

Patient safety programme: improvement plan

Executive summary

On 1 July 2014 the Royal Free London NHS Foundation Trust became one of the largest trusts in the UK by acquiring Barnet and Chase Farm hospitals. Our trust has around 10,000 staff serving 1.6 million patients. It comprises Barnet Hospital, Chase Farm Hospital, the Royal Free Hospital and more than 30 services in the community. This larger scale organisation provides an unprecedented opportunity for us to continue our pioneering work, particularly in finding ways to deliver even better care to our patients.

Our mission is to deliver world class care and expertise in our clinical services, underpinned by world class teaching and research and we will continue to measure our progress against our five governing objectives: excellent outcomes, excellent patient and staff experience, excellent value for taxpayers' money, being safe and meeting our external duties, and building a strong organisation.

Our patient safety aim is to become a zero avoidable harm organisation by 2020, initially by reducing the level of avoidable harm at the Royal Free London NHS Foundation Trust (as measured by incidents relating to NHSLA claims) by 50% by 31 March 2018.

Our Patient Safety Programme strategy, which was launched during our Patient Safety week in October 2014, has been further developed in line with the National Sign up to Safety campaign and is presented below.

We have set out the actions the Royal Free London NHS Foundation Trust will undertake in response to the five Sign up to Safety pledges and have agreed to publish this on our website for staff, patients and the public to see.

1. Background

It has been established that approximately 10% of inpatients suffer harm during hospital admission in both NHS and other health systems. Some of this harm is unavoidable, but most is avoidable. Achieving harm free care requires a combination of leadership, professionalism, measurement, improvement skills, learning and effective systems. A recent study by Frontier Economics suggests that unsafe care costs the NHS £1-2.5 billion per annum.

In recent years the NHS has increased its focus on patient safety, more so since the investigations into care failings at Mid Staffordshire NHS Foundation Trust. Three major current policy initiatives in England focus on safety, building on the 2013 Francis, Berwick and Keogh reports on safety, improvement and learning within the NHS:

- The “Sign up to Safety” Campaign
- Regional Patient Safety Collaborative
- The development of 5,000 Quality Improvement ‘Q’ fellows across the country by 2019

Furthermore, regulators and commissioners have increased their scrutiny of patient safety issues: for example the introduction and publication of ‘never events’ as a category of serious incident, and the new CQC inspection regime which specifically focuses on patient safety as a distinct domain.

The Royal Free London NHS Foundation Trust (RFL) has recently expanded to include Barnet and Chase Farm hospitals and this places the trust in a unique position as one of the largest trusts in the UK, and one with a real need for a consolidated approach to patient safety and quality.

It is now over five years since the Royal Free Hospital participated in the Safer Patient Initiative programme in collaboration with Barts and the London NHS Trust. In that period the trust has continued to set patient safety priorities and worked on specific improvement plans. These include:

- The sepsis programme aimed at reducing the number of patients who deteriorate due to sepsis
- Work to reduce incidents secondary to misplaced nasogastric tubes
- Falls reduction
- Pressure ulcer reduction
- Reduction of the incidence of medication errors

The Royal Free has been engaged at regional level with UCL Partners, embarking on a number of joint patient safety initiatives which include:

- The deteriorating patient project which aims to reduce the incidence of unexpected cardiac arrests
- The response to new NHS initiatives, including the creation of a UCLP hosted regional safety collaborative and with initial focus on acute kidney injury and sepsis.
- Commitment to the national pledge to reduce harm by 50% in Sign up to Safety campaign, collectively sharing and learning through academic health scene networks.

RFL has also embarked on collaborative work on patient safety as part of its buddying arrangements with Basildon & Thurrock NHS Foundation Trust.

At Barnet & Chase Farm Hospital NHS Trust, recent initiatives included:

- work with the Royal Free to establish a sepsis programme
- a focus on falls and pressure ulcer reduction
- secondment of a senior nurse to develop a deteriorating patient programme
- a focus on completion of incident action plans

Our aim is to become a zero avoidable harm organisation by 2020. To achieve this we need to have the right members of staff with appropriate knowledge, skills and competence in post to ensure potential risks are minimised and robust and prompt decisions are made following any incident. This includes identifying appropriate actions and ensuring the use of quality improvement methodology to provide evidence of positive change.

Sign up to Safety aims to deliver harm free care for every patient, every time, everywhere. It champions openness and honesty and supports everyone to improve the safety of patients. It is a national campaign that is designed to help realise the ambition of making the NHS the safest healthcare system in the world by creating a system devoted to continuous learning and improvement

We have set out the actions the Royal Free London NHS Foundation Trust will undertake in response to the five Sign up to Safety pledges and agree to publish this on our website for staff, patients and the public to see. In joining Sign up to Safety we have created this local Safety Improvement Plan which provides evidence of the anticipated harm reduction which will improve patient safety.

2. Programme aim

Our aim is to become a zero avoidable harm organisation by 2020, initially by reducing the level of avoidable harm at the Royal Free London NHS Foundation Trust (as measured by incidents relating to NHSLA claims) by 50% by 31 March 2018.

3. Equality statement

The trust is committed to creating a positive culture of respect for all individuals including job applicants, employees, patients, their families and carers as well as community partners. The intention is, as required by the Equality Act 2010, to identify, remove or minimise discriminatory practice in the nine named protected characteristics of age, disability (including HIV status), gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex or sexual orientation. It is also intended to use the Human Rights Act 1998 to treat fairly and value equality of opportunity regardless of socio-economic status, domestic circumstances, employment status, political affiliation or trade union membership, and to promote positive practice and value the diversity of all individuals and communities.

4. Our Sign up to Safety pledges

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

We will:

- Ensure patient safety is recognised as integral to daily business
- Ensure our staff are equipped with the necessary skills to provide high quality healthcare
- Support our staff in identifying and addressing safety concerns, and in challenging unsafe behaviours
- Further develop and promote our patient safety programme, by ensuring new and existing safety workstreams are appropriately resourced and supported
- Work with our patients, staff and partner organisations to ensure our patient safety programme objectives are patient-centred and aligned with local and national safety priorities
- Improve incident reporting rates by developing risk management systems that ensure staff can easily report, analyse and share learning from safety incidents
- Revise and re-launch our incident policy to ensure roles, responsibilities and expected outcomes are clearly defined and supported by appropriate investigation guidance, training and tools

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.

We will:

- Strengthen our systems for identifying learning from safety incidents, patient feedback and claims by ensuring data are triangulated effectively
- Improve how we disseminate learning from safety reviews by introducing regular safety forums, learning events and a safety bulletin
- Ensure patient safety is given agenda space at meetings at all levels of the organisation, and that robust lines of reporting exist from ward to board
- Use learning from safety reviews to inform staff education programmes, such as the new technical skills day currently being piloted
- Implement facilitated debriefs (after action reviews) as a tool to aid identification of learning following safety events
- Build knowledge and expertise in safety improvement to promote a culture of continual learning and improvement
- We have appointed a patient member to our patient safety programme board, and will develop ways to further engage our patients, their carers and the public

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.

We will:

- Fully implement duty of candour and appoint candour champions
- Work with our staff to build confidence and skills in communicating with patients and their families after safety incidents – particularly when something has gone wrong
- Continue to update and expand the safety metrics we publish on our public website
- Make public our patient safety programme quality improvement plans and updates on progress
- Implement a clinician-led model for investigations of patient safety incidents, led by clinicians from outside the service line in which the incident occurred

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.

We will:

- Continue to play an active, lead role in the patient safety collaborative, working with local and national partners to support national improvement initiatives such as sepsis and acute kidney injury
- Continue to engage with GPs and independent providers following safety incidents to share learning and best practice and support improvement within the wider health economy
- Commit to joining the quality and safety in European Union hospitals initiative, iQUASAR

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.

We will:

- Create a new safety forum, where staff can ask questions or raise concerns in an open and supportive environment
- Openly share examples of improvement at learning events and via the new safety bulletin, and encourage others to share their experiences and ideas
- Promote the provision of timely feedback following safety incidents to demonstrate what action has been taken/is planned or provide an explanation where no action is to be taken
- Celebrate the new staff achievement award for outstanding contribution to patient safety
- Develop a mechanism for real-time patient safety culture "temperature" testing to assess institutional safety culture and identify opportunities for further improvement

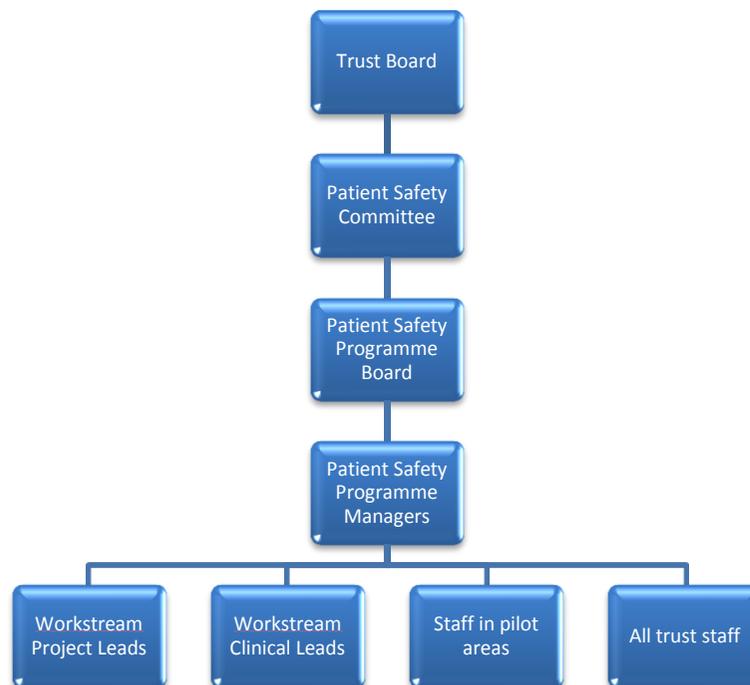
6. Scope

This will be a three year time-limited programme hosted by the Medical Directorate. It will run alongside the business as usual work of Patient Safety & Risk and Clinical Governance & Performance Teams.

The following areas are out of scope:

- Corporate patient experience (complaints and PALS)
- The serious incidents process redesign
- The development of a trust-wide quality improvement function, staff development

7. Governance



The patient safety programme board is established to monitor and oversee the implementation of the programme. It reports to the board-level patient safety committee which, in turn, provides regular updates to the trust board. The workstream project leads, in coordination with their clinical leads will provide update reports to the patient safety programme managers who report to the PSP board.

8. Roles and Responsibilities

- CEO - As accountable officer, the Chief Executive is responsible for patient safety as part of wider governance arrangements within the organisation,
- Medical Director - The Medical Director is ultimately responsible for patient safety as part of a wider clinical governance responsibility, however strategic decisions are taken in conjunction with the Director of Nursing.
- Nurse Director - Works with the medical director to define the strategic direction of the organisation in relation to patient safety.
- Associate Medical Director Patient Safety - The associate medical director is accountable to the medical director and has specific responsibility to provide senior clinical leadership with respect to patient safety throughout the Trust, to promote a culture of patient safety and to take a lead role in developing and implementing the Trust patient safety strategy and programme.
- Deputy Director, Patient Safety and Risk; The head of Patient Safety and Risk, supported by the patient safety manager, is accountable to the Medical Director and is responsible for providing advice on, and facilitating, the effective management of risk (including patient and staff safety). This responsibility includes establishing effective systems and processes to support the early identification of patient safety concerns and creating an enabling framework for all clinicians to engage in and improve patient safety initiatives within the trust.
- Lead Nurse for Patient Safety Programme - The lead nurse for the patient safety programme is accountable to the nurse director and has specific responsibility to provide senior nursing leadership with respect to patient safety throughout the Trust, to promote a culture of patient safety and to take a lead role in developing and implementing the Trust patient safety strategy and programme.
- Senior Management / Divisional Directors - Are responsible for ensuring that they engage fully with the patient safety agenda, and are expected to take ownership of patient safety issues related to the services they manage. They should actively address poor teamwork and poor practices of individuals, using approaches founded on learning, support and continual improvement, as well as effective appraisals, retraining and where appropriate revalidation.
- All trust staff - Every person working for the trust has a duty to identify and help to reduce risks to the safety of patients, and to acquire the skills necessary to do so in relation to their own job and team.

Patient Safety Programme Board

Name	Title	Role/Responsibilities
Caroline Clarke	Director of Finance	Executive Sponsor, Chair of Patient Safety Programme Board
Steve Powis	Medical Director	Clinical Director, Chair, Patient Safety Committee

Hester Wain	Deputy Director Patient Safety and Risk	Programme Lead, Patient Safety Programme Board member
Chris Laing	Associate Medical Director of Patient Safety	Clinical Lead, Patient Safety Programme Board member
Aine Burns	Consultant Nephrologist/ Director Postgraduate Medical Education	Member, Patient Safety Programme Board
Caroline Mabey	Deputy Director Organisational Development	Member, Patient Safety Programme Board
Margaret Mary Devaney	Head of Patient Safety and Risk	Member, Patient Safety Programme Board
Joe Adams	Patient representative	Member, Patient Safety Programme Board
Maura McElligott	Director of Nursing SAS, and Patient Safety Lead	Clinical Lead, Patient Safety Programme Board member
Penelope Smith	Assistant Director Postgraduate Medical Education & Core Medical Training Programme Director	Member, Patient Safety Programme Board
Ragini Patel	Assistant Director of Workforce (Interim)	Member, Patient Safety Programme Board
Sarah Stanley	Consultant Nurse Acute Care and Resuscitation Service and Patient at Risk Team (PARRT)	Member, Patient Safety Programme Board
Suzanna Moore	Patient Safety Manager	Member, Patient Safety Programme Board
Gemma Williams	Corporate Communications Manager	Member, Patient Safety Programme Board
To be confirmed	Patient Safety Programme Manager	Member, Patient Safety Programme Board
Geetika Singh	Patient Safety Programme Manager, Falls	Member, Patient Safety Programme Board

The Patient Safety Programme Managers responsibilities include taking a lead role in planning, managing and overseeing the delivery of a number of multidisciplinary improvement projects and initiatives to achieve a beneficial change to patient safety in line with the quality

objectives of the organisation and national patient safety priorities. This will also include working with, advise and support the workstream leads/clinical experts and patient safety programme leadership team in developing and implementing a set of clear well-structured, user-friendly written documents for detailing and recording the improvement projects from beginning to end, including the objectives, the expected benefits, the expected resource requirements, the expected risks and associated metrics.

Patient Safety Programme Team

Name	Title	Role
To be confirmed	Patient Safety Workstream Lead	Project Lead, Patient Safety Programme
To be confirmed	Patient Safety Workstream Lead	Project Lead, Patient Safety Programme
To be confirmed	Patient Safety Workstream Lead	Project Lead, Patient Safety Programme
To be confirmed	Patient Safety Data Analyst	Project Support, Patient Safety Programme

Workstream leads will develop their QI projects within agreed objectives and terms of reference. Innovation will be encouraged. Educational support in leadership and quality improvement methodology will be offered as needed.

Patient Safety Programme Clinical Leads

Name	Title	PSP workstream
Dipesh Patel	Diabetic Consultant	Acute diabetic management
Chris Laing	Associate Medical Director of Patient Safety	Acute kidney injury
Sarah Stanley	Consultant Nurse Acute Care and Resuscitation	Deteriorating patient (including deteriorating unborn baby)
Geetika Singh	Falls Lead	Falls prevention
Lisa Henderson	Deputy DIPC (Nurse) for Infection prevention and control	Hospital acquired and catheter-related infection
Jose Bennell	Clinical Nurse Specialist In Nutrition Support	Hydration and nutrition
TF Chan	Deputy Chief Pharmacist	Medicines management

Name	Title	PSP workstream
Manoj Chevli	Clinical Governance Pharmacist	
Brian Holloway Simone Towie	Clinical Director of Radiology Head of Radiology	Missed/delayed diagnoses (including Action of abnormal images)
Maura McElligott	Nursing Director of Patient Safety	Pressure ulcers
Andy Cohen Susan Tierney Alan McgLennan	Clinical Director, Consultant Anaesthetics Head of Nursing, Surgery and Associated Services Consultant Anaesthetist	Safer surgery
Sarah Stanley	Consultant Nurse Acute Care and Resuscitation	Sepsis
Professor Amit Nathwani	Director Haemophilia Centre	VTE prevention and inpatient anticoagulation management

9. Anticipated Benefits

The potential reduction in incidents and patient harm that is anticipated following implementation of the successful interventions have been calculated from estimated claims reduction and average harm reduction costs based on published health economics data and estimated numbers of patients affected per year.

10. Deliverables and Outcomes

The key Patient Safety Programme deliverables over the three years are shown below

Milestone	Deliverable
Apr-15	PSP team in place
Apr-15	Set-up Quality Improvement Faculty
Apr-15	Phase 1 workstreams review and development
Jul-15	Complete Patient Safety Culture survey and develop dynamic survey capability
Jul-15	Set up Executive Safety Walkarounds
Sep-15	PSP Conference
Apr-16	Phase 2 workstreams review and development
Sep-16	PSP Conference
Apr-17	Phase 3 workstreams review and development
Sep-17	PSP Conference
Mar-18	PSP Conference

11. Constraints

- While the Board has committed to deliver the Patient Safety Programme, this is dependent on gaining additional funds to support both the delivery of the work (via NHSLA) and the training.
- It has been agreed that clinical time will be made available via SPAs to support the clinical leads and others involved in the work, but it should be understood that this resource is very much limited and will be subject to other influences.
- The two clinical leaders: Associate Medical Director of Patient Safety and Patient Safety Director of Nursing have a great deal of passion for this work, but only limited time. This time resource constraint is mitigated to some degree by the role of Deputy Director of Patient Safety and Risk.

12. Dependencies

- Trust Quality Accounts
- Trust audit programmes, particularly key NICE guidelines pertaining to safety priorities
- Commissioning for quality programmes (CQUIN), Harm FreeCare and the Safety Thermometer.
- Postgraduate training
- UCL Partners via AHSN Patient Safety Collaborative
- UCLP deteriorating patients initiative
- London AKI Network, Improvement Science London (UCLP)
- Regional partnerships: UCLP workstream on pressure ulcer prevention

13. Assumptions

- The trust will receive the full discretionary NHS LA incentive payment for the Safety Improvement Plan
- Further funding such as via HENCEL will be sourced to support training costs and staff development
- The Health Foundation and NHS England have committed a total of nearly £2m of seed funding to launch the Patient Safety Fellows initiative. The first cohort of participants (150-250 people) to the programme will be recruited by spring 2015 and it is anticipated that staff from the Royal Free will be part of this training.
- Advice, support and networking opportunities will be available via UCL Partners.

14. Key Stakeholders

- RFL patients, parents, carers and residents

- RFL Staff: specifically including Divisional Directors, Senior management, Clinical directors forum, Matrons forum, Consultant staff committee
- Local GPs
- Local acute, specialist, mental health and community provider organisations
- Strategic Clinical Networks
- London Ambulance Service
- Local patient, public and voluntary groups
- North and East London Commissioning Support Unit
- Local Clinical Commissioning Groups
- NHS England
- NHSLA
- UCL Partners
- Sign up to Safety

15. Communications and engagement

A full communication and engagement plan will be completed with the PSP team in consultation with the workstreams, staff, patients, carers and the public, based on the following:

- Staff patient safety culture survey
- Development of additional surveys to include
 - Dynamic staff patient safety culture survey
 - Survey of patients, carers and the public
- Invite staff, patients, carers and the public to assist in the design of the engagement approach, drawing in qualitative and quantitative data as required
- Workshops to include :
 - Associate medical director 'drop-in session' for staff to feedback on safety issues and ideas for improvement (fortnightly)
 - Workstream updates (Monthly)
 - Trainee Doctor Safety Forum (quarterly)
 - Publication of Trustwide Safety bulletin (monthly)
 - Draw on best engagement practice nationally.

The following principles will apply to the PSP

- Co-design and co-delivery with staff, patients, carers and the public
- Being courageous and providing the leadership necessary to make change happen
- Continuing to deliver good quality health and social care services whilst we make changes
- Changing to a true partnership with a culture of shared innovation and learning
- Building upon best practice and utilising work already undertaken such as the Safer patients initiative
- Working collaboratively with others where services operate across boundaries

All stakeholders will be supported and communicated with in line with the developing plan.

Promotion of patient stakeholders

At the Royal Free London NHS Foundation Trust we want to engage with our patients in new ways that enhance our quality of care and improve their patient experience. We will be looking to introduce Safety Briefings for patients as part of the Patient Safety Programme. We already have a patient representative on our Patient Safety Programme Board, and will be looking for further opportunities to engage more widely with patients. We do not know what format these may take at this stage, as the safety briefing project will be a co-designed piece of work with patients, their families and carers and staff to identify what patients need and want. This will help us to understand the role that patients can play in their own safety and the different mechanisms that could work to help them be informed and safe.

Alongside work on safety and prevention, we will be actively promoting the Duty of Candour and working to create a more informed process for patients and families around incidents and their investigation.

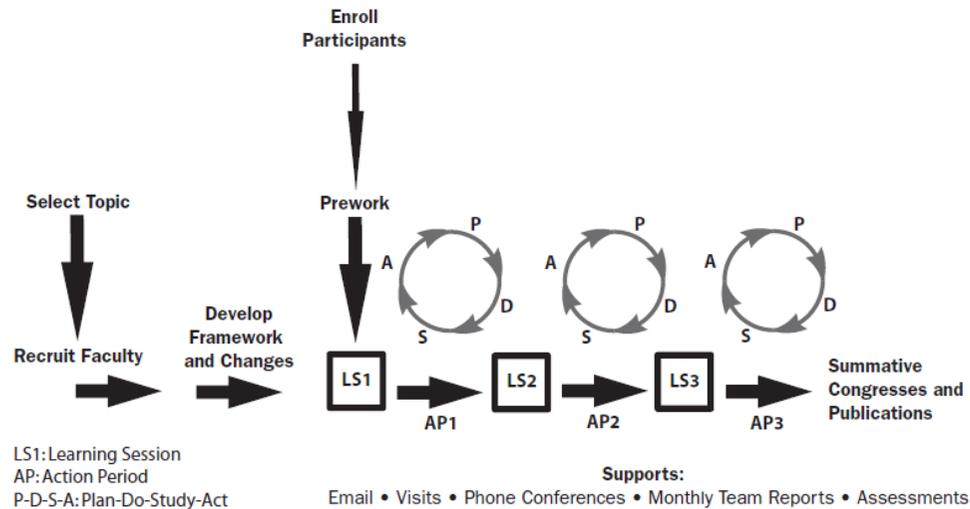
16. Plan

The key areas of focus have been determined following review of the serious incidents, incident trends, complaints and claims across the trust in the last 5 years. Data made available by NHSLA in November 2014 have clarified those areas of greatest litigation costs and these have been emphasised within the plan. The concepts around the trust's three-year Patient Safety Programme (PSP) were launched in October 2014, with a week-long engagement event that hosted National speakers and enabled staff across the whole trust to identify with the programme aims.

An initial driver diagram has been developed to encapsulate our key areas for improvement, and a project plan setting out the timeframe has been put in place. From April 2015, we will have the PSP implementation team in place and can start to develop workstream plans that will enable us to improve patient safety and reduce harm. The full project plan is detailed in the spreadsheet.

The trust developed its Quality Improvement methodology during its participation in the Safer Patients Initiative in 2007-2010, which was based on the IHI Breakthrough Series Collaborative Model (2003), detailed in the diagram.

Figure 2. Breakthrough Series Model



Using this approach for each project the following will be developed:

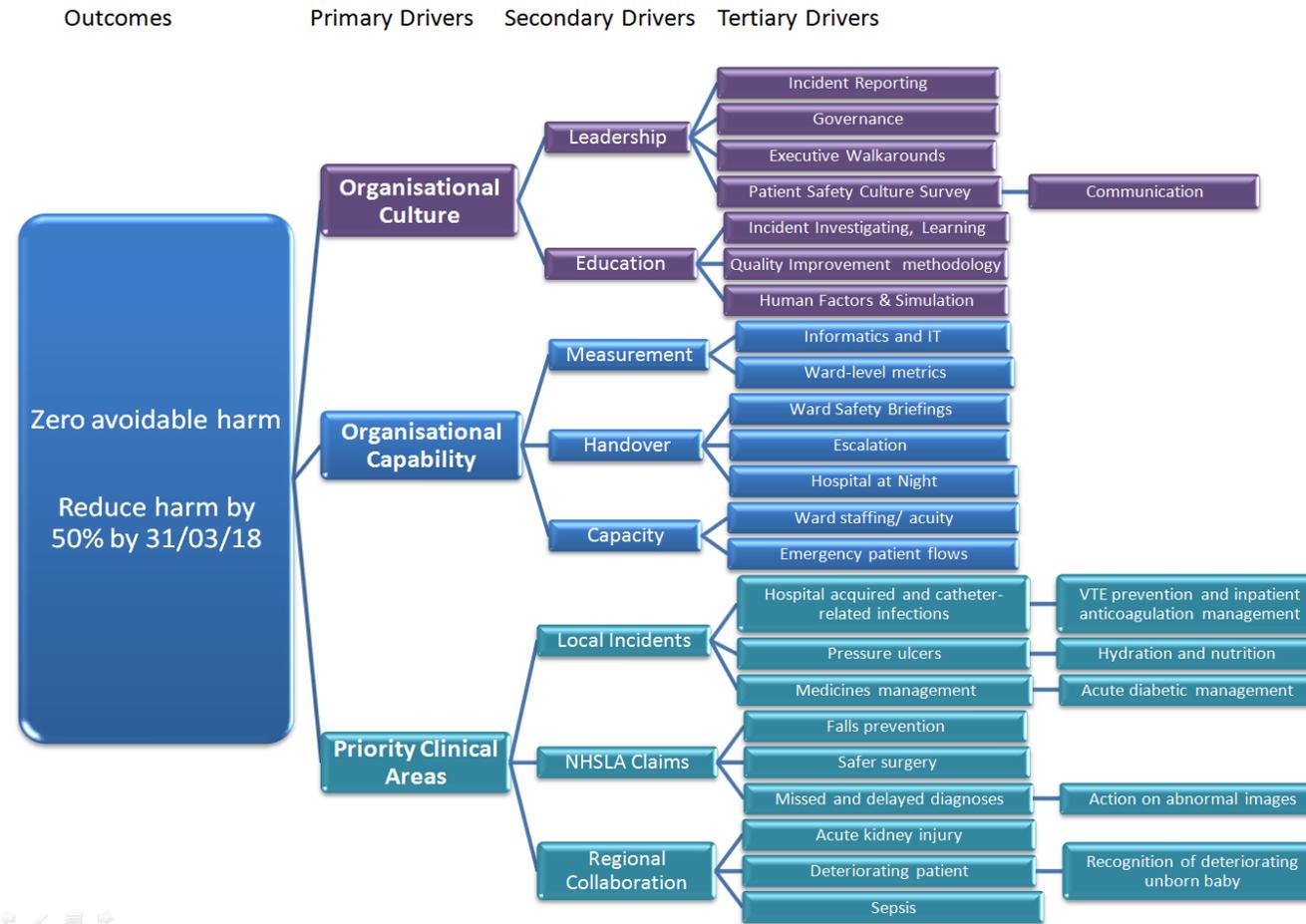
- Baseline data
- Team identified with a clinical lead and ward-based champions
- SMART Aim agreement
- Driver diagram development
- Project implementation plan agreement
- PDSA cycles / measurement review and improvement
- Dissemination options developed with barriers identified/controlled
- Sustainability identified and monitored

Training and Development

We plan to increase the understanding of improvement skills, patient safety and develop a safety culture together with human factors across the trust by completing the following:

- Develop Quality Improvement (QI) training strategy
- Develop Board skills and understanding in QI
- Set up a Quality improvement faculty
- Identify human factors training opportunities
- Provide opportunities for undergraduate and postgraduate multi-disciplinary QI development
- Implement facilitated debriefs (after action reviews)
- Provide online QI resources
- Support staff to become patient safety fellows

PSP Driver Diagram



17. Risk Management

Risk assessments for the programme will be produced by the PSP Team and be managed and monitored by the PSP Board. High level risks will be presented to PSP Board and managed locally within the PSP team workstreams. Risks will be logged on the Datix Risk Register.

18. Cost Estimates

The staffing costs that are needed to take forward the PSP are estimated at £1,797,053 (approximately 10% of our 2014/15 NHSLA contribution). Detailed breakdown of these costs are shown in the attached spreadsheet.

There is currently no Patient Safety Programme Team in place at RFL. The proposed team structure (see below), consisting of 3 Programme Managers (band 8a), five Workstream Managers (band 7), and two administration staff (band 6) would all (bar the Falls lead) need to be recruited before the Patient Safety Programme can be started.

Having undertaken the Safer Patient Initiative from 2007, we know that in order to make effective changes we need to have dedicated project staff in place with quality improvement skills to help support staff, drive improvement and maintain focus for patient safety projects to deliver the project outcomes and become sustainable. The proposed staffing will enable the Trust to support the 12 key clinical workstreams in the three implementation phases over the next three years.

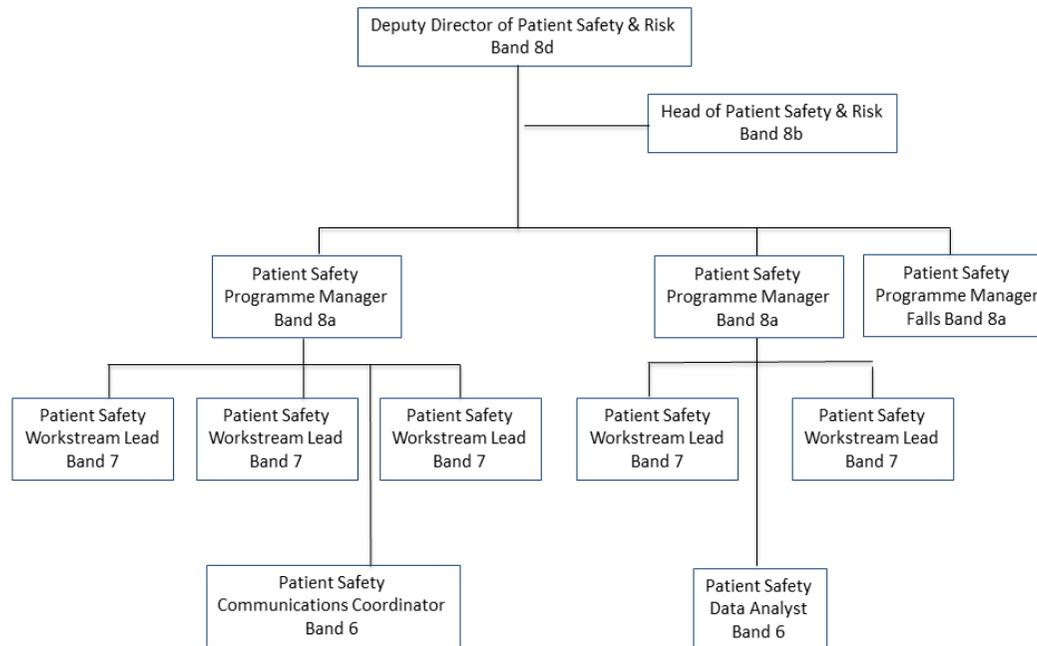
Our aim is to create this team under the leadership of the Deputy Director of Patient Safety and Risk, who has experience of setting up successful quality improvement programmes. This team will be the contact point for staff and will bring together expertise that can be spread throughout the organisation. Our three phased plan is ambitious, containing 12 key clinical workstreams alongside the organisational development in capability and capacity that will be needed. These staff will not only be delivering high quality improvement management, but will also be delivering training to staff to enable quality improvement practices to be developed sustainably across the Trust.

At the Royal Free London NHS FT, we have over 10,000 staff who speak 100 languages who work across 36 different sites. This includes three key hospitals: Royal Free, Barnet, and Chase Farm that are both geographically and in some respects culturally far apart. These hospitals only merged in July 2014, so for us it is crucial to have this team of staff that can move between sites and cultures to develop, deliver and embed quality improvement.

It is planned that the three PSP Programme Managers will have oversight of the Patient Safety Programme and manage the workstream leads and administrative staff. These key people will enable the strategic focus of the Patient Safety Programme to be delivered across the trust. Ensuring that changes are piloted in small areas using PDSA cycles before being ramped up as improvements to be disseminated trustwide. The geographical spread and potential cultural barriers to change within RFL should not be underestimated, and these staff are crucial to the dissemination of planned improvements.

The workstream leads will provide much needed project support to the Patient Safety Programme. They will work closely with the clinical champions and ward staff to understand the issues and deal with day to day challenges. Our ambitious programme of delivering improvements across 12 clinical workstreams on three sites in 3 years, will only be possible with these key staff.

Patient Safety Programme Team



19. Performance Measures and Success Criteria

Quantitative and qualitative data described below will be collected retrospectively from year 2013/14 (or before where possible) and measured from year 2014/15 onwards:

- Hospital standardised mortality rate (HSMR)
- Cardiac arrest rate

- Unexpected admission to critical care rate
- Never event rate
- Reporting of zero-harm or near-miss incidents (should increase)
- Reporting of moderate and significant harm incidents (should decrease)
- Improved staff survey results in relation to patient safety culture
- Dr Foster safety metrics
- Patient Safety Culture survey

Additional data sets will be generated as required for each workstream, ensuring that process, outcome and balancing measures are in place and recorded at regular, frequent intervals.

20. Appendix 1: Abbreviations and Definitions

Abbreviation	Definition
PSP	Royal Free London NHS Foundation Trust's Patient Safety Programme
QI	Quality Improvement
HENCEL	Health Education North Central and East London
UCLP	UCL Partners
PDSA	Plan-Do-Study-Act
CTG	Cardiotocography
RFL	Royal Free London NHS Foundation Trust

21. Appendix 2: Bibliography

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22. Appendix 3a: Workstream Summaries - Phase 1

Falls Prevention

Inpatient falls have been noted as the most frequently reported incident resulting in harm to patients at the Trust. The trust has implemented a number of improvement interventions across a number of wards and has increased the provision of low profile beds, and physical protectors for patients. However, falls (particularly those resulting in harm) continue to be reported at an unacceptable rate, over the last 2 years we have seen a significant increase in both the numbers of reported falls but also the numbers of patients sustaining serious harm from the falls (including fractures).

Goal

Reduce falls by 25%, as measured by incidents reported on Datix, by 31 March 2018.

Our key objectives will be:

- To fully embed the existing improvement programmes for falls prevention across all wards.
- To assess new methods and technology (e.g. electronic patient sensors) to reduce falls risk.

90 Day Actions

April 2015

- Set-up Trustwide Falls Working Group - to carry out root cause analysis of incidents, identify risk factors and areas for improvement
- Identify Falls Champions in each clinical service line across all sites
- Introduction of Falls Screening Tool (based on NSPA's STRATIFY) and Falls Prevention Plan (care bundle approach) by Division across all sites.
- Continue staff education and development on falls prevention

July 2015

- Create sharing process to enable learning from falls incidents, especially serious incidents
- Consolidate updated falls-related policies and post falls protocol across all sites

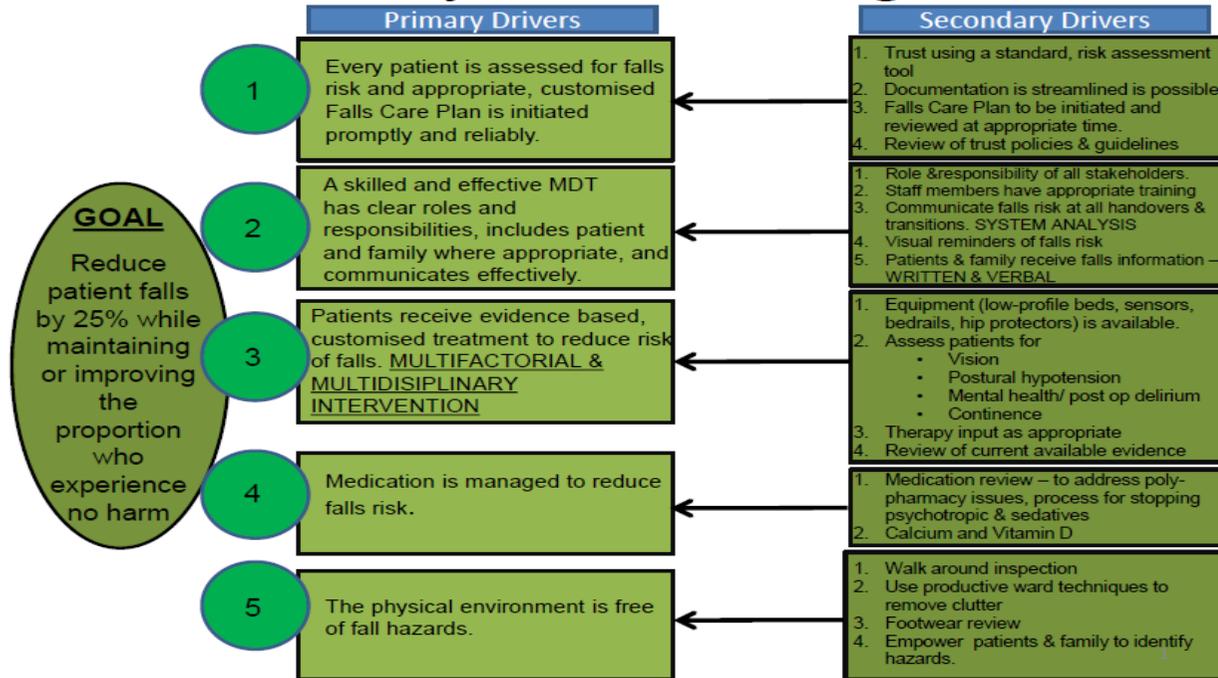
October 2015

- Set-up Falls Awareness Events and training with Trustwide MDT falls study day

January 2016

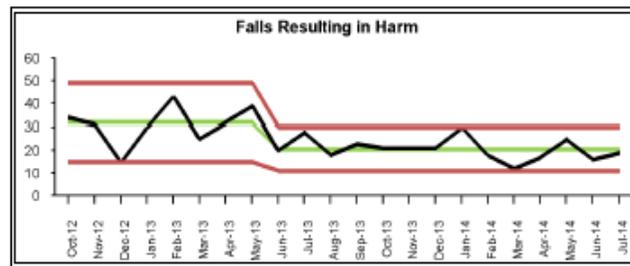
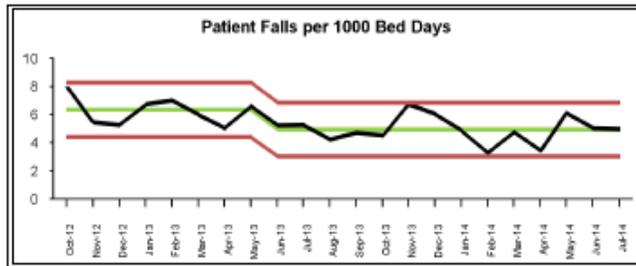
- Initiate Falls podiatry assessment pathway

Falls Project: Driver Diagram

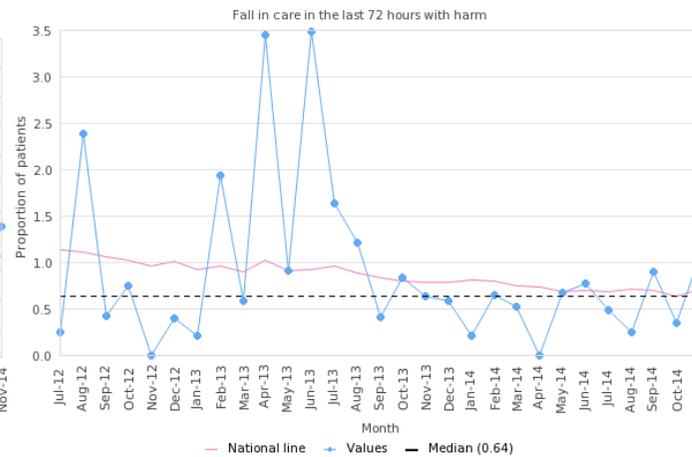
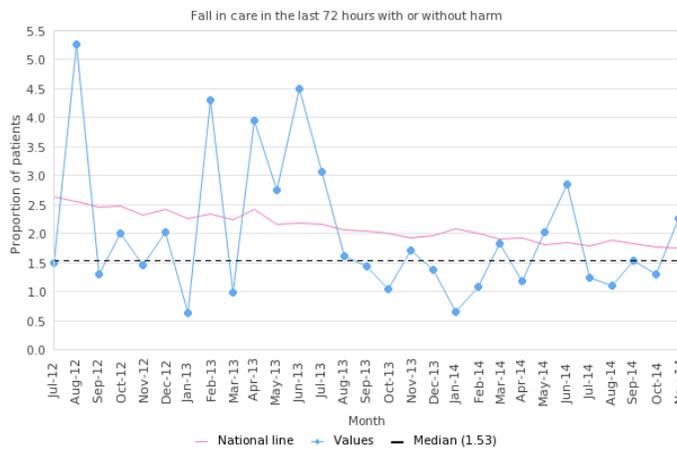


Measures

Patient falls per 1,000 bed days and falls resulting in harm are routinely at the Trust. The rate of patient falls year to date rate is 5.0, with a target of 4.2. The step change down (a statistically significant change in performance) in the rate of falls observable from June 2013 has been sustained. The improved performance results from the Falls Prevention and Injury Reduction work carried out in the care of the elderly wards. As with the rate of falls, a statistically significant reduction in the number of incidents triggers a reducing step change from June 2013.



Safety Thermometer data (from the monthly point prevalence audit) are also routinely monitored.



Additional process measures around completion of falls risk assessments and care bundle compliance will be monitored as needed during quality improvement PDSA cycle interventions.

Acute kidney injury (AKI)

AKI, or acute kidney failure, has received heightened national interest due to emerging evidence of poor recognition and management alongside evidence of its association with increased lengths of stay, morbidity and mortality. Acute kidney injury is seen in 13–18% of all people admitted to hospital, with older adults being particularly affected. It is estimated that people with acute kidney injury stay in hospital an average of 4.7 days longer than people of the same age in the same HRG without acute kidney injury. In spite of having a large, tertiary renal service on site we continue to report clinical incidents relating to AKI recognition and management. A trustwide strategy is required to further improve basic, ward-level care and implementation of the AKI care bundle. This work will build on current work, including a pilot biochemical alert and critical care outreach informatics system.

Our QI work on AKI, is very much in partnership with UCLP, as our Associate Medical Director for Patient Safety is one of the two clinical leads for UCLP's Safety Programme. This programme includes the Deteriorating patient workstream which contains Sepsis and AKI. We are one of five spearhead sites taking this work forwards, which will involve layered interventions to improve care bundle compliance, with auto-alerts from pathology on creatine levels that will integrate with an automatic Outreach Team call. In line with this, we have £0.25m funds from NHSE Innovation to implement enhanced informatics that will enable us to develop an advanced alerting platform, capable of running a series of algorithms that will provide trending and identify AKI-related mortality.

Goal

Increase the number of patients who recover from AKI within 72 hours of admission by 25% by 31 March 2018 and target:

- 25% reduction in AKI mortality
- 25% reduction in length of stay
- 25% reduction in stage 1 AKI that progresses to AKI stage 2 or 3

90 Day Actions

April 2015

- Education of staff by App, website and e-learning
- Identification of access to baseline informatics in pilot areas
- Identification of AKI clinical leaders in pilot areas

July 2015

- Process mapping in pilot areas to understand patient flow and challenges
- Introduction of STOP AKI diagnostic and care bundle in pilot areas
- Introduction of outreach system for moderate AKI using PARRT as well as telemedicine senior renal support in pilot areas

October 2015

- Monitoring of AKI data, review of progress and continual PDSA cycles for improvement

January 2016

- Review and Refresh workshop to use successes and failures to identify how to move to 95% compliance

Measures

- % compliance with completed care bundle
- % patients with USS urinary tract within 24 hours of 1st AKI alert
- Number of patients with hospital-acquired AKI
- Number of patients who die from AKI
- Length of stay of patients with AKI
- % of patients in stage 1 AKI who progress to stage 2/3
- % staff trained
- % of patients who received relief of obstruction in less than 24 hours (after AKI diagnosis)
- % of patients who received therapy for treatable renal disease in than 48 hours

Deteriorating patient

Identification and management of the deteriorating patient is critical to patient safety and mortality reduction. This workstream will focus not only on active management of deteriorating patients but identification and appropriate management of patients who should best be managed conservatively. There is now an active UCLP programme on the deteriorating patient in which we participate.

Key components of this workstream will be quality improvement on timely delivery of physiological observations and responses to physiological triggers. We will investigate the use of electronic recording of physiological monitoring such that acuity of inpatients can be viewed, in real-time, across the organisation and appropriate pre-emptive action can be taken. In addition we will develop a programme on pathology (blood result) alerting of at-risk patients. The ongoing audit of mortality and cardiac arrests will sit within this workstream and this will include formal casenote review.

Goal

Reduce the number of cardiac arrests to less than 1 per 1000 admissions by 31 March 2018

90 Day Actions

April 2015

- Initiate case note review of selected 2222 calls and deaths, and feedback lessons learnt to staff
- Identify baseline data required at ward level and create process to feedback to staff in a timely manner

- Provide staff training on SBAR and EWS monitoring
- Identify pilot areas

July 2015

- Identify ward-based champions in pilot areas
- Educate staff to undertake ward-based case note review
- Review education programmes for clinical staff to further identify current courses that can include SBAR and EWS training

October 2015

- Monitor implementation of SBAR and EWS and use process mapping to consider where interventions are best placed for improvement

January 2016

- Survey staff on pilot CTG training to understand impact on practice and confidence

Measures

- Number of cardiac arrests
- Number of calls to PARRT
- Number of 2222 calls
- % of staff using the SBAR communication tool at shift handover
- % of patients with complete observations (EWS/par score)
- % of patients who triggered that had an appropriate response

Deteriorating unborn baby

Seven claims over 5 years resulted in death or injury to the unborn child. It is known that poor interpretation of cardiotocographs (CTGs) can be a significant factor in the non-detection of a deteriorating unborn baby and the Trust is already improving its uptake of CTG interpretation training, but this would benefit greatly from a QI approach.

The Trust has training and development of staff in place for recognising deteriorating CTGs. However, this is still an area of significant risk and we are currently working on ways that we can create a safer process. This work is very much in the developmental stage.

Goal

Reduce the number of claims relating to deterioration of the unborn baby to 2, between 01/01/15 to 31/03/18

90 Day Actions

April 2015

- Identify baseline data required at ward level and create process to feedback to staff in a timely manner

July 2015

- Determine CTG interpretation skills baseline by staff survey

October 2015

- Identify champions
- Trial CTG testing and simulation training on pilot group of staff

January 2016

- Survey staff on pilot CTG training to understand impact on practice and confidence

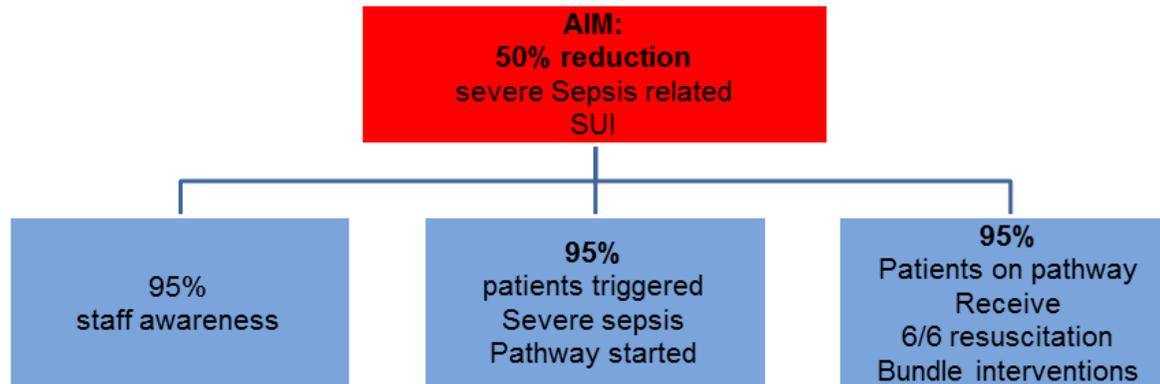
Sepsis

The trust currently has a highly active programme on acute sepsis management which, over a three year period, demonstrated significant outcome benefits for patients, including mortality reduction. This exemplar workstream will be incorporated into the PSP and will serve as a model for quality improvement methodology for the other workstreams, as we have successfully used PDSA methodology in sepsis and other areas, we plan to embed this throughout the organisation. This work will also now be rolled out to our other sites and other areas of need such as Maternity. There are currently 8 pilot sites in various stages of testing and compliance and two new pilot areas at Barnet Hospital.

Goal

Reduce severe sepsis-related serious incidents by 50% across all sites (A&E and Maternity) by 31 March 2018.

Sepsis Driver Diagram



90 Day Actions

April 2015

- Staff training in sepsis recognition in Maternity and Barnet ED

July 2015

- Testing of improvement tools: sepsis trolley, sepsis safety cross, sepsis grab bag, sepsis checklist sticker.
- Introduction of sepsis improvement tools: Severe sepsis 6 protocol

October 2015

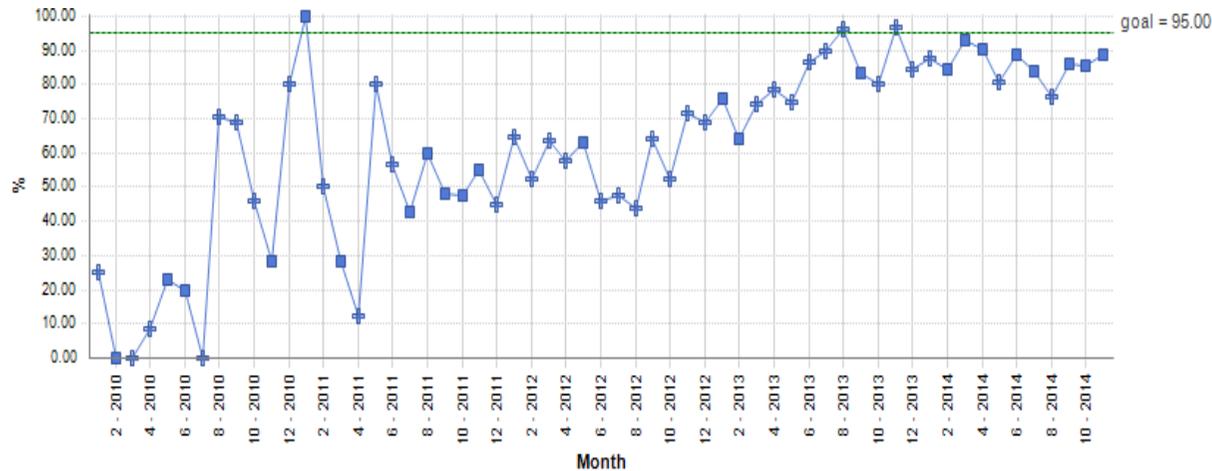
- Monitoring of data and PDSA cycle improvements

January 2016

- Review of improvement to attain 95% compliance

Measures

- % of staff with knowledge of sepsis and the 6 interventions
- % of patients who trigger two or more physiological signs on the pathway
- % of the patients on the pathway who have all 6 interventions completed in one hour from the time the physiological triggers were detected



Percentage compliance with severe sepsis bundle in Royal Free Emergency Department

23. Appendix 3b: Workstream Summaries - Phase 2

Safer Surgery

Theatre safety briefings were introduced into the trust in 2007 as part of the Safer Patient Initiative. Further excellent work has recently been undertaken incorporating the WHO surgical checklist and the NPSA 5 steps to safer surgery. In spite of this, since 2011 the trust has reported 11 never events relating to checking of patients, equipment and consumables within the theatre environment leading to 5 retained objects posts surgery and two wrong site surgeries.

The PSP Team will review practice against the NPSA guidance and will implement an improvement programme to deliver consistent application of the 5 stages to safer surgery. It will review team dynamics and safety culture within theatres as part of this work.

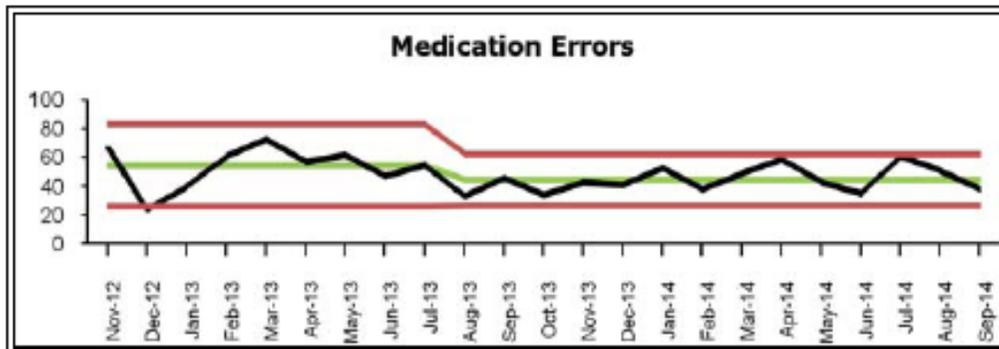
Action of abnormal images

Incidents relating to imaging/radiology reports have been identified by the NPSA as an area for quality improvement. We continue to report incidents relating to both imaging reporting and the timely action of reports by clinicians (these also fall under the missed/delayed diagnostics category). This workstream will therefore seek to strengthen our systems for reducing error and treatment delays in this area.

Medicines management

We continue to report adverse events relating to drug dosage errors (omissions and maladministration). Of particular concern are administration of penicillins to penicillin-allergic patients and maladministration of drugs (such as aminoglycosides) that require drug-level monitoring. This workstream will focus on the reduction of clinical incidents relating to specific, high-risk areas of medicines management. A key development in medicines safety will be the implementation of electronic prescribing and medicines safety priorities will inform this.

Measures



Medication incident reports include those which actually caused harm or had the potential to cause harm involving an error in the process of prescribing, dispensing, preparing, administering, monitoring or providing medicines advice. Over 90% of incidents are associated with no harm or low harm.

Acute Diabetic Management

The Trust continues to report regular instances of low-level and serious harm from failures in acute diabetic management. These relate to failure to administer prescribed insulin, effectively deploy insulin sliding-scales and maladministration of insulin (e.g. overdose). Clinical scenarios include basic ward diabetic care, management of diabetic emergencies and diabetic management in fasting (e.g. perioperative) scenarios.

We will develop QI projects based on the acute diabetic management for inpatients. This will build on existing quality improvement work in this area. This workstream will be led by the diabetic team working as part of the PSP workstream.

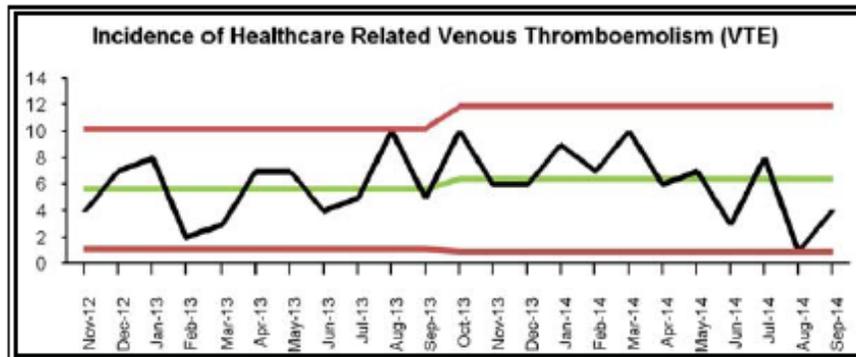
VTE prevention and inpatient anticoagulation management

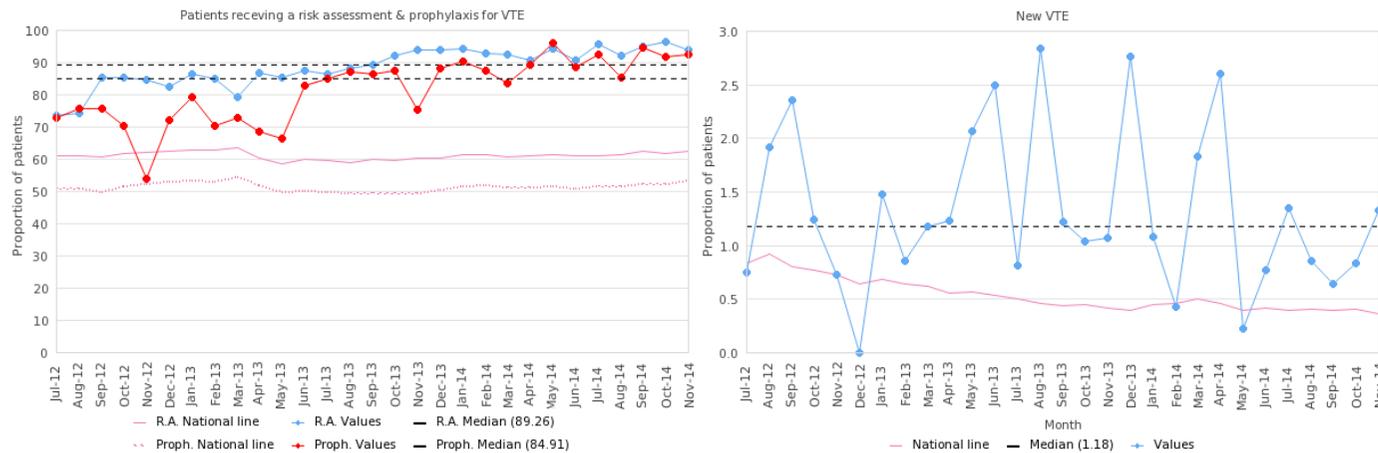
The need for robust assessment of patient risk of VTE and the appropriate management of the patient based on their risk factors to prevent hospital acquired DVTs or PE's has been the focus of national CQUINs for the past few years. Our performance in VTE prevention is also reportable to a parliamentary select committee. By deployment of a pharmacy-driven improvement programme excellent compliance has been achieved. However, we continue to report moderate and serious harm incidents related to anticoagulation management.

Actions

- To maintain current levels of performance in compliance with current and future VTE prevention targets and CQUINs.
- To define clinical targets for national exemplar status in VTE prevention, and achieve them.
- To develop a programme for improving safety in anticoagulation management alongside the medicines management team.

Measures



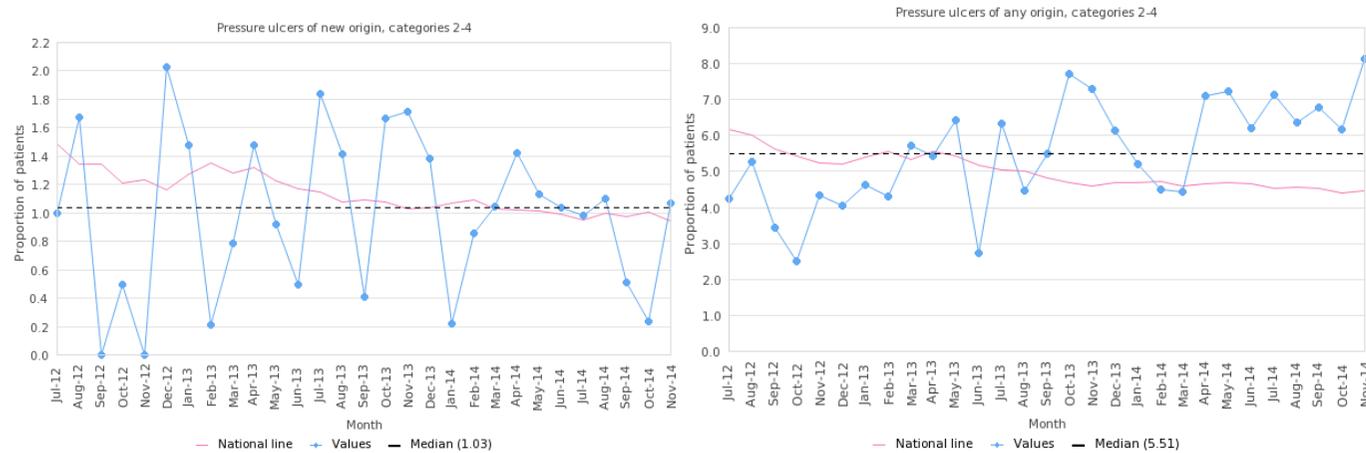


24. Appendix 3c: Workstream Summaries - Phase 3

Pressure ulcers

The trust has already made good headway in tackling the most serious grade hospital acquired pressure ulcers (Grade 3 & 4) through understanding the causes identified via incident investigation and implemented changes in care as a consequence. However, there are still a large number of grade 2 pressure ulcers reported and the trust has not completely prevented grade 3 & 4 acquisition. We will therefore undertake a prevention programme for pressure ulcers with the aim of eliminating grade 3 and 4 ulcer acquisition from the organisation.

Measures



Hydration and nutrition

Hydration and nutrition are fundamentals of care and are an understandable focus of public and media attention. We have a specialist patient mix whose nutritional and hydration demands are complex. We continue to report incidents relating to enteral feeding via nasogastric tubes, including aspiration from accidental endobronchial insertion (which is defined as a 'never event'). Additionally there is now an emerging evidence base on iatrogenic harm caused by the inappropriate administration of intravenous fluids.

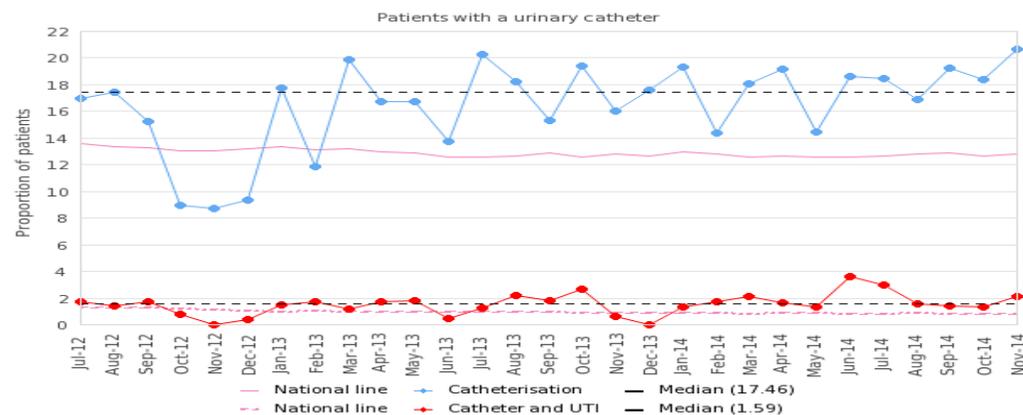
Actions

- Safe use of nasogastric feeding tubes (this will be a year one priority)
- Nutritional screening and monitoring.
- Nutritional support.
- Maintenance intravenous fluid prescription
- Appropriate and accurate use of fluid balance charts

Hospital-associated infections, including catheter-related infections

Hospital-acquired and catheter-related infection are key, externally reportable (via the Safety Thermometer) patient safety indicators. Infection prevention and control has an established governance structure within the Trust, with informatics and defined leadership. Hospital acquired and catheter-related infection will continue within its successful, nationally mandated arrangements. The Infection prevention and control team will be represented within the PSP workstream to help share best-practice in quality improvement and in implementing joined-up IT solutions.

Measures



25. Appendix 4: Equality Analysis

Royal Free London NHS Foundation Trust Equality Analysis

Name of the policy / function / service development being assessed	Patient Safety Programme
Briefly describe its aims and objectives:	Our aim is to become a zero avoidable harm organisation by 2020, initially by reducing the level of avoidable harm at the Royal Free London NHS Foundation Trust (as measured by incidents relating to NHSLA claims) by 50% by 31 March 2018.
Evidence sources: DH, legislation. JSNA, audits, patient and staff feedback	Incident reporting, NHSLA claims analysis

Directorate lead:	Steve Powis
Is the Trust Equality Statement situated in the first three sections of the document? *(where?)	Yes, Section 3

Please ensure any remedial actions are Specific, Measureable, Achievable, Realistic, and Timely (SMART)

Equality Group	Identify negative impacts	What evidence, engagement or audit has been used?	How will you address the issues identified?	Identifies who will lead the work for the changes required?	Please list positive impacts and existing support structures
Age	Possible negative impact identified	Patient records, Datix incident reports, NHSLA Claims, ESR Data	It is acknowledged patients with communication or access requirements due to age or disability will require additional support to ensure informed consent is given.	Clinical Lead	<p>All patients will be supported to receive an equitable service.</p> <p>The Trust has support structures in place for Language interpretation, British Sign Language Advocacy(IMCA) Acute Liaison Nurse for Learning Disability.</p> <p>The trust acknowledges some older people may not realise they do not understand, hear or see as well as they once did and we provide appropriate support services and a specialist Dementia Lead.</p> <p>The Trust has specialist and bariatric equipment for use with patients with specific access needs.</p>
Disability	Possible negative impact identified				
Gender Reassignment	No negative impact identified		Where no negative impact has been identified, should the need arise the issue will be addressed by the relevant clinical lead.		
Marriage and Civil Partnership	No negative impact identified				
Pregnancy and maternity	No negative impact identified				
Race	Possible negative		It is acknowledged patients with English as a second	Clinical Lead	

Equality Group	Identify negative impacts	What evidence, engagement or audit has been used?	How will you address the issues identified?	Identifies who will lead the work for the changes required?	Please list positive impacts and existing support structures
	impact identified		language may need additional interpreting support to ensure informed consent is given.		
Religion or Belief	Possible negative impact identified		The Trust is aware of issues associated with certain procedures and patients' religion or belief, and has policies and protocols in place.		
Sex	No negative impact identified		Where no negative impact has been identified, should the need arise the issue will be addressed by the relevant clinical lead.		
Sexual Orientation	No negative impact identified				
Carers	No negative impact identified				

Equality Analysis completed by:		Date:
Hester Wain	Deputy Director Patient Safety and Risk	December 2014
Jackie Macklin	Equality and Diversity Operational(patient) Manager	January 2015