BRIEFING

The Health Foundation Inspiring Improvement

December 2013

Hard truths: essential actions

The briefing focuses on bridging the gap between the actions set out by the government in *Hard Truths* and their practical application by people working in the service. Our key recommendations are:

- A learning environment is necessary to achieve the profound cultural change being asked of the NHS. There is a pivotal role for the government and NHS England in creating this.
- A large-scale safety collaborative programme has the potential to provide benefit, but NHS England needs to strike the right balance between providing accountability and achieving genuine ownership from front-line teams.
- The focus on measuring safety is welcome, but measures should be developed to assess the future risk of harm, not just the occurrence of past harm.
- The government also needs to be clear how the publication of data will improve safety.

Introduction

On 19 November 2013, the government published *Hard Truths*,[1] its full response to the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry by Robert Francis QC.

Hard Truths built on an initial government response, *Patients First and Foremost*,[2] published in March 2013. That report set out some immediate steps, including the introduction of a new inspection regime operated by the Care Quality Commission (CQC)and plans to promote openness by preventing gagging clauses in contracts for staff.

There can be little doubting the seriousness with which the government has treated the issues raised at Mid Staffordshire, or the rigour with which it has considered Francis's recommendations. In *Hard Truths*, the government responded in full to all 290 recommendations and accepted (at least in principle) all but nine of them.

Much of the debate following the events at Mid Staffordshire has centred on the role of regulation and the introduction of new legislation. The government has committed to:

1. creating **new criminal offences** in cases of wilful or reckless neglect by individuals and healthcare providers, and supplying false or misleading information by providers
2. a **duty of candour** that will be enforced by the CQC, and a consultation on whether NHS trusts should be liable for litigation costs if they are not open with patients and families
3. introducing a new **care certificate**, instead of accepting proposals to regulate healthcare assistants and social care support workers.

This focus on matters of law is an inevitable response to the legalistic nature of any public inquiry, and the limited tools at the disposal of the government. But, as was recognised in both the Francis Report and the government's response, what is really required to improve quality is a profound change of culture to make learning and improvement both continuous and across the board. As Don Berwick put it in the National Advisory Group review, *A promise to learn – a commitment to act*:

> **'Rules, standards, regulations and enforcement have a place in the pursuit of quality, but they pale in potential compared to the power of pervasive and constant learning.'[3]**

The focus of this Health Foundation briefing is on bridging the gap between the actions set out by the government in *Hard Truths* and their practical application by people working in the service. We use the experience gained from our research and improvement programmes to suggest to policy makers how the continual reduction of healthcare-associated harm can be achieved by measuring safety comprehensively and by building the capability of individuals, organisations and systems. In this briefing we make two sets of observations, relating to measuring safety and building capability.

Measuring safety

A central tenet of *Hard Truths* is the importance of improving the collection, analysis and transparency of data and information on the safety of care. Recommendations include:

- developing a central **hospital safety website for the public** which will draw together up-to-date ward-level data on patient safety factors
- encouraging trusts to use the **NHS Safety Thermometer** to target improvement in areas such as pressure ulcers, falls and catheter-associated infections
- requiring trusts to publish **ward level staffing information** including their actual versus planned nursing and midwifery levels.

Publishing data on the safety of care can certainly help to improve quality. However, the government, NHS England and healthcare providers could increase its impact by doing the following:

1. **Be clear about how publishing the information will improve safety**. For instance, is it intended to drive public choice of care providers? Or to develop a competitive spirit between professionals? Or to embarrass staff into action? Or a combination of all three? Without a clear theory as to how data reporting will foster improvement, there is a risk that it will become an end in itself. Our research has shown that the publishing of performance data can prompt staff to improve standards of care, but has little influence on the public's choice of provider.[4] Well below 10% of patients use online information to make decisions about their care.[5]
2. **Safety measurement needs to be recognised as a critical component of safety improvement.** As stated in the NHS Confederation's report, *Challenging Bureaucracy*, to meet the ongoing challenge of improving quality, the health service 'potentially needs more and better data, not less', delivered in a timely way to make it useful.[6] University Hospitals Birmingham, for instance, has invested a significant amount of time, will and money to develop around 500 clinical metrics, analysed in-house, to monitor and improve the quality of care.[7]
3. **Develop safety metrics with clinicians and the public and present them in a way that is meaningful for both**. There is a strong moral case for making data transparent. We saw from the success of publishing consultant level data on cardiac surgery survival rates[8] that such data can contribute to better patient outcomes when there is a sense of ownership from the health professionals involved. However, the way that information is developed and presented should consider how it will be used by both clinicians and the public to change behaviour, and anticipate any potential unintended consequences.
4. **Develop metrics that assess risk of harm, not just past harm**. A variety of data must be brought together so that organisations have a

comprehensive picture of safety.[9] This could include data on the reliability of care (such as the proportion of inpatients screened for MRSA), real-time patient feedback, staffing levels and other risk factors, as well as information on how risks are being anticipated and prepared for. Only then will organisations know that they are investing their efforts in areas most in need of improvement.

5. **Develop metrics to cover handovers of care**. Organisations need to see themselves as part of a wider system of care, requiring data from multiple care settings to reflect the handovers of care so common in a patient's journey, and where many safety problems occur. This is possible with the increasing ability to link data across different care settings, and will be ever-more necessary as integrated care develops.
6. **Monthly data returns can only contribute to improvements in care if they are locally relevant and used to inform management decisions**. Salford Royal NHS Foundation Trust was praised in the health committee report, *After Francis: making a difference*, for making real-time ward staffing levels visible to everyone admitted to, visiting or working on a ward.[10] However, the true value of making this information available is to make transparent the process by which front-line staff and managers use the information to make better decisions in real time, rather than for the sake of completing a data return.

Building capability

The flagship safety improvement initiative announced in *Hard Truths* is the creation of a network of patient safety collaboratives across England. By enabling people to work together and build their skills and capabilities, it is hoped that the programme will develop a culture of learning and improvement over the next five years.

The Health Foundation supports the collaboratives programme, and in particular welcomes the longer time frame which will be key to driving genuine cultural changes rather than potentially superficial quick fixes. We also welcome the inclusion of a range of different organisations and the focus on measurement and capacity building.

However, it will be essential to strike the right balance between providing accountability to external bodies and achieving genuine ownership from front-line teams. Our *Lining Up* research programme illustrates that the application of large-scale improvement programmes can be seen as an opportunity by some, but can cause resistance in others.[11]

We ask NHS England to consider the following recommendations when developing the collaboratives programme:

1. **There should be greater flexibility in what areas each collaborative chooses to work on**. The areas of focus for each collaborative should take into account where significant progress has already been made. Our *Safer Clinical Systems* programme is showing how the local diagnosis of priority areas for improvement can increase the chances of identifying effective solutions.[12] We also urge the programme to look beyond the high profile isolated cause of harm (pressure ulcers and medication errors) to tackling safety more systematically.
2. **Collaboratives will be most effective if they avoid being used for performance management**. Given that there will be varying levels of performance across the organisations within each collaborative, there may be pressure to bring all providers up to a certain bar. While learning across all organisations is essential, a structure that allows organisations to work at their own pace, and peers to work together on priority topics, should lead to greater overall improvement.
3. **Build capability in local leadership.** More than anything else, the success of large-scale improvement programmes depends on the enthusiasm, commitment and credibility of local leaders, rather than top-down push. However, at present there are shortfalls in the skills needed at the most senior levels of organisations to provide effective leadership. More needs to be done to support trust boards, senior executives and clinical leads to develop their awareness and capabilities. We believe the collaboratives programme presents a unique opportunity for organisations and staff to support each other.

Concluding thoughts

We hope the range of policy initiatives and proposed changes to legislation will prove to be effective. For some of these changes, success can only be assessed through a programme of formal evaluation – formative and summative – and we recommend that further thought is given to how this can be done. For instance, the introduction of new criminal offences in cases of wilful or reckless neglect (by individuals and providers) should be evaluated to check for effectiveness and any unintended consequences.

Centrally-driven proposals are, by their very nature, limited in their ability to improve care. As such, the actions set out in *Hard Truths* are only part of the story; it is local providers and commissioners of care, together with those working on the front line, who will be tasked with delivering the actions set out in the report. However, the government and NHS England retain a critical role in creating a learning environment in which these actions are given the best chance to succeed, and are carefully evaluated and learned from.

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The Health Foundation
90 Long Acre
London WC2E 9RA

T 020 7257 8000
E info@health.org.uk

Registered charity number: 286967
Registered company number: 1714937

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