HQIP Healthcare Quality Improvement Partnership

#CAAW26

Patient Safety Webinar: Using Data and Audit to Reduce Harm

Thursday 25 June 2026, 10.30am-12pm

THIS EVENT STARTS AT 10.30AM

Discover all the #CAAW26 events:
Scan the QR code or visit
www.hqip.org.uk/caaw26

In partnership with:

patient safety learning

CLINICAL AUDIT AWARENESS WEEK 2026

Improving lives with healthcare data

www.hqip.org.uk/caaw26

In partnership with:

patient safety learning

Patient Safety: Using Data and Audit to Reduce Harm

Welcome to Clinical Audit Awareness Week, 22-26 June 2026: www.hqip.org.uk/caaw26

Today's agenda:

- **Listening to Patients – A Perspective from the Patient Safety Commissioner**

Professor Henrietta Hughes OBE, *Patient Safety Commissioner*

- **The Role of the National Joint Registry in Patient Safety**

Chris Boulton, *Director of Operations, National Joint Registry*

- **Using National Maternity Data to Drive Patient Safety Improvement**

Faith Sheils, *Director of Midwifery, Northern Care Alliance NHS Foundation Trust*

- **From Incident to Improvement: Using Epilepsy12 Data to Commission a Safer First Seizure Pathway**

Dr Colin Dunkley, *Consultant Paediatrician, Sherwood Forest Hospitals, Epilepsy12 Clinical Lead*

- **Update from Patient Safety Learning**

Clare Wade, *Director, Patient Safety Learning*

- **Q&A**

Before we start…

Being seen and heard

- Event recorded
- Mics off for background noise
- Cameras on, if you are happy to

Asking questions

- Use the Q&A to post your questions
- Contact us via HQIP website if Q&A unavailable for you

Recommendations

- Laptop/PC, not phone
- Try browser version, not app
- If needed, rejoin using rejoin button on screen or original Teams link

Don't forget to share on social media: #CAAW26

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#CAAW26

Listening to Patients:
A Perspective from the Patient Safety Commissioner

Professor Henrietta Hughes OBE

Patient Safety Commissioner

Patient Safety Commissioner
Listening to Patients

Listening to Patients

Prof Henrietta Hughes

Clinical Audit Awareness Week
25 June 2026

Role of the PSC

Patient Safety Commissioner
Listening to Patients

Promote patient safety and the value of listening to patients in relation to medicines and medical devices.

Directly accountable to Parliament, independent of government and the health system. Special legal powers to request information and make recommendations.

Patient Safety Principles

Patient Safety Commissioner
Listening to Patients

- Create a culture of safety
- Put patients at the heart of everything
- Treat people equitably
- Identify and act on inequalities
- Identify and mitigate risks
- Be transparent and accountable
- Use data to drive improved care and outcomes

Patient Safety Principles

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Patient Safety Commissioner
Listening to Patients

Number of medication errors made in England

Medication errors in England

237 million

drug mistakes are made each year

28% could cause moderate or severe harm

700 deaths caused by errors

22,300 more deaths could be related to mistakes

Source: Manchester, York and Sheffield Universities

Patient Safety Commissioner
Listening to Patients

OECD burden of adverse drug reactions

Costs from **avoidable admissions** due to medication-related harms

+

Added length of stay due to preventable hospital-acquired medication-related harms

=

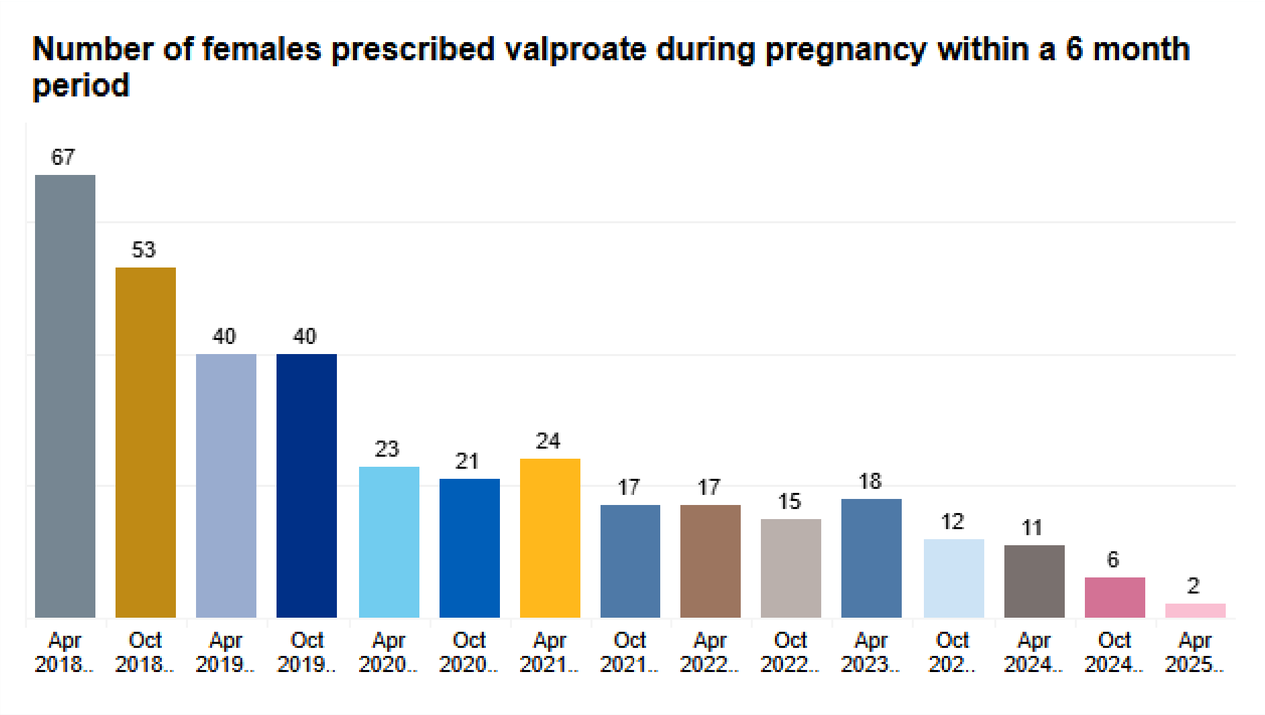
OVER USD 54 billion

in OECD countries, annually

de Bienassis, K. et al. (2022), "The economics of medication safety: Improving medication safety through collective, real-time learning", *OECD Health Working Papers*, No. 147, OECD Publishing, Paris, https://doi.org/10.1787/9a933261-en.

Patient Safety Commissioner
Listening to Patients

Recommendation to NHS England on the safe use of the most potent teratogens



NHS England, Medicines in pregnancy: During pregnancy facts dashboard
Workbook: Meds&Preg

Patient Safety Commissioner
Listening to Patients

Martha’s Rule

NHS England » Martha’s Rule

Patient Safety Commissioner
Listening to Patients

Sep 2024 to Feb 2026 data

- Data from September 2024 to March 2026 shows 13,481 Martha's Rule calls were made, with the highest proportion of calls (72%) made via the family/carer escalation process. 4,336 Martha's Rule escalation calls (32%) related to acute deterioration.
- Of those, 2,504 calls required changes in treatment. This includes 574 calls which resulted in transfers of care to high dependency or intensive care units, enhanced levels of care, tertiary centres or referral/transfer to specialists or a specialist ward. Other changes in treatment (1,930) did not require transfer of a patient from a ward in-patient setting. This includes the introduction of a new medication such as an antibiotic to treat infection, investigations including scans and procedural interventions including going to theatre.
- Where calls were not categorised as being related to acute deterioration, they are still supporting staff to provide better care and address concerns. For example, 3,340 calls led to clinical concerns such as medication or investigation delays being addressed. A further 3,360 calls helped to resolve communication and discharge planning issues.

Statistics » Martha's Rule

The National AI Commission

An independent advisory body shaping the future of AI in healthcare

The Commission brings together world-leading expertise from across healthcare, technology, research, industry, academia, policy and law, providing a uniquely broad perspective on the future of AI in healthcare.

Listening - Input from our specialist Working Groups

Expert insight from across government, healthcare systems, industry and academia.

Cross Government

Ensures policy alignment and collaboration across government departments, helping recommendations work across the whole system.

Devolved Administrations

Brings regional perspectives from all four nations, ensuring recommendations reflect diverse health systems and local contexts.

Health Systems

Examines how AI integrates with health systems, focusing on resilience, real-world application, and operational impact.

Technology

Advises on frontier technologies and regulatory implications, grounding work in technical reality and deployment experience.

Listening - research and engagement

Building one of the most comprehensive evidence bases on AI in healthcare

Call for Evidence	**761 responses** from patients, professionals, innovators, academics and system partners
Targeted Engagement	Health Foundation public deliberation sessions with **75 participants** across three regional locations) and National Voices in depth workshops with over **78 participants** across underepresented groups
Stakeholder Engagement	Professional roundtables involving **117** stakeholders from **31 organisations,** and more including TechUK industry roundtable discussions and engagement with Ada Lovelace Institute engagement
Direct Public Engagement	Regular consultation with the **MHRA Patient and Public Committee** and Ask Me Anything public webinar with **928 registrations** and **180 questions** received
Survey data & public polling	Public polling (**8,000+** people) and NHS workforce survey (**2,027 NHS staff**)
MHRA's AI Airlock	Real-world innovation and regulatory insights from AI Airlock programmes

From Listening to Learning

Common themes from across the research and engagement activites

1

Trust Enables Innovation

The right regulation can support both safety and innovation

2

Support Is Conditional

Confidence depends on how AI is used and governed

3

Regulation Must Evolve

Current frameworks are not well matched to AI

4

Lifecycle Oversight

Ongoing monitoring matters as much as approval

5

Context Shapes Risk

Real-world performance shapes outcomes

6

Transparency & Accountability

Trust requires visible safeguards

7

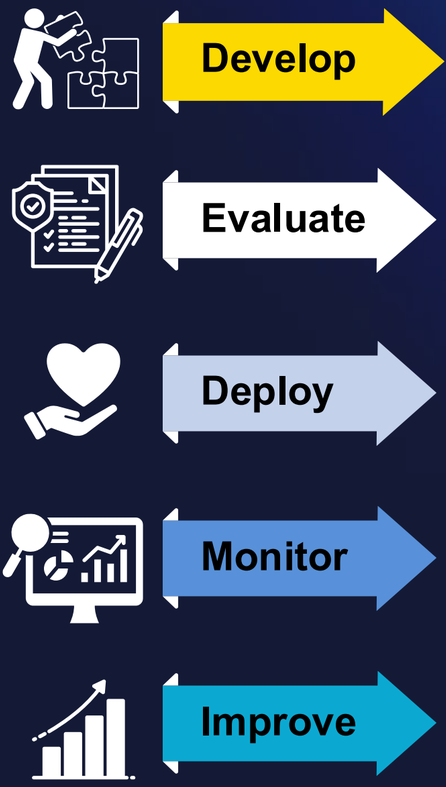
Equity & Inclusion

Fairness must be considered throughout the lifecycle

Despite the diversity of perspectives, there was broad agreement on the conditions required for AI to be adopted safely, effectively and with public confidence..

From Learning to Leading

Toward a lifecycle approach



If AI systems evolve over time, oversight must evolve with them.

Patient Safety Commissioner
Listening to Patients

Thank you!

Scan for more info about the PSC

Website: www.patientsafetycommissioner.org.uk

LinkedIn: linkedin.com/in/henrietta-hughes-psc

Email:

commissioner@patientsafetycommissioner.org.uk

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#CAAW26

The Role of the National Joint Registry in Patient Safety

Chris Boulton

Director of Operations, National Joint Registry

National Joint Registry

Working for patients, committed to excellence

The role of the National Joint Registry in patient safety

Chris Boulton

NJR Director of Operations

Clinical Audit Awareness Week

June 2026

National Joint Registry

Working for patients, committed to excellence

NJR background

2002

Established
by the Department of Health following the 3M Capital Hip Failure Report, 2001

2003

Data collection commenced
April 2003 for hip and knee replacement surgery in England and Wales

2025+

Registry has evolved
to include other joints and geographical locations

Started with one patient safety issue

3M Capital Hip Failure Report, 2001

Grew into a national programme

Hip and knee replacement data collection began in April 2003

Became a global resource

The NJR now informs clinicians, patients and policy worldwide

4.65M+
Joint replacement procedures recorded

~250,000
new records submitted every year

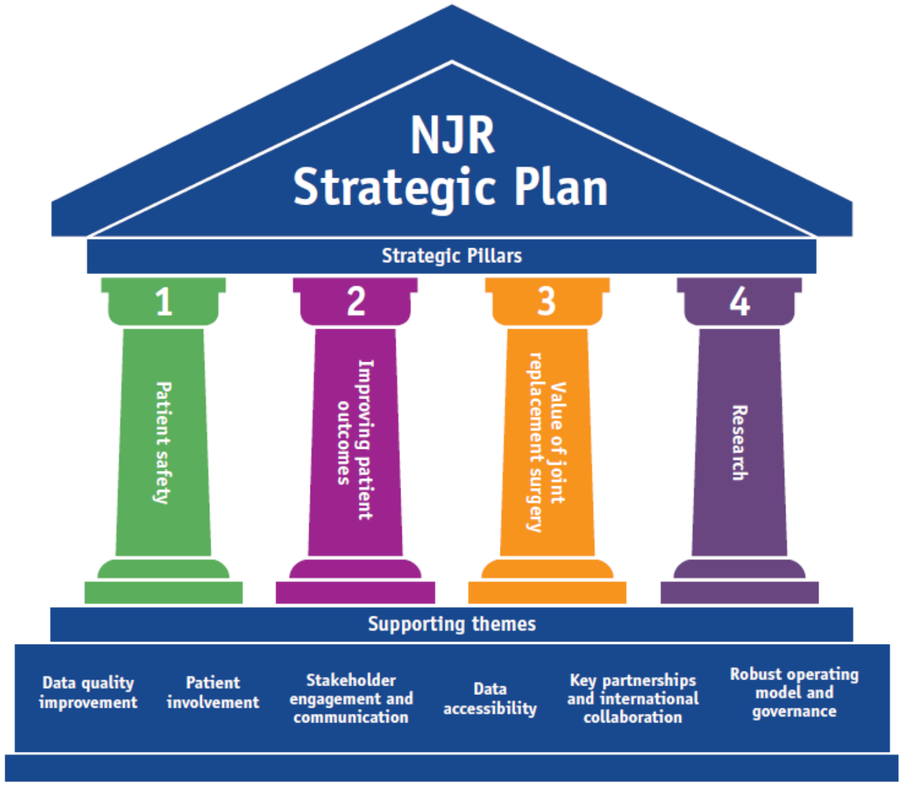
From a single implant failure to the world's largest joint replacement registry

National Joint Registry

Working for patients, committed to excellence

NJR mission

We record, monitor, analyse and report on outcomes of joint replacement surgery to continuously enhance patient safety, support surgeons, and assure value and improved patient outcomes.



National Joint Registry

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Everyone collects data.
Few organisations demonstrate impact.

National Joint Registry

Working for patients, committed to excellence

Why registries matter

Captures **outcomes at national scale**

Allows **identification of variation** impossible to see locally

Creates a **shared evidence base** for surgeons, hospitals and patients

Supports **better decisions** and continuous improvement

4.6 million+

joint replacements recorded

National Joint Registry

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CASE STUDY 1

Identifying poorly performing implants

1

How registry surveillance works

Continuous monitoring of implant performance at scale across the whole population

2

Early identification of concerns

Statistical methods detect unwarranted variation and potential safety signals early

3

Impact on implant selection

Evidence informs decisions, guidance and policy, improving patient safety

Metal-on-metal

Registry data enabled early detection of excess revision risk with metal-on-metal hip implants.

Faster action. Safer choices.

Real impact for patients.

National Joint Registry

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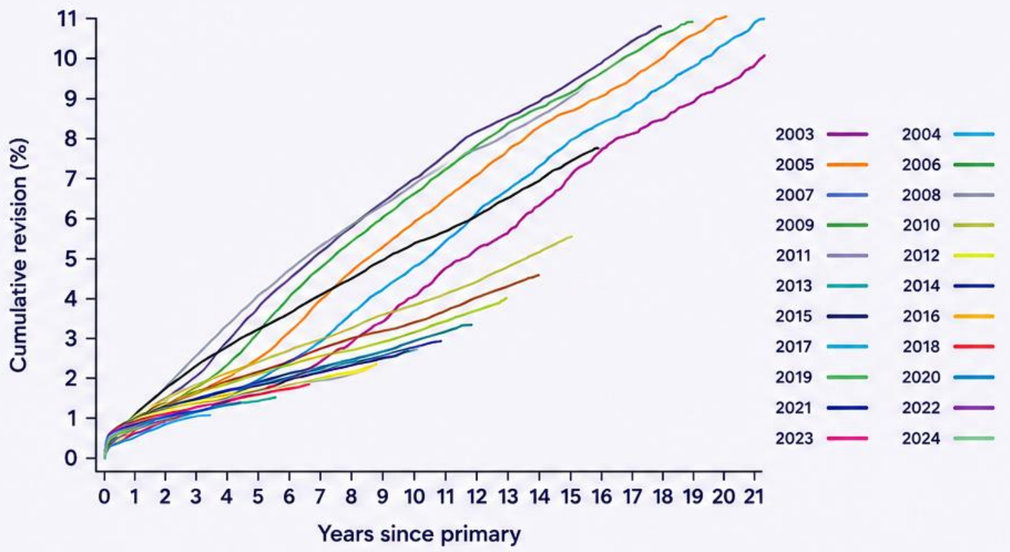
CASE STUDY 2

Reducing revision surgery

Cumulative revision by year in primary hip replacements



Benchmarking and feedback drive improvement.
Revision rates have fallen and outcomes are better for patients.

1. How benchmarking changed practice

Transparent comparison of outcomes highlighted variation and informed clinical and implant choices.

2. Variation reduction

Over time, variation between surgeons and hospitals has reduced as best practice has been adopted.

3. Better outcomes for patients

Lower revision rates mean fewer patients needing further surgery and better long-term outcomes.

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CASE STUDY 3

From registry insight to safer surgery

1

Registry data identified a preventable safety risk

- NJR data identified cases involving incorrect prosthesis combinations
- Rare events, but potentially serious consequences for patients
- Registry intelligence highlighted a wider system issue

2

National investigation and collaboration

- Findings informed the HSSIB investigation
- Collaboration between NJR, HSSIB, MHRA, NHS organisations and clinicians
- Focus shifted from individual error to system-wide safety improvement

HSSIB Report

"Implantation of wrong prostheses during joint replacement surgery"

3

From evidence to intervention

- NJR developed the Implant Scanning Interface
- Real-time validation of implant combinations
- Supports correct implant, side and component selection before implantation

NJR Implant Scanning Interface

Scan. Validate. Prevent.

- Component compatibility
- Side verification
- Size verification
- Product validation
- Safety alerts before implantation

The NJR is not just identifying problems.
It is helping prevent harm before it happens.

"Most people think registries tell us what happened.
The real opportunity is using registry intelligence to stop harm happening in the first place."

National Joint Registry

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Data alone changes nothing

Data is only valuable when it changes decisions and behaviour.

Clinician ownership is critical

Improvement happens when clinicians trust, understand and use the evidence.

Transparency drives improvement

Openness, benchmarking and shared learning reduce unwarranted variation.

DATA → EVIDENCE → ACTION → IMPROVEMENT

National Joint Registry

Working for patients, committed to excellence

Thank you

Contact details:

Chris Boulton
Director of Operations
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Using National Maternity Data to Drive Patient Safety Improvement

Faith Sheils

Director of Midwifery, Northern Care Alliance NHS Foundation Trust

Data Driven Improvement

NHS
Northern Care Alliance
NHS Foundation Trust

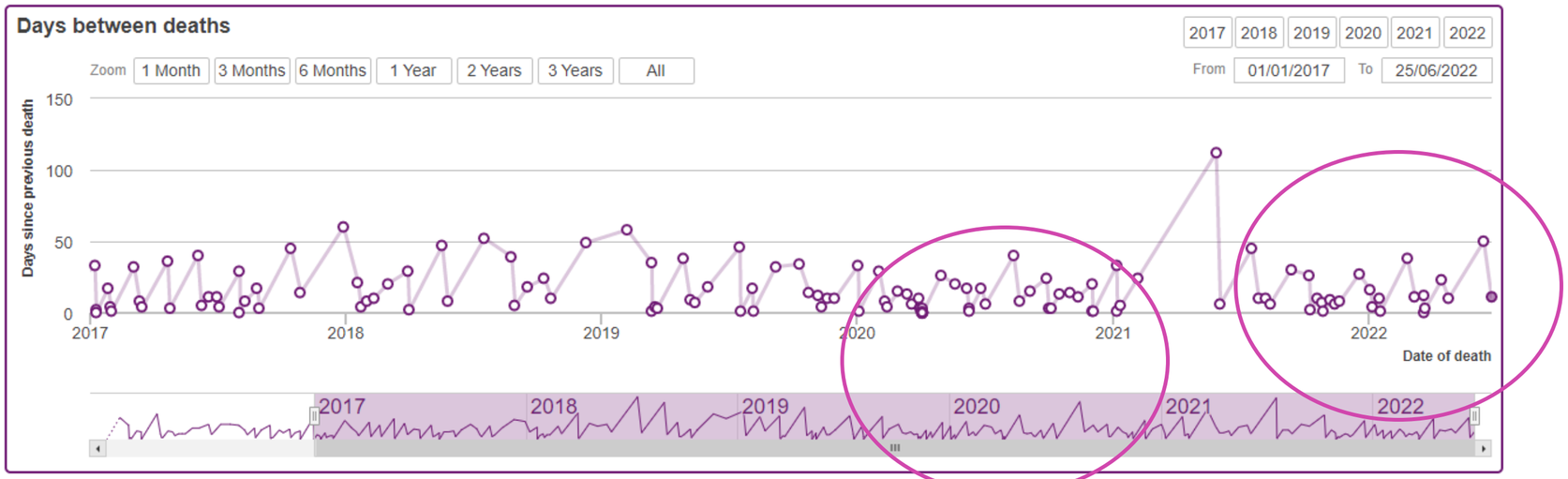
Using MBRRACE-UK data to drive improvement

MBRRACE-UK
Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK

Stabilised & Adjusted mortality rate in **2020 RED** (*More than 5% higher).
Published in October 2022.

Analysis of **crude mortality using MBRRACE-UK Real Time Data Monitoring Tool** indicated from **2021 and 2022 we were likely to be AMBER/RED for Stabilised & Adjusted mortality rate**.

Shift from previously observed crude mortality rates in 2019.



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Maternity Improvement Programme

Northern Care Alliance
NHS Foundation Trust

Measuring success

- Reduction in Stillbirths
- Reduction in neonatal deaths
- Reduction of newborns born with HIE

Phase 1: Understanding core issues and building foundations

1. Mobilisation
2. Diagnostic
3. Identify and deliver core improvements

- Clinical governance
- Safe staffing & training
- High-risk pathways
- Data
- People & Culture
- Listening to our communities

Phase 2: Transformation

6 x Clinical Pathway T&F Groups overseen by the Triumvirate Leadership Team

1. Community-based ante-natal care
2. Maternal medicine
3. Fetal medicine
4. Triage
5. Intrapartum care
6. Post-natal care

* QI approach will underpin all service improvement initiatives across the clinical pathway task and finish groups

- People & culture
- Clinical Governance
- Safe staffing & training
- Engagement & equity

Strategic workstreams

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Programme Initiation Document (PID) – Maternity Improvement Programme (MIP)

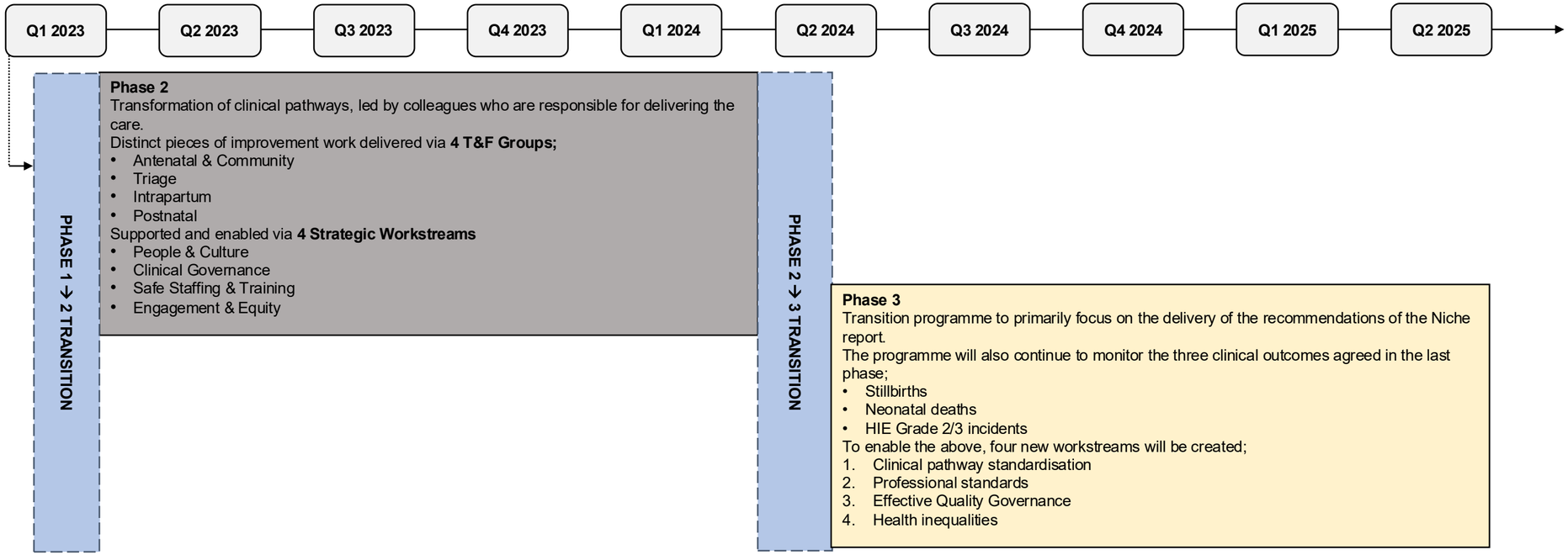
Northern Care Alliance NHS Foundation Trust

Phased Programme Approach:

We want to improve our services quickly and efficiently, as well as develop and operationalise a sustainable solution for the future. To facilitate this the programme has been designed to go through three distinct phases of change;

- **Phase 1** - focused on the journey to gaining a detailed understanding of the core issues, diagnosing and prioritising areas of improvement within maternity services
- **Phase 2 -** focused on delivering identified improvement activities, the process for monitoring activities and ensuring they lead to sustained improvements
- **Phase 3** – focused on the implementation of the recommendations within the Niche report

Timeline:



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MIP Workstream aims

Northern Care Alliance NHS Foundation Trust

Clinical pathway workstreams: *Focus on whole clinical pathway transformation*

Antenatal

- ✓ Design a high-quality antenatal pathway that ensures our women are seen by the right professional at the right time

Triage

- ✓ Women are appropriately risk assessed within the criteria set out by BSOTS

Intrapartum

- ✓ There will be zero avoidable intrapartum stillbirths, a reduction in babies born with HIE.

Postnatal

- ✓ Provide high quality and efficient postnatal patient experience

Strategic workstreams: *Ensuring strategic foundations are in place for the delivery of high-quality clinical pathways*

Clinical Governance

- ✓ Design & implement a patient safety culture capable of evidencing learning from harm into clinical practice

People & Culture

- ✓ This workstream aims to listen to our workforce, understand our culture, and develop a high-quality plan to ensure we act upon what our workforce is telling us.

Safe Staffing & Training

- ✓ Ensure safe, sustainable and productive workforce planning and training is implemented

Engagement and Equity

- ✓ To better understand the needs of our service users and our communities and implement the GM Equity strategy

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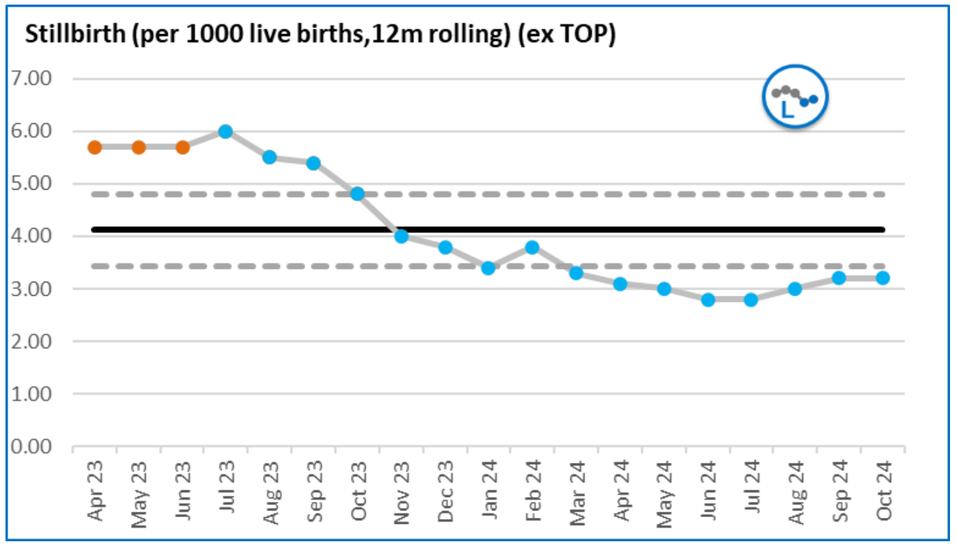
Maternity Improvement Programme

Northern Care Alliance
NHS Foundation Trust

Stillbirths

T Charts used on MBRRACE-UK surveillance platform.

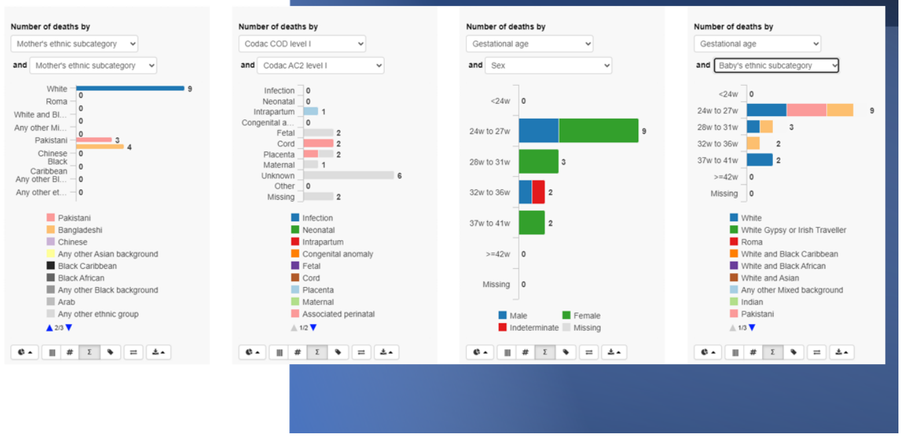
- **Reduction in frequency observed since May 2023, increase in frequency February to April 2024**
- **Special cause improving variation in frequency observed.**



Stillbirths

MBRRACE-UK surveillance platform

- **16 stillbirths observed since Jan to November2024**



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What does good look like?

Know and understand the subject and be able to talk to the data

Have conversations with stakeholders to understand what's happening & use soft intelligence

Ask questions and challenge: bringing a critical view

To represent different perspectives

To get the Board to focus on the right things and influence response

To have the compassion to ask what is happening or what can be done

USING DATA WELL

Leadership	Culture & Capability	Systems & Processes
Your organisation has a clear vision using both quantitative and qualitative data to inform assurance, drive improvement and enhance organisational learning and understanding.	Your staff have the skills and confidence to question, explore and challenge using data and there is strong ownership and utilisation of data operationally and strategically.	Your organisation has clearly articulated and widely adopted processes that deliver reports with clear messages on what the data is saying and actions being taken.

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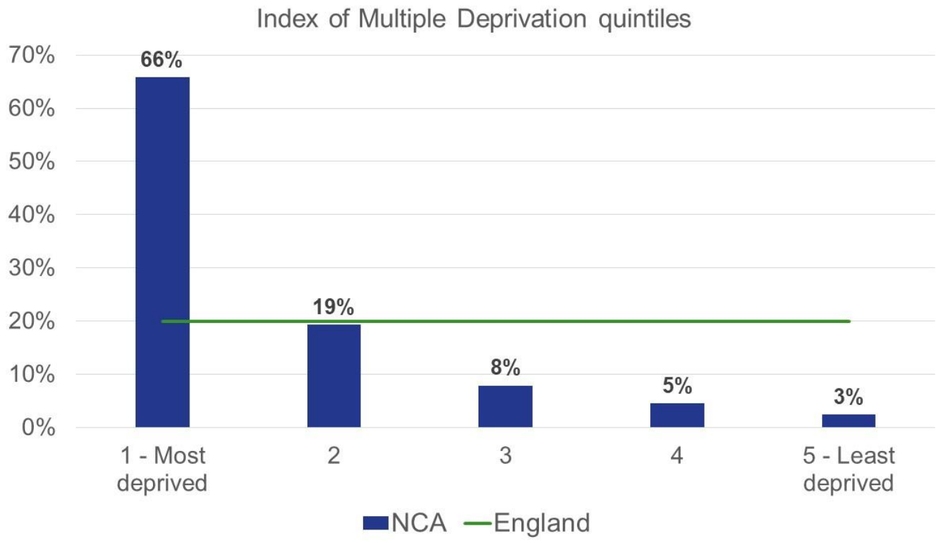
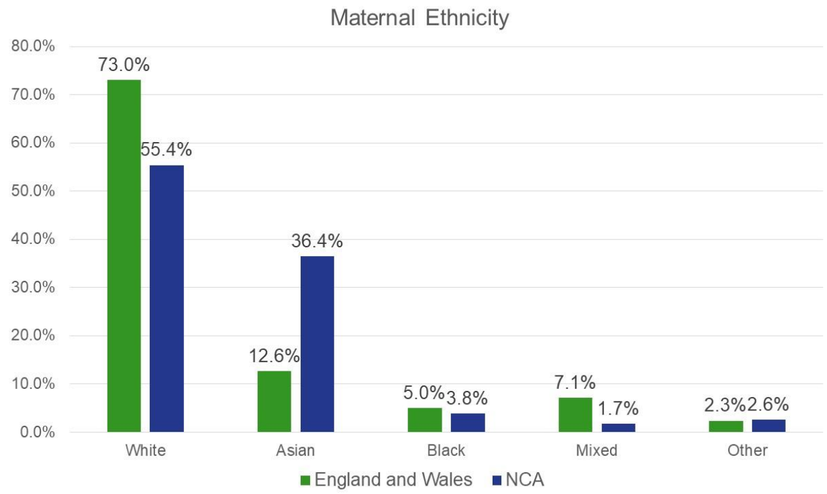
Our population





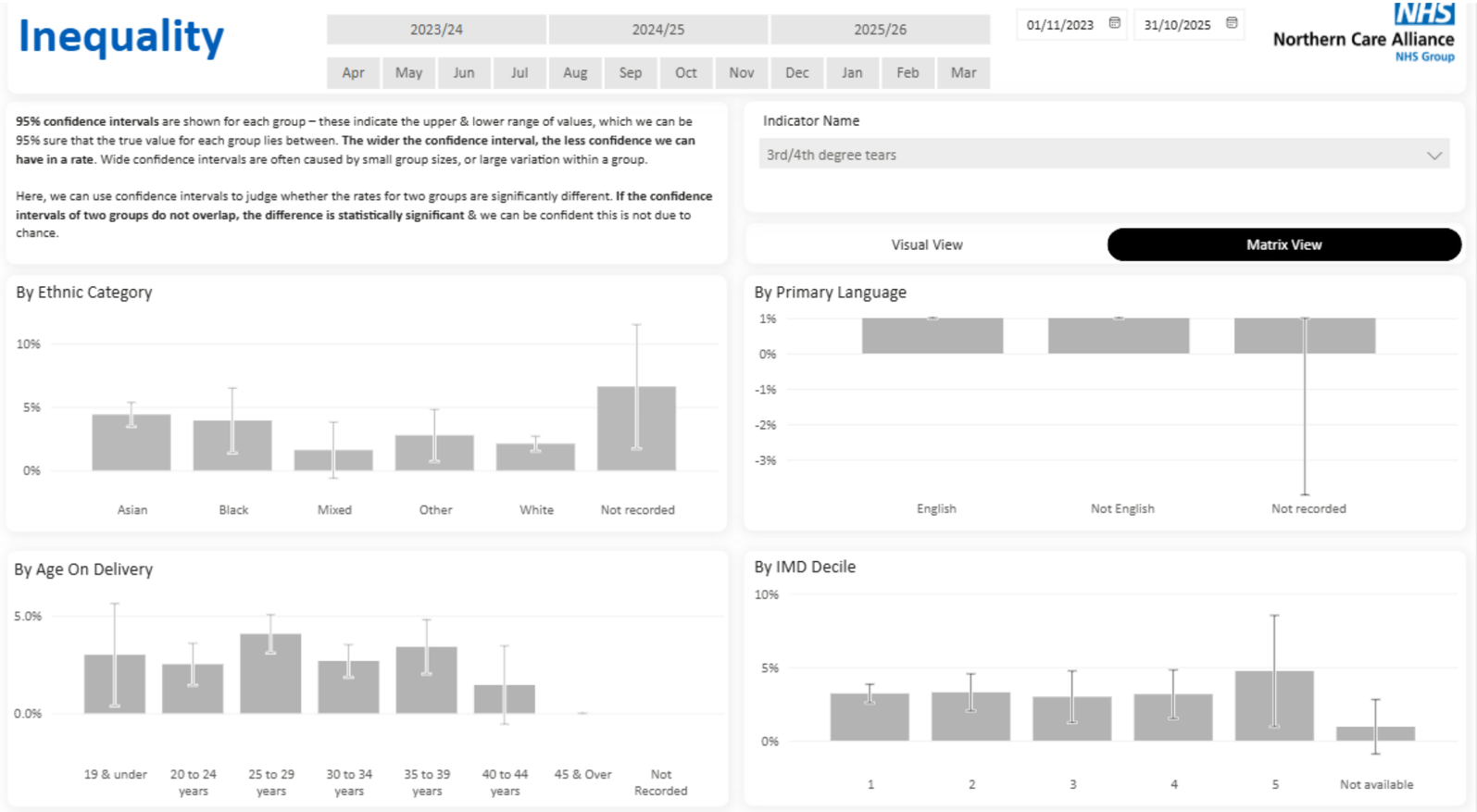
- Health inequalities are unfair and avoidable differences in health across the population, and between different groups within society (Public Health England)
- Race, ethnicity, gender, class and other social risk factors intersect (layer and overlap) to exacerbate the effect of health inequalities – they then become compound risk factors.
- Factors associated with poor childbirth outcomes and experiences of maternity care include (but are not limited to); Black and minority ethnicity, poverty, young motherhood, homelessness, difficulty speaking or understanding English, domestic violence, mental illness, substance abuse and learning disability.
- Deprivation quintiles show 66% of women are most deprived and 26% of our women do not speak English language and over 80 languages are used

Outcomes by Ethnicity

Stillbirth, HIE, ENND – 2 year period

	Number of adverse events	Denominator	Rate/1000	Lower 95% CI	Upper 95% CI
Asian	35	3118	11.2	7.51	14.94
Black	6	365	16.4	3.29	29.59
Mixed	5	165	30.3	3.74	56.86
Other	2	214	9.3	0.00	22.28
White	37	5013	7.4	5.00	9.76

No statistically significant difference in the rate of adverse outcomes by ethnicity



3rd/4th degree tears

No significant differences

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Inequality

2023/24 | 2024/25 | 2025/26

Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar

01/11/2023 31/10/2025

NHS Northern Care Alliance NHS Group

95% confidence intervals are shown for each group – these indicate the upper & lower range of values, which we can be 95% sure that the true value for each group lies between. **The wider the confidence interval, the less confidence we can have in a rate**. Wide confidence intervals are often caused by small group sizes, or large variation within a group.

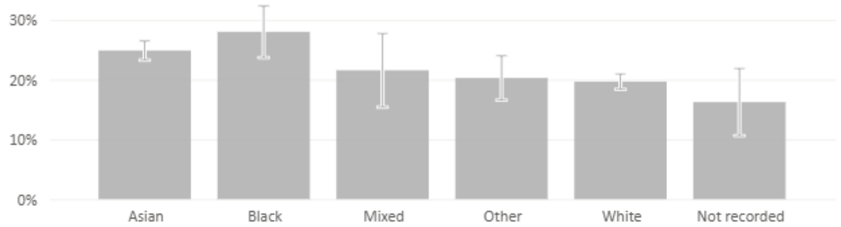
Here, we can use confidence intervals to judge whether the rates for two groups are significantly different. **If the confidence intervals of two groups do not overlap, the difference is statistically significant** & we can be confident this is not due to chance.

Indicator Name

Emergency caesarean sections

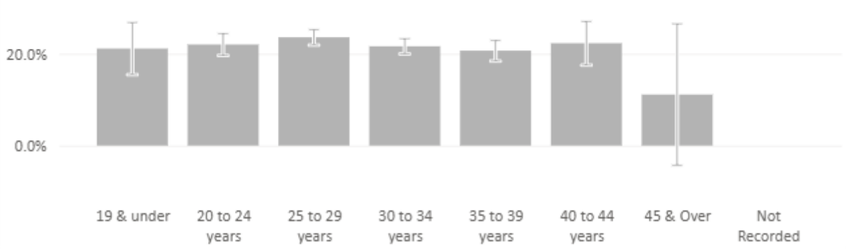
Visual View | **Matrix View**

By Ethnic Category

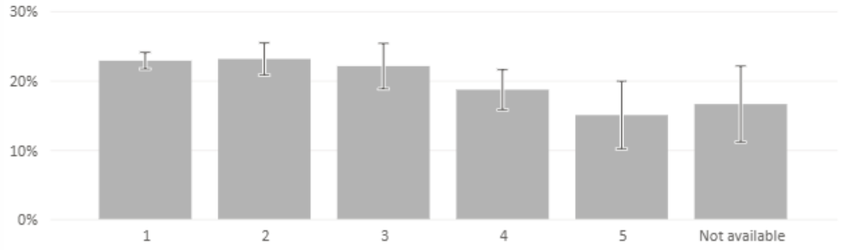


By Primary Language

By Age On Delivery



By IMD Decile



Emergency C-section
Asian & Black > White
Not English lang ↑
More deprived ↑

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NHS
Northern Care Alliance
NHS Foundation Trust

Thank you

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From Incident to Improvement: Using Epilepsy12 Data to Commission a Safer First Seizure Pathway

Dr Colin Dunkley

Consultant Paediatrician, Sherwood Forest Hospitals,
Epilepsy12 Clinical Lead

Removing gaps & ‘going upstream’– ‘First seizures with You’ at Sherwood Forest!

25th June 2026

Dr Colin Dunkley

HQIP
Healthcare Quality Improvement Partnership

EPILEPSY12

RCPCH

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Context…

- Epilepsy effects ~1 in 200 children
- Seizures represent ~5% of outpatient referrals, 5% ED attendances
- Diagnosis remains predominantly clinical, there are lots of pitfalls and management is highly individualised
- First seizure clinics and their associated epilepsy services can easily be ‘overwhelmed’ given majority of presenting events are non-epileptic
- There is significant downstream activity and impact

What is EPILEPSY12

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Epilepsy12 is a **national clinical audit programme** with the continued aim of helping England/Wales health services to **measure and improve the quality of care for children and young people with epilepsies**

Young Epilepsy
NICE National Institute for Health and Care Excellence
epilepsy action
HQIP Healthcare Quality Improvement Partnership
NHS England CYP Transformation Programme
NHS England
OPEN UK Organisation of Paediatric Epilepsy Networks in the United Kingdom
Llywodraeth Cymru Welsh Government

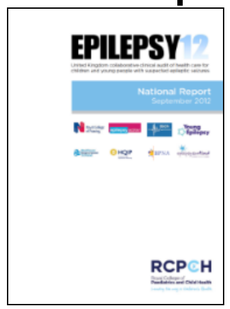
RCPCH Royal College of Paediatrics and Child Health *Leading the way in Children's Health*
RCPCH &Us The voice of children, young people and families

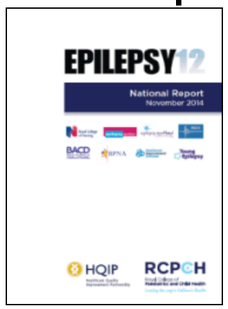
EPILEPSY12

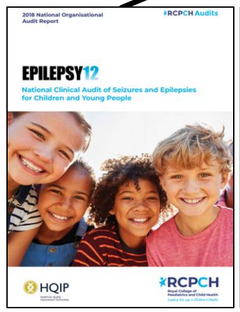
- CLINICAL AUDIT
- ORGANISATIONAL AUDIT
- RCPCH EQIP QUALITY IMPROVEMENT

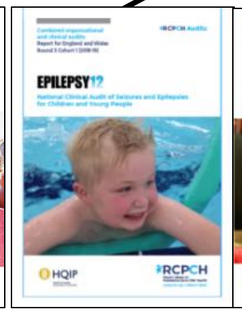
Since 2009

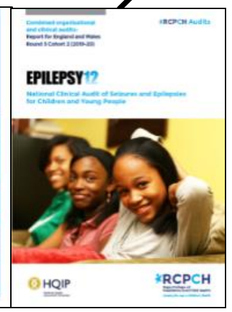
2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026
Round 1					Round 2												
								Cohort 1-3					Cohort 4-6			Cohort 7-8	

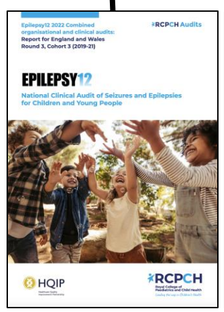


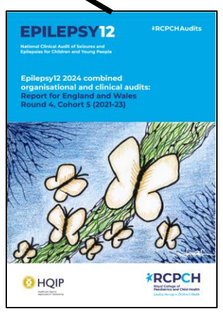






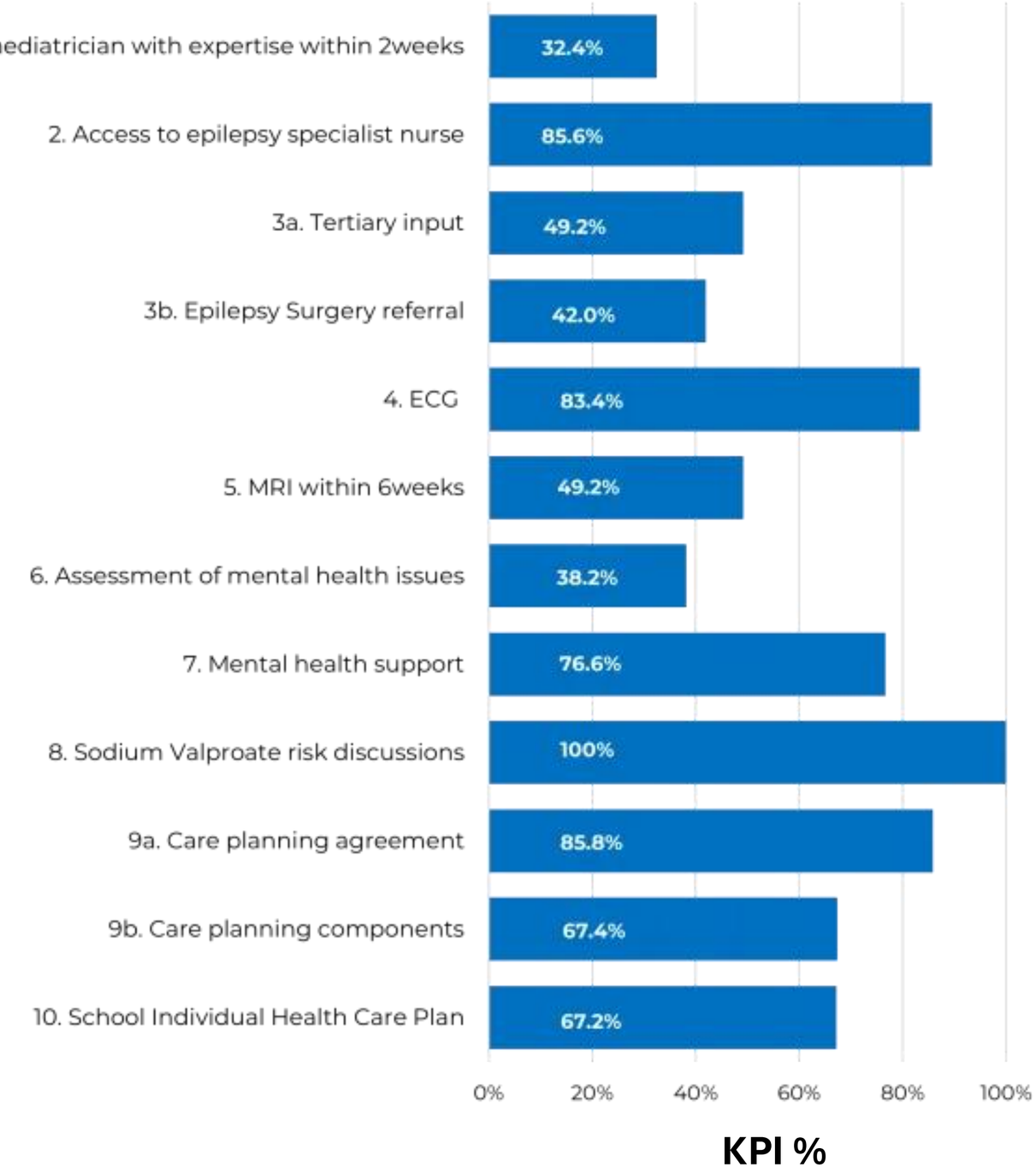






Cohort 6 published 2025

- **N= 3,105**
- 120 hospital and community services
- Comprehensive performance indicators reported for each trust, ICS, country and total



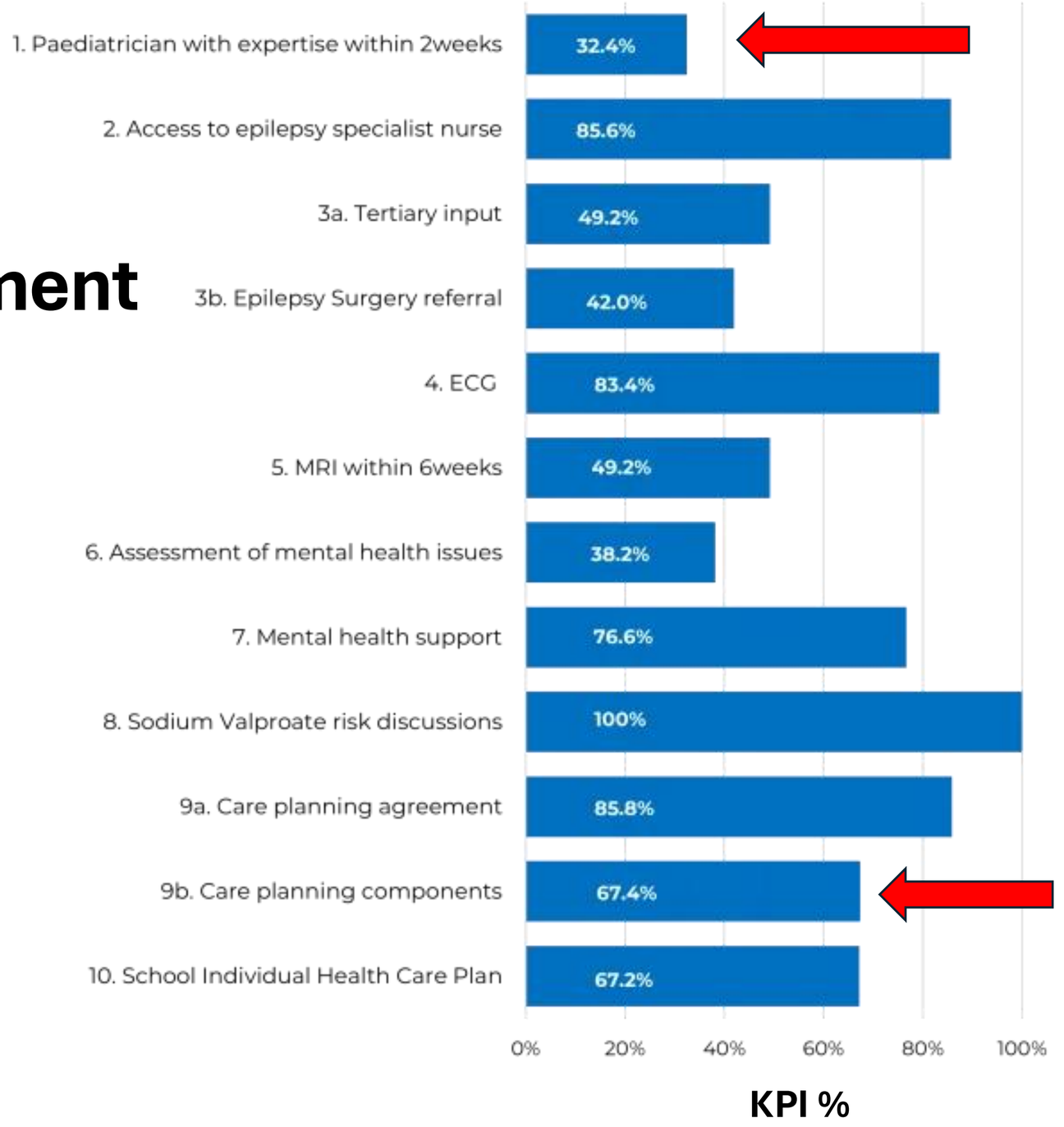
EPILEPSY12

Local data ➡ Local improvement

How our…

-care planning data 2019 ➡ care planning redesign

-timeliness data 2025 ➡ first seizures pathway redesign



EPILEPSY12

2019 care planning KPI

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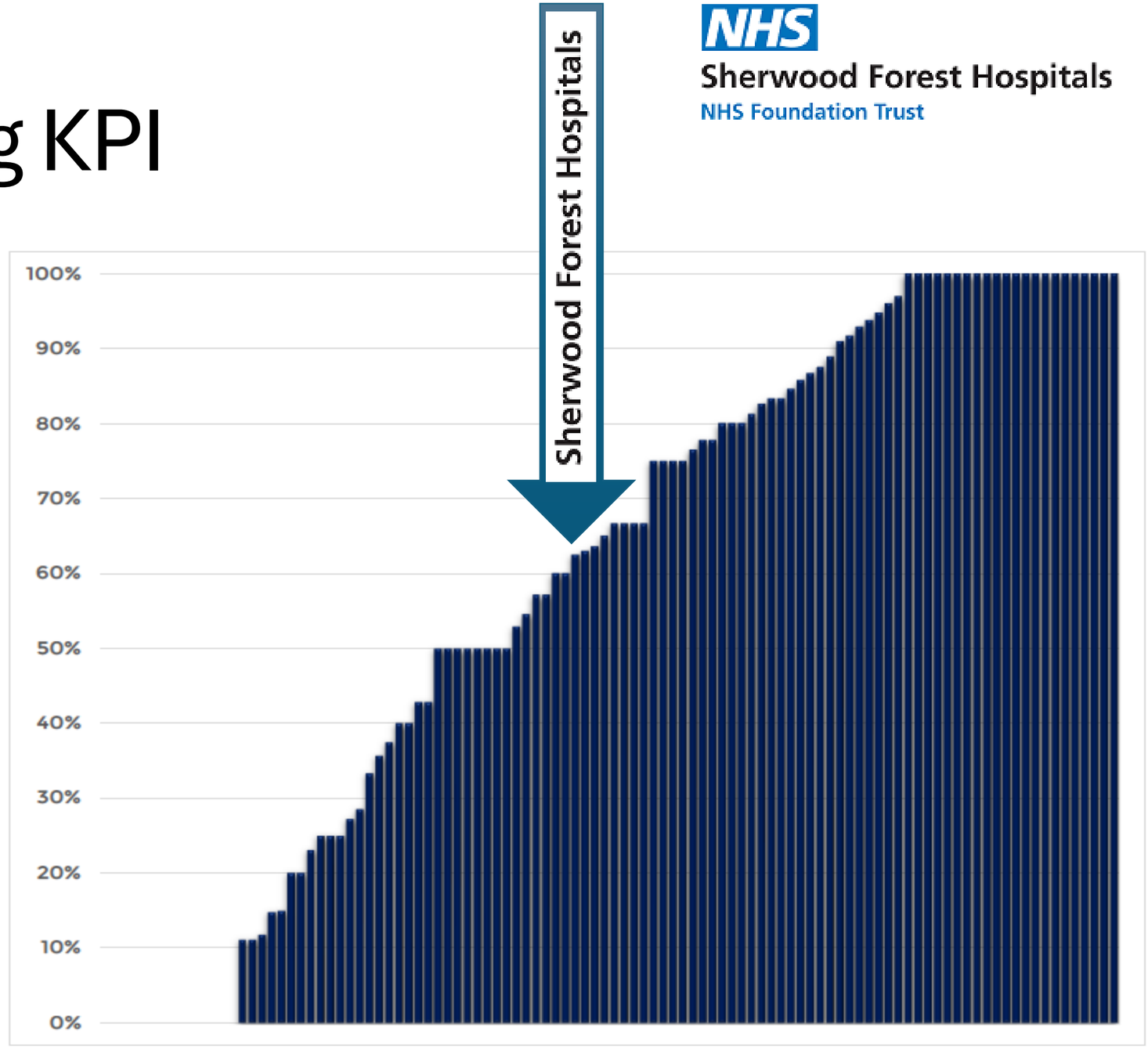

Figure 69: Comprehensive Care Planning agreement, Round 3

EPILEPSY12

Performance target

England and Wales

CEWT

RK5

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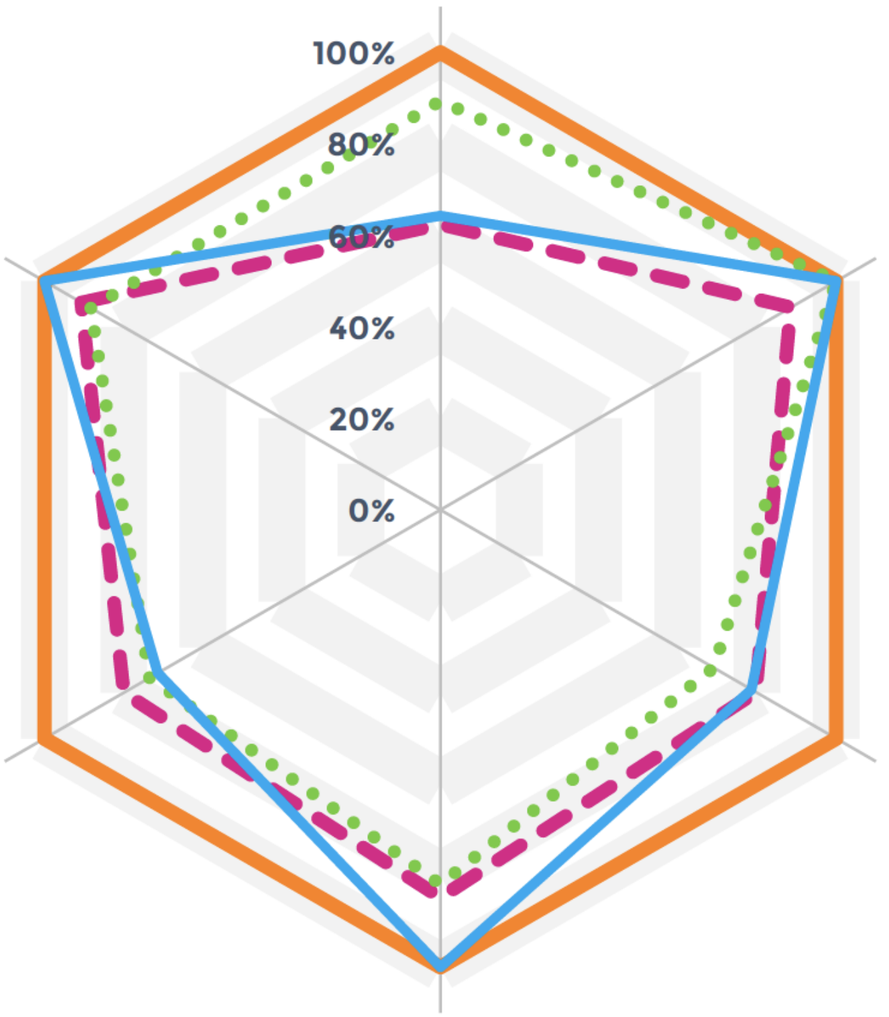

EPILEPSY12

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Team meetings to improve…

RCPCH Royal College of Paediatrics and Child Health
Leading the way in Children's Health

EPILEPSY12

HQIP Healthcare Quality Improvement Partnership

Epilepsy12
2020 National Organisational Audit and Clinical Audit Results

Full comparative results for:
Sherwood Forest Hospitals NHS Foundation Trust (code: RK5)
(This report was prepared by the Epilepsy12 project team in April 2020)

CONFIDENTIAL INFORMATION – NOT FOR CIRCULATION UNTIL RELEASE OF EPILEPSY12 2020 NATIONAL REPORT

This document is for internal review by members of staff within the named Trust and as such is not for public display, further dissemination or to be used for media activities or external communications. It details the data submitted via the registered Epilepsy12 Designated Lead for Sherwood Forest Hospitals NHS Foundation Trust for the Epilepsy12 2019 Organisational Audit which described the organisation of epilepsy services and Clinical Audit which described provision of paediatric epilepsy services/care within the Trust as of November 2019. It contains Trust level summary data and is shared in advance of publication of the national report so that the Trust can access their results as soon as possible.

Trust level data are presented within the column headed 'Trust response', alongside aggregate level results for the Children's Epilepsy Workstream in Trent (CEWT), England and overall results for England and Wales combined.

Organisational Audit Results

If the Trust did not submit 2019 Organisational audit data, the 2019 Trust response column will be 0 but will be able to view the respective 2019 Organisational audit results for regional network, country, overall (England and Wales combined) and 2018 Trust response.

Unless otherwise stated, aggregate level percentages relate to the proportion of HB/Ts that were able to offer, or had in place, a particular paediatric epilepsy service element. For example, in Q2.1 within the Clinic configuration section, the data in the 'overall' column relates to the aggregate proportion of HB/Ts within England and Wales that reported they had defined epilepsy clinics seeing patients at secondary level. If your Trust responded 'yes', then you are one of the 122 out of 136 HB/Ts that had defined epilepsy clinics seeing patients at secondary level. On the other hand, if you responded 'no', you are one of the 14 (136-122=14) HB/Ts that did not have defined epilepsy clinics seeing patients at secondary level.

1 Workforce

	Question	2019 Trust response	2018 Trust response	Regional network	Country	Overall
				CEWT	England	Eng & Wal
1.1	**How many whole time equivalent (WTE) general paediatric consultants (community or hospital based) are there employed within the Health Board or Trust?**					
	Total WTE	18	16	114.7	2016.1	2146
1.2	**Of these, how many WTE general paediatric consultants with 'expertise in epilepsy' are there employed within the Health Board or Trust (excluding paediatric neurologists)?**					
	Health Board or Trust has some level of input from a paediatric consultant with 'expertise in epilepsy'	Yes	Yes	60% (3/5)	93.1% (122/131)	93.4% (127/136)
	Total WTE	2	2	13.5	290.7	308.7
	% of the general paediatric workforce with 'expertise in epilepsy'	11.1% (2/18)	12.5% (2/16)	11.8% (13.5/114.7)	14.4% (290.7/2016.1)	14.4% (308.7/2146)
1.3	**Does the Health Board or Trust have a defined paediatric epilepsy clinical lead?**	Yes	Yes	80% (4/5)	88.5% (116/131)	88.2% (120/136)
	Named clinical lead: Dr Colin Dunkley					

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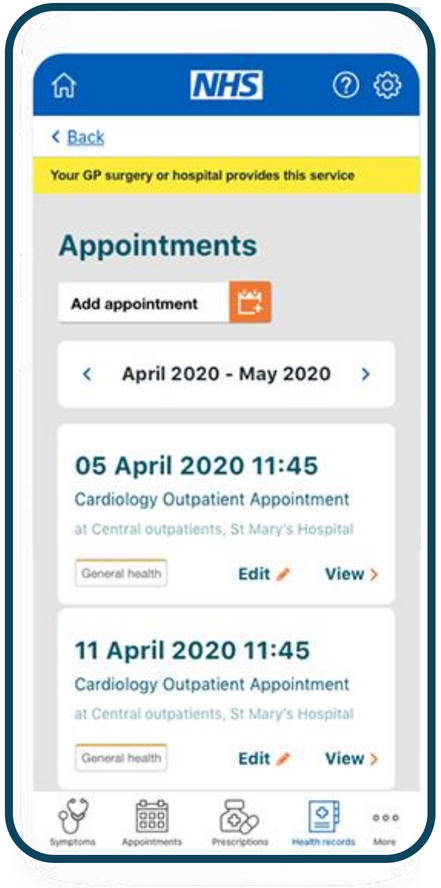
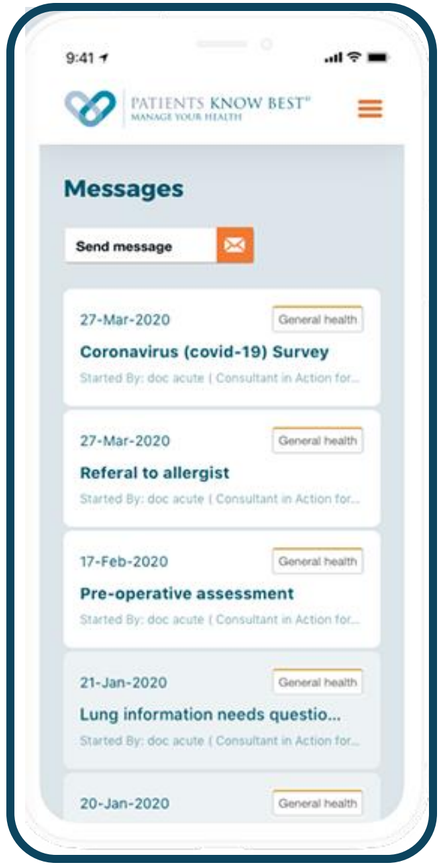
PATIENTS KNOW BEST®
MANAGE YOUR HEALTH





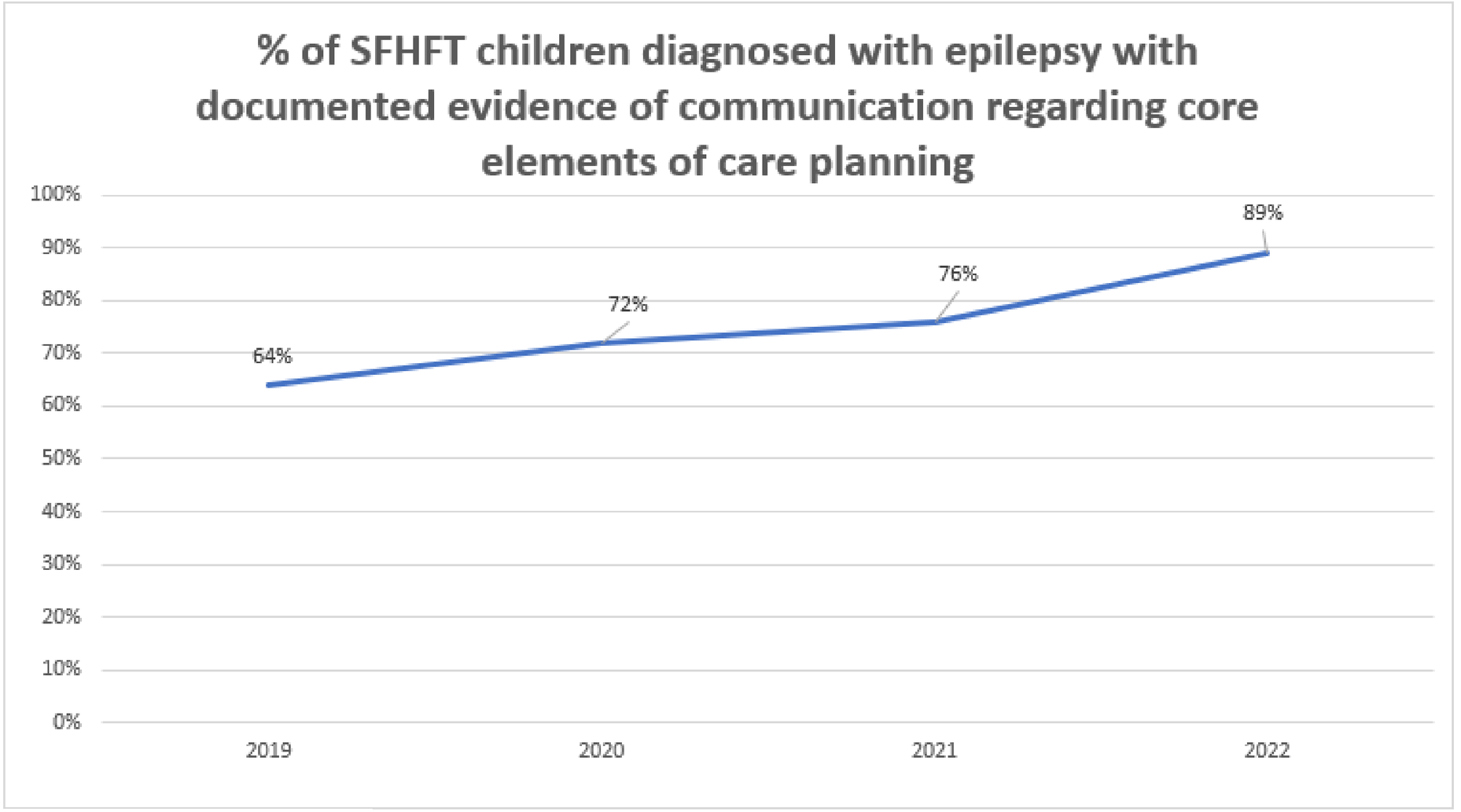
Since 2021…

- Direct team messaging
- Video sharing
- Individualised patient information
- Appts and virtual clinic links
- Proxy access

NHS App

DIGITAL NOTTS
Connecting Health & Care

Sherwood Forest Hospitals
NHS Foundation Trust



EPILEPSY12

Taking too long to arrive in our epilepsy service… 75% > 2 weeks

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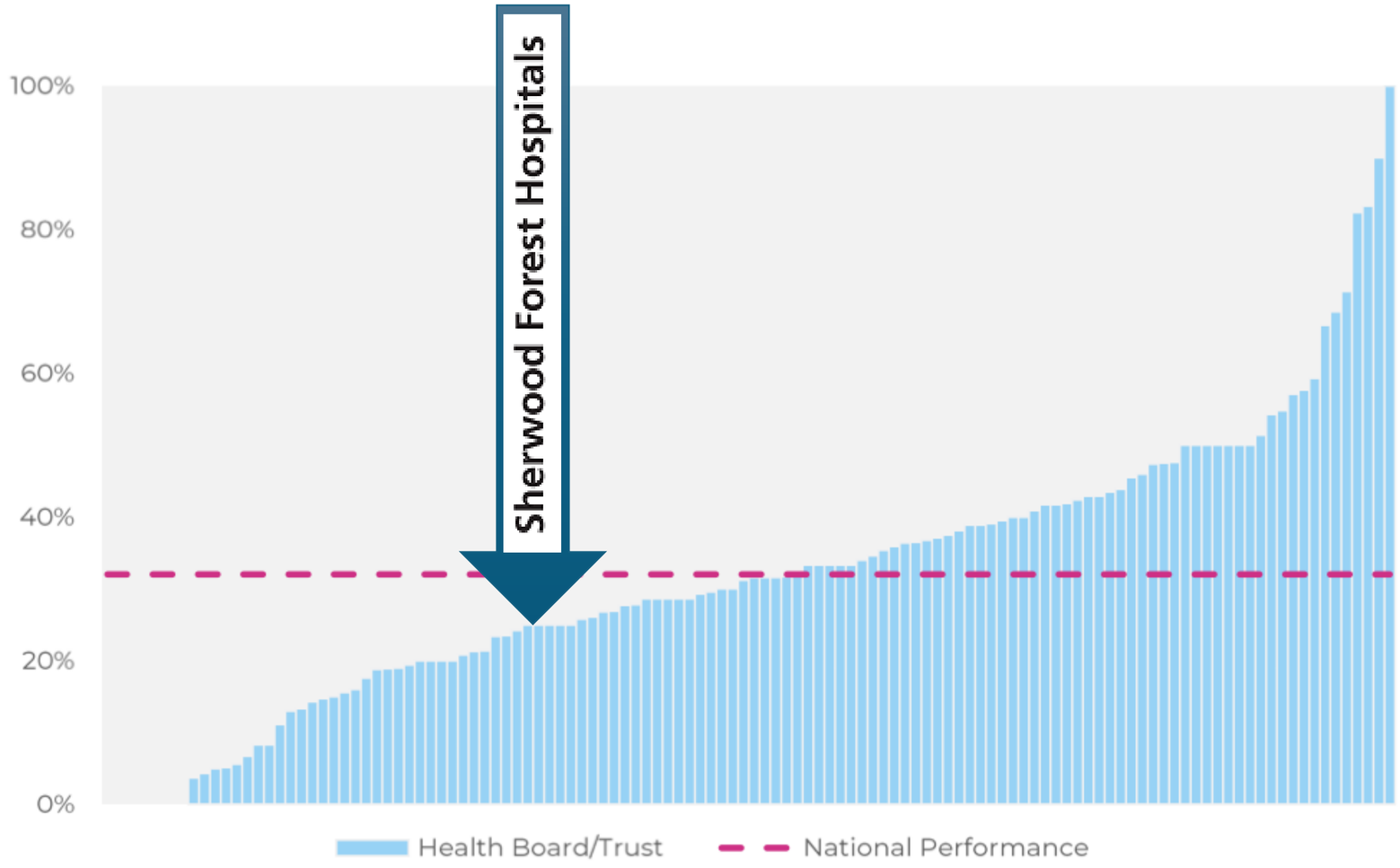

EPILEPSY12

Building an opportunity…

- Our local CDC was looking for pathways and had built clinic capacity into the building design
- Established a CYP asthma diagnostic pathway
- National request proposals and pilot for children via CDC
- We had already developed the ‘digital backbone’

DIGITAL NOTTS
Connecting Health & Care

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Sherwood Forest Hospitals
NHS Foundation Trust

“After a first seizure or seizure-like episode, a specialist children’s nurse and paediatrician will contact and connect with you, provide ongoing individualised support and safety education, contact routes for updates, questions, securely sharing video and seizure descriptions. They will arrange investigations and assessments as needed and stay involved until the diagnosis and next steps are clear.”

DIGITAL NOTTS
Connecting Health & Care

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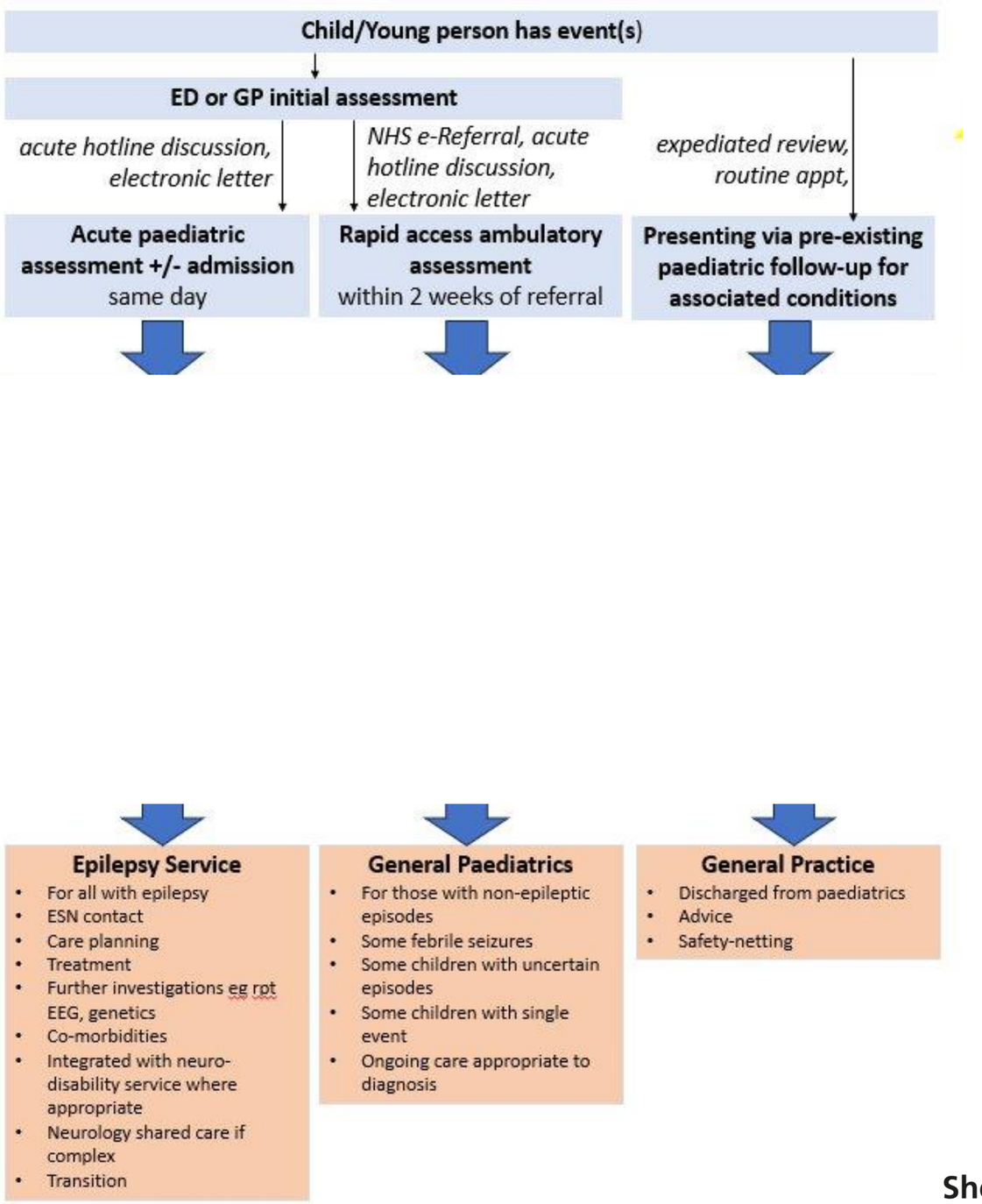
SFH previously…



DIGITAL NOTTS
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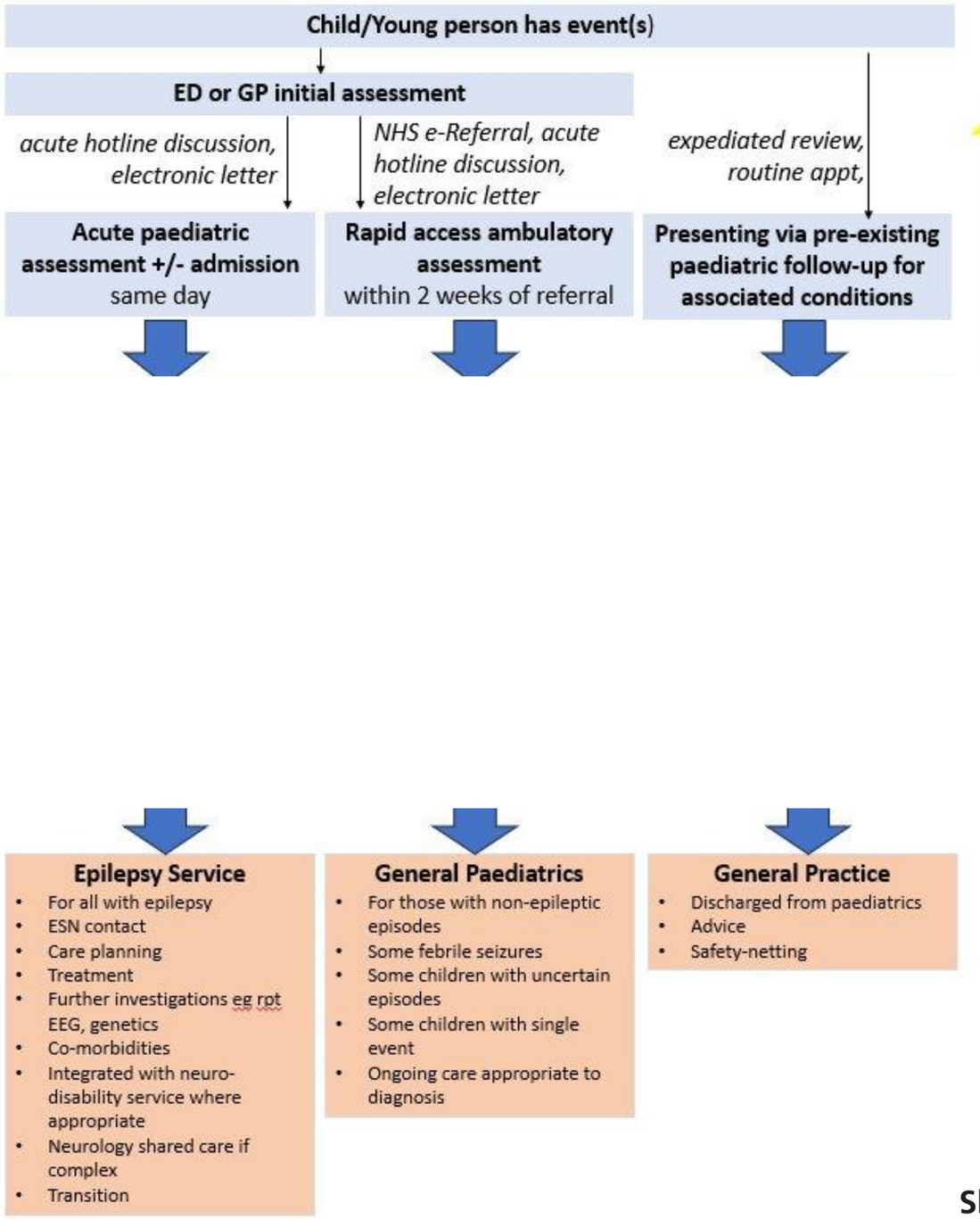
SFH CDC pathway…

A fast-track enhanced triage service, early neighbourhood-facing support, safety-netting, diagnosis, treatment and care

- 1 stop, 2 stop
- New ESN 0.6 WTE
- 1 PAs for clinic and admin
- Go live November 2025
- Community diagnostic centre based



DIGITAL NOTTS
Connecting Health & Care

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SFH CDC pathway…

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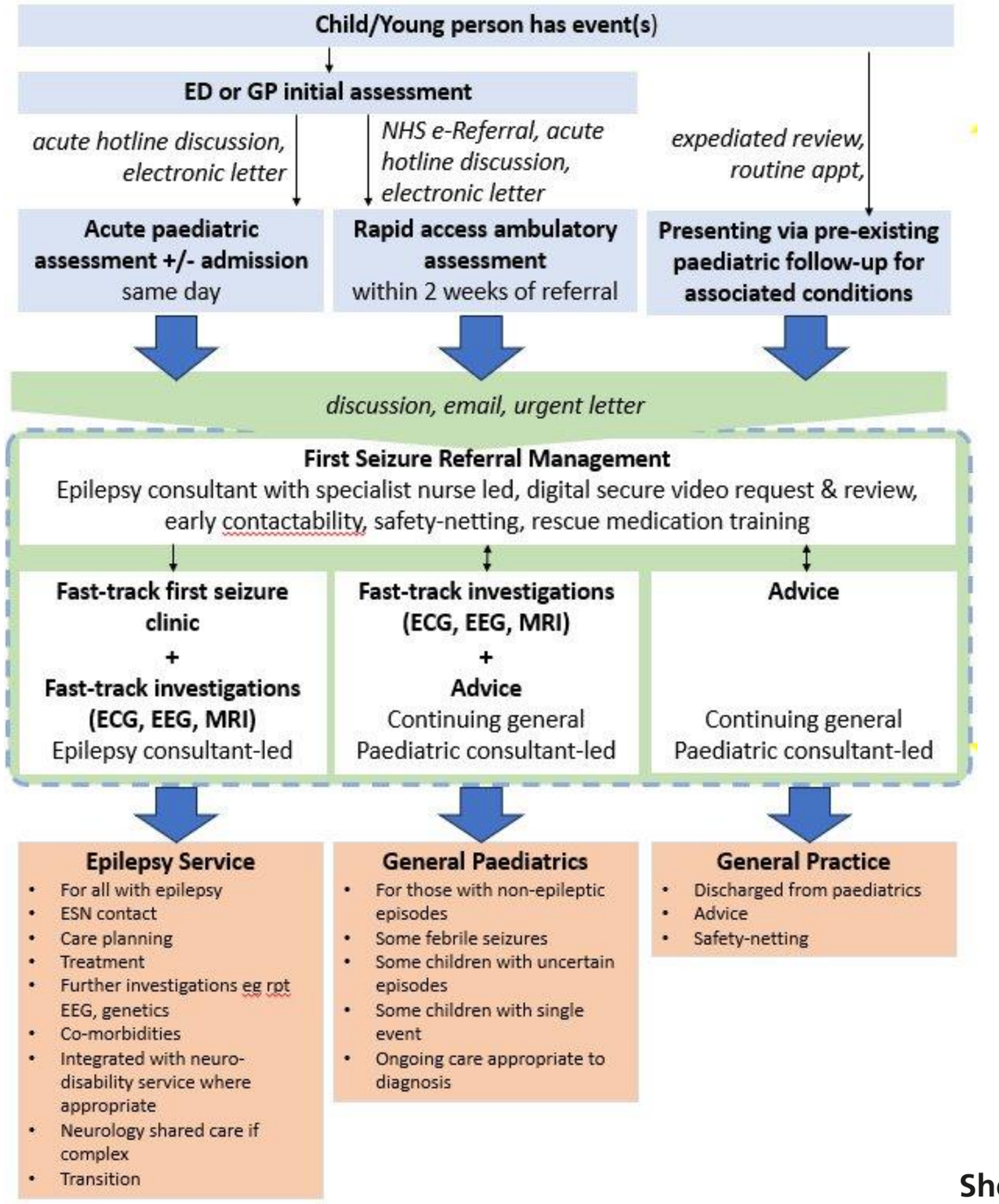

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So far…

- CYP accepted onto pathway since December 2025
- Appointed fixed term ESN initially with pilot funding

And then…

Opened April 2026

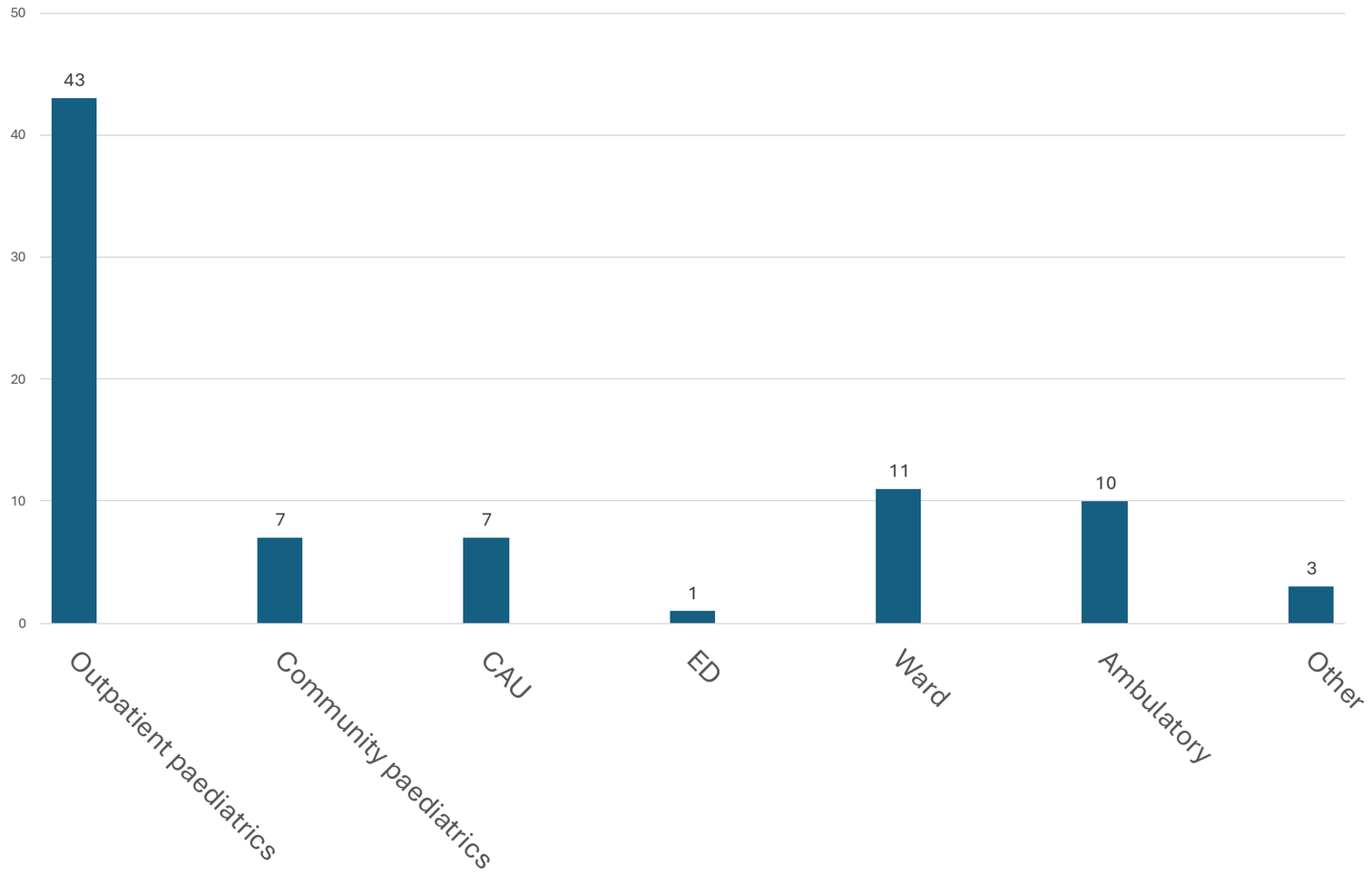
So far…

- CYP accepted onto pathway since December 2025
- Appointed fixed term ESN initially with pilot funding
- **CDC opened April 2026**
- **First young person seen in CDC April 2026**
- **June 2026 secured business case for recurrent funding and substantive ESN post**

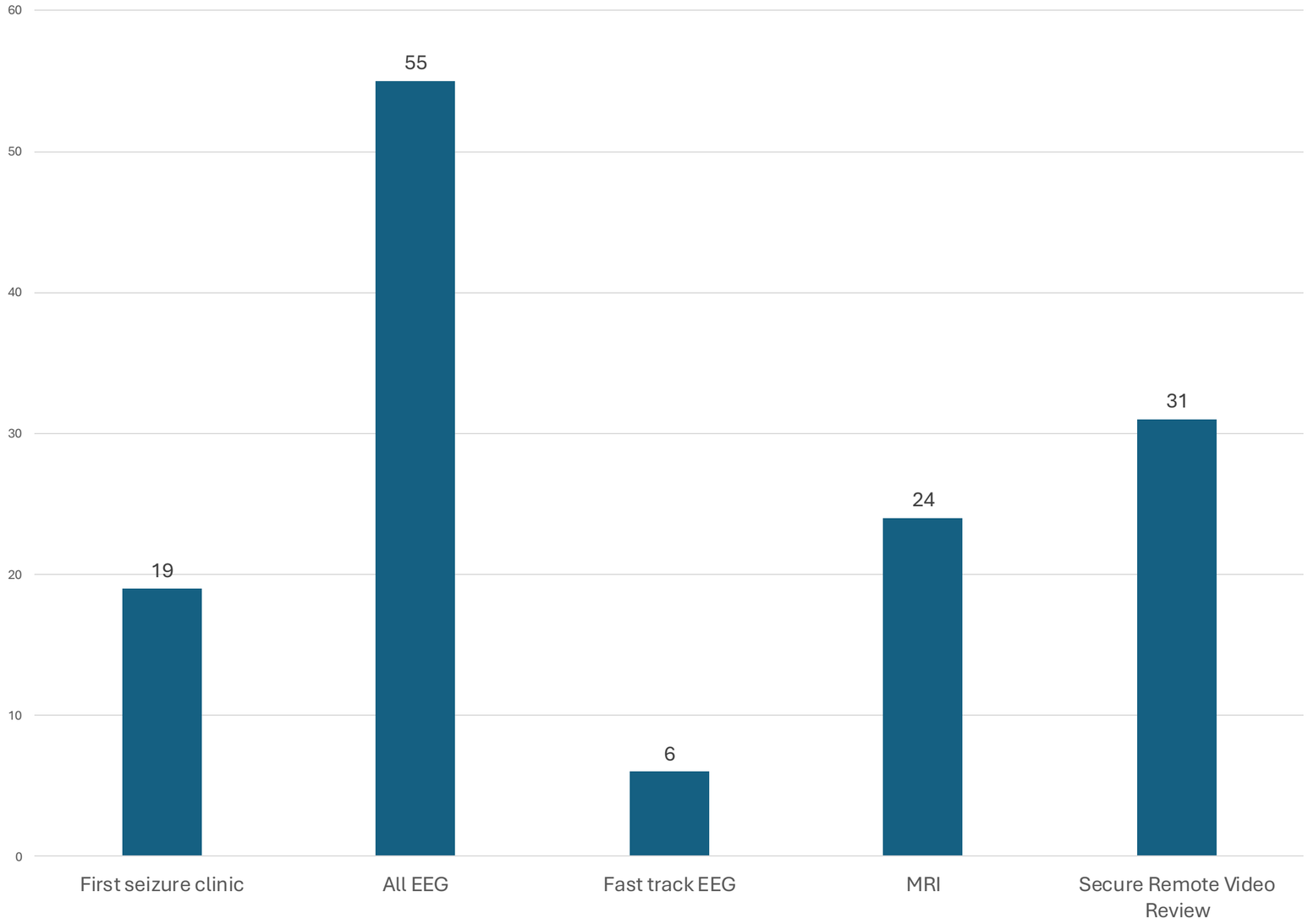
Early data (as of 5/5/26)

- N=80

Source of referral



Activity



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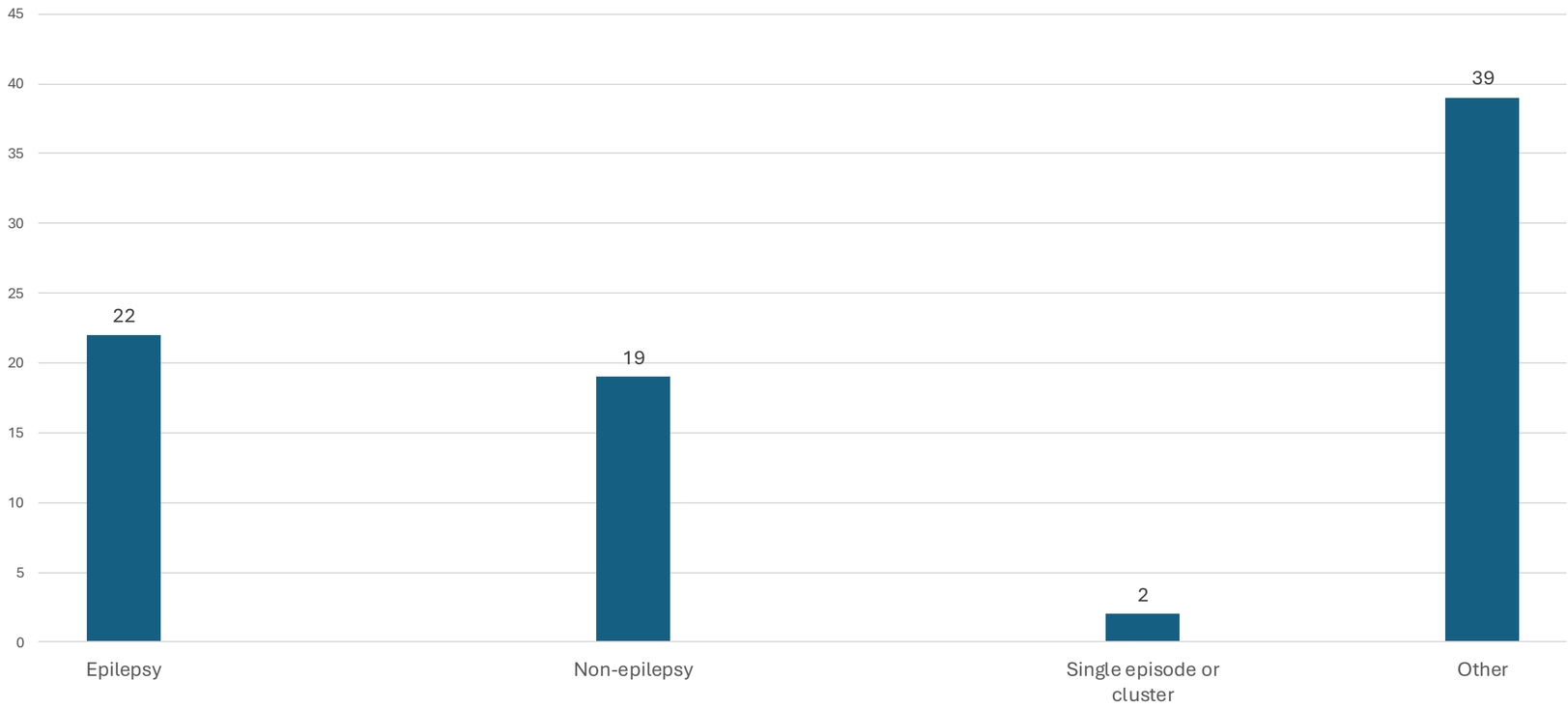
Outcomes



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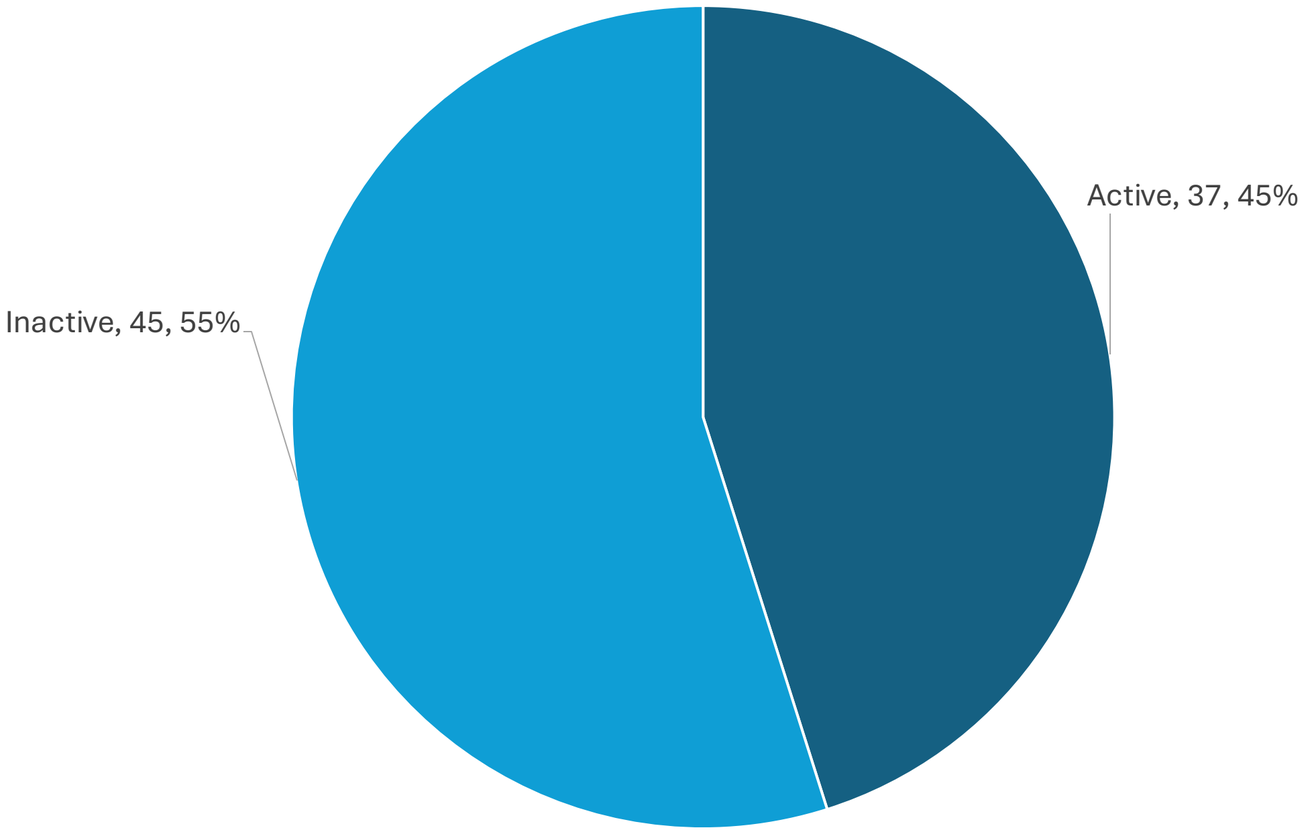
Pathway status



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Next steps and summary

- Develop novel tracker for ongoing ‘dynamic triaging’
- Build 1-stop and 2-stop investigation capabilities
- Evidence improved outcomes, experience and ‘signal’ within Epilepsy12 data
- Consider relevance for other neighbourhood pathways?

Summary…

Epilepsy12 has helped us…

- Direct local change and close gaps
- Jump on strategic national and ICS opportunities
- Created teams, landscape and community where we can systematically evidence and share improvement

HQIP
Healthcare Quality Improvement Partnership

EPILEPSY12

RCPCH

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HQIP Healthcare Quality Improvement Partnership

#CAAW26

Update from Patient Safety Learning

Clare Wade

Director, Patient Safety Learning

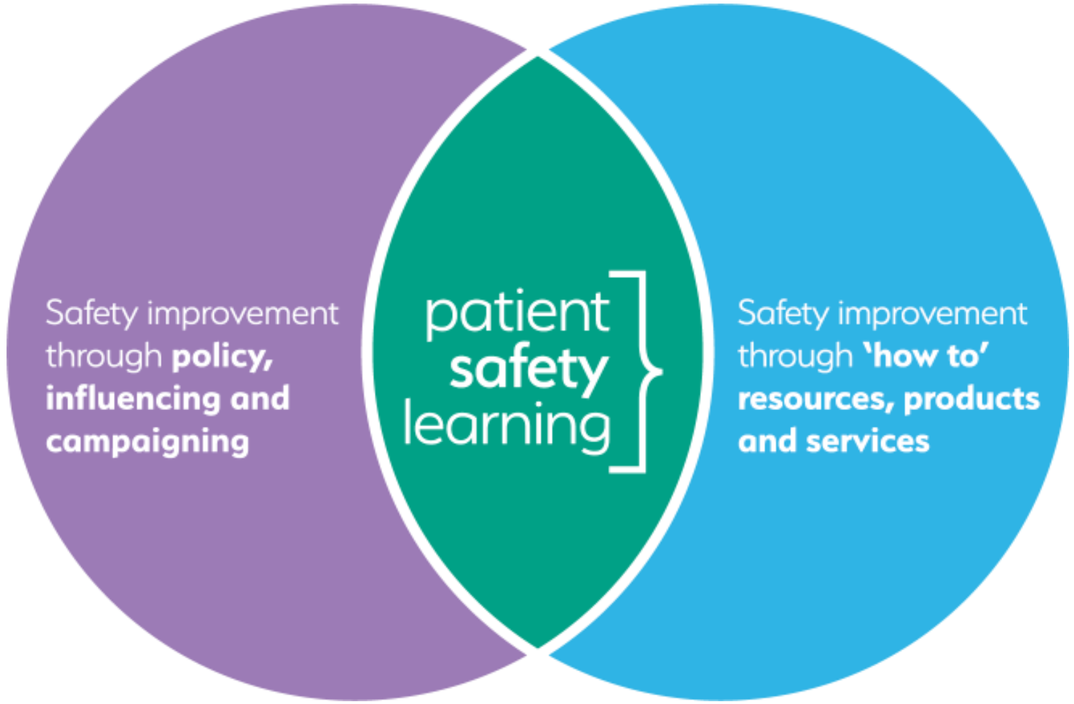
CAAW26 Patient Safety

Using Data and Audit to Reduce Harm

Clare Wade, Patient Safety Learning, 25 June 2026

About Patient Safety Learning

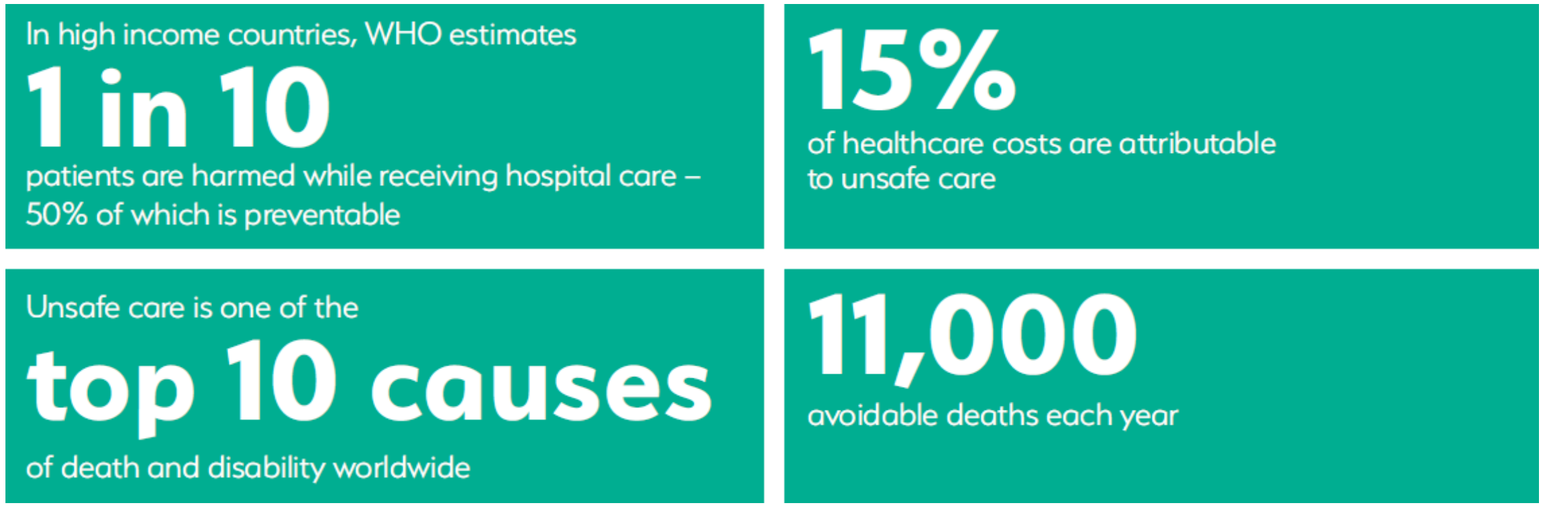
- Founded in 2018
- Charity and independent voice for system-wide change
- Vision
  - To help create a world where patients are free from avoidable harm
- Mission and purpose
  - To transform how health & social care organisations think and act in safety



Listening to, learning from and promoting the voice of the patient safety frontline

patient safety learning

Scale and impact of avoidable harm in healthcare



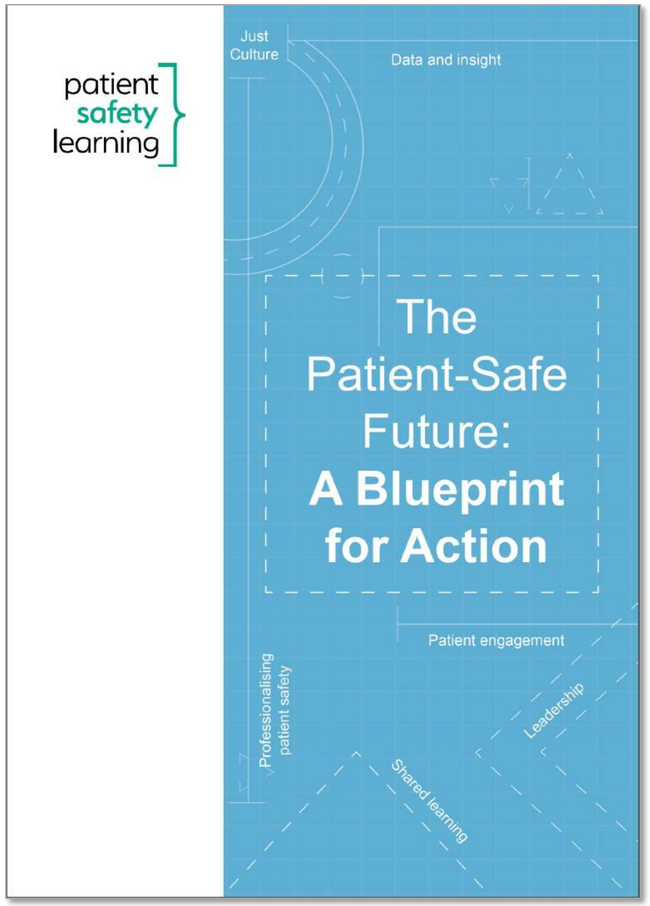
- Patients assume patient safety is a priority until they experience avoidable harm
- Despite the efforts & good work of many people, unsafe care continues to persist
- RCEM estimated at least 305 excess deaths per week linked to long waits (2026)

Have we normalised an unsafe system?

patient safety learning

Why does avoidable harm persist?

- Safety is one priority of many
- Blame culture and fear
- Patents are not engaged
- Lack of leadership and commitment to safety
- Failure to learn and act on good practice/avoidable harm
- Insufficient patient safety and human factors expertise
- Inadequate staff engagement
- Few patient safety standards
- ‘Driving the care looking in the review view mirror
- Lack proactive risk management



patient safety learning

Patient safety must become a core purpose in…

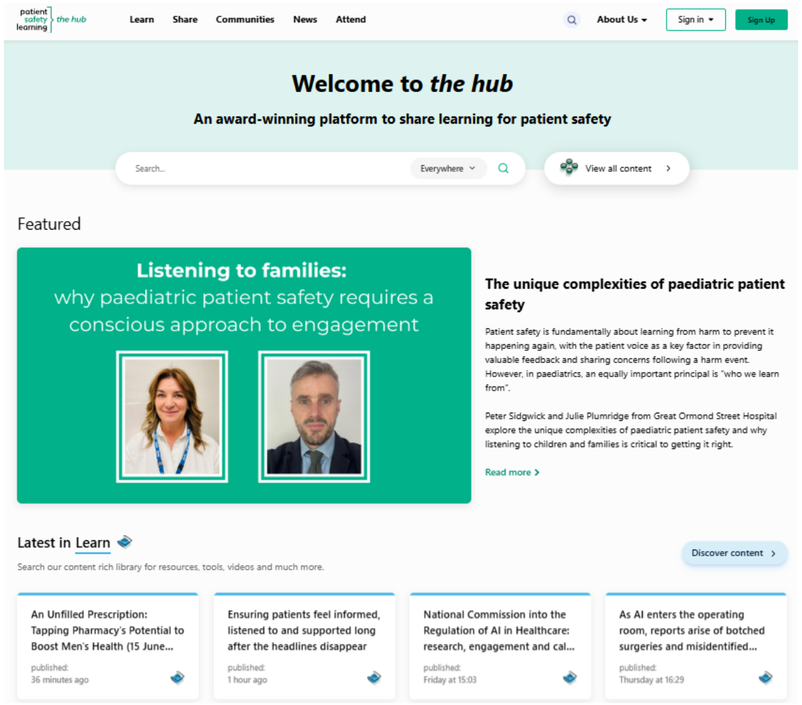
- Policy-making
- Service commissioning and planning
- Standards and good practice governance
- Service provision
- Professional regulation
- System regulation
- Patient and family engagement

… and across the entire health and safety management system

patient safety learning

the hub – an award-winning platform to share learning for patient safety

- Membership is free
- You can register at www.pslhub.org
- The world's largest repository on patient safety
- Hosts networks and communities which give people a place to discuss patient safety concerns and how to address them.
- 'Voice of the patient safety frontline' – staff, patients and families.



patient safety learning

Our patient safety networks

- Informal voluntary networks created by and for staff working in patient safety
- Drop-in sessions with guest speakers
- Information and peer support
- Dedicated private space for discussion and sharing resources on *the hub*
- Helping to develop and strengthen an open and fair safety culture
- Staff and patient safety partner engagement

patient safety management network

patient safety partners network

patient safety education network

patient safety learning

Work with us to create a patient safe future

- Learn and share
- Join a community
- Become a topic expert
- Share your experiences
- Patient safety: a social movement
  - Email: clarew@patientsafetylearning.org
  - Website: www.patientsafetylearning.org
  - LinkedIn: Patient Safety Learning
  - Bluesky: @patientsafetyleaning.org

patient safety learning

HQIP Healthcare Quality Improvement Partnership

#CAAW26

Q&A

CLINICAL AUDIT AWARENESS WEEK 2026

Improving lives with healthcare data

www.hqip.org.uk/caaw26

Upcoming Clinical Audit Awareness Week Webinars

Daily themed webinars and Excellence in Clinical Audit Awards announcements:

- Thu 12.45-1.30pm: Patient Safety Award
- Fri 10am-12pm: Data-Informed Improvement AM
- Fri 1-3pm: Data-Informed Improvement PM, including Evidence in Practice Award

Find out more and register here - or scan the QR code:

www.hqip.org.uk/caaw26

Find lots more on this topic on HQIP's website:

www.hqip.org.uk/impact-of-data/saving-and-improving-lives

THANK YOU!

Please share your feedback:

Go to www.hqip.org.uk/caaw26-feedback

Or scan the QR code

Keep up to date:

- Sign up to HQIP's mailing list: www.hqip.org.uk/subscribe-form/
- Follow us on social media & use the hashtag #CAAW26

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