Safety For All Conference Report

Royal College of Physicians, Regent's Park, London

Tuesday 10 December 2024

SAFER HEALTHCARE BIOSAFETY NETWORK

patient safety learning

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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. It seeks to highlight how poor staff safety standards and practice impact adversely on patient safety and vice versa. The campaign champions the need for a systematic and integrated approach to improve safety for staff and patients across health and social care.

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

Safety For All is jointly coordinated by the Safer Healthcare and Biosafety Network and Patient Safety Learning, supported by Boston Scientific and Stryker.

Safer Healthcare and Biosafety Network

The Safer Healthcare and Biosafety Network is an independent forum focused on improving healthcare worker and patient safety and caring for those who care for us.

It is made up of clinicians, professional associations, trades unions and employers, manufacturers and government agencies with the shared objective to prevent occupationally acquired diseases and improve occupational health and safety in healthcare. The Network was originally founded in 1999 as the Safer Needles Network to protect healthcare workers from needlestick injuries.

In recent years the Network has expanded its agenda to drive awareness and promote a greater range of safer practices and new technology and the role they can play in improving healthcare worker and patient safety standards.

Patient Safety Learning

Patient Safety Learning is a charity and independent voice for improving patient safety.

We harness the knowledge, enthusiasm and commitment of healthcare organisations, professionals and patients for system-wide change and the reduction of harm. We believe patient safety is not just another priority; it is a core purpose of health and social care. Patient safety should not be negotiable.

Through our work we support safety improvement through policy, influencing and campaigning, and the development of ‘how to’ resources such as *the hub*, our free award winning platform to share learning for patient safety, and our unique Patient Safety Standards and support tools.

Themes across the day

The third annual Safety For All Conference was held at the Royal College of Physicians in London on Tuesday 10 December 2024.

The event was chaired by Professor Rob Galloway, Accident and Emergency Consultant at the University Hospitals Sussex NHS Trust. It was attended by over 100 members of the healthcare community, including occupational health professionals, patient safety experts, frontline staff, patients and academics.

Throughout the speeches and panel discussions that ran across the day, there were several recurring themes:

- The important role of leadership in improving staff safety and patient safety. This being cited as the key to creating safer organisational cultures, modelling safety behaviours and advocating on behalf of patients and staff.
- The need for healthcare workers and patients to speak up in order to creating a safer healthcare system, and the challenges of empowering staff to do this and organisations to create safety cultures in a system under significant strain.
- Communication and engagement is key - with staff and patients, and in convening people so they can collaborate for safety. Listening was mentioned throughout as being seen as a luxury, but it is essential to providing person-centred care.
- The challenge of sharing and spreading patient and staff safety initiatives when healthcare workers don't have time/capacity beyond trying to do the day job.
- The divide between those who have someone to advocate on their behalf, who understands the healthcare system, and those who do not.

Keynote speech: Professor Nicola Ranger

The conference was opened by this year's chair, Professor Rob Galloway, Accident and Emergency Consultant at the University Hospitals Sussex NHS Trust, and by Dr Ian Bullock, Chief Executive of the Royal College of Physicians.

Professor Nicola Ranger, Chief Executive of the Royal College of Nursing, then gave the first keynote speech of the day, describing the challenging set of circumstances currently faced by the healthcare system. She noted how in recent years we have moved from a situation where there was pressure to reduce spending, as a result of austerity measures, then straight into the huge crisis of the Covid-19 pandemic. She emphasised that this had inevitably had a significant impact on performance and safety in the NHS.

Professor Ranger highlighted how in response to the pandemic there had been positive examples increased agility and reduced bureaucracy in some ways in which the health service was run. However, she noted that in the post-pandemic period these had not been embedded in everyday practice. She reflected on the missed opportunity to place patients and staff truly at the centre of everything we do in healthcare following Covid-19.

Other key points emphasised in her speech included:

- The need to talk about how we approach patient safety in healthcare. In other safety-critical industries, the balance between junior staff and experienced staff is around an 20/80 split, while in healthcare it is the other way round. This presents huge challenges.
- That we should be reconsidering how we approach pay progression and career structures – with the aim of keeping the experienced staff close to patient care.

- She noted that in the UK currently, for staff in professions such as nursing, to progress and increase their pay this can only happen by moving into roles further and further from the frontline. She said that pay needs to be radically re-thought with safety at the centre of this.
- The absence of professionally and legally enforceable nurse-to-patient ratios, and whether such a situation would be seen as acceptable in other safety critical industries.
- The need to eliminate corridor care. She emphasised that once this is normalised, it may take years to eradicate the practice from our hospitals.
- How we can reduce the number of risk assessment processes that are motivated for defensive purposes, rather than actually resulting in action and meaningful safety improvement.

Below are some further resources related to the content covered in this keynote speech:

- A silent safety scandal: A nurse's first-hand account of a corridor nursing shift (Anonymous blog on *the hub*, February 2024)
- A nurse's response to the NHSE guidance on their principles for providing safe and good quality care in temporary escalation spaces (Anonymous blog on *the hub*, February 2024)
- Corridor care: unsafe, undignified, unacceptable (Royal College of Nursing, June 2024)
- Our work to fix the nursing workforce crisis (Royal College of Nursing, 2024)

Panel 1: Protecting lives while protecting the planet

Panel

- Fiona Adshead, Chair of the Sustainable Healthcare Coalition
- Rose Gallagher, Nursing Sustainability Lead at the Royal College of Nursing
- Nicole Fletcher, Head of Net Zero and Sustainable Procurement at NHS England

Healthcare makes a significant contribution to global greenhouse gas emissions. In recognition of this, the first panel discussion focused on how we can improve sustainability in healthcare in way a way which also supports quality improvement and patient safety.

Key issues covered in this discussion included:

- The direct impact of climate change itself on patients. For some vulnerable patients, this can mean exposure to the adverse effects of pollutants, with higher risks for people living with chronic conditions.
- The need to strike a balance between the practices which healthcare workers, providers and industry adopt to improve sustainability and continuing to deliver high-quality care and patient safety.
- Examples of practical steps that can be taken in specific areas. Fiona referred to the Sustainable Healthcare Coalition's role in developing a 12 steps to Green a Kidney Unit guide.
- A question about whether there needs to be more nationally mandated guidance in areas such as gloves use and re-use and reusable tourniquets to encourage sustainable practices.

- Noting that while we have an increasing number of sustainability projects in healthcare, we currently do not have look enough at how these directly impact the quality of care and patient outcomes.
- A conversation about how and when outdated technology could be used. An example was given of medical devices which due to their use by date may not be suitable for diagnosis, but could still be used for simulation purposes rather than being disposed of. Another example was that of an ultrasound machine, which after a number of years can no longer be used by diagnostic teams, but still could have ongoing benefits if used by vascular access teams.
- There was a conversation around how patient engagement fits into sustainability work in the NHS. It was noted that for effective reporting and learning, see what impact changes have, patient voices are a critical source of data.
- A question about what the role of professional regulators should be in promoting sustainability in healthcare.

Below are some further resources related to the content covered in this panel discussion:

- Climate change: why it needs to be on every Trust's agenda (A blog by Angela Hayes, July 2022)
- Design for Life roadmap (Department of Health and Social Care, October 2024)
- Green Theatre Checklist (The Royal College of Surgeons of Edinburgh)
- Royal College of General Practitioners Net Zero Hub
- Sustainable Healthcare Coalition
- Safety Talks: A Safety For All Podcast - The Drive to Net Zero (August 2024)

Panel 2: Navigating the many faces of violence in healthcare

Panel

- Kim Sunley, Head of Health, Safety and Wellbeing at the Royal College of Nursing
- Naomi Assame, Head of Safety and Learning at NHS Resolution
- Dr Kevin Hambridge, Lecturer at the University of Plymouth
- Josie Irwin, Senior National Officer Equality at UNISON

The second panel session involved a discussion about the scale of violence experienced by healthcare workers and how this can be addressed.

Key issues discussed as part of this included:

- Findings for the Royal College of Nursing's Employment Survey in 2021, including:
  - 64% of all respondents reported that they had experience verbal abuse from a patient, service user or relative in the last 12 months.
  - 26% reported they had experience physical abuse form a patient, service user or relative in the last 12 months.
- The need for improving reporting of these incidents, accompanied by national data collection processes.
- Findings of a survey investigating violence and aggression sustained by nursing and midwifery students in a UK university, including:

    - 57% had sustained some form of violence and aggression in the past academic year.
    - 11.3% had sustained sexual violence and aggression (all female students). 91.7% of this was by patients, and 88.9% by males.
- Findings from a UNISON survey on workplace violence in 2024 including:
    - 77.4% had experience at least one form of violence – physical, verbal, bullying, threads, sexual harassment.
    - Sexual harassment is prevalent, 33% had experience it, 27% more than three times.
- Concerns in healthcare settings that various types of sexual harassment have been normalised, deterring reporting.
- Whether national guidance needs to be looked at. It was noted that the National Patient Safety Strategy does not include staff safety as an area of concern, and neither does the new Patient Safety Incident Response Framework.
- Audience members sharing their experiences of encountering and being subject to sexual harassment while working in healthcare and what was, and what wasn't done in response to this.

Below are some further resources related to the content covered in this panel discussion:

- Calling out the sexist and misogynist culture within healthcare (A blog by Dr Chelcie Jewitt, November 2022)
- Learning from workplace violence claims within the NHS: A thematic overview (NHS Resolution, October 2024)
- Patient Safety Spotlight interview with Dr Kevin Hambridge, Lecturer in Adult Nursing at the University of Plymouth (Patient Safety Learning's *the hub*, February 2024)
- Violence prevention and reduction standard (NHS England)

Panel 3: Caring for caregivers and patients - Mental health and safety in healthcare

Panel

- Dr Stephen Jones, UK Head of Nursing Practice at the Royal College of Nursing
- Carol Menashy, Professional Nurse Advocate
- Claire Goodwin-Fee, Founder and Chief Executive at Frontline 19

The health and wellbeing of frontline healthcare workers is intimately connected with their ability to provide good patient care and ensuring patient safety. There is also a moral imperative that the NHS and all healthcare organisations should care for the wellbeing and mental health of their staff as well as patients. The third panel session of the conference focused on these issues of mental health and wellbeing for those working in healthcare.

Key issues discussed as part of this included:

- The need to understand the subjective nature of harm staff may experience after safety incidents, with how an individual can respond to the same event likely to vary considerably. Need to recognise there is no one size fits all support solution.
- Carol Menashy talking about implementing the SISOS initiative for supporting staff after patient safety incidents.
- Reflections on experiences shared by staff with Frontline 19, who have now spoken to over a million people, and referencing their recent video highlighting these issues, 'Sicker than the patients'.

- The need to tackle the persistence of toxic cultures in healthcare that deter reporting.
- Conversation about the role the pandemic played in helping to raise awareness of staff safety and wellbeing issues, however comments that this has not led to us now having the balance right in this area.
- The need to consider how to create environments within teams that make them safe spaces to share when things go wrong.

Below are some further resources related to the content covered in this panel discussion:

- Check my wellbeing – A self-assessment for Health and Social care staff with a direct link to mental health support resources (NHS England)
- Free and confidential service for frontline workers (Frontline19)
- NHS staff wellbeing: Why investing in organisational and management practices makes business sense (The International Public Policy Observatory, June 2022)
- Prevention and management of stress at work (NHS Employers, 25 May 2022)
- Safety Incident Supporting Our Staff (SISOS): A second victim support initiative at Chase Farm Hospital (A blog by Carol Menashy, November 2019)

Keynote speech: Jane Murkin

The afternoon sessions started with a keynote address from Jane Murkin, Deputy Director Safety and Improvement – Nursing Directorate at NHS England. She provided an overview of some of the key patient safety activities being prioritised by NHS England. Key points emphasised in her speech included:

- The importance of understanding the link between health worker safety and patient safety. She noted how this had been identified as one of the seven strategic objectives in the World Health Organization Global Patient Safety Action Plan.
- The need to understand what is keeping healthcare professionals in systems and what is driving them away. She pointed to recent research which highlighted a safe environment as a key priority for nurses.
- The value of moving towards a "person-centre practice framework", placing the individual at the centre of health and care, and the skills required to support this.
- She spoke about the ongoing work to implement Martha's Rule in the NHS. This is intended to ensure the vitally important concerns of the patient and those who know the patient best are listened to and acted upon.
- The importance of psychological safety. Staff needing to work in environments where they feel able and safe to speak up about safety concerns. Moving from a retributive to a restorative culture in healthcare.
- How NHS England is using its national quality improvement networks in seeking to tackle current healthcare problems.

She ended her speech with a quote on how the future of healthcare depends on our willingness to challenge the status quo and do things differently.

Panel 4: Antimicrobial Resistance - Ensuring patient safety in an era of rising resistance

Panel

- Dr Ron Daniels, Founder and Joint Chief Executive of the UK Sepsis Trust
- Sue Charles, Life Sciences Consultant
- Valya Weston, National Infection and Prevention Control Improvement Lead at NHS England
- Professor Ian Charles OBE
- Jane Murkin, Deputy Director Safety & Improvement – Nursing Directorate at NHS England

The fourth panel session of the day focused on tackling the challenge of antimicrobial resistance (AMR).

AMR occurs when bacteria, viruses, fungi and parasites no longer respond to antimicrobial medicines. As a result of drug resistance, antibiotics and other antimicrobial medicines become ineffective and infections become difficult or impossible to treat, increasing the risk of disease spread, severe illness, disability and death. The misuse and overuse of antimicrobials in humans, animals and plants are the main drivers in the development of drug-resistant pathogens.

AMR has been identified by the World Health Organization as “one of the top public health and development threats”. It is estimated that bacterial AMR was directly responsible for 1.27 million global deaths in 2019 and contributed to 4.95 million deaths.

Key issues discussed as part of this included:

- Conversation around how doctors, particularly in primary care, can be empowered to not prescribe antibiotics unnecessarily. Better diagnostics was identified as being a key component of this,
- Considering what can be done to addressing vaccine hesitancy to help combat AMR.
- How to incentivize pharmaceutical companies to produce antimicrobial medications, which have far lower profit margins than those used to treat conditions such as cancer. It was noted there was an important role that philanthropic partners can and do play in addressing this gap.
- Discussions about varying approaches to surgical mask wearing in healthcare following the pandemic and the cultural barriers to this being embraced in the UK.
- A conversation about how best to communicate about AMR to the wider public. It was suggested that a more successful approach, rather than focusing on the wider picture, would be to focus on individual examples of its impact that are simpler to relate to.
- Whether there needs to be a national campaign to raise awareness of AMR, alongside the development of new infection prevention and control resources that are more easily understood.
- Whether as part of the above we need to revisit the language we use around this to make it more understandable to the layperson.

Below are some further resources related to the content covered in this panel discussion:

- Antibiotic underdosing and disposal in NHS organisations across Great Britain (Report from the Office of Baroness Bennett, November 2023)
- Antimicrobial resistance, 21 November 2023 (WHO, November 2023)
- Centre for Sustainable Healthcare
- Top picks: 14 key resources on antimicrobial resistance
- The UK Sepsis Trust
- Tackling Antimicrobial Resistance: How to keep antibiotics working for the next century (WISH AMR Forum, 2024)

Panel 5: Implementing the Patient Safety Incident Response Framework

Panel

- Clare Cox, Founder of the Patient Safety Management Network
- Emma Smith, Patient Safety Incident Response Lead at Northampton General Hospital NHS Trust
- Clare Wade, Director at Patient Safety Learning

The final panel session of the day was focused on the implementation of the Patient Safety Incident Response Framework (PSIRF).

PSIRF sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. PSIRF replaces the previous approach to dealing with patient safety incidents, the Serious Incident Framework (SIF), which was introduced in 2015.

Key issues discussed as part of this included:

- There remains a lack of awareness about PSIRF among those in frontline clinical roles. Key to effectively implementing this and using the system's tools, the framework recommends having a multidisciplinary approach.
- There is a need for more training. Level 1 and 2 of the Patient Safety Syllabus are available to all, but levels 3 and 4 are only open to those in Patient Safety Specialist roles, inhibiting opportunities to spread this learning more widely.

- Training courses themselves are only part of the picture, this needs to be accompanied by ongoing coaching and support.
- How trusts have implemented PSIRF can vary considerably. One audience member noted at there organisation it felt like this was simply a re-branded version of the Serious Incident Framework.
- Although a new system for recording patient safety incidents, the Learn from patient safety events service (LFPSE), has been recently introduced, data from this is not made readily available for analysis. Trusts can see reports of their own data (which they already have access to) but not system-wide information to help them assess risk or engage with others.
- There are a lack of mechanisms for escalating to a national body the improvements needed to address a system safety issue highlighted by local Patient Safety Incident Investigations or learning responses.
- Coroners understanding of how PSIRF has changed trusts approach to incident investigation, varies considerably. Members of the audience shared both positive and negative experiences of engaging with coroners around this.
- The value of empowering everyone to have reflective skills after incidents and events, using tools such as After Action Reviews.
- Importance of also learning from good care as well as patient safety incidents and the concept of 'GREATix' systems.

Below are some further resources related to the content covered in this panel discussion:

- A Patient Safety Symposium: Learning together to apply PSIRF mindset and methods (Patient Safety Learning, October 2024)
- A simple guide to the Patient Safety Incident Response Framework (PSIRF)
- Patient Safety: Emerging Applications of Safety Science
- Patient Safety Incident Response Framework (NHS England)
- Top picks: PSIRF insights and opinions
- Top picks: PSIRF tools, templates and examples
- "We've created an incredible pool of talented safety people who are up for collaboration." Marking three years of the Patient Safety Management Network (A blog by Claire Cox, July 2024)