

Trust Board

TB2008.57

From: Mrs Elaine Strachan-Hall, Director of Nursing & Clinical Leadership
Date: July 2008
Subject: **Patient Safety Framework 2008 - 2011**
For: **Decision**

Synopsis

One of the ORH's four strategic objectives is to be the hospitals of choice for patients. Safety is paramount in supporting and improving the quality and effectiveness of all our clinical services in order to be chosen by patients. Our performance also feeds directly into quality ratings through core standards and the annual patient surveys.

Increasingly there is a national focus on patient safety with a number of high profile campaigns and media coverage of leading-edge programmes. The ORH patient safety framework demonstrates Board leadership to a series of initiatives intended to embed patient safety across the Trust and to eliminate avoidable harm in all areas.

By approving the framework, the Trust Board will demonstrate this commitment by active involvement in making the ORH safer. A number of measures, including targets for a 20% reduction in hospital standardized mortality rates (HSMR), a 50% reduction in adverse events (using the Global Trigger Tool), will be put in place and performance reported on routinely. In addition, Board members will be involved in at least 24 executive safety walkabouts, reporting the findings, implementing the patient story initiative, and identifying appropriate resources to support the work of the safety action groups.

The Board is asked to approve the attached outline framework and to receive annual updates through the work of the Governance Committee and monthly updates through the balanced score card.

Financial, legal and risk impact

Patient safety is a key element in a quality service. Improving safety will allow the ORH to achieve its strategic aim and to achieve improved ratings for quality. In addition, improving safety by reducing adverse incidents increases the cost effectiveness of our care in a number of ways. Improvements in patient safety must therefore be an element in delivering long-term financial stability.

Patient safety framework 2008 – 2011

Strategic direction for change

1. Across the world in countries such as America, Canada, Japan, Denmark, Australia and several European countries, have taken direct action to reduce levels of avoidable mortality in healthcare. Campaigns such as the “Save 5,000 lives” campaign have demonstrated that hospitals can reduce mortality rates by taking specific action in key areas.
2. Patient safety findings across the UK indicate that around 10% of patients experience an adverse event during an acute admission. The overwhelming majority result in no harm, although around 50% are believed to be avoidable. This also indicates that there are areas of care that could be safer and more efficient which, if unaddressed, lead to unsatisfactory patient experiences.
3. Providing quality of care and safety will also lead to cost-effective care by systematically reducing avoidable adverse events which can result in extended hospital stays and readmissions. This framework outlines programmes of work in which the Trust will strive to be amongst the best at providing quality of care and safety, which is both effective and efficient, and provides patients with a positive experience.
4. Campaigns are underway in Scotland and Wales and the England campaign has been launched with a focus on reducing avoidable mortality and adverse events. The campaign builds on initiatives developed by the Institute for Healthcare Improvement (IHI) where the evidence base has been scrutinised and measurements demonstrating improving safety have been agreed. To meet the Trust’s objective to provide quality of care and safety, this safety framework includes safety programmes to implement the best available practice.
5. One of the ORH strategic objectives for the year is to deliver demonstrably excellent clinical outcomes and indicators of patient safety. Promoting safety can save lives and this document addresses the challenge in building belief, commitment and active involvement to engage in the activities that eliminate avoidable harm.

Culture, values and performance

6. The main aim of this framework is to perpetuate a culture that puts the patient at the centre of everything we do by striving to reduce adverse events. We will reiterate this intention, with examples such as patient stories, in staff and patient meetings in order to build ownership and communicate progress at every opportunity.
7. This framework, endorsed by the Board, sets out an ambitious programme for driving improvements. In order to succeed we will need to motivate our staff to harness this ambition to reduce mortality and adverse events to improve the individual care and experiences of many patients. The patient safety agenda aligns closely to the goals and principles which lead many individuals into healthcare as does the aspiration to

excellence that motivate many others. We will identify those who are most motivated to act as clinical champions.

8. Ambition and aspiration to reduce harm need to be fostered in a congruent culture where staff believe they are treated consistently and fairly at all levels. This means that throughout the organisation managers and clinicians are observed to support staff and approach adverse events and near misses, as an opportunity to learn and improve. The ORH approach will demonstrate that it is better to invest in learning from the 99% of incidents that do not require any formal disciplinary action rather than the 1% that might. Only when a member of staff has been reckless or negligent will disciplinary action be considered.
9. Consistently across the world, evidence shows that most patients who have suffered adverse events want an apology and reassurance that it will not happen again. To achieve this we will grasp every opportunity to learn from incidents, complaints, different types of patient feedback and litigation.
10. Culture is built by congruence 'from board to ward' and therefore the ORH safety culture will be supported by visual safety leadership through executive walkabouts and safety campaign leads, who, will engage front line staff and identify champions to develop solutions. This framework identifies a number of programmes each of which will be sponsored by a Director with the support of a programme lead, and will involve local clinical champions who show an interest in harnessing this agenda.
11. Measuring and promoting progress also promotes higher performance. A dashboard of metrics providing initial benchmarking, monitoring and assurance of performance throughout the Trust will be provided and will be aligned with the PCT contract and other external monitoring needs. This information management process will be supported by effective data collection and robust organisational governance arrangements.
12. To build organisational capacity a comprehensive range of coaching and training will be delivered, (co-ordinated by the risk team) and underpinned by an inclusive risk management system that is integrated into the everyday work of all staff.
13. Patient involvement will be integrated into the work of all programmes so that improvement of safety includes the patient's interpretation of what is important and improves the patient journey and experience within the Trust.

Trust safety aims

14. The Trust will reduce adverse events and mortality by developing a comprehensive safety programme visibly supported by the Board, the right culture, ownership and effective quality and risk systems.
15. To demonstrate the success of the programme the Trust will strive to achieve the following goals

A reduction in Hospital Standardised Mortality Rate by 20% from the current rate (2007) within 3-5 years

16. Hospital Standardised Mortality Rate (HSMR) is a nationally used statistical indicator for acute trusts. It is a measure that needs to be looked at over a long period to provide evidence of change but it can be monitored frequently using run charts to provide an indication of a changing trend. The Trust will monitor annual and monthly figures with a consistently downward trend expected.

A reduction in the rate of adverse events suffered by patients by 50% of the current rate within 3-5 years

17. The Global Trigger Tool for Measuring Adverse Events provides an easy-to-use method for accurately identifying adverse events (harm) and measuring the rate of adverse events over time. Tracking adverse events over time is a useful way to tell if changes being made are improving the safety of the care processes. The Trigger Tool methodology includes a retrospective review of a random sample of patient records using “triggers” (or clues) to identify possible adverse events.

17.1. Many hospitals have used this tool to identify adverse events, to measure the level of harm from each adverse event, and to identify areas for improvement in their organisations. It is important to note, however, that the Global Trigger Tool is not meant to identify every single adverse event in a patient record.

Develop visible safety leadership by completing 24 Executive safety walkabouts a year

18. To improve the ownership and culture of the organisation, the Director of Nursing and Clinical Leadership will establish a programme of safety walkabouts with senior staff. Completion of the walkabout programme and actions taken on the messages and issues received from the workplace will be reported and monitored through to the Trust Board.

Put the patient at the heart of everything we do by reporting a patient story at every Trust Board, Executive Board, Audit Committee and Governance Committee.

19. Patient stories have been shown to be powerful tools that ensure statistics, money and targets remain firmly attached to decision-making about patients. The retelling of real hospital events at each meeting demonstrates that the patient should be at the heart of everything we do.

Key responsibilities

20. The **Trust Board** will set the direction for effective patient safety systems as an integral part of the organisation’s culture, of its values and performance standards. All Board members will ensure the communication of safety programmes and benefits.

21. The **Chief Executive** is the Accountable Officer for the ORH. He is accountable for ensuring that the Trust can discharge its legal duty for all aspects of safety each year, and for the health & safety of staff, visitors and contractors in the Trust.

22. The **Director of Nursing and Clinical Leadership** is the executive lead director for safety. The Director of Nursing, together with the Medical Director, will ensure

organisational arrangements are in place that satisfy the legal requirements of the Trust for quality and continuing quality improvements for patients and staff.

23. **Executive Directors and Directors of Operations** are accountable for the risk activities in their areas of responsibility; their organisational structures must be able to discharge the requirements of patient safety.
24. The **Assistant Director of Quality and Risk** has a particular responsibility for risk management for both clinical and non clinical (health and safety). He manages the risk teams that liaise closely with the Division and Directorate teams to support their activities. He will monitor the safety programmes and ensure they are functioning and provide reports on the appropriate metrics.
25. **All staff and managers** are responsible for safety within their immediate environment and for participating in wider governance, quality and risk issues within their department. In addition, all staff should have clear objectives set and documented as part of their annual performance reviews.

Safety programme

26. Critical areas of care have been identified so that these become part of a managed 3-year rolling programme to reduce harm for patients. This should be based on the PDSA cycle (plan-do-study-act). For each group or area, key targets will be set. For example, a current objective for the Trust is to reduce avoidable infections to zero.
27. Each individual programme will establish a 3-year plan of development, terms of reference and metrics to monitor and measure improvements. The programmes will be monitored (in most cases) by either the Clinical Risk Management Committee or the Health & Safety Committee and assurance will be provided to the Governance Committee. Each programme will produce 6 monthly\annual reports for assurance to the Governance Committee. Key operational concerns will be reported to Executive Board and overall performance to Trust Board via the Director of Nursing and Clinical Leadership. Each group will be led by a clinical champion and a Trust Director, the group will be supported by a programme manager.
28. Recommendations from these groups must be agreed with the Divisions and Directorates that have key involvement and following this agreement, safety programme plans will be established in each Directorate. The Directorate plans will measure their performance and indicate local action to meet the targets set by the specialist group.
29. An important facet of improving safety in any organisation is the demonstration of visible executive leadership. To provide this leadership each year a Director will champion one of the safety programmes (this will be incorporated into their objectives) and completely review the effectiveness of the group, increase its profile and complete specialist walkabouts across the organisation to demonstrate Board commitment.
30. The key areas of work will include:
 - 30.1. No needless infections
 - 30.1.1. Reduction of central line associated bacteraemia

- 30.1.2. Reduction in surgical site infections
- 30.1.3. Prevention of ventilator associated pneumonia
- 30.2. Management of the acutely ill patient
- 30.3. Management of thromboprophylaxis
- 30.4. Reduction in harm from patient falls
- 30.5. Reduction in pressure ulcers
- 30.6. Avoid adverse drug incidents through medicine reconciliation
- 30.7. Avoidable morbidity from inpatient hyperglycaemia
- 30.8. Risk awareness and communication
- 30.9. Improving maternity safety

Meeting national safety standards

- 31. In parallel to the safety programmes, the Trust will also aim to meet all relevant national standards. This will be demonstrated by aiming for NHSLA level 3 for General and Maternity Standards over the next 3-5 years (achieving and or maintaining level 2).
- 32. To implement all safety solutions recommended by the National Patient Safety Agency and the wider Safer Alert Bulletins, and each year demonstrably build on the Healthcare Commission standards relevant to safety.

Summary

- 33. The framework has been developed to be implemented over the next 3-5 years. To implement the framework an operational plan will be developed and monitored each year, which will provide added assurance of progress. The framework will be reviewed and updated as each year to reflect progress and new information.
- 34. The Trust will aim to become the best at reducing unnecessary harm to patients with a comprehensive safety programme led by the Board, developing an open and learning culture, engaging front-line staff to develop solutions, supported by effective information management and by keeping patients at the heart of what we do.

Andrew Seaton
7th July 2008