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Suffolk and North East Essex

Our NatSSIPs 2 Safety Workshop

May 2023

Origins

- The ICB wanted to support our acute providers to improve safety following a series of Never Events raised across our ICS.

Trust\	Never Event		Incident Date
WSFT	Wrong site surgery> wrong patient	Insertion of PICC line	06.01.23
	Wrong implant prosthesis	Incorrect meniscal bearing implant was inserted	30.01.23
ESNEFT	Wrong site surgery	Wrong site nerve block	27.09.22
	Wrong site surgery	Surgery on the incorrect metatarsal space	30.08.22
	Wrong site surgery	Wrong site nerve block	03.01.23

- The highest Never Event classification across SNEE ICS is for wrong site surgery.
- Traditional methods of obtaining assurance between CCG and provider would have been to undertake a structured quality visit.
- We wanted to change that approach; we initially planned to have a workshop based around actions implemented to reduce surgical Never Events. However, in view of the recent NAtSSIPs 2 publication, we took the opportunity to develop a workshop to focus on NatSSIPs 2 implementation.

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Our Agenda

- Introduction to NatSSIPs 2
- Review of recent Never Events, assessing the impact of organisational factors.
- NatSSIPs 8 people, process and planning for senior leaders: implementation planning exercise.
- Collective discussion of improving cultural measures in safety across ICS and formulation of next steps.

We invited surgical teams from our acute hospitals, and our ICB Medical Director attended (who has board level responsibility for safety).

Our discussions

Organisational factors identified regarding our never events:

People. The importance of a good safety culture across the organisation. Patient involvement: restrictions during anaesthesia or during the Covid-19 pandemic.

Staff may be fearful of reporting never events so must feel confident to speak out.

Process. The absence of robust counting and documentation across teams. Importance of a good induction, especially in areas of high staff turnover. Education for staff and important that teams train together. Promote theatre 'visitors' to visualise safety. A team huddle for every theatre list and a debrief post procedure. Scheduling and last minute changes to lists, pressure of patient throughput were identified as important risk factors.

Performance. Feedback on performance and sharing positive outcomes. Sharing data on safety.

Overall – our teams were very quick to identify organisational factors and the importance of the organisational role in safety.

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Our discussions

NatSSIPs 8 people, process and planning for senior leaders

People. Do patients know about safety checks, are they empowered to ask about them? To consider the use of a patient feedback form following procedures. Development of a joint group to explain the WHO checklist, and using Patient Safety Partners to help implement this work.

Our teams felt it was important to have strong board leadership, and holding the organisation and divisional leaders to account for safety. Ward to board approach to training involving all grades of staff and covering the WHO checklist. Embedding the NHS Just Culture even further. Meaningful and compassionate involvement of staff in safety.

Process. We discussed the advantages of checklists being consistent /harmonised across departments/directorates, even across the ICS. Use of digital opportunities to improve safety. Having an organisational standard for induction. Development of patient surveys across our ICS targeting different patient groups and involving Patient Safety Partners. Emphasis on prioritising safety throughout the NHS generally.

Conclusions, aspirations and next steps

- Aim within our ICS to move towards a proactive approach regarding safety (fits with PSIRF) and away from the traditional reactive model as seen with the Serious Incident Framework 2015.
- More observational supportive assessments to encourage what good looks like.
- Work on implementation of NatSSIPs 2 across all surgical specialisms including endoscopy; consider development of NatSSIPs task force.
- Work to standardise documentation and guidance across ICS.
- Patient Safety to be more visible across organsiations and our ICS.
- Further integration of the Just Culture, particularly in respect of Never Events and significant incidents.