



**National Institute for
Health Research**

**NIHR RESEARCH CENTRES FOR NHS PATIENT SAFETY
& SERVICE QUALITY**

Annual Report 2010/11

Note: The accompanying *NIHR Research Centres for NHS Patient Safety & Service Quality – Guidance on Completion of Annual Reports for 2010/11 Financial Year* contains essential guidance on the information you need to provide when completing this proforma.

Please complete the form using a font size no smaller than 10 point (Arial). The completed form should be no longer than 10 pages in total.

1. CENTRE DETAILS

Name of the NIHR Research Centre for NHS Patient Safety & Service Quality:

NIHR King's Patient Safety and Service Quality Research Centre (King's PSSQ)

Name, job title, address, email and telephone number of an individual to whom any queries on this Annual Report will be referred:

Alex Gaskell, Centre Manager, King's PSSQ, 138-142 Strand, London, WC2R 1HH
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2. DECLARATIONS AND SIGNATURES

Name and address of the NHS Organisation administering the NIHR Research Centre for NHS Patient Safety & Service Quality award:

King's College Hospital NHS Foundation Trust

Name of the Chief Executive of the NHS organisation:

Mr Tim Smart

I hereby confirm, as Chief Executive of the NHS organisation administering the NIHR Research Centre for NHS Patient Safety & Service Quality award, that this Annual Report has been completed in accordance with the guidance issued by NIHR and provides an accurate representation of the activities of the NIHR Research Centre:

Signature of Chief Executive: **Date:**

3. PROGRESS REPORT

Please provide a progress report for your NIHR Research Centre for NHS Patient Safety & Service Quality for the 2010/11 financial year, describing any changes to the strategy for your Centre, any significant developments in implementing the strategy, and any highlights of patient safety and service quality research activity supported by the NIHR Research Centre award:

The penultimate year of our first phase of NIHR funding has seen all research and management staff at King's PSSQ working hard to push projects toward completion and maximise the contribution to academic knowledge and policy and practice impact at a local, national and international level. We have considerably increased research capacity, and a number of externally funded new projects which build on and add synergy to the work in the Centre started throughout the year (see further details below).

Levering in additional funding

Following the recruitment of a Project Manager and Research Associate, the QUASER project (Quality and Safety in EU Hospitals) began in September 2010. This three year collaborative project with our sister PSSQ centre at Imperial College and four European partner institutions (in Norway, Sweden, Netherlands and Portugal) is funded by the EU. *3 million Euros* (PI Professor Naomi Fulop, Co-i: Dr Janet Anderson).

Work has also started on a collaborative project with the NIHR funded Biomedical Research Centre at Guy's and St Thomas' NHS Foundation Trust and the specialist Biomedical Research Centre for Mental Health at South London and Maudsley NHS Foundation Trust. The project aims to develop a new screening tool to predict psychiatric adverse events associated with the use of interferon in chronic viral hepatitis C. *A grant of £75,000 was awarded* via the Joint NIHR Biomedical Research Centre Strategic Awards in May 2010.

Professors David Guest and Naomi Fulop have been commissioned to conduct an evaluation of a Dr Foster project entitled *Benchmarking International Hospital Performance as a Path to Performance Improvement*, with a new Research Associate recruited for this year long project. The project brings together a group of 30 internationally renowned hospitals from five countries to share routine administrative data with a view to facilitating quality improvement amongst these hospitals across national boundaries (England, the Netherlands, the US, Italy, and Belgium). These data include, for example, readmission rates, and hospital standardised mortality rates. The evaluation, funded for one year in the first instance, will study whether and how sharing comparative performance data amongst hospitals can facilitate change and improve quality of health care, particularly across national boundaries. *£125,673 awarded*.

The Risk team has taken the lead on a new international project; the *Anglo-Japanese collaboration for Improving Patient Safety (AnJIPS)*, which is funded by the Daiwa Anglo-Japanese Foundation. The project is designed to bring together research communities and medical practitioners who face common challenges in patient safety. Researchers at King's PSSQ and the Japan National Institute of Public Health and practitioners from two partner hospitals (King's College Hospital NHS Foundation Trust and the University of Tokyo Hospital) aim to: (i) understand how various patient safety initiatives were introduced and implemented nationally and locally in the UK and Japan; (ii) identify common issues and challenges in patient safety and learn from each other's experiences; and (iii) identify gaps in the current research and find opportunities for further collaboration between the two countries. *£12,000 awarded*.

Following up Professor Fulop and Dr Angus Ramsay's work on the Department of Health's 'Healthy NHS Board' paper (published in 2010) which presents guidance on the roles and 'building blocks' of Board governance, they were commissioned (working alongside Foresight Partnership as with the first phase) to extend this work to consider what the governance arrangements might be for the proposed GP Commissioning Consortia (GPCC). The extended guidance was developed based on a range of information sources, including interviews; site visits to examples of existing good practice in commissioning; online consultations and debates; and a review of evidence and guidance. This review was used by the Futures Forum in its discussions about governance arrangements for clinical commissioning groups.

Jane Sandall, with international colleagues and Luke Cowie, were commissioned by the King's Fund to review international literature on whether the safety of maternity services would be improved by more effectively deploying existing staffing resources. Further funding has been obtained in collaboration with the Centre for Workforce Intelligence, RCM, London Specialty School of Obstetrics and BirthChoiceUK to examine this issue using secondary sources of routine data funded by NCCSDO, looking at the efficient use of the maternity workforce and the implications for safety & quality in maternity care from an economic perspective. *£20,000 awarded*.

Capacity building

Due to careful budgeting we have been able to recruit two new Research Fellows and three new Research

Associates to drive projects to completion and maximise both academic outputs and practical interventions. We have also secured a new NIHR PhD fellowship, focusing on team working within Academic Health Science Centres, and two new members of NHS staff have joined us on secondment. Pat Lindsay, whose secondment to support fieldwork for her Doctorate in Health Care on the social process of incident reporting in maternity care was supported by PSSQ, has completed, and is now working in the King's Health Partners Academic Health Sciences Centre with ongoing links to King's PSSQ.

Research highlights by programme

Innovations programme

Assessing the safety and quality of innovative procedures – Data collection continued through 2010/11, including ethnographic observations of New Clinical Procedures Committee meetings (ongoing since 2009), document analysis of past and current applications, in-depth interviews with clinical innovators, patients and stakeholders. Feedback has been provided to NICE Interventional Procedures Committee. One paper is in review with *Social Science & Medicine* on balancing innovation with patient safety (which incorporates the interview data so far), another, on comparison of governance in pharmaceutical R&D clinical innovation, is ready for submission, and a third paper reflecting on the Balliol IDEAL recommendations for governance of clinical innovation is also ready for submission. A further four papers are planned from this project, reporting on the patient interviews and across the data set.

Managing complications in medicine and maternity Data collection completed across both sites. This included over 150 hours of observations in medicine and c.120 hours in maternity, 35 staff interviews in medicine and 44 in maternity, 17 maternity user interviews and 14 patient interviews plus review of internal documents and Trust audit data. Reports of the findings have been disseminated to the two relevant NHS Foundation Trusts. There are plans for implementation of various QI projects within maternity in response to the findings, which may include piloting the addition of 'user concern' to a Modified Obstetric Early Warning System (MEOWS), designing a model of good practice for use of the partogram and MEOWS during handover, introducing multidisciplinary team handover, and utilising the principles of experience-based design to look at women's experiences of triage and admission to the service. One paper based on the data set from medicine is in review with BMJQS. A further two are in progress drawing on the maternity data, and two others due for submission reporting on the user interviews.

Learning from national data on mortality and severe morbidity in pregnancy and childbirth – Joint project with the NPSA analysing 2009 and 2010 data from the NPSA learning and reporting database. A report will provide an overview of avoidable factors and inform future reporting requirements in the area.

Medical response to the acutely ill patient within medical wards – Work continued on this PhD project focusing on the construction of 'deterioration' and 'rescue' in acute medicine. Much work on failure to rescue focuses on the detection of deterioration and the effectiveness of track and trigger tools, but there is less attention to social and cultural factors that influence effective medical response, and escalation within and across medical boundaries. Data collection completed.

Birth Place Decisions – Work is almost complete on this PhD (undertaken by an NIHR Research Training Fellow), examining the ways pregnant women and their partners develop ideas about risk and safety in relation to choosing a place of birth. The PhD is an adjunct study to the NPEU 'Birthplace in England' programme of research. The four site case study is due for submission in October 2011.

The social construction of reporting of incidents in maternity care – This DHC thesis explored the process of how and why incidents were reported, and the role of collegial consultation using ethnographic methods. A focus on the social and cultural influences on incident reporting in maternity care showed that there were variations in complete coverage of incidents and in particular around near miss events. Thus opportunities for learning could be improved. Completed in March 2011.

Innovations programme publications - published / in press in 2010/11:-

Berridge, E.J. Mackintosh, N. Freeth, D. (2010) Supporting Patient Safety: Examining Communication within Delivery Suite Teams through contrasting approaches to research observation. *Midwifery*, 26 (5): 512-9.

Devane D, Brennan M, Begley C, Clarke M, Walsh D, Sandall J, Ryan P, Reville P, Normand C. (2010) *A systematic review, meta-analysis, meta-synthesis and economic analysis of midwife-led models of care*. Royal College of Midwives: London.

Ehrich, K. Williams, C., Farsides, B., Scott, R. (in press) Embryo futures and stem cell research: The management of informed uncertainty. *Sociology of Health & Illness*.

Ehrich, K. Farsides, B., Williams, C., Scott, R. (2011) Constructing an ethical framework for embryo donation to research: is it time for a restricted consent policy? *Human Fertility*; Early Online, 1–7.

Ehrich, K. Williams, C. Farsides, B (2011) Fresh or frozen? Classifying 'spare' embryos for donation to hESC research. *Social Science & Medicine* 71(12): 2204-2211.

Harvey, O., Ehrich, K. (2011) Can the embryo 'speak'? Material agency in the laboratory and the clinic. *Eä: Journal of Medical Humanities & Social Studies of Science and Technology* Vol. 2:3 April [online journal <http://www.ea-journal.com>]

Mackintosh, N. & Sandall, J. (2010) Overcoming gendered and professional hierarchies in order to facilitate escalation of care in emergency situations: The role of standardised communication tools, *Social Science and Medicine*. 71 (9):1683-6.

Mackintosh, N. & Sandall, J. (2010) Intelligent Assessment Tools in Healthcare: technological fix or the potential for unintended consequences? Special Issue on Close Calls, near misses and early warnings, *CARR Centre for Risk & Regulation, London School Economics*.

Murray, SFM. Buller, AM. Bewley, S. Sandall, J. (2010) Metrics for monitoring local inequalities in access to maternity care: developing a basket of markers from routinely available data. *Qual Saf Health Care*, doi: 10.1136/qshc.2008.032136.

Sandall, J. Devane, D. Soltani, H. Hatem, M. Gates, S. (2010) Improving Quality and Safety in Maternity Care: The Contribution of Midwife-Led Care, *Journal of Midwifery and Women's Health*, Vol. 55, Issue 3, Pages 255-261. (nominated for best article in 2010 in *Journal of Midwifery and Women's Health*).

Sandall, J. Homer, C. Sadler, E. Rudisill, C. Bourgeault, I. Bewley, S. Nelson, P. Cowie, L. Cooper, C. Curry, N. *The Maternity Workforce: Working Differently to Deliver Safer Care With Existing Resources*, King's Fund.

Organisational Governance programme

Developing the role of Governors' & Members in the Governance of Patient Safety & Quality in a London Foundation Trust - Findings generated this year show that governors and members are interested in quality and safety and want to work with health professionals to improve them, but they tend not to take part in the formal mechanisms governing the safety of patient care. There is a need to promote the benefits of involvement for safety and quality, and identify what hinders or supports involvement. Support is key; training for lay members is needed to clarify expectations and identify the skills and knowledge required. We are rewriting the terms of reference for the Maternity Services Liaison Committee (MSLC) to strengthen lay involvement; creating an audit tool to help improve the quality and safety of the food service provision (involving governors and members in Patient Food Service Quality Ward Rounds); findings presented to the NHS Confederation Annual Conference, and paper accepted for publication in the *Journal Health Expectations*; National survey on Patient and Public Involvement within NHS Trusts completed for the Department of Health on May. The survey provides wider data than the governor/member research in safety by looking at PPI in patient safety at a national level.

Strengthening Governance Arrangements for Infection Control and Medication Errors - Project investigating how a London NHS Foundation Trust is organised to manage healthcare acquired infections and medication errors - how organisational structures and processes try to ensure safe practice:-

Infection control - 50 staff interviewed (nurses, doctors, support staff, infection control staff and management up to Board level). Analysis is ongoing, but findings show where interventions made by the participating Trust are perceived to have been successful and areas where challenges are ongoing. Attitudes vary across professional groups (e.g. nurses and doctors) and across clinical specialties. An interim report has been fed back to the Trust.

Medication safety – Findings from staff interviews showed professional variations in attitudes to reporting adverse incidents, and challenges in spreading awareness of medication safety issues. The medication safety scorecard has had limited impact on ward performance on measures of medication safety. Interim report fed back to the Trust and findings presented to a medication safety themed committee and the governance committee. The project has significantly raised staff awareness of medication safety issues and been extended to a second NHS foundation trust. A paper on the role of professional communities in the governance of medication safety has been produced, with further papers in development.

Using Mortality Data to Improve Patient Safety - Mortality and Morbidity (M&M) meetings have the potential to review all hospital deaths and improve any clinical practice shown to contribute to them, but

need to have a systematic process to do this effectively. As M&M meetings in the host Trust varied considerably, we developed a Mortality Review Form (MRF) – and accompanying database - to examine what impact this would have. Full details of the resulting impact are noted on page 8 under 'Impact on Healthcare Provision'.

Organisational Governance programme publications - published / in press in 2010/11:-

Beecham, J. Ramsay, A. Gordon, K. Maltby, S. Walshe, K. Shaw, I. Worrall, A. King, S (2010) Cost and impact of a quality improvement programme in mental health services. *Journal of Health Services Research & Policy* 15(2):69-75.

Edwards, N. Fulop, N. (2011) General practitioner commissioning groups. How they are held to account and governed matters; the government has a difficult balancing act. *British Medical Journal*; 342:d2667 doi: 10.1136/bmj.d2667

Ramsay A, Magnusson C, Fulop N. The relationship between external and local governance systems: the case of Health Care Associated Infections and Medication Errors in one NHS Trust. *BMJ Quality and Safety in Healthcare* (2010): doi10.1136/qshc.2009.037473.

Snow, R., Fulop, N. (in press) Understanding issues associated with attending a Young Adult Diabetes Clinic: a case study, *Diabetic Medicine*.

Risk programme

Risk management in health care – This study identified the need for healthcare organisations to introduce prospective risk identification methods and to develop systematic ways to reflect upon and improve their risk management processes. Results were presented in a report to King's College Hospital NHS Foundation Trust, highlighting the potential for using prospective risk identification and analysis methods to address safety problems before an incident occurs. We have developed an analytic tool which is currently being tested with risk managers at the Trust.

Using incident data to improve safety – Project to investigate how clinical teams in an acute hospital trust and in a mental health trust use incident data to increase patient safety. Findings showed that incident reporting is well accepted and established, and staff use this as a useful tool for increasing risk awareness and communication. The following improvement areas were identified:- need for increased communication about the learning from incidents; need for expert input into the grading of clinical incidents; increased support for departmental teams that review incidents; improvement of processes for implementing and evaluating changes to improve safety. A framework for analysing the effectiveness of team incident review meetings has been developed and will be introduced for use by team leaders. This framework makes explicit the features of good practice in reviewing incidents.

How do health care professionals assess the risks of interferon-a treatment for Hep-C patients? -

Part of the joint BRC funded project *A new screening tool for the prediction of psychiatric adverse effects in patients receiving interferon-a treatment for chronic viral Hepatitis C*. Data collection complete. Results show that nurses focus on particular indicators of risk (eg. the ability of patients to engage with the clinician) but neglect other indicators of depression. The study identified opportunities to streamline the assessment process and referral to consultant psychiatrists. Nurses were open to using a screening tool, but concerned about the potential for deskilling and emphasised the importance of their clinical judgement and experience. The results will contribute to the development of the screening tool.

Caring for diabetic inpatients - Study to identify the difficulties and challenges encountered by staff in caring for patients with diabetes using the critical incident method to investigate their experiences. Data collection complete, results of data analysis will provide valuable information for quality improvement strategies. PSSQ attends Diabetes team meetings at KCH to ensure close collaboration.

Managing patients with dental emergencies in the Emergency Department - A paper from the initial study of ED practitioners' attitudes to managing dental emergencies is under review. A study of practitioners' ability to correctly interpret facial x-rays has been planned and will be completed by the end of June, 2011.

Imagery, illness perceptions and risk perceptions in women with osteoporosis: An exploratory study. – This PhD project will investigate different methods for increasing medication adherence in women with osteoporosis using imagery. A qualitative study of patients' risk perceptions and imagery has been completed. A conference presentation has been accepted and a journal paper is in preparation. A second quantitative study of risk perceptions, illness perceptions, and adherence to medication has just commenced.

Risk programme publications - published / in press in 2010/11:-

Anderson, J. (2010). What are the challenges for health care in learning from other industries? *CRICO/RMF Forum*, 28, 4-5.

Gifford, M. Anderson, J. (2010). Barriers and motivating factors in reporting incidents of assault in mental health care. *Journal of the American Psychiatric Nurses Association*, 16, 288.

Kodate, N. (2010). Events, public discourses and responsive government: Quality assurance in health care in England, Sweden and Japan. *Journal of Public Policy*, 30: 3, 263-289.

Workforce programme

Bullying and harassment in the NHS - Project completed. Analysis of staff attitude surveys for the NHS Foundation Trusts that form the King's Health Partners Academic Health Sciences Centre confirmed the persistent high levels of bullying and reveal that consequences include lower satisfaction, higher stress and higher intention to leave the Trust. Subsequent qualitative analysis confirmed that the experience can also have a negative effect on the quality of service to patients. Those experiencing bullying reported lower levels of support from management and less faith in the HR systems to address the problem, despite evidence that all the local Trusts have best practice policies in place to tackle the behaviour. This suggests the problem is one of line management implementation, and further interviews have confirmed the key role of line managers in determining bullying, either by preventing it, ignoring it or even causing it. Results have been fed back to senior management at the Trusts for them to decide on action. Two papers have been submitted for publication and others are in preparation.

Evaluation of Lean management change - The first detailed study within one Trust, for which a large amount of 'pre-change' data was collected, was never implemented. A second study, in another Trust, has now been completed with data collected before and after the changes had taken place. Analysis of these data is close to completion. In addition, a systematic review has been completed of the evidence about the impact of lean management in healthcare and this will soon be submitted for publication.

Organisational socialisation, service quality and retention – Project exploring the impact of socialisation processes on service quality, focusing on newcomers' perceptions of the promises which the organization has made to them. All patient-facing staff (except doctors) recruited over a full year were invited to complete questionnaires, with those who provided contact details followed up three months and twelve months later. Initial findings show that newcomers with little prior experience of the health service respond differently to more experienced newcomers. Those who reported more promises made to them by the Trust had higher levels of job satisfaction and commitment, and lower intention to quit. Conversely, more experienced newcomers who reported more promises made to them showed no difference in reaction compared to those who reported fewer promises, perhaps reflecting an assumption that not all promises would be fulfilled. Also promises regarding training, mentoring and support are not consistently kept - a particular concern for newcomers - and this has negative consequences for service quality and patient safety. Findings will be fed back to Trusts when data analysis is complete.

An evaluation of reasons for non-attendance to mandatory training – This work has revealed a series of factors associated with staff attitudes at a London Primary Care Trust to training, perceptions of the utility of training, the organization of training and related issues concerned with the organisation of work, more particularly for those who work part-time. A series of recommendations for future practice has been given to the host Trust and a paper is due to be submitted for publication.

The impact of the employment of temporary staff on the management of risk in a hospital – Project exploring the impact of temporary staff on patient safety and service quality. This has involved interviews with permanent and temporary staff (and their managers) in Emergency Departments, and an evaluation of the introduction of the Major Trauma Centre, where consultants are currently on temporary contracts. Consultants were interviewed before the Centre was introduced and again several months later. Findings show perceptions of the Centre having a positive impact on patient safety, a more positive impact than anticipated on the quality of (working) life of consultants who are sometimes on call for a full 24 hours. However there are tensions and some impact on consultant morale due to the failure to reach rapid agreement on the contract for the consultants and the uncertainty that this creates. Several conference papers have been presented on this project.

An evaluation of King's Values – New project to evaluate King's College Hospital's 'Values' programme. Interviews have focused on assistance that patients receive with eating as this is flagged up in the patient survey as showing the highest levels of dissatisfaction (a related project under the Governance Programme is exploring the patient perspective). Exploring the role of local ward culture and the organisation of feeding

on patient reactions, work has comprised a comparison of wards that receive consistently more or less positive patient feedback on feeding. Nearly fifty interviews and questionnaires have been completed to date. Allied to this, an expert dietitian from the Trust currently working on secondment at King's PSSQ has been exploring workforce factors affecting dietetic care for at risk patients. This project is almost complete and has collected extensive data on aspects of quality assurance and reasons for compliance or deviation from required standards. Findings have been presented at conferences in the UK, Europe and North America. Several papers should emerge from this work once data analysis is complete.

Workforce programme publications - published / in press in 2010/11:-

Woodrow, C. & Guest, D. (in press) An Investigation of Workplace Bullying in Three UK Healthcare Organisations. *New Challenges for a Healthy Workplace in Human Services. Vol. 8: Organizational Psychology and Health Care, 87-104.*

Pajak, S. & Guest, D. (in press) Evaluating a process-based management intervention in healthcare: lessons from a failure. *New Challenges for a Healthy Workplace in Human Services. Vol. 8: Organizational Psychology and Health Care, 221-232.*

Budjanovcanin, A., Pajak, S & Guest, D. (2010) Evaluation of mandatory training in patient safety in a Primary Care Trust: An investigation into non-attendance. *King's PSSQ working paper.*

Bajorek, Z. & Guest, D. (2010) The implementation of the 48 hour working week and Major Trauma Centres in UK hospitals and their Consequences for the Quality of Working Life for hospital staff. *King's PSSQ working paper.*

Woodrow, C. & Guest, D. (2010) Workplace Bullying in the Healthcare Sector: Implications for Quality of Working Life and Patient Care. *King's PSSQ working paper.*

Woodrow, C. & Guest, D. (2010) Exploring the Impact of HRM in a Complex Health System: A Study of Socialisation through the Lens of the Psychological Contract. *King's PSSQ working paper.*

4. IMPACT ON HEALTHCARE PROVISION

Please provide descriptions of impacts/benefits to patients arising from patient safety and service quality research undertaken by the partnership. You should provide examples of impacts that the Centre's research has had on health services or health policy, detailing how research findings have led to changes in the way services are delivered to patients, both locally and further afield:

While the core impact of the research has been felt mainly in the Trusts directly involved in the research, extensive presentation of findings at national and international conferences has been a key part of the strategy to ensure broader dissemination and potential impact. Furthermore, certain projects linked to King's PSSQ but with allied funding have had a wider impact on policy and practice. Below we illustrate these two perspectives, first with respect to local Trusts and secondly at the more national level.

Managing Complications in Medicine and Maternity (core project) - Findings on the barriers and facilitators on the use of track and trigger tools in acute medicine and maternity care have helped with the introduction of outreach service and development of an in-house intelligent assessment tool at King's College Hospital NHS Foundation Trust, and end of life care pathway at Guy's and St Thomas' NHS Foundation Trust. There are plans to co-ordinate policy and practice regarding the use of early warning scores across both Trusts. Findings regarding patient's experience of acute deterioration have informed the matron role as advocate for concerned patients and relatives and access to outreach services for high risk groups, and we are working with them to develop real-time patient feedback as part of the dignity improvement programme at the Trust. Nationally, findings have informed the *1000 Lives Plus* programme in Wales, and are also informing an expert advisory group established by the Division of Health Systems and Public health at WHO Regional Office for Europe on patient safety and patient rights. Professor Jane Sandall has been invited to sit on this advisory group.

Assessing the Safety and Quality of Innovative Procedures project (core project) - report presented to King's College Hospital NHS Foundation Trust Patient Experience & Safety Committee. The Trust's response to this report has been to reconfigure the New Clinical Procedures Committee, with new terms of reference and a new chair. The NCPC instituted a more formal system for tracking approved procedures after an agreed initial period and ensuring that clinicians feedback results. The accountability of clinicians to NCPC has also been strengthened by making it obligatory for all new procedures (not put through the ethics committee as part of a clinical trial) to go through the NCPC. Disciplinary action is possible for failure to apply to the committee in appropriate circumstances.

Using Mortality data to improve patient safety (core project) - we developed a Mortality Review Form (MRF) – and accompanying database - to examine what impact this would have on the effectiveness of Mortality and Morbidity (M&M) meetings at King's College Hospital NHS Foundation Trust. The form had a positive impact on the way meetings reviewed deaths and recorded the data, providing focus and standardisation. Divisions adopted the process into routine practice, using the MRF at M&M meetings and the database to audit for reporting and to guide improvement projects. Analysis of the MRF database showed an easier access to issues of care and resulting corrective measures compared with traditional meeting minutes. A structured analytical tool for reviewing deaths and a database for recording and auditing the data and M&M meetings were recommended to adopt the process. A high-level Mortality Monitoring Committee was established to monitor external mortality data and review activity and outcomes from M&M meetings and the outcomes from the MRF were a requirement of divisional reports. The Trust intends to adopt the mortality review model across all divisions to standardise the way deaths are reviewed.

Influencing policy at a national level:-

Professor Jane Sandall led a review, commissioned by the King's Fund, which found that using midwives and other maternity staff more effectively is the key to improving maternity care in hospitals. Maternity services face significant challenges over the next few years - demographic changes mean that a rising birth rate coupled with the increasing complexity of many births has increased the pressure on services. With the NHS needing to find up to £20 billion in efficiency savings by 2014/15, the report argues that improving productivity through better deployment of the maternity workforce may be a more realistic goal than significantly increasing staffing levels. Deploying midwife-led care much more widely for women at low and medium risk has the potential to improve outcomes for women and babies and to save costs to the NHS. Professor Sandall co-presented the report (with the King's Fund) to the All Parliamentary Group on Maternity Care in House of Commons. The findings have also informed the HRH Global Resource Center, a knowledge management service funded by US-AID, NHS Evidence, ChiMat, the NHS Improvement and NHS Clinical Network, Sustainable.Gov and a range of user and professional organisations including a joint RCOG/RCM report on quality in maternity care.

Professor Sandall also contributed to the landmark *Midwifery 2020 – Delivering expectations* report, published in September 2010. The report was the culmination of the Midwifery 2020 programme, a UK-wide collaboration commissioned by the four UK Chief Nursing Officers in England, Scotland, Wales and Northern Ireland, which focused on how midwives and midwifery can make the greatest contributions to the health and wellbeing of women, babies and families. It sets out a vision for midwifery across the UK and aims to ensure that midwives, as lead maternity care professionals, can build on their professional heritage and develop their education, innovations, skills and attributes to meet the challenges and opportunities of maternity care in the 21st century. Professor Sandall co-chaired the England steering group, and the report cites her Cochrane review in the evidence base on one of the recommended quality indicators on continuity of care. The report provides a framework against which all those with an involvement in maternity services across the UK can benchmark their current services and plan their own responses which will enable midwives to continue to develop appropriate quality care and services.

5. PATIENT AND PUBLIC INVOLVEMENT

Please provide specific examples of how patients and the public have been actively involved in the research undertaken within your Centre (e.g. in informing or developing strategy, identifying research priorities, involvement in the research process itself), detailing the nature of their contribution and the impact this has made:

Lay members have been an integral part of the research on governor/member involvement in safety, on the Research Action Group, discussing findings, commenting on proposals and drafts of documents. They have also played a big part in revising the terms of reference for the Maternity Services Liaison Committee and intervention to develop involvement in the Patient Food Service Quality Rounds.

A group of expert patients has been extensively involved in reviewing the research design, the data collection instruments and advising about recruitment of participants in the *Imagery, illness perceptions and risk perceptions in women with osteoporosis* project. Advice has also been sought from service users who do not have osteoporosis and patient support groups. Interview questions, survey questions and educational material have been pilot tested with these groups.

The Innovations programme has involved users, user representatives and representatives of third sector organisations in the design stage of research. The team has a stakeholder advisory group which involves representatives from the NPSA, NICE, local service users and clinicians. This group has input at the design through to knowledge mobilisation stage, and representatives have also been involved in additionally funded research as co-investigators (SDO workforce and Birthplace Research).

Innovations members have also been working with James Lind Alliance regarding research on the experiences of the expert patient (this is being conducted by a service user/researcher funded by a PSSQ PhD studentship), and the Maternity Service Liaison Committees (MSLC) to get feedback on research findings. MSLC members are also involved in disseminating the findings.

Please also describe how you keep patients and the public informed of the research being undertaken within your Centre:

In order to provide the most comprehensive and accessible information possible for the public we have redesigned and re-launched our website. The new layout is considerably more contemporary, intuitive and user friendly, with all publications, papers, project summaries and upcoming events available in a very clean overall design. The new site retains our original url – www.kingspssq.org.uk.

We also helped to create a new London-wide user involvement website which enables patients and the public to find out how they can get involved in health and social care research and to get up-to-date information on current opportunities. The site aims to bring patients and the public together with researchers who are looking for people to get involved in studies across the capital. Alongside King's PSSQ, *Involving London* was set up by Patient Public Involvement managers from various NHS Trusts, Research Networks/centres and Support Services - www.involvinglondon.co.uk.

We have created lay summaries for all of our core projects (available via the King's PSSQ website). These one page summaries include objectives, findings to date and future plans, along with supporting quotes from NHS trust collaborators to make them as simple and useful as possible for members of the public. They have proved to be invaluable in demystifying our research and have been used extensively alongside our new brochure at conferences and other events.

We also designed a new 16 page brochure with research highlights, case studies and future aims which was aimed at a lay audience as well as catering to our wider range of stakeholders. This very well received publication has been distributed at all King's Health Partners NHS foundation trusts and used at a wide range of public facing events, including Research and Development open days at King's College Hospital and Guy's and St Thomas' NHS Foundation Trusts.

Our monthly e-bulletin is sent to 1,000 stakeholders (NHS staff and governors, academics and members of the public who have signed up via our website or events), with news updates including project developments, new publications, public involvement opportunities and upcoming seminars. Our bi-monthly seminar series continues to attract c. 60 attendees at each event, with all open to the public. These are widely promoted through our website, the monthly e-bulletin, the King's College London and King's College Hospital websites and various email event listings.

6. FORWARD LOOK

Please identify any significant developments (e.g. major research findings or planned initiatives) anticipated in 2011/12, particularly those that are likely to generate media interest:

A significant focus for 2011/12 will be to secure future funding for centre, beyond the end of our current NIHR contract (recently extended by four months, now ending on 31 July 2012) and create synergy with other research funders. We have built an extremely strong team and are keen to keep the momentum going beyond that time. Whilst NIHR funding plans are currently unclear, we have been devoting a great deal of time and energy to developing a strategy for funding. We are also developing leads for a range of other funding opportunities and are very optimistic about the Centre's longevity.

Several PhD students have made excellent progress, with most upgraded over the last year, and we expect them to move towards completion over the next 12 months. We are also due to carry out an evaluation of our secondment programme over the next year; this has been a distinctive feature of our activity and we are keen to assess what we believe to have been its significant impact.

Programme plans

Innovations - The team will continue to explore how innovations in service delivery and new health technologies can improve safety and quality of care by bridging gaps in health systems. We will be working with intensivists across KHP and Phillips in a programme of work investigating the eICU - which uses telemedicine to improve the care of the critically ill. Building on work on the role of patients in patient safety, we will be developing further work around the effectiveness of patient checklists in collaboration with EU partners which we already advise on an EU Handover FP7 project. Finally, we will work with KHP staff

working in the BRC developing novel clinical innovations regarding the social, organisational and patient understanding and use of risk stratification tools such as the development of predictive biomarkers.

Jane Sandall has been a co-investigator with Birthplace in England, a national programme of work involving over 60,000 women investigating the safety by intended place of birth for women who have no complications at the start of care in labour. As part of this programme she has been co-leading organisational case studies exploring how high performing maternity providers deliver safe and high quality care in a range of birthplaces. The report (due to be published in July 2011) will inform national and international policy and practice. A follow-on study funded by NCCSDO (Jane Sandall Co-I £289,000) will examine the operation of Alongside Midwife Led Units. The work will look at appropriate staffing models and their stability, training and preparation for midwife-led care, and inter-professional, cultural and communication issues which may impact on effective working and transfer when escalation of care is required.

Organisational Governance - Work will focus on completing data collection and analysis of outstanding projects on medication safety, infection control, using mortality data, and involving governors and members in patient safety. We have fed back interim results from all these projects to the local Trust over the last few months, and will be feeding back final results as projects are completed. We will be extending the medication safety project into a second local Trust. A PhD student will be submitting her thesis for examination during the year, and we will be submitting a number of papers for publication based on the findings from all projects.

Risk – The team has developed links with the Simulation and Interactive Learning Centre at St. Thomas' Hospital and will undertake an evaluation of a complex training intervention to improve care of the elderly. This will involve mixed methods, including staff surveys and interviews, interviews with patients and observations. Further collaboration to investigate the effectiveness of simulation as a method for reducing risk is under discussion.

Workforce – There will be an extension of the project on bullying and harassment through analysis of the Scottish staff survey data, to which the team has recently gained access. This contains superior questions about bullying and related behaviour compared to the English survey. The focus will also be on completing data collection and analysis of the outstanding projects on organisational socialisation, temporary staff and King's Values, and feeding back the results of these and the other projects to the local Trusts and the wider community - where appropriate we will be encouraging further improvements in service quality. We will be submitting a significant number of papers for publication.

Recent funding wins - We have been successful in securing funds for the following three NIHR SDO Programme bids, with work commencing in 2011/12:-

The efficient use of midwives and the implications for safety & quality in maternity care: An economic perspective. £211,416 awarded, work started in May 2011.

Exploration of safety and quality of care in alongside birth centres, £289,000 total grant award (£136,636 to King's PSSQ) to start 1 September 2011.

Innovations in major system reconfiguration in England: a study of the effectiveness, acceptability and processes of implementation of two models of stroke care. £494,161 awarded, to start 1 September 2011.

This form, together with a completed *Activity, Outputs & Finances* proforma and a publication list for 2010/11 must be submitted, by email, no later than **11:59pm on Thursday 30th June 2011** to Ralph Geerling (ralph.geerling@nihr-ccf.org.uk).

A signed copy of this report (*i.e.* all completed proformas) should be sent, as soon as possible after this date (and no later than **Monday 11th July, 2011**), to:

Ralph Geerling
NIHR Central Commissioning Facility
Grange House,
15, Church Street,
Twickenham TW1 3NL