National Patient Safety Improvement Programme Q1 2024/25 Progress Report

Contents

Section	Page
Executive Summary	4
Key Infographics	6
Managing Deterioration and Martha’s Rule Programme	8
Summary of Q1 2024/25 progress	8
Key updates and achievements	9
Maternity and Neonatal Safety Improvement Programme (MatNeoSIP)	11
Summary of Q1 2024/25 progress	11
Key updates and achievements	14
Learnings	21
Case studies	22
Medicines Safety Improvement Programme (MedSIP)	23
Summary of Q1 2024/25 progress	23
Key updates and achievements	25
Learnings	31
Systems Safety	34
Summary of Q1 2024/25 progress	34
Key updates and achievements	35
Learnings	36
Case studies	37
Glossary	38

List of figures

Figure number	Programme	Description	Page
1	MatNeoSIP	National position total optimisation intervention	17
2	MatNeoSIP	National position optimising place of birth	17
3	MatNeoSIP	National position optimal antenatal steroids	18
4	MatNeoSIP	National position intrapartum antibiotics	18
5	MatNeoSIP	National position optimal cord management	19
6	MatNeoSIP	National position normothermia	19
7	MatNeoSIP	National position early maternal breast milk	20
8	MatNeoSIP	National position antenatal magnesium sulphate	20
9	MedSIP	National 6 month rolling average - long term trend chart (Chronic opioid use):	27
10	MedSIP	Statistical Process Control chart – National chronic opioid use – no. of people prescribed for 4 or more consecutive months	27
11	MedSIP	Statistical Process Control chart – National high dose opioid use – no. of people prescribed >120mg/day in the reporting month	28
12	MedSIP	Numbers of ICBs and the reported approach to high-risk opioid prescribing each quarter	29
13	MedSIP	Numbers of ICBs reported as being in each Phase (2-7) of the Whole System Approach and receiving PSC support each quarter	30
14	MedSIP	Sample ICBs in England with special cause improvement – chronic opioid use	31
15	MedSIP	Sample ICBs in England with special cause concern – chronic opioid use	32
16	System Safety	PSIRF early adopter organisations across England	35

Executive Summary

Managing Deterioration and Martha's Rule Programme

Martha's Rule

- All PSCs worked collaboratively with their pilot sites to support the implementation of Martha's Rule.

PIER

- All PSCs worked collaboratively with their ICBs/ ICSs to support the PIER programme objectives.

Maternity and Neonatal Safety Improvement Programme

Optimisation and stabilisation of the preterm infant

In Q1:

- 687 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.
- 452 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 45 babies were born without group B strep and that 12 babies survived.
- Between 47 – 68 babies born at less than 34 weeks gestational age potentially survived because their umbilical cord was clamped at or after one minute of birth.
- Between 13-16 lives were saved because the mother got antenatal corticosteroids.
- Potentially 72-96 lives were saved due to getting timely interventions.
- 20% of PSCs are reporting all their organisation to be sustainably implementing all 9 interventions.
- In Q1 from the baseline 1000 extra interventions per month were delivered.

Early recognition and management of deterioration of women and babies

In Q1 the development of the digital specifications continued at pace and PSCs were asked to identify organisations that were keen to support Test Sprints. Test sprints were set up to commence in Q2 to provide continuous feedback on inclusions for the digital specifications for both MEWS and NEWTT2.

Maternity Early Warning Score (MEWS)

- During Q1 PSCs continued to support their pathfinder organisations implementing MEWS on paper and supporting ongoing onboarding through 1:1 support call providing support on the condition needed to go live with national MEWS. Learning from the implementation is beginning to emerge and will be collated for wider dissemination, planned for Q2 2024-25.

New-born Early Warning Trigger and Track (NEWTT2)

- During Q1 PSCs continued to support their pathfinder organisations implementing NEWTT2 on paper and supporting ongoing onboarding through 1:1 support call providing support on the condition needed to go live with national NEWTT2. Learning from the implementation is beginning to emerge and will be collated for wider dissemination, planned for Q2 2024-25.

Perinatal Culture and Leadership Programme (PCLP)

- The PSC have begun to identify and engage with the stakeholders, focusing on the year ahead and support required

Medicines Safety Improvement Programme

Reduce harm from opioids in chronic non-cancer pain

- Improvements in the management of chronic pain mean 10,310 fewer people per month are being prescribed high dose opioids compared to the 2021 baseline.
    - This translates to 10,310 patients who have their risk of death from opioids halved.
- Data to May 2024 shows a significant reduction in people prescribed opioids for longer than 3 consecutive months ($p=0.015$) (Chronic opioid use).
    - This translates to 596 lives saved over 2 years.
- We present key learnings plus case studies that demonstrate the programme ambitions.
- In Q1 there are 30 ICBs (71%) taking a Whole Systems Approach to Chronic Pain Management. 27 of those are fully supported by PSCs and further 3 are receiving a light touch support from PSCs.
- An additional 7 ICBs are not implementing a Whole Systems Approach however they are receiving various levels of shared learning, data provision and other support from PSCs to address high risk opioid prescribing. This takes the total number of ICBs engaged in the programme across England to 37 (88%).

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

- Expressions of interest to be the Lead PSC for either/ or both Pipeline Diagnostics were received from 6 PSCs. Lead PSCs chosen and activity commenced.

Systems Safety

- The PSCs continued their contribution to support systems to implement the Patient Safety Incident Response Framework in Q1 in line with the 2024-25 National Patient Safety Improvement Programmes specification under the System Safety workstream.
- In Q1, the PSCs worked collaboratively with their ICSs and stakeholders including the system quality and safety leads and provider leads to support the PSIRF implementation , providers are requesting support to focus on the improvement themes.
- Challenges reported by PSCs include - maturity levels of the ICSs and ICS restructuring, making engagement difficult at times. In a few areas, lack of resources continued to be a challenge.

Key Infographics

Managing Deterioration and Martha's Rule Programme

Managing Deterioration and Martha's Rule Programme

- Working with 143 acute sites to test and implement Martha's Rule
- 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 between 995 and 1,294 lives**
- **Prevented up to 481 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 Q1 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 are able to 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 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 finalise the PIER improvement toolkit based on user feedback and stakeholder engagement.
- PSCs to approach ICSs to begin the early 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 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 commenced work with the pilot sites located within their HIN geographies, scoping and stakeholder engagement has been undertaken in all areas to varying degrees. Some PSCs have delivered initial community of practices with their pilot sites, though most are planning to deliver virtual or face to face engagement in Q2. All PSCs have linked into their regional Critical Care Clinical Operational Delivery Networks (CCCODNs) and Paediatric Critical Care Clinical Operational Delivery Networks (PCCC ODNs).
- NHSE communications team have begun developing the communication infrastructures to support the delivery of the programme. Focus has been given to communicating the plans for developing national communication resources due to many pilot sites unclear on what development of resources they can undertake. Messaging through regional communications teams appears to have not reached some of the 'in trust' communications teams for onward sharing with the pilot site implementation teams. PSC have been effective in facilitating and supporting conveyance of key messages relating to resources and branding for the programme.
- A HIN communications lead has been identified to coordinate messaging between the HINs and the national Communication team, with the aim of achieving consistency and clarity of messaging.

PIER

- All PSCs have identified at least one ICB to engage with to undertake the PIER assessment work.

Key updates and achievements

Martha's Rule

- Launch webinar was held May 20th to give an overview of the programme, all pilot sites, ODNs and PSCs in attendance.
- EOI for paediatric pilots shared in April, and process for selection confirmed.
- Martha's Rule Programme board stakeholders identified, dates and invites shared.

- Measurement plan in development, data insight and permissions being worked on by analytics team.
- Communications toolkit in development by NHSE comms team.
- Martha's Rule toolkit developed by NHSE with support from PSC co-leads.

PIER

- The Co-leads developed the PIER improvement toolkit and supporting resources.
- Engaging with stakeholders for PIER commissions, building working relationships to progress work in Q2.

Context, challenges and expectations

Martha's Rule

- Some PSCs are in the process of recruiting to support the delivery of the programme. Interim resource from within the PSC is being used by some teams to provide immediate support to the 143 sites implementing Martha's Rule.

Maternity and Neonatal Safety Improvement Programme

Summary of Q1 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 regards 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)

- Improvement in safety and culture at Trust and system level as defined by local plans and system agreement.
- Improved staff satisfaction / experience for those working in maternity and neonatal services.
- Improved outcomes for women and babies as a result of good perinatal safety culture.

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 need.
- ❖ 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 outcomes, with the reduction of morbidity and mortality as referenced in the charts below. These outcomes equal *since baseline,* 491 babies avoided contracting Group B strep, with 123 more babies surviving, up to 251 more babies survived with the improvements made in antenatal corticosteroids, 481 cases of cerebral palsy were avoided. Potential number of more babies surviving due to the improvements made with delivering the preterm optimisation bundle is 1,294.

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.

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.

Maternity Early Warning Score (MEWS)

- 28 organisations are at adoption and spread stage 4 or above.

New-born Early Warning Trigger and Track (NEWTT2)

- 31 organisations are at adoption and spread stage 4 or above.

Perinatal Culture and Leadership Programme (PCLP)

- The PCLP team are providing supportive meetings with PSC representatives to enable and inform their support of the PCLP and to build relationships with PSC representatives, these meeting are proving valuable. A lot of enthusiasm and motivation regarding the PCLP from PSC representatives has been demonstrated.
- Further Culture Coach training dates are being facilitated by the PCLP team to ensure that trusts who did not respond to initial offers of training can do so now.
- A national community of practice Future NHS site is in development in collaboration with PSCs, subject to NHS England approval.

Context, challenges and expectations

Optimisation and Stabilisation of the preterm infant

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.

Early Recognition and Management of Deterioration of women and babies

A key challenge for the early recognition and management of deterioration is the slow pace of the development of the national digital specifications. Feedback from system stakeholders indicate frustration in the delay. This work commenced in Q4 with communication to PSCs to disseminate to their systems, the digital specifications will be completed by early autumn 2024.

Capacity in the system is again highlighted, with competing priorities cited as a problem for some. Despite this PSCs consistently evidence improvement and engagement with both the MEWS and NEWTT2 workstreams.

The national data dashboard was raised as a challenge due to the updates not being refreshed in a timely way. This has been escalated to the appropriate NHSE colleagues for action.

Perinatal Culture and Leadership Programme (PCLP)

- Commencement of the commission was delayed impacting on PSC recruitment to PCLP programme lead roles and therefore quarter 1 milestones are in the main being carried over to quarter 2 where key activity is planned.
- Alignment of PCLP activities with other programmes seems appropriate to avoid duplication but there is also a need to ensure the PCLP is not subsumed by other programmes and receives specific input to meet programme deliverables.
- Some concerns regarding engagement with Quad teams have been raised but individual mitigating actions to improve engagement are in place and forms key aspect of PSC input.

Outcome Measures

Optimisation and Stabilisation of the preterm infant

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

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

Optimal Cord Management has contributed to saving the lives of up to 68 babies.

Total Q1 overall outcomes are: 45 babies avoided contracting Group B strep, with 12 more babies surviving, up to 16 more babies survived with the improvements made in antenatal corticosteroids, 413 cases of cerebral palsy were avoided.
Potential number of more babies surviving due to the improvements made with delivering the preterm optimisation bundle is 96

Process Measures

The preterm dashboard continues to be used and help 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 as seen 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 are being achieved to this cohort of babies on average each month.

Figure 2 – Optimising place of birth is an intervention that has been in Quality Control (QC) achieving 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.

Figure 3 – Shows a statistically significant shift down in antenatal corticosteroids being delivered, the initial gains of10% from baseline has not been sustained. This will be reviewed via the PSC WSL meetings to review the data and engage with teams.

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

Figure 5 – optimal cord management has had 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. HIN Manchester is showing a significant proportional improvement, HIN Southwest and Manchester are both achieving over 75 % which is above the national average.

Figure 6 – normothermia is displaying a statistically significant shift down, the same number of babies are receiving the intervention however the overall numbers of babies requiring the intervention has increased, the PSC will be able to use the data to help teams explore the findings and review the delivery of the intervention.

Figure 7 – the data is showing positive signals that this intervention is increasing in the number of interventions being delivered. Since baseline there has been a continued improvement from 17% to 41%.

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

Optimisation and Stabilisation of the preterm infant

Figure 1

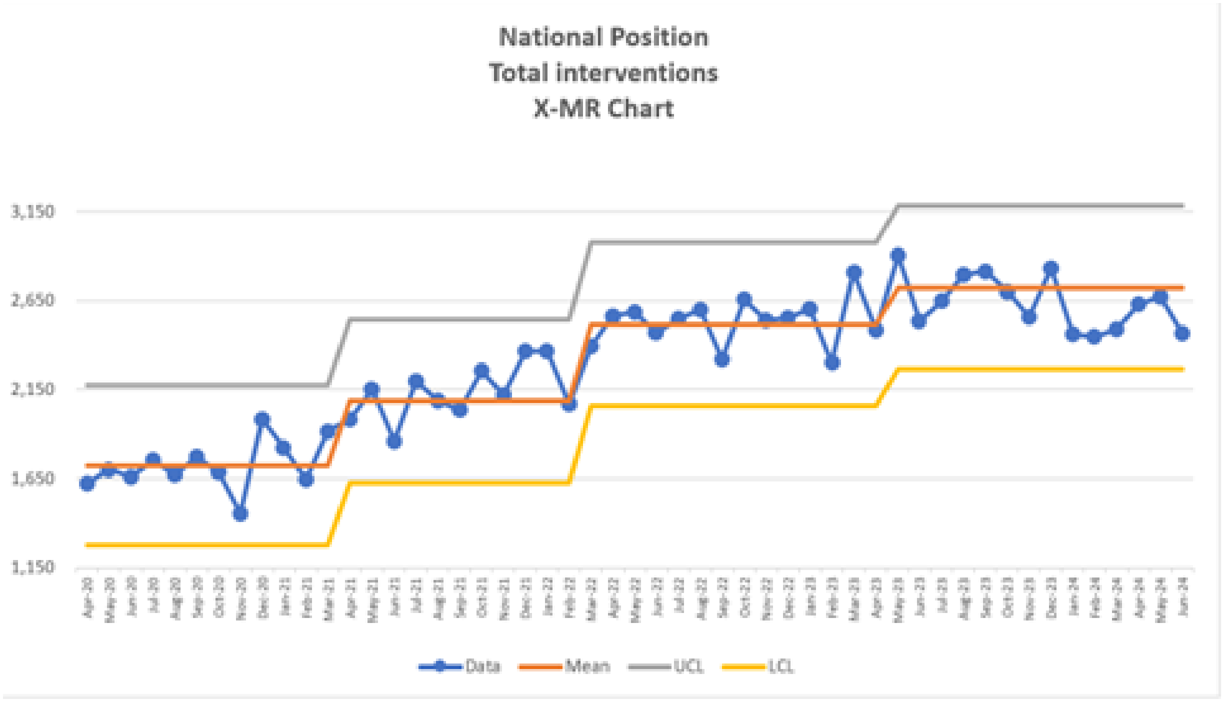


Figure 2

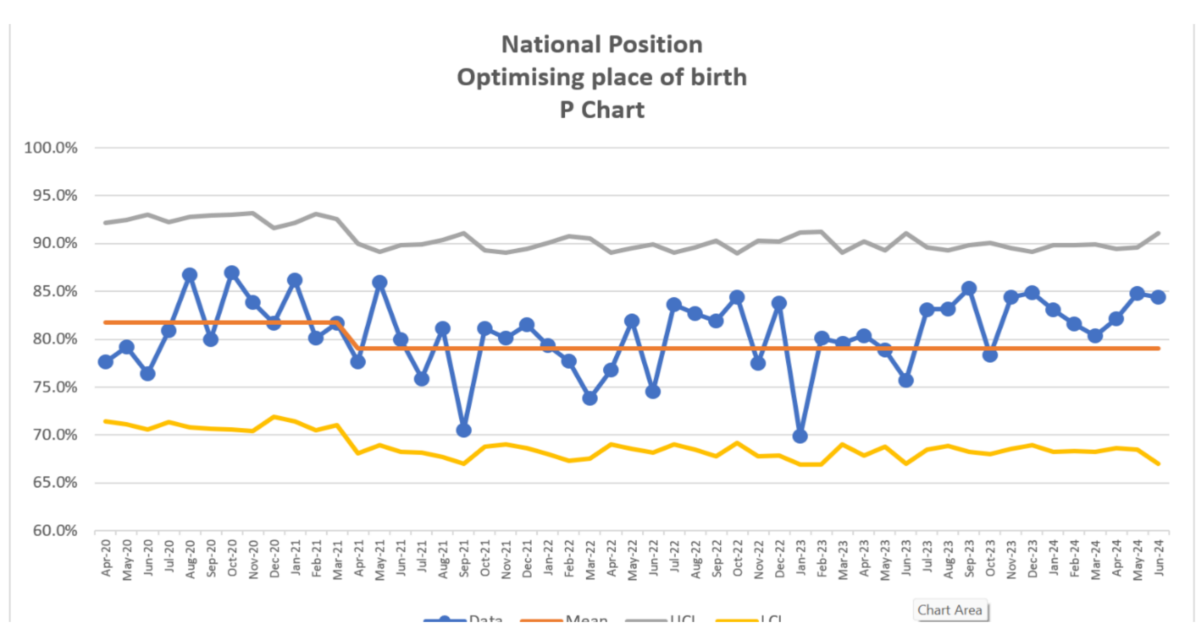


Figure 3

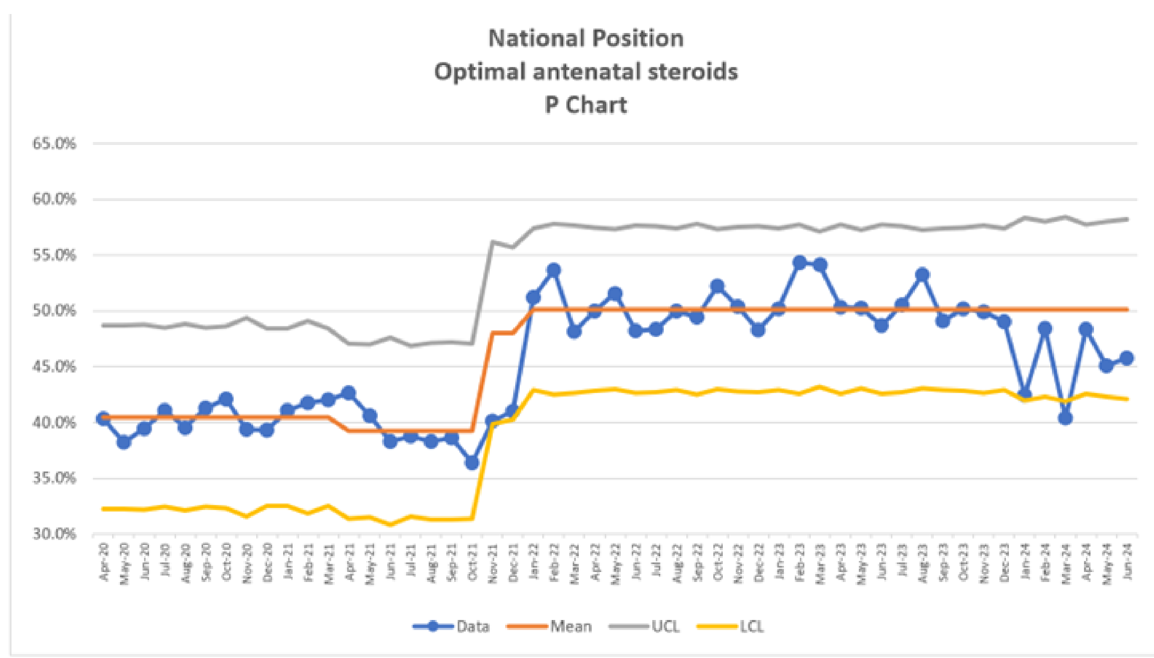


Figure 4

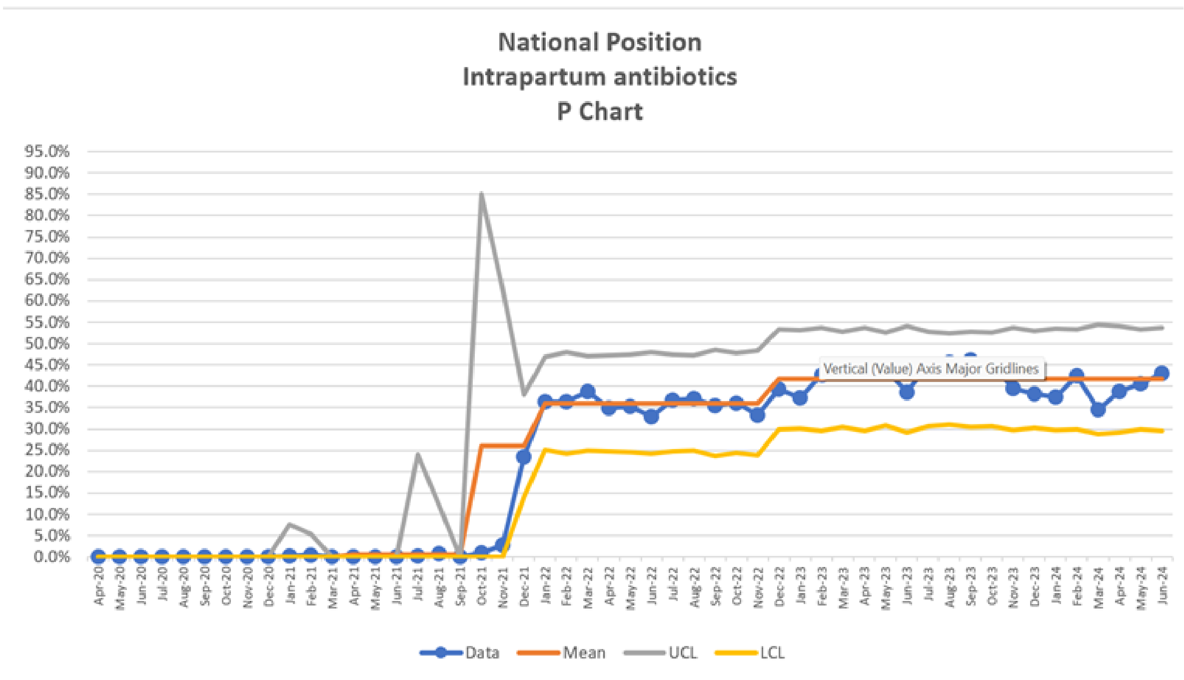


Figure 5

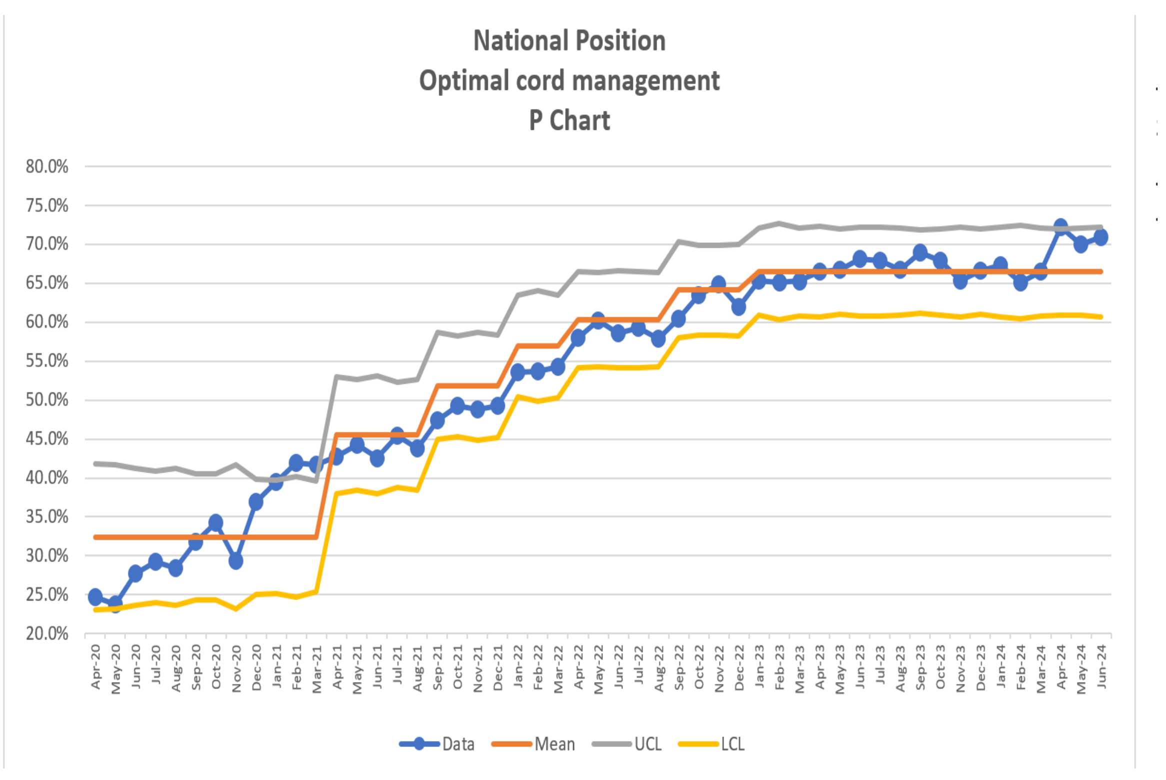


Figure 6

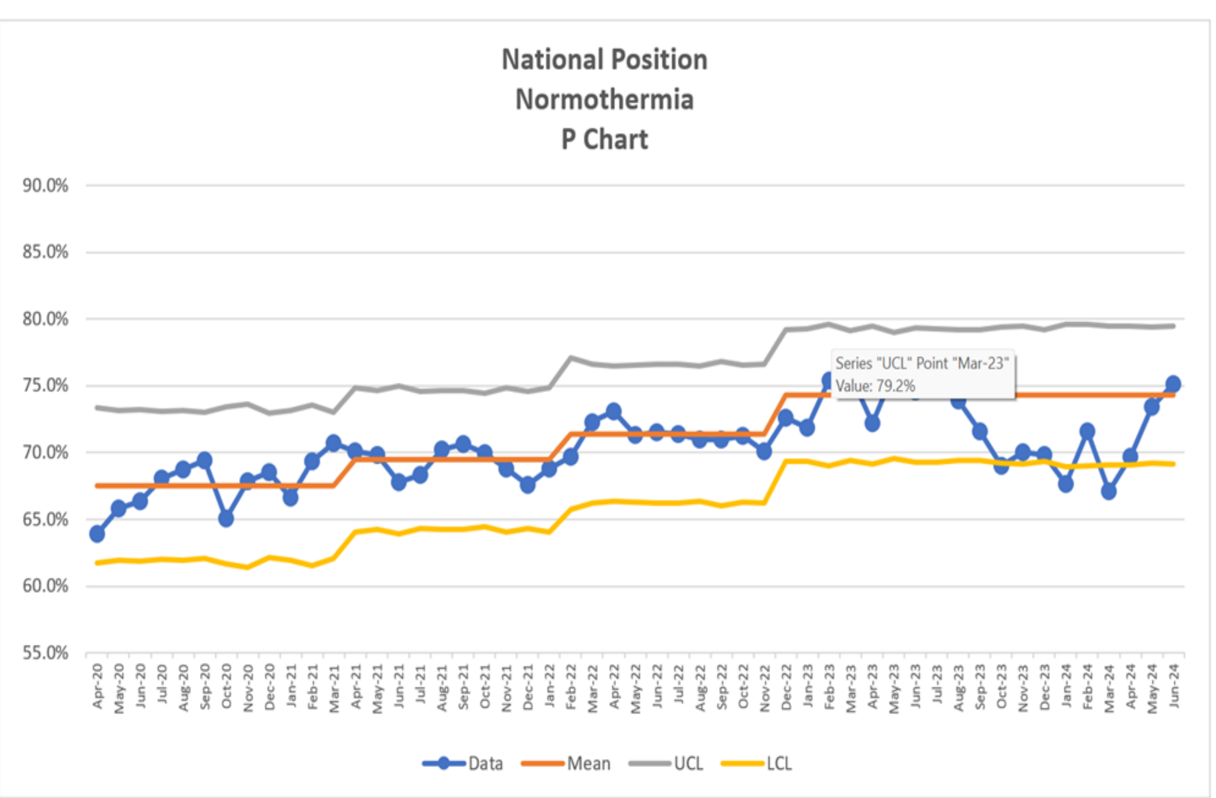


Figure 7

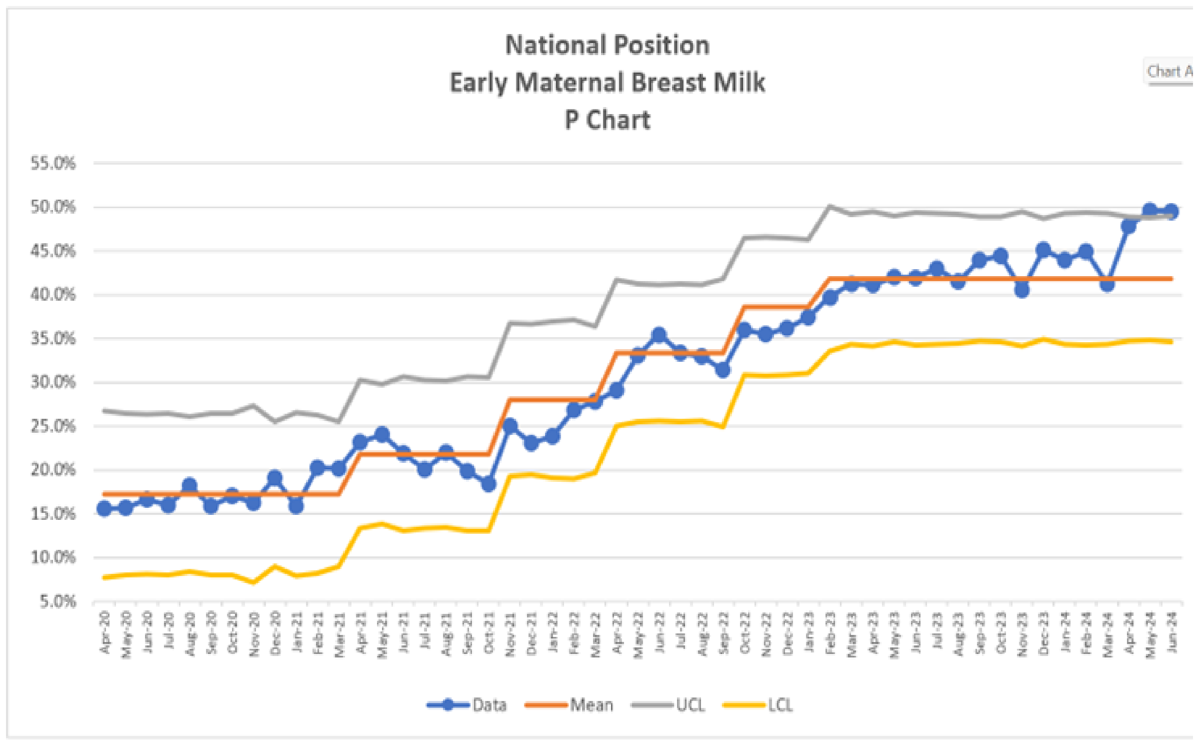
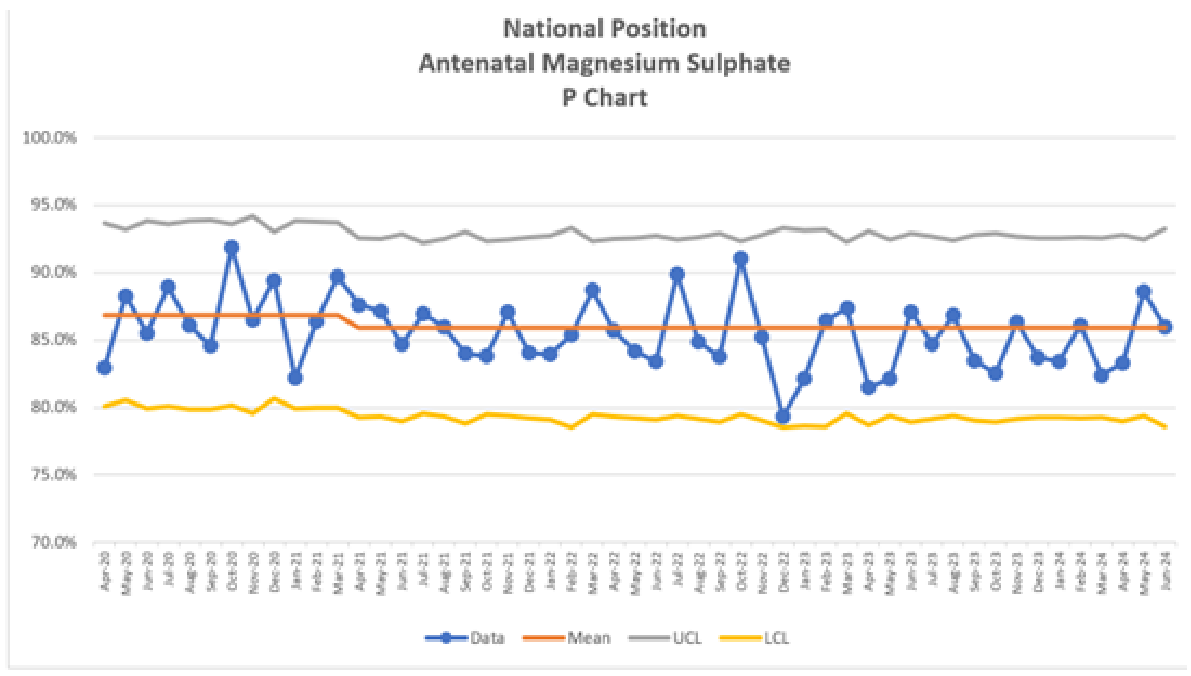


Figure 8



Learnings

Optimisation and Stabilisation of the preterm infant

- HIN East Midlands distributed Optimisation Aide Memoir cards to all 8 trusts which are to be used as a learning resource to support the embedding of understanding to staff across perinatal services.

Early Recognition and Management of Deterioration of women and babies

Maternity Early Warning Score (MEWS) and Newborn Early Warning Track and Trigger (NEWTT2)

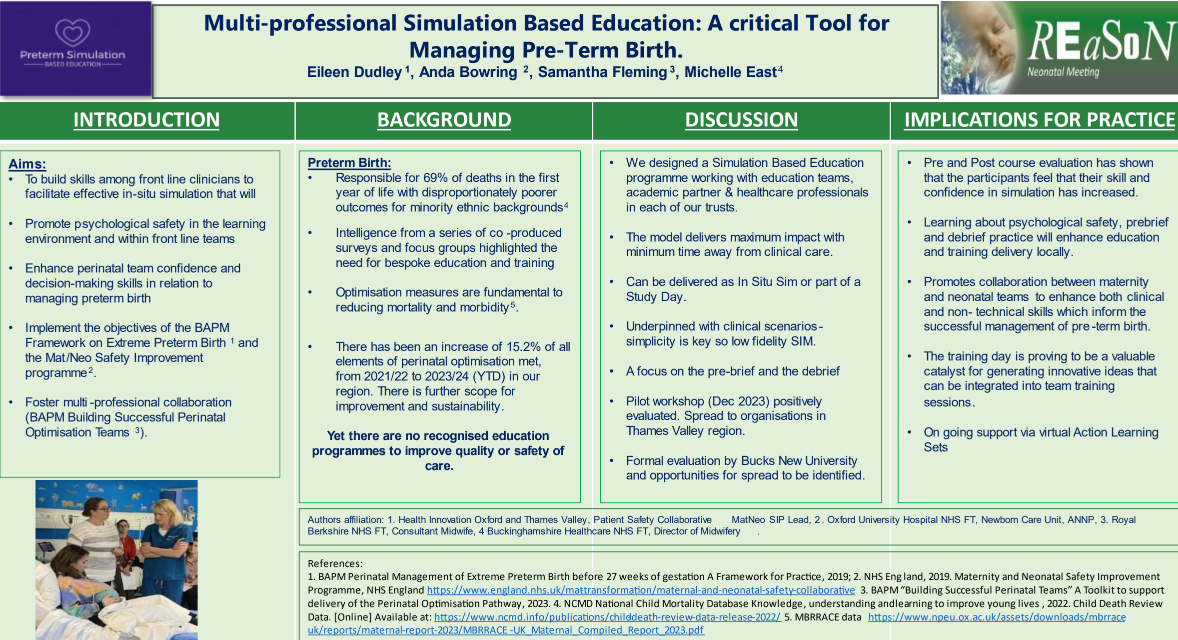
- In HIN KSS staff from MEWS pathfinder sites are qualitatively reporting increased satisfaction with MEWS scoring and that there is an increase in empowerment to escalate deterioration concerns.
- HIN South London have supported translations of the BAPM Parent Passport in 25 most spoken languages in south London which have been published locally and regionally.
- HIN Manchester supported the GMEC Maternity Voices Partnership in their development of a signs and symptoms leaflet that has been co-produced with a voluntary, community and social enterprise organisation using a health literacy approach. This work was shared at our national meeting.
- HIN Wessex have hosted 3 clinical networks inclusive of antenatal care, intrapartum care and triage with system wide engagement, working on standardising pathways of care that reduce variations in clinical practice using the PIER framework.

Perinatal Culture and Leadership Programme (PCLP)

- PCLP connections and relationships with PSC representatives at regular meetings seem key to promoting the PCLP.
- HIN Oxford and Thames Valley are using the culture and leadership lens and to support a project working on the interpretation and escalation of fetal monitoring in labour.

Case studies

Case study from HIN Oxford and Thames Valley



North West Coast Case Study

NWNODN/MatNeo SIP HINWC, HInM BAPM Gopi Menon award Submission.

- This case study is based on a successful application for a BAPM Gopi Menon award submitted by NWNODN Lead QI nurse Catherine Nash on behalf of the collaboration formed by the NWNODN, HINWC, HInM. Link to the video submitted as part of the application https://www.bapm.org/pages/bapm-gopi-menon-awards-2024
- The North-West have taken a unique, collaborative approach to embedding optimal perinatal care. The leadership team comprises of an NWNODN nurse, two Programme Managers from Health Innovation NW Coast and Health Innovation Manchester and a Project Officer. The wider team comprises of obstetricians, midwives, neonatologists, paediatricians, neonatal nurses, AHPs and data administrators from 21 units, alongside ex-neonatal parents and MNVPs.
- The challenge was to implement a plan to improve perinatal optimisation across the North-west of England, but without being able to offer providers additional funding or resources. The NWNODN, HINWC and HInM addressed this challenge by forming a unique, close collaborative partnership enabling delivery at scale across the North-west.

What the team has achieved

- An optimisation tool to collate data on behalf of units, showing percentage of interventions given monthly, quarterly and annually, with patient level data to identify missing data or missed interventions.
- Specialist Interest Group (SIG) educational meetings, with MDT and parent speakers. Regularly over 100 attendees, with over 1000hours of learning since April 2022.
- A regional face-to-face study day and optimisation week with 95 attendees, 500+hours of CPD.
- An implementation plan to roll out Volume Targeted Ventilation across the region, providing training and resources. 6 workshops delivered to-date, with over 100 attendees, 300+hours CPD.
- Designed and produced various resources including optimisation posters/businesscards
- A parent information leaflet explaining the measures, produced in collaboration with the Spoons charity.
- Perinatal Optimisation Groups at numerous units

An increase in the number of interventions achieved, when comparing baseline data (December2021) to March 2024. Highlights include:

- 88% of NW babies born in the right place in 2023.
- A 33% increase in delayed cord clamping (>1min). 1200 babies received DCC, equivalent to 500+ more babies in 2023/24.
- A 10% increase in temperature within range, equating to 160 more babies in 2023/24.
- Almost 1000 babies receiving colostrum within 24hours.
- 94% of eligible babies receiving caffeine by Day2.
- 64% (5057) of eligible interventions given in 2023/24.

- It is testament to the great engagement from all the clinical teams across the North-west that reflect the results we have achieved.
- Through collaboration, implementation of perinatal optimisation has become standard practice in the North-west with a focus on sustainability in 2024.

Patient Safety Collaborative 2

Medicines Safety Improvement Programme

Summary of Q1 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

Progress and contribution to NatPatSIP ambitions 2024/25

Reduce harm from opioids in chronic non-cancer pain

Progressing through the phases of the Whole Systems Approach Framework:

- ❖ In Q1 there are 30 ICBs (71%) taking a Whole Systems Approach to Chronic Pain Management. 27 of those are fully supported by PSCs and further 3 are receiving a light touch support from PSCs.
- ❖ An additional 7 ICBs are not implementing a Whole Systems Approach however they are receiving various levels of shared learning, data provision and other support from PSCs to

address high risk opioid prescribing. This takes the total number of ICBs engaged in the programme across England to 37 (88%).

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

- In Q1 PSCs report a number of initiatives that have data to support adoption into business as usual or spread and are intended to increase in availability, accessibility, awareness of and uptake of biopsychosocial offers including supported self-management, improve the quality of discharge from acute trusts and improve opioid stewardship and/ or pain management in primary care.

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

Expressions of interest to be the Lead PSC for either/ or both Pipeline Diagnostics were received from 6 PSCs. Lead PSCs chosen and activity commenced.

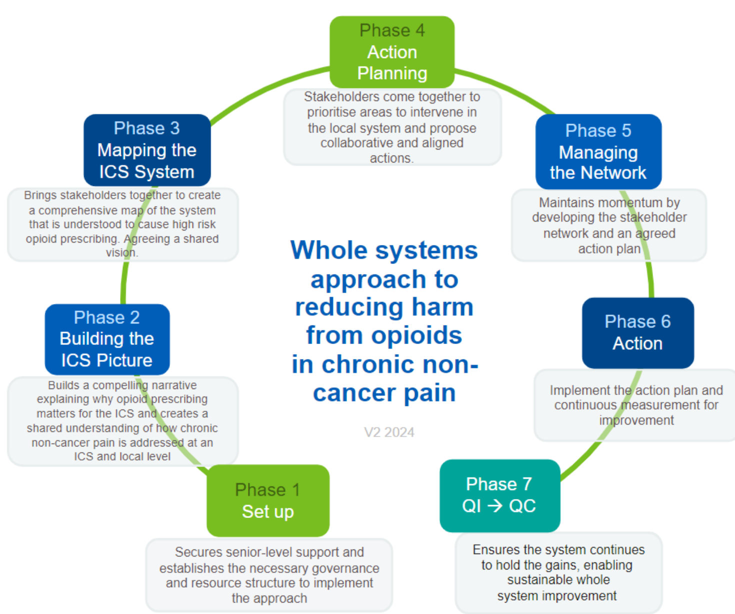
Key updates and achievements

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[1]



[1] 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 (2021). Additions make explicit 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, processes and patterns of behaviour to support sustainability.

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 Q1 the Patient safety Collaboratives (PSCs) hosted by the 15 Health Innovation Networks covering England are supporting 30 ICBs (71%) taking a Whole Systems Approach to Chronic Pain Management. 27 of those are fully supported by PSCs and further 3 are receiving a light touch support from PSCs:
  - 15 PSCs are working with 27 ICBs/ ICSs through Quality Improvement (Phases 4-6).
  - Of these 15 PSCs, 13 are supporting 18 ICBs/ICSs to implement the action plan (Phase 6 – Action).
  - In addition, 2 PSCs are working with 2 ICBs/ICSs through Quality Planning (Phases 2-3).
  - 1 PSC is reporting an ICB in Phase 7 where the ICB is moving to sustaining the new ways of working.

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 Q1 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):

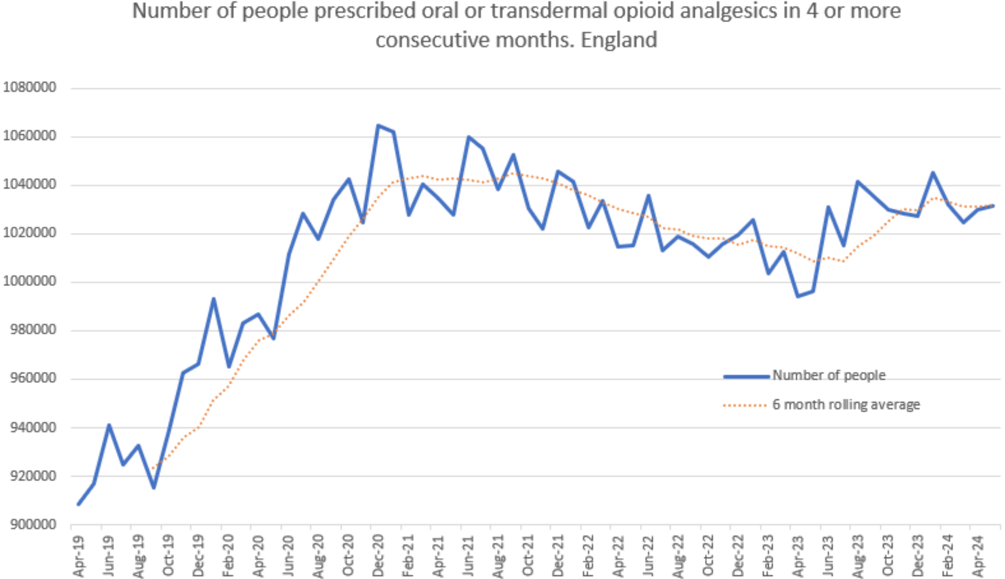


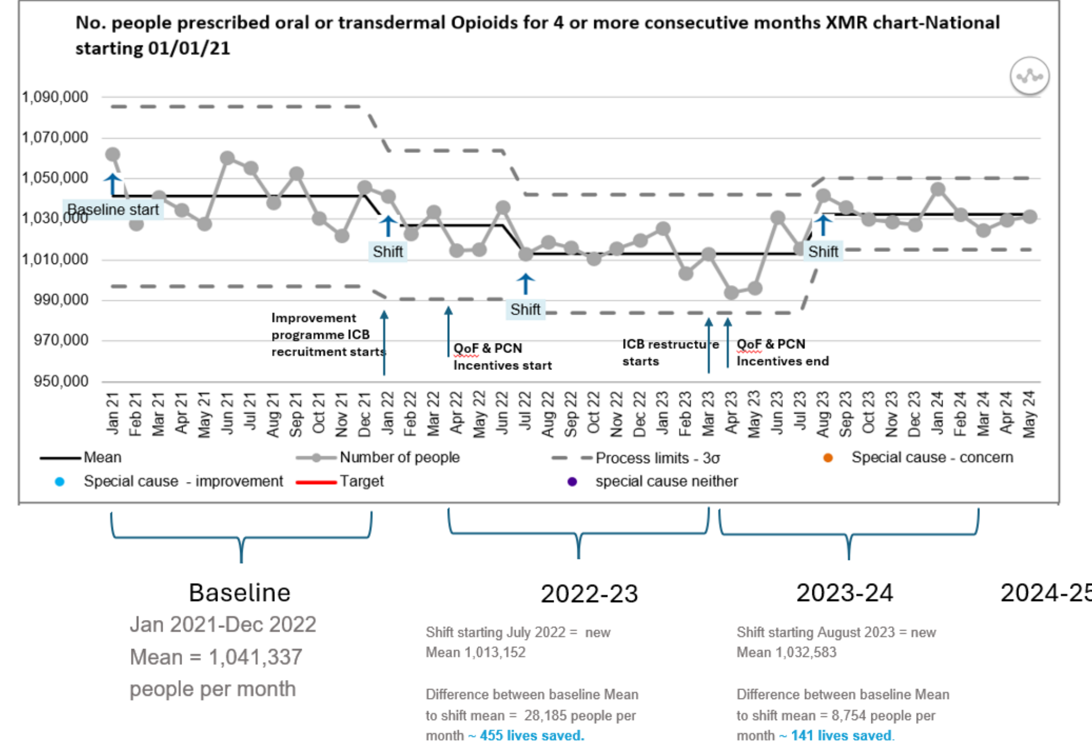
Figure 10

Statistical Process Control chart – National chronic opioid use:

596 lives saved

over the life of the programme to March 2024

Data source = NHSBSA bespoke ePACT2 dataset August 2024

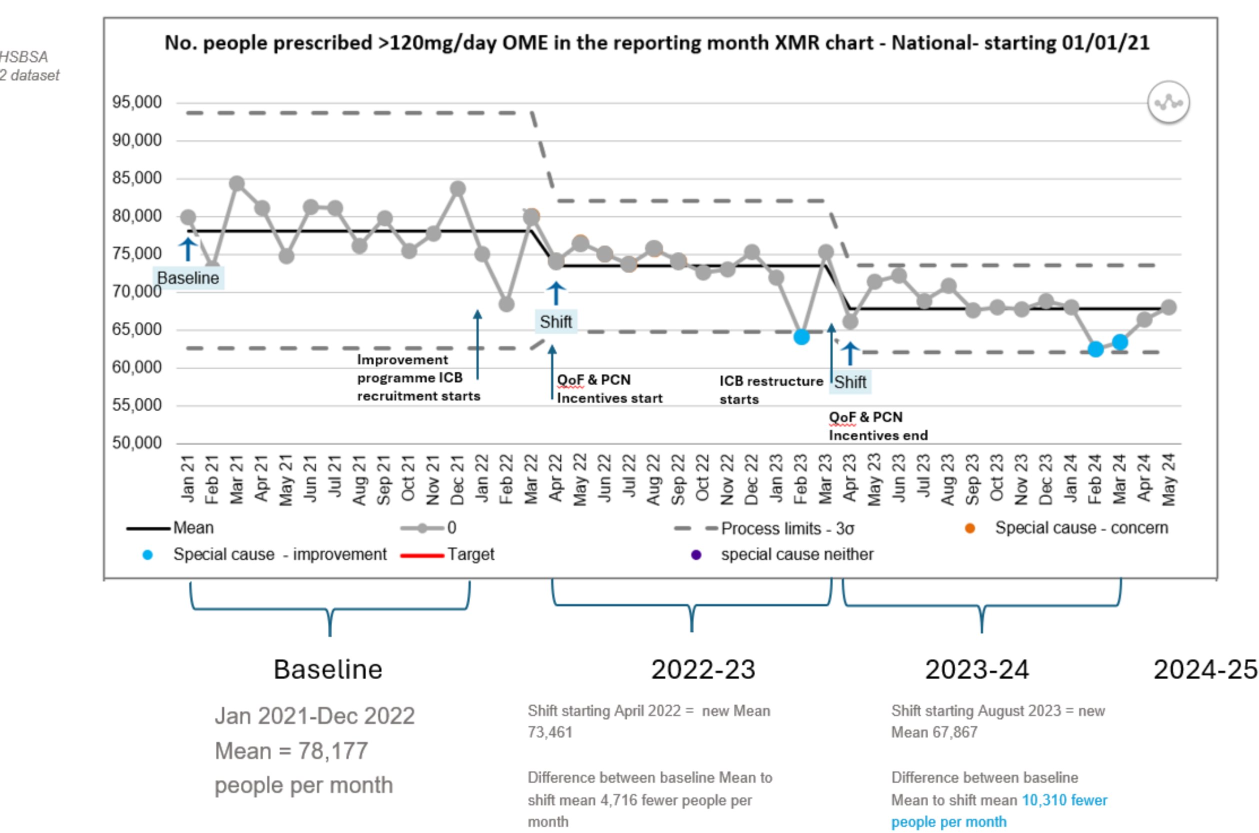


Plotting the data using SPC and modelling using a NNH of 62 to save one life shows that 596 lives have been saved during the course of the programme to end March 2024.

Figure 11

Statistical Process Control chart – National high dose opioid use:

Data source = NHSBSA bespoke ePACT2 dataset August 2024



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.

Increase in availability, accessibility, awareness of and uptake of biopsychosocial offers including supported self-management

In Q1 PSCs report 4 initiatives that have data to support spread and are intended to achieve this outcome:

1. Let's Live Well With Pain (LLWWP) pain management support groups developed with Dr Francis Cole of Live Well with Pain in partnership with Joined Up Care Derbyshire and with Health Innovation East Midlands (HIEM) as well as input from Roger Knaggs of the British Pain Society. They have developed an Implementation guide, Facilitator guide, Patient leaflet and videos explaining the service with user feedback. It employs a validated measure called the LWWP Health and Well-being measure (included in the guides). They have linked this into the GP electronic records via accuRX. https://healthinnovation-em.org.uk/our-work/innovations/improving-the-management-of-non-cancer-pain-reducing-

harm-from-opioids/691-lets-live-well-with-pain. Currently 17 groups across Derbyshire with plans for more.

2. Lincolnshire Empowered relief virtual sessions plus face-to-face cafes - rolling out across Lincolnshire: Empowered Relief :: Lincolnshire Prescribing and Clinical Effectiveness (lincolnshire-pacef.nhs.uk)
3. Cornwall Pain cafes – rolling out across Cornwall, Somerset and Plymouth.
4. King's Health Partners Pain: Equality of Care and Support within the community (PEACS) now being rolled out across South East London and South West London ICBs. https://www.kingshealthpartners.org/our-work/mind-and-body/our-projects/pain-equality-of-care-and-support-within-the-community.

PSCs also describe being in planning stages for initiatives that support this outcome:

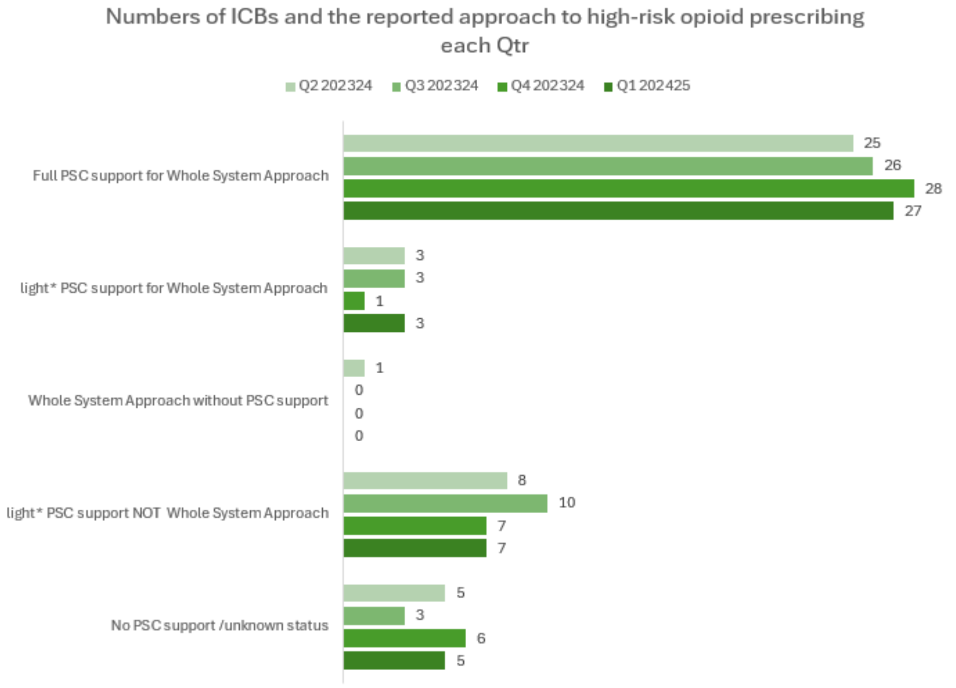
- Pain Ambassadors - NENC are working up a pilot. https://painconcern.org.uk/wp-content/uploads/2023/07/Ambassador-role-description-v1.pdf.
- Following the roll out of Live Well With Pain training across the ICBs supported by HI West Of England they worked with a PCN to co-develop a pilot model incorporating this into changes in practice.
- Live Well With Pain training has been delivered to 100 staff across the West Midlands ICBs with plans in place to build a network of pain cafes.

By capturing local measures PSCs aim to demonstrate the impact of the roll out of these initiatives during 2024-25.

Process Measures

Reduce harm from opioids in chronic non-cancer pain

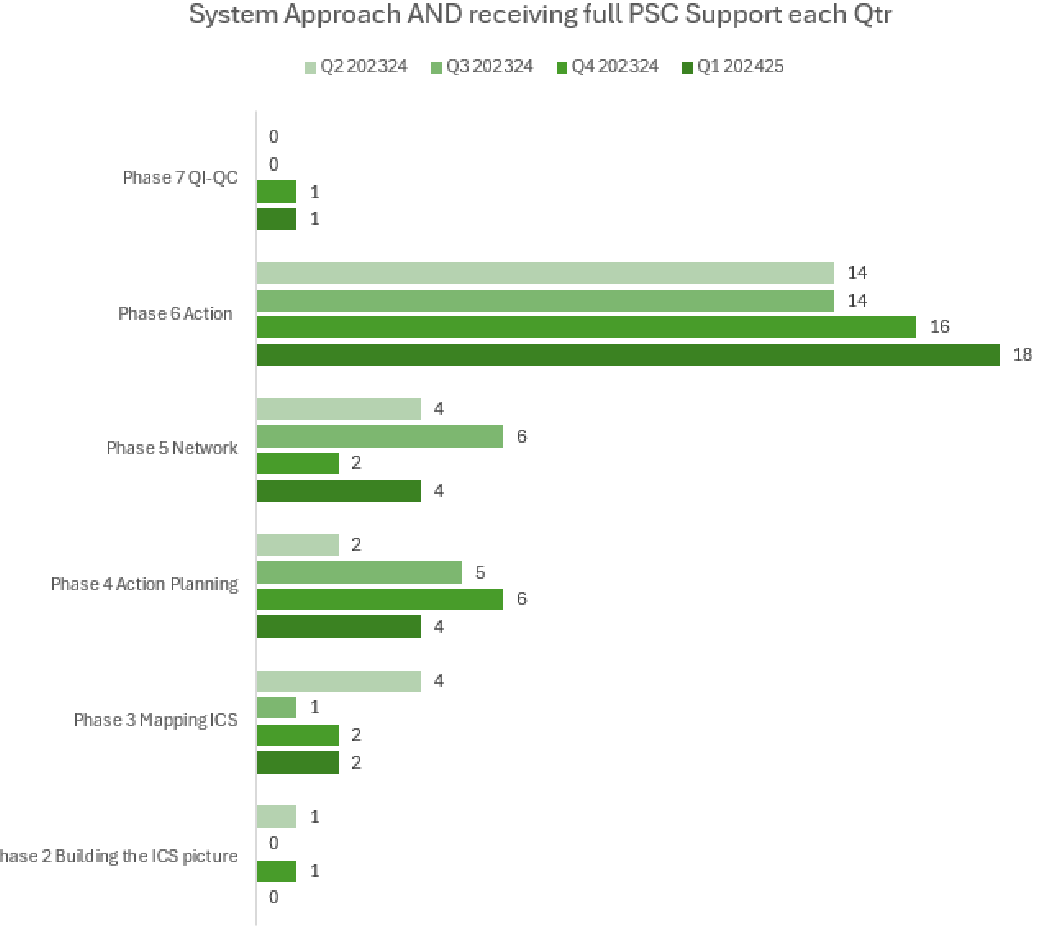
Figure 12



In Q1 there are 30 ICBs (71%) taking a Whole Systems Approach to Chronic Pain Management. 27 of those are fully supported by PSCs and further 3 are receiving a light touch support from PSCs.

An additional 7 ICBs are not implementing a Whole Systems Approach however they are receiving various levels of shared learning, data provision and other support from PSCs to address high risk opioid prescribing. This takes the total number of ICBs engaged in the programme across England to 37 (88%).

Figure 13



15 PSCs are working with 27 ICBs/ ICSs through Quality Improvement (Phases 4-6).

Of these 15 PSCs, 13 are supporting 18 ICBs/ICSs to implement the action plan (Phase 6 – Action).

In addition, 2 PSCs are working with 2 ICBs/ICSs through Quality Planning (Phases 2-3).

Learning

Understanding the national picture – chronic opioid use

The national metrics presented in this report represents data from all 42 ICBs in England. The MedSIP Opioids Dashboard is now live and has allowed further interrogation of the Chronic Opioid Use outcome metric by consideration of each of the 42 ICBs:

For all 42 ICBs there is an increase in the numbers of patients that begins in Q2 2023/24 and continues into Q4 2023/24, corresponding to the shift seen in the national chart. NHSBSA have interrogated the data and have not found any technical cause of this increase.

The extent of that increase is variable between the ICBs and is illustrated by 8 example charts below:

- In 12/42 ICBs the increase can be seen in the data however the numbers remain below the 2021 baseline and the ICB remains in special cause improvement. Of these 12/12 (100%) are working with PSCs through the Whole System Approach Framework.
- In 14/42 ICBs the increase takes them into special cause concern; where the numbers are now higher than the 2021 baseline. Of these 7/14 (50%) are working with PSCs through the Whole System Approach Framework.
- Of the remaining ICBs 11/16 (68.7%) are working with PSCs through the Whole System Approach Framework.

Figure 14

Sample ICBs in England with special cause improvement:

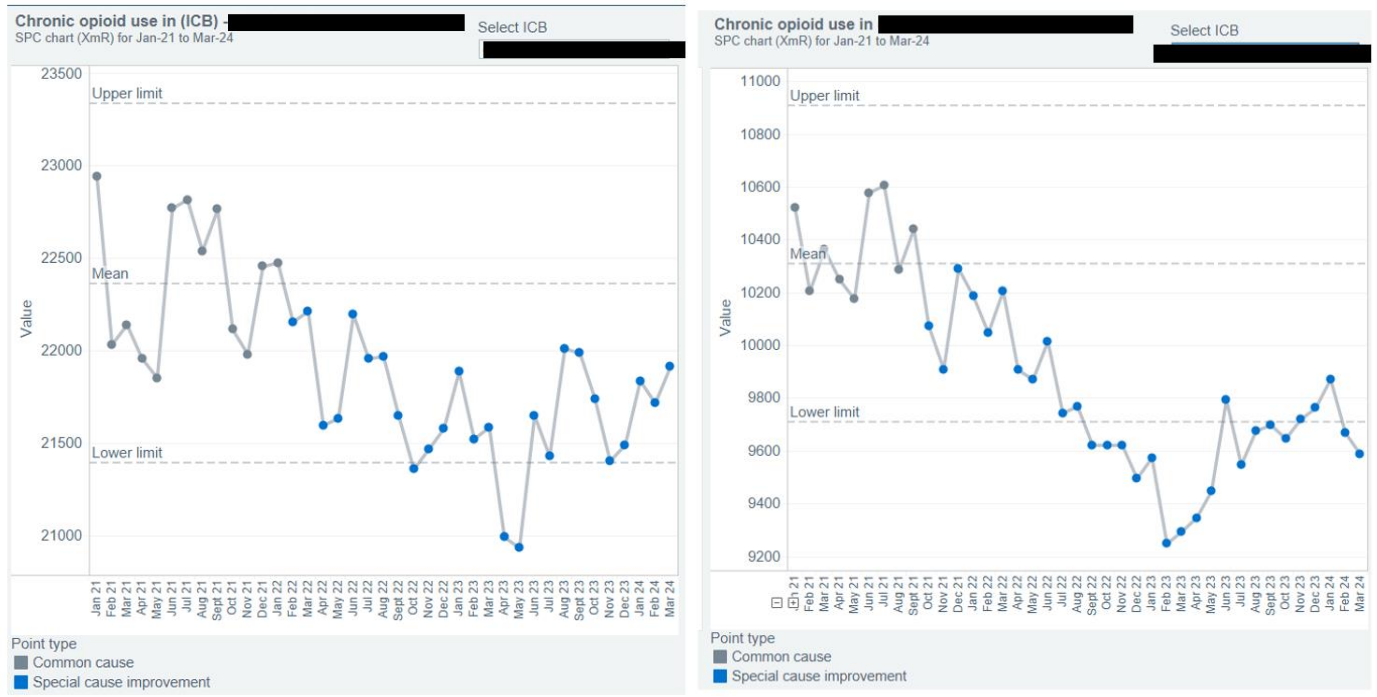


Figure 15

Sample ICBs in England with special cause concern:

Chronic opioid use in (ICB)
SPC chart (XmR) for Jan-21 to Mar-24
Select ICB
Upper limit
Mean
Lower limit
Value
Point type
Common cause
Special cause improvement
Special cause concern
Chronic opioid use in (
SPC chart (XmR) for Jan-21 to Mar-24
Select ICB
Upper limit
Mean
Lower limit
Value
Point type
Common cause
Special cause concern

System Safety

Summary of Q1 2024/25 progress

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 PSC 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.
- By Q1 PSCs to support the lead PSC to identify interested General practices / PCNs and GP Clinical leads in their area and recruit them on the test pilot by liaising with their ICS/PCN clinical directors/leads.
- PSCs 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 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 208/209 99.5% trusts (acute, ambulance, community and mental health) have transitioned to PSIRF.

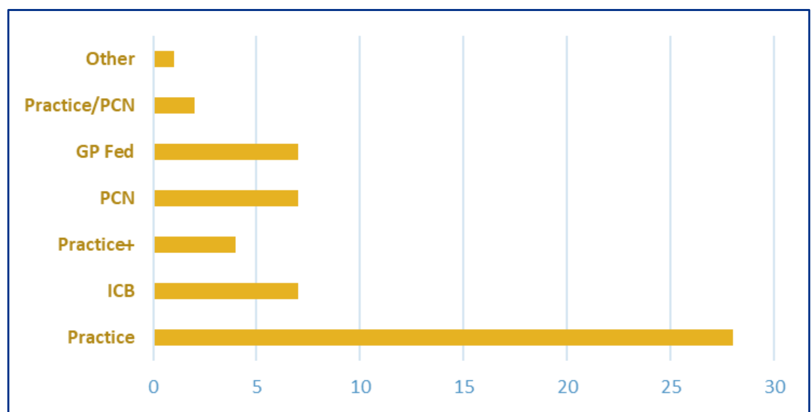
Key updates and achievements

- In Q1, all PSC leads continue engagement with their respective Integrated Care System (ICS) leads and providers in their area via ICB whole system workshops and face to face and virtual learning events including webinars, Ask-the-Expert sessions as well as bespoke 1:1 support.
- 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 in stipulated phases.
- All 15 PSCs are working in partnership with their local systems (ICS) leads, provider leads, Patient Safety Specialist networks and/or pan regional patient safety leadership forums where they exist (e.g. in London), via coaching / improvement academy (e.g. in Yorkshire & Humber and with North East and North Cumbria) as well as in Midlands and the West of England, South West and Wessex - to offer support for the PSIRF implementation and address the needs identified locally.
- This introduction of the Patient Safety Incident Response Framework (PSIRF) into General Practice is being led and coordinated by HIN South London on behalf of the 15 Patient Safety Collaboratives.
- Early Adopter organisations were sought from across England at a range or organisation levels. 56 organisations are actively contributing from across all 7 Regions and from 13 HIN geographies.

Figure 16

PSIRF early adopter organisations across England

Health Innovation Network	Practice	ICB	Practice+	PCN	GP Fed	Practice/PCN	Other	Total
East Midlands	3	1	2				1	7
East	2	2				1		5
South London	6			2				8
ICHP	1			1				2
Kent Surrey Sussex			1					1
North East and North Cumbria					1			1
North West Coast		1						1
UCL Partners	9				1			10
Wessex	1	1						2
West Midlands	2			1	2			5
West of England		2						2
Yorkshire and Humber	4		1	3	3	1		12
Total	28	7	4	7	7	2	1	56



PSCs are supporting the HIN South London 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.

Context, challenges and expectations

- The 15 PSC around England are commissioned to work with all the Integrated Care Systems over 2024-25 by offering support to the providers as they embed PSIRF - in line with the guidance published by NHS England - using quality improvement approaches.
- There are around 270+ NHS providers in England excluding independent providers who worked towards implementing the PSIRF with NHS Acute Trusts leading the way.
- The PSIRF documentation highlights responsibilities of providers, the ICSs and the Patient Safety Collaboratives. While the PSCs have a supportive role to support their local systems to implement PSIRF, NHS England has an assurance role regarding PSIRF implementation via the ICSs.
- While most ICSs are now fully functioning and delivering their statutory responsibilities, governance structures in some ICSs were still being developed with staff yet to be recruited in few ICSs, impacting on engagement. However, the engagement has extended to involve the key quality and safety leads (where appointed) at all ICSs in England to date.
- Reporting progress and governance of patient safety is in the early days, PSCs are working with providers and ICBs to develop this.
- Not all systems have developed a uniform understanding of PSIRF due to various reasons which impacts on fidelity to PSIRF principles.

Learnings

- PSIRF events and learning sessions across England continue, which aid the understanding of the networking landscape, and provides an understanding of how system are embedding PSIRF.
- Positive examples of implementation of PSIRF in maternity settings, mental health providers, ambulance trusts, care homes, community care as well as independent providers alongside the Acute Trusts within available capacity are being identified.
- Use of Quality Improvement tools along with talks on culture, psychological safety, impact of effective leadership, Action learning sessions, discussion on how we can use intelligence to support decision making as well as ask-the-expert sessions with early adopters, are proving useful to ICSs and providers as part of the transitioning from the SII (Serious Incident Investigation) framework to PSIRF.
- Patient safety Specialists alongside the Patient Safety Partners continue to be key allies in improving patient safety at a system level in line with the ambition stated in the National Patient Safety Strategy.
- PSC continue to develop and facilitate learning to support trusts to embed PSIRF, its principles, and the culture to support it.

Case studies

PSIRF case study: Middlewood Partnership and PCN

What changes have you introduced?

1. Looked at technical aspects of reporting patient safety incidents.
2. Governance culture – learning from incidents key input into safety and quality agenda.
3. Change in culture – encourage reporting in a no blame way.

> There has been inputs, but the outputs for the whole organisation are worth it

What challenges did you encounter?

1. Time: made recording easy, using IT sensibly.
2. Culture: turning a patient safety incident from a blame game to a learning opportunity.

Key ingredient:

Identify champions who are willing to challenge the status quo.

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.