Annex 1: NHS Patient Safety Strategy consultation results

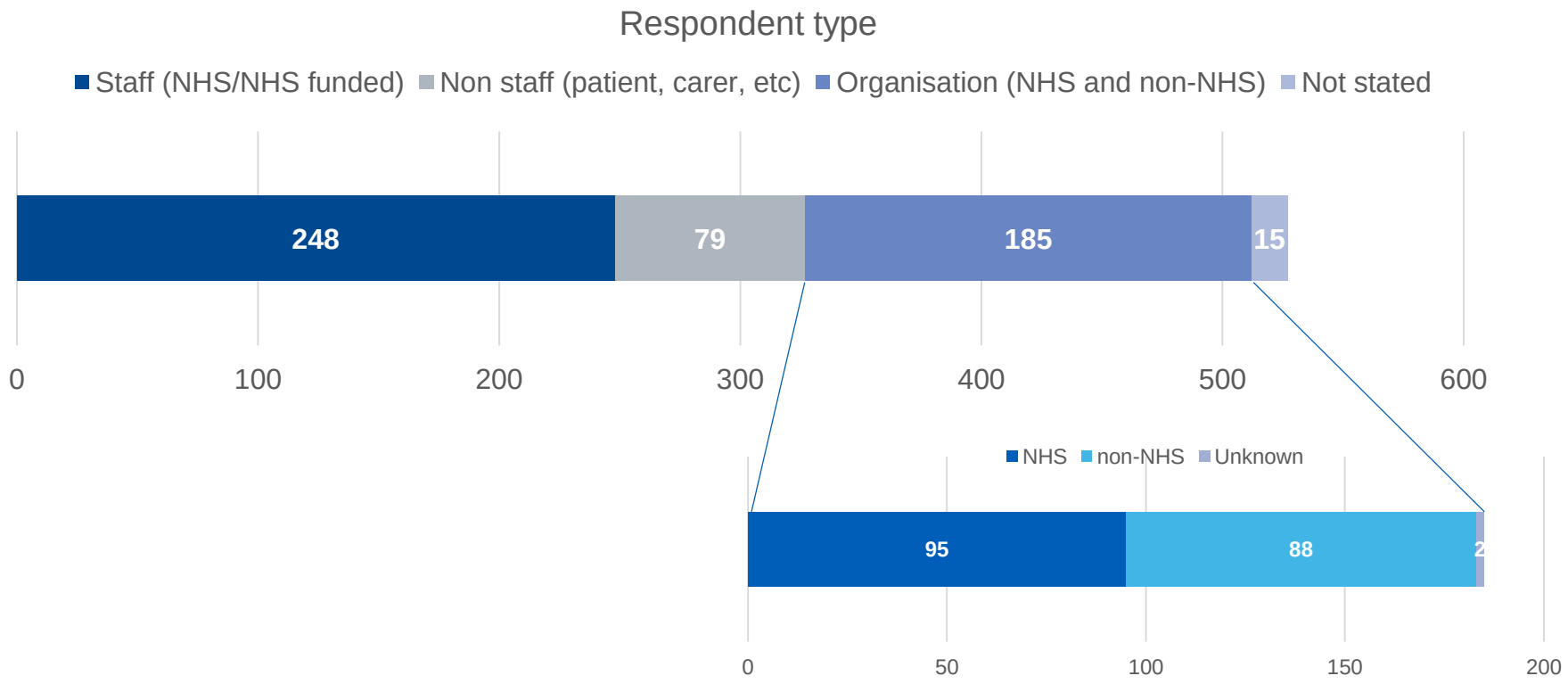
July 2019

NHS England and NHS Improvement

The consultation process

- On 14 December 2018, NHS Improvement launched a consultation on proposals for a new patient safety strategy for the NHS. The consultation document can be found at https://engage.improvement.nhs.uk/policy-strategy-and-delivery-management/patient-safety-strategy/ . This included an easy read version and a downloadable version of the questions.
- Respondents were able to respond directly to the questions posed in the consultation online, or submit answers to the questions and/or more general views on the development of a patient safety strategy to an online mailbox.
- Alongside the consultation, NHS Improvement and others ran a series of more than 20 stakeholder meetings and engagement events. 11 workshops were held across the country focussing on proposals in the consultation, which over 160 people attended, including staff, patients and their representatives, and senior leaders. Online discussions were hosted on Twitter and Department of Health and Social Care's Talk Health and Care platform.
- This consultation ran until 15 February.
- 527 consultation responses were received from individuals (staff and non-staff, including patients and carers), and organisations. These responses were read and themed by the national patient safety team in NHS Improvement, alongside the feedback received from the various workshops, meetings and online conversations.
- Data from the online questionnaire were combined with relevant responses received directly to the consultation mailbox to provide a quantitative analysis of people's views on the proposals.
- The following summary describes the key findings from the consultation and associated discussions. This is not an exhaustive description of all the consultation feedback. It includes views on the proposals made in the consultation document as well themes that were either substantially different or appeared to represent realistic, relevant and constructive additions/alternatives to the content of the proposals.

Who responded to the online consultation

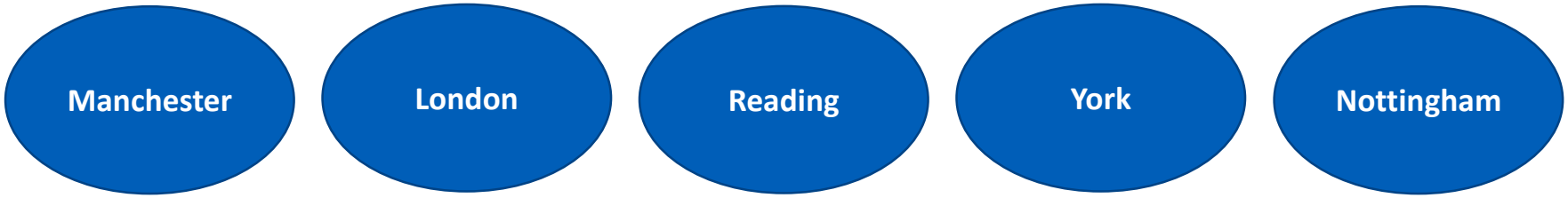


Stakeholder meetings included:

Department of Health and Social Care	Good Governance Institute
General Medical Council	Nursing and Midwifery Council
Health Education England	NHS Providers
NHS Confederation	NHS Resolution
Academy of Medical Royal Colleges	Healthcare Safety Investigation Branch
Academy of Medical Royal Colleges Patient and Lay Committee	Medicines and Healthcare Products Regulatory Agency
National Patient Safety Response Advisory Panel	Royal College of Anaesthetists
Medical device safety officers/medication safety officers	Patient Safety Learning
NHS England/NHS Improvement regions	Academic Health Science Networks
Patient Safety Collaboratives	

Focus groups

11 focus groups covering seven aspects of the strategy: patient safety specialists, organisational support, patient safety curriculum, just culture, patient advocates, patient safety initiatives and primary care.

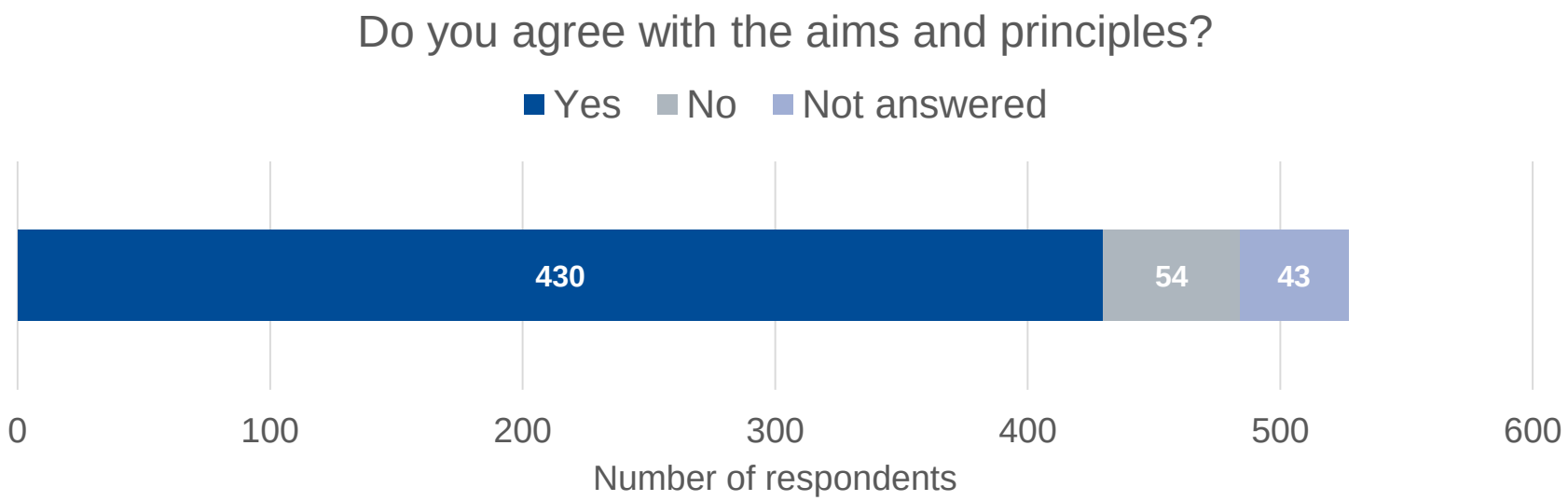


Five locations across the country

Over 160 people attended in total

Attendees included: medical directors, directors of nursing, consultants, heads of patient safety, governance, quality and risk managers, ward managers, representatives from the Department of Health and Social Care.

Aims and principles of the NHS Patient Safety Strategy proposals



Aims and principles

Word cloud analysis of free text comments on the consultation aims and principles

Comments on overall aims and principles

Broadly speaking the aims and principles were welcomed with few strong objections. There were however some comments about the achievability of the vision set out and the overarching vision statement.

"Very welcome and overdue. Learning not blaming, continuous improvement excellent."

"Both reasonable and achievable principles that apply across different clinical areas."

"They embody the principles of the NHS but aim to take us forward to a future that embraces new ways of working, new technology etc. We have to change and evolve as a heath service along with society, research, environment etc."

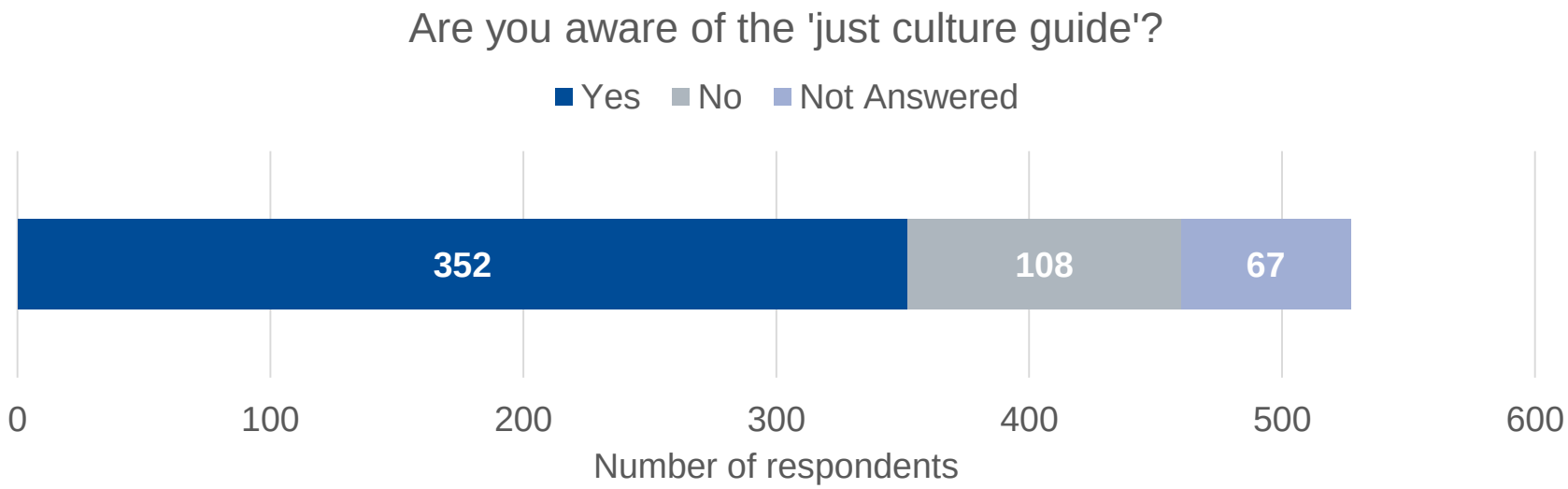
"This consistent approach is long overdue in healthcare. The aims and principles will support the infrastructure that is needed to make healthcare safer."

"We are concerned that the stated goal of being the "safest health service in the world" could be perceived as lacking in the humility required to deliver on the strategy's underlying aims. It could also lack the directness needed to ensure that the commitment staff across the NHS have to patient safety is harnessed during a period of significant change in which longstanding cultural norms will be challenged. We believe that setting out a pragmatic and focused vision such that "every patient should get the safest possible care" is more likely to have credibility and gain traction."

"The aims and principles are lacking the practicalities needed to implement the changes. Resources will be needed to affect the change."

"It is ambitious but worthy. This needs to be underpinned by having enough staff to do a job safely, not just issuing directives. The whole culture of making frontline health professionals work without sufficient staffing, time and resources is the biggest risk to patient safety. This must be the primary aim of this organisation."

Just culture guide



Just culture inhibitors

Word cloud analysis of free text comments on what inhibits the development of a just culture

Comments on culture

The overall consensus was that a focus on a just culture is correct. There were however a number of additional 'culture'-related comments, including calls for better measurement of culture and a wider definition/focus.

"People are important but the culture that the people operate in is key."

"A Just culture alone is insufficient. We are committed to engendering a generative and participatory safety culture, in what is said, what is done and, more importantly, what is believed. Such a culture can be considered to have four primary elements - the Just Culture, the Reporting Culture, the Flexible Culture and the Learning Culture, with a fifth element, the Questioning Culture, being the defence against assumptions and the mechanism for delivering rigour in our approach to safety. These five elements combine to form a proactive, safety-conscious, informed and engaged organisation that is able and willing to deliver an effective Safety Management System (SMS)."

"Yes, we agree with the overarching aims and principles, however the focus on a 'just' culture rather than a 'learning' culture or a 'positive safety culture' may be too narrow and doesn't recognise the other critical cultural elements that support safe care."

"The workforce need to see evidence that this is being applied. Not that there are fewer suspensions or disciplinaries but that there are real examples where the organisation is asking what and why as opposed to who!"

As one of our clinicians stated: "Unless someone does something about the enormous efficiency pressure the staff are under then the just culture idea is like moving the deckchairs around the Titanic. The sheer dread of when things go wrong has itself to be dealt with. It is not how did that happen but [should be] what do you need? I am here for you…"

Views on culture (focus groups)

The barriers to a just culture include the language used - ‘enquiry’ is better than ‘investigation’. This bluntness is reflected in the larger investigation process, which investigates complex information in a tight timeframe, using blame-inducing vocabulary”

Staff are sceptical because of inconsistencies in the disciplinary approach.

Investigation processes are particularly detrimental by being harsh and clinical and making staff feel like they’re being scrutinised under a spotlight, rather than appreciating incidents’ multifaceted causes.

Need to manage public expectations and get patients and families to understand the value of just culture for all. The press’ sensationalist reporting style makes this difficult; there was support for giving NHS statements which included just culture explanations.

Barriers to having a just culture can come from regulators and commissioners: in requesting huge amounts of information in different formats, the focus of incident investigation becomes ticking boxes rather than the learning.

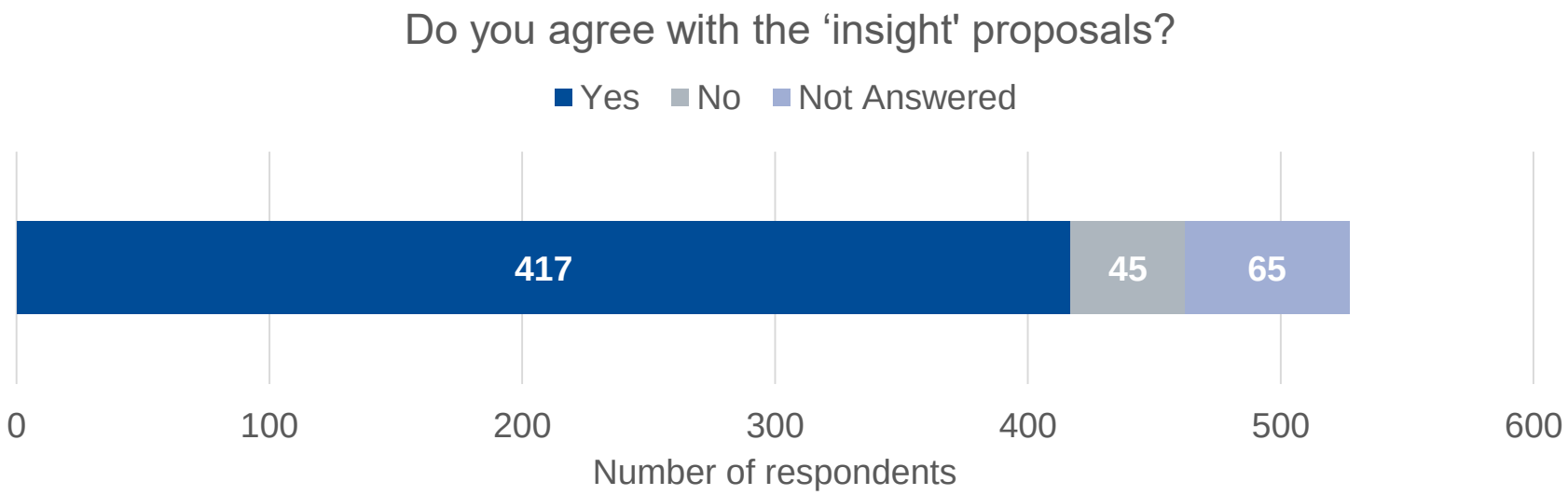
Leverage with the General Medical Council (GMC)/Nursing and Midwifery Council (NMC) would be useful to prevent incidents such as the Bawa-Garba case, which destroyed trust and just culture’s progress.

Embedding the just culture guide would be helped by training for HR staff, legal teams, regulators, clinical commissioning groups (CCGs), Health and Care Professions Council (HCPC) and professional bodies such as royal colleges. It would also be helpful to integrate just culture into trust’s formal documents and policies.

Being realistic and aligning expectations would help to encourage just culture, ie advocating fair blame or shared blame not no blame.

Just culture is when staff feel comfortable to intervene without fear. Just culture is when staff feel comfortable to be honest and describe their work as they did it, rather than as it was presented to them. Just culture is ingrained from the moment you put your uniform on and is evolutionary not static.

Insight


Do you agree with the ‘insight' proposals?
Yes
No
Not Answered
417
45
65
0
100
200
300
400
500
600
Number of respondents

Insight

Word cloud analysis of free text comments on the proposals under the 'Insights' heading

Comments on Insight

There was broad agreement with the ‘Insight’ proposals. There was an interestingly consistent theme around people wanting improved access to information, lessons learned, advice, guidance, risk reduction strategies, etc.

“Prevention of harm is down to people - machines such as artificial intelligence (AI) can't do this. Information is key. Having a joined up non-competitive NHS where sharing experience is normal and where information is disseminated widely rather than hidden would be a good start.”

“Sharing nationally initiatives that have demonstrated sustainability. Availability of toolkits/strategies for maintaining improvement.”

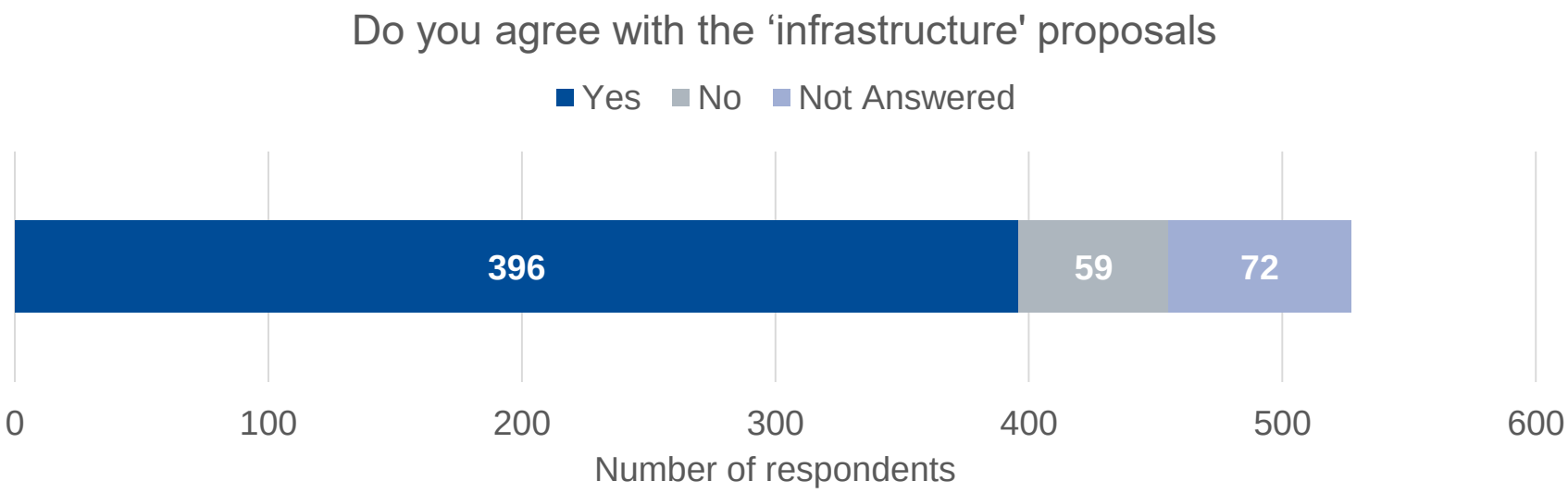
“Improved sharing of learning from incidents should form the basis of any focus on insight, not just type of incident. There is still no ability to interrogate systems at a local, regional or national level to identify key learning and put in place actions to mitigate against the risk of Serious Incidents and Never Events.”

“Doesn't this list itself ring some alarm bells? So many approaches and delivery models, and most of them understood only by the elite few. Doesn't it confirm the point that the whole approach needs to be very different? Learning from mistakes needs rethinking. Q. Put yourself in the shoes of the clinician or manager who makes the mistake. How can you help their successor to avoid it? In the very limited time available. A. Have a regularly updated ‘bible’ of vignettes about risky situations - the links should lead to pages about what you (the clinician) should do next, not just what to avoid.”

“All providers should have to share learning from incidents via a newsletter to staff…Sharing of incidents should be celebrated and staff openly acknowledged for bringing it to attention…we can further support continuous safety improvement via a national newsletter with learning from other areas shared. I would expect this to be available and owned locally and then feed upwards to national level and for staff within the NHS able to access a firm whereby they too can read the cases and learn from other places local incidents and prevention actions.”

“Publishing the information recorded on National Reporting and Learning System (NRLS) or its successor - in particular clinical vignettes into causes of harm and changes made to prevent recurrence.”

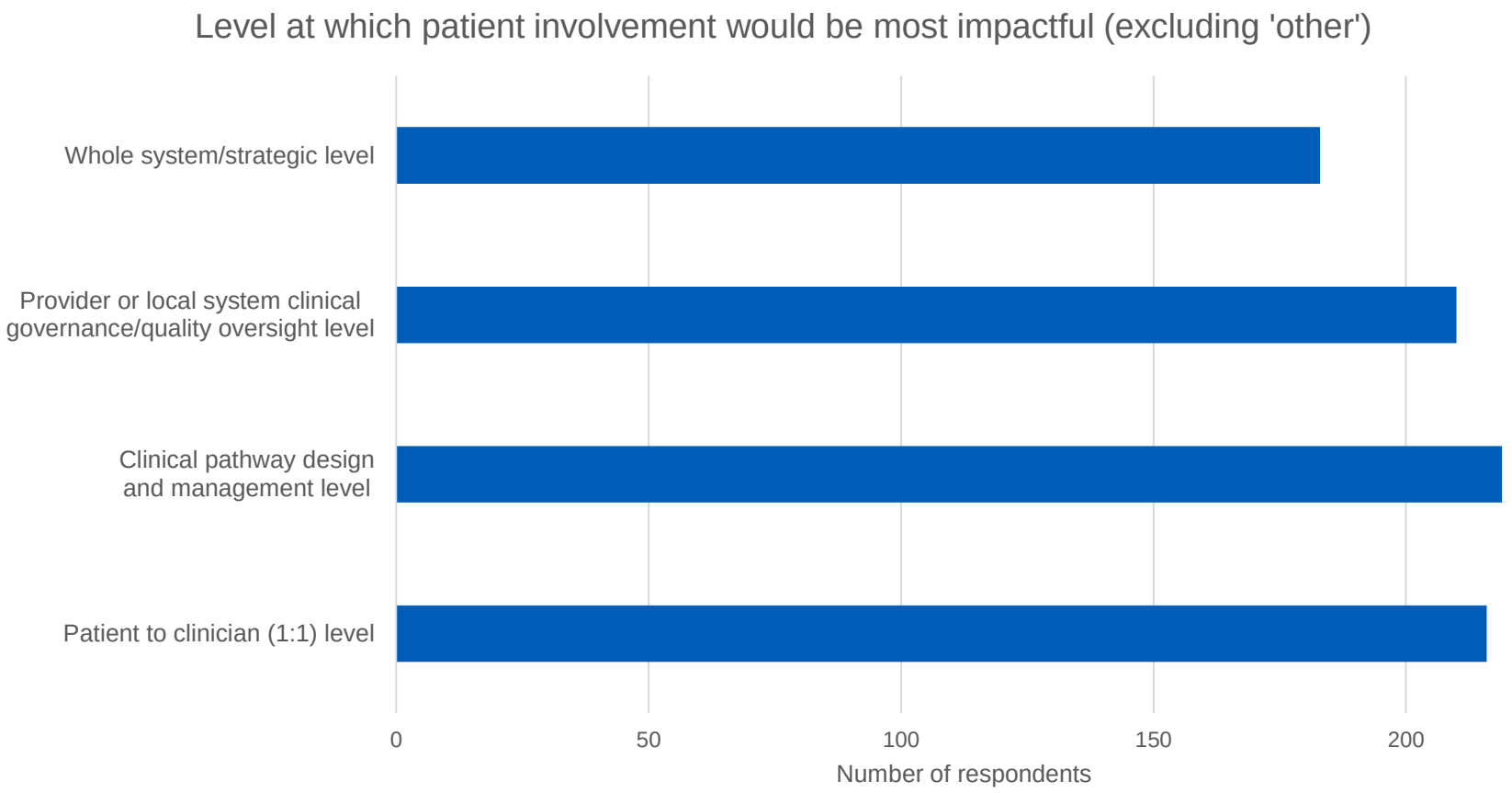
Infrastructure



Infrastructure

Word cloud analysis of free text comments on the proposals under the 'infrastructure' heading

Where would patient involvement be most impactful?



Comments on patient/lay involvement

Many respondents sought more information, emphasis and focus on patient/lay involvement.

"Not enough attention to 1, ignored patient, family advocate experience often only able to be complainant; Berwick said patients must be at the centre even for the way this consultation is framed, phrased…words like empower - how, why not yet .... discuss obstacles, challenges, hurdles from lessons from inquiries."

"'In you shoes' type sessions - facilitated discussion between patient or family member and a consultant or senior doctor so that they can say what was good about their care, and also the things that did not go so well and what impact this has had on their health and wellbeing. I have used this before as a method - not necessarily linking the specific patient and incident and clinician - but more general learning from complaints and incidents."

"Better information for patient/family about the candour process - what it is , what to expect, etc. Could investigations be reviewed by 'Patient Panels' and should there be lay representation within the process? Could patient reps be involved in any change processes resulting from learning - involve lay people and patient reps in the assurance process. Analyse what those people who are good at managing patient/family/care involvement do well? Model training on that. Consider what carers, family, patients want to hear... Record 'candour' as it happens."

"I wonder whether there should be an aim which includes patients in some way - learning from their feedback?"

"We would like more detail about the proposed 'patient advocates for safety'. How would their role be different to statutory NHS complaints advocates? Or that of local Healthwatch who often act as informal advocates for individuals, and who also speak up for seldom heard groups or larger communities via the statutory seat we hold on Health and Wellbeing Boards and representation on other decision-making forums."

"The strategy refers to a proposal to recruit 'patient advocates for safety'. When it says support the NHS to recruit, will this include investment so that the advocates can be paid? For instance, will there be support to develop job descriptions, recruitment processes, support infrastructure, evaluate impact, etc. It would be a shame if every single organisation tried to do this from scratch. Given we are in the safety sphere this needs extra sensitive handling. It is a big deal to talk about something that happened to you, your family member. Recruitment is only the beginning, people need development, ongoing support and the staff they are working with in the system also need help to work in a new way, listening to patient views especially given the need for sensitivity."

Views on patient/lay involvement (focus groups)

‘Patient advocates’ may confuse the role with other professional advocates roles, ‘patient safety partner’ may be clearer.

Language and framing makes a difference: using words such as ‘feedback’ rather than ‘complaint’, and valuing positive feedback are important. When referring to the ‘responsibility’ of patients, must make clear that clinical expertise is still the healthcare professionals’ responsibility.

Being proactive is important: empower patients to feel like they’re equal partners in care, eg involving patients in handovers and preparation before consultations. Engagement should be opt-out rather than opt-in, and regularly ask questions like ‘what makes you feel safe?’

The role should come with credibility and power to contribute to change, and patient safety work should be co-produced with patient advocates from the beginning, ie collegiate working rather than directive.

The main thing for patient advocates to have is experience, beyond this, training on topics such as human factors and just culture would be useful. This could be delivered through identifying core competencies then finding their skills gaps. Ongoing mentorship and support would be invaluable.

There was no clear consensus about whether the role should be paid or unpaid: credible rather than tokenistic if paid vs. more freedom if unpaid and separate from the organisation. Some suggested payment could come from a different source, a collaborative, sustainability and transformation partnership (STP)/integrated care system (ICS) to avoid trust conflict. Support for fixed tenure with the opportunity to renew.

The role itself should be designed to suit somebody with lived experience, preferably recruiting from diverse backgrounds.

There is value in giving patients the opportunity to spend time with people with lived experience: peer support groups and 1:1 feedback sessions help patients to open up more.

Advocates have a role to play in increasing health literacy. Some patients thought patient safety was about people stealing their belongings! Age-appropriate public health messages akin to a public health campaign would be useful to empower patients to understand the role that they play in their own health.

Role of ‘complaints’ and the patient perspective

Some respondents highlighted the existing complaints process as a problem and that complaints should be viewed as the equivalent of incident reports from the patient perspective.

“Patient complaints should be an embedded part of safety culture within healthcare organisations. But cultural attitudes towards complaints can inhibit their use for learning and quality improvement… We need to be clear that patient complaints are not negative criticism, but are a form of incident reporting, complementary to that practised by staff.”

“Better use of patient 'complaints' - change that name because most 'complaints' are patients reporting something they perceived as errors. Perception matters almost as much as reality. If staff see trust responds well to patients, might encourage them to think it will respond well to staff.”

“We would encourage NHS Improvement and the wider healthcare system to use complaints data from across the NHS as well. For example, there are NHS trusts that receive a large number of complaints due to their size, and they manage complaints effectively and use them as a learning tool to prevent the same failings from happening again. As a result, patient safety is improved and very few complaints are referred to the Parliamentary and Health Service Ombudsman (PHSO) because they are resolved effectively by the trust.”

“Ensure families are involved in defining the terms of reference of any Strategic Executive Information System (StEIS) reportable incidents. Ensure cross check between complaints and potential incidents, ie if someone complains, was it reported as an incident - or should it have been if not?”

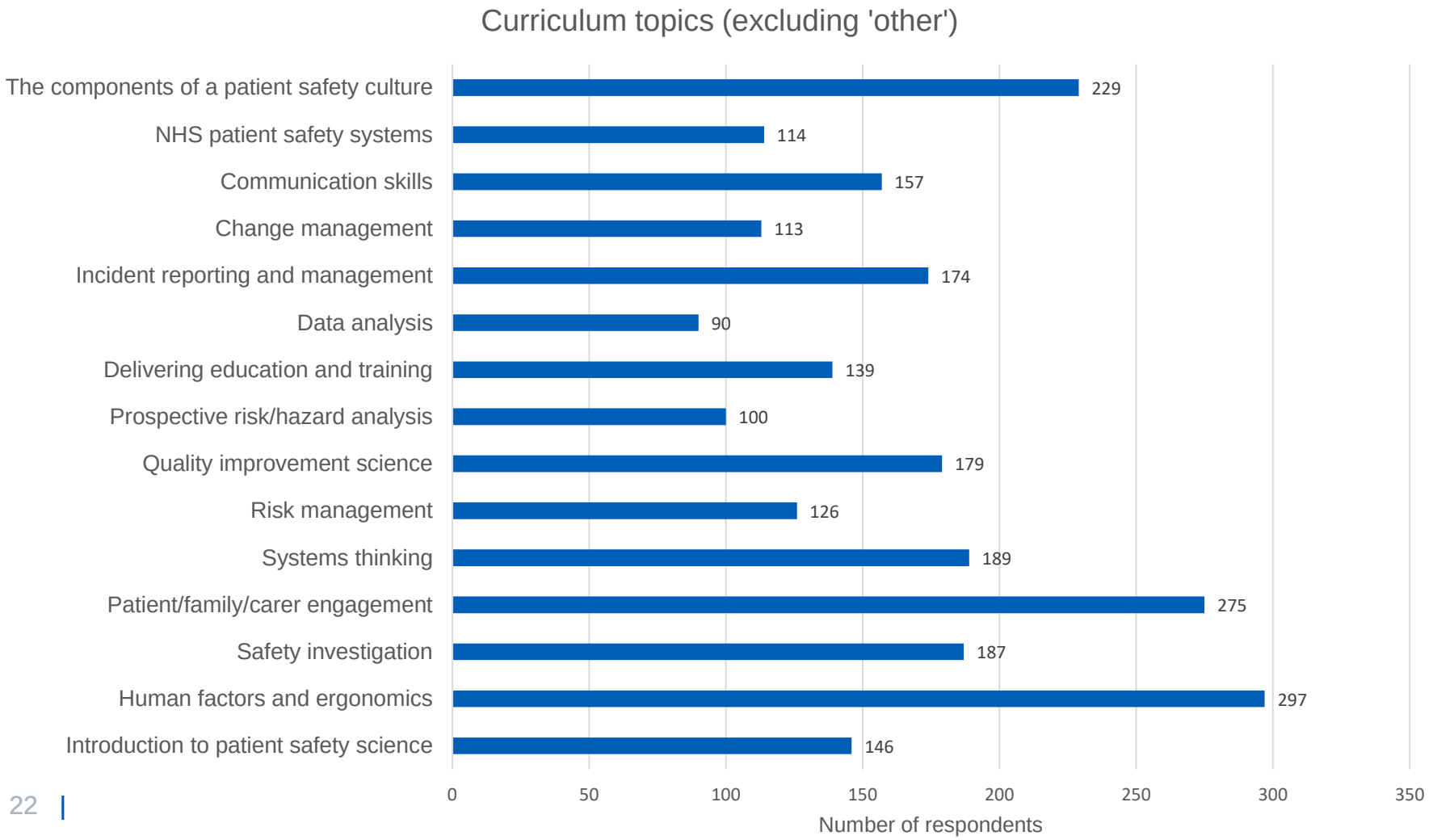
“More training for practice managers and governance leads on how to bring about data driven improvements - triangulate complaints/quality and outcomes framework (QOF)/outcome data/CQC/Friends and Family/audits/significant event (SEA) /serious untoward incident (SUI).”

“Encourage public to speak up to the NHS about their experiences and near misses. We listen when a patient complains but answer the complaint. The complaints don’t seem to trigger a review of the process to see what caused the anger or upset as often a complaint arises due to someone feeling aggrieved and often a better experience can prevent these hostile feeling.”

“Patient experience, including complaints, function, complements, Duty of Candour, bereavement, all needs to be under the safety umbrella”

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

(Select your top five)



Views on the curriculum

There was widespread support for the curriculum proposals with some important caveats including this being viewed as necessary but not sufficient and the need for resources/protected time.

"Very important - higher level surveillance does not deliver practice change only information. Certainly patient safety has to be in people's minds when they practise 'at the coal face' and informed by knowledge."

"The response to Patient Safety Alerts seems to be viewed by many in healthcare as only relevant to a minority, not the majority. Training is insufficient to ensure all are aware of how to improve quality of care."

"Education in the NHS presumes that knowledge = compliance. We need to recognise behavioural and cognitive elements that effect performance... What we don't want is a policy or e-learning package that tells people what to do what we need is a raft of measure that help staff understand and do the right thing I don't think there is one level needed…we have done some work with the The Chartered Institute of Ergonomics and Human Factors (CIEHF) and already suggested the need for several domains that are needed and then thought about how these could be developed at a number of levels ie induction; practitioner (what people need to do their job safely); lead (local lead in specific area this may be focussed on how to redesign storage area optimally); expert (individual working at strategic level)."

"Definitely applaud these recommendations essential must have."

"Long overdue. There is no consistent approach allowing trusts to make it up as they go along and leaving leaders to have to pester and cajole, safety mechanisms should be fully funded and embedded as in the airline industry."

"Depends who the curriculum is aimed at and how is a 'pick and mix' according to role and what already in place, so to reduce duplication and increase waste or variation in provision. Mandated education is already a heavy burden for clinical staff to fit into job planning and activity/capacity. therefore any new addition, while welcome, needs to be either replacing something else or funded…"

"I would suggest e-learning as an effective way of implementing the curriculum. If all NHS employees had to have an up to date 'Patient Safety Certificate' which had to be renewed every 2 or 3 years then the syllabus and learning material could be regularly updated with new principles and information about incidents."

"I think the big challenge here is going to be how do we create the space for staff to be freed up from clinical work to attend when they are under such huge pressures? It needs something radical like back fill money or creative ideas such as paying staff if they give up 2 days annual leave to attend? Staff will tell us what could work."

Views on the curriculum (focus groups)

Strong support for a curriculum, relevant to primary care, mental health, social care and care homes. The training needs to be to both all healthcare undergraduates as well as all NHS staff.

There was a strong feeling that the training needs to be multiprofessional rather than having single professions/groups being trained in isolation.

Participants also talked about the need to have people in practice who can help cascade and embed the training – “skilled facilitators/trained faculty in the workplace”, “senior trained experts cascading ideas”.

A number of participants also talked about the challenge of staff being released to attend training, and the need for board support to implement the curriculum.

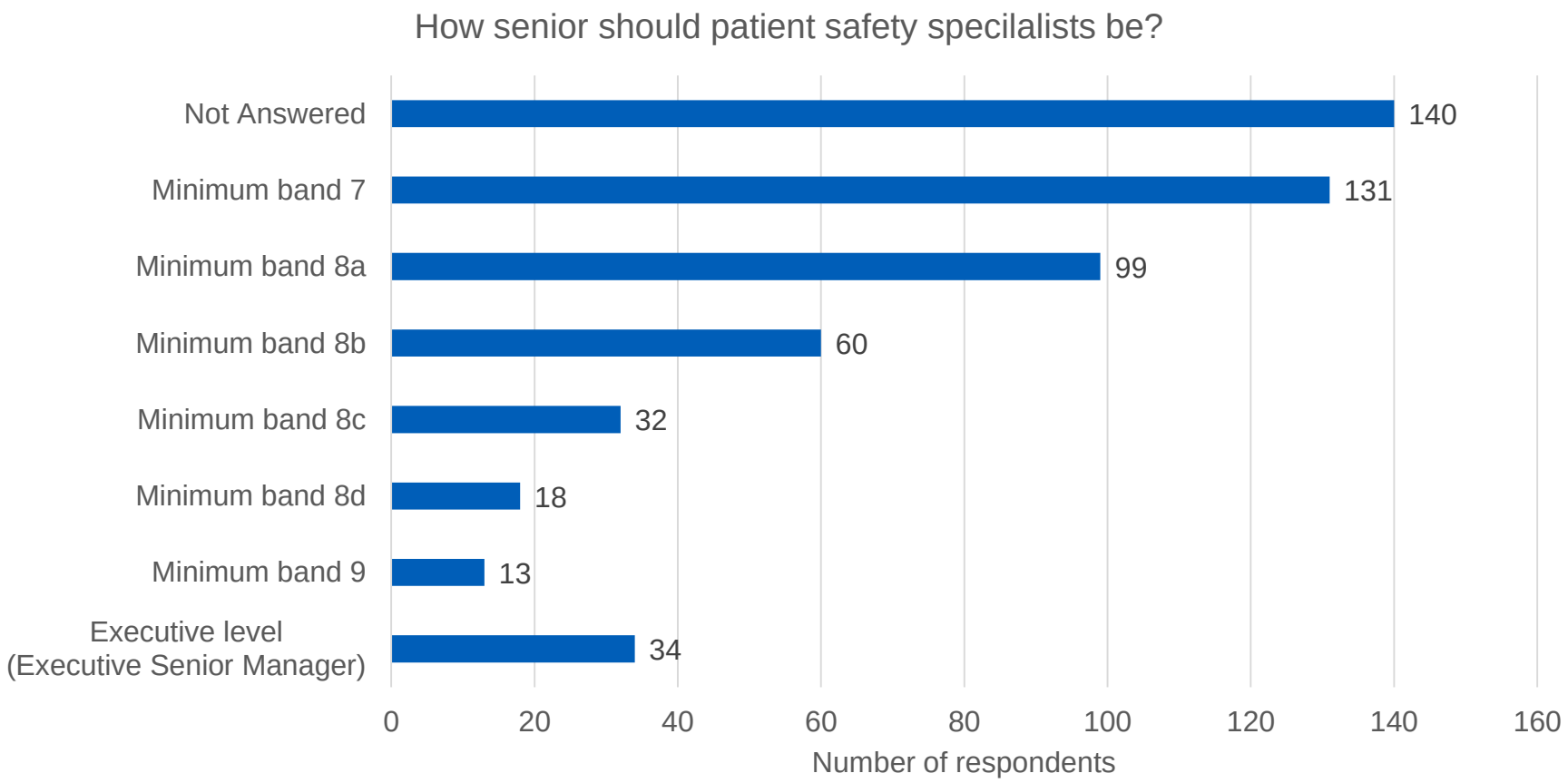
There was support for having a core, consistent curriculum that transcends individual trusts’ decisions.

Some expressed the view that curriculum should include training for patients: empowering patients and allowing them to challenge the safety of their care.

Many thought that roll-out should start with a stocktake of patient safety training already being delivered and a gap analysis of this against the curriculum.

There was support for having a designated body to deliver training, such as a National Patient Safety Academy.

How senior should patient safety specialists be?



Comments on safety specialists

Although mostly positive, some comments challenged aspects of the ‘safety specialists’ proposal. These tended to stem from a view that patient safety is everyone’s job (which it is) and that creating a specialist role will undermine this principle.

“I believe we are all responsible for patient safety and more bureaucracy or need for patient safety officers takes responsibility away from healthcare professionals, etc - wrong direction of travel.”

“Again all of these! We don't need separate patient safety specialists. What we need are all of these principles to become part of core training for all staff, but especially nurses, doctors and paramedical disciplines.”

“The danger of vesting a title such as patient safety specialist with an individual is that other staff may come to believe that is where patient safety rests, rather than thinking that it rests with every single member of the team all the time...”

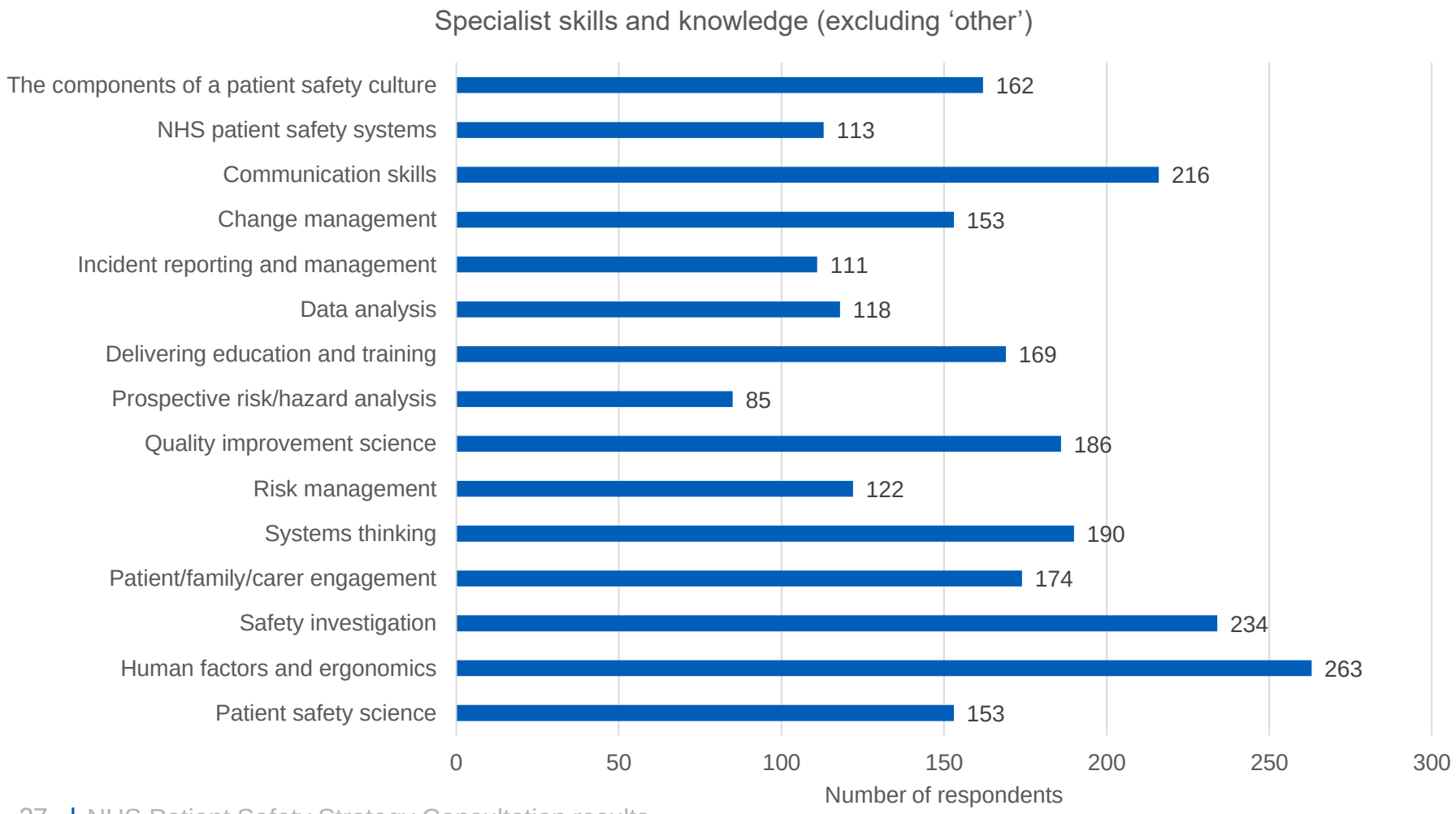
“Creating a cadre of senior patient safety specialists sounds good, however it starts to create a hierarchy and the word 'senior' in the title again suggests a junior cannot become a highly trained trainer. To create a culture across all organisations and generations we should promote facilitators, champions and highly trained trainers; this allows all to take on these roles and encourages ownership by all.”

“Develop a common language and approach to safety across the health and care system. We cannot just focus on the hospital sector. Include the responsibility for safety in job descriptions of all staff including senior leaders. Embed safety training in undergraduate curriculums for all professionals and include in non-registered staff training. Make safety everyone's business and not just the responsibility of senior nursing leaders.”

“It is really positive that the proposals set out a commitment to have patient safety experts within organisations to support learning and changes of culture and understanding. I am also delighted to see this is to be included on the curriculum for staff during training. This should be early on in training programmes and repeated at regular frequency to mitigate against the risk of disconnect between what is seen as reality on the wards and patient safety procedures and initiatives.”

“[For patient safety specialists] Recommend minimum baseline training at accredited PGCert Human Factors for Healthcare (Patient and Staff) Safety (see CIEHF White Paper).”

What skills and knowledge should patient safety specialists have? (Select your top five)



Comments on safety specialists (focus groups)

Professionalising the role was a good thing with a move to accreditation/qualification. The banding should depend on the size of the organisation where the specialist is working, but there was agreement that the specialist must be senior enough to challenge the board if needed. There should be a consistent job description.

There was agreement that the main support for the role could come from a network modelled on medication safety officers (MSOs) with regular meetings sharing good practice. The specialists would need support to stay up to date.

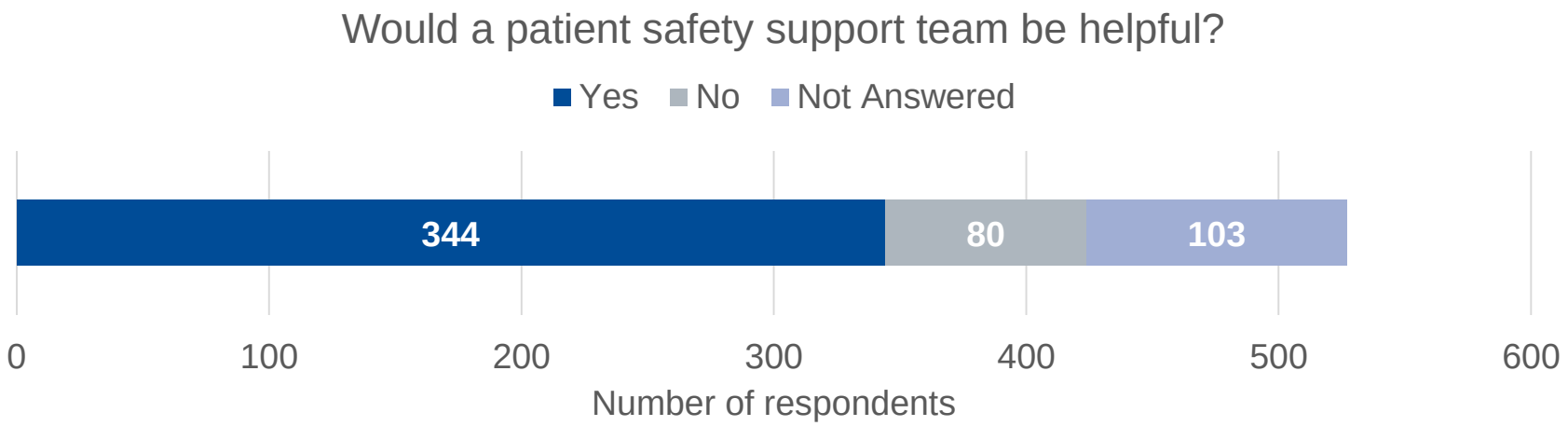
Training should be to a consistent standard to reduce variation. Specialists should work through competency workbooks until they get full accreditation.

Participants felt the barriers to implementing the role are: funding, staffing, CQC/commissioners not understanding safety, managing expectations of the role, the burden of further information requests (FIR) for Serious Incidents from commissioners, credibility, capacity and support from the centre.

The specialist should be able to focus exclusively on safety - one participant said “not being coat hanger for health and safety, infection control, safeguarding, etc”. There is currently a focus on performance and flow which hinders them from prioritising safety.

Training for specialists could be a mix of e-learning and formal teaching, as well as shadowing experiences and leadership training.

Patient safety support team



Comments on patient safety support teams

"It would be better if the patient safety [support] team were integrated into the various staff teams to ensure embedded actions with regard to improving patient safety and in all staff teams and at all levels."

"I think we are creating more teams for the sake of appearance. You need people who work within the NHS to take on additional roles with protected time for these roles. We don't need a new team of specialists coming in. There's so much of this in business now, with more 'teams' so we can show people that it exists but that does not translate to any change."

"As long as they have a broad remit, ie opportunity to look proactively rather than just reactively and organisationally be established to support across the organisation rather than just being seen as an element of risk and governance."

"…this adds a layer of confusion for our providers. There are already individuals undertaking this work in regional team and in the improvement directorate."

"I believe the current Serious Incident (SI) investigators risk managers, etc work well. With an additional team the two would overlap and become confusing. I wonder if it will be better to increase the resource for SI investigators to then have a dual role for patient safety support. But the divisions will own their improvement methods."

"Sounds like yet another committee that needs to report to another committee and the actual responsibility of getting things done is removed from those on the shop floor."

Views on patient safety support teams (focus groups)

Participants felt that language is important. The term ‘challenged trusts’ was punitive. All trusts have issues with patient safety so the support should be available to all, for some this may mean getting support to move from good to outstanding.

Participants felt that rather than a threshold for when the team are involved, it should be more informal with trusts able to approach the team for advice and support at any time and have a continual dialogue: early intervention is key.

Has to be a carrot not stick approach and support should be co-produced/designed with trusts. A coaching approach or critical friend approach would be best. “Lots of people come in now but it’s not support.”

The support team must have values and behaviours that reflect care and support and are non-punitive thereby encouraging trusts to seek help if needed; the proof is in the pudding.

The team should also highlight good work that is going on in a trust to help build confidence and boost morale.

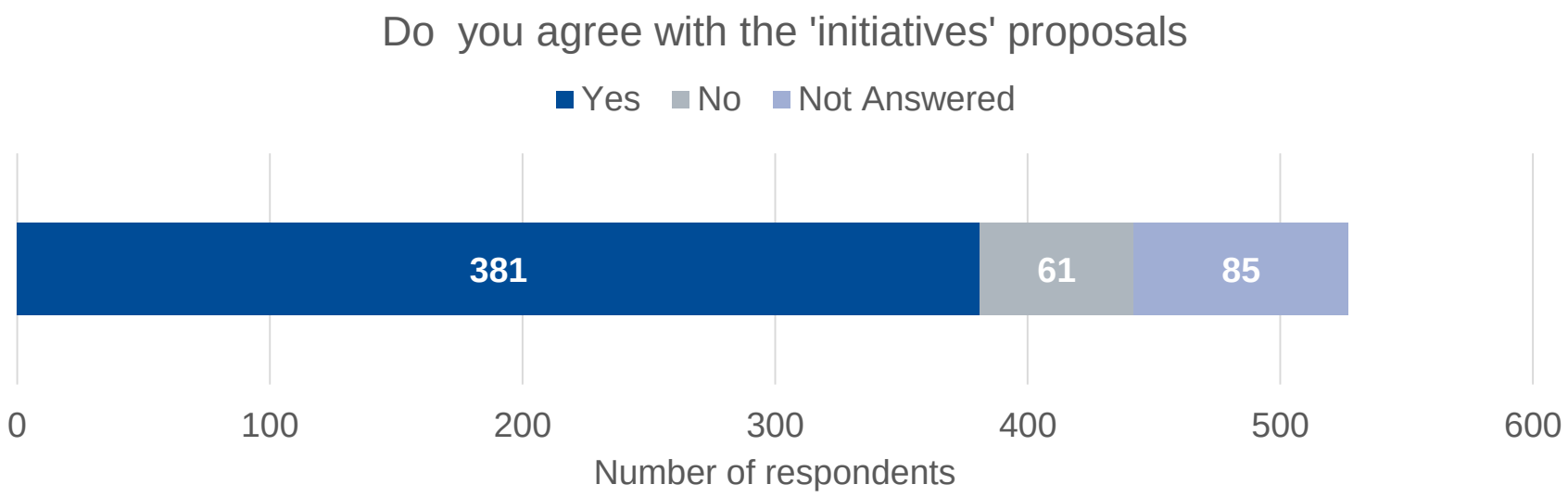
Support should include pairing up trusts, ie matching one which is struggling with an issue and one which is doing well on it.

It would be useful for the support team to have a co-ordination role with other system partners who are already involved in patient safety management, eg CCGs and the CQC.

Several participants felt that the team could be expanded by having a network of associates/fellows from trusts and organisations outside NHS Improvement.

There was support for the team delivering training targeted at boards, as well as support for the team working directly with clinical teams.

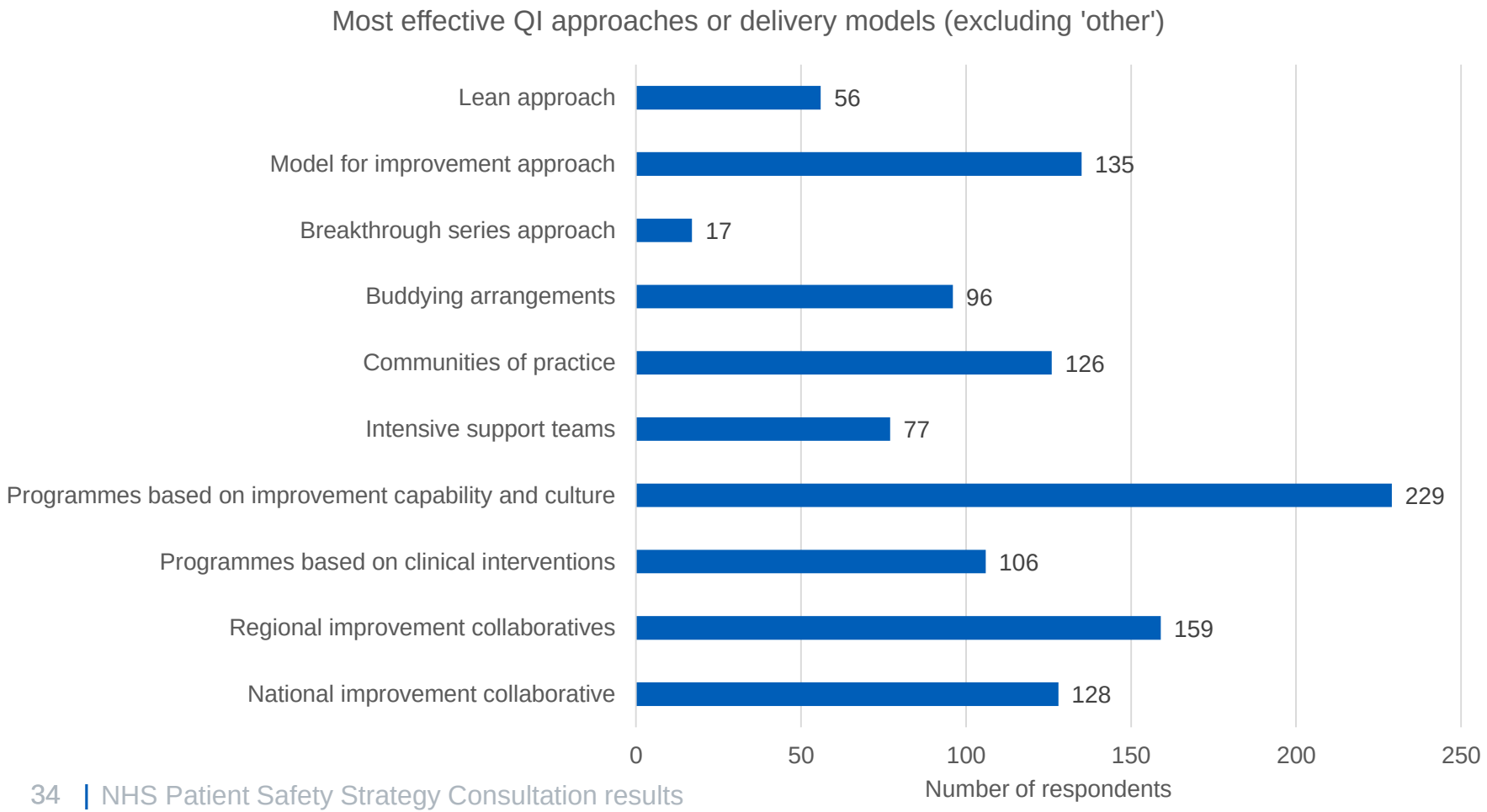
Initiatives



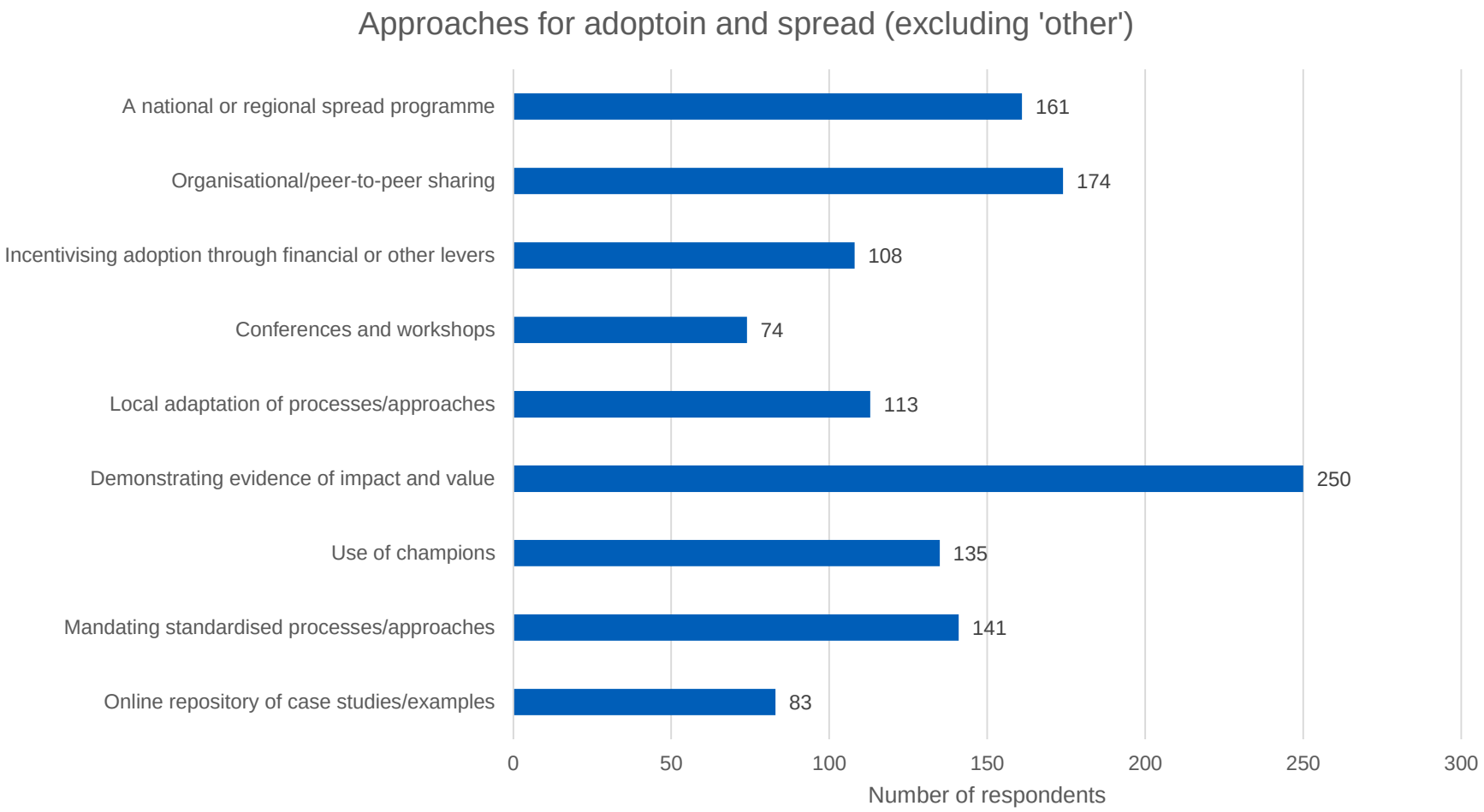
Initiatives

Word cloud analysis of free text comments on the proposals under the 'initiatives' heading

What are the most effective quality improvement approaches or delivery models? (Select your top three answers)



Which approaches for adoption and spread are most effective? (Select your top three answers)



Views on Initiatives (focus groups)

There was support for having a varied toolkit: of improvement approaches - a range of tools (using Institute for Healthcare Improvement model, Virginia Mason, Toyota, etc) for a given set of problems, but also allowing flexibility in its application so that it is specific to local settings, stakeholders and issues. However, there should be a standardised way of measuring improvement.

There was recognition that it is useful for initiatives to have local and national elements, ie have a local co-ordinator with a national platform, which is an opportunity for funding to be applied to a local context while having access to a wider stage for learning and sharing.

Developing capability was one area where support would be useful. The most effective improvement approach is to have staff trained in quality improvement (QI) across all sectors in all methodologies who can blend techniques. Trainers should teach QI methodology in a practical way, and demystify concepts like process-mapping by using language which can be understood by all, rather than creating a siloed group of experts.

A lack of standardised metrics was proposed as one barrier. It needs to be very clear what will be measured and how this information will be collected. One trust highlighted that their sepsis programme lost two years of progress because staff didn't know how to measure appropriately.

NHS England and NHS Improvement should have one approach to adoption and spread, and signpost who to go to when organisations have a problem or want to share good practice. A similar point is NHS Improvement's role in sharing the research element of QI – make it straightforward to find what worked or didn't (horizon-scanning), or to know if you are the trailblazers in an area.

When you take away the initiative's priority status, collaborative and/or funding, progress will be lost unless there is a culture where staff know why they're doing the work and have a personal incentive to continue.

Trusts should be encouraged to be brave with their initiatives: there should be a safe space to be creative.

Views on primary care comments (focus group)

People felt generally that the priorities in the strategy were appropriate for primary care, but that more funding needed to be shifted to primary care for patient safety as there has been under investment in patient safety in primary care. Primary care is behind on blame culture.

The GP contract was seen as very important in engaging GPs – if patient safety initiatives like reporting incidents to NRLS are not in the contract they are less likely to get done.

Talking about patient safety in primary care isn't the norm; this needs to become more like safeguarding, ie be seen as a priority, with mandatory training to different levels and through different modes of delivery.

Participants felt the training should include the following topics: raising concerns, whistleblowing, how to carry out investigations and Freedom To Speak Up (FTSU). Training should be experiential not just e-learning. Flexible models will be needed to deliver training (eg evenings) – as pharmacists for example get a breach notice if they leave the pharmacy during the day. Support for making it a 'must do' but mandatory training has negative connotations.

New networks will have clinical directors – they could have the patient safety specialist role; however clinical director role only has a 0.25 allocation (of time, job plan) so if the clinical director is going to be a safety specialist then will this just be an add on? They would need people below who are the doers; the clinical director could support clinical governance leads in practices, in the same way that safeguarding GPs support safeguarding leads in GP surgeries.

For patients to be involved in their own care, we need to communicate with patients, ie do they know they can be involved in their own safety? This must be expected by patients. Patients can't access their records which is a barrier to involvement: it would be useful if they could log onto a system and check if they've been referred.

Could translate initiatives from acute trusts to primary care to encourage patient involvement, eg positive patient identification (ID). Also useful to include patients in staff training and peer reviews.

#TalkHealthandCare online challenge – how do we create a just culture?

Sharing staff stories with the board in the way we share patient stories will help develop a just culture.

Tackle incivility and respect staff who are doing their best under very difficult circumstances.

There is a blame culture in the NHS.

We need to recognise just culture is part of a wider safety culture and that just culture is related to equality and inclusion and treating all staff fairly.

We must focus on what went wrong and not focus on the actions of individuals making honest mistakes. Managers need to understand systems thinking.

#WeMDT Tweetchat 5 February 2019

- One hour Tweetchat hosted by WeNurses using #WeMDT
- Divided into three parts, each exploring a different aspect of the proposed strategy (just culture, infrastructure, patient advocates for safety)
- 81 people participated, posting 586 tweets
- As well as providing insight, helped further promote the consultation with a reach of over 8.1 million
- Full transcript can be seen at http://www.wecommunities.org/tweet-chats/chat-details/5308.

Just culture (Twitter chat)

A selection of the posted tweets:

Christopher Tuckett @HealthPhysio · Feb 5

Replying to @WeNurses

I feel patients & carers need including in discussions about a 'just' culture. As feedback I've had from clinicians about risk aversion, is that they fear blame from patients and families not their bosses so much. #WeMDT

Elaine Maxwell @maxwele2 · Feb 5

Replying to @WeNurses

Difficult to have a just culture when the strategy is Safety 1 and focused on the harm and root cause rather than prospectively designing environments that create safety #WeMDT

Michael Perera @Emmellar99 · Feb 5

Replying to @WeNurses

being treated fairly is to be supported but the harmed patient may not be so understanding #WeMDT

James Titcombe @JamesTitcombe · Feb 5

Replying to @safety_matt

I think this is hugely important Matt, but achieving it must encompass the whole system aligning to ensure staff involved in patient safety events are treated consistently & fairly - including professional regulators. #WeMDT

Kerri Legg @LeggKerri · Feb 5

#weMDT Q2 - It's essential that we embed the ideology into all clinical governance activity. It's very critical in patient safety investigations but limiting it to here it's becomes only understood under these circumstances including appraisal. It's about changing how we reflect

Christopher Tuckett @HealthPhysio

Any type of culture is a product of the interactions between people and their environment. But it's different for each person as everything is relative. One person's 'just' culture is another person's 'blame' culture depending on context and past experience. #WeMDT

Catherine Pelley RN RHV QN @CatherinePelley · Feb 5

Replying to @WeNurses

It takes time to work within organisation to change culture. That time isn't there consistently to work through this across and through organisations. Building confidence with families takes time and resources that aren't always there

Mothers Instinct @Mothers_Inst_UK · Feb 5

Replying to @HealthPhysio @WeNurses

#WeMDT I think patients should be educated about just culture approach to staff if something goes wrong . Would help them understand and most patients genuinely do want acknowledgement apology and learning

Elaine Maxwell @maxwele2 · Feb 5

Replying to @maxwele2 @WeNurses

A just culture would include recognising safety not just its absence

Christopher Tuckett @HealthPhysio · Feb 5

Replying to @WeNurses

I also think 'culture' is still poorly understood by the majority and academics don't entirely agree what it is either. So to create a 'just' one is difficult. #WeMDT

Mothers Instinct @Mothers_Inst_UK · Feb 5

Replying to @Emmellar99 @WeNurses

Harmed patients need peer support, I believe receiving an explanation of just culture from someone else who's been through what they are going through would help #WeMDT

James Titcombe @JamesTitcombe · Feb 5

Replying to @WeNurses

The role of leadership is crucial - a culture won't feel 'physiologically safe' unless it's observed to be working in practice... #WeMDT

Infrastructure (Twitter chat)

A selection of tweets posted:

Daniella Leloch @DandylionLoves · Feb 5

Replying to @WeNurses

I do agree with this statement, I believe all the members of the MDT should have the same level of training and then this should be built upon. #WeMDT

Matthew Joyes @MatthewJoyes · Feb 5

Replying to @WeNurses

I don't think "patient safety training" should be mandatory - does mandatory training really work? I'd argue in other areas it doesn't i.e. IG.
But staff must know how to work safely and that's more about better role specific training and competency #WeMDT

Dr Sarah Russell @learnhospice · Feb 5

Replying to @WeNurses

#WeMDT I think we do need more education for all ranging from awareness to identification, monitoring, reporting & acting upon- i wonder if we all have a shared definition/understanding- so education important

Teresa Chinn MBE RN @AgencyNurse · Feb 5

Yes the words "mandatory training" fill me with dread and can often be a tick box exercise .... the challenge here would be to not make this one of those #WeMDT

James Titcombe @JamesTitcombe · Feb 5

Replying to @waynerobson51

Hugely important again Wayne, no other safety critical industry operates in the absence of a professionalised approach to safety skills & knowledge. #WeMDT

Matthew Joyes @MatthewJoyes · Feb 5

Replying to @LucieNHSSafety @waynerobson51 @WeNurses

Needs to be part of core curriculum for learners definitely - but if we look at other high risk, high reliability organisations, the approach of developing competency is far ahead of what we call mandatory training #WeMDT

Kelly Fielding @kelly_educator · Feb 5

Replying to @DandylionLoves @WeNurses

I think training is an ideal answer but the format and delivery is difficult, how do to ensure they get value without it being another session or e-learning that become a tick box. #WeMDT

Kerri Legg @LeggKerri · Feb 5

Replying to @waynerobson51 @MatthewJoyes @WeNurses

#weMDT I think group based workshops, yes make it mandatory but away from the classroom and into the simulation suite. Understanding team dynamics, hierarchy, unconscious bias - much better understood in sim - then deliver your teaching

Matthew Joyes @MatthewJoyes · Feb 5

Replying to @waynerobson51 @WeNurses

Mandatory training - at provider level - often translates to standardised generic material, often poor quality e-learning, it doesn't translate into practice change and often becomes tick box #WeMDT

James Titcombe @JamesTitcombe · Feb 5

Replying to @WeGPNs

I'd support this idea - a basic foundation level of training for everyone - but recognising there are some very specialist roles where additional competencies are needed, eg patient safety investigations, implementing improvement strategies, engaging with families... #WeMDT

Matthew Joyes @MatthewJoyes · Feb 5

Replying to @WeNurses

Yes.
No other high risk organisation would not have a senior lead for safety. And that person must be a professional in safety not a bolt on to other roles i.e nursing, governance etc #WeMDT

Twitter chat – Patient advocates for safety A selection of tweets posted:

Evelyn Prodger RN Queens Nurse @evelyn_prodger · Feb 5

Replying to @WeNurses

Understanding the impact on patients/carers is vital. During an academic safety/ quality module I did hearing from a mother was powerful. Stories (done in the right way) are powerful tools **#WeMDT**

AmyMelz @PUNCadp · Feb 5

Replying to @WeNurses

When working with patients with dementia, families can often give us 'tips' to help care for their family member **#WeMDT**

Daniella Leloch @DandylionLoves · Feb 5

Replying to @WeNurses

Understanding their perspective on it and understanding.. Patient experiences... 'talking heads' asking those questions... what would they like to see/do/have provided to improve safety... **#WeMDT**

rebecca @itsneverbecky · Feb 5

Replying to @WeNurses

Access to safety reporting. Known families of long term patients in particular become absolute experts in spotting potential safety concerns **#WeMDT**

Kerri Legg @LeggKerri · Feb 5

I do have to raise the work @RCPath #medicalexaminers here! Having medical examiners in place means families have a direct route for raising concerns about care - the same right as professionals **#WeMDT**

Mothers Instinct @Mothers_Inst_UK

Replying to @WeNurses

Patient safety training, member of trust patient safety committee, patient safety advisory councils, member of board holding trust to account on safety metrics ... pt voice at every level of organisations

Christopher Tuckett @HealthPhysio

Replying to @WeNurses

Yes volunteer's are amazing but too often we reflexively say 'get a volunteer to do it' in the NHS. Why can't people expect to be paid if they're doing a valued job. Good work shouldn't always be free work.

James Titcombe @JamesTitcombe · Feb 5

Replying to @WeNurses

Yes, but there is a real risk of such roles being tokenistic - this needs to be supported with a professionalised curriculum & must involve roles at all levels including senior/board level roles. **#WeMDT**

James Titcombe @JamesTitcombe · Feb 5

Replying to @bird_mike @maxwele2 and 2 others

Real co-production is important Mike, this must involve treating people with lived experience as equal partners & listening to all voices. **#WeMDT**

Kerri Legg @LeggKerri · Feb 5

If we pay public/patient reps, and ask them to fulfil a certain criteria and contract, does it become more of a working relationship and therefore by definition would the outcomes be different. **#WeMDT**

Views from Healthwatch Norfolk consultation workshops

People broadly agreed with the proposed principles of a just culture, openness and transparency and continuous improvement.

While the strategy proposed to embrace all NHS settings of care, it felt skewed towards the acute arena.

There was a strong belief that a number of prerequisites need to be in place first. These included: safe staffing levels, adequate resource and training, effective communication, sharing lessons learnt along with a positive attitude towards the contribution patient feedback can make.

There was support for senior patient safety specialists however these should be drawn from different disciplines and while there was a view that patient safety was everyone's responsibility, this senior individual could take ownership of risks and have the influence required to take action at a service or system-wide level.

The proposal for patient advocates for safety was very well received and this could be an important role so long as the right kind of people were found to fulfil it, who could be truly independent.

Generally, people felt the strategy was a bit 'top down' and would benefit from being more 'bottom up'. It was felt that NHS staff at the frontline of healthcare delivery should be shaping the development of the strategy.

It was felt that individuals receiving care and support also had a responsibility for their own safety, doing whatever they could do, to promote and protect their own safety

Further comments and themes identified

The following slides reflect themes from consultation respondents that were not direct responses to the proposals in the strategy.

These themes were either substantially different in topic/focus to the proposals in the strategy (ie they were raising or commenting on topics that were not discussed in the consultation proposals) and/or they appeared to the national patient safety team to represent realistic, relevant and constructive additions or alternatives to the content of the proposals.

Further comments and themes identified

Measurement

There was a clear desire from respondents to see more information on and content in relation to measurement of safety, both overall and in relation to the specific aims and objectives of the strategy proposals.

"Utilise data better to show what success and 'failure' actually look like - safety is still a very vague and intangible concept. We get told that 90% of what we do is safe and high quality and then in the same breath get told to be even safer. We need open conversations about how safe we actually are now and what we are aiming for. Are we aiming for 100% safety? Is this realistic? What level of harm does the 'world's safest healthcare system' tolerate as acceptable?"

"There needs to be a standard baseline of data, it is well known that incidents are under-reported and therefore the initial data may be flawed. The starting point should be to ensure that the baseline data is accurate before any measurement of sustainability can be gained."

"There is no reference to the triangulation of safety data with softer intelligence from patient feedback which would provide further insight. The current safety measures that are often used relate to hospital care, there are very few safety metrics for primary, community and social care - these need to be further developed. It would also be helpful to consider developing some system-wide measures about safety."

"A measurement of just culture needs to be developed and available (eg monitoring of disciplinary processes and outcomes of these, inspection of evidence of just culture, some performance criteria developed)."

"Success is defined by the results that are achieved against the agreed goal/target. So, any safety improvement programme must have an appropriate system of measurement - this must be measurement for improvement, not measurement for the purposes of performance management."

"It is important to set measures at the appropriate level of the system. A single measure for the whole system runs the risk of not being meaningful or methodologically robust. An alternative would be a suite of measures set at various levels within the system... One-size-fits-all measures can prove to be restrictive in this regard. It is therefore essential that measures are deployed wisely and only where necessary and useful. Good analytical support is important at all levels of the health service… Perhaps most importantly, analysis is central to learning healthcare systems and has been shown to be a vital aspect of high performing organisations."

Comments and themes

The ‘50% harm reduction’ ambition is not popular

While there was some support for the proposal to have a default ambition of reducing specific harms by 50%, most comments about this proposal were negative.

*“*Don't even think of a target at this stage...erase it from your thinking no matter who tells you it is a good thing (assure them it is not and give them my email address if they remain in doubt) ... focus entirely on the development of the just cultures needed to support safety. And make time; this will not be a quick fix; scale and pace are not helpful terms in this arena.”

“My only concern is how we are going to decrease harm in key areas by 50% - a noble projection, but is it realistic? I think 50% is unrealistic. Once unachievable, integrity is lost. But if it works, then great.”

“Give some meaningful measures and be specific for different disciplines. Don’t throw numbers at people because they mean nothing. What does reduce by 50% mean? Asking; 'do you agree harm in key areas is reduced by 50%', is fatuous. Who wouldn't, until you think...”

“In principle....but will 50% get people into the right mindset to really deliver what we want, ie if a patient comes to harm there is always the potential rationalisation that they were in the 50% where harm was inevitable. Zero targets put people into a different mindset... If we had a harm-free health system how would our care look different...a very different question to how do we reduce by 50%. I use zero suicide as an example...this target has resulted in entirely different approaches. I would not want to lose this in mental health.”

“A decrease in harm in key areas of 50% by 2023 is very ambitious especially post Sign up for Safety campaign (falls and pressure ulcers) and antimicrobial Commissioning for Quality and Innovation (CQUIN), where many organisations faced significant challenges in meeting that reduction. A significant reduction in key areas was achieved in the early stages of improvement work. Sustained reduction from 2015 (Sign up to Safety) and further reduction to 2023 would be unachievable. The set reduction target of 50% would also translate into organisational key performance indicator (KPI), which may not encourage a learning culture.”

Comments and themes

Safety II

Building on the measurement theme, a lot of respondents picked up on the proposal to explore the concept of ‘Safety II’ in the new strategy, calling for much more on this and showing significant support.

“Safety should be proactive, eg how to design safety. Why do patients survive is a better question than why do patients die?”

“We do not showcase enough when things have gone well and when we look at things that have not gone so well, we tend to focus on the negatives. I rarely see examples of incidents where good practice identified as part of an investigation is showcased, we focus on the things which went wrong and therefore there is a tendency for people not to wish to discuss these issues more widely. We need to change how we discuss things which have gone wrong and focus on what we have learned and how we will change practice as a result of this learning.”

“The key inhibiting thing is that the focus consistently seems to be on what has gone wrong. Reporting of things that have gone wrong, and learning from things that have gone wrong. To move away from the blame culture we need to focus just as much (nationally and locally) on when things have gone well and spread this learning.”

“You define safety as ‘the avoidance of unintended or unexpected harm...’ which ignores the Safety II addition, which talks about an additive definition - whereby safety is seen as ‘the maximisation of instances of good or great care/care as intended.’ This is complementary, not a replacement for your definition. On the whole, the consultation document only involves Safety II in a tokenistic way - it is only mentioned once in the whole document. If we are serious about incorporating the lessons of the Safety II approach, its message must be in the definition of safety. Otherwise NHS staff and patients alike will continue to attempt to see a good 'outcome' for safety as merely minimising the numbers of adverse events/events resulting in harm to patients, which can result in unrealistic recommendations from incidents and more second victims in the form of staff.”

“Apart from the important points about the need for proactive approaches to patient safety and the importance of human factors/ergonomics, the whole document seems still very much stuck in the ‘Safety I’ mentality - look at what went wrong, try to fix things retrospectively by working out where the weak link was and improvement involves a new policy or more training for people to follow procedure better in future. And this then sits at odds with the stated aims of a just culture, more openness and transparency, etc. It would be a better strategy if it were able to embrace an overall ‘Safety II’ approach. The negative, chastising language in the consultation document needs to be looked at again.”

Comments and themes

Calls to be more hard-line and emphasise accountability

A subset of respondents felt the proposals lacked emphasis around people being held to account for providing safe care and advocated introducing requirements for people to do certain things.

"Reporting incidents should be a mandatory requirement not optional. It should be independently monitored and audited by staff not involved in the incident or department."

"Introduce legally backed compulsory reporting of all adverse events and complications resulting from medical devices or medication."

"There needs to be a fourth principle of accountability, so that there are strong incentives for lessons identified from safety incidents to be learned and embedded into routine practice and service implementation. Without a principle of accountability the current three proposed principles will not be realised in anything other than a suboptimal manner."

"For everyone's contract to include responsibility for supporting continuous safety improvement and for this to be linked in an evidence-based manner to supervisions and appraisals."

"An organisation to be legally required to publish numbers and themes of all levels of incidents and compliance to all recommendations."

"Make it a legally enforceable principle, a universally applied code of practice with a set list of incidents that have to be reported in a certain timeframe. The Human Tissue Authority do this - it maintains a list of human tissue act reportable issues (HTARI) and each incident has to be investigated to a proper standard in a set timeframe. There also needs to be proper action taken regarding notes - trusts are still using the 'oops, the notes have gone missing' defence, when actually they've been taken to the litigation department and hidden. This openly happens and needs to be stopped, made a legally enforceable offence."

"Improve Duty of Candour and make it mandatory."

Comments and themes

Call for more on the whole system including primary care

Some respondents felt the strategy was too focused on secondary care and did not consider the whole system view.

"…there is always a swing in NHS England to focus on the incidents in secondary care as they are reported more frequently. It would be useful to balance the sectors up a little. It is often felt that the reporting from primary care is not really listened to nationally."

"It is important for primary care/GP to be included in improved incident reporting as well as non-NHS providers of NHS care."

"Although it is mentioned I would like to see more emphasis and support for primary care where safety culture is less developed in places."

"Don't forget the care homes! This is an area of great need for support providing care to a very vulnerable population."

"Primary care really needs to see the value in reporting at a primary care network/CCG level and individual levels without the resultant actions then perceived as onerous. How can the learning from reporting be translated at new neighbourhood levels ensuring patient safety learning and QI is integrated as well as the service provision?"

"It still does not cover the learning from across the patient journey, encompassing the interactions between agencies involved in an individual's care. There is not enough about strategies/actions that will help the whole system work together, eg key enablers like the sharing of electronic records."

"The strategy should be broader and focus on health and care services rather than just health. It should also be explicit about all aspects of healthcare including primary care and other primary medical services, including dentists, optometrists, pharmacists. It comes across as very hospital focused."

"It would be helpful if the voluntary sector could also be included. Many charities provide a significant amount of health and social care to people in their homes, in community settings such as hospices. Charities often work in an integrated way with the NHS and are commissioned by the NHS."

Comments and themes

Call for focus on staff safety

Some respondents felt the strategy needed to have a wider focus and in particular that it needed to consider the safety of staff rather than be limited to only the safety of patients. This was felt to actually support patient safety as well. This theme also linked to the need to support staff in the aftermath of incidents.

"NHS Improvement needs to expand the agenda, to include safety for all. With the demise of NHS Protect, the safety of staff and freedom from harm such as aggression and violence agenda has been lost at a national level. The NRLS does not capture the true picture of safety for NHS organisations if only focusing on patient safety."

"I would like to raise the issue of staff health and safety. Staff can only feel safe emotionally and physically when the organisation acts in a safe manner. In my workplace we're working in shocking circumstances - we have no fresh water/no cleaners/no functioning attack alarm system (I could go on and on) and we had not seen a health and safety officer ever (I worked there for nearly 10 years). If staff are not cared for you won't change the culture and help staff to think about safety if patients."

"Ensure staff do not feel victimised or take on more of the burden of guilt than they need to. This should also where necessary include non-team members - people in say clinical governance may feel bad they missed a system fault that resulted in something terrible happening as an example. Staff need to have their welfare put at the centre of what happens to them as much as patients and supporters do, especially after a serious adverse incident."

"Psychological safety is paramount for this to work. It's all fine having board members that can wax lyrical about the importance of a just culture if staff on the frontline are too afraid to raise concerns."

Comments and themes

The system is too complex

Some respondents felt the strategy needed to try and simplify the complexity of the NHS, particularly with respect to patient safety:

"The overall management of the NHS is far too complex and responsibility lines are unclear until this is resolved Patient Safety is being put at risk!"

"We have come along way in terms of creating a culture of learning and transparency, however there are too many systems in place and now is the time to streamline these, so that they work across the new NHS landscape."

"You talk of the NRLS, Patient Safety Incident Management System (PSIMS), National Patient Safety Agency (NPSA), CQC thematic reviews, Patient Safety Alerts, Healthcare Safety Investigation Branch (HSIB), SIR Framework, Medical Examiner system, Learning from Deaths. Come on, that's pretty complicated. And you didn't mention trust complaints; HCPC/NMC/GMC hearings, Coroner's reports… datix, etc."

"Reduce the number of organisations that are duplicating the work/overlapping significantly."

"One idea I put forward was to have a Patient Safety booklet [including]. Quality and governance principles for the whole healthcare system. Areas to consider: National Patient Safety strategy NHS (when published) Your responsibilities/role; Duty of Candour; just culture; information governance ;QI; human factors etc. It is also imperative to ensure that patient safety is not about terminology that not everyone understands, so having information explained clearly and coherently may support all staff to have the underpinning principles, skills and support to improve patient care."

"Pages 12 and 13 of the document refer to several agencies and reports. It would be helpful if all of this could be shown in diagram format rather than just in narrative text. It is tricky to understand how all the various agencies currently co-ordinate across each other and how (if) any of this will change. Which individual agency will oversee them all, or will they remain as they are in that they each seem to have a separate role and function which then impacts on NHS provider organisations and perpetuates the competing demands which so often hinder advances in patient safety."

Comments and themes

The system needs to work together

Related to system complexity, there were calls for greater alignment and leadership of relevant bodies.

"A just safety culture needs to ensure that there is proactive external support from professional bodies, eg CQC, RCN, NMC, allied health professionals (AHP), when staff report incidents, eg staff reported problems to the RCN in Gosport but nothing came of this. The CQC safety requirements needs to align with the workstreams proposed to ensure these are embedded throughout the Independent sector."

"While there continues to be a punitive culture by regulators and commissioners, senior leaders will not be able to align this philosophy with the way they are treated at the most senior levels in the NHS."

"I'd think about this in terms of moving away from 'patient safety improvement' and the sense of 'projectness' and towards strategic national and regional alignment of building improvement capability per se, eg all boards to have access to leading for improvement board development programme, systematic use of quality improvement approaches, organisations govern for assurance and improvement, using data effectively, establish learning networks and aligned and supportive oversight regionally and nationally."

"There needs to be better alignment between CCGs, NHS England and NHS Improvement so that we are clear about our respective roles and how we can work together and/or with providers to make improvements."

…But the focus should be local

"The national elements of the new patient safety incident management system, the role of HSIB, mortality reviews and other national programmes are important. However at a national level this does not include the role of insights from CQC reports and visits, ombudsman reports or litigation claims. How these are co-ordinated is key, and is absent from the current proposals. The proposals currently sit at a national level, and most of the insights will come locally. While the national elements will be important to inform local change, the strategy needs to include and be explicit about what should happen at a local system level, provider level, team level and individual practitioner level. This will include many of the previously mentioned elements of skills in investigation, time and leadership to enable openness, and mechanisms of working at a local system level to enable learning for patients not organisations. The collation of learning and action from incidents, Patient Advice and Liaison Service (PALS), complaints litigation and soft intelligence is essential locally to drive improvement initiatives and actions."

Comments and themes

Educate the public

Some respondents felt we need to do more to ensure that the public know how risky healthcare is, so that they are more understanding when things go wrong.

"Greater honesty and openness about harms that occur and their frequency in healthcare. Informed consent requires knowing what can go wrong - yet on entering a hospital very few patients are informed that it is actually a dangerous environment to be in. A hospital admission should be acknowledged as a risky intervention - the evidence that this is the case is overwhelming yet we still collude in the belief that healthcare is 'safe'. Complex patients, receiving complex interventions, in a complex environment like an acute hospital will experience unintended harm. This should not be a surprise to anyone."

"Developing a narrative with the public that healthcare delivery isn't risk free and ensuring the public are more empowered about understanding patient safety."

"Expand on the hand-washing initiative, which worked really well. Make it clear to patients and their families and carers at admission that services have a duty of candour. Shouldn't be made alarming, but a matter of fact acknowledgement that things can go wrong. Be more open about the complaints process. A family member of mine was recently hospitalised and there was absolutely no mention of safety or the complaints process - but why not? GP practices are also notorious for ignoring concerns and making it difficult for patients to complain."

"Honest conversations with the public at a national and local level that highlight that health and care carry risk. Being open about risks of things like deconditioning of older people when in hospital, infections, etc."

"[For a just culture we need] A national campaign about the need to learn from incidents to set public perception of what happens during investigations."

"The other important factor inhibiting a just culture is a lack of awareness about error among the public - why they occur and how to prevent them. Because of this the public want someone held responsible and they want them punished or removed from their job in the belief that this will prevent further errors and harm. This natural deep-seated reaction stems from fear - fear that if they don't take tough action the people involved have got away with it and more harm and misery will occur to others. We need a public health campaign to educate the public about how errors occur and how the bad apple theory is flawed - we need to reassure them that in rare cases where there are bad people we will act. There are parallels here to crime and punishment. All the evidence shows prison doesn't work but the public feel non-custodial alternatives mean the criminals have got away with it."

Comments and themes

Time and resources

A very common theme in the feedback was that lack of time and resources, in providers and particularly in relation to those working at the point of care, represents a significant barrier to delivery of the strategy and its components.

"Infrastructure - I think this is the most important aim. However, as an NHS employee in a safety environment, it isn't just necessary to have the skills and tools to improve safety; the time is needed to actively investigate incidents and be safety aware while carrying out a role in pressured environments. There needs to be time as well as training and tools in order for this to be achieved."

"I understand the rationale to develop senior patient safety specialists in providers and local systems. However, we need to be mindful of workforce issues, vacancies, recruitment, etc as these will likely add to someone's day job and pressures on work may defeat the object. I don't know the answer, just a highlighted reality. A possible solution is to make it a non-clinical role, to act as an advocate, champion and advisor who could be supervised and sit in a clinical team. New career opportunity/associate role? If it is clinical, you may find a sporadic implementation initially."

"Without the commitment of increased staffing you are setting yourself to fail."

"Staff need the time to talk about patient safety issues in their working environment under a 'just culture' and then to see real changes in patient safety as a result of the time they have spent exploring the issues and suggesting solutions. Too often nothing happens. Do staff really have the time these days to reflect, not just on safety issues but all the other issues that could be improved if staff just had the headspace to reflect on what is going on in their team?"

"I don't believe there is a lack of willingness or understanding - but there is a significant lack or workforce. I don't support the statement that 'progress is being held back by insufficient patient safety education...'; I think the major barrier is workforce numbers. We are carrying gaps in every part of the organisation - and committed staff are struggling to continue working on a daily basis. We need more staff, not more training. I'm also concerned about the patient safety support team. We have been 'supported' by many other bodies - CQC, NHS Improvement and NHS England, Big 6 consultancy firms, etc - but without additional staff to deliver change, only small improvements are possible."

"I agree with the three aims, but key principle underpinning the implementation of the strategy is missing: staff motivation and morale. For too long, NHS staff have seen their numbers fall further behind what is required, while demand for their services rises unsustainably, all while the government pursues a cost-saving agenda by cutting staff pay year after year. In short, staff are asked to do more for less reward and less appreciation."

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