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Submitted to **Developing a patient safety strategy for the NHS**
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Your details

1 What is your name?

Name:
Eric Watts

2 What is your email address?

Email:
eric.watts4@btinternet.com

3 Are you responding as an individual or on behalf of an organisation?

An individual

4 If responding on behalf of an organisation, which organisation do you represent?

Organisation:

5 If responding as an individual, in what capacity/role are you answering (eg as a patient, carer, NHS member of staff, academic etc.)?

Role/capacity:
Doctor with 41 years of experience working in the NHS and aboard. 22 years as a consultant , two years as Clinical Director, Hospital Governor, CCG patient panel member, Board Member of the STP

Proposed aims and principles

6 Do you agree with these aims and principles?

Yes

Please explain your answer:
I agree because I am well aware that there are too many adverse events in medicine. These have been described in the work of Don Berwick in the USA and also in the Department of Health's An Organisation with a Memory published in 2000 which set out clear principles for constructive error management.
In spite of that we continue to see numerous problems.

7 What do you think is inhibiting the development of a just culture?

Please provide details:
The main problem is changing from the traditional culture of blame to a culture of constructive error management. There have been numerous examples of incidents occurring which have been the result of system errors but the individual with the patient at the time has had to shoulder the responsibility of errors which have been made upstream. Many of these examples were quoted in An Organisation with a Memory and they remain valid today.

What we have seen in the 18 years since is that there has not been sufficient change in blame culture. Far too often we see the most junior and least experienced person, working in challenging circumstances being held completely responsible. The traditional legal system of seeking to blame one individual contributes to this and leading figures are now advocating a just culture.

Traditional management styles are a major factor; traditionally managers like to see themselves as In charge and do not welcome questioning or suggestions on junior staff which could lead to improvements. Too often people who question authority are seen as troublemakers or court told 'this is the way we do things here'. There is a particular problem for rotating junior medical staff who come from a hospital with good systems and moved to hospital which does not function as well. If they say they have seen better practice elsewhere they are accused of being disloyal.
Too many managers see cost control as their major objective, they see clinicians concerns as a lower priority. The chief executives' prime responsibility is to stay within their budget and they are censured for overspending. That has led too many of them to institute cost saving measures often resulting in understaffing leading to inadequate and unsafe care. Again it is the most junior staff who have to deal with the realities which has led to poor workplace morale and rapid staff turnover.
Managers are too often too remote and judge themselves according to how well they have carried out the chief executives cost-cutting measures rather than the quality of care. This is not only my personal view based on many years of experience but also the conclusion of Sir Bruce Keogh following his review of failing hospitals including one where I worked.
At that hospital there was a zealous chief executive determined to reduce costs and had a slogan that 'failure was not an option' and anyone who raised an objection was branded as an enemy, marginalised and their legitimate concerns were dismissed. In meetings where concerns were raised the clinician raising the concern might be ridiculed and attacked personally.
After retiring from the hospital I was elected as a governor and took concerns to the Board of Governors and to the chairman of the board where I found they had many ways of deflecting concerns about quality and safety such as stating there would be a group to look into the problem which would never investigate matters

properly or to claim that the meeting was out of time so concerns could not be expressed. The board of directors had a director with the specific purpose of reputation management and she went out of her way to stifle any discussion which could in any way expose the fact that there's anything wrong with the institution.

8 Are you aware of our 'Just Culture Guide'?

Yes

9 What could be done to help further develop a just culture?

Please provide details:
The most important point is to be proactive and establish good practice with improved management and education throughout the system. The 'Just Culture Guide' becomes operative for the patient safety incident has occurred.
It would be much more valuable to learn from the near miss events and establish improved procedures, it is widely reported that for every adverse event there have been 30 near misses.
There should be a recognition by managers and by hospital boards that professionals for obliged to act in the patient's interests and report anything that is untoward in their care. Professionals also are obliged to seek continuous improvement and this means advising their superiors of areas for improvement.
Staff who report problems should be thanked for their efforts. Reporting of disclosures in the public interest should be safeguarded with a national Office for the Whistleblower, there is currently an all-party group at Westminster looking into this.
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Staff who report problems should be thanked for their efforts. Reporting of disclosures in the public interest should be safeguarded with a national Office for the Whistleblower, there is currently an all-party group at Westminster looking into this. There could be managerial code, akin to the Hippocratic oath making it essential that managers act in the best interests of the patient, this would mean that bullying of staff to achieve financial objectives would be forbidden.
We should consider how we measure success in healthcare by managers and executives, financial management is easy to identify and Board meetings spend a great deal of time on this. Clinical quality however is more difficult to measure and in my experience of board meetings is seldom seen as an important item.
We should reward managers and executives who promote safety and just culture and give this the top priority.

10 What more should be done to support openness and transparency?

Please provide details:
We need to appreciate what is preventing openness and transparency and mostly that is the actions of people who fear they will be blamed. This is true of all grades but it is a particular problem to the more senior staff who have the responsibility for investigation of concerns and corrective action.
We need to state that managers must recognise professionals' responsibility green concerns their attention. We must reassure chief executives and board members that we appreciate the problems will occur and we expect them to investigate them honestly rather than trying to cover up the problems.
There has been a very worrying trend in respect of the commercialisation of some health services which means that commercial operators have used legal tactics such as cleaning trade secrets or commercial in confidence comments to escape proper investigation. Whilst I know of a joint venture between a hospital and an non-NHS company which has had dreadful results it has not been possible to hold the company to account. The company has its own personnel management team which means the hospital is not responsible for personnel management and bullying is commonplace. The turnover is exceptionally high but the hospital appears unwilling to deal with this fact. High turnover of staff means that the staff are not able to work as a consistent team and is well recognised as a quality and safety issue.

11 How can we further support continuous safety improvement?

Please provide details:
By implementing all the recommendations from 'An Organisation With a Memory'.
By recognising why these recommendations have not worked so far, as mentioned above the prevalent management style of managers wishing to appear to be strong and not listening to anything that appears to be critical. In brief giving up the shoot the messenger approach.
By recognising that pressures to meet financial targets are often the cause of understaffing. Working with outdated equipment.
By learning from success, it is surprising that amongst the examples of progress in your document you have not mentioned the excellent work of the Serious Hazards of Transfusion (SHOT) initiative. This has been going since 1998 and has made the most significant improvements in quality and safety of any area in medicine but I am aware of. Their work has resulted in a dramatic reduction of transfusion -related deaths from 15 a year to 5. This has been achieved through putting the principles of constructive parent management to work. I shall be happy to provide more information.
And finally by taking those who express concerns seriously.

Insight

12 Do you agree with these proposals?

No

Please explain your answer:
They do not go far enough - as explained in the answers above - the Insight section of a restatement of best principles that were announced in the year 2000 in An Organisation with A memory and we now have 18 years of experience to show that these well-intentioned recommendations have not been followed through. People who expressed concerns have not been taken seriously and have often been labelled as troublemakers by managers too concerned about defending their position.

13 Would you suggest anything different or is there anything you would add?

Please tell us if you have any suggestions:
Studies in human error have indicated how to design best practice to account for human error. This means a ‘failsafe’ system e.g. it prevents people from operating machinery in a dangerous manner or going through a checklist to ensure the essentials are not forgotten.
We need to redesign procedures along these lines.

Infrastructure

14 Do you agree with these proposals?

Yes

Please explain your answer:
This is a qualified yes because although the proposals are well-intentioned experience shows that safety is not given adequate priority particularly if it involves extra cost. Having advocates and officers does not mean that they will be listened to, safety committee reports can be included in board meetings but the recommendations may be ignored or earmarked for action later and then be forgotten.
The senior safety personnel must have real authority and high-level of subject knowledge. For example in the field of transfusion where a simple error can be fatal. The safety officers must know the subject well enough to understand which slips could be fatal and which inconsequential. To be really effective they will need to study the subjects and areas for which they are responsible and should have their level of knowledge assessed and proved to be competent before they are appointed. This will require time and appropriate funding.
We should also recognise the role of external inspectors and require them to have suitable levels of knowledge and also to understand best practice. Organisations that do not follow best practice will need to have an explanation that includes how they deal with the safety implications.

15 Would you suggest anything different or would you add anything?

Please tell us if you have any other suggestions:
Recognition that safety is everyone’s business and that many professionals have dealt with these issues before. It is crucial that the new safety agenda not only builds on what has been established but recognises what we already know that have not been able to implement because of the barriers referred to above i.e. managerial indifference and financial constraints
The safety specialists must not descend out of the blue with a series of charts and boxes to tick but should first of all ask professionals of the workplace what they see as the barriers.

16 Which areas do you think a national patient safety curriculum should cover? Select your top five answers only.

Human factors and ergonomics, Incident reporting and management, Communication skills, The components of a patient safety culture, Other (please provide details below)

Please provide details of any other areas:
Recognition of professionalism - That the vast majority of NHS professionals, including those working for companies contracted to the NHS do wish to work to the highest standards and often it is the circumstances they are in which forces them to work to lower standards.
If the local managers will not listen to concerns then professionals should be advised to contact their professional body or other organisation which will understand e.g. trade union.

17 What skills and knowledge should patient safety specialists have? Select your top five answers only.

Human factors and ergonomics, Systems thinking, NHS patient safety systems, The components of a patient safety culture

Please provide details of any others:
They should have sufficient workplace experience to know how good ideas can be corrupted and to learn how good theories do not fare well in practice.
They should have displayed sufficient independence of mind to know the difficulties of speaking truth unto power.
Some experience in dealing with the complexities of human interactions in the workplace would be helpful, knowledge of how people behave when threatened would be helpful. So experience in the police force, social work or legal profession could help.
They must know about the nature of the work health service workers do including how and when safety issues arise.

18 How senior should patient safety specialists be?

Executive level (Executive Senior Manager)

19 How can patient/family/carer involvement in patient safety be increased and improved?

Please provide details:
By encouraging patients and others to report concerns. Although this happens at the moment it is difficult for example PALS officers are often too defensive. Concerns are often dismissed or dealt with as trivial.

By having a completely independent reporting system as with the Community Health Council in the past.

20 Where would patient involvement be most impactful?

Other (please provide details below)

Please provide details of any other areas:
Patients should be encouraged to raise their concerns immediately and directly to the person they are in contact with. However this does not always work and too often concerns are dismissed. PALS can be useful but not always.
Having a seat on a CCG board provides a channel for communication but again concerns are too easily dismissed. Although it would be most useful to identify problems at an early stage and then rectify them this does not happen early enough.
Those who identify problems at an early stage can be categorised as scaremongers. Instead problems should be investigated on their merits and that would best be done by having someone on the board of sufficient substance and stature with a track record of speaking truth unto power or they will be marginalised.

21 Would a dedicated patient safety support team be helpful in addition to existing support mechanisms?

Yes

Please explain your answer:
It Could help to raise awareness and give confidence to those with concerns.

Initatives

22 Do you agree with these proposals?

Yes

Please explain your answer:
These proposals are reasonable, it would also help to look at the way that SHOT has made progress and to learn from their approach. As in Q11 Serious Hazards of Transfusion (SHOT) initiative. This has been going since 1998 and has made the most significant improvements in quality and safety of any area in medicine but I am aware of. Their work has resulted in a dramatic reduction of transfusion -related deaths from 15 a year to 5.

23 Would you suggest anything different or would you add anything?

Please tell us if you have any other suggestions:
Encourage reporting of all concerns including those that have not yet resulted in patient harm. This would be analogous to the policy in aviation of investigating near misses as well as actual accidents.

24 What are the most effective quality improvement approaches or delivery models? Select your top three answers only.

National improvement collaborative, Communities of practice

Please tell us of any others:

25 Which approaches for adoption and spread are most effective? Select your top three answers only.

Demonstrating evidence of impact and value, Organisational/peer-to-peer sharing, A national or regional spread programme

Please provide details of any others:
Learn from SHOT a/a Q 11

26 How should we achieve sustainability and define success?

Please provide details:
Reporting systems to include never events and documentable areas of harm.
Patient experience reports.
External investigations to review procedures to ensure best practice is being followed.