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NHS

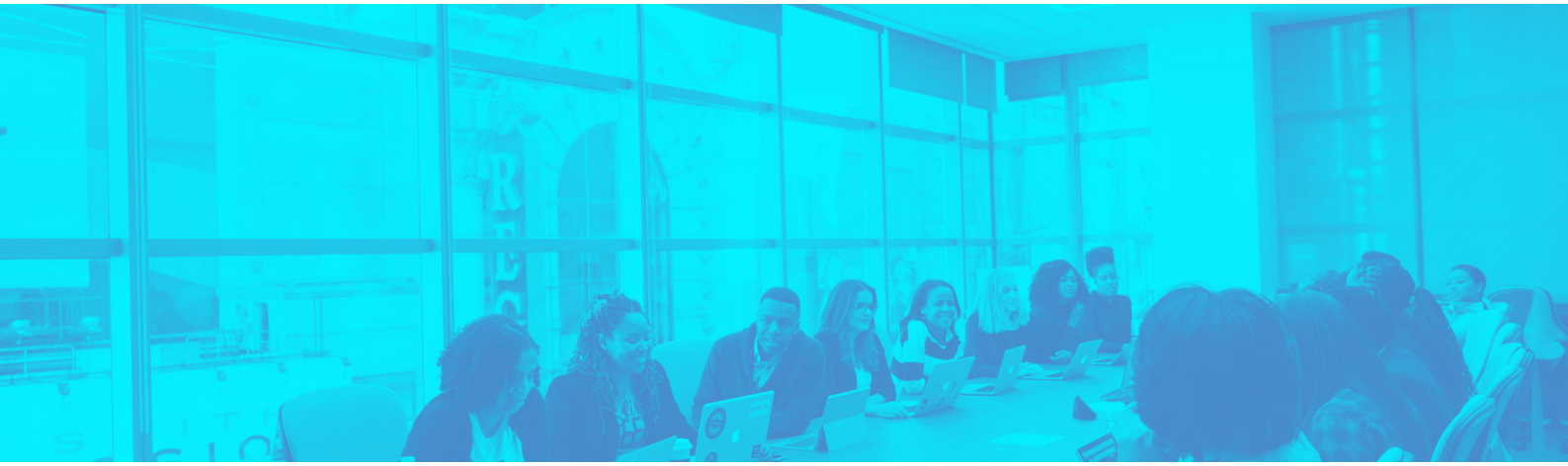
What Should Safety Look Like at a System Level?

April 2023

Introduction

On Friday 9 December, Aqua convened a panel of experts with a wealth of knowledge and experience, chaired by Professor Ted Baker, to consider 'what should safety look like at a system level?' to discuss the key issues and help support the development of Integrated Care Systems. The participants were as follows:

Name	Role
Prof. Ted Baker (Chair)	Former Chief Inspector, CQC Chair, Health Service Safety Investigations Body Special Advisor, Aqua
Helen Hughes	Chief Executive, Patient Safety Learning
Prof. Maggie Boyd	Former Regional Clinical Quality Director (Midlands and East) Executive Coach and Principal Consultant Special Advisor, Aqua
Dr Cheryl Crocker	Patient Safety Director, Academic Health Science Network
Dr Matt Hill	National Clinical Advisor on Safety Culture, NHS England Consultant Anaesthetist, University Hospitals NHS Trust, Plymouth
Dr Lisa Riste	Lived Experience Panel, Aqua
Danielle Oum	Chair, Coventry and Warwickshire Integrated Care Board
Tracey Herlihey	Head of Patient Safety Incident Response Policy, NHS England
Peter Ledwith	Programme Manager (Safety), Aqua



The objectives of the Round Table were:

1. To **equip** systems and organisations with **priorities and insights** to develop their patient safety plans.

2. To **support individuals** to feel empowered in their knowledge of patient safety and what they could be doing to influence and improve at their organisations.

3. To share the importance Aqua and the wider NHS are placing on **patient safety** and showing the relevance and breadth to its impacts.

The discussion was structured around key questions with the main themes captured.

Why Should Integrated Care Systems Prioritise Safety?

Reducing the unintentional harm caused by healthcare is a fundamental priority.

Healthcare is provided by a complex system and is high-risk. The World Health Organisation estimates that 50% of harm in healthcare is avoidable and that avoidable harm is one of the biggest causes of mortality in health services. Prioritising safety is the right thing to do. Lives are damaged and destroyed by avoidable harm.

Prioritising safety enables a more engaged workforce.

Workforce shortages is one of the biggest current risks facing health and care services. Staff need a safe working environment to give of their best. Motivating and retaining committed staff in services where they feel it is unsafe to practice is inevitably difficult. Prioritising safety improves staff well-being, motivation, and retention.

Reducing the risk of harm is a pre-requisite for high performing, productive and financially sustainable health services.

According to OECD, 13-15% of health spend relates to responding to avoidable harm: £300m on a ICB budget of £2bn.

We can't deliver on quality healthcare without consideration of safety.

Safety is a property of the whole system; it is never the just a matter for a single service or provider. Safety gaps in one part of the system lead to patient risks elsewhere in the system. ICS' need to lead on safety to ensure there is learning and improvement across the system.

System working requires a new approach. Systems must ensure that safety is managed as an opportunity for system learning, not as a performance matter. Safety must be central to the governance and oversight of ICS'. It is an opportunity to use systems thinking and embed an improvement approach, reinforcing the relationship between safety and improvement.

We must consider safety in the reduction in healthcare inequalities

There is emerging evidence of the inequalities in safety, and how different communities suffer a larger proportion of harm (see for example Action on patient safety can reduce health inequalities | The BMJ).

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How will ICBs Deliver Effective System Safety?

> "The leadership of safety is everybody's responsbility."

Culture

A culture shift means embracing all those working across health & care to tackle the biggest system challenges across primary, ambulatory, secondary and social care. Fundamental to this is to be clear and explicit about the enabling language we use in every interaction, with everyone; and viewing the system as a complex series of interconnected people serving common goals, rather than a mechanistic organisational analysis.

A system safety culture is collaborative, crafted, nurtured, and created and sustained so all can flourish. Current culture is often too hierarchical and defensive. This needs to change. Improving culture is the most important step, but also the most difficult one, and culture is led by the work that we do. Consistent and thoughtful leadership on culture by systems is crucial to delivering safety for patients in health services across the system.

Improved culture is best supported by new ways of working within services, within organisations and across the whole system. Systems should promote a continuous improvement approach to safety. Healthcare is complex and inevitably things will go wrong. When they do, the response should be proportionate to enable learning and improvement to take place. Establish an iterative cycle of change and improvement. This will involve using existing tools in a consistent and collaborative way across the system. For example, implementation of PSIRF at system level making sure the approach to it is consistent and co-ordinated could be a catalyst for change.

Leadership

Leaders at all levels in a system can demonstrate the correct behaviours to lead a safety culture across their system. ICS leaders are encouraged to understand their role in leading a consistent safety culture of learning and improvement across the whole system. This means equipping board members with the skills and knowledge to 'do safety better': what and how can they approach the cultural shift, away from a performance focus, which is different to adopting the NQB guidance on assurance processes. Clinical leaders from different areas can help develop, shape & champion safety plans and new approaches. ICS leaders must also develop processes and work systems to accommodate the systematic shift in patient safety management brought about by the introduction of PSIRF.

ICS leaders can ask searching questions and be open to hearing the truth - how safe are you? how are you measuring safety? what are the areas you want to work on? how can we push/support the system to move from reactive to proactive with more focus on improvement? There is potential to use Professor Charles Vincent's Measurement and Monitoring of Safety Framework and a BMJ paper by Mary Dixon-Woods, which makes the powerful distinction between problem sensing (actively seek out weaknesses, multiple sources of data, and softer intelligence from active listening to patients and staff and informal, unannounced visits to clinical areas) and comfort seeking (a focus on external impression management and seeking reassurance that all is well, using a limited range of data, and a preoccupation with demonstrating compliance) and provides recommendations for senior leaders.

Systematic Management

Safety can be proactively managed in a consistent way across the whole system. Safety should be at the core of a system operating model, not added at the end. The introduction and appropriate utilisation of PSIRF will support this approach and is in line with the recommendations of the Health Service Safety Investigations Body.

Strategic goals for system safety should be linked to data and health inequalities, with a system-wide approach to engage partners, patients, and staff, and aligned with external regulatory guidance – such as the CQC assessment framework and National Patient Safety Strategy. Organisations can inform their risk assessments and develop and implement safety improvement plans using frameworks, such as Patient Safety Learning's standards for patient safety.

A framework and principles for how we manage safety at a system level should be explored; one that can be applied in different contexts, and with clear benefits. It is important to note that a systematic approach to the management of safety at system level should be integrated with ICB governance and assurance, take a system view, adding value to what is already in place at individual organisation level, not replicating it.

Model of Care

Developing relationships across whole pathways of care is essential. Current models of care are pushing people towards an acute model of care. This impacts the pathways that patients use, putting excess pressures on parts of the system and compromising safety. New models of care using resources across the whole system are needed, and ICBs are ideally placed to affect that change. Safety must be at the core of these new models of care, not added as an afterthought. Current models of care are based on legacy approaches and professional perspectives, rather than what works for patients today.

Listening to patients and people in local communities and learning from their experiences will ensure that new models of care provide safe care is given at the right time in the right place, with Human Factors expertise involved in the beginning of any re-design. There is a strong role for provider collaboratives to adopt this thinking in shaping pathway redesign and adopting QI across an ICS.

Lived Experience

The voice of patients is crucial to setting the right safety priorities and establishing the right culture. This needs to be more than setting up a standalone Patient Participation Group or bringing in this voice when something goes wrong. The identification and appropriate skilling of Patient Safety Partners will be an important strategy. Patients will bring different experiences and expertise to the consideration of safety. ICS' must value this diversity and use the power of knowledge within this wide and varied group to set safety goals and deliver safety improvements.

Health Inequalities

ICBs can play a significant role here at looking at the systems in place to reduce inequalities related to patient (and staff) safety. The current model of care results in disproportionately greater harms to people from some communities.

System leaders are encouraged to take a wider view of inequalities using NHSE Core20PLUS5 approach. Start by collecting and understanding good quality data on safety to reduce inequalities for the particular system population, taking into account access, diagnosis, treatments made on offer, the experience of care, etc.to inform priorities and decision making. The measurement of safety in systems is likely to make inequalities more apparent than in organisations. By being clear about the important of safety, there is an opportunity for leaders to engage staff in safety monitoring.

Learning from safety events for people in those groups who are more likely to experience unsafe care can be used to drive improved safety for all. The Patient Safety Incident Response Framework (PSIRF) can help explore safety issues that may not have previously been explored due to not meeting the serious incident threshold. This provides a learning environment where assumptions can be safely challenged about people from groups who receive poorer outcomes and experience of care.

Safety should be considered as a cross cutting theme when policy and pathways are developed to improve care for people within the Core20PLUS5 approach. NHS England are developing a tool for inequalities and safety.

Innovation

Collaboration, innovation, and improvement within systems between different services, with patients and the local community and with other systems is vital to learn from others and to identify areas of best practice. We cannot change without looking for innovative solutions to our health and care problems: doing more of the same is no longer an option. ICBs have a duty to develop a strategy for innovation and research as a means to support change. Innovation on its own does not bring change, rather

it must be supported by quality improvement, with an equal emphasis on safety. The levers from the NHS Patient Safety Strategy and there is guidance in the NQB to support this.

There is a need to adopt and spread innovation at scale, for too long NICE approved guidance or best practice is left to a postcode lottery and we need to support systems and staff to adopt and adapt innovations at pace and scale. This is relevant to the section on partnerships, systems will need support to do this and will not have the capacity or capability therefore must look to and work with other system partners to help. Find people to partner with to help and support your safety journey, for example, Aqua and Academic Health Science Networks (AHSNs).