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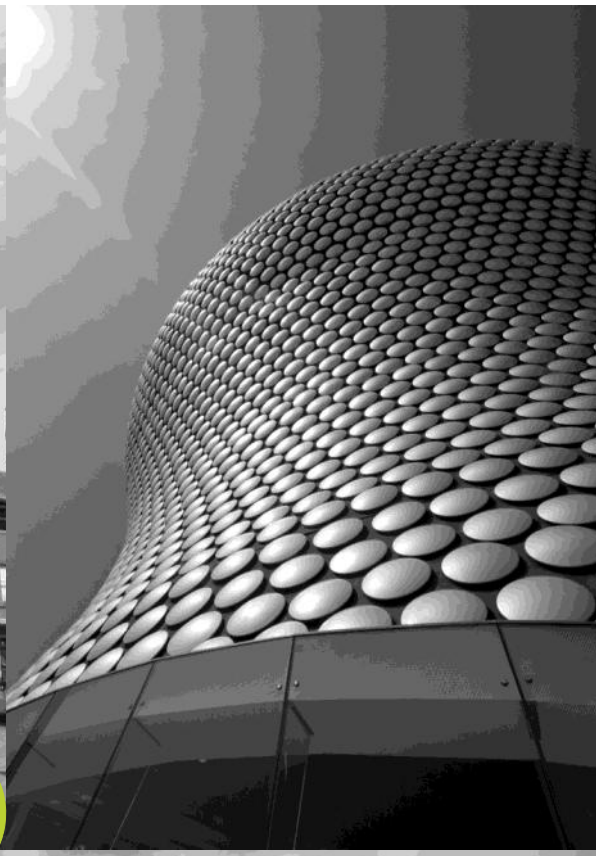
ACADEMIC HEALTH SCIENCE NETWORK



Sign up to Safety - A West Midlands Patient Safety Collaborative workshop output report

Background

The West Midlands Patient Safety Collaborative

The West Midlands Patient Safety Collaborative (PSC), hosted by the West Midlands AHSN, aims to improve safety and continually reduce avoidable harm by supporting organisations in working together to develop, implement, share and spread proven safety interventions that are based on rigorous, evidence-based scientific methodologies.

The collaborative will focus on co-design and co-production with stakeholders and the proposal is to spread successful innovative approaches through a networked approach. The Sign up to Safety campaign is a key component of the work being carried out by the PSC in 2015/16, along with pressure ulcers.

Sign up to Safety

Sign up to Safety is designed to help realise the ambition of making the NHS the safest healthcare system in the world by creating a system devoted to continuous learning and improvement. This ambition is bigger than any individual or organisation and achieving it requires us all to unite behind this common purpose. We need to give patients confidence that we are doing all we can to ensure that the care they receive will be safe and effective at all times.

Sign up to Safety aims to deliver harm free care for every patient, every time, everywhere. It champions openness and honesty and supports everyone to improve the safety of patients.

Sign up to Safety's three year objective is to reduce avoidable harm by 50% and save 6,000 lives.

The five Sign up to Safety pledges

1. **Putting safety first.** Commit to reduce avoidable harm in the NHS by half and make public our locally developed goals and plans
2. **Continually learn**. Make our organisation more resilient to risks, by acting on the feedback from patients and staff and by constantly measuring and monitoring how safe our services are
3. **Being honest**. Be transparent with people about our progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong
4. **Collaborating**. Take a lead role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use
5. **Being supportive**. Help people understand why things go wrong and how to put them right. Give staff the time and support to improve and celebrate progress.

Purpose of the event

This event , held on 19 June 2015 in Birmingham, was aimed at Sign up to Safety and patient safety leads at NHS provider and commissioner organisations across the West Midlands. There were talks, workshops and guidance for getting involved and for those already engaged with the campaign.

Agenda

9.30am Registration, tea and coffee

10am Opening welcome and housekeeping
Professor Gavin Russell, Interim Patient Safety Theme Director, West Midlands Academic Health Science Network

10.05am The Sign up to Safety campaign
Owen Bennett, Patient Safety Programme Lead, Nottingham University Hospitals NHS Trust

10.35am The West Midlands' Sign up to Safety priorities
Professor Gavin Russell

10.50am What's the role for the Patient Safety Collaborative in Sign Up to Safety?
Pete Jeffries, Senior Projects Manager, Birmingham Children's Hospital NHS Foundation Trust

11.15am Tea and coffee

11.30am Human factors
Trevor Dale, Atrainability

12.10pm Q&A
Chaired by Professor Gavin Russell

12.30pm Lunch and networking

1.15pm "Did you know..."

- Safer clinical systems: a paradigm shift in our approach to patient safety—Professor Peter Spurgeon, Director, Institute of Clinical Leadership, University of Warwick
- Demystifying safety cases: concepts and misconceptions—George Despotou, Assistant Professor in Health Informatics, University of Warwick

2.15pm Parallel workshop sessions and brief feedback

- Getting started on Sign up to Safety—Owen Bennett
- Pressure Ulcers—Susan Mason, Tissue Viability, Clinical Lead, Staffordshire and Stoke-on-Trent Partnership NHS Trust
- Handover—Pete Jeffries
- Patient Safety and innovation—Lucy Chatwin, Head of Programmes, WMAHSN

2.50pm Event summary and next steps
Professor Gavin Russell

3pm Close

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Feedback from the workshop

Q. Who were the stakeholders who fed into the priorities?

A. There were two sources: Colleagues we linked in with across the region who had already been in contact with us, which was a representative sample across the region, and we also have a comprehensive database. We also engaged with colleagues who attended our symposium event in October. It was a whole mixture, but if we had had more time we would have taken a more comprehensive approach.

Q. I think that if you had gone to clinicians, you would have had a different set of priorities; ulcers, yes, but cultural and human factors too. If you change the culture, you aspire to excellence; not just not doing harm, but not accepting that the organisation is not doing well with patient safety. Just by focusing on, for example, pressure ulcers, implies that this is a nursing-led initiative.

A. We did have doctors and nurses involved, but we are trying to get across that culture and human factors are paramount, but there are areas specifically where we can work.

Q. What are the successes we can learn from? Organisations tend to work in isolation so we don't hear of successes, only the negative elements.

A. I agree. Our ability to link people up is another strength of the Innovation and Adoption Management Service. We also tend to look at what went wrong, but we need to also look at what went right and see both sides of the coin.

Q. The NHS is very good at work-arounds, but the system lets them down. The PSC should look at pathways—primary care and community included.

A. When people do this, it can be very positive.

Q. But the process is wrong—people develop work-arounds but when those people aren't there, that's when problems start to happen.

Q. I wondered where you are going with metrics, to show if things are working.

A. The honest answer is that we don't yet know. We are scoping what exists at the moment, as this is obviously very important. It is difficult to define the metrics before you have established an approach.

Q. There's an opportunity at the front end to try to discover the scale of issue, otherwise it won't look like you're being successful; this may only uncover problems though.

A. There is a lot of uncertainty in the system. NHS IQ is developing a measurement unit, which will be funded through top slicing AHSNs, but we already have a lot of data available locally; however, it is a question of resources to go through this. There has to be a balance of what we need to do, the data available, and what resource we put in or gain support from NHS IQ to support AHSNs in doing this. There is a £22billion funding gap in the NHS, so we don't want to throw the baby out with the bathwater!

Q. Metrics are important locally, and are a way of getting people on the shop floor engaged.

A. I agree. There are several examples from the south-west where powerful, local information can show improvement.

Q. Some time ago, in 2003 I did a similar presentation to Trevor. Here in 2015, we are still talking about the same things. We have been on this mission for years; I wish I had a magic wand. It is changing, though.

A. We are getting people to change. The message is getting out there and gaining momentum.

Q. You have hit a couple of nails on the head. In my organisation, the culture is a blame culture. Near misses get missed as we focus on SUIs. I want internal incident reporting which brings about change. The culture of accepting poor behaviours of senior people is a stumbling block to change. You need conversations at top level. We allow them to continue to practise and they are not challenged, which has massive effects on the department.

A. The Department of Health has published guidance on HIA oversight. It is almost always the system, not the individual.

Q. I think having patient safety on undergraduate programmes is a good idea. How do we get HEIs to get it on syllabuses?

A. You can't do training in half an hour; it is intensive.

Q. Human factors training would give people the confidence to challenge.

Q. One of the issues is having a culture that allows you to challenge. We can give nurses and HCAs tools, but when we have doctors who are allowed to continue, that puts them into a very difficult situation. People do not challenge consultants because they are scared.

Q. How do we get safety factors into training?

A. One of the workstreams at HEWM is human factors training for nurses. There are two key areas: raising concerns and embedding safety. Some of the issues, such as overnight hydration, are picked up through the quality assurance process. It's not perfect but learning is happening.

Q. Will that happen quite quickly?

A. We are looking at getting the course validated by the RCN.

Q. What are your thoughts around the safety thermometer? I accept that it has limitations.

A. It is too simplistic and it does not tell us enough.

Q. I can imagine a lot of cases where implementing safety cases would be like opening a can of worms. What happened to the information? I am not sure that my organisation would like un-safeness articulated to them!

A. Safety cases are only a driver. You also need a risk assessment, to evaluate risk critically. You should have a quality and risk procedure which is feeding into the system, and you should be alerting the organisation if this is not working.

Q. Would it be worthwhile to do regional safety cases, to avoid duplication, or to come up with innovative solutions?

A. Yes, this would be good for the evidence base.

Parallel workshop sessions feedback

Handover—Pete Jeffries

Q. Are lessons learnt regarding safety in Hospital at Night Handover applicable to all handover scenarios?

The project team felt that there were key pieces of learning that could potentially be transferable and scalable to other healthcare handovers. Human factors and situational awareness issues would probably have common themes, and issues around the fidelity of written information are likely to be common where electronic systems aren't used. There is a note of caution, however, that a key piece of learning was just how contextual some safety issues are. The diagnostic process undertaken at Birmingham Children's Hospital, using tools that teams hadn't used before, did point to hazards that weren't located where teams' initial thoughts on handover safety had indicated they might be.

It's likely the work undertaken suggests a set of principles that can be applied to 'diagnose' and resolve risk in handover, rather than an easy set of intervention that can be lifted and used in all other contexts.

Q. Did you encounter issues around junior team members ability and confidence to challenge information?

Yes we did, the handover bundle we put together which was meant to be the cultural/behavioural 'toolkit' included an assertive challenge tool for this reason. However, the cultural/behavioural interventions were the elements we struggled most to implement and we would suggest this is a longer haul and timeframe to influence, compared to implementing an electronic handover tool.

Q. Do you think the electronic handover tool is sustainable?

Experience suggests it will be. Clinical teams like the tool and can see the value it adds. It almost began to go 'viral' and their is a struggle to keep the scope under control, as teams see it has multiple potential uses outside of its handover safety function.

Patient safety and innovation—Lucy Chatwin, Head of Programmes, WMAHSN

Q. What does innovation mean to you?

- We have lots of input—creative ideas, things that have been tested.
- New uses for old things.
- New ideas.

Q. Who is responsible for innovation?

- Specialist teams
- Everyone in the system.

Q. What will you need from the Innovation and Adoption Management Service for patient safety?

- It's difficult to know what's going on in our own organisation and department, let alone regionally. We ask in the department for solutions.
- We go through Datix reports, uncovering glimpses of brilliance such as "meet, greet and treat", which can from an ex-porter HCA.
- If I have a brilliant idea, who do I tell?
- Repercussions for patient safety, patient experience and organisational reputation are massive.
- A regional collaboration approach to help influence and develop.
- How do we disseminate good ideas?

Getting started on Sign up to Safety—Owen Bennett

The main items of discussion were:

- How individuals can Sign up to Safety
- What it means to sign up and pledge as an organisation and how to—via the website
- How to progress to having a three year safety improvement plan that is locally owned and with measurable outcomes—guidance on website.

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