Everyone's business

Report on the first national clinical governance and patient safety conference

February 2006

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Foreword

This was the first clinical governance and patient safety conference to be hosted by NHS Quality Improvement Scotland. More than 250 delegates took part over the two days, including clinicians, managers, clinical governance, risk and clinical effectiveness staff from all over Scotland. Delegates from further afield, including the NPSA and Northern Ireland also took part.

The theme of the conference was facing challenges and sharing solutions and the context was patient safety and clinical governance. In Scotland, we have focussed on clinical governance first, and we are now tackling patient safety in that context; patient safety must be an integral part of clinical governance.

Patient safety is everyone's business all the time, and there is ample evidence to confirm that where robust systems are in place, risks can be reduced and the quality of care can be improved. We have many examples of this across Scotland – in infection control, blood transfusion and anaesthesia services. However, we also face many challenges, for example in stroke services, in endoscopy and in food and nutritional care in hospital. The two days focussed on facing up to some of the difficult challenges, exploring solutions and then taking those back into the work place and making them work locally.

Since 2000, NHS QIS has carried out four reviews of clinical governance arrangements and has found continual improvement over time. In 2004, we established the Clinical Governance and Patient Safety Unit to co-ordinate all our patient safety initiatives. We now have strong foundations to build on and together we will make health care as safe and effective as possible.

David Steel
Chief Executive, NHS Quality Improvement Scotland

Acknowledgements and Awards

NHS Quality Improvement Scotland gratefully acknowledges the work of the Scottish Health Service Centre Conference Team in undertaking the administrative arrangements for the conference and for their efforts in ensuring the smooth running of the event on both days.

NHS QIS would like to thank all speakers who contributed to the event, and workshop presenters who hosted the parallel sessions. NHS QIS would also like to record its thanks to all staff in the Service who submitted abstracts, and to those staff who were selected to demonstrate their work through poster presentations. This presented an excellent opportunity to share good practice and support the transfer of ideas across NHS Boards and settings. The prizes for the poster presentation were awarded as follows:

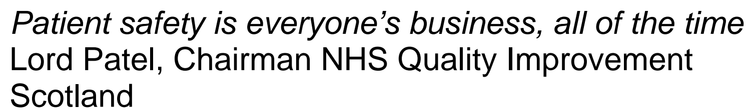
- 1st prize – Medication Administration Intranet Site, NHS Greater Glasgow, Yorkhill Division (Joe Skinner, James Wallace, Karen Thomson, Neil Sommerville)
- 2nd prize – Implementation of the Tidal Model – A Nursing Model which Facilitates Person Centres Care in Practice, NHS Greater Glasgow Mental Health Partnership (Paul McGlynn, Hugh McBride)
- 3rd prize – Re-Audit of the Referral Process within the District Nursing Service in Aberdeen City, NHS Grampian (Janice Rollo)

1ST PRIZE

2ND PRIZE

3RD PRIZE

1 Setting the Scene



Public concern is reflected in the emergence in recent years of books with deliberately alarming titles such as *How to Get out of Hospital Alive, How to Survive your Hospital Stay* and *What Doctors Don't Tell You.* These texts seek to capitalise on an increased awareness among the public that healthcare can be a risky business. Media interest in this issue has also led to mortality rates for NHS surgeons in Scotland being published for the first time under Freedom of Information legislation. This concern is based on research showing that patients have an 8.9% risk of suffering an adverse event while in hospital.

It is also estimated that around half of such incidents are preventable. That level of risk is too high for many people, patients and professionals alike. It means that patient safety, according to Gerry Marr, Chief Executive, NHS Tayside, Acute Services Division, is the overriding issue in healthcare in the 21st century.

Most of the care provided by NHSScotland is safe and of a high standard. Patients are benefiting today from the commitment shown by staff to improve safety and drive up the standards of care. However, adverse events and near-misses continue to occur, highlighting the need for renewed efforts to address this difficult but crucially important issue. *Delivering for Health, 2005,* outlined a vision for NHSScotland where care would be closer, quicker and safer. Making care safer is a considerable challenge but one that has to be faced.

But how, precisely, can care be made safer? What needs to happen to promote positive improvement? And where does responsibility lie for making the changes that are needed?

These were just some of the questions addressed at this first national conference on clinical governance and patient safety entitled *Facing Challenges: Sharing Solutions*. It was attended by around 300 clinicians, risk managers, clinical governance staff and health service managers. It provided a number of examples of successful change in existing services. NHS Tayside is one of four centres in the UK taking part in the £4 million Safer Patients Initiative that aims to make hospitals safer for patients. As part of this work, a group of clinicians travelled to England to witness a demonstration of how ventilator care bundles are improving patient outcomes in intensive care

units. These bundles are a series of interventions that, when implemented together in a consistent fashion, produce better outcomes.

The Tayside clinicians calculated that they were already achieving around 90% of what they had seen demonstrated. However, when they returned to Tayside and measured what was being done, they discovered they were only achieving around 60%. Following implementation of the ventilator bundles model, performance increased to 98% and has remained at that level.

The Scottish Ambulance Service has also had success in promoting a safety culture that encourages staff to report and learn from adverse and near-miss incidents. It has introduced changes including raising awareness among staff on reporting, introducing training on how to report incidents and providing feedback to staff on any incidents. As a result, the number of reported incidents has increased from 12 in 2002 to 1500 in 2005. This has been accompanied by a reduction in the number of high and very high risks and increased learning across the organisation.

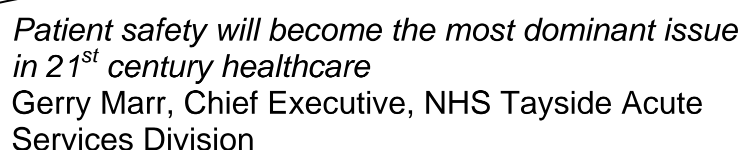
This report contains information about several other examples of good practice.

To do no harm is a central tenet of good patient care. However, patient safety is about more than just doing no harm. It is also about delivering the most effective patient care. Yet there are concerns that patient safety and the clinical governance systems that contribute to it are not given the importance they deserve.

Improving patient safety in Scotland needs action on a number of fronts. Potential areas for action identified at the conference include:

- Developing a national patient safety framework for local action
- Raising awareness among the public and staff about what needs to be done and why
- Establishing an effective safety culture across NHSScotland
- Encouraging the effective engagement and empowerment of all staff
- Sharing success and learning from each other

Patient safety should be everyone's business. To make progress, it has to become everyone's business.



Good Practice in action

Reducing the risk of medication errors in children

Many of the errors in preparing, dispensing and administering medicines are preventable. Research also shows that children may be at particular risk of medication errors, particularly as there are few standardised dosing regimens for children.

Evidence suggests that educating health care providers is an effective way of reducing these risks. To that end, a Medication Administration intranet site was established at Glasgow's Yorkhill Hospital in a collaboration involving Clinical Risk Management, Clinical Effectiveness and Pharmacy. It provides advice and practical tools to help avoid errors, including good practice guidelines, calculation and conversion charts and feedback should actual errors occur.

The site has proved a success and gets around 100 hits a month. There are plans to add additional sections on infection control and reducing complaints.

Saying you have made a mistake does not indicate negligence. It is important that staff are encouraged to report and speak up.
Breda Seaman, Clinical Risk Management Co-ordinator, NHS Forth Valley

2 The challenges

To err is human. To cover up is unforgivable. To fail to learn is inexcusable.
Jonathan Bill, Deputy Director, Northern Ireland Department of Health, Social Services and Public Safety

Patient care is complicated, often involving multiple contacts in a routine course of treatment. Judgements and decisions often have to be made under pressure and at speed. There are many opportunities for things to go wrong and, they sometimes do. Most incidents are due to a catalogue of events, related to systems and human factors.

Scotland's Minister for Health and community Care Andy Kerr, in opening the conference, said much has been achieved in the past six years and some very significant measures have been introduced to improve patient safety. However, the challenges still remain. The reputation of the service can be damaged when just one case of something going wrong is highlighted, even though the vast majority of patients get a high level of treatment. Corrective action has to be taken in each and every case. Learning must be shared and baseline standards improved.

He said clinical governance is the driver to improving patient safety and the challenge for the NHS is to strengthen local clinical governance arrangements to deliver more effective systems.

Put yourselves in the shoes of the patient, the person coming through the door."
Scotland's Minister for Health & Community Care Andy Kerr.

Over the course of the two day conference, speakers identified a series of challenges that require to be faced in addressing this issue. They include:

Current context
The increased demands facing the health service together with changing structures and shifting priorities pose a considerable challenge to work on improving patient safety. Concern was also expressed that the system places a higher priority on certain policies, such as reducing waiting times, than it does on patient safety. Further work is needed to embed clinical governance in front line services and in ensuring that joint working operates effectively across services.

Measuring success

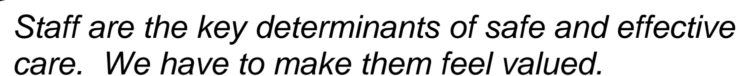
One phrase which was heard repeatedly throughout the conference was Lord Kelvin's dictum: "If you cannot measure it, you cannot improve it." Data, according to Professor Andrew Morris of Dundee University's Department of Diabetic Medicine, are the nutrition of improvement. However, at the moment there is no common reporting system and no electronic health record that can link data to produce seamless care.

Paul Martin, Scotland's Chief Nursing Officer also said there is a history in the NHS of gathering information without being clear about why it is being gathered and what is going to be done with it. Data collection must have a clear focus and be better co-ordinated.

Developing a safety culture

Although improvements are being made in encouraging staff to report incidents, there is still a feeling in some parts of the service that people will be blamed if things go wrong. A blame culture is the enemy of patient safety because it encourages incidents to be covered up and prevents lessons being learned from mistakes. There is a tendency still for systems to be reactive to patient safety issues.

Dr Lesley Holdsworth Clinical Effectiveness Co-ordinator in NHS Forth Valley, identified the barriers to developing a positive safety culture as being protectionism, traditionalism, scepticism and cynicism. Although these are diminishing, they have not been eliminated completely.



Staff are the key determinants of safe and effective care. We have to make them feel valued.
Dr Lesley Holdsworth, Clinical Effectiveness Co-ordinator, NHS Forth Valley

Staff morale

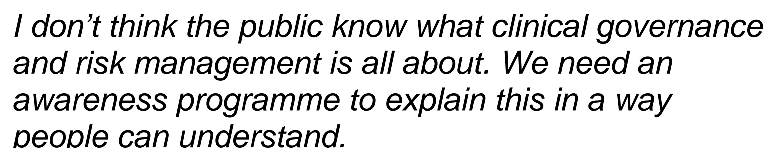
Media reports of mistakes within the NHS can engender a crisis of confidence in the public and adversely affect staff morale. John McGuigan, Chief Executive of NHS 24 said his organisation has experienced such difficulties. Negative media coverage can leave staff feeling constantly berated and

undervalued. It is important, he said, to make staff feel proud of working in an organisation that is delivering high quality care. Clinical governance is the mechanism for achieving that.

Communication and awareness

The Wanless report, *Securing Our Future Health: Taking a Long-Term View, 2002,* concluded that it can only be improved with the full engagement of the public. However, public awareness of the challenges facing the health service is often limited. Changes proposed to maternity services, for instance, in the interest of safety have been wrongly interpreted by the public as a means of saving money.
Robert Bell, a patient representative said the public do not understand concepts such as clinical governance and risk management. There is a need for an awareness programme to inform the public about what the NHS is seeking to achieve and how it aims to do it.

Raising staff awareness is also important. It was said that many staff are uncertain about what the NHS is trying to achieve strategically. They could act as ambassadors to help inform the wider public if clear messages were communicated to them.



Changing values, views and expectations.

Professor Phil Hanlon of Glasgow University's Department of Public Health said the collective ideal that gave birth to the NHS and sustained it in its earlier days has disappeared. It has been replaced with increasing individualism, consumerism and managerialism. Expectations of what the NHS should deliver have increased as a result.

One solution to this problem is to redesign services to increase their efficiency and effectiveness. Professor Hanlon said this was part of the answer but not the complete solution. Many of the people who depend on the NHS have a poor quality of life and they require a more humane approach than a technical, data driven system can deliver. There is also a risk that should such a system fail, it could be replaced with a market-based solution.

The alternative, he suggested, is to demand less of health care providers and develop a much more engaged, collective sense of how the NHS should

develop. However, he admitted we are still a long way off that. The challenge is to develop a new collective consciousness that amalgamates the best of our past and present and reflects the whole of the complexity facing us, he said.

> *If we cannot make the modern National Health Service work, someone will come along with a market solution instead.*
> Professor Phil Hanlon, Department of Public Health, Glasgow University

Good practice in action

Improving telephone advice to patients

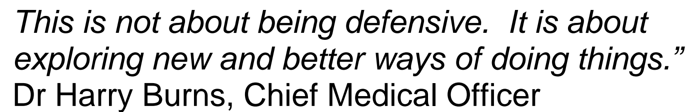
A need was identified for a system that would document telephone advice given by staff to patients at the West of Scotland Cancer Centre. One of the reasons for this was an incident where a patient was allegedly given the wrong advice.

The centre's Practice Development and Research Forum and its Clinical Governance Group developed a specific form to be used to record telephone advice. This was piloted in six clinical areas and was well received by staff. It

- *established uniformity of practice*
- *assisted the communication process with patients*
- *produced a documented audit trail*
- *addressed accountability issues*

It is now being rolled out to all clinical areas and protocols are being developed to guide staff on the correct advice or action to take for common telephone inquiries.

3 Potential solutions



As the Minister said in his opening remarks, much has already been achieved. NHS Quality Improvement Scotland (NHS QIS) has carried out four reviews of clinical governance arrangements which have shown continual improvements over time. The Australian/New Zealand risk management methodology is now in use in Scotland and a risk management network has been established across the country. The chairman of NHS QIS, Lord Naren Patel, said these are strong foundations on which to build.

Lessons from Tayside
Tayside is the Scottish centre taking part in the Safer Patients Initiative, sponsored by the Health Foundation Institute of Health Improvement which aims to make hospitals safer for patients. Gerry Marr, Chief Executive, NHS Tayside Acute Services Division, said the focus of the work is to

- reduce variability
- reduce waste
- reduce harm.

This is being achieved by challenging the fundamental design of services and implementing rapid cycle change (plan, do, study, act.) Mr Marr said he can say with some degree of confidence that it works. After 11 months of the programme, NHS Tayside has improved patient safety outcomes in relation to:

- the safety culture
- communication of patient safety information
- peri-operative care
- medicines management.

He said measurement is usually made to aid judgement, rather than to achieve improvement. In Tayside, measurement is now firmly focused on improvement. One of the big challenges, however, is to ensure that the positive changes achieved in one part of the system are adopted by others. A bottom up approach is being taken in Tayside which is challenging individual wards to spread change across the whole hospital.

Mr Marr's key message was that better results depend on making changes to the system. He added:

- piecemeal efforts do not work
- continuing professional education and courses do not change behaviour
- measurement for itself is not change

- exhortation and incentivisation is not the answer.

He said that greater priority needs to be accorded to patient safety. Tayside has developed a framework and practical examples that will help other organisations measure their own quality improvement and patient safety activities.

Further information is available from pat.o'connor@thb.scot.nhs.uk

Lessons from elsewhere
Solutions in Forth Valley have been found through experience, said Dr Lesley Holdsworth, Clinical Effectiveness Co-ordinator. One example is sharing the learning from significant event analysis in general practice. The results of such analyses were not previously shared among practices. The solution was to design a website that practice staff could use to share experiences. However, despite encouragement, no practices submitted information. A more direct approach was adopted that involved information provided as part of an annual review being posted on the website after permission was sought.

Other successes have included engaging 92 out of 100 dentists in Forth Valley in a rolling programme of clinical effectiveness and developing a co-ordinated approach to the care of people with epilepsy. The epilepsy programme has been led by a multi-disciplinary team which supplied each general practice in Forth Valley with an epilepsy management resource pack, backed up by educational events. Prior to the intervention, few practices had epilepsy registers, recall systems and there were wide variations in the quality of information provided to patients. Now all practices have registers, 76% operate recall systems and 96% provide patients with relevant information.

It has been a well planned programme that has been well received by patients. The learning from this has been considerable and the methodology is increasingly being used in other areas such as asthma management.

Dr Holdsworth said it is important to prioritise between the urgent and non-urgent. Given the plethora of guidance that is issued, it is better to implement two or three of these reports well rather than spread activity too thinly.

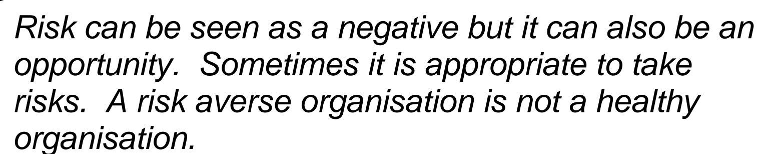
She made a plea for establishing networks to help spread information and good practice across Scotland.

NHS 24 is also talking proactive measures to drive forward improvements. An analysis of significant adverse reports and complaints has identified chest pain as a particular problem area for a telephone-based service. As a result a

national action group has been formed, an audit carried out of chest pain calls and an action plan developed.

An international perspective was provided by Stuart Emslie, an independent consultant in healthcare governance who has worked in a number of countries around the world. He said mindsets, leadership and culture are all important. Systems may make things happen but it is people that make them work. Mechanics are a smaller part of the picture than mindsets.

The aim of an effective safety system should be to see the number of reported incidents increase while the number of high risk incidents comes down. Having a clear focus on what needs to be done and a timescale within which to do it is crucial but the key thing is learning from each other.



Lessons from other industries

Professor Rhona Flin, School of Psychology at the University of Aberdeen highlighted the importance of learning from other industries. She acknowledged that people in the health service can get fed up at times being told what is happening in industry but the behaviour that takes place on aircraft flight desks can be similar to what takes place in intensive care units. Although technical failures are a significant element in adverse incidents, it is important to look at professional behaviours as well. That includes examining how teams work together, thinking skills and team work skills.

There has been an increasing focus in the nuclear and aviation industries in training staff in non-technical skills following evidence that problems in these areas have contributed to major incidents. Prof Flin's team is now working with surgeons and anaesthetists in Scotland in developing similar training involving such things as situation awareness, decision making, communication and leadership. In some industries, tasks are not begun until a full briefing has been carried out – something that is rare in the NHS.

Her work has also uncovered perceived differences in attitudes to patient safety among clinicians and management. A group of surgeons was asked to rank the areas of their activity where failure would most concern them. The choices were patient safety, reduction of waiting lists, saving costs and the reputation of their organisation. All the surgeons chose patient safety. However when asked what they thought would be the most critical area of failure for their organisation only 42% said patient safety – 27% opted for

reducing waiting lists, 16% for the reputation of the organisation and 15% for saving costs. Perceptions of a commitment to safety are regarded as a leading indicator for safe systems.

While there is some justification for saying we have to look at systems issues, we have to look at professional behaviour as well
Professor Rhona Flin, School of Psychology, Aberdeen University

Lessons from using data

Andrew Morris, Professor of Diabetic Medicine at the University of Dundee used the example of progress in diabetes to highlight the role that data collection can play in the improvement of services. The DARTS (Diabetes Audit and Research in Tayside Study) project started life as a static patient register. It has developed to become a live web database of patient information that acts as a dynamic clinical management system and is delivering real improvements in diabetic care.

The CHI (Community Health Index) number has been used in Tayside to link data from multiple sources and has become a key tool in developing seamless care. Professor Morris said use of the CHI needs to be championed across Scotland because of the important clinical benefits it can bring. E-health has to be moved out of the technical environment and made a clinical imperative.

What is needed is a culture of collaboration across professions with the use of CHI as a key clinical tool, he said. The key factors in future success will be leadership, a common infrastructure, senior management support and a focus on measurement for improvement.

If you cannot measure it, you cannot improve it. We need to collect data once and use it often
Professor Andrew Morris, Department of Diabetic Medicine, Dundee University

Good practice in action

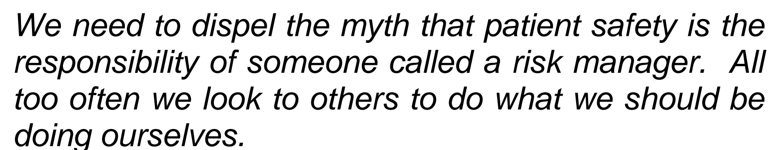
Delivering a new model of care

A model of care based on person-centred support for people with mental health problems was introduced by the NHS Greater Glasgow Mental Health Partnership.

The TIDAL model aims to promote recovery through genuine human caring. Nurses at the Struan ward at Glasgow's McKinnon House were trained in the model. Processes and systems were reviewed and adapted to support implementation.

Evaluation has shown that the model has had a positive impact on the care and treatment of patients. Staff have reported a greater satisfaction in carrying out care. It has also led to a reduction in the number of adverse incidents and complaints.

4 A way forward



There is no one single lever that can be pulled to improve patient safety. It is the responsibility of systems, teams and individuals throughout the health service. A lead can be given from the centre, but success will depend on local initiatives and action. It is not about providing staff with boxes to tick but engaging and empowering them continually to review and measure their practice. It is about rethinking what is done to see if there are benefits in doing it differently. Crucially, it is also about learning from what works elsewhere.

Gordon Jamieson, Director of Nursing in NHS Dumfries and Galloway summed up the two days' proceedings. He started by reflecting on some good news. The reporting of patient safety incidents has increased by around 4% each year and the dissemination of lessons and learning is improving. The safety culture is becoming more open, although many organisations remain predominately reactive. There is evidence that staff fear the consequences of reporting and it is important to get over the message that who made the error is less important than finding out why the safety mechanisms failed.

He said there is a need to:

- raise the profile of patient safety within NHSScotland
- create a climate where staff can report without fear
- establish a culture where people are not penalised if they make an error
- develop a system of collecting, analysing and sharing lessons
- introduce mandatory patient safety training
- ensure sustainable solutions
- provide a clear central direction and leadership
- enhance the contribution of technology and psychology to deliver systems that are safer.

He advocated developing a national patient safety strategy and a single focal point for information on patient safety incidents. The development of improved e-working at both local and national level was also highlighted as a key factor in future success.

We need to raise the profile of patient safety significantly. It is the most important common issue in healthcare internationally
Gordon Jamieson, Director of Nursing NHS Dumfries and Galloway

Good practice in action

Improving the management of long term conditions

One of the key challenges facing the NHS is responding effectively to the needs of an increasing elderly population, many of whom have long term conditions.

NHS Lanarkshire has developed and piloted a multidisciplinary educational programme and competency framework to help health and social care staff develop improved assessment skills to prepare for this challenge.

Staff identified that they required additional skills to improve patient safety. These included assessing and reducing risks associated with polypharmacy, working across boundaries and accessing resources and services.

Staff have valued the additional training and it has helped them become more confident in assessing the needs of older people. They have also reported an improved understanding of the roles of other professions and voluntary agencies.

There is a wonderful buzz about what is happening in Scotland at the moment. You need to capitalise on that.
Stuart Emslie, Independent consultant, Healthcare Governance

For further information on details from the conference, please contact the Clinical Governance and Patient Safety Support Unit (details below).

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