RCN response - Developing a National Patient Safety Strategy for the NHS: Proposals for consultation, February 2019.

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Q6: Do you agree with these aims and principles?

We welcome the publication of the proposed patient safety strategy for the NHS including reforming current working groups and policies already in place. The proposals cover NHS-funded care in England, and consideration should be taken about the ways in which the ambitions can extend to all health and care delivered across the patient pathway.

The new patient safety strategy presents a ground-breaking opportunity to redefine common understanding and ensure that health and care services are regarded as a safety critical industry, as it is indeed a "system comprising individuals, technology and organisations in which safety is of paramount importance and where the consequences of failure or malfunction may be loss of life or serious injury, serious environmental damage, or harm to plant or property."[i] Taking a human factors approach must be front and centre of this strategy.

There is more to be done to raise awareness of the human factors which directly impact on patient safety.[ii] As it stands, the current definition of patient safety within the strategy is too simplistic, defining patient safety as the 'avoidance of unintended or unexpected harm to people during the provision of healthcare'. Patient safety is also about taking a proactive approach and mitigating potential harms and this should be reflected in the definition. Do no harm may apply on an individual practice level, but within health care as a service, it is important to review safety from a system level.

The principles of a just culture, openness and transparency and continuous improvement are helpful terminology but would be more so if they were established as aims with specific measurable objective-based statements and timeframes for delivery

Q7: What do you think is inhibiting the development of a just safety culture?

Health and care staff are too often individually held to account for what is delivered, irrespective of the resources and funding context. This is inhibiting the development and embedding of a just safety culture. In any incident, a system must credibly and adequately analyse the range of factors and circumstances which led to a mistake or failure, and identify learning to apply for the prevention of future problems. Often, these issues are of a systemic nature.

Within the NHS in England, the nursing vacancy rate is above 11%, with total vacant posts at almost 41,000.[iii] Nursing staff report that they are having to manage a disproportionate amount of risk to deliver safe and effective patient care, and that they are afraid that poor working conditions created by understaffing may lead to mistakes.[iv] Without the right staff, in the right place at the right time with the right skills to deliver the care patients need, this strategy will fall at the first hurdle.

For this reason, we suggest amending the flow chart [figure 1] to include an immediate step underneath the stated ambition - 'the safest healthcare system in the world'.[v] This addition should clarify the importance of building a workforce with the right skills, in the right place at the right time to meet patient need and deliver safe and effective care. Without adequate workforce, new patient safety processes, upskilling of existing staff and introduction of improvement programmes will not create a safer health and care system. Safety principles will always be undermined if workforce supply is designed according to available funding rather than modelled to meet patient need within service models that are both safe and

effective. Inadequate staffing has a detrimental impact on the health and wellbeing of patients and nursing staff alike. Nurses feel professionally compromised that they cannot provide nursing care that patients require.[vi]

Q8: Are you aware of a Just Culture guide?

The RCN is aware of the Just Culture guide and supports its purpose. The RCN has worked closely with NHS Improvement on developing it and helped implement this resource.

Q9: What could be done to further help develop a just culture?

The RCN believe that accountability for nurse staffing to provide safe and effective patient care in all settings should be enshrined in law in England. Legislation for safe and effective staffing is already in place in Wales. In Scotland work is well progressed towards having legislation for safe and effective nurse staffing with the recent publication of Health and Care (staffing) (Scotland) Bill. Across the UK, the RCN is calling for accountability for staffing to be specified in law and supporting policy, funding flows and delivery mechanisms, including the requirement for health and social care systems to have credible and robust workforce strategy, and data-driven workforce planning.[vii]

It is important to recognise the impact which challenges in public health and social care have upon the health system as a whole. Last year, 78% of local authorities reported concern about their ability to meet their statutory duty within their existing budgets to ensure care market stability[viii]. Current provision of social care is not sufficient to meet the needs of the population: Age UK estimates that there are more than 1 million people whose needs are not being met. [ix] The NHS cannot be considered in isolation when addressing systemic issues, and this needs to be acknowledged within this strategy.

Q10: What more should be done to support openness and transparency?

We strongly support informing patients when things have gone wrong as an essential part of an open clinical culture that respects the autonomy of the patient. Duty of candour is supported and actively encouraged by the RCN. This only works in practice when nursing staff are free from disproportionate sanctions and blame as this prevents openness and is counterproductive to the welcome ambition to share learning from mistakes. Nursing staff and health care teams should be fully supported to disclose their concerns and reflect openly on the events that led to an incident, rather than fear immediate referral to the Nursing and Midwifery Council (NMC) or other regulators. A collaborative approach to liaising with a patient should be taken with support from the workplace, not relying solely on an individual.

Currently, healthcare professionals have little trust that action will be taken when concerns are raised with employers. Bullying culture within the NHS is still too prevalent and it severely curbs the ability of frontline staff to champion patient safety. The importance of all staff of all grades feeling able to challenge and speak up to both prevent incidents and report them is essential.

In line with the NMC code, there is an obligation on nursing staff to raise concerns when staffing levels are low, which 72% of respondents to our 2017 staffing for safe and effective care survey felt comfortable to do.

However, worryingly, 44% of respondents believed that no action was taken to remedy the unsafe situation identified.[x] Our members tell us that fear of reprisal, abuse and intimidation discourages them from speaking up or raising a patient safety concern. The strategy must do more to encourage employers acting on the concerns raised, and providing a credible response. Further to local action taken by employers, it is essential that the Health Services Safety Investigations Branch (HSSIB) investigations are objective, credible, and capable of enacting meaningful change.

Q11: How can we support continuous safety improvement?

The national database in which incident reports are collated centrally is a useful resource, and we welcome expanding the ways in which this data can be shared, reviewed and used to drive changes on a national scale that would benefit patient safety. There should be

Board-level responsibility and accountability for reviewing and acting upon patient safety data.

The intention to better utilise nationally-reported incident data by harnessing new technologies is welcome. However we are unable to comment further on the use of AI and machine learning without more detail about how this would be applied. Similarly we welcome the new emphasis on learning from what goes right as well as from what can go wrong. This is a salient principle from the application of a Human Factors approach in other industries. We would be interested in seeing how this would work in practise.

Easier and streamlined reporting would be welcomed by staff across the health and care system. Anecdotally, our members report that due to time constraints on shift, they often have to complete reporting paperwork in their own time after contracted hours have ended. Health and care staff working in primary care, or supporting people in the community find incident reporting especially difficult as they are often left behind with technological updates, and working remotely means that they have to fill in paperwork and use IT systems retrospectively after a long day on the road.

Reinstating the budget for CPD for nursing staff is imperative if NHSI is serious about improving patient safety. The Health Education England budget for 'workforce development', which provides CPD for nurses, has been cut by 60%, over two years from £205m in 2015/16 to £83.49m in 2017/18. In contrast, the 'future workforce' postgraduate medical and dental budget was increased by 2.7% in 2017/18. Without restoring CPD funding for nurses, and allowing nursing staff the time to complete mandatory training, the aims of this strategy to equip staff at all levels with the skills and support they need to improve patient safety is fundamentally compromised. Responsibility for training and ensuring staff are up to date on patient safety initiatives and policies lies with the employer. However, as CPD budgets for nursing staff have been dramatically cut, it is increasingly difficult for nursing staff to access CPD, impacting their ability to keep up to date, as well as learn new skills.

Insight

Q12: Do you agree with these proposals?

Employers, regulators and arm's length bodies must understand the importance of human factors, such as confusing medicine labelling, as well as contextual factors, such as the numbers of planned and actual staff on a shift, as these impact on an individual's ability to deliver safe care.

NHS Improvement is in the position to take a system wide view, and to proactively mitigate predictable harm. The principles of ergonomics can be applied to the assessment and mitigation of patient safety risks, and are already used by many other safety critical industries when reflecting on incidents or never events, to better design processes and equipment.

We support the work to date of the National Patient Safety Alerts Committee (NaPSAC). Advancements in technology and the ability to use algorithms to spot patterns and identify systemic patterns in patient care or workplace practice which heighten risk is welcome. There should be a recognition within the strategy, and within Government that technology alone will not resolve patient safety in isolation. Technology should be harnessed to its best use, and to do this the health care system would benefit from expert ergonomics input to examine the human factors which affect patient safety.

The National Reporting and Learning System (NRLS) led by the national patient safety team is a helpful mechanism for understanding patient safety across the NHS, but more could be done to disseminate learning from this resource. The introduction of the Patient Safety Incident Management System (PSIMS) should explore ways technology can identify patterns within reporting, and how these can be analysed so that improvements can be identified and implemented locally and at system level. To this end, the NaPSAC should place more emphasis on the learning as well as on the benefits of reporting. This strategy should

consider how the system as a whole can inform the development of modern safety management methods such as barrier management.

Infrastructure

Q14: Do you agree with these proposals?

Nursing staff are the biggest proportion of the health and care workforce. Recent research has revealed that risk-adjusted hospital mortality rates for common surgeries differed across hospitals, and each increase of one patient in the patient-to-nurse ratio correlated with a 7% increase in mortality.[xi] Without the right numbers of qualified nurses in the right place to care for patients at the right time, there is a detrimental impact on patient care. It is important for the strategy to acknowledge and recognise the importance of workforce, and should address and consider the systemic issues that affect patient safety.

In principle, we agree with proposals to bolster the patient safety infrastructure within the NHS. However, the infrastructure of the health and care system is meaningless unless the workforce is adequate and can meet patient demand, and isn't bound by artificial financial envelopes. A just culture will begin to embed properly when the workforce is commissioned to meet patient need and nursing staff are not working in overstretched and under resourced conditions. To this end, there must be Government, national and local system accountability for staffing for safe and effective care specified in law, aligned to a credible and robust funded workforce strategy based on population need, and data-driven workforce planning.[xii]

Q16: Which areas do you think a national patient safety curriculum should cover?

All.

The ambition to deliver a patient safety curriculum will be best realised if conducted in the workplace so that learning occurs in the teams in which people work, and is closely relatable to their roles. Anecdotally, our members tell us that e-learning can be difficult to access whilst in work and they feel under pressure to complete mandatory training in their own time. NHS Improvement must ensure that there will be the necessary funding, and back-fill in place to enable nursing staff to take the time to learn and develop new skills.

Input and engagement with nursing staff is necessary at all levels of the health care system including within NaPSAC, to ensure concerns and intelligence from nursing staff as to how the system can improve patient safety are raised. We would suggest that enhancing the nursing input to the medical examiner system would be a step in the right direction

Q17: What skills and knowledge should patient safety specialists have?

All.

Further clarity on the role and specific remit of senior patient safety specialists, and where they will be based, is required. It is important that these roles encompass the breadth of care settings e.g. community care as well as acute, to allow for reporting and learning to be shared across the patient pathway and across multidisciplinary teams. If these are to be nationally determined roles, it is crucial that there is early engagement with the job evaluation group through staff side relations to ensure consistent band profiles.

Q21: Would a dedicated patient safety support team be helpful in addition to existing support mechanisms? If yes, how?

Yes, a dedicated patient safety support team would be helpful. Additionally nurse leaders such as ward managers must be supervisory and not counted in the workforce numbers so that they have enough time to work on bolstering patient safety and quality improvement.

Initiatives

Q22: Do you agree with these proposals?

We agree with the proposals, ambitions and direction of travel set out under initiatives, and the RCN is eager to be involved in the development of further initiatives and draw on the frontline experiences of our members who are delivering care in challenging circumstances.

Drawing on the expertise of clinical staff, patients and carers, professional organisations and trade unions, is crucial to enhancing patient safety, and getting health care recognised as a safety critical industry. Ergonomists are able to provide analysis and support on redesigning health and care to ensure that the environment and systems are working to mitigate harm, rather than just avoid it. We would recommend that the strategy draws on ergonomist experts for support.

Q23: Would you suggest anything different or do you have anything to add?

Achieving an increase in patient safety also requires increasing the safety and support of nursing staff while they are on shift. The environment in which nursing staff and other health care professionals work needs a central focus in the patient safety agenda, both in terms of culture and prevalence of bullying and to understand the systemic common errors which may lead to incidents occurring.

Meeting the welfare needs of staff while on shift is paramount to creating a safety focussed culture. Staff while at work must be facilitated to have food, drink and rest breaks so that they are kept hydrated and well.

Overall the strategy's proposals seem too narrowly focused, and are applicable to patients with single pathologies. The strategy does not effectively take into account or address the need to balance the risk and benefits of interventions in the context of people who have co-morbidities and complex needs. A person with co-morbidities may be assessed by many different health care professionals, and their care package will require input from the multidisciplinary team. It is important for this team to work together to identify and mitigate any safety risks that may occur to their patient across the care pathway. Taking a different approach, one that is more holistic which reflects on patient safety before designing and delivering care will mitigate any risks early. It will also encourage health care staff to create a just safety culture within their teams, and support them to speak up and raise concerns in a timely and effective manner.

Q24: What are the most effective improvement approaches and delivery models?

A simple Plan Do Study Act approach is one way that could be explored to help staff test, implement and adopt changes to service delivery without it being overly burdensome. Easy to follow guidelines and processes could be in introduced to provide the necessary checks and balances within daily clinical practice to pre-empt human error and avoid any confusion and lead to better patient outcomes.

A case study included in a review by NHS England - *Human Factors in Healthcare* – describes a scenario where a paediatric patient was administered penicillin despite having an allergy to this medication. Listed as a reason why this mistake happened was that nursing staff faced competing pressures and that the patient's intravenous drip and allergy alert wristband were covered by a bandage. Clear measureable outcomes on how to prevent further instances of this were identified. Patient safety incidents demand additional approaches that supplement traditional quality improvement methods. For instance staff should be introduced to the concept of barrier management and involved in the development of local implementations.

Incidents and learning must be shared not just within the team, or one particular ward or setting but cross-professionally and cross-organisationally. NHS Improvement must also explore possibilities of sharing learning summaries externally with relevant stakeholders to encourage system-wide reflection and continuous improvement.

Q25: Which approaches for adoption and spread are most effective?

The strategy specifically mentions reviewing the spread and adoption of patient safety collaborative programmes such as emergency laparotomy bundle. The RCN are represented on the National Emergency Laparotomy Audit (NELA) Clinical Reference Group and while there are frontline nurses supporting NELA, they do not have a network to share learning, knowledge and for peer support.

The nurses role with NELA are all very different and can vary from audit data input to full clinical involvement in ELA assessment and review, so it can be difficult to map success.

Patient safety collaborative programmes are a helpful way to embed a just culture, and if evaluated, can provide useful future learning, and knowledge sharing.

Q26: How should we achieve sustainability and define success?

Understanding and measuring outcomes following the introduction of proposals will be crucial to review how the learning and culture on patient safety has improved care delivery. Measuring outcomes must not simply focus on the reduction of harm, but should also include evaluation as to whether there has been increased reporting. Increases in reporting are positive because it suggests that health care staff have more confidence from staff willing to identify incidents or near misses, which supports continuous improvement for patient safety.

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