Conference Report

'Patient Safety - Public Trust
A decade of inquiries – what is the learning?'

Report of NIPSO Conference held on
Wednesday 20 March 2024 Malone House, Belfast

Northern Ireland
Public Services
Ombudsman

CONTENTS PAGE

Introduction 3

Role of NIPSO
Why a Patient Safety Conference 4

Aim of the Patient Safety Conference 5

Welcome address from Robin Swann, Minister for Health 6

Ombudsman address from Margaret Kelly 7

Keynote Speech Sir Robert Francis KC 8

Breakout 1: Building an Open and Just Culture 10

Breakout 2: Designing Patient Safety Centred Systems 11

Breakout 3: Implementing an Effective Learning Culture 12

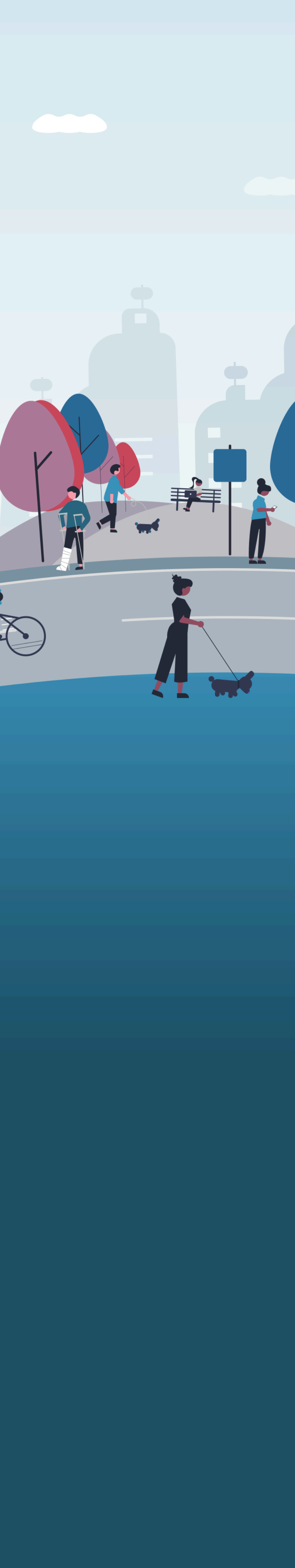
Breakout 4: Addressing Patient Inequalities 13

Patient Voice 14

Whistleblowing and Speaking Up 16

Conclusion and Next Steps 17

Northern Ireland
Public Services
Ombudsman



Introduction

On 20th March 2024, NIPSO held a one-day conference "Patient Safety – Public Trust; A decade of inquiries, what is the learning?" The event brought together over 110 people from a wide range of backgrounds and health settings and the audience heard presentations from 13 different speakers through keynote addresses and breakouts.

This short report aims to summarise the key learning and content from the day. Copies of the full presentations are available here on our website.

The conference also shared four short videos with people talking about their patient safety experiences and who brought their health care complaints to NIPSO for investigation. These can be accessed here.

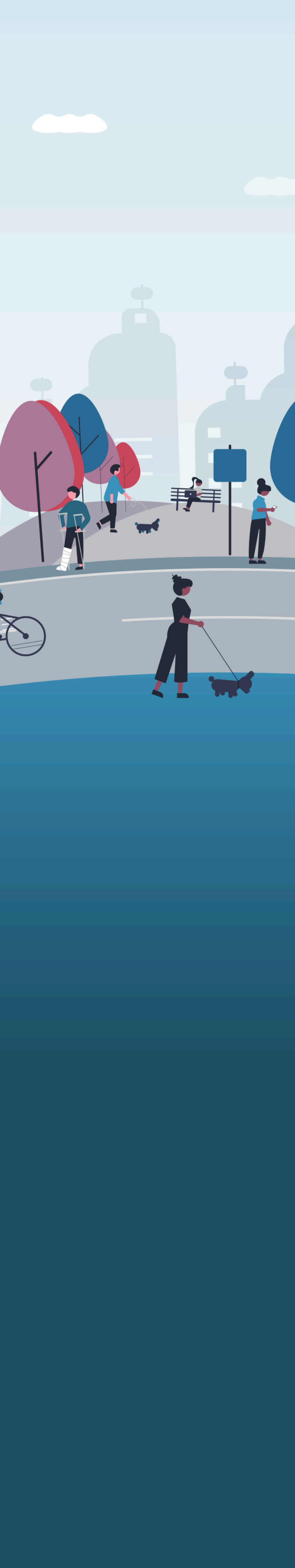
NIPSO is grateful to everyone attended and wishes to particularly thank everyone who contributed and spoke on the day.

Role of NIPSO

The Northern Ireland Public Services Ombudsman (NIPSO) was established by the Public Services Ombudsman Act (NI) 2016. NIPSO's role, is to independently and impartially investigate alleged maladministration in the administrative functions of public services in Northern Ireland and both maladministration and the exercise of professional judgement in health and social care services. The Ombudsman may also undertake investigation on her 'Own Initiative' , without an individual complaint, where there is a reasonable suspicion of widespread failings (systemic maladministration). The services provided by NIPSO play an important role in providing access to justice and redress for individuals, as well as supporting improvement and learning in public services.

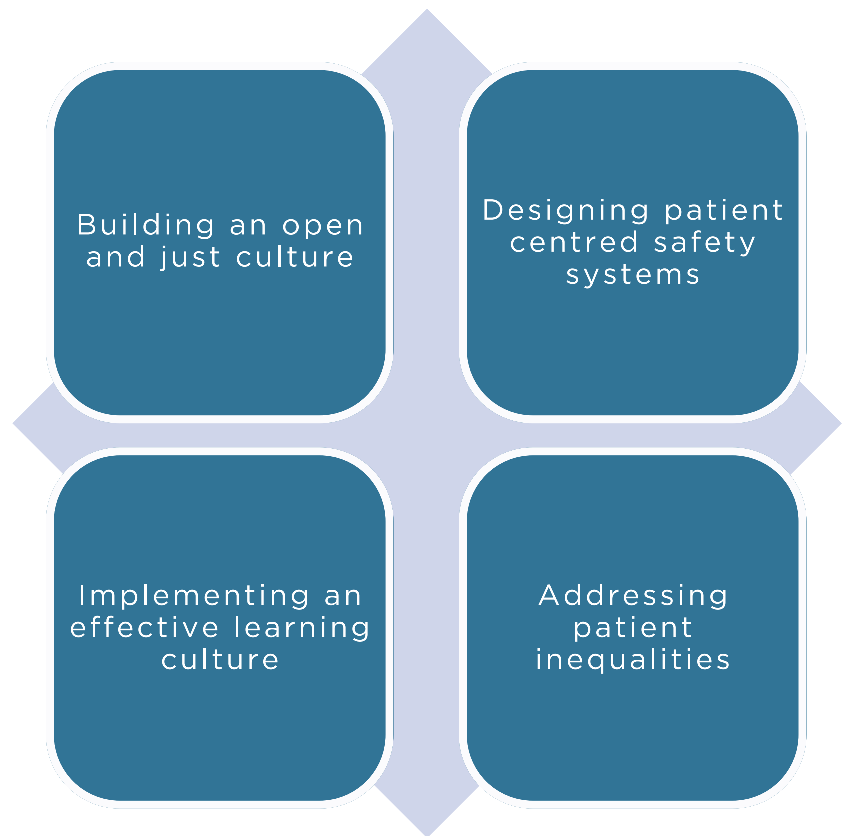
Why a Patient Safety Conference?

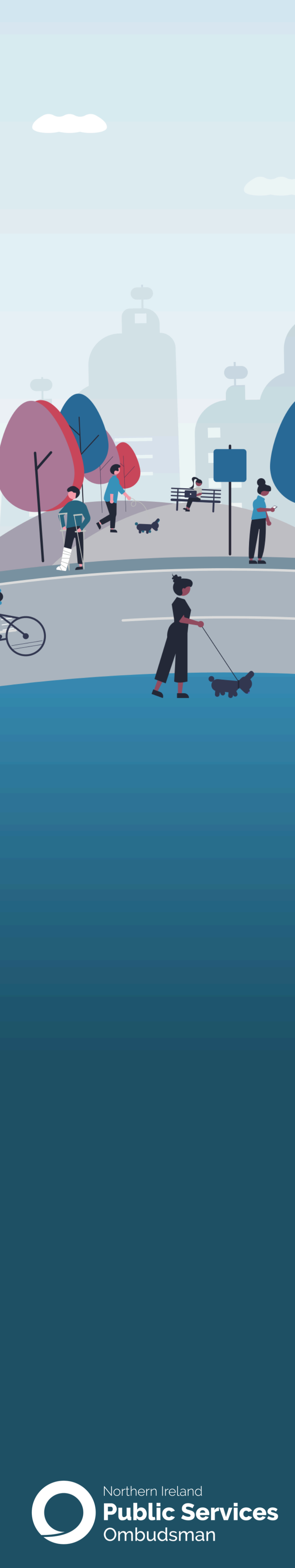
Complaints brought to NIPSO have doubled since the office was established in 2016. Health and social care complaints are by far the largest percentage of complaints received, as well as the largest percentage of complaints which require Further Investigation. Health and social care complaints are increasingly complex, with many highlighting failures in care & treatment, a lack of communication and poor complaints handling. Members of the public report the need to be un-necessarily persistent to navigate the complaints process and obtain the answers they seek. Mistakes and errors are unfortunately a part of life and can never be fully eradicated. However, we need to move from a culture which is sometimes defensive with a lack of openness towards a culture which values complaints and uses patient voices as an opportunity to learn and prevent future harm. A clear thread running through the findings and the recommendations of the many reports and public inquires in recent years is the importance of good complaints handling and learning from complaints. Home Truths, CPEA (Dunmurry Manor) and the Independent Neurology Inquiry all highlighted the fragmented nature of complaints handling and the importance of complaints data to ensure greater oversight and accountability. Despite multiple Public Inquiries into Patient Safety related issues across the UK, and particularly here in NI, there is concern that the same issues are consistently raised without clear evidence of improvement.



Aim of the Patient Safety Conference

The Patient Safety Conference brought together people from a wide range of backgrounds to explore potential strategies and approaches to improving Patient Safety and Public Trust in our health and social care system. The conference content looked at how to drive patient safety improvement in a complex health system and focused on four key issues:





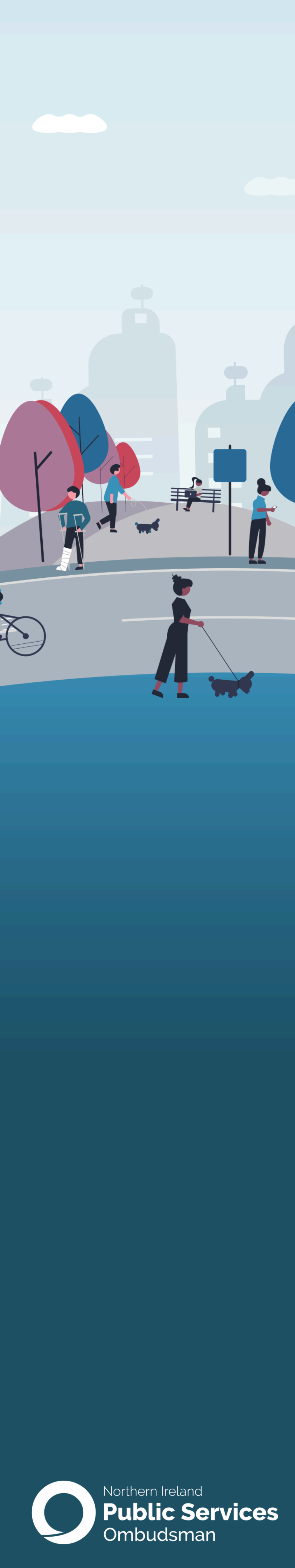
Welcome address from Robin Swann, Minister for Health

The event started with the first of two videos sharing the experiences of people who brought patient safety complaints to NIPSO. We are very grateful to the 5 individuals who shared their stories with us.

The Minister opened the conference by stating that people expect health and social care to be safe. However, if that care fails to meet an acceptable standard, they should experience openness and honesty and be treated with dignity and respect. His speech described how, the Department is continuing to prioritise the implementation of learning and recommendations arising from previous Inquiries and acknowledged the need to enhance patient safety and help restore public confidence.

The Minister said that significant progress has already been made towards implementation of Independent Neurology Inquiry (INI) recommendations and that the ongoing redesign of the Serious Adverse Incident procedure will address recommendations from both the INI and IHRD inquiries. The Department's Permanent Secretary chairs an Inquiries Implementation Programme Board which oversees and brings together this related work.

The Minister also stressed that the "experience" of patients and staff that must be considered alongside traditional benchmarks. Patient voices must be at the heart of health and social care design and delivery and valued as trusted sources of information on patient safety.Staff must be able to voice their views, ideas and concerns without fear. Supporting an environment that welcomes, encourages and seeks out patient and staff experience is essential in the journey of continuous improvement and culture change in this regard will take time.



Ombudsman address from Margaret Kelly

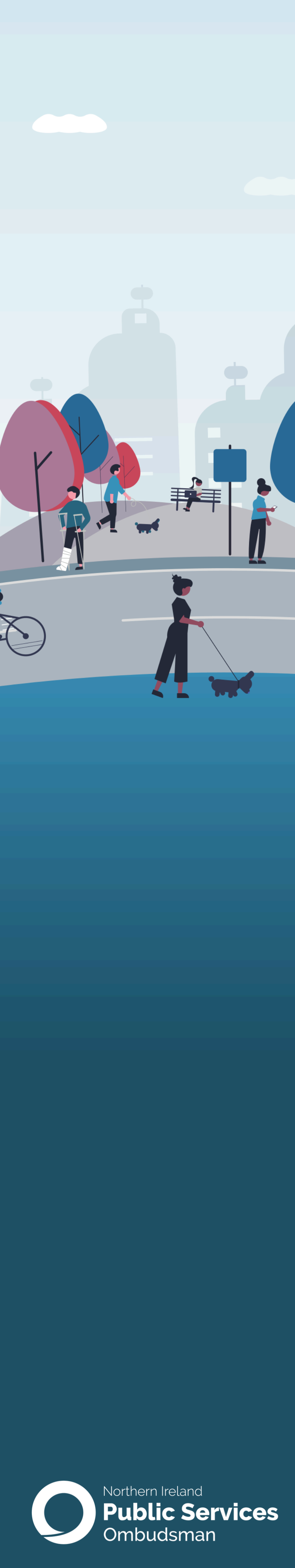
The Ombudsman outlined NIPSO's significant involvement in health and social care. On average NIPSO receives 1100 – 1200 complaints a year, 40% of these are health and social care related. 80% of all complaints that move to further investigation relate to health and social care and many of these will already have been through an SAI process. The Ombudsman highlighted that the most common areas of complaint are: poor communication, premature discharge, delays in care and treatment. Those who do complain are motivated to do so because they want to understand what happened and to make sure that it doesn't happen again.

Ms Kelly shared that unfortunately the office continues to see the compounded harm and trauma when families, patients or relatives raise issues of concern after an incident of significant harm. These have included, a failure to be open and honest about what has gone wrong, a lack of support to navigate the complaints or SAI process and a lack of compassion and empathy. There is also evidence of poor-quality investigations and a failure to really put in place the learning to reduce the risk of the incident happening again.

Pointing to the complex nature of our integrated health and social care service, the pressure the system is under and the multiple number of recent and active inquiries, the Ombudsman outline the need for a Patient Safety Strategy for Northern Ireland.

A Patient Safety Strategy would provide a framework to deliver a co-ordinated and communicative response across the system. To drive systemic improvement across a complex system will require a deeper understanding of patient safety and patient experience. It also requires that we have a culture of candour and openness - we cannot improve patient safety without the patients, and we cannot build public trust without the public.

The ombudsman closed her address by emphasising that the focus of the conference is on learning, improving and change. It is on prioritising and improving patient safety and public trust, for the benefit of all -patients, staff and communities.

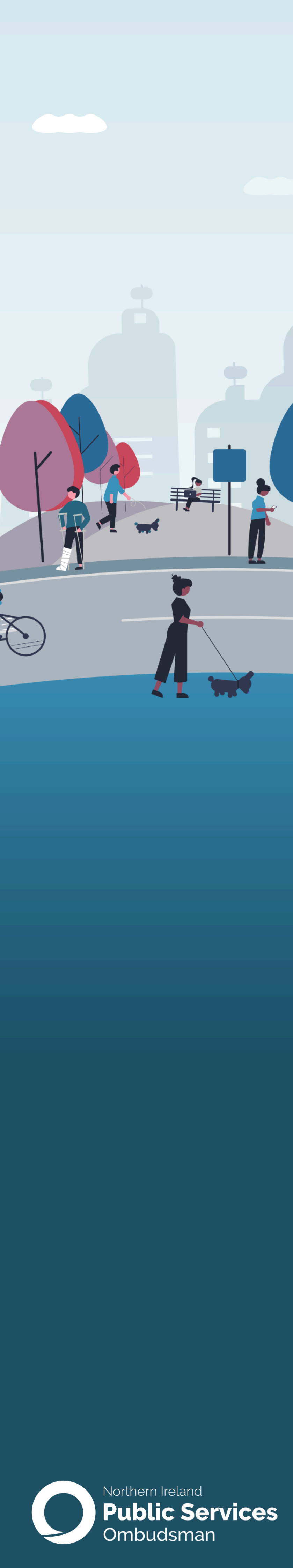


Keynote Speech
Sir Robert Francis KC

Sir Robert began by acknowledging the importance of Public Inquiries – but they are only effective if we learn from them. Between 2005 – 2018 the UK spent £239 million on 19 inquiries, a figure that will be much higher today. The purpose of inquires is to establish: the facts – what happened, accountability - why did it happen? And Lessons – what can be done to prevent it happening again?

Inquiries should also listen to victims, engage stakeholders and consider mediation/ resolution. Achieving these aims is challenging, particularly the balance between accountability and the examination of often complex and disputed data. Sir Robert shared some statistics on healthcare safety and highlighted that 50% of harm is preventable. There are 3 million deaths per year due to unsafe care and half of preventable harm is due to medication. The NHS workforce survey (over 700k staff) regarding the culture amongst Health Care staff portrayed a stark picture of low morale, unrealistic expectations, pressure, bullying and concerns around how fairly those who make errors are treated.

So, what to do about this? Leaders must face reality and those with discomforting truths must be heard. Healthcare leaders must facilitate solutions to the problems, learning from failure as well as success, and review effectiveness - no solution is likely to be permanent. In all they do, leaders must prioritise the effect on those they serve – public but also staff - and promote the organisation's values. Sir Robert highlighted the key findings in Inquiries that show that patient and family voices were often ignored, incident reports and investigations ignored, transparency and candour discouraged, and whistleblowers victimised.



Key steps to improvement highlighted in the keynote were:
·Values which prioritise service purpose and which are owned and followed by all staff

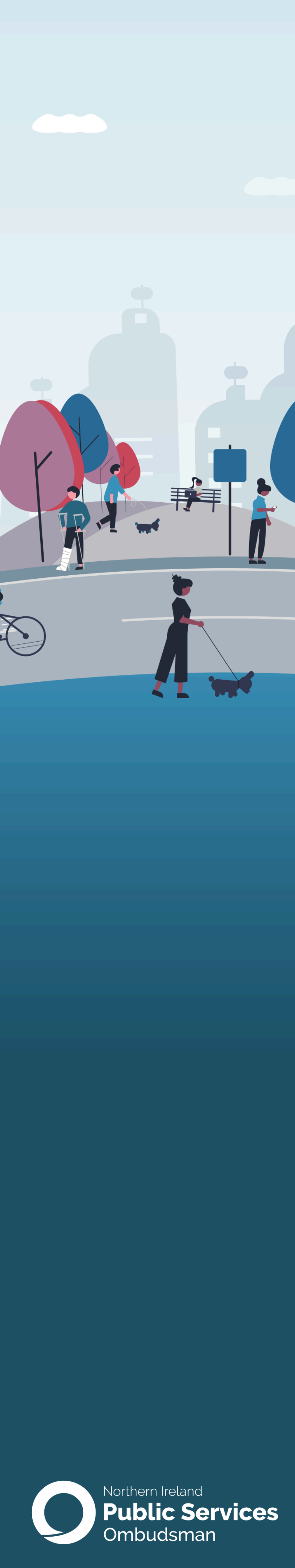
- Aim to look like the organisation you want to lead
- Candour and transparency
- Freedom to Speak Up
- Measure what matters.

In relation to the Duty of Candour, Sir Robert highlighted the following key points:

- **Act in an open and transparent way** with people receiving the service
- **Tell anyone who has been harmed**, in person, as soon as reasonably practicable after becoming aware the incident and provide them with support
- **Provide an account of the incident** which, to the best of the provider's knowledge, is true and includes all of all the facts known about the incident at that date
- **Advise the affected person** what further enquiries are believed to be needed
- **Offer an apology** or context appropriate regrets
- **Follow up** by giving the same information in writing and providing updates on the enquiries
- **Keep a written record** of all communications and enquiries.

Sir Robert finished with some personal reflection on 'Good leaders' and reiterated again the essential role leaders play in patient safety. He urged leaders to:

- **role model** values
- **empower** all to exercise leadership
- **promote** candour about mistakes
- **expect** staff to speak up about concerns and celebrate those who do
- **listen** to those they serve
- **act** on their concerns and report back to those who raise them
- **set** clear goals in agreement with staff
- **measure** progress including their own
- **insist** on constructive professional development, objective appraisal & reflection
- **never be satisfied** with today's success and look for constant quality improvement.



Workshops

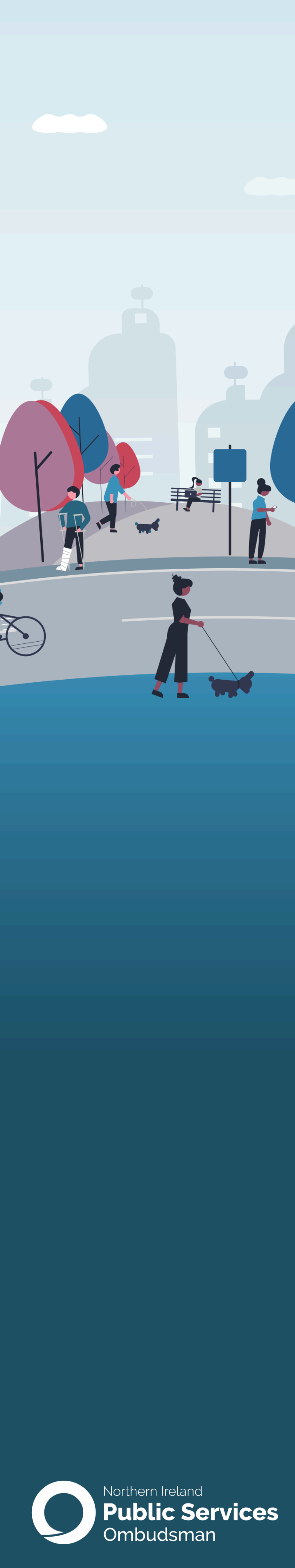
Breakout 1: Building an Open and Just Culture

Professor Gabriel Scally, visiting Professor at the University of Bristol spoke on his experience and the importance of the Duty of Candour. He discussed the detrimental impact on patients and their families where truth is not provided at the outset. This is then sometimes compounded if individuals go through the court system, where they must relive their experience; face sensitive (potentially humiliating) questions and ultimately are not provided with answers. Professor Scally offered several key suggestions to aid an 'Open and Just Culture' with a focus on enhanced patient/democratic engagement and participation.

Peter McBride spoke on his experience and the difficulties in introducing a Statutory Duty of Candour within an area where staff consider that the biggest barrier to an open culture is fear, particularly the fear that mistakes will be punished. He discussed how the perceived punitive nature of the Statutory duty and criminal sanctions may compound this. The 'Being Open' workstream is hoping to find ways to embed openness and support of staff to speak up when things go wrong. He suggested that workplaces should focus on encouraging reflection; constant learning; and 'openness as routine'.
The question and answer session raised several points of discussion including:

- The Government's role in introducing this new culture, and how the relationship between the Department and the Trusts will work in taking this forward.
- The potential issues of NI small size and perceived 'incestuous' nature. However, there was a view from some that transformation could happen if there was political and public will.
- An apparent focus on 'Doctors' in discussions around Duty of Candour. It was suggested that accountabilities are being placed on Doctors when they have little to no authority, with several participants sharing that Doctors do speak up.

In conclusion, the difficulties of a reform of this kind – across a whole system which is already under huge pressure - was discussed. It was again reflected that opportunities need to be created to understand the importance of being open and for this to be embedded in culture. *'This is a lifestyle move, not time limited.'*



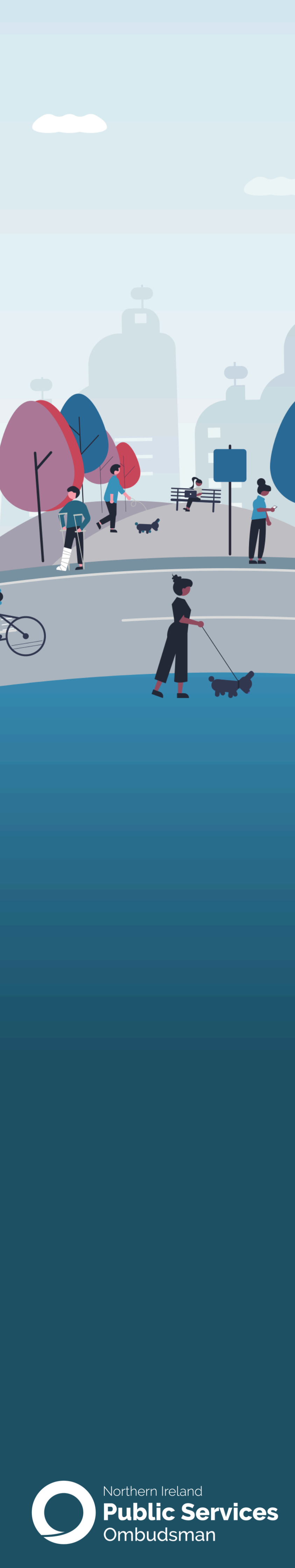
Workshops

Breakout 2: Designing Patient Safety Centred Systems

Helen Hughes, CEO Patient Safety Learning outlined the challenges with a health system which is complex, siloed and where many staff describe experiencing a culture of fear and blame. Drawing attention to recommended changes to address avoidable deaths, preventable harm and the financial costs of unsafe healthcare, Helen highlighted the importance of viewing safety as a core priority and not one that competes with other issues. This involves reviewing cultural and leadership issues and moving from people-focused actions (telling people what to do) to a whole system approach to ensuring good practice and patient safety. Helen also pointed to the English experience to date with Patient Safety Incident Response Framework (PSIRF) – the new system replacing SAIs. This focuses more on compassionate engagement with patients and families and has transferrable learning which could be applied in NI.

Prof Lourda Geoghegan and **Kieran McAteer**, Department for Health - the presentation provided an outline of SAI Review Project, noting that even in good systems things can go wrong and it is how we respond to these which is important. The presenters set out the evidential base for the need for change and the clear mandate from the Minister and the Permanent Secretary for the programme of work to move swiftly. The current SAI process was described as process driven and resource intensive, with engagement with patient and families not always optimal. They shared that a programme of work has agreed and one of the next key stages will be consultation with the public.

The Question & Answer session raised several issues. The importance of having a framework/strategy was highlighted to facilitate a structured approach – patient safety cannot be haphazard. Leadership at all levels or organisations is required to bring about whole organisation change and improvement. Participants talked about how patient safety has become siloed and resulted in a 'technical programme' rather than a more ambitious transformation programme. It was also noted that the relationship between patient safety and quality improvement has become silo'd whereas the two, whilst needing to be distinct must also be integrated and mutually reinforcing to be effective. Staff training was also highlighted as a concern and that sometimes this was a tickbox exercise.



Workshops

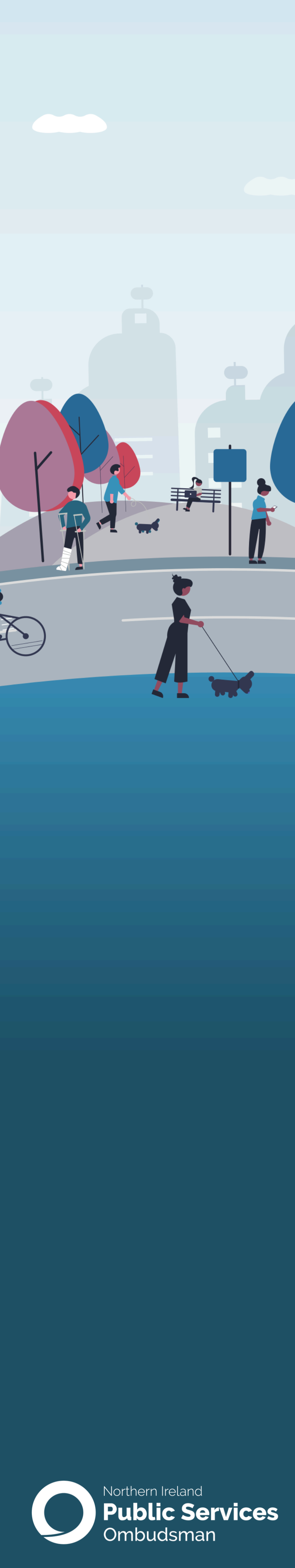
Breakout 3: Implementing an Effective Learning Culture

Sean Martin, Deputy Ombudsman presented on the NIPSO Complaints Standards project which seeks to improve complaints handling process for all public bodies. At the time of the conference this was shortly commencing with the Health & Social Care Trusts (this work has now started), having worked previously with all 11 Councils in NI. In addition to describing the Model Complaints Handling Process the key issues highlighted were – the key role of leadership in setting culture and embedding learning and the essential value of listening to patient voices. Whilst the stages and processes involved in complaints handling are important and must be followed – a crucial factor is the overall culture of valuing the learning from complaints and feedback and using complaints data and information in service improvement.

Prof Annette Boaz, Kings College, London started by sharing a summary of research into the many challenges to building an effective learning culture. Even when staff are afforded time off to engage in learning, they can often face resistance from the organisation when they try to implement what they have learnt. This can be hierarchical – the learning experience is seen as deficient as it is not a clinical trial or resistance comes from peers who are resentful a colleague had 'time out' or that they have been given extra work to do. So even with good intentions, individual learning initiatives often result in little learning at an organisational level.

Prof Boaz then focused on a practical example of how investing in staff capacity to engage with research can yield positive impact. Research studies have shown that research active Trusts had lower risk-adjusted mortality for acute admissions and that high, sustained hospital-level participation in interventional clinical trials improves outcomes for patients. By being part of research, staff were able to learn from other networks, there was more collaboration, staff felt up to date and the supportive context enabled the uptake of new services.

Q&A discussion highlighted the importance of ongoing learning from a range of data and information, not just looking at complaints or when things go wrong. Participants discussed the importance of transparency and the risks of further harm if service users feel like they haven't been given the full story. However, it was also noted that in the relationship between liability and learning this can be difficult. Learning and investigations can often be too individualised – there is a need to also focus on the systems and not just individual accountability.



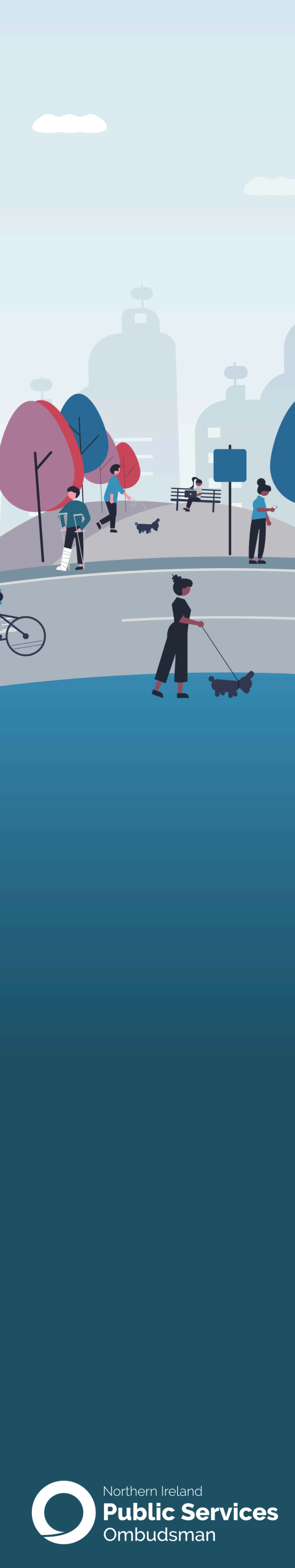
Workshops

Breakout 4: Addressing Patient Inequalities

Graham Mockler, Director Professional Standards Authority highlighted the importance of looking at intersectionality and understanding the experience of different groups. He posed the question – how do we know whether patients from different backgrounds receive the same quality of care? Many health settings fail to collect the data needed to fully understand patient experience from the point of gender, ethnicity, and other inequalities. Without this data, how do we know where and for whom improvement is needed. For example, if we do not know who is complaining we might put energies into the wrong parts of the system. Indeed, not knowing could be counterproductive and drive an ever-bigger inequality gap.
Safer care for all. Solutions from professional regulation and beyond (professionalstandards.org.uk)

Professor Owen Barr, Ulster University focused on the inequalities experienced by people with learning disabilities to highlight the importance of data to fully understand patient experience. Owen's presentation shared research about how little data we routinely collect about this population despite the well documented disparities in health outcomes and life expectancy. Without the data – we cannot address these inequalities. This input challenged health care settings to look at where the blind spots are.

The Q&A session discussed the importance and the challenges around collecting data, especially in a complex health and social care system. The complex nature of meeting the needs of vulnerable patients was discussed and transitions for children with complex, life limiting health conditions were mentioned. One of the challenges to improving how the needs of vulnerable patients are met is the siloed and fractured nature of our health and social care system – there is a strong desire and motivation to improve outcomes in care and treatment amongst staff, but the system can make this difficult. Workshop participants also highlighted the need to better capture and share good practice in meeting the needs of those who need support.



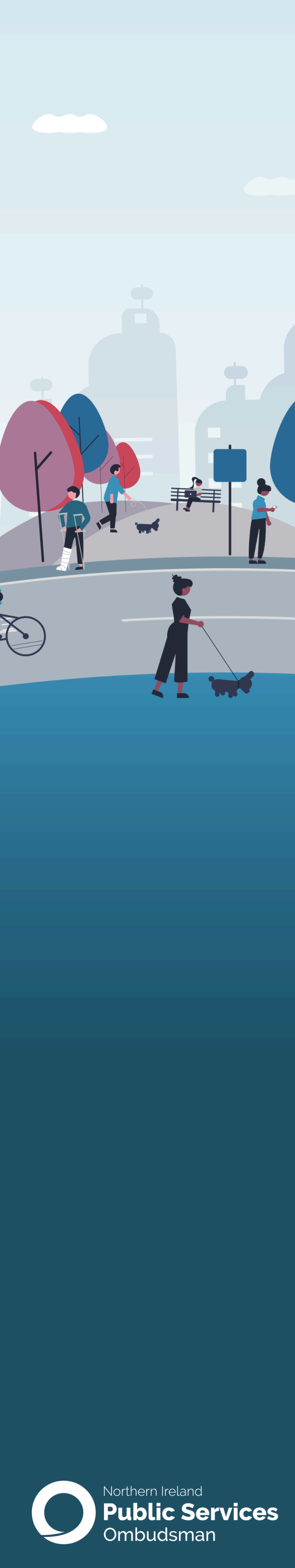
Patient Voice

As with the morning session, the afternoon session started with a video sharing the experiences of people who brought patient safety complaints to NIPSO. This was followed by presentations from Linda Craig (Regional Lead, Patient Client Experience, PHA) and Chris McCann (Director, HealthWatch).

Linda Craig PHA

The aim of the Patient Client Experience programme (PCE) is "*…to proactively enable service users, families and carers to share their narrative/ stories of Health and Social Care through a mechanism which enables regional analysis and can lead to learning and change at all levels of the HSCNI system…*" This includes routine online, service user feedback and bespoke projects using storytelling in settings such as Care Homes. The PCE programme operates as part of a wider Statutory Duty of Quality which includes early intervention intelligence, complaints, Serious Adverse Incidents and Inquiries.

Linda stressed the importance of identifying 'touch points' for learning and the need to embed the earliest opportunity for learning. This echoed the points made throughout the day that learning is all too often retrospective and after an event or incident has occurred. PCE allows patient voice and experience to be captured and responded to in 'real time' and used to inform decision making and improvement. Linda's presentation stressed the importance of building **a culture of listening to the voices of people engaging our services – at all levels.**

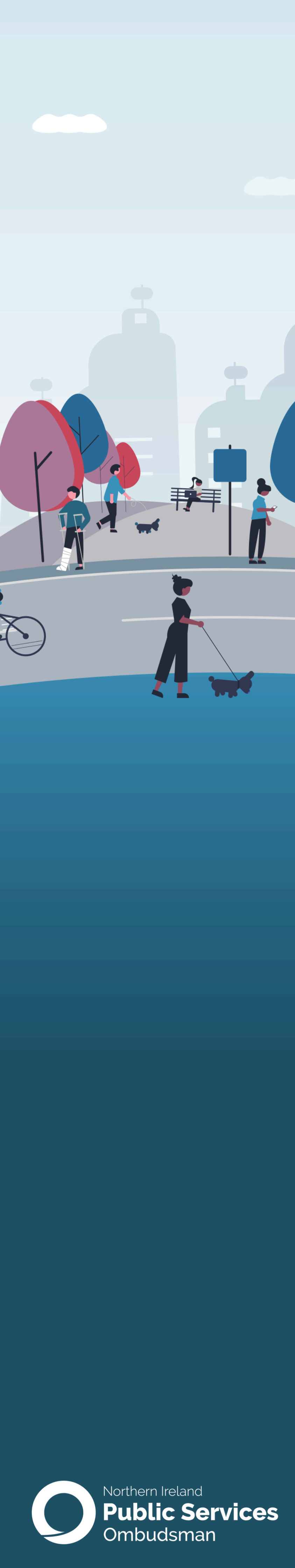


Chris McCann, Healthwatch

Healthwatch is a charity in England which ensures that NHS Leaders and other decision makers hear the public's voice and use that feedback to improve care. They proactively seek people's experience of GP's, hospitals, dentists, care homes and other support services through an England wide network of local Healthwatch organisations. Key current activities include a strategic focus on equality, diversity and inclusion (EDI). This includes continuing to develop an evidence base that focuses on demographics and geographic spread to reflect the communities it represents. Involving more people from affected communities in their work and forming partnerships to help make change happen. Healthwatch research into health disparities in waiting for planned care, highlighted that the impact is not experienced equally across all patient groups and a poor experience of waiting is linked to wealth, disability, education, gender or ethnicity.

Their research highlighted that disabled people, those with lower levels of wealth, women, and people from ethnic minority backgrounds are the most likely groups to have been waiting over four months for treatment and to have experienced a delay or cancellation.

Chris ended his presentation by stressing that when informed by the views and experiences of those who use them, health care services can deliver **what people need, not what professionals think they need.** This requires a culture of openness, but, above all, listening to patients and their loved ones.



Whistleblowing and Speaking Up

Rosemary Agnew

Independent National Whistleblowing Officer for the NHS in Scotland

The final presentation of the day was from Rosemary Agnew, who is both the Scottish Public Health Ombudsman and Independent National Whistleblowing Officer (INWO) for the NHS in Scotland . In her role as Whistleblowing Officer, Rosemary investigates complaints about how whistleblowing concerns about patient safety has been handled by the Scottish NHS, and claims of detriment to individuals resulting from raising whistleblowing concerns. She also sets the principles and standards for the handling of whistleblowing concerns at local level.

The aim of this function is to ensure everyone delivering NHS services in Scotland is able to speak out to raise concerns when they see harm or wrongdoing putting patient safety or service delivery at risk. People must be able to raise concerns, confident that they can do so in a protected way, that will not cause them personal detriment. They also need to be confident they have the right to an independent review if dissatisfied with how the concern was investigated.

The INWO has the power to set out principles and a procedure for NHS Scotland providers to use in handling whistleblowing concerns and to provide an independent review stage to this procedure. The high level principles and detailed procedure for investigating concerns set out in the National Whistleblowing Standards (the Standards) were approved by the Scottish Parliament. They apply to all NHS providers in Scotland, including primary care and contracted providers. They also apply to students, trainees and volunteers as well as all temporary and permanent staff.

Conclusion and Next Steps

Across the full day of presentations, workshops and discussions there was a clear consensus on some of the key actions needed. These are summarised below:

- Address the culture of fear and blame which prevents people (but particularly health care staff) from speaking out.
- Resource more meaningful engagement with patients to learn from their experiences (good and bad).
- Collect and analyse data to better identify and understand inequalities in health and patient safety.
- Tackle the silos in the system through a strategic approach to patient safety.

Key points for change towards building an Open and Just Culture:

- Address the fear and blame culture within health settings
- Better system for complaints
- Support for Whistleblowers
- Meaningful patient involvement
- Democratic engagement with wider civic society

Key points for change in creating patient centred safety systems:

- Address the fear and blame culture within health settings
- Ambitious and brave leadership to drive culture change
- Better integration between patient safety and quality improvement
- A more strategic approach to patient safety

Key points for change in implementing an effective learning culture:

- Leadership is key in driving an effective learning culture
- Enable and resource the collection of patient feedback
- Address the fear and blame in health settings – learning needs a safe space
- Share learning regionally of good practice and not only near misses / mistakes

Key points for change in Health Inequalities and Patient Safety:

- Collect data to understand inequalities in health and patient safety
- Better staff training & resources to recognise and address vulnerabilities
- Access to support for those who need it

Next Steps

Through it's investigatory and Own Initiative powers the Office of the Ombudsman will continue to use investigation findings to highlight issues affecting patient safety and make recommendations to improve public services delivering health care.

NIPSO is leading on a Complaints Standards project which aims to create more consistent and effective complaints handling across public bodies in NI. This work is currently underway with the Health & Social Care Trusts and will explore how best to listen and respond to the patient voice, how to remove barriers and fears around complaining and how to use a frontline, resolution response to address concerns and questions early in the process.

We will engage with relevant organisations, public bodies and other stakeholders to learn about and promote good practice to reduce the health inequalities experienced by patients. In 23/24 we began collecting our own EDI data to understand and improve the accessibility of the Office and ensure that anyone who needs to engage with us is supported to do so.

We will work with elected members, public bodies and government bodies to encourage the development of a Patient Safety Framework for Northern and the consideration of any further statutory powers needed to strengthen the protection of those who wish to speak out to prevent harm.

Research and existing practice in other countries indicates that a Patient Safety Strategy (or Framework) can set out a clear vision and commitment as to how the health care system will support staff and providers with the skills, structure and confidence to prioritise and improve patient safety. A public commitment to a resourced plan to invest in a Patient Safety Framework will, in the long-term not only impact on health outcomes but will help reassure the public and restore trust in health care systems.

Thank you to the following breakout facilitators for their time and expertise:

Breakout 1 – Brian O'Hagan

Breakout 2 – Dr Jennifer Hanratty

Breakout 3 – Majella McCloskey

Breakout 4 – Dr Helga Sneddon

Thank you also to our video participants, who kindly shared their personal stories to emphasise the importance of prioritising patient safety:

Shirley Quinn

Steven & Melanie Cull

Janice Irwin

Vittoria Rotondi

Northern Ireland
Public Services
Ombudsman

Northern Ireland
Public Services
Ombudsman

Northern Ireland Public Services
Ombudsman
Progressive House
33 Wellington Place
Belfast
BT1 6HN

www.nipso.org.uk
0800 34 34 24
nipso@nipso.org.uk

@nipso_comms