The national ‘Sign up to Safety’ campaign aims to reduce avoidable harm to patients by 50% over a three-year period. South Essex Partnership University NHS Foundation Trust has joined this national programme to improve the safety of its services. The Trust’s Safety Improvement Plan builds on and complements the implementation of the Trust’s Quality Strategy.

Following a period of planning and consultation with key staff, the Trust is launching its own ‘Sign up to Safety’ campaign on 27 May 2015.
Introduction

Sign up to Safety Campaign
Listening to patients, carers and staff
Learning from what they say when things go wrong
Taking action to improve patient safety

South Essex Partnership University NHS Foundation Trust (SEPT) has joined the national campaign called ‘Sign up to Safety’. The campaign is designed to support the ambition of making the NHS the safest healthcare system in the world.

This will achieved by creating a system devoted to continuous learning and improvement. This ambition is bigger than any individual or organisation and achieving it requires us all to unite behind this common purpose.

We need to give patients confidence that we are doing all we can to ensure that the care they receive will be safe and effective at all times.

We all recognise that 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.

We must be open with our patients and colleagues about the potential for things to go wrong and for people to get hurt, and most of all, we must continuously learn from what happens in order to improve.

We all accept and embrace the learning that is needed when patients are harmed, and we all know it is important to raise concerns. This campaign will support people to feel safe to speak up when things do go wrong.

Everyone involved in caring for patients needs to know that they can have these conversations and that they will be heard – they can protect patients and save lives.

Everyone involved in caring for patients can make a difference. By harnessing the talent and enthusiasm across the health and care system, together we can make enduring changes to improve safety, halve avoidable harm and most importantly make a positive difference to the people we care for.

Together over the next three years we can save 6,000 lives across the NHS.

Like SEPT, NHS organisations are being asked to develop a plan that describes what they will do to reduce harm and save lives, by working to reduce the causes of harm and take a preventative approach.
The focus on quality of care and patient safety remain the Trust’s priority in providing integrated care covering mental health, learning disability, social care and community services across Bedfordshire, Essex, Luton and Suffolk. Central to this focus is the delivery of harm free care through an organisational and staff culture of safe practice and delivery of care.

This Safety Improvement Plan will build on, complement and integrate with a range of existing strategies – these primarily being our Quality Strategy and Annual Quality Account. It will also strengthen our established governance and safety infrastructure. The improvement plan sets out clear organisational aims statements as how we will reduce avoidable harm by 50% during the three year campaign period and support the Trust’s overall aim of reducing avoidable harm to zero in five years.

Our Safety Improvement Plan will be a dynamic document that will respond to the data and information we routinely collect through our established patient safety reporting systems, staff and service user feedback and as we roll out this plan we support and develop a ‘just culture for safety’.

Setting our aims

The Trust developed its Quality Strategy (2014 – 19) from a range of national, regional and local directives and initiatives, but more importantly tailored the Quality Strategy to meet the local needs of the service users who receive care across the Trust’s communities. This has been done through an analysis of the Trust’s patient harm data, national statistics and consultations with service users and staff. We, therefore, believe that the domains outlined in the Quality Strategy provide the core aims that will drive the Safety Improvement Plan.

These are:

- early detection of the deteriorating patient;
- reduction in avoidable pressure ulcers;
- reduction in harm from falls;
- reduction in unexpected deaths;
- reduction in use of restraint;
- reduction in omitted doses of medication.

These six core aims are relevant both in community and inpatient services, and we will work with and involve our health and social care partners where elements of services are provided by other organisations.
Creating our Team

To develop a ‘just culture for safety’, we need the engagement and involvement of all our staff, the people who use our services and the public. The starting point has been the pledges made by the Trust’s Chief Executive and Executive Director of Clinical Governance and Quality in signing up to the ‘Sign up to Safety’ campaign. To take forward these pledges the following team has been established:

- Executive Lead - Andy Brogan, Executive Director of Clinical Governance and Quality/ Executive Nurse
- Sign up to Safety Campaign Lead - Sarah Browne, Deputy Director of Nursing, DIPC
- Project Manager, David Curtis, external project support officer
- Early detection of the deteriorating patient lead - Ann Nugent, Head of Clinical Quality & Non-medical Tutor
- Reduction in avoidable pressure ulcers lead - Sarah Browne, Deputy Director of Nursing, DIPC
- Reduction in harm from falls lead - Anne Nugent, Head of Clinical Quality & Non-medical Tutor
- Reduction in unexpected deaths lead - Lesley Cullen, Consultant Nurse - Suicide Prevention and Investigation Lead
- Reduction in use of restraint lead - Anna Davis, Integrated Clinical Lead.
- Reduction in omitted doses of medication lead - Hilary Scott, Chief Pharmacist

Each of the leads for the six safety campaign work streams will lead a multidisciplinary group which has clinical, nursing and allied health professional membership from across the Trust’s services. We will look to co-opt membership from partner organisations where indicated and to support the involvement of service users.

Each of the individual work streams has a clear focus on the specific aim and will act as secondary hubs to work with clinical teams. Over the period of the first 90 day action plan they will identify local clinical team champions to support and develop the safety improvement planning process into clinical teams.

Safety Improvement Governance Structure

The Quality Committee receives reports and updates from groups reporting to the committee as well as other relevant data to ensure clinical effectiveness and monitoring of clinical performance. The Committee is responsible for analysing and challenging the information received. The purpose of the reports is to promote safety and excellence in patient care; to identify, prioritise and manage risk arising from clinical care; and to ensure effective and efficient use of resources through evidence based clinical practice. To ensure that there are clear lines of accountability, the Safety Improvement Planning Group will be an integral part of the Trust’s governance process and report into the Quality Committee. As can be seen in the diagram below this will afford the Safety Improvement Plan direct access to the Board of Directors through the existing governance structures.

Local, directorate or service specific quality groups underpin the Trust’s overarching governance framework. These local groups provide the natural interface between Trust wide and service specific clinical governance issues. Ultimately, these service groups are the very essence of delivering clinical governance close to the point of care delivery. The Safety Improvement Planning Group will link into this existing structure to support integration and learning.
The Safety Improvement Plan

The Safety Improvement Plan reflects the aims, actions and goals of the Trust’s quality Strategy. Our quality vision is:

‘To promote a culture and approach where every member of staff has the passion, confidence and skills to champion and compassionately deliver safer, more reliable, care.’

This Safety Improvement Plan is the starting point for the next three years to reduce harm by 50% and will develop and change to meet the outcomes from the work undertaken with staff, service users, their carers and the wider public served by the Trust.
<table>
<thead>
<tr>
<th>Core Aim</th>
<th>What does success look like? What is your goal statement?</th>
<th>Measures</th>
<th>What do we need to do for that success to be realised?</th>
<th>What resources do we need?</th>
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| Early detection of the deteriorating patient | All patients where indicated having a completed MEWS/NEWS assessment and multi-professional action plan. Improving the health and wellbeing of patients to empower them to take responsibility for their own care. Goal. No avoidable deaths in inpatient areas | • Analysis of all inpatient cardiorespiratory arrests.  
• Mortality (HSMR and SHMI) statistics.  
• Clinical audit data.  
• Incident and patient harm reporting.  
• Safety Thermometer data.  
• Case note reviews.  
• Patient surveys and complaints. | Raise awareness. Increased understanding of physical health needs. Embed a system of early detection of deteriorating patient and apply preventative actions. Turn policy into practice. | Data analysis skills.  
Additional staff training and education.  
Patient and public engagement skills. |
| Reduction in harm from falls                  | Reduce the level of harm from falls. Increase the reporting of no/minimal harm from falls. Year on year reduction in the number of avoidable falls resulting in harm Ambition  
Goal. No avoidable falls within inpatient areas | • Analysis of all inpatient and community falls.  
• Clinical audit data.  
• Incident and patient harm reporting.  
• Safety Thermometer data.  
• Case note reviews.  
• Patient surveys  
| **Reduction in avoidable pressure ulcers** | To reduce the number of avoidable category 2, 3, and 4 pressure ulcers. To sustain and improve on the work undertaken in reducing avoidable category 3 and 4 pressure ulcers. Year on year reduction of avoidable pressure ulcers.  

Goal. No avoidable pressure ulcers | • Analysis of all incidents of pressure ulcers.  
• Clinical audit data.  
• Incident and patient harm reporting.  
• Safety Thermometer data.  
• Case note reviews.  
• Patient surveys and complaints.  

Raise staff awareness.  
Raise patient awareness.  
Embed a system of early detection of pressure susceptibility and apply preventative actions.  
Turn policy into practice. | Additional staff training and education for staff and patients.  
Equipment.  
Patient and staff briefings and information.  
Patient and public engagement skills. |

| **Reduction in unexpected deaths** | A year on year reduction in the number of suicides across clinical services Ambition  
Goal. No avoidable suicides of patients known to services | • Analysis of all incidents of suicides patients in contact with services.  
• Clinical audit data.  
• Analysis of economy wide suicide audits.  
• Analysis of national confidential inquiry into homicides and suicides  
• Incident and patient harm reporting.  
• Case note reviews.  
• RCAs and themes/trends  

Review of clinical risk policy to ensure preventative actions are taken.  
Implementation of the suicide prevention strategy covering learning and recommendations from national strategy.  
Involvement of patients, family and carers in identifying concerns and key factors in determining risk.  
To support and take active involvement in any relevant research.  
Turn policy into practice. | Additional staff training and education.  
Patient and public engagement skills. |
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<th>Reduction in use of restraint</th>
<th>Reduction in omitted doses of medication</th>
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<tbody>
<tr>
<td><strong>A year on year reduction in use of prone restraint</strong>&lt;br&gt;Ambition: Zero episodes of prone restraint&lt;br&gt;Goal: No dose of medication will be omitted unless for a valid clinical reason that has been recorded.</td>
<td><strong>A year on year reduction in omitted doses of medication</strong>&lt;br&gt;Ensure that medications are prescribed promptly, administered accurately and safely. Ensure that there is a clear record of administration and that any omissions are recorded and reported.&lt;br&gt;A year on year reduction in omitted doses of medication where no reason is annotated (i.e. blank administration boxes).&lt;br&gt;Goal: No dose of medication will be omitted unless for a valid clinical reason that has been recorded.</td>
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<td>Raise awareness of evidence based practice. Change the culture towards restraint. Increase the involvement of service users in agreeing methodologies and involvement in training. Turn policy into practice.</td>
<td>Analysis of available medication management policy to ensure preventative actions are taken. Implementation of the medicines management policy covering learning and recommendations from national strategy. Change culture. Turn policy into practice.</td>
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<td>Additional safe training and education. Patient and public engagement skills.</td>
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To prepare the Trust for the implementation of the Safety Improvement Plan the following actions will be taken:

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<td>Establish Safety Improvement Planning Team</td>
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<td>National ‘Sign up for Safety’ campaign support team event</td>
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<td>Safety Improvement Team meetings</td>
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<td>Collect and validate existing data sets</td>
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<td>Themed aim listening events</td>
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<td>Service user briefing and listening events</td>
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<td>Revise Safety Improvement Plan</td>
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<td>Launch of Safety Improvement Plan</td>
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David Curtis        Sarah Browne
Project Lead         Sign up to Safety Lead