FOR HEALTHCARE LEADERS
HSJ
Nursing Times
SAFETY
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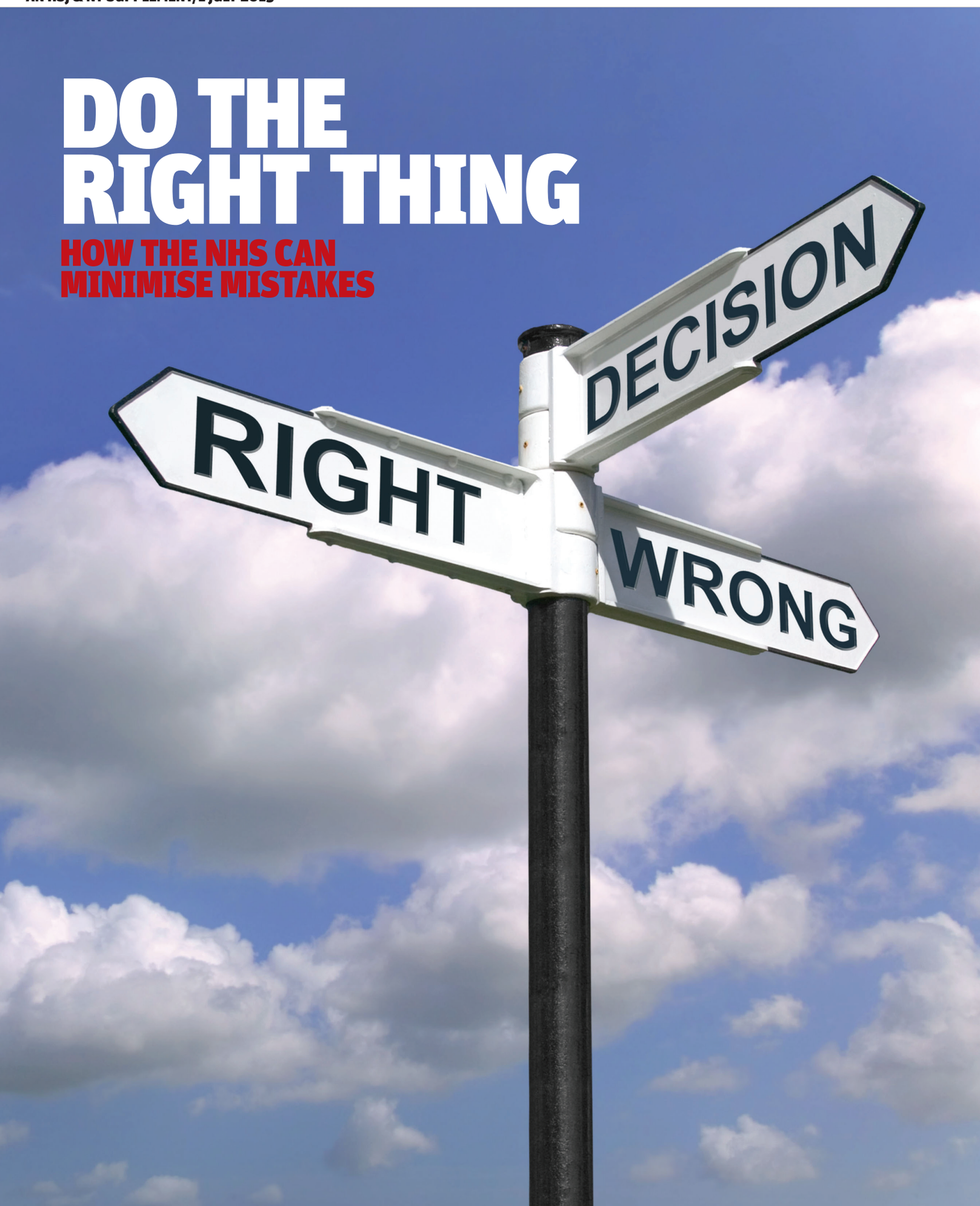
DO THE RIGHT THING

HOW THE NHS CAN MINIMISE MISTAKES



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Since the Francis report, safety is probably the number one concern for the NHS. Experts are urging a new culture of openness and transparency. Staff need to feel free to voice concerns and trusts must learn from other safety critical sectors such as aviation and the nuclear industry. Regulation also needs to more effective. Page 4

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The Sign up to Safety campaign asks staff to identify their own safety improvement goals, creating a network of shared learning and bringing a whole system approach. Page 15

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Research suggests that bringing in the barcode technology widely used by retailers to track products could cut adverse events in healthcare. Barcode scanning will allow the NHS to see exactly which product, from drugs to operating instruments, has been used with which patient and when – and to act swiftly if any batch puts patients at risk. Page 11

PARTNERSHIP

Launched last October, patient safety collaboratives bring together stakeholders including universities, the third sector and industry. Led by academic health science networks, PSCs aim to improve and measure progress on safety but, crucially, also to share learning and best practice. Page 20

FOREWORD

Jenni Middleton

Welcome to the *Nursing Times* and *Health Service Journal* Patient Safety Supplement, published to accompany the Patient Safety Congress 2015 in Birmingham.

I am delighted to be collaborating with my colleagues in *HSJ* and the congress to present to you some not just best – but excellent – practice in patient safety.

Equally, I am delighted that this supplement emphasises it is not just nurses who are now responsible for introducing and implementing patient safety initiatives.

Many of the organisations that we are profiling in these pages have introduced projects that have involved the whole team. It is vital that we remember that colleagues who work in finance or managers who are in leadership positions are as important to successful implementation of these safety initiatives as their clinical peers. Patient safety is everyone's business – and all healthcare staff should remember that the patient or service user must be at the heart

'People in healthcare must feel able to admit they have done things wrong and be prepared to put them right'

of every decision, and nothing is more important than their safety.

If the NHS and independent healthcare colleagues are to put safety first, they must embrace the concept of learning from mistakes. This requires honesty, feedback and the courage to challenge poor practice or decisions.

Healthcare must become a place where people feel able to admit they have done things wrong, and are prepared to put them right or change in order to ensure errors are not repeated.

This has been the backbone of *Nursing Times* Speak Out Safely campaign, which encourages all organisations to create a culture where staff feel able to speak up and raise concerns.

If you haven't signed up already, I hope you consider doing so today and becoming one of the 150-plus organisations who support our ambitions for a safer NHS. More details are at nursingtimes.net/sos. In the meantime, enjoy this supplement and the Patient Safety Congress. ●

Jenni Middleton is editor of Nursing Times

Shreshtha Trivedi

By the time you read this supplement, the health service will be getting ready for the Patient Safety Congress and awards, which are being organised jointly by the *Health Service Journal* and *Nursing Times* for the first time.

We hope the two-day event will be a useful platform for leaders, doctors, nurses, managers, other healthcare professionals and service users to share ideas and learn from best practice.

It is an interesting time for the NHS as it stands at a crossroads. In the aftermath of Francis, patient safety has been a top priority of many trusts and GPs across the country. However, after the general election this year, it looks like making efficiency savings will become the main focus again.

While tensions will emerge sometimes between efforts to reduce the deficit and ensure the safety of patients – the latest announcements on limiting agency staff spend, dropping two waiting time targets and the suspension of work on safe staffing levels are cases in point – it should now be

'It makes both ethical and business sense to deliver safe care'

clear that ignoring safety to chase financial or other targets is counterproductive in the long run, as Mid Staffs, Morecambe Bay and several other disasters confirm.

The financial, emotional and reputational costs of poor care are considerable, so it makes both ethical and business sense to deliver safe, effective and patient-oriented care. And this need not be reliant on fancy care models or increased spend.

Most experts, as you will read in these pages, suggest a no-blame culture, where staff are encouraged to raise safety concerns and admit mistakes, is the biggest game changer. Of course, patient safety can't be improved in a silo without looking at quality, clinical effectiveness, patient and staff engagement and a system-wide approach.

This supplement shines a light on some of the new approaches around patient safety, outstanding work by some organisations and what should be the way forward. You might find certain ideas radical while others might look familiar – however, we hope you will find it an insightful and enjoyable read. ●

Shreshtha Trivedi is commissioning editor at HSJ

OVERVIEW

TO ERR IS HUMAN...

...but dangerous mistakes can be minimised. Shreshtha Trivedi on the journey to a safer health service, including following the lead of industries such as aviation, introducing an open, no-blame culture and scrutinising the whole patient pathway

The financial, emotional and reputational costs of poor care are considerable. The Mid Staffs scandal was a watershed, not only highlighting appalling care standards at the hospital but also fundamentally changing how patient safety is viewed within the NHS.

In response to the Francis report that was triggered by Mid Staffs, Professor Don Berwick's review into patient safety called on the NHS to become a "system devoted to continual learning and improvement of patient care, top to bottom and end to end".

But are the levers in place to enable this to become a reality?

Poor care is expensive and demoralising, both for patients and staff. While the tension between driving efficiencies and ensuring safety of patients – not least with regard to staffing levels – should not be underestimated, it is now clearly understood that ignoring safety to chase financial or other targets is counterproductive in the long run. Recently NICE's decision to suspend its work on nurse staffing levels, in a departure from the recommendations of the Francis report, has generated criticism from workforce and safety experts.

And reducing harm need not be reliant on increased spend, as experts seem to agree that it is the change in culture – with greater openness and transparency – that is the biggest game changer.

Umesh Prabhu is medical director at Wrightington Wigan and Leigh Foundation Trust, which won last year's *HSJ* award for patient safety. Dr Prabhu, along with his team, has been widely credited for turning around the culture of the trust and making patient safety its top most priority.

He is a firm advocate of "value based leadership", focusing on robust governance and a no-blame culture.

"The trust should define its values – what it stands for and appoint the right people on the board. There should also be leadership training for each and every member of the board, in addition to [training] on patient safety: what is it, how to collect evidence, how to challenge non-executive directors," Dr Prabhu says.

He also puts equal emphasis on the importance of staff and patient engagement and acting on their feedback. According to Dr Prabhu, he met all the 1,800 staff in small batches, sought their opinion and suggestions and made organisational changes to reflect these, which included empowering the staff, taking on bullying and racist consultants and ousting ineffectual senior leaders.

The trust has 220 patient safety champions – including doctors, nurses, administrative clerks and porters – working on improvement projects, with the help of data from incident reporting systems, investigations, safety surveys and audits.

The approach seems to have worked for the trust as it has seen impressive results. Patient harm has been reduced by 86 per cent (from 516 in 2007-08 to 73 in 2014-15) and the hospital standardised mortality ratio has fallen from 126 (2007-08) to 86.3 (up to February 2014), he points out. It has been reported that 98 per cent of patients are free of hospital-acquired harm, and patient and staff satisfaction has improved.

However, the important question is how to replicate such success – from a single setting to a system-wide perspective. Patient safety can't be improved in a silo, without looking at quality, clinical effectiveness and a whole system perspective. And it needs a joined up approach.

It is here that campaigns such as Sign Up to Safety can make a difference, taking a bottom-up approach by asking organisations to sign up to a series of pledges and create their own safety improvement plans (see page 15).

'Patient safety can't be improved in a silo without looking at quality, clinical effectiveness and a whole system perspective'

Suzette Woodward, the campaign director, told *HSJ* that they don't want to tell organisations what to do, instead letting frontline teams work on issues that matter to them. "It gives organisations permission to take their time and work on their plans over the next three to five years rather than feel pressured to do something quickly. This is about sustained change rather than transient change."

Sign Up to Safety leads across the country have created a network of shared learning – essential for improving safety and quality. The campaign has already gathered huge momentum with 260 organisations joining within a year of its launch, which includes mostly acute trusts but also clinical commissioning groups, mental health and community trusts, academic health science networks (AHSNs) and GP surgeries, among many others.

Listening process

The role of patients and staff in improving patient safety can't be overestimated.

Andrew McCulloch, chief executive at Picker Institute Europe, warns that disengaged patients will have a negative impact on safe delivery of care. "If patients are disempowered, having a negative experience generally, or not speaking up when something goes wrong, they are threatening their own health. [It's] exactly the same with staff: demoralised staff are

Right turn: the NHS needs to make it more difficult to do the wrong thing

less likely to go through staff practices, and are less likely to engage with patients. It's one big story."

He highlights that, just like any other industry, consumers or patients have knowledge of the system from a different perspective to the provider and their knowledge can be critical to improvement. "Clinicians dip in and out of patients' lives so most of the care is provided by other staff, patients themselves and/or their carers. So all these stakeholders should be engaged."

Mr McCulloch believes that the Francis report has been very helpful in creating awareness of a patient-centred culture, which, he says, can be traced back to Lord Ara Darzi's review *High Quality Care For All* in 2008. However much more needs to be done.

"Safety, patient experience, clinical effectiveness are all interrelated – you have to address quality as a whole," he continues.

"Northumbria is a leader in patient experience and Salford is a leader in clinical engagement. [But] in order to be leaders, they are doing other things well too," he says – adding that patients, clinicians and managers have to come together to bring about change.

Human factors

The concept of human factors is often cited to understand how healthcare can improve its processes, and learn from other safety critical industries such as aviation and nuclear energy.

Martin Bromiley is an airline pilot and chair of Clinical Human Factors Group, an independent organisation of healthcare professionals, service users, managers and human factors experts from health and other high risk professions. He describes human factors as "all those things that affect our performance when we are at work. The variability in output of humans is human factors – the variability in health is around human factors. Anything that affects our performance – [it] can be around environment, cognitive thinking, systems and processes."

In 2005, Mr Bromiley's wife Elaine died as a direct result of medical errors during a routine operation. Following her tragic death, Mr Bromiley sought an independent investigation, which revealed she had died due to simple errors and absence of standardised safety procedures – and not because of incompetence of doctors. Since then he has been a passionate advocate for using human factors in improving safety culture in medicine.

He says understanding human factors is about "making it easy to do the right thing".

But why was healthcare so late in embracing the concept of checklists and standardised protocols, which make it difficult to do the wrong thing? The answer may lie in its history.

Mr Bromiley points out that other high risk industries such as nuclear and aviation are relatively modern, whereas medicine is much older.

He explains: "Two hundred years ago surgeons didn't need nurses, anaesthetists – they worked on their own. In the last 100 years, healthcare has realised that it is no good performing a brilliant piece of brain surgery if the person is dead a week later because they haven't been hydrated or they suffered a post-operative infection.

"Instead of looking at individual component and training for individual component of technical expertise, healthcare needs to focus more broadly. The [main] emphasis is on technical skills, so we haven't focused on non-technical issues and the whole patient journey and experience."

Another major difference is a culture of transparency and admitting mistakes openly.

Mr Bromiley uses the example of how GP surgeries/hospitals communicate test results to patients to illustrate his point.

"They say if we don't call you, it's OK. Any other safety critical industry would say that's the wrong way to do it. For a fail-safe system, they should call you if everything's all right and, if they don't call, please be in touch. It might be something is wrong but they might have mislaid the info/file. You have to assume failure happens.

"I have just finished three days flying with a colleague. I'm in command of the aeroplane, I'm the captain, and at numerous points my junior colleague reminded me that I've forgotten something or the other. And my response every time was 'thank you'. The way of thinking is that error happens all the time, so we design systems to make it difficult to happen and, if the error does happen, then we have multiple systems to stop it from becoming harm."

He says healthcare tends to look at what happened but doesn't understand why. "It gives you victims but not proper answers. In

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a perfect system if something goes wrong, it must be the doctor's or someone's problem."

But isn't healthcare a more complex industry with a wider set of specialities and conditions to deal with? Mr Bromiley agrees unequivocally but says that this makes it even more important to pay attention to details. "The reality is we won't improve patient safety until and unless we get to grips with the final frontier of safety in healthcare, which is human factors."

He adds that healthcare has made great strides in this area in the recent past and perhaps the important thing to learn now is how to get better at assessing individual skills and defining specific good behaviour. "My objective assessment is done both in a simulator as well as during flying on technical and non-technical skills. And those skills are very well defined – it's not just safely landing a plane."

Targets versus safety

Besides the obvious, ongoing conflict of staffing levels and safety, there is the added component of time targets too.

Darren Kilroy is clinical head of service for emergency care at East Cheshire Trust. According to him, the challenge lies in how to balance the need for time targets (four hour targets, mainly) in care with the need for absolute safety in care.

"In a situation like urgent care, where you are working against the clock, it is incredibly challenging for clinicians to be able to work efficiently while keeping safety at the forefront of their minds. This is especially true for trainee docs and junior doctors, who are trying to learn the craft, and need good role models. It is challenging in modern, urgent care systems to give them good role modelling when they are very conscious of time but want to do work to the best of their abilities.

"We need to think of smarter measures which focus on timeliness but also safety of care. For me one of the best measures of safety and timeliness is time taken for a patient to be seen by a competent and proficient clinical decision maker and not just any practitioner."

NHS England announced last month that it is dropping admitted and non admitted elective waiting time targets, as they are creating "perverse incentives". However the main accident and emergency target – seeing 95 per cent of patients within four hours – will be retained.

But can we do away with time-based targets, which have gone a long way in reducing inefficiency in planning and resources? Dr Kilroy agrees they have been beneficial but says urgent care systems "have reached a pinnacle so there are no more efficiencies to be squeezed, at least here".

There is also immense concern around staffing deficits, both in terms of nurses and doctors, which he believes will become their main challenge in five years.

Pre-flight checks: industries such as aviation can show the NHS how to minimise mistakes

"[The] agency staff [issue] tells us where we have gone wrong. We should have a system of rewarding our staff who want to work extra hours without paying agency rates... we should reward them by making their workplaces places to be, [we should] make them happy.

The problem will not be solved by more hirings as it takes years to train clinicians. Rather the focus should be on raising the bar on quality of care and support from systems and local leadership – you should look towards your clinical leadership to support and develop you to raise safety issues," Dr Kilroy says.

Role of regulation

Regulation plays a very important role in ensuring safety and minimising avoidable harm in any safety critical industry, and healthcare is no exception.

After the Bristol Royal Infirmary scandal, the need for scrutiny, monitoring and regulation of clinicians led to the formation of the Commission for Healthcare Improvement, which was followed by the Healthcare Commission in 2003. However, in order to reduce the number of regulators and cut costs, the Care Quality Commission (CQC) was established, bringing together the Healthcare Commission, Commission for Social Care Inspection and Mental Health Act Commission.

'We need to think of smarter measures which focus on timeliness but also safety of care'

The CQC today is the health and social regulator of all services in England, making sure they provide safe, high quality and effective care to all patients and service users. Despite a troubled past with allegations of bullying, mismanagement and excessive bureaucracy, the NHS watchdog is optimistic that it has a key role to play.

James Titcombe is the national adviser on patient safety, culture and quality at the CQC. A former nuclear engineer, Mr Titcombe's spirited campaign over the death of his newborn son Joshua in Furness General Hospital in 2008 resulted in the Morecambe Bay inquiry to review the management, delivery and outcomes of care provided by the maternity and neonatal services of the University Hospitals of Morecambe Bay Foundation Trust.

He outlines the CQC's vision and action points, saying the next few years are critical to carry forward the movement around safety. "If you look at CQC's inspections so far in hospitals, we find that safe domain is the area (the CQC investigates care standards under five domains: safety, effectiveness, caring, responsive and well led) that requires most improvement.

"There is a big move towards duty of candour and we would be looking at that. Obviously we've got new fundamental standards now for the first time so we can go

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‘There is something there in the use of technology for smartly capturing data which can be used to drive safety’

for prosecution without issuing warning notices. For me there has been a big focus on investigation and quality of learning and that’s where I’d like to see most improvements.”

In March this year, the House of Commons public administration select committee’s report called for a national independent patient safety investigation body, stating that the cost of this body would be relatively small, compared to the costs and liabilities arising from clinical incidents at present.

Mr Titcombe believes the investigation body should be different from the regulator. He says, if we look at evidence and at industries such as aviation, there are powerful reasons why there is a need for an independent body to investigate very big systemic problems.

“The Francis and Kirkup inquiries are big, but started a few years after the incident, and by that stage it’s about 90 per cent looking back and 10 per cent looking forward. We want those investigations to happen sooner,” he continues.

“Too often the response in the past has been defensive. Once there is a complaint, you’re already in the wrong place. Safety incidents should be different from complaints. The response should be less adversarial and more working together. Trust breaks down when avoidable harm happens so we need to restore that trust through our response.”

Equally, he calls for a no-blame culture and supports human factors being used in investigation. He cites the open culture in aviation and nuclear industries, where people are “actively rewarded for raising concerns and safety observations”.

He gives the example of Brighton and Sussex University Hospitals, where, under the guidance of their patient safety ombudswoman Delilah Hesling, the trust has given its first award to a member of staff for raising a safety concern. He says commissioners, providers, clinicians and other professionals, regulators and service users need to work together to drive improvement, pointing out the “CQC is part of the system, not the answer on its own”.

“I was there during Morecambe Bay in 2010 and have seen what happens when we don’t have an effective regulator. I still sadly meet families whose loved ones have suffered harm and have had a bad experience. Last week, I met a guy who lost his baby, similar to Joshua. The first two investigations by the trust kept him on the side, treating him as complainant.”

“I passionately believe in the value of robust regulation,” he concludes. “We have started to make a difference.”

Healthy dialogue: NHS staff must feel free to raise concerns and highlight mistakes

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IT investment

Kaiser Permanente is frequently invoked as a shining example of a patient-centric, preventive model of care worth emulating by the NHS organisations.

The US healthcare group has been a leading light in integrating patient safety with organisational culture – with its organisations making it their number one priority. Their track record in reducing newer events, driving rigorous performance improvement and implementing regular system checks have made them the safest care organisations in the world.

However, there are many who argue that the comparison is unfair, as the NHS and its values and structures are different from a fee-paying, market-driven American system. They ask if it is feasible to implement best practice from the United States to our publicly funded healthcare.

Dr Prabhu says it’s a “misconception that Kaiser provides safe care at low cost – the US spends 16 per cent of its GDP on health”. However, he can’t praise them enough for having a fantastic IT system.

“They have spent $4bn over a period of 10 years on IT – it is a great system, which has made audits and performance management easy. Say there is a clinical group of 20 doctors and a senior doctor as its head, the system will send automatic reports every month to the head doctor on other clinicians’ performances on a number of criteria – such as number of patients seen, drugs used, investigations done – making it easy to spot the outliers.” He adds that relevant information about all patients is available to doctors on their iPads, which helps them to monitor their conditions effectively.

Dr Kilroy too rejects the comparison with Kaiser, but calls for greater use of data and technology in improving patient safety.

“Whenever I have gone to the coroner’s court over the years to represent junior staff as a consultant, the things that get flagged up again and again in clinical care are not fancy pathways, brilliant care models or expensive diagnostics but massive gaps in documentation of patient notes and in the diligence with which they are completed. There is something there in the use of technology for smartly capturing data which can be used to drive safety and improvement.”

It often takes a disaster to bring about real change and the NHS is no exception to this. But has there been a seismic shift in priorities, truly placing the need to deliver safe and high quality care above balancing the books? The debate continues. ●

TECHNOLOGY

RAISE THE BAR

Supermarkets can track products that have been declared unsafe immediately, so why can't hospitals? Claire Read on the uses of barcode technology

Trace metals: barcode systems can tell you which instruments were used with which patients

When food inspectors announced that they had found traces of horse meat in frozen beef burgers, supermarkets quickly removed any affected products from their shelves. Stock control systems, based on barcode scanning, meant that retailers knew at the touch of a button whether they had any affected products in store.

The previous year, 2012, a report found that breast implants made by French firm Poly Implant Prothèse (PIP) had double the rupture rate of other implants. Around 300,000 women around the world – 47,000 of them in Britain – were believed to have received the defective prostheses. No one knew which women, however. The lack of a standardised barcode system in healthcare means that it was impossible to know into whom the faulty implants had been placed.

The two contrasting scandals offer a clear insight into the value of standardised barcode technology. The ability to track where products are – and where they have been used – makes recalls significantly easier.

'No one knew which women had received the defective breast implants'

When the Department of Health issued its e-Procurement Strategy in April 2014, barcodes were a central theme. Indeed, the implementation of a standard barcode system – based on GS1 standards, which mean codes can be read globally at any point in the healthcare supply chain – was mandated by the strategy. One of the major reasons: the patient safety benefits.

"There are three core enablers which allow patient safety: the identification of a person, the identification of a product, and the identification of a place," explains Glen Hodgson, head of healthcare at GS1 UK, which brings together 28,000 organisations working across different sectors and helps

GLEN HODGSON ON BARCODING

Against the backdrop of a growing and ageing population, a sustained period of austerity, intense performance scrutiny and increasing patient empowerment, there is consensus that transformational change is needed to put the patient back at the heart of the NHS.

This means a fundamental shift to integrated, patient-centric care provision, focusing not on short term activity targets, but measurable patient outcomes. To achieve this, the NHS must embrace new technologies to provide seamless healthcare provision, centred on patient needs, both inside and outside the hospital setting.

GS1 barcoding standards provide the foundation for this technology – delivering integrated patient care in the NHS by enabling the globally unique identification of each person, product and place.

Because GS1 standards are system agnostic, they enable the exchange of information between different care providers and systems, no matter where or when a patient receives care. This certainty results in reduced errors and improved patient outcomes. Through unique identification everywhere along the patient pathway, it is possible to significantly improve the quality and safety of care.

And these same identification standards also deliver enormous efficiency savings throughout the healthcare supply chain and procurement

'In the retail sector, food is traceable from farm to fork'

and inventory management processes. Great progress has been made since the Department of Health's e-Procurement strategy was published last year, mandating the use of GS1 standards throughout the NHS.

These standards are also integral to the Personalised Health and Care 2020 framework, and will be central to the Carter review into efficiency, which will require the NHS to achieve more with less.

Many departments and processes that benefit from the use of GS1 standards have been identified. There are examples throughout the NHS where benefits are already being realised. But there is still much to be done, and we are working alongside the Department of Health and NHS England to support trusts with the sustainable implementation of GS1 standards.

The GS1 barcode has transformed the retail sector over the last 40 years – ensuring food is traceable from farm-to-fork and delivering savings that run into billions of pounds.

The same standards and barcoding technology are now delivering results throughout the NHS – improving patient safety, regulatory compliance and efficiency.

Glen Hodgson is head of healthcare at GS1 UK

www.gs1uk.org/healthcare

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them use the common language of GS1 global standards.

"What you have with these three core enablers is what I describe as certainty of truth – who did what, to whom, where, when, why and with what. And that means we can prove the equipment is calibrated, we can prove which member of staff administered which dose when, and which product of which batch has gone to which patient."

This degree of traceability is likely to result in significant patient safety benefits. Research from McKinsey suggests that barcode-based scanning procedures cut potential adverse drug events by 51-63 per cent at Brigham and Women's Hospital in Boston in the US, and by 75 per cent at Gelre Hospital in the Netherlands.

When Terence Stephenson chaired a Medicine and Healthcare Products Regulatory Agency review into medical devices, it strongly favoured "a unique identifier for each device used on patients, especially implantable devices". Professor Stephenson, an advisory board member to GS1, explains: "It would allow a 'one stop shop' for healthcare professionals to report problems, as every device would have a unique device identifier and the patient has a unique NHS number."

When Kevin Downs joined the NHS after a career in retail, he found himself "increasingly worried about a lack of appreciation of stock control systems and what they could bring". When he was appointed deputy director of finance at Derby Teaching Hospitals Foundation Trust – he now holds the director role – he was given the opportunity to look at the stock control system. He quickly turned his attention to implementing a barcode system based on GS1 standards, and introducing hand scanning units.

"We scan the barcode on the patient wristband, and then we scan everything that we are using on that patient in theatre. The system then automatically checks from the barcode whether the product is still in date.

"We scan all the prosthesis or implants that we put into a patient, and also scan all the instrumentation. So if at a later date we get a product recall from the manufacturer, we know who we've put the device into, and know how many we've got on the shelf and can automatically stop those from being drawn out of stock. And if we find at a later date that we've operated on a patient who is now thought to have CJD [Creutzfeldt-Jakob disease] or AIDS, we can trace the instrumentation trays that have been used on the patient and that may have been used on another patient after that operation. So I have total traceability back to the patient within seconds."

The trust launched the system in general

Power of technology: retailers can track products precisely across many locations

'Tie this into electronic patient records, and the impact becomes all the more significant'

theatres in April 2014, day case theatres later that year, radiology early this year, and now plans to go to cardiac catheterisation labs. "We can see that the system can go literally everywhere in the hospital," says Mr Downs. "The end game will be [when] we put it on wards." Tie this into electronic patient records, and the impact becomes all the more significant – and in keeping with the direction of travel set out in documents like *Personalised Health and Care 2020*.

Beyond procurement

Mark Stevens also emphasises the wide relevance of GS1 standards. "Although the Department of Health's policy was called an e-procurement strategy, it's a wider ranging document," argues Mr Stevens, service development manager in procurement and e-commerce at Central Manchester University Hospitals Foundation Trust. "It encompassed a lot of things like patient safety, tracking of instruments, inventory management, catalogue management. Because it was called an e-procurement policy, people thought it only affected procurement. But it doesn't – it affects the entire trust." That's why, when the organisation started work on implementing these standards, it created a GS1 group.

"It incorporates all the major areas within the trust, like pharmacy, medical engineering and nursing. So we've got all these people on board so everyone understands the impact it's going to have on their area, and the benefits. It's almost like an internal selling job we've been doing."

Mr Downs took a similar approach, presenting initially to the theatre team about the benefits of the new way of working.

"The hook that got them involved was that this will improve patient safety, because it will tell you at the time if anything is out of date, and give us immediate traceability of any items you use." More than 350 NHS organisations now have some form of GS1 compliance. Mr Hodgson says his organisation is working closely to support trusts in understanding where they are compliant and where action is needed. But he notes a developing understanding of the value of the standards, and the important role they can play in patient safety. ●

Sign up to SAFETY
LISTEN LEARN ACT

STAFF ENGAGEMENT

DO IT YOUR WAY

Daloni Carlisle on a safety campaign that takes a bottom up approach – asking staff to work on areas that matter to them over the next three to five years

Safety in the NHS has been an important topic for a long time. National campaigns on specific actions have made inroads – think of infection control, for example. But, to date, nothing has been able to really embed safety improvement system-wide within NHS organisations. As a result, Sign up to Safety – a campaign with a different approach – was launched a year ago.

It does not tell anyone what issues to tackle but asks organisations to sign up to a series of pledges and identify their own safety improvement action plans with a three to five year timescale.

"I have been in charge of many top down, large scale programmes and they have their place," says campaign director Suzette Woodward. "When I was asked about starting a new campaign, I said this time it has to be different. It has to shine a light on the people who are doing the work."

So far, 260 organisations have joined – that's 100 more than the expectation for the first year (see box, overleaf).

"Our approach is different in that we help organisations create their safety improvement plans from the bottom up," says Ms Woodward. "Rather than being told what to do, frontline teams are working on the areas that matter to them.

"It gives organisations permission to take their time and work on their plans over the next three to five years rather than feel pressured to do something quickly. This is about sustained change rather than transient change." It's an approach that, she says, harnesses the commitment and passion of NHS staff to make care safer (see case studies, overleaf). That commitment is then supported through shared learning – a key ingredient of quality improvement.

Ms Woodward says: "We work through social media, virtual webinars and by getting out and about in site visits. We are using the snowflake model of leadership and spread so that we create leaders across the system. There are now Sign up to Safety leads being developed across the country who are creating this virtual network."

It's been very exciting visiting some of Sign up to Safety sites, she adds. "We have found that it has really captured people's imaginations. A lot of them have launched the campaign themselves so that it belongs to them and not us. They have held launch events, designed posters, hats, cakes, bags, and really embraced the spirit of the campaign. This means that they have engaged with their staff and patients who can see what the organisation is doing to improve safety."

Sign up to Safety does not operate in isolation but works alongside other initiatives such as the patient safety

SIGN UP TO SAFETY PLEDGES

- **Put safety first** Commit to reduce avoidable harm in the NHS by half and make public your locally developed goals and plans
- **Continually learn** Make your 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
- **Be honest** Be transparent with people about your progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong
- **Collaborate** Take a lead role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use
- **Be supportive** Help people understand why things go wrong and how to put them right. Give colleagues the time and support to improve and celebrate progress

DAVID NAYLOR ON KNOWLEDGE CAPTURE

Everybody working in the NHS wants to keep their patients safer. Sign up to Safety is helping project teams to develop practical safety improvement plans [SIPs] and is explicitly valuing their "know how" through "knowledge capture".

Knowledge capture is a method of understanding how individuals turn ideas into effective action and help others to take up this learning in different contexts.

Knowledge capture involves listening, interpreting and recording the practical wisdom people express in their work. It is not instructing or teaching. It is about learning together. People working with patients often know what improvements need to be made. It is this "know how" that people already possess and its translation into practical action that we want to capture, including how context enables people leading those safety improvement plans.

Knowledge capture will make the familiar strange, by enabling project teams to notice the skills and ideas they use to implement their SIPs. The process enables others to notice how any gaps between what teams want to achieve and their capabilities to do so are handled; and to understand how organisational contexts may also limit their progress.

Shared learning is key, with campaign members able to share knowledge through networks, blogs and webinars. A practical knowledge capture method we use is a "webdive". There are four stages. The first is an offline semi-structured conversation with team members. The aim is to get beyond a sanitised narrative and into what people are noticing and learning about implementation. In this conversation we talk about:

- **the scope and discretion people have to lead their SIP;**
- **how governance impacts their work;**
- **how resistance is managed;**
- **how the team keeps going;**
- **how good ideas are silenced;**
- **how people are engaged; and**
- **what the team is learning.**

We then record the SIP story in the team's own words. The third stage is a webinar. The team listen to their recording (in a live online session attended by other participants), offering further reflections and inviting questions.

The final stage is a commitment from other participants to test the team's learning in their own contexts.

Over time the campaign will build a repository of what works to keep people safer in different contexts, developed by those close to patients.

As such knowledge capture is aligned to Berwick's recommendation that continuous learning and the movement of this "know how" around the system, rather than people, is key to safer services.

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www.kingsfund.org.uk

collaboratives (see page 20). These are regional level, run by the 15 academic health science networks, and work to solve intractable problems that cross organisational boundaries.

Another scheme is The Health Foundation's Q Initiative to develop individuals' knowledge and skills across the system and help them share learning.

Cheryl Crocker is regional lead for the East Midlands Patient Safety Collaborative. "We are separate but we are working absolutely in tandem to Sign up to Safety,"

'The biggest challenge is consistent: engaging with primary care, general practice and others in the community'

she says. "We knit things together."

She works closely with Sign up to Safety patient safety leads in individual organisations, identifying their collective priorities and where the collaborative can add value by joining up the dots.

One recent example is work on pressure ulcers. Sign up to Safety hospital leads identified this as a safety issue – but one that was out of their hands. "They have done what they can to reduce pressure ulcers developing in hospitals but were still seeing people admitted from care homes with sores," explains Ms Crocker. "It's an issue for community providers too who are treating patients in residential care."

Now she is working with care homes and nursing homes to implement an internationally recognised audit and improvement tool and to train staff.

Sign up to Safety also has the backing of key organisations such as NHS England, Monitor, the Care Quality Commission, the National Trust Development Authority, the NHS Litigation Authority and Health Education England. This backing comes with support and help to align patient safety activity across the NHS, says Ms Woodward.

Suzie Bailey, development director for Monitor, says: "Our statutory responsibility is to make sure services are safe, effective and patient centred, so building capability for quality and safety improvement at board level is a very important component of our work."

By far the biggest group of organisations signing up so far is acute hospitals. However, Sign up to Safety is for everyone and Ms Woodward is keen to see more primary and community organisations in particular join in. She says: "The biggest challenge is one that has consistently been the same across the globe: engaging with primary care, general practice and others in the community. A lot of the time these types of initiatives are seen as acute focused only.

"We are slowly gaining traction in this area and have 36 clinical commissioning groups and now three GP practices. This may seem tiny but we use these as a way to engage others and grow participation in this area."

It's only a year in and, as the campaign rightly emphasises, improving safety does not happen overnight. But Ms Woodward is hopeful that it could be the breakthrough that embeds a safety culture in the NHS in England. She says: "Sign up to Safety has at last given ownership of improvement to the people who are responsible for delivering safe, high quality care to patients, carers and their families. It is beginning to shift the culture to one of support for people who work in the NHS." ●

ORGANISATIONS SIGNED UP

Total	**260**
Acute trust	137
AHSN	4
Ambulance	7
CCG	36
Community provider	29
GP	3
Mental health trusts	31
Other	13

THE WHOLE JOURNEY

How frontline workers in Nottingham and east London are leading innovations in safety in emergency surgery and mental health

NOTTINGHAM UNIVERSITY HOSPITALS

Safety in emergency surgery is a real and pressing issue and one that Nottingham University Hospitals – a Sign up for Safety trailblazer – is taking seriously.

Victoria Banks, consultant intensivist, explains. "Emergency surgery patients make up 40 to 50 per cent of surgical work but account for around 80 per cent of the adverse outcomes, including mortality," she says. "So they really are a patient group we need to focus on." Dr Jonathan Mole, consultant anaesthetist adds: "Within emergency surgery there is a group who are identified at particularly high risk – those who undergo an emergency laparotomy (where the abdomen is opened). A national audit two years ago showed that the average 30-day mortality rate for these patients was 17 per cent.

"In NUH, between 20 and 35 patients require an emergency laparotomy each month, making it one of the busiest units in the country and providing the potential to benefit significant numbers of patients."

Case reviews had already identified recurrent themes. "We found these included delays in diagnosis, CT scans, and timely arrival to theatre," says Dr Banks.

"Data collected for the National Emergency Laparotomy Audit meant that we could map the success of the initiative and provide meaningful feedback. This in turn helped provide impetus to launch a hospital-wide Emergency Surgery safety improvement programme."

The programme looked at the whole patient pathway. "People tend to focus on the areas they control," says Dr Mole. "We looked at how we could improve the journey as a whole. Reducing risk and improving outcomes for patients in the days and months following involves lots of small improvements along the patient pathway."

Follow the patient: Nottingham's improvement programme looked at the entire pathway

The main driver in the improvement plan was obtaining a thorough and rapid assessment of patients presenting with abdominal pain to identify those at "high risk of death (HROD)" as early as possible and expediting their care.

"It starts at admission when patients are clerked in and are now routinely assessed for high risk factors such as age, signs of sepsis or organ dysfunction," explains Dr Banks. "These HROD patients then trigger an expedited CT scan, scan report and an earlier senior review to obtain a diagnosis and a management plan before they have a chance to deteriorate further."

"The surgical team now routinely score for predicted mortality, allowing them to obtain much better informed consent from patients and their families. When patients get to theatre, there is a new set of evidence-based guidelines for anaesthetists."

This checklist means that optimal care is delivered at all times.

Surgeons use the P-POSSUM scoring system to quantify risk. A high score now mandates a consultant surgeon to operate and means the patient goes to critical care post-operatively.

Since January 2014, overall mortality in emergency laparotomy surgery has dropped from 14 per cent to 11 per cent. Patients are also able to recover more quickly and go home earlier.

The changes are also benefitting other patients having emergency surgery. "One of the things that's been really satisfying is that we are starting to see a cultural change," says Dr Banks.

"Surgeons are starting to change how they make decisions and involving senior people earlier in the decision making process. On call patterns are changing and we are seeing lasting change."

This work, which included a local CQUIN (Commissioning for Quality and Innovation) initiative, initially pre-dated the Sign up to Safety Campaign but, says patient safety programme lead Owen Bennett, the campaign has given it extra impetus. "Sign up to Safety has meant that there is clarity across the organisation around our priorities for safety – emergency laparotomy being one of them," he says. "It's opened up conversations about avoidable harm and the improvement that is already happening and how we can build on it.

"It's meant we can have a more medium to long term approach and has provided a mechanism to share what we are doing and to learn from others."

Dr Mole agrees. "Safety has definitely gone up the agenda.

"The fact that the trust has prioritised this for three years is fantastic and the work we have been doing is now more appreciated trust-wide."

ALAMY

EAST LONDON FT

East London Foundation Trust delivers mental health and community services to some highly disadvantaged people in highly disadvantaged communities. But that has not stopped it taking a system-wide approach to safety and quality.

Amar Shah, associate medical director for quality improvement at the trust, who is also a consultant forensic psychiatrist, explains: "For several years we have been building the case for a new approach to quality and safety. We have been learning from different places around the world that have been using improvement methods to achieve a change in culture."

The team visited different care settings, in the UK and abroad, to look at how other organisations have built quality improvement and safety into their day to day work. In February 2014, the trust launched its QI programme with the mission of supporting the organisation to provide the highest quality mental health and community care in England by 2020. This sets two aims of reducing harm by 30 per cent a year and providing the right care in the right place at the right time.

Dr Shah says: "We have been thinking creatively with teams about the ideas they could try, we have been skilling up our staff and service users and aligning the organisation around our improvement goals.

"Our approach is to help teams with some of the things that matter to them; to help them find the space to tackle them and the skills, tools and senior support to get on with it." Clinical, admin and corporate teams have taken up this work enthusiastically and with some great results. By May 2015, 1,000 of the 3,700 staff were involved in safety and quality projects. "Fifteen months ago we had 20 to 30 people involved," says Dr Shah.

One important area for a mental health provider is reducing the use of "prone" restraint – forcibly placing people face down. "There's no single answer to this and teams have done a range of things... In the last 18 months, we have seen a 56 per cent reduction," says Dr Shah.

Another team on an adult mental health ward has used different approaches to reduce inpatient violence, such as safety huddles, dynamic risk assessments, and using visual displays shared with staff and patients. The number of violent incidents has halved – and done so sustainably. In older adult mental health wards – where there is a greater likelihood of assaults on staff than in any other psychiatric inpatient setting – teams have tried a whole range of creative ideas including aromatherapy, sensory stimulation rooms, meaningful daytime activities, pet therapy and more.

Reducing frustration: creative patient activities have helped to cut assaults on East London FT staff

They too have seen violence reduce by 40 per cent. "We have seen staff sickness come down and the number of assaults on staff go down," says Dr Shah. "We are now spreading the bundle of interventions from our pilot adult ward to all seven adult wards in Tower Hamlets. They are all using the same systematic method but trying different ideas."

'Approaches such as safety huddles and risk assessments were used to reduce inpatient violence'

This is the background with which East London FT came to Sign up for Safety in June 2014. They already had a system-wide approach and saw QI and safety improvement not as an add-on but as an organisational transformation programme.

Kevin Cleary, medical director and director for quality and performance, says joining the campaign adds a whole other dimension.

"It is hard to reliably and sustainably improve the quality and safety of healthcare as an isolated provider," he says. "Being part of networks focused on quality and safety is a critical part of success. We need to hear how other organisations are learning, what is working for them and what we can adapt to help us and to share with them our successes and failures. Sign up to Safety is a great opportunity. We could never build the relationships that are possible in this campaign as an individual organisation.

"It provides a definite focus on safety and a positive nudge for us to develop learning relationships with organisations that we would not normally know or meet.

"There is sometimes a belief expressed that mental health services are very different to other health services, but our patient safety issues are really very similar. Sign up to Safety is an umbrella under which we can all huddle together and collaborate on patient safety." ●

PARTNERSHIP

BRING OUT THE BEST

Liz Mear has a leading role in new patient safety collaboratives. She talks to Jennifer Trueland about how these networks of key players in health economies can spread best practice and measure success

Liz Mear, chief exec of North West Coast AHSN

The Berwick report into patient safety in England called for the NHS to become a system devoted to continual learning and improvement of patient care, "top to bottom, and end to end". But this doesn't stop at the hospital door, or even with the traditional health service – rather, it stretches out to all the players across a local health and care economy. That's where patient safety collaboratives (PSCs) come in.

Launched last October as part of the response to Berwick report, the programme involves 15 PSCs, each led by academic health science networks (AHSNs), which bring together a wide range of stakeholders, including universities, the third sector and industry. The aim is to improve the safety of patients, but also to ensure that patient safety learning sits at the heart of healthcare.

According to Liz Mear, chief executive of North West Coast AHSN, and co-lead for patient safety for AHSNs nationally, the networking approach means huge synergistic opportunities, not just for improving safety, but also transforming quality and experience of care.

"As AHSNs, we're independent enough to hold a mirror up to the system and say where we feel something's working well, or where we think something has to change. But we can also support people to do things differently, especially with the added perspectives from academia and industry."

While NHS England has signalled priority areas for the collaboratives, including healthcare associated infections, and pressure ulcers, each PSC comes up with its own work list, based on what the local system wants or needs. There are, however, national clusters being set up around specific topics, including sepsis and medicines optimisation. Other clusters will be set up as learning develops.

"One thing that's coming out very clearly is that care homes, and the quality of healthcare there, are a big issue for all of us, so that's something we might look at too."

Different priorities

Different areas are choosing different priorities because they are all starting from different points, she says. For example, while South London is having a focus on catheter-related urinary tract infection, her local area felt that it already had suitable tools in place.

'We want examples of things working well, including internationally. We don't want to reinvent the wheel'

"National working gives us the opportunity to pull together best practice. We're also looking for examples of where things are working well, including internationally. We don't want to reinvent the wheel," she adds.

Although they launched less than a year ago, most collaboratives have their patient leads in place, and have been working with their local health and care economies to set priorities, and look at how they will measure what they are doing.

Measurement, locally and nationally, is key to the whole process, she says. Examples of good practice are already coming through. She points to the work being done in the East Midlands to tackle pressure ulcers. "It's system-wide, which is really important. It's about people working together and delivering together. And it means that someone isn't, for example, getting great care in hospital, then finding it all falls apart when they get into the community."

Ms Mear for one believes that the new programme will have a tremendous impact. "I'm very optimistic," she says. "We've really harnessed the enthusiasm of local stakeholders, and that's a much wider group than before, because it includes universities and industry.

"Everyone around the table brings their own experience to the collaborative, whether that is coming from a local authority, third sector or other environment."

Ms Mear's own background – most recently as chief executive of the Walton Centre Foundation Trust – is no exception.

"When I was a trust chief executive we set ourselves a target around falls," she recalls. "We wanted to reduce them by 5 per cent, but we actually achieved 57 per cent reduction. From that we learned that we weren't challenging ourselves enough, but also that when you put a real effort behind something, you can really do great things.

"And one thing that's incredibly powerful is regional measurement. Although of course we use national measures as well, regional measurement really helps people take ownership, and inspires them to do better."

She says that patient safety is here to stay in the NHS. "It's always been here and always will be here," she says. "Patient safety is actually about quality – it's about delivering a high quality service to patients. The collaboratives are helping to make that happen." ●