A Unified Patient Safety Programme

The whole is greater than the sum of its parts

Introduction and purpose of this paper

The NHS in England is a unified system with the ability to make systematic change on a national scale. However, it is also made up of a number of autonomous bodies in relation to patient safety, including national ones, with various responsibilities for provision, commissioning, assurance, leadership, regulation and supervision.

During 2014 the Secretary of State for Health announced a programme of patient safety initiatives that would support a commitment to making our care the safest in the world. The Secretary of State's vision is of a new movement within the NHS in which each and every part of the healthcare system signs up to safety, '*heart and soul, board to ward'*.

This movement includes:

- A national Patient Safety Collaboratives Programme
- A national Safety Fellowship[1]
- Safety Action for England (SAFE)
- A national patient safety campaign, Sign up to Safety
- Patient safety information transparency via NHS Choices

These initiatives are at various stages of development and delivery and involve a range of partner organisations that vary between them in number and scope. There is clearly a need to align activity, coordinate outputs and ensure the many components are pulling in the same direction and deliver more than the sum of their parts. The purpose of this paper is to set out how we can achieve this aim.

The proposal is that this paper is agreed by all those organising and leading on component parts of the English Patient Safety Programme including those responsible for provision, commissioning, assurance, leadership, regulation and supervision. The key messages will be shared at the launch of the patient safety collaboratives and it will be presented at the first Strategy and Advisory Group in October and then shared across relevant stakeholders after that.

[1] Work is still required to determine the best name for these experts to be called

Actions to create a unified programme for a unified system

The key unifying factor for the English Patient Safety Programme is the goal of reducing avoidable harm by half and saving up to 6000 lives. This should be the common and shared goal of the entire NHS in England; providers, commissioners, regulators, oversight bodies and the millions of people who work in it every day. There are **three things** that can be done to support this shared goal and create a unified programme:

1. To demonstrably create a unified English Patient Safety Programme each of the initiatives should agree that reducing avoidable harm by half and saving up to 6000 lives is a shared national goal
2. Each of those organising and leading on component parts should work together and:
    - Set out how they will support this national shared goal to create the heart of the movement
    - Agree to work in synergy with each other, interact, interconnect and produce a result that is larger than each part simply added together
    - Ensure that each initiative uses and builds on each other's strengths in a way that produces a greater gain
    - Agree that discrete elements should be shared, or combined including the current set of safety meetings
    - Consider combining roles, people, events, communications, measurement, evaluation, key messages, presentations, digital plans and materials: all things required to produce system-level results
3. Consideration should also be given to leadership and coordination at the national level to support implementation of the individual initiatives

The English Patient Safety Programme initiatives

The national Patient Safety Collaboratives Programme

The Patient Safety Collaboratives Programme is a new national network of 15 Patient Safety Collaboratives intended to be in place for at least five years. The Secretary of State described this as the engine room of the patient safety improvement throughout England. Each of the 15 Patient Safety Collaboratives will be led by an Academic Health Science Network to improve healthcare through better understanding of why certain healthcare interventions work in certain settings to deliver safe and reliable care. From hospital care to care in custody, and from local GP practices to mental health trusts, the collaboratives will address safety issues in every healthcare setting in a way we have never attempted before.

Healthcare providers and their partners across each healthcare economy will be supported to come together, identify their priorities for improvement, and devise and implement solutions in a collaborative approach that delivers real change. The Patient Safety Collaboratives Programme will be inclusive, bringing people from all settings together, working with patients and carers, along with front line staff and management, and patient

safety academics. Put simply, participation in the Patient Safety Collaborative programme is a clear way for organisations to Sign up to Safety and support the aims of the campaign.

The National Safety Fellowship

The Safety Fellows initiative aims to recruit over the next five years, 5,000 individuals with safety expertise to create enduring '*local change agents and experts; safety ambassadors, safety agitators, safety evangelists - a grassroots safety insurgency across England which will seek out harm, confront it and help to fix it'*. This initiative will be established with The Health Foundation and aims to '*recognise the talent of staff with improvement capability and enable this to be available to other organisations'* and to build a vibrant set of connected safety improvement leaders and experts, all skilled in improvement at an advanced level that will support others to grow within and outside their organisations. By connecting people with expertise in safety and wider quality improvement, the Safety Fellows initiative will accelerate the spread of learning and capability across the NHS in a way that can be sustained and expanded in the future. It is hoped that the Safety Fellows will be offered a chance to access funding and support to tackle some of the key problems in patient safety. The outputs of their work will directly inform the work of the English Patient Safety Programme and support the work of the collaboratives and legacy of the campaign. It will provide recognition and reward for those involved in safety improvement, and will benefit the whole NHS.

Safety Action For England (SAFE)

Safety Action For England (SAFE) is an initiative that will see providers in the NHS being supported by a new small team consisting of patient safety experts with a proven track record in tackling unsafe care; people frontline staff will respect, listen to and work with. This team will provide fast, flexible and intensive support when significant safety problems are recognised by an organisation and they need assistance to get things right. They will support the aims of the English Patient Safety Programme by helping equip organisations with improvement and safety capability and the support needed to fully participate in the campaign and the collaboratives.

A national patient safety campaign - Sign up to Safety

Sign up to Safety is a three year national patient safety campaign that aims to become the golden thread, the unifying force, that runs through the safety improvement activity of every provider of healthcare in England and which aligns the various initiatives underway. The vision for the campaign, and indeed the wider programme of work, is that the whole NHS will rise to the challenge and join. It is about more than the numbers of NHS organisations joining; the campaign will motivate participants to act. The campaign will support the movement to achieve demonstrable change no matter where the starting point is; shifting organisations from good to great. The central campaign organisers will reinforce local messages and energise individuals and teams, going beyond institutions to seek to sign as

many individual staff in the NHS as possible to add to add to the movement. This will support and build with initiatives such as NHS Change Day and the Care Makers. Everyone that chooses to join will commit to the same shared goal: to reduce avoidable harm by a half and saving 6,000 lives nationally over the next three years.

Shared Design principles

With a single shared goal each initiative should have the same design principles. Each of these is relevant for all:

- Create the right culture
- Ensure we represent the patient voice
- Simplicity and focus on doing a few things well
- Creating local ownership and accountability
- Learn from and build on the past
- Ensure a strong focus on effective measurement for improvement
- Listen to staff on the frontline and build clinical engagement; gaining buy in so that all staff feel the initiative contributes and adds value towards their work
- Align the safety work at all levels of the system so that staff understand how everything fits together and how everything can add value to each separate piece

Create the right culture

The initiatives should all support a positive, open and fair (often referred to as 'just') culture rather than one of fear. By shining a light on successes we should aim to instil NHS staff with a sense of pride and joy in their work. An important aspect of the English Patient Safety Programme will be positive messaging, supported by powerful personal narratives of individual achievements that are designed to inspire people to act.

Ensure we represent the patient voice

The English Patient Safety Programme should help create a renewed focus on meaningful engagement with patients and carers in relation to safety. Patient safety improves when patients are more involved in their care and have more control. Patient involvement means more than simply engaging people in a discussions or getting ad hoc feedback about services. Patients and their carers will have ideas on how things can be improved and need to be given the space to share their ideas. The English Patient Safety Programme should build structures and processes to engage regularly and fully with patients and carers, to understand their perspectives on and contributions to patient safety. Patients should be involved in designing safer care and the measuring and monitoring of patient safety at organisational level and at a national level. As the Berwick reports states this will 'require the system to learn and practice partnering with patients and to help patients acquire the skills to do so'. Organisations that join the campaign are asked to seek out the patient and carer voice as an essential asset in monitoring the safety and quality of care and to commit to developing a safety briefing for patients. This will be explored over the period of the

campaign as to what the most effective mechanisms could be for patient briefing. For example patient videos can have significant potential to empower patients in the safety and quality of their care. However, it is important to note that efforts to implement patient safety films in practice need to consider different patient groups' needs and characteristics rather than trying to adopt 'a one size fits all' approach. It is suggested therefore that participants think about the best way to do this in their organisation for their patients. This may be a video or it could be another mechanism such as a leaflet or face to face briefing on admission.

Simplicity and focus on doing a few things well

Successful interventions focus everyone's efforts on a few things, doing them well and fixing them before moving on. Organisations should create their own safety improvement plans which focus on a few things that matter to those who will be implementing them and their patients. The Patient Safety Collaboratives should also do the same thing.

Creating local ownership and accountability

Every person working in NHS-funded care has a duty to identify and help to reduce risks to the safety of patients, and to acquire the skills necessary to do so in relation to their own job, team and adjacent teams. Leaders of health care provider organisations, managers, and clinical leaders have a duty to provide the environment, resources and time to enable staff to acquire these skills. The unified programme should ensure that the initiatives are developed with the frontline NHS staff, those with an understanding of the local context, people, systems and processes. These teams should be supported by individuals with safety expertise who are based within the local context and who are also able to access external evidence and expertise. The safety programme should build on local priorities and current quality and safety plans; supporting activity already happening locally and providing practical resources for teams to use structure their approach. All initiatives should provide complimentary materials for both improvement and local campaigning to help drive ownership of safety to the frontline.

Learn from and build on the past

Over the last decade or so there have been a number of patient safety initiatives at scale. However, the impact of these has not been as much as was hoped by those that created them. Therefore we need to learn what worked and what didn't work. We need to utilise the resources and materials that are the legacy of these initiatives and share them with pride rather than creating new ones. We need to create the foundations for a continuous learning culture across the NHS.

Ensure a strong focus on effective measurement for improvement

Patient safety cannot be improved without active interrogation of information that is generated primarily for learning and improvement, not punishment. Information should include: the perspective of patients and their families; measures of harm; measures of the reliability of critical safety processes; information on practices that encourage the monitoring

of safety on a day to day basis; on the capacity to anticipate safety problems; and on the capacity to respond and learn from safety information. Data on staff attitudes, awareness and feedback are important resources to gain insights into staff concerns. The English Patient Safety Programme will need to aggregate data from improvements made via local safety improvement plans and the Patient Safety Collaborative Programme to demonstrate success at a national level against the goal of reducing avoidable harm by 50% and saving up to 6000 lives.

Building clinical and patient engagement

Listening to staff on the frontline provides a rich source of safety intelligence, especially those that move around the system frequently such as doctors in training. Building clinical engagement is vital; gaining buy in so that all staff feel the initiative contributes and adds value towards their work

Safety improvement plans, the work of the Safety Fellows, the recommendations of the SAFE team and the Patient Safety Collaborative programmes need to describe changes that are relevant and needed; especially to clinicians and patients. The change needs to be better than the current situation with clear benefits, effective and evidence based interventions which have been demonstrated to have worked in the NHS. The plans need to be cost efficient and increase reliability. The changes should be easy to use and easy to adopt, possible to test on a small scale, and adapt to local conditions.

Alignment

The English Patient Safety Programme will align the safety work at all levels of the system so that staff understand how everything fits together and how everything can add value to each separate piece. To help create this unified programme, the organisers and leads for each of the initiatives should work as a team and the leads for the campaign, fellows, SAFE and collaboratives need to work with the fifteen Academic Health Science Networks in each of the four regions.

Where possible the topic themes derived from the personalised safety improvement plans (as part of the sign up to safety campaign) should feed into the safety collaboratives. Those that don't will require separate networking and support. Equally the outputs of the fellows should contribute to the work of the collaboratives wherever possible and appropriate. The SAFE team should operate within a shared agenda for this work but will be also be directed to reflect the findings of the Chief Inspectors for Hospitals, Social Care and General Practice. This is essential so that it is clear at the frontline what they all are, how they all fit together and what NHS staff are expected to do. Additionally system leaders; NHS England, Care Quality Commission, Monitor, Trust Development Authority, the NHS Litigation Authority and Health Education England should work together to put in place support for the NHS to achieve the shared goal.

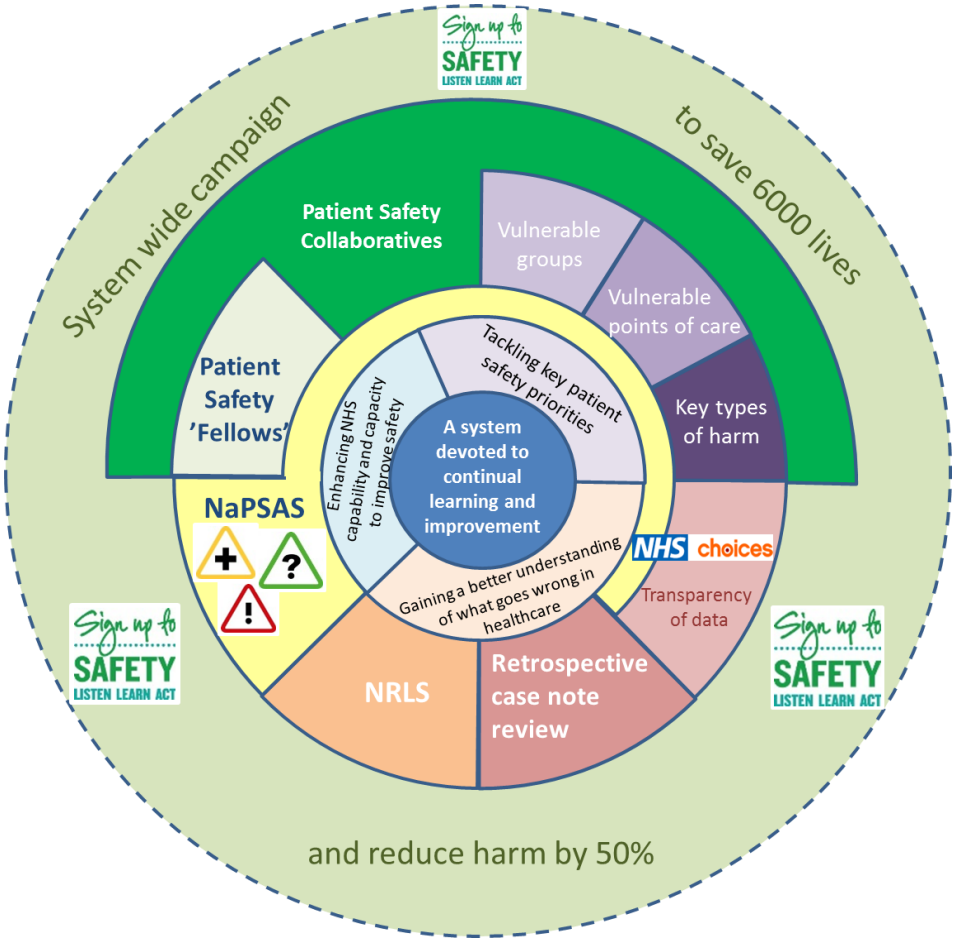
A new group, the Strategy and Advisory Group, Chaired by Sir David Dalton, will support the English Patient Safety Programme by helping align all the national patient safety initiatives and enable partnership working to ensure that each initiative adds value to the other. This strategic group will aim to support alignment of all patient safety initiatives including the campaign. It will:

- Support a consistent approach across the NHS in England and facilitate open discussions and partnership working in relation to patient safety between the system leaders
- Hear from the Chairs and Senior Responsible Officers for the relevant safety groups and initiatives

This is not a governance group as the programme initiatives are not 'reporting' to the Strategy and Advisory Group, but members of that group will commit to providing information and supporting both the overarching shared goal and the alignment of their efforts with all others.

NHS England's Patient Safety Programme

NHS England is the lead organisation for Domain 5 of the Outcomes Framework, is a key contributor to the English Patient Safety Programme and is accountable for delivery of a number of elements as well as hosting a significant proportion of the national-level patient safety expertise in the system. The below schematic represents how NHS England's patient safety programmes are aligned with activity across the system:

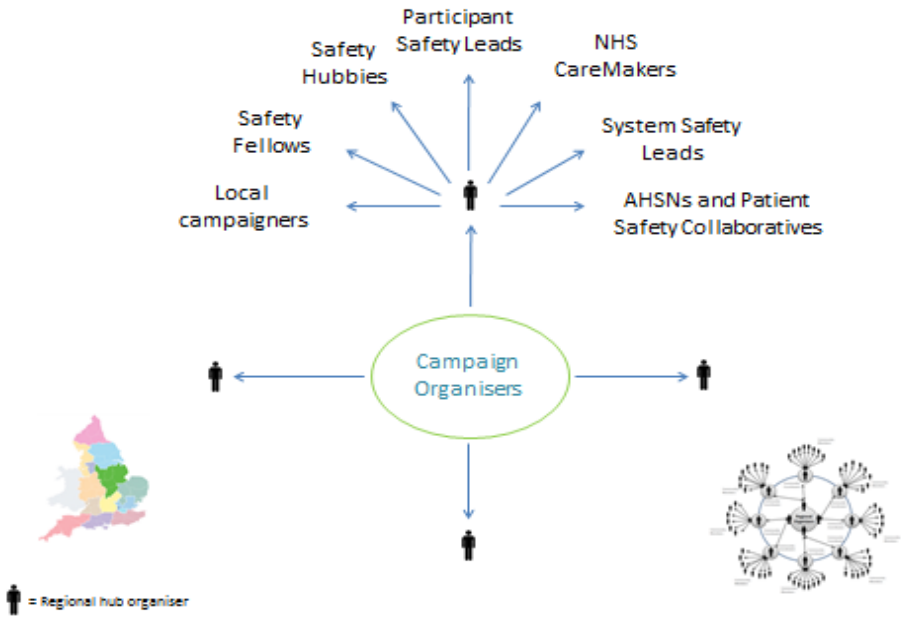


Additional elements of NHS England's work represented above include a series of programmes to tackle key patient safety priorities – across vulnerable groups, vulnerable points of care and in relation to key types of harm. NHS England is also launching a

programme to roll out consistent retrospective case note review initially of in-hospital deaths in order to support organisations to understand the problems that exist in their organisations and to increase our understanding of what goes wrong in the system and improve our ability to measure the safety of healthcare. All these programme are aligned with the wider aims of the English Patient Safety Programme – to reduce harm and save lives.

Organising for impact via Sign up to Safety

Campaigning, change programmes and safety interventions require organisation and organisers to create highly energised, but focused actions with specific goals and deadlines. Sign up to Safety will use the snowflake model. This model shares leadership across the system and does not rely on authority or power, instead it is a web (or snowflake) of interdependent organisers and leaders who support others in becoming leaders (Ref: M Ganz). For Ganz, this is *the difference between leadership as a position, and leadership as a practice, it's about accepting responsibility for enabling others to achieve purpose under conditions of uncertainty.*



The campaign will have a central hub of organisers which are connected to four regional hubs, all of which will develop the relationships, motivate participation, strategise, and motivate people to act. In order to create the unified feel to the English Patient Safety Programme the campaign community will connect the safety leads from participant sites together with the safety leads of the patient safety collaboratives.

The regional hubs will work alongside the AHSNs and be coordinated by the campaign and build a shared understanding of what we are trying to achieve with a sense of urgency, hope and solidarity that challenges feelings of inertia and apathy. We will empower people to take the responsibility to act. The campaign hubs will create the campaign community, bringing

people together, building on current networks and creating new ones, guided towards a vision and goal for reducing avoidable harm by half and saving 6000 lives.

Sign up to Safety will use an innovative approach to creating an extended campaign team linked to the regional hubs. The London Olympics presented the concept of volunteering in a new light and showed just how much can be achieved by a group of committed individuals working towards a shared goal. With lessons from the Games Makers, the campaign will work with the NHS Care Makers, and NHS Change Day Hubbies to create safety volunteers as part of its virtual campaign team.

Key messages

The key messages to share with the NHS for all to agree are:

- The key unifying factor for the English Patient Safety Programme is the goal of reducing avoidable harm by half and saving up to 6000 lives
- This should be the common and shared goal of the entire NHS in England; providers, commissioners, regulators, oversight bodies and the millions of people who work in it every day
- There is clearly a need to align activity, coordinate outputs and ensure the many components are pulling in the same direction and deliver more than the sum of their parts
- Everyone working in the NHS should all support a positive, open and fair (often referred to as 'just') culture
- The English Patient Safety Programme should build structures and processes to engage regularly and fully with patients and carers, to understand their perspectives on and contributions to patient safety
- Successful interventions focus everyone's efforts on a few things, doing them well and fixing them before moving on
- Every person working in NHS-funded care has a duty to identify and help to reduce risks to the safety of patients, and to acquire the skills necessary to do so in relation to their own job, team and adjacent teams
- The English Patient Safety Programme should build on local priorities and current quality and safety plans; supporting activity already happening locally and providing practical resources that teams could use to structure their approach
- We need to learn from the past; what worked and what didn't and create the foundations for a continuous learning culture across the NHS
- All initiatives need to ensure a strong focus on effective measurement for improvement and commence evaluation at the beginning of their work
- Building clinical engagement is vital; gaining buy in so that all staff feel the initiative contributes and adds value towards their work
- The English Patient Safety Programme will align the safety work at all levels of the system so that staff understand how everything fits together and how everything can add value to each separate piece

Conclusion

Over the last decade concerted efforts have been made to improve the safety of patient care but to date the NHS in England has not made as much improvement as was hoped. It is critical therefore that over the next 3 – 6 years and beyond we do our very best to put this right. We can all individually make a difference one by one but collectively we can make a bigger difference by all working together to help the NHS be the safest healthcare system in the world.

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