

# Safety First, Safety Always.

2020 – 2023

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Our strategy for ensuring patient safety





# Foreword

Delivering high quality and safe care is our Trust's top priority. This strategy sets out our approach to ensuring *Safety First, Safety Always*.

Safety is challenging in any mental health setting, and this has been no exception for EPUT and its predecessors. We have been on a journey of improvement with patient safety and have made some good progress. On behalf of the whole Executive Team and the Trust Board, our thanks goes to all of our staff for the dedication they have shown in supporting this vital agenda.

This strategy sets out how we will continue our journey of improvement and take this to the next level of ambition. Included in this is our plan to provide consistently safe, good quality care that is person-centred and puts patients and families at the heart of everything we do. Themes of this strategy will run through the organisation like a golden thread and be supported by our new Accountability Framework and organisational culture. They belong to every member of staff. We all need to know them, own them and deliver them together.

We are committed to learning from our complaints, incidents, staff and patient feedback and will also take learning from the outcomes of national incident enquiries. We will also learn from the best of what happens nationally and globally, whether from exemplar healthcare providers or other innovative and high-risk sectors. We will use this learning to continuously review our actions and improve our outcomes. To ensure delivery we are committed to Trust-wide continuous quality improvement and are working to embed this within our culture.

Delivery of safe and high quality services relies upon having the right culture throughout the organisation. To support this, the Trust has adopted a 'just culture' philosophy. This has changed the way we think about patient safety and quality and is complemented by the new Patient Safety Incident Response Framework (PSIRF) for which the Trust is an early adopter. EPUT will be an exemplar for safety, quality



and innovation – this is no less than our patients, their families, our staff and partners deserve.

As we move through challenging times, we will balance our ambition for quality services, patient safety, productivity and efficiency with grassroots support and development. In this way we will aim to ensure that every member of our staff feels engaged, valued and empowered in helping to continuously drive us towards providing consistently outstanding care.

Whether you are a patient, carer, member of staff or anyone else with an interest in the quality and safety of local health care, we hope you find in this document a clear statement of our intent, a strong commitment to continuous improvement and an easy to follow road map of the next stages of our improvement journey.



**Paul Scott**  
Chief Executive



**Professor Natalie Hammond**  
Executive Nurse



**Alex Green**  
Chief Operating Officer



**Dr Milind Karale**  
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**Sean Leahy**  
Executive Director of People and Culture



**Trevor Smith**  
Chief Finance Officer and Resources Officer



**Nigel Leonard**  
Executive Director of Strategy and Transformation



# Our Strategy

7 Themes to ensure Safety First, Safety Always



## Our Ambition

EPUT will be an organisation that consistently places patient safety at the heart of everything we do. Over the three year life cycle of this strategy, we will embed this through a culture and mindset of *Safety First, Safety Always*.

This will show in everything we do and in all decisions that are made, from ward level to board level and builds upon the national NHS Patient Safety Strategy.

We will have got the balance right between a just and low blame culture and having zero tolerance for risks with patient safety.

EPUT will be recognised as one of the leading Trusts nationally for safety.

## Our priorities to achieve this ambition

Leadership

Culture

Continuous Learning

Wellbeing

Innovation

Enhancing Environments

Governance and Information

## Safety never stops and our continuous journey towards excellence will see...

- Patients, carers and families telling us they trust us to provide good quality, safe care
- A reduction in Patient Safety Incidents for Investigation (PSII) and readmissions
- Commissioners and partners having confidence in the quality of services we provide and that these are safe, effective and innovative
- Staff telling us that they have the skills, tools and time to do their jobs effectively and confidence in the Trust's commitment to providing quality and safe care
- Staff being attracted and retained by our culture of safety
- CQC reflecting the progress we have made



## **Safety First, Safety Always: Our Strategy and Philosophy for Patient Safety**

This strategy firstly sets out our priorities for inpatient safety, recognising that this is where the highest risk areas have been. However, the themes of this strategy will permeate the entire organisation and *Safety First, Safety Always* will be the single, recognisable banner for safety initiatives across all areas of the Trust.





# 7 Themes for Improvement



**Leadership**



**Culture**



**Continuous Learning**



**Wellbeing**



**Innovation**



**Enhancing Environments**



**Governance and Information**

<p>Ensuring there is buy-in, ownership and accountability across the Trust for putting <i>Safety First, Safety Always</i> and delivery this through leadership at all levels – from ward to board</p>	<p>Creating a culture of accountability and ownership, where safety, quality and improvement is everyone's responsibility</p>	<p>Establishing an approach to learning and development that is ongoing by sharing lessons, reflecting and empowering staff</p>	<p>Creating a working environment where staff feel safe, happy and empowered to provide the best quality of care</p>	<p>Facilitating and inspiring patient safety initiatives through new ways of working</p>	<p>Ensuring our buildings and estates support the <i>Safety First, Safety Always</i> agenda</p>	<p>Building the foundations for safety through governance, processes and availability of information that put safety first</p>
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# Leadership



We will be leaders in patient safety, advocating *Safety First, Safety Always*. Leadership in patient safety will take place at all levels of the Trust, ensuring patient safety is everyone's responsibility.

## We will do this by:

- Partnering with a leading quality improvement organisation to rapidly implement this strategy and urgently and systematically address required improvements
- Making patient safety visibly the top priority for the Trust, communicating this strategy to all staff and working with them to apply its principles to their roles
- Recruiting a Patient Safety Specialist to champion patient safety and drive the *Safety First, Safety Always* approach
- Incorporating the National Patient Safety Strategy as core business and becoming an exemplar implementation site
- Implementing Patient Safety Incident Response Framework (PSIRF) and using the thematic learning it generates to lead our approach to quality improvement
- Embedding safety improvement tools such as Safety WalkRounds and safety huddles

## Related strategies and policies

- Accountability Framework
- Organisational Development Framework
- Workforce Framework
- PSIRF

## Existing initiatives

- Leadership development pathways
- Chief Executive live sessions
- Early adopter of PSIRF



# Culture



We will continue to build on a Safety Culture incorporating the ‘just’ culture work to drive a strong patient and staff safety agenda. We will continue to pursue a working environment where staff are encouraged to report incidents and near misses and where anyone can raise concerns over standards of care.

## We will achieve this by:

- Continuing to create a ‘just’ culture, including a low blame environment where people can learn from mistakes
- Embedding safety huddles into everyday practice
- Ensuring a culture of co-production, so that patients, families and partner organisations are systematically involved in improving services
- Instilling a culture of reflective supervision and practice
- Using improvement tools to drive a culture of continuous learning and improvement, e.g. PDSA methodology
- Celebrating what goes right as well as learning from what’s gone wrong
- Embracing a culture of transparency and openness to learn from others through benchmarking, peer reviews and peer challenge

## Related strategies and policies

- Staff Engagement Framework
- Organisational Development Framework
- Workforce Framework
- Co-production Framework

## Existing initiatives

- ‘Just’ culture
- Reverse mentoring
- ‘Heroic efforts’ by staff shared on social media
- Quality Academy



# Continuous Learning



Safety and improvement are continuous processes and so is the learning that underpins them. We will view every event as an opportunity to learn and ensure lessons are shared across the trust and with partners, not just applied within the area in which an incident takes place.

## We will do this by:

- Developing a culture of continuous improvement so that the Trust becomes a learning organisation
- Encouraging reflective practice and observations through techniques such as Schwartz Rounds
- Empowering more managers with the skills and tools to undertake reflective supervisions with staff
- Creating a centre of excellence for training in supervision, clinical practice and collaborative learning
- Using 'collaboratives of learning'
- Promoting and living the 'just' culture principles
- Empowering staff with the skills to undertake Quality Improvement through training in a range of tools, e.g. PDSA, QSIR
- Learning from those with lived experience
- Using a structured feedback programme (such as 'I want great care') to provide feedback to our clinicians to continuously improve their performance

## Related strategies and policies

- Organisational Development Framework
- Workforce Framework
- PSIRF

## Existing initiatives

- Virtual 'Lunch and Learn' sessions attended by over 200 staff
- Reflective Practice
- Job transfer scheme
- Leadership development pathways
- Collaboratives of learning



# Wellbeing



Patient safety begins with a workforce who are happy, healthy, safe and equipped to do their job. We will ensure the wellbeing of staff so that they are best placed to provide care for patients, carers and families.

## We will do this by:

- Implementing Royal College of Psychiatrists' guidance on individual and organisational wellbeing
- Implementing ward dashboards and using insight into staffing levels, workloads, vacancies and absence rates to address risks to staff wellbeing
- Ensuring that staff consider the 'total wellbeing' of patients, including physical and mental health; this must include looking for early signs of deterioration in physical health, assessing these, monitoring and responding appropriately
- Ensuring staff are offered reflective learning and the opportunities to discuss their own health and wellbeing, without it necessarily becoming a formal management process
- Ensuring we support our staff after a Patient Safety Incident for Investigation (PSII)

## Related strategies and policies

- Staff Engagement Framework
- Workforce Framework
- Supervision and appraisal

## Existing initiatives

- Considering health and wellbeing in supervisions
- Introducing reflective practice into supervisions



# Innovation

We will trial new ways of working and new technologies to enhance patient safety. This includes, but is not limited to, digital innovations. We want to engage more with partners, patients, carers and families to improve services and, in turn, improve safety.

## We will do this by:

- Continuing to use EPUT Lab as a test bed for new innovations that can enhance patient safety, e.g. Oxehealth
- Using technology to reach the most relevant groups, e.g. apps for younger people
- Involving partners, patients and families in quality improvement and safety initiatives to provide insight from lived experience and build 'a patient safety system' as outlined in the national strategy
- Driving innovative practice through the Quality Academy and Quality Champions
- Learning lessons from small scale innovation trialed by Quality Champions that could be rolled out more widely
- Looking to unconventional examples outside of the healthcare sector for innovation, e.g. Great Ormond Street reached out to Formula 1 for process improvements



## Related strategies and policies

- IM&T Strategy
- Research Strategy
- Quality Improvement Framework

## Existing initiatives

- PSIRF
- EPUT Lab
- Oxehealth



# Enhancing Environments



As a mental health and community Trust, our estate is diverse, geographically spread and helps us deliver a wide range of services. Our buildings and the facilities within these are central to keeping patients and staff safe.

We will work to improve the standard and quality of our estate to ensure there is no risk to patient safety.

## We will do this by:

- Implementing CCQI and Royal College of Psychiatrists standards for inpatients wards
- Urgently addressing any outstanding security issues across the estate
- Ensuring that our physical environment supports good physical health as well as good mental health
- Enhancing environments for recovery, therapy and wellbeing
- Learning from people with lived experience to prioritise safety improvements in the estate, such as ligatures
- Incorporating best practice on physical environment considerations from relational security

## Related strategies and policies

- Suicide Prevention Strategy
- Estates Strategy
- Security Services Framework

## Existing initiatives

- Oxehealth
- Ligature reduction



# Governance and Information



The foundations of a safe organisation are built on solid governance, process and access to information. This will inform actionable areas for quality improvement, create an environment of responsible reporting and intelligence-led decision making.

## We will do this by:

- Using ward dashboards to track workforce, incidents and quality metrics, inform quality improvement and embed a culture of insight-led improvement ‘from ward to board’
- Embedding SBAR method of communication and relaying safety reports at shift handovers
- Ensuring that information is shared to prevent gaps in handovers between individual clinicals, teams and agencies
- Ensuring rigorous scrutiny of the implementation of this strategy through establishing an Executive Safety Group as well as using existing groups including Executive Team, Quality Committee and Trust Board
- Ensuring external involvement in, and oversight of, the strategy and its delivery by engaging patients, families and partner organisations

## Related strategies and policies

- Accountability Framework
- IM&T Strategy
- National NHS Patient Safety Strategy – Insight workstream
- Co-production Framework

## Existing initiatives

- Establishment of Executive Safety Group
- PSIRF implementation



# Five Key Outcomes

There is a long list of targets and trends that can be set to measure safety, many of which are already in place and being reported as part of national or regulatory requirements. There is an even greater number of supporting initiatives and evidence that can help to deliver and demonstrate safe care. This detail is provided in the Implementation Appendices to the strategy.

At the highest level, there are five key outcomes this strategy must deliver:

1. Patients and families feel safe in EPUT's care
2. Stakeholders have confidence that EPUT is a safe organisation
3. No preventable deaths
4. A reduction in Patient Safety Incidents for Investigation (PSII)
5. A reduction in self-harm



# Measuring Improvement: Five Key Outcomes

Outcome	Measure	Risks/Challenges	Level of Control (H/M/L)	Proxy Measures and Evidence
<b>Patients and families feel safe in EPUT's care</b>	An upward trend in the number of patients and families that say they feel safe in EPUT's care	<ul style="list-style-type: none"> <li>· Facts do not always change perceptions</li> <li>· Each experience will be individual and personal</li> </ul>	M	<ul style="list-style-type: none"> <li>· Anecdotal feedback</li> </ul>
<b>Stakeholders have confidence that EPUT is a safe organisation</b>	An upward trend in the confidence of commissioners and partners that EPUT is a safe organisation	<ul style="list-style-type: none"> <li>· Facts do not always change perceptions</li> <li>· Baseline to be established</li> </ul>	M	<ul style="list-style-type: none"> <li>· Anecdotal feedback</li> <li>· Increase in contracts awarded or extended</li> <li>· Nature of media coverage</li> </ul>
<b>No preventable deaths</b>	Zero instances of preventable deaths	<ul style="list-style-type: none"> <li>· Lack of patient co-operation</li> <li>· No standard definition of a preventable death</li> </ul>	M	<ul style="list-style-type: none"> <li>· 100% of patients have safety plans</li> <li>· 100% of inpatients have been involved in completing their safety plans</li> <li>· Suicide awareness training targets achieved</li> </ul>
<b>A reduction in Patient Safety Incidents for Investigation (PSII)</b>	A downward trend in the number of Patient Safety Incidents for Investigation (PSII)	<ul style="list-style-type: none"> <li>· We must not achieve this outcome as a consequence of under-reporting</li> </ul>	M	<ul style="list-style-type: none"> <li>· 100% of patients have safety plans</li> <li>· 100% of inpatients have been involved in completing their safety plans</li> </ul>
<b>A reduction in self-harm</b>	A downward trend in instances of self-harm	<ul style="list-style-type: none"> <li>· Lack of patient co-operation</li> <li>· We must not achieve this outcome as a consequence of under-reporting</li> </ul>	M	<ul style="list-style-type: none"> <li>· 100% of patients have safety plans</li> <li>· 100% of inpatients have been involved in completing their safety plans</li> </ul>



# Glossary of Acronyms

Acronym	Definition	Description
CCQI	College Centre for Quality Improvement	Part of the Royal College of Psychiatrists that works with mental health services to assess and improve the quality of care they provide
CQC	Care Quality Commission	The regulatory body for health and social care service providers
IM&T	Information Management and Technology	Relating to the Trust's Information Management and Technology Strategy
PCN	Primary Care Network	Groups of general practices who work together and more easily integrate with the wider health and care system
PDSA	Plan, Do, Study, Act	A cycle used for quality improvement projects
PSII	Patient Safety Incident for Investigation	The process followed when a patient safety incident occurs
PSIRF	Patient Safety Incident Response Framework	A national framework for responding to patient safety incidents, of which EPUT is an early adopter Trust
QSIR	Quality, Service Improvement and Redesign	A programme that focusses on improving services
SBAR	Situation, Background, Assessment, Recommendation	A method of communication to ensure safe handover of information



# Glossary of Terms

Term	Description
<b>Co-production</b>	The involvement and contribution of patients to the provision of health services as partners of the provider organisation
<b>EPUT Lab</b>	An EPUT run group that gives clinicians and providers the opportunity to present innovative ideas that can improve patient care
<b>Mental Health Data Service</b>	Brings together national data and information captured on clinical systems as part of patient care
<b>Oxehealth</b>	An innovation implemented by EPUT to support the monitoring of patient's vital signs and behaviours
<b>Reflective Practice</b>	A method of studying personal experiences to improve ways of working and learning
<b>Safety Huddles</b>	A short multidisciplinary briefing focussing on the most at risk patients. Effective safety huddles involve agreed actions, are informed by visual feedback of data and provide the opportunity to celebrate success in reducing harm
<b>Safety WalkRounds</b>	An informal method for leaders to talk with front-line staff about safety issues in the organisation and show support for staff-reported errors. A method of demonstrating commitment to building a culture of safety
<b>Schwartz Rounds</b>	A structured forum where all staff, clinical and non-clinical, come together regularly to discuss the emotional and social aspects of working in healthcare

