NHS Improvement

Our approach to patient safety

NHS Improvement's focus in 2017/18

October 2017

collaboration trust respect innovation courage compassion

We support providers to give patients safe, high quality, compassionate care within local health systems that are financially sustainable.

Contents

1. Summary

1.1. We define patient safety as the avoidance of unintended or unexpected harm to people during the provision of healthcare. We view patient safety as a core component of quality in healthcare, alongside clinical effectiveness and patient experience.

1.2. This guide explains our role across the whole system to help the NHS in England to become the safest healthcare organisation in the world. It describes NHS Improvement's statutory duties in relation to patient safety and what we are doing to meet our strategic patient safety duties. It also summarises our work in 2017/18 to support the NHS to achieve specific system wide safety priorities in relation to:

- maternal and neonatal safety

- antimicrobial resistance and infection prevention and control

- learning from deaths and improving investigations

- medication safety.

2. About us

2.1. NHS Improvement supports NHS trusts and NHS foundation trusts (collectively referred to as NHS trusts in this document) to give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable.

2.2. The national patient safety team, which sits in NHS Improvement's medical directorate, is legally responsible for delivering two statutory patient safety duties across the NHS:

- collecting information about what goes wrong in healthcare, in part by using the National Reporting and Learning System (NRLS) which we are responsible for managing
- using that information to provide advice and guidance "for the purposes of maintaining and improving the safety of the services provided by the health service" (Health and Social Care Act 2012, part 1, section 23, clause 13R).

2.3. Our remit for patient safety extends beyond hospital trusts to all areas of NHS-funded care in England – in short, wherever people use NHS care and whatever their diagnosis.

2.4. While the national patient safety team is legally responsible for delivering the above statutory patient safety duties across the NHS as well as for shaping our wider patient safety remit, improving patient safety is the responsibility of everyone at NHS Improvement. Across the organisation, teams are engaged in vital patient safety improvement work.

3. Our ambition

3.1. Our ambition is for the NHS to be the safest healthcare system in the world. We will achieve this by enabling and encouraging the NHS to become devoted to continuous learning and improvement in its efforts to reduce the risk of harm to people while they use healthcare.

3.2. In practice this looks like:

- an NHS that openly and transparently identifies and acts on risks to patients

- an NHS that demonstrates a just culture, where the whole system works to reduce the chance patient safety incidents occur, individuals are not inappropriately blamed and there is candour with patients and families when things go wrong

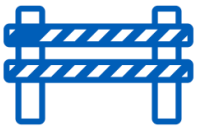
- an NHS where staff, patients and families are empowered to identify where change is needed and are supported to act, and which also recognises where co-ordinated and systemic action is needed.

4. Our role and how we work

4.1. NHS Improvement has a leadership role for patient safety across the NHS, working in partnership with others at local, regional and national levels to improve the safety of care. Below this broad description of our role we have three strategic aims for the safety work that we do:

- We lead a range of initiatives and operate systems to gain a better understanding of what goes wrong in healthcare.

- We lead and support programmes to enhance the capability and capacity of the system to improve safety.



- We lead and support work with others to tackle the underlying barriers to safety improvement in the NHS.

4.2. At a national level, we co-ordinate policy, collate and synthesise information, provide clinical advice on particular patient safety issues, support improvement initiatives and encourage colleagues to build patient safety considerations into all national initiatives.

4.3. Our medical directorate, where the national patient safety team is based, and our nursing directorate play a critical role in providing professional leadership and clinical advice to the NHS, as well as leading on specific patient safety initiatives.

4.4. Our improvement directorate is working to increase capability and capacity in leadership and in quality improvement – both identified in *A promise to learn, a commitment to act* (Don Berwick's report of 2013) as vital for improving safety.

4.5. Our operational productivity directorate supports safety and wider quality improvement by leading work to tackle unwarranted variation in processes, outcomes and costs. The Model Hospital and Getting it Right First Time (GIRFT) programmes are fundamental to this approach.

4.6. Our regional teams form lasting and productive relationships with trusts, supporting them to implement safety and quality improvement initiatives, to assure the quality of care in their organisations and to increase their capacity to learn from incidents. We have four regional teams: London, the North, Midlands and East, and South of England. These are geographically co-terminous with NHS England's regional teams, enabling them to work together.

4.7. All of the patient safety work that NHS Improvement does is in partnership with others – at a national level with other arm's length bodies (such as NHS England, Public Health England – PHE, Care Quality Commission – CQC, NHS Digital and Health Education England – HEE), and with the royal colleges, other professional associations, patients' organisations and frontline NHS providers. We are supporting NHS England with its work programme to improve identification and treatment of sepsis. We will also be supporting CQC to undertake a Secretary of State commissioned thematic review aimed at gaining a better understanding of what can be done to prevent the occurrence of Never Events.

4.8. We value the contribution of patients and families. The patient safety team has a network of patient and public representatives who add insight and value to our work in a number of ways. For example, patient representatives are members of our national patient safety response advisory panel, which considers potential issues arising from emerging data and advises on the development of new patient safety alerts. Representatives are also working with us on a project to explore issues in how safety critical information is communicated in the NHS and how this could be improved.

5. Patient safety in the NHS – where are we now?

5.1. Don Berwick's 2013 report *A promise to learn, a commitment to act* continues to inform our approach to improving patient safety and the quality of care provided by the NHS.

5.2. Four years on, many of the challenges identified in this report remain. In particular, the NHS is not learning as well as it could do when things go wrong, meaning that mistakes are repeated and opportunities to put in place effective systemic barriers to error are missed. Also, more needs to be done to develop the kind of leadership and culture across the whole of the NHS where everyone feels empowered to speak out about safety concerns and where patients and families are always included as full partners in care.

5.3. However, there is also reason to be positive:

- The bravery of families who have spoken out following the death of a loved one in relation to their search for the truth about problems in care is leading to a change in culture and prompting new policy requirements such as Duty of Candour and Learning from Deaths.
- The number of patient safety incidents recorded in our NRLS – from all sectors – continues to rise, indicating that at a local level staff understand the importance of identifying incidents when they occur and recording them to aid learning.
- The UK was ranked first overall in the Commonwealth Fund 2017 review of healthcare in the world's 11 wealthiest countries (achieving first place in nine of the 12 categories, including safe care, effective care and patient-centred care).
- Important areas where the NHS has made particular progress over the last decade include:

- levels of methicillin-resistant *Staphylococcus aureus* (MRSA) and *Clostridium difficile* infections remain at a historical low[1]

- better prevention of venous thromboembolism has saved hundreds of lives[2]

- new devices have been introduced that prevent dangerous medications accidentally being administered by the wrong route[3]

- antimicrobial prescribing has significantly reduced in the last few years, particularly in primary care, to reduce the risk of emergence of antimicrobial resistance[4]

- concentrated potassium solutions have been removed from wards to reduce the risk of accidental administration[5]

- acute kidney injury is better detected following an awareness campaign[6]

- error-prone and confusing designs of syringe drivers that resulted in fatal opioid overdoses or uncontrolled pain in terminal care are no longer used[7]

- we have ensured all hospitals can safely lift patients who have fractures from falls, using equipment equal in safety and comfort to that used by ambulance services[8]

[1] http://www.content.digital.nhs.uk/catalogue/PUB23383; https://www.gov.uk/government/collections/healthcare-associated-infections-hcai-guidance-data-and-analysis
[2] http://www.content.digital.nhs.uk/catalogue/PUB23383
[3] https://improvement.nhs.uk/resources/small-bore-connectors-safety-introduction/, https://improvement.nhs.uk/news-alerts/resources-support-safe-transition-luer-connector-nrfit-intrathecal-and-epidural-procedures-and-delivery-regional-blocks/ https://improvement.nhs.uk/news-alerts/managing-risks-during-transition-period-new-iso-connectors-medical-devices/
[4] https://www.gov.uk/government/publications/english-surveillance-programme-antimicrobial-utilisation-and-resistance-espaur-report, https://fingertips.phe.org.uk/profile/amr-local-indicators
[5] http://www.nrls.npsa.nhs.uk/resources/?entryid45=59882
[6] https://www.thinkkidneys.nhs.uk/, https://improvement.nhs.uk/news-alerts/standardising-early-identification-acute-kidney-injury/, https://improvement.nhs.uk/news-alerts/resources-support-care-patients-acute-kidney-injury/
[7] http://www.nrls.npsa.nhs.uk/alerts/?entryid45=92908
[8] http://www.npsa.nhs.uk/corporate/news/essential-care-after-an-inpatient-fall/

- suicide by people in mental health inpatient care has decreased by over 60%[9]

- the risk of postoperative complications has significantly decreased through implementation of the World Health Organization (WHO) surgical safety checklist.[10]

We recognise these and many more advances are the result of the tremendous efforts of everyone in the NHS in supporting and encouraging a culture of continuous improvement in patient safety.

[9] http://research.bmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/nci/reports/2016-report.pdf
[10] https://www.ncbi.nlm.nih.gov/pubmed/25775063

6. Supporting the NHS with system-wide patient safety priorities

6.1. In this section we describe our work in 2017/18 to support the NHS with specific system-wide patient safety priorities.

Maternal and neonatal safety

6.2. The Department of Health (DH) has committed to halve the number of maternal deaths, stillbirths, neonatal deaths and brain injuries that occur during or soon after birth by 2030, with an interim target of reducing these by 20% by 2020. Recent reports (such as Better Births, the Morecambe Bay Investigation Report, Royal College of Obstetricians and Gynaecologists' Each Baby Counts, the MBRRACE Perinatal Mortality Surveillance Report and NHS Resolution's Five years of cerebral palsy claims) demonstrate that the NHS has more to do to be the best internationally in relation to outcomes for mothers and babies and in how it learns and improves maternity and neonatal care.

6.3. To deliver on this ambition, NHS Improvement has launched the national Maternal and Neonatal Safety Collaborative to support the aims of the Better Births maternity review (2016) and the Maternity Transformation Programme. In this three-year quality improvement programme we are working with all trusts and independent providers in England offering maternity services to make measurable improvements in outcomes for women and their babies by exchanging ideas and best practice.

Antimicrobial resistance and infection prevention and control

6.4. The last decade saw real achievements with MRSA and *C. difficile*. The next challenge, set in 2016 by the then Prime Minister David Cameron, is to reverse the growing number of Gram-negative bloodstream infections

(GNBSI) in England, to protect patients and limit the need for antibiotics, thus reducing the risk of antimicrobial resistance emerging.

6.5. The NHS has been set the objective of reducing healthcare-associated GNBSI and inappropriate antimicrobial prescribing by 50% by 2020/21. NHS Improvement has been charged with leading the reduction in GNBSI and our Executive Director of Nursing is the National Infection Prevention and Control lead. Our focus for 2017/18 is achieving a 10% reduction in *Escherichia coli* bloodstream infections.

6.6. Our antimicrobial resistance project has already had a significant impact in supporting the use of data and of levers available through the commissioning process to reverse rising trends in antibiotic use in the NHS. We are now redoubling our efforts under the leadership of the Chief Pharmaceutical Officer and Chief Scientific Officer, focusing on achieving further reductions in inappropriate antimicrobial use and improved use of diagnostics to target prescribing effectively.

Learning from Deaths and improving investigations

6.7. In December 2016, CQC published its report on the way NHS trusts in England review and investigate the deaths of patients – work requested by the Secretary of State. In its investigation, CQC identified concerns relating to how bereaved families are treated, how deaths are reviewed, and how reviews and investigations are used to improve the quality of care.

6.8. In its report, CQC made a number of recommendations about how approaches to learning from deaths could be standardised across the NHS. These were accepted by the Secretary of State who asked the National Quality Board (NQB)[11] to produce a new framework for the NHS.

6.9. The Learning from Deaths national guidance was published in March 2017 by NQB and is a significant step towards addressing the concerns identified by CQC in its report.

6.10. NHS Improvement is leading work to support NHS trusts to implement the new guidance. We are focusing on supporting trust boards including non-

[11] NQB is made up of the Department of Health, NHS Improvement, NHS England, CQC, PHE, National Institute for Health and Care Excellence – NICE and HEE.

executive directors to understand the new requirements and to ensure these are implemented effectively in their organisations. We have developed new resources such as our information pack for boards and template policies, and we are encouraging trusts to share their learning and practice with each other via case studies and events.

6.11. Recognising the importance of improving the standard and consistency of reviews of deaths, we have commissioned the Royal College of Physicians, through the Healthcare Quality Improvement Partnership (HQIP) to offer training to representatives from every trust in structured judgement review methodology.

6.12. The Serious Incident Framework explains that NHS Serious Incident (SI) investigations are designed to allow the NHS to learn what has gone wrong and why, and from this to make changes to the way care is delivered and so reduce the risk of things going wrong in the future. However, recent reports demonstrate that SI investigation in the NHS varies in quality and generally is done poorly.

6.13. We have committed to review and revise the SI framework in 2017/18 in light of the recent CQC report into the way NHS trusts review and investigate the deaths of patients and government's response to this. As a priority we must understand what changes we can make to the SI framework that will improve how the system learns from things that go wrong.

6.14. The creation of the Healthcare Safety Investigation Branch (HSIB) provides an opportunity to clarify the standards we expect investigations in the NHS to meet and to improve the ability of the NHS to deliver effective investigations. In 2017/18, we are working with HSIB to set out what good looks like, and to ensure that we focus on what matters: making intelligent changes to healthcare provision to reduce risks to patients.

Medication safety

6.15. We are working with DH and NHS England to support the launch of a new medication safety initiative that will link with WHO's new Global Patient Safety Challenge – 'Medication without Harm'. We are supporting a targeted

approach to reduce hospital admissions resulting from use of specific high-risk medicines in defined populations.

6.16. Delivering this work involves a number of actions:

- development of specific measures to assess the impact of key initiatives introduced to reduce medication-related harm; the emerging capacity to link prescribing data with hospital admission data gives these measures the potential to be a world first
- supporting DH to commission work to examine the scale of mortality, serious harm and cost of harm from medication error
- based on this work and other analysis, agreeing the scope of a wider programme to improve medication safety.

7. Our work in 2017/18 to support patient safety improvements across the NHS

7.1. Alongside our work to support the NHS with system-wide patient safety priorities, we have a wider programme to embed patient safety improvement throughout the NHS. Our main projects on this in 2017/18, as well as our business as usual activities, are described in the three sections below.

Gaining a better understanding of what goes wrong in healthcare

Delivering our statutory patient safety functions

7.2. The national patient safety team in NHS Improvement is legally responsible for delivering two statutory patient safety duties across the NHS:

- collecting information about what goes wrong in healthcare, in part by using the NRLS, which we are responsible for managing
- using that information to provide advice and guidance "for the purposes of maintaining and improving the safety of the services provided by the health service".

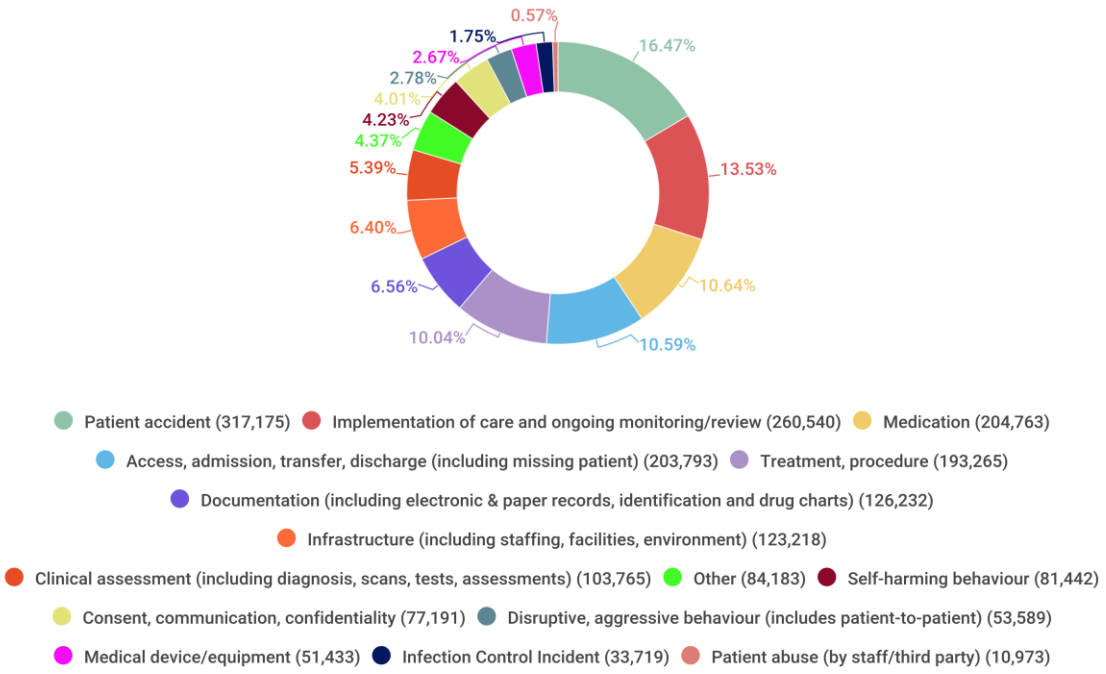
7.3. We use the insight and knowledge gained through routinely analysing this information to support safety improvement work across the system.

7.4. Over two million records of patient safety incidents are reported to the NRLS each year. NHS Improvement reports the number and type of incidents monthly.

7.5. Figure 1 below shows the proportions of the different types of incidents reported to us in 2016/17.

Figure 1: Incidents reported to the NRLS in England, April 2016 to March 2017

By incident type



By degree of harm

Total incidents reported: 1,925,281

7.6. All incidents recorded as having resulted in severe harm or death are individually clinically reviewed. Our team reviews around 300 incidents a week. Some of these incidents – about five a week – describe risks that may be under-recognised or new.

7.7. A multidisciplinary clinical group explores each of these potentially unusual incidents to assess what action may be needed. On average each week we conclude that one or two need to be explored further. We more thoroughly review each of them by searching the NRLS database for incidents related to the issue under review and reported as leading to no, low or moderate harm, to better understand the problem(s). The findings of these reviews inform what we do next.

Developing and issuing patient safety alerts

7.8. For around 12 risks a year, we think the best response is to publish and disseminate a Patient Safety Alert. These alerts are drafted and agreed in partnership with our Response Advisory Panel, which is made up of experts from professional bodies, regulators, clinicians, patients and the public.

7.9. Approved alerts are sent to all relevant parts of the NHS through the Central Alerting System. Healthcare providers are required to share the information with relevant teams in their organisations and to put any necessary actions into practice.

7.10. We issue three types of alert:

- **Warning alerts** are issued to share information on a risk that may be under-recognised and where healthcare providers could take action to reduce the risk of harm. These ask healthcare providers to agree and co-ordinate an action plan, rather than simply distributing the alerts to frontline staff.

- **Resource alerts** are issued to ensure healthcare providers are aware of any substantial new resources – typically guidance or toolkits – that can help improve patient safety. We ask healthcare providers to plan their implementation in a way that ensures sustainable improvement.

- **Directive alerts** are typically issued where one or more specific actions to reduce harm have been developed and tested to the point where they can be universally adopted, or where improvement to patient safety relies on standardisation (of practice or equipment, for example, across providers) by a set date.

7.11. These three types of alerts balance the unique ability of a national reporting and learning system to recognise new risks that are not apparent locally, with recognition that the complexity of more enduring and well-known risks requires new resources or specific actions to resolve them.

7.12. So far in 2017/18, we have issued four alerts:

- *Risk of death and severe harm from ingestion of superabsorbent polymer gel granules*
- *Supporting the safety of girls and women being treated with valproate*
- *Resources to support safe transition to NRFit for intrathecal and epidural procedures, and regional blocks*
- *Risk of severe harm and death from infusing total parenteral nutrition too rapidly in babies*

Figure 2 below shows a dashboard of all alerts issued since the National Patient Safety Alerting System (NaPSAS) was launched in 2013 to September 2017.

Figure 2: Dashboard of alerts issued 2013 to September 2017

7.13. For most of the risks we review in more detail, we conclude that an alert is not the best response. Instead we look to work with professional bodies, other regulators and industry to target advice at specialist clinical groups or to ensure those best placed to take action do so.

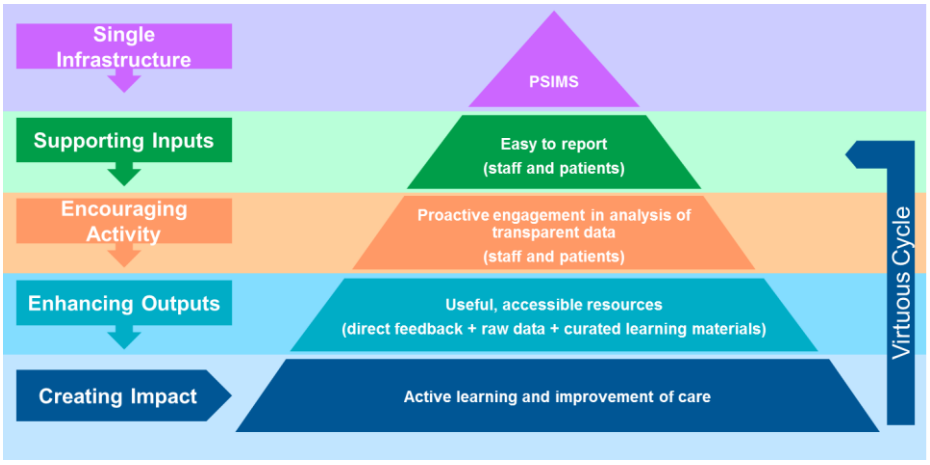
7.14. We have recently published the first in a new series of reports about how we have responded to specific patient safety concerns that do not meet the criteria for an alert.

Developing a new patient safety incident management system

7.15. In 2017/18, we are continuing our work to develop a new patient safety incident management system (PSIMS) to replace the NRLS, which was launched in 2003. This must work well for all those working in healthcare settings who record patient safety incidents. It must give them feedback and support them to share information about things that have gone wrong, minimally disrupt the care they give to patients and assure them that good use will be made of what they tell us. It must also be a source not just of data, but of intelligence and insight about why things go wrong, to inform what actions need to be taken to improve the way care is commissioned and delivered.

7.16. These aims require a rethink of the way we collect information about safety incidents, and use of the technological advances since the NRLS was first built. Figure 3 below summarises our strategic ambition: to rationalise the infrastructure and simplify the data captured, raising its quality and the level of standardisation to allow more fruitful analysis and better feedback of insight – a proactive learning system.

Figure 3: PSIMS strategic ambition



Enhancing the capability and capacity of the system to improve safety

Developing People, Improving Care: The National Improvement and Leadership Framework

7.17. Well-documented reviews and enquiries call for an improved culture in the NHS; the *Five Year Forward View* states that achieving quality requires a "caring culture, professional commitment and strong leadership".

7.18. *Developing People, Improving Care* seeks to build improvement capability in providers and commissioners of services. Following its publication in December 2016, work is underway to design, implement and evaluate activities identified in the framework at national, regional and local levels. NHS Improvement is leading on the following:

- developing programmes for boards and executive teams of provider and commissioning organisations on leading for improvement
- developing guidance for providers on the training required to embed quality improvement capability in their organisations
- identifying the current regional training and support infrastructure in relation to improvement, providing guidance on building organisational and systems improvement capability, and working with improvement organisations to offer regional support.

7.19. We have created an Improvement Hub on our website – a central repository of best practice guides, case studies, resources, data, videos and improvement stories. Spread and scale up is one of the biggest challenges in improvement: this new interactive platform makes this easier for everyone.

7.20. We are working with the King's Fund to produce resources to help NHS providers develop cultures that enable and sustain safe, high quality, compassionate care. Phase 1 'Discover' was launched in 2016, followed by phase 2 'Design' in September 2017.

Patient Safety Collaboratives

7.21. The Patient Safety Collaboratives (PSCs) programme supports organisations to work together to tackle locally identified safety priorities using recognised improvement techniques. Delivered through each of the 15 Academic Health Science Networks (AHSNs), the PSCs are working with local providers, commissioners, patients and others to identify and make progress on what matters to them. The PSCs share their learning with other parts of the country where multiple areas are working on the same priority through cluster groups.

7.22. NHS Improvement has recently commissioned a new Patient Safety Measurement Unit which is supporting individual PSCs to improve how they measure safety improvement and support the spread of capability, as well as helping to evaluate the impact of the programme.

The Q Initiative

7.23. Where the PSCs support organisations, the Q initiative helps individuals to do improvement work and in turn benefit their organisations. Led by the Health Foundation and co-funded by NHS Improvement, Q creates opportunities for people working in health and care across the UK to come together and form a community – sharing ideas, enhancing skills and collaborating to make health and care better.

NHS partnership with Virginia Mason

7.24. The NHS partnership with the Virginia Mason Institute is a five-year programme in which five trusts are being supported to create a sustainable culture of continuous improvement that puts the patient first. This includes a range of training, coaching and mentoring in lean techniques and access to licensed materials.

7.25. Improving quality and safety is central to the programme. Trusts target early improvement work in several key safety areas, including sepsis, patient safety incidents and the management of diarrhoea. Early results are encouraging and there is the opportunity to share what is being learnt more widely.

Tackling the underlying barriers to safety improvement

Developing the patient safety operating model

7.26. Working with our expert stakeholder group, the national patient safety team is devising a new operating model to tackle some of our priority patient safety concerns. The model focuses on those safety topics that are unsuited to being addressed by a Patient Safety Alert – potentially because they are already well-recognised or the potential actions to reduce risk are not clear-cut or are complex to implement.

7.27. The model is designed to support identification, prioritisation and scoping of topics and then the creation of time-limited 'task and finish' style delivery groups, made up of relevant stakeholder experts. These delivery groups will be charged with making progress and delivering specific products in relation to the topic in question. As there will be a limit to the number of potential issues we can consider, robust prioritisation is necessary.

7.28. We are trialling this model over 2017/18. If it proves successful it will become a key part of our core activity.

7.29. One of the first areas this model is looking at is the communication of safety critical information – be that from clinician to clinician or between clinician and patient. Too often a breakdown in communication contributes to patient harm. We will use our new operating model to explore why communication breaks down and what can be done to prevent this having an adverse impact on patients.

Seven day services

7.30. NHS Improvement is supporting the implementation of priority seven day clinical standards in hospitals to ensure all patients, particularly those with urgent and emergency care needs, have access to the same level of consultant assessment and review, diagnostic tests and consultant-led interventions every day of the week by 2020. We expect the implementation of the standards to improve patient experience and patient safety, help hospitals manage demand through better patient flow and efficiency, and enhance standards of clinical supervision at weekends.

Safe staffing

7.31. Ensuring the right numbers of appropriately skilled staff are caring for patients at all times is an important system-wide issue. Together with our national partners and based on NQB's staffing expectations, NHS Improvement is leading the national programme to support providers of NHS services to deliver the right staff, with the right skills, in the right place at the right time.

7.32. We are developing resources to assist providers in the different care settings. So far, we have published the following resources for engagement: acute adult inpatient, district nursing, learning disability services, mental health services and maternity services. The development of each has been independently led by setting-specific experts with national oversight and support from NHS Improvement.

Dealing with the pressures on the system

7.33. A hugely important concern is the well-publicised and unprecedented pressure on activity in the NHS, particularly on the emergency care pathway. We know many of the causes, particularly the increased time spent in emergency departments (EDs) as a result of changing case mix. Hospitals and whole systems need to continuously adapt and improve how they operate to meet patient needs and to maintain safety.

7.34. We are collating examples of good practice and advice from professional groups to show the types of action trusts can take to support both staff and patients. We are also working with trusts to assess levels of risk, understand what mitigating actions are already being taken, provide support and challenge based on known best practice, and liaise with system leaders to effect actions that support emergency care.

7.35. We are providing organisations with practical tools to support these actions. These include:

- tools for audit of patient care in EDs
- a safety matrix to measure the risk in EDs
- safe care prompts to improve care for patients delayed in EDs

- a 12-hour breach assurance tool
- a full capacity protocol
- an emergency flow improvement tool.

7.36. We are also encouraging organisations already measuring their performance to monitor their effectiveness and identify learning for the emergency system as a whole.

8. Conclusion

8.1. This guide explains what NHS Improvement is doing in 2017/18 to improve patient safety in the NHS and specifically how we are supporting the NHS to achieve the Secretary of State's ambitions for a safer NHS for all.

8.2. However, we know that achieving our ambition for the NHS to be the safest healthcare system in the world will require sustained effort and focus over the longer term. To realise this, the NHS will need to become truly devoted to continuous learning and improvement – characterised by a safety culture, a just culture and above all a patient-centred culture.

8.3. NHS Improvement is committed to working in partnership with others to support the NHS to achieve this. There is still much to do, but we must and we are making progress.

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