SIGN UP TO SAFETY CAMPAIGN

Q2 REPORT (JULY – SEPTEMBER 2016)

1.0 Background

In 2015/16 we launched our Sign up to Safety campaign across the Trust, further to funding awarded by the NHS Litigation Authority (NHSLA) of £600,000. The Trust received one of the largest bids for improvement by the NHSLA. The national campaign aims to reduce avoidable harm to patients by 50%, nationally, over the next three years. Frimley Health was chosen as one of 12 hospitals to pilot the programme and leads have been recruited to work on our three focus areas – clinical handover, patient consent and management of the perineum during labour.

Awareness events for staff across all 3 hospital sites were held in January 2016 with the aim of raising awareness around the campaign and encouraging staff and patients to get involved. Interactive information stands were set up in the foyer/entrance areas of both postgraduate centre, presentations from our executive team were delivered to staff across all hospital sites, and a 'roadshow' around the hospital was undertaken visiting wards and departments.

The events were a great success – we received over 250 personal pledges from staff members and were greeted with great positivity and enthusiasm. We were also joined by the NHS LA at the Frimley Park Hospital event who presented on learning from claims and how to use the available data more effectively.

2.0 Participation in the campaign

Communications & engagement

We have a communications and engagement plan in place and are using a range of channels to promote the campaign, including staff newsletters, intranet sites, our Trust website, a safety information leaflet for patients, and social media including Twitter.

Staff engagement

During patient safety training and other staff engagement events staff are being asked to make personal safety pledges and we have now received over 1000 pledges (almost 200 this quarter) and are using them to identify themes for future activities. The most common themes so far are around handover, revalidation (and continual professional development), teamwork, debriefing and staff safety. We are continuing to return safety pledges to staff via email or post 3-6 months after they make their pledge.

Public engagement

The Sign up to Safety Team continue to attend the Trust's constituency events with the aim of engaging members of the public on whether we can do anything to make them feel safer during their stay in hospital. The feedback so far from the public and patients at these events has been extremely informative and positive. The public's comments include how safety is at the forefront of everything that happens at Frimley Health and they are pleased when they hear that many of the staff who make up the patient safety teams have clinical experience.

Topic of the Week

In order to encourage a learning culture across Frimley Health, the concept of Topic of the Week was developed from a multi-departmental discussion. The aim was to stimulate conversations that improved patient safety & quality and encouraged staff wellbeing in an informal setting such as staff rooms. This concept then grew to incorporate learning and collaboration through social media to allow a wider audience for the topic using the twitter hash tag #FH_TOTW. Recent topics have included red flags & safe staffing, sepsis (coinciding with world sepsis day) and 'hello my name is'.

3.0 Collaboration

We are continuing to collaborate with other organisations. Unfortunately, the safety improvement team at Salisbury District Hospital have had to re-arrange their visit originally planned for October. However, we hope to facilitate mutual visits before the New Year.

We have used the webinar resources offered by the national Sign up to Safety Team to enhance our skills and make new connections, including a human factors company who we are in discussion with about bespoke human factors training around breaking down silos, hospital at night and understanding loss of control.

The national Sign up to Safety Team have invited us to take part in a new podcast series on sharing what people know about keeping people safer. This will focus mainly around the handover workstream.

We are currently in the process of arranging an event showcasing the Trusts work in safety improvement and will be inviting Professor Jane Reid, Regional Lead for Sign up to Safety to present an update on the national perspective.

The project lead for LocSSIPs attended a workshop hosted by Barts NHS Trust in September where they presented their LocSSIP journey so far and shared the model they have been working on. The day was very interactive and gave organisations an opportunity to share/generate ideas regarding the development and implementation of LocSSIPs. The Chair of the NatSSIPs Group (from NHS England) gave an update on the national perspective and explained that the CQC would now be looking for evidence that the initial requirements of the Patient Safety Alert have been fulfilled. It was also highlighted that the CQC may ask for evidence that there is multi-disciplinary team training available for procedural teams i.e. human factors training etc.

The NHS Innovation Accelerator Programme has asked the Lead Midwife for Sign up to Safety to provide feedback on our continued experience with the epi-scissors.

4.0 Clinical handover

Summary of planned actions

- Review of existing processes related to handover, including transfer of care between specialists, movement between departments and shift change.
- Establish robust safety focused handover processes.
- Implement standardised safety handovers trust wide.
- Monitor handover practice to ensure sustainability and benefits to patient safety.
- Engage with patient and service users to understand their needs and expectations of safe handover.

Update on actions

Safety SBAR handover training continues for newly qualified nurses, learners and staff on the “nurse in charge masterclass”, as well as ward and team based training (over 400 nursing and care staff since April 2016). In addition a 20 minute presentation was given at the Wexham educational half

day in September to a selection of 70 Consultants and junior doctors focusing on key actions medical teams could take to improve situational awareness, using the SBAR communication tool and encourage patient engagement.

Safety briefings were the biggest change to most handovers and we have been able to demonstrate an improved "total ward knowledge" of key safety issues from 38% before implementation to 78% afterwards on in-patient wards. This means that even if a member of staff is not directly responsible for the care of a patient they are aware of patients who are high risk of falls, have been detained under the mental health act or are requiring input from the critical care outreach team.
In the baseline review of handover practice 60% of staff on the pilot wards told us that information was missed or incorrect at handover at least 2-4 times a week. With Safety SBAR this has reduced to 27%.

Creating a safe place where staff can debrief together as a team has been seen as one of the more controversial parts of Safety SBAR. A cultural shift from wanting to get home as quickly as possible to learning and celebrating each day will take time. An effective and timely handover is essential to allowing this work to progress as expecting staff to stay late after shift to debrief will create a negative environment and may exclude some members of the team.

Working alongside the chief medical registrar a hospital at night handover has been introduced at Frimley Park Hospital (there is already a similar handover at Wexham Park). This is aimed to improve communication between teams, identify key safety issues during the night and proactively manage issues before they reach a critical state.

Next steps

- Final in-patient departments to adopt Safety SBAR handover by November 2016.
- 75% of in patients departments to include daily debrief at shift change by December 2016.
- Review implementation of hospital at night handover at Frimley Park and ensure key standards are reflected across Frimley Health.
- Align Trust transfer policy, including transfers from Emergency Department to wards, ward to ward transfers, transfers to critical care areas.
- Unified electronic solution for specialist referrals (using Safety SBAR format) including acceptable time limits and confirmation of transfer of care.

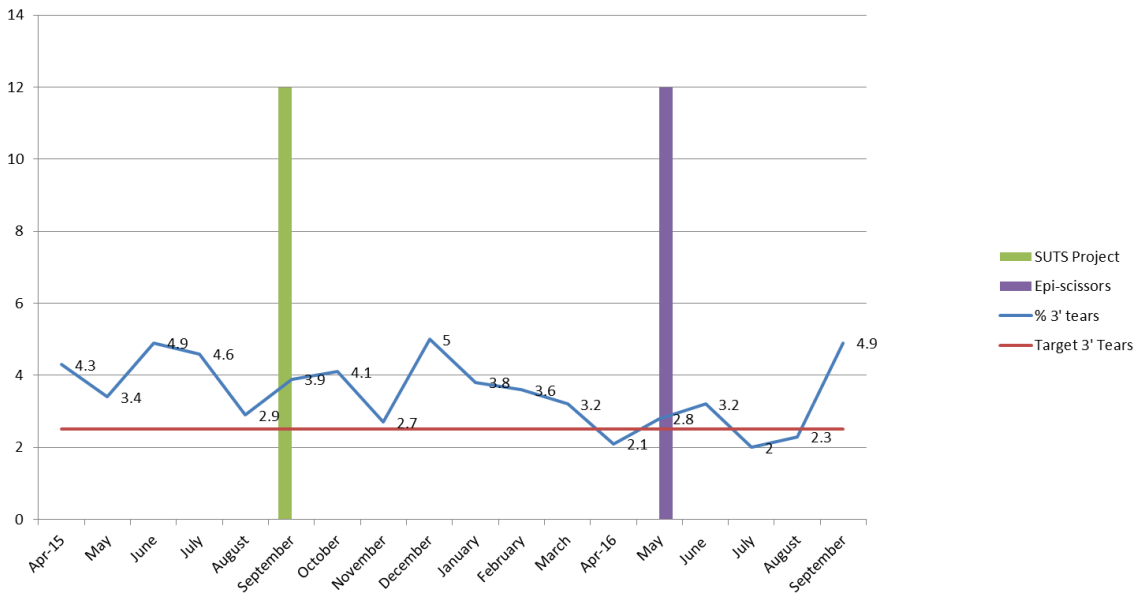
5.0 Management of the perineum during labour

Summary of planned actions

- To improve care of the perineum at the time of childbirth with a focus on reducing the incidence of 3rd/4th degree tears.
- To train midwifery, medical and student staff in management of the perineum in 2nd stage of labour.
- To introduce specialist scissors for performing more accurate 60'episiotomy.
- To develop patient literature.
- To review/maintain associated guidelines.
- To review associated complaints and claims.
- To make national links and contacts.

Update on actions

- The rate of 3rd and 4th degree tears from April – September 2016 is 2.9%. This is a 1% reduction from the same period of the previous year which equates to around 30 less women experiencing 3rd or 4th degree tears.



- The graph above shows a significant increase in September 2016 with 23 women experiencing a tear during labour. The rise in incidents has been investigated in depth and recurrent themes identified and fed back to all staff involved. These include:
  - Women of Asian origin
  - Births attended by student midwives

- Rapid births

These risk factors have been included in previous teaching and now re-iterated. No individual staff member was identified as an outlier for incidents.

- Teaching programme established at WPH site.
- Guidelines and patient literature under development for WPH site.
- Complaints and claims regularly reviewed and fed back to staff.
- Project aligned with pilot for national care bundle (FHFT lead midwife seconded to RCOG/RCM project).

Next steps

- Continue project at second site (WPH).
- Introduce specialist scissors at second site (WPH)(2017).
- Maintain impact of project at FPH site.

6.0 Consent & Local Safety Standards for Invasive Procedures (LocSSIPs)

Summary of planned actions

- Review existing consent policy, documentation and procedures.
- Review existing consent process at specialty level.
- Understand current compliance with the consent policy within specialties, specifically focusing on:
  - quality and timing of process
  - documentation
  - WHO checklist compliance
  - use of patient information
- Identify high risk specialties/procedures.
- Work with patients to establish what they understand about the consent process – focusing on areas of particular interest and areas of concern.
- Ensure that:
  - patients are given sufficient time and knowledge to give informed consent
  - consent always considers patients' individualised comorbidities and the impact of risks and benefits are made clear
- Review current education and training for medical staff around the consent process.
- Implement Local Safety Standards for Invasive Procedures (LocSSIPs) based on NHS England's national guidance.

Update on actions

- Additional Band 7 project lead has been appointed to support consent programme.
- Continued review of existing policies and consent forms in order to align documentation across all sites is underway.
- All existing pre-populated consent forms are currently being reviewed. Development and implementation of new pre-populated consent forms for certain orthopaedic procedures is underway.
- A review of claims data (from 2010 – 2014) has confirmed that Obs & Gynae, Orthopaedics and General Surgery are the high risk areas. The 3 main reasons for claims being:
    - failure to obtain consent for additional procedures undertaken
    - failure to inform the patient of the inherent risks associated with surgery, which materialised
    - alternative treatment options not considered
- Trustwide LocSSIP Policy developed and approved by the Hospital Executive Board. This achieved the deadline for progress with implementation set by NHS England.
- Specialties continue to identify procedures requiring a LocSSIP and to review existing policies to align with national guidance.
- Some areas have already started to write LocSSIPs for particular patient pathways i.e. Radiology, Theatres. The LocSSIP Implementation Group will review and approve new LocSSIPs as a standing agenda item each month.
- Attended LocSSIP workshop at Barts Health NHS Trust to share learning with other Trusts and receive update on national perspective.
- Regular updates on progress are provided to the Quality Committee.

Next steps

- Continue to review current consent processes and align documentation across the whole of Frimley Health.
- Appoint full time Band 7 LocSSIP Lead to be based at WPH – secondment opportunity.
- Appoint full time Band 6 Sign up to Safety Facilitator to support campaign, particularly around consent programme with a key focus on patient information.
- Replicate structure of FPH Consent Committee at WPH.
- Develop implementation plan for LocSSIPs.
- It is recognised that the development, implementation and monitoring of compliance of all LocSSIPs is a complex process involving a significant culture shift in some areas. Therefore, the deadline for completion is to be confirmed at a later stage by NHS England.