Shropshire Community Health NHS
NHS Trust

Safety Improvement Plan

Feb 2015 – Jan 2018

Authors:

Andrew Coleman Deputy Director of Nursing and Quality
Dee Radford Lead Nurse for Quality

Index **Page**

Foreword **3**

Our plan for safety **4**

Aligning our plan **4**

Delivering our plan **5**

Evaluating our plan **5**

Sharing our success **5**

Appendices:

Appendix one: Our overarching plan – driver diagram 6
Appendix two: Our timeline for improvement 7
Appendix three: Metrics for improvement 8

Foreword

This Safety Improvement Plan has come about to support our commitment to the Sign Up to Safety Initiative, which aims to reduce avoidable harm to patients across the NHS by 50% over the next three years.

The plan will be part of our overarching Quality Strategy in which we set out our commitment to be “the best at what we do”. Our values further demonstrate how we plan to ensure that our patients, their families and their carers and our staff receive the care and support they deserve from us either in terms of interventions or enabling them to do their jobs.

We are developing a process called “Values into Action” – enabling teams and individuals to use safety improvement methodologies to improve care and drive developments in their areas. Our Safety Improvement Plan is an important factor in this work as it will help teams to identify priorities on which to concentrate.

When we made our commitment to the Sign Up to Safety Campaign at the end of January 2015 we agreed that we would support the five pledges of the campaign, namely:

- Put Safety First
- Continually Learn
- Honesty
- Collaborate
- Support

We gave specific actions that we would take to support these pledges which will be reflected in this three year plan.

We agreed key areas that we would concentrate on for the next three years where we felt we could make a measurable difference. These are:

- Reducing medication errors
- Transition between paediatric and adult care
- Handover and discharge
- Reduce the number of people absent from work through sickness

We particularly want the difference we make to show improvements in care for vulnerable people as so many of those that we care for are potentially at risk through age, disability, social factors or other reasons and so this is of paramount importance to us. However, this is not to say that there are no other initiatives that we will be working on at the same time – for example, we are determined to reduce the number of people that fall in our community hospitals.

The pages that follow show what we plan to do and how we will ensure that this is a dynamic process that flexes with the needs of our population and our partners in care provision, how we are going to deliver it and how we will measure and share our success.

At all times our Sign Up to Safety work will reflect our vision, contribute to our strategic objectives and help us to live our values.

Our Plan for Safety

The driver diagram at Appendix one shows a high level view of our plan for safety. It shows that our Sign up to Safety commitment is integral to our strategic goals and our values.

To get the plan off the ground we have identified a timeline to ensure that we are sighted on what we need to do. The timeline is at Appendix two.

The specific metrics to support the five pledges of the campaign are at Appendix three.

Below the overarching plan are specific plans for the priority areas that we said that we would really concentrate on. These are also reflected in our Quality Account for 2015-2016 to really demonstrate our commitment to this initiative.

Aligning our Plan

We are very clear that our commitment to the campaign is part of our wider commitment to quality. Therefore the plan will be reflected in or will reflect key strategic documents and priorities as shown below. Not only will this ensure that the initiative stays at the forefront of all we do but it will also be relevant to staff and patients in that it will become business as usual.

Delivering our plan

We will all work together to deliver the plan. Therefore we all need to work together to agree how we are going to do it. We will give our clinical teams assistance to show how they will deliver the plans by:

- Asking them to identify a Safety Improvement Champion to lead the initiative in their area
- Helping them to identify the data and information they need to show their starting point
- Helping them to complete a driver diagram to show how they will change practice
- Assisting them with improvement methodologies/measurement information and other support they need to drive this forward
- Requiring them to feedback at agreed intervals about their progress

We (the corporate teams such as quality, risk, human resources and anyone else that is identified) will:

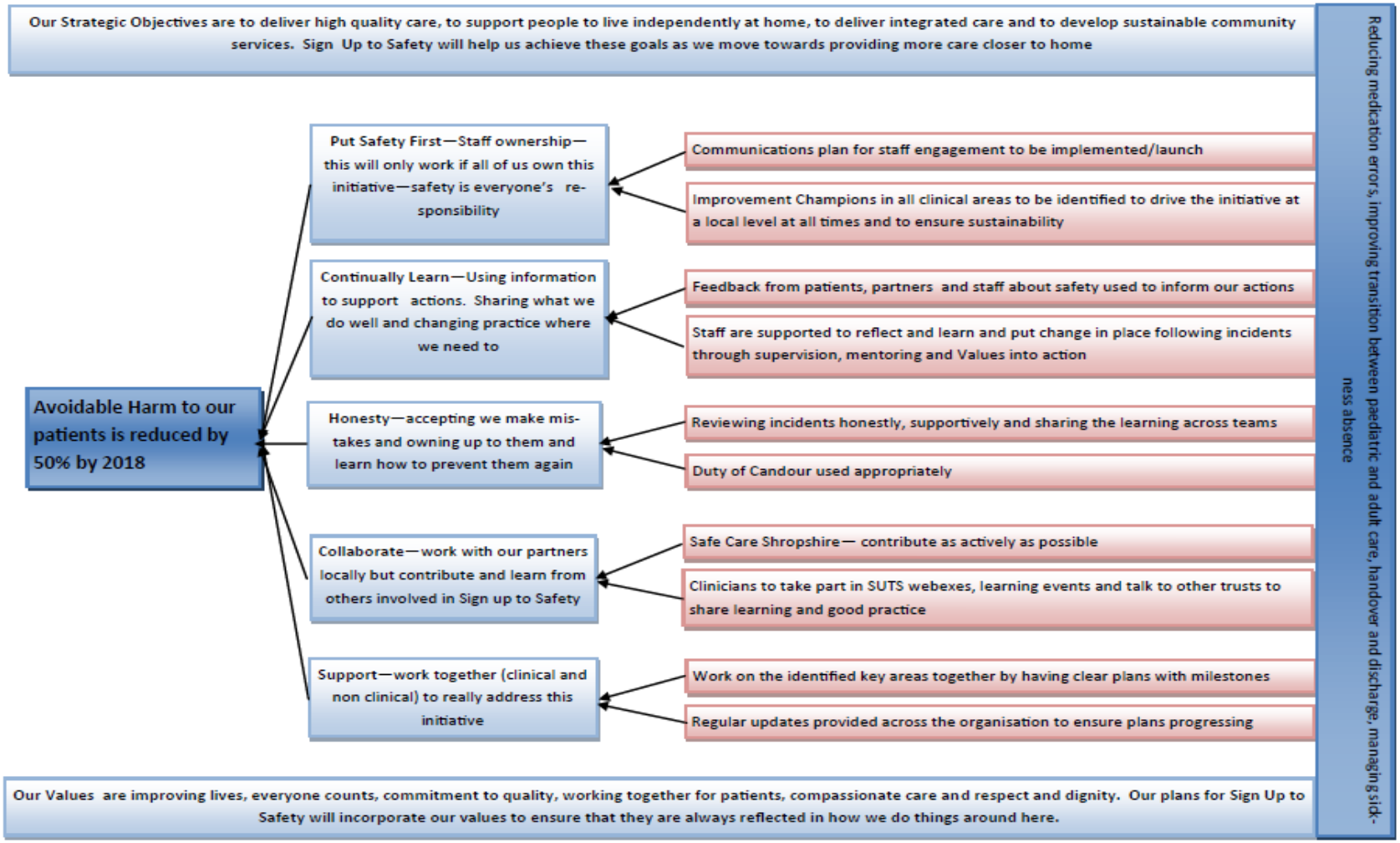
- Provide help as specified above but will also provide regular updates to the Quality and Safety Committee through the quality reporting system
- Will devise a project plan to make sure that key objectives are reached within timescales

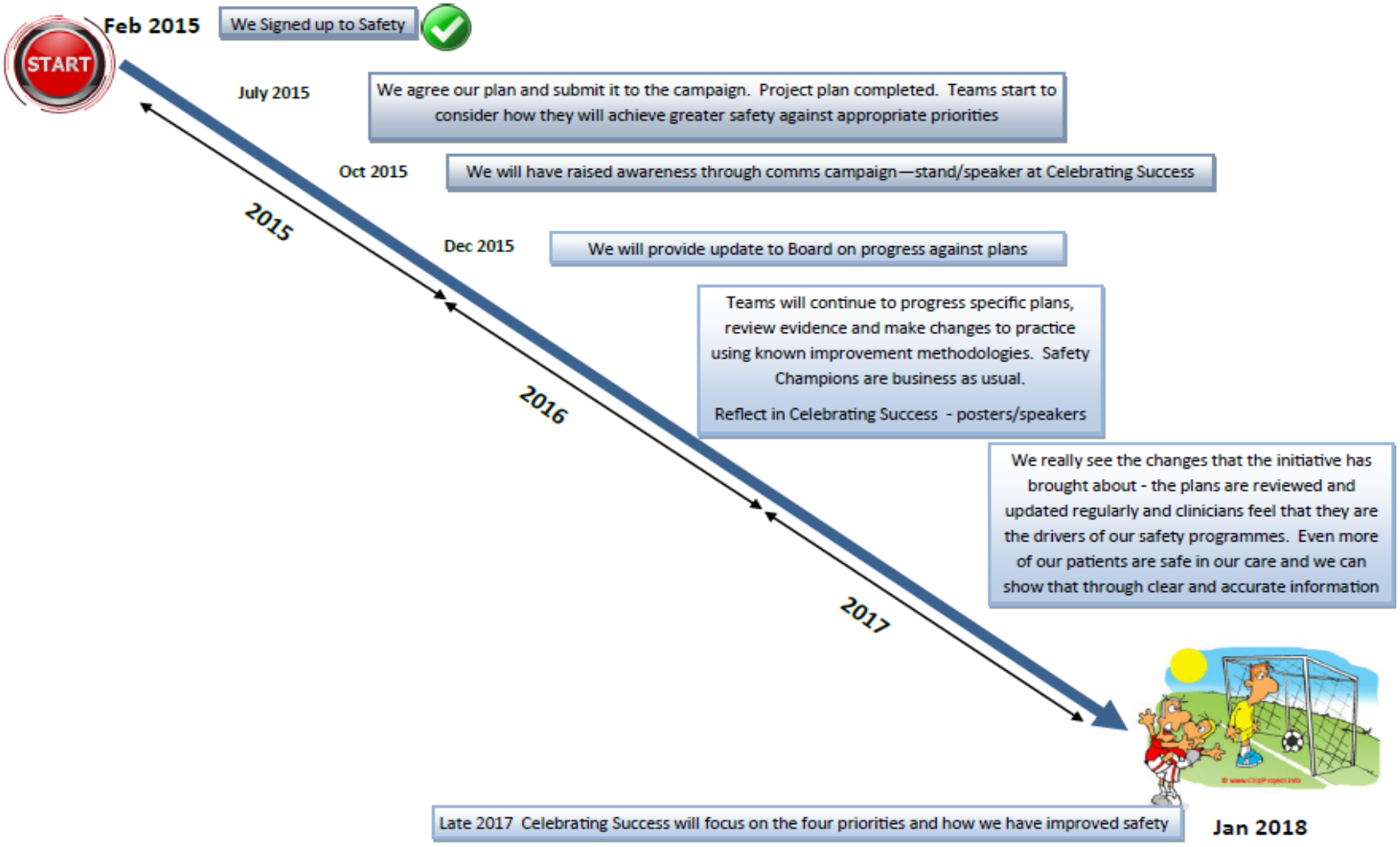
Evaluating our plan

We will measure and evaluate our plan at regular intervals over the three years that it will run. We will require teams to identify their own evaluation points and targets and ask them to provide the evidence that they have achieved these or, where required, realigned their timescales.

Sharing our Success

We will share our success with all our teams through our communications plan, our Celebrating Success Event and possibly through other methods such as the staff awards. We will reflect our progress through our Quality Account, Board reports and feedback to key groups such as the Patient and Carer Panel.


Our Strategic Objectives are to deliver high quality care, to support people to live independently at home, to deliver integrated care and to develop sustainable community services. Sign Up to Safety will help us achieve these goals as we move towards providing more care closer to home
Avoidable Harm to our patients is reduced by 50% by 2018
Put Safety First—Staff ownership—this will only work if all of us own this initiative—safety is everyone's re-sponsibility
Communications plan for staff engagement to be implemented/launch
Improvement Champions in all clinical areas to be identified to drive the initiative at a local level at all times and to ensure sustainability
Continually Learn—Using information to support actions. Sharing what we do well and changing practice where we need to
Feedback from patients, partners and staff about safety used to inform our actions
Staff are supported to reflect and learn and put change in place following incidents through supervision, mentoring and Values into action
Honesty—accepting we make mis-takes and owning up to them and learn how to prevent them again
Reviewing incidents honestly, supportively and sharing the learning across teams
Duty of Candour used appropriately
Collaborate—work with our partners locally but contribute and learn from others involved in Sign up to Safety
Safe Care Shropshire— contribute as actively as possible
Clinicians to take part in SUTS webexes, learning events and talk to other trusts to share learning and good practice
Support—work together (clinical and non clinical) to really address this initiative
Work on the identified key areas together by having clear plans with milestones
Regular updates provided across the organisation to ensure plans progressing
Our Values are improving lives, everyone counts, commitment to quality, working together for patients, compassionate care and respect and dignity. Our plans for Sign Up to Safety will incorporate our values to ensure that they are always reflected in how we do things around here.
Reducing medication errors, improving transition between paediatric and adult care, handover and discharge, managing sick-ness absence


START
Feb 2015
We Signed up to Safety
July 2015
We agree our plan and submit it to the campaign. Project plan completed. Teams start to consider how they will achieve greater safety against appropriate priorities
Oct 2015
We will have raised awareness through comms campaign—stand/speaker at Celebrating Success
2015
Dec 2015
We will provide update to Board on progress against plans
Teams will continue to progress specific plans, review evidence and make changes to practice using known improvement methodologies. Safety Champions are business as usual.
Reflect in Celebrating Success - posters/speakers
2016
We really see the changes that the initiative has brought about - the plans are reviewed and updated regularly and clinicians feel that they are the drivers of our safety programmes. Even more of our patients are safe in our care and we can show that through clear and accurate information
2017
Late 2017 Celebrating Success will focus on the four priorities and how we have improved safety
Jan 2018

Sign up to Safety – Metrics supporting the five safety pledges

Put safety first. Commit to reduce avoidable harm in the NHS by half and make public our goals and plans developed locally.	
We will:	How:
Accurately measure, report and publish our progress against key quality metrics (both nationally mandated and locally agreed) along with clear and measurable actions we are taking to address any shortfalls in order to improve outcomes for our patients.	Link to Quality Schedule and CQUINS requirements over the next three years to reflect current quality requirements Publish in our Quality Accounts each year with clear updates on our progress and what we will do if not achieving our goals Evidence through our internal reporting processes through the year
Support our staff across all our services to recognise safety to be how we do things around here. Include our Patient and Carer Panel in reviewing safety as part of a continual process of improvement.	Specific training such as risk management and RCA Regular publication of patient safety data in areas to encourage staff to be engaged with safety improvement Peer reviews based on CQC questions including patient and carer panel members Staff and panel members to carry out Sit and See – instant feedback to be actioned
Use the NHS Safety Thermometer to measure avoidable harm to our patients both as a Trust and as part of the "Safe Care Shropshire" initiative - an example of co-production that has already demonstrated a significant reduction in harm across the local health economy.	Use of NHS Safety Thermometer to continue
Use evidence based tools such as Plan, Do, Study, Act (PDSA) to constantly review how we may make our services safer before incidents occur - therefore being proactive not reactive. This will be a focus of the Our Way of Working - Values into Action initiative.	Values into Action

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.	
We will:	How:
We will listen to and learn from our patients, their families and their carers and organisations with whom we come into contact by responding positively to their comments and changing our practice and processes where required. We will continually monitor feedback to make sure that changes we have made have made a positive difference to people that use our services.	Friends and Family Test (FFT) and other specific patient and carer feedback surveys with clear action plans Monitor through Divisional Quality and Safety meetings and the Feedback Implementation Group Monitor progress by FFT scores and comments through patient feedback mechanisms Cross reference to Complaints and PALS
Act upon real time feedback from any source to quickly address areas of concern regarding safety issues.	Any comments from patients, their families or carers that reflect a poor experience are fedback immediately to teams for action Complaints and PALS reports give detail of actions
Use feedback from external visits and investigations to learn and make changes in our culture.	Feedback received and actions addressed appropriately
Promote the use of "You said....We did" across the Trust to illustrate to patients and carers how we have acted upon concerns and therefore have made services safer.	Developing this process across Trust Feedback Implementation Group will monitor on a quarterly basis
We will work closely with our patients, their families and carers to ensure they feel empowered to manage their own care effectively and appropriately for their needs thereby improving their lives.	Teams working with their patients in specific ways – reflected in Patient Stories and feedback across all methods

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.	
We will:	How:
Fulfil our obligations under the Duty of Candour Regulation when serious or moderate incidents do occur and we will be open and transparent about how we will put things right when they go wrong.	Report monthly the number of Duty of Candour incidents reported on datix and the outcome of these Managers to support staff to have difficult conversations with patients and their families – to be recorded on datix to ensure we can monitor that this happens Complaints manager to support staff in terms of writing to patients when things have gone wrong
We will be open and honest with all our patients, their families and carers, our commissioners and other organisations to whom we are responsible about our progress in relation to addressing patient safety issues and our progress against targets both internally agreed and externally mandated.	Link to Quality Schedule and CQUINS requirements over the next three years to reflect current quality requirements Publish in our Quality Accounts each year with clear updates on our progress and what we will do if not achieving our goals Evidence through our internal reporting processes through the year
Encourage and support our staff in a values based way to engage in open and honest discussions about patient safety incidents at forums such as the Root Cause Analysis and the Medicines Management challenge meetings. This will mean that our team leaders may share learning following incidents, reduce the incidence of teams working in isolation and identify actions across our services to address common issues thereby preventing further incidents occurring. Further develop the way we present our Quality Account to be clear about our aspirations to provide the safest possible care to our patients	Meetings to continue to discuss outcomes from serious incidents and medication incidents to provide a supportive whilst in depth discussion forum relating to incidents and what can be learned across the Trust Minutes and actions from the meetings are distributed to all team leaders for dissemination Quality Account to reflect national requirements each year. To provide succinct and interesting information

Collaborate. Take a leading role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use.	
We will	How
Work closely with other local organisations to make working together for patients a reality across Shropshire.	Consideration of joint priorities with our colleagues in the acute trust for Quality Accounts Development of Integrated Community Services
Continue to contribute to the Safe Care Shropshire initiative to reduce harm across the local health economy by actively participating in the sub groups of the Project Board and implementing safety improvement actions within our services.	Work with local health economy as required by the Safe Care Shropshire Project Board
Actively contribute to the West Midlands Quality Review Services both as reviewers and as services to be reviewed to improve the quality of care in the local health economy.	First WMQRS review of Intermediate Care planned

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.	
We will	How
Use appreciative inquiry to review our services and improve safety in a systematic way by creating an environment which is supportive and not critical.	Example – Community Hospitals review
Share and recognise good practice through events such as Celebrating Success and the annual Staff Awards.	Celebrating Success and Staff Awards to continue as annual event
Encourage open and honest conversations with the Trust Board, Executive Team and senior managers when they visit services to ensure that staff may raise concerns and also that feedback may be provided. Share outcomes of those conversations with Trust staff and patients (You said....We did).	Trust Board and Executive team visits to teams Feedback via Quality Matters to share themes across services
We will enhance clinical performance through feedback from clinicians and our knowledge of the effects of teamwork, tasks, equipment, culture and organisation on our behaviour and performance to improve the safety of our services.	Community Trust Leadership Forum Admin Staff Away Day Team Away days