2nd Meeting of the Clinical Human Factors Group Summary and Action Points 6 Dec 07

Hosted by the Healthcare Commission, London

Background

In our September 07 meeting we started the process of working on our two priority workstreams:

> "Developing an evidence base to demonstrate the role human factors plays in patient safety and
>
> Engaging the broader NHS in human factors by raising awareness of HF."

The 2nd meeting aimed to move forward both of these, with the majority of time to be spent discussing the "evidence" gathering exercise which ran from October to November.

Attendees

Simona Arena (for Gill Hastings), Martin Bromiley, Jane Carthey, Murray Devine, Bev Norris, Jim Reason, Hugh Rogers, Chris Sadler, Linda Watterson. As our host, Sir Ian Kennedy joined us to explain his view on the importance of our work, and we were also joined by Maggie Kemmner of the HCC.

Summary of Discussions

Sir Ian joined to welcome us and talk about the importance of our work (more of this in a moment). The second meeting had a very different "flavour" to the first. Whilst the first meeting had been very action orientated, the second saw a greater discussion of some of the key assumptions about our work. This went to such an extent that we over-ran our time and have continued the discussion over email for the last week or so! Before moving on to the specific items on the agenda it's very important to share the nature of our discussion (both on the 6 Dec and subsequently).

<u>The "safety agenda" and influential people's view of the CHFG</u> – The point was made (in the light of Sir Ian's comments) that at last the safety agenda really does seem to be attracting the proper attention of those in a position of power (I don't include Sir Ian as he's always been in the vanguard of those championing patient safety). The point was also made that the CHFG "has the eyes and ears of many influential people in healthcare at the moment". That is a position that we must use wisely, it is our best chance.

<u>Scope of the CHFG and our purpose</u> – The scope of our work and the value, or "unique selling point" of the CHFG was queried. . Is "Human Factors" an appropriate title, as this encompasses a massive range such as equipment design, personal skills, process development, systemic problems etc. Jim Reason offered the following:

What exactly is our unique selling proposition? What do we have that other influence groups don't? I don't really have the answers to those questions, but y'all might. Susan Sheridan is a good model here. She's giving the paediatricians (pediatricians in the USA) a very hard time about kernicterus. Maybe we should go after some targets that don't include nosocomials. Which brings me belatedly to my point: we need to focus on specific issues. Human factors is too broad and too diffuse as it stands.

Jane Carthey offered this:

we have acheived some degree of acceptance that even given the problems associated with the term 'human factors', it's the phrase that is out there and one healthcare staff are becoming increasingly familiar with. From now on we need to focus on the collection and collation of stories. They will raise awareness and change people's attitudes and behaviours.

Hugh Rogers:

I am very clear that this group adds value in bringing together like minded folk, while at the same time influencing the broad safety agenda, and trying to align with it.

Linda Watterson:

However, I think the key point to bear in mind is the positive response we keep getting from frontline staff and from those in touch with front line staff. There really does seem to be a desire to have information, resources and signposting to key information. I think our discussion yesterday reflected that we are in a position to draw together some good material and to make it easily accessible to the staff who want it..

The value of "evidence" gathering – What is evidence? There was criticism of an "over-focus" on trying to get "evidence". There's a push in current clinical work of things being "evidence based". It was felt by some that this was a throw back to drug trials which are very precisely controlled yet it's hard to apply the same principles to "human factors". We could be searching for the perfect evidence and creating an expectation among clinicians that the perfect evidence is out there when in fact it may be unobtainable.

There was also the comment that we may be guilty of focussing on human error and failure, but not human heroes or "saves", where good "non-technical skills" etc saved a situation.

There is evidence which is well researched and should be included in our "evidence base", the work at Great Ormond Street (Jane Carthey, Allan Goldman & Marc De Leval), the work from Peter McCulloch & Ken Catchpole et al from Oxford and the work done in Aberdeen & Stirling from Rhona Flin and Nikki Maran. We can add value here by including both summaries of work and more detail background reading on each piece of work in our "portfolio" of evidence/stories. This way these milestones of research can be read by frontline clinicians, managers and policy makers, not just those who subscribe to specific journals.

Murray Devine offered the following in response to the question of evidence and our "value" or "USP":

> *I suspect we should not set out with too high an ambition for repeating the apparent transformation in thinking that occurred in some circles within civil aviation. But any life possibly saved from persuading some practitioners to reflect on the "stories" and thereby be motivated to reduce the consequences of error, just has to be right. I think the trap to avoid is the temptation to formulate some "master plan" that will knit together all aspects of the curriculum, through the provision of training and of implementation tools, to dealing with behaviour and attitude (including that involving rejection).*
>
> *My preference would be to identify a realistic and modest niche for the Group's activity for the first couple of years, possibly including the collation and headline interpretation of the "stories", their promotion via the website and other activities, and a positive focus on the potential for real improvement in securing better outcomes - for patients and for clinicians.*

From my own perspective I offered this:

> *One thing I've pondered on is whether we should focus on specific areas, such as "team skills", "CRM", etc. I'm not sure. There is a massive amount of work to be done in healthcare, such as equipment, process, systems, CRM etc. Maybe we can help initiate some of it or maybe it's too much?*
>
> *The issue for me is that there is very little understanding of "HF" at the grass roots and at management level. Clearly we can't do it all, so maybe our USP is communicating, selling, and persuading people that HF is important and then leaving it to the experts (including members of the CHFG) and frontline staff (with the Royal Colleges, NPSA, NHS III and HCC) to recommend, examine, certify and even regulate? This way we can help to move the cultural change forward, something I don't think we could do if we were even more focussed on very specific projects.*

<u>My view as of today, 20 Dec 07</u>

I've no doubt we all have our own view on how things should move forward, but perhaps you'll allow me to offer this proposal. If we go back to the original reason for me believing such a group was necessary; it was because much of the work on HF in the UK was confined by organisational boundaries (with all the inherent problems that brings); and that awareness of HF was generally limited to those in specialist posts.

For that reason I believe we should continue aiming to be an “influencing and sharing group”. Our USP being that we’re the only group doing this within the “human factors” arena; and that at least for the time being we should not narrow down or exclude anything under that broad agenda, I believe prioritisation will happen naturally. Our long term value to healthcare will be in creating an awareness of human factors so that an understanding of the topic will underpin the work of frontline staff, as well as managers and policy makers. This is all still very broad, but I believe if we focus too heavily on specific areas we will be seen as constraining the applicability of human factors in healthcare to a few narrow arenas.

With that in mind I propose that the final vision & mission statements should read:

Vision

The CHFG’s vision is to engender human factors thinking in the hearts and minds of all healthcare staff and stakeholders. From board to ward and beyond…

Mission

Our mission is to facilitate understanding about how humans interact with their environment and those around them, and to use this to improve patient safety by reducing the possibility and impact of errors.

So what about the Action Points!

Main Item 1 – Key work stream “Developing an evidence base to demonstrate the role HF plays in patient safety”.

In the light of the discussions above it was agreed that it might be better to refer to this workstream as developing a “portfolio” of stories and evidence.

Chris Sadler and Martin Bromiley wrote and sent out a letter asking for people to contribute. The responses were gathered by The Health Foundation and reviewed by Bev Norris. In all 8 people responded with a total of 34 items of “evidence” or materials. It may not sound like much but the file is already very thick. It includes some research already mentioned above as well as new material. One commercial provider also “donated” a raft of material. Sincere thanks to all of you who submitted.

However it was felt the material received is far short of what the Group would hope to get. The point from September was repeated, namely that the richest source of HF “evidence” is likely to be within the supporters of the CHFG, all of us for one reason or another have identified that understanding HF is critical to improving patient safety. The point had also been made by a number of supporters that the deadline was too tight. In the case of one clinician I spoke to, his own “story” is so emotional for him that it will take a number of months of drafts and re-drafts to get it right.

There was strong recognition, (and later again in the subsequent emails which have been quoted from above) that this exercise is core to the CHFG. If we can't get the "stories/evidence portfolio" together we can't convince anyone.

Action Point 1 – Martin Bromiley and Chris Sadler to write again to the supporters of the CHFG asking for a response to the original letter. Deadline to be discussed. Bev Norris to find two good examples from those submissions already received to add to the letter as an example.

Action Point 2 – A second email address to be set up by Suzanne Meadowcroft on the website to receive "stories/evidence" on an on-going basis. Examples will be published on the website (to be selected by Bev Norris). This is something we'll be able to publicise at conferences etc on an on-going basis.

With the work received we looked at how each could be analysed. A dry run was done on Martin Bromiley's submission (his late wife's death). Analysing and providing good "HF" comment was found to be quite challenging, especially given the nature of some of the evidence received. For this reason…..

Action Point 3 – Bev Norris to send out paper copies of story/evidence file so far received to Martin Bromiley, Jane Carthey and Chris Sadler. All 4 people to review and generate (after email & telephone discussion) a format for review. (Some examples discussed at the meeting are attached in appendix 1).

Action Point 4 – Once a format is agreed we will hold an open meeting/workshop of the whole group (as done in June) aiming, amongst other things, to set up small groups to analyse/review stories and evidence to create the "portfolio" that same day. The CHFG will aim to publish these, both on the website and in paper form (probably a folder which can be carried by members, as well as being posted to influential people and left on coffee tables in hospitals). Further discussion will be required on the format, production and distribution. (Regarding costs, both The Health Foundation and NPSA have indicated they would be happy for their funding of the CHFG (see later) to help cover such costs).

Commissioned academic literature review around "human factors". The following excellent examples were noted:

> Patient Safety by Charles Vincent (probably the best summary of the topic for frontline staff and managers, £21)
> Safety and Ethics in Healthcare by W Runciman, W Merryman and M Walton
> Human Error in Medicine (soon to have a 2nd edition with new chapters, ~£30) by S Bogner
> Handbook of Human Factors and Ergonomics in Healthcare and Patient Safety by P Carayon (a massive recent handbook, ~£114)

Main Item 2 - "Engaging the broader NHS in HF by raising awareness".

This is still very dependant on the "portfolio" from above. However we report the following.

Martin Bromiley did contact Bryan Stoten regarding a place for himself and the CHFG at the NHS Confederation Annual Conference. Unfortunately this doesn't appear to have progressed any further.

The idea of an internet forum was briefly discussed. At this stage our existing website can support a forum but it wouldn't be password protected and is probably more work than it's worth in the short term. We'll return to this idea in the future.

Regarding article writing. Martin has completed a draft article for BAMM, the British Association of Medical Managers which now requires expert comment. (Rhona Flin has suggested that one of her colleagues writes a second part analysing the story using their non-technical skills taxonomy developed for anaesthetics. Discussions on-going.) Once completed this could be passed to Hugh Rogers for publishing (using his contacts) in the HSJ. Martin has also completed and submitted an article for the Royal College of Anaesthetists "Bulletin" to be published in March. This mentions the CHFG, directing people to the website.

Action Point 5 - Tony Giddings still to contact Nicholas Timming from the FT and GMC about our work. Martin still to talk to Allan Goldman regarding the Wall Street Journal. Hugh Rogers to send article produced for BAMM (once complete as noted above) to HSJ .

Tony Giddings has looked at the CORESS Group with the thought of a possible link up, (Confidential Reporting System in Surgery, see www.coress.org). However he's aware that they don't seem very clued up on "HF" and the role of non-technical skills in surgical error. Tony will continue to work on this.

Martin Bromiley has suggested a meeting with Professor Sir Bruce Keogh via Martin Marshall as well as passing on the suggestion that the CMO might want to include reference to the CHFG in his next annual report as it's an example of what was suggested two years ago (learning from aviation). That would be a win-win for us and Sir Liam. All this was done prior to Martin leaving his post as DCMO to take up post with the Health Foundation. Martin Marshall did agree to raise both ideas but as yet there's no news from the DH.

At the last meeting it was felt wise to involve the "big" private sector players in our work. Martin Bromiley has failed to follow-up his contact with Andrew Vallance (Medical Director of BUPA) and the CEO of BMI, the healthcare group to talk about our work and seek support. This is due to too much to do!

Main Item 3 – The 3rd Workstream – Human Factors Training, review of a proposal to set-up a sub committee of training providers (commercial and internal).

You will recall that our 3rd workstream came from our June seminar. As a reminder is was proposed to:

- Analyse what training's been done, and what's worked and hasn't

- Identify opportunities for HF training to take place
- Build a core-curriculum, both in terms of behaviours to be trained, and topics to be covered. It has been suggested that in each case we should identify "musts", "shoulds" and "nice to"
- Identify how success can be measured on such training

This work would also provide a framework for the CHFG to "approve" programmes or organisations although that will require significant discussion.

The proposal from this meeting is that the 3rd Workstream could be set up as a sub committee to run parallel to the CHFG. Proposed membership would include commercial providers, any internal trainers, Sim centres (Stirling, Barts, St George's, Doncaster, Chelsea), NAMS (The National Assoc of Medical Simulators, who are already embarking on a similar project), the NHS III and the NPSA.

It was felt that it should be chaired by someone from within the NHS, and that the CHFG should establish approximate terms of reference, invite people to attend and set the first meeting.

Action Point 6 – Martin Bromiley to discuss further with Nikki Maran.

Main Item 4 – Developing the CHFG & Business Plan

Charitable Trust Status – This has been applied for and we are awaiting the response from the Charities Commission. I have proposed that to get the charity up and running we have three trustees, one is me; the other two are friends within my village. It is perfectly acceptable to the Charities Commission to have a small group of trustees delegate the work of the charity, which in this case will be the CHFG's Standing Group. Whilst this seems very incestuous the logic is it enables things to get going quickly (Inc bank accounts set up etc). Any of the trustees will be replaced if a member of the CHFG wishes to take over that responsibility. (At this stage I don't see a rush of volunteers but that may change as amounts of money increase and a need for greater financial scrutiny becomes evident).

Business Plan – As agreed this has been put together by Jane Carthey. A draft version is attached which we believe provides the "very high level" plan we require (a general statement of intent, not a rigid straight jacket). This is a document to be used to help put the CHFG into a framework that those within the system can appreciate. Business Plan attached.

Funding Update – You'll recall that £5000 had been offered by the Health Foundation. Until Charitable Status is confirmed we've asked the Health Foundation to manage the money for us (we have no bank account). Once the status is confirmed we will receive the money. Gill Hastings and Simona Arena have put in for a larger sum on our behalf for the current internal bidding process at the Health Foundation for which I thank them. We shall await further news. The NPSA have clarified their offer of £5000 from earlier on the year. It is conditional on us having a Business Plan

& on us keeping accounts of how the money is used. This is acceptable to us and we will take up the offer as soon as a bank account is set up.

Website – The website has run successfully on a test site. In the light of discussions at the last meeting I want to update some pages, but it should be up and running by the start of 2008. www.chfg.org   The email associated will be info@chfg.org which initially will come to me but this can be changed easily.

The next meeting of the Standing Group will be held on **Thursday 6 March 07 approx 1000 until 1530**. Location to be confirmed but likely to be London.

Appendix 1.

Rough notes for developing a template for analysing portfolio "stories/evidence"

1. Categorise replies using a matrix organised by "HF" heading and clinical speciality.

2. Develop expert comment on each case.

3. Provide questions to help analyse (both to those reviewing and for the final reader) and to prompt reflection on own practice:

> What steps could be taken to prevent this happening at an individual level?
> What are the key learning points for clinicians & managers?
> How could it have been handled differently?
> What issues are there about team working, communication, decision making, and awareness?
> What behaviours might have saved the day?
> How might people's personalities have affected the outcome?
> Where/what opportunities were there to prevent patient harm?
> What barriers/defences were in place that failed and why?