



# Safety Strategy 2015–2018

## Introduction

Healthcare carries some risk and while everyone working in the NHS works hard every day to reduce this risk, harm still happens. Some is avoidable but most isn't. Whenever possible, we must do all we can to deliver harm free care for every patient, every time, everywhere. In 2011 the Trust agreed a strategy to improve safety. Whilst this realised significant improvements in both patient safety and a more open and learning culture, we now need to go even further and set out an ambitious, realistic and succinct strategy to reduce avoidable harm to all patients within our care and go further and faster to support all clinicians of providing a high level of safe care consistently to all our patients.

Delivery of this strategy supports the delivery of:

- The Trust's 2020Vision, to become a world-class clinical academic centre where staff work together to deliver the highest standards of health care in the safest environment
- The Trust's strategic objectives - trusted on quality, delivering for taxpayers and providing excellence in healthcare
- The Patient Improvement Framework
- The Quality Contract, Commissioning for Quality and Innovation (CQUIN)
- The Trust's Quality Accounts
- The Department of Health Operating Framework
- The Care Quality Commission safety Key Line of Enquiry (KLOE)

## Strategic aim

Our vision for 2018 is for a safety culture that is fully embedded and integral to our everyday business, where we are leaders in the field for driving improvements in the safety of our patients and where we have achieved a 50% reduction in the number of patients who suffer avoidable harm. Avoidable harm is best defined as harm that can be reduced by detecting and intervening to prevent an event or chain of events, or where there is evidence that an intervention can reduce or eliminating the harm

Safe care is achieved through reliability in care processes: by delivering the right care to the right patient by the right person, with the right level of competence, within the right time and in the right environment. It is when one or more of these elements go wrong, through either a systems failure or due to human factors that avoidable harm can occur. In reviewing our significant events it is still evident that often these are as a result of a series of errors or omissions. As part of this strategy we need to ensure that we have the appropriate safeguards and barriers in place to prevent such occurrence, underpinned by awareness and training that addresses the contribution of human factors on safety.

A fundamental responsibility of leadership throughout the organisation will be to create an environment where no one is hesitant to voice a concern about a patient or anything that puts the organisation at risk. Leaders will contribute to developing this culture by continuously messaging the core values, addressing behaviours that create unacceptable risk and focusing and debriefing on safety culture data.

We want to align fully our strategy to the NHS England sign up to safety campaign<sup>1</sup> to demonstrate our commitment we have made public 5 key pledges

**We will:**

1. Put safety first. Commit to reduce avoidable harm in the NHS by half and make public our goals and plans developed locally
2. Continually learn. Make our organisation more resilient to risks, by acting on the feedback from patients and by constantly measuring and monitoring how safe our services are
3. Be honest and 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
4. Collaborate. Take a leading role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use
5. 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

## Building on strong foundations for safety

The 2011-2014 safety strategy helped us deliver improvements for patient safety in reporting and learning from patient safety incidents, and in preventing avoidable harm by implementing the safety thermometer bundle.

As a Trust it is important that we learn when things go wrong and as such we take reported incidents very seriously. This year we launched the “safe care in our hands” campaign which included the roll-out of e-reporting of incidents, a focus on culture and asking staff to ‘speak up, speak out’ about practice which compromises patient safety as part of the Trust raising concerns (or whistle blowing) helpline.

E-reporting of incidents, including “near misses” has been well received by staff and it facilitates real time reporting and escalation in order that appropriate action is taken. It has also improved the reporting of themes down to ward level and feedback to those who have reported the incident.

In the national learning reporting system, we were outliers when benchmarked with other Trusts due to the lower number of incidents reported per 100 admissions, the timeliness of reporting and the higher numbers of incidents graded as high and moderate harm. Rolling out e-reporting has improved this position, seeing us move towards being a top reporting trust by reporting more incidents, in a more timely way with a lower number of incidents graded as high and moderate harm. As part of the roll-out we have trained over 2,500 staff using this as an opportunity to raise awareness of incident

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<sup>1</sup> <http://www.england.nhs.uk/signuptosafety/>

reporting, focusing on encouraging reporting near misses and training staff in the appropriate grading of incidents, focusing on actual rather than potential harm.

We have robust processes for the management of incidents and near misses where every incident is graded and analysed, and where required undergoes a root cause analysis investigation

The national safety thermometer is a prevalence audit tool that allows teams to measure harm and the proportion of patients that are “harm free” from four of the most common and preventable causes. These are pressure ulcers, patient falls, VTE (blood clot) and urinary infections due to catheters. The audit is undertaken on a monthly basis and submitted to a national database for benchmarking. We have consistently achieved over 95% for no new harms/new harm free care with over 1,100 patients audited each month.

In terms of actual incidents, real progress has been made with risk assessments for VTE consistently at 95% and reducing catheter related infections. However we did not achieve the challenging reduction in the number of falls and pressure ulcers against our own internal targets. Reducing these avoidable harms is a key focus of the 2015-2018 strategy.

Some safety work streams are well established and we will continue to monitor and sustain these

- **Infection prevention and control**
- **Care of the deteriorating patient**
- **Safer Surgery**
- **Preventing VTE's**
- **Medication safety**
- **Medical device safety**

These work streams are supported by

- **Values & Culture**
- **Quality Governance Strategy**
- **Infection Prevention Strategy**
- **Education and Learning Strategy**

## National context

There is an increased political and public awareness of the importance of safety in the NHS and our strategy endeavours to reflect the changing requirements from our local commissioners, our regulator Monitor and the CQC. There are a number of publications and investigation reports that have influenced our thinking on patient safety. In building this Strategy we have made reference to these in order that the learning and recommendations from these underpin our principles and plans for safety improvement:

**Appendix A** shows the synergy between the safety drivers of the UHS strategy and the key messages from these influential publications and reports

## 5 key initiatives for safety

In order to support the national aim of reducing avoidable harm in the NHS by 50% in the next 3-5 years<sup>2</sup> we will focus on 5 key safety topics. A safety improvement plan will provide clarity about what we want to achieve and when we want to achieve it by. This plan will be a key document used to discuss progress against the strategy at all levels of the organisation from ward to Board.

The plan will be an evolving document. It is recognised that improvement is a cycle of plan, do, study, act and these plans should and will develop as we learn what works and what doesn't.

The Safety Improvement Plan will set out how we will reduce avoidable harm in the organisation through focusing on 5 key initiatives

1. Reducing avoidable harm to patients who have an inpatient fall
2. Reducing avoidable harm to patients caused by pressure damage in adults and children
3. Improve the recognition and timely management of Sepsis in adults and children
4. Prevent and minimise the impact of Acute Kidney Injury in adults and children
5. Reduce complications from failure to interpret or act on abnormal CTG tracing in labour

## How are we making the strategy a reality? What will enable us to improve the safety of care we deliver?

### Aim

**Put safety first.** Commit to reduce avoidable harm in the NHS by half and make public our goals and plans developed locally.

### Objectives

- Align the 2014-17 University Hospitals Southampton NHS FT safety strategy to the sign up for safety pledge and incorporate the safety priorities into our safety driver diagram
- Publish local improvement plans to halve avoidable harm for our 7 key safety initiatives
- Adopt and publish safety briefings for patients and their families to allow them to actively participate in the safety of their care
- Use the safety thermometer to inform and drive improvement in reducing avoidable harm
- Drive reliability of delivery in care processes to reduce avoidable harm
- Communicate our approach and progress on our safety journey from Board to ward

### Aim

**Continually learn.** Make our organisation more resilient to risks, by acting on the feedback from patients and by constantly measuring and monitoring how safe our services are.

### Objectives

- Review our use of data for measurement and improvement of safety in order to use data more intelligently
- Conduct Internal Quality reviews which seek to monitor the safety of departments

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<sup>2</sup> <http://www.england.nhs.uk/signuptosafety/>

- Review 20 notes a month of inpatient deaths to identify aspects of care delivery for improvement, learn from good practice and provide quality assurance on the safety of care
- Develop mechanisms for hearing and acting on patients safety concerns or ideas
- Implement a patient and carer empowerment campaign
- Implement safety walkabouts underpinned by training that focuses on safe and unsafe acts
- Roll out favourable event reporting across the trust to ensure that we focus on safe acts to reinforce these safe behaviours

### Aim

**Be Honest.** 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.

### Objectives

- Ensure all staff understand and abide by the principles of openness and candour
- Provide training and support for staff in saying sorry
- Provide written information for patients and families following a safety incident on what we have learned and the actions we have taken
- Recruit patient representation to key safety work streams

### Aim

**Collaborate.** Take a leading role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use.

### Objectives

- Actively participate in the patient safety collaboratives
- Work across health care providers to reduce avoidable harm, building on links with our clinical commissioning groups and community partners
- Seek to learn from excellent safety practice and ideas in other Trusts

### Aim

**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.

### Objectives

- Maintain an open and honest reporting and learning culture; a culture that creates light not heat
- Identify and implement actions on key root cause themes sharing these across the organisation
- Actively seek to develop patient safety fellows in the organisation each year
- Host a patient safety conference to share and celebrate successful initiatives
- Develop quality material to share learning across the organisation when harm has occurred
- Engage staff and raise the profile of our commitment to safe care
- Improve and embed knowledge and skills in investigation and management of incidents
- Develop and maintain a training programme has a focus on human factors
- Create a network of experts to support staff during the process of investigations
- Develop a recognition and rewards framework to celebrate safety

- Identify opportunities to invest in patient safety and achieve cost reduction through reduced harm to patients.

**Appendix B** demonstrates the key aim, drivers and work streams of the UHS Safety Strategy

Our approach is built on:

- Continuing to develop a culture where there is visible senior management and leadership commitment to safety, shared care and concern for risks and a zero tolerance for avoidable harm and continual reflection of practice through monitoring, analysis and feedback systems
- Putting in place appropriate measures to minimise the risk of harm
- Improving the reliability of processes to reduce variation in clinical practice or provision of sub optimal care, and our ambition to do no harm to patients
- Setting up robust systems to ensure that any incidence of harm to patients is both reported, escalated and monitored
- Making best use of information to ensure that safe and effective care is maintained and that any areas of concern are identified in a timely fashion and acted upon
- Learning from episodes of harm to ensure that best practice is achieved and shared across the organisation. Being transparent with our patients when harm has occurred, in a timely and unequivocal manner.

## Measuring and monitoring for safety

We will use the Vincent et al framework<sup>3</sup>, which is underpinned by a rigorous review of the relevant literature and survey of current practice. This framework highlights five dimensions, which should be included in any safety and monitoring approach in order to give a comprehensive and rounded picture of a healthcare organisation's safety.

Measuring harm is not equivalent to measuring safety but is an essential foundation. Whatever approach is taken to measure harm, it must be valid and reliable. It is important to pay attention to the reliability of the data source and to clearly define what kind of harm is being measured. We need to provide a more rounded approach to safety measurement and monitoring, looking beyond the measurement of harm.

Table 1 shows what measures we propose to use in each of the 5 dimensions

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<sup>3</sup> Source: Vincent C, Burnett S, Carthey J. *The measurement and monitoring of safety*. The Health Foundation, 2013

**Table 1**



Source: Vincent C, Burnett S, Carthey J.  
*The measurement and monitoring of safety.*  
 The Health Foundation, 2013

## Next Steps

To achieve our ambitions by 2018 will require continuous improvement and ongoing evaluation of our performance year on year against our strategic objectives.

This strategy will therefore be reviewed annually as part of the production of the Quality Accounts and reflected in our annual plan. The Safety Strategy can only become embedded into our daily approach to caring for patients if all members of staff are aware of what we are striving to do. Every member of staff needs to understand what needs to change, why it needs to change and how to make change happen. We should also take the opportunity to celebrate success and build on what we are already doing well.

- Development of improvement plans to deliver actions for key drivers
- Application to NHS Litigation Authority for funding to support the sign up to safety campaign
- The Safety Strategy will be promoted both internally and externally using a variety of channels, including: Dedicated area on the public and staff website for sign up to safety campaign and a personalised letter to each member of staff from the Medical Director and Director for Nursing

# Responsibility for delivery of the strategy

The **Director of Nursing** and the **Medical Director** have overall executive responsibility, on behalf of the Board, for the delivery of this strategy.

**Executive Directors** have a responsibility to uphold the Trust's vision and to ensure that clinical quality is a priority for the trust. The Executive Directors are pivotal in influencing senior operational management teams, corporate services and support teams, and in ensuring that the quality of patient care is always considered in business discussions and strategic and operational decision-making.

The **Associate Medical Director and the Director of Quality** have delegated responsibility for overseeing each aspect of the key themes identified within the strategy to ensure that they are delivered and monitoring performance.

**Trust Head Quarters** has a crucial role in encouraging linkages between divisions and corporate departments to support delivery of the safety strategy and work-streams. Each corporate team must recognise how delivery of their key strategies e.g. estates and training and development, impact on patient safety and ensure that any risks to delivery of these strategies recognise and seek to mitigate potential harm to patients

**Work stream leads** have responsibility for overseeing the delivery of the annual work stream plans and securing clinical engagement to them.

**Safety champions** have responsibility for:-

- Ensuring clinical engagement in the safety agenda
- Role modelling through leadership to achieve a safety culture
- Assist the Divisional Clinical Director and the Care Group Clinical leads in Identifying safety themes in specialties and sub specialties
- Assist the Divisional Clinical Director and the Care Group Clinical leads in development and delivery of safety initiatives in specialties and sub specialties

The **Trust's Patient Safety Team** has responsibility for: -

- Supporting the Divisions in the management and learning from incidents and significant incidents requiring investigation (SIRI's).
- Providing assurance on external standards relating to safety
- Supporting the work stream leads in delivery of the action plans
- Providing training on patient safety through an agreed annual training plan
- Ensuring that the incident reporting and management policy is complied with through a program of audit.
- Undertaking impact analysis to ensure that actions taken as a result of incident investigation have appropriately mitigated the risk
- Participating in patient safety walk-about

The **Divisional Management Teams** have responsibility for ensuring that action is taken against the work streams, setting local Divisional targets against the key metrics, overseeing the investigation of incidents and ensuring that learning is embedded.

**All UHS employees** have a responsibility to

- Highlight risks to patient safety



- Report incidents
- Be open and honest with patients and their families
- Commit to providing safe care
- Ensure learning is embedded

The support structure for delivery of the safety strategy is shown in **Appendix C**

## Appendix A

- **Courage and compassion** to create an open and honest culture
- **Commitment** to reduce avoidable harm from Board to ward
- **Competent** staff to ensure reliability of systems
- **Communication** to make patients active participants in safe care

6C



- Constant vigilance, monitoring and learning to make sure our patients do not come to avoidable harm.
- Creating a culture of learning and transparency
- Analysing and understanding data and information on our own performance o making sure we identify risks to patient safety and continually reducing these risks

Berwick




- Setting and monitoring of safety goals
- Approach and systems for safeguarding adults and children and child protection
- Understanding and management of foreseeable risks
- Consistently learn when things go wrong and improve standards of safety as a result of the learning

KLOE



- Emphasis on and commitment to common values throughout the system by all within it
- Readily accessible fundamental standards and means of compliance
- Openness, transparency and candour in all the system's business
- Strong support for leadership roles
- Information accessible and useable by all allowing effective comparison of performance by individuals, services and organisation

Francis




- A public commitment to Sign up to Safety
- Our key aim is to reduce avoidable harm.
- A clear framework for improvement
- We have formed part of a safety collaborative in Wessex a regionally based safety improvement network led by the Academic Health Science Network that will work across whole local systems and all health care sectors, to deliver locally designed safety improvement programmes drawing on recognised evidence based methods.

Sign up to safety

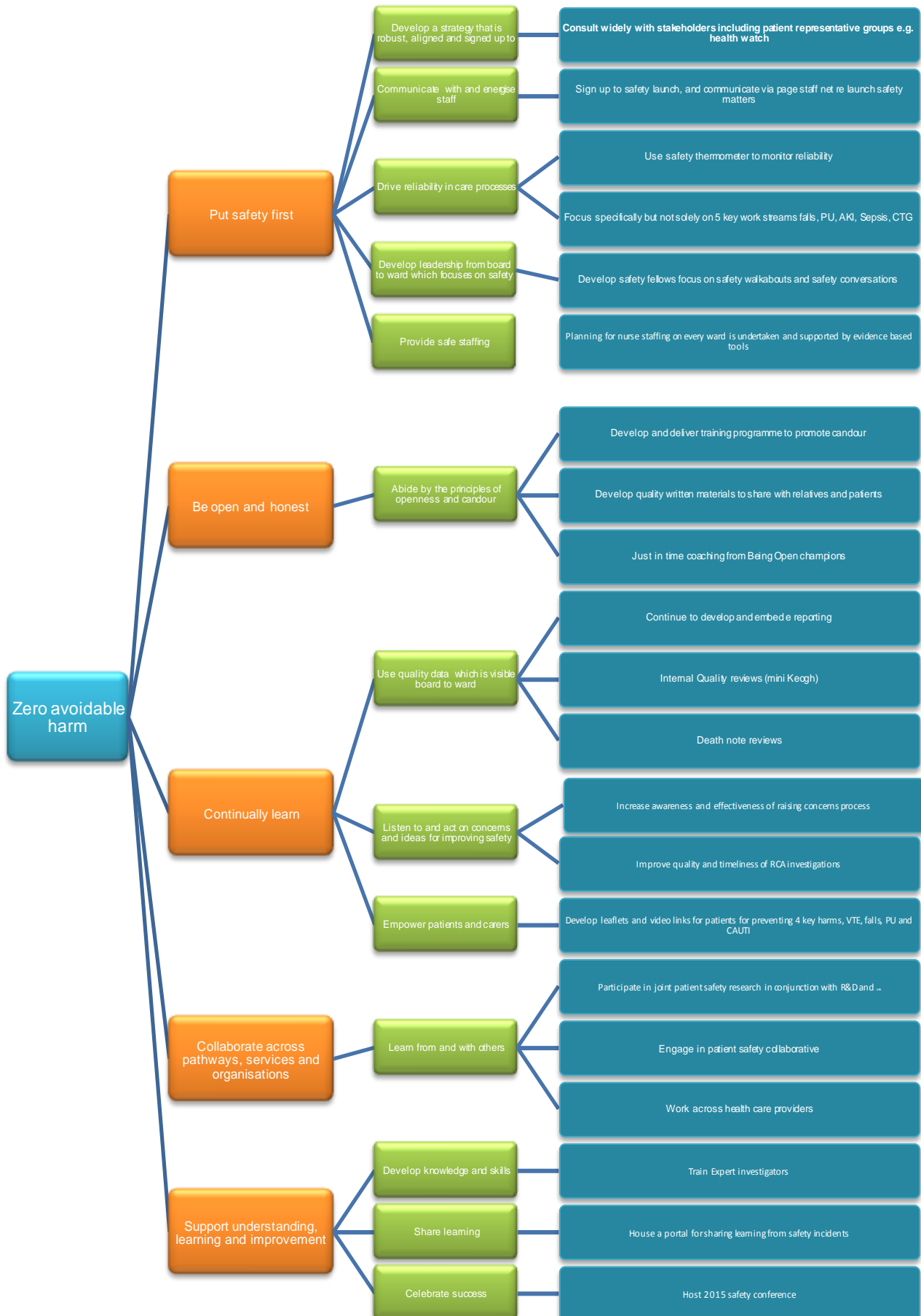


- Reduce number of harm incidents reported as 'moderate, severe or death
- Reduce Number of 'Never Events
- Consistent reporting of Patient Safety incidents
- Focus on reduction of Pressure Ulcers
- 'Monitor and reduce harm' for all four Safety Thermometer Indicators

Keogh



## Appendix B Sign up to Safety Driver Diagram



Structure supporting patient safety

