Safety For All Conference 2022

Royal College of Physicians, Regent's Park, London

Wednesday 7 December

09:00 – 16:00

Conference Report

SAFER HEALTHCARE BIOSAFETY NETWORK

patient safety learning

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Table of Contents

The Safety for All Campaign

The Safety for All campaign is calling for improvements in, and between, patient and healthcare worker safety to prevent safety incidents and deliver better outcomes for all by:

- Improved understanding and advocacy of the mutual benefits to be accrued for patient safety by improving healthcare worker safety, and vice versa, and of the common risks, factors and interventions across patient and healthcare worker safety.
- The application of shared learning and best practice between workplace and patient safety and, where appropriate, aligned or integrated synergistic solutions in safety systems, standards, governance and preventive measures.
- Resources, leadership and staff committed to a stronger, reciprocal patient and workplace safety culture, with safety as a core purpose for both, underpinned by better education and training.
- Greater support for staff, and for them to speak up, following patient safety incidents, including a safety care pathway for both patients and staff, and to ingrain a just culture.
- Improved risk management and reporting of safety incidents, learning and communication across patient and healthcare worker safety.

Campaign Resources

- White Paper: Safety for All: Patient and Healthcare Worker Safety – Two Sides of the Same Coin (20 October 2021)
- Report: Mind the implementation gap: The persistence of avoidable harm in the NHS (7 April 2022)
- Guidance: Staff Support Guide: a good practice resource following serious patient harm (29 June 2022)

Executive Summary

On Wednesday 7 December 2022 the inaugural Safety for All conference was held at the Royal College of Physicians in London. This event brought together a wide range of attendees all with a shared interest in calling for improvements in, and between, patient and healthcare worker safety to prevent safety incidents and deliver better outcomes for all.

Morning keynote addresses

The Conference opened with three keynote addresses.

John Dean, Clinical Vice President at the Royal College of Physicians (RCP) set out the importance of patient safety in their activities. He highlighted the RCP's work to improve the transition of care between hospital and home, including developing a toolkit on safe medicine at discharge and an associated patient health guide and checklist. He also spoke about their work carrying out independent service reviews, providing a source of independent advice and support to healthcare organizations.

Henrietta Hughes, Patient Safety Commissioner for England, spoke about the challenges we face in improving patient safety, including the need for effective engagement and responses to patient concerns and ensuring that staff feel psychologically safe to speak up about safety incidents. She also went on to speak about having seen, in her initial weeks in her new role, many pockets of good practice and efforts being made to put the patient voice first.

Patricia Marquis, Director for the Royal College of Nursing (RCN), spoke about the extremely challenging healthcare environment nursing staff are currently working within and the need for a long-term approach to workforce recruitment and retention. She also reflected on the recent decision by nurses to take industrial action and the steps being taken to ensure patient safety is maintained throughout this period.

Hearing the patient voice

The first panel session at the Conference focused on the importance of engaging with patients and families at the point of care, if things go wrong, in improving services, advocating for changes and in holding the system to account. Some key reflections in this discussion included:

- Patients and family members are a key source of insights and knowledge when undertaking a patient safety investigation, involving them is not only the right thing to do but also crucial to learning.
- Language can often act as a problem for engaging with patients, with too many acronyms and healthcare jargon presenting a significant communication barrier.
- Importance of supporting patients, not just giving them the opportunity to ask questions but the knowledge and tools to know what questions to ask.

Extravasation

In a presentation, Andrew Barton, Chair of the National Infusion and Vascular Access Society, spoke about the risks posed by extravasation injuries. These injuries occur when some intravenous drugs leak outside the vein into the surrounding tissue causing trauma. He set out the scale of this patient safety issue in the NHS and the need to improve reporting and learning from these incidents to prevent avoidable harm.

Improving staff safety

The second panel discussion of the day focused on the importance of ensuring the health, safety and wellbeing of staff across the healthcare system and the benefits that this has for patient outcomes and developing a safety culture. Some key reflections in this discussion included:

- Workplace safety standards and processes must be accompanied by strong leadership and management, underpinned by shared ambition to support this from national agencies, governments and regulators.
- Safety challenges in moving to a new hospital building/re-designing existing spaces, considering examples from Liverpool University Hospitals NHS Foundation Trust.

Afternoon keynote address

Lesley Kay, Deputy Medical Director at the Healthcare Safety Investigation Branch (HSIB), gave the afternoon keynote address to the Conference reflecting on the role of HSIB and its forthcoming organisational transformation into two new bodies in April 2023, the Health Services Safety Investigations Body and the Maternity and Newborn Safety Investigations Special Health Authority. She spoke about some of their recent investigations and their education programme, which to date has had four and a half thousand learners.

Creating a safe environment in hospital theatres

In a presentation, Lisa Nealen, Peri-operative Practitioner at Gateshead Health NHS Foundation Trust, set out the hazards posed by surgical smoke. She outlined the safety risks for staff, current legislation concerning this and spoke about the introduction of smoke evacuation products to reduce the risk of harm.

Persistence of avoidable harm

The third panel discussion was focused on the persistence of avoidable harm in healthcare and the action needed to tackle the implementation gap that exists between what we know improves patient safety and what is done in practice. Some key reflections from the discussion included:

- Problem of incident investigations focusing on guidance being followed correctly and if this is not the case simply prescribing additional training, rather than considering the ‘work-as-done’ reasons why this may not have been implemented.
- Question of whether we are effectively implementing learning from public inquiries, given the monitoring of report recommendations is patchy and evaluation of their effectiveness is unclear.

Preventing workplace stress

The final panel session of the day considered workplace stress, how to prevent and link between this and patient safety. Some key reflections included:

- Highlight various sources of guidance and support available from organisations such as the RCN and NHS Employers.
- The example of the Safety Incident Supporting Our Staff (SISOS) initiative at Chase Farm Hospital in supporting staff involved in patient safety incidents.

Conference Opens

Introduction by Co-Chair Helen Hughes, Chief Executive of Patient Safety Learning.

Helen Hughes:

Hello everybody, I am Helen Hughes, Chief Executive of Patient Safety Learning and I am not going to be saying very much at the moment which anyone that knows me will find quite surprising.

I'm here with my colleague Ian and others from the Safer Healthcare & Biosafety Network (SHBN) for this incredible Safety For All (SFA) conference. There are copies of the white paper which we published last year *Patient And Healthcare Worker Safety – Two Sides Of The Same Coin* around the venue and that's the theme for our conference today. We're very appreciative of all your support by being here and also thankful to the SFA industry group who have ensured that this conference can happen without you having to pay to be here.

The conference is being filmed and recorded because we want to share learning, disseminate good practice and promote everything that needs to be done to improve patient and healthcare worker safety.

I am now going to introduce John from our gracious hosts here at the Royal College of Physicians to give an introductory speech. Thank you.

Morning Keynote Addresses

The conference begun with three keynote addresses.

John Dean, Clinical Vice President at the Royal College of Physicians

I am John Dean, Clinical Vice President at the Royal College of Physicians (RCP). You were going to be hearing from Ian Bullock, who's our Chief Executive. Unfortunately, he is unwell. He wanted to keep us all safe by not spreading his virus around to us all, so you will also be hearing from me a little bit later on the panel when we're focusing on staff safety. At the RCP we take patient and staff safety very seriously. It is part of professional practice and how we support our members and fellows to be delivering safe practice and ensuring there is safety for their patients but also to make sure that as clinical teams and as wider teams in healthcare they are working in safe environments in order to deliver that best care. It is fundamental to what we do.

So, just a little bit about the Royal College, we have 40,000 members and fellows worldwide. About 20% of our membership and fellowship is not in the UK and we bring together over thirty medical specialties, so a large area of clinical practice. Our strategy is around educating, influencing and improving healthcare. Our charitable purpose is improving health and healthcare, so we do that at three levels. We try to advocate and influence on a governmental level. On a national and international level, we support our Members and Fellows and their wider teams through their education and development of improvements in services, including of course, patient safety. As a key theme of that, we work in partnership with our patient and care network and other patient groups in all of these areas.

We know that one of the riskiest elements of care is the transition of care between hospital and home, and we've worked collectively with our patient and carers and across professional group to produce guidance in the toolkit about safe medicine at discharge, a patient health guide and checklist related to that that we believe through implementation in practice will improve safety at this important transition. How we bring the professions together, how we bring patients and families together to co-design guides and support for frontline staff and patients are core to what we do.

Another piece of work we have done recently and had awards related to patient involvement is around patient involvement in decision making in multi-disciplinary wards. Again, advocating for safety of the team, safety of the patient in that environment is key to modern practice. Our patient care network is a multi-stakeholder group, very much influencing our practice.

Another area that we work in is invited service review, this is when a healthcare organisation will invite us to come and do an independent review of practice and some of those have been highlighted quite a lot in the media recently. Safety is at the core of when units and services are not functioning as well as they should, and we can go in and give independent advice with a broader multi-professional and patient team to look at the issues that are going on and come up with recommendations for the employing organisation and of course bringing the lessons together around those is really key so that we can then embed that in our practice and our services going forward.

We have a patient safety Committee which brings together representatives from many of the specialties that work in the area, but also partners in the safety space, be that patient partners, other professional organisations, other arms-length bodies and in fact next week is our Patient Safety committee and we'll be looking at the lessons from the invited service reviews and how we link up lessons with NHS resolution and respond to some real time safety advice.

In all of our programmes we have some lead some national improvement programmes and some of them are highlighted here. We have the accreditation scheme for endoscopy services and how those are safe for staff and patients is core to accreditation of those services. We also produce guidance in terms of asthma and COPD management across the healthcare sectors and similarly in terms of falls and fragility, we run the National Audit of inpatient falls, and there are many lessons for staff and patients that come out of those. How we educate our physicians and the wider team in terms of safety practice and particularly team working and modern team working is key in terms of staff as well as patient safety.

How we work as effective teams looking at real time safety is fundamental, and again, I am sure we will bring that out later on in the discussion.

We're all aware that in healthcare the systems are under enormous pressure and this is an increasing risk to patients and staff and how we manage in the best possible way under those pressures is key.

We are absolutely clear that workforce gaps being inadequate in terms of the numbers of staff for services is a fundamental component of this, and in recent surveys of our staff, members and fellows up to 70% are saying that they are on a daily basis, seeing unsafe services because of understaffing. And we know the pressure that puts on the staff. We continue to advocate extremely strongly for better staffing but also supporting members and fellows and wider teams as to what they can do on a daily basis to make care for staff and patients as safe as possible.

So I welcome today and welcome you all to today's conference. I am sure there will be a lot of learning and lessons that come out of it that we will share widely.

Helen Hughes:

Thank you very much John. I will now introduce our new Patient Safety Commissioner, Dr Henrietta Hughes.

Henrietta Hughes, Patient Safety Commissioner for England

Good morning everyone and lovely to see everybody in real life and thank you so much for the invitation to speak today and I wanted to say that this is a time of unprecedented strain on the service so we meet at a critical time for the health system. Relentless pressure is now the norm in the acute, the primary care and community care sectors. I'm still practising as a GP in my spare time, and I know how difficult it is.

At the weekend I triaged 150 patients and you know, it's immediate. You can see the problems that people are having, the emergence of infections, etc. but budgets are squeezed and staff are scarce and exhausted, and there's no time. There is no doubt that times are tough. The terrain is ambiguous and appears to be becoming more so with political volatility that leads to delay in important reports that we're still waiting for. Pressure is growing and one of the things I'm concerned about is that the time to reflect has all but disappeared. And faced with the stress of illnesses and uncertainty, patients must also work within a healthcare system under extreme pressure alongside a cost-of-living crisis. We know that for many patients with long term conditions, they face additional costs.

I am sure the Members and fellows of this college are aware of patients who have additional costs related to their long-term conditions. But this pressure not only has a huge impact on patients and the public, but also on you. You're the staff who must manage the ever-growing needs with an exhausted workforce. In this environment it's all too easy for the culture of our organisations and our core values to be lost.

Based on a paper that looks at the way that different organisations respond to patient feedback, I've developed this thermometer of leadership. You can be at the bottom of the organisation where you don't respond to concerns or you put out defensive or irrelevant communications. The response might be slow and it can be siloed. And what does that feel like as a patient? Patients don't feel heard, patients escalate to other roots, including to their MPs, to the press, to social media and litigation. The staff feel helpless.

Impersonal, generic timely responses to patient concerns where boards feel falsely reassured that the feedback is being responded to. Their obligations are fulfilled, but the staff feel disenfranchised. But what I would like to see is organisations that are warm, where the responses are personal, compassionate, timely, relevant and they're used for learning. The difference that this makes is that patients feel valued and listened to. They know that the information is used to prevent future harm and the staff feel empowered and staff morale improves.

So patient safety and staff safety are two sides of the same coin. And as Helen alluded to, listening to patient voice, listening to staff voice or worker voice in my view are absolutely key and a key part of this is leaders listening and acting and following up. This is a psychologically safe environment where you can raise matters. You can ask questions without fear of being victimised, humiliated or worse where you do not have reprisals for raising concerns. It's a culture that works for patients and staff and I think what's really important is that this forms part of the regulatory framework. What we've seen in recent times is that for organisations who think that they can silence the voices, it will come back on them. It will come back on them when they have their CQC inspection.

So, how can we work together to ensure that our organisations retain their core values and continue to demonstrate warmth to our patients and each other and remain at the top of the thermometer?

I believe that the reason that we came into the health system is to improve the lives of our patients, to learn what matters to them and thereby put them on the road to recovery. When

faced with illness or accident, I've been listening to patients and they want to help design better services by having their views taken into consideration. They want information and data to make informed decisions about their care and they want to feel included in the process, I contend that adopting this approach not only reduces the risk of adverse event outcomes and resulting pain and injury, but also reduces the spend on resource and by reducing the risk of adverse reactions, we can save time which can be fed back into direct patient care.

But I understand also how the call to carry the torch for the patient voice can seem impossible when you're trying to manage increased demand with staff shortages and threatened budget cuts, but I think it can be done and it doesn't require a lot of additional resource. For example, how much does it cost to put a patient story at the top of your agenda of your board meetings, or to have a named director for patient voice? It does not cost anything. But what does it cost if we do not? There is a risk that the patient voice is not heard at all during these important meetings.

So, I wanted to go back in my memory and think about the first patient that I ever met and I'd like you to think about the first patient that you ever met. Or maybe the first client or the first service user that you ever met.

If I just tell you about the first patient that I met, I was a medical student. I was on a surgical firm. I knew that I was told to go and clerk a patient. This was the first time I had ever done it. I was quite terrified, and I'd read up about the anatomy, the physiology, the pathology, the surgical technique, and then I went to meet him and he told me he had bowel cancer. He was going to have surgery for bowel cancer, but he also told me that he was a widower. That he had a 14-year-old daughter and no other family in the world. He told me he needed to live because otherwise she was going to get taken into care. That is what mattered to him so that is what mattered to me. I'm pleased to say that he did have a good outcome from his surgery. But if I had only been focused on the anatomy, the physiology, the pathology, and the surgical technique, I would have missed everything that was important to him.

I want to now talk about some of the good things that I've come across. There are really great strides being made to improve patient safety by putting the patient voice first and in my first few months in this role, I've seen many pockets of good practice.

I want to suggest 30 minutes that could change your life. And if it doesn't change your life, it could certainly change your patient's life. I want to talk about NHS resolution – the work that they've been doing on informed consent. I don't know if you know that of the over 1200 claims for incidents between 2012 and 2017, nearly two thirds were under review due to complexities around consent and NHS resolution has set out to change this, it's created resources on supported decision making and a video that outlines the case that led to the landmark Montgomery versus Lanarkshire Health Board ruling in 2015. This emphasised the importance of clinicians discussing with their patients the various treatment options, including doing nothing. Clinicians must be satisfied that they've discussed the material risks of each option with their patients. I recommend you log on to their website to watch Nadine Montgomery's story.

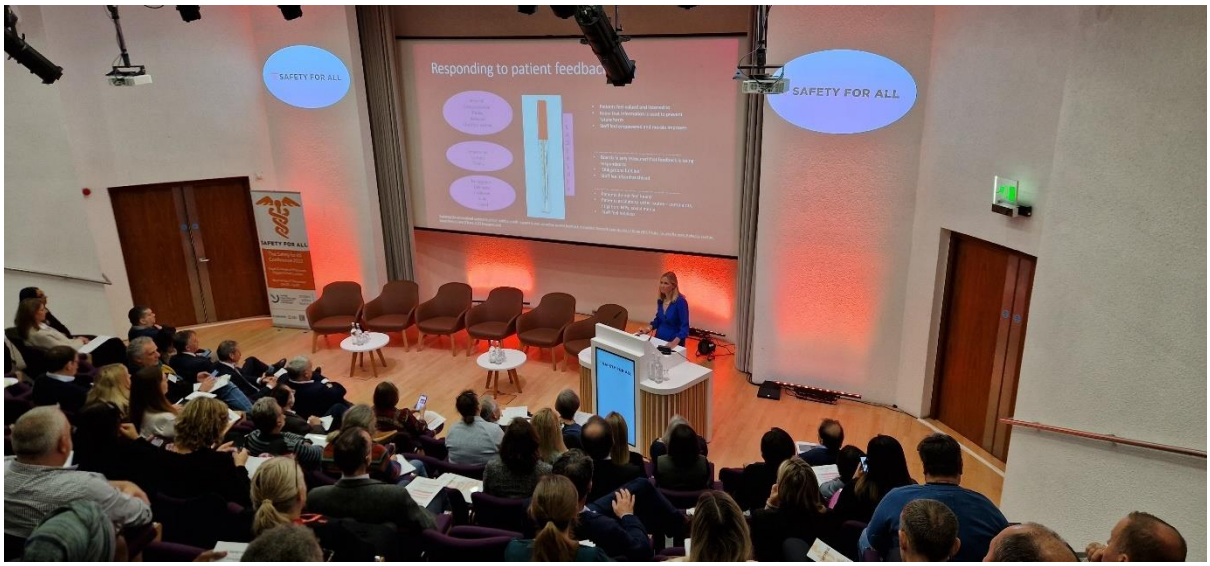
I had the absolute privilege of meeting Nadine last week, and we owe it to our patients to ensure that we do this correctly.

The next thing is around scan for safety.

When the horse meat scandal hit the supermarkets, the products were recalled in two hours. Could we do this in the NHS? The 2016 Carter report highlighted potential savings of £5 billion could be made from improvements to efficiency. The streamlining of patient pathways,

a more positive patient experience through releasing clinical time back to care and scan for safety, offers an opportunity to do just that and provide full traceability where products are in real time. It was initially piloted in six acute NHS trusts with data that now underpins better decision making and improved operational performance. Using global standard one barcodes, all products and patients are scanned so the right product is used for the right patient at the right time. The full programme rolled out across the NHS acute sector has the potential to generate over a billion pounds of benefits in seven years.

From listening to patients, what I've heard is that we need a new offer, better information and data, a psychologically secure culture, and a swift and compassionate system response when adverse events occur and I want to work with you to achieve this, my role is to help empower you to manage through the complexity. I aim to support you where you get stuck at a national level and to unblock the barriers where I can whatever the pressures and whatever the environment in which you work, you can always do one thing to improve patient safety.



I want you to think about one way in which you can place the voice of patients at the top of your agenda. In your organisation you might want to think about some of the ideas I have shared with you or share with me the way that you're doing this.

You are the best people to do this. You know your organisations and you know how patients currently interact with them.

We know that not listening to patients and families has led to catastrophic failures, loss and untold suffering. Let us be the change we want to see and put the voices of patients and families at the top of the agenda.

Helen Hughes:

That is fantastic. Thanks Henrietta. We could have had another hour I think, and certainly more of those conversations within the audience.

I'm now going to introduce Patricia Marquis who's from the Royal College of Nursing. It is a really important time to be having this conversation I think, so welcome.

Patricia Marquis, Director for the Royal College of Nursing

Thank you for that introduction. I'm Patricia Marquis, Director for the Royal College of Nursing in England and I'm here for my boss, the general secretary, Pat Cullen, who's a bit tied up at the minute organising a UK strike. So, we are quite busy but it is brilliant to be here and I am really pleased to be able to speak to all of you today on behalf of the Royal College of Nursing.

It will come as no surprise to you that staff safety and patient safety are firmly at the top of our and also my personal agenda. It is in my blood as a nurse. Nursing is my heart, my soul. It is what I am, and I will fight for everything and with everything I have, and the organisation has to rise up to the profession and do my best to improve conditions for our 500,000 members.

The RCN has been making headlines recently as our members across the UK balloted to take strike action over fair pay and patient safety. Those strikes are due to take place in a matter of days and I assure you this is not a course of action that our members or we have taken lightly. But we have reached a tipping point. As Henrietta said, the system is under incredible pressure and our members are under increasing pressure and just cannot continue.

As the voice of patients, we can't sit by and witness the ongoing erosion of our health and social care system and the blatant undermining of the workforce. Everyone who works in health and social care knows that pay and safety go hand in hand. Our campaign for fair pay is about improving recruitment and retention, which in turn protects our patients. Our campaign is about patient safety. No matter which way you look at.

The evidence is clear. More registered nurses in our workforce equals safer and more effective care equals better health outcomes. It is as simple as that.

Our campaign is about genuinely valuing nurses and everyone who works in the nursing profession, encouraging them to enter and to remain. It's about staff feeling supported financially, professionally, physically and emotionally so they can continue to deliver the care that patients and service users need.

As we did in Northern Ireland in 2019, when RCN members went on strike over pay parity and safe staffing, we will work with employers and staff to ensure patient safety is at the core of all discussions and planning, and that patient care is protected.

It really does sadden me to say that our nursing staff in the UK are not being treated fairly and they haven't been genuinely respected for years. They are left working with too few staff to deliver the care that they want to, but also that patients need and deserve. Something has got to change.

Despite a recent UK public poll revealing that nurses are the most trusted profession; successive governments have failed to do the decent and right thing by improving pay and creating a fully funded workforce plan to future proof our health and care workforce.

Nursing has remained at the top of the public and political agenda since the COVID pandemic first began. What a journey we have all been on.

Indeed, we're still feeling the impact of COVID, since it continues to affect staff, patients and the general public. It's been a great challenge, but also a great privilege as a Royal College professional body and union, representing the majority of the UK's nursing workforce, we

had to change rapidly to rise to that occasion. We recalibrated the full organisation so that it could represent its members when they needed us most.

We act as a facilitator and a conduit, but during the height of the pandemic we were speaking for them. They were so consumed by the professional task that we had to step in as their clinical professional and political voice. Our priority was simply to support our members and respond to their needs and experiences with compassion, precision and expertise. Day after day they, like many of you were dealing with the highest patient mortality rates ever witnessed, but also with the death of their own colleagues and family members. They were in the eye of the storm, literally. In many cases, risking their own lives as they led care given to patients with complex medical needs, learning new skills every day. As the virus delivered blow after blow, our members continued to turn up to work, to understaffed shifts in many cases, often lacking essential resources and without the PPE that they needed to keep themselves and patients safe. I'm sure you'll all agree that looking back, it almost feels unreal now.

Long COVID repeated infections, ongoing mental and physical health conditions. The nursing staff continue to feel the force of the pandemic. As a Royal College, our priority is to protect our members in all roles across all settings and wherever they are in the UK.

Our members are our greatest teachers. They are our eyes and ears, and they help us to take the temperature of the profession. We create resources that reflect what members are experiencing in their daily lives.

In 2021, we launched our nursing workforce standards. These are the first national blueprint for tackling the nursing staff shortages across the UK. They set the standard for excellent patient care and nursing support in all settings across all UK countries.

They were developed by our Professional nursing committee. They set a road map for designing our workforce for both NHS and wider health and social care sectors that can offer patients the quality of care they deserve. We launched them at a time when we thought that health services were beginning to return to normal. How wrong we were.

It's now clear there's no such thing as normal. The standards work alongside each nation's legislation and can be used by nursing staff along with those responsible for funding, planning and commissioning services that require a nursing workforce.

They are a powerful tool for everyone in healthcare to use as a bar against which they can assess their own workplace performance. In three areas, responsibility, accountable clinical leadership and safety and health safety and well-being. It's our aim for the standards to be formally adopted by employers and regulators to have them recognised as the standard which must be reached as a minimum. We're working to have them embedded into degree course curriculums, so they become the go to resource. Reliable, useful, accessible and able to drive change.

Speaking of students, our members in this vital group tell us that COVID is all they've ever known. That really struck me when members said that to me for the first time. Imagine having never known a ward or a community or a clinic before COVID. We owe these brilliant people who are joining our profession at these uncertain times an extra debt of gratitude. We must support them clinically, emotionally, mentally, and physically. They've chosen to enter the nursing profession despite knowing the dangers and the substandard working conditions many of them now face.

The same goes for those who worked in the NHS and across the independent sector for years who have pledged to push through whatever barriers come their way to deliver excellent care and prioritise patient safety whatever they face.

I am sure you will agree. Nursing really is the very best of people.

As we continued to understand what our members needed from the COVID pandemic, we created a set of online FAQ's and we regularly updated those to make sure information was accessible, accurate and available 24/7.

We increased the capacity of our support services to manage the volume of calls we were receiving on complex issues. The range of issues that our members face daily changed from questions about the lack of adequate PPE to employment rights to personal issues, about whether they should work when they were pregnant, whether they were eligible to claim life insurance should a terrible moment come, to sick pay if they'd contracted COVID or suffered the impact of long COVID and many more personal and professional issues that frankly nurses should never have had to contemplate.

We shared advice on how to raise concerns safely. This is something which we know our members find particularly challenging due to the fear of reprisals and have been seen as unprofessional.

Let me be clear, if a member of the nursing profession wishes to raise a legitimate complaint that staffing is unsafe or patients are at risk they must be fully supported to do so. We should not be under any illusion that escalating concerns is a negative thing. Indeed, it takes courage to do so. And what do we want from our members and from our nurses if not courage and integrity?

Earlier this year we asked our members about their experiences in work. We do it about every two years, and it acts as a temperature check for the nursing profession. The results, I'm sorry to say, were completely shocking.

Eight out of ten people who responded said that there weren't enough nursing staff to meet all the patients' needs safely and effectively on their last shift.

Just one quarter had the planned number of registered nurses.

And only 18% said they had enough time to provide the care that they'd have liked to have been able to do. 18%. That's only 18% said they could do what they thought they should be doing.

These stark findings clearly demonstrated a risk to patient services and to the health and care staff that is simply unacceptable.

Nursing continues to be under unsustainable pressure and the governments are failing the profession and public by refusing to address nursing pay or take accountability for the nursing workforce planning and supply.

Our population is living longer with more complex health needs than ever before.

This is a fact, and it cannot be ignored.

Speaking up for safety, hearing the patient voice

Panel Session Synopsis: Patients and their families need to be considered part of the team that provides safe care. They should be engaged for safety at the point of care, if things go wrong, in improving services, advocating for changes and in holding the system to account. In this session the panellists discussed what needs to be done to put this into practice.

Helen Hughes:

We are now going to go into our first panel session. It is focussed on the need for patients and families to be considered as part of the team that provides safe care and features Jono Broad, a patient campaigner, Professor Tony Woolf, Louise Pye from HSIB and Jane O'Hara, an academic.

Jono Broad:

I have the great privilege of being both a member of staff for NHS England, yes, I did say it's a privilege to work for NHS England, and also a long-term conditions patient.

I really do have one foot in each camp and if anyone's looking at me going 'God he looks healthy for a long-term conditions patient' you should have been at the Patient Safety Congress.

I talked about patient safety at home and gave IV's live on stage, so that's already been asked of me this morning. Am I going to do anything like that? No, I want to do something a bit different though.

And I have just got a little bit of magic for you all.

Let's be honest, patient safety has a very long list of things that need to be sorted out, doesn't it? It is quite big in the world currently. And we have heard today about the fact that there are two sides to the coin. This part of the coin is the staff side. If you notice, the staff are not as big in 'patient safety; as patient safety itself, and let's be honest, it's because you're being ignored most of the time, and the third that's missing is the bit that's really important.

It is really important in patient safety to bring people together and to get them all into the same room as it evens things out. You see, it doesn't actually matter, you are equal when you're in the same room, you are

equal as people with opinions.

We must bring patients and healthcare workers together.

Tony Woolf:

I am a clinical rheumatologist and throughout my career I've been focused on delivering person centred care with shared decision making delivered with an integrated multi professional team and I think that's the fundamental thing and very much agree with this thing of bringing everyone together. So not only clinically but I've been involved in organisations which bring together all stakeholders - people with learned experience, but people with lived experience working in an equal way, but I think that's crucial.

Now, speaking as a clinician, I'm going to say a few things that Henrietta was highlighting in a way. Engrained in us should be to do no harm. That's sort of the essence of healthcare and that means providing the right care which is effective and safe. So I would like to bring in making sure people get the right care under the safety thing rather than just about avoiding accidents and injuries.

It needs the right care at the right time. The right person in the right environment, which has a culture of safety and people working within their abilities and resources. You have to have enough staff to get the right level of care. It must meet people's needs. It has to be very much a consensus about what we're trying to achieve because most of the complaints come from people who understand what was going to be achieved or what was going to happen to them. Therefore we do need, as has been mentioned, that open culture, those open conversations with people being encouraged to speak up. I think when services get very pressured, people think I haven't got time for that but with experience you learn how to get around that and create that open attitude where people will talk up or you have other people in your team like a specialist nurse who people might find easier to open up to and have those conversations with.

The key thing is for people to feel that they can speak up and that they don't go out saying I wasn't asked about this, but they were actually able to ask those questions before they went out.

I think we do need to educate and support patients. Give them tools to ask the right questions. As a rheumatologist, as someone was seeing the orthopaedic surgeon about whether to have an operation or not, one used to say, well, these are things you need to ask. What happens if I have it? What happens if I do not have it? What if it works? What if it doesn't work? To give them some idea about what to ask and to make that informed decision.

Those are the key things.

And we just really have to embed it in the culture that we're all doing the right thing, and we're supported and enabled by the environment we work in to do the right thing.

Louise Pye:

Good morning, everybody. My name's Lou Pye. I am the head of family engagement at the Healthcare Safety Investigation Branch (HSIB), and I suppose I am a little bit of the odd one out really.

I am not from a clinical background, and I come from a completely different sector, and I've bought in some of those transferable skills from that sector into the patient safety landscape.

My background is 30 years as a police officer, 28 years as a detective doing serious and complex investigations. The transferable skills from that work are within serious and complex investigations within the police service. Quite some years ago now, as a result of the Stephen Lawrence Inquiry we brought in the role of family liaison officers to work with families following a serious incident or a serious investigation. It started in the police service when I joined 35 years ago that it was a case of ‘watch one do one’ in relation to working with families you just learned on the job. You did your best. You went in with as much compassion as you could, but nobody told you how to do it and sometimes you did a really good job and sometimes you didn't do such a good job.

When that started to be professionalised back in the early 90s, and in the later 90s when it became completely professionalised, we developed a really strong professional role within investigations and I was really fortunate enough to be involved in that from the very beginning until the day I left the police service.

I was really fortunate to have the opportunity to take from that what I could into the patient safety landscape within HSIB. There are many differences, of course, but there are many similarities as well.

Within HSIB we started with a blank bit of paper, there was a deep desire to work with patients and families well within the investigations. But there was no plan. I go back to my earlier comment, there was no guidance. There were pockets of good practice around various trusts and around the country, but no one really told us how to do it, so we set about deciding how we were actually going to do that and how we were going to establish our processes.

Now it might sound remarkably familiar to some of you in the room in relation to the launch of PSIRF and what PSIRF actually asks you to do and expects you to do. How on earth do you go about doing it? Firstly, why should we do it?

I would suggest there is five reasons why we should do it.

First of all, it's morally the right thing to do if you ignore the regulations and the duty of candour etc., it's morally the right thing to do, and I think that's first.

Secondly, after a patient safety incident, the quality of the investigation is not sound if you haven't spoken to the relevant people. Patients and families absolutely are front and centre of being the relevant people and that is the wider family as well as the patient themselves. Or sadly if the person has died, people that were with them at the time or around the time.

I think thirdly, if we do not do it, we compound harm and we continue the perpetual circle of the experience that patients and families have had.

Fourthly, confidence and trust in the system, and I think that's really important that people go back into the same healthcare system, where perhaps they've suffered harm and they need to have that confidence and trust.

Lastly, and perhaps a little bit more controversially, it's potentially restorative, and I think there's a long way to go with that, and I think we need to understand that a lot better, but there are certainly things that we can do along that pathway.

In relation to PSIRF, it has now given some guidance and given a framework as to how this work should take place.

The first part of the document talks about the leadership, the foundations and the areas that need to exist to enable this work to happen. The second and larger part of the document is actually how you do it. We are still learning. We will iterate that document as we learn and we seek feedback, but hopefully it's the start to actually bringing in some consistency of practice across the patient safety landscape.

I'm just going to mention the seven foundations quickly that that document talks about, because hopefully they'll speak for themselves.

It talks about the leadership and the leadership leading by example in words and in actions. It talks about training and competencies and the minimal standard that's expected for people to conduct this work, not the ‘see one do one’ that I referred to earlier. It talks about the support that needs to be there for both the staff conducting the role, but also the families to be part of the investigation or to be supported with needs that sit outside of the investigation or the response.

It talks about accessibility and inclusivity, and it's all about not expecting people to fit our system but expecting our system to fit our people.

It talks about the information and resources that support the work, and it also talks about seeking feedback to close that loop and evaluate how good we are and then improve where there is an opportunity to do so, and then how we manage the dissatisfaction where we don't get it right. And acknowledging that we do not get it right.

Just a couple of final thoughts from me before we hand over to Jane, what I'd ask you to consider as a result of the conversations that we're having now, is what is your own system and how can you improve it? What model works for you within your setting? How can we provide support networks and guidance to each other to improve that consistency?

I'll just stop with one thing that a family said to me very recently. All they ask for is compassion and competence. And that actually sums it up really well.

Jane O’Hara:

I'm a researcher based at the University of Leeds, and I used to be a psychologist. Now I consider myself to be a patient safety researcher and I came into patient safety, not really knowing much about patient safety, but one of the first things that I was thrown into was this idea that actually patients can help us manage the safety of our systems. Early on in that work I read this paper which has really stayed with me since then and forms the foundation of why I think we should be involved in patients contributing to their safety, but also the management of our safety systems.

What this paper said was that the patient is the only common denominator across all healthcare presentations. They are always there when you are seeing them when they're going to the GP when they're in the hospital, and so when you think about it like that, it

almost makes it illogical that we haven't really tried to look to patients and families to help us help them, but also help them help us to manage the system.

I'm not going to get really geeky and academic on you, but I do want to talk about three key ways that that we've been sort of developing evidence around the idea that patients and families can support their safety but also system safety.

The first thing I was doing when I came into patient safety was exploring how patients and families can tell us about things that have happened. Back in 2010 when we started this work, it was pretty unknown. People didn't think that patients and families could tell us about things but of course they can. They can tell us about things that have happened to them. They can tell us about things that have happened to other people in the services. They can tell us about things that contribute to unsafe situations that may lead to future healthcare harm.

The really important thing that we were able to do within our research was to say, ok, if we can gather that data from patients, is it duplication?

We looked at other forms of data. We looked at complaints. We looked at case, note, review and what we found was that data was not being duplicated in these other forms of safety intelligence.

We know that not only can they tell us, but we should be asking them because they are a different source of information.

The second thing that we've really established in our work is that patients and families can help us understand why things went wrong and what happened when we have healthcare harm.

Patients and families are the common denominator and if we don't actually speak to them, we are missing a really key part of the jigsaw when we're putting together all the pieces about what happened following healthcare harm so it is really the logical thing to do apart from anything else including the moral aspects of it.

The third thing that I think that patients and families can do is co-create their safety and in doing that, they help to support not just their own safety, but system level safety. What do I mean by this?

You will all know I am not a clinician. You will all know that traditionally patients are known to affect the outcomes of things like surgery, for example. If you're smoking, you'll be asked to stop smoking before you have surgery and if you don't, that will affect the outcome. But what we don't know and what is unseen is all of the sort of activity that is undertaken by patients and families that contribute to their safety.

This can be quite challenging for us as healthcare professionals because we don't really want to acknowledge that our systems fail even when they're well-resourced and everybody is doing their jobs correctly and everything is going well. It is a complex system. It will fail at some time.

We also know that there are different parts of the system that are riskier; there are gaps in our healthcare systems and where often staff step into those gaps what we're increasingly understanding is that patients and families step into those gaps too. There are a number of informal ways of supporting safety and we have heard examples of these already this morning.

My final plea to you is please do not assume that you know how your system level performance, safety performance is achieved without asking about what patients or families are doing to contribute to not only their own safety, but also the safety outcomes that you're seeing from your services. If we don't know that, we can't close those gaps or create better ways to help people navigate the system and to not fall between the gaps.

Helen Hughes:

We talk about risk. We talk about harm. It can be emotionally quite challenging dealing with this all the time because that is what we want to improve, but I think part of what we do at Patient Safety Learning with our hub is to celebrate good practice and try and disseminate and share. Can any of you identify some tangible examples to kind of inspire and inform people here?

Jono Broad:

I think patients need to get involved in everything and one of the things we do in the NHS and the reason I say about things like acronyms is we're terrible about the language in the NHS and we've got our own language. I learned that by being the very first patient in the UK to be asked to go and do IHI training as a patient safety officer. I thought ‘oh, it's wonderful’ and then didn't understand half of the words that were being used yet alone anything else. What I realised was actually we need to share our training and our ability to learn with our patients as well as our boardrooms.

I had been a part of the Health Foundation's QI community then and managed to get some funding and we set up a quality improvement group in the South West where we trained staff and patients together and those patients then went into all of the QI projects that the trusts were performing in the South West and it really equalised it. But it equalised it because they had been trained in the same way using the same methodologies and been treated the same in the way that we did it.

I was challenged when we put the plan together to get a village hall and train the patients separately in there. I said so you're going to put the staff up for five days in a nice hotel. You're going to really look after them and you're going to give them a high-quality training impact, but you want me to take the patients to a village hall and only get tea and coffee. These are the sort of silly differences that happen so I think it's really important that we work and train and do things together.

Henrietta spoke about having a board director who would be the voice of patients. I would suggest that that person is themselves a patient or former patient. NICE guidance on shared decision making came out in 2020 and it said that every trust should be recommended to have a shared decision making director who came from lived experience. So far from evidence in this country, only one trust has applied that, they've only applied it since they got into serious patient safety issues and it's East Kent. They now have a shared decision making director who comes from and was created deliberately from a lived experience background. Then you don't need to ask a board member who isn't a patient to have the voice of patients because you've got a patient with that voice on the board.

Tony Woolf:

I would fully agree that you need to have everyone round the table and equality amongst all those people and that needs training. I work very closely with patients and patient representatives and just having one token person around on the table doesn't work. They feel unequal and not comfortable to speak up.

You need to have training and in European Rheumatology we now run a training programme, for example for participation in research to encourage research partners who can feel equal in sitting around the table with academics. I think when it comes to some practical examples of what can come out of that, I've done several projects very much involving all stakeholders. We developed some standards of care of what people with arthritis should expect from their care and that really shifted the focus, quite rightly, from the medical model, to enabling them to have normal lives to do what they want and need to do.

I think it is very important because it really does keep the focus on what is wanted and needed by the most important person. Our role is to try and deliver that as best as possible.

Louise Pye:

I am going to say something slightly different about structures, because we're an independent investigation body, so we don't have the same forum as many of you in the room will have, but I'll make two comments.

I've certainly noticed avoidance of doing exactly this and I think the avoidance is based on the structures, the processes, the awareness, the training and particularly, the time and resource as well. I have definitely noticed people are scared of it being seen as an admission of liability, therefore it is not done in the right way. As far as our own processes are concerned, what we try and do is embed the patient and family voice in everything we do from our advisory panel, our citizens partnership, our co-design of our resources.

Lastly the feedback and the dissatisfaction elements that we do have and how that feeds back in to the quality improvement of the processes and the systems, ultimately making sure we remember why we're doing what we're doing, and it's all about the people.

Jane O'Hara:

I think one of the things that's less talked about is co-design with people of services. We talk about shared decision making. This is about having people in the room and not making assumptions about what the problem is, and I will give you an example of that.

Years ago, we worked with a consultant cardiologist at our local trust and he said he really needed our help. His medical secretary was always getting people phoning three days after their appointment to talk about their medications. Nobody knew what their medications was and everyone was really confused.

So we set out to do an experience-based co-design process with them and some of the really simple things that came out from the patients was the complicated use of medical language at a crucial time in their lives. Patients felt confused about what had actually happened to them. They require a clearer understanding of what it's like to be there at that life-changing point.

The session was concluded with a brief Q&A session before the conference paused for the morning refreshments break. The primary topic of discussion was electroconvulsive therapy (ECT) and the impact that it has had and continues to have on patient safety. The consensus from the panel was that it is an issue that warrants public discussion.

Extravasation; a national safety campaign

*A **presentation** from Andrew Barton, Chair of the National Infusion and Vascular Access Society and IV nurse consultant (Frimley NHS Trust).*

Andrew Barton:

Good morning. My name is Andrew Barton and I am a nurse consultant at Frimley Health in Surrey in vascular access and IV therapy, and I also chair the National Infusion and Vascular Access Society (NIVAS) and I have had the privilege to work alongside Helen and her colleagues in Patient Safety Learning and also NHS resolution and BD have supported us through industry as well.

Extravasation. Some of you may have heard of the term extravasation. If you work in oncology, if you're cancer nurses, if you've had chemotherapy, you will have heard the term extravasation and you probably know more about this than some of your colleagues that haven't heard that term. Extravasation is essentially when you give an IV therapy and you give it through a vascular access device and it leaks into the tissue and that's called an infiltration extravasation, an injury that can cause tissue damage and can be devastating to the patients.

Chemotherapy has the risk of causing damage to tissue if it infiltrates, however, the non-chemotherapy drugs have just as much potential to cause damage to tissue and also cause really negative outcomes.

I was lucky enough to work with NHS Resolution in 2021. They have just released an updated version of a document called ‘Did You Know’, which focuses on extravasation claims. It looked at all of the claims through the NHS over the last 10 years or so and found that there were 444 claims and they paid out on 197 of those to the cost of £15.6 million. But more importantly, 444 patients ended up with some form of serious injury caused through extravasation or infiltration and only a small number were chemotherapy related. The others were all non-chemotherapy drugs so those patients were harmed by IV therapy. Extravasation would not have been the first thought in these situations, staff would look for another diagnosis such as an infection or a phlebitis and therefore patients would not have received the correct treatment for that extravasation.

Some of the drugs we are talking about are metoclopramide, vancomycin, gentamicin, acyclovir, phenytoin and these are all IV drugs that are available in a range of clinical areas, and they're all given to patients on a daily basis, with probably not much regard for the fact they could cause an extravasation injury.

There is more concern around phlebitis and preventing infection through vascular access devices and reducing the use of IV therapy and switching to oral. We are giving drugs to patients peripherally, when we should be giving those drugs centrally and we're seeing injuries occurring there.

When I train nurses and doctors to give IV therapy, and when I myself had training, we were taught that you can give a drug with a pH between 5 and 9 peripherally through a cannula or plastic tube in the vein. However, any pH that isn't the same neutrality as our blood can cause significant damage to the tissue.

If you go to any chemotherapy unit in the NHS, they will have an extravasation lead. That is a requirement for them. These units make up only a small percentage and chemotherapy extravasation is often avoided because the practice in those cancer units is so focused on prevention. If you go into a clinical ward extravasation is not considered in that way.

Andrew then presented specific examples of patients impacted by extravasation and detailed the steps which were taken to treat the injuries. He went on to conclude his presentation.

Learning around extravasation and around the prevention, recognition, treatment, follow up and reporting we have produced some campaign material.

Unless we pick these injuries up within the first few hours, we can't stop that tissue damage occurring and we can't activate any antidotes or wash out which would lead to the tissue dying.

What we will be asking for now is that all organisations have an extravasation lead. Not just in chemotherapy, but across all hospital departments so that there is an awareness of non-chemotherapy extravasation and guidelines and protocols can be put in place.

We want a standardised way of reporting, even in my own organisation we don't have the term extravasation on our reporting system. There's no standardised reporting, so I would argue that if every hospital in the country started reporting their extravasation rates of non-chemotherapy extravasation that there would be a significantly high number of extravasation injuries happening to our patients.

With the support of BD and NHS Resolution we are going to produce a national campaign next year with a tool kit for every organisation to produce guidelines and a local way of reporting and hopefully then we can have a national reporting system for extravasation and can reduce these injuries happening and improve patient safety.

Thank you very much for listening.

Improving staff safety beyond Covid-19

Panel Session Synopsis - The Covid-19 pandemic has underlined the importance of ensuring the health, safety, and wellbeing of healthcare workers across the NHS and social care, which leads to better patient outcomes as part of a positive safety culture. In this session panellists Rose Gallagher and Leona Cameron from the RCN, Stewart Crowe and Neal Jones from Liverpool University Hospitals NHS Foundation Trust, and John Dean from the RCP discussed how best to implement workplace health and safety standards and ensure that legislation is complied with in practice.

Leona Cameron:

I am head of Health and Safety at the Royal College of Nursing.

Health, safety and well-being of the nursing and healthcare workforce is essential to the quality of care provided.

The impact of the COVID-19 pandemic has been unprecedented, laying bare and exasperating long standing problems, including increasing demands with decreased staffing, working intensively with few breaks which can lead to psychological harm occurring. For many staff the default position is to put patient interests over their own.

Under regulation three of the management of Health and Safety at Work regulations where significant harm can occur at work, employers have a legal duty to carry out a suitable and sufficient risk assessment and ensure adequate control measures are in place in consultation with employees and or their representatives.

It should be remembered that under regulation five of the management of health and Safety at Work regulations, all employing organisations have a legal duty to ensure they have effective arrangements in place to manage health and safety in their workplaces, and that includes planning organisation, monitoring and review of preventative and protective measures. The aim is to ensure, so far as is reasonably practicable, the health, safety, and welfare of all employees when they are at work and this means balancing the level of risk against the measures needed to control the real risk in terms of money, time, or trouble.

Using formal management systems or frameworks to manage health and safety can be a great benefit to organisations. For example, ISO 454-5001 is an international standard for health and Safety at Work developed by national and international standards committees, independent of government.

The RCN has developed its own workforce standards, which can be shared across any healthcare organisation that covers responsibility and accountability, clinical leadership and safety and health, safety, and well-being. Standards 11 to 14 of the nursing workforce standards cover health, safety and well-being. There is also the health, safety and well-being group which represents NHS employing organisations and trade unions and is a subgroup of the NHS Staff Council. They have developed workplace health and safety standards with the support of the Health and Safety Executive aimed at directors and managers with health and safety responsibilities, health and safety professionals and trade union safety representatives. The standards describe the principles which provide the basis of effective health and safety management, setting out the issues which need to be addressed, and they're based on the HSE's principal framework of *plan, do, check, act*.

Some of the key components to an effective health and safety management system include strong leadership and management. A workforce which is trained to carry out the duties required of them and a working environment where staff are trusted and involved. When these aspects of an organisation become dysfunctional, important risks can become normalised, leading to serious consequences.

The management approach should be systematic, with staff understanding the risks and control measures associated with their work and clearly understanding their roles and what is expected of them, including their level of responsibility and that of others.

Whilst following workplace standards will go some way to improving the health, safety and well-being of our healthcare workforce to achieve the improvements required, there needs to be shared ambition and renewed collaboration among the main national agencies, governments, regulators and employers across the four countries.

Rose Gallagher:

I'm here with you today representing Infection Prevention and Control. The prevention of infection is acknowledged as the foundation of quality healthcare delivery today, both in developed and low and middle income countries, and it's unique in its applicability to patients and healthcare workers who may be harmed by it.

The management of infection through prevention, the development of policies, strategies, governance and surveillance falls to many, including governments, policy developers, health system leaders, local managers and individual healthcare workers as well. It is relevant to all and affects all within health and care services.

Healthcare acquired infection can result in a range of harms from minor to serious and even result in death. It also affects patients and their loved ones in terms of a poor experience of care. Significant direct and indirect costs are attributed to organisations, so the spectrum of harm can be significant. We know that healthcare workers are affected by infection acquired in the workplace. The range is significant, but today we're talking about COVID-19.

It doesn't just impact on them; it impacts on their colleagues, their teams and on their patients because it results in the removal of that healthcare worker from the workplace. The WHO describes infection, prevention and control as *a practical evidence based approach preventing patients and healthcare workers from being harmed by avoidable infections*.

The main determinant is exposure over time to COVID-19, this can be through multiple small exposures or exposure over a large period of time and that is unavoidable for healthcare workers because in order to deliver care we must have close contact with our patients.

The pandemic has provided us with a focus like never before on the role and risks associated with respiratory infections and the need for respiratory protection and this is a huge opportunity for learning and improvement in the future, because we need to learn, we need to plan for future events.

The language we use in health and safety and the language we use commonly in infection prevention and control; wider nursing practise and occupational health differs. Whilst health and safety has always been a core element of practice, its integration into everyday practice is limited. For example, the management of spillages of blood and body fluids, the constitution of disinfectant solutions to decontaminate contaminated environments or the use of safer sharps devices.

The language we use in infection control policies often refers to pathogens or infection. Rarely do we use the term a *biological hazard* which is used in health and safety, so we have different language used to describe the same risks. The use of harm or hazards in colloquial health professional language does not exist.

The second point is around risk assessment and a precautionary approach to managing risk. This is not new and we use a precautionary approach every time we put a pair of gloves on, we should be using gloves if we know or anticipate exposure to blood and body fluids that may contain bloodborne viruses.

My last point brings me to the role of infection prevention and control in enabling health and safety guidance and regulation.

It is absolutely critical that stakeholders who need to implement infection prevention, control policies and guidance in practice are involved in the development of guidance that they will ultimately use in practice.

Infection prevention and control is not an alternative to health and safety requirements. Its role is to enable the application of health and safety legislation in all care settings, not to direct it. It must reflect the context in which healthcare workers deliver care and consider other factors that may enhance or inhibit the implementation of infection, prevention and control. How we determine what is avoidable infection has yet to be agreed.

Stewart Crowe:

I'm Assistant Director of Health and Safety at Liverpool University Hospitals.

We have talked briefly about patient safety culture and health and safety culture, but we need to really take a step back and look at our organisational culture. If the root of our organisational culture is not right then all the drivers we try to promote and influence from a patient safety perspective or a health and safety perspective we're not going to be able to achieve.

We need to really take a step back and look at our organisations, at our trusts and look at the core values and beliefs of what our organisation is all about and build upon that. Once we've got that right, that should be the heartbeat of our organisation. Everything we do should be built around the cultural values and beliefs of our organisation, so when we're pushing forward health and safety initiatives and patient safety initiatives, we are able to drive that continual change.

Sometimes we need to look backwards as well to enable us to reflect and move forward.

Hudson's cultural ladder has been a reference point for the work done at Liverpool. At the bottom of the ladder representing the least informed and the lowest level of trust and accountability is 'Pathological – who cares as long as we're not caught'. At the top of the ladder is 'Generative – how we do business round here' and this represents the most informed and highest level of trust and accountability. There are three interim stages progressing from Reactive to Calculative to Proactive. You can apply Hudson's cultural

ladder to patient safety or healthcare worker safety and there's plenty of research documents which apply either subject to this particular ladder and show you where you are, and you can measure against that.

When I started my role at Liverpool University Hospitals our health and safety approach was really just an estate and facilities function so the first thing that we had to do was move our health and safety committee from within estate and facilities people to a wider group so we could have greater influence. We had to get commitment and engagement from the right people because if we don't get leadership on board - we don't get the values right.

We revitalised our health and safety group. We changed it from being an estate and facilities group to being a more inclusive group which brought in patient safety.

With Neil coming on board, we brought in hospital leadership teams to the health and safety group.

We have brought in the workforce. We have brought in Human Resources. We included a wider group of people to help us drive what we wanted to change and shift the culture as we move up that ladder.

We are starting to benchmark ourselves against the NHS workplace health and safety standards and we've got colleagues in the room here today who are part of that. The enforcement authority is part of that group and have been driving it forward. We are promoting a webinar soon about what that standard looks like and how impactful it is as well as raising awareness about that standard across the NHS environment.

At Liverpool we are taking that standard forward to really raise awareness of health and safety. We've approached this at ward level, at our care group level and asked each care group to measure themselves against this particular standard, and we've asked the ward managers and the maintenance staff to take the lead on this so they've got ownership and they can help and be part of that journey we're on together. It is not just being forced upon them; it is creating that safe environment of learning.

We've spent a lot of time looking at data and information so we can learn what we get right and where there are areas for improvement.

Education and awareness are really important. Looking after our staff and feeding back when they have raised concerns about what we've done differently to change things in their environment to help them is important. SLT accountability has also helped us drive this forward.

One thing that I think is really important is we need to celebrate success. We have done something really well. We need to go out and tell people about it.

We have highlighted the problem. We have done something about it. We have changed. It has had this impact. We must tell everyone in our organisation about that and then give assurances right up through the chain to the board to say this is the journey we're on.

Thank you very much for your time. I am going to hand over to Neal who is going to talk through a bit of a case study to bring this all together.

Neal Jones:

Good morning, my name is Neal Jones. I'm the director of patient safety at Liverpool and work very closely with Stewart.

We found ourselves in a rather challenging position post-pandemic, we faced the move into a brand new hospital, a brand new hospital that had a depleted workforce, and a hospital that is so vast that if you were to walk around without passing yourself once, you would cover about 6.2 miles.

The anxieties I had were around the appropriateness and effectiveness of transporting models of care from a completely different environmental state into one that we hadn't experienced. And to understand what the impact upon, most importantly, our staff because if we don't create the conditions for success for our workforce, they certainly can't deliver safe and effective care to our patients.

The first thing we did was look to understand the variation between clinical environments and undertook ergonomic assessment looking at sequential task variation. Ward rounds, medicine rounds, observation rounds - the things that take time. The variation between the two environments anthropologically measured using cross section of staff with different stride lengths and laser measurements was up to 136% increase in physical time and movement.

Many of you will be familiar with the concept of optimising violations that if we increase task load, then staff have to take shortcuts ultimately to try and get the job done. So the challenge to us as an organisation was to try and come up with a model of care that would not only make it more effective for staff on a physical and cognitive level but would also deliver higher quality of care for our patients. We also wanted to understand the variation in environmental challenges. Whilst a beautiful brand new hospital with exclusively single occupancy side rooms is massively helpful as a starting point with the likes of nosocomial transmission it still brings additional challenges.

What we found was that the increase in physical movement was significant, that significant that we were concerned that our workforce wouldn't be able to cope, and certainly wouldn't be able to deliver the same levels of care and complete the same levels of tasks.

The environments themselves are expansive and whilst that's amazing for a lot of our patients, staff face the significant challenge of being able to function effectively within such an expansive environment.

Whilst to be commended and arguably understood, designing an entire hospital building on the base ergonomic measurements of a wheelchair user that makes up 6% of your patient population is not without consequence. The height of showers meant that a patient over the height of five foot seven wouldn't be able to stand upright and have a shower. The height of the grab rails meant that grab rails were around mid-thigh height rather than at waist height, so you'd have to stoop to grab them. There were many other examples. We spend a lot of time removing, replacing, repairing, and fixing all of these things and you'll be happy to know

that at six foot four I can stand happily in the shower in the hospital now, as can every patient that we have.

From a model of care perspective, we compartmentalised each ward so no small multidisciplinary team would look after more than a group of eight patients in any one shift period. We've also brought all equipment care provision, accessories, medicines and everything into the compartmentalised areas. This has allowed us to achieve a safe staffing ratio of around 1 to 7 registered nurses and on top of this we now have all based pharmacists, therapists and medical staff.

On top of that, we have registered nurse Coordinators and HCAs to help with the running and other bits and pieces to try and keep our staff in those hub areas with their patients to ensure visibility, reduce physical movement and optimise task performance and task completion.

The one bit that we're still trying to work through is how we further optimise our staff performance and within this is some of the most challenging areas for us as healthcare leaders because some of the biggest areas we could improve – the likes of shift length, breaking service in between nights to days to normalise and stabilise circadian rhythm – are dependent upon having a significant number of staff available.

At this point, whilst we have optimised the environment, we've reduced physical movement, cognitive load, the feedback from our staff is that they are genuinely enjoying working within the new hospital.

We only finished moving in on the 21st of October, so it's still a little early to suggest we've got some clinical outcomes to demonstrate improvement.

From our perspective as an organisation, we're asking the questions as to why, within other high reliability and high risk industries, regulation creates the conditions within which staff are prevented from being put in a position within which their performance is compromised at the expense of harm to others. But yet within healthcare those rules are not necessarily applied in the same way, certainly consistently and effectively.

The ambition of the organisation and Stewart and I is to ensure that our focus is to protect our staff so that they may protect our patients. Thank you.

John Dean:

In the context of this session, learning from the pandemic, when we reflect back on what we learned as clinical teams, it was how interdependent we all were and how we needed to look out for each other, work together more effectively and ensure we were working in a safe environment. If you think of some of the initiatives that developed during that, the one that particularly comes to mind is the ‘start well end well’ approach which embeds staff in a unit coming together at the start of a shift asking how everybody is, asking how safe it is today and looking proactively at what risks there are, how they might mitigate that.

I am really interested that you're looking at the shift length because I think we've got ourselves into a really difficult position for staff to work safely, particularly towards the end of the shift.

You have always got the lens of staff safety and patient safety together. We are not forcing them together, it's just part of the culture of how we work and how we look at safety. I think we have seen exemplars of that coming through the pandemic, but I think what we are seeing is that the current pressures that people are having to work under are putting those

ways of working under pressure, and that's what we have to preserve, because that's what preserved us during the height of the pandemic.

Following the presentations from the panel there was an extensive Q&A session of which some have been detailed below.

Question:

I am a patient safety researcher, but I'm interested in your views on whether divorcing patient safety from staff safety, health and safety has actually potentially caused more problems than it's resolved. Should we move more towards a healthcare system safety approach rather than divorcing different aspects of safety and looking at them myopically in siloes?

Answer (Stewart Crowe):

I think the two come hand in hand really. If we don't get it right with our staff and our colleagues, they're not going to come into the right environment in the right frame of mind to give that patient care that we want them to give.

We need to build and maintain that culture of creating a workplace where staff feel safe, healthy and want to come to work. We want to create the best environment for them to give the best care they can possibly give to the patients coming to see us.

Answer (Rose Gallagher):

For me it is a yes. Anything that removes perceived or actual silo working is to be welcomed. It all has to integrate. It all has to complement and enable each other.

Answer (Leona Cameron):

I am totally in agreement and I think the analogy of two sides of the same coin is perfect.

Answer (John Dean):

There are two elements to this one. One is a common language and understanding and we've touched on that before. The language and understanding around system safety is what we need and if we start to do that, if we start to understand systems, we start to understand hazards, risks, barriers, etc., and that becomes a common part of healthcare language and practice then we won't even be asking that question in the first place. It will just be naturally part of what we do.

Answer (Neal Jones):

I think as a healthcare system globally we are transitioning into a different mindset, and one that for decades has centred more around defensiveness and self-protection than it has about curiosity and humility. It's going to take time to establish the effective systems and I think the challenge we have really is that whilst we can start to move forward and better understand how to create additional reliability across the systems within which we work, if we don't apply the same level of improvement to the conditions within which our staff work, those systems will remain compromised.

Question:
I would be interested to know on the panel who they think should have oversight of strategic risk assessments which failed during Covid-19. This is a serious issue and I think when

talking about system approaches, the key issues are those strategic risk assessments and whether they're actually robust and whether there is oversight of them.

Answer (Helen Hughes):

There is no oversight committee. If you look at aviation and transportation, both of those industries have an organising leadership committee that brings all parts of the industry together. There is no equivalent in healthcare and that is a massive omission I think because then you are not going to be bringing those parties together.

Answer (John Dean):

It needs to be clarified absolutely. Within England at the moment, we're piling everything onto integrated care boards, but if we really are looking at health and care as a system then the local knowledge that will inform whether those are correct would naturally sit at that oversight level otherwise all you're doing is pushing the risks somewhere else frankly.

The session was brought to a close as the conference broke for lunch.

Afternoon session

Introduction by Co-Chair Ian Lindsley, Secretary of the Safer Healthcare and Biosafety Network

Ian Lindsley:

My name is Ian Lindsley. I am the secretary of the Safer Healthcare and Biosafety Network, and we're delighted that you all came today.

The first of our speakers this afternoon is Doctor Leslie Kay, and she is from the Healthcare Safety Investigation Branch (HSIB) and was telling me just now that she's a consultant rheumatologist as well.

Afternoon Keynote Address

There was one keynote address to open the afternoon session of the Conference.

Lesley Kay, Deputy Medical Director at the Healthcare Safety Investigation Branch

I have got 10 minutes to tell you about HSIB and what our contribution is to patient safety in England.

We have been in existence for nearly six years now. We're based on the model of the Air Accident Investigation branch and our main role is patient safety event investigation. We are independent and NHS funded. We have the absolute privilege and luxury that we are not allowed to apportion blame or liability.

We very much are systems thinkers. We have got a lot of chartered economists working in our team. As well as a lot of safety scientists.

One of our main aims is to make patient safety investigation a professional activity done well, done fairly and to make a real difference.

We have got lots of different people in our team from different industries including nuclear experts, defence, police, different types of military investigation and an odd scattering of healthcare professionals. We're a real example of how diversity of view gives you a different perspective on what you see. Some of my colleagues from engineering, for example, will see a problem completely differently from the way I see it, and that's just a joy. I love working in that kind of environment. We cannot blame anybody and that gives us free access to learning, and we have a real remit to try and collaborate with as many people as we can.

HSIB started in 2017. We had a very small team, then a remit to do investigations into issues and events of patient safety nationally, shortly afterwards the maternity programme was added. I'm not going to concentrate on the maternity programme today but am happy to answer questions about it.

For our national programme we have set criteria but we are at the discretion of our chief investigator as to what we investigate and we do up to 30 investigations a year.

Come next spring, we've now got a legal basis that we're going to separate into two bodies. HSS IB will replace our national team. We will have statutory independence and we will have some new legal powers that we do not currently have, and the maternity investigation team will go into its own new Special Health Authority.

And our new arm is the investigation education team who've been going about a year and a half now. Part of this team is focussed on professionalising safety investigation and improving the quality of safety investigation across England.

I can't possibly cover everything that we do, so this is the new title of the report: *Harm caused by delays transferring patients to the right place of care.* This came about after we had almost in the same day five different referrals to us of patients who had been harmed by delays, either a patient in an ambulance coming to pick them up, coming to assess them at home, or hand over delays in the back. We took these five and sent teams out to go and look. We did a scoping investigation as we normally do to see what the risks and hazards were and to try and understand how these harms are happening.

We've had two interim bulletins come out from this investigation so far, the second of which was just a couple of weeks ago, and the main finding from the second one was really trying to look at a system of ‘where is this patient at most risk?’ We concluded that the patient is most at risk before they've been assessed at home and their risk gradually decreases as they're in a place of safety. Then there's a complete accountability gap – what we've called a patient safety air gap between that patient being ready for discharge and being able to go safely home.

We have worked with NHS England. We've taken part in some of the national medical directors’ workshops about emergency care.

The main finding in our first bulletin was that everybody at each of these stages is doing their absolute best for the patient in front of them. Everyone's working their socks off, but nobody is sitting back and saying ‘where are the risks across this system? How do we minimise risk overall?’

These workshops have started to try and address this, and they have got control centres now that they're building up exactly to do this. ‘Where is the risk in my local system? How do I remove the patients from that area of highest risk down to lowest risk?’ I think everyone at home with the person on the floor waiting for the ambulance can see that risk because it is in front of them. This is the kind of contribution we hope to make to the system that we are coming in to look and see where the risks are.

Where can the biggest differences be made? So that is our second interim bulletin. The third will be out in the new Year. Following that the final report will be produced.

What we also try to do is to learn from the aggregate themes. What can we bring together to learn from these investigations that we've done and we found that we've done 10 reports

looking at never events, all done individually. We code the learning from these reports. We use a recognised qualitative methodology to theme them and to come out with what we think are the important things.

It is sometimes too easy just to look at a narrow causal chain, but what we are trying to look at is, was there something about this organisation that made this more likely to happen, or less likely to happen? What is it in the environment? What is it about the staff? At the end of their 12-hour shift have they got problems at home? What equipment have we got for them?

This is a framework that we use both in our investigations, but even more importantly for secondary analysis and learning. We do try to be systematic in looking at what we have learned from these investigations.

It is really important for staff to know that if a never event has happened, it needs to be investigated. It does not mean that that person was reckless at work, so we need to be examining what the barriers are and how we can prevent these things.

I'd like to talk a little bit about our education programme. At the moment four and a half thousand learners have been through some of our programmes so far. We have made sure that our training meets all of the standards laid out in the Patient Safety Incident Response Framework (PSIRF). We have a general course that we're calling our Level 2 online course, which currently is available to anybody who works in English funded NHS Care. It is an online course with unlimited numbers. It is turning into a really interactive network. It feels really generative, really productive in itself.

We also have a number of specialty modules. One of the first ones that we had was for strategic decision makers. It is really important to get senior level buy in about systems thinking about the right kind of investigation and the right kind of learning to get from these incidents. It is a 45-minute module. We found it works really well if you get a trust board together.

At HSIB we really do focus on system focused investigations. We know we're not the only people doing this. We know there are really good practices in some areas in healthcare, but we know that there's still a lot of root cause analysis going on out there and blame. So we are really keen to make sure firstly that we get it right, and that we're in a position to be able to role model it, and that we make recommendations that really will influence change in the system.

We mentioned safety management systems. One of the things that has been so surprising to a number of our investigators coming from other industries is the lack of structure we have around patient safety in healthcare. We do not have defined standards going forward.

We will be saying more in the new financial year about how safety management systems might apply to health. It will be a big cultural shift in health when we work out how to structure safety management systems in healthcare.

Creating a safe environment in hospital theatres

*A **presentation** from Lisa Nealen, Peri-operative Practitioner at Gateshead Health NHS Foundation Trust.*

Lisa Nealen:

Good afternoon. I am a practising registered nurse in the Queen Elizabeth at Gateshead. I have been there for 32 years, and I have been in theatres for 28 years and 26 of those have been in Orthopaedics. Seven years ago, on the back of a government initiative for all level 1 nurses to be at degree level. I took up a practice development degree at Northumbria University. I got to experience some modules which related to what I was currently doing in theatre and what was quite alarming was the lack of understanding of legislation around which products we should be using within our departments to keep ourselves and our patients safe.

I decided to write my dissertation on surgical smoke and plume and how to make your stay at the theatre environment safer. We need to empower staff to go back into their units and change cultures. That is what we need to do in our theatre departments because lack of education, means a lot of us don't understand the dangers around surgical smoke. There's over 30 decades of research out there showing that it's as dangerous as smoking.

As practising professionals we all have made a promise that we're going to make sure that we maintain the safety of ourselves and the patients that come into our areas of expertise. And if we know that there's any danger that we act immediately. We're all under the umbrella of the Health & Safety Executive and have to carry out risk assessments within our areas to ensure that anybody coming into that area is going to be safe.

As employees, we've got to help our managers by ensuring that these risk assessments are adhered to and whatever equipment that we put in place to use is being used correctly.

In the UK in 2006 it was made illegal for us to smoke in public and workspaces. We know the majority of hospitals in the NHS proclaim that they are smoke free but how many are still using products that are generating smoke?

The Public Health Act doesn't just relate to tobacco, it does actually state that if there is any substance, when lit, that causes smoke that's hazardous to health then we should be protecting the people in that environment.

There was a piece of research done by the American Association of Nurses, and it looked at 750 perioperative nurses and the research found that as a general population they were twice as likely to develop a long term respiratory disorder.

The Royal College of Surgeons are pushing their green surgery programme which looks at how much waste we are actually generating. In hospitals, theatres can often generate up to 1/3 of hospital waste.

Based on the back of one of our particular orthopaedic surgeons who was generating for some of his shoulder surgeries up to 24 litres of fluid waste which was ending up in surgical bags and landfill, we put in place a waste management system which is mobile. It has a completely sealed system so you don't get any splashback. It's got other products that you

can use on the floor to suck up your fluid waste from the floor therefore reducing your risk of slip trips and falls.

During some surgery, smoke is breathed straight into the face of the surgeons. How many of you just wear a standard mask?

Your standard mask only protects you from blood particles of about 0.5 even with the surgical smoke evacuation, so we should all wear an FFP 3 mask, especially in the surgical field because the smaller that particle, the further down your airways it's getting into your lungs and we have worked alongside a surgeon who ended up with a double lung transplant and is convinced that it was caused by his lung damage.

One of the things that I want to talk about is how I achieved the culture change within my department. You have to include everybody including surgeons, managers, your risk assessment manager (who is one of the most important people that you're going to talk to because they're the ones that you're going to invite into your department to actually come and do the risk assessment), procurement (the ones that are going to work closely with the companies to bring the products into your department to instigate the trials) and general staff.

You want enthusiastic staff as your trainers alongside the reps because they're going to make the change as easy and smooth as possible.

I found that it was my management that I needed to educate the most when I instigated this change.

My management were from an anaesthetic background, so they didn't really have any knowledge around surgical smoke and its dangers or about the amount of fluid that we were generating in waste.

I certainly didn't know about the dangers of surgical smoke when I trained as a nurse.

In order to ensure a smooth transition, you need to involve the whole team. You need to have your feedback forms to make sure that you're all in agreement that the products you decide to use, or that procurement that you use is the one that you're going to be the happiest to use.

Following these steps will lead to a safer environment for our patients and staff.

Mind the implementation gap; The persistence of avoidable harm in the NHS

Panel Session Synopsis - The NHS estimates that there are around 11,000 avoidable deaths annually due to safety concerns. However, despite a range of international and national initiatives aimed at reducing avoidable harm, it remains a wide-scale problem. In this session panellists discussed why avoidable harm continues to persist in healthcare and how we tackle the implementation gap, the difference between what we know improves patient safety and what is done in practice.

Ian Lindsley:

I have spent 20 years working on healthcare worker safety and occupational safety but couldn't believe that 11,000 was the number of avoidable deaths when I was told that that the estimate.

Helen Hughes:

The College of Emergency Medicine has said that the scale of pressure at the moment is leading to probably 500 avoidable deaths a month at the moment because of the pressure on emergency departments, so the 11,000 avoidable deaths, which is the statistic we use in the UK, and we've been using it since I've been involved in patient safety, has probably doubled.

Ian Lindsley:

One of the things that we've tried to do about it is to look at helping staff following patient safety incidents. We've worked together to produce the *Staff Support Guide* which is now published. We have also produced the *Mind the Implementation Gap Report* which is about avoidable harm and the fact that there have been so many public inquiries, so many scandals which have resulted in a lot of box-ticking and very little action. This session is really aimed at trying to address that issue and discuss how we reduce avoidable harm.

We heard a fantastic presentation of that from Leslie using the example of aviation for the work that HSIB does. Keith Conradi is sitting next to me. I am told he previously was chief investigator at HSIB and Chief Inspector at the Air Accidents Investigation Branch.

Then we have Claire Cox, who is Patient Safety Lead at KCL and co-founder of the Patient Safety Management network.

When I go on a plane now, I'm pretty sure that plane isn't going to crash and there were lots of air accidents when I was growing up. Something changed from the sixties. What changed?

Keith Conradi:

The last public inquiry into an aviation accident was in 1973, which I think is interesting in its own right. But what has changed I think, is the culture of the people who work in the industry.

Operationally health and aviation are hugely different, and I think the big mistake is sometimes people think that we should be trying to import from one to another, but that's not

the case. I think culturally there is and has been a lot to learn and a lot has actually moved across from one to the other.

There is this huge emphasis on safety. It is easier in aviation because if you lose an aeroplane, it is hugely compelling. It is headlines. It is the end of the airline and everybody knows that. However, in the health system, many people will be dying anyway, and so when they do die, it doesn't get the same attention, which I think is why it happened earlier in aviation.

There are a couple of other things which I think are extremely important. Leadership in aviation has really helped that and I'm talking the absolute top leadership – the Secretary of State level and the leadership of the regulator and there is only one regulator in aviation, which I think also helps. The Civil Aviation Authority (CAA).

The way safety is structured has an impact as well. It is formalised. There is a proper structure which is mandated for every entity, every airline, every organisation that supports aviation throughout the world.

It is well-regulated by the Civil Aviation Authority so that gives it the basic framework to make it happen which I think has been lacking in healthcare.

Ian Lindsley:

Do you think that the decentralised and federated nature of the NHS is one of those problems?

Keith Conradi:

I don't think it has to be a part of the problem but potentially it can be. I think if you have that same templated structure of safety which could exist from a GP practice up to the Department of Health and Social Care, they could all have broadly similar principles of safety. All the airlines are very similar in comparison to all the sort of different health providers, but they all seem to manage and there are a huge number of enthusiasts and real experts in safety in healthcare but they're just not able to work within that structured system and have the support of the very, very top leadership.

Ian Lindsley:

What do we do about this cultural issue which clearly is a problem in healthcare?

Claire Cox:

The cultural bit starts with what we are looking at. We look at harm and we measure how much harm we've given someone, how many incidents we've had and then we just investigate and investigate and investigate. In the last six months we investigated 1.3 million events in the NHS, which is significant.

When you're looking at numbers that can often give people the assurance that we're doing better because they like to look at the numbers coming down. When you've got lines of inquiry from the CQC and other regulators, they're looking at how many incidents you have open and they want to see those incidents coming down.

When you're looking at harms, you're looking at gaps as well. That is where all these guidelines are coming in. There is the guidance on the extravasation which we spoke about. There's so much guidance because something fell down the gap.

The guideline goes in and as a nurse when I'm working under 100 to 150 different guidelines during any one shift, and I follow all the guidelines to the letter I wouldn't get any work done at all.

When a safety incident occurs, they look to see if you have followed the guidance correctly. If you have not done it a very quick way of shutting it down is to say you need more training and you didn't follow that guideline. It adds layers and layers and does not make it safe.

I always feel that we're the ones to blame when things go wrong, so we might cover up things if things aren't going quite right.

At the moment I'm trying to make a pathway for mental health patients coming from the Community into acute care and then back out again. But where am I going to find the time to get all of these people together? Big transformative changes are quite difficult and people often shy away from them but the culture is difficult and tricky and there is a long way to go.

Helen Hughes:

Reflecting on what Keith said which leads to Claire's point. I am really taken aback by you saying that the last big inquiry in aviation was in 1973. Especially when compared to how many inquiries we are having even in this year in the NHS. This was the focus of the *Mind the Implementation Gap Report*.

There's a kneejerk response to do lots of inquiries but do we learn and do we apply the knowledge from those? Or do we just do another inquiry? You can change the culture of an organisation if you do investigations properly. If you learn and then you apply that learning but it has to be applied in real life. Trying to redesign for safety is so important and building from the ground up rather than just imposing another set of Standard Operating Procedures when and if they go wrong.

In the *Mind the Implementation Gap Report* we looked at public enquiries and reviews. We looked at reports preventing future deaths, reports that coroners undertake, investigations into clinical negligence, we looked at patient complaints and how they are managed and then the incidents and investigations that Claire talks about. What struck us was the absence of a safety management system approach, either at an organisation level or as a health system level.

Nobody could give us a concrete answer as to whether the recommendations made in these reports were put into place. Nobody is owning that. There is no national body that is making sure the insights that we've got from learning is being implemented. If you agree to the recommendations in those excellent reports but you don’t implement them, where's the accountability? it's not a not blaming of individuals, but the system has to be accountable for that.

In one of the transport industries there is a coordinating body for making sure that the safety management system operates and there is nothing like that in healthcare. Not just in the UK but in the industry globally.

Keith Conradi:

That is true but I would temper that with the fact that transport is a whole lot smaller. In healthcare it is a significantly bigger challenge, but that shouldn't stop it.

There was the start of bringing together the heads of many of the regulators to look at some of the more difficult recommendations that we made out of the responses that we had that we weren't particularly comfortable with. It started before COVID when I left six months ago. It still hadn't looked at the first safety recommendation response, but at least there was something there that was starting off. If it has the attention of the highest leadership, it can happen and that is the biggest difference that I see, because anything can happen if you give it enough priority and I personally don't see the same level of priority given.

Ian Lindsley:

When you go on a plane the Captain says to you, every single time, safety is our number one priority. When I go to my GP surgery, the GP doesn't say safety is my number one priority and that does reflect a difference.

Helen Hughes:

One of the biggest issues around safety is overcrowding in our hospitals. We have not got the service is right in our communities and community services and in in primary care. We've lost one third of the district nurses in the last 10 years, so we are seeing more and more people in hospital that don't really need to be there.

The session was opened up to questions from the audience and the panel discussed the worsening of patient safety since the Covid pandemic and the need for a systems approach.

Preventing workplace stress

Panel Session Synopsis - In this session panellists considered the reasons for workplace stress and how to prevent it, including the role of high-pressure work environments and how a lack of support and bullying or violence can exacerbate stress, anxiety and depression and damage both the individual and the organisation in healthcare.

Ian Lindsley:

The session this afternoon is about preventing workplace stress. Kim Sunley, who is going to speak to you first, is the National Officer for health, safety and well-being as well as Co-Chair of the NHS working Group on health and safety.

Kim Sunley:

Our group, the Health, Safety and Wellbeing Partnership group is a subgroup of the NHS staff Council. The NHS Staff Council has a remit from the Secretary of State to negotiate on paid terms and conditions and within that remit is working conditions as well.

They talk about pay and pensions for staff on agenda for change terms and conditions, and we've got four subgroups, one being our group and other groups like the Equality Diversity and Inclusion group.

We've got one task and finish group at the moment looking at home working and hybrid working and that includes obviously terms and conditions for home and hybrid workers, but also some of the safety implications for home workers in terms of working with computers and mental health risks of working on your own.

Our group has been established for a number of years and it is a tripartite group, so we've got staff-side representatives from the NHS trade unions, we have management-side representatives, we have health and safety managers, occupational health specialists and HR as well.

NHS Resolution are in our group and provide really helpful data in terms of staff, non-clinical injuries and risks. The Health and Safety Executive are on the group along with the Institute of Occupational Safety and Health. Our remit is to raise standards of workplace health and safety and well-being in healthcare organisations and to promote a safer working environment for all healthcare staff.

The NHS staff survey for England, which I am told is one of the biggest workplace surveys in the entire world, showed that in the last 12 months from when the survey was taken, just under 50% of staff felt unwell as a result of work-related stress. If you look at the data, it's been on the rise since the 2007 survey from 38.4% to 46.8%. This is not just about COVID, this is about a steady rise in work-related stress.

I want to just take some data from the HSE. They released a report on workplace stress statistics, looking at sources like the Labour Force Survey which looks at rates of self-reported work-related stress, anxiety or depression in Great Britain's working age people. Health professionals are significantly the highest group compared to all other professions. We must not forget our ancillary support staff, our porters, our domestics who are contributing to that safe quality care who may be on precarious employment contracts. It is

also worth noting that across all sectors, women between the age of 25 and 54 report significantly higher rates of work-related stress, anxiety and depression than men.

That is the background. Just talking a little bit about the group. Workplace stress has been something that we have been focusing on recently.

We support the HSE's definition of stress. We all need a bit of pressure to get out of bed in the morning, but when excessive pressure or demands and a lack of resources happen then that can lead to harmful stress.

In line with legislation, we view work related stress as a work-related health and safety hazard that can lead to the risk of harm be that physical or psychological ill health. We all know the impact of stress on the body. Long term exposure to stress on both our physical health and our mental health. Employers should be taking reasonable steps to prevent harm using the HSE's management standard framework.

It is not enough to provide resilience training, which is a secondary intervention. It is a bit like giving a construction worker a hard hat and saying off you go. You wouldn't put a construction worker on a construction site without safe systems of work, so just like a construction worker needs those safe systems of work, a healthcare worker needs to be physically and psychologically safe in their work environment.

We advocate working in partnership with the staff and their representatives, the people doing the jobs day in, day out are the ones who know what the solutions are. We heard this morning about co-design with patients and collaboration with patients but actually we also need to co-design and collaborate with staff and staff representatives and trade unions health and safety representatives.

We have developed guidance which is hosted on the NHS Employers website and this guidance can provide a framework and act as an enabler to have discussions. Take it to health and safety meetings, take it to workplace meetings and use it as a review of what you're doing. The guidance talks about signs and symptoms, the impacted individuals, the impact on the organisation. It outlines the management standards and then also looks at things like qualitative and quantitative data that can be used to form a picture on where you know the issues are occurring and where the hotspots are. It supports organisations to develop a policy.

Some of the other resources that we have developed include work on domestic violence and abuse, work on personal safety and a piece of work on shift work as well using the HSE's guidance on shift work and fatigue.

There are big issues we need to tackle. There are things we can do as individuals, as managers, as colleagues. And it is the trivial things that matter, and this is a quote taken from a piece of research from Nottingham Trent University: "At the end of the day for somebody – just anybody – to come to you and say, 'thank you.' It is a big word, thank you. Sometimes that is just all you need."

Martin McMahon:

I would like to speak for a few minutes to clarify some thoughts on workplace stress and to give a bit more information on what the HSE have been doing and will be doing. First of all, I just want to clarify where the applicability of health and safety legislation comes in within healthcare. Now let us be clear. If it is a place of work, health and safety legislation applies.

If you have specific examples of situations in your experience that you can advise us of where you believe employers are not fulfilling the health and safety legislation, please contact the HSE.

We will not investigate every single concern that comes in but if we never hear about it, we never get to make that triaging decision about what we do with it.

We believe that work-related stress is a workplace hazard that can be prevented and can be managed. We have web pages on stress have done for quite a while.

It comes under Section 2 of the Health and Safety at work act – duty to control the risk so far as reasonably practicable, the health and safety and welfare of your employees and the management of health and Safety at Work regulations to make a suitable and sufficient risk assessment and implement control measures. That applies to work-related stress as it does to other workplace hazards.

We do have to realise internally as an organisation that we need to have some thoughts about what we're going to do to try to tackle this. I'm standing here saying that we don't know yet how we're going to go about it, but we do know it is part of our 10 year strategy which is a bold strategy.

If work-related stress is made a priority, it can be prevented and managed, it is going to be better for everyone including the people at risk, which is clearly the most important thing. It is more efficient. It will save money in the long run and is the right thing to do.

We already have some tools available to help control that risk. The management standards have been there for a long, long time. You are probably most familiar with it. It is focused on six main aspects of managing stress within our workplace:

- Demand
- Control
- Support
- Relationships
- Roles
- Change

Communication is key. If you feel you have an employee who is exhibiting signs of stress there are toolkits to assist you in having that discussion and there is also the Working Minds campaign, which has been going for a year and at the moment is focused on small and medium sized enterprises. The aim is to make organisations more aware of the importance of work-related stress and mental health in the workplace.

Back in 2018 HSE carried out an inspection campaign on NHS trusts and boards in Scotland, England and Wales. They were management inspections looking at the management of risk in relation to two particular topics, one of which is violence and aggression within NHS organisations. The intention was twenty inspections a year. We missed a year because of COVID. The findings from those inspections will be on our website, hopefully very soon. I have been involved in doing the analysis of that work. It is currently going through the sign off process. Although one important headline is that 60% of NHS trusts and boards had contraventions of health and safety.

Carol Menashy:

I want to share with you all today this initiative that I set up to support staff involved in safety incidents. I have been a theatre nurse for more than 20 years. The catalyst for this initiative,

which is called SISOS (Safety Incident Supporting Our Staff) was a never event. What I recognised with this never event was the lack of timely and accessible support for our staff. And so I went home following this never event and I thought ‘this is not acceptable.’

I reflected on an incident that I'd been involved in as a scrub nurse some years earlier where I'd accidentally handed some unsterile wires to the surgeon who then drilled them into the patient’s bone. I asked myself one question. ‘What would have helped me when I sat in that tearoom at 1:00 o'clock in the morning at Chase Farm Hospital alone and devastated?’ And the answer came back pretty sharp – peer support. I needed the reassurance of my peers because I knew that they would get it and they would be non-judgmental and they'd also understand that any one of them could have found themselves in my shoes.

The other thing that I knew we needed was safe spaces. A physical space where I could have been supported and my dignity protected.

I got myself together and did a presentation to our department, the Theatre Department, and most people were interested. About five or six members of staff came to me and said ‘Carol, we like this. We know we need it. What can we do now?’ At the time our organisation was introducing mental health first aid training, so we opted for that. That was the basis of what we do as peer supporters, we all have mental health first aid training, but on top of that I have added other training packages.

The next step in the process was for me to go to my department and say ‘we need a room. We need some space.’ After some convincing and some reorganisation of the orthopaedic storeroom we were given a space. It's a triangle, it's got no windows, and it's tiny, but it's right there next to the tearoom. It's accessible, no one has to get changed in or out of scrubs to use that space, and it's confidential.

Then I go to the charities. Get the charities fund setting up this room and we've got a safe space. This room was transformative because suddenly we got our badges on. Suddenly people came up to us. It made it real, and I heard so many times from people: ‘We feel valued. We actually think people care and this is wonderful.’ I was very worried that I'd created something that wouldn't be used and so I put a counting box in the room and I just said to people put a counter in if you've used the room and you've found it beneficial and at the end of the first week we had over 50 counters, I was absolutely flabbergasted.

We ended up with three of these spaces which we now call wobble rooms to fit in with the national trend and I spoke to staff and we got more people trained and we had a team.

I then decided that I was going to write a job description. I needed this job. I was not going to go back to scrubbing because SISOS would flounder. So, I resigned, and I wrote the job description and I stood by it, and I was determined that we would have this staff support initiative that was working so well.

I got the job and a colleague got the job and then we went back to Chase Farm and we re-evaluated where we were and where we needed to be and where we would like to be.

We found another room; it was used by the unions. They didn't mind and we turned that into a staff well-being hub and I believe that every single new hospital that is built should have a staff safe space and a staff support hub.

The other thing that I instigated is a staff self-help station because not everybody wants to come up to you and ask for help and we understand that it's absolutely fine. We move our staff self-help station around to meet the biggest footfall.

The other thing that I've just applied for funding for is a staff therapy suite. We need a therapy suite with a massage table and chair. A place where pregnant staff can put their feet up and relax. So that is next on the agenda.

We invite people to look at this exemplar at Chase Farm Hospital. See what we have got and then they want it. Then they take ownership of it, and it grows. And that is how this initiative is growing.

Every week we walk about on the weekly well-being walkabout and we introduce ourselves and we wear this bright red badge so that people know it's that funny woman again. The walkabout is about sharing this initiative and allowing people to come and get the help, and we've got fantastic help. There's great support out there, it's just making it accessible, so that's it from me. Thank you.

The session and conference concluded with a Q&A in which the attendees and panel participants discussed peer support in more detail and the various methods which can be deployed to help staff.

Related reading

Below is a collection of additional resources related to the content covered in this Conference:

Morning keynote addresses

- How patients' voices can improve safety in the health service in relation to medicines and medical devices by Henrietta Hughes (8 November 2022)
- RCP, Patient Safety: RCP Projects and resources
- RCN, Striking a balance: patient safety during industrial action (20 July 2022)

Speaking up for safety, hearing the patient voice

- NHS England, Framework for involving patients in patient safety (29 June 2021)
- Patient Safety Spotlight interview with Jono Broad, Quality Improvement through Patient Involvement (3 May 2022)
- Patient Safety Spotlight interview with Tony Woolf, consultant rheumatologist and Co-Chair of the Global Alliance for Musculoskeletal Health

Extravasation; a national safety campaign

- Information leaflet - Extravasation: a patient safety priority (28 June 2022)
- NHS Resolution, Did you know? Extravasation (30 November 2022)

Improving staff safety beyond Covid-19
Creating a safe environment in hospital theatres

- DS Hill et al, Surgical Smoke - a health hazard in the operating theatre. A study to quantify exposure and a survey of the use of smoke extractor systems in UK plastic surgery units (2012)
- NG Mowbray et al, Safe management of surgical smoke in the age of COVID-19 (2020)

Afternoon keynote addresses

- HSIB Education Courses
- HSIB, Support for staff following patient safety incidents (14 January 2021)

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Mind the implementation gap; The persistence of avoidable harm in the NHS

- Mind the implementation gap: The persistence of avoidable harm in the NHS (7 April 2022)
- Patient Safety Spotlight interview with Claire Cox, Patient Safety Lead and founder of the Patient Safety Management Network (28 June 2022)
- Why healthcare needs to operate as a safety management system: In conversation with Keith Conradi (24 October 2022)

Preventing workplace stress

- NHS Employers, Guidance on prevention and management of stress at work (25 May 2022)
- Safety Incident Support Out Staff (SISOS): A second victim support initiative at Chase Farm Hospital (27 November 2019)