Patient Safety Strategy
2014 - 2017
## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>2</td>
<td>4</td>
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<tr>
<td>3</td>
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<td>12</td>
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<td>15</td>
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<td>16</td>
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<tr>
<td>8.5</td>
<td>17</td>
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<tr>
<td>9</td>
<td>18</td>
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<tr>
<td>10</td>
<td>18</td>
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<td>20</td>
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<tr>
<td>16</td>
<td>20</td>
</tr>
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## Review and Amendment Log

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<td>1</td>
<td>New</td>
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<td>Developed to outline the trust’s priorities in relation to the Trust’s commitment to delivering high quality safe clinical services ensuring patients are free from harm</td>
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</tbody>
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1. Foreword

Wirral Community NHS Trust is committed to safeguarding patients and service users, ensuring that patient safety is placed at the heart of everything we do. The trust already has an excellent reputation for patient safety, being identified as the safest community trust by the NHS Benchmarking Network in 2013, based on monthly Safety Thermometer submissions.

The patient safety strategy sets out our vision for patient safety, supported by specific annual quality goals reported monthly in the Quality Report, with the aim of providing safer community services for patients.

Staff Safety is also very important to the Trust but is not within the scope of this Strategy. Staff safety is covered within various Health and Safety policies and Guidelines for Dealing with Physical and Non-Physical Assaults Against Staff (Zero Tolerance), which are accessible via the StaffZone.

The trust’s patient safety strategy is based on the five principles outlined in the Sign up to Safety Campaign, supported by NHS England, the Care Quality Commission (CQC), the NHS Trust Development Authority, Monitor, NHS Improving Quality (NHS IQ) and the NHS Litigation Authority (NHS LA).

The campaign aims to make the NHS the safest healthcare system in the world, building on the recommendations of the Berwick Advisory Group. The ambition is to halve avoidable harm in the NHS over the next three years and save 6,000 lives as a result. By signing up to the campaign, Wirral Community NHS Trust demonstrates commitment to listening to patients, carers and staff, learning from what they say when things go wrong and taking action to improve patient’s safety helping to ensure patients get harm free care every time, everywhere.

It has been widely established from the many reports which have followed recent failings in healthcare that one among them – safety – emerges repeatedly as the most expected priority for patients, families and the public. “First do no harm” is not just a slogan in health care; it is a central aim.

Patient safety should therefore be the ever-present concern of every person working in or affecting the services we deliver.

The quality of patient care comes before all other considerations in the leadership and conduct of the organisation, and patient safety is the keystone dimension of quality. Implementation of the patient safety strategy will require shared ownership of this vision, clear leadership, openness to change and innovation.

This Patient Safety Strategy has been developed for the period 2014 – 2017 to promote a safety culture that encourages, shares and supports this vision and the commitment that as an organisation, we will place the quality of patient care, especially patient safety, above all other aims.

Simon Gilby,

Chief Executive
2. **Strategic Principles for Patient Safety**

Wirral Community Trust is committed to delivering high quality, safe patient care, free from harm.

The trust’s objectives to achieve patient safety are based on the five priorities outlined by the Sign up to Safety Campaign – Listen Learn Act.

1. **Priority One:** Put safety first
2. **Priority Two:** Continually learn
3. **Priority Three:** Honesty
4. **Priority Four:** Collaborate
5. **Priority Five:** Support

These principles support the trust’s strategic objective to deliver safe and effective patient care

3. **Introduction**

Patient Safety is recognised as a top priority for the NHS. At its core, the NHS remains a world-leading example of commitment to health and health care as a human right – the endeavour of a whole society to ensure that all people in their time of need are supported, cared for, and healed. It is a fine institution. But the events at Mid Staffordshire have triggered a need to re-examine what the NHS does and determine how it can improve further.

The various accounts of Mid Staffordshire, as well as the recommendations of Robert Francis and others, have highlighted the following problems:

- Patient safety problems exist throughout the NHS as with every other health care system in the world.
- NHS staff are not to blame – in the vast majority of cases it is the systems, procedures, conditions, environment and constraints they face that lead to patient safety problems.
- Incorrect priorities do damage: other goals are important, but the central focus must always be on patients.
- In some instances, including Mid Staffordshire, clear warning signals abounded and were not heeded, especially the voices of patients and carers.
- When responsibility is diffused, it is not clearly owned: with too many in charge, no-one is.
• Improvement requires a system of support: the NHS needs a considered, resourced and driven agenda of capability-building in order to deliver continuous improvement.
• Fear is toxic to both safety and improvement.

To address these issues the organisation must:

• Recognise with clarity and courage the need for wide systemic change.
• Abandon blame as a tool and trust the goodwill and good intentions of the staff.
• Reassert the primacy of working with patients and carers to achieve health care goals.
• Use quantitative targets with caution. Such goals do have an important role en route to progress, but should never displace the primary goal of better care.

This strategy addresses how we are going to achieve this, and reflects what Wirral Community NHS Trust is recognised for:

**Putting People First**

We take the time to listen and respond to the needs of our patients, our community and our colleagues.

**Trusted to deliver**

We take pride in the excellence of our work, our friendly and caring people and the reliability and professionalism of our service.

**Passionate about health**

We use our knowledge and skills in innovative ways. We care about having a positive and supportive effect on the lives of our population.
4. Trust Vision and Values

The trust vision is to be the outstanding provider of high quality, integrated community care to Wirral and the communities we serve.

Our values show what we stand for, believe in and are passionate about:

- Health is our passion, with patients at the heart of everything we do
- Exceptional care as standard
- Actively supporting each other to do our jobs
- Responsive, professional and innovative
- Trusted to deliver

5. National drivers

Care Quality Commission

The Care Quality Commission is the independent regulator of health and adult social care in England. The purpose of the CQC is to make sure health and social care services provide people with safe, effective, compassionate, high-quality care; they also encourage care services to improve.

The CQC monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety; findings are published including performance ratings to help people to choose care.

The principles of the CQC are:

- To put people who use services at the centre of their work
- To be independent, rigorous, fair and consistent
- To have an open and accessible culture
- To work in partnership across the health and social care system
- To be committed to being a high performing organisation, applying the same standards of continuous improvement internally
- To promote equality, diversity and human rights.
NICE

The National Institute for Health and Care Excellence (NICE) sets the nationally agreed standards for quality safe healthcare. Guidance is evidence based and cost effectiveness is considered.

Patient Safety Collaboratives

Patient Safety collaboratives are regionally based safety improvement networks led by Academic Health Science Networks that will work across whole local systems and all health care sectors, to deliver locally designed safety improvement programmes drawing on recognised evidence based methods.

Patient Safety Fellows

Patient Safety Fellows consist of a group of 5,000 respected, enthusiastic and effective safety improvers who will become the backbone of patient safety improvement over the coming decade, making an active contribution to improving safety.

New National Reporting and Learning System (NRLS)

The NRLS is currently being reviewed and will be re-commissioned. The system is already the world’s most comprehensive incident reporting system and this will be developed further to make incident reporting as easy, effective and rewarding as possible, so that learning and improvement continue to grow across the system.

SAFE team

A new Safety Action for England team will be developed to provide short-term support to individual trusts in the area of patient safety. SAFE will provide trusts with a clinical and managerial resource to help to develop organisational and staff capabilities to help improve the delivery of safe treatment and care.

Speak Out Safely

The Speak out Safely campaign led by the Nursing Times aims to encourage NHS organisations and independent healthcare providers to develop cultures that are honest and transparent, to actively encourage staff to raise the alarm when they see poor practice, and to protect them when they do so.

Human Factors

Human factors encompass all those factors that can influence people and their behaviour. In a work context, human factors are the environmental, organisational and job factors, and individual characteristics which influence behaviour at work.
Clinical Human Factors are defined as: ‘enhancing clinical performance through an understanding of the effects of teamwork, tasks, equipment, workspace, culture, organisation on human behaviour and abilities, and application of that knowledge in clinical settings’. (K. Catchpole, [www.chfg.org.uk](http://www.chfg.org.uk)).

**Open and Honest**

Open and honest care: driving improvements is a central part of NHS England’s ambition to ensure every patient gets high-quality care, and to build improved services for the future.

The publication of monthly Open and Honest reports demonstrate a continued journey of openness and transparency across the NHS. There are clear links between excellent healthcare and an excellent reporting culture where issues are raised early and discussed openly, so lessons can be learnt and improvements put in place. The reports develop this principle further, by enabling members of the public to access key information about their local health service.

The information included in the trusts ‘Open and Honest’ reports include:

- NHS Safety Thermometer
- Information on healthcare associated infection (MRSA and C Diff)
- Pressure Ulcers
- Falls causing moderate or greater harm
- Information on staff experience
- Information on patient experience including Friends and Family Test
- A patient story
- An improvement story describing what the trust has learnt and what improvement they are making

**Duty of Candour**

The introduction of a statutory Duty of Candour is a major step towards implementing a key recommendation from the Mid Staffordshire NHS Foundation Trust Public Inquiry (the Francis Inquiry). The Duty of Candour will place a requirement on providers of health and social care to be open with patient when things go wrong.

Providers should establish the duty throughout their organisations, ensuring that honesty and transparency is the expected standard in every organisation registered by the CQC.

**Safety Thermometer**

The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and ‘harm free’ care.
The tool provide a quick and simple method for surveying patient harms and analysing results so that you can measure and monitor local improvement and harm free care over time.

**Central Alerting System**

The Central Alerting System (CAS) is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and other, including independent providers of health and social care.

Alerts available on the CAS website include safety alerts, CMO messages, drug alerts, Dear Doctor letters and Medical Device Alerts.

**Serious Untoward Incidents**

A serious incident requiring investigation is defined as an incident that occurred in relation to NHS-funded services and care resulting in one of the following:

- Unexpected or avoidable death of one or more patients, staff, visitors or members of the public;
- Serious harm to one or more patients, staff, visitors or members of the public or where the outcome requires life-saving intervention, major surgical/medical intervention, permanent harm or will shorten life expectancy or result in prolonged pain or psychological harm
- A scenario that prevents or threatens to prevent a provider organisation’s ability to continue to deliver healthcare services, for example, actual or potential loss of personal/organisational information, damage to property, reputation or the environment, IT failure or incidents in population programmes like screening and immunisation where harm potentially extend to a large population;
- Allegations of abuse;
- Adverse media coverage or public concern about the organisation or the wider NHS;
- One of the core set of never events.


**Never Events**

Never Events are serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented by the healthcare provider.
6. Roles and Responsibilities

Trust Board

The Board of Directors has overall responsibility for ensuring that the trust delivers high quality services that are efficient, effective and safe. The Board is made up of the Chairman, Chief Executive, Executive Directors, Director of Quality and Nursing, Medical Director and Non-Executive Directors. The Board demonstrates commitment to patient safety by the endorsement of this strategy.

Chief Executive

The Chief Executive is accountable for the quality and compliance with safe and effective clinical governance systems for all aspects of patient safety within the trust.

Quality and Governance Committee

The Quality and Governance Committee oversees, with delegated responsibility from Board all aspects of quality governance. The Quality, Patient Experience & Risk Group (QPER) monitors operational performance and reports to Quality and Governance Committee. The Pressure Ulcer Multi-Disciplinary Review Meeting and the Harm Free Care Collaborative, report to the Quality, Patient Experience & Risk Group.

Pressure Ulcer Multi-Disciplinary Review Group

The pressure ulcer multi-disciplinary review group is responsible for reviewing clinical patient records for those individuals who develop a community acquired grade 3 or 4 (EPUAP) pressure ulcer. From a review of the available evidence, and in partnership with all clinical services involved, the group are responsible for determining if the developed pressure ulcer was avoidable or unavoidable, in accordance with the Department of Health Definition.

All grade 3 and 4 community acquired avoidable pressure ulcers will be subjected to a root cause analysis investigation.

Evidence to support decision making in respect of unavoidable pressure ulcers will be submitted to the Commissioning Support Unit for review at the Clinical Commissioning Group’s Quality Committee / Serious Untoward Incident meeting.

Reporting of community acquired grade 3 and 4 pressure ulcers via the Strategic Executive Information System (StEIS) and root cause analysis investigation is conducted in accordance with the trust’s incident reporting policy.
Harm Free Care Collaborative

The harm free care collaborative supports collaborative working with Wirral University Teaching Hospital NHS Foundation Trust, supporting patient safety and learning from health economy incidents with the aim of delivering harm free care to patients.

Divisional Managers

The divisional manager is responsible for monitoring that service leads have appropriate systems in place to promote patient safety, and for disseminating lessons learned from incidents, complaints and concerns to continuously improve patient safety.

Service Leads

The service lead is responsible for ensuring that all relevant staff are conversant with this strategy and are appropriately trained and qualified to fulfil their specific duties.

Individual Employees

Individual employees are responsible for maintaining patient safety, reporting incidents and prevented patient safety incidents to facilitate the identification of learning from experience.
7. Wirral Community Trust Strategic Objectives

The principles of patient safety are in line with the trust’s strategic objectives which are grouped into four themes as outlined below:

Our Patients and Community: Putting our patients and communities at the centre

- We will deliver safe and effective patient care
- We will deliver a positive experience of our services
- We will engage effectively with the patients and communities we serve
- Reducing inequalities will be integral to all service development and delivery

Our Services: Leading, developing and delivering high quality services

- We will effectively manage and develop our relationships with our current and new commissioners and stakeholders
- We will defend and grow our core business
- We will lead the delivery of out of hospital integrated care
- We will deliver to expectations of our commissioners and demonstrate quality and value

Our People: Valuing the individual, the team and the organisation

- We will further develop and maintain a competent, caring and flexible workforce
- We will develop leadership at every level of the organisation
- We will continuously develop the organisation and its governance framework

Our Sustainability: Supporting sustainable delivery

- We will optimise the use of our resources
- Our support and infrastructure services will operate to enhance the delivery of our services and secure future sustainability
- We will develop our information and business intelligence to make informed decisions about what we do
- We will effectively manage our finances and fully deliver our efficiency programmes
- We will deliver transformation supported by innovation and research
8. Patient Safety priorities

8.1 Priority One: Put Safety First.
Commit to reduce avoidable harm in the NHS by half and make public our goals and plans developed locally.

To achieve this we will:

Deliver 95% community harm free care as defined by the Safety Thermometer Tool.

Achieve a continued and sustained reduction in the development of grade 2, 3 and 4 community acquired pressure ulcers.

Conduct a root cause analysis investigation on all avoidable grade 3 and 4 community acquired pressure ulcers, and all incidents causing significant patient harm or death.

Maintain, and continuously strive towards achieving zero avoidable healthcare associated infections caused by our services.

Ensure people using Wirral Community NHS Trust Services, and those close to them are protected from abuse and avoidable harm. People say they feel safe.

To measure improvement we will monitor:

- Monthly rates of harm as defined by the safety thermometer tool, and reported via the trust's monthly Quality Report.
- The Trust's monthly Quality Dashboard for current month and year to date trends.
- The incidence of community trust acquired pressure ulcers and successful completion of action plans reported to the Quality, Patient Experience and Risk Group, and Quality and Governance Committee.
- And thoroughly investigate all reported healthcare associated infections caused by our services to determine whether they are avoidable.
- And cross-reference referrals to the trust's Safeguarding service with incidents involving safeguarding concerns, to ensure people using the trust's services are protected from abuse and avoidable harm.
8.2 Priority Two: Continually Learn

Develop a resilient risk culture at all levels of Wirral Community NHS Trust, by acting on the feedback from patients, and by constantly measuring and monitoring safety of services.

To achieve this we will:-

- Deliver a comprehensive patient experience service responding to concerns and complaints within agreed timeframes, demonstrating learning from investigations and identifying quality improvements.
- Use Datix and proDacapo to identify trends in harm in a timely manner from the triangulation of incidents, complaints and concerns.
- Engage with patient and their families at Patient and Staff Quality groups to gain feedback on their lived experience of the safety of the trusts' services.
- Invite patients in receipt of Wirral Community NHS Trust Services to participate in telling their story of care when a patient safety incident has occurred.
- Publish a monthly patient safety: learning from experience update to disseminate learning from incidents, complaints and concerns.

To measure improvement we will monitor:

- Responses to reported concerns and complaints, and the number of quality of improvements resulting from investigations.
- Trends analysis of information reported via Datix, ensuring appropriate escalation to the trust's risk register as required.
- Feedback obtained from patient and their families.
- The number of patients engaging with the trust to tell their story of care when a patient safety incident has occurred.
- The quality of the trust’s patient safety: learning from experience update, and monitor subsequent reporting of incidents, complaints and concerns relating to the on-going dissemination of lessons learned.
8.3 Priority Three: 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.

To achieve this we will:

- Respond to concerns and complaints about care in an open, responsive and timely way.
- Fully adhere to the Duty of Candour throughout all services within the organisation.
- Publish monthly Open and Honest reports on the Trust external website.
- Involve patients, families and their carers in root cause analysis investigations, providing evidence of organisational learning at every opportunity.
- Publish the number and theme of all Serious Untoward Incidents and Never Events in the trust's annual Quality Account.

To measure improvement we will monitor:

- Timeframes for responses to concerns and complaints.
- Outcomes from Open and Honest reports, and public feedback in response to the reports.
- Outcomes from involving patients, families and their carers in root cause analysis investigations.
- The trust’s monthly friends and family test score, by service, division and trust wide.
- Feedback from the publication of the trust’s annual Quality Account.
8.4 Priority Four: Collaborate

Take a leading role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use.

To achieve this we will:

- Work in partnership with Wirral University Teaching Hospital NHS Foundation Trust to jointly lead a harm free care collaborative group.
- Work in partnership with Care Homes, delivering training to support shared care with a particular focus on pressure ulcer prevention.
- Report all patient safety incidents and prevented patient safety incidents to the NRLS to support national learning.
- Provide timely reports in relation to learning from serious untoward incidents to Commissioning Support Units and Clinical Commissioning Groups.
- Disseminate all Patient Safety Alerts issued via the Central Alerting System to all relevant trust services, sharing examples of best practice externally.

To measure improvement we will monitor:

- Outcomes, learning and quality improvements resulting from the Harm Free Care Collaborative group, aim monitor rates of clinical patient harm.
- Feedback from Care Homes in receipt of training from Wirral Community NHS trust.
- The quality of shared pressure ulcer prevention care plans, and the incidence and prevalence of pressure ulcers in Care Homes.
- Reporting timescales to the Commissioning Support Units and Clinical Commissioning Groups.
- The dissemination of patient safety alerts, and any action plans developed and implemented in response to an alert.
8.5 Priority Five: 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.

To achieve this we will:

- Ensure staff receive training in the principles of Human Factors.
- Provide training and support for lead investigators in root cause analysis investigations, complaints and concerns.
- Provide continuous quality improvement methodology training to staff with support provided for practical implementation.
- Continue with the established leadership and patient safety walk rounds conducted by the Trust Board and Executive Team.
- Work with staff to deliver innovative, safe, quality care via promotion of the trust’s innovation fund.

To measure improvement we will monitor:

- Attendance rates at trust training.
- The quality and impact of RCA action plans.
- Learning resulting from complaints and concerns as reported monthly to Trust Board, identifying any repeated trends.
- The number and impact of quality improvements delivered throughout the trust.
- Outcomes resulting from patient safety walk rounds.
- Innovations implemented throughout the trust.
9. Equality Impact Assessment

During the development of this strategy the trust has considered the needs of each protected characteristic as outlined in the Equality Act (2010) with the aim of minimising and if possible removing any disproportionate impact on patients for each of the protected characteristics, age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief, sexual orientation.

If staff become aware of any clinical evidence of exclusion impacting on the delivery of care, a trust incident form must be completed and an appropriate action plan developed.

Safeguarding

In any situation where staff may consider a patient to be a vulnerable adult/child or the feedback relates to a safeguarding issue, staff need to follow the trust safeguarding policies and discuss the situation with their line manager and document outcomes. The Director of Quality and Nursing must also be informed.

10. Delivery and Monitoring

The Director of Quality and Nursing is responsible for the delivery of the trust’s patient safety priorities as detailed within the patient safety strategy.

The strategy will be delivered through the Quality and Governance Division, working with partners both within the Trust and externally.

Progress will be monitored through a combination of:

- Progress against patient safety quality goals will be reported monthly to the Quality and Governance Committee via the Quality Report.
- Risks to patient safety will initially be reviewed by the Quality, Patient Experience and Risk Group, with escalation to the Quality and Governance Committee for risks rated as 15 and above, potentially impacting on the trust’s strategic patient safety objectives.
- Monthly reporting of the quality dashboard to Trust Board.

11. Cross references with key trust documents

The Patient Safety Strategy cannot work in isolation developed a range of strategies to outline its strategic objectives and vision for the future, these include:

- Quality Strategy
- Medicines Optimisation Strategy
- Risk Strategy
- Engagement and Experience Strategy
- Research and Innovation Strategy
Equality and Diversity Strategy
Human Resources Strategy
Nursing Strategy
Clinical Strategy
Concerns and Complaints Policy
Incident Reporting Policy
Being Open Policy
Safeguarding Policies
Infection Prevention and Control Policies

This list of documents is not exhaustive; documents should be accessed via the trust's staff zone to ensure they are the most up-to-date version.

12. Conclusion

Wirral Community NHS Trust is committed to the delivery of harm free, safe patient care. Implementation of the Patient Safety strategy will ensure that the trust is a leading patient safety organisation, listening to patients, carers and staff, learning from what they say when things go wrong and take action to improve patients' safety.

13. References


14. Consultation

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<th>Directors</th>
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15. Strategic Review

This strategy will be reviewed annually by the Quality, Patient Experience and Risk Group.