



West of England
Academic Health
Science Network

WEST OF ENGLAND
ACADEMIC HEALTH
SCIENCE NETWORK

**Patient Safety
Collaborative Annual
Report 2016/17
Appendices**

Appendices

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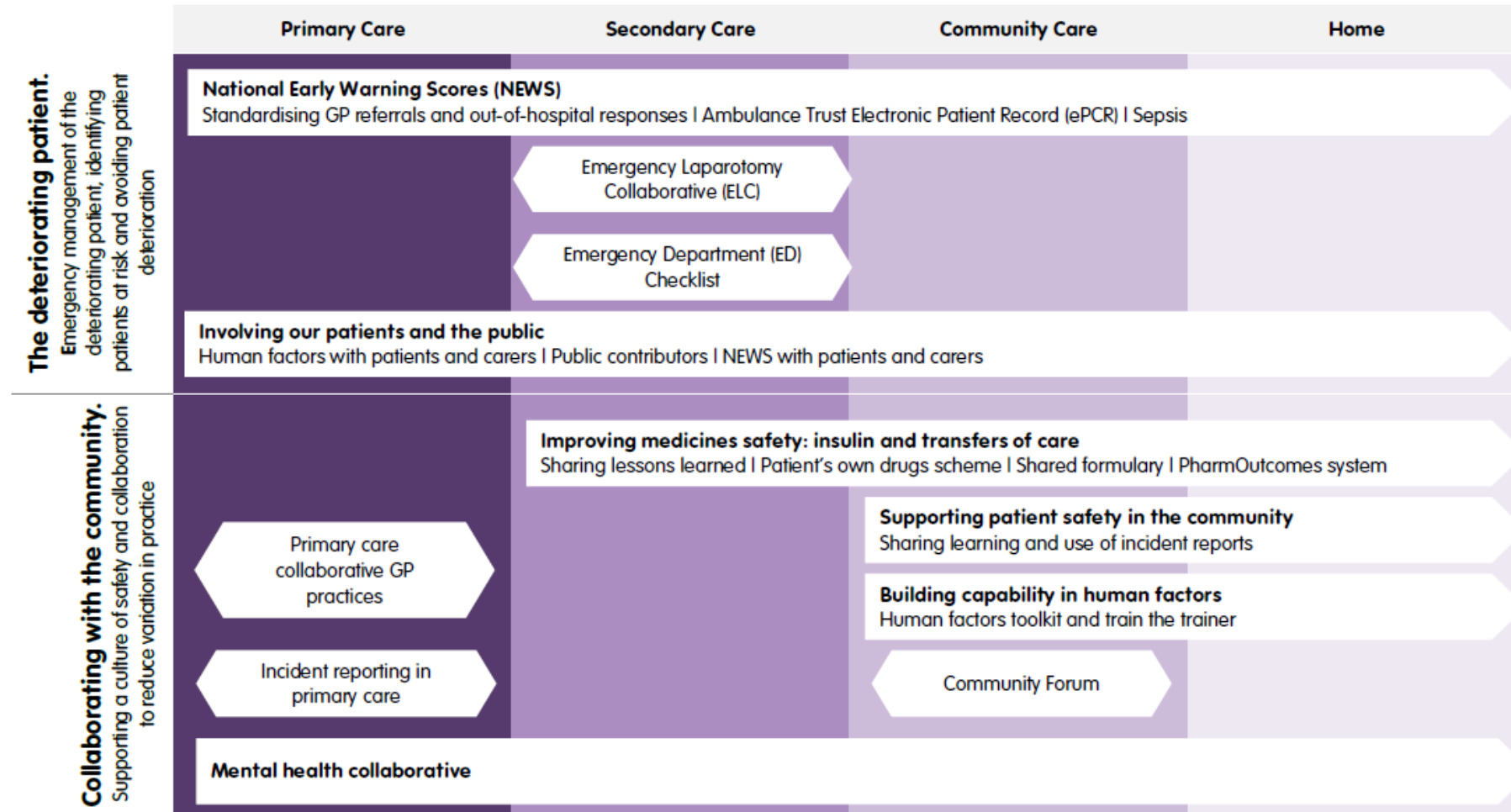
Appendix 1: West of England Patient Safety Collaborative Organisations

Organisations 2016/17
2gether NHS Foundation Trust
Bath and North East Somerset Clinical Commissioning Group
Bristol Clinical Commissioning Group
Bristol Community Health
Gloucestershire Clinical Commissioning Group
Gloucestershire Care Services NHS Foundation Trust
Gloucestershire Hospitals NHS Foundation Trust
Great Western Hospitals NHS Foundation Trust
North Bristol NHS Trust
North Somerset Clinical Commissioning Group
North Somerset Community Partnership
Royal United Hospitals Bath NHS Foundation Trust
Sirona Care and Health Community Interest Company
South Gloucestershire Clinical Commissioning Group
South Western Ambulance Services NHS Foundation Trust
Swindon Community Health Services (previously recorded as SEQOL until Jan 2017 Board meeting)
Swindon Clinical Commissioning Group
University Hospitals Bristol NHS Foundation Trust
Weston Area Health NHS Trust
Wiltshire Clinical Commissioning Group
Wiltshire Health and Care

Partners in attendance 2016/17
Bath, Gloucester, Swindon and Wiltshire Area Team
NHS England

Patient Safety Collaborative – supporting and enabling improvement

Plan on a Page 2016/17



Connect with us  www.weahsn.net  @weahsn  patientsafety@weahsn.net
WE CARE – WE QUESTION – WE HELP – WE CREATE – WE DEBATE – WE COLLABORATE – WE INNOVATE – WE WORK

Patient Safety Collaborative: plan on a page 2016/17

Each year in the West of England...



On average 22% of patients with diabetes on insulin experienced one or more insulin prescription or management errors during their inpatient stay; we are working with our hospitals to reduce this.

Supporting ePCR for ambulance services across South West



SECONDARY



ED Safety Checklist will be used in 200,000 major cases.



Using NEWS and ED checklist for the 218,000 people admitted each year will get people the right care quicker to improve outcomes.



Emergency laparotomy collaborative implementing care bundle approach

1,100 patients have an emergency laparotomy, with 85% survival rate.

Around 3,600 people develop sepsis, with only 65% survival rate.

Using the National Early Warning Score (NEWS) as a common language across the system will improve care for the 350,000 patients transported by ambulance to our hospitals each year.



Human Factors target 2,500 staff trained in six organisations including staff working in patient's homes, care homes and prisons in next 12 months, plus a faculty over 40 facilitators.

Our community forum links together six community providers to share learning on safety incidents.

HOME & COMMUNITY



WE COLLABORATE FOR SAFER PATIENT CARE

www.weahsn.net
contactus@weahsn.net

Find out more... @WEAHSN



3,500 reported incidents of violence and aggression. Our two mental health trusts are collaborating with others across the South of England to reduce these as well as reducing self-harm.

MENTAL HEALTH



14 GP practices in our Primary Care Collaborative

PRIMARY

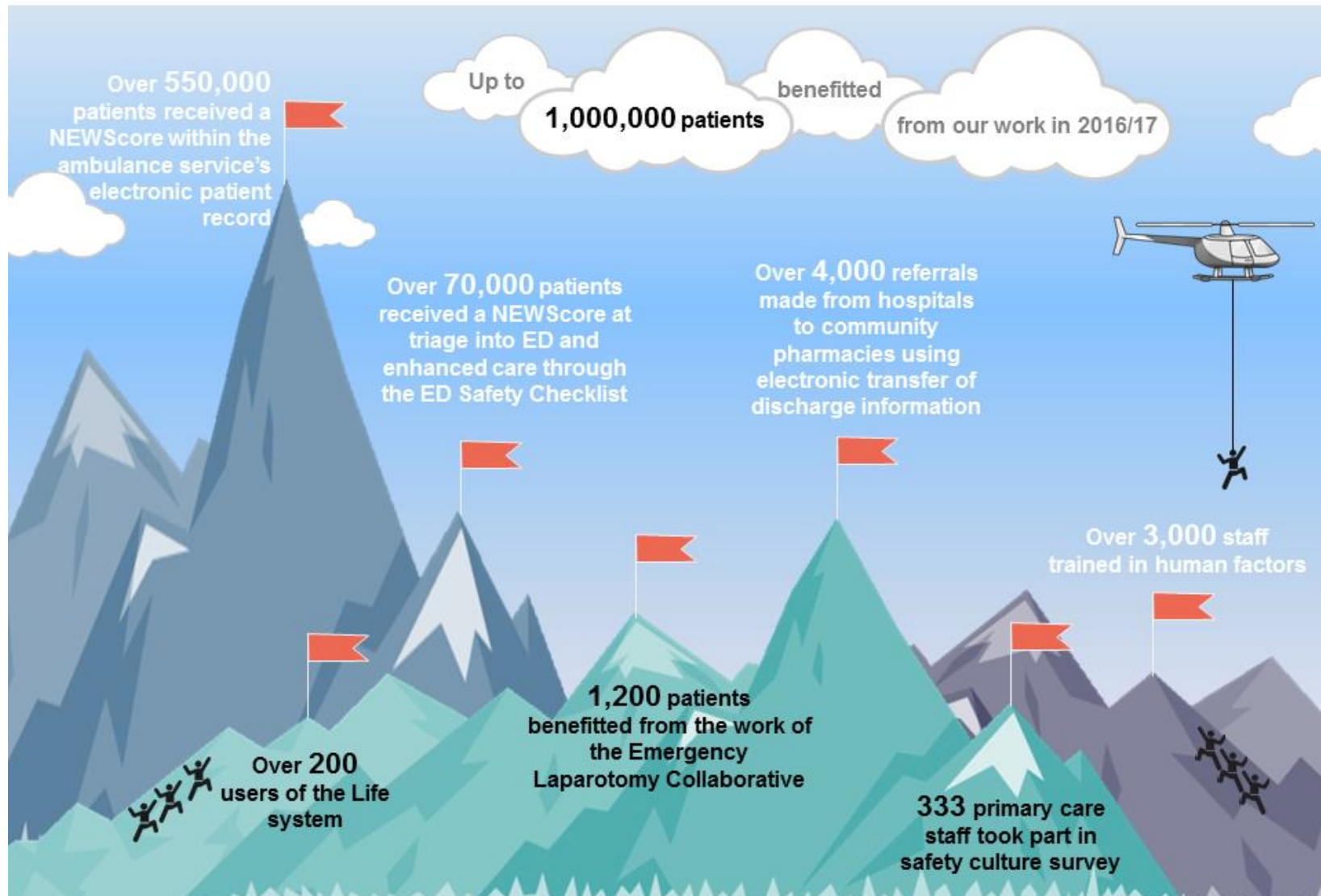
Appendix 3: What we've achieved



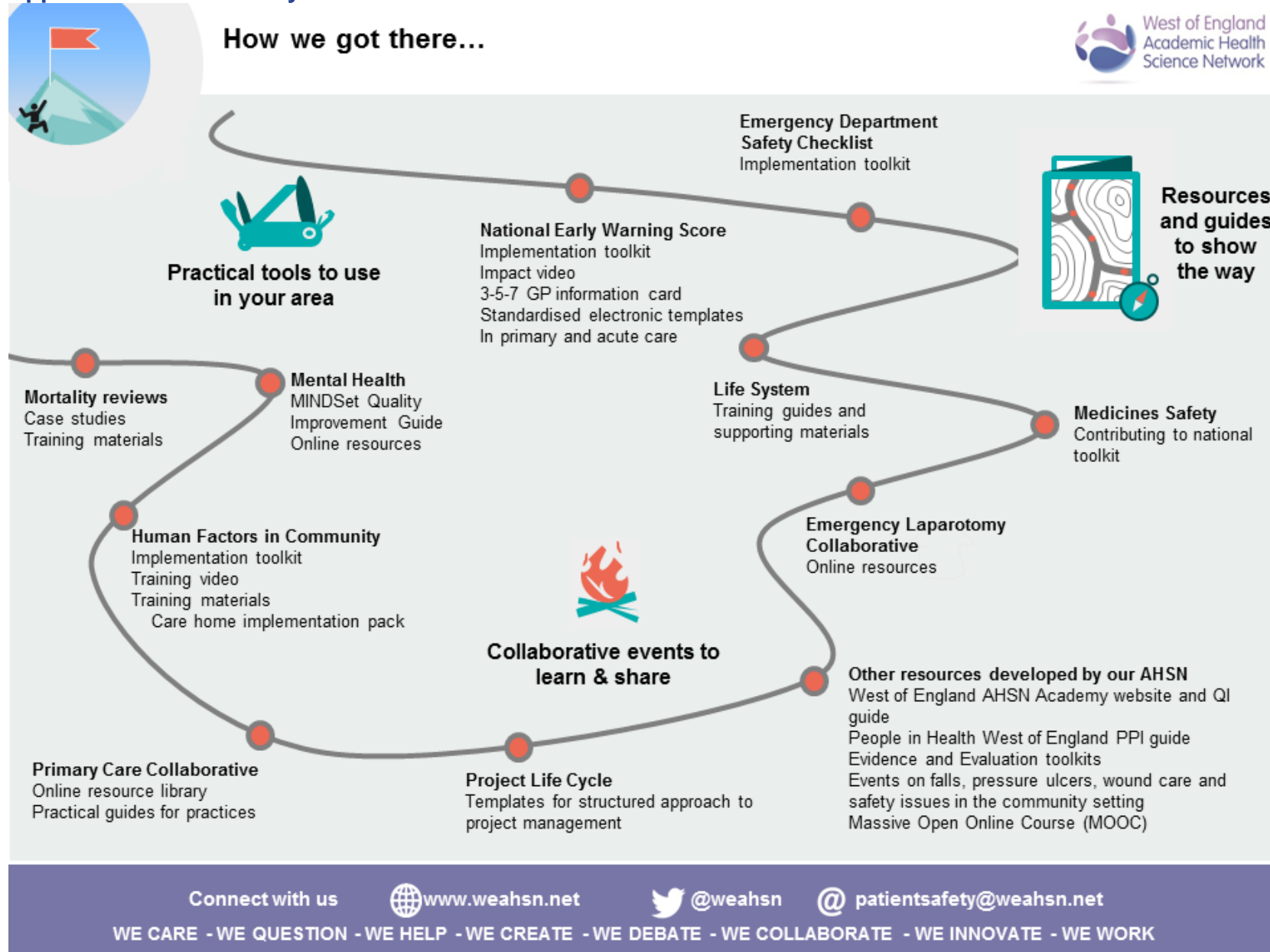
Patient Safety Collaborative – Highlights from 2016/17



Organisations involved in our Patient Safety Collaborative have reached the following peaks...



Appendix 4: Our Journey



Appendix 5: West of England Emergency Laparotomy Collaborative Results

Measure / Outcome	Baseline ¹	2015/16 Q3	2015/16 Q4	2016/17 Q1	2016/17 Q2	2016/17 Q3	Baseline to 16/17 Q3 actual change	Baseline to 16/17 Q3 % change
WEST OF ENGLAND								
Blood Lactate	66.4%	68.2%	74.1%	76.8%	76.9%	79.5%	13.1%	19.7%
Antibiotics Before Surgery	55.9%	50.4%	56.0%	57.1%	54.8%	51.0%	-4.9%	-8.8%
Time To Theatre (hrs) – Immediate	73.0%	62.5%	74.3%	77.8%	65.7%	86.4%	13.4%	18.4%
Time To Theatre (hrs) – Urgent 2A	79.6%	78.4%	74.4%	81.6%	73.2%	79.1%	-0.5%	-0.6%
Goal Directed Fluid Therapy	29.7%	35.7%	31.3%	28.5%	35.4%	47.3%	17.6%	59.3%
Post Op Critical Care	62.2%	66.7%	67.4%	68.6%	76.5%	77.4%	15.2%	24.4%
Consultant or Post-CCT Anaesthetist	73.3%	81.8%	83.2%	84.2%	84.7%	86.6%	13.3%	18.1%
Consultant or Post-CCT Surgeon	82.8%	84.3%	88.0%	91.2%	87.4%	94.6%	11.8%	14.3%
Consultant or Post-CCT Anaesthetist and Surgeon	64.2%	70.4%	73.7%	78.2%	75.2%	82.8%	18.6%	29.0%
Composite Quality Score	56.3%	58.7%	60.6%	62.9%	63.8%	67.9%	11.6%	20.6%
Length of Stay	19.5	18.4	18.5	18.8	18.6	16.4	- 3.1	-15.9%
In Hospital 30 day Crude Mortality	9.9%	10.4%	9.8%	10.7%	8.2%	10.9%	1.0%	10.1%
In Hospital 30 Day Risk Adjusted Mortality (using Pre-Op P-POSSUM)	5.3%	5.8%	5.8%	6.5%	3.8%	7.0%	1.7%	32.1%
In Hospital 30 Day Risk Adjusted Mortality (using Post-Op P-POSSUM)	5.3%	6.1%	5.7%	6.4%	3.9%	6.8%	1.5%	28.3%
Patient Volume	1,468	280	316	354	294	239		

Notes:

1. Baseline of Emergency Laparotomy cases over a 15 month period from July 2014 to September 2015
2. This appendix will be updated in May 2017 to show numbers of cases in addition to the percentages.
3. Contact kevin.hunter@weahsn.net for further information

Measure / Outcome	Baseline	2015/16 Q3	2015/16 Q4	2016/17 Q1	2016/17 Q2	2016/17 Q3	Baseline to 16/17 Q3 actual change	Baseline to 16/17 Q3 % change
ALL								
Blood Lactate	62.2%	66.1%	70.2%	70.0%	72.3%	74.1%	11.9%	19.1%
Antibiotics Before Surgery	56.6%	54.7%	55.7%	56.1%	59.7%	56.8%	0.2%	0.4%
Time To Theatre (hrs) – Immediate	63.2%	70.3%	67.8%	71.7%	69.0%	71.0%	7.8%	12.3%
Time To Theatre (hrs) – Urgent 2A	77.2%	78.5%	79.1%	82.3%	76.6%	78.2%	1.0%	1.3%
Goal Directed Fluid Therapy	40.7%	44.6%	45.3%	39.3%	43.0%	48.5%	7.8%	19.2%
Post Op Critical Care	61.9%	66.8%	67.9%	66.9%	72.0%	72.6%	10.7%	17.3%
Consultant or Post-CCT Anaesthetist	75.5%	82.7%	87.1%	85.8%	87.4%	85.4%	9.9%	13.1%
Consultant or Post-CCT Surgeon	87.5%	90.5%	91.9%	92.2%	91.7%	94.6%	7.1%	8.1%
Consultant or Post-CCT Anaesthetist and Surgeon	68.6%	75.8%	80.9%	80.4%	81.1%	81.7%	13.1%	19.1%
Composite Quality Score	58.1%	61.8%	63.9%	63.0%	65.5%	66.2%	8.1%	13.9%
Length of Stay	20.1	18.7	18.9	19	19.2	15.9	-4.2	-20.9%
In Hospital 30 day Crude Mortality	9.7%	9.0%	9.6%	8.7%	7.5%	8.1%	-1.6%	-16.5%
In Hospital 30 Day Risk Adjusted Mortality (using Pre-Op P-POSSUM)	5.3%	4.7%	5.5%	4.7%	3.5%	4.4%	-0.9%	-17.0%
In Hospital 30 Day Risk Adjusted Mortality (using Post-Op P-POSSUM)	5.3%	4.8%	5.6%	4.5%	3.5%	4.4%	-0.9%	-17.0%
Patient Volume	5,898	1,185	1,217	1,320	1,194	911		

Notes:

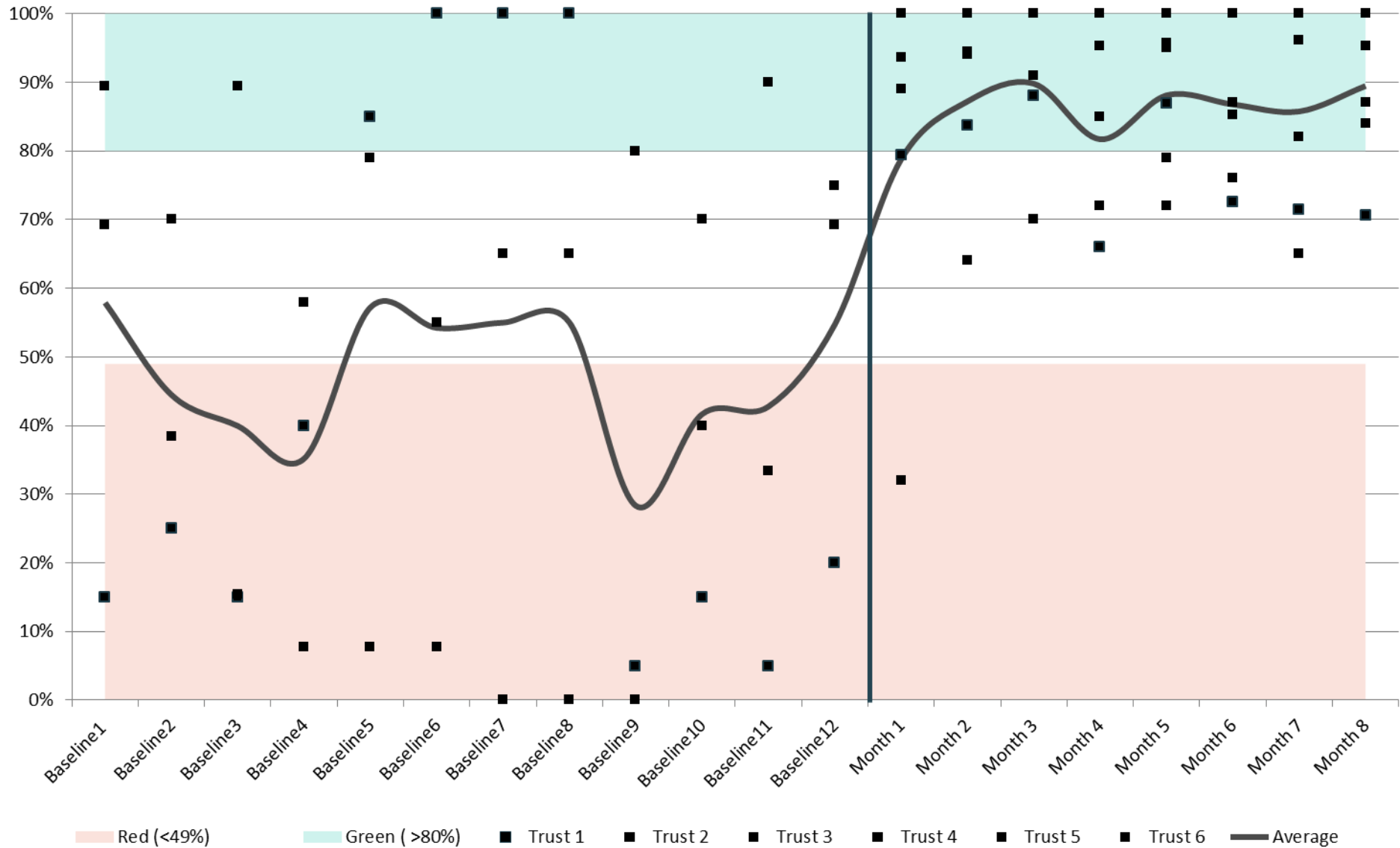
1. Baseline of Emergency Laparotomy cases over a 15 month period from July 2014 to September 2015
2. This appendix will be updated in May 2017 to show numbers of cases in addition to the percentages.
3. Contact kevin.hunter@weahsn.net for further information

Appendix 6: Emergency Department Collaborative results

NEWS at triage	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Trust 1			94%	94%	100%	95%	95%	100%	100%
Trust 2	94%	91%	85%	96%	85%	96%	95%	95%	100%
Trust 3			76%	84%	86%	66%	100%	73%	71%
Trust 4	100%	100%	100%	100%	100%	100%	100%	100%	100%
Trust 5	98%	98%	100%	98%	98%	96%	100%	80%	100%
Trust 6	99%	100%	100%	97%	100%	100%	97%	99%	100%
AVERAGE	98%	97%	92%	95%	95%	92%	98%	91%	95%
Vital Signs Measured Hourly	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Trust 1			77%	88%	64%	95%	63%	83%	91%
Trust 2	78%	78%	78%	83%	65%	92%	58%	73%	75%
Trust 3			50%	12%	38%	25%	67%	13%	15%
Trust 4		60%	70%	70%	66%	69%	76%	73%	75%
Trust 5	58%	56%	54%	62%	60%	74%	75%	93%	93%
Trust 6	88%	84%	77%	96%	99%	95%	76%	94%	88%
AVERAGE	75%	69%	68%	68%	65%	75%	69%	71%	73%
Analgesia administered at Triage (if appropriate)	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Trust 1			80%	100%	75%	100%	100%	96%	100%
Trust 2	86%	100%	69%	100%	67%	75%	75%	100%	100%
Trust 3			41%	30%	30%	12%	0%	5%	9%
Trust 4	81%	94%	100%	88%	100%	100%	100%	100%	100%
Trust 5	82%	86%	92%	86%	92%	73%	100%	63%	69%
Trust 6	85%	84%	84%	87%	100%	88%	83%	91%	90%
AVERAGE	83%	91%	78%	82%	77%	75%	76%	76%	78%
Pain Score assessed hourly	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Trust 1			76%	88%	55%	90%	65%	87%	97%
Trust 2	78%	77%	82%	79%	65%	84%	25%	73%	75%
Trust 3			38%	12%	35%	19%	100%	13%	8%
Trust 4	67%	62%	85%	83%	80%	82%	88%	85%	86%
Trust 5	78%	80%	90%	60%	68%	65%	75%	67%	87%
Trust 6	83%	81%	70%	91%	99%	89%	75%	89%	83%
AVERAGE	76%	75%	73%	69%	67%	72%	71%	69%	73%
Stroke - CT within 1st Hour									
Trust 1			0%	0%	-	100%	33%	0%	50%
Trust 2	-	-	-	-	-	-	-	-	-
Trust 3			100%	100%	100%	100%	-	-	100%
Trust 4	92%	100%	100%	100%	100%	100%			
Trust 5	-	100%	-	-	-	-	-	-	-
Trust 6	99.3%	98.7%	100%	98.7%	80.7%	96%	100%	97.3%	100%
AVERAGE									
Chest Pain - ECG done & reviewed within 30mins / ECG reviewed within 30mins of ECG	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Trust 1			96%	100%	100%	94%	93%	100%	100%
Trust 2	100%	100%	100%	100%	100%	60%	80%	100%	100%
Trust 3			69%	45%	73%	61%	60%	69%	51%
Trust 4		75%	83%	92%	88%	92%	95%	95%	90%
Trust 5	78%	91%	89%	100%	80%	67%	-	100%	-
Trust 6	95%	95%	99%	100%	100%	99%	95%	95%	99%
AVERAGE	91%	90%	89%	90%	90%	79%	85%	93%	88%

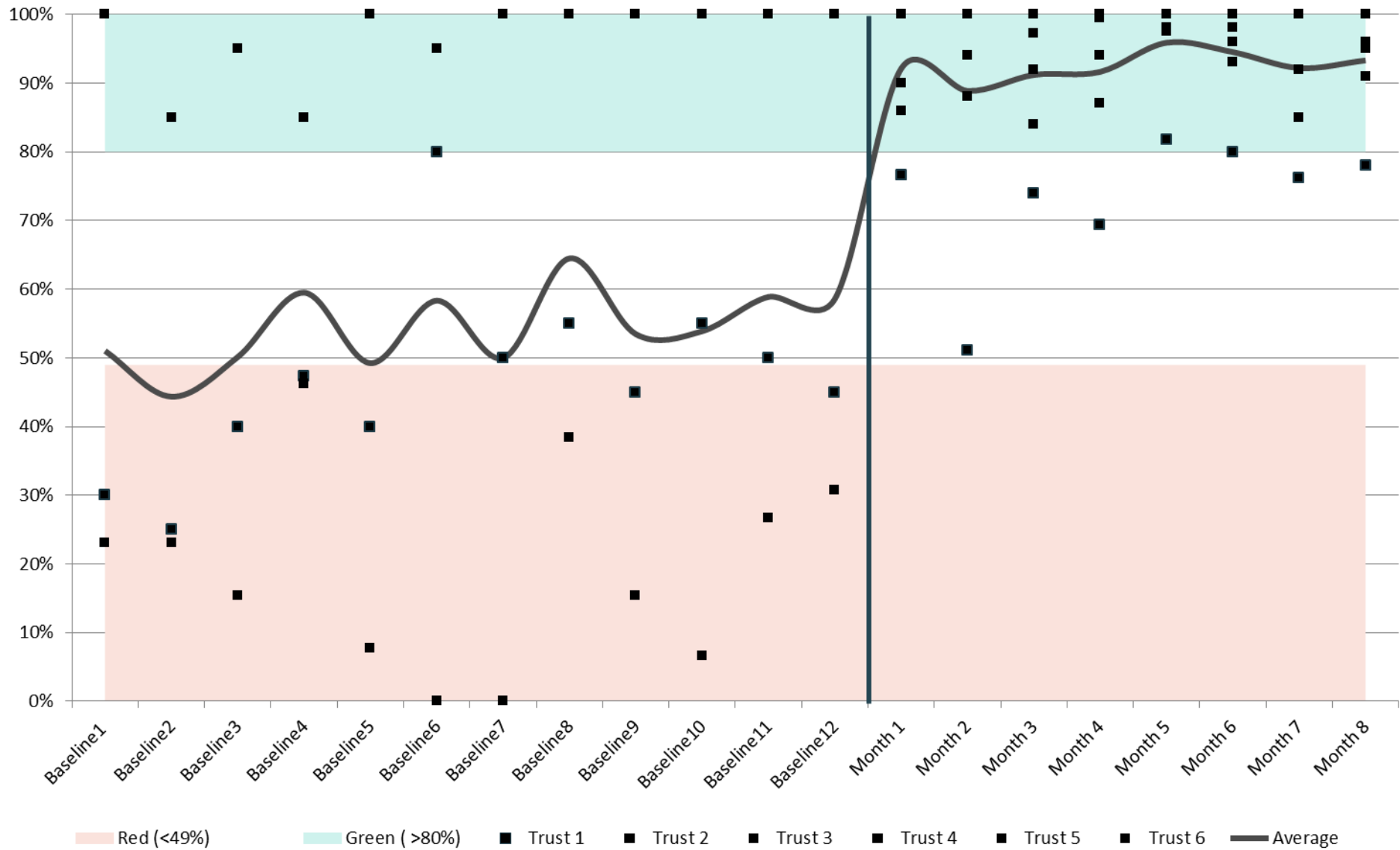
Note: baseline = mean of 3 trusts performance,
implementation = mean of 5 trusts

NEWScore on admission to ED



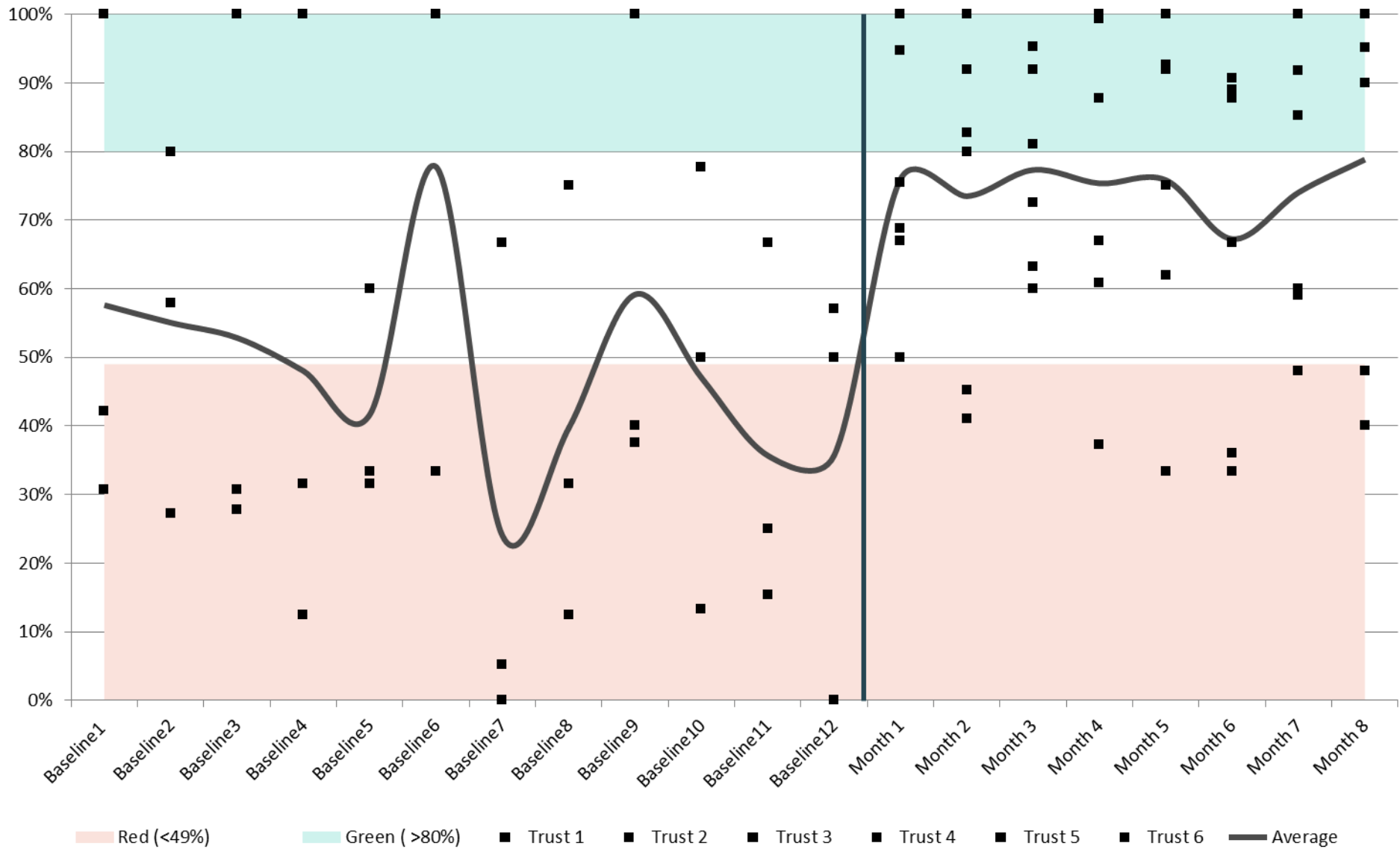
Note: baseline = mean of 3 trusts performance,
implementation = mean of 5 trusts

Pain Score at Triage



Note: baseline = mean of 3 trusts performance,
 implementation = mean of 5 trusts

ECG within 10 min of arrival at ED



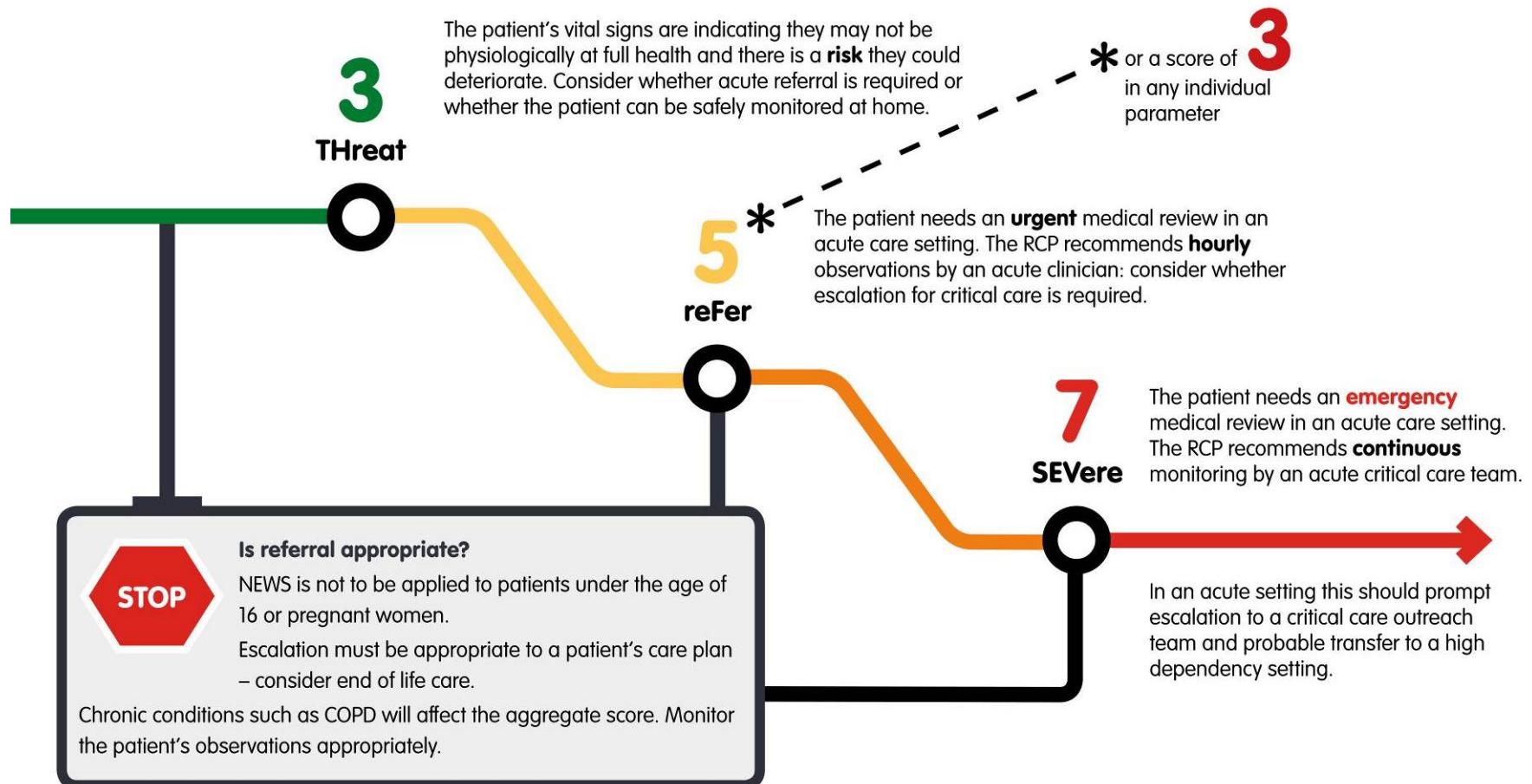
Appendix 7: NEWS Trigger diagram

What NEWS means for your patient:
your guide to NEWS for **normally well patients**

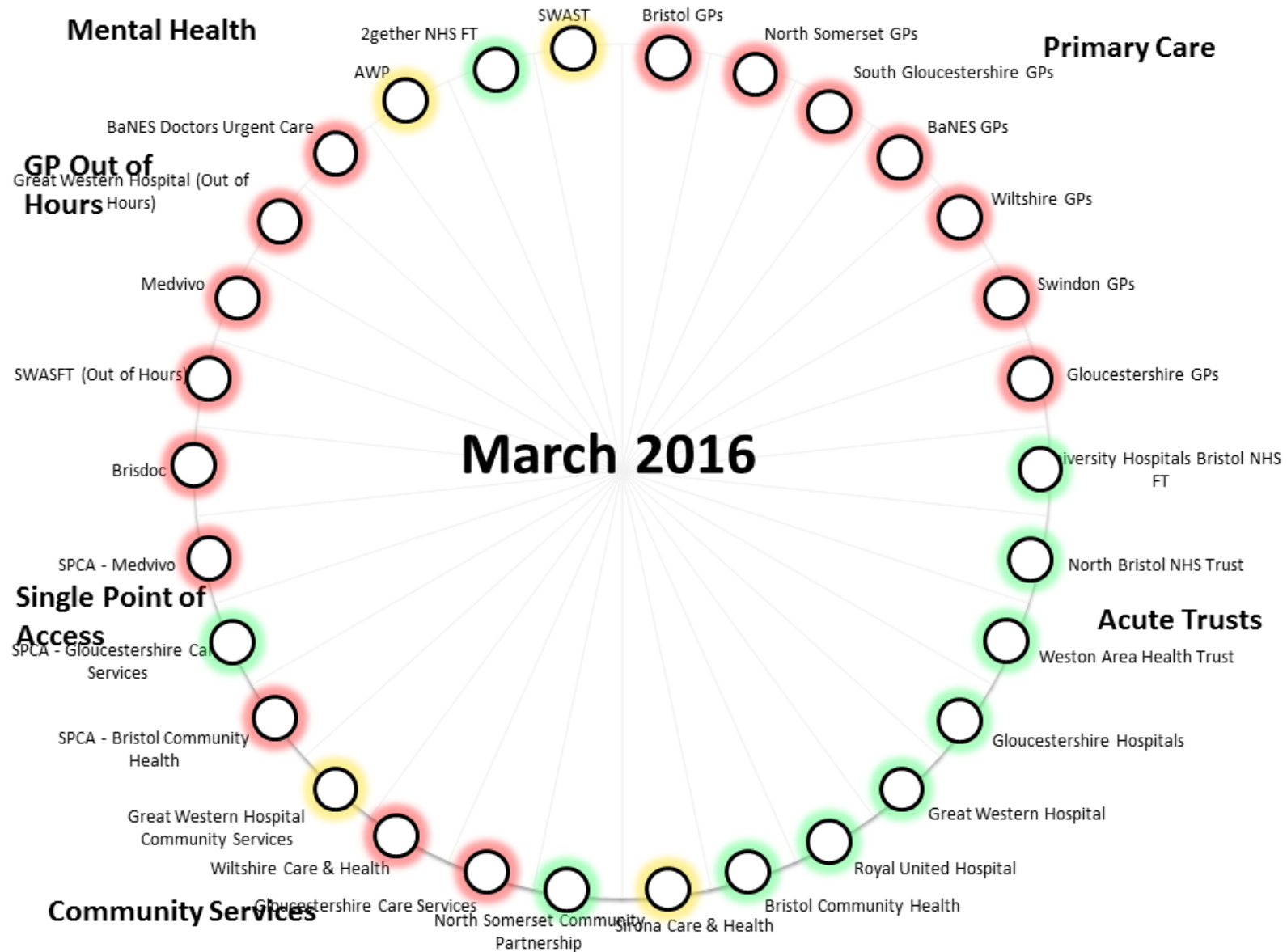
Concern about a patient should lead to escalation, regardless of the score.

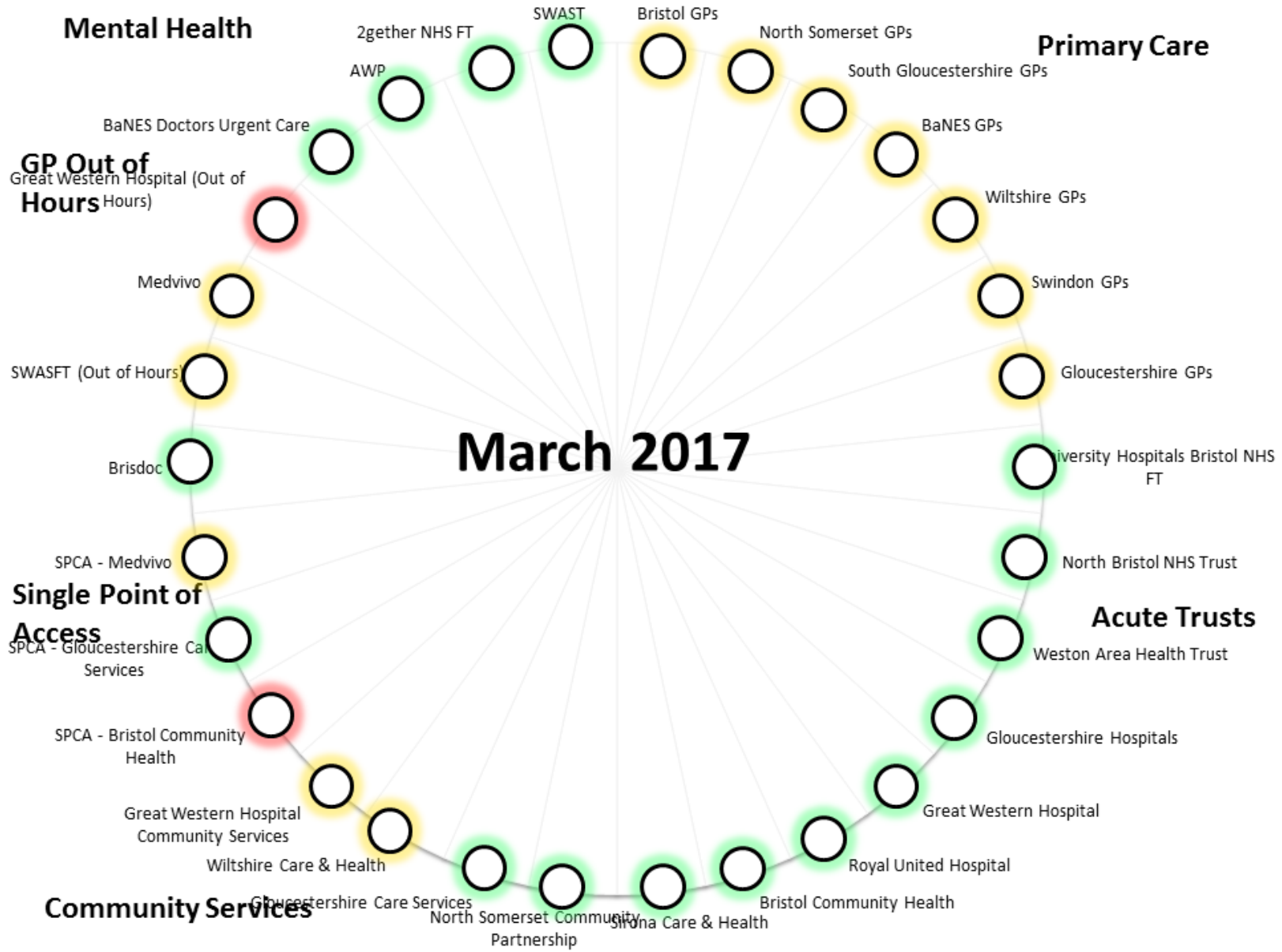
Think sepsis. Time = life.

Does the patient look ill? Are they triggering an early warning score? Are there signs of infection? Chemotherapy in last 6 weeks? This could be sepsis. **Check for red flags.**



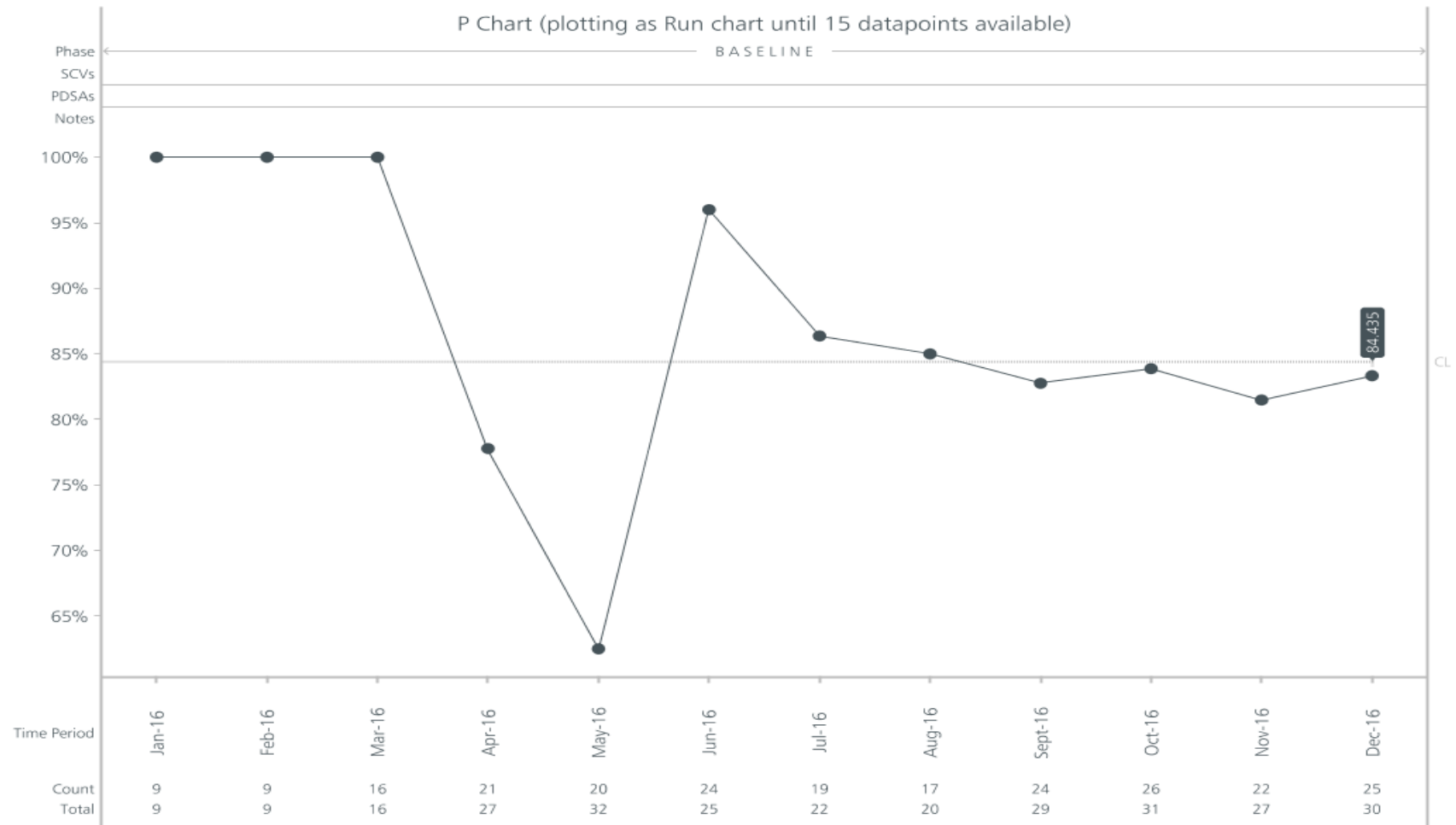
Appendix 8: Routine use of NEWS activity mapping March 2016 and March 2017



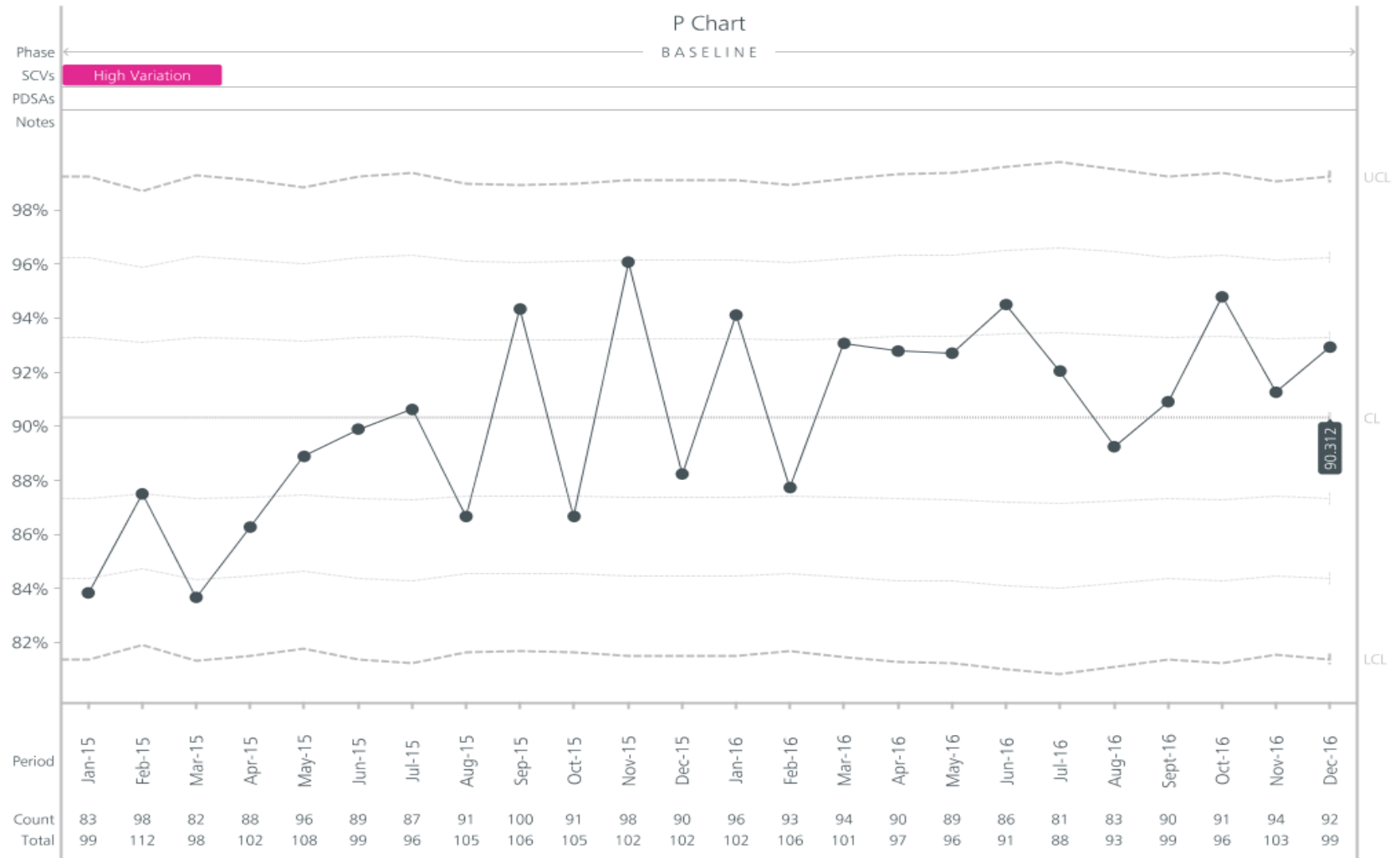


Appendix 9: 2Gether NEWS SPC Charts 2016/17

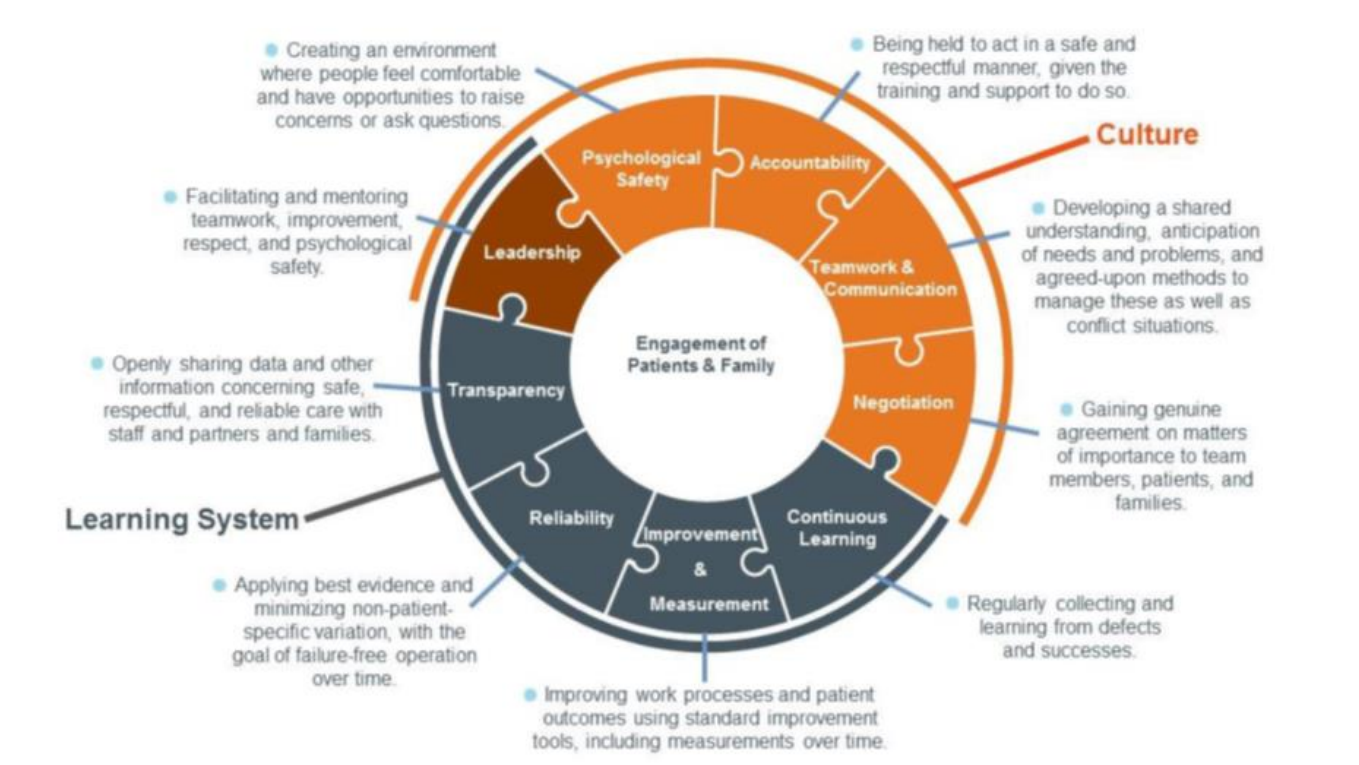
(Community) NEWScore calculated



(Inpatients) NEWScore calculated



Appendix 10: SCORE Culture survey graphic – Primary Care Collaborative

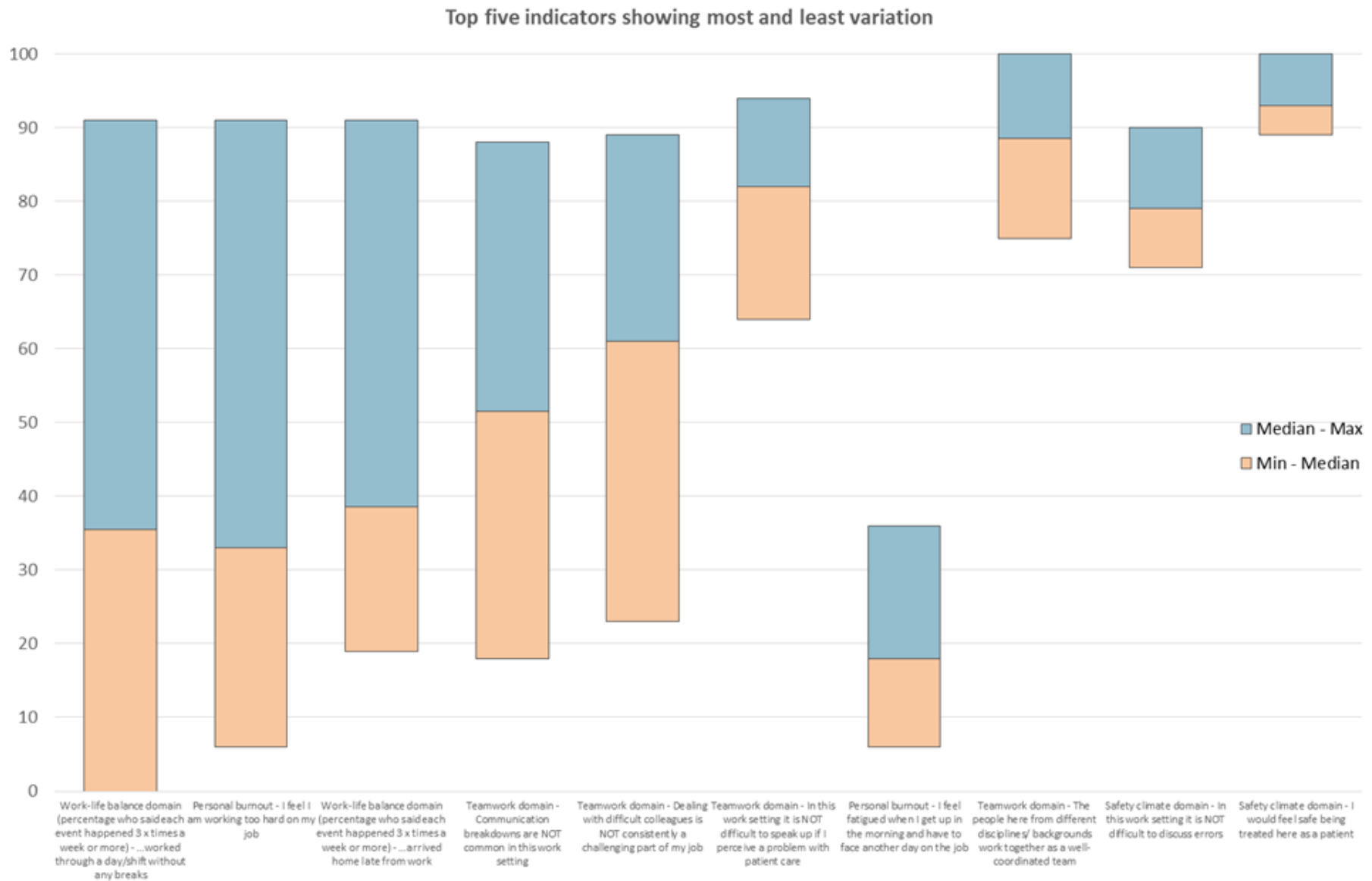


Aggregate quantitative output from culture survey results – by domain

	Median > 80%	Median 60-80%	Median < 60%
Domains		Learning environment Personal burnout Safety climate Work life balance	Local leadership Burnout climate Teamwork

The chart below indicates the variation in responses across practices and shows the top five indicators with the most variation and the top five indicators with the least variation. Of note is that “I would feel safe being treated here as a patient” had the least variation: 11% ranging from 89% to 100% of respondents agreeing with this statement.

Range of variation in quantitative output from culture survey results – by indicator



Note: This is the sum of the West of England Primary Care SCORE Survey in 2017 from 12 practices and 333 respondents

Appendix 11: 2016/17 West of England Academy Patient Safety Events

Date	Event/activity	Key Aims	Attended	Comments
12-Apr	Human Factors	Last in series of three train the trainer events for community organisations	16	41 facilitators trained
25-Apr	ED Safety Checklist	Showcase the ED Checklist to colleagues from across England	22	
25-May	Primary Care Collaborative 1	Launch of Primary Care Collaborative	37	
08-Jun	Human Factors and Patient Safety in the Community Forum	Human factors and shared learning on incidents and NEWS	18	Opportunity for community providers to share and learn
10-Jun	Emergency Laparotomy 2	Local event focused on QI skills development and using data	26	
24-Jun	Medicines Safety Collaborative 2	Supports Medicines Collaborative	24	
2-3Jul	South of England Mental Health Collaborative	Learning Session 10	164	
07-Sep	Primary Care Collaborative 2	Second event of the series	43	Keynote speakers include Paulette Knight, Suzette Woodward and a local GP
15-Sep	NEWS 4: The Deteriorating Patient: Handover to me, hand over to you	Sharing and learning of progress to date and next steps	123	
2-3 Oct	South of England Mental Health Collaborative	Learning Session 11	152	
07-Oct	Mortality Reviews	First Train the Trainer event to introduce the Structured Judgement Review system	44	Train the trainer event
24-Nov	Emergency Laparotomy 3	Local event – sharing of learning	31	
30-Nov	Primary Care Collaborative 3	Third event of the series	33	Keynote speakers from Coroner's office and EDF nuclear energy
01-Mar	Primary Care Collaborative 4	Fourth event of the series	30	A number of potential cohort 2 delegates joined this event

Date	Event/activity	Key Aims	Attended	Comments
8-9 Mar	South of England Mental Health Collaborative	Learning Session 12	147	
13-Mar	Reducing harm from falls	One off event at request of Patient Safety Board	54	
16-Mar	NEWS 5: The Deteriorating Patient - Let the numbers do the talking	Using data to tell the story	101	
Total Patient Safety Event attendees 2016/17 = 1065				
Total attendees at all West of England Academy Events 2016/17 = 2173 (Including Mental Health Collaborative events)				

Appendix 12: Resources

National Early Warning Score

Implementation toolkit – www.weahsn.net/NEWS-toolkit

Impact video – <https://vimeo.com/208284106>

3-5-7 GP information card http://www.weahsn.net/wp-content/uploads/NEWS_GP-Information-Sheet_Oct2016.pdf

Standardised electronic templates and other resources – www.weahsn.net/dp

Emergency Department Safety Checklist

Implementation toolkit – www.weahsn.net/ED-checklist

Medicines Safety

Contributing to national toolkit – <http://www.weahsn.net/what-we-do/enhancing-patient-safety/collaborating-in-the-community/medicines-safety-collaborative/>

Life System

Training guides and supporting materials – www.weahsn.net/life

Project Life Cycle

Templates for structured approach to project management – Available upon request

Emergency Laparotomy Collaborative

Online resources – <http://www.weahsn.net/what-we-do/enhancing-patient-safety/the-deteriorating-patient/emergency-laparotomy-collaborative/>

Mental Health

MINDSet Quality Improvement Guide – <http://mindsetqi.net/index/>

Online resources – <https://iqmentalhealth.co.uk/>

Mortality reviews

Resources, case studies & training material – <http://www.weahsn.net/what-we-do/enhancing-patient-safety/the-deteriorating-patient/structured-mortality-reviews/>

Human Factors in Community

Implementation toolkit including training materials – www.weahsn.net/human-factors-toolkit

Training video – <https://vimeo.com/207630363>

Video resource page – <http://www.weahsn.net/human-factors/step-by-step-guide-human-factors/human-factors-training-videos/>

Primary Care Collaborative

Online resource library – www.weahsn.net/wepcc1 including practical guides for practices

Other resources developed by our AHSN

West of England AHSN Academy website and QI guide – www.weahsn.net/academy

People in Health West of England PPI guide – www.weahsn.net/ppi-toolkit

Evidence and Evaluation toolkits – www.nhsevidencetoolkit.net and
www.nhsevaluationtoolkit.net

Events on falls, pressure ulcers, wound care and safety issues in the community setting.

Massive Open Online Course (MOOC) – <https://www.futurelearn.com/courses/quality-improvement/>

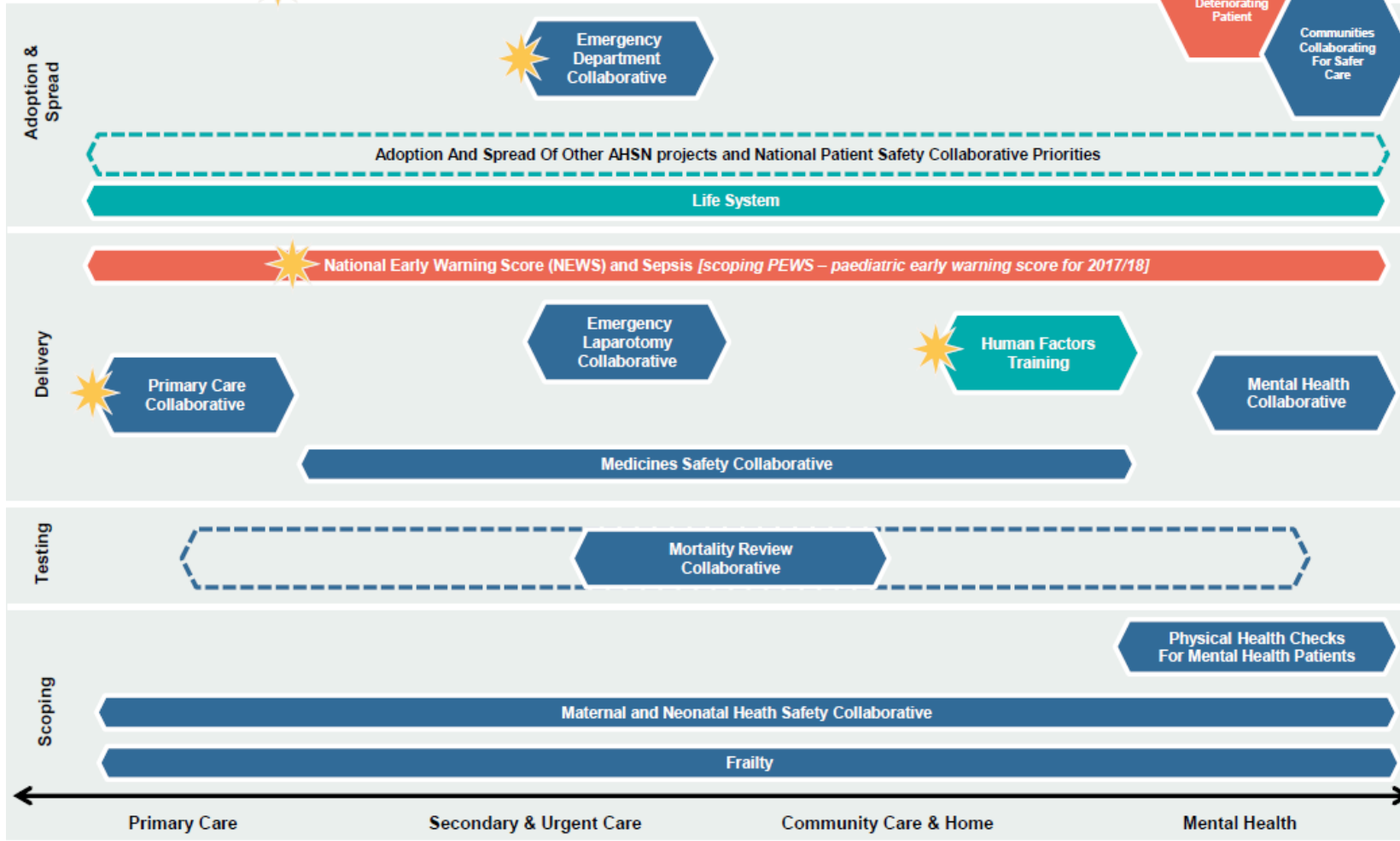
Appendix 13: 2017/18 Plan on a Page



Patient Safety Collaborative Plan on a Page 2017/18

Toolkit / Resources

National priorities: Maternal and neonatal health Culture and leadership
The deteriorating patient



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