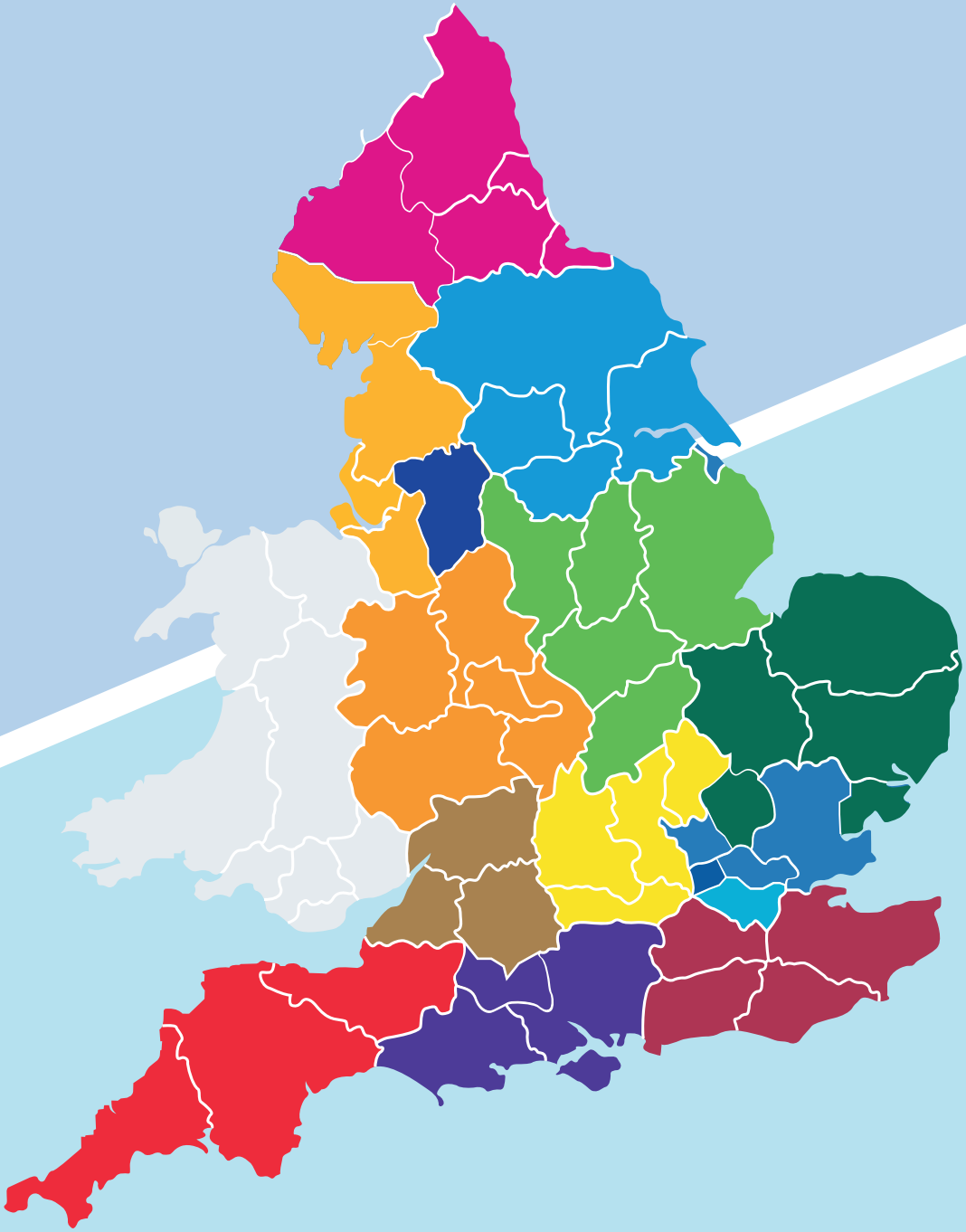
NHS
Improving Quality

Patient Safety Collaboratives

PLAN ON A PAGE

In partnership with
TheAHSNNetwork

AHSN Networks



Introduction

NHS Improving Quality and NHS England are working nationally with the Academic Health Science Networks to provide support and opportunities for the Collaboratives to learn from each other, ensuring the most effective and successful solutions are rapidly spread and adopted across England.

For the next five years, each Collaborative will support individuals, teams and organisations to build skills and knowledge about patient safety and quality improvement to create space and time to work on the challenges, and provide opportunities to learn from each other.

The programme is borne out of Professor Don Berwick's report last year into the safety of patients in England and builds on learning from the Francis and Winterbourne View recommendations. The report, *A Promise to Learn – a commitment to act*, made a series of recommendations to improve patient safety; and called for the NHS "to become, more than ever before, a system devoted to continual learning and improvement of patient care, top to bottom and end to end."

Aligned with and supporting the 'Sign up to Safety' campaign, the programme aims to make the NHS the safest healthcare system in the world by creating the culture to support a system devoted to continuous learning and improvement.

This resource summarises the Patient Safety Collaboratives current priority plans. Some of these plans are in consultation with partner organisations and may be subject to change.

For more information please visit our website at: www.nhsiq.nhs.uk/improvement-programmes/patient-safety.aspx

Patient Safety:
A National and Local Priority

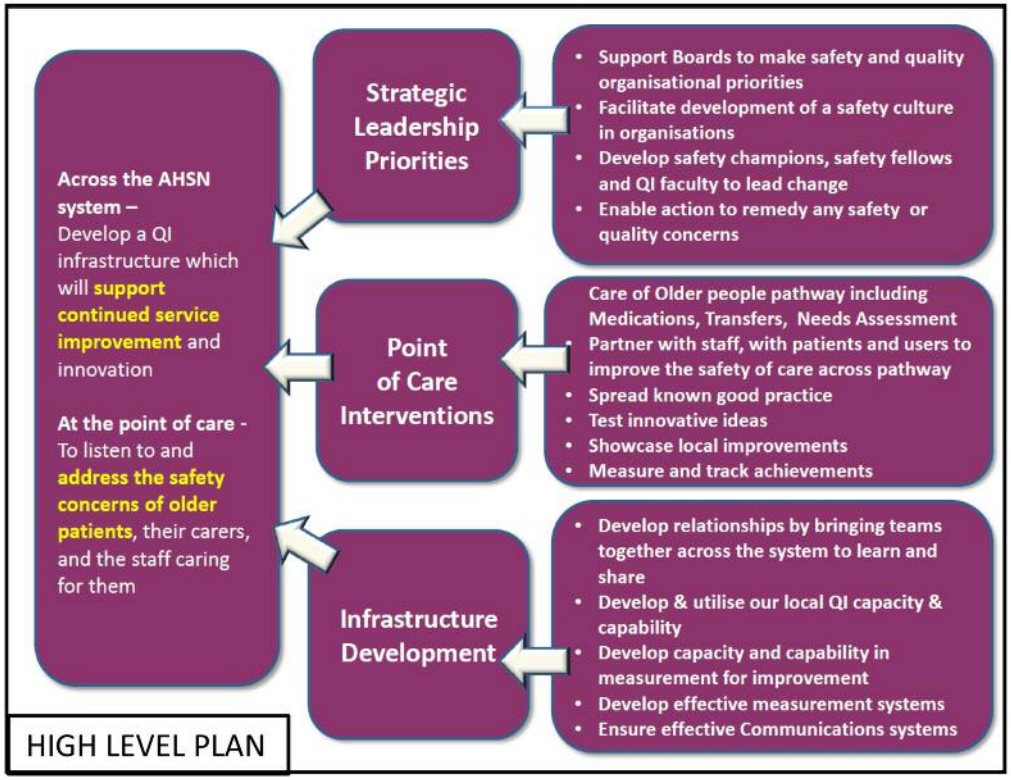
EAHSN
The Eastern Academic Health Science Network

Our Patient Safety Collaborative aims:
Across the AHSN system: To develop a QI infrastructure which will support continued service improvement and innovation
At the point of care: To listen to and address the safety concerns of older patients, their carers, and the staff caring for them

Design Principles. We will seek to make our collaborative practical and helpful by:
Building on the strength of our existing patient safety work;
Working in partnership with staff, carers and users to design the work programme;
Working in partnership with other organisations and networks involved in safety;
Avoiding duplication for the service;
Aligning interventions across care settings, reducing the number of unique or sector specific interventions;
Advocating organisational, managerial and clinical leadership for safety and quality;
Developing the capacity and capability of the system to use data and to drive improvements in quality and safety;
Working across the continuum of improvement, testing innovative ideas, spreading good practice and encouraging reliable implementation;
Ensuring evaluation is integral to the design and delivery.

Our Partners
EAHSN Patient Safety Clinical Study Group
East of England Citizens Senate
NHSIQ
AQuA /NHS Leadership Academy/CLAHRC
EAHSN Academia

Delivery method
Adapted BTS collaborative model with twice yearly whole system learning events



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Susan Went EAHSN PSC lead - susan.went@eahsn.org

EMAHSN has **consulted and engaged** with our partners to **develop consensus** on key patient safety priorities [see below]. **We will:** build alliances to **optimise and share existing best practice** support and enable organisations to **accelerate the pace and scale of improvement activities.**

East Midlands Academic Health Science Network
Igniting Innovation

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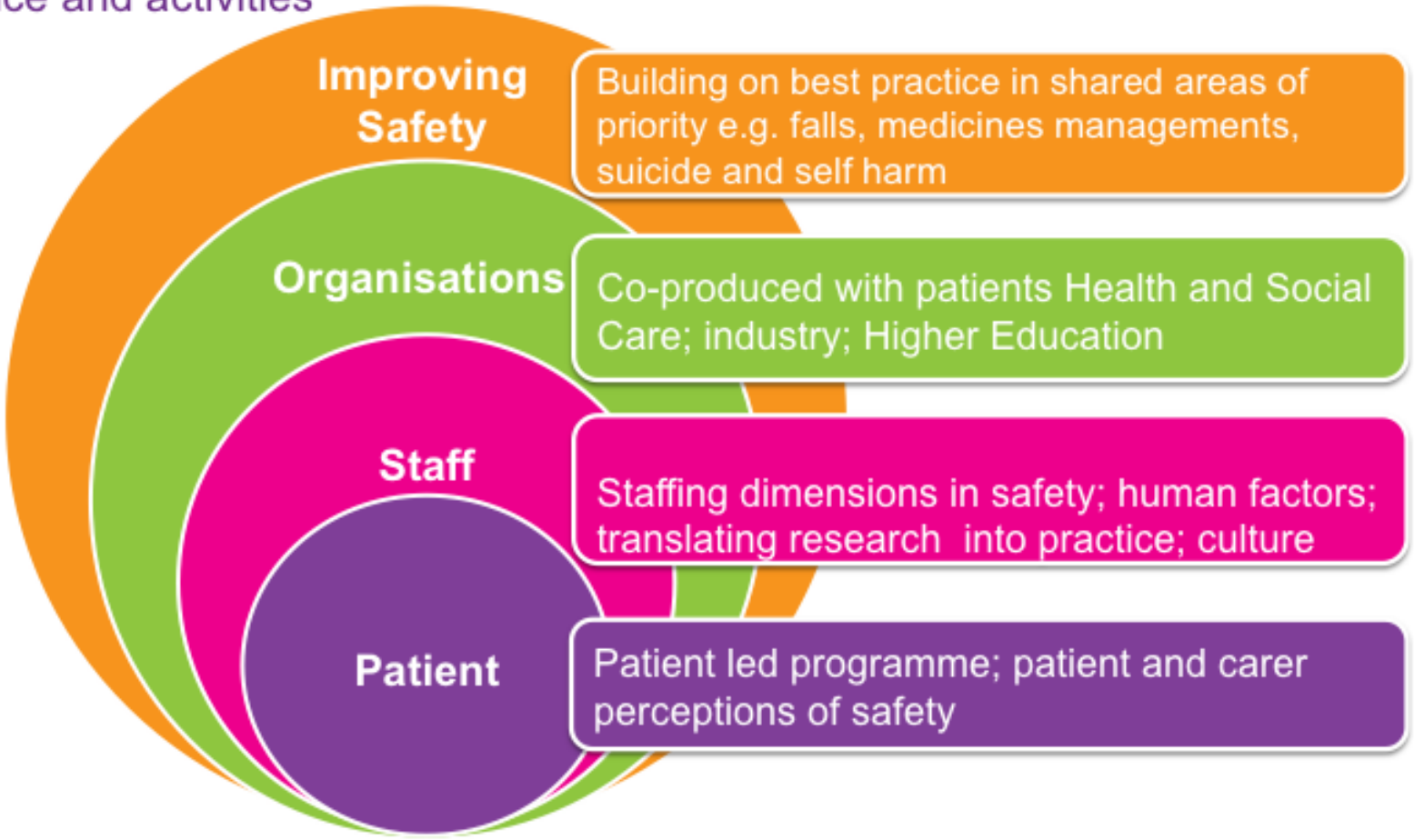
EMAHSN Patient Safety Collaborative

East Midlands Academic Health Science Network
Igniting Innovation

Potentiating: existing initiatives, making the most of what is happening already
Supporting: staff and patients to articulate their views
Connecting: our partners in order to spread their best practice evidence and activities



GREATER MANCHESTER ACADEMIC HEALTH SCIENCE NETWORK

GM AHSN Patient Safety Collaborative – Plan on a Page

		Oct-Dec '14	Jan-March '15	Apr-Jun '15	July-Sept '15	Oct-Dec '15	Jan-Mar '16
Patient-owned care	Identify what makes a patient feel safe when taking medicines		Qualitative exploration with patient groups	Utilise output to inform work streams e.g. what does good patient information look like, supporting mechanisms for on-going			
	Patient access to their data		Link to connected healthcare monitoring below				
	Point of care testing	Increase the uptake of point of care testing for anticoagulant monitoring – 3 CCGs participating					
	Patient decision aids	Work with designer of NICE CG Patient Decision Aid to support evaluation and understanding of GP educational needs in using this tool					
	Supported self-care & self-management	From identified sites / CCGs support the uptake in self-monitoring and self-management – 3 CCGs participating					
Solving problems	Understand baseline data	Utilising existing database sources to understand patient safety in terms of medicines utilization, linked to the harms in PSC safety topics					
	Governance	GM AHSN will co-ordinate programme, source and analyze information and measurement from across the local health economy and provide feedback					
	Build leadership & workforce capabilities in safety	AQUA programme inc advanced team training (12 teams of 6), PS champions training (40 people), improvement practitioner modules 240 places) and Sign up to Safety Network launch and 6 month engagement for all AHSN members (up to 160 attendees) Health Foundation 'Closing the Gap' programme for Board Level Collaborative on safety (10 localities), commencing in Feb 15					
	Connected healthcare monitoring		Utilise capabilities of existing systems that allow patients access to their records eg. Renal Pt View, and adapt, adopt and spread				
	Real-time monitoring & measurement	Increase uptake of FARSITE in GP practices across AHSN footprint from 25% to 60% by March '15		Increase uptake of FARSITE in GP practices across AHSN footprint from 25% to 60% by March '15			
	Social networking & media	Working with FT to design and run a Hackathon for young adults with Diabetes					
New mechanisms for care	Evidence the interventions which improve adherence		Work with colleagues in Primary Care Patient Safety Translation Research Centre to align current evidence, further advance research studies and spread of PINCER studies.				
	Drug safety monitoring in real world			Identify and work with 2 sites for utilisation of GP practice level safety dashboards designed by Primary Care Patient Safety Translation Research Centre, refine prior to spread of tool.			
	Early adoption of evidence, research & technology	Launch & deploy Innovation Nexus (IN)- review and support of SME developments	Ongoing IN delivery with evaluation of impact and return on investment. In partnership with NICE design an audit tool for the uptake of NICE guidelines for Medicines Management in Nursing homes				
	Identify unmet health care needs and support development	Technology Innovation Fund – Nutrition and Hydration £80k	Technology Innovation Fund – Medicines Optimisation £80£				
Scope	**All members across GM e.g. Community hospitals, nursing homes, district nursing teams, acute hospitals, mental healthcare, commissioning**						

GREATER MANCHESTER ACADEMIC HEALTH SCIENCE NETWORK

Greater Manchester AHSN Patient Safety Collaborative

'a whole system collaborative approach to medicines optimisation will achieve the very best it can for the community it serves.

....where medication is needed it will be used to its maximum benefit, with responsible stewardship, placing patient safety as the tenant of its use, to the extent that associated harms are exceptions not an accepted consequence'.

Health Innovation Network Patient Safety Collaborative - Patient Safety from Board to Bus Stop

The Health Innovation Network (HIN) is embarking on a five-year programme to support NHS organisations in South London in achieving their patient safety aims, from Board to Bus Stop. The HIN Patient Safety Collaborative (PSC) will be built with over time with patients and carers, frontline staff, Board leaders and other stakeholders, working together across the whole healthcare system - from hospitals to patients own homes - to co-design interventions and initiatives to reduce avoidable harm, save lives and embed a patient safety culture.

Our embedded aims are to support South London health and social care organisations to:

- Develop strong leadership and to set an early collective tone and approach for improvement
- Ensure that patients and carers are at the heart of our programmes, actively involved in both design and delivery of projects
- Identify evidence-based and reliable practice (locally, nationally and internationally), and to scale up and spread this in a sustainable way
- Embed a safety culture and help spark social movements for safer care through broad staff involvement
- Develop improvement capability within organisations and leaders
- Help staff analyse, monitor and learn from safety and quality information
- Be a national exemplar of practice, and to create strategic partnerships with other exemplars
- Develop interventions and initiatives which can be applied or adapted to all care settings.

We are working with our stakeholders to understand which patient safety issues should be prioritised, and how a collaborative approach might be able to add value to what organisations are already doing to meet national requirements. The programme will also be closely linked with national and local initiatives, including 'Sign up to Safety', Quality Accounts, Safety Thermometer, NHS Change Day, and King's Health Partners Safety Connections programme.

Priorities identified for potential early action identified include: pressure ulcers, falls, catheter-associated urinary tract infection (CAUTI), deteriorating patient, and medications safety (insulin management). In year one, plans are under way to scale up the following interventions:

- Right Insulin, Right Time, Right Dose – a breakthrough collaborative focused on reducing harm to diabetic patients through better insulin management.
- No Catheter, No CAUTI – a collaborative to reduce harm from CAUTIs by improving appropriate urinary catheter management in patients in hospital and following discharge.
- A range of interprofessional interventions are being explored, including a potential interdisciplinary 'rounding' offer and development of communities of practice.

All interventions will be underpinned by a strong measurement function supporting front line staff, and focused work with local education commissioners to scope educational needs in priority areas and to ensure that these needs can be met. A faculty of experts will act as critical friends for the PSC, advising on proposals, evaluating impact, and acting as coaches, facilitators and mentors for PSC projects and for HIN member patient safety initiatives. Over time, we will evaluate impact, and embed programmes, ensuring sustainability in the long-term. We will also deliver stretch targets (expanding work to cover additional priority areas), develop commercial partnerships, and explore innovative technologies that support patient safety.

Patient Safety Programme

IMPERIAL COLLEGE HEALTH PARTNERS

VISION

Our vision is to support organisations to embed safety in every aspect of their work. This means:

- Patient and carer views are obtained and heard at all levels as a critical indicator of safety
- There is a strong ethic of team working and shared responsibility for patient safety
- Effective safety measurement and monitoring systems are in place in all clinical settings
- Clinical processes, practices, equipment and environment are standardised and simplified

PROJECTS	DESCRIPTION OF ACTIVITY
Patient Safety Champion Network	• North West London (NWL) wide network of service users and citizens, supporting and promoting their involvement in the design and delivery of the Partnership's patient safety work programme. • Acts as a catalyst for broader citizen and service user engagement in NWL.
Foundations of Safety Best Practice Forum	• NWL wide series of expert forums for nominated Board executives, non-executives, senior leaders, commissioners and patient representatives. • Participants will be able to foster shared best practice and innovation to deliver organisational and cultural change.
Safety measurement and monitoring	• Collaboration with NHS trusts to test and further develop – through application in practice – a holistic framework for measuring and monitoring safety, developed by the Centre for Patient Safety and Service Quality (CPSSQ) at Imperial College London.
Prioritisation of research	• Research to identify clinician and patient views on the key priorities for patient safety in primary care, mental health and cancer care. • Provides crucial intelligence to support future initiatives within these domains.
Prescribing improvement model	• Pilot improving pharmacists' provision of feedback to doctors on their prescribing errors, which aims to support better communication between pharmacists and doctors.
Standardising junior doctor inductions	• Programme to standardise induction for junior doctors, and to create a single communication channel for key safety messages to be delivered to this group.
Avoidable mortality research	• Project to create a reliable review mechanism for the assessment of all deaths associated with hospital care, in order to assess what proportion were avoidable and the factors that should be rectified.

MEASURING IMPACT

Our programme will deliver:

- Increased service user and citizen involvement and participation in patient safety improvement initiatives across NWL
- Improved understanding of patient safety issues and protocols amongst senior staff
- Improved spread of innovation and good practice among partner organisations
- A combined and robust approach to junior doctors' induction across NWL
- A secure single platform for communication amongst junior doctors
- Increased prescriber identification and reduction in prescribing errors
- Increased awareness of key safety drivers to reduce variation

Contact us

For more information contact our Patient Safety team on:

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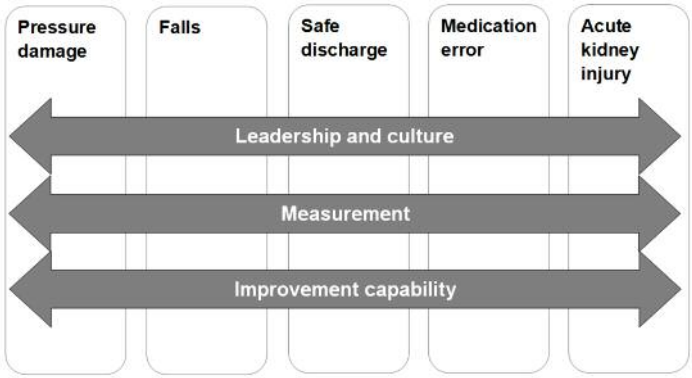
Kent Surrey Sussex Patient Safety Collaborative

Proposed priorities



Mission

To improve quality of care for patients in all care settings and conditions, through a clearer understanding of the risk of harm, effective use of measurement, collaborative learning and effective systems of leadership, resulting in improved patient safety

Starting position 2014/15

Objective 1

Establish an effective fully functioning KSS PSC

Delivered through:

- KSS PSC core team in place by October 2014
- Clinical topic workstreams of the KSS PSC identified and agreed following consultation across KSS by October 2014
- Workstream leads and team members in place by December 2014
- Baseline data collated and 'atlas of variation' produced, measurement and scope of all workstream defined by February 2015
- Workplans for workstream set out for 2015-17
- Work plan implementation underway by March 2015.

KSS PSC is hosted by Kent Surrey Sussex Academic Health Science Network

Objective 2

Collaborative engagement and participation in the PSC across health and social care in KSS and involving patients and carers

Delivered in 2014/15 through:

- Safety and quality leads of all health and social care organisations identified by November 2014
- Contacts database represents all partner agencies in health and social care across KSS by January 2015
- Full patient participation in design and implementation of KSS PSC (by September 2014)
- Patient/carer representation on core operational team and in all workstreams from April 2014 onwards
- Three county whole systems engagement events by March 2015
- KSS leadership and capability co-ordination group in place by February 2015.

ACADEMIC HEALTH SCIENCE NETWORK
NORTH EAST AND NORTH CUMBRIA
PATIENT SAFETY COLLABORATIVE

NENC Patient Safety Collaborative plan-on-a-page 2014/15

Objective 1: Leadership and accountability

To ensure that there is leadership and accountability for safety throughout the system

Delivered through:
- Effective governance at project, Academic Health Science Network and national levels
- Membership of national Steering group
- Membership of Measurement and communications sub-groups
- Delegation to national launch event.

Objective 2: Creating the conditions for safety

To create the conditions that help prevent patient safety incidents from occurring in the first place, engendering a sense of pride

Delivered through:
- Building system wide capability for staff and patients in patient safety improvement science.
- Creating environments and opportunities where people can come together to learn from each other, including regional engagement and project learning events

Objective 3: Transparency, reliability, resilience, learning and improvement

To foster a safety culture of transparency, reliability, resilience, continual learning and improvement, based on sound safety science

Delivered through:
- Systematic spread of quality improvements across health and social care.
- To be innovative, whilst grounded in evidence and using tried and tested methods
- To build upon existing initiatives and stimulate new ideas linked to national and local priorities

Objective 4: Working in genuine partnership

To develop genuine partnerships between those who give care and those who receive care to improve their safety

Delivered through:
- A focus on patient-centred approaches, which engage the patient in understanding and managing their own safety in accordance with their wishes.
- To co-produce solutions involving staff and patients

Objective 5: Improvement programme

To deliver a system-wide, locally owned and led, programme that delivers year on year improvements in safety

Delivered through:
- Locally owned and structured quality improvement initiatives leading to transformational change
- Active management of the *circa* £465k of Patient Safety Collaborative funding (£275 from national pot and £190k from existing AHSN budget)
- Ensuring improvements are measurable and sustainable

Objective 6: To collaborate

To enable NHS staff in the North East and North Cumbria to have the opportunity to: work together in a collaborative way, both inside and outside their own organisations and with national and international expertise

Delivered through:
- People being supported to engage with all levels of the organisations within which they work
- Bringing together patients and carers, national and international safety expertise with practical experience, in partnership with NHS England, NHS Improving Quality, and other national, international and local bodies interested in improving safety
- Being inclusive of all health sectors, with parity of mental, physical and psychological health, in particular focussing on safety across care boundaries
- Working in partnership with other AHSNs where there are opportunities to share expertise

Objective 7: Sign up to Safety

To align with and complement the ambitions of the 'Sign up to Safety' campaign

Delivered through:
- Encouraging local organisations to sign up to the campaign and to develop credible plans to achieve the campaign objectives
- Help participants in the national patient safety fellowship scheme to achieve their objectives locally, through networking and other support

Overseen through the following governance arrangements:

- **Accountable** to NHS Improving Quality/NHS England at a national level.
- A ***Board and Exec Team*** that are credible, engaged and active in support of the AHSN objectives
- Clear leadership from **SRO**, supported by a **small core team**
- A well run **Steering Group**, representative of and responsive to constituent stakeholders and projects
- ***Robust management*** of SLAs and project-specific contracts for all funding
- ***Proactive and vibrant communication*** ensuring broad stakeholder awareness and engagement

Measured using the following success criteria

- Having clear measurable objectives at programme and project levels
- Improvements in patient safety as measured by milestones and KPIs
- Bi-monthly progress reports showing project development and spread of improvement.
- Match funding and wealth creation used as a criteria for investment.
- AHSN additional funding sought through business development opportunities.

North West Coast Academic Health Science Network Patient Safety Collaborative

NORTH WEST COAST ACADEMIC HEALTH SCIENCE NETWORK

Organisations involved to date

NWC AHSN has involved all of its NHS partners – providers, commissioners and improvement bodies (AQuA, HAELO and NW Leadership Academy) in the development of its proposals and plans for the PSC (please visit www.nwcahsn.nhs.uk for details of colleague organisations). On 17 September, NWC AHSN held a stakeholder engagement event to which all of its NHS and academic partners were invited. The event was designed to gain agreement on a number of clinical and action priorities proposed by the AHSN. Organisations unable to send representatives have been consulted on the outcomes of the day.

Priority areas of work

NWC AHSN will ensure that all of the current NHS England requirements are met. Based on outputs from its recent enagement event, its clinical safety priorities will be medicines optimisation; management of sepsis; transition between paediatric and adult care; and hydration. It has already agreed a contract with a provider for a significant element of its medicines optimisation work.

Its priority areas for action will be providing Board level development in safety; providing safety training and development to staff working at patient care level; agreeing a regional policy on patient safety; setting up learning networks around safety improvement themes; developing safety champions or leads in each organisation; and undertaking technology reviews to identify solutions to safety issues.

High level workplan/approach

NWC AHSN will continue to use the principle of working with existing structres and resources, unless they are patently unfit for purpose.

To drive and accelerate the Patient Safety agenda, NWC AHSN has issued, with a short turnaround, a number of Preferred Supplier Agreements to regional improvement bodies for support to its improvement themes (which will be at the heart of how the PSC brings about improvement); building leadership capacity and capability; networking; board development; and measurement and data analysis. NWC AHSN has asked all its suppliers to work within the established structures for patient, carer and community engagement.

Contact

North West Coast Patient Safety Collaborative
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North West Coast Patient Safety Collaborative

Oxford Academic Health Science Network Patient Safety Collaborative

Achieving safe health care has the potential to bring very great benefits to patients, families and all involved in the delivery of care. The impact of even small improvements in patient safety is massive, both in terms of reducing the disease burden and in the huge economic benefits of safer healthcare. Many safety initiatives are in progress in the Oxford AHSN geography in acute NHS hospitals, community and mental health settings and in the patient's home. The bodies involved in this work include NHS acute trusts, NHS community trusts, NHS mental health trusts, care homes, social care bodies within county councils, care commissioning groups, universities and pre-existing collaboratives and federations.

The Oxford Academic Health Science Network Patient Safety Collaborative (PSC) will initially focus on a small number of clinical programmes but also act as an umbrella and coordinating centre for the many important patient safety initiatives, both practice and research, within the Oxford AHSN geography of Berkshire, Buckinghamshire, Bedfordshire and Oxfordshire. The PSC will work alongside the clinical networks within Oxford AHSN's Best Care programme and ultimately be accountable to the Oxford AHSN Partnership Board on which all NHS providers, CCGs and Universities are represented.

The principal aims of the PSC will be to:

- Develop safety from its present narrow focus on hospital medicine to embrace the entire patient pathway
- Develop and sustain clinical safety improvement programmes within the Oxford AHSN
- Develop initiatives to build safer clinical systems across the Oxford AHSN
- Collaborate and support sister safety programmes both nationally and internationally.

Early priorities are:

- The active engagement of patients and carers
- The development of a safety information system for the PSC
- Establishment and support of programmes on acute kidney injury, medication safety, pressure ulcers and safety in mental health
- Developing capacity and capability in leadership for safety improvement.

The PSC has chosen to focus on a small number of core areas in the first instance. We are conscious that further consultation needs to take place with a wide range of partners and that the full programme of work will only emerge gradually. The priorities set out here should be seen as a starting point and not a definitive account.
In time we hope to develop programmes which will address risks and systems vulnerabilities across the system and which are oriented towards building a safer healthcare system. Our longer term aim must be to design safe systems of care rather than address individual safety and quality issues.

SW AHSN Patient Safety Collaborative Plan on a Page

South West Academic Health Science Network

Improve patient safety and quality of care through whole health system collaboration

Improve culture	Foster an environment of psychological safety within and between teams and organisations, use validated tools and techniques to measure and improve safety culture. Develop a model that supports genuine partnership working with patients and the public. Set cultural and behavioural standards for the collaborative and lead by example.
Improve capability	Work with NHSIQ and local partners to design and implement a sustainable capability development programme that influences a critical mass. The programme will make use of the full range of methods available to reach the maximum number of staff and settings. We will focus on developing expertise in improvement, safety, human factors and measurement.
Improve capacity	Reduce duplication of activity through improved collaboration. Rationalise improvement activity focusing on achieving sustained improvement in a small number of common issues. Avoid additional resource intensive activities that are not adding significant value. Align with other work to improve access to shared learning.
Improve collaboration	Provide a flexible and accessible approach to collaboration using virtual and real interfaces to connect teams and individuals. Use partnership working to identify and address pathway or system issues that cannot be addressed within silos. Provide a 'safe space' where information can be shared without fear, blame or competition.
Improve understanding	Work with experts to extract best possible intelligence from existing data sources, employing a combination of quantitative and qualitative analysis. Share this intelligence with patients and frontline staff to ensure priorities selected are appropriate. Work with all partner to understanding of true cause of system problems before designing and implementing appropriate interventions.

Priority Activities - October 2014 to March 2015

Listening & Engagement	Alignment	Governance	Measurement
We are conducting a 'stocktake' exercise to ensure we understand concerns, needs and ambitions of our healthcare system before we select topics for improvement. We will work with patients and staff when selecting priorities. Interventions will be based on evidence and experience.	We are aligning the evolving collaborative with related work programmes including Sign Up To Safety, regional networks, local issues identified through the 'stocktake' and existing SW AHSN programmes.	We are implementing an interim governance structure under the leadership our our Board which represents our member organisations. A steering group will be formed to include patient and staff representation from different sectors and geographies.	We are working with NHSIQ during the development of the national measurement strategy. Local measurement will be determined by the selection of local priorities which must be measurable in order for us to evidence progress. We will use currently available data whenever possible to demonstrate improvement.

UCLPartners' Patient Safety Programme: A collaborative approach to sustained improvement in patient safety

UCLPartners
Academic Health Science Partnership

The aim of the UCLPartners programme is to build, develop and support improvement capabilities for front-line staff and to improve patient safety outcomes for a population of six million people across our partnership. Our focus is on progressively reducing avoidable harm and embedding safety through an ethos of building continuous improvement into routine practice at scale; establishing safety as normal practice across UCLPartners. Nine design principles inform our approach. These are:

- To have meaningful patient, carer and family involvement
- To make partnership initiatives relevant to local priorities; embedding safety into mainstream delivery
- To make safety relevant to the mainstream front line of care
- To build networks across the partnership and promote shared learning
- To ensure educational and trainee involvement and build leadership capacity in safety
- To ground work in authentic and rigorous time series measurement
- To support partner organisations to build improvement capacity and capability at scale
- To implement core informatics enablers for safe care
- To ensure robust evaluation.

Our approach to measurement will align teams' understanding of where they are currently and where the highest priority areas for attention lie. This is rooted in four simple questions:

- Do you know how good you are?
- Do you know where you stand relative to the best?
- Do you know how much variation exists, and at what level in your system?
- Do you know your rate of improvement over time?

UCLPartners will ensure the safety and improvement work draws from and informs/supports work in other regions and AHSNs wherever it usefully can. We are focusing on informing commissioning priorities and approaches to better align the whole system in supporting safety and improvement most effectively.

Building on existing foundations

UCLPartners' patient safety programme builds on improvements and learnings gained from existing UCLPartners collaborations including, the Deteriorating Patient Initiative, which over the last three years has grown to involve 16 acute trusts across UCLPartners' geography.

Our priorities are derived from patient and population need matched to partner organisations' current safety priorities and their views on where partnership working can add most value to local safety efforts. A small team, rooted in the efforts of clinicians and front line teams across the partnership, will report to the UCLPartners Executive, via a Programme Board chaired by Clare Panniker, Chief Executive of Basildon and Thurrock University Hospitals NHS Foundation Trust.

The initial priorities include sepsis and acute kidney injury (AKI). Discussions are ongoing with partners regarding other partnership-level priority areas, for example, falls and pressure ulcers. Each of these areas contributes to our overall aim of reducing mortality across the partnership, and, crucially, each is also amenable to a whole health system approach – i.e. relevant in all settings from care homes/usual place of residence to the acute hospital.

Each of UCLPartners' integrated AHSN programmes is placing further and more explicit emphasis on patient safety. These programmes include: cardiovascular, mental health, neuroscience, children and young people, cancer and complex patients. Their priority areas are currently being determined.

About UCLPartners

UCLPartners is an academic health science partnership with over 40 higher education and NHS members, including 23 acute, mental health and community NHS organisations. Through UCLPartners, members collaborate to improve health outcomes and create wealth for a population of over six million people in north east and north central London, south and west Hertfordshire, south Bedfordshire, and south west and mid Essex.
Tel: 020 7679 6633 www.uclpartners.com

West Midlands Patient Safety Collaborative (PSC) – summary plan

Contact details of PSC leads

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Brief details of collaborative

The West Midlands PSC is developing the work programme using principles of co-design and co-production with stakeholders and looking to spread successful innovative approaches through a networked approach. With this in mind, a stakeholder survey has been undertaken and the following draft principles identified:

- Priority areas developed through transparent consultation and agreement with stakeholders
- The PSC needs to demonstrate the added value, and ensure spread and sustainability of evidence-based and best practice initiatives
- A systematic approach focused on achieving change at the frontline
- Collaboration should be promoted, particularly between acute and community care providers, with existing initiatives linked up
- Training need to be supported to ensure sustainability of approaches.

Organisations involved to date

NHS commissioners, providers, private providers, voluntary organisations, local authorities, HealthWatch and other West Midlands patient groups and safety leads; linked with the Midlands East Pressure Ulcer Programme.

Priority areas of work

Priority areas from a stakeholder survey are to be agreed at a stakeholder symposium on 5 November, leading to the establishment of networks for priority areas. Stakeholders were asked if they would support a priority area around pressure ulcer reduction (particularly in community providers and residential homes), linked to a focus on nutrition, hydration and acute kidney injury, as well as a priority area around falls. 56% of respondents agreed with the priority areas. Through the survey, respondents highlighted the following as patient safety priority areas:

- 22% cited the human aspects of patient safety, particularly organisational culture, leadership and communication – with a focus on the point of handover within and between organisations
- 20% deteriorating patients and sepsis
- 20% medicines management
- 10% dementia and delirium
- 10% the systems of reporting incidents and investigating incidents
- 8% would welcome a focus on paediatrics, for example paediatric early warning systems
- 8% falls

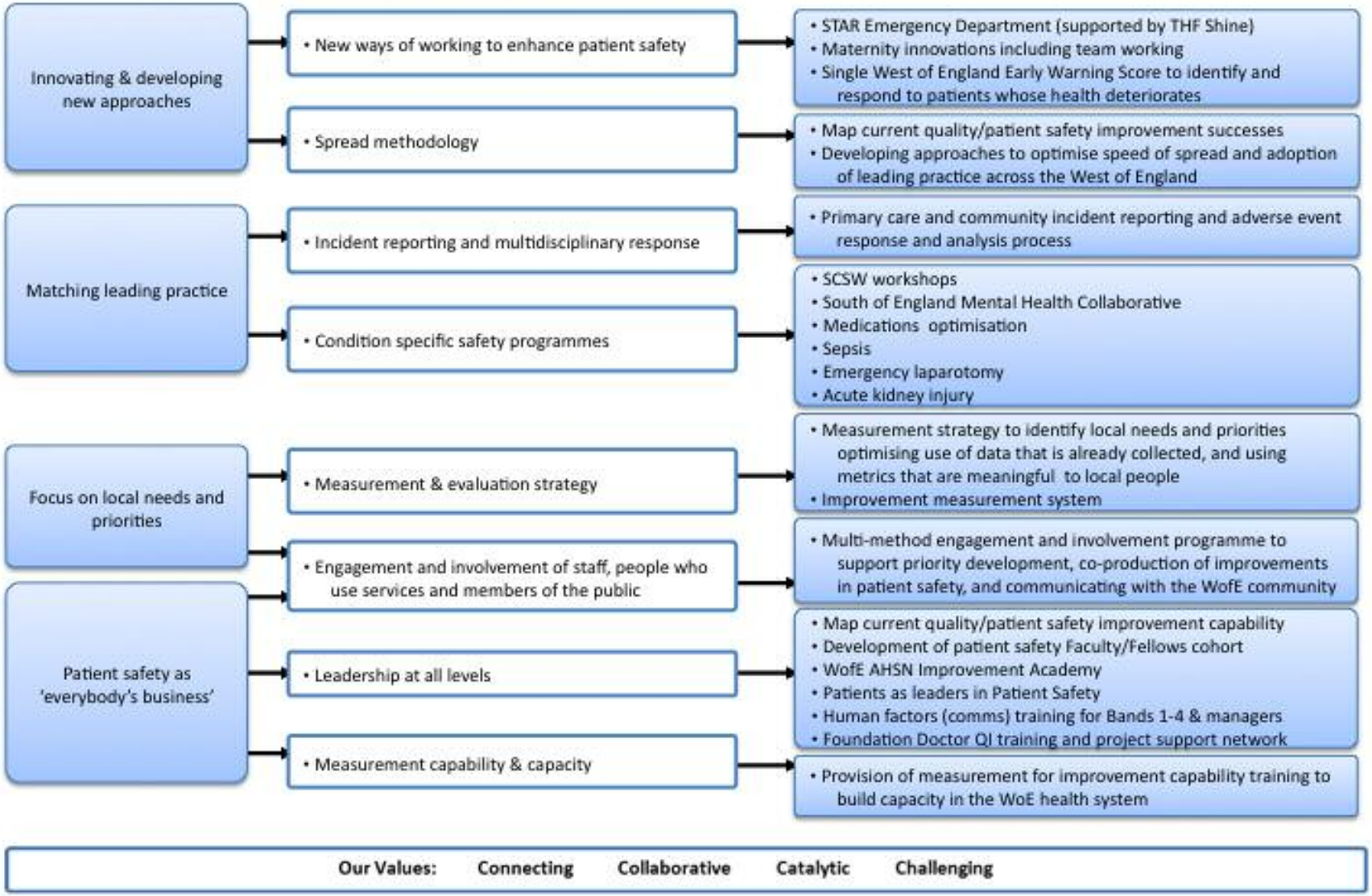
Individual respondents also cited: mortality reviews; infection control; using technology to reduce errors; strokes; mental health crisis for adults and children; and care homes.

High level work plan/approach

- PSC themed networks for priority areas will be established to agree and deliver safety implementation plans using expertise in leadership, measurement and innovation to support improvement
- A PSC Advisory Group will oversee the work of the networks and facilitate prioritisation as required, reporting to the AHSN Board
- Improvement experts will be engaged and evaluation will be inbuilt into the delivery to ensure roll out of optimum approaches across the West Midlands
- Developing the baseline data set will be undertaken directly after sign-off of priority areas. The PSC will continually look to exploit opportunities to embed safety and measurement into organisational and cross-organisational processes (e.g. within contracting frameworks, core education and training)
- The PSC will map current projects and the skills and capabilities within the evidence-based AHSN and non-AHSN programmes to use existing resources effectively and address gaps (e.g. there will be links to WMAHSN's Drug Safety clinical priority)
- The PSC will also promote the Sign up to Safety campaign and encourage all providers to be involved.

West of England AHSN – Patient Safety 'Plan on a page'
2014/15 – 15/16 (Draft v0.5)

West of England Academic Health Science Network



Wessex Patient Safety Collaborative

Working to improve safety for patients in Hampshire, Dorset , Isle of Wight and South Wiltshire

Wessex Patient Safety Collaborative Support Team
Wessex AHSN Chief Executive – Martin Stephens
Director of Patient Safety Collaborative – Keith Lincoln
Clinical Lead for Patient Safety Collaborative – Professor Jane Reid
Patient Safety Collaborative Manager – Geoff Coper
(emails to: first name.lastname@wessexahsn.net)

Priority Safety Topics

Subject to a Launch and Listen event on 11 Nov 14 where the emphasis will be on co-design and co-production, the Wessex Patient Safety Collaborative will look to address the following areas in the first instance:

The 'essentials'
Leadership and Measurement

Other sources of potential harm
Medication Errors
Transfers of Care – to include reduced readmissions, improved patient and carer experience, reduced out of hours referrals and fewer specific harms e.g. AKI.

Current Position

Priority areas of work

- Engage with members, partners and wider stakeholders to achieve awareness of the PSC and buy-in to the programme
- A successful Launch and Learn event for Wessex PSC (11th Nov) to identify areas of work and achieve participation from all stakeholders. Also, to highlight the alignment to Sign up to Safety to support organisations in complimentary activity.
- Baseline patient safety topics across Wessex

High Level Work plan

Oct 14 - National PSC launch event. Develop overarching PSC plan including aims, objectives, strategic delivery plans that align with the national programme measurement strategy.
Nov 14 - Wessex PSC launch event – identify areas of patient safety to be addressed by the PSC. Consolidate information and learning from launch event. Establish PSC Steering Committee. Communicate launch event outcomes with stakeholders.
Dec 15 Identify initial areas for PSC to tackle and start to co-ordinate interested stakeholders for quality improvement events. Engage support to build quality improvement capability within Wessex.

Organisations engaged as of 30 Sep 14

Provider Trusts
Isle of Wight NHS Trust
The Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust
Poole Hospital NHS Foundation Trust
Salisbury NHS Foundation Trust
University Hospital Southampton NHS Foundation Trust
Portsmouth Hospitals NHS Trust
Dorset County Hospital Foundation Trust
Hampshire Hospitals NHS Foundation Trust
Dorset Healthcare University NHS Foundation Trust
Solent NHS Trust
Southern Health NHS Foundation Trust
South Central Ambulance Service NHS Foundation Trust
South Western Ambulance Service NHS Foundation Trust

Clinical Commissioning Groups
North East Hampshire and Farnham
Isle of Wight
Fareham & Gosport
North Hampshire
Dorset
Portsmouth
South Eastern Hampshire
Southampton City
West Hampshire
Wiltshire (Sarum locality)

Universities
Bournemouth
Southampton Solent
Portsmouth
Southampton
Winchester

Local Authorities
Dorset County Council
Hampshire County Council
Isle of Wight Council
Portsmouth City Council
Southampton City Council
Wiltshire County Council

Other Stakeholders
Local Medical Committee
Health watch Hampshire
Health watch Dorset

Wessex Academic Health Science Network, Innovation Centre, Southampton Science Park, 2 Venture Road, Chilworth, Southampton SO16 7NP
Tel: 02382 020 840

Yorkshire and Humber

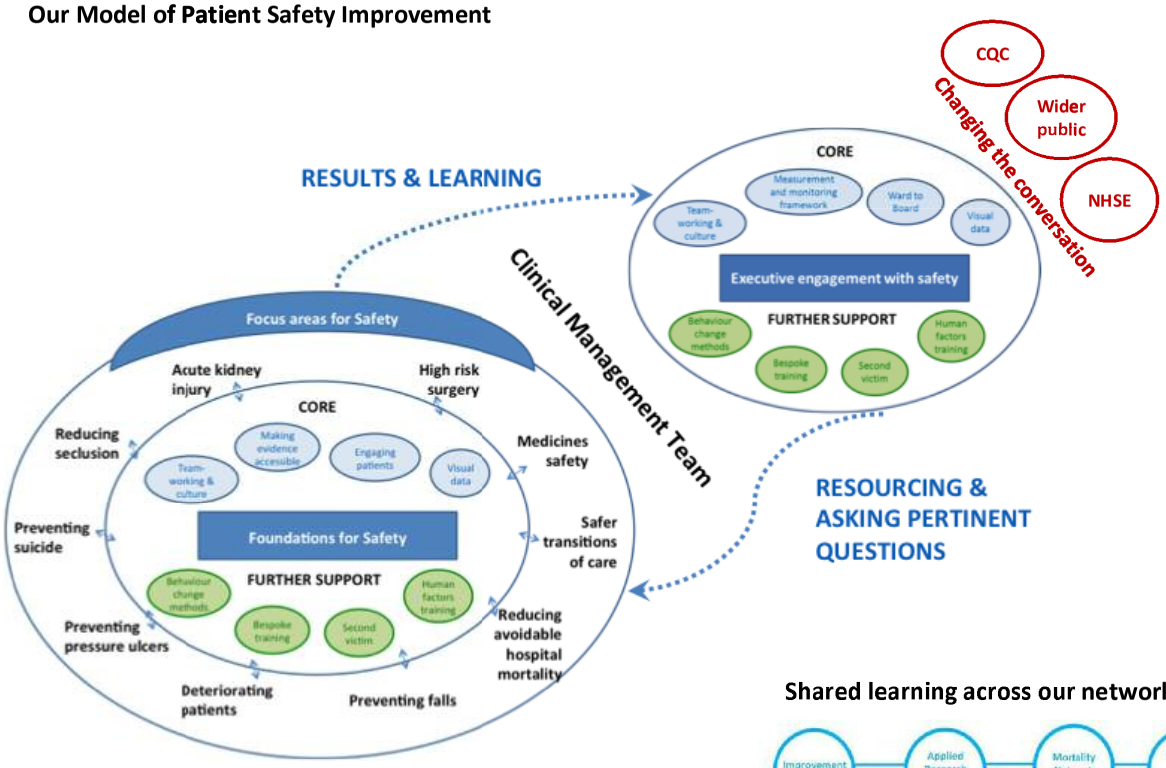
Improvement Academy

Patient Safety Collaborative (2014-2019)
'Bottom-up, from the top'

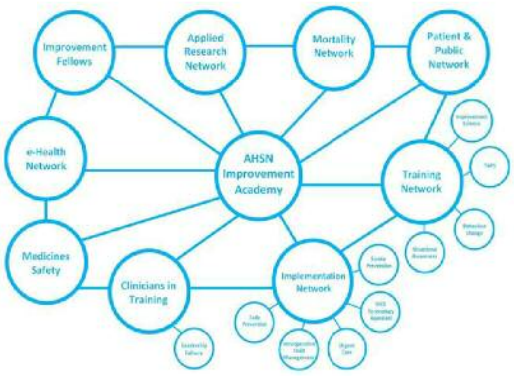
Our patient safety collaborative will build on our successful patient safety work with frontline teams, involving everyone from cleaners to consultants, in both community and hospital settings, including mental health and learning disability services.

Mobilising frontline teams to focus on those areas of safety that are most important to our partner organisations, we will reduce patient harm, increase the capability of our partner organisations and their frontline teams for independent safety improvement, improve patient safety culture among staff, improve patient experience, and share learning across Yorkshire and Humber. Our aim is to use evidence and practical support to help our partners become High Reliability Organisations for safety, improving care 'bottom-up from the top.'

Our Model of Patient Safety Improvement



Shared learning across our networks



⇒ *Roundtable discussions* ⇒ *Masterclasses*
⇒ *Action Learning Sets* ⇒ *Peer review methods*

Evidence-based resources for safety improvement

- *Effectiveness Matters* summaries of research evidence
- Patient safety huddles for frontline teams
- Assessing patient safety culture at team level
- Improvement data close to frontline
- Accessing the patient voice in safety (e.g. PRASE)
- Safety measurement and monitoring framework
- Managing tensions between learning and performance
- Online safety training resources

Ref:140925

Yorkshire & Humber partners
Academic Health Science Network

Further information:
AHSN Improvement Academy,
Bradford Institute for Health Research
Tel: 01274 383926
www.improvementacademy.org

To find out more about NHS Improving Quality:

www.nhsiq.nhs.uk/improvement-programmes/patient-safety.aspx

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Improving health outcomes across England by providing improvement and change expertise

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