Browne Jacobson

International Patient Safety Day – achieving a safety culture in the NHS

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The journey to developing a safety culture in the NHS

Cultural issues have been in the spotlight for some time in the NHS, having been a key element of the Francis inquiry into events at Mid Staffordshire NHS Foundation Trust. In particular, Robert Francis' Report, published in 2013, concluded that a focus on reaching national targets, achieving financial balance and foundation trust status had all driven behaviours which contributed to an "*insidious negative culture"* in an organisation where patients and staff who had valuable insights into deficiencies in the system were not listened to.

In the six years since the publication of the Francis report, considerable progress has been made in the development of a safety culture in the NHS. However, as the CQC has recently identified, there remains a need for ongoing focus in this area. In its report 'Opening the door to change' published in December 2018, the CQC examined the underlying issues in the NHS that contribute to the occurrence of Never Events and the learning which can be applied to wider safety issues. As part of the review, the CQC found a fundamental difference in the approach to safety by safety-critical industries and healthcare. Safety critical industries such as aviation, nuclear and fire and rescue think of everything they do as 'high risk' which, in turn, informs everything they do. In contrast, healthcare (which in statistical terms is higher risk than any of the industries consulted) generally considers that safety is the norm and that things only go wrong in exceptional circumstances.

This has significant implications when things do go wrong. Whilst the majority of NHS staff appreciate that what they do carries risk, the culture of the system in which they work is one that considers itself essentially safe, so 'human error' is often cited in incident investigations. However, this approach fails to recognise the complex environment in which NHS staff work and implies individual blame (even if unintended). This, in turn, can leave staff feeling, at best, unsupported and, at worst, fearful and defensive. Neither is conducive for effective learning.

Facilitating effective learning - supporting staff through a just and learning culture

Whilst a safety culture encompasses much more than creating a 'just culture', the importance of appropriately supporting staff following incidents is highlighted in 'Being Fair', a paper published by NHS Resolution in July 2019. This excellent resource for those working in and receiving health and social care, looks at the key elements of a just and learning culture and demonstrates the benefits of such an approach, sharing examples where NHS organisations have successfully implemented practices that emphasise learning rather than blame. In doing so, it makes it clear that a 'just culture' does not mean 'no blame' but rather "*the balance of fairness, justice and learning and taking responsibility for actions*".

In this respect, ‘Being Fair’ signposts NHS Trusts to the NHS Improvement ‘Just culture’ guide which was published in 2018. This guide, (which is due to be reviewed later this year in light of the recommendations from the Professor Sir Normal Williams Review), asks a series of questions to help clarify whether there is something specific about an individual that needs support or management, as opposed to a wider systems based issue, in which case any individual remedial action is often unfair and counterproductive, also failing to identify and tackle the root cause(s) of the incident.

The NHS Improvement ‘Just culture’ guide also helps to reduce the role of unconscious bias when making decisions to help ensure all individuals are treated equally and fairly no matter what their staff group, profession or background. This is important because, as ‘Being Fair’ highlights, research has shown that different individuals can experience inequity and discrimination and suffer disproportionate levels of disciplinary action, in particular black, Asian and minority ethnic groups.

Whilst patients and their families are, of course, at the heart of a safety culture, **all** staff need to feel supported within a compassionate and inclusive environment, knowing that they will be treated fairly if things go wrong or they speak up to prevent incidents occurring.

Facilitating effective learning – proposed changes to incident investigation

A just culture and improving the way staff are supported when things go wrong are vital elements for a patient safety culture but other changes are needed to improve learning from incidents, as recognised by the NHS Patient Safety Strategy (‘the Strategy’), published by NHS Improvement and NHS England, also in July 2019.

The Strategy, designed to be a ‘golden thread’ running though healthcare, sets out a vision for the NHS to continuously improve patient safety building on the foundations of a patient safety culture and a patient safety system with three strategic aims:

- Improving understanding of safety by drawing insight from multiple sources of patient safety information (insight)
- Equipping patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system (Involvement)
- Designing and supporting programmes that deliver effective and sustainable change in the most important areas (Improvement)

The Strategy sets out various actions the NHS will take in the above areas in order to achieve its safety vision, including proposed changes to the way the NHS investigates and learns from incidents.
One aspect of this is a new digital system to replace the National Reporting and Learning System (NRLS) and Strategic Executive Information System (StEIS). The new system will be designed to create a single, simple portal making it easier and more efficient for frontline staff to use, with easier access to safety data and a shared space to enable the exchange of ideas and lessons.

In addition, in recognition of shortcomings in the current system, the Serious Incident Framework is to be replaced by the new Patient Safety Incident Response Framework (PSIRF). This will run alongside the investigation expertise at the Healthcare Safety Investigation Branch (HSIB) which will continue to focus on the system-level causes of harm, modelling values and behaviours that support transparency and blame-free learning.

Further guidance about the PSIRF is due to be published very shortly but the proposals include the use of a broader scope for investigations, enabling discretion by Trusts to respond to patient safety incidents in a variety of ways using a risk-based approach, selecting incidents for investigation on the opportunity they present for learning. The Strategy reinforces the purpose of patient safety investigations so that investigations should not pronounce on avoidability, predictability, liability, fitness to practise or cause of death. It also proposes a departure from the strict 60 working day deadline, with timeframes instead based on an investigation management plan, agreed where possible with those affected, particularly patients, families and/or carers.

There is no intention to alter the need to investigate specified incidents such as deaths where there is reason to believe the death may have resulted from problems in care as set out in the Learning from Deaths framework (which now includes ambulance Trusts in addition to NHS acute, mental health and community Trusts). In addition, the data and analysis from the Learning from Deaths programme will be enriched by information and learning from the medical examiner system which, over the course of 2020/21, will be expanded to encompass all deaths, including those occurring in the community and independent practice.

Safety II – safety differently

All of the above focuses on learning from what goes wrong and, historically, much focus has been given to learning from incidents. However, the Strategy also promotes the need to look at ‘Safety II’, in other words why things routinely “go right”, and sharing knowledge and ideas about what works, rather than focusing on when things go wrong (‘Safety I’).

In this respect, the Strategy explains that a different mindset is needed. Conversations and a curious approach to understanding are important, for example, understanding how day to day tasks are completed, despite the pressures, resource limitations and goal conflicts. There is also a suggestion that staff could report problems via an incident reporting system, without waiting for an incident to happen first, freeing up the whole process of learning as it will not be restricted by any reticence to report actual errors and harm. Under the proposals, the NHS will explore how to give staff the skills to take a Safety II approach without losing their focus on Safety I and Safety II principles will feature in a new system-wide patient safety syllabus which all staff will follow.

Conclusion

The Strategy sets out an ambitious but laudable vision for continuous improvement in patient safety over the next five to ten years and whilst further guidance will be needed along the way to enable NHS Trusts to deliver this vision, the Strategy helpfully pulls together the latest thinking on how to make tangible progress in improving safety, with a recognition that there need to be significant improvements in the way the NHS learns – both from what goes wrong and what goes well. A just culture is a key element of this and with an increasing number of practical resources available for NHS Trusts, such as ‘Being Fair’ there are lots of reasons to be positive that a safer culture, safer systems and safer care for patients can be achieved.

We are organising a number of meetings/forums over the next few months to facilitate discussions between Trusts about a number of topics discussed in this article, including the learning from deaths programme, developing a just and learning culture and improvements in incident investigation with a move towards Safety II. We would be delighted to hear from you if you are interested in attending any of these meetings, please contact Amelia on +44 (0)115 908 4856 or amelia.newbold@brownejacobson.com**.**

Contact

Amelia Newbold

Risk Management Lead

Amelia.Newbold@brownejacobson.com

+44 (0)115 908 4856

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