NQB (13)(05)(01)

NATIONAL QUALITY BOARD

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The Patient Safety Collaborative Programme – a paper for the NQB

Purpose

1. This paper describes for the NQB the current proposals in relation to the Patient Safety Collaborative Programme. This Programme, launched as part of NHS England's response to the Francis and Berwick reports, is still in the design phase. NHS England is keen to engage with the NQB regarding the proposals and use the NQB's feedback as part of their ongoing design work.

Recommendations

2. NQB members are asked to consider the proposals, which will be presented to the NQB by Dr Mike Durkin, Director of Patient Safety in NHS England, and provide thoughts, observations and comments on the issues raised.

Background

3. 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. Our urgent challenge is to systematically tackle the causes of patient safety incidents and so continuously reduce harm

4. The recent Berwick report, *'A Promise to Learn - a Commitment to Act'* stated that *"The single most important change in the NHS … 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"*. It then goes on to recommend:

    - NHS England should be given the resources to support and learn from existing collaborative safety improvement networks and to sponsor the development of new regional or sub-regional collaborative networks across

the country, perhaps aligned to and working with the new Academic Health Science Networks.

- Every NHS organisation should participate in one or more collaborative improvement networks as the norm.

- Improvement networks should include processes for monitoring and evaluation by the networks together with NHS England in order to understand what works and to assure that best processes are spread and scaled to benefit all patients in the system.

- NHS England should organise a national system of NHS Improvement Fellowships, to recognise the talent of staff with improvement capability and enable this to be available to other organisations.

5. This paper provides an outline proposal for the delivery of these recommended actions primarily through the establishment of a network of Patient Safety Collaboratives across England. This is a joint initiative between the NHS England Patient Safety Domain, NHS Improving Quality and providers and commissioners across the NHS. This should be seen as a key element of the wider NHS England National Patient Safety Plan which is in development.

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

    - We will establish and support 15 Patient Safety Collaboratives that will deliver definitive improvements in specific patient safety issues over the next five years as a minimum and build local capability and energy for change.

    - We will develop a system-wide capability for patient safety and quality improvement through a national system of NHS Improvement Fellowships and the technology and structures to support them along with creating a systematic programme of capability improvement for organisations and existing NHS leaders at all levels – 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.

The current proposal – aims and objectives

7. The aim of the Patient Safety Collaborative Programme is to contribute to the continual reduction of avoidable harm and death by creating a comprehensive,

effective, and sustainable collaborative improvement system that underpins a culture of continual learning and patient safety improvement across England.

8. The objectives of the Patient Safety Collaborative Programme are to:

- Establish and connect 15 improvement collaboratives covering every geographical part of England by the end of 2014/15.

- Ensure every provider and commissioner of NHS-funded care is involved to some extent in collaborative patient safety improvement activity by the end of March 2019.

- Deliver a significant increase in the patient safety improvement capability of the NHS by the creation of an NHS Improvement Fellows programme as measured by the number of accredited individuals awarded that accolade; we propose 200 Fellows in year one, 1000 by end of year two, 5000 by end of year five.

- Deliver a significant increase in the patient safety improvement capability of the NHS by ensuring NHS staff, from board to ward, participate in identified development initiatives that support collaborative improvement activity and improve their knowledge and skills in the practical application of improvement science. We propose 700 people per year (around one per NHS organisation per year).

- Develop and embed a nationally consistent system for patient safety measurement and improvement across each collaborative by the end of 2014/15.

- Create a culture of patient safety across the NHS as measured by continually increasing the reporting of patient safety incidents and decreasing the overall levels of harm that result from patient safety incidents, including the number of deaths attributable to problems in care as measured by NHS Outcomes Framework indicators 5a, 5b and 5c.

- Reduce harm from pressure ulcers and medication errors demonstrated by a statistically significant difference in the numbers of these harms by Autumn 2015

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- Reduce harm from other specific patient safety incidents known to cause significant levels of harm, as measured by the Outcomes Framework domain indicators 5.1-5.6, and other priority areas as determined by NHS England

analysis and Patient Safety Collaboratives' own assessment of their local priorities.

9. There have been a number of excellent national and regional patient safety improvement initiatives in recent years including, for example, Investing in Behaviours in the North East, the Safety Express work that grew out of the QIPP Safer Care work programme, and the South West England Safety Collaborative. In addition, a number of organisations have been contributing to the focus on improving patient safety such as NHS AQuA (Advancing Quality Alliance) , NHS Quest and the Health Foundation. We must not lose the gains delivered by these organisations in these areas, but equally we need to build on this work, and ensure that the improvement effort reaches to every part of England. Our aim is to support full spread and complete engagement. We will learn from past programmes in patient safety but also from the improvement collaboratives who have had an impact across England in other clinical areas, notably in cancer, heart disease and stroke.

10. We know that this will fail if we create a system based on centralised command and control. Great work is already being done in many areas, so we will look for existing groups and teams in relevant geographical footprints/locations to apply for funding against a set of criteria. This will ensure transparency and accountability to the public about the use of resources. Successful applicants will demonstrate how all key stakeholders are or will be engaged in the safety effort, and that work is clearly cooperative, crossing sector and organisational boundaries and professions.

11. The programme will encourage and use improvement techniques in combination with the up-to-date technology, novel social media approaches and the latest thinking on large scale change to deliver and spread improvement at pace. This means we will adapt our approaches to take advantage of developments in the use of social media and new knowledge systems as they develop. We will use the Institute for Healthcare Improvement Breakthrough Collaborative methodology where appropriate, but that is by no means the only methodology that will be used. Patient Safety Collaboratives themselves will also be encouraged to innovate, using varied methods to drive improvement, including appropriate use of Human Factors, owning the responsibility to establish the effectiveness and value of their chosen methods and sharing their safety improvement practices.

12. As a publically-funded healthcare system, the NHS must demonstrate quality and value for money in everything that it does. For that reason we will set some essential ingredients that will form part of each Patient Safety Collaborative, thereby ensuring that the collaboratives are based on firm foundations in terms of capability and also contribute to key national patient

safety objectives, as well as facilitating the sharing of learning across the system and delivering a step change in safety after 12 months.

13. We are engaging widely on which priorities we should focus on in year one, but the current proposals are as follows:

- **Leadership for Patient Safety.** Delivering improvement requires leaders in every organisation to put safety first. Leaders of this safety 'movement' have a key role in enabling others to run improvement projects. They must become the guardians of their organisational learning system which is required to underpin any safety culture.

- **Measurement for Patient Safety.** If harm is not measured, reported or recorded, we cannot analyse it, understand it and determine how to improve or indeed understand whether what we are doing is working. Measuring safety is not always easy, but it is vital for improvement.

- **Pressure Ulcers.** Pressure ulcers affect around 5-6% of patients in acute hospitals, and up to 9% of people in community hospitals (NHS Safety Thermometer 2012/13). Despite this there are clear interventions that can deliver significant improvement in the burden of harm represented by pressure ulcers. Unless significant progress has already been made in an area, we propose requiring Patient Safety Collaboratives to focus on the issue of pressure damage and demonstrate rapid improvement.

- **Medication Errors.** Over 500,000 medication incidents were reported nationally between 2005 and 2010. Of these, 822 involved severe harm or death of a patient. A separate study has shown 1 in 20 prescribed items included a prescription error, with 1 in 550 classed as a serious error. Given that 1 billion items were prescribed in 2012, this equates to 1.8 million serious prescribing errors. The sheer burden of harm that results from medication error means that this should be a priority for the Collaborative programme.

14. Collaboratives will have the opportunity to demonstrate that they have already addressed one or more of the four core improvement areas and so choose to focus on other priorities if appropriate. We will also ensure that the final set of core priorities take into account the wider priorities set for the system via the usual mechanisms such as the Planning Guidance. We would also need to be clear the safety improvement work via the Collaboratives would complement but not replace other patient safety requirements set elsewhere.

The application process

14. Information on the application process is set out at **Annex A.**

Supporting the Patient Safety Collaboratives

15. We will provide guidance, tools, standards, commissioning support, and capability building support to the Patient Safety Collaboratives. In particular, NHS England's Patient Safety Domain will provide relevant patient safety expertise and advice, and NHS IQ will provide support around and lead on improvement techniques, logistics, capability building, learning and spread.

16. National 'communities of interest' will continue to be supported and encouraged to generate energy, tools and guidance for key safety concerns. These are distinct to Patient Safety Collaboratives in that they will coalesce around specific patient safety topics and concerns and will include participants from across England. They will directly link individuals and teams across the country who are interested in working on particular topics. This widens the opportunity for sharing and learning.

17. Collaborative co-ordinators will help make the links between patient safety collaboratives, providing intelligence and insight regarding wider patient safety concerns and issues and support the coordination of patient safety-related activity both within and outside the Patient Safety Collaborative programme.

Governance

18. While this programme of work is being created and supported centrally as part of the wider NHS England National Patient Safety Plan, it is important to be very clear that the local Patient Safety Collaborative teams are not under the control of or directly performance managed by, NHS England or NHS Improving Quality (a governance organogram is at **Annex B**)

19. We are proposing that the Patient Safety Collaboratives Programme 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. The National Advisory Group will be established as a sub-group of the NHS IQ Programme Board with the delegated responsibility to allocate relevant funding to each Patient Safety Collaborative based on their ability to meet the criteria set out earlier. It will also support and oversee the ability of the collaboratives to continue to meet the agreed criteria. The Group will include the Director of Patient Safety in NHS England and the NHS IQ Head of Patient Safety Programmes and other experts in relevant disciplines,

including international subject matter experts as well as application experts, representatives of supervisory organisations and individual clinicians who have demonstrated significant achievements in their own practice. It will also include representatives from local Patient Safety Collaboratives.

20. Each of the 15 Patient Safety Collaboratives will have a local steering board made up of key members of the participating organisations (Trusts, CCGs, clinical champions, at least two patient/carer representatives etc.) with a Chair. They will meet regularly (quarterly) and will hold the local Programme to account re plans, progress, performance etc.

The NHS Improvement Fellowships

21. Information on the proposed Fellowship programme is at **Annex C.**

Supporting NHS leadership capability

22. Detail on proposals to support NHS leadership capability is at **Annex D.**

Next steps

23. We are planning a 'Design Day' on 15 January to which we are inviting improvement experts, frontline clinicians, national leaders and others to further inform how we can develop a model that will be in place into the next decade but which will be organic enough to develop and reframe as our techniques of learning and sharing knowledge improve, which will meet the needs of every sector and every setting and we tap into every modality using every available tool and technique to demonstrate that we get absolute local ownership working within a national frame of ambition and confidence.

24. We will also hold 4 regional engagement events to further develop the enthusiasm and interest that this programme requires, during the course of February.

25. The Patient Safety Collaborative Programme proposals will be taken to the NHS England Board meeting on 24 January for their approval. It is after that point, and once we receive confirmation of the required programme funding through the NHS England business planning process that we would begin the process of establishing the collaboratives via receiving applications etc.

Mike Durkin
Director of Patient Safety: NHS England
December 2013

Annex A

The application process

1. We will support the principle that this is a locally-owned and led process of patient safety improvement by inviting applications for funding from locally-organised groups to run the Patient Safety Collaborative for their geographical area. We expect there to be 15 collaboratives in total covering the same geography as the Academic Health Science Networks. We expect to receive applications to run collaboratives from the AHSNs themselves who are well-placed to host and support local patient safety improvement work, however, we do not want to constrain the delivery mechanism where local organisations feel alternative proposals fit their needs.

2. Applications will therefore be welcome from alternative sources or configurations of organisations including consortia of providers or single large organisations, provided they represent a system-wide approach covering an AHSN's geography (or combination of AHSNs if felt appropriate). Applications will equally be very welcome from groups or systematic improvement collaboratives that are already in place and operational. Where these are successful and already delivering the kinds of improvement we want to see, we will look to these existing groups to become exemplar collaboratives, raising the bar for the others and at the vanguard of national improvement activity.

3. It would be important in any application to provide assurance that the application is an inclusive one, rather than receiving multiple competing applications from different organisations or groups covering the same geography. They will also need to demonstrate how they are including groups from across the local health care economy including third sector, Health and Well-Being Boards, social care providers and others - not just healthcare providers and commissioners.

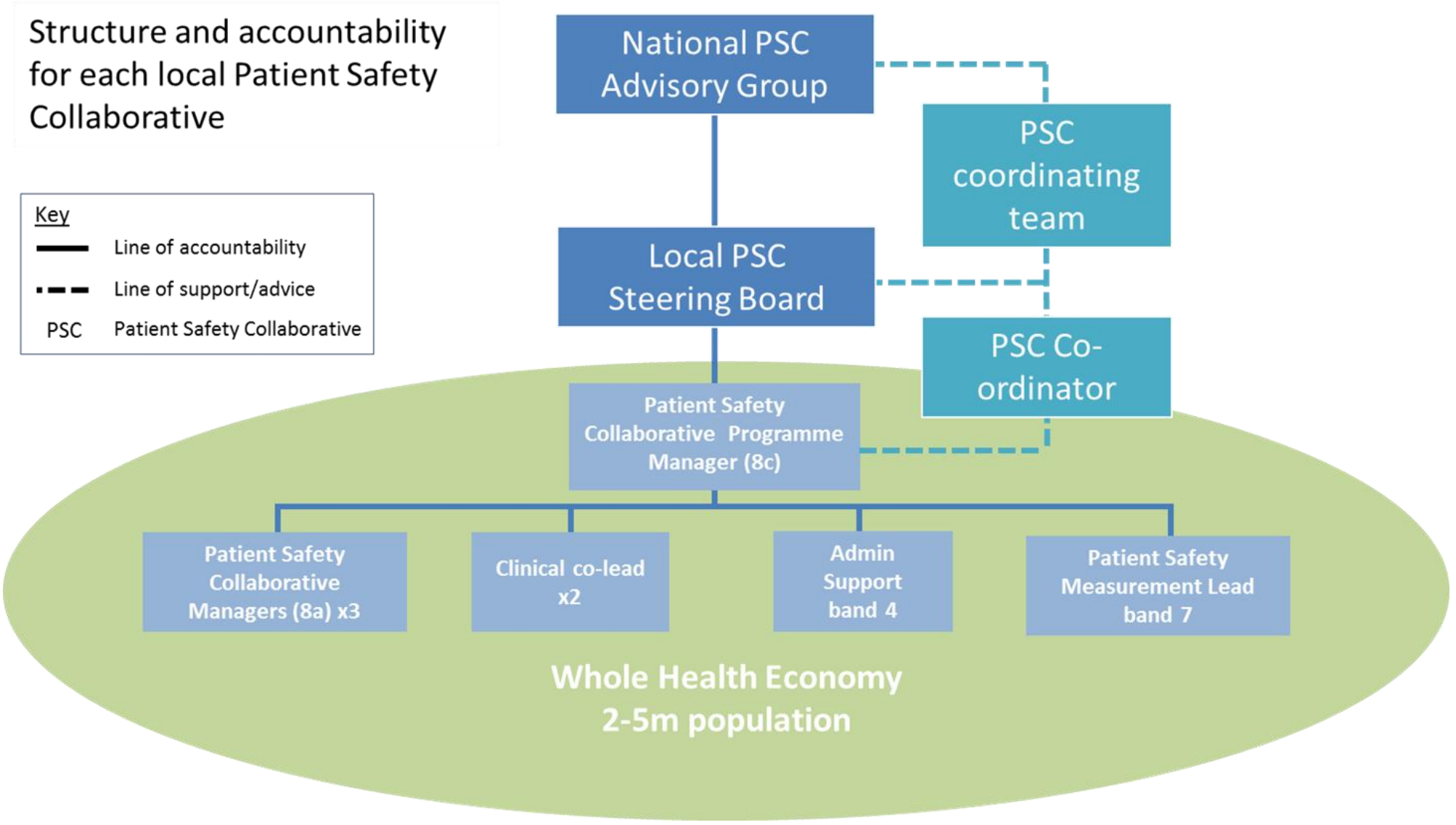
4. Prospective collaboratives will apply against a number of key selection criteria. Each Patient Safety Collaborative will need to demonstrate how it intends to meet the required criteria on a whole pathway basis, deliver measurable improved outcomes over five years, contribute to national patient safety learning, and use the available support to best effect.

5. Clarity about what is expected from each Patient Safety Collaborative and in turn what support NHS IQ and NHS England will provide will be made explicit in a written agreement following discussion and on site meetings with candidates. A detailed application and selection process will be set out.

6. Given the importance of patient involvement, the Patient Safety Collaborative programme will invite applicants who wish to become one of the 15 Collaboratives to:

    - Demonstrate in their application how they will actively and constructively involve patients and carers as equal partners throughout the collaborative work streams, going above and beyond patients/carer representation on their local PSC steering board, and including groups such as local HealthWatch.
    - State how they plan to work with each of their participant organisations (within the local safety collaborative programme), to ensure they all have a patient/carer/Lay member sitting on any governance committees that look at safety issues
    - State how (if successful) the local collaborative will work with their local patient experience team to ensure that there is a local support programme to help patients/carers to acquire the skills to help them be effective on committees.
    - State their local plans to demonstrate how they will set up/use an existing Patient and Carer Advisory Group as an integral part of the safety design work

Annex B – Governance Organogram



Annex C

The NHS Improvement Fellowships

1. We propose a Fellowship programme based on the concept of awarding Fellow status as an ‘accolade’ rather than on competing for funding/having been funded as a Fellow. The concept is based not on what training programme an individual has been on, but what they’ve done with it. We envisage creating Fellowship criteria in partnership with existing improvement experts and bodies and establishing a standing panel of NHS leaders and improvement experts who would award fellowship status to those individuals who demonstrate excellence in the field of health care quality improvement, and particularly safety improvement. They will have been trained in improvement science, applied their knowledge, and led work that improves safety outcomes.

2. Fellows would receive recognition for their contribution and we propose that, once confirmed, we would look to provide a central fund they could access for carrying out further local improvement work. They would also be expected to contribute to and provide expertise for the Patient Safety Collaboratives in their locality. NHS IQ would organise for a nationally coordinated networking structure, with regular meetings and conference sessions provided for Fellows, thus establishing a community of passionate and gifted health care improvement experts across the NHS.

Annex D

Supporting NHS leadership capability

- We propose to offer every trust and CCG the opportunity to train a senior executive to an advanced level in patient safety science (the level of the IHI Patient Safety Executive course). We would provide a UK-based course using a mixture of British faculty and IHI trained staff. This would teach an agreed model for safety. Each week long programme would train up to 50 people, so we would provide repeat courses to create a critical mass of Patient Safety Executive trained people who would then support and engage in their local Patient Safety Collaborative programmes.

- To complement this and ensure that safety capability exists on boards we are working with the NHS Leadership Academy to ensure there is a robust safety element included on their board level programmes, including significant focus on just culture and leadership for safety.

- The NHS IQ 'Patient at the Centre of Care' Programme will include a number of units which will focus on the development of safety culture and these units will be used by the Safety Programme team to train all Patient Safety Collaborative teams in safety improvement if they are not already highly qualified, using the IHI framework for safety and relevant pieces on measurement and culture and the NHS Change Model as a means to understand how to deliver sustainable change.