

**Action Points**  
**9th Meeting of the Clinical Human Factors Group**  
**Weds 3 Mar 10 held at the CQC**

**Attendees** (not all attended for the whole meeting):

Murray Anderson-Wallace, Martin Bromiley, Ken Catchpole, Brian Edwards, Benjamin Ellis, Rhona Flin, Tony Giddings, Allan Goldman, Nikki Maran, Dave Murray, Cate Quinn, Jane Reid, Hugh Rogers, Matthew Sargeant, Denis Wilkins, Pamela Winton.

Sincere thanks to Cate Quinn and the team at the CQC for hosting our meeting.

*Important Note: The order of the minutes and action points don't necessarily reflect the order of the discussions, they've been re-ordered to make more logical sense. The meeting had so much to discuss that we ran out of time. As a result only the first half of the agenda was dealt with!*

Background

The purpose of this first meeting since the Strategy review in December was to review activities to within each key activity clusters that we agreed on to support our “campaign” to promote human factors in healthcare.

**Item 1 – The current “state of play” regarding patient safety and human factors:**

This meeting takes place with a number of wider issues which will impact on the whole patient safety debate. The election is looming and it's likely that there'll be a slowing of political process which may create a void for a while. The ongoing review of arms length bodies will also impact, and the Chairmanship of the NPSA is about to change. Significantly Patient Safety First comes to an “end” in March, but the work will be continued through the NPSA and Maxine Power's QIPP on Safety.

Earlier in 2010 the CHFG supported Patient Safety First's “Human Factors Week” – Murray Anderson-Wallace reported that there was a fantastic response and a significant amount of people downloaded the HF How to guide. Clearly there's a great and improving appetite for HF.

In the last week the Mid Staffs Inquiry has been published, although the story “blew-up” dramatically it was interesting how quickly the story died, very different to the Dr Foster report which created a great deal of discomfort, especially for the CQC. Arguably this tells us that how you manage the media is very important. Next two or three months will be very important, as discussed previously we have an opportunity in the turbulence of the election. There is the potential in the dead weight of the

Francis report to provide policy briefings to the main political parties. Not to influence their campaign strategy, but to influence their thinking for how they develop the NHS after the election. The winner shouldn't be relevant. It was felt that a small team could look at policy briefing and that this was an opportunity to good to miss although with accepted risks.

“Cure the NHS” had publicly asked for more responsibility and discretion to be given to frontline clinicians. The problem is that unless we give those same professionals the right skills (through HF training) to do this nothing will change.

It was agreed that ultimately it's only the profession that can make the change, but the change in philosophy is not being spoken about by enough managers often enough or repeated enough. Leadership needs to create the space for professionals to allow things to happen. Targets are good and here to stay but not to the point that they immobilise care.

Over the next few months the CHFG will need to navigate in a very turbulent period. There is a disconnect between managers and clinicians. We have an opportunity to provide commentary around how managers and clinicians can work together. We also have to avoid being alarmist, we need to shake the tree but not bring it down!

The CQC has been completely restructuring itself away from a central structure to a more regional structure with three functions; Registration; Compliance/monitoring and Performance (driving performance over and above requirements). There will no longer be a central investigation function.

Progress north of the border has been encouraging through the Scottish Patient Safety Programme. Some areas such as cardiac care and work around DVT have really changed. Generally people are not quite sure what to do next, interventions seem to work but there's still a lack of understanding of the safety science behind it. The whole programme is away from awareness giving to maintenance. After the first wave of excitement the next bit is hard, bringing on the low adopters!

## **Item 2 – Likely work/projects to support key activity clusters (to include current projects).**

**Lobbying/influencing Politicians, Leaders, Patient Groups & Media Engagement. Three key projects were discussed:**

### **CHFG Buddy Programme, Speaking Up Project and Policy Briefing for the Political Parties**

#### **CHFG Buddy Programme**

The Buddy Programme has its first round of volunteers and we already have a number of organisations who have come forward for help. The first Buddy meeting is already organised for the Chief Exec and Chair of the NHS III. At the most recent National Patient Safety Forum Bruce Keogh encouraged all Forum members to take up the CHFG's offer of a Buddy.

The training programme is drafted but with further work to do. It takes place on 25 & 26 March in London, Day 1 has been developed jointly by Jane Carthey, Ken Catchpole and Charles Vincent and aims to raise knowledge among the Buddies of HF in its broadest sense by following a patient's journey. Day 2 will be a facilitated day aiming to manage the role, parameters, boundaries and risks associated with the programme. It's hoped that a second training programme can happen later in the year. We're still not sure "Buddy" is the right term!

**Action: Jane Reid to follow up with Denis Wilkins about being part of the programme.**

Speaking Up Project (now named "Difficult Conversations")

This project was initiated last year to provide a public and open programme for encouraging people to speak up and be heard. Originally we believed this might be aimed at Nursing staff but it's clear that virtually every grade in the NHS would benefit from being exposed to this. We're still struggling to find a good title though. "Speaking up/Situationally Aware/Sharing information/whistle blowing/listening, we lack a vocabulary to decide what "this" is. Murray Anderson-Wallace led a conference call which included the RCN, AfPP, a journalist as well as representation of the CNO. At this stage we've already seen a piece written by Phil Hammond in Private Eye (8-15 Feb edition) specifically about the problem of speaking up. The AfPP have now discussed having speaking up as a theme for their autumn conference and having people such as Phil Hammond open the conference. We will need to continue having one to ones with other organisations as well as using the media contacts we have. Jane Feinmann is interested in seeing what she can work up with the broad sheets, but this has to be carefully thought through work, not big disaster media splashes (although that doesn't mean that we shouldn't highlight the issues around situations such as Mid Staffs).

It was discussed that lack of feedback after speaking up is a major barrier, as is the ability of those around to listen. At the moment it's perceived that the cost of speaking up is greater than the cost of being silent. How can we change that?

There is also a patient dimension here. Encouraging patients to speak up as well as encouraging patients to share stories of what happened when no one did. We need to engage the patient groups but not create antibodies from the professionals.

Interestingly it was pointed out that a number of professional bodies are working on programmes to encourage speaking out and listening; but that the work is poorly publicised (if at all). More transparency would help.

Rhona Flin discussed the issue in other high risk industries and suggested that this is about "difficult conversations". It was agreed that as a working title this was much more appropriate. It was suggested that as this is a common problem to all industry we should look at what is done else where. The lesson from elsewhere is that you need to give people the skills and strategies for these difficult conversations.

How do you say "I screwed up", how do you say "You screwed up"?

Where do we go from here? It was agreed that although a public campaign would raise consciousness simply exhorting people to speak up and listen won't work. Maybe a top down approach would work a lock in for leaders almost as a starter? There is a concern that certain professional groups will see training in these skills as "demeaning for their profession". As someone phrased it "delusions of adequacy". We also have training routes; for example every member of staff goes through an induction, maybe we should approach human resources to encourage speaking up? Other routes include Trade Unions (eg BMA or Unison). NHS Employers would also be a starting point.

**Action: Murray Anderson-Wallace to further review feedback from interested parties on the project and consider next steps before reporting back. In the meantime we will encourage and support other groups to publicise the issue (a gentle build).**

#### Policy Briefing for the Political Parties

After the earlier discussions about the current state of play it was agreed that having the opportunity to brief politicians on the relevance of human factors to future policy would be very useful although there were various risks. But now is a great opportunity. We could link to our submission to the parliamentary inquiry, the DH response and of course Mid Staffs.

It was mentioned that we are not trying to influencing the campaign now, or down the road but we want to provide something to prime the policymaking in the post election period. The theme would be around improving human performance and a reduction in expenditure; or making better use of the existing money. Productivity and safety.

It was suggested that evidence would be needed; apparently the HSE did a report on costs of accidents to work/business in a booklet (using an iceberg model). We also used the HFI MoD Leaflet with the National Patient Safety Forum and of course we also have evidence in the Parliamentary Inquiry. If further data was needed we could make a call to the wider group.

**Action: Martin Bromiley to provide Murray Anderson-Wallace with our PI Submission and follow-on papers, Murray Anderson-Wallace to follow up and speak with appropriate people. If a team is formed to do the Policy Briefing initially it's proposed to be Murray Anderson-Wallace, Martin Bromiley and Tony Giddings.**

#### **Influencing student, under-graduate level and the curriculum & lobbying for curriculum and simulation development.**

We started this part with a presentation (slides attached) by Benjamin Ellis who's been working with the CMO. He's the Project Manager for the 2<sup>nd</sup> edition of the multi-professional patient safety curriculum guide for the WHO. This project was led by Prof Barraclough from Sydney and included Rhona Flin in the team. It aimed to produce a standard worldwide curriculum for patient safety. It includes reference to

human factors at a basic level. A copy can be downloaded for free at <http://www.who.int/patientsafety/education/curriculum/en/> along with slides for teaching. You can also download individual chapters. The programme focuses on behaviours and has pulled together international representation of medical, dental and pharmaceutical students.

The project has an email address at [pcurriculum@who.int](mailto:pcurriculum@who.int) . From today until 10 March there is a global facilitated discussion involving 1300 participants in 110 countries about the curriculum. You can log on to Health Professions Global Network at [www.hpgn.org/patientsafety](http://www.hpgn.org/patientsafety) for more details.

Benjamin offered some interesting and useful perspectives on patient safety as seen by junior doctors. Any intervention must make their job easier within the difficult system that already exists; and most medics really aren't sure about patient safety, some would see falls and maybe infection as patient safety, where as for example a catheter infection would be seen as an accepted complication. The fact that he/she hasn't had time to provide drugs to patient because of workload isn't seen as a patient safety problem.

He suggested that uptake of the curriculum might be quicker in Scotland than England, and that it does seem to have snowballed. It is being piloted in four medical schools in Ethiopia and the Federal Ministry of Health has committed to including it in the curriculum for all medical schools. (Martin's view – why can't we do that)?

The discussion then broadened into the lack of knowledge generally about HF. We heard that the RCoA are organising a two day programme on HF on 17 & 18 March RCoA and that the Assoc of Paediatric Anaesthetists also have a day in May. All this is encouraging; but we need to see HF embedded into curriculum and training quicker.

Pamela Winton explained to us the use of "Glossy's" in the AAGBI and offered to lead writing one in the hope that some exams will refer to it.

**Actions: Martin Bromiley to email Pamela Winton, Rhona Flin, Ken Catchpole and Dave Murray to develop an HF Glossy for the AAGBI. Pamela Winton to lead the work. Cate Quinn to arrange a sharing of contact detail so that Pamela Winton can meet with David Haslam to discuss how a questionnaire around safety could be used to engage junior doctors, and to include elements of culture.**

### **Conversations with Boards & Snr Managers/Story-telling**

CHFG presenting to the National Quality Board.

The CHFG has an opportunity to present to the NQB. Possible volunteers so far include Mark Emerton, Jane Reid, Hugh Rogers, Ken Catchpole, Karen Woo, Brian Edwards, Steve Powell, Matthew Sargeant, Nick Sevdalis, Krishna Moorthy, Pamela Winton, Rhona Flin, Nikki Maran & Melinda Lyons.

The NQB has stated that their role is to provide strategic oversight and leadership for quality across the NHS. In summary the NQB wants to drive quality improvements faster and embed them in the culture. It's work is done through 12 QIPP's or workstreams each focusing on a particular area.

It was felt by the group that we needed to challenge the NQB; not just give solutions which won't happen but make them think about their influence on frontline delivery. It was agreed that the inability of the centre to make things happen at the frontline is also tied in with a lack of understanding of the humans within the system.

There were a number of angles discussed. I shall summarise these in an uncoordinated way by listing the possible elements that could make up our presentation. Brought together in a coordinated way these could provide a stimulating route forward.

Possible element, Looking at the QIPP's and HF: The NQB has 12 QIPP's which make up its workstreams (one of which is "safety"). However it was felt that we should start by identifying how human factors impacts on all 12 of these QIPP's.

Possible element, Looking at Workarounds: Having a theme of "workarounds" and helping the NQB recognise how the system encourages workarounds and the long term affect on safety, quality improvement and productivity. The use of standard methods of work would be explored as well to improve productivity.

Possible element, Visioning 5 years time from a frontline perspective: We would challenge them to think about how they want people to behave within the system in 5 years time. In other words visioning specific examples for them to then consider the routes to make it possible/easier for this to happen via their decisions now. (For example Ken Catchpole often shows the photo of a piece of equipment labelled "do not use after Dec 06", this was taken some years later while the item was still in regular use - the open question to the NQB would be "Faced with this label, what would you want those clinicians to do"? "And therefore what do you need to do to ensure this happens"?). In this way we want to bridge the disconnect between policy and practice. The point was made that so far no one has defined what a safe hospital looks like?

Possible element, Developing a Human Factors Intervention: We need to stress that quality and safety improvements can't be done without human factors, and that the culture must be right. We're still over focussed on evidence based interventions, although there was a suggestion of offering a specific human factors based intervention, or even a culture based intervention.

Possible element, Highlighting how to/how not to change culture using the Checklist as an example: Another possible theme was to use the checklist implementation as an example of the good and bad practice.

Our challenge is to tie these elements together in a coordinated way!

**Action: Martin Bromiley to follow-up with Mark Emerton about leading the NQB project and initially arranging a telecom with other interested people to develop our presentation. Martin Bromiley to email Murray Devine to firm up a presentation date.**

At this point the meeting ended with the following items still to be discussed. The follow-up to discussions of a trial of independent investigation will be via email.

- Lobbying for “quality” HF and incident investigation.
- Multi-professional training
- Liaison with other HF groups both UK and internationally
- Website work on resources & signposting the evidence
- Review of CHFG funding and budget, as well as requests for funding.

#### **Meeting schedule and next meeting.**

The next meeting will hopefully be hosted by GOSH on Weds 7 July. Details to follow. We will pick up the other agenda items at the next meeting.

Martin Bromiley