



Care Meeting Department of Health and Social Care

Update: 2 July 2018

Overview: CQC Patient Safety Review



Purpose:

The Secretary of State has asked CQC, in collaboration with NHS Improvement, to examine the underlying issues in NHS Trusts in England that contribute to the occurrence of Never Events and thereafter the learning we can apply to wider safety issues.

Outcomes:

Published report into how organisations can reduce the risk of Never Events by promoting the positive work identified. This will highlight how CQC can improve its assessment of safety, inform future areas of work for NHSI, identify where practical resources or existing guidance requires revision and make recommendations to Trusts and other patient safety bodies.

Timescale: Report published in October 2018.

Overarching hypothesis



- There are barriers to correctly implementing the guidance produced to prevent the occurrence of Never Events
- We are using Never Events as a *can opener*, enabling us to look at wider pieces of safety guidance and safety practice.
- To this end we have developed four questions which we wish to answer in order to understand how implementation occurs and where barriers lie:

Key questions



1. How is the guidance (to prevent Never Events) performing*?

- This will consider the guidance as a product and whether it could be improved/presented differently. Evidence is being gathered during the fieldwork and through wider engagement.

2. How do trusts implement this safety guidance?

- This will be largely covered during fieldwork and our second roundtable and will consider governance, leadership, culture, capacity/capability and local and national variation.

3. How do other system partners support trusts with implementation of safety guidance? Does trusts' understanding of their role align with this?

- We are engaging with system partners to understand roles and during fieldwork to assess trusts' experience of working with the wider system

4. What lessons can we actually learn from other industries?

- A literature review, interviews and roundtable event will support this workstream.

*This will link to the new National Patient Safety Alert Committee

Timeline and progress to date – 1



Reviews of safety literature

Site visits to industries including RAF and BA

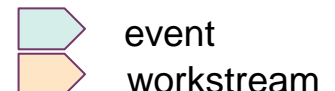
Roundtable event to learn about safety cultures & applicability to NHS from other industries (April)

External Advisory Group to steer and provide ideas including ALBs, Gov. depts, safety experts, clinicians

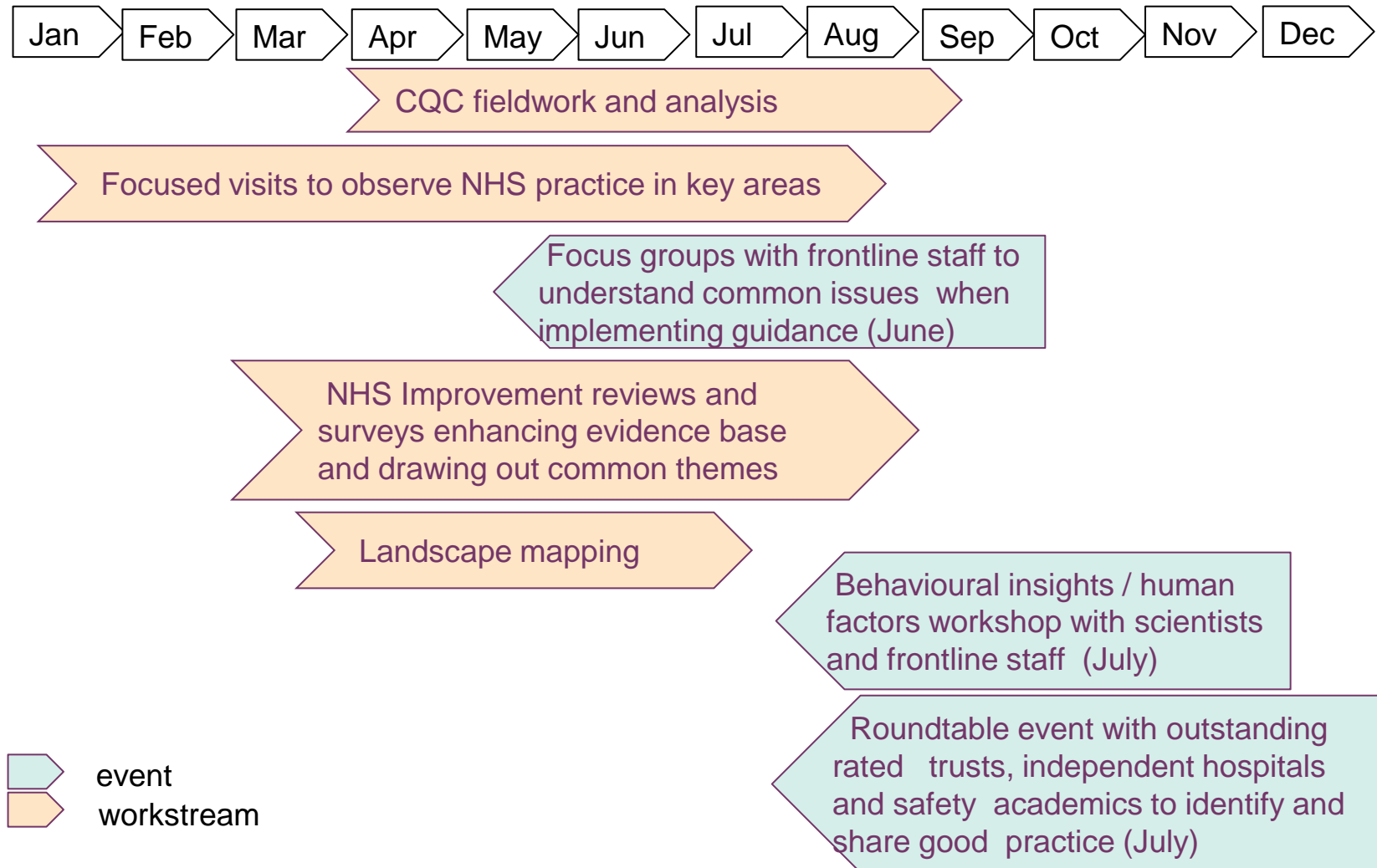
Engagement with safety bodies eg. MHRA, HSIB

Engagement with leading academics in safety

Meeting EPSO (April)



Timeline and progress to date – 2



Early emerging themes



1. Health care is a high risk industry, but this is not consistently reflected in culture and practice. It sits in a complex landscape with the following tensions:
 - Professional autonomy is important and necessary to enable clinicians to deal with complexities BUT this is all too often prioritised at the expense of proven safety protocols and policies. It is common to find workarounds even where protocols have been put in place. It may now be time to create standardized operating protocols for certain tasks, as we see used effectively in other safety critical industries.
 - Providing safe care can come second to providing sufficient and timely care given the pressures in the NHS. How do we support effective patient safety environments when 'stopping the line' has significant implications?
2. Embedding safety may need to be a fundamental element of every individual's role and this may need to be reflected in mandatory learning and training – should this be a priority rather than optional? How do we ensure such training is effective and sustained throughout careers? It will take time to change the safety culture through learning so what options are there in the interim?
3. It may be time that we recognize the fallibility of practice, understand the tension between the concept of never events vs human factors and work to manage risks proactively rather than purely reactively.

- Our themes so far are ideas and are not yet fully evidence based.
- We will continue to engage with safety experts, frontline staff and other bodies. This will meet the evidence gathering activity we committed to and ensure recommendations are applicable and tangible to those working in NHS trusts.
- Over the next two months we will analyse the fieldwork as our primary evidence source to corroborate information from other workstreams and, to identify any new findings.
- We will use the multiple sources outlined in slides 5 & 6 to construct an evidence-based report providing recommendations for multiple audiences. These recommendations will be tested with relevant bodies in advance of publication.

Appendix - who we have worked with so far



Fieldwork

- City Hospitals Sunderland NHS Foundation Trust
- East Kent Hospitals University NHS Foundation Trust
- Essex Partnership University NHS Foundation Trust
- Gateshead Health NHS Foundation Trust
- Kingston Hospital NHS Foundation Trust
- Leeds Teaching Hospitals NHS Trust
- London North West Healthcare NHS Trust
- Medway NHS Foundation Trust
- Moorfields NHS Foundation Trust
- Northamptonshire Healthcare NHS Foundation Trust
- Northumberland, Tyne and Wear NHS Foundation Trust
- Portsmouth Hospitals NHS Trust
- Queen Victoria NHS Foundation Trust
- Salford Royal NHS Foundation Trust
- Sherwood Forest Hospitals NHS Foundation Trust
- The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust
- University Hospital Southampton NHS Foundation Trust
- University Hospitals Bristol NHS Foundation Trust

Academics

- University of Leicester
- Loughborough University
- Kings College London
- London South Bank University
- University of Cambridge (incl. Mary Dixon Woods)
- Imperial College, London (incl. Susan Burnett & Lord Darzi fellows)
- University College, London
- University of Oxford (incl. Charles Vincent)

EPSO

Patient safety leads from:-

- | | |
|---------------|------------|
| • Denmark | • Latvia |
| • Sweden | • Turkey |
| • New Zealand | • Bulgaria |
| • Kosovo | • Portugal |
| • Iceland | • Estonia |

Appendix- who we have worked with so far



Forum 1

- Royal Air Force Safety Centre
- Defence Safety Authority
- British Airways
- CAA
- GMC
- Fire and Rescue services
- Heli offshore
- Trimetis
- Jacobs
- Needhams
- National Guardian's Office
- Health & Safety Executive
- MHRA
- HSIB
- NHS Resolution
- Clinical Human Factors Group
- Royal College of Obstetricians and Gynaecologists
- Royal College of Radiologists
- North Middlesex University Hospital
- Camden Health Improvement Practice
- Yeovil District hospital
- Imperial College Healthcare NHS Trust
- Patient representatives x 3
- Cambridge Engineering Design Centre
- University College London Hospitals
- Sign up to safety

Forum 2

- Bradford Institute for health research
- GS1 UK
- Frimley Health NHS Foundation Trust
- Patient Safety Translational Research Centre (PSTRC) Imperial College London
- Kings Lynn NHS Trust
- NIHR Greater Manchester PSTRC
- Northumbria Healthcare NHS Foundation Trust
- Nuffield Health Brentwood Hospital
- Southern Health NHS Foundation Trust
- The Newcastle upon Tyne Hospitals NHS Foundation Trust
- The Nottingham NHS Treatment Centre
- Western Sussex Hospitals NHS Foundation Trust
- North Tees and Hartlepool NHS Foundation Trust
- Derby Teaching Hospitals NHS Foundation Trust

Appendix- who we have worked with so far



Public Focus Group

- Experts by experience
- Imperial College, London
- Patient Safety Learning/ James Titcombe
- The Patients Association

Behavioural Insights Workshop

- Clinical Human Factors Group (CHFG)
- Behavioural insight Team
- HSIB
- Leeds University
- Oxford University

Landscape Mapping

- Royal College of Surgeons
- Royal College of Anaesthetists
- NHS England

Other engagement

- Sir Robert Francis- Board sponsor
- External Advisory Group
- CQC co-production group
- NHS Improvement frontline staff focus groups
- Ormskirk and Southport NHS Trust (visit)
- East Kent/ Canterbury Christchurch University pre-registration learning (visit)
- St Marys Hospital London (visit)
- North Middlesex Hospital (visit)
- RAF Benson (visit)
- British Airways (visit)

Thank you



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