Health Innovation Network

Local change, national impact

NHS England

National Patient Safety Improvement Programmes 2024-2025

Summer 2025

Contents

Introduction

It has been five years since the NHS Patient Safety Strategy was published. The strategy's aim 'for the NHS to continuously improve patient safety', and ambition to save 1,000 extra lives and £100 million every year from 2023/24 (excluding litigation costs) has been supported by the Patient Safety Collaboratives (PSCs) since 2014. Commissioned by NHS England Patient Team. The PSCs are part of the fifteen health innovation networks across England.

This report summarises the progress across our programmes from April 2024 to March 2025, however many of the programmes have continued over a number of years.

To date at least

2,508

lives have been saved due to the National Patient Safety Improvement programme interventions.

The NHS Patient Safety Strategy aims to save

1,000 extra lives

and £100 million

every year from 2023/24 excluding litigation costs

I speak on behalf of all our colleagues across all health innovation networks when I say how privileged we feel to host the 15 Patient Safety Collaboratives across England. Through these we contribute to the delivery of the NHS Patient Safety Strategy by supporting frontline teams to translate national ambitions into practical activity on the ground.

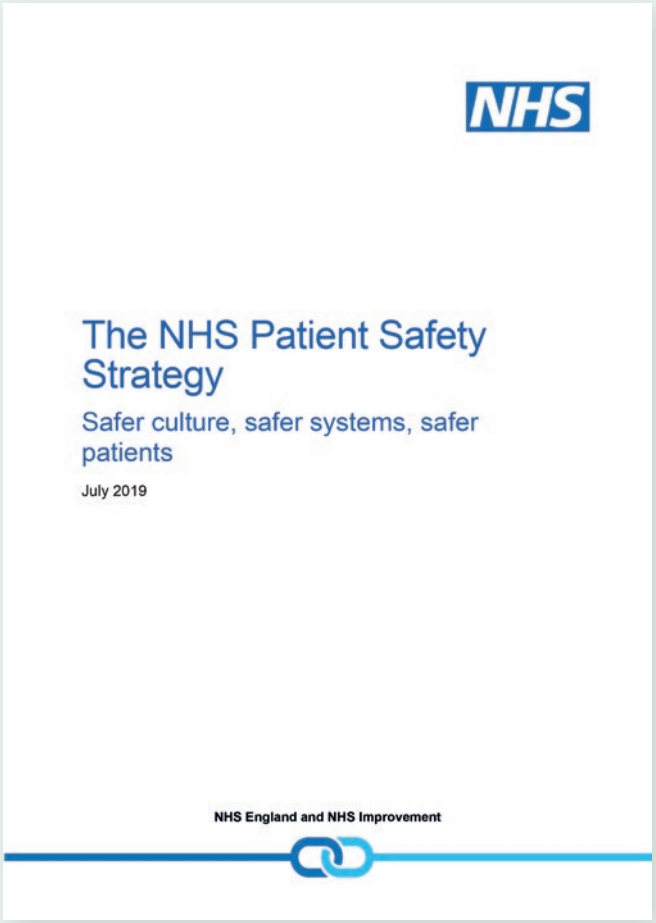
By being firmly embedded as a trusted partner in each of our local health and care systems, we are able to serve as an effective 'ground force'. Our commitment to empowering staff is helping to drive the successful implementation of national safety priorities, standardising care by removing variation, improving safety and saving lives as a direct result.

Natasha Swinscoe,
Chief Officer Lead for Patient Safety,
Health Innovation Network

The Patient Safety Collaboratives have been essential partners in delivering the ambitions of the NHS Patient Safety Strategy. Their expertise, leadership, and local relationships have driven meaningful improvements in outcomes in maternity, mental health, management of deterioration, medicines safety, and system safety. They bring improvement science to life in frontline settings and provide vital support to systems and clinical teams. The progress we've seen including through the implementation of Martha's Rule would not have been possible without their commitment, agility, and relentless focus on learning and collaboration in patient safety improvement.

Heather Pritchard,
Head of Martha's Rule and Patient Safety
Improvement Programmes, NHS England

The NHS Patient Safety Strategy



Continuously improving patient safety

Improve our understanding of safety by drawing insight from multiple sources of patient safety information.

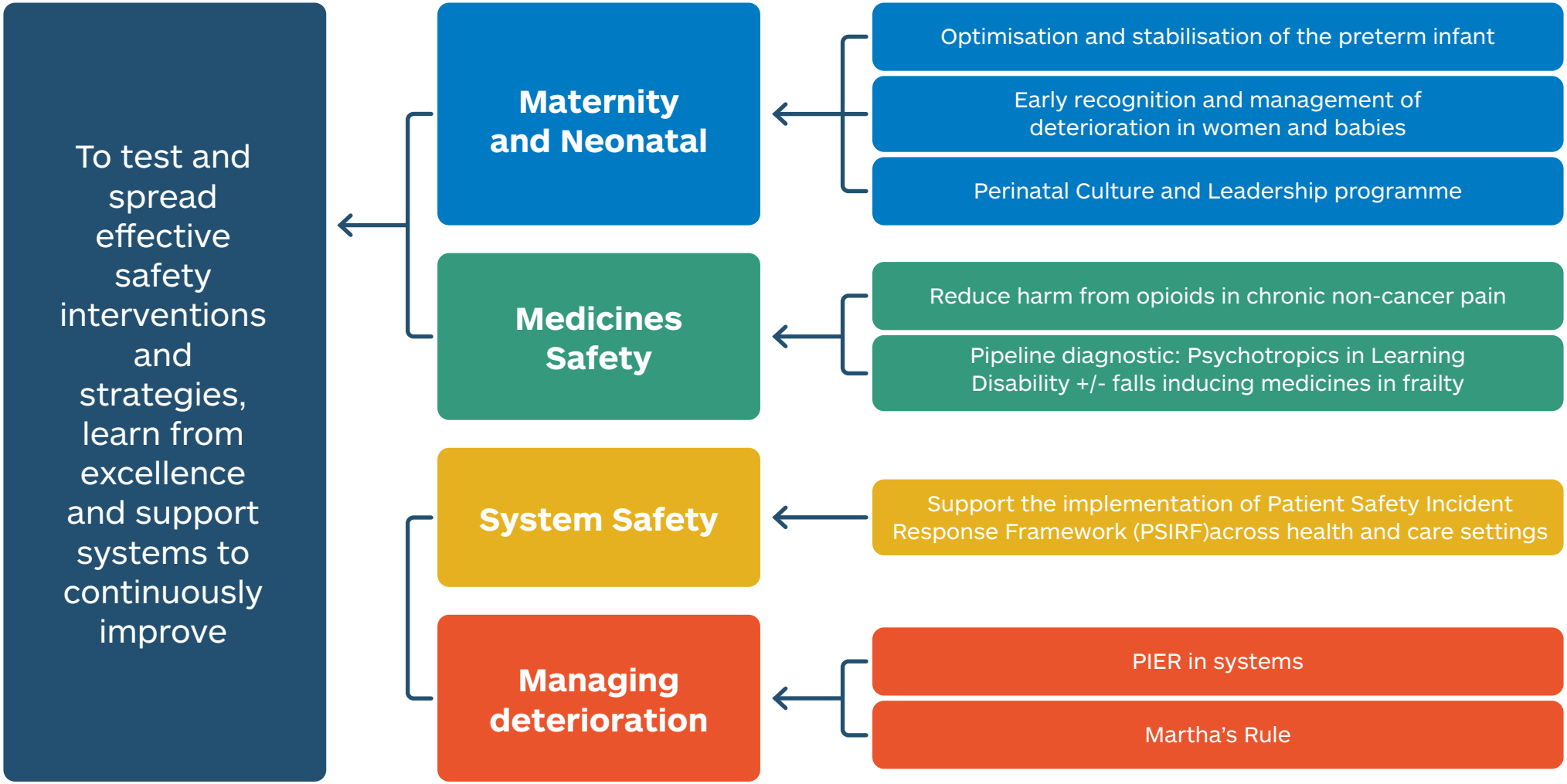
People have the skills and opportunities to improve patient safety, throughout the whole system.

Improvement programmes enable effective and sustainable change in the most important areas.

Insight | **Involvement** | **Improvement**

A patient safety ***culture***
A patient safety ***system***

Driver Diagram 2024/25



NHS Patient Safety: impacts to date

Maternal and Neonatal Safety

Saved up to
1,592
lives

Prevented up to
536
cases of cerebral palsy

50 organisations using the national **Newborn Early Warning Track and Trigger (NEWTT2)**

44 organisations using the national **Maternity Early Warning Score (MEWS)** tool.

The national MEWS and NEWTT2 improves the early recognition of deterioration of women and babies, leading to timely escalation.

Patient Benefit from Medicines Safety

884
lives saved

Halved the risk of death for
13,334
pain sufferers

Safety Culture Improvement

100%

of organisations have implemented the **Patient Safety Incident Response Framework (PSIRF)**

Managing Deterioration in Care Homes

Worked with
11,827
care homes to support safe care

Prevented over
44,969
emergency admissions

Managing Deterioration and Martha's Rule

Working with
143
pilot sites to implement Martha's Rule.

129
potentially life-saving interventions triggered.

Working with
15
ICS to test the PIER approach across systems to manage deterioration.

Maternity and Neonatal Safety

Optimisation and stabilisation of the pre-term infant

The NHS maternity and neonatal pre-optimisation care bundle is a set of evidence-based interventions designed to improve outcomes for babies born prematurely (before 34 weeks gestation) or with other complications and is aligned to NHS England best practice for reducing baby mortality Saving Babies Lives V3. It focuses on optimising care before and during birth. The goal is to reduce variations in care and improve outcomes for mothers and babies across England.

Key Components of the Care Bundle:

- **Place of Birth:** Ensuring appropriate level of care based on the risk assessment and gestational age.
- **Antenatal Steroids:** Administering corticosteroids to the mother before birth to help the baby's lungs develop.
- **Magnesium Sulphate:** Administering magnesium sulphate to the mother before birth to help protect the baby's brain.
- **Intrapartum Antibiotics:** Providing antibiotics to mothers at risk of infection.
- **Optimal Cord Management:** Delaying clamping of the umbilical cord to allow for blood flow to the baby.
- **Normothermia:** Maintaining a stable body temperature for the baby after birth.
- **Maternal Breast Milk:** Encouraging and supporting breastfeeding, as it provides essential nutrients and antibodies for the baby.
- **Volume targeted ventilation:** to minimize lung injury.
- **Caffeine:** stimulates the babies respiratory centre and helps regulate breathing.

Programme Ambitions

- Increase in rates of babies surviving until discharged home.
- Reduction in brain injury.
- Reduction in incidents of necrotising enterocolitis.
- Reduction in bronchopulmonary dysplasia.

Impacts

1,000

more interventions per month since 2020 = 2725 pm

***654**

babies avoided Strep B

163

lives saved

536

cases of cerebral palsy avoided, and

£536 million

costs avoided in long term social care and health needs.

Data cumulative since 2018

***299**

babies survives due to antenatal steroids

***1,130**

babies survived due to optimal cord management

***1,592**

babies survived because of receiving the care bundles

**Data cumulative since 2020*

Reducing the risk of cerebral palsy

Summary of Innovation

The spread and adoption of NICE-recommended Magnesium Sulphate (MgSO4) through a quality improvement programme, reduces the risk of cerebral palsy in pre-term infants.

> **The PReCePT national QI programme demonstrates that a collaborative and coordinated...perinatal implementation programme supporting every hospital in England, can accelerate the uptake of new evidence-based treatments into routine practice, enabling equitable health benefits to babies and ultimately reductions in lifetime societal costs.**
>
> Karen Luyt, Professor in Neonatal Medicine at the University of Bristol

Around **1 in 10** babies of a very low birth rate develop a form of cerebral palsy. The lifetime cost per patient is estimated to be **£850,000 - £1m**. In 2015, NICE recommended administration of Magnesium Sulphate (MgSO4) in very preterm birth to substantially reduce the risk.

The Prevention of Cerebral Palsy in PreTerm Labour (PreCEPT) programme was devised in the West of England in 2014 and, after successful rollout across the region, became a national Health Innovation Network programme, and spread across England. It was the first perinatal improvement programme delivered at scale across the country. Work has continued through the NHSE patient safety commission which has meant this has been sustained.

Impact of the innovation

- **536 cases** of cerebral palsy avoided.
- **The fastest perinatal evidence-based intervention that has ever been adopted successfully into national policy and clinical practice.**

Health and care system success

- By March 2020, **152 maternity units** in England had adopted the intervention, reducing variation in administration rates of MgSO4 and achieving the national target of 85% uptake.
- MgSO4 use increased to 89% by January 2023 with, regional ranges of 87% to 92%.
- **For every 37 mothers who receive MgSO4, one case of cerebral palsy can be prevented.**

Network support

- Pilot developed in the West of England with University Hospitals Bristol and Weston NHS Trust. Evidence of benefit and cost effectiveness.
- 2018-2020 selected as a Health Innovation Network adoption and spread programme.
- 2020 to date has formed part of the NHSE Maternity and Neonatal Safety Improvement programme delivered by PSC.
- Adopted into national and clinical policy.

Scalability prospect/next steps

- Programme successfully scaled across England to all **152 maternity units**, within two years, achieving the national target of 85% uptake.

Economic success

- An estimated **£536 million avoided cost** to the health and social care sector, thanks to the prevention of cerebral palsy development.
- At £1 a dose, it is a highly cost-effective intervention which prevents future NHS costs.

£506m
cost avoided to the NHS

Find out more:
thehealthinnovationnetwork.co.uk

Improving access to appropriately fitted equipment to support mothers expressing breastmilk

Health Innovation Wessex

Summary

Inspired by a mother's experience of developing mastitis whilst expressing breastmilk for her premature baby, the project focuses on equity of access to appropriate equipment for expressing breastmilk.

> **"I love the patient education video - the information is so clearly explained and visual. I am really excited to use this within our trust and I think it will hugely improve the outcomes for our families who use breast pumps."**
>
> Infant feeding lead

Innovation summary

- Treatment to Prevention
- Hospital to Community
- Health Inequalities
- Patient Safety

Research shows correctly measured and fitted flanges on breast pumps increase yield of breastmilk, reduce mother's discomfort, and could reduce the risk of developing mastitis. Early breastmilk reduces the risk of sepsis, necrotising enterocolitis, and improves longer-term neurodevelopmental health. Health Innovation Wessex led on the development and rollout of an early breastmilk toolkit, including a new tool to support mothers to pump breastmilk, and education to support staff.

Impact of innovation

- Percentage of pre-term infants receiving breastmilk in the neonatal unit has increased by 13%.
- Virtual toolkit accessed more than 2,000 times.

Network support

Health Innovation Wessex, working with University Hospital Southampton (UHS), have:

- Collated the resources developed and project learning into a free toolkit to encourage implementation, spread, and scale beyond Wessex.
- Designed and produced a nipple sizing tool
- Created an education video and training webinar for staff
- Worked to improve access to the correct equipment through NHS procurement

Next steps

- Contacts are being made within NHS England to discuss national adoption.
- The toolkit is free and available to support spread and scale of this project.

Economic success

Potential benefits are being evaluated and include:

- Increased duration of breastfeeding and associated impact on long-term health economics.
- Reduction in mastitis, antibiotic prescribing and readmission rate.
- Less donor and formula milk purchased by the hospital.
- Increased orders with nipple measuring tool manufacturer and flange distributor.

Health and care system success

- Initial project feedback from staff using the resources has been very positive.
- Benefits to the mother include less likelihood of developing mastitis.

Access the toolkit:

Early recognition and management of deterioration of women and babies

Early recognition and management of deterioration in women and babies is crucial for improving outcomes. This involves using tools like Maternity Early Warning Scores (MEWS) and Newborn Early Warning Track and Trigger (NEWTT2) to identify subtle changes in vital signs and overall condition, prompting timely escalation of care. The PIER framework (Prevention, Identification, Escalation, Response) provides a structured approach to managing deterioration in both maternal and neonatal settings.

The Birmingham Symptomatic Triage System (BSOTS) is a standardised system used in England to prioritise women attending maternity triage based on their clinical needs. It involves a brief initial assessment by a midwife within 15 minutes of arrival to determine the urgency of the situation. BSOTS categorises patients into different levels of urgency (e.g., Green, Yellow, Orange) to ensure timely and appropriate care.

BSOTS
BIRMINGHAM SYMPTOM SPECIFIC OBSTETRIC TRIAGE SYSTEM

Programme Ambitions

- Ensure the use of the national Maternity Early Warning Score (MEWS) tool is implemented within an effective PIER pathway for managing deterioration and support.
- Ensure the use of the Newborn Early Warning Trigger and Track (NEWTT2) tool is implemented within an effective PIER pathway for managing deterioration and support.

Impact

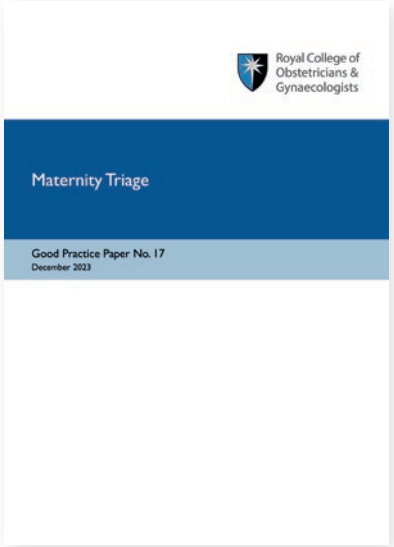
Improved communication between staff using a common safety critical language embedded within the PIER pathway.

Improved woman and family experience through engagement with healthcare professionals regarding escalating concern.

BSOTS adopted in **109 units**, with an additional **62 sites** in the process of adoption, representing

90%
of UK maternity units.

The system has also been recognised internationally, with adoption in Australia and New Zealand. Endorsed by RCOG Dec 2023.



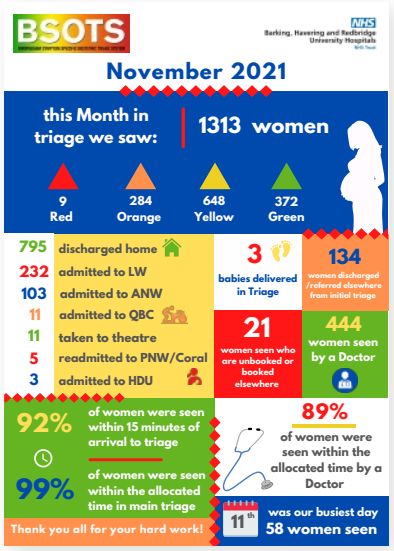
Improved standardisation across England of early recognition and management of deterioration.

***44**

sites at stage 4 or more for MEWS and 50 for NEWTT2

***7**

PSCs supporting BSOTS (triage system in maternity units)



Perinatal Culture and Leadership programme

The Perinatal Culture and Leadership Programme is an initiative by NHS England aimed at improving the safety and quality of maternity and neonatal care by fostering positive leadership and culture. It focuses on equipping senior leaders to create psychologically safe, inclusive, and compassionate working environments. The programme involves a "quadrumvirate" of senior leaders (Director of Midwifery, Operations Director, Clinical Director, and Neonatal Nurse Director) who work together to implement changes within their teams. Teams used MOMENTS, a framework to support cultural development and drive improvements with front line teams (see next page).

Programme Ambitions

PSCs will provide ongoing support to 150 Quads and their change teams, covering all Trusts with a maternity and neonatal service in England, to implement and further develop their improvement plans with a QI lens, including offering and delivering QI coaching.

Impacts: Use of MOMENTS

MOMENTS: A framework of resources to nurture safety culture through everyday practices.

MOMENTS has been developed out of research carried out by the SAPPHIRE (Social science APPlied Healthcare and Improvement REsearch) group, University of Leicester, on what makes a good safety culture, drawing on the experiences of ten maternity and neonatal services across England.

The project was a positive enquiry, identifying strengths without only focusing on mistakes, accidents or incidents, and exploring what contributes to a good safety culture.

MOMENTS

> **I was in a group about safety huddles. I spoke to a matron from another area and was invited to attend their huddle today.**

MOMENTS has been used to support the programme, using a 'train the trainer' model which has cascaded to 100% of units. The use of MOMENTS has seen a number of advantages and benefits as described below.

> **Effective communication is key to building up a healthy workplace.**

Examples of identified opportunities to use MOMENTS

Cascade training to PMA team and building in sessions into PMA work stream
Education team will get together to implement a plan going forward
For neonatal service leads
PMA and newly qualified conversation around cultural impact
PMA's Education leads
Team meeting to discuss SIG issueNW Managers meeting
Important activity Enabling shared strategic plans
Conversations, development, incident reports, audits, safety huddles
With PMA's and quality improvement teams
Within Triage team to discuss BSOTS way of working
Discuss cases. Also when teams seem not be functioning well rather to bring

Medicines Safety

Reducing high-dose opioids in chronic non-cancer patients

Opioids are very good analgesics for acute pain and pain at the end of life but there is little evidence that they are helpful for long-term pain. Despite this, they are widely prescribed for this reason – opioid prescribing more than doubled in the period 1998 to 2018. This has been referred to as an opioid epidemic in the UK, similar but not at the same scale as the opioid crisis in the USA.

The harms of this prescribing are now better understood.

Guidance from NICE is clear that opioids are not indicated for chronic pain, and guidance from the Royal College of Anaesthetists (the professional body for doctors that specialise in pain) has been clear about the harm that can be caused.

Programme Ambitions

Work with over 50% of ICBs to:

Consider the problem of high-risk opioids in chronic non-cancer pain from the perspective of the entire patient pathway from a whole system approach.

Management of chronic non-cancer pain requires personalised care and shared decision making at its core with patients requiring a mixture of biopsychosocial support so that they can live well with their pain. Therefore, a key factor in making improvement against this priority is support for the system to move away from the prevailing medical model of chronic pain management which has resulted in over 1million people in England with high-risk opioid prescribing, towards a biopsychosocial model, including supported self-management.

Impact to date - Feb 2025

54,824

fewer people are prescribed oral or transdermal opioids (of any dose) for more than 3 months (NNH 62) compared to baseline.

13,334

fewer people per month are being prescribed high dose opioids compared to the 2021 baseline.

This translates to

12,657

patients who have their **risk of death from opioids halved.**

Sustained

5% reduction

in the rate of prescribing of chronic opioid use vs baseline

Continued significant reduction in numbers of adults prescribed chronic vs 2021 baseline

This translates to

884

lives saved over 2 years.

supported 28 ICBs (67%) taking a Whole Systems Approach to Chronic Pain Management.

Increase in availability and awareness of biopsychosocial offers:

At least

12,093

patients have benefited from support to self-manage their chronic pain,

At least

4,462

other stakeholders benefited from training or other biopsychosocial awareness raising

At least

65

additional pain groups/cafés in existence as a result of the MedSIP

Reducing high-dose opioids in chronic non-cancer patients

Phase 4
Action Planning

Stakeholders come together to prioritise areas to intervene in the local system and propose collaborative and aligned actions.

Phase 3
Mapping the ICS System

Brings stakeholders together to create a comprehensive map of the system that is understood to cause high-risk opioid prescribing. Agreeing a shared vision.

Phase 5
Managing the Network

Maintains momentum by developing the stakeholder network and an agreed action plan

Whole systems approach to high-risk opioid prescribing

Phase 2
Building the ICS Picture

Builds a compelling narrative explaining why opioid prescribing matters for the ICS and creates a shared understanding of how chronic non-cancer pain is addressed at an ICS and local level

Phase 6
Action

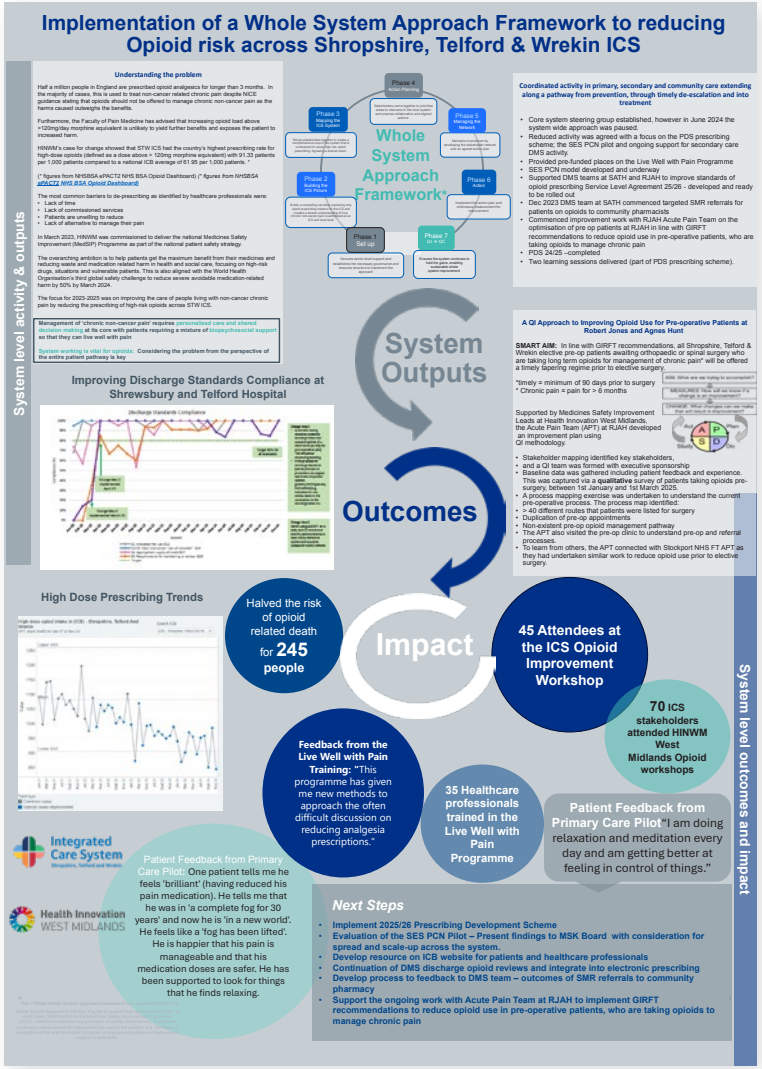
Implement the action plan and continuous measurement for improvement

Phase 1
Set up

Secures senior-level support and establishes the necessary governance and resource sturcture to implement the approach

Phase 7
QI > QC

Ensuring the system continues to hold the gains following the improvement work



PSCs have taken a whole system approach to reducing harm from opioids in chronic non-cancer pain. The 7 phased approach identifies key stages for project implementation. Novel solutions such as the introduction and spread of pain cafés have been successful in supporting patients with chronic pain.

Health Innovation South West

Pain café innovation scales up across Devon and peninsula supporting people with multiple long-term conditions

Peninsula-wide

Rural

Long-term conditions

Urgent and emergency care

Analogue to digital

Challenge: Rural and coastal communities in the South West of England experience high levels of chronic pain and an over-reliance on ineffective opioids.

Innovation: Pain cafes have been developed as a biopsychosocial tool to support patients in their pain management journey. Pain cafes offer support, raise awareness and improve availability of non-medical strategies for people with pain.

Solution: Pain cafés are informal, non-judgmental peer support groups happening across Cornwall, Devon and Somerset for people living with chronic pain using pain management techniques. Pain cafes draw on evidence-based pain management resources developed by clinicians and are facilitated by people with training and/or experience of chronic pain, with many set up and led or supported by people with lived experience.

This financial year we have focused on growing the approach in Devon.

Impact:

- Patients report that they feel more able to manage their pain, and some are able to re-engage with important things in their life, such as returning to work.
- Cornwall found that from the first sample, 64% of participants had decreased their medication, with 28% staying on the same levels. (Some people had commented that staying on the same level was better than increasing medication levels, as might have happened previously to joining the cafes.
- After joining pain cafes, 50% of respondents reported seeing a GP less and 40% about the same. 31% reported seeing a pain clinic or other service less.
- Feedback from some Devon-based attendees:
    - “It’s great that you’ve brought [pain cafes] into the community, I wouldn’t have thought to attend help for my chronic pain otherwise”.
    - “I feel so much more positive after our meet up” (This person has also since returned to work).

Joined Up Care
Derbyshire

Medicines

The use of digital pain management resources in primary care

Improvement summary

Background
The East Midlands Patient Safety Collaborative (EMPSC) have been supporting Joined Up Care Derbyshire Integrated Care System (JUCD) to take a systems approach to improving the management of chronic non-cancer pain (CNCP). At a system-wide action planning event in March 2023, which was attended by a range of stakeholders including lived experience, one of the priorities identified was the need for a holistic pain management action plan that is owned by the patient and is accessible across the system. This priority was included in the action planning for 23/24. The clinical system primarily used across the ICS is SystmOne and there were no suitable digital solutions already in place.

What happened
Having identified that there was no digital solutions already available and tested nationally. We took advice from Prof Roger Knaggs, a national pain specialist, and explored possible solutions with Dr Frances Cole from the not-for-profit organisation Live Well with Pain (LWWP). This resulted in a collaboration to create, test, and evaluate a suite of digital tools using Accurx and SystmOne that are both in regular use in clinical practice. We based the content on LWWP's existing well-tested paper-based tools. The digital tools support a biopsychosocial approach, effective clinical reviews of chronic pain, and empower patients to better self-manage their chronic pain.

What was the change?

Two types of digital tools were created:

- **Accurx Floreys.** These are pre-appointment questionnaires that are sent electronically via text using Accurx within the clinical system. Replies are logged in the clinical system ready for review by the healthcare professional.
  - A health and well-being florey which can be used by any healthcare professional to understand how pain is affecting quality of life.
  - A medicines review florey that helps the patient reflect on and communicate how well their medicines are working for them and any potential concerns.
- **SystmOne Chronic Pain management template and action plan.** That support a holistic review using:
- A pain management review template that is completed in the clinical system during a consultation and includes a medicines review section but also assesses wellbeing.
- A pain management action plan with two parts (self-management and medicines). The action plan is created with the patient during the consultation and can then be printed or sent electronically. Once created it is accessible to all members of the primary and secondary healthcare team via the communication folder in SystmOne.

What worked well?

- Working with a trusted national partner to both lead the collaboration and to ensure sustainability, future updating of the tools, and wider adoption and spread.
- The EMPSC acting as an enabler.
- Working with lived experience trainers in the development of the patient facing tool. Examples of this within the work include:
  - Creation and formatting of all suggested patient facing content and questions.
  - Testing of all tools such as Accurx questionnaires on digital devices.
- Having specialist skills available e.g. pain specialist, academic, evaluation.
- Co-creating these tools with members of the healthcare team in general practice ensured that the tools are fit for purpose in the clinical environment and fulfil any reporting requirements.
- Piloting tools early to allow for improvements.
- Thinking about ownership of the digital tools early. For this work, the tools will be owned by LWWP with credit for developing and testing to both JUCD and Health Innovation East Midlands (as the host organisation for the EMPSC).
- Aligning the tools to a way of working that was already common practice – practices are already using AccuRx and SysmOne templates so whilst the content is new, the practice is not.

How were the changes embedded into practice?

- A user guide and short videos were created to support new users with the tools.
- Drop-in sessions with LWWP and JUCD leads to support implementation and obtain feedback.
- Initially, a number of clinicians were recruited to start using the tool with a view to provide feedback from themselves and their patients via two MS Teams Forms. Feedback rates were low but anecdotally, use was high and feedback positive.
- As we were not receiving any negative feedback the tools were launched at scale to all prescribers via protected learning time events, (QUEST sessions). Further drop-in sessions were offered to support implementation.
- Even though the tools have been shared widely feedback using the MS Teams forms or email has been very low.
- An interview with Sam Farrow (Senior Practice Pharmacist) describes how they have been using the tools as business as usual in practice for every pain management consultation. (see more on next slide)
- A strong possible reason for the low feedback rates is that the tools align with methods already in daily use in clinical practice and therefore they have been embedded easily. The lack of negative feedback or improvement requests possibly support the effectiveness of the co-production process used.

Who was involved in the collaboration?

The collaboration included a range of stakeholders who were all motivated to improve chronic pain management with notable contributions from:

- **Live Well With Pain:** Dr Frances Cole and Dr Emma Davies as pain management specialists and Lived Experience Trainers
- **Joined Up Care Derbyshire:** Medicines management team member providing clinical and technical input plus project management and engagement support, lived experience representation.
- **Health Innovation East Midlands:** Medicines Safety, project management and enabling support
- **Local GP practice and PCN teams;** including doctors, health and wellbeing coaches who are running pain management programmes, PCN pharmacy staff, PCN manager with technical skills
- **National pain specialist and academic support:** Prof Roger Knaggs
- **Durham University:** for evaluation support from Prof. Paul Chazot

What was challenging?

- Identifying the capacity to develop the tools "on-top of the day job" within the changing environment in the NHS.
- Communicating virtually and in a timely manner.
- Obtaining feedback on the tools
- Developing tools for a system that some parties did not have access to i.e.SystmOne.

"The use of digital tools aims to support the move from analogue to digital"

Delivered by:
East Midlands
Patient Safety Collaborative

Led by:
NHS England

Health Innovation East Midlands
Local change, national impact

www.healthinnovation-em.org.uk

Development of a pipeline

To explore the opportunity for a national Medicines Safety Improvement programme around two pipelines:

1. **Psychotropic prescribing in learning disability, autism, or both. This pipeline should consider patients of all ages.**

2. **Medicines optimisation to reduce falls and/or fractures in frailty. This pipeline should consider deprescribing and prescribing.**

By end of October 2024 PSCs, working with willing ICSs, will collectively achieve the following outcome:

- Problem definition(s)
- Descriptions of the potential harms and
- Summary of the learning from any successful actions identified that were designed to address the problem(s).

Our Methodology

National Appreciative Inquiry

- An appreciative inquiry methodology was applied to understanding the current improvement work at system level. 83 responses outlining 86 projects relating to psychotropics in learning disability, autism or both

Interviews with national leaders

- 15 Interviews with national leaders

Rapid Evidence Review

- Number of academic papers included in evidence summary = 31

Benefits Mapping

- Benefits mapping was undertaken.

Human Factors analysis of the system

- A human factors approach was undertaken to graphically map the multiple combining factors of a system affecting the prescribing of psychotics for behaviours that challenge. This is referred to as an Acci-map.

Managing Deterioration: PIER

Managing Deterioration: PIER

Prevention, Identification, Escalation, Response to physical deterioration, through better system co-ordination as part of safe and reliable pathways of care.

The new PIER approach will enable the effective management of acute physical deterioration in health and care and will apply to all conditions, clinical settings and specialities.

The PIER approach views deterioration as a whole pathway which is supported by systems rather than only advocating a single strategy for identification.

Acute physical deterioration is the rapid worsening of a patient's condition. It can be identified from changes in physiology, such as respiratory rate, blood pressure or consciousness, or more subtle signs, such as not eating and a patient or their family's concerns and observations around wellness, mental status or behaviour.

Deterioration can occur in any health and care setting and is the common pathway in all emergency admissions, prolonged illnesses and deaths.

PIER stands for:

- **P**revention: planning ahead of any episode of deterioration to stop what is preventable, considering indicators of risk and patient choice
- **I**dentification: tools and methods to identify when deterioration is occurring in a standardised way
- **E**scalation: timely escalation of care when deterioration has been identified using standardised communication tools
- **R**esponse: timely, appropriate and effective response to escalation of the deteriorating patient/person.

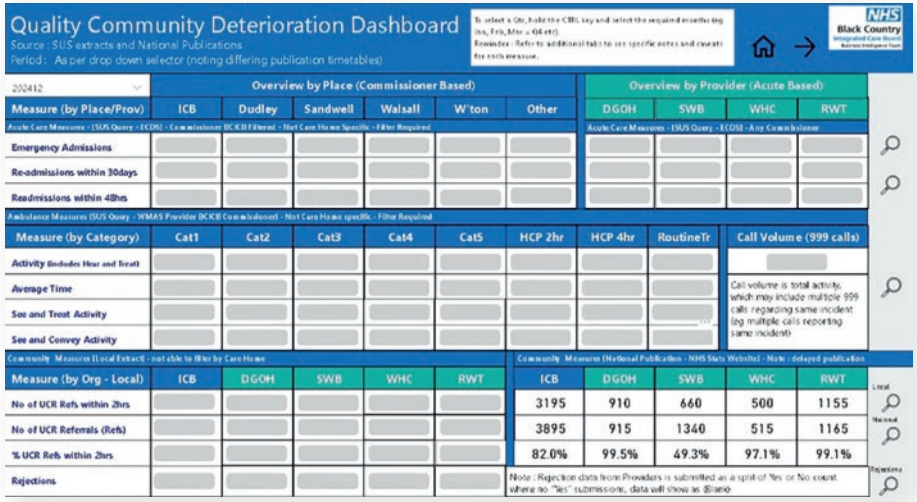
PIER Programme Expected Outcomes

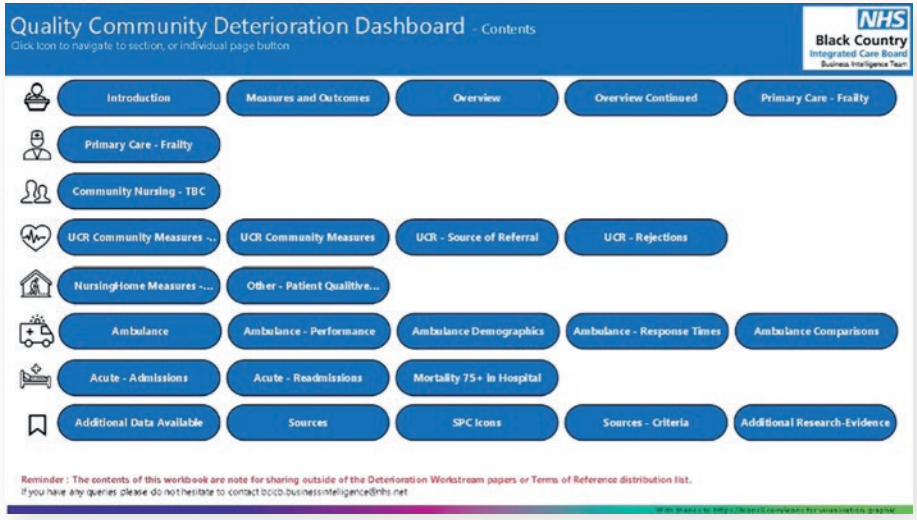
PSCs to continue supporting their systems to work through the improvement toolkit, focussing on improving the pathway(s) that the mapping phase identified as being amenable to improvement and to work with and support system stakeholders to develop spread and sustainability plans.

Impacts

Progress

- The PIER framework has been socialised with all 42 ICBs.
- Some PSCs have developed toolkits and presentations to engage and share the messaging around the PIER framework, this has enabled ICBs to appreciate a system level approach to deterioration and plan cross-system safety work accordingly.
- The Midlands region have developed a deterioration dashboard which tracks progress. The following slide provides one example of a deterioration strategy developed across an integrated care system.





Community Deterioration Strategy on a Page 2025 - 2029

Herefordshire and Worcestershire Integrated Care System

Our vision for local people is to…

Effectively manage deterioration by spotting that a person's physical condition is worsening and responding appropriately to support best health outcomes, keep them safe, and provide a positive experience of care.

Our mission is to…

Reduce deterioration-associated harm by improving the **P**revention, **I**dentification, **E**scalation, and **R**esponse (**PIER**) to physical deterioration in patients in community settings through better system coordination and as part of safe and reliable pathways of care.

PREVENTION
Planning ahead of any episode of deterioration to stop what is preventable.

IDENTIFICATION
Tools & methods to identify when deterioration occurs in a standardised way using signs, data, and concerns.

ESCALATION
Timely escalation of care when deterioration identified using standardised communication tools.

RESPONSE
Timely, appropriate, & effective response to escalation of deteriorating person, with feedback loops for monitoring & adjusting.

Our objectives are to…

- Have a skilled workforce equipped with the knowledge to manage deterioration in the community
- Have equitable training pathways & tools across the system for planning for, assessing, & managing deterioration
- Establish a dashboard to monitor deterioration in the community & identify areas of good practice & areas for improvement
- Examine deterioration through the lens of health inequalities to reduce inequalities across the system

Our priorities will be aligned to those of existing ICB strategies for…

Living Well with Long Term Conditions

- Achieve best possible physical, mental, & social wellbeing
- Appropriate signposting
- High impact intervention access
- Proactive ID & support for at risk
- LTCs ID sooner & near home
- Education, support, & resources
- Proactive advice & assessment for people with multiple LTCs
- Increased coordination across services for care closer to home
- Adopted self-management tech

People at Risk of or Living with Frailty

- Increased community intervention measures
- Early ID of living or at risk
- Proactive comp. assessment
- Accessible & co-ordinated personalised care
- Advance care planning
- Frailty attuned acute care
- Reablement & rehabilitation
- High quality end of life care
- Workforce with appropriate skills for specialist care

Personalised End of Life Care

- 24/7 single point of access to timely support & advice
- Education & training on comms & clinical skills
- Access to hospice at home & child transitional services
- Shared access to electronic patient information
- Embedded ReSPECT process across providers

Our Settings based approach will deliver strategic outcomes across…

Care Homes & Community Hospitals

GPs & Pharmacies

Domiciliary Care

Our plan is to…

- Establish place based and system level stakeholder groups including patient and public representatives
- Conduct a mapping exercise of the scope and breadth of current deterioration work & alignment opportunities
- Commence the development of a shared deterioration management culture across system stakeholders
- Identify key priority areas to guide a systems approach to managing deterioration in the community

Managing Deterioration: Martha's Rule

Managing Deterioration: Martha's Rule Programme

Martha Mills died in 2021 after developing sepsis in hospital, where she had been admitted with a pancreatic injury after falling off her bike. Martha's family's concerns about her deteriorating condition were not responded to, and in 2023 a coroner ruled that Martha would probably have survived had she been moved to intensive care earlier. In response to this and other cases related to the management of deterioration, the Secretary of State for Health and Social Care and NHS England committed to implement the Patient Safety Commissioner's recommendation of 'Martha's Rule'; to ensure the vitally important concerns of the patient and those who know the patient best are listened to and acted upon.

Key Deliverables

Support sites to test and implement Martha's Rule.

Work with sites and key stakeholders to identify and understand the impact of Martha's Rule by supporting the development of local measurement plans that can inform learning and show impact of Martha's Rule.

The 3 components of Martha's Rule are:

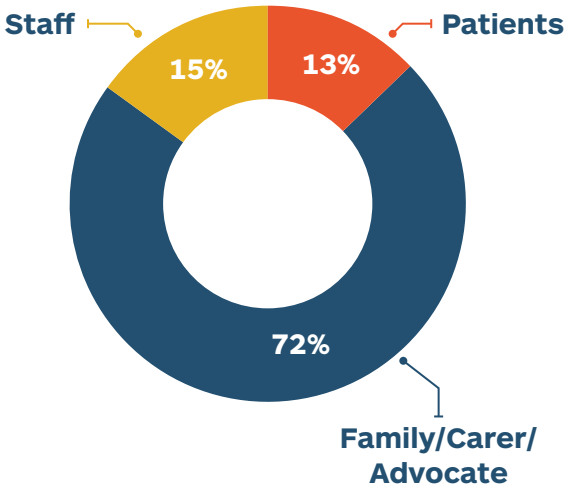
1. Patients will be asked, at least daily, about how they are feeling, and if they are getting better or worse, and this information will be acted on in a structured way.
2. All staff will be able, at any time, to ask for a review from a different team if they are concerned that a patient is deteriorating, and they are not being responded to.
3. This escalation route will also always be available to patients themselves, their families and carers and advertised across the hospital.

Impacts

Martha's Rule Programme

From Sept 2024 – March 2025

3,035
escalations calls received



1,409
escalations calls related to acute deterioration

159
Escalations of care

- **69** calls resulted in admissions to HDU/ICU
- **15** calls resulted in transfers to enhanced care or a tertiary centre
- **75** calls resulted in 'Other' transfers to specialist services

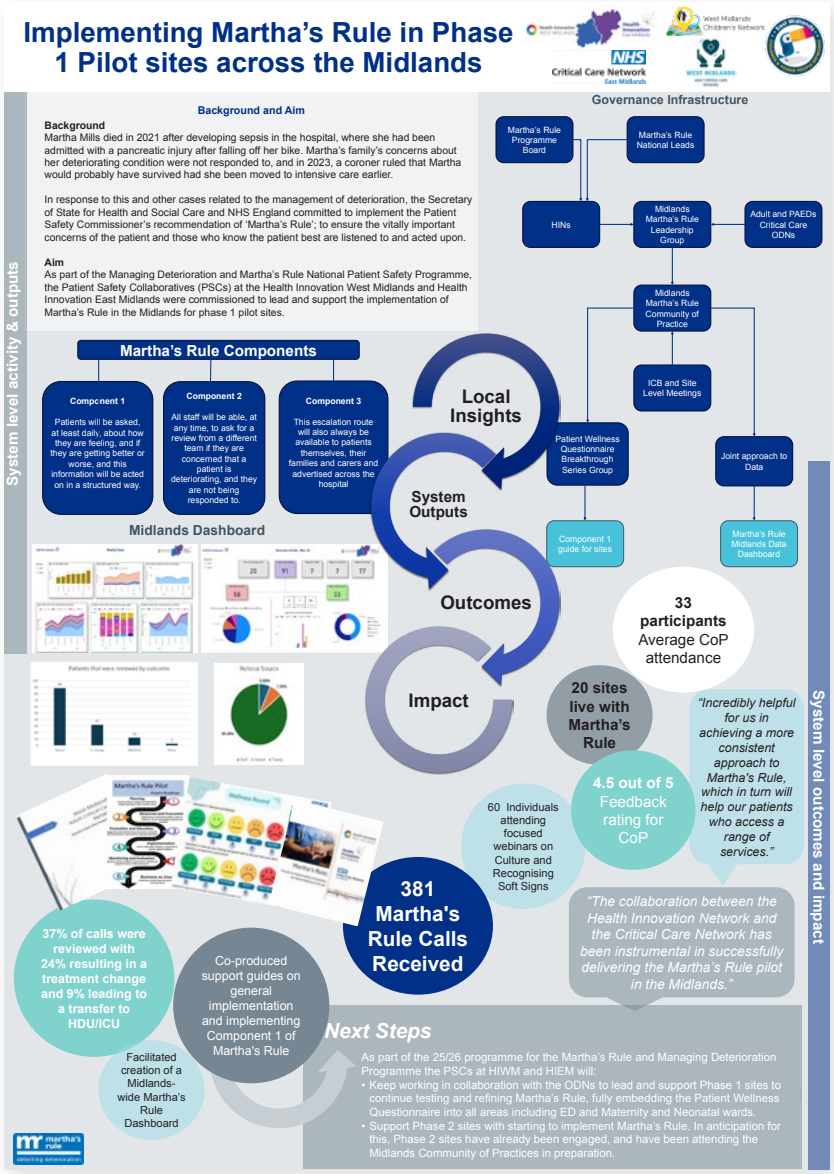
437
Change in management / treatment

- New medications and antibiotics
- Investigations
- Specialist input
- Optimisation - hydration, oxygen or changes to nursing care

Martha's Rule has been piloted in **143** provider sites. Data has shown there have been **129** potentially life-saving interventions triggered and **336** changes to treatment management as a result.

Case Study

The first patient at King's Mill Hospital to have their condition urgently reviewed under Martha's Rule has described their experience as 'amazing'. Tony Prout, of New Ollerton, had been in hospital for nine days when he and his partner Karen Woods felt that they weren't being listened to when it came to all of Tony's complex medical needs. Within an hour, a member of the team had been to speak to both Tony and Karen and reviewed his medical notes, discussed the pair's concerns with consultants, doctors, and nurses, made suggestions to get specialist teams involved and a plan was agreed, with a follow-up taking place the next day. Karen said: "Within 24 hours there was a complete turnaround and Tony's complex needs had been addressed. Tony and I felt the result was an amazing development from making a phone call".



HEALTH INNOVATION North West Coast

National Patient Safety Improvement Programmes

Managing Deterioration

MARTHA'S RULE

14 HOURS

of collaboration in attending Martha's Rule Communities of Practice, and the monthly Cheshire & Merseyside catch ups.

100%

attendance from all phase 1 sites to the North West Coast Communities of Practice.

8 X CHESHIRE & MERSEYSIDE COLLABORATIVES

3 X NORTH WEST COAST COMMUNITIES OF PRACTICE

Good ideas and suggestions
Share learning
Shared learning
Empowering
Very informative
Gathering of information
Shared learning is imperative
National updates are essential
Learning from other trusts

Every phase 1 site given the opportunity to present at the North West Coast Communities of Practice.

"Thank you for all your support with all this. The regular links are great to keep focus"

"These are the most beneficial sessions in my opinion - thank you"

"Really good to share the learning especially from sites who are further along with the implementation of MR."

"Great information about the gathering of information as well as the introduction of PWQs."

100%

of attendees found the site updates useful.

100%

of attendees found the National updates useful.

Alder Hey Children's NHS Foundation Trust
The Walton Centre NHS Foundation Trust
Countess of Chester Hospital NHS Foundation Trust
Wirral University Teaching Hospital NHS Foundation Trust
Mid Cheshire Hospitals NHS Foundation Trust
Warrington and Halton Teaching Hospitals NHS Foundation Trust
University Hospitals of Liverpool Group
Mersey and West Lancashire Teaching Hospitals NHS Trust
Blackpool Teaching Hospitals NHS Foundation Trust
Lancashire Teaching Hospitals NHS Foundation Trust
East Lancashire Hospitals NHS Trust

System Safety

Systems Safety

The 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.

NHS England » Patient Safety Incident Response Framework

Expected Outcomes

- Support the coalition of stakeholders involved in PSIRF.
- Facilitate and nurture a learning culture and improvement approach by providing coaching and support to systems as they embed PSIRF including bespoke support to services that require it.
- Support the fidelity of the PSIRF principles as set out in the published guidance.
- PSCs to support ICBs to understand the patient safety themes and the quality improvement work across their system to develop a learning system and support knowledge transfer.
- Pilot PSIRF in General Practice.

Impact

100% of trusts (acute, ambulance, community, and mental health) have transitioned to PSIRF. A number of resources have been developed to support the implementation of PSIRF as illustrated here.

Evidence from HI East evaluation of PSIRF demonstrated:

The evaluation found that the Patient Safety Collaborative's role has been instrumental in guiding ICB and regional leads, helping to facilitate change, and to create and host meaningful and supportive networking opportunities.

The intervention was forward-thinking, fostered collective understanding, and created safe spaces in which to share successes and overcome challenges.

The evaluation result received positive feedback from ICB and regional NHS leads, alongside patient safety specialists. They appreciated the Patient Safety Collaborative's role in bringing the key stakeholders together and appreciate its continued support.

86% of survey respondents strongly agreed or agreed that the events and activities they attended had supported their ability to implement and embed PSIRF in their organisation.

This led to further evaluations in HI Wessex and UCLP who found:

Creating shared learning spaces

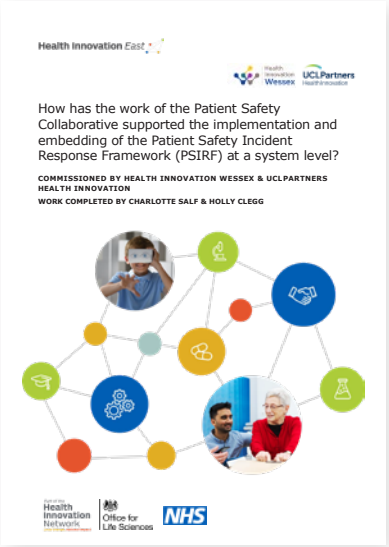
PSC created opportunities to share learning, collectively problem-solve and connect with peers.

Creating opportunities for peer support

Providers brought together through shared learning spaces were found to have a continued relationship, proving beneficial insharing early learning.

Capacity and staffing

Barriers to implementing PSIRF, largely encompassed capacity and staffing difficulties.



Pilot in General Practice

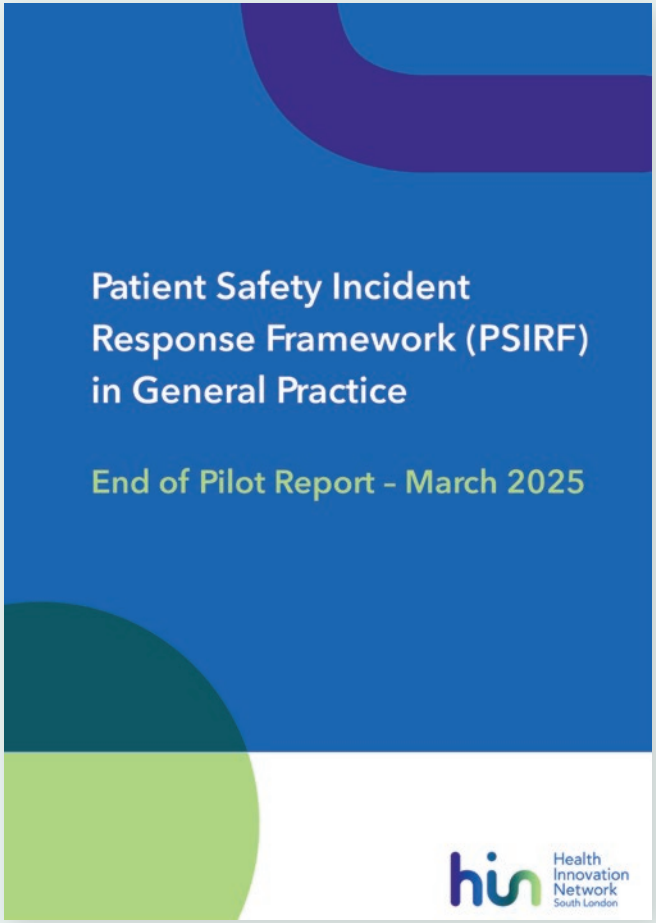
We are working with General Practice sites to develop a PSIRF model.

There have been valuable insights and learnings captured through communities of practice.

Piloting PSIRF in General Practice has generated a great deal of learning. The approach builds on learning about the implementation of PSIRF in secondary care and other settings over the past few years.

The PSIRF principles of compassionate engagement, systems-based approach, proportionate response and supportive oversight were core to this work.

During the pilot, a Learning Continuum was developed to describe the key phases of learning that support PSIRF in General Practice: capturing the incident, surfacing insights, sharing learning and widening involvement, all underpinned by a culture of psychological safety



“It’s great to see the shift in thinking, and a move to a more caring approach to incidents. I am encouraged to see more incidents being highlighted as this is always how we will learn most effectively.”

Impact

National Patient Safety Improvement Programmes

System Safety

West Midlands PSIRF Priorities Top 10

6 Integrated Care Systems

- Birmingham and Solihull
- Black Country
- Coventry and Warwickshire
- Staffordshire & Stoke-on-Trent
- Shropshire and Telford and Wrekin
- Herefordshire and Worcestershire

24 Provider Trusts

Medication

100% 6 out of 6 ICS

83% 20 out of 24 Trusts

Tissue Viability

100% 6 out of 6 ICS

54% 13 out of 24 Trusts

Patient Falls

83% 5 out of 6 ICS

58% 14 out of 24 Trusts

Deteriorating Patient

83% 5 out of 6 ICS

50% 12 out of 24 Trusts

Admission, Discharge & Transfer

66% 4 out of 6 ICS

29% 7 out of 24 Trusts

Infection Prevention & Control

50% 3 out of 6 ICS

29% 7 out of 24 Trusts

Delay in Treatment, Diagnosis and Pathways

50% 3 out of 6 ICS

25% 6 out of 24 Trusts

Imaging, Radiology & Diagnostics

66% 4 out of 6 ICS

25% 6 out of 24 Trusts

Maternity / Obstetrics

66% 4 out of 6 ICS

25% 6 out of 24 Trusts

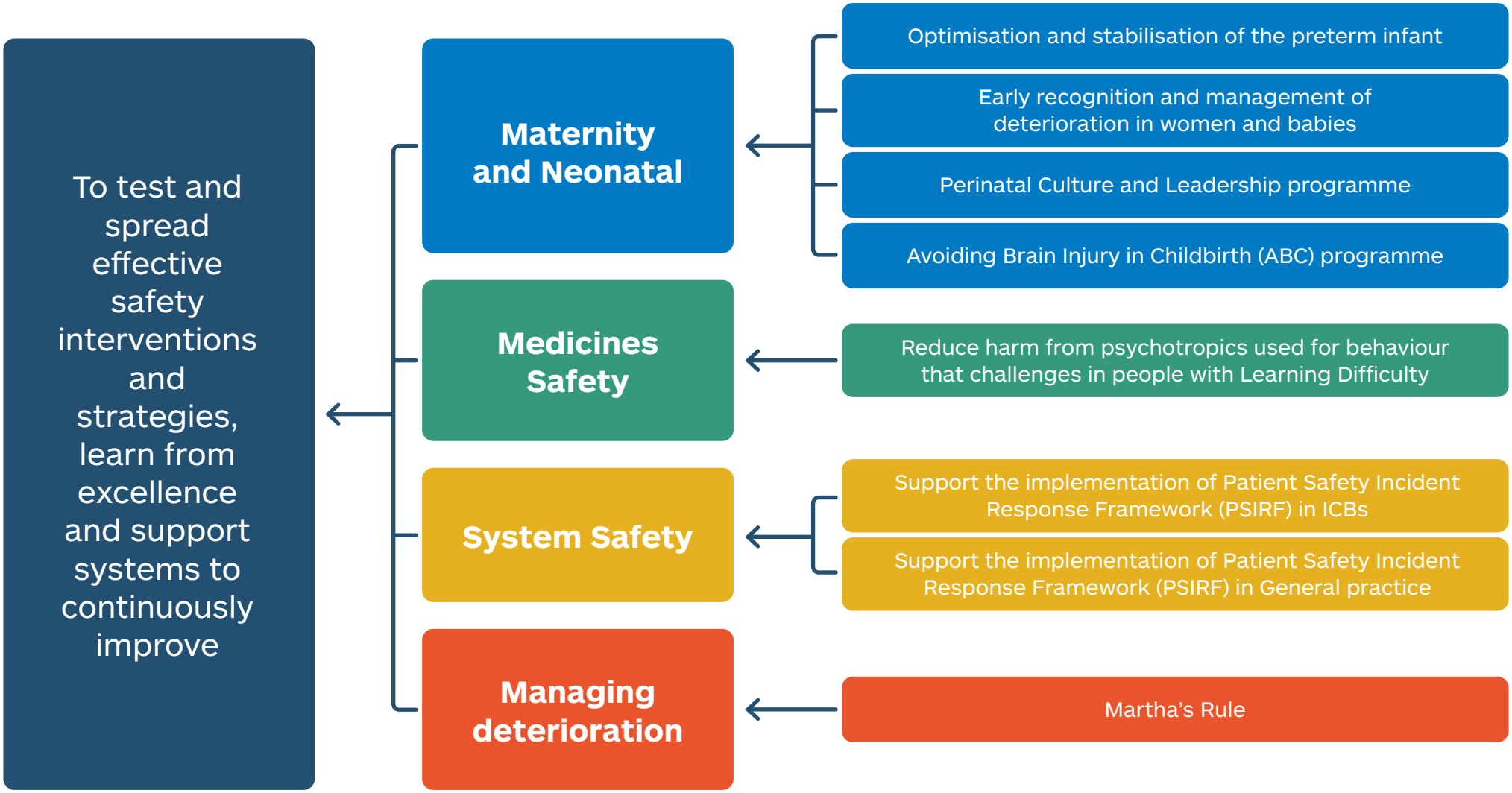
Self Harm

50% 3 out of 6 ICS

13% 3 out of 24 Trusts

PSCs have been working with their regional teams to identify themes from PSIR plans and to support improvement across these key areas. West Midlands is provided as an example.

Looking Forward 2025/26



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Health Innovation Network
Local change, national impact

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