

Quality and Safety Strategy Insight Workshop Pack

Interactive Feedback



“Insight” SWOT – for discussion

Strengths

Weaknesses

SWOT

Opportunities

Threats

TIME

SI Panel has improved - open to challenge - less defensive, more open

Positive engagement for CAMHS from our organisation

Insight from patient experience stories

Friendly, supportive and welcoming approach across the organisation

Level of Intelligence through PSQB

Keeping on top of/being informed by themes of patient safety and changing processes based on this - TRIANGULATION

reoccurring issue but not gaining insight from this eg: Safeguarding - lack of or poor communication with patients eg care plans

QI resource and support insufficient/not available?

Timing of meetings and clinics - insufficient notice

Board stories - ensuring we are open to all stories, both positive and negative

Openness and honesty

openness and transparency - we have a candid approach and keen to take actions where possible

Culture of psychological safety

Governance arrangements are much stronger

Huge time pressures due to staffing issues reduce the opportunities for clinicians to engage with quality and safety issues

Still have a reactive approach rather than investing time and resources into being proactive

Contact lists are never updated when people change roles so the right people often don't even get invited to relevant meetings

MDT meetings don't always have the clinician representation that we need - lack of clinical engagement

clinical governance process adds demands on clinical leads

Governance support resource

Complaints - added pressure and the procedure (via email) not the most efficient process - could this be guided or supported in a more efficient way?

Risk Management Committee is on a journey to open and constructive challenge

benchmarking

Safety Summit

Communications have improved but could be better

prioritise allocated time to learn from the data and feedback we have

comms is great but is there a more efficient way of prioritising the information to clinicians and others with time pressures to promote learning opportunities in a digestible way?

So many forms to be completed / email burden - agendas are very long could we have easier more efficient ways of capturing the information or sharing information

improve alignment of patient's journey through complaints and SIs or other processes

Wealth of auditing - insufficient time to lean from the outputs of this - creating headspace by doing less and allowing time to learn more

So rich in data - don't have time to reflect and learn from this - headspace

Poor staffing across the board with frequent requests to take on additional duties (paid or unpaid)

Optimising learning from what we already know/what our partners have done - "pinch with pride"

Defining Quality and Safety

How do you define quality and safety?

Quality is...

Patient Safety.
Patient
Experience.
Clinical
Effectiveness

**Good
Care**

What
does it
look and
feel like?

Meeting or
exceeding
expectations

How you or a
member of
your family
would like to
be treated

Consistent
care

Responsive

care based on
individual
needs based
on best
practice

Care that is truly
patient-centred.

shared
understanding and
shared language of
the standard and
expectations of
what we are trying
to achieve

**Good
outcomes**

As a patient -
care I fully
understand
and I can trust

ensuring patients
receive the right
care, in the right
place at the right
time

Safety is...

proportionate
response to
risk

...is safe
and feels
safe

Pro-active in
avoiding and
responding where
necessary to safety
intelligence/ insight.

**Managing
Risks**

**Avoiding
harm**

Care delivered
by highly
trained staff

for
learning and
improvement
- promoting
psychological
safety

working to
ensure that
we minimize
and focus on
preventable
harm

**Adequate
staffing**

**a safe
culture**

**Maintaining
the
environment**

Excellent
communication

learning
organisation

**resource -
adequate
tools to do**

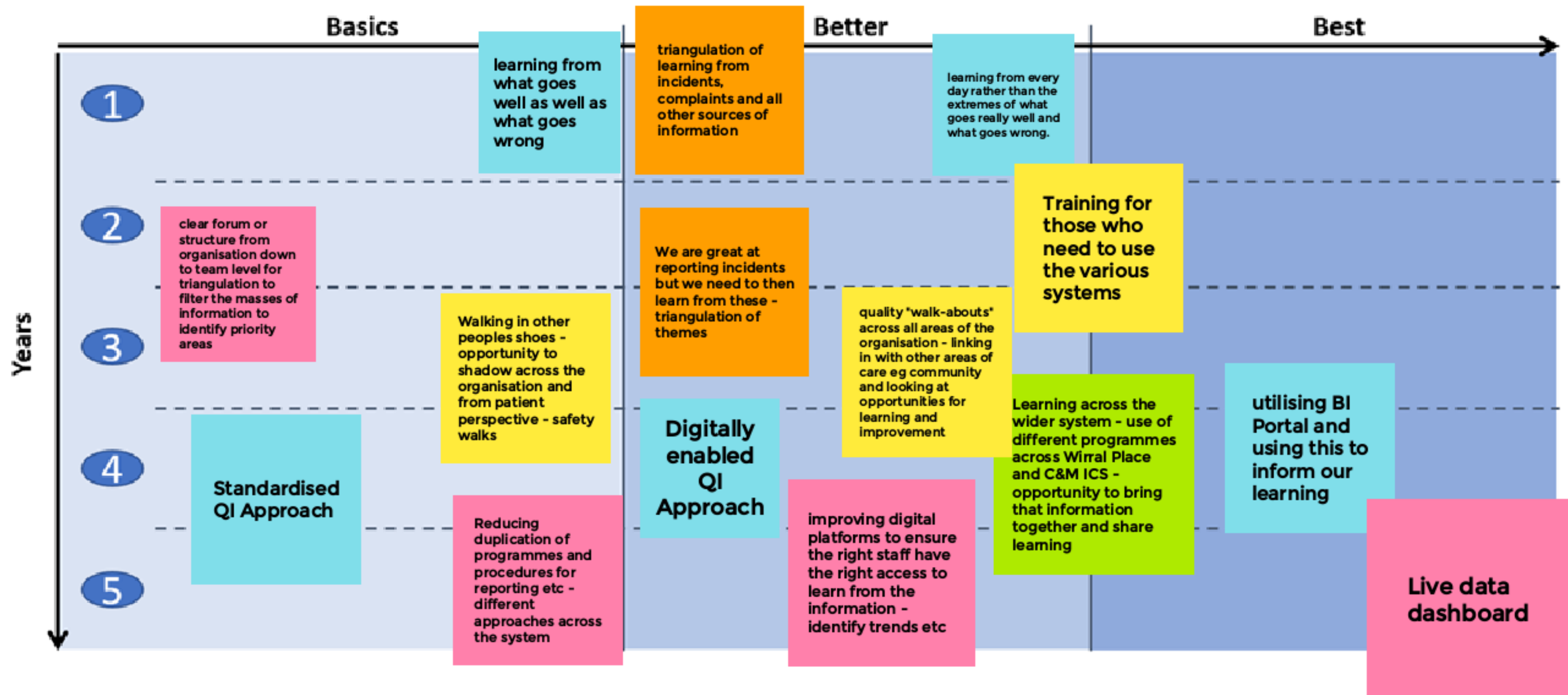
Drawing Intelligence from multiple sources

How can we understand patient stories?

How can we utilise staff feedback?

How can we be responsive to these sources of information?

Triangulation – incidents, audits, complaints, benchmarking, claims – what can we learn from these?



Assuring quality and safety

How can we ensure we are “well-led” with clear leadership and governance?

How can we understand risk?

How can we sustain responsiveness?

How can we effectively measure quality and safety?

