Two years to make a difference in Welsh Healthcare

2008-2010
Every health board and trust was involved in the Campaign, working on up to seven key content areas. These include reducing healthcare associated infections and surgical complications, and improving critical care and medicines management.

The Campaign has used a new measurement tool which has enabled organisations to identify where harm occurs. This represents the first time harm has been measured on a national level and is to be the subject of a major four year research study.

The final figures indicate that 50,000 episodes of harm have been prevented, but it is recognised that the methodology needs further work in order to provide a greater degree of confidence.

“It’s important that we are able to measure when, and where, harm takes place,” says Campaign Director Dr Alan Willson. “The work undertaken by organisations through the Campaign provides the basis for ongoing work to reduce harm in Welsh healthcare.”

Best initiative

The Campaign has been effective in rolling out best practice across Wales, as seen in the implementation of the World Health Organization’s Surgical Safety Checklist, which is now being used by operating theatre teams throughout Wales.

The checklist ensures that there is effective communication by those involved in the surgery. It focuses on basic good practice: checking the patient’s identity and the correct part of the body for operation, ensuring all necessary equipment is available and providing an opportunity for discussing any complications that may arise.

WalkRounds

Patient safety WalkRounds have been introduced in nursing homes, GP practices and hospitals. These help staff to raise safety concerns, suggest solutions and ensure concerns are quickly acted upon directly with senior managers. More than 600 WalkRounds have already taken place across Wales.

Working with health boards and trusts over the last two years, the 1000 Lives Campaign has:

- Made sure that patients with deteriorating conditions are now being identified earlier, so that nursing staff can intervene more quickly and request medical intervention;
- Implemented a procedure to prevent pressure ulcers, which has led to some wards having gone more than a year without a case;
- Changed attitudes towards infections caused by central lines - they are now regarded as avoidable and often investigated as a critical incident when they occur;
- Engaged patients in the safety agenda by using more of their stories to complement traditional reports and data-based information in board meetings;
- Reduced the number of infections related to surgery - thanks to the replacement of razors with surgical clippers and better monitoring of patients’ temperatures before, during and after surgery;
- Worked with GPs to improve the reliability of drug dosage instructions given to patients, particularly in relation to Warfarin;
- Improved treatment for patients with chronic heart failure through enhanced services, including improvements in diagnosis, medication and lifestyle advice;
- Developed a number of ‘trigger tools’, which are now being used by GPs, the Welsh Ambulance Service and staff at Velindre Cancer Centre to identify and track potential harm.

Maintain the momentum

“Patient safety is now on the agenda of every health board and trust in Wales and the Campaign’s new ways of working are clearly making an impact,” says Dr Alan Willson.

“However, it’s essential we maintain the momentum and don’t lose focus. The ultimate goal will be to have this good practice embedded in every organisation, so that it can be reliably and consistently delivered.”

For further details on how the mortality and harm figures were attained, visit www.tinyurl.com/3yvkcqw

The Campaign is estimating that 1,199 additional lives have been saved by NHS staff in Wales between April 2008 and April 2010.
Introduction

NHS staff save lives every day - the 1000 Lives Campaign has helped them save more.

We know that modern healthcare can cause harm - and yet we know that no-one working in healthcare goes into work each day to do less than a good job. The size of the system, the complexity of the tasks and the diversity of treatments often conspires to work against the best endeavours of individuals, ultimately causing patients harm.

It was against this backdrop that the 1000 Lives Campaign was launched in April 2008 - with the aim of saving an additional 1,000 lives and preventing 50,000 episodes of harm in Welsh healthcare.

As you turn the pages of this report, which reflects some of the Campaign's major highlights, you will read of the commitment and determination of NHS Wales staff - in both clinical and non-clinical settings - to introduce changes to improve the care they deliver.

The 1000 Lives Campaign illustrates what can be achieved when we work together - and the final figures are evidence of the real difference that has been made. The changes that have been introduced in health boards and trusts throughout Wales will benefit generations of patients to come.

We want to say a sincere 'Thank you' to staff across Wales for the care they provide to patients every day - and for taking up the challenge of the 1000 Lives Campaign and making it such a success.

The Campaign's achievements have provided a solid foundation for the 1000 Lives Plus national programme which has succeeded it. With a commitment to providing patients the care they need, by reducing harm, waste and variation, the programme will ensure that the Campaign's aim to ensure consistent care across Wales will continue.

This work is truly transformational. It enables staff to heal, not harm; to help, not hurt; and to bring life, hope and comfort to those who suffer and are in pain.

Thank you for your commitment, which has already achieved so much. It is a humbling and inspiring task to chair this programme as we move forward. We welcome the opportunity to work alongside you as we continue to build a better health service for the people of Wales.

Professor Sir Mansel Aylward, CB, Chair, Public Health Wales
Dr Chris Jones, Medical Director, NHS Wales

Chairs, 1000 Lives Plus

The 1000 Lives Campaign was run as a collaborative, which involved the National Leadership and Innovation Agency for Healthcare, National Patient Safety Agency, Public Health Wales and the Clinical Governance Support and Development Unit. Support has also been provided by the Institute for Healthcare Improvement and the Health Foundation.
Empowering frontline staff to improve patient care

The creation of a culture where sustainable patient safety and quality care is at the top of the NHS agenda is one of the legacies of the 1000 Lives Campaign, according to its directors.

Reflecting on the two year Campaign, Drs Jonathon Gray and Alan Wilson explain why it has been the small changes that have made the biggest difference to patient care across Wales.

When the 1000 Lives Campaign launched in April 2008, its leaders knew that the biggest challenge would be engendering a culture change that would ensure improving patient safety became the norm for everyone in NHS Wales.

And the key to this was to empower frontline staff to make small changes that would improve patient care.

Dr Wilson said, “We knew that the Campaign was ambitious, but we also knew that it was the right course of action to improve patient safety in hospitals and community settings across Wales.”

Sustainable

“Sustainable changes for the future had to be made in many areas. Patient safety and quality has to be the main focus for everyone and patients need to be central to all that is delivered.

“We had to engender a culture change where situations were not accepted as unavoidable, but solutions were sought that would deliver better care.

“Frontline staff have been able to implement small changes such as improved hand washing, listening to patients needs and spending more time at the bedside, that have made a big difference to care.”

Existing initiatives

Building on existing initiatives and good practice, improvements have been made in a number of key areas, providing a new standard of care for many patients.

Significant developments delivered by staff have included the introduction of care bundles to reduce central line infections and ventilator associated pneumonias in critical care wards, improved hand hygiene leading to a reduction in infections and action to reduce pressure ulcers, with some wards going more than a year without a case.

The key, according to Dr Gray, has been to empower staff to deliver and accelerate change.

He said, “We were aware when we began the Campaign that success would only come if frontline staff were driving forward change and were engaged in monitoring and delivering results.

“Organisations needed to own their improvement work and this has been achieved by improved leadership and better engagement with mortality data.

“Measurement is now being used for improvement not for judgement and there is a shared goal across NHS Wales of ensuring that safe healthcare becomes a matter of routine.

“There are myriads of examples of staff applying interventions and making simple changes to everyday practices. The Campaign has enabled not just one person to be responsible, but a whole army of staff to bring about change to improve care.”

And it is this reusable network of skilled frontline staff that has delivered success, and will ensure
that patient safety and quality improvements continue in the future.

**Enthusiasm**

Dr Willson said, “The enthusiasm, commitment and energy of NHS staff over the Campaign period has been remarkable.

“There has been staff engagement on a huge scale, the work captured hearts and minds and when we asked them to improve, they all believed they could.

“The buy in from those at the top was vital and there was no argument about signing up to deliver the aims of the Campaign. It was the right cause and the right time.

“Now we have created a reusable network of people who have the belief and technical skills to make change happen.”

**Patient pathway**

Wales has been able to make improvements to the whole patient pathway by becoming the first country to include primary care, the ambulance service and oncology into a patient safety initiative.

Dr Gray said: “The integrated nature of the health service has made innovation appropriate and success has been delivered in every area of Wales.

“Wales took improvement ideas and turned them into a Welsh product, which is now being looked at by countries around the world.”

For patients there have been visible signs of improvements including the implementation of the surgical checklist, Warfarin monitoring and improved ward environments.

The introduction of patient stories has also enabled organisations to learn from experiences and improve healthcare delivered.

Dr Willson said, “In terms of a national campaign, it may sound trivial to say that huge success has come from nurses spending more time at the bedside or asking patients if there is anything they need?

“But it is these small things that are making a big impact in improving the patient experience.

The Campaign is succeeded by the 1000 Lives Plus programme, which was launched in May 2010.

**Avoiding Harm**

As a national programme in a five year strategic framework for NHS Wales, it will focus on giving patients the care they need by avoiding harm, waste and variation.

The inclusion of the programme indicates just how far the patient safety and improvement agenda has come since the Campaign was launched in 2008.

Dr Gray said, “We are confident that patient safety will continue to improve and that things won’t return to the way they were.

“The Campaign has ensured that there is a focus on patient safety in every health organisation and that staff at all levels are in the habit of actively supporting and delivering improvement.

“Everyone, wherever they live in Wales, deserves world class healthcare and the Campaign has laid excellent foundations for this to be delivered.”
Senior leaders, staff and patients have worked together to help improve the healthcare delivered. Patient stories have become a regular item at many board level meetings, creating a patient-centred focus at the most senior level.

Establishing communication
Establishing board member WalkRounds has enabled staff in both primary and secondary care to talk openly to senior staff about their concerns and hopes for improvement.

In turn, it has created a platform for leaders and managers to engage in real dialogue with staff about patient safety and enabled organisations to take forward changes to improve patient care.

Establishing communication
Senior leaders, staff and patients have worked together to help improve the healthcare delivered. Patient stories have become a regular item at many board level meetings, creating a patient-centred focus at the most senior level.

WalkRounds have become routine practice in secondary care. The primary care sector has quickly followed, with WalkRounds taking place in GP practices, community pharmacies and nursing homes.

Primary Care WalkRounds
Aneurin Bevan Health Board was one of the first to carry out a WalkRound in a nursing home and found the experience strengthened the relationship between the two organisations.

One staff member said, “The emphasis on patient safety was welcomed and it gave all staff the opportunity to demonstrate the quality of care.”

Most Executives described their lead roles in WalkRounds useful and energising, with evidence of learning and good practice.

Patient safety tops agenda of every health organisation in Wales

Patient safety is now a priority in health organisations across Wales due to the Improving Leadership for Quality content area.

Patient Safety Fridays
Cardiff and Vale University Health Board introduced ‘Patient Safety Fridays’, the first of their kind in Wales.

The initiative involved board members and directors dedicating Friday mornings to engage with frontline staff, patients and visitors to improve patient safety.

Chair, David Francis, said ‘The ‘Patient Safety Friday’ initiative provided us with an opportunity to bridge the gap that can often open up between board members and frontline staff.

“We wanted to support our staff, who work so hard to deliver high quality services, understanding the pressures they face and sharing our thoughts and observations.”

Patient safety is now a priority in health organisations across Wales due to the Improving Leadership for Quality content area.
Staff appreciated the element of visible leadership, the opportunity to articulate concerns and to implement changes which could make a real difference to patients.

An independent member said, “It is vital to go on as many WalkRounds as you possibly can. It gives an enormous insight into the way your organisation works and the issues that need addressing. It gives you a better picture than any report.”

**Surveying the culture**

Culture assessment surveys have also provided organisations with a valuable insight into staff views about their own working environment.

The survey looked at areas including leadership, communication, learning and innovation, relationships with the organisation, staff engagement and safety culture.

In addition to secondary care, Wales became the first country to arrange a culture survey for its general medical primary care services at a national level.

Response rates to this survey were excellent, with around 63% of GP practices across Wales taking part.

The results enabled organisations to prioritise areas for action and implement immediate changes that reduced the risk of harm across the whole patient pathway.

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**Major successes**

- Patient safety topped all health organisations’ agendas
- Over 600 WalkRounds conducted in primary and secondary care
- Around 63% of GP practices in Wales participated in culture survey
- Patient stories used in Board meetings

Faculty Member, Dr Andrew Goodall, Chief Executive of Aneurin Bevan Health Board, said, “We have empowered our staff to talk openly about their concerns and hopes for improvement through culture surveys, and through the establishment of patient safety WalkRounds. This has been a real success and now we must ensure we continue these conversations so they become an integral part of our work in the future.”

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**WalkRounds undertaken by Health Boards during the Campaign**

*93 WalkRounds were carried out prior to the launch of the campaign.

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**Patient stories open Board meeting**

During the Campaign, the opening item of every Welsh Ambulance Service board meeting involved a patient discussing a recent experience of using the service.

The patient either attended in person or their story was told digitally via a short film or audio recording.

The impact of sharing information directly with senior staff has been invaluable in helping the trust inform current practices and shape future provision.

One story illustrated how a patient’s dignity was maintained following a fall. It was used as an example of good practice.

As one member of staff said, “This is not about blame, but about good patient care. The insights we have gained inspired us to work together to make improvements and deliver the best service we can.”

Lisa Miller, Director of Operations, Velindre Cancer Centre

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**Improving Leadership for Quality**
Winning the battle against healthcare associated infections

Better hand hygiene, cleaner clinical settings and more appropriate prescribing of antibiotics made a big impact on the ongoing battle to reduce healthcare associated infections.

Cleaner commodes reduce infections

A pilot project to ensure commodes are cleaner has helped reduce healthcare associated infections at wards in the Princess of Wales Hospital, Bridgend and Morriston Hospital, Swansea.

Similar to the system guests find at toilets in hotel rooms, a tape has been placed over clean commodes. The tape is then signed to confirm it’s been cleaned.

New wipes have also replaced water and have been proven to destroy bacteria including C. difficile, MRSA and E.coli.

Sister Beverly Williams said, “Our commodes are spotless and this has gone down well with patients. The feedback on the cleanliness has been very pleasing.”

The initiative is being spread across Wales.

Health boards and trusts have worked hard to prevent and minimise infection and the biggest success has been the significant improvement in hand hygiene across Wales.

Compliance with hand hygiene rates has increased to between 95% and 100% on pilot wards in all Welsh hospitals and this good practice is currently being spread throughout all healthcare organisations.

The improvement is down to more awareness and better engagement with staff.

Historically, hand hygiene audits have been done in hospitals by external teams. Now staff have ownership of audits at ward level and this has made all the difference.

Cleaner environments

There has also been more monitoring of the time it takes to clean environments and better checks to ensure that equipment and wards are as clean as possible.

Another key area of success has come through improving the cleaning of ambulances and equipment to ensure patients are treated in a safe and infection-free environment.

The Welsh Ambulance Services NHS Trust has focused on ensuring there are adequate cleaning facilities and equipment at ambulance stations.

Staff have been able to challenge their colleagues and feed back results on a weekly basis.

This has enabled a better understanding of their own performance and motivated them to achieve better results.

Better hand hygiene, cleaner clinical settings and more appropriate prescribing of antibiotics made a big impact on the ongoing battle to reduce healthcare associated infections.
The Trust has also worked with health boards throughout Wales and bordering areas of England to provide facilities to allow ambulance crews to clean vehicle interiors at Accident and Emergency departments.

**Primary Care**

Standards of hand hygiene have also improved across primary care.

In Cardiff, improved infection control measures were implemented in nursing homes, GP practices and HM Prison Cardiff.

The prison participated in an infection control audit to improve hand hygiene, waste management and environmental control.

Senior Nurse, Kath Hier said, “The 1000 Lives Campaign has given us the opportunity to look at those basic small changes in practice which can deliver a much greater reduction in healthcare associated infections than we have done to date.”

**Antibiotic control**

More appropriate prescribing of antibiotics has also reduced the risk of patients developing antibiotic-resistant infections.

In Anglesey, previously the highest prescriber of antibiotics in Wales, patients were given information explaining why they were not prescribed an antibiotic for their condition.

Improved stewardship of antibiotics by pharmacists has also proved successful in other areas of Wales and good practice has continued to spread to all organisations.

If you don’t wash your hands and clean your equipment, then someone may get an infection. It’s that simple.

“Washing your hands has to become a habitual part of the job to ensure our healthcare settings are as safe from infections as possible.”

Dr Kurt Burkhart, Infection Control Lead in Cwm Taf General Practice.
Excellent progress has been made in reducing the rate of Ventilator Associated Pneumonia (VAP) and Central Line Infections (CLI), by implementing agreed care bundles and ensuring compliance.

In critical care, the bundle included procedures for minimising infections from equipment use, improved care and early intervention before a patient’s condition declined.

Staff embraced the new procedures and as a result, many organisations have gone months without any patients developing Central Line Infections. Some hospitals have gone more than a year without a case. Several intensive care units across Wales have also reported months without Ventilator Associated Pneumonias.

Examples of success
Cardiff and Vale University Health Board saw particular success in this area with the critical care unit at University Hospital of Wales going more than two years without a Central Line Infection since the introduction of the care bundle.

Similarly, Llandough Hospital critical care unit has not had a VAP case for over a year.

The new care procedures have been accompanied by a change in attitude towards CLI and VAP, which are now seen as something avoidable, rather than an expected complication.

In fact, the development of a CLI will now be investigated as a critical incident when it occurs.

Reducing catheter risk
In Abertawe Bro Morgannwg University Health Board, the work carried out to reduce the risk of catheter associated infections was recognised as best practice and nominated in the NHS Wales Awards 2010.

Staff including a consultant urologist, microbiologist and nurses developed a care bundle specifically for this area as there was not one available already.

It was piloted in the Princess of Wales Hospital in Bridgend and had great success with 100% compliance in the wards in which it was tested.

Faculty Member and Intensive Care Consultant at Abertawe Bro Morgannwg University Health Board, Dr Dave Hope said, “We’ve shown that by implementing evidence based procedures, better care and helping patients before their condition declines, we can cut infection rates across Wales.”

Infection rates in critical care units across Wales have fallen significantly, thanks to new ways of working implemented in the Improving Critical Care content area.

Aneurin Bevan Health Board % compliance with CVC maintenance care bundle - Royal Gwent Hospital

Velindre Cancer Centre celebrates Sepsis success
Improving rapid response to acute illness in Velindre Cancer Centre has made a big impact on patient care.

The implementation of the Sepsis Six care bundle on a chemotherapy ward, along with improved reliability of observations, ensured that patients were less likely to be transferred to a District General Hospital due to acute illness.

Ceri Stubbs, Velindre Cancer Centre Clinical Lead, said, “You have to get the basics right and by improving the reliability of observations we have ensured patients receive the best treatment as soon as they need it.”
Critical care bundles have really worked in intensive care. They have helped us give the best treatment to our patients – every day – without fail. By continuing this work we can ensure patients have less chance of infection and recover more quickly so they can leave hospital faster and be home with their families.

Chris Hancock, Improving Critical Care Lead, 1000 Lives Campaign

Major successes

- A reduction in Central Line Infections with organisations going months without incident
- Catheter-related blood stream infections are now a rare, rather than common, event in Wales
- Several intensive care units reporting months without patients developing Ventilator Associated Pneumonias (VAPs)
- Improvements in severe sepsis treatment thanks to the implementation of Sepsis Six care bundle
- Establishment of rapid response teams for acutely ill patients in wards across Welsh hospitals

Faculty Member and Cardiff and Vale University Health Board Clinical Director, Dr Mark Smithies said, “We have continued to see a fall in the number of patients contracting infections on critical care wards. “This is particularly good news as these infections were, until recently, considered an unfortunate, but inevitable consequence of modern healthcare. The excellent work of staff in critical care units across Wales shows the progress made, making a real difference to patients.”

“Critical care bundles have really worked in intensive care. They have helped us give the best treatment to our patients - every day - without fail. By continuing this work we can ensure patients have less chance of infection and recover more quickly so they can leave hospital faster and be home with their families.”

Chris Hancock, Improving Critical Care Lead, 1000 Lives Campaign

Central Line Infections at zero

Cardiff and Vale University Health Board’s Central Line Infection rates have fallen dramatically with no patient developing an infection for more than two years.

The critical care team improved practice by introducing Care Bundles, which were measured on a daily basis.

The health board also encouraged nurses to stop a procedure if they felt full sterile status had not been maintained by a doctor.

Consultant Nurse in Critical Care Services, Gemma Ellis said: “The introduction of the care bundle has strengthened our team working and empowered the frontline nurse to stop a procedure if they felt it was necessary and start again. We are happy to remind everyone, including doctors, to wash their hands and use the alcohol gel.”
Health boards have worked closely with GPs and pharmacists to deliver vital changes to ensure patients receive maximum benefits from their medication.

The work, which was part of the Improving Medicines Management content area, has concentrated on improving the safety, reliability and management of high risk medication such as Warfarin.

Improved access to monitoring for patients on Warfarin has taken place across Wales with new anti-coagulation clinics established and regular INR tests undertaken.

Working in the community
Health boards have worked with community pharmacists to encourage patients to bring in their yellow record book, which includes information on their INR level and dosage instructions at the time that a new prescription is dispensed.

This has ensured that it is safe for the patient to have their prescription and that they fully understood the correct dosage to take.

GP practices have also carried out baseline assessments on patients using Warfarin to ensure patients receive the
Major successes

- Improved monitoring and reliability of instructions to patients taking the drug Warfarin by GPs
- Improved medicines reconciliation across Wales
- Pharmacists working closely with patients to ensure better understanding of dosage instructions

Faculty Member and 1000 Lives Campaign Director Dr Alan Willson said, “There is much good work being carried out across the NHS and what is encouraging is the willingness to share the expertise that has been developed by these sites with other organisations.

“The work with Warfarin has been just the start. There are several other medicines which will benefit from a similar approach and we are looking forward to progressing this vital work.”

maximum benefit and least harm from the therapy.

The tool acts as an aide-memoire to raise key information like age, history of uncontrolled blood pressure, falls, alcohol use, monitoring and mental capacity.

In South Wales, Cardiff and Vale University Health Board have promoted the collection of data by incorporating an audit of Warfarin into their incentive scheme for GPs.

And in North Wales, Betsi Cadwaladr University Health Board has reduced the time it takes to stabilise patients on the right dose and to redesign Warfarin prescription charts.

Both these examples of good practice have been spread to other health boards across Wales.

Medicines reconciliation

Vital work has also been carried out on reconciling discrepancies and omissions at key points in the patient’s journey, for example, when they enter and leave hospital.

Checklists for community pharmacists and for secondary care to complete before a patient is discharged are now being used.

Medicines have also been managed more reliably through a tracking system called medicines reconciliation which has helped communicate changes to GPs.

In secondary care, progress has been made in improving the safety of medicines administration in hospital wards.

Aiding concentration

Many organisations have encouraged nurses to wear red tabards during drug rounds to alert others not to interrupt them unnecessarily when they are preparing medications.

The scheme was implemented by nurses in Cardiff and Vale University Health Board following the observation that a nurse who administered medications was interrupted up to 17 times during one drug round.

The red tabard has enabled the nurse to concentrate without distraction, with other members of staff aware of the job being carried out.

Llandough Hospital Medical Rehabilitation Nurse, Ann Solonott said: “Wearing a tabard is an excellent idea and, for me, it means there is less room for errors whilst making people aware of what we do.”

There is great support for the Improving Medicines Management content area as it has given us a clinical impetus to focus on a challenging area of medicine that might otherwise not receive the attention it deserves.

“The work done has ensured medicines are safer and patients receive maximum benefit from their treatment.”

Dr Brendan Lloyd, Medical Director, Powys Teaching Health Board

New clinic improves monitoring and treatment of Warfarin patients

Cwm Taf Health Board has developed a new clinic to improve the monitoring and treatment of patients taking the drug Warfarin.

The pharmacist-led clinic at the Royal Glamorgan Hospital, Llantrisant, acts as a one-stop shop for all patients, enabling a more efficient service.

Patients are now being seen within an appointment system, have face-to-face consultation with healthcare professionals and receive results during their appointment time.

This has ensured that regular checks can be made to ensure the dosage is correct and the patients understand how to use the medication.

David Lewis, Medicines Management Lead, said, “The new clinic has been a much better experience for patients and an improved use of resources.”
Safer surgery for patients across Wales

The introduction of new measures have reduced errors and risks of infection.

The introduction of the World Health Organization (WHO) Safer Surgery checklist was successfully spread to all organisations and has been mandatory for all operating theatres since February 2010.

The simple set of questions asked during a surgical episode, has ensured the best standard of care for patients, protecting them from potential harm.

The process enables more effective communication amongst those involved in the surgery and provides a clear, consistent approach.

It focuses on basic good practice: checking the patient’s identity, the correct site for operation and provides an opportunity for discussing any complications that may arise.

It also highlights potential risks of haemorrhage, reaction to antibiotics and allergies.

Cardiff and Vale University Health Board received particular praise for the way in which it educated staff to get behind the checklist and rapidly implemented it in all its 44 theatres.

The organisation held learning sessions to discuss how best to implement the list, provided written information for staff and began with a month long pilot in Llandough Hospital before moving to the main theatres in the University Hospital of Wales.

It then introduced the checklist into a new theatre every week until all theatres were on board.

**Simple and effective changes**

In addition to the checklist, hospitals have also focused on other steps which have helped reduce surgical complications.

One of the simplest, yet potentially most effective changes the Campaign introduced was a

**Hot air gowns reduce infections**

The introduction of specialised gowns in all Powys Teaching Health Board’s operating theatres has made a major impact on the safety of patient care.

The gowns, called Bair Huggers, are filled with hot air to keep patients warm before, during and after surgery.

By maintaining a normal temperature, fewer patients were developing infections following surgery, their length of stay in hospital was shorter and there were fewer re-admissions.

The innovative work scooped an NHS Wales Award 2010 and was recognised as best practice.

Theatre Manager and Matron, Rosanne Lyles said, “The improved ways of working ensured our patients received safer care, recovered more quickly and spent less time in hospital following surgery.”

Powys Teaching Health Board won a number of awards for their use of Bair Huggers to maintain patients’ temperature.
national change of practice in using clippers, instead of razors, to prepare patients for surgery.

Shaving the body can cause tiny cuts, and research suggested that although they can’t always be seen, they may lead to post-surgical infections.

Recent studies revealed that if hair was removed with surgical clippers in theatre, prior to surgery, the risk of infection could be significantly reduced.

The potential to reduce infections in this way also extended to patients who sometimes shave before coming into hospital for an operation.

Hospitals have encouraged patients not to shave the area of their body where surgery is planned, for at least a week before their operation.

This has helped to lower infection rates after surgery and also avoided other problems, including further pain, scars and a longer stay in hospital.

Keeping patients warm

Another simple, but significant consideration, has been the importance of keeping patients warm before and after surgery.

Nursing staff across Wales closely monitored patients’ temperatures during each stage of their hospital stay.

By maintaining a normal temperature, patients were less likely to develop infections following surgery and recover more quickly.

Reducing hospital acquired thrombosis

The number of patients developing a hospital acquired thrombosis fell from eight a month to three thanks to improvements delivered by staff in Aneurin Bevan Health Board.

Buy-in from staff at all levels to ensure all patients were properly risk assessed was crucial to the success.

Honorary Palliative Care Consultant Dr Simon Noble, said, “With support at the top you have the teeth to make changes and with support at the frontline you can ensure these changes are implemented.”

The All Wales Thrombosis Risk Assessment tool enabled staff to carry out a thorough evaluation of a patient’s risk of developing a blood clot.

Once the risk was assessed, simple treatment could ensure thrombosis was prevented safely and effectively.

Major successes

- Introduction and spread of the WHO Safer Surgery Checklist in all Welsh operating theatres
- Razors replaced by surgical clippers in all Welsh hospitals, reducing chance of infection
- Improved measures to address normothermia
- Improved team briefings resulting in better communication and handovers
- Reduction in incidents of hospital acquired thrombosis

Faculty Member and 1000 Lives Campaign Director, Dr Jonathon Gray said, “We know that if we reduce surgical complications, we can make a huge impact on patient safety - possibly reducing overall errors that occur in healthcare around 40%.

“That’s why the 1000 Lives Campaign was committed to reducing surgical complications - it’s not only widely supported by staff throughout the NHS, but vital for patient safety.”

Improved communication meant that issues concerning allergies, correct equipment and post operative care were addressed at the earliest opportunity. The checklist gave everyone in the team a voice to express any concerns they may have had. We questioned each other and invited the patient to question us, so that the lines of communication were maintained.”

Helen Curtis, Theatre Practice Educator, Nevill Hall Hospital, Abergavenny
Making communication between staff as effective as possible was a key factor in the Improving General Medical and Surgical Care content area.

All health boards and trusts in Wales tested a new standardised method of communication which ensured that accurate patient information was passed on during handovers.

SBAR (Situation, Background, Assessment and Recommendation) is a framework for communication between members of the healthcare team about a patient’s condition and is used to frame a conversation or written report. This includes transitions of care from one setting to another, for example, admission unit to the ward, and shift handovers.

**Essential information**

SBAR provides essential information on the patient’s condition and gives consistency to handovers of patient care whilst developing teamwork and a culture of patient safety.

It has already proved to be particularly useful in areas where a patient is in urgent need of help, as it structures the discussion and provides all the information needed to put immediate action into place.

Every Welsh hospital has tested SBAR and it’s also proved to be a very useful tool for the Ambulance Service.

Ambulance staff have found that it has enabled them to have a structured way of communicating with hospital staff when they handover a patient from their care.

A number of organisations in Wales have adopted the use of the SBAR tool for other communications.

New techniques helping to save lives

Improved communication, better treatment for chronic heart failure patients and the development of new measures to identify harm have all made a fundamental impact on the quality of care delivered in Wales.

An early warning observation system which alerts staff if a patient’s condition deteriorates has been introduced in Powys community hospitals, enabling the correct action to be rapidly taken every time.

The track and trigger tool was designed to meet the needs of patients from a large rural community.

It was used to link the normal monitoring of the signs that indicate a patient’s condition, with a scoring matrix that shows when a patient is deteriorating and action is needed.

Cathy Davies, Matron in Llandrindod Wells Hospital, said, “In Powys, journey times can be long and we don’t have a District General Hospital, so it’s important that we know as early as possible about a deterioration in a patient’s condition. “The tool has helped to save lives.”
Betsi Cadwaladr University Health Board –
Wrexham Maelor Hospital - % trained and using SBAR
including reporting patient safety incidents to a review group and communicating with the hospital at night team.

Reducing admissions
In other steps, health boards have worked closely with GPs to reduce, where possible, the number of unnecessary hospital admissions and re-admissions for patients with chronic heart failure.

More than 80 GP practices across Wales agreed to develop Local Enhanced Services for Cardiology that ensured patients with chronic heart failure lived a better quality of life.

The promotion of evidence-based procedures such as timely and accurate diagnosis, medication therapy, and lifestyle advice has had a significant impact on the disease process.

The new service has enabled GPs to provide care and support to people closer to their homes.

It also looked at prescribing medicines to manage chronic heart failure.

By optimising the use of these drugs and regularly reviewing the patient, chronic heart failure sufferers could see improvement in their symptoms, including more energy, and less likelihood of admission to hospital.

The improvements made by working closely with GPs and other primary care providers, have garnered praise from many other countries including improvement experts in the USA, who helped shape the concept of the 1000 Lives Campaign.

The quality of care for patients across Wales was also improved by the development of a number of trigger tools which are being used by GPs, the Welsh Ambulance Services, Velindre Cancer Centre and other organisations.

The tools identify and track potential harm by using a retrospective review of a random sample of patient records to identify possible adverse events.

Faculty Member, Dr Brendan Boylan said, “Good communication in any environment can make a real difference - but within a healthcare setting it literally can save lives.

“The structured approach of SBAR offers every member of staff, whether junior or senior, a way to impart the essential information and guidance to ensure the patient receives the best possible care.”

Wales leads the way with primary care trigger tool
The development in Wales of a primary care trigger tool enabled GPs to measure improvements in community healthcare.

The tool looks at harm caused by failure to recognise or adequately manage a new presentation of an acute illness.

If a patient’s situation did not respond to treatment or they developed an adverse reaction, they were more likely to make another appointment.

It was these unscheduled re-attendances that could act as triggers of possible harm.

Dr Bill Whitehead, who led the work in North Wales said, “We have seen the difference this trigger tool has made to the care we delivered, and we are looking forward to spreading the learning to help ensure GP practices are as safe as possible.”

The 1000 Lives Campaign
is easily the best initiative that I’ve ever been asked to participate in and is exactly aligned with what we needed to do in Powys to ensure that our services were safe.

“The communication work has given staff additional confidence in highlighting concerns about a patient and a clear approach to doing so.”

Ailsa Dunn, Consultant Physician, Powys Teaching Health Board
Transforming Care at the Bedside was initially tested in three pilot sites – Abertawe Bro Morgannwg University, Hywel Dda and Betsi Cadwaladr University Health Boards – and delivered real, lasting improvements to patient care.

It encouraged nurses to spend more time with patients at the bedside and in turn, enabled patients to engage with staff and become partners in their own care.

The programme also delivered huge success in reducing pressure ulcers, more commonly known as bed sores, and a reduction in patient falls.

Redesigning processes

Using effective tools and methods, frontline staff redesigned processes and ward environments to release time, which was reinvested in patient safety and quality of care.

Staff now spend around one third more of their time with patients, which has improved care and communication, with patients able to express their needs and be listened to.

This ensured the focus was on patient-centred care and specific needs were being met which led to a better experience in hospital and a faster recovery.

Redesigning wards with appropriate and easily accessible equipment also ensured less waste and more efficiency.

Change in culture

The work to reduce pressure ulcers has delivered phenomenal results with many wards going more than a year without a single incident.

Improving the patient experience

Transforming Care at the Bedside has enabled frontline staff to deliver changes that have improved patient outcomes and their experience.

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The ‘not-so-secret’ diary of an NHS patient

Patients on one ward in Prince Philip Hospital were given diaries, as part of a pilot project to give them more ownership of their journey to recovery.

The diaries were penned by patients, clinicians, nurses and other healthcare professionals at the bedside.

They were used from admission to discharge and included a range of information, from reflections and goal setting to treatment and achievements.

The aim was to empower patients, whilst giving healthcare professionals a patient-centred account of their experience. The diaries were also used as a communication tool for family members.
Intentional rounding guided nurses to deliver more structured care and included hourly checks on patients to look at any potential risks such as the position they were lying in and the condition of their skin. There was a big cultural shift in attitudes with staff moving from a passive acceptance that pressure ulcers were unavoidable to a realisation that they can be avoided and taking preventative steps. For patients it has made a huge difference, sparing them distress, pain and a longer stay in hospital. Steps were also taken to reduce patient falls. Hospitals have reported fewer falls in care of the elderly wards due to hourly checks on patients and ensuring equipment to help mobility is easily available. Hywel Dda Health Board reported more than a year without a fall on its pilot ward and other organisations have also gone months without an incident.

Nurses spend more time at bedside
Nurses in Hywel Dda Health Board have spent up to a third more of their time at the bedside thanks to new ways of working. The redesign of work space has enhanced efficiency and reduced waste. Work to improve the organisation of storerooms on the wards so nurses spend less time looking for equipment, for example, released two and a half hours per day. This was the equivalent of 912 hours a year, which can be invested directly into patient care.

Other improvements included reducing nurse interruptions and improved communication between staff and patients. Senior Nurse, Gill Webber said, “We implemented numerous changes, including smarter placement of equipment within the ward and completion of patient paperwork at the bedside. These simple changes made a real difference to patients.”

Making pressure ulcers a thing of the past
Dozens of wards in Abertawe Bro Morgannwg University Health Board went more than 100 days without a pressure ulcer case and one ward more than two years. The introduction of the SKIN bundle (Surface, Keep patient moving, Incontinence, Nutrition), which was a checklist of good practices for managing vulnerable patients, ensured pressure ulcers could be avoided. Senior Charge Nurse Nigel Broad said, “Pressure ulcers used to be something which were expected to happen. Now we have both the culture change and the model of care to ensure this is no longer the norm.” Patients were regularly assessed for risk and the number of days a ward went without a pressure ulcer incident was clearly recorded on a notice board.

Engaging with patients was vital and the safety cross, showing the number of days without a pressure ulcer on the ward, was always clearly visible. “The positive press coverage also meant that patients understood what we were trying to do. So much so, that many patients rang up and asked to be on that ward!” Hamish Laing, Consultant Plastic Surgeon, Abertawe Bro Morgannwg University Health Board

Major successes
- Significant reduction in patients developing pressure ulcers
- Reduction in patient falls
- Nurses spending more time at the bedside
- Improved patient satisfaction with their experience of care

Faculty Member, Annette Bartley said, “Transforming Care at the Bedside was important because it focused on improving patient outcomes and their direct experience of care.

“The work that has been done to prevent pressure ulcers developing has been a phenomenal success and has made a real difference to the patients’ quality of life and experience in hospital and their recovery.

“Changing the way nurses work so they can spend more quality time with patients has also made a big impact as it has improved not only care, but communication.”

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Measurement for improvement

Measurement has been at the heart of the healthcare improvements delivered by the Campaign.

This focus on measurement has allowed organisations to determine their current position and provided the means to evaluate how successful efforts have been in improving healthcare delivered.

For example, by recording incidents of pressure ulcers or wound infections for the first time, it has been possible to measure how much better the new ways of working have been.

**Culture change**

Faculty Member and Director of Acute Care at Abertawe Bro Morgannwg Health Board, Hamish Laing said the widespread use of measurement has represented a culture change for the health service in Wales.

He said, “In the old days, hospitals would not have known what their death rates were and so certainly would not have been able to discuss this out loud or with other hospitals.

“This has been very much the start of a culture change for the NHS.

“Collecting clinically meaningful data has to become an integral part of our work. By recording incidents of in a highly visible way for the first time we have been able to measure how much better our new ways of working were. And if you improve quality you improve safety and save money.”

**Data collection**

The improvement in data collection, particularly process data, has enabled staff at all levels to engage with information proactively and intelligently.

The development of the global trigger tool has been an excellent example of this.

By reviewing patient case notes, staff have been able to identify areas of potential harm before it happens and put solutions in place to rectify the issue.

By measuring process, such as the results of better hand hygiene leading to a reduction in infections, it has been possible to see what difference has been made to patient care as a result of changes in working practices.

Dr Brian Tehan, Assistant Medical Director at Betsi Cadwaladr University Health Board, believes measurement has been vital to improving patient safety.

He said, “Monitoring patient safety in this way has given us an insight into harm from a patient’s perspective and changed the perceptions of those delivering the care.

“Continuous measurement has ensured that patient safety continues to improve through the implementation of evidence-based care and that the processes involved are totally reliable.”

Campaign Director Dr Alan Willson said, “Measurement for improvement and not for judgement has become a focus and mantra for the Campaign and for healthcare teams at the frontline.”

**Attitude**

“In the past two years we have seen a definite change in attitude to reporting data and in how data is being used to improve the healthcare we deliver.

“Everyone knows that in order to be able to make improvements you have to be able to benchmark where you are and identify areas of concern.

“Only then can you begin to measure the quality of the services you are delivering.”

Measurement has been at the heart of the healthcare improvements delivered by the Campaign.
Putting the PR into Patient Safety

The Campaign’s communications aimed to engage NHS staff, ensure key stakeholders were kept informed of progress and impact, and raise public awareness of the improvements being made.

It worked closely with organisations across Wales to build its profile internally with staff, and externally with the media. A robust communications strategy guided the work delivered during the two years and local action plans enabled organisations to support the Campaign.

The focus of communications work was the frontline staff who implemented the interventions. This was summarised in its key statement: “NHS staff save lives every day - the Campaign will help them save more.”

Staff were regularly profiled in the monthly e-Newsletter, through a special poster campaign (‘Count me in!’) and local and national media coverage. They also featured in over sixty videos, which were included in presentations and made available online.

Involving local teams

The involvement of communications officers from health organisations throughout Wales was central to building a strong profile with staff, the public and the media.

Support was provided through special study days, WebEx sessions and conference calls, as well as resources, including template press releases and articles, PowerPoint presentations and imagery.

Pat Tempest, Planning and Corporate Services Manager, Powys Teaching Health Board, said, “The Campaign understood the challenges we faced in local organisations, particularly with internal communications. They have been a tremendous help, always willing to share expertise and encouraging us in our work.”

The development and management of the Campaign’s brand ensured effective recognition, becoming well known and respected within NHS Wales.

Relationships were built with the media in Wales, which resulted in widespread, consistent and positive coverage of the Campaign.

Local progress

Stories of local progress and achievements took the 1000 Lives Campaign into the public sphere, underlining that change can happen, healthcare can improve, and lives can be saved.

A monthly patient safety column in The Western Mail has also been helpful in profiling the various interventions, achievements and milestones.

The creation of the Campaign’s e-Newsletter has been successful in spreading the good work delivered by staff across Wales. It was recently awarded Gold for Best Newsletter in the CIPR’s PRide Cymru awards.

The Campaign’s online presence included an intranet site, English and Welsh language websites and a YouTube page, which carried interviews with frontline staff on the improvement work in which they were engaged.

Whilst it was the clinical interventions which directly saved lives, the communications work has strengthened the case for healthcare improvement, taking frontline staff on the journey. It has also helped spread improvements across organisations to ensure they become embedded in the care given to patients.
Patient experiences help improve healthcare

The introduction of patient stories into board meetings across Wales has helped inform current practices and shaped future healthcare provision.

Whether a patient’s experience has been good or bad, the impact of sharing information directly with senior staff has been valuable in helping organisations make vital changes.

One staff member explained, “This has not been about blame but about good customer care. The insights we have gained have inspired us to work together to make improvements and deliver the best service we can.”

Many organisations have opened each board meeting with a patient story and have found that it has encouraged staff to focus on the patient as a person, rather than a condition or an outcome.

The patient has either attended in person or their story has been told digitally via a short film or audio recording.

Unlocking potential

The use of stories in board meetings has provided a platform for growth of this powerful tool. Many organisations have learned to unlock the potential for using stories through the Campaign’s ‘1 story, 4 uses’ framework. As a result they are now developing central repositories of stories to help share best practice.

Patient stories are proving a useful tool to increase patients’ participation and engagement. The learning acquired during the Campaign is continuing to grow and is helping organisations to become more proactive in seeking patient feedback and to learn from their stories.

Using patient stories to complement data reports has also increased focus and engagement with quality and safety issues.

For example, patient stories have become well established as the first agenda item in all Quality and Safety Meetings in Cwm Taf Health Board.

The stories have been an invaluable tool for engaging all members in a focused discussion on quality and safety issues.

Patient participation

There has been a clear need for sensitivity and an ethical approach in collecting stories to ensure the patient has understood how the information will be used.

However, most organisations have found that the majority of patients have been more than happy to share their experiences - if they know it will make a difference to someone else’s care.

There have been numerous examples where patient stories have raised issues that needed to be addressed and solutions found.

One intensive care ward addressed the issue of noise levels after a patient was asked on discharge, what would have improved her experience - she replied a good night’s sleep.

Protected meal times have also become more established because patient’s comments and perspectives have been heard and acted upon.

Campaign Director Dr Jonathon Gray said, “These personal insights have reminded us that the patient is at the heart of everything we do.

“The voice of a patient in a board meeting, on the ward, in conversation with a frontline member of staff has helped to galvanise action, encourage and challenge the workforce and ultimately bring about positive change.

“Whether it was a prescribing error, praise for outstanding care, a surgical complication or a poor diagnosis, the real urgency has been to learn from these episodes to ensure that good practice was captured and spread, and lessons were learnt to ensure it didn’t happen again.”

The introduction of patient stories into board meetings across Wales has helped inform current practices and shaped future healthcare provision.
1000 Lives Plus - the next step in healthcare improvement

“It has enabled us to focus more closely on our patients and reminds me of why I went into the NHS - to save lives.”

These words from a frontline member of staff show how the 1000 Lives Campaign has captured the imagination of NHS staff across Wales.

Now 1000 Lives Plus, a national programme to improve patient safety and reduce harm, is aiming to build on the successes of the Campaign’s work.

Patient safety has become an integral part of mainstream long term plans for NHS Wales.

With an increased emphasis on patient-centred care and a commitment to working across the primary and secondary sectors, the programme will have a transformational impact on Welsh healthcare.

NHS Wales Chief Executive, Paul Williams, believes 1000 Lives Plus is well placed to effectively introduce change.

He said, “I can’t think of a better way to engage all our colleagues than the aim of delivering a safer and quality service. As far as the patient is concerned, quality is an absolute right.”

1000 Lives Plus was launched in May 2010 and organisations have outlined specific aims to reduce mortality and harm.

The programme incorporates several new areas of work and will focus on reducing harm, waste and variation.

In total, there are fourteen programme areas which are being phased in over the next twelve months. These include:

- Preventing stroke and providing better rehabilitation
- Preventing Acute Coronary Syndrome
- Preventing falls in community care
- Enhanced Recovery After Surgery
- Improving maternity services
- Offering better treatment to those suffering from mental health disorders

A quality agenda

Many of these new areas involve both primary and secondary clinical organisations, with a definite agenda to institute quality ‘from board to ward to home’.

The methodology introduced by the Campaign - applying small tests of change before wider implementation - will continue to be used.

Work is already well under way in many of the areas and 1000 Lives Plus will continue to engage, support, equip and motivate frontline staff to deliver the changes needed.

Mrs Jan Davies, 1000 Lives Plus Director said, “The programme is committed to accelerating the pace of change to spread the new ways of working introduced by the Campaign from ward to ward, practice to practice and organisation to organisation.

“Every health board and trust is involved, with the focus on patients having the right to expect the same high quality of care wherever they receive their treatment in NHS Wales.”

Putting patients central

One of the key elements of 1000 Lives Plus is patient involvement and work will continue to ensure patients are central to its initiatives.

Educating patients about their treatment, and encouraging them to question the care they receive is vital.

Some programme areas are very reliant on partnership between patients and staff. Enhanced Recovery After Surgery, requires patients to follow nutritional guidelines and other preparatory measures in the run-up to surgery, in order for quicker healing afterwards.

Quality improvement also offers opportunities for greater efficiencies and in many cases, higher quality can be achieved at a lower cost to the NHS.

Examples already achieved in this area include the reduction in infections and pressure ulcers leading to shorter stays in hospital.

Most importantly, 1000 Lives Plus ensures that the improvement work begun by the Campaign will continue until every patient in Wales receives the same level of quality care.

“It has enabled us to focus more closely on our patients and reminds me of why I went into the NHS - to save lives.”

Left: Paul Williams, Chief Executive of NHS Wales, showed his commitment to improving the quality and safety of patient care by launching 1000 Lives Plus in May 2010.

Right: New programme areas in 1000 Lives Plus, like Enhanced Recovery After Surgery, are focussed on reducing harm, waste and variation.
Giving the patient the care they need by reducing harm, waste and variation

If we can improve care for one patient, then we can do it for ten.

If we can do it for ten, then we can do it for a 100.

If we can do it for a 100, we can do it for a 1000.

And if we can do it for a 1000, we can do it for everyone in Wales.

www.1000livesplus.wales.nhs.uk