The AHSN Network

NHS Improvement

Deteriorating Patient Learning System

24th May 2018

Greater Manchester & Eastern Cheshire

Patient Safety Collaborative

The AHSN Network

NHS Improvement

Welcome

Ben Bridgewater

Chief Executive Officer

Health Innovation Manchester

Greater Manchester & Eastern Cheshire

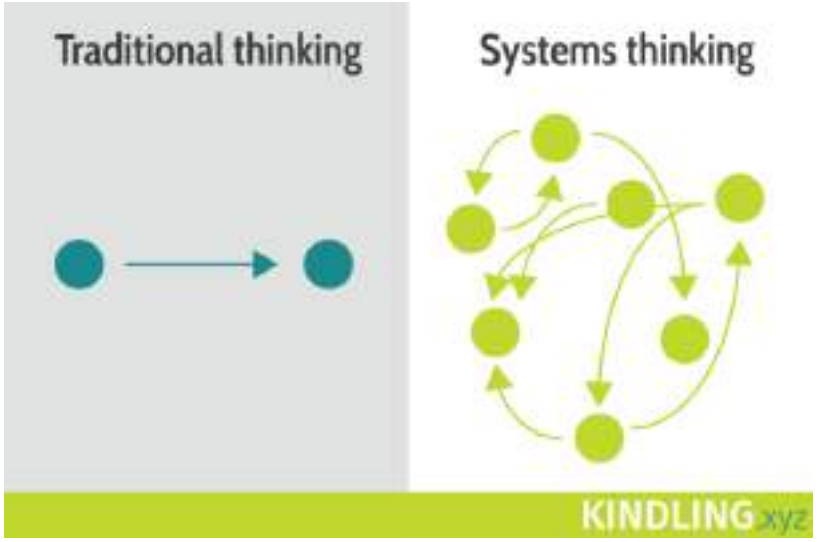
Patient Safety Collaborative

Health Innovation Manchester (HInM)

- GM is the first region in the country to take control of its combined health & social care budgets, with a budget of more than six billion pounds

- GM health devolution has enabled the formation of an Academic Health Science System facilitating the acceleration of clinical research into clinical practice

Health Innovation Manchester (HInM)



- HInM supports a 'One Manchester Team' to tackle GM health & care challenges and delivers the GMEC Patient Safety Collaborative with a mandate to create a culture of continuous learning and improvement in the NHS
- Promoting a system thinking approach to patient safety and population health across Greater Manchester and Eastern Cheshire

Patient Safety Collaborative National Context

The national PSC is the largest safety initiative in the history of the NHS, supporting and encouraging a culture of safety, continuous learning and improvement, across the health and care system.

For further information on Health Innovation Manchester Patient Safety Collaborative

Ben Bridgewater

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The AHSN Network

NHS Improvement

Patient Safety collaborative overview

Jay Hamilton

Associate Director, Patient Safety Collaborative

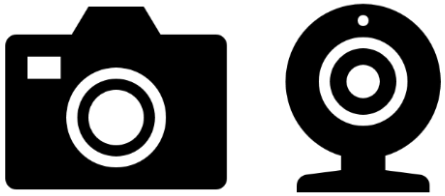
Patient Safety Collaborative Steering Group (Vice Chair)

Greater Manchester & Eastern Cheshire

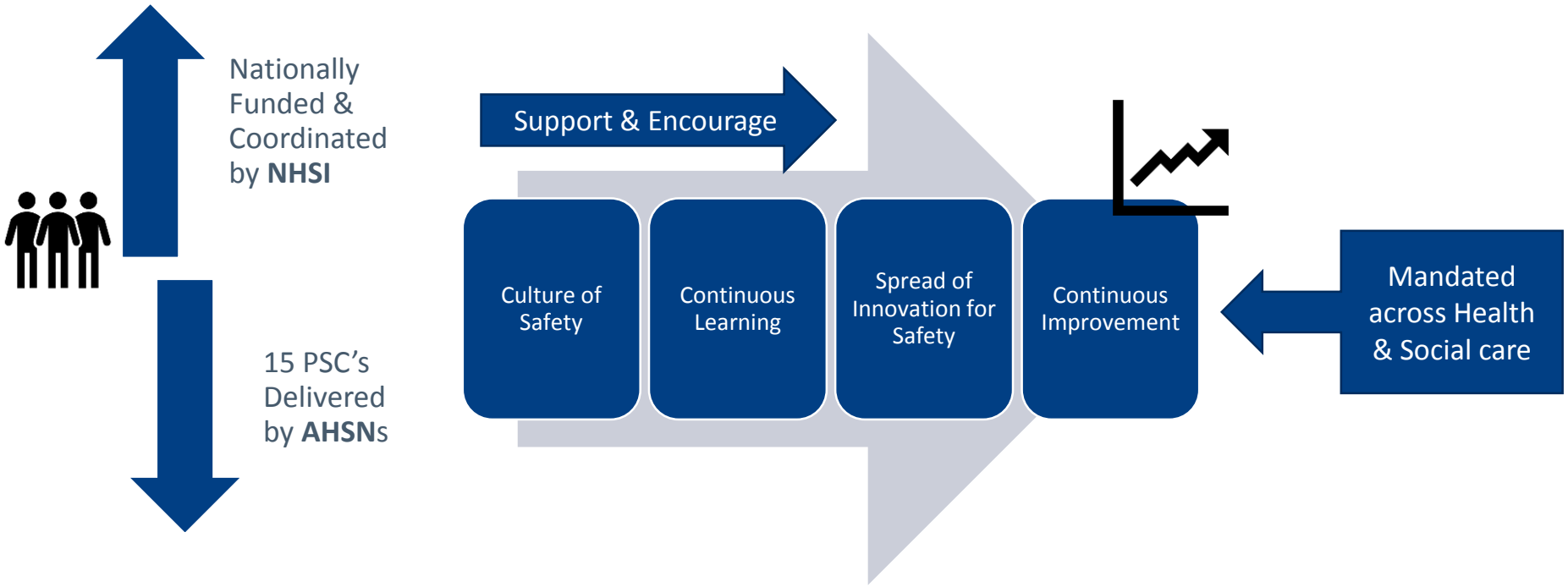
Patient Safety Collaborative

Housekeeping

@GMEC_PSC



National Patient Safety Collaboratives



PSC workstream

Workstream 1: Deteriorating Patient

- *To reduce avoidable harm & enhance the outcomes & experience of patients who are deteriorating*

Workstream 2: Culture & Leadership

- *To help create the conditions that will enable healthcare organisations to nurture & develop a culture of safety by 31st March 2019*

Workstream 3: Maternity & Neonatal

- *To improve maternity & neonatal care, specifically reducing the rate of stillbirth, neonatal death & brain injuries occurring during or soon after birth by 20% by 2020*

The Patient Safety Collaborative – Our Mission

Question

What would you like to get out of today's Deteriorating Patient learning system launch event?

(answers via Slido.com)

- *We want to make sure we address your most important questions and concerns at today's event. Therefore, we'll be using a simple tool called Slido that allows you to easily submit your questions and express your opinion by voting on live polls.*
- *Please take out your smartphones and connect to the wifi*
- *Open the web browser*
- *Go to www.slido.com and enter the event code: #2961*

For further information on Health Innovation Manchester Patient Safety Collaborative

Jay Hamilton

Managing Director Health Innovation Manchester

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Tel: 0161 509 3851

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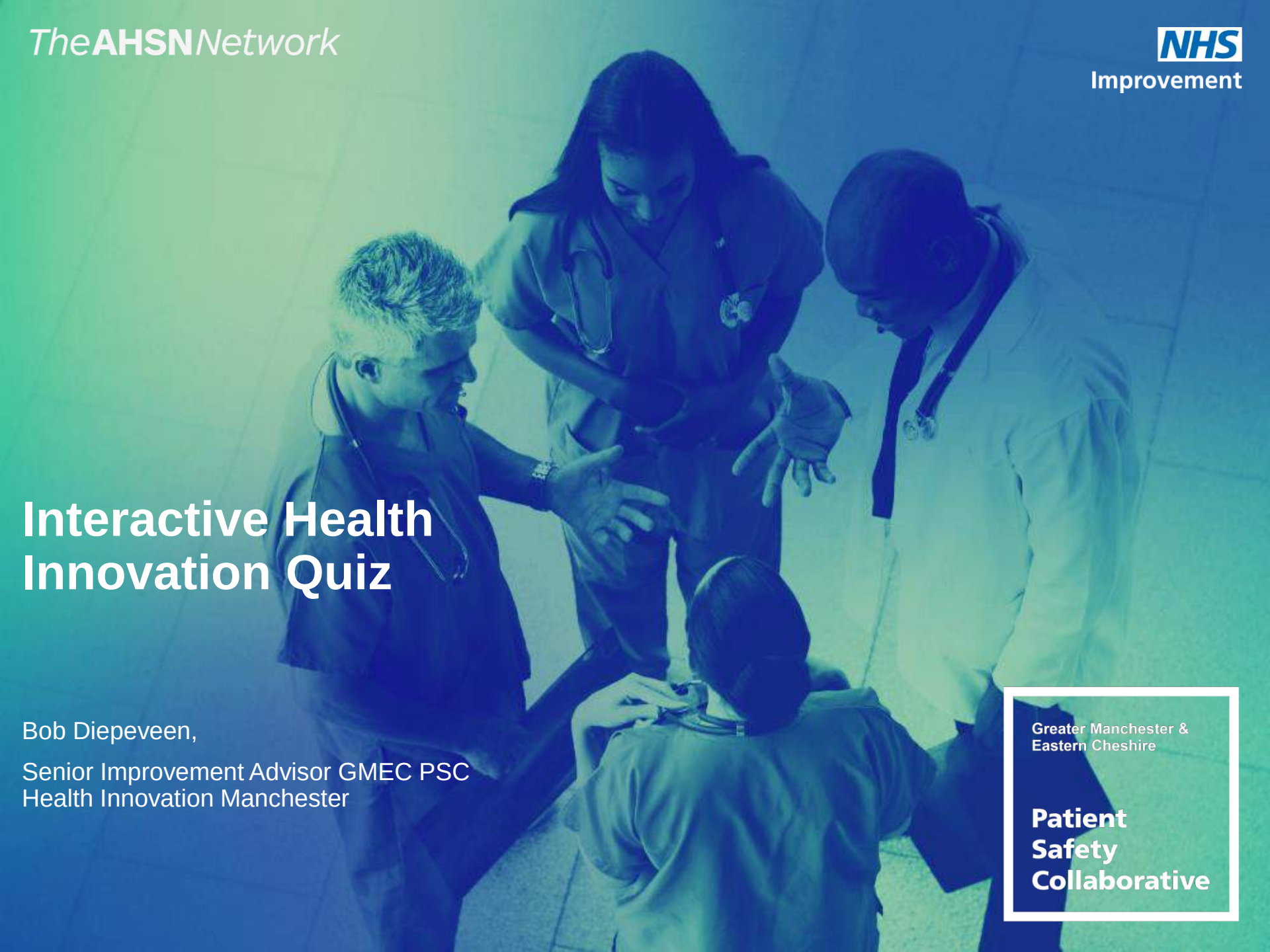

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Interactive Health Innovation Quiz

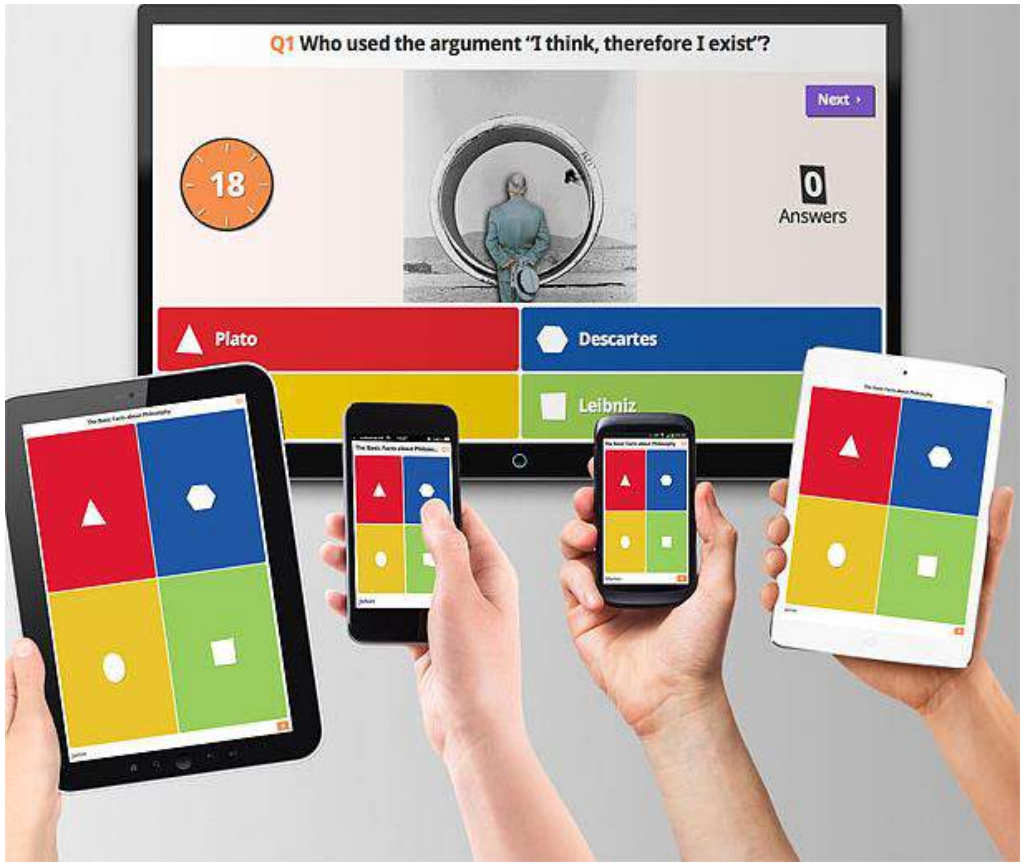
Bob Diepeveen,

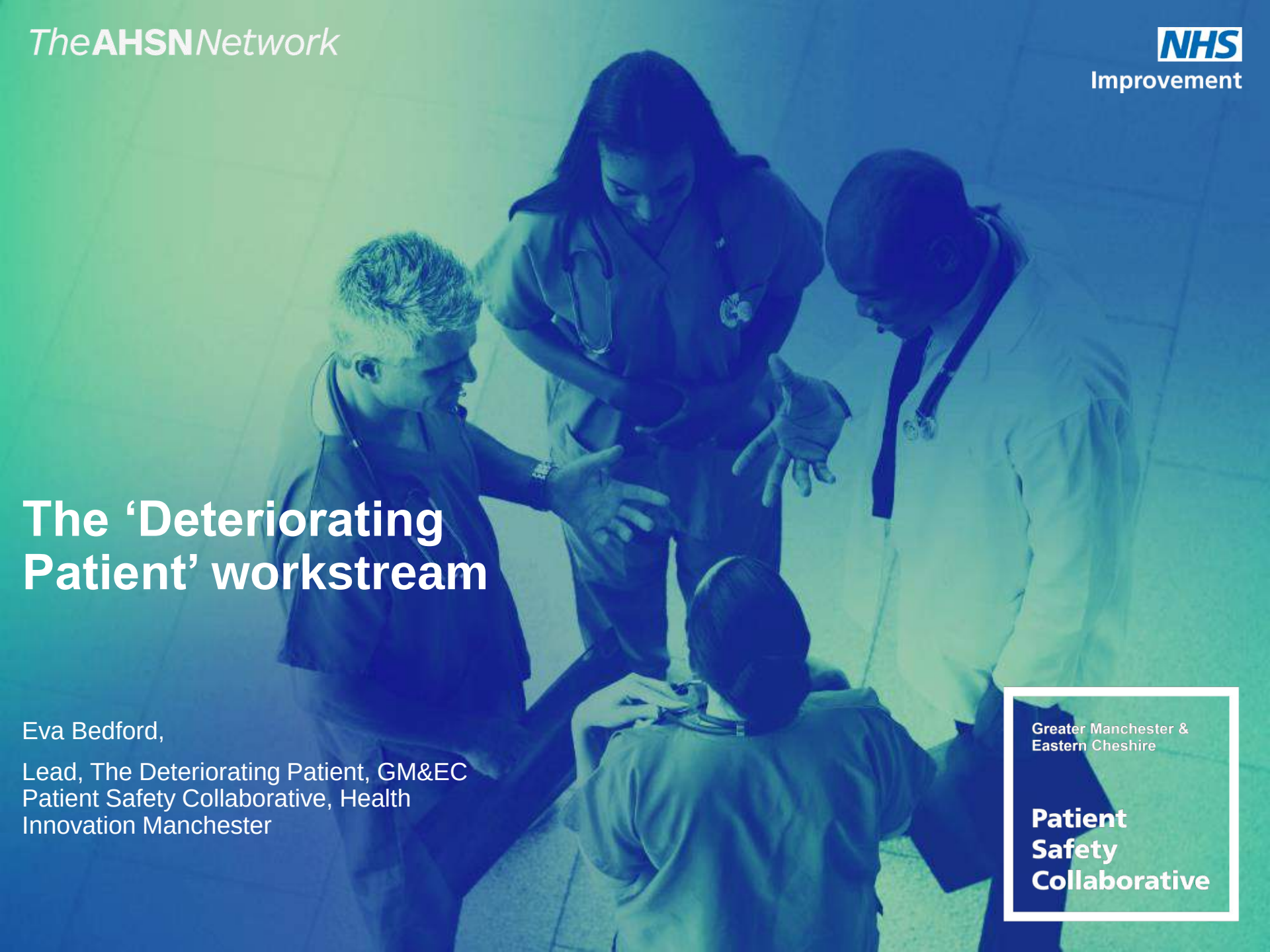
Senior Improvement Advisor GMEC PSC
Health Innovation Manchester

Greater Manchester & Eastern Cheshire

Patient Safety Collaborative

What do you already know about today?





The ‘Deteriorating Patient’ workstream

Eva Bedford,

Lead, The Deteriorating Patient, GM&EC Patient Safety Collaborative, Health Innovation Manchester

Why is the deteriorating patient a patient safety issue?

Safety Critical Industry

It can happen at any time

Timely recognition & response is critical

3-5% hospital deaths preventable

Failure to detect deterioration remains a cause for concern

The Deteriorating Patient - NHSI Aim & Primary Drivers

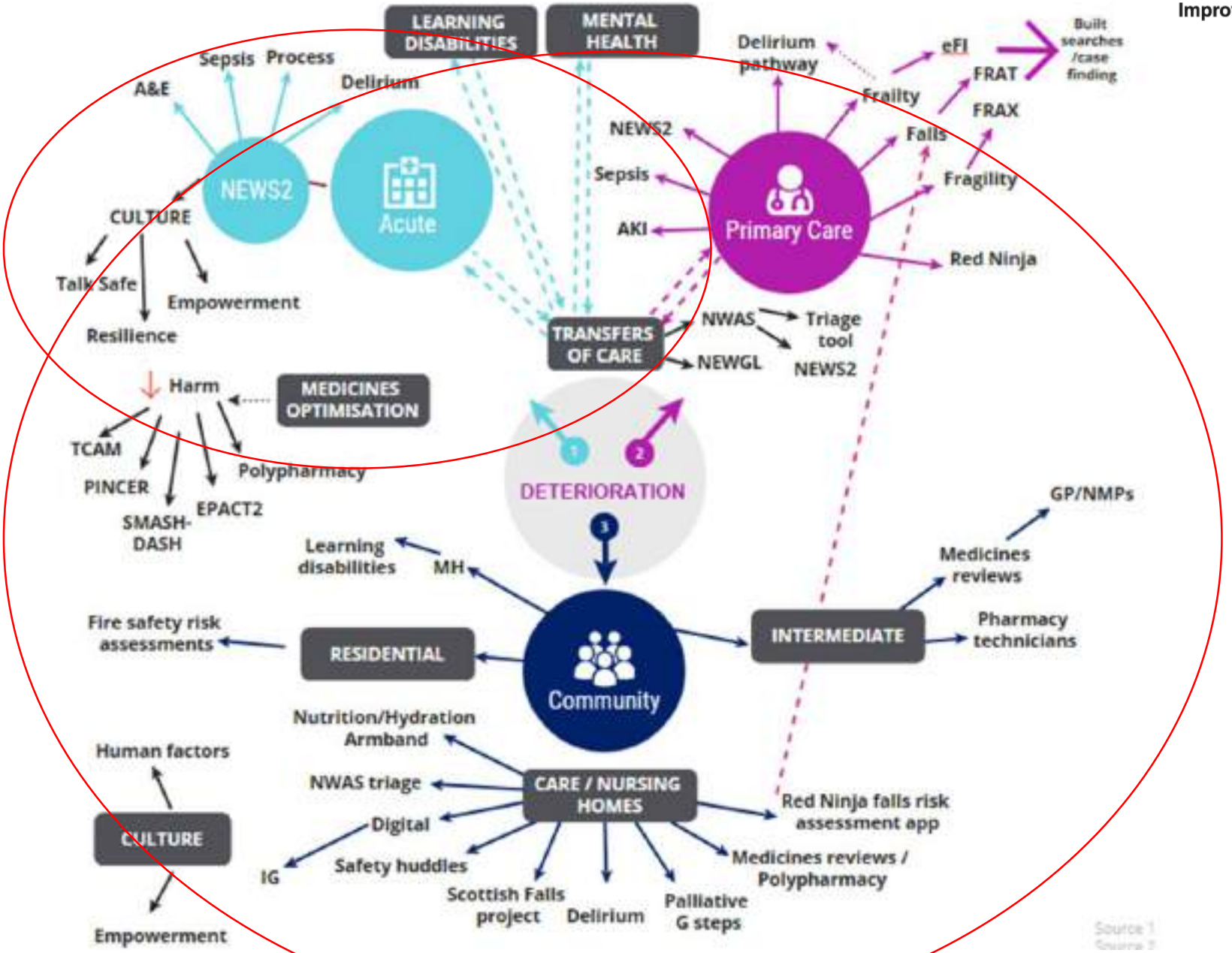
AIM
To reduce avoidable harm and enhance the outcomes and experience of patients who are deteriorating

Recognition
Reliable identification, assessment and monitoring of the patient's physiological condition

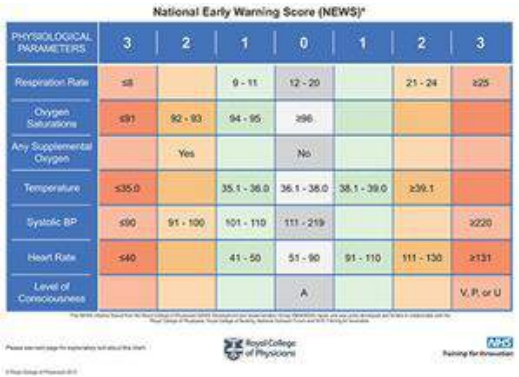
Response
Reliable activation, response to and communication of deterioration

Communication
Between healthcare professionals – high quality and structured at handover across care settings and at shift changes

Communication
With patients and carers – informed and inclusive pro-active decision making


LEARNING DISABILITIES
MENTAL HEALTH
Sepsis
Process
A&E
Delirium
NEWS2
Acute
CULTURE
Talk
Safe
Empowerment
Resilience
Delirium pathway
eFI
Built searches /case finding
Frailty
FRAT
FRAX
Falls
Fragility
NEWS2
Sepsis
AKI
Primary Care
Red Ninja
TRANSFERS OF CARE
NWAS
Triage tool
NEWS2
NEWGL
Harm
MEDICINES OPTIMISATION
TCAM
PINCER
SMASH-DASH
EPACT2
Polypharmacy
DETERIORATION
GP/NMPs
Learning disabilities
MH
Medicines reviews
Fire safety risk assessments
RESIDENTIAL
Community
INTERMEDIATE
Pharmacy technicians
Nutrition/Hydration Armband
Human factors
NWAS triage
CARE / NURSING HOMES
Red Ninja falls risk assessment app
CULTURE
Digital
IG
Safety huddles
Scottish Falls project
Delirium
Palliative G steps
Medicines reviews / Polypharmacy
Empowerment

Deteriorating Patient – GMECPSC 2018/19


National Early Warning Score (NEWS)*

PHYSIOLOGICAL PARAMETERS	3	2	1	0	1	2	3
Respiration Rate	≤8		9 - 11	12 - 20		21 - 24	≥25
Oxygen Saturations	≤91	92 - 93	94 - 95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0		35.1 - 36.0	36.1 - 38.0	38.1 - 39.0	≥39.1	
Systolic BP	≤90	91 - 100	101 - 110	111 - 219			≥220
Heart Rate	≤40		41 - 50	51 - 90	91 - 110	111 - 130	≥131
Level of Consciousness				A			V, P, or U

Early Warning Score Systems

EWS system developed to improve the detection of and response to clinical deterioration in patients with acute illness.

They provide for structured assessment of routine physiological measurements and allocate points on the basis of their deviation from 'normal' range

Aggregate scores provide a trigger for clinical response

Improved clinical outcomes including cardiopulmonary arrest, mortality, serious adverse events, length of hospital stay, observation frequency and ICU/HDU admission following implementation of EWS

No standard early warning scoring system in use currently, nationally or locally

National Data - 2018

How are we using the National Early Warning Score in England?

79%

OF ACUTE TRUSTS

are using NEWS in all or part of the organisation

127 acute trusts and all 10 ambulance trusts responded to the survey of NEWS use

1 in 20 acute trusts adapt NEWS to their local needs

100%

OF AMBULANCE TRUSTS

are using NEWS in all or part of the organisation

Ambulance trusts use a variety of criteria to trigger transfers:

A NEWS score of 5+:	4/10 trusts
A NEWS score of 3+:	1/10 trusts
Combination of NEWS score & other markers:	5/10 trusts

Local Data - 2018

How are we using the National Early Warning Score (NEWS) within Greater Manchester & Eastern Cheshire?

67%

of Acute Trusts are using NEWS or an adapted version of NEWS

(Remaining Acute Trusts are using another EWS)

100%

of Acute Trusts and NWAS responded to the survey about NEWS use

North West Ambulance Service (NWAS) using NEWS across the entire region

- 3 x Acute Trusts using an electronic scoring system
- 3 x Acute Trusts + NWAS using a paper scoring system
- 3 x Acute Trusts using a mixture of electronic and paper scoring systems

The National Early Warning Score2 (NEWS2)

- **NHS England endorsing** adoption of NEWS2 for non-pregnant adult patients across all acute hospital and ambulance trusts **by March 2019**.
- **NEWS2 tool** reliably detects deterioration & sepsis in adults, triggering review, treatment and escalation of care (NHSI 2018).
- **Update includes** consideration of hypercapnic respiratory failure and new confusion
- **Joint 'Patient Safety Alert'** issued 25 April 2018 identifying resources necessary to support the safe adoption of NEWS2 – **completion 21st June 2018**
- **Nominate** a NEWS2 champion
- **Identify/ establish** a reporting committee to plan adoption of NEWS2
- **Identify actions** required to ensure trust-wide adoption of NEWS2 by March 2019

How will this improve patient safety?

Reduce variation and **improve the quality** of care by:

- **Standardising** approach to identifying and grading acute-illness severity, in order to trigger a timely and appropriate clinical response
- **Enabling** effective communication throughout the patient pathway
- **Common Language** – to communicate the score and criteria
- **Critical Language** – Ensuring key message is transmitted and received appropriately as part of escalation/de-escalation

Why is improving communication a key theme?

- Breakdown in communication has been identified as a leading factor in adverse patient events and is a major cause of inadequacies in healthcare delivery
- Poor communication especially common at the interfaces of care and culminate in adverse events, including an increase in preventable hospital admissions
- Effective communication is essential both within and between teams to ensure co-operation and coordination of care
- Clear, accurate, and timely communication can improve patient outcomes, safety and satisfaction

References

- Illingworth J. (2015). Is the NHS getting safer? London: The Health Foundation. https://www.health.org.uk/sites/default/files/IsTheNHSGettingSafer.pdf. (accessed 13/05/2018)
- The National Patient Safety Agency (2007). Recognising and responding appropriately to early signs of deterioration in hospitalised patients. ISBN: 978-0-9556340-8-6. www.npsa.nhs.uk. (accessed 04/03/2018)
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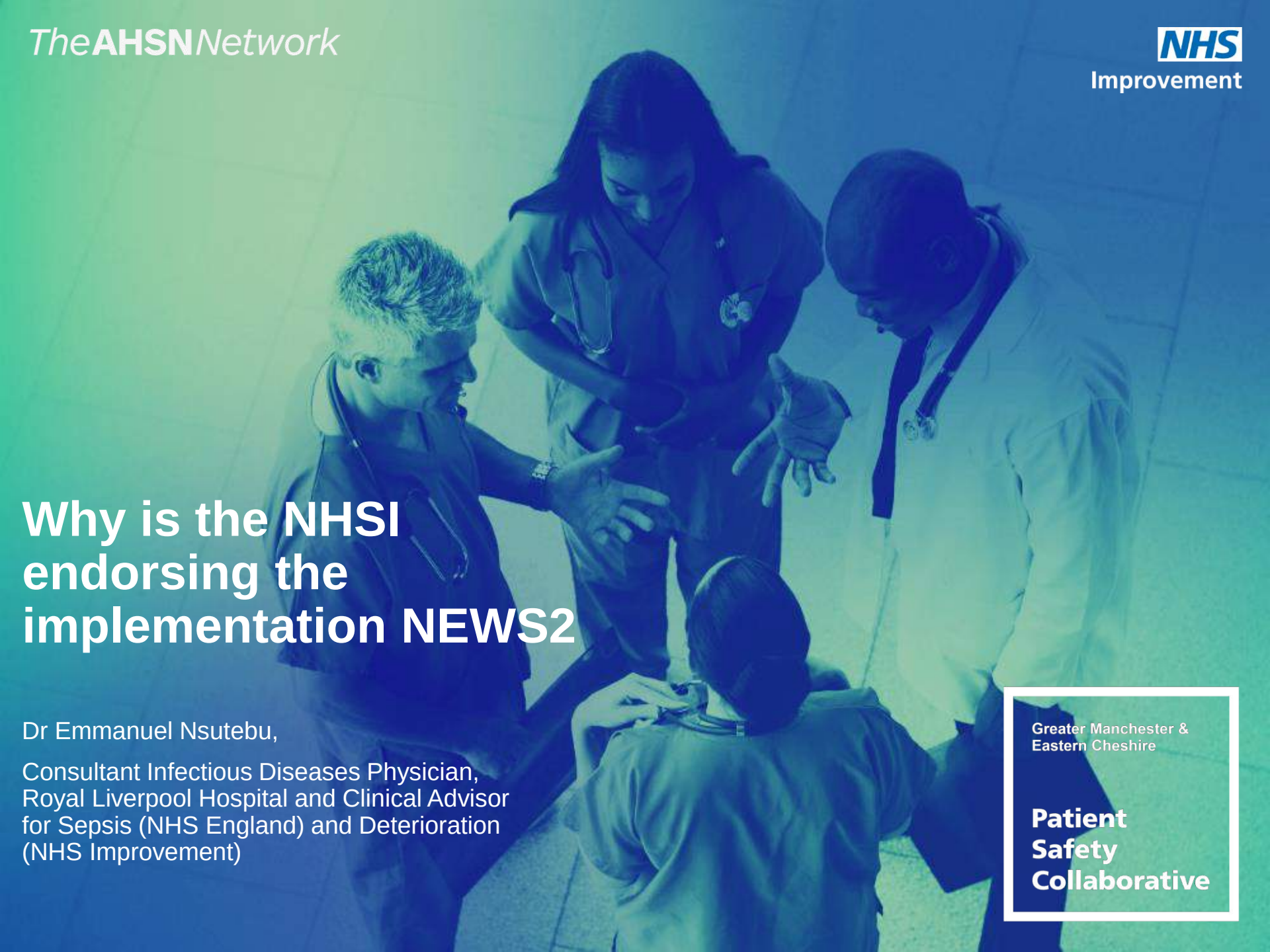
- Royal College of Physicians (2017). National Early Warning Score (NEWS) 2 Standardising the assessment of acute-illness severity in the NHS. Updated report of a working party. https://www.rcplondon.ac.uk/projects/outputs/national-early-warning-score-news-2. (accessed 21/02/2018)
- NHS England & NHS Improvement (2018). Resources to support the safe adoption of the revised National Early Warning Score (NEWS2). Alert reference number: NHS/PSA/RE/2018/003: https://improvement.nhs.uk/documents/2508/Patient_Safety_Alert_-_adoption_of_NEWS2.pdf (accessed 01/05/2018)



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NHS Improvement

Why is the NHSI endorsing the implementation NEWS2

Dr Emmanuel Nsutebu,

Consultant Infectious Diseases Physician, Royal Liverpool Hospital and Clinical Advisor for Sepsis (NHS England) and Deterioration (NHS Improvement)

Greater Manchester & Eastern Cheshire

Patient Safety Collaborative

Royal Liverpool & Broadgreen University Hospitals NHS Trust

NHS

NEWS2 and improving culture, systems and teams for responding to deterioration

Dr Emmanuel Nsutebu
Consultant Infectious Disease Physician & Clinical lead for sepsis
National Advisor Deterioration (NHS Improvement) and Sepsis (NHS England)

Delphine's tragic story…31.07.2003…….

Key messages

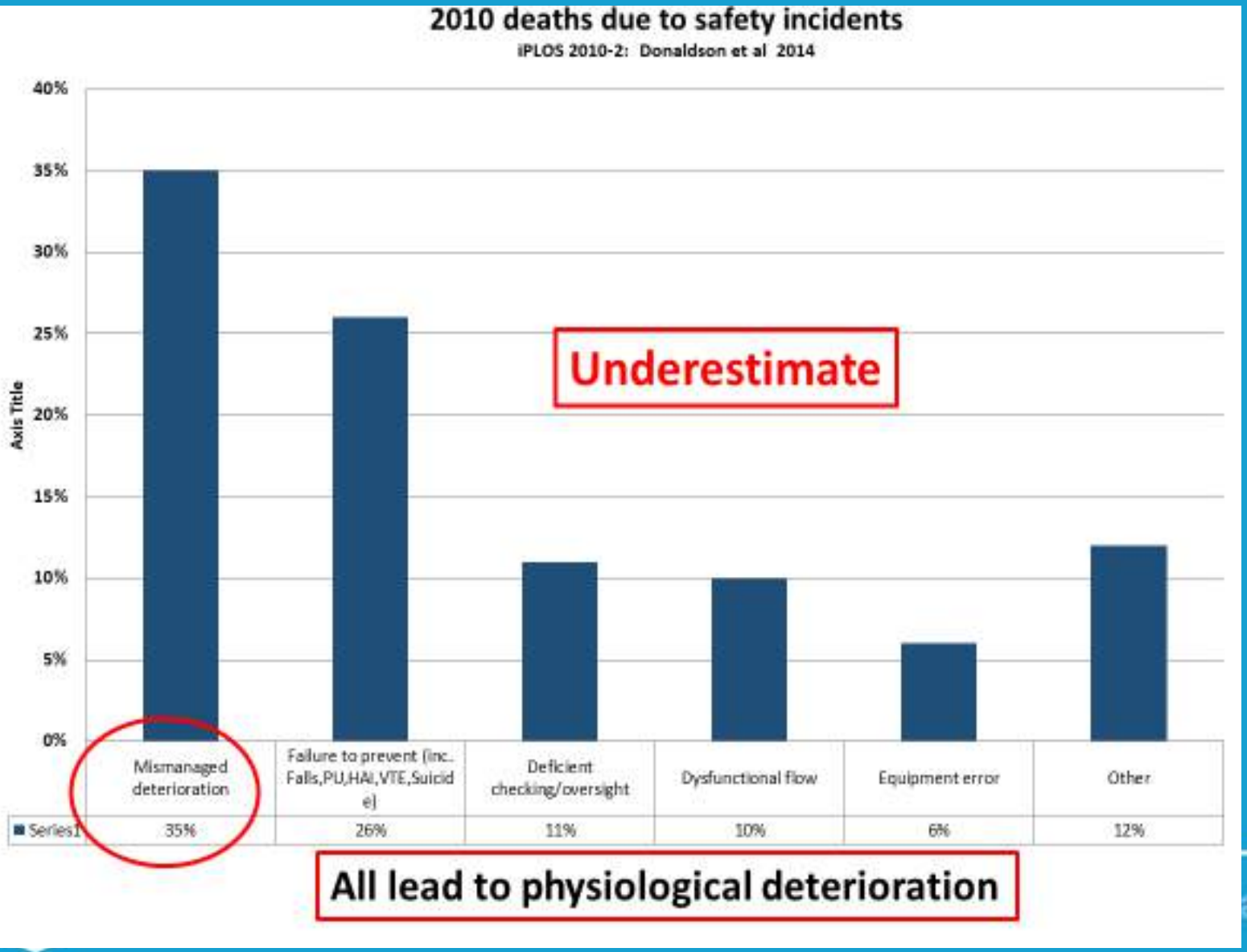
- Patients want us to “make them better, not harm them, be nice to them, continue to improve”
- “Quality & Patient safety is about culture, systems and trained staff working in teams”
- “Every system is designed to deliver what it delivers”

Objectives

- Illustrate with patient stories

- What is deterioration?
- What needs to improve?
- Role of culture/systems and teams
- NEWS & NEWS2 – NHS England policy

Mismanaged Deterioration is the #1 Avoidable cause of de



How safe are our hospital wards?

- Example of last week's patients

Key messages

- Principles of improving deterioration
  - Recognition: Obs (make vital signs great again) and EWS
  - Response – action and escalation
  - Communication – SBAR
- Electronic systems are important however avoid over-reliance
- The escalation plan should allow clinicians to escalate care based only subjective concern - (‘worried’ criterion).
- Rapid Response Teams are important however nursing and medical team are ultimately responsible

Transfer of care – problems at transition of care

- Another patient story

Have I got NEWS for your?

National Early Warning Score (NEWS)*

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Heart Rate	≤40		41 - 50	51 - 90	91 - 110	111 - 130	≥131
Level of Consciousness				A			V, P, or U

*The NEWS chart is based on the Royal College of Physicians' NEWS Development and Implementation Group (NEWS2020) report, and was jointly developed and tested in collaboration with the Royal College of Physicians, Royal College of Nursing, National Outreach Forum and NHS Training for Innovation

© Royal College of Physicians 2012

Chart 4: Clinical response to the NEWS trigger thresholds

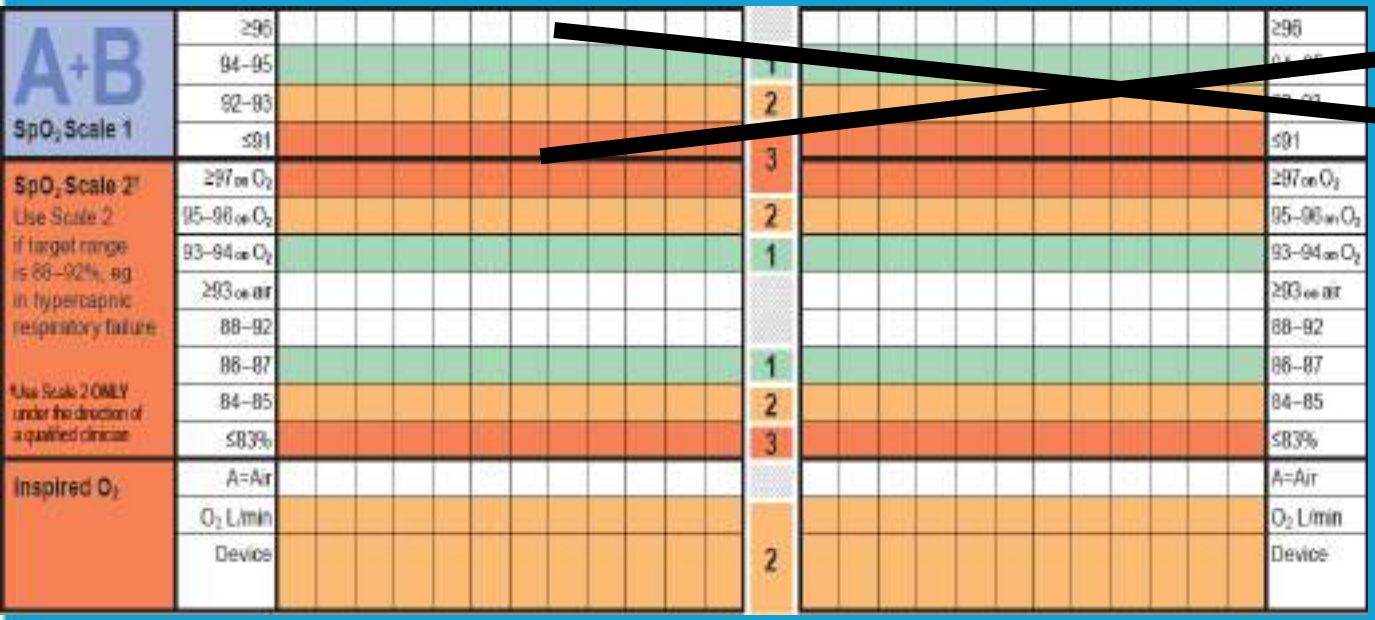
NEW score	Frequency of monitoring	Clinical response
0	Minimum 12 hourly	• Continue routine NEWS monitoring
Total 1–4	Minimum 4–6 hourly	• Inform registered nurse, who must assess the patient • Registered nurse decides whether increased frequency of monitoring and/or escalation of care is required
3 in single parameter	Minimum 1 hourly	• Registered nurse to inform medical team caring for the patient, who will review and decide whether escalation of care is necessary
Total 5 or more Urgent response threshold	Minimum 1 hourly	• Registered nurse to immediately inform the medical team caring for the patient • Registered nurse to request urgent assessment by a clinician or team with core competencies in the care of acutely ill patients • Provide clinical care in an environment with monitoring facilities
Total 7 or more Emergency response threshold	Continuous monitoring of vital signs	• Registered nurse to immediately inform the medical team caring for the patient – this should be at least at specialist registrar level • Emergency assessment by a team with critical care competencies, including practitioner(s) with advanced airway management skills • Consider transfer of care to a level 2 or 3 clinical care facility, ie higher-dependency unit or ICU • Clinical care in an environment with

NEWS2

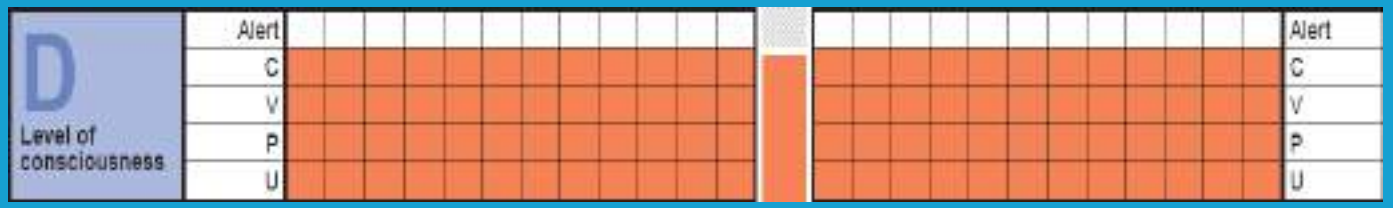
- Chronic hypoxia subchart
- Addition of NEW Confusion to AVPU scoring a 3
- De-escalation of single parameter 3 value
- Sepsis chapter defining the place of NEWS in Infection = screen if NEWS 5 or more

NEWS2

2 Oxygenation scales- Chronic hypoxia & normal



NEW Confusion- off baseline. “Do I think that Mr X is more confused than norma



Sepsis Chapter defining the place of NEWS in Sepsis

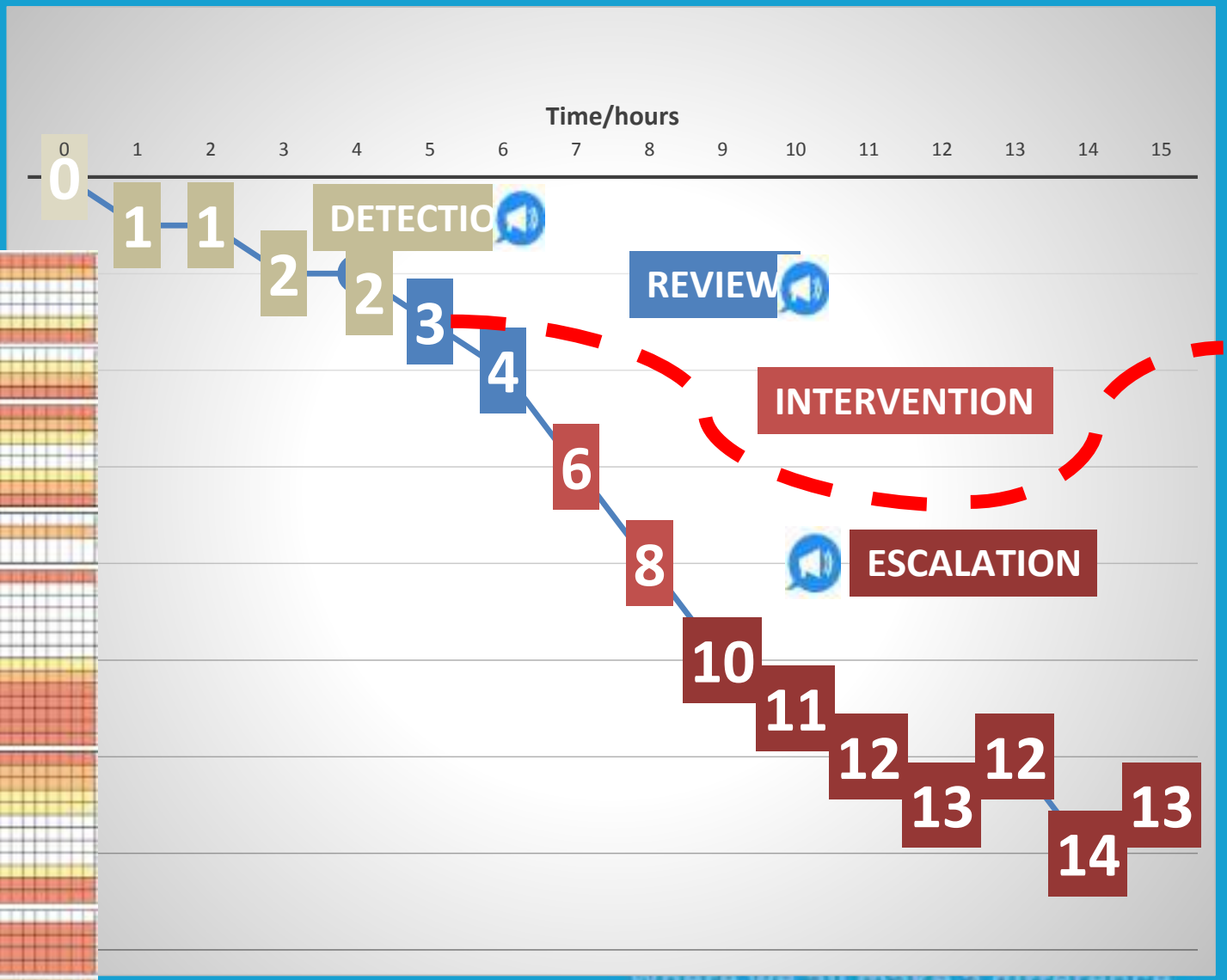
NEWS2

- De-escalation of single parameter 3 value
- Sepsis chapter defining the place of NEWS in Infection = screen if NEWS 5 or more
- Not recommended for us in children <16, pregnant women and spinal cord injury

What about using NEWS in the community?

- Validated for ambulance services
- Various parts of England using it and evaluation is required
- Important principles
  - Not a diagnosis
  - Clinical judgement remains crucial
  - Useful to communicate concern when referring a patient
  - Needs to be used with support in the community e.g. someone to phone and discuss

NEWS - A Standardised Systems Solution for deterioratio



S

Situation:
I am (name), a nurse on ward (X)
I am calling about (child X)
I am calling because I am concerned that…
(e.g. BP is low/high, pulse is XXX temperature is XX, Early Warning Score is XX)

B

Background:
Child (X) was admitted on (XX date) with
(e.g. respiratory infection)
They have had (X operation/procedure/investigation)
Child (X)'s condition has changed in the last (XX mins)
Their last set of obs were (XXX)
The child's normal condition is…
(e.g. alert/drowsy/confused, pain free)

A

Assessment:
I think the problem is (XXX)
and I have…
(e.g. given O_2/analgesia, stopped the infusion)
OR
I am not sure what the problem is but child (X) is deteriorating
OR
I don't know what's wrong but I am really worried

R

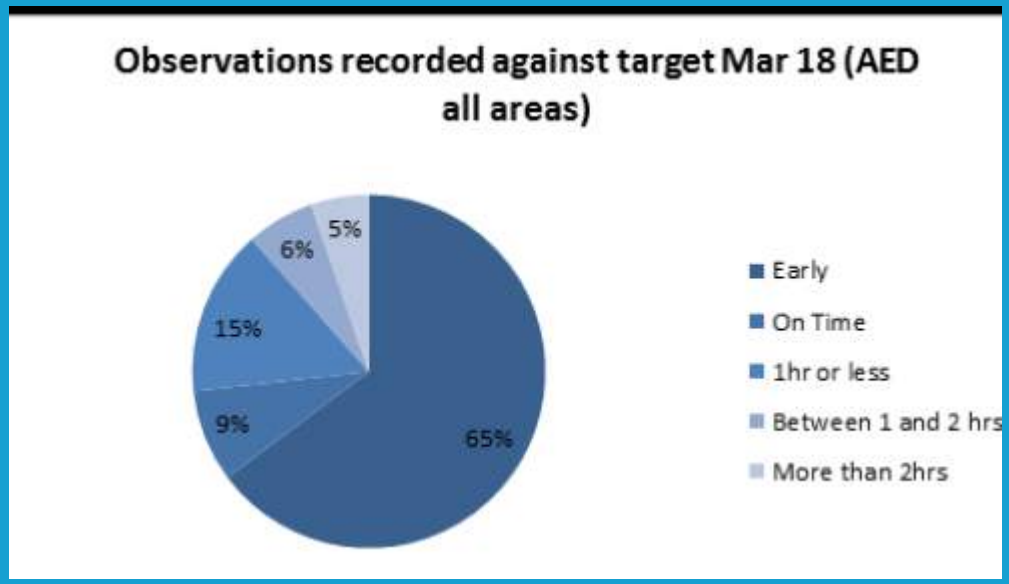
Recommendation:
I need you to…
Come to see the child in the next (XX mins)
AND
Is there anything I need to do in the meantime?
(e.g. stop the fluid/repeat the obs)

Ask receiver to repeat key information to ensure understanding

The SBAR tool originated from the US Navy and was adapted for use in healthcare by Dr M Leonard and colleagues from Kaiser Permanente, Colorado, USA

If you require further copies quote SC043

In God we Trust, every body else bring data!



Key messages

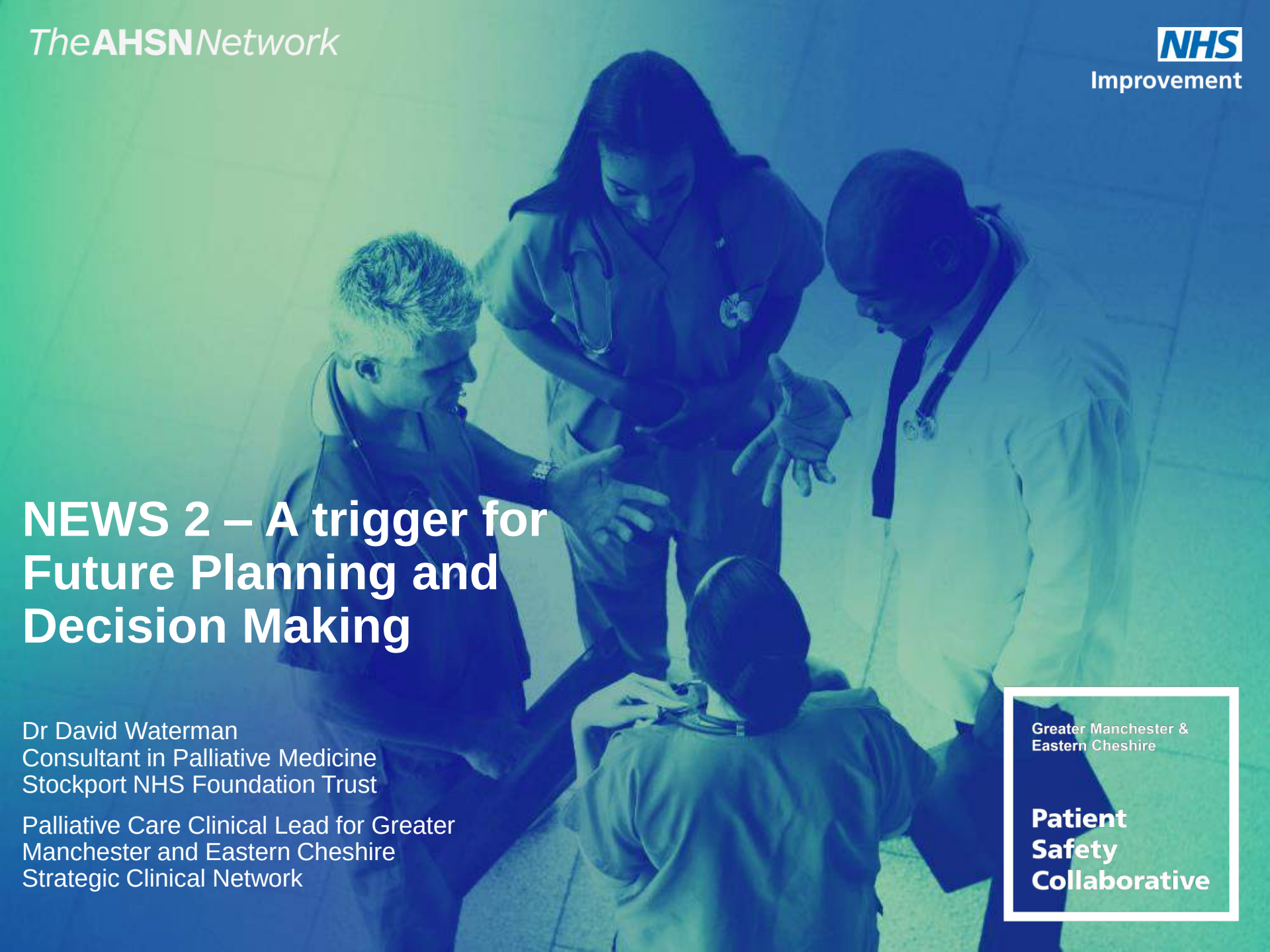
- Every system is designed to deliver what it achieves
- Culture eats systems for breakfast, systems are better than teams and teams are better than highly trained individuals
- Widespread adoption of NEWS2 can help improve safety by standardising recognition and response to deterioration

Thank you

- Emmanuel.Nsutebu@nhs.net

Common questions about NEWS

- There is a risk of large numbers of admission to hospital and ITU because confusion has been added to NEWS2
- What if a patient refuses all observations e.g. mental health problems?
- What about hospitals with electronic systems, it isn't easy to switch from NEWS to NEWS2
- Should HCAs be taking observations?
- What if hospitals modify triggers for NEWS?
- What if we have our own EWS or modified NEWS which works for us and is also validated?
- Why is urine output not part of NEWS or NEWS2
- What about specialist Trusts who require closer neurological monitoring or have pregnant women or children?



NEWS 2 – A trigger for Future Planning and Decision Making

Dr David Waterman
Consultant in Palliative Medicine
Stockport NHS Foundation Trust

Palliative Care Clinical Lead for Greater Manchester and Eastern Cheshire Strategic Clinical Network

The AHSN Network

NHS Improvement

Greater Manchester & Eastern Cheshire

Patient Safety Collaborative

NEWS 2 – Physiological Scores

Chart 1: The NEWS scoring system

Physiological parameter	Score 3	2	1	0	1	2	3
Respiration rate (per minute)	≤8		9–11	12–20		21–24	≥25
SpO_2 Scale 1 (%)	≤91	92–93	94–95	≥96			
SpO_2 Scale 2 (%)	≤83	84–85	86–87	88–92 ≥93 on air	93–94 on oxygen	95–96 on oxygen	≥97 on oxygen
Air or oxygen?		Oxygen		Air			
Systolic blood pressure (mmHg)							
Pulse (per minute)							
Consciousness							
Temperature (°C)							

Chart 2: NEWS thresholds and triggers

NEW score	Clinical risk	Response
Aggregate score 0–4	Low	Ward-based response
Red score Score of 3 in any individual parameter	Low–medium	Urgent ward-based response*
Aggregate score 5–6	Medium	Key threshold for urgent response*
Aggregate score 7 or more	High	Urgent or emergency response**

* Response by a clinician or team with competence in the assessment and treatment of acutely ill patients and in recognising when the escalation of care to a critical care team is appropriate.

**The response team must also include staff with critical care skills, including airway management.

Patient Safety Alert NEWS 2 – April 2018

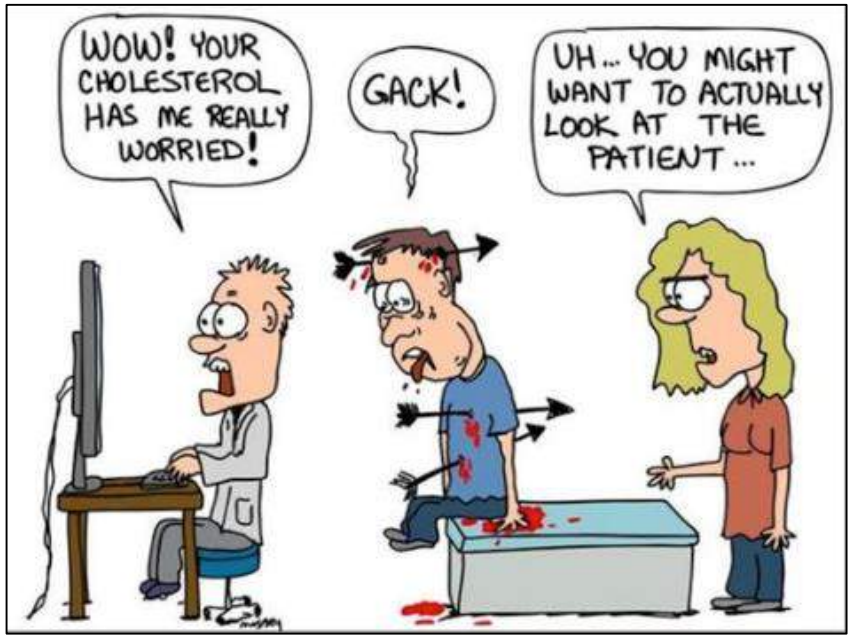
Resources to support the safe adoption of the revised National Early Warning Score

- 'Failure to recognise or act on signs that a patient is deteriorating… is a key patient safety issue' – **What are the options for actions?**

- '……deterioration may not have been recognised or acted on and the patient died. Although these patients may not have survived with prompt action, the care provided did not give them the best possible chance of survival' – **How to maximise the care of those with reversibility and irreversibility?**

- 'NEWS 2 ….reliably detects deterioration in adults, triggering review, treatment and escalation of care where appropriate' – **How can the trigger aid decision making and future care planning?**

Recognition of Deterioration



- A Trigger for further assessment
- Consideration of clinical history
- Treatment options
- Degree of Reversibility
- Previous Wishes/ Advance Plans

Decision Making Context - Populations

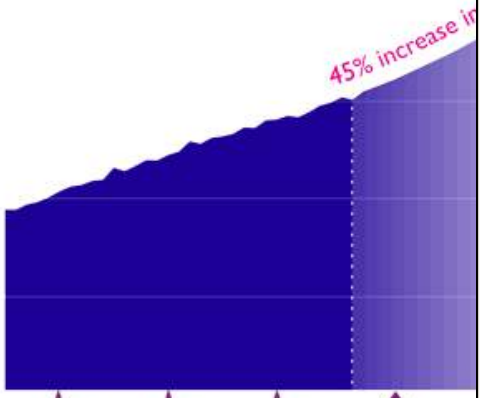
- GM - 23,866 deaths (ONS 2016) - Of these 49.8% died in hospital

61%

increase in the number of over 65s in the UK by 2032

Britain's over 65s already outnumber its under 16s

Cancer cases to



Clinical Frailty Scale*

1 **Very Fit** – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 **Well** – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.

3 **Managing Well** – People whose **medical problems are well controlled,** but are **not regularly active** beyond routine walking.

4 **Vulnerable** – While **not dependent** on others for daily help, often **symptoms limit activities.** A common complaint is being "slowed up", and/or being tired during the day.

5 **Mildly Frail** – These people often have **more evident slowing,** and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 **Moderately Frail** – People need help with **all outside activities** and with **keeping house.** Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.

7 **Severely Frail** – **Completely dependent for personal care,** from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 **Very Severely Frail** – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9. **Terminally Ill** - Approaching the end of life. This category applies to people with **a life expectancy <6 months,** who are **not otherwise evidently frail.**

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia,** recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

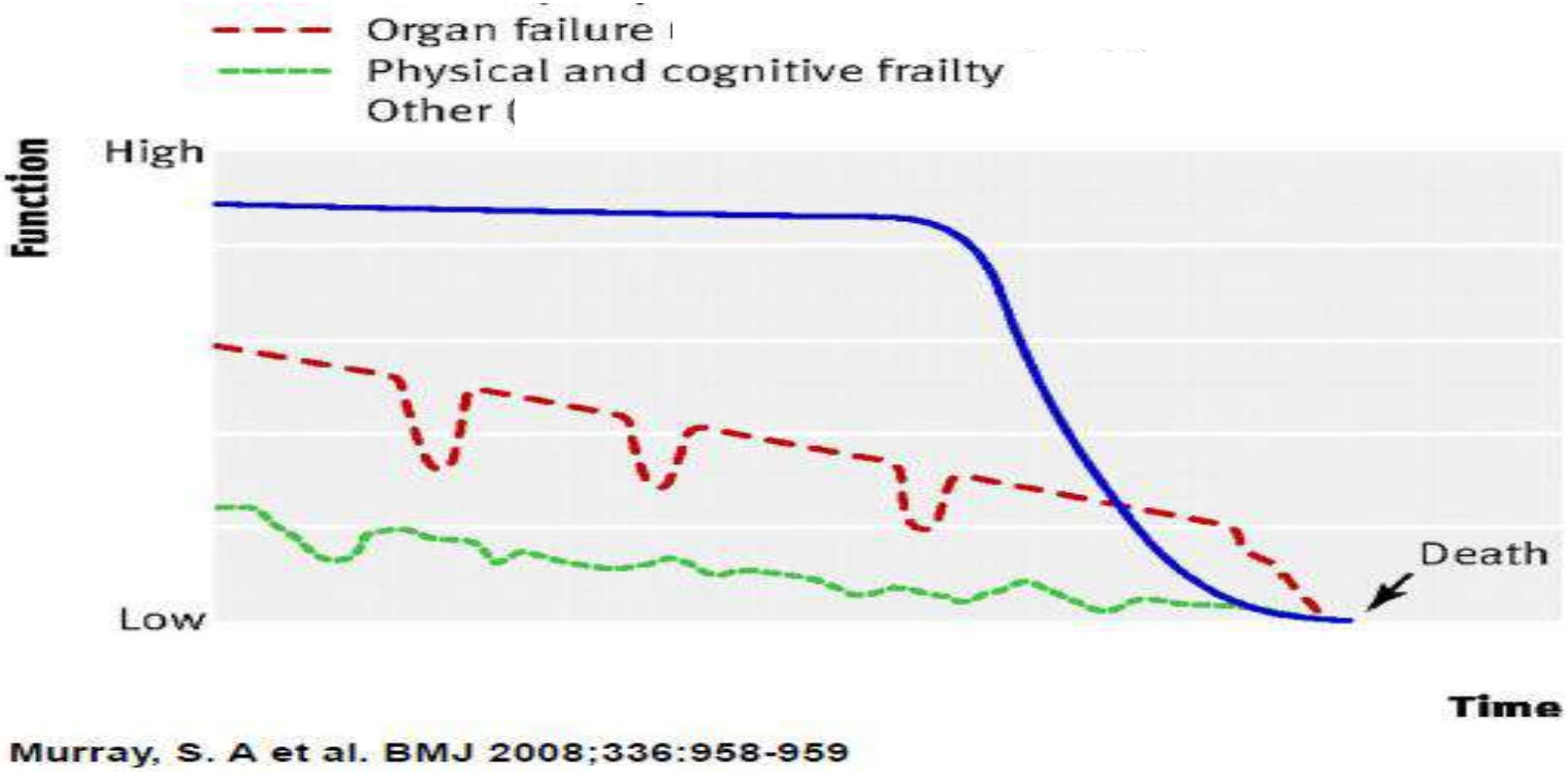
In **severe dementia,** they cannot do personal care without help.

IADL–instrumental activity of daily living.
Reproduced with permission from Rockwood.[6]

* 1. Canadian Study on Health & Aging, Revised 2008.
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

DALHOUSIE UNIVERSITY *Inspiring Minds*

Clinical Context of Decision Making



Murray, S. A et al. BMJ 2008;336:958-959

Supportive and
Palliative Care

Active Treatment and
Management

Hospital Admission Data

- 28.8% patients died during the one year follow up period in a Scottish study (1/10 of those who died were during that admission)
- Likelihood of dying three times higher at one year for patients aged 85 and over, compared to those who were under 60.

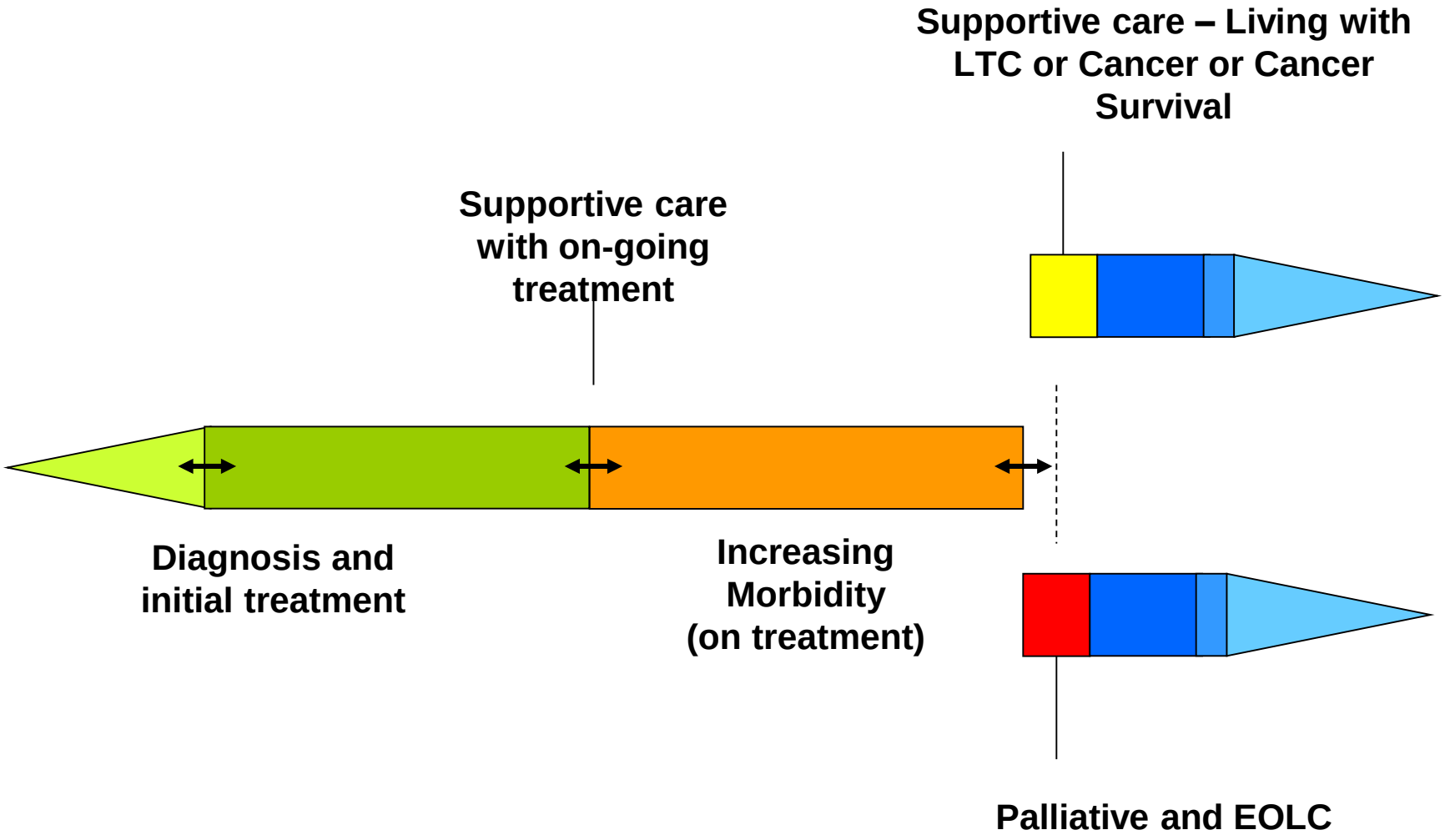
Clark, D et al. Imminence of death among hospital inpatients: a prevalent cohort study. *Palliative Medicine* March 2014

- The National Audit of Heart Failure - 32% of patients died within the year of their admission for heart failure (2010)

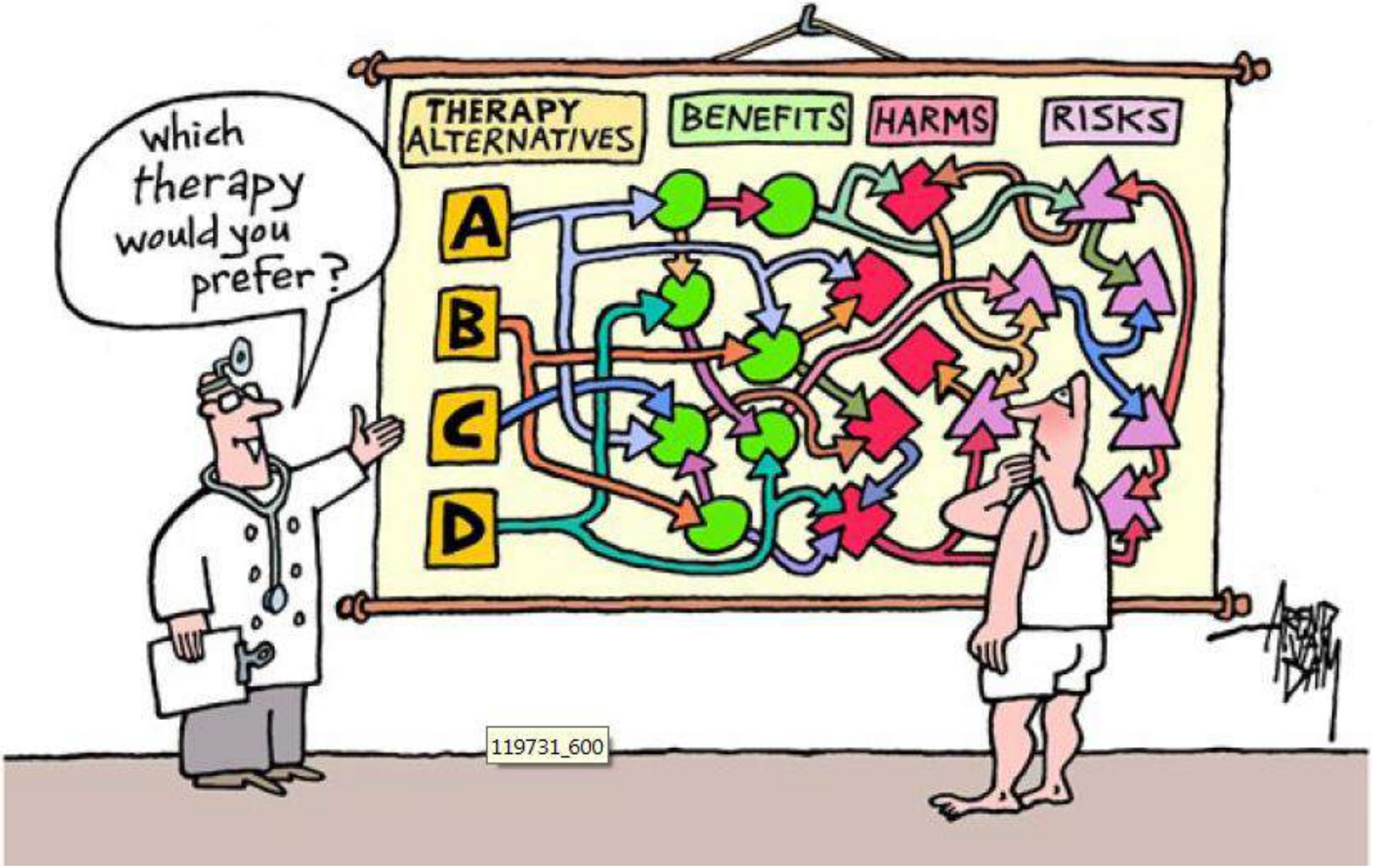
- Acute hospitals dealing with a very large number of people who are nearing the end of their lives – though they may not always be recognised

Clinical Complexity

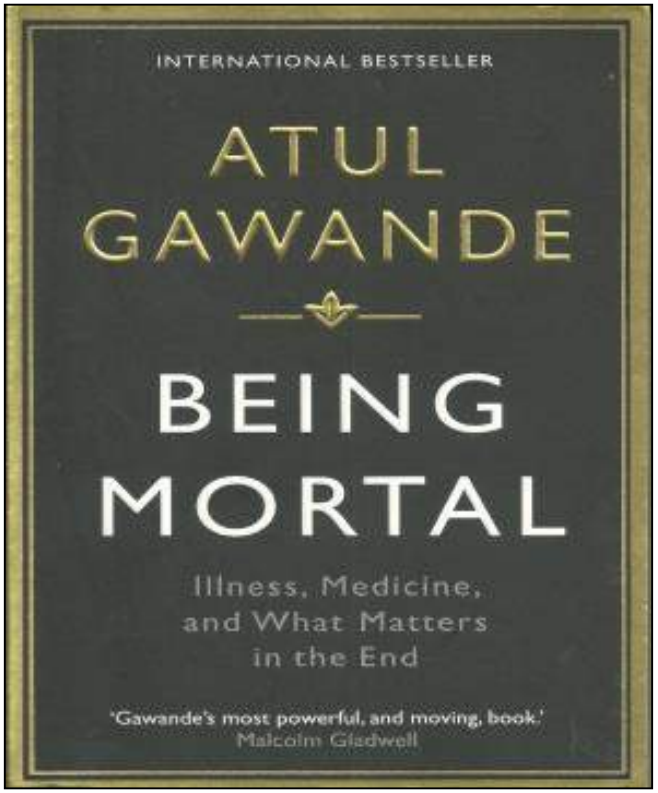
Increasing complexity and options for interventions



Decision Making

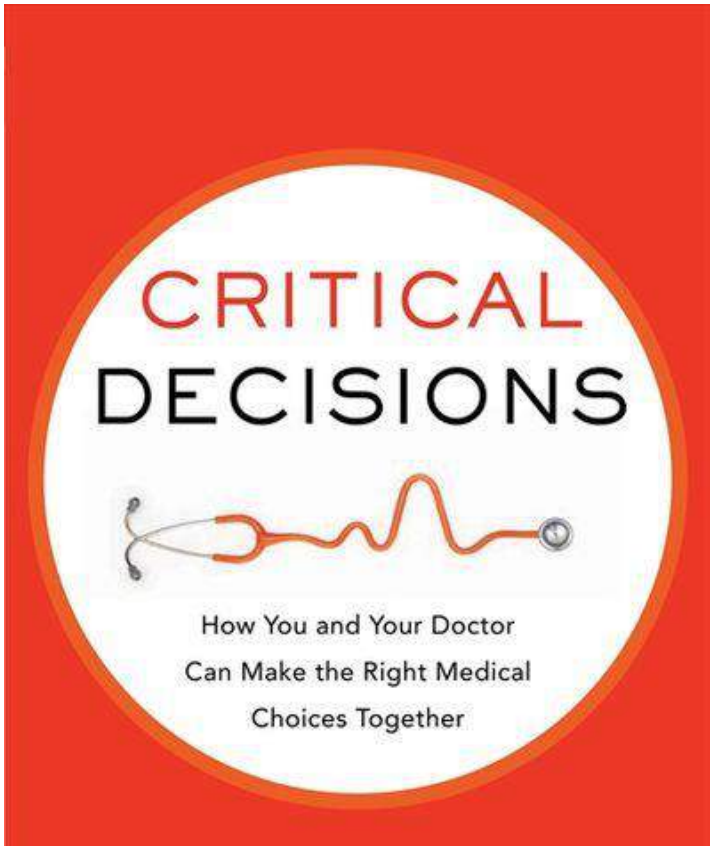


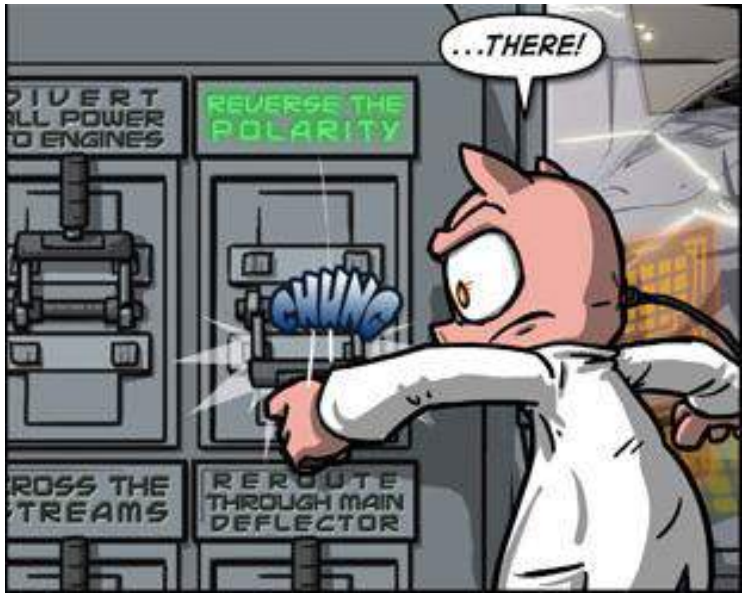
Practical Decision Making?



'In theory, a person should make decisions about life and death matters analytically, on the basis of facts……holes and uncertainties…Making choices required somehow filling the gaps.'

Reverse the Reversible



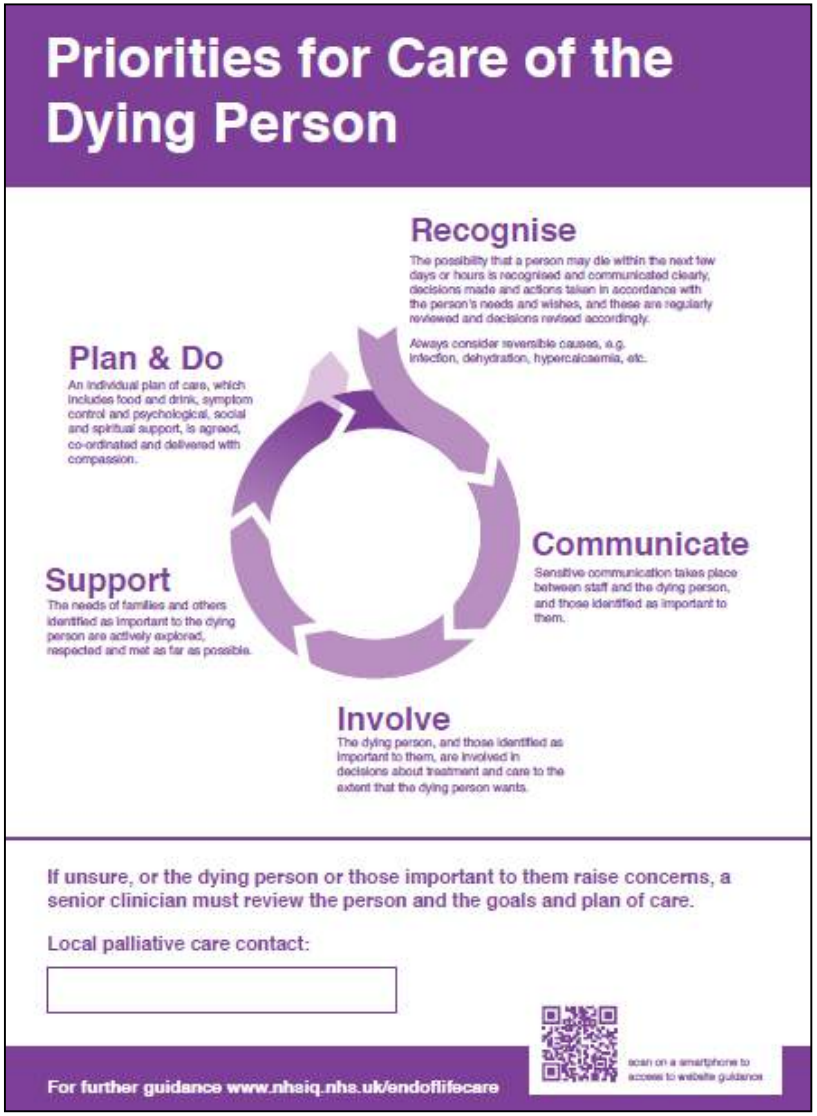


Uncertainty and Limits of Care

Principles of:

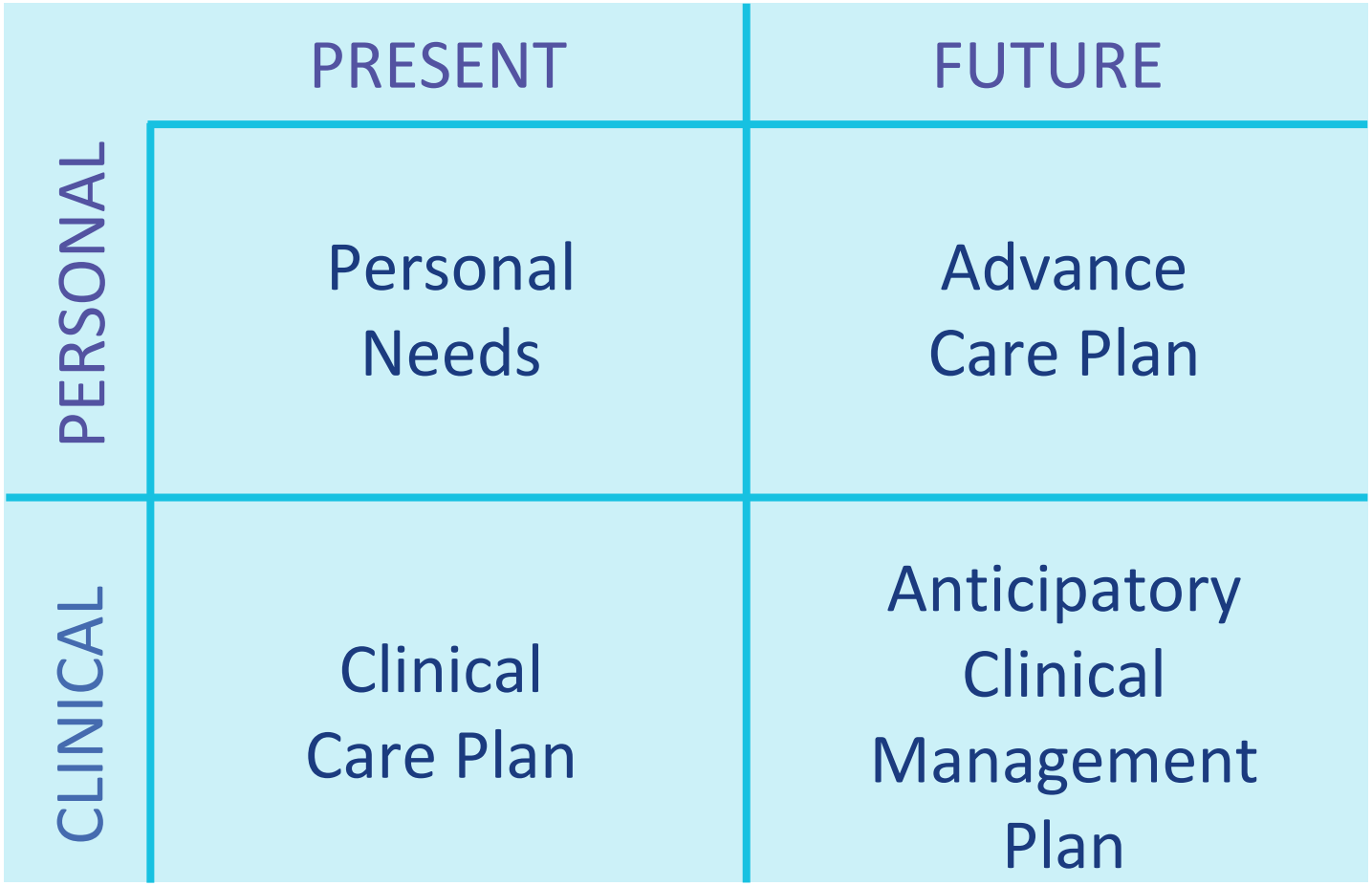
- Uncertain whether a patient will recover in part due to underlying chronic conditions or frailty
- Proactive management of these types of situations that may be dynamic and changing
- Encourages to continue with treatment in the hope of a recovery
- While talking openly about people's wishes and putting plans in place should the worst happen
- Deciding together how the person will be cared for should their condition get worse and documenting a plan
- Agreeing these plans with all of the clinical team looking after the person

Irreversibility and Ongoing Deterioration



- Consider quality of life
- Burdens of treatment
- Prolongation of Distress
- Undignified Death

Care Planning & Future Care Planning



Care Plans

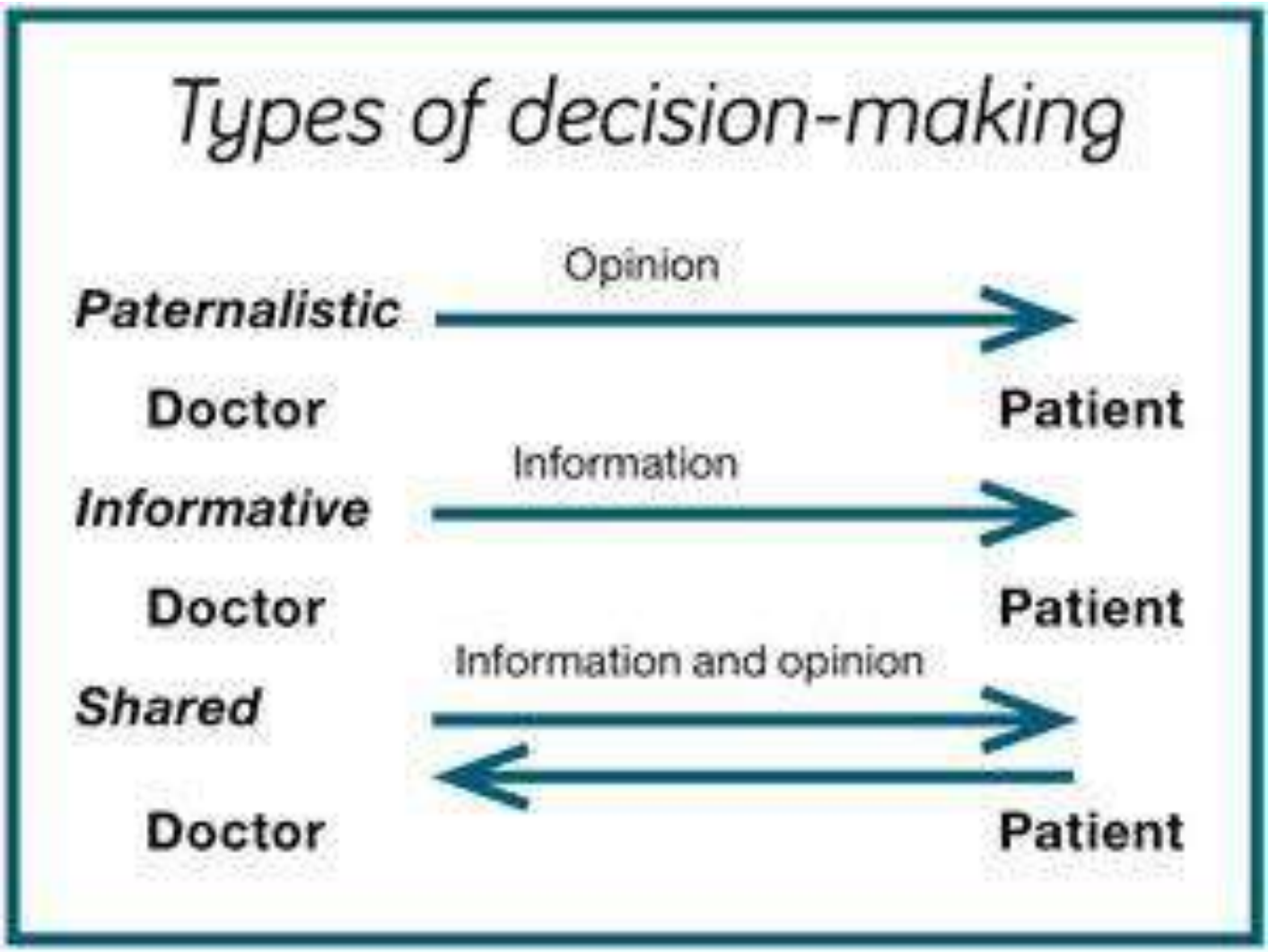

Complex Care Plan
Wishes/ Priorities for Care
LPA
Care Plans
DNACPR
Advance Care Plan
RESPECT
Ceilings of Care
Best interest decision
Advanced Decision to Refuse treatment (ADRT)

Shared Decision Making

An approach where clinicians and patients make decisions **together**, using the best available **evidence** to deliberate about the likely benefits and harms, and where patients are **supported** to arrive at **informed preferences**.

Elwyn G, Frosch D, et al. Shared decision making: a model for clinical practice. *J Gen Internal Medicine* 2012;**10**:1361–7.

Shared Decision Making



Communicating Decision Making

"Giving patients, their relatives or carers information about what is going to happen to them is an aspect of treating them with respect and dignity. Effective communication with patients and families helps to inspire confidence and trust. Conversely, poor communication can lead to a loss of confidence and trust."

(More Care Less Pathway, Parliamentary Review 2013)

Think about it | Talk about it | Record it | Share it

1. THINK ABOUT IT

2. TALK

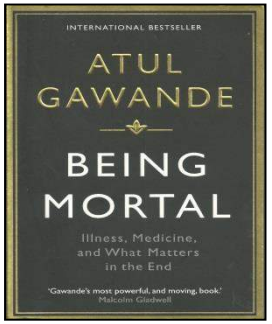
3. RECORD IT

4. SHARE IT

‘It is a procedure, and it requires no less skill than performing an operation’

Health Education England | North West Coast Strategic Clinical Networks | Greater Manchester and Eastern Cheshire Strategic Clinical Networks | ADVANCE CARE PLANNING | North West Coast Learning Collaborative

Communication & Values



- 'What would the best day possible mean now?'
- 'What have you been forced to give up?'
- 'If time becomes short, what is most important to you?'
- 'What are your fears and concerns about what lies ahead?'
- 'What kind of trade offs are you willing to make and what ones are you not?'
- 'Who do you want to make decisions if you can't?'

Final Thoughts/ Summary

- NEWS2 as a positive trigger for decision making
- Implementation to consider the clinical context of that decision
- Reverse the reversible
- Acknowledge the Irreversible
- Individual needs different if irreversibility or reversibility
- Communicate uncertainties
- Shared Decision Making and Planning in all circumstances
- Compassion and dignity

More People Less Patients

The Lives of Others' Des Spence
BMJ 22March 2014 (348): 41

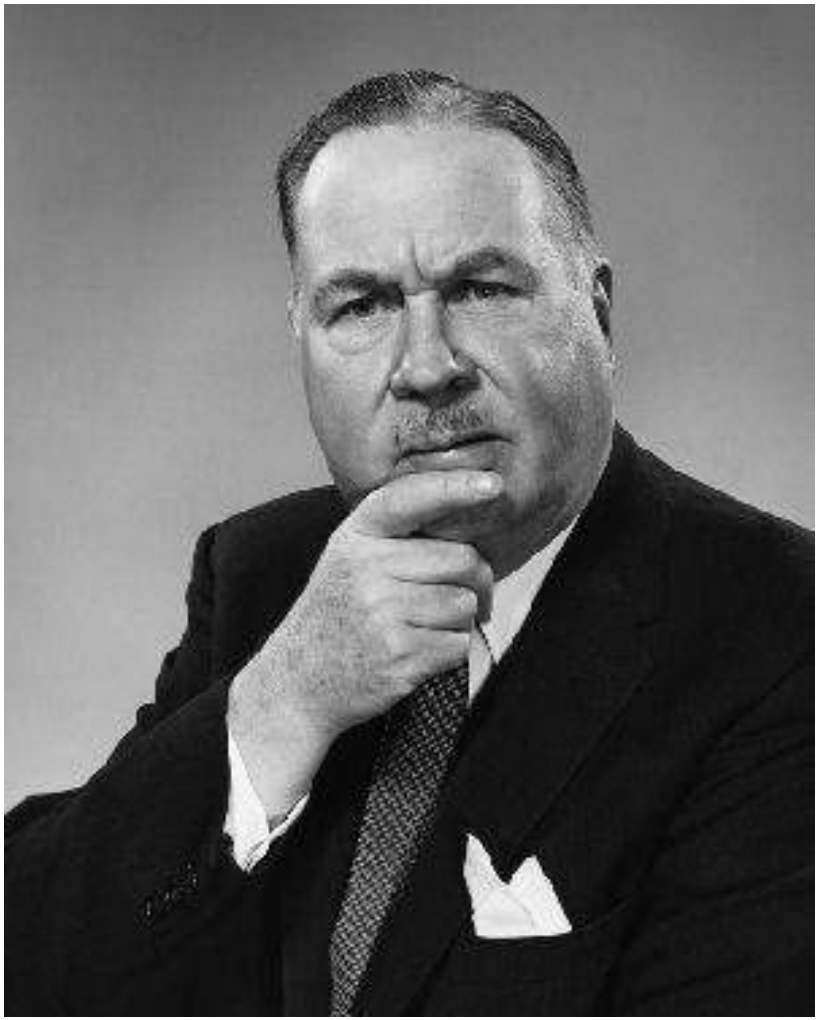
'…Treat others as you would want to be treated yourself. Remember that the patient is someone's son, daughter, sister, brother or mother……In modern jargon this might be called empathy….but it is more than that….We have to consider how we would feel, what we would want, how we would wish to be spoken to'

What matters to them

NOT JUST

What is the matter with them?

Comments/ Questions



Patient story

Tricia McDonnell,

Occupational Therapist,
Wrightington Wigan and
Leigh NHS Foundation Trust

The AHSN Network

NHS Improvement

Lunch & learn

Greater Manchester & Eastern Cheshire

Patient Safety Collaborative

Market Stall	Organisation	Facilitator
1	Patient Track	Andrew Clark and David Proctor, Patient Track
2	AQuA	Liz Kanwar, AQ Programme Manager, AQuA
3	Life QI	Bob Diepeveen, Improvement Advisor, GM&EC Patient Safety Collaborative, Health Innovation Manchester (HInM)
4	Urgent Care 24	John Caldwell, Medical Lead, Integrated Urgent Care
5	PINGR, SMASH DASH, FFF	Dai Roberts, Programme Development Lead, Health Innovation Manchester (HInM)
6	Salford Royal Foundation Trust Delirium Pathway	Emma Vardy, Consultant Geriatrician and Clinical Dementia Lead, Salford Royal Foundation Trust

Use of Quality Improvement

Bob Diepeveen,

Senior Improvement Advisor GMEC PSC
Health Innovation Manchester

What is Quality Improvement?

"The use of methods and tools to continuously improve quality of care and outcomes for patients"

https://www.kingsfund.org.uk/publications/making-case-quality-improvement

Other source: Quick guide health foundation
https://www.health.org.uk/sites/health/files/QualityImprovementMadeSimple.pdf

STEEEP

Source picture: https://em3.org.uk/foamed/4/1/2017/modified-valsalva-manoeuvre-svt

Source content: Crossing the Quality Chasm: A New Health System for the 21st Century, 2001 Institute of Medicine

EDITORIALS

BMJ 2018;361:k1924 doi: 10.1136/bmj.k1924 (Published 17 May 2018)

Creating space for quality improvement

OPEN ACCESS

Dominique Allwood *assistant director of improvement*, Rebecca Fisher *policy fellow*, Will Warburton *director of improvement*, Jennifer Dixon *chief executive*

Health Foundation, London, UK

"Clinicians already have the motivation; now they need time, skills, and support"

Quality Improvement Knowledge

- Please fill out this short questionnaire:

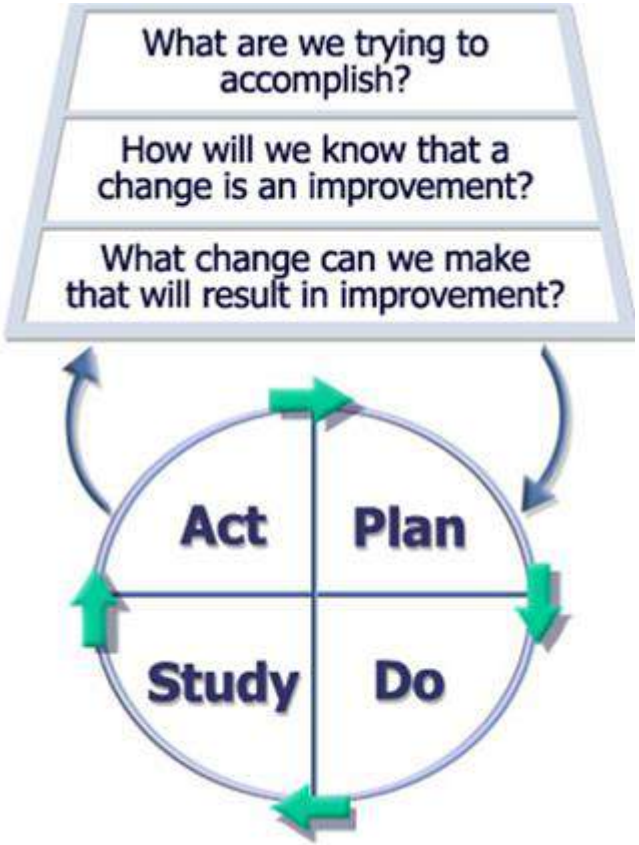
https://www.surveymonkey.co.uk/r/KHH5BGP

Please rate yourself for each of the following theories, methodologies or skills of Quality Improvement using the scoring below:

Level 0	I have no knowledge of this.
Level 1	I have some awareness of this but I do not know how to apply it.
Level 2	I am able to apply this in limited scenarios with some assistance.
Level 3	I know when, where and how to apply this and am able to do so on my own.
Level 4	I have good experience of using this and am able to adapt to use in a multitude of situations.
Level 5	I can teach this theory, methodology or skill to others.

My first improvement project

Model for Improvement



Langley G, Nolan K, Nolan T, Norman C, Provost L, editors. The improvement guide. San Francisco: Josey-Bass; 1996.

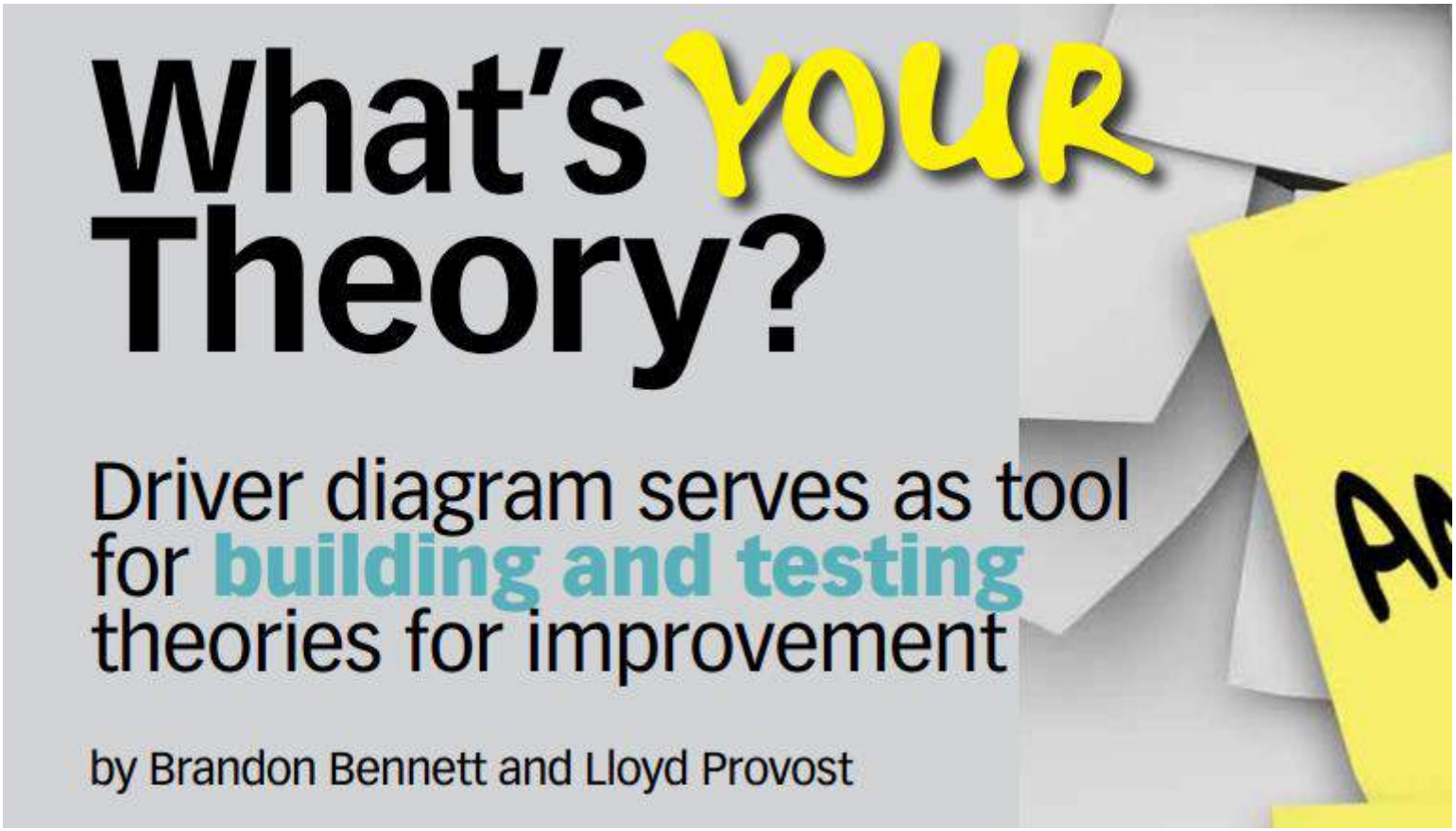
What are you trying to accomplish?

Criteria for a good aim

- Specific
- Measurable
- Timely

To walk more than 15 consecutive steps by 31/03/1985

What change can we make that will result in improvement?



Bennet B, Provost L. What's your theory, QP, 2015-07:36-43

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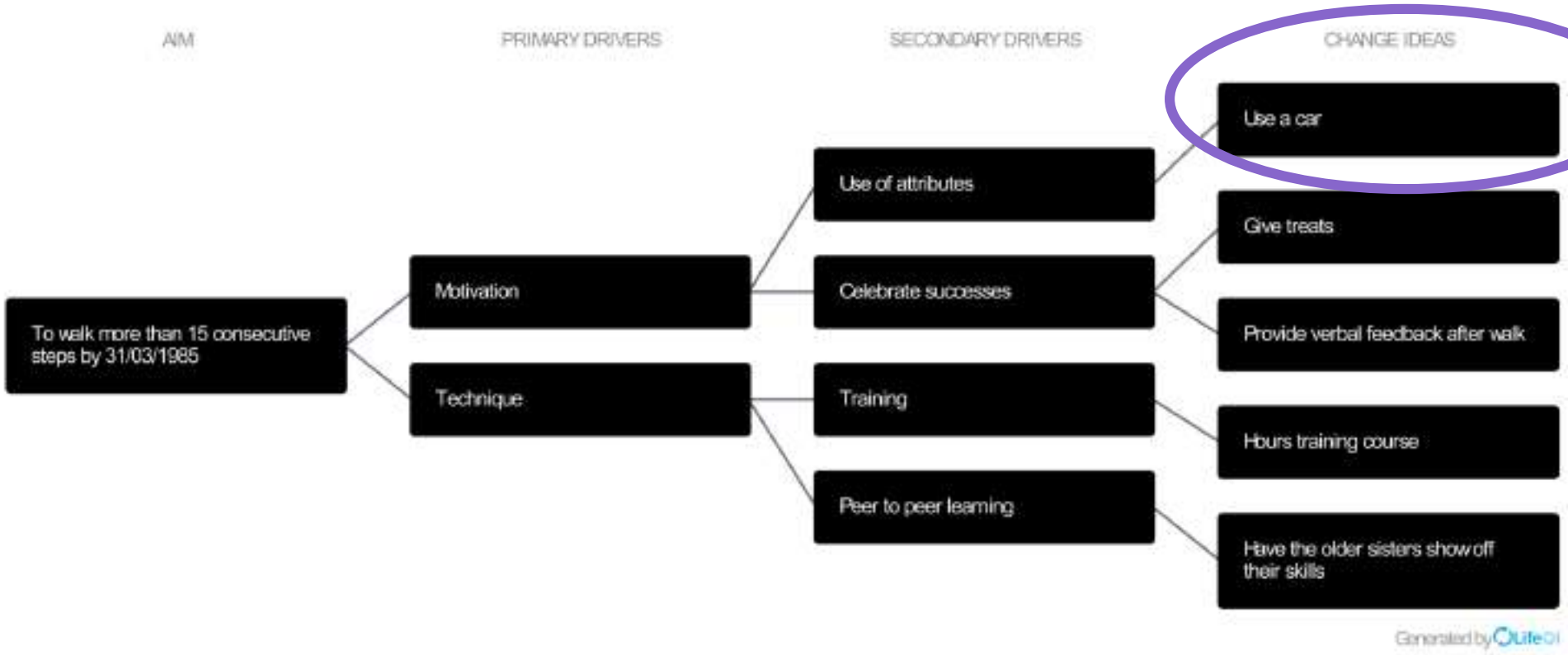
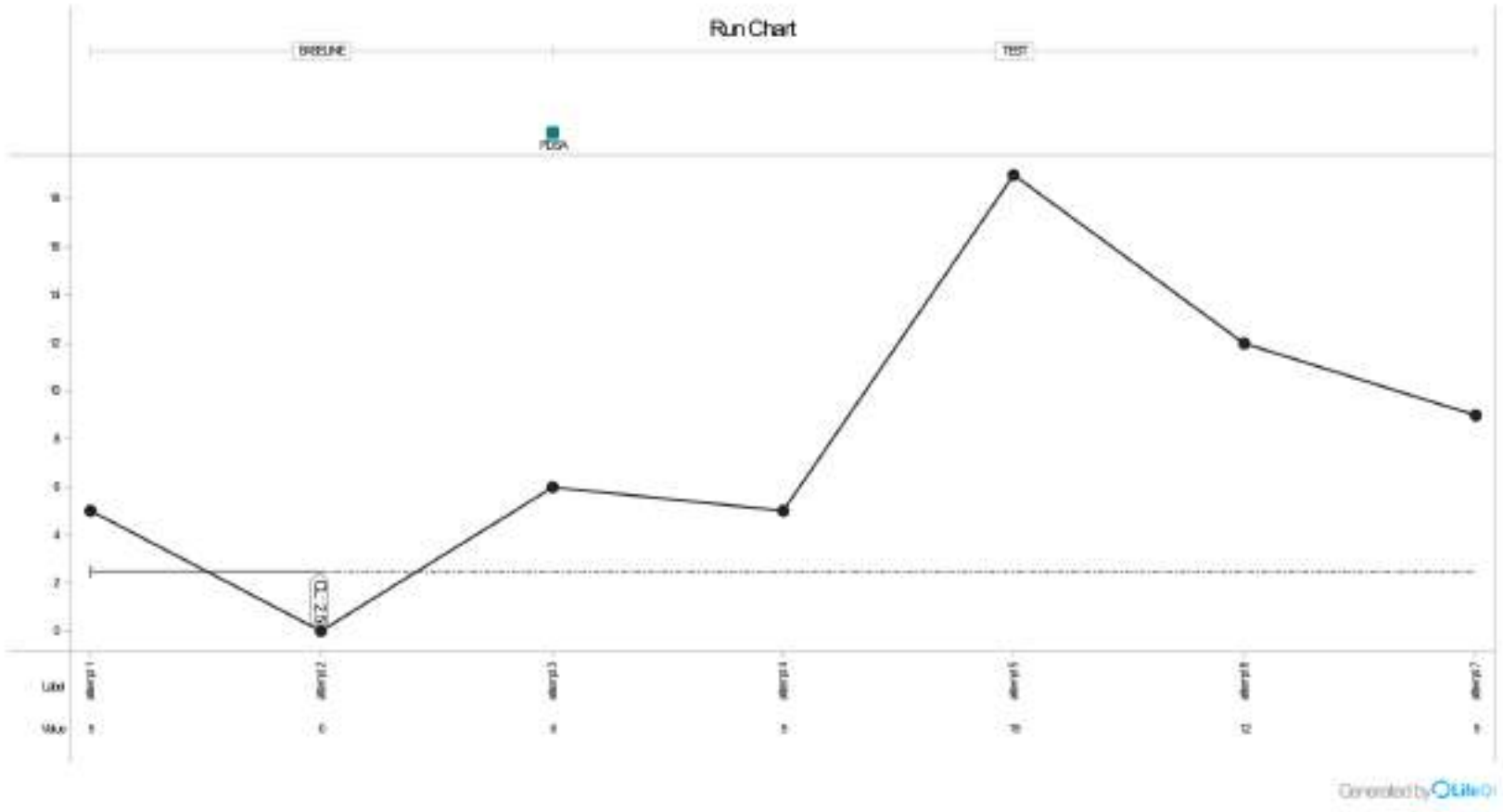
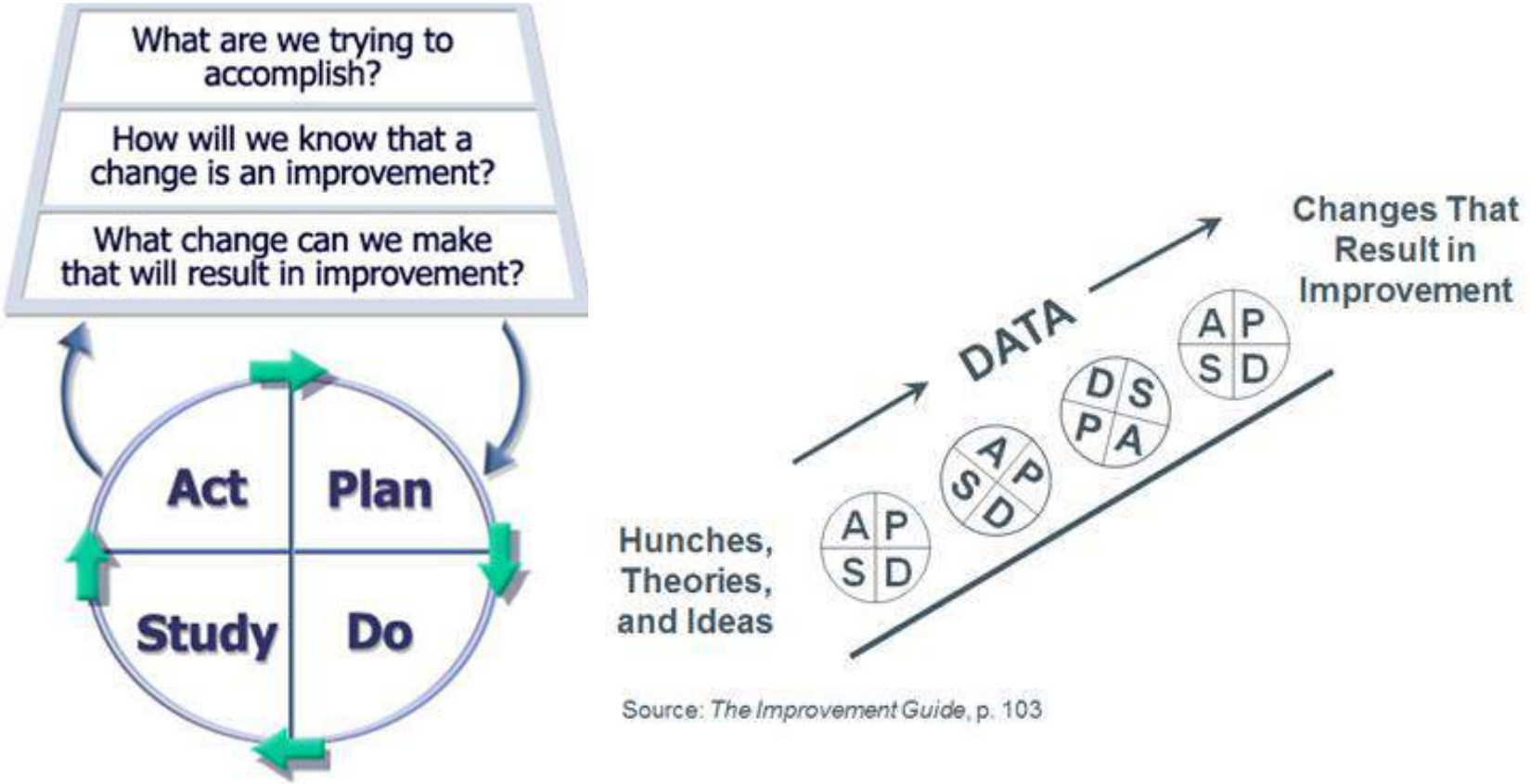


How do we know that a change is an improvement?



Model for Improvement

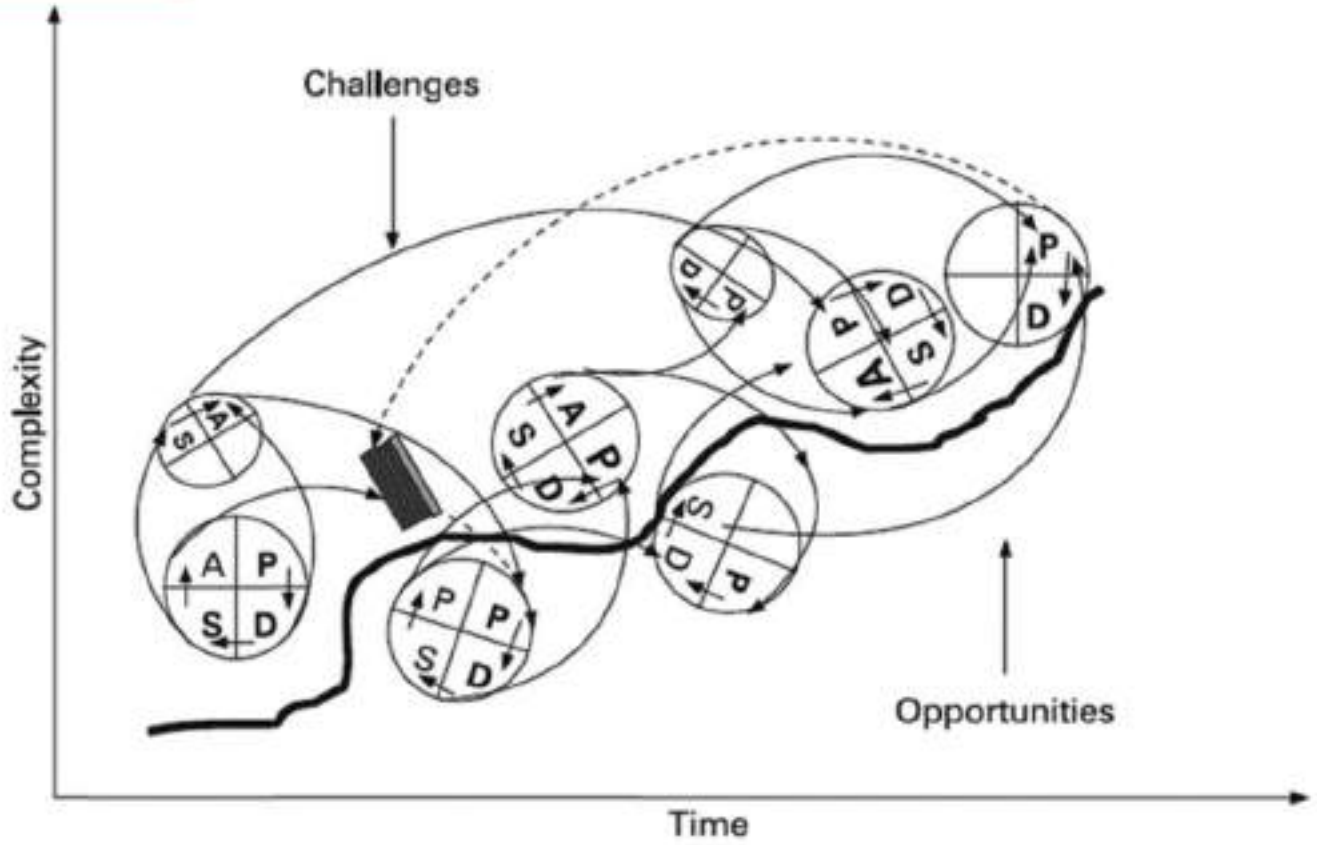


Langley G, Nolan K, Nolan T, Norman C, Provost L, editors. The improvement guide. San Francisco: Josey-Bass; 1996.

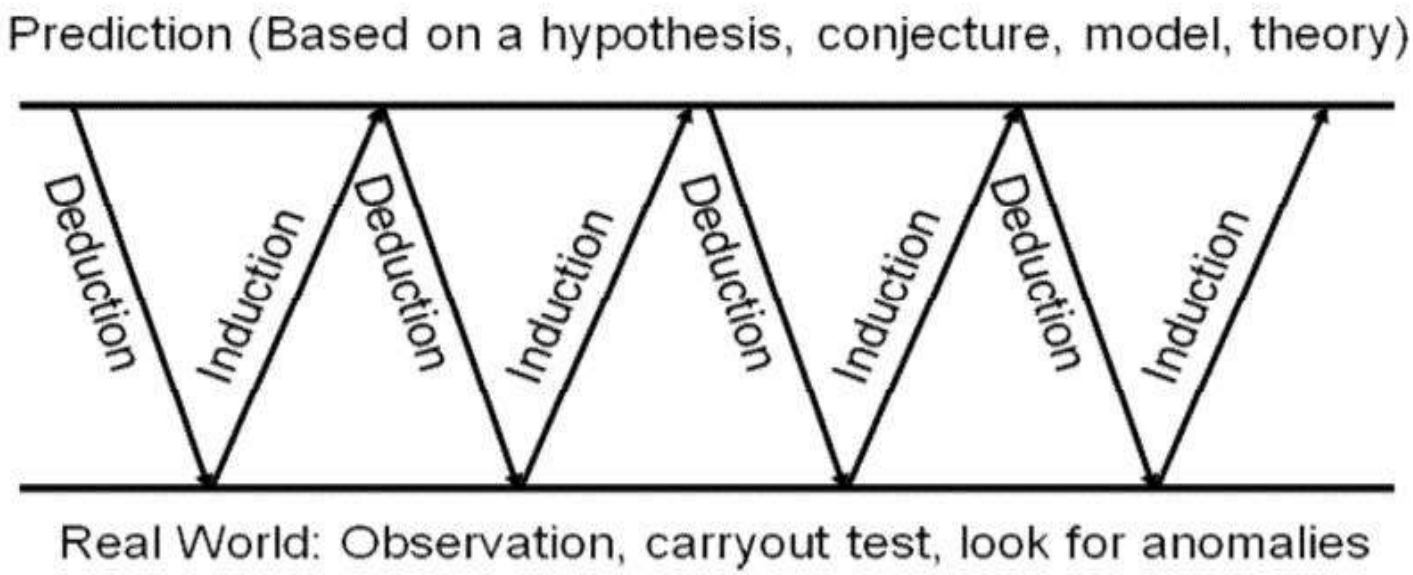
BMJ Quality & Safety

Building knowledge, asking questions

Greg Ogrinc and Kaveh G Shojania *BMJ Qual Saf* 2013;0:1–3.



Scientific Method



Source: Evolution of the PDCA Cycle, Ronald Moen , Clifford Norman

QUALITY IMPROVEMENT

Changing how we think about healthcare improvement

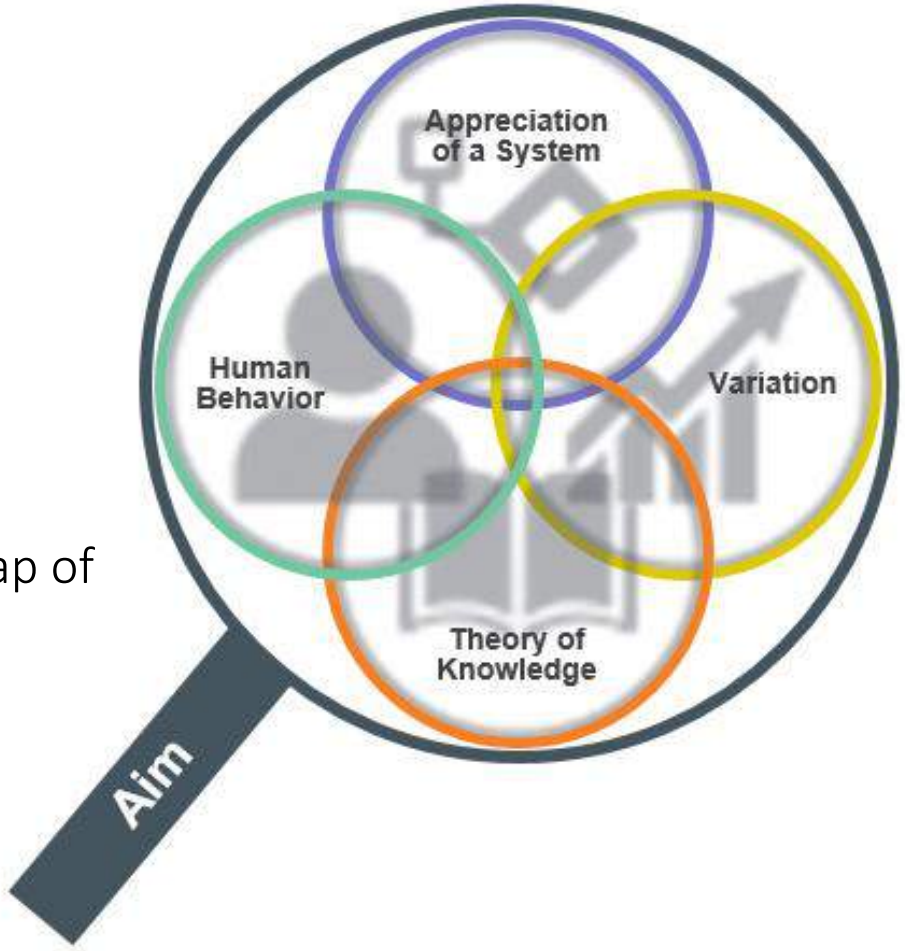
Complexity science offers ways to change our collective mindset about healthcare systems, enabling us to improve performance that is otherwise stagnant, argues **Jeffrey Braithwaite**

thebmj | *BMJ* 2018;361:k2014 | doi: 10.1136/bmj.k2014

"We need to turn healthcare into a learning system, with participants attuned to systems features and with strong feedback loops to try to build momentum for change."

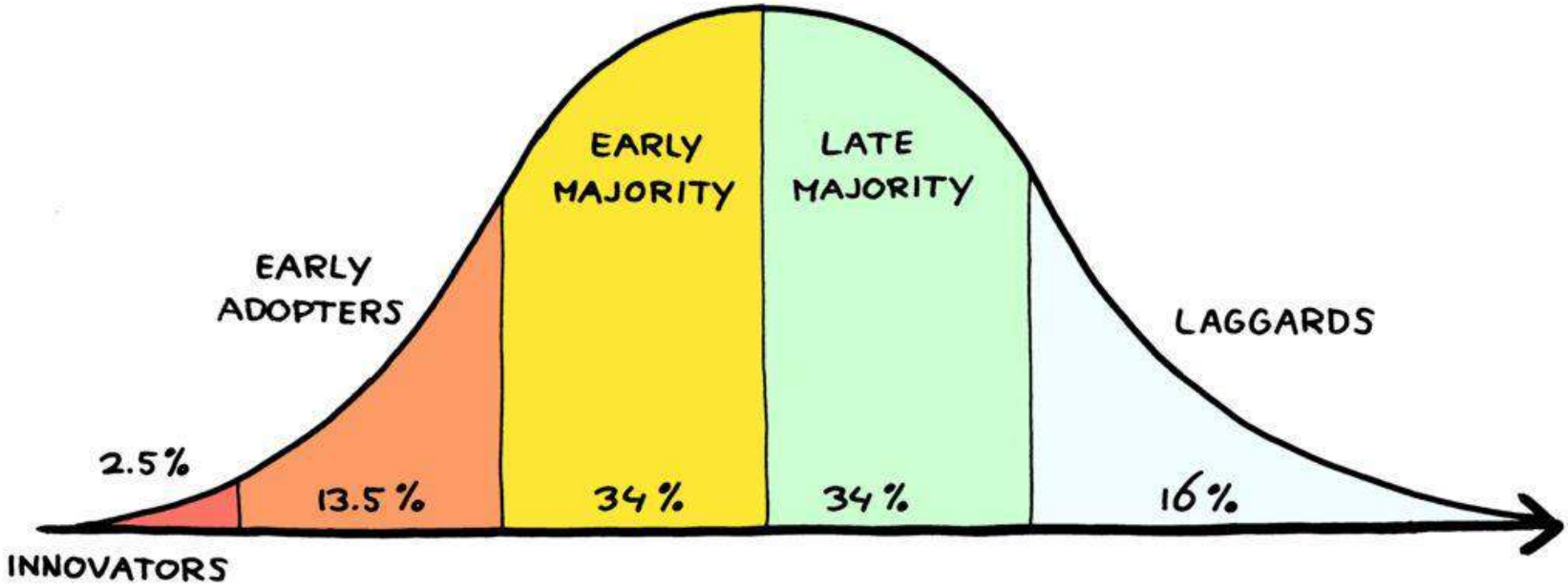
Lens of Profound knowledge

"The system of profound knowledge provides a lens. It provides a new map of theory by which to understand and optimize our organizations"



Source: Out of the crisis W Edwards Deming

Human behaviour / psychology



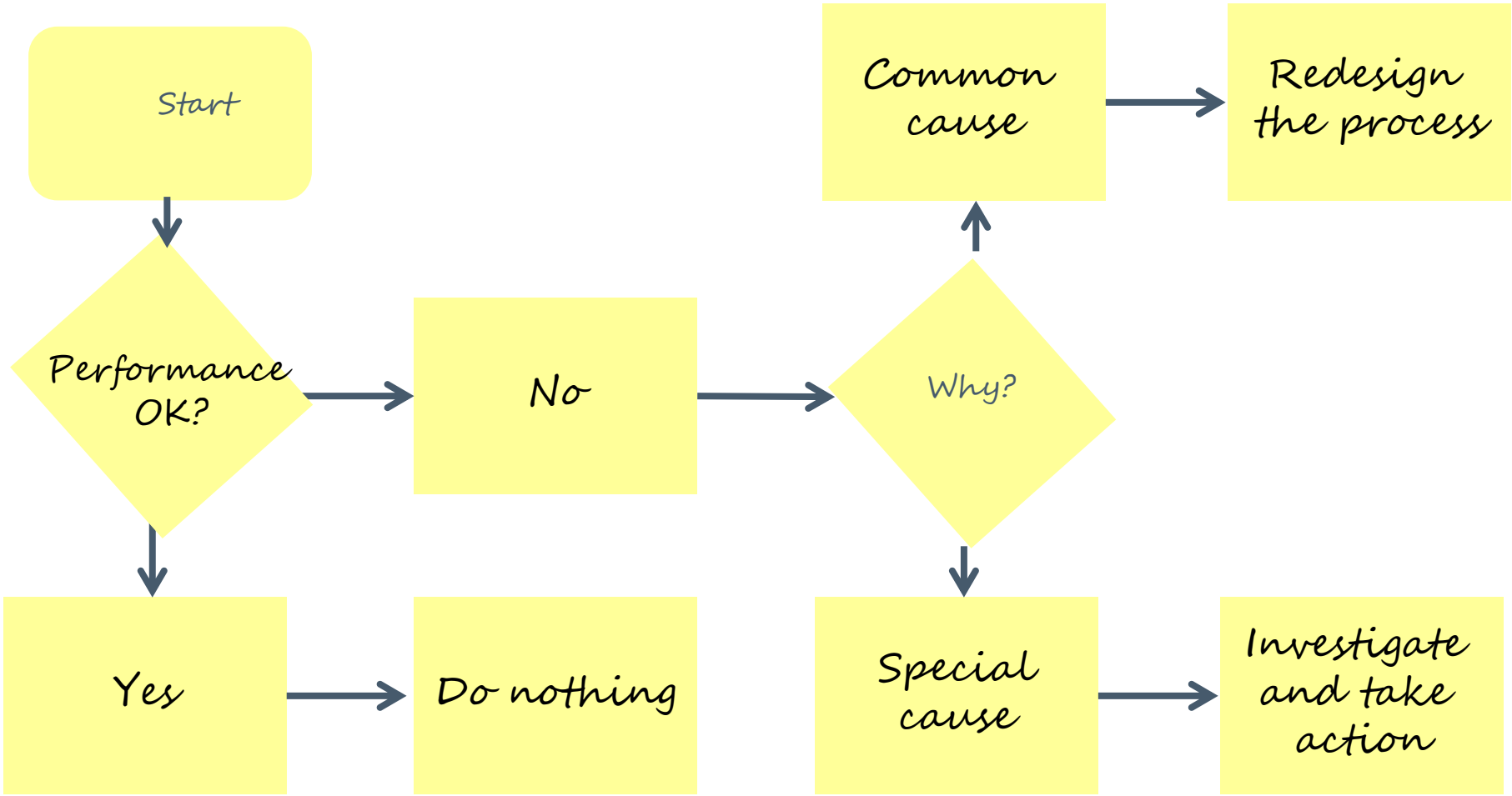
Source: E.M. Rogers

Variation

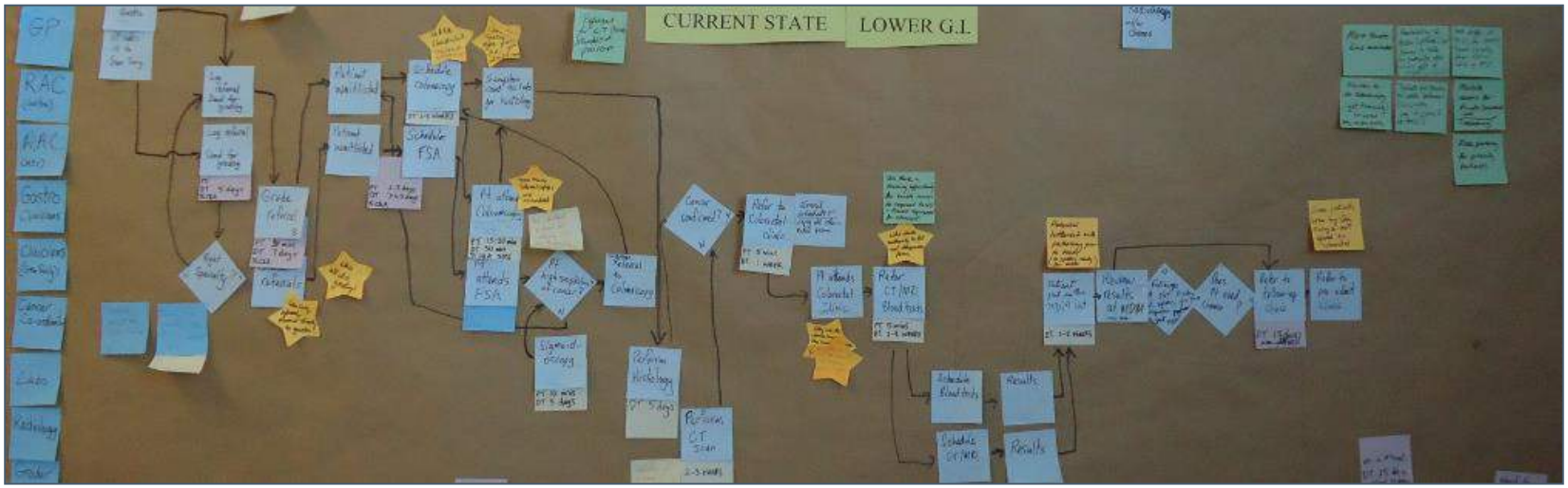
- Shewhart's Theory of variation

Common Cause: Those causes inherent in the system over time, affect everyone working in the system, and affect all outcomes of the system

Special Cause: those causes not part of the system al the time or do not affect everyone, but arise because of specific circumstances


Start
Performance OK?
No
Why?
Common cause
Redesign the process
Yes
Do nothing
Special cause
Investigate and take action

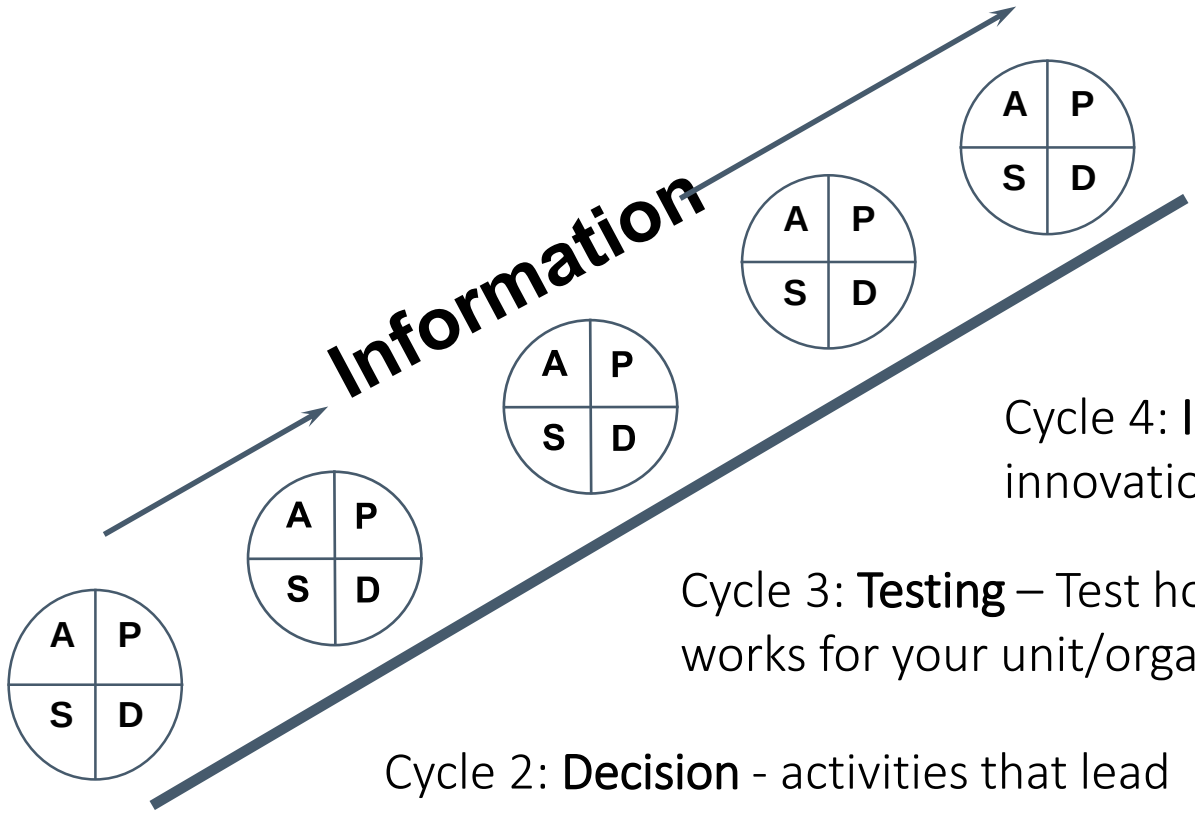
Appreciation of a system



"Every system is perfectly designed to achieve the results it gets"

Paul Batalen

Spread Fundamentals: Innovation-Decision Process



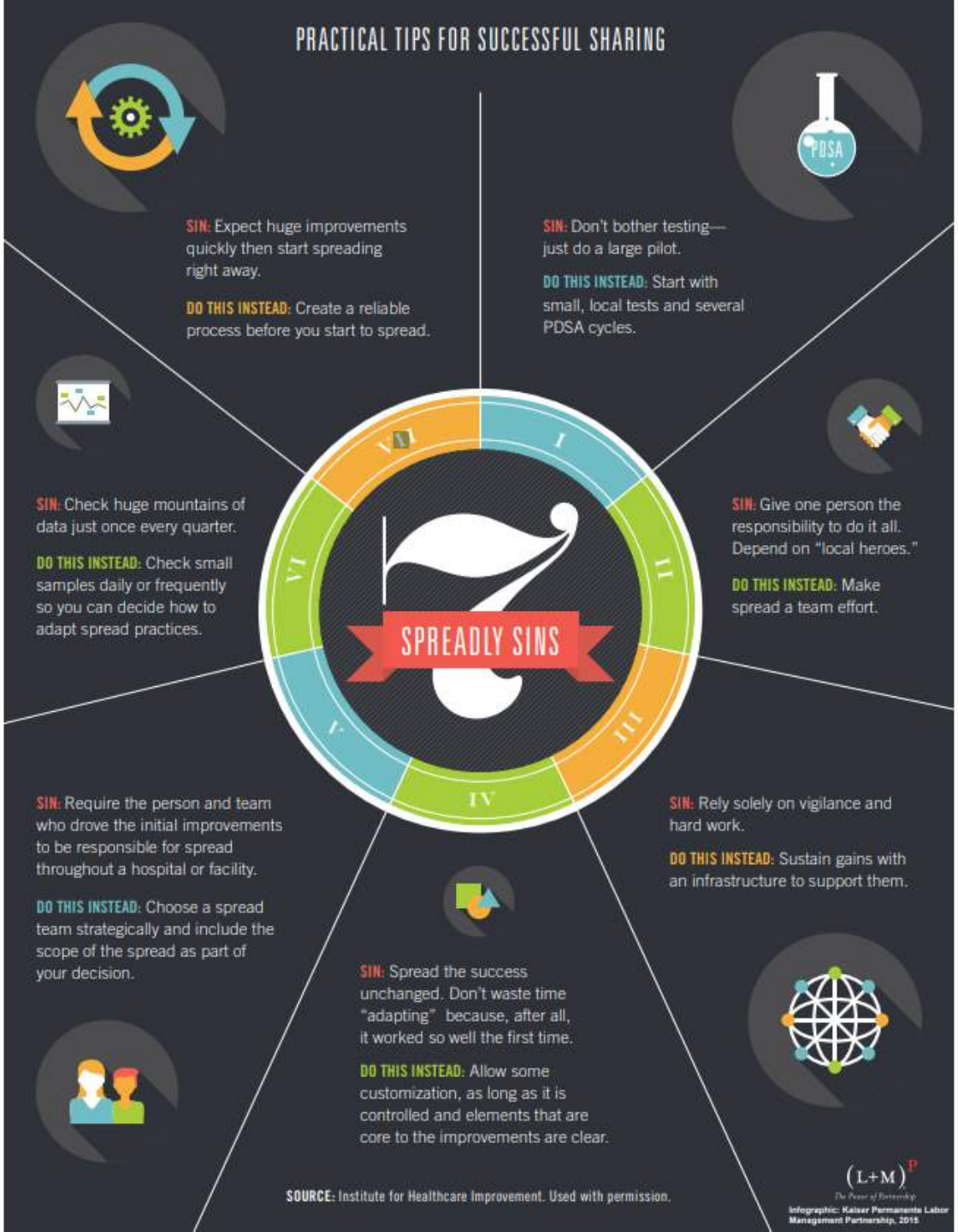
Cycle 5: **Instillation (or embedding)-** seek reinforcement of the decision about innovation

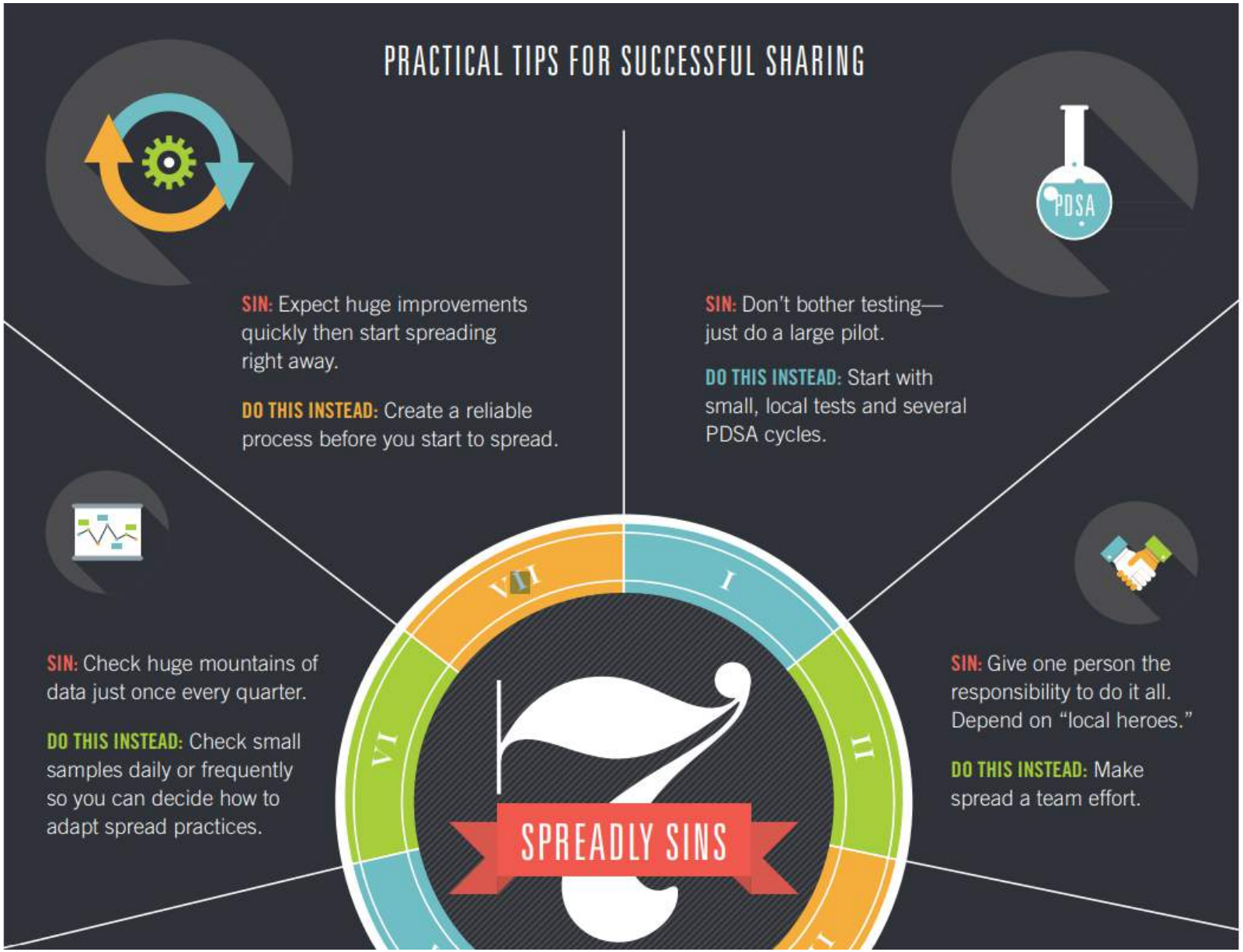
Cycle 4: **Implementation** - put the innovation into use

Cycle 3: **Testing** – Test how the innovation works for your unit/organisation

Cycle 2: **Decision** - activities that lead to making a choice to adopt

Cycle 1: **Persuasion** - form a favorable attitude toward the innovation


PRACTICAL TIPS FOR SUCCESSFUL SHARING
SIN: Expect huge improvements quickly then start spreading right away.
DO THIS INSTEAD: Create a reliable process before you start to spread.
SIN: Don't bother testing—just do a large pilot.
DO THIS INSTEAD: Start with small, local tests and several PDSA cycles.
PDSA
SIN: Check huge mountains of data just once every quarter.
DO THIS INSTEAD: Check small samples daily or frequently so you can decide how to adapt spread practices.
SPREADLY SINS
I
II
III
IV
V
VI
SIN: Give one person the responsibility to do it all. Depend on "local heroes."
DO THIS INSTEAD: Make spread a team effort.
SIN: Require the person and team who drove the initial improvements to be responsible for spread throughout a hospital or facility.
DO THIS INSTEAD: Choose a spread team strategically and include the scope of the spread as part of your decision.
SIN: Spread the success unchanged. Don't waste time "adapting" because, after all, it worked so well the first time.
DO THIS INSTEAD: Allow some customization, as long as it is controlled and elements that are core to the improvements are clear.
SIN: Rely solely on vigilance and hard work.
DO THIS INSTEAD: Sustain gains with an infrastructure to support them.
SOURCE: Institute for Healthcare Improvement. Used with permission.
(L+M)P
The Power of Partnership
Infographic: Kaiser Permanente Labor Management Partnership, 2015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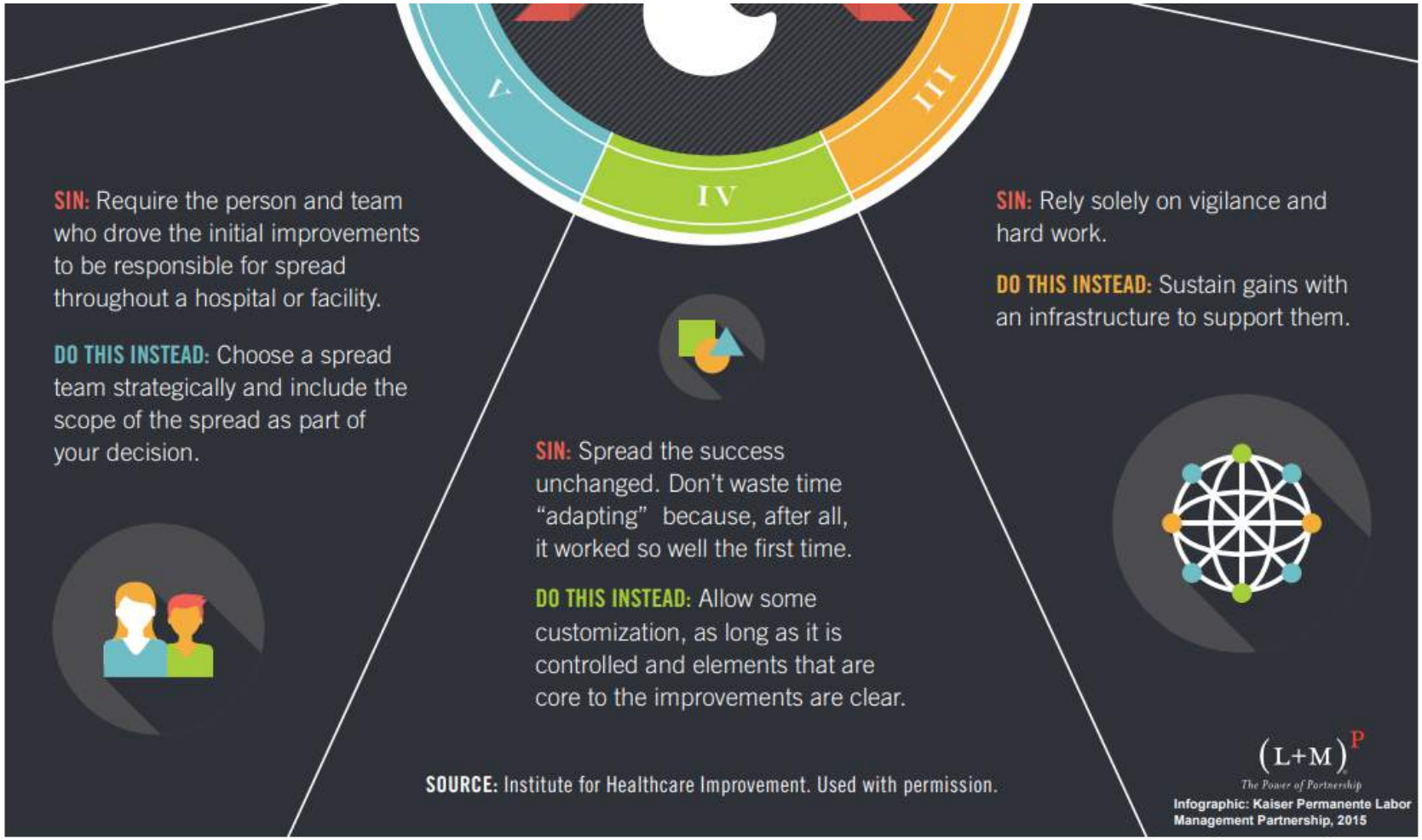
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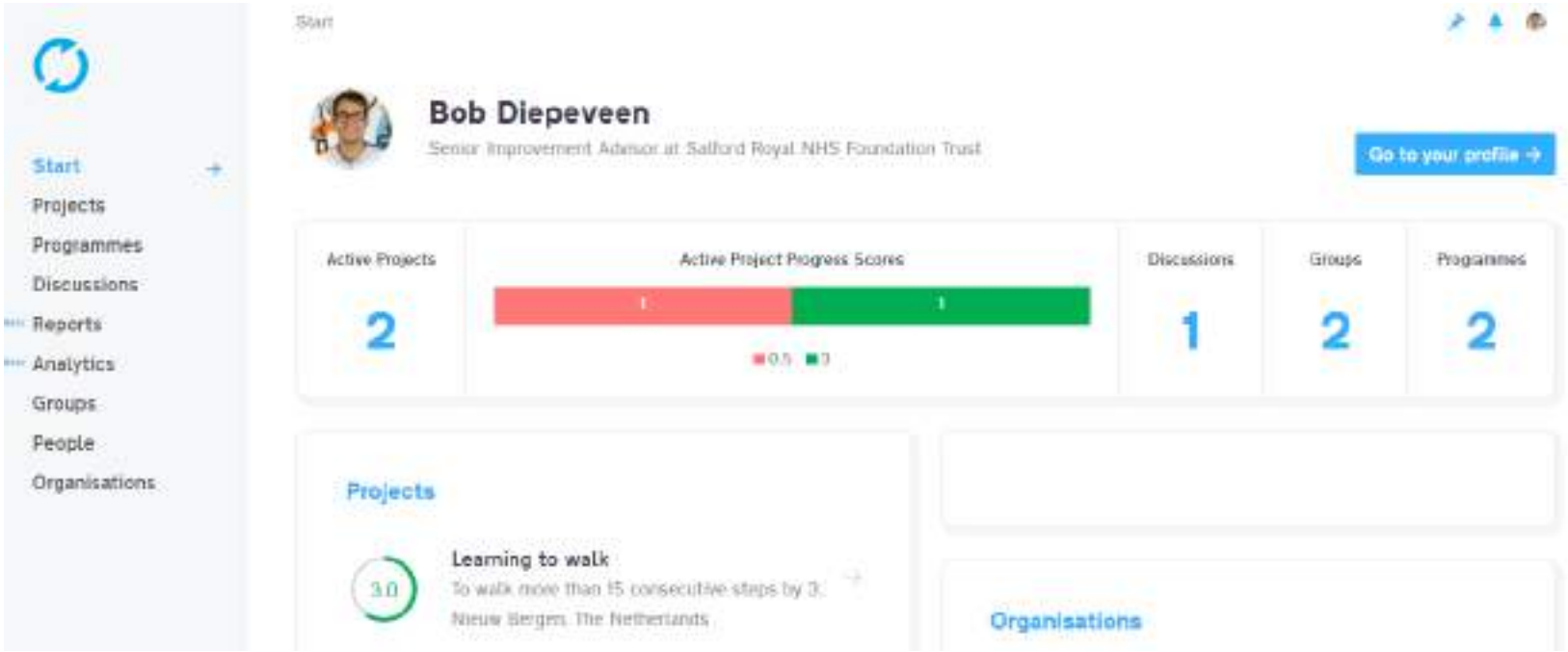
(L+M)P
The Power of Partnership
Infographic: Kaiser Permanente Labor Management Partnership, 2015

Team roles

- Clinical Leader
- Day to day leader
- Technical expert (data analyst / improvement advisor / LifeQI)
- Subject matter expert
- Patient representative
- Project Sponsor

http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementFormingtheTeam.aspx

Life QI platform



https://uk.lifeqisystem.com/

NEWS Story & Toolkit

Joanna Garrett

Patient Safety Improvement Lead, West of England Academic Health Science Network

TheAHSNNetwork

NHS Improvement

West of England Academic Health Science Network

Joanna Garrett
Patient Safety Improvement Lead

@GMEC_PSC #GMECDetPat

NEWS

- Who we are
- Why NEWS
- How we spread NEWS across a health system
- Preliminary results and evaluation
- Research and innovation

The West of England AHSN

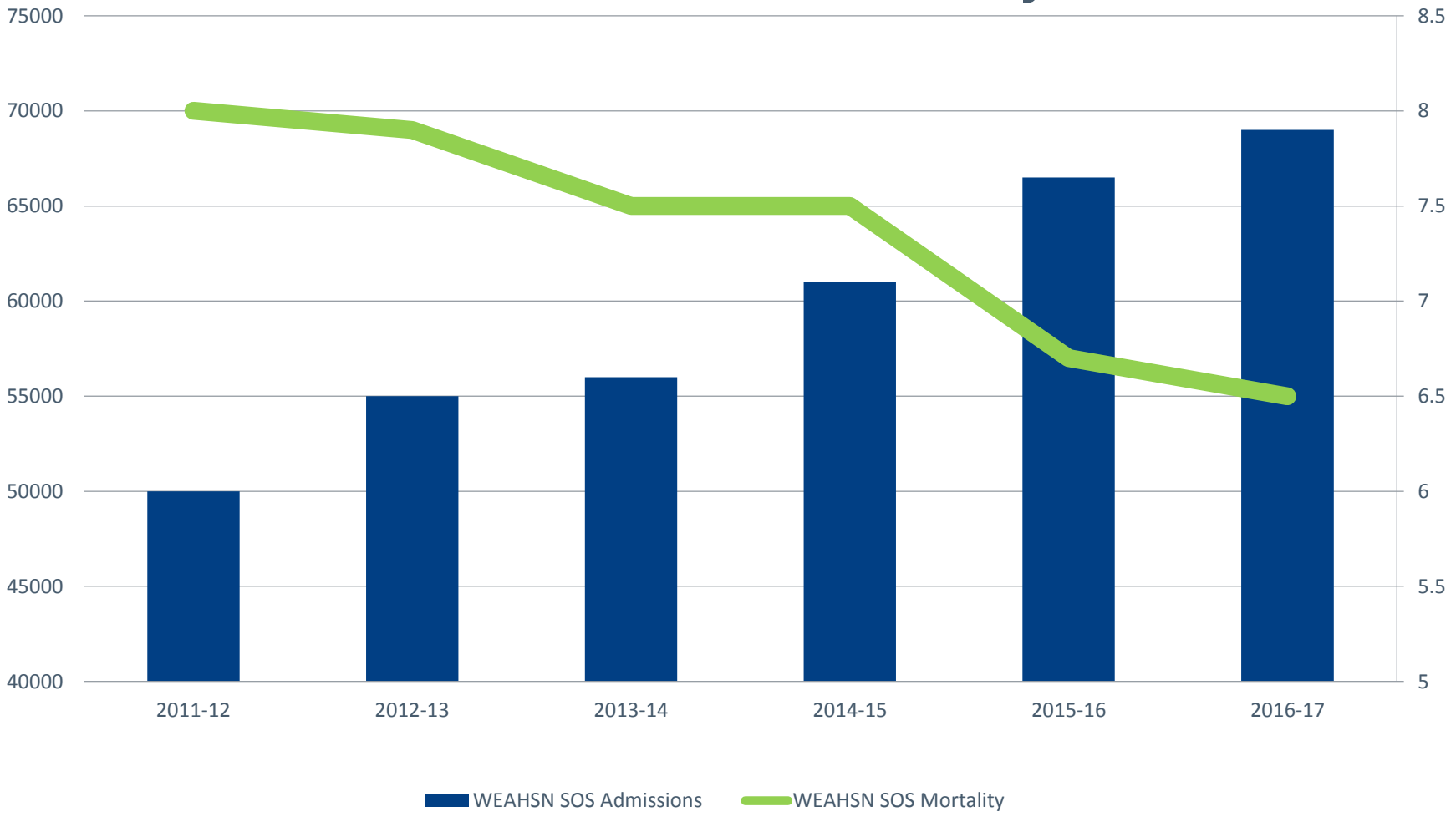
West of England Academic Health Science Network Map

A	South Gloucestershire
B	Bristol
C	North Somerset
D	Bath and North East Somerset
E	Gloucestershire
F	Swindon
G	Wiltshire

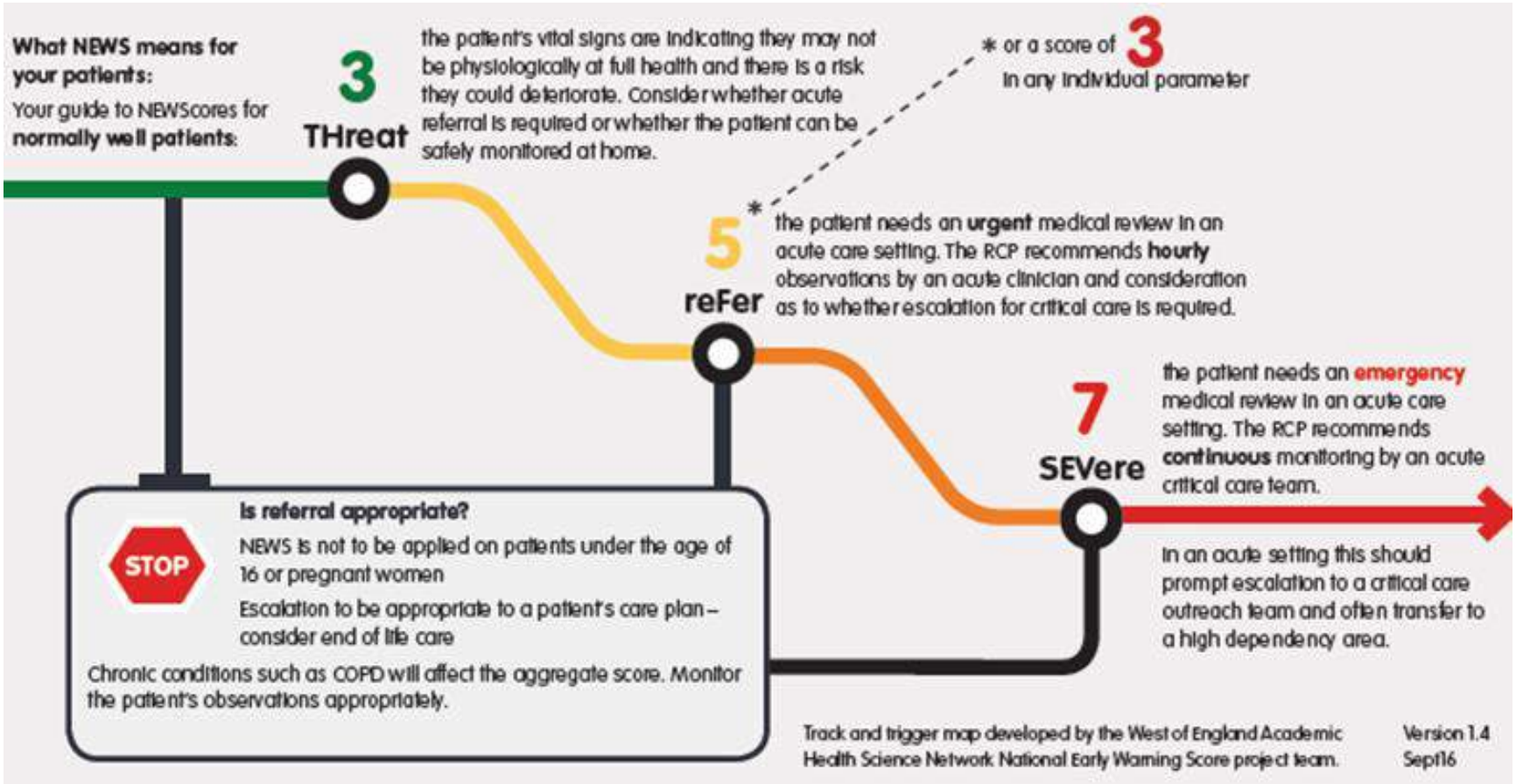

3 Universities
7 Clinical Commissioning Groups
1 Ambulance Trust
2.4 million residents
6 Acute Trusts
7 Community Service
2 Mental Health Trusts

Why NEWS?

WEAHSN SOS admission/mortality 2011-17



Cross System



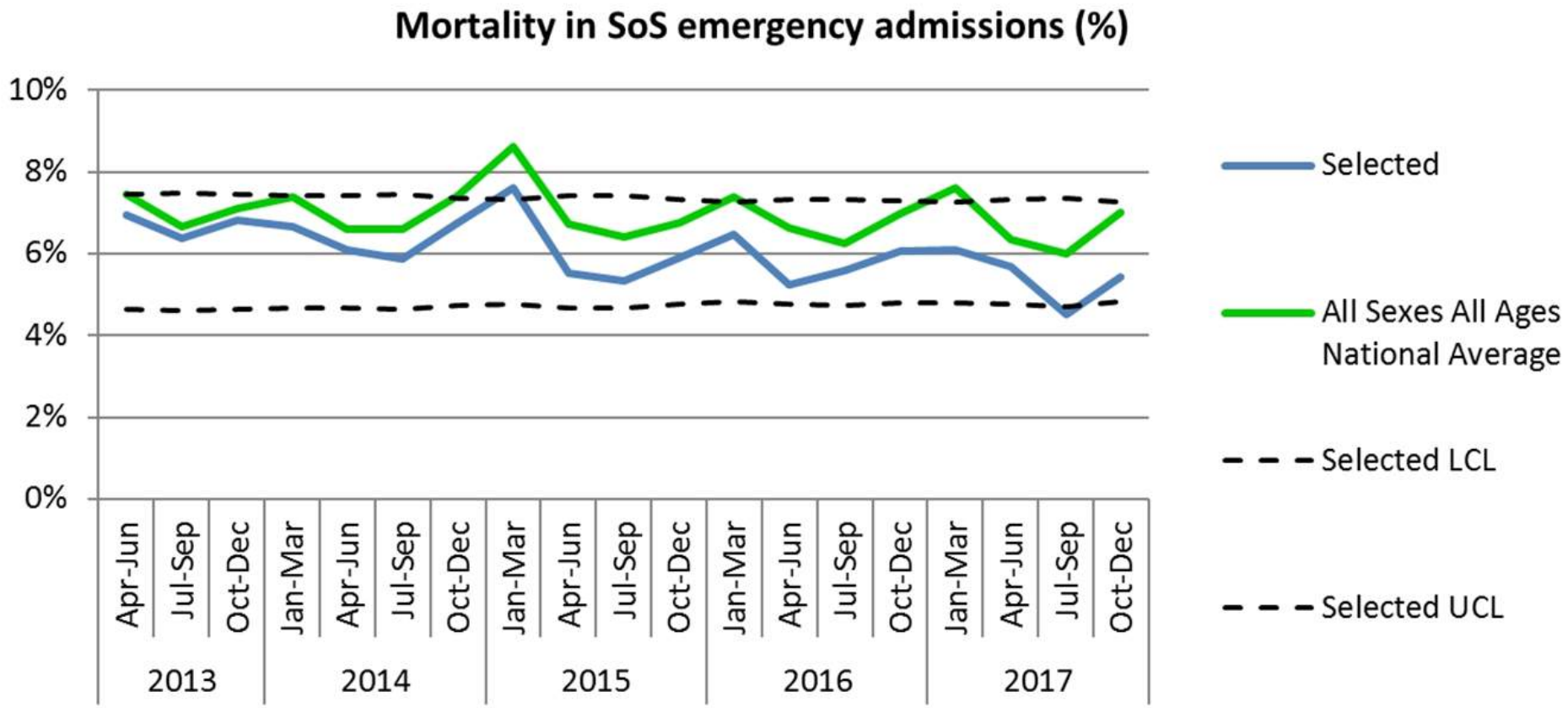
Cross system

West of England Academic Health Science Network


COLLABORATION
TOGETHER
SUCCESS
KNOWLEDGE
LEARNING
SECTION
BASED
SKILLS
ADDING
COMMUNITY
USED
TERM
WORKING
COMMUNICATION
INDUSTRY
INCLUDING
CHALLENGED
PEER
TECHNIQUES
BENEFITS
SOURCES
PRODUCTION
UNITED
SHARING
RESOURCES
THEORY
INTEREST
MANAGEMENT
GROUPS
WORK
PROJECT
PROJECTS
COMPLEX
COLLABORATIVE
LEADERSHIP
CORPORATION
SOFTWARE
PEOPLE
GROUP
POLITICAL
DEVELOPMENT
PRACTICE
INTERNET
TOOLS
HELP
TRADE
BETWEEN
COMMUNITIES
ORGANIZATIONS
IMPROVE
CITATIONS
SOCIAL
ORGANIZATION
INCLUDE
RELIABLE
PERFORMANCE
MEMBERS
SHARED
EDUCATION
SCIENTIFIC
TIME
GOAL
INFORMATION
PERSONAL
INDIVIDUAL
IMPORTANT
CONSTRUCTION
ESTABLISHED
COLLECTIVE
LARGE
WEB
FORMED
SPECIFICALLY
BUILT
GREATER
IDEAS
CREATIVE
CONTROL
WIDELY
PRACTICAL
FOUNDED
INDUSTRIAL
WORLD
STAFF
TEAMS
WEBSITE
SERVES
QUICKLY
TOOL
STANDARDS
PARTNERS
MODERN
CULTURE
SET
MEDIA
LEVEL
SELECTED
PART
WEEKEND
SHORT
CITE
SCALING
RISE
COMPLEXITY
CREATED
TEAM
BUILDING
SUPPORT
PROCESS
RESEARCH
OCCUPATION
SYSTEM
RECOGNITION
INTERNATIONAL
MARKET
GOALS
SENSE
DISCUSSION
ADDITIONAL
DEVELOP
VENTURE
GOAL
ALLOWS
STRONG
PRIVATE
BUSINESS
FIELDS
TECHNOLOGY
WIDE
HIGH
WAYS
BLOGS
POPULAR
RELATIONSHIP

How we do it

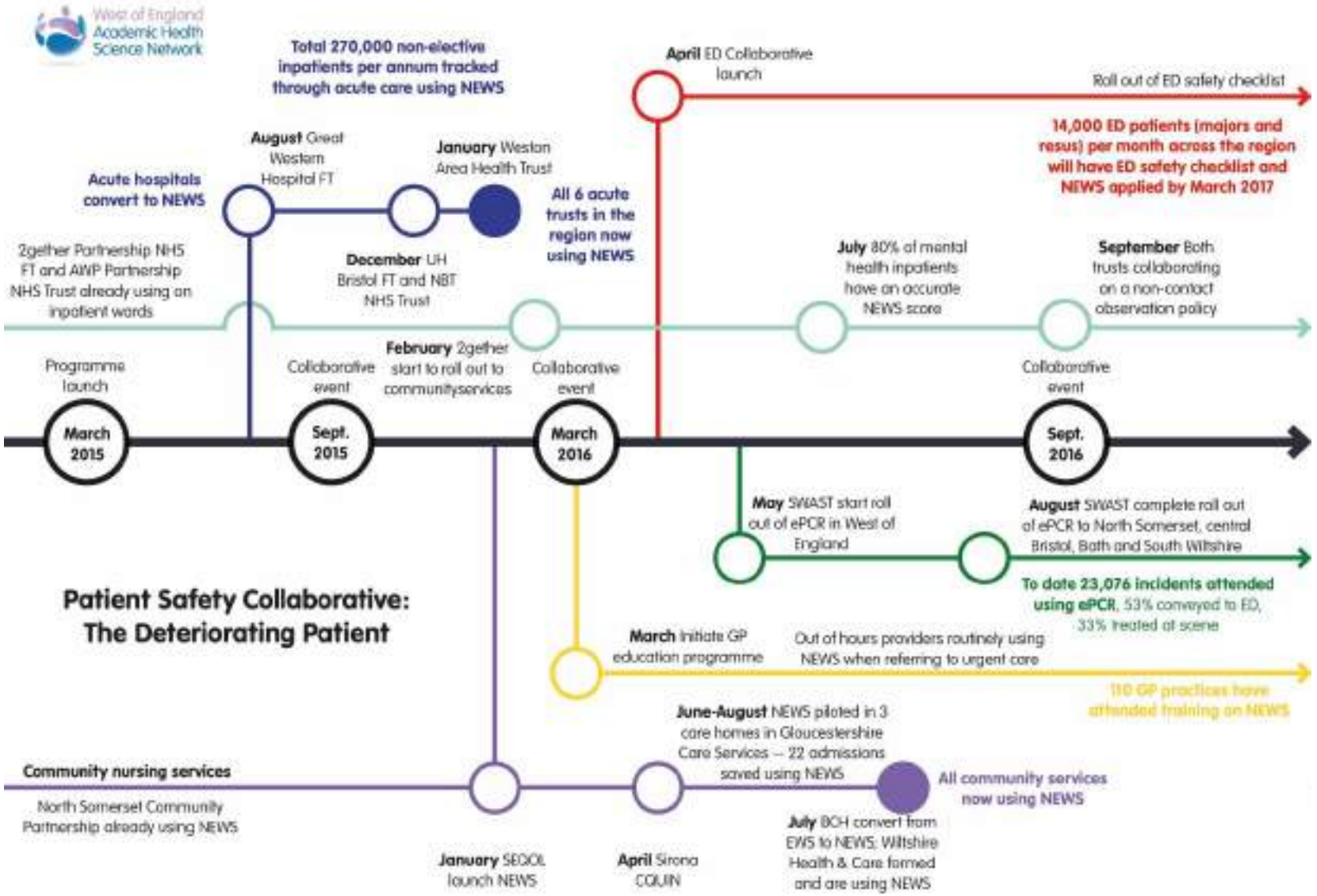
- IHI breakthrough collaborative model
- Health community work streams
- Primary care and ED collaboratives
- QI methodology
- Strategic change
- Harnessing existing programmes e.g. SWAST ePCR


Mortality in SoS emergency admissions (%)
10%
8%
6%
4%
2%
0%
Apr-Jun
Jul-Sep
Oct-Dec
Jan-Mar
2013
2014
2015
2016
2017
Selected
All Sexes All Ages National Average
Selected LCL
Selected UCL

Year 1

- Focus on introducing NEWS to all settings and using NEWS accurately
- Some acute organisations had EWS so changed to NEWS


2gether
Making life better
NHS
Avon and Wiltshire
Mental Health Partnership NHS Trust
NHS
BrisDoc
NHS
Bath and
North East Somerset
Clinical Commissioning Group
Bristol
Community
Health
NSCP
Sirona
care & health
NHS
South Gloucestershire
Clinical Commissioning Group
NHS
Swindon
Clinical Commissioning Group
Gloucestershire Care Services
NHS Trust
NHS
SEQOL
care · health · support
NHS
University Hospitals Bristol
NHS Foundation Trust
NHS
North Somerset
Clinical Commissioning Group
North Bristol
NHS Trust
NHS
Royal United Hospitals Bath
NHS Foundation Trust
NHS
medvivo
integrating health and care
NHS
Bristol
Clinical Commissioning Group
Great Western Hospitals
NHS Foundation Trust
NHS
Gloucestershire Hospitals
NHS Foundation Trust
NHS
Weston Area Health
NHS Trust
NHS
Gloucestershire
Clinical Commissioning Group
care UK
South Western Ambulance Service
NHS Foundation Trust
NHS


West of England Academic Health Science Network
Total 270,000 non-elective inpatients per annum tracked through acute care using NEWS
April ED Collaborative launch
Roll out of ED safety checklist
14,000 ED patients (majors and resus) per month across the region will have ED safety checklist and NEWS applied by March 2017
August Great Western Hospital FT
January Weston Area Health Trust
Acute hospitals convert to NEWS
All 6 acute trusts in the region now using NEWS
December UH Bristol FT and NBT NHS Trust
2gether Partnership NHS FT and AWP Partnership NHS Trust already using on inpatient wards
July 80% of mental health inpatients have an accurate NEWS score
September Both trusts collaborating on a non-contact observation policy
Programme launch
March 2015
Collaborative event
Sept. 2015
February 2gether start to roll out to communityservices
Collaborative event
March 2016
Collaborative event
Sept. 2016
May SWAST start roll out of ePCR in West of England
August SWAST complete roll out of ePCR to North Somerset, central Bristol, Bath and South Wiltshire
To date 23,076 incidents attended using ePCR, 53% conveyed to ED, 33% treated at scene
Patient Safety Collaborative: The Deteriorating Patient
March Initiate GP education programme
Out of hours providers routinely using NEWS when referring to urgent care
110 GP practices have attended training on NEWS
June-August NEWS piloted in 3 care homes in Gloucestershire Care Services – 22 admissions saved using NEWS
Community nursing services
North Somerset Community Partnership already using NEWS
January SEQOL launch NEWS
April Sirona COUIN
July BCH convert from EWS to NEWS; Wiltshire Health & Care formed and are using NEWS
All community services now using NEWS

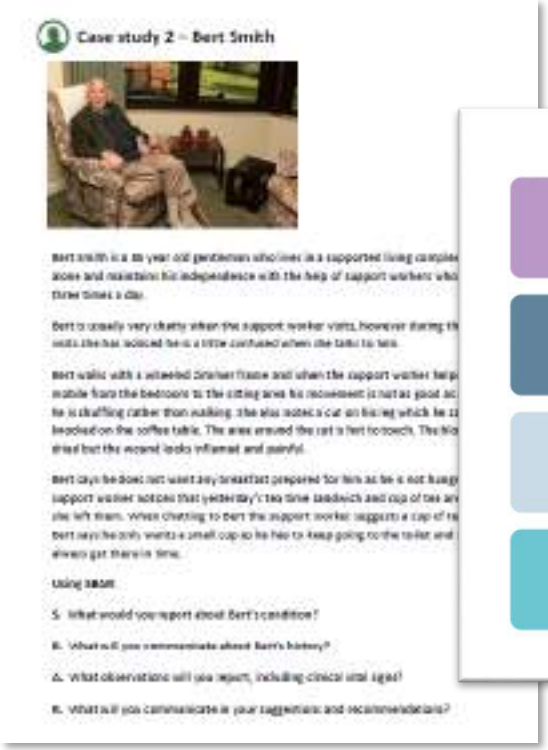
Human Factors

SITUATION S

BACKGROUND B

ASSESSMENT A

RECOMMENDATION R

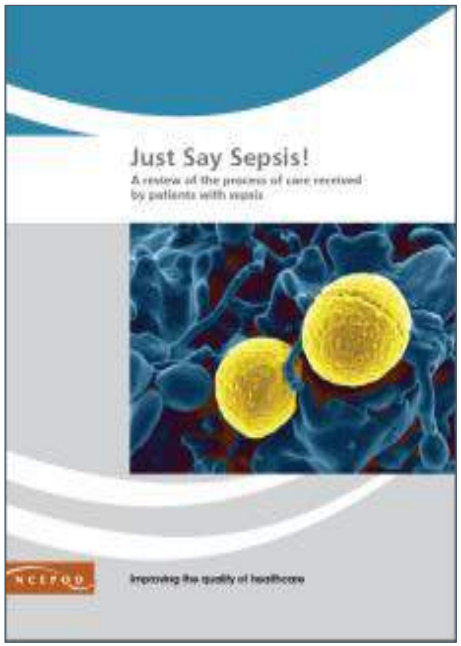


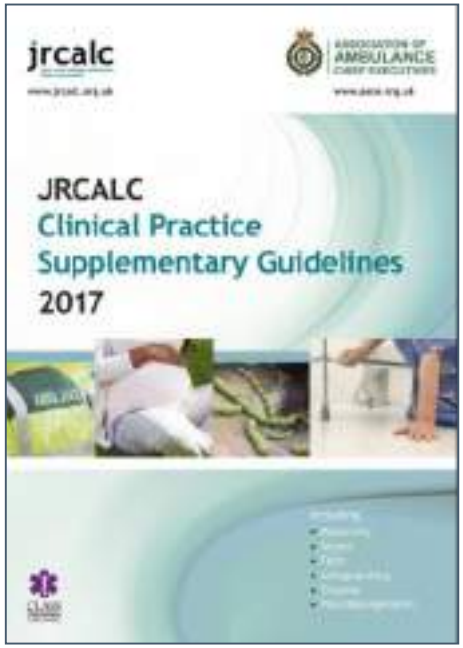
S	**Situation:** patient's / client's details - identify reason for this communication, describe your concern
B	**Background:** relating to the patient / client, significant history - this may include medications, investigations, treatments
A	**Assessment:** your assessment of the patient / client or situation - this can include clinical impression, concerns, vital signs, early warning score
R	**Recommendations:** be specific - explain what you need, make suggestions, clarify expectations, confirm actions to be taken

West of England Academic Health Science Network

But it is not validated in primary care……

The National Early Warning Score





NEWS 2 AND SEPSIS

NEWS 2 sepsis score is not validated in primary care

Alex Burns *general practitioner*

Acute GP Service, Treliske Hospital, Truro TR1 3LQ, UK

Inada-Kim and Nsutebu urge the health system to use the NEWS 2 score in all healthcare settings.[1] They say that "a score in one setting must mean the same in any other." The problem is that it doesn't.

Improved communication in health systems should be encouraged, but as Bernard Shaw (maybe) said about the United Kingdom and United States, primary and secondary care will always be separated by the same language.

As with any scoring system, diagnostic test, or risk stratification tool, the predictive value is governed by the pre-test probability as well as the characteristics of the test. A NEWS score of 4 in an emergency medical setting[2] does not mean the same as in an ambulance call-out[3] or a GP surgery, for the simple reason that serious illness is not as common in these settings.

Clinicians should observe patients and be alert to sickness, but we should acknowledge that the NEWS score is not validated in primary care, let alone as a screening tool. We need research to establish what any warning score means in primary care; until then, we must accept that the NEWS score from primary care is spoken with a different dialect.

Competing interests: None declared.

1 Inada-Kim M, Nsutebu E. NEWS 2: an opportunity to standardise the management of deterioration and sepsis. *BMJ* 2018;360:k1260. 10.1136/bmj.k1260 29563039

2 Smith GB, Prytherch DR, Meredith P, Schmidt PE, Featherstone PI. The ability of the National Early Warning Score (NEWS) to discriminate patients at risk of early cardiac arrest, unanticipated intensive care unit admission, and death. *Resuscitation* 2013;84:465-70. 10.1016/j.resuscitation.2012.12.016 23295778

3 Silcock DJ, Corfield AR, Gowens PA, Rooney KD. Validation of the National Early Warning Score in the prehospital setting. *Resuscitation* 2015;89:31-5. 10.1016/j.resuscitation.2014.12.029 25596149

NEWS 2 AND SEPSIS

NEWS 2 ... care

Alex Burns *gen*

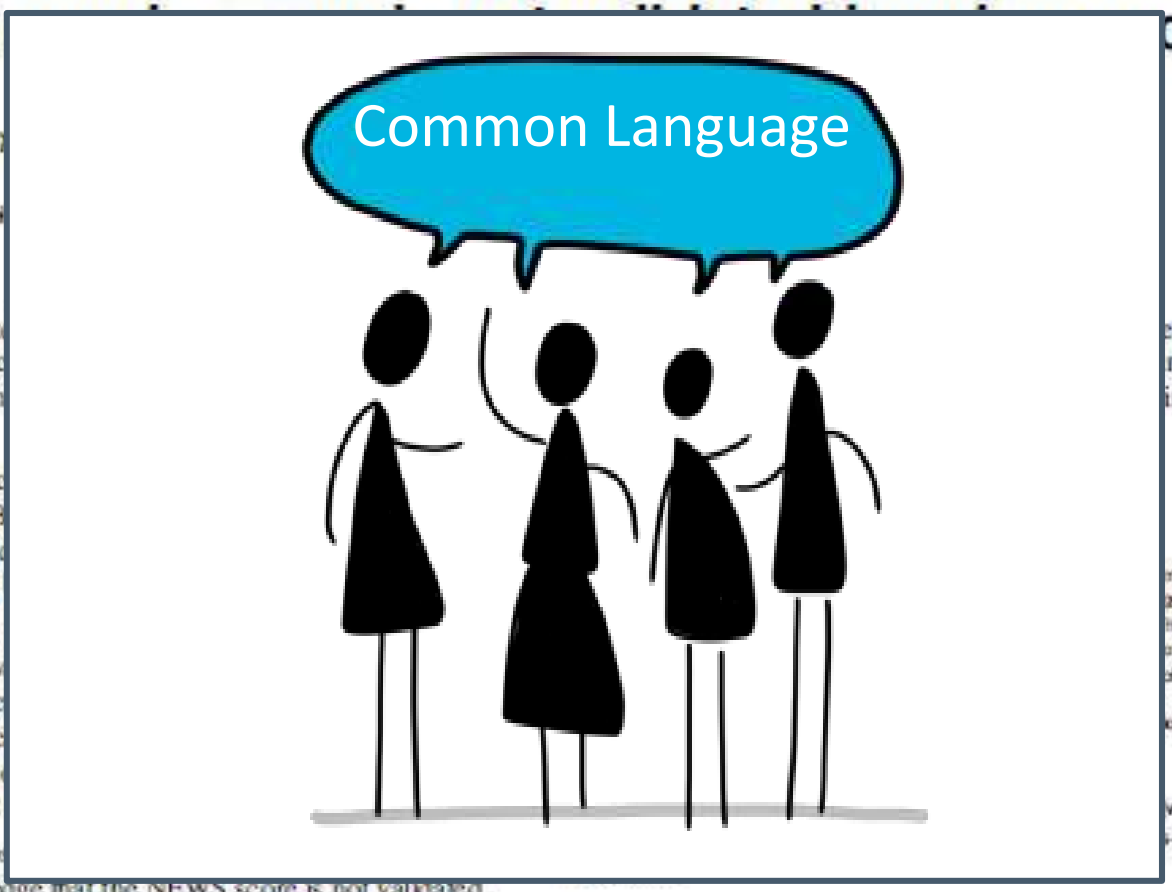
Acute GP Service, Tre

Inada-Kim and Nsut... ...ed research
2 score in all healthc... ...ry care; until
setting must mean th... ...imary care
it doesn't.

Improved communic...
encouraged, but as B...
Kingdom and Unite...
always be separated

As with any scoring ...
tool, the predictive v...
as well as the charac...
an emergency medic...
ambulance call-out[3] ...
serious illness is not ...

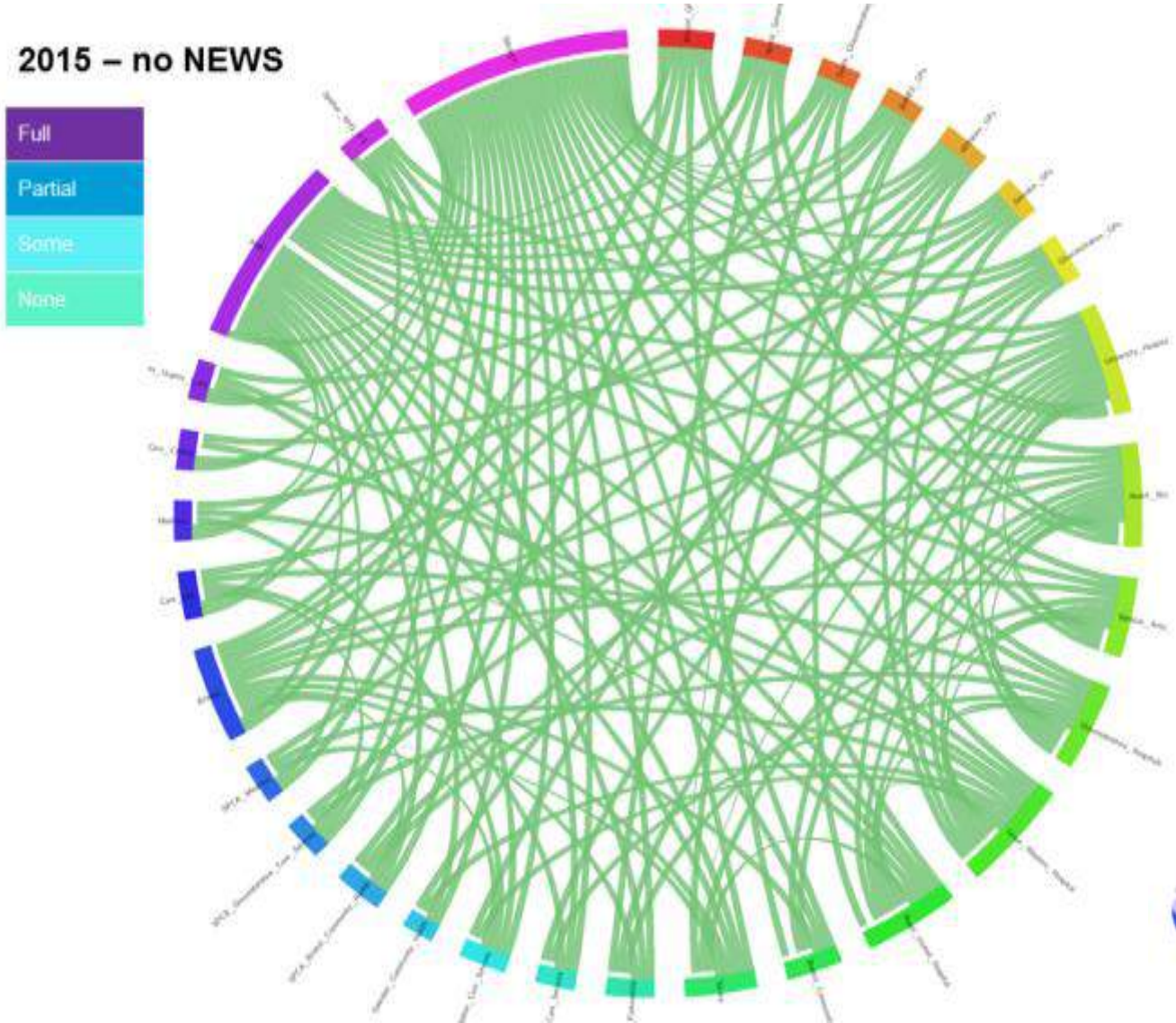
Clinicians should ob...
we should acknowledge that the NEWS score is not validated



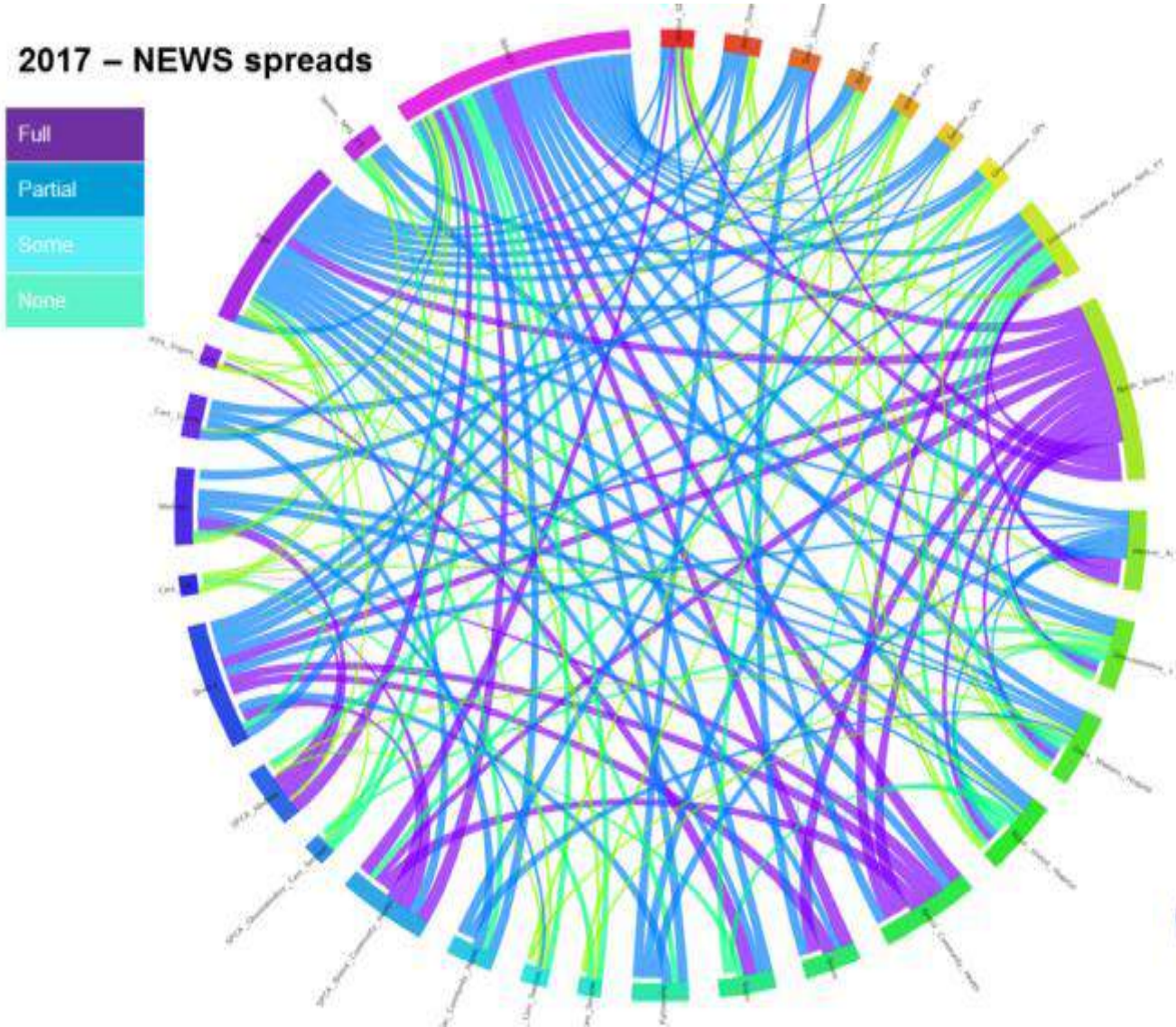
Year 2

- Focus on using NEWS at handover of care

Connections March 2015



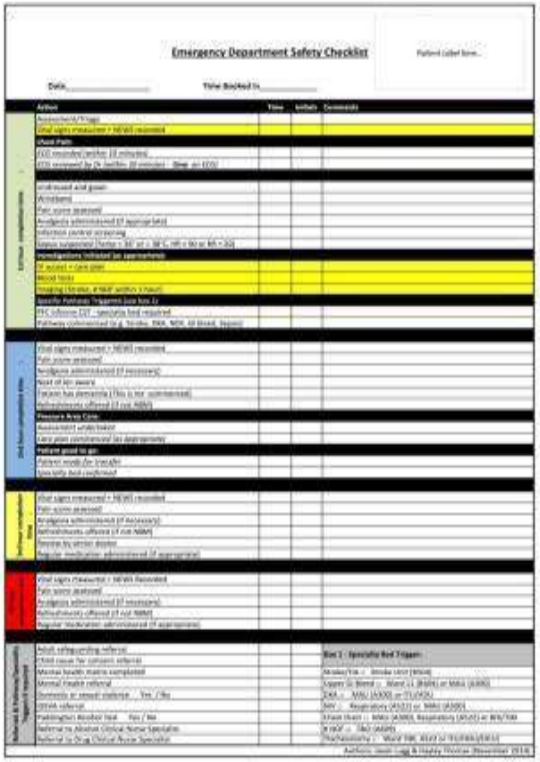
Connections – July 2017



News at handover

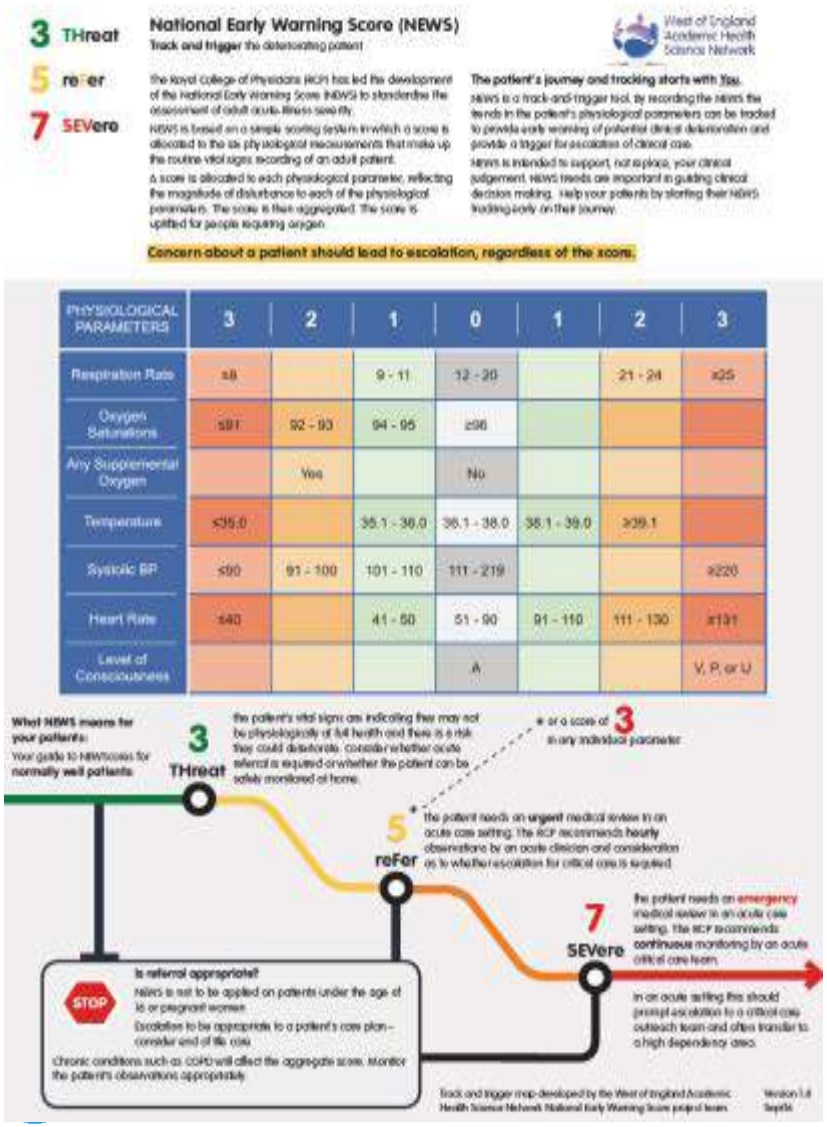
Single Point of Access

ED safety checklist



Community baseline measurement

Primary Care



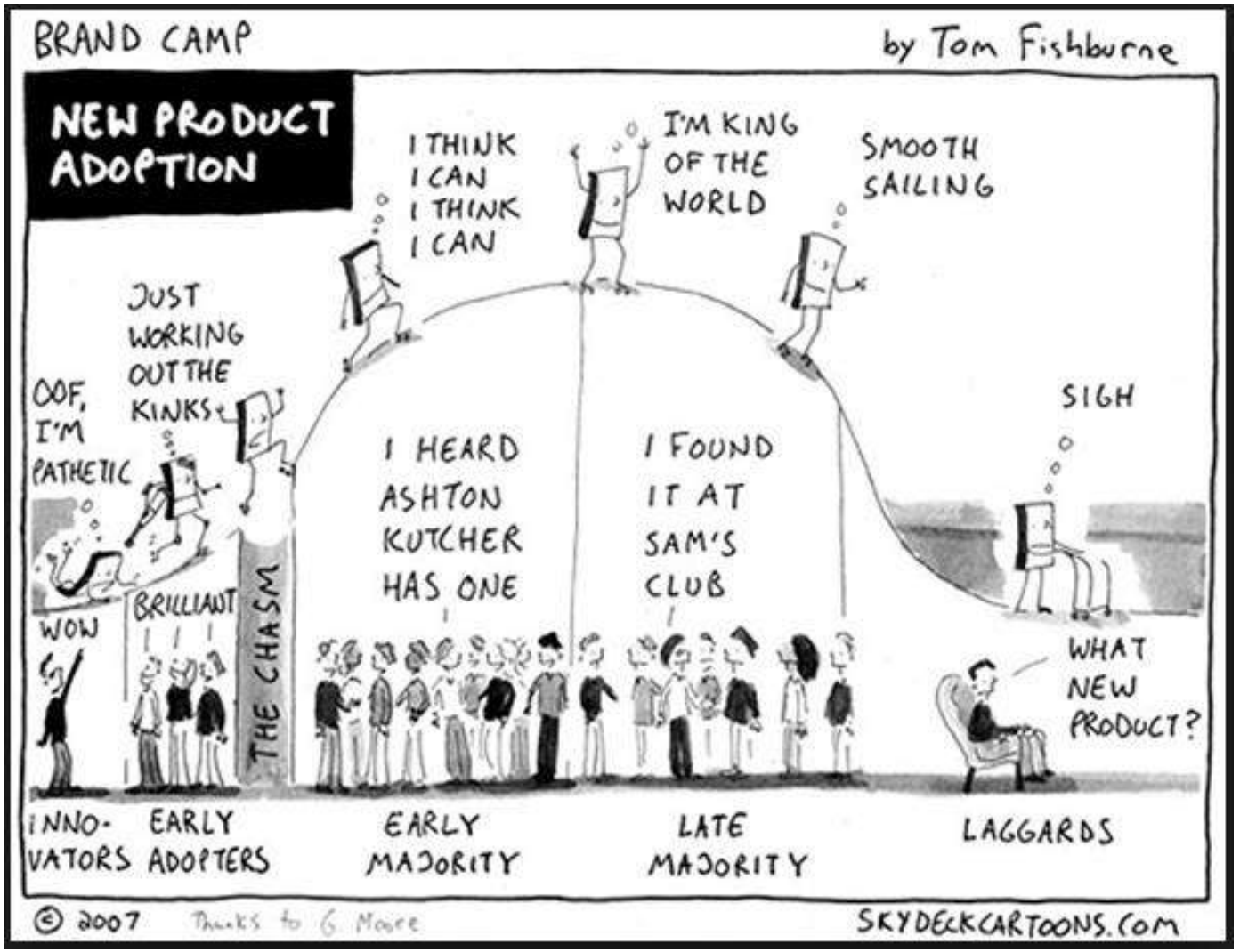
- Information and education
- Presentations to practices
- Primary care collaborative
- Digital templates

West of England Academic Health Science Network

South Western Ambulance Service NHS
NHS Foundation Trust

West of England Academic Health Science Network

Year 3


BRAND CAMP
by Tom Fishburne
NEW PRODUCT ADOPTION
I THINK I CAN I THINK I CAN
I'M KING OF THE WORLD
SMOOTH SAILING
JUST WORKING OUT THE KINKS
OOF, I'M PATHETIC
SIGH
I HEARD ASHTON KUTCHER HAS ONE
I FOUND IT AT SAM'S CLUB
WOW
BRILLIANT
THE CHASM
WHAT NEW PRODUCT?
INNO-VATORS
EARLY ADOPTERS
EARLY MAJORITY
LATE MAJORITY
LAGGARDS
© 2007 Thanks to G. Moore
SKYDECKCARTOONS.COM

Evaluation

NHS National Institute for Health Research

CLAHRC West

Systematic Review

Qualitative

Quantitative

Systematic Review

- No evidence where EWS has been put into a prehospital system
- 17 studies (n=157 878)
- Low EWS and high EWS predict mortality

Qualitative Research

- Improved communication
  - across systems
  - across professional roles
- Supported clinical decision making & prioritisation

But it will increase referrals. I see lots of people with a NEWS of 5…….

Quantitative Research

- 8% of 122 000 ED attendances
- 18% of 1.1 million South West ambulance service conveyances
- 12% of 21 000 Bristol community health visits

NEWS 5+ uncommon

NEWS : a common language

This chap has had 2x admissions to Southmead c sepsis from cellulitis. (see enclosed).

Acutely unwell again today:

T 39.3 SaO_2 91%

P 120 BP 140 systolic RR 18

NEWS = 7

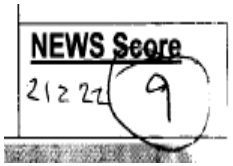
IMP – Sepsis 2° to cellulitis

Ambulance ePCR

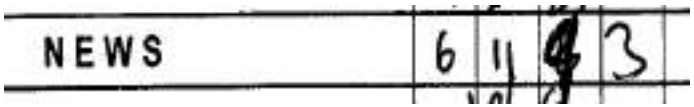
GP

1. Incident
NEWS 8

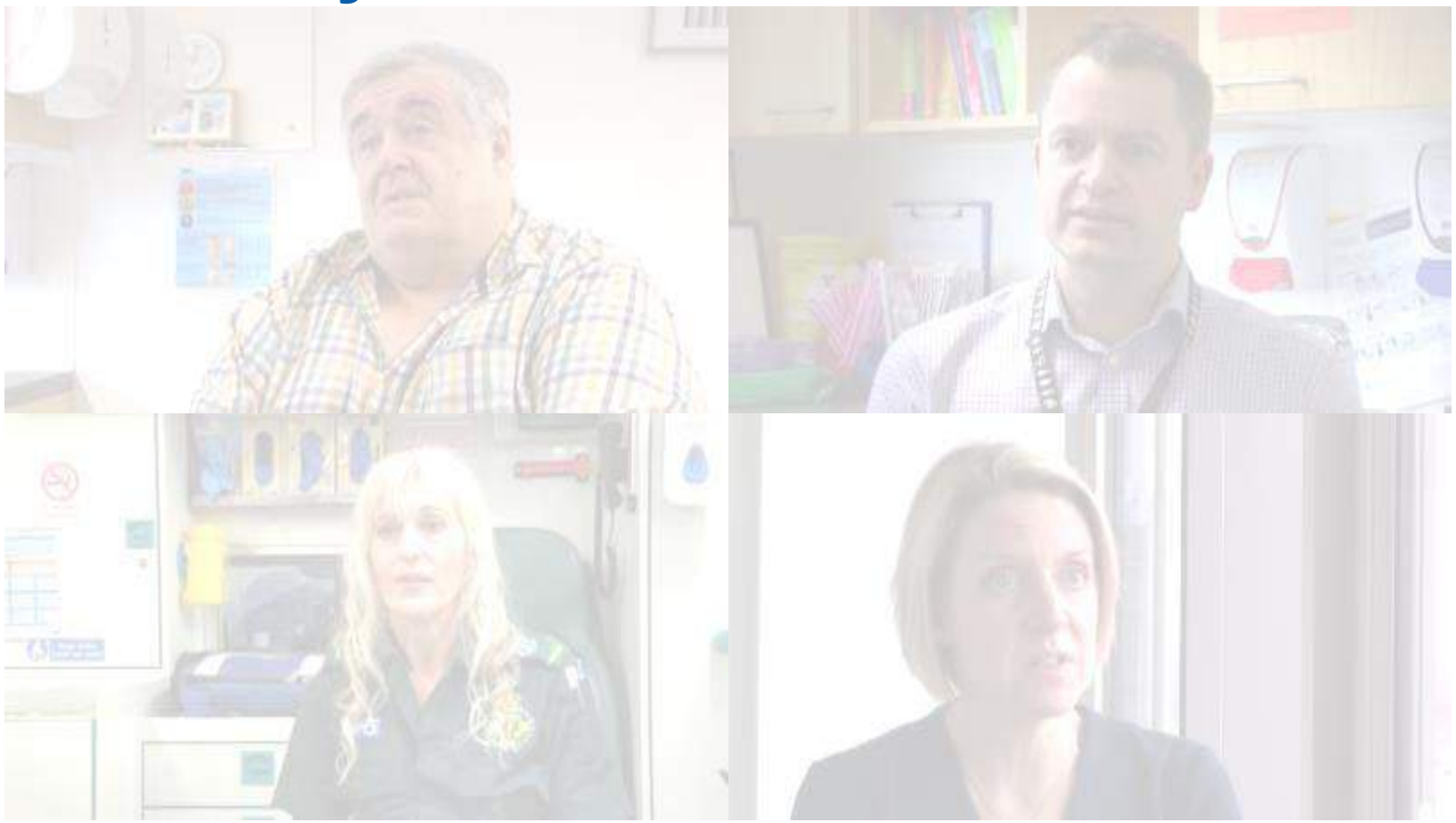
ED Triage



After treatment

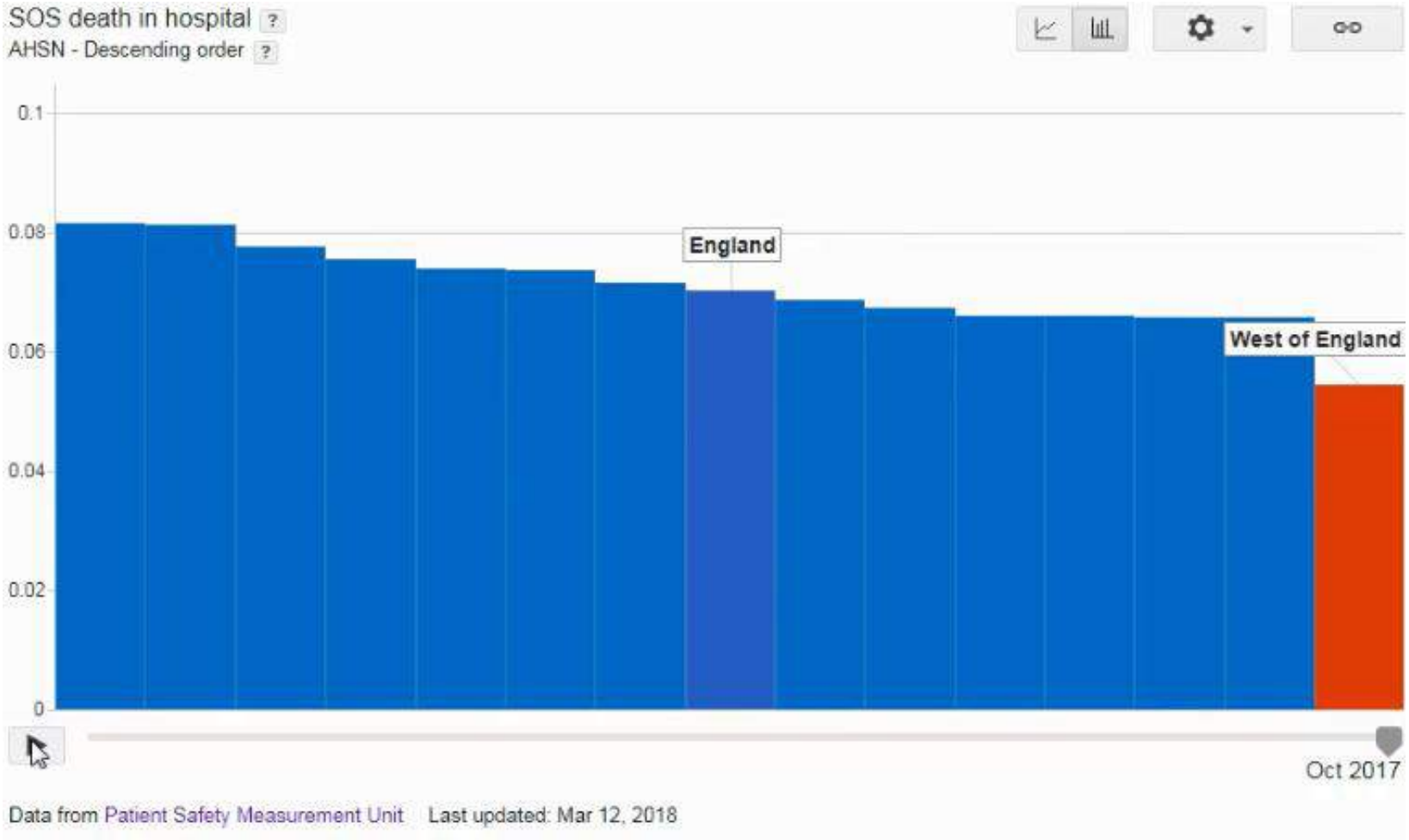


Paul's Story



https://vimeo.com/208284106

Mortality from Suspicion of Sepsis



Tools available

Podcasts

http://www.weahsn.net/news/patient-safety-podcasts/

Toolkits

http://www.weahsn.net/what-we-do/enhancing-patient-safety/the-deteriorating-patient/

@GMEC_PSC #GMECDetPat

West of England Academic Health Science Network


Alliance Medical
BMJ Best Practice
General Medical Council
The Health Foundation
hospice
NICE
RCOA

Connect with us

@weahsn
@paramedicjoanna

LinkedIn

Break out session

The AHSN Network

NHS Improvement

Greater Manchester & Eastern Cheshire

Patient Safety Collaborative

Plan your News journey

Greater Manchester & Eastern Cheshire Patient Safety Collaborative

Deteriorating Patient – Learning System Launch Event 24th May 2018

Organisation (Name): _____

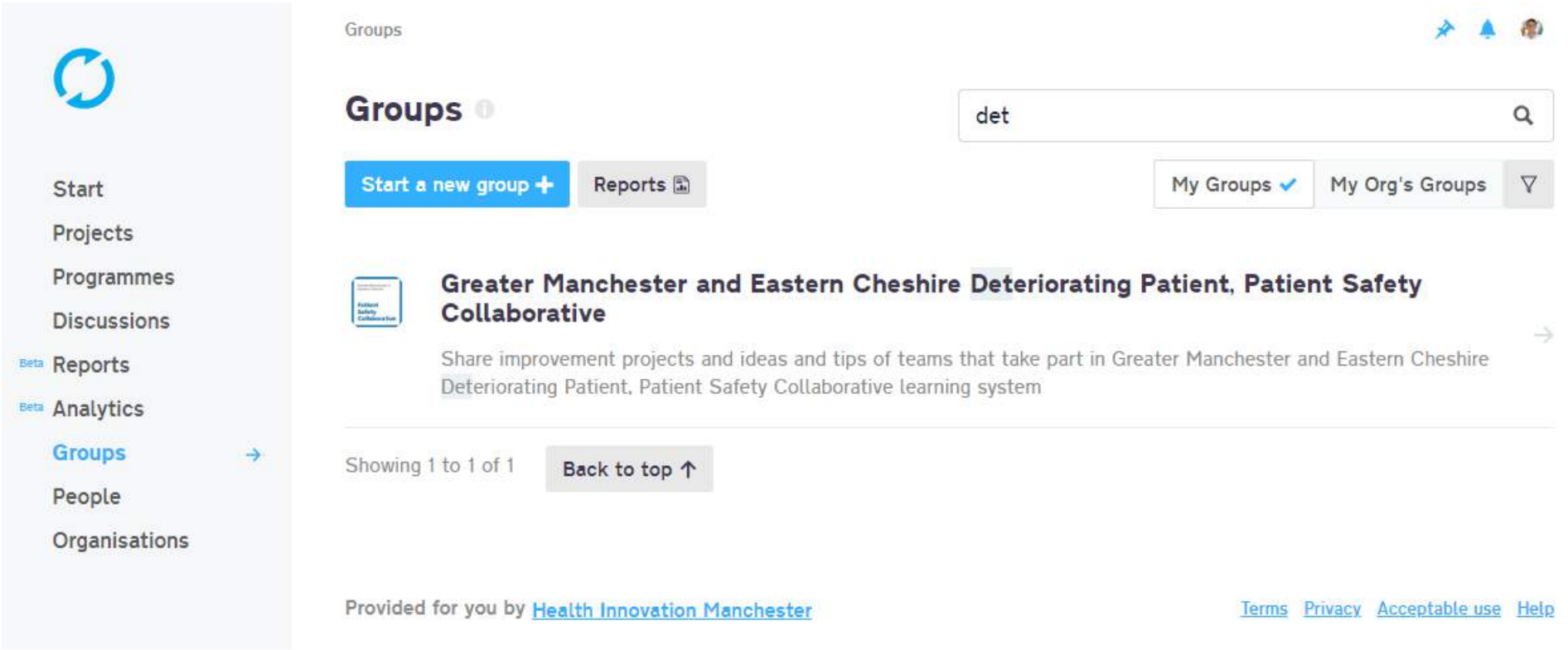
1: Why Change?	2: Form your team	3: Agree your measures
What are the benefits of having a standard approach to the assessment of acutely unwell patients for your organisation?	Who will you need in your team to oversee delivery of the project? Consider representation from all key groups influenced by the change.	What will you measure? – consider process; outcome; balancing measures. Who will measure it, how and with what frequency?
1) Standardisation will mean NHS staff who move between trusts are using a consistent set of measures for diagnosing patients. 2) Shared common language 3) Clear communications throughout the patient pathway		

4: Agree your actions	5: Known Issues	6: What help might you need?
Think about the phases involved in establishing a new process. 1) **Introduction** – development work and publicising change 2) **Implementation** – rolling out the change across the organisation 3) **Instillation** (Embedding) – ensuring that the change is thoroughly embedded and working well	Some issues can be considered at the start of the process others may arise as the process of implementation progresses. Initially you may want to consider: 1) Training 2) Cultural Change 3) Trigger resetting 4) Communication processes & tools e.g. SBARr	Consider what expertise you have currently within your system/ organisation. Are there elements of expertise missing from your project team? What sort of assistance might you need?


Implementing the National Early Warning Score (NEWS)
NEWS
West of England Academic Health Science Network
Introduction
Why change?
Form your team
Agree your measures
Agree your actions
Known issues
Appendices

- Gather with the people from your organisation and work on the worksheet till 14:15
  - Please do talk to other organisations in the room or the facilitators for more inspiration
- 14:15 Facilitators to take pictures of the results

- These sheets will be shared on our Greater Manchester and Eastern Cheshire Deteriorating Patient, Patient Safety Collaborative group within LifeQI.
  - Only visible to people who signed up


Start
Projects
Programmes
Discussions
Beta Reports
Beta Analytics
Groups
People
Organisations
Groups
Groups
det
Start a new group +
Reports
My Groups
My Org's Groups
Greater Manchester and Eastern Cheshire Deteriorating Patient, Patient Safety Collaborative
Share improvement projects and ideas and tips of teams that take part in Greater Manchester and Eastern Cheshire Deteriorating Patient, Patient Safety Collaborative learning system
Showing 1 to 1 of 1
Back to top
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Help

A local perspective

Professor Alison Lynch

Chief Nurse & Director of Quality Governance, Stockport NHS Foundation Trust

Greater Manchester & Eastern Cheshire

Patient Safety Collaborative

Implementing NEWS 2
Stockport NHS FT Local Perspective

24th May 2018

Professor Alison Lynch
Chief Nurse
Stockport NHS Foundation Trust

Your Health. Our Priority.

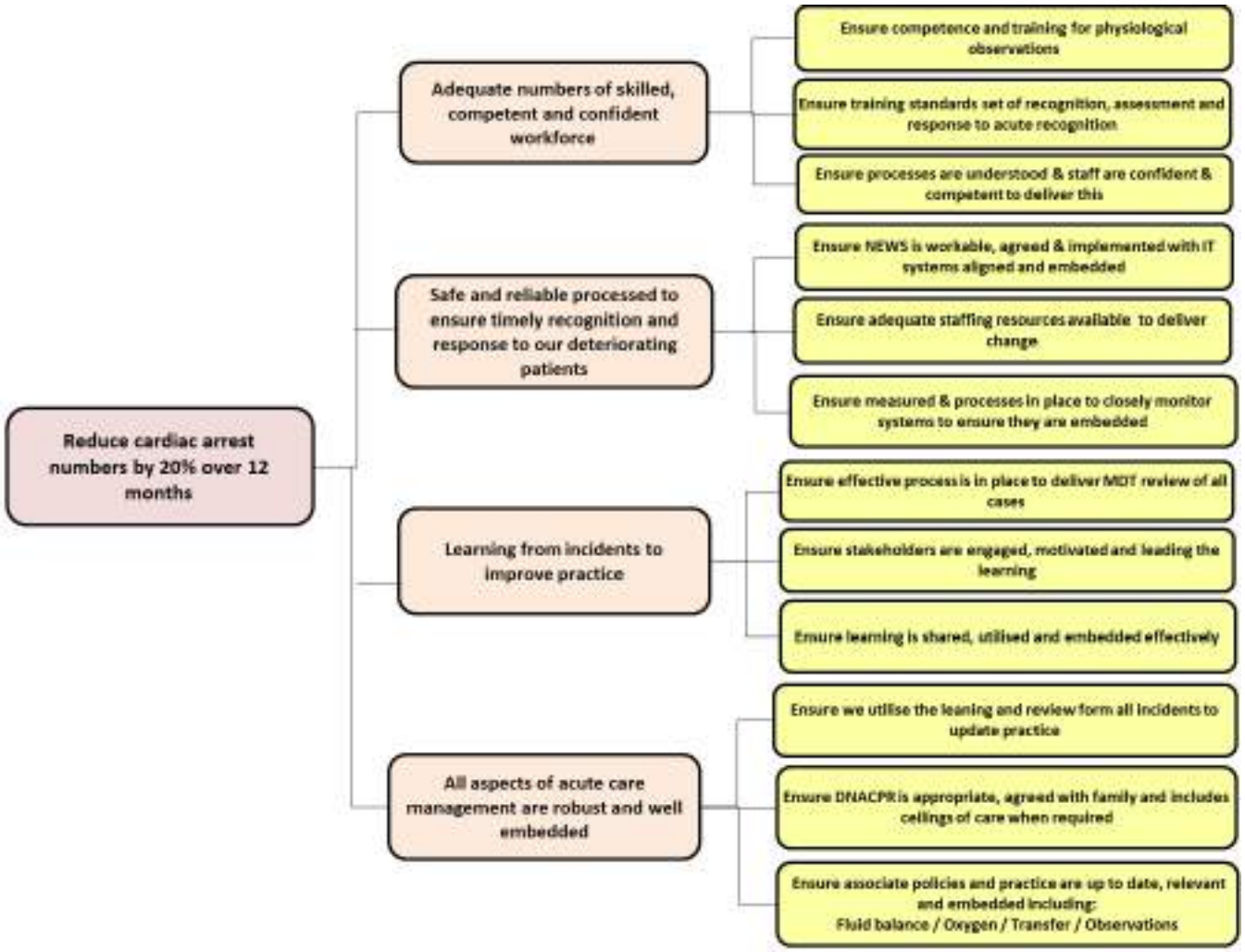
Local Context

- Stockport NHS FT is on a quality improvement journey
- CQC rating as ‘Inadequate’ for medical care and safety in Emergency Care and as ‘Inadequate’
- To address this, a Quality Improvement Plan (QIP) has been developed with the ambition to be rated “Good” by 2019 and “Outstanding” by 2020
- The QIP consists of seven key themes
  - ***NEWS 2 sits within the “Reducing Unwarranted Variation in Clinical Practice” the***

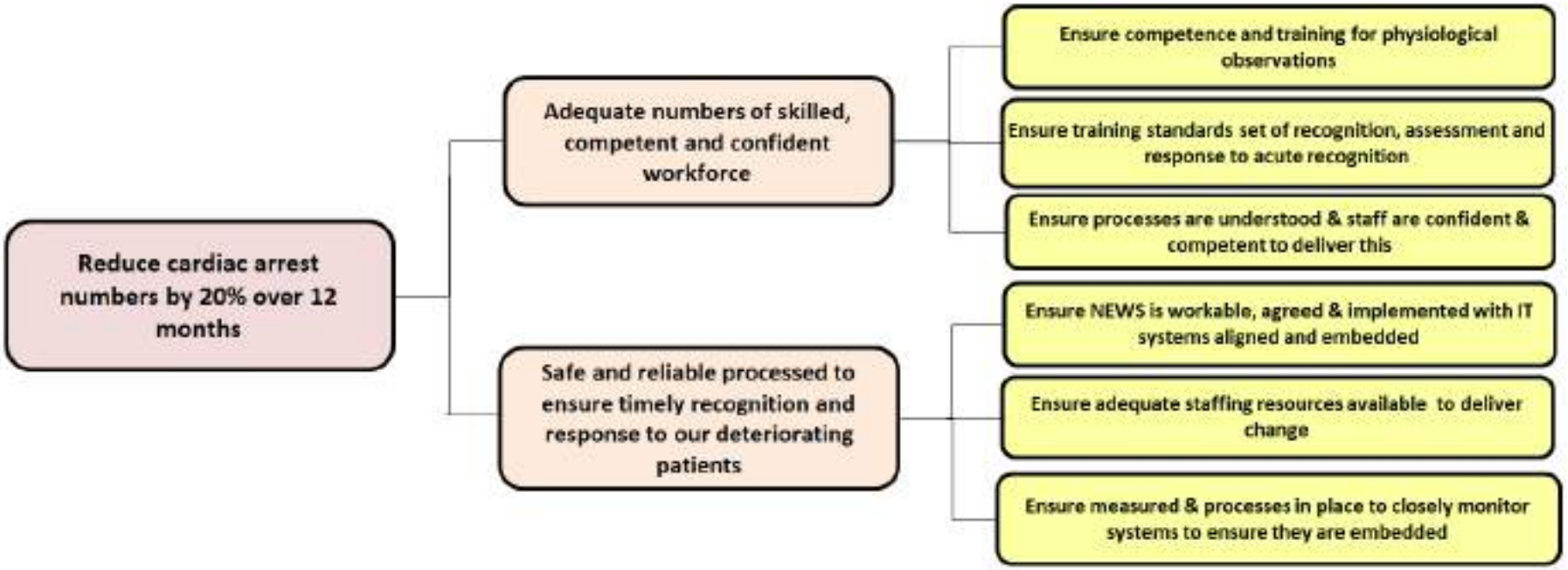
Quality Improvement Plan

- The Trust's Quality Improvement Plan seeks to ensure:
  - ***Safe, effective, high quality services for patients***
  - ***Lessons are learned and shared across the trust thus reducing the risk of incidents and improving responsiveness, quality of care and experience for patients***
  - *The trust has robust systems and processes in place thus reducing clinical and reputational risk*
  - *The trust is compliant with CQC regulations*
  - ***Well trained and valued staff***
  - ***There is a sustainable trust-wide process and governance arrangements are in place to move programme work into business as usual at local level when appropriate***
  - *Senior oversight on progress and any slippage allows executives to prioritise work*

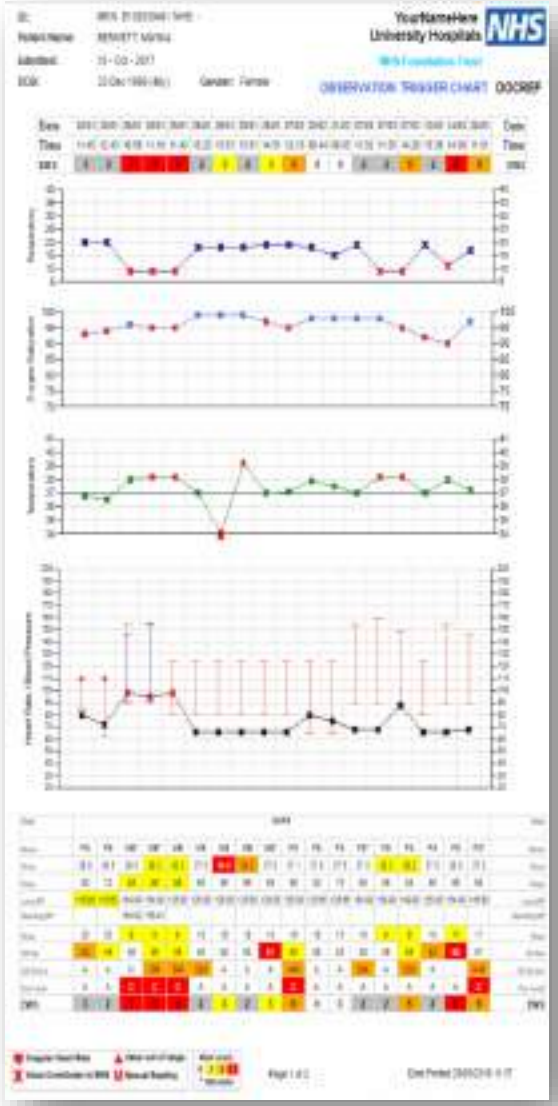
Implementing NEWS: Driver Diagram



People, Processes…..



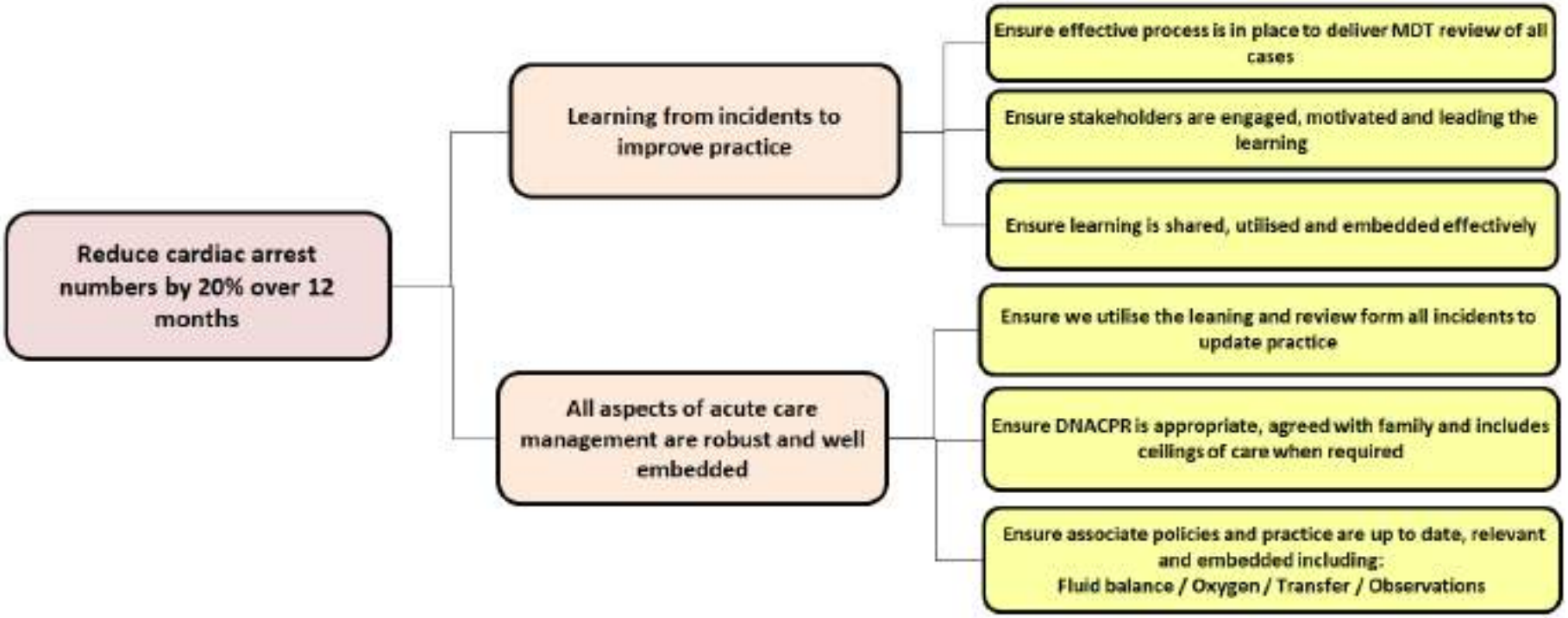
People, Processes…..



Notes

NEWS 2 colour coding

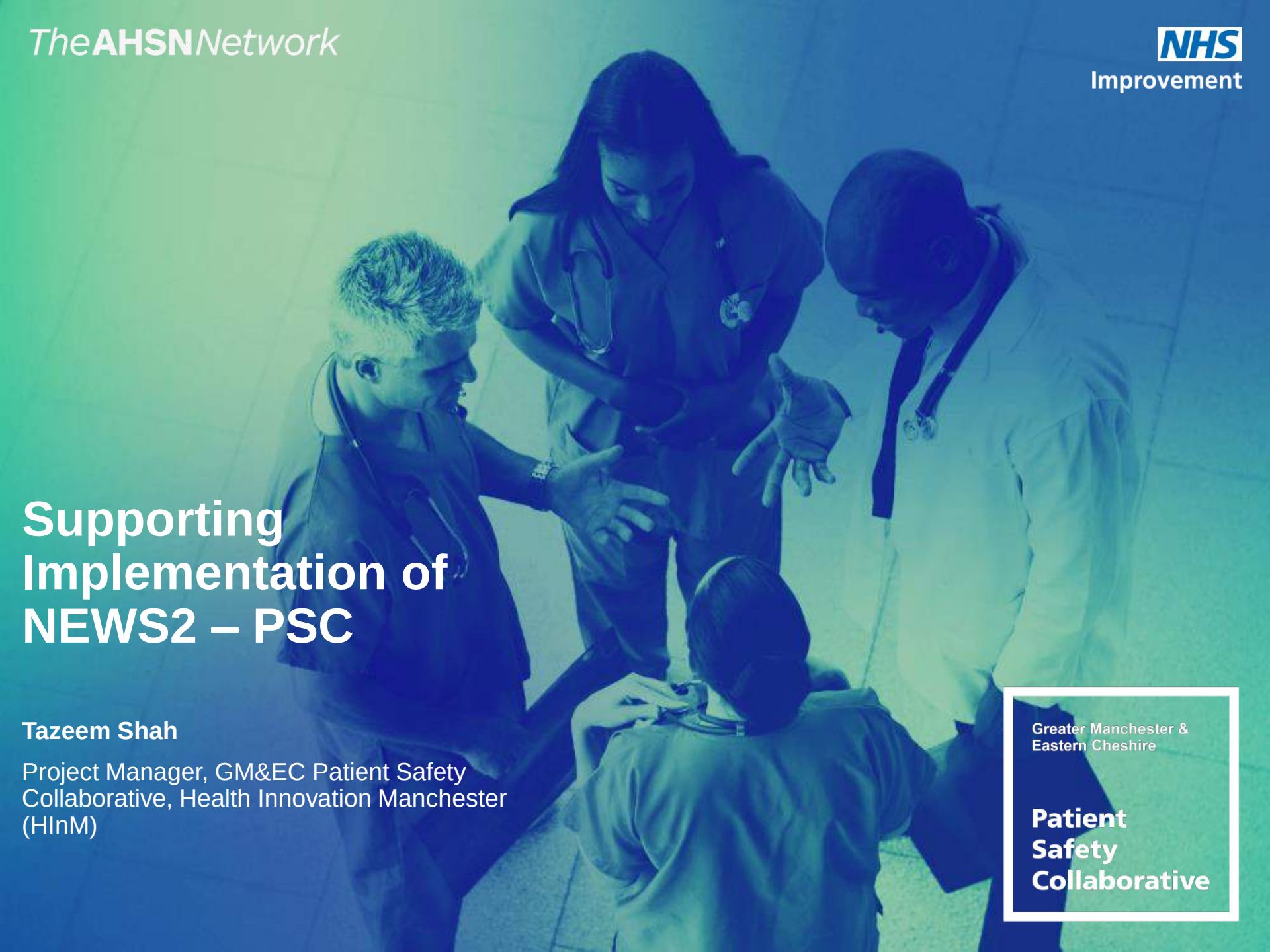
…..and Systems


Reduce cardiac arrest numbers by 20% over 12 months
Learning from incidents to improve practice
All aspects of acute care management are robust and well embedded
Ensure effective process is in place to deliver MDT review of all cases
Ensure stakeholders are engaged, motivated and leading the learning
Ensure learning is shared, utilised and embedded effectively
Ensure we utilise the leaning and review form all incidents to update practice
Ensure DNACPR is appropriate, agreed with family and includes ceilings of care when required
Ensure associate policies and practice are up to date, relevant and embedded including:
Fluid balance / Oxygen / Transfer / Observations

Challenges

- Present compliance with EWS
- Expected increase to alerts
- Two EPR systems for observations
- Engaging the hearts and minds
- …many other changes required – *we can do this!*

Implementing NEWS: Next Steps



Supporting Implementation of NEWS2 – PSC

Tazeem Shah

Project Manager, GM&EC Patient Safety Collaborative, Health Innovation Manchester (HInM)

Prof. Don Berwick's Report

The report of Don Berwick's National Advisory Group on the Safety of Patients in England stated that:

''The most important single change in the NHS in response to this report 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.''

What is a Local Learning System?

The learning system is an ‘improvement forum’ where individuals, across different professions, and from different organizations, come together to share and learn about improvement approaches and outcomes.

PSC support for Greater Manchester & Eastern Cheshire

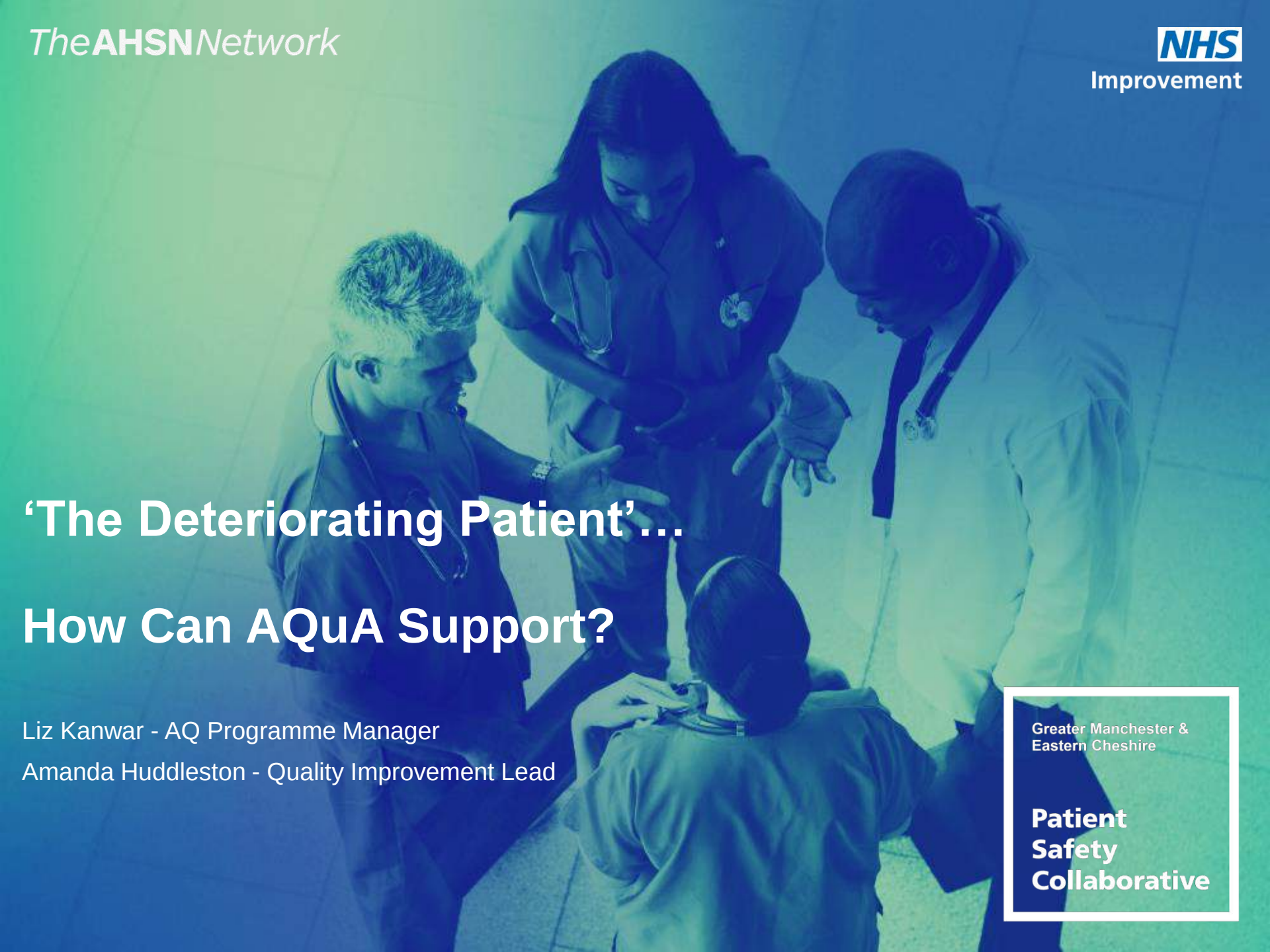
- Focus on quality improvement - Life QI
- Work directly with local teams, supporting you to make sure you have the right skills and resources to implement successful improvement
- Focus on people-centred care, across all care settings
- Influence across the health system including acute, community and mental health trusts, GPs, and care homes to share good practice
- Identify local priorities for quality improvements that will make a difference to our local health care systems
- Link and build relationships with frontline staff, businesses and academia helping to stimulate innovation and improvement

Question

Use one word to describe:

What you think the deteriorating patient local learning system should offer you?

Answers via www.slido.com and enter the event code: #2961



The AHSN Network

NHS Improvement

‘The Deteriorating Patient’…

How Can AQuA Support?

Liz Kanwar - AQ Programme Manager

Amanda Huddleston - Quality Improvement Lead

Greater Manchester & Eastern Cheshire

Patient Safety Collaborative

AQuA
Advancing Quality Alliance

NHS

‘The Deteriorating Patient’…
How Can AQuA Support ?

Liz Kanwar - AQ Programme Manager
Amanda Huddleston - Quality Improvement Lead

Who are AQuA?

Advancing Quality Alliance (AQuA) - established in 2010 to improve health and care quality in the North West

- Hosted by Salford Royal NHS Foundation Trust – **NHS not for profit**
- North West membership model - **60+ members -** Acute, primary care, community, CCG, mental health and ambulance trusts
- **Consultancy and grant** work all across the UK.
- **4 Improvement Priorities:**
  - Supporting System Transformation
  - Delivering Person Centred Care
  - Building Capability for Improvement
  - Delivering High Quality Care

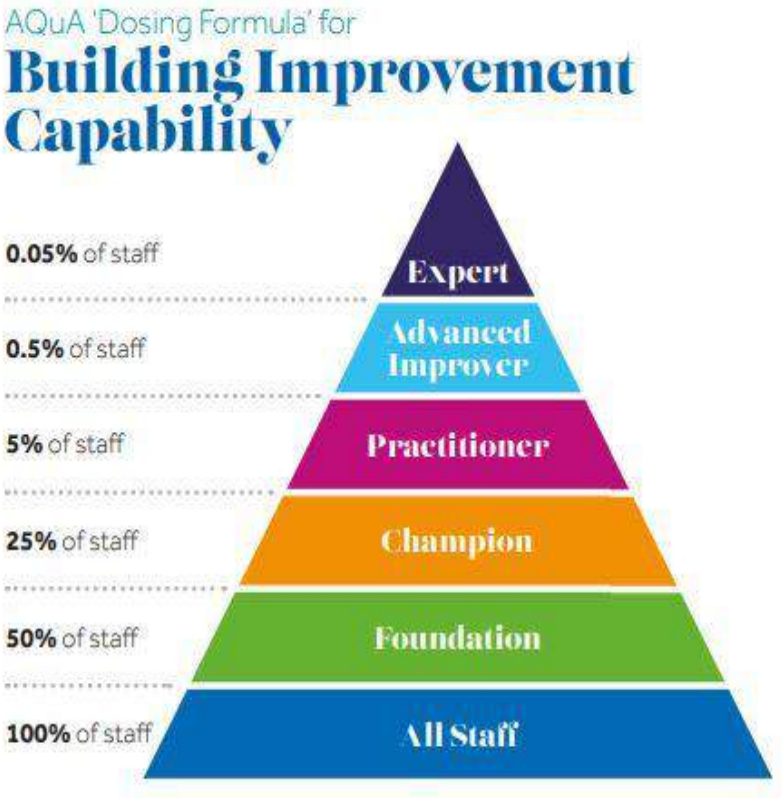
www.AQuAnw.nhs.uk AQuA@srft.nhs.uk

Building Capability for Improvement

Delivering high levels of performance across all domains of quality is dependent on organisational design, leadership and culture, measurement systems, and capability of the workforce.

We work with members to:

- Build a culture and system for Quality Improvement
- Develop capacity and capability for Quality Improvement across organisations
- Provide development opportunities, advice and support to all staff; from frontline teams and service users, to managers, Boards and Non-Executive Directors
- Represent a whole system approach for improvement



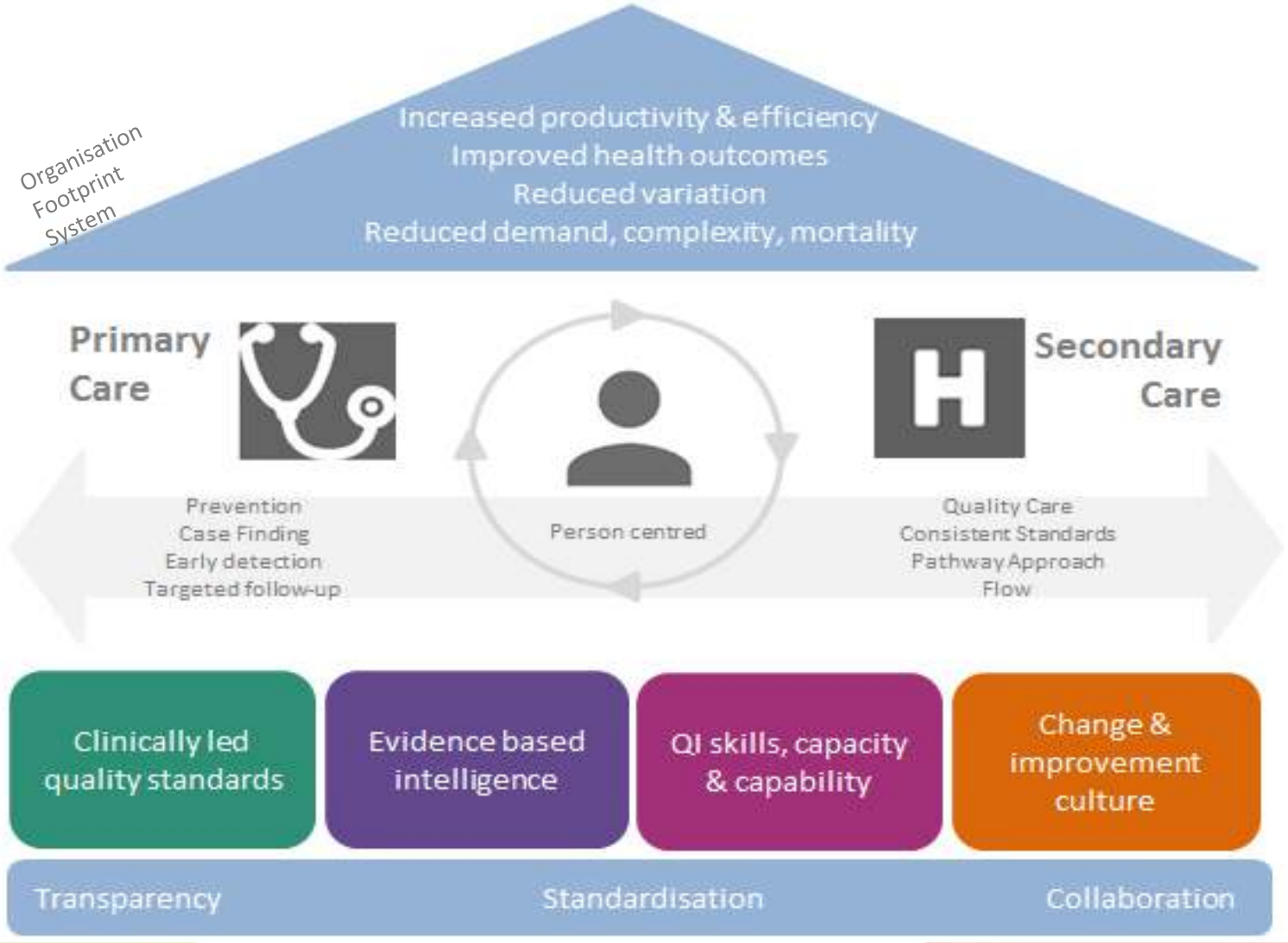
Delivering High Quality Care

Aim to support members to become high reliable organisations, delivering high quality health and care services that reflect the needs of patients, service users and staff

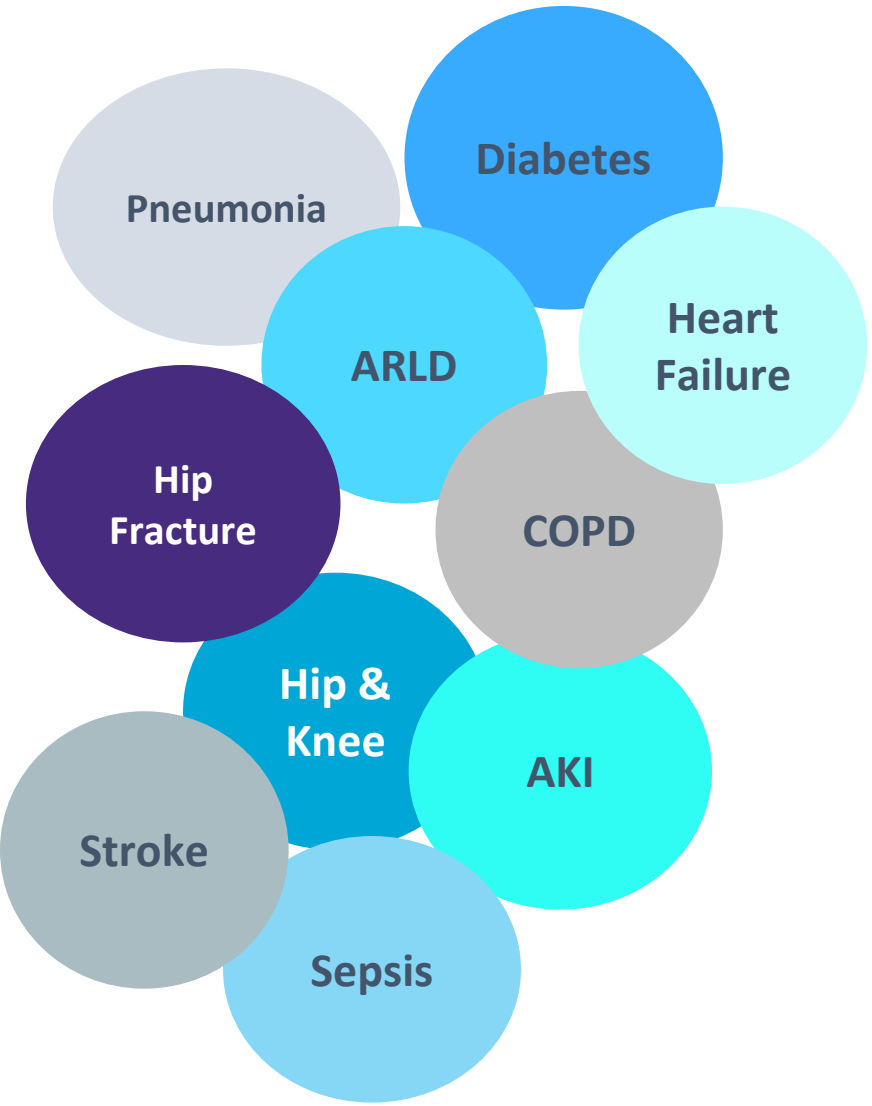
Through a wide range of offers we will support members across a variety of health and care settings to:

- Tackle specific care and quality issues e.g. reducing patient harm or deterioration or improving local waiting and access times
- Use evidence, knowledge & understanding to enable continuous improvement, best practise and quality assurance
- Support a culture for safety focusing on human factors and psychological safety to improve outcomes

Advancing Quality: High Reliability



Clinical Focus Areas



- 10 highly prevalent clinical conditions – 6 x data collection
- Derived from National guidelines eg NICE
- Supported by National Research Organisations eg BMJ Lit
- Improve clinical outcomes eg mortality , LOS , readmissions
- Allows teams to identify improvement opportunities
- Support improvement opportunities utilising QI methodology

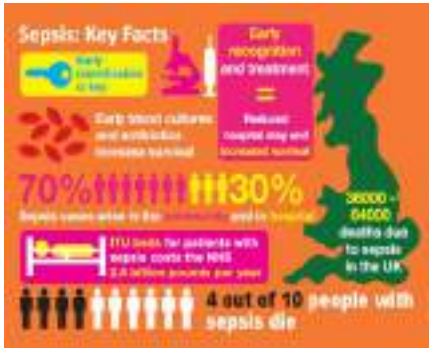
Sepsis

Measures devised 2015

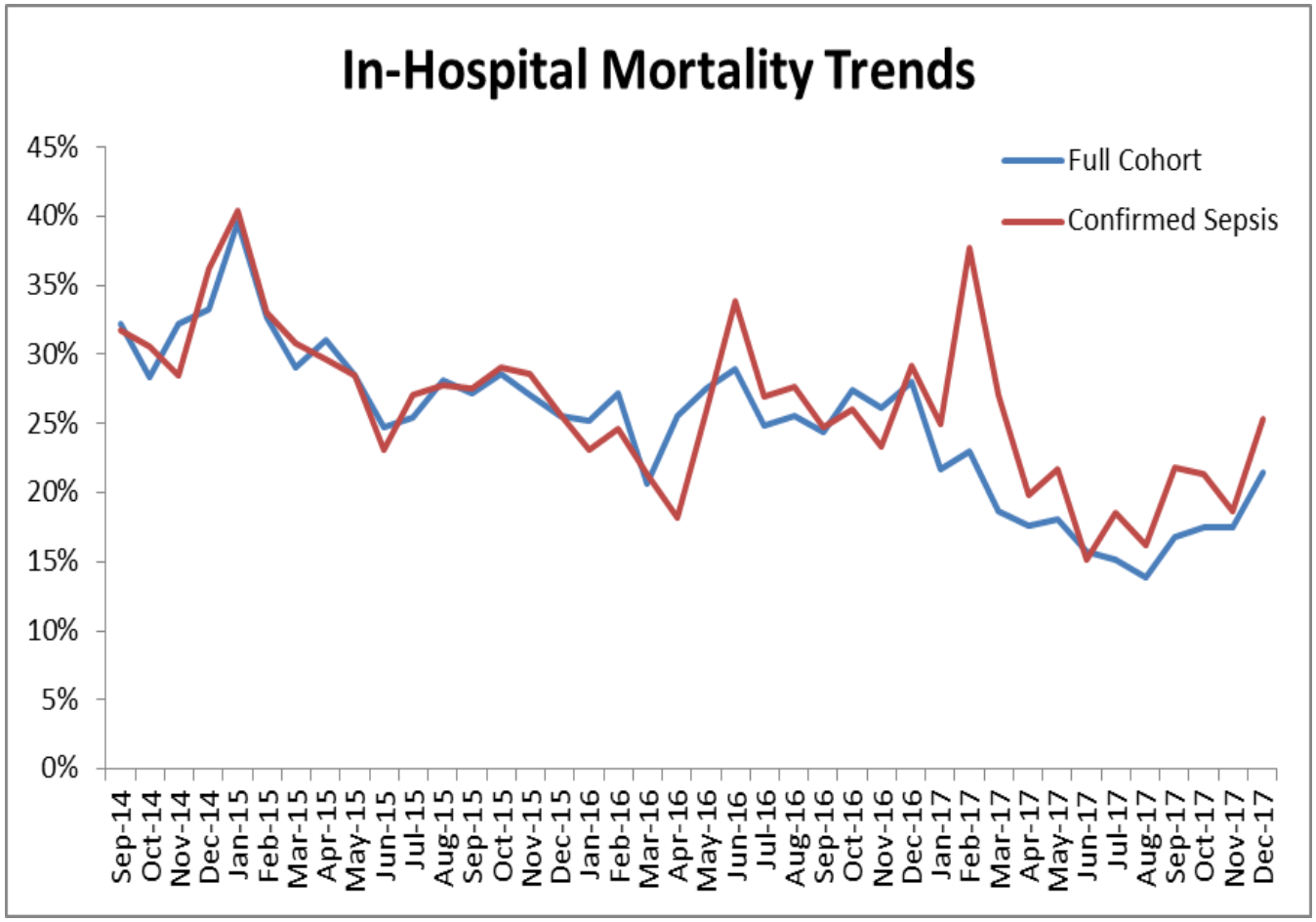
- Utilised arrival time as time zero
- ICD10 codes identify population
- Follow patient pathway

Measures Revised 2017

- NHS England recommendation for the use of NEWS2
- Utilising sepsis diagnosis time as time zero
- Follow patient pathway
- Cheshire & Mersey priority area of Health & Care Partnership
- Collaborative working PSC / AQ

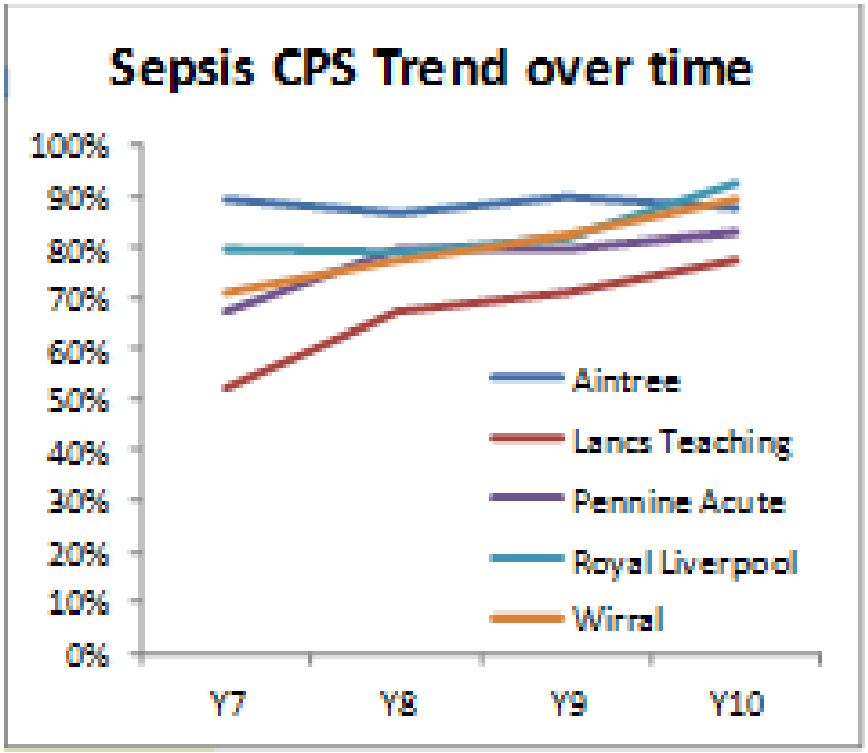


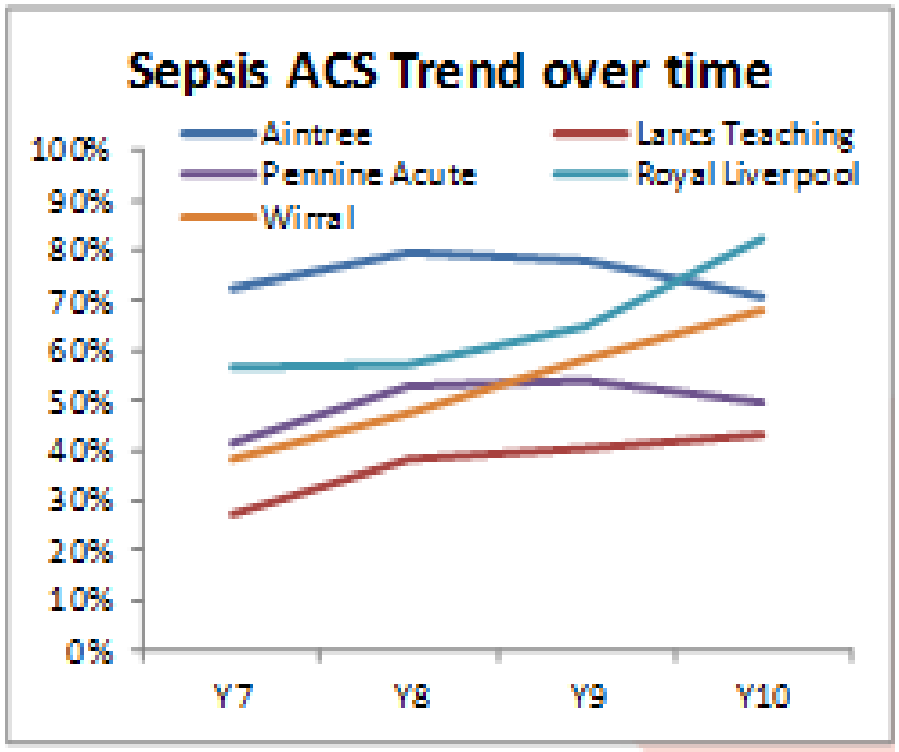
In-Hospital Mortality



All outcomes calculations include only patients that are confirmed sepsis and 2017 providers.

Sepsis Improvement Trends

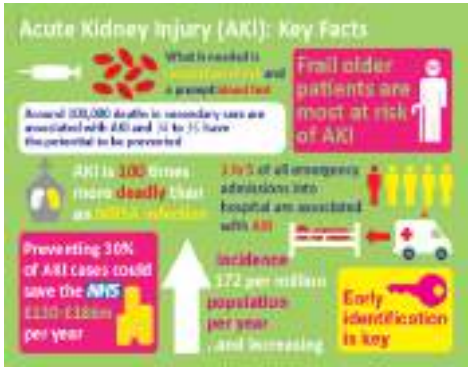




Acute Kidney Injury

Measures devised 2015

- Use of national algorithm to identify patient population
- Matched with national HES data - outcomes
- All AKI3 patients included with ‘look back’ at care delivery
- Stage progression analysis
- Follow patient pathway



Shortlisted for Patient Safety Awards 2018

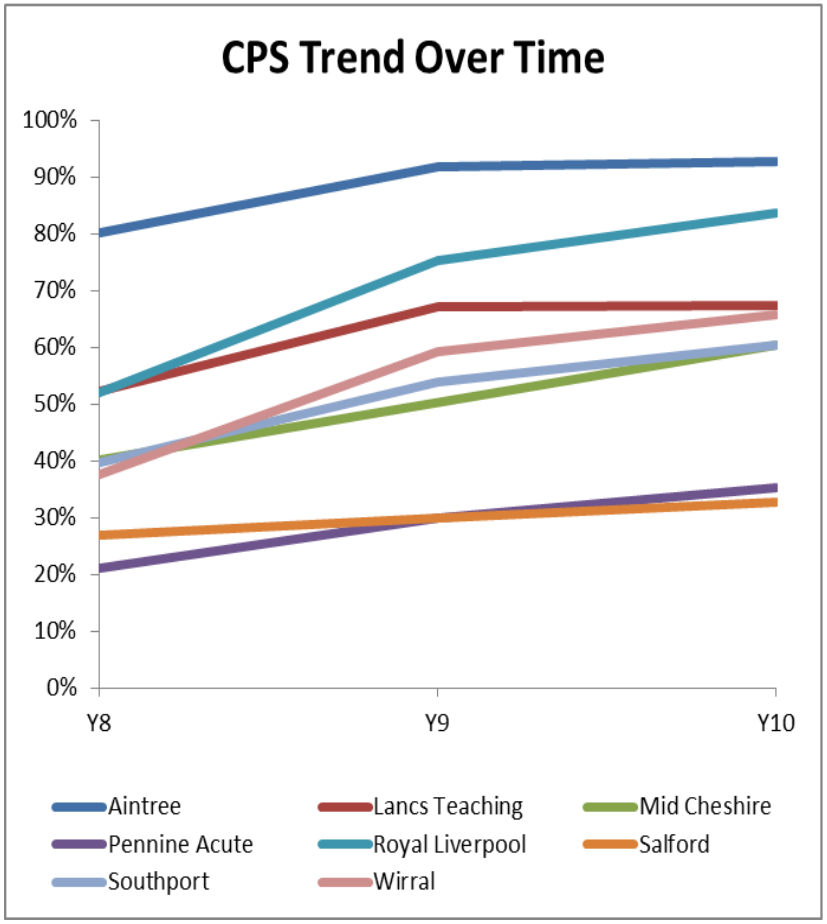
Early Identification and Treatment of AKI to Improve Patient Outcomes

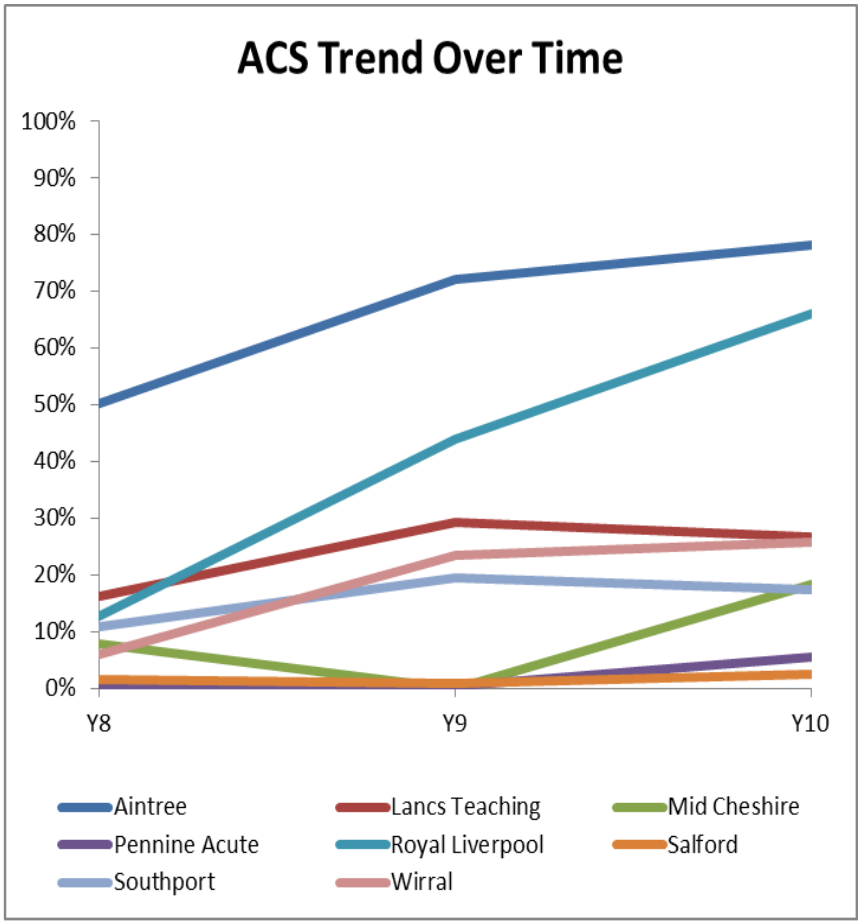
18.6% (n 1,312) of patients received all eligible measures resulting in a mean length of stay **2.23 days shorter** than those not receiving all measures

Potential savings of over **12,000 bed days** might have been realised if remaining patients had a matched length of stay (n5758 X (19.1-16.8) = 12,866 bed days saved). At an average cost of £250 per bed day that is a value of **~£3.2 million**

Jul 2015 - Sep 2017 AQ AKI Patients			
AQ AKI	Count	Bed Days	Avg Bed Days
Passed	1,312	22,063	16.82
Failed	5,758	109,695	19.05
Total	7,070	131,758	18.64

AKI Trends





CPS Improvement from Y8 – Y10 has ranged from 6% to 32%

ACS Improvement from Y8 – Y 10 has ranged from 1% to 53%

AQuA : Example

Advanced Team Training for Deteriorating Patient

Focus on : Frail Elderly population

Team Focus: Identification issues to include assessment and intervention review

AQuA can offer forum for members to come together to identify part of the system and risk areas to patient

Thank you

For further information please contact: AQuA@srft.nhs.uk

Summary

Jay Hamilton

Associate Director, Lead for GM Patient Safety Collaborative, Health Innovation Manchester

Please fill out the forms on your table

Resources

- Website


The AHSN Network
NHS
Improvement
Thank you
Greater Manchester &
Eastern Cheshire
Patient
Safety
Collaborative