# Patient Safety Webinar Quarter 1 2022/23

18 August 2022
Zoom 85817843345 pass 12345

# 19 August 2022 Patient Safety Webinar 13.00 – 14.30hrs

Welcome. Thank you for joining us today.

We are just setting up. Please do mute yourselves while joining or during presentations. (We may mute you on entry – this is not an audio fault and you can of course unmute yourself any time).

Do introduce yourself in the Chat Box by full name and organisation and please make use of it throughout for Q&A.

Any issues please message ‘Stuart Duncan’ in the Chat Box and we will try to assist.

# Agenda

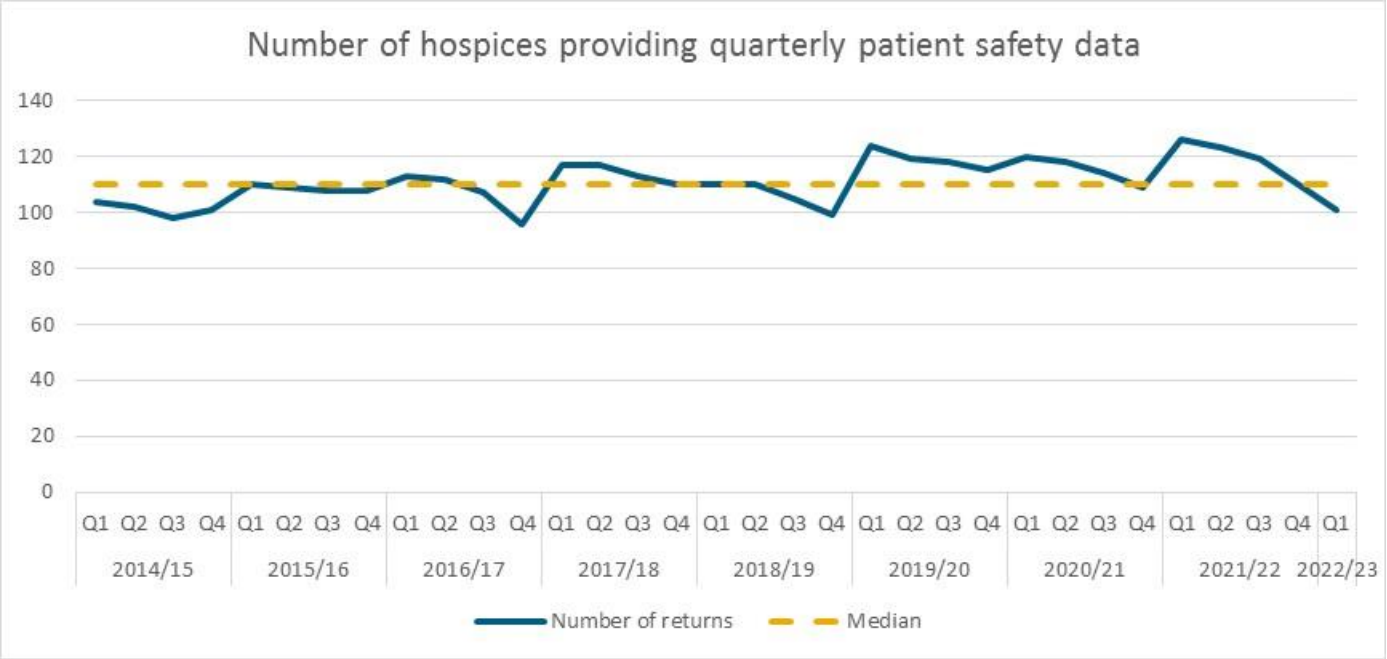
Welcome and Introductions

**Julia Russell and Stuart Duncan,** Hospice UK
Review of Quarter 1 data

**Lauren Mosley** Head of Patient Safety Implementation, NHS England

*We would like to thank you for your input, which has made this agenda possible.*

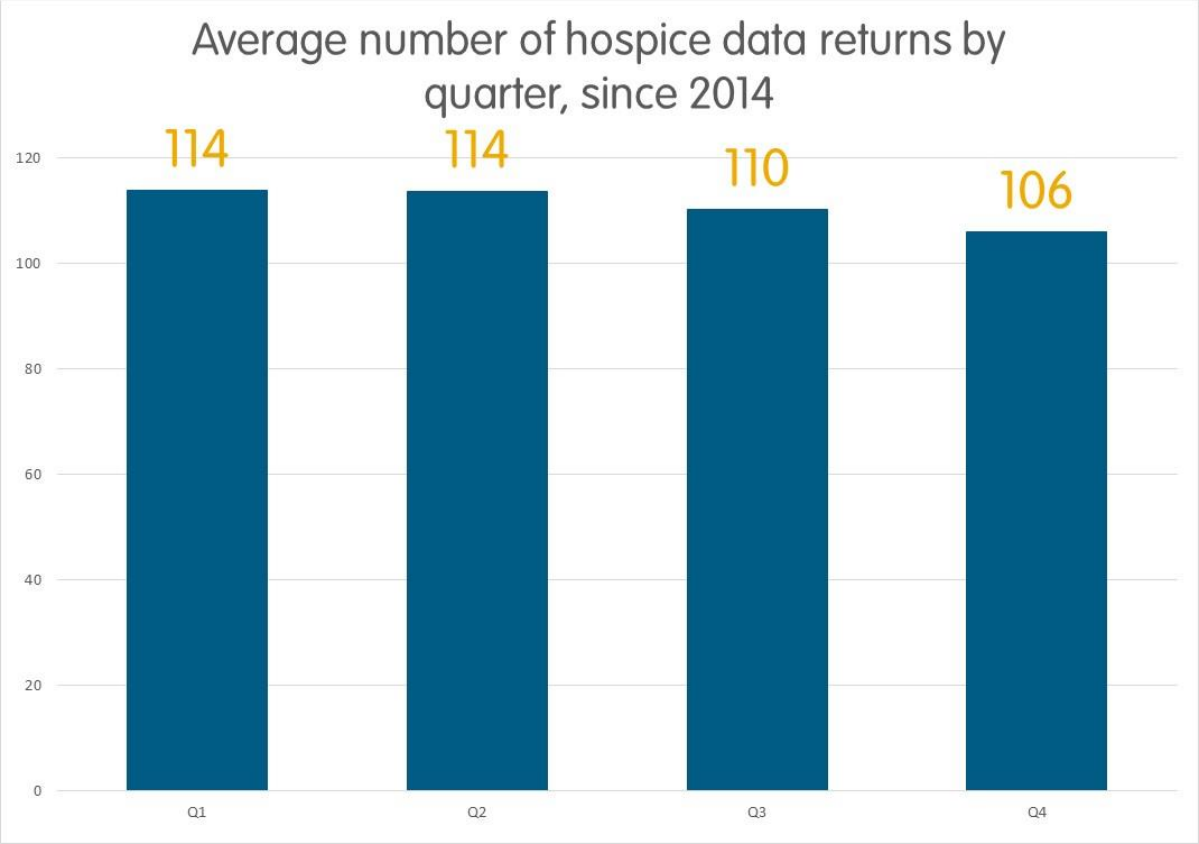
# Data Submissions: Years and Quarters




From the beginning!



Note:
2018/19 full denominators
2019/20 revised defn tissue viability




On average, a shortfall of eight hospices.

# Adult falls:
## Categories & proportions

**Five categories**

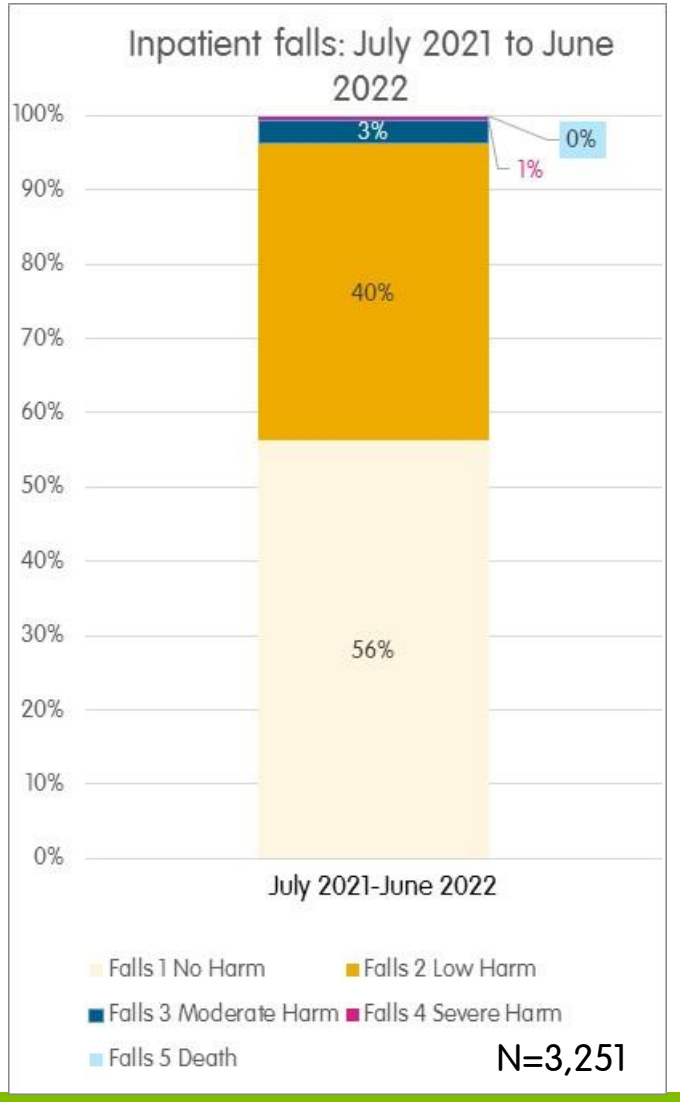
**Most recent four quarters**

- 56% no harm
- 44% harm (4% low harm)
- 2 falls at the highest level

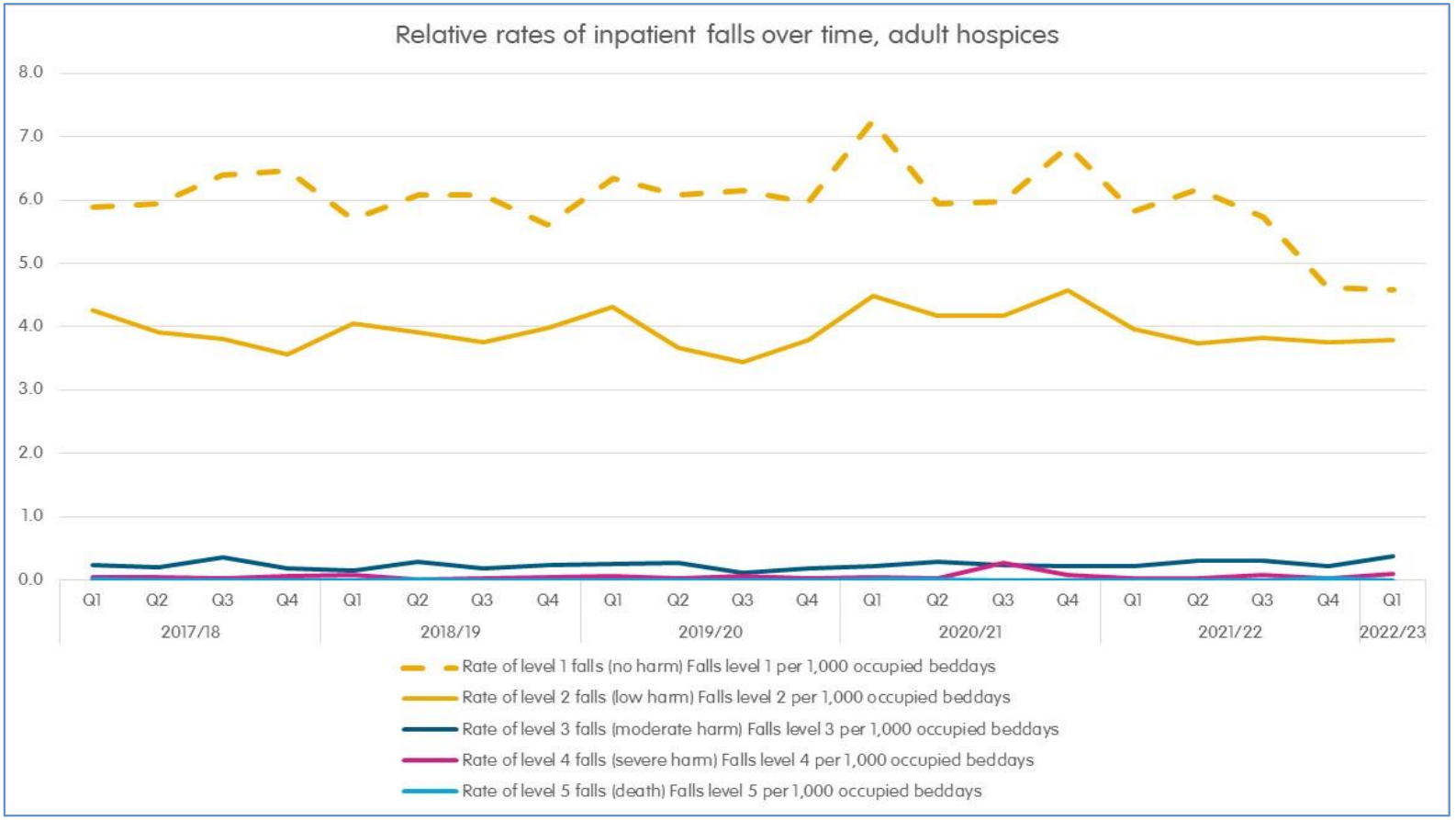
**Total opportunity in this period**

- 346,551 occupied bed-days

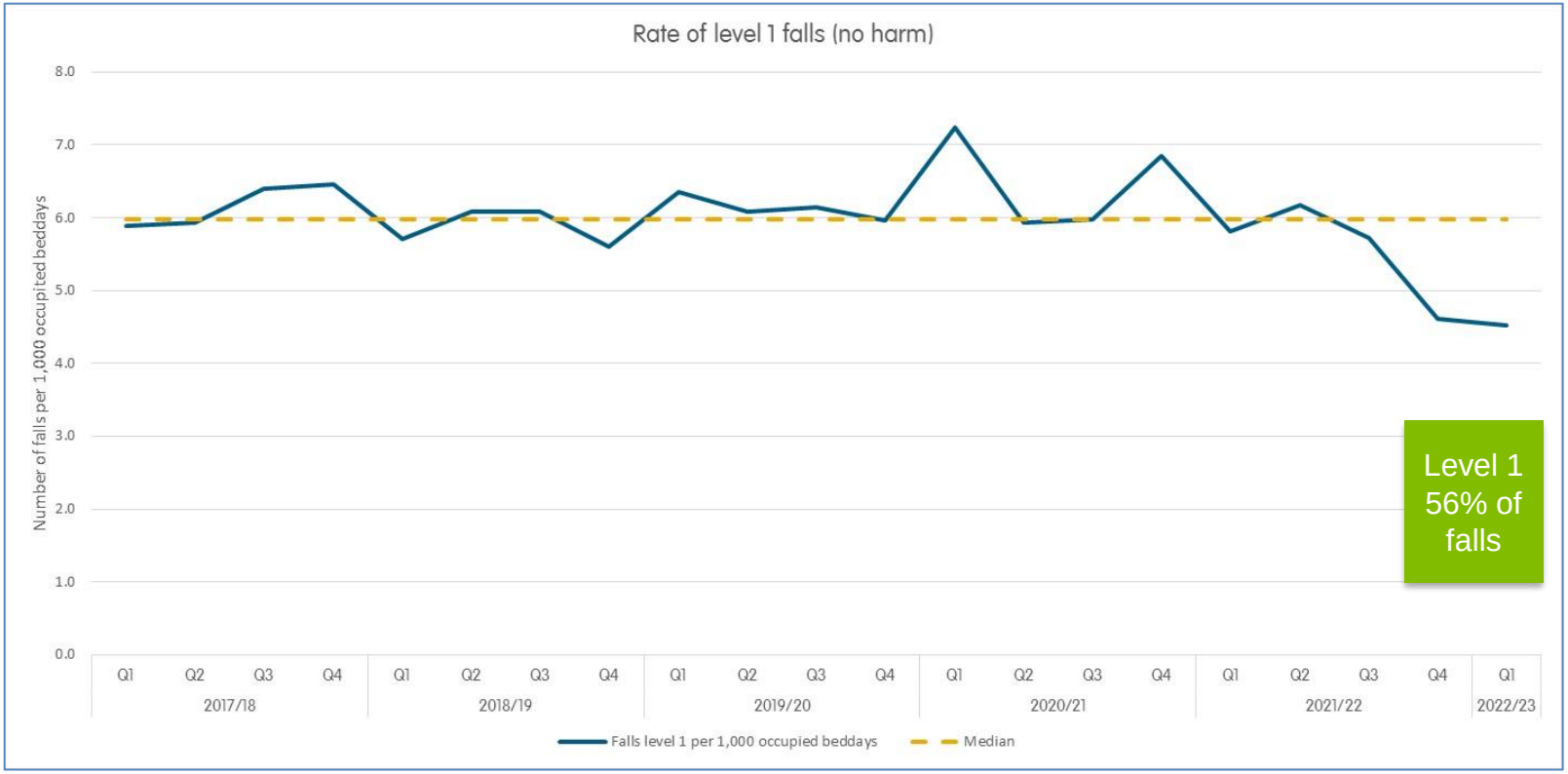
## Proportions most recent 12 months



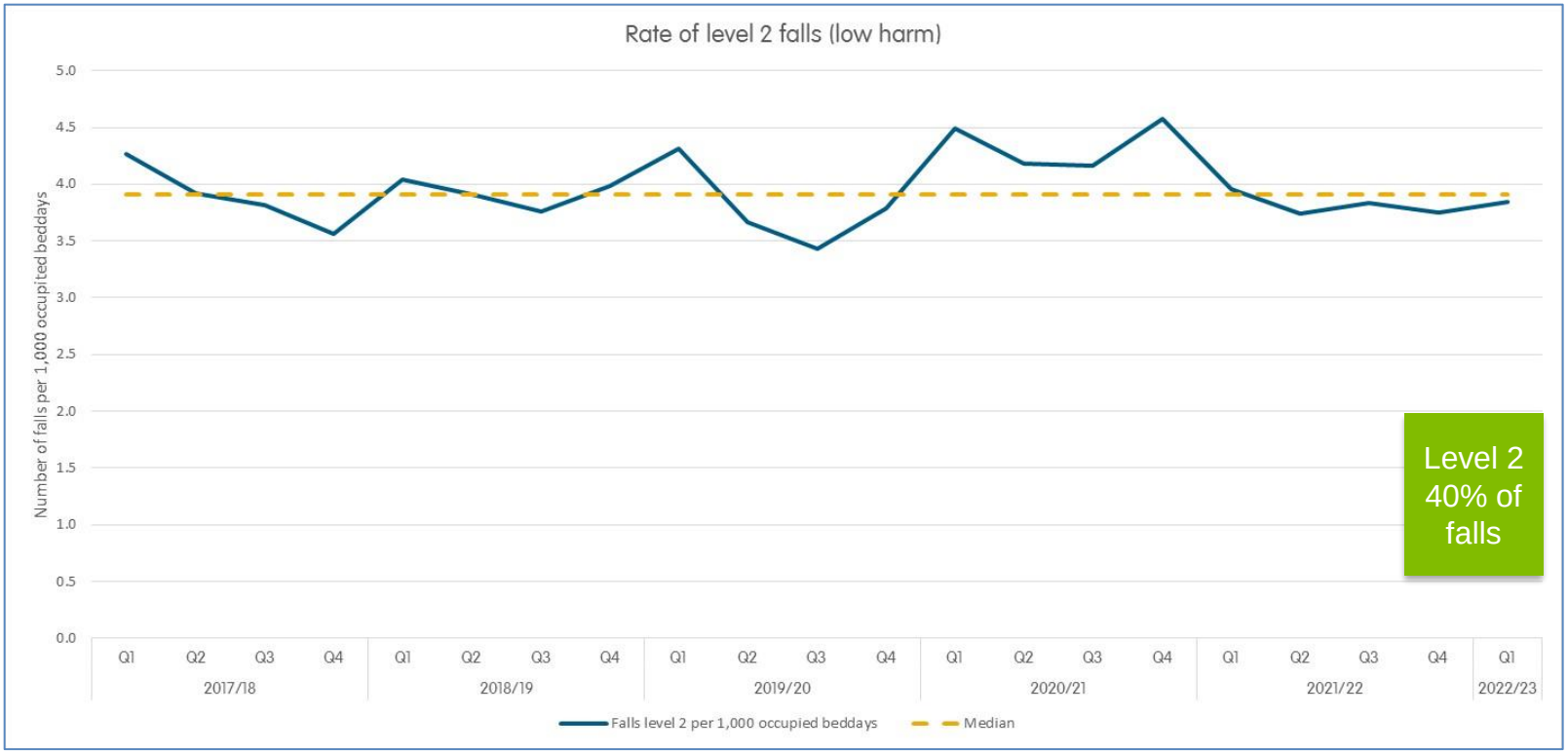
# Relative rates by level, inpatient falls



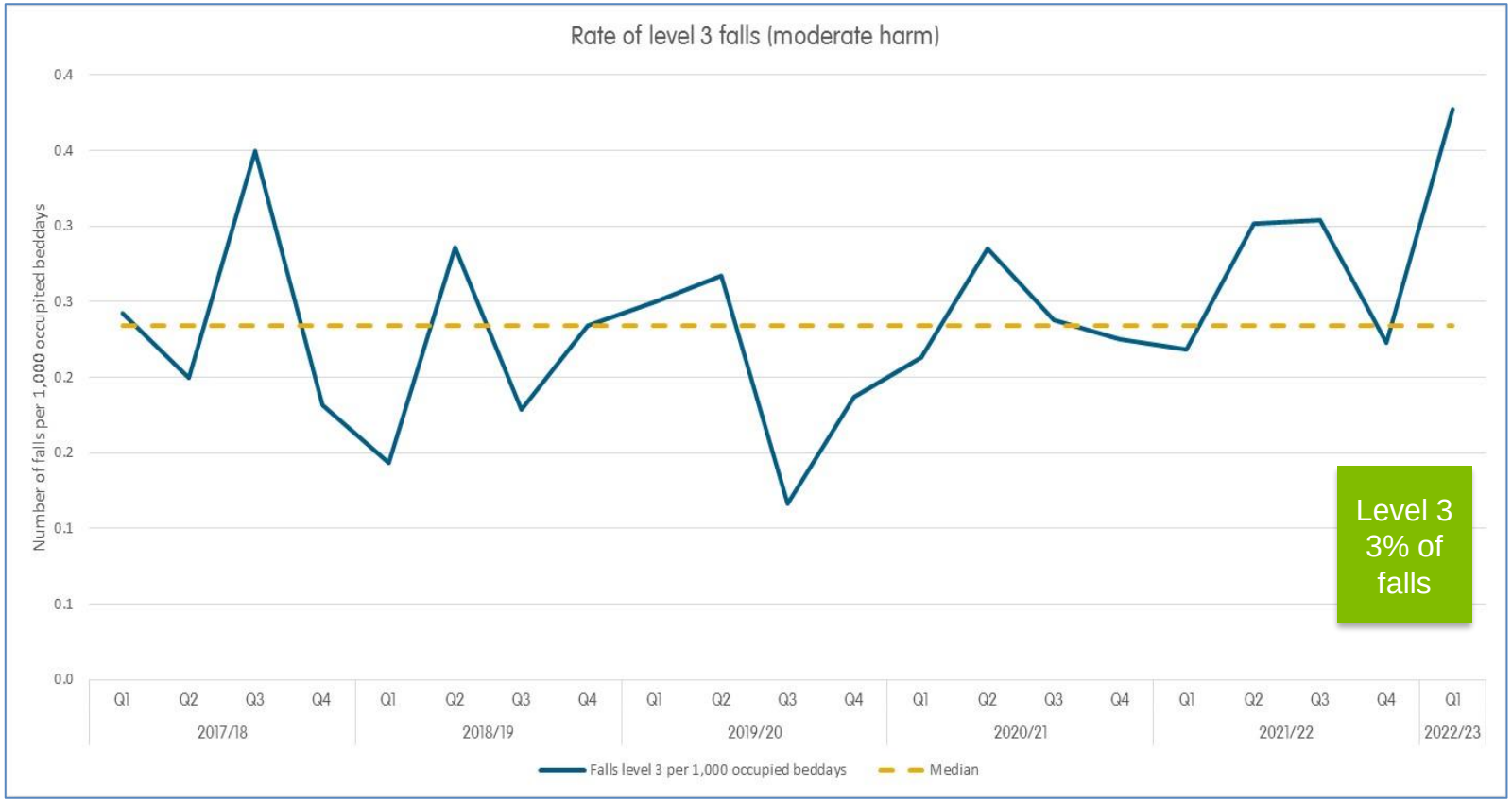
# Level 1 falls over time: adult inpatient hospice



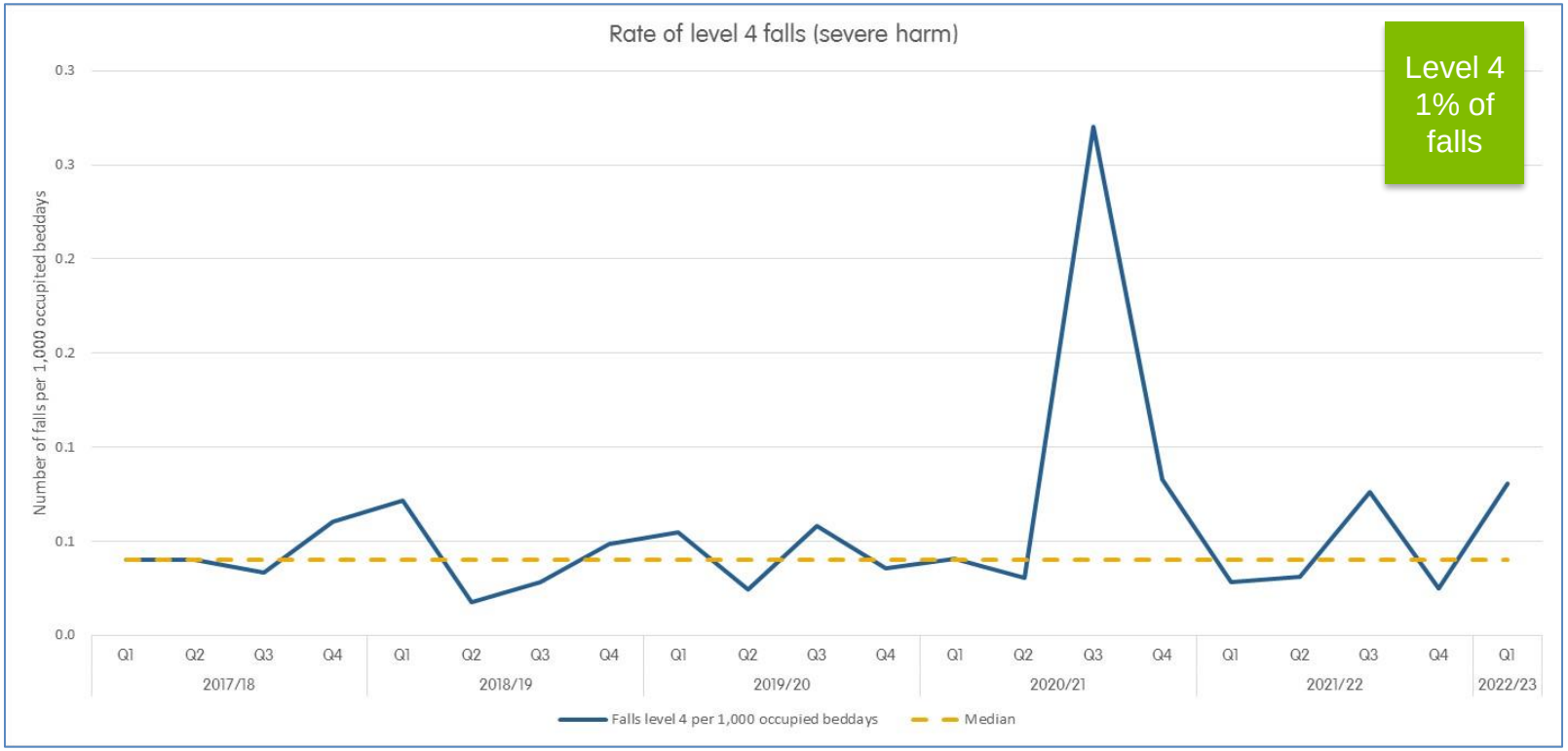
# Level 2 falls (low harm) over time: adult inpatient hospices



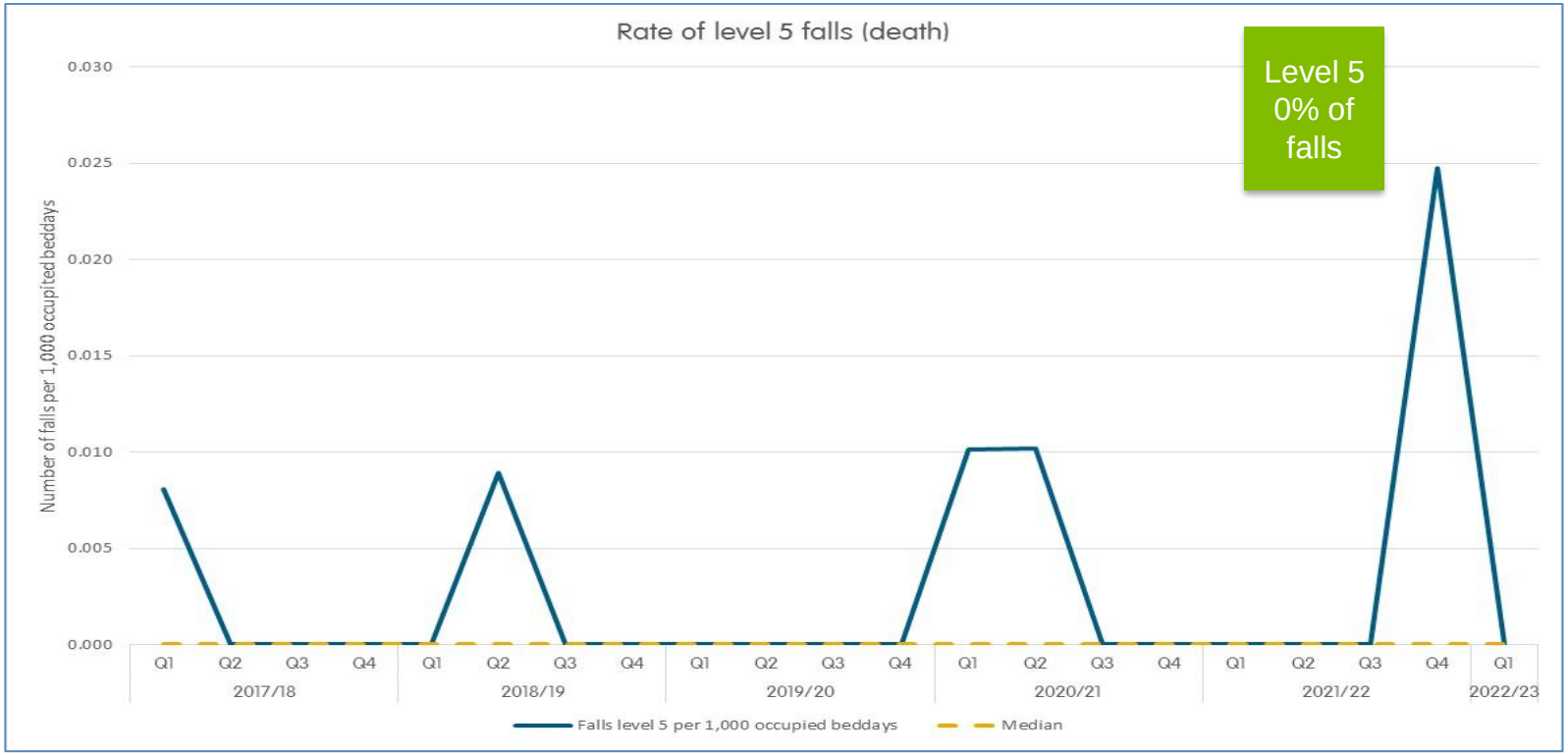
# Rate of level 3 falls (moderate harm)



# Rate of level 4 falls over time, adult hospices



# Rate of level 5 falls (death) over time: adult hospices



# Children falls:
## Categories & proportions

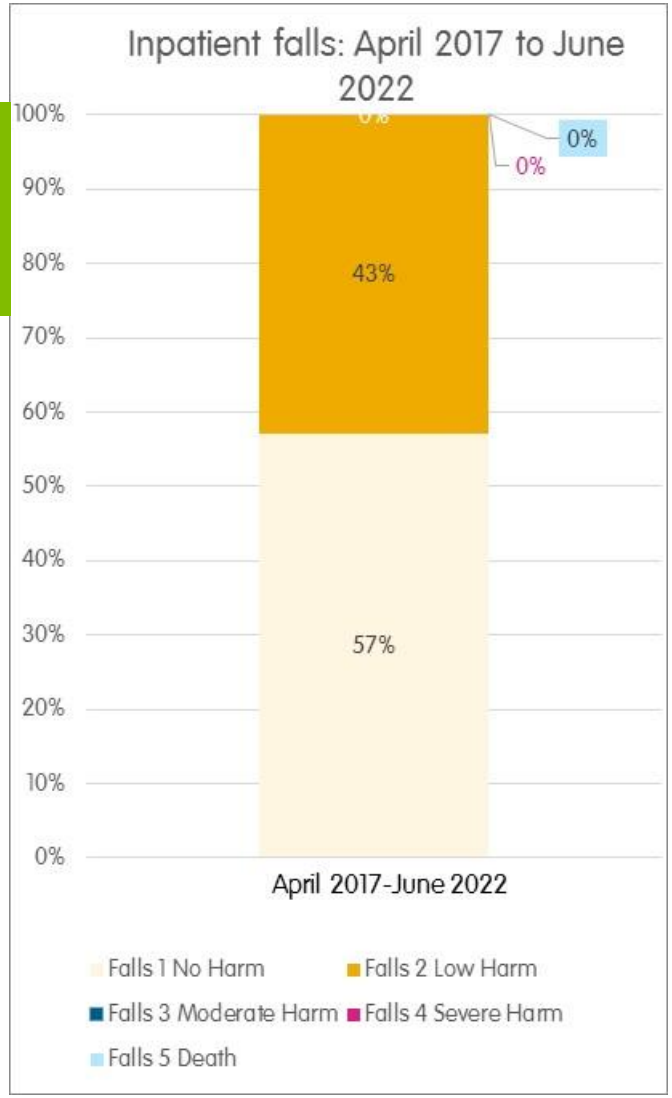
**Five categories**

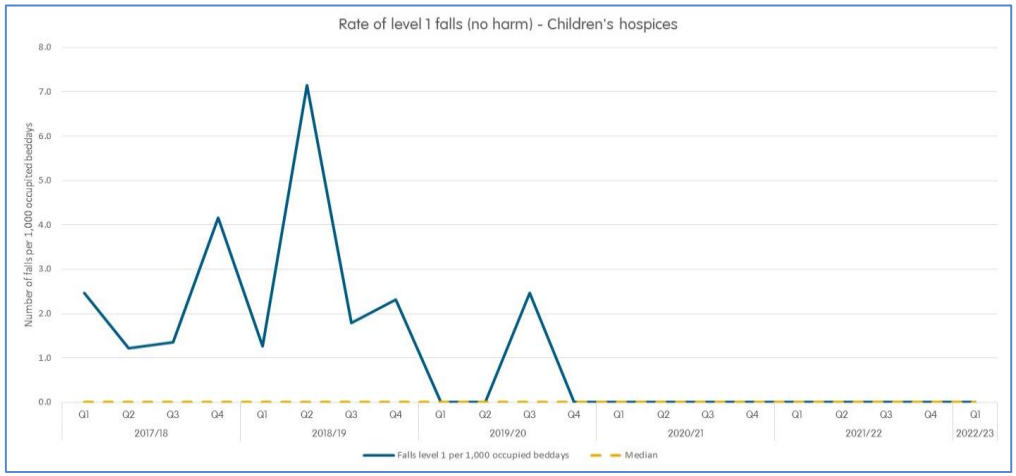
- 57% no harm (1)
- 43% low harm (2)
- 0 falls at the higher levels of harm

**Total opportunity in this period**

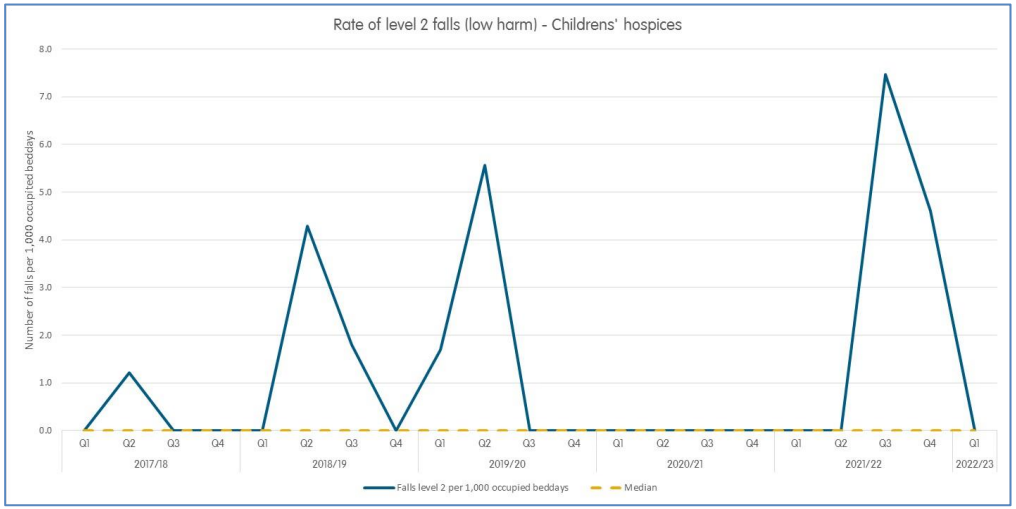
- 10,026 occupied bed-days

## Proportions 5 years 1 quarter



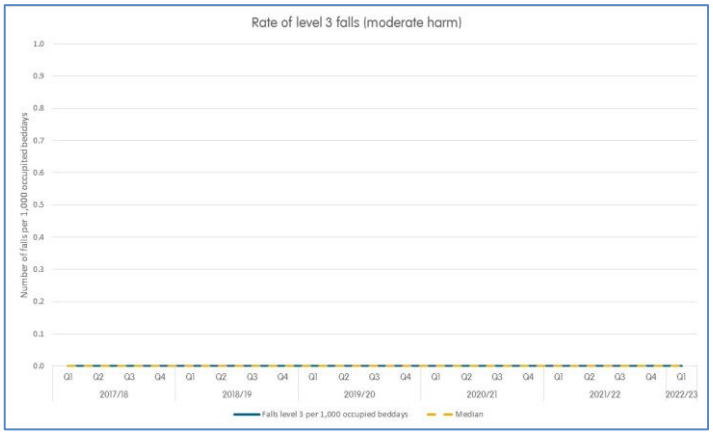


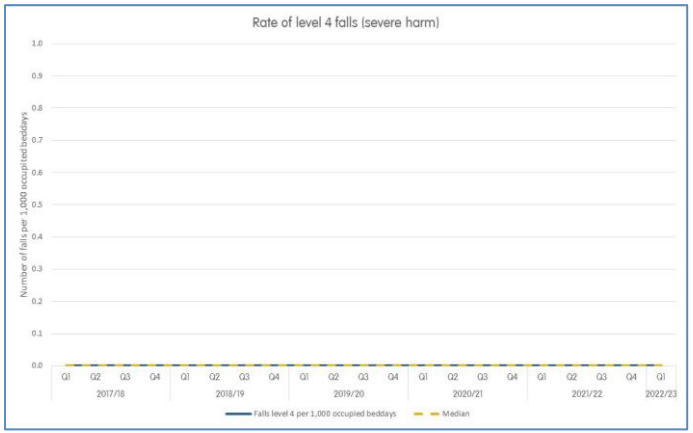

Level 1
57% of falls

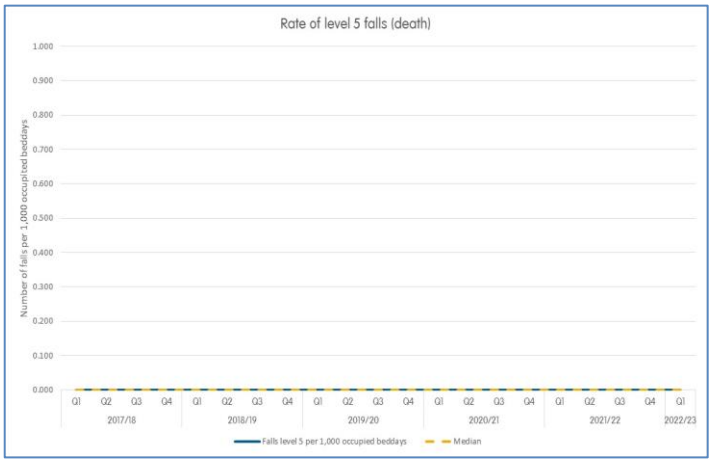



Level 2
43% of falls

# Rates of falls in children's hospices




Levels 3 to 5
0% of falls


hospiceUK
Medication

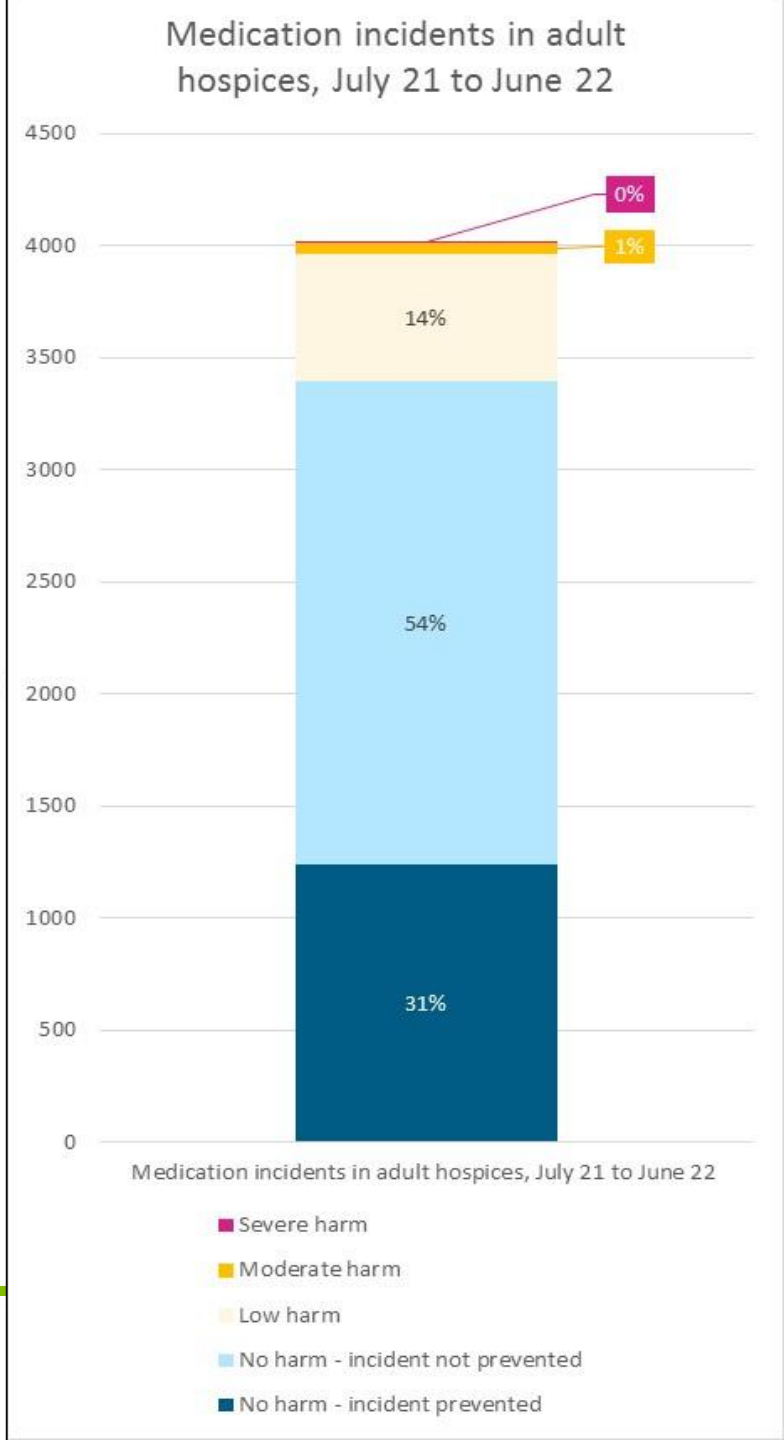
# Adult's hospices - medication incidents

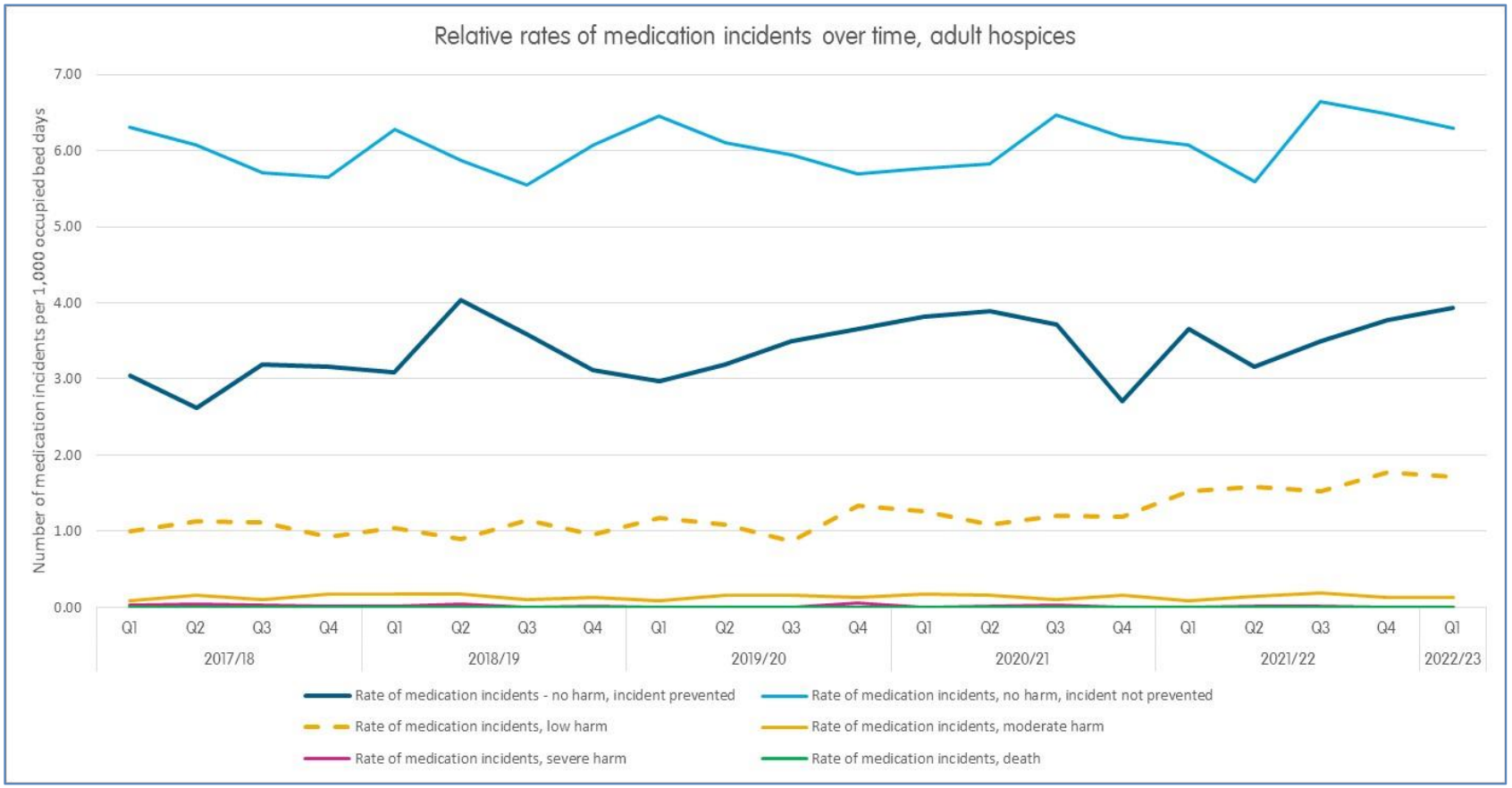
## Five categories
## Most recent four quarters

- 85% no harm
- 15% harm (14% low harm)
- 0 resulting in death

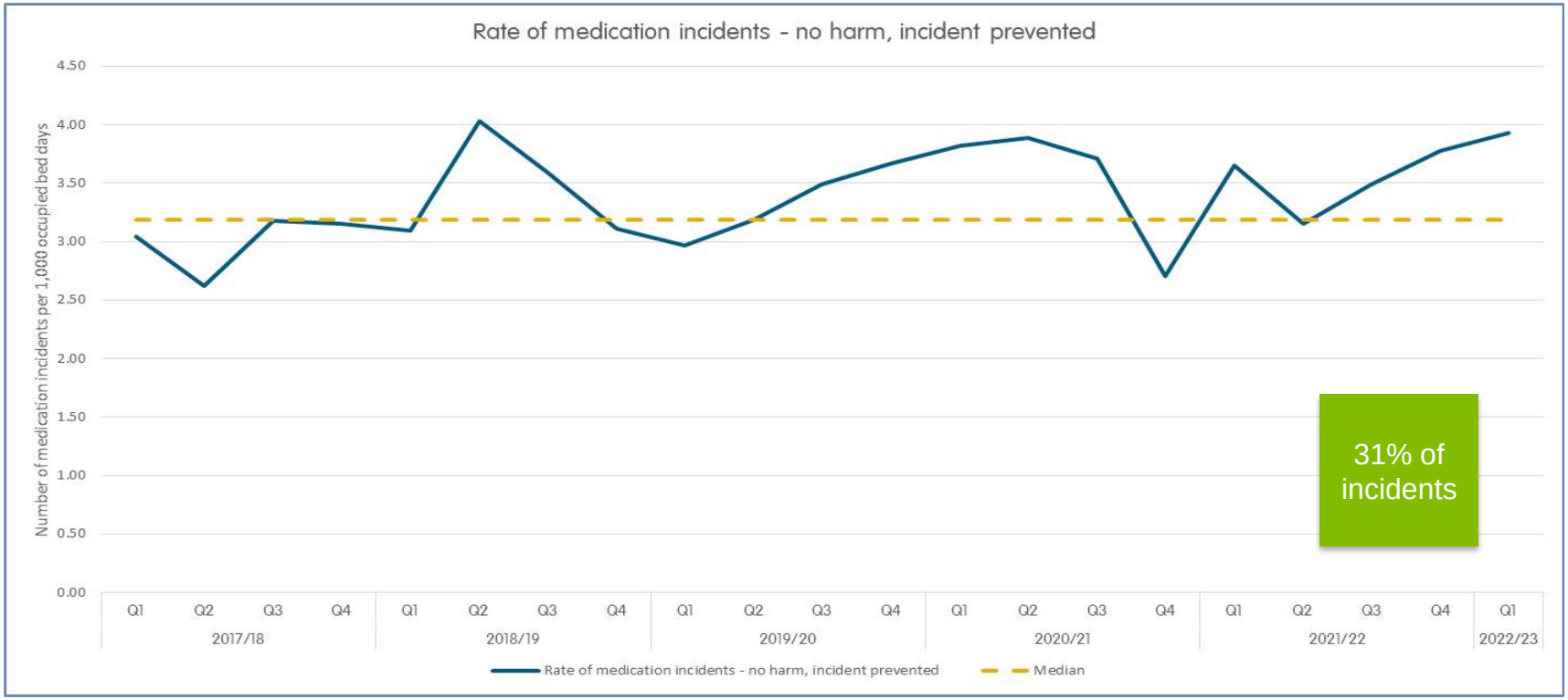
## Total opportunity in this period

- 346,551 occupied bed days

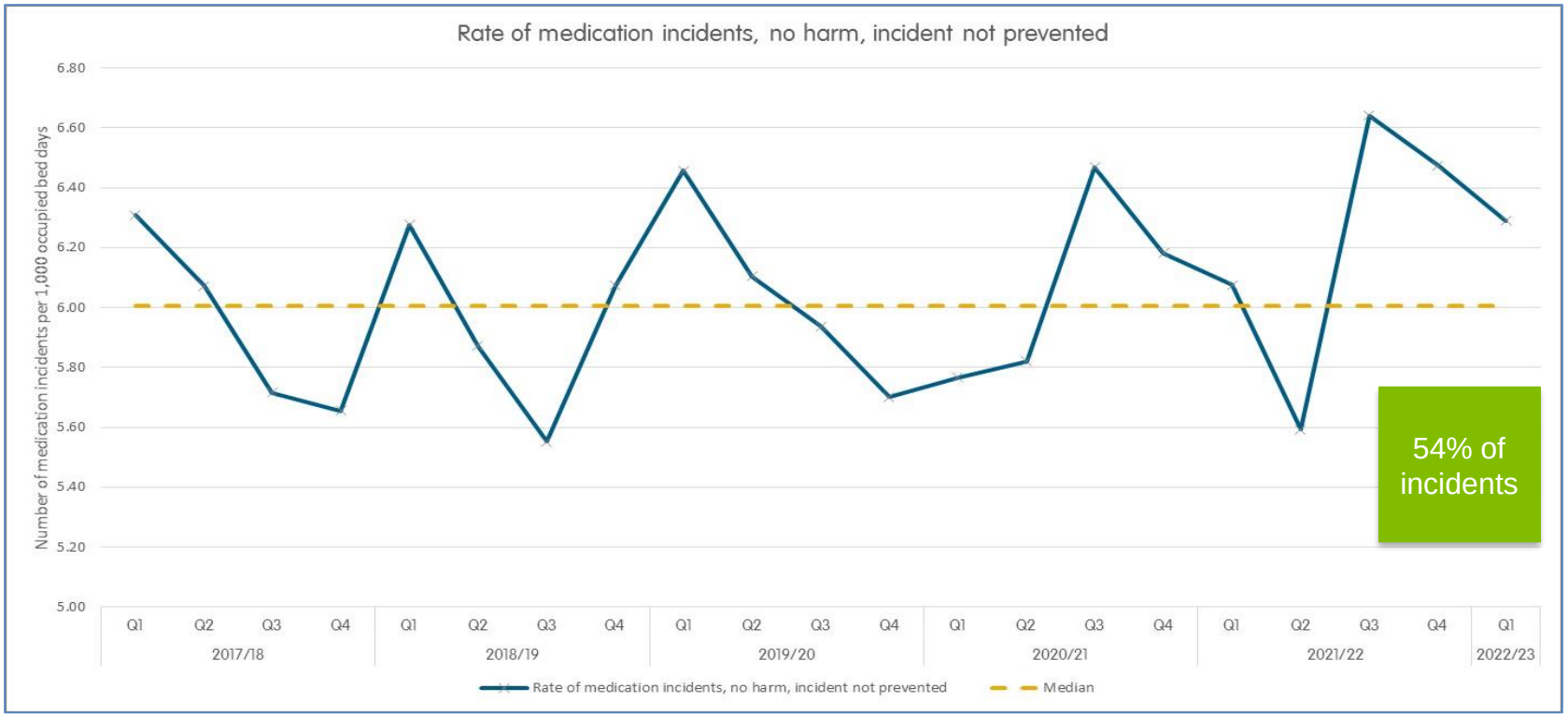



Relative rates of medication incidents over time, adult hospices
Number of medication incidents per 1,000 occupied bed days
7.00
6.00
5.00
4.00
3.00
2.00
1.00
0.00
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1
2017/18
2018/19
2019/20
2020/21
2021/22
2022/23
Rate of medication incidents - no harm, incident prevented
Rate of medication incidents, no harm, incident not prevented
Rate of medication incidents, low harm
Rate of medication incidents, moderate harm
Rate of medication incidents, severe harm
Rate of medication incidents, death

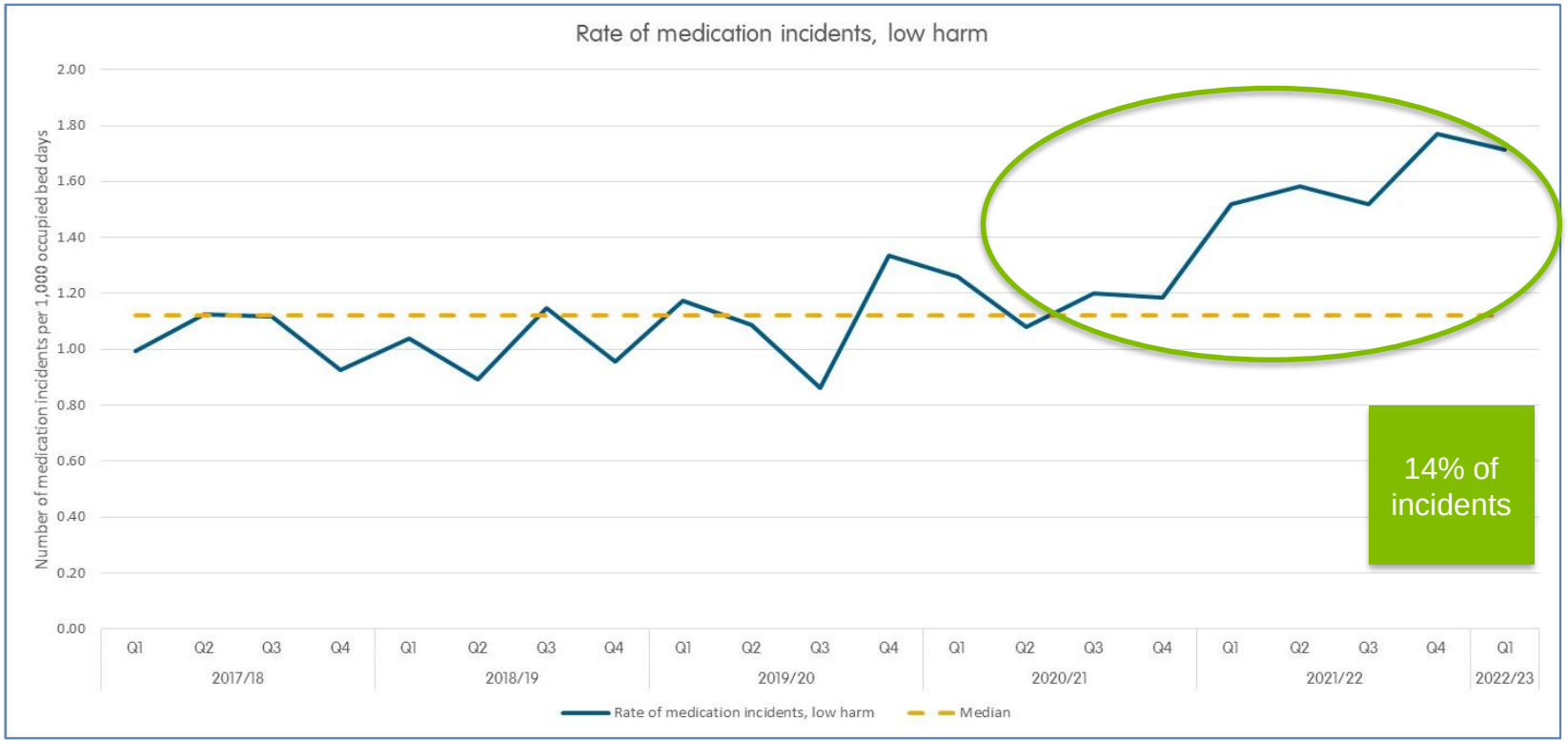
# Rate of medication incidents – no harm – incident prevented (adults)



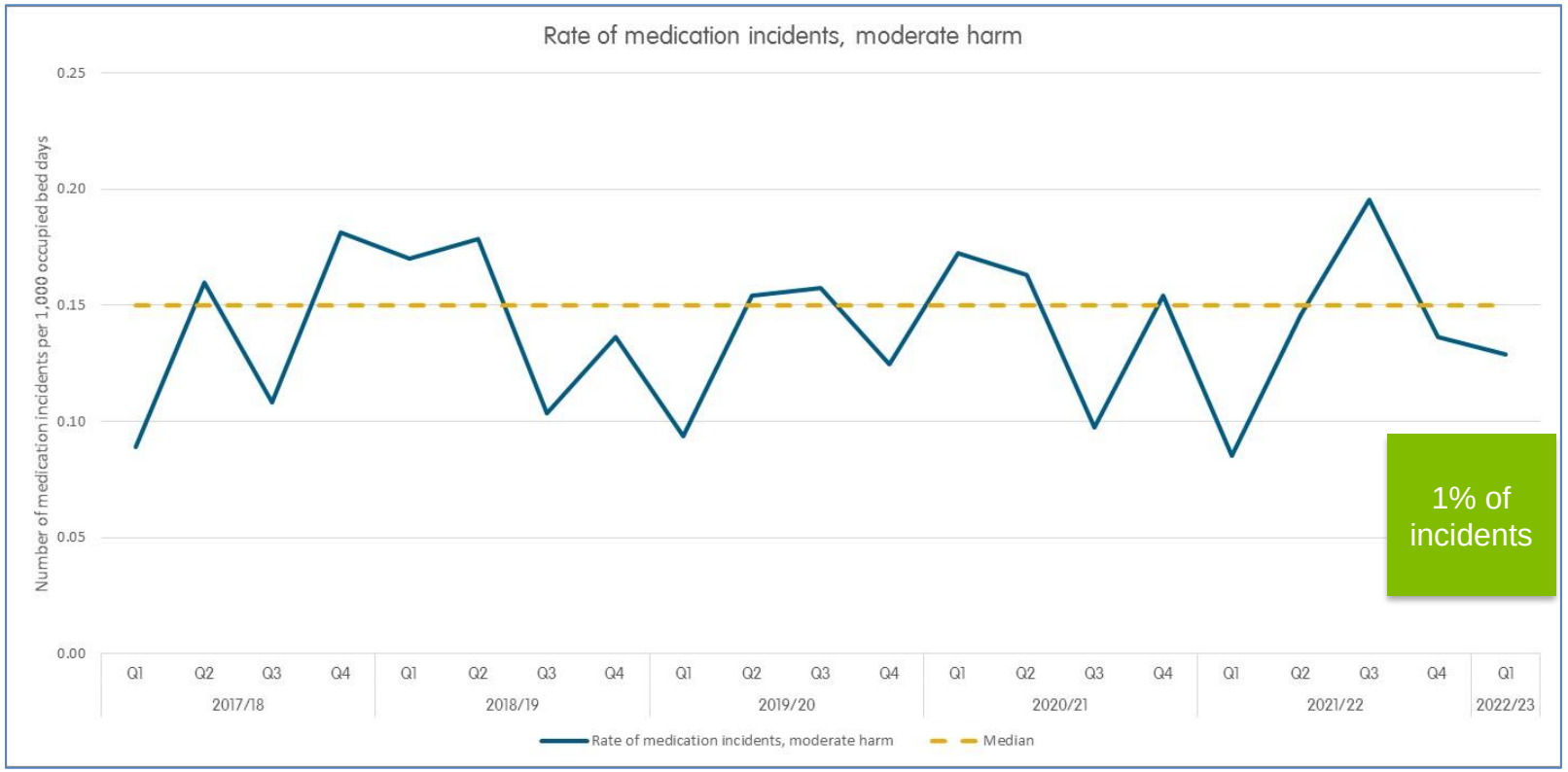
# Rate of medication incidents – no harm –incident not prevented



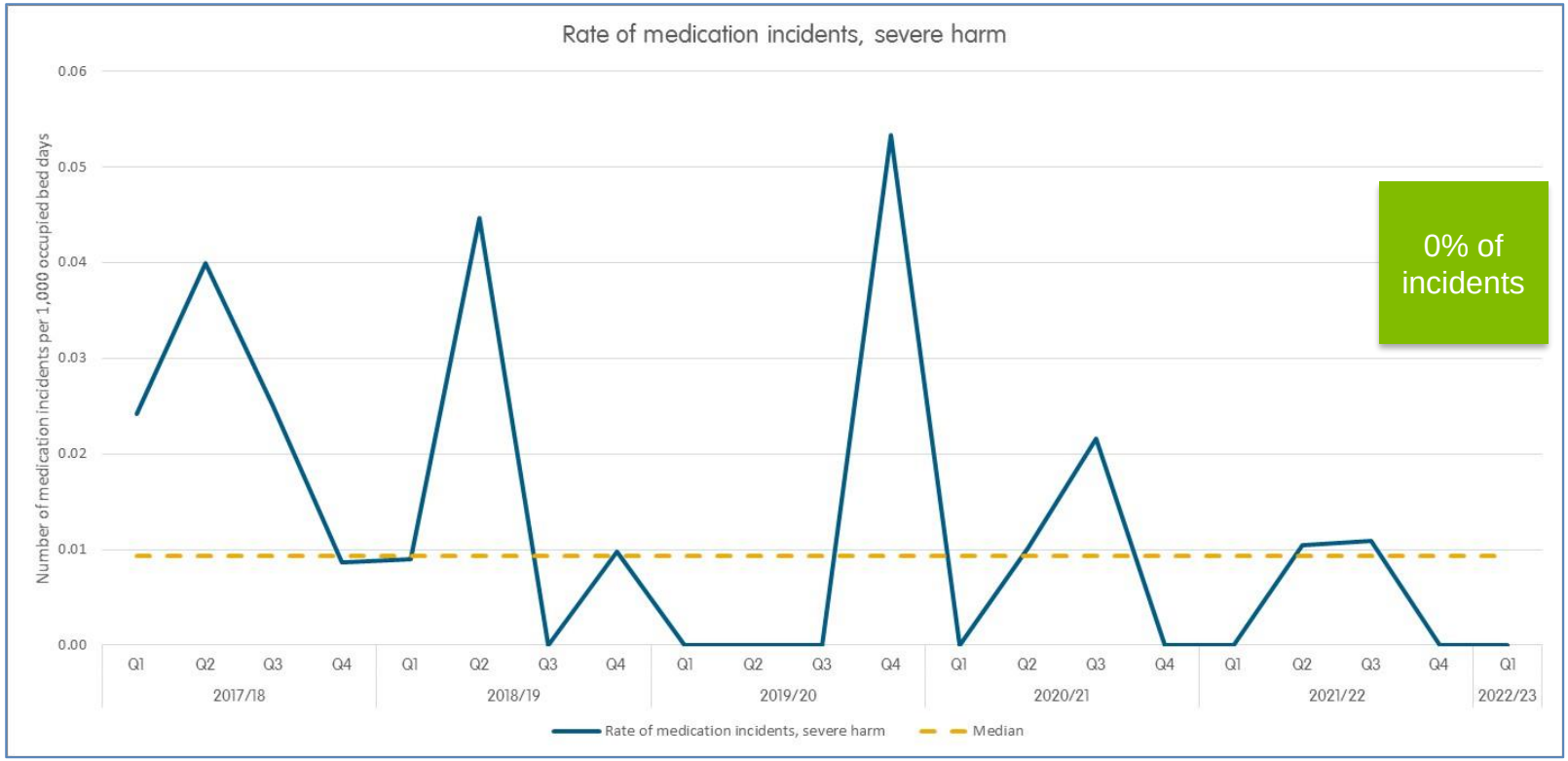
# Rate of medication incidents – low harm



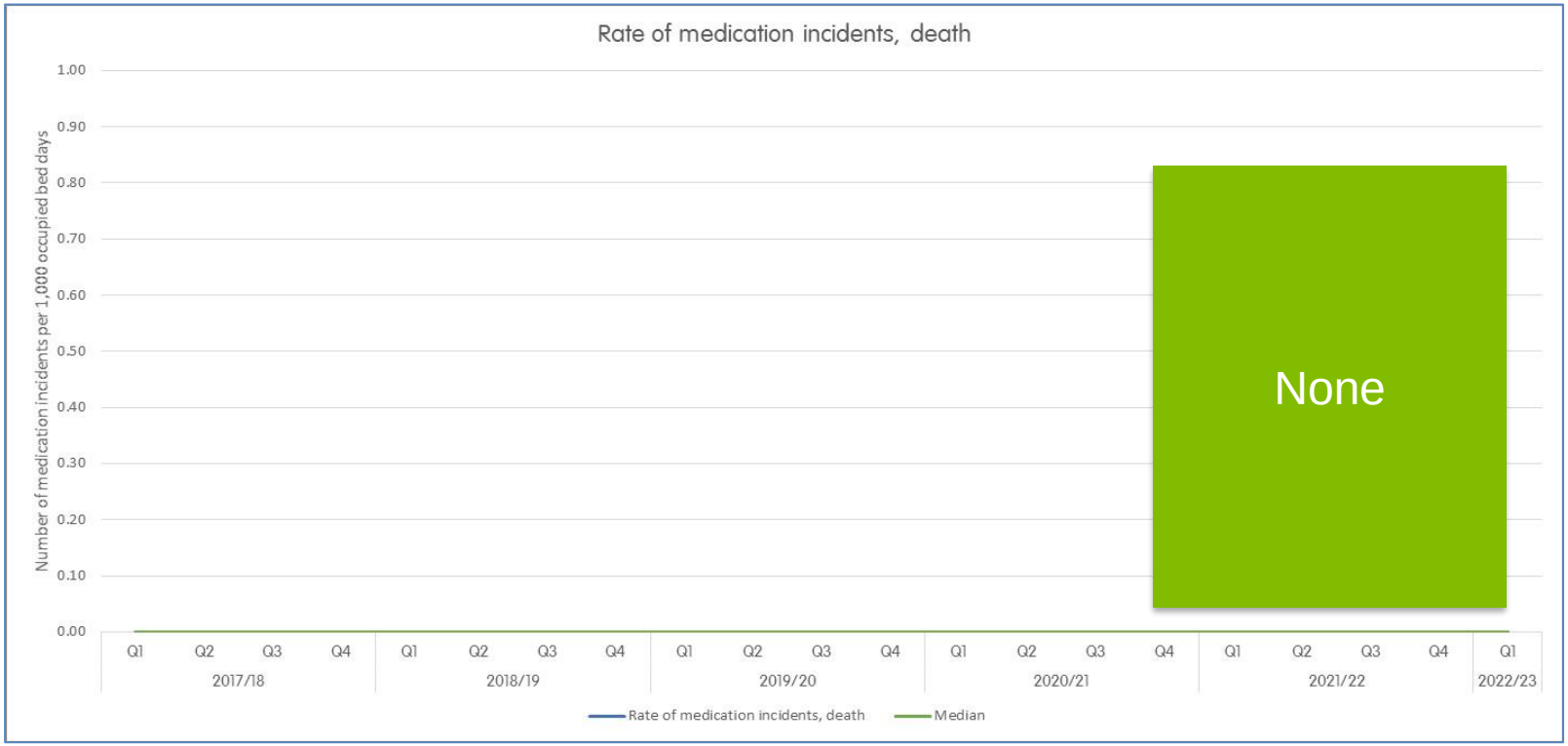
# Rate of medication incidents – moderate harm



# Rate of medication incidents, severe harm



# Rate of medication incidents, death

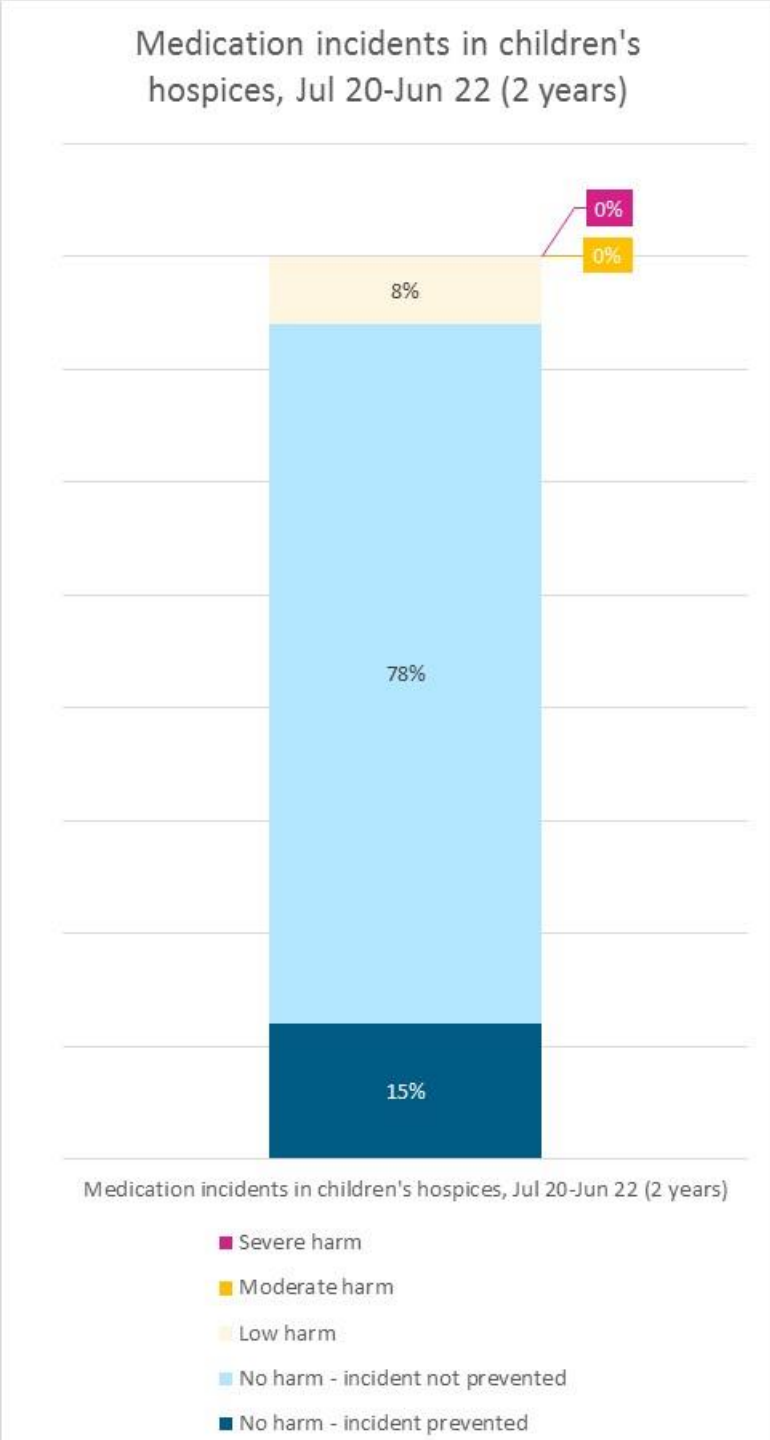


# Children's hospices - medication incidents

## Six categories

Most recent eight quarters

- 92.5% resulted in no harm
- 7.5% resulted in low harm
- No incidents of moderate or severe harm



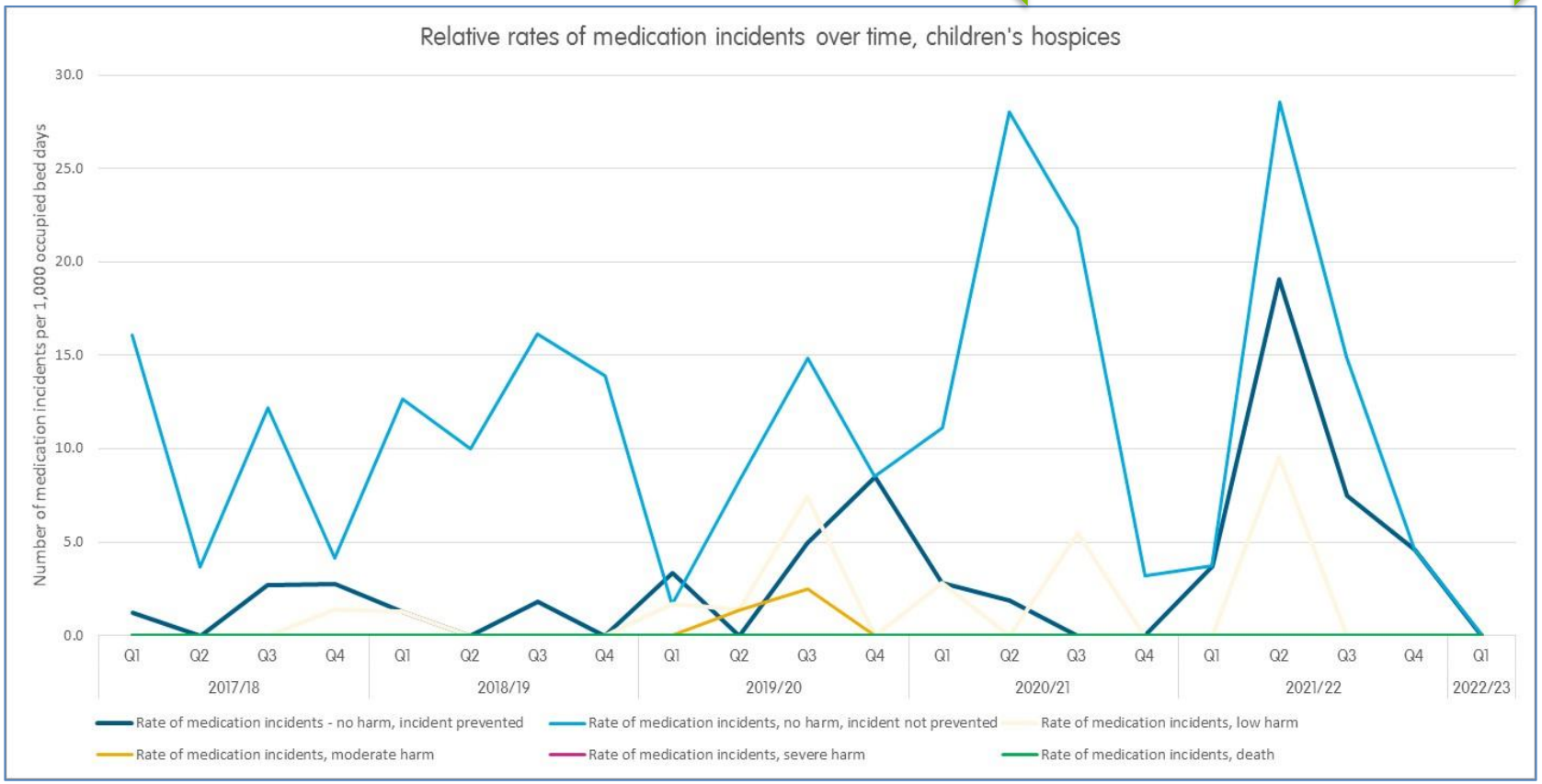



**40 incidents**

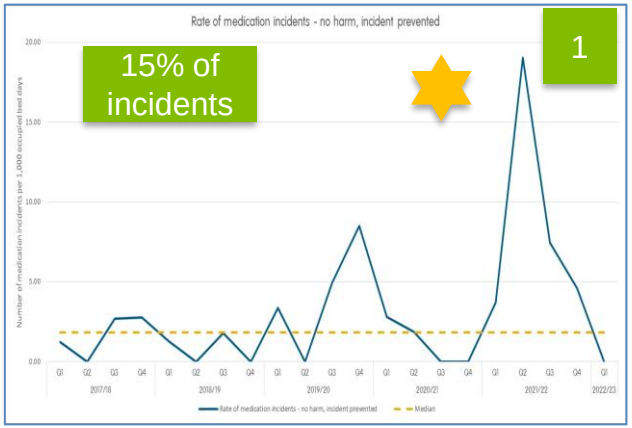
# Relative rates of medication incidents by level

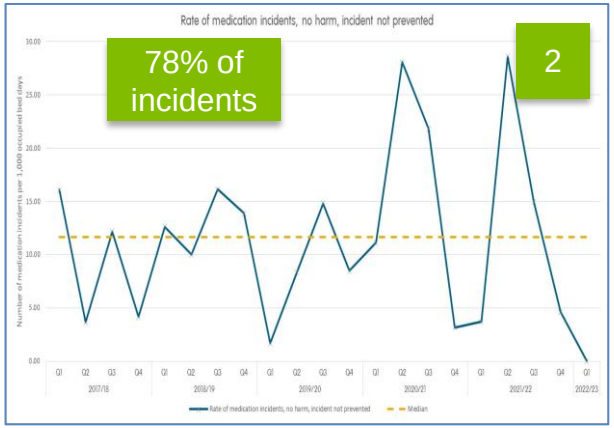
## April 2017 to June 2022, Children's hospices

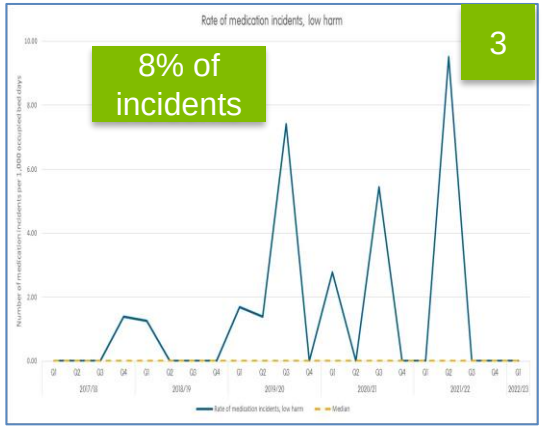
Previous slide's four quarters

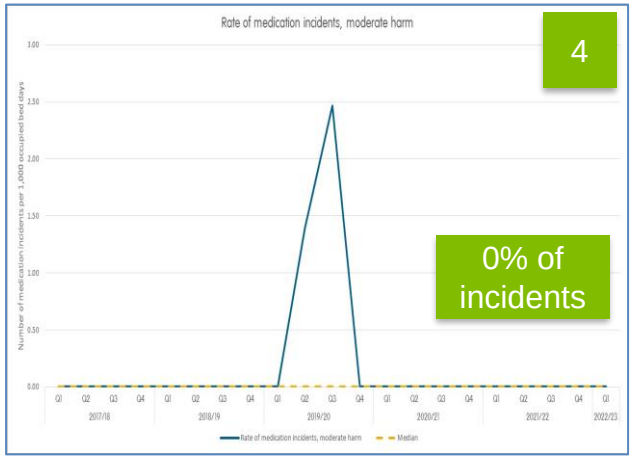


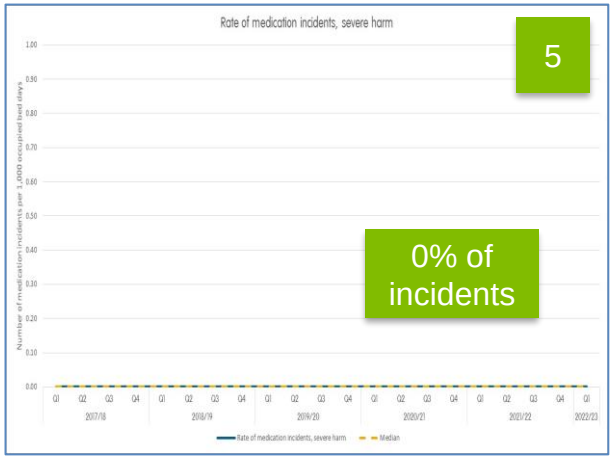
# Rate of medication incidents, children's hospices

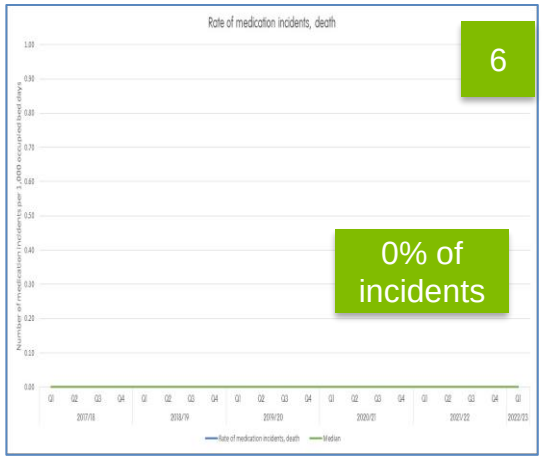


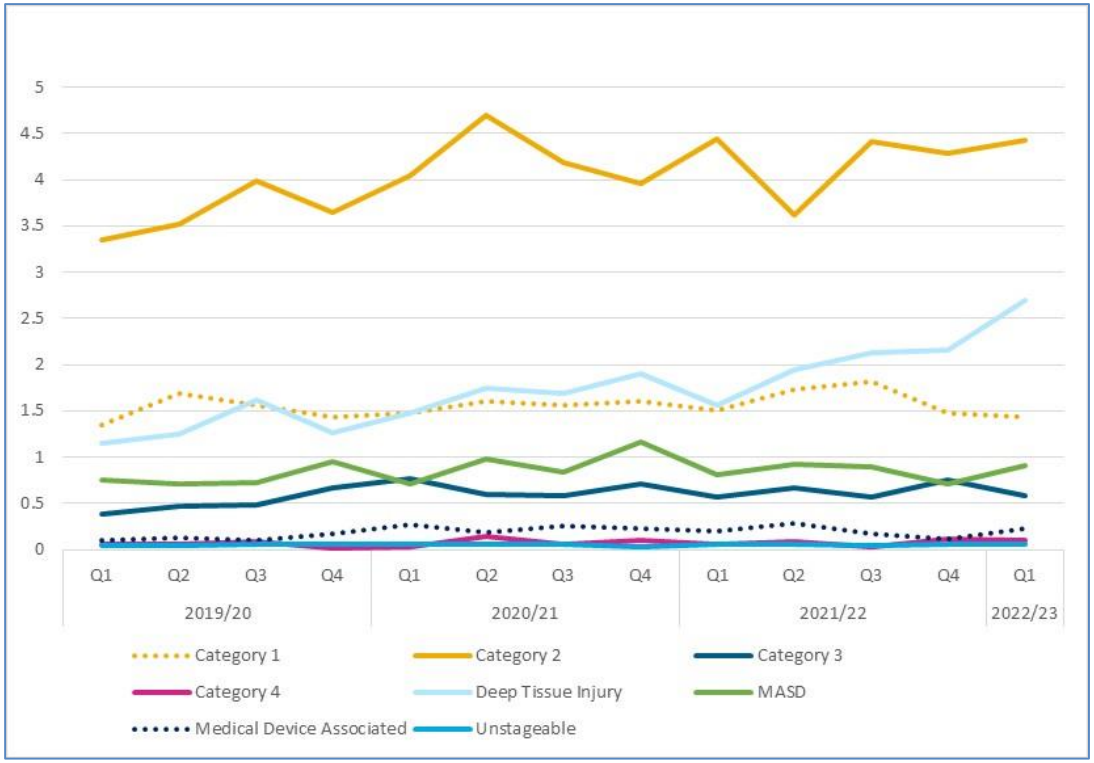



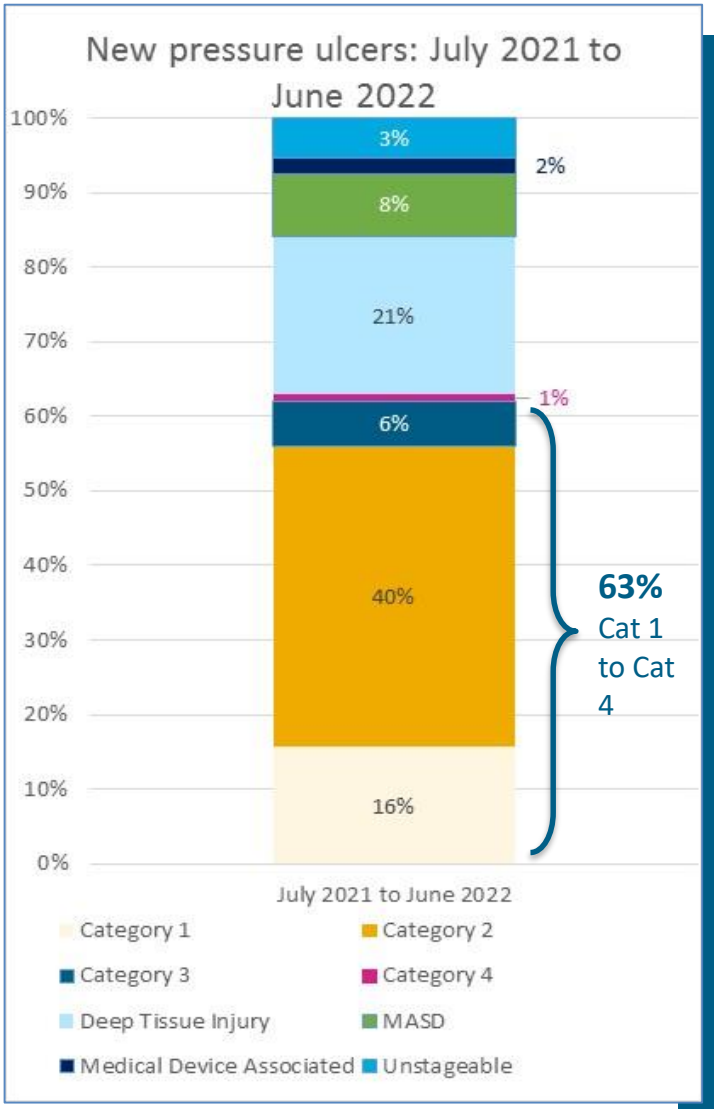



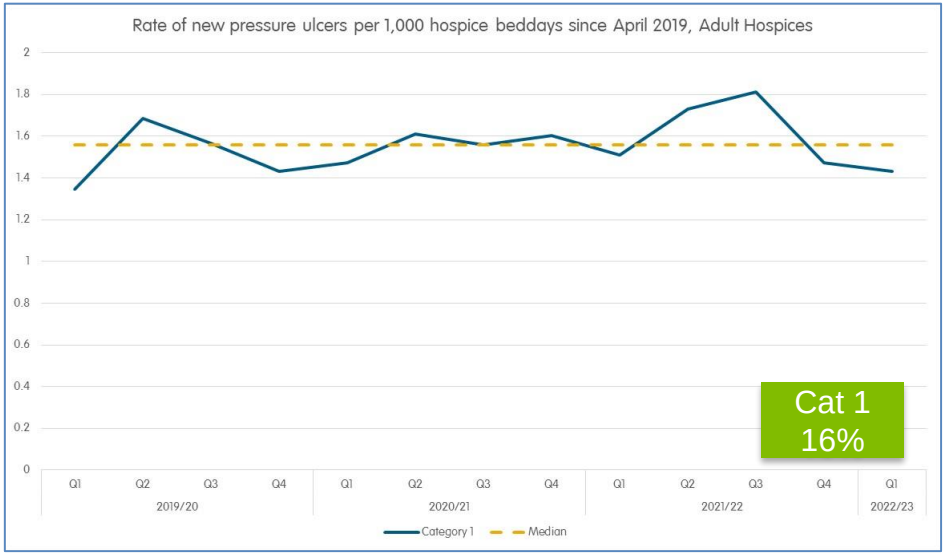



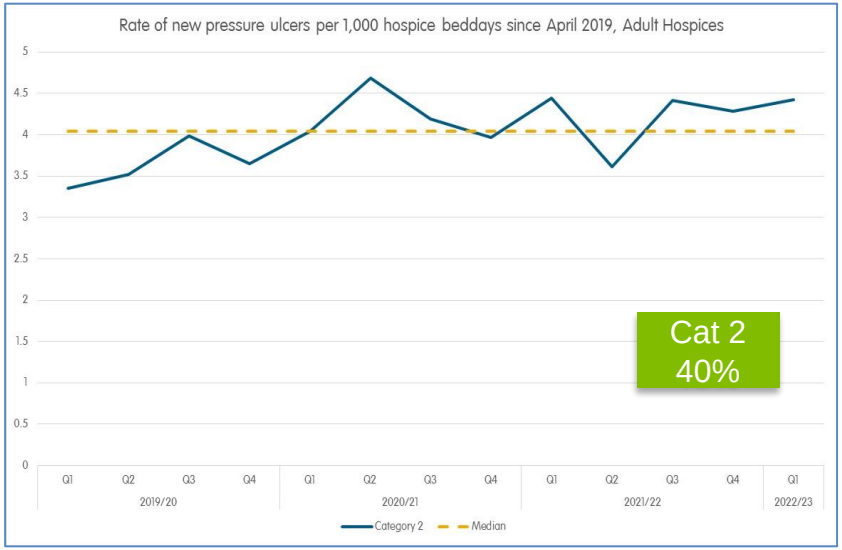



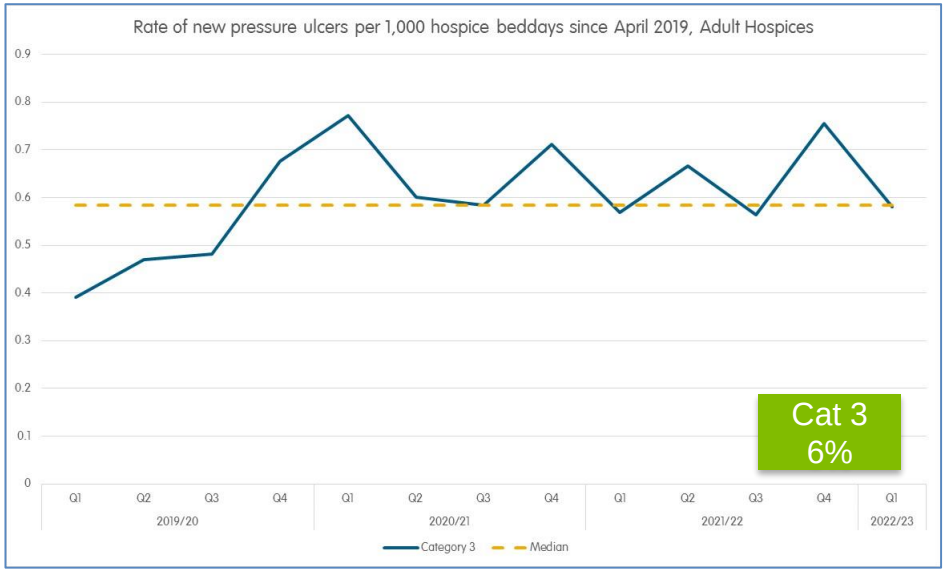
# Tissue viability
# New pressure ulcers - adults

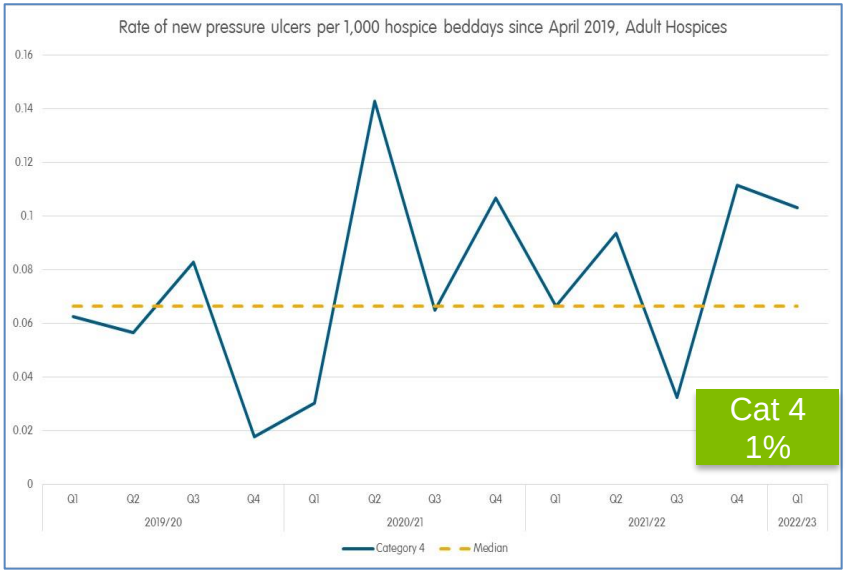


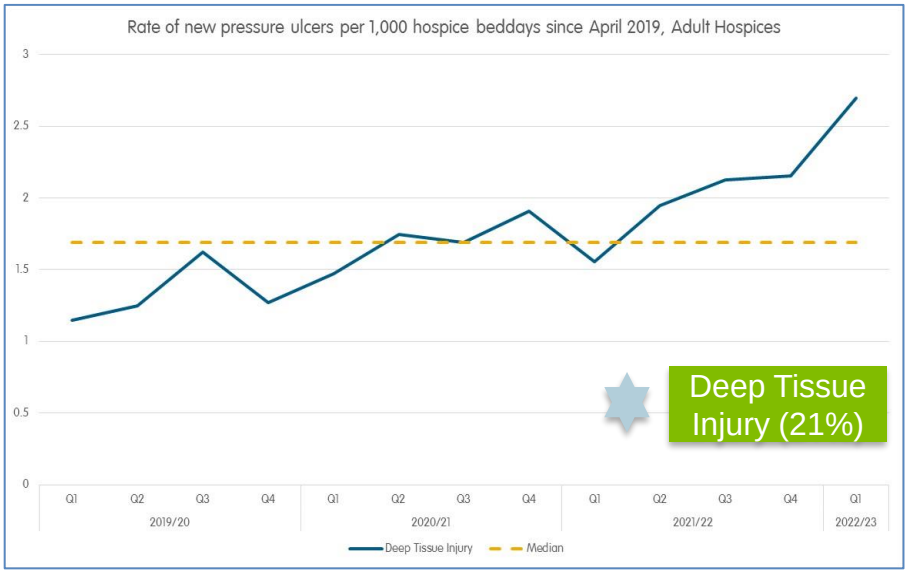




Rate of new pressure ulcers per 1,000 hospice beddays since April 2019, Adult Hospices
2
1.8
1.6
1.4
1.2
1
0.8
0.6
0.4
0.2
0
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1
2019/20
2020/21
2021/22
2022/23
Category 1
Median
Cat 1
16%

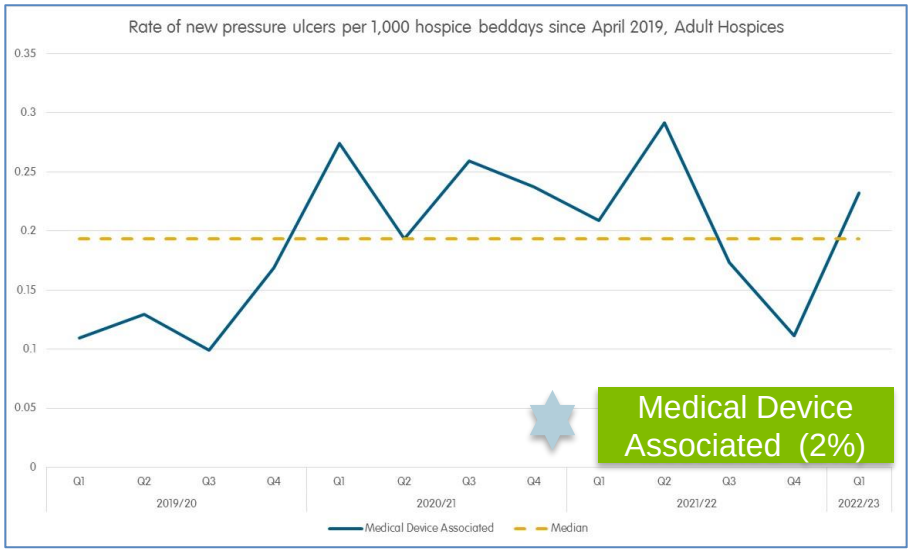

Rate of new pressure ulcers per 1,000 hospice beddays since April 2019, Adult Hospices
5
4.5
4
3.5
3
2.5
2
1.5
1
0.5
0
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1
2019/20
2020/21
2021/22
2022/23
Category 2
Median
Cat 2
40%

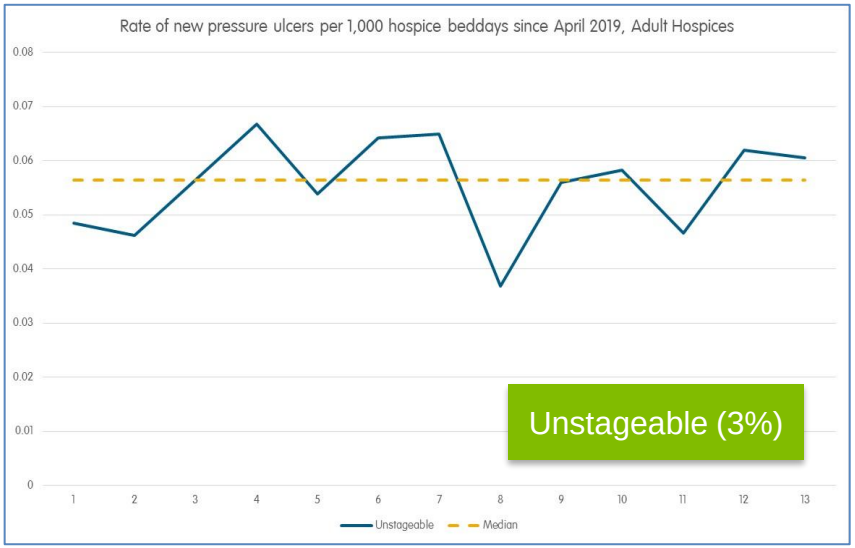

Rate of new pressure ulcers per 1,000 hospice beddays since April 2019, Adult Hospices
0.9
0.8
0.7
0.6
0.5
0.4
0.3
0.2
0.1
0
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1
2019/20
2020/21
2021/22
2022/23
Category 3
Median
Cat 3
6%


Rate of new pressure ulcers per 1,000 hospice beddays since April 2019, Adult Hospices
0.16
0.14
0.12
0.1
0.08
0.06
0.04
0.02
0
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1
2019/20
2020/21
2021/22
2022/23
Category 4
Median
Cat 4
1%

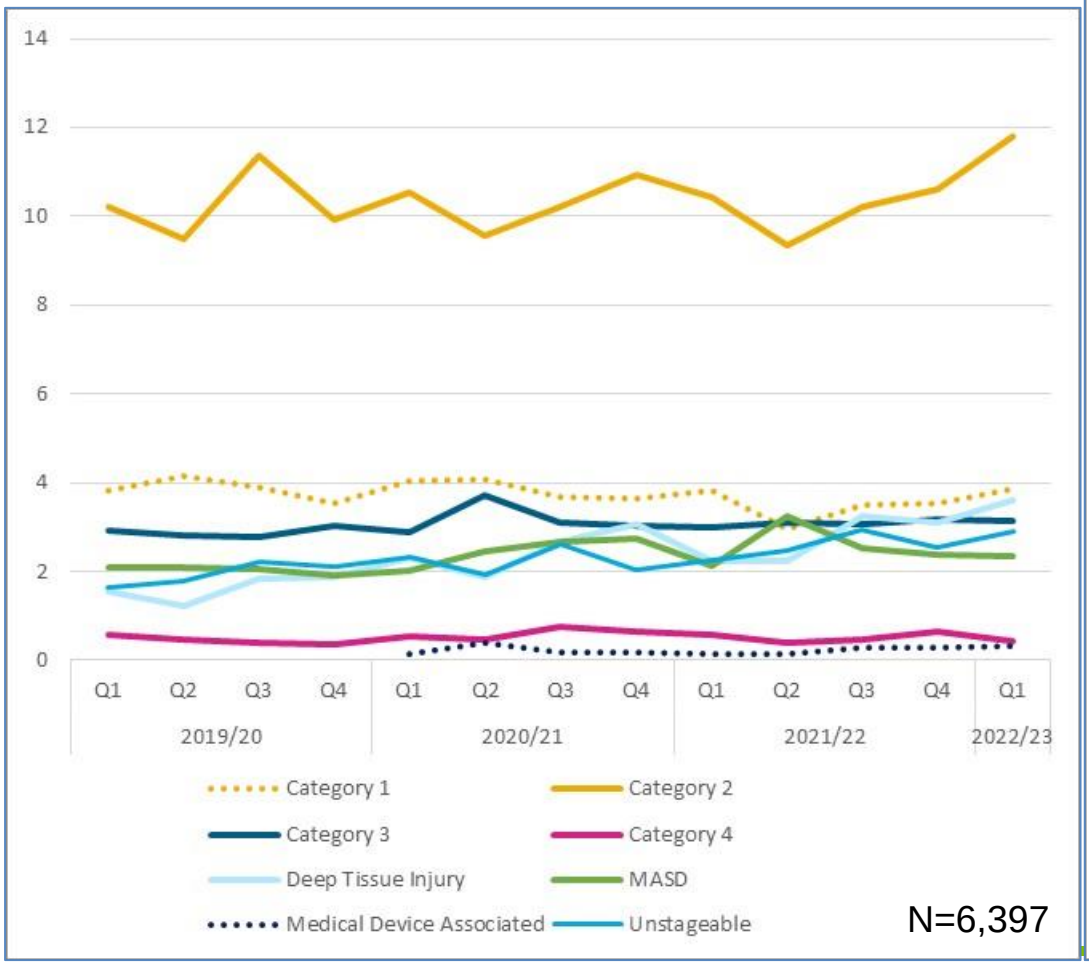

Rate of new pressure ulcers per 1,000 hospice beddays since April 2019, Adult Hospices
3
2.5
2
1.5
1
0.5
0
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1
2019/20
2020/21
2021/22
2022/23
Deep Tissue Injury
Median
Deep Tissue Injury (21%)

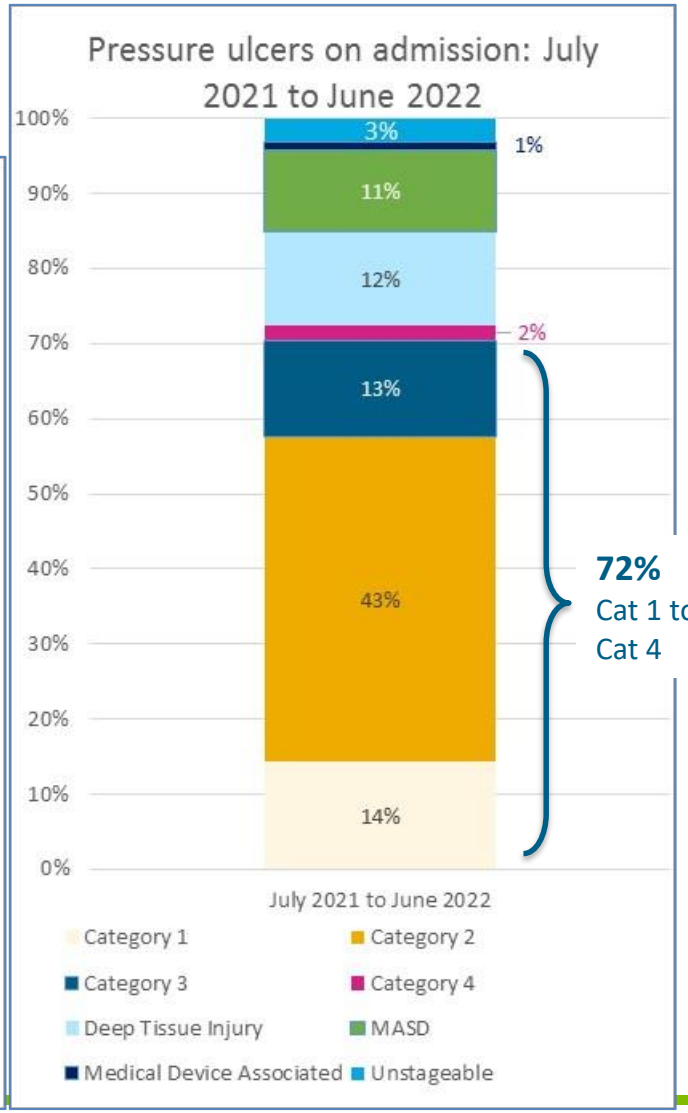

Rate of new pressure ulcers per 1,000 hospice beddays since April 2019, Adult Hospices
1.4
1.2
1
0.8
0.6
0.4
0.2
0
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1
2019/20
2020/21
2021/22
2022/23
MASD
Median
MASD (8%)

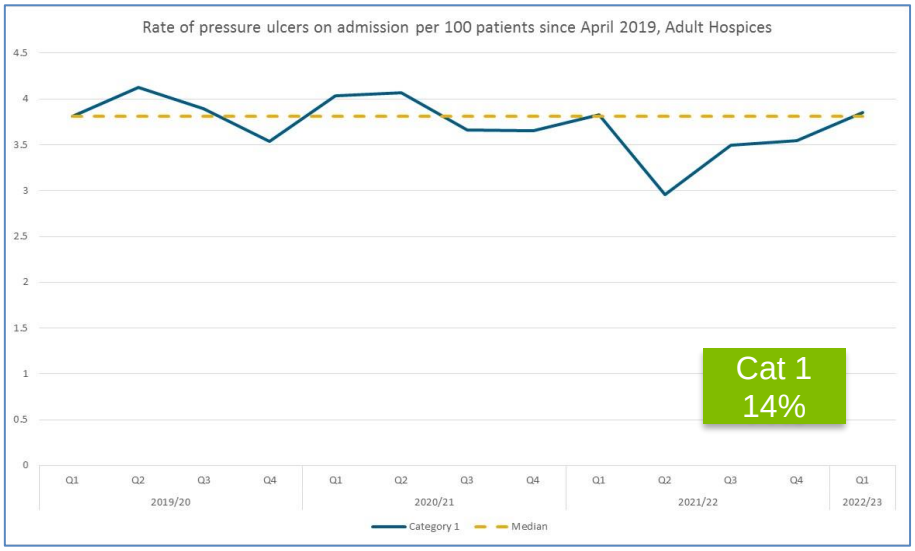

Rate of new pressure ulcers per 1,000 hospice beddays since April 2019, Adult Hospices
0.35
0.3
0.25
0.2
0.15
0.1
0.05
0
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1
2019/20
2020/21
2021/22
2022/23
Medical Device Associated
Median
Medical Device Associated (2%)

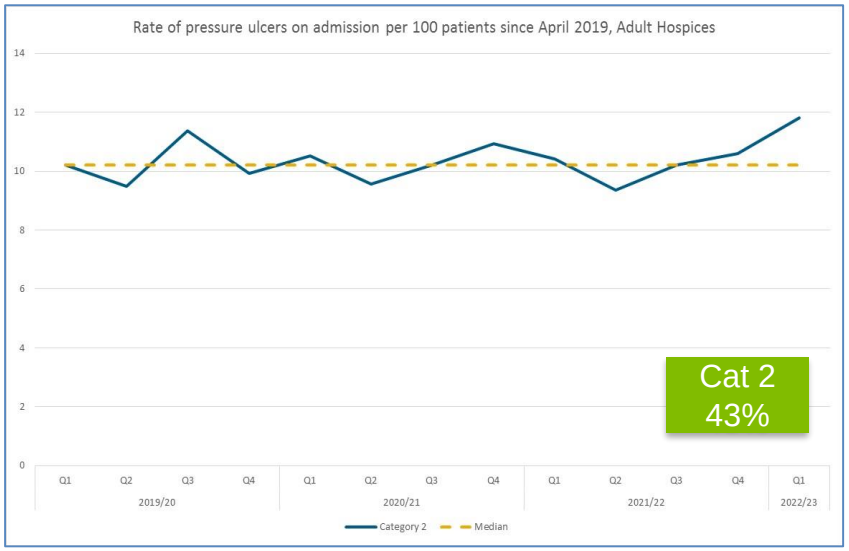

Rate of new pressure ulcers per 1,000 hospice beddays since April 2019, Adult Hospices
0.08
0.07
0.06
0.05
0.04
0.03
0.02
0.01
0
1 2 3 4 5 6 7 8 9 10 11 12 13
Unstageable
Median
Unstageable (3%)

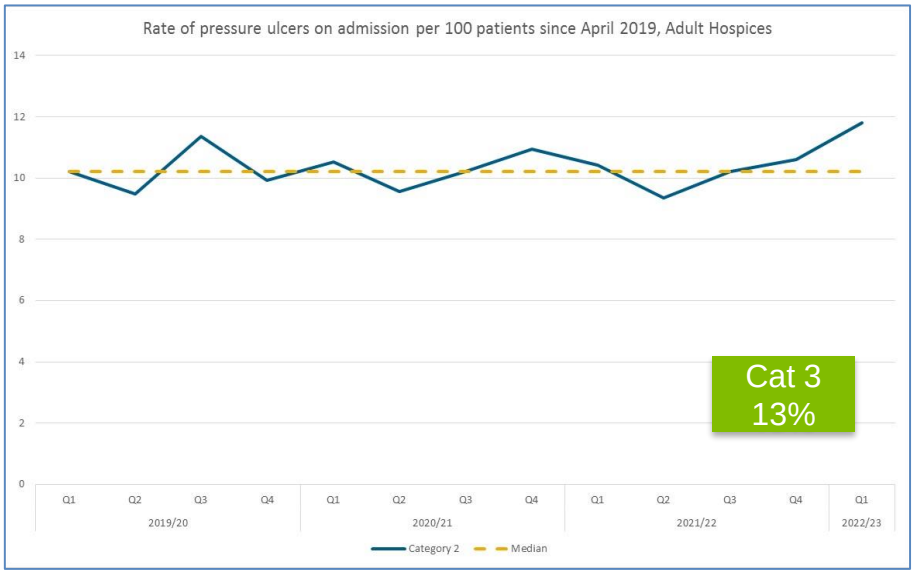
# Pressure ulcers on admission



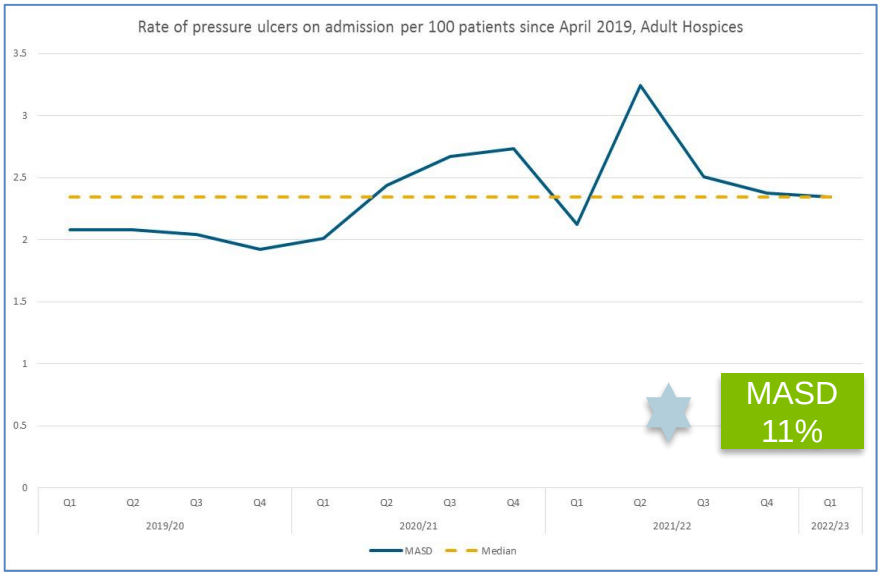

Rate of pressure ulcers on admission per 100 patients since April 2019, Adult Hospices
4.5
4
3.5
3
2.5
2
1.5
1
0.5
0
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1
2019/20
2020/21
2021/22
2022/23
Category 1
Median
Cat 1
14%

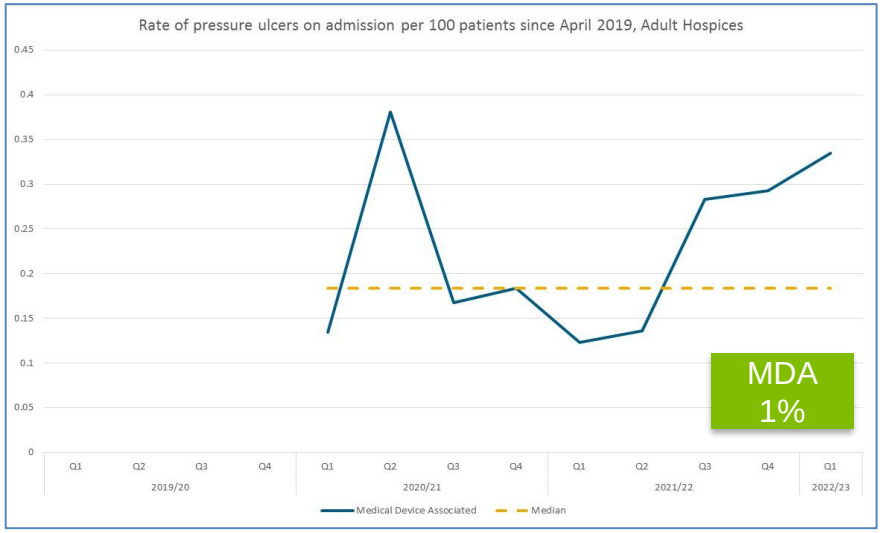

Rate of pressure ulcers on admission per 100 patients since April 2019, Adult Hospices
14
12
10
8
6
4
2
0
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1
2019/20
2020/21
2021/22
2022/23
Category 2
Median
Cat 2
43%

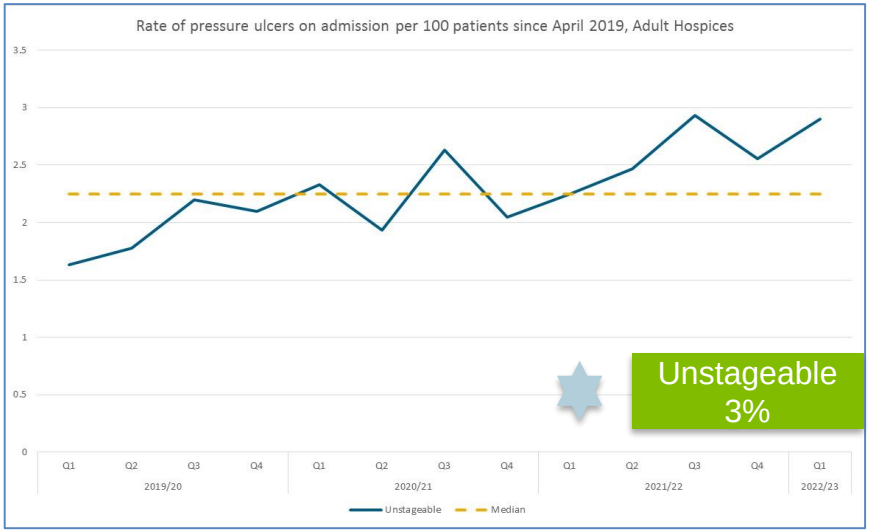

Rate of pressure ulcers on admission per 100 patients since April 2019, Adult Hospices
14
12
10
8
6
4
2
0
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1
2019/20
2020/21
2021/22
2022/23
Category 2
Median
Cat 3
13%


Rate of pressure ulcers on admission per 100 patients since April 2019, Adult Hospices
0.8
0.7
0.6
0.5
0.4
0.3
0.2
0.1
0
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1
2019/20
2020/21
2021/22
2022/23
Category 4
Median
Cat 4
2%

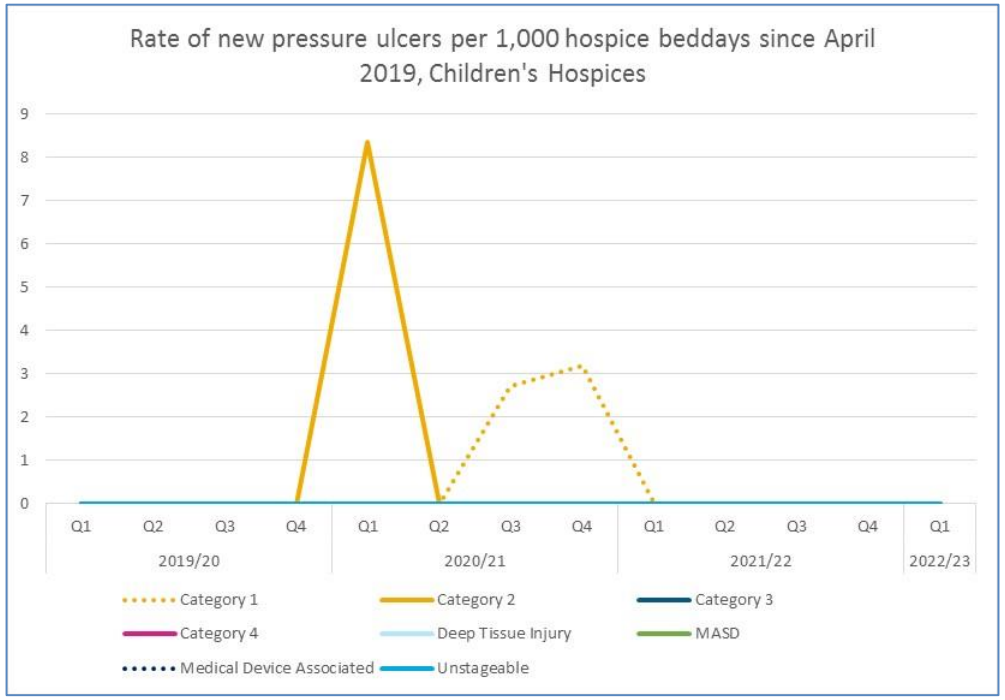

Rate of pressure ulcers on admission per 100 patients since April 2019, Adult Hospices
DTI
12%
Deep Tissue Injury
Median

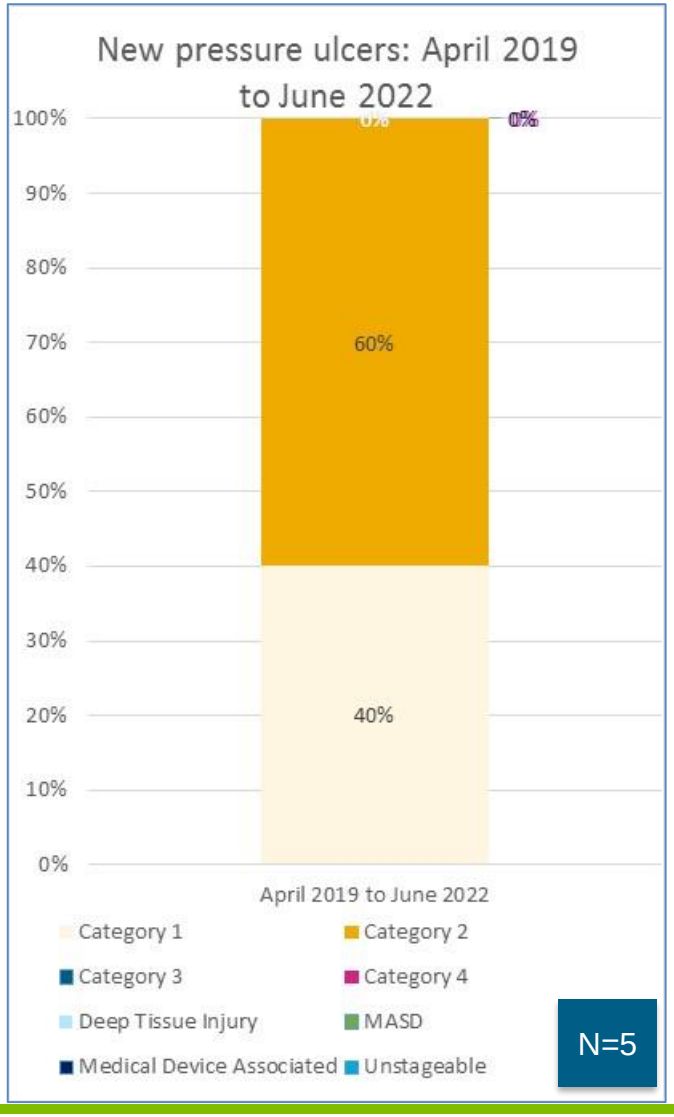

Rate of pressure ulcers on admission per 100 patients since April 2019, Adult Hospices
MASD
11%
MASD
Median


Rate of pressure ulcers on admission per 100 patients since April 2019, Adult Hospices
MDA
1%
Medical Device Associated
Median

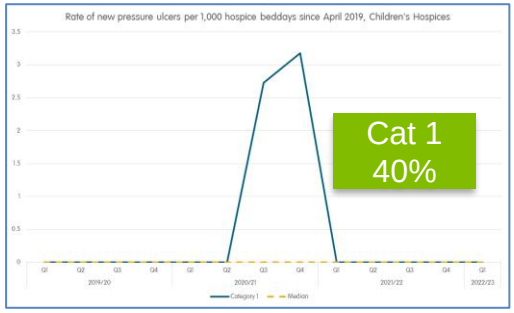

Rate of pressure ulcers on admission per 100 patients since April 2019, Adult Hospices
Unstageable
3%
Unstageable
Median

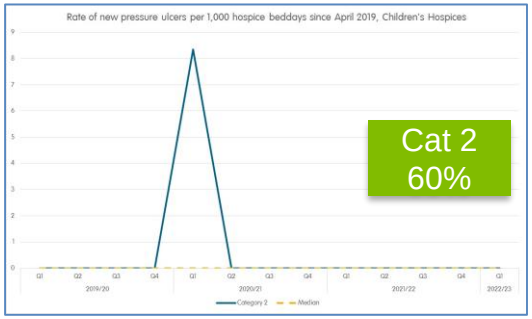
# Tissue viability
# New pressure ulcers – Children's hospices



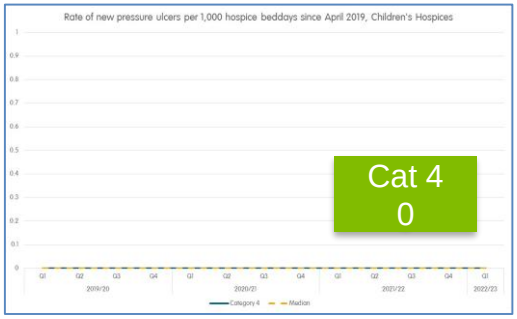



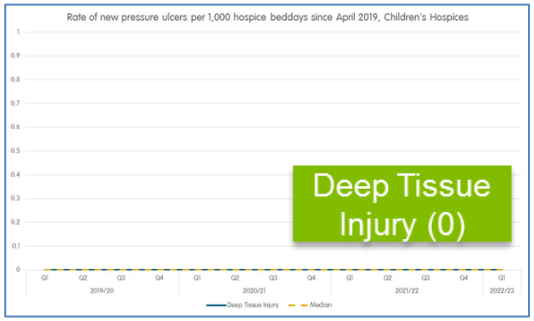
# Rate of new pressure ulcers, children's hospices

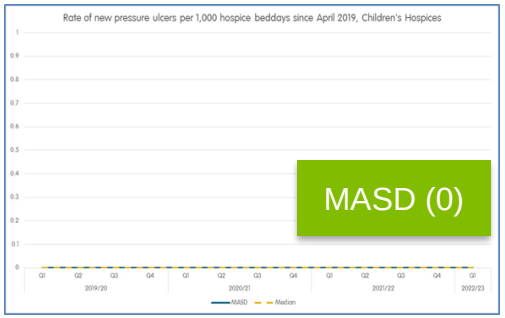


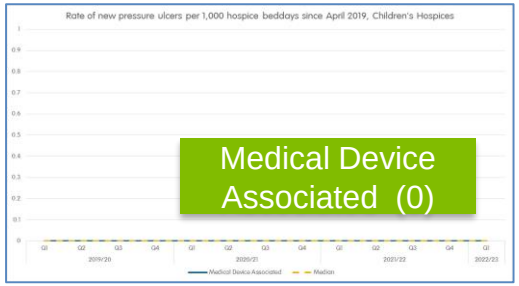





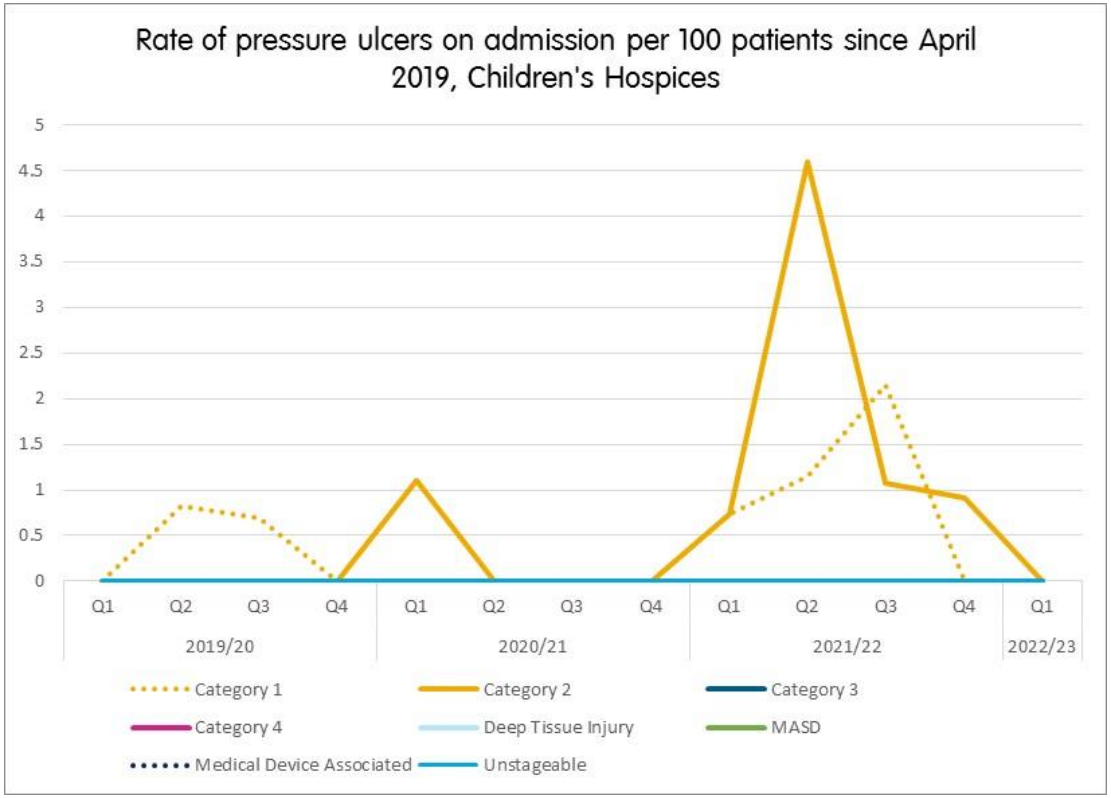


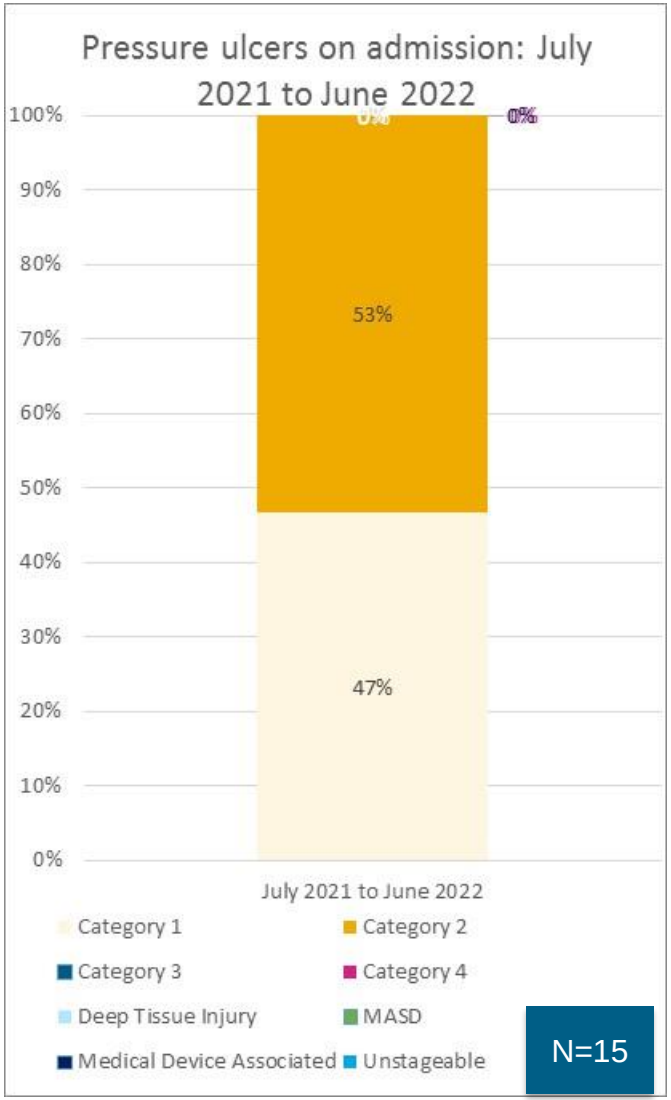



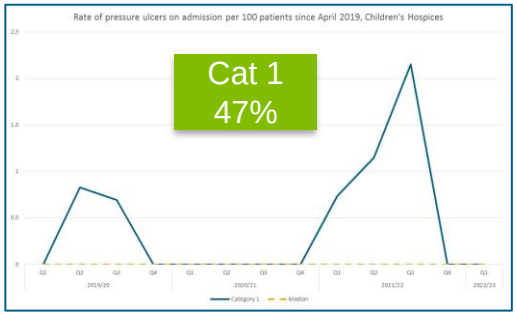



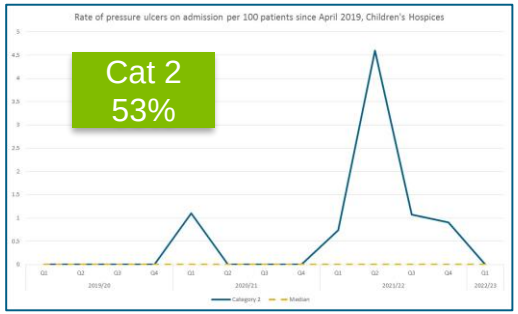

# Tissue viability pressure ulcers on admission– Children's

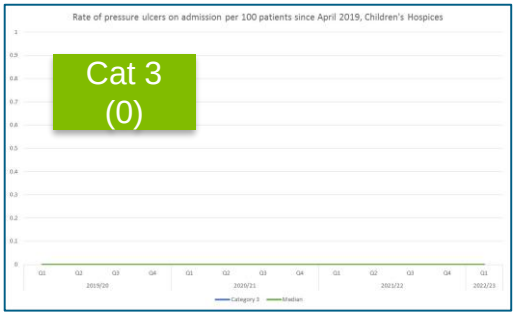


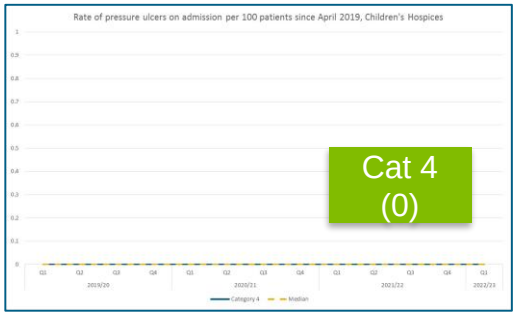



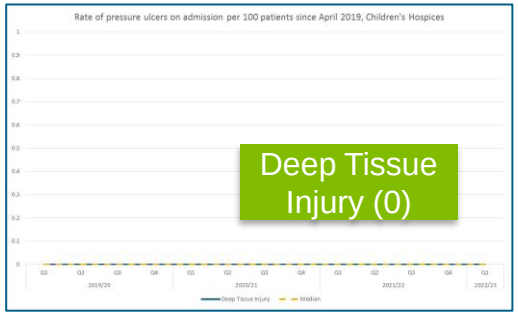
# Rate of pressure ulcers on admission, Children's hospices

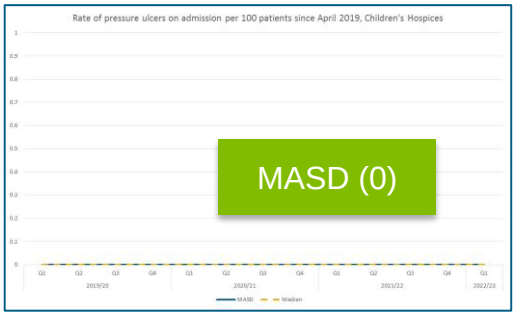


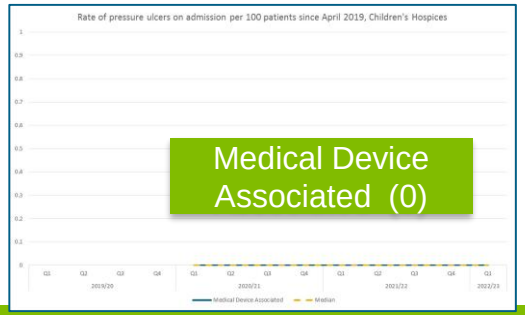



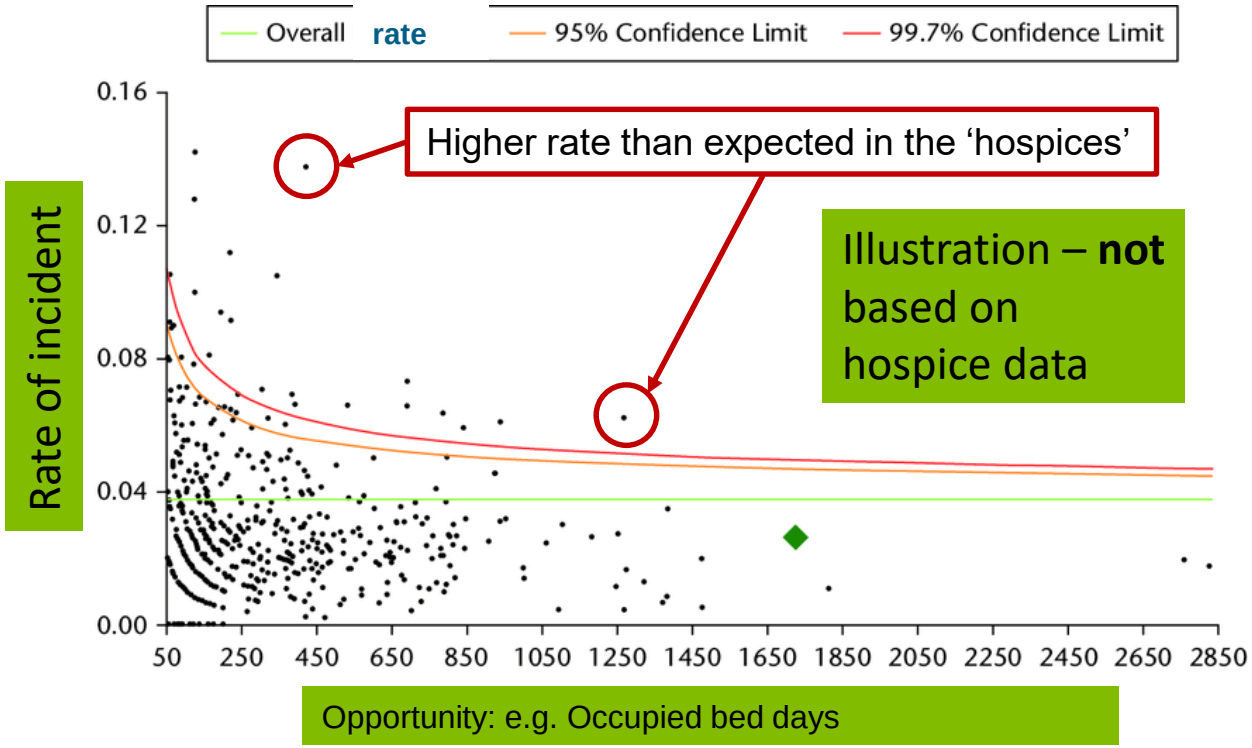



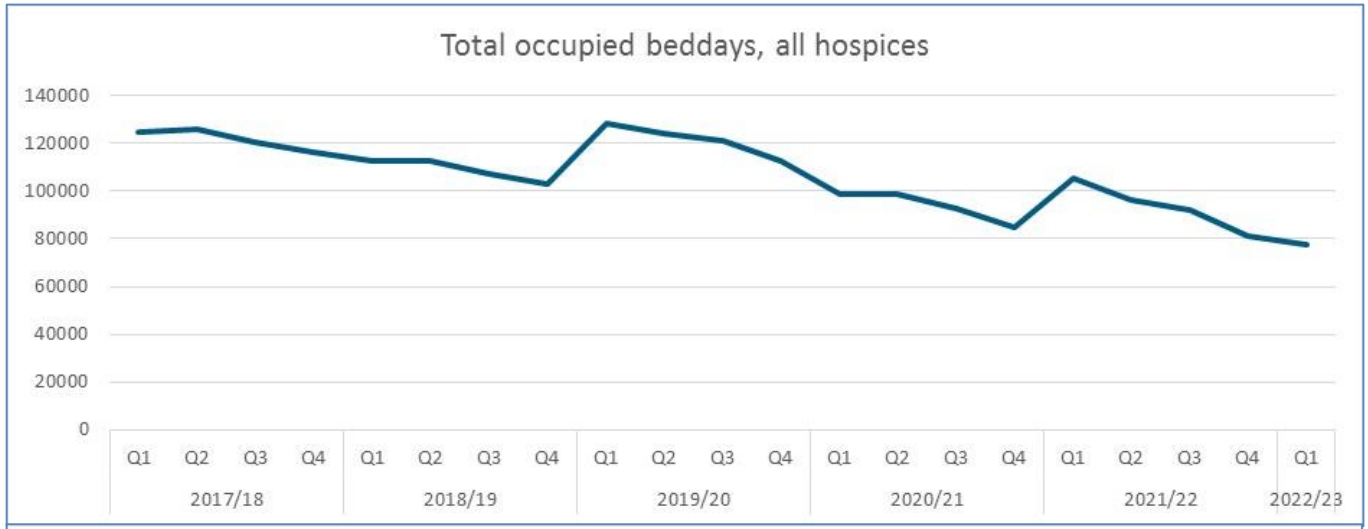

# Next analytical approach 2

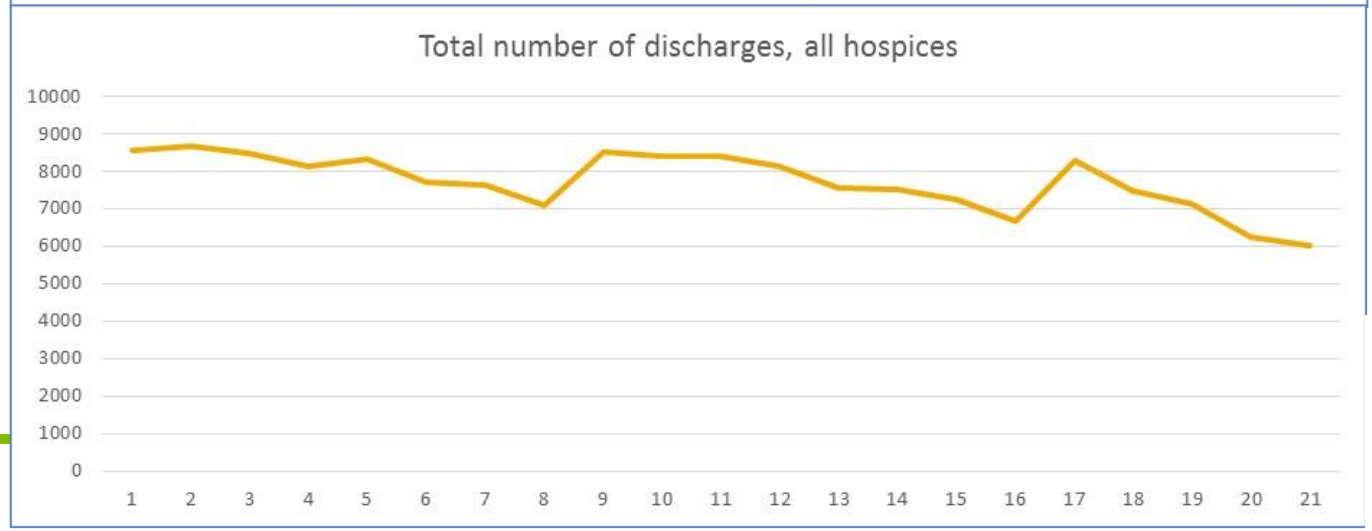
Funnel plot to understand differences in rates between individual hospices.

Mock-up



# Methodology: denominators used to develop the standardised rates.




*Note discharges are **all** patients who leave inpatient unit*

Submit

# Submission Dates

| | Months | Submission Deadline | Final Reports Circulated |
|---|---|---|---|
| Q1 | Apr, May, Jun | 14 July 2022 | 30 July 2022 |
| Q2 | Jul, Aug, Sep | 14 October 2022 | 27 Oct 2022 |
| Q3 | Oct, Nov, Dec | 12 Jan 2023 | 29 Jan 2023 |
| Q4 | Jan, Feb, Mar | 14 Apr 2023 | 28 Apr 2023 |

Submission link request:
https://www.hospiceuk.org/what-we-offer/clinical-and-care-support/quality-assurance/patient-safety

# WELCOME

**Lauren Mosley**

Head of Patient Safety Implementation

NHS England

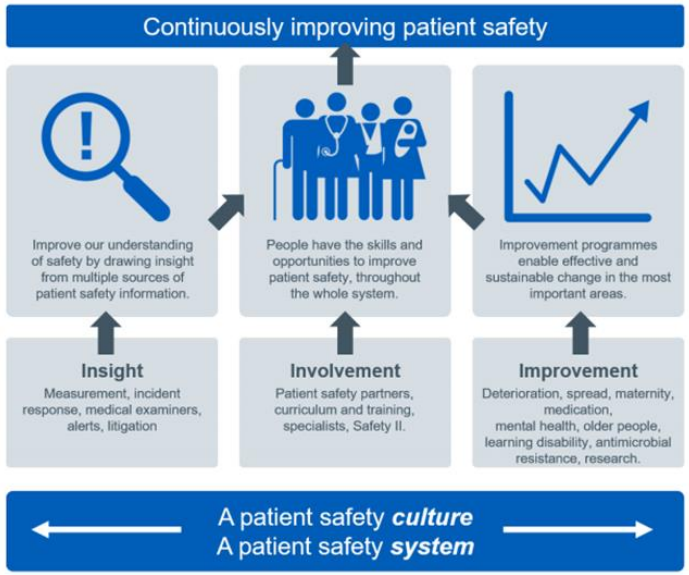
# NHS England, Patient Safety, PSIRF and Strategy update

Lauren Mosley, Head of Patient Safety Implementation

# The NHS Patient Safety Strategy

The NHS Patient Safety Strategy provides a structure for all our patient safety work:

- **A patient safety culture** – encouraging engaged, visible leadership promoting openness, just culture and continuous improvement, valuing diversity and equality.
- **Patient safety systems** – governance, accountability, supporting whole systemic and systematic improvement, including primary care, intelligent use of digital.
- **Insight** – a whole organisation commitment to identifying risks, reporting incidents, understanding what contributes to safety, identifying how we normally keep our patients safe
- **Involvement** – a focus on people, giving them the skills and support they need, fundamentally involving patients and the public, recognising the need for specific expertise
- **Improvement** – identification and implementation of improvement priorities using quality improvement science to continuously reduce risks to patients.

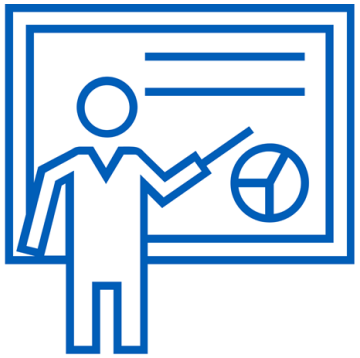


# The Learn from Patient Safety Events (LfPSE) service

A single port of call for recording, accessing, sharing and learning from patient safety events, in order to support improvement in the safety of NHS-funded services at all levels of the health system
This programme will replace NRLS and STEIS, upgrading aging infrastructure and creating a modern digital service that is fit for purpose and the future.
LFPSE is;

- More focussed on learning for improvement
- More suitable for use across the whole of healthcare and not just in hospitals
- Better aligned with the complexity of modern healthcare delivery
- Making better use of digital technology

For more information see the LFPSE webpage



# Patient Safety Specialists

CQC's thematic review of Never Events recommended that we should ''*create and maintain a network of patient safety leaders to support every NHS organisation, with all working towards a just safety culture that supports the implementation of patient safety alerts and continuous safety improvement*''

We have therefore established the role of Patient Safety Specialists in providers and local systems to become the backbone of patient safety in the NHS, including in NHS regional teams, regulators and commissioners. There are over 700 Specialists in over 350 organisations

Patient Safety Specialists will be equipped with the **knowledge and skills** to thrive as safety leaders.

They will spread understanding across their organisation of the principles, values and behaviours that support a good **patient safety culture**.

While safety is everyone's business, Patient Safety Specialists can be considered '**captains of the team**', able to support and lead their colleagues' safety improvement activities.

# Patient Safety Syllabus

[NHS Patient Safety Syllabus training - elearning for healthcare (e-lfh.org.uk)]

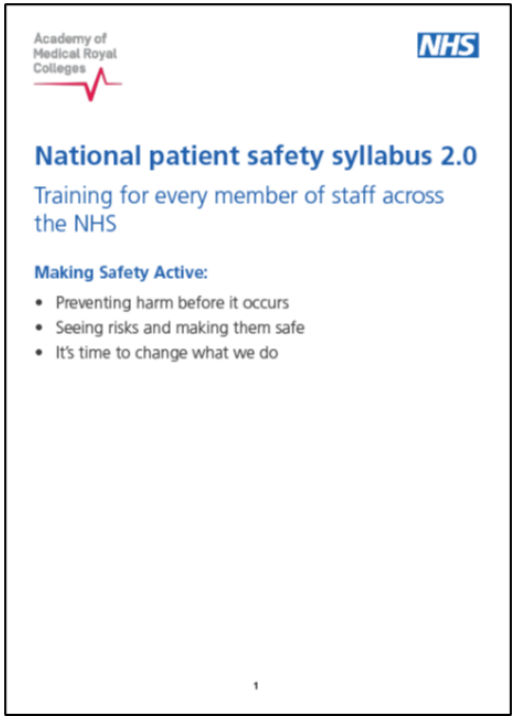
Level 1 (Essentials) Patient Safety Syllabus educational materials will be for all staff

- Essentials e-learning educational module (all staff)
- Essentials e-learning module for Boards and Senior Leadership teams

Level 2 (Access to Practice) e-learning educational module for those who wish to progress further

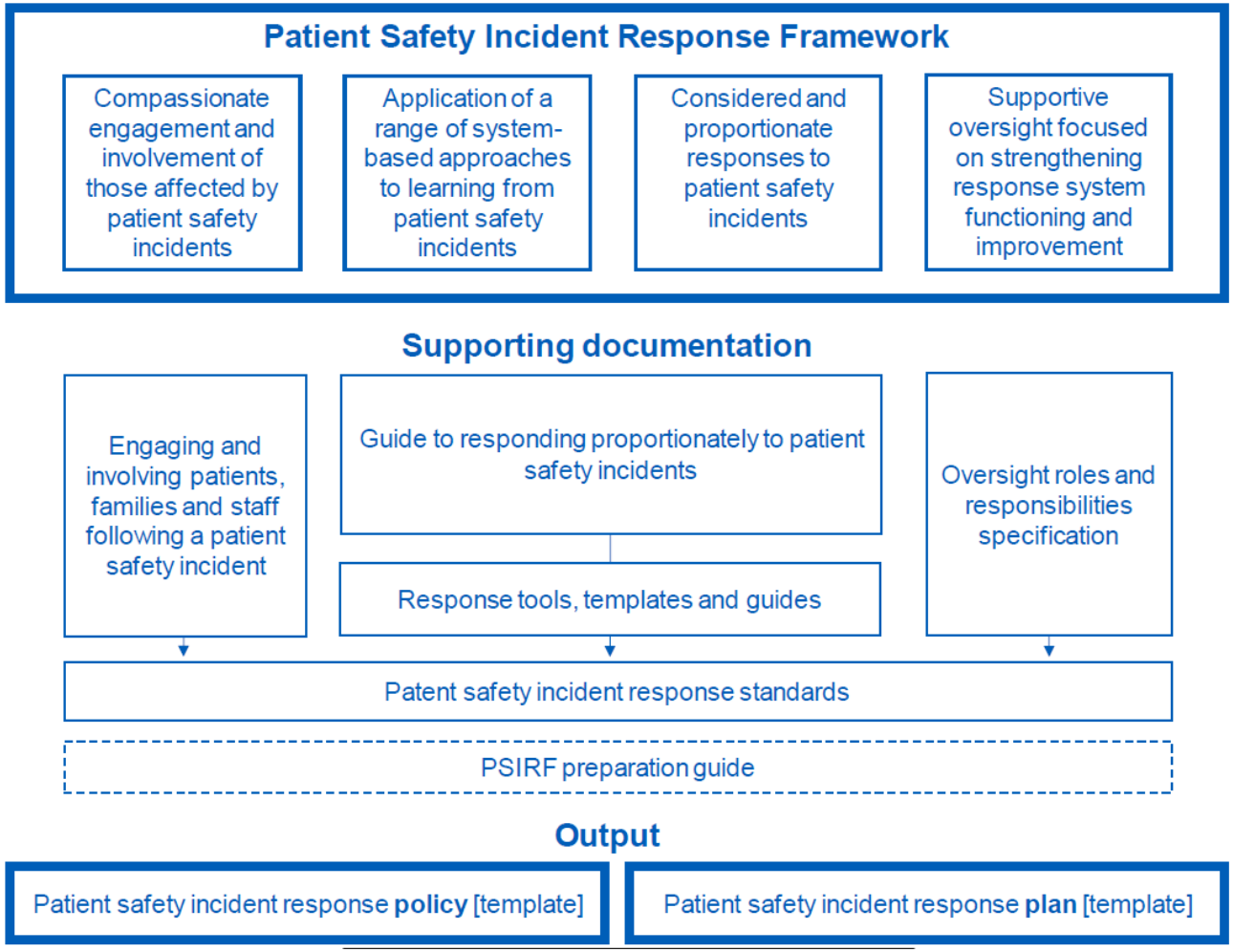
Not yet mandatory

Patient safety specialists will be trained in all levels of the syllabus

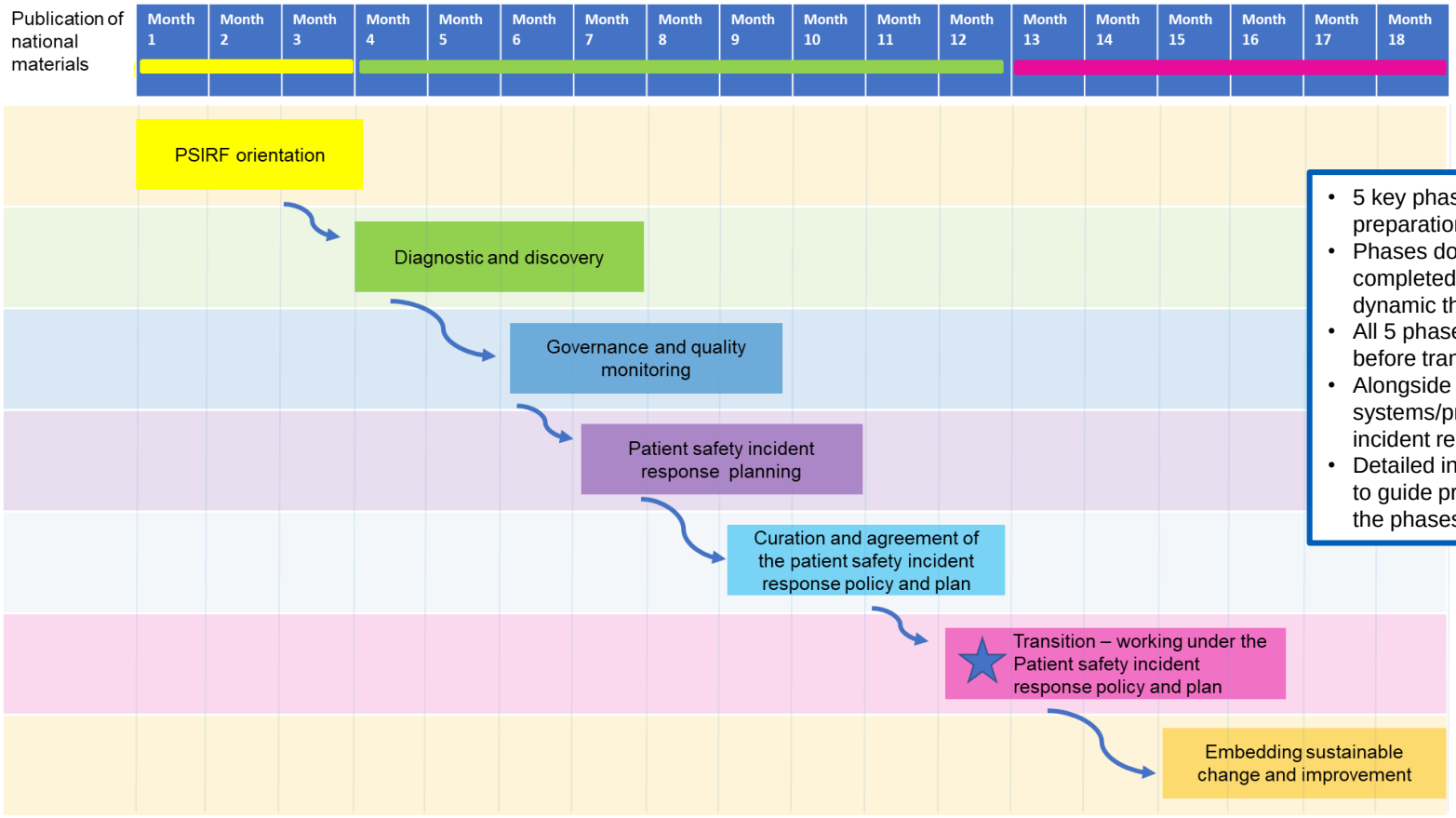


# Patient Safety Incident Response Framework (PSIRF)

- Sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.
- Replaces the Serious Incident Framework and removes the 'serious incident' classification and threshold for it.
- Embeds patient safety incident response within a wider system of improvement.
- Prompts a significant cultural shift towards systematic patient safety management


Patient Safety Incident Response Framework
Compassionate engagement and involvement of those affected by patient safety incidents
Application of a range of system-based approaches to learning from patient safety incidents
Considered and proportionate responses to patient safety incidents
Supportive oversight focused on strengthening response system functioning and improvement
Supporting documentation
Engaging and involving patients, families and staff following a patient safety incident
Guide to responding proportionately to patient safety incidents
Response tools, templates and guides
Oversight roles and responsibilities specification
Patent safety incident response standards
PSIRF preparation guide
Output
Patient safety incident response policy [template]
Patient safety incident response plan [template]

# Preparing to implement PSIRF




- 5 key phases to support the PSIRF preparation
- Phases do not need to be completed in a linear fashion (more dynamic than diagram suggests!)
- All 5 phases must be completed before transition can happen
- Alongside this work will be current systems/processes to support incident response (i.e. SIF)
- Detailed information will be provided to guide progress through each of the phases

# Summary of preparation phases

| Phase | Duration | Purpose |
|---|---|---|
| 1.PSIRF orientation | Months 1-3 | The purpose of this phase is to support PSIRF leads at all levels of the system to become familiarised with the revised Framework and associated requirements.<br>This phase sets important foundations for PSIRF preparation and subsequent implementation. |
| 2.Diagnostic and discovery | Months 4-8 | The purpose of this phase is to understand how developed your systems and processes are for responding to patient safety incidents for the purpose of learning and improvement. In this phase you will identify strengths and weaknesses, and ultimately define where improvement is required in areas that will support PSIRF requirements and transition. |
| 3.Governance and quality monitoring | Months 6-9 | During this phase organisations at all levels of the system (provider, ICS, region) will begin to define the oversight structures and ways of working that will come into place once transitioned to PSIRF. |
| 4.Patient Safety Incident Response Planning | Months 7-10 | The purpose of this phase is for organisations to understand their patient safety incident profile, patient safety improvement profile and available patient safety incident resources. This information is used to develop a Patient Safety Incident Response Plan that will sit as part of their Patient Safety Incident Response Policy to guide proactively agreed responses to patient safety incidents. |
| 5.Curation and agreement of Policy and Plan | Months 9-12 | The purpose of this phase is to draft and agree a Patient Safety Incident Response Policy and Plan based on work undertaken as part of preparation phases outlined in this guide. |
| 6.Transition | Months 12+ | Congratulations! Getting to this phase is an amazing achievement.<br>As part of this phase you will continue to adapt and learn as you put the systems and processes you have designed into place. |

# Working with Patient Safety Collaboratives

PSCs will:

Bring PSIRF leaders together utilising existing networks

Facilitate progression through PSIRF preparation phases

Identify and use improvement expertise to support specific activities

Support provider PSIRF leads to access support through signposting

# To find out more…

NHS Patient Safety
@ptsafetyNHS

If you haven't joined the NHS Patient Safety FutureNHS workspace yet what are you waiting for? It's free, there's lots of patient safety resources and information on offer and you can collaborative with colleagues whenever you want. Email NHSps-manager@future.nhs.uk for access


**5th September 2022 – 14:05 -15:30**

[Implementing the new Patient Safety Incident Response Framework (online webinar) | NHS England Events]

# Network Recording Declaration

During this ECHO session discussions will be recorded so that people who cannot attend will be able to benefit at another time. Filming is regarded as ‘personal data’ under the Data Protection Act 2018 General Data Protection Regulations (GDPR), under that law we need you to be aware that:

- This Data will be stored with password protection on the internet.
- This Data will be available for as long as your network continues to meet and will then be taken down from the internet and either stored securely at the Superhub or deleted.

Your ongoing participation in this ECHO session is assumed to imply your agreement to the use of your data in this way.

If you are NOT willing for your data to be used in this way, please LEAVE the session at this point.

# Testing of submission document

Stuart

# Webinar Content

*Sharing experiences and creating feedback loops*

Please share with us:

- Topics for presentations
- Case studies
- Shared experiences
- How you use the data
- Improvements in patient safety




# HOSPICE UK NATIONAL CONFERENCE 2022

22 – 24th November, Glasgow.

https://www.compleatconference.co.uk/events/hospiceuk-2022

# World Patient Safety Day 17 September 2019

## Speak up for patient safety!

https://future.nhs.uk/connect.ti/NHSps/view?objectId=36980720
WHO website

# NEXT MEETING: 17 November 2022
# SAM RILEY
# Director of Making Data Count
# #plotthedots

# Thank you!

Evaluation -

1. One new thing you have learnt today?
2. What will you change as a result of attending today?

Please write in the chat……