patient safety learning

Patient Safety Learning's response to the Patient Safety Specialists consultation

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The NHS Patient Safety Strategy, published in June 2019, sets out three strategic aims around Insight, Involvement and Improvement which will enable it to achieve its safety vision. It defines the Involvement aim as 'equipping patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system'.[1]

A key action associated with this is a proposal to create Patient Safety Specialists within each NHS organisation in England. The strategy explains that 'giving everyone in the NHS a foundation level understanding of patient safety is critical, but we also need experts to lead on safety in their own organisations'.[2] NHS England and NHS Improvement have published draft Patient Safety Specialist requirements for public consultation.

In Patient Safety Learning's report *A Blueprint for Action* we identified the need to professionalise patient safety as one of the six core foundations of safer care.[3] We believe that there are several components required to professionalise patient safety:

- Clear standards for safe care
- Accreditation processes for safe care
- Leadership and governance for safe care
- An agreed competency framework as the basis for education and training
- Evidence-based training for all staff, with continual professional development
- Specialist patient safety and human factors experts

Considering the above we welcome an increase in patient safety capacity and expertise in the NHS and have provided below our feedback on the draft requirements for this specific role.

Implementation

Patient Safety Specialists are expected to provide leadership and support for patient safety in their organisation and it is vital that they have the right mix of knowledge, skills and behaviours to carry this out. We consider that this role needs to be part of a team with the capacity and expertise to ensure there is learning to improve patient safety and that learning leads to action and improvement. One role in isolation just won't be enough to address the scale of avoidable harm.

Considering the implementation of these roles, the draft requirements document notes that 'it should not be necessary to recruit new people unless an organisation wishes to'. While we recognise that in some cases there may be suitable candidates at the organisation already who are in different roles, we have some reservations about how widely this may apply in practice.

Reflecting on the specific Patient Safety Specialist role as envisioned, the best candidate may not be a staff member currently in post. There might be a need to strengthen skills and leadership and a new appointment may need to be made from outside the organisation. It is concerning that the underlying assumption is that any current role holder is the right person. This view disregards the benefits that organisations may gain from having a fresh perspective, rather than a candidate already embedded in existing practices which may require reform.

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[1] NHS England and NHS Improvement, The NHS Patient Safety Strategy: Safer culture, safe systems, safer patients, July 2019. https://improvement.nhs.uk/documents/5472/190708_Patient_Safety_Strategy_for_website_v4.pdf

[2] Ibid.

[3] Patient Safety Learning, The Patient-Safe Future: A Blueprint For Action, 2019. https://s3-eu-west-1.amazonaws.com/ddme-psl/content/A-Blueprint-for-Action-240619.pdf?mtime=20190701143409

We also note that these roles are due to be identified by trusts in June 2020 and are concerned that coupled with this statement in the draft requirements this may lead to organisations making the quickest, rather than the most appropriate, appointment. Appointing an internal candidate offers the prospect of minimising staff costs of a new role and savings in recruitment costs and time. This may make it easier to meet this deadline but runs the risk of appointing an individual with some experience but perhaps not the best qualified candidate.

Accountability and responsibilities

We welcome the statement in the draft requirements that 'the patient safety specialist should be able to influence and have direct access to their executive team, including access at no notice to escalate immediate risks or issues'. We also note that this is listed again in the key relationships section of the document.

We support this principle and believe that if there is to be effective leadership at a Board level for patient safety then leaders need to 'know the risks to safety in their organisations and attend to them'.[4] To deliver this they require the appropriate patient safety knowledge and skills and a clear line of sight of the key issues in the organisation, with the necessary governance frameworks in place to support this.

We believe that there should be a clear and direct reporting line from the Patient Safety Specialist to a named executive director on the Board with an assigned patient safety role and to a non-executive director in a similar role. Having this formal relationship with a senior director would demonstrate organisational commitment to patient safety and provide the Patient Safety Specialist will have the authority and status to lead.

Key relationships

We agree with the key relationships outlined in the draft requirements and further to the roles identified would recommend five additions:

1) **Medical Examiners and coroners** – the new medical examiner system is currently being rolled out across England and Wales.[5] These roles can play a key in sharing insights and learning from deaths in hospitals and helping to identify patient safety concerns. It is important that, where applicable, the organisation's Patient Safety Specialist has a close working relationship with the Medical Examiner. They should also have developed relationships with coroners, especially in relation to supporting inquests and responding to Prevention of Future Deaths reports.

2) **Healthcare Safety and Investigation Branch (HSIB)** – it may have been envisaged that this relationship would come under the heading 'patient safety specialists in other organisations', however we believe that HSIB should be specifically referenced as a key relationship. It's important that they work closely with them when required to as part of investigations and are informed and engaged with their recommendations and latest thinking. This should also apply to its successor, the Health Service Safety Investigations Body, should the current bill passing through parliament become law.[6]

[4] Ibid.
[5] NHS England and NHS Improvement, The national medical examiner system, Last Accessed 10 March 2020. https://improvement.nhs.uk/resources/establishing-medical-examiner-system-nhs/
[6] Gov.uk, Health Service Safety Investigations Bill, Last Accessed 10 March 2020. https://www.gov.uk/government/publications/health-service-safety-investigations-bill--2

3) **Governors and non-executive board members** – this follows on from our statement above regarding accountability and responsibilities and the importance of a clear line of sight on organisation patient safety for these senior roles.

4) **Human Resources (HR) Director** – there is a clear alignment between HR and patient safety which makes this relationship an important one. The HR Director should play a key role in supporting the creation of a patient safety culture in the organisation and ensuring that this is promoted throughout recruitment, training and performance appraisal of all staff. In doing so we would anticipate that they would work closely with the Patient Safety Specialist to do this and in other areas, such as promoting specific patient safety improvement initiatives and ensuring investigations into unsafe care are fair.

5) **NHS Resolution** – we would expect Patient Safety Specialists to develop relationships with colleagues at NHS Resolution, specifically with their Safety and Learning team who review clinical negligence claims data for sources of learning.[7]

Working with patients, families and carers

Now turning to the knowledge and experience required by Patient Safety Specialists set out in the draft requirements, we feel that one area in need of strengthening is how they will work with patients, families and carers.

The draft requirements note that the role holder should have 'knowledge and experience of driving improvement for the safety of patients' and in terms of values and behaviours should demonstrate that they 'involve patients and the public in their work'. We welcome the inclusion of these points; however, we think that there needs to be an explicit reference to having experience of involving patients, families and carers in the requirements for the role.

In *A Blueprint for Action* and on *the hub* we describe how vital it is that patients are effectively engaged for patient safety during the care process, if things go wrong and in the redesign of health and social care using the insight and wisdom from patients. There is clear research evidence that active patient engagement reduces unsafe care. Patients tell us that they are often not engaged properly in their care, instead treated as passive participants in the process.

We need staff and leaders equipped with the right skills to engage with patients, families and carers. For a Patient Safety Specialist to lead on patient safety they must clearly be able to demonstrate that they meet this requirement and can support their organisation to engage effectively in co-production with patients and families.

A willingness to learn or necessary requirement?

The draft requirements contain several areas where it describes the role holder as needing to demonstrate a 'willingness and commitment to develop expertise' where we believe there should be a more specific requirement in place.

[7] NHS Resolution, Safety and Learning, Last Accessed 12 March 2020. https://resolution.nhs.uk/privacy-cookies/safety-and-learning/

Investigations and complaints
Previous reports into investigations by NHS England and NHS Improvement have reflected on the importance of improving these processes.[8] Patient Safety Specialists should play a key role in highlighting the importance of investigations as one of the best sources of learning from patient safety failures and it is important they have a clear understanding of these and best practice. They must have expertise in safety investigations and the experience and resilience to ensure recommendations are acted on using quality improvement methodologies.

We note that in the key relationships section of the draft requirements that the 'PALS and complaints teams' are listed. As with investigations, complaints are an important source of knowledge, but too often existing processes do not enable these to be effectively tapped for patient safety insights. They can also be insensitive and seem adversarial, inflicting further harm on patients and their relatives. We think it is important that there is a direct reference to understanding and learning from complaints processes as part of the requirements for this role.

Just culture and systems thinking
In stating the purpose of this role, the draft requirements note that they will be responsible for overseeing that 'just culture principles are embedded in all patient safety processes'. Given this we feel that Patient Safety Specialists will require expertise from the offset, as opposed to a willingness to develop this.

To lead on this, it is important that they can demonstrate the appropriate behaviours and take charge of designing and implementing just cultures, which would be difficult to do without some experience/prior understanding. They will need an understanding of the importance of psychological safety and how to support staff in raising concerns, shared learning and challenging the status quo, in addition to a broader knowledge of systems thinking.

Human factors
We believe that the need for human factors/ergonomics expertise and training is another area of the Patient Safety Specialist role which should be classed as a requirement for the role holder, rather than an area where they need a willingness to develop such skills.

An understanding of the role and effect of humans in complex systems and the fundamentals of human factors is identified as one of the five key domains of the draft National patient safety syllabus.[9] If, as the draft requirements suggest, Patient Safety Specialists are to lead on embedding this thinking through patient safety processes in their organisation then it is important that they have a strong grasp of this when starting in these roles.

Learning and Development

We note that the draft requirements reference the importance of 'in-depth training in patient safety for specialists' based on the National patient safety syllabus which is currently under the development by Health Education England. The Academy of Medical Royal Colleges,

[8] NHS Improvement, The future of NHS patient safety investigation, March 2018. https://improvement.nhs.uk/documents/2525/The_future_of_NHS_patient_safety_investigations_for_publication_proofed_5.pdf
[9] Academy of Medical Royal Colleges, National patient safety syllabus 1.0, January 2020. https://www.aomrc.org.uk/wp-content/uploads/2020/01/National_Patient_safety_syllabus_v1.0_0120.pdf

who have been commissioned to assist with this, recently held a consultation on the initial draft of this document and our full response in this respect can be found here.[10]

Engaging with frontline staff

One final observation from reviewing the draft requirements document for the Patient Safety Specialist role is the lack of reference to how they will interact and engage with frontline staff at the sharp end of care. Each department in a hospital for example will have its own nuances with staff who have a key impact on safety, ranging from doctors and nurses to cleaners and porters.

Frontline staff often see risks well in advance of the management, but how to they connect into this Patient Safety Specialist role? Is there a need for direct engagement here? In the knowledge and experience required for the role it is stated that 'being a healthcare professional with relevant clinical qualification and registration is desirable but not essential'. While this may be the case, there is clearly a need to ensure that those appointed into Patient Safety Specialist roles have a thorough understanding how healthcare professionals work and the competing priorities they face. Without which, how can they assess and influence organisational and team cultures, encouraging staff speaking up and driving quality improvement implementation?

[10] Patient Safety Learning, Patient Safety Learning's response to the National patient safety syllabus 1.0, February 2020. https://s3-eu-west-1.amazonaws.com/ddme-psl/NationalPatientSafetySyllabus_PSLConsultationSubmission_Issued.pdf?mtime=20200302102700&focal=none