Solent NHS Trust
Safety Improvement Plan

(Submitted to the Sign Up to Safety campaign for consideration as incentive refund bid)

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1.0 What is our vision and mission?
Our vision is: **To lead the way in local care**
Our mission is: **To work in partnership to deliver better health and local care**

1.1 Who are we?
We were formed in April 2011, following an establishment order by the Secretary of State for Health, after operating for one year as a merged organisation formed from Southampton and Portsmouth City Primary Care Trust’s provider arms.
We are a large specialist community and mental health providers in the NHS with annual revenue of £188m for 2013/14, a workforce in excess of 3,600 (3,144 full time equivalent) staff and delivering nearly 1.5 million service user contacts per annum.

1.2 What do we do?
Our role is to provide high quality, effective and efficient community and mental health services to local people. We deliver services to people across Southampton, Portsmouth and Hampshire. Our services are provided from a range of locations including community hospitals and day hospitals, as well as numerous outpatient and other settings within the community such as health centres, children’s centres and within people’s homes.
Our goal is to help individuals to stay safe and well at, or close to, home. We do this by supporting families to ensure children get the best start in life, providing services for people with complex care needs and helping older people keep their independence. We also provide screening and health promotion services which support people to lead a healthier lifestyle.
We work closely with other trusts, primary care, social care providers and the voluntary sector to make sure your care is joined up and organised around you.

1.3 Who do we serve?
We provide services to people living in Southampton, Portsmouth and wider Hampshire. For some services we also provide a small amount of care to people who live outside of Hampshire, such as for alcohol and drug detoxification and rehabilitation.
We are commissioned by Clinical Commissioning Groups and local authorities in Southampton, Portsmouth and Hampshire.
Southampton and Portsmouth have around 200,000 people living within each city, covering a relatively small urban geographic area with significant health inequalities and needs generally worse than the English average. Wider Hampshire is predominantly more rural and affluent, but has some areas of significant deprivation and health needs.

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*Place the quality of patient care, especially patient safety, above all other aims.*

*Engage, empower, and hear patients and carers at all times.*

*Foster whole-heartedly the growth and development of all staff, including their ability and support to improve the processes in which they work.*

*Embrace transparency unequivocally and everywhere, in the service of accountability, trust, and the growth of knowledge.*

1.4 What services do we have?

Our services
Our services operate under eight service lines.

- Primary Care and Long Term Conditions Services
- Substance Misuse Services
- Child and Family Services
- Adult Services, Portsmouth
- Adult Services, Southampton
- Sexual Health Services
- Specialist Care Dental Services
- Adult Mental Health Services

The delivery footprint of service varies according to commissioner’s specific contracts. The geographical areas served by each individual service broadly covers three constituencies:

- Southampton city
- Portsmouth city
- Hampshire county.

During 2013/14 we were contracted to deliver three additional services across Hampshire, including the two cities:

- Sexual Health Services
- Substance Misuse Services
- Specialist Care Dental Services.

A summary of our activity in 2013 - 2014
1.5 What are our priorities?

Solent NHS Trust is committed to providing excellent quality care which embraces the 6 C's throughout the care provided. We strive to continuously improve the quality of the care we provide and aim to learn through complaints, claims and incidents to address issues as they arise.

During 2013-2014 the following patient safety priorities were identified by the service line clinical governance leads as important to not only patient safety but also to the cost effectiveness of the care provided.

These priorities are
- Reduce harm from pressure ulcers
- Early detection of the deteriorating patient
- Reduce harm from handover/transfer of care and lack of information.

1.6 What will we focus on?

We will ensure that when patients are in our care, their safety is our top priority.

*Doing the right thing,*  
*the right way,*  
*at the right time,*  
*in the right amount,*  
*for the right patient*  
*that does not result*  
in harm to the patient *H. John Keimig, MHA, FACHE*

- Provide quality information for the eight services which means they can react quickly to any changes
- Ensure safe staffing levels in all services
- Ensure all high risk and serious incidents are audited, reviewed and have action plans communicated to those affected by the incident and action completed.
2.0 Solent Safety Improvement Plan

This patient safety improvement plan is a three year plan which will not only aim to improve patient safety throughout the Trust and will focus upon three key areas for improvement identified and the reduction of avoidable harm by 50%. On commencing the project the Trust are aware of the importance of patient safety through leadership in order to drive the aims of the improvement plan for the future care of patients.

2.1 Trust board

Accountable to the Secretary of State, the Board is responsible for the effective direction of the affairs of Solent NHS Trust, setting the strategic direction and appetite for risk. The Board establishes arrangements for effective governance and management as well as holding management to account for delivery, with particular emphasis on the safety and quality of the Trust’s services.

The Board leads the Trust by undertaking the following key roles:

- ensuring the management of patient safety and staff welfare
- formulating strategy, defining the organisation's purpose and identifying priorities
- ensuring accountability by holding the organisation to account for the delivery of the Strategy and scrutinising performance
- seeking assurance that systems of governance and internal control are robust and reliable and to set the appetite for risk
- shaping a patient safety culture for the board and the organisation

2.2 Chief Nurse

Is the nominated Executive Sponsor for patient safety, risk management and governance providing drive, vision and senior level leadership for the safety improvement agenda.

2.3 Deputy Director of Nursing

The Deputy Director of Nursing is responsible for leadership of the quality governance, assurance, patient safety and risk management agenda and developing and overseeing the internal procedures and risk structures to ensure the safety improvement plan is deliverable.

2.4 Lead for Patient safety

Lead and support the group of internal patient safety champions in order to ensure that high standards of clinical practice are maintained.

Play a lead role in the continued development and improvement of all aspects of clinical service and the delivery of the safety improvement plan

Utilise relevant knowledge to facilitate the link between effective clinical governance, clinical audit, incidents, claims and complaints to drive the safety improvement agenda

Collate and report data on a monthly basis to enable the analysis of success of the plan
2.5 Solent Sign up to safety pledges

- **Put safety first.** Commit to reduce avoidable harm in the NHS by half and make public our goals and plans developed locally.

  *We will ensure all staff are aware of the importance of patient safety and how they can work to further reduce harm.*

- **Continually learn.** Make our organisation more resilient to risks, by acting on the feedback from patients and by constantly measuring and monitoring how safe our services are.

  *We will ensure learning is disseminated across the organization by monitoring service line action plans for evidence that lessons have been learnt*

- **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.

  *We will Build upon and promote the organizations open and honest culture through information and training. Be sincere and honest in all responses to complaints and claims*

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

  *We will identify patient safety 'champions' within each service line to act as a resource and be able to disseminate patient safety information. Participate, and build upon the work of the Wessex patient safety collaborative*

- **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.

  *We will ensure staff understand that when they report an issue their concerns will be dealt with without prejudice and appropriately and ensure staff continue to receive supervision in a supportive manner.*
2.6 Patient safety culture and leadership

Embedding the safety culture of the organisation is pivotal to delivering on the key trust objectives and is supported by the Trust Board and executives. An innovative approach needs to be adopted ways to not only embed patient safety but also to understand the patient journey from their perspective. At Solent one way in which this occurs is by regular ‘board to floor’ visits.

These are held in high regard by the Executive and Non-Executive Directors and provide staff who participate in the visit with an opportunity to talk openly about quality and safety. This information is then communicated back and a report completed with relevant actions to progress any identified issues.

Using this information and returning to the National Reporting and Learning Service principles (2004) allows for the concept to become an essential part of the culture. They define the seven steps as:

1. Build a safety culture.
2. Lead and support your staff.
3. Integrate your risk management activity.
4. Promote reporting.
5. Involve and communicate with patients and the public.
7. Implement solutions to prevent harm.

The culture at Solent is ‘fair and open’ and staff need to be encouraged to report incidents and to articulate any concerns that arise from clinical situations.
Aim

Solent NHS Trust will reduce avoidable harm in targeted areas by 50% within 3 years (Jan 2018)

Primary Drivers

- Education, training and competence
- Leadership for safety & safety culture within clinical and support services
- Measurement/data available
- Harm specific topics
  - Avoidable pressure ulcers
  - Early recognition of the deteriorating patient
  - Transfer/handover of care

Secondary Drivers

- Staff training – internal/external
- Competency framework for staff roles
- Learning from incidents
- AQuA & AHSN safety networks
- Staff safety leads at all levels
- Include safety statement in JD
- Safety strategies & policies
- Culture surveys & tools
- Patient & staff experience
- Training & education compliance
- Complaint, incident and risk reporting
- National & local data sources & KPI's
- Specialist training & knowledge
- Planning & documentation
- Risk assessments & documentation
- Measurement of specific harm

Solent NHS Trust Safety Improvement Plan
2.7 Priority one – Avoidable grade 3/4 pressure ulcers

Solent NHS Trust will reduce the number of avoidable grade 3/4 pressure ulcers in our care by at least 50% within 3 years (Jan 2018)

**Primary Drivers**

- Education, training and competence in recognition and management of pressure ulcers
- Leadership for safety awareness dissemination of incidents and lessons learnt
- Standardisation of documentation and care plans
- Improved patient experience

**Secondary Drivers**

- Competency framework for staff roles
- Training to understand patients who are most at risk
- Establish and build upon work of pressure ulcer strategy group
- Patient and carer engagement and tailored education
- Ensure learning encouraged through supervision
- Case discussion and support
- Use of the serious incident framework for shared learning
- Pressure ulcer steering group to review and implement change
- Effective communication and transfer/handover of care
- Patient and staff experience feedback to data
- Complaints, claims and incident reporting
- Audit of quality markers for pressure ulcers
- Recruit service users as safety leads
**Priority one – Avoidable grade 3/4 pressure ulcers**

<table>
<thead>
<tr>
<th>Primary Driver</th>
<th>Secondary Driver</th>
<th>Key Change Concept / Change Idea</th>
</tr>
</thead>
</table>
| Education, training and competence in recognition and management of pressure ulcers | Competency framework for staff roles | • Able to assess/inspect skin/pressure areas with a frequency dependant on risk and advice/clinical judgement dependant on individual’s needs to identify quickly pressure damage.  
• Identify methods to manage the moisture of patients whose skin is exposed to increased moisture. (wound drainage, continence issues, leaks, discharge, excessive sweating).  
• Ensure skin is kept clean and dry (note excessive dry skin presents an increased risk).  
• Ensure staff are able to complete RCA template  
• Know how to contact the Tissue Viability Advisor if required. |
| Training to understand patients who are most at risk | | • Clear guidance on how to understand pressure ulcer risk factors  
• Understand how to minimise pressure damage by ensuring manual handling equipment is available when turning patients assessed as at risk if possible  
• Assess tissue viability risk at first contact with new patient and re-assess when change in condition |
| Establish and build upon work of pressure ulcer strategy group | | • Arrange for staff to spend time shadowing the Tissue Viability Nurse Specialists.  
• Review the use of pressure relieving devices in line with the Trust guidelines. |
| Patient and carer engagement and tailored education | | • Patient and carer education tailored to individual needs  
• Educate patients, families and families how they can help to minimize pressure ulcer risk whilst in hospital and at home, where relevant. |
| Leadership for safety awareness dissemination of incidents and lessons learnt | Ensure learning encouraged through supervision | • Ensure the skills, knowledge and competency of your team are up to date.  
• Develop revised RCA template for all pressure ulcers and implement in the teams  
• Disseminate lessons learned from SUI’s / RCA’s  
• Build upon the safety culture and use a marketing approach to raise awareness |
| --- | --- | --- |
| | Case discussion and support | • Utilise formal and informal learning opportunities to educate your teams about pressure ulcer risk.  
• Use patient stories to educate, motivate and inspire staff. |
| Use of the serious incident framework for shared learning | | • Arrangements for shared learning are clear  
• Evidence required is completed |
| Standardisation of documentation and care plans | Pressure ulcer steering group to review and implement change | • Review all documentation and care plans  
• Standardise care plans |
| Effective communication and transfer/handover of care | Patient and staff experience feedback to data | • Use SBAR approach to written handover notes |
| Improved patient experience | | • Arrangements for shared learning are clear |
| Complaints, claims and incident reporting | | • Educate staff, patients on pressure ulcer contributory factors.  
• Provide patients and relatives with information on the risks of pressure ulcers on admission/transfer or when there is a change in their condition that puts them at risk, with consideration of understanding  
• Work with patients and families as co-partners in their care. |
| Audit of quality markers for pressure ulcers | Review monthly data with services |
| Recruit service users as safety leads | Use the patient safety campaign as a tool for recruitment |
Pressure ulcer prevention

Ensuring best practice in pressure ulcer (PU) prevention and the early detection and treatment of PUs requires close collaboration across health and social care providers and a no-blame culture which places the patient’s wellbeing at the centre of decision making. In 2014 a total of nine avoidable grade 3 and 4 pressure ulcers were acquired whilst in our care. Whilst we record other pressure ulcers within our performance data, these were not acquired in our care (for example, the patient transferred in with the pressure ulcer from primary or acute care).

<table>
<thead>
<tr>
<th></th>
<th>2014</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
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<tbody>
<tr>
<td>Grade 3 In Solent Care</td>
<td>21</td>
<td>3</td>
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<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>4</td>
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<td>3</td>
<td>2</td>
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<td>3</td>
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<tr>
<td>Grade 3 Out of Solent Care</td>
<td>60</td>
<td>3</td>
<td>6</td>
<td>14</td>
<td>5</td>
<td>5</td>
<td>8</td>
<td>8</td>
<td>6</td>
<td>6</td>
<td>9</td>
<td>5</td>
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<tr>
<td>Grade 4 In Solent Care</td>
<td>34</td>
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<td>6</td>
<td>4</td>
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<td>0</td>
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<tr>
<td>Grade 4 Out of Solent Care</td>
<td>61</td>
<td>11</td>
<td>6</td>
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<tr>
<td>Avoidable In Our Care</td>
<td>9</td>
<td>1</td>
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<td>Avoidable Outside Our Care</td>
<td>4</td>
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<tr>
<td>Unavoidable</td>
<td>63</td>
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<td>7</td>
<td>0</td>
<td>25</td>
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Why did we make this a priority?

Pressure ulcers develop when a large amount of pressure is applied to an area of skin over a short period of time, or they can occur when less force is applied but over a longer period of time. Treating and caring for people in a safe environment and protecting them from avoidable harm is a key priority for the Trust therefore, preventing the incidence of newly acquired pressure ulcers continues to be a key focus for improvement.

The Trust acknowledges that, whilst at times we care for a very complex and vulnerable patient group, we must do everything we can to prevent a newly acquired pressure ulcer occurring while a patient is under our care, whether that be on our inpatient wards or for a patient who is at home and receiving care from our Community / District Nurse Teams. We also acknowledge that many of our patients move throughout different healthcare environments (such as the acute hospitals, to rehabilitation wards and then to their own home or to a care home). It is therefore essential that our nursing staff communicate clearly and effectively with other nursing or care teams to ensure that the correct equipment and support is available at all times.

A significant amount of work has already been undertaken during 2013/14 to ensure the appropriate reporting and management of pressure ulcers and to verify that our staff have the relevant skills required to manage this. Treating and caring for people in a safe environment and protecting them from avoidable harm remains a key priority for the Trust. Therefore, preventing the incidence of newly acquired pressure ulcers continues to be a key focus for improvement.
2.7 Early detection of the deteriorating patient

Solent NHS Trust will reduce avoidable harm by early recognition of the deteriorating patient in our care by at least 50% within 3 years (Jan 2018)

- Education, training and competence in recognition of the deteriorating patient
- Leadership for safety awareness dissemination of incidents and lessons learnt
- Standardisation of documentation and care plans
- Improved patient experience

- Competency framework for staff roles
- Use of NEWS for inpatient and community teams
- Use of intentional rounding to review and implement change
- Patient and carer engagement and tailored education
- Ensure learning encouraged through supervision
- Case discussion and support
- Use of the serious incident framework for shared learning
- Safe staffing levels
- Effective communication and transfer/handover of care
- Patient and staff experience feedback to data
- Complaints, claims and incident reporting
- Audit of all emergency treatment/admissions
- Recruit service users as safety leads
### 2.7 Early detection of the deteriorating patient

<table>
<thead>
<tr>
<th>Primary Driver</th>
<th>Secondary Driver</th>
<th>Key Change Concept / Change Idea</th>
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</thead>
<tbody>
<tr>
<td>Education, training and competence in recognition and management of the deteriorating patient</td>
<td>Competency framework for staff roles</td>
<td>• Develop specific competency</td>
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<tr>
<td></td>
<td></td>
<td>• Re-launch the NEWS tool</td>
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<tr>
<td>The use of NEWS for inpatient and community teams</td>
<td></td>
<td>• Engage with patients and families to recognise when the symptoms of their condition changes and when they need to initiate</td>
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<tr>
<td>Use of intentional rounding to review and implement change</td>
<td></td>
<td>• Communicate to appropriate clinical staff in the team and consider visible means (e.g. patient status at a glance white boards) as a way of communicating acuity of patients (Inpatient areas)</td>
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<tr>
<td></td>
<td></td>
<td>• Develop an accepted ‘status at a glance’ for the community</td>
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<tr>
<td>Patient and carer engagement and tailored education</td>
<td></td>
<td>• Patient and carer education tailored to individual needs</td>
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<td></td>
<td></td>
<td>• Educate patients, families and families how they can identify deterioration and raise concerns</td>
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<tr>
<td>Leadership for safety awareness dissemination of incidents and lessons learnt</td>
<td>Ensure learning encouraged through supervision</td>
<td>• Ensure the skills, knowledge and competency of your team are up to date.</td>
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<td></td>
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<td>• Disseminate lessons learned from SUI’s / RCA’s</td>
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<td></td>
<td>Case discussion and support</td>
<td>• Utilise formal and informal learning opportunities to educate your teams about the use of NEWS.</td>
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<td>• Use patient stories to educate, motivate and inspire staff.</td>
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<td></td>
<td>Use of the serious incident framework for shared learning</td>
<td>• Utilise formal and informal learning opportunities to educate your teams about the use of NEWS.</td>
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<tr>
<td>Safe staffing levels</td>
<td>Define safe staffing levels for each service area</td>
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<tr>
<td>Standardisation of documentation and care plans</td>
<td>Effective communication and transfer/handover of care</td>
<td>Escalation or care i.e when, if, how</td>
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<tr>
<td>Improved patient experience</td>
<td>Patient and staff experience feedback to data</td>
<td>Arrangements for shared learning are clear</td>
</tr>
<tr>
<td>Complaints, claims and incident reporting</td>
<td>Educate staff and patients on emergency admissions and the contributory factors. Provide patients and relatives with information on the risks of further deterioration or a change in their condition that puts them at risk, with consideration of understanding. Work with patients and families as co-partners in their care.</td>
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<tr>
<td>Audit of emergency admissions/treatment</td>
<td>Monthly incident reporting</td>
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<tr>
<td>Recruit service users as safety leads</td>
<td>Use the patient safety campaign as a tool for recruitment</td>
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Why did we make this a priority?
The sooner a change in medical condition is detected the better for the patient and yet early
detection of deterioration can be difficult in patients with complex needs.
Identification and management of the deteriorating patient has been one of our priorities for a
number of years. Recognising and treating patients promptly when they become sicker will lead
to reduced mortality and morbidity. We know that the outcome for the patient is better if any
deterioration is recognised promptly and measures are taken to treat the illness by well trained
staff and sufficient senior staff.
By using robust and reliable early warning systems and standard ways of communicating
concerns about a patient who is deteriorating, we are treating our patients more effectively.
During 2013/14 we continued this work, focusing very much on the escalation of these patients.
We know that our staff are good at timely, accurate observations and also good at recording the
early warning scores.

We developed a pilot to introduce a screening and trigger tool, National Early Warning Score
(NEWS), which was developed by the Royal College of Physicians. Our focus was to ensure that
once a patient ‘triggers’ (i.e. has a warning score which indicates that they are unwell or
deteriorating) then the correct processes for calling senior staff are followed. This includes calling
an ambulance, where necessary, and that call comes from nurses, if necessary, rather than
waiting to go through a hierarchy of clinical doctors.
By using robust and reliable early warning systems and standard ways of communicating we know that the outcome for the patient is better. This is because if any deterioration is recognised promptly and measures are taken to treat the illness by well trained staff, we are treating our patients more effectively. We need to build upon the work already completed by using the existing tool and adapt this as required for use in community teams and areas.
2.8 Handover/transfer of care

Solent NHS Trust will reduce avoidable harm from inappropriate/poor communication at critical transfer points in the patient journey within 3 years (Jan 2018)

- Organisational engagement within and external to Solent
- Leadership for safety awareness dissemination of incidents and lessons learnt
- Risk assessment standardisation
- Safe transfer and improved patient experience

### Strategies:

- Clear policies and guidelines across all organisations
- Standardise and implement a clinical handover checklist for use in and out of Solent
- Communication strategy
- Ensure learning encouraged through supervision both formal and informal
- Basic level human factors training for staff
- Use of the serious incident framework for shared learning
- Clear roles and responsibilities
- Effective communication and transfer/handover of care standard timing for observations
- Patient and staff experience feedback to data
- Complaints, claims and incident reporting
- Audit of transfers both within and external to Solent
### 2.8 Handover/transfer of care

<table>
<thead>
<tr>
<th>Primary Driver</th>
<th>Secondary Driver</th>
<th>Key Change Concept / Change Idea</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organisational engagement within and external to Solent</td>
<td>Clear policies and guidelines across all organisations</td>
<td>• Review policies and procedures relating to handover/transfer</td>
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<tr>
<td></td>
<td>Standardise and implement a clinical handover checklist for use in and out of Solent</td>
<td>• Develop a multi-organisation handover/checklist agreed by all organisations</td>
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<tr>
<td></td>
<td>Communication strategy</td>
<td>• To maximise engagement from other care providers</td>
</tr>
</tbody>
</table>
| Leadership for safety awareness dissemination of incidents and lessons learnt | Basic level human factors training for staff | • Patient and carer education tailored to individual needs  
  • Educate patients, families and families how they can identify deterioration and raise concerns |
| | Use of the serious incident framework for shared learning | • Ensure the skills, knowledge and competency of your team are up to date.  
  • Facilitate basic level training throughout the teams  
  • Disseminate lessons learned from SUI’s / RCA’s |
<p>| | Clear roles and responsibilities | Ensure understanding and definition around key transfer |</p>
<table>
<thead>
<tr>
<th>Points in the clinical pathway</th>
<th>Risk assessment standardisation</th>
<th>Effective communication and transfer/handover of care standard timing for observations</th>
<th>Integrated risk assessment and handover tool/document</th>
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<tbody>
<tr>
<td></td>
<td>Patient and staff experience feedback to data</td>
<td></td>
<td>Arrangements for shared learning are clear</td>
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<tr>
<td>Safe transfer and improved patient experience</td>
<td>Complaints, claims and incident reporting</td>
<td>Educate staff and patients on emergency admissions and the contributory factors. Provide patients and relatives with information on the risks of further deterioration or a change in their condition that puts them at risk, with consideration of understanding.</td>
<td>Work with patients and families as co-partners in their care.</td>
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<tr>
<td>Audit of transfers both within and external to Solent</td>
<td>Monthly data and 6 monthly audits</td>
<td>Recruit service users as safety leads</td>
<td>Use the patient safety campaign as a tool for recruitment</td>
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Why did we make this a priority?

As a mental health and community Trust a large number of our patients and service users are referred or transferred to our care from other providers. There are also times when patients/service users transfer between services depending upon their clinical need.

As part of the lessons learnt process from serious incident investigations and from incident reporting it was identified that handover communication could be improved to prevent avoidable harm. It is also not always clear in the current documentation that there is a documented handover of the care which is especially important when delivering shared care with social care colleagues.

It was also found that there was not always a documented clinical management plans, especially from acute to community providers which then has the potential for a readmission of the patient. Transfer processes were sometimes organised at short notice and not thorough in detail or planning also between other providers of the care.

It is therefore important as part of the safety improvement plan to work together with acute trusts and other care providers to standardise the information required at handover and also to ensure the suitability of taking over the care dependent upon the care needs of the patient.

Across organisation communication campaign will be designed sign up from those involved will be encouraged by working alongside the local Clinical Commissioning groups in order to drive the campaign for safer handover/transfer of care and improve the communication between areas and organisations.
3.0 Measurement

The Solent Safety Improvement Plan will be part of a three year project to improve patient safety within the organisation. At the start of the project baseline data will be used to assess where we are currently in with patient safety; this will involve undertaking baseline measures of the relevant drivers underlining the Safety Improvement Plan as well as data relating to the Safety Improvement areas.

The key drivers to measure would include
- safety culture
- skills assessments
- patient safety champions (numbers, clinical areas, and roles), tissue viability champions (numbers, clinical areas, and roles), falls champions (numbers, clinical areas, and roles),
- patient safety knowledge of patient safety champions.

It is also important to undertake an assessment of the staff understanding of patient safety and what their opinion is by conducting a staff patient safety survey. We currently undertake the measurement of both patient and staff experiences and these will also this will be reviewed throughout the project, to further evaluate the implementation of the Safety Improvement Plan. All of Solent safety domains are measured through the on-line incident reporting system and themes are picked up through the service line clinical governance forums. The Patient Safety Thermometer and the CQUINs data also provide valuable assessment information and are measurable.
### 4.0 Ninety day plans

#### 1st 90 day cycle - January 2015 – March 2015

<table>
<thead>
<tr>
<th>Goal</th>
<th>Action</th>
<th>Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>To reduce avoidable harm in by 50% by focusing on three domains with cross cutting themes</td>
<td>Identify and recruit multi-disciplinary patient safety champions throughout the organisation</td>
<td>Sign up to safety lead and service Clinical Governance leads</td>
</tr>
<tr>
<td>Review data collected using PDSA test sheet (see below)</td>
<td>Review data collected using PDSA test sheet (see below)</td>
<td>Sign up to safety lead and service Clinical Governance leads</td>
</tr>
<tr>
<td>Collect and compare monthly data for reducing harm from pressure ulcers, unrecognised patient deterioration and poor handover/transfer and report at service line clinical governance meetings</td>
<td>Collect and compare monthly data for reducing harm from pressure ulcers, unrecognised patient deterioration and poor handover/transfer and report at service line clinical governance meetings</td>
<td>Sign up to safety lead and service Clinical Governance leads</td>
</tr>
<tr>
<td>Analyse serious incident</td>
<td>Analyse serious incident</td>
<td>Deputy Director of Nursing/Sign up to Safety Lead</td>
</tr>
</tbody>
</table>

#### 2nd 90 day cycle – April 2015 – June 2015

<table>
<thead>
<tr>
<th>Goal</th>
<th>Action</th>
<th>Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review data collected using PDSA test sheet (see below)</td>
<td>Review data collected using PDSA test sheet (see below)</td>
<td>Sign up to safety lead and service Clinical Governance leads</td>
</tr>
<tr>
<td>Collect and compare monthly data for reducing harm from pressure ulcers, unrecognised patient deterioration and poor handover/transfer and report at service line clinical governance meetings</td>
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<td>Sign up to safety lead and service Clinical Governance leads</td>
</tr>
<tr>
<td>Analyse serious incident</td>
<td>Analyse serious incident</td>
<td>Deputy Director of Nursing/Sign up to Safety Lead</td>
</tr>
<tr>
<td>Goal</td>
<td>Action</td>
<td>Lead</td>
</tr>
<tr>
<td>------</td>
<td>--------</td>
<td>------</td>
</tr>
<tr>
<td>To reduce avoidable harm in by 50% by focusing on three domains with cross cutting themes</td>
<td>Use measurement data to identify clinical areas where there is variability or performance is not reaching the measurement for improvement goals.</td>
<td>Sign up to safety lead and service Clinical Governance leads</td>
</tr>
<tr>
<td>Report on the overall reduction in frequency of harms from pressure ulcers, unrecognised patient deterioration and poor handover/transfer using the incident reporting data.</td>
<td></td>
<td>Sign up to safety lead</td>
</tr>
</tbody>
</table>

3\(^{rd}\) 90 day cycle – July 2015 – September 2015 (as per 2\(^{nd}\) cycle)
4\(^{th}\) 90 day cycle – October 2015 – December 2015 (as per 2\(^{nd}\) cycle)
5\(^{th}\) 90 day cycle – January 2016 – March 2016 (as per 2\(^{nd}\) cycle)

PDSA Worksheet for Testing Change

**Aim:** (overall goal you wish to achieve)

| Every goal will require multiple smaller tests of change |
| Describe your first (or next) test of change | Person responsible | When to be done | Where to be done |
| | |

**Plan**

List the tasks needed to set up this test of change | Person responsible | When to be done | Where to be done |
| | |

**Do**

Predict what will happen when the test is carried out | Measures to determine if prediction succeeds |
| | |

**Study**

Describe the measured results and how they compared to the predictions

**Act**

Describe what modifications to the plan will be made for the next cycle from what you learned
<table>
<thead>
<tr>
<th>Develop a briefing for all teams and Trust board on progress to date and goals for future improvement</th>
<th>Deputy Director of Nursing/Sign up to Safety Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review data collected using PDSA test sheet</td>
<td>Sign up to Safety Lead</td>
</tr>
</tbody>
</table>

5.0 Claims – (Past harm)

![Number of Claims Graph](image)

Solent NHS Trust, when compared to national claims data, report a low number of low value claims. Over the past two years there have been no claims for avoidable pressure ulcers acquired in our care however it is known that not only do pressure ulcers cause significant distress they also incur costs in the ongoing care. For a more severe ulcer, the costs can be anything up to £374 per day (Bennett, Dealey and Posnett, 2012) due to nursing time, dressings, antibiotics, diagnostic tests and pressure relieving equipment.
6.0 Governance of the service improvement plan

The lead for Sign up to Safety at Solent will be the Clinical Risk Manager, supported by the Deputy Director of Nursing and the service line Clinical Governance Leads. The executive sponsor is the Chief Nurse.

All the work related to the 90 day cycles will be reported on monthly to the service line clinical governance meetings and the Quality and Risk Group who will report to the Assurance Committee and via the Assurance committee to the Trust Board.

In supporting services to develop their local action plans we will ask how their services wish to present their successes centrally and what they require from those they are reporting to. This will ensure that local leaders are able to tailor reporting methods to their service change and get the right support from the quality and risk team in analysing their report.

We will invite a patient safety champion each month to present an update on their local action plan and this will be shared across the services.

Overviews on Trust wide progress will be provided quarterly to the Quality and Risk group, Assurance Committee and the board. Any risks associated with the improvement plan will be monitored through the risk register as appropriate.

7.0 Patient experience

Patient Experience is of course one of the key components for measuring quality and improvement within the NHS and healthcare providers are expected to clearly evidence that patients’ experience is reflected in systems for delivering and improving care. It is therefore important to consider the impact of communication and cognitive disabilities on the patient’s ability to access from the health advice, interventions and self-management as part of the implementation of the plan. In consideration of this staff must also be aware of the difficulty for some patients to identify early warning signs of their own health deterioration and the ability to understand the advice given.

The consultation document on making health and social care information accessible (Marsay 2014) suggests the following standards are considered:

- Stage 1 – identification and recording of needs. This means finding out if someone has any information or communication needs and recording them if they do.

- Stage 2 – sharing and referring to recorded needs. This means passing on information about someone’s needs to other people who are looking after them. It also means seeing that they have needs the next time they come to the service.

- Stage 3 – provision of support / meeting of needs. This means making sure that the person’s needs are met, for example sending them information in the right format or providing the communication support they need.
8.0 The Human Factor

Human factors incorporate all of the factors that can influence people and their personal behaviour. When we put this into a work context, human factors relate to the environmental, organisational and job factors, and individual attributes which influence their behaviour at work.

As part of the NHS Solent NHS Trust treat lots of patients each day and this treatment is provided safely by dedicated healthcare professionals who are motivated to provide high quality and safe clinical care. However, a small number of patients are either harmed as a result of their treatment or as a consequence of their admission to the service which, on review of the care, may have been avoided.

These are often due to human factors such as

- mental workload
- distractions
- the physical environment
- physical demands
- device/product design
- teamwork
- process design. (Patient safety first 2012)

By having an awareness of human factors and delivering basic training can improve the safety culture and also lesson the likelihood of patient harm. The concept of the human factor recognition will be integrated into the implementation plan.
9.0 NHSLA bid

Solent NHS Trust has multiple sites and a number of diverse services and therefore presents a challenge when driving change with a concept that is Trust wide. Although the data available shows that we are a safe organisation improvements can and should be made to ensure avoidable harm is eliminated as much as possible.

A key concept to the success of the project is the assurance that all clinical operating procedures are, where possible, organisational wide and that there is a consistent focus to clinical training around the safety improvement areas of focus. If the bid is successful the funding would be used to further enable this work by providing a dedicated resource for providing the essential safety improvement training across the organisation.

This training would focus on three areas, reducing avoidable harm through pressure ulcers, not recognising the deteriorating patient early and lack of information regarding handover/transfer of care. The work would also include providing any targeted training to specific areas around the three improvement areas identified through the incidents, claims and complaints process.

<table>
<thead>
<tr>
<th>Heading</th>
<th>Content</th>
</tr>
</thead>
<tbody>
<tr>
<td>Area of focus</td>
<td>Reducing avoidable harm through pressure ulcers, not recognising the deteriorating patient early and lack of information regarding handover/transfer of care.</td>
</tr>
<tr>
<td>Number</td>
<td>There were only three recent claims all of low value however improvement in these areas of focus will reduce future claims.</td>
</tr>
<tr>
<td>Value</td>
<td>Circa 50,000 (final value unknown)</td>
</tr>
<tr>
<td>Goal</td>
<td>To reduce for avoidable harm across the organisation focusing on the three areas to prevent the high costs of care following avoidable harm and the potential for high cost claims.</td>
</tr>
</tbody>
</table>
| Actions | • Consistent training using NEWS, and pressure ulcer recognition and management.  
• Review of documentation  
• Organise multi-agency group to agree and implement handover/transfer tool  
• Facilitate basic human factors training  
• Work with quality and risk team especially when reviewing serious incidents to identify and target training needs |
| Measures | The quality and risk team will work with the performance and information team to agree the metrics to be used and review these monthly |
| Financial data | • Any successful bid will be invested into the provision of a dedicated resource which would cost for 1 WTE member of staff at band 7 at a cost of (with consideration of on costs) £60,000  
If the bid is unsuccessful the dedicated |
The current contribution is approx. £271,000

The member of staff would be employed initially for 12 months from April 2015

The potential outcomes would be

- Reduction in avoidable harm
- Increase in positive patient experience
- Reduction in costs for the investigation of incidents which result in harm
- Reduction in costs to providing treatment/care following avoidable harm
- Improved safety culture

10.0 References

Carthey, J and Clarke, J Implementing human factors in healthcare Patient Safety First 2012

Institute for Healthcare Improvement Model for Improvement
http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx

Marsay, S Making health and social care information accessible Consultation document summer / autumn 2014