# Leeds Teaching Hospitals NHS Trust: Measuring progress and celebrating success with safety huddles

**What was the aim?**

Leeds Teaching Hospitals NHS Trust (LTHT) wanted to take a whole-team approach to reducing patient harm.

**What they did.**

Ward teams now meet every day in a ‘safety huddle’ to discuss patient harm such as falls, pressure ulcers and avoidable deterioration.

“The ward team meets for a five to 10-minute focus around a safety issue relevant to their patients,” says Alison Cracknell, Consultant Geriatrician. “For example, on an older people’s ward the team will look at ‘who are we most worried about falling today, and what actions can we take as a team to prevent harm?’ They review data – for example, days since the last fall – celebrate milestones and share learning about why the last patient fell.”

Staff from all roles and seniority levels update the team with information and insights into individual patients’ risk levels and the action they plan to prevent harm. Healthcare assistants, housekeepers, students and therapists are often central to information gathering, and feel able to voice their concerns and insights to medical and nursing colleagues.

Visual displays and reminders show the importance that teams place on safety. Eye-catching signs displaying the number of days since the last harm event are updated in the huddle.


Milestones in performance are marked by presenting certificates to teams.

*"*A week between falls was a rare event on a medical ward," says Dr Cracknell. "So the idea began of celebrating 10 days as a bronze certificate, silver for 20 days and what seemed unachievable – gold for 30 days between falls.*"*

Medical admissions reached this seemingly impossible target of 30 days without a fall, while one older people's ward went 56 days. The neuro-rehabilitation unit achieved more than 100 days between falls, and a cardiology ward went over 130 days between cardiac arrests.

After hearing a presentation by Dr Anna Winfield – Patient Safety and Quality Manager, on involving non-clinical staff in promoting patient safety, Paul Tobin, a porter at St James's Hospital, and colleagues introduced portering patient safety huddles – the first of their kind in the UK. These build on the portering team's unique access to every ward and clinical area, and take place twice a week.

Porters across the trust highlight issues and discuss improvements to patient safety. Their regular contact with staff and patients means they are ideally placed to propose changes that make a lasting difference to patients' comfort and safety.

Guest speakers are regularly invited to attend the huddle to raise awareness of specific patient safety issues. The infection control team, information governance team, cystic fibrosis specialist nurse, blood products team and haematology matron have all shared valuable insights.

Issues raised by porters have led to action to improve patient safety and experience: for example, their work with the blood bank helped reinforce the correct procedure for ordering blood products.

Dr Winfield says: *"*Porters are an essential part of our multidisciplinary team, and through their huddles have raised awareness of their valuable role and made many positive contributions to patient safety. They recently won an LTHT 'Time to shine' award for best support team. It is a privilege to work with such a fantastic team.*"*

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Congratulations to Paul Tobin (left), Anna Winfield (third left) and colleagues on the success of portering safety huddles

# Porters score UK first with new safety huddles

An exciting new initiative launched by members of the portering team at Leeds Teaching Hospitals is making a real impact on patient safety and has won this year's Time to Shine Award for 'Best Support Team'.

Paul Tobin, a Porter at St James's Hospital and his colleagues have introduced portering patient safety huddles - the first of their kind in the UK - which build upon the portering team's unique access to every ward and clinical area in the Trust.

Paul was inspired to adapt the huddles concept to the portering world after seeing a presentation given by Dr Anna Winfield, Patient Safety Manager at the Trust's Talent for Care conference last September. Anna spoke on involving non-clinical staff in huddles and promoting patient safety.

A few weeks later, Paul led the first portering safety huddle in the UK at the Trust and since then they have continued twice weekly, supported by the portering management team.

The porters' regular contact with staff and patients means they are in an ideal position to propose changes that make a lasting difference to patients' comfort and safety.

**As a result of issues raised by porters, a number of positive actions have been taken to improve patient safety and experience.**

Paul said: "Our huddles give porters across the Trust a platform to highlight issues and discuss the improvements that could be made."

Guest speakers are regularly invited to attend the huddles to raise awareness of specific patient safety issues.

Valuable insights have been shared by the infection control, information governance and blood products teams, the Cystic Fibrosis Specialist Nurse and Haematology Matron.

The huddles are already a huge success. As a result of issues raised by porters, a number of positive actions have been taken to improve patient safety and experience. An example is their work with the blood bank to reinforce the correct procedure for ordering blood products.

Anna is delighted with the huddles' progress, saying: "Porters are an essential part of our multidisciplinary team and through their huddles they have raised awareness of their valuable role and made many positive contributions to patient safety. It is a privilege to support such a fantastic team."

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**What are the outcomes?**

All team members see the huddles as a daily investment to improve patient outcomes and staff morale.

The huddles include regularly measuring progress and celebrating success, helping teams to continually learn and improve. Teamwork and safety culture measurements

have shown positive changes. Ward staff report that the huddles encourage healthy competition: if the ward next door can get to 20 days between falls, another wants to get to 30. Staff say they feel more confident in the huddle to speak up about patient safety concerns. In addition, non-clinical staff such as housekeepers reported increased job satisfaction and a sense of feeling part of the wider multidisciplinary team.

After two-and-a-half years, more than 90% of wards have a daily huddle.  Across the trust, falls and cardiac arrests have reduced by 25%, safety culture has improved and staff feel recognised for their work.

**What is the learning ?**

Our approach uses the science of improvement methodology and the art of coaching. It takes time and patience. The huddle brings people together to give them a voice and role in safety. It brings non-stop learning, testing new ideas, developing, sharing, listening, talking, collaborating and celebrating. It requires people with improvement and engagement skills to coach – and learn with – each team as they test and adapt huddles. No two wards are the same.

The key to success is empowering teams that work together to improve together by using QI methods at scale and creating a learning environment. The executive team's support for ward teams, and its pride in their achievements, enabled the work to flourish in a way that engages and energises local teams. Discussing ward-level data in the huddle brings ownership and a belief that new milestones can be achieved. Celebrating teams' results drives them to go even further.


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