Executive Summary:

Sign up to Safety (SU2S) is a NHS England campaign that aims to make the NHS in England the safest healthcare system in the world, building on the recommendations of the Berwick Advisory Group. The ambition for the NHS in England is to halve avoidable harm in the NHS and save 6,000 lives as a result. The Royal Wolverhampton NHS Trust has signed up to this campaign and in so doing has committed to the following pledge headings:

- **Put safety first.** Commit to reducing avoidable harm in the NHS in England by half and make public the goals and plans developed locally.
- **Continually learn.** Be more resilient to risks as an organisation, by acting on the feedback from patients and by constantly measuring and monitoring how safe services are.
- **Be Honest.** Be transparent with people about progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong.
- **Take a leading role in supporting local collaborative learning, so that improvements are made across all the local services that patients use.**
- **Be Supportive.** Help people understand why things go wrong and how to put them right. Give staff the time and support to improve and celebrate progress.

The NHS Litigation Authority have committed to support the SU2S campaign by providing financial incentives (i.e. one off payment of up to 10% of the annual premium) to members who are participants of SU2S; and whose Safety improvement plans include proposals that will address particular areas that relate to higher value and/or higher volume claims.

The Trust submitted a Safety Improvement plan setting out its priorities to improve quality and safety over the next 3 years (See appendix 1).

In addition the Trust submitted a funding bid to the NHSLA incentive scheme to support targeted work on claims reduction trust wide - both high value and high volume.
claims (See appendix 2).

In terms of the funding bid, of the 243 bids received the Trust was one of 67 that were successful, in total securing £348,868.00 (adjusted to include services at Cannock) to deliver the bid proposal (in appendix 2).

The Trust has responded to the NHS Litigation Authority with the following commitments:

1. Confirmation that the funds allocated will be used only in relation to the submitted bid;
2. The Trust is asked to publish a summary of their successful bid, including details of the anticipated outcomes, on their public website;
3. The Trust will provide details of their successful bid(s) to their Trust Board and their local commissioners and provide regular updates on the monitoring of their progress;
4. The Trust will provide feedback and share safety and learning themes with external partners and directly with the Safety and Learning team at the NHS LA;
5. The Trust will agree to collaborate with the NHS LA and Royal Colleges in the progress of implementation of the bid and in particular for all maternity bids with relevant Royal Colleges as regards maternity claims and outcomes from the bid. More details will follow.
6. The Trust will agree to ‘buddy’ with an unsuccessful bidder in terms of sharing best practice to support quality improvements to those requiring additional support;
7. The Trust will agree to coordinate with Trusts requesting the same specific equipment or training to ensure procurement benefits from economies of scale and value for money – NHS LA will be in contact to provide details of those Trusts with shared purposes, equipment and training.

In regard to the bid proposal planning has begun on a more detailed implementation plan, project initiation document and to establish the necessary group within the Trust structure.

<table>
<thead>
<tr>
<th>Action Requested:</th>
<th>For Board note as per commitment 3 above</th>
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<tbody>
<tr>
<td>Report of:</td>
<td>Chief Nurse</td>
</tr>
<tr>
<td>Author:</td>
<td>Head of Governance and Legal Services</td>
</tr>
<tr>
<td>Contact Details:</td>
<td>Tel 01902 695114 Email <a href="mailto:maria.arthur@nhs.net">maria.arthur@nhs.net</a></td>
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</table>
| Links to Trust Strategic Objectives | • Create a culture of compassion, safety and quality.  
• Be in the top quartile for all performance indicators. |
<table>
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<tr>
<td>Resource Implications:</td>
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<tr>
<td>Risks: BAF/ TRR</td>
<td>NA</td>
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<td>Public or Private: (with reasons if private)</td>
<td>Public Session</td>
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<td>References: (eg from/to other committees)</td>
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<tr>
<td>Appendices</td>
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| NHS Constitution: (How it impacts on any decision-making) | In determining this matter, the Board should have regard to the Core principles contained in the Constitution of:  
- Equality of treatment and access to services  
- High standards of excellence and professionalism  
- Service user preferences  
- Cross community working  
- Best Value  
- Accountability through local influence and scrutiny |

**Background Details**
Appendix 1 Safety Improvement Plan – Author Deputy Chief Nurse

1. Summary

2. Background to the Trust

2.1. The Royal Wolverhampton NHS Trust was established in 1994 and is a major acute Trust providing a comprehensive range of services for the people of Wolverhampton, the wider Black Country, Staffordshire, North Worcestershire and Shropshire. It gained Cancer Centre status in 1997, was designated as the 4th Regional Heart & Lung Centre during 2004/05 and became one of the first wave Bowel Screening Centres in 2006. The Trust is the largest teaching hospital in the Black Country providing teaching and training to around 130 medical students on rotation from the University of Birmingham Medical School. It also provides training for nurses, midwives and allied health professionals through well-established links with the University of Wolverhampton. One of the largest acute and community providers in the West Midlands the Trust has an operating budget of almost £380 million, more than 800 beds across 3 sites and employs around 8,000 staff.

2.2. The Trust serves the catchment area of Wolverhampton with a core population in excess of 245,000 for its community services, 336,000 for its secondary care services and around one million for its tertiary services. The Trust has grown its specialist service portfolio and its income significantly over the last few years as part of a business strategy to increase tertiary services both directly and as a driver to secure secondary service referrals from Clinical Commissioning Groups on our geographical boundaries.

2.3. A range of specialty services are provided along with excellent pathology services based within a new state of the art building covering most aspects of clinical biochemistry, haematology, microbiology and histology. There is a large, modern radiology department and an on-site neurophysiology department.

2.4. The Trust provides a comprehensive range of community, acute and specialist/tertiary services from the following locations:

2.5. New Cross Hospital (secondary and tertiary services, Maternity, Accident & Emergency, Critical Care, outpatients)

2.6. West Park Hospital (rehabilitation inpatient and day care services, therapy services, outpatients)

2.7. More than 20 Community sites (community services for children and adults, Walk in Centre, therapy and rehabilitation services)

2.8. Cannock Chase Hospital (CCH) over the coming months we will be integrating services at Cannock having taken over the running of CCH on 1 November 2014)

2.9. The Directorate of Ophthalmology based at The Wolverhampton and Midland Counties Eye Infirmary (WEI) on the New Cross site provides an ophthalmic service to the residents of Wolverhampton, Walsall and South Staffordshire as well as adjacent counties. The Eye Infirmary enjoys an excellent reputation serving the local population by providing specialist diagnostic, in patient and theatre facilities.
3.0 Achievements

3.1 The last few years have seen the Trust reinforce its position as a leading healthcare provider. We have continued to drive forward change with clinicians and managers working in partnership to deliver the patient safety and quality agenda, push the boundaries of efficiency and productivity and embed cultural change to proactively manage issues such as mortality and Never Events. Our recent achievements include:

- Setting the UK record for days without a healthcare acquired MRSA bacteraemia (1142); more than 60% reduction in MSSA bacteraemia
- Seeing a continued reduction in the number of cases of C. difficile
- Universal surgical site infection surveillance, including post-discharge surveillance
- Enhanced our position as a tertiary provider by becoming the first Trust in the West Midlands to perform robotic surgery
- Achieved NHSLA level 3 standards for General Services and level 2 for our Maternity Services
- Opened a Midwifery Led Unit to increase the choice for mothers
- Implemented 7 day consultant working across the majority of specialties
- Achieved a reduction of more than 70% in avoidable hospital acquired pressure ulcers; more than 70% of our wards had zero avoidable pressure ulcers and we are using telemedicine to improve community reporting where they are over 380 days without an avoidable pressure ulcer
- Reducing mortality rates to national benchmarks, working with the CQC to understand the drivers of mortality and contribute to national guidance
- Demonstrated our commitment to patient safety by offering a comprehensive inter-professional training programme in our Clinical Simulator Centre
- Have been held up as exemplary practice in the compliance to the use of the WHO surgical checklist through the application of human factors.

4.0 Our Vision

An NHS organisation that continually strives to improve patients’ experiences and outcomes. A key strategic objective to achieve this vision is to create a culture which makes safety and quality our priority every day.

5.0 Our Values

Patients are at the centre of all we do.

- We maintain a professional approach in all we do.
- We are open and honest at all times.
• We involve patients and their families and carers in decisions about their treatment and care.

Working together we deliver top quality services.

• We work in partnership with others.

• Working in teams we will recognise and respect our differences.

• We support each other as members of the Trust.

We will be innovative in how we work.

• We make it easy to do the right thing.

• We continue to improve the experiences of those who use our services.

• We encourage and support people who lead change.

We create an environment in which people thrive.

• We empower people to explore new ideas.

• We act as positive role models.

• We work hard for our patients.

7.0 Safety Improvement Plan Executive leadership, and clinical engagement.

The Executive sponsor for Quality and Safety is the Chief Nursing Officer. The development of a Quality and Safety Strategy is supported by the Chief Executive Officer, Medical Director, Chief Operating Officer and Head of Human resources.

Our safety improvement plan places patient safety at the heart of the Trust Quality & Safety Strategy, with the setting of priorities on patient safety issues including:

• Improving the Sepsis pathway that further improves how we diagnose and treat patients with infections (sepsis) at an earlier stage in their illness

• Reducing falls and falls with harm

• Reducing mis/delayed diagnoses

• Improving medicines management to reduce medication errors

In addition cross cutting themes are:

• Using effective leadership and robust measurement to ensure a safety culture, draw on existing good practice and focus on the quality and safety areas that will significantly reduce patient harm

• Provide person-centred care and improve patient experience by delivering safe care, in a safe environment by safe, competent, caring staff.
Develop a workplace culture that enables and sustains quality improvement. Focusing on ‘human factors’ such as behaviours,

The priorities were identified following a risk review within the Trust and consultation with the public (members).

Each theme is summarised in the driver diagrams (Appendix 1 a - d)

6.0 The journey so far

Our 3 year Trust Quality & Safety Strategy is under development. This Safety Improvement Plan will be an integral part of the strategy enabling us to build on existing quality improvement work and will inform our quality priorities for 2015 -2018.

Developing the Safety Improvement Plan has enabled us to draw together and focus on the quality and safety areas that will significantly reduce patient harm at the Trust our chosen priorities for the next 3 years will be; medication errors, Falls mis/delayed diagnosis and sepsis. Delivering the plan will ensure an evidence-based approach to measuring improvement is adopted and enable us to improve quality improvement skills across the organisation, measure success and recognise achievements.

We have robust governance structure for quality assurance including The Quality Standards Action Group which is responsible for the detail review of compliance with regulatory and national standards, Quality performance and related risk. It exists to monitor the extent to which the Trust meets the requirements of external regulators, review bodies and commissioners in Local and National standards. The Patient Safety Improvement Group is responsible for the detail review and analysis of quality and safety information in order to detect and manage risk and improve quality in service delivery.

Creating Best practice is the name of a project launched by the Royal Wolverhampton Trust and its sole aim is to improve the experience and safety of patients in our care. By using innovative ideas from front line staff and evidenced based best practice a number of changes have already been made to care delivery. A number of work streams are in place to take forward and sustain improvement. Work streams exist for improvements to Sepsis care, and medicines management. Falls pathways and strategic development is overseen by a Falls working Group. It is through these established routes, and others; we will drive the implementation of our plan and overall strategy.

Our Education resources are well placed to develop a Trust programme of Patient Safety Training educating our staff in human factors and why things go wrong - using the principle error is inevitable, harm is not. Provide and measure the use of practical tools that foster good communication, confident and competent decision making, emotional intelligence and sound situational awareness.

In the past, we have made the mistake of addressing multiple issues affecting improvement in the short term only for that improvement not to be sustained over time.

We recognise that we need to use the opportunities identified in this submission for the measurement and monitoring of our safety strategy and plan to inform our approach to building robust measurement and accountability processes around our safety initiatives ensuring their sustainability.
Appendix 1a – Safety Improvement Plan – Falls

**Risk Assessment**
- Analyse local falls risk - use of scatter plot graphs.
- Early identification and assessment of risk at first point of entry into care and periodic thereafter

**Intervention**
- Patient specific falls assessments
- Environmental assessments
- Pain management
- Medication review
- Appropriate use of restraint
- Care plans / care pathway developed following on from patient specific risk assessments
- Preparing the environment
- Comfort rounds
- Visual triggers
- Involvement of patient and family
- Integrate falls risks in ward handovers and safety briefings
- Intelligent root cause analysis
- Walking teams
- Multi professional work group
- Technology to reduce falls risk

**Education and Audit**
- Human factors
- Falls prevention training and awareness
- Learning from incidents
- Sharing good practice
- Education of patients and families
- Monitoring of incidence falls and incidence rates per occupied bed day

Reduce falls resulting in harm by 50% by March 2016
Appendix 1b - Safety Improvement plan – Missed/Delayed Diagnosis

- Clinical audit
- Incident reporting
- Teamwork

- Radiology validation and recall
- Mortality / morbidity reviews

- Robust handover / handoffs

- Induction for staff
- Clinical practices / algorithms

- Systems of work
- Job roles
- Medical rota standards
- Increased consultant cover

- Human factors
- Education programmes
Radiology education programmes

- Clinical audit
- Thematic analysis of incidents and sharing good practice
- Increasing use of simulation and behaviours in education programmes and root cause analysis
- Learning from incidents and sharing good practice

Mis / delayed diagnosis. Radiology reduction by 10% by March 2016
Appendix 1c – Safety Improvement plan – Sepsis

Early identification of patients with sepsis

- Algorithms
- Reliable sepsis screening (EWS and SIRS)

- Ensure reliable communication of at risk patients across clinical teams and points of transition
- SBARD

- Ensure timely escalation and rescue by clinical teams who are competent in managing sepsis
- SBARD

- Ensure reliable delivery of sepsis 6 within 1 hour

Reliable delivery of sepsis 6 care bundle

- Ensure reliable escalation of septic patients to higher levels of care

- Improve antibiotic stewardship across the Trust

Education and awareness

- Educate Trust staff on the extent of the harms caused by sepsis and our current performance

- Educate staff and provide training to enhance their clinical knowledge and ability to respond to sepsis in a timely way

- Educate and empower staff in quality improvement skills
  - Creating Best Practice Workstream

Reduce patient harm from sepsis by 25% by March 2016

- Mortality reviews
- Use of simulation training
- Human Factor
- Analysis of incidents
- Learning lessons and sharing good practice
- RCA learning
Appendix 1d - Safety Improvement Plan - Medication errors

To ensure the safe effective & appropriate use of medicines in all Trust care settings

Reliable medicines management processes
- Safe prescribing systems
- Reliable / timely procurement systems
- Safe, reliable & timely administration
- Policy and practice

Multi-disciplinary approach to medicines management – embedding medicines management into care co-ordination
- Reliable & timely access to specialist clinical pharmacy support and advice
- Availability and governance of non-medical prescribers

- Accurate up to date list of medicines available at all times
- All intended changes to a person’s medication accurately recorded in notes
- Standard discharge information sent to GP to include relevant information on current medication via e-discharge
- Service user understands why they are taking each medicine and how to take the medicine to achieve most

Education and Audit
- Education programmes
- Competency assessment to support error management

- Incident data
- Trust medicines safety group
- Trend analysis and lessons learnt
Appendix 2 Sign up to Safety - NHSLA bid – Author Head of Governance and Legal Services

Claims related Improvement plan

The Safety Improvement plan will focus on the reduction of claims predominantly seen in the Accident and Emergency Department (A&E), Obstetrics and Orthopaedic specialties. A review of the NHSLA claims scorecard between 2009 and 2014 identified these areas in the category of high value low volume and high volume low value claim categories.

Case for Obstetrics

Within Obstetrics a key component in high value claims related to failure to interpret ultrasound and failure/delay in recognition of CTG deterioration leading to various adverse outcomes including delay in decision to proceed to caesarean section. In both cases it is seen that otherwise clinically competent and trained clinicians fall short in their judgement/decision to act. Routine and regular training already exists and is mandatory for Midwives and Sonographers, however a number of other issues predicate these events. Although skill and experience in for example CTG interpretation is a necessary factor there is more and more indication which points to clinical judgement, perception, decision making, human and circumstantial factors that affect the choice of action or inaction which the clinician might take. This finding indicates there is more to be understood about the ‘why’. What are the causal factors intrinsic in people’s perception and behaviour that bypass routine training, instruction and policy.

This work requires a look at a number of elements:- the circumstantial environment, human behaviours, perceptions, norms and tolerances, the process of communication and the impact on the individual/s (staff and patient).

Case for A&E

A further area indicating a similar need is A&E Department. Here the claims predominantly relate to failure or delayed diagnosis/treatment and failure to interpret and undertake x-rays. In a high pressured and busy environment there are perhaps different contributing/influencing factors such as the high volume and pace of turnover of patients, bed capacity pressures, however the common dependency is the need for accurate clinical judgement and action. An added issue is the frequent rotation of junior staff and the need to not only train but to influence staff behaviour and impress a safety culture on every new intake within a short spate of time.

The ED recognises this challenge and has in place routine local induction for staff, Governance and Management team meetings as well as local policies and practices to direct staff. These elements provide one line of defence against adverse events leading to claims; but are not in themselves fully efficient.

Here again a key element to examine is that of the environment in which decision are made. This includes communication, individual and team characteristics, preferences and predominant behaviours and how this affects the culture and environment within which individuals operate.

Case for Orthopaedics

Within Orthopaedics prominent claim causes were Failure or delay in diagnosis/treatment or inappropriate treatment within a variety of circumstances. Communication is a common
theme seen in complaints in this area and contributes to incidents which could lead to claims.

The proposals within this bid will not occur in isolation as a redress to claims. The areas receive regular feedback on claim findings and lesson and continue to strengthen their systems through specialist training and supervision, local policies, processes and practice. Proactive compliance with National guidance/best practice, safe staffing levels, along with audit and trends monitoring allow us to actively pre-empt, prevent and improve.

The focus on improving communication and recognising human factors is a significant part of understanding ‘the why’ as well as the potential for incidents/complaints which lead to claims.

The tables below identify the most common claim injuries and causes within ED, Obstetrics and Orthopaedics.

<table>
<thead>
<tr>
<th>Area</th>
<th>Injury</th>
<th>Cause (common theme underlined)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED</td>
<td>Fatality</td>
<td>Failure to perform tests</td>
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<tr>
<td></td>
<td></td>
<td>Failure/ delay treatment</td>
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<tr>
<td></td>
<td></td>
<td>Failure/delay in diagnosis (13)</td>
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<tr>
<td></td>
<td></td>
<td>Failure/ delay treatment (10)</td>
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<tr>
<td></td>
<td></td>
<td>Inappropriate treatment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Failure/delay treatment</td>
</tr>
<tr>
<td>Obstetrics</td>
<td>Unnecessary pain (CS)</td>
<td>Insufficient pain relief</td>
</tr>
<tr>
<td></td>
<td>Additional/unnecessary operation</td>
<td>Failure/delay treatment - Inadequate suturing 3rd degree tear</td>
</tr>
<tr>
<td></td>
<td>Neonatal death</td>
<td>Failure to monitor 1st stage labour, FHR and transfer to deliver suite</td>
</tr>
<tr>
<td></td>
<td>Unnecessary pain</td>
<td>Failure/delay treatment – placental</td>
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</table>
remains not evacuated

Additional/unnecessary operation | Inappropriate treatment - inappropriate incision leading to uterine tear and emergency surgery.

<table>
<thead>
<tr>
<th>Area</th>
<th>Injury</th>
<th>Cause (common theme underlines)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orthopaedics</td>
<td>Other Infection</td>
<td>Fail/delay treatment</td>
</tr>
<tr>
<td></td>
<td>Additional unnecessary operation</td>
<td>Fail/delay treatment</td>
</tr>
<tr>
<td></td>
<td>Lower Amputation</td>
<td>Fail/delay treatment</td>
</tr>
<tr>
<td></td>
<td>Unnecessary pain</td>
<td>Fail/delay treatment</td>
</tr>
<tr>
<td></td>
<td>Nerve damage during surgery</td>
<td>Inappropriate treatment</td>
</tr>
<tr>
<td></td>
<td>Pressure ulcer to heel</td>
<td>Inappropriate treatment</td>
</tr>
<tr>
<td></td>
<td>Unexplained cut post-surgery ulcerated</td>
<td>Inappropriate treatment</td>
</tr>
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</table>

Across a large majority of cases (within and outside the priority groups stated above) unexpected adverse events are shown to be due to Human Factors – specifically the actions and behaviours of those looking after patients. Although there are limits to what we can control as far as human capabilities and differences, there is more we can do in relation to understanding how and why medical error occurs, the contributions made by poor communication/behaviours, better insights on perceptions of self and others, behaviours in distress and how to reduce these effects leading to adverse events.

PCM explains how certain types of behaviour contribute to errors occurring and shows the degree to which these behaviours are predictable and correctable. It offers tools for recognition and redress of human behaviour through a number of means e.g. verbal and non-verbal communication, language awareness, understanding and meeting one’s own psychological needs and those of others be it patients, colleagues and others. The aim being to engender the best possible engagement, communication and relationship outcomes between staff, staff and patients and staff and others at every level of contact. In addition to reducing adverse incidents, complaints and claims, the aim has other gains such as improving organisational culture, team and people development, patient and stakeholder empathy and engagement. All of which are in line with the ambitions of the NHS and especially in light of the Francis report.

The above seems ambitious and idealistic to some but perhaps that is because we have not appreciated that behaviours that are predictable can be recognised and dealt with; and PCM gives us the tools to achieve this.
Put simply, once we have the tools that have been shown to improve behaviour, we will be on the road to providing a safer healthcare system.

To do this it is essential to do the following:

1. Improve relationships (inc behaviours) and communication amongst all members of the healthcare team – nurses, doctors, administrators, patients and others

2. Recognise actual/potential distress communication and behaviour taking action to reduce/correct distress patterns and adverse results.

The challenge to reduce harm and improve patient safety is particularly daunting as it will continue within a labour-intensive business that is people dependant. This alone builds the strongest case for turning our focus to people; their communication, behaviour and its impact on the healthcare environment and outcomes.

Why PCM? - PCM History

Nearly 40 yrs ago Dr Taibi Kahler discovered a process – a sequence by which people interact with each other in both positive & negative ways.

The uniqueness of this discovery was that human behaviour could be objectively identified, literally second by second as being either productive, or non-productive.

Both patterns are sequential, measurable & predictable.

In 1978 Kahler was invited to become NASA’s interviewing psychologist. For more than two decades NASA have used PCM to find out which Astronauts would be the most mentally strong & capable under situations of extreme stress & pressure. NASA chose PCM because they needed a system with a high level of predictability – as being able to predict stress helps to get out of it quickly.

PCM has been continually updated and today is state of the art – one of the best validated tools, with in excess of one million people having undertaken it globally.

It is used extensively in healthcare across America, Australia & New Zealand – where it is curriculum training for Doctors, and run by the Royal Australasian College of Surgeons.

The Trust recognises that both Quality tools and communication go hand in hand in accomplishing the goal of sustained high performance healthcare.

‘To be effective communicators healthcare professionals must understand the personalities of their colleagues, how they perceive the world, how they communicate and how they are motivated. They must ensure that all staff members get their psychological needs met every day so they are capable of thinking clearly. They also must ensure that they themselves get their motivational needs met everyday so they are able to think clearly and deal positively with many stressful situations they encounter each day.’ (Pauley J&J, Establishing a Culture of Patient Safety)

The importance and power of relationship in effective healthcare systems is further recognised in the work of Jody Hoffer Gittell (*see links below) where she expounds that relationship and relational co-ordination can be used to achieve high performance in quality, efficiency and resilience in the healthcare setting. Relational coordination comprises frequent, timely, accurate communication, as well as problem-solving, shared goals, shared knowledge, and mutual respect among health care providers.
The Trust has seen some progress in the reduction of claims over the past 3 or so years compared with national and member type average but recognises an opportunity to address a different but significant theme in its activities. A carefully considered and detailed plan is proposed for delivery of PCM training to staff; a high level intention of the plan is given in table 1 below.

**Case for Deep dive analysis/case review (incident complaints and claims)**

The Trust needs to commission a bespoke piece of work to analyse themes and trends in case findings, Complaints and serious and reportable Patient Safety incidents. This level of focused analysis has never been done before and is much needed in order to better analyse the myriad of causes and contributing factors leading to incidents/complaints and the potential mitigating factors leading to proactive claim management. The precise scope and resource requirement for this work is will be defined as part of detailed planning; and will include the set up of a process of systematic on-going review to maintain this valuable work.

The project will include an evaluation of Claims, incidents and Complaints managed by the Trust over a 5 year period. In effect an independent ‘own account’ study of intelligence data using Research methodologies. In discussion with the Trust R&D Department it is determined that although the planned work does not fit a true research definition, where there is any potential for Research implications there will be appropriate ethics (or other) approval prior to progression.

At this stage it is anticipated that the piece of research work will be done over a 9 to 12 month period (from planning to publishing) with a draft at 9 months and 3 month allowed for data validation and final publishing.

**NHSLA Bid Template**

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<th>Content</th>
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<td><strong>Area</strong></td>
</tr>
<tr>
<td></td>
<td>A&amp;E</td>
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<tr>
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<tr>
<td></td>
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<td><strong>Value:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Goal(s):</strong></td>
<td>To roll out conscious awareness of the Process Communication Model®</td>
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across the organisation from Board to support staff.

To improve staff self-awareness on an individual and team level.

To evaluate the impact of this aspect of human factors training on staff behaviours and patient outcomes.

To determine if a combination of control barriers (e.g. training, policy/practice monitoring and an audit of feedback) together with a more deliberate awareness of individual and team attributes and influences positively impacts/reduces incidents identified within the claims history.

To undertake a focused piece of work to deeply interrogate and analysis incidents, complaints and claims findings to better define contributory and causative factors. Please note the improvement targets identified for safety priorities within the safety improvement plan. (driver diagrams)

**Actions:**

**Offerings:**

Based on a model of prioritisation, determined through a TNA (to confirm staff group priority and level of training) deliver a 5 year rolling programme of PCM (Process Communication Model®) that incorporates the following:

- 2 hourly Board development session(s)- A modular approach to the Board Development Programme to engage and engender support of the strategy and principles as well as undertake core learning

- 2 hour sessions for support staff- to understand the principles of PCM and to enable a common language across the organisation (core learning)

- 1 day manager’s seminar– for those with line management responsibility – to undertake core learning plus understand how to spot levels of distress and how to deal with them.

- 3 day programme – for clinical facing staff at bands 5 and above

- Where appropriate pre course learning will be undertaken

- All staff will undertake a self-assessment and will receive this back as their individual PCM profile, this will be explained either during the appropriate sessions as identified above or through 1:1 or group follow-on sessions.

- All of the initial approaches defined above will include an offering of more in depth/advanced skills and knowledge acquisition, in order to support further individual and organisational advanced development

**Prioritisation:**

Priority will be for clinical leaders initially, followed closely by clinical & admin staff.

**Evaluation:**
Evaluation will be undertaken using a number of approaches all focused around impact assessment.

- Pre and post survey questionnaire- all delegates- this is a survey developed but not yet launched by the PCM designers in America. We would be a pilot site for this tool
- Impact using 'hard data' – e.g. complaints numbers and themes (dataset to be determined)
- Organisational measures – though staff survey and Chatback

Resources:

- Trainers – up skilling of existing trainers/new trainers to deliver PCM (Train the Trainers Programme)
- Administration of the programmes, technical support and administration of the profiles etc
- PCM profiles for all staff attending the training (a pre-requisite)
- PCM training sessions- materials
  - PCM Manuals
  - Magnetic Board Kits
  - Well-stocked reference section in the Library
  - Merchandising/Marketing
  - Room hire costs
  - Printing and photocopying
  - Refreshment costs

Measures:

Local Monitoring

Monitoring of incidents, complaints and claims trends/themes

Evaluation of Learning and application of leaning- see above under actions.

Please note the improvement targets identified for safety priorities within the safety improvement plan (driver diagrams).

Global Monitoring/Research

The Trust tends to take part in a Global Research Study to measure PCM outcomes. Led by Dr. Ryan Donlan (Assistant Professor, Department of Educational Leadership at Indiana State University USA) the study will measure participants’ self-efficacy and impact on 3 points in time: before the training, immediately thereafter and 6 week after the training. To measure the impact of PCM training we will ask participants to comment on how the
Training helps with their personal relationships, work relationships, leadership skills and teamwork. Participants will also be asked to compare the PCM model and whether or not they would recommend to others. Data collection will occur between January and December 15. As participants of the study the data will be analysed specifically for the Trust and a report produced.

Utilising a combination of internal and external independent measures the Trust plans to ensure it gains a well-rounded evaluation of the impact of the training. Monitoring against its identified improvement targets as well as seeking out other gains to the safety and quality agenda. A further detail on this research piece is available from the Trust on request.

<table>
<thead>
<tr>
<th>Financial data:</th>
<th>PCM Training –</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(Refer Table 2 Financial breakdown below which excludes any applicable VAT)</td>
</tr>
<tr>
<td>1. Train the Trainer Programme</td>
<td></td>
</tr>
<tr>
<td>2. Band 7 x 2 trainers for 3 years</td>
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</tr>
<tr>
<td>3. Admin staff/backfill to administer the programme (to include course set up and planning, managing bookings, maintaining training records and reports, evaluation analysis and reporting etc) – Band 3 x 1 for 3 years</td>
<td></td>
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<tr>
<td>4. PCM Profiles/Manuals</td>
<td></td>
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<tr>
<td>5. Magnetic Board Kits</td>
<td></td>
</tr>
<tr>
<td>6. Merchandising, Marketing, Reference materials (resources within library)</td>
<td></td>
</tr>
<tr>
<td>7. Room space hire costs</td>
<td></td>
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<tr>
<td>8. Refreshment costs</td>
<td></td>
</tr>
</tbody>
</table>

**Deep dive analysis/case review (incident complaints and claims) - TBC**

The precise requirements are to be confirmed however it is anticipated 1 wte (administration support within item 3 above) will be necessary for this work grade/level of:

9. 1 x band 7 wte

Work apportionment will be confirmed within the final plan once the workload has been cohorned (assessing the volume of claims, complaints and incidents) objectives and limitations identified. It is anticipated that 1 band 7 post will be required by virtue of the 3 part review of incidents, complaints and claims for a 3-5 year period, data collection, analysis and report production.

Funding for above resource will be for a 12 month period.
Timing:

Train the Trainer programme – During April – Dec 15

TNA plan for staff – From April 15

Training programme – Set from Q1 to Q4 each year (via TNA priority)

Quarterly and annual evaluation

Quarterly monitoring of incidents and complaints

6 monthly – annual monitoring of claims notified/settled

Refer also high level scoping plan – table 1 below

Deep dive analysis/case review (incident complaints and claims) – Proposed to run the project over 12 months - Q1 15/16 to 16/17

Benefit:

PCM Training Programme

PCM shows that the most productive way to minimise error is to look at how healthcare specialists function and communicate.

It then gives us some very specific tools to influence this behaviour in a way that eliminates many of the human factors that contribute to medical error within health service e.g. we know that behaviour affected by stress contributes to medical errors.

Process Communication makes it easy to:

• observe and understand your own behaviour,

• understand the behaviour of others and know how to communicate with them effectively

• analyse distress, conflict and miscommunication and know how to find resolution and a return to effective communication.

The purpose of this programme is to provide a road map to enable healthcare professionals to establish a culture of patient safety in their facilities and practices, provide high quality healthcare and increase patient & staff satisfaction by improving communication amongst staff members and between medical staff and patients.

The programme will achieve this by teaching what each of the six types of personality will do in distress, by providing strategies that will allow healthcare professionals to deal more effectively with staff members and patients in distress, and by showing healthcare professionals how to keep themselves out of distress by getting their motivational needs met positively every day.

The concepts taught in this programme are scientifically based and have withstood more than 40 years of scrutiny and scientific enquiry. They were first used as a clinical model to help patients help themselves, and are still used clinically. The originator of the concepts – Dr Taibi Kahler is an internationally recognised clinical psychologist who was awarded the 1977
Eric Berne Memorial Scientific Award for the clinical application of a discovery he made in 1971. That discovery enabled clinicians to significantly shorten the treatment time of patients by reducing their resistance as a result of miscommunication between their doctors and themselves.

PCM is now used extensively in Healthcare facilities across America, Europe, New Zealand & Australia – where it is core curriculum training for Surgeons.

It is brand new in the UK and we have the only PCM Certified Trainer in the NHS currently working at RWH.

A large number of the Clinical Human Factors Group are attending a 2 day seminar on PCM in January to understand how PCM gives staff the skills to be more situationally aware through increased self-awareness & awareness of others.

Deep dive analysis/case review (incident complaints and claims)

To facilitate a focused analysis and extraction of data intelligence (qualitative and quantitative) which produces risk indication for the Trust and an evidence based signpost for priority action.
<table>
<thead>
<tr>
<th>Activity</th>
<th>April</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
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<tbody>
<tr>
<td><strong>Year 1 - 2015/16</strong></td>
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<td>Board training</td>
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<td>Monthly training for Middle to senior managers via external trainers</td>
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<tr>
<td>Train the Trainer (2 Master trainers)</td>
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<tr>
<td>Agree final TNA and cohorting of staff in priority groups</td>
<td>X</td>
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<tr>
<td>Agree/define scope / levels of course and content for various staff</td>
<td>X</td>
<td>X</td>
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<td>Internal course configuration with input from trainers</td>
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<td>groups by work area and role (define minimum objectives for each</td>
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<td>level of training course)</td>
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<tr>
<td>Define top up requirements and develop top up course/material</td>
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<td>Top up course to be configured with</td>
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<tr>
<td>Agree initial indicators for monitoring/evaluation (includes, incidents, complaints, claims themes, trends and numbers, 360 feedback, surveys, impact assessments on self, team &amp; service delivery, internal chatback)</td>
<td>X</td>
<td>X</td>
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<td>master trainers</td>
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<tr>
<td>Develop tools/templates for course evaluation and monitoring</td>
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<tr>
<td>Quarterly review of course evaluations and impact</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Develop Marketing, Course support and resources (inc library resources, website, staff prompts, leaflets etc)</td>
<td>X</td>
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<td>Year 2 – 2016/17</td>
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<tr>
<td>Roll out training to targeting staff groups as per programme plan.</td>
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</tbody>
</table>
Deliver top up schedule for 16/17 as agreed in year 1

Quarterly review of course evaluation and impact.

Year 3, 4 and 5 (2017 – 2019/2020) repeated – with flexibility/adjustment as indicated by course evaluations and impact monitoring.
<table>
<thead>
<tr>
<th>Item</th>
<th>Cost £</th>
<th>Total cost (£K)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 PCM train the trainers course costs</td>
<td>6K per trainer</td>
<td>12</td>
</tr>
<tr>
<td>2 Band 7 (x 2) trainers for 3 years</td>
<td>86.6K/year</td>
<td>259.8</td>
</tr>
<tr>
<td>3 Band 3 administrator for 3 years</td>
<td>21.3K/year</td>
<td>63.9</td>
</tr>
<tr>
<td>4 PCM profiles (1000 profiles over 3 years)</td>
<td>100 each</td>
<td>100</td>
</tr>
<tr>
<td>5 Kit (Magnetic boards)</td>
<td>1K per board</td>
<td>3</td>
</tr>
<tr>
<td>6 Merchandising &amp; marketing</td>
<td>2K across the 3 years</td>
<td>2</td>
</tr>
<tr>
<td>7 Room hire</td>
<td>across the 3 years</td>
<td>5</td>
</tr>
<tr>
<td>8 Refreshments</td>
<td>2K across the 3 years</td>
<td>2</td>
</tr>
<tr>
<td>9 1 x Band 7 (deep dive analysis)</td>
<td>43.3K for one year</td>
<td>43.3</td>
</tr>
</tbody>
</table>

Total: 491