

Council of Governors (in Public)

Item 9.6

Subject: Report of Patient Safety Congress, Manchester Central Convention Centre, 2-3 July 2019
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1. Introduction

This was the 12th annual congress for this major event. It was attended by over 1000 delegates from the UK and several other countries (three delegates from LHCH attended). There were 120 main speakers, which included 50 patient speakers. The congress was organised and sponsored by the Health Service Journal (HSJ) and supported by a wide range of health service providers. The congress was chaired by Shaun Lintern, Senior Patient Safety Correspondent, HSJ.

The congress was arranged on the basis of staging key plenary sessions at the beginning and end of each day. These key sessions dealt with: *Listening to Patients and Families; The NHS Patient Safety Strategy; Putting the Patient First; The Fallacies of Work as Imagined; Creating the Right Communication Culture; A Vision for the Nursing and Care Professions and Exploring Blame*. There were a number of optional themes throughout each day, each staged at five different locations. These included: *Mastering Governance and Regulation; Learning from other Safety Critical Industries; Supporting your Workforce to Deliver Patient Care; Using Technology to Improve Safety; Putting Human Factors into Action; Effective Response to the Deteriorating Patient; Enabling a Learning Culture and Safety for Vulnerable People*. There were 36 sessions covering these themes requiring each delegate to select 8 of them. All sessions concluded with a selected panel to deal with questions.

In the main concourse, there was an exhibition from a range of organisations associated with the NHS and patient safety. There was also a poster competition for which delegates were encouraged to vote.

2.0 Issues Arising from Plenary Keynote Sessions

2.1 Listening to Patients and Families

This was based on a case study of a vulnerable person with learning difficulties who died because staff did not note the deterioration of the patient. It was shown how staff made subjective assumptions about the patient's ability to understand instructions and tell staff about his feelings. Insufficient attention was given to the views of parents and early signs of serious deterioration were missed.

The lessons learned from this example pointed to the need to involve families in the care and welfare of patients, particularly those who may have learning disabilities. Attempts

should also be made to include patients themselves by being sure they react appropriately when being cared for.

2.2 The NHS Patient Safety Strategy

NHS England and NHS Improvement took the opportunity at the Congress to launch their joint publication *The NHS Patient Safety Strategy*, since this was the day of its official release. This new document resulted from widespread consultation and a full outline of outcomes was presented. To produce the new strategy, the authors firstly gained a clear understanding and measurement of safety issues. Considerable work was undertaken to explore what is meant by a safety culture before the new system was proposed. Importantly, it was stressed that a blame culture needs to be replaced with a process of objective accountability. Furthermore, the system of ensuring safety for patients needs extensive clarification, accompanied with appropriate training. This renewed approach will hopefully create an effective culture for patient safety.

The difficulties of measuring the impact of medical errors and resultant costs to the economy were outlined; the costs of litigation arising from negligence alone mean that the system needs to change. This can be done by eliminating the toxic blame culture and encouraging staff to understand that learning can take place from all incidents. For this to happen, effective leadership is necessary together with widespread introduction of technology.

2.3 Patients First: why it is not so simple

This session dealt with fatigue in relation to staff and patients. Within an organisation that functions 24 hours each day for 365 days a year, it is difficult to cater for the amount and quality of sleep that patients need. For patients to be stable and make a proper recovery, a good night's sleep is essential.

As far as staff are concerned, the situation is just as problematic. Too many junior doctors work for too many hours; illustrations were given to show that at the end of night shifts doctors make more risky decisions. Generally, there is a need for greater awareness of tensions and stress when staff work beyond peak performance. An initiative has been launched to address stress on staff; this includes limits on hours worked and length of breaks and how these should be incorporated in contracts.

Generally, it was shown how deprivation of sleep affects concentration and how moderate loss of sleep impairs cognitive and motor performance.

2.4 The Fallacies of Work as Imagined

This session dealt with perceptions of how work is conducted. As far as hospitals are concerned, there often seems to be a disconnect between what is said to be going on and what staff on the ground feel or see is going on. Of particular note is the lack of understanding of risk in the workplace. Arising from this, there may be occasions when someone may not wish to report mistakes. Issues that may affect and hinder accurate reporting arise from goal conflicts, production pressures, systems being not as planned, procedural complexities, and barriers to providing meaningful feedback. There is also a fear of litigation during investigation and follow-up after an incident.

Human error and deliberate and accidental violations often come to light quickly after an event. Usually there is high personalisation, even in situations of low context and low complexity. With hindsight, many errors appear to be easily preventable and fixed. Nevertheless, they are nearly always newsworthy and become public.

The discrepancies between work as imagined, work as prescribed, work as disclosed and work as done need to be clarified, tested and monitored continuously. To help clarify and establish a workable culture that registers work as done, it is necessary to have widespread understanding of human factors. The NHS has over one million workers but only a few hospitals have a human factors specialist with responsibility for work design. There is also a widespread problem of getting front-line staff properly trained in human factors. While the lack of resources to do this is recognised, an organisation's hierarchy can sometimes not be fully attuned and, therefore, hinder communication and development.

An important aspect of dealing with human error is clear communication. Communication and civility need to be correct and appropriate in order for accurate understanding and to enable staff to seek clarification. Sometimes, it may be necessary to assess and subsequently train staff to improve their ability to understand and make communications. This may particularly be the case with some overseas trained professionals or staff with communication difficulties who may require a *communication passport* or acknowledgment of their ability.

2.5 Creating the Right Communication Culture to Improve Patient Safety

There was an emphasis on spoken communication during this session. Knowing what good verbal communication is like and what leads to poor communication were discussed. However, to enable ideas and instructions to be understood may be more than just words. To enable effective communication to assist with patient safety, there needs to be recognition about the flow of component parts of the communication and opportunity for it to be a two-way process. The concept of the skills of listening is important. This is particularly the case when dealing with complex procedures and guidelines and staff should be encouraged to talk to each other in such circumstances. Scripted communications can usually reinforce verbal statements. Videos of staff at work can also be powerful in consolidating understanding of patient safety.

The purpose of good communication should be to reduce errors and their consequences. By understanding the task and the person's role, it is possible to consider how best to shape required performance and whether there is a fighting chance of success. It will never be possible to eliminate error but if the task is designed in such a way that allows mistakes to happen then they will happen. Nevertheless, we need to be realistic about how much we can do to eliminate human error and we may often be starting from a position which is better than we think.

2.6 A Vision for Nursing, Midwifery and Care Professionals

The Chief Nursing Officer for England explained her views on the future of nursing. The role of nurses to deliver the *Long Term Plan* was emphasised. Several priorities were outlined; these included plans to retain existing staff, how new recruitment methods will target undergraduate candidates, development of leadership and how digital technology will assist this, taking account of the diverse nature of the workforce and the importance of volunteers. The new award for nursing excellence and how this will help the perception of nursing was mentioned. There are also plans to celebrate more the accomplishments of nursing.

2.7 Exploring Blame

An analysis of events that led to the conviction of David Sellu for gross negligence manslaughter was the basis of this session. Congress heard from David Sellu himself about the events that led to his conviction, imprisonment and his later exoneration. It was shown how healthcare needs to transform to avoid a blame culture. The need for greater consistency throughout the NHS for dealing with serious cases was explained; at the moment there is too much variation and the regulatory process needs to be strengthened. The importance of evidence from professionals and understanding of issues around the event at an early stage were stressed.

3.0 Issues Arising from Optional Sessions

3.1 Learning from Other Industries

Presentations here were based on the Costa Concordia case. It was shown how the management of risk and safety was negligent and resulted in the ship going aground. A critical factor in the accident was the rapid expansion of the cruise industry and the rapid promotion of staff to senior positions. This saw shortcuts being made in the training of staff and a system of training taking place in the real situation. This also resulted in the shortening of the skill gradient. In this case, the qualifications of the captain were insufficient to deliver training on the job. Furthermore, when a critical phase of the accident was reached, junior, inexperienced and trainee staff did not feel able to speak up and challenge the captain; this was the case even when it became clear that the captain deliberately violated specified procedures.

Lessons to be learned from this accident include the need for recognising errors as they are happening, the importance of teamwork, the need for subordinate staff to speak up and challenge senior staff where necessary and for senior staff to expect others in the team to challenge them.

3.2 Patient Safety in the Digital Age

Reports from research focusing on preventable medical errors that cause harm using data collection and simple operational changes to patient flow were outlined. It was shown that patient safety has not kept up with innovation that has taken place in medicine generally. There is now the opportunity to use data to compare safety across different hospital systems. Data can be used to estimate the likelihood of error and to calculate costs per error as well as determining how to make savings.

Moves are afoot to involve staff, patients and the public in the recording of data which can lead to learning. At the same time, the collection of structured data will help organisations to share and exchange ideas in order to improve patient safety. The more widespread analysis of data will allow trends to be illustrated and reveal hidden aspects of patient safety that can lead to better provision.

3.3 Using Technology to Reduce Medication Errors

There is wide variation in the kind of medication errors that could be eliminated with suitable software. Intravenous medicines bring a higher risk because they are complex to prepare and administer. Up to 38 per cent of errors occur at the administrative stage while errors attributable to devices run at approximately 11 per cent. Medication errors in wards account for most errors.

Attempts are being made to reduce intravenous medication errors by using software. Where this is introduced, it is important that everyone should be included in the rollout and suitable training provided. Where smart infusion devices are used, there has been a reduction in the risk of over-infusing and fewer over-dosing mistakes, for example, when making settings of 100 instead of 10. However, care is still needed because technology can be subject to human error. Once technology is in hand, human factors can bring new kinds of errors.

3.4 The New Medical Examiner Service

The new system which will apply to England and Wales arose from events surrounding Harold Shipman. There will be regional arrangements and medical examiners will function on an independent basis. Appointments of new medical examiners are already being made.

The work of the new medical examiners will focus on providing accurate information to doctors, registrars, coroners, local authorities, families and hospital trusts. Medical examiners will provide clarity about how deaths happen and whether there are any clinical concerns. Where discussions are necessary, the bereaved will be fully involved.

3.5 System Design and Human Factors in Preventing Errors in Healthcare

There has been considerable work to reduce errors in healthcare. The most prevalent aspect has featured around human factors and learning why mistakes are made. Most innovations have started with clarification of the task and checks to ensure that staff understand the task in hand. New approaches to dealing with errors reflect a changing culture of openness. Old approaches relied on training without proper follow-up, the production of checklists, and reminders and warnings, often leading to punishment. While checklists can be invaluable, too often they are completed after a procedure and if used during a procedure they can interrupt the flow of work. Rare errors are sometimes forgotten and disappear from schedules.

Improving patient safety requires staff, patients and families to know what is meant by patient safety. Most patients don't recognise that they may be harmed and are unaware of potential risks. They know that when things go wrong, their hospital will have a complaints procedure. Currently, many complaints procedures are flawed and there is an instinct to cover up and too little learning emerges from errors.

It is now recognised that human factors is a science but too few working in healthcare have sufficient understanding; most staff pick up bits and don't have the total picture. The establishment of a human factors team is central to system design and programme development. A system based on proper understanding and implementation of human factors aids a no-blame culture, thus giving rise to learning. Widespread acceptance and understanding of human factors can professionalise patient safety.

3.6 Preventing Never Events

The Care Quality Commission's (CQC) inspections show a wide range of ratings. In turn, although 60 per cent of hospitals are rated as good, and 6 per cent as outstanding, there are 34 per cent requiring improvement or are inadequate. From these situations, there are high risks of the occurrence of never events. In 2017/18 there were 468 never events in trusts. This is a continuing situation which is a challenge to staff and one that requires a cultural shift.

CQC ratings suggest that the best hospitals are curious and actively seek to do better tomorrow than today. There is focus on the improvement of quality that is driven from the

frontline. Hospitals that have openness and transparency learn from errors and improve safety. It can be seen that better hospitals stand a greater chance of avoiding never events. Factors that hold back improvement to safety include top-down leadership, professional rivalries, an inflexible approach to workforce planning and unsustainable financial arrangements. When never events happen, there is often a link between staff working beyond hours and at weekends, a failure to follow guidelines accompanied with poor documentation and organisation pressure. Sometimes, complacency leads to a feeling that *it couldn't happen here*.

During questions it was suggested that never events should be classified as governance events and that reporting of never events should be in a more positive light, rather than as a negation of care.

3.7 Being Fair Following Incidents

The emphasis in this session was on how to create a supportive culture for staff and patients following an incident. The recently released guidance *Being Fair: Supporting a Just and Learning Culture for Staff and Patients* formed the focus of discussion. A range of barriers that prevent fairness in relation to staff and patients following incidents was explained. There are disproportionate levels of disciplinary action across hospitals. Fear and blame cultures prevent appropriate action and learning and there is too much reliance on *who* and not enough on *what*.

It is hoped that the emerging context will contribute to the implementation of the *Long Term Plan*. Inherently, there will be a balance between fairness, justice, learning and taking responsibility for actions. There will be no relaxation of accountability. Human factors will be given prominence in investigations as will the failure to provide a safe workplace.

4.0 Conclusions

This was a complex and well-organised congress. There was something for everyone in relation to safety in healthcare.

The over-riding feature was how recent legislation and regulation will help create conditions where staff and patient safety and welfare will become more central to work design, and form the basis of a changing culture in hospitals. It is clear that future training for safety will have greater emphasis on the design of work practices and schedules. Human factors and human error will become more prominent, as will the design of equipment for use in healthcare.