NHS South Central

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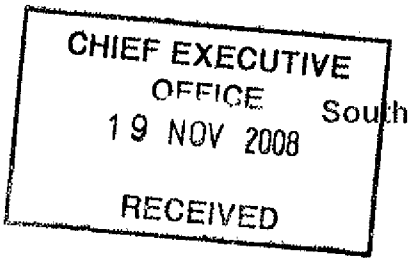
NHS South Central
Chief Executives



17 November 2008

→ ① RICHARD SAMUEL
② FIONA SMART
FYI 20/11

Dear Colleague

Patient Safety Federation - The Next Steps

The best evidence tells us that we harm 1 in 10 patients admitted to NHS Care – and that 50% of these incidents could be prevented with better systems and processes. This is not acceptable. Individual organisations, and together through the Patient Safety Federation, we have begun to tackle this - but I believe these efforts are not yet sufficient.

I am writing to ask you to consider a significant increase in the funding for the Patient Safety Federation and to engage in a system wide effort to measure, and to publish the measurements of, patient harm.

We need to measure harm systematically and rigorously. We need to systematically put processes in place to root out the cause to prevent future harm. The scale of the change required is unprecedented.

Now that quality and safety are the overarching principles of the NHS, the leadership community has to drive the changes required, equip and enable front-line staff to make the changes. The skills, tools and techniques necessary to implement the changes are well known. What is needed is a concentrated effort to use them. This requires focussed leadership and resources.

NHS South Central has shown its commitment to driving this agenda by establishing the Patient Safety Federation, which is owned and led by your organisations. You all supported its establishment by contributing £10k last year. The progress it has made is reported in the attached sheet. It has achieved a significant amount and has started the movement of change in pockets across the region. But it is dependent upon the good will of its leaders going the extra mile in their spare time.

It is time to mainstream this work and provide the infrastructure needed to sustain and measure the changes. I would like to formally ask all Boards to consider increasing this amount to £100k per organisation from 2009/10 onwards.

These resources would be applied by you in pursuit of the goals and programmes set out in the draft Patient Safety strategy (attached). The process of consultation runs from now until the SHA Board meeting in February. I would like you to consider adopting the final version of this strategy with your Board. We very much need your thoughts and views during the period of consultation so that we have a strategy that is owned by each of our organisations.

You will see that the central aim is to "*REDUCE THE RATE OF PREVENTABLE HARM AND DEATH BY 50% AS MEASURED BY GLOBAL TRIGGER TOOL BY DECEMBER 2015*" This is a significant commitment.

It will also require the introduction of new measurement and information systems.

I would like to ask all Boards to consider voluntary participation in a programme of collecting and jointly publishing the key data required by the strategy. This would not be the SHA collecting and publishing information for performance management, but the local NHS deciding to collect and publish key data to support improvement. I recognise this will require careful handling.

Please find enclosed a copy of the DVD of the conference held recently - which was very well attended and evaluated.

A workshop led by myself will be held on the 21 January to which a number of CEO's will be invited. This event will finalise the strategy and associated resources prior to its adoption by the SHA Board.

I look forward to your support for this important work

Yours sincerely

Code A

Jim Easton
Chief Executive

cc Katherine Fenton

Enc – DVD / Pat Safety Strat (draft) / progress so far PSF

NHS South Central Patient Safety Strategy 2009-2011

Trusts across NHS South Central have a track record for the commissioning and delivery of high quality and safe care. We know this is not always been consistently applied across organisations. Patient Safety is now subject to a number of high profile national and international campaigns. This is not enough. In the UK it is estimated that 1 in 10 patients continue to be the victims of avoidable harm.

NHS South Central has placed patient safety as central to its agenda and has shown this commitment through the establishment of the Patient Safety Federation which is owned by its organisations. In driving this agenda the SHA wishes to agree a strategy with all Trusts, ensuring that this both is complimentary to the national campaign and supports local services in their work to improve patient safety.

Quality and patient safety has been declared as the overarching operating principle of the NHS.

Our future aspiration is to be recognised as being at the forefront of patient safety both nationally and internationally. Implementation of this strategy will serve to enhance organisations reputations, significantly reduce harm and reduce costs incurred through error, securing a sustainable future as highly reliable organisations delivering on safety, cost, performance and quality.

Following a full consultation process to gain agreement and local ownership, all Chief Executives will be asked to sign up to it's implementation and to support it with appropriate resources.

Preface by Katherine & Jim

Signed

The overall aim of the Patient Safety Federation
"To improve patient safety in all healthcare organisations
across South Central and to lead the way
Nationally and Internationally in reducing harm to patients".

"Continuously improving patient safety should be at the top of the healthcare agenda for the 21st Century. The injunction to do no harm is one of the defining principles of the clinical professions".

"...Safety must be paramount for the NHS. Public Trust in the NHS is conditional on our ability to keep patients safe when they are in our care"

Darzi, High Quality Health Care for All

1. Setting the Context

1.1 This strategy sets out to ensure that: -

"By 2011, Patient Safety is driving every South Central Board agenda and that the safety of the patient is demonstrably an integral part of our Commissioners and Providers day-to-day business."

REDUCE THE RATE OF PREVENTABLE HARM AND DEATH BY 50% AS MEASURED BY GLOBAL TRIGGER TOOL BY 2015

1.2 Our strategic goals are, to ensure that by 2011: -

- Safety is a living priority for every organisation
- Every organisation has plans and quantified goals for improvement
- Every organisation is using the best knowledge available to reach these goals

1.3 The strategy is underpinned by evidence based guidance on patient safety both nationally and internationally, the work of the Patient Safety Federation and the assurance and regulation required for Patient Safety through the Operating Framework, the Next Stage Review and the SHA's Towards a Healthier Future. The strategy provides an external catalyst for change to Patient Safety, across all organisations, by promoting success, spreading good practice and fostering a patient safety culture.

1.4 The strategy:-

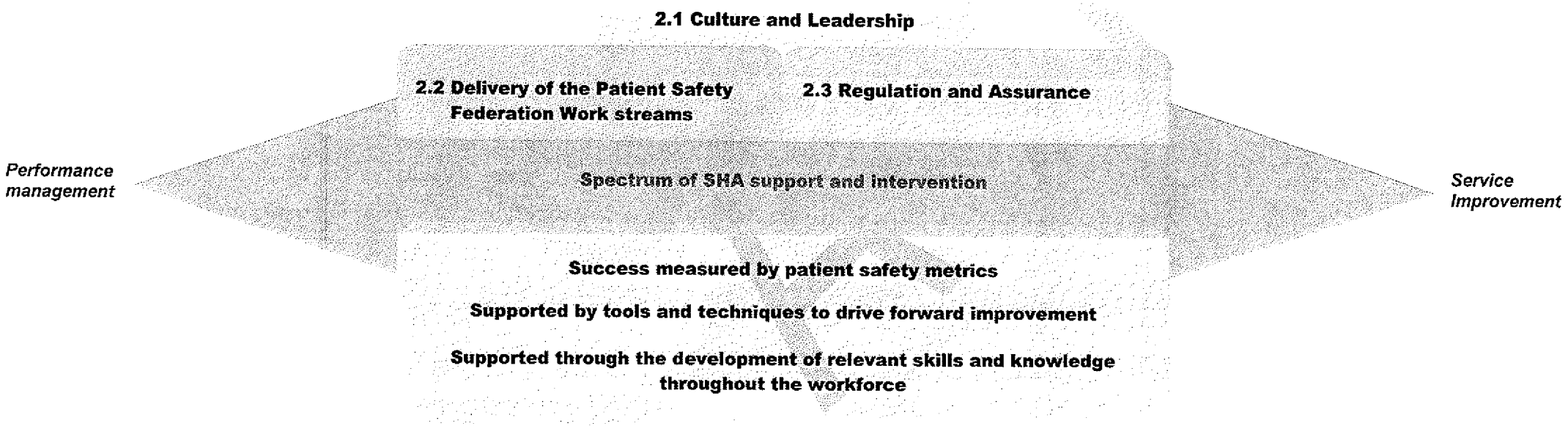
- Supports the challenges set out in "High Quality Health for All"
- Is aligned to and builds on the National Patient Safety Campaign, "Safety First"
- Reflects the South Central Strategic Health Authority's vision "Towards a Healthier Future" (particularly ambitions 7 and 9)
- Forms the basis for the implementation of the South Central Strategic Health Authority (SCSHA) Service Improvement Strategy
- Supports the Clinical Advisory Strategy
- Will underpin and support the delivery of local Patient Safety Strategies across NHS South Central

1.5 There is a concordat of organisations supporting NHS South Central in delivering this strategy, including the National Patient Safety Agency, the Healthcare Commission, the Health Foundation, Imperial College, London and the NHS Institute for Innovation and Improvement.

1.6 The South Central Patient Safety Action Team (PSAT) will facilitate and support the local implementation of the national patient safety agenda, complementing and supporting the work of Trusts in delivering this strategy. The PSAT will also develop links to the patient, carer and Patient Safety Champions and seek to bring their voice to the fore in safety developments.

2. Themes

There are three key themes for this strategy, which are shown in the diagram below:-



The involvement of the Strategic Health Authority in patient safety is seen across a spectrum: from the requirement for intervention and performance management where there is unsafe practice and within the context of it's statutory responsibility to the ultimate aim of providing support for quality and service improvement. Performance management will increasingly be delegated to the Commissioners of care as set out in World Class Commissioning.

Successful delivery of the key themes will need to be measured by the development of a Patient Safety Barometer, supported by relevant tools.

To support the successful delivery a patient safety training and development plan will be developed in collaboration with Trusts and NHS Education South Central. This will include Board development, a training package for local patient safety officers, the development of local improvement skills through the PDSA cycle and an increase in human factors simulation training for frontline staff.

How the key themes will be delivered across NHS South Central is contained in appendix 1

2.1 Culture and Leadership

Ambition 1: **To develop a culture where patient safety is integral to organisational business.**

In the development of their local plans and strategies Trusts are asked to consider the following actions: -

- To introduce Patient Safety Executive Walk rounds (supported by a package)
- To agree three metrics to be reported across NHS South Central
- To agree three metrics to reported at the Board
- To review Governance structures and Board level accountability to encompass patient safety

A framework for organisations developing Patient Safety is set out in appendix II

2.2 Delivery of Patient Safety Federation Work streams

Ambition 2: **To support and facilitate the delivery of the PSF work streams and deliver a 30% reduction in avoidable harm.**

The patient safety work steams are set out in Appendix III. The Patient Safety Federation will continually evaluate the delivery of the work streams and the requirement for further work streams. The PSF will commission a undertake a review of Board reporting on Patient Safety and implement the findings from the review.

2.3 Regulation and Assurance

Ambition 3: **To deliver compliance of the Operating Framework, ensure lessons are learnt from SUI's, deliver 100% compliance against Standards for Better Health and develop patient safety improvements with the Annual Quality Accounts**

This will be achieved through robust commissioning and monitoring with agreed escalation and processes for improvement against non- compliance

3. Conclusion

3.1 This strategic framework will be supported by implementation plans agreed by NHS South Central Oganisations

3.2 Progress of implementation of this Strategy will be reviewed on a regular basis and reported to the Patient Safety Federation, at Trust Board level and the Strategic Health Authority Board. This progress will be best demonstrated by an overall improvement in the patient safety metrics.

3.3 Signing up to this strategy will see a reduction in avoidable harm to our patients, an improvement in patient care and a culture where Patient Safety is an integral part of everything we do. NHS South Central will have highly reliable organisations, with a reputation of being at the forefront of patient safety.

Appendix I: How will it be delivered?

Organisation	Levers for Delivery: -
South Central SHA	• Supporting all Trusts in their drive to improve Patient Safety and delivery of their plans • Building partnerships across the SHA to share learning and experience • Co-ordinating relationships with National organisations • Coordinating and leading the Patient Safety Federation • Statutory remit and the Operating Plan • Acting as a conduit for accessing expertise and through the knowledge base of the Quality Observatory • Monitoring system improvement, identifying areas for support and targeting areas for service improvement
The Patient Safety Federation	• Redefining the work streams and overseeing the delivery of the work stream project plans • Advising on standards and priorities for the SHA, through leadership goals and through the commissioning process • Facilitating grass roots activity through workshops and learning events • Increasing commitment and capability to leadership, supporting Board development and Safety Patient Initiatives • Acting as a practical resource for Trusts and providing a knowledge warehouse for patient safety • Identifying areas for future training in partnership with NHS Education South Central • Reviewing collated clinical patient safety metrics and identifying areas for future service improvement
Commissioners	• Robustly dealing with any failures of safety through the enactment of the performance management regime • Choosing priorities of "never events" to be contained in their annual operating plan • Incorporating standards and key patient safety performance indicators within their annual operating plan Vital Signs • Seeking regular assurance from providers on patient safety, clinical outcomes, Standards for Better Health, implementation of NICE guidelines • Seeking external support and service improvement for non compliance or lack of assurance against the contract
Trusts	• Developing and implementing local Patient Safety Strategy and goals to reflect this strategy • Empowering an Executive Director to lead on Patient Safety and oversee the implementation of local plans • Providing annual quality accounts which include patient safety improvements • Reporting patient safety and clinical outcomes at Board meetings • Supporting the work of the Patient Safety Federation • Signing up to Patient Safety First campaign • All Trusts across NHS South Central to develop Safer Patient Initiatives organisations

Appendix II: Patient safety Framework

The Patient Safety Framework adapted from the Institute for Health Improvement (IHI) sets out an approach for organisations the delivery of this strategy
Broad framework supported by Regional and Individual Trust development

Patient Safety Framework

Achieving safe and Reliable healthcare aligning:-

Strategy
Structure
Work
Environment

Organisational Strategy

- Requires outstanding leadership
- Evidenced based care
- Sustainable Safety culture
- Enhanced workforce
- Market place success

Organisational Structure

- Governance Committee with oversight of safety
- Clear reporting relationships
- Incentives (alignment between reimbursement and quality)
- Appropriate resources
- Effective Design for reliability

Work and Measurement

- Fair and Just culture
- Accountability principles
- Patient involvement
- Training
- Leadership engagement
- Using appropriate tools and techniques, e.g. LEAN, project management, social marketing, GTT
- Agreed clinical metrics
- Reporting and audits
- Risk assessments
- Patient Safety Culture surveys
- Learning from Serious Untoward Incidents

Using Reliable design and human factors, enabled by Information technology

Appendix III The Patient Safety Work steams

Work Stream	Success measures; by 2011:-	Source
No needless deaths	10 % reduction in number of deaths (as measured by patients who are admitted and die in our care)	HES
No needless harm	50% Reduction in avoidable harm as measured by Global Trigger Tool	
No needless falls	30 % reduction in number of falls reported as incidents	NRLS data
No needless pressure ulcers	30% Reduction Pressure ulcer incidence and rates	NRLS data
No needless malnutrition	30% reduction in the number of reported incidents associated with malnutrition	NRLS data
No needless ignorance	5% NHS South Central staff trained in human factors	NESC
No needless medication errors	30 % reduction in Medicine reconciliation Anticoagulants 20% improvement in Medicine Storage Reduction in medication reported incidents	NRLS data
No needless Healthcare Associated Infection	Zero avoidable Hospital Acquired Infection 20 % reduction in VAP 30% improvement in care bundles audits	UNIFY

Progress on Patient Safety Work Streams
November 2008

This report provides a brief summary of the progress to date on the Patient Safety Federation work streams.

Patient Safety Federation Overall Aim

"To improve patient safety in all healthcare organisations in the South Central Areas and to lead the way nationally and internationally in reducing harm to patients"

No Needless Pressure Ulcers

Lead: Suzie Loader, Director of Nursing, Heatherwood and Wexham Park NHS Foundation Trust

Aim:
To eliminate needless skin breakdown amongst the population of South Central'

Progress:
Terms of Reference agreed
Two workshops held with Tissue viability nurses
Committee Structure and work plan established with 4 work streams: -

- **Education**
  Needs Analysis undertaken, competence statements for staff and agreement to a range of policies which underpin care
- **Resources**
  To work up and submit bid to support work stream
- **Raising the profile**
  Developing a role definition, assessment of current profile under way, planning a raising the profile campaign
- **Data & tools**
  To support consistent and complete reporting of incidents around pressure ulcers and falls

No needless Falls

Lead: Judy Hillier, Director of Clinical Services, Portsmouth City Teaching PCT

Aim:
To reduce the incidence of falls across home, community and acute settings.

Priorities

- To agree and standardise a set of board and practice level metrics to assess performance
- To develop 20 Key principles to share evidence based practice
- To develop 10 Quick wins to share transformational practice
- To establish relevant practitioner and commissioner networks both actual and virtual linked

Progress:

- Steering Group established including public health and commissioning in quality links
- Relevant practitioner and commissioner networks both actual and virtual linked established
- Basic metrics assessed and shared with organisations
- 20 Key Principles agreed and shared with NPSA and HCC

No Needless Medication Errors

Lead: Sheila Paul, Chief Operating Officer, Isle of Wight

Aim: To reduce the number of medication errors

Progress

Established steering group
Identified work streams:-

- **Promoting Safer Use of Injectable Medicines**
  A common agreed list is now available to support nurses and pharmacists, and a procurement project to contract for ready made infusions for high risk medicines is underway
- **Reducing Medication Errors along the Patient Pathway – Patients Own SCSHA Green 'Pod' Bags**
- **Safe Admission To Hospital, Reconciliation Of Medicines**
  A collaborative hub is producing SHA wide policies, standard operating procedures, and audit tools for medicine. This ensure that all adults admitted into a hospital in NHS South Central are assessed by consistent processes within 24 hours of admission.

No Needless Ignorance – Human Factors

Lead: Fizz Thompson, Director of Clinical Services, South Central Ambulance Service

Aim: To become more proactive in identification and prevention of causes of harm to patients, and in particular the contribution of human factors

Current Projects

- Exploration of available human factors training to all NHS staff
- Use of simulation to engage and promote human factors and communication skills
- Formation of DVD to provide 'real life' case study (mental health/primary care)
- Identifying 3 key elements of 'handovers' and audit use across South Central

Future Developments

- Case studies on DVD's that are relevant to all areas and Trusts to use as part of education programmes
- Move towards consistent core approach to patient handovers
- More staff trainers to help reflect and teach about use of communication skills and human factor interactions

No Needless Deaths

Lead: Rory Shaw, Medical Director, Royal Berkshire NHS Foundation Trust

Aim: *10 %* reduction in number of deaths (as measured by patients who are admitted and die in our care)

Progress

- Discussion on appropriate measurement for deaths at Medical Directors Forum, agreed that the measure should provide system issues not individual competencies
- Serious Untoward Incident reviews
- Lessons from SUI's fed back to commissioner, provider and mental health forums

Next Steps:

- Work shop to be held in December to determine the future project plan and supporting metrics
- Empirical research project to be undertaken to support the work stream
- To agree how deaths should be reported at Board level
- To align Never Events
- Multi-disciplinary working group to be established
- Align work undertaken on the deteriorating patient with this work stream

No Needless Harm

Leads: David Birnie, Associate Medical Director, Portsmouth Hospitals NHS Trust & Anne Owen, Director of Clinical services, NHS Berkshire West

Aim: To reduce the rate of preventable harm and death by 50% as measured by the Global Trigger Tool by December 2015

Progress

- Two work shops held this year providing training to clinical teams in undertaking Global Trigger Tool
- Funding provided to support the implementation of GTT audits
- All acute Trusts implementing GTT to a greater or lesser extent

Next Steps

- To review and identify future training requirements and develop training package
- To reviewing reporting mechanisms i.e. ensure GTT reviews are being reported to the right committee and staff groups for action.
- To refine / standards and process
- To form a network for central reporting across NHS South Central
- To develop a combined report sharing how the Trusts are implementing GTT and how information is communicated
- To identify future funding requirements
- To develop a project plan for GTT
- To report back on collated themes and findings to relevant Patient Safety Federation work stream

No needless malnutrition, Hunger or Thirst

Lead: Gill Prager, Director of Clinical Standards and Engagement, Milton Keynes PCT

Aim: The PSF Nutrition Group are working together to ensure that all patients in South Central Region receive the best nutritional care

Progress

The Steering Group have identified three key aims:

- Every person in a care setting will have nutritional screening and appropriate care plan.
- All Carers (paid or unpaid) will have mandatory nutrition training.
- Board members will be accountable for leadership and ensuring best nutritional care in all organisations.

- **Metrics / Measurement**
  - R&D Audit
- **Patient & Public Empowerment**
  - Involvement
  - Appropriate representation on Steering Group
- **Communications**
  - Awareness
  - Campaigns
  - Standardisation
  - Information

Next Steps

- 26/11 'e' learning programme for Nutrition
- 26/11 Steering Group
- Agree Leads for Work streams & Key Deliverables
- Baseline Assessments Jan – Feb – Work plans developed

No Needless Infection

Leads: Tony Berendt, Medical Director, Nuffield Orthopaedic Centre NHS Trust & Judy Gillow, Director of Nursing of Nursing, Southampton University Hospitals NHS Trust

Aim: To aim for zero avoidable infections by 2011 and adopt a zero tolerance for poor practice

Progress

- Structure in place i.e. Directors of Infection Control & Prevention Meetings & North and South Community Healthcare Associated Infection Network Meetings
- Across South Central on target to deliver MRSA and Clostridium Difficile limits for 2008/09
- NHS South Central Healthcare Associated Infection plan agreed
- All Trusts have developed and are implementing HCAI plans
- Terms of Engagement agreed for level of intervention
- Peer review audit agreed for implementation across NHS South Central

Next Steps

- Agree plan for aiming for zero
- Determine definition for unavoidable HCAI's
- Agree project plan for the way forward

Further information van be found on the Patient Safety Work streams on our website
www.http.patientsafetyfederation.nhs.uk