**Part of a Case for Support for a Research Proposal**

**ALTERNATIVE VERSION**

## A Problem with NHS Hospital Patient Safety Programmes

The problem to be addressed in this proposal is one of too much prescription built on too little evidence. Characteristic of the expanding array of NHS hospital safety programmes is to identify organisational factors that should be in place to promote good practice. Yet there is little empirical basis for the assumption that these specified factors impact positively on health outcomes.

Early NHS policy responses to the growing awareness of patient safety problems identified the need to introduce programmes that aid 'a just culture', build local capacity, and sustain change through performance improvement monitoring (DH 2001, NAO 2005). Since the establishment of the National Patient Safety Agency (NPSA) in 2001, these policy goals have been pursued in England and Wales through the four main hospital safety programmes summarised in Table 1.

Table 1: NHS Hospital Patient Safety Programmes in England and Wales

| Programme | Agency | Participants | Programme Summary |
|---|---|---|---|
| ***Safer Patient Initiative Phase 1*: 2004-2008** | The Health Foundation (£4.3 million) | 4 Trusts, 1 from each nation: Luton & Dunstable, Conwy & Denbighshire, Down Lisburn, & Tayside | 1. Evidence-based interventions in 5 clinical areas.<br>2. Teaching methods for quality improvement<br>3. Executive role development |
| ***Safer Patient Initiative* Phase 2: 2006-2008** | The Health Foundation (£165k per Trust plus support) | 20 Trusts working in pairs including Southmead with Bristol Royal Infirmary | As phase 1 with aim to reduce mortality by >15% & adverse events by > 30% |
| ***1000 Lives*: 2008-2010** | Collaboration including National Leadership and Innovation Agency for Healthcare, Wales Centre for Health, & National Patient Safety Agency | All Welsh NHS trusts & commissioning boards | Evidence-based interventions in 6 'content areas' including: leadership & medicines management. Use of resources including: central support structure, & 'how to' implementation guides. |
| ***Safety First*** | Collaboration under National Patient Safety Forum | English Strategic Health Authorities & National Leadership and Innovation Agency for Healthcare | Formation of Patient Safety Action Teams to support the delivery of the national patient safety agenda by local NHS organisations. |

**Source:** Summarised from Health Foundation 2008

Inspired by safety approaches in other 'high-risk' industries (e.g. airlines) and the work of the US-based Institute of Health Improvement, NHS hospital patient safety programmes aim to improve service reliability by implementing evidence-based clinical practices, and enhancing performance monitoring systems (Sutcliffe and Weick 2001). In each NHS hospital patient safety programme, organisational factors are acknowledged to be 'critical'. However, in contrast to the evidence-base supporting the clinical interventions, relations between organisational factors and the outcomes of hospital patient safety programmes are both under-theorised and under-researched (Shortell et al., 2007; Grol et al., 2008). The prescribed organisational features outlined in Table 2 below are unsupported by any systematic and independent analysis of the relationship between organisational factors and the outcomes of patient safety programmes in NHS hospitals (McKee et al. 2008, Bate et al. 2008, Bates 2008).