The AHSN Network

NHS Improvement

Delivering on ‘A Promise to Learn – A Commitment to Act’

The National Patient Safety Collaborative learning event

Patient Safety Collaborative

Welcome and aims of the day

- **Dr Mike Durkin**
  NHS National Director of Patient Safety
  NHS Improvement

- **Aidan Fowler**
  Director of NHS Quality Improvement and
  Director of the 1000 Lives Improvement Service
  Public Health Wales

The national patient safety collaborative programme

- **Dr Liz Mear**
  Chief Executive, Innovation Agency and
  Chair, AHSN Network

- **Phil Duncan**
  Head of Programmes – Patient Safety
  NHS Improvement

The AHSN Network

Patient safety – at the heart of Academic Health Science Networks

Dr Liz Mear
Chair AHSN Network

23 May 2017

Connecting and collaborating within regions and nationally

Evolved to become a mature network of collaboratives, well connected within our regions and across boundaries, working closely with NHS Improvement

Strong relationships regionally and nationally

Leading and collaborating to improve patient safety

Benefits of being part of the AHSN Network

- **AHSNs are uniquely placed – strong relationships with NHS, universities, patient groups and businesses**
- Robust engagement with industry
- Ability to work flexibly and respond to national and local priorities
- Magnet for collaborations and external investment

AHSNs – 'innovation connectors'

Hackathons:

Bring together clinicians, entrepreneurs, charities – result in innovations to improve care in different settings

Ecosystem events:

Focus on digital innovation and introduce businesses to health and care professionals

Innovation networks:

Innovation Scouts; communities of practice; Q fellows

Innovation Exchanges and Atlas

Online platforms for innovations

"A series of seemingly small failures led to delays which almost cost me my life."

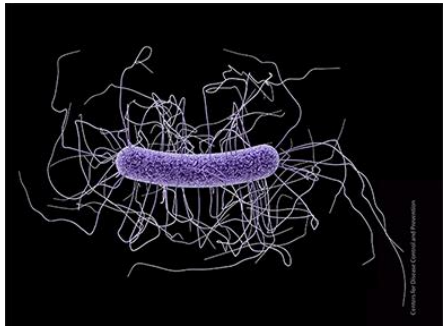
Julie Carman, former sepsis patient speaking at a hackathon

How AHSNs support Patient Safety Collaborative priorities

- Spreading innovations which improve patient safety
- Involving industry and brokering partnerships and collaborations
- Part of system transformation
- Delivering improvement at pace and scale
- Supporting national programmes, eg NIA Accelerator and Innovation and Technology Tariff

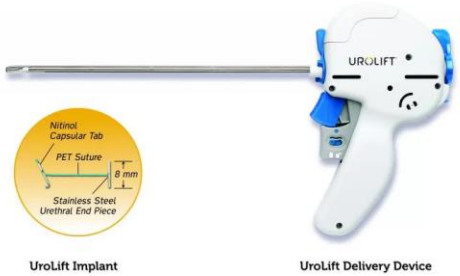
Achieving improvements in quality and efficiency of care

Web-based applications for the self-management of chronic obstructive pulmonary disease



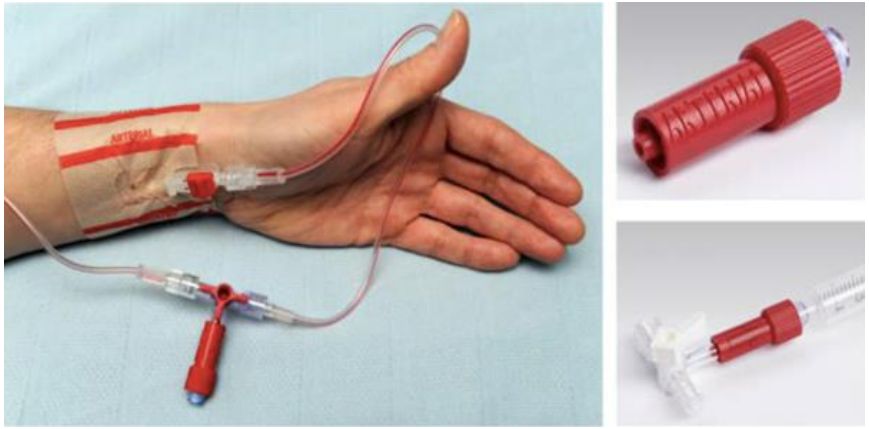
Frozen Faecal microbiota transplantation (FMT) for recurrent Clostridium difficile infection (CDI) rates

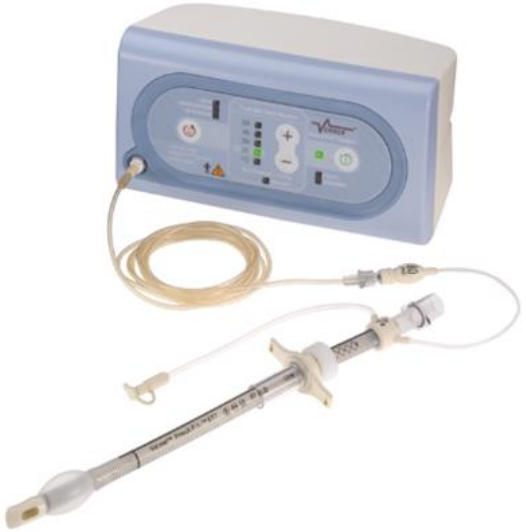
Management of benign prostatic hyperplasia as a day case



Using mobile ECG tech to identify AF

Improving safety in intensive care

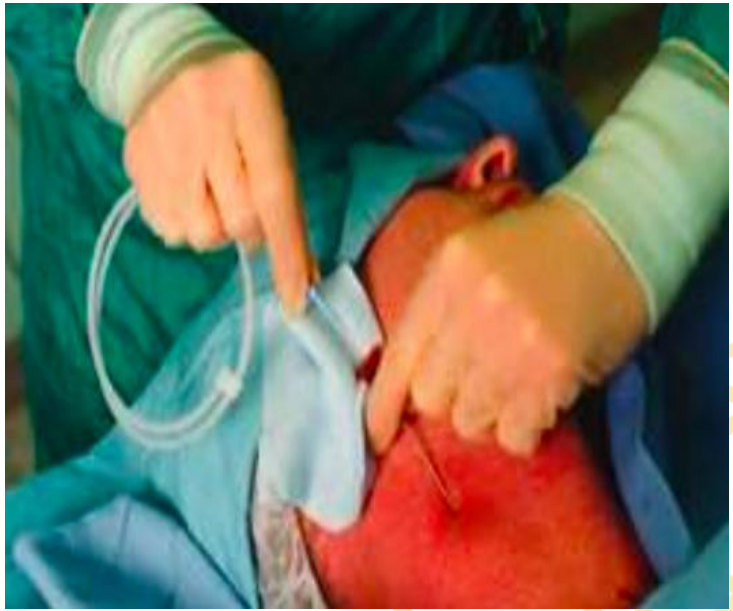




•Non Injectable Arterial Connector – NIC prevents wrong route drug administration

•Pneux – stops ventilator associated pneumonia, the leading cause of hospital acquired mortality in ITUs

From another NHS Innovation Fellow - WireSafe



Key AHSN impacts since 2013

- · **6.3M people** have benefited from AHSN activity
- · **226 innovations** have been adopted via significant AHSN involvement
- · **Over £330M in innovation funding** has been leveraged by AHSNs
- · AHSN-enabled innovations have been implemented in **over 11,400 sites**
- · Over 500 jobs have been created.

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Patient Safety Collaborative activities in numbers

In the last year, we have:

- Trained 10,500 people, including 400 patients as part of QI capability building; 3,422 in measurement; 936 in safety leadership and 4,055 in cultural awareness
- Recruited 1,972 patient safety champions, Q Fellows and QI experts
- Engaged with 1,575 organisations including 333 care homes, 635 in primary care and 219 provider trusts

Listening and involving public – PIES and PIGs

AHSNs engage patients and citizens in programmes of work including patient safety

Consultation and feedback on innovations; part of projects such as preventing AF-related strokes; and testing self-care tech

National forum of AHSN Patient and Public Involvement Leads share learning and solve problems together

"I am impressed with the work of the AHSNs' pioneering new approaches to self-management with the voluntary sector and directly with patients."
Hilary Newiss
Chair, Patient Voices

AHSNs' future role

Aligned with national innovation and improvement aims

With local direction from transformation partnerships and our regional stakeholders

Objectives:

Innovators, commissioners, clinicians and patients develop closer collaboration and a demonstrably clearer understanding of NHS needs and opportunities

Patients and the NHS have demonstrably faster access to cost effective innovations and improvements

Patients are demonstrably safer and systems are demonstrably more focused on continual learning and improvement of patient care

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NHS Improvement

A commitment to act

Phil Duncan

Head of Programmes – Patient Safety

Patient Safety Collaborative

Learning from the last 3 years

Goal: By 2019, everyone (patients and the public) can be confident that care is safer for patients based on a culture of openness, continual learning and improvement.

- Progress over the last 3 years - iterative journey of improvement
- Refocus national programme and define specific priorities for next 2 years
- Key focus on helping to create the conditions for a culture of safety and development of the learning system
- Further work on measurement and spread and adoption of learning across the NHS

Back to Berwick

"The most important single change in the NHS in response to this report 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, August 2013

For NHS Staff and Clinicians

- Participate actively in the improvement of systems of care
- Acquire the skills to do so
- Speak up when things go wrong
- Involve patients as active partners and co-producers in their own care

Why Do Improvement Project Fail?

- Insufficient commitment from senior executives
- No engagement of middle manager
- No engagement of people at the point of care
- No clear line of sight between work and organizational objectives
- No understanding of the behavioral and cultural changes needed to support process change
- No understanding of the improvement methods needed
- No understanding that improvement is not a project but a way of working

Thinking Differently about Large-Scale Change

- Improvement programmes are typically based on a clinical problem or challenge
- Many struggle to demonstrate measurable improvement, sustainability and spread
- An additional focus on culture can provide a key component of an overall improvement plan
- Quality improvement science and an understanding of safety culture can develop the often missing ‘HOW’ to improve

Key Improvement Questions

Are we thinking about patient safety in the right way? – Is the definition of harm too narrow?

How is safety achieved in different settings? – Has only part of the healthcare system has been addressed?

Do we need a wider range of safety strategies and interventions? – Has current progress has been slower than anticipated?

Can a framework of strategies and interventions be developed? Across care settings - hospital, home, primary care. Across levels - patient, frontline, organisation, regulation and government?

Patient Safety Collaboratives

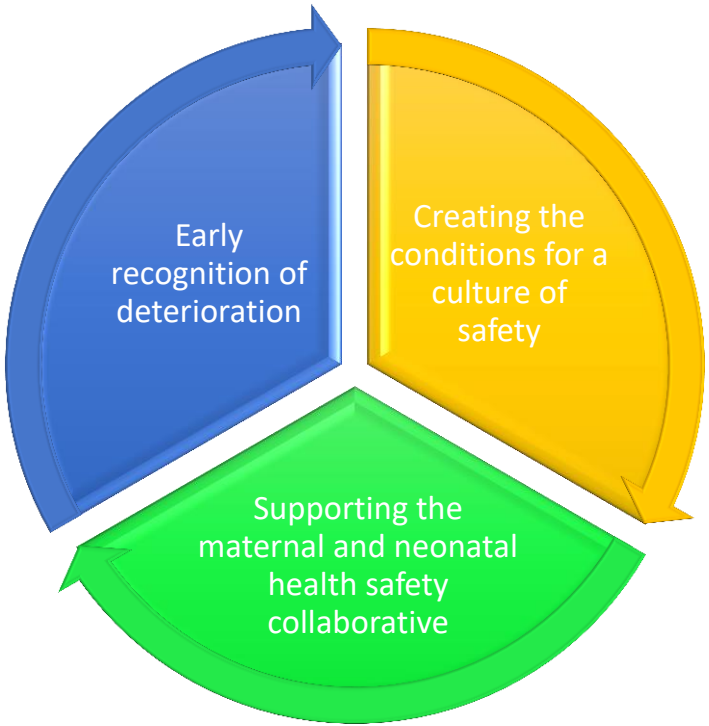
- 15 Academic Health Science Network patient safety collaboratives
- More systematic approach to quality improvement
- Local engagement and focus on safety concerns across all care settings
- Test and develop change ideas
- Improved mechanism for spread and adoption of improvement
- Harness talents - staff, patients, academia and industry
- Build QI science, measurement and leadership for safety capability
- National focus on creating safety culture conditions

Meeting Local Priorities

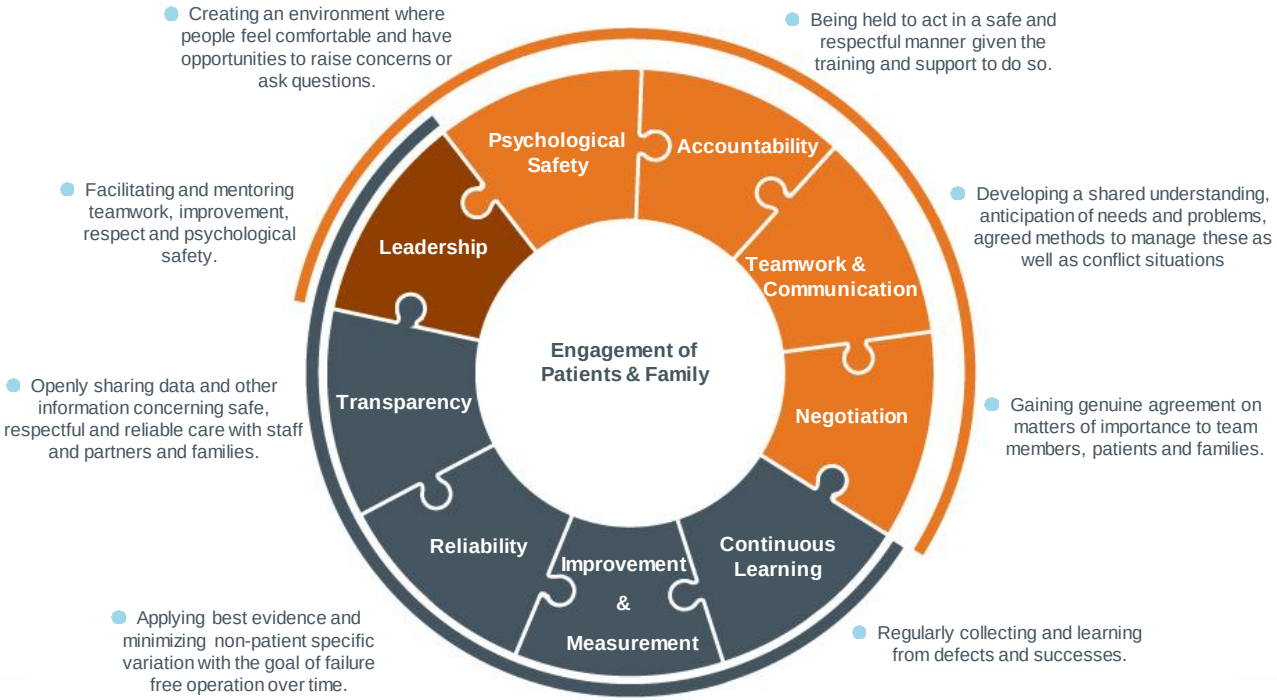
- Continue to respond to local and regional priorities
- Actively seek engagement with staff and patients and work towards true partnerships
- Address local safety concerns
- Work with individuals teams and organisations
- Disseminate learning and support spread

National Workstreams

- Strength in collaboration across the patient safety collaboratives
- Accelerate the pace and scale of learning and improvement
- Actively look for common themes
- Collective priorities for 2017/18



Framework for Clinical Excellence



Building Capability

- Raising awareness of quality and safety improvement science
- Providing tools and approaches to support individuals, teams and organisations
- Supporting and coaching to improve
- More focus on ‘how’
- Linking individuals through ‘Q’ and ‘sign up to safety’ camapign

Measurement

- Launch of the Patient Safety Measurement Unit (PSMU)
- Developing the patient safety programmes measurement strategies and measures
- Build measurement for improvement capability across the system
- Support the dissemination of learning, evidence and impact
- Helping to improve the measurement of safety

Learning from mistakes – the family experience

- **Scott Morrish**
  Family representative

- **Professor Jane Reid**
  Clinical Lead
  Wessex Patient Safety Collaborative

Performing at 50 below

- **Ann Daniels**
  Polar Explorer

Ann Daniels

Resilience

Performing @ 50 below

@AnnDanielsGB


M&G ISA


M&G
NORTH POLE EXPEDITION 2002


SIBERIA
Yenisey
Ob
Sea of Okhotsk
RUSSIA
Lena
Kolyma
Kara Sea
Laptev Sea
Barents Sea
Novaya Zemlya
Severnaya Zemlya
FINLAND
New Siberian Is
Franz Josef Land
SWEDEN
East Siberian Sea
Arctic Ocean
NORWAY
Norwegian Sea
Wrangel I.
Svalbard (Norway)
Chukchi Sea
North Pole
Greenland Sea
Bering Strait
Ellesmere I.
ICELAND
ALASKA (US)
Magnetic North Pole
Beaufort Sea
GREENLAND (Denmark)
Denmark Strait
Yukon
Queen Elizabeth Is
Baffin Bay
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NASA

Keeping people safe; closing the gap between policy and practice

- **Chair: Dr Suzette Woodward**
  Director, Sign up to Safety

- Scott Morrish
  Family representative
- Dr Mike Durkin
  NHS National Director of Patient Safety, NHS Improvement
- Aidan Fowler
  Director of NHS Quality Improvement, and 1000 Live, Public Health Wales
- Heidi Smoult
  Deputy Chief Inspector of Hospitals, CQC
- Keith Conradi
  Chief Investigator, Healthcare Safety Investigation Branch

Final remarks

- **Dr Cheryl Crocker**
  Regional Lead, Patient Safety Collaborative
  East Midlands Academic Health Science Network

- **Jane Macdonald**
  Director of Improvement and Nursing
  Greater Manchester AHSN Patient Safety Lead

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