NHS Resolution's response to the Patient Safety Commissioner's Consultation 'Principles of Better Patient Safety' 2024

Our answers, set out below, were submitted via the Patient Safety Commissioner's online portal on 2 September 2024

Answers

"About you" questions (most are drop down responses)

1. In what capacity are you responding to this consultation? On behalf of an organisation

2. Where are you based in the UK? England

3. What is the name of your Organisation? NHS Resolution, the operating name of the NHS Litigation Authority.

4. Please tell us what type of organisation you work for? An arm's length body and Other NHS body

Main questions

5. 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.

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

You can provide a brief explanation if desired (optional) Up to 250 words/2000 characters

NHS Resolution strongly support this principle's emphasis on leaders inspiring a just and learning culture in healthcare. As an organisation we continue to promote the benefits of such a culture, where there is a balance of fairness, justice, learning and taking responsibility for actions.

We have published a variety of learning resources focused on embedding a just and learning culture, promoting compassionate conversations and the value of a diverse, person-centred workplace that is compassionate, safe and fair. These resources set out below, including a just and learning charter, may be of use to leaders working to fulfil this principle.

The Commissioner may want to reconsider the language in this principle to ensure that it goes beyond inspiring a just and learning culture and that it acts as a call upon leaders to take meaningful action to create and sustain a safe culture. In addition, we suggest that the consultation and subsequent framework explicitly recognises and accepts a pragmatic approach to continuity of care given the NHS continues to face service pressures and workforce issues.

We are fully committed to supporting the Commissioner and system partners to work on embedding this culture in the NHS.

(1) https://resolution.nhs.uk/resources/being-fair/
(2) https://resolution.nhs.uk/2023/03/30/being-fair-2-improving-organisational-culture-in-the-nhs/
(3) https://resolution.nhs.uk/resources/saying-sorry/
(4) https://resolution.nhs.uk/2023/06/22/launch-of-just-and-learning-culture-charter/

6. 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.

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

You can provide a brief explanation if desired (optional) Up to 250 words/2000 characters

NHS Resolution fully support this principle - it is vital that the patient's voice is central to decision-making and informed consent.

Of potential interest to the Commissioner, we have several learning resources that support this messaging that could be shared with leaders as useful training resources. Released in 2020, we worked with one of our legal panel firms to produce educational videos to support general practice staff to better understand the process of patient consent. (1)

We have also published resources to help the system better understand the legal context of the issues associated with consent following the 2015 *Montgomery* ruling. (2)(3) On the topic of consent, it was important for us to share the experience and reflections of Nadine Montgomery herself, who we interviewed for our website. (4)

In the maternity space, alongside working directly with independent family groups to listen to the patient voice we also work closely with our Maternity Voices

Advisory Group. (5) The group is made up of key external stakeholders, families and their representatives. We have found this a beneficial way to hear the experiences of the families involved which has helped us improve our Early Notification Scheme (6) and how we engage with families, including developing new forms of communication incorporating family feedback.

(1) https://resolution.nhs.uk/resources/supporting-general-practice-consent/
(2) https://resolution.nhs.uk/resources/consent-legal-context/
(3) https://resolution.nhs.uk/resources/an-introduction-to-nadines-story/
(4) https://resolution.nhs.uk/resources/nadines-story-consent/
(5) https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/early-notification-scheme/maternity-voices-advisory-group/
(6) https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/early-notification-scheme/

7. 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.

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

You can provide a brief explanation if desired (optional) Up to 250 words/2000 characters

NHS Resolution strongly agree with this third principle. Treating all involved with fairness, respect, equality and dignity underpins our just and learning work mentioned above.

From a litigation perspective you might be interested in our 2018 research conducted with the Behavioural Insights Team. (1) It found that one of the main motivators for pursuing a claim was the desire to receive an explanation of the incident. Some interviewees suggested that if the initial process had been better handled, they may not have pursued their claim.

It is vital that when things go wrong staff are treated fairly to enable them to be open about what happened and feel confident to speak up, without fear of being blamed. (2) (3) (4) Placing an emphasis on the importance of listening to the feedback of patients, families, carers and staff, as this principle does, could improve patient care, prevent future claims and preserve important resources for patient care.

The Commissioner may want to add carers in the list of individuals highlighted in this principle. We note that carers are included in other Commissioner workstreams such as Martha's rule. Their inclusion would support consistency and prevent confusion amongst leaders. We would also suggest that it would be appropriate to recognise the important role of the family, staff and carers in the first sentence alongside patients.

(1) https://resolution.nhs.uk/wp-content/uploads/2018/10/Behavioural-insights-into-patient-motivation-to-make-a-claim-for-clinical-negligence.pdf
(2) https://resolution.nhs.uk/wp-content/uploads/2018/09/NHS-Resolution-Saying-Sorry-2023-2.pdf
(3) https://resolution.nhs.uk/wp-content/uploads/2019/07/NHS-Resolution_Being-fair-Website2.pdf
(4) https://resolution.nhs.uk/wp-content/uploads/2023/03/Being-fair-2-final-1.pdf

8. 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.

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

You can provide a brief explanation if desired (optional) Up to 250 words/2000 characters

NHS Resolution strongly agree with this principle which is consistent with many important ongoing programmes and initiatives in the healthcare space.

As an organisation we are committed to exploring opportunities where we could support a greater understanding of health inequalities and how these can be acted upon as set out in *Our strategy to 2025: Advise, Resolve and Learn*. (1)

The Commissioner may want to be cognisant of the challenges organisations may face collecting and sharing ethnicity and demographic data to help identify and act on health inequalities.

(1) https://resolution.nhs.uk/wp-content/uploads/2022/05/NHSR-Our-strategy-to-2025.pdf

9. 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.

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

You can provide a brief explanation if desired (optional) Up to 250 words/2000 characters

It is important that the healthcare system can learn from mistakes and enable staff to proactively identify risks. In relation to the latter, the success of this principle will rely heavily on the implementation of the just and learning culture set out in the previous principles. Such a culture allows staff to feel safe raising concerns and identifying risks.

From NHS Resolution's perspective, although we are not a regulator, there is a real opportunity to share learning from harm, compensation claims and our Practitioner Performance Advice cases (1) to prevent future incidents. The leaders being asked to implement the Commissioner's principles may also be especially interested in the work of our Safety and Learning team. (2) The team work closely with our scheme members to help them better understand their claims risk profiles so they can target their safety activity appropriately. (3) The team also engage with the broader healthcare system through free educational events, publishing thematic reviews and case stories using claims data on a particular issue.

To best support the uptake of this principle, the Commissioner might want to openly acknowledge the complexity of the landscape when it comes to escalating patient safety concerns. It would be a positive step if this consultation and the creation of the principles could act as an opportunity or lever to clarify escalation pathways at a national and regional level.

(1) https://resolution.nhs.uk/services/practitioner-performance-advice/
(2) https://resolution.nhs.uk/services/safety-and-learning/
(3) https://resolution.nhs.uk/services/safety-and-learning/claims-scorecards/

10. 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.

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

You can provide a brief explanation if desired (optional) Up to 250 words/2000 characters

As mentioned in our discussion of principle one, embedding the right culture is essential for supporting patient safety. One way to support healthcare providers to be honest, open, transparent and respectful is to have an embedded culture of safety.

The Commissioner and leaders may be interested in our 2017 publication *Saying Sorry*. (1) The resource makes several things clear: that not only is saying sorry when an incident has taken place the morally right thing to do, it is also a statutory, regulatory and professional requirement. We make clear that saying sorry is (i) always the right thing to do; (ii) not an admission of liability; and (iii) the first important step to learning from what happened and to prevent it from recurring. This resource may help leaders better understand the principles and how they may apply in practice.

The Commissioner may want to work with system partners to understand any limitations or challenges posed by the duty of candour. In 2022 we published our Duty of Candour animation offering guidance on the importance of being open and honest and how the two duties (statutory and professional) can be fulfilled effectively. (2) Based on our Safety and Learning team's ongoing engagement with healthcare providers, we understand that there is a tendency for healthcare professionals to focus on the minutiae of the statutory duty rather than recognising the important, overarching purpose to direct health and social care providers to be open and transparent with people receiving care.

(1) https://resolution.nhs.uk/wp-content/uploads/2018/09/NHS-Resolution-Saying-Sorry-2023-2.pdf
(2) https://resolution.nhs.uk/resources/duty-of-candour-animation/

11. 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.

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

You can provide a brief explanation if desired (optional) Up to 250 words/2000 characters

It is positive to see the inclusion of this principle as we strongly agree that the proper use of good quality data offers excellent opportunities to drive improvements to healthcare and patient outcomes.

Although we are reading all the principles as interconnected, we think this principle is most strongly linked to principles one and four. Having a health system underpinned by the proper sharing and use of good quality data can

assist in evaluating organisational culture and support the identification of risks, hazards and improvements – supporting data driven decision-making.

The Commissioner and leaders may be interested in our work in this area. We hold one of the largest databases of healthcare-related compensation claims in the world, complemented by data on practitioner performance concerns and the causes of contracting disputes in primary care. We have a duty to use this information responsibly to drive positive change for patients and staff. (1) However, we are only one part of the picture, this is why principle seven is important to ensure sharing data is kept at the forefront of leaders' minds when they are providing, commissioning or regulating care.

We ask that the Commissioner is cognisant of the general challenges in extracting key insights from datasets and sharing certain pieces of data across the system. In particular, collecting and sharing data relating to specific groups of people and protected characteristics. It would be helpful for the Commissioner to highlight this and refer leaders to information and support to help fulfil this principle.

(1) https://resolution.nhs.uk/wp-content/uploads/2022/05/NHSR-Our-strategy-to-2025.pdf

Importance

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

Given the principles are deeply inter-connected and we did not want to de-prioritise any, we did not answer this optional question.

Additional areas

13. Do you wish to highlight any other areas not covered by the draft principles that you think should be included in our final version? (optional)

We have provided suggestions on specific changes to the individual principles above.

In general, when the principles are formalised into a clear framework for decision-making, planning and collaborative working we would urge the Commissioner to consider and set out how leaders should be supported by the Commissioner to implement the principles. Furthermore, it would be helpful to develop guidance on how organisations such as NHS Resolution can support the successful implementation and embedding of the principles across the system.

Usefulness

Overall, how useful do you think these principles will be as a guide for senior leaders?

Please indicate to what extent you agree or disagree with the following statements:

Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree

14. The principles will be useful when taking strategic decisions- Agree

15. The principles will be useful when designing services- Neither agree or disagree

16. The principles will be useful when making individual decisions about patient care- Neither agree or disagree

17. The principles will be useful when responding to a concern from a patient – Neither agree or disagree

18. The principles will be useful after an adverse event - Agree

19. The principles will be useful in supporting staff development - Agree

20. If you wish to explain any of your answers above, please do so here (optional)

We have focussed our responses on the areas where NHS Resolution has a system role/perspective. We have not commented on the application of the principles to the design of services, or individual clinical decision making (15, 16, 17). We suggest that the usefulness of the principles is assessed at regular intervals following implementation by engaging directly with the leaders asked to utilise them.

Additional comments

21. If you wish to include any final comments, please do share here (optional)

This is an important consultation for the patient safety system, coming to a shared understanding of the issues that face us is fundamental to driving important change. We hope that these principles will provide a solid foundation on which we can collectively build improvements to patient safety. We are committed to supporting the Commissioner and system partners with this important work and are happy to be part of any further discussion in relation to this consultation and work with you to progress further.

Reflecting on all the principles we would suggest that the Commissioner consider how the language and content sits alongside pre-existing recommendations and principles in the system such as the NHS Constitution, the General Medical Council's Good Medical Practice and Nursing and Midwifery Council's Code. It would be beneficial if recommendations and advice in the healthcare system are as co-ordinated and simple to follow as possible to mitigate any risk of confusion or dilution.

Please note that in relation to our answer for question 2 "Where are you based in the UK?" in addition to England our Practitioner Performance Advice function also provide services in Wales, Northern Ireland etc.

In case the Commissioner or leaders are interested in the purpose and role of NHS Resolution, they can find out more on our website: https://resolution.nhs.uk/