1. There are currently a set of initiatives to help the NHS improve the safety of patient care over the next three to five years. They are interconnected pieces of the jigsaw that will make up a safer NHS in England. Collectively and cumulatively they will help improve the safety of patient care.

2. The Secretary of State stated the following when announcing these initiatives:

   Sign up to Safety Movement: So today, I sign up to safety. I want today to mark the start of a new movement within the NHS in which each and every part of our remarkable healthcare system signs up to safety, heart and soul, board to ward. Professor Berwick said the heart of safe care is a culture of learning. So the engine room of this new movement will be a new national network housed in NHS England, a collaboration of all NHS organisations and local patients, who share, learn and improve ideas for reducing harm and saving lives.
   The first 12 vanguard (DN: this was the old term for the trailblazers) signed up to the movement this week. Within the next few months I will write to every NHS organisation in England, inviting them to join and sign up to safety. I hope over time that every hospital in England will rise to the challenge and join the campaign. Every hospital Trust that chooses to join will commit to a new ambition: to reduce avoidable harm by a half, reduce the costs of harm by one half, and in doing so contribute to saving up to 6,000 lives nationally over the next three years.
   I have asked NHS England, Monitor and the Trust Development Authority to work together to put in place support for hospitals to develop their plans to do this. They will provide advice to ensure that each plan takes full account of the international evidence as to what measures have the most impact.
   For those hospitals that sign up, The Chief Inspector of Hospitals will include progress against these plans as important evidence to inform the inspection and ratings regime. They will also be reviewed by the NHS Litigation Authority, which indemnifies trusts against law suits, and, when approved, they will reduce the premiums paid by all hospitals successfully implementing them.
   Starting this year, the campaign will recruit 5,000 safety champions as local change agents and experts - safety ambassadors, safety agitators, safety evangelists - a grassroots safety insurgency across England which will seek out harm, confront it and help to fix it.
   We will go beyond institutions to seek to sign as many staff in the NHS as we can to the safety campaign. Just as more than 500,000 people this month made individual pledges to improve care for patients on NHS Change Day, the movement will seek to harness that great well of values and expertise in the NHS to a common endeavour on safety.
   Members of the campaign, which will be formally launched in June, will be supported by a new team, Safety Action For England, consisting of senior clinicians, managers and patients with a proven track record in tackling unsafe care - people frontline staff will respect, listen to and work with. They will ensure fast, flexible and intensive support when the line needs to be stopped and a lesson needs to be learned in England. A whole system will be wired together so that where unsafe practice is detected at one end of the country, the lesson is learned at the other end as well.

3. From this the concluded view is that the overarching public goal across the NHS in England is one of reducing avoidable harm by 50% and saving 6000 lives. This is the goal of the combined initiatives and not just that of the campaign and therefore the collective programme of work is designed to improve safety and reduce avoidable harm, supporting the ambition to save up to 6000 lives by 2017[1]. The key issue here is 'how is that to be measured and evaluated?'.

4. All initiatives, no matter what type of methodology, must be measured in order to know if we are making a difference or not. In the case of the collective programme, the principal examination question is '*do these*

[1] Note this is the end date of the campaign – we need to agree that this is the date we are working to or whether it is the end of the five years of the patient safety collaboratives which would be 2019.

combined interventions lead to improved patient safety outcomes'. However, we know that this is difficult to answer; there can be no control group and it is difficult to quantify the independent contribution of one intervention from the other i.e. it is not possible to evaluate a single intervention under experimental conditions.

5. Aspects already in progress are:

- The **NHS LA's** 'plans for reducing claims':
  - This is part of their day to day work; their role is to support their members to learn from claims and to reduce their numbers through the real time safety and learning data they share with their members.
  - The incentive scheme they have run for 2015 has completed and they have allocated all of the money across to successful bidders.
  - The NHS LA will not performance manage this scheme and have stated this is the role of individual Boards to be responsible for assessing progress and change associated with the projects they have launched using this money.
  - The NHS LA monitor their claims numbers regularly but only report on an annual basis - mainly because they are relatively small in number and have a time lag of, on average, 2-3 years from incident to claim notification.
  - They will not, by their very nature, show any significant change from the actions of this year until at least 2017 or 2018. The Secretary of State is well aware of this.
  - So this is covered and does not need additional resource or consideration.

- The **campaign** 'measuring the impact of the methodology' (see Annex B):
  - The campaign has its own knowledge capture and evaluation strategy which is all about studying implementation and not outcomes - how we will learn from the participants on what is working and how they (frontline organisations and individuals) are making their changes in real time.
  - The campaign will not be measuring outcomes e.g. *reduced avoidable harm and saved lives*. It has not been set up to do this and does not have the resource to do this.
  - We are also not capturing local measurement of safety improvement plans – this again has been agreed as the responsibility for local frontline boards.
  - We are not setting up an additional reporting system for frontline organisations to report through to the campaign – that has never been the agreed approach and was one thing the Secretary of State was adamant on – 'that we didn't create any new reporting mechanisms' or 'additional burden on frontline staff'.
  - The campaign is using a real world evaluation methodology which uses formative and developmental evaluation principles and sits very much within the campaign.
  - We don't need any help on this as we already have someone from the Kings Fund supporting us on this.

6. Aspects that need clarification are:

- Measurement and evaluation of the AHSN **patient safety collaboratives** - this is the responsibility of the patient safety collaboratives programme board chaired by Sir Norman Williams. They have a measurement sub-group – which is working up a long term solution.
- Measurement and evaluation of the **total programme** - how we need to measure it and who will measure it at what level of the system. How will we answer the inevitable question 'have you reduced avoidable harm by 50% and how many lives have you saved?'

- Sign up to Safety is not creating a reporting process for progress or outcomes related to individual safety improvement plans – frontline organisations are not required to report up centrally – a key principle is that no new reporting mechanisms were set up and that local ownership of measurement was to be encouraged. Therefore what other ways can we show at a national level the data aggregated in respect of the top themes across England from the local safety improvement plans related to:
    i. Falls
    ii. Pressure ulcers
    iii. Medication safety
    iv. Sepsis
    v. Deterioration
    vi. Maternity (maternal and foetal deterioration)
    vii. Surgical never events
    viii. Safety culture
    ix. VTE
    x. Acute Kidney Injury

- What are the other members of the Strategy and Advisory Group doing in relation to measuring safety across the system e.g. the NTDA (LeAN transformation) and CQC (ratings) and the DH evaluation programme which impacts on collaboratives

Annex A – Baseline analysis conducted by Haelo (previously shared in May)

Annex B - Sign up to Safety Evaluation

1. The evaluation of the campaign will use real world research theory and be practical and process-oriented, delivering information that can be channelled quickly back into the campaign as it is implemented.

2. The evaluation will have two main purposes:

    a. To evaluate the outputs, uptake (for example numbers of organisations and individuals joined) and impact of the campaign (for example lessons from the methods and techniques used during the campaign):
        i. input – all background information, planning and research
        ii. output – quantitative measure of the messages that go out as part of the communications process;
        iii. uptake - measure of audience participation, audience awareness, understanding and memory of messages;
        iv. outcome – measure of the extent to which the campaign alters or influences knowledge,
        v. beliefs and/or behaviours

    b. To conduct evaluation during and share the lessons internally with the team to shape activities and externally with key external stakeholders to provide evidence of performance and impact:
        i. Metrics: Metrics will be captured in terms of output, uptake, and impact.
        ii. Output – Page views of website(s), views of campaign-related videos, media coverage of the campaign, number of articles in print or online media over the course of the campaign, distribution of the campaign's e-newsletter SignUPdate, number of unique recipients.
        iii. Uptake - A basic measure of engagement will be the number of organisations and individuals that sign up to, and maintain their participation in, the campaign, brand

perceptions, attendance, in webinars, events, national learning events, the number of e-newsletter recipients, twitter.

iv. Impact - Awareness raising in frontline organisations about patient safety (and the campaign), contribution to a positive cultural shift, presentations and stories of results from the frontline

3. The evaluation of the campaign will be a mix of 'Summative', 'Developmental', 'Rapid Cycle' and 'Formative' [adapted from The Health Foundation 'Evaluation, what to consider']:

   a. A developmental evaluation involves 'double loop learning' – where the theories and assumptions are revised over time, with the result that the goals might also be changed. This type of formative evaluation also facilitates real-time, or close to real-time, feedback to the team. It assists with trying out new ideas, documenting activities and their short-term consequences, identifying processes and outcomes as they emerge and helping people to make sense of them. This allows ongoing development of the intervention, theories of change and occasionally the aims of the initiative.

   b. A formative evaluation is designed to help form or shape an intervention. It is used as the intervention evolves and can provide information about how best to revise and modify the work taking place. It can help people to explore not only whether improvement has been achieved, but also how it has occurred in their particular environment. The data from a formative evaluation is likely to be both quantitative (numerical data through statistics, surveys, questionnaires and structured interviews) and qualitative (semi-structured or unstructured interviews, focus groups, observations and document analysis). The data can be used to develop the intervention, fixing implementation problems so that it is more likely to be successful.

   c. A summative evaluation can be seen as a 'summing up' of the overall effect of the intervention. It is often carried out at the end, when all the data are available to help the evaluation team to determine whether it has been a success or not, often against stated goals. This type of evaluation might show whether the intervention worked and met its objectives, what improvements, if any, it created, and how the benefits compared to the costs. It is useful for judging the overall worth and significance of an intervention.

   d. Rapid cycle evaluation is an example of formative evaluation which aims to use 'single loop learning' – where the goals are treated as being relatively fixed, but details about how to obtain these goals might be refined. Methods are used to determine on a regular basis whether an intervention is effective, and enable people to continuously improve their interventions by experimenting with different adaptations.

References

The Health Foundation, 'Using Communication approaches to spread improvement found at: http://www.health.org.uk/public/cms/75/76/313/5565/UsingCommunicationsApproachesToSpreadImprovement.pdf?realName=utDV1o.pdf

The Health Foundation, 'Evaluation, what to consider' found at: http://www.health.org.uk/public/cms/75/76/313/5564/EvaluationWhatToConsider.pdf?realName=F8gtl2.pdf