Guide for developing a Safety Improvement Plan for Acute, Mental Health, Ambulance and Community settings

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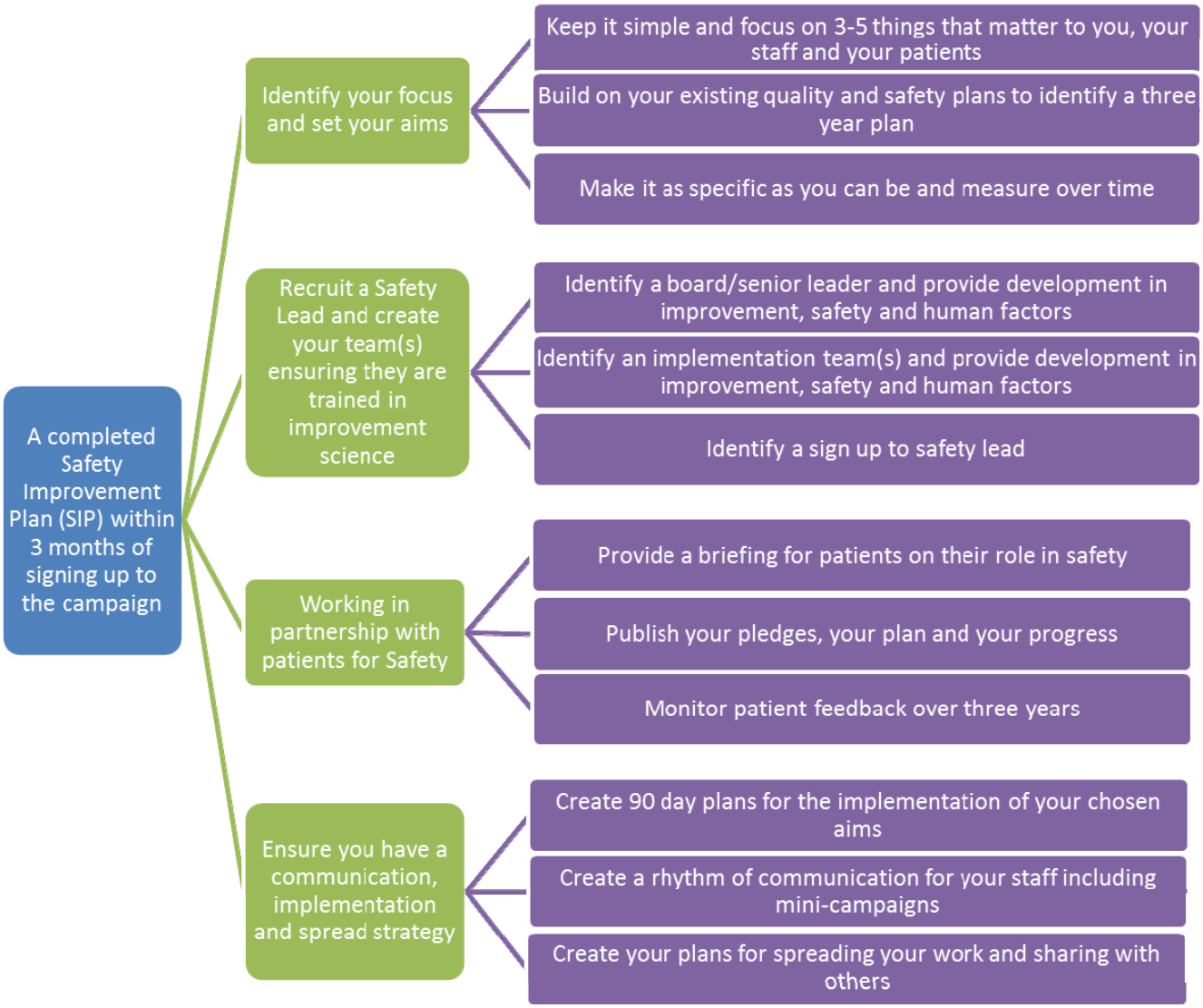
Safety Improvement Plan – driver diagram



NOTE: This guidance will evolve over time as we learn together and be shared on the Sign up to Safety website and distributed via the Safety Leads in each participant organisation.

Foreword

Over the last decade or so, the NHS in England has developed an understanding of the nature and scale of the problem in patient safety and the interventions that, when effectively implemented, can help to make care significantly safer. We have a National Reporting and Learning System (NRLS) which tells us about the types of incidents reported across the country, we have an alert system which informs the NHS about areas of concern and we have developed interventions in relation to medication safety, improving communication, understanding and measuring a safety culture, reducing harm associated with falls, pressure ulcers, infections, venous thromboembolism, sepsis and others.

There is clarity about what works; that a just culture supports safety, that risks associated with handover between units, hospitals and care settings can be addressed through simple communication tools, that a checklist used pre, during and post-surgery can significantly reduce harm and save lives.

The future of patient safety in England is now supported by a number of initiatives;

- A patient safety campaign – Sign up to Safety – to support the NHS to reduce avoidable harm by 50% and save 6000 lives
- The Patient Safety Collaborative Programme
- The Safety Fellowship initiative
- A SAFE team
- A set of safety indicators publically available
- The ongoing development of the National Reporting and Learning System

The following document provides guidance on the development of a key component of the Sign up to Safety campaign, the Safety Improvement Plan. The guidance is purposefully not prescriptive. Rather is seeks to provide advice and tips of what a good plan looks like.

What is it and why do you need one?

A Safety Improvement Plan is a document[1] which sets out the organisation's[2] plans for the next 3-5 years in relation to quality and safety. The plan will help you and your organisation be clear about what you want to achieve and when you want to achieve it by.

The plan can be a single place where you bring together all of your current work on quality and safety and can be used to explain to your staff and patients what you intend to do. It can also explain how you as an organisation will be coordinating all of the different external initiatives ensuring that they add value to your work and not either be seen as an 'add on' or isolated projects or act as a distraction to that which you are already doing. This plan can then go on to

[1] The plan can take many forms; a word document with appendices, a slide set, a series of one pagers linked together by a unifying summary

[2] For the purposes of this paper the term organisation is used to refer to a Trust, Foundation Trust, General Practice, and Independent Body

be a key document you discuss at all levels of your organisation from the Board room / practice leadership through to those that deliver hands on care. Equally it can be used to share with anyone who comes in to scrutinise your safety activity including the regulators such as the Care Quality Commission, Monitor and NHS Trust Development Authority.

What should the plan include?

With the principles that no 'one size fits all' – each plan across the NHS in England needs to be tailored to the organisation that develops it. A Safety Improvement Plan for a mental health trust will be very different from that of a community or ambulance trust. Equally a Safety Improvement Plan for a General Practice will be very different from that of a specialist orthopaedic trust.

To work your play needs to be owned by you and your staff. To do this we suggest a few tips:

- Create local ownership and accountability by working with your clinicians, managers and improvement teams and by conducting a listening exercise with your staff. Ask your staff what they think you should all be working on, find out what top 5 things 'keeps them awake at night' and build engagement; gaining buy in so that all staff feel the plan contributes and adds value towards their day to day work. This will generate a long list of priorities.
- Review your current safety data and match that against the long list of priorities to help you create your short list. The short list should be whittled down to between 3 and 5 areas to work on for the next 3-5 years. If you concentrate on around 3-5 areas it will enable you to focus on doing a few things well. Ideally the 3-5 areas would be a mix of
    - cross cutting system themes e.g. improving information, improving handover
    - safety specific e.g. improving medication safety and
    - disease specific e.g. Sepsis or Acute Kidney Injury (AKI)
- Check back with your staff – do they agree these are the areas of focus?
- Ensure that the leadership of the organisation will commit to resources to support improvements in these areas.
- Once you have the short list of areas you want to work on you need to work out what would be the things that would make the most difference. Conduct a reflective and learning exercise on your past initiatives in safety – what went well, what could have gone better? This will help you not make the same mistakes and build on your previous successes.
- It would help to answer the following questions:
    - What could everyone do to make an improvement in this area?
    - What does success look like?

- What do we need to do in order for that success to be realised?
- What are the things that would make the most difference?
- What would be the things we could do that would make us more resilient?
- Who can we learn from, who is getting this right?
- What are the interventions, tools, technology or solutions that have been proven to work in this area?
- What resources do you need?

Setting your aim

Your Safety Improvement Plan will then set out your clear aim statement(s) as to how you will reduce avoidable harm by 50% in your organisation through focusing on your chosen areas. Each focus area should have its own goal for what you want to achieve over the next three years i.e. what do you want to achieve by when. It is helpful if your goals are as specific as possible; rather than general – for example:

- A general goal would be, 'Get in shape', but a specific goal would say, 'I will join a health club and work out 3 days a week to get in shape and lower my cholesterol'
- A general goal would be, 'Reduce falls', but a specific goal would say 'A systematic review of our harm data has demonstrated that we should focus on reducing patient falls. Our current falls are x number and we would therefore like to reduce these by 50% from [x – y] by 2017.' 'Our current number of avoidable deaths associated with falls is [x] and we will aim reduce this to [y] by 2017 through [intervention]'

These could be plotted as either driver diagrams or as a table such as:

	What are the areas we could make the most difference?	What does success look like? What is your goal statement?	Measures	What do we need to do for that success to be realised?	What resources do we need?
1	e.g. Sepsis	e.g. What: reduced mortality related to sepsis How much: by 50% By When: 2017	e.g. % compliance with antibiotic administration	e.g. raised awareness. Increased understanding Antibiotic prescribing protocol etc	e.g. equipment, people, time etc
2					
3					
4					
5					

This leads you to create workstreams for your plan which all could have individual 90 day action plans that join up to the overarching plan. Each workstream would have a lead, someone who is accountable for delivery.

	Workstream	Goal	Actions – every 90 days	Lead
1				
2				
3				
4				
5				

NOTE: We will share examples of plans and the areas people have chosen to work on over the course of the campaign. We will also share driver diagrams developed by

Creating your team

When you join the campaign we ask you to nominate a **Safety Lead.** This is so that the central campaign team and regional hubs can work with these individuals to form a virtual network across the NHS in England. The campaign team will keep this network informed about developments and offers from Sign up to Safety to help and provide information for them about the other initiatives such as the Patient Safety Collaboratives programme and the Safety Fellowship initiative. They will be invited to join the regular webinars and online activity which they can then share across the organisation. This creates the wider virtual campaign team stretching across the whole of the NHS.

We also suggest that you nominate a **senior leader** to be your champion at the highest level. This could be an executive sponsor or lead GP. These can ensure that resources are made available and progress is reported on. These senior leaders should be visible to the frontline, listening and learning directly from them. Culture change and continual improvement comes from what leaders do through their commitment, encouragement, compassion and modelling of appropriate behaviours. The senior leaders should regularly review the safety improvement plans at their Board or leadership meetings.

You could also recruit **campaign ambassadors** / role models: A key success factor for implementation of improvement interventions is to engage and use role models and clinical leaders as the front face of the intervention – these can be your campaign ambassadors who would provide peer to peer influence.

Most organisations will have a core **team of people** who are working on quality and safety. You could use the work under the banner of Sign up to Safety as a way of bringing these disparate teams together. For example, those that work in patient safety, quality, complaints, claims, incident reporting, risk and others could all work together for the same cause of reducing avoidable harm and saving lives. Your safety improvement plan 'teams' should be multidisciplinary including where appropriate patients led by your Safety Lead. These are the people who will deliver and implement your safety improvement plan.

Building skills

You may want to identify who in your organisation knows about safety, quality improvement and other specialist subjects such as human factors. You may also identify those you think should know and provide training, mentoring and coaching for these people. Having the right people, doing the right things at the right time are core principles of quality improvement strategies. Consider providing improvement sessions for your senior leaders. The aim should be to increase the skills and knowledge around patient safety and improvement across and in every department of your organisation. A crucial part of this understanding is to be clear about what we mean when we talk about the 'just culture' for safety. To create this just culture all organisations should understand about:

- The impact of blame on patient safety
- How to respond when things go wrong
- How to encourage staff and patients to speak out
- How to learn from failure and success

- How to value the patient voice in development and improvement
- How to seek out and listen to staff about what keeps them awake at night
- How to learn, master and apply modern improvement methods
- How to use data accurately to support an improvement culture
- How to lead by example, through commitment, encouragement, compassion and a learning approach and infuse pride and joy in work
- How to help others to improve their own leadership capability
- How to recognise that some problems require technical action but that others are complex and may require multiple solutions involving all who have a stake in the problem

NOTE: Rather than telling you what support we could provide we ask you to let us know what you need. Contact the campaign team if you need expertise such as coaching, board development programmes – or whatever it is you need to help implement your plan.

Safety Briefings for Patients

One of the areas we want to explore in Sign up to Safety is the role that patients can play in their own safety and the different mechanisms that make work to help them be informed and safe. This should also build on your current strategy for engagement with patients and carers and could be used to create conversations about openness, transparency and issues such as the duty of candour.

Research has shown that patient safety improves when patients are more aware of the way they can help to contribute to their safety but it is extremely difficult to do in practice.

So you may want to show in your safety improvement plan how you will represents the patient voice and over the next three years considers how your organisation could create a safety briefing for patients. An example would be to use patient videos which can have significant potential to empower patients in the safety and quality of their care. However, it is important to note that efforts to implement patient safety videos in practice need to consider different patient groups' needs and characteristics rather than trying to adopt 'a one size fits all' approach. It is suggested therefore that participants think about the best way to do this in their organisation for their patients

An example has been developed by Haelo/harmfreecare.org in conjunction with Guys and St Thomas' Hospital and can be found in the following links:

Harmfreecare website

YouTube

NOTE: Over time we will post different examples of briefing patients for you all to learn from.

Measurement

Your safety improvement plan should have a section on how you will measure the activity. Your measurement plan should set out how you will support the overarching goal of reducing avoidable harm by 50%.

We suggest you create your baseline data and where possible collect both qualitative and quantitative data. Record these data retrospectively if possible so that you have a trend line.

We suggest you think about what good or success looks like and set your goals and develop your plans for monitoring progress towards this. The measures need to be real time, continuous monitoring. You could break it down one department at a time, test what works, evaluate and then spread.

In 'the measurement and monitoring of safety' Professor Charles Vincent and colleagues suggests that we should draw evidence from a range of sources:

- Part harm – e.g. incident reports, claims and complaints
- Reliability – e.g. measures of behaviour, processes and systems through audit and research
- Sensitivity to operations – e.g. the ability to monitor safety in real time and therefore to be able to react quickly
- Anticipation and preparedness – e.g. the ability to anticipate and be prepared for error, incidents and other safety issues
- Integration and learning – e.g. the ability to respond to and improve from safety information

The available measures will come from:

- Mortality statistics (HSMR and SHMI)
- Safety Thermometer data
- Case note review
- Incident reporting
- Clinical audit data
- Patient safety culture survey
- Intelligence from safety walk-rounds, safety huddles, safety briefing and de-briefing
- Staff and patient surveys

Sharing progress

Organisations will also be required to share their Safety Improvement Plan with their staff and the public. At the end of financial year 2015/16 each participant will be asked to share the impact of their work via an end of year report on progress. This should also be shared with staff, the public and the central campaign organisers who will share it with the wider community.

Implementation of your plan

Once you have thought about what you want to achieve and where you want to focus you need to then think about how you will achieve your aim. You can do this by having an implementation section in your plan. This will describe how you will support your staff to make improvements and how you will spread interventions that are known to reduce harm so that the changes you make are sustained and embedded into everyday practice. Implementation is a process not an event, it is complex and requires both expertise and concerted effort; it most definitely is not about simply telling people to 'do it'.

Success factors

- Demonstrating that the change is better than status quo and relevant, with tangible benefits
    - i.e. the answer to the question 'Why should I bother?' or put it another way, 'there needs to be a need for the change'
- Help make the change implementable
    - i.e. don't issue a 100 page manual or depend upon intense hours of training
    - Adapt to local conditions – i.e. something that works in another country, another organisation or even another team will not automatically work for others – you have to test it, adapt it, and test it again to get everything to feel it fits for them
- Influence - the change will be more successful if it is implemented by people who are respected, often referred to as peer to peer influence or the use of opinion / role models
    - i.e. people will implement changes that are liked by people who do a similar job, and they think are sensible, possibly even charismatic, and they want to a) be like them and c) do what they do because if they like it, it must be good
- The change matches intrinsic motivators
    - i.e. presses the buttons that make people want to do things, like beliefs, moral compass, ethics, desires, competitive streak, positive feedback, energising activities and so on
- Reward and recognition
    - i.e. people need to be recognised for their actions, thanked and valued for their contribution to safer care
- Measurement and visible results

- i.e. I know obvious, but you can't tell how well you are doing, you can't offer recognition and make people feel good about what they have done, if you haven't measured it

- Breaking it down to help implementation
  - A great way of breaking down the enormity of the task is to set out the timeline of activity for the first year – divided up into 90 day plans

Sharing

In joining Sign up to Safety we ask that organisations make their pledges, safety improvement plans and progress available to their staff and public. We ask that the organisation declares that they have joined up on the home page of their website together with the Sign up to Safety logo.

So your plan should set out how you will make your plans public and how you will share your progress with your staff, the public and the central campaign organisers who will share it with the wider community. This will include creating mini-campaigns in your organisation to raise awareness of what you are doing and showcase your work to your staff and the public, how you will spread across departments or across the health economy and the wider NHS.

For ongoing reference materials:

Sign up to Safety via www.signuptosafety.nhs.yj

Annex A Checklist for your Safety Improvement Plan

Step	Action	✓
People	You may want to nominate an Executive sponsor or senior lead from your organisation or practice to provide strong leadership	
	You will need to nominate one or more Sign up to Safety Leads to be the face of the campaign locally in your organisation	
	Identify the people you want to lead on the areas of harm you want to reduce	
	Identify a core team of staff who will support them to implement the plan	
Champions and role models	You may want to think about who the clinical and managerial role models in your organisation are that could help promote your plan	
	Over the next few months you will also consider who you want to recruit to be put forward to become safety fellows as part of the safety fellowship initiative	
Your plan – the basics	What are you aiming to do? • Provide a clear 'aim statement' for your plan with individual aims for each of the areas that are important to you; focus on doing a few things well • Create a driver diagram for each area and set out how you will measure what you are doing • Describe your milestones and deliverables for year one • Set out what data you want to collect and where possible record the qualitative and quantitative data retrospectively from year 2013/14 or before if you have the data and/ or set out to measure for year 2014/15 onwards • In order to understand your safety culture and create some baseline data you may want to conduct a patient safety culture survey • Describe the roles and responsibilities for the team • Set out how it builds on your existing quality and safety plans	
	Describe your plan for developing Safety Briefings for patients	
	Set out how you will implement your plan and how you will spread the work as appropriate, this includes a timeline of activity divided up into 90 day plans	
Increasing improvement skills to support your plan	Consider a Board development programme on improvement and measurement skills for reducing harm and improving safety	
	Consider a learning plan for how you will increase the understanding of improvement skills, patient safety and a safety a culture together with human factors across your organisation	
Sharing knowledge, scale up, spread and communication	Create a communications plan for how you will share your safety improvement plans and progress with your staff and the public via your website	
	Align with the central campaign activities and run mini-campaigns in your organisation to raise awareness of what you are doing and showcase your work to your staff and the public	
	Share progress with the central campaign team who can highlight your success and share your tips, tools, documentation with the wider community via our webinars and website	
	Connect with your local academic Health Science Network	
	Set out how your plan will spread across departments or across the health economy via commissioners for example	

Annex B Prioritisation

You can use a table to map across all your harm data to identify a short priority list. For example:

Top	Patient Safety Incidents	Clinical Negligence Claims	Complaints	Safety Thermometer data	Case Note Review data	Morbidity and Mortality Data	Never Events	Serious Incidents
1								
2								
3								

Grid to demonstrate the evidence of areas of avoidable harm used to set national priorities – you can use this to find out what work others are doing and what is happening at a national level to address these areas. You may want to find out what your AHSN will focus on with their patient safety collaborative and use all this to identify your focus area(s) for your personalised plan.

Topic area	Patient Safety Topic							
The 'essentials'	Leadership			Measurement				
NHS Outcomes Framework improvement areas	Venous Thrombo-embolism	Healthcare Associated Infections	Pressure Ulcers	Maternity	Medication Errors	Deterioration in children		
Other major sources of death and severe harm	Falls	Handover and Discharge	Nutrition and hydration	Acute Kidney Injury	Missed and delayed diagnosis	Deterioration of patients	Medical Device Errors	Sepsis
Vulnerable groups for whom improving safety is a priority	People with Mental Health needs	People with Learning Disabilities	Children	Offenders	Acutely ill older people	Transition between paediatric and adult care		

Annex C Driver Diagram

A driver diagram help provide you with a clear framework for improvement. The campaign will be providing support for creating driver diagrams for the safety improvement plan activities. For example: