4ward

NHS
Worcestershire
Acute Hospitals
NHS Trust

Our Patient Safety Plan | 2018 - 2021

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Acknowledgements

Our thanks go to our patients, their carers, the public and our patient representatives for their involvement in the development of this plan and in our journey of continuous improvement.

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Strategic Patient Safety Plan to underpin the Quality Improvement Strategy 2018-2021

Our ambition:

Our ambition is to be one of the safest healthcare providers in the UK.

Introduction:

By safe care we mean that no patient should suffer avoidable harm whilst in our care. Safe care should be consistently delivered to our patients regardless of their condition, when they are treated or by whom they are treated.

Improving patient safety is the responsibility of every single staff member in our Trust. It is a core component of quality alongside clinical effectiveness and patient experience.

Purpose:

The purpose of this strategic safety plan is to establish the key safety objectives and define our ambition, areas of focus and pledges for the next 3 years to ensure that all divisions and corporate teams are working together to deliver the safety improvements required.

The Patient Safety Plan supports delivery of the Quality Improvement Strategy 2018-2021.

Supporting programmes and strategies

The 4ward culture programme will provide a vehicle to support consistent behaviours and a positive working environment to enhance improvements in patient safety. The People and Culture Strategy will support the professional development and training.

NHS Improvement have provided a national guidance document *"Our approach to patient safety – NHS Improvement's focus in 2017-18"* which provides context and support to the priorities set out in this plan.

Measuring outcomes:

Annually the outcomes and effectiveness of this Patient Safety Plan will be demonstrated through the annual Quality Account.

Overall aims of the Patient Safety Plan:

- We aim to give every patient consistently safe, high quality and compassionate care
- We aim to protect every patient from unintended or unexpected harm whilst in our care
- We will learn from our excellence and our mistakes and improve care provided as a result
- Staff will be taught both clinical and improvement skills to continually improve care. We will work together to achieve excellence.

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Building on foundations

A Trust Quality Improvement Plan has been in place during 2017. The plan has enabled us to focus on improvements in patient outcomes and has been fundamental to establishing the base line for this plan.

For the first time every clinical area now has access to their patient safety data through the Safety and Quality Improvement Dashboard (SQUID).

Providing visibility of data to each area allows total visibility of performance for staff within the areas themselves and also those of peers. Clinical teams can identify areas that are performing well and learn from their successes.

We have a robust incident management process, incidents are graded and analysed, root cause analysis undertaken and learning disseminated through divisional governance structures.

The Trust has implemented the new Mortality Review process as adopted from the Royal College of Physicians. Our completion of primary mortality reviews have increased. The new process provides us with a mechanism to identify important themes from which clinical teams can learn to improve the safety of care provided to patients.

We have seen an overall improvement in the percentage of patients screened for venous thromboembolism (VTE) following admission to hospital. The National Early Warning Score has been introduced; the accuracy of how patients are assessed has increased significantly month on month.

Sepsis screening and treatment has improved for both patients attending as emergencies and inpatients. This has been enabled by systematic adoption of the National Early Warning Score (NEWS) or PEWS (Paediatric Early Warning Score) to identify deteriorating patients; this has been supported by improving escalation processes.

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Core processes fundamental to improving safety are being rolled out across the Trust

Work has started to improve handover, thus creating a consistent approach and reducing the risk of vital information being missed.

The processes with the greatest potential for improving safety includes electronic observations, patient tracking and electronic prescribing and the Trust will be actively reviewing how we can introduce these.

Safety huddles provide a focus on ensuring all members of the team are clear on the plans to ensure patient safety.

SBAR (situation, background, assessment and recommendations) communication is refining how we pass messages about clinical care.

Management of the patient journey is being co-ordinated to ensure clear plans to enable safe and timely discharge.

Checklists to increase safety for procedures outside of surgery are being rolled out as part of our LoCSiiPS programme.

However, we are not consistent with these safety processes and Year 1 of our plan will focus on a campaign to consistently apply all of these safety principles. Signing up to the *"Sign up to Safety Campaign"* will provide support for us to lead those improvements. There will be important national patient safety initiatives which are relevant to clinical divisions and the Trust through the Quality Improvement Strategy makes a clear commitment to support teams to join those relevant safety programmes.

We have also been able to join some of the national safety collaboratives established by NHSI which will support our improvement journey. One of these includes phase 3 of the Maternity and Neonatal Health network where the national target is to reduce still births and neonatal deaths by 50% before 2025.

Sign up to SAFETY

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Delivering our ambition

Pledge 1: We will give every patient consistently safe, high quality and compassionate care.

DO WHAT WE SAY WE WILL DO
We will give every patient consistently safe, high quality and compassionate care.

- We will reduce variation in care provided. Every patient should expect their care to reflect best practice
- We will provide written care assessments and care planning within 4 hours of admission
- Every patient will have an expected date of discharge, care will be co-ordinated to ensure this is achieved
- Medical, Nursing and Allied Health Professionals will document their agreed clinical plan for patient care on a daily basis
- We will consistently administer the patients prescribed medications when they are required
- Board rounds and ward rounds will meet internal professional standards to ensure the patient is supported through their clinical pathway as effectively as possible
- We will adopt NICE guidance and adopt best practice
- We will respond effectively to safety alerts in a timely manner, co-ordinating changes to practice and policy as required.

Pledge 2: We will protect every patient from unintended or unexpected harm.

NO DELAYS, EVERY DAY
We will protect every patient from unintended or unexpected harm.

- We will participate in the national campaign designed to support the NHS to reduce avoidable harm by 50%
- Staff, patients and their carers will be actively encouraged to identify risks to patient safety and to resolve them at a local level where possible. If not we as leaders will work with our teams to support them in resolving specific safety issues
- We will recruit staff who actively demonstrate our Trust behaviours
- Our culture will ensure patients and staff are at the heart of decision making and involved in developing safer care, they are the experts in how it feels to receive and deliver care in our Trust
- We will work with our partners to safeguard our patients from harm
- We will work with national collaboratives to ensure we work effectively to implement best practice.

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Pledge 3: We will improve care by learning from our mistakes.

WE LISTEN, WE LEARN, WE LEAD
We will improve care by learning from our mistakes.

- Our first safety culture survey will provide a frank baseline of where we are now and enable us to set clear aims and objectives to improve care
- We will provide high quality Mortality Reviews systematically understanding the care provided prior to the deaths of our patients. We will identify themes for improvement, we will share the learning and ensure improvements are made
- We will investigate and learn from serious incidents implementing improvements where required
- All staff will be encouraged to speak to our Freedom to Speak up Guardian, creating a culture of openness and honesty
- Patients will be encouraged to identify and highlight risks and issues they perceive to their care. We will commit to resolve them
- We will develop our network of safety champions ensuring both patients and staff have access to advice, guidance and support
- We will undertake a programme of targeted clinical improvement projects
- We will develop an innovative workforce plan beyond 2020 to ensure a competent NHS workforce to deliver the best possible patient care.

Pledge 4: Our staff will be taught the clinical and improvement skills required to provide high quality care. We will work together to achieve excellence.

WORK TOGETHER, CELEBRATE TOGETHER
Our staff will be taught the clinical and improvement skills required to provide high quality care. We will work together to achieve excellence.

- We will work with patients and their carers to develop high quality pathways designed to meet their needs
- We will learn from excellent practice ensuring the principles are spread across the Trust
- We will learn from our peers ensuring best practice is adopted at the Trust
- We will work with our system partners to develop smooth transitions for patients between all our organisations
- All staff will have access to improvement training designed to enable them to identify where improvements can be made and to implement sustainable improvements
- Staff will be taught Human Factors skills thus improving their own performance and that of their teams
- We will work with experts in training and development such as West Midlands Academic Health Sciences Network, NHS Improvement, Health Education England and the National Collaborative.

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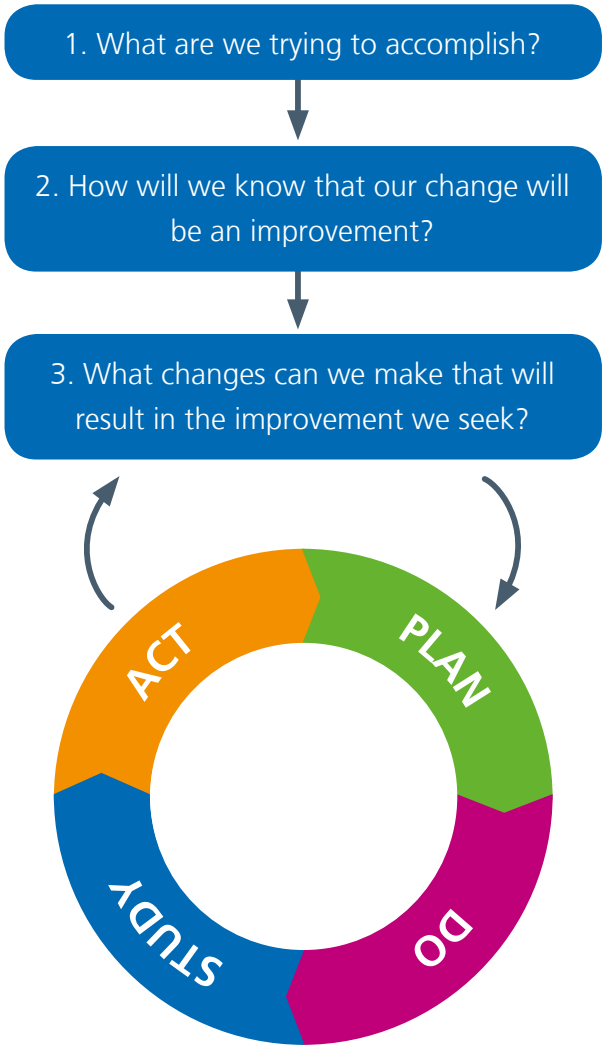
Measuring and sustaining improvements

The Model for Improvement underpins our methodology for improvement.

We are committed to measuring our progress to ensure we continue to provide the standards we aspire to. The model focuses improvement efforts through three questions ensuring clarity of aim and systematically testing ideas for change through Plan, Do Study, Act (PDSA) cycles. The 4ward programme provides an improvement framework through the process flow conversations to understand our baseline position and systematically improve patient safety in each of our priority areas.

The overall progress within each pledge will be measured along with specific safety improvement objectives (Appendix 1).

A summary of high level examples are provided within the component areas of the plan.



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DO WHAT WE SAY WE WILL DO
We will give every patient consistently safe, high quality and compassionate care.

OUTCOME: IMPROVED HOSPITAL STANDARDISED MORTALITY RATIO

- Standardised hospital mortality indicator
- Specific project measures
- % primary mortality reviews undertaken within 30 days of death
- % patients screened for sepsis according to Trust policy
- % patients treated within 1 hour of confirmed sepsis
- % patients for whom NEWS/PEWS score has been calculated correctly
- % patients identified as deteriorating escalated per Trust protocol.

NO DELAYS, EVERY DAY
We will protect every patient from unintended or unexpected harm.

OUTCOME: REDUCTION OF AVOIDABLE HARM

- Reduction in infections across a range of nationally mandated figures
- Reduction in the number of avoidable hospital acquired pressure ulcers
- Improved hand hygiene compliance in inpatient areas
- Reduction in the number of patient falls resulting in harm per 1000 bed days
- Prescribe, administer and supply the right medicines at the right time for the right patient.

WE LISTEN, WE LEARN, WE LEAD
We will improve care by learning from our mistakes.

OUTCOME: IMPROVED SAFETY CULTURE SCORE

- Mortality rates which are improving year on year
- % root cause analysis investigations which are fully completed within 45 days
- % of action plans completed from complaints and serious incidents within agreed timescales
- Themes from serious incidents and complaints learning triangulated with lessons learned from mortality reviews and utilised to prioritise our improvement programme.

WORK TOGETHER, CELEBRATE TOGETHER
Our staff will be taught the clinical and improvement skills required to provide high quality care. We will work together to achieve excellence.

OUTCOME: DEMONSTRABLE AND SUSTAINED IMPROVEMENTS IN PRIORITY SAFETY OBJECTIVES

- Number of staff involved in improvement projects
- Number of staff who have undertaken Human Factor Training
- Number of staff have completed Level 1 Quality Improvement Training
- Staff who are confident and competent to deliver patient care according to their professional scope of practice
- Working with national collaborative in specific improvement areas to ensure we achieve excellence.

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APPENDIX 1

Patient Safety Plan, 2018-2021 – Objectives and timelines

Working together – putting patients, their carers and the community at the forefront of all we do will ensure we collectively lead the changes required in the provision of safe, effective and reliable care and services.

This is the foundation required to ensure we deliver for our patients and their carers.

Signature Behaviours			
We do what we say we will do	No delays, every day	We listen, we learn, we lead	Work together, celebrate together

Safety Objective	Baseline position (outturn 2017-18)	Year 1 Trajectory 2018-19 % reduction and actual number	Year 2 Trajectory 2019-20 % reduction and actual number	Year 3 Trajectory 2020-21 % reduction and actual number
To reduce avoidable mortality	HSMR	HSMR of 100	Below HSMR of 100	Top quartile of national mortality indicators
Reduction of avoidable hospital acquired pressure ulcers (HAPU)	**Baseline position for 2017**	**2018-19**	**2019-20**	**2020-21**
Grade 4	Zero	Grade 4: zero occurrence of avoidable hospital acquired pressure ulcers	Grade 4: zero occurrence of avoidable hospital acquired pressure ulcers	Grade 4: zero occurrence of avoidable hospital acquired pressure ulcers
Grade 3 and Deep and Upgradable (D&U)	17	<15 x grade 3 and/or D&U avoidable HAPU per annum - demonstrating a 12% reduction	< 13 x grade 3 and/or D&U avoidable HAPU per annum - demonstrating a 13% reduction	< 11 x grade 3 and/or D&U avoidable HAPU per annum - demonstrating a 15% reduction
Grade 2 avoidable	97	<80 grade 2 HAPU (avoidable) per annum demonstrating a 10% reduction (9 patients)	<72 grade 2 HAPU (avoidable) demonstrating a 10% reduction (8 patients)	< 65 grade 2 HAPU (avoidable) demonstrating a 10% reduction (7 patients)

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Safety Objective	Baseline position (outturn 2017-18)	Year 1 Trajectory 2018-19 % reduction and actual number	Year 2 Trajectory 2019-20 % reduction and actual number	Year 3 Trajectory 2020-21 % reduction and actual number
Reduce the number of patients who fall whilst under our care	**Baseline position for 2017**	**2018-19**	**2019-20**	**2020-21**
Reduce the number of patients who have a fall whilst under our care	4.82 falls per 1000 bed days 1385 - actual falls	4.43 falls per 1000 bed days representing a 8% improvement and remain below the national average of 6.63 falls per 1000 bed days 1274 - actual falls	4.21 falls per 1000 bed days representing a further 5% improvement and remain below the national average of 6.63 falls per 1000 bed days 1210 - actual falls	4.13 falls per 1000 bed days representing a further 2% improvement and remain below the national average of 6.63 falls per 1000 bed days 1186 - actual falls
Reduce the number of patients who have a fall resulting in serious harm whilst under our care	0.08 Falls per 1000 bed days resulting in serious harm 22 - actual serious harm falls	0.07 serious harm falls per 1000 bed days representing a 10% improvement and remain below the national average of 0.19 serious harm falls per 1000 bed days 20 - actual serious harm falls	0.06 serious harm falls per 1000 bed days representing a further 10% improvement and remain below the national average of 0.19 serious harm falls per 1000 bed days 18 - actual serious harm falls	0.05 serious harm falls per 1000 bed days representing a further 10% improvement and remain below the national average of 0.19 serious harm falls per 1000 bed days 16 - actual serious harm falls

Safety Objective	**Baseline position** (outturn 2017-18)	**Year 1 Trajectory 2018-19** % reduction and actual number	**Year 2 Trajectory 2019-20** % reduction and actual number	**Year 3 Trajectory 2020-21** % reduction and actual number
Infection, prevention and Control	**Baseline position for 2017**	**2018-19**	**2019-20**	**2020-21**
MRSA bacteraemia	zero	Sustain zero Trust attributable MRSA bacteraemia	Sustain zero Trust attributable MRSA bacteraemia	Sustain zero Trust attributable MRSA bacteraemia
MSSA bacteraemia	16	<12 MSSA bacteraemia demonstrating 25% improvement	<10 MSSA bacteraemia demonstrating 16% improvement	<8 MSSA bacteraemia demonstrating 20% improvement
Reduction in the cases of *Clostridium difficile* *Underpinned by:-* Root cause analysis which demonstrates reduction in C difficile red lapses of care	33 against a trajectory of 32	<31 C difficile infection demonstrating 6% improvement	<29 C difficile infection demonstrating 6% improvement	<27 C difficile infection demonstrating 7% improvement
Reduction in Gram negative blood stream infections with a focus on E coli bacteraemia	59 (National requirement to reduce by 50% by 2021)	<47 E coli bacteraemia demonstrating 20% improvement in line with national trajectories	<37 E coli bacteraemia demonstrating 21% improvement in line with national trajectories	<29 E coli bacteraemia demonstrating 22% improvement in line with national trajectories
Hand hygiene compliance for patient areas	77.3% compliance in 77.1% of patient areas	>95% compliance in 100% of patient areas	>97% compliance in 100% of patient areas	>98% compliance in 100% of patient areas

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Safety Objective	Baseline position (outturn 2017-18)	Year 1 Trajectory 2018-19 % reduction and actual number	Year 2 Trajectory 2019-20 % reduction and actual number	Year 3 Trajectory 2020-21 % reduction and actual number
Antimicrobial Stewardship	**Baseline position for 2017/18**	**2018-19**	**2019-20**	**2020-21**
Carbapenem consumption (compared against other non-teaching Trusts using the AMR fingertips tool)	Highest quintile amongst non-teaching trusts in England	75th percentile or below	50th percentile or below	25th percentile or below
% compliance with guidelines or documented justification for deviation	78%	≥85%	≥90%	≥95%
% of antimicrobial prescriptions undergoing a structured review by a senior clinician 24-72 hours following initiation	c. 60%	≥70%	≥80%	≥90%

Safety Objective	Baseline position (outturn 2017-18)	Year 1 Trajectory 2018-19 % reduction and actual number	Year 2 Trajectory 2019-20 % reduction and actual number	Year 3 Trajectory 2020-21 % reduction and actual number
Medicines Safety	**Baseline position for 2017/18**	**2018-19**	**2019-20**	**2020-21**
Increase the reporting of medicines near misses and incidents across the Trust	Baseline Trust position: **3.52 reported incidents per 1000 bed days**	Achieve NHSE national average of: **4.47 reported incidents per 1000 bed days**	Achieve NHSE upper quartile: **4.88 reported incidents per 1000 bed days**	Exceed NHSE upper quartile: **>4.88 reported incidents per 1000 bed days**
Reduce the percentage of medicines incidents causing harm across the Trust	Baseline Trust position: **19.53% harm per 1000 bed days**	Halve the difference in % harm between Trust baseline and the NHSE national average: **15.62% harm per 1000 bed days**	Achieve the NHSE national average: **11.71% harm per 1000 bed days**	Reduce % harm below the NHSE national average: **<11.71%harm per 1000 bed days**
Implement Nursing/ Midwifery staff medicines e-competency assurance programme to assure Trust that staff able to competently administer medicines safely	Current medicines training in place on induction for all staff, for newly qualified nurses/midwives on appointment, as part of the preceptorship programme and mandatory training updates for clinical staff	**30% of nursing and midwifery staff complete e-Competency assurance** on Medicines Safety Thermometer indicators and provide evidence of assurance of competency	**60% of nursing and midwifery staff complete e-Competency assurance** on Medicines Safety Thermometer indicators and provide evidence of assurance of competency	**90% of nursing and midwifery staff complete e-Competency assurance** on Medicines Safety Thermometer indicators and provide evidence of assurance of competency
Implement E-prescribing and administration (EPMA) system across Trust to reduce prescribing and administration errors	Electronic Discharge Summaries only in place	Secure funding for EPMA system and complete tender process	Implement EPMA system across Trust according to roll-out plan	Optimise EPMA system across Trust according to roll-out plan

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Safety Objective	Baseline position (outturn 2017-18)	Year 1 Trajectory 2018-19 % reduction and actual number	Year 2 Trajectory 2019-20 % reduction and actual number	Year 3 Trajectory 2020-21 % reduction and actual number
Medicines Safety	**Baseline position for 2017/18**	**2018-19**	**2019-20**	**2020-21**
Provide Assurance that Medicines are safely and securely handled. Non-compliance and action plans -Ward level are not part of Divisional dashboards	100% of wards/clinical areas are audited annually 100% of wards/clinical areas are audited quarterly	**Safe and Secure medicines handling annual audits:** 100% of wards are audited annually Wards are >80% compliant with standards **Quarterly CD audit:** 100% of wards are audited quarterly Wards are >90% complaint with standards	**Safe and Secure medicines handling annual audits:** 100% of wards are audited annually Wards are >90% compliant with standards **Quarterly CD audit:** 100% of wards are audited quarterly Wards are >90% complaint with standards	**Safe and Secure medicines handling annual audits:** 100% of wards are audited annually Wards are >90% compliant with standards **Quarterly CD audit:** 100% of wards are audited quarterly Wards are >90% complaint with standards
Ensure that all patients presenting post fall have a comprehensive in-patient medication review (Metrics on in-patient medication reviews not currently collected)	Medication review pro-forma under development by frailty team.	**50%** of patients who present post-fall receive an in-patient medication review (implement standardised reviews)	**80%** of patients who present post-fall receive an in-patient medication review (deliver national target)	**90%** of patients who present post-fall receive an in-patient medication review (review national target to validate % improvements - standard to be to exceed national target)

Safety Objective	Baseline position (outturn 2017-18)	Year 1 Trajectory 2018-19 % reduction and actual number	Year 2 Trajectory 2019-20 % reduction and actual number	Year 3 Trajectory 2020-21 % reduction and actual number
Identification and escalation of deteriorating patients (Sepsis)	**Baseline position for 2017/18**	**2018-19**	**2019-20**	**2020-21**
Emergency Department (ED) Sepsis screening	83%	>85%	>90%	95%
Inpatient Sepsis screening	67%	>75%	>85%	>95%
Sepsis 6 Bundle compliance (ED)	50%	>60%	>70%	>80%
Sepsis 6 Bundle compliance (Inpatients)	80%	>85%	>90%	>95%
Preventing VTE - Compliance with screening	92%	>95%	>95%	>95%

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