National Patient Safety
Improvement Programmes

National
Programmes

Ensuring our patients are safe: Meeting the needs of our local population

9 June 2021, 2-4pm

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National Patient Safety
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National Programmes

Welcome

Professor Julia Newton
Medical Director
AHSN NENC

@NatPatSIP / @MatNeoSIP

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- Please ensure your microphone and video are turned of in the main session. They can be turned on while in breakout sessions so that you can participate.
- Please amend your user name to clearly show who you are. This can be done via moving your mouse over your picture and clicking on the 3 dots.
- If you have any questions through out the session then please use the chat facility. We will attempt to address questions, if we can’t then we will follow up after the event.
- Please note the session is being recorded.

14:00	Welcome	Julia Newton (Chair) Medical Director, AHSN NENC
14:00 – 14:20	Welcome and Introduction	Tony Roberts Deputy Director (Clinical Effectiveness), South Tees Hospitals NHS FT Deputy Director, North East Quality Observatory Service (NEQOS) Patient Safety Lead, AHSN NENC Ruth James Patient Safety Lead, AHSN NENC
14:20 – 14:22	Maternity and Neonatal Safety Improvement Programme	Julia Wood Maternity and Neonatal Safety Improvement Lead
14:22 – 14:24	Managing Deterioration Safety Improvement Programme	Karen Verrill Programme Manager
14:24 – 14:26	Mental Health Safety Improvement Programme	Paul Johnson Workstream Lead
14:26 – 14:28	Medicines Safety Improvement Programme	Tracy Marshall, Project Lead Emily Whales, Project Lead
14:28 – 14:30	Adoption and Spread Safety Improvement Programme: • COPD & Asthma • Emergency Laparotomy	 Sue Hart, Health Programme Manager Liz Brown, Health Programme Manager
14:30-14:45	Maternity Voices Partnership (MVP) Presentation	Sarah Wall Service User Voice Representative Northumbria, Tyne & Wear, Durham Local Maternity System
14:45 – 15:05	Breakout Session 1: Delegates select one option from the sessions below	
	Maternity and Neonatal Safety Improvement Programme Managing Deterioration Safety Improvement Programme Mental Health Safety Improvement Programme Medicines Safety Improvement Programme Adoption and Spread Safety Improvement Programme	
15:05 – 15:15	Comfort Break	
15:15 – 15:35	Breakout Session 2: Delegates select one option from the sessions below	
	As session one	
15:35 – 15:55	Breakout Session Feedback and Summary	Julia Newton Medical Director, AHSN NENC
16:00	Close	Julia Newton Medical Director, AHSN NENC

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Patient Safety Collaboratives and the National Patient Safety Improvement Programmes

Tony Roberts &
Ruth James
Patient Safety Leads

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Patient Safety Collaborative

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The Academic Health Science Network (AHSN) and Patient Safety Collaborative (PSC)

What is the Academic Health Science Network and what do they do?

- 15 AHSNs covering England and established by NHS England in 2013.
- Connect NHS and academic organisations, local authorities, the third sector and industry acting as catalysts to facilitate change and spread innovation at pace and scale
- Remit to occupy a unique space outside of the usual NHS service contract and performance management structures
  - Promote economic growth
  - Diffusing innovation
  - Improving patient safety
  - Optimising medicine use
  - Improving quality and reducing variation
  - Putting research into practice
  - Collaborating on national programmes

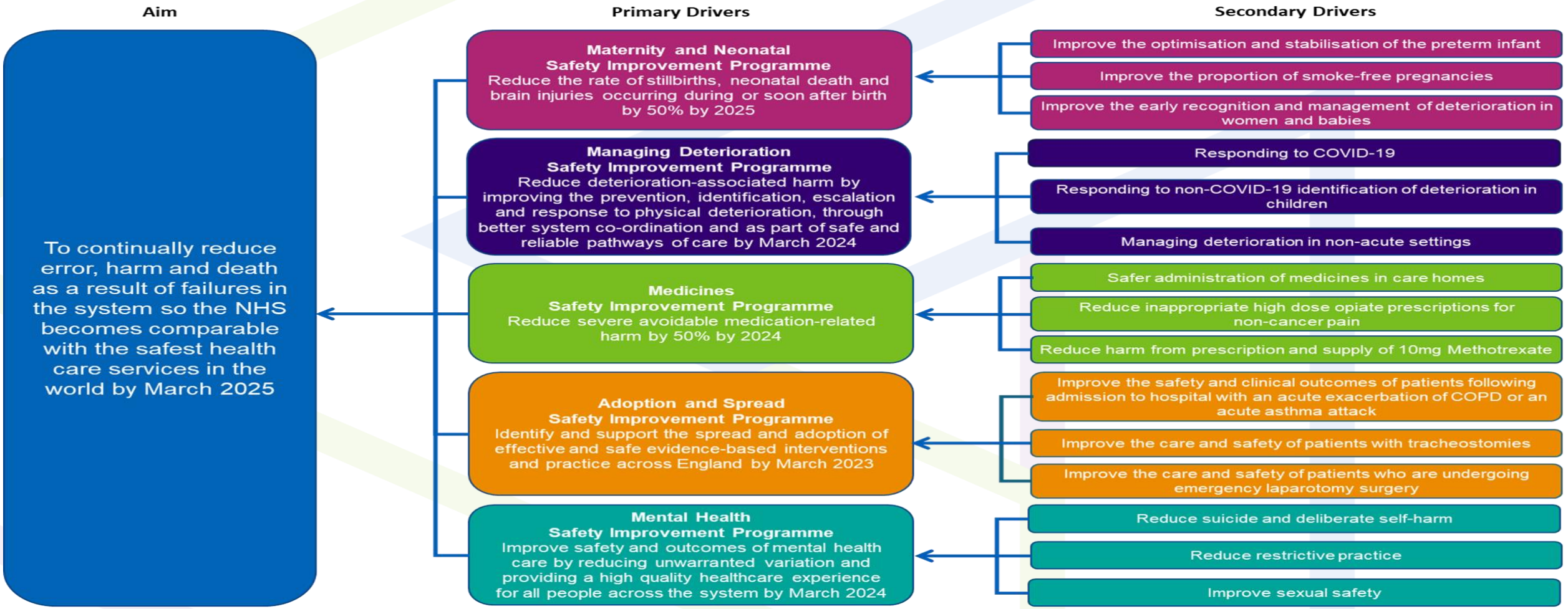
What are Patient Safety Collaboratives?

- PSCs manage the Safety Improvement Programmes (SIPs) launched in July 2019 as part of the NHS Patient Safety Strategy. The NHS Improvement national patient safety team commissions AHSNs to manage the PSCs.
- Patient Safety Collaboratives were established in 2014.
- PSCs are made up of NHS providers and commissioners. They include hospitals, community services, primary care, mental health and ambulance services and clinical commissioning groups. They are also working with the newer structures including Integrated Care Systems (ICSs) and Primary Care Networks (PCNs).

National Patient Safety Improvement Programmes

PSCs run NatPatSIP: 5 Safety Improvement Programmes (SIPs)

National Programmes



Academic Health Science Network
North East and North Cumbria

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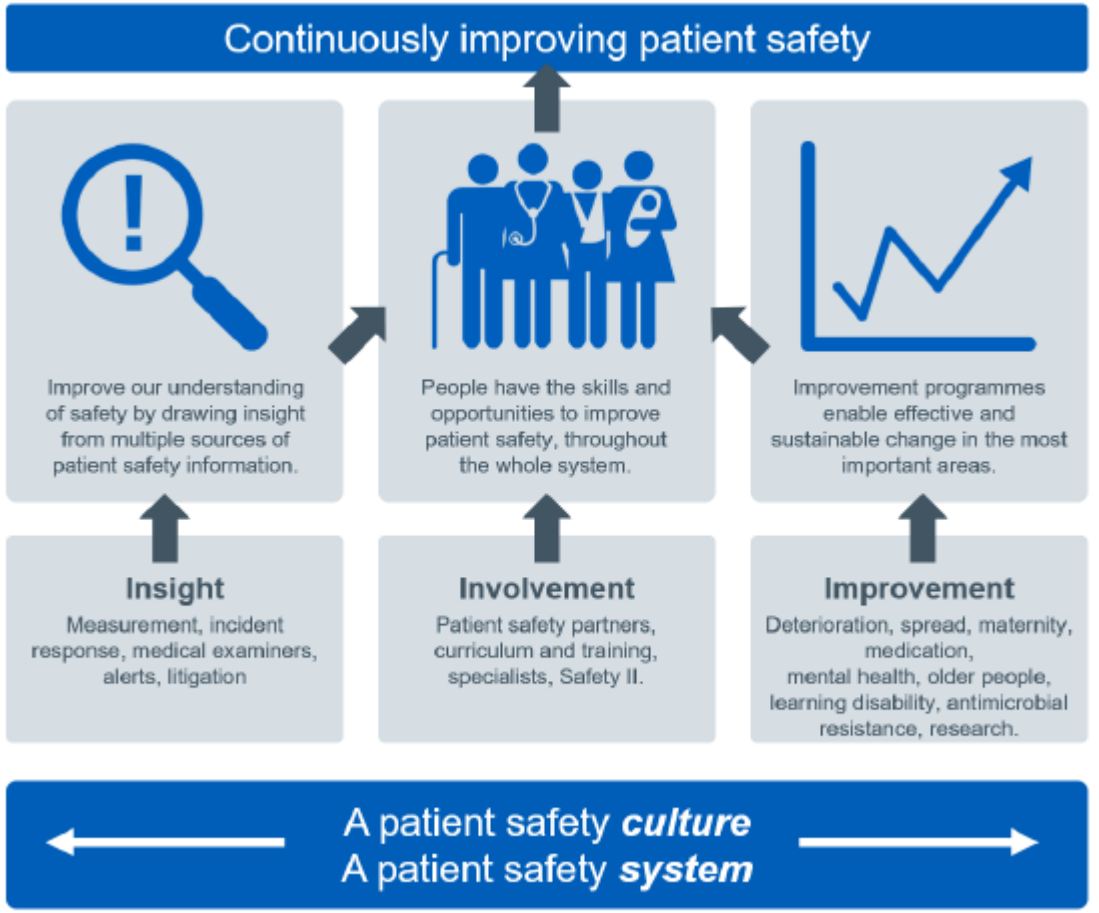
@AHSN_NENC

Quality and Patient Safety – the wider context……

Quality in the NHS

The NHS Patient Safety Strategy published in 2019 to accompany the NHS Long Term Plan



Patient Safety in the North East and North Cumbria

- Quality and safety governance structures in place but evolving
- Patient Safety Networks
- Regional QI Network
- Patient Safety Specialists

Involvement - engagement of service users and carers so that we -

- Learn more about the patient's experience and better understanding their needs and priorities
- Improve experience for patients and carers
- Improve services
- Improving user relationships with professionals

A view from patient safety partners:

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Maternity and Neonatal

Maternity and Neonatal Safety Improvement Programme (MatNeoSIP)

Julia Wood
Maternity and Neonatal Safety Improvement Lead

@NatPatSIP / @MatNeoSIP

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Aims and programmes of work

- Improve the safety outcomes of maternal and neonatal care by reducing unwarranted variation and providing a high quality healthcare experience for all women, babies and families across maternity and neonatal care settings in England
- Contribute to the national ambition to reduce the rates of maternal and neonatal deaths, stillbirths and brain injuries that occur during or soon after birth by 50% by 2025
- Contribute to the national ambition to reduce the national rate of preterm births from 8% to 6%

Increase the number of smoke free pregnancies

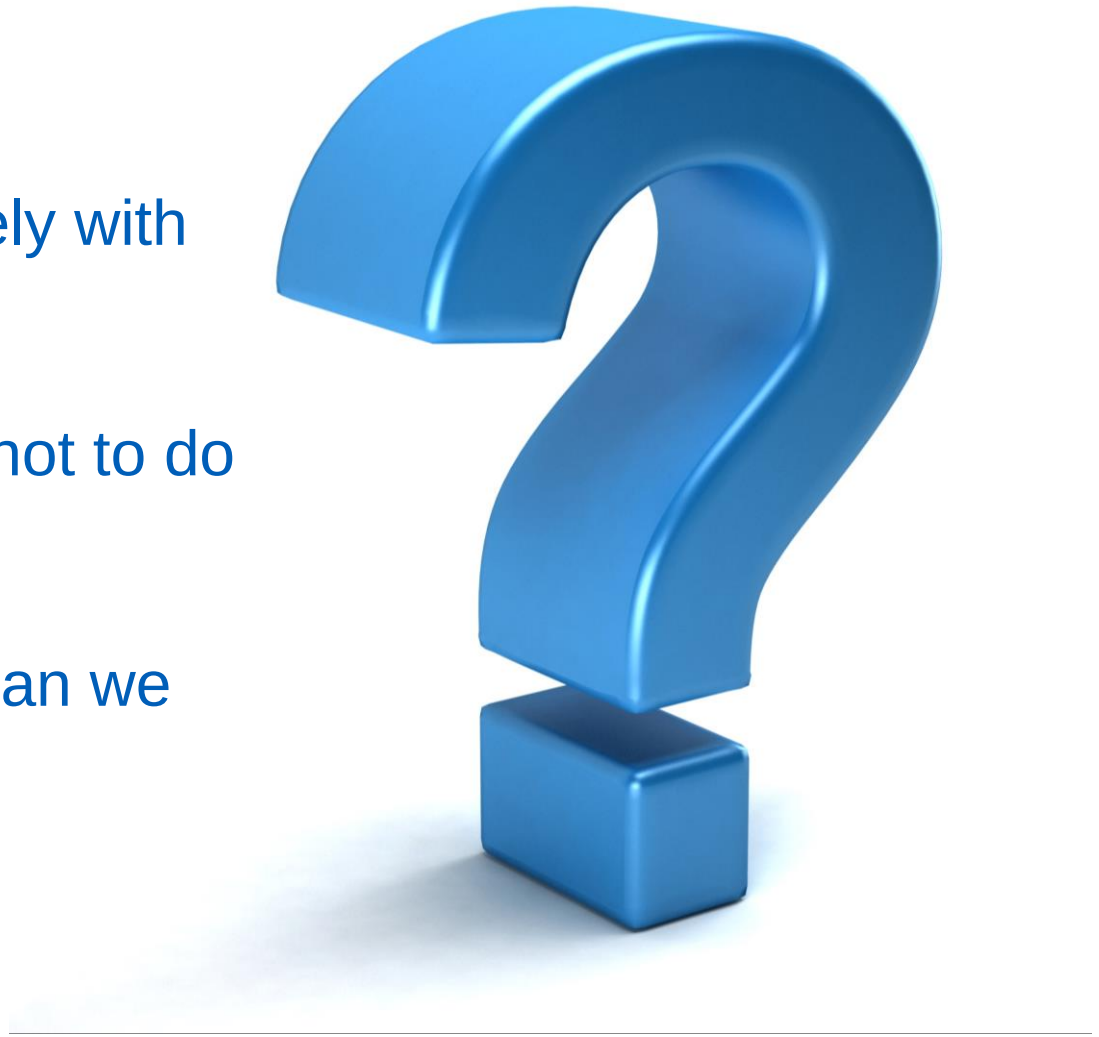
Optimisation and stabilisation of the preterm infant

Early recognition and management of deterioration of women and babies

How can we work more effectively with women and families?

What lessons are there as how not to do it?

What are the barriers and how can we overcome them?



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Managing Deterioration

Managing Deterioration Workstream

Karen Verrill
Programme Manager

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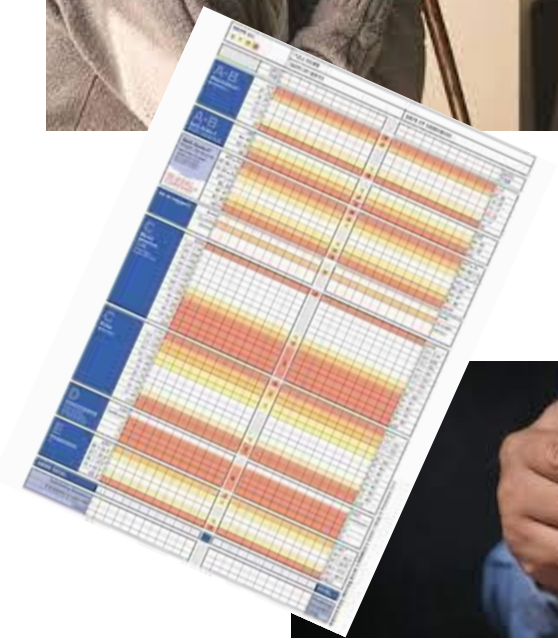
Managing Deterioration

Early signs of physical “unwellness” can be recognised intuitively by physical healthcare practitioners as evidenced by staff saying “I know something is wrong, I just don’t know what”.

Even people without training, but who are familiar with someone’s usual behaviour and habits, can often sense a problem resulting in them reporting that the relative, resident or child in their care “just isn’t themselves”.

Cooper, G. (2020) Using Soft Signs to Identify Deteriorati Wessex Patient Safety Collaborative white paper. Wessex Academic Health Science Network (Available on https://wessexahsn.org.uk)



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Mental
Health

How can we work with you to support the delivery of the Mental Health Patient Safety Programme

Paul Johnson
Workstream Lead

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National Patient Safety Improvement Programme, Mental Health

Key ambitions of the Mental Health Patient Safety Improvement programme:

- Reduce the incidence of restrictive practice in inpatient mental health and learning disability services by 50% by March 2024
- Reduce suicide and self harm in inpatient services, the health care workforce and non-mental health acute settings.
- Improve sexual safety of patients and staff on inpatient mental health units by 50% above baseline by March 2024.

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Medicines Safety Improvement Programme (MedSIP)

Tracy Marshall, Project Lead
Emily Whales, Project Lead

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Medicines Safety Improvement Programme (MedSIP)

Aim: Reduce severe avoidable medication related harm by 50% by 2024

This Safety Improvement Programme (SIP) has two main drivers:

- **Opioid Primary Driver** – Reduce inappropriate high dose opioid prescriptions for non-cancer pain
  - Opioids are very good analgesics for acute pain and pain at the end of life. There is no evidence that high dose opioids (>120mg/day morphine equivalent) are effective in long term pain. Increasing opioid dose above this is unlikely to improve pain control and exposes patients to increased harm.

- **Care Home Primary Driver** – Safer administration of medicines in care homes
  - Safety Huddles
  - Learning from errors
  - 3-way communication
  - Managing interruptions

The concept of Safety Champions in care homes is also being explored and will be tested in partnership with these four interventions.

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Adopt and Spread

Adopt & Spread
COPD and Asthma Discharge Bundles

Sue Hart
Health Programme Manager

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COPD & Asthma Discharge Bundles

PSC aim is to improve the safety of, and outcomes for patients, by quickly and effectively sharing, spreading and adopting tested, evidence-based practice across England.

- Support an increase in the proportion of patients in acute hospitals receiving every element for which they are eligible:

  - COPD Discharge Bundle to 80% by March 2022.
  - Asthma Discharge Bundle to 80% by March 2023.

The bundles:

A set of evidence-based interventions aimed at improving specific outcomes for patients.

> COPD:

- Assessment of inhaler technique
- Provision of written information and medication rescue packs
- Offered referral to smoking cessation services
- Assessed for enrolment into a pulmonary rehab programme
- Appropriate follow up arrangements

> Asthma:

- Assessment of inhaler technique
- Provision of a written action plan and patient self-management plan
- Review of medications
- Consideration of triggering and exacerbating factors
- Appropriate follow-up arrangements

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Adopt and Spread

Adopt & Spread Emergency Laparotomy

Liz Brown
Health Programme Manager

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EMERGENCY LAPAROTOMY (EmLap)

This programme involves the spread and adoption of the evidence-based **Emergency Laparotomy Pathway Quality Improvement Care (ELPQuiC)** bundle within NHS Trusts. By implementing the EmLap pathway, research suggests that the patient mortality rate will decrease and the recovery period in hospital reduces following an Emergency Laparotomy.

Programme Aims:

1. Early identification of patients who pose the most risk of deterioration
2. Sepsis screening and early implementation of antibiotics for patients
3. Prompt diagnosis and surgery with 6 hours for the patient
4. Consultant delivered care throughout surgery
5. Fluid optimisation during surgery and critical care
6. Post operative intensive care for all.

In NENC, we have developed two pathways for implementation across the region which encompass these requirements. I'd like to talk to you about the challenges of implementation and how we can help

Maternity Voices Partnerships

Sarah Wall

Service User Voice Representative

NTWD Local Maternity System

NE & Yorkshire Maternity Transformation Program

sarahlwall@hotmail.com

"Local maternity systems should be responsible for ensuring that they co-design services with service users and local communities."

Service User Voice… why listen?

Co-production acknowledges that people with ‘lived experience’ are best placed to advise on what support and services will make a positive difference to their lives. Done well, co-production helps to ground discussions in reality, and to maintain a person-centered perspective.

MATERNITY VOICES PARTNERSHIPS


Co-production
Co-design
Engagement
Consultation
Informing
Educating
Coercion
Doing with
in an equal and reciprocal partnership
Doing for
engaging and involving people
Doing to
trying to fix people who are passive recipients of service

Clinical Negligence Scheme for Trusts - Safety Action Point 7, MVPs

‘Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?

- Terms of Reference for your MVP
- Minutes of MVP meetings demonstrating explicitly how feedback is obtained and the consistent involvement of Trust staff in coproducing service developments based on this feedback
- Evidence of service developments resulting from coproduction with service users
- Written confirmation from the service user chair that they are being remunerated for their work and that they and other service user members of the Committee are able to claim out of pocket expenses
- Evidence that the MVP is prioritising hearing the voices of women from Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation, as a result of UKOSS 2020 coronavirus data.

2) **Listening to Women and their Families**
   a) Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services

“In a maternity context, the best way of instituting service user co-production is through a Maternity Voices Partnership.” – Better Births

What is a Maternity Voices Partnership (MVP)?

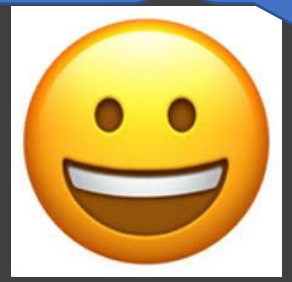
A team of people who use maternity services, along with midwives, obstetricians and commissioners, working together to review, co-design and co-produce local maternity services.

The Role of a Service User Voice Representative

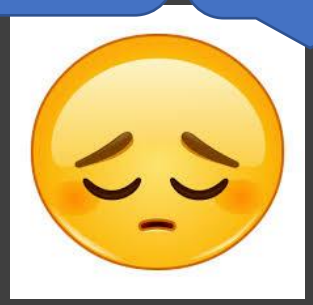
- Champion the diversity of patient & public voice, views and **experiences**
- Provide critical friend **challenge**
- Champion and advocate for increasing patient and public **awareness**

Engagement via the MVP

Online Survey



Community Outreach



Parents' Voices

Walk the Patch

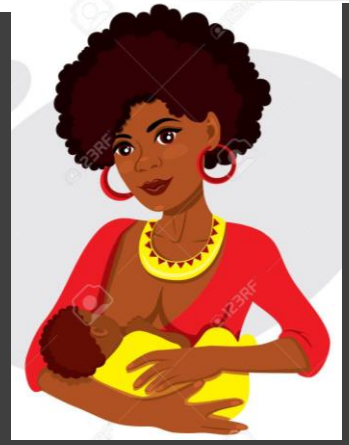
Asking: what was good, what wasn't so good, what ideas do YOU have for improvement?

These build on CQC, Friends & Family Test or a one off Whose Shoes event.

Whose voices are we particularly keen to hear?

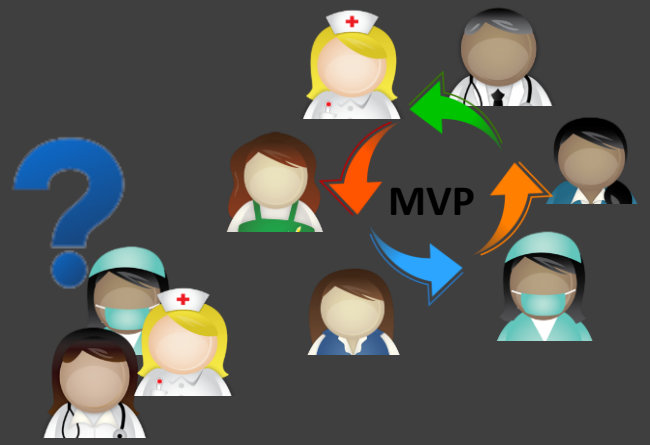






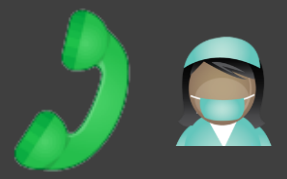

MVP Chair

- *Are* Covid tests compulsory?
  - Access to senior staff to find out



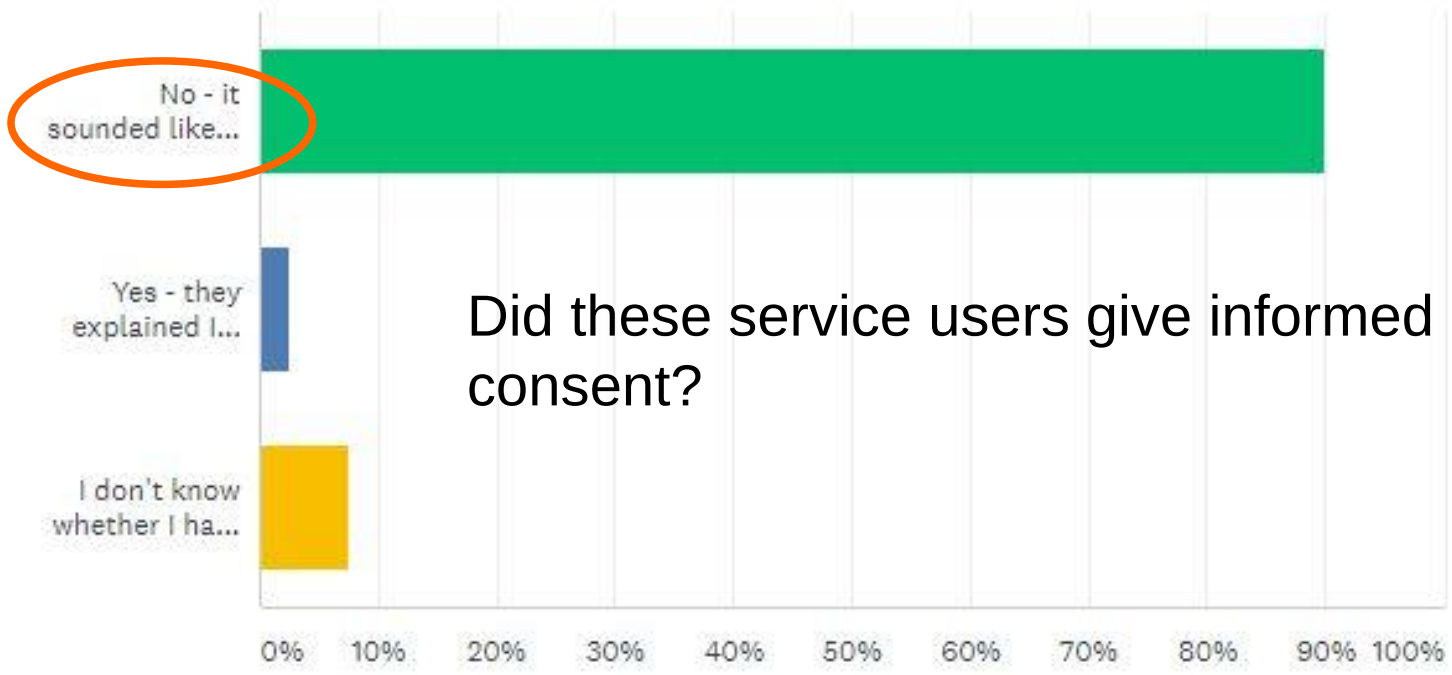
- Isolated incidents or more generalised issue?
  - Ask more service users
  - Ask some detailed questions

- Signposting individual service users
  - 24h Maternity Advice Line
  - Professional Midwifery Advocates



Did you know that you didn't have to have the Covid test?

Answered: 40 Skipped: 0



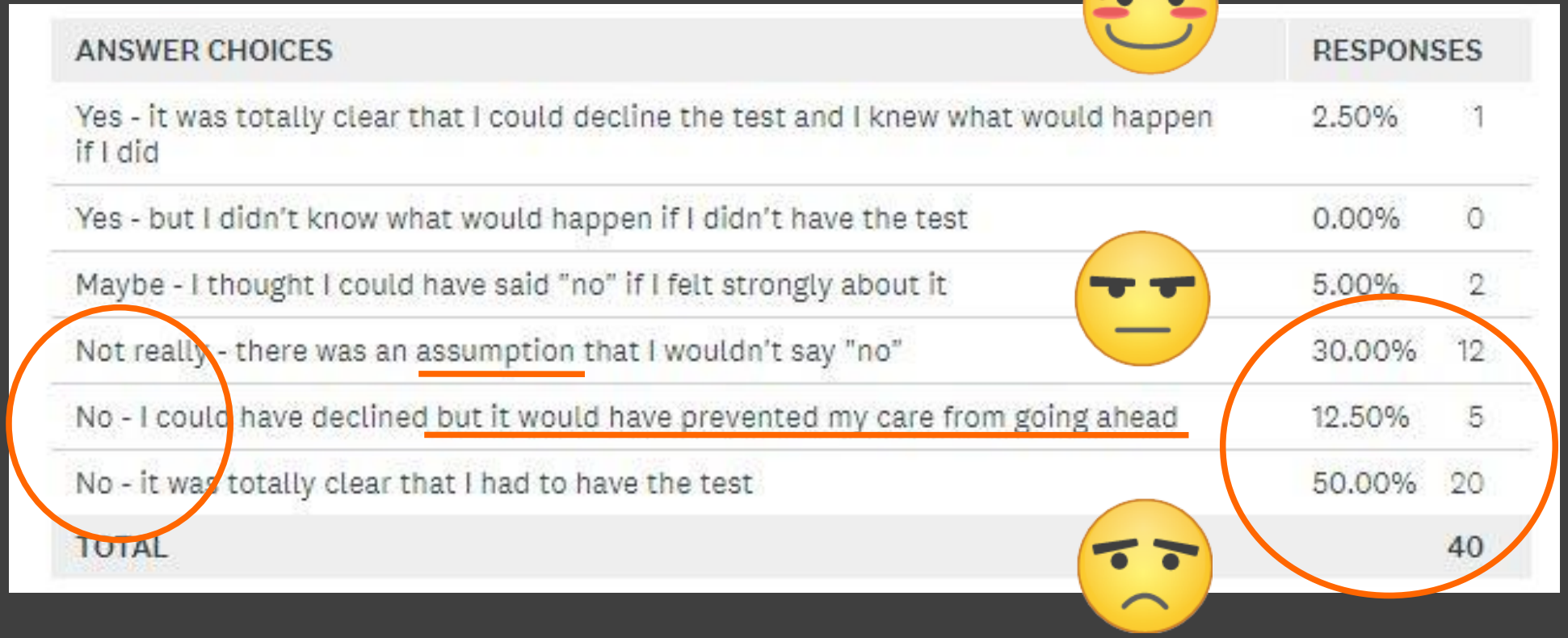
Did these service users give informed consent?

ANSWER CHOICES	RESPONSES	
No - it sounded like I had to have it	90.00%	36
Yes - they explained I didn't have to have it	2.50%	1
I don't know whether I had to have it or not	7.50%	3
TOTAL		40

Did you feel that saying "no" to a Covid test was an option?

Answered: 40 Skipped: 0

Could these service users give informed consent?



ANSWER CHOICES	RESPONSES	
Yes - it was totally clear that I could decline the test and I knew what would happen if I did	2.50%	1
Yes - but I didn't know what would happen if I didn't have the test	0.00%	0
Maybe - I thought I could have said "no" if I felt strongly about it	5.00%	2
Not really - there was an assumption that I wouldn't say "no"	30.00%	12
No - I could have declined but it would have prevented my care from going ahead	12.50%	5
No - it was totally clear that I had to have the test	50.00%	20
TOTAL		40

MVP Chair

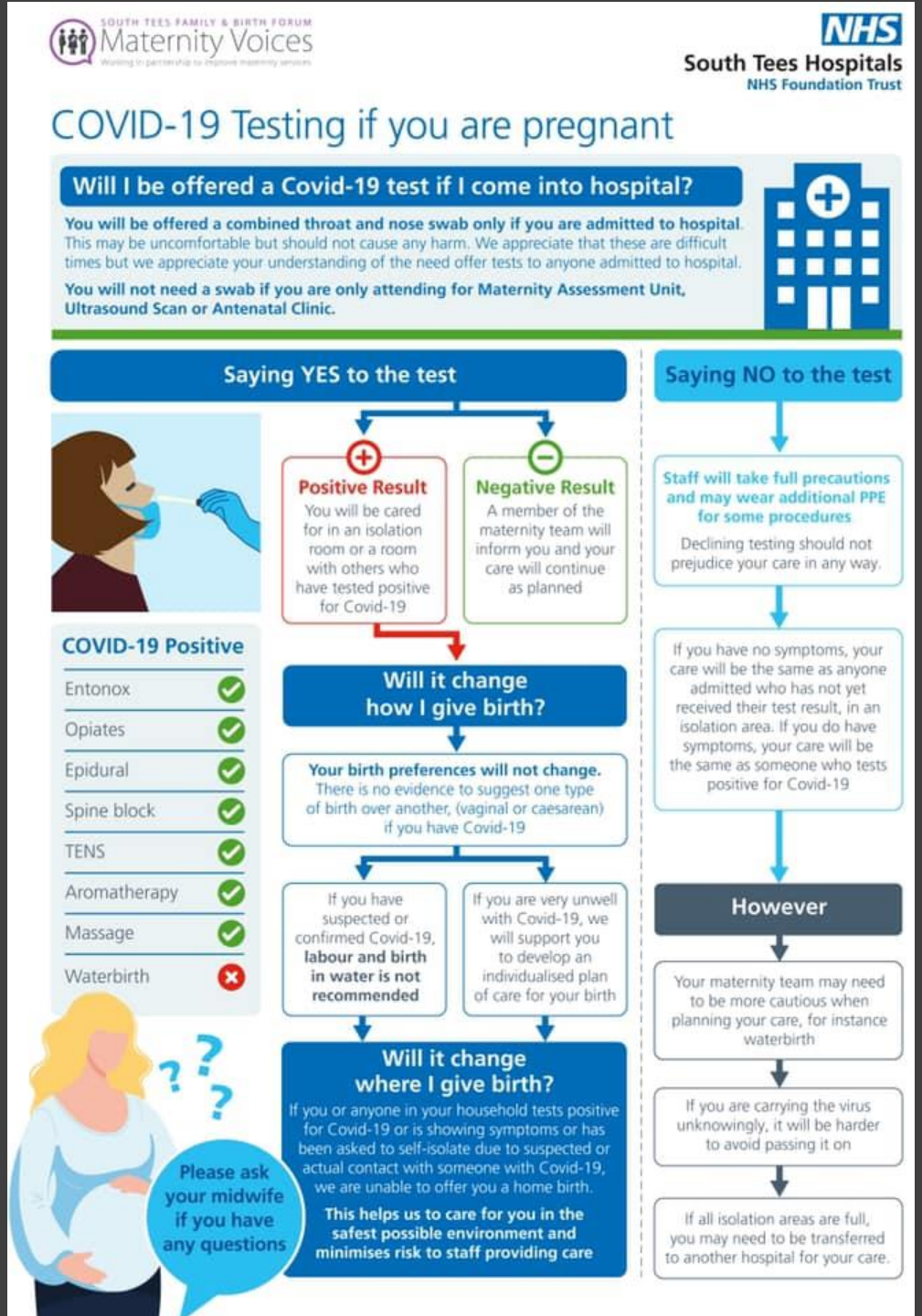
- Bring the issue to the MVP group
  - Discuss with staff and service user members to raise awareness of the issue

- Coproduction of clear information
  - Draft shared to MVP group for comments
  - Changes made to improve accessibility
  - Infographic signed off
  - Infographic shared via MVP and Trust social media

Is it...

Informative?
Accurate?
Clear?
Kind?
Comprehensive?
Reassuring?
Neutral?
Respectful of choice?
Honest?
Inclusive?
Accessible?

Is it easier to coproduce effective communications than go it alone?



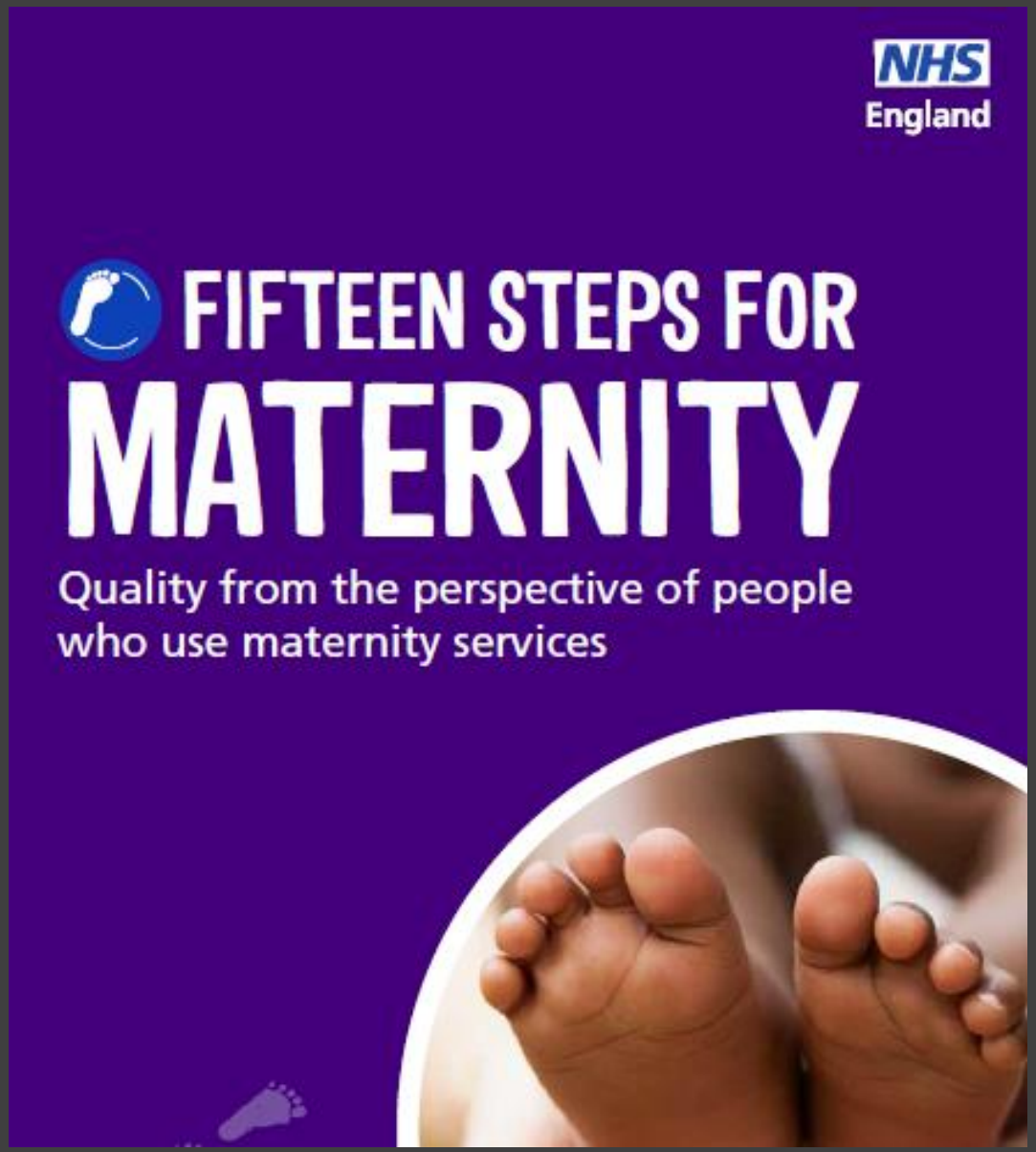
Ownership, understanding and support of co-production by all

A culture of openness and honesty

A commitment to sharing power and decisions with citizens

Clear communication in plain English

A culture in which people are valued and respected



Small, diverse team of Service Users walk the unit and give their perspective on how it looks, makes them feel, what is missing and how it can be improved.

What do you see when you look at this room?

Firstly, as a Healthcare Professional, then put yourself in the shoes of a service user.

Are there any differences?

Very clean

Well organised

Bed allows for many birthing positions

Room to move around the bed

Very Clinical

Bed dominates the room

Bland walls

Uncomfortable looking chair for birth partner

No positive birthing information


VK.COM/PITERSKII_PUNK_WALL
I love it!
Me too!

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Close

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Thank you for coming…

> As a reminder the main session was recorded and will be shared along with the slides

> If you would like further information or to connect with one of our speakers please email sarah.black@ahsn-nenc.org.uk