Annex 2: NHS Patient Safety Strategy equality impact assessment

July 2019

NHS England and NHS Improvement

Under the Equality Act 2010 (the public sector equality duty) we have analysed the potential impact of the NHS Patient Safety Strategy on health equality and on groups with protected characteristics. We have considered each element of the strategy separately and used available evidence to inform our assessment.

This assessment demonstrates that the strategy will make an overall positive contribution to advancing equality in relation to patient safety improvement across the NHS. We do not anticipate its implementation will have any negative impact on equality for people with protected characteristics.

The full assessment below demonstrates that proper regard has been paid to our Public Sector Equality Duty.

Section of the strategy	Commenting on and assessing the impact on equality
Foundations	
A patient safety culture	The strategy identifies that culture is a huge determinant of the safety of the healthcare system. The strategy identifies key ingredients for creating a patient safety culture. These include: fostering psychological safety, valuing diversity, having a compelling vision, providing compassionate leadership, supporting teamwork, encouraging openness, providing a learning environment and increasing civility. The strategy asks local systems specifically to: • use the NHS Staff Survey to understand and improve their safety culture • adopt the NHS Improvement Just Culture Guide or equivalent • embed the principles of a safety culture and align safety culture work with the well-led framework.

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	An environment where all staff feel supported and psychologically safe will be one that fosters inclusivity, with all staff confident to speak up. In such an environment, factors known to inhibit people raising concerns about safety, including ethnicity and seniority[1,2] and often linked to senior people being older, are addressed. We know that clarity of vision and compassionate leadership is reflected in mutual understanding and support for staff throughout the organisation and we would expect organisational policies and procedures, eg recruitment and flexible working policies, to be inclusive of people with protected characteristics. Separate reports by Robert Francis and Roger Kline showed that Black and minority ethnic (BME) staff who raise concerns are treated less favourably than white staff and are more likely to experience bullying/harassment and be referred to professional regulators.[3,4] Initiatives to improve teamwork and civility will encourage inclusivity and support among staff as well as openness with each other and patients. Similarly, the development of a just culture where staff are treated fairly and not inappropriately blamed will reduce the unequal treatment of staff. **Assessment:** Collectively, the initiatives to promote a patient safety culture will have a positive impact on all staff, particularly those from BME backgrounds, and indirectly a positive impact on all patients.

[1] https://www.cqc.org.uk/publications/themed-work/opening-door-change
[2] https://improvement.nhs.uk/resources/improving-safety-critical-spoken-communication/
[3] Francis R (2015) *Freedom to Speak Up: An independent review into creating an open and honest reporting culture in the NHS*. https://www.gov.uk/government/publications/sir-robert-francis-freedom-to-speak-up-review
[4] Kline R (2014) *The "snowy white peaks" of the NHS: a survey of discrimination in governance and leadership and the potential impact on patient care in London and England*. Middlesex University.

Section of the strategy	Commenting on and assessing the impact on equality
A patient safety system	The strategy acknowledges the complexity of the healthcare system and clarifies that different issues need action at different levels of the system and by bodies with different remits. Given that people's understanding of where issues are best addressed is key, NHS England and NHS Improvement will: • work with national, regional and local organisations to support the development of a patient safety system that ensures that the right roles and responsibilities are vested in the right places • publish a definitive guide to who does what in relation to patient safety in the NHS and keep this updated. Ensuring that roles and responsibilities in relation to patient safety are vested in the right places will ensure a cohesive approach to patient safety and reduce confusion about the approach for NHS staff and the public. This will have an indirect impact on all patients as individual safety issues will be addressed by the part of the system that can most effectively reduce harm. Communicating who does what will be vital and the definitive guide to this must support those with communication challenges to understand how the safety system should operate. The guide will therefore be tested with those groups and made available in appropriate formats. The strategy acknowledges workforce is the most important component of a safety system, but also recognises there are significant workforce challenges. These challenges will be addressed through the wider NHS People Plan. The interim plan[5] states that "we are committed to

[5] https://improvement.nh.uk/resources/interim-nhs-people-plan/

Section of the strategy	Commenting on and assessing the impact on equality
	advancing equality of opportunity and working productively with key stakeholders across the protected characteristics". **Assessment:** Any improvement to the system will have a positive impact on all staff and patients.
Insight – to be world leading at drawing insight from multiple sources of patient safety information	
A new digital system to support patient safety learning	The strategy confirms that a new digital system to support patient safety learning is being developed to replace the National Reporting and Learning System (NRLS). The new system will require a change to the underlying taxonomy of the data collected and protected characteristics data will be part of the new data taxonomy. However, the collection of this data cannot be mandated because information on any protected characteristics of the patients or staff involved in an incident may not be immediately available to the reporter. Making its collection mandatory could act as a barrier to reporting and lead to fewer patient safety incidents being reported. We consider it is more important to collect incomplete information about risks to patients than to potentially block reporting of that information by mandating the inclusion of information that reporters may not have. We intend to explore mandating the provision of information on protected characteristics as part of the development of the incident response management modules of the new system (as opposed to the incident reporting modules). The more involved nature of incident response

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	processes – investigation or case record review for example – means that users of those modules may have access to more information regarding the protected characteristics of those involved in the incident. The issue of lack of data acting as a barrier to incident reporting may then be irrelevant. In addition, as the ambition to improve collection of protected characteristic data through administrative datasets (eg HES) embeds, the potential for linking the new system and these other datasets will be explored to determine whether protective characteristics trends can be identified in data. The strategy identifies the need for new data collection portals, to cover a wider range of settings in the system and allow incidents to be reported from mobile devices. The help required for those with specific needs to report data will be identified as the new portals are developed with input from patients, carers and families. The new system is also assessed against the GDS Service Standard,[6] which has a specific requirement[7] to ensure the service is accessible to people with disabilities or other protected characteristics to report incidents. This means, for example, that screen readers will be usable for all tools and public-facing pages will be written in plain English. New tools are being tested by digital accessibility specialists to ensure accessibility is built into the system, and accessibility will continue to be a priority as the service develops.

[6] https://www.gov.uk/service-manual/service-standard
[7] https://www.gov.uk/service-manual/service-standard/point-5-make-sure-everyone-can-use-the-service

Section of the strategy	Commenting on and assessing the impact on equality
	Assessment: The new digital system should improve access to incident reporting from groups who currently find this difficult. The system as a whole will improve patient safety for all patients and further developments in data linkage and collection should make it possible to identify any patient safety concerns that may disproportionately impact on groups with protected characteristics.
Patient Safety Incident Response Framework	This strategy identifies that a new approach to incident investigation is required as there is evidence that organisations need further support to operate systems that assist learning and improvement. New approaches and expectations in the Patient Safety Incident Response Framework with particular relevance to patients, families and carers are: • The ability to take a broader system or theme-based approach to incident investigation, eg investigating incidents involving minority groups/groups with protected characteristics, as this provides the opportunity to investigate those incidents that previously did not meet the definition of a Serious Incident. • Need for improved transparency and support for those affected. • Timescales for investigation shared and agreed wherever possible with patients, families and carers. There is evidence from the Netherlands that patients of minority cultural and language backgrounds are disproportionately at risk of experiencing “preventable adverse events”’ while in

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	hospital "compared with mainstream patient groups".[8] One reason put forward for this is the "critical relationship that exists between culture, language and safety". There is also evidence that certain groups with learning disabilities may be more at risk of patient safety incidents in acute NHS hospitals due to their vulnerable status.[9] **Assessment:** The more flexible approaches to investigation in the strategy may make it easier to address concerns specific to patients from minority cultural and language backgrounds, and those with disabilities. Involving patients, families and carers more in the investigation of their incident should help them feel their concerns are being addressed.
The medical examiner system	The strategy states that a new system is being introduced to enhance the scrutiny of all death certification, detect concerning patterns of death and support referral of cases to NHS patient safety systems. This, together with the Learning from Deaths programme, will be a crucial source of safety information to inform national work as well how the NHS can better support the bereaved. The digital systems being developed to support this work will collect information on some protected characteristics – age, gender, learning disability and probably pregnancy, as these will be on the death certificate. This will provide the opportunity to identify previously under-recognised themes relating to safety in people with these protected characteristics. The Learning

[8] Johnstone MJ, Kanitsaki O (2006) Culture, language, and patient safety: making the link. *Int J Qual Health Care* (18(5): 383-8.
[9] Tuffrey-Winje I, Goulding L, Gordon V, Abraham E, Giatras N, Edwards C, Gillard S, Hollins S (2014) The challenges in monitoring and preventing patient safety incidents for people with intellectual disabilities in NHS acute hospitals: evidence from a mixed-methods study. *BMC Health Serv Res* 14*:* 432.

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	from Deaths programme has also created the opportunity for learning and improving safety in relation to children and people with learning disabilities and severe mental health issues. Responsibility for the review of maternal deaths and babies now falls with HSIB as part of its maternity investigation programme. This will provide more detailed insight into how these deaths can be prevented. Work will continue with faith communities to address concerns that this increased scrutiny of death certificates may delay the release of the body for burial or cremation. Feedback from the death certification pilots and early adopter sites includes no indication of any negative impact from the introduction of the medical examiner system. As is the case now, any delays will be kept to a minimum. Based on the pilots, we anticipate that the new process of independent medical scrutiny will take no longer to complete than the current required process of medical certification before a cremation or burial can take place. Plans for the use of electronic communications will further support the efficiency of the process. **Assessment:** Both the medical examiner system and Learning from Deaths programme will have a positive impact on groups of people with protected characteristics. Concerns that some ethnic groups will be disproportionately disadvantaged are being appropriately addressed.

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National Patient Safety Alerts Committee	The strategy confirms that the clarity of the actions in alerts as well as robust local systems to implement these actions are fundamental in ensuring that the safety advice and guidance identified in alerts has the required impact.[10] A National Patient Safety Alerting Committee has been established to ensure that future national Patient Safety Alerts set out clear and effective actions that providers and local systems must take on safety-critical issues. **Assessment:** Some alerts may focus on certain protected characteristics, eg pregnancy or learning disability, due to the nature of the processes for the systematic review of the NRLS. There is no reason that the proposed improvements to the production of alerts will have any impact on equality beyond that where an alert is specifically relevant to a group with a protected characteristic. In those cases the impact will be positive.
Involvement – aiming to ensure that patients, staff and our partners have the skills and opportunities to improve patient safety throughout the system	
Patient, carer, family involvement	Practical action has lagged behind this increasing recognition of the role of patients, their families and carers in improving the quality of NHS care. The strategy describes the principles and roles that a diverse group of patient representatives believes are needed to ensure patient

[10] https://www.cqc.org.uk/news/releases/cqc-calls-change-safety-culture-across-nhs-reduce-avoidable-harm-0

Section of the strategy	Commenting on and assessing the impact on equality
	safety partners (PSPs) are effective across all areas of the NHS at various levels – from greater involvement in the safety of their own care, patient safety groups and committees, to the development of patient safety strategy and policy. The patient representatives recognise that an important element of the PSP's role is to ensure that the organisation gives full consideration to equality and diversity where appropriate in its work. The emerging principles identify that organisations should ensure that the PSPs they recruit are representative of the population they serve, including those people with protected characteristics. They will need to overcome challenges in promoting these roles to all groups and providing equal opportunity during interview. Consideration will also need to be given to how PSPs with certain protected characteristics, such as disability, can access the training and other support necessary to fulfil this role; some PSPs will need to attend safety committees. The PSP framework to be developed by the NHS England and NHS Improvement national patient safety team in collaboration with PSPs will provide further guidance on the development and implementation of these roles. **Assessment:** If PSPs are implemented in accordance with forthcoming national guidance, they will have a positive impact on the safety all patients, including those with protected characteristics. Those with protected characteristics should have equal opportunity to apply to be PSPs.
Patient safety education and training	The strategy states that, while the situation has improved, many people across the system have a limited understanding of safety. This is being addressed through the development and delivery

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	of a patient safety syllabus designed to ensure that all NHS staff and PSPs receive a level of training appropriate to the requirements of their role. Initial plans identify that where possible patient safety training will be delivered in multidisciplinary teams and across patient pathways to reflect the way services are delivered. This supports the earlier recognition that initiatives to improve teamwork will encourage inclusivity and support among staff as well as openness with each other and patients. Protected characteristics of trainees should be considered in the development and delivery of training materials. The training of staff should also have a positive impact on health inequalities and patients with protected characteristics, eg by promoting an understanding of how the design of equipment and packaging can support the elderly, people with disabilities and children. **Assessment:** Patient safety education and training should have a positive impact on all staff and patients.
Patient safety specialists	This initiative identifies the requirement for a network of senior patient safety specialists across the NHS to ensure consistency of approach to safety improvement, governance and accountability. As these specialists will be fully trained in patient safety, we expect them to have a good understanding of the current evidence base regarding patient safety and equalities considerations, including any emerging evidence regarding any disproportionate impact of safety

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	on those with protected characteristics. Similarly, these specialists will be well placed to access relevant local data and use their expertise to identify any trends in patients with protected characteristics, and then prioritise improvement action or escalation accordingly. As new policy or safety initiatives are developed, they will be well placed to ensure that full consideration is given to equality and diversity. **Assessment:** Patient safety specialists should have a positive impact on all patients including those with protected characteristics.
Improvement – aiming to develop and support safety improvement programmes that prioritise the most important safety issues	
The Patient Safety Improvement Programme	The strategy describes our ongoing intention to prioritise improvement programmes based on where the most significant harm is seen, litigation costs are highest, unwarranted variation is greatest and evidence-based interventions are known to mitigate risk. Current priorities, in addition to those specifically mentioned below, are: the prevention of deterioration and sepsis; and support for adoption and spread, including the emergency laparotomy care bundle, PReCePT, emergency department safety checklist and chronic obstructive airway disease (COPD) care bundle.

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	Patients admitted for emergency surgery are often elderly with several co-morbidities.[11] Introduction of the emergency laparotomy care bundle will particularly support this age group The PReCePT initiative focuses on reducing cerebral palsy in preterm labour, so this will positively discriminate in favour of pregnant women and their babies. The emergency department (ED) safety checklist helps staff provide the right care for all patients admitted to an ED. As most of the people seen in EDs are older, this initiative will particularly support this age group. COPD is a chronic condition that is usually diagnosed over the age of 40 and is most common in older people, so again this initiative has positive bias to older patients. Smoking is its main cause and death rates from tobacco are two to three times higher among disadvantaged social groups than the better off, so this work should also disproportionately benefit these social groups. **Assessment:** Each of these improvement programmes will have a greater positive impact on groups with the protected characteristics of age or pregnancy and maternity. One will also impact on disadvantaged social groups.
The Maternity and Neonatal Safety Improvement Programme	Improving the safety of services for mothers and babies remains a priority. Although rates of stillbirths and neonatal deaths are falling, errors still occur and the litigation costs for these are significant. Infant mortality is highest in the most deprived communities.[12]

[11] https://emergencylaparotomy.org.uk/aims-of-the-project/about-the-project/
[12] https://www.gov.uk/government/publications/health-profile-for-england/chapter-5-inequality-in-health

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	Assessment: As this work programme focuses on stillbirths and neonatal deaths it will have a positive impact on pregnant women and babies as well as disadvantaged social groups.
The Medication Safety Improvement Programme	The strategy states that the aim of the national Medication Safety Improvement Programme (MSIP) is to reduce avoidable, medication-related harm in the NHS, focusing on high risk drugs, situations and vulnerable patients. Medication errors are more likely in older people[13] and there will be a particular focus on this group through work on problematic polypharmacy, people with complex long-term conditions and better medicines safety in care homes. The work on complex long-term conditions will also benefit patients with physical or learning disabilities and mental health needs. The programme will also seek safer use of anticoagulants and other high-risk drugs prescribed for chronic diseases, many of which are closely associated with specific ethnic groups. As aspects of MSIP are specified, an equality impact assessment on each will be done as appropriate. **Assessment:** MSIP will positively impact on some groups of patients with protected characteristics and should not have a negative impact on others.

[13] Elliott RA, Camacho E, Campbell F, Jankovic D, Marrissa Martyn St J, Kaltenthaler E, et al (2018) *Medication errors: Prevalence and economic burden of medication errors in the NHS in England*. Policy Research Unit in Economic Evaluation of Health & Care Interventions, Universities of Sheffield and York. http://www.eepru.org.uk/wp-content/uploads/2018/02/eepru-report-medication-error-feb-2018.pdf

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The Mental Health Safety Improvement Programme	The strategy states that mental health services face complex challenges. In a recent report[14] CQC identifies safety as the biggest concern in mental health services. In response to this, a mental health safety improvement programme has been initiated. Mental health problems are associated with poverty and socioeconomic disadvantage[15] so work to improve the quality of mental health services should have a generally positive impact. The strategy identifies two specific improvement initiatives: • **Reduction in restrictive practice.** Black African and Caribbean people are disproportionately detained under the Mental Health Act and more likely to be subject to the most coercive powers under the Act, such as forcible restraint.[16] It is reasonable to think that work to reduce restrictive practice will have a positive impact on these people. • **Improving sexual safety**. This initiative will not be gender or sexual orientation specific. There is no evidence this work will have a negatively disproportionate impact on any group. **Assessment:** This programme will specifically prioritise those with mental health problems as it directly addresses safety issues faced by these groups. It will also have a potentially beneficial impact on people with mental health problems from BME backgrounds and socioeconomically disadvantaged groups.

[14] https://www.cqc.org.uk/publicactions/major-report/monitoring-mental-heatlh-act-report
[15] https://www.mentalhealth.org.uk/sites/default/files/Poverty%20and%20Mental%20Health.pdf
[16] https://www.mind.org.uk/media/24107564/mind-mhar-submission-final.pdf

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Safety issues that affect older people	Older people are more likely to experience harm in both acute hospitals and primary care,[17,18] and particular causes of harm include falls, pressure damage, infections, medication errors and inadequate nutrition and hydration. The strategy highlights initiatives relevant to these areas and the safety of older people. The Falls Collaborative Programme will benefit all older patients but those with physical disability and therefore at higher risk of falls will get additional benefit. The Stop the Pressure Programme – a national programme to reduce the incidence and severity of pressure ulcers and improve the management of lower limb and surgical wounds will also have potential additional benefit for people with diabetes. This group is at greater risk of wounds not healing and their limited motility is a risk factor for tissue damage. **Assessment:** As well as having a positive impact on older people, these improvement programmes may also have a positive impact on groups with disabilities.
Safety and learning disabilities	The strategy identifies the continued requirement to improve the quality of care provided to people with learning disabilities.

[17] Vincent C, Neale G, Woloshynowych M (2001) Adverse events in British Hospitals: preliminary retrospective record review. *BMJ* 322:517.
[18] de Wet C, Bowie P (2008) The preliminary development and testing of a global trigger tool to detect error and patient harm in primary care records. *BMJ Postgrad Med J* 85:1002.

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	The Learning Disabilities Mortality Review programme (LeDeR) has already demonstrated that there is an increased burden of respiratory problems, diagnostic overshadowing and under-recognition of early deterioration in people with learning disabilities. STAMP (Supporting Treatment and Appropriate Medication in Paediatrics) prioritises children with learning disabilities. **Assessment:** These initiatives will have a positive impact on groups with disabilities
Antimicrobial resistance and healthcare associated infections	The strategy highlights that AMR continues to threaten the effective and safe functioning of the healthcare system. Current efforts to tackle this involve both prevention of infection and optimisation of antibiotic use. Healthcare associated infections are prevalent in older patients so initiatives such as the management of urinary tract infections (UTIs) in primary care, the CQUIN for UTIs in older people in acute hospitals and reducing inappropriate use of antibiotics in older people all give priority to this group. **Assessment:** Addressing AMR will benefit all patients but particularly groups with the protected characteristic of age.

Response to consultation

To inform the development of the strategy we published a consultation document in December 2018 and received 527 responses from individuals (staff and non-staff, including patients and carers) and organisations. These responses have been reviewed to identify those providing feedback on the potential impact of the consultation proposals on health equality and groups with protected characteristics.

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Equality and diversity	Nine responses highlighted general issues in relation to equality and diversity. Most of these reflected the need when developing a just culture to appropriately consider equality in the workforce and the training of staff in both equality and diversity. HSIB identified that NHS patient safety improvement efforts should encompass a greater range of initiatives including health inequality interventions. Others commented that a focus on diversity of voice and participation is needed when considering patient involvement, which ensures involvement from people with protected characteristics and from other 'seldom heard/vulnerable' groups who are too often under-represented in patient safety discussions/initiatives. We have responded to this feedback in the NHS Patient Safety Strategy including by highlighting the importance of valuing diversity in our description of a safety culture and emphasising the need for diverse involvement within the general principles of PSPs. Some respondents also highlighted the need for staff to be trained in communication requirements for people with learning disabilities. We will work with HEE to ensure that equality and diversity are appropriately embedded in the future patient safety syllabus. In addition, work already underway in relation to patient safety and communication but not

	referenced in the strategy, is actively exploring the use of 'patient communication passports' that support those with communication challenges, including people with learning disabilities.
Age	Some responses made particular reference to the need to further prioritise older people and children. For the former, the concerns related to insufficient priority being given to care homes and the need for improved predischarge planning. Safety challenges in older people now have a specific section in the strategy. Concerns were also expressed about the provision of social care. This is not within the direct scope of this strategy but does link to initiatives that relate to older people. We also received feedback about the need to further link relevant patient safety initiatives with safeguarding reviews for adults and children. Again, safeguarding is out of scope for the strategy.
Disability	Most of the feedback that we received about equality related to mental health and people with learning disabilities. Under the Equality Act 2010 a mental health condition is considered a disability if it has a long-term effect on normal day-to-day activity. Long term is defined as lasting, or likely to last, 12 months. Reference to mental health in this section is made on the understanding that a number of mental health patients classify as disabled. There was mixed feedback. Some people/organisations said that the proposals did not have sufficient focus on mental health safety initiatives, eg Healthwatch considers more work is needed on the physical care of patients with mental illness. Others felt insufficient priority is given to patients in the community at risk of suicide. Some, including the PHSO, welcomed

	the inclusion of mental health initiatives in the strategy. The strategy now provides more detail on the relevant mental health safety improvement programmes. Some said that insufficient priority was given to people with learning disabilities and that the strategy needed to be more explicit about how training and actions to improve patient safety culture will impact on people, including children, with learning disabilities. The strategy now contains a section describing various safety-related initiatives focused on the care of people with learning disabilities.
Race	Feedback from MIND and one patient highlighted that Black, African and Caribbean people are disproportionately detained under the Mental Health Act and are more likely to be subject to the more coercive powers under the Act, such as physical restraint. The planned work identified in the strategy on reducing restrictive practice will impact positively on this group. Concerns were received, including from NHS England's London Region, about how discrimination and unconscious bias against BME groups results in higher rates of complaints against staff from BME backgrounds and their over-representation in disciplinary proceedings. The importance of valuing diversity is noted in the discussion on patient safety culture. Related work under the interim NHS People Plan[19] also recognises these concerns: that to embed the Workforce Race Equality Standard and that promoting BME representation on boards.

[19] https://www.longtermplan.nhs.uk/wp-content/uploads/2019/05/Interim-NHS-People-Plan_June2019.pdf

Sex	A comment was made that part-time working needs more support to rebalance the male-to-female ratio in higher grades/management in the workforce; imbalance has potential impact on culture. Work related to this is being addressed through the interim NHS People Plan.

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This publication can be made available in a number of formats on request.

NHS Improvement publication code: CG 43/19
Publication approval reference: 000717