Academic Health Science Network for the North East and North Cumbria

Patient Safety Collaborative

Baseline Survey of Patient Safety Capability and Capacity

Final Report

Version 1.0
03.06.15
Summary of Findings and Commentary

This report details the findings of a survey of NHS organisations and academic bodies in the North East and North Cumbria, undertaken to provide baseline information concerning the current structures, initiatives, training, progress measures and barriers and enablers for improvements in patient safety. The survey findings are intended to inform the planning of the work programme for the Patient Safety Collaborative established by the Academic Health Science Network for the North East and North Cumbria. Six CCGs, eight acute Foundation Trusts, two mental health Foundation Trusts, the Ambulance Trust, NHS England Local Area Team, the North East Commissioning Support Unit and five Universities took part in the survey. The survey was conducted using 30 minute telephone interviews.

The findings illustrated some strong capacity and capability for patient safety although there was a marked contrast in culture, incident reporting and confidence about embedding learning between NHS Foundation Trusts, primary care and care homes. Bridging this gap so that patient safety activity in primary care and care homes reaches that of NHS Foundation Trusts was perceived as urgent.

Patient safety data are widely available particularly on topics such as falls and pressure ulcers. There are effective governance and communication systems and clear safety goals, particularly in NHS Foundation Trusts. Barriers to improvement include time and resources, and the difficulty of ensuring that lessons learned following a safety incident are sustained over time. Enablers include drive, enthusiasm, and goodwill.

Greater co-operation between NHS bodies and the academic sector on specific safety issues would be welcomed.

The Patient Safety Collaborative is strongly welcomed and a number of roles and tasks were suggested including the provision of a whole system forum for sharing ideas and good practice, and supporting a strategic approach. It was clear from the survey that colleagues wish to embed what is known, achieving wide coverage across the whole health system, rather than starting new initiatives.

Background

The Academic Health Science Network (AHSN) for the North East and North Cumbria has established a Patient Safety Collaborative with the aim of improving patient safety by increasing and accelerating the implementation of best practice and learning.

The Collaborative has committed to developing a locally owned and structured quality improvement programme leading towards transformational change, which builds system-
wide capability for safety improvement across the region. It also needs to build on existing initiatives, connecting pockets of excellence and spreading the learning.

The Collaborative recognises that it needs to do a few things really well and have some clearly identified priorities. It has therefore commissioned Clarity & Partnership Ltd to undertake a baseline survey of the AHSN’s member organisations to explore existing capability and capacity for patient safety improvement and the extent of investment in patient safety initiatives.

This report provides the findings of this baseline survey and summarises the key messages.

**Approach**

The survey was undertaken in three stages. During the first stage, project initiation, the review team reviewed the outputs that were required and agreed the approach. Survey instruments for both service and academic organisations were developed and piloted.

In the second stage the AHSN emailed all named contacts in partner organisations and invited them to participate. These contacts were then approached by Clarity & Partnership Ltd and invited to participate in a 30 minute telephone interview. A maximum of three attempts at contacting each organisation were made. Interviews were arranged with all who responded positively and the information gathered was consolidated.

In the final stage a report was written. In the first instance an interim report was provided, as a key participant postponed their interview. This allowed the opportunity for feedback from AHSN. Subsequently, this final report was provided which took into account feedback from the interim report.

**Findings - NHS bodies**

**Organisations Reviewed**

**Commissioners:** NHS Darlington, NHS Durham Dales, Easington and Sedgefield CCGs; Hartlepool and Stockton-on-Tees CCG; Hambleton, Richmondshire and Whitby CCG; North Durham CCG; South Tees CCG; this represents six of the CCGs in the region.

**Secondary and community care providers:** County Durham and Darlington NHS Foundation Trust; Gateshead Health NHS Foundation Trust; North Cumbria University Hospitals NHS Trust; North Tees and Hartlepool NHS Foundation Trust; Northumbria Health Care NHS Foundation Trust; South Tees Hospitals NHS
Foundation Trust; South Tyneside NHS Foundation Trust; The Newcastle upon Tyne Hospitals NHS Foundation Trust. This represents eight of the nine acute and community providers in the region.

**Mental health service providers:** Northumberland, Tyne and Wear NHS Foundation Trust; Tees, Esk and Wear Valleys NHS Foundation Trust. This represents two of the three mental health service providers in the region.

**Ambulance service provider:** North East Ambulance Service NHS Foundation Trust.

**Other organisations:** NHS England Local Area Team for Cumbria, Northumberland, Tyne & Wear; North East Commissioning Support Unit (NECS).

**People**

**Capability and capacity for patient safety improvement**

NHS Trusts reported that executive and senior team members have responsibility for patient safety, together with clinical directors. Several Trusts described patient safety teams and co-ordinators in clinical directorates; one also mentioned an organisational development team with service improvement staff linked to the patient safety agenda, as well as links to governance teams and clinical audit teams. However these staff members were always embedded in wider functions, typically ‘quality and safety’ or ‘safety and risk management’. Exceptions included Tees, Esk and Wear Valleys and Gateshead Health NHSFTs, which had safety specific teams.

CCGs reported similar, but much smaller structures with Executive Nurse lead, and a small team with responsibility for quality and safety. Some reported a GP lead for quality. The situation was similar to NHS Trusts in that these staff resources typically addressed both safety and quality. CCGs are supported by the North East Commissioning Support Unit (NECS), which provides a service incorporating incident reporting, analysis of themes and trends, and triangulation of themes with relevant aspects of contractual activity and conformity with care pathways. NECS has its own incident management system which accesses incidents reported on STEIS (from provider Trusts) or on primary care incident management systems, deploys tools including the Safety Thermometer and quality dashboards, and supports monitoring of actions in incident reports. This service incorporates incident reporting and management in relation to all organisations from which CCGs commission services, namely, secondary care, primary care, hospices and nursing homes. Safety incidents in GP practices and in the pharmacy, dentistry and optometry sectors are managed by the NHS England Local Area Team.
Numbers, roles and safety related qualifications of staff with specific responsibilities for patient safety

Respondents to the survey generally did not report that specific safety qualifications were undertaken by staff with responsibility for patient safety; several examples were given of safety leads undertaking a Masters degree with a dissertation on a safety related topic, but this was their personal choice. Similarly, some staff undertake the Postgraduate Certificate in Innovation and Improvement at Teesside University as part of their personal development. Tees, Esk and Wear Valleys, Gateshead Health and North Cumbria University Hospitals NHS Trusts reported that individual members of staff had a qualification (Institute of Health Care Improvement (Boston), Diploma and Health Foundation courses respectively).

Training

Mandatory and discretionary education and training directly relating to patient safety

Training in incident investigation and in root cause analysis is widely offered in NHS Trusts. Additional training offered includes core safety awareness, use of the organisation’s risk management system, clinical audit training, human factors training, training on consent, the Duty of Candour, and training on specific topics such as falls prevention, medication safety, prevention of pressure ulcers and so on. Patient safety is a core topic in induction procedures. Some Trusts include human factors (or Crew Resource Management) training. Training resources include the NHS Improving Quality handbooks.

CCGs mentioned training in Safeguarding, incident reporting and root cause analysis.

One CCG reported that training for the CCG Governing Body on clinical governance and quality has led to increased understanding and challenge on safety issues.

Training on how to embed learning

There was some evidence given of specific training in how to embed and sustain learning. Those NHS bodies that did not have such training reported that this would be useful. NHS Trusts reported various of means of ensuring learning: examples included the Kirkpatrick model of evaluating learning\(^1\); an audit strategy which ensures that key safety standards are met; and a tight governance system for ensuring that action plans are delivered. However all commented that serious incidents do occur again, and this has included a small number of never events. On the positive side however, one Trust reported a very substantial reduction in pressure ulcers following sustained focus on achieving this. Some Trusts had IT

\(^1\) NHS England has used the Kirkpatrick model to develop its approach to human factors and behaviour training across the region
based systems to support dissemination of learning and identification of repeat incidents.

CCGs reported that there was no means of knowing whether learning was embedded either in primary care or in care homes, and both sectors were in any case poor reporters of safety incidents compared with NHS Trusts. This was a matter of great concern. However one CCG reported active processes for engaging these sectors on this issue.

**Measurement and monitoring of the effectiveness of this training**

Some respondents said that there was no framework as such for measurement and monitoring of the effectiveness of safety training. However, some said that monitoring of specific safety data such as falls causing harm, pressure ulcers, CQUINs and so on yielded proxy measures. Some CCGs had systems that were closely integrated with those of their provider Trusts, including the measurement and monitoring of primary/secondary care handover related incidents. CCGs reported that it was difficult to manage the effectiveness of training in primary care and care homes; one CCG reported an incident relating to the use of certain equipment even though there had been an MRHA safety alert about that equipment. This may demonstrate a development need in relation to the commissioning role.

**Communication**

**Communication channels used for sharing safety information such as lessons learned, patient safety alerts**

A wide variety of communications channels were described, and some respondents commented that **different approaches are needed to make sure the message is seen**, rather than “absorbed into the wallpaper”. NHS Trusts reported the use of bulletins, newsletters, one-line communications, one side of A4 communications, briefings, patient safety forums, communications between groups up and down the organisation, Medical and Nursing Director cascade processes, communications to and from topic specific groups, and from MDTs to their own teams. One Trust described **Schwartz Rounds**\(^2\), open to all, where individuals can reflect on the emotional aspects of their work; and **'Dragon's Den' type projects** where safety ideas can be put forward by anyone. All reported effective, tested cascade systems for Alerts.

CCGs described similar communications systems including newsletters, quality and safety meetings which GPs may be incentivised to attend, care home forums and weekly incident reports to the senior team. A number of CCGs described the value of Clinical Quality Review Groups which are local forums for reviewing quality and safety issues with their Trusts supported by NECS.

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\(^2\) [www.pointofcarefoundation.org.uk](http://www.pointofcarefoundation.org.uk)
Governance

Governance arrangements for patient safety and fit with other arrangements for quality improvement

All NHS Trusts reported that they have a robust and well-established structure for patient safety committees, reporting ultimately within the hierarchy in each Trust to the Trust Board. Related committees addressing quality, clinical risk, clinical audit and so on are linked into the information flow and reporting arrangements.

CCGs also have committees which address patient safety issues reporting to the CCG governing body; in some CCGs this committee addresses commissioning, quality, finance and performance while in others there is a quality and performance committee. One CCG had a joint process with NHS England in relation to primary care contractors.

Some Trusts and CCGs have specific arrangements for challenge of the adequacy of the organisational response to alerts or incidents (often using non-executive directors).

In many cases there is a strong link or overlap with the organisation’s approach to quality improvement and/or risk management. This clearly worked well in terms of being able to integrate relevant information flows (incidents, near misses, complaints and litigation).

Specific priorities currently for patient safety including goals/objectives, local performance targets, CQUINs

This is reported to be well established. Organisational targets are set out in CQUINs, Quality Accounts and Sign up to Safety pledges. CCGs monitor outcomes based quality indicators in primary care contracts.

Specific topic priorities include: falls; pressure damage; acquired kidney injury; venous thrombo-embolism; COPD; HCAI; the deteriorating patient; sepsis; community acquired pneumonia; mortality; Safeguarding; linking Trust IT systems to avoid missed diagnosis and mis-diagnosis as patients travel through hospital departments; and in mental health trusts, physical health, safe practice around restraint and violence against staff. The Ambulance Trust has priorities that include medicines management (controlled drugs), medical device safety, pressure area care and Safeguarding.

Measures used to improve patient safety

NHS Trusts reported a wide variety of measures including:

- increase in incidents reported against a target increase (for example, one Trust felt that medication errors were under-reported and set a target for increase)
- topic specific measures on eg falls per 100 bed days, pressure sores, HCAI and many others (one Trusts described a RAG rated pressure ulcer prevention score)
- Trust dashboard at Trust, clinical centre/directorate and ward level
• compliance with safety targets in Quality Accounts
• NEQOS annual report on incident data which allows loose benchmarking.

A number of Trusts are collaborating in the development of mortality indicators supported by NEQOS.

Leading and lagging indicators are generally not in use, though one Trust reported the use of lagging indicators and plans to introduce leading indicators.

CCGs described:

• Sign up to Safety targets and measures
• quality indicators suite
• CQUINs
• the Safety Thermometer
• STEIS data including trends, quality metrics, backlog of incidents
• daily incidence of C difficile and weekly incidence of HCAI.

NHS Trusts described a wide range of activities to ensure that lessons from incidents were learned, and the learning sustained:

• audit, tracking and trending
• trend analysis over five quarters (for incidents where there are large numbers)
• reviewing peaks and troughs, and likely causes
• reviewing clinical performance following a specific incident
• checking actions implemented from historic incidents
• testing changes in all departments where a particular incident could occur, not just the department where it did occur
• reviewing similar incidents to look for links in causative factors
• reviewing the Top Ten incidents from their incident reporting system
• ensuring a quick response to incidents, and putting education in place
• reviewing hot spots
• maintaining run charts and achievement charts on every ward
• keeping specific issues on the radar
• a central safety team maintaining data and memory.

CCGs described:

• review of Trust major incidents and validation of actions
• a rigorous approach, but CCGs are dependent upon organisations reporting incidents
• review of complaints, claims and issued raised through PALS as well as safety incidents to give the widest possible picture; review of hot topics by Quality Review Groups
• developing quality requirements in contracts to ensure that lessons learned are always recorded in incident investigation reports.
Trusts and a CCG described the importance of their internal incident and safety monitoring systems. Most use DATIX but some use Ulysses. One CCG described using the same system as their major providers so that they could have an integrated system. All CCGs across NECS are using the same system for reporting incidents.

**Arrangements for involving patients and the public in patient safety improvement work**

NHS Trusts, including the Ambulance Trust, generally were able to describe involvement of patients and the public in patient safety work, though some said they would like to involve patients more; it was thought that implementation of the Duty of Candour would help. Patient stories are widely used, at the Trust Board, in governance meetings and patient safety briefings to inform behavioural work. Trusts referred to the role of Governors, non-executives, the community advisory panel and Healthwatch. One Trust described the link between their Sign up to Safety initiative and their service user and carer forum, and reported that patients can be involved in the investigation of serious incidents.

CCGs as commissioners reported less patient involvement except through lay membership of CCG governing bodies. They rely on the goodwill of providers to report patient stories, though one CCG said that red rated complaints are being shared. Primary care complaints are received by the NHS England Local Area Team and one CCG is trying to set up a mechanism to receive lessons from these.

**Barriers and enablers to improvement in patient safety**

**Barriers**

Barriers described by NHS Trusts (as providers) included:

- time
- training resources
- getting people together
- inadequate time for reflection
- inadequate frontline capacity
- establishing an appropriate culture
- only using lagging indicators at present
- staff knowledge of how to interpret safety data, and robustness of data
- junior doctors' audits not always completed
- pace of change
- mindset
- staff uncertainty and unhappiness at times of organisational change
- communication in a large and complex organisation - consistently getting to the front line
- service pressures
• failure to understand that mental health services are different.

Barriers described by CCGs (as commissioners) included:

• complexities of current commissioning arrangements
• independence of primary care and care home sectors
• time
• capacity
• fear of disciplinary action
• staff knowledge of use of data, and failure to spot trends
• poor understanding of how much remains to be done.

Barriers described by NHS England included:

• primary care culture 10 years behind that of Foundation Trusts, including incident reporting where there is a low level because of fear of sanctions. Primary care contracts are not specific enough to promote specific safety development programmes, and the NHS structure makes a systematic approach very difficult.

Enablers

Enablers described by NHS Trusts included:

• CQUINs
• national safety reports
• organisational culture and climate
• drive and motivation
• passion and enthusiasm
• leadership
• engagement of the Board and the public
• goodwill
• good practice
• use of common language
• education
• positive attitude
• root cause analysis
• belief that every individual can be a change agent
• resource of people and processes
• the new CQC inspection regime.

Enablers described by CCGs included:

• people willing to learn and run with ideas
• goodwill
• the ability to change service models
• move to a common IT system in primary care including out of hours
• CQC
• education
• co-commissioning would help.

Approaches to implementing the contractual Duty of Candour

All NHS Trusts described their approach which included policy development, staff training, forums and workshops, specific training on grading of incidents, and review meetings to discuss what falls into the remit of Duty of Candour. Many organisations already had a Being Open policy, which needed to be revised and updated. The importance of leadership by the Chief Executive and the Board was emphasised. Some Trusts engaged law firms to provide training. Those organisations using Ulysses commented on the helpfulness of the system’s internal reminders and reporting processes.

As commissioners some CCGs used their quality requirements framework to ensure implementation; in one CCG this included nursing homes and hospices. CCGs notified GP practices and care homes and provided supporting explanation. One CCG commented that "primary care has a long way to go; we expect candour of NHS Trusts but much less so of primary care organisations”.

Safety initiatives, research and sharing good practice

Active and legacy patient safety initiatives

NHS Trusts described a range of active and legacy patient safety initiatives (described in more detail in Appendix 1):

| A new safety strategy incorporating the best of former initiatives, especially from Safer Care North East |
| Re-launch of Early Warning Scores |
| Sepsis 6 |
| Management of the Deteriorating Patient |
| Sign up to Safety |
| Falls Safe |
| Safety Thermometer |
| ThinkSafe |
| NPSA Patient Safety Framework |
Leading Improvement in Patient Safety (mental health Trusts)

Simulation laboratory to improve competency and training.

One respondent said that constant purpose was required, not new initiatives; the service has "initiative fatigue" and needs to focus on embedding what is already known.

CCGs reported fewer initiatives but mentioned the Safety Thermometer, CQUINs, and initiatives focusing on falls and pressure ulcers. One CCG emphasised the importance of following up legacy patient safety incidents, so that the follow through and learning is not lost.

Investment in patient safety initiatives and research activity

Respondents described very little research on patient safety topics. However a number of organisations are involved with ThinkSafe, led by Newcastle University, which focuses on involving patients in safety issues. North Cumbria University Hospitals Trust has an established relationship with Lancaster University to undertake a range of small scale patient safety research projects, which is internally funded.

The North East Ambulance Trust has an internally funded research department looking at a wide range of issues such as a pilot system of direct ambulance service referral to a Trust Tissue Viability team in order to reduce serious pressure injuries, and the benefits of using an automatic chest compressor for resuscitation, allowing paramedics to get on with other life-saving tasks such as drug administration.

Availability of good examples of local patient safety improvements suitable for sharing

NHS Trusts quoted a range of examples of good practice, including examples of measureable safety improvement:

- Safety Attitude Questionnaire (cultural audit)
- Schwartz rounds, enabling staff to reflect on the emotional aspects of their work
- the role of clinical directors as influencers in patient safety
- a dedicated investigation team
- identifying patients at risk from falls and medication incidents
- improvement work on prevention of moisture lesions
- the regional Trust mortality project
- hospital acquired pressure ulcers down to single figures in a large Trust
- no moderate harm (or above) from medication errors for a year in the same Trust
- Trust based accreditation for quality and care - a Quality Mark at ward level can be achieved
• patient safety partnership working across a whole health economy – the Cumbria Collaborative
• a team based tissue viability incident review process, including immediate feedback and learning.

CCGs mentioned:

• data driven analysis - "what gets looked at gets addressed"
• primary care is getting used to performance monitoring, though not yet totally comfortable
• primary care is on the same journey as NHS Trusts, but there is a big separation in time; the approach is partly educational and partly supportive
• a specific project to reduce diabetic foot ulcers
• Safeguarding in care homes.

Arrangements for sharing best practice with other organisations

Arrangements for sharing best practice include: Quality Review Groups chaired by CCGs, attended by providers and facilitated by NECS; the Serious Incident Collaborative facilitated by NHS England Local Area Team for Durham and Tees; The Regional Mortality Review Group; and local arrangements such as joint work between mental health trusts, and work on pressure ulcers between the acute trusts in Durham and Tees.

How the Collaborative can best help organisations in their patient safety work

• have a pragmatic approach
• provide a forum (including NHS England) for sharing ideas, good practice and to support a strategic approach to common problems across the whole health care system
• provide training to develop capacity, especially on how to embed learning and evaluate the effectiveness of initiatives and programmes
• develop common tools for investigation, which everyone can use
• establish systems to share benchmarking information across the region in a timely way
• know what's going on in similar networks in other regions, nationally and internationally and circulate information
• offer funding
• establish peer to peer relationships with centres of excellence (e.g. Salford Royal NHS Foundation Trust) and academic organisations
• link with good practice from Safer Care North East
• provide a platform to recognise and celebrate good practice
• support learning in primary care and provide challenge to support a change in culture in primary care, as well as encouraging primary care to do more eg identifying patients at risk of falls
• develop programmes to support the engagement of nursing and residential homes
• provide academic input as organisations have little time to research things independently
• commission specific research
• offer a service specific framework; target organisations by type and ask them what they need. The Collaborative needs to fit with what people are already doing.

Findings – academic bodies

Organisations reviewed

Representatives of health disciplines in Durham, Newcastle, Northumbria, Sunderland and Teesside Universities were reviewed. This represents five of the six universities in the region.

People and training

Academic capacity for patient safety - teaching and research

In general, academic staff in health disciplines have knowledge of patient safety concepts and issues but only small numbers of individuals have very specific teaching and research interests and expertise: examples include Ph.D students researching a safety theme, joint working with CCGs on safety topics and a major project ‘ThinkSafe’ at Newcastle University which seeks to involve patients in safety issues.

Provision of courses where patient safety is included as a significant part of the syllabus

All undergraduate courses incorporate patient safety, mapped through the various programmes of medical, nursing, AHP and pharmacy undergraduate training. Medicines management in pharmacy training is a particularly strong example. Teesside University has links with the South Tees Hospitals Trust through human factors training; Newcastle University highlights the impact of medical errors in the first year of medical training, and looks at safety outcomes throughout the course.

Provision of other courses where patient safety is included

Several examples were given: Newcastle University's M.Sc in public health has a module on quality in health care that includes patient safety; Teesside University has a PG Certificate and a Masters in Quality Improvement and Clinical Governance
which incorporates patient safety; Teesside University also has a PG Certificate in Advancing Human Factors in Health and Social Care; and Sunderland University has modules for health care assistants in nursing homes on medication safety.

Expertise in using patient safety related tools or instruments

A number of examples were given, including: a medicines safety climate tool (University of Durham); tools to prevent falls in older people, and interventions to improve patient resilience (Northumbria University); and as previously mentioned, ThinkSafe at Newcastle University.

Current patient safety research interests, funding and partners

A small number of examples were given: these included work on medication safety in children (Durham); falls in sheltered housing (Northumbria); the impact of organisational culture on patient safety (Northumbria); ThinkSafe (Newcastle); and virtual reality in patient safety (Newcastle).

Academic partners mentioned included Sheffield University and John Moores University; service partners included neighbouring NHS Trusts; Kings College Hospital; Great Ormond Street Hospital, sheltered housing and care homes, CCGs and pharmaceutical companies.

How the Collaborative can help academic organisations contribute to improved patient safety

- promote integrated, evidence based patient safety
- support applied / translational research
- support development of long term partners, especially in the NHS so that interventions can be properly assessed
- provide an environment where new and innovative conversations can be held
- help develop an academic awareness of clinical issues which leads to an opportunity to think differently
- encourage Health Education North East to provide support to fully identify patient safety activity in teaching and assess what is currently happening across all courses
- encourage nurses and AHPs to do Human Factors training.
- the Collaborative should say what it can do - Universities would collaborate if asked.
Discussion

The first key finding from the interviews undertaken is that NHS provider trusts in the North East demonstrate a very high standard of knowledge, expertise and good practice, clearly built up over many years of successful patient safety initiatives which organisations have implemented and adapted to their local circumstances. This level of expertise constitutes a very considerable resource and should perhaps be recognised by the Collaborative at an early stage in its work programme. There is likely to be little merit in supporting interventions which are already well known and well understood; rather, benefit is more likely to accrue from work across organisations on how best to embed learning following an incident, and ensure that this learning is sustained over the longer term as staff turn over and priorities change. Many respondents commented on the difficulty of sustaining learning, especially in large, complex organisations. One insightful example was "how do we ensure we deliver safety messages through many layers in an organisation, to a staff member who perhaps only works two night shifts per week?"

Few respondents reported specific safety qualifications amongst patient safety leads, except where individuals choose to undertake postgraduate study and select a patient safety topic for their dissertation. However this does not detract from the collective expertise embedded in the many years of experience of these patient safety leads.

The second critical finding is the gap in incident reporting and embedding learning in the primary care and in the care home sectors, compared with arrangements in NHS Trusts. A number of CCGs raised this as a particular concern and commented that while primary care and care homes were on the same pathway and trajectory as NHS Trusts in relation to patient safety, there was a huge gap in time. It was felt that closing this gap was of great importance, and support in this area would be particularly welcome.

Governance and communications are clearly well established and effective. NHS organisations have clear priorities in their patient safety improvement programmes and several were able to cite successful, measurable outcomes including reduction in harm from medication errors and reduction in the incidence of pressure ulcers.

The questions on perceived barriers and enablers to improving patient safety provided insightful responses. In addition to the expected barriers around time, resources, service pressure and the pace of change, both CCG and NHS Trust respondents mentioned the relatively limited ability of front line staff to interpret data and charts, and identify trends. Enablers were almost universally about enthusiasm, goodwill, drive and the value of education.
Academic organisations responded openly to the interviews and quoted a number of examples of links with the NHS in teaching and research. However, overall it was perhaps surprising that there was not a greater degree of collaboration. We gained the impression that stronger practical links would be highly desirable.

The Patient Safety Collaborative is seen as a welcome development and members of the AHSN are keen to engage. There are a number of common aspirations by NHS organisations which include:

*Providing a platform for sharing good practice, practical solutions and for debating potential approaches to 'hard to solve' patient safety issues.* This idea very much builds on the work done by Don Berwick. Several respondents suggested that any such forum should be a whole health economy one. This is because the problems are shared by all organisations including commissioners. Additionally there is the potential to develop solutions across whole health economies (including nursing and residential homes). There is also the potential to apply solutions developed in one sector by applying them to another with appropriate development. This process was described by one respondent as "developing a community of practice".

*Supporting the development of patient safety capability and capacity.* This could be done in a number of ways: supporting the development of a strategic approach to capability and capacity development across commissioners and providers on a whole health economy basis; educational initiatives; developing good practice; sharing relationships with external organisations including universities with appropriate expertise (one respondent specifically mentioned the Salford Royal NHS Foundation Trust).

*Providing a setting for the local recognition and celebration of good practice.* This was felt to be more appropriately focused on teams and individuals rather than whole organisations.

*Supporting the development of local information and feedback resources* that were both more timely and gave peer benchmarking across the region served by the AHSN, to support the understanding of performance and to help identify those organisations that were generating learning. The existing mortality project was cited as an example of what was needed.

The academic organisations surveyed had other priorities; these were:

*Supporting the development of academic / service partnerships* (described by one respondent as "long term relationships") where the academics are embedded...
enough in the service development arena to be able to develop and provide evidence or plan evaluation of work at the earliest stage.

Providing an environment where new, innovative conversations can be developed so that the opportunity to think differently is achieved.

Supporting the development of translational and applied research into patient safety and/or supporting the development of effective processes for bidding for funds.

Funding specific research, e.g. answering the research question ‘what is a safe workload?’

Conclusions and key messages

1. There is considerable enthusiasm about the value of the Collaborative and its potential to move the patient safety agenda forward, addressing common problems.
2. There is an unmet need for networking, sharing of experience, comparative information at regional level and ready access to national work.
3. There is a need for recognition and celebration of successful work.
4. There is very considerable expertise in patient safety and there are measureable improvements in safety outcomes in some areas.
5. It is much more important to embed what is known, than to introduce additional initiatives which are not markedly different from the many initiatives which have already been adopted.
6. Developments in the secondary care sector are significantly in advance of those in primary care and in the care home sectors. This needs to be addressed with some urgency.
7. Support for specific, service-based research and master classes on agreed topics would be welcome.
8. The role of academic organisations in their long term relationships with NHS organisations on patient safety matters could be strengthened, and academic input into safety initiatives would be welcome, particularly in relation to innovation and evaluation.
9. Education of front line staff in the use and interpretation of data is needed, and proves to be a good investment.
10. Opportunities to bid for funding would be welcome.
Appendix 1

Safety Initiatives

Early Warning Scores: a guide used by medical services to quickly determine the degree of illness of a patient, based on data derived from physiological readings and observation.

Sepsis 6: a set of six interventions to be undertaken to increase the chance of survival of a sepsis patient.

Management of the Deteriorating Patient: a set of responses and actions to identify, prevent and manage clinical deterioration.

Sign up to Safety: led by NHS England, Sign up to Safety aims to reduce avoidable harm by 50% and save 6000 lives over three years; organisations make five pledges to put safety first, continuously learn, be honest, collaborate, and be supportive.

Falls Safe: a quality improvement programme introduced by the National Falls and Bone Health programme to reduce accidental falls in hospitals through introducing an evidence based care bundle.

Safety Thermometer: developed by the NHS to allow teams to measure harm and the proportion of patients that are harm free over a specified period of time.

ThinkSafe: an initiative led by Newcastle University on involving patients in safety matters.


Leading Improvement in Patient Safety: a programme to build capacity and capability in teams to improve patient safety.