

## King's PSSQ Annual Report 2008/09

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# PROGRESS REPORT

## Overview

As King's Patient Safety and Service Quality Research Centre (King's PSSQ) nears the half-way point for the first phase of funding, work is progressing well. The partnership between King's College London and King's College Hospital NHS Foundation Trust has been cemented with the Centre's full integration with both organisations, and awareness of its work is spreading to an ever wider group of internal and external stakeholders. King's PSSQ enjoys strong support from the most senior figures at the College and Trust, and is considered an important asset for King's Health Partners, the recently accredited Academic Health Sciences Centre. We contributed to the application that led to that accreditation.

The King's PSSQ strategy document (appended here) was approved by our Scientific Advisory Board in November 2008, and work to meet our strategic aims is on course:-

### **Strategic aims:-**

- *Develop a body of research on patient safety and service quality that focuses distinctively on factors at the organisational level that are likely to have a significant impact on patient outcomes.*
- *Conduct research within four themes – Innovations, Organisational Governance, Risk and Workforce.*
- *Apply expertise from a range of academic disciplines available within the partnership. Use the inter-disciplinary analysis to develop, introduce and carefully evaluate novel interventions to improve patient safety and service quality.*

There are currently 18 projects active under the four programmes, approaching a wide variety of issues. See *Research Highlights* below for an update on the ten projects developed since the last report. Below we outline progress in three key strategic areas for the Centre:-

### **Building Capacity**

**Strategic aim:-** *Build capacity for, and involvement in research related to patient safety and service quality by enabling NHS staff to participate in research activity through a process of secondment. Ensure effective practices to involve stakeholders such as patients, representatives of the local and hospital communities and early career researchers.*

The Centre has recruited six staff on secondment from King's College Hospital NHS Foundation Trust for up to one year. Their first-hand knowledge of NHS staff combined with our researchers' specialised academic expertise is improving knowledge exchange, and already yielding project results and building research and implementation capacity. Three new Centre PhD studentships have been recruited to start in September 2009, in addition to the three PhD students externally funded (two ESRC CASE studentships, and one NIHR studentship), and a PhD student working at King's College Hospital NHS Foundation Trust sponsored by the Centre - taking the total number of full-time PhD students to seven. We also have three members of PSSQ staff undertaking PhDs related to the Centre's work.

### **Communications and Dissemination**

**Strategic aim:-** *Communicate to stakeholder groups as well as national and international academic, policy and practitioner audiences.*

Our interim Centre Manager has expertise in communications and is able to deliver all print, web and press related media materials. He meets with the Trust corporate communications team on a weekly basis and is in close contact with communications teams at KCL, King's Health Partners and the GSTT and SLaM Biomedical Research Centres to ensure knowledge sharing and secure opportunities for joint working (PSSQ brochures were included in 200 delegate packs for the KHP conference – we were the only organisation to take advantage of this).

A series of bi-monthly open seminars has been established, with high-profile speakers addressing an average of 60 invited stakeholders, including health care professionals, managers, policy makers, lay people and academics. These have proved to be very successful both in raising awareness of specific aspects of the Centre's work, and in promoting our wider agenda. They are widely advertised at the College, Trust and further afield via e-bulletins, posters and a range of listserves.

A monthly PSSQ e-bulletin is circulated to c.500 stakeholders, with news updates, information about conference presentations and upcoming seminars. Media coverage has included articles in key sector publications including *Nursing Times* and *Nursing Standard*, as well as high-profile cover stories and features in King's College London and King's College Hospital NHS Foundation Trust internal magazines. We are working

closely with the King's Health Partners AHSC to promote our work under their wider umbrella when relevant to ensure the widest possible national and international pick-up of news stories.

Papers published by PSSQ staff members are listed in an appended document.

### **Levering in additional funding**

**Strategic aim:-** *Secure additional external funding to a minimum total value of 10% of the main NIHR funding (i.e. approximately £500,000 by 2012)*

The Centre has been successful in obtaining a substantial EU grant (3 million Euros, subject to contract) to lead a project investigating patient safety in hospitals across five European countries. This will be undertaken in collaboration with Imperial PSSQ and partners in Sweden, Portugal, Norway and the Netherlands. The three-year study, starting in 2010, will explore the relationships between the organisational and cultural characteristics of hospitals, and how these impact upon clinical effectiveness, patient safety and experience.

Whilst this grant meets our total additional funding goal for the first five years of the Centre (we expect the PSSQ share to be approximately £500,000), we will of course seek further grant opportunities on an ongoing basis. See *Forward Look* on page 8 for further information on the EU project. NIHR provided £15,000 towards costs of developing the bid.

We have secured funding for two ESRC CASE studentships (£16,940 each annually) and an NIHR PhD fellowship (£184,588). In addition, the Department of Health commissioned a review of the evidence base on integrated care (£8,500).

### **Research Highlights**

Good progress continues to be made on the eight projects highlighted in the 2007/08 Annual Report, and thanks to taking on additional research staff and secondees we have been able to initiate an additional nine new projects during 2008/09. All have been developed through an iterative process, taking account of Trust, wider King's Health Partners and national priorities, research expertise (including that of the recently recruited secondees from the Trust), and focus of the Centre. Each new project has been developed drawing on the relevant theoretical and empirical literature.

Updates on projects announced in 07/08 Annual Report:-

***Assessing patient safety and patient experience of innovative healthcare procedures and therapeutic innovation (Innovations)*** - NHS Research Ethics Committee and Research and Development approval have been obtained for the entire project. Ethnographic observation of the New Clinical Procedures Committees' meetings are ongoing, as is documentary analysis of past and current application forms and committee meeting minutes. In-depth, semi-structured interviews with Committee members are currently being undertaken, while interviews with local and national stakeholders and patients will commence in October 2009. A conference paper will be presented at the European Sociological Association in Lisbon in September

***Failure to rescue: problems and solutions: Managing Complications in Maternity & Acute Medicine (Innovations)*** - Project to explore how certain patient safety strategies and tools (designed to facilitate the management of deterioration and escalation of care) are implemented and assimilated into the workplace and assess the impact of socio-cultural and institutional context of work on implementation and successful use. Ethnographic observation, interviews and documentary analysis has been collected in acute medicine and will start in maternity in September 2009. Paper accepted for publication in the Centre for Analysis of Risk and Regulation Conference Series and two conference papers will be presented at the European Sociological Association in Lisbon in September.

***Developing the role of foundation trust governors and members in the governance of patient safety and quality (Organisational Governance)*** - A research plan and university ethics approval has been completed for the first phase of the research. A Research Action Group (RAG) has been established and a background working paper produced. A mapping exercise has also been conducted to ascertain where governors and members are currently involved in the governance context of patient safety and quality at the trust.

***Improving the governance of medication safety (Organisational Governance)*** - Analysis of trust-level governance and external drivers is complete and will feed into an article to be submitted to *Quality and Safety in Healthcare*. The study proposal has been agreed by senior governance, risk and medication safety personnel at KCH, as well as personnel in the division where the intervention will be implemented. Three participating wards have been identified, as have relevant ward leads. An ethics application has been drafted and will be submitted in July 2009.

***Bullying and Harassment at King's College Hospital (Workforce)*** - All diagnostic work at KCH has been completed. Analysis of staff survey data has also been undertaken at Guy's and St Thomas' NHS Foundation Trust and South London and Maudsley NHS Foundation Trust. The research team are currently in the process of extending the research into Lambeth Primary Care Trust. Following this, an intervention will be developed and implemented at KCH during 2010.

***Evaluation of 'Lean Management' Interventions in Child Health and Liver (Workforce)*** - A 'pre-change' survey has been completed in the Thomas Cook Children's Critical Care Centre of Child Health with usable data collected from 60 staff. This has been analysed and a report containing the key findings and a detailed breakdown of results has been sent to First Choice. It was originally expected that the next stage would be to collect critical incidents of events occurring in the Thomas Cook Centre, which it was intended would be followed up by the 'after-change' phase of questionnaire data collection. However, First Choice have indicated that the Teamwork and Leadership intervention in Child Health is no longer a priority for them and the future activities for the evaluation project are therefore uncertain. Despite the frustrations faced in our attempts to carry out this evaluation, we have the opportunity to present the documentation of the experiences, barriers and learning of trying to evaluate a hospital-based change programme through a paper which has been accepted at the European Conference on Organizational Psychology and Human Service Work (ENOP) October 2009.

***Using incident data to improve safety (Risk)*** - Analysis of the minutes of key meetings at which adverse incidents are reviewed has been undertaken. Interviews will now be conducted with staff to investigate what action was taken following incidents, whether any changes were effective in improving safety, what information is disseminated to staff about incidents and safety and the impact of the information on practice. Interviews will commence in September 2009.

***The impact of the Employment of Temporary Staff on the Management of Risk in a Hospital: Implications for Patient Safety and Service Quality (Risk/Workforce)*** - This project is a collaborative project between the workforce and risk programmes. It is an ESRC Case awarded PhD studentship. The project is at an early stage and the current work includes a review of the relevant literatures within the employment and risk fields.

#### **New projects:-**

***Rescuing the Deteriorating Patient: Factors Influencing Medical Response (PhD – Innovations)*** - Project exploring how deterioration is 'socially constructed' within medicine and how this influences response behaviour. Investigating the patterns of medical response, what forms of 'encoded knowledge' are perceived to signify deterioration, what written & unwritten rules, socio-cultural & political influence government response to calls for help. Ethnographic observation, interviews and documentary analysis in medicine are currently underway in two sites.

***Birth Place Decisions: A prospective, qualitative study of how mothers and their partners make sense of risk, safety and uncertainty when deciding where to give birth (PhD – Innovations)*** - The aim is to describe the process of making decisions about place of birth in contemporary NHS maternity services from the perspectives of mothers and their partners, and identify factors that affect these choices. To explore perceptions of risk and uncertainty in relation to place of birth (obstetric unit, midwife led unit or at home), and provide in-depth evidence about extent to which perceptions of risk are shared, disputed and negotiated. The project is linked to the 'Birthplace in England' research programme funded by NCCSDO and DH. The study has ethical approval, R&D approvals in progress. Data gathering and analysis is due to progress at each site.

***Continuity of care: Cochrane review of effects on quality and safety of care and health outcomes (Innovations)*** - There is evidence that failures in referral and handover affect patient safety and quality, particularly where critical incidents are frequent. The fragmented and distributed nature of healthcare leads to disadvantaged populations falling through gaps in services. Previous reviews have highlighted that interpersonal continuity of care has the greatest potential to impact on a range of outcomes, but there is a lack of synthesized evidence relating to impact on quality, safety and effectiveness of care, including morbidity, mortality and psychosocial outcomes. The title has been accepted by EPOC Cochrane group and the protocol refined. The work on the review has slowed down as Joanne Fielding has returned from her secondment to the NHS, however another secondee has welcomed the opportunity to work on the review along with Professor Caroline Homer who is working with Jane Sandall on a sabbatical from the University of Technology Sydney. A first draft of the review will be submitted for editorial approval in December 2009. Details of presentations and publications from previous work on continuity of care which inform this review are provided in the Appendix.

***Social and cultural processes around reporting of adverse events in maternity care (Sponsored PhD, Innovations)*** - The aim of the study is to understand the socio-cultural influences on reporting of adverse events and near misses in maternity care, including an understanding of what influences health care staff in their decision to report or not to report. Thesis due to be submitted by December 2009.

**Organisational governance and accountability for Healthcare Associated Infections (ESRC CASE studentship, Organisational Governance)** – Study investigating which kinds of formal and informal accountability arrangements for infection control is present in King's College Hospital NHS Foundation Trust, what kind of organisational accountability is appropriate in relation to patient safety and what implications do the different accountability 'models' have on patient safety. The mapping exercise has been completed. The student was successfully 'upgraded' to PhD status in March 2009.

**Improving the governance of Healthcare Associated Infections (Organisational Governance)** - The aim is to learn how organisational governance influences Healthcare Associated Infections (HCAI). To explore efforts to reduce HCAI levels at KCH in recent years; and consider the factors that have influenced this, including national policy drivers, organisational factors, variations in local professional cultures, managerial cultures and case mix. Analysis of Trust-level governance and external drivers is complete. Findings from HCAI and medication errors mapping have been presented at NPSA research conference, Patient Safety Congress, and SDO conference, and a project report will be produced identifying profession and specialty-specific factors supporting receptivity to improvement initiatives. We will also provide guidance on implementing initiatives in different care groups based on learning from this analysis.

**Using mortality data to improve patient safety (Organisational Governance)** - The study aims to assess if mortality data, routinely collected by a hospital for external agencies, can be used effectively within the hospital to improve patient safety. The study will develop and trial an intervention to improve the governance of the data and evaluate the impact that the intervention has on accountability for deaths and improving practice to provide safer care for patients. A mapping exercise of the current governance structures took place in May and a report of the findings will be presented to the Trust's Clinical Directors in July. Four draft templates and a new governance structure have been developed for the interventional phase which will be piloted in September. Additional output includes a draft working paper capturing the context of the study.

**Organisational Socialisation, Service Quality and Retention (Workforce)** - This study is examining how the experiences of new starters at KCH relate to their attitudes and behaviour, with respect to quality and retention, at a later time. A secondary aim is to develop an intervention to maximise the socialisation process through which newcomers pass, for the good of both the organisation and the individual. Preparatory work has been completed (literature review, attendance at trust induction sessions, interviews with various stakeholders and analysis of labour turnover data), a full protocol has been worked up for the survey research and is being considered by an ethics committee. It is envisaged that quantitative data collection will commence in September 2009 and will last for two years. Qualitative data collection should commence in the summer of 2010. It is hoped that an intervention will be designed and implemented from late 2010.

**Review of Workforce Procedures at King's College Hospital (Workforce)** - Both KCH workforce monitoring data and evaluation work conducted elsewhere suggests that black and minority ethnic staff are disproportionately involved in procedures to deal with difficulties and issues experienced by staff members, including the capability, disciplinary and grievance procedures. The inappropriate use of the procedures may have serious consequences for patient safety and service quality. The primary aim of this project is to review the content, operation and application of the procedures. A review of existing recommendations for best practice in the use of the procedures is underway, and the findings are being used to analyse current KCH policy. The data analysis and case file analysis phases will commence by mid July 2009, and consultation with relevant stakeholders is ongoing. All data collection will be complete by September 2009, and all analysis will be complete by October 2009.

**Risk management in health care (Risk)** - The aim of this study is to provide information and tools to enable hospitals to critically assess and adjust their risk management processes. The study will examine how risk management in healthcare is carried out and identify how it could be improved. Key staff members with risk management responsibilities have been interviewed in detail about the risk management functions that are conducted, how they relate to each other and the organisational structures and processes that carry out those functions. Risk management functions will be mapped and a risk management analysis tool will be developed to analyse how risk management could be improved. The results will be presented to the Research Advisory Group of stakeholders in August 2009.

### **Conferences & Publications**

A list of publications has been included with this report. King's PSSQ staff presented findings at a number of high profile conferences through 2008/09. These included:-

- Magnusson, C., Horton, K. (2008) *Nurse Student Retention in Higher Education: role and process of student exit interviews*. 10th International Conference on Education, 26-29 May, Athens.
- Finlay, S., Sandall, J. (2008) *Making childbearing safe and accessible for disadvantaged women: Continuity of care, Choice, Access and Safety*, NCCSDO, Delivering Better Health Services, 4-5 June, Manchester.
- Anderson, J., Colligan, L., Buckle, P., Ward, J. & Clarkson, J. (2008). *Proactive risk assessment in healthcare: How do experts select the best methods?* Poster. Proceedings of Healthcare Systems, Ergonomics and Patient Safety conference. June 25-27, Strasbourg, France.
- Anderson, J., Buckle, P. & Lim, R. (2008). *Cognitive work analysis: A systems approach to patient safety*. Proceedings of Healthcare Systems, Ergonomics and Patient Safety Conference. June 25-27, Strasbourg, France.
- Cole, P & Anderson, J. (2008). *Equipment procurement in an NHS trust*. Proceedings of the Improving Patient Safety Conference. From safe design to safe practice. July 16-18, Cambridge.
- Fulop, N. (2008) *Integrated care: lessons from the research*. Sir Roger Bannister Annual Health Seminar, Nuffield Trust, Leeds Castle, September.
- Sandall, J. (2008) Oral evidence called for by the Health Committee Inquiry on Health Inequalities, The impact of maternity services on health inequalities, 23 October.
- Guest, D. (2008) *Tackling Bullying and Harassment*. NHS Employers Conference, 5 November, Birmingham
- Fulop, N. (2008) *Governing for patient safety: controlling infection and reducing medication errors*. National Patient Safety Agency Research Conference, November.
- Guest, D. (2008) *HRM and performance in the NHS*. East Midlands Health Authority, 24 November.
- Finlay, S. & Sandall, J. (2009) *Access, Quality and Safety in Maternity Care; Continuity Counts*. Poster session at International Forum on Quality and Safety in Health Care, 17-20 March, Berlin, Germany.
- Magnusson, C. (2009) *Organisational Governance and Patient Safety: Case of Healthcare Associated Infection (HCAI)*. 7th Annual Meeting of the Quality Improvement Research Network, 23 March. Mannheim, Germany.
- Mackintosh, N & Sandall, J. (2009) *"VitalPAC: a means of hospital-wide physiological surveillance?"* Oral Presentation at *Close Calls: Organizations, Near-Misses and Alarms*: ESRC Centre for Analysis of Risk and Regulation, March 26-27 2009, London School of Economics and Political Science.

Staff were also invited to present at the following:-

- Dodds, Anneliese & Kodate, Nao (2009). *Accountability, organizational learning, and risks to patient safety in England*. Political Studies Association Annual Conference, 7-9 April, Manchester.
- Kodate, Nao (2009) *Institutional adaptation in risk regulation in the health sector in England and Japan: Proactive response or staged retreat?* Political Studies Association Annual Conference in Manchester.
- Magnusson, C. (2009) *Governing for Patient Safety. Workshop: Critical Perspectives on Governance*. 15-17 April, University of Bath.
- Ocloo, J. (2009) *'Harmed Patients Gaining Voice Challenging Dominant Perspectives in the Construction of Medical Harm and Patient Safety Reforms'*. BSA Conference 16- 18<sup>th</sup> April, Cardiff.
- Sandall, J. (2009) What can maternity services do to improve the quality and safety of maternity care for socially excluded and vulnerable women, NHS Quality Improvement Scotland Annual Network Event, 24<sup>th</sup> April, Glasgow.
- Guest D, Fulop N. (2009) How can studying organisational issues improve patient safety? Patient Safety Congress, May, Birmingham.
- Sandall, J. (2009) *Midwife-led versus other models of care for childbearing women: implications of findings from a Cochrane meta-analysis*, Association of Ontario Midwives to provide a keynote and closing plenary at the Annual meeting *"Joining Hands: Supporting Midwifery in the Second Stage"* 12-14 May, Toronto.

- Guest, D., Woodrow, C. (2009) *The consequences of violent and non-violent bullying and harassment of UK NHS staff*, European Association of Workforce Organisations, May, Santiago de Compostela, Spain.
- Sandall, J. (2009) *Midwife-led versus other models of care for childbearing women: findings from a Cochrane meta-analysis*, American College of Nurse-Midwives 54th Annual Meeting & Exposition, 21–27 May, Seattle.
- Sandall, J. (2009) *Midwife-led versus other models of care for childbearing women: implications of findings from a Cochrane meta-analysis*, SDO Network and HSRN Conference, 3-4 June, Birmingham.
- Mackintosh, N & Sandall, J. (2009) “*VitalPAC: a means of hospital-wide physiological surveillance?*” Oral Presentation at Scottish Patient Safety Research Meeting, 5th - 7th June, The Burn, Scotland
- Ocloo, J. (2009) *Developing the role of Governors & Members in Patient Safety*. NHS Confederation Conference 10-12 June, Liverpool.
- Fulop N, Sandall J. (2009) *How studying organisational issues improve patient safety*. NIHR SDO conference, June.
- Mackintosh, N. & Sandall, J. (2009) *The construction of risks and uncertainties in relation to the avoidable death*. ESA Conference, Sept, Lisbon, Portugal.
- Finlay, S. & Sandall, S. (2009) *Regulating the uncertainty and risk of technique-centred innovations in healthcare*. RN22 Sociology of Risk and Uncertainty, ESA Conference, Sept, Lisbon, Portugal.

Sandall, J. Mackintosh, N. (2009) *Standardised communication tools as an aide to facilitating calling for help and the escalation of care: the importance of understanding professional boundary work*, RN19 Sociology of Professions, ESA Conference, Sept, Lisbon, Portugal.

## IMPACT ON HEALTHCARE PROVISION

Due to the timescales associated with our projects it is too early to show evidence of the translation of research findings into patient benefit. However, previous related work undertaken by PSSQ staff includes the following:-

Professor Jane Sandall's Cochrane review on midwife-led care is in the top twenty of Cochrane downloads and has informed Healthcare for London Commissioning Guidance & national reviews of maternity care in the USA & Australia. Hatem M, Sandall, J. (Joint First Author and Contact Author) Devane D, Soltani H. Gates, S. (2008) *Midwife-led versus other models of care for childbearing women*, *Cochrane Database of Systematic Reviews* 2008, Issue 4 (2008).

Professor Sandall has also given policy advice as Chair, Department of Health for England, Quality of Midwifery Care Committee (2008), Clinical Expert Panel Member, Healthcare for London Maternity Project (2009), Co-Chair England, Department of Health, Midwifery 2020 Steering Group (2009).

Professor Naomi Fulop and Dr Angus Ramsay were commissioned by DH to review the evidence base for integrated health care in support of the DH Integrated Care Pilot Programme, which aims to develop clinically-led “Integrated Care Organisations”. The review guided healthcare organisations in developing their applications for pilot status; it also identified topics to be used when evaluating the programme's impacts. In April 16 pilot sites were selected - they will commence work shortly and run for the next two years. This was an excellent opportunity for King's PSSQ to support the Department of Health in taking an evidence-based approach to organisational change and service improvement. Fulop and Ramsay, together with Nigel Edwards from the NHS Confederation, published an article in the April edition of *the Journal of Integrated Care* based on the review.

Dr Josephine Ocloo has been commissioned by the Department of Health to work on a new project investigating Patient and Public Involvement in Patient Safety. Josephine leads on research concerned with developing the role of governors and members in the governance context of patient safety and quality at King's College Hospital NHS Foundation Trust. This work feeds into the NHS drive to develop patient and public involvement in all aspects of healthcare service planning and better community engagement and accountability with local communities. The new project will help deliver the Department's strategic goals to ensure that patients and carers play an integral part in all initiatives to introduce a patient safety culture change within the NHS.

## PATIENT AND PUBLIC INVOLVEMENT

**Strategic aim:-** *Establish demonstrable public and patient involvement (PPI) in the work of the Centre, including both Centre governance and research programmes*

**King's PSSQ PPI Group** - Four members were recruited to our Patient and Public Involvement Group during the summer of 2008, with meetings taking place every 6 weeks since then. All are Members of King's College Hospital NHS Foundation Trust. Researchers and PhD students linked to all four of the programmes have presented work in progress to secure feedback from the PPI group, which has proven to be extremely valuable. The PPI group will be extended to encourage a diverse range of feedback, with four additional members to be recruited by September 2009.

Examples of how feedback has influenced projects:-

**Improving Governance of Medication Safety (Organisational Governance)** - Members stressed the importance of referring to equivalent patterns in other organisations and industries, such as the financial sector. They also suggested focusing on the extent to which errors reported by staff reflect the number and type of errors actually being made at the front line - how these are investigated and how learning is fed back to staff. The focus on measuring actual errors represented a useful addition to the proposal, which had aimed initially only to consider reported errors. Consultation with KCH personnel also indicated that a more concrete measure of medication errors would be attractive. Consequently, the project has been amended to incorporate a medication safety scorecard, which measures a range of errors occurring at ward level.

**The Psychological Contract, Socialisation and Service Quality (Workforce)** - This proposed research relates to the development of what employees believe their organisation has promised to do for them and what they have promised to do for their organisation in return. Members raised a number of issues related to the types of staff outcomes which the project might focus on (such as examining factors relating to staff support), which may vary from team to team. The researcher subsequently conducted scoping work and found that the frequency and type of events do vary by department and manager.

Following the suggestion that demonstrating a causal link between newcomers' early experience and quality outcomes would be problematic, the researcher is now considering whether semi-qualitative research with a smaller group of staff may be a better way of examining the quality issue. He is also discussing recruitment approaches with the Trust HR team following feedback that it may be difficult to persuade new members of staff to engage with the research.

**Birth Place Decisions study (Innovations)** – Members highlighted that some women may choose to opt out of NHS care by going abroad to give birth or choosing private care. This led the researcher to alter her interview approach, asking what decisions were made about selecting a care provider at the beginning of pregnancy, rather than assuming that people are having NHS care if they are recruited into the study.

Members also suggested exploring key drivers such as trust in the midwife, awareness of local resources, and how local services are compatible with religious/cultural needs. This sharpened the researcher's interest in what people 'imagine' birth will be like in the different possible settings and following up in ante-natal interviews to ask 'when you saw it, was it as you expected?'

**Managing Complications in Maternity & Acute Medicine (Innovations)** – Members raised the need to consider what follow-up care was offered following the episode in question. If this support was insufficient how could additional support have helped? This was considered to be an extremely valid point that informed interviews going forward.

**Developing the role of foundation trust governors and members in the governance of patient safety and quality (Organisational Governance)** - In addition to the PPI group, this project is focusing specifically on the impact of Member involvement. The aim of this project is to develop the role of foundation trust governors and members in the governance context of patient safety and quality at King's College Hospital NHS Foundation Trust.

**Using incident data to improve safety (Risk)** - Members questioned the effectiveness of incident reporting systems for promoting learning, as compared with other tools and methods for ensuring safety such as case reviews, checklists, complaints from patients, ward rounds and clinical effectiveness monitoring. The Risk team incorporated these concerns into the design of the incident reporting project, so that during interviews key staff members were asked to explicitly contrast incident reporting with the other methods of risk management in which they are engaged. PPI feedback also influenced the team's developing project on Risk Management, which will now take a holistic view of the topic rather than focusing on any one method to the exclusion of others.

**Other ways of keeping patients and the public informed** - We have a full communications programme that places equal emphasis on external and internal communications. As outlined in the *Progress Report* this included a cover story and full page spread on our secondees in *King's News*, the main King's College Hospital NHS Foundation Trust staff and patient magazine in February this year. We regularly run news stories on the Trust's public website and had a very visible presence at both the 2008 and 2009 Trust Open Days – discussing goals and results to date with patients and members of the public, as well as encouraging sign-up for our monthly e-bulletin.

Our popular monthly seminar series is open to all members of the public, and the King's PSSQ website has been overhauled to ensure speedy news updates, clarity of purpose and swift feedback to all enquiries.

## FORWARD LOOK

### Grant awards

As mentioned in the Progress Report, King's PSSQ is taking the lead on a major new international research project on quality and safety in European hospitals: *Quality and Safety in European Union Hospitals: A Research-based Guide for Implementing Best Practice and a Framework for Assessing Performance (QUASER)*. A grant of €3 million has been secured for the work (subject to contract), which will also involve the PSSQ Research Centre at Imperial College and partners from Sweden, the Netherlands, Portugal and Norway.

The three-year study, starting in Spring 2010, will explore the relationships between the organisational and cultural characteristics of hospitals, and how these impact upon clinical effectiveness, patient safety and experience in European countries. Data will be collected in two hospitals in each of the five partner countries, with additional studies of two particular clinical areas in one hospital in each country.

Professor Sandall, Nicola Mackintosh and Natasha Folkes have been commissioned by the King's Fund (£20,000) to provide a scoping review of the evidence base to inform the King's Fund Safer Birth Initiative to improve safety in maternity care.

Professor Jane Sandall has been awarded £142,923 as part of additional funding from the DH PRP programme to the Birthplace in England Research Programme to explore organisational and cultural factors associated with high performing maternity service providers.

### Under Review:-

- King's College Teaching Innovation Fund – to develop *Interprofessional clinical simulation in critical care for final year and newly qualified medical, nursing and midwifery trainees*, Gill,E, Richardson,S, Slonina,J, Jaye,P, Sandall,J, Bassett,S, Fordham Clarke,C.
- DH Policy Research Programme Stage 2 application for Research Unit in Maternal Health and Care, Sandall,J, Poston,L., Howard, L., Renfrew,M.

### Innovations projects

*Managing complications in medicine and maternity* – further data collection and interviews will be carried out through to October 2009, and a paper presented at the ESA conference in September. An intervention will be developed and tested in medicine in two Trusts through 2010. For maternity a best practice model will be developed through 2010. A final report will be prepared by December 2010.

*Assessing the safety, quality, and patient experience of technique-centred innovations in healthcare* - A Research Associate will be recruited to take over the project from September. The focus will then be on writing up emerging themes from ethnographic observations, document analysis, and interviews with NCPC members for publication. The following will be interviewed:- applicants to NCPC, local and national stakeholders, patients who have been offered and or have undergone procedures approved by the NCPC.

### Organisational Governance projects

*Using mortality data to improve patient safety* - A report to the Trust of the findings from the mapping exercise will be produced and a paper prepared for submission to either BMJ or Quality and Safety in Healthcare.

*Improving the governance of Healthcare Associated Infections* - A paper is in preparation for Quality and Safety in Healthcare on the findings from the mapping of governance arrangements for HCAI and medication error, and a further paper based on the case study findings will be prepared for submission to another peer reviewed journal.

*Improving the governance of medication safety* – An ethics application will be submitted very shortly, with the analysis phase taking place through August, the intervention phase from September-November 2009, and the report written up by January 2010.

### **Workforce projects**

*Organisational Socialisation, Service Quality and Retention* - The study will generate a number of academic publications and conference presentations in the coming year.

*Review of Workforce Procedures at King's College Hospital* - A report, including detailed recommendations for action, will be fed back to the project group at the Trust in October 2009. A presentation will also be made to the Trust executive board at this time.

The Workforce team is also in discussion with Lambeth PCT to develop a project about the effectiveness of mandatory training sessions.

### **Risk projects**

*Risk Management in Healthcare* - This will result in a paper in a peer reviewed journal and a conference paper. An analysis tool that will be used by risk managers in healthcare to assess and reflect on how effectively risk is being managed will be developed and evaluated by stakeholders. Following refinement it will be disseminated for wider use.

*Using incident data to improve safety* - This will result in a number of peer reviewed journal papers and a conference paper. An intervention will be developed in conjunction with the Research Advisory Group with the aim of increasing the effectiveness of organisational responses to adverse incidents.

*Possible new project with Lambeth/Southwark PCTs* - We are in discussion with Lambeth and Southwark PCTs about whether they would like us to undertake a project concerning PCTs' role in the assurance of safety and quality services. The aim is to examine PCTs' roles in fostering particular approaches to risk management in the services which they commission- an innovative, albeit controversial, new form of regulation in healthcare. A preliminary literature review of risk management in primary care has already been undertaken. We are awaiting news from the PCTs as to whether they would like to engage in this project.

*Possible joint project with SLaM/IoP BRC* – We are in discussion with SLaM/IoP about investigating the use of the Case Register Interactive Search (CRIS) to improve detection and analysis of patient safety incidents. Aims are to investigate the potential of electronic medical records as a tool for detecting adverse events; develop search terms which are highly indicative of an adverse incident; assess their predictive value. Proposed outcomes would include evidence about how the CRIS system can (or cannot) be used to improve patient safety by augmenting existing risk management strategies, enable the proactive identification of adverse events, and facilitate the expansion of any successful methods beyond mental health into other contexts. A preliminary literature review has been undertaken and we await news on the practicalities of the project from SLaM/IoP.

Three new PhD students join the Centre in September. They will be studying topics including Health Care Associated Infections, and the intercultural aspects of patient/staff interactions (both from the perspective of risk communication).

A number of the Centre's projects have faced delays due to the challenge of partnership working with the Trust. Research & Development clearance and ethical approval have been a particular cause of delay, meaning that some timescales have slipped as a result. This has been discussed with the relevant teams at the Trust and we have been assured that approval will speed up as more staff are taken on by the R&D team to tackle the backlog.