Patient Safety Collaboratives: Innovating to tackle the leading causes of harm to patients

*Dr Janet Williamson & Dr Mike Durkin*

Creating a system devoted to continual learning and improvement
“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.
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
Underpinning principle

- Pathway of care
- Whole system
- Many interdependencies
- Not one solution
- Context specific
The programme has three 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.

Create a national movement for safety, supporting 'lots of lots' - conferences, campaigns, young HCPs who are tomorrows leaders, use of media, social media and other communication methods such as hackathons, virtual summits and other innovative methods to galvanize and enthuse and build momentum.
Collaboration, Commitment and Courage

Seven Day Whole System - Communities of Practice
A system devoted to continual learning and improvement

Patient safety collaboratives

- AHSN footprint
- 2-5m population
- Call for applications
- Devolved funding for;
  - 1 collaborative manager
  - 2 clinical co-leads
  - 1 analytical lead
  - 3 improvement managers and 1 admin support
  - + locally commissioned improvement support
### Patient safety collaboratives – core priorities

<table>
<thead>
<tr>
<th>Core Collaborative improvement areas</th>
<th>Pressure Ulcers</th>
<th>Medication Errors</th>
<th>Measurement</th>
<th>Leadership</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Outcomes Framework Improvement Area</td>
<td>VTE</td>
<td>HCAI</td>
<td>Maternity</td>
<td>Deterioration in children</td>
</tr>
<tr>
<td>Tackling other major sources of death and severe harm</td>
<td>Falls</td>
<td>Handover and Discharge</td>
<td>Nutrition and hydration</td>
<td>AKI</td>
</tr>
<tr>
<td>Improving safety for vulnerable patient groups</td>
<td>People with Mental Health needs</td>
<td>People with Learning Disabilities</td>
<td>Children</td>
<td>Offenders</td>
</tr>
</tbody>
</table>

**Patient involvement**
- Whole pathway, and cross-sector
- Evidence-based with consistent measurement for 5 years, centrally supported.
A system devoted to continual learning and improvement

Possible structure and accountability for each local PSC

Key
- Line of accountability
- Line of support/advice
- PSC Patient Safety Collaborative

Whole Health Economy
2-5m population
**National v local** – building the learning system to support a safety culture & continuous improvement. Building networks that align to local clinical communities.

Transparent sensible measurement - : “If you’re not measuring you’re not improving, if you are measuring stupidly you are not improving, and if you are only measuring you are not improving” – Mary Dixon Woods.

**Inclusion** – patients equity partnership

**Preparedness** – work before the work – don’t start too soon. Prepare staff, communicate, build in evaluation from the start. Build in capability and embed as part of the day job.

**Leadership, sustainability** – what does success look like? Align system drivers.
Leading improvement from the future….  

Giving voice to young leaders, trainees & students  

Crowdsourcing: getting a very big crowd of people to help with a task  

Hackathon  

- innovate  
- share  
- connect  
- collaborate
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.
Next Steps:

• Work on the process for getting the finance to localities & process for application/bids: Grant or procurement?
• Working through the design principles from the design day event to incorporate into the safety plan
• Writing a spec that reflects design principles - How do we balance local ownership with national priorities?
• Engagement events – to describe the process and engage & stimulate interest in localities on safety plans
“BE AMBITIOUS AND NOT CONSTRAINED BY THE PAST”

Patients NHS England AGM 2013

- Transactional change: Doing things better
- Process
  - Service - pathway
  - Strategic whole system
- Transformational change:
  - Doing better things
  - How we deliver care