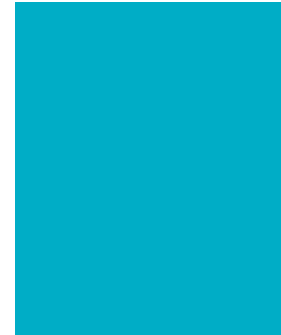
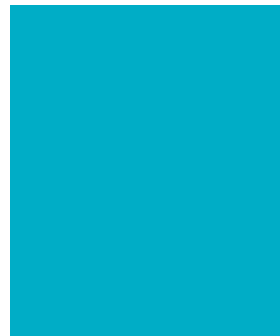


The Patient Safety Collaboratives Programme 2014-2019



Creating a system
devoted to
continual learning
and improvement



A system devoted to continual learning and improvement

NHS
Improving Quality

NHS
England

Don Berwick Findings

“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.”

“Our most important recommendations for the way forward envision the NHS as a learning organisation, fully committed to the following:”

- Placing the quality of patient care, especially patient safety, above all other aims:
- Engaging, empowering, and hearing patients and carers throughout the entire system and at all times:
- Fostering whole-heartedly the growth and development of all staff, including their ability and support to improve the processes in which they work:
- Embracing transparency unequivocally and everywhere, in the service of accountability, trust, and the growth of knowledge.

The Patient Safety Collaborative for England

Key features:

- ✓ Learning from the past, adapting what works in improvement
- ✓ Systematic application across England with widespread engagement
- ✓ Positioned as transformational not transactional change
- ✓ Set within the context of NHS England's Patient Safety Plan
- ✓ Clinically led; across all healthcare organisations and all sectors – providers and commissioners
- ✓ Focused on less but at scale to demonstrate results in year one
- ✓ Using a range of improvement tools, techniques, social movement approaches and capability building

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The programme has two major strands

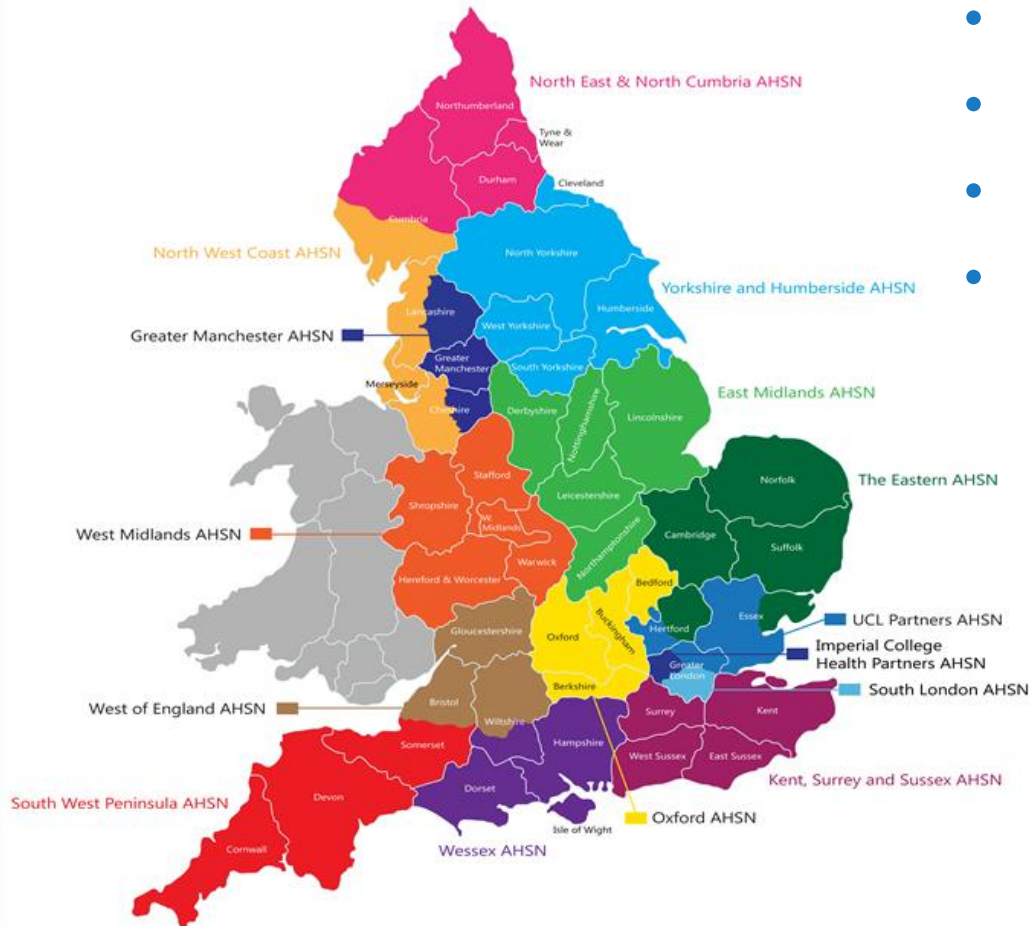
Establish and support **15 networked and connected Patient Safety Collaboratives** across England - focused on delivering definitive and measurable improvements in specific patient safety issues over the next 5 years

Build System wide capability for patient safety across England **through a systematic education and training programme** - in collaboration with key education and capability partners with safety becoming a core skill across healthcare

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Patient safety collaboratives



- AHSN footprint
- 2-5m population
- Call for bids
- Around £500k funding for;
 - 1 collaborative manager
 - 2 clinical co-leads
 - 1 analytical lead
 - 3 improvement managers and 1 admin support
 - + locally commissioned improvement support

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Patient safety collaboratives – core priorities

Core Collaborative improvement areas	Pressure Ulcers		Medication Errors		Measurement		Leadership	
NHS Outcomes Framework Improvement Area	VTE		HCAI		Maternity		Deterioration in children	
Tackling other major sources of death and severe harm	Falls	Handover and Discharge	Nutrition and hydration	AKI	Deterioration in adults	<i>Plus any focus where the collaborative can make the case that it represents a major source of avoidable harm</i>		
Improving safety for vulnerable patient groups	People with Mental Health needs	People with Learning Disabilities	Children	Offenders	Acutely ill older people	Transition between paediatric and adult care		

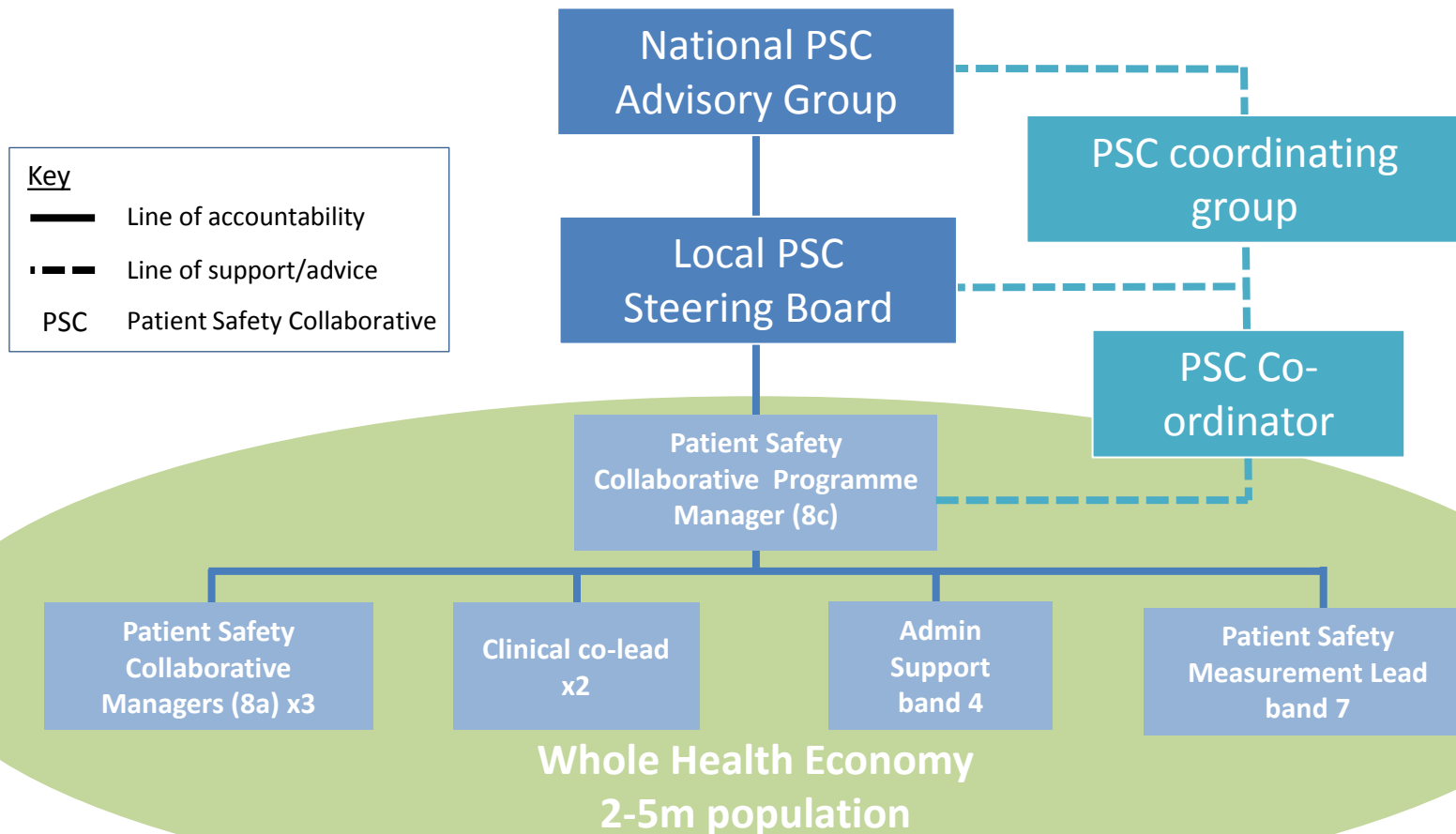
Patient involvement

Whole pathway, and cross-sector

Evidence-based with consistent measurement for 5 years, centrally supported.

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Structure and accountability for each local PSC



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What we will achieve in year 1

Establish and connect 15 improvement collaboratives covering every geographical part of England .

Creation of a NHS Improvement Fellows programme; we propose 200 Fellows in year one, 1000 by end of year two, 5000 by end of year five.

Develop and embed a nationally consistent system for patient safety measurement and improvement across each collaborative.

Ensure 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).

Reducing harm from pressure ulcers and medication errors demonstrated by a statistically significant difference in the numbers of these harms.

For discussion

- What more can we do to make this a success?
- How do we balance local ownership with national priorities?
- How do we keep this adaptable and responsive?
- How do we make it work for all sectors and across sectors?
- To what extent does this need sub-national coordination?
- What improvement methodologies should we employ?
- What are the major pitfalls we need to avoid?
- Anything else?