Understanding the factors influencing implementation and integration of a new national patient safety policy: Lessons from Learning from Deaths

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Background

- LfD was introduced across NHS Trusts in 2017

- Aimed to promote:
  - Systematic case sampling and review of deaths by trained reviewers
  - Governance systems
  - Better care of families after bereavement

- Other developments:
  - Roll out of the Medical Examiner programme

Study Aims and Objectives

Aims

- To determine how external and internal contextual factors shaped the implementation and integration of a new patient safety policy and influenced patient safety priorities and actions within a range of English NHS providers.

Objectives

- Understand the development of the LfD policy in the context of key drivers of change in the patient safety agenda at the national level and how these influenced programme goals
- Compare how a range of NHS organisations have implemented the LfD policy
- Identify which implementation and integration factors at macro, meso and micro level have enabled or hindered the attainment of the LfD goals

Objective 1: Understanding the development of LfD

Method

- Semi-structured interviews with stakeholders (n=12) (DHSC, NHSE/I, CQC, national experts) to establish key drivers of development, intended goals, perceived challenges to implementation

Key findings

Context: avoidable harm, transparency, measurement

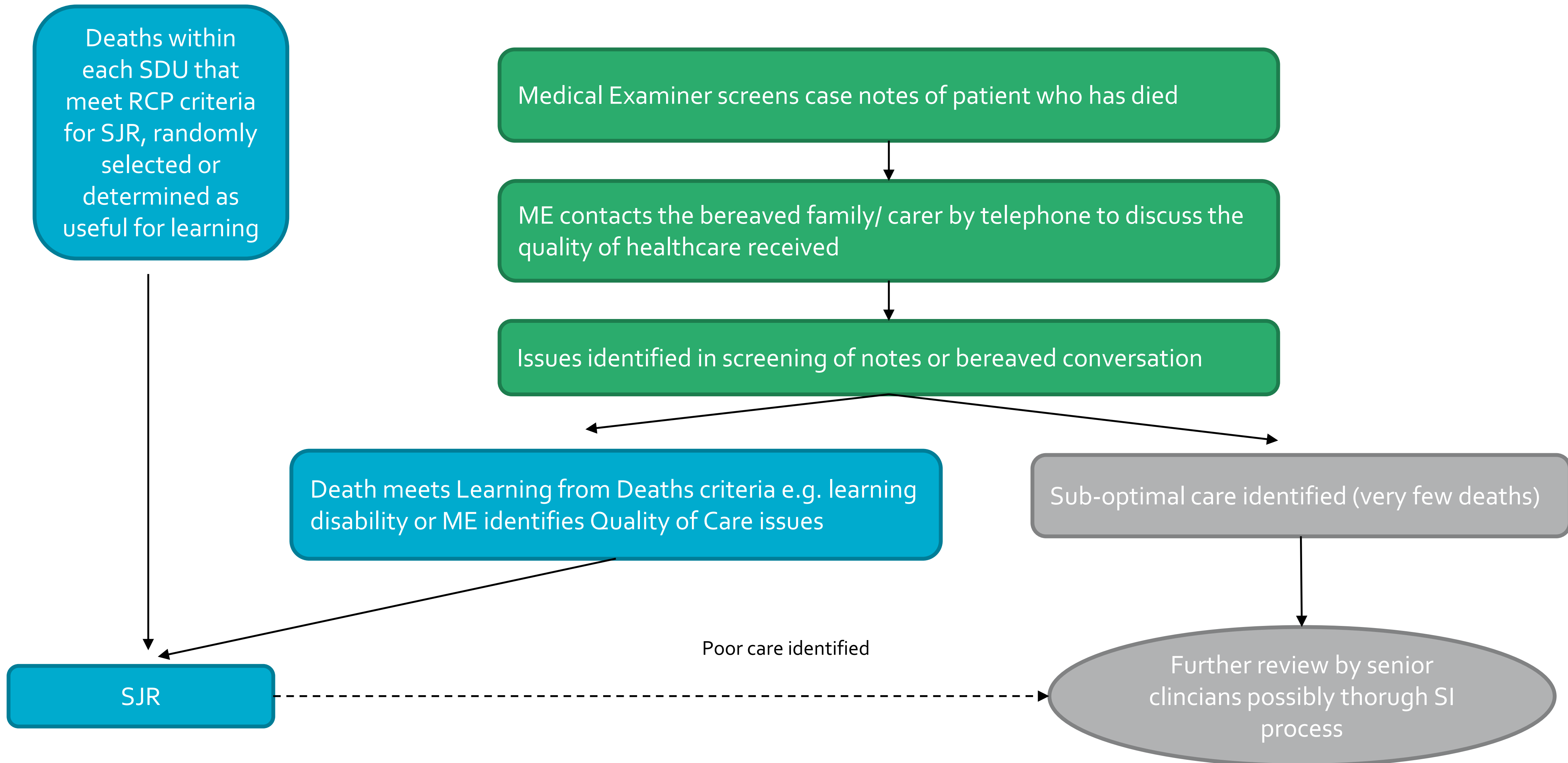
Policy window: Southern Health independent review and CQC report
Learning, candour and accountability

Objectives 2 and 3: compare how NHS organisations have implemented LfD and key enablers and challenges

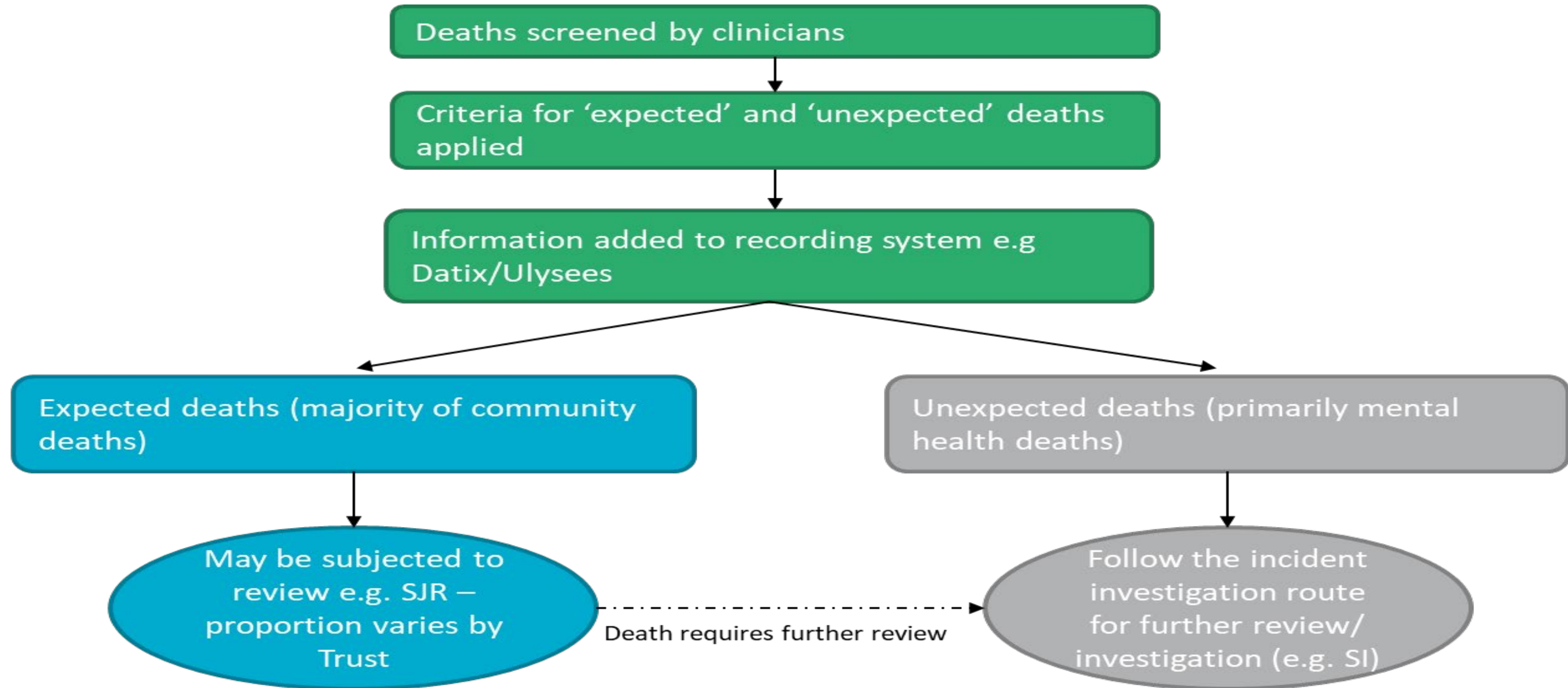
Method

- Case studies - field work in five Trusts (3 acute, 2 CMHT) during 2019/ 2020
- 40 semi-structured interviews (NED, Medical Directors, Clinical Directors, Chief Medical Officers, Chief Nurses, Patient Safety Managers, Complaints and Incidents Managers, Medical Examiners, senior clinicians)
- 30 hours observation of meetings (MRG/MSG, SI panels, M&M, EOLC meetings, regional mortality meetings)
- Documentary review (LfD policy, Quality Accounts, meeting minutes, Board papers, reports)
- Use of Damshroeders “Consolidated Framework of Implementation Research” to identify themes (challenges and enablers to achieving LfD intended goals)
- Workshop for Trusts to discuss findings

Findings: Acute Models



Findings: CMHT Models



Expected – death of a patient anticipated
Unexpected – death of a patient is sudden or not anticipated

External and Internal Factors Affecting Implementation and achievement of LfD goals

System in place to gather information on deaths for learning

CFIR	Implementation Enablers	Implementation Barriers
Outer Setting	External networks	Funding, top down implementation
Inner Setting	Broadened awareness, historical context, **clinical leadership**	
Intervention characteristics	Uniformity of approach to replace variety, defined roles	**Adapted for different contexts**
Individual characteristics		Workload, lack of shared responsibility
Implementation process:	Vision of organisation, defined roles, **ME**	

Synthesising learning across the organisation

CFIR	Implementation Enablers	Implementation Barriers
Inner Setting	**Structures and processes in place for sharing**	Physician engagement, MDT engagement
Intervention characteristics		Unclear value
Individual characteristics	Intra-organisational boundary spanners	**Human integrators**
Implementation process	Variety of mechanisms for intra-Trust learning, **integration of safety programmes**, triangulation of safety data, **learn from positives**, action-orientated information	Ability to learn, quality of information, **siloed information**, data management

Organisation-wide learning with assurance and transparent reporting on performance

CFIR	Implementation Enablers	Implementation Barriers
Inner Setting		**Focus on performance data, publicly available information, policy-maker motives, framing**
Intervention characteristics	**Role of NED**, increased transparency	Board learning vs performance
Individual characteristics	Developing learning culture	Defensive behaviours
Implementation process:	**Independence of reviews**, quality control, ME role	

Improved experience of families and carers

CFIR	Implementation Enablers	Implementation Barriers
Inner Setting		**Poor integration of safety information**
Intervention characteristics	**Focus on end of life** Improved communication	
Implementation process:	Use family and carer feedback	Families and carers request SJRs, **mechanisms for feedback**

Promotion of inter-organisational learning (across care boundaries)

CFIR	Implementation Enablers	Implementation Barriers
Outer Setting	**Cross-provider relationships**	**Information sharing across organisations, inter-agency collaboration**
Individual characteristics	**Inter-organisational boundary spanners**	
Implementation process:	Established multi-agency working, coordinator	**Siloed learning**

Summary (1)

- Elements likely to promote sustainability of programme

Acute	CMHT
Standardisation of tools, structures e.g. role of M&M and MRG	Ability to adapt LfD to better suit structures e.g. incident reporting system
Strong clinical leadership to shape vision/ values and engagement	Leadership able to secure extra resources from the board
Sharing and learning with external peers	Effective triangulation of safety data and utilised for thematic reviews
Integration with ME programme helps manage workload	Multidisciplinary reviewing
Board level representation via NED	Effective cross-organisational relationships
Promotes cultural shift towards increased transparency and openness	

Summary (2)

Threats to goals

Acute Trusts

- Narrow scoped use of data
- Failure to disseminate learning across the organisation to keep reviewers engaged and motivated
- Underuse of resources of wider MDT
- Boards still performance-orientated
- Time and resources for cross-organisational work

CMHT

- Tailoring to needs of MHT given the origins of MH, longer term trajectories of care
- Need other organisations to commit to system learning

Setting our findings in the wider context

- Programmes addressing wider system issues have a high profile- result in high levels of engagement initially but sustainable adoption is much more challenging
- Sustained adoption is determined by local level factors such as technical and financial resource, staff engagement, leadership, clarity of purpose, culture etc. (Dixon-Woods, 2019)
- Successful implementation developing a ‘coalition of the willing’ (Dixon Woods, 2019)
- Role of Board – set the tone for an organisation, encourage openness, promote engagement in patient safety work, supports staff to focus on learning and improvement (Mannion R, 2018)
- Implementation is facilitated by external peer networks (AHSNs) (Illingworth, 2020)

Implications for the policy cycle

- **Design**
  - National coalition and wide engagement
- **Piloting:**
  - Fit
  - Enablers and challenges to implementation,
- **Introduction**
  - Clear articulation at the point of introduction, measurement reflects values and goals
  - Roles
  - Flexibility
  - Peer support and learning
- **Monitoring**
  - Understand how programme is changing/ adaptations
  - Support enablers
  - Further gain likely or not

Future Development

A number of elements in the National Patient Safety Strategy (2019) could influence sustainability

- Patient Safety Specialists
- Patient Safety Incident Management System
- Patient Safety Incident Response Framework

Integrated Care Systems

- Forums for sharing information and learning across care system
- Role of regulator
- Integrated digital care records and data sharing barriers addressed

Any Questions?

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