Implementing change: lessons from the patient safety movement

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Interventions to reduce harm already exist. One of the key messages in relation to patient safety is not about finding new knowledge but about translating that knowledge into practice. There is genuinely a lot known about factors that help and factors that hinder successful implementation. Implementation usually starts with a new idea or new method and people therefore tend to think that it is ‘a single event’. Implementation is a whole journey from the concept of that idea. It is really important that those who develop that idea think about implementation, all the way through to whether somebody will ‘listen to that idea’, ‘think it’s a good idea’, ‘choose to adopt it’, ‘choose to adapt it once they have adopted it’, and then ‘choose to embed it and sustain it throughout everything that we do’. This is true implementation, it is not just a one-off episode of the delivery of care; the complexity around implementation should not be disregarded. However, there are things that can simplify that complexity and the world of implementation science can help do that.

There is a commonly held view often reflected in targets, that if you start something, that if you just ‘click your fingers’, that you’ll make a difference in a few months. Most of the National Patient Safety Alerts in England said ‘comply with this in about 6 months and then we will test you in about a year’. Yet, if we compare these challenges with something like the European Space Agency’s Rosetta space mission, this was a project that was planned to take 10 years for that wonderful journey to be completed. Imagine being in the room when they started thinking about it: ‘right, we want to land on a comet, we are going to figure out how we’re going to do that, we’re going to do that in about 10 years’ time and we’re going to monitor it as it goes round and round and it’s just going to land perfectly on the day that we expect it to’. The three lessons from Rosetta are:

- First, never think that something cannot happen; the impossible is always possible but sometimes takes 10 years for large changes to be made, some quality

improvements introduced to the National Health Service (NHS) 10 years ago are only now being embedded into everyday practice.

- Second, you have to monitor it all the way along the entire journey just to keep it on track, you have to monitor, measure, evaluate and tell everyone and learn from the successes and the failures along the way.
- Third, be positive about success and failure. One of the most joyous things about the Rosetta story was the absolute elation in those people’s faces because they had achieved something but also the brilliant way in which they described the things which did not work – ‘Ah well that’s fantastic, that’s fascinating, why didn’t it work, lets learn from that, and this is what we need to do’, not ‘we’ve failed’ and lets punish ourselves or various individuals along the way.

Research and experience have shown that there are lots of factors that can help successful implementation. The World Health Organization (WHO) surgical checklist is a good example of these. This single document came about from a lot of work and ultimately agreement from 54 member states of the WHO. We often struggle in the NHS to agree on definitions, on levels, on parameters but 54 member states agreed the core components and then agreed the rest of the components that can be adapted for local environments. Local adaptability is one of the crucial elements that help make implementation work. As described by Atul

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Figure 1. Initiatives to address the Berwick recommendations for the NHS in England.

Gawande (2011) creating a successful checklist is about talking to people and trying to understand what they think. You might have the evidence base that it saves lives, reduce harms, saves time, improves team-working but you still need to ask ‘why won’t people like it?’, ‘why won’t people implement it?’. So even today we need to ask ‘why is compliance less than 90%?’.

A checklist needs to be easy to use; it needs to be intuitive so that no additional notes or lengthy training are required. It also needs to be tested on a small scale, for example with the WHO surgical checklist we encouraged people to test it one theatre or one session at a time, or one specialty or even just one surgeon at a time. By repeating these tests you can learn each time what works and what doesn’t work.

It is also not just about adoption, it is adoption plus adaption. The surgical checklist is now being adapted by dentists, midwives and outpatients, and for ward rounds and outpatient sessions. One crucial thing that worked for the WHO surgical checklist implementation in the NHS in England was getting peers to talk to peers; they speak the same language, they resonate with each other, they know how it feels to be each other and it makes a big difference. Language and acronyms can be crippling and it is vital that you have clarified understanding among those who you are asking to use it.

In the report on NHS in England, Don Berwick said that it ‘*can become the safest healthcare system in the world. That will require unified will, optimism, investment and change. Everyone can and should help and it will require a culture firmly rooted in continual improvement*’ (National

Advisory Group on the Safety of Patients in England, 2013). Everything in this report has been converted into objectives, goals and expectations for different part of the NHS, such as patient safety and human factors training by Health Education England, the Patient Safety Collaboratives being led by the Academic Health Science Networks, developments in the National Reporting and Learning System and the *Sign Up to Safety* initiative. Figure 1 illustrates how these recommendations are being addressed.

Sign Up to Safety

Sign Up to Safety is aiming to help the NHS to reduce harm by 50% and save 6000 lives by creating a space and connection between organisations, individuals, experts and people to share and learn from each other. It is a crime that we do not share what we do and that we continue to reinvent the wheel every single time.

Unlike the *Patient Safety First* initiative, which involved five interventions chosen from the centre, *Sign Up to Safety* is intended to be locally-owned with up to five interventions chosen locally. Figure 2 explains more about the campaign and how it aims to improve the safety of patient care. Each organisation who joins creates an individual safety improvement plan based on their personal learning from what has happened over the last 3–5 years and focusing on up to five ‘pledges’ for improvement over the next 3–5 years (Woodward, 2015). *Sign Up to Safety* aims to connect people around a common purpose towards delivering safer patient care – the time to change is now – be part of the movement.

Figure 2. Sign Up to Safety – National Patient Safety Campaign.

Sign up to Safety - National Patient Safety Campaign June 2014 – June 2017

Sign up to Safety is a three year national patient safety campaign launched in June 2014, one of a set of initiatives to help the NHS improve the safety of patient care. Collectively and cumulatively they will help improve the safety of patient care.

Our shared purpose: To connect people around a common purpose, inspire and drive momentum towards delivering safer care, wherever it takes place. We will connect the three year aim with long term sustained change by capturing our shared learning

Our pledges

- **Putting safety first:** We are committed to supporting the NHS to place patient safety first. Patient safety is the organising principle of high quality healthcare; only safe healthcare services are truly efficient, effective and able to offer the best experience for staff and for patients, carers, relatives and families.
- **Continually learn:** We will promote a culture of learning. We will support the capture, gathering and sharing of local knowledge and experience, helping people to achieve their ambitions for patient safety. We will promote measurement for safety improvement that is meaningful.
- **Being Honest:** We will promote a just culture approach to patient safety - the fundamental aspects that underpin safety, where individuals are encouraged to be open, honest and candid with patients and carers and each other. We will promote respect and trust between healthcare practitioners and those that manage and lead them.
- **Collaborating:** We support collaboration as a way of learning and sharing best practice. We will encourage people to join forces and play an active part in creating the safest healthcare system in the world.
- **Being Supportive:** We will create a shared purpose and commitment for safety improvement from the board to the frontline and create the opportunities that enable this to happen. We will help towards improvements in the health, wellbeing and joy of the workforce.

Our work is organised around 3 key areas.

1 – Raising awareness and building local engagement: By assisting the NHS in and out of hospital care, including GP practices, to understand the areas of harm in their area and develop personalised and targeted Safety Improvement Plans that set out their aims to reduce these areas of harm over the next three to five years

2 – Mobilising and motivating: By inspiring people to take action, rewarding and recognising local activity and connecting them together to share progress and stories

3 – Capturing knowledge: By learning and sharing knowledge about what works and what could be done differently in order to identify the right conditions that support a safer NHS and address the problem of unsafe care and avoidable harm

A movement to prioritise safe care is spreading across the whole NHS. The time for change is now. Be part of it.

www.signuptosafety.nhs.uk

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