Northern Devon Healthcare NHS Trust: Patient Safety Improvement Plan

August 2015 to July 2018

Introduction and overview of Northern Devon Healthcare NHS Trust

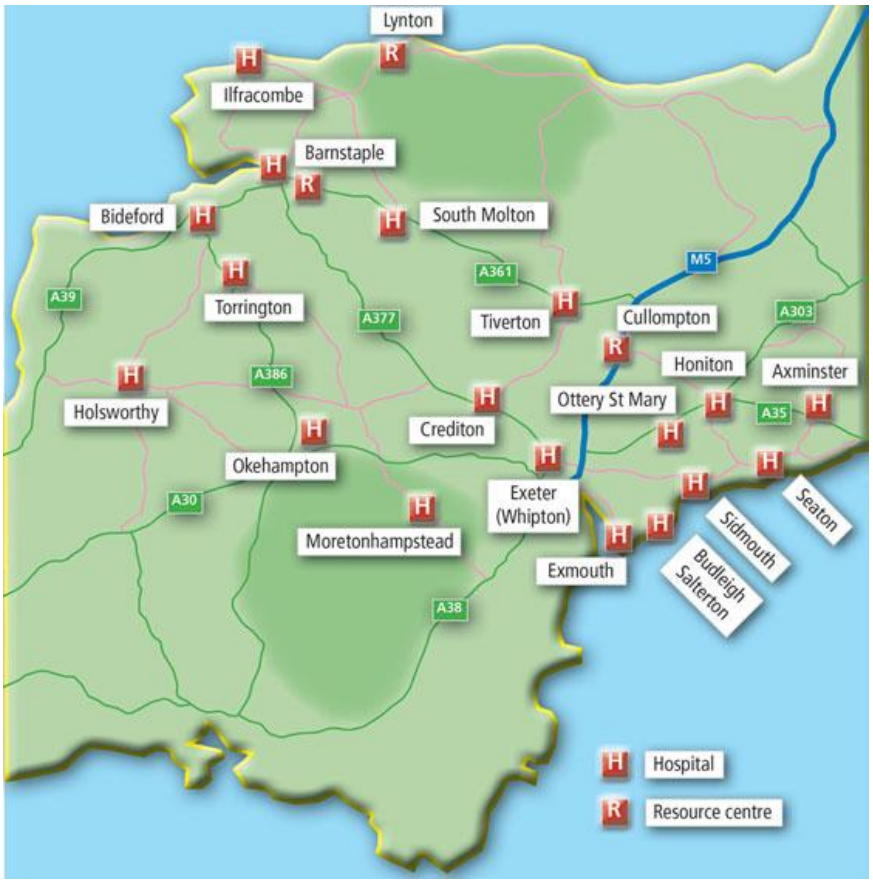
We provide health and social care services that make a real difference to peoples' lives.

Across Devon, our teams of care professionals work with patients and their families to support your independence, health, and well-being. We provide support that avoids hospital admissions, or if an admission is necessary, makes your stay in hospital as short and effective as possible before working with you on a safe discharge home.

Our values guide everything we do: you will receive excellent and safe care from staff who operate with integrity and compassion and who understand that your needs are unique, that your care plan will be personal to you.

The Care Quality Commission inspected our services in 2014 and found our community services to be 'close to outstanding' with inspectors wishing they lived in Devon. Our medical inpatient services at NDDH were the first to be judged as 'outstanding' by the CQC.

We offer a wide range of hospital, outpatient, home facing, and specialist services across most of Devon. We have a huge range of clinical expertise that we share across professional spheres to ensure you get world-class care when you need it.


Lynton
Ilfracombe
Barnstaple
Bideford
South Molton
A361
M5
A39
Torrington
A377
Tiverton
Cullompton
A303
Honiton
Axminster
A386
Holsworthy
Ottery St Mary
A35
Crediton
Okehampton
Exeter
(Whipton)
Seaton
A30
Moretonhampstead
Sidmouth
Exmouth
Budleigh
Salterton
A38
Hospital
Resource centre

Sign up to Safety

Sign up to Safety is harnessing the commitment of staff across the NHS in England to make care safer. A patient safety campaign, it is one of a set of national initiatives to help the NHS improve the safety of patient care. Collectively and cumulatively, these initiatives aim to reduce avoidable harm by 50% and support the ambition to save 6,000 lives.

Ethically and professionally, patient safety should be the core business of healthcare. Sign up to Safety is for everybody, in every part of the NHS. The campaign unites organisations and staff across the NHS by a common goal; to make the care we give our patients as safe as possible. Healthcare is high risk and mistakes can happen. It's crucial that we can discuss safety openly with patients, carers and colleagues. Everyone in the NHS has a role to play and the campaign helps staff and organisations take action to improve care.

This is why Northern Devon Healthcare NHS Trust has joined the Sign up to Safety campaign. The campaign will support people to feel safe to speak up when things do go wrong. Everyone involved in caring for patients, including those in roles supporting care for patients, need to know that these conversations are important, that concerns can be raised, and that they will be heard when they do speak up – and that they may save lives by doing so. Knowingly offering patients unsafe or poor care is morally and ethically wrong and a greater transparency in and focus on healthcare outcomes will expose bad practice. After all, our families, friends, and we could be the next ones affected. Additionally, there is a growing evidence base that safer care equates to cost-savings and efficiencies.

Everyone involved in the care delivered to patients by Northern Devon Healthcare NHS Trust services can make a difference. We have enthusiastic and talented staff and, by harnessing this ability, and working with our partners, we can make lasting changes to the safety of patient care, halve avoidable harm and make a positive difference to the lives and experiences of the people we care for, and who use our services. These changes start with the Trust Board, who are passionate about the provision of harm free care by our front line teams.

Core pledges

The Sign up to Safety campaign has five core pledges:

1. **Putting safety first**
    - ❖ Commit to reduce avoidable harm in the NHS by half and make public our locally developed goals and plans
2. **Continually learn**

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

3. **Being honest**
   - 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
4. **Collaborating**
   - Take a lead role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use
5. **Being supportive**
   - Help people understand why things go wrong and how to put them right.
   - Give staff the time and support to improve and celebrate progress

In addition, we have set ourselves some further local aims:

6. **Being open, transparent and honest**
   - When something goes wrong, we will be open and honest with patients and their relatives from the outset, offering them an opportunity to contribute to the investigation process and providing them with details of the outcomes of any investigation
   - Give staff a high level of support when things go wrong, in order to encourage a culture of openness, and to allow learning to occur
   - We will publish the learning from any serious incidents or complaints
7. **Creating a culture of continuous improvement**
   - We will build on existing resource and abilities within our workforce to increase the capacity and capability in quality improvement skills and methodology

The safety improvement plan

This safety improvement plan describes the Trust's three year plan to support the national programme and our local workstreams and initiatives.

Northern Devon Healthcare NHS Trust has a strong history of patient safety improvement, having participated in and been supported by previous national and local safety improvement programmes. The Leading Improvement in Patient Safety (LIPS), developed by the NHS Institute for Innovation and Improvement, and the NHS South West Quality and Patient Safety Improvement Programme (latterly the Safer Care South West Collaborative) have allowed the Trust to build capability over time in using the 'model for improvement', leading to significant improvements in care for patients and knowledge and skills for staff.

Participation in these programmes led to:

- Increased knowledge and use of the model for improvement
- Collaborative working with other NHS providers regionally by learning from others and sharing our own good practice
- Increasing the visibility of senior leaders by implementing a programme of patient safety walkrounds
- Real improvements in the safety of patient care – earlier recognition and escalation of the deteriorating patient leading to a reduction in cardiac arrests, a reduction in

harmful falls and pressure ulcers, significant improvements in communication and clinical handover, and increases in medicines safety.

However, there are things we would do differently, and some of the lessons we have learned are:

- Patient safety improvement workstreams tended to focus on specific areas of concern, and we have sometimes failed to spread good practice and firmly embed improvement in all areas
- We have not increased capacity and capability in quality and safety improvement widely or deeply enough
- We need to clearly define the aims of the safety improvement strategy, publicise workstreams or celebrate successes

Strategic alignment

The patient safety improvement plan is aligned to existing priorities and strategies, in order to help maximise its successful delivery.

Corporate aims and objectives

The patient safety improvement plan supports one of the Trust's key objectives, 'We will be recognised for delivering care of the highest quality, measured in terms of clinical effectiveness, patient safety and the patient experience', and reflects the values by which the Trust will be judged in the delivery of its vision, specifically demonstrating compassion, striving for excellence, acting with integrity, and listening and supporting others.

The Academic Health and Science Network (AHSN)

The South West AHSN is creating a collaborative that aims to improve patient safety and quality of care throughout Cornwall and the Isles of Scilly, Devon, and Somerset. In its 'plan on a page', the South West AHSN describes the achievement of that aim as requiring an improved culture, capability, capacity, collaboration and understanding. We have already had the opportunity to work with the AHSN by sending a group of staff on an Institute for Health Improvement (IHI) Patient Safety Officer training course, with more opportunities being offered in the future. The AHSN is also supporting us in the development of our mortality review processes by working with senior clinicians and managers.

Quality Account

The Quality Account has identified four areas for improvement for 2015/16, as well as providing a review of progress during 2014/15. These include:

- Care in the chair – preventing pressure damage when a patient is out of bed
- Better communication with our patients, their families and carers

The Care Quality Commission (CQC)

The patient safety improvement plan aims to support the continued improvement made following the CQC's Chief Inspector of Hospitals visit to the Trust in July 2014. Whilst the action plan developed as a result of the CQC's feedback is now complete, the safety improvement plan will strengthen and sustain changes made.

Duty of Candour

Underpinned by a contractual and statutory requirement to be open with patients and carers when things go wrong, we believe that trust and transparency is the foundation of our commitment to learn from error and mistakes.

Our focus

The overarching aim of the patient safety improvement plan is to reduce avoidable harm across all services in our Trust by 50%, and we plan to do this by focussing on some key areas of concern over the next three years.

By listening to clinicians, managers and our patients, and by reviewing our safety and quality data and measures, we have reviewed themes and trends, and safety and disease specific issues. We have identified some key areas of focus.

By July 2018, we aim to:

- Reduce our overall patient falls rate in our acute and community inpatient services to be at, or below, the national average, and to reduce the harmful falls occurring in our care by 50%. The national averages for falls, measured per 1000 bed days are 5.6 for acute services and 8.6 for community inpatient services
- Reduce the incidence of pressure ulcers acquired in our care. We aim to reduce grade two pressure ulcers by 50% and to eliminate grade three and grade four pressure ulcers
- Ensure that our teams are using the very highest standards of communication, including clinical record keeping, to help identify risks and safety concerns to
    - Aid early recognition of patient deterioration, including identification of acute kidney injury (AKI) and sepsis
    - Ensure handovers (whether within a ward or team, or from one healthcare setting to another) are safe and robust to ensure continuity of care and avoid lapses in information
    - Ensure that patients are discharged from our care safety, which includes transfers from community hospitals and community nursing teams
- Improve the identification and sharing of learning when things go wrong, including the publication of serious incident investigations and complaints on our Trust website. We will ensure that learning from harm events and near misses is shared widely across the Trust and is embedded into quality improvement processes
- Increase capacity and capability across the organisation in quality improvement skills, to allow staff at all levels to innovate without barriers, and to support quality improvement at scale
- Work in partnership with patients and their families to prevent harm whilst in our care

Setting our aims

Each of our safety improvement workstreams requires an overarching goal for measuring success over the next three years.

Focus	The measure of success by July 2018
Falls	1. The falls rate will reduce to or below the national falls rate of a. 5.6 per 1000 bed days (acute inpatient services) b. 8.6 per 1000 bed days (community inpatient services) 2. The rate of harmful falls will reduce by 50%
Pressure ulcers acquired in our care	1. The percentage per 1000 bed days of grade two pressure ulcers will reduce by 50% 2. To have zero grade three and grade four pressure ulcers acquired in our care which were preventable
Communication and identifying avoidable harm	1. The number of communication related incidents will reduce by 50% 2. To have zero cardiac arrests, outside of the Emergency Department, that were predicable 3. To have zero diagnoses of avoidable acute kidney injury acquired in our care 4. To have zero diagnoses of avoidable sepsis acquired in our care 5. Implementation of an electronic system of recording physiological observations, handover and hospital at night
Sharing learning	1. We will publish, with the knowledge of patients / or families, serious incident investigation reports 2. We will publish, with the knowledge of patients / or families, outcomes from complaints and concerns 3. We will publish compliments received from patients and their families about our services 4. Divisional governance meeting agendas will have safety and quality as a key component, and standing item 5. Thematic reports relating to serious event audits and serious incidents will be available to all staff, wherever they work in the Trust 6. Incidents causing harm to patients will reduce by 50% We will take a 'safety temperature' check using the following statements - the measure of success is more than 80% of staff agreeing with the statements a. 'I feel safe to report safety concerns' b. 'I feel that patient safety and quality is the Trust's top priority' 7. The Trust will have a full and ongoing programme of patient safety walkrounds across every clinical and clinical support service
Quality improvement	1. We will formally train 50 staff in quality improvement methodology 2. The Trust will have a central source of information and support relating to quality improvement methodology 3. All new quality improvement projects supported by the patient safety team / staff trained in quality improvement will use improvement methodology

	4. We will prescribe information to all patients (and their families, where that is appropriate), which will help them to prevent harm whilst in our care. This will include the use of various media, including hospital radio and end of bed televisions

The Medicines Governance Group have developed an improvement plan specific to medicines safety improvement, and therefore specific goals in relation to this are not included as part of the strategy.

Where are we now, and how will we measure our success?

Falls

Measure number	Measure name and descriptor	Measure type	Calculation of the measure			Goal	Source	Acute / Community Hospital / Community Nursing (A / CH / CN)	Position as at July 2015
			Numerator	Denominator	Measure				
1	Days between falls resulting in significant harm	Outcome	Date of falls with significant harm (medium, severe, death)	N/A	Days between	500 days between falls with significant harm	Datix Incidents must be validated in relation to severity	A CH	*0* *Count start date: 01.10.2015*
2	Rate of falls per 1000 bed days	Outcome	Number of falls reported	Number of bed days	Rate per 1000 bed days	< 5.6 per 1000 bed days (acute)	Datix	A	7.637 *Monthly average over last year (July 2014 to July 2015)*
						< 8.6 per 1000 bed days (community inpatients)		CH	10.525 *Monthly average over last year (July 2014 to July 2015)*
3	Number of harmful falls	Outcome	Number of falls reported	N/A	Number	<7 (acute)	Datix	A	14 (acute) *Annual average over the last three years*

						<8 (eastern CH)		CH	16 (eastern CH) *Annual average over the last three years*
						<2 (northern CH)		CH	5 (northern CH) *Annual average over the last three years*
4	Percentage of falls risk assessments completed	Process	Number of risk assessments completed on admission	Number of patients audited	Percentage	95%	Clinical Effectiveness Tool	A CH CN	Acute 88% *Monthly average (March 2015 to August 2015)*
									Community Hospital 100% *Monthly average (March 2015 to August 2015)*
									Community Nursing *Monthly average (August 2015 to November 2015) to be established in December 2015*
5	Percentage of patients at risk of falling with a care plan in place	Process	Number of patients at risk of falling with evidence of a	Number of patients audited	Percentage	95%	Clinical Effectiveness Tool	A CH	Acute 93% *Monthly average*

			care plan					CN	*(March 2015 to August 2015)*
									Community Hospital 96% *Monthly average (March 2015 to August 2015)*
									Community Nursing *Monthly average (August 2015 to November 2015) to be established in December 2015*
6	Percentage of patients at risk of falls with a plan of care implemented	Process	Number of patients at risk of falling with evidence of implementation of a plan of care	Number of patients audited	Percentage	95%	Clinical Effectiveness Tool	A CH CN	Acute 89% *Monthly average (March 2015 to August 2015)*
									Community Hospital 95% *Monthly average (March 2015 to August 2015)*
									Community Nursing *Monthly average*

									(August 2015 to November 2015) to be established in December 2015
7	Percentage of patients at risk of falls with a plan of care that has ongoing review	Process	Number of patients with evidence of evaluation and ongoing review of a plan of care	Number of patients audited	Percentage	95%	Clinical Effectiveness Tool	A CH CN	Acute 89% *Monthly average (March 2015 to August 2015)* Community Hospital 94% *Monthly average (March 2015 to August 2015)* Community Nursing *Monthly average (August 2015 to November 2015) to be established in December 2015*

Pressure ulcers acquired in our care

Measure number	Measure name and descriptor	Measure type	Calculation of the measure			Goal	Source	Acute / Community Hospital / Community	Position as at July 2015
			Numerator	Denominator	Measure				

								Nursing **(A / CH / CN)**	
1	Days between pressure ulcers (all grades)	Outcome	Date of pressure ulcer (all grades)	N/A	Days between	200 days between pressure ulcers	Datix Incidents must be validated in relation to severity	A CH CN	0 *Count start date: 01.10.2015*
2	Rate of pressure ulcers per 1000 bed days	Outcome	Number of pressure ulcers reported	Number of bed days	Rate per 1000 bed days	To be agreed following baseline period	Datix	A CH	*To be established*
3	Number of pressure ulcers • Grade 1 • Grade 2 • Grade 3 • Grade 4	Outcome	Number of pressure ulcers reported	N/A	Number	< (acute)	Datix	A CH CN	Acute 306 *Annual average over the last three years*
						< (eastern CH)			Eastern Community Hospital 116 *Annual average over the last three years*
						< (northern CH)			Northern Community

									Hospital 96 *Annual average over the last three years*
						< (eastern CN)			Eastern Community Nursing 254 *Annual average over the last three years*
						< (northern CN)			Northern Community Nursing 219 *Annual average over the last three years*
4	Percentage of pressure ulcer risk assessments completed within 6 hours of admission	Process	Number of risk assessments completed on admission (to ward or caseload)	Number of patients audited	Percentage	95%	Clinical Effectiveness Tool	A CH CN	Acute 90% *Monthly average (March 2015 to August 2015)*
									Community Hospital 95% *Monthly average (March 2015 to August 2015)*
									Community

									Nursing *Monthly average (August 2015 to November 2015) to be established in December 2015*
5	Percentage of patients at risk of developing pressure damage with a care plan in place	Process	Number of patients at risk of developing pressure damage with evidence of a care plan	Number of patients audited	Percentage	95%	Clinical Effectiveness Tool	A CH CN	Acute 88% *Monthly average (March 2015 to August 2015)*
									Community Hospital 99% *Monthly average (March 2015 to August 2015)*
									Community Nursing *Monthly average (August 2015 to November 2015) to be established in December 2015*
6	Percentage of patients at risk of developing pressure damage with a plan of care implemented	Process	Number of patients at risk of developing pressure damage with evidence of implementation of	Number of patients audited	Percentage	95%	Clinical Effectiveness Tool	A CH CN	Acute 85% *Monthly average (March 2015 to August 2015)*

			a plan of care						Community Hospital 98% *Monthly average (March 2015 to August 2015)* Community Nursing *Monthly average (August 2015 to November 2015) to be established in December 2015*
7	Percentage of patients at risk of developing pressure damage with a plan of care that has ongoing review	Process	Number of patients at risk of pressure damage with evidence of evaluation and ongoing review of a plan of care	Number of patients audited	Percentage	95%	Clinical Effectiveness Tool	A CH CN	Acute 87% *Monthly average (March 2015 to August 2015)* Community Hospital 97% *Monthly average (March 2015 to August 2015)* Community Nursing *Monthly average (August 2015 to November 2015) to be established in December*

									2015

Communication and identifying avoidable harm

Measure number	Measure name and descriptor	Measure type	Calculation of the measure			Goal	Source	Acute / Community Hospital / Community Nursing (A / CH / CN)	Position as at July 2015
			Numerator	Denominator	Measure				
1	Number of communication related incidents	Outcome	Number of communication related incidents reported	N/A	Number	To be agreed once baseline established	Datix	A CH CN	231 *Total number reported August 2014 to July 2015*
2	Rate of communication related incidents per 1000 bed days	Outcome	Number of communication related incidents	Number of bed days	Rate per 1000 bed days	To be agreed once baseline established	Datix	A CH CN	Baseline to be established by December 2015
3	Number of cardiac arrests outside of the Emergency Department	Outcome	Number of cardiac arrests occurring outside of the Emergency Department	N/A	Number	No cardiac arrests that were preventable or where the patient's deterioration had not been recognised and appropriately escalated	Datix and investigation processes	A CH	Acute 2 *(August 2013 to July 2015)* Community Hospital 0 *(August 2013 to July 2015)*
4	Number of patients diagnosed with acute	Outcome	Number of patients with a clinical	N/A	Number	To be agreed once baseline	Coding	A	

	kidney injury >24 hours post admission		diagnosis of acute kidney injury >24 hours post admission			established		CH	
5	Number of patients who meet the criteria for potential sepsis, who are screened as part of the admission process in the Emergency Department	Process	Number of patients who are identified as having the criteria for potential sepsis who are screened as part of the admission process	Number of patients identified as having the criteria for potential sepsis	Percentage	>95%	CQUIN audit	A	87.5% *Q1 2015/16*
6	Number of patients who are diagnosed as having sepsis who receive IV antibiotics within one hour of assessment	Process	Number of patients who are identified as having sepsis who receive IV antibiotics within one hour of assessment	Number of patient who are diagnosed as having sepsis	Percentage	>95%	CQUIN audit	A	100% *Q2 2015/16*
7	Percentage of wards with electronic system of recording physiological observations in place	Process	Number of wards with Nervecentre observations module in place	Number of wards in Trust	Percentage	100%	Audit	A CH	0 *As of July 2015. Two wards identified as early adopters from September 2015*
8	Percentage of wards with electronic system of recording handover in place	Process	Number of wards with Nervecentre handover module in place	Number of wards in Trust	Percentage	100%	Audit	A CH	0
9	Implementation of electronic hospital at night task delegation system	Process	Implementation progress of Nervecentre hospital at night module in place	N/A	Complete implementation	Complete implementation	Audit	A CH	0

Sharing learning

Measure number	Measure name and descriptor	Measure type	Calculation of the measure			Goal	Source	Acute / Community Hospital / Community Nursing (A / CH / CN)	Position as at July 2015
			Numerator	Denominator	Measure				
1	Summaries of all serious incident investigations will be published on the Trust website	Balancing	Number of serious incident investigations published on the Trust website	Number of serious incident investigations	Percentage	100%	Corporate Governance	Whole Trust	0
2	Summaries of all complaints will be published on the Trust website	Balancing	Number of complaints published on the Trust website	Number of complaints	Percentage	100%	Customer Relations	Whole Trust	0
3	Compliments will be published on the Trust website	Balancing	Number of compliments published on the Trust website	Number of compliments	Percentage	100%	Customer Relations	Whole Trust	0
4	Number of divisional governance meetings with safety and quality as a core agenda item	Balancing	Number of divisional governance meetings with safety and quality as a core agenda item	Number of divisional governance meetings	Percentage	100%	Audit	Whole Trust	To be established
5	SEA thematic reports will be shared with all staff	Balancing	Number of quarterly SEA thematic reports that are 1. Published on Bob	Number of SEA thematic reports	Percentage	100%	Corporate Governance	Whole Trust	0

			2. Shared at divisional governance meetings 3. Included as links in Chief Executive Bulletin						
6	SIRI thematic reports will be shared with all staff	Balancing	Number of quarterly SIRI thematic reports that are 1. Published on Bob 2. Shared at divisional governance meetings 3. Included as links in Chief Executive Bulletin	Number of SIRI thematic reports	Percentage	100%	Corporate Governance	Whole Trust	0
7	Number of incidents resulting in harm to patients	Outcome	Number of incidents resulting in harm to patients	Number of patient related incidents reported	Percentage	To be agreed once baseline established *will reduce by 50%*	Datix Team	Whole Trust	5883 *Total number August 2014 to July 2015*
8	Percentage of staff who agree with the 'safety temperature' check statements	Balancing	Number of staff who agree with the statement 'I feel safe to report safety concerns'	Number of staff who are surveyed	Percentage	>80%	Local staff survey	Whole Trust	Baseline audit to take place by December 2015
			Number of staff who agree with the statement 'I feel that patient safety and quality is the	Number of staff who are surveyed	Percentage	>80%	Local staff survey	Whole Trust	Baseline audit to take place by December 2015

			Trust's top priority'						
9	Number of patient safety walkrounds / visits taking place per month	Process	Number of patient safety walkrounds /visits taking place in each calendar month	N/A	Number	A minimum of four per calendar month	Patient Safety Team	Whole Trust	0

Quality Improvement

Measure number	Measure name and descriptor	Measure type	Calculation of the measure			Goal	Source	Acute / Community Hospital / Community Nursing (A / CH / CN)	Position as at July 2015
			Numerator	Denominator	Measure				
1	Number of staff formally trained in quality improvement methodology	Number	Number of staff formally trained in quality improvement methodology (e.g. IHI / AHSN)	50	Number	50	Workforce Development	Whole Trust	5
2	Development of a central source of information and support in quality improvement methodology	Process	A central source, available to all staff, for information and support relating to quality improvement methodology, maintained by the patient safety team. This will contain, as a minimum	N/A	N/A	To be completed by July 2016 and maintained on a monthly basis	Patient Safety Team	Whole Trust	No resources currently available

			1. QI methodology training resources 2. Details of ongoing QI projects 3. Details of QI trained staff						
3	Percentage of QI projects supported by the Patient Safety Team	Process	Number of QI projects currently supported (via QI methodology) by the Patient Safety Team	Number of QI projects currently in place	Percentage	>95%	Patient Safety Team via a QI database	Whole Trust	There is currently no central record of QI projects taking place in the Trust. The Patient Safety Team support projects on an ad hoc basis
4	Development of patient information resources relating to self-maintenance of safety whilst in our care	Process	Development of 1. A film for patients that informs them of how they can contribute to their safety, this will be available on information screens around the Trust, end of bed TVs and on the Trust's website 2. Development of a leaflet reflecting the above	N/A	N/A	To be completed by July 2016	Patient Safety Team	Whole Trust	There are currently no resources available that jointly inform patients about safety risks and how they can help to prevent them