Hearing the Patient Voice

Welcome

11 March 2024

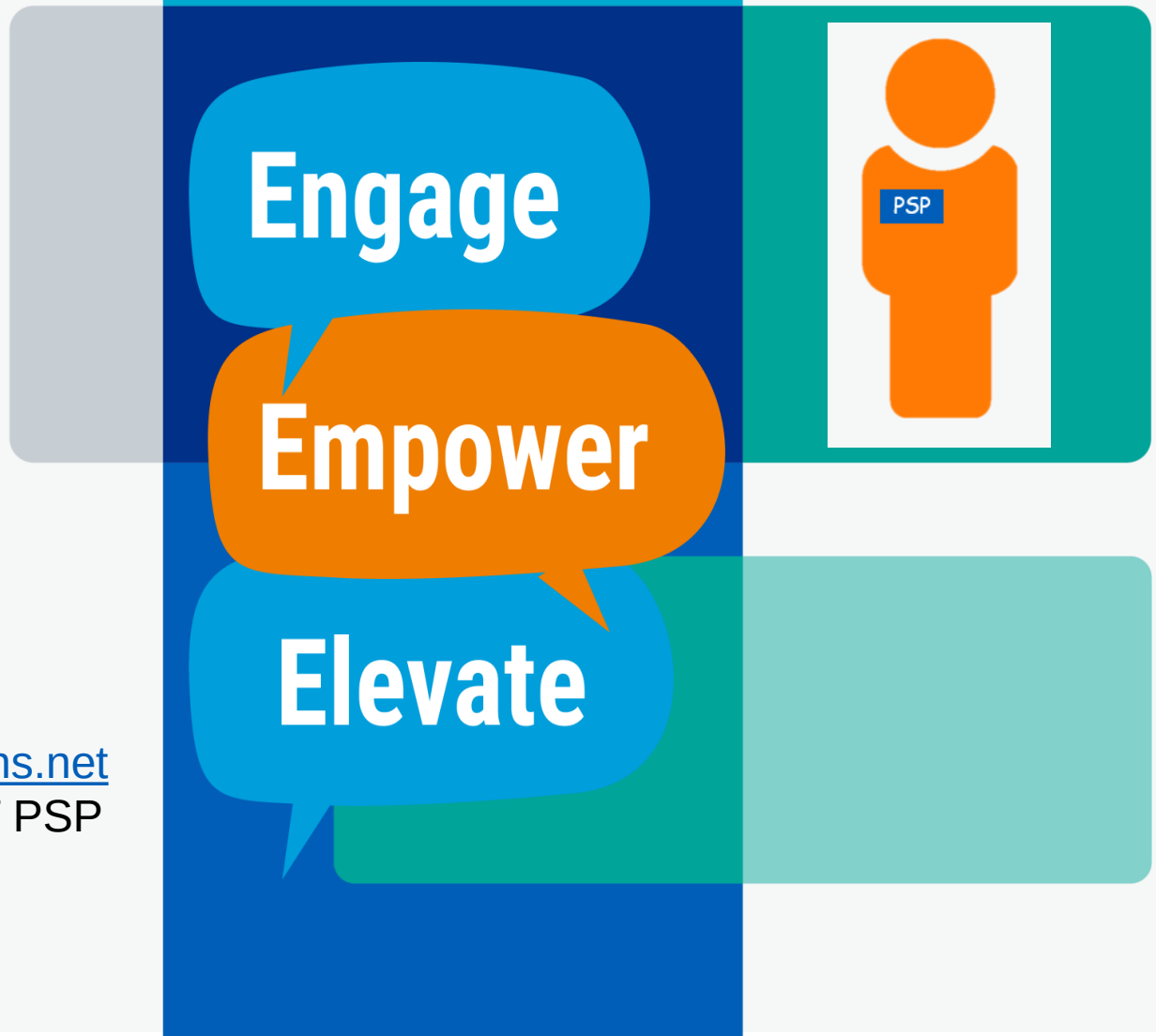
Involving Patients in Patient Safety

Hester Wain, Head of Patient Safety Policy, NHS England
Mark Smith, NHSE Patient Safety Partner (PSP) and SWYPFT PSP

@ptsafetyNHS

NHS England

Involving patients in patient safety

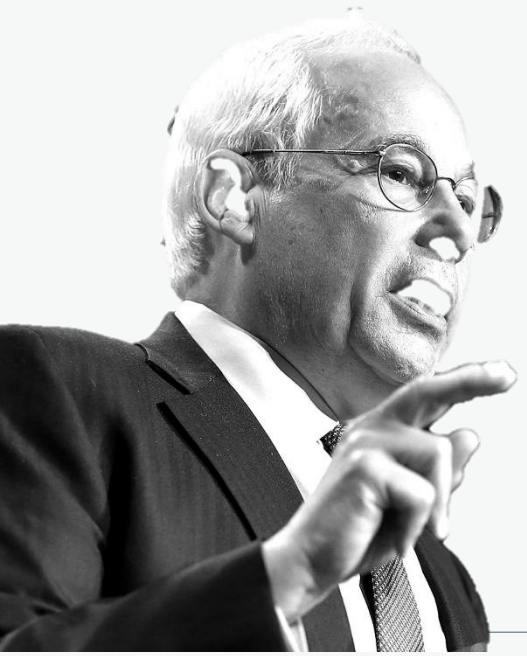


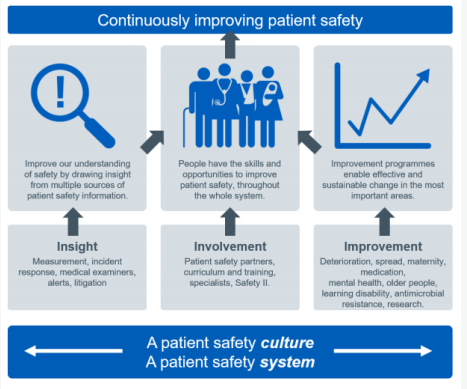
March 2024

- Hester Wain (she/her), #CallMe “Hes” or “Hester”
  Head of Patient Safety Policy, NHSE hester.wain@nhs.net
- Mark Smith, NHSE Patient safety partner & SWYPFT PSP

Our vision

"patients and their carers
should be
present, powerful partners"





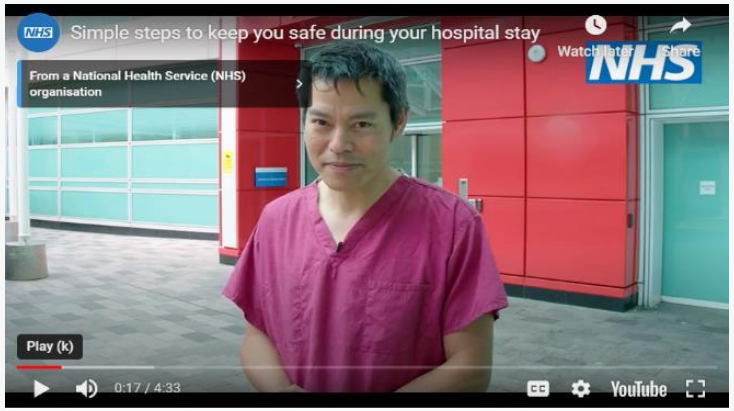
Involving patients in patient safety (IPIPS) framework

Part A:

Describes how organisations should support patients, their families and carers to be directly involved in their own or their loved one's safety eg video

Part B:

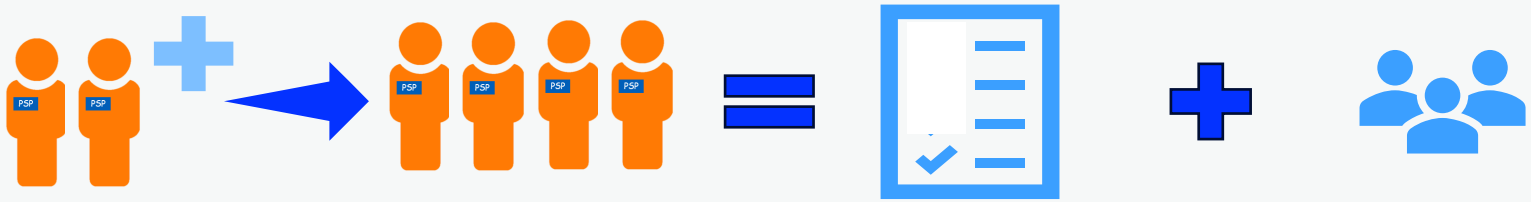
Describes how organisations should support patient safety partners (PSP) to be involved in wider governance and leadership of safety activities.



- Simple steps to keep you safe during your hospital stay
- Simple Steps with subtitles
- Simple steps comms toolkit
- Simple steps leaflet

PSPs are patients, carers, family members or other lay people recruited to work in partnership with staff to influence and improve the governance and leadership of safety within an NHS organisation.

IPIPS Framework key PSP concepts

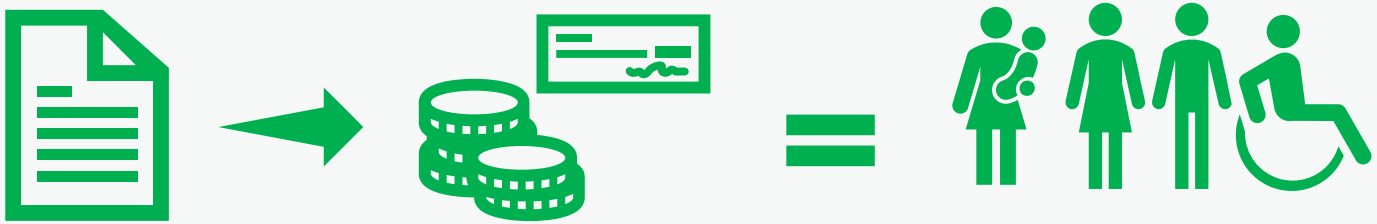


Patient Safety Partners

Role 4

Collaborate

Variety of tasks
Roles 1-4



Involvement Policy

Involvement Payments

Inclusion Diversity

NHSE PPV roles and payment

In line with: [NHS England Working with our Patient and Public Voice (PPV) Partners Policy]

Role 1 - Someone who chooses to attend, respond or comment on **open access engagement opportunities**, eg responding to online surveys. **No expenses can be claimed**

Role 2 - Someone who is invited to attend workshops/events/ focus groups on a **one-off basis.**
Out-of-pocket expenses should be covered/ reimbursed.

Role 3 - Someone who is a member of a **working group which meets regularly** that **does not make recommendations** to committees that have the delegated authority of the board.
Out-of-pocket expenses should be covered/ reimbursed.

Role 4 - Someone who participates in Expert Advisor roles, **decision-making activity**, including groups that **make recommendations** to committees that have the delegated authority **Out-of-pocket expenses and should be offered AND involvement payment**

By checking whether you have 2 or more PSPs in your organisation

... and enabling involvement payments

Most 'hard to reach' or 'lack of engagement' patients are due to barriers created in healthcare

Lack of education: English only leaflet, no one to talk things through with, non- representative guidance, no time to discuss in detail or hard to contact again

Psychological: Uncompassionate and bias interactions, feeling scared, no one to relate to their identity

Lack of resources: Limited slots, no privacy, poor infrastructure, lack of staff and rooms or treatment not available

Complex design -Too many steps: Expect them to ring and wait in a queue, attend, check in and fill a form

Time: Long waits, pressurised appointment or other commitments

Cost: Time, travel, waiting, parking or medication

Lack of cultural appreciation: Stigma attached to some conditions requires different approach

Location: Remote, tertiary centre, not near a bus route or poor parking

Communication: Lack of interpreters or only English language leaflets

Physical: Lifts or stairs

What if the problem isn't the patients? What if it's our approach, logic, biases and healthcare assumptions?

Services designed by well-educated, English speaking, non-diverse and stable income healthcare staff

Level of barriers generated for diverse population

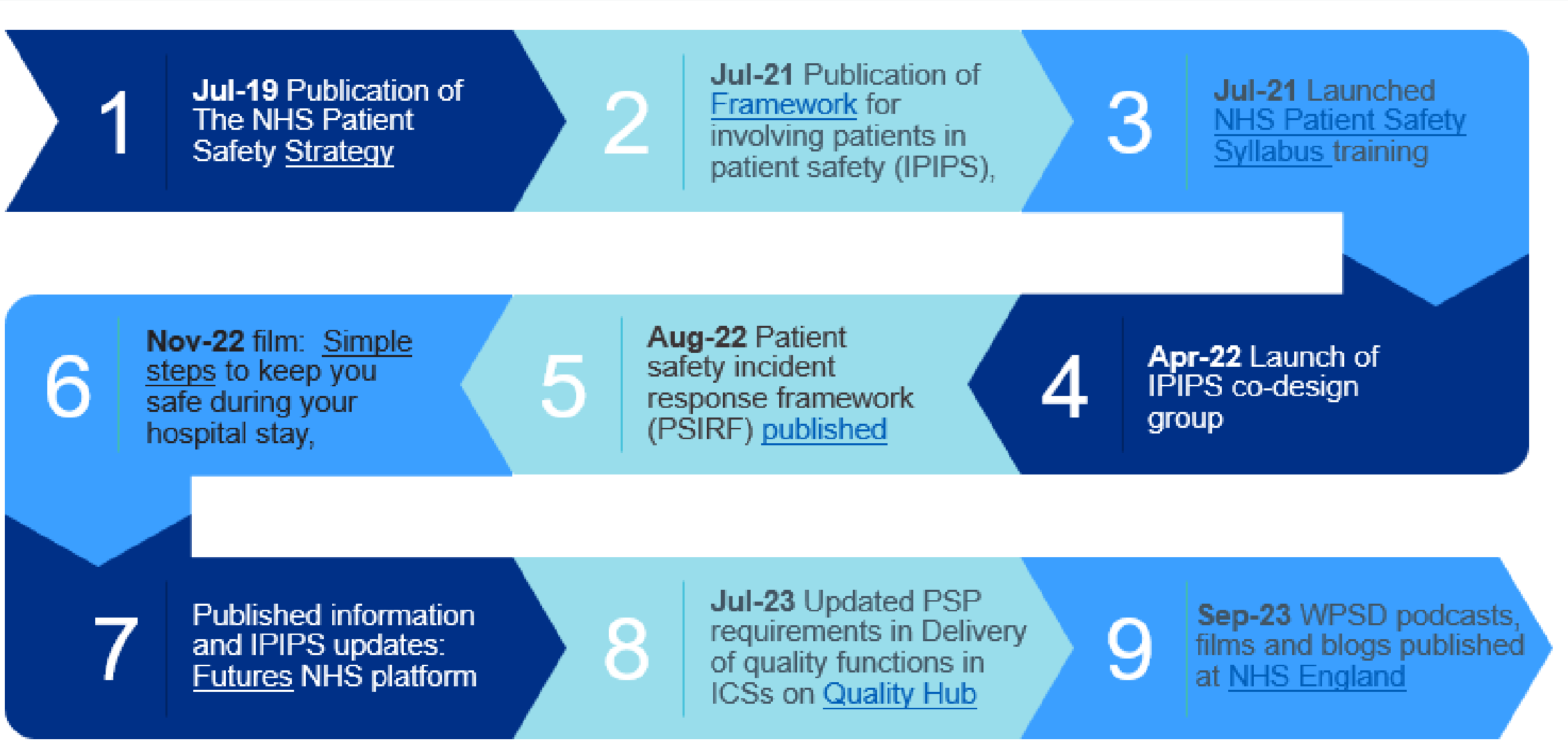
soniasparklesdraws @sonia_sparkles Soniasparkles.com

Not 'hard to reach' but 'hardly reached'

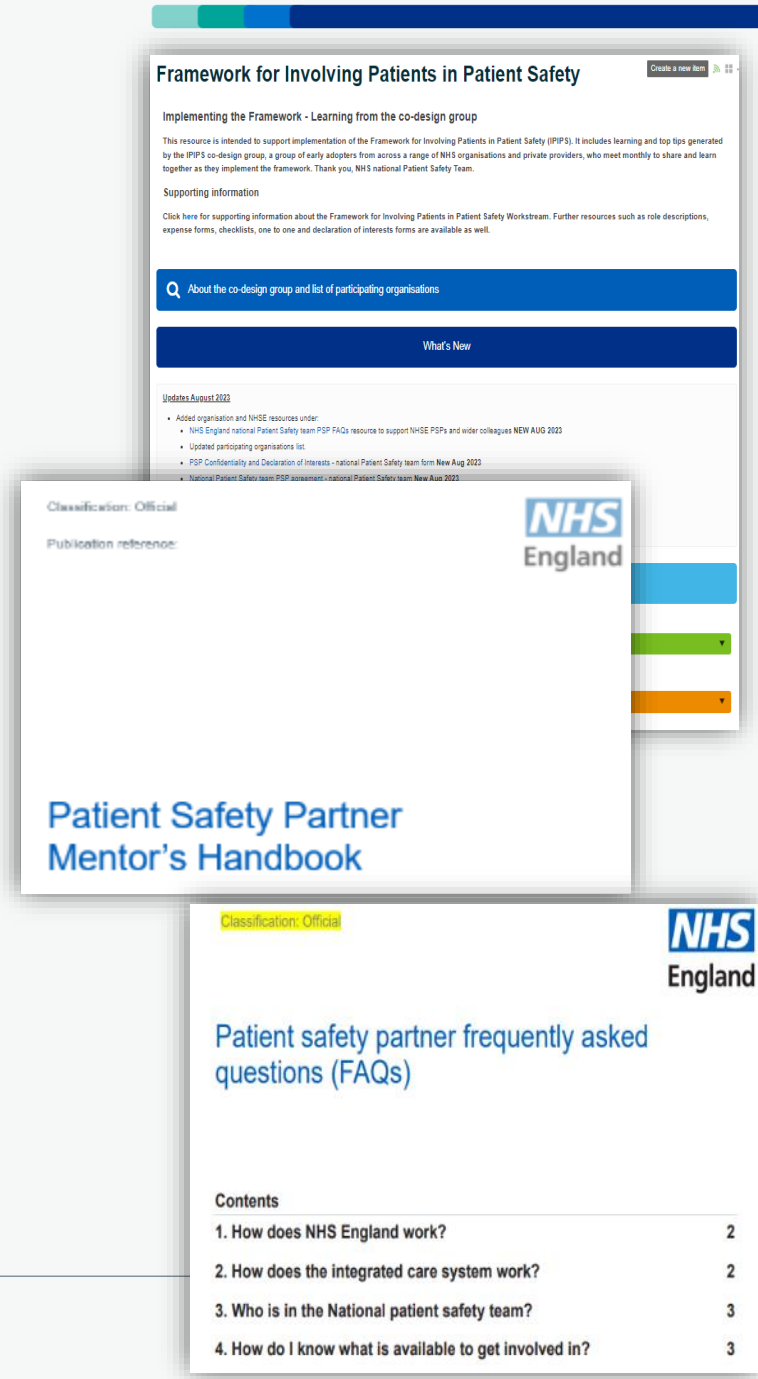
Enabling PSP inclusion and enhancing diversity

- The organisation monitors the diversity of the PSP team, and implements procedures to increase diversity and representation from the local community
- Your PSP recruitment plan needs to address how people with protected characteristics and from diverse backgrounds will be able to access the opportunity to become PSPs and apply for these roles. The need to support diversity should also be included in role descriptions and discussed during selection
- There should be 2 or more PSPs on committees – “Wherever possible PSPs should work in pairs or greater numbers to provide peer support.” Having more PSPs increases the opportunity for diverse representation.
- Providing involvement payments, as well as expenses, is a crucial part of enabling inclusion and enhancing the diversity of the PSPs in your organisation
- Consider when and where meetings with PSP participation may take place. Offering remote access, hybrid meetings, evening or weekend meetings, under 1 hour meetings all provide increased opportunities for involvement
- Check the wording and format of your advert – is the language simple and clear, would it be relevant in another language, is the language inclusive (ask your EDI lead / PSP to review it). Add in phrases that will make it more attractive to those with diverse protected characteristics.
- Consider whether a “traditional” interview is the most appropriate mechanism
- Enable applications to be made in different formats eg voice recording, film

Our Achievements



National PSP involvement



National PSP support

Patient safety update

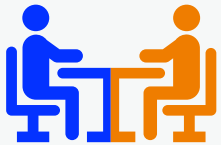
PSP Mentors handbook

Mentoring

Drop-ins

WhatsApp group

Annual reflections



Temperature check-ins

Support needs of PSPs

Mentor training

PSP meetings

PSP Matters

Buddy / peer support

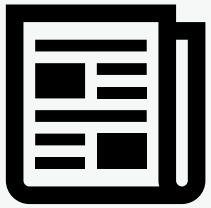
Coffee roulette

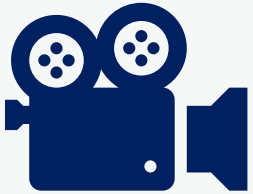
[PSP Mentors handbook 2022]

National PSP task variety

Programme task and finish and implementation groups

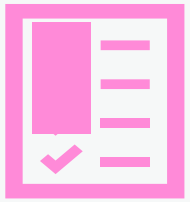
Newsletter development





podcasts and films

Document review



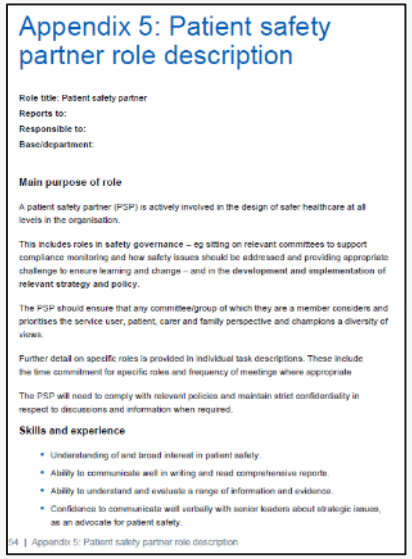
Staff/PSP recruitment

Regular Programme committees

Presenting to national and international audiences

PSP document co-design

Each task has a profile



Appendix 5: Patient safety partner role description

Role title: Patient safety partner
Reports to:
Responsible to:
Base/department:

Main purpose of role

A patient safety partner (PSP) is actively involved in the design of safer healthcare at all levels in the organisation.

This includes roles in safety governance – eg sitting on relevant committees to support compliance monitoring and how safety issues should be addressed and providing appropriate challenge to ensure learning and change – and in the development and implementation of relevant strategy and policy.

The PSP should ensure that any committee/group of which they are a member considers and prioritises the service user, patient, carer and family perspective and champions a diversity of views.

Further detail on specific roles is provided in individual task descriptions. These include the time commitment for specific roles and frequency of meetings where appropriate

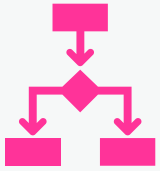
The PSP will need to comply with relevant policies and maintain strict confidentiality in respect to discussions and information when required.

Skills and experience

- Understanding of and broad interest in patient safety.
- Ability to communicate well in writing and read comprehensive reports.
- Ability to understand and evaluate a range of information and evidence.
- Confidence to communicate well verbally with senior leaders about strategic issues, as an advocate for patient safety.

54 | Appendix 5: Patient safety partner role description

Task description



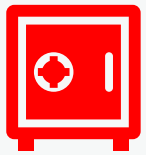
Impact measurement

Time commitment

Reviewing and commenting

Share perspective and experience

Publicity of your name and contributions



Adherence to confidentiality agreements

Interact with multiple stakeholders

Consent to the storage of your personal data

Demonstrating NHSE ways of working

Option to resign from group

Declaration of your conflicts of interest

By checking that your organisation has an infrastructure that fully supports PSP integration and development

… and meeting with your PSPs

Impact – Patient safety healthcare inequalities reduction

- 2 PSPs on Patient safety healthcare inequalities reduction group

Reducing workforce and system biases

Person story: Seni Lewis

Seni Lewis was a university graduate, a son, a brother, an uncle, a grandson, a friend. He was loved and known as a kind, loving and easy going individual who would always make time for people.

Aged 23, Seni voluntarily admitted himself into hospital for mental health treatment on 31 August 2010, having sufferec
inadequate risk assessment
members. When he became
disproportionate and unreas
compliance techniques and r
according to the conclusions

Justice for Seni Law to preve

Encouraging and activating patient engagement in their own care

Case study: Project SMiLE in North Bristol

Community leaders from North Bristol Trust and Shahporan Islamic Centre undertook focus groups to understand the experiences and perspectives of antenatal care for women from global majority communities in North Bristol. 'Knock and wait' signs were among the quality improvements identified.

FutureNHS collaboration platform: BNSSG Project Smile – NHS Patient Safety

Impact – Primary care patient safety strategy

- 3 PSPs on Primary care patient safety group (PCPSG)

Ambition

We want more active involvement of patients, service users, carers and families in co-producing patient safety improvements in all areas of primary care. This will expand on the work of the patient participation groups (PPG) that have existed within general practice for a number of decades, and as a contractual requirement since 2015. We want to encourage further diversity within the PPGs to ensure the needs of all patients are met and the safety of all patients are considered when safety improvements are co-produced.

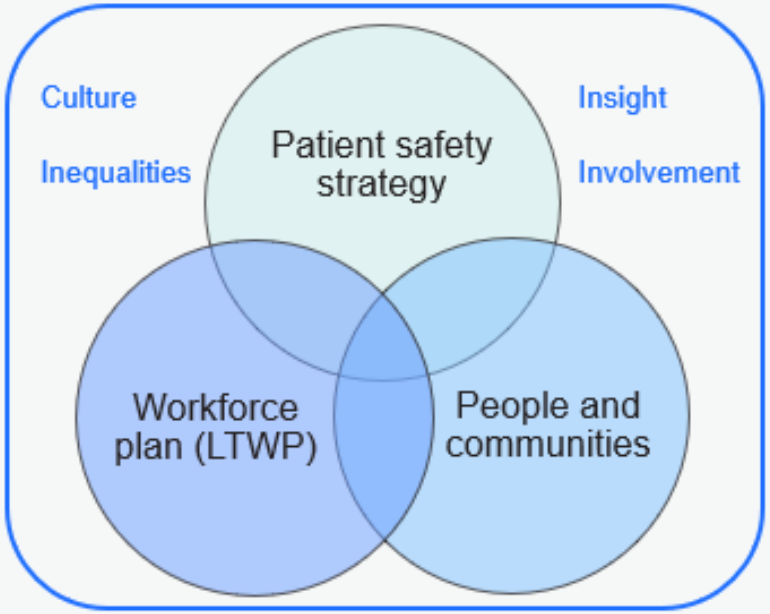
The COVID-19 pandemic has also further highlighted the gaps in healthcare for people from different groups who face inequalities such as people on low incomes and from minority ethnic backgrounds who find it harder to afford and access dental care[30,31].

Impact – Safety culture improvement

- 2-3 PSPs on Safety culture implementation group (SCIG)

Positive safety culture is defined as one where the environment is collaboratively crafted, created and nurtured so that everybody (individual staff, teams, patients, service users, families, and carers) can flourish to ensure brilliant, safe care by:

- Continuous learning and improvement of safety risks
- Supportive, psychologically safe teamwork
- Enabling and empowering speaking up by all



Balancing measures

- Yearly comparison: "We are safe and healthy" People Promise scores (via Model Health System)
- Yearly comparison: HIA4: Address Health Inequalities with their workforce scores (via Model Health System)
- Yearly comparison: Patient experience scores (via Friends and Family Test, or GP patient survey)

PSIRF - A new approach to learning from safety events

From prescription to principles

Compassionate:

Meaningful, compassionate engagement with those affected by safety events through answering questions, addressing concerns and involvement throughout a learning response meets both a moral and logical imperative.

Systems-based:

Focused on understanding how a safety event happened and not who to blame.

Exploring work conditions and processes, placing an emphasis on creating a psychologically safe space for the honest collection of insight.

Proportionate:

Focused on areas where there's the greatest potential for learning and improvement.

Defining local priorities increases engagement and investment in organisational improvement.

Supported:

Leadership engages and empowers organisations by asking questions to understand rather than to judge, looking beyond simple measurement and monitoring.

Focused on enabling improvement and collaboration, moving away from bureaucratic and transactional approach that drain time and deflect resources away from improvement activity

What changes?

From SIF to PSIRF

Compassionate:

- New guidance
- Training and competency standards

Proportionate:

- Development of response plan and policy
- Removed mandated SI threshold
- Removed requirement for the application of specific methodology

Systems-based:

- Learning response toolkit replaces outdated investigation methodology
- Embedding safety within wider system of improvement
- Training and competency standards

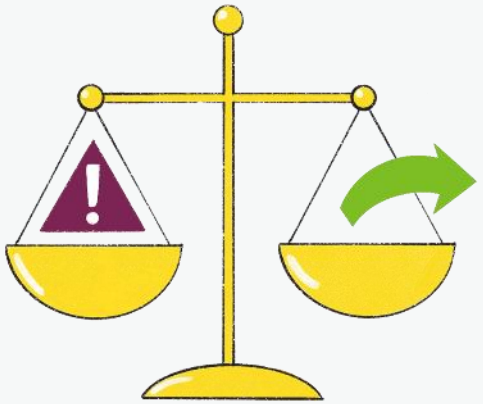
Supported:

- Change in roles and responsibilities of boards and commissioners
- Removal of 60-day timeframe for completion of learning response
- Peer review of learning responses
- Training and competency standards

Patient safety incident response standards

A collective work setting out an agreed way of learning from safety events

Policy, planning and oversight	Competence and capacity
Engagement and involvement of those affected by patient safety incidents	Proportionate responses



[B1465-5.-Patient-Safety-Incident-Response-standards-v1-FINAL.pdf (england.nhs.uk)]

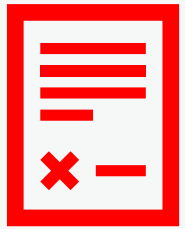
By identifying programmes of work that you are, or will be undertaking that can be co-designed with patients

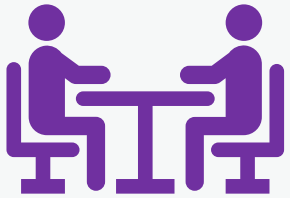
… and enabling PSP task profile development

National next steps for more patient involvement

Part A
case studies

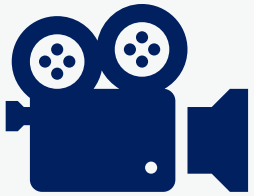
Contractual
requirement





LFPSE patient
interface

Publish
podcasts and
films



Response and
learning PSIRF

PSP
Newsletter

Research
evaluation

Inequalities stories

IPIPS futures
platform

Mapping PSPs
across local/
regional/ national

Acknowledgements:
National Patient safety partners, IPIPS co-design group

#CallMe
Because names matter

https://callmebecausenamesmatter.org/
https://kindnessinhealthcare.world/

Thank you

@nhsengland

company/nhsengland

england.nhs.uk

Expectations around patient experience, involvement and engagement from Internal Audit and CQC

Kristina Dickinson, Assistant Director – Clinical Quality at 360 Assurance

Sandra Glaister, Internal Audit Manager at Audit Yorkshire

Content of Presentation

- Introduction
- Internal Audit
  - Patient experience topic areas
  - Governance
  - Risk management
  - Controls
- Areas of good practice/ innovations
- Care Quality Commission
  - Expectations
  - How feedback is gathered
  - Using Patient Experience Surveys to determine CQC expectations

Purpose of Internal Audit

It helps an organisation accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of **risk management**, **control** and **governance** processes.

Public Sector Internal Audit Standards, 2017


Hearing the patient voice topic areas
Patient Engagement
Overarching systems and processes
Complaints
Learning from feedback
Health inequalities
Family and Friends Test
Claims
Incidents/ PSIRF

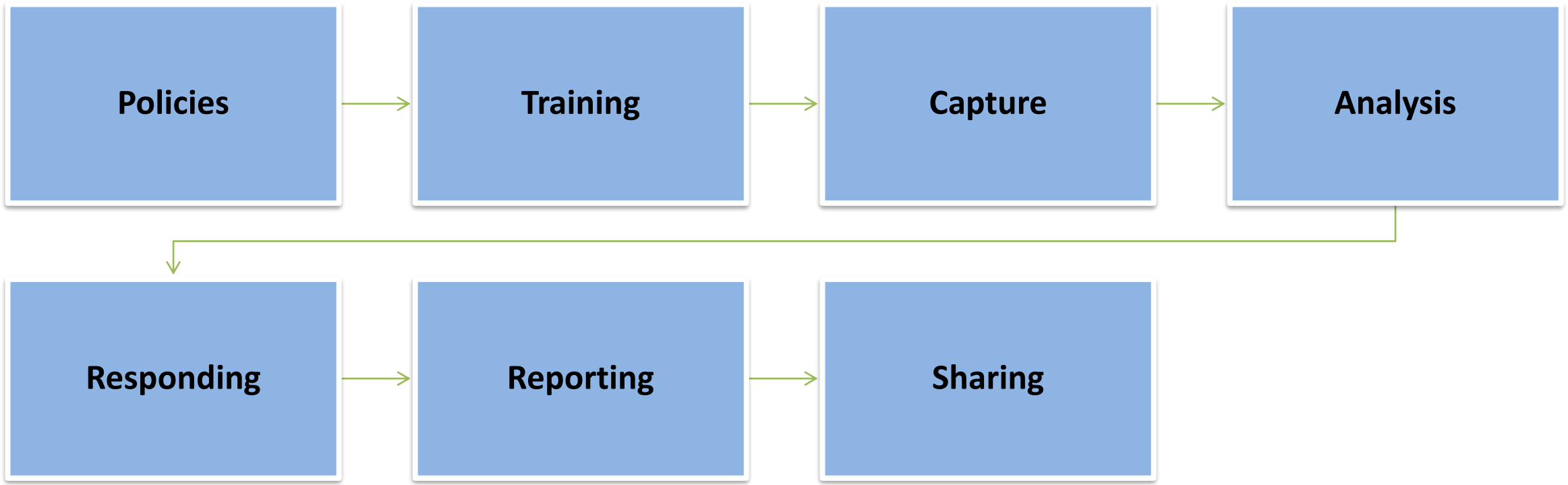
Governance expectations

- Strategy, priorities/ objectives
- A governance structure
- Terms of reference for related groups
- Minutes for groups
- Reporting arrangements
- Oversight of risk
- Communication

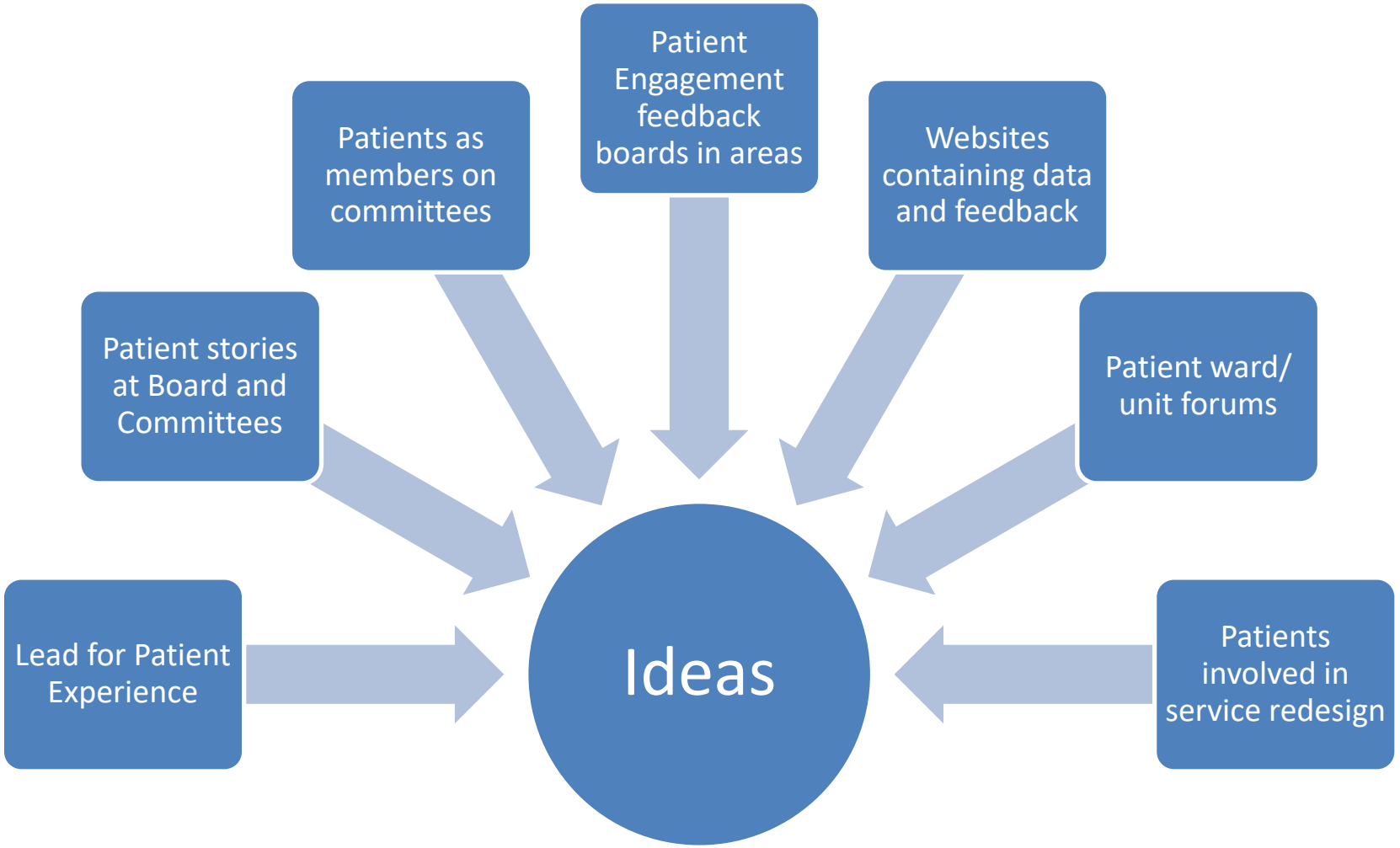
Risk management expectations

- Strategy relates to strategic objectives and Board Assurance Framework.
- Identification, capture and challenge of risks.
- Mitigations and gaps in assurance identified.
- Risks and actions are communicated.
- Review of risks.
- Integrated Care Board/ System communication

Controls expectations



Examples of good practice/ innovations



Care Quality Commission

The CQC defines people's experience as:

'a person's needs, expectations, lived experience and satisfaction with their care, support and treatment. This includes access to and transfers between services.'

Responsive - Listening to and involving people

CQC Quality statement

We expect providers, commissioners and system leaders live up to this statement:

We make it easy for people to share feedback and ideas or raise complaints about their care, treatment and support. We involve them in decisions about their care and tell them what's changed as a result.

What this quality statement means

People know how to give feedback

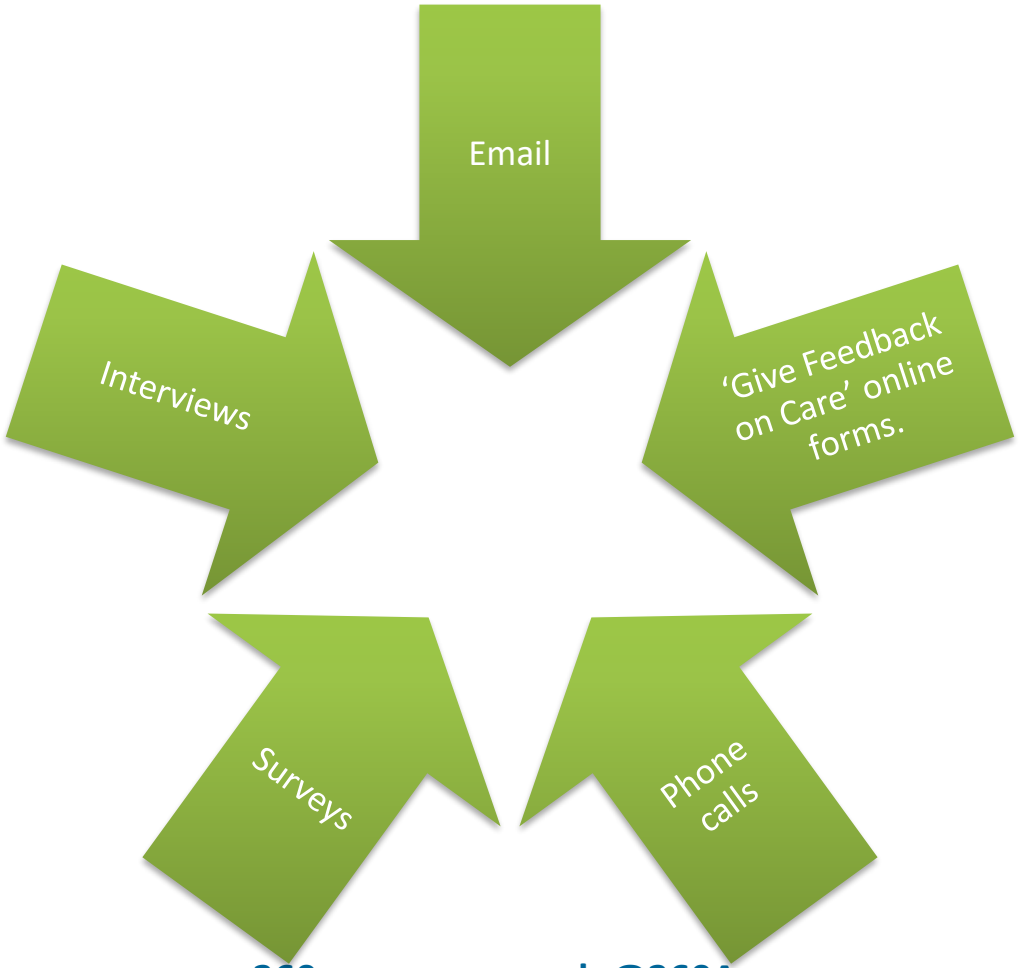
People feel confident to complain.

People feel that their complaint or concern will be explored thoroughly.

People are kept informed about how their feedback was acted on.

Learning from complaints and concerns is seen as an opportunity for improvement.

How the CQC gather feedback



CQC Surveys

Recent surveys

- Maternity survey 2023 (Published: February 2024)
- Adult inpatient survey 2022 (Published: September 2023)
- Urgent and emergency care survey 2022 (Published: July 2023)
- Community mental health survey 2022 (Published: October 2022)

Maternity Survey focus areas

(Published February 2024)

- Information and advice throughout and following treatment
- Involvement in decision making and information on the associated risks
- Quality of pain management throughout and following treatment
- Involvement of family and friends during treatment
- Staff identifying themselves and their role in patient care, building confidence and trust
- Staff knowledge of individual patients and their medical history
- Staff support during treatment and at times when patients feel vulnerable or alone
- Patient concerns being taken seriously
- Kindness and understanding throughout and following treatment
- Respect for patient decisions about their care
- Cleanliness of the environment

Key findings that can be related to all aspects of patient experience

One in four respondents were not given the opportunity to ask questions about their labour and birth.

People were left alone at some point during, or shortly after, the birth at a time when it worried them.

A downward trend for women saying they saw or spoke to a midwife as much as they wanted after the birth in hospital.

Summary

We have explained what the minimum expectations of an internal audit would be.

We have provided some ideas for good practice in relation to patient involvement, engagement and experience.

We have outlined the expectations of the CQC and recent survey results that are related to patient experience.

Conclusion

Hearing the patient voice helps organisations understand how their patients truly feel, their needs, expectations and concerns during every point of the care journey.

This in turn supports planning and quality improvement initiatives in services to deliver compliance with regulatory requirements.

Any questions?

Little Voices

Garry Perry, Associate Director Patient Relations & Experience, Walsall Healthcare NHS Trust

Charlotte Yale, Divisional Director of Nursing Children, Young People & Neonates, Walsall Healthcare NHS Trust

Patient Relations & Experience

Walsall Healthcare NHS Trust

Communicating Effectively

Walsall Healthcare NHS Trust

‘Little Voices’

HELLO
MY NAME IS

Garry Perry
Associate Director
Patient Voice

HELLO
MY NAME IS

Charlotte Yale
Divisional Director of Nursing
Children, Young People & Neonates

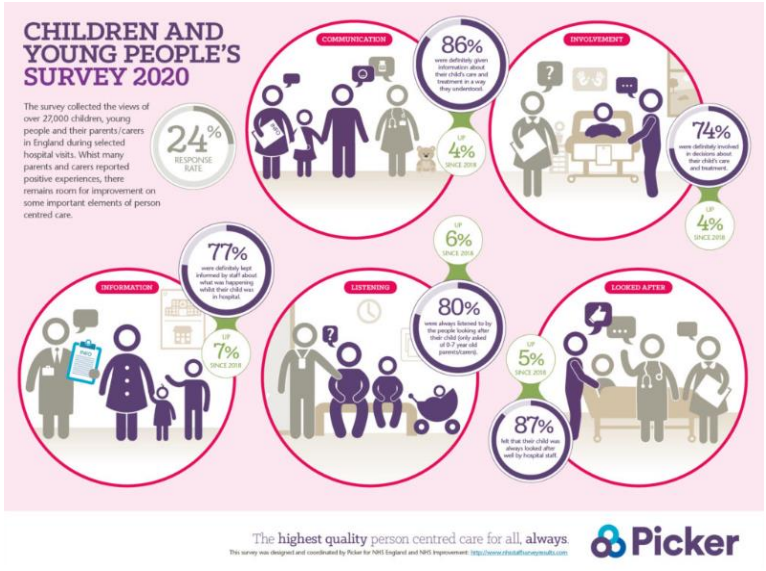
ABOUT US

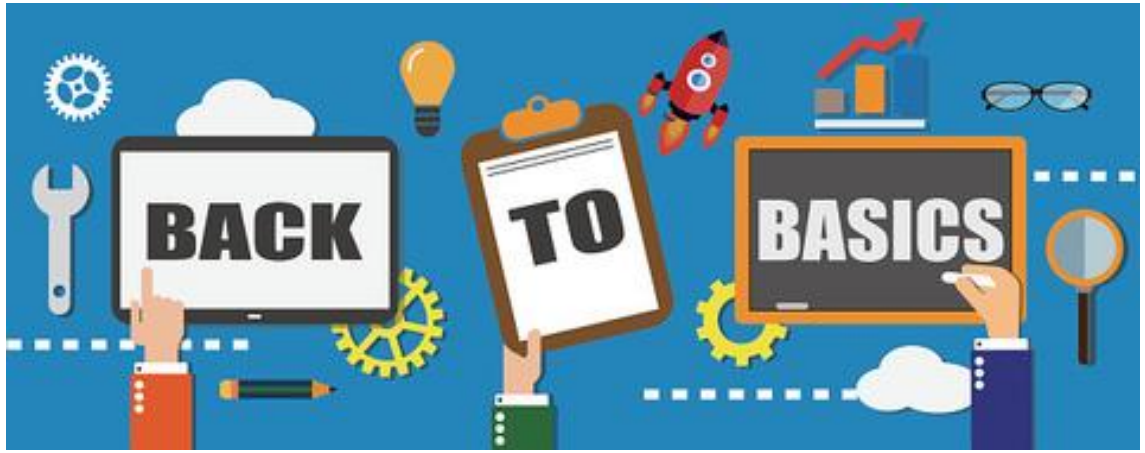
- Serves a population of 270,000
- 550 acute beds
- 24 hour Emergency Department recent £40m new build – PAU co-located
- 21 in-patient paediatric beds
- Level 1 Paediatric Critical Care
- UECC – 24 hr front door paediatrics. Separate day case location
- COPD
- CCN team with a Virtual Ward
- 15 cot, level 2 NNU
- CNS – Respiratory, Epilepsy & Diabetes

Feedback

- FFT
- Tops and Pants
- Ups and Downs
- Sharks and Dolphins
- Parent Support Group in NNU
- Patient Involvement Partners
- Increasing use of volunteers
- Mystery Patients

‘Little Voices’ – the beginning





outside

‘Little Voices’ The team

- Freya
- Tommy
- Alfie
- Kayden
- Melody
- Molly

‘Little Voices’ Pre-inspection visit

Pre-visit Monday 24 April 2023 @ 10:00am - Pelsall Village School

Setting expectations:

- Who we are
- What we do
- What to expect
- How to use the toolkit
- What to look for
- Confidentiality
- Infection Control

‘Little Voices’ – Little Steps (15 steps visit)

Is the ward welcoming?

Questions to ask yourself	Your notes
Did I have to wait long to enter the ward?	No, people noticed us very quickly
What can I see, hear, and smell?	cleaning products, smelt fresh, machines, 'beeping'
What made me feel welcome?	smiling staff, waving, saying 'hi', explained things
Is the ward welcoming for children of my age?	yes, very clean & tidy, and lots of room
What is the atmosphere like?	good, feels like a nice place, calm
What is the environment like?	clean, no clutter, felt fresh and airy
Is there an information board, what does it have on it?	yes, we saw lots of information - ups & down's, feedback

Things to look out for

Please tick what you can see

- ☑ A welcoming and comfortable space to wait that isn't cramped and has things to do
- ☑ Staff smiling at you
- ☑ The ward is bright and clean
- ☑ Welcome signs and information suitable for all ages
- ☑ A board saying who everyone is

Is the ward a safe area?

Questions to ask yourself	Your notes
Does the area make me feel safe? Why or why not?	Yes, lots of nice staff - reassuring & explain things
Are staff easy to recognise?	Yes, yellow name badges & uniforms can be seen
Are medicines/liquids left out on the ward?	No did not see any-chain on medicines trolley in resus
Are the playrooms/teenage rooms etc safe for children on the ward?	Yes,concern re: mirror in sensory room

Things to look out for

Please tick what you can see

- ☑ Are entrance and exit doors always locked for safety?
- ☑ Lots of hand sanitizer available for staff to wash their hands
- ☑ Staff ID badges are clearly visible
- ☑ Confidentiality is respected
- ☑ Can you see any medicines on the ward?
- ☑ Fire doors are kept shut

Will this ward care for and involve me?

Questions to ask yourself	Your notes
How have staff made me feel?	Welcoming and made us feel happy
Is the ward private? (Curtains pulled round the beds etc)	Yes, we saw curtains pulled when staff entering
Are staff friendly and polite when talking to patients and families?	yes, smiling, introducing themselves, kind staff
Is there any patient feedback displayed on the ward?	yes, could do with more colour and more things on wall
Do staff work well as a team?	yes, they help each other

Can you see information on the following? If yes please tick what you can see

- ☐ Information on Patient Groups
- ☑ Information on making a complaint

Other Need a children's poster version

Things to look out for

Please tick what you can see

- ☑ Staff talk to children not just parents/adults
- ☐ People are given information on their treatment in ways they can access (e.g., leaflets, online)
- ☑ There are some activities suitable for all ages on the ward
- ☑ Staff are communicating in a positive way
- ☑ Staff check on patients regularly
- ☑ Patient feedback is displayed openly for everyone to see

Is this ward well organised and calm?

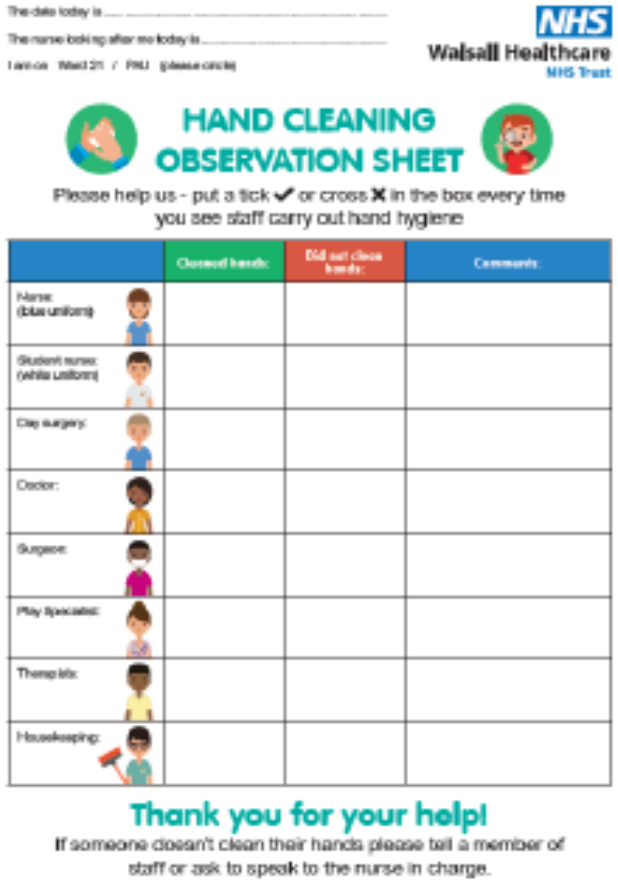
Questions to ask yourself	Your notes
Is this a good space for children and young people?	yes, we saw play room being refurbished
Does the ward feel calm even though it may be busy?	yes,calm and quiet
Do staff put away equipment when they have finished?	yes, saw this lots of times
Do the beds have basic patient information above?	some do some don't, 'about me' boards being installed
Can I see into other rooms (e.g., stock/linen cupboard, staff room or kitchen)? Do they look organised, clean, and uncluttered?	No medicine left out, all areas clean and tidy

Things to look out for

Please tick what you can see

- ☑ The area is clean
- ☑ There is space – the ward and beds aren't cramped
- ☑ Clear signage to toilets etc.
- ☑ Organised areas
- ☑ There is space for activities and games, or quiet time away from the ward beds

‘Little Voices’ – Little Steps 15 visit



‘They said’ ……









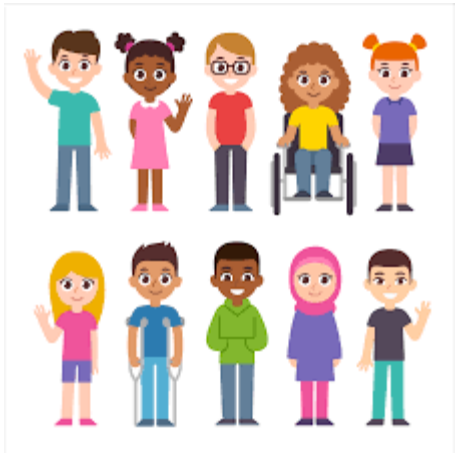
What could improve

- More toys in the childrens waiting room in the Emergency Department (ED)
- There is a scribble wall - but no pens (ED)
- Hand Gel Dispensers - child friendly and a height that small children/wheelchair users can reach

- More colour/pictures on walls
- Need a picture of a football in named bay in PAU
- Kid's themed pillows/linen
- Mirror is dangerous in sensory room can walk into - remove?
- Toilet signs so children can see where they are

‘We did’

- Toilet/Hand hygiene poster produced
- Refurbished play room opened
- Play volunteer role descriptor progressed (4 EWE volunteers now in place)
- Hand gel dispenser – bespoke design in progress, reduced height for children/wheelchair users



Walsall Healthcare Voluntary Service

Walsall Healthcare NHS Trust

Volunteer Role Profile

Paediatric Play Volunteer

Purpose of the role

This role will support our young patients across the Paediatric wards and clinics by offering craft and play activities plus storytelling in waiting areas and inpatient wards including the Paediatric A&E. Volunteers use a variety of toys, books, craft materials and their own creative ideas to engage young people through play to support them whilst they wait to be seen by clinical staff. 121 activities are provided at the bedside whilst small groups are hosted in the well-stocked playrooms. By providing this service, our volunteers distract young patients using play, free up time for the clinical staff, develop new skills, and deepen their understanding of the role of the Paediatric Play Specialist Team This role is a very special opportunity to support young people and their families throughout a difficult time, providing fun opportunities and truly making a difference.

‘we have’ ……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NHS Trust
IT'S OK TO ASK
TIPS TO CLEAR HEALTH COMMUNICATION
It's OK to ask again if you don't understand something.
Don't feel rushed or embarrassed.
It's OK to bring a friend or someone from your family.
It's OK for them to ask questions and to help you.
It's OK to make a list of things you want to talk about.
It's OK to make a list of the medicines you are taking and take it with you.
It's hard to remember all of the names.
It's OK to ask at the pharmacy too. Remember, they are there to help you.
IT'S OK TO ASK
1 What is my child's main concern?
2 What do we need to do?
3 Why is it important we do this?
Asking questions can help you to:
• take care of your health
• Prepare for medical tests
• Take your medicines in the right way


#IPSAwards #IP2023Conf #IPW
IPS Infection Prevention Society
IMPACT AWARDS 2023
IPS Award for Patient Experience
(Joint) Gold Award:
Mrs Amy Boden, Mr Garry Perry, & Ms Charlotte Yale


Little Journey


Issue Aug-23
Patient Voice Report - Paediatrics
Ward 21
PAU
Ward 28
Paed OPD
Ward 21 93 %
Ward 28 92 %
PAU 94 %
Paed OPD 0 %
FFT - Positive Themes
FFT - Negative Themes
Number of responses
W21 74
PAU 63
W28 12
OPD 0
Friends and Family Test (FFT)
Response Rate
Mystery Patient Feedback
*Feedback received on a rolling 3 month basis
Mystery Patient Free Text Comments
Remember:
- Patient's can be surveyed at any point during their care, this can be done by using the QR code on the bedside posters or by using a tablet
- Ensure that every bedside has the new updated version of the Mystery Patient / FFT
Patient Relations - Complaints, Concerns and Compliments

And finally……


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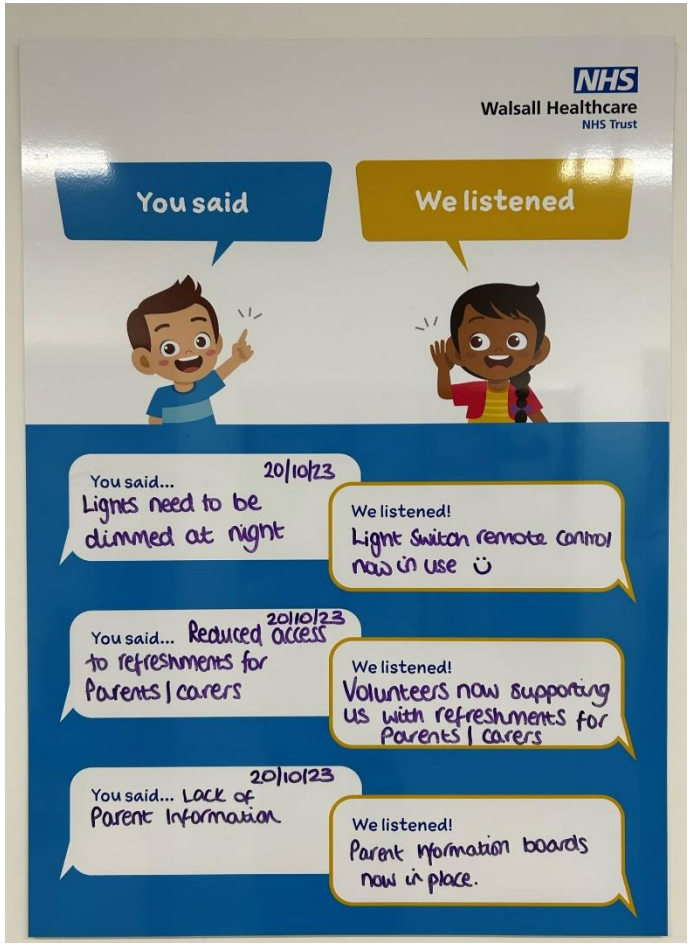
Patient Relations & Experience
Gift a Gown


clean up toys
go to the toilet
have a wash
brush teeth
put on PJs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You said
We listened
You said... 20/10/23
Lights need to be dimmed at night
We listened!
Light Switch remote control now in use
You said... Reduced access 20/10/23
to refreshments for Parents | carers
We listened!
Volunteers now supporting us with refreshments for Parents | carers
You said... Lack of 20/10/23
Parent Information
We listened!
Parent information boards now in place.


See me
Hear me
Know me

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Why sleep matters for kids

Sleep recharges kids' bodies and brains so they can:
- Feel calm and refreshed
- Make good choices
- Pay attention in school
- Remember what you learned
- Feel more active

After 1 or 2 nights of less sleep, you may:
- Feel more disruptive
- Make poor choices
- Pay less attention
- Forget what you learned
- Feel less active
- Not wanting to participate

Kids who are sleep deprived:
- Feel sad, worried or anxious
- Have a less healthy weight
- Make risky choices

To deliver exceptional care together to improve the health and wellbeing of our communities

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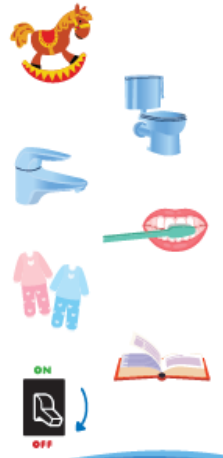
Sleep time matters

What matters to me

- [ ] clean up toys
- [ ] go to the toilet
- [ ] have a wash
- [ ] brush teeth
- [ ] put on PJs
- [ ] bedtime story
- [ ] lights out



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Why is sleep important?

All of us need to sleep. Sleep is important as it helps us in lots of different ways.
Can you write in each of the bubbles why you think sleep is important.

To deliver exceptional care together to improve the health and wellbeing of our communities

Patient Relations & Experience

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Bring a Blanket

Whilst in hospital we want you to be as comfortable as possible, so you are more than welcome to bring your own clean personal blanket/duvet from home if you would like to.

Please leave anything valuable at home as we cannot accept responsibility for the loss of or damage to your belongings.

The space on our ward is quite limited so please only bring 1 or 2 items.

To deliver exceptional care together to improve the health and wellbeing of our communities

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Brushing My Teeth

1. Put a small dot of toothpaste on my toothbrush.
2. Put water from the tap, on my toothbrush.
3. Brush my teeth: top teeth, bottom teeth, front teeth, outside of teeth, inside of teeth.
4. Spit the toothpaste in my mouth, into the sink.
5. Put away my toothbrush and smile with my clean teeth!


THANK YOU
THANK YOU
THANK YOU
THANK YOU

Hearing the Patient Voice throughout a Quality Strategy

Fiona Bakewell, Head of Patient Safety at
Nottingham University Hospitals NHS Trust

NUH QUALITY & PATIENT SAFETY TEAM

Creating the conditions to make care safer at NUH

NHS
Nottingham University Hospitals
NHS Trust

Hearing the Patient Voice

Ongoing work at Nottingham University Hospitals NHS Trust (NUH)

We Listen We Care

Patient Safety Incident Response Framework (PSIRF) at NUH

- **JULY 2021 –** Successful business case for £0.5M investment to support the delivery of PSIRF
- **JANUARY – APRIL 2022** –Recruitment of key roles
- **OCTOBER 2022** – Staff fully trained and developing well in the roll
- **APRIL 2023** – Patient Safety Incident Response Plan and Policy Consultation Starts
- **NOVEMBER 2023** – Recruitment to additional Investigators (Maternity)
- **MARCH 2024** – Approval of NUH PSIRP and Policy for 2024/25 by both Trust and ICB

Developing the role of the Patient Safety Partner – thoughts from our own Patient Safety Partner at NUH . . .

- Early stages of developing these roles – the emphasis at NUH is to make this role purposeful, enjoyable and ensure it is sustainable. As a PSP this feels like the right approach.

- Attending network events, the national picture suggests that no provider has fully cracked the PSP role and in some places it has already failed. The local Trust's abilities to shape the role is both a help and a hindrance. I'm not sure many Trusts are invested in the project - no money, no time, unsure of its value.

- There is too much emphasis on PSIRF rather than the originally wider vision for PSPs improving safety overall and, of course, Part A of the Framework for involving patients in patient safety – this framework is really about creating the culture in which every patient can be a partner in their own safety.

Developing our Quality Strategy – Consultation and Engagement

Patient Safety

- **Fundamentals of Care** – ensure that this is understood and **implemented by everyone**
- **Capacity of staff** and inability to meet workforce plans
- **Lack of 'thinking time'** for staff - work is reactive and fast paced.
- **Empowering staff** to have permission to act and **empowering patients** to be involved in their care
- **Sharing good practice** and **learning** in an effective way
- **Visibility of Senior Leaders** to understand and appreciate 'Front-line' challenges

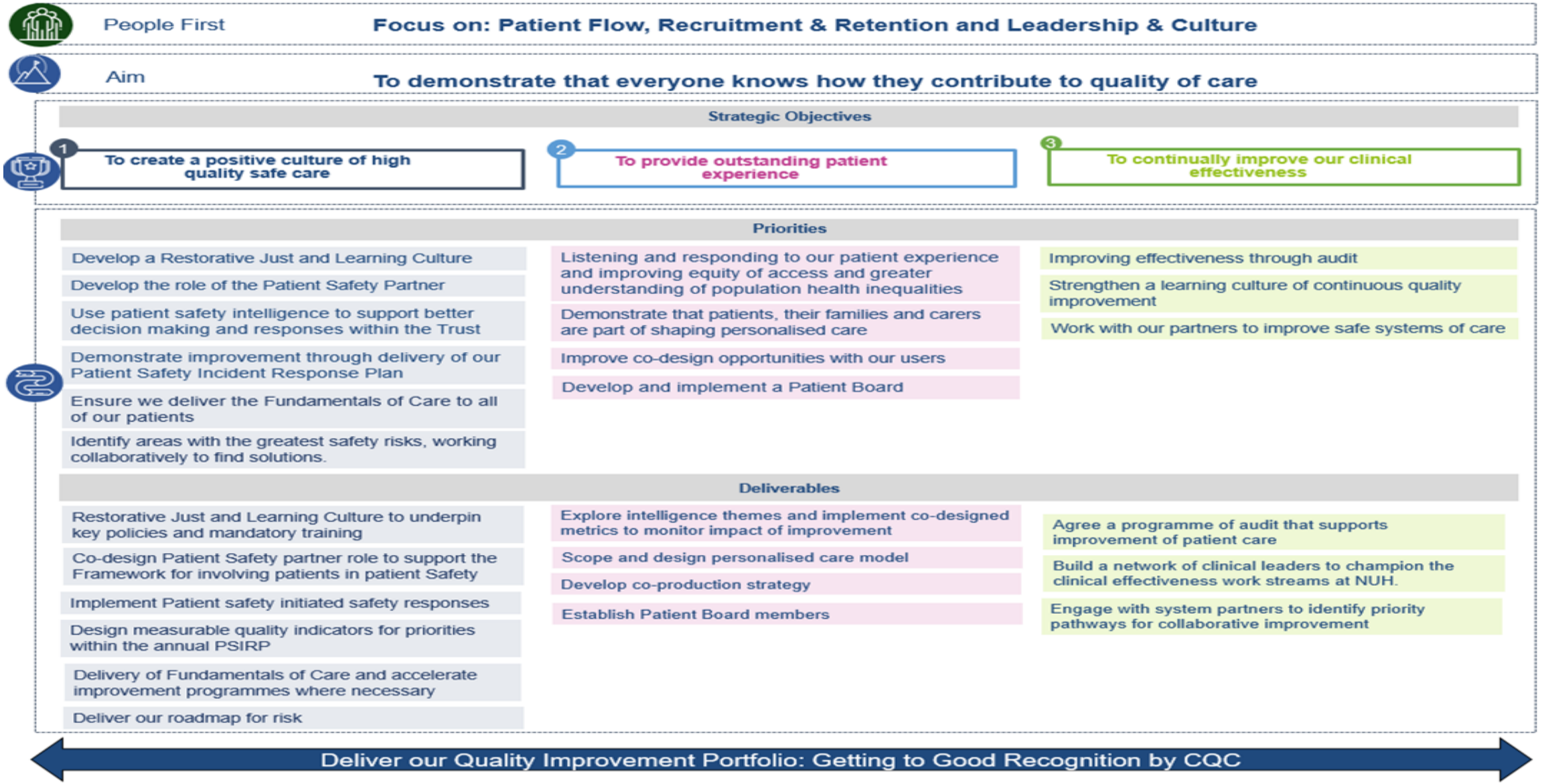
Patient Experience

- **Disconnected and impersonalised care:** patients need to be able to build relationships, physical interactions have reduced due to digitalisation
- **Capability to deal with challenging** and **confrontational conversations** regarding patient concerns
- Need more focus groups/wider **representative patient group** to consult with
- **Enable consistent and wide communication** throughout the whole patient journey between patient, staff and entire system
- Need to **celebrate and share the positives** and not just focus on the negatives (less than 0.1% of patients complain formally)

Clinical Effectiveness

- **Embrace continual learning and improvement** as key components for growth
- **Emerging health inequalities** –we must meet the needs of our patient population and ensure equity of care
- **Personalised Care-** we must consider **the individual needs and** expectations **of our patients,** carers and families
- Publish our results: **share our successes and learnings** rather than just focus on the negatives
- **Consistency of care** both throughout the **organisation** and the entire **patient journey**

The Quality Strategy on a page



Hearing the Patient Voice

Our aspirations moving forward at NUH

- Continue to co-design and co-develop the role of PSP
- Continue our work with patients and families impacted by safety incidents
- Co-design the delivery of our 2025/26 PSIRF Local Priorities
- Implement a rapid system for patients to escalate safety concerns to a leader in the right area.
- Develop Quality Indicators that mean something to our patients, families and the public
- **Development of a Patient Board at NUH**

The NUH Patient Board

Introduction of a Patient Board

We want to demonstrate a commitment to improving engagement with our patients and communities, and will develop a Patient Board that will cover the following areas to identify opportunities for improved engagement:

Improved health outcomes – to create better chances of creating services that meet peoples need, improving their experience and outcomes
Value for money – services designed with people to effectively meet their needs
Better decision making – brining a view of the world from lived experience
Improved quality – designing services that meet the needs and preferences of our patients
Accountability and transparency - The NHS Constitution states: 'The system of responsibility and accountability for taking decisions in the NHS should be transparent and clear to the public, patients and staff.'
Participating for health improvements – can reduce isolation, increase confidence and improve motivation towards wellbeing
Meeting legal duties – failure to meet legal duties risks legal challenge, impacting financially which can damage relationships, trust and confidence
Addressing health inequalities – through developing joint solutions
NHS England » Personalised care

"For me, 'Quality' IS patient experience, there is no good experience to be had from mediocre and impersonal care. Quality is when patients and their loved ones encounter compassion and respect, when they are engaged and involved – as much as they wish to be – in timely, safe and effective care.

Compassionate communication enables relationships to thrive and gives staff members confidence to speak up when things are not right or mistakes happen, when they are stressed or unhappy. If staff receive a good response, patients will have a similar experience when they raise concerns. I am a great believer that the culture for staff – for every team – becomes the culture for patients.

Healthcare is a partnership – quality and experience flow from the relationship between the Trust and its population and clinical teams and patients. Every Trust employee contributes to the many and varied aspects of quality at NUH, which in turn contributes to the quality of patient experience."

Helena Durham, Patient Safety Partner, 2023

Future Events

People Committee
Focus on: **Hearing the Staff Voice**
13th June 9am-12.30pm

Finance Committee
Focus on: **Planning at a System Level**
12th September 1pm-4.30pm

Audit Committee
Focus on:
Governance/Risk
10th December 9am-12.30pm

Can all be booked now at: https://www.360assurance.co.uk/events/ or by emailing Kirstie.anderson1@nhs.net

www.360assurance.co.uk @360Assurance
www.audityorkshire.nhs.uk @AuditYorkshire

Thank you for coming