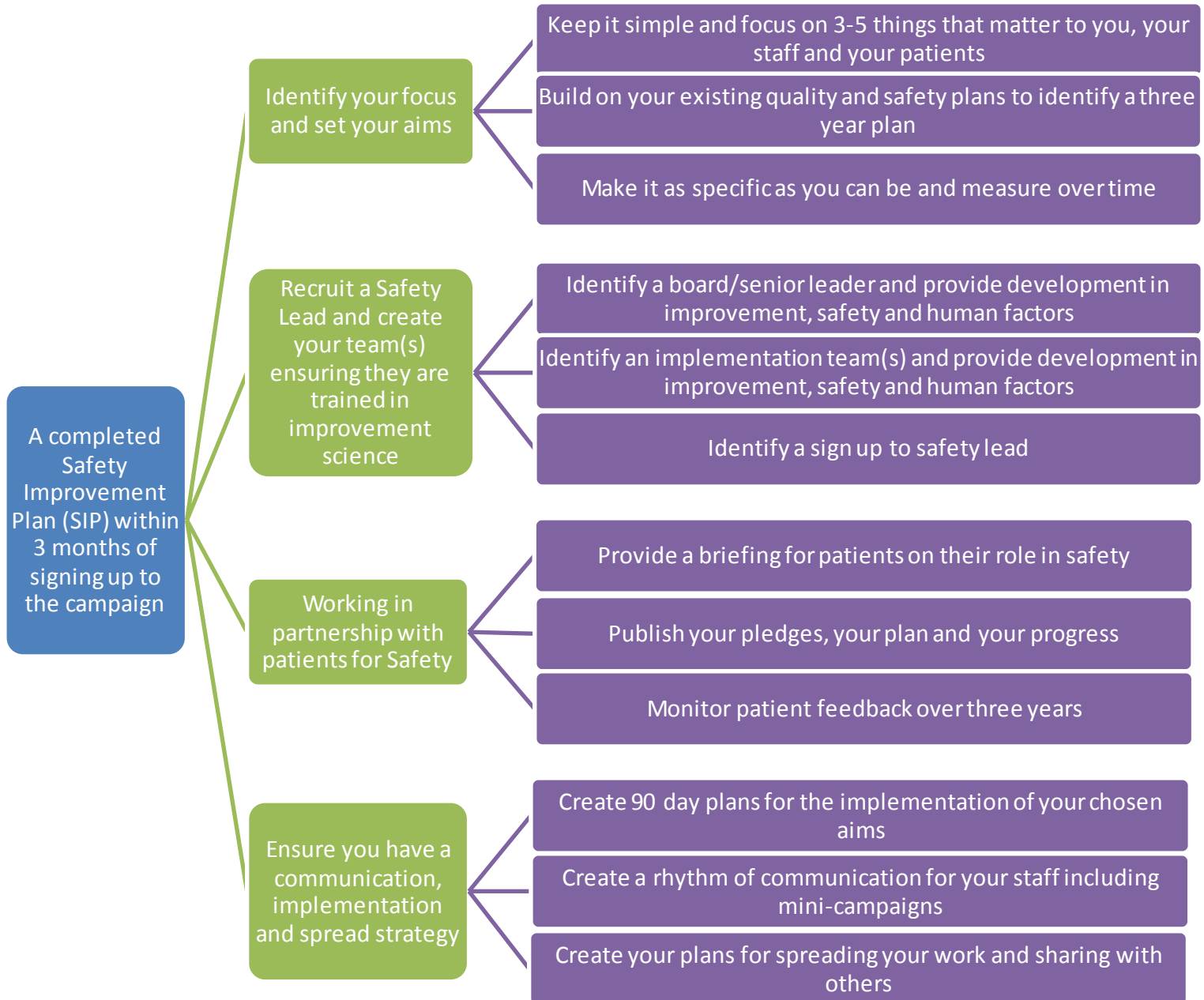


Safety Improvement Plan Guidance Notes

Sign up to Safety



Getting Started

- You can use the safety improvement plan to create the right culture in your organisation
- Ideally the safety improvement plan will build on and bring together all of your quality and safety work
- Ensure a strong focus on effective measurement for improvement
- Use Sign up to Safety and your plan to help the organisation bring together all the external patient safety initiatives your organisation may be involved in e.g. the Safety Fellowship programme, the Patient Safety Collaboratives

Focus

- We suggest that you create local ownership and accountability by working with your clinicians, managers and improvement teams and by conducting a listening exercise with your staff
- 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
- Learn from and build on past initiatives you have worked on – what went well, what could have gone better
- Concentrate on around 3-5 areas so that you keep it simple and focused on doing a few things well
- Your focus could 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)

Setting your aim

- The first step is to create the long list of priorities
- The second step is to review your current safety data and match that against the long list of priorities to help you create your short list. The short list you be between 3 and 5 areas for your safety improvement plan
- The third step is to ensure that the key stakeholders in your organisation agree these are the areas of focus and that the leadership of the organisation will commit to resources to support improvements in these areas
- 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)

Creating an aim statement

- Your Safety Improvement Plan will then set out your clear aim statement as to how you will reduce avoidable harm by 50% in your organisation through focusing on these areas
- Each focus area should have a goal for what you want to achieve over the next three years i.e. what do you want to achieve by when
- Your goals should be 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."
 - For example, 'A systematic review of our harm data has demonstrated that we should focus on reducing patient falls by half from [x – y] by 2017.' 'Our current number of avoidable deaths is [x] and we will aim reduce this to [y] by 2017 through [intervention]'

Creating your team

- Each organisation is asked to nominate a Sign up to Safety Lead
 - The central campaign team and regional hubs will 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
- Your safety team could include the name of executive sponsor or senior leader
 - The executive sponsor / senior lead can provide encouragement and support your resource needs. They can also report progress to the Board
 - The Board and senior leaders should be visible to the frontline, learning directly from them
 - Culture change and continual improvement come from what leaders do through their; commitment, encouragement, compassion and modelling of appropriate behaviours
 - The organisations leaders should define their strategic aims in patient safety, and should regularly review data and actions on quality, patient safety and continual improvement at their Board or leadership meetings

Creating your team (2)

- 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 are your campaign ambassadors and peer to peer influencers
- Bringing the team together
 - Most organisations will have a core team of people who are working on quality and safety. These will be able to support the different workstreams identified in your safety improvement plan. The workstream leads may require training, mentoring and coaching.
 - Your safety team should be a multidisciplinary team including where appropriate patients led by your Safety Lead. These are the people who will support the implementation of your safety improvement plan

Building skills in your organisation

- 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
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- The work generated by your safety improvement plan could help increase the understanding of patient safety across your organisation
- Support your staff with improvement skills, what a safety culture is and how understanding human factors can help them and your organisation

Safety briefings for patients

- The safety improvement plan should help engagement with patients and carers in relation to safety
- Patient safety improves when patients are more aware of the way they can help to contribute to their safety
- Ensure your safety improvement plan 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

Measurement

- Your measurement plan should set out how you will support the overarching goal of reducing avoidable harm by 50%
- 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
- What does good look like? Set your goals and develop your plans for monitoring progress towards your goals; real time, continuous monitoring would be the most ideal. 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

Example table

	What are the areas we could make the most difference?	What does success look like?	What do you need to do for that success to be realised?	What resources do you need?
1	e.g. Sepsis	Your goal statement. E.g. reduced mortality related to sepsis by 50% by 2017	Raise awareness Increased understanding Antibiotic prescribing protocol etc	e.g. equipment, people, time etc
2				
3				
4				
5				

Example table

	Workstream	Goal	Actions	Lead
1	e.g. Sepsis	Your goal statement. E.g. reduced mortality related to sepsis by 50% by 2017	Raise awareness Increased understanding Antibiotic prescribing protocol etc	
2				
3				
4				
5				

Plan Do Study Act

A rapid cycle improvement model could be used to transform information into activities that will improve the care delivery and outcomes.

Questions that frame each workstream are:

- 1) What are we trying to accomplish
- 2) What change can we make that will result in an improvement?
- 3) How will we measure the improvement?

The Plan-Do-Study-Act improvement model is the approach used for most improvement projects

- Plan – Develop a plan, set objectives, make predictions regarding expected outcome, identify actions, define responsibilities and timeframes and define the methods and frequency of measurement. Plan a small test of change to test the approach
- Do – Teams implement small tests of change, make modifications as needed
- Study – Evaluate the data, compare results to anticipated results and summarize findings
- Act – Teams act based on results of the study

Implementation Tips

- 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

Implementation Tips (2)

- 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