

Opening the door to change

NHS safety culture and the need for transformation



Never Events are incidents with the potential to cause serious patient harm or death that are wholly preventable if national guidance or safety recommendations are followed.

The Secretary of State for Health and Social Care asked us to work with NHS Improvement to look at issues in NHS trusts that contribute to Never Events taking place. We wanted to understand what makes it easier – or harder – for the people and organisations in the NHS to prevent Never Events. We also wanted to see what could be learned from other industries and countries.

The review sought to answer four questions:

- How do trusts regard existing guidance to prevent Never Events?
- How effectively do trusts use safety guidance?
- How do other system partners support the implementation of safety guidance?
- What can we learn from other industries?

What we did

We visited 18 NHS trusts (both acute and mental health) between April and June 2018. We carried out one-to-one interviews,

visited different services and reviewed policies and procedures. We held forums, workshops and focus groups with patient representatives, people from the NHS, other healthcare organisations and other industries, as well as safety and human factors experts. We spoke with experts in other safety-critical industries to understand their approach to safety.

What we found

The challenges faced by trusts:

Although patient safety alerts are generally seen as an effective way to share safety guidance, competing pressures, including high workloads, and different approaches to governance are creating challenges for trusts.

The challenges across the healthcare system as a whole:

Arm's-length bodies, including CQC, royal colleges and professional regulators, have a substantial role to play within patient safety, but the

current system is confused and complex, with no clear understanding of how it is organised and who is responsible for what. This makes it difficult for NHS trusts to prioritise what needs to be done and when.

The challenges in educating and training staff:

Various bodies are responsible for different aspects of clinical and wider professional education in England. This includes universities, royal colleges, deaneries, professional regulators, Health Education England and employers like NHS trusts. It is not easy to establish who is responsible for which elements of education or who has the authority to decide which elements of training are mandatory, for example around patient safety, and place them consistently within training programmes.

Encouraging change in the NHS safety culture

Never Events continue to happen despite the hard work and efforts of frontline staff. While we do not underestimate the huge level of enthusiasm and work which is already happening to improve safety in the NHS, we have made recommendations to encourage a change in culture and behaviour, and in turn reduce the risk of harm to patients. These include:

1. NHS Improvement working in partnership with Health Education England and others to make sure that the entire NHS workforce has a common understanding of patient safety, and the skills, behaviours and leadership culture necessary to make it a priority.
2. The National Patient Safety Strategy supporting the NHS to have safety as a top priority.
3. Leaders with a responsibility for patient safety having the appropriate training, expertise and support to drive safety improvement in trusts.
4. NHS Improvement working with professional regulators, royal colleges, frontline staff and patient groups to develop a framework for identifying where clinical processes and other elements, such as equipment and governance processes, can and should be standardised.
5. The National Patient Safety Alert Committee overseeing a standardised patient safety alert system.
6. NHS Improvement working with professional regulators and royal colleges to review the Never Events framework.
7. CQC using the findings of the report to improve the way we assess and regulate safety.

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