Patient Safety and the 10 Year Plan for the NHS

Submission from the All-Party Parliamentary Group on Patient Safety

February 2025

Executive summary

Unsafe care continues to take an immense human, societal, and financial toll on the NHS. An estimated 13,500 lives could be saved each year if the NHS matched the performance of the top 10% of OECD countries and international experts say unsafe care costs the system over £14 billion annually. The path to safer care is also the path to lower cost as well as an ethical imperative. As the NHS confronts unprecedented waiting lists, it is vital that a focus on waiting times does not reintroduce the targets culture that did so much damage during the period of Mid Staffs.

As we change the way the UK delivers healthcare for the 21st century, developing the most effective, evidence-based systems can help us match the performance already being achieved in other countries, saving lives and reducing costs at the same time. This must be at the heart of the new 10-year plan.

This report sets out three key areas where a focus on patient safety will save both lives and money:

1. Make patient safety a system goal in the 10-year plan
2. Develop a workforce with the skills and culture to improve patient safety
3. Measure and report on critical patient safety issues

Key recommendations:

1. Making patient safety a system goal in the 10 year plan

a) Create a comprehensive, unified patient safety management & oversight system.

There are a great many risks in healthcare which could be better managed, if all the information and lessons gathered from investigations could be prioritised and implemented through a single process. Currently the system is good at writing numerous reports but poor at implementing the recommendations they contain. The Health Services Safety Investigation Body (HSSIB) is legally established to be independent; it is free of conflicts of interest and is therefore best placed to lead in this role. Its statutory duty is to learn from failures in patient safety without finding blame, and to make recommendations to improve patient safety across the whole of healthcare. But its role needs to be complemented with a proper system to make sure recommendations are actually implemented which currently they are not.

b) Commission an independent review of the current clinical negligence & litigation system considering the relative risks and benefits of alternatives

The current system of litigation for patients who have suffered harm is expensive, protracted and stressful for harmed patients and their families and for the healthcare workers involved. It costs the NHS over £4 bn a year but instead of leading to better outcomes the process often compounds the initial harm. The NHS should commission an independent review to examine whether the approaches used in countries like Sweden, New Zealand and Japan could save both lives and money. Better systems for supporting harmed patients and for improving learning from events should be included as a fundamental part of this.

c) Set a new national ambition for maternity safety as the 2025 ambition comes to an end.

A *new national ambition for maternity safety should serve as a unifying goal, guiding all other initiatives within maternity. The ambition should be supported by transparent reporting at all levels, from individual units to national bodies, to ensure accountability and continuous improvement. It should be a strategy not a target.*

2. Committing to securing a workforce with the skills and culture to improve patient safety

a) Ensure chartered human factors professionals are available to national and local healthcare teams.

Human factors is the science of simultaneously improving both efficiency and safety through good design and optimising teamworking. Aviation, nuclear power, rail, and offshore oil employ chartered human factors professionals as an essential part of their teams to ensure that when designing infrastructure and systems their businesses stay safe, reliable and remain cost effective. Healthcare must embrace human factors to match these industries and put an end to the repeated stories of poorly designed wards, inadequate computer systems and dysfunctional teams leading to patient harm.

b) Establish a national improvement support team for patient safety staffed with suitably qualified and experienced professionals

Problems faced by failing hospitals are at the heart of NHS safety issues. A system of rapid support is needed that can be called upon when serious safety issues have been identified by the CQC or other regulatory bodies. A team of suitably qualified people should be available to support safety improvement work in person, on site wherever they are needed.

c) Make it a requirement for there to be a director of patient safety on every board

Boards are rightly required to have a director of finance, a medical director and a director of nursing but there is no such requirement for a director of patient safety. The unintended consequence of this is that the financial security and staffing needs of NHS organisations are seen to be given a much greater priority than patient safety. Mandating every board to have a suitably qualified and experienced professional responsible for patient safety would start to redress this imbalance, bringing a similar focus to patient safety as is seen in other areas.

3. Measuring and reporting on critical patient safety issues

a) Streamline the process for issuing and responding to patient safety alerts and recommendations

The NHS is not keeping pace with the large number of recommendations and patient safety actions being published. Multiple recommendations from national inquiries remain to be addressed in healthcare organisations across the country. With no steer on where to place limited resources, organisations may take "easy wins" rather than identifying where the greatest benefit is likely to be achieved. A taskforce should be established to review the current list of required actions across the whole system. Those which pose the greatest risks to patient safety should be prioritised and a clear delivery plan developed.

b) Include the views of patients and staff when collecting data on safety issues.

Data is collected from NHS staff in a variety of ways including the national staff survey, local hospital and departmental surveys and other initiatives such as wellbeing surveys. Data is collected from patients via local satisfaction surveys and, since 2013, via the national NHS Friends and Family Test. The enormous amount of data collected should be used in a structured way to contribute to a local and national understanding of safety issues.

c) Develop a set of validated safety metrics and publish a national patient safety dashboard

Identifying services in difficulty, including those that pose a risk to patient safety is difficult. This means that problems often remain hidden until they become serious; sometimes they are uncovered only after episodes of significant patient harm. A carefully developed and regularly reviewed dashboard, capturing data on core validated patient safety indicators would pick up struggling departments sooner, allowing early interventions to improve safety and reduce harm.

Discussion

The All-Party Parliamentary Group for Patient Safety was established in November 2024. The group's aims are to help make health and social care safer by promoting best practice, transparency, accountability and reliable, safe systems. This submission reflects the collective views of APPG members and has been written with assistance from the APPG secretariat. We hope that the submission will assist the Department of Health and Social Care as it works to develop the 10-year Health Plan for the NHS.

Recent research carried out by Imperial College London (commissioned by Patient Safety Watch) sets out the human, societal and economic cost of clinical harm in the NHS. The research found that the costs of unsafe care in England (excluding the indirect impact of harm, such as on people's quality of life and ability to work, and the rising costs of clinical negligence claims) can be conservatively estimated at **£14.7 billion per year**. The work also found that if the UK matched the top 10% of OECD countries for deaths from treatable causes (such as sepsis and blood clots) then this would equate to **13,495 fewer deaths per year**.

The 10-year plan must therefore have a significant focus on patient safety as well as efficiency.
To create and maintain safety, healthcare services need to be designed as well as possible, outcomes must be measured, data published, and guidance provided on how to prioritise improvements. Expert skilled assistance should be available where improvement work is proving difficult and support for harmed patients and families needs to be prioritised when care has gone wrong.

Many bodies in and around the NHS investigate clinical incidents and avoidable deaths in our health system. Between them, they spend significant sums of money, but with varying benefits to safety management and the safety culture. A unified system of safety management, which exists in other safety critical sectors of our society, such as in transport, or nuclear power, would bring clarity about how lessons learned should be implemented. The Health Services Safety Investigation Body (HSSIB) is legally established to be independent and has a statutory duty to learn from failures in patient safety without finding blame and is best placed to lead in this role across the whole of healthcare.
The complexity of healthcare and the multiplicity of risks present particular challenges to safety management, but this strengthens the case for adopting this approach. HSSIB has no role in setting health policy, or managing or funding healthcare, this independence makes it the ideal body to be at the apex of the healthcare safety system. *[recommendation 1a) Create a unified patient safety management and oversight system]*

Effective, compassionate, patient-centred and safe care is the standard everyone who uses the NHS deserves, and it is the standard that dedicated, hard-working healthcare professionals strive to deliver. This cannot be achieved without an aligned and supportive wider infrastructure; including sufficient investment, national leadership and a regulatory landscape that effectively senses problems and supports improvement. The demands and expectations from the public have never been higher and the 10-year plan must build trust and confidence in the NHS. To do this, the priority must be on ensuring healthcare organisations adopt and implement safe systems of care but also ensure that when harm does occur, the response is characterised by candour, compassion (ideally through a restorative lens of practice) and crucially, learning and improvement.

Too often we hear of cases of patients being harmed only to find that NHS organisations then failed to engage in supporting them to understand what happened and failed to provide clarity as to what improvements would be made to prevent similar harm happening to other people.

When things go wrong in healthcare, the response from the NHS must be to prioritise learning as well as providing compassionate support for those affected. In addition to a system-wide 'just culture', where staff can be confident that the response to patient safety events will focus on system learning and avoid blame, the response to harm also needs to enable those affected to heal and recover as best they can.

Harmed patients and their families often feel they have to resort to litigation to get their voices heard and their questions answered. The process is long, difficult and expensive, and being adversarial in nature always has a loser which will either be the NHS or the patient. Restorative practice aims to promote learning, healing and reconciliation between patients' families and care providers and provide the support that the harmed parties want and need.

There should be an independent review of the current litigation system, investigating the impact the current system has on patients, parents and families that go through it. The review should examine the role of the litigation system in terms of patient safety learning and whether the current system could be improved. The possibility of alternative equivalently funded systems, for example 'no fault' schemes (as have been implemented in countries such as Sweden and Japan), could also be considered as an option for the NHS, along with initiatives such as the Harmed Patient Pathway project[4] which could be supported through funded trials. *[recommendation 1b) Commission an independent review of clinical negligence and litigation]*

The 2024 National State of Patient Safety report: Prioritising improvement efforts in a system under stress highlighted that for the first time in a decade, rates of maternal and neonatal deaths have risen and that the maternal death rates for women from Black ethnic backgrounds are almost three times higher than for White women. The new 10-year plan for the NHS must ensure that reversing these trends, addressing inequality, and improving patient safety is at the very core of its purpose. Over many years there have been repeated maternity investigations identifying similar failings but there is no national framework to determine how to respond when serious concerns about maternity safety in specific service emerge. Developing such a framework would help provide objective assessments and identify actionable recommendations for struggling services. There should be clearer processes for establishing such investigations, including factors such as concerns raised by parents and families, concerns raised by staff (including whistleblowers), insights and intelligence from national data and regulatory and oversight bodies (such as the NMC, CQC and MNSI).

A new national target to reduce harm in maternity services should be established as the 2025 targets come to end. This should include clear metrics and a robust system for monitoring progress supporting the ambitions proposed by the joint Sands and Tommy's joint policy unit , with a deadline of 2035 to align with the 10-Year Plan for the NHS in England: A stillbirth rate of 2.0 stillbirths per 1,000 total births, a neonatal mortality rate of 0.5 neonatal deaths per 1,000 live births for babies born at 24 weeks' gestation and over, and a preterm birth rate of 6.0% with inequalities in these outcomes based on ethnicity and deprivation addressed. *[recommendation 1c) Set a new national ambition for maternity safety]*

There is no doubt that within healthcare, clinical staff and board members alike care passionately about providing the safest services they are able to deliver. The traditional model for achieving this in medicine has been through striving for individual excellence. With the increasing complexity of healthcare delivery in the 21st century where multidisciplinary teams routinely provide combined care across community, primary, secondary and tertiary services and social care, trying to ensure safety by relying on highly performing individuals is no longer effective. Safety now increasingly depends on an understanding of complex systems and ensuring that all systems are designed optimally to support the

multiple healthcare professionals who are involved in looking after any one individual patient or family. It is unrealistic to expect the majority of clinical staff and senior non-clinical healthcare managers to have expertise in systems engineering, digital safety, and building design which are all needed to ensure patient safety in the modern era. Other safety critical industries (aviation, nuclear power, rail, offshore oil) routinely employ human factors professionals in their organisations to manage these risks alongside the subject matter experts who are delivering the services 'on the ground'. Despite many healthcare organisations (including the Care Quality Commission, Department of Health and Social Care, Health Education England, The Parliamentary & Health Service Ombudsman for England, NHS Employers, NHS England, National Institute for Health and Care Excellence, General Medical Council, Nursing and Midwifery Council and others) recognising the value of human factors science in improving safety and signing up to the "human factors in healthcare concordat" in 2013 there has been little progress in ensuring that the expertise of human factors scientists is routinely available to (and used by) the NHS to improve safety.

We must now fully embrace human factors as an essential part of the NHS to ensure that when designing infrastructure and systems, healthcare stays safe, reliable and remains cost effective, and we can put an end to repeated stories of poorly designed wards, inadequate computer systems and dysfunctional teams leading to patient harm. *[recommendation 2a) Ensure chartered human factors professionals are available to national and local healthcare teams]*

The Patient Safety Incident Response Framework (PSIRF), piloted in 2019 and rolled out from 2022-24 uses a systems-based approach to investigation. This helps local investigators identify the wide variety of contributory factors that interact and can eventually lead to patient harm. Basic PSIRF incident investigation training has been made available to patient safety specialists and to governance teams through NHS England and through HSSIB. A parallel initiative, Learning from Patient Safety Events also uses human factors / system investigation tools to help understand safety events at a local level (albeit with the possibility of voluntary reporting to a central database). Unfortunately, the training given and the tools used do not routinely include methods for determining how to manage or reduce risks that have been identified during investigations. A direct healthcare analogy would be a clinician who has been taught to diagnose a medical condition but has not been taught how to treat it. A similar problem, on a larger scale, can be seen with failing hospitals or failing services identified by the CQC or other regulatory bodies. Reports may be written highlighting areas requiring improvement but the teams in those organisations may not have the skills to make the improvements that are needed. Problems faced by failing organisations are at the heart of NHS safety issues. A system of rapid support is needed that can be called upon when serious safety issues have been identified. A trained team of suitably qualified and experienced professionals should be available to support safety improvement work in person, on site wherever they are needed. *[recommendation 2b) Establish a national improvement support team for patient safety]*

Under current NHS systems, responsibility for patient safety is distributed through organisations with the ultimate responsibility lying with the Chief Executive Officer. This responsibility is usually and necessarily derogated to the medical director, an associate medical director, or the director of nursing. In practical terms however, accountability for patient safety is routinely devolved to the head of the governance team, and people working in the newly created 'patient safety specialist' role. Basic level training has been made available for governance teams and patient safety specialists in a scheme devolved by NHSE to Loughborough University, but the perceived value and usefulness of this short course training has been questioned and is the subject of an independent evaluation by investigators from the University of Leeds. The NHS (rightly) would not accept a situation where an organisation did

not have a director of finance or where the director of finance did not have a formal qualification in finance / accounting. Similarly, hospitals are required to have a suitably qualified medical director and director of nursing. The current approach to patient safety is out of step with this. Boards are rightly required to have a director of finance, a medical director and a director of nursing but there is no such requirement for a director of patient safety. The unintended consequence of this is that the financial security and staffing needs of NHS organisations are seen to be given a much greater priority than patient safety. Mandating every board to have a suitably qualified and experienced professional responsible for patient safety would start to redress this imbalance, bringing a similar focus to patient safety as is seen in other areas. *[recommendation 2c) Make it a requirement to have a Director/ NED responsible for Patient Safety on every Board]*

The NHS is not keeping pace with the large number of recommendations and patient safety actions being published. Multiple recommendations from national inquiries remain to be addressed in healthcare organisations across the country. This failure can compound harm to patients and can impact public confidence in the healthcare system. With no steer on where to place limited resources organisations may not be able to identify which recommendations are likely to provide the greatest benefits and may therefore take "easy wins" with limited value in improving care.

Most safety recommendations do not require a formal response from healthcare organisations and a lack of monitoring means there is no opportunity to support organisations where changes have not been made. Even where formal responses are mandated by law such as with Coronial Prevention of Future Deaths reports, less than half of the 400-500 reports written each year receive a response to the coroner within 56 days. At a local level only a minority of hospitals comply with their statutory duties in relation to Learning from Deaths reviews, including the obligation to estimate and publish the number of preventable deaths in their organisations. There are some independently funded systems monitoring compliance with recommendations such as the Preventable Deaths Tracker but this is the exception rather than the rule. Formalised guidance on the creation, implementation and monitoring of recommendations, with appropriate funding, would help provider organisations manage nationally identified risks much more effectively than they are currently able to do. *[recommendation 3a) Streamline the process for issuing and responding to patient safety alerts and recommendations]*

The recently introduced Patient Safety Incident Response Framework has brought the opportunity for a change in the way healthcare organisations manage patient safety. Hospitals now have more autonomy to focus on emerging areas of concern identified locally through reviewing near misses and tracking trends in data collected automatically through electronic patient records such as early warning scoring systems. This is a valuable step forwards from concentrating almost exclusively on a prescribed list of serious but rare events but still misses out on an opportunity to include insights from patients and staff to areas in organisations that are beginning to struggle to provide safe care.
Data is collected from NHS staff in a variety of ways including the national staff survey, local hospital and departmental surveys and other initiatives such as well-being surveys collected at organizational levels. Staff do not always feel safe speaking up or using organisational systems such as Datix when they identify risks to patient safety. The NHS must ensure staff are properly cared for, in a culture that prioritises learning and candour and where speaking up about patient safety problems or concerns is not just permitted, but actively encouraged and rewarded. Freedom to Speak Up Guardians and the National Guardian were established in 2016, following the events at Mid-Staffordshire. These roles should be reviewed to identify what has worked well, and what could be improved to ensure speaking up in the NHS becomes routine. Data is collected from patients via local satisfaction surveys and since 2013 via the national NHS Friends and Family Test.

The enormous amount of data collected is not consistently used in a structured way to contribute to local and national understanding of safety issues. Using this information and triangulating it with other sources of safety data would provide an opportunity to develop a much-improved safety management system. *[recommendation 3b) Include the views of patients and staff when collecting data on safety issues]*

Access to accurate, transparent and timely data on patient safety is crucial in order to identify problems early and to prioritise improvement efforts effectively. With the benefit of hindsight, unsafe care can be clearly seen and measuring patient harm is then frequently used (incorrectly) as a surrogate for the safety of care. Individual organisations choose different harm metrics at different times to focus on aspects of care that they consider are in need of improvement (falls, MRSA infections, complaints, unplanned returns to the operating theatre and others). Various metrics have been used at a national level in similar ways over the years including waiting times, cancer outcomes and standardized mortality ratios. While measuring against these standards can be helpful in determining if individual aspects of care are improving or worsening, they are not in themselves reliable indicators of organisational safety. Identifying services in difficulty, including those that pose a risk to patient safety is problematic, meaning that unsafe services are sometimes uncovered only after episodes of significant patient harm. Identifying measures that correlate with safety is possible and a carefully developed and regularly reviewed dashboard which captured data on core validated patient safety indicators could pick up struggling organisations sooner. This would allow earlier interventions to improve and maintain safety. *[Recommendation 3c) Develop a set of validated safety metrics and publish a national patient safety dashboard]*

There is already a great deal of good work which will feed into the 10-year plan including the 2023 NHS long term work force plan, the ongoing Thirwell inquiry, Sir Gordon Messenger's review and more. The Darzi review which is pivotal to the 10-year health plan inevitably drew from his National State of Patient Safety 2024 report and it is important that in line with this we make patient safety a system goal in the 10-year plan; commit to securing a workforce with the skills and culture to improve patient safety and measure and report on critical patient safety issues.

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