

## Opening the door to change: NHS safety culture and the need for transformation

This briefing summarises the report *Opening the door to change: NHS safety culture and the need for transformation* published today by the Care Quality Commission, which shares the findings of a review examining the issues that contribute to the occurrence of Never Events and wider patient safety incidents in NHS trusts in England. The briefing summarises the key messages followed by sections of the report, the report's recommendations and includes NHS Providers media statement. The key recommendations in this report align with proposals raised in *NHS Improvement's current consultation on a new National Patient Safety Strategy*, commenced on 4 December and closing on 15 February 2019, to sit alongside the NHS long term plan. For comments and queries on this briefing, CQC's report or the patient safety strategy consultation please contact [Cassandra.Cameron@nhsproviders.org](mailto:Cassandra.Cameron@nhsproviders.org).

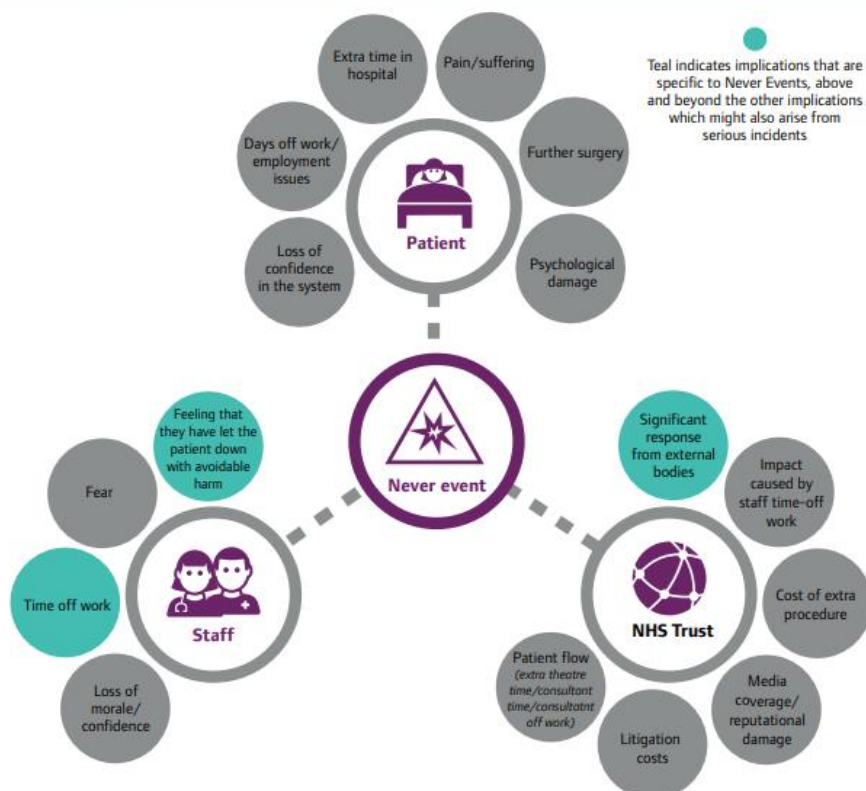
### Key messages

- There is a strong commitment from NHS staff to make the care of patients as safe as possible but this is impeded by the current patient safety system, which is complex.
- Trusts receive safety guidance from different bodies, creating confusion about which organisations can best provide information and support. The added impact of increasing patient demand and staff shortages means trusts have insufficient time and support to implement safety guidance effectively.
- Although healthcare is by its nature high risk, the increasing pressures within the NHS mean that this reality is not consistently reflected in culture and practice. This contrasts with other safety critical industries which recognise their high risk and ensure this approach informs everything that they do.
- While recognising that healthcare is different, there is much the NHS can learn from these high risk industries to ensure risks are identified and managed proactively, with a greater understanding of team dynamics, situational awareness and human factors, and with safety protocols followed consistently.
- CQC's analysis found that only 4% of Never Events are amenable to quick fixes and technical solutions, the overwhelming majority require human factors based solutions, which will require widespread education and training to equip NHS staff with knowledge and skills to implement.
- There are seven recommendations including for a common curriculum for patient safety education, training and ongoing professional development; a national patient safety strategy; a new leadership role for patient safety culture in all trusts; standardisation of healthcare processes where appropriate; a new national approach to patient safety alerts; revision of the Never Events Framework; and improved CQC expertise in inspecting and regulating for safety.

## Introduction

- CQC's review of Never Events was commissioned by the former Secretary of State in Autumn 2017 to understand the barriers to improving patient safety, through a specific focus on Never Events.
- The NHS Never Events Framework launched in 2009 and consists of 15 events that are considered as wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented effectively.
- Never Events are a very small proportion of approximately two million patient safety incidents reported to the National Reporting and Learning System (NRLS) annually (74% of which are considered to have caused no harm to the patient) and 21,500 serious incidents reported in 2017/18 in the NHS in England.
- A well-functioning clinical governance system should make sure that Never Events are prevented, but a single Never Event can act as a red flag that an organisation's systems may not be robust. When a Never Event happens, it should trigger a substantial response, with a focus on learning not blame. However, the implications of a Never Event for patients, staff and the NHS are significant (Figure 1, below).

FIGURE 1: POSSIBLE IMPLICATIONS OF A NEVER EVENT\*



\* Never Events will have different consequences for different people and groups.  
This graphic represents things people have told us can sometimes happen as a result of a Never Event.

- Between April and June 2018, CQC visited 18 NHS acute and mental health trusts to research patient safety approaches to preventing, managing and responding to Never Events. This research was supplemented with forums and workshops with patient representatives, people from the NHS, other healthcare organisations, and safety and human factors experts from health and other safety-critical industries, such as aviation, nuclear and fire and rescue, to help address four key questions:

- 1 How is the guidance to prevent Never Events, including patient safety alerts, regarded by trusts?
- 2 How effectively do trusts implement the safety guidance?
- 3 How do other system partners support trusts with the implementation of safety guidance?
- 4 What can we learn from other industries?

## Patient safety and the challenges for NHS trusts

*Workload and prioritisation, lack of standard processes, and leadership and governance*

- Patient safety alerts are generally viewed as an effective way to disseminate guidance to trusts, but it is the context into which they land that creates challenges.
- With the competing pressures on staff due to high workloads, implementing patient safety alerts can be seen as just one more thing to do, and can lead to staff taking a mechanistic and siloed approach.
- Passing responsibility for implementing alerts to multiple individuals, rather than having a system in place to coordinate implementation, can lead to many adaptations of the same piece of guidance.
- Greater standardisation of processes, as found in other safety critical industries, might help to ease this pressure, and make it easier for staff to speak up with confidence if processes are not being followed.
- However, standardisation should not override clinician's ability to use their professional judgement and act flexibly when circumstances require this.
- Different approaches to governance mean that processes don't drive or monitor progress effectively, and too much reliance is placed on the individuals delegated the task of implementing alerts. In addition, CQC found that boards are not consistently prioritising meaningful discussions about Never Events and associated safety alerts.
- Leadership styles and hierarchies can have a detrimental effect on trust safety cultures; rigid hierarchical structures prevent people from speaking up about potential safety critical incidents. A number of initiatives across the NHS are helping to tackle this problem.

## Patient safety in the wider healthcare system

*Communication and coordination of messaging; support from national bodies and clinical commissioning groups; sharing learning nationally; Trust patient safety systems and cultures; and involving patients*

- The current patient safety landscape is confused and complex, with no clear understanding of how it is organised and who is responsible for what tasks, making it difficult for trusts to prioritise
- Trusts receive too many safety-related messages from too many different source; they want better communication and coordination between national bodies, and greater clarity around the roles of the various organisations that send these messages.
- Trusts were generally positive about the support available CCGs following the publication of an alert or after a Never Event. However, this is variable. Some CCGs were comprehensive and collaborative in their approach, visiting trusts to observe how they implemented guidance, talking with staff and patients, and having frequent meetings with trust leaders. Some saw assurance and monitoring as simply checking what trusts are doing administratively, without getting involved.

- There is no clear system for staff to share learning at a national level. Local reporting systems are often poor quality and do not support staff well. Lessons can be learned from other industries with simpler and more transparent reporting systems, underpinned by a culture that drives good reporting. Patient safety collaboratives are uniquely placed to support organisations to improve patient safety outcomes.
- Patient safety systems are more likely to be effective if patients are actively involved, but patient involvement is not done consistently well.

## Education and training for staff on safety systems and processes

*National patient safety education; local and post-qualification education; leadership in patient safety.*

- The health education system is complex, with multiple bodies working at different levels with different staff types. This means it is not easy to establish who is responsible for which elements of education or who has the authority to deem any element of training mandatory. As patient safety training is incorporated implicitly within professional healthcare programmes, it can sometimes be difficult, for both the learner and the casual observer, to identify where it is explicit.
- Understanding human factors and ergonomics is a key to building a better patient safety system. Training in human factors and ergonomics as part of safety system design, incident investigation and solution development has long been recognised as important but has not been effectively implemented. The role of human factors and ergonomics in safety are being recognised more widely, and there is an opportunity to learn from other high-risk industries, for example nuclear, where this type of training is already being delivered as a core element of staff education.
- There is ample evidence and support for the benefits of multidisciplinary training rather than training in individual clinical groups. Working and training as a multidisciplinary team helps to break down hierarchies as seen in other industries, such as aviation, that have implemented this.
- While trusts recognised the importance of patient safety, safety education is not a priority for leaders in the same way that operational targets are. Other industries regard ongoing training as crucial.

## Report recommendations

- 1 NHS Improvement and Health Education England to develop a **common curriculum for patient safety education, training and ongoing development** that includes the role of systems, design, effective communication, risk, just culture, human factors and ergonomics for all in frontline care.
  - NHS trusts must offer ongoing training, continuing professional development and development.
  - Leaders should release staff to carry out this development as a vital part of every employee's role.
  - A new education, training and CPD plan with milestones towards a specialism in patient safety.
- 2 A **National Patient Safety Strategy** as **recently announced by NHS Improvement**, developed in partnership with professional regulators, royal colleges, frontline staff and patient representatives, with progress overseen by the National Director of Patient Safety at NHSI on accountability for delivery.



- 3 **Leaders with a responsibility for patient safety in each trust** to make sure that the trust reviews its safety culture on an ongoing basis and is centred on learning and improvement. They should report back to NHSI to support learning. NHSI should specify the responsibilities, skills and experience required for these leaders, as part of its work to devise a curriculum for patient safety.
- 4 **A standardisation framework** for identifying clinical processes, equipment and governance processes, that could benefit from standardisation, how this will happen, where the standardisation should apply, and how the framework will lead to tangible action and delivery.
- 5 The National Patient Safety Alert Committee (NaPSAC) should oversee **a new patient safety alerts system that aligns the processes and outputs of all bodies and teams that issue alerts**, make sure that they set out clear and effective actions that providers must take on safety-critical issues and should include guidance on the tools that might be needed by providers and the role of patient insight.
- 6 NHS Improvement should **review the Never Events Framework** with a focus on the leadership and culture needed to underpin safety, taking into account the different settings in which Never Events occur, including acute, mental health and community settings, and fair assessment of compliance.
- 7 **CQC will improve its own patient safety expertise** to ensure that regulation does not stifle new systems thinking and innovation and supports the report's recommendations.

## NHS Providers media statement

### Care Quality Commission recommendations will bring clarity to patient safety improvement efforts

Responding to *Opening the door to change: NHS safety culture and the need for transformation* by the Care Quality Commission, the head of policy at NHS Providers, Amber Jabbal said:

"Patient safety will always be a top priority for the NHS and Care Quality Commission (CQC) make clear that NHS staff are committed to ensuring that patients are kept as safe as possible. However, the CQC also found that funding, rising demand and workforce challenges make it difficult to learn from incidents and make changes effectively amid so many competing priorities, and that the current NHS approach to patient safety improvement adds confusion on top of these pressures.

"We very much welcome the report and are supporting the development of a national patient safety strategy. The CQC have made recommendations that will bring much-needed clarity, consistency and alignment to patient safety efforts across the NHS. It is vital that they are supported as a priority, with all NHS organisations and staff given the training, expertise and resources needed to fully embed an effective safety culture, underpinned by a new coordinated national long term patient safety strategy. Organisations must be able to respond effectively when staff raise concerns about risk and harm in NHS care, to help reduce the risk of further patient safety incidents."

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