PSC (denominators). The number of care homes per PSC ranges from 263 to 1,679. The PSCs with some of the lowest percentage adoption often have many times more care homes in their region. Equally, some of the regions had an existing care home programme prior to the commissioned work commencing so were further ahead than others at the start of the programme.

As seen in Figure 2 below, there has been a small increase in the number of care homes at the Decision stage (Stage 3) or further, moving from 75% in Q3 2022/23 to 78% Q4 2022/23 (n=11,621). There has been an increase in the proportion of care homes at the Adoption stage (Stage 5) or further, increasing from 55% to 61% in Q4 2022/23 (n=9,164). A similar increase was observed in the proportion of care homes at the Sustained stage (Stage 7), resulting in 20% in Q4 2022/23 (n=2,984), up from 16% in the previous quarter. Additionally, allowing for changes in denominators, improving methods for obtaining insights, and assessing confidence are key factors that have supported the observed increase.

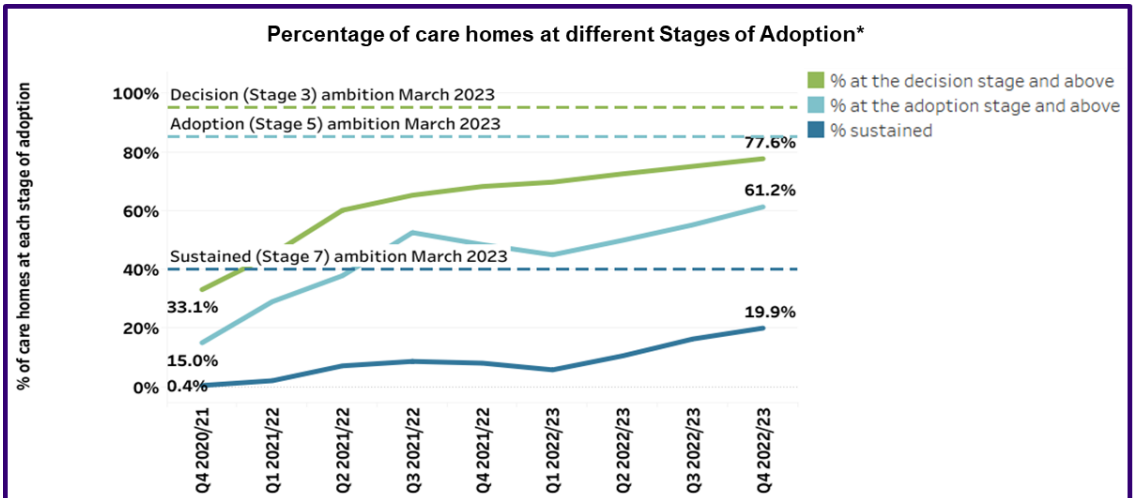


*Figure 2: National percentage of care homes at different stages of adoption (Stage 3: Decision, Stage 5: Adoption, Stage 7: Sustained). *Note that this metric is cumulative and reflects the total number of care homes at each stage in each quarter.*

Figure 3 below shows the number of care homes at each Stage of Adoption for each deterioration tool. 9,164 care homes were at the ≥ Stage 5: Adoption. The most widespread tool in use was NEWS2 and Soft Signs with 6,351 care homes at ≥ Stage 5: Adoption. This was followed by Soft Signs, where 1,971 care homes were at ≥ Stage 5: Adoption. 1,849 care homes were at the Decision stage (Stage 3) or lower for Tool Undecided, meaning that they have not yet implemented a deterioration tool. This has decreased by 10% since the previous quarter.

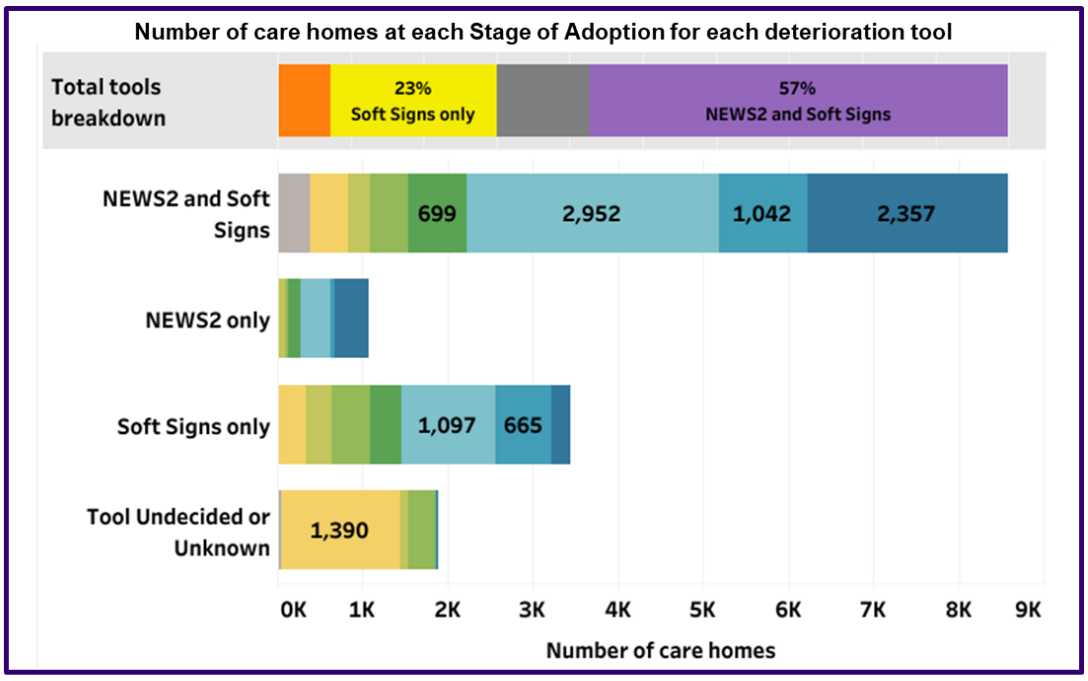


Figure 3: Number of care homes at each Stage of Adoption for each deterioration tool (NEWS2 and/or Soft Signs).

Detailed information

Key updates and achievements

- PSCs have been continuing to engage with their systems to support increased training for care homes. This has included face to face training, e-learning and virtual 'train the trainer' sessions either directly with care homes or with system partners. It is noted that training attendance and progress in some areas has been hindered due to system pressures, staff sickness and lack of backfill / release of staff to attend. However, PSCs continue to respond to local changes and adapt plans to ensure providers are aware of and able to ensure a common language approach to managing deterioration.
- PSCs have been continuing to work with key system stakeholders to review and map existing escalation and response pathways for care homes. Where possible, some have worked with integrated care systems (ICSs) to design and test methods to improve pathways.
- This quarter PSCs have undertaken focused work to develop sustainability plans for the ongoing training and adoption of deterioration management tools. Some PSCs have identified a process for transition and handover, aligning priorities and pooling available resources for the ICS to drive this work locally. For other areas where the ICS may be less mature or still recruiting to roles, this has not yet been possible and discussions with key system stakeholders has identified risks beyond PSC involvement. Where appropriate PSCs are exploring further opportunities for funding and ongoing training. The sustainability and handover of work will remain a key area of focus moving into Q1 22/23.
- Last quarter the national team worked with the Unity Insights Team and West Midlands PSC to determine the potential impact care homes adopting deterioration management tools could have on key outcome measures. West Midlands was chosen at it was the first region able to link care homes with key outcome data and had permission to share. This quarter further analysis and modelling has been undertaken to taken into account the latest Q4 PSC data submissions.
- The forecast / extrapolation model (based on data from the West Midlands region) has shown that in the 9,164 care homes where a deterioration management tool has been adopted in England, it has the potential for (time period: Q4 2020/21 to Q4 2022/23):

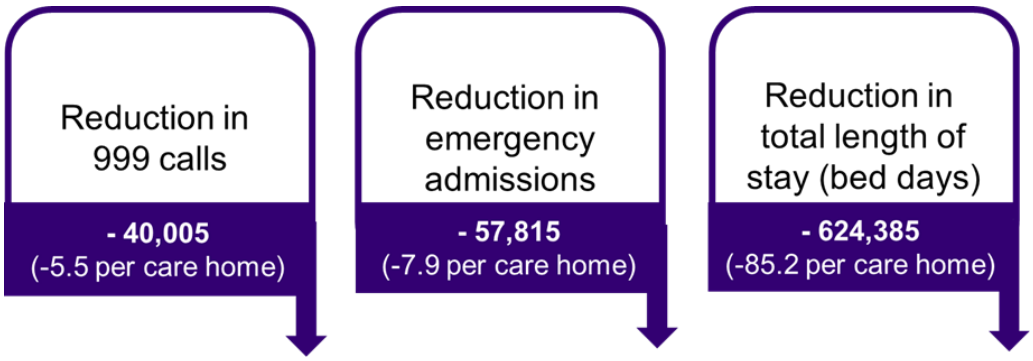


Figure 4: The reductions above show the potential benefits in two views: the England aggregate figure and the benefits per care home.

- These reductions could have a significant impact to the quality and experience of care received by residents and could exhibit cost savings to the system if this approach was replicated across all 15,140 care homes in England.
- It is important to note that the forecast model was developed to showcase the estimated national impact if the West Midlands improvement work could be achieved across the country. Analysis controlled for common trends between regions (e.g. increasing population, demographic change). The key assumption is that the West Midlands results are replicable. In reality, the results will vary between regions. Other key limitations & assumptions to be aware of are:
- It is possible that confounding factors may limit attribution (e.g. COVID-19 pandemic or other NHS programmes/initiatives) and other
- Other programmes may have impacted results at local level

- The Intervention and control groups were assumed to have parallel trends in the absence of any intervention
- Care home bed occupancy rates were assumed to be similar across England
- Control group received some form of the intervention (deterioration management tool adoption in care homes) – this was adjusted within the methodology
- The control group was not a perfect match, meaning that confounding factors are possible (e.g. demographics or service differences)

Context, challenges, and expectations

The delivery of quality improvement programmes within care homes remains complex, and deterioration management in care homes continues to rely on multiple providers of care. This quarter there were similar challenges to previous quarters based on this context, but some key points of note are:

- Integrated Care Boards (ICBs) continue to be at different levels of maturity which has impacted both the PSCs ability to work with system leaders and to maintain local and regional strategies in relation to deterioration. Where ICBs are mature, there has been good engagement and agreements for on-going sustainability and support of the work. In some areas, this has been included as part of ICS delivery plans and /or in others, included as part of commissioning arrangements for local contracts.
- The sustainability of training continues to be a challenge for PSCs and systems. This is likely to continue to be a challenge due to high levels of care home staff turnover. However, strategic alignment with integrated care systems, continued investment in 'train the trainer' models and increased access to e-learning appears to be having an impact.
- There remain many national initiatives to support care homes. Whilst this is positive, and has enabled collaborative working, there is more to do to ensure a joined-up approach. Care home staff do not consistently have capacity to deliver the number of programmes currently in place, and with a national focus on falls this means that in some areas it is difficult to maintain focus and attention on increasing the adoption of deterioration management tools.
- Nationally there remains no central data set that enables measurement of processes and outcomes in relation to care homes. Obtaining accurate data and insights into tool use is therefore challenging, nevertheless PSCs continue to work hard to triangulate information via surveys/questionnaires and working alongside Local Authorities, Ageing Well Teams and other key stakeholders. Whilst it is recognised that some of this data is sampled, insights do suggest that levels of adoption and/or sustainability of deterioration management tools is likely under-reported each quarter and thus actual levels of adoption are higher in many areas.

Key Learning

- Some digital platforms are being decommissioned or licenses not being renewed by ICS.
- Primary care engagement challenging and affecting use of digital platforms.
- Need to focus on P prevention otherwise the urgent care needs are moved from ED to UEC rather than prevented.
- Where EHCH created inequalities through place-based protocols, Man det programme has reduced these by taking a system wide approach.
- The man/det work has had benefits to the system by exceeding the specification in a number of cases, such as WM falls work etc reducing 'longlyers' reduced chest infections etc and had a system benefit.
- Many care homes do not have a handover time meaning handover often gets missed unless staff are paid.
- Care homes prefer face to face training so e-learning may not be a sustainable solution for some.
- Important to get an understanding of each sectors understanding/expectations of the UEC pathway.

Case Study

Primary care engagement with remote monitoring in North Central London – evaluation report and accompanying video content were published and well received -"This is a really great report. Thank you for sharing."

Summary of Q4 2022/2023 Progress

Programme Expected Outcomes

- Increase in rates of babies surviving until discharge home (Less than 34 + 0 weeks gestation)
- Reduction in brain injury, visible on imaging (grade 3&4 IVH and/or cystic periventricular leukomalacia (cPVL) on ultrasound) (Less than 34 + 0 weeks gestation)
- Reduction in incidents of necrotising enterocolitis (based on diagnosis at surgery, post-mortem or the presence of radiological signs) (Less than 34 + 0 weeks gestation)
- Reduction in bronchopulmonary dysplasia (oxygen or respiratory support at 36+0 weeks post menstrual age) (Less than 34 + 0 weeks gestation)

Maternity Early Warning Score (MEWS):

- Reduction in rates of severe maternal complications associated with maternal deterioration (including severe postpartum haemorrhage, severe pre-eclampsia, eclampsia, ruptured uterus, and severe complications of abortion)
- Reduction in critical interventions required (including admission to intensive care units, interventional radiography, laparotomy, and use of blood products)
- Improved communication between staff using a common language embedded within the PIER pathway.
- Improved woman and family experience as MEWS includes worry and concern within escalation.

New-born Early Warning Trigger and Track (NEWTT2):

- Improved recognition of deterioration that leads to interventions and admission to the neonatal unit, for instance, hypoglycaemia, hypothermia and early onset group B strep.
- Improved communication between staff using a common language embedded within the PIER pathway.
- Improved parent and family experience as NEWTT2 includes worry and concern within escalation.
- The proportion of babies admitted to the neonatal unit who have been cared for using the NEWTT2 pathway.

Programme Deliverables

- Ensure the effective optimisation and stabilisation of the preterm infant by embedding a pathway of care encompassing seven evidence-based interventions leading to improved health outcomes.
- All 7 key interventions to be implemented, as a pathway approach, in at least 65% of maternity and neonatal providers by March 2023.
- Ensure the use of MEWS tool and the NEWTT2 tool are embedded within an effective PIER pathway for managing deterioration and support.

MEWS:

- All pilot sites to have undertaken phase 1 testing by June 2022 - completed.
- All pilot sites to have completed phase 2 testing by September 2022 – commencing in Q3 2022/23
- A local plan for adoption and spread of the national MEWS.

NEWTT2:

- All pilot sites to have undertaken phase 1 testing by May 2022- completed.
- A local plan for spread of the national NEWTT2 Implementation

Both workstreams, early recognition and management of deterioration of women and babies and optimisation and stabilisation of the newborn, are progressing well. Improvements are being evidenced in the uptake of the pathway approach within optimisation and stabilisation, this is highlighted by the new national data dashboard which illustrates improvements in all interventions, and the number of interventions being delivered.

Progress and contribution to NatPatSIP ambitions 22/23

As we can see in figure1, there have been significant improvements in the level of activity for most of the seven-interventions We have utilised the action learning sets and peer learning to help increase the adoption and spread in maternal breast milk and antenatal steroids, while ensuring we maintain sustainability in place of birth and magnesium sulphate. Figure 1 shows all the interventions achieving the national ambition of 65%, individually.

Furthermore, as seen in Figure 2, 56% of all sites across the country have adopted all seven interventions as a pathway approach. We did not see the anticipated increase to meet the national standards however, work continues to help support and deliver improvements in those areas below the A&S criteria, which will enable us to meet our national ambition for 2023/24.

The activity data represented in Figures 5 & 6 is now translating into statistical shifts in process data as seen in figures 9, 10, 11, 12 meaning more babies are reliably getting this intervention each month. These improvements in processes are resulting in translatable outcomes as seen in figure 9.

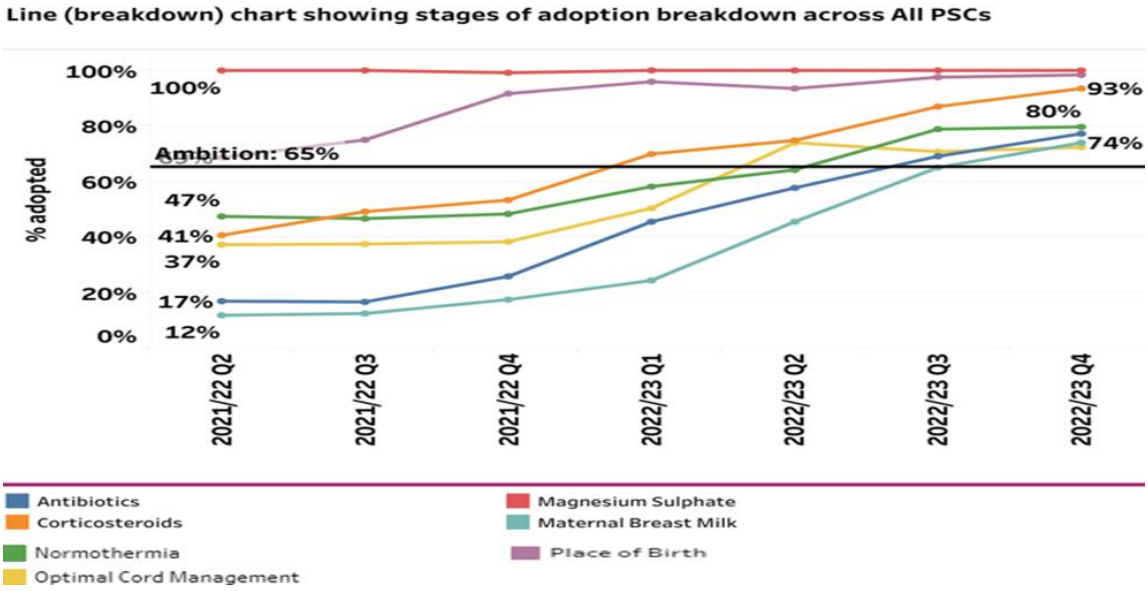


Figure 5

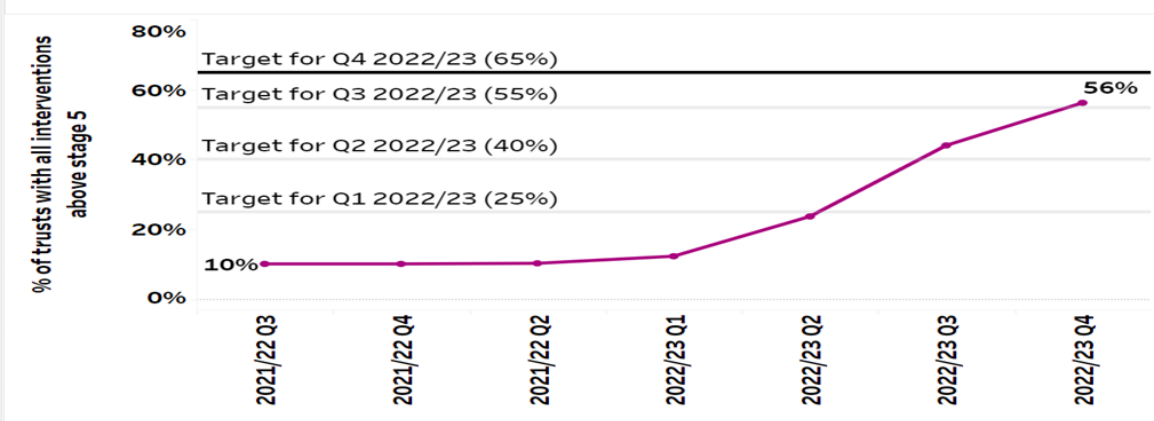


Figure 6

Detailed information

Key updates and achievements

Optimisation and stabilisation of the preterm infant.

Patient safety leads and workstream leads continue to engage with the national data dashboard for the preterm workstream. These data are being used to inform improvements and enable strategic conversations about the successes of the national workstream and where resource can be best allocated. The national team continues to collect and utilise feedback to improve the functionality of the platform, with further iterations imminent. From this feedback we can now provide data at national, Region, ODN, PSC, ICS level. By stratifying the data in this way colleagues can help articulate improvements across various system stakeholders. Figures 4 & 8 and figures 3 & 7 demonstrate the Cost-Effective-Analysis of improvements in morbidity and mortality associated with optimal cord management and magnesium sulphate. These data illustrate the importance of this work and the aggregated efforts nationally. We have saved up to 465 lives with OCM and reduced babies born with cerebral palsy by up to 385 respectively. Furthermore, the financial impact to welfare and society is up to £385million.

We continue to work and engage with Clevermed, our systems provided to improve data entry and data flow. The release of Saving Babies Lives V3 due expected 1st June will incentivise improvements with the effectiveness of the preterm optimisation pathway. The last action learning set was undertaken looking to pull on various case studies around improvements with Antenatal Corticosteroids. This was a huge success and learning was shared regarding how teams can target their attendance on certain cohorts of women in preterm labour. This can be seen in the data represented in figure 6 with improvements nationally for Antenatal steroids baseline of 40% to 49%.

With the collective improvements made over the commissioned year we have maintained an average of 1617 interventions being delivered each month, which is 510 more interventions than April 2020, and is the second statistical shift.

Early recognition and management of deterioration of women and babies.

To ensure both the national Maternity Early Warning Score (MEWS) and Newborn Early Warning Track and Trigger (NEWTT2) is implemented safely in a range of clinical settings a phased approach to testing and implementation has been established. These phases have been designed based on improvement methodology and safety science principles. The sample of organisations involved have ensured wide demographics have been accounted, therefore providing representation for England.

Phase 1 - Navigating the tool - COMPLETE.

- Testing of the tool in this phase is designed to ensure a broad range of healthcare professionals find the language used within the tool is consistent and navigates the user as intended.

Phase 2 - Using the tool in practice settings – COMPLETED In Q4 2022/23

- To maintain safe practice Phase 2 testing will happen in parallel to the use of existing tools. In this phase the aim is to understand how interactions between the healthcare professional and the tool perform.

Phase 3 - Early implementation with Pathfinder Organisations – scoping of requirements for this phase has commenced.

- Whereby organisations progress to using the national MEWS and NEWTT2 within their clinical areas. The aim is to support organisations transitioning to the national MEWS and NEWTT2, using QI methodology.

Phase 4 – Implementation with remaining paper-based organisations.

- Remaining paper-based organisations will progress to using the national MEWS and NEWTT2 in maternity settings and utilise learning from Phase 4 implementation to provide support.

Phase 5 – Digital testing.

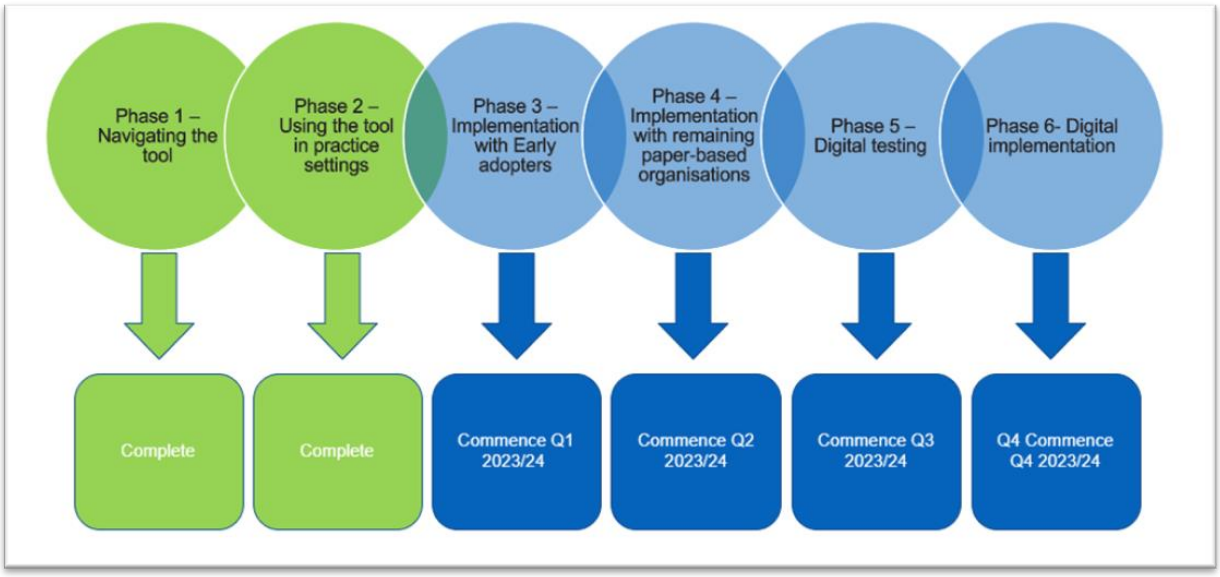
- Following the completion of the digital specification testing of the national MEWS and NEWTT2 will commence with digital platform providers.

Phase 6 – Digital implementation.

- Organisation progress to implementing the national MEWS and NEWTT2 with support and learning from phases 3 to 5.

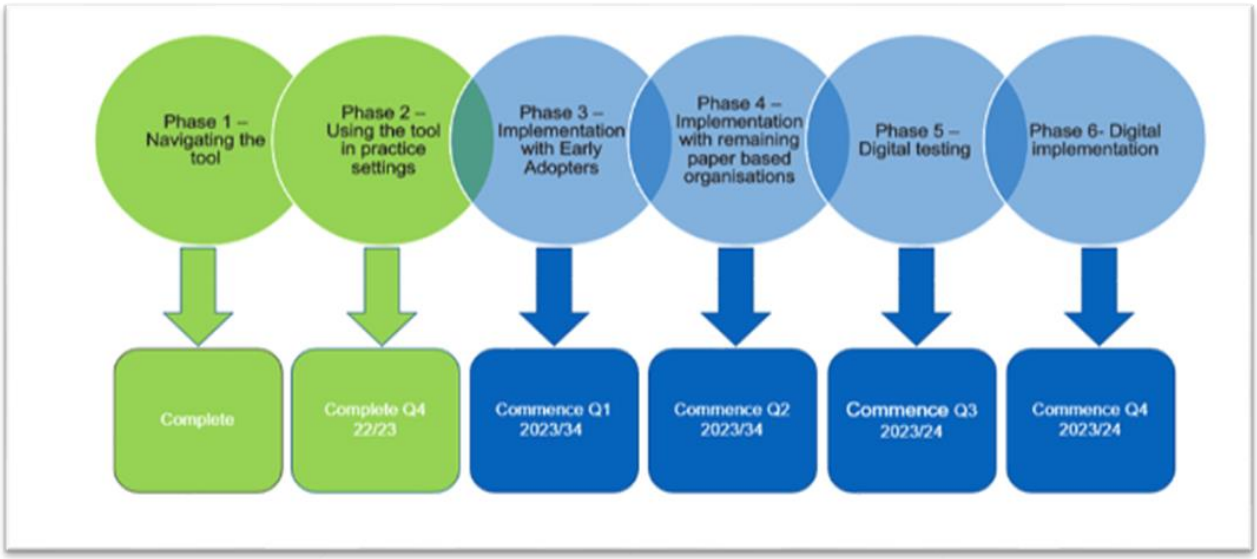
NB: The above timelines are correct at the time of completing the report.

MEWS Phases



Phase Two improvement testing completed in Q4 20222/23. The results of which have been shared with the key representative stakeholder group ahead of Phase 3 implementation.

NEWTT2 Phases



The NEWTT2 tool was published as a key component of the Deterioration of the newborn framework by British Association of Perinatal Medicine (BAPM) in January 2023.

This was following collaboration with the key representative stakeholder group and support for the testing phases by the PSC.

Progress will next be made with organisations who have identified themselves to move to implementation as pathfinder sites.

Training and digitalisation.

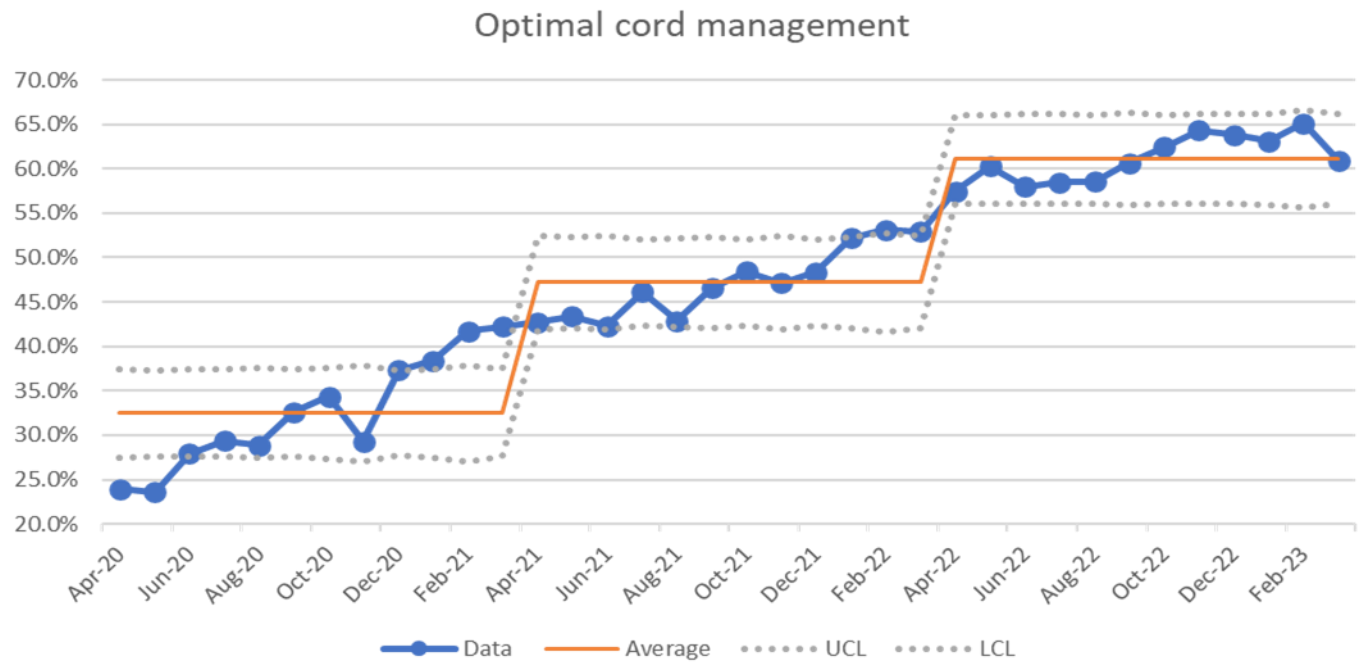
Health Education England (HEE) are finalising the e-Learning for HEalth modules for MEWS and NEWTT2. Key contributions to the training materials were supported by clinical PSC colleagues.

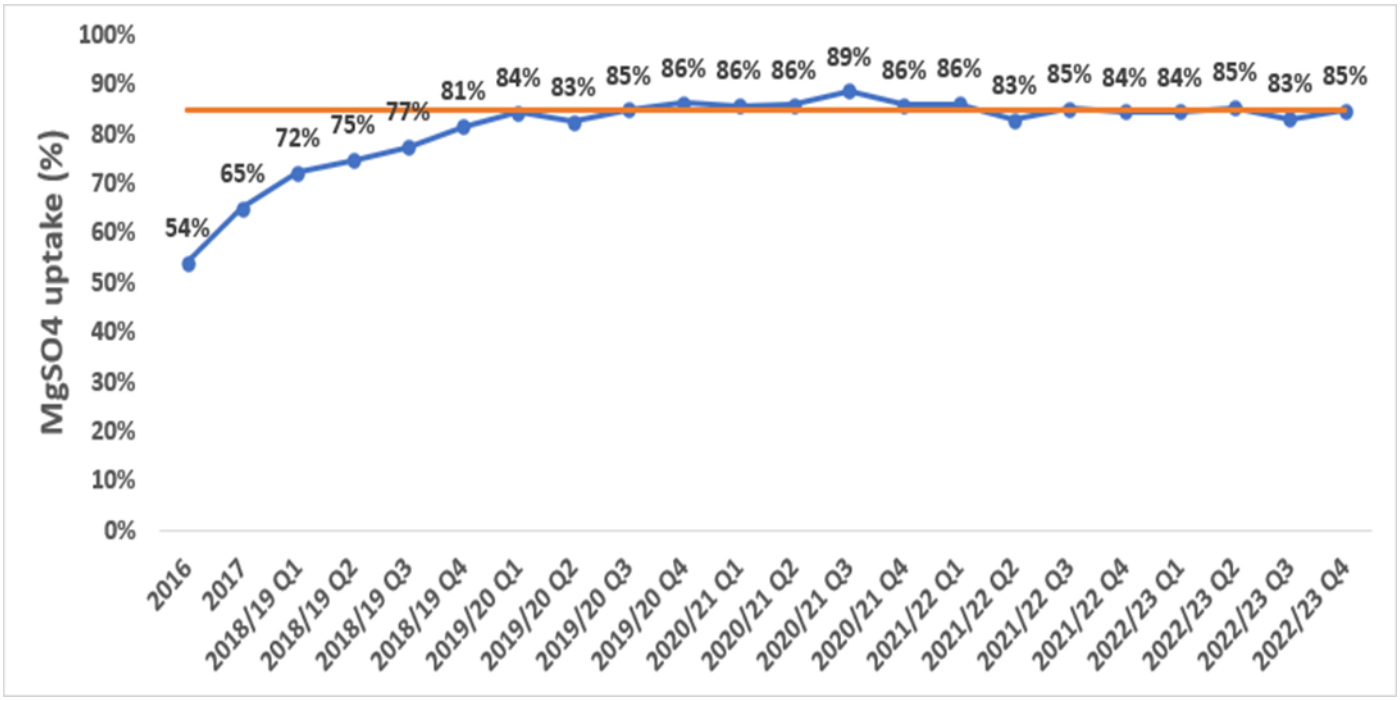
Plans are continuing to commission a provider to develop a national digital specification for both MEWS and NEWTT2. Currently planning for this work to commence in Q1 2023/24.

Context, challenges, and expectations

Maternity staffing levels and capacity within units remains a key challenge. despite most wanting to participate some areas are unable to engage at present. Despite this PSCs are continuing to show improvement, as evidenced above.

Process Measures




MgSO4 uptake (%)
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
54%
65%
72%
75%
77%
81%
84%
83%
85%
86%
86%
86%
89%
86%
86%
83%
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2016
2017
2018/19 Q1
2018/19 Q2
2018/19 Q3
2018/19 Q4
2019/20 Q1
2019/20 Q2
2019/20 Q3
2019/20 Q4
2020/21 Q1
2020/21 Q2
2020/21 Q3
2020/21 Q4
2021/22 Q1
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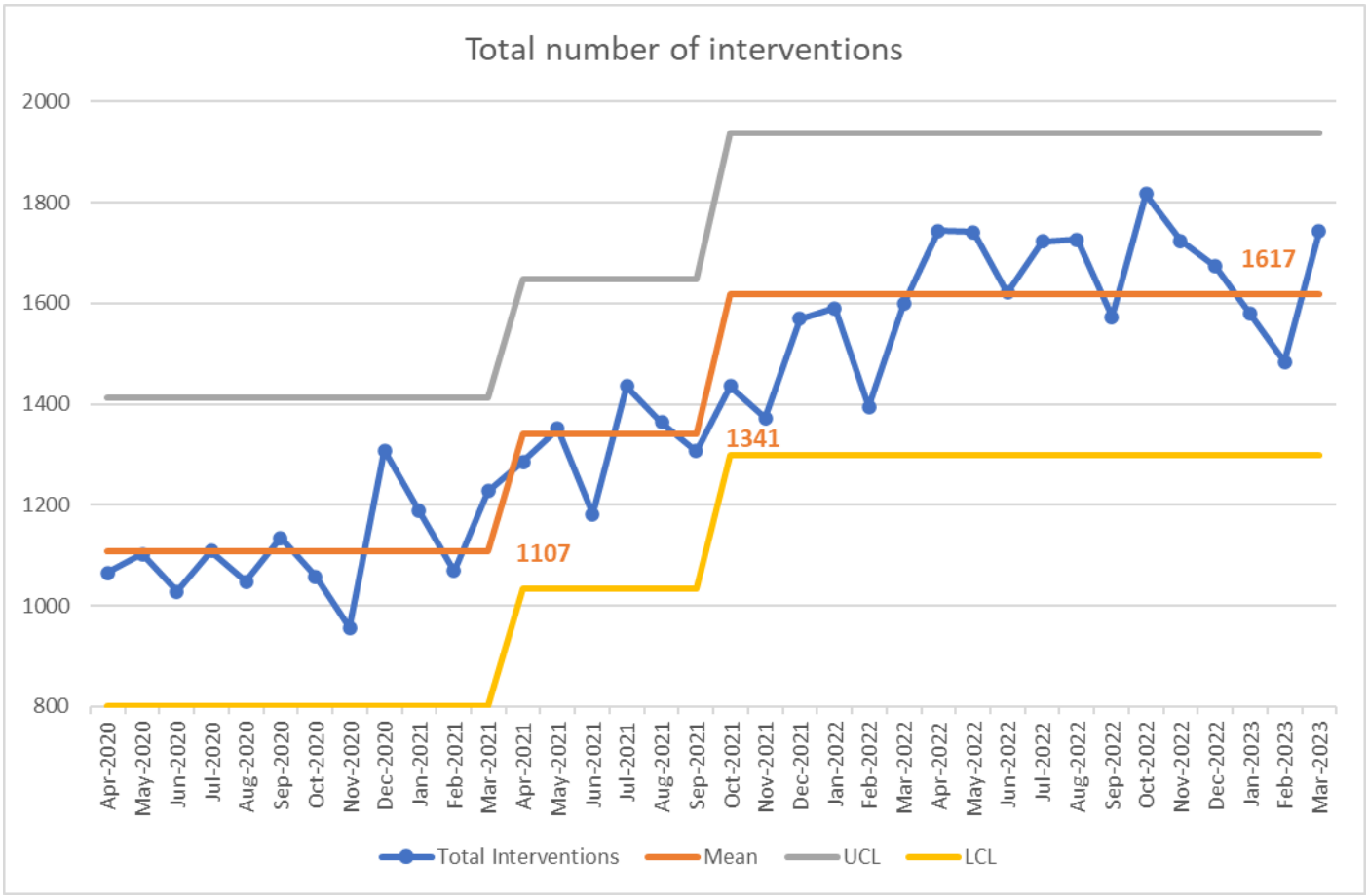
2022/23 Q3
2022/23 Q4


Total number of interventions
2000
1800
1600
1400
1200
1000
800
1617
1341
1107
Apr-2020
May-2020
Jun-2020
Jul-2020
Aug-2020
Sep-2020
Oct-2020
Nov-2020
Dec-2020
Jan-2021
Feb-2021
Mar-2021
Apr-2021
May-2021
Jun-2021
Jul-2021
Aug-2021
Sep-2021
Oct-2021
Nov-2021
Dec-2021
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Feb-2022
Mar-2022
Apr-2022
May-2022
Jun-2022
Jul-2022
Aug-2022
Sep-2022
Oct-2022
Nov-2022
Dec-2022
Jan-2023
Feb-2023
Mar-2023
Total Interventions
Mean
UCL
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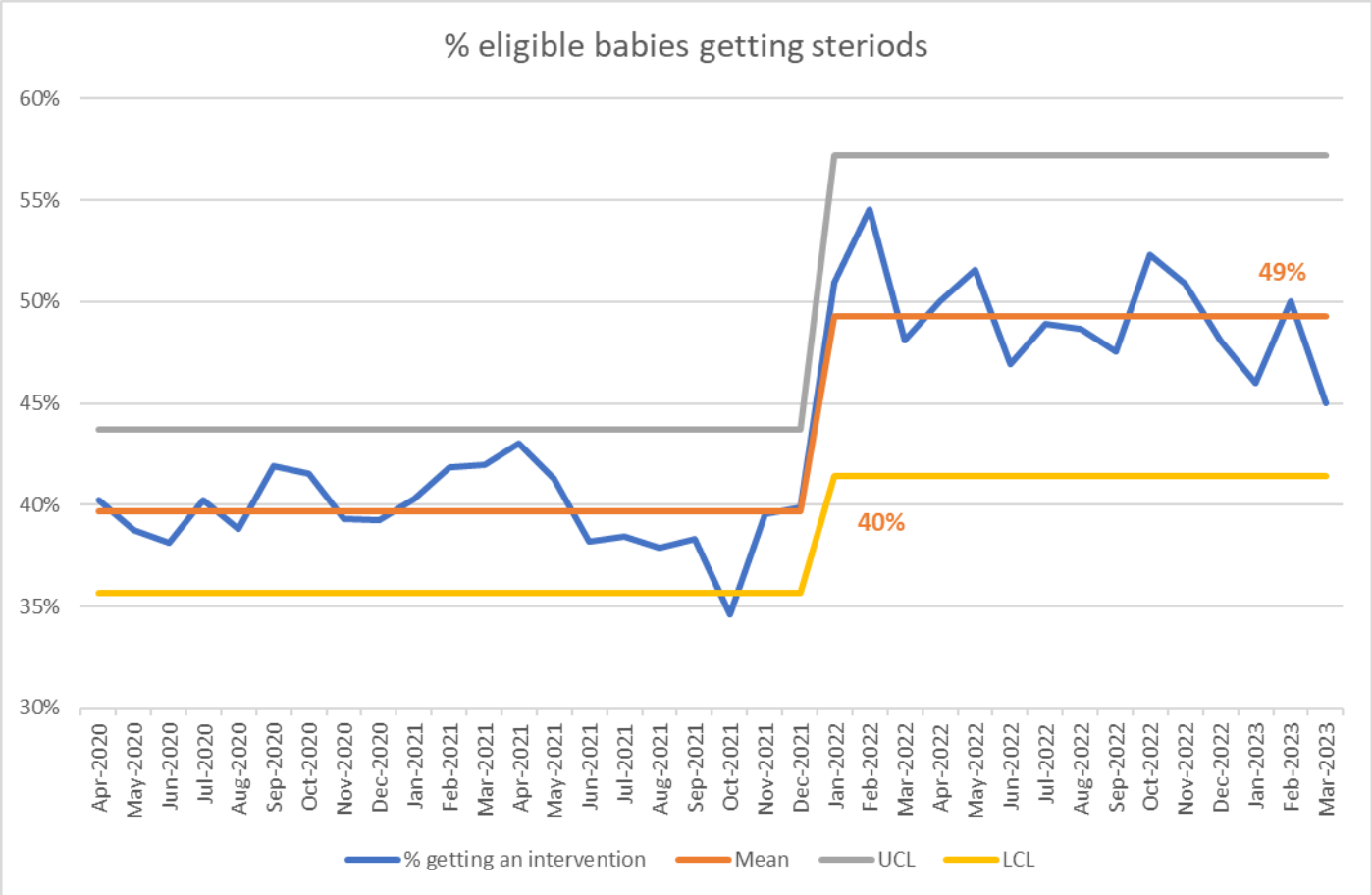


Optimal Cord Management has contributed to saving the lives of up to 465 babies

Magnesium Sulphate treatment prevented cerebral palsy in up to 385 babies

Key Learnings

Eastern - Optimisation Forums held to enable sharing from trusts about their QI projects. Feedback identified the need for streamlined and clearer presentations; therefore, a template report was created. This has been shared with the region's key stakeholders for comment- positive feedback and slight amendments. Outside of PSC commission but aligning well with MatNeo, Eastern PSC have been commissioned by Health Education England to deliver a Perinatal Equality, Diversity and Inclusion Development programme. Co-produced with Leadership Academy and other stakeholders, plans to start May 2023. To include action learning sets, improving leadership, and learning about quality improvement through a MatNeo project.

East Midlands- Improvement plans shared by all 8 Trusts implementing the Each Baby Counts escalation toolkits (as part of a Midlands approach in collaboration with WMAHSN)

Health Innovation Network- Publication of 1st Year Darzi fellow (21/22) blogs: Recommendations for improving perinatal health inequalities: A Darzi journey

Health Innovation Network – Manchester - A parent leaflet on the 7 optimisation measures has been developed by SPOONS and for roll out in Q1 22/23. The MVPs have been commissioned to produce a leaflet on the signs and symptoms of preterm birth.

Innovation Agency- It has been noted that the teams that are making the biggest gains on their improvement data are those with strong perinatal team relationships and leadership. Therefore planning a focus on 'Building successful perinatal teams. In collaboration with the ODN & HinM held a 'optimisation awards event'. Teams were invited to self-nominate and then nominated by MatNeoSIP teams for various awards. Good attendance and feedback highlighted teams appreciation for the hard work undertaken with the optimisation workstream.

North East and North Cumbria – To improve the data quality, each Trust has identified leads whom have responsibility for the accuracy of the optimisation data.

North East and North Cumbria and Yorkshire and Humber - Held a joint Escalation Toolkit 'launch', with planning underway to run several support sessions to support implementation.

Oxford- Antenatal steroid data is showing improvements and case reviews are encouraged to share learning where there are missed opportunities. Presented our Preterm Birth co-produced (funded) project at the Inaugural HEE TV-W Simulation Networking Event in January and succeeded in gaining First prize.

Wessex- Digital versions of the Ante Natal Care Pathway (ANCP) are embedded in trusts to support the wider deterioration work stream. ANCP process using the PIER framework see Future.NHS. The 'SHIP AN triage project' has been shortlisted for a RCM award, category: *Outstanding contribution to midwifery services: digital.*

Case study: Improve data entry on Badgernet – Royal Bolton Hospital

Programme aim:

- Contribute to the national ambition set out in Better Births, to reduce the rates of maternal and neonatal deaths, stillbirths and brain injuries that occur during or soon after birth by 50% by 2025
- Contribute to the national ambition, set out in Safer Maternity Care, to reduce the national rate of preterm births from 8% to 6% by 2025
- Improve the safety and outcomes of maternal and neonatal care by reducing unwarranted variation and provide a high quality healthcare experience for all women, babies, and families across maternity and neonatal settings.

What problem were you trying to solve?

At the Royal Bolton Hospital we were aiming to improve the 7 interventions that Optimise pre term infants and give them a better outcomes in both mortality and morbidity.

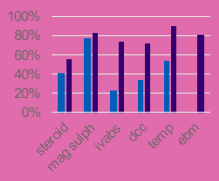
Specific for data entry within these field of Optimisation we aimed to improve the training for all medical staff and Midwifery collegues regarding entering data on Badgernet and ensuring the important information completed correctly at the time the intervention for Optimisation was given

What did you do?

- Included the Badgernet training as part of the induction programme.
- Introduced short teaching sessions to reinforce the importance of accurately recording data.
- Developed a pre term pathway utilising the Optimisation passport
- Developed and produced monthly visual reports and graphs to show data which is easy to understand and shared on a regular basis.
- Highlight reasons for noncompliance or incorrect entry.

How did it go?

- We have seen a sharp increase in the Optimisation Interventions that we are achieving over at Royal Bolton NICU – this is showing that the data entry is becoming inputted routinely. The chart below shows our improvements for 2023 compared to 2022



What did you learn?

- For sustainability need to continue with training.
- Data visuals are really important and can have a positive impact on motivation.
- To continue driving the optimisations daily and its importance

1 | National Patient Safety Improvement Programmes

Case study: Improve early initiation of maternal breast milk – Royal Bolton Hospital

Programme aim:

- Contribute to the national ambition set out in Better Births, to reduce the rates of maternal and neonatal deaths, stillbirths and brain injuries that occur during or soon after birth by 50% by 2025
- Contribute to the national ambition, set out in Safer Maternity Care, to reduce the national rate of preterm births from 8% to 6% by 2025
- Improve the safety and outcomes of maternal and neonatal care by reducing unwarranted variation and provide a high quality healthcare experience for all women, babies, and families across maternity and neonatal settings.

What problem were you trying to solve?

- Improving early expression of maternal breast milk in preterm babies.

What did you do?

- Set up a Multidisciplinary Team with neonatal, medical, nursing and midwifery teams.
- Used QI tools to understand, analyse and communicate ideas.

What did you do continued..

- Education and training information for Mothers has been made available at antenatal counselling sessions.
- Education and training neonatal and midwifery staff along with written information on how to help Mothers express in the first 2 hours after birth.
- Help Mothers to express milk while on the delivery suite.
- Introduced colostrum mouthcare for preterm babies. (Guideline to follow)

How did it go?

- Improvement in early breast feeding has been presented at both regional and national MatNeoSIP meetings.
- Rates of early breast milk delivery for preterm babies has improved from
- In quarter Jan/Feb/March 2021 we had no data recorded for breast milk as we had no documentation to show it and no processes in place. For the Jan/Feb/March quarter of 2023 we are at 81%. Through monthly data checking we are lower due to parents choosing formula as this is no a contra indication to this outcome

What did you learn?

- Training staff on how to help Mothers to express early has improved staff confidence.
- It is crucial to work as a team to drive improvement.
- Continually to educate and train staff and reminding staff of the importance of maternal breast milk.
- Taking into consideration factors that could inhibit our data results ie choosing formula
- Creating parent friendly leaflets and tools to help with expressing

2 | National Patient Safety Improvement Programmes

Case study: Improve Optimal Cord Management – Royal Bolton Hospital

Programme aim:

- Contribute to the national ambition set out in Better Births, to reduce the rates of maternal and neonatal deaths, stillbirths and brain injuries that occur during or soon after birth by 50% by 2025
- Contribute to the national ambition, set out in Safer Maternity Care, to reduce the national rate of preterm births from 8% to 6% by 2025
- Improve the safety and outcomes of maternal and neonatal care by reducing unwarranted variation and provide a high quality healthcare experience for all women, babies, and families across maternity and neonatal settings.

What problem were you trying to solve?

- To improve delayed cord clamping with preterm babies.

What did you do?

- Carried out simulation sessions on Optimal Cord Management for midwifery, obstetric, theatre and neonatal staff.
- Education posters to show staff members what their roles and responsibilities are when it comes to DCC
- In general conversations at each delivery this highlights the importance of DCC and helps educate 365 days a year

How did it go?

- DCC is now becoming an Optimisation that we are doing for every eligible baby
- With monthly data checks we are looking at why the babies didn't receive DCC so far for 2023 every baby that has not received DCC is because there has been a contraindication ie MCDA twins, maternal bleeds or placenta that have been delivered with baby
- Data for 2022 quarter Jan/Feb/Mar showed us at 33% and 2023 quarter Jan/Feb/March 2023 we are at 71%

What did you learn?

- Education is key so that everyone knows the process with DCC and what babies are eligible and not eligible so we don't but any babies/ mothers at risk
- DCC doesn't need fancy equipment it can be achieved with the equipment that you already on NICU
- Regular contact with obstetric and medical staff helps them to grow their confidence when it comes to DCC

Case study: Improve Intrapartum Antibiotics administration – Royal Bolton Hospital

Programme aim:

- Contribute to the national ambition set out in Better Births, to reduce the rates of maternal and neonatal deaths, stillbirths and brain injuries that occur during or soon after birth by 50% by 2025
- Contribute to the national ambition, set out in Safer Maternity Care, to reduce the national rate of preterm births from 8% to 6% by 2025
- Improve the safety and outcomes of maternal and neonatal care by reducing unwarranted variation and provide a high quality healthcare experience for all women, babies, and families across maternity and neonatal settings.

What problem were you trying to solve?

- To improve the administration of Intrapartum during active labour of preterm babies.

What did you do?

- Introducing steroids, mag sulph and antibiotics as a package rather than individual interventions.
- Therefore, when staff are concerned about a Mother delivering prematurely we will offer all three interventions.

How did it go?

- Intrapartum antibiotics administration rates for quarter Jan/Feb/Mar 2022 was 23% and now for quarter Jan/Feb/March 2023 we are at 71%
- On monthly examination of the data all women who were eligible for antibiotics received them but some delivered within 4 hours of administration so didn't achieve the outcome but we are 100% giving rate

What did you learn?

- That antibiotics should be part of the package for steroids and Magnesium Sulphate. If we are that worried about pre term labour to give the first two we should be giving the antibiotics too. I have had a conversation recently were an obstetric didn't want to give antibiotics as she thought that the mother wasn't going to delvier but was going to give steroids and magsulph which then led to the conversation of if you don't think she will deliver why are we giving the steroids and magsulph in the first place

Case study: Improving Optimal Cord Management – MFT Wythenshawe

Programme aim:

- Contribute to the national ambition set out in Better Births, to reduce the rates of maternal and neonatal deaths, stillbirths and brain injuries that occur during or soon after birth by 50% by 2025
- Contribute to the national ambition, set out in Safer Maternity Care, to reduce the national rate of preterm births from 8% to 6% by 2025
- Improve the safety and outcomes of maternal and neonatal care by reducing unwarranted variation and provide a high quality healthcare experience for all women, babies, and families across maternity and neonatal settings.

What problem were you trying to solve?

- To improve Optimal Cord Management (OCM)
- Therefore, all eligible babies less than 34 weeks gestation should not have their umbilical cord clamped for at least 60 seconds after birth

What did you?

- Recruited a diverse and energetic team across Maternity and Neonatology, dedicated towards Optimisation interventions for the preterm newborn
- Used QI tools (e.g. driver diagrams and stakeholder maps) to dissect out existent barriers and devised a plan of action
- Implemented a new policy for Deferred Cord Clamping and submitted a Business Case for a Life Start Trolley as part of the quality improvement project

What did you continue to do...

- Involved key stakeholders in several directions including: senior managers, specialist clinicians, patients and voluntary organisations
- Imparted education across the unit to all midwives, obstetricians and neonatology staff about the importance of each intervention, with special emphasis OCM.
- Implemented the use of a LifeStart Trolley across 2 Maternity Units of the Trust
- Extensive training and simulations on OCM and the use of the LifeStart Trolley

How did it go?

- Communication between maternity and neonatal teams have improved
- Education and simulations have improved knowledge, skills and confidence across both maternity and neonatal teams
- There has been an obvious positive impact on the data for OCM at Wythenshawe.
- Monitored teething problems of using the LS trolley – short cord, vaginal deliveries needing ultrasound machine near bed, twin deliveries by CS etc and improvised around available facilities within the safety margin for best outcome

What did you learn?

- Working together as a team is key to implementing change
- Appreciation of the challenges of changing practice and the layers of governance process to complete to implement actions.
- Skills to review and adjust change ideas based on most recent feedback
- Improved awareness of the steps required to implement change
- A love for MDT working across multiple sites to deliver the same standards of care across the Trust
- Better data management skills in a completely electronic environment

Case study: Improving early breast-feeding – MFT Wythenshawe

Programme aim:

- Contribute to the national ambition set out in Better Births, to reduce the rates of maternal and neonatal deaths, stillbirths and brain injuries that occur during or soon after birth by 50% by 2025
- Contribute to the national ambition, set out in Safer Maternity Care, to reduce the national rate of preterm births from 8% to 6% by 2025
- Improve the safety and outcomes of maternal and neonatal care by reducing unwarranted variation and provide a high quality healthcare experience for all women, babies, and families across maternity and neonatal settings.

What problem were you trying to solve?

- Improve awareness and implementation of early breast feeding after preterm births.
- Babies born below 34 weeks gestational age should receive their own mother's milk within 24 hours of birth.

What did you do?

- Developed an action plan in co-ordination with the senior midwifery and neonatology team to involve support workers in initiating and supporting breast feeding or expressing breast milk just after delivery in postnatal women

What did you continue to do?

- Impart staff education about benefits of EBM for the preterm neonate
- Parent education in the antepartum period about benefits of EBM and awareness of all the preterm optimisation interventions, especially in maternity specialist clinics caring for women at higher risk for preterm delivery
- Staff training sessions on breast pumps and promoting BFI skills around hand-expressing
- Provision for availability of breast pumps and colostrum packs at delivery
- Multidisciplinary working between maternity and neonatal staff

How did it go?

- Staffing issues in midwifery for postnatal care – role of support workers
- Difficulty in engaging patients for early EBM – ongoing education and support
- Infant feeding team involved for special focus on preterm births
- Achieved significant improvement in numbers by the end of the year
- BF initiatives well-accepted upon appropriate counselling

What did you learn?

- Importance of teamworking at challenging times
- Documentation of utmost importance to ensure data is appropriately captured for audit
- The importance of early communication with families who are due to deliver early
- Having the correct equipment at the right time is key
- Knowledge for parents is power and the language we use matters

Case Study: iNeed – An Adaptation of Each Baby Counts Learn & Support Toolkit at United Lincolnshire Hospitals Trust (EMAHSN)

NHS England

Aim	To utilise the EBC L+S Toolkit to implement a validated escalation tool, using scripted language to improve escalation communication, reduce poor outcomes for mothers and babies and improve staff wellbeing at work.
Background	Nationally escalation is a continuing theme in reports into maternity services as well as HSIB reports. Early recognition and management of the deteriorating women and babies is also a primary driver of the Maternity and Neonatal Safety Improvement Programme (MatNeoSIP). At ULHT escalation has been identified as a factor in some Divisional and Serious Incidents. The ULHT Maternity Patient Safety Team and Fetal Monitoring Team identified this as an area for quality improvement. EBC L+S was previously piloted on one site within ULHT but pilot not completed due to covid and sickness. In 2022/23 the adoption and spread of the RCOG Each Baby Counts (EBC) Escalation Toolkit was identified as a local priority for improvement across the East Midlands region and ULHT were invited to participate in the Midlands Improving Clinical Escalation improvement programme.
Outcome	We are thrilled at the adoption of iNeed and the response from staff. iNeed has become part of everyday life at ULHT and some staff members have actively approached us with stories of how it helped a difficult situation. Starting to see staff use references to iNeed escalation in their documentation despite this not being a requirement. We are launching iNeed in our neonatal service and other Trust departments are interested in adopting it too. Enquiries from other Trusts about using resources for their own use.

Change Ideas

Toolkit relaunched with fresh branding so as not to cause confusion

Rename toiNeedto make toolkit immediately identifiable as an escalation tool

Createa strong brand that is recognisable and enable iNeedto embed in local vernacular

Use a variety of methods to reach all staff members and learning styles:
- Social media - Posters - Video
- Teach Trolley Teaching - Handover discussions
- Role model in case review meetings & mandatory training

Address practicalities of escalating through use of scripted language:

- *"I need advice…*
- *I need to inform you…*
- *I need you to… (do something)"*

As well as making escalation easier for those asking for help, also making it easier for those receiving an escalation

- *"What do you need from me?"*

Support psychological safety through messages around civility and the impact of uncivil responses to escalation

Use escalation moments to facilitate teaching and learning conversations in a kind respectful manner
- *Teach or Treat*

Measurement

Baseline survey undertaken prior to launch, to be repeated at end of 6 month period.

As this I largely a behavioural change we decided to undertake a mixed methods survey of staff using
- Quantitative Likert scales to measure confidence when escalating
- Qualitative free text responses for rich data around experiences of escalation

52 responses from staff, mainly Band 6 midwives but some HCSWs, Band 5 and Consultant Obstetricians. No responses from SHOs or Registrars, despite targeted approach.

Main themes

- Staff were more confident escalating to midwives and slightly less confident escalating to doctors.
- Difficulty accessing the right person
- Respecting individuals expertise
- Kind and friendly discussions
- Worrying about the workloads of others
- Hierarchy between wards
- Building team connections

We also monitor timely escalation through fetal monitoring fresh eyes audit

Learning

Realistic deadlines are needed to ensure project runs to plan.

Social media increased awareness but there was no interaction with social media posts on staff groups

Introduce principles at ward handovers, very short sessions of less than 5 minutes

Tea Trolley teaching was very popular but needs to be brief and simple, acuity does not allow for lengthy teaching sessions

Staff resistant to change ideas did not fully understand the benefit to them, quickly resolved through a short teaching session

Pens are good for morale

Simplicity: a new behaviour tool needs to be simple enough to recall without needing prompts and can be taught in a matter of minutes

Continuous reinforcement required, we include in case reviews, CTG meetings and now on our mandatory training.

UHLT iNeed Project Leads:

Jules Bambridge – Patient Safety Midwife

Bhavana Mangal – Consultant Obstetrician and Fetal Monitoring Lead

Amber Brandon – Fetal Monitoring Lead Midwife

National Patient Safety Improvement Programmes

Medicines

Summary of Q4 2022/2023 Progress

Programme Expected Outcomes

The Ambition of this programme is that by end of March 2023 Patient Safety Collaboratives (PSCs), working with a minimum of 15 ICSs, will collectively achieve the following outcomes:

- 30,000 fewer people prescribed oral or transdermal opioids (of any dose) for more than 3 months.
- Of the 30,000 above 4,500 of these people will have been prescribed a high dose (>120mg day OME) at baseline and have now stopped opioids.

Programme Deliverables

- Improve chronic pain management by reducing harm from Opioids.
- In 2022/23 support a minimum of 1 ICS per PSC to implement the "Whole Systems Approach to High-Risk Opioid Prescribing" framework.

Progress and contribution to NatPatSIP ambitions 22/23

- 19 ICBs/ ICSs were working with Patient Safety Collaboratives (PSCs) through Quality Improvement in Q4. Of these, 10 are in Phase 6 – Action.
- We await the end of year data from NHSBSA (expected early June 2023) that will provide national outcome data up to end of March 2023. This update will correct any boundary changes as well as include updates such as the second national outcome metric (High Dose).

Detailed information

Key updates and achievements

Systematic approach to improvement and structured support to understand the problem:

There is overwhelming interest in the Opioids Safety Improvement Programme from ICSs across England; our ambition is to support 15 ICSs through the whole systems approach framework in 2022/23.

Q4 2022/23 has seen 14 PSCs working with 19 ICBs/ ICSs through Quality Improvement (Phases 4-6) whereby the ICB is encouraged to work with stakeholders using the insights from Quality Planning (Phases 2 and 3) to:

- Agree which patients the system wants to target or prioritise to reduce the inequitable distribution of harm associated with inequalities and opioid use.
- Agree which patient groups will be out of scope.
- Agree the shared vision and programme improvement aim.
- Produce a draft whole system action plan
- Develop a measurement plan
- Develop the structure of the system network
- Undertake system network meetings
- Present the finalised shared vision to the network
- Agree the action plan with the network
- Implement the action plan, maintain momentum through regular meetings, sharing learning and continuous measurement for improvement

Of these, 7 PSCs have been supporting 10 ICBs/ICSs to implement the action plan (Phase 6 – Action).

In addition, 5 PSCs are working with 14 additional ICBs/ICSs through Quality Planning (Phases 2-3, detail of which was previously described in the Q1 narrative report).

National outcome measurement:

Further development of the National Opioid Outcome dashboard has been undertaken in Q4. Unity Insights have produced a Tableau Dashboard based on the prototype used to date. We await the end of year data from NHSBSA (expected early June 2023) that will provide data up to end of March 2023. This update will correct any boundary changes as well as include updates such as the second national outcome metric (High Dose) and improved functionality.

Learning between ICSs:

One of the mechanisms by which the National Patient Safety Team is supporting this programme is via national Action and Learning sessions (NALS) which are planned for every Quarter of 2022/23. These Action and Learning Sessions are an opportunity for peer-to-peer coaching which helps us expose, consider and address problems that are mutually challenging then generate change ideas that teams can take back to their wider stakeholders as well as inform support requirements for the national programme

The Q4 NALS for MedSIP was held in February 2023 and it was designed as an opportunity to reflect together on the last 12 months of working on the Opioid Safety Improvement Programme: Celebrating what is going well, sharing learning and hopefully providing some extra motivation as we move into to the next year.

Our intention was to explore what we have collectively learned over this period in order to improve as teams and build a strong programme going forwards.

We heard from all the teams working across England with respect to:

- **Reflections on Empowering Patients as Key Partners:** In the third of our national Action and Learning Sessions our main focus was “Empowering patients as key partners”, specifically, we brought teams together to consider how the teams who are leading this programme of work across their geographies can successfully engage and empower patients. During the Q4 NALS we invited each team to share verbally their reflections on Empowering Patients as Key Partners in your work so far:
    - What is going well?
    - Have you faced any challenges?
    - Can you describe any key learnings so far?

- **Reflections on Our Journey So Far:** Each team completed a pre-work task to undertake a 4Ls retrospective, identifying what they loved, loathed, learned, and longed for whilst working on the Opioids Safety Improvement programme. During the Q4 NALS we invited each team to share;
    - Where their system started from
    - The approach their system is taking.
    - 1-2 actions they identified as part of the 4Ls retrospective that they believe will make an impact on their teams work in 2023/34

(Further information will be included in the 2022/23 end of year report)

Context, challenges, and expectations

Q4 has seen a significant number of ICSs (19) being supported by PSCs to move into and start to undertake Quality Improvement activity.

The PSCs have identified the following risks and challenges:

- Primary care capacity
- Lack of clarity over PSC commission and budgets from NHS England

Outcome Measures

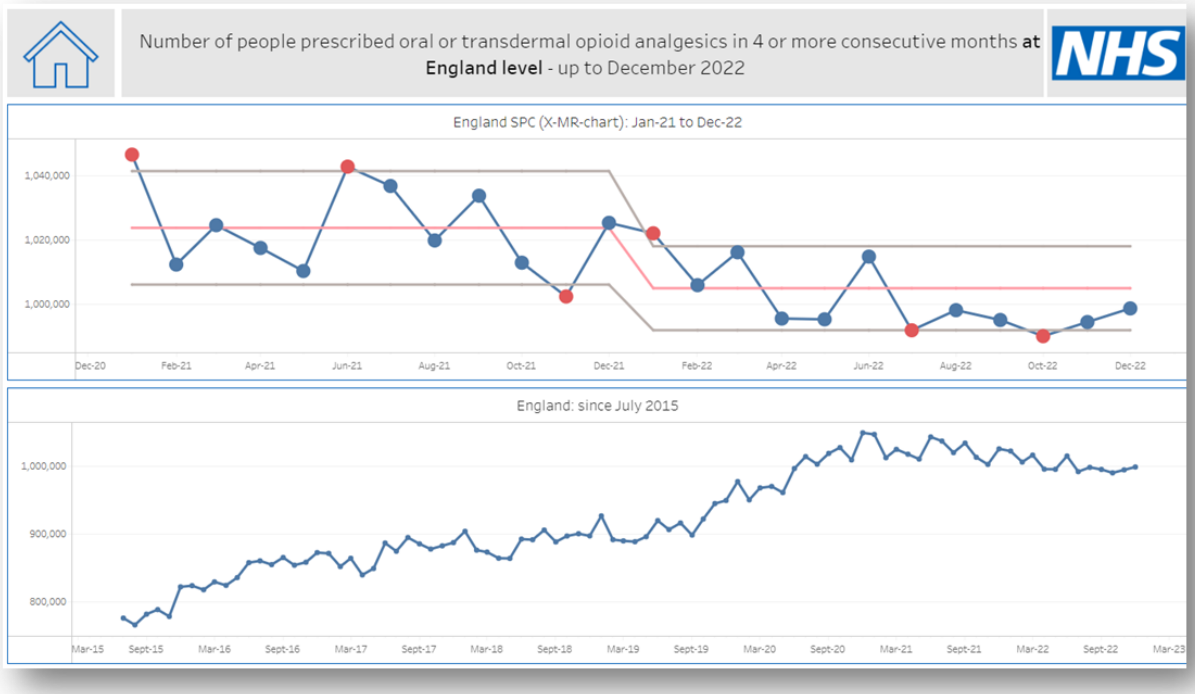
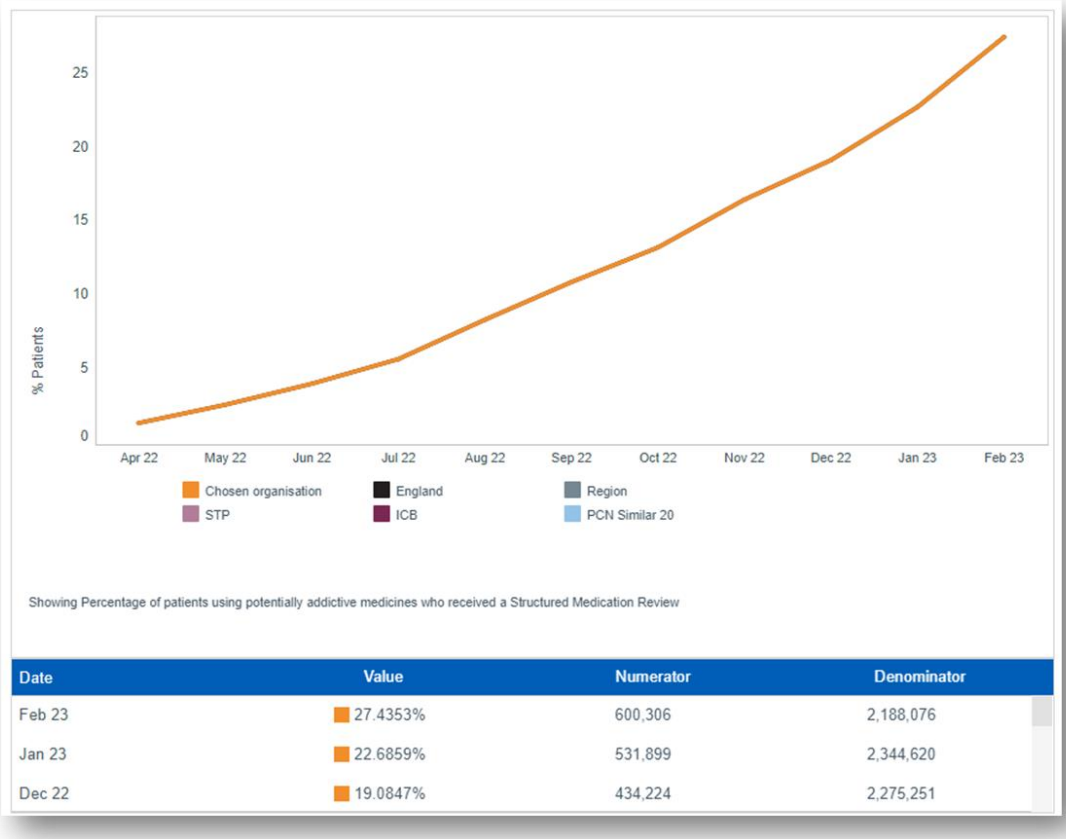


Figure 15: Patients who have been prescribed an oral or transdermal opioid in the specified month and the three preceding months meaning they have had a prescription for four consecutive months.
All England data January 2021 -December 2022 (XMR Chart)

Impact modelling has been developed for this programme alongside Unity Insights that allows the National Team to estimate impact of the programme and was previously described in the Q3 report.

We await the end of year data from NHSBSA (expected early June 2023) that will provide data up to end of March 2023. (Further information will be included in the 2022/23 end of year report)

Process Measures:



Date	Value	Numerator	Denominator
Feb 23	27.4353%	600,306	2,188,076
Jan 23	22.6859%	531,899	2,344,620
Dec 22	19.0847%	434,224	2,275,251

Figure 16: Percentage of patients using potentially addictive medicines who received a structured medication review in Primary Care in England (SMR-01C)

By February 2023 structured medication reviews (SMRs) in Primary Care in England had been performed with 600,306 (27.4%) eligible patients who are prescribed potentially addictive medicines. (source GPES data via the PCN Dashboard). This is an increase of 166,082 patients in Q4.

Key Learnings

(Further information including key learnings will be included in the 2022/23 end of year report)

National Patient Safety Improvement Programmes

Mental Health

Summary of Q4 2022/2023 Progress

Programme Expected Outcomes

25% reduction in incidence of restrictive practice in all inpatient mental health, learning disabilities and autism wards engaged in the programme, including the networks by April 2023.

Programme Deliverables

Engage all NHS MHLDA Trusts with the programme.

Directly support at least 10% of wards in each NHS MHLDA Trust to utilise the RRP change package and so test and implement interventions that lead to a minimum 25% reduction in restrictive practice.

Support the patient safety improvement networks (mental health) to engage greater numbers of wards (or their representatives) as part of this work, including private providers, enabling access to broader learning, coaching and improvement support as required.

Support wards to measure the reductions in restrictive practice as part of an individual network and national picture of progress and impact.

Support the dissemination of improvement learning through the networks, paying particular attention to understanding the benefits, impact and outcomes of reducing restrictive practice.

Progress and contribution to NatPatSIP ambitions 22/23

During Q4 22/23, further progress has been made towards all key ambitions and deliverables of the MHSIP. As at the end of Q4:

- The programme has 51 of 52 eligible NHS MHLDA Trusts (98%) involved with the programme, either supported directly by PSCs or involved through the mental health patient safety networks. This is an increase from 47 at the end of Q4 21/22.
- 261 wards across England are actively engaged in the MHSIP RRP work, including wards across NHS MHLDA Trusts, as well as all of the major private providers of NHS-funded mental health inpatient services.
- Overall, PSCs are directly supporting 13% of all wards in NHS MHLDA Trusts in England to utilise the RRP change package, which means the programme is already exceeding the 22/23 commission target of 10%. 80% of PSCs are directly supporting 10% or more within their AHSN footprint.
- Further progress has been seen in the number of wards implementing the RRP Change Package – an increase from 69% in Q2 to 76% of directly supported wards in Q4.
- Wards are being supported by each PSC to measure reductions in restrictive practice. Continued efforts since Q3 to improve data input to the RRP dashboard will build on preliminary data analysis during Q3 showing 29 wards that have so far achieved an aggregate reduction in their use of restrictive practices (restraint, seclusion and rapid tranquilisation). Improving data quality will remains a priority for the remainder of the commission.

Detailed information

Key updates and achievements

The Mental Health Safety Improvement Programme (MHSIP) has established Mental Health Patient Safety Networks covering all regions. The networks are being supported to engage with the local system to align and drive the improvement work.

Reducing Restrictive Practice

In Q4 22/23 Trusts have continued to utilise quality improvement methodology (IHI's breakthrough series collaborative model or a model equivalent to this) to scale up the reducing restrictive practice change package developed by the National Collaborating Centre for Mental Health (NCCMH). The number of wards actively engaged has now increased to 261 wards (an increase of 85 wards since the start of the 22/23 commission) within 98% of all eligible NHS Mental Health, Learning Disability and Autism Trusts in England and all of the major private providers of NHS-funded inpatient services. The Patient Safety Collaborative (PSC) and NCCMH commission will be coming to an end in September 2023, therefore PSCs are focusing on supporting the wards they already have engaged in the work, rather than focusing on recruitment of new wards at this stage.

There is a diverse and broad range of wards participating in the programme which include: acute adult inpatients; children and young people's services; PICUs; older adults services; medium secure units; low secure units; and learning disability wards. Specialty-based informal networks have continued to enable similar ward types to come together to share learning and experience pertinent to their specialised areas.

Across the country there has been much work undertaken to accelerate improvement through the power of people, including patient and carer co-design, building QI capability, achieving patient safety equity by addressing inequalities and supporting participating teams to understand safety culture. 213 wards are receiving direct improvement support from PSCs to implement the RRP change package and 90% of those wards are actively engaged in improvement activity (either baselining or testing/implementing the RRP change package).

In Q4, the NCCMH and MHSIP Co-leads had a particular focus on data to help workstream and programme leads connect with the data they had been entering into the programme data dashboard. The NCCMH analysed ward-level data ahead of a data clinic on the 26th January 2023, producing statistical process control (SPC) charts for each participating ward for which data was available. Workstream leads, programme leads and ward staff were invited to attend the data clinic, where the NCCMH talked through a sample of SPC charts and invited thoughts, reflections and discussion from the group. The purpose of the data clinic was to not only share the SPC charts, but to demonstrate how the workstream leads can use ward-level data and their SPC chart to prompt questions, reflections and generate change ideas when working with wards. The data clinic was well attended and helped with momentum across the programme. As a result, the NCCMH and MHSIP Co-leads are holding a follow-up data clinic on the 22nd June 2023 and will analyse the latest dataset ahead of the event.

The change in commission (the end of PSC and NCCMH involvement in the RRP programme) understandably brought uncertainty during Q4. To manage this, the NCCMH and MHSIP Co-leads built discussions around the future of the RRP work into the agenda for the in-person Action Learning Set held on the 13th March 2023. Kate Lorrimer, Deputy Head of Quality Transformation (Quality of Care) at NHSE, provided an overview of the Quality Transformation Programme for the PSCs and the NCCMH and MHSIP Co-leads facilitated discussions on priorities for the final six months of the programme. PSCs will continue to support wards to collect data, obtain stories and the impact that this work has had for the participating wards and start to encourage wards to consider how they will ensure their project is sustained.

The NCCMH and MHSIP Co-leads continued the discussion around the future of the RRP programme at a virtual workshop for PSCs, held on the 3rd May 2023, and provided further clarity on how the QI work that wards are undertaking will continue under the Quality Transformation Programme. Discussions in this workshop built on those in the previous in-person event around PSC's priorities for the final months of the programme.

Patient and carer co-design remains integral to the programme at every level. Four Service User Voice Representatives (PPV Partners) have continued to support the central team in championing people who use mental health services and their families/carers' experience, outcomes, viewpoints and voices, ensuring their needs are met through the programme. A presentation one of the MHSIP PPV Partners gave at a PSC mental health patient safety network event can be listened to here. Within the regions there are many examples of patient and carer co-design including; the recruitment of regional experts by experience with various approaches being developed to help advise on involvement and co-production across the programme and to feed into our wider co-production and co-design agenda.

Targeted QI capacity and capability building of individuals and teams in Trusts continues to be supported by the PSCs and NCCMH coaches to help develop competencies and skills to sustain quality improvement activity. This includes supporting existing QI teams within organisations to be involved and connect with the ward teams undertaking the improvement work, so providing additional resource and support to the teams. In turn, helping with spread and sustainability planning and aligning the improvement work with ongoing Trust improvement strategies.

Within regions, alignment with the wider system continues to progress. Improvement work is being included in ICS quality plans and Trust improvement plans supported by NHSE.

Input to the programme's data dashboard continues to build and will remain a key focus throughout the remainder of the commission. Preliminary analysis of this data for 94 wards shows:

- 29 wards have so far achieved an aggregate reduction in their overall use of restrictive practices (restraint, seclusion and rapid tranquilisation).
- 23 wards have reduced their use of restraint.
- 25 wards have reduced their use of seclusion.
- 11 wards have reduced their use of rapid tranquilisation.

Context, challenges, and expectations

Covid and the operational pressures inherent to post-covid recovery continues to significantly impact the programme and MHLDA Trusts more generally, with chronic understaffing, limited resource and capacity impacting the ability to engage fully in quality improvement work. Further, the impact of those challenges has a direct correlation with rates of restrictive practice (for example, understaffing is known to increase the incidence of restrictive practice). Despite these significant challenges on the frontline, continued work to engage wards and Trusts, as well as coaching support to accelerate the improvement, has resulted in further progress towards the key ambitions over the course of Q4.

Data quality for the programme remains variable but is improving and will continue as a key focus for the remainder of the programme.

In Q4 changes to the programme commission and the transition to sitting within NHS England's Mental Health, Learning Disabilities and Autism Inpatient Quality Transformation Programme has brought challenges, which are being addressed as described above. For the remainder of the commission the programme will continue to focus on supporting local areas to build organisational capability to sustain the work to reduce restrictive practice.

Key Learnings

MHLDA Trusts are under huge pressure as recovery continues post-pandemic, as described above. This continues to have a significant impact on programme delivery. Despite this, good progress has continued in moving wards to implementation of the RRP change package. Those PSCs leading the way have several common features supporting their delivery:

- They respond creatively and flexibly to challenges with engagement and delivery – increasing face-to-face ward meetings, sharing learning through newsletters and regular updates, co-ordinating network events with a mixture of virtual and face-to-face delivery modes, providing a variety of opportunities for coaching and improvement support (network events, direct ward meetings/support, additional NCCMH coach support, drop-in sessions, etc).
- They are supporting their teams to understand and respond to their data and adhere to the measurement plan/input data to the dashboard.
- They have good models for engaging Trusts across their PSC footprint and facilitating delivery with strategic oversight and strong senior sponsorship.
- They utilise a whole team approach to programme delivery, engaging NCCMH colleagues and other local QI support to increase capacity for direct improvement support.

Process Measures

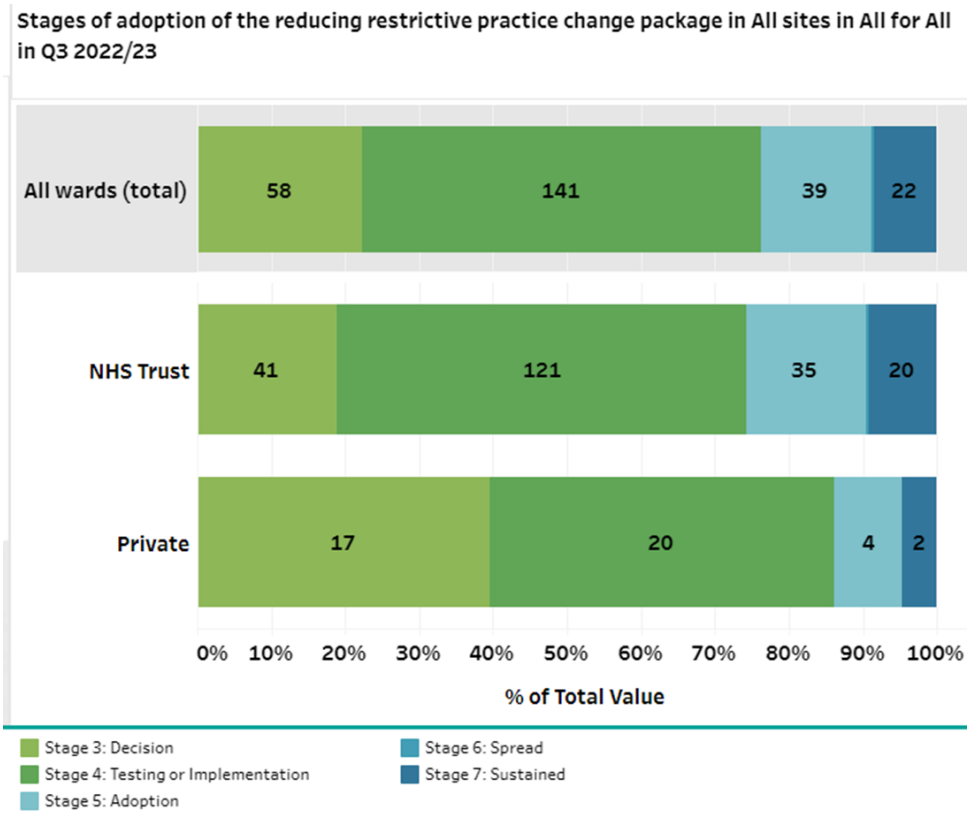


Figure 17 shows the number of wards actively engaged (Stage 3 and above) across the MHSIP. This figure represents a total of 261 wards directly supported by PSCs and engaged through the patient safety improvement networks, across 51 NHS MHLDA Trusts and all of the major private providers of NHS-funded inpatient services.

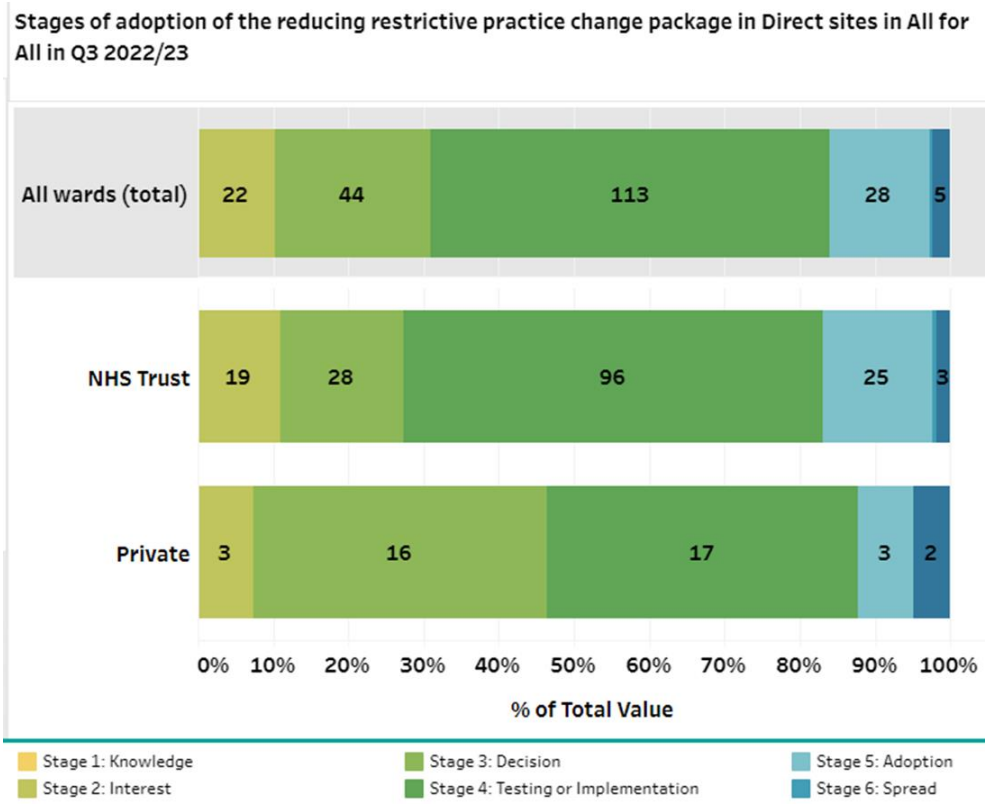


Figure 18 shows the number of wards directly supported by PSCs (at all Stages of Adoption) across the MHSIP. PSCs are directly supporting a total of 213 wards across the country. 172 of these directly supported wards are spread across 47 NHS MHLDA Trusts (90% of all eligible NHS MHLDA Trusts) and 41 across all the major private providers of NHS-funded inpatient services.

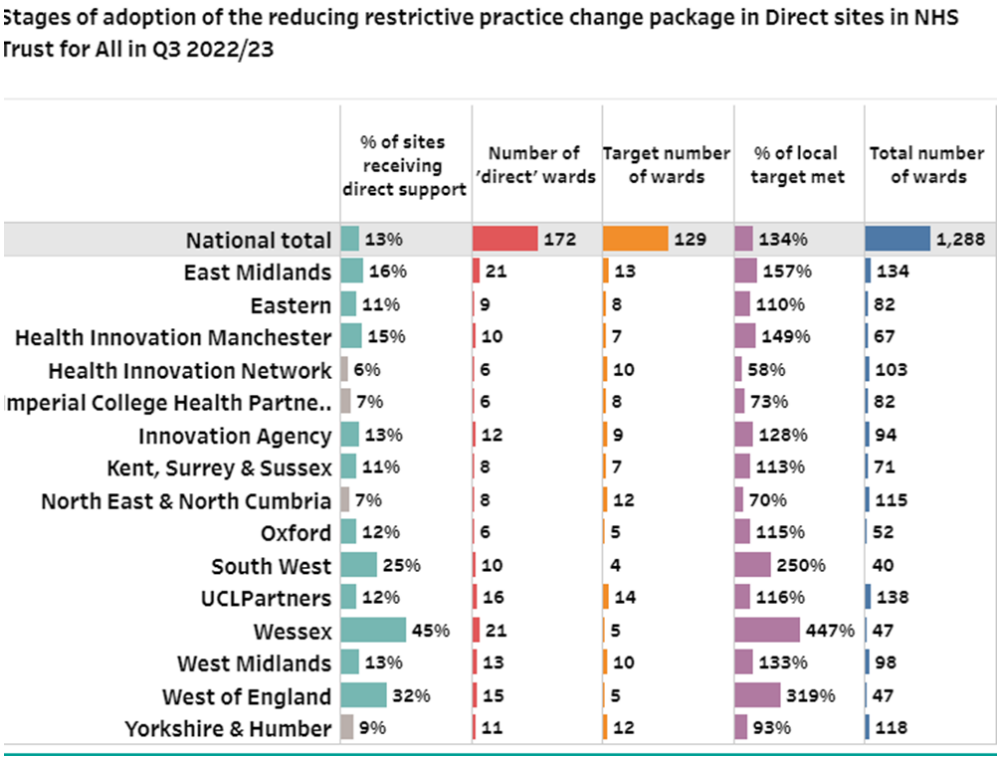


Figure 19 shows the total number and % of NHS MHLDA wards directly supported by each PSC. 12 of 15 PSCs are already meeting or exceeding the 22/23 commission target to directly support 10% of the total wards in their PSC footprint. Nationally the programme is already exceeding that same 10% target, supporting 13% of all wards in NHS MHLDA Trusts across the country.

Case Study

The MHSIP leadership team have been encouraging PSCs to collect case studies and examples of change ideas and good practice taking place across the programme. The following provide some qualitative examples of the impact of the work being done at individual ward level to reduce restrictive practice prior to and over the course of Q4.

Sandpiper written story : 

Sandpiper recycle ward : 

Isle of Wight, Afton Ward : 

National Patient Safety Improvement Programmes

System Safety

Summary of Q4 2022/2023 Progress

Programme Expected Outcomes and Programme Deliverables

The key deliverables as part of the 2022-23 specification are -

- Patient Safety Collaboratives (PSCs) to support effective patient safety networking between stakeholders at Region and ICS level over 2022-23; demonstrating purpose and direction, governance and structure, leadership and facilitation, integrity and vitality, learning and improvement, impact and value, sustainability and renewal.
- PSCs to co-ordinate the development of a safety improvement plan in collaboration with the local systems (ICSs) that reflects a system level response to the 2023-24 specification (as part of the ambitions outlines in the NHS Patient Safety Strategy), by no later than end April 2023.
- PSCs to support the national adoption and scale up of the Patient Safety Incident Response Framework (PSIRF) with fidelity to core principles with an ambition for majority (>85%) NHS Trusts to have completed Phase 1 (orientation) and Phase 2 (Diagnostic and Discovery) by March 2023.

Process Measures

- All 15 PSCs to have co-ordinated and developed a safety improvement plan across all 42 ICSs in England in collaboration with the ICS leads that reflects a system level response to deliver the 2023-24 patient safety improvement ambitions in line with the NHS Patient Safety Strategy.
- By 31st March 2023, >85% of all NHS Trusts will have completed activities relating to phases 1 and 2 (out of the 7 phases) of PSIRF implementation.

Progress and contribution to NatPatSIP ambitions 22/23

The progress of work done by the Patient Safety Collaboratives (PSCs) is measured via the QART stocktake process which includes a quantitative dashboard and a qualitative slide set wherein updates are provided by each PSC every quarter. All changes to the expected outcomes and programme deliverables including change in ambition and consequent process measures are taking into account while evaluating the progress each quarter.

In Q4, all 15 PSC teams continued their engagement with the ICSs and providers in their area especially the Quality and safety leads, Chief Nurses, Patient Safety Specialists, amongst other stakeholders to support the System Safety workstream deliverables over Q4.

PSCs have engaged with all 42 ICSs in England to support the System Safety work via learning events, webinars and resource sharing. There is variation in terms of the level of engagement and PSIRF phase completion depending on local pressures and priorities. No quantitative data (phases completed by Trusts) is being collected via the QART dashboard mainly to enable systems to progress at their pace, but with a vision for all NHS provider Trusts to transition to PSIRF by Autumn 2023.

System safety co-ordinators from the PSCs contributed to and participated in the NHS England led PSIRF Regional Implementation group meetings. PSC representatives also joined the NHS England led webinars in Q4.

Detailed Information

Key updates and achievements

- In Q4, all Patient Safety Collaborative leads continued engagement with their respective Integrated Care System (ICS) leads and providers in their area via ICB whole system workshops and face to face and virtual learning events.
- Stakeholders engaged include Quality and Safety leads, Chief Nurses, Patient Safety Specialists, Patient Safety Partners where available, AD for Quality, Midwives, clinicians, clinical and non-clinical networks as well as external stakeholders such as independent providers as part of progressing the Patient Safety Incident Response Framework (PSIRF) implementation in stipulated phases.
- In Q4 PSCs conducted events and webinars to support stakeholders in the PSIRF transition which included topics on Compassionate engagement, Culture etc.
- All 15 PSCs are working in partnership with their local systems (ICS) leads, provider leads, Patient Safety Specialist networks and/or pan regional patient safety leadership forums where they exist (e.g. in London), and via coaching / improvement academy (eg in Yorkshire & Humber and with North East and North Cumbria) as well as in Midlands and the West of England, South West and Wessex - to offer support for the PSIRF implementation and address the support needs identified locally.

For PSIRF

NHS England published the PSIRF documentation in August 2022 following which the work to implement the PSIRF framework in line with the implementation guidelines commenced. The framework will be implemented in following seven phases (which will overlap) described in the table below –

Phase	Duration	Purpose
Phase 1 – Orientation	Months 1-3 Sep-Dec 22	To help PSIRF leads at all levels of the system familiarise themselves with the revised framework and associated requirements.
Phase 2 – Diagnostic and Discovery	Months 4-7 Dec 22 – Mar 23	To understand how developed systems and processes already are to respond to patient safety incidents for the purpose of learning and improvement.
Phase 3 – Governance and quality monitoring	Months 6-9 Feb/Mar – May/Jun 23	Organisations at all levels of the system (provider, ICB, region) begin to define the oversight structures and ways of working once they transition to PSIRF
Phase 4 – Patient Safety incident response planning	Months 7-10 Apr – Jul 23	Organisations to understand their patient safety incident profile, improvement profile and available resources.
Phase 5 – Curation and agreement of the policy and plan	Months 9-12 Jul to Autumn 23	To draft and agree a patient safety incident response policy and plan based on the findings from the work undertaken in preceding phases.
Phase 6 -Transition – working under the PSIR – Policy and Plan	Months 12+ Sep/Oct 23 onwards	Organisations continue to adapt and learn as the designed systems and processes are put in place
Phase 7 – Embedding sustainable change and improvement	Months 12+ Q3-Q4 23/4	Sustainability of the PSRIF across local systems to become business as usual.

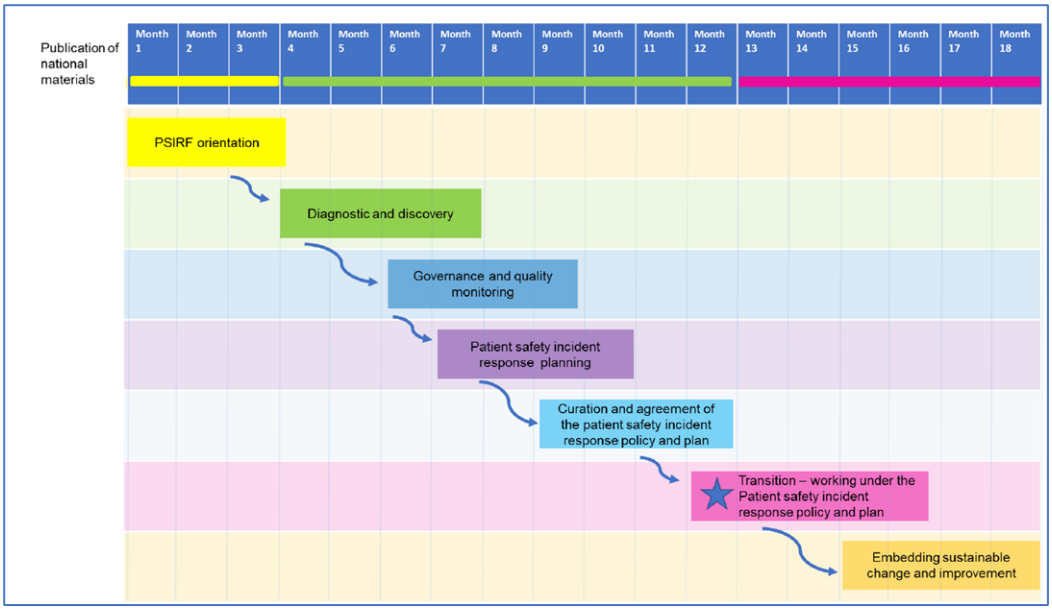
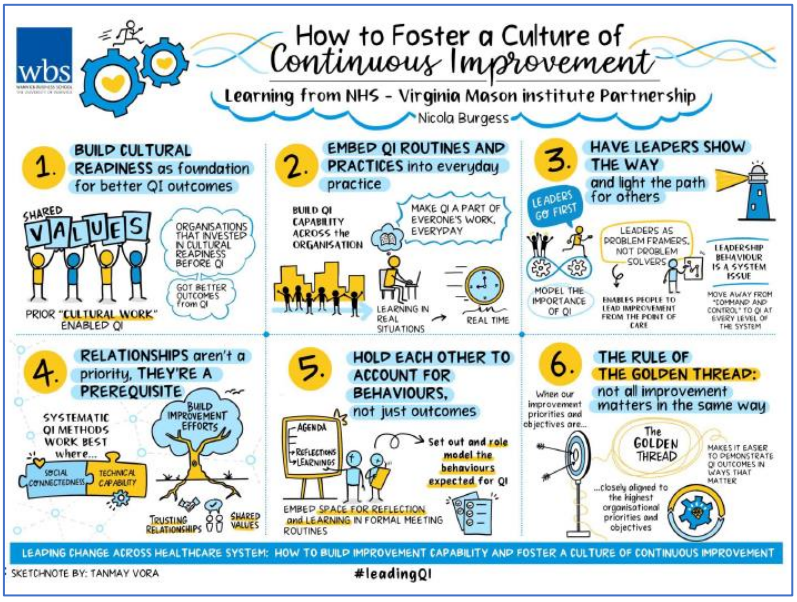


Figure 20: PSIRF implementation phases and the timeline published in the PSIRF preparation guide

Work Underway

The ambition set out for 2022/23 was for majority of NHS Trusts to have completed Phase 1 (Orientation) by Dec 22 and Phase 2 (diagnostic and discovery) by Mar 23 apart from the early adopters who are in the transition phase (6) having been through earlier phases.

- PSCs have co-ordinated face to face and virtual sessions, webinars, inaugural events, for stakeholders to support the implementation of PSIRF through action learning events and QI skill related webinars to capacity and capability of ICSs to transition to PSIRF. A range of topics have been covered including discussion related to:
  - Systems Engineering in Patient Safety
  - Compassionate engagement
  - Process mapping & Stakeholder engagement.
  - Safety culture
  - Just culture in practice



Infographic on 'Six key lessons from the NHS and Virginia Mason Institute Partnership, Warwick Business School shared at the Eastern PSC Collaborative PSIRF event is shown below on –'How to foster a culture of continuous improvement'

- PSCs have also used 'Ask the expert' sessions where early adopters of PSIRF contribute to learning and education of the PSIRF work. Community of practice, reading groups and similar such approaches are also implemented to support the PSIRF implementation work.

- Many PSCs continue to work collaboratively with their partner PSCs e.g. Innovation Agency NWC and Health Innovation–Manchester; all London PSCs e.g. Imperial in Northwest London, Health Innovation – South London and UCLP – North Central and North East London as well as in the Midlands (East and West Midlands) and in the West and South West of England – with shared learning across the systems.
- There was active participation and contribution via the seven NHS England Regional leads and specialists led national PSIRF implementation group that is driving the progress of PSIRF across all the 42 ICSs in England.
- The dedicated section on the NHS Futures platform continues to be used to share useful learning and resources, including outputs from the Action Learning Sessions, and are benefiting stakeholders to support the PSIRF work. Redefining locations in the NHS Futures to enable ease of access to required resources is underway to facilitate stakeholders accessing PSIRF resources via the NHS Futures platform.

Action learning Set (ALS) session

Following early discussions to scope the Action learning set (ALS) sessions undertaken by NHS England in partnership with the System Safety Co-ordinators and the associate, two action learning sessions have been delivered in Dec 22 and Feb 23 to share learning and develop actions to support PSC leads with their System safety work.

This ALS model broadly includes -

- Sharing learning from across systems
- Defining an issue or challenge to address
- Discuss and explore possible solutions (e.g. QI tools) to address the issue
- Define actions for delivery – to be reviewed at the future ALS sessions.

The first national Action Learning Set (ALS) session was held on 13th Dec 2022 where all the PSC workstream leads came together to share learning, discuss aspects of culture in implementation of PSIRF as well as devising actions (using QI methods and tools) to address any issues or challenges identified or faced by the ICSs and providers.

The second ALS session in Q4 was held on 14th Feb 2023 with good attendance from across the Patient Safety Collaboratives. Topics covered included -

- National updates on PSIRF via the National leads.
- A session on LfPSE – Learning from Patient Safety Events as a system that will replace the National Reporting and Learning System (NRLS).
- A talk and open discussion with Q&As on ‘Family engagement in patient safety’. The talk was delivered by Prof. Jane O’Hara – Professor of Healthcare Quality and Safety, University of Leeds and Deputy Director of Yorkshire Quality and Safety Research Group. Below is one of the slides in the video shared on some of the ‘Principles of meaningful involvement of stakeholders’ as part of a patient safety investigation -

- Breakout room workshops were held using jamboard slides for the participants including review of actions from the previous ALS session in December 2022. This followed discussion on challenges and issues to explore solutions and agree actions to be taken forward as part of the support offer to the system to implement PSIRF in the stipulated phases, which the participants found very useful.

Outputs of this ALS session were shared and uploaded to the relevant NHS Futures pages for collaboratively learning.

Context, challenges, and expectations

The 15 PSCs around England were commissioned to work with ICSs over 2022-23 by offering support to the ICSs and their providers in close partnership to deliver the local and national patient safety improvement priorities including the implementation of the Patient Safety Incident Response Framework (PSIRF) - in line with the guidance published by NHS England - using quality improvement approaches.

There are around 270+ NHS providers in England excluding independent providers who will be working towards implementing the PSIRF with NHS Acute Trusts leading the way. Work is also extending to primary care as well as independent providers who serve NHS patient directly. The PSIRF documentation highlights responsibilities of providers, the ICSs and the Patient Safety Collaboratives. The PSCs have a supportive role to support their local systems to implement PSIRF. NHS England has an assurance role regarding PSIRF implementation via the ICSs.

The provider organisations (Acute Trusts, Ambulance Trusts as well as ICSs) who were early adopter sites of the Patient Safety Incident Response Framework implementation are providing key learning & sharing their experience to support other provider organisations and PSCs via learning sessions, webinars, meetings & podcasts; to support the wider implementation and roll out nationally.

The main challenges faced by the PSCs in Q4 were -

- Work to support 42 ICSs and around 270+ providers (excluding the independent providers) is a large-scale task with inherent challenges across the system (ICS) as a whole.
- System wide pressures, medical staff strikes have possibly affected participation from certain providers and regions at webinars/events. Winter pressures and system and staff capacity (e.g resources) were also cited by the ICSs and providers as challenges over Q4 by providers impacting the PSIRF work.
- While most ICSs are now fully functioning and delivering their statutory responsibilities, governance structures or staff there-in in few ICSs were still being recruited, delaying engagement. However, the engagement has extended to involve the key quality and safety leads (where appointed) at all ICSs in England over Q4.
- There is variation in the transition of organisations in the stipulated PSIRF implementation phases within ICSs as well as regions. This is being reviewed to ensure areas or providers who need

focussed support are prioritised via the PSC input. The PSCs to date have worked under the direction of their ICB leads to support organisations including those lagging in the transition stages.

- Not all systems have developed a uniform understanding of PSIRF which may impact timely transition and may result in variation. The NHS Regional leads have oversight in terms of assurance and sharing of intelligence between PSCs and NHSE Regional leads has been discussed to support the understanding of progress to enable timely transition by NHS Trusts to PSIRF by Autumn 2023 as per the plan.
- Providers expressed a need for additional resources / funding and/or development of business cases to get resources to implement different aspects of the National Patient Safety Strategy such as PSIRF, LfPSE (Learning from Patient Safety Events), PSP (Patient Safety Partner) recruitment.

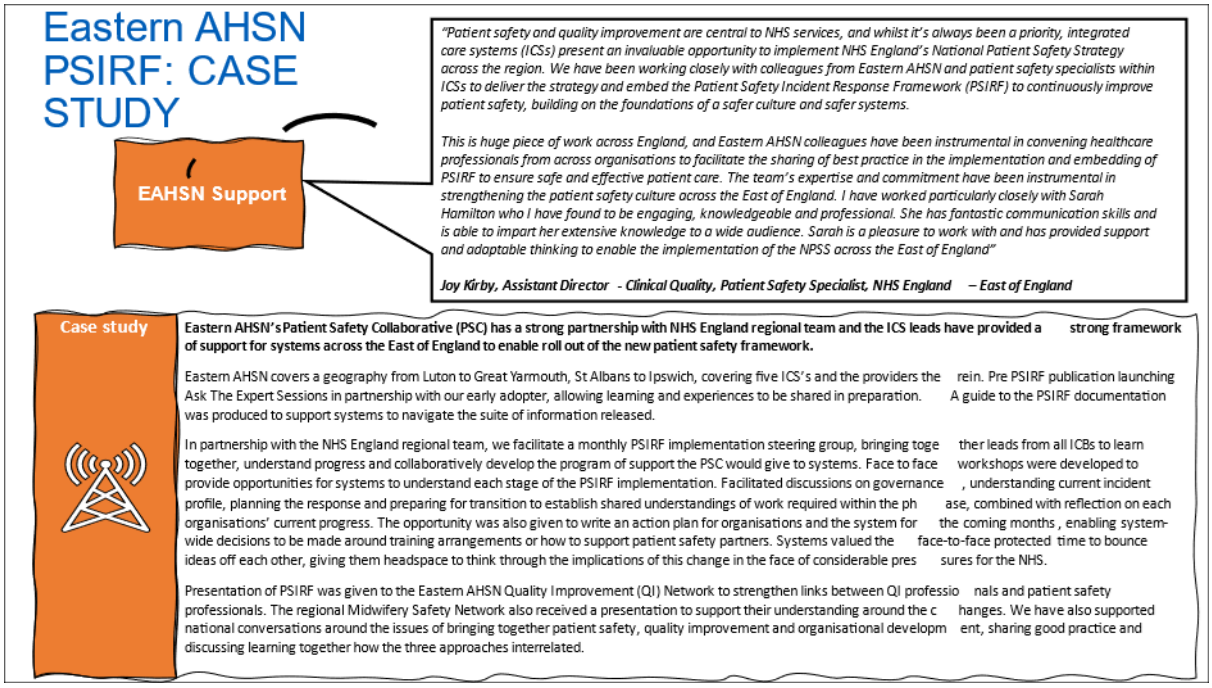
Key learnings

- NHS England continued direct discussions via visits to PSC organised events to join the PSIRF learning sessions across England, which aided the understanding of the networking landscape, ICS and provider interface to improve patient safety at a system level as well as the progress in the implementation of PSIRF.
- ICS leads continue to lead the way in partnership with the provider leads and NHSE regional PSIRF leads in terms of implementing the PSIRF framework. Discussions are continuing with regard to implementation of PSIRF in maternity settings, mental health providers, ambulance trusts, care homes, primary care, community care as well as independent providers alongside the Acute Trusts.
- Use of Quality Improvement tools along with talks on culture, psychological safety, impact of effective leadership, discussion on how we can use intelligence to support decision making as well as ask the expert sessions with early adopters, are proving useful to ICSs and providers as part of the transitioning from the SII (Serious Incident Investigation) framework to PSIRF.
- PSIRF aligns with other priorities in the National Patient Safety Strategy such as the implementation of LfPSE (Learning from Patient Safety Events) which will replace the NRLS (National Reporting and Learning System) and Patient Safety Partners recruitment as part of the Involving Patients in Patient Safety (IPIPS) framework.
- Patient safety Specialists alongside the Patient Safety Partners continue to be key allies in improving patient safety at a system level in line with the ambition stated in the National Patient Safety Strategy.

Over 2023/24 the Patient Safety Collaboratives will continue offering support to the ICSs and providers therein, to support the PSIRF transition work in the stipulated phases

Case Study

1st Case study from: Eastern Patient Safety Collaborative



Eastern AHSN PSIRF: CASE STUDY

EAHSN Support

"Patient safety and quality improvement are central to NHS services, and whilst it's always been a priority, integrated care systems (ICSs) present an invaluable opportunity to implement NHS England's National Patient Safety Strategy across the region. We have been working closely with colleagues from Eastern AHSN and patient safety specialists within ICSs to deliver the strategy and embed the Patient Safety Incident Response Framework (PSIRF) to continuously improve patient safety, building on the foundations of a safer culture and safer systems.

This is huge piece of work across England, and Eastern AHSN colleagues have been instrumental in convening healthcare professionals from across organisations to facilitate the sharing of best practice in the implementation and embedding of PSIRF to ensure safe and effective patient care. The team's expertise and commitment have been instrumental in strengthening the patient safety culture across the East of England. I have worked particularly closely with Sarah Hamilton who I have found to be engaging, knowledgeable and professional. She has fantastic communication skills and is able to impart her extensive knowledge to a wide audience. Sarah is a pleasure to work with and has provided support and adaptable thinking to enable the implementation of the NPSS across the East of England"

Joy Kirby, Assistant Director - Clinical Quality, Patient Safety Specialist, NHS England – East of England

Case study

Eastern AHSN's Patient Safety Collaborative (PSC) has a strong partnership with NHS England regional team and the ICS leads have provided a strong framework of support for systems across the East of England to enable roll out of the new patient safety framework.

Eastern AHSN covers a geography from Luton to Great Yarmouth, St Albans to Ipswich, covering five ICS's and the providers the rein. Pre PSIRF publication launching Ask The Expert Sessions in partnership with our early adopter, allowing learning and experiences to be shared in preparation. A guide to the PSIRF documentation was produced to support systems to navigate the suite of information released.

In partnership with the NHS England regional team, we facilitate a monthly PSIRF implementation steering group, bringing toge ther leads from all ICBs to learn together, understand progress and collaboratively develop the program of support the PSC would give to systems. Face to face workshops were developed to provide opportunities for systems to understand each stage of the PSIRF implementation. Facilitated discussions on governance , understanding current incident profile, planning the response and preparing for transition to establish shared understandings of work required within the ph ase, combined with reflection on each organisations' current progress. The opportunity was also given to write an action plan for organisations and the system for the coming months , enabling system-wide decisions to be made around training arrangements or how to support patient safety partners. Systems valued the face-to-face protected time to bounce ideas off each other, giving them headspace to think through the implications of this change in the face of considerable pres sures for the NHS.

Presentation of PSIRF was given to the Eastern AHSN Quality Improvement (QI) Network to strengthen links between QI professio nals and patient safety professionals. The regional Midwifery Safety Network also received a presentation to support their understanding around the c hanges. We have also supported national conversations around the issues of bringing together patient safety, quality improvement and organisational developm ent, sharing good practice and discussing learning together how the three approaches interrelated.

2nd Case study from: Wessex Patient Safety Collaborative

National Patient Safety Improvement Programmes

System Safety

NHS CASE STUDY

Supporting the implementation of the Patient Safety Incident Response Framework (PSIRF) across Wessex

Background

In 2022/23 PSCs were commissioned to support the national adoption and scale up of the Patient Safety Incident Response Framework (PSIRF).

PSIRF sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

"The introduction of this framework represents a significant shift in the way the NHS responds to patient safety incidents, increasing focus on understanding how incidents happen – including the factors which contribute to them."

Aidan Fowler, National Director of Pt Safety, NHS England

Feedback from our Partners

Thank you for talking to us, we felt more positive about our PSIRF journey after talking to you and I think we can get some momentum now to start moving forward.

AD Quality, Governance and Risk | Pt Safety Specialist

Can I say that as PSIRF Programme Lead I found the session enormously helpful in showing us where the biggest gaps were in understanding and awareness of PSIRF which has helped us to understand how we need to pitch and target our communications

Patient Safety Project Consultant

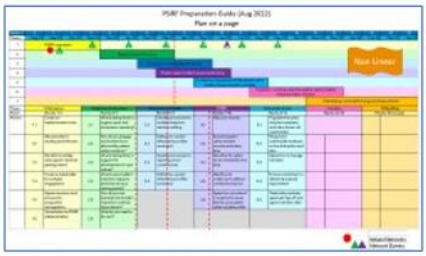
Just to say thank you for today's session - it was really helpful and informative I've received some good feedback

Head of Quality, Pt Safety & Governance

The help of the PSC is invaluable. You are absolutely part of our journey, driving us forward and providing that challenge and insight from a wider perspective.

Head of Risk Management

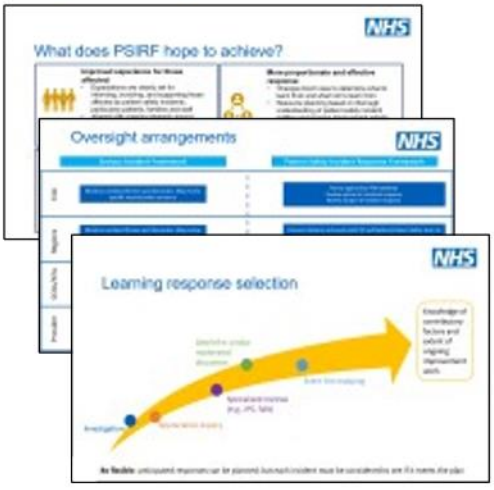
PSIRF Roadmap (Plan on a Page)



Our Approach

- Wessex PSC has supported the development of system wide networks by helping to convene and facilitate meetings, co-ordinate network activities and provide coaching and improvement support using a QI / coaching approach.
- Wessex PSC has also engaged with national and regional PSIRF leads, Regional Patient Safety Specialists and Patient Partners to support local initiatives and promote communications between stakeholders, including amongst others: maternity services, specialised commissioning and independent providers.
- As part of a flexible and scaleable support approach Wessex PSC has facilitated workshops in provider organisations to help them assess their capability and capacity to meet PSIRF requirements.
- Wessex PSC facilitated workshops have helped organisations surface and start to address key issues including
  - capability and capacity assessments
  - assessing training requirements
  - identifying incident themes
  - enabling staff engagement and
  - exploring methods for sharing learning and communicating improvement approaches.

Example Workshop activities



Appendix A

Further breakdown of deterioration stages of adoption

Stage	Description/Definition
Stage 0	The site has not yet been contacted or responded to contact. Based on the setting type and the number of organisations within that setting for each PSC, where there is no knowledge of contact or activity the number of relevant sites should be detailed here.
Stage 1	This relates to where communications have been sent out to organisations and there is evidence they are aware of the work in relation to the appropriate tools. This may be through response to the initial contact or through network events or other forms of communication, whether directly by PSCs or through other stakeholders e.g., CCG.
Stage 2	The site's interest has been assessed. Like stage 1 this may be through response to communications or through events/meetings.
Stage 3	The sites' decision to participate in using the appropriate tools is evident. This may be through individual agreement or through organisational or regional strategic priority i.e., CCG commitment. This might include attendance at information events or tool training. In order to reach stage 4 it is expected that training will already have been undertaken. An organisation may be designated as commencing training where at least one person in that organisation has been trained. As part of delivery planning PSCs should consider how training is made sustainable taking into account staff turnover etc. as well as develop local measures of activity such as individuals trained. Where sites are using digital solutions, it is assumed that they will be familiar with the tools and have undertaken some basic training – if no further knowledge of application and use is available then those sites should only be identified as stage 3.
Stage 4	The intervention i.e., the EWS, deterioration tool or PCSP is being tested. Testing is where the appropriate tool has been used on at least one occasion with one patient/resident/person.
Stage 5	The intervention is being used on a proportion of the organisation's patients/residents/people but not all. This might be 2 out of 5 GPs in a practice using NEWS2 with their caseload, a section of a care home etc.
Stage 6	The intervention is being used for all appropriate patients, by all staff within an organisation i.e., 5 out of 5 GPs in a practice, the whole care home.
Stage 7	The intervention is embedded in business as usual and is being consistently used (where appropriate) i.e., every patient/resident/person every time.

Appendix B

Further breakdown Project Progress Score definitions

Score	Description/Definition
0.5	Intent to participate
1.0	Commitment to participate
1.5	Planning for project has begun
2.0	Activity but no improvement
2.5	Changes but no improvement
3.0	Modest improvement: Qualitative Improvement
3.5	Improvement: Significant improvement towards the ICS's *Improvement Aim* that can be demonstrated using data.
4.0	Significant improvement: The ICS's *Improvement Aim* has been achieved and can be demonstrated using data.
4.5	Sustainable improvement: Improvement that continues >6 months as a result of embedding change
5.0	Outstanding sustainable results: Improvement that continues >12 months as a result of embedding change

Places

The term 'place' is used flexibly due to the variability observed within local arrangements. There is no 'one size fits all' approach to define a place; each place reflects a unique geography and relationship to local people and communities.

The NHS has defined 'place' as meaning geographies comprising populations of between 250,000 and 500,000. In many areas, there are existing geographies at the scale of upper and lower-tier local authorities that already have a significant degree of coherence, including effective governance structures.

As described in Shifting the Centre of Gravity: Making Place-Based, Person-Centred Care A Reality, the boundaries of the local place should be determined "following local discussion and considering the role of all the partners who contribute to health and care in a place" (Local Government Association et al., 2018)

Local places also build naturally on previous efforts to integrate care and local services, such as the Better Care Fund and integrated care pioneers. Strategic leadership at the place level also supports the development of primary care networks and integrated care providers.

Glossary

Acronyms

ACS – Appropriate Care Score

CO@h – COVID Oximetry@home

CVW – COVID Virtual Wards

CQS – Composite Quality Score

ICB – Integrated Care Board

ICS – Integrated Care System

LIP – Local Improvement Plan

ManDetSIP – Managing Deterioration Safety Improvement Programme

MatNeoSIP – Maternity and Neonatal Safety Improvement Programme

MSDS – Maternity Service Data Set

MedSIP – Medicines Safety Improvement Programme

MEWS – Maternity Early Warning Score

MHSIP – Mental Health Safety Improvement Programme

NCCMH – National Collaborating Centre for Mental Health

NatPatSIPs – National Patient Safety Improvement Programmes

NEWS2 – National Early Warning System 2

PEWS – Paediatric Early Warning Score

PSC – Patient Safety Collaborative

PSIRF – Patient Safety Incident Response Framework

PSL – Patient Safety Lead

PSNs – Patient Safety Networks

PSP – Patient Safety Partner

PSS – Patient Safety Specialist

PAS – Progression Assessment Score

SIP – Safety Improvement Programmes

WSL – Workstream Leads

Key Enablers

- **Addressing inequalities** – understand local health inequalities to ensure selected interventions improve the lives of those with the worst health outcomes fastest.
- **Patient / carer codesign** – employ a co-production approach with patients, carers and service users who represent the diversity of the population served.
- **Safety culture** – use safety culture insights to inform quality improvement approaches
- **Patient safety networks** – to coordinate and facilitate patient safety networks to provide the delivery architecture for safety improvement
- **Improvement leadership** – identify and nurture leadership, including clinical leaders, to lead improvement through the networks.
- **Building capacity and capability** – use a dosing approach to build quality improvement capacity and capability.
- **Measurement for improvement** – develop a robust measurement plan including relevant process, balancing and outcomes metrics.
- **Improvement and innovation pipeline** - undertake horizon scanning and prioritisation to inform future national work.