Humber Teaching
NHS Foundation Trust

Patient Safety Strategy 2019-22

Becoming a High Reliability Organisation

'Better today than yesterday, every day'

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Forward

A Message from our Chief Executive and Chair

We have great pleasure in introducing our Patient Safety Strategy for 2019-22. This strategy aligns with the ambition set out in the national NHS Patient Safety Strategy (2019), builds on the fantastic achievements from our previous strategy (2016-18), and sets ambitious goals for the next three years in order to realise our ambition to become an outstanding organisation.

Patient safety is central to all that we do. Through the delivery of our previous Patient Safety Strategy considerable progress has been achieved and recognised nationally. In 2018 we were awarded 'highly commended' at the Health Service Journal (HSJ) annual patient safety awards for our work in relation to reducing restrictive interventions work and in 2019 our corporate safety huddle was shortlisted for a HSJ Patient Safety Award. This strategy aims to build further on the progress made to ensure that we continue on our improvement journey in the delivery of high quality safe care to all who use our services.

As a Trust we recognise that adverse incidents will and do occur but assert that with a strong safety and learning leadership culture the impact in terms of harm and recurrence will reduce. We recognise that the priorities we have set ourselves in this strategy will require the right organisational culture. All staff must feel safe to report patient safety issues without fear of retribution, and be empowered to act swiftly to address risk. This underlines the importance of distributed leadership with leaders at all levels having the skills and qualities essential for the promotion of a 'just culture' [(1)] that listens to staff, users of our services and our partners to ensure services are developed aligned to need and recognise the context in which they will be delivered.

To promote this culture the Trust will:

- ✓ Continue to invest in leadership to ensure teams are confident, curious and empowered with patients at the centre of everything they do
- ✓ Ensure reporting and speak up systems are easy to use, responsive and inform organisational learning
- ✓ Not tolerate bullying and harassment in teams which can lead to patient safety incidents/poor care not being reported for fear of retribution
- ✓ Listen to patients, their advocates and carers and develop strategies to ensure they can inform and influence the patient safety agenda for the Trust

This strategy supports and enables Humber's overarching Trust Strategy and sits as part of a suite of strategies and work programmes which together will enable our aspirations for a Care Quality Commission (CQC) rating of Outstanding across all domains. The Trust's PROUD leadership programme launched in 2019 supports the development of the leadership culture and capability required to achieve the priorities outlined in this strategy. In addition our approach to quality improvement alongside our Patient and Carer Experience strategy supports a culture of continual improvement which further supports our commitment to continuously improving the quality, safety and experience of care delivered to our patients and carers.

Michele Moran (Chief Executive)

Sharon Mays (Chairman)

1.0 Executive Summary

Patient safety is fundamental to the provision of high quality services and is defined by NHS England and NHS Improvement[2] as 'maximising the things that go right and minimising the things that go wrong for people experiencing healthcare'. The impact of patient harm is felt widely; by patients themselves, families, loved ones and the teams delivering care. The CQC State of Care review 2017/18[3] asserts that nationally, safety remains a real concern with 40% of NHS acute hospitals' core services and 37% of NHS mental health trusts' core services rated as requires improvement on safety at the end of July 2018. NHSI [1] estimate that by boosting patient safety understanding and capability to reduces harm by a modest 2%, an extra 200 lives and £20 million could be saved. Even more compelling is their assertion that by focussing improvement programmes on the areas that cause most harm 568 lives could be saved and £65 million.

The Health Foundation[4] has learnt over the course of many years and studies that a number of systems in health care are not designed with safety in mind, meaning that it is only the skill and resilience of health care professionals that prevents many more episodes of harm. They note that many care processes are unreliable, which can mean that the right equipment is not available, or the wrong drug is given to a patient. They also learnt that many institutions do not have a complete picture of safety, because they focus largely on past events rather than current or future risks.

The NHS Patient Safety Strategy asserts that continuously improving patient safety involves the NHS building on the foundations of a patient safety culture and systems. To achieve this; the NHS system has identified 3 key aims, Insight, Involvement and Improvement; these are explained in the box below.

The NHS Patient Safety Strategy Aims

- Improve its understanding of safety by drawing insight from multiple sources of patient safety information (**Insight**)
- Equip patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system **(Involvement)**
- Design and support programmes that deliver effective and sustainable change in the most important areas (**Improvement**)

As a Trust we have made significant progress across all three of these priority areas, examples of which are shown below:

1. **Insight –** The introduction of safety huddles (corporate and team based), introduction of the Pressure Ulcer Review and Learning (PURL) group, improvements in the way we present and use data (statistical process control charts).

2. **Involvement** – Introduction of Always Events©, launch of the Patient and Carer involvement Strategy, the Patient and Carer Experience Forum (PaCE) and the Staff Champions of Patient Experience forum (SCoPE).

3. **Improvement –** The launch of the Quality Improvement Strategy and investment in increasing the improvement skills and knowledge of the workforce through the Quality Service Improvement and Redesign College training, which also included two experts by experience, reducing the use of prone restraint, reducing the incidence of grade 4 pressure ulcers and improving the quality of our incident investigation processes.

Please refer to appendix 1 for a full summary of the progress made.

This strategy aims to build on the considerable progress made to date and continue our journey to achieving an outstanding reputation for patient safety.

Our vision for 2019-2022 is to develop a 'high reliability' culture of safety, which is based on the experience of high-risk industries such as the aviation and the nuclear industries. Such a culture ensures consistency to ensure that all our staff understand, collaborate, develop and share learning in relation to patient safety across the organisation in conjunction with patients, carers and wider agencies and partners. Embedded within the Trust approach to patient safety is the requirement that every person working in Humber Teaching NHS Foundation Trust is aware of their responsibilities in relation to ensuring the safety of our patients, carers and families and takes appropriate action to maintain safety in our most vulnerable service users. Equally, we assert that our staff must feel safe; safe to report incidents without fear of reprisal, safe to question practice or resources and safe in their daily work. As an organisation we recognise that our staff are our greatest asset and we are committed to developing a culture of learning, transparency and openness that enables us to continue to improve patient safety and make Humber Teaching NHS Foundation Trust an excellent place for staff to work.

We have identified six priorities across the three areas (insight, involvement and improvement) identified in the NHS Patient Safety Strategy and these are aligned to our overall Trust strategy goals.

Our Patient Safety Priorities

Insight

1. To become a 'develop a positive and proactive safety culture
2. To reduce the number of Patient Safety Incidents resulting in harm

Involvement

3. To work with patients, carers and key partners to continuously improve patient safety
4. To ensure staff are equipped with the appropriate patient safety knowledge and skills to embed an organisational wide culture of learning from patient safety incidents

Improvement

5. To ensure a culture of continuous improvement
6. To work with the wider community to improve patient safety

The priorities were developed through a review of incident data, benchmarking data, CQC reports, national reports, the NHS Patient Safety Strategy, review of available patient safety literature and most crucially through extensive consultation with staff at all levels of the organisation. These are explained in detail in section 5.

2.0 The Aim of the Patient Safety Strategy

This strategy builds on the achievements of our 2016-18 Patient Safety strategy (appendix 1) and sets out the Trust ambitions to maximise safety and reduce harm experienced by people receiving care within Humber Teaching NHS Foundation Trust. The strategy seeks to deliver and support these aims by promoting a quality harm free experience for patients and carers and to ensure the Trust is sustained to deliver high quality, safe care, now and well into the future.

The delivery of this strategy aims to enable the Trust to achieve its aspiration to become a high reliability organisation. High reliability organisations are organisations that work in situations that have the potential for large-scale risk and harm, but which manage to balance effectiveness, efficiency and safety. They also minimise errors through teamwork, awareness of potential risk and constant improvement.

The delivery of the 2016-18 Patient Safety Strategy commenced our journey to becoming a high reliability organisation and this current strategy aims to build on our progress to date and achieve our aspiration to be a provider of high quality safe services. Appendix 1 provides an overview of our patient safety journey to date.

To implement this strategy we have aligned our priorities to the organisation's six goals:

3.0 Our Mission, Vision and Values

The Patient Safety Strategy describes how Humber Teaching NHS Foundation Trust will ensure that we embed a culture of safety and learning that supports the delivery of high quality, safe, effective care across all the services we provide. The strategy has been designed to support the delivery of the Trust's visions and values which include:

4.0 Recognising our Patient Safety Challenges

As a multi-speciality provider we have a broad range of services, across a large geographical footprint each with differing patient safety issues and challenges. Therefore, it is essential that our approach to patient safety takes account of the unique challenges that each service brings.

Ensuring the highest quality safe care requires the organisation to have sufficient numbers of staff equipped with the right skills, knowledge and values. Humber, like the majority of healthcare providers across the country, is experiencing significant difficulties in recruiting to nursing and medical posts. This means that there is a reliance on temporary staffing solutions and skill mix is not consistently optimal. Therefore, we recognise that in order to achieve our patient safety aspirations, we must place a great deal of emphasis on the recruitment and retention of our workforce. Therefore, this strategy is intrinsically linked to the workforce strategy to deliver optimal safety.

The National Patient Safety Strategy cites one of the biggest challenges to the delivery of safe care as the fear of blame resulting in staff closing ranks and losing sight of the need to improve. The Trust has worked hard to improve the confidence of staff to report incidents without fear of blame. This commitment was underlined through the formal launch of the NHSI Just Culture Tool at the Learning the Lessons Conference in May 2018. However, in order to make a sustained improvement in staff confidence that the Trust operates a 'no blame' culture, will take a number of years to achieve through staff seeing it in action. The legacy of previous negative experiences of staff in relation to the investigation and management of incidents will take time to be replaced with the new open transparent culture of trust, continuous learning and quality improvement to which the Trust is committed.

The NHS Patient Safety Strategy highlights Primary Care as an area for specific focus. Primary Care is a growing area of care provision for Humber, with currently seven practices at the time of publishing this strategy. The NHS strategy notes that while it is recognised that nationally the vast majority of people receive safe care in Primary Care, around 2-3% of incidents reported nationally are attributable to primary care, with approximately 25% of those involving serious harm. As a Trust we recognise that a tailored approach for Primary Care is required to ensure that they are supported to both report and investigate patient safety incidents. This work is already underway and will continue to be developed over the course of this strategy.

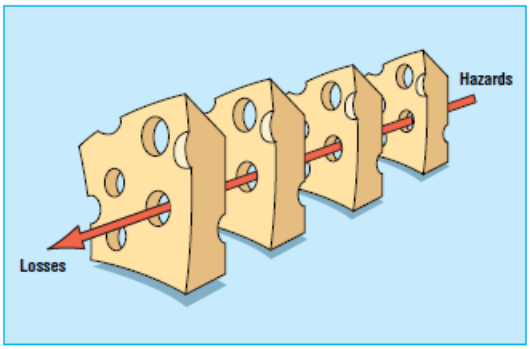
5.0 Aim and Priorities for Improvement 2019-22

We are proud of the progress we have made in improving patient safety through the delivery of the previous strategy, however we recognise that we are on a journey and there is still much more we can do to improve the quality, safety and experience of our services. This section sets out our commitment to achieving a high standard of patient safety through becoming a 'high reliability organisation'. The concept of high reliability is outlined in section 5.1 below. In order to achieve our commitment to patient safety we have identified six priorities for improvement aligned to the NHS Patient Safety Strategy that we believe will enable us to achieve high-reliability, these are outlined in section 5.2.

5.1 Becoming a High Reliability Organisation

Traditionally, two approaches to the management of errors have prevailed, the person approach and the systems approach. The person approach focusses on the unsafe acts or omissions of people while the systems approach assumes that humans are fallible and errors are to be expected, even in the best organisations, therefore emphasis is placed on system and process-based defences to prevent errors. Both approaches however, have their weaknesses as the person approach seeks to blame individuals and therefore suppresses honesty and transparency, thus learning is stifled and the system approach does not take account of the human factors that caused the systems and processes to fail. In contrast, the high reliability approach which is most commonly seen in high risk industries such as the nuclear and aviation industries, takes account of both systems and people. Reason[5] uses a Swiss cheese analogy to describe this approach. He describes a series of slices of Swiss cheese however unlike cheese the holes are moving position, opening and closing. The presence of a hole in one slice does not normally cause a bad outcome; when the holes in many layers momentarily line up is when harm can occur. High reliability organisations recognise that the ability of the workforce to compensate for and adapt to changing events (holes occurring) represents one of the system's most important safeguards. Reliability is described by Reason as “a dynamic non-event”. It is dynamic because safety is preserved by timely adjustments by the workforce and; it is a non-event because the avoided event as a result of the adjustment is rarely recognised.

The Swiss Cheese Model



High reliability organisations are characterised by five key principles that facilitate both problem detection and problem management [6]. These are as follows:

1. Preoccupation with failure: using failure and near failure as ways to gain insight into the strengths and weaknesses of the system
2. Reluctance to simplify: avoiding the tendency to minimise or explain away problems
3. Sensitivity to operations: being aware of the 'big picture', specifically how all the components of work fit together and how problems in one area can spread to other areas
4. Resilience: developing the capability to cope with un-expected events
5. Deference to expertise: under-standing where the expertise is in the organisation and ensuring that decisions about how to deal with problems are made by those expert

The development of an organisational culture that supports transparency, encourages people to speak up without fear of reprisal, avoids a tendency to blame, avoids naïve reliance on mechanistic processes is central to achieving high-reliability. High reliability organisations manage to balance effectiveness, efficiency and safety whilst operating in situations that have the potential for high risk and harm. They minimise errors through teamwork, awareness of potential risk and constant improvement. As a multi-speciality healthcare provider Humber works with highly complex patients and manages considerable risk on a daily basis, therefore it is essential that we seek to achieve high reliability. This involves not only preventing errors or failures, but also learning quickly and taking action to prevent reoccurrence.

5.2 Our Priorities for Improvement 2019-22.

In order to achieve our aim to be a high-reliability organisation and deliver the aims of the NHS Patient Safety Strategy we have identified six priorities aligned to our strategic goals which aim to build on our progress to date. These priorities while aligned to the NHS Patient Safety Strategy also include further improvements the Trust wish to achieve; informed by the following:

- Patient and carer feedback gathered through a range of mechanisms such as patient and carer forums, Friends and Family Test, national patient surveys etc.
- The national Staff Survey
- Review of our own internal safety reporting intelligence mechanisms such as Datix, audits, investigations and complaints to identify themes and trends,
- Review of our CQC and external peer review reports
- Review of national patient safety reports and initiatives, examples include: the CQC sexual safety in mental health wards report, the NHS Improvement Preventing healthcare associated Gram-negative bacterial bloodstream infections resource, the National Confidential Inquiry into Suicide and safety and reports produced by the Healthcare, safety Investigations Branch (HSIB).
- Feedback through our annual 'Building Our Priorities' event, attended by a patients, carers, staff, commissioners and third sector organisations.
- Feedback from staff through workshops, presentations to staff groups, clinical networks and a range of other forums.

The priorities we have identified for 2019-22 are grouped under the three NHS Patient Safety Strategy aims (insight, involvement and improvement) and are aligned to our Trust strategic goals. These are outlined below:

Insight Priorities

Priority 1 ***To develop a positive and proactive safety culture***		**Strategic Goal 1** Innovating quality and patient safety
Priority 2 ***To reduce the number of Patient Safety Incidents resulting in harm whilst maintaining high levels of reporting***		**Strategic Goal 2** Enhancing prevention, wellbeing and recovery

Involvement Priorities

Priority 3 ***To work with patients, carers and key partners to continuously improve patient safety***		**Strategic Goal 3** Fostering Integration, Partnership and Alliances
Priority 4 ***To ensure staff are equipped with the appropriate patient safety knowledge and skills to embed an organisational wide culture of learning from patient safety incidents***		**Strategic Goal 4** Developing an effective and empowered workforce

Improvement Priorities

Priority 5 ***To ensure a culture of learning and continuous improvement***	**Strategic Goal 5** **Maximising an Efficient and Sustainable Organisation**
Priority 6 ***To work with the wider community to improve patient safety***	**Strategic Goal 6:** **Promoting People, Communities and Social Values**

5.21 Our Insight Priorities

Priority 1: **To develop a positive and proactive safety culture**

The development of an organisational culture that supports transparency, encourages people to speak up without fear of reprisal, avoids a tendency to blame, avoids naïve reliance on mechanistic targets, and appreciates the pressures that can accumulate under resource constraints is seen as the cornerstone of safety.[6]

In order to achieve our aim of being a high-reliability organisation it is essential that we ensure safety incidents are reported and shared. In order to do so staff need to feel safe to report incidents and to speak up regarding concerns for safety. High reliability organisations have what is referred to as a ***'group mindfulness'***, which is an organisation-wide awareness of and expectation that errors will and do occur. This is accompanied by continual vigilance and awareness of the early signs of emerging risks. Responsibility and accountability for reliability is distributed throughout the organisation. Such organisations aim to increase the quality of attention and alertness to potential errors across all departments and teams.

The NHS Patient Safety Strategy identifies six key components of a patient safety culture:

- Psychological safety for staff
- Diversity
- Compelling vision
- Leadership and teamwork
- Open to learning
- Kindness and civility

It is refreshing to see such a strong emphasis on investment in staff well-being as a fundamental part of the national strategy. The staff well-being and leadership agenda is also high priority for the Trust and therefore there is a strong interdependence between this strategy and the PROUD programme.

There is a consensus among patient safety advisors that the best way of improving reporting and reducing harm is to target the underlying systems failures rather than take action against individual members of staff. In 2018 NHS improvement published the Just Culture Tool in order to support organisations to develop a culture of openness and learning by making staff feel confident to speak up when things go wrong. Humber Teaching NHS Foundation Trust embraces this approach and firmly believes that the implementation of the tool will enable staff to report incidents and supports a true culture of learning and incident prevention within the Trust.

In order to achieve this priority we aim to do the following:

Aims	What we will see
• To ensure psychological debrief for staff following incidents is embedded across services • To develop our leaders to ensure compassion, kindness and civility are at the core of leadership behaviours • To develop a culture of 'group mindfulness' • To ensure the NHSI Just Culture Tool is embedded within the organisation • To continue to embed a positive and proactive safety culture • To continue to embed a culture of continuous learning and improvement • To continue to strengthen our monitoring systems and address emerging risks in a timely manner • To further empower our staff to review redundant or flawed systems and processes • To ensure we benchmark positively with other providers.	✓ Leaders demonstrating compassion, kindness and civility ✓ High number of incidents reported with low/no harm. Increasing number of near miss incidents reported ✓ Positive staff perceptions of the fairness and effectiveness of incident management demonstrated in the annual staff survey ✓ Staff using the Freedom to Speak up Guardian processes ✓ Safety conversations within teams utilising data and learning from investigations at team level/division and corporate level ✓ Quality improvement initiatives at all levels of the organisation ✓ Benchmarking data routinely used in performance reporting and quality reports to drive continuous improvement.

Priority 2: To reduce the number of Patient Safety Incidents resulting in harm

The prevention of patient safety incidents underpins our approach to ensuring the safety of our patients. While not all patient safety incidents can be predicted, many are preventable. Whilst human error can never be completely eradicated, there are often a number of different 'contributory factors', spanning cross-organisational, organisational and individual levels, which underpin adverse events. High reliability organisations avoid the tendency to avoid or explain away problems, therefore it is essential that we identify emerging risks early and act to prevent more serious harm and embed a culture of continuous learning and improvement.

Intrinsic to ensuring patient safety is the availability and use of data. Teams need to have access to meaningful data to enable them to be able to identify their patient safety risks. To enable meaningful data is available we first need to enable incidents are reported (priority 1) and then develop the mechanisms for which the data will be collated and used throughout all levels of the organisation.

In order to achieve this priority we aim to do the following:

Aims	What we will see
• To ensure learning from incidents is embedded in practice • To ensure low harm/no harm incidents are reviewed to detect emerging risks • To develop, launch and embed a real-time patient safety and experience dashboard for use at all levels (from team/ward to board) • To ensure emerging risks are appropriately assessed, managed and communicated • To ensure that patient safety initiatives are used in practice (e.g. SafeWards) • To ensure policies and procedures reduce the risk of harm • To ensure teams proactively use incident data to identify emerging risks • To ensure the right information about patents is transferred at the right time to the right service.	✓ Use of safety huddles across all teams to address team specific risk themes to drive improvement ✓ Teams routinely reviewing and analysing data to identify and address patient safety issues ✓ Early identification of emerging risks with mitigating action taken at team and organisation wide levels ✓ Learning routinely shared at all levels ✓ ePMA embedded in all in-patient areas ✓ SafeWards embedded in practice in our mental health in patient units ✓ Emerging risks being robustly identified, assessed, managed and communicated ✓ Risk registers embedded in the culture of teams ✓ Staff who feel supported and safe to report incidents and learn ✓ A reduction in poor communication as a theme in investigation findings.

5.22 Our Involvement Priorities

Priority 3: To work with patients, carers, staff and key partners to continuously improve patient safety

Humber Teaching NHS Foundation Trust is committed to a culture of co-production with patients, carers and staff. Involvement of patients and carers in quality improvement initiatives aimed at improving safety will ensure that we maximise opportunities to design and deliver the highest quality services for the people we support.

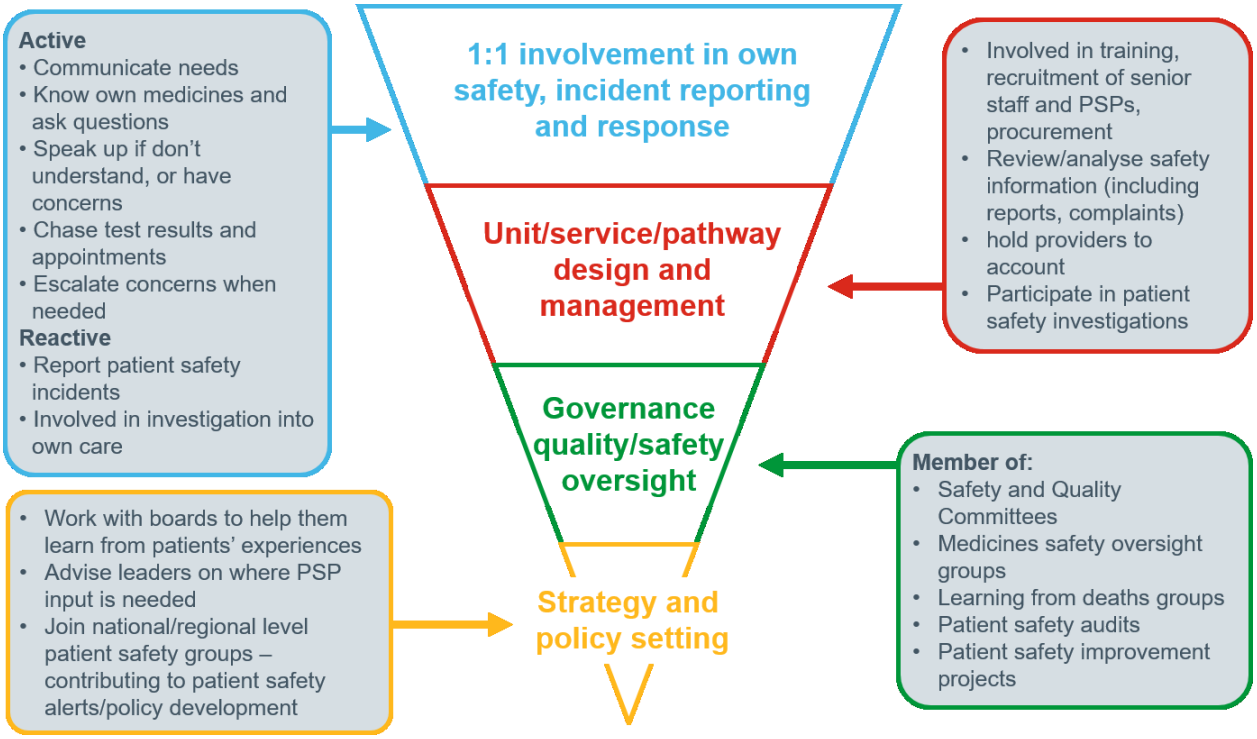
Working collaboratively with other organisations, sharing patient safety initiatives and undertaking peer reviews provides opportunities for learning across the wider system.

In the NHS strategy both NHSE and NHSI assert that they have ‘heard the call to explore the inter-relationship between complaints and incidents – not least the assertion that complaints are a form of incident reporting’, as a result they plan to explore how this can be achieved through the new reporting system. Humber has already recognised the importance of the link between complaints and incidents and as a result the complaints and risk department work closely together. A dashboard to triangulate incidents, complaints and compliments is already in development.

The NHS Patient Safety Strategy sets out an intention to create ‘patient safety partners’ (PSPs), as NHSE and NHSI believe that it is ‘the right way to make real what Don Berwick called for when he said that “patients and their carers should be present, powerful and involved at all levels of healthcare organisations from wards to the boards of trusts.’

The NHS Patient Safety Strategy has indicated the below potential roles of Patient Safety Partners:

Potential roles of Patient Safety Partners



As a Trust we wholeheartedly endorse this approach and already have a range of mechanisms in place for involving patients and carers in investigations, service developments and quality improvement. The development of PSP roles will further support our commitment to co-production, outlined in out Patient and Carer Experience Strategy.

In order to achieve this priority we aim to do the following:

Aims	What we will see
• To develop, recruit to and embed the role of Patient Safety Partners • Identify a non-executive to support the Executive Director of Nursing to implement and champion the role of the Patient Safety Partners. • To implement the changes to systems and process required to enable the replacement for NRLS to be seamlessly introduced • Ensure all staff know how to report incidents • To co-produce quality improvement initiatives with patients and carers • To collaboratively share learning and initiatives across the wider healthcare system • Increased participation in patient safety research.	✓ Patient Safety Partners as integral part of the Trust approach to safety ✓ Patients and carers involved, informed and at times leading on quality improvement initiatives ✓ Active involvement in national and regional forums relating to patient safety ✓ Participation in peer reviews with other organisations ✓ Patients and carers actively supported and involved in the investigation of safety incidents. ✓ Continued active research portfolio with an emphasis on patient safety.

Priority 4: To ensure staff are equipped with the appropriate patient safety knowledge and skills to embed an organisational wide culture of learning from patient safety incidents

In order to ensure Humber Teaching NHS Foundation achieves its aspiration to become a high reliability organisation, it is essential that priority is given to the skillset of our staff, particularly in relation to patient safety. As the NHS Patient Safety Strategy points out other high risk industries teach their workforce about safety and the NHS should do the same. As a Trust we have invested in training across a wide range of patient safety related areas, such as safety huddles, quality improvement, Root Cause Analysis (RCA), Human Factors, Structured Judgement Reviews to name but a few. However, the development of a skilled workforce is an ever evolving process, as the workforce changes and new tools and techniques are developed and the evidence base grows. Continued investment in the skills of the workforce underpins the successful delivery of this strategy.

The NHS Patient Safety Strategy sets an ambitious plan for NHSE and NHSI to work collaboratively with Health Education England (HEE) to develop a consistent national patient safety syllabus to apply across a variety of competence levels and address the different learning needs of 1.3 million staff in across 350 different careers. The diagram below shows the potential patient safety training syllabus

In addition to the development of patient safety training, to provide all staff with a foundation level of training the NHS Patient Safety Strategy proposes that organisations identify Patient Safety Specialists; experts to lead on safety. As a Trust we have a growing level of expertise in this field within the patient safety team, and we support the national direction of travel to identify a specific post that will have oversight of and provide support for patient safety activities across the Trust. Part of their role will be to ensure that systems thinking, human factors and just culture principles are embedded in all patient safety activity.

There is a commitment within the NHS Patient Strategy for a shift in emphasis from simply focussing on what goes wrong (known as safety I) to what goes right (known as safety II). Safety II in practice is described in the box below.

Safety II in practice

- People understand that the act of keeping patients safe is about having a constantly enquiring mind; noticing what happens every moment of every day; noticing when things go right; noticing when they could go wrong; and noticing when they do go wrong. They will then appreciate how they constantly adapt their behaviour and practice to work safely.
- Appreciative inquiry and learning from excellence are embedded to create a more positive culture and provide meaningful positive feedback.
- Leaders have the humility and curiosity to discover how the world looks from others' points of view; and the self-discipline to halt judgement and develop explanations for why people do what they do.

In order to achieve this priority we aim to do the following:

Aims	What we will see
• Through the delivery of the HEE training programme staff will be educated from ward to Board in relation to the scientific evidence base of safety • Introduce a safety II culture through the development of leadership skills in appreciative inquiry • A core group of staff will be invested in to develop the skillset to undertake investigations into patient safety incidents in line with the Trust policy • Continue to develop evidence based clinical models with associated skills requirement matrices • Continue to implement our approach to distributed leadership to ensure we have a workforce that is empowered to deliver safe care.	✓ The Patient Safety Specialist, leading the development of a patient safety culture and knowledge base across the Trust and linking in with the wider system ✓ The development of patient safety champions across services ✓ A culture of appreciative inquiry ✓ Evidence based models of care ✓ High quality risk assessments and associated management plans ✓ High quality investigations demonstrating awareness of human factors and other approved methodologies in line with the Trust incident reporting policy ✓ Leaders at all levels empowered to report incidents and make swift improvements to maximise patient safety ✓ Improved staff morale evidenced through the annual staff survey.

5.23 Our Improvement Priorities

Priority 5: To ensure a culture of continual improvement

The NHS Patient Safety Strategy asserts that the NHS safety system must support continuous and sustainable improvement, with everyone habitually learning from insights to provide safer care tomorrow than today. Quality improvement is described as providing the necessary coherence and aligned understanding of this shared approach to maximise its impact. It offers tools to understand variation, study systems, build learning and capability, and determine evidence-based interventions and implementation approaches to achieve the desired outcomes.

Four national priorities have been identified because of their potential to enable the most significant impact on patient safety, these are as follows:

- Preventing deterioration and sepsis
- Medicines safety
- Maternal and Neonatal safety
- Adoption and spread of tested interventions

As a Trust we have placed a great deal of emphasis on the identification of the deteriorating patient and sepsis, with the introduction of a refreshed policy in line with NICE guidance and national policy. The National Early Warning Score version 2 (NEWS2) was launched in 2018 with access to e-learning for all staff. However, developing the skillset of our staff to recognise the deteriorating patient remains a high priority and failure to recognise the deteriorating patient is currently a Trust zero event monitored by the Board. Zero events are incidents we have identified for quality improvement to enable their incidence to be reduced and ideally eliminated. The physical health skillset of our mental health workforce is also a key priority.

Medicines safety is high priority for the Trust with the phased introduction of electronic prescribing and medicines administration (EPMA). In addition, the role of the Medicines Safety Officer has been strengthened with a greater alignment to the corporate Patient Safety Team and involvement in the daily corporate safety huddle.

The delivery of consistently safe, high-quality effective care to our patients requires clear service models to be in place, with staff equipped with the skills necessary to deliver the models. Service models are developed in line with the evidence base and commissioning requirements. A commitment to evidence-based models of care requires the organisation to stay in step with NICE guidance and national guidance and to develop a culture within the organisation of continual quality improvement. This commitment to ensuring service are continually developed in line with best practice is reinforced through our Quality Improvement Strategy launched in 2018. The development of clearly defined models and operational procedures reduces the opportunity for omissions and errors to be made as staff are clear regarding expectations and process.

In order to achieve this priority we aim to do the following:

Aims	What we will see
• To ensure that our service models are developed in line with the evidence base • To continue the roll out of EPMA across all in-patient areas • To ensure that each service has a clearly articulated model developed in collaboration with patients, carers and commissioners and clearly understood by our staff • To ensure that benchmarking data is used in the assessment of the quality, safety and effectiveness of our services • To further develop the audit programme.	✓ Care delivered to a consistently high standard ✓ An engaged workforce involved in service development ✓ ePMA embedded across the organisation ✓ Models of care delivery in line with NICE guidance, national guidance and national and local learning from incidents ✓ All changes to models of care will have a quality impact assessment (QIA) completed ✓ Evidence of benchmarking data being used in performance reports ✓ Evidence of audits across all clinical networks.

Priority 6: To work with the wider community to improve patient safety

Along with other organisations and Public Health England, Humber Teaching NHS Foundation Trust, plays an important role in improving the safety of the community within the wider Integrated Care System (ICS). Working together across a whole system can ensure that patient receive care seamlessly at the right time, in the right place to prevent safety incidents from occurring. One important example is the work that Humber is contributing to in relation to suicide prevention and post suicide support to families and carers. The trust is committed to continuing to work within the local community and ICS to improve the safety of care delivery. Understanding the safety risks within the community can enable services to be developed to meet the needs of the local population.

In order to achieve this priority we aim to do the following:

Aims	What we will see
• To become a system leader in patient safety • Ensure learning from the national Learning Disabilities Mortality Review programme (LeDeR) is embedded in practice • To continue to work in partnership across organisations to increase awareness of safeguarding across the communities we serve • Proactively work with other organisations to learn from patient safety incidents • To continue to work as part of the Integrated Care System to develop services that work together to improve the safety of patients within the local and wider system.	✓ Humber leading on safeguarding initiatives across our communities to increase awareness and thereby reporting of safety issues ✓ Collaborative working with other agencies and organisations to share learning from patient safety incidents, LeDeR reviews and best practice. ✓ Clearly defined pathways of care between Humber and other organisations based on best available evidence ✓ Presenting learning in national events and forums.

6.0 Implementing the Strategy

The success of our strategy will be measured through the following:

- The experience of the people who use our services, carers and staff, in relation to the provision of safe care
- The rating of the safe domain provided by the CQC
- Comparison of incident data with national benchmarks such as NRLS
- The use of Statistical Process Control (SPC) charts to monitor progress in relation to safety metrics monitored through the Board performance Report

Each clinical division of the Trust will be required to incorporate work programmes aligned to the priorities in this strategy into their Quality Improvement Plans. Divisions will be encouraged to involve patients, service users, carers and staff in identifying the key actions to implement the strategy. The work programmes will be annually reviewed to ensure they remain in step with the division performance and the best available evidence base.

Monitoring and review of the strategy will be through the quarterly review of Division Quality Improvement plans by the Quality and Patient Safety Group (QPaS) and six monthly by the Quality Committee. Patient Safety is also monitored by the Trust Board on a monthly basis through the Board Performance report and reports from the Quality Committee.

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Appendix 1 Progress achieved through the delivery of the 2016-18 Patient Safety Strategy: Our Patient Safety Journey to Date

In our 2016-18 Patient Safety Strategy we identified seven priority areas for delivery these were as follows:

1. Develop a patient safety culture across the Trust
2. Increase understanding of violence and aggression within mental health services and reduce restrictive interventions in the Trust
3. Reduce Severe Self harm events and support a Zero Suicide culture within the Trust
4. Interrogate issues relating to ensuring safer staffing across the Trust to ensure our workforce is equipped with the knowledge and skills and organised in the right way to deliver optimum care
5. Reduce the number and severity of pressure ulcers acquired within our care
6. Improve medicines management and knowledge within the Trust
7. Reduce communication errors and associated patient harms through appropriate electronic technology for patient records

What we have achieved:

Priority One: Develop a patient safety culture across the Trust

Over the past three years we have worked to develop a safety culture across the organisation. We signed up as planned to the safety pledges and have continued our commitment to improving the safety of the services we provide. We have reviewed our incident reporting system Datix and ensured that staff know how to report incidents and are supported to do so. We have introduced a daily organisation wide safety huddle, led by the corporate patient safety team with the aim of embedding an organisational safety culture through:

- Ensuring timely feedback on incidents reported by staff
- Taking immediate action on significant risks- providing oversight and support to teams to maximise safety
- Early identification of emerging themes and trends

A number of teams across the organisation have introduced safety huddles to address specific safety concerns within their area, such as falls and self-harm.

We have refreshed our serious incident processes and ensured that staff undertaking investigations understand Root Cause Analysis methodology and the Human Factors involved in patient safety incidents. The Just Culture Tool launched by NHS Improvement in March 2018, has been adopted as a part of our investigation processes to ensure that we ensure an open transparent, no blame culture that maximises the opportunity for learning. The emphasis on learning is further supported by twice yearly Learning the Lessons events, where staff come together to present and share learning from incidents, complaints and quality improvement initiatives.

The launch of the Patient and Carer Experience Strategy in 2018, and the launch of our live Friends and Family Test dashboard has ensured that patient and carer experience is central to all that we do.

Priority 2: Increase understanding of episodes of violence and aggression within mental health services and reduce restrictive interventions in the Trust

What we have achieved so far

Over the last three years we have made significant progress in relation to reducing restrictive interventions and this has been positively recognised by the CQC during their 2017 and 2019 well-led

inspections. In order to support staff to prevent and appropriately manage episodes of violence and aggression we have developed an in-house Positive Engagement Team (PET), which both delivers training and support teams in planning the care of patients with complex and challenging presentations.

The use of prone restraint has reduced significantly and is only used when absolutely appropriate. All incidences of restraint are reviewed by the PET team and teams are supported to reflect and continually learn. The Board have oversight of restraint incidents, and restrictive interventions through the monthly integrated performance report (IQPT) and quarterly reports to the Quality Committee in relation to restrictive interventions

We have introduced a Reducing Restrictive Practice group which has led the development of policy and overseen the addressing of areas of restrictive practice. Our PET team was highly commended at the Health Service Journal (HSJ) Patient safety awards in 2018.

Priority Three: **Reduce Severe Self harm events and support a Zero Suicide Culture within the Trust**

The Trust has developed Suicide and Self-harm training which is being rolled out across all mental health services. The initial focus of the training delivery has been Mental Health Response and A&E liaison. However, the training will continue to be rolled out across all mental health teams. The Trust is a member of the Zero Suicide Alliance and continues to work across the wider system with key partners and stakeholders to aim to reduce the incidence of suicide within the Humber region.

While the Trust recognise that National Confidential Inquiry into Suicide and Safety, assert that risk assessment tools have limited predictive ability, we have invested in the introduction of a risk assessment tool (FACE) with the aim of providing our staff with the skills to assess and formulate risk. The structure of the tool enables staff to ask the appropriate questions and collaboratively develop management plans to support patient's experiencing a heightened risk of self-harm.

The introduction of both the organisation wide and team safety huddles has further supported our approach to reducing instance of serious self-harm.

Priority Four: **Interrogate the issues relating to ensuring safer staffing across the Trust to ensure our workforce is equipped with the knowledge and skills and organised in the right way to deliver optimum care.**

Over the course of the last three years we have continued to strengthen our daily oversight of staffing across the organisation. The Trust introduced a staffing escalation policy in 2018 and has mechanisms in place across all services to ensure that safe staffing is maintained across our teams. The Deputy Director of Nursing leads the safer staffing agenda and ensures that all staffing establishments are reviewed annually in line with the NHS Improvement guidance.

The Board maintains oversight of the safer staffing position through the integrated Quality and Performance Tracker (IQPT), safer staffing dashboard and the six-monthly safer staffing reports.

As is the position nationally we continue to experience challenges in relation to recruitment to qualified nurse vacancies. As a result we are focussing a great deal of attention on recruitment and retention.

We have developed a robust preceptorship programme for newly qualified staff and this has been evaluated positively by the cohorts that have completed the programme. It is hoped that investment in the development of our staff will continue to retain and attract high quality staff.

Priority Five: Reduce the number and severity of pressure ulcers acquired within our care

In 2017 the Trust introduced a suite of 'zero events' that are monitored by the board through the IQPT and Quality Committee. The aim of zero events is to provide a focus on patient safety issues that we believe would benefit from an enhanced focus and quality improvement. In 2017 the Trust agreed a zero event for category 4 pressure ulcers and as a result the incidence of this category of pressure ulcer reduced to zero. In 2018 the Trust determined to stretch its aspirations to reduce the incidence of pressure ulcers by widening the zero event to include category 3 and above pressure ulcers.

Our approach to the monitoring of pressure ulcer incidents was further strengthened in 2018 with the daily safety huddle initially reviewing reported incidents of pressure ulcers and requesting 72-hour reports. The Pressure Ulcer Review and Learning (PURL) forum was increased to fortnightly from monthly and has oversight of all pressure ulcer incidents and associated 72-hour reports commissioned by the daily safety huddle. The pressure ulcer policy was also refreshed in line with the new guidance produced by NHS Improvement.

Priority Six: Improve medicines management and knowledge within the Trust

Over the past three years the Trust has worked to strengthen the reporting of medicines errors and worked closely with staff and leaders to address the underlying causes of medicines errors. The Medicines Safety Officer works alongside the Patient Safety Team and attending the daily huddle and Clinical Risk Management Group.

The Lead Medicines Optimisation Nurse, Medicines Safety Officer and the wider pharmacy team are working with the Link Practitioners to discuss medicine-related incidents and establish ways to prevent similar incidents from occurring again. Moreover, "Medicines Optimisation Work-Based Competency Programme" is currently being rolled out to improve and maintain standards. From October 2017, pharmacy technicians were linked with individual wards and teams to establish and support good practice.

Priority Seven: Reduce communication errors and associated patient harm through appropriate electronic technology for patient records

In 2017 the Trust introduced the Lorenzo electronic record system across all mental health service and SystmOne in Whitby Community Hospital. This has been a significant undertaking, involving both system developments and a cultural shift for our staff. The quality of record keeping standards however, remains variable across the organisation and is the main current focus of attention in relation to record keeping. Record keeping audits across our wards are undertaken monthly using an app based audit platform and further audit tools are being developed for implementation across all of our services.