Health Foundation - Closing the Gap in Patient Safety Programme

Safer Care Pathways in Mental Health

Project Newsletter: June 2016

Welcome to this our final newsletter! After two years of work, we are writing up our final reports for the Health Foundation and looking forward to our showcase event on 20 June at Newmarket, when we will share our findings and learning.

Project aims
The Safer Care Pathways in Mental Health is one of ten projects in the national ‘Closing the Gap in Patient Safety’ programme, funded by the Health Foundation. For more information, go to [www.health.org.uk](http://www.health.org.uk). Our project aimed to support clinical teams with patient safety improvement in mental health care pathways, making these pathways safer and more reliable for service users and their families, and for staff. We have focused on dementia care pathways and adult mental health care pathways. We also aimed to test out an integrated patient safety package involving system safety assessment (SSA) and human factors training and coaching (HF).

Patient safety intervention package
System safety assessment – ‘Looking for trouble’
We trained each of our five project sites in the SSA tool and supported them to undertake a Systems Safety Assessment for their chosen care pathway. This involved assessing all of the things that could possibly go wrong with patient care in a service and analysing which of the risks identified is the highest priority for action. Clinical teams worked with project staff on these assessments, and then worked on designing solutions to improve safety and reliability. For more info - [http://www.ssatoolkit.com/](http://www.ssatoolkit.com/)

Human factors training and coaching – ‘People are not robots!’
Human factors encompass all those factors that can influence people and their behaviour to act more safely, including teamwork, leadership and culture. For more information go to: [www.chfg.org](http://www.chfg.org). We provided two programmes of training:

Patient safety champions - Five patient safety champions from each trust received five days training and coaching equipping them to introduce human factors tools and techniques within their clinical teams.

Frontline clinical staff - Twenty five frontline clinical staff from each trust received one-day human factors training. The training included ‘Why errors happen? And what can we do to prevent errors and to learn from them?’ We also covered some of the common tools and techniques for strengthening patient safety communication.
The patient safety intervention package also involved project improvement support, and service user and carer involvement support.

**Our project sites**

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<tr>
<th>Trust</th>
<th>Site</th>
<th>Project site, patient safety focus and planned intervention</th>
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<tbody>
<tr>
<td>NEPFT Colchester</td>
<td>Site: Older adults functional care ward, and dementia care ward&lt;br&gt;<strong>Patient safety focus:</strong> Self-harm and violence &amp; aggression&lt;br&gt;<strong>Planned intervention:</strong> Training, handovers and person-centred care</td>
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<tr>
<td>NSFT Norwich</td>
<td>Site: Dementia care wards&lt;br&gt;<strong>Patient safety focus:</strong> Falls prevention and aggression&lt;br&gt;<strong>Planned interventions:</strong> Revised admission process, engagement with carers, SBAR communication, therapeutic engagement with patients</td>
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<td>CPFT Cambridge</td>
<td>Site: Dementia care ward and older adults functional care ward&lt;br&gt;<strong>Patient safety focus:</strong> Falls prevention and management&lt;br&gt;<strong>Planned intervention:</strong> New approach to falls assessment, more use of eLearning, assistive technology and equipment changes</td>
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<td>SEPT Basildon</td>
<td>Site: Adult acute CRHTs&lt;br&gt;<strong>Patient safety focus:</strong> point of entry to the service, and caseload management.&lt;br&gt;<strong>Planned intervention:</strong> SBAR communication and clinical review communication</td>
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<td>HPFT South and East Herts</td>
<td>Site: Adult acute day treatment unit and CRHT&lt;br&gt;<strong>Patient safety focus:</strong> Transfer between services&lt;br&gt;<strong>Planned intervention:</strong> Care call for people discharged, ‘Next Step’ person-centred planning</td>
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Our findings and learning outcomes

- There are strong indicators and practical examples of clinical practice behavioural change across the trusts involved, principally supported by qualitative data and narratives.
- Service user and carer involvement enhanced the design and impact of improvement changes in some sites.
- There were indications of staff behavioural change in clinical teams across the trusts involved. Narratives to that end are provided in various qualitative sections in the evaluation report.
- The Safer Systems Assessment training and the Human Factors training were positively received. Clinical staff who participated provided valuable suggestions for improvement for future applications to mental health settings. This is the first time, to our knowledge, that human factors training has been applied at scale in mental health care in the UK.
- Attitudes toward both training domains generally improved throughout the project.
- The overall rating of patient safety culture improved significantly in the same time period as the intervention, however there are interpretive limitations due to sampling issues with the safety culture questionnaire survey.
- The most poorly-rated domain – staffing – of patient safety culture improved from an overall negative to an overall positive.

Process

- Sites who had a committed lead for coordinating improvement projects were generally able to provide more insight for application and evaluation.
- Whilst training courses were generally well received, it was felt the training sessions could have been arranged closer together in time periods to maintain momentum and focus.
- Maintaining project site involvement and engagement was at times challenged by internal transformation processes and external events such as CQC inspections and commissioning changes.
Finally, we would like to thank everyone involved in the project for their support, and in particular all of the clinical teams involved for their enthusiasm and commitment to the project over the last two years. We wish them well and every continued success with their safety and quality improvement work!

Tim Bryson
Project Manager

Project webpage
http://mentalhealthpartnerships.com/project/safer-care-pathways-in-mental-health-project/
Project twitter account, which is #safercarepathways.

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