To:	**Trust Board**
From:	**Chief Nurse**
Date:	**31st July 2014**

Title:	**'Sign Up to Safety'**

Author/Responsible Director: Director of Safety and Risk

Purpose of the Report:

- To provide an overview of the national Sign Up For Safety campaign.
- To provide organisational improvements/recommendations for inclusion in the 'Sign up to Safety' campaign.

The Report is provided to the Board for:

Decision		Discussion	X
Assurance	X	Endorsement	X

Summary / Key Points:

- Introduction to the national Sign Up to Safety campaign
- Organisational improvements/recommendations are identified in this report for inclusion in the UHL 'Sign up to Safety' campaign under the following five domains;
  - Put Safety First
  - Continually Learn
  - Honesty
  - Collaborate
  - Support

Recommendations:

Trust Board is invited to note the content of this paper and:-

- Note the Government launch of the 'Sign up to Safety' movement;
- Support the organisational improvements/recommendations identified in this report for inclusion in the 'Sign up to Safety' campaign.

Strategic Risk Register Linked with relevant risks on SRR and operational risk register.	Performance KPIs year to date CQC outcomes Quality Schedule requirements CQUIN Framework

Resource Implications (e.g. Financial, HR) Not yet known to be reported via EQB and QAC.

Assurance Implications Relevant CQC, NHSLA, PHSO and NHS complaint regulations compliance

Patient and Public Involvement (PPI) Implications Engagement with public and patients in LLR as part of plan. A stand is planned at the Annual Public Meeting in September 2014.
Equality Impact None
Information exempt from Disclosure None
Requirement for further review? Monthly updates to QAC.

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **TRUST BOARD**

DATE: **31ST JULY 2014**

REPORT BY: **CHIEF NURSE**

SUBJECT: **'SIGN UP TO SAFETY'**

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1. INTRODUCTION

1.1 On the 24th June, the Secretary of State for Health launched a package of measures aimed to support transparency with regard to reporting on patient safety.

1.2 A new campaign 'Sign up to Safety' will be led by Sir David Dalton, Chief Executive of Salford Royal NHS Foundation Trust, inviting all healthcare organisations to commit to delivering a safety plan, reviewed and supported by the financial incentives from the NHS Litigation Authority, which will help contribute to the Government's ambition to reduce avoidable harm by half (an estimated 6000 lives) over the next three years. To be approved, the plans must include information on how the organisation will meet two national patient safety priorities and two local priorities.

1.3 Its principle is about **listening** to patients, carers and staff, **learning** from what they say when things go wrong and take **action** to improve patients' safety.

1.4 Organisations are invited to sign up to the campaign by setting out what the organisation will do to strengthen patient safety by:-

- Describing the actions that the organisation will undertake in response to the five Sign up to Safety pledges and agreed to publish this on your organisation's website for staff, patients and the public to see.
- Committing to turn proposed actions in to a safety improvement plan which will show how the organisation intends to save lives and reduce harm for patients over the next three years.
- Within the safety improvement plan, will be asked to identify the patient safety improvement areas that will be focused on.

1.5 This will become an integral part of the UHL Safety and Quality work led by the Director of Safety and Risk and will be reported monthly to Executive Quality Board and Quality Assurance Committee.

2. UHL AND 'SIGN UP TO SAFETY'

2.1 UHL will be signing up to this campaign and use the pledges as a vehicle to formulate a comprehensive safety improvement plan. This will integrate with the implementation of the existing safety programmes within the Quality Commitment. It will also support the actions required in response to the "Learning Lessons to Improve

Care" review that was recently undertaken by LLR and support improvements to the Emergency Care System within LLR.

2.2 The five domains are as follows:-

i. Put Safety First

UHL will develop and deliver a framework for "safety culture" across the organisation. The "UHL Safety Culture" will have three broad strands:-

- The psychological aspect of safety (how people feel): what are the values, beliefs and perceptions regarding patient safety.
- The behavioural aspect of safety (how people behave): safety related actions and behaviours of leaders and the workforce; a programme that supports professionalism by addressing unprofessional behaviours that undermine a culture of safety.
- The situational aspect of safety (what does the organisation have): policies, procedures, regulations, structures and management - how are they aligned with delivering safer care

The outcomes of this project would include:-

- Observable degree of effort by which all organisational members direct their attention and actions to improve safety on a daily basis. This would be measured directly (safety questionnaires) and indirectly (evidenced through improvements in safety reporting and learning systems).
- Measureable degree of reduction in harm to patients across non-elective and elective care.
- Provide value for money – this would be triangulated from reductions in avoidable harm.

The "safety culture" approach will link the four pillars on quality, workforce, strategy and finance as part of UHL's "Delivering Care at its Best".

This has been detailed in the Trust's Quality Commitment and reflects the known standards and targets for 2014-15 including key quality improvement initiatives as deemed from recent review. This includes the CQC visit and the LLR 'Learning Lessons to Improve Care" review. It also recognises specific work streams around the Emergency Care programme. We will continue to make sure that the Quality Commitment reflects the change in circumstances after outcome of review. In order to continue delivering the Quality Commitment, we will strengthen our "safety culture".

ii. 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 modify the "bed rounds" to include data on staffing, equipment, patient and family concerns, staff concerns and census (influenced by the 'safety huddles' from Cincinnati Children's Hospital Medical Centre. http://www.ihi.org/resources/Pages/AudioandVideo/WIHISituationalAwarenessPtSafety.aspx

- We will develop the UHL Patient Safety Learning Portal to ensure all staff have easy access to safety messages, safety tools, RCA reports and safety alerts (in development; reported on to EQB and should be going live in August/September 2014) and promote the profile of safety across the organisation.
- We will encourage all areas to develop safety briefings that can be used for staff induction and on-going training.
- UHL will track and monitor the trend chart regarding harm events within the Trust; report this monthly to EQB and publish on the public website. This would also be shared with every service as part of an improvement drive.
- The patient satisfaction and experience survey will be used to develop and deliver improvements in services.
- The constant learning from the themes of incidents, complaints, claims and inquests is a necessity to enable us to feedback to the CMGs regularly. We will use the CMG Performance Review meetings to allow a more thorough response to learning within the CMGs and services.

iii. 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.

- UHL will track and monitor our “Duty of Candour” compliance and publish this on our public website.
- We will publish the LLR "Learning Lessons to Improve Care" review and commence actions for improvement that affect UHL and co-lead on interventions across LLR that reduce mortality and avoidable harm.
- We will engage with patients and the public of LLR to publish outcome and safety data.
- We will refine the Datix reporting system to enable feedback to staff to improve reporting of patient safety incidents and of unprofessional behaviours that undermine a culture of safety. This will include work to support the Doctors in Training LiA action group to improve feedback from incidents for those who report.

iv. Collaborate

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

- UHL will implement the LLR Better Care Together programme in collaboration with our health and social care partners. The strategic outcome of this being to provide the highest levels of quality care, as assessed by clinical outcomes, patient satisfaction and patient safety.
- We will launch the Leicester Innovation and Improvement in Patient Safety (LIIPS) Unit (UHL with academic health partners) to implement and embed quality improvement methodologies and improvement science. We will implement two to three demonstrator projects from September 2014 – 2015. It is envisioned that this unit will remain as a “shadow” unit over this period. The initial projects will include an e-learning project, “Introduction to Quality

Improvement", which will be followed up by further projects on quality. As part of this work, an MSc in Quality and Safety will be developed.

v. 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.

- In order to transform in to a "High Reliability" safety organisation, we need to support people effectively. This will include implementing our safety culture with specific work streams dedicated towards improving our finest safety surveillance system – the workforce. We will also develop further the technological aspects of safety surveillance in conjunction with application of Human Factors design. In addition to learning safety systems and supporting the front line through effective processes, we would explore the development and delivery of a "Second Victim" programme to support staff and families. This has been implemented across many hospitals in the UK and USA with demonstrable improvements in staff learning and engagement on safety. (For such a programme please see MITSS: http://mitss.org).
- We will promote and develop the organisational safety culture work with Trust Board and the CMGs by making certain that safety is one of the principle features in all decision making.
- We will support Human Factors work and monitor outcomes including reductions in avoidable death and harm. A Fellowship to support this work will be developed within UHL in collaboration with academic health partners.
- We plan to hold an annual patient safety conference at UHL showcasing projects with improved outcomes that will be another way of celebrating success.

3. RECOMMENDATIONS

3.1 Trust Board is invited to note the content of this paper and:-

i. Note the Government launch of the 'Sign up to Safety' movement;
ii. Support the organisational improvements/recommendations identified in this report for inclusion in the 'Sign up to Safety' campaign.
iii. Regular updates to be provided to Executive Quality Board and Quality Assurance Committee as part of the Patient Safety report.
iv. To receive further updates on this initiative in the coming months.

Dr. Jay Banerjee
Associate Medical Director/
Claire Rudkin, Critical Safety Action Lead
July 2014