ROYAL PHARMACEUTICAL SOCIETY

Developing a patient safety strategy for the NHS: Proposals for consultation
Royal Pharmaceutical Society response

Q1: Principles

A. Do you agree with these aims and principles? Would you suggest any others?

We agree with the principles and aims of the patient safety strategy. We believe that the three aims, underpinned by the three principles, form a sound basis for the proposed strategy
We suggest that an additional principle should be developed and be focused on exploring workplace pressures and the impact these have on patient safety. Healthcare providers also need support with developing policies and procedures with regard to safe staffing levels.

B. What do you think is inhibiting the development of a just safety culture?

- A lack of awareness of the need to distinguish human error from at-risk, or reckless behaviour and treating both the same
- Historical cultural barriers as well as policies within organisations which were based on punishment of human error
- Fear of authority such as the regulator or employing organisation

Sometimes culture takes a backseat in relation to metrics and targets on specific issues. Team and organisational culture needs to be seen as important and measures put in place to recognise unsafe cultures for example via trainee or anonymised employee surveys. The results from the surveys can highlight areas of concern whilst protecting those completing the survey, especially if a particular area receives a number of responses. Any surveys undertaken must ensure that the individual cannot be identified to ensure honesty and transparency.

C. Are you aware of A just culture guide?

Yes, we are aware of this document and it is a valuable practical guide to inform consistent, constructive and fair evaluation of the actions of staff involved in patient safety incidents. However, we do not believe that all of our members are aware of this guide.

D. What could be done to help further develop a just culture?

The first step, within an organisation, is to identify the degree of understanding of a just culture, and then to use targeted evidence-based educational approaches to increase knowledge and understanding of the principles and the application of these principles.

Success measures and progress indicators for safety would be valuable so that teams and organisations can monitor whether they are on the right track.

Employers need to ensure they have systems and processes in place for employees to raise concerns in relation to patient safety and that their staff are encouraged to use them. In addition, results from cases where whistleblowing has resulted in a change in practice, without the whistleblower being penalised, need to be publicised. Currently we are more aware of cases where whistleblowing has had deleterious effects on an individual's working life.

E. What more should be done to support openness and transparency?
Having a consistent, overarching national strategy will enable staff working in the NHS to know what to expect in terms of raising a concern, what protection they are offered and the processes around this. However, this must guarantee confidentiality for staff and be a robust strategy. NHS funded organisations such as GP surgeries and community pharmacies have an NHS contract but people working within these organisations are not directly employed by the NHS. We believe that any organisation providing NHS services to patients should practice to the same standard. Clarity is required as to whether the proposals around a universal safety curriculum for all staff extend to those providing NHS-funded care or does this only impact NHS staff who are directly employed by the NHS.

Staff could be provided with training in ways of raising concerns as well as having systems in place that empower them and give them the confidence to do so.

F. How can we further support continuous safety improvement?
By ensuring a better understanding in NHS organisations of the fact that

- Patient safety is improved in organisations which have a fair blame culture and encourage reporting of events and near misses whenever they occur
- And that doing so is an integral component of the professional responsibilities of all healthcare professionals

Continuous safety can be encouraged by promoting the good practice that results from developing a safe and just environment in which to practice. The Patient Safety Collaboratives, working within their AHSNs and collaboratively across the country, will have a significant role in continually improving patient safety.

There needs to be greater collaboration across healthcare providers, regulators, royal colleges etc with each having a defined role and responsibility.

Q2: Insight

A. Do you agree with these proposals? Please give the reasons for your answer.
The approach to use multiple sources of data and improved technology to analyse them is one that we support. We particularly welcome the development of a Patient safety Incident Management System to build upon the National Reporting and Learning System and the Strategic Executive Information System. However, unless there is a clear mechanism for driving action to redress concerns then the whole exercise will be meaningless.

B. Would you suggest anything different or is there anything you would add?

Reports from Professional regulators should also be part of the data capture system as there is learning to be had from these as well.

Q3: Infrastructure

A. Do you agree with these proposals? Please give the reasons for your answer.
Yes we agree with the proposals to develop an infrastructure that supports patient safety. We welcome the proposal concerning the cross-system development of a shared, consistent and tailored patient safety curriculum for all current and future NHS staff, and this should include contracted staff. This development should be informed by the excellent WHO multi-professional Patient Safety Curriculum Guide.

We also strongly support the proposal to develop a network of senior patient safety specialists.

B. Would you suggest anything different or would you add anything?
We believe that having a just culture, and an environment to practice in that supports this, will be critical to making this work. It is not just about the people working at the frontline but also about the system that they work within. The strategy must ensure that there is a constant evolution of the strategy in light of new data.

C. Which areas do you think a national patient safety curriculum should cover?
Our top five areas that should be covered are:

- Introduction to patient safety science
- Human factors and ergonomics
- Quality improvement science
- The components of a patient safety culture
- Patient / family / carer engagement

D. How should training be delivered?
Training should be delivered using blended learning techniques such as a mixture of online and face to face training. There should be a particular emphasis on approaches which have been shown to be most effective in clinical situations such as interactive case-based learning, and by applying multi-professional approaches.

The training also needs to be available at times that suit the workforce as different areas of the workforce across the NHS will have different times that suit them. All healthcare professionals should be provided with protected time to undertake learning and training relevant to their role.

E. What skills and knowledge should patient safety specialists have?
The skills and knowledge that patient safety specialists should have are:

- Human factors and ergonomics
- Patient / family / carer engagement
- Systems thinking
- Quality improvement science
- Communication skills

Senior patient safety specialists should be a minimum band 8a or have the equivalent skills and knowledge.

F. How can patient/family/carer involvement in patient safety be increased and improved?
By adopting co-production principles in which patients, family and carers are consulted at all stages and are able to have a meaningful impact on the decisions which are arrived at. There may be differences of opinion but these need to be discussed openly and a decision reached.

In addition, for individual patient safety incidents, all those involved in the incident, including the person affected, need to be involved and kept informed on a regular and timely basis, about progress to make change happen to ensure such an incident is less likely to occur in the future.

G. Where would patient involvement be most impactful?
Patient involvement would be most impactful across the whole system / strategic level, including in health professional training.

It is important that people are listened to when things go wrong whether it has caused harm or nearly caused harm. There should be a variety of patient perspectives included in incident reports and discussions.

H. Would a dedicated patient safety support team be helpful in addition to existing support mechanisms? If yes, how?
In the context it is mentioned in the consultation document, we believe that a patient safety support team would be useful to support those organisations that are struggling with safety. The patient safety support team should have a responsibility for training the wider workforce.

Q4: Initiatives

A. Do you agree with these proposals? Please give the reasons for your answer.
Yes we agree with the proposals and we are pleased to see the medication without harm initiative included in this strategy. However, although the proposals are strong on reporting processes and culture, they are less strong on actual areas and initiatives to improve safety and sustainability. The proposals need to be robust and have drivers to ensure implementation.

B. Would you suggest anything different or do you have anything to add?
There is a need for high quality information (usable, accessible and understandable) across the board. There should be a focus on co-design with patients with thought given to engaging the views of a wide variety of patients, rather than just a vocal minority. All areas of safety improvements will need better information for both patients and staff. Improving standardised systems for developing and disseminating consistent information could have a wide ranging positive impact on patient safety.

C. What are the most effective improvement approaches and delivery models?
The top three most effective approaches are:

- Regional improvement collaboratives
- Programmes based on clinical interventions

- Programmes based on improvement capability and culture

D. Which approaches for adoption and spread are most effective?
The top three approaches are:

- Demonstrating evidence of impact and value
- Local adaptation of processes / approaches
- Conferences and workshops

E. How should we achieve sustainability and define success?
Success could initially be assessed by a reduction in "NEVER" events, and also by measuring reduction in medicine-related harm, one of the most common patient safety issues. The strategy needs to ensure sustainability of patient safety within the NHS. This requires long term commitments and the development of an infrastructure to support the changes made.

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Chair, English Pharmacy Board

About us

The Royal Pharmaceutical Society (RPS) is the professional body for every pharmacist in Great Britain. We are the only body that represents all sectors and specialisms of pharmacy in Great Britain.

The RPS leads and supports the development of the pharmacy profession to deliver excellence of care and service to patients and the public. This includes the advancement of science, practice, education and knowledge in pharmacy and the provision of professional standards and guidance to promote and deliver excellence. In addition, it promotes the profession's policies and views to a range of external stakeholders in a number of different forums.

Its functions and services include:

Leadership, representation and advocacy: Ensuring the expertise of the pharmacist is heard by governments, the media and the public.

Professional development, education and support: helping pharmacists deliver excellent care and also to advance their careers through professional advancement, career advice and guidance on good practice.

Professional networking and publications: hosting and facilitating a series of communication channels to enable pharmacists to discuss areas of common interest, develop and learn.