

*The***AHSN***Network*

Patient safety in partnership

**Our plan for a safer future 2019-2025:
Progress report – one year on**

December 2020



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The Academic Health Science Network's (AHSN Network) plan for patient safety was published in September 2019 in response to the *NHS Patient Safety Strategy: Safer culture, safer systems, safer patients*, 2019 (improvement.nhs.uk/resources/patient-safety-strategy).

The strategy acknowledges the work of Patient Safety Collaboratives (PSCs) – commissioned through and hosted by England's 15 Academic Health Science Networks (AHSNs) – as a key improvement and delivery arm for the National Patient Safety Improvement Programmes (NatPatSIP).

Introduction

One year on...

In response to the NHS Patient Safety Strategy, the Academic Health Science (AHSN) Network developed a plan for patient safety: *Patient safety in Partnership* 2019-2025 outlining our ambition and commitment to working in partnership to support the delivery of this important strategy. One year on we outline our progress against our objectives, highlighting successes and outlining new programmes of work. We briefly cover our response to the COVID-19 global pandemic.

We have reached 98.7% adoption of NEWS2 in acute hospitals and ambulance services. In addition we have tested and supported the adoption of NEWS2 or Soft Signs tools in non-acute sectors. We are pleased to see RESTORE2/RESTORE2mini adopted in 13 out of 15 AHSN regions in our care home sectors. This has been supported by training through e-learning materials and live webinars.

Our spread work has resulted in a number of impacts such as an increase from five maternity and neonatal units to 156 units adopting the PReCePT programme, increasing the number of mothers receiving magnesium

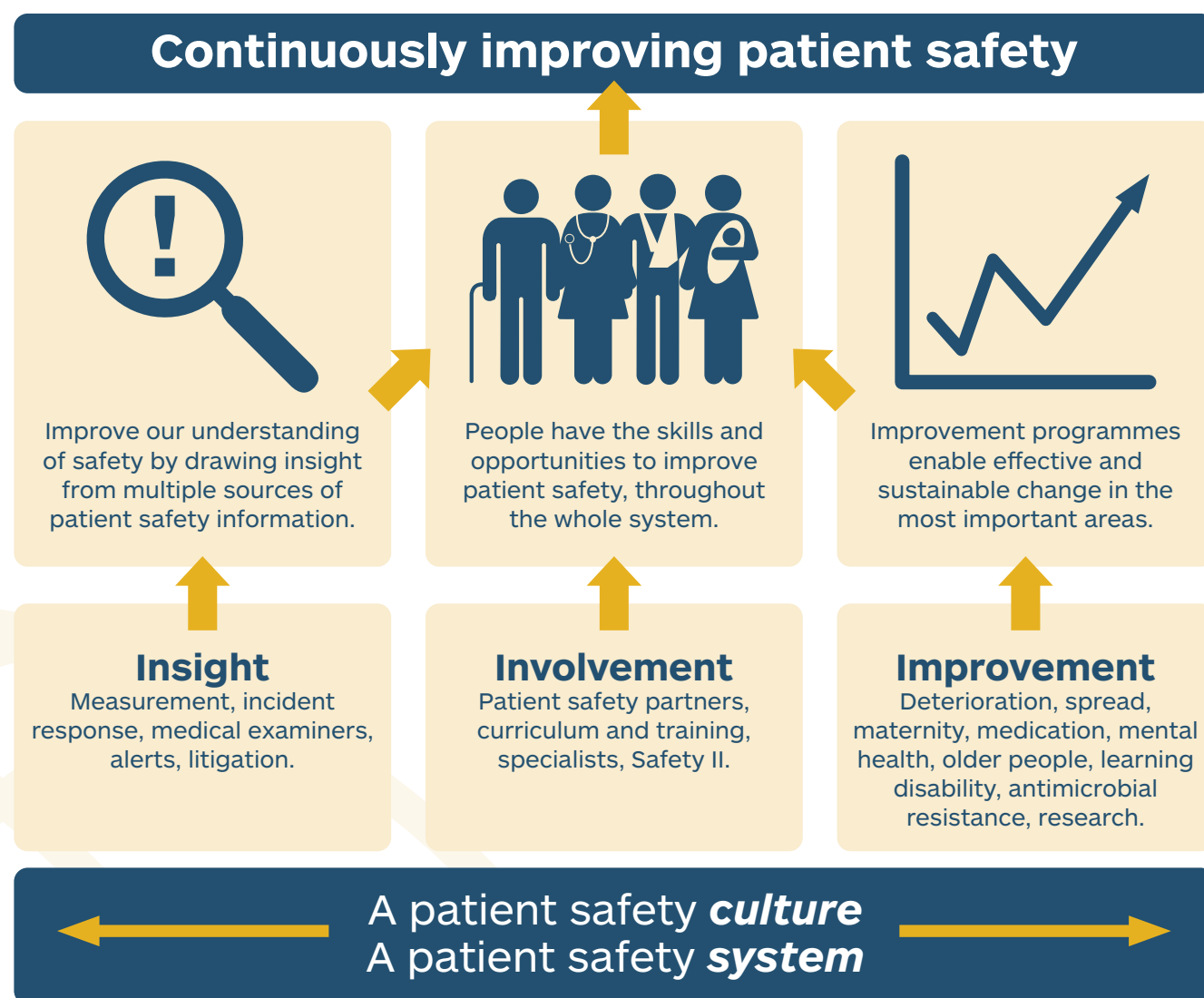
sulphate. Care bundles for COPD discharge are being implemented across the country, with 92% of trusts adopting one or more elements so far. Whilst there is more work to do this is an important area which will result in more people being managed effectively out of hospital and reduced admissions.

We have been commissioned to deliver new safety improvement programmes including mental health. Our medicines work is being expanded, delivering on the NHS Medicines Strategy which will contribute to the World Health Organisation Challenge target (2017) to reduce severe avoidable medication-related harm globally by 50% over five years.

Our response to the COVID-19 pandemic has been swift, agile and effective. We have re-prioritised programmes of work to align with regional and national priorities, for example the rapid implementation of the three safety interventions of the Safer Tracheostomy Care Programme. We achieved an uptake of 87%. We are also supporting the roll-out of pulse oximeters in local health and care systems, as part of the national COVID Oximetry @home model.

“Our response to the COVID-19 pandemic has been swift, agile and effective. We have reprioritised programmes of work to align with regional and national priorities.”





A summary of the *NHS patient safety strategy* (page 18)

Patient safety remains a central priority and guiding principle for all AHSNs. It is the lens through which we look and is embedded in all we do across an inter-connected landscape that aims to improve the safety of services for all users of the health and care system. To do this successfully we must actively involve patients, carers and the public in all aspects of patient safety work. As a result, we are developing a Patient and Public Involvement strategy.

Our future work builds on the programmes to date, re-prioritised to support the global pandemic, and takes into account the learning from COVID-19.

N Swinscoe

Natasha Swinscoe
Chief Officer Lead Patient Safety

Piers Ricketts

Piers Ricketts
Chair of The AHSN Network

“ Patient safety remains a central priority and guiding principle for all AHSNs. ”

Responding to COVID-19

Patient Safety Collaboratives, and the Academic Health Science Networks which host them, are supporting their local health and care systems during the response to the COVID-19 outbreak in hospitals, care homes and the community.

Once the outbreak began, Patient Safety Collaboratives' work was rapidly redirected to focus on the following priorities:

- Identifying and managing people at risk of deterioration;
- Implementing the Safer Tracheostomy Care programme to help support hospital staff to care for patients with a tracheostomy;
- Support for maternity and neonatal units to safeguard mothers and their new born infants.

PSCs are now returning to existing or new programmes of work and will continue to support the response to COVID-19, including implementing COVID virtual wards and the use of pulse oximetry and remote monitoring.

Read more in our companion report, *Safer care during COVID-19*: www.ahsnnetwork.com/patient-safety-covid19-report

There is much more information and further resources on the AHSN Network website: www.ahsnnetwork.com/patient-safety-during-covid-19

Our vision

Our ambition remains to support the delivery of the NHS Patient Safety Strategy and therefore our vision is aligned to the national strategy: **‘for the NHS to continuously improve patient safety.’**

The national strategy does not set a target, but looks for opportunities to be safer. It estimates that there is potential for a minimum of 928 extra lives saved and £98.5 million in treatment costs saved.

The NHS Patient Safety Strategy aims to save

1,000 extra lives and £100 million

every year from 2023/24
excluding litigation costs

The AHSN Network is already
making a significant contribution.

What we are doing

1

We will support the foundations of the national strategy: a patient safety culture and a patient safety system, across all settings of care.

- Employing quality improvement methods we have implemented tools to identify and respond to deterioration across systems and supported pathways of care. Our work on RESTORE2, a tool for detecting and responding to deterioration in non-acute settings (page 27) demonstrates the progress we have made and the impact this has had on the lives and experience of residents in care homes. Through all our programmes we attend to building QI capability and supporting cultural change to ensure change is effective and embedded.

2

The PSCs will deliver the patient safety strategy improvements and seek the next tranche of national programmes for national adoption and spread.

- We have met the targets of our commission and in some cases exceeded these and co-produced new safety improvement programmes in mental health and medicines safety. We have a rigorous pipeline process in development in order to identify innovative programmes of work for spread.

3

We will work with our members, STPs and ICSs to roll out and embed these national initiatives in the local areas, ensuring ownership and sustainability.

- The COVID-19 pandemic has accelerated change and opportunities to work across systems of care, as we describe in detail in our *Safer care during COVID-19* report. PReCePT, a programme for prevention of cerebral palsy, has been successfully embedded in all maternity and neonatal units across England with an increase from 5 to 156 maternity units adopting it. This programme of work is now part of the national maternity and neonatal safety improvement programme (page 11). TCAM and PINCER are two medicines safety programmes which we have also successfully spread (page 32).

4

We will work alongside the Regional Patient Safety Teams focusing on their system-wide objectives to support STPs and ICSs to identify and implement transformational change.

- We have been working closely with our regional teams to support them during the pandemic with increased IT solutions and digital applications for deterioration tools (page 26). We continue to work in partnership with our regional teams to identify local programmes of work.

5

We will support the capacity and capability and leadership development programmes helping our local system leaders and partners to build knowledge and understanding of the innovation landscape and the opportunities for their own organisation's and wider system's safety agendas.

- Our local care homes and ageing well programmes have supported leaders to respond to changing priorities and support the care of the most vulnerable in society (page 39). We recently launched a series of training films for care homes staff in partnership with Health Education England (page 38).

6

We will build on the operational and strategic relationships we have with other national bodies including continued partnership working with Health Education England, the Health Foundation and NICE.

- We have trained staff in the HEE Star programme to support workforce transformation and are working in partnership with NICE. The Health Foundation supported the early development of a number of projects that have developed into national patient safety initiatives.

Our impact

Academic Health Science Networks and Patient Safety Collaboratives are important delivery agents for the NHS Patient Safety Strategy, linking front-line staff, system leaders, commissioners, researchers and innovators. Here are some of our headline achievements over the last year.



Managing deterioration

98.7% of all acute and ambulance trusts use NEWS2

The soft signs tools RESTORE2 and RESTORE2mini are being used in **13 out of the 15** PSC areas



Adoption and spread

92% of acute trusts are using one or more elements of the COPD care bundle

The number of sites using the ED Checklist has increased by **50%** in 2019/20



Maternity and neonatal

Through PReCePT, **850** additional mothers in preterm labour have received magnesium sulphate in 2019/20

An estimated **30** cases of cerebral palsy have been avoided as a result of the PReCePT programme



Medicines safety

42% of acute trusts have implemented Transfer of Care Around Medicines pathways

13,387 fewer patients now at risk from clinically significant medication errors as a result of the PINCER intervention (pharmacist-led information technology intervention for reducing clinically important errors)



Safety of older people

7% of England's care homes responded to our medicines safety survey

Over **30** AHSN projects featured in our care homes report and 17 NHS 'Ageing Well' projects are currently active



Training

Over **120,000** views of our training films for care home staff on YouTube

More than **15,000** views of our three joint webinars with the Royal College of General Practitioners



Research and innovation

479,000+ patients benefitting from AHSNs' two-year national spread and adoption programmes

553,290 Innovation and Technology Payment units/scans supplied for patients in the last three years



Data and insight

The Suspicion of Sepsis (SOS) Insights Dashboard had a total of **8,676** views by **5,140** users across 161 trusts and 41 CCGs in 12 AHSNs, from September 2019 to September 2020

Insight

Improving the understanding of safety by drawing intelligence from multiple sources of patient safety information.

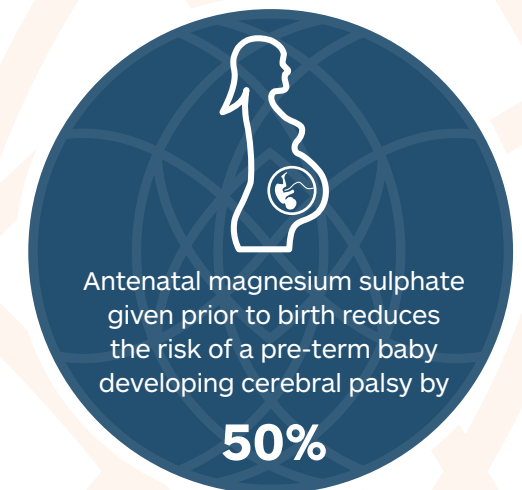
Our experience and ability to learn, share and spread has been demonstrated by a number of programmes developed through AHSNs and PSCs which have all been adopted as national programmes for roll-out across NHS sites in England.

PReCePT

The learning from the spread of PReCePT (prevention of cerebral palsy in preterm labour) to all maternity units in the West of England was adopted as national programme, to increase uptake across England.

The PReCePT programme is reducing the incidence of

cerebral palsy by offering magnesium sulphate to all eligible women in England during preterm labour. The PReCePT programme has successfully raised awareness of the importance of administering magnesium sulphate in pre-term labour.



PReCePT Midwife Champion Treena Wild decided to become a **midwife champion** for the PReCePT programme after attending a learning event with Health Innovation Manchester and hearing about the benefits of delivering the treatment to women in preterm labour.

She said: “Our neonatal unit cares for some of the most vulnerable and preterm babies in the North West. After hearing

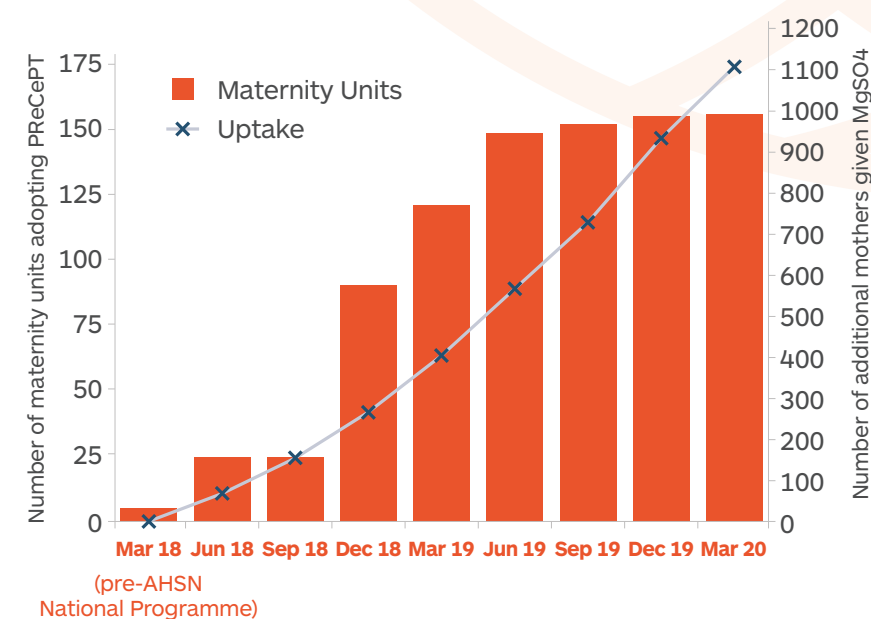
about the benefits, I wanted to take the lead in our hospital and lead in looking at ways to implement PReCePT on our unit and educate others.”

With the support of Health Innovation Manchester and the Patient Safety Collaborative, Treena and her colleagues began implementing PReCePT and introduced “grab bags” at the unit, with all the required equipment to



Treena Wild (right) with Melanie Wildman (left)

enable midwives to be able to deliver the magnesium sulphate promptly and without any delay.



- Additional **1,106** mothers received magnesium sulphate
- An estimated **30** cases of cerebral palsy avoided
- Increase from 5 maternity units adopting to **156**
- Estimated **£23.9 million** savings in lifetime health and social care costs

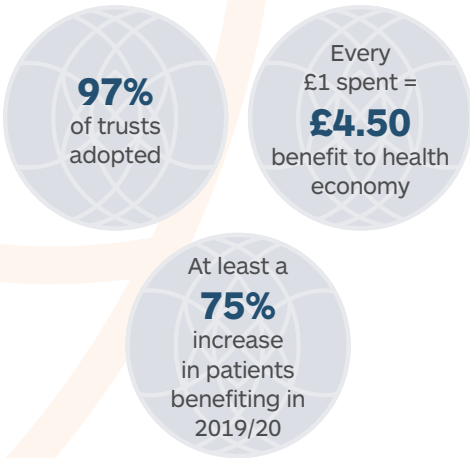
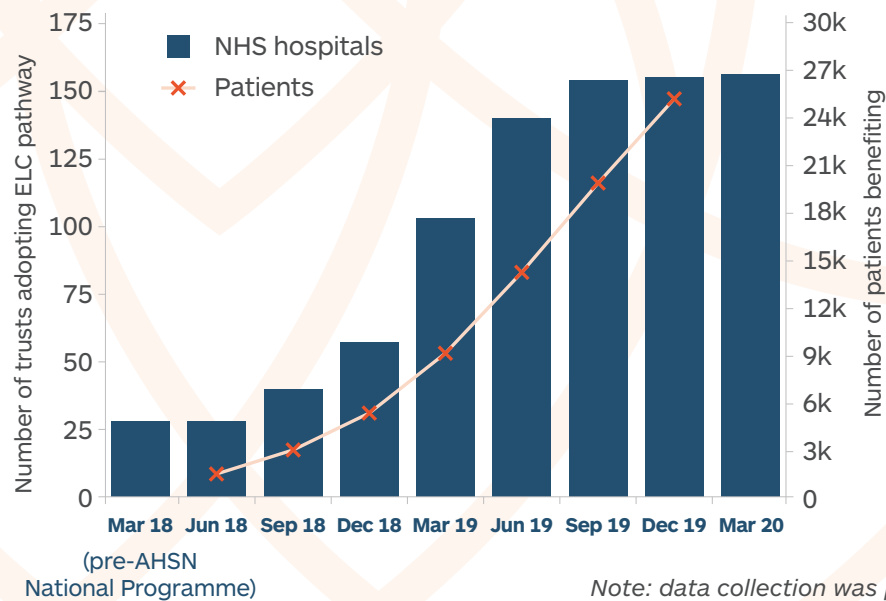


HSJ Patient Safety Award Winner 2020
Imperial College Health Partners

Emergency Laparotomy Collaborative (ELC)

Using a breakthrough series collaborative methodology the ELC care bundle (six elements) was rolled out across three AHSNs and demonstrated reduced mortality and lives saved.

The impact of the original work showed **a reduction in crude 30-day mortality from 9.8% to 8.2%** and a **length of stay reduction of 1.3 days, from 20.2 days to 18.9 days**.



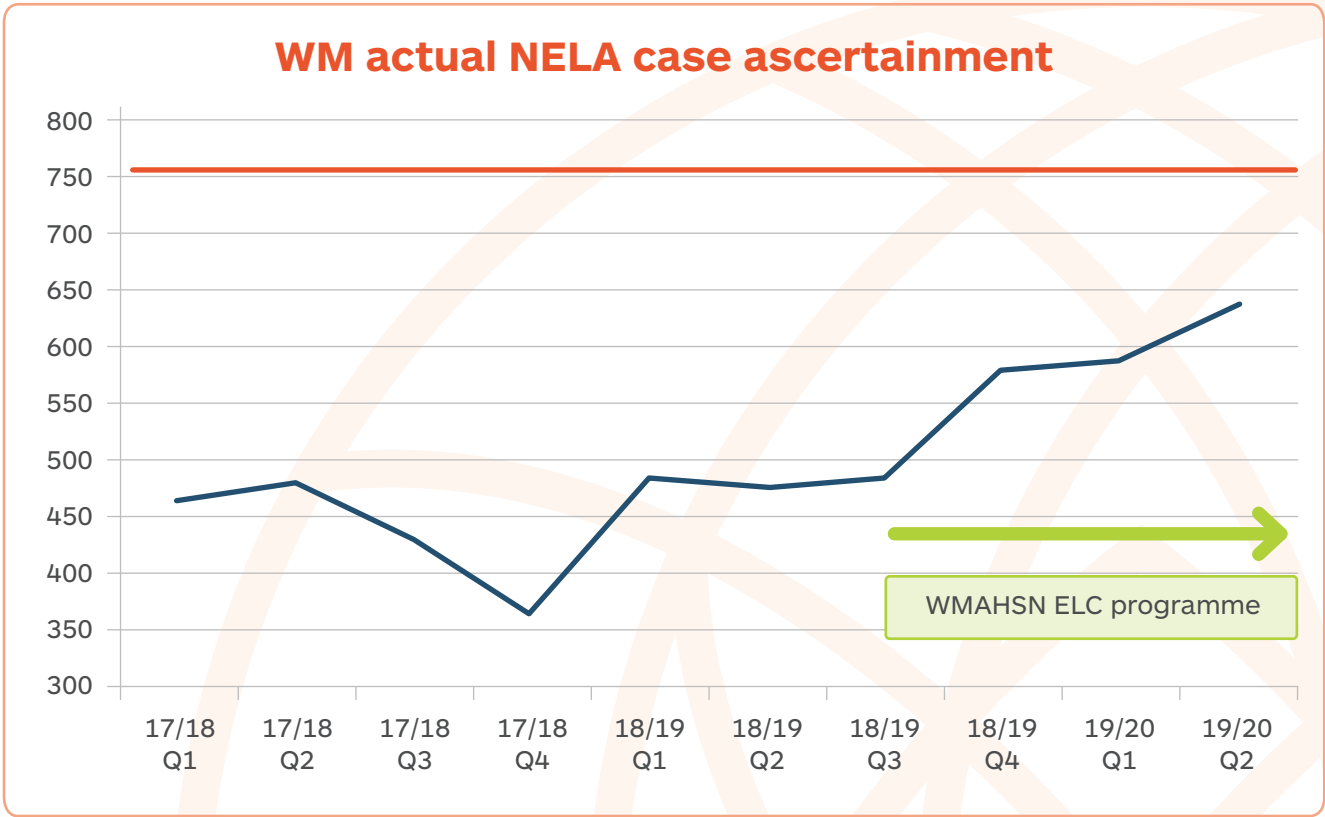
Note: data collection was paused in March 2020 due to COVID-19.

The WMAHSN Emergency Laparotomy Collaborative (ELC), has provided a vehicle for all hospitals in the region to engage in the further development and optimisation of their clinical and National Emergency Laparotomy Audit

(NELA) pathways. They have achieved this through delivering training, proactively managing data, and sharing progress.

The multidisciplinary engagement has been inspiring

and productive with hospital teams coming together to share excellence and challenge openly and constructively. Every team has taken change back to their hospital site and data shows an increasing numbers of patients benefiting.

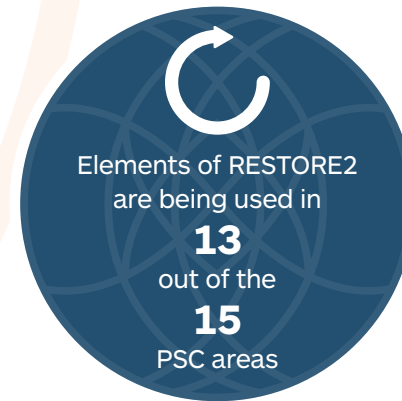
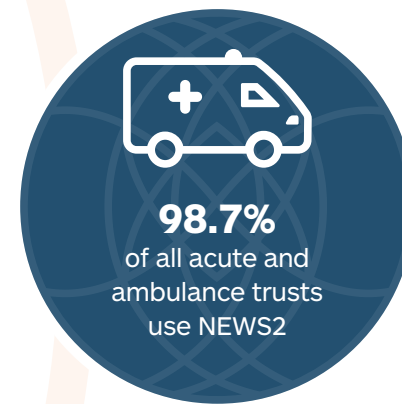


A graph showing case ascertainment / patients benefitting in the West Midlands.

National Early Warning Score (NEWS and NEWS2)

NEWS is an example of the many patient safety improvements supported by the 15 Patient Safety Collaboratives. NEWS is a well-established tool to assess risk of deterioration, making handovers quicker and more effective. It has

now been taken up by almost all acute hospital trusts and all ambulance service trusts in England, with work now focussing on using NEWS and 'soft sign' equivalents such as RESTORE2 which is designed for use in care homes.

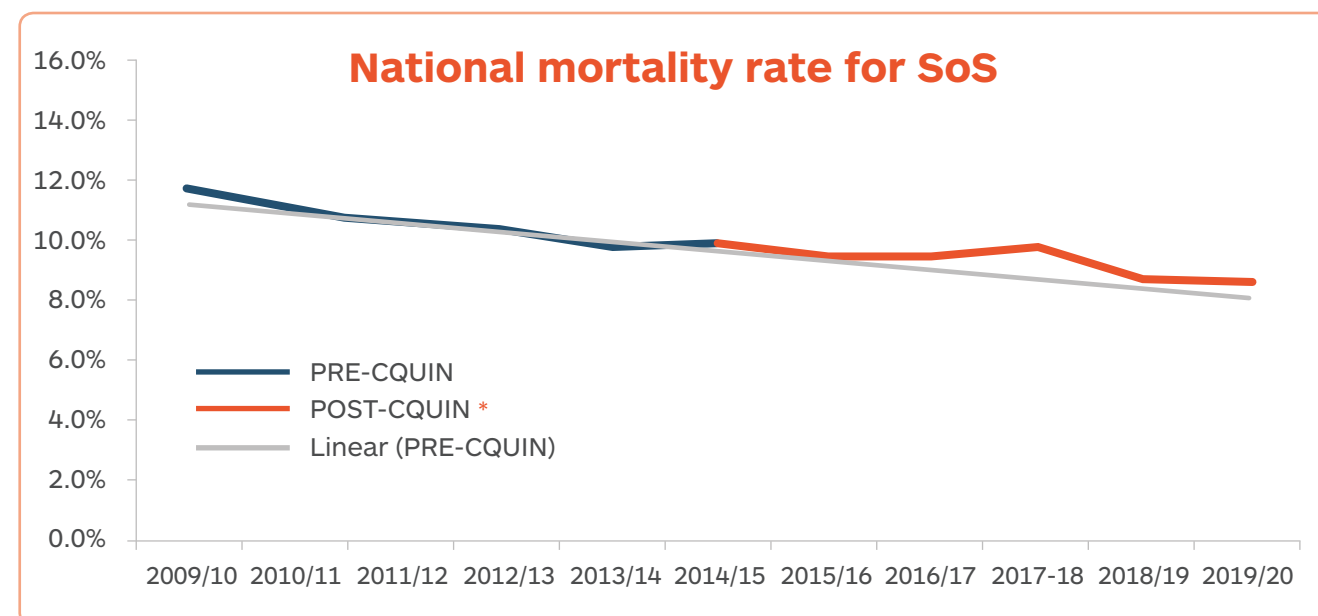


SOS insights dashboard

Developed by Imperial College Health Partners, the Suspicions of Sepsis Insights Dashboard enables NHS staff for the first time ever to use reliable data to monitor and assess the impact of interventions on deteriorating patients with a suspicion of sepsis. The dashboard is already starting to show the power and

importance of the use of data in the right context.

Sepsis is a serious complication of an infection. Although treatable, it kills 37,000 people a year in the UK. Patients who have a suspicion of sepsis (SoS) can be identified in routine administrative data.



* Commissioning for Quality and Innovation

Measurement

The AHSN Network will support the measurement and metrics development for the Patient Safety Collaborative commission. This will entail support in delivery of the quarterly metrics collection, analysis and measurement; support in measurement and insights to the programme workstreams; and support

in evidencing the impact and value of the PSC programme as a whole.

Working in collaboration with the NHS England and NHS Improvement commissioning team, the AHSN Network will contribute to the development of the overarching measurement strategy.

Learning from the Gosport Report

Following the Gosport Independent Panel Report (2018), Health Education England, working with the AHSN Network, commissioned a review of improvements related to supporting and preparing staff to work with patients and families at the time of death.

related to communication within staff groups.

Some staff felt able to have open, honest and compassionate conversations about what mattered to people at the end of their lives, while others reported feeling worried and fearful of adding to patient and family distress.

The Gosport Report highlighted a disregard for life, with lives being shortened, a failure to listen to families and patients, and a culture of defensiveness and reluctance to act.

Two Patient Safety Fellows were recruited to explore factors that enable good practice and continued learning at and around the time of death.

What we found was that there was real variance in the perceived levels of confidence and competence

It was also noted that conversations may be started by senior members of the team and needed to be expanded. Communication around the time of death should be seen as a team dialogue rather than a one-off event.

The full report will be published shortly. In response to COVID-19, we shared learning from the report on promoting staff wellbeing and examples of good practice (available at www.ahsnnetwork.com/patient-safety-during-covid-19).

“It was a real privilege to talk to clinical staff nationally to gain an understanding from them about learning from deaths and then share these insights with experts at a roundtable event (pre-lockdown) to agree recommendations. A great collaborative learning process.”

Heather Stacey,
Patient Safety Fellow

Atrial fibrillation

Atrial Fibrillation (AF) is the most common cause of an irregular heart rhythm and the cause of 20% of strokes. Despite the serious impact, many people are unaware they have the condition and Public Health England estimates that 300,000 people in England have undiagnosed AF.

It occurs more often in people aged over 65 or with other long-term conditions, and it increases a person's risk of stroke fivefold. Some people do not experience symptoms, which increases the likelihood of their AF remaining undiagnosed

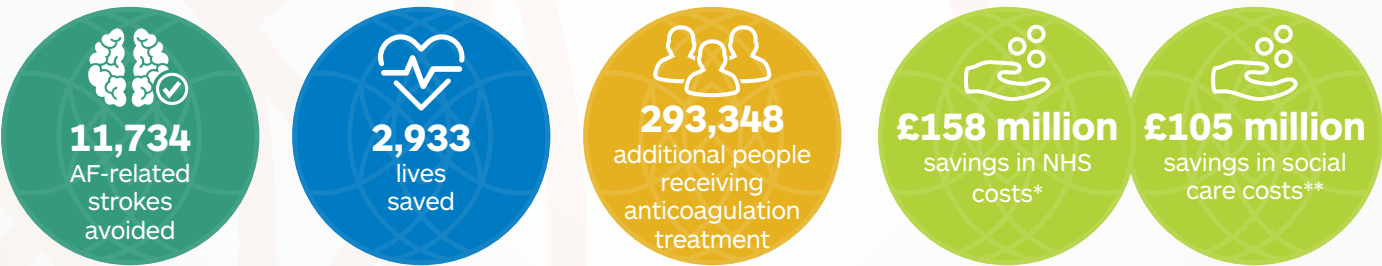
and places them at greatest risk of a stroke.

Since 2017, the AHSN Network has been driving the spread and adoption of AF best practice across the country to improve care and outcomes for patients.

Atrial Fibrillation Programme The AHSN Network 2015/16 - 2019/20

DETECT: To improve diagnosis of those at high risk of AF-related stroke

PROTECT: To improve management through anticoagulation treatment



* Based on average £13,452 cost to the NHS in the first year following a stroke.
** Based on average £8,977 social care costs in the first year following a stroke.

Involvement

Equipping patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system.

As an AHSN Network we have engaged, collaborated with, supported and developed local systems. Here, we describe our achievements and our ability to work across boundaries and with partners in the system.

Health Education England

The AHSN Network is a key member of **Health Education England's (HEE) Patient Safety Syllabus Advisory Board**. The Network have undertaken a mapping exercise to support HEE to understand the current level of training matched to the key domains of the syllabus. We are working closely with HEE to support them to deliver the syllabus through a series of workshops designed to identify collaborative areas of working.

The AHSN Network also supports HEE's Technology Enhanced Learning (TEL) programme. The TEL collaboration includes the newly launched Learning Hub, which is a national platform that enables

the sharing of learning resources between health and social care professionals, and encourages the development of subject based communities.

The collaboration is exploring the mutual benefits of using the platform as a medium for further promoting the work of the AHSN Network whilst simultaneously developing the capability of the platform.

Other aspects of our partnership work focus on simulation, immersive technologies, virtual reality, augmented reality and their application to learning in health and social care.

Human factors

In partnership with Health Education England (HEE) we have raised awareness of the importance of **human factors** in both understanding how harm occurs, but also how harm can be prevented when attention is focused on human factors.

During the first spike of COVID-19, the Chartered Institute of Ergonomics & Human Factors (CIEHF) has been working with the AHSN Network and others to provide rapid responses to key safety issues. The ventilator challenge was the first project with CIEHF members volunteering from many sectors, such as rail, oil and gas, and nuclear energy. They started with **medical device guidance** on user requirements and **usability testing** and then developed bedside action cards for the **care of ventilated patients**.

The CIEHF Healthcare Group (LANTERN) asked for tracheostomy guidance to be considered, with a view to improving the design of the user interface. This has led to the development of a **routine care guide**.

As we enter our first COVID-19 winter, taking a professional approach to patient safety should be one of the highest priorities in the NHS to send strong reassurance to patients, families, staff and the public of the continuing importance of this issue. LANTERN is currently developing a learning pathway in response to the national patient safety syllabus. This will provide an accredited, professional approach with targeted education and training for patient safety specialists, investigators (local and national) and other key personnel.

Patient safety syllabus

HEE and AHSNs completed a mapping exercise of existing patient safety education and training, which will support the ongoing development of a set of quality standards and accreditation framework for an NHS patient safety syllabus.

A **draft syllabus** was published in January 2020 for consultation. HEE will work to ensure the syllabus can be implemented across all healthcare sectors and all staff groups with an e-learning programme set to be available by April 2021.

Collaboration with NICE

NICE and the AHSN Network jointly hosted a virtual knowledge exchange workshop in July 2020. Over 100 people attended from NICE and all 15 AHSNs. The workshop identified a number of areas of mutual interest where there could be opportunities for collaboration, such as digital transformation and evaluation of innovations and technologies.

We are also looking for ways to work together on quality improvement, to ensure NICE quality standards and evidence are utilised in our National Patient Safety Improvement Programmes.

REACT TO



AHSNs have developed a number of resources and products which support **multi-disciplinary training (MDT)** such as **The REACT TO** series of training resources for care homes. These are available free of charge at www.reactto.co.uk.

2019 saw three new additions to the series, including React to Infection, React to Malnutrition and Dehydration and React to Dementia.

React to Dementia was entirely produced by a local care home in Nottingham with support from Dementia campaigner and speaker Ian Donaghy.

The creators of React to Falls have recently released an app-based version of the resource. [Read more here.](#)

The React To series has also been translated and used with international partners working on East Midlands AHSN's **LPZ care home project**.

Just culture and workforce

The AHSNs have appreciated the importance of supporting staff and the relationship between a just culture and workforce wellbeing and productivity. Every PSC has been working developing

tools and resources to support **cultural change** from diagnostic tools such as safety climate surveys, safety huddles, learning from excellence and the use of appreciative inquiry methods.

Impacts are seen through the way staff use these methods to improve care, for example in sepsis management, supporting staff following harm events, and reducing harm through safety huddles.

Safety culture toolkit

In partnership with NHS England and NHS Improvement, the AHSN Network is developing a safety culture toolkit. Culture can either be a barrier or an enabler to improving patient safety. Interventions that improve safety culture, such as around teamwork and communication, can change clinical outcomes for the better and reduce adverse events.

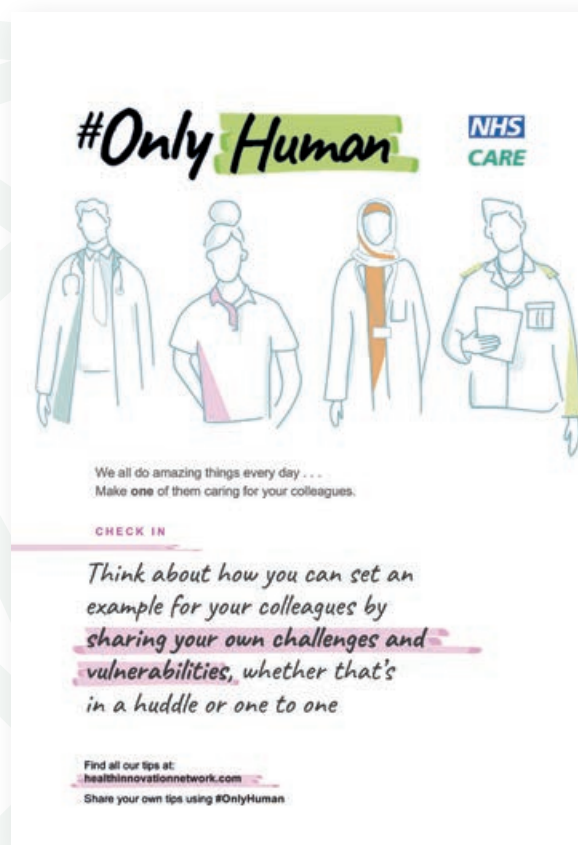
The toolkit is intended for leaders, teams and individuals wishing to better understand and improve their safety culture. It will provide ideas and resources, with practical tips and case studies to show how addressing culture can contribute to the delivery of safe, high-quality care. It will explore the following themes:

1. Leadership
2. Continuous learning and improvement
3. Teamwork and communication
4. Just culture and psychological safety
5. Promoting inclusive behaviours

Only Human campaign

The Patient Safety and Experience team at London's Health Innovation Network worked with behavioural insights specialists on a 'nudge' campaign to positively support front-line health and care staff to prioritise their physical health and emotional wellbeing needs – which have been likely to have been neglected due to the impact of COVID-19.

They have created a suite of materials including an [Only Human web page](#) and using the hashtag #OnlyHuman on [Twitter](#). The campaign takes a peer-to-peer approach since it was found staff can struggle to identify signs of stress in themselves and are better at spotting this in other colleagues.



Partnering with patients – an organisational perspective

Catherine Dale, Programme Director – Patient Safety and Experience at the Health Innovation Network, has been supporting the development of Patient Safety Partner roles in hospital trusts. They are an opportunity for patients and their carers to be active and high-profile partners in their own safety, as well as the safety of healthcare organisations. Catherine was invited to give a perspective on what these roles might mean to organisations as part of the forward to the consultation document.

My first job in the NHS was working with volunteers in a hospital in central London, as well as setting up a Patient Advice and Liaison Service, and I learnt that sometimes the people providing services do not always pay enough attention to the things that assure people that our services are safe. If someone gets the wrong information in a

letter about their appointment, if the doctor cannot access the information in their notes, if areas seem cluttered and chaotic – all these things put doubts in people's minds about whether or not they will be safely cared for when they are at their most vulnerable.

For the past 15 years I have worked on improvement projects and programmes to make health services even better and throughout this time the most powerful work has happened when staff have partnered with patients or members of the public. I worked alongside a cancer patient reference group, who supported the construction of the Cancer Centre at Guy's Hospital. The group, chaired by a patient leader, helped select the architects and contributed towards the design of the layout and services within the building.

Patients became an integral part of the team and ambassadors for



the Cancer Centre. This helped me realise the impact that partnering with patients could have in relation to patient safety.

As staff we can be apprehensive about working with patients. Sometimes this is because we believe that as healthcare professionals, we are responsible for all aspects of treatment and care. I know from experience that when we work in partnership with patients and actively engage with each other professionally and as fellow participants in the complex, challenging and rewarding work of making healthcare safer, everyone benefits.

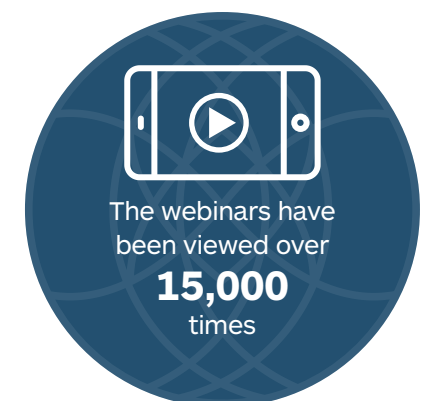
RCGP collaboration

As a result of the COVID-19 pandemic, we teamed up with the Royal College of General Practitioners (RCGP) to address the growing need for information in primary care to understand the latest evidence on the virus and its impact across the community.

The AHSN Network partnered the RCGP to deliver a webinar at the end of April on physiology and oximetry. It became the first of three in a series which has

also covered care homes, and – with the addition of the Royal College of Paediatrics and Child Health (RCPCH) – COVID-19 in children.

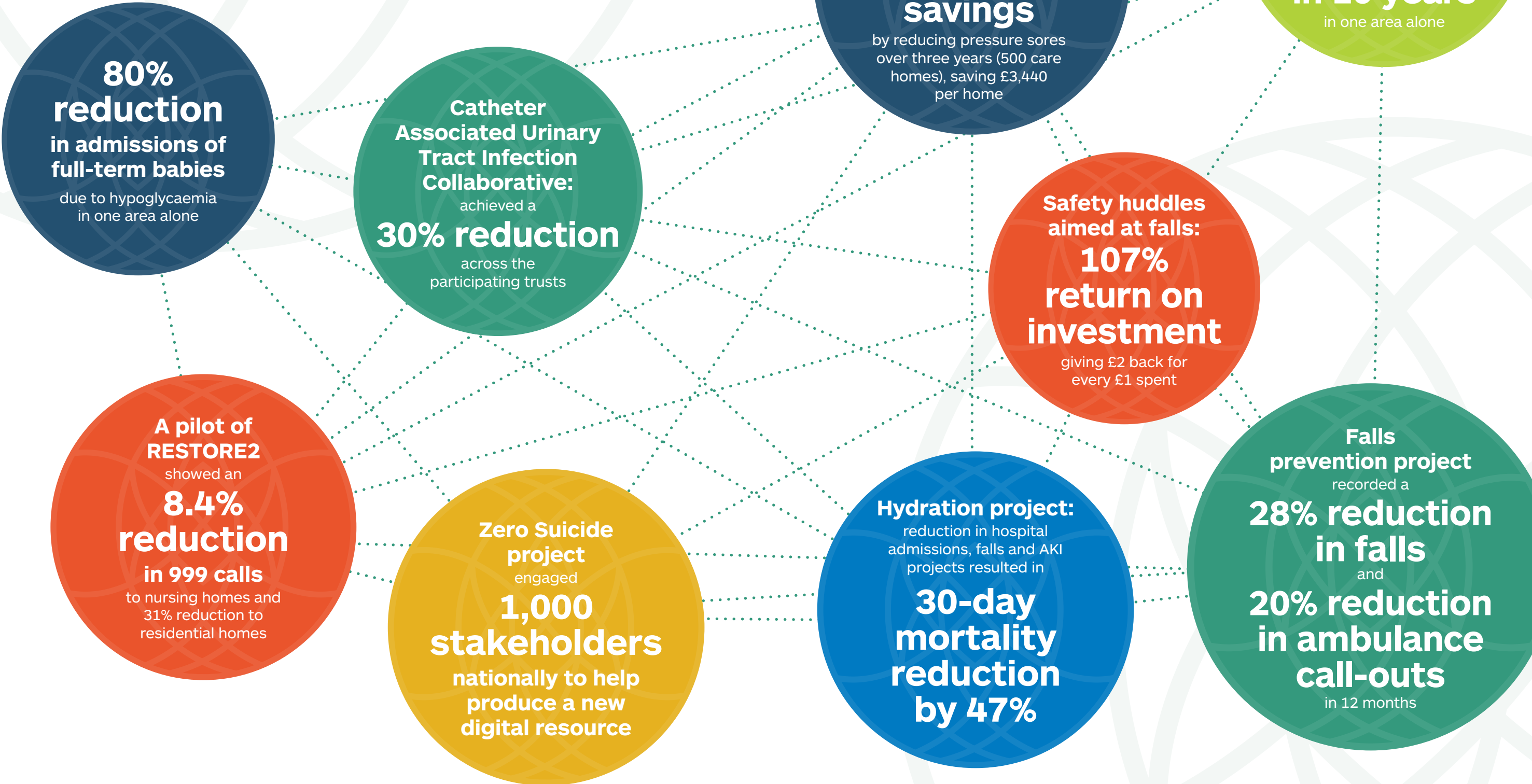
The webinars were aimed primarily at GPs but have also been useful for care home staff, nurses and returning workforce. Together, they have been viewed over 15,000 times. It's hoped we will continue to offer future webinars in partnership with Royal Colleges in future.



You can [watch the webinar](#) and find further resources for [primary care](#) here.

Examples of impact

Through many partnership projects around the country, we have tested new ideas and ways of working with potential to make a big impact on patient safety and reduced costs.



Improvement

Delivering a range of interventions to provide safer care for patients and people in the community.

In this section we set out our current work programmes and update on progress.

Working in partnership

It is clear the PSCs have collectively risen to the challenges set out in the Berwick Report. 'A promise to learn – a commitment to act' (Department for Health and Social Care, 2013, www.gov.uk/government/publications/berwick-review-into-patient-safety).

Through networks, use of evidence, sharing of best practice and most of all, by engaging and involving staff and patients, they have delivered service, quality and safety improvements, and avoidance of harm.

There is always room for improvement in learning organisations and the 'Patient Safety Collaboratives – a retrospective review' (NHS Improvement, 2018, improvement.nhs.uk/resources/patient-safety-strategy) and the 'Improving patient safety through collaboration' report by the Kings Fund (2019, www.kingsfund.org.uk/blog/2019/03/quality-improvement-patient-safety) suggested some ways to achieve this.

Our 'matrix' approach to patient safety, cutting across our two key themes of improvement and innovation and seeing all our work through the lens of safety, ensures we are able to make the connections between these different agendas.

The AHSN Network's approach to patient safety is that it should not be vested in the PSCs alone, but that it will be woven throughout our wider improvement and innovation agenda. Full integration with the AHSN Network programmes, supported by good quality improvement methodology, research and evaluation and an innovative and underpinning

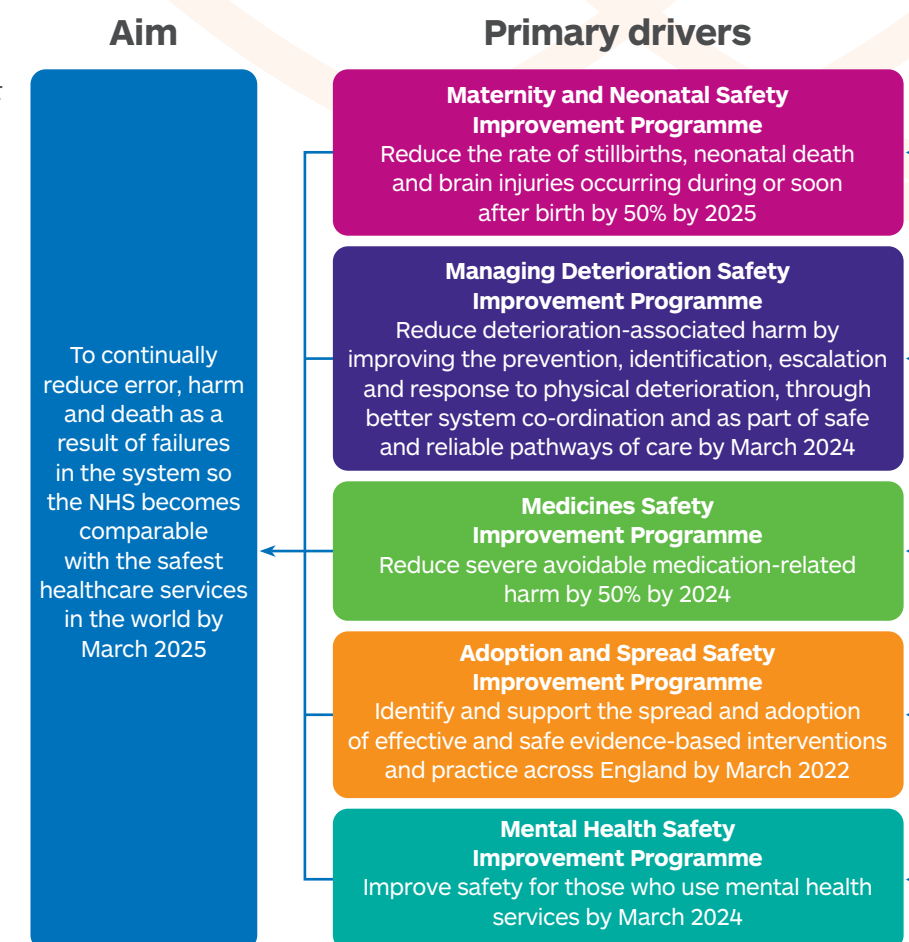
philosophy of experiment will succeed and be sustained when the conditions are right to receive them. These conditions are cultural readiness, effective leadership and quality improvement capability. The AHSN Network provides the wrap-around functions for all of these that in turn underpin the PSC and wider patient safety delivery.

We are also working to develop a **pipeline for the future**.

The aim is to identify the right opportunities for large-scale programme change that are well-evidenced and deliver improvement in patient outcomes alongside cost-effectiveness.

Emerging opportunities that show promise can also be selected for further evaluation in a real-world environment supported by AHSNs. This approach seeks to make an early assessment of barriers to rapid uptake and how these might be overcome, taking the learning from the adoption and spread programmes that AHSNs have delivered to date.

Under the recommissioned National Patient Safety Improvement Programmes, and with development of further national quality improvement work, **the AHSN Network can make a significant contribution to the NHS Patient Safety Strategy**.



The driver diagram for the National Patient Safety Improvement Programmes.

Managing deterioration

This national safety improvement programme contributes to the avoidance of harm or death caused by the failure to recognise or respond to physical deterioration in a patient's condition, wherever they are being cared for. We do this by promoting new system pathways that include the use of the National Early Warning Score (NEWS2).

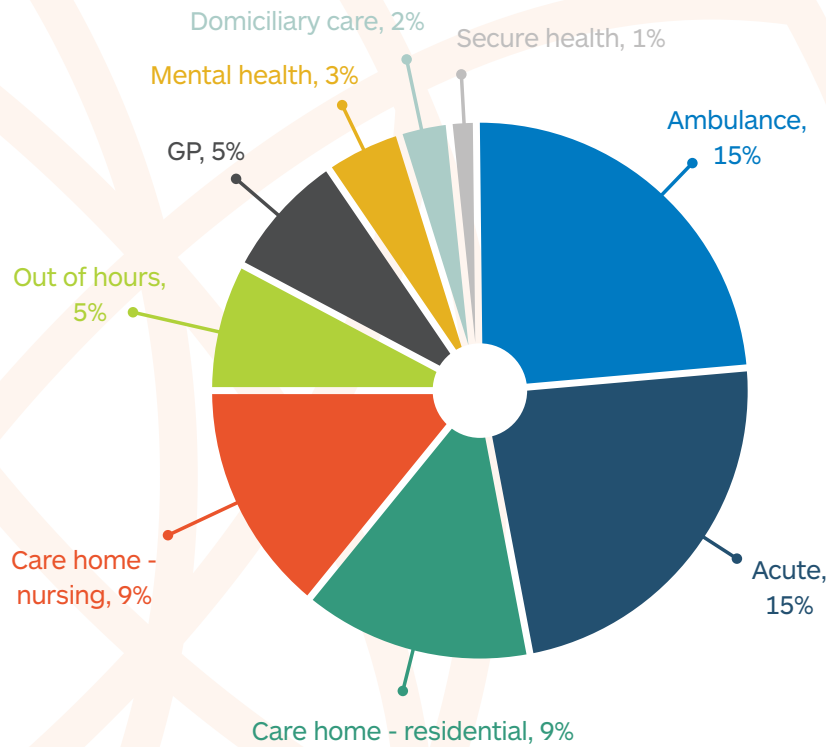
In community settings such as care homes, we promote equivalents that can spot the 'soft signs' of deterioration such as the RESTORE2 tool.

NEWS2 digital interoperability

AHSNs carried out a snapshot survey of digital tools currently used for managing and communicating NEWS2 scores. It drew on the knowledge and awareness of deterioration workstream leads at the time, to establish a baseline of existing and future digital solutions to support the recording/transfer of the NEWS2 score across different healthcare settings.

The findings will be used by AHSNs to explore how more digital solutions can be implemented, particularly in response to COVID-19.

Uptake of digital across healthcare settings



Managing deterioration in out-of-hospital settings

In 2019, UCLPartners began a programme to improve the ability of non-clinically trained staff to recognise, escalate and communicate the early signs of deterioration using two complementary innovations.

Working with four partner organisations, the project aimed to improve the experience and outcomes for people cared for in the community who were at risk or already experiencing physical deterioration, by testing and implementing two innovative approaches:

Significant 7+ – a paper-based guide to enable care workers to detect the early signs of deterioration. Use of the tool and training package has previously been associated with reduction in hospital admissions (of 30% in care homes),

RESTORE2

Spotting when a patient's condition is deteriorating is often managed in acute settings using the National Early Warning Score (NEWS2).

RESTORE2 (Recognise Early Soft signs, Take Observations, Respond, Escalate) was created by West Hampshire CCG and Wessex AHSN. Designed specifically for nursing and care homes, it combines recognising early soft signs with taking measurements for a NEWS2 score, and escalating concerns through a structured communications tool.

In situations where it is not considered appropriate to carry out the observations required to calculate a NEWS2 score, such as some residential care homes, other tools that focus on the 'soft signs' of deterioration can be more useful, such as RESTORE2mini.



UCLPartners Significant 7+ hydration training

reduction in episodes of pressure ulcers and falls, and an increase in the confidence of carers in their role.

The Whzan Blue Box – a monitoring kit and NEWS2 based digital tele-health solution. Whzan's use in care homes has previously shown a 49% reduction in hospital

RESTORE2 has been recommended for care and nursing homes by the British Geriatrics Society in their guidance: [COVID-19: Managing the COVID-19 pandemic in care homes](#).

National guidance from CQC, DHSC, NHSE & PHE (July 2020, www.gov.uk/government/publications/coronavirus-covid-19-admission-and-care-of-people-in-care-homes) includes reference to RESTORE2 as one of the tools available to support staff in recognising when a patient is unwell.

It's now being spread to care homes by most PSCs. A market specification is also being developed to digitalise RESTORE2 in order to accelerate the introduction of digital applications and tools for care homes.

The Whzan Blue Box has previously shown a **49% reduction** in bed-days

bed days, significant cost saving in A&E attendances and ambulance services, and increased staff engagement and satisfaction.

To date, 14 care homes are using the Whzan Blue Box, and the Significant 7+ facilitators have trained a further 150 carers across 22 care homes and domiciliary care providers. In response to COVID-19, the Whzan Blue Box is now being rolled out to 250 care homes across the Mid and South Essex STP area, and a new soft signs of deterioration tool, **Significant Care**, has been launched in partnership with North East London Foundation Trust and Care City.

A pilot from 2016-2019 showed an **8.4% reduction** in 999 calls to nursing homes and **31% reduction** to residential homes

Find out more about RESTORE2 here and download resources including a white paper from Geoff Cooper at Wessex AHSN, which looks in more detail at how to [recognise soft signs in practice](#).

HSJ Patient Safety Award Winner 2020
Wessex AHSN

Maternity and Neonatal SIP

Academic Health Science Networks have been supporting the national Maternal and Neonatal Safety Improvement Programme (MNSIP) since it began in 2016. Using opportunities for system-level learning, AHSNs and PSCs support organisations to improve safety for mothers and babies and develop new initiatives.

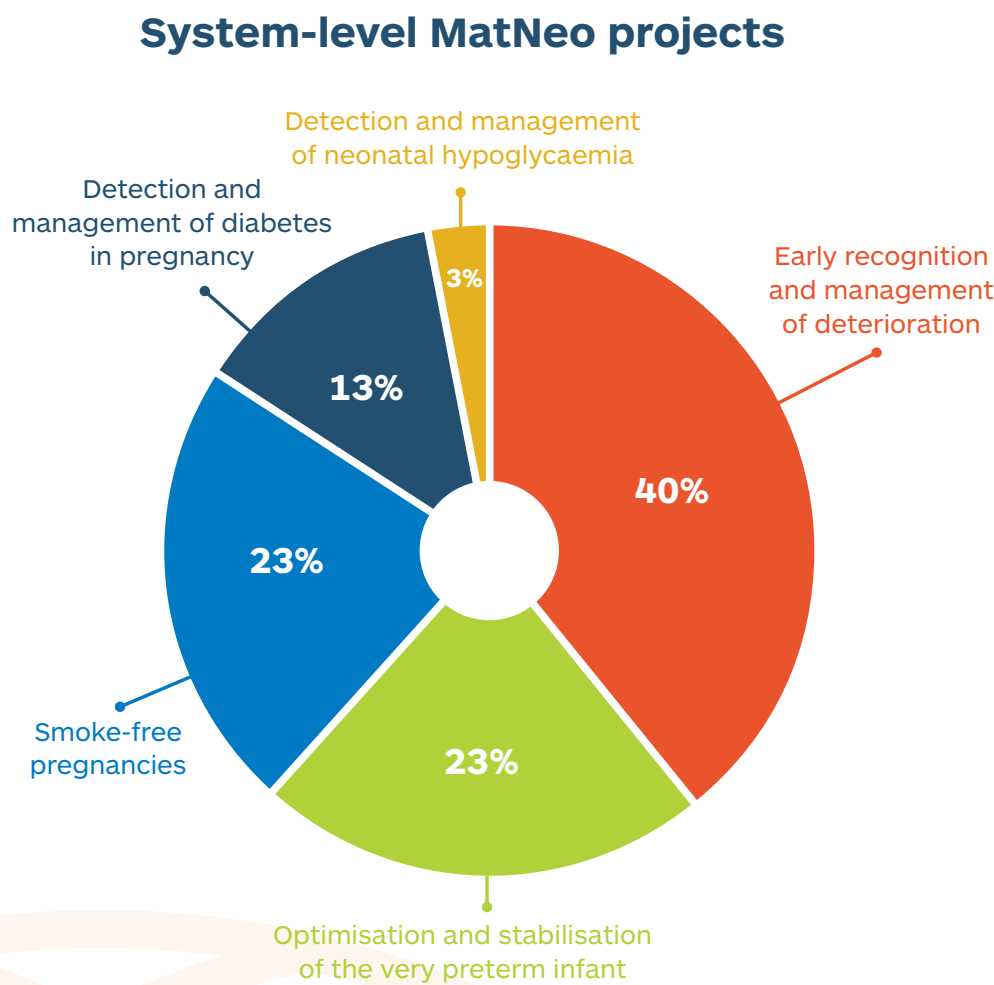
Patient Safety Networks

The MNSIP is the first collaborative of its kind on such a wide scale in Europe. It brings together all the maternal and neonatal services across England to focus on continuous improvement, in line with the national ambition to reduce stillbirths, neonatal deaths, maternal deaths and brain injury by 50% by 2025 to bring about system-level change that leads to safer care for mothers and babies.

Previously known as Local Learning Systems, Patient Safety Networks bring together the organisations and networks involved in providing and commissioning maternal and neonatal care to ensure continued focus on the aims of the MNHSC.

The AHSNs and PSCs have a key role to ensure the sustainability of the improvement work, supporting maternal and neonatal services in continuous improvement through the use of evidenced quality improvement methodology.

One of the examples of outputs from the Patient Safety Networks is reducing smoking in pregnancy, learning from existing work in the South West with a view to connecting with others projects across the country.



A Maternal Early Warning Score (MEWS) to spot deterioration will be developed by the Royal College of Obstetricians and Gynaecologists, with a potential focus on post-natal care. Post-natal care is frequently seen as an area where women are least satisfied and is a sometimes an unidentified area of risk for mothers.

The Birmingham Symptom-specific Obstetric Triage System (BSOTS)



Other system-wide programmes of work include The Birmingham Symptom-specific Obstetric Triage System (BSOTS). Unlike mainstream emergency medicine, there is currently no standardised triage system within maternity for unscheduled appointments. BSOTS was co-produced in 2013 by midwives and obstetricians from Birmingham Women's and Children's NHS Foundation Trust

and the National Institute for Health Research Collaboration for Leadership in Applied Health Research and Care (CLAHRC).

Through BSOTS, the number of women seeing a midwife within 15 minutes of arrival increased from 39% to 54%.

BSOTS is now in 25 maternity units across the UK from Portsmouth

and Southampton through the Midlands and as far north as Liverpool. Based on numbers from the initial evaluation, that means approximately 33,000 women have been assessed sooner.

It's estimated that if BSOTS were implemented in all the maternity units in the UK, over 2m women may be seen sooner and assessed in a standardised way.

B	Birmingham
S	Symptom-specific
O	Obstetric
T	Triage
S	System

Evaluation by NIHR CLAHRC West Midlands demonstrated that BSOTS:

- Significantly improved number of women assessed within 15 minutes of arrival (particularly red/amber)
- Is likely to improve safety for women and babies
- The system has strong inter-rater reliability suggesting it offers a reliable method of triaging women
- All the midwives reported that BSOTS training had improved their knowledge and confidence

This maternity triage system has now spread from West Midlands to other AHSNs demonstrating the potential to scale up evidence-based innovations through our networks.

Hypoglycaemia project makes it better for baby

Lancashire Teaching Hospitals' maternity and neonatal team have succeeded in reducing admissions of full-term babies due to hypoglycaemia, following an Innovation Agency programme.

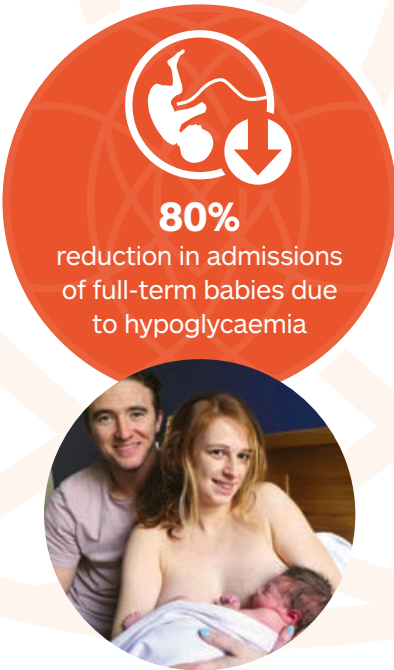
In an effort to keep babies warm and create the conditions for early feeding, thereby reducing the risk of hypoglycaemia, the trust has improved the number of babies who receive skin-to-skin care following birth for at least an hour or until the first feed.

Through Innovation Agency-facilitated coaching and mentoring support, quality improvement tools and techniques, and access to a

network of maternity and neonatal teams across the region, the trust implemented an initiative to reduce the percentage of term babies being separated from their mothers. The trust has subsequently seen an 80% reduction in admissions of full-term babies to the neonatal unit due to hypoglycaemia.

Baby Reggie was weighed after his first breastfeed at 6 pounds, 6 ounces. Mother Lauren was keen to have uninterrupted skin-to-skin time after hearing about the benefits from her midwife during antenatal classes.

Lauren said: 'I really enjoyed the experience of holding my baby



skin to skin; it felt natural to have that time together, I was able to relax and concentrate on my breathing, it was reassuring to hold baby close and it was calming for us both.'

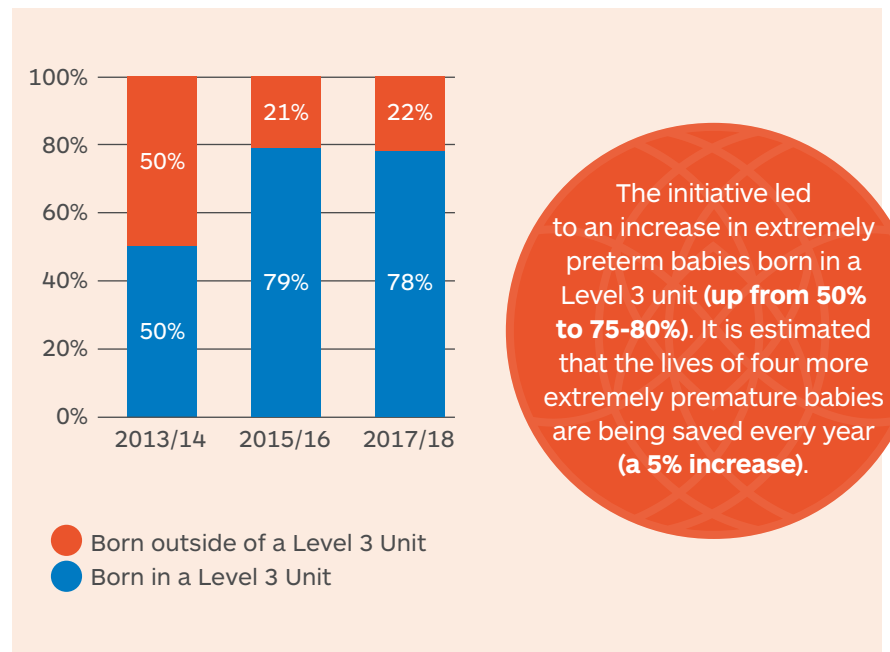
Improving regional referral pathway saves lives of premature babies



HSJ Patient Safety Award Winner 2020

The Oxford AHSN Maternity Network brought together stakeholders from across the region to work together so that more extremely premature babies are born in a Level 3 unit with a region-wide package of improvements put in place. This required a significant shift in working practices from making decisions based on availability of beds/staff to focus on the risks for the mother and baby.

The programme continues to work together to improve further, and capture and learning through themed analysis of the cases where this does not happen.



PERIPrem

PERIPrem (Perinatal Excellence to Reduce Injury in Premature Birth) is a new perinatal care bundle to improve the outcomes for premature babies across the West and South West regions. The bundle will consist of a number of interventions that will demonstrate a significant impact on brain injury and mortality rates amongst babies born prematurely.

The bundle is the first of its kind, and builds on lessons learned from designing and delivering the PReCePT project as well as being clinically owned and driven by perinatal staff across the region. It will support maternity and neonatal units



in implementing or improving innovative elements of care that will contribute to a reduction in brain injury and death in the smallest and earliest born babies.



Medicines safety

Through the AHSN Medicines Optimisation programme, we have the ability to test an initiative in one area and quickly scale up to others by pooling resources and capitalising on the expertise, infrastructure, connections and skills we already have.

In addition the PSC will support the **NHS Medicines Safety Strategy** (awaiting publication), and help deliver the National Medicines Safety Improvement Programme (NatMedSIP).

The themes of the programme that PSCs will support are:

1. Improve the safety of medicines administration in care homes.
2. Reduce inappropriate high-dose opiate prescriptions for non-cancer pain.
3. Reduction of inappropriate polypharmacy
4. Safer use of anticoagulants

This will in part be achieved through setting up care home patient safety networks and testing interventions such as safety huddles, learning from safety incidents, managing interruptions and three-way communication between care homes, prescribers and pharmacies.

Directly supported by the PSCs, Patient Safety Networks will provide an infrastructure to become the 'engine room' of safety improvement at sub-regional level. Bringing together key stakeholders into one network will help improve alignment and collaborative working, and reduce the potential burden of meeting attendance by staff working in these areas.



Medicines safety in care homes

We carried out a scoping survey to gather views on what the programme activities should prioritise, which received 1,102 responses. Analysis showed common themes around were:

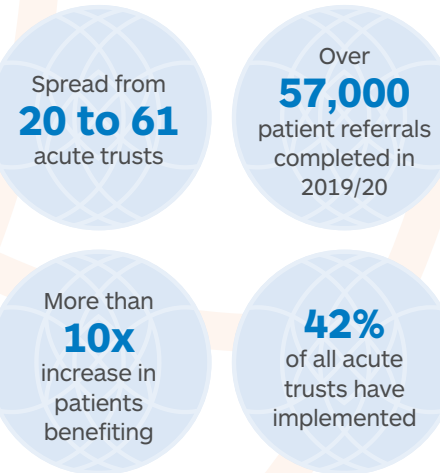
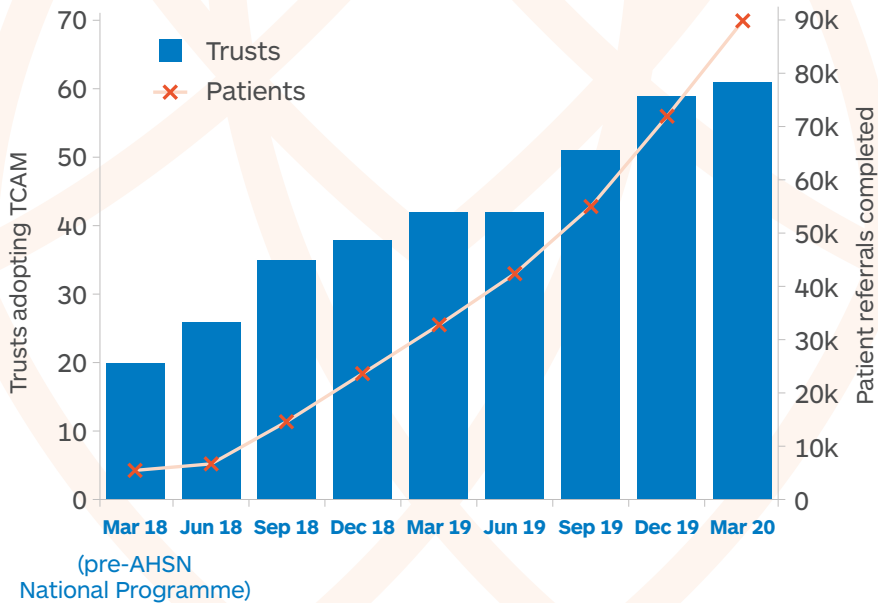
- Transitions of care
- Interruptions during medicines administration
- Communication between professionals

An example of the safety huddle model

Transfers of Care Around Medicine (TCAM)

It is estimated that 60% of patients have three or more changes made to their medicines during a hospital stay. The transfer of care process is associated with an increased risk of adverse effects (AEDs).

Transfer of Care Around Medicines (TCAM) is an innovative and impactful programme of work to prevent harm at transitions of care. **TCAM in mental health** organisations is also being tested.



Medicines safety triumph

TCAM in Aintree was set up through a partnership between Aintree University Hospital, part of Liverpool University Hospitals NHS Foundation Trust; NHS England Local Pharmacy Network and the Innovation Agency.

The three partners were named joint winners of the prestigious PrescQIPP award for developing or working across health and care boundaries. PrescQIPP is an NHS-funded not-for-profit

organisation that supports the best possible prescribing of medicines.

Up to March 2020, implementation of TCAM resulted in an estimated £19m of NHS savings in the North West Coast, based on the hospital readmission costs of patients who instead received support from their pharmacist. A total of 13 trusts in the North West Coast have adopted TCAM, with over 1,000 community pharmacies taking part.



Representatives of the three organisations collect their award.

Based on figures modelled from a study in Newcastle-upon-Tyne (2019, <https://bmjopen.bmj.com/content/6/10/e012532>).

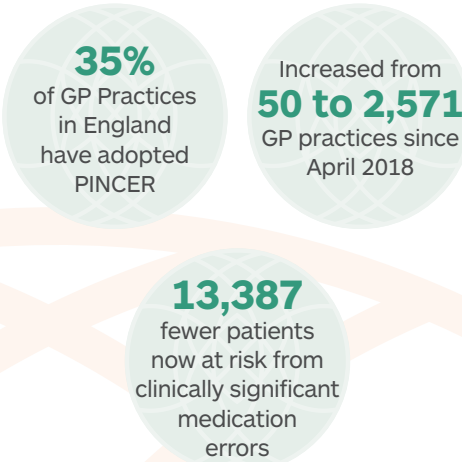
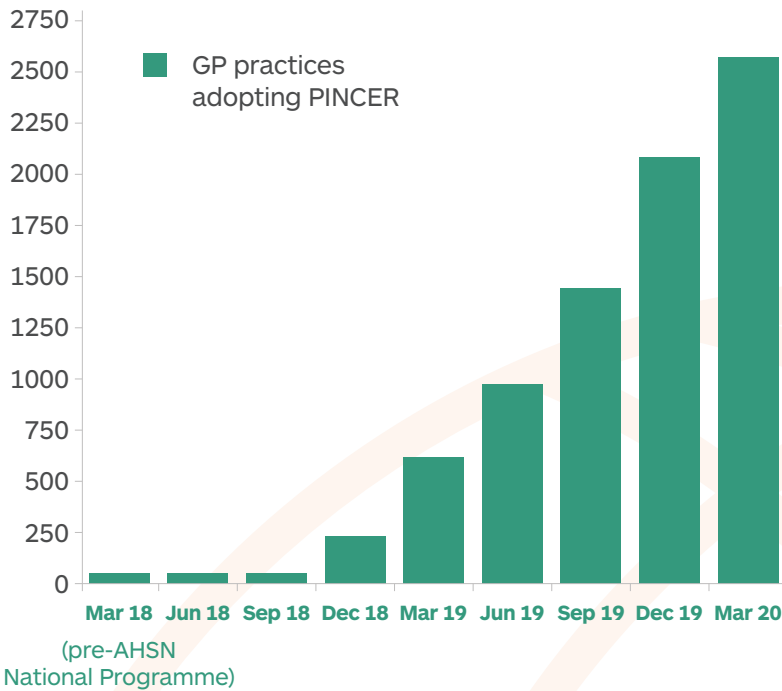


PINCER

The PINCER intervention (pharmacist-led information technology intervention for reducing clinically important errors) has been shown to reduce risk from clinically medication errors by up to 50%. Scale-up to general practices in the East Midlands using a large-scale Quality Improvement Collaborative (QIC), with Health Foundation and East Midlands AHSN funding and support, identified an estimated 21,636 instances of potentially dangerous prescriptions across

13 prescribing indicators – enabling action to be taken.

This work was then scaled up across all 15 AHSNs in collaboration with PRIMIS from the University of Nottingham. By March 2020, over 2,400 practices had utilised the PINCER indicators and 13,387 fewer patients were at risk from clinically significant medication errors. This collaboration has recently been shortlisted for patient safety team of the year by the HSJ awards.



Adoption and spread

Both AHSNs and PSCs share an aim of reducing the time it takes for innovation to be adopted in the NHS.

- Increasing the sustainable adoption and spread of innovation and improvement through a variety of methodologies.
- Supporting organisations and teams in relation to learning and sharing successful approaches.

An AHSN-wide steering group has been set up to gather and co-ordinate the rich learning from the extensive adoption and spread work across the network and to share this learning.

As a result of our work to date, it is clear that well-defined

local processes and a common infrastructure for feeding into a national pipeline for adoption are key to future national adoption and spread programmes.

An extensive piece of work is being undertaken across the

network to develop a pipeline, led by Health Innovation Manchester, in collaboration with all other AHSNs. The work is focusing on defining a consistent approach and set of principles around the themes of **discover, develop and deploy**.

Asthma and COPD collaboration with the RCP

The AHSN Network is working collaboratively with the Royal College of Physicians' National Asthma & COPD Audit Programme (NACAP) Team in support of COPD and Asthma discharge care bundles improvement work.

Collaboration has helped us understand our respective

programmes and identify opportunities to work together to provide enhanced support to respiratory teams, such as audit support and signposting to quality improvement events.

As part of the programme, a national dashboard, which uses NACAP data, has been produced

to support effective delivery of the COPD discharge care bundle. The dashboard provides insight into discharge care bundle delivery and outcomes, supporting improvement in the care of hospitalised COPD patients, reducing variation and improving patient safety on discharge.

Adoption and Spread Safety Improvement Programme

2019/20:

- COPD discharge care bundle
- Emergency department safety checklist
- Emergency laparotomy discharge care bundle
- Preventing cerebral palsy in preterm babies (PRCePT)

2020/21:

- COPD discharge bundle
- Safer tracheostomy care
- Asthma programme (expected 2021)

Patient Safety Collaboratives also support the adoption and spread of effective, evidence-based practice, including:

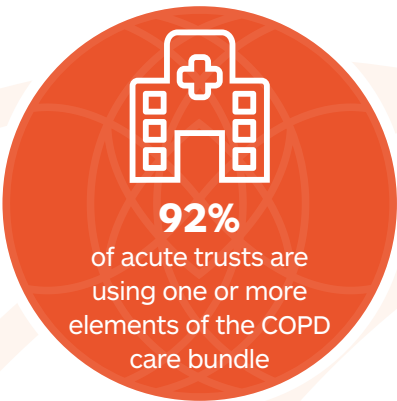
COPD discharge care bundle

The British Thoracic Society (BTS) has developed COPD admission and discharge care bundles with the aim of improving care, helping patients manage their condition at home, and reducing readmissions.

Acute hospital trusts are being encouraged to deliver all appropriate elements of the COPD discharge care bundle for patients admitted to hospital with COPD.

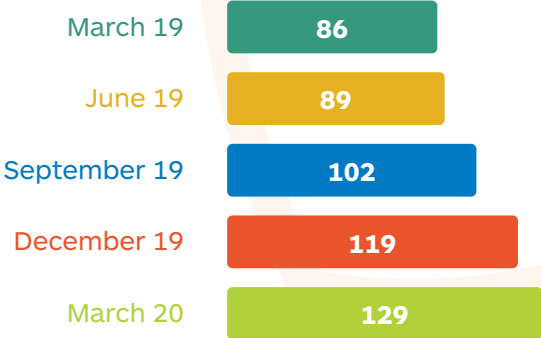
In the Kent Surrey Sussex area, improved outcomes were recorded from 2014/15 to 2018/19, during which COPD care bundle compliance increased:

- **Reduced length of stay:** from 5.7 days to 4.8 days
- **Regional downward trend in in-patient mortality:** from 4.49% to 3.67%



Emergency Department (ED) checklist

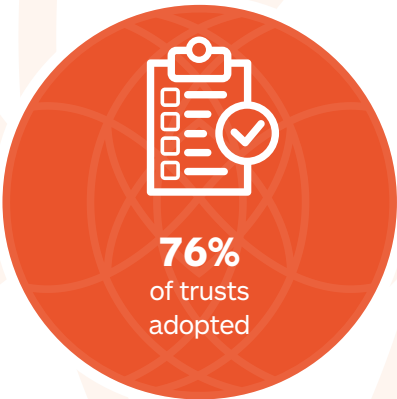
Developed in the West of England to improve recognition and treatment of serious illness such as stroke, heart attack and sepsis, the ED checklist is now recommended for national use across the NHS.



Number of hospitals using the ED checklist

Results from research in the West of England showed that the ED checklist improved clinical quality and patient safety, for example:

- An increase of over 5% in CT scanning within an hour for patients with suspected stroke.
- An increase of 25% in hourly observations.
- No clinical incidents relating to failure or delay in recognising a deteriorating patient.
- Reduction in the number of complaints received from patients and families.



Mental health

The AHSN Network will continue to deliver improvements in mental health, through a new safety improvement programme from 2020/21. This will develop innovation and improvement to support patients, families and staff within mental health settings.

Examples include the national AHSN programmes on Focus ADHD, which involves working with mental health trusts and community paediatric services to improve the assessment process for Attention Deficit Hyperactivity Disorder or the Eating Disorder Programme to speed up diagnosis and treatment of eating disorders in young people aged 16 to 25.

The previous two years saw a focus on Serenity Integrated Mentoring which formed integrated mental health and policing teams to provide

a unique blend of care for patients who place intensive demands on a wide range of operational services.

The AHSNs continue to build networks where learning, sharing and implementation can take place at scale, with examples including the South of England Mental Health Collaborative or the East Midlands Mental Health and Learning Disability Alliance. In addition to supporting and translating national projects into pan-local implementation, they are supporting Quality

Improvement capability and capacity building and improvement priorities of the local membership.

Patient Safety Collaboratives are collectively developing a national improvement programme to deliver some of the key ambitions of the NHSI Mental Health Safety Improvement Programme. The areas of focus and topics for these are still being explored but aim to improve safety outcomes for those who use mental health services by March 2023.



Zero Suicide Alliance

The number of suicides in Britain has reached record levels. Office for National Statistics data for the most recent period (2018) shows that England registered 5,021 deaths.

Health Innovation Network is a member of the **Zero Suicide Alliance** (ZSA)

and was commissioned by Mersey Care NHS Foundation Trust on behalf of the ZSA to undertake national engagement with key leaders and stakeholders involved in suicide prevention.

They engaged close to 1,000 national stakeholders over six weeks in the summer

of 2019, and the findings will inform the production of a new digital resource intended to become the 'go-to' source for accessible and evidence-based examples of training, interventions, research and statistical information for all sectors involved in suicide prevention. Find out more on the [HIN website](#).



Improving the physical health of people with serious mental illness

- The Bradford Physical Health Review Template improves the quality of health checks for people with a serious mental illness (SMI) who are at risk of dying prematurely due to preventable physical conditions.
- Supports healthcare professionals to identify patients with conditions including high blood pressure, diabetes and cardiovascular problems.
- With 47,713 health checks, potential cost savings in the Yorkshire and Humber region alone are estimated to be £11.3 million over the next 10 years.



Safety of older people

Patient safety issues such as falls, pressure damage, infections and problems related to nutrition and hydration affect older people more than any other population group.

Working with care homes

Specific safety initiatives to address the complex factors present in care homes are an important and enduring feature of the NHS's work and you will find many examples in our report *Improving safety in care homes* (2019, www.ahsnnetwork.com/care-homes-report).

Previous work includes the development of nutrition toolkits, hydration resources, training and dementia screening to name a few. The AHSN Network is exploring the range of local work programmes to support improvement programmes that improve the health and safety of older people.

We have combined the work in care homes with the NHS Ageing Well and frailty programmes to provide a comprehensive summary of the scope and breadth of work. We are now theming this work in order to understand how the AHSN Network can effectively contribute to supporting older people.

Training for care home staff

We collaborated with Health Education England to create a [training programme for care home staff](#), including 14 films that explain how to spot the early signs of sepsis and serious illness, and how to take the measurements needed for a NEWS2 score. The videos were released in March 2020.

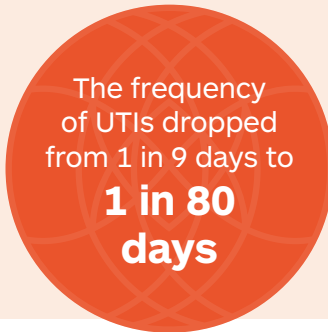
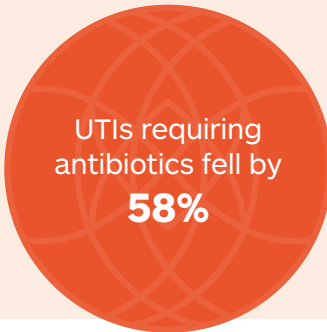
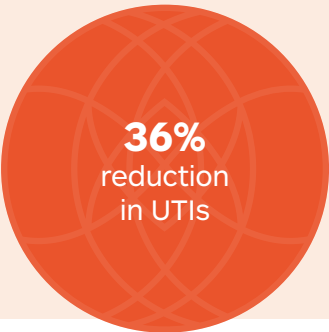


Good hydration!

The aim of this initiative in the Oxford area was to reduce the number of urinary tract infections (UTIs) that required antibiotics or hospital admission by improving hydration in care home residents.

Following the overwhelming success of the pilot in East Berkshire, the training has been rolled out to six regions in the Oxford AHSN area and beyond (including New Zealand).

A paper publishing the results has subsequently been [published](#). All of the training resources are available on the [Oxford AHSN website](#).



Focus	Need being met	Project	AHSN lead	Notes
Residents	End of life decisions	Advance Care Planning - CMC record creation and publication	HIN	Builds on previous south London pilot to work with 10 care homes to implement CMC.
	Hydration and Nutrition	Nutrition Wheel	Wessex	
		Hydration	Wessex/UCLP	
		Nutrition and hydration eToolkit	Wessex	
		Waterdrop	UCLP	
	Falls	Digital falls assessment	EMAHSN	Partnerships with ambulance service. Ambulance have done their first digital falls assessment, but COVID-19 has delayed further progress. Reinitiating project.
	Managing the unwell resident recognising deterioration	Soft signs frameworks matrix	HIN	Comparison of five common frameworks for managing the unwell resident.
		RESTORE2/ RESTORE2mini	WEAHSN/ Wessex	Project involves delivering training and rolling out RESTORE2. Alongside training, offering care home managers wellbeing and coaching sessions.
		Significant 7+/Care	UCLP	Recognition of soft signs.
	Technology to support remote monitoring	AHSN-wide scoping exercise	AHSN Network	Pilots include: • Whzan • CliniTouch • Feebis • Docobo
Staff	Telemedicine	Hampshire Airedale model	Wessex/ HIN	Working with Hampshire CCG to implement telemedicine. Telemedicine implementation toolkit for care homes.
	Connecting with family	Facebook portals	HIN	Supported NHSX in the distribution of Facebook portal devices to care homes. Portals allow residents to connect with friends and family. Ongoing evaluation.
	Communication	MS teams	Wessex	Digital Social Care has resources and training to support MS Teams uptake.
	Wellbeing	HealthSHIP	HIN	Volunteers programme, medical and health students have pledged time to support social care workers.
	Mental Health	Mental health awareness training	HIN	HIN in partnership with Hyatt Consultancy are delivering a two-hour awareness session with ongoing support in south London
	Leadership development	Care Home Pioneers programme	HIN	Leadership development programme for care home managers.
Infrastructure	Digital maturity	Mapping care home's digital maturity	Wessex/HIN	

A survey of some of the live projects AHSNs are running under the NHS 'Ageing Well' programme to support people living with frailty (www.england.nhs.uk/ourwork/clinical-policy/older-people/frailty)

Safe Steps



106

Health & care organisations

10,283

Risk screenings

28%

Falls reduction

20%

Fewer NWAS falls related callouts

We have many examples of work to reduce falls across the system. Our partnership working with care homes has helped us to make progress in this sector by reducing and preventing falls. There is significant potential for us to capitalise on this nationally by aligning activity and resources with the wider AHSN Network and the frailty programmes AHSNs are invested in.

One example is Safe Steps, a digital health app designed to help reduce falls for older people

living in care homes. Safe Steps is currently live in over 100 care homes in and around the North West. It has also been trialled at a 95-bed intermediate care unit in Tameside where it has been used almost 3,000 times by 46 members of staff to prevent falls on the unit.

The tool measures 12 key risk factors based on NICE guidelines and provides a personalised action plan with evidence-based recommendations to reduce falls risks. Initial evaluations over 12 months indicated a 21% reduction

in falls and a 20% reduction in ambulance service call-outs.

In response to COVID-19, health and care professionals from Greater Manchester have worked with Safe Steps to develop a UK-first digital innovation that helps care homes to track the disease. The tool allows care home staff to input information about a resident's COVID-19 related symptoms into a tracker, which can be shared directly with the resident's GP and NHS community response team to ensure that a swift assessment and response can be put in place.

SPACE QI training to upskill care home staff

SPACE (Safer Provision and Care Excellence) has been rolled out across the West Midlands region, supporting staff in care homes to improve quality of care and reduce avoidable harm in their care settings.

SPACE was originally a two-year large-scale quality improvement (QI) pilot programme in 35 care homes across the West Midlands sponsored by the West Midlands Patient Safety Collaborative.

It aimed to upskill care home staff through training them in basic QI techniques and methodologies which empower staff to identify solutions to common problems within their care settings.

Improvements following the SPACE programme included:

- A downward trend in recorded falls
- A reduction in the number of more severe pressure ulcers.
- Significant improvement in safety culture and in uptake of Quality Improvement methods
- Significant uptake of staff led initiatives

So far 105 of the region's 1,200 care homes have taken part in the QI training. There's more information at: meridian.wmahsn.org.



Research and innovation

Our connections to academia including Patient Safety Translational Research centres (PSTRCs) and the Applied Research Collaboratives (ARCs) are important, both for identifying evidence and research that can lead to new programmes of work for piloting and testing, and then evaluations of those programmes of work in small 'test of change' areas before they are ready for wider adoption.

The interrelation between research-active organisations and the AHSN Network is through a combination of strategic joint oversight groups (AHS/ARC and AHSN / Academic Health Science Centre steering groups) and regional coordination and collaboration across individual AHSN regions.

Our local entrepreneurs and innovators have ideas for how to improve pathways, devices, med tech and digital solutions that are ready for adoption or need additional work to test and evaluate.

Our PSCs and AHSNs have the relationships to find local test beds or demonstrator sites to support this real-world evaluation. This means we can advance the uptake of

new patient safety solutions in a systematic and safe way, delivered through local partnerships underpinned by strong methodologies of continuous quality improvement.

Because we know our local footprints so well, we understand how to capitalise on the local context and where local variation is acceptable. This adds depth and breadth to the evidence base, allowing innovations to be considered for scale-up through various accelerator programmes for nationwide adoption and spread.

Without the real-world evaluation, new innovations would not get supported and the realm of patient safety would not move forwards.



479,000+

patients benefitting from AHSNs' two-year national spread and adoption programmes



553,290

Innovation and Technology Payment units/scans supplied for patients in the last three years

Conclusion: delivering patient safety together

AHSNs continue to deliver on the NHS Patient Safety Strategy.

2020 has been an extraordinary year. COVID-19 has highlighted the tremendous flexibility and resilience of our National Health Service, while making us acutely aware of the importance of supporting our amazing healthcare workforce, within hospitals, care homes and the community.

Patient safety has been at the forefront of AHSNs' response to coronavirus. Its principles of quality improvement, developing a positive safety culture, building capacity and capability, and addressing inequalities provide a framework that has allowed responsive programmes to be rolled out at lightning speed, while keeping patients' needs at its core.

AHSNs and the PSCs which they host are truly connected at all levels in their local areas

as trusted system partners. This strength has been evident in the pandemic, through our fast, co-ordinated activity with teams on the front-line, local STPs/ICSSs and regional NHS teams. These partnerships are the key to AHSNs' unique place in a nationally-led, locally responsive improvement and innovation system.

PSCs are a major delivery partner for the NHS Patient Safety Strategy and are getting underway with two new programmes of work on medicines safety and mental health. These are timely additions to our well-established and successful programmes on managing deterioration and maternity and neonatal safety.

AHSNs continue to develop a pipeline of innovations that will

also positively impact patient safety. Some of these have in turn become commissioned through the NHS England and NHS Improvement Adoption and Spread SIP, such as our work on the COPD discharge care bundle. AHSNs are recording impressive achievements in the best practice management of atrial fibrillation, and our portfolio of projects to support care homes and domiciliary care staff continues to grow.

Despite the current situation, we know there is still a huge amount of enthusiasm and dedication for patient safety work, and through this Patient Safety Plan we look forward to exploring many more opportunities with our partners. To find out more and get involved, contact your local Academic Health Science Network.

Acknowledgements

This plan was created following consultation with many internal and external stakeholders. It represents the ambition of all 15 AHSNs as a national AHSN Network. We would like to thank everyone who has contributed and shared their work for this update.

The AHSN Network

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