To: Mr Steve Brine MP, Chair, Health and Social Care Select Committee and Mr William Wragg MP, Chair, Public Administration and Constitutional Affairs Committee

cc. Rob Behrens CBE, Ombudsman and Chair, Parliamentary and Health Service Ombudsman

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

10 January 2024

Dear Mr Brine and Mr Wragg

Response to PHSO patient safety report *Broken trust: Making patient safety more than just a promise*

Please accept our apologies for the delay in responding. I am writing to provide the response on behalf of NHS England to the Parliamentary and Health Service Ombudsman's request for an update on progress against recommendations from the report on patient safety, *Broken Trust: Making patient safety more than just a promise*. The report acknowledged the significant developments in patient safety over the last decade but raised concerns which are important for us to reflect on; namely the quality of safety investigations, how to involve patients and families in patient safety, and the challenges of embedding a safety culture across the NHS. Addressing these issues are key tenets of the National Patient Safety Strategy, and this report highlights the importance of that work.

The introduction of the Patient Safety Incident Response Framework (PSIRF) represents a fundamental shift in how the NHS responds to patient safety incidents for learning and improvement. We welcomed the report's positive comments on the Patient Safety Incident Response Framework (PSIRF), and would add that early adopters have said it is helping to improve safety cultures, with more focus on improving practice to reduce the risk of future harm.

We also fully support the central message of the report; involving patients and families in patient safety, and supporting a just culture across the NHS. The theme of this year's World Patient Safety Day was 'Elevating the voice of patients' which is closely linked to the *Framework for involving patients in patient safety* and provided an opportunity to showcase our work to date, and a reminder to maintain our focus on this going forward.

The medical examiner system was mentioned briefly, but the vital role medical examiners are playing to support bereaved families should not be underestimated. Since the roll out of

the medical examiner system in 2019, medical examiners are providing independent scrutiny of nearly all non-coronial deaths in acute settings and a growing number of deaths in non-acute settings. This provides not just an independent review of records to detect issues or concerns, but an opportunity for bereaved people to ask questions and raise concerns. The feedback from bereaved people has been overwhelmingly positive.

Finally the report commented on a 'disconnect between increasing levels of activity and consciousness about patient safety and the level of progress we see on the front line'. The NHS Patient Safety syllabus is seeking to address this. It is building knowledge, capability, and capacity in systems thinking and safety culture, through the creation of the first system-wide standardised approach to training and education in patient safety across the NHS. The training includes a module for Boards and senior leaders to increase Board capability in safety measurement, governance in patient safety, and leading a just culture.

The report included a number of recommendations addressed to NHS England and a request for us to write to the Health and Social Care Select Committee and the Public Administration and Constitutional Affairs Committee within six months of the publication date. Below we have set out our responses to the relevant recommendations:

Accountability for a robust and compassionate response to harm, which supports learning for systems and healing for families

Recommendation 1: Integrated care boards, with oversight from NHS England, should closely monitor the impact of the PSIRF to identify any negative consequences of the new flexibility it offers, which gives Trusts more autonomy to decide when a patient safety investigation is needed. This should include paying special attention to the balance of patient safety investigations versus other learning responses in Trusts (or service areas of a Trust) where there are poor CQC ratings for safety and leadership, or where other national bodies have raised concerns

NHSE welcome the PHSO's focus on oversight. PSIRF brings key changes in this area. The PSIRF Oversight roles and responsibilities guide outlines the specific roles of provider boards, ICBs and NHS England as well as the mindset principles that should underpin the oversight approach.

The document describes five roles for ICBs including overseeing effectiveness and supporting systems to achieve improvement following patient safety incidents. We would caution against paying attention solely to the methods used to learn from patient safety incidents, and indeed the extent one method is selected over another. There is no one size fits all when it comes to choosing an appropriate response method; a method applied in one context may not be appropriate in another and in some contexts a patient safety incident investigation may not be appropriate.

It is not the case that more investigations lead to more learning and improvement; we are more concerned with whether organisations are applying the various available methods in an appropriate way. ICBs should pay particular attention to whether learning responses are conducted in a way that gains trust and builds psychological safety, and that generate actionable insight that reduces future risk. Rather than counting the ratio of PSIIs to swarm huddles, for example, ICBs should focus on whether an organisation's approach to incident response captures learning to inform the development of meaningful actions and whether these actions are implemented and monitored within a wider system of improvement (which the ICB should also work to support). When looking at the methods used, ICBs should ensure organisations are steered away from bureaucratic form filling that adds unnecessary burden and turns reflective learning responses into a tick box exercise.

Where there are concerns about the safety and leadership of an organisation flagged by CQC or other national bodies, ICBs should provide constructive support, working with relevant partners to help the organisation improve. This should not lead to ever more intensive scrutiny on the numbers of incidents recorded and investigations conducted but should be a catalyst to identifying the underlying challenges an organisation is facing, and supporting them to take positive actions to improve.

It is worth noting that the overall feedback on PSIRF implementation so far is that it increases the amount of safety learning and improvement activity that providers undertake.

Recommendation 2: As part of their quality monitoring role, the PSIRF executive lead on each Board should look at any discrepancies between local and PHSO investigations, or other independent investigations, and make sure the Board discusses them. This should include where local investigations did not take place, or did not find that things went wrong, but PHSO or another independent oversight body later identified failings.

PSIRF executive leads have a key role to play in oversight of the quality of patient safety incident responses within their organisation. We support the requirement for discussion and consideration when learning responses conducted by external bodies find additional areas for improvement that may not have previously been considered. We would like to extend this to ensure PSIRF executive leads also consider how the additional findings might be integrated into organisational governance processes to contribute to generating meaningful improvements.

However, it is important to recognise that new findings highlighted in learning responses conducted by external bodies may not necessarily indicate that the original response was of lesser quality but simply that the focus was different. Learning responses, including patient

safety incident investigations, are necessarily constrained by the agreed scope and purpose, or specific terms of reference where created. This is to ensure the learning response is focused and can contribute to the production of meaningful improvements and is an approach widely used by independent investigation branches such as the Healthcare Services Safety Investigations Body (HSSIB). A learning response with different terms of reference or a different lens applied (e.g., a different system-based framework) will likely highlight different areas for improvement.

It is also quite possible for similar learning processes conducted by different teams at different times to reach different conclusions irrespective of the quality of the learning response.

Recommendation 3: The Department of Health and Social Care and NHS England should further scrutinise the lack of compliance with duty of candour. They should review the operation of duty of candour to assess its effectiveness and make recommendations for improvement

The Duty of candour regulation is set by the Department of Health and Social Care, with implementation overseen by the CQC as part of the Fundamental Standards of Quality and Safety, and covered under the regulations they assess. It is therefore not within the remit of NHSE to determine whether the current requirements for the Duty of Candour are effective, however NHSE would welcome the opportunity to contribute to any review undertaken by DHSC or CQC.

Yours sincerely,

Professor Stephen Powis
National Medical Director]

Dr Aidan Fowler
National Director for Patient Safety