The AHSN Network

NHS Improvement

A commitment to act

Patient Safety Collaborative

Contents

Foreword

Never in the history of the NHS has there been such a focus on patient safety. This is something we must take full advantage of to ensure the NHS becomes the safest healthcare system in the world.

The national Patient Safety Collaborative (PSC) programme – the largest patient safety initiative in the history of the NHS – is making a profound contribution to building a culture of safety, continuous learning and improvement.

The programme was launched following Professor Don Berwick's seminal report on the safety of patients in England, A promise to learn – a commitment to act: improving the safety of patients in England[1], and our commitment to the promise is as strong as ever.

Over the last three years the PSC programme has played an increasingly crucial role in supporting staff and patients to maintain a focus on safety. It consists of 15 regional collaboratives across England, led by the Academic Health Science Networks (AHSNs), which are ideally placed to deliver continued improvement in patient safety and innovation in care, and to promote the adoption and spread of good practice across the country.

On a regional basis each collaborative uses practical quality improvement methods and approaches to identify safety priorities and develop solutions, while also creating the right conditions for safer systems of care, learning from errors and reducing avoidable harm.

At a national level, the collaborative approach has encouraged the formation of networks and communities of practice, ensuring each and every collaborative is sharing with the others.

The programme brings together patients, carers, clinicians and managers alongside national and international safety experts. It is supported by national and regional partners, and aligns with and complements the Sign up to Safety campaign and The Q Community – a diverse and growing community of people committed to improving the quality of health and care across the UK.

In the following pages you will find examples of how the collaboratives are sharing success nationally, allowing for proven best practice to be adopted across the country.

From my personal visits to the regions and reading through this brochure it gives me a great sense of pride to see such commitment from each and every collaborative. They are all playing a key role in our improvement journey, and nationally their efforts are pivotal in making the NHS the safest healthcare system in the world.

Dr Mike Durkin
NHS National Director of Patient Safety
NHS Improvement
May 2017

Dr Mike Durkin

NHS National Director of Patient Safety

[1] A promise to learn – a commitment to act: improving the safety of patients in England is available at: www.gov.uk/government/publications/berwick-review-into-patient-safety

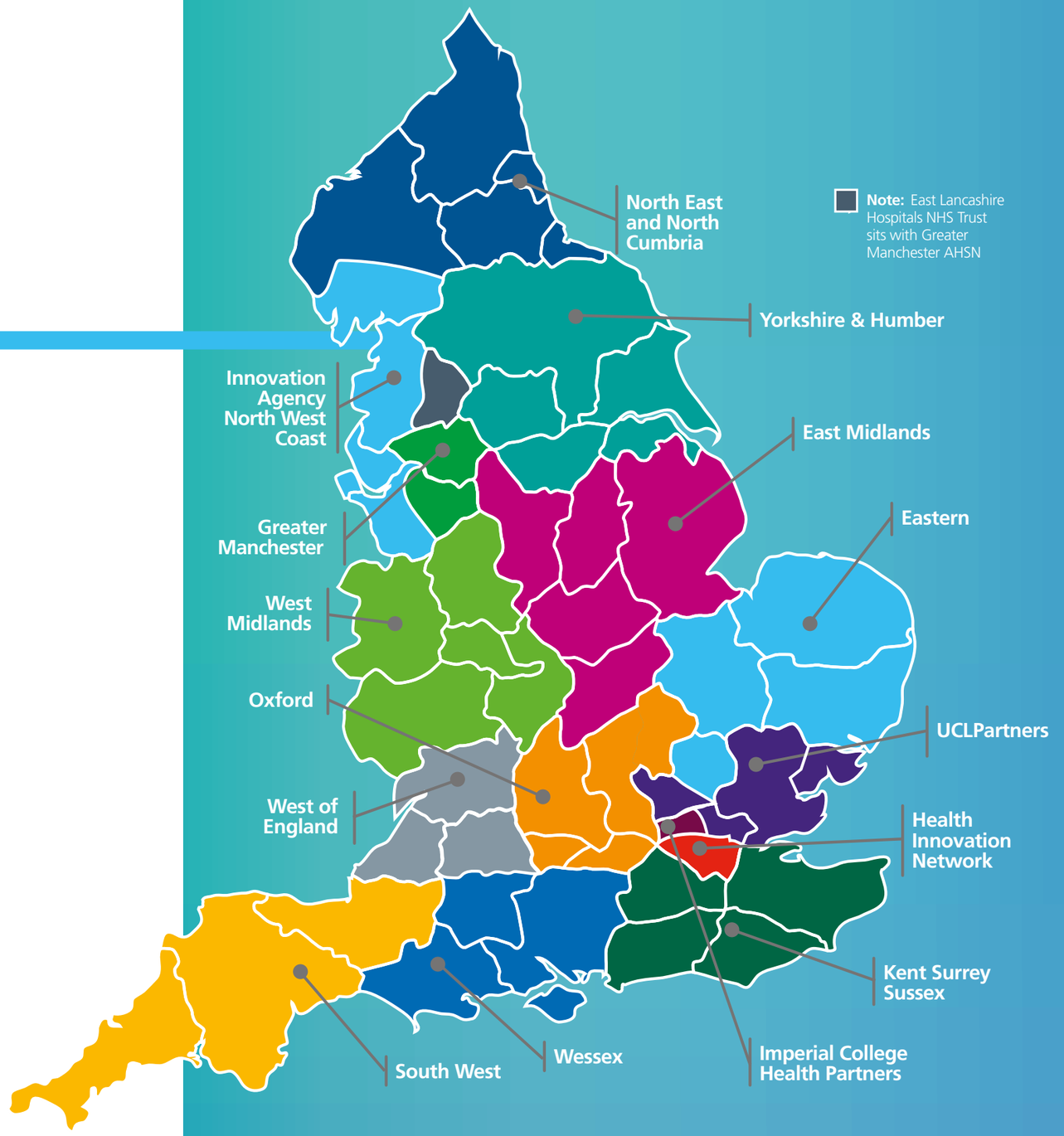
The national Patient Safety Collaborative programme

The national Patient Safety Collaborative (PSC) programme is the largest and most comprehensive programme of its type in the world, bringing together people with a passion and commitment to improve patient safety across England.

It is funded and co-ordinated centrally by NHS Improvement, and organised and delivered locally by the 15 Academic Health Science Networks (AHSNs). The 15 regional collaboratives work with networks of NHS staff, patients, national and local partners, academics, businesses and voluntary organisations to implement patient safety initiatives.

"Each collaborative empowers local patients and healthcare staff to work together to identify safety priorities and develop solutions, and incorporates health innovations co-created by the NHS, industry and universities to improve patient safety. We have worked within and together across regions and nationally, to learn from each other and to spread best practice and innovations."

Dr Liz Mear, AHSN Network Chair



Our collective ambition

The Patient Safety Collaborative ambition is for improvement to extend across the entire healthcare system in England, so that care is safer for all.

The aim is to build a culture of safety, continuous learning and improvement to achieve a continual reduction in harm, so patients and the public can be confident that care is safer now than ever before.

We expect safer and more reliable systems of care to develop as we learn from errors and excellence, and reduce avoidable harm.

Achieving our ambition

The collaboratives use practical quality improvement (QI) methods and approaches, and focus on:

- **leadership for safety** at all levels
- assessment of **culture**: creating the conditions to foster a culture of safety and engaged teams
- system-wide **capability-building** for both staff and patients in safety and quality improvement science
- the creation of a system for **continuous learning** and improvement, encouraging the adoption and spread of evidence-based improvements through networks
- developing skills and capability for **measurement for improvement**
- improvement of topic-specific **clinical care processes**
- facilitation and promotion of **innovation for safety in healthcare**.

Our work so far demonstrates how working collaboratively can achieve great results that spread beyond regional boundaries.

Leadership
Culture
Capability
Learning
Measurement
Process
Innovation

"Our work over the last three years has tackled major areas of concern including sepsis, acute kidney injury, medicine optimisation, transfers of care and improving mental health services.

We are committed to sharing good work and continually learning how we can accelerate and spread improvements to avoid harm and improve the safety of patients in our care.

To get involved in our work, please contact your regional Patient Safety Lead."

Dr Cheryl Crocker and Jane Macdonald, Patient Safety Collaborative Leads Forum Co-chairs

Our activity

In 2016/17...

We engaged with **1,575** organisations including:

333 care homes

635 in primary care

219 providers

We recruited **1,972** patient safety champions, Q fellows and QI experts.

We completed the necessary foundation steps to run the collaboratives successfully.

We started **451** QI projects of which we completed **170**.

We trained **10,150** people as part of QI capability building including...

400 patients

4,055 trained in cultural awareness

936 trained in safety leadership

3,422 trained in measurement

Our learning and insights:

"We've encountered a huge desire from clinical staff to work beyond their organisation's boundaries to tackle complex safety issues and our collaborative is seen as a great partner to overcome barriers between different parts of the NHS."
Tony Roberts, PSC Programme Lead, North East and North Cumbria AHSN

"Keep talking to the front line staff – they often have the answers to why things can go wrong and have the best ideas for improvements."
Mel Johnson, PSC Programme Manager, Yorkshire and Humber AHSN

"To reduce unwarranted clinical variation in practice, the improvement journey teams will go on cannot be standardised…there is no one size that fits all."
Peter Carpenter, Programme Director – Quality and Safety Improvement Collaborative, Kent Surrey Sussex AHSN

"There is opportunity to show significant impact through relatively small changes – keep things simple, avoid setting unrealistic goals and doing too much, too quickly."
Kate Hall, Director of Capability Development, UCLPartners

"The collaboratives are having meaningful conversations with patients about aspects of care, and are working in partnership to co-design and improve services."
Sarah Tilford, Improvement Manager – Patient safety, NHS Improvement

Wessex's 'recipe for good collaborative work':

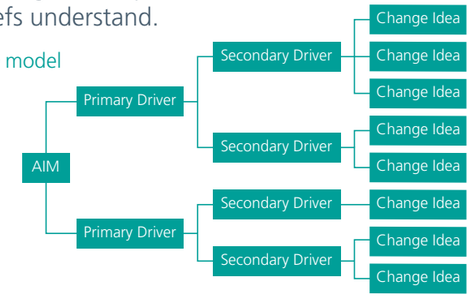
Together
Everyone
Achieves
More

Get your chefs of all levels together in the kitchen, agree the recipe and work collaboratively.

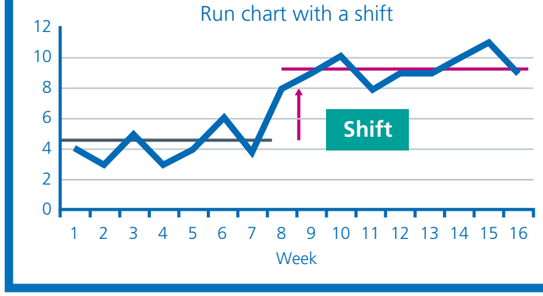
Make sure you add the right measure of patient at the start not at the end of the bake.

Use a good recipe that all the chefs understand.

The model



Measure your ingredients carefully using small data, this is time well spent and will affect your bake. Review often to check the cooking progress.



Leadership for safety

Teams recognise the critical role leaders play in developing a safety culture, achieving high performance and enabling change.

Board quality and safety leadership programme

Eastern, East Midlands, Greater Manchester, Innovation Agency North West Coast, and West Midlands

From investigations into NHS failures we know that board dynamics play a key part in how organisations perform. High performing organisations consistently have quality as their top priority.

Five regions are working with the Advancing Quality Alliance (AQuA) to deliver a quality and safety development programme for NHS provider boards. The programme enhances board members' knowledge and skills, and their confidence to lead quality and safety improvement initiatives. It has demonstrated that changes in board and organisational behaviour lead to a longer term impact on quality, and has put safety at the heart of boards.

"This was a fantastic opportunity… to look at how effective we were and whether we were using the correct information to make decisions at board level. We were able to identify where we had excellent practice and where we needed to make significant improvements… I would really recommend the experience."

Sandy Brown, Deputy Chief Executive and Director of Nursing and Clinical Quality, East of England Ambulance Service NHS Trust

36 organisations
have taken part in the Board Quality and Safety Leadership programme.

Building the foundations of safety

Imperial College Health Partners

Imperial College Health Partners' Foundations of Safety programme, delivered in partnership with Ashridge Business School, engaged healthcare leaders and patient representatives across North West London to explore the factors underpinning quality and safety improvement. The programme gave leaders a platform to learn and share ideas, and was a catalyst for participants to successfully implement change initiatives.

One trust reduced spend on agency staff by **30%** by using a daily safety template to identify staff capacity and patient acuity.

Patient leadership for safety

Eastern

Patient leaders play a key role in improving patient safety. Eastern has encouraged patient involvement and leadership by involving them in co-designing and shaping the content of the programme, taking part in learning events, and steering group activity.

"[Eastern] recognises the value of the patient and carer voice. The Citizens' Senate helped co-design the collaborative, ensuring the public, patient and carer voice was at the centre of Action on Frailty…ensuring that patients can play a greater role in the design and delivery of improvement."

Trevor Fernandes, Co-Chair of the East of England Citizens' Senate

Focus on safety culture

Improving the culture of safety is an essential component of preventing and reducing harm, and improving the quality of care.

Safety huddles
Yorkshire and Humber

Safety huddles help reduce patient harm and improve safety culture by enhancing communication and behaviours in teams, and providing a safe space where staff meet regularly to discuss, learn and improve.

"I am so proud of our ward huddle and the impact it is having … and there has been a direct effect on the number of falls on the ward."

Camilla Smith, Senior Sister, The Leeds Teaching Hospitals NHS Trust

Since the initiative began **2,439** falls have been potentially avoided.

One ward in an acute trust has increased its average of 20 days between pressure ulcers to **160 days**.

Five mental health trusts use huddles to avoid patient harm. On one ward, daily safety huddles delivered a **58% reduction** in seclusion episodes.

The work has now been adopted and spread across **10** acute providers, **five** mental health and community providers, **six** care homes and **two** medical practices.

90 teams in **23** organisations in the region and **six** outside have adopted huddles.

Assessing safety culture
South West, and Yorkshire and Humber

Regions, including South West and Yorkshire and Humber, are using measurement tools, including surveys, to assess team culture and understand the impact of culture on safety. Although the technical aspects of administering surveys are important, the real value lies in the debriefing and action-planning, and these rely on the skill and sensitivity of the trained facilitator to interpret the safety culture data and provide feedback.

Yorkshire and Humber has carried out **313 culture surveys** with frontline teams and facilitated feedback from the survey results. The South West has supported the assessment of **56 frontline teams** spanning primary care, mental health and acute care settings, and **trained over 1,000 frontline professionals** in safety culture and quality improvement.

Analysing human factors to improve Serious Incident investigations
East Midlands

A management tool that identifies human causes of accidents is improving the efficiency of Serious Incident investigations in the East Midlands.

Five mental health and two large acute providers are using the Human Factors Analysis and Classification System (HFACS) to aid investigations. HFACS studies the relationships between individuals, the tools they use and the environment in which they live and work. This involves a retrospective review of Serious Incidents. In one review relating to suicide, previously unrecognised contributory human factors were identified.

The same methodology is being applied to Never Events and is yielding new learning. The next stage is to explore how to sustain and spread the use of this methodology.

From submarines to social care
West of England

Communication and team-working have a significant impact on patient safety. The West of England, in partnership with a number of organisations, developed a human factors training programme to improve team communication specifically for community support staff.

All resources are open access at **www.weahsn.net/human-factors**

To date a faculty of **41 facilitators** have **trained over 3000 staff** in the situation–background–assessment–recommendation (SBAR) tool which originated in submarines to improve the transmission of important information.

"I just think this is a really positive way of doing things. We do get really focused on the detail. This feels much more about how do we make our systems, processes and organisation safer. I think that's really positive for everyone."

Workshop participant trained in using the tool

Building improvement capability

Enabling staff to develop the skills, tools and knowledge to improve the quality and safety of the care they provide is a core component of the collaboratives' work.

Improvement Fellows Programme

UCLPartners

The region established a 12-month Improvement Fellows Programme to build QI skills and capability, and create a network of enthusiastic and motivated people to drive improvement in their organisations and professional communities.

The fellows attend workshops and masterclasses on improvement, and collaborate and share learning with colleagues and the faculty. They also have access to the Institute for Healthcare Improvement's (IHI) Open School, and have the opportunity to engage with a wider community of improvers.

"As soon as you connect with others you are reminded that we all face similar challenges. So for me, it's a great chance to triangulate my experience with that of others and to learn about the strategies they are using."

Dave Grewcock, Head of Improvement, UCLH Institute, University College London Hospitals NHS Foundation Trust

Sepsis e-learning: early recognition and response

Innovation Agency North West Coast

North West Coast has supported the development of an e-learning tool, the Sepsis Careworker's Guide, to help residential care and nursing home staff detect sepsis.

The tool covers early recognition of the potential for sepsis and actions to take when a resident shows certain warning signs.

To access the tool visit **www.the-uk-sepsis-trust.create-elearning.org/en/org-course**

"This is an excellent short training course for care workers. A high percentage of people who develop sepsis come from the community setting and it's hugely important to increase awareness of this life-threatening condition."

Dr Matt Inada-Kim, Consultant Acute Physician and Clinical Lead for Sepsis at Wessex AHSN

Capability-building for quality improvement

Yorkshire and Humber

Yorkshire and Humber is supporting health and care organisations to build capacity and capability among all NHS staff groups to improve quality and safety by offering three levels of QI training.

Bronze: free and available online, introduces the model for improvement and practical improvement tools – around 1,500 health and care staff trained

Silver: in-depth sessions on the practical application of QI methods, tools and techniques – nearly 500 staff trained

Gold: Train the Trainer programme to maintain and enhance a sustainable improvement culture – 39 staff trained.

For further information visit **www.improvementacademy.org**

The Patient Safety Launch Pad

South West

The South West has designed and implemented a patient safety development programme called the Patient Safety Launch Pad.

This is a five-day programme over nine months, free to delegates in the South West. It's a bespoke version of the region's successful Accelerated Patient Safety Officer programme and supports delegates to implement a patient safety and QI plan at ward, unit, hospital or system level. It's delivered by a team of QI experts from across the region and the UK.

"The Launch Pad builds on a successful three-year partnership with the Institute for Healthcare Improvement where we co-delivered three Patient Safety Officer programmes to over 240 clinicians, frontline teams and patients across the South West."

William Lilley, Patient Safety Lead, South West AHSN

Creating a learning system

"The most important single change in the NHS… would be for it to become, more than ever before, a system devoted to continual learning and improvement of patient care, top to bottom and end to end."

(Berwick Report 2013)

"We tend to regard excellence as something to gratefully accept, rather than something to study and understand. Our preoccupation with avoiding error and harm in healthcare has resulted in the rise of rules and rigidity, and cultivated a culture of fear and stifled innovation. It is time to redress the balance. We believe that studying excellence in healthcare can create new opportunities for learning and improving resilience and staff morale."

Adrian Plunkett, Consultant Paediatric Intensivist, Birmingham Children's Hospital

Learning from Excellence

West Midlands

Learning from Excellence is a project across the West Midlands to identify, appreciate, study and learn from episodes of excellence in healthcare delivery. Safety in healthcare has traditionally focused on avoiding harm by learning from error.

Staff at Birmingham Children's Hospital have been using 'appreciative inquiry' to learn from excellence. Other health organisations in the region are adopting the method in their work.

For more information visit **www.learningfromexcellence.com**

Medicines safety: learning in action

Greater Manchester

Medications management and safety on transfer between different healthcare settings are key areas for improvement.

Greater Manchester worked with Haelo on a year-long local Breakthrough Series Collaborative programme to increase the number of patients experiencing 'defect-free medicines care'.

Nine health economy teams attended learning sessions, interspersed with three 'action periods' identifying and testing initiatives. Collectively, there was a **58% relative improvement** in 'defect free medicines care' **from 26.6% to 42.4%**.

Teams were positive about the programme, particularly the opportunity for collective learning and improvement, and the chance to replicate improvement in their local organisations.

Using communities of practice to enhance learning and improve safety

Health Innovation Network, and Kent Surrey Sussex

Communities of practice cross boundaries to involve different organisations, professions, hierarchies and sectors. They access intelligence that is already in the system and apply it to complex problems.

The Health Innovation Network (HIN) in South London brought together clinicians, risk managers, Action against Medical Accidents and Healthwatch to focus on improving duty of candour practices. The community developed training materials that shared good practice and prevented duplication of work across organisations.

Kent Surrey Sussex set up a community of practice to develop, design and test a training package to improve the quality of Serious Incident investigations.

Jessica Wickham @grrrrrrjess · 24 Jun 2015
Great Improving Medicines Safety event yesterday, now to set up our team meetings and map out our actions! #IMSTransfers #transformation

Measuring improvement and monitoring safety

Measurement is an essential component of any improvement programme. It needs to take place at every stage of a project – before, during and after to show the impact.

Central measurement unit

NHS Improvement has commissioned a central measurement unit to help the PSC programme use measurement to drive improvement and aid the sharing of learning. The unit will support the regional and national work of the collaboratives, and provide practical guidance and measurement for improvement training.

"The central measurement unit supports the national patient safety programmes, brings together and advises on safety information, and supports the collaboratives by providing expertise and access to information and metrics."

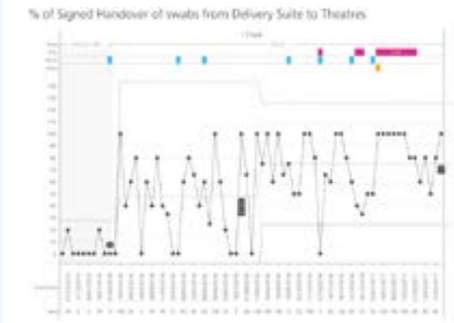
Sarah Scobie, Associate Director, Transformation Analytics and Health Economics, NHS South, Central and West Commissioning Support Unit

Reducing swab retention Never Events to zero in maternity

Oxford

Oxford partnered with a large maternity hospital on a QI project to reduce the incidence of retained vagina swabs – a Never Event – in the maternity department to zero within 36 months.

It focused on standardising processes relating to swab counts, and handover and documentation of swabs. Statistical process control charts were used to measure the impact of the tests of change.



The project is demonstrating measurable improvements:

600 days incident free

In the nine months before the project there were three Never Events; since the project has been underway the department has been more than **600 days free of incident.**

Improvements in handover

77%

27%

Verbal handover of swabs from delivery suite to theatre has **increased from 27% to 77%**

63%

4%

Written handover of swabs from delivery suite to theatre has **increased** from **4% to 63%**

Improving clinical care processes

The collaboratives are prioritising initiatives to improve the clinical process of care across the health and care system.

Identifying patients most at need in the emergency department

West of England

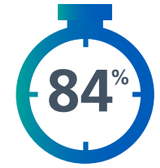
An emergency department (ED) safety checklist has been developed in the West of England to help improve the recognition and treatment of serious illnesses such as stroke, heart attack and sepsis.

It was created in response to overcrowding in EDs, to enable staff to quickly assess the sickest patients and triage them. A multidisciplinary team at University Hospitals Bristol NHS Foundation Trust used the checklist and used QI methods to pilot and implement it.

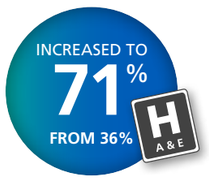
The checklist and associated toolkit have been adopted by all acute trusts and the ambulance service in the region.

"International evidence, highlighted in the Keogh Urgent and Emergency Care Review, clearly demonstrates the risks that crowded EDs pose to patient safety and outcomes. This intervention is designed to directly address these challenges and has already been shown to be effective."

Professor Jonathan Benger, National Clinical Director for Urgent Care at NHS England



The number of acutely unwell patients having their National Early Warning Score (NEWS) calculated within an hour of admission to EDs has improved from an average of **55% to 84%**, and calculation of Painscores increased from **59% to 93%**.



The number of electrocardiograms (ECGs) being instructed within 10 minutes of people arriving in EDs has **increased** from **36% to 71%** of all appropriate patients.

To download the toolkit visit
www.weahsn.net/emergency-department/

Focus on hydration improves care in residential and nursing homes

Oxford

The introduction of structured drinks rounds is helping to reduce urinary tract infections (UTI) in care homes.

The project used themed trolleys, and diaries to record fluid intake and diet. It also established a training programme for staff and residents.

The average frequency of UTIs requiring antibiotics decreased from one every **four days to one every 30 days**.

"The training has given us an understanding of why it is important to ensure that residents have enough fluids. It's looking at the whole system not just a drink."

Training programme participant

Emergency Laparotomy Collaborative

Kent Surrey Sussex, Wessex, and West of England

Three collaboratives, Kent Surrey Sussex, Wessex and West of England, have joined forces to form the Emergency Laparotomy Collaborative (ELC).

The programme aims to save 1000 lives over two years by improving standards of care and outcomes for patients undergoing emergency laparotomy surgery.

It involves the adoption and spread of the evidence-based Emergency Laparotomy Pathway Quality Improvement Care bundle (ELPQuIC) from four to 28 hospitals across the three regions. It encourages a culture of collaboration across the regions, and is embedding QI improvement skills to ensure sustainability of change.

8.5%
decrease in length of stay

Length of stay has fallen by **8.5%** (1.5 days), equating to non-cash releasing savings of £1.3m in the first nine months.

18%
decrease in mortality

Risk-adjusted mortality rate fell by **18%** in the first three months.

For more information visit
www.emergencylaparotomy.org.uk/

Innovation for safety

Innovations in healthcare can result in safer systems, increased productivity, efficiency and effectiveness, and can be financially beneficial. The collaboratives are well positioned to engage with partners to seek out such opportunities.

Precision medicine with genotype-guided warfarin dosing

Innovation Agency North West Coast

North West Coast is supporting a pioneering project that uses gene testing to prescribe individualised dosages of warfarin for patients with atrial fibrillation (AF).

Warfarin is an effective anticoagulant but determining the correct dose is difficult and often takes six to eight visits to a clinic.

In the project led by the Wolfson Centre for Personalised Medicine, new patients with AF undergo genotyping before being prescribed warfarin. This has brought personalised medicine to more than 100 people in the first year.

"When my mum went on warfarin eight months ago, she was back and forward to the clinic at least four times a week before they got the dose right. When I started on warfarin, I went back once, and felt well enough to go back to normal life straightaway. I think this a win-win for me and the health service."

Paul Downie, patient

PaperWeight: helping fight malnutrition

Greater Manchester

Greater Manchester introduced an initiative revolutionising the way healthcare professionals tackle malnutrition. It involves a simple slip of paper: the PaperWeight armband.

The armband is a quick, non-intrusive measurement to signpost people who are malnourished to online nutrition information. It measures the mid arm circumference, and if that is less than 23.5cm a Quick Response (QR) code can be used to access nutrition information on the Age UK (Salford) website. The armband provides support workers making home visits with instant information, and reduces the need for referrals to dieticians.

Teams have worked closely with the voluntary and social care sector to make staff more aware of malnutrition in older people, and support use of the armband as part of existing toolkits.

"Our support workers provided advice on simple dietary changes to increase calorie intake. The results were really positive."

www.ageuk.org.uk/salford/paperweight/
Follow on Twitter **@PArmband**

Age UK Salford

£300,000
saving

Since Greater Manchester introduced the initiative, oral nutritional (sip feed) prescribing costs have fallen by £80,000 from 2013/14 to 2015/16, with the integrated approach halving service expenditure and saving over **£300,000**.

Reducing the incidence of acute kidney injury

North East and North Cumbria

Acute kidney injury (AKI) can occur as a complication of another serious illness. When it presents in patients it can result in increased mortality, or increased length of stay and treatment costs. If recognised early, AKI can be treated easily and effectively.

In partnership with North East and North Cumbria, a team at South Tees Hospitals NHS Foundation Trust has shown that having processes for consistent detection and treatment can substantially reduce the incidence of AKI.

The AKI prevention programme has been rolled out to **seven** other trusts across the North East.

South Tees Hospitals NHS Foundation Trust estimates a cost saving of about **£500,000** per year.

Between June 2016 and November 2016 the AKI incidence on surgical wards was reduced by **36%**

Learning and sharing

The PSC programme is founded on the principles of the adoption and spread of good practice, innovation and sustained improvement, and the collaboratives are actively contributing to national sharing and learning.

Improvement Hub

The Improvement Hub on NHS Improvement's website is a quick and easy way of accessing improvement tools, resources and ideas from across the health sector on a range of topics. Use the hub to discuss your ideas with colleagues, share your own improvement stories (lessons learned and successes) and share improvement resources you've seen elsewhere.

Visit **www.improvement.nhs.uk/improvement-hub/**

LifeQI

Sharing through Life QI

Life QI, an independent platform used by many of the collaboratives, makes it easy for teams to set up and run QI projects, document their projects, and share and learn from others.

Life QI is used by more than **450 organisations nationwide**, with around **4,400 registered users** and **1,700 live projects**, and is available in **24 other countries**.

"Life QI has given our stakeholders unprecedented visibility of the great QI work in the West of England."

Kevin Hunter, Patient Safety Programme Manager, West of England AHSN

[2] **A The Breakthrough Series: IHI's Collaborative Model for Achieving Breakthrough Improvement is available at: www.ihi.org/resources/Pages/IHIWhitePapers/TheBreakthroughSeriesIHIsCollaborativeModelforAchievingBreakthroughImprovement.aspx**

Collaborative learning sessions: all teach all learn

Using the IHI's Breakthrough Series Collaborative Model[2] in the South of England Mental Health Improvement Collaborative, teams are coming together after working on projects and tests of change periods to share improvement insights. These are valuable learning opportunities.

99% of attendees reported that the sessions were positive and contributed to learning and improving patient care.

"As Clinical Lead I never cease to be inspired by the enthusiasm and passion that I see at every collaborative event, and the quality of work teams produce. The desire to share and learn is palpable and infectious."

Dr Helen Smith, Medical Director Devon Partnership NHS Trust and Clinical Lead of the South of England Improving Safety in Mental Health Collaborative

Developing partnerships: widening our networks

Improving safety in the health and care system requires the NHS to work in partnership across boundaries, and beyond traditional structures and silos at national and local levels. This allows alignment of aims, knowledge transfer and collective problem-solving.

The collaboratives have partnered with many national and local organisations and NHS arm's length bodies to improve patient safety.

Local partnerships

Preventing high intensity mental health crisis, Wessex

A collaborative model of care is changing the way mental health crises are managed in Wessex, helping police officers to better understand the connection between emotional trauma and offending.

The criminal justice system is rarely the right solution for people struggling with highly intensive patterns of mental illness and behavioural disorders, and places pressure on police officers. Serenity Integrated Mentoring (SIM) trains police officers to support these people. This model of care also includes training in risk management and clinical theory.

For more information visit **www.wessexahsn.org.uk/projects/128/serenity-integrated-mentoring-sim** and **www.england.nhs.uk/ourwork/innovation/nia/**

Follow on Twitter **@SIMintensive**

"We must stop treating patients like criminals and start treating criminals like patients. By matching the intensity of their need with the intensity of our support, we've now shown how profound an impact that can have on individuals' lives and how we can change futures."

Sgt Paul Jennings, SIM Project Leader and NHS Innovation Accelerator 2016 Fellow

Sign up to SAFETY

National partnerships

Sign up to Safety

Sign up to Safety is a national campaign with a distinct and unique role that complements the PSC programme. The campaign focuses on creating the conditions for a safety culture, and promotes the theory and methods in relation to safety conversations – conversations which help people talk to each other. This is to help build a culture from the bottom up where people can speak up and share their concerns as well as their ideas about how care could be safer.

For more information and resources visit **www.signuptosafety.nhs.uk**

Follow on Twitter **@Signuptosafety**

stands for quality

Q is an initiative connecting people with improvement expertise across the UK, creating opportunities to come together as an improvement community – sharing ideas, enhancing skills and collaborating to make health and care better.

Q is being led by The Health Foundation, and supported and co-funded by NHS Improvement. The Q community is made up of a diverse range of people, including those at the front line of health and social care, patient leaders, commissioners, managers, researchers and policymakers, and includes many who are focused on patient safety. This diversity provides initiatives such as the PSC programme with easier ways to tap into insights and energy from across the UK.

The Health Foundation has partnered with each of the 15 AHSNs in order to grow the community.

For more information visit **q.health.org.uk**

Q currently has over **799 members**, and by the end of 2017 it will be an established long-term home for thousands of improvers.

Health Education England: enhancing education and training for safety

The independent report by the Commission on Education and Training for Patient Safety sets out the future of education and training for patient safety in the NHS over the next 10 years, making 12 recommendations to Health Education England (HEE) and the wider system.

HEE is working with key organisations across all levels in the system including the AHSN network, in taking the recommendations forward. The PSC programme is engaging with HEE to align with the recommendations in the report.

The Improving Safety through Education and Training report can be found at **https://hee.nhs.uk/sites/default/files/documents/FULL%20report%20medium%20res%20for%20web.pdf**

Next steps

If we look back at the last three years of the PSC programme we should be proud of what we have achieved.

We have made great progress in improving patient safety across the country by helping to build a culture of continuous learning and improvement. But we know there is still more to be done.

While the collaboratives have worked together, much of the focus has been at a local level. It is now time to strengthen relationships and employ a collective and systematic approach to our work and its impact.

From 2017/18, we will invest in three areas of national significance and importance:

- **creating the conditions for a culture of safety**
  A positive safety culture has a direct impact on patient safety, as it helps prevent and reduce harm, and improve the quality of care. The collaboratives will enable and support organisations to assess and improve their safety culture.
- **improved recognition of physical deterioration, including sepsis and AKI**
  The early identification of and response to patients who have become acutely unwell is essential to reduce subsequent catastrophic effects and to save lives. Much local work has been done by the collaboratives, and now the collaboratives will draw and build upon this work, co-ordinating it nationally to make collective improvements.
- **improving maternal and neonatal safety**
  The collaboratives will support the national Maternal and Neonatal Health Safety Collaborative to reduce the rate of stillbirths, neonatal and maternal deaths, and brain injuries that can occur during or soon after birth.

"The years ahead are an exciting time for the PSC programme as we continue to build on our successes and increase our collective efforts. We will strive to ensure that the programme makes care safer for all."

Phil Duncan, Head of Programmes – Patient Safety, NHS Improvement

For more information or to get involved in our work please contact your local collaborative.

Contact us

AHSN Network	www.ahsnnetwork.com
NHS Improvement	www.improvement.nhs.uk
East Midlands	www.emahsn.org.uk
Eastern	www.eahsn.org.uk
Greater Manchester	www.gmahsn.org
Health Innovation Network	www.hin-southlondon.org
Imperial College Health Partners	www.imperialcollegehealthpartners.com
Innovation Agency North West Coast	www.innovationagencynwc.nhs.uk
Kent Surrey Sussex	www.kssahsn.net
North East and North Cumbria	www.ahsn-nenc.org.uk
Oxford	www.oxfordahsn.org
South West	www.swahsn.com
UCLPartners	www.uclpartners.com
Wessex	www.wessexahsn.net
West Midlands	www.wmahsn.org
West of England	www.weahsn.net
Yorkshire & Humber	www.yhahsn.org.uk

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