NHS
The Leeds Teaching Hospitals
NHS Trust

Patient Safety & Quality Strategy

2024-2027

FOREWORD

We are pleased to introduce you to the Trust's Patient Safety and Quality Strategy 2024-2027, building on the principles and replacing our Clinical Quality Strategy that was published in 2021.

Our strategy defines how we will use **insight** to understand our quality and safety; **involve** patients, staff and partners; and how we will **improve** our services.

Since joining the Trust, we have both been impressed and assured by the systems and processes in place to ensure we are providing outstanding, safe care to patients. Our ambition is to build on this to ensure we are delivering patient-centred, harm free care to every patient, every time.

The commitment to improve our response when patient safety events or near misses occur and to learn from this is being strengthened through the implementation of the Patient Safety Incident Response Framework (PSIRF). PSIRF provides a real opportunity for the Trust to develop staff to be ambassadors of patient safety and provides nationally developed tools to understand where elements within our work systems require improvement or redesign.

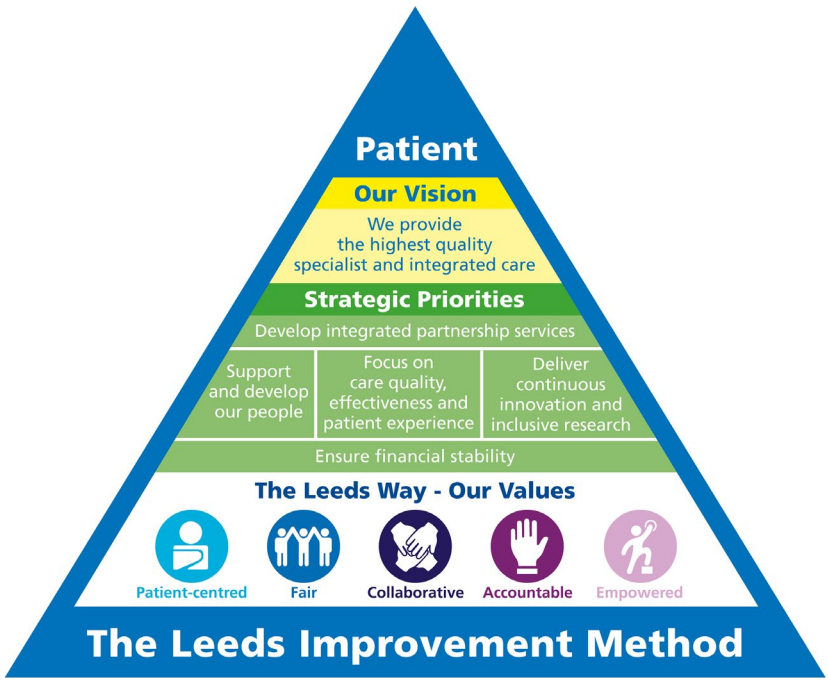
We look forward to continuing to work with you all to deliver the highest standards of treatment and care to our patients in line with the Trust's vision and goals, annual commitments and the Leeds Way values.

Dr Magnus Harrison
Chief Medical Officer

Rabina Tindale
Chief Nurse

OUR STRATEGY

Leeds Teaching Hospitals NHS Trust is an ambitious organisation with a clear vision to provide the highest quality specialist and integrated care. Our vision, values and strategic priorities are summarised in our strategic triangle below, which shows patients at the centre of everything we do.



Our mission:

to be an internationally renowned academic healthcare institution, working in partnership to deliver the highest quality, safe, effective and innovative care which improves outcomes.

- One of the **largest teaching hospitals** in the country
- A **regional and national centre for specialist treatment** and the **local hospital for the Leeds community**
- **Seven hospitals** across **five sites** in the city
- Treat around **1.6 million patients** every year
- Spend around **£1.9 billion** each year
- Almost **22,000 staff**
- Established **Centre of Excellence** for Research and Innovation at scale and a top recruiter for clinical trials

To support delivery of the strategy, we have seven multi-year goals which drive our long term activity and seven annual commitments which are refreshed each year to consolidate our in-year priorities.

Our multi-year goals are:

- Deliver fit for purpose healthcare.
- Deliver top quartile healthcare performance.
- Deliver a sustainable surplus by becoming the most efficient teaching hospital.
- Have an embedded culture of service improvement and innovation.
- To be a leading academic healthcare institution.
- Have a consistent, high performing and sustainable workforce.
- People receive person-centred care in the most appropriate setting.

Our 7 annual commitments are available on our website.

The Leeds Way

The Leeds Way is what we stand for and what we want to achieve. It is how we do things around here and what makes Leeds Teaching Hospitals different to other organisations. The Leeds Way is described in our strategic triangle; it encompasses our ambition through our vision and strategic priorities and our culture through our values, as created by our staff. It sets out what our stakeholders can expect from us as a Trust.

The Leeds Improvement Method

The Leeds Improvement Method (LIM) is our philosophy of continuous improvement that underpins all our organisational strategies. It brings the principles of daily management methods, improvement methodology, respectful behaviours and the removal of waste from processes together.

Our strategy framework

This strategy is part of a wider suite of strategies that work together to support the Trust to meet its overarching vision. At the centre of this is the Trust's corporate strategy, supported by three core strategies and ten enabling strategies. This strategy framework enables us to ensure our strategies align and are updated appropriately to reflect and support the overall Trust strategy.

INTRODUCTION

The Trust's Patient Safety and Quality Strategy 2024-27 sets out what we will do in response to the National Patient Safety Strategy. Our strategy sets out how we will develop our patient safety culture, learn from incidents and change the way we investigate through implementing the Patient Safety Incident Response Framework (PSIRF).

STRATEGIC PRIORITIES

Quality and safety are an integral part of the Trust strategy 2024-26 and our vision to provide the highest quality specialist and integrated care.

We are committed to providing outstanding care for all patients, working collaboratively across the health and social care system to support service development and continuous quality improvement. In order to achieve our goal of being the best for patient safety, quality and experience we work in partnership with our staff, patients, and their families/carers. We respect individual needs and values to ensure that we treat every patient as an individual, deliver the best clinical outcomes, provide a positive patient experience and one which is free from avoidable harm.

STRATEGIC AIMS

Our strategy links to the following multiyear goals.

- Deliver fit for purpose healthcare.
- Have an embedded culture of service improvement and innovation.
- Have a consistent, high-performing and sustainable workforce.
- Ensure people receive person-centred care in the most appropriate setting.

OUR AMBITION

We will continuously improve patient safety and the quality of the care our patients receive.

We will deliver this based on the Leeds Way values.

We will embrace patient safety insight and ensure our workforce has the skills, confidence and mechanisms to improve clinical quality.

We will ensure continuous improvement is truly at the heart of everything we do.

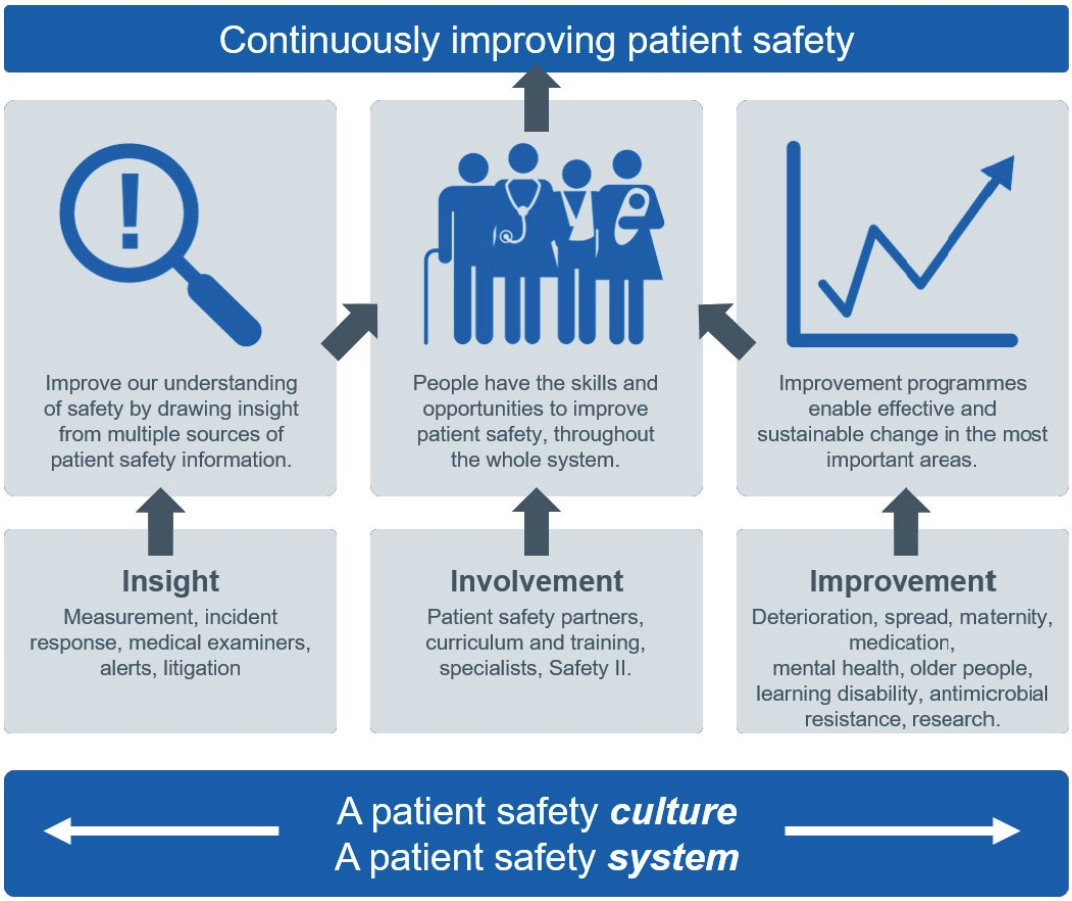
We will build a culture of psychological safety where staff can be open, empowered to admit when things have gone wrong and feel supported to speak up.

This will enable Leeds Teaching Hospitals NHS Trust to be a locally, nationally and internationally renowned centre of excellence for patient care, education and research.

IMPROVING QUALITY AND PATIENT SAFETY

Patient safety is about maximising the things that go right and minimising the things that go wrong for people experiencing healthcare. It is integral to the NHS's definition of quality in healthcare, alongside effectiveness and patient experience.

Our Patient Safety and Quality Strategy 2024-27 is aligned to the NHS Patient Safety Strategy and its supporting programme of **insight, involvement and improvement**. Our strategy describes how we will continuously improve patient safety and sets out our key workstreams under each program and key deliverables for the next three years.



Insight

We will continue to understand patient safety by enhancing current systems and implementing new systems and processes to draw upon multiple sources of patient safety information.

Learn from Patient Safety Events (LFPSE)

In 2024 the Trust will implement the Learn from Patient Safety Events (LFPSE) service, which is a new national NHS service for the recording and analysis of patient safety events that occur in healthcare.

LFPSE will create a single national NHS system for recording patient safety events, replacing the National Reporting and Learning System (NRLS). It introduces improved capabilities for the analysis of patient safety events occurring across healthcare and enables better use of the latest technology to create outputs that offer a greater depth of insight and learning that can be shared both locally and nationally.

- We will utilise Datix to implement the Learn from Patient Safety Events service in 2024.
- We will provide training and support to staff to use Datix to report patient safety incidents to promote a positive reporting culture, enabling us to learn.
- We will support staff to raise concerns about patient safety and respond to this.

Patient Safety Incident Response Framework (PSIRF)

The Trust approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety is defined in our PSIRF policy.

The PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. It embeds patient safety incident response within a wider system of improvement. It is a significant cultural shift towards systematic patient safety management.

The policy supports development and maintenance of an effective patient safety incident response system that integrates the four key aims of the PSIRF:

- Compassionate engagement and involvement of those affected by patient safety incidents.
- Application of a range of system-based approaches to learning from patient safety incidents.
- Considered and proportionate responses to patient safety incidents and safety issues.
- Supportive oversight focused on strengthening response system functioning and improvement.

Patient Safety Incident Response Plan (PSIRP)

The Patient Safety Incident Response Plan (PSIRP) sets out how Leeds Teaching Hospitals will respond to patient safety events. Whilst the plan sets out our priorities, there may be changes during this period. We will remain flexible, consider the specific circumstances in which patient safety events occurred, how we can respond to improve our services, and focus on the needs of those affected.

Our PSIRP includes an assessment of the patient safety event profile and identifies our national and local priorities. PSIRF enables us to maximise our resources to focus on improvement, rather than repeatedly responding to and reviewing patient safety events based on thresholds and definitions of harm that can often be subjective. This is important as reviewing a number of similar events will result in very limited new learning, whereas focusing on improving systems and culture, including those that impact on the wider Trust will bring greater benefits for patients and staff.

- We will respond to patient safety events and investigate patient safety incidents in line with our PSIRP.
- We will identify safety actions and learning from patient safety incidents and share this with staff across the Trust and link this to our improvement programmes.
- We will review patient safety incidents that have been reported to identify emerging themes, to agree actions for improvement.
- We will provide training for staff to lead on patient safety incident investigations based on the methods set out in PSIRF and support them in this process.

Medical Examiner System

The Trust has established its medical examiner structure, to lead on the process for learning from deaths. Through this process we will provide a better service for the bereaved and give them opportunity to raise concerns about care with a doctor who had not been involved in that care. We will enhance patient safety by ensuring that all non-coronial deaths are scrutinised by an independent medical examiner so that any issues related to the quality of care can be identified and acted on. We will also ensure the appropriate referral of deaths to the coroner and improve the quality of death certification.

- We will review all non-coronial deaths to inform where greater scrutiny or patient safety response may be required.
- We will learn from deaths and share themes emerging from these reviews.

Patient Safety Specialists

The NHS Patient Safety Strategy recognises that a foundation level understanding of patient safety is critical for staff; there is also a need for experts to lead on safety in their own organisations. The Trust has identified Patient Safety Specialists to meet the requirements of the role set out in the profile published by NHS England (August 2020), developing existing people rather than creating new posts, as set out in the NHS Patient Safety Strategy. A number of clinical leads and senior managers cover the requirements in their portfolios and have been registered as Patient Safety Specialists.

The Trust Patient Safety Specialists will continue to engage with the network that has been developed, both nationally and with partners through local systems.

- We will support the Patient Safety Specialists to develop their profile across the Trust, acting as key leaders within the safety system.
- We will support Patient Safety Specialists to complete the NHS England level 3 and level 4 patient safety training to support the development of their knowledge and skills in this role to support staff in their work.

Patient Safety Alerts (PSAs)

NHS England reviewed the framework and process for issuing Patient Safety Alerts (PSAs) to facilitate learning from continuous feedback. Where an issue is new or under-recognised and can be addressed through relatively simple and widely applicable actions, an alert can prompt and support local systems to take action.

The Trust has revised its local processes for responding to PSAs and providing assurance that actions have been completed, incorporating this into the fortnightly quality and safety briefings.

- We will ensure the PSA process continues to be implemented, raise awareness amongst staff and clarify the actions that need to be taken by local teams to improve safety.

Psychological safety

The NHS Patient Safety Strategy 2019 recognises the significance of psychological safety in improving the safety and quality of patient care. Developing a psychological safe, just culture means we can all hear and learn more, and act to improve patient care.

People's voices act as an early warning system for the Trust so we must enable each individual to feel able to speak up about anything they feel or know isn't working. This should be as an essential part of being assured that safety is being proactively and effectively managed.

- We will ensure staff involved in patient safety events are supported.
- We will ensure staff are aware of how to raise concerns through Freedom to Speak Up.

Involvement

We will equip patients, staff and partners with the skills and opportunities to improve patient safety.

Patient collaboration and engagement

Patient involvement is essential to the delivery of safe healthcare and in the design of our clinical pathways, the delivery of our clinical services and evaluation of clinical outcomes. This includes working with our partners to ensure that our services and feedback is representative of our large and diverse population across Leeds and the wider West Yorkshire region.

Patient experience is at the heart of all we do. Patients, their families and carers are integral to the achievement of the Trust's ambitions, and we will continue to ensure clinical care is delivered in partnership with our patients and include them in decision making, goal setting, care design, quality improvement and patient safety.

- We will be open with our patients and their families when a patient safety incident has occurred, keeping them informed about progress and share findings of our investigations.
- We will use patient feedback to inform our improvement programmes.
- We will use a range of patient surveys, the Friends and Family Test and engage with our patient groups across the city to ensure that opportunity for improvements are identified and action is taken.
- We will engage with partners, including Healthwatch Leeds and the local authority, to seek feedback from patient groups.
- We will listen and act on concerns raised about treatment and care by families, supporting the implementation of Martha's Rule in our hospitals.
- We will review the impact of patient safety incidents on health inequalities and work with partners and patients to address this.

Patient Safety Partners

Our Partner Programme was established in 2019, recruiting members of the public and embedding them into our programmes of work to improve quality and safety. The programme has continued to grow, successfully bringing in further partners to support the organisation to meet the requirements of NHSE National Patient Safety Strategy, Involving Patients in Patient Safety Framework.

- We will continue to expand the partner programme to help us deliver patient-centred improvement.
- We will provide training and ongoing support for our Patient Safety Partners to enable them to engage in improvement programmes.

Regulation

We recognise that quality and safety systems are underpinned by Regulation to ensure that fundamental standards are being met and that action is taken when they are not.

As we develop our plans, we will incorporate the ambitions set out in the revised Care Quality Commission (CQC) single assessment framework and quality statements. We engage with other regulators, including Medicines and Medical Devices and Healthcare Products Regulatory Agency (MHRA), Health and Safety Executive (HSE) and professional regulators, including the General Medical Council (GMC) and the Nursing & Midwifery Council (NMC).

- We will work in partnership with the CQC to implement the single assessment framework, underpinned by quality statements and support our staff in this.
- We will engage with the CQC through our monthly meetings with the Relationship Owner (RO).
- We will support our staff to meet the fundamental standards and prepare for inspections.

Improvement

We will design and support programmes that deliver effective and sustainable change in the most important areas.

Improvement Strategy

The Leeds Improvement Method (LIM) is our approach to continuous improvement that underpins all of our organisational strategies. It brings together the principles of daily management methods, improvement methodology, respectful behaviours and the removal of waste from processes.

The improvement strategy incorporates developing our staff to have the skills and capability to deliver meaningful changes in their services, increasing value and reducing waste. Our approach to continuous learning and use of data for improvement equips senior leaders to better understand the current challenges in the local system and determine our key priority areas.

- We will support and promote a culture of continuous quality improvement involving all of our staff.
- We will use the Leeds Improvement Method to improve the quality and safety of the services we provide for our patients.

PSIRF Improvement actions

Learning from patient safety incidents informs our actions to make safety improvements where gaps have been identified. Whilst these relate specifically to the patient safety event being reviewed, and the departments involved in the patient safety event, there is often scope for wider learning throughout the Trust, which will be used to inform our Improvement Collaboratives.

The Quality Improvement Steering Group provides oversight and monitors all improvement plans developed in response to a Patient Safety Incident Investigation (PSII). The group promotes a positive culture of continuous learning and improvement using Leeds Improvement methodology to facilitate Trust-wide learning and improvement.

- We will use the Quality Improvement Steering Group to monitor improvement actions and use these to inform our Collaborative programmes.

Measuring improvement

We measure our improvements through the use of national indicators and standards to benchmark our Trust practice and patient outcomes with peers. We triangulate external and internal data to better understand patient outcomes and areas for improvement, eg Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI). We monitor the achievement of constitutional standards, giving consideration to the safety of patients waiting for treatment and actions that can be implemented to support patients' health and wellbeing.

- We will measure quality and safety through national and local qualitative and quantitative data analysis.
- We will support and train our staff to use data and develop their skills for improvement.

Sharing learning

Learning from patient safety events is shared across relevant committees and forums. The Trust Patient Safety Learning Hub works together to identify learning that can be applied to a wider audience, and this is shared through a learning bulletin. Key messages are published in Quality and Safety briefings that are shared by staff at safety huddles, handover and team meetings.

Through the West Yorkshire Association of Acute Trusts (WYAAT), learning from incidents is shared with neighbouring NHS trusts to support wider learning and reduce potential harm across the region.

- We will be innovative in our approach to share learning to reach staff to improve safety.
- We will engage with partners through the WYAAT shared learning network to identify emerging themes to improve quality and safety.