Paper: 011406

BOARD PAPER - NHS ENGLAND

Title: Patient safety collaborative proposals
Clearance: Jane Cummings, Chief Nursing Officer.
Purpose of paper: • To inform the Board of the proposals for the Patient Safety Collaborative Programme and to seek their support for the Programme
Key issues and recommendations: The report of Don Berwick's National Advisory Group on the Safety of Patients in England stated that ''*The most important single change in the NHS in response to this report would be for it to become, more than ever before, a system devoted to continual learning and improvement of patient care, top to bottom and end to end*.'' NHS England's Patient Safety Domain and NHS Improving Quality therefore propose supporting the establishment of a network of Patient Safety Collaboratives (PSCs) across England. The Programme would help create and support 15 PSCs covering every geographical part of England, whose role would be to offer staff, users, carers and patients, throughout the healthcare system the opportunity to work together locally to tackle specific patient safety problems, improve the safety of their systems of care, to build patient safety improvement capability, and to focus on the actions that can make the biggest difference to their patients using evidence-based improvement methodologies
Actions required by Board Members: • The Board is asked to support the Patient Safety Collaborative Programme

Patient safety collaborative proposals

1. The aim of the Patient Safety Collaborative Programme is to create a comprehensive, effective, and sustainable collaborative improvement system that will support the development of a culture of continual learning and improvement in patient safety across England. Too many people are harmed by things going wrong during their healthcare. The vast majority of these patient safety incidents are not the fault of the people providing healthcare, but are a result of problems with the systems, procedures, environment, behaviours and pressures that occur in the environment in which they work.

2. Don Berwick's challenge to the NHS is for our whole healthcare system to systematically support and foster a culture of continual learning and improvement that tackles these problems and supports staff to provide the safe care they all want to do, ensuring patients are at the centre of care. All organisations and healthcare communities should strive to make health care more safe, not just in 'islands of excellence'.

3. We therefore want to support the NHS in every part of England to ensure everyone involved in healthcare; staff, clinicians, patients, leaders, commissioners and regulators, are able to work together in a collaborative way to assess and improve safety, to build capability, and to focus on the actions that can make the biggest difference to patients. The NHS has produced many improvement initiatives related to patient safety or quality more generally. Groups of NHS staff have developed numerous programmes ranging from pressure ulcer prevention, through stroke treatment and recovery, to improving post-operative mortality via specific, evidence based interventions. We need to support this kind of activity at scale across every sector.

4. Our proposals have two major strands, inextricably linked and interdependent, focussing on the use of quality improvement science:

    - Support the formation of 15 Patient Safety Collaboratives (PSCs), enabled to create and nurture sustainable local continual learning environments. This fundamental focus on continual learning systems will encourage the kind of organisation and system-wide patient safety culture that can deliver definitive improvements in specific patient safety issues and build local capability and energy for change.

    - Develop system-wide capability for patient safety improvement. This will involve a number of initiatives including a systematic programme of training to deliver improved capability for organisations and existing NHS leaders at all levels, plus a national system of NHS Improvement Fellowships and the technology and structures to support them – thereby building a vibrant set of connected safety improvement leaders and experts, all skilled in improvement at an advanced level and supporting others to grow within and outside their organisations.

5. The programme will use a variety of improvement tools and techniques and harness the latest thinking and expertise on safety and large scale change. PSCs themselves will innovate, using varied methods to drive improvement, owning the responsibility to establish the effectiveness and value of their chosen methods and sharing their safety improvement practices.

Objectives and priorities

6. The objectives of the Patient Safety Collaborative Programme are to;

- Establish and connect 15 PSCs covering every geographical part of England by the end of 2014/15;
- Ensure every provider and commissioner of NHS-funded care is involved in collaborative patient safety improvement activity by 2018/19;
- Develop and embed a nationally consistent system for patient safety measurement across each collaborative by the end of 2014/15;
- Demonstrate a sustainable and statistically significant reduction in patient harm by Autumn 2015;
- Support the development of a patient safety culture across the NHS as measured by NHS Outcomes Framework indicators 5a, 5b and 5c and through other measures such as culture surveys;
- Create an NHS Improvement Fellows programme, measured by the number of individuals awarded that accolade; we would aim for 5000 within 5 years;
- Deliver a significant increase in the patient safety improvement capability of the NHS by ensuring a substantial number of NHS staff across all grades participate in identified development initiatives that support collaborative improvement activity and improve their knowledge and skills in the practical application of improvement science.

7. A focus on some consistent, ‘essential’ issues in the first year, by each PSC, will help ensure the collaboratives are based on firm foundations. This will help to test out new ways of facilitating the sharing of learning across the system, will build the confidence upon which to widen the scope of improvement areas in year two and, importantly, deliver safety improvement in 12 months. This prioritisation of improvement activity must be done with the system, but initially, we are proposing four essential ingredients, split between two core ‘capability’ priorities and two core clinical priorities;

- **Leadership for Patient Safety** - *Delivering improvement requires leaders in every organisation to put safety first. Executive leaders and boards will be the focus in the first year.*
- **Measurement for Patient Safety -** *Using data well is crucial to all quality improvement.*
- **Pressure Ulcers -** *There are clear interventions that can deliver significant improvement in the burden of harm represented by pressure ulcers, but clearly they remain a significant burden, particularly outside the acute sector.*

- **Medication Errors -***The prescribing, dispensing and administration of medicines is a huge area where error and poor process has the potential to affect large numbers of patients, making this a priority area for reducing harm.*

8. We expect improvement activity to be much broader than this even in year 1 however, and the range of areas covered will increase further as PSCs mature. We have identified a set of topics which could serve as a 'pick-list' for PSCs to choose from and for which we will develop and provide guidance, tools and change packages (see Appendix 1). PSCs will be able to adapt these and propose additional areas and interventions that deliver significant patient safety improvements. To support the spread of good practice and collaboration we will encourage the development of 'communities of interest' covering the whole of England that will link experts in particular patient safety topics, so that different PSCs can learn from each other's experience.

9. The suggestions for the 'essential' and 'pick-list' issues were a core topic for discussion at the Patient Safety Collaborative Programme 'Design Day' held on 15 January 2014. Given the proximity of this event to the NHS England Board meeting and the timetable for submitting papers it has not been possible to update this paper with the outputs from the Design Day. However, it is a core principle of this programme that it must be co-produced with the whole system and adapted as necessary to ensure the greatest benefit for patients.

Delivering the Programme

10. Delivering a locally-owned and led process of patient safety improvement requires organisations outside of 'the centre' to be enabled to do this work. We propose to do this by providing funding to local groups to run the PSC for their geographical area. We expect 15 PSCs will be established covering the same geographies as the Academic Health Science Networks (AHSNs). AHSN geographies have been chosen as they cover roughly the right sized population for this model of improvement (2-5 million) and are distinct from existing parts of the provider/commissioner system.

11. We expect to receive proposals to run collaboratives from the AHSNs themselves who are well-placed to host and support local patient safety improvement work, but we are not limiting this to AHSNs and proposals will be welcome from alternative sources or configurations of organisations including consortia of providers, combinations of AHSNs or single large organisations, provided they represent a system-wide approach covering a suitable area. It will be important to ensure the process is an inclusive one, rather than receiving multiple competing proposals from different groups covering the same area.

12. The Programme will need to run for a minimum of five years to deliver sustainable improvement in both capability and safety and to support the long-term development of a patient safety culture in the NHS. PSCs will therefore need to demonstrate success during this period to ensure effective use of public money. The criteria for defining 'success' and the associated measurement

strategy must be co-produced with the NHS and should not be a process of performance management or command and control. That said, some core criteria, including full partnership with patients will be non-negotiable.

13. We propose that the assessment of 'success' will be supported and guided nationally by a National Advisory Group, chaired by a suitable, very senior individual, such as a non-executive director of NHS England, professional leader or healthcare advocate. The National Advisory Group will likely be established as a sub-group of the NHS IQ Programme Board with delegated responsibility to allocate relevant funding to each Patient Safety Collaborative based on their record of success.

Cost

14. This is a major national programme and will require sustained funding for a minimum of five years, with reviews at the one and three year stage. An annual investment of around **£12 million** is required to support local delivery of safety improvement to meet local needs. Some of this investment will support central resources and the programme of capability building, but the majority will fund each local PSC to employ sufficient leadership, analytical, improvement and administrative expertise and deliver its agreed plans.

15. We are currently in the process of identifying the most appropriate mechanism for ensuring relevant funding is provided to the PSCs. It is a key design principle that funds are used locally, and this will be a major investment into around 100 improvement experts working locally, with a small regional and national coordinating function. The proposals also represent a moderate level of investment when considered in the context of earlier collaborative improvement programmes, for example cancer (£21 million) or heart disease (£18 million).

16. There is unlikely to be significant additional funding available through this programme for provider organisations to purchase additional capacity for improvement activity. Healthcare organisations are expected to undertake quality improvement as part of their usual business. The collaboratives will provide support and structure to that process.

Recommendation

17. The Board are asked to note and support the proposals for the Patient Safety Collaborative Programme.

Jane Cummings

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January 2014

Appendix 1 – Proposed 'pick-list' of patient safety priority areas that Collaboratives can choose from and which we will provide supporting material and guidance for.

Please note this list is not exhaustive and some 'topics' require further definition and expansion given the breadth of issues they cover. Position in the table is not a reflection of importance or burden of harm.

Topic area	Patient Safety Topic						
Suggested 'essentials'	Leadership	Measurement	Pressure Ulcers	Medication Errors			
NHS Outcomes Framework improvement areas	VTE	HCAI	Maternity	Deterioration in children			
Major sources of death and severe harm	Falls	Handover and Discharge	Nutrition and hydration	AKI	Deterioration in adults	Sepsis	Medical Device Errors
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	