

King's Patient Safety and Service Quality Research Centre

Annual Report 2009/10

PROGRESS REPORT

As NIHR King's Patient Safety and Service Quality Research Centre (King's PSSQ) has moved into the second half of its funding period, our emphasis has been on consolidating our existing work programmes, increasing research capacity and focusing priorities towards assessing the impact of patient safety strategies and solutions, and considerably increasing submissions to peer reviewed journals. 18 projects were reported in the 2008/09 report and two of these are now complete. 8 new projects began in 2009/10, with 24 in total underway as of 31 March 2010. Updates on all are provided from page 5 (three additional Risk projects started after 31 March 2010 but are included for information).

Our supportive network of contacts across the King's Health Partners Academic Health Sciences Centre and wider UK health economy has enabled us to work steadily towards the strategic aims outlined at the beginning of the Centre, and build a very solid foundation for a second NIHR funding competition. Below we outline progress in the three key strategic areas for the Centre through 2009/10:-

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 a total of ten staff on secondment from King's College Hospital and Guy's and St Thomas' NHS Foundation Trusts (this is a core group - many more King's Health Partners staff are involved in projects). Their extensive NHS expertise (ranging from midwifery to dietetics, dentistry and risk management) continues to be invaluable in facilitating projects with the partner Trusts, disseminating an awareness of research within the NHS teams they return to, and building research capacity within the South London health economy. We continue to publicise secondment involvement wherever possible, with presentations and project updates given at a number of staff events at King's College Hospital NHS Foundation Trust over the last year.

Three new Centre PhD studentships started in September 2009, working alongside two ESRC CASE studentships, one NIHR studentship, and a DHC student working at King's College Hospital NHS Foundation Trust sponsored by the Centre. In addition, one of our Research Associates has completed her PSSQ-related PhD, two other Research Associates continue to work on theirs and a further NIHR PhD fellowship was awarded in 2010.

We have completely revised our user involvement strategy, as detailed in 'Patient and Public Involvement' on page 8, engaging a host of end users across the South London health economy. We have also continued to reach out to residents local to King's College Hospital NHS Foundation Trust by participating in the Trust's annual Open Day and presenting at a series of community meetings.

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 contract for a 3 million Euro EU grant for a project investigating patient safety in hospitals across five European countries was signed in February, with c. £550,000 coming to King's PSSQ as project lead. Other partners include Imperial PSSQ and work package leads from Sweden, Portugal, Norway and the Netherlands. We were also successful in securing the following funding during 2009/10:-

Birthplace in England Programme Organisational Case Studies, 2009-2010, DH PRP/NIHR SDO Programme (£89,000 to King's PSSQ)

Delivering the Healthy NHS Board (£33,000). King's PSSQ played a key role in drafting this guidance for NHS Boards, and it is likely that a second piece of related work will also come to the Centre.

DH funding to carry out National Survey on Patient and Public Involvement in Patient Safety - £30,000

Inter-professional patient safety clinical simulation in critical care for final year and newly qualified medical, nursing and midwifery trainees, 2009-2010, College Teaching Fund, PSSQ co-investigator - £30,000

Maternity Safety, Workforce Deployment and Skill Mix, impact on intrapartum safety; A scoping Review, 2009-2010, King's Fund - £20,000

Whilst we have already exceeded our overall 10% fund-raising target, bringing in additional funds remains a top priority and a number of subsequent bids have already been submitted (see 'Forward Look').

Communications and Dissemination

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

Our Centre Manager (who has 10 years communications expertise) continues to deliver all print, web and press related media materials. He meets with the corporate communications contacts at all King's Health Partners Trusts on a regular basis, as well as liaising with counterparts in the King's College London PR team and Imperial PSSQ Centre to maximise knowledge sharing and opportunities for joint working.

During 2009/10 we presented research findings at a King's College Hospital NHS Foundation Trust staff event on risk management that welcomed several hundred attendees, and our secondees presented their work at the Trust's Research & Development day. We secured news coverage on all King's Health partners websites and intranets for a variety of projects, including the publication of the 'Governing the NHS' document (detailed on page 8) and securing funding for a joint BRC project. In addition, our monthly e-bulletin updates almost 1,000 stakeholders with news on upcoming events, recent publications, grant wins, vacancies and project findings.

Our ongoing seminar series (which welcomes international speakers every six weeks) continues to be very successful, with 60-80 attendees at each event, including health care professionals, managers, policy makers, lay people and academics. These are open to all and have been essential in raising awareness of the Centre's work with a key external audience. This seminar model is now being used by our sister PSSQ Centre at Imperial.

Always looking for other ways to keep the public informed, we had a very visible presence at the 2009 King's College Hospital Open Day – discussing goals and results to date with patients and members of the public, as well as encouraging sign-up for our e-bulletin. We also attended a series of Trust-led community events to give an overview of the Centre's work.

Staff have been busy presenting papers and posters at a host of conferences over the last year – a full list of these is appended to this report. We are continuing with article submissions to peer reviewed journals. A full list of published, in press and submitted publications is included below (this does *not* include publications from projects where PSSQ was a collaborator however), along with details of King's PSSQ working papers, which have been downloaded from our website over 1,400 times. Articles published during 2009/10 have also been listed in the appended 'Publications and Conference' document.

Published papers

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

Colligan, L., Anderson, J., Potts, H. Berman, J. (2010). Does the process map influence the outcome of quality improvement work? A comparison of a sequential flow diagram and a hierarchical task analysis diagram. *BMC Health Services Research*, 10:7. doi:10.1186/1472-6963-10-7 [Highly accessed article].

Dodds, A. Fulop, N. (2009) The challenge of improving patient safety in primary care. *British Journal of General Practice* 2009; 59: 805-806.

O'Driscoll, M. Smith, P. Magnusson, C. (2009) Evaluation of a part-time adult diploma nursing programme – 'tailor made' provision? *Nurse Education Today* 29, 208-216.

Ramsay, A. Fulop, N. (2009) The evidence base for vertical integration in health care, *Journal of Integrated Care*, Volume 17, Issue 2.

Ocloo, J. (2010) Harmed patients gaining voice: Challenging dominant perspectives in the construction of medical harm, *Social Science and Medicine* 71 (2010) 510-516.

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

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 and Policy*, 15, 69-75.

Sandall, J. Morton, C. Bick, D. (2010) Safety in childbirth and the three 'C's: Community, context and culture, *Midwifery*, 26, 481-482.

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.

Sandall, J. Hatem, M. Devane, D. Soltani, H. Gates, S. (2009) Discussion of findings from a Cochrane Review of midwife-led versus other models of care for childbearing women, *Midwifery*, 25, 8-13.

Hatem, M. Sandall, J. (Joint First Author and Contact Author) Devane, D. Soltani, H. Gates, S. (2009) Comparaison des modèles de soins obstétricaux dirigés par les sages-femmes à d'autres modèles de soins offerts aux femmes enceintes: une revue systématique Cochrane, *Pratiques et organisation des soins*, 2009, vol. 40, n°4, pp. 267-274.

Papers in press

Mackintosh, N. Sandall, J. Overcoming gendered and professional hierarchies in order to facilitate escalation of care in emergency situations: The role of standardised communication tools: In press, *Social Science and Medicine*.

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

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

Pajak, S. Guest, D. Evaluating a process-based management intervention in healthcare: lessons from a failure. In S. Silva (ed) *Organizational Psychology and Health Care*.

Woodrow, C. Guest, D. A comparison of the factors associated with workplace bullying in three UK healthcare organizations. In S. Silva (ed) *op cit*.

Papers submitted / under review

Sandall, J. Homer, C. Sadler, E. Rudisill, C. Bourgeault, I. Bewley, S. Cowie, L. Nelson, P. Cooper, C. (in press) Maternity safety, workforce deployment and skill mix, Report submitted to the King's Fund.

Dodds, A. Kodate, N. Accountability, organisational learning and risks to patient safety in England: conflict or compromise? *Health, Risk and Society*. Accepted pending revisions.

Kodate, N. Trial and error? The impact of major incidents on hospital sector regulation in England and Japan. Submitted to *Regulation and Governance*.

Woodrow, C. Guest, D. A study of the management of workplace bullying in a National Health Service Hospital. Submitted to the *Journal of Health Organization and Management*.

Ocloo, J. Fulop, N. Developing a 'critical' approach to patient and public involvement in patient safety in the NHS: learning lessons from other parts of the public sector? Submitted to *Health Expectations*.

Ocloo, J. Broadening the patient safety movement: listening, involving and learning from patients and the public. *Chapter in Book (eds) Socio-Cultural Perspectives on Patient Safety by Rowley, C. Waring, J.*

Working papers

Fulop, N. Magnusson, C. Chamberlain, J. Baeza, J. Humphrey, C. Rothstein, H (2008) Governing for patient safety.

Kodate, N. Dodds, A (2008) Factors affecting willingness to report patient safety in incidents in hospitals.

Mackintosh, N, Sandall, J. (2009) Failure to rescue: Problems and Solutions.

Finlay, S. Sandall, J. (2009) Balancing Innovation and safety.

Ocloo, J. Fulop, N (2010) Developing a patient and public involvement agenda in patient safety and quality

Kodate, N. Anderson, J. Dodds, A (2009) Use of incident data for improving patient safety.

Dodds, A. (2010) The management of risks to patient safety and service quality in primary care.

Woodrow, C. Guest, D (2008) Workplace bullying, patient violence and quality of care.

Research highlights by programme

Innovations:-

Managing complications in maternity and acute medicine and the implementation of patient safety tools and strategies on the frontline - Two year study in four wards (two medicine, two maternity in two Foundation Trusts). Data collection in medicine is complete (ongoing in maternity); preliminary findings from maternity will be fed back in December 2010, final data analysis across both medicine and maternity will take place from September-December. An interim report on the management of complications in medicine was sent to both Trusts in January, providing a basis for discussion regarding service development and future collaboration. Findings from interviews with patients and their relatives, women and their birth partners will contribute to future work on the potential for service users and their families to contribute to their own safety. Outputs include two publications in peer-reviewed journals and a working paper. Project updates have also been presented at a range of international conferences.

Assessing patient safety and patient experience of innovative healthcare procedures and therapeutic innovation - This project explores the development, diffusion, governance and impact of technique-centred innovations at Trust level (to better understand the safety and quality implications of such innovations). Ethnographic observations of a committee governing new clinical procedures including documentary analysis and interviews with NCPC members are complete. Ongoing work includes interviews with clinical innovators, and service users undergoing procedures in order to explore patient experience and understanding of risk and benefit. Data collection and analysis will progress concurrently.

Rescuing the deteriorating patient: factors influencing medical response (PhD) - Project exploring how deterioration is 'socially constructed' within medicine and how this influences response behaviour. Ethnographic observation, interviews and documentary analysis in medicine in two sites have all been completed, and the PhD passed upgrade in April 2010. Findings have been presented at four conferences.

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) – Project to describe the decision making process around place of birth in NHS maternity services from the perspectives of mothers and their partners, and identify contributing factors. Data collection is underway and study recruitment completed. The sample includes a diverse group of 38 women, with partners participating in about one third of cases. Antenatal interviews are ongoing, and 'follow up' end of pregnancy interviews are underway. Upgrade from MPhil to PhD passed in September 2009.

Continuity of care: Cochrane review of effects on quality and safety of care and health outcomes – Cochrane review looking at the effects of health care delivery models which offer relationship continuity over time to health service users with complex health and social needs; who need care from a range of health professionals and agencies; and/or who are socially vulnerable. The title has been accepted by EPOC Cochrane group and the protocol significantly refined.

Social and cultural processes around reporting of adverse events in maternity care (Sponsored PhD) - Study 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 submitted September 2010).

Impact of new service delivery models on Safety and Quality in Maternal Health Care: Cochrane Review – Review comparing midwife-led models of care with other models for childbearing women and their infants. Outputs have included four publications and a host of international conference presentations.

Organisational Governance:-

Developing the role of foundation trust governors and members in the governance of patient safety and quality - A mapping exercise has been completed to ascertain where governors and members at King's College Hospital NHS Foundation Trust (KCH) are currently involved in the governance of patient safety and quality at the host trust. Some interviews / observations have been completed on governor involvement in the governance context of patient safety and quality. Work is now proceeding to clarify how an intervention might work (looking at the possibility of recruiting more governors/members to this process).

Improving the governance of medication safety - Analysis of trust-level governance and external drivers is complete, and an article based on initial mapping accepted for publication in *Quality and Safety in Healthcare*. The analysis phase was completed in January 2010 and the intervention phase began in April.

Organisational governance and accountability for Healthcare Associated Infections (ESRC CASE studentship) – NHS ethics approval was received in August 2009, documentary analysis has been completed and data analysed. A draft theoretical perspectives and methodology chapter has been written up, interviews have been completed.

Reducing Health Care Associated Infections: an evaluation of key interventions and the influence of organisational governance - This study aims to improve understanding of how interventions have improved Health Care Associated Infection prevention and control over the period 2003-2010 and to investigate how organisational governance has supported this. Analysis of Trust-level governance and external drivers – based on interviews with key informants and documentary analysis – is complete, and care group-specific data have been accessed. A project steering group was formed in May 2009 and has generated useful discussion. The project proposal was distributed in March 2010 - based on this, the full protocol was developed and submitted for ethical review.

Using mortality data to improve patient safety - The study aims to improve the governance of mortality data within a local NHS Foundation Trust. A baseline survey has been completed and the findings reported to the Trust. Recommendations have been incorporated into the Trust's mortality data improvement programme. An intervention (a structured Mortality Review Form) has been developed in collaboration with clinicians and is currently being tested and evaluated in 3 specialities.

Risk:-

Risk management in health care – This study aims to identify and describe how operational risk is managed in an acute hospital trust and in a mental health trust. Data analysis is nearing an end and the intervention has been planned now that a working version of the analytic tool has been developed and discussed with the programme's Research Advisory Group. Depending on the results of the intervention study (to be completed Autumn 2010) there is potential to extend the work.

Prospective hazard analysis in healthcare – The aim of this project was to increase knowledge about how prospective methods could be used for analysing risks in health care. Studies were undertaken to:

1. Investigate the requirements for successful use of the methods in health care. This qualitative study identified the needs of health care professionals, their knowledge and understanding of the methods, and the aspects of the healthcare environment that would constrain the use of the methods.
2. To compare and contrast two methods for mapping health care processes.
3. To compare the effectiveness and advantages and disadvantages of two different methods for analysing hazards. HFMEA and SWIFT were applied to the same clinical process and the results were compared.

The results of the mapping study have been published in BMC Health Services Research and papers are being prepared from the other two studies.

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. Research reviews have been conducted on organisational learning, incident reporting in mental health, and communities of practice. The policy context for incident reporting has also been investigated (a presentation on this was given at the OBHC conference and a paper accepted for publication in *Health, Risk and Society*). Data analysis is complete and the results are being written up for journal publications. Project findings have been presented to the North British Patient Safety Research Symposium. A process for structured dissemination of findings to the trusts is being planned.

Safety feedback in health care – This project is exploring the effectiveness of different methods for providing feedback to clinical staff about safety. The theoretical framework for the study will be developed based on integration of different perspectives from the literatures on risk communication, risk perception and system

safety. A preliminary investigation has examined different methods of feedback employed in some areas of King's College Hospital NHS Foundation Trust. A literature review has been commenced.

Exploring the implications for patient safety of linguistic and cultural diversity in the workplace through an examination of doctor-patient communication around informed consent – This PhD study is investigating the challenges of linguistic and cultural diversity in the informed consent process. A literature review on risk communication, communication failures and patient safety, and cultural/linguistic diversity in the delivery of healthcare is underway.

Imagery, illness perceptions and risk perceptions in women with osteoporosis: An exploratory study – This PhD study is investigating different methods for increasing medication adherence in women with osteoporosis using imagery. A literature review on risk communication, risk perception, illness representations; and interventions in the treatment of osteoporosis has been commenced. Ethical and R&D approval has been gained and recruiting for the first phase has begun.

How do health care professionals assess the risks of interferon-a treatment for Hep-C patients? (new project, post April 2010) - This study is 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'. The study is funded by the Joint NIHR Biomedical Research Centre Strategic Awards and we will work in partnership with the sBRC and cBRC on the project. Application for ethical approval submitted.

Caring for diabetic inpatients (new project, post April 2010) - This aims to identify the difficulties and challenges encountered by staff in caring for patients with diabetes. The study will use the critical incident method to investigate their experiences and identify opportunities for providing additional support to practitioners in the form of information and decision support tools. Ethical approval has been obtained and recruiting for participants has commenced.

Managing patients with dental emergencies in the Emergency Department (new project, post April 2010) - This study will focus on improving the management of dental emergencies, which are frequently subject to low quality and unsafe care in Emergency Departments. The team will conduct a qualitative study to investigate current practices concerning the management of dental emergencies and identify organisational and cultural impediments to better management.

Workforce:-

Bullying and harassment at King's College Hospital NHS Foundation Trust - All diagnostic work at the Trust has been completed and an intervention will be piloted during the second half of 2010. Analysis of staff survey data has also been undertaken at Guy's and St Thomas' and South London and Maudsley NHS Foundation Trusts. Staff interviews have also been extended into South London and Maudsley NHS Foundation Trust and Lambeth Primary Care Trust. The results of the data analysis and policy review phase at KCH have been written up and submitted to an academic journal, as well as being presented at a number of European conferences.

Evaluating a process-based management intervention in Child Health and Liver - A 'pre-change' survey was completed and a report of key findings sent to First Choice. However, First Choice then indicated that the Teamwork and Leadership intervention in Child Health was no longer a priority and the project was abandoned. Despite this setback, the experiences, barriers and learning of trying to evaluate a hospital-based change programme were presented at the European Conference on Organizational Psychology and Human Service Work in October 2009. This paper has been further developed and submitted as a book chapter for publication in association with the conference. Project complete.

The impact of the employment of temporary staff on the management of risk in a hospital: implications for patient safety and service quality - ESRC Case awarded PhD studentship. A full literature review has been undertaken covering the nature and extent of temporary employment, the different forms of temporary employment in the NHS and the implications of temporary employment for patient safety and service quality. An allied focus has been a review of the introduction of the European Working Time Directive and how it has influenced the use of temporary staff.

Organisational socialisation, service quality and retention - A period of preparatory work to inform the study design was completed during 2009. This included a literature and scale review, attendance at King's College Hospital NHS Foundation Trust induction sessions, interviews with various stakeholders and analysis of labour turnover data. Quantitative and qualitative data collection is underway and will be completed by the end of 2010. A report has been delivered to the Trust detailing the analysis of labour turnover data. The literature review will be written up as a working paper.

Review of the disciplinary procedure at King's College Hospital NHS Foundation Trust - This project is now complete. Statistical analysis revealed a disproportionate number of BME staff as well as male and more junior staff were disciplined but other data collected as part of the study provided little evidence of discrimination or unfair treatment. Findings and recommendations were presented to both the Equality and Diversity Committee at the Trust and the project steering group in December 2009. The final written report was submitted in January 2010.

An evaluation of a lean management change programme at South London and Maudsley NHS Foundation Trust – reorganisation of Lewisham's Home Treatment Teams – This aims to evaluate the impact on patient and staff outcomes of the introduction into the health sector of lean-based management policies and practices. 'Pre-change' interviews were completed in early 2010 with 25 staff in two of the Home Treatment Teams. The findings have been analysed and a report sent to project stakeholders documenting the views, fears and expectations of staff with regard to the forthcoming service reconfiguration.

An evaluation of reasons for non-attendance to mandatory training in Lambeth PCT - Project to identify reasons for attendance / non-attendance and identify factors that would improve attendance at mandatory training. The findings are expected to have implications for improved training participation. Interviews will be completed by Autumn 2010 and a report provided shortly after. Further research and outputs depend on the nature of the findings and recommendations.

Evaluating the impact of the consultant resident on-call for trauma project at the Major Trauma Centre, Kings College Hospital NHS Foundation Trust - Project to look at the professional and personal impact of the scheme for the consultants being asked to join the 24 hour residency rota. Pre-implementation interviews with consultants have been completed and analysis is now being conducted to highlight key themes arising from those. A paper outlining the project and some preliminary findings was presented at an EAWOP Quality of Working Life Workshop, Paris, March 2010.

IMPACT ON HEALTHCARE PROVISION

- The National Leadership Council (NLC) appointed King's PSSQ, working with Foresight Partnership, to renew the governance guidance for NHS Boards. The work was carried out as part of the NLC's 'Board Development' work stream. The resulting 'Governing the NHS' document developed an overview strategy focusing on key principles emphasising how Boards 'add value', and giving practical advice on what Boards and their members are expected to do in order to enact good governance. In support of this a review of health care and general governance literature was carried out to ensure the guidance was suitably evidence based.
- Professor Jane Sandall led a Cochrane review of *Midwife-led versus other models of care for childbearing women*. This has been summarized in the DynaMed Weekly Update 270109 as an "article most likely to change clinical practice", and reproduced in the WHO Reproductive Health Library for low income countries. Findings have informed local NHS guidelines for midwife-led care and the Healthcare for London strategic review of maternity services. Nationally it has informed the UK Policy Review of Midwifery - '*Midwifery 20/20*', the UK government Commission on Nursing and Midwifery, and the maternity quality improvement strategy in Scotland. Internationally it has informed campaigns of maternity consumer groups in the USA and Australia; government reviews of maternity services in the USA, Brazil and Australia; policy statements from midwifery associations in the UK, Australian, USA and Canada.
- PhD Carin Magnusson co-authored the *Patient safety in health care professional educational curricula: examining the learning experience* report for the Department of Health. This investigated the formal and informal ways pre-registration students from healthcare professions learn about patient safety. Findings were used as evidence in the House of Commons Health Committee on Patient Safety in 2009.
- *Managing complications in medicine and maternity* - A report sent to both partner Trusts is being used to help map and improve the pathway of acutely ill patients. The project has also facilitated the introduction of an outreach service at King's College Hospital and an AMBER care bundle (to support the reliable intervention of appropriate palliative care alongside patient's treatment) at Guy's and St Thomas'. The team is currently working with National Patient Safety Association managers to scope the extent and details of failure to rescue within maternity care at a national level, and with the World Health Organisation to help develop a Mother and Baby safer care tool.
- *Improving the governance of medication safety* – A 'medication safety scorecard', featuring measures such as drug omissions and allergy documentation on drug charts, has been implemented on three general medicine wards and we are analysing its impact. We are also nearing completion of our analysis of ward and division level governance of medication safety. This will improve our understanding of how organisational

governance supports medication safety, and how improvement techniques such as scorecards interact with the settings into which they are introduced.

- *Using mortality data to improve patient safety* – We have developed a Mortality Review Form in collaboration with clinical staff at King's College Hospital in order to see what impact this would have on the process of reviewing deaths; the way that M&M meetings are carried out; clinicians' attitudes toward its introduction and how meetings' outcomes are reported into the wider hospital governance framework. Clinical areas testing the form will be compared with a clinical area within the same division not using the form. The Trust is conducting a parallel pilot in two other divisions.

PATIENT AND PUBLIC INVOLVEMENT

In order to encourage a wider contact group of users and develop a more effective ongoing working relationship that would benefit researchers and users equally, a decision was taken to disband the previous PPI group, which was made up of four members local to King's College Hospital, and empower researchers to build their own contacts with users linked to their particular programmes. As our research does not have a clinical focus, engaging the patient groups that are traditionally the focus for PPI has been problematic, but following discussion with NIHR and Involve King's PSSQ now includes 'end users' such as NHS staff and Governors within our PPI strategy as they are most directly affected by our research. We have continued to engage directly with members of the public wherever possible and relevant to our work however.

All King's PSSQ staff attended a training session given by the Research Design Service and PPI Manager at the Guy's and St Thomas' Comprehensive Biomedical Research Centre, and a number of projects are forging ahead in building new relations with users that are already paying dividends. We have also welcomed two new King's College Hospital Governors to our Steering Group, and have PSSQ representation on the Governors Patient Experience Group.

Examples of user involvement in research projects:-

- Our work on the 'Developing the role of foundation trust governors and members in the governance of patient safety and quality' project has seen continual governor and other patient and public involvement through the project's Research Action Group.
- A PSSQ sponsored Masters project to explore the reasons behind non-attendance at a diabetes outpatient clinic was designed and carried out by a patient/researcher with input at all stages from others with diabetes.
- Parents-to-be were heavily involved in the development of the 'Birth Place Decisions' PhD study design. The researcher established antenatal groups and maternity services liaison committees to discuss the study. Parents commented on proposed methods for recruiting partners as well as women, discussed their beliefs about who should make the decision about where to give birth, and commented on the acceptability of the proposed home-based interview format. The study was also presented to PSSQ's previous PPI group, which proposed additional sensitivity to the choices that London women make, including private maternity care provision, and accessing health care in other countries.
- The *Imagery, illness perceptions, risk perceptions and adherence to medication in osteoporosis* PhD study has used patients and the public extensively in the study design. Two patients with osteoporosis at Guy's Hospital have been involved in the design of the overall PhD project idea to check that this is important and relevant to patients. They have also helped to design the interview schedule, PIS, and consent form, by advising on user friendly terminology. The interview schedule has been piloted with expert patients, and they have been involved in the selection of intervention materials (pictures to represent osteoporosis for a behaviour change intervention). An element of using drawing as a research method is being used in this study, and this method was tested with expert patients to check if it was feasible. Similarly, members of the public (service users who do not have osteoporosis) were involved in the design of questions for the interview schedule, and piloting the interview schedule to determine a suitable order of questions. It is hoped that expert patients and service users will continue to be involved throughout the project, especially with guidance for the dissemination of findings to service users.
- The Risk programme has established a Research Advisory Group comprised of risk managers from King's College Hospital and South London and Maudsley NHS Foundation Trusts. The group advised on the design and implementation of two projects – "Risk management in healthcare" and "Using incident data to improve patient safety". The group reviewed methods and materials and facilitated recruitment of participants. They will also advise on and assist with the dissemination of the results of the studies.

FORWARD LOOK

Future planning

To ensure the Centre is prepared for a second funding bid we have developed a future strategy document based on discussions with staff, stakeholders and experts at our Steering Group, Management Board and Scientific Advisory Board. This review of our current strategy, programmes and projects takes into account the changing economic climate and likely policy priorities. It will be developed further as funding options become clear. In addition to planning for future funding we are focusing on maximising research outputs, demonstrating impact on policy and raising awareness of successes to date with stakeholders. We are planning a joint event with Imperial CPSSQ (to take place in Spring 2011) and joining a range of events at King's College Hospital and Guy's and St Thomas' NHS Foundation Trusts in the coming months.

Grant awards - The following outline proposals have been submitted to the NIHR SDO Programme call:-

- The Birthplace in England Research programme; further analyses to enhance policy and service delivery decision-making for planned place of birth. PI: Brocklehurst, Sandall and Birthplace co-investigators. *Shortlisted.*
- An organisational study of Alongside Midwifery-Units: a follow-on study from the Birthplace in England Research programme. PI: McCourt, Sandall, Rance, Rayment, Beake, Cooke, Newburn. *Shortlisted.*
- Developing a Theory Driven Model to Guide Involvement and Evaluation in Patient Safety'. Principal investigator: McKeivitt, co-investigators: Ocloo, Fulop, Staniszewska, Beresford, MacNaughton. *Shortlisted.*
- Governing for patient safety: the role of NHS Boards. PI: Fulop; co-investigators: Ramsay, Higginson, Denis, Baker, Fresko, Rubenstein. *Shortlisted.*
- Inter and intra organisational governance of patient safety. PI: Baeza, co-investigators: Fulop, Sandall, Thornicroft, Cowie. *Shortlisted.*
- The productivity costs of patient safety: implications for hospital efficiency. PI: De Coulon, co-investigators: Cookson, Fulop.
- Innovations in major system reconfiguration in England: a study of the effectiveness, acceptability and processes of implementation of two models of stroke care. PI: Fulop, co-investigators: Ramsay, Rudd, Wolfe et al. *Shortlisted*
- A Formative Evaluation of the NHS South Central Strategic Health Authority's Mental Health and Learning Disabilities Clinical Improvement Programme. PI: Worrall; co-investigators: King, Beecham, Shaw, Gregoire, Gordon, Ramsay. *Shortlisted.*
- Maternal and infant admissions within 30 days of routine hospital discharge: risk factors and consequences for NHS costs and workload management submitted to SDO programme. PI: Bick, co-investigators: Sandall, Jones, Mackintosh, Griffiths, Beake, Cookson, Bewley, Newburn.
- The efficient use of midwives and the implications for safety & quality in maternity care: An economic perspective, submitted to SDO programme, PI: Sandall, Bick, Bewley, Dodwell, mackintosh, Cookson, Hamilton-Fairley.

Additional grant award:- How do health care professionals assess the risks of interferon-a treatment for Hep-C patients? Joint NIHR Biomedical Research Centre Strategic Awards funding call (£75,000 overall). *Grant awarded May 2010, project due to start shortly.*

Programme plans

Innovations work through 2010/11 will include working with the WHO Patient Safety programme piloting and testing a mother and baby safer care tool. Also working with the comprehensive BRC on the safety in type II translational research.

Organisational Governance work will include extending the medication safety project into Guy's and St Thomas' NHS Foundation Trust and developing plans to extend the mortality data project into the same trust. We will be carrying out a national survey of all NHS trusts in England as part of the Department of Health (DH) funded project '*Developing Patient and Public Involvement in Patient Safety and Clinical Governance*'. We will also be working on an extension of the NHS Healthy Boards project to look at governance arrangements for the proposed GP consortia (funded by the National Leadership Council).

The Risk team will continue to develop the risk management analysis tool. Key developments will include extending the work on diabetic inpatients with the diabetes team and evaluating different methods for giving safety feedback to clinical staff.

Workforce will extend the study of temporary working and socialisation of newcomers into service quality. New projects on the role of the workforce in ensuring appropriate dietary provision; the impact of the King's College Hospital vision on employee attitudes and behaviour relating to quality of service provision; and the implementation of policies to affect the staff contribution to service quality will also progress.