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The keys to improving patient safety

Reducing risks in healthcare

A summary of roundtable discussion

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Deloitte Centre *for* Health Solutions

The Deloitte Centre for Health Solution's roundtable discussion, held on 18 July 2016, was convened to discuss the critical issue of patient safety, following publication of the findings in the report from Health Education England's Independent Commission on Education and Training for Patient Safety.[i]

Researchers consistently estimate that one in ten people in the developed world suffer avoidable harm caused by a range of errors or adverse events in the course of receiving hospital care.[ii] These researchers and the participants attending the roundtable, however, recognise that people are fallible, mistakes do happen, but that by instilling the right culture and behaviours across health and care organisations we can minimise risks and help improve patient safety.

Indeed, the participants who attended the roundtable share a strong belief that instilling the right culture from the beginning of a healthcare worker's career will help implant a commitment to prevention and learning from errors and keep the mind receptive to new ideas and improvements. And that this learning will ensure patient safety is uppermost in their considerations, in both their personal and professional lives.

The Commission on Education and Training for Patient Safety identified the following challenges:

- how to engage people across all healthcare organisations and foster ownership for and leadership of patient safety
- the need for simplifying and standardising patient pathways and healthcare processes across and within healthcare organisations
- the extent to which performance management of both technical and non-technical performance can be improved through defining reliable outcomes based metrics
- the role of technology to generate reliable performance data and optimise standardisation of patient pathways.[iii]

Deloitte have seen these challenges first-hand, through our work with health and social care organisations. We also recognise the demand and supply challenges currently facing the NHS and consider that improving patient safety has an important role to play in enabling organisations to meet the funding and productivity challenges. Consequently, we convened this roundtable to bring together key stakeholders who are committed to improving patient safety and invited participants to consider two key questions:

1. how can the NHS meet the unprecedented financial challenges it faces while giving sufficient prominence to improving patient safety?

2. what are the key fundamental changes that need to happen?

There are a plethora of national and international reviews and reports highlighting the challenges in attempting to improve patient safety.

This Perspective provides an over-view of the discussion and a summary of the ideas and suggestions made for helping to improve patient safety. In introducing the discussion, the Chair of the roundtable, Karen Taylor, Director of the Centre for Health Solutions, highlighted the large volume of reports, reviews, enquiries and academic studies on patient safety, published over the past 15 or so years, often in response to high profile failures.

In particular that the seminal report in 2001 by the then Chief Medical Officer Liam Donaldson, *An Organisation with a Memory*; other key reports like Lord Darzi's *High-Quality Care For All* report in 2008 and the National Quality Board's Human Factors in Healthcare Concordat in 2013; were all based on a general consensus of raise the profile of patient safety and 'make patient safety the organising principle of the NHS'.

However, many of these reports and initiatives occurred at a time of significant growth in NHS funding, when resources were available to invest in quality and safety, improve staff numbers and support leadership development interventions. Yet despite this investment and increased focus the number of patient safety incidents remained stubbornly static. While there are examples of real improvements in areas which received targeted attention, like healthcare associated infection reduction targets; in a complex, safety critical industry like healthcare, serious examples of failures, errors and omissions have continued to occur with relentless monotony.

For example, in 2013-14 some 1.4 million patient safety incidents were reported to the NHS. Around 1.3 million of these were categorised as 'low harm' or 'no harm (49,000 incidents resulted in moderate harm; 4,500 in severe harm and there were 338 'never events'). Researchers estimate that half of all such patient safety incidents are likely to have been avoidable. At the same time however, research also suggest that despite introducing systems and processes to encourage staff to report incidents, the numbers reported are likely to be an underestimate due to the accepted fact of underreporting.

Participants at the roundtable acknowledged that Health Education England Commission's report on Education and Training for Patient Safety while the most recent in a long line of reports, is instrumental in recognising the need to address patient safety from the very outset of everyone's career.[iv] And that while the report highlights some of the improvements that have been delivered it also shows just how far the NHS still has to travel to improve patient safety and staff wellbeing. In particular that:

- major changes are needed in multi-specialty and team working
- greater emphasis is required on human factors
- simulation should become commonplace in all sorts of scenarios
- a much more transparent and open reporting system needs to be established to move the NHS from a blame culture to a learning organisation.

The environment in which improvements need to be delivered has become more challenging

The participants recognised that a key difference facing organisations and staff in 2016 is that implementing improvements and introducing real change comes at a time of unprecedented financial and demand challenges – the full extent of which is only now being realised.

Participants acknowledged that while the discussion often focuses on patient safety in the hospital setting, equivalent attention needs to be given to all levels of patient care and, in particular, at the interface of services. For example, risks to patient safety are particularly evident at point of diagnosis, on hospital admission, discharge and in handing over responsibility for follow-up care. There was a consensus that every opportunity should be taken to stress that safety in healthcare is not just an 'acute hospital only' matter. While there are specific contextual requirements and risks in hospital settings, the NHS cannot neglect safety issues in primary, community and ambulance service or, importantly, in mental health, especially as the NHS moves to ensure that mental health is given parity of esteem with physical health.

NHS organisations, staff, patients and the public are increasingly raising concerns that meeting the financial challenges presents real risks to patient safety.

How we organise and train the healthcare workforce matters

How we organise the healthcare workforce today is at the heart of what safe and sustainable care might look like for future generations, given that health and care has always been and will remain a 'people service'. The opportunity for and risk to safe care is influenced by how people work within teams, how teams work with each other, and how all staff behave when delivering care to patients.

At the same time it's impossible to ignore the fact that the workforce remains the single biggest cost for NHS organisations, representing around 63 per cent of hospitals total spend in 2015-16. Inadequate deployment of the workforce has a negative impact on the quality and quantity of service delivery. Getting it right, first time, benefits the triple aim of safety, quality and finances. However, for many of the participants, concerns were growing that for the past few months the pendulum has swung from an emphasis on safe staffing to the need to make savings. When the reality is that all organisations still need to ensure they have the right people, with the right skills, in the right place at the right time, focused on patients' needs.

Many of the workforce metrics that boards and wards should now be reviewing, ideally on a real time basis, should attempt to balance both safety and savings objectives. This means having timely information about patient numbers and their health and care needs and it means having accurate details of the availability and skills of staff. It also involves a more dynamic approach to matching these two elements and an acknowledgement that improving safety might require investment but will save costs in the long run.

Boards also need to recognise that one way of improving safety is to simplify and standardise processes. For example, reducing the number of steps involved in the emergency patient pathway, and defining and ensuring adherence to standard protocols which make it easier for staff to do the right things and harder to do the wrong things.

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The challenges that undermine the delivery of patient safety

The roundtable participants identified a number of challenges to achieving the aim of safe healthcare that is high quality and accessible. These are:

- **Cultural challenges**
  - requiring effective leadership, with tone in the middle as important as tone at the top, and leadership demonstrated across all disciplines/ professional groups
  - health organisations are complex and there is often not a single organisational culture but layers of cultures or micro-cultures highlighting the importance and need to recognise this and develop more specific metrics.
- **Financial challenges**
  - deficits and financial pressures adversely impact services and patient experience
  - financial management that is focused on reducing headcount to improve efficiency without the data or information to understand workforce productivity impacts negatively on performance.
- **Organisational challenges**
  - the risks of a target culture and a shift away from investing in prevention
  - the danger of having a system that is based on paying fines for failing to meet targets leading to organisations trying to avoid paying fines rather than addressing the reasons for the fines. However, the discussion recognised that this could be counteracted by targets that focus around health outcomes rather than inputs.

Key Solutions

Following discussion on the challenges, the focus turned to the types of solutions that could and should be mainstreamed. The 10 solutions that resonated most were:

Acknowledging that safety necessitates adequate initial investment to enable transformation of systems and processes and encourage cultural change within healthcare organisations.

Understanding that patient safety as a model of organisation can serve as a way to reduce variations in care, such has the variations identified in the Carter-Review, and help to deliver the NHS Five Year Forward View (FYFV). Patient safety in this sense is taken to mean the underlying principle of all healthcare activity that enables organisations to deliver better cost-efficiency and health outcomes.

Transformation of the education and recruitment agenda across all levels of professionals working within healthcare as pre-requisite to encourage behavioural and cultural change.

Changing organisational behaviour through leadership, enabling people to develop from a backwards looking approach on mistakes towards a forwards looking approach to solutions with knowledge that is gathered on the grass-roots.

Metrics on performance which should be granular enough to incorporate local variations of cultures. Real time data is needed to allow organisational learning on what, who and how to measure and plan for a forward looking assessment of possible safety risks as opposed to quality improvement that is backwards focused on mistakes and problems already occurred.

Changes to systems and processes underpinned by and understanding of the benefits of standardisation and simplification of pathways. However, participants agreed, that these changes necessarily need to be positioned in a framework that prepares and engages staff throughout the transformation period. This can foster ownership throughout the workforce and encourage people within organisations to show an "intelligent appetite for risk and willingness to try new processes and systems".

Human factors (ergonomics), as an organising principle rather than just a side-effect – and a way of delivering Carter and FYFV.

Sustainability and Transformation Plans (STPs) as potential enablers for collaboration and a means to achieve process improvement and safer services across organisations. However, participants suggested that leaders within the STPs will have to focus on fostering trust amongst the organisations which are being brought together within this new operating model in order to overcome the traditional experience of competition, rivalry and with-holding information in the face of austerity. STPs will also need to adopt metrics for monitoring and improving patient safety.

The whole system should take a preventative and anticipatory approach to health that reduces patient risks by stopping individuals becoming patients in the first place. The NHS and its organisations should continue trans-organisational learning from other industries such as aviation. While technical specifics might be different, human behaviour is not too different, and there are best practice examples illustrated – strategies to increase an understanding of the added-value of patient safety that might be adopted from similar approaches elsewhere. Outcomes based incentives, for example benefitting all those contributing to reductions of hospitals admissions, as seen within the Alzira model in Spain.

The need to make better use of the opportunities of the variety of people engaged in health, namely non-executive directors (NEDs) in hospitals, patients and volunteers. The better training and coordination of NEDs would allow for real time and real world experience within the organisations they support, untapping the potential for improvement in patient safety that has thus far not been deployed effectively.

'Speaking truth to power'

What keeps people safe are effective interpersonal skills and willingness and openness to be challenged – this requires cross disciplinary thinking and structures that encourage people who are generally the most reluctant to raise concerns to voice their concerns. In 'Speaking truth to power', Boards have a responsibility to ask the right questions and to ensure that they are informed fully on the following:

- early warning metrics
- safe staffing
- quality and safety targets
- quality control
- risk benefit analysis
- freedom to speak up guardians
- people given permission to lead at all levels of the organisation.

The intention to move to a paperless NHS and the digitisation of the NHS has the power to improve patient safety by building in key checks and balances. But applied badly, can reduce safety.

Examples of good practice

During the discussion a number of specific examples of good practice were highlighted which participants thought should be adopted more widely. These include:

- The Chartered Institute of Ergonomics and Human Factors: Design for patient safety[v]
- NHS speaking up and e-learning on whistleblowing[vi]
- The King's Fund and NHS Improvement's two-year programme aimed at helping NHS trusts develop a culture that enables and sustains safe, high quality, compassionate care[vii]
- NHS Scotland Quality Improvement Hub, Human Factors, in Primary Care[viii]
- Clinical Human Factors Group best practice.[ix]

Participants discussed the gap between what we know improves patient safety and what is actually done in practice. One attempt to address this is the 'Sign up to Safety' campaign team which draws on support from The King's Fund to help develop a theory about why the implementation gap exists, and explore ways of overcoming it. This roundtable discussion agreed that the key ingredients to patient safety are well known and understood. Implementation is more often about making smaller changes that can incrementally make things easier, better, safer and more effective. And it requires ongoing maintenance. Consequently, the problem of implementation needs to be owned by all.

Overall, the NHS knows what good has to look like and should encourage a culture of learning from best case examples, with a particular focus on how to enable real change and motivation through the right leadership. The time has come to look at solutions to disrupt the status quo and that a focus on the issues and suggestions covered by the roundtable would be a good place to start.

Conclusion

Healthcare is a safety-critical industry and patient safety must be its core business. Knowingly offering patients unsafe care is not just absurd, but morally and ethically wrong. What is needed is greater transparency and focus on healthcare outcomes (neither of which will go away) as this will expose bad practice. Instead organisations continue to spend public money on remedying or compensating unsafe care which is having massive implications and is an unjustifiable waste of people's taxes. It also undermines confidence in the NHS.

The roundtable discussion highlighted the key role of: collaboration and leadership; standardised clinical and management processes; and the adequate application of technology for clinical practice. It also emphasised the importance of collecting performance data to improve patient safety and deliver higher quality, more cost effective services. All of us have a vested interest in making sure this happens as a matter of urgency.

Everyone working in the NHS should reflect on the fact that without the changes identified, they or their families and friends could be the next ones affected.

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Endnotes

i. Independent Commission on Education and Training for Patient Safety. March 2016. See also: http://www.hee.nhs.uk/our-work/hospitals-primary-community-care/learning-be-safer/commission-education-training-patient-safety

ii. World Health Organisation 10 Facts On Patient Safety. June 2014. See also http://www.who.int/features/factfiles/patient_safety/en/

iii. Independent Commission on Education and Training for Patient Safety. March 2016. See also: http://www.hee.nhs.uk/our-work/hospitals-primary-community-care/learning-be-safer/commission-education-training-patient-safety

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v. http://www.ergonomics.org.uk/wp-content/uploads/2015/05/16-Design-for-patient-safety.pdf

vi. http://www.e-lfh.org.uk/programmes/freedom-to-speak-up/

vii. http://www.kingsfund.org.uk/projects/changing-culture-collective-leadership

viii. http://www.qihub.scot.nhs.uk/safe/human-factors.aspx http://www.qihub.scot.nhs.uk/safe/patient-safety/patient-safety-resources/publications-and-posters.aspx

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