NQB(14)(01)(02)

NATIONAL QUALITY BOARD

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Patient Safety Collaborative Programme

A paper from the Patient Safety Domain

Purpose

1. At the December NQB meeting, a presentation was given on the work being undertaken to establish a network of Patient Safety Collaboratives across England. This paper:
   - provides an update on the work; and
   - sets out potential areas where NQB organisations could support this work.

Recommendations

2. NQB members are asked to:
   - note the work being undertaken on the Patient Safety Collaborative Programme; and
   - consider the potential areas in which they could support this work programme.

Background – Patient Safety Collaboratives

3. The Patient Safety Collaboratives Programme, launched as part of NHS England's response to the Francis and Berwick reports, aims 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.

4. This programme is still in design phase. On 15 January, a 'Design Day' was held for the Collaboratives. Around 120 senior delegates joined in London to contribute to building the Design Principles for the Patient Safety Collaborative programme and to tackle a number of specific challenges identified by the Design

Team as being crucial for ensuring successful delivery of the Collaborative programme.

5. Delegates attended from a range of organisations – NHS providers, commissioners, regulators, primary care, secondary care, mental health care – as well as international patient safety and improvement experts, including from the Institute for Health Improvement (IHI), and patients and patient advocates.

6. The outputs from the day have been collated and are available in **Annex A** and **Annex B**. Clear themes that emerged from the day were:

   - Patients, their carers and families must be at the core of the planning of this initiative and not an add-on;
   - Enable priorities to be set locally in each collaborative - national support and focus should only be used to add extra value, to make improvement easier to do;
   - Emphasise a strong focus on measuring what we are trying to improve, and measuring it correctly – at the frontline, for improvement;
   - Learn from what is already being done, not just in this country but across the world, and ensure best practice can be shared across all healthcare settings;
   - Be inclusive, listen to and involve all levels of staff within healthcare organisations;
   - Put a simple vision at the heart of the collaboratives rather than a complex system of structures and directions, and communicate it well, to establish an identity;
   - Have a central focus on learning, sharing and innovating – bring clarity to the breadth of available information;
   - Use patient safety data transparently and where appropriate to recognise where problems exist, not for blame, punishment or performance management;
   - Set up collaboratives at the right scale to ensure local buy in, so that all local people feel they can access and contribute towards their work; and
   - Ensure formative, real-time evaluation to keep the programme on track.

Next steps for the Collaboratives programme

7. Priorities for the next 4 weeks include:
    - agreeing the mechanism for identification of the bodies running each of the local Collaboratives;
    - ensuring available funding and the mechanism for sharing this funding with the Collaboratives; and
    - setting dates for engagement with potential host organisations and a number of regional events to communicate the more structural and formal elements of the programme.

Considerations for NQB

8. Key to the success of the programme will be ensuring that the wider system recognises and contributes as appropriate to the Collaboratives programme. Below we have suggested how NQB member bodies could contribute, but members will wish to consider these proposals in more detail:

There is a considerable role for organisational regulators and supervisors – **CQC, Monitor, TDA** – in ensuring that the work of the Collaboratives goes with the grain of the regulatory system. In particular, we think it important that efforts to engage and contribute to the Collaborative programme by relevant providers are recognised and encouraged by the regulatory/supervisory system.

It would be a very powerful driver for engagement and therefore improvement if regulators and supervisors could ask the question ‘’how are you working across the local system to improve the safety and quality of what you do?’’

There is a significant role for professional regulators and educators – **GMC, NMC, HEE and others** – in ensuring staff receive appropriate recognition for their improvement efforts and are encouraged to do so through processes such as revalidation and through relevant training and education. Ensuring patient safety improvement forms a fundamental part to relevant curricula is key.

Patient advocates and representatives – including **Healthwatch** – and particularly at the local level, should be core partners in the improvement activity. Collaborative improvement programmes must reflect patient and carer priorities, involve them in governance, planning and implementation, and be supported by relevant local patient groups.

The aim is that expert bodies – **NICE, PHE, SCIE** – will consider Collaborative programmes as a rich resource for the development and identification of best practice. They will also have a key role in ensuring Collaboratives are able to use the most effective and evidence-based interventions to improve the safety and quality of care, and in contributing to the knowledge and innovation spread that the Collaboratives programme will rely on.

Specific points raised by NQB members on 3 December

9. NQB members raised a number of queries during discussion on 3 December, which we have collated and responded to below:

10. Perception of the programme as top-down – NQB members highlighted that there is a risk that the programme could be perceived as top-down. Although, this is a relevant challenge, feedback received at the Design Day (Annex A and B), indicates any form of top-down approach is not an option. The role of the centre will be to provide support and add value, not performance manage. NQB organisations will be as crucial as any other partners in ensuring the message of local design and implementation is reinforced and that there is no reversion to central command and control or performance management.

11. Concerns that the programme could appear to focus on past harm rather than prevention – NQB members expressed some concern that the Collaborative programme would be focussed on recording, measuring and investigating past harm to the detriment of prevention. Whilst this is an understandable concern, the Collaborative programme is focussed on improvement, which requires prevention to be a central principle. Success must ultimately be measured through improved outcomes, not recording and measuring harm.

12. Evidence base for the Collaborative approach – NQB members queried whether evidence had shown that a collaborative improvement approach would work better than any other approach.

We are not wedded to a single methodology – any evidence-based improvement methodology is potentially relevant and inevitably, mixed methods will be used. The concept of using collaborative methods is based on learning from the US, Scotland, Denmark, the North East of England and the South West of England, all of whom have successfully demonstrated that with the right approach to improvement, which we will emulate, improving safety is achievable. For example the South West has demonstrated;

- HSMR – 20% reduction from 2009 baseline
- MRSA bloodstream infection rate in ITU –seven out of sixteen units have had no cases for a year or more
- VAP - nine units reporting zero cases for one year or longer. In seven it is over 2 years since the last case.
- patients with observations complete – from 79.26 to 100% compliance
- falls resulting in harm reported by five hospitals shows a reduction from five in 2011 to zero or one in 2013
- patients with no medication reconciliation at admission –improved from 25% in June 2011 to less than 10%
- compliance with World Health Organisation (WHO) check list – compliance over 99% since September 2012

13. Success criteria for the Collaboratives' activities, setting aspirations and clarity about aims – The NQB highlighted that it would be vital for success criteria to be developed at the start of the programme. Our intention is to develop these at the outset with the local organisations who will run the Collaboratives. They will include measures of participation and culture as well as outcomes and process measures, and we will work with participants to determine how success will be defined in terms of achievements. There does need to be an aspiration to excellence and provide and support an inspiring vision for the system.

14. Involvement of Human Factors - The power of Human Factors approaches lie in their considered application at the front line as part of business as usual, including as part of improvement work. While we will not be dictating how Collaboratives work, we do intend to look for evidence of how each Collaborative intends to fulfil the aspirations of the Human Factors concordat.

15. The risk of yet another group - Initiative fatigue and adding confusion to the system is a real risk. There is not a simple, existing organisational model that fits all the necessary criteria, but using Academic Health Science Network (AHSN) footprints provides several advantages. Key will be ensuring the model is permissive to adaptation and involvement of relevant local groups and is not constrained by any organisational barriers.

16. Cross-system focus - A clear message from the Design Day and one which we have been clear on from the start is that the Collaborative programme must work across the system in all settings and not be limited to the acute sector where our understanding of safety is arguably greatest. This includes a clear focus on MH care safety issues including areas like suicide and self-harm, access, restraint and psychological safety as well as other areas perceived as not receiving sufficient attention (Children and Young People, Learning Disabilities, offender health etc.)

The contribution of technology and medical devices

17. The NQB asked NHS England about patient safety improvement work in terms of the design of technology and medical devices. NHS England is working closely with MHRA, including in relation to devices safety. Current initiatives include a New Patient Safety Alert on improving the reporting and learning from medical device incidents. This involves joint working and incident sharing with the MHRA and the alert will require the identification of Medical Device Safety Officers in large healthcare provider and commissioning organisations and the formation of a National Medical Device Safety Network to improve reporting and share safer practice. This Network will work with the patient safety Collaboratives to address device safety concerns.

18. NHS England has also issued a new Patient Safety Alert on the risks from non-use of haemofiltration heaters and is considering issuing other Alerts on risks from the unsafe design of some ECG machines and the risks from omitted or delayed medical devices.

NQB members are asked to:

- ***note progress to date;***
- ***consider the potential areas in which they could support this work programme.***

Mike Durkin

Director: Patient Safety, NHS England

Annex A – See Patient Safety Collaborative Design Day Rules

Annex B – See Patient Safety Collaborative Design Day Challenge Questions