NATIONAL QUALITY BOARD

For meeting on: 05 December 2018

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Paper for:

Decision	Discussion	Information
X	X	

NEVER EVENTS THEMATIC REVIEW

SUMMARY

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

This paper summarises the key findings and recommendations contained within the report which we aim to publish in December 2018.

PURPOSE

The NQB is asked to:

1) **Endorse** (formally, collectively and publicly) the recommendations of the CQC/NHSI Never Events thematic report; and

2) **Discuss** the role NQB may have in oversight and co-ordination of the work of the different ALBs in taking forward specific recommendations, given there is no current governance group to oversee delivery of the recommendations.

ALB involvement in development and sign-off of paper:

NHS England	Care Quality Commission	NHS Improvement	NHS Health Education England
	X	X	

Public Health England	NICE National Institute for Health and Care Excellence	NHS Digital	Department of Health

Never Events thematic review

National Quality Board 5th December 2018

Anna Edwards- Strategy Manager

Care Quality Commission/ NHS Improvement Patient Safety Review

Overview as agreed with Secretary of State for Health and Social Care, UK Government

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

Outcome: A report into how organisations can reduce the risk of Never Events by promoting the positive work identified. Identify how compliance with mandatory safety guidance can be increased. Understand the learning which can be applied to other safety incidents beyond Never Events.

Timescale: Report in December 2018.

Our Approach- overview

Overarching hypothesis:

There are barriers to correctly implementing the guidance produced to prevent the occurrence of Never Events.

We believe we should use 'Never Events' as a vehicle enabling us to look at wider pieces of safety guidance. To this end we have developed four questions which we wish to answer in order to understand how implementation occurs and where barriers lie.

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. We will work with the Behavioural Insights Team to assess.

2. How do trusts implement this safety guidance?

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

3. What do other system partners do to support trusts with implementation of safety guidance? Does trust understanding of their role(s) align with this?

We will look across system partners to understand roles and ask Trusts whether this aligns with understanding. This will include CCGs.

4. What lessons can we learn from other industries and other countries?

We will work with other high risk industries e.g. BA, RAF, oil and gas and other countries through our EPSO/CQC partnership to understand their models and identify factors that may be transferable to NHS Trusts.

Our Approach – what we have done

- 8 week fieldwork exercise
- Focus groups with frontline staff
- Focussed patient workstream
- Additional site visits- NHS and non NHS
- Literature Reviews
- Roundtable events
- External Advisory Group
- NHS Improvement Reviews and Surveys
- Engagement with academics
- Call for evidence and joint working- system partners
- Work with international partners

In total, across our work, we have spoken with 427 people, including:
21 service users, experts by experience or people working in patient groups, 261 people working in trusts, 31 people working in clinical commissioning groups (CCGs), 54 people working in national bodies, 26 academics or patient safety/human factors experts, 15 people working in other industries, 19 people working in other countries

Our findings

System-
Our patient safety system can be confusing and has lots of layers and different bodies with different roles and responsibilities nationally, regionally and locally. There is inconsistency in the type of support offered and confusion in terms of what bodies exist to help NHS Trusts improve.

Alert dissemination process-
Too often, alerts are disseminated and actions implemented through an uncoordinated delegation of tasks. This can lead to inconsistency and contradiction depending on who carries out the tasks.
Alerts do not specify exactly how implementation should be managed and this, coupled with other pressures and priorities makes it hard for NHS Trusts to manage implementation. Alerts are not accompanied by supporting information like how to guides, exemplars, videos, blogs or other communication methods. Alerts do not sit in isolation from other guidance sent to trusts from different bodies including professional regulators, Royal Colleges etc. This amount of information can create confusion and leave Trusts feeling overwhelmed.

Our findings

Definition of Never Event-

Our current definition of a Never Event doesn't make the distinction between events that require one, or very few, actions to prevent them occurring (e.g. removing a type of device) and those which require ongoing and repeated adherence to processes and/or human:human interactions to prevent them occurring. The latter type of events are more likely to occur due to the inherently greater difficulties in preventing them. This has implications for the kind of guidance that should be issued, how the Never Events Framework is structured and how CQC regulates against the occurrence of a Never Event.

Standardisation-

NHS Trusts are struggling under the pressure of constant demands and they are juggling different priorities such as finance, effectiveness, access and care. We need to make it easier for them to do the right thing and more standardisation of practice (as heralded by the WHO) is one way to do this. Standardisation won't work for everything but where it is appropriate we should focus on developing necessary protocols.

Our findings

Governance and safety expertise-
NHS Trusts have inconsistent governance structures which do not always ensure that patient safety is prioritised at the most senior level within the hospital. There are a lack of visible and empowered patient safety specialists in each hospital, and a similar lack within oversight and support bodies, who can insist on effective governance systems, deeply understand patient safety, drive the right safety culture and lead improvement. At present there are few staff members who have safety as their only role who can ensure it is their priority.

Education-
Our education system is disparate and there are too many bodies with a role in designing and delivering training to different staff groups. This makes it difficult to create an aligned approach to sustainable, mandatory, high quality training for all which uses a common language and knowledge base. It is important to educate ALL staff on patient safety overall and human factors and systems as this is where the safety dial on culture can really be pushed. This should include education, training and CPD at undergraduate level and throughout careers.

… for the regulator?

Regulation-

If systems, along with roles and responsibilities, are clearer then it will make it easier to regulate properly and pinpoint where accountability and action needs to happen. Having greater standardisation and a clearer definition of Never Events will also make it easier to do our job.

A new national committee for patient safety alerts will agree standards for the development of safety alerts across all alert issuing bodies and as a regulator we will inspect these specifically to understand how Trusts are implementing them and where the challenges exist so that we can feed this learning back into the system.

We will need to continue to see patient safety as a priority and look to appoint safety leads within our organisation and ensure appropriate patient safety training is delivered to our staff.

We will need to ensure our methods and processes take account of the pressures on Trusts whilst acknowledging that they must prioritise patient safety in its widest sense (e.g. not just health and safety or medicines management)

Recommendations for all

1. Patient Safety Strategy
The recently announced national patient safety strategy must support the NHS to have safety as a top priority. It should be developed in partnership with professional regulators, royal colleges, frontline staff and patient representatives. We recommend this includes:

a) A clear vision of patient safety with a roadmap setting out how we can achieve these priorities.
b) A description of the roles and responsibilities of each of the main players in achieving these priorities – including commissioners, regulators and professional bodies.
c) A description of how this system would support the NHS to balance safety with efficiency and productivity to deliver high-quality care at times of greatest demand.
d) Explicit explanation of what the patient role is within the system.

The National Director of Patient Safety at NHS Improvement should oversee progress and be clear who is accountable for delivery of the strategy and the recommendations in this report.

Recommendations for all

2. Leaders in patient safety in NHS Trusts
Leaders with a responsibility for patient safety must have the appropriate training, expertise and support to drive safety improvement in trusts. Their role is to make sure that the trust reviews its safety culture on an ongoing basis to ensure that it meets the highest possible standards and is centred on learning and improvement. They should have an active role in feeding this insight back to NHS Improvement so that other NHS organisations can learn from it, as is the case in other industries.

NHS Improvement should specify the responsibilities, skills, and experience required for these leaders as part of its work to devise a curriculum for patient safety (recommendation 6). They should also put in place the mechanisms for trusts to be able to provide early feedback on alerts and guidance.

Professional regulators also have a role in gathering insight and feedback on patient safety from staff and using this to feedback to NHS Improvement.

NHS Improvement should also create and maintain a network of patient safety leaders to support every NHS organisation, with all working towards a just safety culture that supports the implementation of patient safety alerts and continuous safety improvement.

Recommendations for all

3. Standardisation
NHS Improvement should work with professional regulators, royal colleges, frontline staff and patient groups to develop a framework for identifying clinical processes and other elements, such as equipment and governance processes, that could benefit from standardisation, how this will happen and where the standardisation should apply. This will include clarity on how the framework will lead to tangible action and delivery of standardisation throughout the health sector.

Recommendations for all

4. NaPSAC Support with patient safety alert development for all bodies issuing alerts
The National Patient Safety Alert Committee (NaPSAC) should oversee a new patient safety alerts system that aligns the processes and outputs of all bodies and teams that issue alerts, and ensures they set out clear and effective actions that providers must take on safety-critical issues.

- It should set out guidance on how to develop patient safety alerts, including expectations on involving front line clinicians, patients and others
- It should develop clear standards for the format and content of the alerts, including SMART (specific, measurable, achievable, relevant and time-bound) actions and more use of supporting resources such as the use of personal stories and case studies and examples of good practice to make the case for change.
- It should oversee an improved method for dissemination of patient safety alerts from central bodies to providers to ensure that alerts reach all organisations that need to take action, and they can record the action they have taken.
- It should support development of mechanisms for providers to share information on their experience of alert implementation between themselves and with central bodies to ensure that we can all learn from each other's experiences.
- It should describe in detail what good implementation looks like as part of good clinical governance, highlighting a system that plans and coordinates implementation within organisations and ensures continuing compliance. This should include guidance on the tools that might be needed by providers, and the role of patient insight.
- NaPSAC should intervene when bodies issuing National Patient Safety Alerts produce materials that do not meet required standards.
- NaPSAC should consider national trends in how providers implement and respond to National Patient Safety Alerts and support CQC to inspect actions required.

Recommendations for all

5. Never events framework

NHS Improvement should review the never events framework and work with professional regulators and royal colleges to take account of the difference in the strength of different kinds of barrier to errors (such as distinguishing between those that should be prevented by human interactions and behaviours such as using checklists, counts and sign-in processes and those that could be designed out entirely such as through removing equipment or fitting/using physical barriers to risks).

CQC should work with NHS Improvement to assess compliance with the never events framework in a fair and proportionate way that will drive the right behaviours at national and local levels.

Recommendations for all

6. NHSI and HEE working together to develop a common curriculum and basis for patient safety education, training and ongoing development

NHS Improvement should lead work with Health Education England and others to ensure that the entire clinical and non-clinical NHS workforce has a common understanding of patient safety and the skills and behaviours necessary to make it a priority. Understanding the role of systems, design, effective communication, risk, just culture, human factors and ergonomics must be understood by all and taken as seriously as understanding in other related areas such as health and safety at work.

High quality safety training should start as soon as staff begin their education and training whether that be at a higher education institution or within the trust itself.

This national drive to improve patient safety education must be replicated in NHS trusts and indeed all healthcare organisations. Here, patient safety should form part of ongoing mandatory training, and be included as part of CPD requirements and ongoing development. Leaders should release their staff from their substantive duties to undertake this development not as an optional extra but as a vital part of every employee's role.

A new education, training and continuing professional development plan should set out significant milestones to be delivered. The end goal should be a specialism in patient safety that staff can study as part of their clinical training or as a separate discipline.

This recommendation should build on work already taking place across England. There should be a clear plan outlined on how it will be achieved with significant milestones articulated to all system partners.

Recommendations for CQC

7. CQC will also improve our assessment of safety across all sectors

The Care Quality Commission also commit to change which will support patient safety becoming a top priority for all.

- We will improve our patient safety expertise and appoint a specific patient safety lead/team with relevant patient safety expertise who can advise on our processes and methodologies to ensure that regulation does not stifle new systems thinking and innovation.
- We will work with NHS Improvement and Health Education England to:
  - assess how we can improve patient safety knowledge for all staff, including human factors and systems thinking.
  - review our approach to regulating safety in NHS trusts, including how we react to never events and engage providers in any changes we make.
  - review specific patient safety alerts as part of our ongoing inspections and take regulatory action where implementation is not appropriate – starting with NHS trusts and expanding to other sectors as appropriate .
- We will work with the public and people who use services to ensure that processes are clear and transparent and where possible involve patients in their design.
- We will consider how we can apply the findings in this report to the regulation of adult social care services, primary medical care services and newly emerging integrated care systems.
- We will work with others to ensure that patient safety is a priority for all and as these recommendations are delivered reflect them where necessary in CQCs approach.

Implementation plans

- On 5th November we met with a number of key stakeholders who will be responsible for implementing the recommendations in this report. There was agreement in the room that these were the right points to focus on. This meeting gave these organisations the opportunity to have early sight of our thinking and provided them with the opportunity to start considering how implementation may work.

- Over the coming months CQC will consider how we can incorporate any changes into our methodology/ assessment frameworks with a view to extending improvements to other sectors as appropriate. We will also consider how we can improve our own patient safety expertise.

- NHSI are responsible for a number of workstreams as a consequence of these recommendations. Over the next few weeks they will create relevant workplans to deliver their responsibilities and work with other organisations to ensure that there is clarity and alignment with all aiming for the same goals.

Role for NQB

1. Formally, collectively and publicly endorse the recommendations of the CQC/NHSI Never Events thematic report.

2. At present there is no governance mechanism or group to over see the delivery of these recommendations. Discuss the role of NQB in oversight and co-ordination of the work of the different ALBs in taking forward specific recommendations.