Together

NHS
Lancashire Teaching Hospitals
NHS Foundation Trust

Always Safety First Strategy
2021–2024

Together, we do extraordinary things

Excellent care with compassion

@LancsHospitals

Sections

Foreword

I was delighted to be asked to write this foreword to the new Lancashire Teaching Hospital's *Always Safety First* strategy. Nursing and midwifery leadership across the patient safety agenda has never been more critical, and programmes such as *Always Safety First* are so important in ensuring visibility, engagement, innovation and improvement.

The **NHS Patient Safety Strategy** (2019) was commissioned to be a 'golden thread running through healthcare'. It is not a prescriptive document but rather a statement of our collective intent, as a national health service, to improve safety. It recognises, crucially, that to make progress we must significantly improve the way we learn, treat staff and involve patients. Patient safety is about maximising the things that go right and minimising the things that go wrong. It's absolutely integral to the NHS' definition of quality in healthcare, alongside effectiveness and patient experience. Learning from local patient safety events is so important and I really welcome the *Always Safety First* approach, linking local learning to national priorities, and your commitment to tracking and sharing your data via the *Always Safety First* dashboard.

The **2021 update to the NHS Patient Safety Strategy** includes a new objective focused on reducing health inequalities. There is increasing evidence of disparities in healthcare outcomes and interactions between different ethnic groups - e.g. in COVID-19 outcomes, maternal mortality and mental health - and we know that socioeconomic status and where in the country someone lives also impact on morbidity and mortality. I would urge you, in your delivery of this new patient safety strategy, to take every opportunity to address issues of equality, diversity and inclusion. Treating our patients as partners and formalising these roles is key to moving the NHS Patient Safety Strategy forward and I welcome your commitment to doing this within the *Always Safety First* programme.

Adopting an implementation approach that is underpinned by improvement science will be so important in truly delivering the aims of this ambitious strategy. Such an approach will serve not only to improve patient outcomes and experience in a systemic, sustainable way, but will also foster engagement across the workforce and expand the numbers of future patient safety leaders, equipped with improvement science skills.

I'm grateful to you all for the leadership you are showing in bringing the NHS Patient Safety Strategy to life in your organisation and look forward to seeing and sharing the learning you gain and the improvements you make for patients.

Ruth May
Chief Nursing Officer

Strategy Overview

The national patient safety strategy was launched in July 2019 and updated in February 2021, outlining the work required at all levels of the NHS to deliver the new approach to patient safety. It outlines the vision for patient safety, foundations for safer care (where we are now and where we need to be), a patient safety culture and a patient safety system.

Safety is referred to within this strategy in its broadest sense and ranges from reducing medication errors, falls, pressure ulcers to reducing harm due to a failure to recognise deteriorating patients, misinterpretation of results or diagnostics and any harm related incidents.

Always Safety First was our organisational response to the national strategy, developed by our multi-professional leaders in partnership with industry specialists and launched on the first World Patient Safety Day. During 2020/21 the concept, methodology and focus of our programmes of work have been tested, leading to the development and launch of our Always Safety First strategy. The strategy sets our objectives for the next three years.

The national strategy describes the work needed in three sections;

i. **Insight**: Improve our understanding of safety by drawing insight from multiple sources of patient safety information
ii. **Involvement**: Equip patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system
iii. **Improvement**: Design and support programmes that deliver effective and sustainable change in the most important areas including delivery of a safety culture

Continuously improving patient safety involves the NHS building on the foundations of a patient safety culture and systems, this includes recognising our role to identify and take steps to reduce health inequalities. It also includes a focus on Safety-I and Safety-II .

Through this strategy we will identify how current patient safety culture and mechanisms contribute to health inequalities, including by engaging with patient, staff and other stakeholder groups. We will then set specific actions for our teams, local stakeholders and individual clinicians to address inequalities in patient safety as a golden thread through the strategy.

The priorities identified within the strategy are driven by national and local priorities and a review of the organisations current quality and safety metrics. These will become our Always Safety First Dashboard.

Our ambition to meet the needs of people who are more likely to experience adverse outcomes continues in the improvement strand, notably the objectives to address the safety issues faced by older people, people with a learning disability, physical disability and a mental health diagnosis.

Our strategy reflects the areas of focus identified through the COVID-19 pandemic with a specific focus on delivering further improvements for respiratory patients.

Key enablers and stakeholders are identified within the strategy, specifically creating the infrastructure for safety. The appointment of our patient safety specialists, human factors clinical leads, the development of a safety monitoring dashboard, safety culture and education programmes of work alongside the ability to analyse data consciously considering the effects of safety outcomes on all protected characteristic groups are key to the future success of this strategy. This strategy will be delivered by our medical, nursing, midwifery and AHP leaders, in partnership with patients and supported by our corporate and support services.

Patients as Partners in Patient Safety

The involvement of patients in their care and in the development of safer services are both priorities for the NHS. People now have a greater expectation that they will be involved in their care and in ensuring it is safe. A Framework for involving patients in patient safety was launched in 2021 and will be used to move towards a patients as partners approach.

With this in mind, the strategy, whilst written for staff and developed with patients will be produced in a patient format that patients are able to understand, this reflects our commitment to work with patients to ensure safety in healthcare is understood by patients and in doing so they are able to bring their experiences to work with us as partners to improve their experience of this and their overall outcomes.

As part of year one of Always Safety First we have cemented our approach in involving patients and significant others in setting terms of reference for all serious investigations and using their experiences within Serious incident reports to convey their feelings and ensure meaningful involvement in what can be a traumatic experience for patients.

Our Patient Advice and Liaison teams work with patients to find solutions early in patient pathways that contribute towards avoiding safety incidents and reducing the need to complain, accepting that when this occurs we have failed to take the action required to prevent an adverse experience.

Experience is considered a core component of our safety culture and working with patients as partners will shape the actions we take, the way we design our systems and the continuous improvement of our services.

The introduction of patient safety partners will include a role description, training and education and will be a fundamental part of the change in culture we aim to achieve as a result of our patient safety strategy.

Patients as partners will become part of our Always Safety First subcommittee and will be integral in evaluating the impact of this strategy through the monitoring of patient outcome measures.

Our Values

Our aim is to always provide excellent care with compassion which we do from three facilities:

- Chorley and South Ribble Hospital
- Royal Preston Hospital
- The Specialist Mobility and Rehabilitation Centre

We are a values driven organisation. Our values were designed by our staff and patients and are embedded in the way we work on a day to day basis:

Being caring and compassionate

Being caring and compassionate is at the heart of everything we do, we will understand what each person needs and strive to make a positive difference in whatever way we can.

Recognising individuality

We appreciate differences, making staff and patients feel respected and valued.

Seeking to involve

We will actively get involved and encourage others to contribute and share their ideas, information, knowledge and skills in order to provide a joined up service.

Building team spirit

We will work together as one team with shared goals doing what it takes to provide the best possible service.

Taking personal responsibility

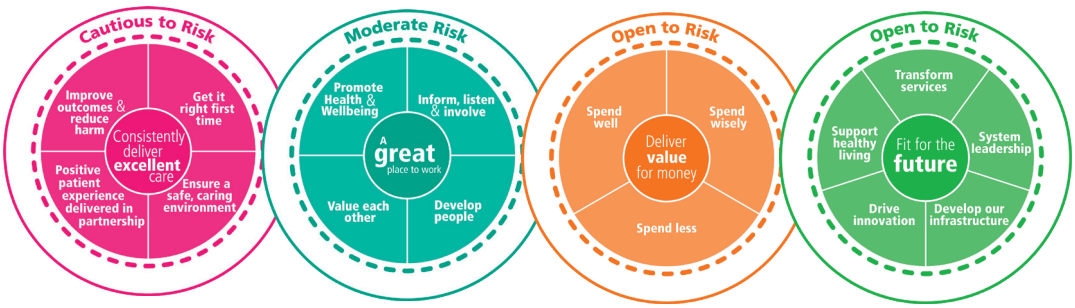
We are each accountable for achieving improvements to obtain the highest standards of care in the most professional way, resulting in a service we can all be proud of.

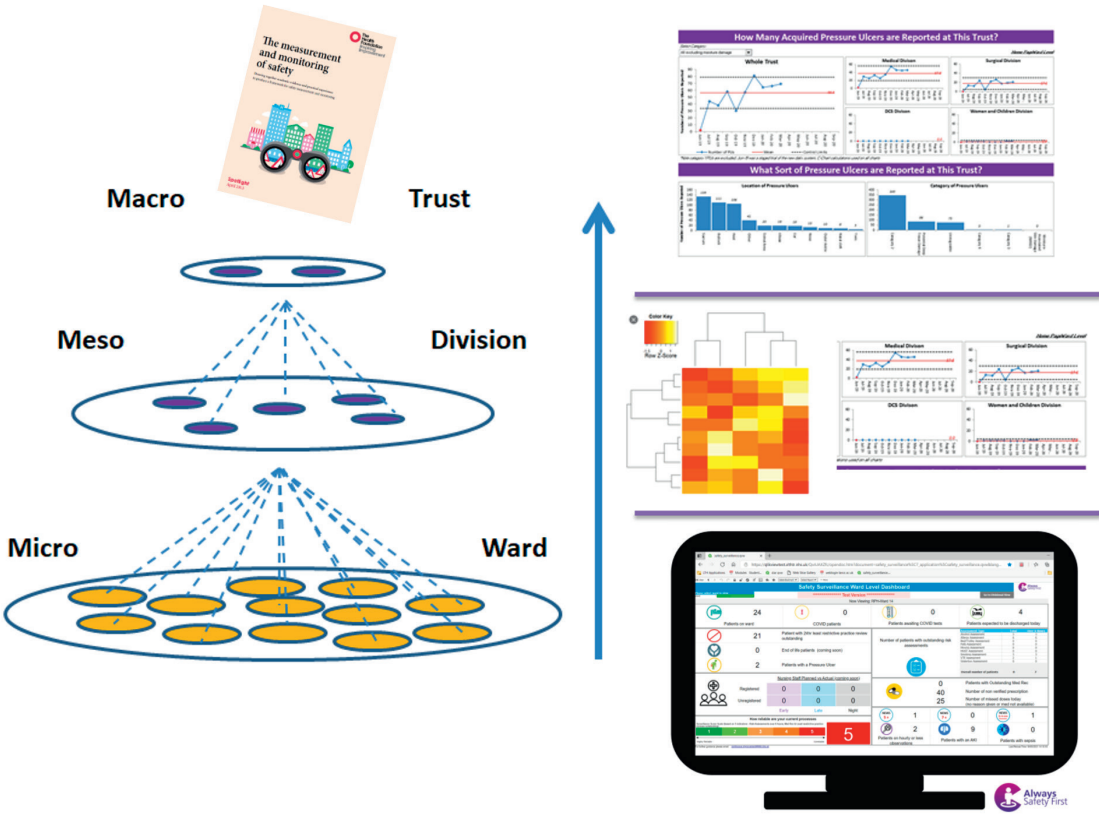
Alignment to Trust Objectives

The objectives defined in this plan are derived from the Trust's core objectives which are:

- To provide sustainable and outstanding healthcare to our local communities
- To offer a range of high quality services to patients in Lancashire and South Cumbria
- To drive health innovation through world class education, training and research

These objectives are translated into key deliverables founded on four ambitions:





How will we work differently?

Through this strategy the role of safety leaders will be defined across our organisation. This section of the strategy contains an outline of how this will be achieved and how our teams will work together to build our Insight, build our Involvement with patients, visitors, staff and partners and build our robust methodology for Improvement. It describes our response to safety triggers and incidents to ensure we are truly a learning organisation and a centre of excellence for safety. Our mission is straightforward; we are here to always provide safe, excellent care with compassion in partnership with our patients.

Our clinical and corporate teams will work together to implement this strategy. Each team will have a clearly defined role in supporting improvements in patient safety.

Insight: Teams will work together to improve our understanding of safety by drawing insight from multiple sources of patient safety data and information. Data will be reviewed together at the Always Safety First sub-committee of the Safety and Quality Committee to ensure a shared understanding of our organisational intelligence from a range of sources of our safety and quality metrics.

Involvement: Our strategy has been co-designed with patients, visitors to our organisation, staff and partners. Our approach has used a variety of data sources, ranging from experiences, complaints, incidents, compliments, national and local priorities to ensure that our improvement addresses the areas that matter most to staff and patients. The draft strategy was circulated widely amongst patient and staff groups to ensure the final product identifies what matters most to our communities and the strategy will remain responsive as each year progresses with the ability to add to and take away as priorities change.

Improvement: Our Board has committed to adopting a robust improvement methodology across our organisation. This strategy will be underpinned by improvement and the Always Safety First Improvement programme will be informed by the insights and intelligence from the review of our data and the involvement of our staff, patients, visitors and partners. Our teams will work together to deliver effective and sustainable change in the most important areas whilst educating and enabling teams to feel confident in improvement methodology that can then be applied to other areas of the organisation. Learning from all improvement programmes will be shared with staff, patients and partners.

Learning from Excellence – (Safety I and II)

Safety is often defined as the absence of accidents and incidents, or as an acceptable level of risk. In this perspective, safety is defined as a state where as few things as possible go wrong (Safety-I). A Safety-I approach "presumes that things go wrong because of identifiable failures or malfunctions of specific components: technology, procedures, the human workers and the organisations in which they are embedded" (Safety-I to Safety-II White Paper, 2015). The purpose of incident reviews in a Safety- I approach is to identify the causes and contributory factors of adverse outcomes, using risk assessments to calculate how likely they are to occur and the anticipated level of harm. Teams respond to incidents and high levels of risks, aiming to reduce the risks through mitigating actions. This approach became widespread in safety critical industries between the 1960s and 1980s and was subsequently adopted by the NHS. At that time performance targets were significantly lower and systems were simpler. This approach is based on an assumption that systems can be broken down into individual parts which either worked correctly or incorrectly, leading a focus on finding root causes of identified problems and fixes. These assumptions no longer serve us well, either in industries or in health care (Safety-I to Safety-II White Paper, 2015).

In health care, microsystems such as theatres, critical care and emergency departments cannot be deconstructed in a meaningful way and the functions within these systems are not bimodal. Clinical work is, and must be, variable and flexible. Critically, the Safety-I approach that we have adopted in healthcare for decades does not routinely consider why human performance practically always goes right. Things do not go right in the delivery of clinical care because people behave as they are supposed to, but because people can and do adjust what they do to match the conditions of work. As systems continue to develop and introduce more complexity, these adjustments become increasingly important to maintain good performance. Our systems function so well because our staff have been skilful at finding work arounds to improve clinical care, where systems have let them down and not made it easy for them to do the right thing. The challenge for safety improvement today is to understand how performance usually goes right in spite of the uncertainties, ambiguities, and pressures of increased demand. Despite the obvious importance of things going right, traditional safety management hasn't really focused on this.

Safety is now switching from minimising things that can go wrong to ensuring 'as many things as possible go right'. This approach is called Safety-II; it "relates to the system's ability to succeed under varying conditions". A Safety-II approach assumes that everyday performance variability provides the adaptations that are needed to respond to varying conditions, and hence is the reason why things go right. Humans are consequently seen as a resource necessary for system flexibility and resilience. In Safety-II the purpose of investigations changes to become an understanding of how things usually go right, since that is the basis for explaining how things occasionally go wrong. Risk assessment tries to understand the conditions where performance variability can become difficult or impossible to monitor and control" (Safety-I to Safety-II White Paper, 2015). We will therefore build our focus on safety into our everyday work, anticipating developments and potential harms, and responding to maintain safety. Our newly developed Safety Surveillance System will support this work in our ward areas and further work will be undertaken during this strategy to build on this early work in other clinical areas, such as theatres and the emergency departments. To be in a position to respond effectively to our increasing demands and system complexity, we must adjust our approach to safety. While reported adverse events will continue to be managed by a Safety-I approach, our way forward will be combining the two approaches. Our Safety-II work is in its infancy will require new practices to "look for what goes right, to focus on frequent events, to maintain a sensitivity to the possibility of failure, to wisely balance thoroughness and efficiency, and to view an investment in safety as an investment in productivity" (Safety-I to Safety-II White Paper, 2015).

As a core element of this work teams will further develop their skill in reflective practice, team feedback, debrief and clinical supervision.

Who will be involved?

The Always Safety First sub-committee of the Safety and Quality Committee will bring together a range of teams to work together. This will include, but is not limited to:

Patients, visitors and partners will be central to identifying the improvements required and co-designing the improvement programmes delivered including ensuring adjustments are made to ensure health inequalities are thoroughly considered and addressed as part of this work and patients feel they receive individualised care in our services.

Clinical Specialities and Frontline teams responsible for delivering the care to our patients. Specialities and frontline teams will be represented to ensure those delivering frontline care are designing the solutions. Porters, administrators, Doctors, Nurses, Midwives, Allied Health Professions, operational and support service staff are all key to delivering safety.

Divisional Leadership teams will be represented to ensure that our work is fully integrated into divisional business, reporting through to divisional boards and divisional always safety first meetings as required.

Education and Training will be central to our work, developing the tools required to deliver outstanding safe care and ensuring our training and education is world class and linked to our organisational priorities, informed by the insights work.

Organisational Development will support the development of a culture of openness, transparency and learning from incidents in line with the principles of Just Culture.

Human factors will be at the core of our work to ensure that we understand human activity and how we interact as individuals and teams in the delivery of our patient safety strategy and enhance the wellbeing and performance of our staff and teams. Human factors will also inform our understanding of the design, processes, procedures, equipment and technologies to optimise how we function safely within our complex environments.

Governance provides the systems of internal control including those related to risk management in support of the Always Safety First Agenda. The key principle in ensuring that safe care is always delivered is to recognise, investigate and learn from when things go wrong.

Digital the implementation of standardised documentation in our electronic systems will enable us to design for optimal safety. Evidence based practice guidelines will be incorporated into our electronic systems.

Research and Innovation will underpin our strategy and inform the development of our improvement programmes and safety solutions.

Continuous Improvement team colleagues will be involved to lead the design of the improvement methodology to be utilised and to facilitate the improvement programmes delivered. The CI team will also have responsibility for tracking the improvements delivered over time, tracking variation in clinical areas and reporting these to the Safety and Quality Committee and Board.

Key safety roles including; safety specialists, human factors leads, medical device safety officer, medicine safety officer, named nurses safeguarding children, adults, mental health, learning disability and autism, governance leads.

Delivering the Plan

A new Always Safety First sub-committee of the Safety and Quality Committee has been established. The purpose of this committee is to oversee the implementation of this strategy, the committee will focus on the three major areas of work outlined in the national patient safety strategy; insights, involvement and improvement. This includes creating a committee with a flattened hierarchy of team members to optimise our data and experience driven intelligence to identify the improvement priorities ('insights'),further improving the involvement of our patients, staff and stakeholders in designing the improvements required ('involvement') and overseeing the design, testing, implementation and monitoring of our improvement programmes ('improvement').

A measurement strategy will be designed by the committee to track the progress of implementation of the Always Safety First strategy and the committee will ensure that the measurement strategy is implemented and monitored in order to demonstrate that our patient safety strategy is delivered.

- The deliverables outlined in this strategy will be delivered through the Always Safety First sub-committee and monitored by the Trust Safety and Quality Committee, the committee will use the intelligence created through the subcommittee to inform future priorities of 'The Big Plan'.
- Progress will be monitored through an Always Safety First dashboard, which will be developed to support the work of the Always Safety First committee. Progress will be reported twice per year to the Safety and Quality Committee and through an annual report. The Always Safety First dashboard will also be reported to the Divisional Management boards to ensure connectivity from ward to board.
- The Safety Triangulation Accreditation (STAR) Programme will be a key vehicle to test the deliverables of the strategy in action from ward to board.
- The action plan will be reviewed quarterly to ensure delivery continues to remain on track and to ensure it continues to fully align with the Trust's Big Plan
- The strategy will be considered as a fundamental strategy of the organisation and will evolve each year, considering broader learning elicited through other strategies across the organisation.

The 3 Year Always Safety First Plan

1. INSIGHT	AIM	
Year 1	**Year 2**	**Year 3**
Improving understanding of safety by drawing intelligence from multiple sources of patient safety information. Adopt and promote key safety measurement principles and use culture metrics to better understand how safe care is. • use new technologies to support learning from what does and does not go well, by replacing the National Reporting and Learning System with a new safety learning system • introduce the Patient Safety Incident Response Framework to improve the response to and investigation of incidents • implement a new medical examiner system to scrutinise deaths • improve the response to new and emerging risks, supported by the new National Patient Safety Alerts Committee • share insight from litigation to prevent harm.		
Outcome	**Outcome**	**Outcome**
Measurement	**Measurement**	**Measurement**
Driving improvement Create an Always safety First committee and a dashboard of always safety first outcomes measures. Initiate key programmes of work and define reporting and monitoring arrangements for programmes of work.	**Driving improvement** Use intelligence from the ASF committee to inform improvement priorities for FCA and MCA.	**Driving improvement** Review and refine the approach.
Defining key programmes of work (safety issues) Define key improvement (top 5 programmes of work) and initiate test of change on leading safety programmes of work.	**Defining key programmes of work** Evaluate outcome of test of change methodology, refine and apply to next set of key programmes of work.	**Defining key programmes of work** Deliver the improvement programme identified at the end of year 2.
Safety Surveillance System Design and test a new real time safety surveillance system, undertake tests of change in co-designing the approach to using safety surveillance in practice in ward areas. Commence the design of a Safety Surveillance system in another clinical microsystem such as critical care, theatres or the Emergency Department.	**Safety Surveillance System** Further develop the measures within the dashboard and develop intelligence to use the data for predictions whilst standardising approach to safety surveillance across the organisation. Test the introduction of the system within another clinical microsystem and begin designing for the next one. Develop a programme to ensure a plan is in place for all high risk clinical areas to have a safety surveillance system supporting the adoption of Safety-II.	**Safety Surveillance System** Develop the intelligence to use the data to predict future harms and mitigate before the harms for the early adopter Safety Surveillance Systems and deliver the plan developed in Year 2.
Patient safety equality, diversity and inclusion Through Quadramed and Datix mandate collection of each protected characteristic to enable the analysis of inequalities and patient safety processes, functions and outcomes. Organise reports within the organisation to enable teams to review data through the eyes of people with protected characteristics developing a road map for year 2.	**Patient safety equality, diversity and inclusion** Based on a year 1 of analysis, identify key priorities within each area based on protected characteristic data. Expand the definition of protected characteristics to include Indices of multiple deprivation analysis.	**Patient safety equality, diversity and inclusion** Demonstrate improvements in identified areas of inequalities based on year 1 and 2 analysis and programmes of work.

Governance KPI dashboards that include key safety and risk measurement principles.	**Governance** Specialty dashboards are specifically linked to the assessment of identified patient safety outcomes pertinent to the specialty. To be developed in conjunction with divisions.	**Governance** Specialty and governance dashboards demonstrate improvements in patient outcomes.
Reporting Culture Analyse Datix reporting activity for each department understanding any areas of low reporting share outcomes with team, providing tools to explore and understand why leading to improved reporting.	**Reporting Culture** Evidence consistency in reporting culture improvements and design reporting for Safety-II.	**Reporting Culture** Review progress of combining Safety-I and Safety-II approaches, and develop a work programme for the year based on key learning.
Thematic Analysis Thematic analysis of patient safety incidents to be undertaken focusing on serious untoward incidents and near misses in each division, using the outcomes to inform areas of focus and preventing future harm.	**Thematic Analysis** Repeat thematic analysis to identify new themes to address, building the findings into the work programme.	**Thematic Analysis** Repeat thematic analysis to identify new themes to address, building the findings into the work programme.
Patient Safety Culture Establish baseline of safety culture using the Barret culture survey and staff survey. Train specialty business unit triumvirates in the foundations of measurement for improvement.	**Patient Safety Culture** Improve safety culture questions in staff survey by 10%. Train all clinical and non clinical department managers in the foundations of measurement for improvement.	**Patient Safety Culture** Improve safety measures in staff survey by 10%. Evaluate the success of the programme and identify this year's programme of work, informed by the evaluation.
Medication safety Co-develop a Medicines Safety Improvement Programme dashboard for reporting incorporating medicine safety metrics into the Big plan and accountability framework.	**Medication safety** Medication KPIs are specifically linked to the assessment of patient outcomes and present within each division Always safety first metrics.	**Medication safety** Medication safety dashboards that are specifically linked to the assessment of patient outcomes are delivering improved patient outcomes.
Research Develop a plan for the integration of research and innovation to support safety improvement.	**Research** Evidence of one research and development programme that can evidence transactional patient safety improvement.	**Research** Evidence of one research and development programme from each division that can evidence transactional patient safety improvement.
Patient Safety Incident Response Framework To connect to the new national National Reporting and Learning System (NRLS) system by end Q4 2021/22 subject to local software compatibility. Develop arrangements for the implementation of the new patient safety incident response framework.	**Patient Safety Incident Response Framework** Monitor on an annual basis the balance of resources for patient safety incident investigation versus improvement across the local system and whether actions completed in response to patient safety incidents measurably and sustainably reduce risk.	**Patient Safety Incident Response Framework** Review learning from year 1 and 2 and define and deliver the programme of work for in-year delivery.
Learning from systems work **The Healthcare Safety Investigation Branch (HSIB)** HSIB maternity investigations learning to be presented to Safety and Learning Group to broaden opportunity to learn from external reviews. Incident specific HSIB reports to be factored into internal incident review process and learning.	**The Healthcare Safety Investigation Branch (HSIB)** Develop approaches to incident investigation processes learning from HSIB and applying where relevant.	**The Healthcare Safety Investigation Branch (HSIB)** Evaluate the success to date and plan and deliver the work programme for year 3.

Insight continues overleaf

Always Safety First Communications Learning to improve bulletin will develop further to become the Always Safety First Bulletin and be physically displayed throughout key public areas of the organisation demonstrating a transparent approach to learning from safety within the organisation.	**Always Safety First Communications** Learning from Always Safety First will be evident throughout the organisation, with case studies and teams celebrating the successes of the programmes.	**Always Safety First Communications** Teams will be supported to gain national recognition for their achievements.
The Medical Examiner system To continue to implement the medical examiner process whilst developing the learning mechanisms as a result of the Structured Judgement reviews (SJR). All patients with a learning disability who die will undergo a SJR. All patients with a mental health diagnosis who die will undergo a SJR. Refine learning from cases and integrate into systems of learning.	**The Medical Examiner system** All patients with a physical disability will undergo a SJR. Facilitate the extension of medical examiner scrutiny from deaths in acute trusts to deaths in non-acute settings.	**The Medical Examiner system** Undertake a formal evaluation of the first 2 years and identify the priorities for delivery in year 3.
National Clinical review and response To maintain 100% compliance with Patient Safety Alerts. To respond and comply with the outputs of the review of all historical National Patient Safety Agency and NHS England and NHS Improvement alerts to identify any requirements which remain viable beyond their original action date.	**National Clinical review and response** To ensure there is planned programme of audit on PSA < 1 year old to ensure continued deliver.	**National Clinical review and response** Design how we can next develop the integration of Safety –I and Safety-II approaches to achieve the next level of improvement in safety management.
Clinical negligence and litigation Design a refreshed approach to learning from litigation. Evidence learning from clinical negligence schemes within divisional governance arrangements. Incorporate claims learning into learning to improve arrangements.	**Clinical negligence and litigation** Select improvement programmes of work based on themes identified within claims data ensuring integrated into clinical audit programme.	**Clinical negligence and litigation** Testing of the learning leading to improved outcomes evidenced through audit programmes of work.

2. INVOLVEMENT	AIM	
Year 1	Year 2	Year 3
Patients are recruited as patient safety partners, families and carers are seen as partners in care, these are reflective of the local community the Trust serves. The national patient safety syllabus and patient safety partner framework is used as a vehicle to ensure involvement at every level. The NHS will:. • establish principles and expectations for the involvement of patients, families, carers and other lay people in providing safer care • create the first system-wide and consistent patient safety syllabus, training and education framework for the NHS • establish patient safety specialists to lead safety improvement across the system • ensure people are equipped to learn from what goes well as well as to respond appropriately to things going wrong • ensure the whole healthcare system is involved in the safety agenda.		
Outcome	Outcome	Outcome

Involvement continues overleaf

Patients, carers, families and lay people as partners Recruit to the role of Patient Safety Partners (PSP) representative of the community we serve. PSP will reflect the diversity of the community we serve. PSP join the Always safety First subcommittee and participate in the evaluation of evidence and design of solutions.	**Patients, carers, families and lay people as partners** PSP review the Always safety Strategy year 1 and ensure year 2 reflects the areas that are important to them.	**Patients, carers, families and lay people as partners** Evaluate the role and identify priorities for delivery in year 3.
Safety leaders Define the role of leaders within the organisation in relation to patient safety and working with patients as partners. All wards will participate in the Micro Coaching Academy (MCA).	**Safety leaders** Leaders at every level of the organisation will have an objective linked to improving safety as part of their annual appraisal. Each clinical leader will be responsible for leading an improvement project that impacts on safety outcomes. All clinical departments will participate in the MCA.	**Safety leaders** Evaluate effectiveness of interventions and activity in year 2 and use to inform year 3 priorities. Evaluate the impact of MCA participation on safety.
Patient safety education and training National patient safety syllabus 2.0 training will be formulated leading to 50% clinical staff trained in basic patient safety training with 10% trained in intermediate patient safety.	**Patient safety education and training** Develop advanced patient safety training and identified clinical leaders to undertake advanced patient safety training, outlining target audience for advanced patient safety training. 50% of all staff will complete basic patient safety training with . 20% clinical staff completing intermediate patient safety training.	**Patient safety education and training** To be agreed using a co design approach in year 2.
Patient safety specialists Identify LTHTR approach to patient safety specialists. Appoint three in year 1. Patient safety specialists to participate in national training to inform and lead internal patient safety strategy.	**Patient safety specialists** Patient safety specialists to participate in national training to inform and lead internal patient safety strategy.	**Patient safety specialists** To be agreed using a co design approach in year 2.
Safety I and Safety II Develop our approach to the introduction of Safety-II and test in clinical wards. Training for Safety I and II will be incorporated into intermediate safety training. Governance Leads within the divisions will be trained in appreciative enquiry techniques. Just culture decision making matrix will be present in all Serious incident, disciplinary and managing allegations investigations. Develop a suite of Safety II measurement metrics.	**Safety I and Safety II** Review year one progress and design the programme for year 2. Qualitative evaluation to demonstrate the impact and capture the learning from Safety II.	**Safety I and Safety II** Review year one progress and design the programme for year 2. . Evaluate progress and establish actions for year 3. .
Implement a shared governance model creating flattened hierarchy approach to patient safety. Contribute to the development of a whole system approach to safety (at ICP and/or ICS level) as led by the ICS / ICP Safety and Quality programme. .	Continue to develop shared governance model introducing organisation systematic approaches to shared governance. Integrate with our Magnet programme. Implement the relevant elements of the whole system approach to safety (at ICP and/or ICS level) as led by the ICS / ICP Safety and Quality programme.	Evaluate the work undertaken n year 1 and 2 and design the year three programme informed by the results of the evaluation.

3. IMPROVEMENT	AIM	
Year 1	**Year 2**	**Year 3**
The NHS safety system must support continuous and sustainable improvement, with everyone habitually learning from insights to provide safer care tomorrow than today. Quality improvement provides the necessary coherence and aligned understanding of this shared approach to maximise its impact. 'Improvement' work aims to develop and support safety improvement programmes that prioritise the most important safety issues and employ consistent measurement and effective improvement methods.		
Outcome	**Outcome**	**Outcome**
Improvement Priorities	**Improvement Priorities**	**Improvement Priorities**
National Safety Strategy Priorities	**National Safety Strategy Priorities**	**National Safety Strategy Priorities**
COPD Support the adoption of the COVID-19 oximetry@home and COVID Virtual Ward models across England by Q1 2021/22.	**COPD** Support the increase in the proportion of patients in acute hospitals receiving every element of the British Thoracic Society chronic obstructive pulmonary disease discharge care bundle for which they are eligible by Q1 2022/23. Review the data from the insights work and design and deliver the next wave of improvement as part of Always Safety First.	**COPD** Review the data from the insights work and design and deliver the next wave of improvement as part of Always Safety First.
Tracheostomy Define tracheostomy cohort wards, fully adopt three evidence-based tracheostomy safety interventions (bedhead signs, availability of emergency equipment, daily care bundle) by Q1 2021/22.	**Tracheostomy** Define year 2 actions based on learning from year 1.	**Tracheostomy** Review the data from the insights work and design and deliver the next wave of improvement as part of Always Safety First.
Asthma Increase in the proportion of patients in acute hospitals receiving every element of the asthma discharge care bundle for which they are eligible, to start Q1 2021/22.	**Asthma** Evidence continued focus on care bundle delivery and report outcomes relating to this safety action.	**Asthma** Review the data from the insights work and design and deliver the next wave of improvement as part of Always Safety First.
Did Not Attend/Was Not Brought Some of the most vulnerable people in our communities are reliant on the support of others to ensure they are able to attend appointments within healthcare settings. The learning from national safeguarding cases and physical health incidents indicates that there are missed opportunities when appointments are missed. A highly reliable process will be developed to ensure that the patients most at risk are contacted and supported to attend their appointment.	**Did Not Attend/Was Not Brought** Audit impact of year 1 activity. Use findings to inform improvement that will be delivered within year 2 and 3.	**Did Not Attend/Was Not Brought** Action improvements identified in year 2.
Local Safety Priorities (as reflected in the big plan)	**Local Safety Priorities (as reflected in the big plan)**	**Local Safety Priorities (as reflected in the big plan)**
Managing deterioration Reduce the number of cardiac arrests by 10%.	**Managing deterioration** Reduce cardiac arrests by a further 10%.	**Managing deterioration** Maintain improvement.

Improvement continues overleaf

Adults Flow Coaching Academy methodology to be used to create a 'Big Room' for managing deterioration. Actions to be identified within the room focusing on early identification and escalation.	**Adults** Actions to be determined by big room.	**Adults** Review the data from the insights work and design and deliver the next wave of improvement as part of Always Safety First.
Children and Young People and PEWS Participate in wave of the National NEWS implementation programme. Achieve 90% compliance with sepsis safety outcomes.	**Children** Evidence compliance with PEWS. Maintain 90% compliance with sepsis safety outcomes.	**Children** Review the data from the insights work and design and deliver the next wave of improvement as part of Always Safety First.
Maternity and Neonatal Implement national Maternity early Warning Score. Implement Maternity triage tool. Undertake deep dive analysis of still birth incidence to identify areas for improvement and develop still birth improvement programme. Design a team working and leadership development plan within maternity services and implement actions identified.	**Maternity and Neonatal** To be determined based on the national maternity and neonatal safety programme and reflected within CNST 10 key safety actions. Track improvements in still birth improvement programme. Track effectiveness of interventions through staff survey and TED.	**Maternity and Neonatal** To be determined based on the national maternity and neonatal safety programme and reflected within CNST 10 key safety actions. Agree priorities based on feedback from year 2 development in this area.
VTE Demonstrate >90% compliance with inpatient VTE risk assessment and treatment.	**VTE** Maintain compliance.	**VTE** Maintain compliance.
Pressure Ulcers Reduce pressure ulcers by 10%.	**Pressure Ulcers** Reduce pressure ulcers by a further 5%.	**Pressure Ulcers** Reduce pressure ulcers by a further 5%.
Falls Reduce falls by 5%.	**Falls** Reduce falls by a further 5%.	**Falls** Reduce falls by a further 5%.
Maternity & Neonatal Transformation Achieve the 10 key safety actions as outlined and defined within Maternity CNST incorporating safety measures into monthly dashboard featured within accountability framework.	**Maternity & Neonatal Transformation** Achieve the 10 key safety actions as outlined and defined within Maternity CNST.	**Maternity & Neonatal Transformation** Achieve the 10 key safety actions as outlined and defined within Maternity CNST.
Children and Young People Create 10 key safety actions for children aligned to the facing Future Standards, incorporating safety measures into monthly dashboard featured in accountability framework.	**Children and Young People** Learn from year 1 key safety actions and strengthen year 2.	**Children and Young People** Complete a self-assessment against the 10 key safety actions and design the programme for year 3, informed by the findings.
Medical Device Safety Officer Undertake analysis of medical device safety incidents in the context of wider incident reporting and identify any low reporting areas. Incorporate medical device safety into learning to improve. Achieve minimum 80% compliance in all medical device training.	**Medical Device Safety Officer** Increase medical device incident reporting in low reporting areas as identified in year 1. Identify priorities to standardise medical devices and create a plan that will guide purchase focus.	**Medical Device Safety Officer** Develop year 3 actions based on the outcomes of year 1 and 2.

Improvement continues overleaf

Patients Safety System working Patient Safety Specialists to contribute towards setting up patient safety collaborative at system level. • Deteriorating patient • Maternity and neonatal • Mental health	**Patients Safety System working** Patient Safety Specialists to contribute towards the design of the next patient safety collaborative at system level. • Priorities to be identified, informed by data	**Patients Safety System working** Patient Safety Specialists to contribute towards the design of the next patient safety collaborative at system level. • Priorities to be identified, informed by data
Medicine Safety Improvement Plan Improve safe medicines management processes. Complete adult EPMA roll out at CDH. Complete CYP EPMA. Complete Neonatal EPMA. Further development of the BI Pharmacy. Reduce the number of missed doses of medication. Implement STOMP and STAMP. (appropriate use and review of anti-psychotropics).	**Medicine Safety Improvement Plan** Reduce harm from opioid medicines by reducing high dose prescribing of opioids through scoping and intervention identification as developed by the national team. Develop a programme to reduce severe harms associated with anticoagulants.	**Medicine Safety Improvement Plan** Develop a programme to reduce problematic polypharmacy for the most at-risk populations, which can be delivered from Q1 2023/24.
The Mental Health Safety Implement self-harm risk assessment tool to reduce the number of patients who harm themselves whilst in hospital. Join the suicide alliance and prepare year 1 foundations. Reduce number of patients who without capacity abscond from hospital. Launch mental health and autism strategy including safety actions for patients with a primary mental health diagnosis at risk within the hospital including but not limited to:. • Identify area of estate to upgrade to improve safety whilst patients who require a mental health admission can experience improved safety conditions. • Standardise offer of mental health training and key safety actions to reduce harm.	**The Mental Health Safety** Evidence consistent use of the tool for all applicable patients. Increase by 20% the number of team leaders participating in the suicide alliance training. Roll out purple for purpose, sock recognition programme. Use technology to aid early identification of patients who abscond. Upgrade estate to provide enhanced safety areas for patients with primary mental health and physical health conditions.	**The Mental Health Safety** Delivery of the learning disability strategy reported to safeguarding board. STAR will reflect specific learning disability standards. Evidence implementation of learning from LeDER mortality reviews.
Safety and learning disabilities and autism The Trust will continue to Co-design annually a specific learning disability strategy in partnership with local community groups. STAR will reflect specific learning disability standards. Evidence implementation of learning from LeDER mortality reviews.	**Safety and learning disabilities and autism** Delivery of the learning disability strategy reported to safeguarding board. STAR will reflect specific learning disability standards. Evidence implementation of learning from LeDER mortality reviews.	**Safety and learning disabilities and autism** Delivery of the learning disability strategy reported to safeguarding board. STAR will reflect specific learning disability standards. Evidence implementation of learning from LeDER mortality reviews.
Infection Prevention and Control Maintain C.difficile numbers within the nationally set trajectory. Implement 'To Dip or Not To Dip' improvement toolkit.	**Infection Prevention and Control** Maintain C.difficile numbers within the nationally set trajectory. Reduce healthcare-associated infection (HCAI), in particular aiming to reduce healthcare-associated Gram-negative blood stream infections (GNBSIs) by 50% by 2023/24.	**Infection Prevention and Control** Maintain C.difficile numbers within the nationally set trajectory. Local systems should develop plans to:. Reduce community antibiotic use by 25% (from 2013/14 baseline) by 2024. Reduce use of 'reserve' and 'watch' antibiotics by 10% (from 2017 baseline) by 2024.