Patient Safety Collaborative (PSC)

What we do

Wessex PSC is one of 15 regional collaboratives across England, aiming to reduce avoidable patient harm within specified national programmes. We work with staff and patients across health and social care pathways in Wessex using Quality Improvement (QI), networking and scale up methods.

Why are we doing it?

Patient Safety Collaboratives were borne out of Professor Don Berwick's 2014 report, A Promise to Learn: A Commitment to Act. This report called for the NHS "to become, more than ever before, a system devoted to continual learning and improvement of patient care, top to bottom and end to end."

Each PSC is funded and nationally co-ordinated by NHS England and NHS Improvement, and hosted locally by the Academic Health Science Networks (AHSNs).

Wessex PSC comprises all the NHS providers and commissioners across the region, including hospitals, mental health and community organisations, the ambulance service, primary care, and Integrated Care Systems.

It brings together local patients and healthcare staff, all driven by a shared vision to bring about system-wide improvements to ensure the safety and wellbeing of people in the care of our health services.

We support this work with three objectives: to develop QI capability, to encourage patient, family, and carer involvement in improvement and to facilitate the development of a positive safety culture.

Our patient safety work programme is informed by the NHS Patient Safety Strategy and the National Patient Safety Improvement Programmes (known as NatPatSIP), which are led by NHS England and NHS Improvement.

Wessex Academic Health Science Network

Wessex Patient Safety Collaborative

Part of The AHSN Network

NHS

Patient Safety Collaborative (PSC)

Achieved over 1 million views of the suite of videos to support RESTORE2 and pulse oximetry

Developed national NHS BSA prescribing comparators dashboard to support non-cancer opioid reduction

Supported four sites to test the national Paediatric Early Warning Score (PEWS)

PSCs (with national partners) won the HSJ Award for Patient Safety in November 2021 for the support given to implement Covid Oximetry @ home and virtual wards

Trained 167 super trainers in RESTORE2mini Learning Disabilities, who in turn have trained over 7000 families and carers of people with a learning disability

Shortlisted in 2 categories for the 2021 HSJ Patient Safety Awards with RESTORE2mini Learning Disability project

Held 18 virtual events across the southern England region and Wessex network, with a total of over 1000 attendees

19
in-patient wards from five mental health providers engaged in Reducing Restrictive Practice

Facilitated a South West rapid insights and learning event for 61 attendees on the implementation and expansion of Covid Oximetry @home and Covid Virtual Wards

Exceeded the national average in all elements with five trusts achieving at least 90% in 2 or more elements of the asthma discharge care bundle

What we delivered in 2021-22:

- Worked with system partners to achieve the objectives and deliverables of our commission for the five priority Safety Improvement Programmes (SIPs) set out in the NHS Patient Safety Strategy. Key enablers included addressing inequalities, patient and carer co-design, safety culture, improvement leadership, building capacity and capability, and measurement for improvement
- Developed and matured Patient Safety Networks as the main route for delivering on these SIPs.

Deterioration

- Won HSJ Award (as part of national network) for supporting the implementation of Covid Oximetry @home
- RESTORE2mini versions adapted through co-production for learning disability, domiciliary and prison healthcare settings
- RESTORE2mini Learning Disability project shortlisted twice for the 2021 HSJ Patient Safety Awards
- RESTORE2 and pulse oximetry videos viewed over 1 million times
- Collaborated with PSCs and Operational Delivery Networks across the South East, supporting four trusts to test the national Paediatric Early Warning Scores (PEWS)
- Produced a suite of case studies to demonstrate our work.

Maternity and neonatal

- Facilitated regional and local network events and sessions to support teams working on smoke-free pregnancy and optimisation of the pre-term infant, and to prepare for the national maternity and newborn early warning scores
- Maternity and neonatal units sustained an 84% rate of administration of magnesium sulphate to clinically eligible women in pre-term labour, to reduce the incidence of cerebral palsy in newborns.

Medicines safety

- Developed NHS Business Services Authority prescribing comparators/ dashboard to support opioid reduction programme.

Adoption and spread

- Supported organisations to deliver COPD and asthma discharge bundles, with Wessex achieving above the national average in all elements
- Five trusts achieving at least 90% in two or more elements of the asthma discharge care bundle.

Mental health

- Engaged 19 wards to test change ideas to reduce the incidence of restrictive practice in inpatient mental health and learning disability acute settings.

Patient Safety Collaborative (PSC)

"All care home staff should be trained in how to identify and respond to residents who deteriorate medically. The RESTORE-2 tool has been used successfully by many care home staff during the pandemic and is useful even when staff are not trained to measure or record vital signs."

COVID-19: Managing the COVID-19 pandemic in care homes, British Geriatrics Society (bgs.org.uk)

Plans for 2019-20:

The Patient Safety Collaboratives will continue to support the provision of the national patient safety improvement programmes, described in the NHS Patient Safety Strategy. There is an ongoing commissioning focus on the impact on patient outcomes. Oversight of the work of the Patient Safety Collaborative will continue to be provided by the Wessex Patient Safety Partnership Board (PSPB).

Commissioned priority areas for 2022/23 (licence continues until March 2025):

Aim

To test and spread effective safety interventions and strategies, learn from excellence and support systems to continuously improve

Primary areas

- Care Homes
- Mental Health, Learning Disability and Autism
- Medicines Safety
- System Safety
- Maternity and Neonatal

PSC Workstreams 22/23

- Managing adult deterioration in care homes
- Managing paediatric deterioration in acute settings – to end Q2
- Reduce restrictive practice
- Improve chronic non-cancer pain management by reducing high-risk opioid prescribing
- PSIRF and Safety Networks
- Improve the optimisation and stabilisation of the preterm infanct
- Improve the early recognition and management of deterioration in women and babies

Additional work during 22/23
(subject to funding)

- Safety culture programme
- Fetal monitoring

Care homes

Reduce deterioration-associated harm by improving the prevention, identification, escalation and response to physical deterioration, through system co-ordination and safe and reliable pathways of care by March 2024

- **Managing deterioration in care homes, continuing the spread of deterioration tools and personalised care support planning**
- **Managing paediatric deterioration in acute settings, completing support in year to acute and emergency care settings for roll out of Paediatric Early Warning Score (PEWS).**

Mental Health, Learning Disability and Autism

Improve safety and outcomes of mental health care by reducing unwarranted variation and providing a high-quality healthcare experience for all people across the system by March 2024

- **Support the reduction of restrictive practice in mental health inpatient settings.**

Medicines Safety

Reduce medication-related harm in health and social care, focusing on high-risk drugs, situations, and vulnerable patients. Contribute to the WHO Challenge (2017) to reduce severe avoidable medication-related harm by 50% over five years

- **Reduce inappropriate high dose opiate prescriptions for non-cancer pain.**

System Safety

A new programme delivered by Patient Safety Networks

- **Patient Safety Incident Reporting Framework – support systems as part of a wider national programme.**

Maternity and Neonatal

Contribute to the national ambition to reduce the rates of maternal and neonatal deaths, stillbirths and brain injuries that occur during or soon after birth by 50% by 2025; contribute to the national ambition to reduce the national rate of preterm births from 8% to 6%; improve the safety and outcomes of maternal and neonatal care by reducing unwarranted variation and provide a high-quality healthcare experience

- **Improve the optimisation and stabilisation of the preterm infant**
- **Improve the early recognition and management of deterioration in women and babies**
- **Focus on safety culture as part of a wider national programme**
- **Fetal monitoring (currently being codesigned with the relevant royal colleges).**

About the Academic Health Science Network

Wessex Academic Health Science Network (AHSN) is one of 15 AHSNs across England, established by NHS England in 2013 to spread innovation at pace and scale - improving health and generating economic growth.

The region's life sciences industry employs 9,000 and has a turnover of **£2.5 billion**

10% of the workforce in Wessex is employed in the health economy

We've supported over 250 innovations in 2021-22, including clinicians, academics and commercial innovators

The region's population of 3 million is served by

2* Integrated Care Systems

*Plus Salisbury and South Wilts

8 local authorities

11 NHS service providers and

7 higher education institutions

Our input has been attributed to the creation or safeguarding of 180.5 jobs in the last two years

We've directly supported Wessex innovators to achieve over £56 million in sales, grants and investment in the last two years

Working with Wessex CRN we have brought together 4 academic/ commercial bid teams for clinical research

Want to find out more?

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NHS