NHS

National Patient Safety
Improvement Programmes

National Patient Safety Improvement Programme

Q2 2023/2024

Progress Report

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Executive Summary

Maternity and Neonatal Safety Improvement Programme

Optimisation and stabilisation of the preterm infant:

- A significant increase in the implementation of the communication tools namely in the form of a preterm passport. These have supported women, families and clinicians in what interventions have been given and what can be expected.
- Work continues with scoping and reviewing organisations who are implementing the two new interventions caffeine, and volume-targeted-ventilation (VTV). Some Patient Safety Collaboratives (PSCs) have started to report caffeine and VTV data within the QART with high levels of reliability.
- 88% of all elements across the country are at stage 5 or above.

Early recognition and management of deterioration of women and babies:

- NEWTT2 onboarding meetings with paper-based organisations continue.
- MEWS onboarding meetings with paper-based organisations continue.
- 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.
- Feedback beginning to emerge from Pathfinder organisations and providing insight for those organisations seeking implementation support.

Medicines Safety Improvement Programme

- Data for the period September 2022 to July 2023 shows 7,217 fewer people per month being prescribed high-dose opioids compared to the 2021 baseline.
  - 7,217 pts have had their risk of death from opioids halved.
- (from Q1 report) Data shows a reduction in the number of people being prescribed opioids for more than 3 months.
  - 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,
  - Patients report better quality of life, less pain and less disability as a result of improved care.
- In Q2, there are 29 ICBs taking a Whole Systems Approach to high-risk opioid prescribing. 25 of those are fully supported by PSCs and further 3 are receiving a light touch support from PSCs.
- An additional 8 ICBs are not implementing a Whole Systems Approach however they are receiving support from PSCs such as shared learning and data provision to address high risk opioid prescribing.

Mental Health Safety Improvement Programme

The Mental Health Safety Improvement Programme's work to reduce restrictive practice concluded at the end of September 2023. Much of the work being undertaken by providers across the country will be sustained locally and built upon in ongoing and new programmes of work. The learning from this national improvement work has been incorporated into the design of NHS England's Quality Transformation Programme, specifically within the co-production of the Culture of Care Standards for Mental Health Inpatient Services and the associated national implementation support offer which will see a new Culture Change Programme delivered across all NHS-commissioned providers of inpatient services. Further information on this can be found here.

A separate final report of the MHSIP Reducing Restrictive Practice Collaborative is currently being finalised. This report will detail the engagement across the country, the work undertaken, the results, impact and all of the learning from the programme. It will be a valuable resource for connecting the work of the programme to future opportunities for improvement and for shared learning across the system.

Systems Safety

- The PSCs continued their contribution to the implementation of the Patient Safety Incident Response Framework in Q2 in line with the 2023-24 National Patient Safety Improvement Programmes specification under the System Safety workstream.
- In Q2 the PSCs worked collaboratively with their ICSs and stakeholders including the system quality and safety leads and provider leads to support the PSIRF implementation based on their requirements.
- In Q2, the PSCs continued to understand the gaps and identify ICS/providers who need focused PSIRF support using coaching / improvement methods.
- PSCs offered support to review the PSIR – Plans through a Quality Improvement (QI) lens where possible.
- An NHSE led Action Learning Session (ALS) was held in July for the workstream leads and patient safety leads in the PSCs; focusing on Learning response tools with effective talks given by early adopters and experts on swarm huddles, MDT (multi-disciplinary team) reviews, after action reviews and Thematic reviews.
- Few challenges reported by PSCs include - maturity levels of the ICSs and the ICS restructuring making engagement difficult at times. In a few areas, lack of resources continued to be a challenge to progress the transition to PSIRF due to pressures and other priorities.
- Most PSCs are working in partnership at regional level to maximise their input across England however there is variation in terms of the type and level of support which is subject to local engagement and stakeholder buy-in.
- PSCs continued offering support to implement PSIRF in maternity settings, mental health providers, ambulance trusts and care homes (as part of support to the independent providers).

Key Infographics

Maternity and Neonatal Safety Improvement Programme

Maternity and Neonatal Safety

Improving the care of premature babies has:

- Saved up to 627 lives
- Prevented up to 420 cases of cerebral palsy

Medicines Safety Improvement Programme

Patient benefit from Medicines Safety

Saving 414 lives over 2 years

Prevented 2,570 moderate harms per year

7,217 fewer people per month being prescribed high-dose opioids

Systems Safety

System Safety

Supporting the implementation of **Patient Safety Incident Response Framework** (PSIRF) in **all** NHS provider organisations in England

Summary of Q2 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 Q2 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 (A&S) score has reached 88%. This is a great achievement to date and teams in areas which are at stage 4 (Implementation), have concrete plans to address the specific elements and reach the national ambition of 100%. Furthermore, improvements continue to be made in the five areas where there is good data quality. Some of the elements are in quality control/sustainability. Nationally work is being done to address poor data quality and therefore we are likely to see an increase over the coming quarters reporting.

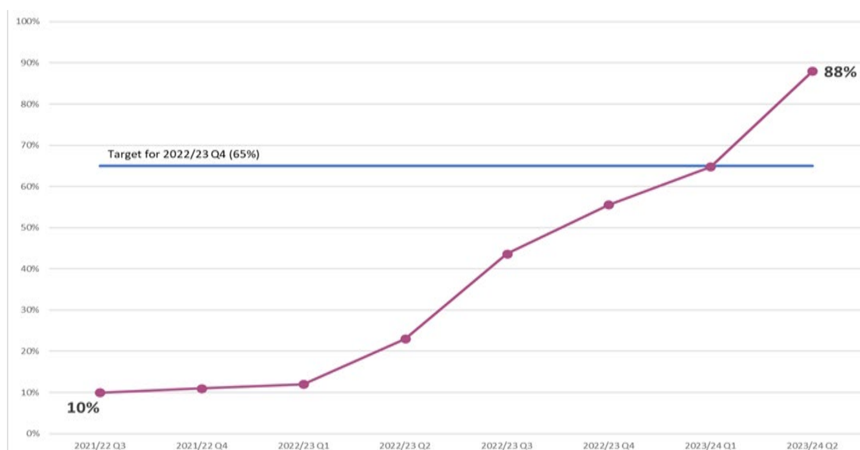


Figure 1

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, 71 cases of Group B strep which have been avoided, a reduction of 420 cases cerebral palsy, which equals a saving to welfare and society of up to £420 million. Finally, up to 627 lives saved with antibiotic and optical cord management.

The PSCs continue to support key stakeholders within their systems to drive improvement. With more effective data sharing and facilitation, these data are being used to support decision making and augment delivery of the preterm optimisation pathway. With the release of Saving Babies Lives V3, the patient safety networks are aligning efforts at a more strategic level to achieve economies of scale as evidenced by the sharing of best practice with NEOTripps in London. A group of clinical colleagues who blend evidence and best practice together with organisations to improve reliability with the maternal breast milk standard. This will likely have a positive impact our composite measure.

This can be best seen in figure 7 which showed an average of 1,213, interventions being delivered each month to now on average 1,722. Which is a national increase of 509 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. Further iterations are expected in Q3 and Q4 with external colleagues providing Quality Assurance on data integrity.

Figure 2 – 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 two new interventions and resource scarcity.

Figure 3 – 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 year's commission.

Figure 4 – magnesium sulphate continues to maintain a 86.2% 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 66.5% 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, 76.1% on average each month.

We continue to work with our system stakeholders to improve data quality, flow, and translation. A meeting this quarter has enabled a change to the system which will provide clinical colleagues a better opportunity to capture processes and describe the real level of reliability. This change to the electronic system will go live in January 2023 and will be reported on in Q4.

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.

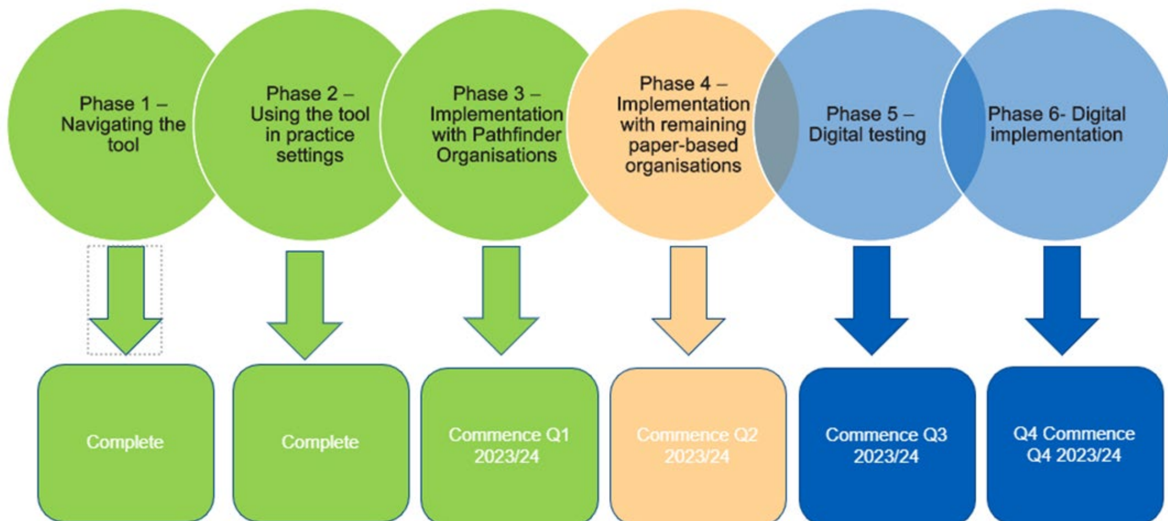
Remaining paper-based organisations will progress to using the national MEWS and NEWTT2 in maternity settings and utilise learning from Phase 4 implementation to provide support.

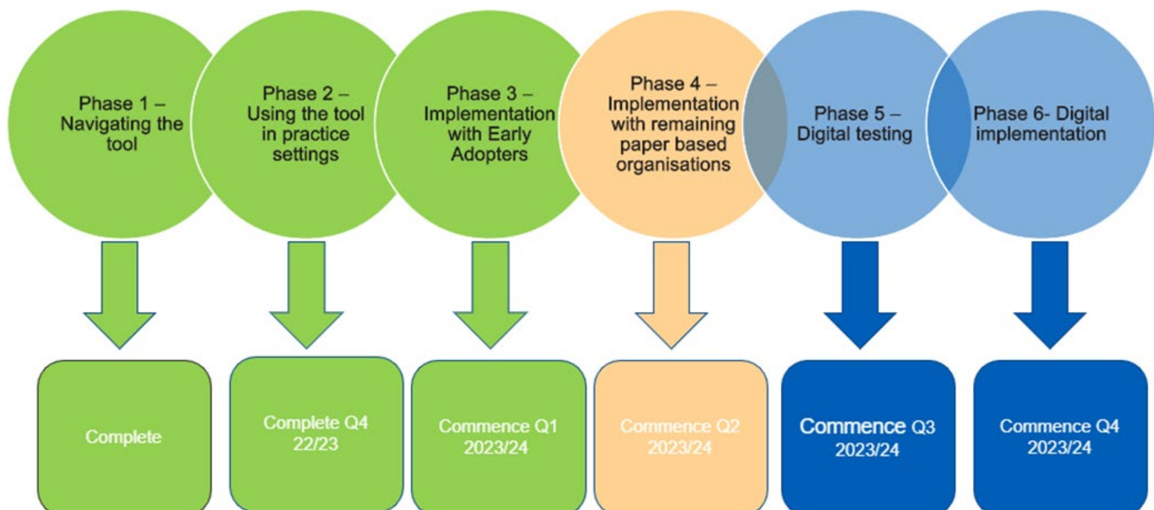
*Phase 5 – Digital testing. *There will be a delay to commencing this phase due to the development of digital specification for MEWS and NEWTT2**

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. This is being updated regularly to reflect learning and feedback from the system.

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

Early feedback is emerging from Pathfinder organisations which will continue to be collated and responded too.

Heath Education England: The training packages are now live for those organisations wanting to implement and information shared when onboarding meetings taking place. Initial feedback from the first three months of the materials being live is positive with 4.5/5 users Highly Recommending the training resources.

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

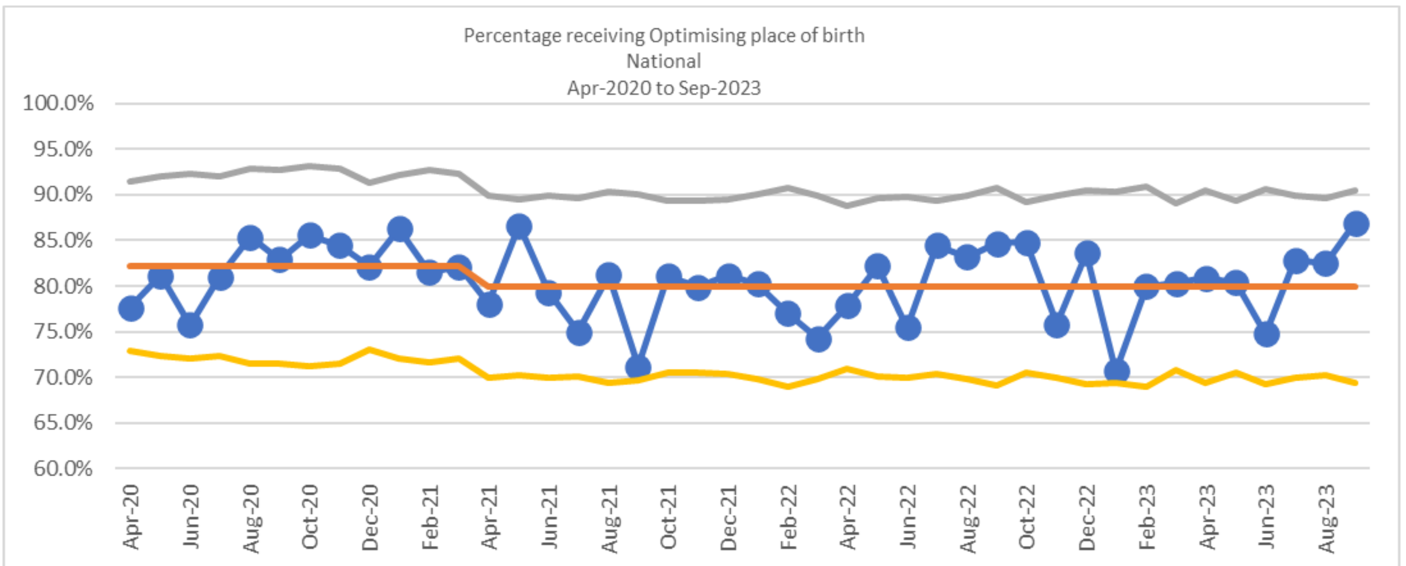


Figure 2

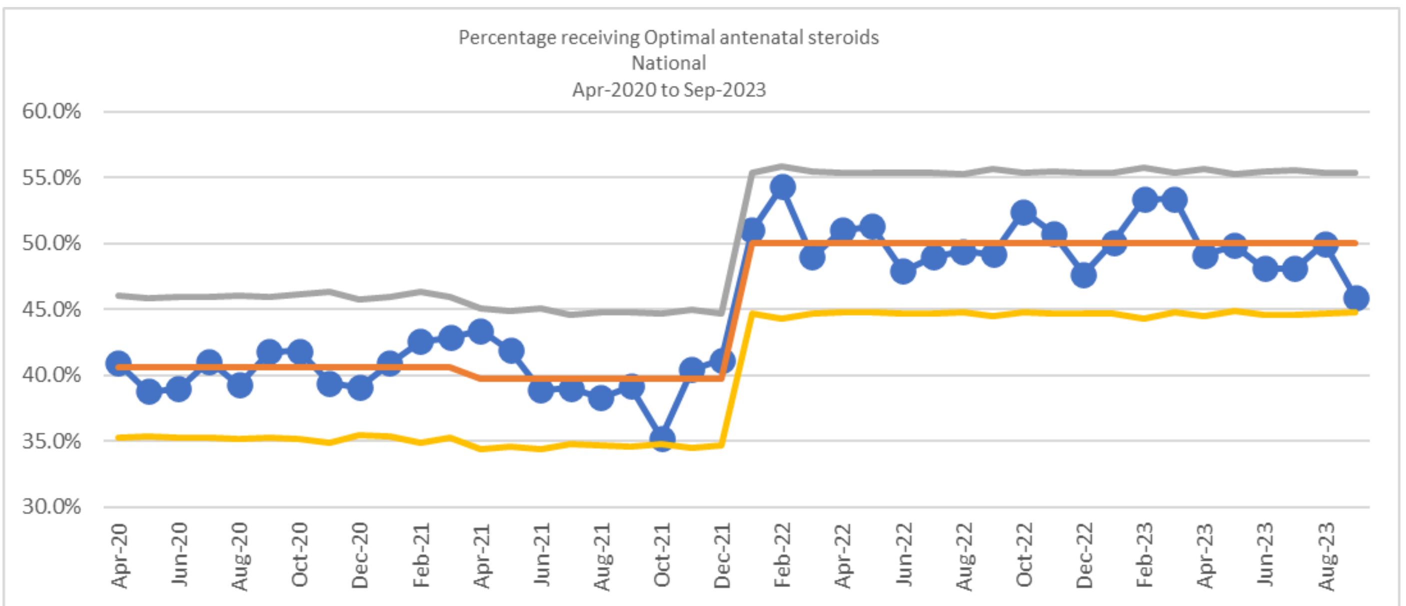


Figure 3

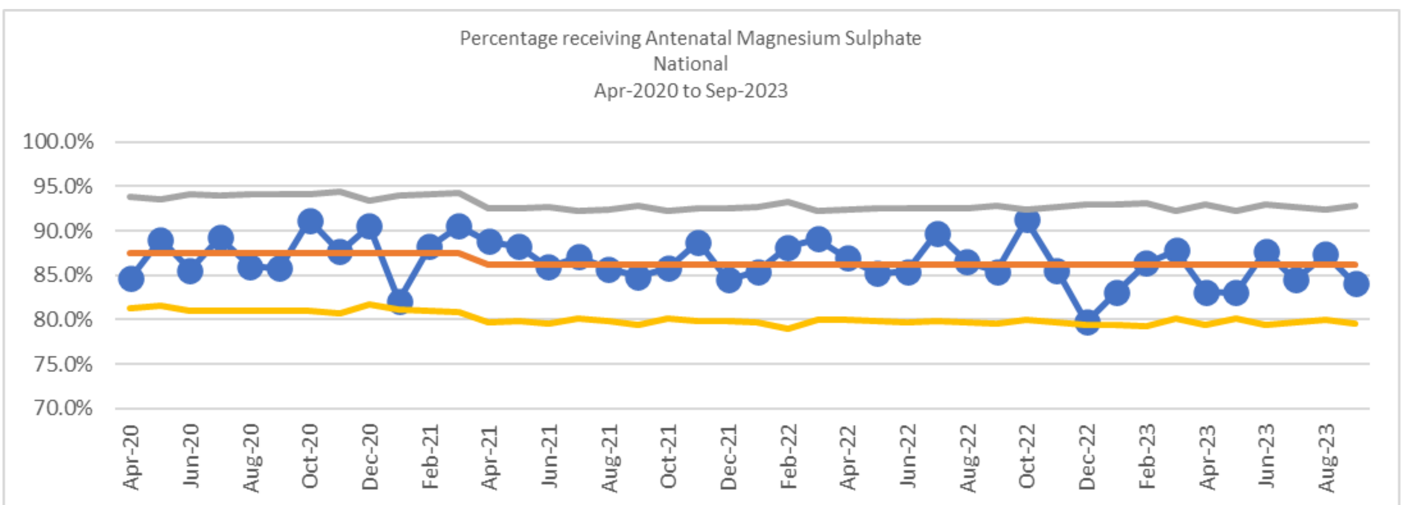


Figure 4

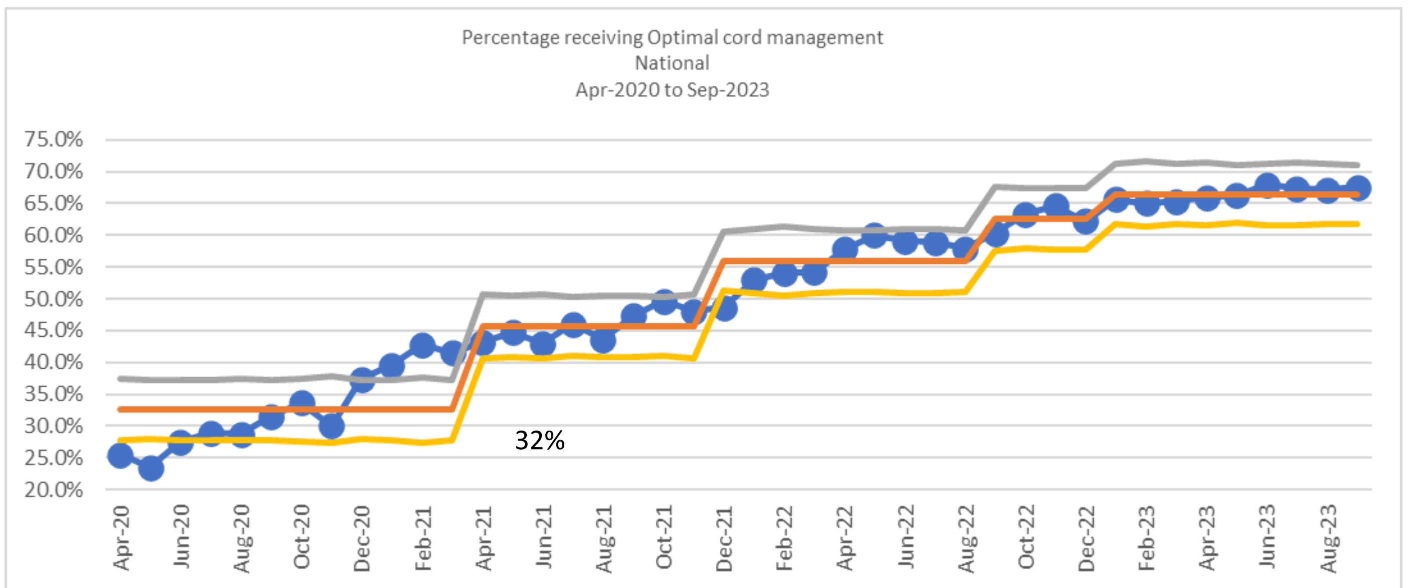


Figure 5

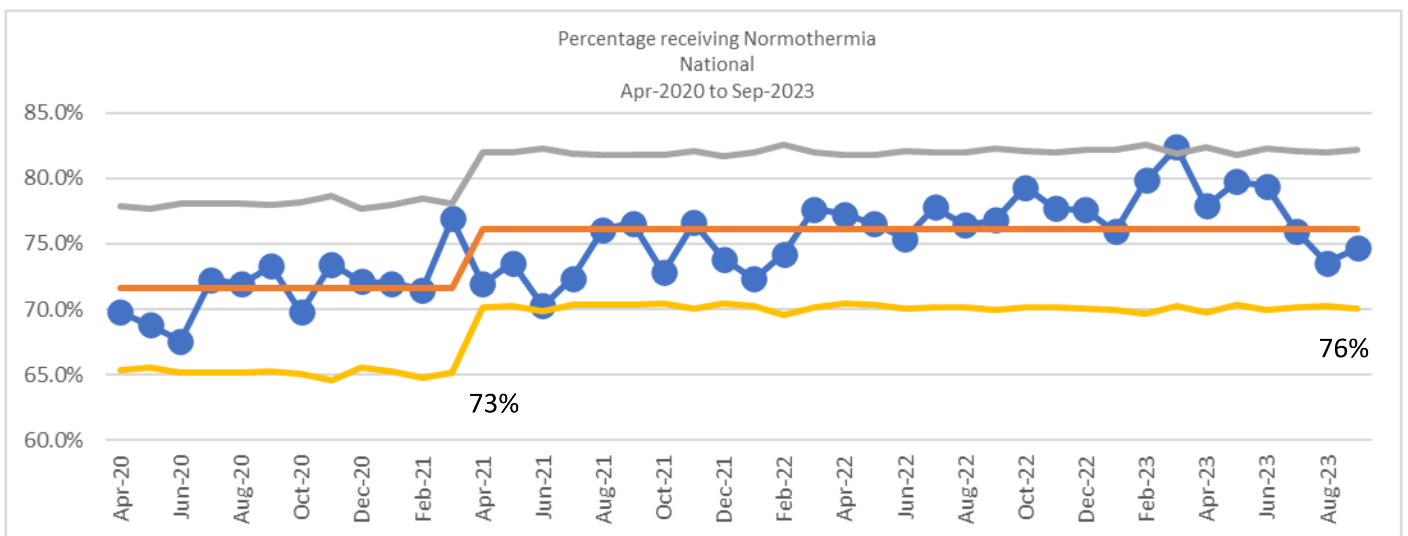


Figure 6

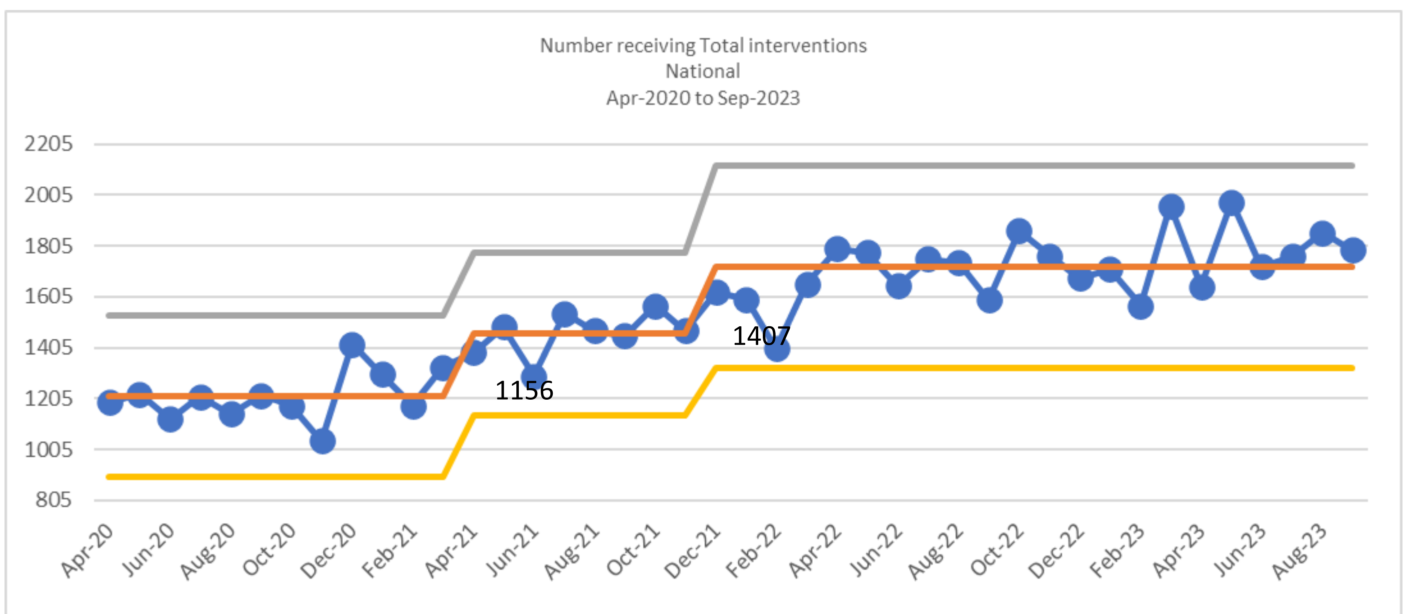


Figure7

Outcome Measures:

Magnesium Sulphate treatment prevented cerebral palsy in up to 420 babies.

Figure 8

Savings in a cost to welfare and society £420 million.

Figure 9

Optimal Cord Management has contributed to saving the lives of up to 627 babies.

Figure 10

Total overall outcomes are: 71 babies avoided contracting Group B strep, 385 cases of cerebral palsy were avoided.
And up to 645 babies lives saved with antibiotics and optimal cord management.

Figure 11

Key Learnings

- **Health Innovation -East Midlands:** All Trusts within East Midlands Neonatal Operational Delivery unit have agreed to adopt the regional Peri-Prem Passport for use across their maternity/neonatal services. It was launched at the PSC MatNeoSIP Network Event in July 23 and has already been implemented at Northampton General Hospital (NGH) & Kettering General Hospital (KGH), with University Hospitals Derby and Burton (UHDB) & University Hospitals of Leicester (UHL) moving forward in Q3. Nottingham University Hospitals (NUH), Sherwood Forest Hospital Trust (SFH) & United Lincolnshire Hospitals NHS Trust (UHLT) are in the process of moving from their existing Trust Passport to the regional version. Chesterfield Royal Hospital will continue to use the Yorkshire and Humber passport; however, will seek to have it adapted to include the same information as the version used in the East Midlands.
- **Health Innovation East:** There has been introduction of PERIPrem tools (data collection tool and passport) in units across the region. Cambridge have successfully introduced their own Rosie Preterm Bundle
- **Health Innovation East:** NEWTT2 tool has been adopted in three hospitals in the East of England.
- **Health Innovation West Midlands:** Good progress with the escalation toolkit across the West Midlands. The regional chief midwife is an active champion of this work. The PSC is supporting regional learning sets, individual informal 'check in' calls & open drop-in sessions. It is felt that the decision to adopt the toolkit prior to the full roll out of MEWS & NEWTT2 has been very beneficial in enabling effective escalation of deterioration in advance of the introduction of the early warning score tools.
- **Health Innovation Oxford: Buckinghamshire Healthcare NHS Trust** (BHT) has decided to implement NEWTT2; onboarding meeting with NHSE completed and team currently reviewing guidelines which may be impacted by the change

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

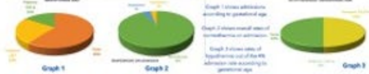
What did you learn?

- 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

Health Innovation Network – South London

Maintaining normothermia on admission to the neonatal unit

Drupti Jogia, Alina Emilia Petric, Caroline Nyawira
Croydon Health Services NHS Trust



Improving Optimal Cord Management and Normothermia in Preterm Neonates

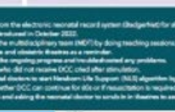
Maria Zaid, Rob Burnie, Sonal Datir, Catherine Baker, Jilly Lloyd, Basia Chmielewska, Katherine Dedicatoria, Mercy Ugbeajabo
Guy's & St Thomas' NHS Foundation Trust

Optimum cord management-"Hurry-up and Wait"

King's College Hospital NHS Foundation Trust (KCH FT)

Improving compliance with Delayed Cord Clamping (DCC) for preterm babies < 34 weeks

Moustafa Eldalal, Senior Clinical Fellow
Supervisor: Dr Siddhartha Paliwal, Paediatric Consultant and Neonatal Lead
Queen Elizabeth Hospital (Lewisham & Greenwich NHS Trust)



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Optimising Cord Management for Preterm Infants <34 Weeks Gestation

St George's Hospital Neonatal and Maternity Team
St George's University Hospitals NHS Foundation Trust

SMART Aim

Our aim is to increase the percentage of Delayed Cord Clamping (DCC) of 60 seconds or more for babies born <34 weeks from an average of 45.9% for the year of 2022 to 65% for quarters 1 and 2 of 2023 by using the bedside (LifeStart) resuscitaire.

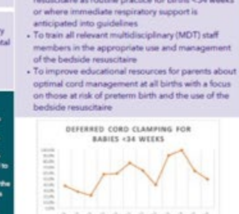
Background

St George's Hospital NHS Foundation Trust is a tertiary referral centre for Maternity Care with a level 3 Neonatal Unit. There are up to 400 births per month with a broadly socioeconomic and multicultural patient demographic.

Introduction

Our main aims to optimise and standardise our cord management for preterm births included:

- To improve the number of babies born <34 weeks that receive DCC of one minute or more from birth
- To integrate the use of the bedside (LifeStart) resuscitaire as routine practice for births <34 weeks or where immediate respiratory support is anticipated into guidelines
- To train all relevant multidisciplinary (MDT) staff members in the appropriate use and management of the bedside resuscitaire
- To improve educational resources for parents about optimal cord management at all births with a focus on those at risk of preterm birth and the use of the bedside resuscitaire



Summary of Q2 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 Q2 there are 29 ICBs (69%) taking a Whole Systems Approach to high-risk opioid prescribing. 25 of those are fully supported by PSCs and further 3 are receiving a light touch support from PSCs.
- An additional 8 ICBs are not implementing a Whole Systems Approach however they are receiving various levels of shared learning, data provision and other support from PSCs to address high risk opioid prescribing. This takes the total number of ICBs engaged in the programme across England to 37 (88%).

Detailed information

Key updates and achievements

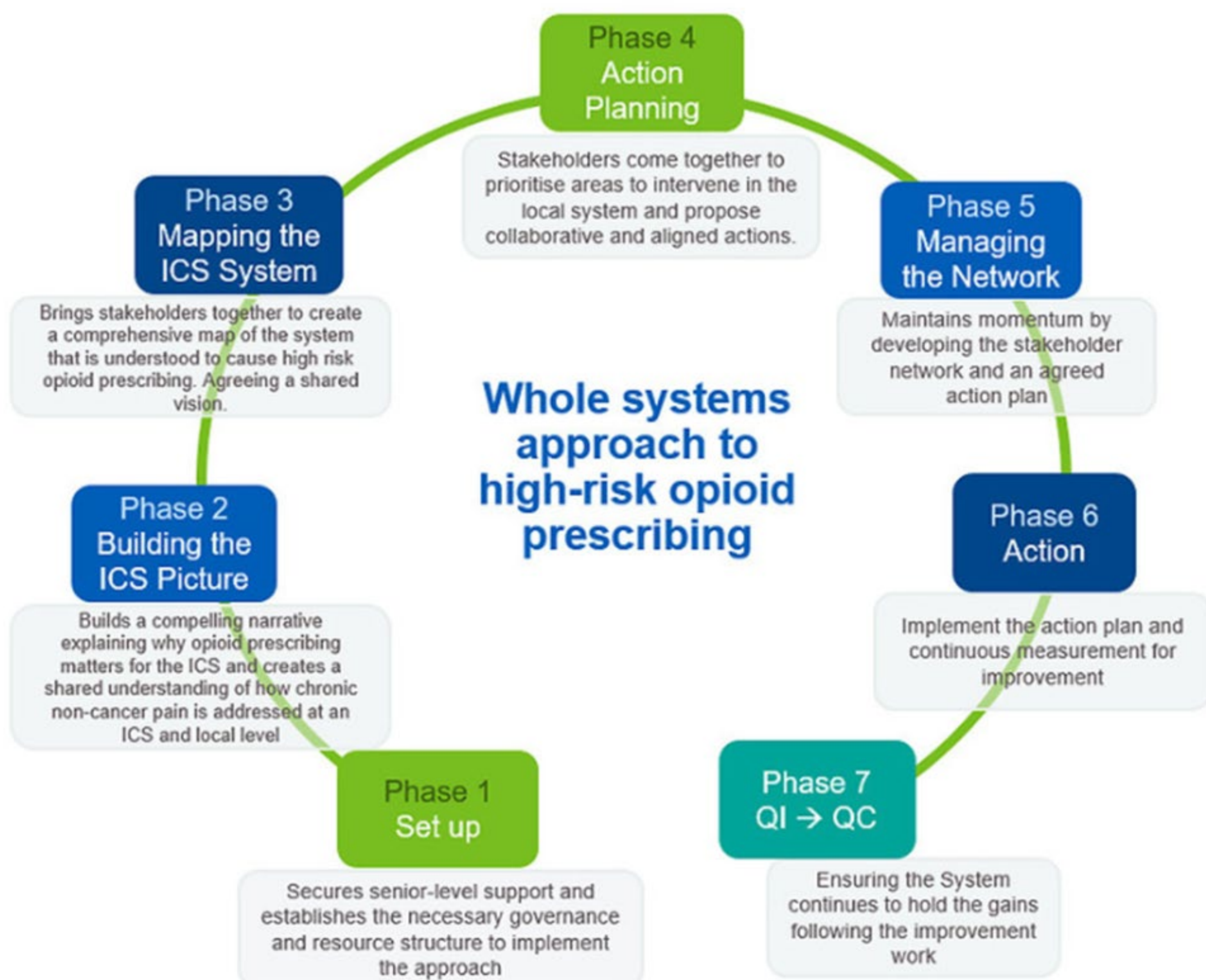
Systematic approach to improvement and structured support to understand the problem:

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 Q2, PSCs were engaged with 37 ICBs, supporting 28 ICBs (67%) to implement the Whole Systems Approach and an additional 8 ICBs via various levels of shared learning and data provision. 25 ICBs are being supported intensively. Of those:

- 14 PSCs have been working with 14 ICBs/ICSs to implement the action plan (Phase 6 – Action).
- 14 PSCs have been working with 6 ICBs/ ICSs through Phases 4 and 5
- In addition, 4 PSCs are working with 5 additional ICBs/ICSs through Phases 2-3

See the Case Studies provided at the end of this section for examples from PSCs of how they are working with ICBs through the various phases. In particular, this Quarter we provide examples of approaches to co-development of resources, system mapping, empowering people with lived experience and of setting up a Breakthrough Series Collaborative (BTS) to support Places across an ICB footprint.



National outcome measurement:

Agreement has been gained to publish the national outcomes dashboard on NHSE platform OKTA. Work continues to complete the build and publish. Data to populate this dashboard continues to flow monthly directly from NHSBSA the National Team for both the national outcome measures:

- Number of people (18 years or over) prescribed oral or transdermal opioids in the reporting month PLUS the previous 3 consecutive months, meaning they have had a prescription for opioids for at least 4 consecutive months. (excluding methadone and low dose co products)
- Number of people (18 years and over) prescribed >120mg OME/ day in the reporting month.

Context, challenges, and expectations

Q2 has seen a significant number of ICSs (20) being supported by PSCs to move into and undertake Quality Improvement activity.

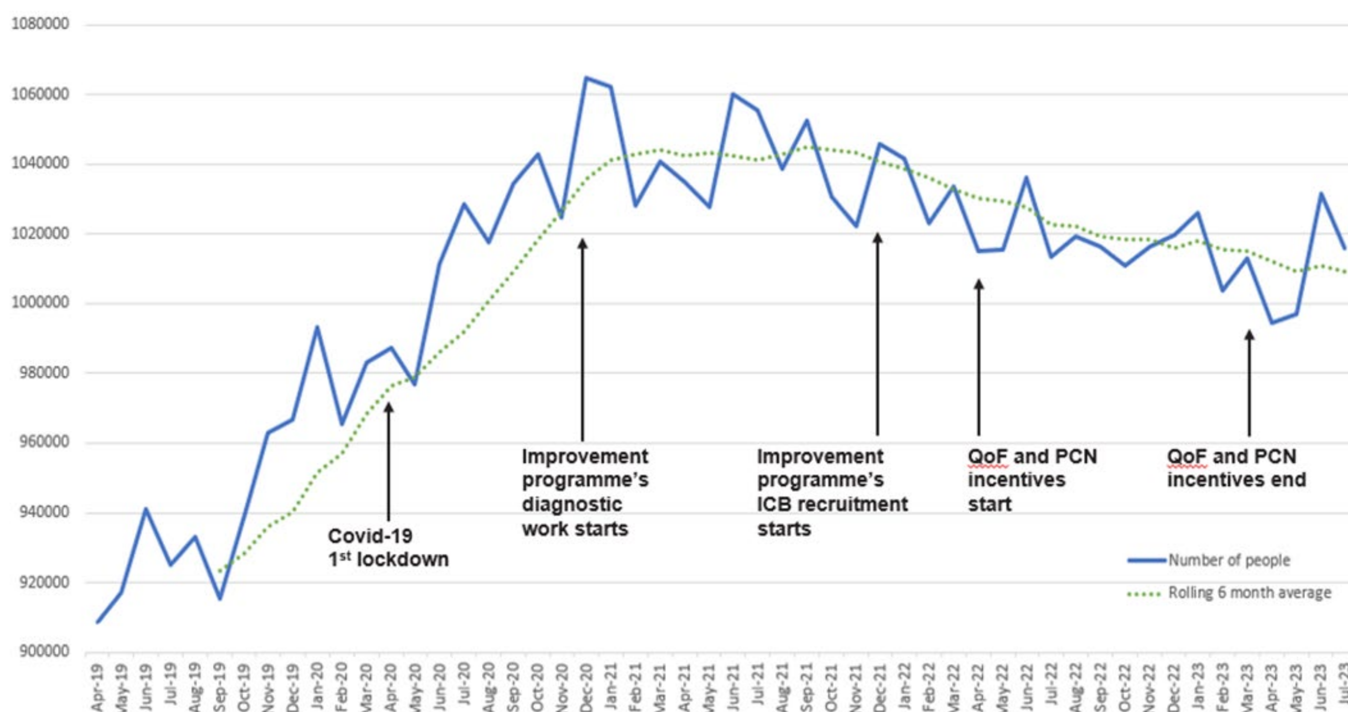
Although there is greater engagement with ICBs there is a risk to the pace of this improvement in 2023/24 due to the removal of the financial incentives for primary care via QoF and PCN IIF.

Restructuring of Regions, ICBs and NHS England has impacted engagement and momentum with PSCs reporting this is impacting the pace of the work in their ICBs.

There is significant demand for the national outcomes data dashboard however the progress of publishing has been impacted by NHSE restructure processes.

There has been no Q1 or Q2 National Action Learning sessions due to delays in the PSC commissioning process into Q2 and restructuring of the National Team.

Outcome Measures



(Note that ePACT2 data lags) There continues to be a decrease nationally in the rolling 6 monthly average number of people 18 years and over prescribed oral or transdermal opioids in 4 or more consecutive months, which follows a continuously increasing trend, shown here from 2019.

There is a risk to the pace of this improvement in 2023/24 due to 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 with PSCs reporting this is impacting the pace of the work in their ICBs.

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)

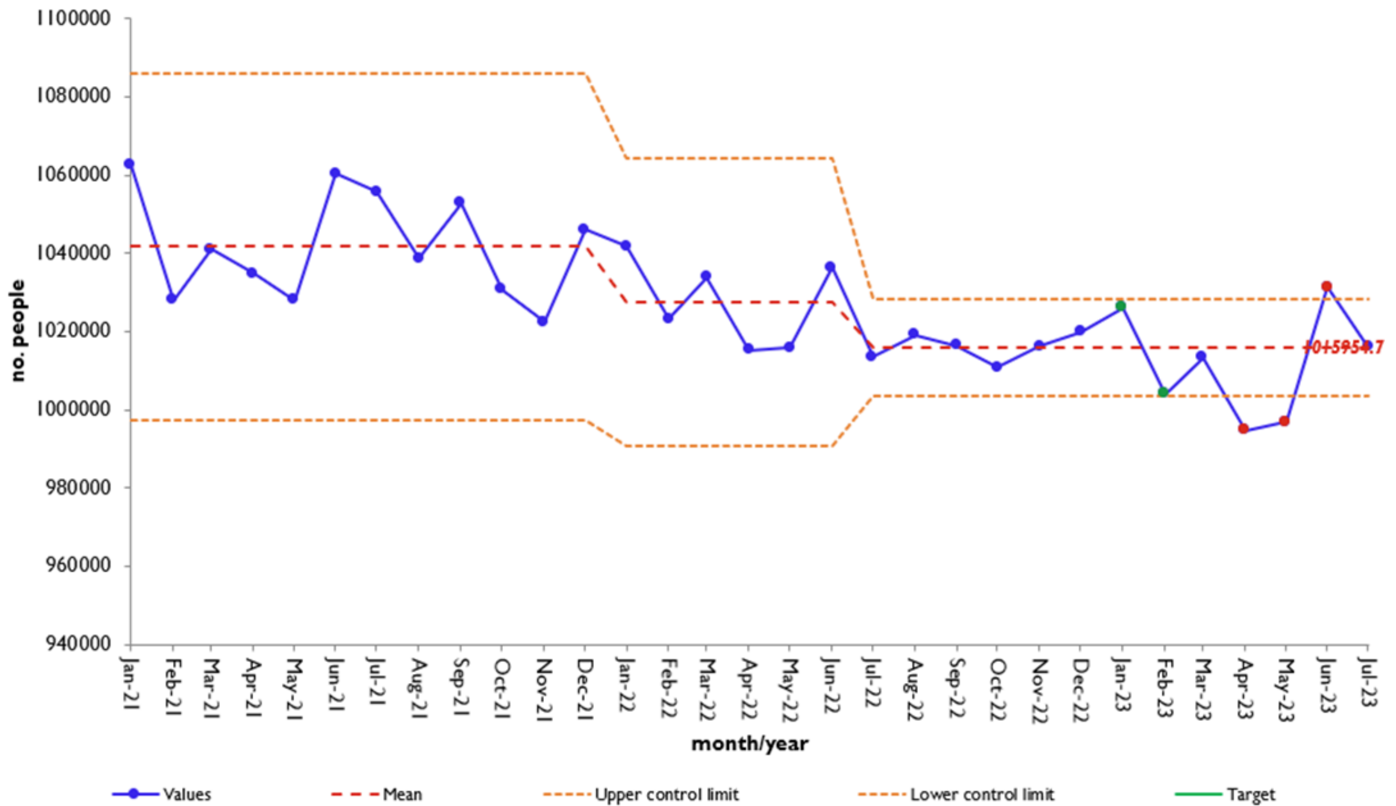
This translates to as many as 414 lives saved over the next 2 years.

aqua

Shape Change Inspire Quality Transform Care

No.people prescribed oral or transdermal opioids for 4 consecutive months

I-Chart



- Astronomical Point
- Inner Thirds
- Outer Thirds

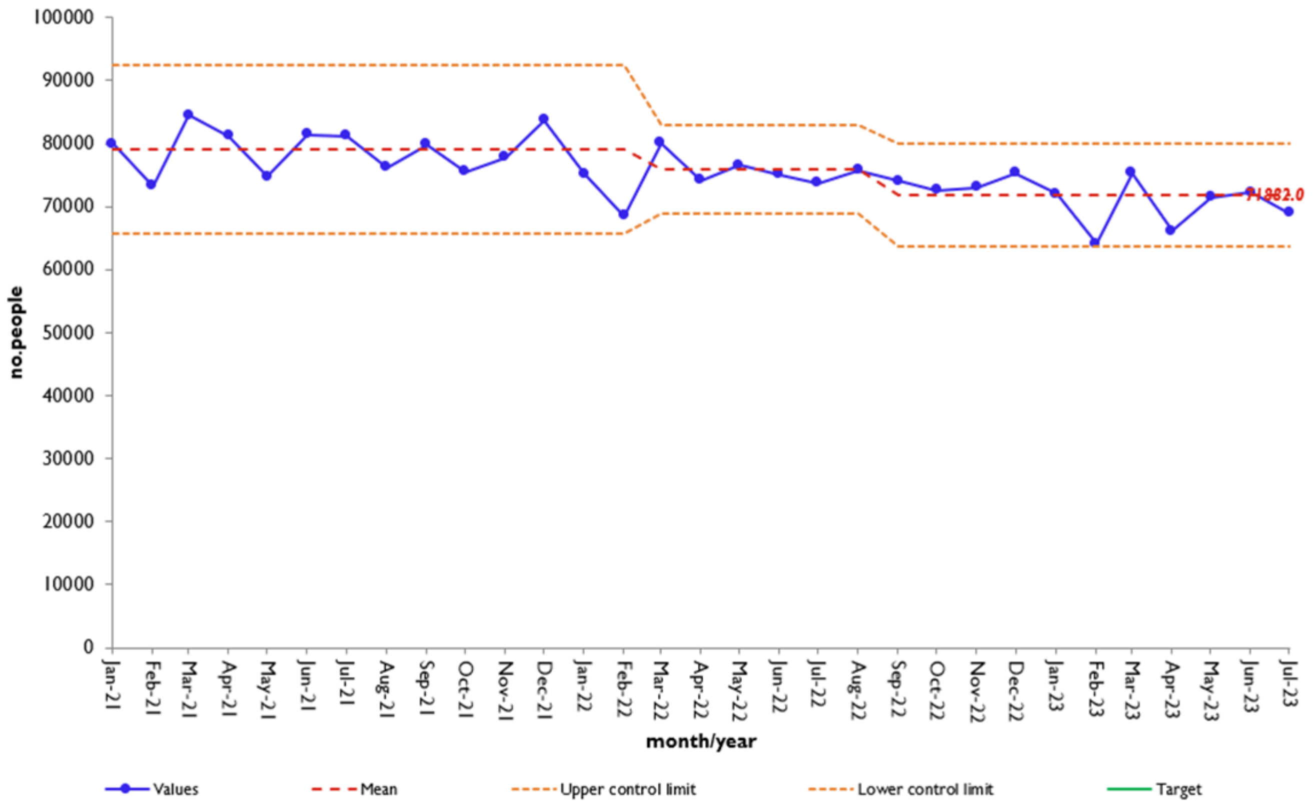
For the period July 2022 to March 2023 there are 25,693 fewer people per month being prescribed oral or transdermal opioids for longer than 3 months compared to the 2021 baseline (P=0.015)

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

The 3 data points for April, May and June 2023 are astronomical points - sitting outside of the upper or lower control limits. A similarly noticeable increase is seen between May and June data points throughout the data.

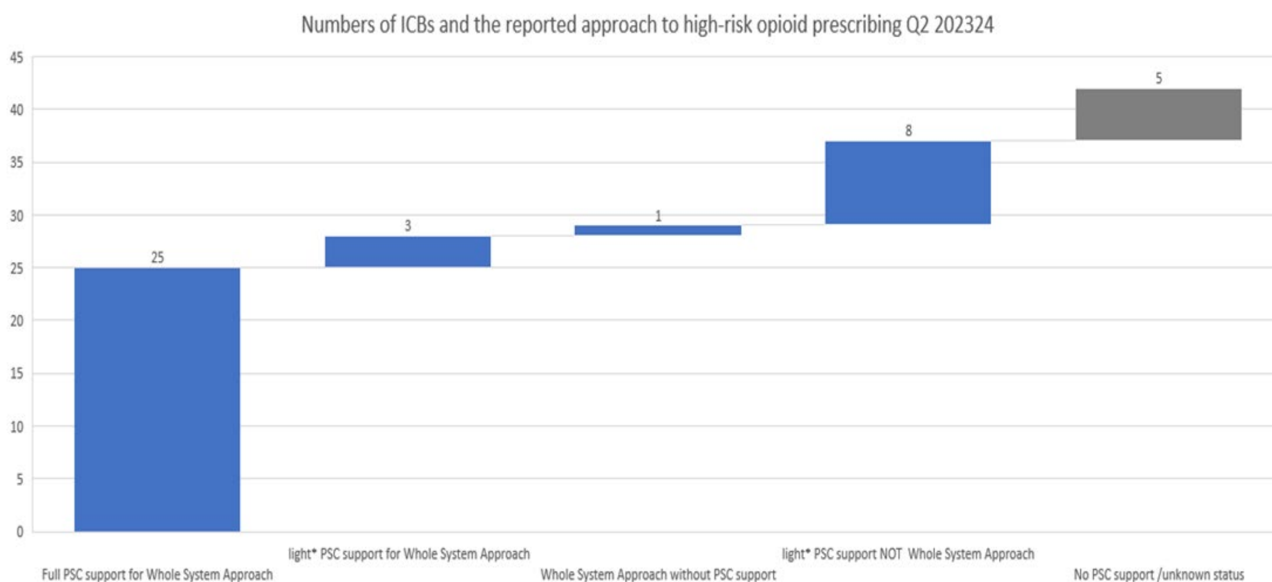
This can likely be explained by the way bank holidays fall during this period each year: The number of bank holidays within a given month reduces the number of days where prescriptions can be ordered and dispensed. Additionally, for a significant number of people bank holidays may represent a break from normal routine, which can affect the way people behave with respect to their prescription ordering and collection. April and May both have a number of bank holidays. The result we see repeated in the data is an increase in prescriptions dispensed in June following lower dispensing in the preceding month. Note also that in 2023 there was an additional May bank holiday.

no.people prescribed >120mg/day OME in the reporting month
I-Chart



For the period September 2022 to July 2023 there are 7,217 fewer people per month being prescribed high dose opioids compared to the 2021 baseline. The equates to 7,217 patients who have had their risk of death from opioids halved.

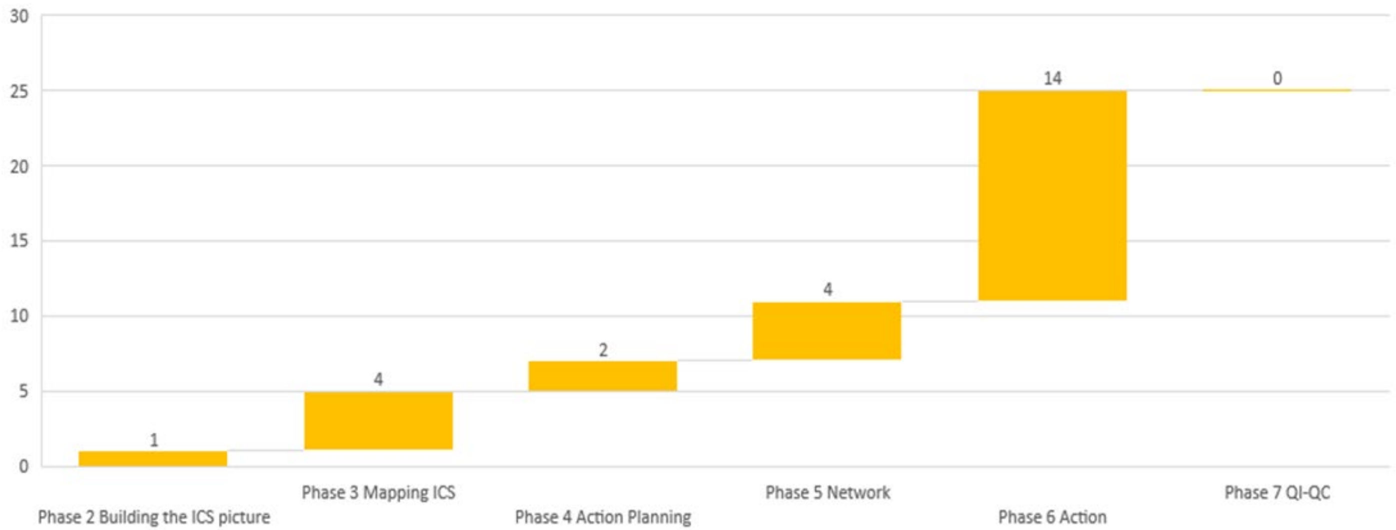
Process Measures



In Q2 there are 29 ICBs (69%) taking a Whole Systems Approach to high-risk opioid prescribing. 25 of those are fully supported by PSCs and further 3 are receiving a light touch support from PSCs.

An additional 8 ICBs are not implementing a Whole Systems Approach however they are receiving various levels of shared learning, data provision and other support from PSCs to address high risk opioid prescribing. This takes the total number of ICBs engaged in the programme across England to 37 (88%).

Examples of *Light PSC support in Q2
Programme updates provided at CD LIN meetings. Participants identified to attend funded places on Live Well With Pain training. Presenter and participants identified for WM opioid shared learning event.
Meet with ICB chief pharmacist and PCN lead pharmacist every 6 weeks to discuss MO including opioids. ICB Database shared for Q1 data using Epact OP2 indicator that can be sliced to PCN/practice and deprivation quintiles. Tools produced in Joined Up Care Derbyshire have been shared with key links. Regional Controlled Drug Accountable Officer has been in touch to arrange programme update presentation at next Controlled Drug Local Improvement Network (CDLIN).
ICB Database shared for Q1 data using epact OP2 indicator that can be sliced to PCN/practice and deprivation quintiles. Tools produced in Joined Up Care Derbyshire have been shared with key links.
ICB Database shared for Q1 data using epact OP2 indicator that can be sliced to PCN/practice and deprivation quintiles. Tools produced in Joined Up Care Derbyshire have been shared with key links. I am on the IPMO working group for opioids to provide advice and share learning. Regional Controlled Drug Accountable Officer has been in touch to arrange programme update presentation at next Controlled Drug Local Improvement Network (CDLIN).
supporting 1 person with lived experience: stakeholder mapping/engagement/ prescribing data for ICS and PCN/ connecting with ICS and Somerset FT personnel for support with project
Linking in with ICB meetings and sharing information with stakeholders.



14 PSCs are working with 20 ICBs/ ICSs through Quality Improvement (Phases 4-6)

Of these 14 PSCs, 10 have been supporting 14 ICBs/ICSs to implement the action plan (Phase 6 – Action).

In addition, 4 PSCs are working with 5 additional ICBs/ICSs through Quality Planning (Phases 2-3).

Case Studies

1. Co-developing digital pain management resources with lived experience representatives, local leads, third sector, and national subject matter experts. (HIN EM)
2. System Mapping Workshops, Kent and Medway Integrated Care. (HIN KSS)
3. Setting up a Breakthrough Series Collaborative (BTS) to support Places across an ICB footprint. (HIN NWC)
4. Empowering people with lived experience of chronic pain to lead change in Plymouth. (HIN SW)

Case Study (1): Co-developing digital pain management resources with lived experience representatives, local leads, third sector, and national subject matter experts.

Background

The East Midlands Patient Safety Collaborative (EMPSC) have been supporting Joined Up Care Derbyshire Integrated Care System (JUCD) to take a systems approach to improving the management of chronic non-cancer pain. At the third system-wide action planning event in March 2023, which was attended by a range of stakeholders including lived experience, one of the priorities identified was the need for a holistic pain management action plan that is owned by the patient and is accessible across the system. This priority was included in the driver diagram for the systems approach for 23/24. The clinical system primarily used across the ICS is SystmOne and there were no suitable digital solutions already in place.

What happened

We scanned whether there was a digital solution already available and tested nationally, took advice from Dr Roger Knaggs, a national pain specialist, and explored possible solutions with Dr Frances Cole from the national charity Live Well with Pain (LWWP). This resulted in a collaboration to create, test, and evaluate a suite of digital tools based on LWWP's existing well-tested paper-based tools. The digital tools support a biopsychosocial approach, effective clinical reviews of chronic pain, and empower patients to better self-manage their chronic pain.

The digital tools created are:

- Two floreys. These are pre-appointment questionnaires that are sent electronically via text using Accurx within the clinical system. Replies are logged in the clinical system ready for review by the healthcare professional.
    - A health and well-being florey which can be used by any healthcare professional to understand how pain is affecting quality of life.
    - A medicines review florey that helps the patient reflect on and communicate how well their medicines are working for them and any potential concerns.
- A holistic pain management review template that is completed in the clinical system during a consultation and includes a medicines review section.
- A holistic pain management action plan with two parts (self-management and medicines). The action plan is created with the patient during the consultation and can then be printed or sent electronically. Once created it is accessible to all members of the primary and secondary healthcare team via the communication folder in SystmOne.

Who was involved in the collaboration?

The collaboration included a range of stakeholders who were all motivated to improve chronic pain management with notable contributions from:

- Live Well With Pain: Dr Frances Cole and Dr Emma Davies as pain management specialists and Lived Experience Trainers

- Joined Up Care Derbyshire: Medicines management team member providing clinical and technical input plus project management and engagement support, lived experience representation.
- Health Innovation East Midlands: Medicines Safety, project management and enabling support
- Local GP practice and PCN teams; including doctors, health and wellbeing coaches who are running pain management programmes, PCN pharmacy staff, PCN manager with technical skills
- National pain specialist and academic support: Dr Roger Knaggs
- Durham University: for evaluation support from Prof. Paul Chazot

What worked well?

- Working with a trusted national charity to both lead the collaboration and to ensure sustainability, future updating of the tools, and wider adoption and spread.
- The EMPSC acting as an enabler.
- Identifying, then using, everyone's skills effectively whilst being mindful of and adapting to local clinical pressures.
- Ensuring lived experience input is central to the development of any patient facing tool. This worked optimally when LWWP Lived Experience Trainers input alongside local lived experience. Examples of this within the work include:
    - Creation and formatting of all suggested patient facing content and questions.
    - Testing of all tools such as Accurx questionnaires on digital devices.
- Having specialist skills available e.g. pain specialist, academic, evaluation.
- Co-creating these tools with members of the healthcare team in general practice ensured that the tools are fit for purpose in the clinical environment and fulfil any reporting requirements.
- Piloting tools early to allow for improvements.
- Thinking about ownership of the digital tools early. For this work, the tools will be owned by LWWP with credit for developing and testing to both JUCD and Health Innovation East Midlands (as the host organisation for the EMPSC).

What was challenging?

- Identifying the capacity to develop the tools "on-top of the day job" within the changing environment in the NHS.
- Communicating virtually and in a timely manner.
- Developing tools for a system that some parties did not have access to i.e.SystmOne.

Where are we now (Nov 2023)?

- The health and well-being florey, pain management action template, and pain management action plan are all in the piloting phase.
- The medicines florey is being finalised.
- Evaluation using patient and clinician surveys is planned for January and March 2024.

Summary

This collaboration was highly effective in co-developing useful digital tools to improve the management of chronic pain. It ensured scrutiny, encouraged diverse views, and created robust resources that are adaptable to different working styles in general practice, and promote a biopsychosocial approach. We hope the evaluation will support wider adoption and spread of these tools within the NHS.

Case Study (2): System Mapping Workshops, Kent and Medway Integrated Care

Workshop Aim

To identify pain services across Kent and Medway Integrated Care System (ICS) and collate this information to produce a comprehensive map of all services, including traditional pharmaceutical services and biopsychosocial support available.

Background

Kent and Medway has a large geographical footprint of approximately 1400 miles, including more than 350 miles of coastline. It's population of 1.7 million residents primarily live in urban areas. Kent is divided into 12 local authority and the Medway Unitary Authority. Its population is diverse with a broad range of variation in socioeconomic determinants. Using the NHS BSA Opioid Comparator Dashboard, we determined that while the number of people prescribed an opioid (for any duration of treatment) was in line with the national Integrated Care Board (ICB) average there was significant variation at place (HCP) level, with East Kent being the greatest outlier.

We approached the Lead Medicines Optimisation Pharmacist at Kent and Medway ICB to discuss our programme of work designed to reduce harm from opioids and quickly identified that to make the work relevant to the whole system it would be necessary to work at a place or Health Care Partnership (HCP) level and then combine the results. Several projects had already taken place, primarily within East Kent, focusing on reducing opioid usage however these had taken place in silo and the full extent of pain services across the county was unknown. It was therefore decided to complete a series of system mapping workshops at a HCP level to map current service provision, and additionally identify gaps in service provision with a view to designing business cases for the new financial year.

Each HCP medicines optimisation team designed their own half day workshop. Delegates were invited from primary and secondary care, Ambulance and out of hours providers in addition to representative from voluntary, community and social enterprises. The workshops consisted of a presentation about the importance of reducing harm from opioids at a system-level and a place-based expert was invited to discuss work that had been happening locally. Delegates were then given time to discuss the service provision that they represented and how traditional pain management service could be complemented by the biopsychosocial offering and peer-to-peer support available. The conversations also organically developed to include supporting individuals across the primary/secondary interface and how data could be shared for the benefit of service users.

Outcome

Four place level maps will be produced, one from each workshop. These will then be combined into a single document representing the whole system which will be held by Kent and Medway ICB and shared with all providers. Knowledge of both traditional and non-medical services should improve the holistic approach required to support patients living with chronic (non-cancer) pain reducing the reliance on opioid medicines. Scrutiny of the system map will also allow development of business cases to address gaps in service provision moving forward.

Case study (3): Setting up a Breakthrough Series Collaborative to support Places across an ICB footprint

The North West Coast covers two Integrated Care Systems (ICSs) with some of the highest prescribing rates in the country. To work at scale across both systems during 23/24, the North West Coast Patient Safety Collaborative developed a support offer in partnership with our ICS Chief Pharmacists.

Our support offer takes the format of a Breakthrough Series Collaborative, offered to Places identified by both ICS Chief Pharmacists, which was initiated with a launch event in July, and consists of four full-day virtual workshops over the course of the commission. The four workshops have been aligned to the seven phases of the Whole Systems Approach and are designed to equip place-based teams with some of the tools, techniques and theories that will support them to implement the approach locally.

The model requires a nominated place lead who attends the workshops with a small core project team. Following the workshop, the place lead and their core project team then go away to a broader multidisciplinary 'home' team/community of practice to implement the learning.

Some of the key enablers to setting up the Breakthrough Series Collaborative have been:

- From the North West Coast Patient Safety Collaborative: matrix working across our organisation to provide programme management, quality improvement, coaching, PPIE and events expertise to organise, plan and facilitate the series.
- Clinical leadership to support the generation of workshop content, as well as to be an advocate for the programme across both systems.
- System leadership and advocacy for teams to be involved. The support offer was developed and disseminated by both ICS Chief Pharmacists who supported the nomination of a named place lead for those areas engaging.
- Getting dates into diaries as early as possible given the time commitment needed. Time also needed to be factored to socialise the offer in our systems and enable place leads time to recruit a team.
- Having a named place lead who has ownership for ensuring a team is established and that the learning is shared and built upon beyond the workshops.
- Setting clear expectations about what to expect, as well as outlining pre-work in advance of workshop 1 to ensure teams came prepped and ready
- Establishment of a dedicated NHS Futures space for the series – a space for collaboration and sharing of information

Some of the challenges to setting up the Breakthrough Series Collaborative have been:

- Given timescale and budget considerations, the workshops are being held virtually as opposed to face to face. Although there are huge benefits from in-person workshops, we have been really impressed with the richness of discussions and inputs in team breakout rooms.
- All places are at different stages in the establishment of their 'home' team/community of practice, however we have been clear from the outset that this is to be expected – the series is about supporting teams on their journey to implement a whole systems approach, at whatever pace is appropriate for their localities.

At the end of Q2 we held our launch event and first workshop. The launch event was an opportunity for registered teams to learn more about the Medicines Safety Improvement Programme and the PSC commission, to get more detail on what to expect from the workshops, and to hear a powerful lived experience perspective to ensure that patient voice is front and centre from the outset. The importance of patient voice was continued into workshop 1 which had a significant emphasis on stakeholders, systems thinking, Patient and Public Involvement and reflections from an individual with experience. Place-based teams made a start on their system maps and initiated thinking around aim statements, driver diagrams and a first PDSA cycle

More recently, and to ensure that the learning from the programme is being shared locally, place-based teams from one of our ICSs gave an overview of the "Benefits of MedSIP (so far!)" at a regional

polypharmacy community of practice. Feedback included “great for sharing ideas and encouraging new ways of working”, “encouraged local community of practice to develop an aim statement”, “access to tools and resources that will help us structure the work” and “considering the bigger picture – priorities, challenges, consequences, stakeholders and their roles/relationships”.

It is a pleasure to work with such passionate individuals and we thank system leaders for advocating that teams have the time and space to take this on.

Case study (4): Empowering people with lived experience of chronic pain to lead change in Plymouth.

The city of Plymouth is located on the south coast of Devon, bordered by the county of Cornwall to the west and Dartmoor to the north-east. It is home to approximately 265,000 people, making it the second largest city in the South West after Bristol. A rural and coastal community, the city faces significant health inequalities and social care challenges, with lower life expectancy and more years spent in poor health in comparison to those in the surrounding areas and wider South West region.

Following a deep-dive data exercise for opioid prescribing in 2022 by Dr Stuart Spicer, PenARC, and Research Fellow at University of Plymouth, Devon was highlighted as an area in need of support to implement the national Patient Safety Programme in 2021. Primary Care Networks (PCN) within Plymouth were identified as having higher proportion of people receiving high dose long-term opioids. The extra support offered by Health Innovation South West and the South West Patient Safety Collaborative was welcomed by the multi-disciplinary teams addressing medicines safety in the city. As a result the 'Chronic Pain Task and Finish Group' was established and led by the Public Health Team at Plymouth City Council, supported by the Programme Manager at Health Innovation South West.

At its advent, core membership of the group included GPs, Social Prescribers, Public Health Consultants, people with lived experience, specialist practitioners from the acute trusts Chronic Pain service, Medicines Optimisation Leads on Devon's Integrated Care Board (ICB) and primary and secondary care Pharmacy leads.

The focus on urgent and long-term conditions within the ICB, combined with mounting challenges within the PCNs and personnel changes have impacted upon the ambition for a system-level approach. Over time the group lost some momentum creating an increased risk the programmes goals would not be achieved. I joined the Medicines Safety Improvement Programme in July 2023 and co-ordinated a membership re-fresh in early summer of 2023 which has created space to listen and hear other voices in the system. The 'Chronic Pain Task and Finish Group' had a slight change of tack, with the impetus for change coming from people with lived experience. Their desire to make a tangible difference to others living with chronic pain was compelling and inspired us to move forward. We developed a plan to support the implementation of two Pilot Pain Cafes in the city, with the aim of holding the first one by 30 November 2023. To support the work of Social Prescribers and Pharmacists in one PCN we negotiated with the Plymouth Public Health team to fund places on the 'Live Well with Pain' training programme.

We've been inspired by the tenacity of one person with lived experience to bring her idea to life. 'Chronic Pain Coaching CIC' is a local not-for-profit community-based group in Plymouth, which aims to support people living with chronic pain using pain management techniques in a supportive, non-judgemental peer support group, set-up and led by a person with lived experience, who is now medication free.

We worked with Evaluation and Learning specialists at Health Innovation South West to create a logic model, helping her to focus the scope of the pilot pain café, think about inclusion and exclusion criteria and referral pathways and fundamental ways to demonstrate impact for group participants in the short and long-term. Our involvement has led to signposting to local pots of money/ access small grants and enabled her to successfully apply for a business account to pay for insurances to set up the pilot project. Guided movement is a key part of the coaching session and pain café, so we've reached out to friends, the local community and used social media to help find a Yoga instructor who can give 30 minutes of their time each month.

We're on our way to achieving our aim; the first pilot pain café took place on 8 November 2023 with 14 people participating in the session and they've all provided feedback about what they would like to include in the forthcoming sessions! We're aware this pilot will generate a small data set and is unlikely to impact upon the prescribing data for the PCN for some considerable time, but the immediate psycho-social impact upon those participating in the sessions and peer support networks are where the benefits will be felt the most. Our advice to others is to go with the willing, be brave and start small, use QI methodology to test out ideas and learn from the feedback and soon others will want to be part of the movement you're creating!

It’s been a real privilege and great opportunity to adapt my programme management skills, to work alongside a small team of dedicated individuals, who have shared their personal stories about living through pain, to become opioid-free and are focused on helping others in their community embark on their journey.

Summary of Q2 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 Q2 (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 Q2, all 15 PSC teams continued their engagement with the ICSs and providers in their area – e.g the Quality and safety leads, Chief Nurses, Patient Safety Specialists, amongst other stakeholders to offer PSIRF implementation support.

PSCs have engaged with all 42 ICSs in England to support the System Safety work via learning events, webinars and resource sharing to narrow the variation in implementation and understanding of PSIRF.

There is variation in terms of the level of engagement and PSIRF phase completion at provider level 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.

The NHS England team have started collecting information on PSIRF transition status at provider level which will be useful to systems and PSCs to understand variation and offer bespoke support as required.

System safety co-ordinators from the PSCs contributed to and participated in the NHS England led PSIRF Regional Implementation group meetings, NHSE led webinars and the Action Learning Sessions.

Key updates and achievements

- In Q2, 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 webinars, Ask-the-Expert sessions as well as bespoke 1:1 support.
- Stakeholders include - Chief Nurses, Patient Safety Specialists, Quality and Safety leads, 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.
- An Action Learning Session led by NHS England and jointly planned with the System Safety Co-ordinators and Associate was held on 21st July with useful contribution on Learning Response methods (SWARM, MDT Reviews, Thematic review) by leads from Isle of Wight, University Hospital Sussex and Lancashire Teaching Hospitals Trusts along with updates from PSIRF National leads to the PSC attendees - which received positive feedback.
- 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.
- The various topics covered via the PSC learning sessions included – Reflecting on PSIRF plans through a QI lens, Lived experience of patients and lead investigators, Asset based stocktake in relation to PSIRF implementation, Patient Safety Partner input, Learning response tools (After Action Reviews, SWARM huddle, Multidisciplinary team review) & Thematic reviews.

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.

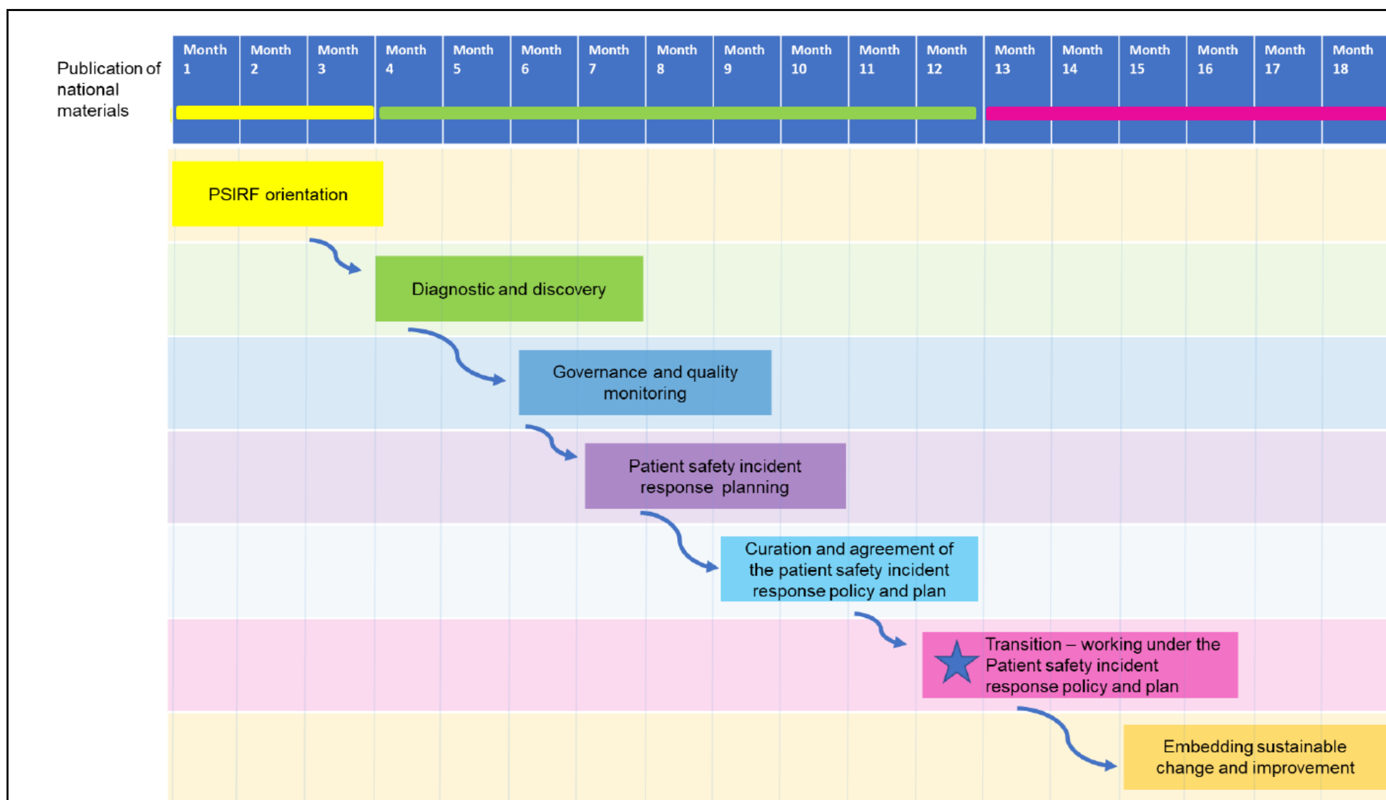


Figure: PSIRF implementation phases and the timeline published in the PSIRF preparation guide.

Work Underway

The ambition set for Q2 2023/24 includes:

- In Q2 PSCs identified ICSs and providers who need focused PSIRF support to address any gaps and needs to enable providers to transition to PSIRF by Autumn 23.
- 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- 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 uploaded on the System Safety FuturesNHS page to facilitate stakeholders in finding PSIRF related resources easily. Available here - https://future.nhs.uk/NHSps/view?objectID=36938352

Action learning Set (ALS) session

Over 2022/23 two action learning set (ALS) sessions were successfully conducted with the PSC leads in Q3 and Q4 22/23 in Dec 22 and Feb 23 respectively 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.

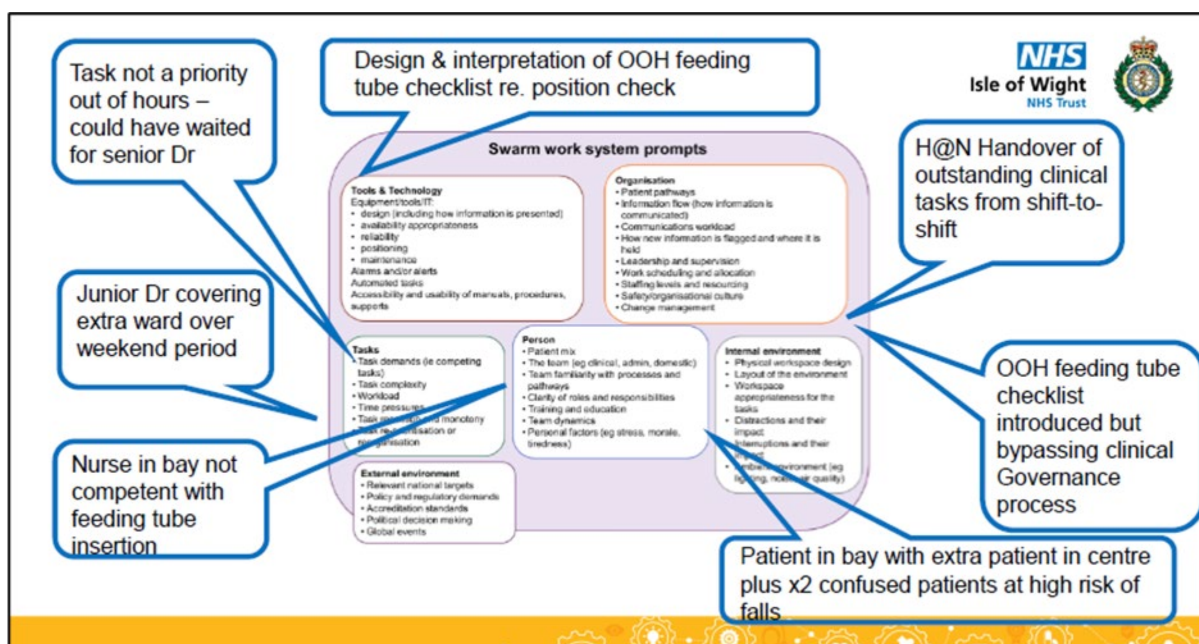
The first national ALS session was held on 13th Dec 2022 where all the PSC workstream leads came together to share learning, discuss aspects of culture in implementation of PSIRF as well as devising actions (using QI methods and tools) to address any issues or challenges identified or faced by the ICSs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

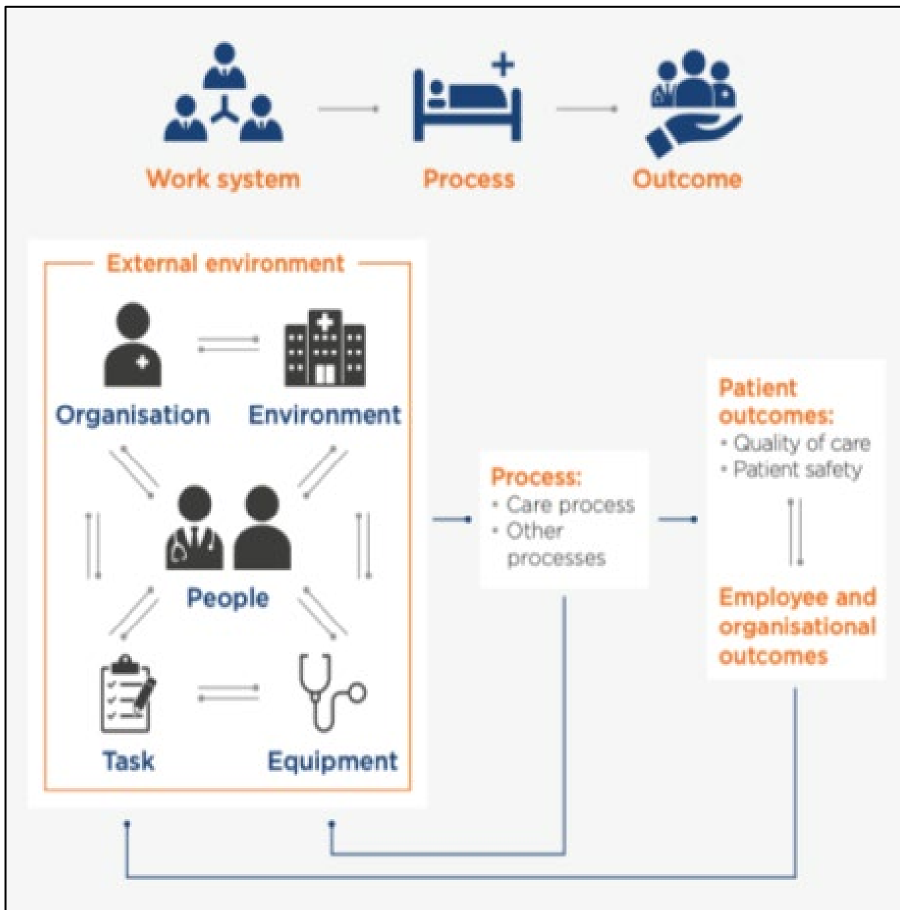
Outputs of this ALS session were shared and uploaded to the relevant NHS Futures pages for collaboratively learning.

In Q2 2023/24, a third ALS session was held with the PSC members 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 using practical real life examples.

The slide below was shared by Isle of Wight speaker demonstrating the use of SEIPS in swarm huddles using an example of a misplaced nasogastric tube –



Slide on SEIPS (Systems Engineering in Patient Safety) in action



Context, challenges, and expectations

The 15 PSCs around England are commissioned to work with all the Integrated Care Systems over 2023-24 by offering support to the providers 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.

The PSIRF documentation highlights responsibilities of providers, the ICSs and the PSCs. While 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 & 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.

Main challenges

While most ICSs are now fully functioning and delivering their statutory responsibilities, governance structures in some 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 due to various reasons 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.

Access to training for independent providers e.g. from HSSIB was described as a challenge.

Key learnings

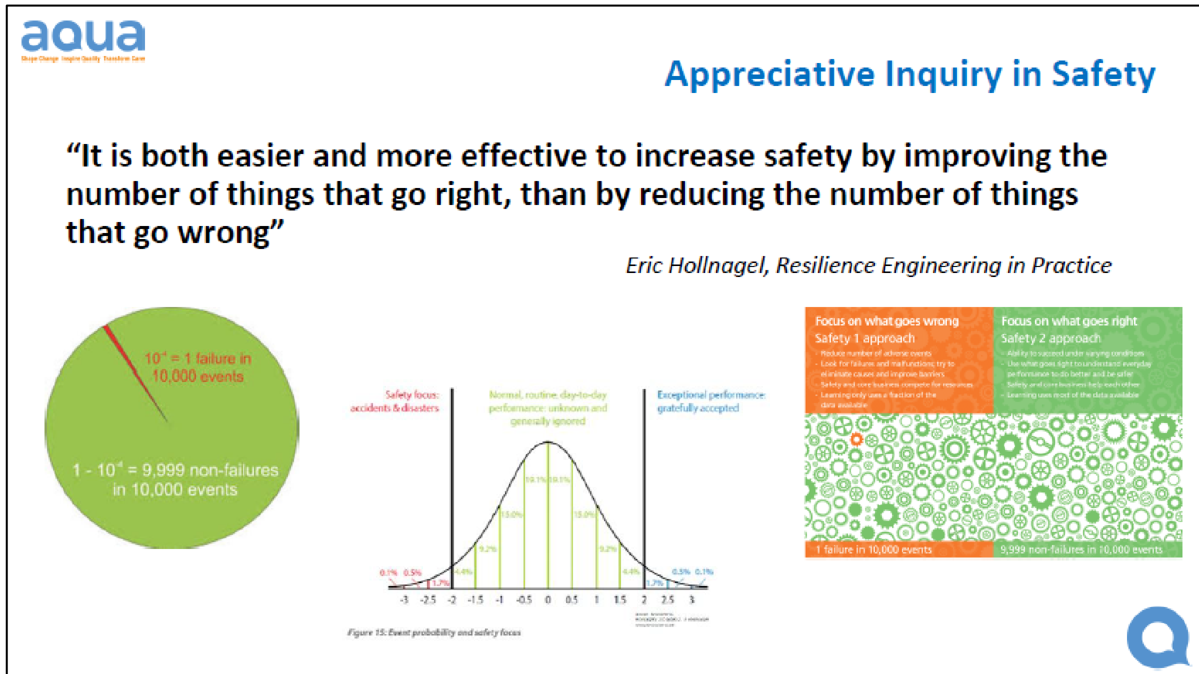
- NHS England continued direct discussions with PSCs and joined PSIRF events and learning sessions across England, which aided the understanding of the networking landscape, ICS and provider interface to improve patient safety at a system level as well as the progress with regard to the implementation of PSIRF.
- Discussions are continuing with regard to implementation of PSIRF in maternity settings, mental health providers, ambulance trusts, care homes, 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, Action learning sessions, 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 Q3 and Q4 2023/24, the PSCs will continue offering support to the ICSs and providers therein, to support the PSIRF transition work in the stipulated phases.

A blog published by the North West Collaborative – Health Innovation Manchester on a NW collaborative event held in Q2 is available here

https://www.linkedin.com/pulse/blog-nw-psirf-implementation-event-stuart-kaill?utm_source=share&utm_medium=member_android&utm_campaign=share_via

Below is a slide shared at the event by colleagues from AQUA on 'Appreciate enquiry in safety' –

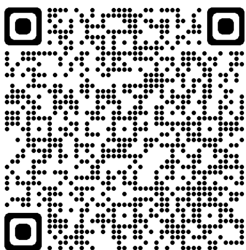


An article on 'Understanding the Patient Safety Partner role: Oct 2023 is published by the Yorkshire and Humber PSC on their PSIRF Padlet and is available via the link below –

https://padlet.com/patientsafetycollaborative/patient-safety-incident-response-framework-psirf-odhf4j5eamj6y8fc/wish/2763231945

Link to the resource on the Padlet - (padlet.com) https://padlet.com/patientsafetycollaborative/patient-safety-incident-response-framework-psirf-odhf4j5eamj6y8fc

QR code



A case study provided by the Oxford PSC on PSIRF support to a Trust is below –

PSC Oxford & Thames Valley PSIRF: CASE STUDY

Trust Support

Working as one system colleagues from Health Innovation Oxford & Thames Valley, NHS E SE and Buckinghamshire, Oxfordshire & Berkshire ICB are coordinating capabilities and capacity to support a Trust to meet their PSIRF aims and deadlines.

We identified the Trust as requiring support and consistently delivered to various levels of the organisation an offer of assistance that has evolve as we have improved our understanding of their needs. This has resulted in acceptance of support, that is being refined to meet the Trust's specific circumstances.

Case study

The Trust is multi-site, a factor that contributes to a complex culture. They have chosen to go-live with PSIRF on 1st of April 2024. This does give them sufficient time to make a success of PSIRF implementation and provides sufficient opportunity for us to understand and deliver their support needs.

We began by meeting virtually with Trust colleagues to help them refine their approach to PSIRF and start planning their documentation. Although not strictly a sequential QI approach (this was not the assistance the Trust wanted) this effectively equated to an IHI style discovery phase and the Trust have planned a PDSA cycle for January 2024 to test their implementation of After-Action Reviews. Discussions resulted in the Trust deciding to organise some 'Implementing PSIRF summits' for their staff, to both better inform staff and gather staff input into the emerging changes. We attended the summits in person to help field questions and gain intelligence. We have fed back to Trust colleagues and helped with their current areas of work around process mapping for learning response decision making, prioritising topics and staff communications. The Trust also had concerns that are now being addressed regarding specific elements of PSIRF training for key staff, such as After-Action Reviews. The Trust's bespoke training begins on 6th of December, and I have been invited to observe. We have now suggested a timeline/road map to help colleagues successfully reach their go-live date and we are encouraging them to produce and share for comment very early drafts of their Policy and Plan to avoid major revisions nearer to deadlines. (Timeline: 27.9.23 pivotal virtual meeting to agree approach to support | October we supported four safety summits | November feedback | December incident response methods training | December & January very earliest drafts of policy and plan | January AAR PDSA | 2.2.24 First full draft submission for comment | 8.3.24 PSIRP & Policy to BOB ICB SQG | 20.3.24 BOB ICB sign off). This tailored and coordinated system wide support we believe will not only assist the Trust to meet their April deadline but should put them in the best position to use the outputs of their analysis to focus on the areas of maximum learning in 2024/25.

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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.