effective. Inadequate staffing has a detrimental impact on the health and wellbeing of patients and nursing staff alike. Nurses feel professionally compromised that they cannot provide nursing care that patients require.[vi]

Q8: Are you aware of a Just Culture guide?

The RCN is aware of the Just Culture guide and supports its purpose. The RCN has worked closely with NHS Improvement on developing it and helped implement this resource.

Q9: What could be done to further help develop a just culture?

The RCN believe that accountability for nurse staffing to provide safe and effective patient care in all settings should be enshrined in law in England. Legislation for safe and effective staffing is already in place in Wales. In Scotland work is well progressed towards having legislation for safe and effective nurse staffing with the recent publication of Health and Care (staffing) (Scotland) Bill. Across the UK, the RCN is calling for accountability for staffing to be specified in law and supporting policy, funding flows and delivery mechanisms, including the requirement for health and social care systems to have credible and robust workforce strategy, and data-driven workforce planning.[vii]

It is important to recognise the impact which challenges in public health and social care have upon the health system as a whole. Last year, 78% of local authorities reported concern about their ability to meet their statutory duty within their existing budgets to ensure care market stability[viii]. Current provision of social care is not sufficient to meet the needs of the population: Age UK estimates that there are more than 1 million people whose needs are not being met. [ix] The NHS cannot be considered in isolation when addressing systemic issues, and this needs to be acknowledged within this strategy.

Q10: What more should be done to support openness and transparency?

We strongly support informing patients when things have gone wrong as an essential part of an open clinical culture that respects the autonomy of the patient. Duty of candour is supported and actively encouraged by the RCN. This only works in practice when nursing staff are free from disproportionate sanctions and blame as this prevents openness and is counterproductive to the welcome ambition to share learning from mistakes. Nursing staff and health care teams should be fully supported to disclose their concerns and reflect openly on the events that led to an incident, rather than fear immediate referral to the Nursing and Midwifery Council (NMC) or other regulators. A collaborative approach to liaising with a patient should be taken with support from the workplace, not relying solely on an individual.

Board-level responsibility and accountability for reviewing and acting upon patient safety data.

The intention to better utilise nationally-reported incident data by harnessing new technologies is welcome. However we are unable to comment further on the use of AI and machine learning without more detail about how this would be applied. Similarly we welcome the new emphasis on learning from what goes right as well as from what can go wrong. This

consider how the system as a whole can inform the development of modern safety management methods such as barrier management.

Infrastructure

Q14: Do you agree with these proposals?

Nursing staff are the biggest proportion of the health and care workforce. Recent research has revealed that risk-adjusted hospital mortality rates for common surgeries differed across hospitals, and each increase of one patient in the patient-to-nurse ratio correlated with a 7% increase in mortality.[xi] Without the right numbers of qualified nurses in the right place to care for patients at the right time, there is a detrimental impact on patient care. It is important for

Drawing on the expertise of clinical staff, patients and carers, professional organisations and trade unions, is crucial to enhancing patient safety, and getting health care recognised as a safety critical industry. Ergonomists are able to provide analysis and support on redesigning health and care to ensure that the environment and systems are working to mitigate harm, rather than just avoid it. We would recommend that the strategy draws on ergonomist experts for support.

Q23: Would you suggest anything different or do you have anything to add?

Achieving an increase in patient safety also requires increasing the safety and support of nursing staff while they are on shift. The environment in which nursing staff and other health care professionals work needs a central focus in the patient safety agenda, both in terms of culture and prevalence of bullying and to understand the systemic common errors which may lead to incidents occurring.

Meeting the welfare needs of staff while on shift is paramount to creating a safety focussed culture. Staff while at work must be facilitated to have food, drink and rest breaks so that they are kept hydrated and well.

with single pathologies. The strategy does not effectively take into account or address the need to balance the risk and benefits of interventions in the context of people who have co-morbidities and complex needs. A person with co-morbidities may be assessed by many different health care professionals, and their care package will require input from the multidisciplinary team. It is important for this team to work together to identify and mitigate any safety risks that may occur to their patient across the care pathway. Taking a different approach, one that is more holistic which reflects on patient safety before designing and delivering care will mitigate any risks early. It will also encourage health care staff to create a just safety culture within their teams, and support them to speak up and raise concerns in a timely and effective manner.

Q24: What are the most effective improvement approaches and delivery models?

A simple Plan Do Study Act approach is one way that could be explored to help staff test, implement and adopt changes to service delivery without it being overly burdensome. Easy to follow guidelines and processes could be in introduced to provide the necessary checks and balances within daily clinical practice to pre-empt human error and avoid any confusion and lead to better patient outcomes.

A case study included in a review by NHS England - *Human Factors in Healthcare*

Patient safety collaborative programmes are a helpful way to embed a just culture, and if evaluated, can provide useful future learning, and knowledge sharing.

Q26: How should we achieve sustainability and define success?

Understanding and measuring outcomes following the introduction of proposals will be crucial to review how the learning and culture on patient safety has improved care delivery. Measuring outcomes must not simply focus on the reduction of harm, but should also include evaluation as to whether there has been increased reporting. Increases in reporting are positive because it suggests that health care staff have more confidence from staff willing to identify incidents or near misses, which supports continuous improvement for patient safety.

References

[i] Baron, M.M. & Pate-Cornell, M.E. (1999) *Designing risk-management strategies for critical engineering systems IEEE Transactions on Engineering Management*, 46(1) 87-100. Available here: http://fionasaunders.co.uk/safety-critical-industries-definitions-tensions-and-