Safer Care
The NHS Institute for Innovation and Improvement supports the NHS to transform healthcare for patients and the public by rapidly developing and spreading new ways of working, new technology and world class leadership.
The NHS Institute: the way we work

Build on what we know and generate new knowledge

- Working methodology
- Clinical systems improvement
- Productive series
- Sustainability guide
- Thinking differently

- Graduate programmes
- Board development
- Clinical development programmes
- Breaking through & Gateway

- Service Transformation
- Product & Technology Innovation (NIC)
- Agreed programme priorities
- Learning

- Local Innovation Hubs
- Innovation fund
- Improvement leaders guides
- Learning modules
- Involvement framework
- HR/OD/WFP network
Our brief from the Department of Health

#11: NHS Institute to work with medical Royal Colleges and others to ensure that advances are made in education & training to support patient safety.

#3: The National Patient Safety Forum should oversee the design and implementation of a national patient safety campaign-focused initiative. The objective of this initiative should be to engage, inform and motivate clinical staff and healthcare providers to address the challenge of providing safer healthcare.

Building an NHS where every member of staff has the passion, confidence and skills to eliminate harm to patients
Safer Care: building an NHS where every member of staff has the passion, confidence and skills to eliminate harm to patients

**Education and Training for technical competence**
- Training for new and current staff
  - Leading Improvement in Patient Safety course (LIPS)
  - Global Trigger Tool Training
  - Joint events with Royal Colleges
  - Clinical Systems Improvement training
  - Safety in undergraduate courses

- Creating a strong network
  - Safety improvement faculty
  - Junior doctors and safety

- Expanding into Primary care
  - Primary care Global Trigger Tool developed and training provided

**Organisational competence**
- Developing senior leaders
  - Executive Quality and Safety Academy for senior leadership teams
  - Safety for Boards
  - Safety Improvement for SHAs and NPSA

- Roll out
  - Leading Improvement in Patient Safety
  - Global Trigger Tool training
  - Increase role of faculty

- Help lead NHS Campaign
  - Co-leading the campaign
    - Helping shape and set up the campaign
    - Supporting activities
  - Compelling communications
    - Martin Bromiley DVD
    - Patient and staff stories
    - Experience Based Design work with MRSA patients

**Key: Expected delivery to the NHS**
- Year 1
- Years 2 and 3
<table>
<thead>
<tr>
<th>Will</th>
<th>Individual</th>
<th>Organisation</th>
<th>Cross-Organisational</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Compelling communications, Campaign, Global Trigger Tool</td>
<td>Compelling communications, EQSA, Global Trigger Tool</td>
<td>Campaign</td>
</tr>
<tr>
<td>Understanding</td>
<td>Campaign, Global Trigger Tool, Core Module, Patient Safety Managers, Primary Care scoping</td>
<td>EQSA, Boards on Board Campaign, Global Trigger Tool, LIPS programme</td>
<td>Campaign, Primary Care LIPS programme</td>
</tr>
<tr>
<td>Skills technical and behavioural</td>
<td>Campaign, CSI modules, Undergraduate modules, Faculty development, Improvement Advisors development</td>
<td>Campaign, LIPS programme</td>
<td>Campaign, NPSA training undergraduate modules, Faculty development, Improvement Advisors</td>
</tr>
<tr>
<td>Confidence, individual and organisational</td>
<td>Campaign, CSI modules</td>
<td>Campaign, SHA training, NPSA training</td>
<td>Campaign, SHA training, NPSA training</td>
</tr>
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How will we measure the impact of what we do?

**Safer Care Programme level**
- Number of participating organisations undertaking GTT and reporting
- CASIL measures
- Evaluation of Leading Improvement in Patient Safety

**NHS organisational level**
- HSMR
- Self-assessment framework (Chris Collison)
- Global Trigger Tool
- Process measures

Co-development of a measurement framework is required
## Safer Care Programme measures

From CASIL .....

<p>| | |</p>
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>2</td>
<td><strong>INDIVIDUALS IN ORGANISATIONS</strong></td>
</tr>
<tr>
<td>C</td>
<td>Deliver LIPS and EQA 6 times</td>
</tr>
<tr>
<td>A</td>
<td>80% of campaign members and 25% of other Trusts are aware of available training</td>
</tr>
<tr>
<td>S</td>
<td>60% of the organisations with trained staff can demonstrate an increased focus on safety</td>
</tr>
<tr>
<td>I1</td>
<td>Measurable reduction in harm as measured by GTT or HSMR</td>
</tr>
<tr>
<td>I2</td>
<td>60% Acute Trust with people trained can demonstrate improvement in at least one key safety measure</td>
</tr>
<tr>
<td>L</td>
<td>Learning capture, understand and reframe</td>
</tr>
</tbody>
</table>
LIPS Components; Learning

LIPS → GTT/SPC/FU → EQSA → PSM

GTT/SPC/ baseline measures → EQSA → LIPS → 3 follow up sessions: Pursuing, Progressing and Sustaining Improvement
‘we have devoted an entire Trust Policy Group Meeting to patient safety and have 3 ‘trigger tool’ audits up and running, so we have been busy and I think the level of awareness in our Trust has certainly been raised significantly- Medical Director

‘the LIPS programme has been instrumental in catapulting patient safety to the top of the organisation’s agenda’ - Doctor

“I think I really have learnt quite a lot. Some things I thought I knew it turns out maybe I didn’t know them in the depth I need to know them. I leave the course stronger than when I arrived”
Some challenges

- How do we develop a measurement framework that quantifiably demonstrates the impact of our products on organisations and their individuals?
- How do we train the volume of staff required?
  - Out of 10,000 doctors how many do we need to influence?
- What do we need to do to develop our safety improvement faculty?
What does an organisation need to do this?

- **Will**
  - Commitment of senior leaders & frontline managers

- **Ideas**
  - Publications
  - Case studies

- **Execution / Implementation**
  - Advanced improvement capability
Executive Quality and Safety Academy

Seven Leadership Leverage Points for Organisation-Level Improvement in Health Care
Set specific system-level aims and oversee their achievement at the highest level of governance
Build an executable strategy to achieve the aims
Channel leadership attention
Put patients and families on the team
Make the Director of Finance a quality champion
Engage doctors
Build improvement capability

J Reinertsen IHI
EQSA

“This was the most thought provoking programme I have ever experienced. It offers a new approach to the quality agenda which challenged our thinking”

Chris Burke CE Stockport

“Carrying out the EQA programme together gave our medical director, chief operating officer/nursing director and me a great opportunity to focus on moving the patient safety agenda forward. Since we completed the EQA we have radically restructured our governance, performance and service improvement arrangements…the EQA have us the momentum to make this radical change and without it I doubt we would have achieved a consensus on the way forward”

Sue James  CE Walsall
Where are we as an organisation?

Is safety what the health care commission tells us?

Is safety very important work and competes with other priorities?

Is safety the right of every patient and a given in the hospital?
Do our systems help?

Systems to measure error are in place and reported to senior leadership.

Error reporting is actively encouraged, some aggregation occurs. Improvement efforts centre around strong champions and root cause analysis.

Systems to measure harm and errors are used to drive rates ever lower. Standardisation and reduction in variation are embraced. There is data transparency.
Patient Safety as Strategy

Is safety improvement in the objectives of all staff?

Are we interested in hearing from patients on safety issues?

Are we clear about the barriers to improvement and have we the will to address them?
Patient Safety as Strategy

Be ambitious

Do we believe we can be the best and exceed safety goals and targets?

Is it clear that everybody is involved in the achievement of safe care?

Are all strategies aligned to safety improvement?
Improve Care

Is safety improvement in the objectives of all staff?

Are we interested in hearing from patients on safety issues?

Are we clear about the barriers to improvement and have we the will to address them?

Do we invest in the improvement skills of our staff?
Lead for Safety

Are organisational strategies aligned to patient safety? E.g. is safety embedded in audit, clinical governance plans, clinical management team agendas?

Is safety embedded in the performance of individuals and directorates?

Are the roles of project leads and clinicians leading safety work clear particularly in relation to accountability?

Do clinicians have the time to lead and be involved in patient safety?

Is standardisation pushed where applicable?
What does an individual need to do this?

- **Will**
  - An understanding of the scale of harm and the reasons

- **Ideas**
  - Publications
  - Case studies

- **Execution / Implementation**

- Advanced improvement capability
Mortality Reviews

Institute for Healthcare Improvement (IHI)
www.ihi.org
The Mortality Diagnostic – 2x2 Matrix

Review (most recent)
50 consecutive deaths
Place them into a two by two matrix based on:
- Was the patient *admitted* for palliative care?
- Was the patient *admitted* to the ICU?
Focus your work initially on boxes that have at least 20% of your mortality.
Change ideas are linked to these boxes
<table>
<thead>
<tr>
<th>Comfort Care</th>
<th>ICU admission</th>
<th></th>
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</thead>
<tbody>
<tr>
<td><strong>YES</strong></td>
<td>Yes</td>
<td>ITU admission criteria</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>Care bundles Glucose control Multidisciplinary rounds</td>
</tr>
<tr>
<td><strong>NO</strong></td>
<td></td>
<td>4</td>
</tr>
</tbody>
</table>

**SAFETY CHANGE STRATEGIES**
The Mortality Diagnostic;
Failure to Recognise, Plan, Communicate

Analyse deaths in box 3 and 4 for evidence of failure to: recognise, communicate, plan.

This will help you understand the local environment.
The Mortality Diagnostic;
Failure to Recognise, Plan, Communicate

Analyse deaths in box 3 and 4 for evidence of adverse events using the Global Trigger Tool.

This will give some further direction to local problems.
Why Use Trigger Tools?

Traditional reporting of errors, incidents, or events does not reliably occur in the best of cultures in healthcare.

Voluntary methods underestimate events and concentrate on what is interpreted as being preventable.

Easily identifies events without complex technology.

Can be integrated into a good sampling methodology.
IHI Global Trigger Tool (UK)

**General care module**
- G1 Lack of early warning score or early warning score requiring response
- G2 Any patient fall
- G3 Decubiti
- G4 Readmission to hospital within 30 days
- G5 Shock or cardiac arrest
- G6 DVT/PE following admission evidenced by imaging +/- or D dimmers

**Surgical care module**
- S1 Return to theatre
- S2 Change in planned procedure
- S3 Removal/Injury or repair of organ

**Intensive care module**
- I1 Readmission to ICU or HDU
- I2 Unplanned transfer to ICU or HDU

**Medication module**
- M1 Vitamin K
- M2 Naloxone
- M3 Flumazenil
- M4 Glucagon or 50% glucose

**Lab test modules**

**Haematology**
- L1 High INR (>5)
- L2 Transfusion
- L3 Abrupt drop in Hb or Hct (>25%)

**Biochemistry**
- L4 Rising urea or creatinine (>2x baseline)
- L5 L6 Electrolyte abnormalities Na+ <120 or >160K+ <2.5 or >6.5
- L7 Hypoglycaemia (<3mmol/l)
- L8 Raised Troponin (>1.5 ng/ml)

**Microbiology**
- L9 MRSA bacteraemia
- L10 C. Difficile
- L11 VRE
- L12 Wound infection
- L13 Nosocomial pneumonia
- L14 Positive blood culture
Category of Harm NCCMERP Index

- **E**: Temporary harm, intervention required
- **F**: Temporary harm, initial or prolonged hospitalization
- **G**: Permanent patient harm
- **H**: Life sustaining intervention required
- **I**: Contributing to Death
Adverse Events

Special Cause Flag

Individual Value

Period

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Insert Date

SHN
What skills and knowledge do individuals need to have?

Model for Improvement
Measurement
Systems thinking
Reliability

Just culture
Human Factors
Violation and Migration
Teamwork and communication