Healthcare Improvement Scotland

SCOTTISH PATIENT SAFETY PROGRAMME

SPSP National Learning Event 2024

Creating the Conditions for Safe Care
September 2024

This event will commence 09:45

Leading quality health and care for Scotland

NHS SCOTLAND

Chairs Welcome

Robbie Pearson

Chief Executive

Healthcare Improvement Scotland

Housekeeping

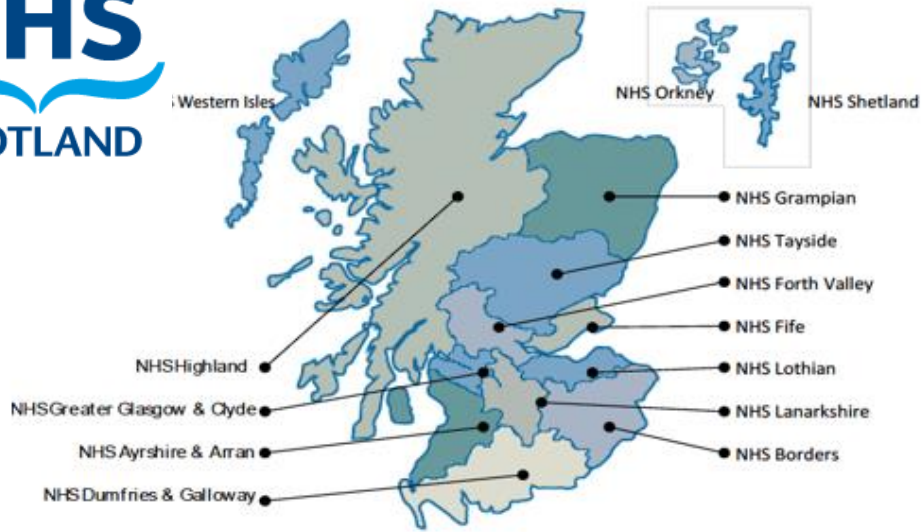
- Wi-fi name: GJCH Public Wi-Fi
- If you hear a fire alarm, please proceed to the nearest exit
- Please set mobile phones to silent
- Digital delegate bag will contain all resources and recordings from the event
- We will be using Slido throughout the day to capture real-time audience feedback

Welcome to our Virtual Audience

- Fully hybrid event
- Interactive plenary and breakout sessions with the opportunity to participate in Q&A and chat
- This session is being recorded

Who is here today.....

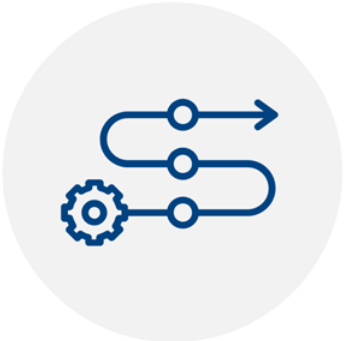
All NHS Scotland territorial and special health boards represented



Aims of the Day

- Learn how the SPSP Essentials of Safe Care can support improvements in safety
- Provide an opportunity to contribute to and learn from ongoing efforts within SPSP programmes of work
- Provide a forum for leaders and teams working across all SPSP programmes to come together to share and learn



Morning Agenda

	Title	Lead
09:45	**Chair's Welcome**	**Robbie Pearson,** Chief Executive, Healthcare Improvement Scotland
09:50	**Ministerial Address**	**MSP Neil Gray,** Cabinet Secretary for Health and Social Care
10:00	**Creating the Conditions for Safety – The HIS Approach**	**Robbie Pearson,** Chief Executive, Healthcare Improvement Scotland **Joanne Matthews**, Associate Director of Improvement & Safety, Healthcare Improvement Scotland
10:30	**Safer Healthcare Strategies for the Short & Longer Term**	**Professor Charles Vincent,** Professor of Psychology University of Oxford and Emeritus Professor Clinical Safety Research, Imperial College London
11:25	**Coffee Break (and transitions to morning breakouts)**	
11:50	**Breakout sessions. Focussing on SPSP Essentials of Safe Care** • Values based reflective practice (VBRP) and the creation of psychologically safe spaces • Staff wellbeing for safety • Creating a learning system within and between boards	

Ministerial Address

MSP Neil Gray, Cabinet Secretary for Health and Social Care

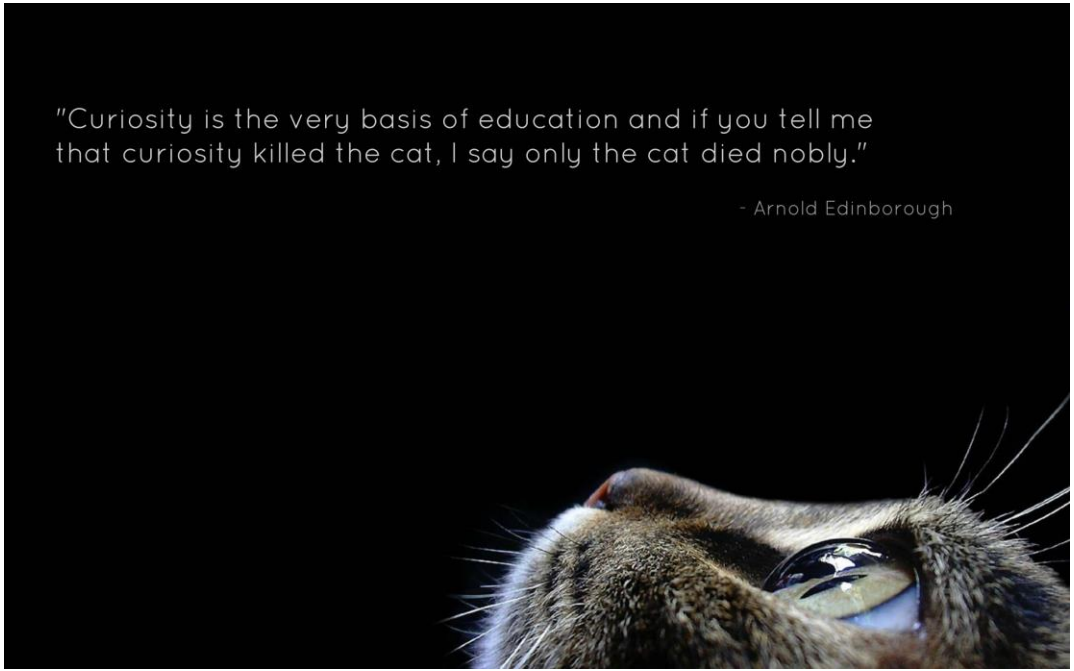
Ministerial Address Recording

Creating the Conditions for Safety
The HIS Approach

Robbie Pearson, Chief Executive, Healthcare Improvement Scotland
Joanne Matthews, Associate Director, Improvement & Safety, Healthcare Improvement Scotland

Encouraging curiosity in what we do

Curiosity Killed the Cat



“Safety is a continually emerging property of a complex system”

Professor James Reason

Shared Ownership

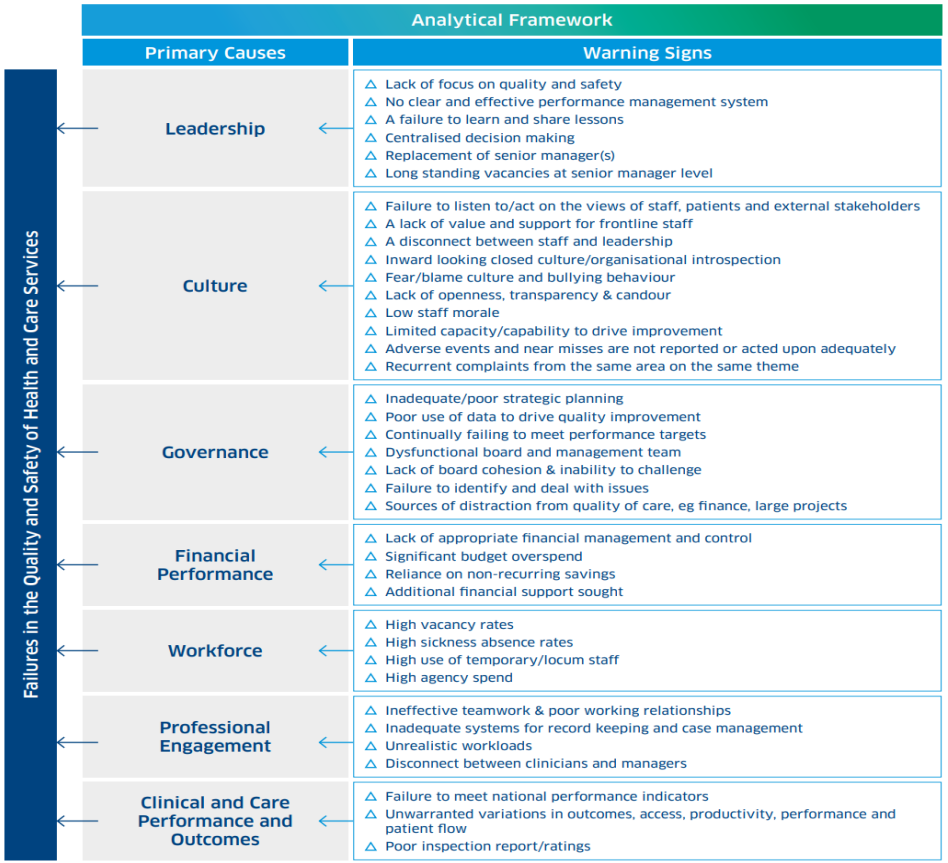
“It is rare that one single thing goes wrong when failure occurs or that a single person is to blame. Instead the ownership of failure is shared…the identification of failure is frequently followed by the attribution of blame. Indeed, research is consistent in showing that 70 to 80% of inquiries across a range of industries and professions attribute tragedies to the error of particular individuals.
However, the case studies suggest that an over-reliance on the blame of an individual could forestall a more rigorous attempt to understand why failure arose, how it could be resolved and what might be done to prevent its re-occurrence”

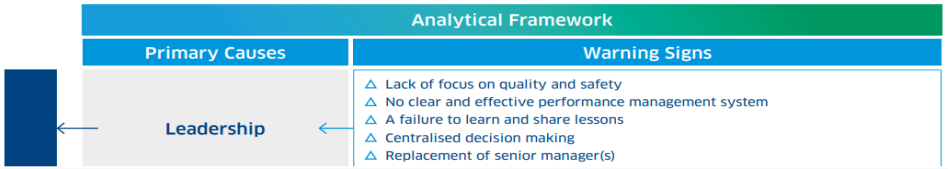
INSTITUTE FOR GOVERNMENT

Incubation Period

What these disasters typically reveal is that the factors accounting for them usually had “long incubation periods, typified by rule violations, discrepant events that accumulated unnoticed, and cultural beliefs about hazards that together prevented interventions that might have staved off harmful outcomes”

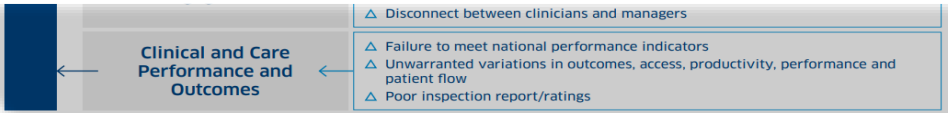
Vaughan D. The dark side of organizations: Mistakes, misconduct, and disaster. *Annual Review of Sociology.* 1999


Analytical Framework
Primary Causes
Warning Signs
Failures in the Quality and Safety of Health and Care Services
Leadership
△ Lack of focus on quality and safety
△ No clear and effective performance management system
△ A failure to learn and share lessons
△ Centralised decision making
△ Replacement of senior manager(s)
△ Long standing vacancies at senior manager level
Culture
△ Failure to listen to/act on the views of staff, patients and external stakeholders
△ A lack of value and support for frontline staff
△ A disconnect between staff and leadership
△ Inward looking closed culture/organisational introspection
△ Fear/blame culture and bullying behaviour
△ Lack of openness, transparency & candour
△ Low staff morale
△ Limited capacity/capability to drive improvement
△ Adverse events and near misses are not reported or acted upon adequately
△ Recurrent complaints from the same area on the same theme
Governance
△ Inadequate/poor strategic planning
△ Poor use of data to drive quality improvement
△ Continually failing to meet performance targets
△ Dysfunctional board and management team
△ Lack of board cohesion & inability to challenge
△ Failure to identify and deal with issues
△ Sources of distraction from quality of care, eg finance, large projects
Financial Performance
△ Lack of appropriate financial management and control
△ Significant budget overspend
△ Reliance on non-recurring savings
△ Additional financial support sought
Workforce
△ High vacancy rates
△ High sickness absence rates
△ High use of temporary/locum staff
△ High agency spend
Professional Engagement
△ Ineffective teamwork & poor working relationships
△ Inadequate systems for record keeping and case management
△ Unrealistic workloads
△ Disconnect between clinicians and managers
Clinical and Care Performance and Outcomes
△ Failure to meet national performance indicators
△ Unwarranted variations in outcomes, access, productivity, performance and patient flow
△ Poor inspection report/ratings



Safety Culture

- Limited capacity/capability to drive improvement
- Failure to listen to/act on the views of staff, service users, stakeholders
- Recurrent complaints from the same area on the same theme
- Normalisation of deviant practices
- Incidents especially near misses, are not reported or acted upon adequately
- Punitive approach to safety event reporting
- Inadequate training and administrative support for safety



"THE IMPORTANT THING IS NOT
TO STOP QUESTIONING.
CURIOSITY HAS
ITS OWN REASON FOR
EXISTENCE."

~ALBERT EINSTEIN

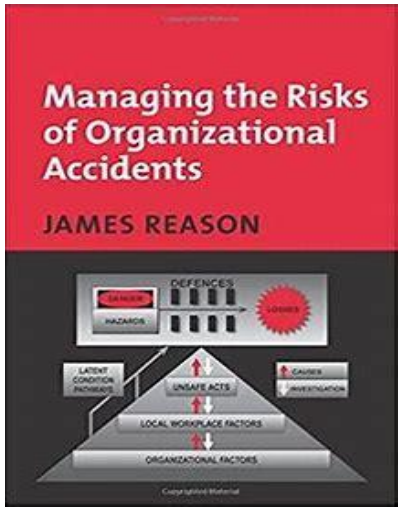
Ian Paterson Inquiry

We believe there **was a notable lack of curiosity about him from those running both HEFT and Spire, and that this was sustained for many years**. From the evidence we heard, we believe the culture set from the top was **one of avoiding problems by managing them as isolated incidents, with a lack of critical thinking about what the real issues were**. It was convenient for Paterson to be characterised as a unique rogue by those who worked with him and those in charge – this ***lack of curiosity*** was to have far reaching and devastating consequences.

Ian Paterson Inquiry

Managers and those charged with governance do not always interrogate data well, but instead seem to look for patterns which reassure rather than disturb. This capacity for wilful blindness is illustrated by the way in which Paterson's behaviour and aberrant clinical practice was excused or even favoured. Many simply avoided or worked round him. Some could have known, while others should have known, and a few must have known. **At the very least a great deal more curiosity was needed, and a broader sense of responsibility for safety in the wider healthcare system by both clinicians and managers alike**.

So, if we know .....



"Securing safety is a task that cannot be finished ever. Safety is a continually emerging property of a complex system."

Increasing complexity and challenge across and within our health and care system

"The pursuit of safety is dependent on volunteerism, continually support intrinsic motivation"

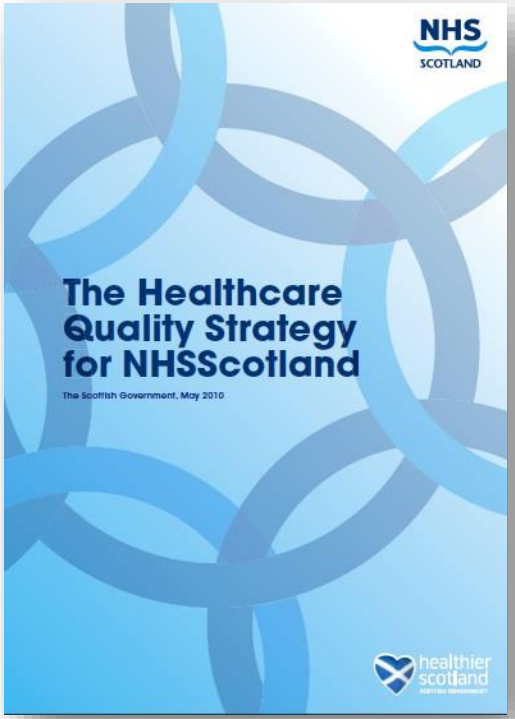
slido

Please download and install the
Slido app on all computers you use

Why are you here today?

ⓘ Start presenting to display the poll results on this slide.

Getting Back to the Why



To deliver the highest quality healthcare services to the people of Scotland through a focus on safe ,effective and person-centred care

HIS Strategic Priorities

Healthcare Improvement Scotland

Leading quality health and care for Scotland:

Our Strategy 2023–28

1	Enable a better understanding of the safety and quality of health and care services and the high impact opportunities for improvement.
2	Assess and share intelligence and evidence which supports the design, delivery and assurance of high quality health and care service.
3	Enable the health and care system to place the voices and rights of people and communities at the heart of improvements to the safety and quality of care.
4	Deliver practical support that accelerates the delivery of sustainable improvements in the safety and quality of health and care services across Scotland.

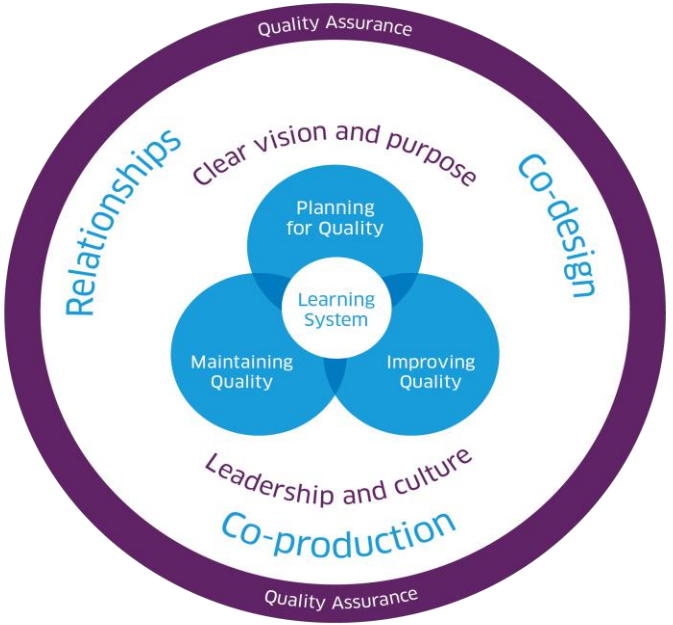
Managing Quality

Planning for Quality – identifying priorities for improvement and designing appropriate changes to achieve them.

Improving Quality– practical implementation of changes through repeated testing and measurement.

Maintaining Quality– proportionate routine monitoring of ‘day to day’ quality of services to ensure they’re good enough.

Assuring Quality– independent assessment of the both the quality of care and the enablers of high quality care



Please note: The QMS Framework is continuously evolving, for the most up to date version please visit: https://ihub.scot

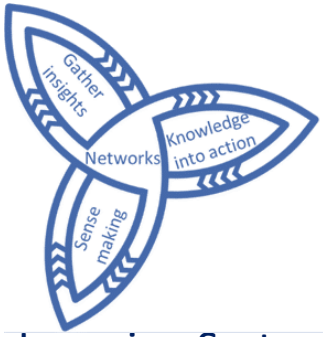
Creating the Conditions

Helping to make it easier for people to do the right thing

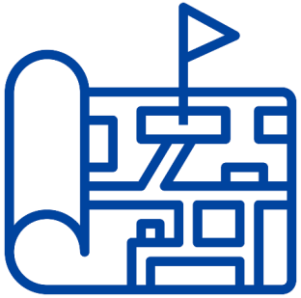
Creating the Conditions

Measurement

Co-designed



Learning System



Tailored support

Leadership and building community

Essentials of Safe Care

Creating the Conditions

SPSP aims to improve the safety and reliability of care and reduce harm

Core Themes

- **Essentials of Safe Care**
- **SPSP Programme improvement focus**
  Maternity, Neonatal, Paediatric, Acute Care, and Mental Health
- **SPSP Learning System**

Essentials of Safe Care

Aim

To enable the delivery of Safe Care for every person within every system every time

Primary Drivers

- Person centred systems and behaviours are embedded and support safety for everyone
- Safe communications within and between teams
- Leadership to promote a culture of safety at all levels
- Safe consistent clinical and care processes across health and social care settings

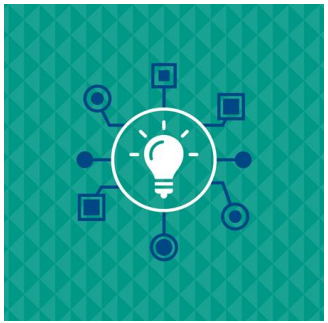
Secondary Drivers

- Structures & processes that enable safe, person centred care
- Inclusion and involvement
- Workforce capacity and capability
- Skills : appropriate language, format and content
- Practice : use of standardised tools for communication
- Critical Situations : management of communication in different situations
- Psychological safety
- Staff wellbeing
- System for learning
- Reliable implementation of Standard Infection Prevention and Control Precautions (SICPS)
- Safe Staffing

SPSP Learning System

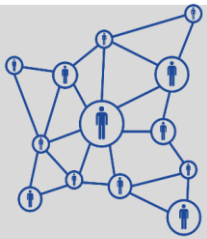
The **SPSP Learning System** is a key element of our work and underpins all our activities. It aims to accelerate sharing of learning and improvement work through a range of engagement and learning opportunities.

Learning events and webinars



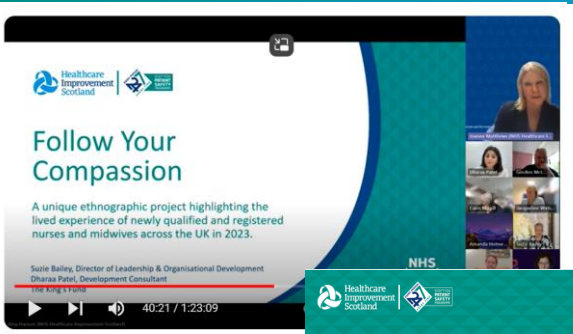
Sharing data, supporting measurement and evaluation

Supporting Networks

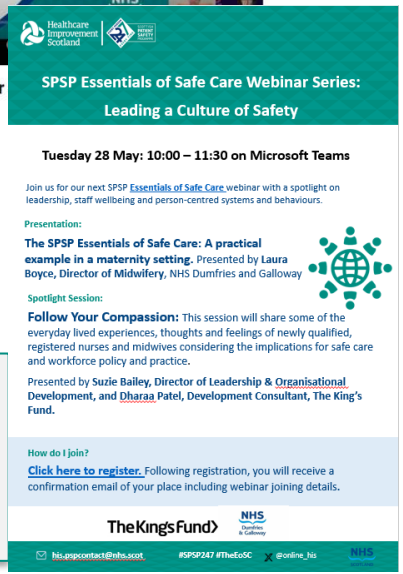


Producing evidence summaries and case studies

SPSP Learning System



SPSP Essentials of Safe Care Webinar Series: Leading a Culture of Safety



Spring 2024 webinar

"Leading a Culture of Safety"

Kings Fund Suzie Bailey

"Follow your Compassion"

You asked how do we build on this ?

"We aren't alone in our challenges; we can learn so much from each other"

"Very emotive session. Experiences need to be shared across all sectors"

High Quality Care Cultures

Performance

People

Cultural Elements	Values	The way we do things
Vision and Values	Constant commitment to quality of care	**Everyone** taking responsibility in their work for living a shared vision and embodying shared values
Goals and performance	Effective, efficient, high-quality performance	**Everyone** ensuring that there are shared priorities and objectives at every level and intelligent data constantly informing all about performance
Learning and innovation	Continuous learning , quality improvement and innovation	**Everyone** taking responsibility for improving quality , learning and developing better ways of doing things
Support and Compassion	Support and compassion for all patients and staff	**Everyone** making sure that all interactions involve careful attention empathy and intent to take intelligent helping action
Equity and Inclusion	Trust, transparency, health equalities, civility, pride, staff wellbeing, and innovation	**Everyone** demonstrates equity, diversity, and inclusion. Promoting inclusion at every level, ensuring equity, helping all to grow and lead and ensuring diversity is positively valued and developed
Teamwork	Enthusiastic cooperation, team working and support within and across organisations	**Everyone** taking responsibility for effective team-based working, interconnectedness within and across organisations, systems thinking and acting

NHS England » The Culture and Leadership programme

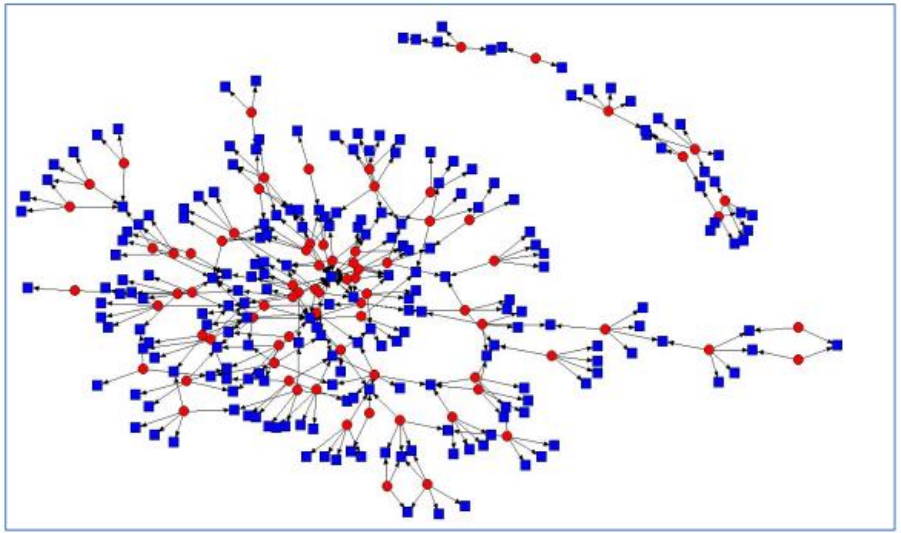
Living the Culture Through Leadership

Collective Leadership	Compassionate Leadership	Inclusive Leadership
Leadership by all, and for all	**Listens to understand and takes action**	**Enables equity, true inclusion and belonging**
A culture where all are empowered as individuals and in teams to provide leadership at various points in their daily work and in their careers.	A culture where all feel supported, listened to and where action is taken which leads to improvement.	A culture which recognises the unique needs of individuals, so that all feel valued and have the opportunity to thrive.

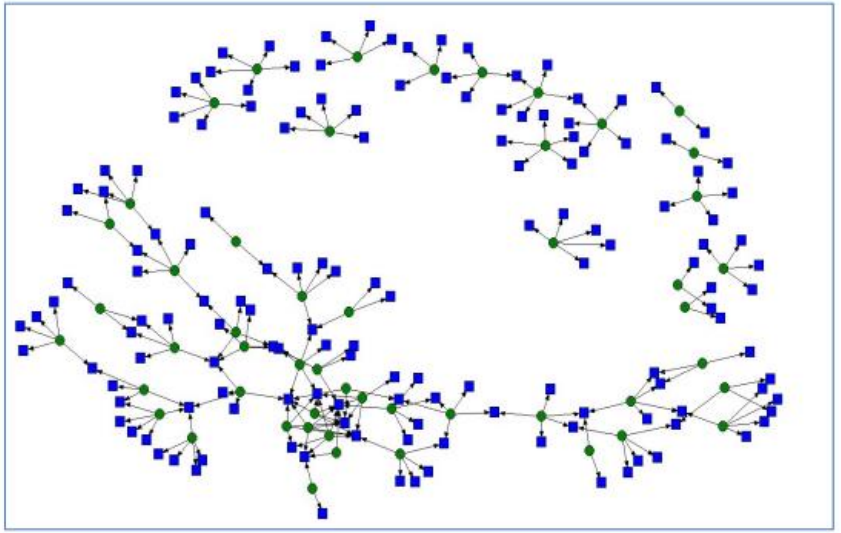
NHS England » The Culture and Leadership programme

Relationships Relationships Relationships

Hospital A
Performance rating:
'Outstanding'



Hospital B
Performance Rating:
'special measures'



[Why social networks are vital for continuous improvement | News | Warwick Business School (wbs.ac.uk)]

Leadership… Culture...Outcomes..

All levels of the NHS

The culture of an organisation impacts behaviour at all levels within and across organisations.

Leadership behaviours

Leadership is the most powerful factor influencing culture because leaders signal, through their behaviour, the values and the norms – ‘ the way we do things around here.’

Cultural elements

The six specific cultural elements are associated with high quality healthcare cultures. They are grouped into two overarching categories of performance and people.

Outcomes

Staff performance and engagement are affected by organisation culture. This in turn impacts patient satisfaction, care quality, financial performance and patient mortality.

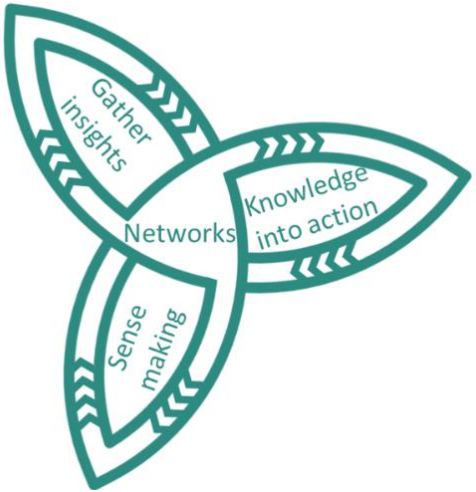
Workforce capacity

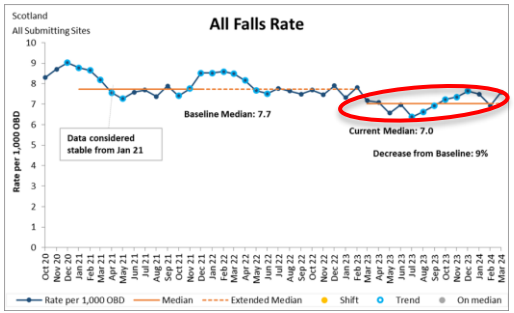
- Capacity
- Diversity and demographics
- Knowledge, skills and abilities

NHS England » The Culture and Leadership programme

SPSP Acute Adult

Understanding systems

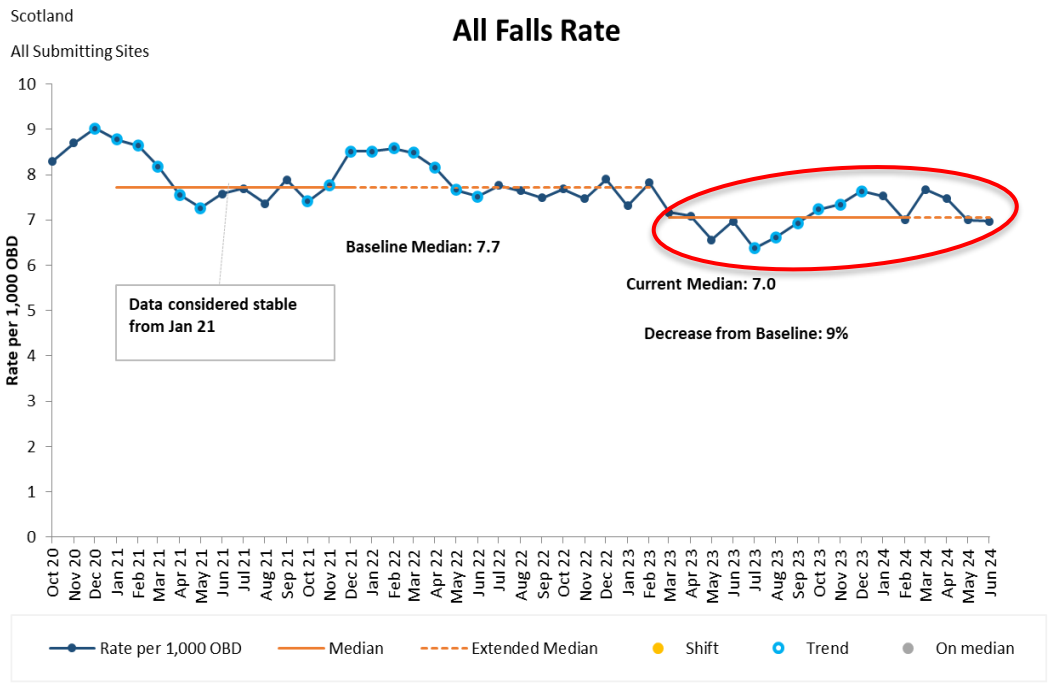




Reducing Harm

Shifting Culture

Falls in Acute Care



9%

reduction

11

acute hospitals

demonstrated a sustained reduction in the rate of falls of between 9% and 21%

Creating the Conditions

Helping to make it easier for people to do the right thing

Thank you

Safer Healthcare Strategies for the Short and Longer Term

Professor Charles Vincent, Professor of Psychology University of Oxford
C0-them lead, YHPSRC

With Rene Amalberti, Foundation for Industrial Safety, Toulouse

Overview

- The original vision: meeting the standards
- The varying levels of care
- Models of safety in different contexts
- A portfolio of interventions to build safer systems
- Complemented by adaptive strategies to manage short term pressures
- What does this mean for teams and leaders?

The essential drivers of safe care

Working in partnership with health and social care teams and a number of representative bodies across Scotland, the following essentials were identified as being central to supporting the safe delivery of care in any setting.

Person centred care

Person centred systems and behaviours are embedded and support safety for everyone

Find out more

Safe communications

Safe communications within and between teams

Find out more

Leadership & culture

Leadership to promote a culture of safety at all levels

Find out more

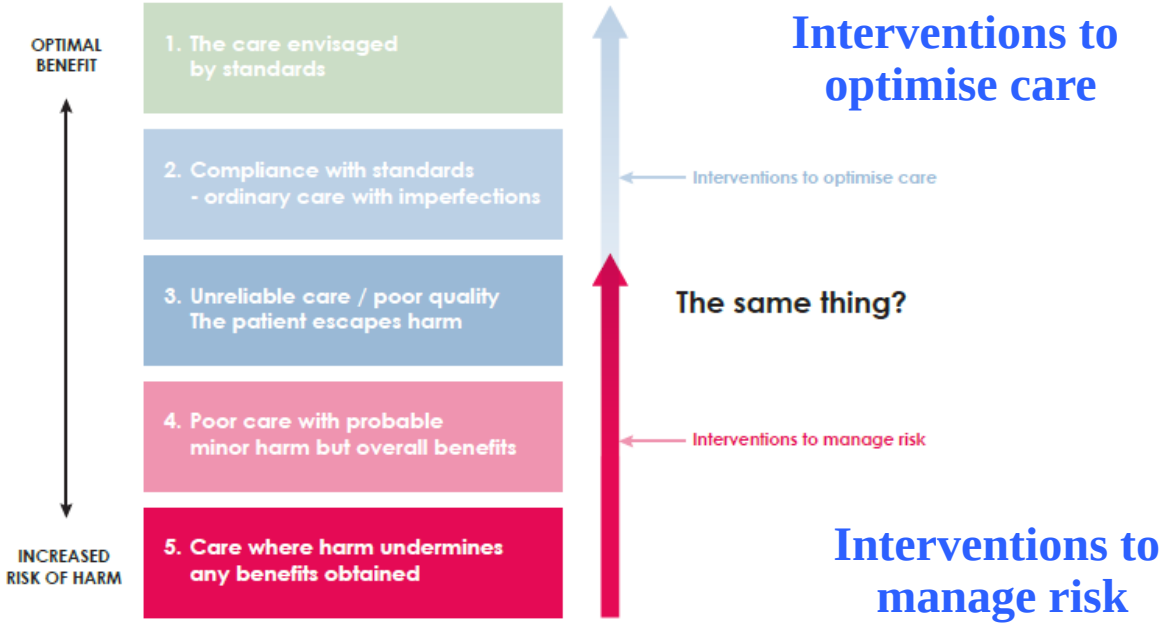
Safe clinical and care processes

Safe consistent clinical and care processes across health and social care settings

Find out more


FIRST, DO NO HARM
TO ERR IS HUM
BUILDING A SAFER HEALTH S
INSTITUTE OF MEDI
INSTITUTE OF MEDICINE
CROSSING THE
QUALITY CHASI
A New Health System for the 21st Century
DH Department of Health
learning
ERROR
culture
standard
EVALUATE
management
protocols
LEARN
active
near-misses
organisation
CULTURE
hazard
accountability
An organisation with a memory
Report of an expert group on learning
from adverse events in the NHS
chaired by the Chief Medical Officer

5 levels of care



Three Models of Safety Avoiding Risk: Ultra Safe

- Risk is excluded as far as possible
- Procedures & supervisory systems
- Priority given to prevention
- Strong regulatory control
- Training in rigorous procedures
- and management of workload

Managing Risk: High Reliability Model

- Risk in not sought out but is inherent in the profession
- Group intelligence and adaptation
- Mutual protection of team members.
- Training and safety focused on adaptability and flexibility of procedures

Embracing Risk: Ultra-Adaptive

- Taking risks is the essence of the profession
- Working conditions are unstable and sometimes unforeseeable
- Cult of champions and heroes
- Success analysis more important than accident analysis
- Training is acquisition of expertise, understanding own limitations

Three contrasting approaches to safety

ULTRA ADAPTIVE
Embracing risk

Context: **Taking risks is the essence of the profession:**
Deep sea fishing, military in war time, drilling industry, rare cancer, treatment of trauma.

Safety model: **Power to experts** to rely on personal resilience, expertise and technology to survive and prosper in adverse conditions.

Training through peer-to-peer learning shadowing, acquiring professional experience, knowing one's own limitations.

Priority to adaptation and recovery strategies

HIGH RELIABILITY
Managing risk

Context: **Risk is not sought out but is inherent in the profession:**
Marine, shipping, oil Industry, fire-fighters, elective surgery.

Safety model: **Power to the group** to organise itself, provide mutual protection, apply procedures, adapt, and make sense of the environment.

Training in teams to prepare and rehearse flexible routines for the management of hazards.

Priority to procedures and adaptation strategies

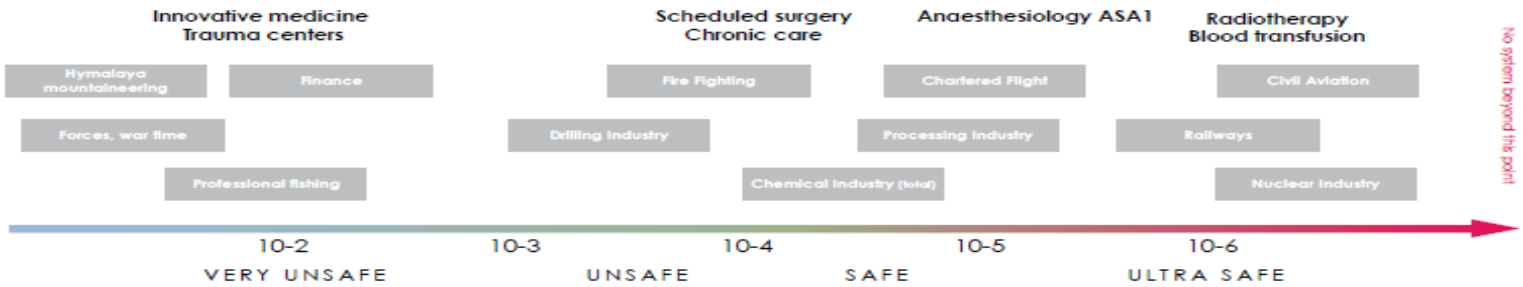
ULTRA SAFE
Avoiding risk

Context: **Risk is excluded as far as possible:** Civil aviation, nuclear Industry, public transport, food industry, medical laboratory, blood transfusion.

Safety model: **Power to regulators and supervision** of the system to avoid exposing front-line actors to unnecessary risks.

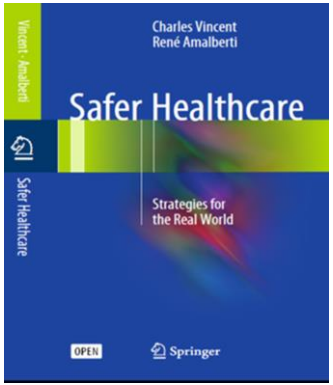
Training in teams to apply procedures for both routine operations and emergencies.

Priority to prevention strategies

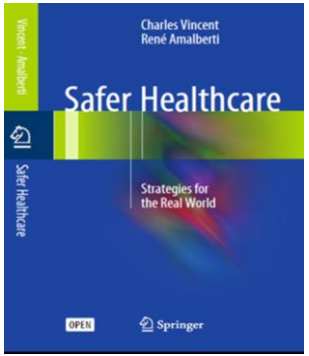


Our Ambition and Questions

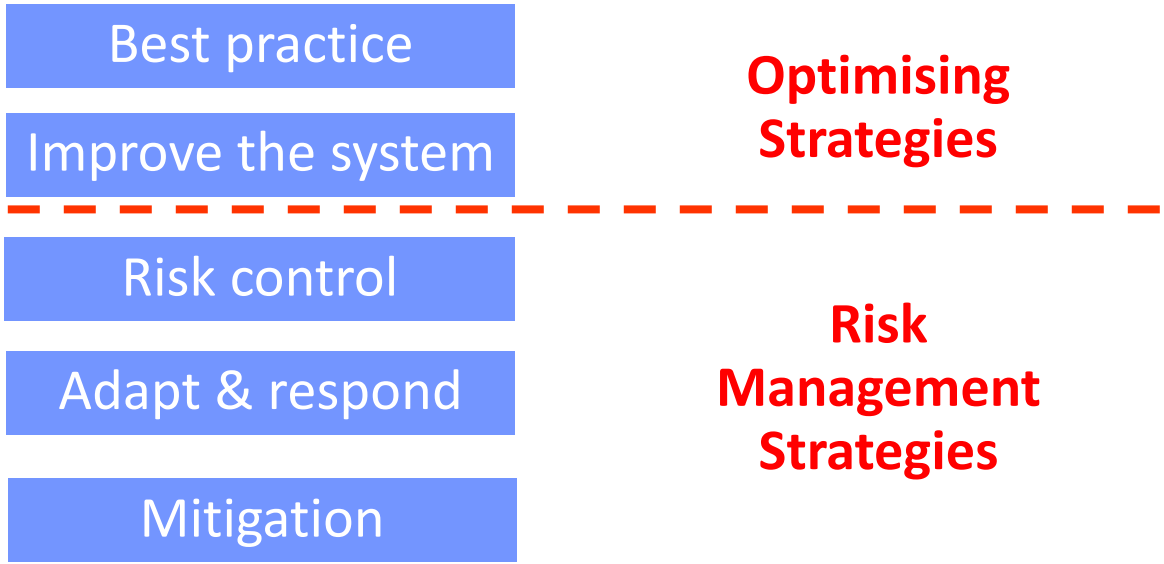
- How are safety and quality achieved in different settings?
- A wider range of safety strategies and interventions?
- Can a framework of strategies and interventions be developed ?
  - Applicable across contexts? Hospital, home, primary care
  - Across levels? Patient, frontline, organisation, regulation and government?



Safety Strategies and Interventions
Building for the Longer-term



Families of Safety Interventions



I Aspire to Standards – Safety as Best Practice

- Targeted at specific events
- Aim is to optimise reliability of basic procedures
- Quality improvement approach

Annals of Internal Medicine | SUPPLEMENT

The Top Patient Safety Strategies That Can Be Encouraged for Adoption Now

Table 2. **Patient Safety Strategies Ready for Adoption Now**

Strongly encouraged
Preoperative checklists and anesthesia checklists to prevent operative and postoperative events
Bundles that include checklists to prevent central line–associated bloodstream infections
Interventions to reduce urinary catheter use, including catheter reminders, stop orders, or nurse-initiated removal protocols
Bundles that include head-of-bed elevation, sedation vacations, oral care with chlorhexidine, and subglottic suctioning endotracheal tubes to prevent ventilator-associated pneumonia
Hand hygiene
The do-not-use list for hazardous abbreviations
Multicomponent interventions to reduce pressure ulcers
Barrier precautions to prevent health care–associated infections
Use of real-time ultrasonography for central line placement
Interventions to improve prophylaxis for venous thromboembolisms

Shekelle et al, 2013

II Safer Systems – Multiple Avenues

Improved teamwork as an example

- Introduce tools such as whiteboards to facilitate team communication
- Define essential tasks and who is responsible for each task.
- Establish joint medical and nursing handovers.
- Use shared medical and nursing records.

Vincent et al, 1998; Carayon et al, 2006

Simplify the Working Environment

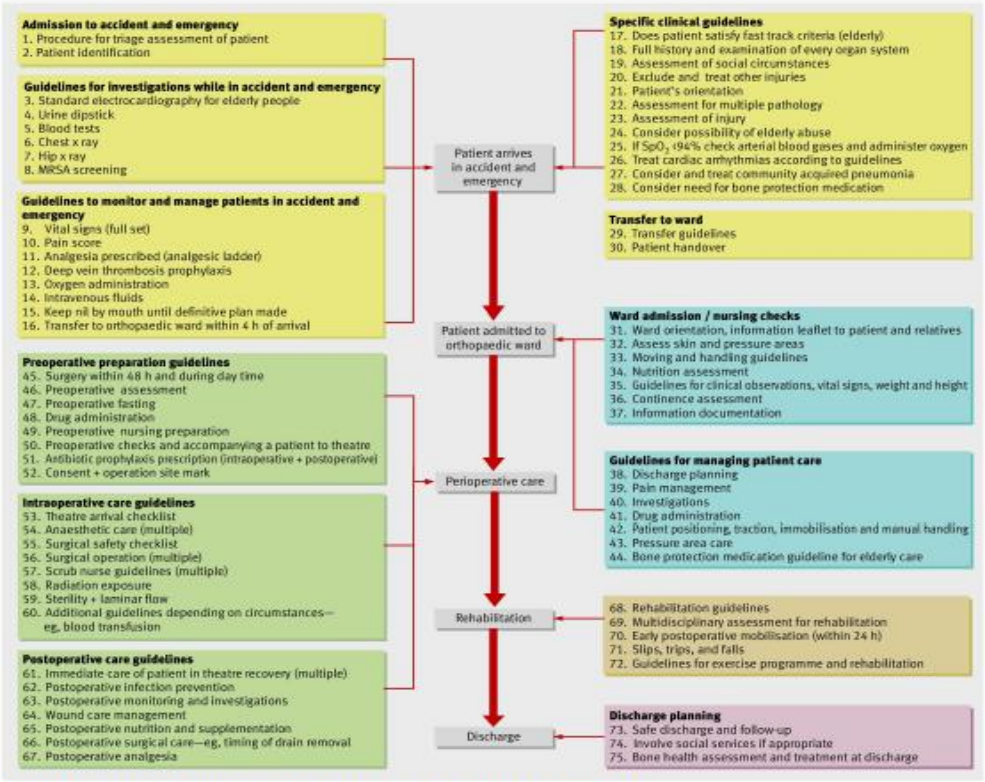


Fig 1 Typical patient journey for an elderly patient with fractured neck of femur

III Risk control

- Withdraw services
- Place restrictions on services
- Place restrictions on conditions of operation
- Place restrictions on individuals
- Prioritisation of activities

Potential for Risk Control in Anaesthesia

Faulty gas analyser: Go or No Go?

GO

Use TIVA with propofol (BIS monitored)... I am well aware that a functioning oxygen monitor is present in the guidelines. To cancel would be the counsel of perfection, but this won't get the patient the treatment he needs

[Consultant; 25 years' experience]

NO-GO

Completely elective cases with faulty kit I would not proceed. There is a risk of awareness/hypoxia. Proceeding fails my stand up in court test.

[Consultant; 10 years' experience]

Go/no-go decision in anaesthesia: wide variation in risk tolerance amongst anaesthetists

P. R. Greig[1,*], H. E. Higham[1], J. L. Darbyshire[1] and C. Vincent[2]

[1]Nuffield Department of Clinical Neurosciences, University of Oxford, John Radcliffe Hospital, Oxford, UK and [2]Department of Psychology, University of Oxford, Oxford, UK

*Corresponding author. E-mail: paul.greig@ndcn.ox.ac.uk

Contrasting Strategies

- Options for dealing with missing equipment
  - Clinical judgment
    - Preserves status quo
  - Surgical checklist (enhance monitoring)
    - Preserves status quo
  - Go/no go hard stop rule (risk control)
    - Which may force improved system efficiency
- Benefits and limitations of each approach and highly dependent on wider context

IV Monitoring, Adaptation and Response (Resilience)

Experts are constantly thinking ahead

- Pre-mission planning for fighter pilots often takes longer than the mission
- Route is analysed for threats, whether from hostile aircraft, personal factors, weather
- During the flight pilots devoted over 90% of available time to anticipation
- Typically developed a ‘tree’ of events that might occur

Amalberti & Deblon, 1992

IV Monitoring, Adaptation and Response

- Building the capacity to detect and respond to problems in real time
- Resilient teamwork at the frontline
- Supportive interventions
  - Briefing and de-briefing
  - Team training for cross checking, monitoring
- Develop planned approaches to adaptation and recovery

V Mitigation

- Support for patients, families and carers
- Support for staff
- Financial and legal planning
- Management of media
- Response to regulators

Mitigation in Home Haemodialysis

Pauly et al, 2015

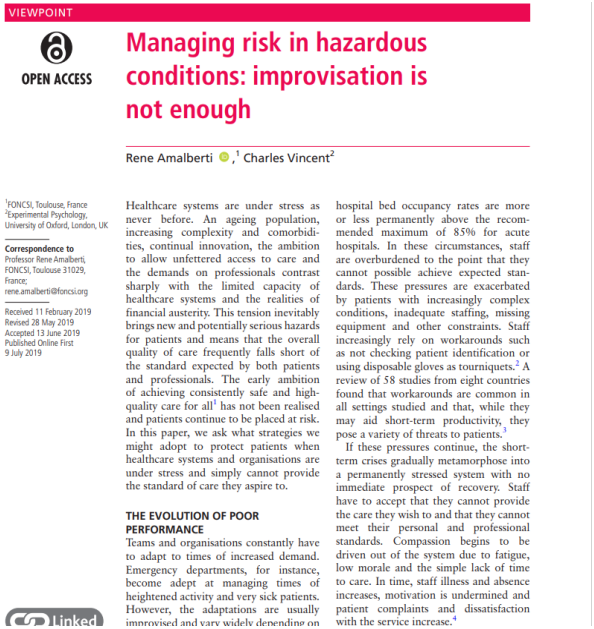
- Provide training and prepare patients and carers
- Instil culture of safety without alarming the patient
- Mitigate the impact of errors
- Ensuring the patient is fully briefed in emergency procedures, letter for emergency department
- An explicit and comprehensive set of safety strategies

Adaptive Strategies for the Short-term

Improvisation is Not Enough

- *" The pressure on all healthcare systems is simply the daily reality for all clinicians and managers and for any patient or family member dealing with serious illness"*

- *"The first priority in developing practical strategies is to carry out primarily descriptive studies…. "*



VIEWPOINT

OPEN ACCESS

Managing risk in hazardous conditions: improvisation is not enough

Rene Amalberti [1], Charles Vincent [2]

[1]FONCSI, Toulouse, France
[2]Experimental Psychology, University of Oxford, London, UK

Correspondence to
Professor Rene Amalberti, FONCSI, Toulouse 31029, France;
rene.amalberti@foncsi.org

Received 11 February 2019
Revised 28 May 2019
Accepted 13 June 2019
Published Online First
9 July 2019

Linked

Healthcare systems are under stress as never before. An ageing population, increasing complexity and comorbidities, continual innovation, the ambition to allow unfettered access to care and the demands on professionals contrast sharply with the limited capacity of healthcare systems and the realities of financial austerity. This tension inevitably brings new and potentially serious hazards for patients and means that the overall quality of care frequently falls short of the standard expected by both patients and professionals. The early ambition of achieving consistently safe and high-quality care for all[1] has not been realised and patients continue to be placed at risk. In this paper, we ask what strategies we might adopt to protect patients when healthcare systems and organisations are under stress and simply cannot provide the standard of care they aspire to.

THE EVOLUTION OF POOR PERFORMANCE

Teams and organisations constantly have to adapt to times of increased demand. Emergency departments, for instance, become adept at managing times of heightened activity and very sick patients. However, the adaptations are usually improvised and vary widely depending on hospital bed occupancy rates are more or less permanently above the recommended maximum of 85% for acute hospitals. In these circumstances, staff are overburdened to the point that they cannot possible achieve expected standards. These pressures are exacerbated by patients with increasingly complex conditions, inadequate staffing, missing equipment and other constraints. Staff increasingly rely on workarounds such as not checking patient identification or using disposable gloves as tourniquets.[2] A review of 58 studies from eight countries found that workarounds are common in all settings studied and that, while they may aid short-term productivity, they pose a variety of threats to patients.[3]

If these pressures continue, the short-term crises gradually metamorphose into a permanently stressed system with no immediate prospect of recovery. Staff have to accept that they cannot provide the care they wish to and that they cannot meet their personal and professional standards. Compassion begins to be driven out of the system due to fatigue, low morale and the simple lack of time to care. In time, staff illness and absence increases, motivation is undermined and patient complaints and dissatisfaction with the service increase.[4]

OPEN ACCESS

Health services under pressure: a scoping review and development of a taxonomy of adaptive strategies

Bethan Page ,[1,2] Dulcie Irving,[1] Rene Amalberti ,[3] Charles Vincent [1]

► Additional supplemental material is published online only. To view, please visit the journal online (http://dx.doi.org/10.1136/bmjqs-2023-016686).

[1]Department of Experimental Psychology, University of Oxford, Oxford, UK
[2]Cicely Saunders Institute, King's College London, London, UK
[3]Foundation for Industrial Safety Culture, FONCSI, Toulouse, France

Correspondence to
Bethan Page, Department of Experimental Psychology, University of Oxford, Oxford, Oxfordshire, UK;
bethan.page@psy.ox.ac.uk

Received 29 August 2023
Accepted 7 November 2023

ABSTRACT

Objective The objective of this review was to develop a taxonomy of pressures experienced by health services and an accompanying taxonomy of strategies for adapting in response to these pressures. The taxonomies were developed from a review of observational studies directly assessing care delivered in a variety of clinical environments.

Design In the first phase, a scoping review of the relevant literature was conducted. In the second phase, pressures and strategies were systematically coded from the included papers, and categorised.

Data sources Electronic databases (MEDLINE, Embase, CINAHL, PsycInfo and Scopus) and reference lists from recent reviews of the resilient healthcare literature.

Eligibility criteria Studies were included from the resilient healthcare literature, which used descriptive methodologies to directly assess a clinical environment. The studies were required to contain strategies for managing under pressure.

Results 5402 potential articles were identified with 17 papers meeting the inclusion criteria. The principal source of pressure described in the studies was the demand for care exceeding capacity (ie, the resources available), which in turn led to difficult working conditions and problems with system functioning. Strategies for responding to pressures were categorised into anticipatory and on-the-day adaptations.

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ Healthcare systems are operating under substantial pressures and often simply cannot provide the standard of care they aspire to within the available resources.

⇒ Organisations, managers and individual clinicians make constant adaptations in response to these pressures which are typically improvised, highly variable and not coordinated across clinical teams.

WHAT THIS STUDY ADDS

⇒ This paper presents an empirically developed taxonomy of pressures and strategies providing a menu of options that can be used by clinical leaders and teams, to help them adapt when healthcare systems and organisations are under stress and simply cannot provide the standard of care they aspire to.

Scoping Review: Pressures and Strategies

Staff skill-mix mismatch with demand

The intended increase in capacity was compromised by a skill mix problem.

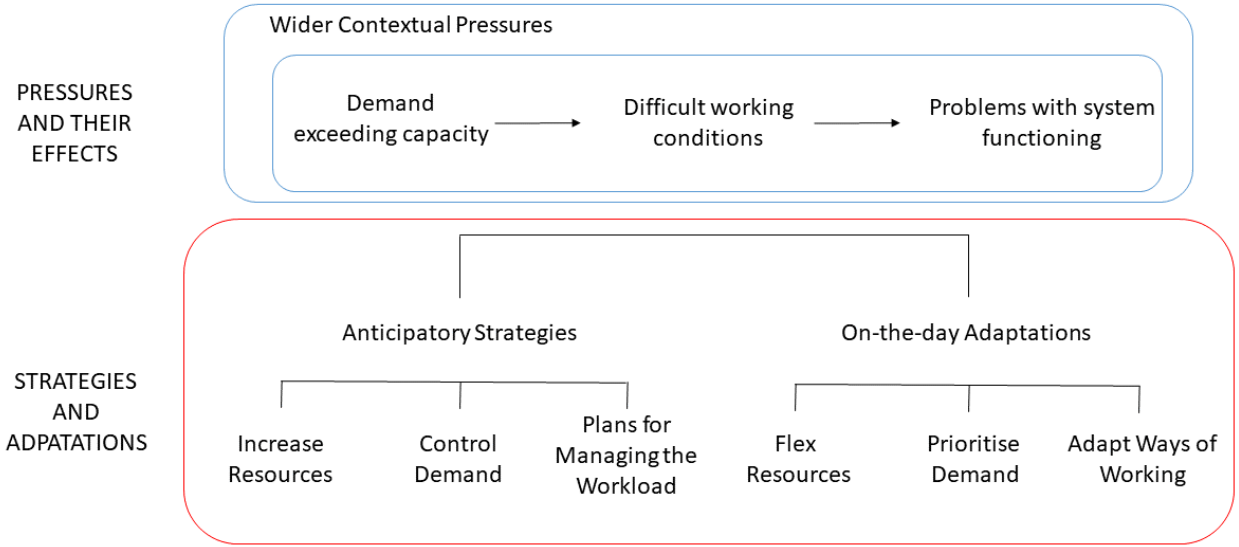
Improve skill-mix

Training staff in more general and acute functions allowed them to offer support in the high-demand wards (Gifford et al., 2022)

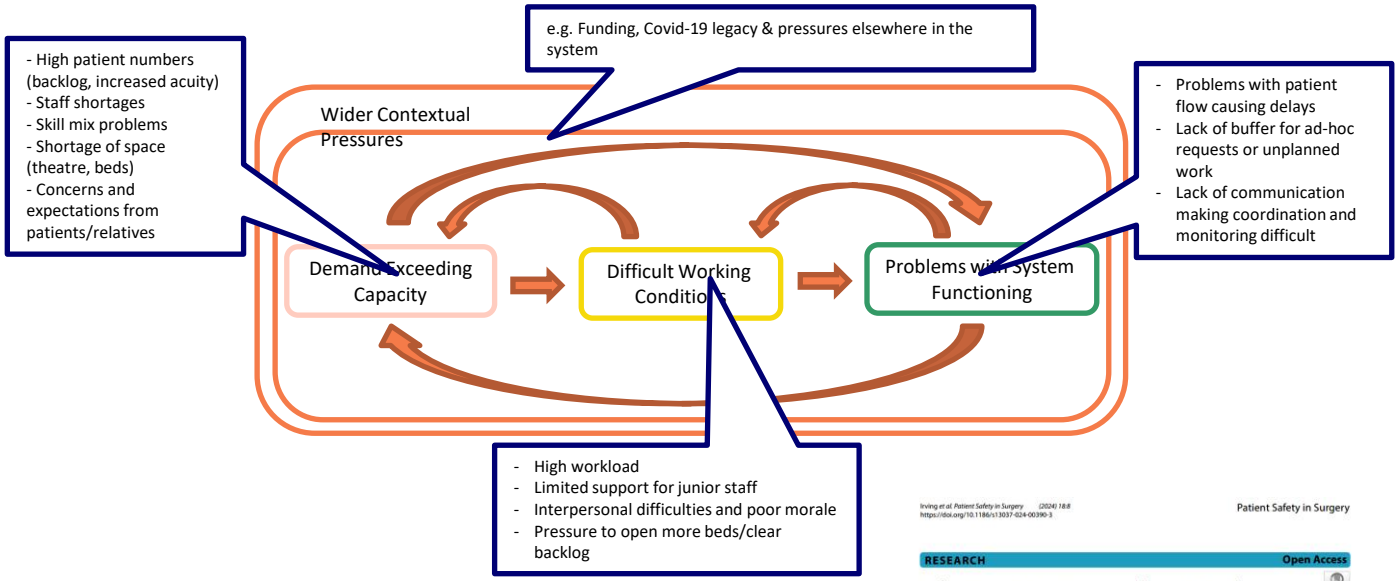
Flexing staff to address skill-mix

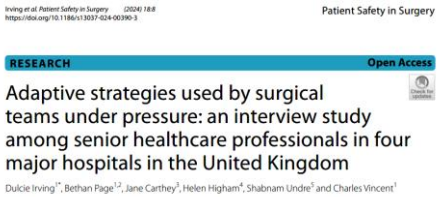
Mixed care teams with at least one experienced staff member to counterbalance and support the high number of junior staff (Saurin et al. 2022)

Conceptual Framework



Pressures in ICU and Surgery




Irving et al. Patient Safety in Surgery (2024) 18:8
https://doi.org/10.1186/s13037-024-00390-3

Patient Safety in Surgery

RESEARCH Open Access

Adaptive strategies used by surgical teams under pressure: an interview study among senior healthcare professionals in four major hospitals in the United Kingdom

Dulcie Irving[1*], Bethan Page[1,2], Jane Carthey[3], Helen Higham[4], Shabnam Undre[5] and Charles Vincent[1]

Strategies for adapting under pressure: an interview study in intensive care units

Bethan Page ,[1,2] Dulcie Irving,[1] Jane Carthey ,[3] John Welch,[4] Helen Higham ,[5,6] Charles Vincent [1]

Page B, *et al*. *BMJ Qual Saf* 2024;**0**:1–11. doi:10.1136/bmjqs-2024-017385

Main Objective When Under Pressure

"That's a really good question, because I could very easily say patient safety, but you can't… What's the main objective? We have to manage the risk to the best of our ability. That's the main objective, I think. I think the main objective on a day like that is risk management, and you can't walk around being risk averse, because obviously risk has gone up, hasn't it? So it's risk reduction, as much as you possibly can."

Anticipatory Strategies (ICU)

Examples

Improve skill-mix

“We’ve looked at upscaling our HCA just to have more awareness of deteriorations in blood pressure and things like that to just help them along, to give them that reassurance. That they’ve got the confidence to say, I don’t know what’s going on with that patient, but his blood pressures changed by 20, you might want to have a look.”

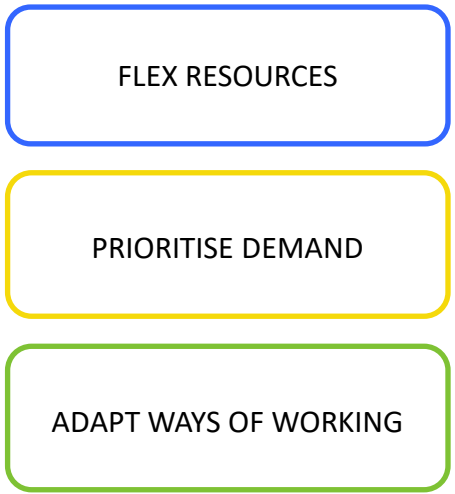
Discharge patients

"*The pressures of the wider hospital and the beds, we've discharged quite a few people home from critical care instead of to a ward, which was never heard of before*"

Use of protocols

“There's a lot of mixed messages from the organisation, and outside of the organisation, that it’s a Christmas day service. And so, if it’s a Christmas day service, we apply the staffing model that we would on a Christmas day service”

On-the-day Adaptations (ICU)



Examples

Task-shifting

“Fairly large education team who are pretty skilled. On the days when things are tight, they have to stop educating and start caring for patients.”

Temporarily stopping or delaying activities/types of care

“Tell people that actually it’s okay if you can’t, for example, turn that patient for four hours if you’ve had other things to do. Sometimes you can delay an antibiotic for an hour.”

More huddles/team communication

"It’s not just the daily huddle at the beginning. When the days are really busy, what I’ll do is I’ll recall to the office, and I’ll just say, can folks come to the office for a bit of a huddle? And then we’ll test and adjust."

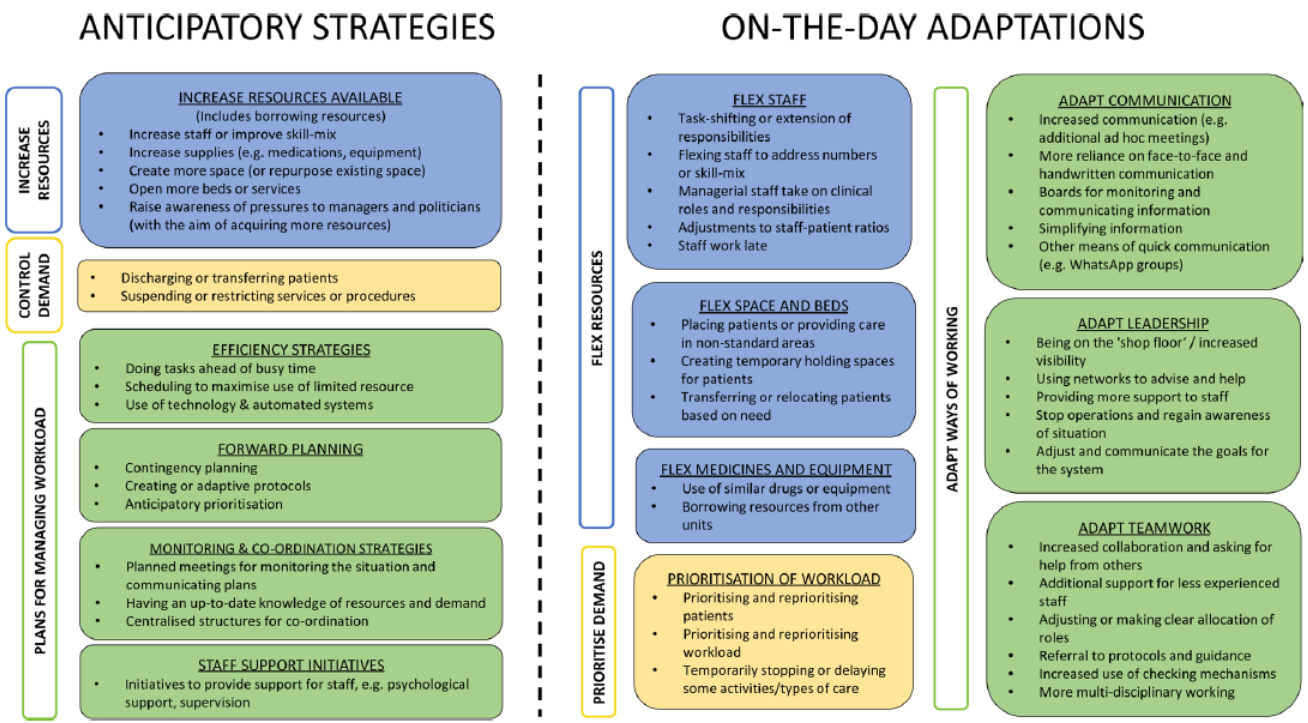
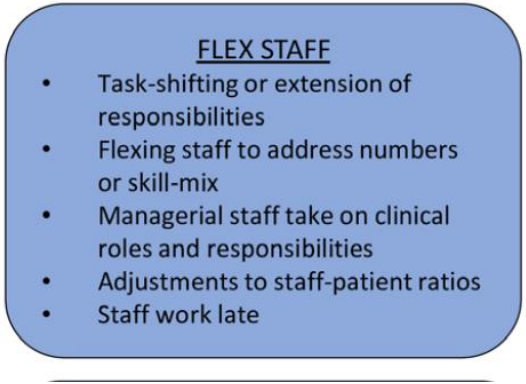


Figure 3 A taxonomy of strategies for adapting to pressures. The taxonomy includes two broad classes of adaptive strategies: anticipatory strategies to prepare for pressures and on-the-day adaptations to manage immediate pressures.

Examples of Generic on the day Adaptations



What does this mean for clinical teams and leaders?

Training in Managing Risk

- Total and SNCF training in values to maintain ‘safety first’ in adverse conditions
- Focus is on conflict and management of conflicts between safety and production pressures
  - Training in managing competing priorities at executive level
  - Middle managers as buffers between frontline and executive
  - Compensatory strategies at the frontline

TOTAL

FONCSI
Foundation for an Industrial Safety Culture

SNCF

Guiding Questions for the Short-term

- What are our main pressures? What effect do they have on working conditions and the system?
- What strategies do we currently use, either improvised or planned?
- What choices do we have for:
  - Anticipatory strategies
  - On the day strategies
- What time limits and restraints should we put on adaptive strategies?

Implications for Leaders: Short-term

- Acknowledge and communicate openly when standards cannot be met
- Allow and encourage adaptations that are explicit, shared and monitored
- Training programmes can be developed
- A coordinated approach to adaptation will be safer than ‘hidden’ individual and team adaptation
- Adaptations are not forever!

Guiding Questions for the Longer-term

- To improve safety (and quality) across a clinical area:
  - What processes need to be reliable?
  - What aspects of the system would be most beneficial to improve?
  - What restraints and risk controls would be helpful and proportionate?
  - Where do we need to increase scope for monitoring and response?
  - How will we mitigate any harm that occurs?

Implications for Leaders: Long-term

- Use a portfolio of strategies that can be customised to context and problem
- Maintain long-term programmes at times of pressure
- Shift to projects that aim to reduce burden on staff
- Simplification and standardisation will improve both safety and efficiency

A Portfolio of Strategies

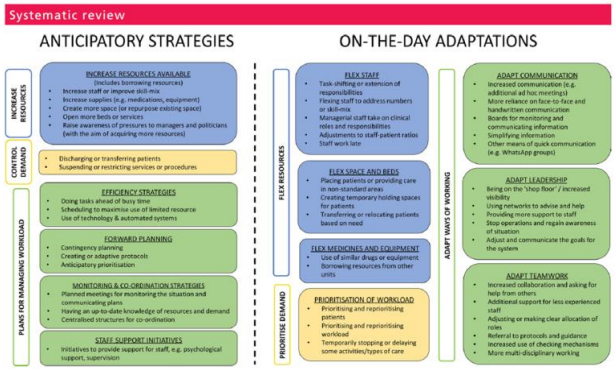


Figure 3 A taxonomy of strategies for adapting to pressures. The taxonomy includes two broad classes of adaptive strategies: anticipatory strategies to prepare for pressures and on-the-day adaptations to manage immediate pressures.

Families of safety interventions

- Best practice
- Improve the system

Optimising Strategies

- Risk control
- Adapt & respond
- Mitigation

Risk Management Strategies

Q&A

Morning Breakouts

Breakout sessions. Focussing on SPSP Essentials of Safe Care

- Values based reflective practice (VBRP) and the creation of psychologically safe spaces
- Staff wellbeing for safety
- Creating a learning system within and between boards

Poster & networking session open over morning coffee and lunch in Creation Room located off main reception area