#theEoSC
#spsp247

Creating the Conditions for Safe Care

SPSP National Learning Event
27th September 2022

Welcome

Professor Sir Gregor Smith

Chief Medical Officer,

Scottish Government

Welcome virtual audience

- MS Teams Audience
- Interactive/participate in Q&A
- Recording & photography

Housekeeping

- Wi-Fi name: SRU Guest
- Organising team – yellow lanyard
- If you hear a fire alarm, please proceed to the nearest exit
- During the meeting please set mobiles to silent
- Morning session recording & photography

Aims of the day

- Explore the organisational and system wide conditions that enable the safe delivery of care amidst increasing system pressures.
- Learn how the SPSP Essentials of Safe Care are supporting improvements in safety.
- Provide a forum for leaders and teams working across all aspects of SPSP to come together to share and learn.

Virtual delegate bag

- Agenda
- Speakers information
- Presentations
- Resources
- Accessed via QR code

Evaluation form

We value your feedback.

Please scan the **Evaluation QR code** on your table or speak to a member of the organising team.

Agenda – morning

Time	Topic	Lead
10.00	Chair's welcome	Professor Sir Gregor Smith, Chief Medical Officer for Scotland, Scottish Government
10:10	Ministerial Address	Maree Todd, Member of the Scottish Parliament & Minister for Public Health, Women's Health and Sport
10:25	Scottish Patient Safety Programme Update	Joanne Matthews, Head of Improvement Support & Safety, Healthcare Improvement Scotland
10:35	Creating the Conditions for Safe Care	Professor Mary Dixon-Woods, Health Foundation Professor of Healthcare Improvement Studies & Director of THIS Institute at University of Cambridge
11:25	Plenary Questions & Answers	Professor Mary Dixon-Woods & chaired by Professor Sir Gregor Smith
11:35	A System View	Robbie Pearson, Chief Executive, Healthcare Improvement Scotland
11:50	Chair's Summary	Professor Sir Gregor Smith, Chief Medical Officer for Scotland, Scottish Government
12:00	Lunch and Networking	

Agenda – afternoon

Time	Topic	
13:00	First Breakout Session	
	1. Person-centred approaches to safe care (Cap & Thistle) 2. Safe Communication, Safe Care (Moncrieff) 3. Leadership to Promote a Culture of Safety (President's 1) 4. Clinical & Care Processes: Improving Patient Safety in a Complex System (Thistle 2)	
14:15	Refreshments and Transition to Second Breakout Session	
14:30	Second Breakout Session	
	1. Person-centred approaches to safe care (Cap & Thistle) 2. Safe Communication, Safe Care (Moncrieff) 3. Leadership to Promote a Culture of Safety (President's 1) 4. Clinical & Care Processes: Improving Patient Safety in a Complex System (Thistle 2)	
15:45	Transition to Main Room	
15:50	Closing remarks	Joanne Matthews, Head of Improvement Support & Safety, Healthcare Improvement Scotland
16:00	Close	

Ministerial Address

Maree Todd, MSP

Member of the Scottish Parliament &
Minister for Public Health, Women's
Health and Sport

The Scottish Patient Safety Programme

Creating the Conditions for Safe Care

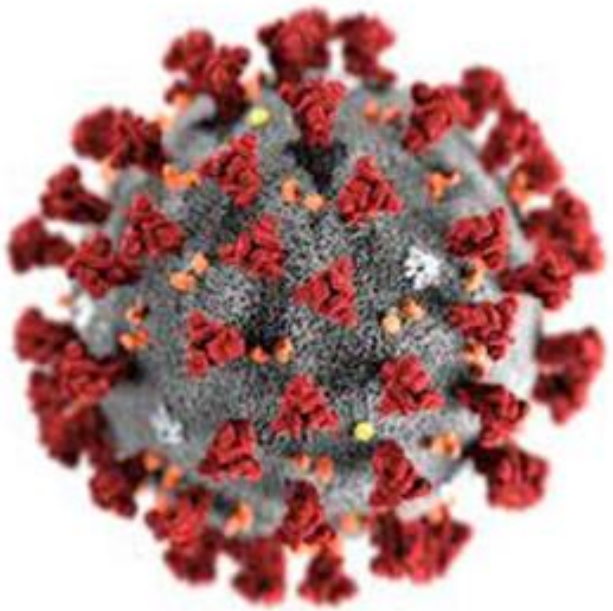
Joanne Matthews

Head of Improvement Support and Safety

@joanne37m

Collaboration

Little Did We Know…….



Safety is Not Done

SPSP

SPSP aims to improve the safety and reliability of care and reduce harm

Core Themes

- Essentials of Safe Care
- SPSP Programme improvement focus Maternity ,Neonatal, Paediatric Acute Care, Primary Care, Medicines and Mental Health
- SPSP Learning System

Creating the Conditions

Essentials of Safe Care

A practical package of evidence based guidance and support that enables Scotland's health and social care system to deliver safe care for every person, within every setting, every time.

Essentials of Safe Care

Healthcare Improvement Scotland

SCOTTISH PATIENT SAFETY PROGRAMME

Aim

To enable the delivery of Safe Care for every person within every system every time

Primary Drivers

- Person centred systems and behaviours are embedded and support safety for everyone
- Safe communications within and between teams
- Leadership to promote a culture of safety at all levels
- Safe consistent clinical and care processes across health and social care settings

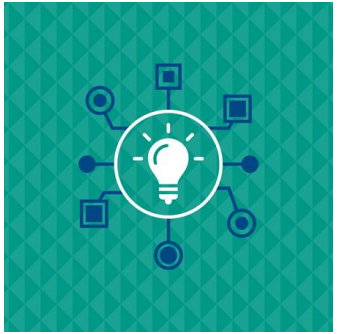
Secondary Drivers

- Structures & processes that enable safe, person centred care
- Inclusion and involvement
- Workforce capacity and capability
- Skills : appropriate language, format and content
- Practice : use of standardised tools for communication
- Critical Situations : management of communication in different situations
- Psychological safety
- Staff wellbeing
- System for learning
- Reliable implementation of Standard Infection Prevention and Control Precautions (SICPS)
- Safe Staffing

Creating the Conditions

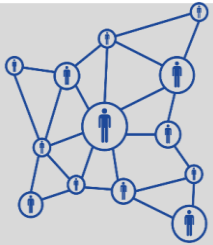
The **SPSP Learning System** will be a key element of our work and underpins all our activities. It aims to accelerate sharing of learning and improvement work through a range of engagement and learning opportunities.

Learning events and webinars



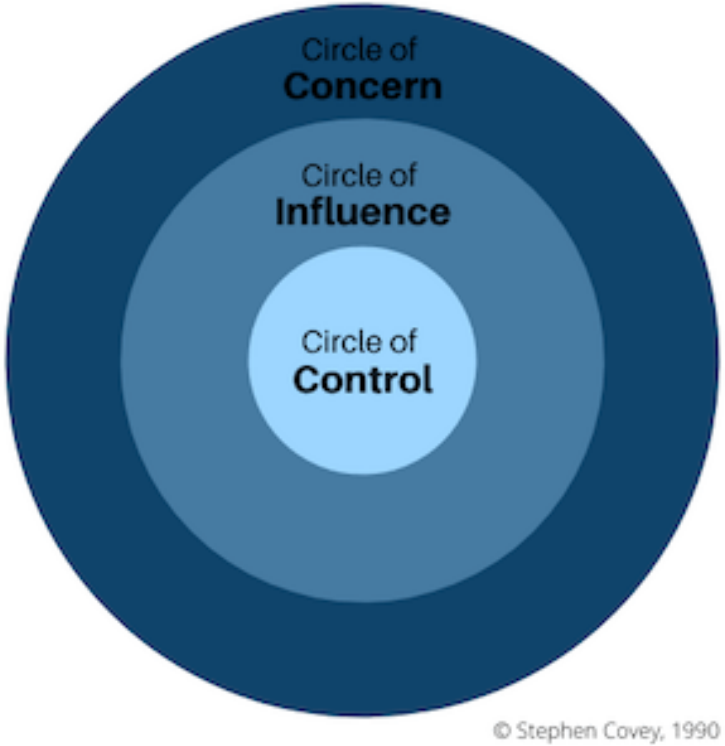
Sharing data, supporting measurement and Evaluation

Supporting Networks



Producing evidence summaries and case studies studies

What Can You Do?



Collaboration

Thank you


EVERY PERSON
EVERY TIME
SCOTTISH
PATIENT
SAFETY
PROGRAMME

Creating the Conditions for Safe Care

Professor Mary Dixon-Woods

Foundation Professor of Healthcare Improvement Studies & Director of THIS Institute at University of Cambridge

Questions & Answers with Professor Mary Dixon-Woods

A system view

‘To enable the delivery of Safe Care for every person within every system every time’

Robbie Pearson

Chief Executive

Healthcare Improvement Scotland

‘Smoke detectors’

‘…routinely collect, analyse and respond to local measures that serve as early warning signals of quality and safety problems such as the voice of the patients and the staff, staffing levels, the reliability of critical processes and other quality metrics. These can be ‘smoke detectors’ as much as mortality rates are, and they can signal problems earlier than mortality rates do.’

Don Berwick 2013

Four next steps for a safer system

- A **connected system** of safety
- A **focal point for safety** for the system
- **‘Shock absorbers’** for a system under pressure
- A greater focus on **the blind spots**

A connected system of safety

- A visible **thread of safety** woven through the design and delivery of our NHS
- An **uninterrupted line of sight** from the frontline to the board room on safety
- **Proactive identification** of systems at risk

Focal point for safety of the system

- Bringing together our wealth of **knowledge and intelligence** in Scotland on safety at all levels
- Understanding and responding to **the safety data** as we do for the performance metrics of the system
- **Curiosity,** asking the questions, providing support

Shock absorbers for the system

- Acting **responsibly, practically and proactively** to support the system
- Mutual support and **psychological safety**
- **Well-being** for staff

A focus on the blind spots

- A stronger focus on safety in the services **that lack measurement data**
- Ensuring that safety is for **a connected system of care**, including less high profile services

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Thank you

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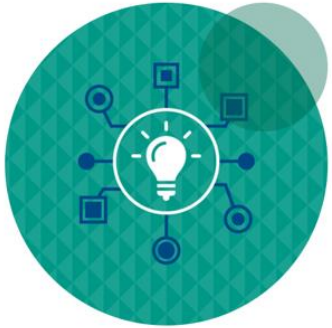
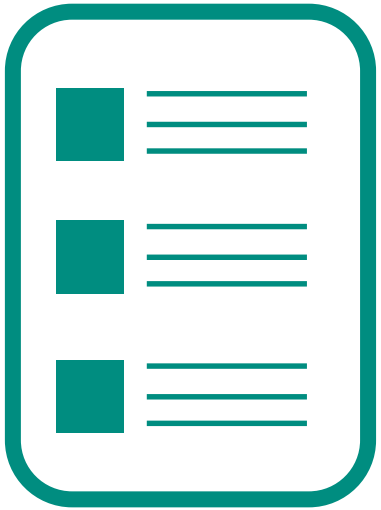
Chair’s summary





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15:50	Closing remarks	Joanne Matthews, Head of Improvement Support & Safety, Healthcare Improvement Scotland
16:00	Close	

Thank you for attending

Breakout Session Rooms

1. **Person-centred approaches to safe care**
   (Cap and Thistle room)
2. **Leadership to Promote a Culture of Safety**
   (Presidents 1)
3. **Safe Communication, Safe Care**
   (Moncrieff)
4. **Clinical & Care Processes: Improving Patient Safety in a Complex System**
   (Thistle 2)

Thank you & Feedback

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