National Patient Safety Improvement Programmes

National Programmes

National Patient Safety Improvement Programme

Q1 2023/2024

Progress Report

@NatPatSIP / @MatNeoSIP

www.england.nhs.uk

Delivered by:
TheAHSNNetwork

Led by:
NHS England

Contents

Table of Figures

Executive Summary

Maternity and Neonatal Safety Improvement Programme

Optimisation and stabilisation of the preterm infant:

- Thorough diagnostics have been undertaken for the 2 new interventions, which have enabled systems to see how well caffeine and volume targeted ventilation (VTV) is being achieved. This will add to the effectiveness of the preterm optimisation pathway.
- Increases in adoption and spread (A&S), continued to be demonstrated, showing the activity of the workstream remains high despite other initiatives.
- Significant increases in process measures and outcomes, are being seen in figure 2, 3, 4, 5, 6, 7, 8, 9, 10, and 11. These data demonstrate a reduction in variation and improvement in achieving the programmes ambition.
- Organisations providing permission for data to be used for the Preterm Optimisation data is now at 93% across England.
- System stakeholder involvement on dashboard design has been carried out.

Early recognition and management of deterioration of women and babies:

- NEWTT2 onboarding meetings with paper-based organisations commenced.
- MEWS onboarding meetings with paper-based organisations commenced.
- Patient Safety Collaboratives (PSCs) continue to support the E and R of PIER by supporting implementation of the Each Baby Counts Learn and Support toolkits.
- BSOTS remains a key component of the deterioration work with PSCs supporting implementation where needed.
- BSOTS algorithms have been aligned with the national MEWS and being shared with organisations as part of the onboarding process.

Managing Deterioration Safety Improvement Programme

There has been continued movement in the adoption of a deterioration tool. The PSCs are working with 11,827 (79% against the 95% target) care homes with 9,530 care homes at adoption stage 5 or more (64% against the 85% target).

This programme has paused at the end of Q1. West Midlands data shows: 60% of UCR are from care homes, a sustained decrease in 999 calls and emergency department admissions with 97% of residents dying in their preferred place (this data is used to model national impact).

There is interest from some integrated care systems (ICSs) to continue this work and some PSCs are exploring how they can do this.

Medicines Safety Improvement Programme

- In Q1 the PSCs gained agreement to work with all 42 ICBs in 2023/24, supporting 24 ICBs (>50%) to implement the Whole Systems Approach and the remaining via various levels of shared learning and data provision.
- Data to end of March 2023 shows a reduction in the number of people being prescribed opioids for more than 3 months and a reduction in people prescribed high dose opioids.
    - Saving 414 lives over 2 years and 2,570 fewer cases of moderate harm each year as a result of fewer people with chronic pain being prescribed long-term opioid analgesics than in 2021,
    - 4,200 fewer people prescribed high dose opioids (>120mg OME per day).
    - Patients report better quality of life, less pain and less disability as a result of improved care.

Mental Health Safety Improvement Programme

As of the end of Q4 22/23, the MHSIP had 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 were 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.

The MHSIP has been extended for a further 6 months (Q1 & Q2 23/24), now funded by NHS England's Mental Health, Learning Disability and Autism Inpatient Quality Transformation Programme in the Chief Operating Officer's Directorate. After those 6 months the MHSIP will come to a close and mental health, learning disability and autism provider organisations will be supported to transition to the new Quality Transformation Programme's wider work to improve the culture of care in inpatient settings. The current focus of the MHSIP commission for the remaining 6 months is to build sustainability of the work within provider organisations, share and collate the learning from the programme to reduce restrictive practices.

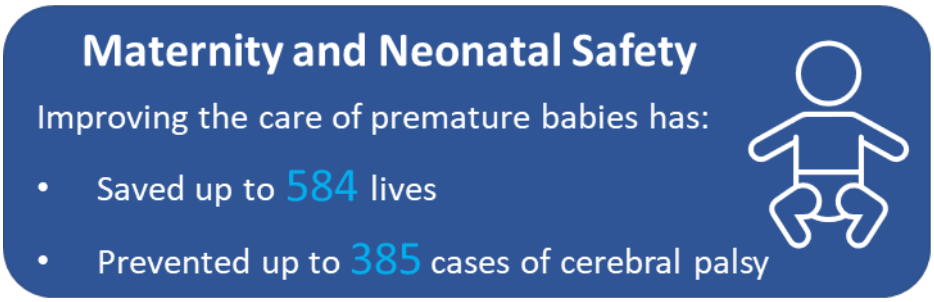
Systems Safety

- The PSCs continued their contribution to the implementation of the Patient Safety Incident Response Framework (PSIRF) in Q1 in line with the 2023-24 National Patient Safety Improvement Programmes requirements under the System Safety workstream.
- In Q1 the PSCs focused on developing the 'Support Offer' with the systems especially the Integrated Care Board (ICB) quality and safety leads and provider leads to define the PSC support to implement PSIRF in the stipulated phases.
- In Q1, the PSCs continued to understand the variation and identify ICS/providers who need focused PSIRF support working in partnership with system leads for the same using coaching / improvement methods as well as offering support to review PSIR – Plans via a Quality Improvement (QI) lens.
- A joint entry to the HSJ poster competition was submitted on behalf of the North West Collaborative summarising all the PSIRF events delivered and the outputs. A blog was also published by Health Innovation Manchester summarising the PSIRF events in the North West.
- Few challenges encountered include - maturity of ICSs that may impact on timely transition to PSIRF in a few areas, lack of resources quoted by system leads due to pressures and other priorities.
- Many PSCs are working in partnership at regional level to maximise their input.
- Discussions are continuing with regard to the PSC support in terms of 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 within available capacity.

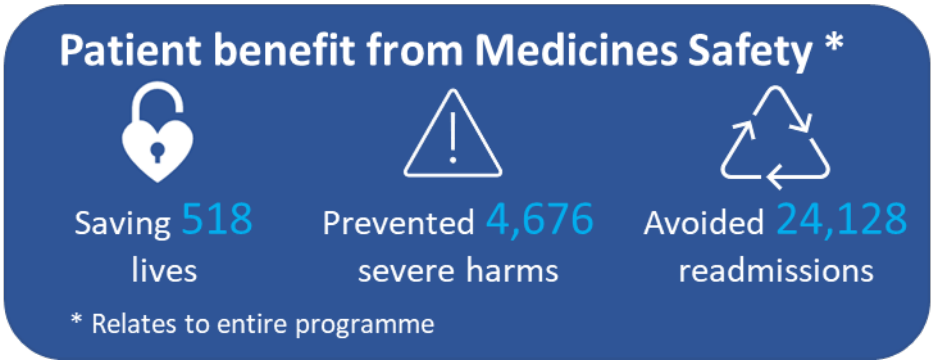
Key Infographics

Managing Deterioration Safety Improvement Programme

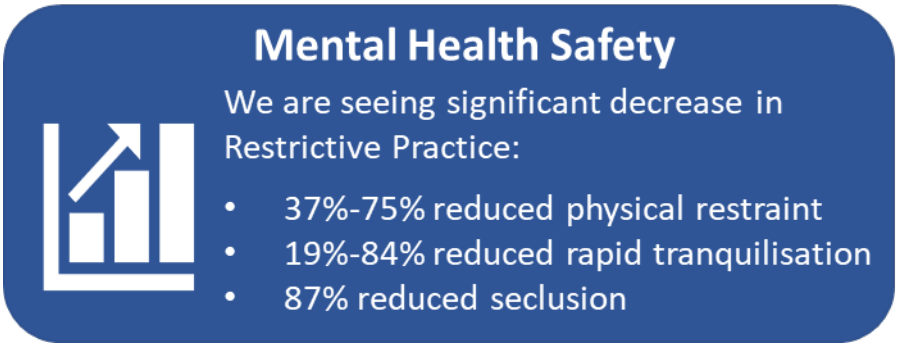
Maternity and Neonatal Safety Improvement Programme



Medicines Safety Improvement Programme



Mental Health Safety Improvement Programme



Systems Safety

Summary of Q1 2023/2024 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.

Newborn 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

Optimisation and Stabilisation of the preterm infant.

- Ensure the effective optimisation and stabilisation of the preterm infant by embedding a pathway of care consisting of nine evidence-based interventions leading to improved health outcomes.
- All 9 key interventions to be implemented, as a pathway approach.

Early Recognition and Management of Deterioration of women and babies.

Ensure the use of the Maternity Early Warning Score (MEWS) tool is supported within an effective PIER pathway for managing deterioration and support:

- All Early implementer sites to be identified before Q1 2023 to commence implementation at start of April 2023.
- All sites identified for Phase 4 by June 2023.
- All sites for Phase 5 (Digital sites) to be identified by July 2023.
- All sites identified for Phase 6 to be identified by December 2023.
- Develop a local plan that outlines how Phase 3 to 6 will be implemented.

Ensure the use of the Newborn Early Warning Trigger and Track (NEWTT2) tool is supported within an effective PIER pathway for managing deterioration and support:

- All Early implementer sites to be embedded within Phase 3 by June 2023.
- All sites identified for Phase 4 to be embedded by September 2023.
- All sites for Phase 5 (Digital sites) to be identified by September 2023.
- All sites identified for Phase 6 to be embedded by January 2024.
- Phase 3 to 6 to be supported with a local plan for adoption and spread.

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 23/24

As we can see in figure 1, the Adoption and Spread has reached 65%, which was the ambition set for Q4. This is a great achievement with plans in place for Q2 to address the specificity of reporting to increase the up take. 5 of the 7 elements remain really high and 3 of which are in quality control/sustainability. As seen in Figures 3, 4, and 6. Further work is being undertaken in Q2 to explore these concepts and imbed these interventions without the current improvement resource allocation.

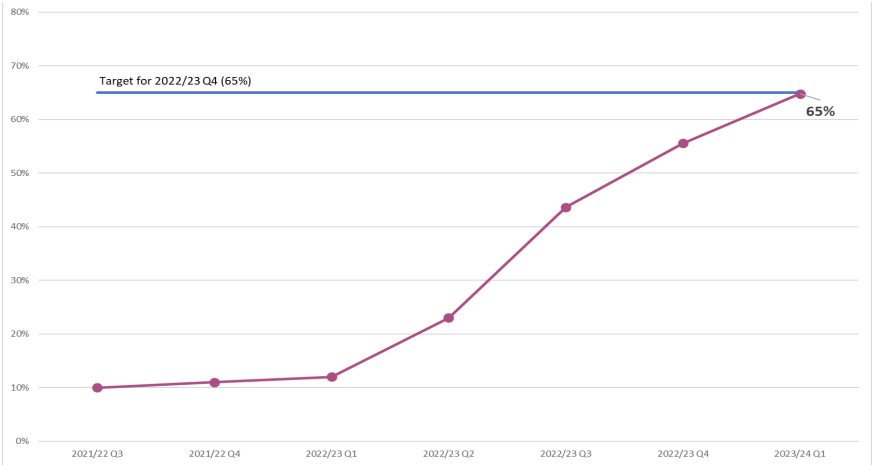


Figure 1

Detailed information

Key updates and achievements

Optimisation and stabilisation of the preterm infant.

Preterm optimisation continues to demonstrate improvement in outcomes, with the reduction of morbidity and mortality as referenced in figures 8, 9, 10, and 11. These outcomes equal, 61 cases of Group B strep which have been avoided, a reduction of 385 cases cerebral palsy, which equals a saving to welfare and society of up to £385 million. And finally up to 584 lives saved with antibiotic and optical cord management.

Patient Safety Leads and Workstream Leads, continue to support their systems enabling improvement through facilitation and data sharing. These conversations are helping to shape a more strategic approach to aligning the necessary resources to specific components of the pathway which are looking to increase the overall composite measure. This can be best seen in figure 7 which showed an average of 1156, interventions being delivered each month to now on average 1728. Which is a national increase of 572 more interventions are being achieved to this cohort of babies on average each month.

The preterm dashboard continues to be used and help augment decision making by providing the right level of intelligence to people who require it.

Figure 2 – Shows a significant increase in antenatal corticosteroids being delivered, with an increase of 10%. This improvement has been supplemented by the national learning sets held in last years commission.

Figure 3 – Optimising place of birth is an intervention in Quality Control (QC) which will be used as a case study to support how improvement can morph from QI to QC. This is important with the addition of the 2 new interventions and resource scarcity.

Figure 4 – magnesium sulphate continues to maintain a 91% average level of reliability and is very much in Quality Control. Along with optimising place of birth this will be used as a case study to determine how improvements can be maintained.

Figure 5 – optimal cord management has had a 100% improvement from baseline with 64% of babies receiving this intervention nationally. This is a great achievement and the numbers of babies receiving this intervention means each month up to 17 lives are saved and that is 9 more than baseline.

Figure 6 – normothermia continues to be delivered reliable and has achieved a really high level of performance.

We continue to work and engage with Clevermed, our systems provided to improve data entry and data flow. A meeting organised for Q2 will help us in further increasing the functionality of the dashboard and demonstrate more lives impacted.

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 – Commenced in Q1 2023/34

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.

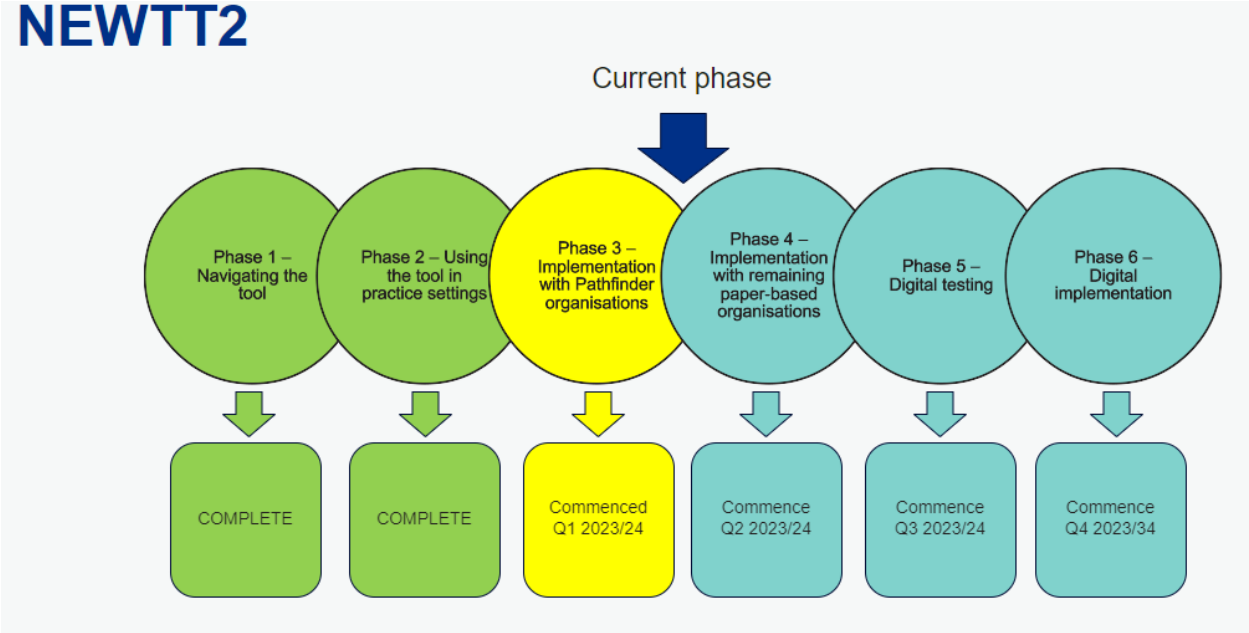
Remaining paper-based organisations will progress to using the national MEWS and NEWTT2 in maternity settings and utilise learning from Phase 4 implementation to provide support.

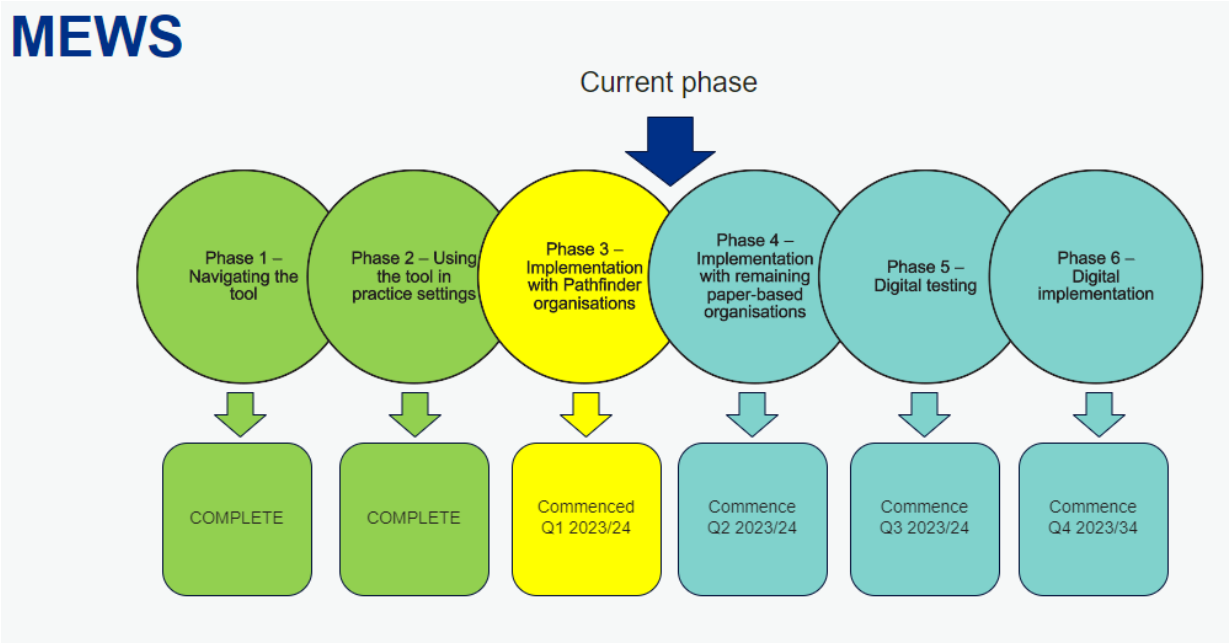
Phase 5 – Digital testing.

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.





Work has progressed with both the NEWTT2 tool and MEWS tool in paper-based organisations. A collaborative approach has been developed for the onboarding of organisations. During the onboarding

meetings the considerations for organisational readiness are described and the support offer from both the national team and PSCs.

There is variation in how organisations want to move forward with implementation and differing timelines adopted due to the organisational complexities.

Heath Education England: The training packages are now live for those organisations wanting to implement and information shared when onboarding meetings taking place.

Context, challenges, and expectations

A key challenge the early recognition and management of deterioration has is the pace that the development of the national digital specifications is taking. Feedback from system stakeholders indicate frustration in the delay. This has been escalated to all relevant stakeholders.

Capacity in the system is again highlighted, with competing priorities cited as a problem for some. Despite this PSCs consistently evidence improvement and engagement with both workstreams.

Process Measures

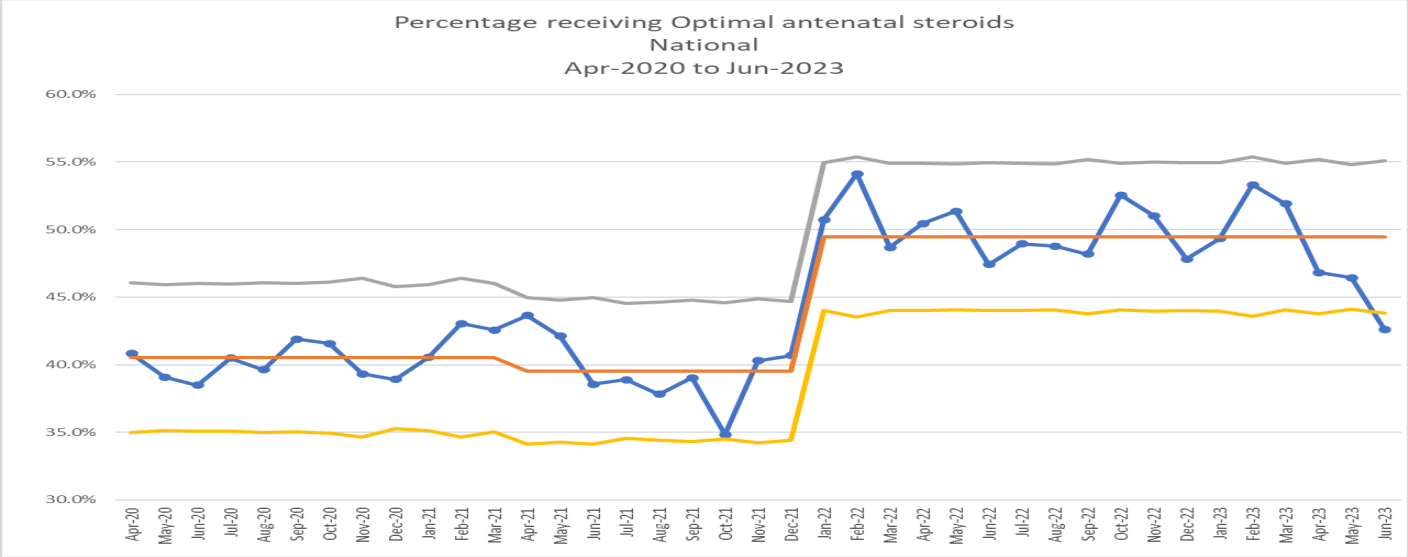


Figure 2

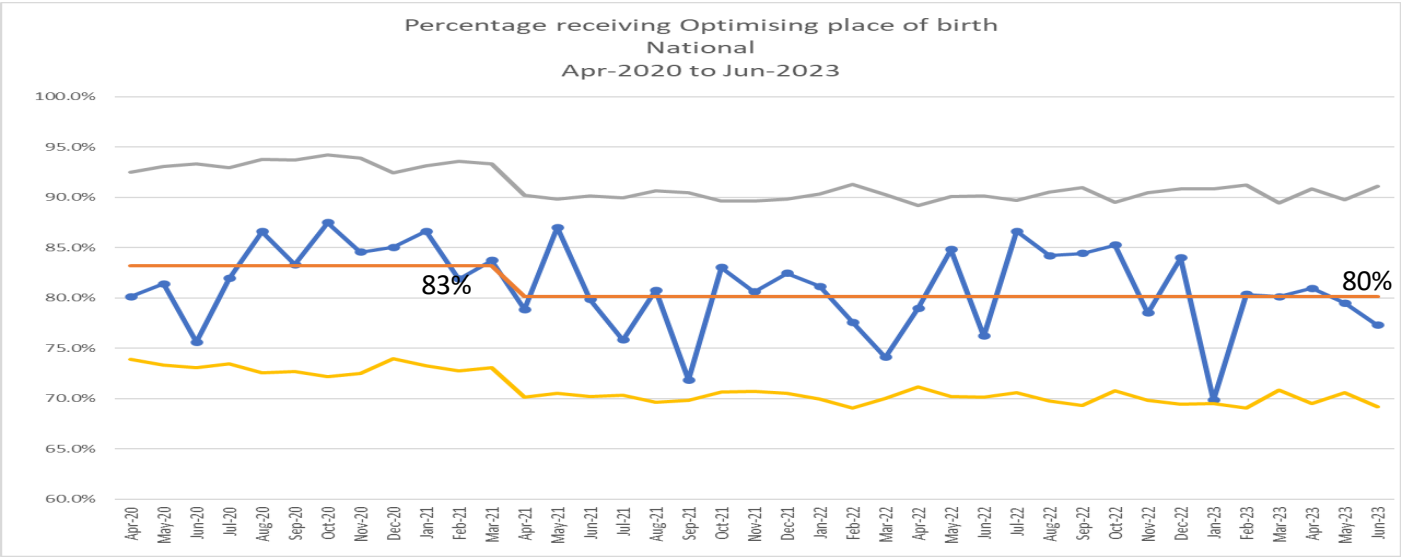


Figure 3

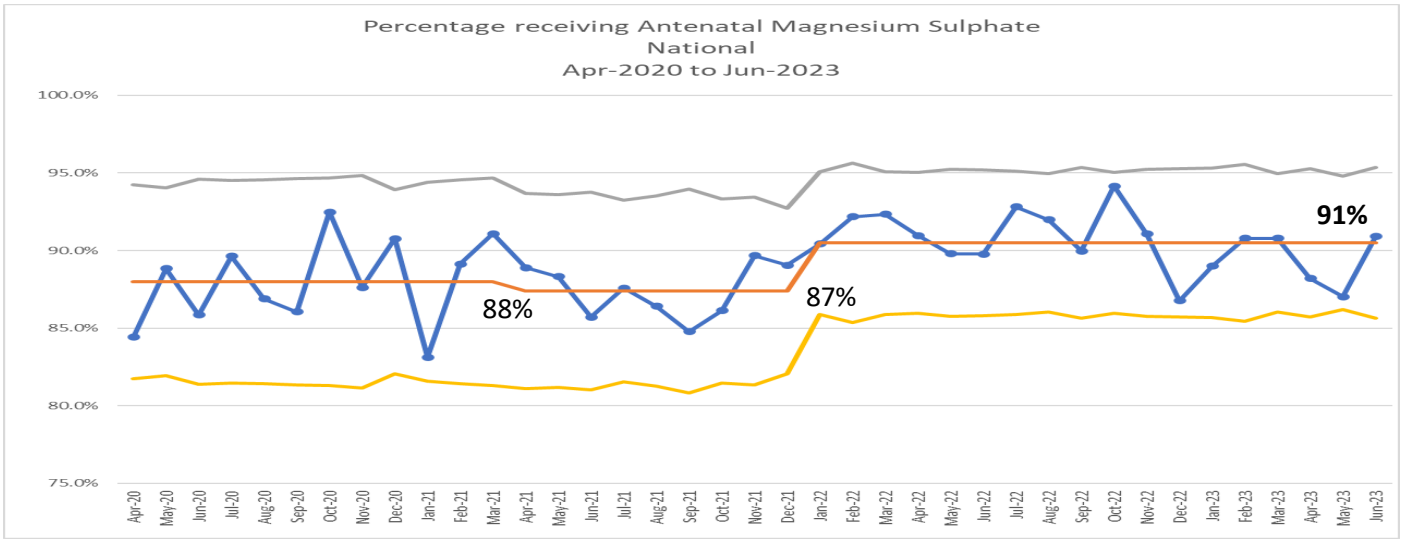


Figure 4

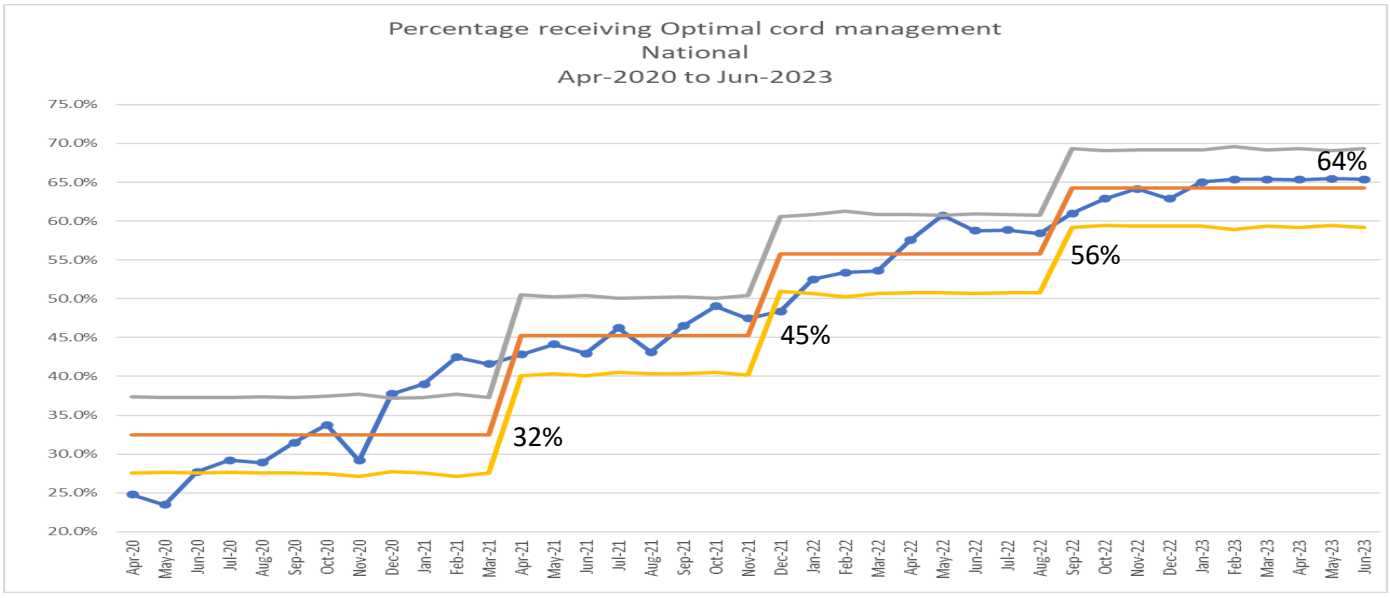


Figure 5

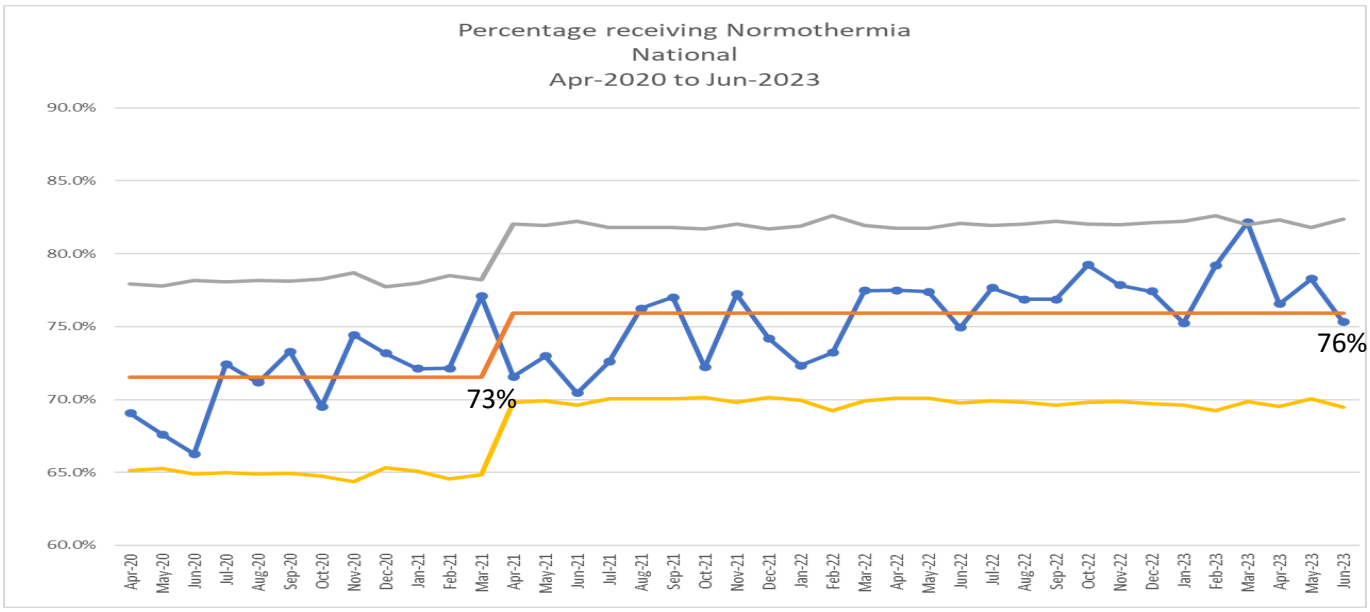


Figure 6

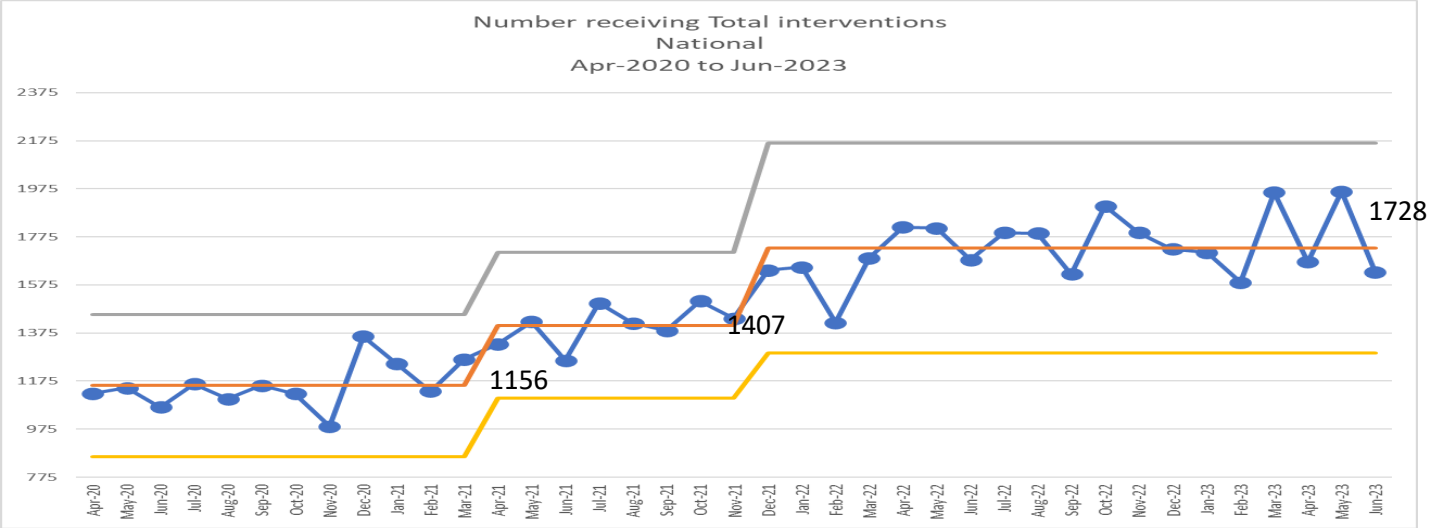


Figure7

Outcome Measures:

Magnesium Sulphate treatment prevented cerebral palsy in up to 385 babies.

Figure 8

Savings in a cost to welfare and society £385 million.

Figure 9

Optimal Cord Management has contributed to saving the lives of up to 569 babies.

Figure 10

Total overall outcomes are: 61 babies avoided contracting Group B strep, 385 cases of cerebral palsy were avoided.

And up to 584 lives saved with antibiotics and optimal cord management.

Figure 11

Key Learnings

- *Health Innovation Network* – Held a very successful end of MatNeoSIP QI collaborative with optimisation posters submitted by all providers in south London bar one i.e., 5 completed projects written up.
- *Health Innovation Network - Manchester* - East Cheshire have re-opened intrapartum services and launched with the National MEWS and NEWTT2, with input from NHSE Senior Improvement Manager (SIM).
- *Innovation Agency -* Joint SIG with HiNM & NWNODN 'Pre-term birth, the next steps'. Event well attended with positive feedback. Event linked with regional SCN and coincided with launch of regional pre-term birth guideline and launch of 'Improving the outcomes for preterm babies: information leaflet that has been co-produced by parents within Spoons charity, MatNeo SIP (HiNM/IA) NWNODN. This leaflet has been included as an appendix within the regional pre-term guideline.
- 4 paper-based sites for NEWTT2 – meetings complete with national team and provider to discuss implementation, 1 team commenced implementation. 2 teams plan implementation for Sept/Oct 23 due to current capacity issues.
- *Kent, Surrey and Sussex -* With data from NNAP, Trust data and the ODN optimisation dashboard, MatNeo have been able to triangulate outcome measures which shows an increase in optimisation interventions across all LMNS's.
  PREM7+ certificates have been awarded to the Infant feeding coordinators in Sussex and Kent for their excellent work supporting preterm infants and mothers with Early Breast Milk (EBM).
- *South West –* Babies Born Before Arrival Project; supporting normothermia, place of birth and DCC elements of optimization. Phase 2 completed the end of June and impact report shred. Poster won second place at Bristol Patient Safety Conference in May and 1st place at 999conference with 'most likely to change practice'.
- *Wessex –* Deterioration Community of Practice developed for a whole region approach to deterioration of women and babies. Links provided for Values and Actions and development of the COP (unable to share in this document).

Case Studies

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 to iNeed to make toolkit immediately identifiable as an escalation tool

Create a strong brand that is recognisable and enable iNeed to 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.

iNeed making escalation easier

What do you need?

"I need ADVICE..."

"I need to INFORM..."

"I need you to DO..."

If you are escalating, start your conversation by stating what you NEED before giving your SBAR, this enables the receiver to mentally prepare for the right response

Teach or Treat

Does the iNeed escalation require treatment?

YES!

Thank the person for escalating, acknowledge why it was correct and treat!

Not Yet!

- Thank the person for escalating their concerns
- Have a kind and respectful conversation about why treatment is not required yet
- Decide together when another escalation would be appropriate
- Reassure that you will attend again if required

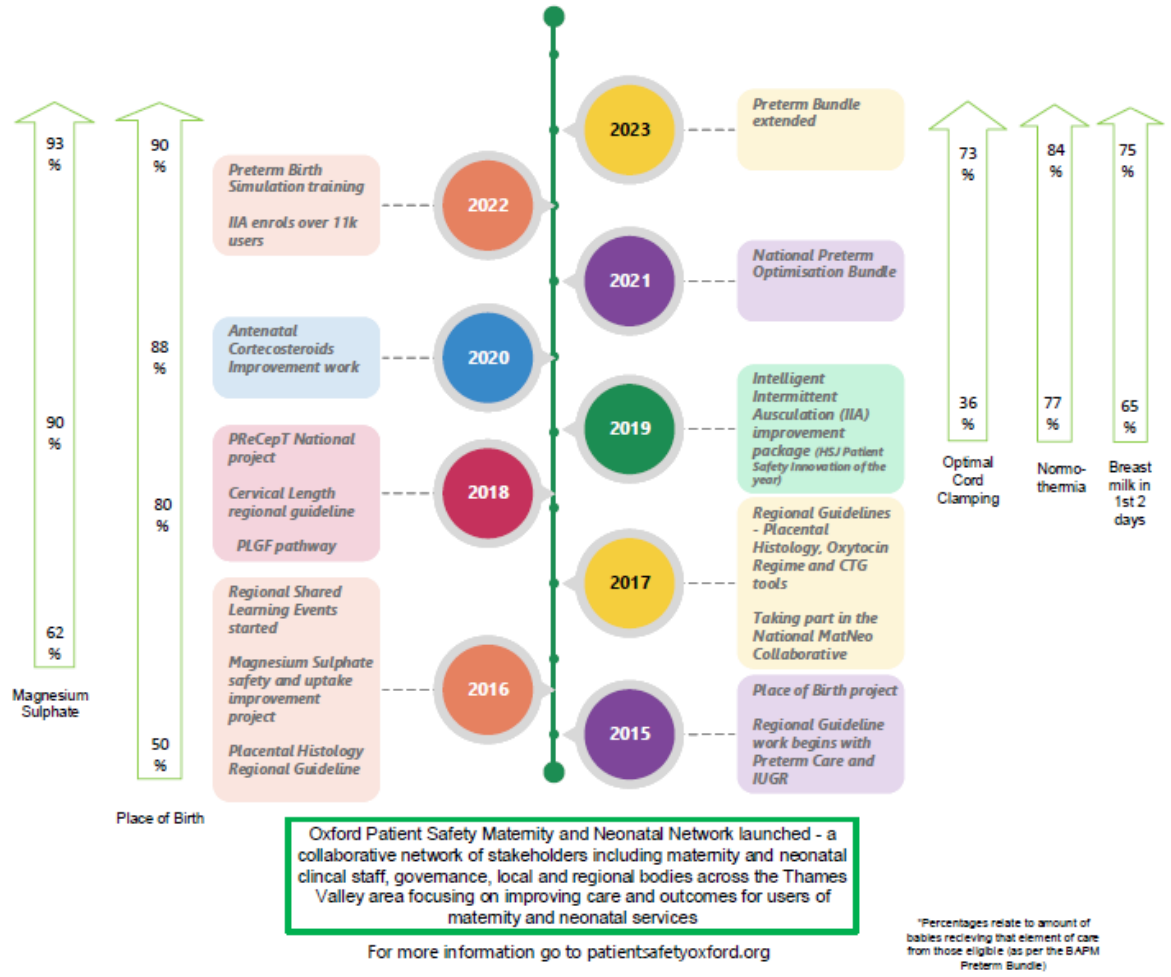
UHLT iNeed Project Leads:

Jules Bambridge – Patient Safety Midwife

Bhavana Mangal – Consultant Obstetrician and Fetal Monitoring Lead

Amber Brandon – Fetal Monitoring Lead Midwife

Oxford Patient Safety Collaborative Maternity and Neonatal activity relating to preterm birth



Oxford Patient Safety Maternity and Neonatal Network launched - a collaborative network of stakeholders including maternity and neonatal clincal staff, governance, local and regional bodies across the Thames Valley area focusing on improving care and outcomes for users of maternity and neonatal services

For more information go to patientsafetyoxford.org

*Percentages relate to amount of babies recieving that element of care from those eligible (as per the BAPM Preterm Bundle)

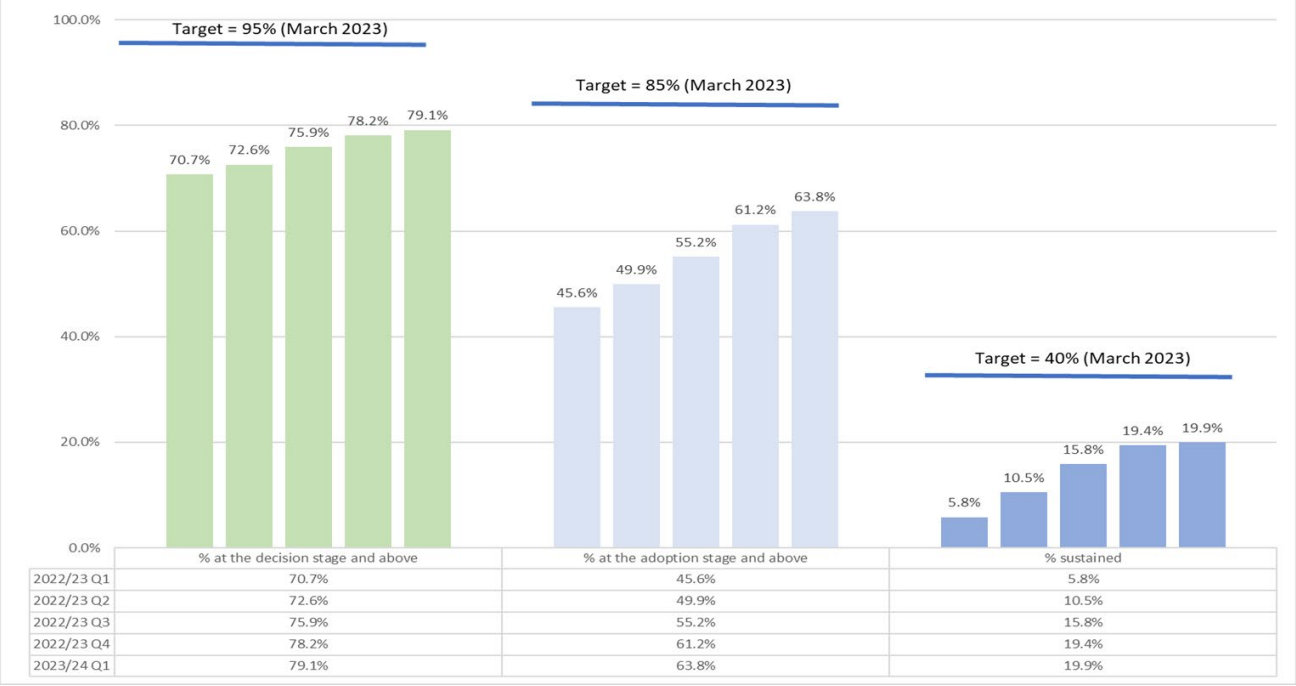
Summary of Q1 2023/2024 Progress

Programme Expected Outcomes

There has been continued adoption of the deterioration tools and continued interest in managing deterioration in care homes.

All PSCs have a sustainability plan and have handed over the work to other system stakeholders with varied success.

Whilst there has been some movement in the adoption scores this has tailed off as the programme comes to an end. Whilst sustainability plans are in place there is the risk that without adequate levers in the system this work will not be sustained in the longer term.



	% at the decision stage and above	% at the adoption stage and above	% sustained
2022/23 Q1	70.7%	45.6%	5.8%
2022/23 Q2	72.6%	49.9%	10.5%
2022/23 Q3	75.9%	55.2%	15.8%
2022/23 Q4	78.2%	61.2%	19.4%
2023/24 Q1	79.1%	63.8%	19.9%

Key Learning

- Turmoil within the system resulting in difficulty handing over the programme legacy.
- Continues to be an interest and a focus on the next stages of deterioration (PIER).
- NHSE versus local systems understanding of what is in place differ.
- Some PSCs keeping care homes networks ‘warm’ with some supporting other programmes of work.
- An impact report on the programme is due in Q3 2023/24.

National Patient Safety Improvement Programmes

Medicines

Summary of Q1 2023/2024 Progress

Programme Expected Outcomes

By end of March 2024 PSCs, working with willing ICSs, will collectively achieve the following outcomes:

- At least 15 ICBs, with an aspiration for 50% of ICBs, are progressing through the phases of a whole systems approach and providing visible and sustainable system leadership of the programme.
- We anticipate this will mean that by 31st March 2024, 30,000 fewer people are prescribed oral or transdermal opioids (of any dose) for more than 3 months (NNH 62) compared to 31st March 2023, preventing ~484 deaths.

Programme Deliverables

- Improve chronic pain management by reducing harm from Opioids.
- In 2023/24 support willing ICSs to implement the "Whole Systems Approach to High-Risk Opioid Prescribing" framework.

Progress and contribution to NatPatSIP ambitions 23/24

- In Q1 the PSCs gained agreement to work with all 42 ICBs in 2023/24, supporting 24 ICBs (>50%) to implement the Whole Systems Approach and the remaining via various levels of shared learning and data provision.
- Data to end of March 2023 shows a reduction in the number of people being prescribed opioids for more than 3 months and a reduction in people prescribed high dose opioids. Saving 414 lives over 2 years and 2,570 fewer cases of moderate harm each year as a result of fewer people with chronic pain being prescribed long-term opioid analgesics than in 2021, 4,200 fewer people prescribed high dose opioids (>120mg OME per day). Patients report better quality of life, less pain and less disability as a result of improved care.

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 at least 15 ICBs, with an aspiration for 50% of ICBs, to be progressing through the phases of a whole systems approach and providing visible and sustainable system leadership of the programme.

In Q1 the PSCs gained agreement to work with all 42 ICBs in 2023/24, supporting 24 ICBs (>50%) to implement the Whole Systems Approach and the remaining via various levels of shared learning and data provision

National outcome measurement:

End of year data from NHSBSA was received in June 2023. This update is the corrected data including boundary changes as well as the second national outcome metric (High Dose).

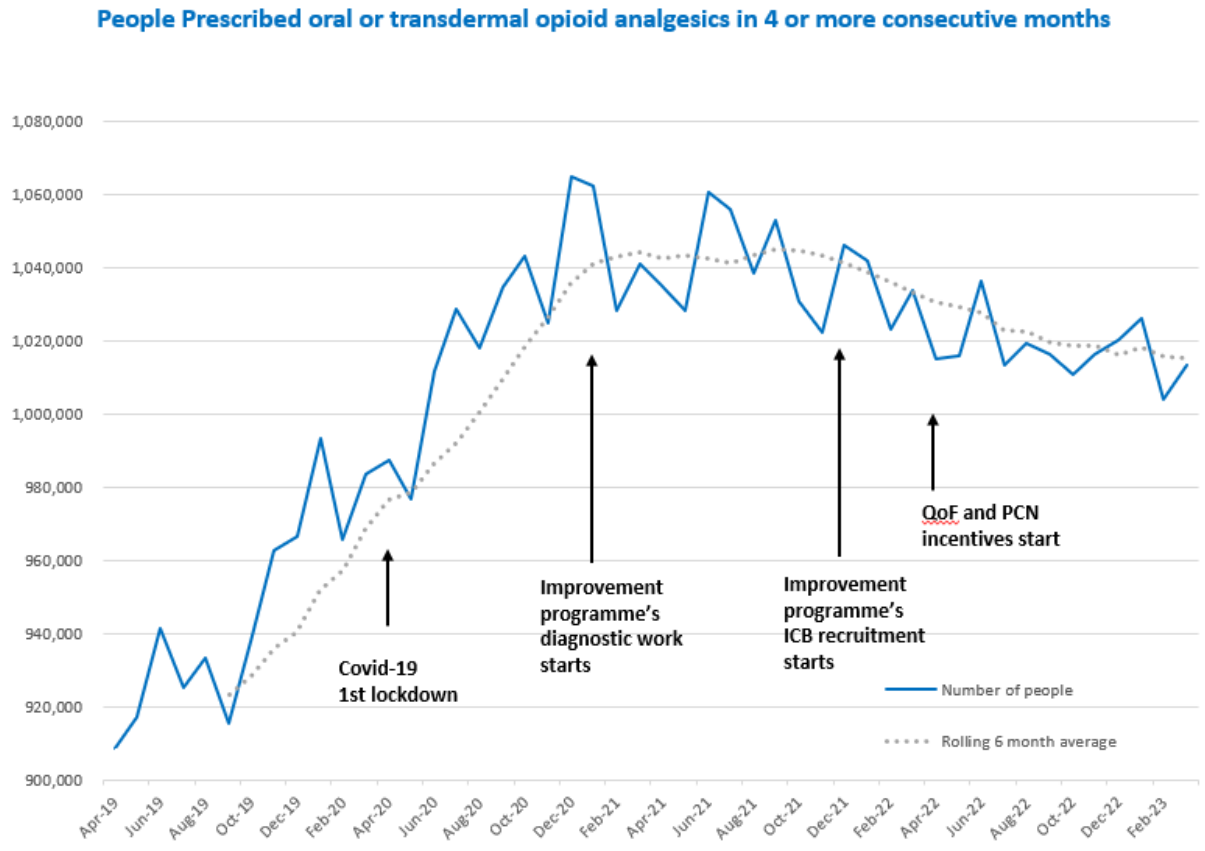
Unity Insights have produced a prototype Tableau Dashboard based on the excel prototype used to date. The national team are now building this into Tableau with anticipated completion end of September 2023.

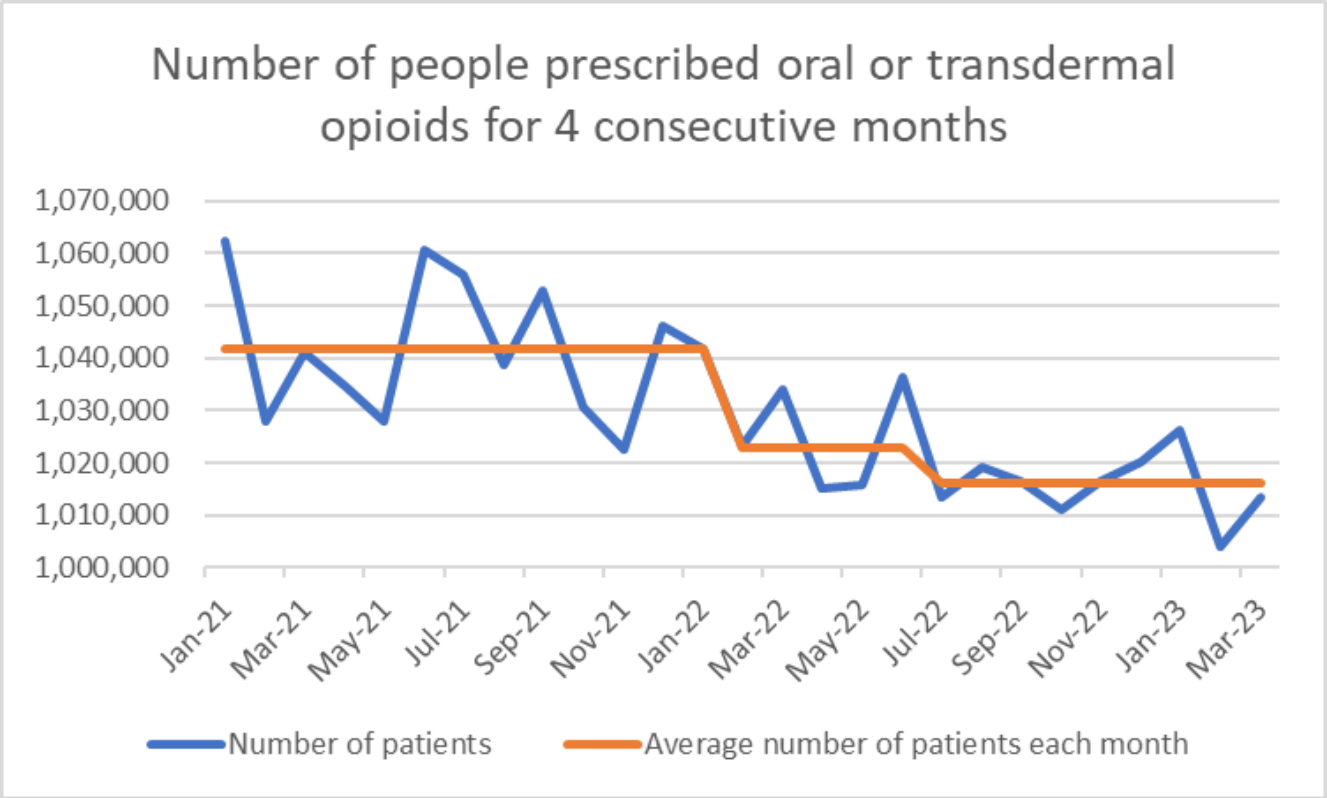
Context, challenges, and expectations

Although there is greater engagement with ICBs there is a risk to the progress of this improvement in 2023/24 as a result of the removal of the financial incentives for primary care via QoF and PCN IIF.

Restructuring of Regions, ICBs and NHS England has impacted engagement and momentum. There has been no Q1 National Action Learning sessions due to delays in the PSC commissioning process into Q2.

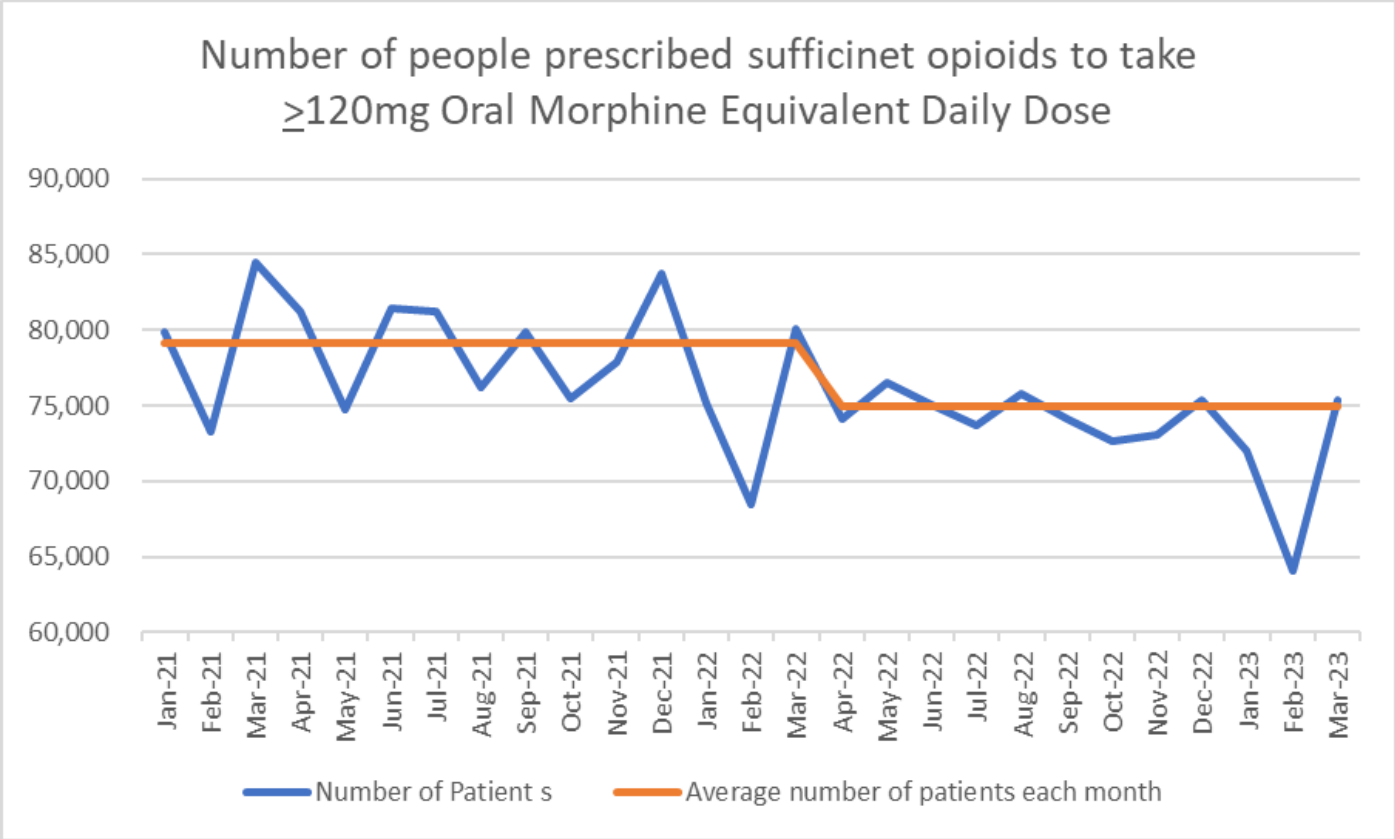
Outcome Measures





For the period July 2022 to March 2023 there are 25,693 fewer people per month being prescribed oral or transdermal opioids for longer than 3 months compared to the 2021 baseline (P=0.015)

This translates to as many as 414 lives saved over the next 2 years.



For the period April 2022 to March 2023 there are 4,206 fewer people per month being prescribed high dose compared to the 2021 baseline (P>0.005)

Case Studies

The following illustrate just some of the interventions being put into place in 2 of the ICBs

Joined up Care Derbyshire (EMAHSN)

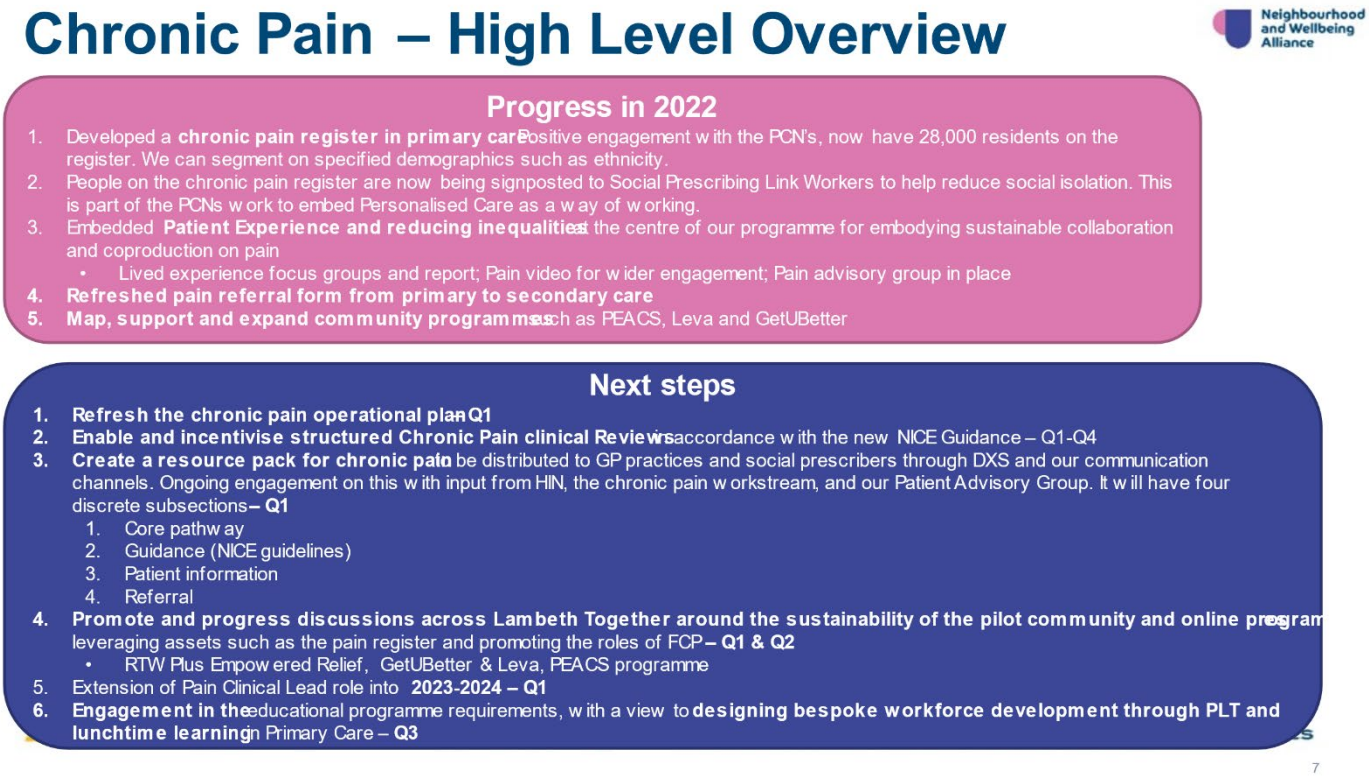
- https://emahsn.org.uk/images/QI_toolkit_opioids_for_General_practice_July_2023.pdf
- Lister House Surgery, Derby Pain Management Support Group
- https://joinedupcarederbyshire.co.uk/stay-well/pain-management/

Lambeth Together, South East London (HIN)

Lambeth Together (located in SEL ICB) are working with patients in particular those who are socially deprived and from ethnic minority backgrounds to improve the care for people living with chronic pain in Lambeth.

- A full slide set of the presentation on the PSC Secure Area in the Health Innovation Network folder here.
- Chronic Pain - Lambeth Together website
- Challenges of living with chronic pain - Lambeth Together (Lived experience video) https://youtu.be/s0QxDi5CMO0
- PEACs (a culturally competent chronic pain offer) Tackling chronic pain in Lambeth (kingshealthpartners.org) . Please note this is an affiliated project led by King's Health Partners and more information can be provided.

High level summary (below)



National Patient Safety Improvement Programmes

Mental Health

Summary of Q1 2023/2024 Progress

Programme Expected Outcomes

Sustained improvement work to reduce restrictive practice in all inpatient mental health, learning disabilities and autism wards engaged in the programme, including the networks, by September 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 23/24

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 remain a priority for the remainder of the commission.

During Q1 23/24, the work of the MHSIP is focused on sustaining the above and working towards the programme closure in September 23. Workstream Leads within the PSCs are supporting organisations to independently sustain the work they have undertaken and build on that locally. Workstream Leads, supported by NCCMH, will work to collate the stories and learning from the MHSIP so that this can be shared nationally.

The RRP work (and any other improvement work) each organisation is doing will then be brought within the governance and infrastructure created within that organisation as part of the wider Quality Transformation Programme. QI coaching, at ward level and across the wider organisation, and leadership support will be offered as part of that wider programme.

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 Q1 23/24 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 by the end of Q4 22/23 was 261 wards (a significant increase 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 PSCs 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.

In Q4 22/23, 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, which has continued into Q1 23/24. The NCCMH analysed ward-level data ahead of a data clinic on the 22nd June 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 change in commission (the end of PSC and NCCMH involvement in the RRP programme) has continued to create some level uncertainty during Q1. To manage this, the NCCMH and MHSIP Co-leads built discussions around the future of the RRP work into the agenda for discussion with providers and patient safety networks. 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.

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 22/23 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 that have continued into Q1, 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

A programme level decision was made not to continue to report on process measures for the remainder of the commission as there is no active work taking place to increase numbers of wards or organisations involved, instead the focus has been on sustaining the hard work already being done to reduce restrictive practice and prepare organisations for the new Quality Transformation Programme.

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. Workstream Leads, supported by the NCCMH, are working to collate as many stories as possible from across the programme over Q1 and Q2 23/24, to package the learning from the MHSIP for national dissemination. This will be presented after the programme ends in September 2023.

National Patient Safety Improvement Programmes

System Safety

Summary of Q1 2023/2024 Progress

Programme Expected Outcomes and Programme Deliverables

The main objective of the System Safety workstream as part of the 2023-24 National Patient Safety improvement specification is to:

- Support the national implementation of the Patient Safety Incident Response Framework (PSIRF) in stipulated phases with fidelity to core principles.

The key deliverables for 2023-24 are -

- By Q1 (June 2023) PSCs to identify ICSs and providers who need focused PSIRF support and create a plan for the support that will enable the providers to transition to PSIRF by Autumn 23.

- Between Q3-Q4 (Oct 23 - Mar 24) all PSCs to use an approach (e.g. coaching systems) to support systems (i.e. ICSs and providers) with ongoing PSIRF activities to embed changes and improvements.

Key tasks

- All 15 PSCs will work collaboratively with the ICSs and providers to co-ordinate activities, provide coaching and quality improvement support via action learning and a sharing insights approach.
- Over 2023-24 PSCs will support ICSs and Providers to transition through phases 3-6 of PSIRF for all providers of NHS funded care to transition to PSIRF by the end of Autumn 2023.
- Over Q3 – Q4, PSCs will support organisations to embed sustainable change and improvement as demonstrated via the QART (qualitative/descriptive) returns and will also contribute to the monitoring and evaluation of PSIRF led by NHS England.

Progress and contribution to NatPatSIP ambitions 23/24

The progress of work done by the PSCs is measured via the QART stocktake process which includes 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 considered while evaluating the progress each quarter.

In Q1, 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 develop the Support offers for 23/24 and to support the System Safety workstream deliverables.

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. There is no quantitative data (phases completed by Trusts) 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 join the NHS England led webinars.

Key updates and achievements

❖ In Q1, all PSC 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. Including continued engagement and support to the National team.

❖ 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 Q1 PSCs developed the Support Offer for 2023/24 in partnership with their local stakeholders (ICSs) to describe the support for PSIRF over Q1-Q4 23/24. PSCs also continued with their planned events and webinars to support stakeholders in the PSIRF transition.

❖ 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), 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 needs identified locally.

❖ A joint entry to the HSJ poster competition was submitted on behalf of the North West Collaborative summarising all the PSIRF events delivered and the outputs. Please see the case study section which includes the poster, later in this report A blog was also published by Health Innovation Manchester summarising the PSIRF events in the North West.

PSIRF guidance

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 2023	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.

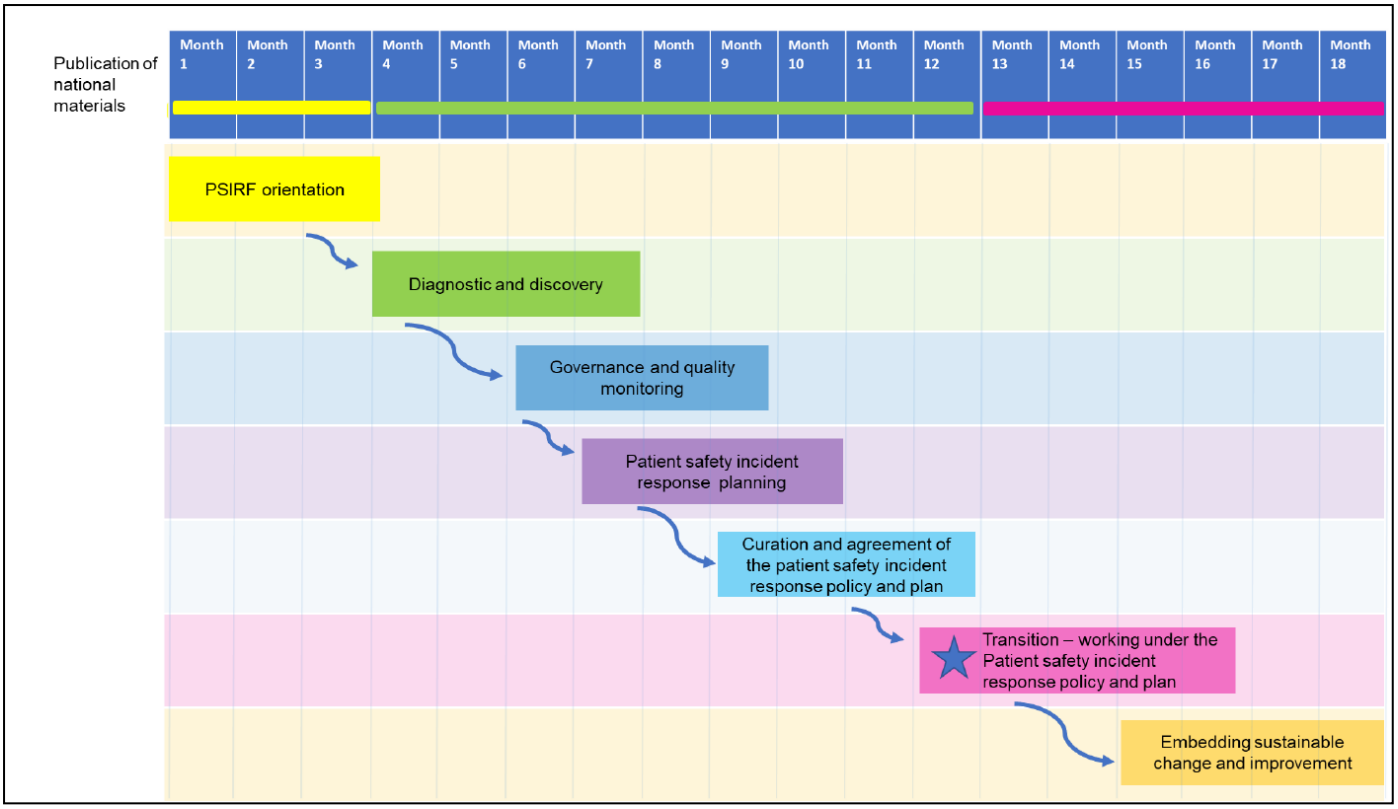


Figure: PSIRF implementation phases and the timeline published in the PSIRF preparation guide.

Work Underway

The ambition set for Q1 2023/24 includes:

- By Q1 (June 2023) PSCs to identify ICSs and providers who need focused PSIRF support and create a plan for the support that will enable the providers to transition to PSIRF by Autumn 23.
- PSCs continued their engagement with ICSs and providers to deliver the support via face to face sessions, webinars and learning events including 'Ask the expert' sessions.
- Many PSCs continued 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.
- 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.
- A new resource pack summarising all the FuturesNHS PSIRF related documents was in development in Q1 to facilitate stakeholders in finding resources easily as there is a lot of content on FuturesNHS related to PSIRF. This resource pack will be finalised in Q2.

Action learning Set (ALS) session

Over 2022/23 2 action learning set (ALS) sessions were successfully conducted with the PSC leads 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 PSCs. Topics covered included a session on LfPSE – Learning from Patient Safety Events as a system that will replace the National Reporting and Learning System (NRLS); followed by 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 -

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

In Q2 2023/24, a third ALS session focussing on the practical use of the PSIRF learning response tools – e.g. SWARM huddles, Multi-disciplinary team review, After Action reviews and Thematic reviews will be delivered.

Context, challenges, and expectations

The 15 PSCs around England are commissioned to work with ICSs over 2023-24 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 PSCs. 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 Q1 23/24 were -

- While most ICSs are now fully functioning and delivering their statutory responsibilities, governance structures in few ICSs were still being developed with staff yet to be recruited, delaying engagement. However, the engagement has extended to involve the key quality and safety leads (where appointed) at all ICSs in England to date.
- 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.

- Nationally supporting Execs around never events, adverse events and responding in a way that promotes psychological safety – comfort seeking vs problem sensing behaviour at a board level continued.

Key learnings

- NHS England continued direct discussions via visits to PSC PSIRF events and 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.

- 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 within available capacity.

- 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 PSCs will continue offering support to the ICSs and providers therein, to support the PSIRF transition work in the stipulated phases.

Poster submitted by the North West Collaborative – Health Innovation Manchester and the Innovation Agency NWC to the HSJ for the annual poster competition.

Collaborating Across the North West Region to Support PSIRF Implementation

Overview

When the Patient Safety Incident Response Framework (PSIRF) was published in August 2022, Integrated Care Systems and providers of NHS funded care were asked to work through a series of implementation phases towards implementation of PSIRF by autumn 2023. NHS England (NHSE) regions and Patient Safety Collaboratives (PSC) were tasked with supporting this implementation and, in the North West, Aqua (The Advancing Quality Alliance) were ready to offer support.

The North West PSIRF Collaborative was established in September 2022 in order to support NHS providers from across the region through the various phases of PSIRF implementation. The collaborative was brought about through partnership working between the Greater Manchester and Eastern Cheshire PSC (Health Innovation Manchester), the North West Coast PSC (Innovation Agency), NHSE North West Region and Aqua. Integrated Care Boards and NHS provider organisations from across the 3 Integrated Care Systems in the North West have all participated, as well national and local independent providers.

The collaborative utilised economies of scale by pooling time, resources, ideas and expertise to create impactful face to face events, accessible bitesized action period offers, coaching and signposting via a dedicated FutureNHS space. It also provided a single point of access to expertise within local PSIRF early adopters and the national Patient Safety team.

Above: PSIRF implementation timeline

Objectives and Methods

4 face to face learning events were delivered at a central North West location and content structured as follows:

Event 1: 'Orientation'	• PSIRF preparation • First hand insight from early adopter site
Event 2: 'Insight'	• Safety culture and psychological safety • Practical tools for safety culture
Event 3: 'Involvement'	• Patient Safety Partner programme and local recruitment stories • Patient and Public Involvement and Experience and Insight
Event 4: 'Improvement'	• Quality Improvement (QI) and PSIRF • Learning response tools 'marketplace' • Peer to peer sharing session

Event speakers covering a wide range of expertise have included:
James Titcombe OBE - Patient Safety and Policy Consultant
Tracey Herlihey - Head of Patient Safety Incident Response Policy, NHSE
Hester Wain - Head of Patient Safety Policy (inequalities, safety culture, primary care), NHSE
Jacquetta Hardacre - Assistant Director of Patient Safety and Effectiveness and named Patient Safety Specialist at East Lancashire Hospitals NHS Trust - one of the early adopters of PSIRF
Pete Ledwith - Human Factors and Safety expert with Aqua
Wendy Burton - Safety Culture expert with the Innovation Agency
Stuart Kalli - QI Expert with Health Innovation Manchester

A range of online session and resources were curated and offered in the intervening 'action periods', including:

NHS Futures workspace – Resources, signposting, discussion
- 160 members
- 726 document downloads

SEIPS workshops
Coaching offer

Lunch & Learn sessions:
- Stakeholder analysis
- Process and system mapping
- Ask the expert: Patient and public involvement
- Healthcare inequalities

Our events and remote offers created an environment for sharing, networking and collaborating. Collaborative faculty have played facilitative and critical friend roles to Patient Safety Specialists on their PSIRF journey.

Results

Collaborating with @NWAmbulance at the North West PSIRF learning event. @GM_ICP @JonathanNWAS #PSIRFNWEvents

Day 4 of the #PSIRFNWEvents meeting today. Great to network with colleagues from across the region @tracycamps @NicolaFirth6 @k_mantron @nhsdavies @Tameside_STT

A pleasure to share experiences and learning with colleagues in the North West today. #JoshuasStory #PSIRFNWEvents

Fantastic relationship being described between early PSIRF adopters and ICB, absolute key to success ..... Follow the patient journey, bringing everyone together to share learning #PSIRFNWEvents @ELHT_NHS

Event	Number of attendees	% delegates who felt engaged and supported	Number of organisations represented
Nov	119	97%	59
Dec	87	72%	54
Mar	130	93%	55
Apr	93	79%	53

41 organisations have joined the PSIRF North West Collaborative workspace

"I feel much more confident that we are all working together to have a successful journey in working with the systems to implement PSIRF and other key deliverables."
- Elizabeth Ratcliffe, Deputy Director of Quality, Regional Safeguarding & Investigations Lead (NHS England North West Clinical Directorate)

Conclusion and Next Steps

The North West PSIRF collaborative is a great example of partnership working and successful network building to meet the needs of the local system in working towards a national ambition.

As ICBs and providers in the North West move nearer to PSIRF implementation, this collaborative provides an excellent platform to continue networking and support that will benefit members beyond implentation as they work to make PSIRF 'business as usual'.

A further event is planned to mark the 'go-live' of PSIRF in September and the collaborative will look at ways to improve inclusivity and accessibility as more independent providers begin their PSIRF journey.

INNOVATION AGENCY
aqua
Health Innovation Manchester
NHS England

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.