14 February 2019

NHS Providers' response to NHS Improvement's consultation on developing a patient safety strategy

About NHS Providers

NHS Providers is the membership organisation and trade association for the NHS hospital, mental health, community and ambulance services that treat patients and service users in the NHS. We help those NHS foundation trusts and trusts to deliver high-quality, patient-focused care by enabling them to learn from each other, acting as their public voice and helping shape the system in which they operate.

NHS Providers has all trusts in membership, collectively accounting for £84 billion of annual expenditure and employing over one million staff.

Key messages

- NHS Providers welcomes the opportunity to submit a response to NHS Improvement to inform the development of a national patient safety strategy.
- We know that NHS trusts and foundation trusts operate in a high risk environment and are fully committed to continually improving their approaches to safeguard patients and service users. Patient safety remains paramount for NHS providers, at the heart of each trust board's agenda, and of crucial importance for committed frontline staff who want the best for patients and service users at all times.
- We have previously stressed the importance of a new coordinated national long term patient safety strategy to underpin efforts to fully embed an effective safety culture across the NHS – accompanied by the appropriate training, expertise and resources for NHS organisations and staff. We are therefore pleased that NHS Improvement has set out a clear commitment to bringing a more strategic, planned and aligned approach to patient safety policy across the NHS.
- We think the main challenges with the proposals included in the document lie in facilitating and enabling the changes required for proposals to be delivered on. Regulation pressures, misaligned requirements around reporting, bureaucratic burden, local variation, and workforce shortages will all present barriers to delivering the strategy .
- Trusts will need to be supported to prioritise this work, not only through what the national bodies ask them to do, but also through greater commitment and effort by national bodies to eliminate burdensome and ineffective processes and regulatory requirements.
- Clarity on how outcomes will be assessed and measured will also be essential. Without this it will not be possible to demonstrate success locally and nationally against the strategy.

Principles

Do you agree with these aims and principles? Would you suggest any others?

We agree with the aims of the patient safety strategy and the principles that should underpin its implementation. They are familiar and in line with previous policy supporting the development of cultures of learning and improvement in the NHS.

We particularly welcome NHS Improvement revisiting Don Berwick's 2013 report, 'A promise to learn, a commitment to act', and its recommendations to help inform the strategy's aims and principles. NHS Providers has strongly supported the expansion of 'human factors' approaches in the NHS that do not punish people for making mistakes and speaking honestly about their involvement in errors in the delivery of care.

There is strong evidence, in the NHS and in other countries, that organisational cultures that support staff to speak up have higher levels of staff engagement and patient satisfaction and are associated with reduced errors in care and better safety.

What do you think is inhibiting the development of a just safety culture? What could be done to help further develop a just culture?

We think that the continued promotion of a just culture is needed, as it is still not widely understood. This is in part because a 'just culture' means different things to different participants in the healthcare system. For most NHS staff, a just culture needs to be experienced consistently at the team and organisational level to be meaningful.

As the NHS moves more to local system working and outcomes based measurement, the openness and transparency that underpins a just culture will need to extend across organisations as well as within them. This requires clarity and alignment at all levels of leadership on what behaviours and attitudes represent a 'just culture' approach, as well as the systems and processes that support it.

The acknowledgement of a just culture in national policy needs to be reflected through the reporting practices around harm, and the national bodies' endorsement of appropriate management responses to harm. A just culture can be hard to evidence (as can openness and transparency) as it is an outcome of a combination of factors that influence an individual's subjective view of their working environment. It will therefore be important to clarify how the NHS will measure improvement in a just culture.

What more should be done to support openness and transparency?

The level of openness and transparency within the NHS will be most effectively improved by: giving staff the confidence that they will be treated fairly in response to safety concerns (just culture); providing staff with the tools and support to proactively improve patient safety (quality improvement); and by reducing any reporting processes that do not contribute meaningfully to patient safety improvement.

It is crucial that openness and transparency is reciprocal. If it is not, centralised patient safety reporting can disappear into a void with no feedback or synthesis into meaningful intelligence that can be acted on in real time. There also needs to be consistency and alignment across the various bodies (i.e. arms length bodies, regulatory bodies, professional bodies) in their approach to harm and expectations of staff in order to build confidence amongst staff that the ambitions for safety are shared.

How can we further support continuous safety improvement?

Empowering all staff to feel ownership of patient safety improvement is essential for the type of collaboration required to improve care outcomes across pathways and within local systems. Quality Improvement (QI) skills are key to this and we have seen that, where organisations have had the time and resources to invest in the training of their staff in line with an organisational-wide approach, this is yielding benefits. Training for QI skills is therefore worth supporting and prioritising. With this in mind, NHS Providers is exploring how we might work with partners to offer more support to trust boards to roll out QI approaches.

Like culture change, patient safety improvement is a long-term ambition and unrealistic expectations risk undermining staff's confidence that is a worthwhile investment of time and resource. The evolution of the Virginia Mason Institute partnership to meet the specific needs of NHS organisations is welcome recognition that different trusts will have different needs with respect to QI and that QI across organisational boundaries is going to be essential to resolve challenges that face many services. QI is not as well established in primary and social care. Developing local system approaches that build shared responsibility for QI while addressing the resourcing challenges for smaller partners will be essential to the strategy's longer term effectiveness.

As much as possible, the NHS should seek to maximise existing programs rather than continue to add onto what is already in development. Getting It Right First Time (GIRFT), trust's own organisational QI, QI within specific services and patient safety collaboratives, and AHSN projects make the NHS a very active environment for QI already.

Patient safety improvement also benefits when there is a focus on learning from what has gone well, not just what has gone wrong. Supporting the NHS to identify and learn from good practice and to celebrate successes is essential to creating confidence amongst trusts and staff that there are solutions to the patient safety problems they face. Celebrating positive outcomes of patient safety improvement in care is important to countering the unhelpful negative bias in media reporting on NHS performance, the morale of current staff, and the appeal of working in the NHS to prospective staff.

Insight

Do you agree with these proposals? Would you suggest anything different or is there anything you would add?

The ambitions set out in the 'insight' section of the consultation document helpfully demonstrate continuity of previous policy and trajectory of an approach that seeks to maximise learning opportunities by placing a stronger focus on thematic analysis and standardisation of patient safety processes across the system.

A high reporting culture is a positive correlate of an open culture and a strong safety culture. However, it is important to support the move towards greater openness and transparency with reporting requirements that are demonstrably contributing to insight and change where appropriate.

Trusts are best able to prepare and implement changes to processes and systems when there is sufficient lead-in time and clarity of communication and expectation. Several of the policies mentioned in the consultation document – such as introducing the Medical Examiner system and updating the Serious Incident Framework – have commenced but there is at present little information about progress, timescales and outcomes. The national patient safety strategy promises welcome coherence and alignment on these initiatives but it would be helpful if clarifying progress, timescales and outcomes could be made a priority at the very outset of this work.

We strongly support NHS Improvement's intention to support delivery of the Healthcare Safety Investigation Branch's recommendations across the system through the new National Patient Safety Alerts Committee (NaPSAC). Strengthened system leadership between national bodies is imperative if the commitments are to be realised at organisational level and these commitments need to be reviewed for impact across the system.

Infrastructure

Do you agree with these proposals? Would you suggest anything different or would you add anything?

This section of the consultation document helpfully recognises that it is hard to change culture when the systemic context does not support the right behaviours and ways of working.

The proposal to develop a NHS-wide standard patient safety curriculum is positive and has the opportunity to establish consensus and expectations amongst NHS staff – current and new – about what a strong safety culture looks, feels and sounds like in the context of day to day working. It is important that this translates down to organisational practices where appropriate.

The proposal to develop a network of senior patient safety specialists within trusts to help lead, oversee and coordinate providers' strategic approach to patient safety is positive. However, the proposal that it be the role of someone with existing duties (i.e. not a new appointee) will necessitate very clear guidelines

and boundaries of duties and remit. Some trusts – particularly those which encompass very large geographies – may find that they need to appoint several people into such a position.

A dedicated patient safety support team in NHS Improvement offered in a non-judgemental way has the scope to be helpful and we would therefore welcome this proposition in principle. However, what the team's scope of remit will be and how it will interact with regulatory activity will need to be made clear. Risks to safety are one of the main triggers of Care Quality Commission Warning Notices and are also a precursor of regulatory intervention in the form of quality special measures.

Other areas related to the patient safety support team that require clarity include: whether the team will be funded by NHS Improvement or trusts will need to 'commission' the team's support; whether trusts will need to bid for the team's support; and how the team will prioritise its work.

Which areas do you think a national patient safety curriculum should cover?

The national curriculum needs to encompass: human factors; some basic insight into systems approaches to safety; 'Safety II' thinking, which emphasises learning from what works well; as well as the key learning from Sign Up To Safety, which provides insight into the psychology of effective team working and about the importance of effective and supportive communication at all levels.

The curriculum should provide all participants with the basic skills to: support speaking up about risks to safety; encourage strong safety cultures in their own teams and organisations; make patients and families feel safe and confident about raising concerns; and give insight into why it matters. It should also teach participants how to be self-aware about 'compassion fatigue', the importance of self-care and knowing one's limits to safe working, in line with human factors science.

Initiatives

Do you agree with these proposals? Would you suggest anything different or do you have anything to add?

Commitments to 'reduce harm' by a target amount have proved notoriously challenging to achieve and 'harm' is, as the consultation document explains, very difficult to quantify. The proposal to work closely with the various expert bodies on priorities and initiatives to drive through changes that, on the basis of expert analysis, promise to help reduce risk and harm is welcome. However, this will need to be consistent and a long-term commitment. The target to decrease harm in key areas by 50% seems particularly challenging given 2023/24 will be only three years away when the strategy is released.

What are the most effective improvement approaches and delivery models?

The continued support, with greater strategic focus, of the patient safety collaboratives is a positive approach and it make sense to align with NHS Improvement / NHS England regional structures. It will be important to ensure that the patient safety collaboratives' work supports where possible patient safety work already underway.

Involvement of primary and social care in the work suggested in this section will be important to its success. Greater alignment with Public Health England's work and recognition that Public Health England is an important partner in the NHS's contribution to promotion of health and wellbeing and successful early intervention will also be crucial.

How should we achieve sustainability and define success?

To aid transparency, openness and alignment, we would recommend that NHS Improvement report annually on progress against the final patient safety strategy commitments. This annual report should include timescales and full insight into any changes in implementation timescales, as well as recognition of what is working well.

Achievability will rest on an implementation and delivery plan that is realistic, resourced appropriately and with clearly measurable outcomes and milestones. Clarity on how outcomes will be assessed and measured will be particularly essential. Without this it will not be possible to demonstrate success locally and nationally against the strategy.

We think that the main challenges with the proposals included in the document lie in facilitating and enabling the changes required for proposals to be delivered on. Regulation pressures, misaligned requirements around reporting, bureaucratic burden, local variation, and workforce shortages will all present barriers to delivering the strategy.

Trusts will need to be supported to prioritise this work, not only through what the national bodies ask them to do, but also through greater commitment and effort by national bodies to eliminate burdensome and ineffective processes and regulatory requirements. Stability of purpose will be required to ensure that any changes to process have time to mature.

Summary

In summary we welcome that NHS Improvement has set out a clear commitment to bringing a more strategic, planned and aligned approach to patient safety policy across the NHS. This is vital, alongside the appropriate training, expertise and resources for NHS organisations and staff, to fully embed an effective safety culture across the NHS. We are also pleased to see the aims and principles of the strategy are in line with previous policy and proposals are aligned to priorities already underway.

In our view, the main challenges with the proposals in included in the document lie in facilitating and enabling the changes required for the strategy's ambitions to be realised. Regulation pressures, misaligned requirements around reporting, bureaucratic burden, local variation, and workforce shortages will all present barriers to delivering the strategy. Trusts will need to be supported to prioritise this work and changes to process will need to be given time to mature. Clarity on how outcomes will be assessed and measured will also be essential.

We would be very happy to discuss our consultation response if helpful and to facilitate engagement with our members to support the development of the strategy going forwards; for further information please contact Amber Jabbal, Head of Policy, amber.jabbal@nhsproviders.org.