Hand out 1 Incident decision tree. Per person-in pack
Handout 2 YCFF habd out (2 sided with explanations) per person in pack
Handout 3 NPSA quick ref guide to SEA. per person in pack
Handout 4 Our SEA template per person in pack
Handouts 5 Strictly warfarin. 1 set per 4 people.
Handout 6 barrier flash cards 1 set per 6 people.
Handout 7 SEA examples
Handout 8 (for speaker) the answers to why the SEA were good or bad.
Housekeeping
Our # for the Event

@Improve_Academy

#SEAlisforSafety
Tony Jamieson
Clinical Lead for Medicines
Yorkshire & Humber Academic Health Science Network

Table introductions

@PharmSafe
Objective

To be sufficiently equipped with the knowledge and tools needed to support GP practices to carry out Significant Event Audit (SEA) in a way that optimises the chances of improving patient safety.
Pre-course learning

12 Responses:
Very consistent correct answers for 10 of the questions.
An injury caused by medical management (rather than the underlying disease) that either prolongs patient hospitalisation, or produces a disability at the time of discharge, or both.

ADVERSE EVENT OR MEDICAL NEGLIGENCE
Which of the following would you presume to not be a component of effective team communication?

DEFERENCE TO THE AUTHORITY OF THE MOST EXPERIENCED PHYSICIAN IN A MEDICAL EMERGENCY
STANDARDISATION OF ALL CLINICAL OPERATING PROCEDURES AND TERMINOLOGY
TEAM LEADER UTILISES A “COMMAND AND CONTROL” APPROACH DURING A MAJOR INCIDENT
Shall we consider what errors we have made recently, For my part my journey here today contained many errors.
I forgot to put the dog’s collar on when I took him out for his walk today, it’s a good job he’s too old to run off on me!
I washed what hair I have twice this morning once with shampoo as I intended and once with body-wash which I intended to be for my armpits. And I have brought my car keys out with me despite coming here on the train.
Take a few moments to consider, according to this definition whether you have made any errors recently, perhaps even like me, this morning.

So what makes for a Patient Safety Incident looking at this definition. It’s pretty wide. It covers errors because the result of an error is either unintended or unexpected. And crucially this definition points out that it is not necessary for harm to have occurred it is sufficient for there to have been a risk of harm.
Let us consider a simple prescription of amoxicillin which gives the patient a rash. Is that a patient safety issue?
What about if the drug was prescribed to a person with a viral sore throat where antibiotics are not warranted and when the risk of a rash is higher?
Let’s take it a step further and say that the patient was known to be allergic to penicillin and could have had a severe allergic reaction to the amoxicillin?
Now not all patient safety incidents are related to medicines but in general practice many are. Examples:
1 blood pressure taken incorrectly that leads to a decision to treat the patient for high blood pressure.
2 Dizziness from low blood pressure when caused by an antihypertensive such as amlodipine prescribed for high blood pressure.
3 Dizziness from amlodipine when the doctor intended to prescribe amiloride.
4 A fall (not an ADR) that results from the dizziness (an ADR) from the amiloride/amlodipine error.
5 No effect on the patient from the amiloride/amlodipine error.

But all of these are patient safety incidents.
We are using medicines as examples of patient safety issues because it’s a big deal as shown from these figures. However everything we talk about today is transferrable to other patient safety issues such as diagnostic errors or health and safety issues. But most of our information about patient safety is drawn from secondary care. There is relatively little information about primary care.

For info the breakdown of the detail of the top line figures above is provided here; Prescribing errors:

No directions 25%
Prescribing something not needed 18%
Directions incomplete 11%
Over supply 11%
Strength missing 9%
Quantity missing 8%
No Signature 5% (Other 13%)

Dispensing:

3.3 of items
1.6% labelling errors
1.7% content errors
We will start to look at why humans make mistakes. We are genetically predetermined to make errors in the face of an overwhelmingly complex activity like the delivery of healthcare. We will look at a few examples to make this point.
The audience should be started off by the speaker with a steady rhythm reading each word aloud.

- In this illustration, you are required to say the **colour** of the word, not what the word says.
Remind the audience on the next slide to say the colour of the word not the text of the word
Here we note how difficult it is to perform a task when our brains are geared up to do the most natural thing...read the written word.
Here we note how our attention can be taken over by concentration on another task. This one clip changed my dispensing behaviours and stopped me bragging about how good I was at observation and multitasking.

Test 2

- Selective perception test
  
  www.youtube.com/watch?v=vJG698U2Mvo
In this exercise the audience is asked to memorise the 10 drug names in 15 to 20 seconds. During this time the speaker distracts the audience with: “these were the drugs that were most frequently named in a selection of incident reports submitted by Leeds GPs” Then write them down without conferring. See how many they got.

This is an example of using working memory. Working memory can only hold 5±2 pieces of info, so wen you have read a list of 10 drugs you are very likely to have forgotten 3, 5 or even 7 of them.

Consider when we GPs are checking for changes to a patients repeat medication list how much information needs to be stored at the same time to do this accurately.
You will encounter these myths when you talk to people about becoming safer. The person centred view of the world is that errors are a failure of an individual, normally because they were considered to lack the skills or aptitude for the task that they failed at.

Well its true that human error is the cause of most patient safety incidents. But errors are made by clinically sound, well intentioned, skilled and capable people. And that is why when a person makes an error we need to apply Johnson’s substitution test, the basis for the Bolam principle.
It is not uncommon for diligent people in the NHS to be suspended immediately following an error. The NHS has lost many person years of experience to inappropriate suspension of people following and incident. As a result the NPSA developed the Incident decision tree to help organisations appreciate the effect of systems on individuals. This tool help us apply Johnson’s substitution test.

I will now hand over to Rebecca Lawton to look at the impact of errors on the people who make errors and to take us through the alternative to the person centred view of errors into the systems view.
60% of those 1,755 responding to the survey said yes to the statement:

Do you believe that involvement in a near miss or adverse event has affected your personal or professional life
Hospitals and healthcare organisations adequately support doctors in dealing with the stress associated with near misses or adverse events.
Human Factors in healthcare is an approach to enhancing clinical performance through an understanding of the effects that teamwork, tasks, equipment, workspace, culture and organisation have on human behaviour and abilities.

“Things that make it easier to do the right things, to the best of our ability”

Human Factors in healthcare is an approach to enhancing clinical performance through an understanding of the effects of teamwork, tasks, equipment, workspace, culture and organisation have on human behaviour and abilities. It has foundations in psychology, sociology, physiology and engineering and is the key to understanding why errors are made and how to prevent them. The NHS has been slow to follow the lead of other safety critical industries in the adoption of Human Factors, particularly so in primary care. The motor, aviation and petrochemical industries which have all adopted Human Factor to improve safety. The National Quality Board published a concordat on Human factors in 2013 which describes the commitment of leadership organisations in the NHS to increase the understanding and use of Human Factors to improve safety.

Human Factors in Healthcare - A Concordat from the National Quality Board. NQB 2013.

Why it sometimes goes wrong. Systems Based Approach

Representation of James Reason's Swiss Cheese Model
Ladbroke Grove train disaster (Lawton and Ward, 2005)

**Organization**
- Processes
  - Organisational learning
  - Poor management of training
  - Planning and design of Paddington layout

**Task/Environment**
- Conditions
  - Bright sunlight
  - Complexity of track layout
  - Signal obstructions
  - Inappropriate SPAD response
  - Training
  - Poor local communication about hazards

**Individuals**
- Unsafe Acts
  - Driver misread signal or signal aspect
  - Signallers expected the driver to stop and so did not act with haste

**Defenses**
- Region of Hazards
- Accident

Inadequate defences

Inadequate engineered safety devices, signalling procedures and sighting standards
We conducted a large systematic review of all the studies that have investigated the causes of errors in healthcare, identified 95 papers, extracted all the causes and then coded them – then developed a framework for understanding unsafe acts. Now, one of the things you need to think about in this programme is
Refreshments and Networking

#t1noefs
An injury caused by medical management (rather than the underlying disease) that either prolongs patient hospitalisation, or produces a disability at the time of discharge, or both.

ADVERSE EVENT OR MEDICAL NEGLIGENCE
Which of the following would you presume to **not** be a component of effective team communication?

- **deference to the authority of the most experienced physician in a medical emergency**
- **standardisation of all clinical operating procedures and terminology**
- **team leader utilises a “command and control” approach during a major incident**
Exploring the domains of the YCFF using examples See reverse of YCFF hand out.
Buzz Group – At tables people spend 2 minutes describing why it is a good thing to do significant event audit or review of a patient safety incident.

Discuss/flipchart the responses.
During discussion bring out these points.
SEA is just one of many quality improvement tools such as benchmarking & audit, peer review, pdsa etc. its not the only thing practices can do to improve safety. It is helpful because:
It includes a patient story which is usually a powerful driver for change.
There is generally some emotional attachment to the event which is helpful.
SEA demonstrates to CQC that the practice tries to learn from errors.
SEA can contribute to GP appraisal and revalidation.
SEA can provide assurance to patients that errors they were involved in have been taken seriously a,d that action has been taken to avoid recurrence.
Steps to SEA.
This is taken from the NPSA guide but has been streamlined.
The steps hold a meeting and analyse the events in reality always happen together.
Also write it up is implicit in what we are doing so is taken as read that this will be done.

Otherwise the background information on how to do SEA is very well explained in the NPSA documents.

In step 1 – many practices struggle with this. There must be an internal mechanism for recording an incident has been discovered. My preference is to read code it in the patient’s journal. This them becomes searchable. Tasking the Practice manager also works. Other systems like “I’ll bring it up at the next practice meeting” seem a little hit and miss. Systematising is good. The practice should work to its strengths when deciding how to do this.
There is no right or wrong way to prioritise the incidents for taking forward to SEA. Certainly not all incidents can get reviewed.
If there has been patient harm then it seem obvious that SEA would be necessary. A cluster of similar incidents might also trigger picking one for review. Otherwise it is probably reasonable to have a free choice.

Step 2 – information gathering. Best to do a combination of a trawl of the records and a personal account of the event.
Step 3 analysis – this is where the practice attempts to describe the contributory factors and decide which of the factors is the most significant. Ideally the “Active Failure” will have been described (see YCFF).

This lead to the lesson; Such a thing went wrong because of this active failure which came about because of these contributing factors of which this contributing factor was the most significant. Addressing this contributing factor is likely to reduce the chance of similar errors.
Discuss.
Worth spending some time on this discussion.
Myths to dispel:
Patients will get a lawyer at the drop of the hat. Not so...and if there is no harm then there can be no claim!
It might worry the patient...possibly but including them in the process of preventing future harm will reduce the worry.
Patient’s don’t understand what goes on.....they do from their point of view.
Patient’s would rather not know...patients want the facts about themselves, and they certainly don’t like secrets!

Most patients involved in a patient safety incident want:
An apology.
A explanation of what happened.
Assurance that it won’t happen to them again.
Assurance that it won’t happen to anyone else.

They can be provided with all of this by involving them in SEA.

Indemnifiers are supportive of this approach to avoid claims being made.

Also  CQC and GMC require candour:
The legal duty of candour came into effect for General Practices from 1 April 2015
Cadour is a legal requirement for:

- the death of the service user, where the death relates directly to the incident rather than to the natural course of the service user’s illness or underlying condition,
- an impairment of the sensory, motor or intellectual functions of the service user which has lasted, or is likely to last, for a continuous period of at least 28 days,
- changes to the structure of the service user’s body,
- the service user experiencing prolonged pain or prolonged psychological harm, or
- the shortening of the life expectancy of the service user
- requirement for additional treatment to prevent one of the harms described above.

Once a notifiable safety incident has been identified the practice must:

- Make sure it acts in an open and transparent way with relevant persons in relation to care and treatment provided to people who use services in carrying on a regulated activity.
- Tell the relevant person in person as soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred, and provide support to them in relation to the incident, including when giving the notification.
- Provide an account of the incident which, to the best of the health service body’s knowledge, is true of all the facts the body knows about the incident as at the date of the notification.
- Advise the relevant person what further enquiries the provider believes are appropriate.
- Offer an apology.
- Follow this up by giving the same information in writing, and providing an update on the enquiries.
- Keep a written record of all communication with the relevant person.
Work through the written example.
Flash cards – table top exercise ask the participants to put each “remedial action” into the strong, moderate and weaker categories hierarchy of effectiveness (Lee and Hirschler – *How to make the most of actions and outcomes*).

**Stronger Actions**
- Architectural / physical plant or equipment changes
- New device with usability testing before purchasing
- Engineering controls (interlock / forcing function)
- Simplify the process and remove unnecessary steps
- Standardise equipment or processes or care plans
- Tangible involvement and action by leadership in support of Patient Safety

**Moderately Strong Actions**
- Increase in staffing / decrease in workload
- Software enhancements / modifications
- Eliminate / reduce distractions
- Checklist / cognitive aid
- Eliminate look and sound-a-likes
- Enhanced documentation
- Enhanced communication

**Weaker Actions**
• Double checks
• Warnings and labels
• New procedure / policy Training
• Additional study / analysis
• Disciplinary action
Stronger Actions – Make it easier to do the right thing they compliment human nature.
Architectural / physical plant or equipment changes
New device with usability testing before purchasing
Engineering controls (interlock / forcing function)
Simplify the process and remove unnecessary steps
Standardise equipment or processes or care plans
Tangible involvement and action by leadership in support of Patient Safety

Moderately Strong Actions – Compliment some aspects of human behaviour but are easier to circumvent.
Increase in staffing / decrease in workload
Software enhancements / modifications
Eliminate / reduce distractions
Checklist / cognitive aid
Eliminate look and sound-a-likes
Enhanced documentation
Enhanced communication

Weaker Actions – Require additional work or effort to be effective/sustained or are miss-aligned to the cause of the error or are easily ignores (consciously or otherwise)
Double checks
Warnings and labels
New procedure / policy Training
Additional study / analysis
Disciplinary action
Lunch

#SEAisforSafety
Let's Get Critical

Use what you know to analyse some SEA.

Use example of SEA to draw out the good the bad and the ugly.
Reporting incidents onto NRLS supports nationwide analysis of patient safety concerns. Reporting is easy. Using:

https://report.nrls.nhs.uk/GP_eForm

Feedback relies on locally managed systems. Access NRLS through your Governance Team or

https://report.nrls.nhs.uk/nrlsreporting/CreateUser.aspx


Like the slide says.
Its really easy – Ask your GPs to identify themselves using **ODS practice code** and if the option allows select your CCG to be notified
No-one like reporting into a black hole.
Encourage your practices to share their SEA with you. A simple access database (available on request) can help to record, review and analyse SEA for their quality and common contributory factors.
There are a number of propriety providers of softwareed solutions available such as datix, Uleseyss (other platforms exist)
If practices share their SEA with you than you can apply these characteristics make for effective knowledge transferr.
The aim is to provide practices with practical information that they could use to make patients safer before the incident happen in their practice
Part 2 – Training the Practices

Maureen McGeorge
Programme Manager
AHSN’s Improvement Academy
So what next?

- Recruit a cohort of six individual GPs/GP practices to receive the SEA training.
- Report back to the Improvement Academy (IA) on progress after 3 months and again at 6 months including the number of incident reports uploaded to NRLS weekly by your member individuals/practices.
- Encourage and support two of your GPs/GP practices to complete the IA silver level ‘quality improvement training for teams’ which is taking place on 18 November 2015. Note: the subject of the training will be focused around key findings from their significant event audits.
So what next?

- **SEA should be** an improvement activity
- You and your teams will get out what you put in
- Levels of engagement:
  - Deliver SEA training ... who, when, how often?
  - Encourage collection of NRLS data
  - Support completion of SEA (and submit to IA for critical review)
  - Support teams become ‘improvers’ (based on identified issues)
Resources to support the work
Resources for SEA

- NRLS e-form
- NPSA quick-reference guide
- SEA template
- Contributory Factors Checklist
- YCCF
- E-learning package
- NPSA guide to SEA
- Critical review by Improvement Academy
Resources for Quality Improvement

- **Bronze level training**: e-learning entry level QI training
- **Silver level training for individuals**: aims to give individual healthcare staff an opportunity to share examples of methods, tools and techniques that engage multidisciplinary teams in Quality Improvement initiatives
- **Silver level training for teams**: designed for teams that are ready and keen to work together improve aspects of their services, but who lack the skills and confidence to get started. The training will take a very practical focus and throughout the day teams will be supported to work together to plan their own improvement project.
Resources for Behaviour Change

How can we get the most out of this?

<table>
<thead>
<tr>
<th>Skills</th>
<th>Competencies</th>
<th>Other e.g. time, facilities, admin support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recruit 6 GPs/practices</td>
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<tr>
<td>Deliver SEA training</td>
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<tr>
<td>Support NRLS data collection</td>
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<tr>
<td>Support completion of SEA</td>
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<tr>
<td>Support teams become ‘improvers’ (QI and behaviour change)</td>
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</table>
Refreshment break
Challenges you may face and how to overcome them

SEA is an improvement activity... so expect to be challenged

What challenges do you expect to hear? And how will you reply?
Challenges you may face and how to overcome them

Be prepared for a tough time
“Surely more incident reports is a bad thing.”
“If I tell you you’ll come down on me hard.”
“Won’t patients think I’m awful if I report more?”
“What will NHS England think?”
“Won’t I get sued?”
Challenges you may face and how to overcome them

- Any improvement is a change
- Any change can be perceived as a threat to security
- Any threat to security can give rise to emotional resistance
- Emotional resistance can only be overcome by a stronger emotion
Understanding resistance
Challenges you may face and how to overcome them

**Understanding resistance**
There are three different levels of resistance that you may encounter:

**Level 1** resistance relates to information: a lack of, confusion over or disagreement with key information.
*To overcome this level of resistance, you need to give people more information, more convincing arguments and detailed facts. This is best done through presentations and question and answer sessions.*
Challenges you may face and how to overcome them

Understanding resistance

**Level 3** resistance goes beyond the immediate situation and is based on what the change represents to the individual. It may be deeply entrenched and may also encompass personal or cultural differences. *To deal with this level of resistance*, begin to rebuild relationships before presenting new ideas. Or, at the very least, your change management strategies must include ways of building bridges whilst you plan and implement.
Challenges you may face and how to overcome them

Understanding resistance

Level 2 resistance is an emotional and physiological reaction to change based on fear of loss, incompetence or abandonment – likely to be unconscious and uncontrollable.

To deal with this level of resistance, you need to adopt a different strategy. Discuss and fully explore the idea with staff: listening and meaningful dialogue are essential.
Challenges you may face and how to overcome them

Or expressed differently...

“The core of the matter is always about changing the behaviour of people, and behaviour change happens in highly successful situations mostly by speaking to people’s feelings”
Clinical Engagement

• Do........

• Don’t.......
Who to involve (and how)

- Key players – strong buy-in
- Active Consultation
- Maintain Interest
- Keep Informed

Power

Impact

High

Medium

Low
Adopter categorization
Sarah W Fraser (Moore 1991)

Innovators
Enthusiast

Early
Adopters
Visionary

Early
Majority
Pragmatist

Late
Majority
Conservative

Laggards
Sceptic
Who to involve (and how)

Enthusiasts and visionaries look forward and want changes that go along with their more strategic and purposeful ideas
- Enthusiasts tend to show creativity and excitement
- Visionaries temper excitement with idealism
Who to involve (and how)

The other three groups look backwards

- Pragmatists need to be convinced new ideas will not collapse the systems (Hint: show them it working; adapt the change so it is acceptable to them)
Who to involve (and how)

“Professionals value innovation & experimentation in their clinical work, but past experience of change gives them little reason to believe it will improve the quality of care or their own working lives”

Locock 2001 – Research into Practice programme summary report No.1 July 2002
Why are some people sceptical about change?

- Insufficient information about the nature, purpose & significance of change
- Seeing change as being ‘top down’
- Believing there are other more important priorities
- The change is unfamiliar or irrelevant
- Fearing change will be threatening to individual status and power

• From Research into Practice report – from scepticism to support – what are the influencing factors?
  • Scepticism often manifests as resistance
  • Resistance to changes does not indicate staff are unwilling to bring improvements
  • Changes in clinical practice are influenced in some degree by research, however, organisational change must rely more on persuasion to be successful.
  • Persuading means influencing people by getting them to alter their attitudes and beliefs (more later in the course)
  • People must become motivated to change otherwise they will pay lip service to it.

• Having a few ‘resistors’ can be helpful – stops you getting carried away and going too far down the wrong track!
Being reasonable to change is easier if you have little to lose. Transition deficit causes over reaction to seemingly small changes (ie death of Princess Diana – mass grieving especially by those who were still grieving their own loved ones).

You might want to share a story of your own here, to get people to open up themselves.
Change, learning and comfort

**People respond differently**
- Some feel it’s an adventure and are excited and stimulated
- Some feel it is a mission or a duty and just have to get on with it
- Some feel it is a forced march and are fearful and cautious
- Some feel out of control and are overwhelmed, depressed and de-motivated
It is important to note that the three components must all be present to overcome the resistance to change in an organisation. If any of the three is zero or near zero, their product will be zero or near zero, and the resistance to change will dominate.
Tools: “What’s In It For Me?” Framework

- Identify key people or groups e.g. those for, those against, neutrals
- For each, consider positives and negatives of “what’s in it for me?”
- What could they do to support or prevent the change?
- What might we do to
  - Reduce non-compliant activities
  - Encourage and support compliant ones?
Tools: Force Field Analysis

State Desired Change Here

EQUILIBRIUM OR CURRENT STATUS

DRIVING FORCES

Forces favouring the change

RESTRAINING FORCES

Forces resisting the change
## Tools: Commitment Mapping

<table>
<thead>
<tr>
<th>People</th>
<th>Oppose It</th>
<th>Let it Happen</th>
<th>Help it Happen</th>
<th>Make it Happen</th>
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</thead>
<tbody>
<tr>
<td>PCT Board</td>
<td>X</td>
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<tr>
<td>Chief Exec</td>
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<td>Clinical Gov Lead</td>
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<td>Nurse Lead</td>
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<td>Quality Facilitator</td>
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<td>Dr A</td>
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<tr>
<td>Dr J</td>
<td>X</td>
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</table>
Carrots and sticks

- It’s good for CQC
- It’s good for appraisal and revalidation
- Consider local financial incentives to kick-start the process
- Publicly commend and congratulate your highest contributors
And remember ...

“Leadership is the art of getting someone else to do something you want done because he wants to do it.”

*Dwight D Eisenhower*
## Action planning

<table>
<thead>
<tr>
<th>Who?</th>
<th>By when?</th>
<th>Next steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recruit GPs/practices</td>
<td></td>
<td>Think about any additional skills/support you will need</td>
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<tr>
<td>Deliver SEA training</td>
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<td>Support NRIS data collection</td>
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*Note: The table is incomplete and some entries are placeholders.*
Action Planning – additional prompts

1. Who will be the clinical champion?
2. Which practices will lead the way?
3. Will there be an incentive?
4. How will the CCG get access to the SEA?
5. Is there a local risk management system (eg Datix*)
6. How will the feedback loop be closed?
7. What support do the practices need?
8. How will the support be delivered?

* Other risk management systems are available.
Summary and close

- Named contact for each CCG
- Copies of action plans
- Addressed envelope
- Returned in 1 month with invite to set a date to talk with us
- Report back in 3 months and 6 months
- QI Silver for Teams – 10 November 2015

# SEAsforSafety
Thank you for attending

Please complete the evaluation form in your pack, and return your badges before leaving.
Contact Details

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