National Patient Safety Improvement Programme Q2 2024/25 Progress Report

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Executive Summary

Managing Deterioration and Martha's Rule Programme

Martha's Rule

- In Q2 PSCs have delivered a minimum of one Community of Practice per PSC, via virtual and in person events to progress the programme deliverables.
- Individual pilot site coaching has been delivered by all PSCs to progress the commission.
- PSCs have also actively engaged and promoted National webinars and supported their pilot sites to embed and progress associated work based on this shared content.
- All pilot sites have engaged in the development process for data submission and are preparing to submit data in Q3.

PIER

- The PSCs have socialised the PIER framework with their ICBs, some have been able to progress and identify key areas of focus (frailty, learning disabilities etc).
- Some PSCs are planning more direct engagement in Q3 due to ICB restructuring impacting the progression of this work within their local ICBs in Q2.

Maternity and Neonatal Safety Improvement Programme

Optimisation and stabilisation of the preterm infant

In Q2:

- 677 Women giving birth at less than 30 weeks of gestation received magnesium sulphate within 24 hrs of birth which potentially means that 18 babies will not develop cerebral palsy. With a sum total of 36 fewer cases of Cerebral Palsy for Q1 and Q2.
- 557 women in preterm labour at less than 34 weeks of gestation received intravenous intrapartum antibiotics prophylaxis to prevent early onset neonatal Group B Streptococcal (GBS) infection. This potentially means that 57 babies were born without group B strep and that 13 babies survived. With a sum total of 25 more babies surviving for Q1 and Q2.
- Up to 64 babies born at less than 34 weeks gestational age potentially survived because their umbilical cord was clamped at or after one minute of birth. With a sum total of 132 more babies surviving for Q1 and Q2.
- Up to 22 lives were saved because the mother got a full course of antenatal corticosteroids. With a sum total of 38 more babies surviving for Q1 and Q2.
- For Q2 up to 99 lives were saved due to the total number of interventions delivered and up to 195 lives for Q1 and Q2 combined.
- 20% of PSCs are reporting that all their organisations are sustainably implementing all 9 interventions.

Early recognition and management of deterioration of women and babies

Maternity Early Warning Score (MEWS)

- In Q2 it has been reported that 28 organisations are now 'live' with the national MEWS.

New-born Early Warning Trigger and Track (NEWTT2)

- Q2, it has been reported that 31 organisations are now 'live' with NEWTT2.

Perinatal Culture and Leadership Programme (PCLP)

- **Context:** Activity by the PSCs is ongoing to socialise the PCLP within regions and engage with Quad and change teams at trust level to support the development of culture improvement plans.
- **Engagement:** While the QUAD teams have been identified across all Trusts and some have shown strong engagement, challenges in staff capacity, competing priorities, and varying stages of program development have led to inconsistent participation and delays in completing critical tasks (e.g., improvement plans).
- **Development of Improvement Plans:** Improvement plans are in varying stages of development, with some Trusts progressing more slowly than expected due to internal pressures and capacity issues. Overall progress is dependent on Quad teams finalising and then discussing their improvement plans with PSC leads to ensure targeted support to enable culture improvements.
- **In conclusion**, while there is some good engagement from most QUAD teams, widespread inconsistencies in the completion of improvement plans remain significant barriers to effectively progressing the program. Contextual understanding of the stage of development of the Quad team and the challenges they are facing is essential to supporting them to progress. Ongoing efforts to provide external support and align with system priorities will be crucial in helping these teams overcome their challenges.

Medicines Safety Improvement Programme

Reduce harm from opioids in chronic non-cancer pain

- **Achievements:** PSCs are supporting 29 ICBs (69%) taking a Whole Systems Approach to Chronic Pain Management, the majority of these are implementing their action plans which include opioid stewardship across the system, capability building and increasing the availability, awareness of and access to biopsychosocial support.
- **Risks**: The restructuring of ICBs remains ongoing in many ICBs across England in Q2 and PSCs have again raised this as a risk to delivery in 2024-25.
- **Learning:** V3 of the 7 Phase Whole System Approach Framework, recognises the network as central to the approach, insight gained through implementation over 3 years. This further strengthens the theory that the framework supports the development of a Learning Health System which has potential to enable whole system continuous improvement.

2 x Pipeline Diagnostic: (1) Psychotropics in Learning Disability (2) Fall inducing medicines in Frailty

- The 15 PSCs collectively provided 191 semi-structures interview submissions as part of the appreciative enquiry.
- The Lead PSCs completed a rapid evidence review and one of 3 Benefits mapping sessions.

Systems Safety

- Support is provided, at all levels, and within multiple settings, regional support (Macro – regional, Meso – ICB and Micro – Provider organisations).
- Support to establish and nurture the development of learning systems continues. This includes helping stakeholders to create the conditions, such as removing hierarchies, introducing effective approaches to collaborating and engaging such as appreciative enquiry.

Key Infographics

Managing Deterioration and Martha's Rule Programme

Martha's Rule Programme

- Working with 143 acute sites to test and implement the 3 components of the Martha's Rule Programme:
  - Patient wellness questions
  - Patient / family /carer escalation process
  - Staff escalation process

Managing Deterioration

- Working with 15 ICSs to test the PIER approach to managing acute deteriorations across systems

Maternity and Neonatal Safety Improvement Programme

Maternity and Neonatal Safety

Improving the care of premature babies has:

- Saved up to 1,431 lives
- Prevented up to 506 cases of cerebral palsy

Medicines Safety Improvement Programme

Medicines Safety

Improving the management of chronic non-cancer pain has:

- Saved up to 596 lives.
- 10,310 people have halved the risk of opioid related death.
- Patients report better quality of life, less pain and less disability

Systems Safety

Systems Safety

Supporting the embedding of Patient Safety Incident Response Framework (PSIRF) in all NHS provider organisations in England

Managing Deterioration and Martha's Rule Programme

Summary of Q2 2024/25 progress

Programme Expected Outcomes

Martha's Rule

- Support sites to test and implement Martha's Rule.
- Work with sites and key stakeholders to identify and understand the impact of Martha's Rule by supporting the development of local measurement plans that can inform learning and show impact of Martha's rule.
- Lead, facilitate and nurture the coalition and learning of stakeholders involved in implementation, through appropriate models, such as Break Through Series Collaboratives, Communities of Practice, and/ or Learning Networks.
- Work with and support system stakeholders to develop spread and sustainability plans for Martha's Rule.

PIER

- PSCs to support Co-leads to promote, refine and embed the PIER improvement toolkit based on user feedback and stakeholder engagement.
- PSCs to continue working with ICSs on the appreciation and understanding phases of this work.
- PSCs to continue supporting their systems to work through the improvement toolkit, focussing on improving the pathway(s) that the mapping phase identified as being amenable to improvement.
- Over Q2-Q4 work with and support system stakeholders to develop spread and sustainability plans.

Programme Deliverables

Martha's Rule

The PSCs will support the implementation of Martha's Rule by:

- Providing pilot sites with expertise and coaching in Quality Improvement (QI) methods.
- Facilitating effective stakeholder engagement with provider sites, QI Leads, provider teams, PCC ODNs, ACC ODNs, Patient Safety Specialists, Patient Safety Partners, and any other relevant local systems and/or networks.
- Bringing together phase one sites, and all relevant system stakeholders using a variety of modes to facilitate and nurture learning via break through series collaboratives; action learning sets; webinars; workshops; networks; communities of practices; and rapid insights sessions.
- Work with all those involved in the programme (from those site-based to system/region-based), providing a safe space to think, acting as a critical friend and mentor.

- ❖ Provide enhanced support to those providers requiring it.
- ❖ Support systems to use methodologies for sustaining change and improvement, and share the learning across sites, systems, regions and with the National Managing Deterioration and Martha's Rule Programme Team.
- ❖ Support systems to identify and understand the impact of Martha's Rule using national metrics and local measurement methods.

PIER

- ❖ Each PSC will support at least one Integrated Care System (ICS) to implement the Prevention, Identification, Escalation and Response (PIER) improvement toolkit.

Progress and contribution to NatPatSIP ambitions 2024/25

Martha's Rule

- ❖ All PSCs have progressed and built upon Q1 work with the pilot sites located within their HIN geographies, scoping and stakeholder engagement has now been undertaken in all areas.
- ❖ All PSCs have delivered at least one community of practice with their pilot sites, some have been face-to-face but predominantly these have been virtual in delivery approach. All PSCs continue to link and work with their regional Critical Care Clinical Operational Delivery Networks (CCCODNs) and Paediatric Critical Care Clinical Operational Delivery Networks (PCCC ODNs).
- ❖ Support for the national data submissions process has been evident from all 15 PSCs with focus on this as part of the COP and virtual coaching sessions delivered. All pilot sites are in a position to submit data in Q3.
- ❖ The NHSE team have been invited to present at a number of COP meetings and have been able to give and gain insight on data and communications elements.
- ❖ Communication around the branding and feedback from PSCs has given valuable insight to NHSE, enabling closer management of the messaging around the delayed timelines for central branding out to the pilot site teams.

PIER

- ❖ All PSCs have identified at least one ICB to engage with to undertake the PIER assessment work, though some have struggled to progress this work in Q2 due to ICB restructures.

Key updates and achievements

Martha's Rule

- ❖ The second national webinar was held on Wednesday 14 August 2024 and gave an overview of the work supporting the Martha's Rule Patient Wellness Question component which states 'the NHS must implement a structured approach to obtain information relating to a patient's condition directly from patients and their families at least daily'. Prof Rebecca Lawton and the Bradford NHS FT teams presented on the evidence base and real-word application of this in healthcare settings.

- NHSE communication regional engagement sessions were held in mid Sept with all pilot site areas. These were very helpful in shaping our central team understanding on a national visual identity for the programme and what resources and comms assets would be helpful in supporting Martha's Rule implementation. A central communications insight plan is in development by the NHSE Comms team for wider sharing once the business case has been approved.
- The data measurement plan is now in place and the defined process for submission of data has been clarified and shared with all pilot sites. All sites will commence monthly uploads of data to the SDCS system as from October- for September's data.
- A webinar giving both an overview of this data submission process and that of the formative and summative evaluation approach being taken by NHSE was held on Thursday 26 September 2024.
- FuturesNHS resources are being added to, with further content developed and uploaded as more COP are held/ delivered.
- A FAQs document has been developed for collation of queries coming to the national team via webinars and email sources. Responses to these are being gathered from clinical experts related to the query, with sharing directly back to the individual where possible (some are anonymous on webinars) or into a shared searchable resource hosted on the FuturesNHS platform.

PIER

- Progression has been slower for the PIER commission within the PSCs with many highlighting their focus has been on Martha's Rule delivery for Q2.
- Scoping and engagement work with stakeholders for the PIER commissions, building working relationships to progress the work has been undertaken.
- There remain some challenges for PSCs on ICB engagement, with a variation nationally in appetite for this from the latter.

Context, challenges, and expectations

Martha's Rule

- Many PSCs have new team members who are gaining insight into how the commission functions and is delivered. These individuals in some cases are also completely new to the PSC commission as well as the HINs.
- The ICB system nationally remains pressured and engagement with the PIER approach varies across PSCs.
- Communications -national insight work has not progressed as quickly as expected which has presented challenges around messaging for PSCs working with those sites who have existing branding in place (e.g. Call4Concern) or those who have been waiting for a central NHSE 'steer' on what the branding should contain. Clear messaging has been shared with the PSC teams for onwards dissemination to pilot site teams around this i.e. using existing branding referencing Martha's Rule somewhere on this or launching as Martha's Rule if nothing has been in place previously.

Qualitative feedback from sites

Martha's Rule

Whilst data submissions have not yet commenced sites have been sharing feedback they are receiving from staff, patients, carers, and relatives about the implementation of Martha's Rule.

"A patient's wife was concerned about her husband's condition, she had seen a "Martha's Rule" poster on the ward, so called the number and a member of the CCOT came and reviewed him"

"By introducing the patient escalation component 2 we have had a patient taken back to theatre because their relative raised concern."

"We have had a patient who would have returned to critical care if the staff member hadn't escalated their concern"

"Patients have expressed reassurance knowing this service is now in place for them …"

"One patient's care was de-escalated and palliated support to have a dignified death."

Maternity and Neonatal Safety Improvement Programme

Summary of Q2 2024/25 Progress

Programme Expected Outcomes

Optimisation and Stabilisation of the preterm infant

- Increase in rates of babies surviving until discharge home (Less than 34+0 weeks gestation).
- Reduction in brain injury, visible on imaging (grade 3&4 IVH and/or cystic periventricular leukomalacia (cPVL) on ultrasound) (Less than 34+0 weeks gestation).
- Reduction in incidents of necrotising enterocolitis (based on diagnosis at surgery, post-mortem, or the presence of radiological signs) (Less than 34+0 weeks gestation).
- Reduction in bronchopulmonary dysplasia (oxygen or respiratory support at 36+0 weeks post menstrual age) (Less than 34+0 weeks gestation).
- Agreed local/system level ambitions for each evidence-base intervention, where there is good data quality should be agreed by the PSCs for their system. These should be no lower than what is preset in SBLv3.
- Where there is high reliability in an intervention, quality control/sustainability should be implemented resulting in no unwarranted variation or regression.
- Measurement of:
  - Volume targeted ventilation
  - Caffeine.

Early Recognition and Management of Deterioration of women and babies

Maternity Early Warning Score (MEWS)

- Improved communication between staff using a common safety critical language embedded within the PIER pathway.
- Improved woman and family experience through engagement with healthcare professionals regarding escalating concern.
- Improved standardisation across England of early recognition and management of deterioration.

New-born Early Warning Trigger and Track (NEWTT2)

- Adoption and spread metrics in quarterly reporting.
- An increase from baseline in the network maturity matrix for all eight domains. Evidence of an increase in score should be provided for both workstreams as a programme.
- Identification and engagement scores for T and F groups will be captured in the QART.
- Numbers of staff trained in the use of the NEWTT2 tool.
- Audit of compliance of correct completion of the tool.

- Co-designed local measures to understand positive and negative impact of the tool (e.g., time to escalation, ATAIN data).
- Co-designed local measurement to ensure the tool is used reliably in perinatal settings (e.g., Sampling of tools).
- Co-designed local measurement to understand the impact of NEWTT2 on women and family experience.

Perinatal Culture and Leadership Programme (PCLP) expected outcomes

- Improvement in the quality of care by enabling leaders to drive change with a better understanding of the relationship between leadership, safety improvement and safety culture.
- Provision of support to perinatal leadership teams to create and craft the conditions for a positive culture of safety and continuous improvement, enabling a more psychologically safe, collaborative, and supportive workplace.

Programme Deliverables

Optimisation and Stabilisation of the preterm infant

- Improve the effectiveness of the preterm optimisation pathway, which consists of nine-evidence based interventions.
- Achieve high reliability as a pathway approach of the nine evidence-based interventions.
- PSCs to use Quality Improvement methodologies to support their local healthcare providers and systems to embed Continuous QI.

Early Recognition and Management of Deterioration of women and babies

Maternity Early Warning Score (MEWS)

- Ensure the use of the national Maternity Early Warning Score (MEWS) tool is implemented within an effective PIER pathway for managing deterioration and support.

  Phases 1 to 4 completed in 2023/24 specification.

  Phase 5 – Development of Representative Stakeholder Groups, commencing Q1 2024/25:

  - PSCs will be required to develop representative stakeholder Task and Finish (T&F) groups.
  - T&F group to develop the implementation plan to support digital transition of the national MEWS tools.

  Phase 6 – T&F Groups and Pilot Testing, commencing Q2 2024/25:

  - PSCs will continue to support T&F Groups exploring all components of PIER, e.g., BSOTS and EBC Learn and Support Toolkits, in readiness for implementation.
  - PSCs will be required to support organisations identified as Pilot Sites for the development of the national digital specification.

  Phase 7 – Systematic Implementation, Autumn to Spring 2024/25:

- Systematic implementation in digital organisations.

New-born Early Warning Trigger and Track (NEWTT2)

- ❖ Ensure the use of the Newborn Early Warning Trigger and Track (NEWTT2) tool is implemented within an effective PIER pathway for managing deterioration and support.

  Phases 1 to 4 completed in 2023/24 specification.

  Phase 5 - Commencing Q1 2024/25:

  - PSCs will be required to develop representative stakeholder task and finish groups to support digital transition of MEWS tools.

  Phase 6 – Commencing Q2 2024/25:

  - PSCs will continue to support Task and Finish Groups exploring all components of PIER, e.g. EBC Laren and Support Toolkits, in readiness for implementation.
  - PSCs will be required to support organisations identified as Pilot Sites for the development of the national digital specification.

  Phase 7 – Autumn 2024/25:

  - Rapid implementation in digital organisations.

Perinatal Culture and Leadership Programme (PCLP)

- ❖ The PSCs will facilitate the provision for the teams to come together and continue to share learning and best practice. The 150 teams that have worked through the Quad programme will have local level support from PSCs to realise their culture improvement plans and provide support for the interventions the teams identify.
- ❖ Using QI coaching skills, the PSCs will continue building on improvement planning with a focus on developing relationships and collaboration across the perinatal team, and motivating improvement based on the shared vision and purpose established in phase one of the PCLP.
- ❖ Continue to build trust and collaboration, understanding the perspectives of those involved and how this can motivate action and drive the improvement plan.
- ❖ Delivery of local QI projects/initiatives relating to Trusts safety culture improvement plans.
- ❖ Sustainable mechanisms for sharing learning, collaboration, and time to focus for Quads and Change Teams.
- ❖ Ongoing opportunities for development for Quads and Change Team.
- ❖ Support the adoption and spread of safety culture interventions and resources, these could include the NHSE Civility and Respect Toolkit, SBAR and the Each Baby Counts Learn and Support Toolkits, as well as newly emerging evidence-based tools.
- ❖ Using the IHI Joy in Work framework identify how core components can be identified and implemented with QUADS and Change teams.

Key updates and achievements

Optimisation and Stabilisation of the preterm infant

Preterm optimisation continues to demonstrate improvement in processes and outcomes, with the reduction of morbidity and mortality as referenced in the charts below. These outcomes equal *since baseline* that:

- 567 babies avoided contracting Group B strep, with 141 more babies surviving.
- Up to 274 more babies survived with the improvements made in antenatal corticosteroids.
- Up to 1016 more babies survived with the improvements made in optimal cord management.
- 506 cases of cerebral palsy were avoided.

Potential number of more babies surviving due to the improvements made with delivering the preterm optimisation bundle is 1,431.

Early Recognition and Management of Deterioration of women and babies

Refreshed timelines for MEWS and NEWTT2 are being drafted with consideration to the development of digital specifications, user interfaces and wireframes.

PSCs and their team supported a series of test sprints in Q2 to ensure the clinical teams were able to provide clinical input into the draft national specifications.

A core component to the early recognition and management of the deterioration of women and babies is the PIER toolkit. Great achievements continue to be evidenced in the wider adoption of the Each Baby Counts Learn and Support toolkits and collaborative examples of support provided to organisations with the implementation of BSOTS.

Perinatal Culture and Leadership Programme (PCLP)

- Patient Safety Collaboratives (PSCs) PCLP Leads have now all been recruited.
- MOMENTS (a framework of resources to nurture safety culture development through everyday practices) training was delivered one day in September to PSC PCLP Leads, with an additional one for October 2024 also planned. The MOMENTS training and resources were received well, and PSCs are now facilitating and planning the spread of MOMENTS via change teams.
- The PCLP team continue to provide supportive meetings with PSC PCLP Leads to enable and inform the PCLP commission.
- Extra Culture Coach training dates are planned to be facilitated by the PCLP team in October 2024 to enable trusts who did not respond to initial offers of training to build their culture coach capacity. From now on Culture Coach training will be offered as a self-directed learning facility using resources accessible via the PCLP Future NHS site.
- The development of a national community of practice Future NHS site is ongoing and subject to NHS England concept approval.
- A dedicated learning and sharing meeting for PSC PCLP leads, facilitated by Matt Hill, has been welcomed by PSCs and is in the early stages of development.

Context, challenges, and expectations

Optimisation and Stabilisation of the preterm infant.

Capacity remains an issue with clinical teams not always able to attend QI sessions to support implementation or changes to practice. However, even with the reduction in capacity teams continue to engage and build on the momentum of the elements of preterm birth improvement and perinatal optimisation.

Early Recognition and Management of Deterioration of women and babies

Capacity of clinical teams to engage in improvement activity remains a challenge, both for the teams wanting to make improvements to the quality and safety of their services and to the PSC in finding ways to engage and support teams. Despite this, improvement activity happens in areas where there are aligned prioritise locally. The importance of the role of the PSC in being able to provide the continued focus of attention in these areas is evident.

Delays to the publication of the national digital specification for digital services are reported in Q2. Reassurance has been provided that they are near finalisation. And support to communicate to the system.

Perinatal Culture and Leadership Programme (PCLP)

The key issues that have not worked as expected in the PCLP include **low and inconsistent engagement** from QUAD teams and providers, **capacity, and resource constraints**, particularly with QUAD members balancing other responsibilities, organisational changes, logistical challenges, and **slow development of improvement plans** across Trusts. These challenges have hindered the timely execution of key activities, such as setting up meetings, co-producing strategies, and finalising improvement plans. As a result, the program has faced difficulties in maintaining momentum and achieving the expected outcomes within the original timelines. Understanding the stage of development of Quad teams is crucial to providing the right support at the right time to enable improvement planning.

- **Low and inconsistent engagement with Quad teams:** This is mainly due to capacity issues and competing demands and priorities resulting in Quad members not having the time to work on the PCLP. PSCs are therefore having to seek work around solutions e.g., flexible approaches to support offers, sensitive rather than excessive communication and requests for PCLP engagement and enabling engagement indirectly with the Quad teams by accessing other members of the change team, such as Culture Coaches.
- **Quad teams are at different stages of development**: Some Quad teams are still working through the PCLP with the Korn Ferry consulting organisation and therefore not yet in a position to engage with PSCs. Time has lapsed since some Quad teams completed the first Perinatal Culture and Leadership Programmes also potentiating engagement issues and lost momentum.
- **Changes to Quad team membership:** There has been changes to some Quad team membership. New Quad members have therefore not had the opportunity to benefit from the formative leadership development and coaching in the preceding phases of the programme. Whilst PSC leads may not be able to fill a leadership development need, they will hopefully be able to help Quad teams to reteam, by working out problems, testing

solutions, encouraging perinatal teams to work together, enabling peer support and effective communication of vision and values.

- **Alignment of PCLP activities with other programmes**: Applying a 'culture lens' to other work programmes seems appropriately opportunistic. However, finding the right balance is tricky. Whilst there is a need to avoid duplication there is also a need to ensure the PCLP is not subsumed by other programmes and receives individual input to meet specific programme deliverables. Relationships built through the progression of other work programmes are being used to advance the PCLP taking care not to strain relationships when there is a lack of engagement with the PCLP.

Outcome Measures

Optimisation and Stabilisation of the preterm infant

Magnesium Sulphate treatment prevented cerebral palsy in up to 18 babies.

Savings in a cost t welfare and society £18 million.

Optimal Cord Management has contributed to saving the lives of up to 64.

Total Q2 overall outcomes are 45 babies avoided contracting Group B strep with 12 more babies surviving, up to 22 more babies survived with the improvements made in antenatal corticosteroids.
Quarter 2 total of lives saved are 99 and 195 this financial year.

Perinatal Culture and Leadership Programme (PCLP)

Key measures created to monitor the Perinatal Culture and Leadership Programme include engagement logs, maturity matrices, event participation tracking, and staff outcome metrics.

Improvement plans are in varying stages of development across different Trusts, with some already showing tangible actions, such as the comprehensive action plan from Kingston Neonatal Unit. Improvement efforts focus on culture, leadership, and workforce changes, and include ongoing support through Community of Practice learning and sharing forums, MOMENTS training, and collaboration across Trusts. The programme is also incorporating stakeholder feedback and is committed to co-designing measures with system partners to ensure alignment with regional and organisational needs.

Measurement of progress in the culture and leadership space is complex since engagement and behaviour change, its impact on people, feelings, experiences, and practice, are difficult to quantify prompting more qualitative measures which still pose challenges in trying to capture and define culture change.

Outcome measures as set out in specification:

- **Maturity matrix scores**: Some PSCs have begun to use maturity matrix scores whilst the majority are waiting for further progress to be seen to make such measurement worthwhile.
- **Community of Practice outputs and engagement**: Most PSCs are developing or using existing learning networks to engage various members of the culture change teams in learning and sharing best practice.
- **Case studies:** Potential case studies showcasing innovative and motivational practice are emerging and being identified.
- **Qualitative feedback**: From both Quad and change teams including culture coaches story telling their culture improvement journeys.

Process Measures

Optimisation and Stabilisation of the preterm infant

The preterm dashboard continues to be used, helping to augment decision making by providing the right level of intelligence to people who require it. The dashboard now has more functionality and shows a wider range of data to help all organisations, teams, systems and nationally.

With these cross-boundary collaborations supporting quality Improvement data shown below in **Figure 1** shows an increase in the number of interventions being given each month. This has resulted in a national increase of 1000 more interventions being achieved to this cohort of babies on average each month. Nationally, on average 2725 interventions have been given to babies born preterm.

Figure 2 – Optimising place of birth is an intervention that has been in Quality Control (QC) with an achievement level of 79.1% nationally; however, there has been a statistically significant shift showing improvement. This improvement has been achieved due to a change in process relating to optimising the place of birth in two of the PSC areas and its now at 83%, with the national ambition of 85%.

Figure 3 – Shows a statistically significant shift down in antenatal corticosteroids being delivered, the initial gains of 10% from baseline have not been sustained. This will be reviewed via the PSC WSL meetings to review the data and engage with teams. The new average delivery rate is 47.2%.

Figure 4 – Demonstrates the continued level of reliability for intrapartum antibiotics which is now at 41.7% and remains sustainable. This is a great achievement nationally but also represents the hard work invested into the design of the dashboard. This data is not shown on the NNAP dashboard, so it is very helpful for teams to see their performance.

Figure 5 – Optimal cord management has had an over 100% improvement from baseline with 66.5% of babies receiving this intervention nationally. This is a great achievement and is an intervention with the greatest improvement from baseline. There are now seven data points above the average which highlights great reliability and is likely to lead to another statistical shift.

Figure 6 – Normothermia is displaying a statistically significant shift down, with the average showing the same number of babies receiving the intervention. The PSC will be able to use this data to help teams explore the findings and review the delivery of the intervention and determine next steps. The new average is 70.1%.

Figure 7 – the data is showing positive signals that this intervention is increasing in number. Since baseline there has been a continued improvement from 17% to 41%. There are now seven data points above the average which highlights great reliability and is likely to lead to another statistical shift.

Figure 8 – magnesium sulphate continues to maintain 85.9% average level of reliability and is very much in Quality Control.

Figure 1. Total interventions

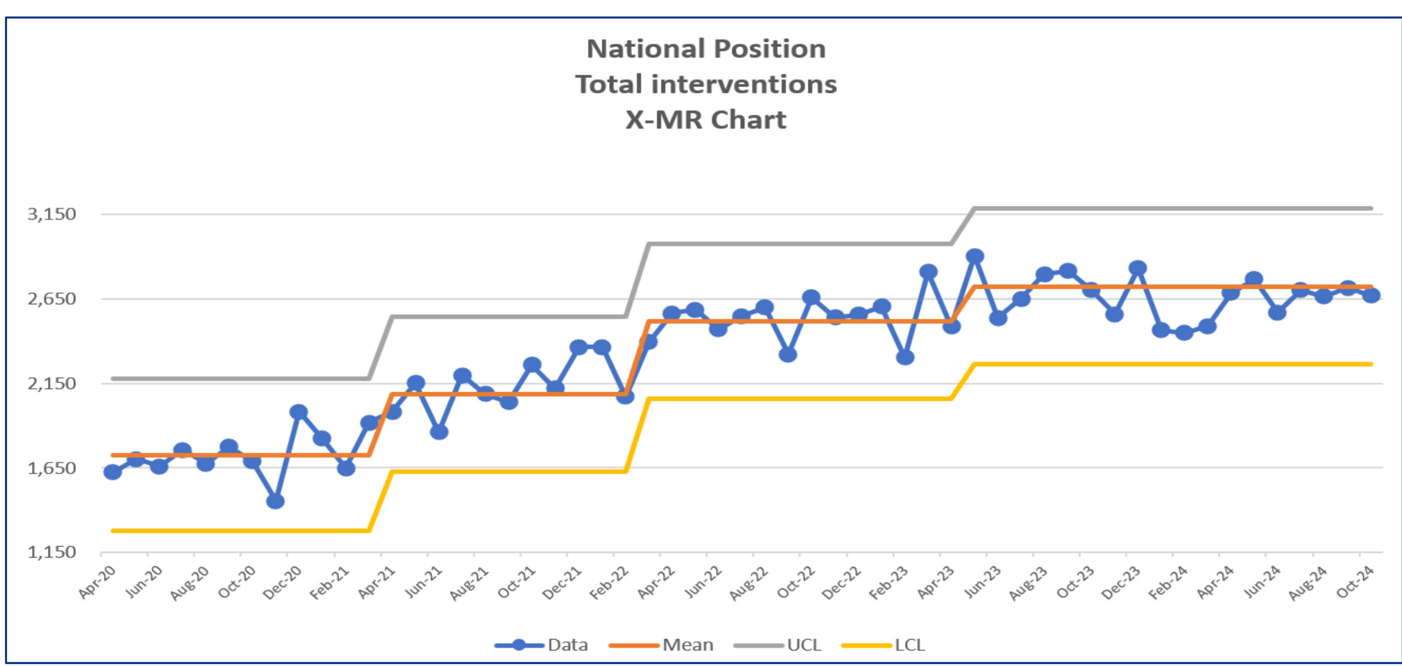


Figure 2. Place of birth

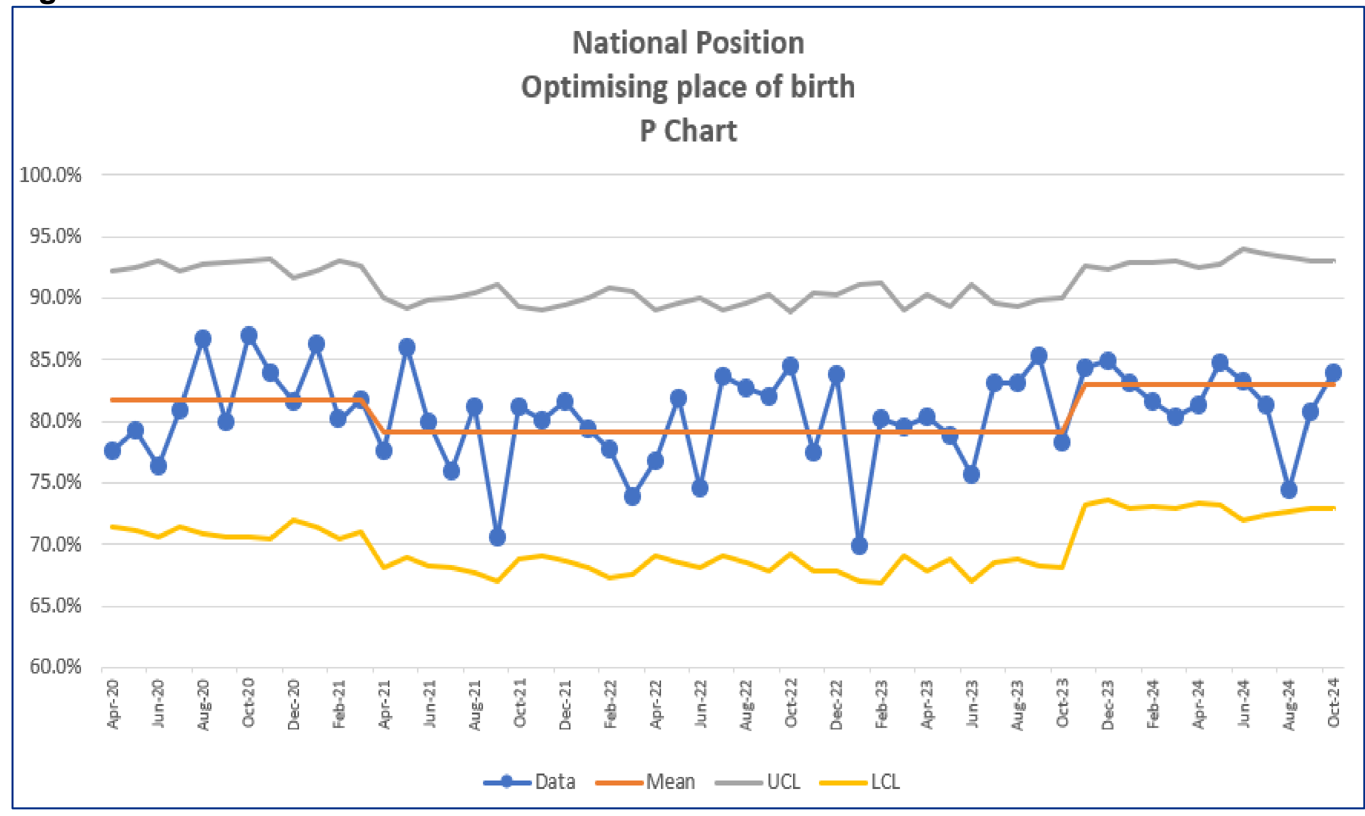


Figure 3. Steroids

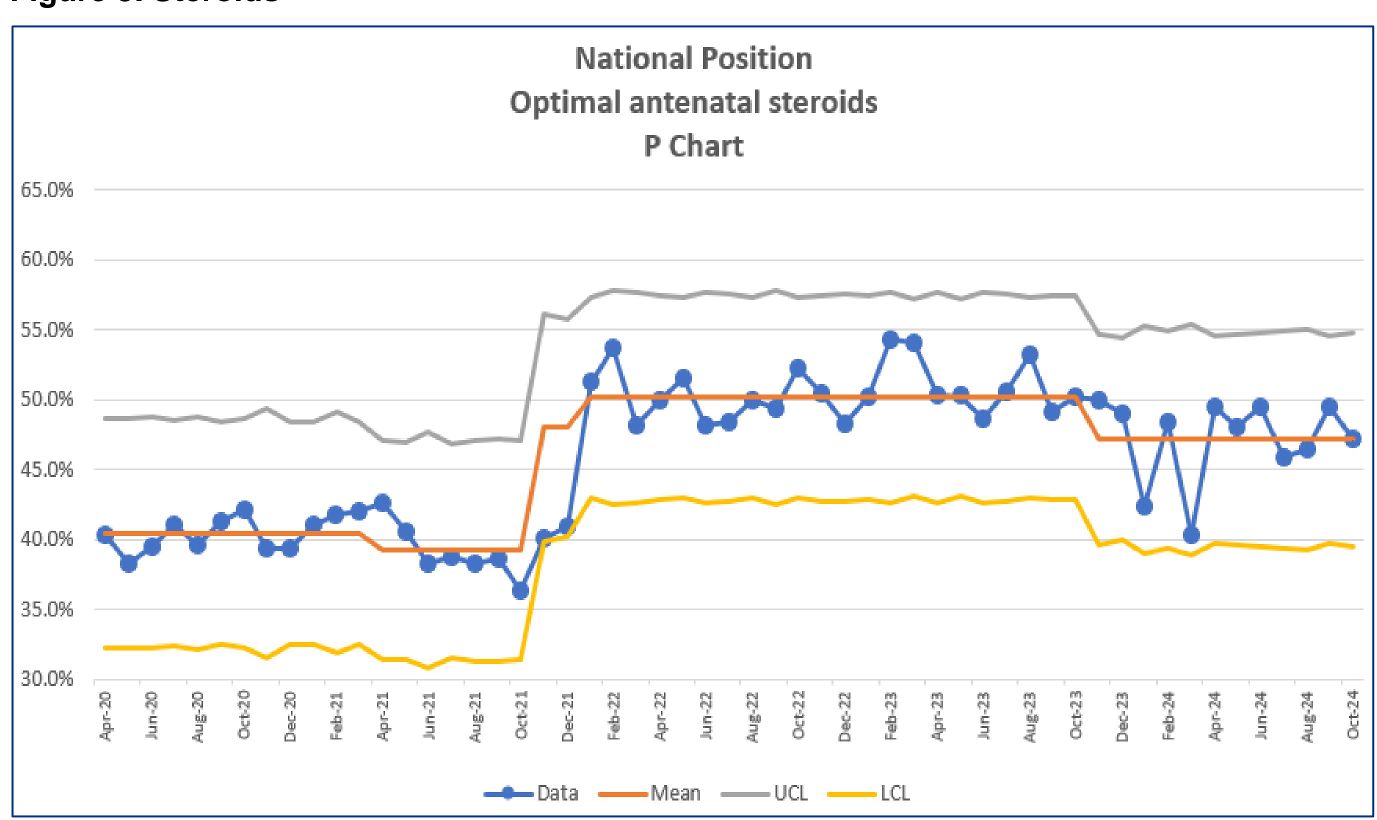


Figure 4. Antibiotics

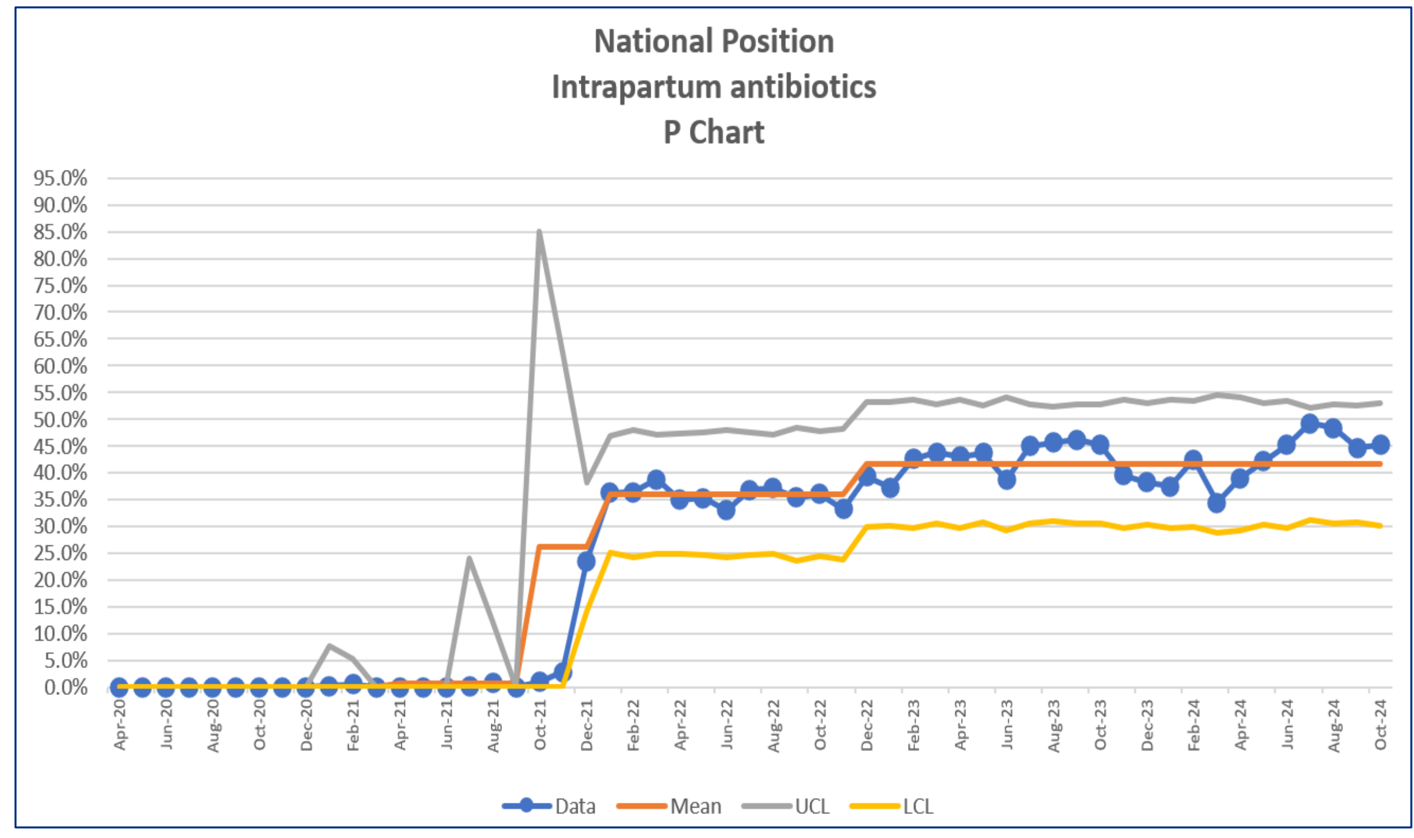


Figure 5. Optimal cord management

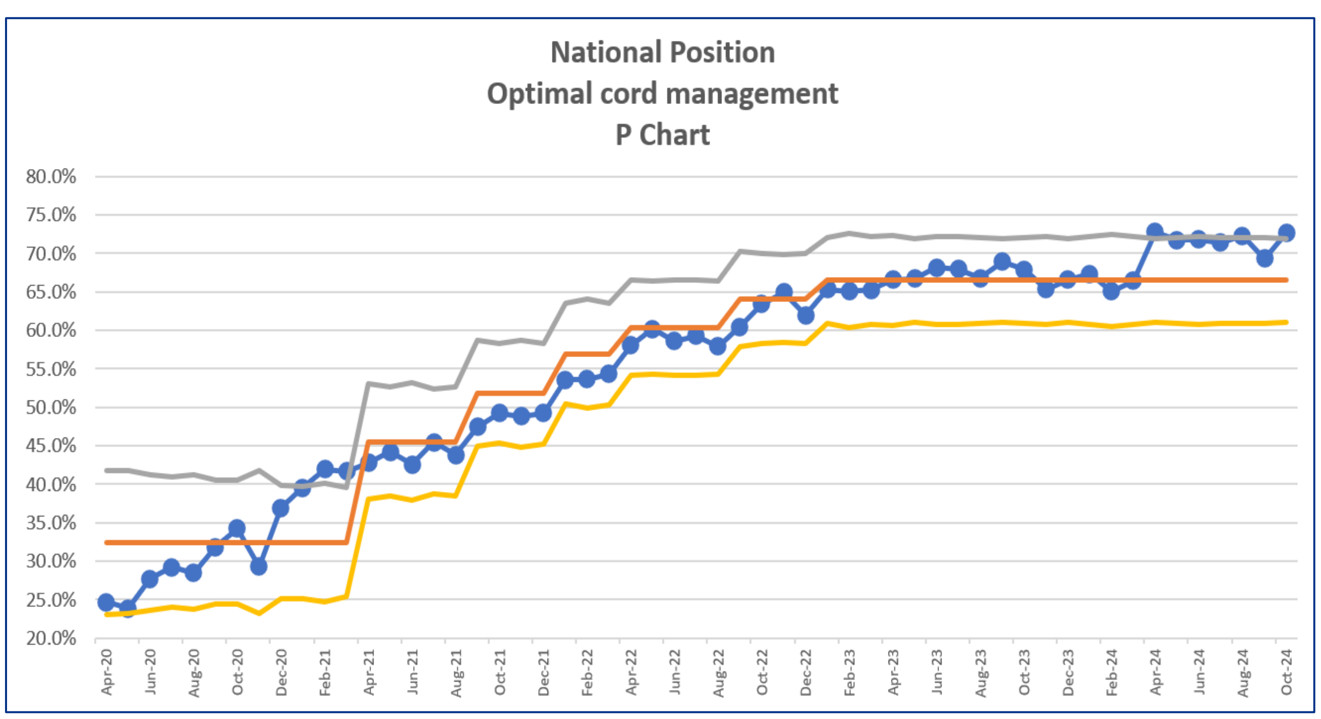


Figure 6. Normothermia

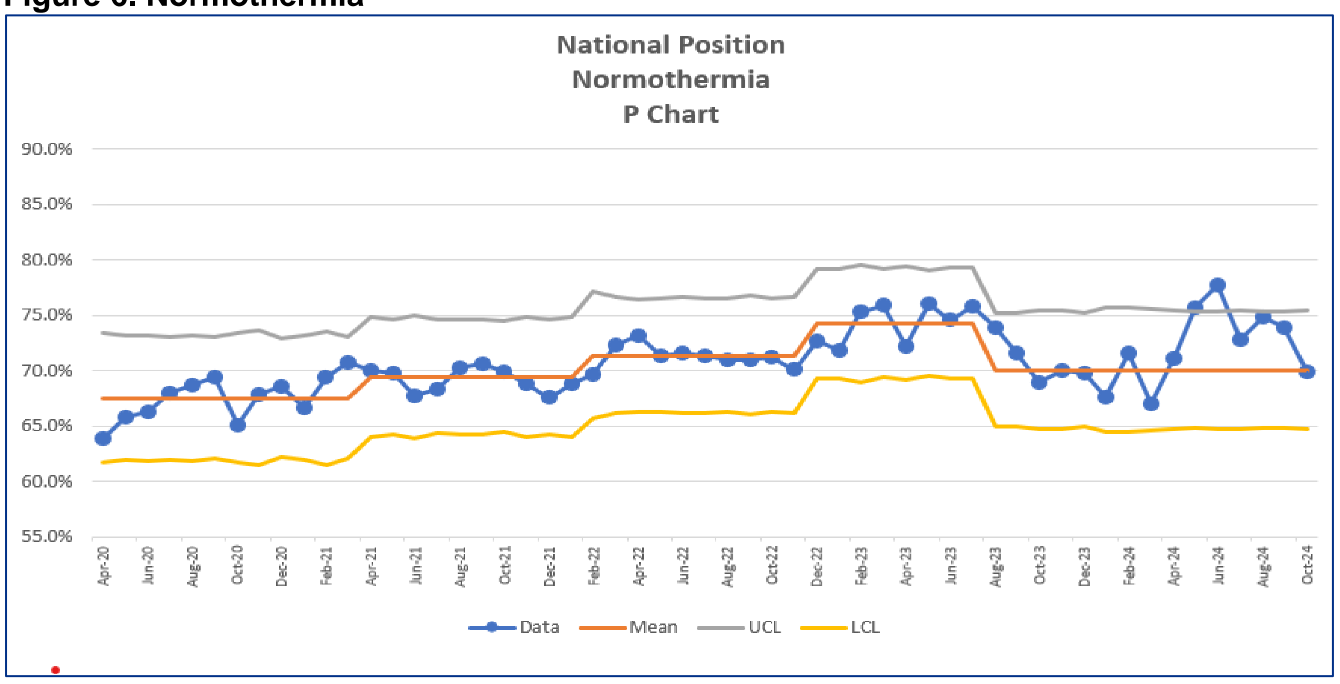


Figure 7. Breast milk

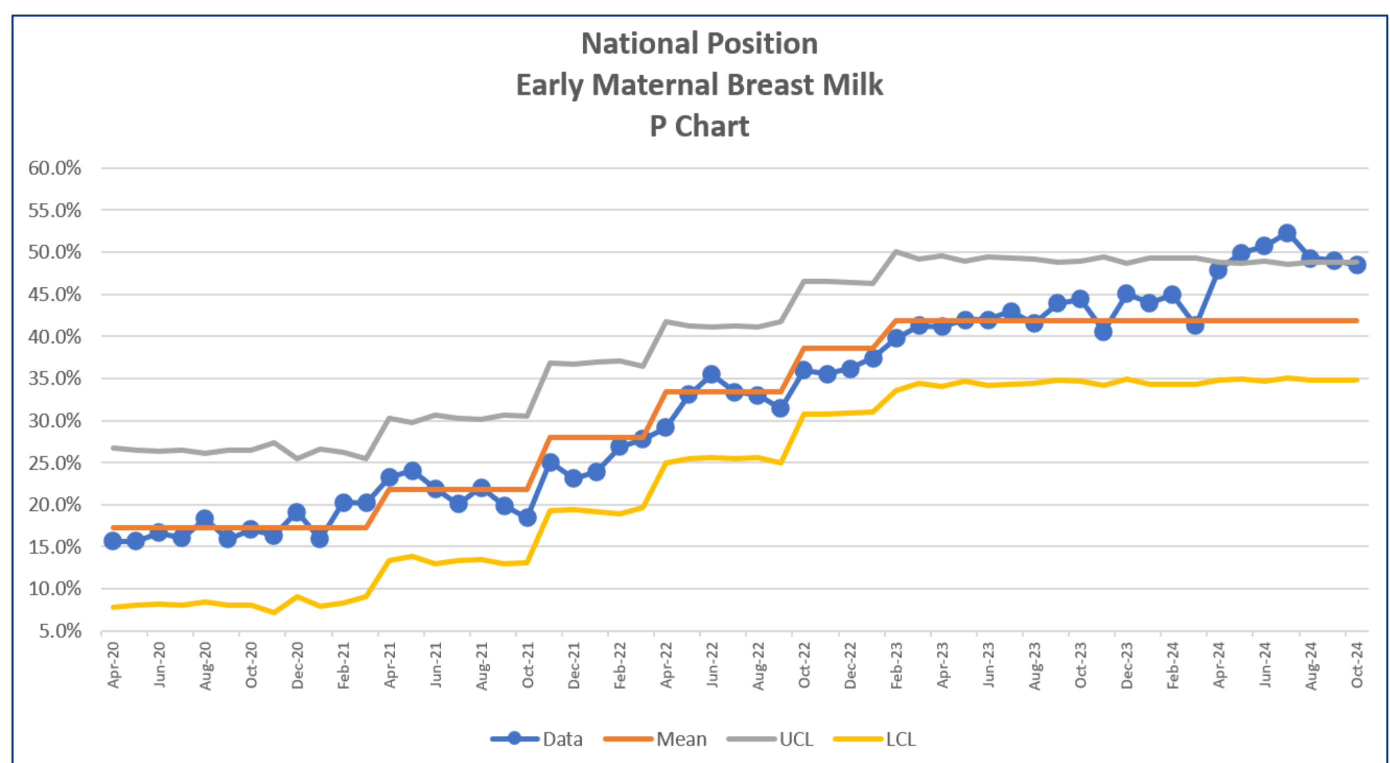


Figure 8. Magnesium sulphate

National Position
Antenatal Magnesium Sulphate
P Chart

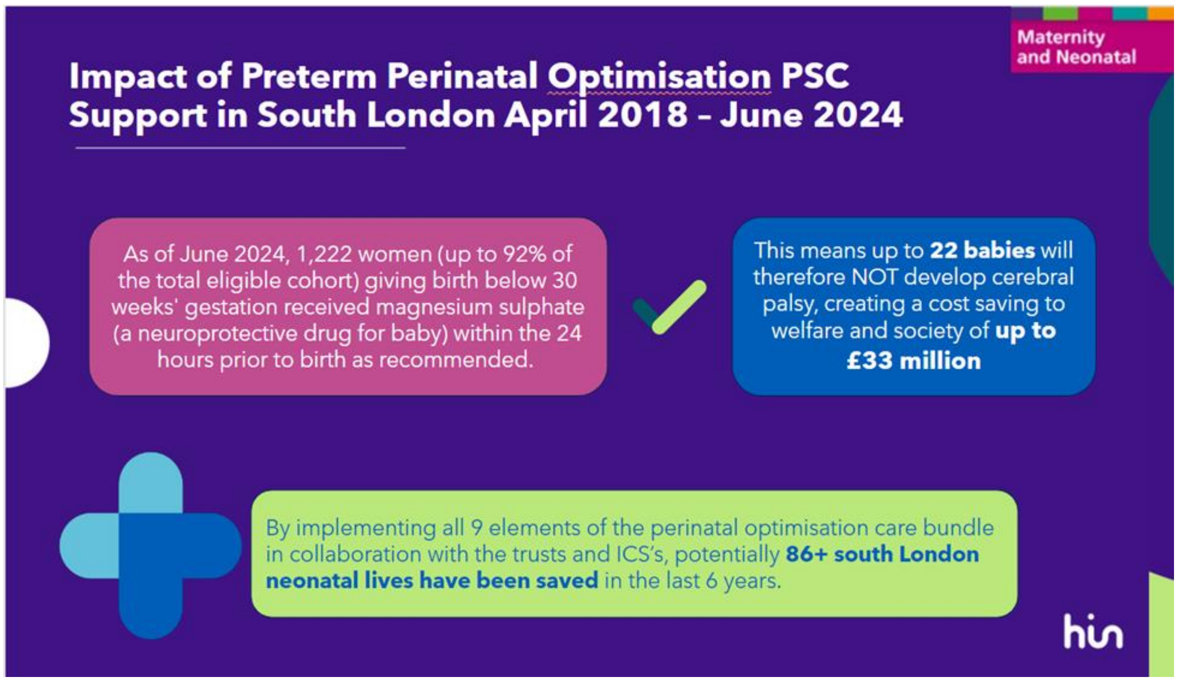
100.0%
95.0%
90.0%
85.0%
80.0%
75.0%
70.0%

Apr-20 Jun-20 Aug-20 Oct-20 Dec-20 Feb-21 Apr-21 Jun-21 Aug-21 Oct-21 Dec-21 Feb-22 Apr-22 Jun-22 Aug-22 Oct-22 Dec-22 Feb-23 Apr-23 Jun-23 Aug-23 Oct-23 Dec-23 Feb-24 Apr-24 Jun-24 Aug-24 Oct-24

Data Mean UCL LCL

Learnings

Optimisation and Stabilisation of the preterm infant



Health Innovation South London has successfully maintained a pathway approach to delivering all aspects of the preterm pathway bundle, as evidenced by their QART submission. By prioritising this pathway, they have achieved significant improvements and ensured the sustainability of care across all elements.

Perinatal Culture and Leadership Programme (PCLP)

- Individual members of the Perinatal, Culture and Leadership team link with and hold regular supportive meetings with all PSC PCLP Leads. These meetings are proving essential to building relationships and understanding the context, challenges, and successes in the PSC PCLP commission.
- The MOMENTS framework and resources offer potential for nurturing safety culture development through everyday practices. Capturing the experience and impact of MOMENTS seems essential and how this could be achieved may need to be specified.
- Engagement with Quad teams is variable for many reasons and there is a risk that some may not engage in the future. However, the offer of support needs to be open and easily available to Quad teams. Supporting Quad teams to provide evidence of reviewing culture in units and influencing plans of action may be an essential starting point.
- Whilst other workstreams provide an opportunistic vehicle for initiating work on the PCLP such alignment should not form the entire PSC approach.
- Outcome measures in future specifications perhaps need to be more explanatory to try to mitigate the complexity and challenge of measuring engagement and culture improvements. Ensuring collaborative agreement on definitions used in metrics seems essential moving forward.

Medicines Safety Improvement Programme

Summary of Q2 2024/25 Progress

Programme Expected Outcomes

Reduce harm from opioids in chronic non-cancer pain

- By end of March 2025, PSCs working with willing ICSs, will collectively contribute to the following outcomes:

  Through a structured approach to improvement, at least 50% of ICBs will:

  - progress through the phases of the Whole Systems Approach Framework*
  - identify change ideas/ initiatives with data to support adoption into business as usual and/ or spread.
  - provide visible and sustainable system leadership for this priority.

Benefits

We anticipate this will mean that by 31 March 2025, across England:

- 25,000 fewer people are prescribed oral or transdermal opioids (of any dose) for more than 3 months (NNH 62) compared to 31st March 2024, preventing ~400 deaths.
- 4,500 fewer people are prescribed high dose opioids (>120mg OME/day) compared to 31st March 2024 (aOR 2.2), halving their risk of opioid related death.
- people with chronic non-cancer pain reporting better quality of life, more able to be economically active and less disability.
- increase in availability, accessibility, awareness of and uptake of biopsychosocial offers including supported self-management.

2 x Pipeline Diagnostic: (1) Psychotropics in Learning Disability (2) Fall inducing medicines in Frailty

- By end of October 2024 PSCs, working with willing ICSs, will collectively achieve the following outcome:
  - Problem definition(s), descriptions of the potential harms and summary of the learning from any successful actions identified that were designed to address the problem(s).
- By end of March 2025 PSCs, working with the National Patient Safety Team and the MedSIP Co-leads, will collectively achieve the following outcomes:
  - Co-design of an improvement programme ready for delivery 2025/26
  - Opportunities for implementation/testing
  - Theory of change
  - Execution plan
  - Identification of measures
  - Measurement framework
  - Scale up plan

- Comms and engagement plan
- EQIA
- Refine prototype with the system.

Programme Deliverables

Reduce harm from opioids in chronic non-cancer pain

- All PSCs to continue to deliver the “Reduce harm from opioids in chronic non-cancer pain” priority. Key principles for the delivery of this priority are:
  - Considering the problem of high-risk opioids in chronic non-cancer pain from the perspective of the entire patient pathway is key and this requires system working.
  - Management of chronic non-cancer pain requires personalised care and shared decision making at its core with patients requiring a mixture of biopsychosocial support so that they can live well with their pain. Therefore, a key factor in making improvement against this priority is support for the system to move away from the prevailing medical model of chronic pain management which has resulted in over 1million people in England with high-risk opioid prescribing, towards a biopsychosocial model, including supported self-management.
- In 2024/25 support willing ICSs per to implement the “Whole Systems Approach to High-Risk Opioid Prescribing” framework.

2 x Pipeline Diagnostic: (1) Psychotropics in Learning Disability (2) Fall inducing medicines in Frailty

- All PSCs to contribute to the delivery of two “Pipeline diagnostics” to support the scoping and development of potential future medicines safety improvement priorities.
- All PSCs to contribute to developing and delivering the pipeline priority for BOTH secondary drivers. PSCs are either “Lead PSC” and/or “Supporting PSC.” Deliverables include:
  - A rapid evidence review.
  - System wide semi-structured interviews across a wide range of ICS geographies across England exploring problem themes with wide ranging stakeholders.
  - Identification of any actions already undertaken that were designed to address the problem theme(s)
  - Benefits mapping.

Key updates and achievements

Reduce harm from opioids in chronic non-cancer pain

- Systematic approach to improvement and structured support to understand the problem.

  There is overwhelming interest in this priority from ICSs across England; our ambition is to support at least 21 ICBs to:

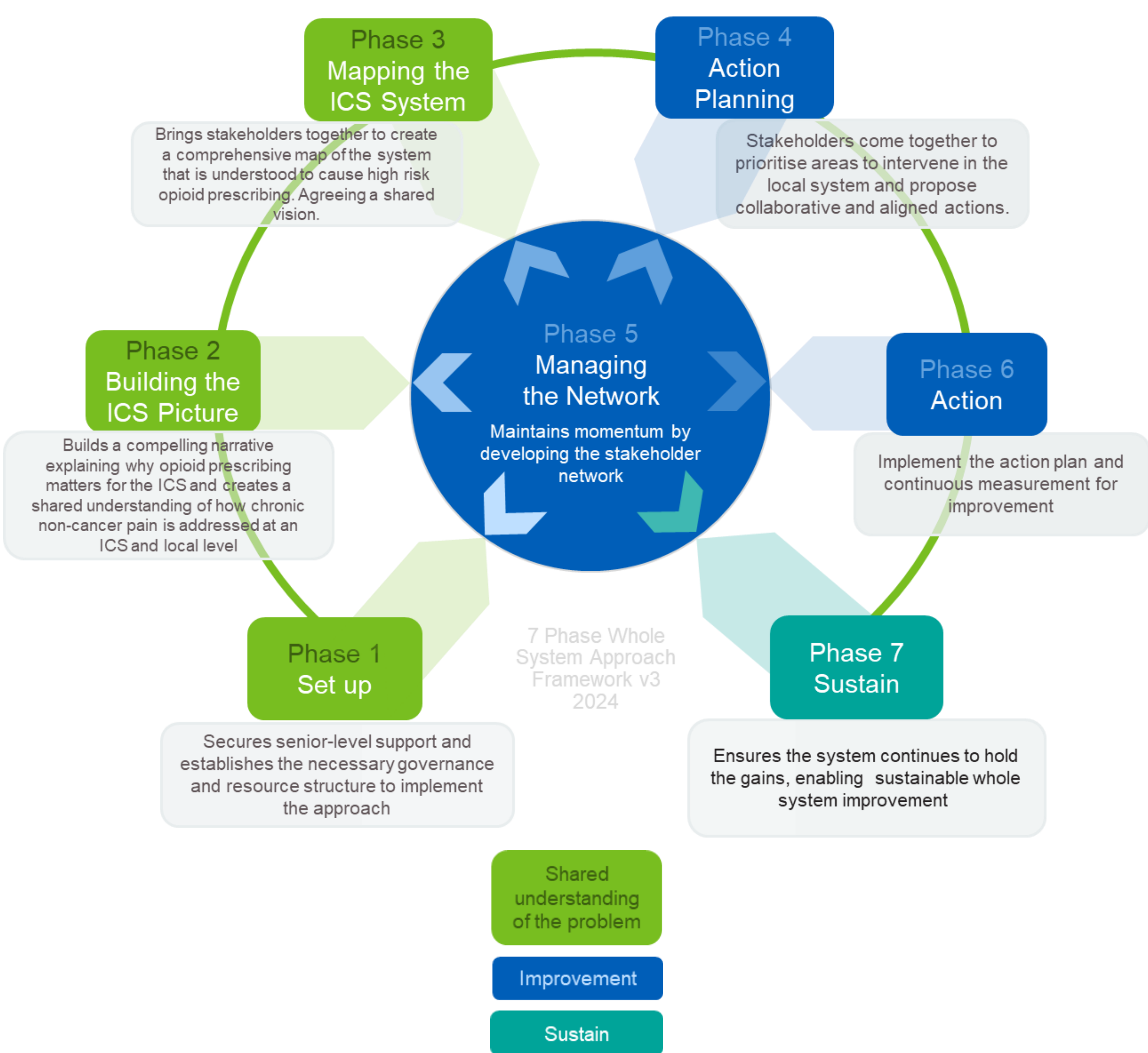
  a) Progress through the 7 Phase Whole Systems Approach Framework (see diagram below).

  b) Identifying change ideas/ initiatives with data to support adoption into business as usual and/ or spread.

  c) Providing visible and sustainable system leadership of this priority.

- In Q2 the PSCs are supporting 29 ICBs (69%) taking a Whole Systems Approach to Chronic Pain Management. 28 of those are fully supported by PSCs and further 3 are receiving a light touch support from PSCs:
  - 15 PSCs are working with 23 ICBs/ ICSs through Quality Improvement (Phases 4-6.)
  - Of these PSCs are supporting 15 ICBs/ICSs to implement the action plan (Phase 6 – Action).
  - In addition, 2 PSCs are working with 3 ICBs/ICSs through Quality Planning (Phases 2-3).
  - PSCs report 3 ICBs in Phase 7 where the ICB is moving to sustaining the new ways of working.

Whole system approach to reducing harm from opioids in chronic non-cancer pain*



* **The 7 Phase Whole System Approach Framework** was adapted from the PHE "Whole System Approach to Obesity: A guide to support local approaches (2019)" by Ruth Dales (MRPharmS) for the Medicines Safety Improvement Programme (December 2021). The additions emphasise key principles of Quality Improvement, in particular continuous measurement for improvement as well as the addition of a 7th Phase in recognition of the need to embed structures and processes to support sustainability. V3 recognises the network as central to the approach, insight gained through implementation over 3 years.

2 x Pipeline Diagnostic: (1) Psychotropics in Learning Disability (2) Fall inducing medicines in Frailty

- In Q2 (and into Q3) the 15 PSCs collectively provided 191 semi-structures interview submissions as part of the appreciative enquiry.

Interview Submissions (updated on 11.11.2024)

PSC	Psychotropics in LD autism or both	Medicines and falls/fractures in frailty
East	1	5
East Midlands	9	12
Kent Surrey Sussex	1	4
Manchester	5	10
South London	11	10
North East North Cumbria	12	10
North West Coast	3	2
Oxford & Thames Valley	4	6
South West	9	6
Wessex	4	8
West Midlands	7	13
West of England	8	8
Yorkshire & Humber	0	6
Imperial College Health Partners	1	0
UCL Partners	8	8
Total 2 | National Patient Safety Improvement Programmes	83	108

In Q2 the Lead PSCs completed a rapid evidence review and one of 3 Benefits mapping sessions.

Context, challenges, and expectations

Reduce harm from opioids in chronic non-cancer pain

The Whole System Approach Framework* is intended to support ICBs to provide visible and sustainable leadership of a specified priority to enable the ICS to co-ordinate action towards a specified ambition. Throughout 2023-24 PSCs reported that restructuring of Regions, ICBs and NHS England had impacted the ability of willing ICBs to engage with the work which impacted momentum; PSC and ICB colleagues reported throughout 2023-24 that this impacted the pace of the work in their ICBs.

The restructuring of ICBs remains ongoing in many ICBs across England in Q2 and PSCs have again raised this as a risk to delivery in 2024-25.

Outcome Measures

Reduce harm from opioids in chronic non-cancer pain

Figure 9. National 6 month rolling average - long term trend chart (Chronic opioid use)

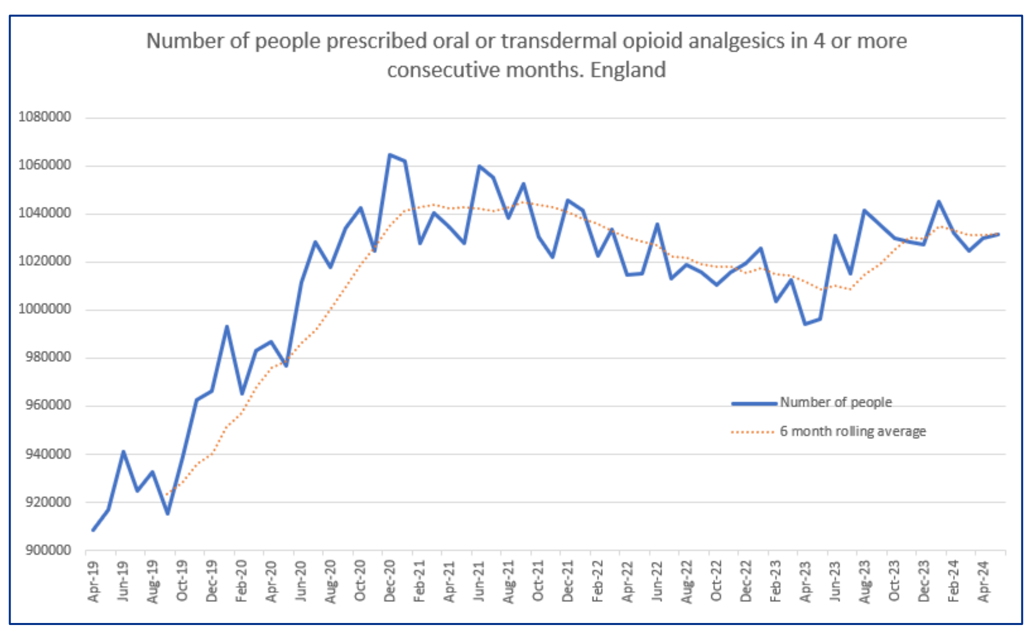
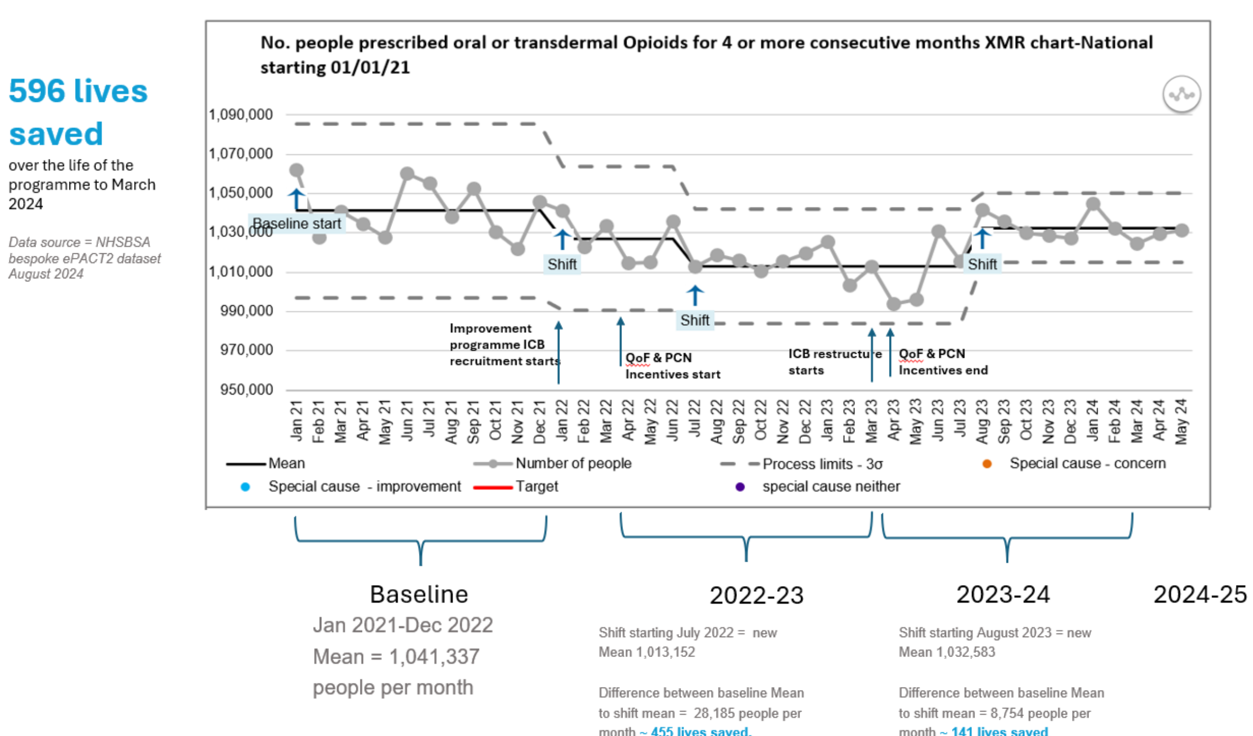
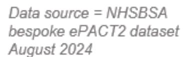


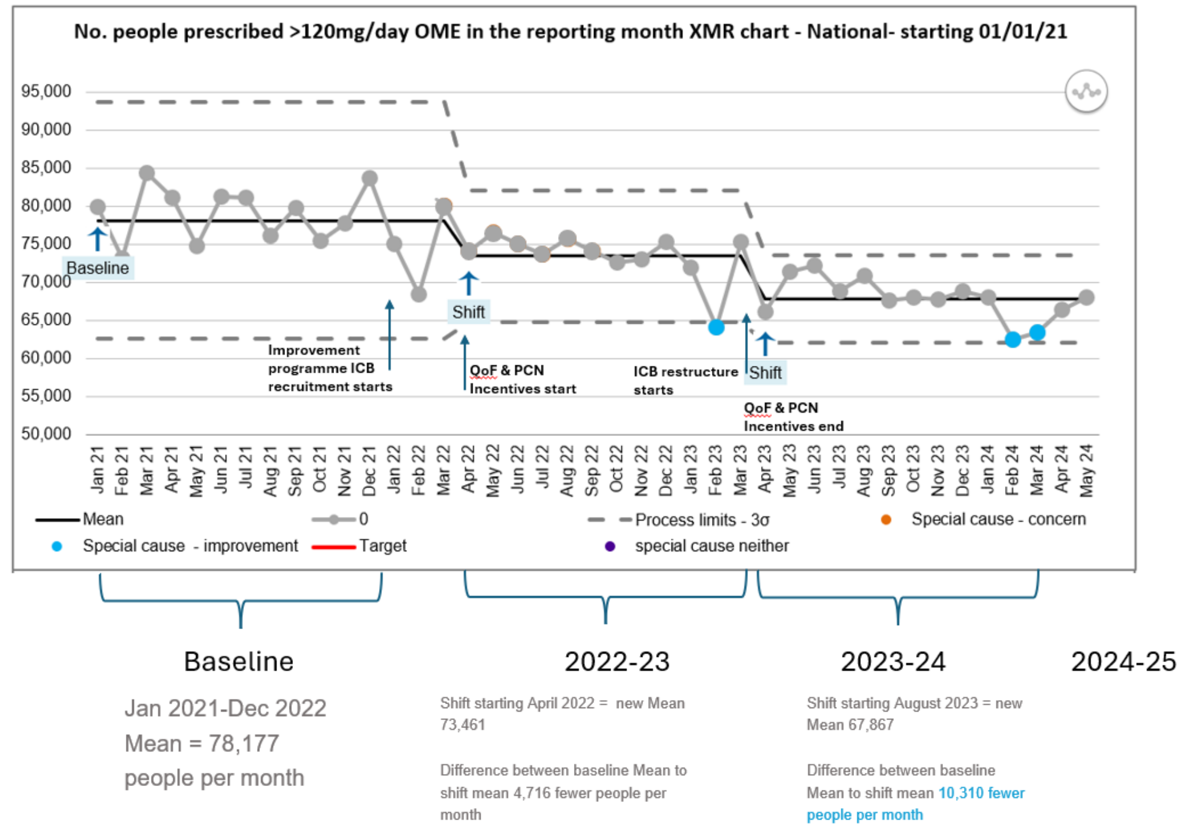
Figure 10. Statistical Process Control chart – National chronic opioid use



Plotting the data using SPC and modelling using a NNH of 62 to save one life shows that 596 lives have been saved during the course of the programme to end March 2024.

Figure 11. Statistical Process Control chart – National high dose opioid use



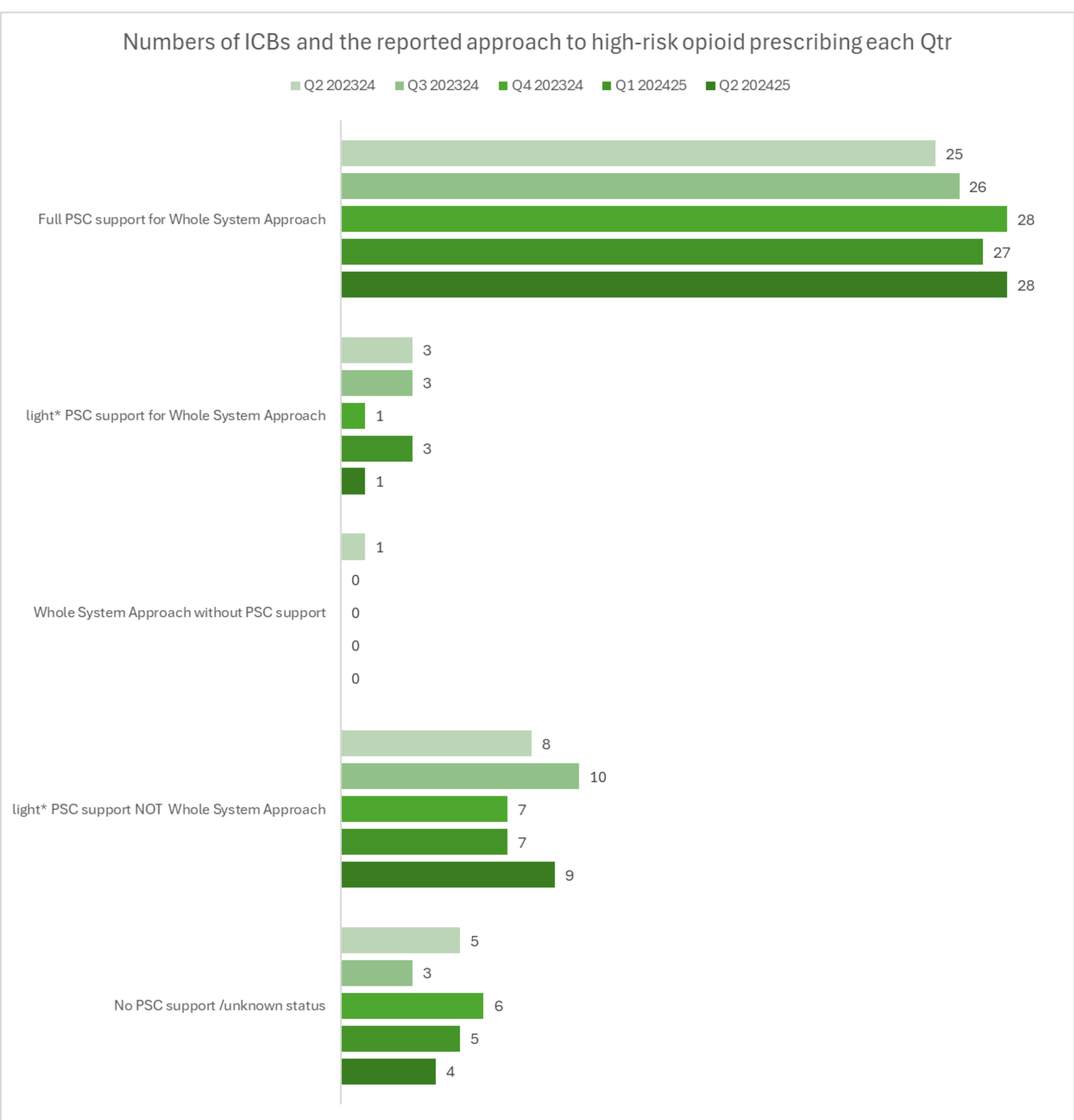


For the period since April 2023 there are on average **10,310 fewer** people per month being prescribed high dose opioids compared to the 2021 baseline. This equates to **10,198** patients who have their **risk of death from opioids halved**.

Process Measures

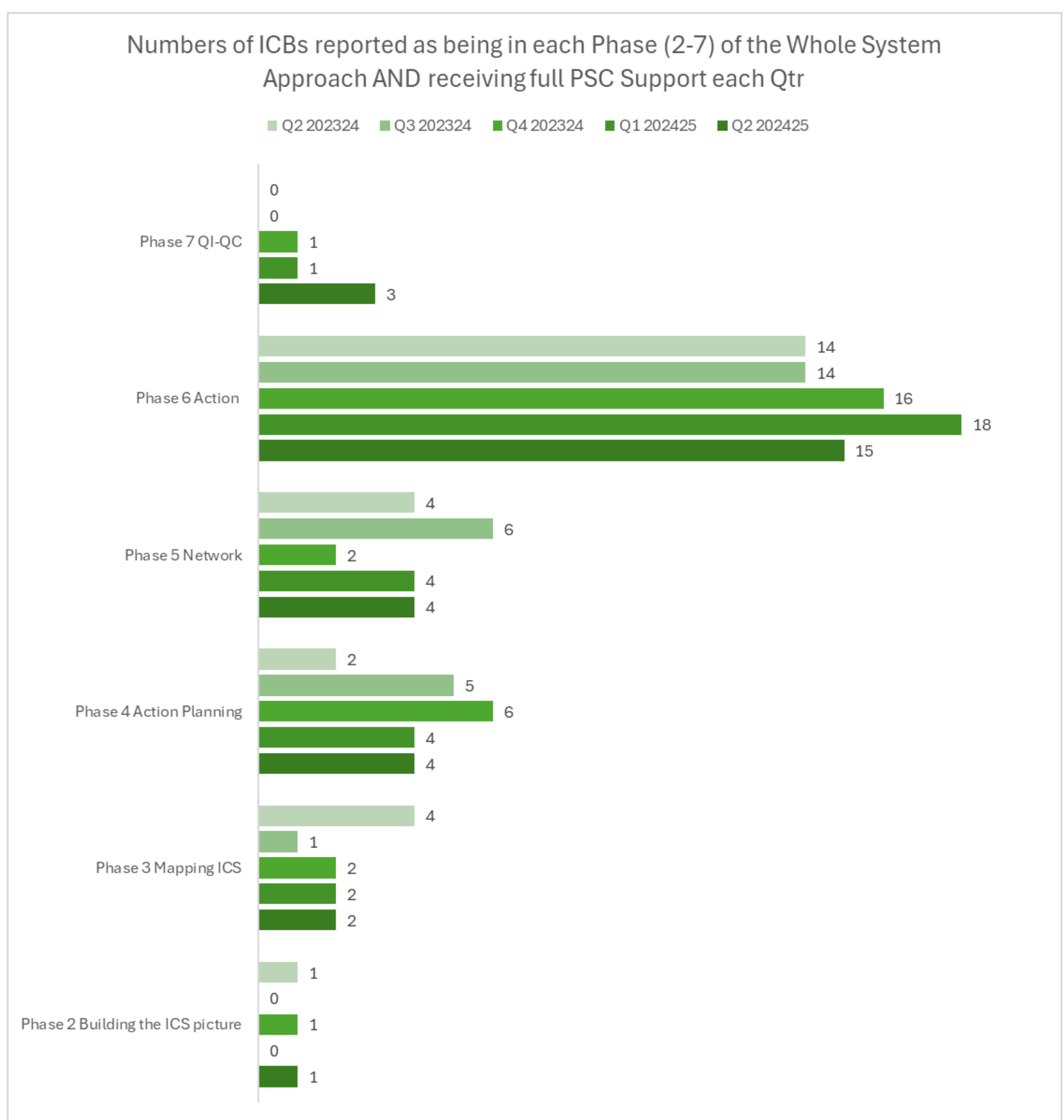
Reduce harm from opioids in chronic non-cancer pain

Figure 12.



PSCs are supporting 29 ICBs (69%) taking a Whole Systems Approach to Chronic Pain Management. 28 of those are fully supported by PSCs and further 3 are receiving a light touch support from PSCs.

Figure 13.



- 15 PSCs are working with 23 ICBs/ ICSs through Quality Improvement (Phases 4-6).
- Of these PSCs are supporting 15 ICBs/ICSs to implement the action plan (Phase 6 – Action).
- In addition, 2 PSCs are working with 3 ICBs/ICSs through Quality Planning (Phases 2-3).
- PSCs report 3 ICBs in Phase 7 where the ICB is moving to sustaining the new ways of working.

Learnings

V3 of the 7 Phase Whole System Approach Framework recognises the network as central to the approach, insight gained through implementation over 3 years. This further strengthens the theory that the framework supports the development of a Learning Health System which has potential to enable whole system continuous improvement. For example:

- At the end of 2023/24 we saw the networks of ICBs who are in Phase 6 (action) revisit phases 3 and 4 (mapping and action planning) in order to reflect on their progress against their action plan in order to refine it for the year 2024/25.
- The ongoing risk reported due to ICB restructure has seen ICSs lose key posts within the Core Working group and/ or the Leadership team and/ or the Network; this has prompted the Network to revisit earlier phases and rebuild/ course correct where required.

System Safety

Summary of Q2 2024/25 progress

The support to providers and systems through facilitation of networks, creating safe collaboration spaces, coaching and the role of a "critical friend" to implementation of PSIRF continues to be well received. The PSCs continue to provide a focus to PSIRF, consistency in resource and implementation and quality improvement expertise to the system.

Programme Expected Outcomes

- Support the coalition of stakeholders involved in PSIRF.
- Facilitate and nurture a learning culture and improvement approach by providing coaching and support to systems as they embed PSIRF including bespoke support to services that require it.
- Support the fidelity of the PSIRF principles as set out in the published guidance.
- By Q3 PSCs to support ICBs to understand the patient safety themes and the quality improvement work across their system to develop a learning system and support knowledge transfer.
- Work with system stakeholders to identify and understand the impact of PSIRF by supporting the development of measurement plans with systems to monitor the progress and impact of PSIRF including - for example:
  - Development and communication of case studies and other qualitative metrics
  - Work with and support system stakeholders to develop sustainability plans for PSIRF.
- From Q1 insight PSCs to continue to support the lead PSC with those identified as interested General practices / PCNs and GP Clinical leads in their area on the test pilot by liaising with their ICS/PCN clinical directors/leads.
- PSCs to continue to support the lead PSC in organising key learning/coaching events by liaising with relevant stakeholders in their area to maximise participation from GPs as well as other interested primary care stakeholders.
- PSCs to continue to support the lead PSC with developing case studies, experiential outputs to present the experience of PSIRF implementation in general practices in their area and to share the insight and experience with the National team.

Programme Deliverables

- Support the move from PSIRF transition (phase 6) to embedding change and improvement (phase 7) across systems and providers delivering NHS funded care in England with fidelity to the core principles.

- Support the test pilot of PSIRF implementation in General practices to enable interested GPs / PCNs to transition to PSIRF in each of the Patient Safety Collaborative areas by March 2025 and share the learning with the National (NHSE) team.

Progress and contribution to NatPatSIP ambitions 2024/25

The Patient Safety Incident Response Framework sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

Data shows 100% trusts (acute, ambulance, community, and mental health) have transitioned to PSIRF.

Key updates and achievements

- Support is provided, at all levels, and within multiple settings, regional support (Macro – regional, Meso – ICB and Micro – Provider organisations) as well as inter and intra ICS level. The approach taken ensures that PSC can offer bespoke support based on the needs of the stakeholder.
- Stakeholders involved include Chief Nurses, Patient Safety Specialists, Quality and Safety leads, Patient Safety Partners (where available), AD for Quality, Midwives, clinicians, clinical and non-clinical networks, as well as external stakeholders such as independent providers as part of progressing the PSIRF implementation.
- Support to establish and nurture the development of learning systems continues. This includes helping stakeholders to create the conditions, such as removing hierarchies, introducing effective approaches to collaborating and engaging such as appreciative enquiry.
- Facilitating review of provider plans, enabling the findings to be shared across systems, providing the opportunity to identify possible cross system improvement work.
- Supporting the system, to identify how to sustain PSIRF and maintain fidelity.
- Supporting systems with implementation of quality improvement work, aligning to other priorities both locally and nationally.
- Supporting systems to think through and consider responses in key areas that will support PSIRF in practice, the role of oversight, how to measure impact, how to learn, proportionate responses.
- Continued engagement from general practices, there are 54 organisations in this early adopter's group: made up of 30 practices; 8 PCNs; 7 ICBs; 8 GP Federations or providers and 3 other types of organisations.
- A learning continuum was shared which further clarified probable areas of application of PSIRF in general practice: capturing learning, surfacing insights, sharing learning and wider involvement. Early adopters were encouraged to share tools they are developing or testing.

Context, challenges, and expectations

- Systems are continuing to look for support from the PSC as they transition to PSIRF being business as usual.
- The impact of staff turnover and reorganisation within systems continue to impact negatively. Challenges include variation in knowledge and understanding of PSIRF principles, capacity to support systemwide working, competing priorities.
- Challenges in resources may impact on the ability to engage and participate in supportive activities.
- Challenge in achieving fidelity to the PSIRF principles due to expectations, requests, and behaviours from key stakeholders, such as requests from coroners, system, and provider leaders.
- Specific settings continue to require additional support, such as maternity and mental health. PSC work closely as a network and wit the central team to enable the support and messaging to be consistent.

Learnings

- Supporting systems to develop a PSIRF learning health system is a long-term process, but with a clear benefit that this approach will enable systems to horizon scan, share learning and develop approaches to safety improvement that can be tested and scaled across an ICS.
- There is a consensus that working collaboratively as a system to tackle cross system safety themes is the right approach, and there is a real desire to use quality improvement to harness the deep learning that PSIRF is generating.
- Systemwide themes that have been identified include, Falls, Frailty, Deterioration.
- Appreciative enquiry is being well received by systems as an approach to realise effective collaboration and events.

Case studies

UCLPartners PSIRF Case Study: Implementation in North Central London ICS

Context

UCLPartners have worked with colleagues in the North Central London ICS to support implementation and embedding of PSIRF through establishing and delivering a system wide Community of Practice.

UCLPartners (UCLP) works with colleagues across North Central London (NCL), North East London (NEL) and Mid & South Essex (MSE) to support implementation and embedding of the Patient Safety Incident Response Framework.

NCL ICB and UCLPartners PSC have brought together providers to overcome system implementation challenges and share learning from implementation and business as usual operation of PSIRF. To support this UCLPartners and NCL ICB have established a Community of Practice.

Establishing and delivering a PSIRF community of practice

UCLPartners and NCL ICB launched the community of practice in April 2024 to support PSIRF embedding. It was agreed by the system the PSIRF Community of Practice should act as a function for the following:

- A space to share stories of success and challenges from PSIRF implementation
- A space for safety improvement work to be shared and developed.
- A space for organisational just culture adoption best practice to be shared.
- A space to collaborate on system challenges such as investigation and reducing health inequalities.
- Scan for emerging safety themes.
- Hear from internal and external speakers.

It was also agreed that the UCLPartners would act as chair and facilitator for this Community of Practice

Since the establishment and launch of the NCL PSIRF Community of Practice there has been sessions focussed on:

- Co-production and development of a process map for Cross System Learning Responses and associated system wide sharing.
- Sharing learning and best practice on how provider boards are working with safety teams to provide oversight.
- Sharing learning and best practice from learning responses.
- Developing an understanding of what a cross-system approach towards PSIRF training looks like. As a result of this session a task and finish group has been established to develop and pilot system wide PSIRF training.

Next Steps: The future of the Community of Practice

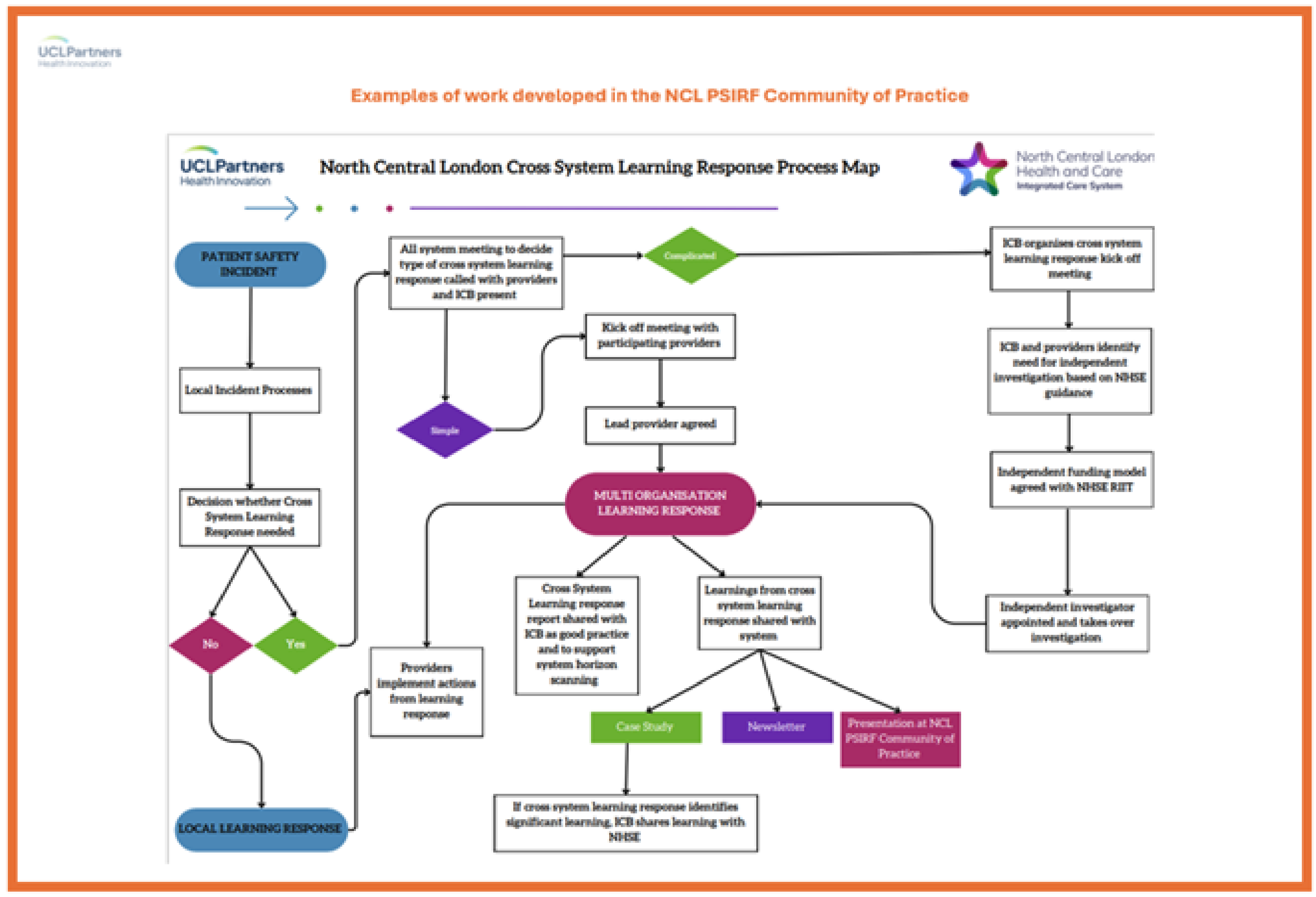
The Community of Practice will continue to play a key role in ensuring PSIRF is embedded and sustained across NCL as it will provide a space for patient safety teams to work together to identify and horizon scan common and emerging safety themes to be targeted by the system safety improvement group.

The Community of Practice will continue to provide a space for provider patient safety teams to share learning and optimise embedded PSIRF processes to maximise post incident safety learning.

Examples of Community of Practice Sessions:

North Central London Patient Safety Incident Framework Response Community of Practice

[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	
[illegible]	[illegible]	Presentation and discussion	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	Break		
[illegible]	[illegible]	Workshop	All attendees
[illegible]	Break		
[illegible]	[illegible]	Workshop	All attendees
[illegible]	[illegible]	Presentation	[illegible]


UCLPartners
Health Innovation
Examples of work developed in the NCL PSIRF Community of Practice
UCLPartners
Health Innovation
North Central London Cross System Learning Response Process Map
North Central London
Health and Care
Integrated Care System
PATIENT SAFETY INCIDENT
Local Incident Processes
Decision whether Cross System Learning Response needed
No
Yes
LOCAL LEARNING RESPONSE
All system meeting to decide type of cross system learning response called with providers and ICB present
Complicated
Simple
Kick off meeting with participating providers
Lead provider agreed
MULTI ORGANISATION LEARNING RESPONSE
Providers implement actions from learning response
Cross System Learning response report shared with ICB as good practice and to support system horizon scanning
Learnings from cross system learning response shared with system
Case Study
Newsletter
Presentation at NCL PSIRF Community of Practice
If cross system learning response identifies significant learning, ICB shares learning with NHSE
ICB organises cross system learning response kick off meeting
ICB and providers identify need for independent investigation based on NHSE guidance
Independent funding model agreed with NHSE RIIT
Independent investigator appointed and takes over investigation

Glossary

Acronyms

ACS – Appropriate Care Score

CQS – Composite Quality Score

HIN – Heath Innovation Network

ICB – Integrated Care Board

ICS – Integrated Care System

ManDet & MR Programme– Managing Deterioration and Martha's Rule Programme

MatNeoSIP – Maternity and Neonatal Safety Improvement Programme

MSDS – Maternity Service Data Set

MedSIP – Medicines Safety Improvement Programme

MEWS – Maternity Early Warning Score

NatPatSIPs – National Patient Safety Improvement Programmes

NEWS2 – National Early Warning System 2

PEWS – Paediatric Early Warning Score

PIER - prevention, identification, escalation, and response

PSC – Patient Safety Collaborative

PSIRF – Patient Safety Incident Response Framework

PSLs – Patient Safety Leads

PSNs – Patient Safety Networks

PSP – Patient Safety Partner

PSS – Patient Safety Specialist

PAS – Progression Assessment Score

SIP – Safety Improvement Programme

WSLs – Workstream Leads

Key Enablers

- **Addressing inequalities** – understand local health inequalities to ensure selected interventions improve the lives of those with the worst health outcomes fastest.
- **Patient / carer codesign** – employ a co-production approach with patients, carers and service users who represent the diversity of the population served.
- **Safety culture** – use safety culture insights to inform quality improvement approaches
- **Patient safety networks** – to coordinate and facilitate patient safety networks to provide the delivery architecture for safety improvement

- **Improvement leadership** – identify and nurture leadership, including clinical leaders, to lead improvement through the networks.
- **Building capacity and capability** – use a dosing approach to build quality improvement capacity and capability.
- **Measurement for improvement** – develop a robust measurement plan including relevant process, balancing and outcomes metrics.
- **Improvement and innovation pipeline** - undertake horizon scanning and prioritisation to inform future national work.