Trust Board Meeting: Wednesday 8th July 2015
TB2015.80

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Executive Summary

1. Sign up to Safety is a national campaign that aims to make the NHS the safest healthcare system in the world, building on the recommendations of the Berwick Advisory Group. It has the ambitious but important aim of reducing avoidable harm by half in the next three years and saving 6,000 lives.

2. In signing up to the programme OUH is committing to turn these actions into a safety improvement plan which will show how our organisation intends to save lives and reduce harm for patients over the next three years.

3. In joining Sign up to Safety the Trust is required to make specific commitments (of its choosing) in each of five domains (that are nationally specified, with accompanying wording as shown below). The five domains are:
   a. “Put safety first. Commit to reduce avoidable harm in the NHS by half and make public our goals and plans developed locally.”
   b. “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.”
   c. “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.”
   d. “Collaborate. Take a leading role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use.”
   e. “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.”

4. This paper sets out detailed pledges in each of the five domains of safety-related activity shown above.

5. The Sign up to Safety plan reiterates work that the Trust has already committed to in the Quality Priorities to be published in the forthcoming Quality Account. These in turn are aligned with the goals of the Quality Strategy which includes ambitious safety-related goals.

6. Agreement to this plan, as the Trust’s commitment to Sign up to Safety, is logical and pragmatic.

7. This paper was endorsed by the Trust Management Executive on 14th May 2015. on the basis that TME has agreed in principle to consider business case support for elements of this plan where material additional safety benefits can be demonstrated.

Recommendation

The Trust Board is asked
- to endorse the Trust’s commitment to the “Sign up to Safety” campaign.
Sign up to Safety plan

1.0 Sign up to Safety is a national campaign that aims to make the NHS the safest healthcare system in the world, building on the recommendations of the Berwick Advisory Group. It has the ambitious but important aim of reducing avoidable harm by half in the next three years and saving 6,000 lives.

2.0 Appendix 1 sets out the actions that will take place at OUH to make it the safest hospital possible.

3.0 In signing up to the programme OUH is committing to turn these actions into a safety improvement plan which will show how our organisation intends to save lives and reduce harm for patients over the next three years.

4.0 Sign up to Safety pledges are publicly available on the Sign up to Safety website and Trusts are encouraged to monitor progress against them in a transparent and publicly available way.

5.0 The pledges should be viewed in the context of the Trust’s Quality Strategy and the Quality Priorities for 2015-16 that are set out in the Quality Account, as shown diagrammatically within the figure below.

6.0 The pledges set out work some of which is already embedded and in progress (though not yet expected to have had its full potential impact on safety, and hence entirely legitimate to re-commit to via this process). These are labelled E in the text below.

7.0 The pledges also set out new or refreshed work, which is already reflected within the 2015-16 Quality Priorities that were developed and agreed during Q4 of
2014-15 and are due to be published in the Quality Account. They have thus already been approved as Quality Priorities by Clinical Governance Committee, TME, and the Trust Board. These are labelled QP in the text below.

8.0 In joining Sign up to Safety the Trust is required to make specific commitments (of its choosing) in each of five domains (that are nationally specified, with accompanying wording as shown below). The five domains are:

8.1 **Put safety first.** Commit to reduce avoidable harm in the NHS by half and make public our goals and plans developed locally.”

8.2 **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.”

8.3 **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.”

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

8.5 **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.”

9.0 The proposed Trust pledges are:

9.1 **Put safety first. We will:**

9.1.01 Increase the number of patients receiving Harm Free Care as measured through the NHS Safety Thermometer to above 95% (E). [note E = existing work; QP = new work in 2015-16 Quality Priorities]

9.1.02 Reduce the number of cardiac arrests and unplanned admissions to Critical Care through earlier recognition and treatment of deteriorating patients via our SEND project to use technology developed at OUH to allow remote monitoring of vital signs on tablets to provide track and trigger alerts and provide decision support. (QP)

9.1.03 Improve safety by more rapid escalation of possible Serious Incidents to allow lessons to be learned and actions put in place to protect future patients and achieve zero Never Events. (E)

9.1.04 Improve the recognition, prevention and management of Acute Kidney Injury (AKI) and communicaiton to primary care in collaboration with partners in the OAHSN. (QP)

9.1.05 Reduce the number of medication related incidents through improving medicines reconciliation between home and hospital settings (QP)

9.1.06 Improve early recognition and treatment of sepsis through raising awareness and training our staff. Develop an
organisation-wide sepsis management protocol and apply evidence-based guidelines into clinical practice. (QP)

9.1.07 Improve the timeliness and reliability of review of results of diagnostic tests, of inpatient discharge summaries, and of outpatient letters. (E, QP)

9.2 Continually learn. We will:

9.2.01 Continue to undertake and develop processes for systematic review of the quality and safety of the services we provide including the internal Peer Review Programme and Executive Quality Walk Rounds. (E)

9.2.02 Improve measurement and monitoring of the outcomes of incident investigations, complaints and claims to ensure the outputs are effective in reducing risk and enhancing patient safety. (E)

9.2.03 Strengthen the review of all deaths that occur in the Trust, to understand how we can improve our care and achieve a year on year reduction in mortality. (E, QP)

9.2.04 Take every opportunity to hear patient and carers views through increasing responses to the Friends and Family Test, sourcing service-specific patient feedback wherever possible and continuing the 'Patient Story' programme for presentation at Trust Board and wider learning. (E,QP)

9.2.05 Develop tools for monitoring quality and safety including patient experience dashboards and nurse-sensitive quality indicator dashboards. (E)

9.2.06 Ensure learning from safety incidents, claims and complaints is on every clinical governance meeting agenda at every level of the organisation. (E)

9.2.07 Ensure learning from safety incidents, claims and complaints is shared throughout the organisation including regular 'Quality Matters' newsletters. (E)

9.2.08 Continue to benchmark indicators of safety with peer organisations and look for opportunities to identify further performance measures. (E)

9.3 Honesty. We will:

9.3.01 Provide training and support to staff in being open with patients and carers when things go wrong in line with the Duty of Candour and monitor our compliance with this.(QP)

9.3.02 Continue to review all incidents, comments and complaints with an honest and transparent approach. (E)

9.3.03 Display patient safety information on wards in a consistent and clear way for patients and visitors to see. (E, QP)
9.3.04 Continue to publish safety related performance information on our Trust website, including staffing levels, infection rates and specialty outcomes. (E)

9.3.05 Be accurate and open in reporting our achievements or challenges in improving patient safety in our annual Quality Account. (E)

9.3.06 Articulate and publicly display our yearly Quality Priorities at Trust, Division and Directorate level throughout the organisation and monitor and publicly report progress with these. (E)

9.4 **Collaborate. **We will:

9.4.01 Be active participants in the Oxford Academic Health Sciences Network and Patient Safety Collaborative. (E)

9.4.02 Continue collaborative working with local education commissioners and providers including Oxford University, Oxford Brookes University and the Patient Safety Academy to ensure our students and staff are receiving educational programmes which support our ambitions for a workforce committed to patient safety. (E)

9.4.03 Continue to work with our local primary health and social care partners to improve communication and take a system-wide approach to standardising care, streamlining patient pathways and reducing harm where possible. (E, QP)

9.4.04 Continue to work with partners in the Shelford Group of hospitals to share learning and best practice in delivering safe care and identify opportunities for further improvement. (E)

9.4.05 Continue to work with commissioners to achieve high reliability of communication with clinical partners outside the Trust (E, QP)

9.5 **Support. **We will:

9.5.01 Provide training on incident reporting and investigation, quality improvement and Human Factors across the multidisciplinary team. (E, QP)

9.5.02 Improve our mechanisms for staff to hear of actions taken and lessons learned in response to incidents and near misses. (E)

9.5.03 Continue our Listening in to Action programme and apply at local (team based) level to promote ownership for sustained quality improvement. (E)

9.5.04 Continue to promote our Trust values of 'Delivering Compassionate Excellence'; encouraging the types of behaviours that support patient safety. (E)

9.5.05 Undertake Values Based Interviewing to ensure we have a work-force who adopt a person-centred approach to providing safe and compassionate care. (E)

9.5.06 Value staff through continuous professional development, appraisal, listening to feedback and recognising achievements
through our 'Staff Recognition' and 'Good Thinking' reward schemes. (E)

9.5.07 Improve compliance with Statutory and Mandatory Training to ensure all staff are knowledgeable in providing safe, quality care. (E)

10.0 Discussion.

10.1 The Sign up to Safety plan incorporates work that the Trust has already committed to in the Quality Priorities to be published in the forthcoming Quality Account. These in turn are aligned with the goals of the Quality Strategy which includes ambitious safety-related goals.

10.2 For these reasons agreement to this plan, as the Trust’s commitment to Sign up to Safety, is logical and pragmatic.

10.3 TME was mindful that implementation of this plan at scale and pace will require careful consideration of resources for each area of work. In some cases resource is already committed. In others it is not. The original Sign up to Safety process allowed Trusts to “bid”, for investment the Trust made in its safety plan, to be discounted in part from the increased NHSLA premium.

10.4 The process effectively redirected a proportion of the increased NHSLA premium into safety-related investments within the Trust rather than being paid out to the NHSLA. Trusts were nonetheless required to commit to making the investments in advance of “funding”.

10.5 The Trust did not enter this bidding process due to ongoing work at the time to refresh the Quality Strategy and develop the Quality Priorities ensuring alignment, along with other activities relevant to the Quality Governance Framework Assessment process.

10.6 It is possible that NHSLA will still consider cases for rebate of premium (for investment in safety initiatives). It is also possible that other funding sources might be found.

11.0 Conclusion.

11.1 TME agreed the Sign up to Safety plan for signature by the Chief Executive on 14th May 2015.

11.2 TME agreed to the principle that it will consider business case support for elements of this plan provided material safety benefits can be demonstrated.

12.0 Recommendation

The Trust Board is asked

12.1 to endorse the Trust’s commitment to the “Sign up to Safety” campaign.

Tony Berendt
Medical Director
May 2015