

# Patient Safety Collaboratives

A retrospective review

January 2019

We support providers to give patients safe, high quality, compassionate care within local health systems that are financially sustainable.

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# Summary

Patient safety is a priority for the NHS. In September 2018, the Secretary of State for Health and Social Care announced there would be a new patient safety strategy, stating that “every patient – whether in hospital, at home, in a GP surgery – expects compassionate, effective and safe care. To achieve that, we need to improve learning, we need to better shout about the work that the best trusts are doing, and the NHS must be as open and transparent as we can.”<sup>1</sup> As Patient Safety Collaboratives (PSCs) are in a unique position to connect networks of organisations to identify and spread good patient safety practice, they will be critical to delivering this strategy.

The PSC programme was established in April 2014 and officially launched in October 2014 in response to the findings of the 2013 Berwick review, *A Promise to learn – a commitment to act*: “the single most important change in the NHS ... would be for it to become, more than ever before, a system devoted to continual learning and improvement of patient care, top to bottom and end to end.”<sup>2</sup>

Nearly five years on NHS Improvement commissioned this review to better understand the mechanics of the delivery of PSCs and their impact, and to make recommendations for the recommissioning of the PSCs.

The PSCs have established structures, processes and networks that provide the opportunity to drive patient safety improvement work across the country, backed by the enormous commitment and goodwill of those involved. We know that in some regions and pathways, the PSCs have been particularly important in identifying and spreading patient safety initiatives. However, there remains significant scope for the PSCs to contribute to further improvements in patient safety.

From its outset the programme has been based on the principles of local priorities and engagement, resulting in a wide range of approaches and initiatives from the 15 PSCs and a lack of national impact measures.

<sup>1</sup> The Rt Hon Matt Hancock. 26 September 2018. <https://www.gov.uk/government/speeches/patient-safety-no-room-for-complacency>

<sup>2</sup> National Advisory Group on the Safety of Patients in England (2013) *A promise to learn – a commitment to act: improving the safety of patients in England*. 6 Aug 2013.

The programme's yearly budget is £8.5 million, of which £7 million is distributed to PSCs on a weighted per capita basis (an average of £450,000 per PSC).

Steps taken in 2017/18 have increased the programme's national co-ordination and oversight. These included:

- developing three national workstreams (safety culture improvement, earlier recognition of deterioration, and support for the maternal and neonatal programme)
- introducing a more structured assurance process
- increasing focus on measurement and creating the Patient Safety Measurement Unit (PSMU).

But these steps have not addressed the lack of outcome measures and it remains difficult quantitatively to assess what impact the PSCs have had on patient safety nationally.

Most PSCs have an established infrastructure that can be used to deliver improvements in patient safety. The [new national patient safety strategy](#) should allow the PSCs to be more focused and to work closely with other organisations, and is the opportunity to promote their pivotal work. They should be central to the delivery of the strategy.

This review makes recommendations to strengthen the programme, building on momentum achieved to date, and informs the future operating model and commission for the PSCs.

These recommendations are:

- **Structure and oversight:** PSCs could be more effective if the role of commissioners were strengthened. Commissioners should translate the national patient safety strategy into clear priorities, expected outcomes and indicators with periodic oversight and performance management.
- **Operational model:** The Academic Health Science Networks (AHSNs) host the PSCs. This review does not recommend changing this hosting model, because restructuring is unlikely to materially improve the programme in the short term and could delay the impact of existing patient

safety initiatives, particularly given the changes to the NHS England and NHS Improvement regional structures.

- **Variability:** The design of the PSC programme allowed each PSC to tailor its approach to meet local needs, and the variability arising from this has meant the national impact of the programme is difficult to demonstrate. Specifying minimum standards and expectations should make their approaches more consistent but still allow the flexibility to meet local needs and fit with local culture.
- **Workstreams:** There is a perceived tension between the programme's local and national workstreams. A more data-driven approach will help reveal where national workstreams are needed. This will allow the PSCs to focus their capacity on the areas that will have greatest impact, tailored to suit local needs. National workstreams can benefit from collaborative working and learning to increase the speed and scale of change.
- **Profile:** The PSC programme has a lower profile than some other quality improvement initiatives: providers more frequently reference work with Virginia Mason, the Institute for Healthcare Improvement (IHI) and other NHS Improvement programmes such as the Emergency Care Intensive Support Team (ECIST). A higher profile should increase demand for and engagement with PSC initiatives, again accelerating change.
- **Quality improvement:** PSCs have not been consistent in using robust quality improvement methodology to test and iterate initiatives, and this has affected their ability to gather evidence to support their impact in real-world settings. This is clear from the lack of outcome data on some initiatives, especially those concerned with training staff. Measurement and being able to quantify the impact of programmes are critical to quality improvement, and every PSC should have access to these abilities.
- **Alignment:** The development of a new national strategy for patient safety is the opportunity to fully align the patient safety work of the PSC programme with the wider work of NHS Improvement, NHS England, the Care Quality Commission and other key stakeholders.

# Recommendations

Ref	Recommendation	Responsible organisation	Milestone
1	<p><b>National patient safety strategy</b></p> <p>A new <a href="#">national patient safety strategy</a> is being developed. This will help align the different programmes on patient safety, clarify accountabilities and support teams to capitalise on interdependencies to maximise benefit for patients. It should define patient safety and set the priorities all NHS bodies are signed up to.</p> <p>The role of the PSCs in delivering the strategy must be clearly defined.</p>	NHS Improvement	31 Dec 2018
2	<p><b>National bodies</b></p> <p>The PSC programme must be more collaborative across the national bodies to avoid duplication of effort and to make best use of the skills of NHS Improvement's patient safety, improvement and regional teams. More communication between teams and alignment of work will maximise the impact of the PSC resources.</p>	NHS Improvement and PSCs	31 Dec 2018
3	<p><b>PSC specification</b></p> <p>The PSC commission should be translated into a clear specification articulating the priorities, expected outcomes, key performance indicators and approach to monitoring delivery and performance management. It should also give the PSCs a common understanding of what a 'collaborative' is and how this model can be used to effect change. The PSCs must buy in to delivering this specification.</p> <p>The three commissioners of the AHSNs (NHS England, NHS Improvement and the Office of Life Sciences) should continue to work closely together to ensure their oversights are aligned and proportionate.</p>	NHS Improvement, NHS England and Office of Life Sciences (OLS)	31 March 2019
4	<p><b>Priorities and initiatives</b></p> <p>Initiatives should be prioritised based on a robust, data-driven methodology that also considers soft</p>	National bodies, PSCs and PSMU	31 March 2019

Ref	Recommendation	Responsible organisation	Milestone
	<p>intelligence, and fits with the overall strategy (including the workstreams agreed by NHS Improvement) and existing initiatives on patient safety.</p> <p>The focus should be national initiatives born from local issues and challenges. Initiatives may include those that need to be widely adopted because of clear evidence of their impact, and those supported by clinical evidence but less operational evidence that require testing and iterating using quality improvement approaches.</p> <p>A systematic review by PSCs of their current initiatives is needed to understand which should continue and which should stop. We expect the outcome would be fewer initiatives overall but greater national consistency that the PSCs can translate into a local setting.</p>		
5	<p><b>Local improvement plans</b></p> <p>The 2019/20 local improvement plans must include clear, measurable outcomes for all initiative. These should be prioritised based on national priorities translated to suit local needs, available data, expected benefits and resource availability. Clear milestones for delivery should be set to assist with assurance.</p>	PSCs	31 March 2019
6	<p><b>Spread and adoption</b></p> <p>The approach to spread and adoption must be systematic, including:</p> <ul style="list-style-type: none"> <li>• Definition of minimum expectations for data collection and measurement on every programme, to ensure that the impact of programmes can be evaluated and compared.</li> <li>• Consistent use of robust quality improvement methodology for cycles of testing, with evaluation and refinement across multiple settings as appropriate.</li> <li>• Consideration of the role of national bodies in spread and adoption of good practice, building on the work currently done by NHS England. Mandating adoption has limited evidence of</li> </ul>	PSCs and national bodies	31 March 2019



Ref	Recommendation	Responsible organisation	Milestone
	<p>success and is unlikely to be identified as the best approach. However, national bodies can provide overarching leadership, ensure there are forums and opportunities to collaborate, monitor performance and work with PSCs to address barriers where they arise.</p>		
7	<p><b>Role of the PSCs</b></p> <p>Define and agree the responsibilities and accountabilities of the PSCs. Together these should give a clear description of what success looks like for the PSCs.</p>	NHS Improvement	31 Dec 2018
8	<p><b>Long-term operating model</b></p> <p>A medium-term plan should be developed to review the operating model of the PSCs, including how they align with regional and national bodies.</p>	NHS Improvement, NHS England and OLS	31 March 2020
9	<p><b>Capacity and capability</b></p> <p>A common understanding should be developed of the core skills all PSCs and patient safety leads need, with appreciation of the need for economies of scale and how specialist expertise across the system is shared. Where specific PSCs have skill gaps, how these will be closed locally should be considered, or where specialist resources and expertise sit in the country determined and how PSCs can access these communicated. PSCs should consider their skill mix and ensure that any gaps are addressed through recruitment, training or accessing skill sets across the system.</p>	NHS Improvement and PSCs	31 Dec 2018
11	<p><b>Visual identity</b></p> <p>The national approach to visual identity must be fully adopted by all PSCs to raise their recognition through consistency. Communication strategies joint with NHS Improvement and NHS England regional teams should be used to raise awareness of the PSCs' offer.</p>	PSCs	31 March 2019
12	<p><b>Engagement</b></p> <p>Wherever possible, PSCs should use existing networks within the regions, including those</p>	PSCs, NHS Improvement and NHS England	31 Dec 2018

Ref	Recommendation	Responsible organisation	Milestone
	<p>established as part of sustainability and transformation partnerships (STPs) and by the regional NHS Improvement and NHS England teams, to maximise engagement with their current capacity.</p> <p>Regional NHS Improvement and NHS England teams should encourage providers, commissioners and other stakeholders to participate in the work of the PSCs where it aligns to their priorities.</p>		
13	<p><b>Quality improvement methodology, measurement and use of data</b></p> <p>The ability to apply quality improvement methodology, including measurement capability, should be part of the core skill set of all PSCs, to ensure they can fulfil their fundamental roles.</p> <p>Where measurement skills, or more broadly quality improvement skills, are not present in the PSCs, the PSMU or the central NHS Improvement team must be used when designing initiatives, to ensure methodology is robust and that the impact of the initiative can be assessed.</p> <p>Minimum expectations for data collection and measurement on every programme should be defined to ensure that the impact of programmes can be evaluated and compared.</p>	PSMU	31 March 2019

# 1. Introduction

## Background

Co-ordinated and commissioned nationally by NHS Improvement, the PSC programme was launched in 2014 in response to the recommendations made in the 2013 Berwick review, *A promise to learn – a commitment to act*, to improve the safety of patients in England. The Berwick review was a response to the findings of the Francis inquiry.<sup>3</sup>

The Berwick review stated that “the single most important change in the NHS ... would be for it to become, more than ever before, a system devoted to continual learning and improvement of patient care, top to bottom and end to end”.

It recommended:

- The NHS should be given the resources to support and learn from existing collaborative safety improvement networks and to sponsor the development of new regional or subregional collaborative networks across the country, perhaps aligned to and working with the new Academic Health Science Networks (AHSNs).
- Every NHS organisation should participate in one or more collaborative improvement network as the norm.
- Improvement networks should include processes for monitoring and evaluation together with NHS England, to understand what works and to assure that best processes are spread and scaled to benefit all patients in the system.

‘Guiding’ principles were proposed for the programme with the expectation that each of the 15 PSCs would use these to underpin their locally determined priorities. The Secretary of State for Health and NHS England committed to these principles when establishing a five-year programme to deliver the PSC programme in April 2014: this began operating fully in October 2014.

Delivered through the 15 AHSNs, the programme is designed to provide

<sup>3</sup> Robert Francis QC (2013) [The Mid Staffordshire NHS Foundation Trust Public Inquiry](#). 6 Feb 2013.

infrastructure and support for locally-led patient safety improvement work across provider, commissioner and other stakeholder organisations. Each AHSN hosts one PSC and up until April 2016 was funded to do so by NHS England.

In April 2016 NHS Improvement took over responsibility for the PSC programme as part of the transfer of the patient safety function from NHS England. NHS Improvement provides £8.5 million per annum to the programme of which £7 million is distributed among the PSCs on a weighted per capita basis (an average of £450,000 per PSC).

## Aims of the programme

The goal of this programme is that by 2019 everyone (patients and the public) can be confident that care is safer for patients based on a culture of openness, continual learning and improvement through specific activities at local and regional level. These are:

- measure and assess culture and give attention to the factors that help create or foster a safety culture and an engaged workforce
- develop organisational leadership for safety at all levels
- build system-wide capability for both staff and patients in quality and safety improvement
- facilitate and promote innovation in practice
- build skills and capability for measurement for improvement
- improve topic-specific clinical processes and pathways of care
- generate commitment to sustainability and encourage the adoption and spread of evidence-based improvements locally, regionally and nationally
- contribute to national networking, sharing and learning on topics of national significance.

## Priorities

The PSCs are charged with leading safety improvement projects across their local health and care organisations. The programmes they lead are split evenly between nationally mandated priorities and locally identified priorities. When the national priorities were introduced in 2017/18 this split was 35:65, respectively.

The current nationally mandated priorities are:

- improve the conditions for a culture of safety
- improve the early recognition of the deteriorating patient (including supporting the local adoption of national early warning score 2 (NEWS2) across all acute providers)
- support the ambitions of the maternal and neonatal health safety collaborative.

## Refocusing the programme

During 2017/18, the overall programme began a process to rebrand and refocus its patient safety improvement work to ensure that:

- the programme governance and assurance process is strengthened
- work is underpinned by quality improvement methodology that builds an evidence base
- PSCs work more collectively and systematically, including the need to become more cost-effective by identifying economies of scale
- individual PSCs regroup around a common patient safety programme brand that the NHS can easily identify and so help raise the profile of the work
- individual PSC work is more consistent with the national areas of work
- the programme refines and further develops its measurement strategy, specifically around impact and/or outcome metrics
- the programme focuses on adoption and spread of innovation and improvement
- the programme revisits Berwick's recommendations and refocuses on improvement work that not only captures the spirit of the ambitions, but adds a unique contribution and value to the system as a whole, including partnering with patients.

Equally, the now three commissioners of AHSNs (NHS England, NHS Improvement and the Office of Life Sciences (OLS)) are working together to identify economies of scale and joint working, including on aspects of the governance, assurance and business planning process.

The programme was conceived to run for five years, with 2018/19 the final year. NHS Improvement, supported by NHS England and OLS, has agreed to consider recommissioning the programme for a further five years.

## Review methodology

This review looked at the PSC programme's operating and delivery model, including the overall impact of the programme and its added value to the system. It was undertaken to inform a new national programme operating model and to ensure the national PSC programme is fit for purpose for the next programme phase.

Its objectives were to:

- review the PSC programme's operating and delivery model to understand its effectiveness, including by evaluating its objectives, governance, implementation and monitoring plans
- identify good practice, insight and learnings to be shared
- recommend how the programme can maximise the value it brings to the NHS.

We used a range of approaches, including:

- interviews with patient safety leads, AHSN staff and leadership, NHS Improvement central and regional teams, NHS England regional teams, providers, patient groups and other stakeholders with a role in patient safety
- surveys of a range of stakeholders, including AHSN staff and leadership, NHS Improvement central and regional teams, NHS England regional teams and other stakeholders with a role in patient safety
- review of key documentation relating to the PSCs, including national programme objectives and local delivery plans
- review of literature on quality improvement and patient safety.

## 2. Impact of the PSCs

Since 2014, the PSCs have built structures, processes and networks that enable patient safety improvement across the country; however, their strength varies significantly between PSCs.

The PSCs are uniquely positioned to work across local health economies, build networks of patient safety practitioners, and link to industry and academia through the AHSNs.

In a few regions and pathways, the PSCs have played an important role in the identification, adoption and spread of patient safety initiatives. Examples of their achievements can be found across the country.

Most NHS providers have benefitted to some extent from the work of the PSCs, although the depth and breadth of this varies significantly. A few have benefitted from pathway changes with measurable impacts, but the involvement with PSCs for most has been limited to attendance at their events or seminars.

In terms of spread and adoption of good practice, the PSCs have not gone as far or as fast as intended: only a very few programmes have had national impact. This can be partly attributed to a lack of clarity about the fundamental purpose of the PSCs and the role they should play in delivering systematic quality improvement, including raising the profile of this work, sharing good practice, and collaborating and gathering evidence to support initiatives.

To illustrate where the work of PSCs has had impact, we have published [six case studies](#) summarising programmes that have shown measurable benefits for at least one provider, but in most a larger number. The Health Foundation provided additional funding in three of these and most were delivered with some support from the AHSNs. The case studies concern:

- safety huddles
- suspicion of sepsis dashboard
- national early warning score
- prevention of cerebral palsy in preterm labour

- emergency department checklist
- emergency laparotomy.<sup>4</sup>

Throughout this document we have also highlighted areas of good practice not directly related to an individual initiative.

However, the variability built into the locally owned and led model, particularly the different outcome measures, made it difficult to quantify the national impact of the programme. The absence of improvement measures in the design of some initiatives made even a local assessment difficult for some programmes. Consistently establishing impact measures for all projects using robust quality improvement methodology must be a priority in future.

The translation of a new national patient safety strategy into a clear national specification and contract should allow the PSCs to be more focused and to work closely with other organisations, and is the opportunity to promote the work of the PSCs and to ensure that they are central to the delivery of this strategy.

In our review we identified areas where the momentum already established by the PSCs could be built on. These are identified in the remainder of this report, with recommendations for the PSCs, national bodies and other stakeholders to consider as the programme is recommissioned.

<sup>4</sup> Further details of each of these programmes can be found in the AHSN atlas.  
<http://atlas.ahsnnetwork.com/>



# 3. National patient safety agenda

## Patient safety strategy

A [national strategy for patient safety](#) is being developed. This presents the opportunity to better connect systems and align patient safety improvement work across the entire health and care system, and to clarify the role of the PSCs.

The new national patient safety strategy should:

- support the alignment of different programmes on patient safety
- clarify accountabilities and support teams to capitalise on interdependencies to maximise benefit to patients
- define patient safety and set the priorities which all NHS bodies are signed up to
- define the role of the PSCs in delivering the strategy.

The strategy should be translated into a clear specification and contract that articulates what the PSC programme is, including its aims and objectives, and the roles and responsibilities of the individual PSCs.

The PSC programme is one element of the patient safety infrastructure. The PSCs themselves have limited capacity, meaning they must focus on their role within this larger infrastructure. The PSCs bring together networks of individuals focused on patient safety and quality improvement, and through the AHSNs have links to academia. PSCs can best use their unique capabilities through closer working across different bodies, rather than working in isolation on a wide range of priorities.

## Working with other organisations

Critical to strengthening the current PSC model is closer working with other organisations focused on quality improvement, and other patient safety workstreams (eg within NHS Improvement or NHS England), to maximise benefits and capitalise on interdependencies. PSCs must ensure they are fully embedded in

national and local networks of organisations and individuals working to improve clinical practice and patient safety.

While this is already the case in some regions, where the PSCs are less embedded in regional networks, efforts may be duplicated. The integration of NHS Improvement and NHS England regional teams into seven combined regional teams will join up delivery of continuous improvement and other patient safety initiatives, as well as develop a pipeline of ideas for future commissions appropriate to the remit of the PSC programme. Regional teams can create regional AHSN hubs and act as conduits for AHSN collaboration. Significant funding has been invested in the PSCs – on average £450,000 per PSC per annum – and they must maximise opportunities to share resource and deliver economies of scale.

NHS Improvement and NHS England, among others, lead other collaboratives and similar initiatives in health systems: for example, those focused on falls, pressure ulcers and mental health. PSCs must engage with these where appropriate, to benefit from synergies and to avoid duplication of effort.

# 4. Priorities and delivery plans

## PSC specification

The PSCs were set up with relative freedom to determine their own priorities to enable and support local ownership. While guiding principles set out expectations, their different interpretations by PSCs lead to a variety of operating models and workstreams. The introduction of the three national workstreams in 2017/18 (safety culture improvement, earlier recognition of deterioration, and support for the maternal and neonatal programme) provided a clearer steer on what is expected of the PSCs and helped focus the initiatives under three main themes.

The PSCs' overall remit is not consistently understood by the PSCs themselves or by stakeholders in regional and local teams. The specification and contract for the PSCs must set this out, giving clarity on their scope, functions, minimum expectations, priorities and expected outcomes. This should help give PSCs a common understanding of what a 'collaborative' is and how this model can be used to effect change.

### What is a 'collaborative'?

"A multi-organisational structured approach with five essential features: (1) there is a specified topic; (2) clinical experts and experts in quality improvement provide ideas and support for improvement; (3) multi-professional teams from multiple sites participate; (4) there is a model for improvement (setting targets, collecting data and testing changes); and (5) the collaborative process involves a series of structured activities." (Hulscher et al (2009) *Collaboratives*. London: The Health Foundation)

## National and local priorities

Initially the PSCs worked solely on delivering locally scoped initiatives within a national framework but the range of initiatives on which they are collectively

focused has widened considerably. The introduction of the three national workstreams meant a choice for PSCs between badging local initiatives under a national workstream, continuing them as local initiatives alongside national priority initiatives, and discontinuing them. While some discontinued initiatives, others incorporated them in the new priority areas.

This has meant that while many of the current initiatives fall under the three national workstreams, the scope and design of initiatives on the same topic vary between PSCs. This makes it more difficult to measure impact in a consistent way. Similarly, the many local priorities across the PSCs are being scoped and executed in different ways.

Our review of 2018/19 local delivery plans (see below) identified 273 initiatives: 194 aligned to the national workstreams and 79 related to other local priorities. While most PSCs are delivering at least one initiative in collaboration with several other PSCs, many initiatives and particularly those with a relatively narrow scope, are limited to a single PSC and indicate a real risk that PSCs are spreading their resources too thinly.

## Selection of priorities

The three national workstreams were identified from engagement with national bodies, experts and other senior stakeholders. Their introduction has improved the focus of and collaboration across PSCs.

Locally, initiative selection is primarily driven by the national priorities and engagement with stakeholders, but the level of engagement varies across the PSCs (see Section 10). As a result a local initiative can be perceived as representing the needs of a small number of individuals who have engaged with the PSC, not those of the system.

Priorities must be based on a robust, data-driven methodology that also considers soft intelligence, and linked to an overall strategy and an understanding of existing patient safety initiatives. They must build on evidence of clinical and operational impact. This approach is likely to narrow the differences between national and local priorities, while still allowing for locally-focused delivery, and will cut the number of initiatives PSCs work on to allow them to better focus their resources.

## Local delivery and improvement plans

In 2017/18 and 2018/19, NHS Improvement asked each PSC to submit a local delivery plan (renamed a local improvement plan in 2018/19). The plans cover both national and local initiatives, including activities, expected outcomes and resource required.

This request has provided some consistency in approach across initiatives, but we found significant variation in the quality of these plans. While about a third of PSCs included clear outcomes and measures, the others struggled to articulate these and provided no clear view of what success would look like. Problems with capacity and capability may be the reason for this (see Section 6).

The 2019/20 local improvement plans must include clear, rationale and measurable outcomes for all projects, as well as milestones for assurance purposes.

# 5. Spread and adoption

Variation in the way PSCs were established in the different regions and their operation as 15 separate collaboratives have made it more difficult for PSCs to share successes and lead the spread and adoption of innovation and improvement across a wider footprint. There has been no systematic approach either to identifying programmes with the greatest impact for spread and adoption, or to spread and adoption itself.

Despite this, some PSCs have led the spread and adoption of some of their initiatives; examples are included in [the case studies](#). They have tended to lead where relationships between patient safety leads and AHSNs at a regional level have often made this possible.

PSC clusters were set up between those working on similar areas to encourage spread and adoption. However, these have not been sufficiently action-focused and their impact has been limited.

The AHSNs have begun to standardise the process of spread and adoption, which PSCs are learning from.

The introduction of patient safety lead meetings and a patient safety lead chair has increased the engagement and collaboration between the PSCs, and increased sharing is expected. The AHSN Atlas has been used to share good practice case studies, and the PSMU will be involved in developing more of these. Two national workshops have also been held on spread and adoption.

The action to date has increased sharing but there is further to go. There is an opportunity for national bodies to facilitate spread and adoption. However, as noted previously, identifying the programmes most suited to adoption and spread is challenging without more consistent and robust approaches to evaluation.

A systematic approach to spread and adoption must be adopted that:

- defines the minimum expectations for data collection and measurement on every programme, to ensure that the impact of programmes can be evaluated and compared

- ensures all PSCs apply a quality improvement methodology to their initiatives, to allow evidence to be gathered to support the effectiveness of programmes
- considers the role of national bodies in accelerating spread and adoption of good practice, building on the work currently done by NHS England. Mandating adoption has limited evidence of success and is unlikely to be the identified best approach. However, national bodies can provide overarching leadership, ensure there are forums and opportunities to collaborate, monitor performance and work with PSCs to address barriers where they arise.

# 6. Roles and responsibilities

## Role of national bodies

NHS Improvement is the main commissioner of the PSC programme. When this programme started, there was more emphasis on the national team supporting the PSCs by acting as a delivery partner, especially in providing improvement expertise. Since then there has been a gradual shift, at least in terms of perception, of NHS Improvement's role: most PSCs now view us as a commissioner they are accountable to.

We must clarify what our role is for the PSCs, to reduce the risk of misunderstanding and to make clear what central support is available to PSCs. As a commissioner, we must set clear expectations and hold PSCs accountable for delivery. The PSCs could also draw on the experience of delivering national quality improvement programmes in the national patient safety team.

The central team in NHS Improvement holds the PSCs to account through a quarterly return and regular oversight meetings. Recently, these meetings have been joint with NHS England, OLS and the co-commissioners of the AHSNs, improving joint working between national bodies. The integration work between NHS Improvement and NHS England is an opportunity to make oversight even more joined up in future.

The commissioners should work together to translate the national strategy into clear priorities for the PSCs. Improving the system for oversight and management of the PSCs, including setting expected outcomes and building on the system for oversight and performance management, should help increase the pace of change.



# 7. Delivery model and governance

## Expected variation

Consistent with the way they were set up, the PSCs operate as 15 separate organisations. They have developed infrastructure, resources and a 'space' to bring together people involved in patient safety improvement, tailored to meet local needs and culture. They often have a strong local identity.

This potential for variation was built into the programme design from the outset, and a wide range of delivery models, governance structures and priority areas are seen across the 15 PSCs. PSCs are carrying out many initiatives with little standardisation in terms of scope and approach to delivery, even for similar initiatives. While it is generally understood that there will be a degree of variability across initiatives in terms of how they are being delivered, some standardisation of scope and approach among similar initiatives would improve measurement and economies of scale, and aid spread and adoption. As such, guidance setting out a standard approach to priority setting, scoping, expected outcomes, measurement of impact, and the approach to engagement and collaboration would be beneficial.

## Examples of good practice

Delivery model approaches across the PSCs that have had a positive impact include:

- Application of a consistent quality improvement methodology across all programmes. The consistency rather than the specific methodology appears to be what has a significant impact on the success of the delivery model.
- About 50% of PSCs have a delivery model that is firmly embedded in the AHSNs. This approach has been successful where the AHSN recognises patient safety as a priority and gives it at least equal weighting with its other workstreams. In these cases, the ability of the PSC to access AHSN skills and networks was a real benefit.

- For PSCs that are more removed from the AHSNs, making it more difficult for them to access capacity, capability and networks because of their small size, the delivery model needs to use the strong existing local and regional networks to be successful.

There is further scope for PSCs to benefit from economies of scale, especially as they often work on similar initiatives. For this, the following need to be identified: where PSCs should be collaborating, where resources sit nationally and how all PSCs can access them, as well as what initiatives need to be scaled up. For example, several PSCs commission human factors experts in their work; others have limited access to this skill set. If experts worked across several PSCs, access to more specialist skill sets could be increased. Currently if a PSC needs extra skills, it tends to commission these independently or source them from AHSNs. We found only a few examples of PSCs looking for opportunities to share resources.

Cultural changes such as greater collaboration take time. National bodies should be encouraging the sharing of resources across PSCs, perhaps through assurance meetings and workstream meetings at which opportunities for collaboration and to share resources across similar initiatives, respectively, could be identified.

## Relationship with AHSNs

The AHSNs across the country were selected to host the programme because they work across organisations and connect NHS bodies to academic organisations and industry, to facilitate change across whole local health and social care economies.

PSCs are embedded in their host AHSNs to a varying degree. Those that are deeply embedded may be benefitting from interdependencies with specialist workstreams – for example, technology, innovation and quality improvement – as well as operational support. Some report benefitting from an AHSN's positioning in the local health and care system, including by using its network. AHSN boards give some PSCs strategic direction, and where an AHSN board is made up of executive leadership from partner organisations, the PSCs can also access system leadership and direction. PSCs see most AHSNs as neutral, with no alliance to a single provider or any regulatory role. A few AHSNs have provided extra funding to boost a PSC's resources.

AHSNs are not formal NHS bodies. We found that PSCs could face fewer challenges if they were hosted by an NHS organisation. The most frequently cited challenges include:

- accessing data from NHS stakeholders
- competing incentives because AHSNs and PSCs have different commissioners and specifications
- employment challenges (recruitment and retention), particularly from the need to offer fixed-term, non-NHS contracts because of uncertainty about funding.

Stakeholders expressed a range of views about where PSCs should be hosted, but many providers also said hosting arrangements were a low priority. As highlighted above, hosting by AHSNs has advantages and disadvantages.

While NHS Improvement and NHS England regional structures are in flux, moving the PSCs out of the AHSNs would likely undermine the progress made and momentum generated to date. However, once these structures are more certain, the PSC operating model should be reviewed. National and regional improvement structures need to complement each other if collectively they are to deliver the patient safety agenda.

In the short term, PSCs should work more closely with regional NHS Improvement and NHS England teams to ensure that regional quality improvement work is joined up. AHSNs must ensure their PSCs establish effective working relationships with the new NHS regional structures, to allow them to identify duplicated work and remove this, and to find economies of scale by working collaboratively.

## Oversight

NHS Improvement oversees the PSC programme, while NHS England and OLS jointly oversee the AHSNs. The different accountabilities work well for the most part, but do mean duplication in the reporting and oversight for most PSCs and AHSNs. Joint assurance meetings between the three commissioners have improved alignment (see Section 4), and they should continue to work closely together to ensure oversight is aligned and proportionate.

# 8. Capacity and capability

## Capacity to deliver

As PSC governance structures vary, their team make ups are not the same. However, each PSC has a patient safety lead who is responsible for driving the collaborative's activity. To support the delivery of their projects, PSCs employ a small number of staff, draw on resource from their AHSNs (typically administrative, communication and financial support) and/or buy-in extra resource where necessary. A few also draw on other organisations for specialist support with quality improvement, human factors or technology – for example, PSCs in North West Coast use the skills of the Advancing Quality Alliance.

The small size of each of the 15 PSCs means their work is often constrained by a lack of capacity. The following would help alleviate this in the future operating models of the PSCs:

- fewer programmes from more prioritisation and focus on those most closely aligned to national priorities; current initiatives that can be stopped will need to be identified
- clarity around whether PSCs have a role in carrying out genuine improvement activities as well as enabling activities (eg training).

PSCs do give high-level resourcing estimates against projects in their local delivery plans, but these estimates should be better, and project prioritisation based more closely on the strategic importance of each, local need, available data, expected benefits and resource availability.

## Skills and experience

PSCs have a wide range of skills and experience, including project management, quality improvement and direct clinical experience. However, skill sets across the 15 PSCs are not always consistent and there is a perception all do not have the required skill set to effectively carry out their work, particularly the skills to apply quality improvement methodology, patient safety expertise and skills around data and measurement. All PSCs should have the same understanding of the core skills

they should embed, and what extra skills they could share or access from other organisations.

As mentioned in Section 7, the funding uncertainty has made recruitment to many PSC roles difficult, exacerbating any shortage of capacity and capability. Advertised PSC jobs are often on very short-term contracts.

As PSC delivery teams are small and often work discreetly within the wider AHSN structure, delivery of projects and initiatives can depend on a few individuals. Turnover risks loss of continuity and organisational memory.

As a wealth of specialist skills sits across the 15 PSCs and centrally in the national bodies, PSCs should tap into these where they need to fill skills gaps. For example, the PSMU is a central resource that supports the measurement of improvement: it can help with, for example, data collection and analysis. However, only a few PSCs are making use of the skills of the PSMU in the design and delivery of their programmes; the number accessing the central programme team's quality improvement skills and expertise is also small.

To ensure PSCs use the skills available to them across the country, the national team should better define what skills are needed to run effective improvement collaboratives, identify where these skills are located and tell the PSCs how they can access them. PSCs should consider their skill mix and address any gaps through recruitment, training or accessing skills from across the system.

# 9. Visual identity

## PSC profile

Feedback from providers, commissioners and patient groups suggests the PSC brand has a relatively low profile in many areas of the country. Providers recognise other improvement 'brands' such as Virginia Mason ahead of the PSC programme.

Several factors have contributed to this:

- PSCs had individual local visual identities from the start of the programme; this has weakened the national identity. PSCs are often not recognised as a national programme.
- The longer established improvement networks or AHSNs are well recognised in some regions. For example, the Improvement Academy brand has strong identity in Yorkshire and Humber, and PSC work is seen as part of that brand.
- PSCs often work with frontline staff, but organisation-wide recognition of this work or recognition by board members is not high.

We introduced a national visual identity in 2017/18 and this, jointly with AHSN branding, is now used more widely and consistently. But further work is required to raise the profile of the overall PSC programme.

While high brand recognition is not essential to effective improvement work, a strong national visual identity for the PSCs would support the spread and adoption of good practice by:

- making PSCs and their initiatives recognisable as part of a national programme formed as a partnership between NHS Improvement and the AHSN network
- creating awareness – by word of mouth and using case studies – among providers, commissioners and patient groups, which would lead to demand for PSC services
- acknowledging the impact the PSCs have had at a regional and national level.

The national brand must be fully and consistently adopted by all PSCs to promote recognition, with commitment to a shared model to strengthen communications. Joint communication strategies with NHS Improvement and NHS England regional teams should be used to raise awareness of the PSCs' offer.

## Emergency Care Intensive Support Team: a visible national brand

ECIST is a clinically-led and designed national NHS improvement team that helps health and care systems to deliver safe and effective urgent and emergency care. Its offer includes intensive support from improvement experts; national and regional conferences and workshops; help to use a range of expert tools; and consultancy where lighter-touch help is appropriate.

Since it was set up in 2009, ECIST has become well-established and its brand is well recognised as part of the NHS 'family'. This has been achieved with:

- a clear offer with on-site support and use of a collaborative consultancy approach
- clarity on governance and how ECIST works and communicates with regional teams
- senior, credible, personable team members including clinicians
- an approach to measuring impact across a range of areas; this includes the Kirkpatrick model for training
- clear and useable resources on the central (NHS Improvement) website, such as case studies and rapid improvement guides.
- a strong social media presence.

# 10. Engagement

## Stakeholder engagement

Since Q3 2017/18 PSCs have rated their level of engagement with clinical, leadership and managerial stakeholders across a range of organisations in their quarterly returns to the PSMU. It is too soon to know if this level is changing.

The PSC self-assessment shows that on average engagement is greatest with acute providers and lowest with social care. These findings mirror those from our own surveys of stakeholders.

While the Berwick review recommended that “every NHS organisation should participate in one or more collaborative improvement networks”, some providers are not currently participating in PSC-led initiatives. Competing operational, financial and staffing pressures were frequently given as reasons for non-participation, coupled with changing provider and PSC leadership affecting relationships. While we do not believe the answer is to mandate involvement, we should highlight where PSC initiatives align with provider priorities and encourage participation from providers.

The most established PSCs can provide evidence of their engagement with all providers and commissioners in their region, and that each of these has been involved in at least one PSC initiative. However, even in these regions, PSC recognition at provider and commissioner board level is uneven. This may be due in part to the profile of PSCs (see Section 9) and in part to their work often being with staff at an operational level. Staff turnover can also weaken recognition.

The most successful PSCs have built a strong network of engaged individuals using a range of engagement techniques, including formal meetings, events, publications and newsletters. They have not mandated engagement, but engage regularly with stakeholders to ensure that the programmes they are offering address the needs of the system, respond to feedback from previous programmes and have a strong evidence base. This allows participants to complete the business cases their organisations require to implement initiatives.



PSCs without a strong network to build on should focus their capacity on fewer engaged organisations where measurable impact can be made. This will encourage word-of-mouth spread and generate case studies to help further spread.

## Stakeholder feedback

PSC functions most valued by providers, commissioners and stakeholders:

- the opportunity to network with peers across the region
- access to experts in patient safety
- sharing good practice, with the opportunity to learn from the experience of others and showcase the work taking place in their organisation
- the opportunity to identify and test innovations.

Challenges identified:

- sharing data between organisations – the impact of some initiatives is limited by not being able to benchmark with peers
- workstreams and initiatives sometimes withdrawn without notice; the overall plan for the programme is not always clear
- senior engagement – organisations with significant operational and financial pressures do not always prioritise quality improvement. Without buy-in at board level, it can be difficult for organisations to free up the necessary time and to remain engaged in initiatives.

## Patient and public involvement

The Berwick review recommended that “patients and their carers should be present, powerful and involved at all levels of healthcare organisations from wards to the boards of trusts”.

Most PSCs ensure that patients and the public are engaged in their programmes, especially during the design stage. Most AHSNs have structures for engaging patients and the public, and PSCs can benefit from these. However, some PSCs need to strengthen their engagement with patients and the public.

## The patient voice should be heard and heeded at all times

“Patient involvement means more than simply engaging people in a discussion about services ... Evidence shows that patient safety improves when patients are more involved in their care and have more control. Patient involvement is crucial to the delivery of appropriate, meaningful and safe healthcare and is essential at every stage of the care cycle ...

The goal is not for patients and carers to be the passive recipients of increased engagement, but rather to achieve a pervasive culture that welcomes authentic patient partnership – in their own care and in the processes of designing and delivering care. This should include participation in decision-making, goal-setting, care design, quality improvement, and the measuring and monitoring of patient safety. Patients and their carers should be involved in specific actions to improve the safety of the healthcare system and help the NHS to move from asking, “What’s the matter?” to, “What matters to you?” This will require the system to learn and practice partnering with patients, and to help patients acquire the skills to do so.” (Berwick (2013) *A promise to learn – a commitment to act*)

## Approaches to engagement

Commonly adopted approaches include:

- establishing a provider forum with representatives from providers across the region
- using existing forums, including those held by the AHSN and in some regions, by STPs.

The depth, breadth and frequency of engagement tends to vary by region. A few PSCs only engage with stakeholders when setting their priorities, but most use periodic provider challenge on delivery to continue to develop their approach. All PSCs convene groups or networks on specific subjects: two to over ten established per PSC. These subjects tend to link to a PSC’s priorities.

All the PSCs have had some success in building relationships across their systems. The most successful tend to be based in regions with more established infrastructure, including networks of providers and patients with an interest in patient safety and other improvement activity. They have been able to build the networks needed for greater engagement. For PSCs where engagement is lower, either these networks do not exist or if they do, PSCs have not capitalised on them.

PSCs must now capitalise on the relationships they have built and their engagement to roll out patient safety initiatives and facilitate measurable improvements. Wherever possible, PSCs should use existing regional networks, including those established by STPs and the regional NHS Improvement and NHS England teams, to maximise the engagement possible with current capacity.

## Good practice in patient and public involvement

The following good practices could be more widely adopted by PSCs:

- having a clear purpose for engaging patients and the public, rather than doing so because it is seen as the right thing to do
- developing a clear role for the patient or public representative(s) to ensure they contribute directly to the development of the initiative
- using individuals with specific experience/interest in particular initiatives, as well as a patient or public representative with a broader role across the remit of the PSC
- using patient and public representatives to access wider networks to broaden the represented viewpoint
- evaluating the impact of patient and public involvement to refine the approach for future programmes.

# 11. Quality improvement, measurement and use of data

## Use of data in setting priorities

PSC priorities are primarily developed through stakeholder engagement, rather than a consistent, data-driven approach based on analysis of the causes of harm in the system. While this approach ensures stakeholders are engaged with a PSC's work, it increases the variation in priorities across the PSCs, and contributes to the perceived tension between local and national focus.

## Measurement for quality improvement

Measurement skills are fundamental in applying quality improvement methodology. The right measures must be selected if evidence is to be gathered of impact in operational settings.

Some programmes have been established with a robust approach to measurement from the outset, but PSCs do not do this consistently. In particular, the measure in capability building programmes is the number of individuals who have received training, not the impact of training on patient safety in the system. Without such impact measures, PSCs cannot evaluate and iterate an intervention to gather evidence of its impact.

Demonstrating the impact of programmes where measurement is not embedded from the outset has proved difficult. This has hindered adoption and spread because it is not possible to identify the programmes that merit this.

Challenges facing the PSCs in measuring the impact of programmes include: access to data, the quality of data available, attribution of impact to PSC programmes, and shortage of analytical skills within PSCs.

## Measurement capability

Because of variation in the way each PSC was set up and in their degree of integration with wider AHSN functions, measurement skill sets vary between PSCs. The ability to build meaningful measures into programmes from the outset and to analyse data to assess impact is a core quality improvement capability and should be available in each of the PSCs.

The PSMU intends to develop a capability development plan for all PSCs based on a needs assessment. This will be essential to ensuring the effective use of data by building the necessary skills.

## Patient Safety Measurement Unit

The PSMU was established in 2017 to support NHS Improvement's patient safety improvement programmes, including the PSC programme. It is a central resource the system can draw on to help address problems with using existing patient safety measures, their presentation and understanding to support improvement. Its focus is impact at a PSC and a national level, not individual local programmes. NHS Improvement also commissions the PMSU to improve measurement capability across the PSCs.

PSCs have positively received the PMSU as a source of skills and capacity to collect and analyse data to measure improvement in patient safety. However, all have yet to consistently use it. The PSMU can support PSCs with the design of their initiatives, embedding measurement from the outset.

Where a PSC does not have these skills, it must use the PSMU in the design of initiatives, to ensure robust methodology and that the impact of the initiative can be assessed. Minimum expectations for data collection and measurement on every programme should be defined, to ensure that the impact of programmes can be evaluated and compared.

The PSMU's introduction of a quarterly national return from Q3 2017/18, completed by the PSCs, is giving greater understanding of the overall impact of the PSCs on a more consistent national basis. However, PSCs find national returns complex to complete and the metrics included do not necessarily demonstrate impact. This approach is still being developed to provide a meaningful national dataset.

The PSMU also offers all PSCs training in and support for measurement for improvement, but uptake across the PSCs has been limited because of a lack of awareness of this central support function.

## Access to data

Access to data has been a challenge for PSCs and AHSNs in general. The PMSU identified that PSCs often do not have timely access to data and in some cases, there are cost implications for PSCs. The PMSU has committed to supporting PSCs to access key data sources.

### Measurement for improvement

Measurement and data gathering are central to any quality improvement methodology, to assess the impact of initiatives. The IHI recommends three sets of measures for all improvement projects:

- 1. Outcome measures:** these measure the impact of quality improvement work on service users.
- 2. Process measures:** these measure whether the project is functioning and on track to deliver as expected
- 3. Balancing measures:** these are the unintended 'side effects' of a change.

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Contact us:

**NHS Improvement**

Wellington House  
133-155 Waterloo Road  
London  
SE1 8UG

**0300 123 2257**

**[enquiries@improvement.nhs.uk](mailto:enquiries@improvement.nhs.uk)**

**[improvement.nhs.uk](http://improvement.nhs.uk)**

**Follow us on Twitter [@NHSImprovement](https://twitter.com/NHSImprovement)**

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