

**Dr. Aidan Fowler**

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Dear Aidan,

**Consultation on the new patient safety strategy**

I am writing in response to NHSI's consultation on the new patient safety strategy. The aim of the strategy – to make the NHS the safest healthcare system in the world – is ambitious and one that the BMA shares. We believe the three underpinning principles outlined in the consultation are vital to delivering it – a just culture, openness and transparency, and a drive for continuous improvement.

The BMA has been engaging in a conversation with our members over the past year to hear their current experiences and ideas for how we move towards an NHS that delivers excellent patient care, provides a supportive working environment, and encourages collaboration across primary and secondary care. Through our [Caring, Supportive, Collaborative project](#) we are discussing issues that are highly relevant to the development and implementation of the new patient safety strategy. We are hosting a roundtable on culture, one of the project's themes that will cover barriers to patient safety, on 7 March. You have been invited and I do hope that you can join us. Below are some initial comments in response to the consultation paper but I look forward to hopefully discussing issues in more depth at the roundtable.

**1. Aims and principles**

As already stated the aims and principles set out in the consultation are ones that we support. The strategy needs to acknowledge, however, the scale of the current pressures in the system and the persistence of a culture of fear and blame. These are significant barriers to realising these principles in practice and delivering safe care. Last year, the BMA carried out a wide-ranging survey, which nearly 8,000 doctors and medical students responded to. Some of the findings highlighted that there had been little progress towards creating a just culture since the Berwick report was published five years previously:



- 95% of doctors were occasionally or often fearful of making an error and over half (55%) said that they were more fearful now than when the Berwick report came out (40% said they were as fearful and only 9% said they were less fearful).
- The main reason given for being likely to make errors was pressure or lack of capacity in the workplace (89%), followed by system failings (59%) and human error (59%).
- The majority of doctors (59%) said they feared being unfairly blamed for errors that were due to workload pressures or system failings.

The findings also highlighted how workload pressures and the current culture stand in the way of developing greater openness, transparency and learning:

- Half of doctors said they practised defensively because they worked in a blame culture.
- Half said there was insufficient protection and support for those reporting errors.
- Only two-fifths said they worked in a learning environment in which reporting contributed to preventing, errors, near misses and incidents in the future.
- 62% of doctors said they were cautious or significantly worried about recording reflective practice because they feared it could be used against them.

### What needs to change

The consultation asks what more can be done to help further a just culture, support greater openness and transparency, and secure continuous safety improvement. A range of action is needed across the whole NHS system if these principles are going to become a reality and significant improvements in patient safety are going to be achieved.

- More resources and staff are urgently needed to address the rising workloads and rota gaps. As the [BMA has highlighted](#) the lack of beds is a patient safety issue. As the [BMA response](#) to the Long-Term Plan said we need a robust workforce plan that addresses the reality of the current staffing crises. The UK has fewer beds and fewer practising doctors per population than most of the rest of the EU. The Long-Term Plan will not correct this.
- The BMA outlined in [our recent report and recommendations](#) on tackling bullying and harassment in the NHS a range of steps that need to be taken to create a more supportive and inclusive culture, including the need for a change in leadership-style from the very top. In particular, NHS leaders and politicians must recognise that the vast majority of healthcare staff strive to provide good quality, safe care in difficult circumstances and they need support and compassion to do that, not bullying or blame.
- Ensuring adequate rest and facilities for staff is another way of helping to build positive, open and collaborative working relationships, enabling staff to cope and perform better in pressurised environments. Organisations should sign up to the [BMA's Fatigue and Facilities Charter](#).
- There needs to be a clear shift in priorities so that the quality and safety of care takes precedence over operational and financial targets (as Berwick also advised). Three-quarters of doctors responding to our member survey said financial targets were prioritised over the quality of care.

- We need fair and proportionate regulation that acknowledges system pressures, the impact they have on patient safety and the likelihood of errors occurring. According to our member survey, 71% of doctors believe CQC inspections add to fear in their workplace. Only 15% believe they create motivation to improve and only 11% say they take into account context and pressure in assessing performance. We would propose reforming the nature of CQC inspections so that they: are experienced as supportive; recognise context and facilitate improvement rather than fear; and do not significantly detract from the delivery of patient care.
- Staff need improved support to raise concerns. Again, resources and the pressure in the system are clear barriers, with 59% of doctors telling us they find it difficult to find the time to report concerns. Half said they were afraid of being blamed and almost half that the lack of feedback discouraged them. We need to normalise the raising of concerns and the protection for employees who raise them. Providers should view raising concerns as a method of continual improvement and act on them. There also needs to be much greater awareness amongst employers of the rules to protect NHS whistleblowers against discrimination in recruitment (*The Employment Rights Act 1996 (NHS Recruitment – Protected Disclosure) Regulations 2018*).
- We need legal protection for doctors' reflections in all education and training documents, as the BMA called for in [its response](#) to the GMC's Review of Gross Negligence Manslaughter.
- We welcome the introduction of 'safe spaces' in healthcare investigations for investigations carried out by the Health Safety Investigation Branch. HSIB need to play a role in training and supporting local investigators to take an approach focused on learning rather than apportioning blame.

## 2. Insight

The proposals outlined in the consultation on improving the quality of safety investigations and standardising safety critical advice and guidance across the NHS are welcome. There are now multiple bodies responsible for investigations and different sources of advice, which can present a confusing and complex picture.

The consultation outlines that NHSI is working with the National Patient Safety Alerts Committee (NaPSAC) on standardising national patient safety alerts and to support the whole health and social care system's response to recommendations from HSIB investigations.

- It is important in this work that consideration is given to how safety alerts are disseminated, ensuring that the right frontline healthcare staff receive relevant alerts avoiding overwhelming volumes.
- It is important too for there to be some understanding of local contexts and the capacity for implementation. This is most likely to come from having good representation of people with recent and relevant practice involved in developing recommendations.

- Finally, any underlying causes or barriers to implementation that are linked to wider system failings or lack of resources must be identified and clearly brought to the attention of system leaders by regulatory, investigatory and patient safety bodies.

### 3. Infrastructure

The introduction of a national patient safety curriculum for all current and future NHS staff is a good idea.

- Core to this must be training and education on human factors. Senior NHS leaders, the staff of NHS regulators, and arm's length bodies must also undertake such training, not just all NHS frontline staff. Patient and lay representatives should be offered it as well.

The CQC's own review into Never Events identified a cultural disconnect between frontline NHS staff who experience the high-risk reality of healthcare every day and others in the system who assume the NHS is intrinsically safe and things only go wrong in exceptional circumstances. This fuels the blame and focus on finding fault in individuals when things do go wrong and senior leaders and regulators not adequately anticipating and planning to minimise risks and human error in a proactive way. It is also at odds with the approach taken in other safety-critical industries where there is an acceptance throughout the system that there are high risks, people are human, errors happen, and they need to approach everything with that in mind.

The proposals for senior patient safety specialists, patient advocates for safety, and patient safety support teams are welcome. We recognise that these staff and advocates have the potential to help spread learning and change behaviour within organisations. The proposal to have these specialists within regional teams, regulators and commissioners is welcome. This should help to ensure a common understanding and prioritisation of patient safety throughout the system. The consultation says that existing staff, potentially doctors or others already working in safety-related roles, will be expected and supported to become the senior patient safety specialists.

- If the senior patient safety specialists are to have the impact on culture and learning that is envisaged, they must be properly resourced and be given the time and training necessary to undertake these roles. The new patient advocates for safety similarly need to be supported and engaged with throughout the system.

Finally, I want to reiterate that the current lack of resources and the staffing crisis in the NHS is a major patient safety risk. BMA members have told us they are more fearful of making mistakes now compared to five years ago and the main reason for that is pressure and lack of capacity. They say they find it hard to find the time to raise concerns about patient safety because of workload pressures, and they say that bullying is a problem in NHS workplaces because people are under pressure. Patient safety is not only about improving processes for reporting errors, sharing learning and training individual staff on patient safety issues. Ensuring adequate resourcing and staffing must be central to any strategy to improve patient safety.

I hope you find these initial comments useful in taking forward the development of the new patient safety strategy. I would be happy to talk to you further or help arrange meetings with relevant BMA staff or elected representatives on specific issues related to the new strategy. As I said at the outset, I hope to see you at our roundtable on 7 March too, where we can talk more about culture and progress towards improving patient safety and creating an open and learning environment.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'Chaand Nagpaul'.

**Dr Chaand Nagpaul CBE**  
BMA Council chair