



York Teaching Hospital  
NHS Foundation Trust



# Patient Safety Strategy 2019 - 2024

# Introduction

Our priority is to support our staff to deliver safe, reliable, and effective care with zero avoidable harm to our patients.



We aim to be recognised as one of the safest healthcare organisations nationally and internationally, delivering safe, evidence-based care, by acting and learning when we identify a need for improvement. The Trust recognises the value of working with patients and carers to achieve this aim and we welcome patient partnership and aspire to support patients to be more involved in their care.

Our staff work in situations where high risks are inherent and not always recognised by teams. We will strive to maintain working conditions with safe and supportive systems, whilst promoting an environment that also recognises responsibility and accountability. We will continue to encourage reporting of errors and incidents in order to learn and to promote positive reinforcement rather than blame or punishment.

Staff, patients and relatives need to be actively encouraged to be involved in designing systems to reduce harm. Isolated piecemeal actions which focus on behaviour change of individuals involved with incidents rarely result in sustainable solutions to risk. If we are serious about reducing harm then we need to focus on system re-design utilising a patient-centred approach and the national patient safety curriculum to do this.

The increasing complexity of healthcare is creating new or previously unrecognised risks. Furthermore the increasing age of our patient population means that we are often delivering care to people with multiple chronic conditions and the associated polypharmacy in some circumstances results in additional harm. Prolonged hospital stay, increased acuity, delay in discharge, patient deconditioning and co-morbidities are all recognised to increase the risk of patients having an adverse event whilst in our care.

Diagnostic errors and delays have been acknowledged and are particularly evident in our learning from litigation. However, due to the growing complexity of patients with multiple chronic illnesses, combined with multiple health care providers and healthcare records we need to carefully monitor outcomes and consider where we need to strengthen our diagnostic processes, referral pathways and IT record systems.

Due to the increasing volume of data captured in the medical records and the ability for the computerised patient data records to be widely accessed we are likely to see an increase in non-clinical patient harm due to information governance breaches. Therefore before we move to broadening the scale of access to health records we need to consider and establish tighter security and access in order to persuade our patients that the benefits to their healthcare delivery are worth the risks.

Antimicrobial resistance is a recognised and increasing concern. It is estimated that if current trends continue the number of extra deaths attributed to antimicrobial resistance will be higher than any other single disease. We must as a matter of urgency change our antimicrobial prescribing practices and prevent our patients from acquiring infections whilst they are in our care.

Cost and efficiency is at the forefront of our improvement work and we must be mindful of budget limitations; the financial and human cost of poor outcomes should not be under-estimated. Despite the increased complexity of the care we are providing, budgets must be controlled and resources will potentially be restricted. It is therefore more important than ever that we consider the outcomes of our work and specifically in relation to patient safety carefully monitor staffing, resources including training and equipment and the state of our facilities.

# How are we doing?



We have achieved tangible improvements in patient safety over recent years. Examples include a reduction in unexpected admission to Critical Care, reduction in antibiotic usage, increased incident reporting rates and a reduction in serious injury from patient falls in hospital. We have also seen a significant improvement in the number of patients we screen for sepsis, a reduction in the number of patients with pressure ulcers and extensive use and understanding of the national early warning system (NEWS).

Individuals, wards and departments, both in community and acute settings, have all made a contribution to improve patient safety. We have reduced harm in some areas through the use of systematic review of root cause and contributory factors of errors and we are continuing to develop the skills of our staff in incident investigation, analysis and quality improvement. Whilst we recognise that we cannot completely eliminate harm we are striving to minimise the impact and increase recognition that errors are often caused by human factors due to unsuitable systems, conditions, processes and environments.

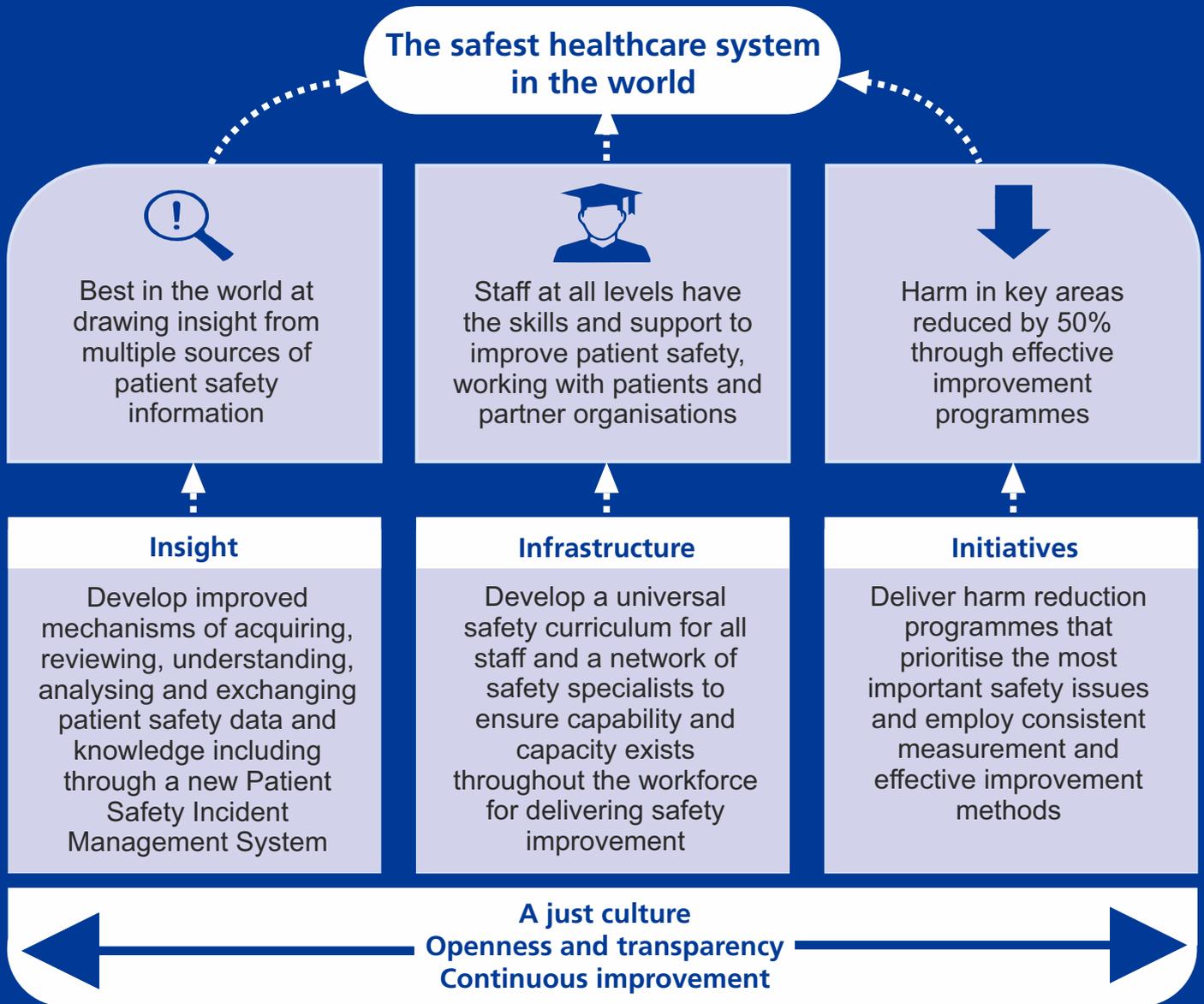
We deliver an improving seven day service, although we acknowledge that in some specialties further work is required.

We have introduced our Learning from Deaths Policy, and provided training for a cohort of our senior clinical staff on conducting case note reviews to support organisational learning. Progress is monitored by quarterly reports to Trust Board of Directors and learning is shared at Directorate Governance meetings.

We will continue to celebrate success and to promote and adopt best practice, recognising that robust evidence of patient safety effectiveness is still emerging.

# Driving principles

The proposed National Patient Safety Strategy describes an aspiration for the NHS to be the safest healthcare system in the world.



NHS Improvement (2018). Developing a patient safety strategy for the NHS

Our strategy aligns to this national strategy with the key aim of providing safe, patient centred care, assisted by four driving principles and underpinned by openness and transparency. These principles are:



# A just culture of safety



We strive to deliver a cultural change programme that brings together quality improvement, research, innovation, global health and patient safety specialists to become leaders in delivering safe, innovative patient care.

We encourage and require all our staff to report adverse events and unsafe conditions, to take immediate action when it is needed and to seek assistance when concerned about the quality and safety of care being delivered. Our staff survey tells us that we need to improve the fairness and effectiveness of our reporting procedures and take more action in order for staff to feel confident in reporting unsafe clinical practice.

Our aim is to promote an open culture as openness and transparency is crucial to learning. Staff should be aware that they are accountable for their actions, we want to develop and maintain an environment that feels safe. In encouraging honest disclosure of information we must be committed to rectifying problems and not apportioning blame.

In order to measure harm we encourage all our staff to use the electronic incident reporting system. We will look to strengthen the format of the learning from the data to ensure that it is understood, used and fed back to staff in a way that is meaningful.

Patient Safety Walk rounds have provided valuable opportunities for senior leaders to discuss safety issues with frontline staff. We commit to continue to undertake regular walk rounds and to provide a summary report to the Trust Board of Directors.

We will continue to promote the importance of designing safe systems that reduce harm and will incorporate human factors principles in our learning and training. We will look to advance our technology infrastructure and utilise digital solutions wherever possible to improve patient safety and quality.

# Continuous learning and improvement

We openly share safety information and focus on learning and improving from incidents, complaints and litigation. However, we should remember to not only provide feedback about error and harm but to feedback and share information on success and good practice. Safety briefs and huddles are mechanisms through which staff can disseminate learning effectively at local level; staff should be encouraged to use these to foster a learning culture within and between teams.

The Trust is committed to a process of continued review and of transparency and to a programme of focussed continuous professional development for staff. Professional capabilities and behaviours profoundly impact on the patients' experience. The quality of education and training is vital, too often training and e-learning is viewed as a tick box exercise and retention of knowledge from these modalities is poor. Team based and scenario simulation training is recognised to be effective and well received amongst clinical staff, therefore we should make efforts to expand our simulation training portfolio and to look for learning from adverse events which can be applied to clinical situation teaching and training. We have a commitment to learn and promise to act by using quality improvement methodologies and approaches to design as well as implement pathway and system change. We will use existing frameworks to measure and monitor safety.

The skills and competencies of our staff are key to the delivery of safe, high quality and cost effective care. It is essential that we have sufficient staff to care for the number and acuity of our patients. We recognise that, in particular, numbers of training grade doctors, nurses and non-consultant grade medical staff are low. Constraints remain with regard to the number of training grade medical and nursing staff required nationally. The Trust is committed to delivering alternatives approaches and investing as required.



# Patient and carer engagement

Patients need to be recognised for the contribution they can make to offering solutions to system failures and to be given more active encouragement to raise concerns without fear of recrimination. We actively promote being open with patients and families and apply the Duty of Candour but we need to consider effective educational strategies to support patients and carers to be equal partners in our patient safety strategy.

Relying on incident reporting systems to measure patient safety will currently rule out the involvement of our patients as they don't have access to our system and have to rely on other mechanisms to raise concerns. It is therefore important that user complaints are viewed as an aspect of our patient safety intelligence and measurement. In line with the Nursing and Midwifery Strategy we will develop services that support and recognise carers and family members' contribution to patient care. Case note reviews or stories presented by patients or carers will provide valuable information into the effectiveness of our systems from a user perspective.

Providing patients and carers with knowledge of what to expect of the healthcare system should help them to understand when things are going wrong and to alert staff to take prompt action.

## Leadership and quality improvement (QI)



Improving safety is often about changing behaviour and requires a commitment from senior leaders to enforce and reinforce standards of care. The Trust is committed to embedding patient safety and healthcare governance into Care Groups as part of an operational review.

There is a strong association between clinical leadership and positive outcomes, with poor outcomes being noted from areas with clinical hierarchies, as junior clinicians often fear reprisal if they report an adverse event. Therefore we need to foster a culture where all of our staff recognise their role as leaders in patient safety and wherever possible we should encourage patients and their carers to contribute to reducing harm.

Local patient safety strategies will be developed by frontline staff. We will develop the capacity and capability of staff as place based safety teams to identify and deliver quality improvement at local level. These activities will be monitored through specialty focussed plans and development of a dashboard approach to measurement of quality improvement.

We will continue to adopt a trust wide approach to QI from Ward to Board, developing skills, as important as clinical skills underpinned by the model for improvement.

# Key areas of work

Our guiding principle is to provide safe, patient-centered care to a consistently high standard. To achieve this we will focus on six key areas of work:





## 1 Consistency of care

Clinical leaders continually review our systems of work to ensure that patients in our care receive a consistent quality of service 24 hours a day, seven days a week.

Reviews of learning from deaths, incidents, complaints and litigation indicates that in some instances patients can wait too long to be seen or have treatment initiated. This can be a significant and contributing factor in the failure to promptly identify and treat some patients.

### We will ensure that:

- Patients who are admitted to hospital for urgent treatment are assessed promptly
- Every patient who requires to be seen daily by a doctor, is seen daily
- All patients have a consultant review within 14 hours of being admitted to hospital
- Patients get access to specialist, consultant-directed interventions
- Patients get access to diagnostic tests within a 24-hour turnaround time or within 12 hours for urgent cases and within one hour for critical patients



## 2 Early detection and treatment

Problems surrounding the management of the deteriorating patient are often multi-factorial.

To improve the medical response, we have developed a deteriorating patient pathway to support the junior doctors in their initial assessment. Targeted work on the recognition and treatment of Sepsis will continue.

The escalation policy is a graded response which ensures a structured and timely approach to the deteriorating patient. The Trust will see implementation of NEWS2 in spring 2019 which will provide an opportunity to review our escalation policy. We need to strengthen the recording of patients' ceiling of care as a fundamental part of this. Further work is also planned to help identify barriers and challenges

to appropriate and timely escalation, providing insight into where focus can be placed to achieve behaviour change where this is deemed necessary.

### We will:

- Increase knowledge of critical illness recognition and management
- Have a clear process for early detection of the deteriorating patient
- Establish robust escalation processes uniformly throughout the Trust
- Promote robust risk assessment and intervention for patients at risk of harm
- Provide prompt initiation of treatment for those where time to treatment is essential.
- Ensure robust communication between disciplines when making escalation decisions



Ensuring our patients are in the right place to receive the right care, optimising flow and tackling unnecessary prolonged stays in hospital are all key goals for reducing harm. Improving the movement of patients between departments is recognised to reduce delays and bottlenecks in clinical areas. Currently when our Emergency Departments are busy there is often a delay in getting an ill patient to an in-patient ward. Similarly when the hospital is busy the Operating Department can

experience delays waiting to transfer patients to Critical Care.

The key to improving patient flow in hospitals is believed to be reducing unwarranted variation in process. A key part to ensuring our patients are in the right place to receive the right care, improving flow and reducing delays is the SAFER care bundle. Simply, it relies on implementation of a bundle of elements of best practice to achieve the cumulative benefits.

## We will implement the SAFER Patient Flow Bundle:

- Senior Review. All patients should have a senior review before midday by a clinician able to make management and discharge decisions
- All patients will have an Expected Discharge Date and Clinical Criteria for Discharge set by assuming ideal recovery and assuming no unnecessary waiting
- Flow of patients to commence at the earliest opportunity from assessment units to inpatient wards. Wards routinely receiving patients from assessment units will ensure the first patient arrives on the ward by 10am
- Early discharge. 33% of patients will be discharged from base inpatient wards before midday
- Review. A systematic multi-disciplinary team (MDT) review of patients with extended lengths of stay > 7 days, to get them 'home first'





Hospital acquired infection remains a threat to the well-being of our patients and antimicrobial resistance presents additional challenges in care.

The emergence of antimicrobial resistance, for example Carbapenamase-producing Enterobacteriaceae (CRE/CPE) is a key concern and we will continually review our antimicrobial formulary and audit compliance with antimicrobial prevention guidelines including documentation of indication and course length.

The Director of Infection Prevention and Control will continue to monitor and report to the Trust Board of Directors, data on IPC compliance, and continue to promote a culture amongst all staff of infection prevention awareness.

### **We will reduce the Incidence of Healthcare Associated Infections and encourage Antimicrobial Stewardship by:**

- Ensuring awareness of IPC measures via staff education, particularly hand hygiene and aseptic non touch technique
- Continuing to report surveillance and audit results to Executive Board and Board of Directors and to improve the results where necessary
- Improving the quality of antimicrobial prescribing and promote antimicrobial stewardship and commitment to improve
- Screening patients for resistant infections and provide timely isolation
- Learning from adverse events and ensuring MDT involvement in Post Infection Review (PIR) processes

## 5 Areas of frequent harm

Analysis of adverse events in the Trust identifies recurrent themes of potentially avoidable harm. These include morbidity and mortality from falls, errors associated with medicine administration and prescribing, development and deterioration of pressure ulcers and Never Events. Each will be subject to Serious Incident investigation and progress will be reported to Trust Board of Directors.

The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) has identified a number of recurrent themes and common conditions for which the Trust will monitor as part of the Serious Incident review process, to ensure areas of frequent harm are addressed.

### We will:

- Continue to reduce the incidence of serious harm to patients who fall in our care
- Monitor and respond to trends relating to medicine prescribing and administration following the implementation of Electronic Prescribing and Medicines Administration (EPMA)
- Continue to reduce the incidence of pressure ulcer development to patients in our care
- Introduce local safety standards for invasive procedures.
- Learn from 'near misses'
- Develop capability and capacity to carry out good quality investigations
- Reduce harm caused by hospital related functional decline (deconditioning) as a result of unnecessary prolonged hospital stays





Learning all we can from critically examining care that patients receive before they die can teach us how to deliver safer care. This element of the strategy will continue to refine systems which ensure that a standardised approach will be taken to performing mortality reviews. Where trends can be identified, learning from reviews will be cascaded efficiently and improvements to patient safety made.

We are refining systems for mortality review which will be consistently applied in all clinical areas including our community hospitals. Where we are concerned about care prior to death we will investigate using either our serious incident process or the recently introduced structured judgement case-note review.

### We will:

- Continue to promote and develop the existing processes of mortality review for all patients who die in our hospitals
- Develop processes for dissemination of learning from mortality review
- Ensure that all in-patient deaths are promptly reviewed by a consultant
- Promote discussion of learning from mortality review at department governance meetings using the three monthly summary reports

# In summary



## Monitoring progress

This strategy will be applied locally, supported by a number of corporate work streams and groups.

Progress with implementation of the Patient Safety Strategy will be monitored by the Patient Safety Group.

For further information please contact:  
Becky Hoskins – Deputy Director of Patient Safety  
Rebecca.hoskins@york.nhs.uk  
01904 725544

 @hoskinsbecky