Safety For All Conference Report

Royal College of Physicians, Regent's Park, London

Tuesday 5 December 2023

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About the Safety For All campaign

The Safety For All campaign was launched in 2021 and is focused on driving improvements in and between healthcare worker safety and patient safety, highlighting how poor staff safety standards and practice impact adversely on patient safety and vice versa. It is championing the need for a systematic and integrated approach to improve safety practice for staff and patients across health and social care so that the sum is greater than the parts.

Patient and healthcare worker safety are two sides of the same coin.

Safety For All Conference 2023

The second annual Safety For All conference was held at the Royal College of Physicians in London on Tuesday 5th December 2023. Over 100 members of the healthcare community attended this event, including occupational health professionals, patient safety experts, frontline staff, patients and academics. The conference was hosted by the Safer Healthcare and Biosafety Network and Patient Safety Learning as part of the Safety For All campaign, supported by B. Braun, BD, Boston Scientific and Stryker.

Attendees had the opportunity to hear from two keynote speakers: Lynn Woolsey, UK Deputy Chief Nurse at the Royal College of Nursing and Dr Henrietta Hughes, Patient Safety Commissioner for England. The conference was chaired and facilitated by Dr Rob Galloway, A&E Consultant at Brighton and Sussex Hospital NHS Trust, with a welcome introduction from Dr Ian Bullock, CEO of the Royal College of Physicians. There were a number of panel sessions and presentations throughout the day which have been detailed below.

Sustainability and safer care

Panellists:

- Dimitri Nepogodiev, NIHR Academic Clinical Lecturer, University of Birmingham
- Heidi Barnard, Head of Sustainability, NHS Supply Chain
- Fiona Adshead, Chair, Sustainable Healthcare Coalition
- Michelle Sullivan, Chair, ABHI Sustainability Group

The first panel discussed the significant contribution healthcare makes to global greenhouse gas emissions and the practices which healthcare professionals and organisations can and should adopt to address the issue whilst delivering high-quality care and patient safety. The key takeaways from this session were:

- Achieving systemic change and embedding sustainable practices requires a collaborative approach across all healthcare sectors and levels, with aligned methods for improvement, regular revaluation and training, starting at a graduate and postgraduate level.
- The question of whether healthcare should be more sustainable has passed. The focus now is how to make sustainability operationally easier.
- Balancing individual safety with population health and safety necessitates a considered approach. Members of the panel called upon the audience to question the current practices, asking their employers whether there was a more sustainable option.
- Moving towards more sustainable practices in healthcare is not simply the right thing to do, but a financial imperative. Panellist discussed how this was an essential element of making the case for change in practice by organisations and companies.

Antimicrobial Resistance and antibiotic underdosing

Panellists:

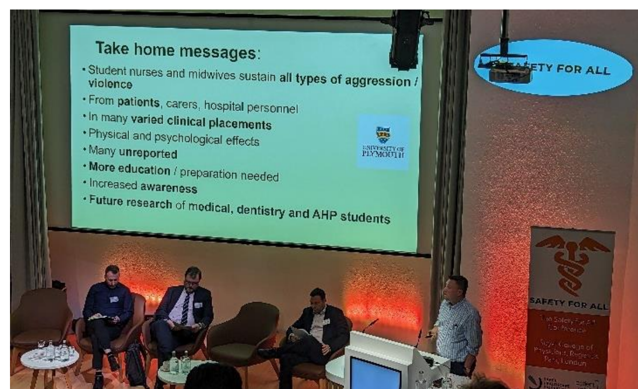
- Baroness Natalie Bennett, member of the House of Lords and former leader of the Green Party of England and Wales
- Harry Serafi, a patient living with spina bifada
- Dame Sally Davies, UK special envoy on AMR
- Rose Gallagher, Professional Lead IPC/AMR, Royal College of Nursing

In a presentation, Baroness Natalie Bennett spoke about antimicrobial resistance (AMR) and its connection with antibiotic underdosing. The latter is an under recognised issue that results in the misuse of antibiotics and exacerbates AMR. She spoke about a report published by her office last month on this issue which highlighted the findings of a comprehensive study of antibiotic 'line flushing' and disposal practices in NHS organisations across Great Britain. She also highlighted about how she has sought to increase the representation of AMR in political discussions, through reports, parliamentary debates and questions and new legislative proposals.

Following this presentation there was a panel session which featured personal testimony from Harry Serafi, a 13 year old patient with spina bifida, who, with the support of his mother, has managed to reduce the use of his antibiotics. He, Dame Sally Davies, special envoy for AMR and former Chief Medical Officer, Rose Gallagher and Baroness Bennett discussed the AMR crisis and how healthcare organisations and professionals could facilitate the use of preventative therapies and increase the efficacy of antibiotic and antimicrobial drugs in the future. They spoke about how to engage patients and the public on these issues and the

importance of approaches aimed at reducing the use of antibiotics to be personalised towards patients' individual care needs.

Harry drew upon his own experience of conducting urine tests to detect and address urinary tract infections at an early stage, thereby preventing the need to subsequently use antibiotics. These tests involve using a dipstick which indicates the presence of certain substances when dipped into a urine sample. He spoke the importance of more patients having access to testing methods such as this and the need for greater investment in such testing aids and into tackling the AMR crisis more broadly.



Violence at work

Panellists:

- Dr Kevin Hambridge, Lecturer in Adult Nursing at Plymouth University
- Joe Donnelly, National Officer for Health and Safety, UNISON
- John Crookes, Head of Health and Social Care Services, HSE

The third panel session discussed the troubling issue of violence within the healthcare system. The session started with a presentation from Dr Kevin Hambridge based on findings of survey of healthcare students on these issues, highlighting that 54.7% of nurses and midwives had sustained violence and aggression in the past academic year (2022-2023) and that around 90% of violence was caused by a patient. It also highlighted concerns about the physical and psychological impact of this and concerns about significant underreporting. In subsequently discussing this issue as a panel, key takeaways from the session were:

- Not only does greater active support need to be provided to staff, but there should be tougher legislation for anyone who assaults staff.
- There needs to be closer monitoring and adherence by organisations to the NHS Violence prevention and reduction standard. This aims to deliver a risk-based framework that supports a safe and secure working environment for NHS staff, safeguarding theme against abuse, aggression and violence.
- That violence in healthcare settings often disproportionality impacts women.
- There was a discussion about whether increased investment in technologies such a body cameras could have an impact in lowering cases of violence in the workplace.
- There were discussions about how different approaches to communication and understanding of cultural differences could help to alleviate some issues, but also the importance of balancing such points with not blaming victims of violence in healthcare for these behaviours.

Clinical Communications

Presenter:
- Helen Moore, Director of Planning, Performance and Informatics, South Eastern Health and Social Care Trust

Helen Moore from the South Eastern Health and Social Care Trust in Northern Ireland gave a presentation on the importance of improving clinical communications.

She spoke about how difficulties in interpersonal communication, fear of failure, human factors, stress, fatigue and team instability were all key factors that could impact of the delivering effective communications in a healthcare team. She highlighted the high stakes associated with poor or inefficient communications, which could ultimately put patients at risk of harm..

Outlining how they had approached improving this at the South Eastern Health and Social Care Trust, she explained how they had moved towards using a single platform for all clinical and operational communications, helping them to:

- Align communications to hospital workflows.
- Updated legacy communication methods for critical alerts.
- Introduce real-time communication between staff.
- Introduce escalations for patient safety.
- Tackle big Trust challenges around patient flow, discharges and critical alerts.

Keynote Address 1

Speaker:
- Lynn Woolsey, UK Deputy Chief Nurse at the Royal College of Nursing

Lynn Woolsey gave the first keynote speech of the afternoon offering her views on the current safety conditions for nurses and highlighted the following points:

- The Royal College of Nursing’s campaign calling on the Government to recognise of long covid as an occupational disease.
- The impact of ongoing workforce shortages on the health of nurses, calling for the need to stop to the normalisation of nurse sickness as a result of this.

- The importance and principles behind the Sexual safety in healthcare charter, signed by 200 organisations including the Royal College This commits its signatories to a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours towards their workforce.

Keynote Address 2

Speaker:

- Dr Henrietta Hughes, Patient Safety Commissioner for England

In the second keynote address Henrietta Hughes she reflected on her work over the past 15 months as the inaugural Patient Safety Commissioner for England. Key points she highlighted included:

- Martha's rule, which would mean that if a patient, family member or carer suspected deterioration or a serious concern, they would have the right to easily call for a rapid review or second opinion from a doctor within the same hospital.
- She explained that having been asked by the Government to run a series of policy sprint meetings to set out what would make implementing Martha's Rule a success in England, she had gone back to the Secretary of State with three recommendations:
    - A structured approach to listening – relating to a patient's condition directly from patients and their families.
    - 24/7 escalation route to a Clinical Care Outreach Team for staff who they can contact should they have concerns about a patient.
    - Offering the same 24/7 escalation route to patients, families, carers and advocates.
- Her work with campaigners and harmed patients to improve safety in relation to the risks associated with taking sodium valproate during pregnancy. She spoke about how this had resulted in changes to the Human Medicines Regulations meaning that safety warnings will now have to be provided with every valproate-containing medicine.
- Moving towards a safety management systems approach in healthcare, an organised approach to managing safety which is widely used in other safety critical industries.

Human Factors

Presenters:
- Professor Chris Frerk, Chair of Clinical Human Factors Group
- Dr Rob Galloway, A&E Consultant at Brighton and Sussex Hospital NHS Trust

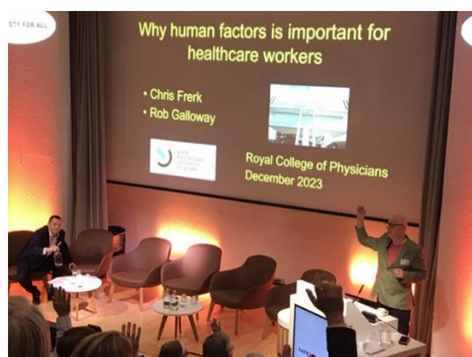
Many patient safety issues are caused by systemic problems with poor design at their core. Human factors and ergonomics are hugely important in understanding human performance issues in health and social care and helping to identify risk of avoidable harm and solutions needed to ensure patient and staff safety.

In a presentation, Professor Chris Frerk and Dr Rob Galloway detailed their views on addressing the fallible nature of humans. Chris started by highlighting:

- the need to improve design, such as controls, lighting and alarms, and systems, such as procedures and shifts.
- Talking about adapting James Reason's Swiss cheese model of accident causation to reflect the reality of health care and all too often its approach to responding to hazards.

Rob continued to discuss:

- Cognitive limitations and how we've developed approaches to decision making that don't work for us in the complex world of work fast vs slow thinking.
- Cognitive biases in our decision making, e.g. confirmation bias, loss aversion, gamblers fallacy, framing effective, bandwagon effect, dunning-Kiruger effect etc.
- What we can do to improve chances ot patients getting the correct treatment, such as creating a 'sterile cockpit' applying specific 'acute' leadership skills, checklists, civility skills and involving patients.
- Importance of such tools in overcoming issues that arise from a lack of situation awareness.



Implementing the Patient Safety Incident Response Framework (PSIRF)

Panellists:
- Helen Hughes, Chief Executive of Patient Safety Learning
- Claire Cox, Founder of the Patient Safety Management Network
- Margarida Pacheco, Associate Chief Nurse, West Hertfordshire Teaching Hospital
- Anne Rouse, Patient Safety Partner, Royal United Hospitals Bath NHS Foundation Trust.

PSIRF is the new NHS approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. This replaced the previous Serious Incident Framework, with organisations expected to implement this from September 2023 onwards.

In the fourth panel of the day there was a lively discussion about the implementation of PSIRF, why it was needed, and the opportunities and challenges faced in putting this into place. Key points highlighted in this discussion included:

- This represents a significant change in approach to incident investigations and that it is crucial that the staff have the right support from their organisational leaders and resources to support its implementation.
- These places are a welcome emphasis on engaging with patients as part of the investigation process.
- Challenges that can be faced in attempting to implement PSIRF in Trusts where there is not a positive safety culture.
- The role of Patient Safety Partners in supporting the implementation of PSIRF.
- Questions around the governance of this new framework and how this will be monitored.

Women's health and the menopause

Panellists:
- Deborah Holloway, Specialist Menopause Practitioner
- Kim Sunley, Royal College of Nursing and co-chair of NHS Staff Council's Safety and Wellbeing Group Health
- Jenny Michael, NHS Employers and Portsmouth Hospitals

The final panel session of the day focused on the impact of the menopause, what needs to be done to raise awareness of the menopause and the steps that can be taken to help staff experiencing symptoms. Key takeaways included:

- Despite women making up a large part of the healthcare workforce there is little widespread comprehensive support provided to women experiencing symptoms of menopause.
- That in the absence of this support, staff may not only have difficulty being able to conduct their roles, but also that this may have significant consequences for patient safety
- Types of support that can be provided, such as a staff menopausal clinic, hospital design considerations and menopause cafés,
- The importance a more efficient dialogue between employers and staff who are experiencing menopause. should be considered across healthcare systems.
- The need to break the stigma about menopause and the importance of both men and women of all ages being involved in these conversations.
- How to tailor support services, such as discussion groups, to people’s personal needs. There was a discussion about the value in offering both mixed sex and same sex forums for discussions about menopause.

Related reading

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

Sustainability and safer care

- ABHI Sustainability Framework for Action
- Sustainable Healthcare Coalition Website

Antimicrobial Resistance and antibiotic underdosing

- Report from the Office of Baroness Bennett: Antibiotic underdosing and disposal in NHS organisations across Great Britain (November 2023)
- Claire Davies: Short-term intermittent IV antibiotics – Understanding the issue of under delivery (November 2023)
- Claire Davies: Understanding the importance of accurate antibiotic administration through an IV administration set (drip): A patient's guide (November 2023)

Violence at work

- NHS England: Violence prevention and reduction standard (January 2021)

Afternoon Keynote Addresses

- NHS England: Sexual safety in healthcare – organisational charter (September 2023)
- Demos: Martha's Rule: A new policy to amplify patient voice and improve safety in hospitals (September 2023)
- Patient Safety Commissioner for England: Recommendations on Martha's Rule implementation go to government (November 2023)

Implementing the Patient Safety Incident Response Framework (PSIRF)

- Patient Safety Learning: A simple guide to the Patient Safety Incident Response Framework (December 2023)
- Patient Safety Learning: PSIRF insights and opinions (October 2023)
- Patient Safety Learning: PSIRF tools, templates and resources (October 2023)

Women's health and the menopause

- NHS England: Supporting our NHS people through menopause: guidance for line managers and colleagues (November 2022)