Welcome to our webinar on Sign up to Safety.

Thank you for joining us. This is Year two and beyond.

You will be muted on entry to keep the background noise to a minimum.
Our aim

• Sign up to safety is on a mission to help the NHS in England to improve patient safety by:
  – Advancing patient safety knowledge and in particular the science of implementation
  – Fostering consistent exchange and use of best practices
  – Working with and through others to address common interests related to patient safety
  – Advocating on behalf of the campaign participants and others
  – Interacting with key stakeholder groups on specific issues
  – Reinforcing the essential role of improving patient safety as a distinct part of the wider quality improvement activity
The life of a campaign

START UP

ENERGISE AND MOBILISE

LEARN
Key points

• Everyone at different starting points

• This is your campaign – it is not a top down intervention

• There is no reporting ‘up’ but expectations that you will learn, share progress with your Board, your staff and your patients

• Start up can take longer than you think

• Once you have motivated people to join and take action – give them time to implement the changes and learn from how as much as what they are doing
Gaps

- Implementation support
- Sharing of good practice
- Cultural change support
- Behavioural change help
- Primary care
**Total signed up Organisations**: 278

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<td>CCG</td>
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Participant by organisation type

<table>
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<th>Organisation Type</th>
<th>% of Total</th>
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<td>40%</td>
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<td>CCG</td>
<td>21%</td>
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High level stats

• 192 safety improvement plans shared (out of a possible 203)

• Total of 673 individual projects to reduce avoidable harm divided between:
  – Topic specific (419)
  – Cross cutting themes (155)
  – Specialty specific (99)
Focus on topic specific harms

Number of organisations

- Falls: 23
- Pressure ulcers: 14
- Medication Safety incl diabetes: 25
- Sepsis: 61
- Deterioration: 61
- Infections incl CAUTI: 56
- VTE: 68
- Acute kidney injury: 73
- Failure or delayed diagnosis: 32
- Assault, violence: 2
- Patient restraint: 14

Top 6
Focus on cross cutting factors

Number of organisations

- Communication: 30
- Safety culture: 73
- Mortality reviews: 10
- Patient engagement: 30
- Leadership: 11
- Increasing QI and safety skills: 21
- Nutrition and hydration: 13
- Incident analysis: 18
- Tests and screening: 17
- Safe staffing: 10
- Team work: 10
3 areas of focus

1. re(\textit{think}) Patient Safety (system)

2. Learning about implementation (organisational)

3. Sign up to Safety \textit{and me} (individual)
3 key messages

1. For the next 15 years we need to review where we have been and potentially re(think) Patient Safety and do something differently for the next 15 years.

2. We urgently need to change our focus and concentrate our efforts on solutions that address the cross cutting causal factors and we learn more about how to implement these solutions in a way that leads to lasting change.

3. Patient Safety is the responsibility of everyone and is built upon the actions of individuals. Sign up to Safety will build our community of individuals and support them to action their pledges and more.
3 areas of focus

1. re(think) Patient Safety

2. Learning about implementation

3. Sign up to Safety and me
Sign up to Safety will

• Help galvanise the field of patient safety to move forward over the next fifteen years with a unified view of the future

• To create a world where patients and those who care for them are free from avoidable harm
15 years
re(think) Patient Safety

1. How are we learning from incident reporting and investigations

2. What is the right culture for safety

3. Competing interests and priorities
3 things we should all agree on

• The best people can make the worst mistake

• Systems will never be perfect

• Humans will never be perfect
Expect

• Expect to administer ten times the dose
• Expect to operate on the wrong leg
• Expect to ....

• A preoccupation with failure rather than counting where we have failed
Learning culture?
avoidable versus unavoidable

• Are you really listening or are you just waiting your turn to talk?

  – Quote: Robert Montgomery
Don’t bring me problems

bring me solutions
Just culture

• People who make an error (human error) are cared for and supported

• People who don't adhere to policies (risky behaviour) are asked first before being judged

• People who intentionally put their patients or themselves at risk (reckless behaviour) are accountable for their actions
The right safety culture is one that combines:

- Just culture
- Continual learning
- Designing out error
- Procurement for safety
- Resilience systems so we are adaptable and prevent the little things getting bigger
Competing priorities

- Infection control
- AKI
- Falls
- Sepsis

- Medication safety
- Deterioration

- VTE
- Pressure ulcers
Five common causal factors

- Information
- Communication
- Observation
- Design
- Relationships
Human factors

- Mental workload
- Fatigue
- Boredom
- Scheduling
- Barriers
- Rules
- Distractions
- The physical environment
- Physical demands
- Device/product design
- Teamwork
- Process design
- Abbreviations
- Assessment
Are we designing out error?

Thanks to Ross Scrivener @Scr1v via twitter
Are we standardising where we can?

Mary Dixon Woods
Webinar for HIS QI Connect June 2015
RE(think) solutions

Reducing harm topic by topic

Relentless focus on the cross cutting factors

Use design to remove potential for error

Procure the same things across the NHS and standardise where we can
Sign up to Safety will....

- Hold a summit of national leads to identify the commonalities, the core areas that link all of these different areas of harm or competing interests

- Share our learning and all work together in harmony to help you feel less conflicted as well as address these common causes
Aims

• To bring together the national leads for falls, pressure ulcers, VTE. med safety, sepsis, and deterioration and AKI

• To explore our proposition that the passion of each ‘change agent’ can create local competing interests and confusion

• To identify and agree the cross cutting themes that are common to all these initiatives

• To agree to share the learning and key messages to help frontline staff and organisations maximise their work in these areas
We convince ourselves to keep carrying on when the solution may not be the right one

Our recommendation

Stopping or doing things in a very different way may be the only step to take
3 areas of focus

1. re(think) Patient Safety

2. Learning about implementation

3. Sign up to Safety and me
Theory  

Gap  
10-17 years  

Practice
A dilemma in the patient safety field is that it often takes a long time to see the benefits of a new method.
Implementation

- Implementation is a process of specified set of activities designed to put into practice an activity or program or solution.

- To implement =
  - introduce and put new ideas into use
  - establish and use a method in practice
  - realise, apply or put plans, ideas, models, norms or policies into operation
Local adaptation

• The new method to be adopted needs *necessary local adjustments made*, to integrate or assimilate to the local context.

• The method is considered *institutionalised, embedded or sustained*, if it is taken for granted or is the ‘way we do things’ regardless of reorganisations, personnel turnover and political changes.
Implementation research has identified the common factors or components that have significant bearing on the success or failure of implementation

- The recognition that there is an explicit need for change and the solution and that the proposed method is the right one in the context
- There are visible benefits
- The solution is in line with the norms, values and working methods of the individuals, teams or organisation implementing it
- The solution is easy to use and it can be tested on a small scale
- It gives rise to knowledge that can be generalised to other contexts and can be adapted to the needs of the recipient and the context
Implementation research has also identified the **tools or methods** that usually help

- Oral or written information (guidance, how to guides, standards, alerts etc.) is normally offered when a new method or change is to be introduced, however offering **only** information, or education or practical training is usually not enough in isolation

- The research has found that an optimum **combination** of several measures is required, e.g. education **and** practical training **and** feedback

- If a new method does not lead to the anticipated effects, it should be possible to find out whether it was:
  - the solution that was not right for the particular problem or
  - the method of dissemination itself that did not work or
  - whether it was down to unsuccessful implementation approach
Great we are not alone!

‘The problem with...’

• A new series in BMJ Quality and Safety
  – Covers pervasive problems that seem to resist solution
    • Kaveh Shojania and Ken Catchpole

• http://qualitysafety.bmj.com/
  – ‘The problem with..’ checklists - Ken Catchpole and Stephanie Russ
Our proposition

• Over the last fifteen years in the patient safety field there has been a lot of guidance (alerts, solutions, interventions, standards) for those that work in healthcare to help them ‘make care safer’.

• Many of us have tried to introduce new ideas, but after a while we have been forced to admit that things didn’t turn out as we had originally intended and planned.

• To put it simply - to implement – is easier said than done.
Sign up to Safety will....

• The Sign up to Safety campaign team will explore the subject of implementation with our community, topic experts and expert practitioners in delivery of healthcare

• We hope to increase our understanding and knowledge in this area in order to help them think about how it might fit into their context
3 areas of focus

1. re(think) Patient Safety

2. Learning about implementation

3. Sign up to Safety and me
Our first birthday was used to energise individuals to sign up and make personal pledges
Sign up to Safety will....

• Build on our birthday focus and continue to create a community of individuals who choose to join the campaign
References
Science of implementation

Implementation Science – and open access on line journal via
http://www.implementationscience.com/
Patient Safety after 15 years: Disappointments, Successes, and What's on the Horizon (May 27, 2015)

Top sites for more information

- NHS Scotland, Quality Improvement Hub (Qihub) via [http://www.qihub.scot.nhs.uk](http://www.qihub.scot.nhs.uk) [this one has a whole section on quality and efficiency supporting the business case for safety]
- BMJ Open – open access online journal via [http://bmjopen.bmj.com/](http://bmjopen.bmj.com/)
- IHI – the institute for healthcare improvement via [http://www.ihi.org/](http://www.ihi.org/)
Any questions?

Suzette Woodward
National Campaign Director
Sign up to Safety

Thank you!