Patient Safety Commissioner

The Principles of Better Patient Safety – consultation

A response by the Association of Personal Injury Lawyers

August 2024

Introduction

APIL is grateful for the opportunity to respond to the Patient Safety Commissioner's consultation on the draft Principles of Better Patient Safety.

We support the codification of these principles, which will provide an easily accessible framework for decision-making, planning, and collaborative working. However, we question the effectiveness of such principles in practice and their ability to make a meaningful impact on patient safety or improve the culture within the NHS. Leaders must take action to implement the principles. Furthermore, we believe there is a need for regulation, stricter monitoring of outcomes, and increased accountability for NHS leaders. We also note that there have been numerous consultations on the topic of patient safety over the past year, and our response to this consultation should be read in conjunction with those responses, which are below[1].

APIL's longstanding policy on patient safety is that there is an urgent need for a coordinated overarching strategy to tackle the issues which cause needless injuries and deaths in the first place. The current approach to patient safety is extremely fragmented, with a multitude of programmes, frameworks, reporting schemes and organisations. These include the NHS Patient Safety Strategy, the National Patient Safety Improvement Programme, the National Learning Report, the Care Quality Commission, and the Health Services Safety Investigations Body (HSSIB), among others. We maintain that in order for there to be improvements in patient safety, strong and coherent leadership around patient safety is needed, with an overarching link between patients, regulators, healthcare providers and policymakers.

Principle one: Create a culture of safety

Leaders have a responsibility to lead by example to inspire a just and learning culture of patient safety and quality improvement. They set out to keep people safe, supporting continuity of care, and foster a culture of compassion, listening and restorative practice.

5. To what extent do you agree or disagree with the first principle?

Strongly disagree / Disagree / Neither agree or disagree / Agree / Strongly agree / Don't know

[1] APIL response to the Department of Health and Social Care's call for evidence – Duty of Candour review available at https://www.apil.org.uk/files/pdf/ConsultationDocuments/4231.pdf
APIL response to NHS England's consultation – Never events framework review available at https://www.apil.org.uk/files/pdf/ConsultationDocuments/4228.pdf
APIL response to the Ministry of Justice's consultation available at https://www.apil.org.uk/files/pdf/ConsultationDocuments/4232.pdf

We strongly agree with the first principle. APIL's view is that one of the main challenges to improvements in patient safety is the lack of monitoring and accountability in leadership roles. Since the introduction of the statutory duty of candour in 2014, healthcare providers must be open and transparent with service users about their care and treatment, including when it goes wrong. However, our members report that compliance with the duty has been sporadic, with an inconsistent approach across different trusts (please see case study below).

Case study 1

The patient experienced a very distressing removal of retained products of pregnancy following a traumatic miscarriage. Multiple points of complaint were raised. The NHS trust's internal incident review supported parts of the allegations. However, no section 20 notice was issued and the duty of candour was not complied with. The trust has not made admissions and, four and a half years later the failures in care are still being denied.

This coupled with deep-rooted issues in the NHS has meant that patient safety improvements have been scarce. Since 2010, NHS organisations have been mandated to report all patient safety incidents resulting in severe harm or death. During that time no progress has been made in reducing the number of incidents. In fact, APIL analysis of data for the last 10 years (between 2012/13 and 2022/23) shows that there was a 30% rise in the number of patient safety incidents reported to have resulted in severe harm or death. [2] We believe that meaningful change in patient safety and a culture of transparency and openness in the NHS will only be possible once staff, managers and those in leadership positions adhere to the requirements of the statutory duty.

Principle two: Put patients at the heart of everything

Leaders put the patient at the heart of all the work that they do, with patient partnerships the default position at all levels of the organisation. They consider the needs of patients, working collaboratively with them to identify risks, and deliver person centred care. Leaders ensure that the patient voice is central to fully informed consent and shared decision making.

6. To what extent do you agree or disagree with the second principle?

Strongly disagree / Disagree / Neither agree or disagree / Agree / Strongly agree / Don't know

We strongly agree with Principle two. We have concerns that those affected by patient safety incidents are not getting access to clear, independent information about their rights and options. Person-centred care should mean that there is a tailored approach to the individual's needs. More needs to be done regarding the emotional and psychological support provided to patients and families when a patient safety incident occurs. Part of the problem lies in the power imbalance between organisations and patients and their families. Too often, those who are injured feel left in the dark about what has happened, and that they are unable to have confidence in what the hospital trust tells them. Many would benefit from speaking to an independent advocate who can understand their needs and offer detailed advice and guidance. Some will go on to seek independent legal advice from a lawyer, but

[2] National patient safety incident reports, NHS England, available at https://www.england.nhs.uk/patient-safety/national-patient-safety-incident-reports/ (latest data published October 2022)

most patient safety incidents will not be actionable as a claim. 14,383 patient safety incidents resulted in severe harm or death in 2022/23 – an average of 39 every day. 745,610 incidents resulted in any degree of harm. In the same year, the NHS received just 13,511 clinical negligence claims. This suggests that less than 2% of safety incidents involving patient harm result in a clinical negligence claim against the NHS.[3] Families and patients in these cases would benefit from independent support, advice and guidance in ensuring that the duty of candour is complied with and that they are able to engage meaningfully in discussions about what happened and the learning that will come out of it.

Principle three: Treat people as equals

Patients are treated with fairness, respect, equality, and dignity. Leaders incorporate the views of all, and proactively seek and capture meaningful feedback from patients, families, and staff. Feedback is acted on, to embed equality of voice.

7. To what extent do you agree or disagree with the third principle?

Strongly disagree / Disagree / Neither agree or disagree / Agree / Strongly agree / Don't know

We strongly agree with this principle. Often staff involved in care are honest and open when explaining that there was a mistake in the treatment, but when the incident gets reported and senior managers and in-house legal teams become involved, there is a tendency to discourage disclosure, due to fears or reputational damage, professional repercussions, and sometimes fear of litigation. Our members have frequently encountered this pattern where healthcare staff make admissions and provide an apology but as the investigation progresses, liability is denied, and it then takes years for there to be an admission.

Meaningful change in patient safety will only be possible once the NHS cover-up culture, often incentivised by those in leadership, is addressed. We note that while there has been an improvement in the perception of fair treatment of staff involved in errors, near misses and incidents, the most recent NHS staff survey 2023 results indicated that 40 per cent still did not think they were treated fairly.[4] The cultural issues that prevent individual clinicians from reporting incidents to patients must be addressed. Leaders must demonstrate fair treatment of staff so that they feel safe to raise safety concerns.

There is a lack of accountability for those in leadership positions, and there is no separate regulator for leaders. Efficient leadership plays a pivotal role in improving the way services are delivered. Leaders and managers should be subject to a set of agreed professional standards and national regulations governing their conduct, responsibilities and development.

Considering equality of voice for patients, our members' feedback is that they still come across several examples of patients being ignored by staff or systemic mistakes in patient safety. The case study below highlights this issue:

Case study 2

There was a failure to manage the claimant's major haemorrhage to adequate standard. This resulted in periods of hypotension despite fluid resuscitation during the claimant's

[3] ibid
[4] NHS Staff Survey National Results, available at https://www.nhsstaffsurveys.com/results/national-results/

shoulder replacement surgery, causing total blindness (Non-Arteritic Anterior Ischemic Optic Neuropathy). The trust underwent an investigation and produced a comprehensive investigation report. The result was that the investigation had not identified any failings. The trust fully denies liability.

The claimant in this case submitted a complaint including the following allegations:

"…visited by surgeon and anaesthetist who both apologised…no other information, nor an explanation of their actions has been forthcoming".

"Despite numerous requests from me, to date nobody has had a conversation with my wife and all the conversations have been had with me alone without any support or advocacy at all".

"At no point has anyone actually acknowledged the complete devastation this has caused to me and my whole family".

"I told staff I couldn't see. Despite me continuing to tell staff that I could not see, nobody accepted how serious this was, nor was any explanation forthcoming".

Principle four: Identify and act on inequalities

Health inequalities, and the drivers of health inequalities, are identified and acted upon at every stage of healthcare design and delivery.

8. To what extent do you agree or disagree with the fourth principle?

Strongly disagree / Disagree / Neither agree or disagree / Agree / Strongly agree / Don't know

We strongly agree with this. Individuals living in rural and poorer areas, those from Black, Asian and minority ethnic communities are still experiencing health inequalities. We understand that there are other drivers involved when considering health inequalities, but we believe it is crucial to identify the areas where NHS services are not available, of lower quality or availability and these should be guaranteed extra funding to ensure that individuals are not subject to 'postcode lottery' when it comes to healthcare.

Although many of the causes of ethnic health inequalities are beyond the NHS's control, more needs to be done to tackle them. The Ethnic health inequalities and the NHS report 2021[5] recommended action to diversify NHS senior leadership and improve the experience of staff from Black and minority ethnic groups. Representation and diversity in leadership positions could help address disparities in outcomes within those groups. The NHS Workforce Race Equality Standard (WRES) 2023 report indicated that the percentage of black and minority ethnic (BME) staff at very senior manager (VSM) level is only 11.2%, while 26.4% of the workforce across NHS trusts in England were of a BME background. It is fundamental that the workforce reflects the community it serves to understand and respond to its needs.

[5] The King's Fund, Ethnic health inequalities and the NHS 2021 available online at https://www.nhsrho.org/wp-content/uploads/2023/05/Ethnic-Health-Inequalities-Kings-Fund-Report.pdf

Principle five: Identify and mitigate risks

Targeted and coordinated action is directed to mitigate patient safety risks. Leaders escalate new and existing risks to healthcare commissioners and regulators. Staff are supported and empowered to proactively identify risks, hazards, and improvements.

9. To what extent do you agree or disagree with the fifth principle?

Strongly disagree / Disagree / Neither agree or disagree / Agree / Strongly agree / Don't know

APIL strongly agrees that leaders should escalate new and existing risks to healthcare commissioners and regulators and staff are supported and empowered to proactively identify risks, hazards, and improvements. The NHS national staff survey still indicates that staff does not feel confident in speaking up about their concerns. Although there has been a slight improvement from the two previous years, this shows that cover-up culture is still present in the NHS.

Our members report a lack of compliance with the duty of candour and a feeling that organisations do not support their clinicians in admitting medical error when it arises. Such systemic features are suppressing transparency in healthcare and restricting improvements in patient safety. Understanding human factors is a key element of a better patient safety system. Leaders should support initiatives aimed at breaking down inter-professional boundaries and fostering a sense of shared purpose across the organisation. The presence of a just culture is critical to building effective teams and establishing good relationships between staff and their senior colleagues and between specialities.

We strongly believe that these issues can be tackled through further education for healthcare teams, including practice managers, senior health leaders and health service commissioners. Alongside their mandatory training on clinical governance, such professionals should be encouraged to engage in ethical training in order to support their clinicians in being more open and honest with their patients. Clinicians must feel supported by their healthcare teams. There must also be more training and further improvement of the perception of how staff are treated when they are involved in errors, near misses and incidents, to encourage people to open up when things go wrong. Everyone in the organisation must be made aware of the significant psychological burden that injured people face after a patient safety incident.

Furthermore, we believe that enforcement by the Care Quality Commission (CQC) regarding patient safety incidents and compliance with the duty of candour should be stronger. Since the duty's implementation in 2014, the frequency of prosecutions for breaches has remained notably low. The first recorded prosecution to reach court was as recently as October 2020, underscoring the pressing need for a more robust enforcement mechanism. The current leniency in enforcement fails to sufficiently uphold the principles of honesty and openness that the duty of candour seeks which has a direct impact on patient safety. Strengthening enforcement measures will not only serve as a deterrent against non-compliance but also reinforce public trust in the healthcare system's commitment to transparency and patient safety.

Principle six: Be transparent and accountable

Leaders create a culture where there is honest, respectful, and open dialogue and where candour is the default position. This work enables a continuous improvement cycle and ensures that patients and staff do not face avoidable harm due to a cover up culture.

10. To what extent do you agree or disagree with the sixth principle?

Strongly disagree / Disagree / Neither agree or disagree / Agree / Strongly agree / Don't know

APIL strongly agrees with the sixth principle. Please see responses to questions 5 and 9.

Principle seven: Use information and data to drive improved care and outcomes for patients and help others to do the same

Leaders use and provide information and data of all types to drive their work, from all sources available to them. They should ensure that good quality data captures and meets the needs of all patients, including those from underrepresented groups. All staff are supported to pass on information relevant to the improvement of patient care. Best practice should be shared widely.

11. To what extent do you agree or disagree with the seventh principle?

Strongly disagree / Disagree / Neither agree or disagree / Agree / Strongly agree / Don't know

We strongly agree. Best practices should be shared widely and benchmarking data must be collected to effectively monitor and analyse outcomes and performance. Leaders should be committed to the contemporaneous collection and analysis of data to respond in a timely way to areas of concern and highlight and share good practices. Too frequently, organisations rely on retrospective analysis of data, by which time it can be too late or later than it should be to respond to the issue. Better data collection and analysis would require investment of time and resources and joined-up practice with other healthcare providers and organisations. Data improvements will also be useful to address healthcare inequalities. The quality of ethnicity data should be improved and used to identify the specific health needs of Black and minority ethnic groups locally and monitor access to and outcomes of care, to support action where needed.

12. Which of these principles do you consider to be of the highest importance? (optional)

If more than one principle is of high importance to you, please choose all that apply

Principle one: Create a culture of safety

Principle two: Put patients at the heart of everything

Principle three: Treat people as equals

Principle four: Identify and act on inequalities

Principle five: Identify and mitigate risks

Principle six: Be transparent and accountable

Principle seven: Use information and data to drive improved care and outcomes for patients and help others to do the same

We believe all the principles are important and none are mutually exclusive. All principles will be fundamental to create a culture of safety.

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