East London NHS Foundation Trust

REPORT TO THE TRUST BOARD - PUBLIC
23 September 2021

Title	Patient Safety – Going Forward
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Purpose of the report

The aim of this paper is to review the patient safety systems we have presently in ELFT, consider where improvements can be made and create a way forward in how we will improve our approach to Patient Safety.

Maintaining patient safety is important. We need a culture where staff and service users feel safe to point out areas where we can improve patient safety. Where patient safety incidents occur, we need to study and learn from these incidents so we can continuously improve the quality of service we provide.

Committees/meetings where this item has been considered

06/09/21	Quality Assurance Committee

Key messages

This paper provides assurance that we have reviewed our patient safety system within the organisation both internally and externally and we are satisfied that we have good systems in place that meet the guidance outlined in the National Patient Safety Strategy 2019.

We have used Quality Improvement interventions to improve our patient safety approach within the organisation with good results.

The paper outlines the main components that are envisaged as being part of this improved patient safety culture and system within ELFT. These are based around engaging with the assets already identified in the Trust:

- Service user involvement
- Staff engagement
- Quality Improvement
- Clinical Leadership.

We are in the process of developing a post for a Director of Patient Safety who will lead on this development work, and also engage and ensure all patient safety improvement is fully embraced with the Quality Improvement agenda.

We have already established a Patient Safety Forum which meets monthly to discuss the themes arising within the organisation on patient safety, the progress of patient safety improvement work and how we are learning from patient safety incidents.

Strategic priorities this paper supports

Improved population health outcomes	☒	Improving patient safety should improve the safety, not only for our patients, but should be shared with our patient safety partners to improve the safety for the communities we serve.
Improved experience of care	☒	Improving patient safety is at the heart of improving our service users experience of care.
Improved staff experience	☒	Part of our improvement in patient safety will be in developing a patient safety culture within the organisation which should

		improve staff experience in identifying and learning form patient safety issues.
Improved value	☐	

Implications

Equality Analysis	This report has no direct impact on equalities.
Risk and Assurance	This paper addresses improvement of patient safety which is hoped t improve risk management and provide improved assurance.
Service User/ Carer/Staff	Improved patient safety culture and patient safety systems will have a direct impact on service users, carers and staff. It is aimed to have a positive impact.
Financial	There are financial implications with this proposal moving forward. These need to be further developed and brought back in more detail to the Committee.
Quality	Improvement in patient safety within the organisation will have a direct impact on the improvement in quality of care that is provided. The patient safety improvements will be closely aligned to the quality improvement agenda.

1.0 Background/Introduction

1.1 The aim of this paper is to review the patient safety systems we have presently in ELFT, consider where improvements can be made and create a way forward in how we will improve our approach to patient safety.

1.2 Maintaining patient safety is important. We need a culture where staff and service users feel safe to point out areas where we can improve patient safety. Where patient safety incidents occur, we need to study and learn from these incidents so that we can continuously improve the quality of service we provide.

2.0 Present ELFT Approach to Patient Safety

2.1 When a patient safety incident occurs, it is logged onto our incident system (DATIX). There is a daily review of these incident reports and those that are deemed to have caused above moderate harm are escalated to be reviewed by a senior clinician. The senior clinician will decide if there is a need for a 48-hour report and whether there is an issue of duty of candour. A 48-hour report is completed by the reporter of the incident. It will give more detail around the incident and identify if any immediate action needs to take place to maintain patient safety. Duty of candour is a statutory (legal) duty to be open and honest with patients, service users, or their families, when an incident occurs which could have caused or could lead to significant harm in the future. It applies to all health and social care organisations registered with the regulator, the Care Quality Commission (CQC) in England.

2.2 When a 48-hour report is completed, it is reviewed by a senior clinician who will decide whether further investigation is required or not. If further investigation is required, this may be by a concise report; this is a more detailed report that is carried out by the author of the 48-hour report. The incident may require a more independent investigation through a serious untoward incident (SI) review. This investigation is carried out by an independent reviewer from the risk and governance department. The reviewer will be supported by a clinician and, if a panel review, the clinicians will be senior and from another area of the organisation.

2.3 Completed concise and SI reports are reviewed twice weekly by a panel of senior clinicians, independent investigators and the risk and governance team. This panel checks the quality of the reports. They ensure the report covers all issues and an appropriate action plan is put in place to address any issues that have been identified. The SI report then goes to a monthly SI meeting attended by all Clinical Directors, Medical Directors, Chief Medical Officer, Chief Nurse, Directors of Nursing and members of the Risk and Governance department. Clinical Directors present SI reports from their area and the learning from these are shared. This is an opportunity for shared learning. Clinical Directors will then take the reports back to their areas and share with their team. They will then monitor the action plan and ensure this is completed.

2.4 Directorates will monitor their SIs and will hold Learning Lessons events four times per year where they will look at themes from SIs and what has been learnt. Twice yearly, there is a Trust-wide Learning Lesson events where themes are reviewed across the organisation.

3.0 What have we done at ELFT to improve Patient Safety?

3.1 Since 2013, the Chief Quality Officer at ELFT has led the adoption of a systematic approach to understanding and solving complex patient safety issues, supported

through our partnership with the Institute for Healthcare Improvement (IHI). The use of quality improvement has resulted in:

- Greater involvement of staff, service users, carers and stakeholders in identifying safety issues and then developing and testing creative solutions to address these. This has shifted the balance of power so that ELFT teams of staff and service users feel more able to identify and solve their greatest safety issues, as demonstrated in our annual NHS staff survey;

- Almost 5000 people have learnt skills in understanding and improving complex systems since 2014, and this programme continues in order to equip everyone with the skills and confidence they need to improve safety and quality;

- Safety improvement in a number of high priority issues:
  Violence reduction (the most commonly reported safety incident at ELFT) - Since 2013, we have been applying quality improvement to understand the factors leading to violence in a range of inpatient settings, and to test new ideas that can help us better predict and prevent violence. This has led to a 30% sustained reduction in physical violence across adult mental health inpatient services. We have also seen a >50% reduction in physical violence in older adult inpatient settings. This work has now moved into quality control (holding on to the gains as part of routine operations, with visual management, measurement of key practices and processes, daily huddles and clear escalation protocols). See links below for more details about this work:
  https://qi.elft.nhs.uk/wp-content/uploads/2017/02/Violence-reduction-at-ELFT.pdf
  https://qi.elft.nhs.uk/wp-content/uploads/2016/10/Safer-wards-reducing-violence-on-older-peoples-mental-health-wards.pdf

- Pressure ulcer reduction - Community acquired pressure ulcers were our second most commonly reported safety incident at ELFT. A quality improvement programme achieved a reduction in grade 2, 3 and 4 pressure ulcers across our community health services.

- Medicine safety - A number of quality improvement projects, led by our pharmacy team, have focused on our major medicine safety issues. As an example, a research project showed that the most common safety issue was related to missed doses of medication. A subsequent quality improvement project achieved a 93% reduction in missed doses across our six older adult mental health inpatient wards:
  https://qi.elft.nhs.uk/wp-content/uploads/2015/08/alan-cottney-using-league-tables-to-reduce-missed-dose-medication.pdf

3.2 Teams across the Trust are now applying their quality and safety improvement skills to tackle other complex safety issues, such as transitions between teams and sexual safety in inpatient services

4.0 Review of ELFT Patient Safety

4.1 The Chief Medical Officer started a review of ELFT Patient Safety Systems in 2018. On this review, he was assured that our present systems are safe but he also identified areas that can be further improved.

4.2 In 2019, Professor Carl Macrae, an expert in Patient Safety based at the University of Nottingham, was commissioned to carry out an external review of ELFT Patient Safety systems, review the international evidence base of patient safety systems and then

recommend how we could further improve our patient safety systems. Professor Macrae reported back his findings in late 2020.

4.3 We are assured from these reviews that our systems are in keeping with the National Patient Safety Strategy 2019.

5.0 What are the Assets in ELFT?

5.1 Moving forward in improving, patient safety needs to take into account the other areas the organisation is well known for. These include:

- Service user involvement
- Staff engagement
- Quality Improvement
- Clinical Leadership.

5.2 It is important to incorporate these assets into our improvement of patient safety.

6.0 Improvement in ELFT Patient Safety – Going Forward

6.1 Following the work we have carried out to date, we plan to further improve Patient Safety at ELFT. This will be scoped over the next six months and a timeline will be set for the project. The improvement will be based on the following principles.

6.1.1 *Engagement of Staff in the development of a Patient Safety Culture*
We will engage with staff in developing an organisational culture where patient safety is front and central. We will work with staff to develop a just culture within the organisation, where patient safety incidents are studied to learn how we can further improve processes. Staff will develop a better understanding around improvement approaches in patient safety

6.1.2 *Partner with Service Users and Families*
We will partner with service users and their families to study patient safety incidents and engage them in developing actions and learning going forward. Through this, we will continue to improve the quality of service we provide.

6.1.3 *Create a centralised and coordinated oversight of patient safety*
We will create a system for systematic and systemic studying of patient safety incidents throughout the organisation so that actions and learning can be developed and improved on.

6.1.4 *Create a common set of safety measures that reflect meaningful outcomes*
These metrics will allow us to build a foundation to continuous improvement and allow identification of risks proactively.

6.1.5 *Use digital systems to support us in this development*
We will develop digital systems to support us in our patient safety improvement work. We will build on our digital capacity to further develop our patient safety system.

6.1.6 *Use Quality Improvement methodology to ensure we continually improve*
We will use quality improvement methodology to ensure our actions plans are smart and measurable and that our learning is sustained. We will ensure patient safety improvement is well engaged with the Quality Improvement agenda.

7.0 Director of Patient Safety

7.1 To lead on this work, we are developing a post for a Director of Patient Safety.

7.2 The Director of Patient Safety will be the lead Patient Safety Expert in the organisation. They will carry out the role of Patient Safety Specialist as outlined in the NHS patient safety strategy (2019). They will help support the development of patient safety culture within the organisation and patient safety systems that are continually improving.

7.3 The Director of Patient Safety will ensure that there is evidence of system thinking, human factor understanding and just culture principles embedded within patient safety processes.

7.4 As Patient Safety leader within the organisation, they will lead and manage others in the improvement of patient safety. They will provide compassionate and collaborative senior leadership, visibility and expert support to the patient safety work within the organisation.

7.5 They will have key relationships with Trust Executive team:

- Chief Medical Officer - Executive lead for Patient Safety and line manager;
- Chief Quality Officer - to ensure patient safety improvements are embedded in the quality improvement agenda;
- Chief Nurse - to ensure patient safety is fully engaged with regulatory requirements and engagement with the Risk and Governance department;
- Chief Operating Officer - to ensure patient safety improvements are fully embedded operationally within the organisation.

7.6 We are aiming to recruit the Director of Patient Safety before the end of 2021.

8.0 Patient Safety Forum

8.1 In August 2021 we developed a monthly Trust Patient Safety Forum.

8.2 The Patient Safety Forum has been set up to provide a forum for discussion of improvement of patient safety processes within the organisation. Any issues that need to be escalated will feed into the Trust Quality Committee. The duties of the forum can be categorised as follows:

- To discuss themes relating to patient safety that have been raised in Serious Untoward Incident investigations;
- To discuss improvement plans relating to patient safety;
- To monitor and guide approach to the most frequent and high priority patient safety incidents;
- To develop a culture of patient safety within the organisation;
- To develop learning from patient safety incidents;
- To develop learning from outcomes of Coroners' hearings and Prevention of Future Death Notices;
- To provide leadership in patient safety;
- To develop an action plan from the external review carried out in 2020 and monitor the implementation;
- To ensure compliance with the National Patient Safety Framework;
- To consider how digital can help support improvements in patient safety.

9.0 Action being requested

9.1 The Board is asked to

- **RECEIVE** and **DISCUSS** the report
- **NOTE** the assurance provided and **CONSIDER** if further sources of assurance are required.