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Guide for developing a Safety Improvement Plan for General Practice

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Executive summary

The Sign up to Safety campaign was launched in 2014. It is a three year long campaign that supports the NHS in its aim to reduce avoidable harm by 50% and save 6,000 lives. The vast majority of care provided by the NHS is safe but staff are fallible and sometimes mistakes are made that can have adverse outcomes for patients. This national campaign aims to raise awareness of the scale and nature of the problem and provide a platform to share learning and ideas about good practice. Historically, much of the patient safety focus has resided in the secondary care setting and yet the vast majority of patients are seen and treated within primary care. Consequently, this guidance has been specifically produced to support General Practices that sign up to the campaign, with their Safety Improvement Plan.

Foreword

Over the last decade or so, improving patient safety and reducing harm has received significant attention throughout the NHS. Much of the focus however, has resided within Acute Trusts and consequently there is greater clarity about what works in this setting. To date, patient safety within General Practice has had less attention and has frequently focused on Significant Event Audits (SEAs). Despite many GPs being committed to improving patient safety, national reporting regarding safety incidents is comparatively low; consequently there is a significant opportunity for more learning through increased reporting.

Across the NHS, the majority of care takes place within primary care and despite best endeavours; it is human to err and inevitable that mistakes will be made that result in 'low level' errors and sometimes serious harm. Those mundane, everyday 'glitches' that occur in General Practice can be just as important as the dramatic failures that can occur in secondary care and by reporting these, the whole system can learn and improve the safety of services. Indeed, alerts are informed by those who share the learning from both near misses and actual harm, leading to safer systems and processes. It is our intention that patient safety within General Practice receives due attention and support and that together, we can discover those interventions that will reduce harm in this setting.

We recognise that unlike large acute Trusts, general practice does not have the same infrastructure and resources to support governance and safety arrangements. Furthermore, patient safety is competing for attention in the busy lives of staff working in general practice and regulators, commissioners and patients are increasingly paying greater attention to this too. With this in mind the Sign up to Safety campaign can really help you and your practice staff. By joining the campaign, we can help you to make a difference - harnessing the learning- successes and setbacks from all the participating practices across the country.

The Sign up to Safety campaign was launched in 2014. It is a three year long campaign that supports the NHS to reduce avoidable harm by 50% and save 6,000 lives. The core team within the campaign can offer support and guidance and the wider network of participating peers who are sharing tools, stories and resources has already proved popular.

This 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 but seeks to provide advice and tips on what a good plan looks like.

What is a Safety Improvement Plan and why do you need one?

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

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. The plan can also inform discussions with all stakeholders including commissioners or regulators such as the Care Quality Commission, who assess the quality of your practice and safety activity.

What should the plan include?

A Safety Improvement Plan for a General Practice will naturally be very different from that of an Acute Trust. There is no ideal plan – the best plan is one that works for you and your practice. To do this we suggest a few tips:

- Create local ownership and accountability by listening to, and working with, your Primary Health Care Team (clinical and administrative). Ask them what they think you should all be working on, find out what top five 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 (e.g. from previous SEAs) 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 three and five areas to work on for the next three -five years. If you concentrate on just a few areas, it will enable you to focus on doing those things well. Ideally the priorities would be a mix of
    - cross cutting system themes e.g. improving information sharing, processes for reviewing and acting on lab results
    - safety specific e.g. improving medication safety, appropriate cold chain storage of vaccines, appropriate equipment available i.e. blood glucose monitoring, disposal of clinical waste
    - disease specific e.g. early identification and management of sepsis, management of patients with co-morbidities
- Check back with your staff – do they agree these are the areas of focus?
- Ensure that the Partners/ Management Team are prepared to commit time to support improvements in these areas.

[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

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- Review previous initiatives in safety – what went well, what could have gone better? This will help you to avoid making the same mistakes and build on your previous successes.
- Identify what support and resources you need.

Setting your aim

Your Safety Improvement Plan will include your clear aim statement(s) as to how you will reduce avoidable harm by 50% in your practice 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 you want to achieve and by when. It is helpful if your goals are as specific as possible; rather than general – for example:

- A general goal would be, 'Reduce medication errors', but a specific goal would say 'Our current medication errors are x number and we would want to reduce these by 50% from [x – y] by 2017.' To do this we will [intervention].

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

	What 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 UK Sepsis Trust Primary Care Toolkit[2]	e.g. raised awareness and use of two part screening process to determine severity i.e. screening for SIRS and evaluation for Red Flag Sepsis etc.	e.g. equipment (such as pulse oximetry), people, time etc.
2					
3					

[2] http://sepsistrust.org/wp-content/files_mf/1409322498GPtoolkit2014.pdf

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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				

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 participants.

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 this individual 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 Collaborative. They will be invited to join the regular webinars and online activity which they can then share across the practice.

We also suggest that you **nominate a senior leader** - this could be the lead GP. They should ensure that resources are made available and progress is reported. As a GP, this person will already be visible to the Primary Healthcare Team and can support a listening and learning culture across the practice. The practice management team should regularly review the safety improvement plans at their practice meetings.

Many practices will already have individual staff with responsibility for risk management, health and safety and dealing with complaints etc. and their work could be brought under the banner of Sign up to Safety. This could be the formation of a small safety team, all working together to share learning and reduce avoidable harm. Ideally, your team should be multidisciplinary and you might like to include patient representatives where appropriate.

Building skills

You may want to identify who in your practice knows about safety, quality improvement and other specialist subjects such as human factors. You may also identify those you think would benefit from such knowledge – by joining the campaign, they can benefit from the training and mentoring that is provided. Having the right people, doing the right things at the right time are core principles of quality improvement strategies. The aim is to increase the skills and knowledge regarding patient safety and improvement across the primary healthcare team.

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, team development programmes, quality improvement skills or human factors training – or whatever it is you need to help implement your plan.

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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 might work to help them be informed and safe. Many practices already have a Patient Engagement Group and this could be a valuable resource to utilise. You may want to show in your safety improvement plan how you will represent the patient voice and how your practice could engage patients in your safety work. An example would be to use patient videos or messages in the waiting area which can have significant potential to empower patients in the safety and quality of their care.

Measurement

Your safety improvement plan should have a section on how you will measure the activity so that you will know which changes have led to an improvement. We suggest you create your baseline data and where possible collect both qualitative and quantitative data. We can help you to develop your measures but suggest you think about what good looks like and set your goals and develop your plans for monitoring progress towards this. You could break the measures down to one clinic at a time, test what works, evaluate and then spread across the practice.

The measures could come from a variety of sources such as:

- Significant Event Audits
- Case note review
- Incident reporting
- Clinical audit data
- Local intelligence from meetings or 'safety huddles'
- Complaints
- Staff and patient surveys

Sharing progress

Practices will be asked to share their Safety Improvement Plan with staff and patients. At the end of the 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 could form part of the Practice's Annual Report).

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 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'.

Again, we are able to offer support with this and to help you identify success factors such as identifying the key influencers within the practice, tapping into intrinsic motivation and dividing the work up into achievable steps.

Sharing

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

For ongoing reference materials:

The Sign up to Safety website: www.signuptosafety.nhs.uk

The Patient Safety Incident Reporting e-form for General Practice can be found at: https://report.nrls.nhs.uk/GP_eForm

In addition, information about your local Patient Safety Collaborative can be found in Annex C

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Annex A: Suggested checklist for developing your Safety Improvement Plan

Step	Action	✓
People	You may want to nominate a senior lead from your practice to provide strong leadership	
	You will need to nominate a Sign up to Safety Lead to be the link between the practice and the campaign	
	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 implementation of the plan	
Champions and role models	You may want to think about who the clinical and managerial role models in your practice are that could help promote your plan	
	Over the next few months you should 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 2014/15 or before if you have the data and/ or set out to measure for year 2015/16 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 practice 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 the practice	
Sharing knowledge, scale up, spread and communication	Create a communications plan for how you will share your safety improvement plans and progress with staff and patients via your website	
	Align with the central campaign activities and raise awareness of what you are doing/ showcase your work to staff and patients	
	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 and Patient Safety Collaborative	

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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	Health and Safety data	Case Note Review data	Commissioner/ Regulator feedback
1						
2						

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Annex C: Patient Safety Collaborative contacts

Patient Safety Collaborative	First name	Last name	Job Title	Email
East Midlands	Cheryl	Crocker	PSC Regional Lead	cheryl.crocker@nottingham.ac.uk
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Annex D: Example Driver Diagram

A driver diagram helps 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: