PATIENT SAFETY AWARDS 2020

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PROJECT SHOWCASE

CHANGING CULTURE AWARD

WINNER

ROYAL SURREY FT

DEVELOPMENT OF THE ALCOHOL CARE TEAM AND THE POSITIVE IMPACT ON PATIENT CARE AND OUTCOMES

The service was initially developed in 2014 following a review of inpatients and a significant number of patients were identified with alcohol difficulties.

The lead Gastroenterologist initiated the development of an inpatient alcohol liaison team and in 2014 there was a hospital CQUIN to support this. Since the inception of the service it has been noted that the service was needed in all areas of the hospital and quickly expanded in getting referrals from all areas including paeds, mental health, oncology and outpatients. The service then expanded and developed an outpatient clinic 2 sessions a week and the general view that more resource was required. The Risky Behaviour CQUIN (2017-2019) allowed for further funding to be drawn down following building a successful business case and maintaining data to show outcomes to ensure continued funding.

JUDGES COMMENTS

The judges said the ambition of setting up a new service and involving all key stakeholders instantly elevated this project. The winner gave a very good presentation demonstrating the development of the service through the increase of the team, and how it has effectively embedded across multiple areas over time. The benefits to the patients were clearly set out and the use of the patient story gave a good indication of value. Not many initiatives change the culture of both the service and the patient. Well done!

CHANGING CULTURE AWARD

HIGHLY COMMENDED

The Clatterbridge Cancer Centre FT
'Culturally Aware'- Learning from deaths in Tertiary Cancer Care

In 2017, to improve their culture of learning from deaths, the team appointed key patient safety champions from floor to board to oversee the mortality review process. They developed a process for involving bereaved families in learning lessons from deaths and embedded a bespoke statistical dashboard and peer review process to 'check their blind spot'. By 2020, evidence of the change could be seen in consultant and multi-professional engagement, an improved reporting culture, and a suite of quality improvement projects stemming from the mortality process. The positive change has facilitated collaborations between trusts to improve patient safety across the region.

JUDGES COMMENTS

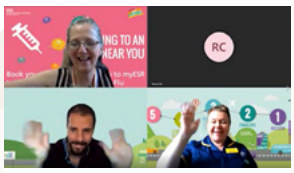
Judges considered this to be a great initiative that has engaged the full multidisciplinary team and spread best practice across other units. The project shows interesting developments in cancer care and the level of honesty in the evaluation they undertook should see this initiative demonstrating ongoing improvements in the culture.

FINALISTS

Hertfordshire Partnership University FT
Fostering a 'just culture' of learning and safety

Hertfordshire Partnership NHS University Foundation Trust's Quality Strategy has a key focus on safety, which is a top priority. It is about asking services users what matters to them, as feeling safe when at you are most vulnerable is a key component of providing high quality services.

The Quality Strategy formalises the work carried out over the previous 18 months focusing on improving safety by creating a 'just and fair culture' and being honest and open, as opposed to a set of actions. The Quality Strategy sets clear objectives, with a priority on learning from incidents, by listening to staff, service users, their carers and families and then taking positive action, when changes need to be made.



Northamptonshire Healthcare FT
Quality and Safety at the foundation of all we do: Keeping Everyone Safe Week

Co-produced Trust-wide, NHFT's strategy includes 'Quality and Safety at the Foundation of all we do' – a resounding endorsement of the importance of safety from ward to board. Previous activity focussed on promoting learning, transparency and no blame, ensuring staff feel confident to report errors and incidents, and embedding safety discussions as business as usual. Keen to continuously improve, NHFT renewed its commitment to safety in 2019 by embarking on a priority programme – Keep Everyone Safe, which included a flagship event – Keep Everyone Safe (KES) Week. The main goal was to raise the profile of safety in the organisation, and positively impact safety culture by encouraging staff to consider the many different elements and how to improve.

CHANGING CULTURE AWARD

FINALISTS

Oldham Care Organisations part of the Northern Care Alliance Group

The Kindness Collaborative

Oldham Care Organisation joined the Northern Care Alliance in 2016/2017 and, as a result of the amalgamation of the Trusts, a new management team was introduced. During the winter period of 2017 & 2018 the Director of Operations noticed a number of challenging behaviours (developed under the previous regime), that would – if left unaddressed – undermine the focus on safety, governance and quality. From these observations the Director of Operations and the Quality Improvement (QI) team developed the framework that would later become the Kindness Collaborative. The aim of the project was to create a "culture of kindness" across the organisation by using the literature to underpin a Breakthrough Series Collaborative approach and QI methodology.

Sandwell and West Birmingham Trust

Positive Pioneers

The Trust had an ambition to improve multi-professional working and joined up decision making. A Pioneer programme was established within the Trust, which offered teams and Departments the opportunity to apply to be a early adopter pioneer team, with the aim of improving engagement, team work and ultimately patient safety.

The City ED team were awarded pioneer status which meant they had investment and support from the Trust, with two executive sponsors, to bring alive new staff ideas for improvement around workforce and safety. One of the key areas where value can be seen is around recruitment and retention, and the pioneer programme also had an impact on sickness absence rates, with overall sickness reducing within ED.

Sherwood Forest Hospitals FT, Nottingham University Business School and East Midlands Patient Safety Collaborative

An evaluation of the impact of the PASCAL safety climate survey on Quality Improvement

Between 2014 and 2020 Sherwood Forest Hospitals NHS Foundation Trust has improved their CQC rating from 'special measures' to 'good' with 'outstanding' for care. A Patient Safety Culture programme was central to the sustained improvements. An independent evaluation of the programme undertaken by the East Midlands Patient Safety Collaborative and Nottingham University Business School, found that the PASCAL safety climate survey in particular the debrief conversations, contributed positively towards engagement between the executive board and the clinical frontline. The leadership in the organisation, quality improvement plan and the Service Improvement team were also key factors in the improvement that occurred.

University Hospital Coventry & Warwickshire Trust

Saving babies lives: meeting national targets through a change in safety culture

In 2016, the Saving Babies Lives Care Bundle (SBLCB) was launched. UHCW noted a concerning increase in stillbirths towards the end of 2018, so UHCW Improvement methodology was applied to a Safety Improvement Plan and the organisation has now seen a step change in outcomes. Staff and patient engagement was pivotal to the plan to ensure all understood the rationale of SBLCB and associated approaches to care.

Support has come through leadership at all levels; two board-level Maternity Safety Champions attend the Labour ward bi-weekly to openly discuss MDT key performance indicators, and learning is shared from recent cases. A patient is invited to attend each session, with Patient Experience Midwife support.

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