West of England Academic Health Science Network

WEST OF ENGLAND

ACADEMIC HEALTH

SCIENCE NETWORK

Patient Safety Collaborative Annual Report 2016/17

Contents

Appendices (Separate Document)

Introduction

This report summarises the work of the West of England Patient Safety Collaborative during 2016/17.

1. Context

Patient Safety Collaboratives are hosted by Academic Health Science Networks and conform to their geographical footprints. They arise from the Berwick Report which advised the government on best practice in patient safety following failures in care in Mid Staffordshire.

The Patient Safety Collaboratives are funded initially on a five year licence, with a ring fenced allocation for the West of England of approximately £500,000 per annum. Their brief is to bring together NHS Commissioners, and providers of care to work collaboratively on building capacity and capability to support patient safety and to address specific local priorities for patient safety.

The West of England Patient Safety Collaborative formally includes all AHSN health member organisations and our public contributors. We also have several partners who are very actively engaged in our work, such as BRISDOC and the other local GP Out of Hours services.

Chaired by James Scott, Chief Executive of Royal United Hospitals Bath, the Patient Safety Collaborative consists of 7 Clinical Commissioning Groups, 6 acute Trusts, 5 providers of community health services, 2 mental health Trusts, 2 public contributors and the South West Ambulance Trust. See Appendix 1.

Our success factors are:

- Every organisation is actively involved in our Patient Safety Collaborative
- We have a multidisciplinary faculty and extensive clinical engagement
- Public contributors work with us at every level and provide great leadership
- We are ambitious and all projects are West of England wide
- Adoption and spread is built in to all our projects
- Several of our projects are multi – AHSN partnerships, or are being taken up beyond our boundaries

2. Partnerships and Leadership

We benefit from a wide range of partnerships. Those which have been most active in 2016/17 are with:

- The Health Foundation; notably Q cohorts 1 and 2
- Sign up to Safety; Suzette Woodward addressed our primary care collaborative
- Other Patient Safety Collaboratives – especially KSS, Wessex and South West
- Universities of Bristol, Bath and West of England
- Health Education England: our partners in the Human Factors project
- The South of England mental health collaborative for whom we are the lead AHSN

- Our clinical faculty, who not only support us, teach and present at conferences or support other PSCs and includes Dr Tricia Woodhead, Dr Emma Redfern, Ms Anne Pullyblank, Dr Hein Le Roux and Anna Burhouse.
- We led the Patient Safety Collaboratives' collective work on metrics development in 2016/17
- Our Managing Director lead the Patient Safety Collaboratives' national work in 2016.

3. Highlights of our 2016/17 Patient Safety Programme

3.1 Primary care – Clinical Lead; Dr Hein LeRoux, GP and Gloucestershire CCG Board member

14 GP practices took part in the first cohort of the Primary Care Collaborative. Practices undertook the SCORE culture survey and debriefing process as a method of reflecting on their current status and culture for safety. Over 300 staff have completed the surveys so far with a response rate of 70% across 10 practices. BRISDOC Out of Hours services have also joined the Collaborative.

Collaborative meetings include specific input from speakers on Sign Upto Safety, a Coroners perspective, incident reporting and safety in the nuclear industry.

A second cohort of 11 practices has been recruited and will run in tandem with cohort 1 during 2017/18. Feedback from practices is that the sharing of good practice and networking has been particularly beneficial. During 2017/18 we will be scoping a frailty workstream.

3.2 Human Factors in community services: Clinical Lead; Jane Hadfield, Assistant Director of Learning and Development, North Bristol Trust

The project to train bands 1 – 4 community staff in Human Factors was piloted by Sirona Health and Care during 2015/16, was evaluated**,** and a toolkit produced.

During 2016/17 the project moved into its adoption and spread phase and a further 2,900 staff were trained including 44 trainers who will sustain the programme in future. Dedicated human factors training sessions are now being discontinued as human factors is now part of induction and other CPD programmes; however we know that we reached over 60% of bands 1 – 4 staff across all community providers.

Health Education South West funded and supported this programme and in March 2017 we produced a film to support spread of Human Factors into Care Homes which can be found here: https://vimeo.com/207630363.

3.3 Medicines Safety: Clinical Lead: Steve Brown Director of Medicines, University Hospitals Bristol

During 2016/17 over 4,000 referrals were made to community pharmacists using the PharmOutcomes system on discharge of patients from hospitals. Under this arrangement the pharmacy checks for changes in medications for patients using dosette boxes, reducing waste in 60% of occasions.

2017/18 will see the wider adoption and spread of this system across the West of England.

3.4 Emergency Laparotomy Collaborative: Clinical Lead Anne Pullyblank, Consultant Surgeon, North Bristol Trust and Clinical Director West of England Patient Safety Collaborative

The six acute hospitals in the West of England are all part of this collaborative which has been funded by a Health Foundation Scaling Up grant to implement common standards in emergency laparotomy care across 30 hospitals in three AHSNS (Kent, Surrey & Sussex, Wessex and West of England).

Baseline data was collected by all six hospitals in November 2015 using the National Emergency Laparotomy Audit for a care bundle i.e. time to theatre, sepsis screening, consultant presence, goal directed fluid therapy.

Since April 2016 over 1200 West of England patients have been part of this programme and the collaborative has had regular local (West of England) and regional learning sessions. See Appendix 5 for the Emergency Laparotomy results.

During 2017/18 we will embed this programme and ensure that it is sustainable.

3.5 Emergency Department Safety Checklist: Clinical Lead: Dr Emma Redfern, ED Consultant Bristol Royal Infirmary

Developed at Bristol Royal Infirmary and tested in situ with the support of a Health Foundation SHINE grant, this time based checklist ensures that all “majors” patients have all their observations, diagnostics and pain relief and deterioration is spotted and treated. South West Ambulance Trust paramedics also use the checklist for patients who are in the Emergency Department queue. The CQC have been highly complimentary about this initiative.

During 2016/17 the checklist has been rolled out across all six Emergency Departments in the West of England as part of our Emergency Department Collaborative. The full year reach of the safety checklist is 140,000 patients a year – i.e. all those who are treated as “majors” in our Emergency Departments. See Appendix 6 for results.

Emergency Departments from all over the UK have asked to use the checklist and we produced a toolkit (see Appendix 12) and offered master classes in Bristol, Wessex and South West AHSNs.

During 2017/18 we will embed the checklist fully in all 6 Emergency Departments.

3.6 National Early Warning Score: Clinical Lead Anne Pullyblank, Consultant Surgeon, North Bristol Trust and Clinical Director West of England Patient Safety Collaborative

The aims of this ambitious programme are to spot deterioration earlier and act on it, so reducing avoidable mortality (see Appendix 7 for Trigger diagram). This is to be enabled by implementing a single early warning score; the National Early Warning Score in every organisation and using it across all interfaces of care.

This is a complex project which was launched in March 2015 and over 2015/16 saw:

- All acute hospitals in the West of England adopt NEWS – in particular the two Bristol trusts converted together from a local early warning score
- Agreement from South West Ambulance Trust to build NEWS into its electronic patient record
- Introducing NEWS into GP out of hours services and interface services such as GP run assessment units
- Community health services extending their use of NEWS and using it across interfaces of care such as Single Points of Clinical Access
- Our mental health Trusts working collaboratively to consolidate their use of NEWS and extend it to patients being transferred to and from acute hospitals.

During 2016/17 our collaborative has massively extended the reach and use of NEWS:

- SWAST have completely rolled out its EPR / NEWS and trained over 3,000 staff. The full year effect is that 9000,000 patients (i.e. all those conveyed to hospitals and all those not conveyed to hospital) in the South West region will have a NEWS score to inform paramedics' clinical judgement
- GPs are beginning to use NEWS in clinical consultations and we have presented to 50% of GP practices
- NEWS is well embedded across community services and mental health and is being used in innovative ways (to avoid hospital admissions from nursing homes).

See the charts at Appendix 8 for NEWS activity mapping.

In 2017/18 we will continue to extend and embed NEWS, including NEWS2 and scope and pilot a programme to implement the Paediatric Early Warning System (PEWS) starting with SWAST, Emergency Departments and Out of Hours Services.

3.7 Acute Hospital Mortality Reviews

During 2016/17 the six acute Trusts in the West of England plus two guests (Musgrove Park, Taunton and Salisbury Hospital) have been working together to implement the new programme of structured case note reviews for deaths in hospital.

So far we have:

- Exchanged current practice between Trusts
- Developed a draft best practice framework
- Developed a public facing statement for use by Trusts
- Held a train the trainer day for 3 of our 8 Trusts' clinical reviewers (our early implementers) and all our Steering Group
- Identified some "super trainers" who have been trained by RCP as "tier 1" trainers
- Liaised with our Gloucestershire Medical Examiner pilot to understand their best practice
- Started work with our 2 mental health Trusts – who want to amend the case note review methodology for their purposes
- Worked with one of our Trusts to amend the methodology to support a review of emergency laparotomy deaths arising from our EL Collaborative.

In 2017/18 we will run training sessions for the clinical reviewers at our remaining five Trusts, support them to implement the system and continue the dialogue between the partners so we can identify and act on themes which lend themselves to pan AHSN QI projects (such as building on the deteriorating patient programme, medicines safety or end of life care).

5 Measurement and Evaluation

The Patient Safety Collaborative has an overarching measurement strategy and each project creates a driver diagram as part of setting objectives and defining measures.

In partnership with 10 other AHSNs we have adopted the Seedata Life System. During 2016/17 we have been working with our partners and started introducing the system to our member organisations. There are now over 200 active users of the Life system in the West of England working on 127 projects.

Our partners in the South of England Mental Health Collaborative have been active in migrating their safety projects onto the Life system. See Appendix 9 for an example from 2Gether from our Deteriorating patient programme.

Our objective during 2017/18 is to drive up the number of active users in the West of England and to continue to develop capability in the use of life and wider measurement techniques.

We aim to evaluate all our projects, using a range of evaluation partners. CLAHRC west is currently evaluating the Emergency Department Safety checklist and NEWS.

6 Developing the Capacity and Capability to support Patient Safety

Our patient safety collaborative has a strong emphasis on delivery of projects which address specific harms.

A Patient Safety "Logic Model" has been developed by NHS IQ with input from Patient Safety Collaboratives across the country. It allows each Patient Safety Collaborative to

assess its approach against six enablers which are measurement, learning, capability building, leadership, culture and innovation. We are using the Logic Model as a tool to help us consider our development needs.

In the West of England we have an "Academy" which is the umbrella for all the training, development and collaborative learning which we offer. Appendix 11 shows the 2016/17 schedule for patient safety events.

All Patient Safety Collaboratives worked with the Health Foundation to recruit a first cohort of the "Q initiative" a national cadre of QI experts with the experience and confidence to lead Quality Improvement in the workplace. During 2016/17 we were pleased to be chosen as one of three AHSNs to recruit a local cohort of 120 local Q members. Our launch event was on 29 March.

During 2017/18 we will offer an Improvement Coach course and 5 dedicated events to our cadre of Q colleagues.

7 National Priorities for 2017/18

NHS Improvement are now the Commissioners of Patient Safety Collaboratives and are keen to see all PSCs working on some common national priorities. For 2017/18 these are physical deterioration, maternal and neonatal health, and culture & leadership. We are well placed to support work on these:

Deteriorating patient – this is our biggest programme, with projects on:

- ED safety checklist
- NEWS at interfaces of care
- Emergency Laparotomy Collaborative
- Acute Hospital Mortality Reviews

All 21 member organisations are actively involved as are a wide range of other partners such as GP out of hours co-operatives.

Maternal and neonatal health Safety Collaborative:

- Our Patient Safety Programme Director is also the Clinical Director for the South West Maternity Clinical network and sits on the national steering group for the collaborative
- The AHSN completed a project across all 5 maternity units in 2014/15 on use of magnesium sulphate as a neuro protector in pre term babies. We can demonstrate statistically significant outcomes from this work which is now embedded and is estimated to have saved 7 babies from having cerebral palsy
- We are considering adoption and spread of a telehealth pilot at Great Western Hospital for women with raised blood pressure ante natally.

Culture & Leadership:

- Changing culture has been a focus throughout all our workstreams and continues to be so
- Through the AHSN Academy we have offered a wide range of open invitation or bespoke development activities
- Offering the SCORE culture survey has been a central feature of our Primary Care Collaborative

- We have public contributors in all our projects who contribute to an open and positive culture
- We have a strong cohort of nationally recognised patient safety clinical leaders in the West of England who provide visible leadership and who are active at national level in organisations such as the Royal Colleges, NCEPOD and the Health Foundation.

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Contact us: patientsafety@weahsn.net
Or visit our meet the team page for direct contact details: http://www.weahsn.net/what-we-do/enhancing-patient-safety/meet-the-team/