Scaling Up Improvement
Round 1

Scaling up Patient Safety Huddles to enhance patient safety and safety culture in hospital wards

Leeds Teaching Hospitals NHS Trust in partnership with: Barnsley Hospital NHS Foundation Trust & York Teaching Hospital NHS Foundation Trust
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About the project

Project title:
Scaling up Patient Safety Huddles to enhance patient safety and safety culture in hospital wards.

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Barnsley Hospital NHS Foundation Trust
York Teaching Hospital NHS Foundation Trust
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Part 1: Abstract

Estimates suggest that approximately 5–10% of hospitalised patients in high-income countries experience harm, and about one third of these harmful events are preventable.

To date, international patient safety initiatives that have been designed over the last decade have almost all failed to demonstrate significant sustained impact. Reducing harm across a hospital requires behavioural change at a ward team level.

Leeds Teaching Hospitals NHS Trust developed and piloted ‘patient safety Huddles’ at ward level, to help reduce patient harm. The Huddles are led by the most senior clinician and take place at a regular time each day for 10–15 minutes. They provide a non-judgemental, no-fear space in the daily workflow of ward staff. Team members develop confidence to speak up and jointly act on any safety concerns they have. They become a vehicle for ward teams to continually learn and improve. The initiative also involves the introduction of improvement tools, including regular measurement of progress and celebration of success. Safety culture assessment allows the ward team to reflect on how they work together, and enhances team working. The pilot of the patient safety Huddles demonstrated a reduction in the number of falls, an increase in overall staff morale and improved teamwork.

The Health Foundation scaling up improvement grant for Huddle Up for Safer Healthcare (HUSH) began in February 2015, with the aim to:

- Implement Patient Safety Huddles in all ward teams across five acute hospitals in the three partner NHS Trusts:
  - Leeds General Infirmary, St James’ Hospital and Chapel Allerton Hospital (*96 inpatient wards) – Leeds Teaching Hospitals NHS Trust.
  - Barnsley General Hospital (*27 inpatient wards) – Barnsley Hospital NHS Foundation Trust.
  - Scarborough Hospital (*13 inpatient wards) – York Hospital NHS Foundation Trust.

* Ward numbers have changed since last report due to organisational changes.

- Deliver demonstrable improvements in ward-level patient safety culture.
- Deliver a significant reduction in patient harm.
- Determine the whole-system benefits and challenges of implementing patient safety Huddles at scale, in hospitals of different sizes and contexts, and draw out the implications of this for healthcare providers striving to be high-reliability organisations.
- Disseminate learning regionally across the AHSN geography in Yorkshire and Humber, nationally across the NHS, and internationally.
This final report describes our learning and progress during the 30 months from February 2015 until July 2017.

We are proud to report that by the end of the implementation phase 119 out of 136 (87.5%) wards across the 5 sites are huddling and 102 out of 123* (83%) have achieved HUSH standard embedded Huddles (happening Mon-Fri for at least 3 consecutive weeks in a row). We are excited to see the full evaluation report due Nov 2017, but we are able to report that 51/123 wards (41%) with embedded HUSH Huddles have seen a step reduction in the harm they focus their Huddles on.

* NOTE: embedded Huddles figure does not include 12 Paediatric wards in Leeds and 1 paediatric ward in Scarborough, as they are involved in “SAFE” Huddles, part of the Situational Awareness For Everyone project, endorsed by the Royal College of Paediatrics and evaluated out with our HUSH project.

Approximate words: 450 (actual 516)
Part 2: Journey

**Improvement journey and intervention. What has happened during the lifetime of the project.**

Our safety Huddles journey began in 2013, with one ward team, who wanted to reduce falls. They tested holding a focused Huddle on “who we were worried about falling” and “what can we do as a team”. Their aim was to go 30 days without a fall, although the team didn’t believe this was possible. A week between falls was rare, so the idea of celebrating 10 days between falls with a bronze certificate began. The dream of a Gold certificate of 30 days seemed impossible, with a fear they would “fail”. Many ‘Plan Do Study Act’ (PDSA) cycles later, the Huddle was embedded into the ward routine and 7 other medical wards followed their example. The Huddle brought together doctors, pharmacists, care support workers, housekeepers, nurses and therapists to focus on reducing harm. Statistical Process Control (SPC) charts started to show improvements with step reductions and 50% fewer falls.

We then commenced our journey with our grant to scale up Huddles across three organisations. This has brought rich learning, given us the opportunity to develop, and most importantly, learn that this is not about implementing or mandating anything. It’s about using the science of improvement and learning the art of coaching teams to adapt Huddles in their world and their organisation. Adaptation is key, working a Huddle to reflect the individuality of each ward team, their patients and the complexities of each shift.

We learnt that one of the key ingredients to the Huddle is data. A simple “days since last fall” chart worked best. Prompting discussions about why did the last event occur, and what could we have done differently – this brings team learning and a change in belief.

Celebration became our second key ingredient, with certificates and ward parties. Celebration was supported by the organisation’s executive and communication teams. Medical Admissions Units reached their ‘impossible’ - 30 days without a fall. Older People’s wards achieved more than 50 days between falls, a cardiology ward 190 days between emergency calls, and many more.
The original “pilot” wards were included in the Operational Plan, as there was ongoing support to these wards provided by the HUSH coaches, and learning was transferred to the scale up wards. For the purposes of the project they haven’t been included in the final Evaluation Report. However, an additional evaluation will be undertaken on these “pilot” wards, which should be ready by April 2018. A copy of the final letter to cover this extended period to undertake the additional evaluation is attached.

see attachment: 1._Final letter to confirm the end date extension and additional payment 12.06.17

Safety Huddles have now become a flagship programme in the Improvement Academy and is an integral part of their work as part of the Yorkshire and Humber Patient Safety Collaborative.

What changes have you made to the design and delivery of your project along the way? You may find it helpful to think about it in terms of stages set out in your project plan, or any particular incidents and turning points that you have experienced along the way that have shaped your project.

The Operational Plan was split into 3 phases: pre-implementation/engagement (4 weeks), implementation/testing (16 weeks) and sustainability/embedded (4 weeks). We decided the best approach was to work with the wards which were most engaged and had expressed an interest. We then used these teams to tell their story and used their learning to support spread to other wards. The early cohorts therefore became much larger than planned, as some CSUs (Clinical Service Units) were already keen for their areas to Huddle. The Operational Plan therefore became very dynamic and flexible.

see attachment: 2._Operational Plan

It was identified early on, that some highly specialised wards such as Obstetrics, Gynaecology and Paediatric Intensive Care, would require more coaching support for adaptation of Huddles into their world, and their focus was often bespoke harms where data was not being routinely collected. Therefore, these wards were spread throughout the cohorts within the Operational Plan. In the early stages, there were limited coaching resources in the Barnsley and Scarborough sites, so after recruitment and training of new coaches, these wards were supported in the later cohorts.

Another major challenge included wards opening, closing (due to winter pressures), ward merges and moves. In terms of data measurement, this proved to be an added challenge to keep track of.

In some wards areas, after initial engagement, it would become clear that the timing was not right to start testing Huddles. These wards moved into later cohorts to revisit at a later stage. Frequently, these ward teams would come back to us before we revisited to say they were ready and wanted support. We identified learning about when the timing to engage ward teams was not right, including a ward move being imminent, change in ward leader due to occur, and significant staffing issues.
We also identified learning in the implementation phase that the time taken to embed Huddles could be very variable from the set “16 week” period. Some wards would reach embedded and sustained Huddles within 4 weeks, others took many more months. There were many contributory factors, but teams valued ongoing support after testing as they wished to reach embedded stage, so the light touch coaching support was continued by the HUSH team throughout this period, to support teams to overcome any barriers.

**Who was involved in the project and how were those relationships managed, from both the core team and adopter sites perspective? How have you built and maintained strong relationships?**

Each year, the Improvement Academy and Leeds Teaching Hospitals have recruited clinical leadership fellows on a 1 year secondment to work on various improvement projects. The HUSH Project Clinical Lead and HUSH Programme Director have encouraged participation from clinical leadership fellows in 3 annual cohorts over the lifetime of the project to work as HUSH coaches. Informally, the earlier cohorts of leadership fellows supported the new coaches coming on board, and this led to the development of the HUSH coaches training workshops. This supported “light touch” coaching methods, peer learning, invitations to weekly HUSH project meetings, site visits, buddy training new coaches with existing coaches, and providing ward folders to complete details of progress on the wards.

Relationships with coaches on Barnsley and Scarborough sites were strengthened with monthly site visits by the HUSH Clinical Lead and other coaches.

Early executive level engagement with regular Steering Group meetings helped overcome initial challenges such as obtaining data for evaluation. Relationships at executive level in Scarborough had to be re-established after the original Medical Director (who had signed up and supported the grant) retired. The executive monthly steering groups became the vehicle to build relationships at this level over time.

In June 2017, the Improvement Academy hosted their first visit for members of the IK Improvement Alliance (UKIA), focusing on sharing learning regarding scaling up safety Huddles across organisations. This was attended by 12 visitors from England, Scotland & Ireland.

Alongside interactive presentations, we organised for members to observe two Huddles in different healthcare settings. The visit was a great success and very well received.

Here are some quotes relating to the visit:

“**I felt thoroughly welcomed and found the whole visit inspiring**”

Anonymous

Belfast, Ireland
To follow this up, the team did a short evaluation of the visit documented in the attachment below.

**see attachments:**
3. _UKIA Safety Huddles Visit Programme 7-8 June 2017_
3. _Report_UKIAvisit_June 2017_

### How were the patients involved in the design and delivery of the intervention?

#### General advice:
The Quality & Safety Patient Panel at the Bradford Institute for Health Research was regularly consulted on the project throughout, from proposal stage through to project completion. In addition, 2 members of this panel were recruited to work more closely with Claire Marsh in an advisory capacity throughout, as she planned involvement activities with hospitals.

#### Involvement of patient groups at each hospital:
At the beginning of the project (between Oct 2015 and Jan 2016), a focus group with members of the public (6-8 people attending each) was held at each of the 3 hospitals involved. These were organised in liaison with the Patient Experience Teams at each hospital who invited Trust members, volunteers, members of other existing patient groups, as well as advertising generally in the hospitals. The PPE lead Claire Marsh facilitated these focus groups which had the following aims:

- To raise awareness of the Huddles programme amongst the patient representative community of each hospital.
- To get feedback from members of the public about what they would like to see the project achieve.

The focus groups were sound recorded and analysed by Claire Marsh to obtain a summary of key feedback from participants to inform intervention development and delivery. Participants asked:

- Whether patients/carers views could be systematically brought into Huddles.
- Whether there is room in the Huddles for issues of importance to patients/carers which can differ to issues deemed important by staff.

This was fed back to the project management team, to the steering group, and to the coaches via a coaches workshop (February 2016). Ideas and tests of change generated from the PPI panel are described further in section 4(vi).

**Approximate words: 800 (actual 1387)**
Part 3: Impact

**What have you achieved to date - what difference has your project made and in what ways?**

Our HUSH video showcases our achievements to date and what the impact of Huddles has been on staff, patients and organisations. Huddles enable frontline teams to learn and improve. They empower staff to really focus on patient safety, resulting in significant reductions in patient harm and improved safety culture.

To view the HUSH video click [here](#).

A summary of our achievements to date (as at 07.08.17):

<table>
<thead>
<tr>
<th></th>
<th>Total wards</th>
<th>Embedded (excl SAFE*)</th>
<th>Wards huddling</th>
<th>Total wards with step change (includes non-embedded wards) (excl SAFE)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Barnsley</strong></td>
<td>27</td>
<td>18/27 (67%)</td>
<td>19/27 (70%)</td>
<td>9/27 (33%)</td>
</tr>
<tr>
<td><strong>Leeds</strong></td>
<td>84 (+12 SAFE*) = 96</td>
<td>72/84 (86%)</td>
<td>87/96 (91%)</td>
<td>38/84 (45%)</td>
</tr>
<tr>
<td><strong>Scarborough</strong></td>
<td>12 (+1 SAFE*) = 13</td>
<td>12/12 (100%)</td>
<td>13/13 (100%)</td>
<td>6/12 (50%)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>136</td>
<td>102/123 (83%)</td>
<td>119/136 (87.5%)</td>
<td>51/123 (41%)</td>
</tr>
</tbody>
</table>

“SAFE” = Situational Awareness For Everyone project, endorsed by the Royal College of Paediatrics and evaluated out with our HUSH project.

Step changes relate to frequently occurring harms such as falls measured by SPC charts. The significance in reduction of less frequently occurring harms such as pressure ulcers and cardiac arrest calls will be highlighted in the evaluation.

**What outcomes have you seen, including any wider evidence of impact? Who has benefitted and how? How has patient care changed as a result?**

Evidence of how Huddles have led to a reduction in falls and cardiac arrests at ward level, and then at organisational level as a result of “scaling up”, can be seen on the attached impact reports.

Additionally, Leeds Teaching Hospitals NHS Trust were identified by the CQC as achieving significant improvements, and were chosen to feature in their report: Driving Improvement, case studies from eight NHS Trusts, CQC 2017.

Safety Huddles, and the learning from this scale up is showcased within the report. Ali Cracknell was also invited to write a blog for the Health Foundation in relation to this report: [how safety Huddles can drive improvement and reduce harm](#).

The Improvement Academy, have been working with frontline teams across all Trusts and CCGs in Yorkshire, approximately 88 which have adapted Huddles into their organisations. Bradford District Care NHS Foundation Trust (Mental Health) is just one example of an organisation that has now scaled up safety Huddles, supported by our
learning from this grant. This has led to Huddles featuring as a tool for understanding how safe care is today, in the Measurement and Monitoring of Safety Framework e-guide: better questions, safer care: http://cdn.basw.co.uk/upload/basw_40205-4.pdf see attachments:
4. Impact report for NHSI
4. 2222 case study

How did you measure and evaluate the impact and outcomes of your project?
What you were measuring and how the data was captured?
Teams choose a harm relevant to them to focus on within their Huddle. The three main areas chosen by teams are one or more of the following: Falls, Pressure Ulcers and reducing avoidable deterioration (measured by number of 2222 calls).

Once teams start to test a Huddle, baseline data on their chosen harm is obtained from routine data collected by the Trust (at least 6 months retrospective data). For Falls data, this is displayed in a Statistical Process Control (SPC) chart and for Pressure Ulcers and 2222 calls in a “days between” format. Data is provided monthly to the ward teams by the coach so the wards can track their progress.

Bespoke data is often measured on a “days between” basis, with wards keeping track themselves, using specially designed charts displayed in their ward area and discussed within the Huddle e.g. days since of last line infection, number of days since re-admission.

An couple of examples of our bespoke charts are shown below:

As part of the data collection by the HUSH Implementation Team and for the purposes of evaluation, ward milestones are recorded on the Stages of Implementation Checklist (SIC) and ward level report. These key dates are then annotated on the SPC (Statistical Process Control) charts. This enables teams to see at a glance how Huddles are impacting on their data over time and tells the Huddles journey. Some updated charts (from those shown in the previous report) and the impact of Huddles are shown below:
Falls (Statistical Process Control), chart show the average number of falls pw. UCL = upper control limit. A step change reduction = improvement i.e. W21 (Gastro) – from 4.5 falls pw to 3 falls pw.

Pressure Ulcers and 2222 calls (days between), the higher number (days between) the better.

**Culture Surveys**

The Implementation Team have completed culture surveys on a large proportion of the wards within the Operational Plan as follows:

1st surveys: 114/123 (92.68%)
2nd surveys: 78/123 (63.41%)

Some of the wards have shown very positive results between the 1st and 2nd surveys. Some comparison slides are shown below. The green bars represent a more positive response when compared to the 1st survey.
Please provide a distinction between what the Evaluation Team was responsible for and what the project team was responsible for, and how you have managed this separation throughout the project.

Implementation Team

The main role of the Implementation Team was to: meet with each clinical team, discuss the role a Huddle may have, support teams in identifying the harm area they wish to focus on, ensure baseline data available, and then coach/support each team in testing and adapting Huddles into their world. Additionally the Implementation Team reviewed monthly harms data at ward level, feed this back to ward teams in a conversation, distributed certificates of achievement and collected Teamwork and Safety Climate (TSC) culture surveys from each ward at 2 stages:*

- 1st baseline survey (before testing Huddles/after initial engagement); and
- 2nd follow up survey (when the ward has achieved embedded Huddles. allowing a minimum 20 week period from start of implementation)

*excluding the 13 Paediatric “SAFE” wards in the Operational Plan.

Raw data from these surveys was sent to the Evaluation Team to compare pre and post survey results. The challenge from the Implementation Team has been achieving a true baseline, as some wards had already been testing Huddles or, in some cases, they had become embedded before a team culture survey was undertaken. This was highlighted to the Evaluation Team in real time. The results from each TSC survey are fed back to the ward team in a facilitated session, led by a coach from the Implementation Team. The TSC survey is an intervention in itself, identifying areas for a team to work on, as well as identifying many areas to celebrate their teamwork. Outstanding responses to questions were celebrated with the staff with a laminated slide (some examples below):

As mentioned earlier, a SIC (Stages of Implementation Checklist) and Ward Level Report were initially provided for each ward to complete to enable the Evaluation Team to build a story of the ward throughout the implementation period. These completed forms were sent to the Evaluation Team at regular intervals throughout the project by cohort, and used by the Evaluation Team to calculate a SIC score for each ward alongside recording the time spent (weeks) in each of the three phases of implementation (pre-implementation/engagement, implementation/testing and sustainability/embedded).
As the original forms were very lengthy and requested a lot of detail, in the later part of the project, after discussion with the Evaluation Team, only the SIC forms (not ward level reports) have been completed and updated regularly at the weekly operational team meetings using knowledge from the relevant coach.

Where teams have been slow to start testing Huddles, the Implementation Team have undertaken the Barriers and Facilitators to Patient Safety Huddles Questionnaires to identify barriers and facilitators to the implementation process. Results of these surveys have been scanned and sent to Dr Judith Dyson (Behaviour Change expert at the University of Hull) for analysis, and will feature in the evaluation report. Out of the 10 wards undertaking these ‘Barriers to Huddles’ questionnaires, three have completed both baseline surveys (to identify the barriers to Huddles) and follow up (to identify if the barriers have been successfully addressed) surveys. The Implementation Team supported teams to design interventions to overcome their barriers, often by sharing examples of how other teams have overcome a similar barrier.

see att: 5. Barriers to Huddles questionnaire distribution V5

By providing information to the Evaluation Team in a timely manner, this contributed to the “evaluation dress rehearsals” throughout the lifetime of the project to keep stakeholders and other interested parties up to date on the progress of the evaluation, and to ensure critical information from implementation is maintained.

The Evaluation Team also attended the weekly operational project meetings in the setup phase, and executive steering group meetings throughout the project. The latter in particular contributed to understanding and overcoming challenges, such as data flow from organisations and robustness of survey data collection.

Both evaluation and Implementation Teams have learnt together during the project, how to scale up a complex intervention, and enable simultaneous credible evaluation.

The implementation and Evaluation Teams worked jointly at the outset of the project to agree with each of the three NHS Trusts data sets for the routine collection of patient harms and balancing data. This data provided on a 4 weekly basis, has been used by the Implementation Team to generate Statistical Process Control (SPC) charts for the focus harm(s) which are discussed at the Patient Safety Huddle (PSH) on each ward e.g. falls, pressure ulcers and 2222 calls. SPC charts indicate whether there has been a step change in the harms data over time (ideally up to 6 months before first engagement and then 6 months after achieving embedded status). The harms data has subsequently been shared with the Evaluation Team to enable them to investigate the incidence of patient harms across ward groups, hospitals and trusts over time and to support statistical analysis.

The Public and Patient Involvement (PPI) aspects of the project have been led by Claire Marsh, Senior Research Fellow and member of the Implementation Team. Claire led on user consultation workshops with service user groups from each of the three NHS Trusts at key points in the project. Feedback from these PPI workshops informed testing of patient involvement in the PSH on two wards. Claire subsequently worked alongside the Evaluation
Fellow to include PPI questions in the evaluation questionnaires and interviews (time 2) and to conduct five group interviews with ward teams that incorporated discussion of the potential for patient/carer contributions to the PSH.

**Evaluation Team**

In addition to the data from the Implementation Team, the Evaluation Team have been conducting their own evaluation survey questionnaires, observations and interviews with ward teams to investigate the fidelity of Patient Safety Huddles (PSH), the scaling up and implementation process and the project impact and outcomes. In depth evaluation among n=25 ‘deep dive’ wards selected as a purposive sample, has provided insights to scaling up and exploration of the views of ward teams involved in the PSH. The Return on Investment (RoI) conducted by the York Health Economics Consortium (YHEC) has provided an economic evaluation for the project. Stakeholder feedback was sought from project leaders, coaches and other senior NHS stakeholders (either interviews or questionnaires). On an on-going basis throughout the project, the Evaluation Team has provided updates on the progress of the evaluation and shared emerging results with the Implementation Team. This ‘double loop’ communication (Developmental Evaluation) has enabled both teams to respond to the evolution of the project and the specific challenges of achieving scaling up across three NHS Trusts and five hospitals, within the context of a dynamic and complex setting.

**Are there any other benefits that have emerged beyond the original scope of the project?**

We have observed an increased awareness and empowerment among staff in clinical and non-clinical roles as to what they can do as a team to prevent harm, by taking ownership for their data, and believing they can make a difference. Furthermore, there has been greater collaboration between teams, sharing ideas, arranging to visit other teams’ Huddles and an awareness of how far other teams have gone, creating healthy competition to go further themselves. Mind-sets have definitely changed, and these are powerfully articulated in a video, with staff now believing milestones that felt impossible can be reality (e.g. achieving 50 days without a fall on an Elderly Care ward). To view the video, click [here](#).

Evidence can also be seen in the pride that some teams have in their Safety Huddles and the milestones that they have achieved. Some examples of these empowered teams can be seen on our Twitter account [@HUSH_safe](https://twitter.com/HUSH_safe).

Anna Winfield has written a piece used by NHS Improvement which is around a Huddles case study for culture and leadership (attached). [see attachment 6. Leeds FINAL AW](#)
The value of the non-clinical voice has really been an additional benefit, again described in the video. Indeed, a presentation in 2016 at the Leeds Teaching Hospitals ‘Talent for Care’ Support Staff Conference, by a housekeeper and 2 care support workers from ward J17 about their role in the safety Huddle, led to a porter approaching Anna to explore if Huddles could work in their area. Subsequently, the HUSH team supported the portering team to test and adapt Huddles to their environment, with further success, generating national interest and a “Time to Shine Awards” at Leeds Teaching Hospitals.

As Clinical Lead, Ali Cracknell really values the benefits the Health Foundation Grant has brought to the development of herself and the core team members in learning how to lead the scale up of a successful intervention across organisations. The grant has provided time, structure, and space to learn and has definitely brought new skills, confidence and credibility to the team.

Ali describes, “The Huddle is only as good as the people, team and organisational values behind it” and leading this work is about:

- Relentless commitment and patience, improvement and engagement skills and a willingness to learn with every team.
- Meeting every clinical team, understanding their world, and their safety concerns. Listening to their challenges, linking teams together to find solutions and coach them through PDSA cycles.
- Learning to support teams at the right time for them, not because a particular ward has ‘a problem’.
- Providing ongoing support and sharing new learning, alongside really celebrating achievements and being open about failure to share what doesn’t work, as much as what does.

Ali and Anna Winfield were recently runners up in the NHS Improvement Sir Peter Carr award, where the scaling up work played a significant part in their success.

The communication and celebration of ward level achievements, has brought interest from many other areas. Again, where this is local the HUSH team and Improvement Academy have been able to support the approach with “hands on” coaching support. Huddles are now occurring in care homes, mental health trusts, hospices and GP surgeries in Yorkshire. To give one example, Field Head Court Care Home have embraced Huddles and are showing excellent progress.

A copy of their recent SPC chart can be seen below which shows a step reduction in their falls. They have recently been awarded a certificate for 70 days without a fall.
Part 4: Learning

Did you achieve all of what you hoped to achieve at the start of the project?
At the beginning of the project we did not know if it was possible to Huddle successfully on every ward, with different specialties, differing team dynamics and in different organisations. Furthermore with the challenges of varying levels of engagement and cynicism that can come with new ideas to change how a team work, we did not we would be able to get even get most teams to try testing a Huddle in their area. We are surprised and proud that approximately 90% of the wards are huddling and that we have been able to learn how Huddles can be adapted to many different areas with benefits to both frontline staff and patients.

This is mainly down to the relentless commitment of the core project team and coaches, to continue to support a ward through their challenges for as long as it takes, unless it was clear a ward didn't believe Huddles would work for them. This was the case in only a small number of highly specialised areas, often with very small patient numbers and just one team of staff to care for them (e.g. 4 bedded Surgical HDU at Barnsley). Where wards were struggling to embed Huddles, it was usually not down to a lack of willingness to do them, but factors that needed to be overcome with time, support and improvement methods.

We have achieved an impact far beyond our ambitions, and the HUSH work continues to spread well beyond these 3 organisations.

What did you learn about your intervention as a result of trying to scale it up?

(i) Have you changed how you think about or describe your intervention as a result of implementing it in other sites?
One of the key points is that we have learnt to modify our theory of the key ingredients to a successful Huddle. The original key ingredients identified were that Huddles:

- Are Informed by QI tools and visual feedback
- Are Focused about one or more agreed patient harm/s
  - who are the patients most likely at risk of harm?
- Have Agreed actions
  - set of team/individual actions (aimed at reducing risk of patient harm)
- Are Multidisciplinary with whole frontline team invited to attend
  - including non-clinical
- Have Senior clinical leadership
  - Non-judgemental environment and all team staff empowered to speak up
- Are Daily (Monday - Friday as minimum).
  - Predictable time and venue (appropriate to team and context)
  - Brief (5-15 minutes)
- Are Celebratory with recognition of milestones
We have learnt data and celebration really are key, and are what makes a “HUSH Huddle” different from other Huddles or handovers. We have also learnt senior clinical leadership is not as essential as we thought, but senior engagement is still important. Being led by the right leader, who is respected and credible for that team is crucial, in some cases this has been a physiotherapist, band 5 nurse or ward clerk, although most Huddles are led by the nurse in charge.

This has helped us develop our theory of how organisations can embed and sustain Huddles. This is illustrated in the PowerPoint slides below and will complement the development of our logic model, which will be informed by the project evaluation (December 2017).

see attachment: 7._Theory of Change – from HUSH project to sustainable cultural change

(ii) Have you had any concerns about fidelity to the original intervention during implementation?
In Barnsley and Scarborough, they have adapted their Huddles to suit their working environment and culture (not always referring to them as Huddles but “debriefs” for example). Sometimes their Huddles are implemented in a different way, but with the same basic principles and achieving positive results (i.e. a reduction in their harms and positive impact on the staff who have embraced Huddles). Involvement of medical staff, has been also more challenging on these sites, especially as the senior medical workforce has a higher proportion of locum staff.

(iii) Have you seen innovations from other teams as a result of adapting the intervention?
We are really proud of how other teams have been empowered to test Huddles in different environments, as a result of hearing the success of the HUSH teams.

One specific example of this is the way some non-clinical teams have learnt to use Huddles successfully in their worlds. The twice weekly portering Huddle in Leeds is described in the video and has attracted national interest.
Porters in Leeds have adapted their Huddles in the following ways: porter Huddles are held twice a week instead of 5-7 days per week and the focus is around safety and experience in the eyes of a porter. Every Huddle is supported by Anna or Ali to provide a clinical link and on an approximately weekly basis they invite an external speaker from another area of the hospital to both provide information about their area and to help support the team in leading improvements in clinical processes (e.g. Cystic fibrosis team explaining reasons behind different transport route for patients with *Burkholderia cepacia* and hospital transfusion team to improve process for transportation of blood products)

Some care homes have successfully adapted Huddles, and hold them twice a day.

Yorkshire Ambulance Service have adapted safety Huddles for use within their Emergency Operations Centre (EOC) successfully, with a focus on learning from safety incidents within the last 24 hours and things that might affect safety that day; such as staffing levels, traffic incidents and weather. They have undertaken human factors training for key staff within the EOC to support the process and enable staff to recognise common human factors that negatively affect safety in this setting. Safety Huddles support excellence in communication and enable informal learning to take place on the job.

Mental Health Teams within Bradford District Care NHS Foundation Trust have had great success with implementing their Huddles around reducing violence and aggression, with their clinical practitioners recently awarded winners in the Healthcare Heroes Shine at You’re A Star Awards 2017.

They have also written an article around positive change as part of the Sign up to Safety campaign.

(iv) What constitutes the essential ‘ingredients’ of the intervention and which elements may need to be adapted to different contexts?

The essential ingredients of the intervention are detailed in the Huddles Manual. We have created a HUSH banner which summarises 8 essential ingredients to a Huddle (*HUSH pop-up*). We have learnt senior clinical leadership is not essential, but where possible should be strived for. Adapting the principles to different contexts is crucial and learning what is important to focus the Huddle on for each team.

Coaching support is key to the success, supporting and nudging the teams to test and learn how to Huddle. Data within the Huddle, and using this to have a conversation, helps the team learn from harm, why it occurs in their area and creates team memory of harm events. Furthermore, data brings celebration of the milestones, key to the sustainability of Huddles and ongoing motivation of teams to go even further.

see attachments:
8._Huddles Manual Booklet_May2017
8._HUSH pop-up
(v) What are the key things others would need to know / put in place if they were to adopt your intervention?

The factors below are key areas for an organisation to have in place to support adoption of Huddles at scale:

- **Stakeholder engagement:** ensuring the support of key people at executive/board level in the organisation beforehand. For example: Chief Medical Officer, Chief Nurse and making sure they have some capacity to contribute to the spread of the intervention, joining in celebration of team achievements and supporting the requirement for data infrastructure.

- **An Organisational Clinical Lead:** to champion Huddles and support the vital frontline clinical engagement.

- **Informatics and data support:** agreement in advance with key IT contact to supply requested data on a regular basis (and adhering to data governance requirements) and making sure there are enough resources within the organisation to support the production/monitoring of charts and data for reporting purposes, and to inform the celebration of achievements.

- **Coaching support:** identifying key personal internally to become Huddles coaches. Supporting them to learn by shadowing other more experienced coaches and observing wards who are successfully huddling. Keeping them up-to-date of any relevant processes relating to their role (i.e. ward engagement, capturing key milestones, data measurement with teams, the relevance of measuring culture before and after and giving feedback to teams). This will be supported by the ongoing coaches training offered by the Improvement Academy as part of their Huddles Coaching Network.

- **Administration/project support:** sufficient resources to support the scaling up in creating support material i.e. days between charts, certificates, etc. and keeping a rolling record of wards, supporting the coaches in recording key milestones.

- **Ward engagement/meeting:** with key ward staff before any intervention by the lead or coach for Huddles (usually a consultant and/or ward manager). Usually followed by identification of an enthusiastic individual on the ward to act as a link between the frontline staff and coach (this could be the ward manager, a B5 nurse, therapist or junior doctor, etc).

The above is covered as part of the sustainability plan. However, we have supported natural spread in approximately 88 teams across other organisations using the principles and learning detailed above.

**What were the enablers that helped you?**

The key enablers were:

- Support at executive level from the Chief Medical Officer and Chief Nurse which helped to influence and resolve major issues (such as access to data).
• Input from the Clinical Project Lead and the Patient Safety and Quality Manager at Leeds Teaching Hospitals acting in an engagement/coaching capacity.

• Coach support within each organisation to act as a link to the frontline staff and the HUSH team, e.g.: from the Patient Safety and Quality Lead in Barnsley and the Patient Safety Manager in Scarborough plus the clinical leadership fellows appointed within the Improvement Academy and Leeds Teaching Hospitals.

• Project and administration support – for keeping records up-to-date such as the operational plan, finance, steering group and project meetings/actions, production of support material and arranging meetings, related events, etc.

• Sustained and continuous leadership from both the Improvement Academy (Alison Lovatt) and the Project Clinical Lead (Ali Cracknell) to ensure that, at every level, the project rigorously adhered to improvement principles and faithful application of the learning about what makes an effective Huddle.

(vi) Did contribution of a particular individual or group make the difference? Why was this important? How did you ensure patient and staff buy-in?

Leadership of the project by the whole team across the organisations has been key, bringing collaboration and learning across organisations as well as between frontline teams.

Identifying local leaders and support new coaches to continue to spread the work and learn is important, and resulted in the formation of the HUSH Coaches Network. Supporting local areas and departments to take ownership for supporting scale up in their wards has worked well, for example the Oncology Clinical Service Unit (CSU) in Leeds Teaching Hospitals.

Staff buy-in: was achieved through peer- learning; encouraging new wards/staff to observe and learn from other wards successfully huddling to act as a role model, and showing evidence of where harms had improved (i.e. through SPC charts), the key link for developing new areas being the coach.

We held a HUSH Celebration event on 25th May 2017 where we brought frontline staff from the three organisations together, alongside teams from other areas huddling outside the scale-up grant. This was a really great day, with teams taking new learning and new ideas away, with support from their coaches to try them out. see attachment: 9._Flyer_HUSH_CLEvent_25.05.17

Patient buy-in: because of these focus groups and subsequent team discussions, Claire Marsh (with the help of the coaches) discussed the findings with 5 ward teams, 3 of which agreed to instigate small scale tests of patient/carer involvement. Informed by materials developed in other Huddles projects nationally, a flyer was developed to support these tests. This was designed to allow patients and carers to record concerns that they wished to submit to Huddles. One ward tested the collection of these concerns via nursing staff, and the other via volunteers. The other ward did not use any formal collection form.
Through these discussions and tests the project team learnt that the incorporation of patient and carer concerns in Huddles is not straightforward. Our main finding has been that patients/carers’ concerns (e.g. communication, attitudes, staffing & resources, noise / sleep, medication queries) are indeed different to those that staff wish to focus on in Huddles (e.g. pressure ulcers, falls, 2222 calls). There is therefore much hesitation from staff about how appropriate it is for their concerns to be brought in regularly when Huddles are designed to be brief and focused. Staff in these tests also believed that if a patient had a safety concern, they would already be aware of it from less formal communications with patients, and so would bring these anyway without the need for a formal process.

**Patient & staff buy-in:**
The project team fed back the findings of these tests to staff and patient advisors via project meetings, evaluation dress rehearsals, the HUSH Celebration Event, and the Quality & Safety Patient Panel. It was agreed that it was inappropriate to continue further testing before the topic was understood in more depth. Claire Marsh has therefore worked with the Evaluation Fellow (Kate Crosswaite) to incorporate some exploratory questions about patient/carer involvement into the evaluation questionnaire which will reach large numbers of staff involved in the Huddles. Claire and Kate have also incorporating this topic into in-depth ward interviews with 7 ward teams.

The outcome of this involvement work has been a far greater understanding of the potential role (including challenges and limitations) of patient/carer voice within Huddles. This has led to the addition of a specific section including recommendations on this issue, to be included in the final evaluation when this was not originally planned. This will inform Huddles teams about how they can consider this important issue in a meaningful manner.

The patient experience teams who supported the initial focus groups will be provided with a summary of these findings for circulation to those from their patient groups who participated.

(vii) **Was there an aspect of culture, technology or policy (national or local) that helped you?**
Twitter and social media has definitely had a positive influence, sharing and showcasing ward achievements, helping frontline staff feel recognised, and generating interest from other teams both locally and externally.

The culture of giving the whole team a voice in the Huddle empowers them to speak up / raise concerns, and take responsibility to learn together and improve even more. Alongside bringing a positive culture of learning and celebrating to the ward environment, showcasing great care and what can be achieved, rather than focusing on when things have gone wrong.
What didn’t work out quite as planned?

(viii) *Were any of these predictable risks? How effective were your mitigation strategies?*

Risks identified were documented on our risk register (risks which have been fully mitigated are shaded out in grey). One of the main predictable risks was the delay in implementation on of some wards. This was successfully mitigated by HUSH coaches attending departmental meetings attended by key people, where the HUSH coaches spoke to them about the Huddles work (for example in Critical Care and Obstetrics and Gynaecology), and having a flexible and dynamic operations plan. In Barnsley and Scarborough, where initially there was not a consistent coaching presence (before the appointment of Lisa Pinkney), Ali Cracknell and Alison Lovatt made monthly visits to the wards to keep momentum and support these wards.  
*see attachment: 10._HUSH_Risk Register 12.07.17*

(ix) *Were any of these unexpected challenges? How did you try to overcome them and how successful were these efforts?*

The principal coach in Barnsley, Wayne Robson, left the Trust so Heather McNair the Chief Nurse identified 2 further coaches. Ali Cracknell visited Barnsley on 23rd August 2017 to accompany the new coaches on the wards and give them guidance.

Another unexpected challenge was the departure of Michael Rooney, Senior Analyst at the Improvement Academy in April 2017. Improvement Analyst Jaspal Bagral took on the tasks previously done by Michael, but there were some temporary delays in the production of the SPC and days between charts. Other staff within the Improvement Academy have been trained in culture survey analysis and annotation of SPC charts to increase capacity.

As mentioned in the previous report, there were challenges in the culture survey collections in Barnsley and Scarborough:

- **Barnsley** - the planned organisational wide AQuA survey had a very low response rate in early 2017, so the HUSH team had to re-visit the wards and collect further teamwork and safety culture surveys.

- **Scarborough** - the initial surveys were completed at the end of 2014 as part of a “Fresh Start” initiative. However, these surveys did not have the additional patient safety question (question 28: overall grade on patient safety), and some changes may have occurred with the ward teams and their environment prior to Huddles work.

As a result of these delays, some of the wards in both sites became embedded before the follow up 2nd survey could be completed or, in the case of Scarborough, before we could re-do the 1st survey (with the additional patient safety question). The Evaluation Team have been kept up-to-date throughout this process.
(x) Were there any aspects of culture, technology or policy (national or local) that acted as a barrier?
A summary of the key barriers related to the above identified are:

- The introduction of new ward initiatives which ate into staff time and resources, for example e-meds, e-obs, SAFER initiative, sepsis campaigns.
- Key staff leaving / staff shortages and workforce challenges.
- Ward moves/closures/merges.

(xi) Did you get any feedback that surprised you?
It has surprised our team that only a small proportion of wards have either not wanted to do Huddles or feel that Huddles would not have an impact on their ward (usually due to them being a very small unit with less than 5 beds). Out of 136 wards in the Operational plan, only approximately 8 wards are not likely to achieve embedded Huddles or do not want to Huddle.

Dr Yvette Oade was particularly surprised that teams not only continued to Huddle but new teams came on board during the winter months when the hospital was at its busiest. Winter did not stop the momentum.

Following a visit from the Care Quality Commission, we were surprised to see Huddles featured as a vehicle for empowering staff to lead improvements and creating an organisational culture of improvement: Driving Improvement, case studies from eight NHS Trusts, CQC 2017.

(xii) What will you – personally, as a team or as an organisation – take away from this project?
Scaling up Huddles has been an immense commitment, but incredibly rewarding, as we have seen teams achieve results they just did not believe were possible.

We have all learnt so much, particularly the lessons of scaling up, which we are already using to support other organisations. Also about using the science of improvement and learning the art of coaching teams to adapt Huddles in their world and their organisation; understanding why some wards take 18 months to embed the principles, others a few weeks.

We learnt the key ingredients to embed successful Huddles, and that the Huddle allows the team to adapt to the complexities of the shift, bring all the team together to see the bigger picture and have a voice in safety; with non-stop learning, testing new ideas, sharing, listening, collaborating and celebrating.

As Clinical Lead, Ali Cracknell feels she has developed and grown as a leader, appreciating it is about doing it, meeting every clinical team, understanding their world, and their safety concerns. Co-ordinating the approach, not telling anyone how to Huddle, but listening to their challenges, linking teams together to find solutions, nudging and coaching them through PDSA cycles. Mandating Huddles doesn’t work.
Learning to support when the time is right, not when you are told because this ward “has a problem”, to be there when they are ready, but equally them knowing you will be back, and by then we will have even more learning to help them. And of course knowing it’s okay to fail, as sharing that is equally as important.

Every coach has developed new skills and an appreciation of how to support improvement on the frontline. Anna Winfield has taken these skills into totally new areas, for example supporting the Huddles within the Portering team at Leeds.

At an Executive level, we have learnt to allow the space for the work to develop and flourish in a way that engages and energises at ward level. The art here is not to “performance manage” the scale up.

We will all take away the importance of celebrating and sharing achievements, something that can be undervalued.

*Approximate words: 1200 (actual 3225)*
Part 5: Embed and spread

**Will your intervention be sustained in all organisations / sites where it was implemented beyond the funding period?**

(i) **If no, why is this? If yes, how did you gain support?**

The Implementation Team has been working for over 2½ years on sustaining and embedding Huddles at ward level and within the organisations. Teams that were huddling in 2015 still continue to do so, with minimal ongoing light touch support. We are confident and proud to say that the intervention will be sustained. Many staff tell us if they were told to stop huddling tomorrow, they wouldn’t!

Sustainability meetings with the executive leads have now taken place on all sites:

- Scarborough - 10.03.17
- Barnsley - 10.04.17, and
- Leeds 18.05.17

Further site visits by the Clinical Lead to Barnsley and Scarborough will be taking place in August and September. We have created a one page sustainability plan for each site covering the resources required for scaling up and supported by material and further training from the Improvement Academy. These are being supported by both Yvette Oade in Leeds and Heather McNair in Barnsley. York Trust are currently now scaling up Huddles to their other sites and this has been included as part of their own sustainability planning, supported by Diane Palmer. So not only are sustainability plans in place, further spread and scale up is happening.

**see attachments:**
- 11._Sustainability_plan_Scarborough_v3
- 11._Sustainability_plan_Barnsley_v0.2
- 11._Sustainability_plan_Leeds_v0.4

**What are the biggest risks and challenges you face in embedding the intervention into routine practice? What progress have you made to date and how are you planning to overcome them in the future?**

We have found that a large majority of the teams that are doing Huddles have embedded these within their routine practice after coaching support.

Measures put in place to ensure that Huddles are maintained and embedded into routine practice are outlined in the sustainability plans above and include:

- Coach(es) to do routine visits approximately half a day per month on a rotation basis to the wards.
- To encourage wards and corporate nursing teams to proactively contact coaches and advise them of any changes on wards planned, so coaching support can be increased again. For example, a key person leaving or a ward moving. Visits to these wards would be prioritised to offer coaching support to keep the momentum of Huddles.
• Being aware of new initiatives introduced at organisational level and predicting if this could impact on taking precious time away from Huddles.

• For organisations wanting to “mandate” Huddles and the area of focus, the team feels strongly that this would hinder the implementation process. We would use the evidence we have from the scale-up, to confidently articulate why we believe this would be a risk e.g. Staff would see this as just another “job” and not feel engaged and part of the success.

• Keeping the momentum of celebration and data achievements and success via Twitter and other social media. This keeps awareness “fresh” amongst the teams and encourages friendly competition and pride amongst team members.

Do you plan to spread this intervention beyond the Scaling Up Improvement sites?

(ii) If so, how?
This is already being done as part of the work of the Improvement Academy with each partner organisation, and also supporting the Safety Measurement Framework within Trusts. To date we have teams Huddling in 18 other healthcare organisations throughout the region. This covers: Acute Hospital Trusts, Mental Health Trusts, Community, Care Homes (via CCGs), Hospices and Yorkshire Ambulance Services. One of our coaches has recently been contacted by a Special Needs School in the region who want to look at starting Huddles.

In addition to the Yorkshire and Humber region, we have also received interest from other parties outside the region as part of the UKIA Huddles visit and one being a direct enquiry from a large national security firm. We are currently looking at putting together a 12 month coaching support package for organisations outside the Yorkshire and Humber region. This proposal has currently been created in draft format - to be finalised. Alison Lovatt, Ali Cracknell and Anna Winfield have also supported colleagues from Kent, Surrey and Sussex AHSN to implement Huddles and measure culture in their organisations.

(iii) What additional resources will you need to support this activity beyond the funding period, and from whom?
The following support and commitments have been agreed by the organisations:

Leeds: continuing Stakeholder support provided by Yvette Oade, Chief Medical Officer and Jackie Whittle, Head of Nursing for Informatics to act in a Steering Group capacity. Ali Cracknell and Anna Winfield will continue coaching and overseeing the work, with coaching support from clinical leadership fellows and others expressing interest/attending training via the coaching training network established by the Improvement Academy.

Administration support from within the Quality Department and Clinical Service Units to help with production of certificates and SPC charts, keeping up-to-date records of
milestones achieved and ensure certificates are awarded to teams backed up by publicity in-house. Key individuals within CSU’s have been identified by Ali and Anna to continue to supply data at ward level.

**Barnsley:** support at Stakeholder level to be provided by Heather McNair, Chief Nurse. Two new coaches: a Falls Specialist Nurse and Tissue Viability Nurse who have had introductions and training on 23.08.17. Data to be supplied by Interim Risk Management Co-ordinator. Colleague identified as key person for communication and celebration of milestones.

**Scarborough:** support at Stakeholder level to be provided by Head of Nursing. Coaching from Lisa Pinkney, Patient Safety Manager. Data to be completed in house and administrative support for milestones and certificates.

For outside the project, the Improvement Academy have set up monthly Huddles meetings to include all Improvement Academy staff working with teams on Huddles within their projects. We are consolidating the knowledge and materials we used within the HUSH project to utilise in other organisations. This will be part of the programme for the Coaching for Safety Huddles Training Workshop 14.09.17 (see below: upcoming milestones/activities beyond our funding).

**What external interest and recognition have you had on your intervention?**

(i) *Have you received any awards, spoken at conferences, been published or had media interest?*

A full summary of recent awards and presentations are shown on the attached log.

Our work has achieved national interest and recognition.

We are most proud of the following (please click on links below for further information):

- Nursing Times Awards – ward J21 is shortlisted for the **category Team of the Year category** (September 2017).
- Porters ‘Time to Shine’ awards – one of the winners in the **Best Support Worker/Team Category**.
- Bradford District Care NHS Foundation Trust – (Lynn Pearl and Katie Cray) – Highly commended in the **Patient Safety Awards 2017** around Changing Culture relating to Safety Huddles (July 2017).
- Ali Cracknell and Anna Winfield were recently awarded a £10k grant as runners up to The Sir Peter Carr award.
(ii) What communities or networks have you targeted for ensure the further spread of your intervention? What contacts have you made?
We have used the National Patient Safety Collaborative network to showcase our work and gain further interest, alongside the network of the Improvement Academy and Yorkshire and Humber AHSN presenting our work at national conferences.

**November 2017:** Science of Improvement, Harrogate Conference Centre. A 2-day conference organised by the Improvement Academy attended by approximately 387 people nationwide where we ran a workshop “How can I make Patient Safety Huddles work in my area?”

**March 2017:** the HUSH team attended the National Patient Safety Collaborative Learning Event in London where we did a workshop on Safety Huddles.

**July 2017:** Claire Ashby, Natalie Jackson and Liz Watson who work for the Improvement Academy, attended a coaching programme in Swindon in July 2017. This programme is being developed through the West of England Academic Health and Science Network. Some of their objectives are in line with those that the Improvement Academy are proposing for their coaching training workshops, so would give both parties a good opportunity to share knowledge and learning. A blog on the learning from this course can be seen [here](#): Ali and Anna have taken opportunities provided by the Royal Society of Medicine (June 2017), Royal College of Physicians Annual Conference 2016, Patient Safety first to showcase the work too (November 2017).

*see attachment: 12._Awards_Presentations_Publications*

**What are some of the upcoming milestones/ activities beyond our funding?**
As part of our ongoing work and sustainability planning, the Improvement Academy are holding a “Coaching for Safety Huddles Training workshop” on 14th September 2017. This comprehensive training programme is targeted for existing coaches that have already started work in implementing Huddles, and people who have been nominated to start work in a coaching role within their organisation. Attendees are invited from a variety of healthcare sectors throughout the whole of the Yorkshire and Humber region (including Mental Health, Community, Care Homes, Yorkshire Ambulance Services). An additional 2 free places have also been offered to candidates outside the region on a first come first served basis. The plan is to hold these training workshops on a regular basis as part of our national coach training network.

*see attachment: 13._Flyer_HUSH_14.09.17*

Another up and coming event is the Patient Safety First Conference on 21 & 22 November 2017, London where we will be doing a presentation: Safety Huddles: Bringing fun to the Frontline.

After the success of the UKIA visit and event, the Improvement Academy are exploring the possibility of holding further events and site visits to Huddles. *Approximate words: 800 (actual 1447)*
Part 6: Feedback to the Health Foundation

The support from the Health Foundation has been important to us and readily accessible whenever we have needed. We have found the initial planning event with the other teams in the setup phase useful, alongside the early site visit to identify where are strengths and gaps as individuals lay. The mid point event also provided us with the nudge to really commit to planning the sustainability phase - an area we could have neglected otherwise as we concentrated on the immense task of implementation.

It was important to us for representation from the Health Foundation to come to our Celebration Event which took part on 25th May 2017, to hear and feel what the project has meant to the teams involved across the hospitals, and we were proud to demonstrate our achievements with the award.

The communications team have been helpful and supportive whenever needed. A final event with the other teams, to hear their progress and achievements at the end of evaluation phase would be really rewarding.

Any queries and considerations of adjustment to the budget were always dealt with promptly.
### Appendix 1: Resources / outputs to share

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