Patient Safety Collaboratives - Delivering Definitive and Measurable Improvements in Patient Safety

Nuffield Trust-HSRN - Universities UK- West of England AHSN

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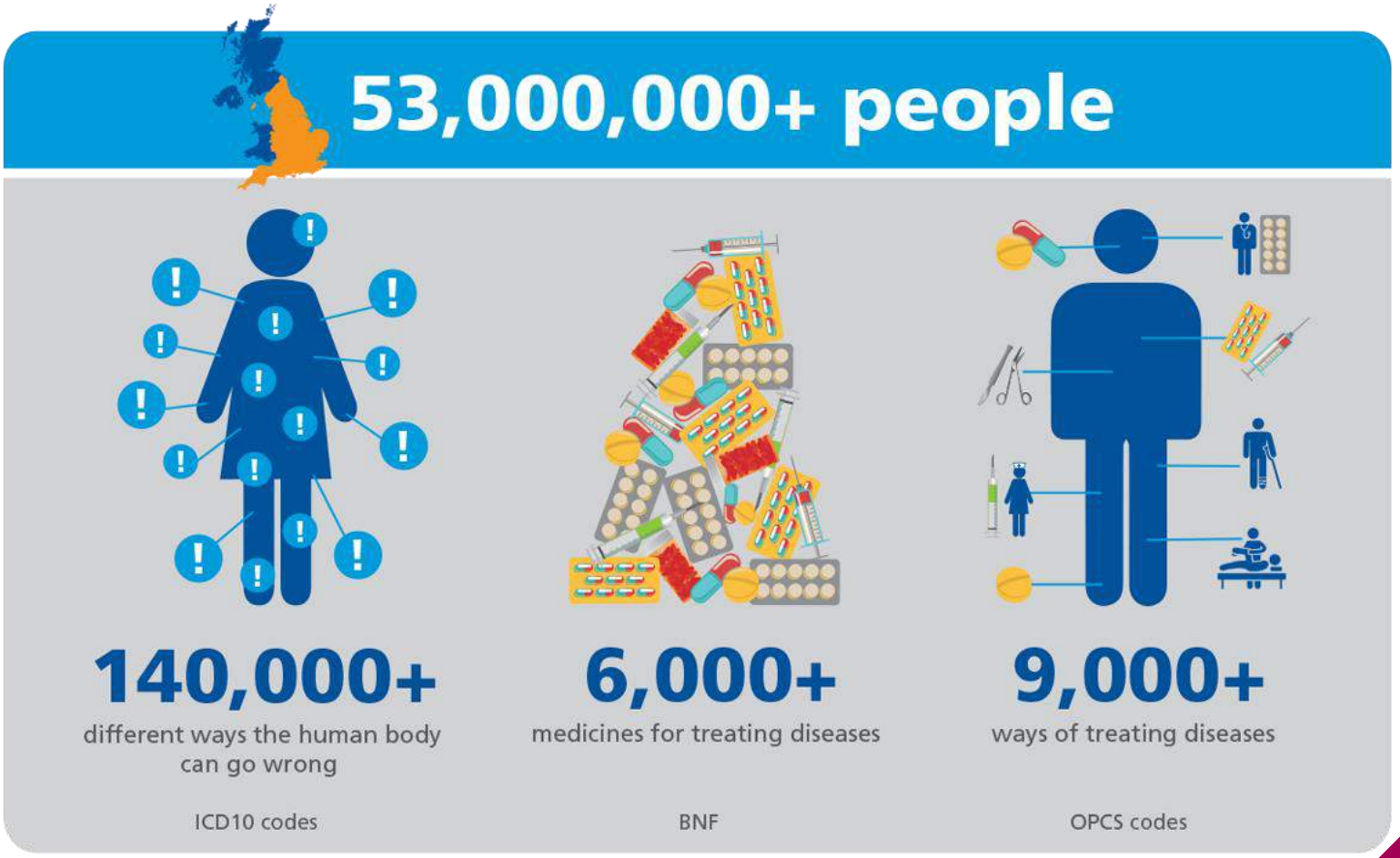
Delivering definitive and measurable improvements in patient safety

Session overview:

- Provide an overview of the role and function of the Patient Safety Collaboratives;
- What has been achieved and what is planned;
- Explore the role of evaluation in the implementation of the Collaboratives

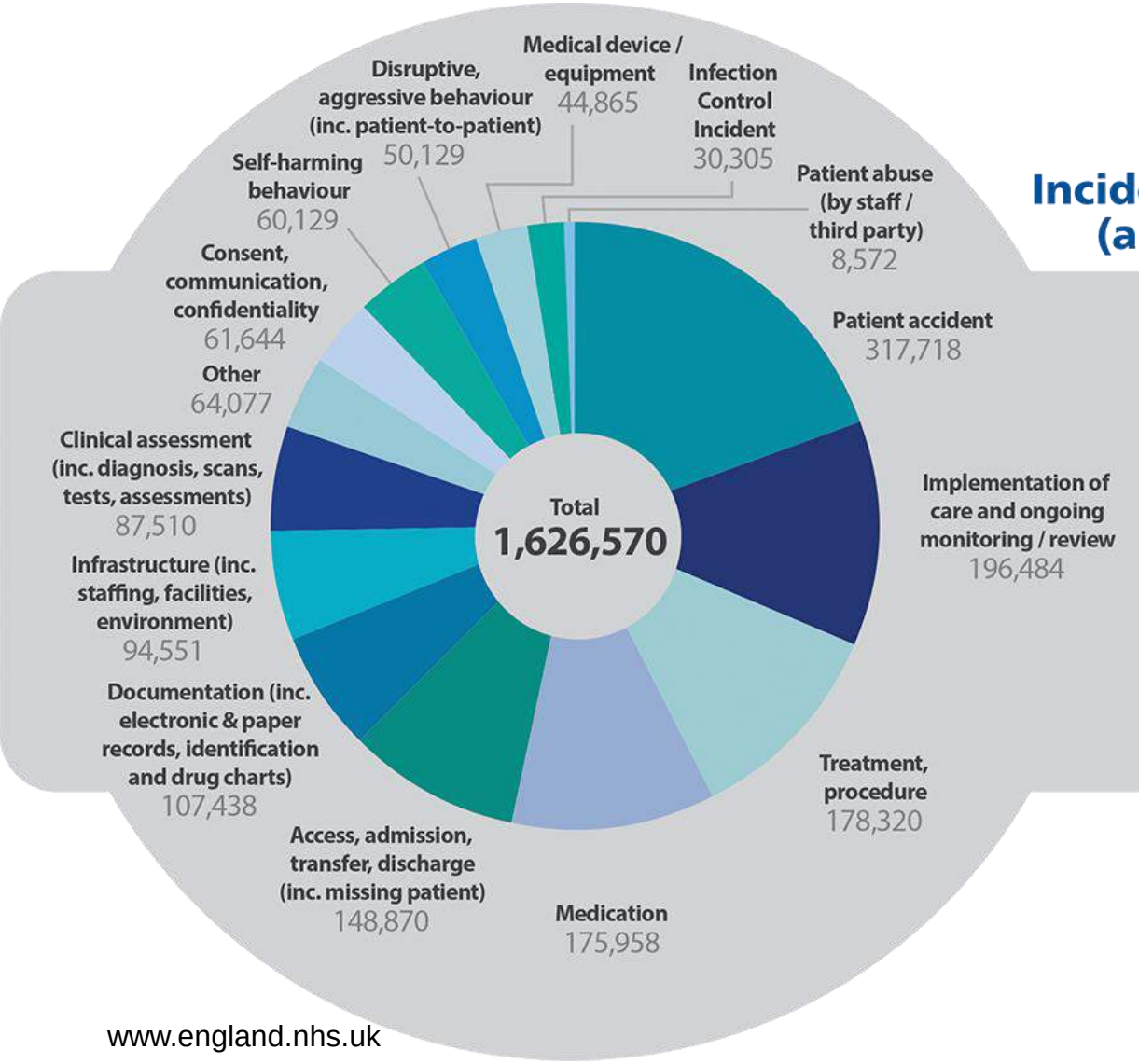
Great potential for error



and we wonder why things go wrong….

The National Reporting and Learning System (NRLS)

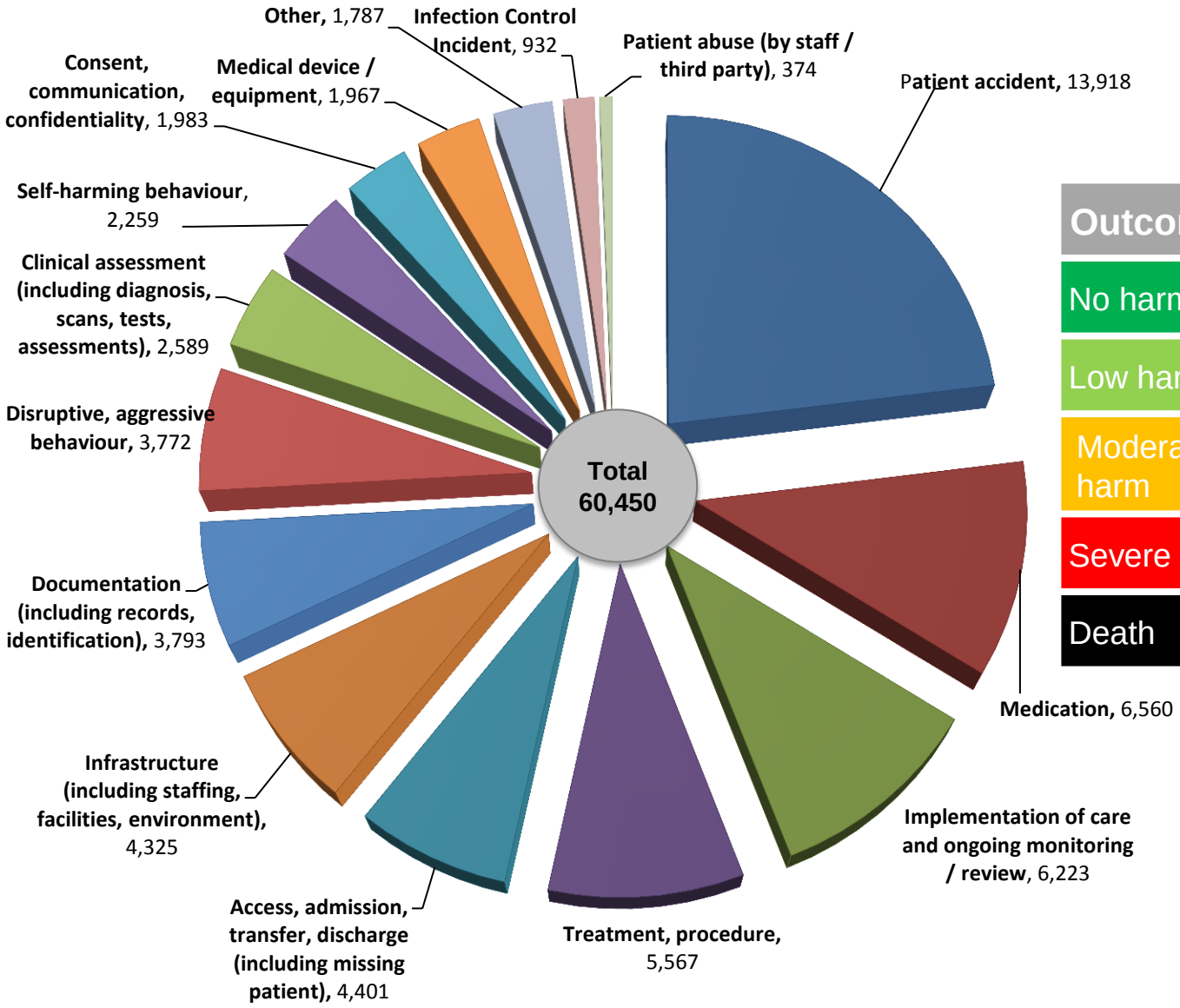
NHS England



Incidents reported to the NRLS (annual figures for 2014)

Outcome	Number	%
No harm to the patient (near misses)	1,136,751	69.9
Low harm	393,441	24.2
Moderate harm	85,329	5.2
Severe harm	7,167	0.4
Death	3,882	0.2

Incident reported to NRLS from West of England AHSN area (2013/14)



Outcome	Number	%
No harm	39523	65.4%
Low harm	17369	28.7%
Moderate harm	3059	5.1%
Severe harm	367	0.6%
Death	132	0.2%

NHS England

Medication safety in your AHSN locality

At the heart of future NHS challenges

20% of people over 70 years old take five or more medicines. With an ageing population and multiple chronic medical conditions these numbers will just keep increasing

2.5 million **doses of medicines** are administered every year in the average acute hospital

! **215,000** errors

Up to **40,000** **non-elective hospital admissions** are due to medicines

70% of these are preventable

5 classes of medicine account for most admissions

- NSAIDs
- Antiplatelets
- Anticoagulants
- Diuretics
- Antihypertensives

66 million **prescriptions** are issued every year in primary care

! **3.3 million** prescribing errors

! **26,000 – 2.2 million** dispensing errors

½ million **inpatient prescriptions** every year in the average acute hospital

! **45,000** prescribing errors with **550** potentially fatal

! **40–100** dispensing errors

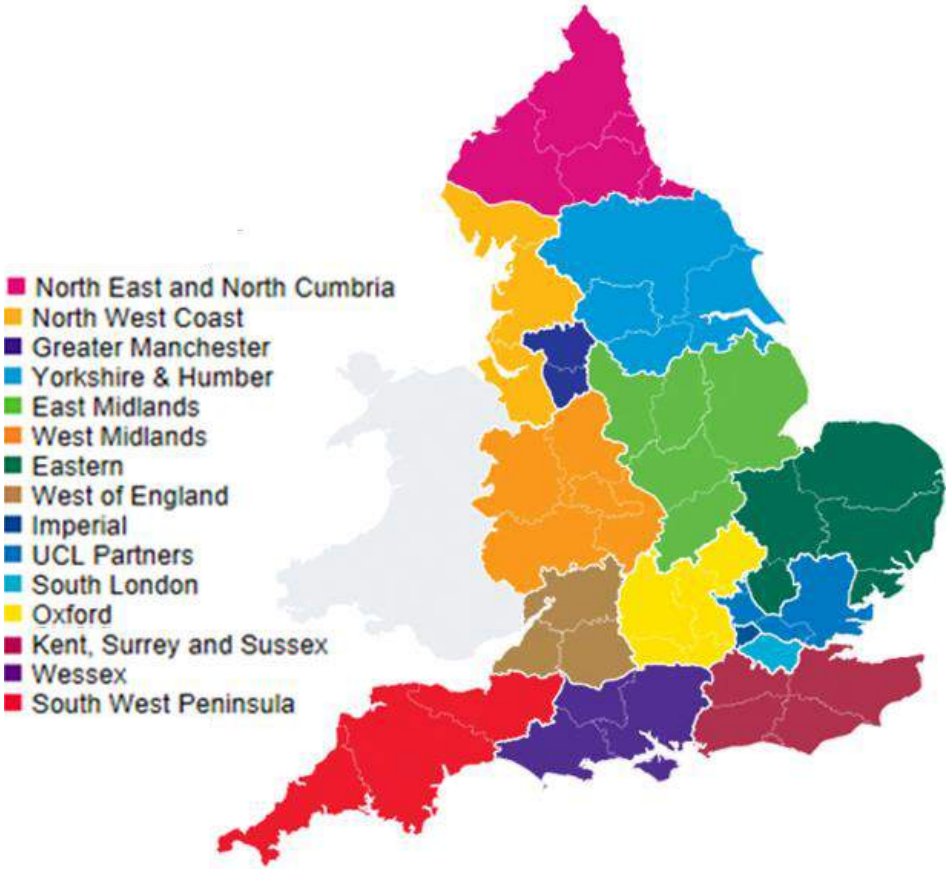
167 **preventable deaths** in your acute hospitals are due to medicines

! **6,500** patients admitted to your hospitals suffer from harm due to medicines

97% of medication errors reported to the NHS result in no or low patient harm

www.england.nhs.uk

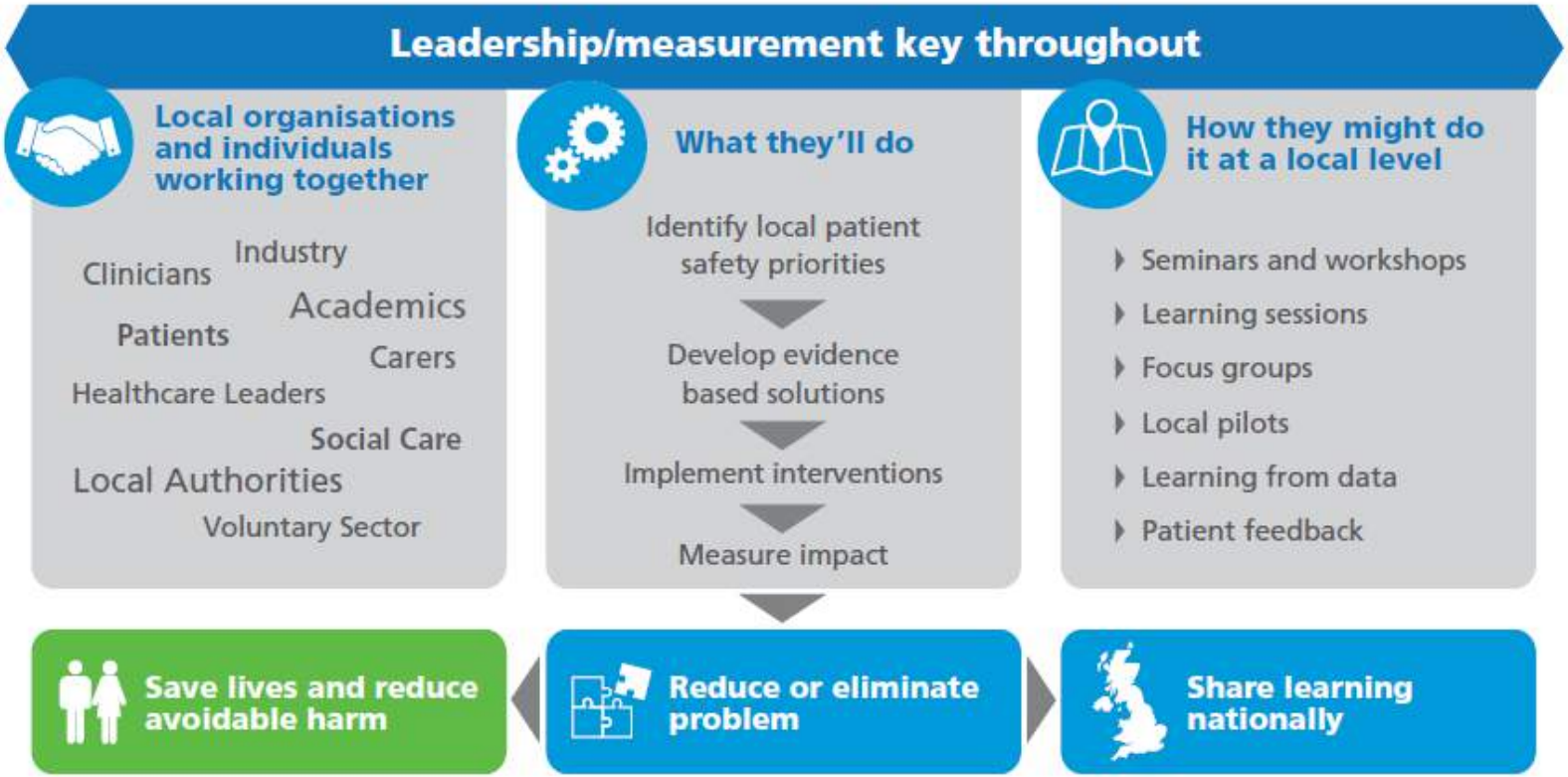
Patient Safety Collaboratives



Our big opportunity

- 15 collaboratives led with the innovation and expertise of the AHSNs
- Each covers 2-5m population
- Locally owned and run
- A unique opportunity only the NHS can bring
- Largest collaborative patient safety programme in the world
- Stronger by learning together

How a patient safety collaborative works at a local level



Local priority determination

- Core principle is the identification and improvement of local processes of care that impact on the safety of patients
- Data sources and clinical evidence suggests there are key patient safety issues which are affecting the quality of care across all NHS providers
- Each AHSN will select **3-5 priorities**
- **Measurement** and **leadership** have been selected as cross-cutting themes relevant for all local collaboratives.
- Also select from core clinical priorities for the national programme – or can chose others where appropriate

Collaborative – core clinical priorities

NHS England

Topic area	Patient Safety Topic							
The 'essentials'	Leadership					Measurement		
NHS Outcomes Framework improvement areas	Falls	Venus Thromboembolism	Healthcare Associated Infections			Pressure Ulcers		Maternity
Other major sources of death and severe harm	Nutrition and Hydration	Handover and Discharge	Missed and Delayed Diagnosis	Medical Device Error	Acute Kidney Injury	Medication Errors	Sepsis	Avoidable Deterioration of Adults and Children
Vulnerable groups for whom improving safety is a priority	People with Mental Health needs	People with Learning Disabilities	Children	Offenders		Acutely Ill Older People		Transition between paediatric and adult care

Collaborative operational model

- Each AHSN might also identify separate pieces of work specific to their local requirements, i.e. work on sepsis measurement development, or developing local leaders as guardians of learning
- Taking a whole system approach, member organisations will establish project steering groups to guide and support this work locally
- Member organisations will decide on the number of safety projects they become involved in, with an aim of widespread engagement

South London PSC - World-class, fully-engaged membership

NHS England

Third Sector
- Hospices
- NFP community providers

Primary Care
- General practice
- General dental practice
- Pharmacists

Commissioners
- Clinical Commissioning Groups
- Specialised commissioning

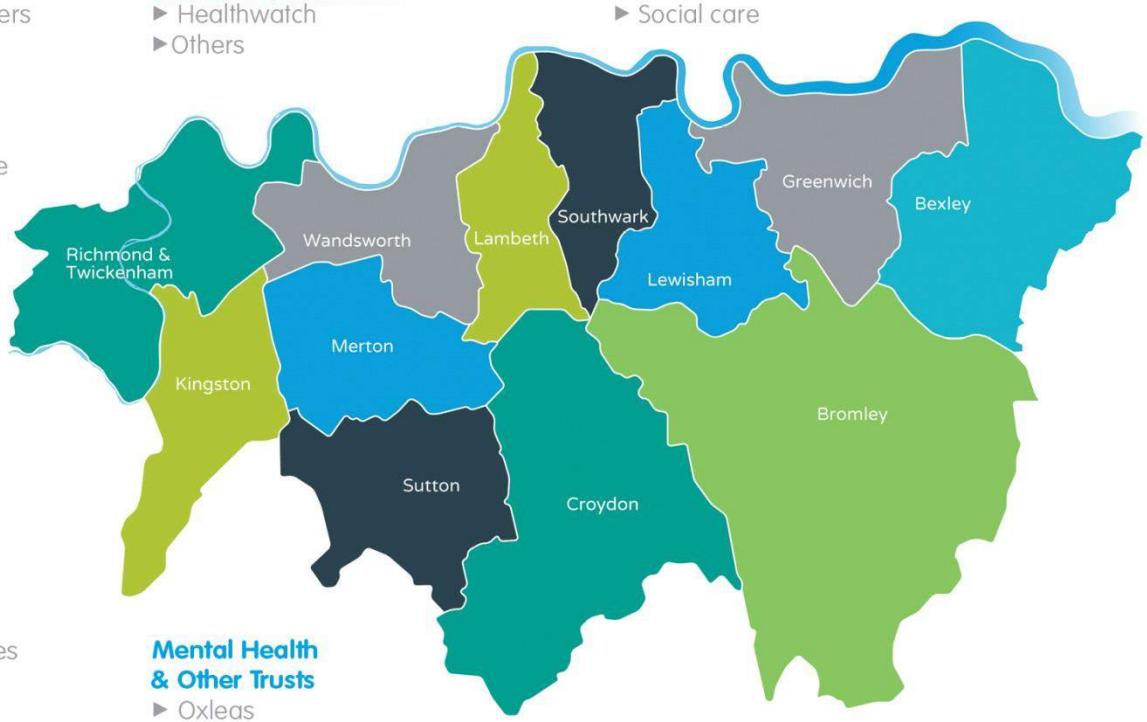
Acute Trusts in South West London
- Croydon Health Services
- Epsom & St Helier
- Kingston Hospital
- Royal Marsden Hospital
- St George's Healthcare

Other Patient & Charity Organisations
- Healthwatch
- Others

Mental Health & Other Trusts
- Oxleas
- South London and Maudsley
- South West London and St George's

Local Authorities
- Public health
- Social care

- London Ambulance Service
- London Helicopter Emergency Service



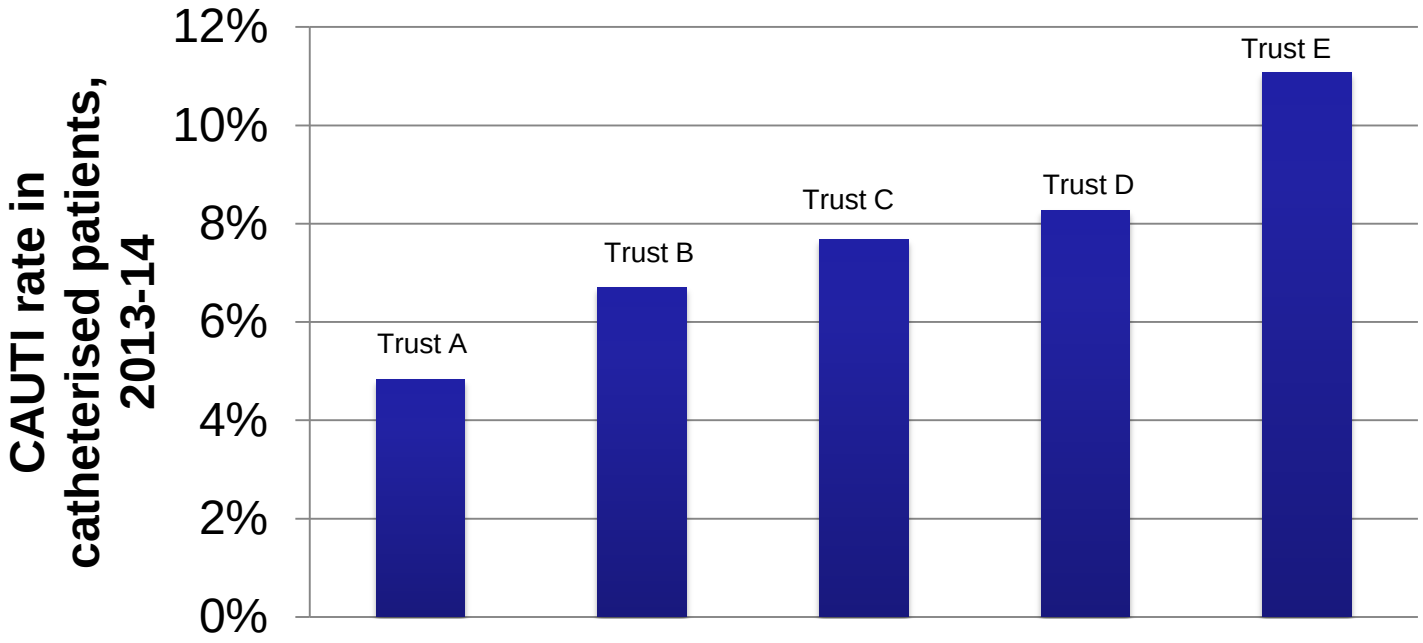
Higher Education Institutions
- Goldsmith College
- Greenwich University
- King's College London
- Kingston University
- Roehampton University
- Southbank University
- St George's University of London

Industry & Commercial Partners
- Trade Associations
- Individual companies

Acute Trusts in South East London
- Guy's and St Thomas's
- King's College Hospital
- Lewisham & Greenwich

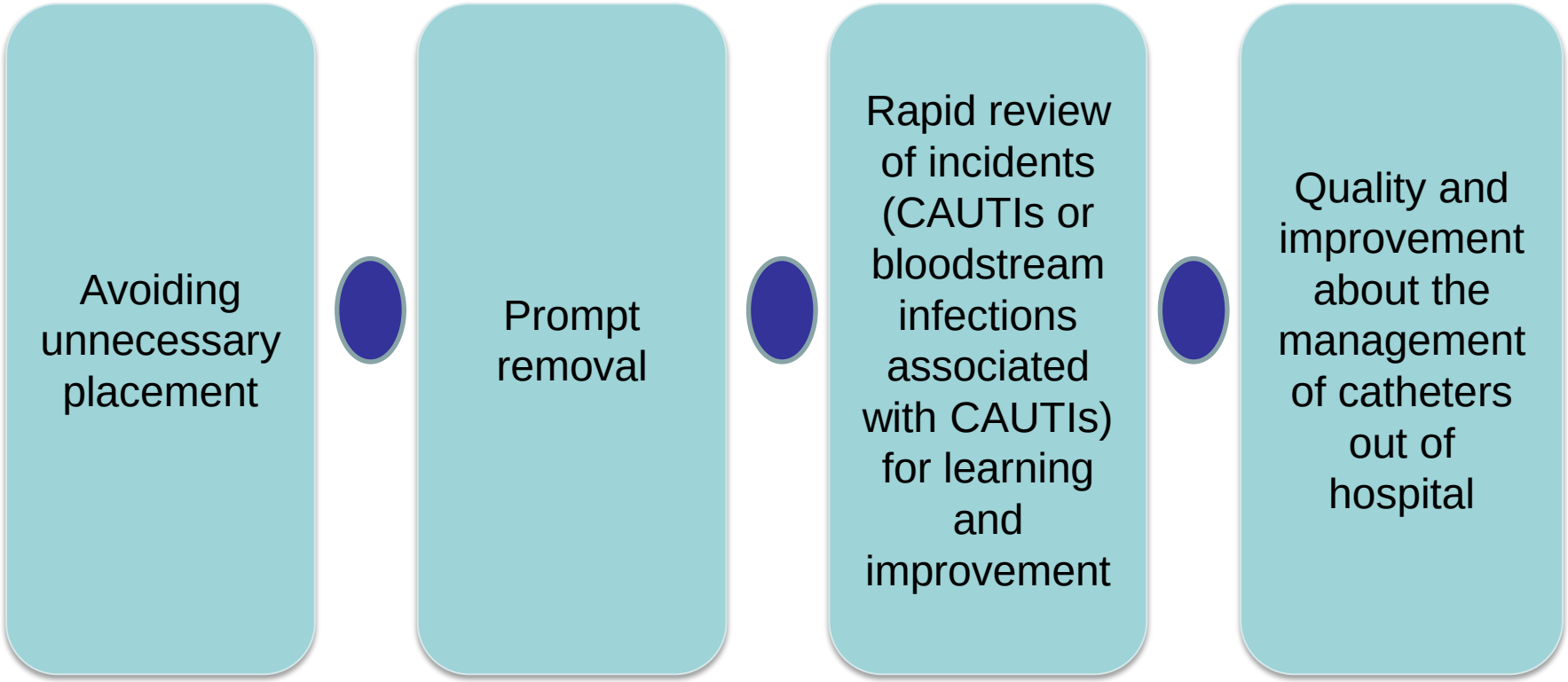
Reported UTI rates in catheterised patients range from 5% to 11%

Insight Health Economics



- The estimated annual cost of excess bed days associated with CAUTIs across the 5 'Phase I' South London trusts is £14.6m
- There are further costs arising from ICU, A&E, readmissions, social care etc.

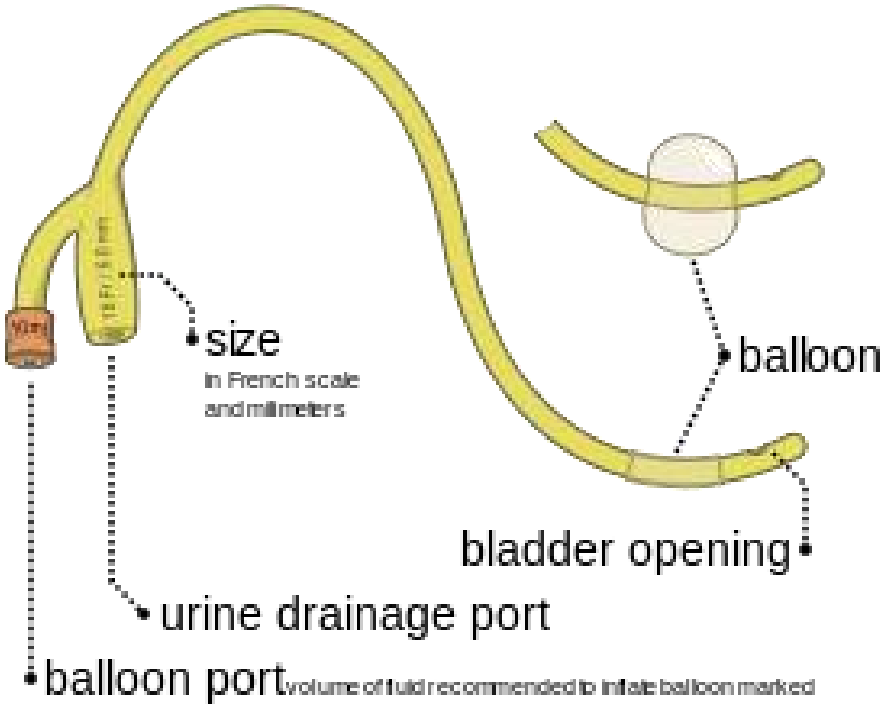
No Catheter, No CAUTI 'Care Bundle'



- HIN is working with partners across South London to deliver a Breakthrough Collaborative at scale – Phase I will be 5 Trusts, then scale up to include all providers in South London (linking with commissioners)
- Partnership with AgeUK and major continence charities to deliver patient and carer-led co-design for the programme

Innovating with Industry:
ABHI GSTT Smart Catheter Challenge

abhi **Association of British Healthcare Industries**

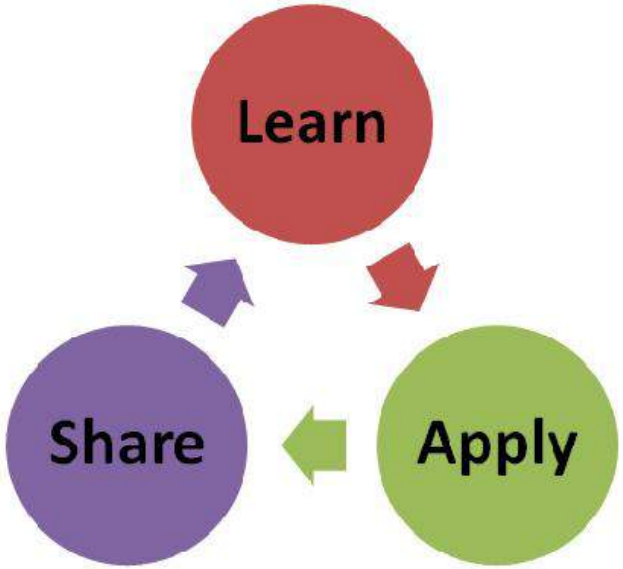


Cluster groups

- The number of cluster groups will be determined by the local priorities agreed by each AHSN
- Envisaged that separate cluster groups will be established for leadership, measurement, capability and PPI
- Cluster groups may be developed where new cross-cutting themes are identified e.g. working with care homes etc.
- NHS England measurement for improvement and building capability strategy will work with clusters to support capability requirements, and ensure relevant metrics requirements

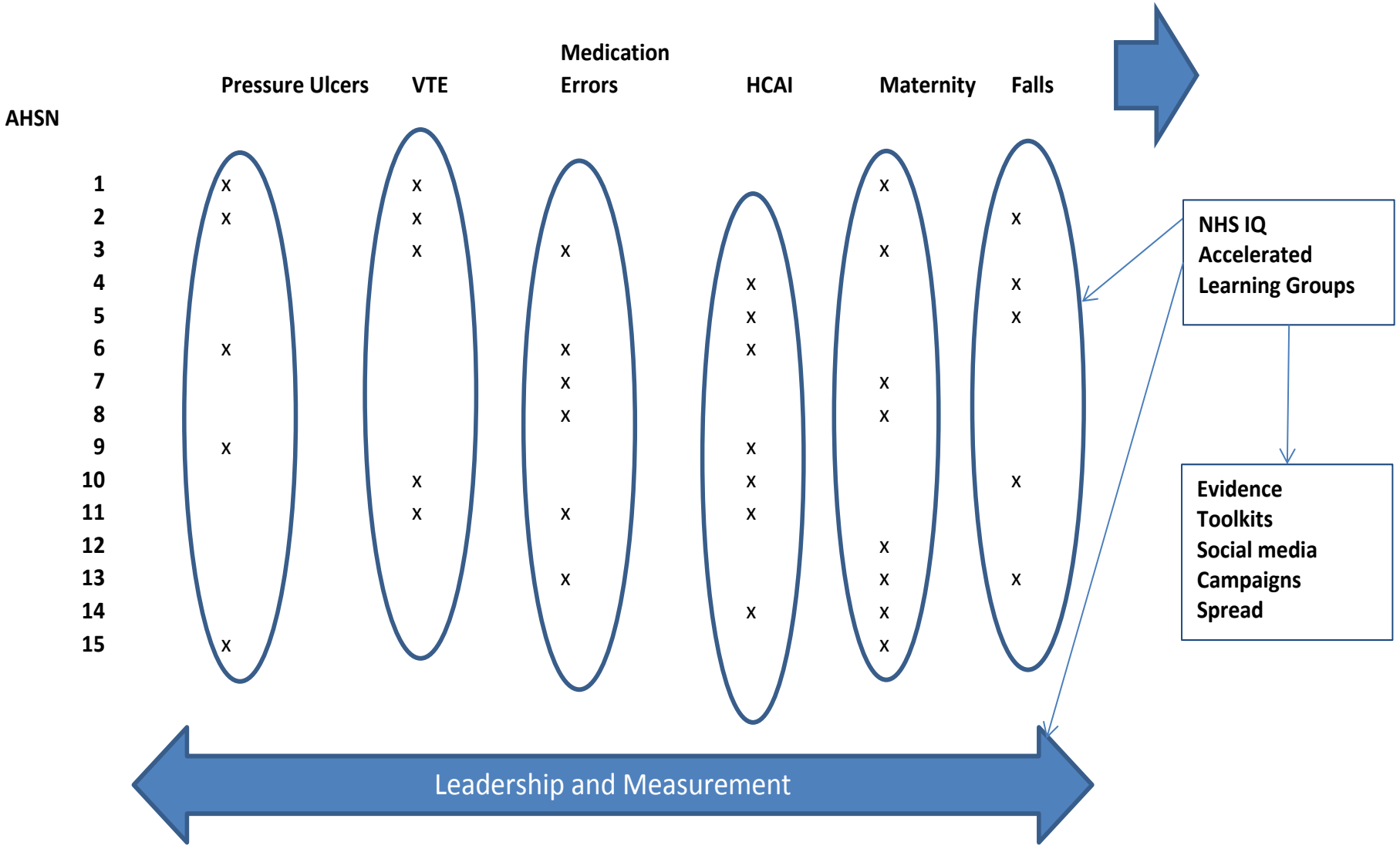
Principles of the cluster groups

- NHS England will undertake mapping exercise to understand which priorities have been agreed by each AHSN
- AHSNs working on similar priorities will be supported to form ‘cluster’ groups with a view to:
  - developing local improvement metrics
  - sharing learning
  - developing expertise
  - build on the evidence base
  - sharing the outputs of the work with the wider NHS
- Clusters will have support for quality improvement and ‘accelerated learning group’ systems, with external expertise to assist and consequent large scale change



National Patient Safety Collaborative Programme – Operational model

NHS England



Primary framework of cluster groups

Each cluster group should ideally provide:

- Stakeholder input
- Shared and accelerated learning
- Peer support
- Innovation and creativity
- A forum to access expertise

Members may include:

- AHSN core staff
- Central team and NHS England
- Clinicians including nurses, AHPs, GP's etc.
- Individuals from organisations undertaking topic specific improvement work
- External QI and safety experts
- Charities and patient representatives
- Social care

Common objectives may include:

- Understand the scope and challenges within a specific topic
- Balance strategy with practical implementation
- Maximise collective intelligence and problem solving
- Identify key learning and principles as improvement work progresses
- Explore the impact of good measurement and leadership as cross-cutting themes
- 'Drive' the improvement work
- Build on the evidence base or test new ways of working
- Create opportunities for the alignment of work across other organisations i.e. SCNs etc.

‘First wave’ of cluster groups

The ‘first wave’ of cluster group development will focus on the five most common priorities identified across all collaboratives:

- **Medicines optimisation**
- **Pressure ulcers**
- **Acute Kidney Injury**
- **Deteriorating patient (including sepsis)**
- **Mental health**

Subsequent ‘waves’ will establish additional groups in due course.

Patient Safety Collaborative Clusters

NHS England

Leadership and Culture | Measurement and Evaluation | Capability Building | Patient and Public Voice

Cluster Groups

Medications	Acute Kidney Injury	Pressure Ulcers	Mental Health	Deterioration and Sepsis
• Greater Manchester	• North East	• Yorkshire and Humber	• West of England	• East Midlands
• North East North Cumbria	• North Cumbria	• East Midlands	• South West Peninsula	• North West Coast
• Yorkshire and Humber	• Yorkshire and Humber	• West Midlands	• Kent Surrey and Sussex	• West Midlands
• Eastern	• North West Coast (Hydration)	• Eastern	• Wessex	• North East North Cumbria
• West Midlands	• Kent Surrey Sussex	• HIN South London	• Oxford	• HIN South London
• HIN South London	• Oxford	• Kent Surrey Sussex	• Yorkshire and Humber	• UCL Partners
• Kent Surrey Sussex	• UCL Partners	• Oxford	• East Midlands	• West of England
• Oxford	• West of England			• Wessex
	• South West Peninsula			• South West Peninsula

Primary and Secondary Care | Social Care and Voluntary Sector | Community and Mental Health

Measurement

- Central support will be made available to local improvement teams as a means to assist with project management, data capture and analysis,
- Access to a range of improvement tools, and improvement story and case study sharing
- Central host for a national measure collection platform that teams will be able to readily access
- Local and national approaches to commence programme evaluation

The Development of Human Factors Capability in the East Midlands –

Health Education East Midlands

Developing Priorities-Task and Action Groups

Human Factors Exchange (HFE) *(Sept 2014, 2-monthly meetings)*

- **5-7 year timeline for** combination of:
  - focussed education
  - workforce development projects

Proposal 1 –HFE knowledge hub

Proposal 2 –HFE Roadshows for Senior NHS staff

Proposal 3 – Explore support for existing Fellows/Educators through a CPD offer

Proposal 4 – Identify a focussed project for HFE in healthcare and implement solutions

Proposal 5 – Formal collaboration with the East Midlands Patient Safety Collaborative, AHSN and other Patient Safety and Quality Improvement initiatives

Proposal 6 – Set up an Educational/Fellowship Programme for HFE for long term educational improvement and creation of an internal pool of HFE Experts

Forming Priorities

Proposal 1: Creation of a Knowledge Hub on HEEM/HEE/TEL website

Proposal 2-3-6: Education & training pathway 'Awareness-to-Expert'

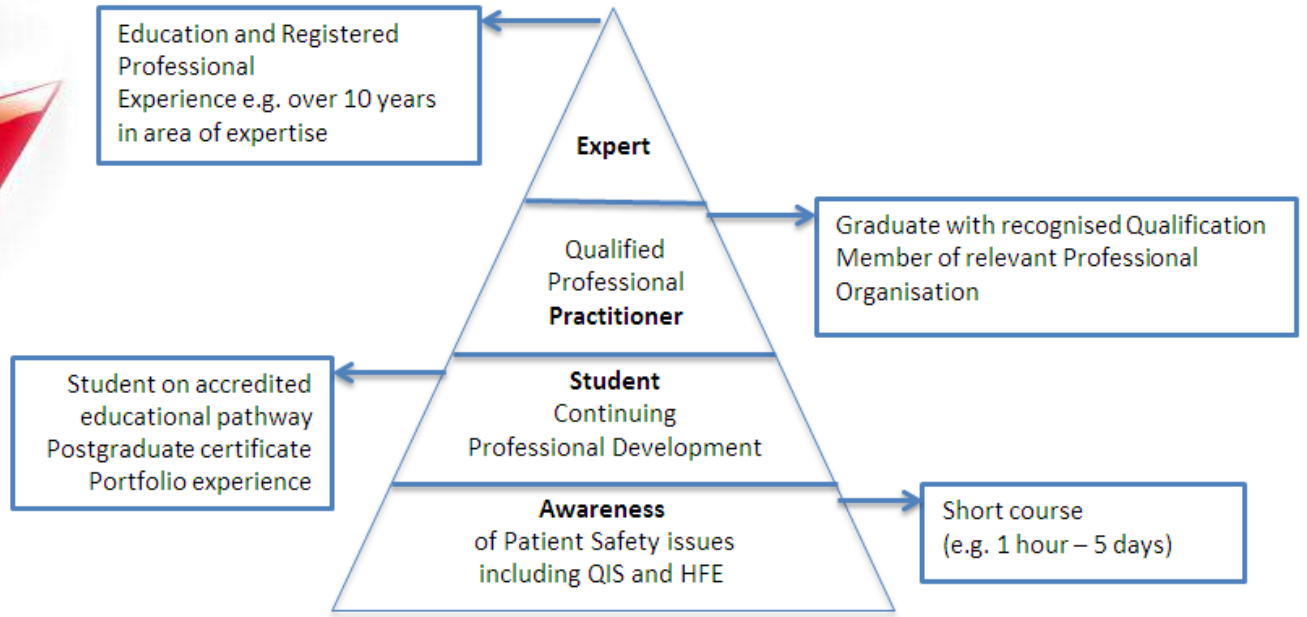
Proposal 4: HF solutions to support PS

- »Root Cause Analysis (RCA)
- »Bespoke HF educational solutions for Patient Safety eg medication errors

Underpinned by The Learning to be Safer Programme, formal collaboration with the East Midlands Patient Safety Collaborative, AHSN and other Patient Safety and Quality Improvement initiatives

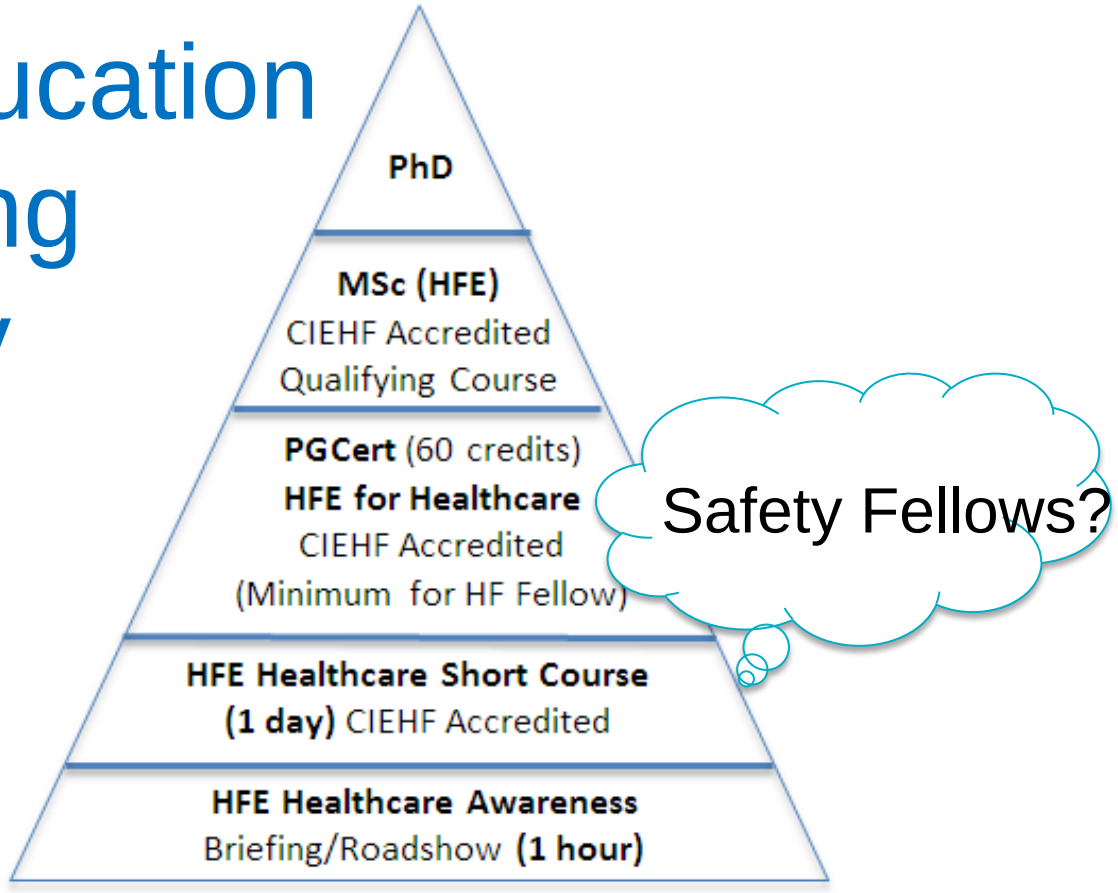
Awareness-to-Expert pathway (previously proposal 2,3 and 6)

Health Education East Midlands



Health Education East Midlands

Proposed HFE Education & Training Pathway



A connected community working together
to improve health care quality across the UK

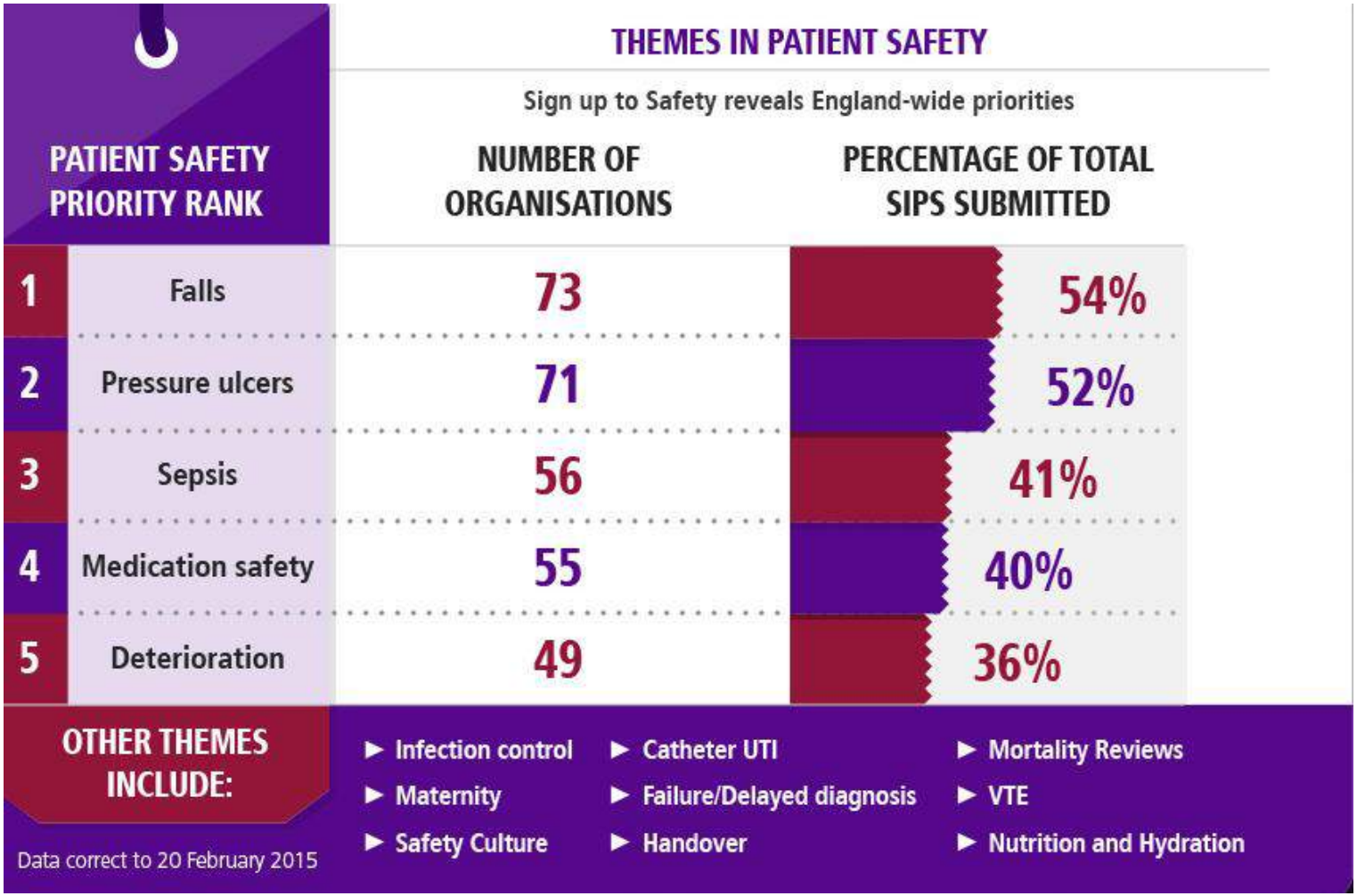
- The Health Foundation and NHS England have developed an ambitious initiative that will connect and support people with expertise in safety and wider quality improvement working in health care across the UK.
- The initiative will recruit people from across the UK with advanced improvement expertise.
- We are working with organisations at the forefront of safety and wider quality improvement to develop and run the initiative.
- Began recruiting participants in March 2015.
- Aim is to recruit 5,000 participants over five years.

Our vision: For the NHS in England to be the safest healthcare system in the world

Our mission: To help everyone in the NHS in England to create the conditions that supports a safer NHS

Our shared goal: The collective programme of work is designed to tackle and reduce avoidable harm and improve safety, supporting the ambition to save up to 6000 lives by 2017

Identified priorities through Sign up to Safety



The Seven *Spreadly* Sins

(If you do these things, Spread efforts will fail!)

Step #1 Start with large pilots

Step #2 Find one person willing to do it all

Step #3 Expect vigilance and hard work to solve the problem

Step #4 If a pilot works then spread the pilot unchanged

Step #5 Require the person and team who drove the pilot to be responsible for system-wide spread

Step #6 Look at process and outcome measures on a quarterly basis

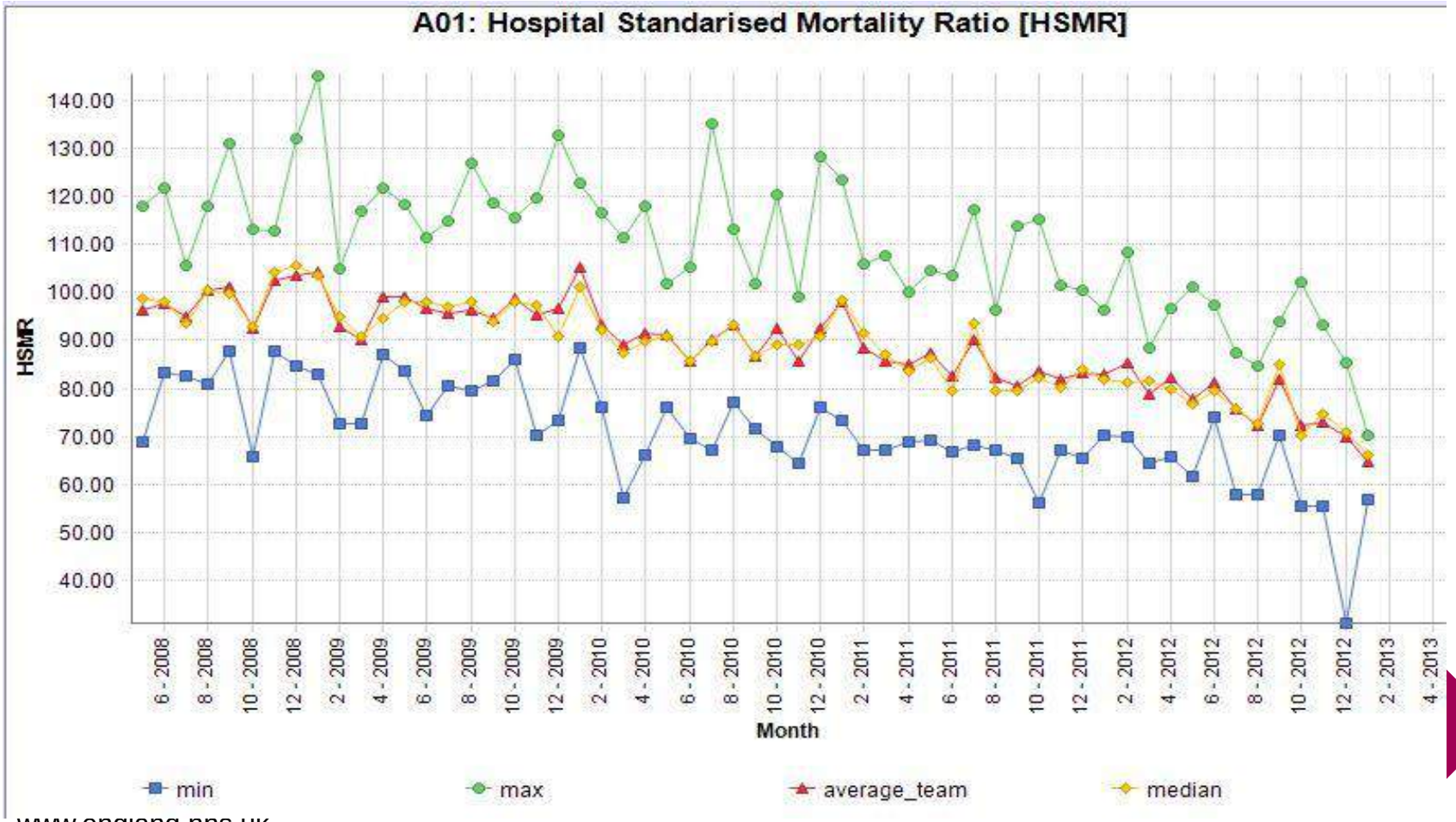
Step #7 Early on expect marked improvement in outcomes without attention to process reliability

Measurement and evaluation

- Striking the right balance
- Consistent measures and local freedoms?
- Improvement over time and peer comparison?
- Structure, Culture, Process and Outcome measures?
- Organisation level or PSC level?

South West All 16 Acute Trusts HSMR over the Collaborative 2009- 2013

(data not rebased each year)



“Systems awareness and systems design are important for health professionals, but they are not enough. They are enabling mechanisms only. It is the ethical dimensions of individuals that are essential to a system’s success. Ultimately, the secret of quality is love.”

Professor Avedis Donabedian