Board of Directors' Meeting Report – 29th October 2014

Agenda item 314/15

Title	Sign up to safety
Sponsoring Director	Neil Rothnie – Medical Director
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Purpose	To inform the Board of the Trust's wish to sign up to this new initiative and agree the safety pledges.
Previously considered at	Corporate Team 14th October 2014
Executive Summary This paper is to give the Board an overview of an initiative by NHS England to reduce avoidable harm in the NHS over the next 3 years with the aim of saving 6,000 lives as a result. The Board are requested to review the safety pledges that have been identified, so that the next stages of signing up to the campaign can be taken forward.	
Related Trust Objective	1. Patient Focus – keep getting better
Related Risk	BAF Risk 2 – Patient safety, experience and outcomes compromised CRR: Risk ID – 12, 2093 and 72
Legal implications / regulatory requirements	Good governance demands that organisations look at initiatives to improve patient safety.
Quality impact assessment	The aim of this paper is to promote high quality care through having a plan of our safety objectives.
Equality impact assessment	Patient safety affects individuals in all of the protected characteristics. It is therefore highly important we ensure we have plans in place to improve.
Recommendations: The Board is asked to note this report and the safety pledges identified.	

Sign up to Safety - Listen, Learn, Act

The vision is for the whole of the NHS to become the safest healthcare system in the world, aiming to deliver harm free care for every patient every time. Sign up to Safety has an ambition of halving avoidable harm in the NHS over the next three years with the aim of saving 6,000 lives as a result.

Organisations are being asked to develop a plan that describes how we will reduce harm and save lives, by working to reduce the causes of harm and take a preventative approach. We are asked to identify two or more national patient safety priorities, such as medication errors or deterioration of patients (Appendix 1 shows the complete table), and two or more local priorities to focus our plans. We will then make public our plans and update regularly on progress against it. The ambition was to have 60 organisations sign up in the first 6 months, to date over 100 have joined the campaign.

While very few patient safety incidents result in a claim, all represent potentially devastating consequences for patients and can be very expensive for the NHS. The NHS Litigation Authority will review Trusts' plans and if the plans are robust and will reduce claims, we will receive a financial incentive to support implementation of the plan. Any savings made in this way have to be redirected into frontline care.

As an organisation that signs up to the campaign we will be able to draw on a variety of expert support to help ensure that we realise the ambitions described in our plans. These include the use of staff briefings and de-briefings, the use of communication tools, increased skills in investigations and communicating with patients, and the approaches to designing safe care using tools and techniques from other industries, including checklists.

We are invited to set out what our organisation will do to strengthen patient safety by:-

- Setting out the actions we will undertake in response to the five key pledges and agreeing to publish this on our website for staff, patients and the public to see.
- Committing to turn our proposed actions into a safety improvement plan which will show how our organisation intends to save lives and reduce harm for patients over the next 3 years
- Within our safety improvement plan we will be asked to identify the patient safety improvement areas we will focus on. We will be supported to identify 2 or more areas from a national menu of high priority issues and 2 or more from our own local priorities.

The Five Key pledges are:

- **Put safety first**. Commit to reducing avoidable harm in the NHS by half and make public the goals and plans developed locally.
- **Continually learn**. Make organisations more resilient to risks, by acting on the feedback from patients and by constantly measuring and monitoring how safe their services are.
- **Honesty**. Be transparent with people about our progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong.
- **Collaborate**. Take a leading role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use.
- **Support**. Help people understand why things go wrong and how to put them right. Give staff the time and support to improve and celebrate the progress.

The ideas listed below relate to what we believe the vision of our Trust to be and incorporating our quality strategy is;

Put Safety First

Safety is the Trust's number one priority and this is demonstrated by the actions that we are taking.

1. Managing the deteriorating patient. By implementing technology to support the deteriorating patients project, the hospital at night and patient handovers, sepsis bundle and AKI (Acute Kidney Injury).
2. Establish Patient Safety Champions. To have a robust process in place to support all of the work that we are undertaking and continue to reflect on our learning from events when things go wrong.
3. Establish a Clinical Safety Group. We will instigate case reviews of patient deaths and have up to date reporting on our Mortality and Morbidity to determine any harm events that may have been a contributing factor.
4. Patient involvement. We are fully committed to supporting patients to be involved in their care and we aim to work with patients, carers and staff to build this culture together in the "Do I know what is happening to me" project
5. Implementation of the SAFER bundle. We will introduce a SAFER (Senior Review, All patients having an estimated date of discharge, Flow, Early Discharge, Review) flow bundle to be developed and launched Trust-wide. The work will be focused on the timely and safe discharge of patients from our wards

Continually Learn

We want to improve systems for learning from complaints, claims, serious incidents and Inquests. In doing this we will take the following actions:

1. Take a proactive approach to the feedback from our patients and their carers by extending the work on sharing and Friends and Family free texting comments, feeding back the outcomes of claims, serious incidents and inquests to improve safety and the patient's journey.

2. Engage and undertake external audits and look at developing an external review panel for our complaints.

3. Training for our staff around human factors, including effective team working and reducing errors for all those involved in delivering patient care by implementing a simulation suite.

4. Continue to implement learning from the “perfect week”.

5. Strengthen our clinical governance structure and learn from unexpected deaths and near misses.

6. Learn from other organisations including root cause analysis training and sharing of Never Events.

Honesty

The Trust has a policy to have a duty of candour and we will ensure through training that staff are fully aware of their obligations and how to break the news when something has gone wrong. We will do this by:

1. Implementation of Business Unit training for staff in the duty of candour.

Collaborate

We will continue to collaborate with other Trusts by:

1. Having a clinical link to provide the leadership in developing our links with the community projects on early intervention of sepsis and AKI which will incorporate our links with working on the UCLH 6C’s project.

2. Developing our work with ARH Partnership and UCL partners on clinical safety projects.

3. Initially we will develop our non-elective 7 day pathway to reduce the risk to our high risk patients by developing Early Senior Clinician review 7 days a week; handovers between day and night staff and developing the “hospital at night” project. This will then form the foundation for the full 7 day working project.

Support

We make learning from harm and acknowledging duty of candour available for all of our staff by

1. Ensuring that the training is available during evenings as well as during the day

2. Supporting our staff during the Inquest process and will offer training sessions on RCA, action planning, preparing reports as well as inquest simulation training

3. Developing an online portal for case studies of Serious and critical incidents to be posted to develop the sharing and learning.

4. Participating in both national and regional learning events.

Next steps

Following agreement of safety pledges we are required to undertake the following over the next 90 days:

- Make public our pledges; place the logo on our home page
- Create our personalised safety improvement plan – nominating safety leads
- Identify and name campaign leads “Campaign Ambassadors” who can lead on local campaigns to mirror the national campaign activity
- Create a briefing for patients
- Garner support of the main commissioner and partners in care across the system
- Co-produce our plan with our Academic Health Science Network patient safety team
- Use existing measurement tools
- Support the campaign with volunteers

Appendix 1

Topic area	Patient Safety Topic							
The 'essentials'	Leadership			Measurement				
NHS Outcomes Framework improvement areas	Venous Thrombo-embolism	Healthcare Associated Infections	Pressure Ulcers	Maternity	Medication Errors	Deterioration in children		
Other major sources of death and severe harm	Falls	Handover and Discharge	Nutrition and hydration	Acute Kidney Injury	Missed and delayed diagnosis	Deterioration of patients	Medical Device Errors	Sepsis
Vulnerable groups for whom improving safety is a priority	People with Mental Health needs	People with Learning Disabilities	Children	Offenders	Acutely ill older people	Transition between paediatric and adult care		